CITY AND COUNTY OF SAN FRANCISCO

BOARD OF SUPERVISORS

BUDGET AND LEGISLATIVE ANALYST
1390 Market Street, Suite 1150, San Francisco, CA 94102
PHONE (415) 552-9292 FAX (415) 252-0461

Policy Analysis Report

To:	Supervisor Ronen
From:	Budget and Legislative Analyst's Office
Re:	Referrals for Mental Health Services
Date:	May 17, 2022

Summary of Requested Action

Your office requested a report on referrals to mental health services, including the services requested, services authorized, services received, and wait times; and the role of the Office of Coordinated Care in overseeing the collection, analysis, and maintenance of the data necessary to operate and evaluate an effective system of care for adults suffering from mental illness. In consultation with your office, we focused our report on requests for mental health services for unhoused adults with a review of services authorized in calendar years 2020 and 2021.

Executive Summary

- According to the Department of Public Health, 18,529 individuals were identified by the agency as experiencing homelessness in San Francisco in 2021, of whom 3,612 received mental health services through Behavioral Health Services (BHS), representing more than one in five of the department's 16,165 mental health clients that year. While BHS provides both mental health and substance use disorder services, our report focuses on BHS mental health services and clients.

- More than 80 percent of mental health services provided to individuals experiencing homelessness in 2021 were routine services, including outpatient services and case management. However, more than one in three individuals experiencing homelessness who received BHS mental health service in 2021 were treated at least once and some more than once at Psychiatric Emergency Services.

- The Budget and Legislative Analyst's 2018 performance audit of Behavioral Health Services identified the need for increased Intensive Case Management services and treatment beds to reduce wait times for severely mentally ill patients. San Francisco voters approved Proposition C in 2018 to fund services to unhoused individuals, including mental health services, and the Board of Supervisors adopted Mental

Health SF in 2019 to improve access to behavioral health services for people experiencing homelessness, the uninsured, and other vulnerable populations.

- The Office of Coordinated Care was established by Mental Health SF to streamline delivery of mental health and substance use disorder treatment services, including gathering data to prioritize resources in order to reduce wait times. Although implementation of the Office was delayed amid the onset of the pandemic, BHS announced its opening on May 6, 2022 after hiring a director in February 2022 and filling other new positions.

- Wait times and unavailability of placements have continued to be a problem for Intensive Case Management and residential services for individuals with mental illness. In 2021, the median time between referral and placement in Intensive Case Management services was just under three months, and as of March 2022, 150 individuals were on the combined wait list for Intensive Case Management.

- Between July 2021 and December 2021, the average wait time for locked sub-acute treatment was 45 days, and the average wait time for psychiatric skilled nursing facilities was 37 days. The Department was not able to provide wait time data for other levels of care, including Residential Care Facilities, also known as Board and Care facilities.

- Under the Tenderloin Emergency declaration, the Department plans to add 35 civil service case management positions and 22 community-based provider case management position to reduce case management wait times.

- The Department has also presented a plan to add 400 residential beds, of which approximately 145 beds are currently available and approximately 135 additional beds are expected to be available by the end of 2022.

- Behavioral Health Services does not have good data on wait times for Intensive Case Management or residential placement. Efforts to gather data about mental health services are complicated by the use of multiple medical records systems, multiple methods of submitting referrals, and non-digital referral forms, and the lack of a single wait time database. According to DPH staff, the Department is working to make wait time data available prior to its planned transition to a single electronic medical records system in 2024, which will enable unified tracking. The Department is currently also creating a new Utilization Management unit covering Intensive Case Management, mental health residential care, and substance abuse residential treatment in 2023.

Policy Options

To better understand and oversee the Department of Public Health's progress in implementing streamlined processes and systems for authorizing and placing individuals in appropriate mental health services, and in reducing placement wait times, the Board of Supervisors should request the Behavioral Health Services Director to:

- Present an update by December 31, 2022 on progress toward eliminating the wait list for Intensive Case Management and residential placement that includes establishing measurable department goals for wait times; and

- Present an update by December 31, 2022 on (1) planned changes to referral data collection, (2) progress toward combining authorization units into a single Utilization Management unit, (3) planned changes and possible improvements to data collection methods affecting the referral, authorization and placement processes of providing mental health services, and (4) the Department's efforts to improve tracking of wait times for Intensive Case Management and residential services.

Project Staff: Severin Campbell, Amanda Guma, Adam Sege

Budget and Legislative Analyst

Table of Contents

Department of Public Health Mental Health Services

The City and County of San Francisco provides mental health treatment through Behavioral Health Services (BHS), a division of the Department of Public Health (the Department). The largest provider of behavioral health services in the city, BHS serves any resident with behavioral health needs who lacks private health insurance[1]. Services include crisis interventions, outpatient services, Intensive Case Management (ICM), and long-term treatment in a Residential System of Care (RSOC). While this report focuses on mental health services, which the majority of BHS clients receive, the division also provides substance use disorder services to thousands of clients annually[2].

In 2018, a performance audit of BHS published by our office found significant barriers to accessing mental health care. We found that clients could wait two to 10 months for ICM services, and in one month analyzed by the audit team, there were no placement beds available for 35 clients who had been authorized for placement in a locked residential mental health facility. The audit also found gaps in the City's data tracking, including a lack of point-in-time waiting lists, that limited insight into how to best address these problems.

Barriers to timely and high-quality mental health care have a disproportionate impact on San Franciscans experiencing homelessness, who access BHS mental health services at a higher rate than the rest of the city's population. According to Department data, people who had experienced homelessness within the past year accounted for roughly 22 percent of BHS mental health clients in 2021, despite making up just 2 percent of city residents[3]. When the city's most vulnerable residents struggle to obtain sufficient mental health care, that affects San Francisco's emergency response, criminal justice, health care and social service systems, and ultimately every resident.

Mental Health SF

On December 10, 2019, the Board of Supervisors voted unanimously to overhaul the City's approach to behavioral health care and create Mental Health SF, a program designed to improve access to behavioral health services for people experiencing homelessness, the uninsured, and other vulnerable populations.

---

[1] BHS also serves residents who have private insurance, in crisis situations.
[2] BHS served 16,613 mental health clients and 4,628 substance abuse clients in FY 2020-2021. Some clients received both categories of services.
[3] DPH records indicate that 18,529 individuals were known to the Department in 2021 who had experienced homelessness within the past year. The U.S. Census Bureau estimates that 815,201 people live in San Francisco.

The ordinance creating Mental Health SF had five key components:

- **Creating an around-the-clock service center** for patients seeking access to behavioral health services

- **Establishing an Office of Coordinated Care,** responsible for streamlining delivery of care across the entities making up the city's behavioral health systems

- **Creating Street Crisis Response Teams** to connect people experiencing crises on the city's streets with behavioral health services

- **Expanding the city's treatment capacity to reduce wait times,** including acquiring new treatment beds and facilities and hiring more case managers

- **Establishing an Office of Private Health Insurance Accountability**, to advocate for privately insured residents with behavioral health needs[4]

Funding for Mental Health SF

The FY 2021-22 appropriation for Mental Health SF is $55.3 million, funded by Proposition C. The FY 2021-22 and FY 2022-23 appropriation supports Beds and Facilities, tasked with acquiring new mental health and substance use disorder treatment beds, Office of Coordinated Care, the Behavioral Health Access Center/ Mental Health Service Center, and the Street Crisis Response teams, shown in Exhibit 1 below.

Exhibit 1: FY 2021-23 Proposition C Spending Plan for Mental Health SF

	FY 2021-22	FY 2022-23
Sources		
Proposition C	$55,309,513	$59,150,685
Total Sources	**$55,309,513**	**$59,150,685**
Uses		
Beds & Facilities	$29,646,496	$30,564,755
Office of Coordinated Care	9,673,484	9,954,985
Behavioral Health Access Center/ Mental Health Service Center	4,192,020	6,306,684
Street Crisis Response	11,797,513	12,324,261
Total Uses	**$55,309,513**	**$59,150,685**

Source: City Budget System

---

[4] This component of Mental Health SF is not currently active. According to the February 2022 update on implementation from BHS, "Funding for this Office is not currently identified and planning for this component of the legislation will be addressed in the future."

Implementation Status

According to discussion in the January 20, 2022 Government Audit and Oversight Committee, the Board initially hoped DPH would complete the overhaul within two years, but the Covid-19 pandemic has delayed the implementation timeline. As a result, BHS is still implementing key portions of Mental Health SF, while simultaneously trying to meet daily care needs amid a pandemic that has exacerbated mental health challenges, disrupted social services networks and brought new hiring and retention difficulties.

This report first offers **a statistical snapshot** of individuals experiencing homelessness who access mental health services from BHS. It next gives an overview of **Intensive Case Management** and the **Residential System of Care,** two systems of care that Mental Health SF identified as critical to improving public access to health care**,** including updates on **waiting list issues** in each system. It then addresses **gaps in data collection and inefficiencies in the referral process**. Finally, it discussions policy implications and offers **recommendations** for the Board.

This analysis draws on interviews with more than a dozen behavioral health professionals from both the City and community-based organizations. At our request, BHS staff also provided case studies of four individual clients who received referrals to the Residential System of Care in late 2021 and early 2022, to provide context regarding the specific types of challenges encountered in successfully placing clients. Summaries of these case studies can be found in Appendix I to this report. BHS also provided a response to our request for summary statistics related to unhoused mental health clients, as well as answers to numerous questions about the agency's ongoing efforts and future plans.

Mental Health Clients Experiencing Homelessness

Statistics provided by BHS make clear the strong association between homelessness and mental health needs in San Francisco. According to DPH records, the Department identified 18,529 persons experiencing homelessness in 2021 in San Francisco, which the Department defines as individuals who experienced homelessness within the past year[5]. Of these individuals, 3,612 received mental health services through BHS in 2021, representing more than one in five of the department's 16,165 mental health clients that year.

---

[5] DPH tallied all persons experiencing homelessness known to the agency using records from Epic (electronic medical records), Avatar (electronic behavioral health records), the Office of Homelessness and Supportive Housing, and a Covid-19 shelter-in-place, isolation and quarantine bed system developed by the software firm RTZ. The agency uses the Department of Housing and Urban Development's Category 1 (Literally Homeless) definition of homelessness when counting persons experiencing homelessness.

Types of Services

More than one in three clients experiencing homelessness who received BHS services in 2021 were treated at least once at Psychiatric Emergency Services (PES) at Zuckerberg San Francisco General Hospital and Trauma Center. Some of these clients were treated at PES more than once, and people experiencing homelessness accounted for more than 3,300 PES visits. Yet these visits and other urgent care services made up a small fraction of the mental health services that BHS provided to people experiencing homelessness: Most services, more than 80 percent, were routine care. Exhibit 2 below shows the mental health services provided in 2021 to people experiencing homelessness[6].

Exhibit 2: Mental Health Services Provided to Persons Experiencing Homelessness, 2021

Service	Service Type	Number of Visits
MH Outpatient	Routine	37,511
MH Residential Treatment	Routine	34,666
MH Intensive Case Management	Routine	33,537
MH Inpatient	Urgent	13,438
MH Crisis Residential	Urgent	8,336
MH Skilled Nursing Facility*	Routine	6,690
MH Linkage Services	Routine	5,489
MH Institute for Mental Disease	Routine	5,162
MH Crisis Stabilization	Urgent	5,005
MH Residential Care Facility	Routine	1,854
MH OP in Crisis Residential	Urgent	1,825
MH Crisis	Urgent	1,338
MH Wraparound and Other Services	Routine	440
MH OP in Residential	Routine	424
MH Ancillary	Routine	69
MH Linkage Services	Urgent	41
MH Day Treatment in Residential	Routine	< 10
MH Representative Payee*	Urgent	< 10
	Routine Total	125,849
	Urgent Total	29,986
	Grand Total	155,835

* Values are represented as "< 10" when fewer than 10 access services to protect anonymity.
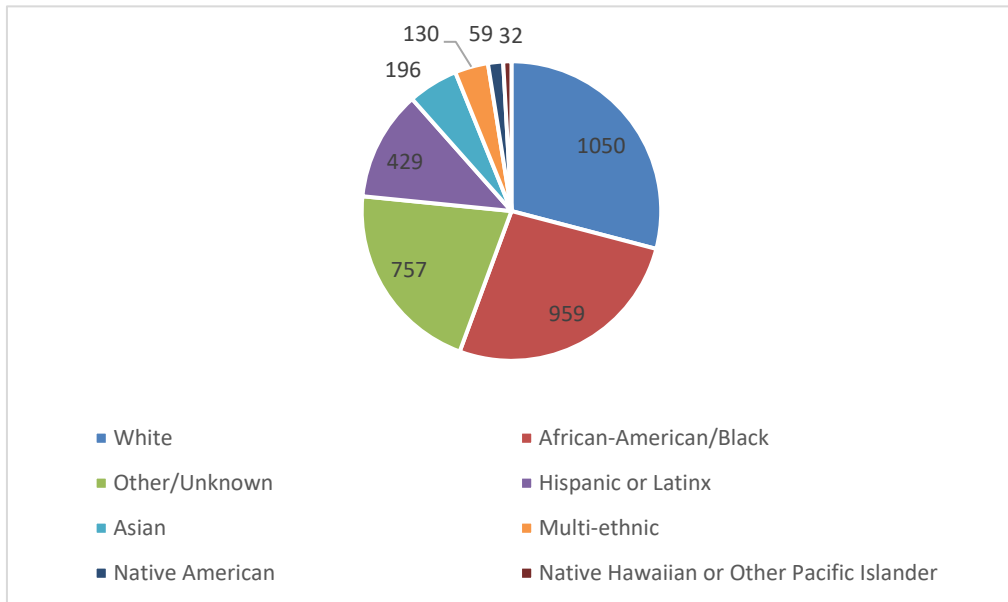
Source: Behavioral Health Services

---

[6] BHS provided data on "outclient" and "inclient" care, though BHS staff also use the words "outpatient" and "inpatient" in other contexts. For clarity and consistency, we will use "outpatient" and "inpatient."

Demographics of BHS Mental Health Clients Experiencing Homelessness in 2021

Race/Ethnicity

White clients comprised the largest race/ethnicity category among people experiencing homelessness who accessed BHS mental health services in 2021, accounting for 1,050 (29 percent) of the total 3,581 clients, followed by Black/African American clients who counted for 959 (27 percent) of the 3,581 total clients. Department records show that 429 clients (12 percent) were Hispanic or Latinx, 196 (5 percent) were Asian, 130 clients (4 percent) were multi-ethnic, 59 clients (2 percent) were Native American, and 32 clients (1 percent) were Native Hawaiian or Other Pacific Islander. For 757 clients (21 percent), Department records indicate race as "unknown" or "other". Exhibit 3 below shows the racial demographics of mental health clients experiencing homelessness.

Exhibit 3: 2021 Mental Health Clients Experiencing Homelessness, by Race/ Ethnicity

Source: Behavioral Health Services

Languages Spoken

Clients who spoke English as a primary language made up the largest language category, accounting for 2,621 (73 percent) of the clients experiencing homelessness who accessed BHS mental health services in 2021. Representing the five threshold languages in San Francisco, department records show that 168 clients (5 percent) spoke Spanish, 36 clients (1 percent) spoke Cantonese, 13 clients (less than 1 percent) spoke Vietnamese, 11 clients spoke Russian (less than 1 percent) and seven clients spoke Mandarin (less than 1 percent). For 756 clients (21 percent),

language was recorded as "Other." Exhibit 4 below shows the language demographics of mental health clients experiencing homelessness.

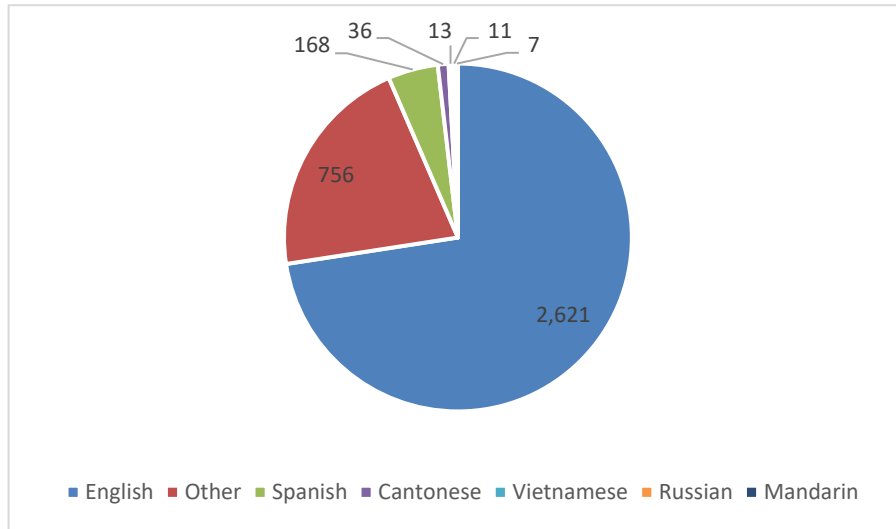**Exhibit 4: 2021 Mental Health Clients Experiencing Homelessness, by Primary Language**

Source: Behavioral Health Services

Gender Identity

Clients who identified as male made up the largest gender category, accounting for 2,358 (65 percent) of the clients experiencing homelessness who accessed BHS mental health services in 2021. Department records show that 1,114 clients (31 percent) identified as female, 86 clients (2 percent) identified as trans female, 38 (1 percent) identified as genderqueer or gender non-binary, and 11 clients (less than 1 percent) identified as trans male. For 5 clients (less than 1 percent), gender was recorded as "Unknown". Exhibit 5 below shows the gender demographics of mental health clients experiencing homelessness.

Exhibit 5: 2021 Mental Health Clients Experiencing Homelessness, by Gender Identity
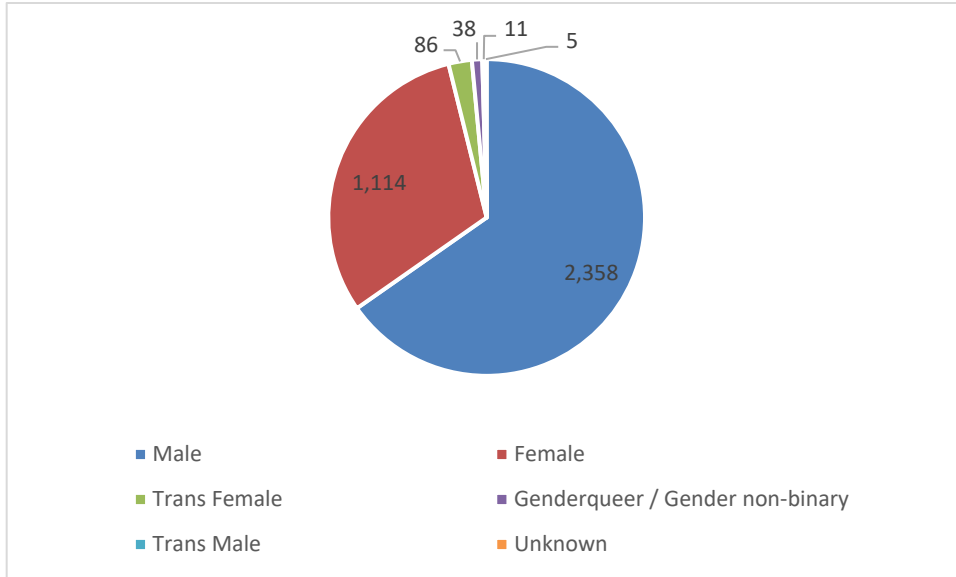

Source: Behavioral Health Services

Age

Clients between the ages of 26 and 59 made up the largest age category, accounting for 2,723 (75 percent) of the clients experiencing homelessness who accessed BHS mental health services in 2021. Department records show that 616 clients (17 percent) were 60 or older, 213 (6 percent) were between the ages of 18 and 25, and 60 clients (2 percent) were under the age of 18. Exhibit 6 below shows the age demographics of mental health clients experiencing homelessness.

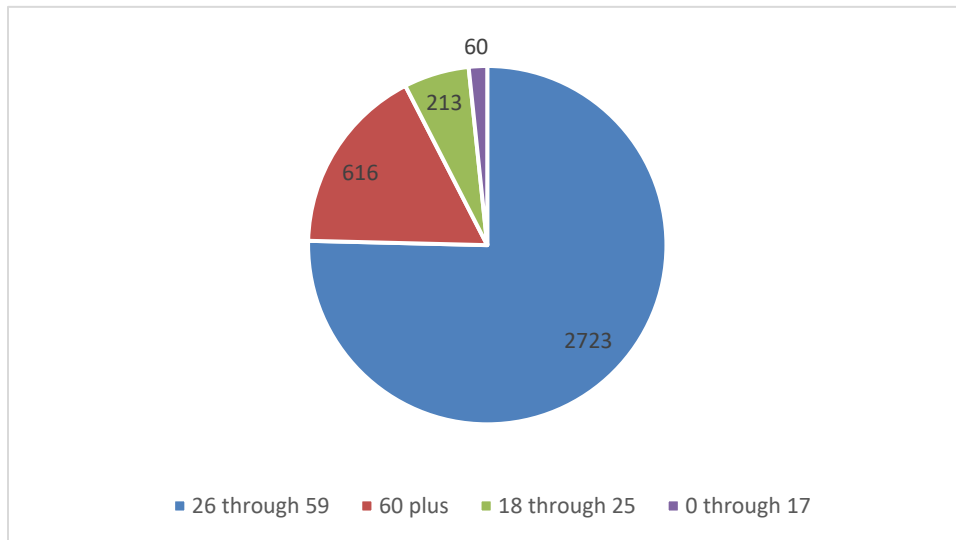**Exhibit 6: 2021 Mental Health Clients Experiencing Homelessness, by Age**

Source: Behavioral Health Services

Intensive Case Management

Overview of Intensive Case Management Services

The City's Intensive Case Management (ICM) system provides outpatient mental health care and wrap-around social services to clients with chronic behavioral health conditions that are severely affecting their health and safety. The system is designed for clients with acute needs that cannot be sufficiently met through traditional, office-based mental health services and that have contributed to homelessness, frequent use of psychiatric emergency services, and/or involvement in the criminal justice system. Intensive case managers typically meet their clients in the community, and they provide counseling and linkage to other social services with the goal of stabilizing clients and supporting them on a path to recovery. Clinics limit intensive case managers' caseloads to allow them to meet frequently with clients, from twice a week to multiple times daily when needed.
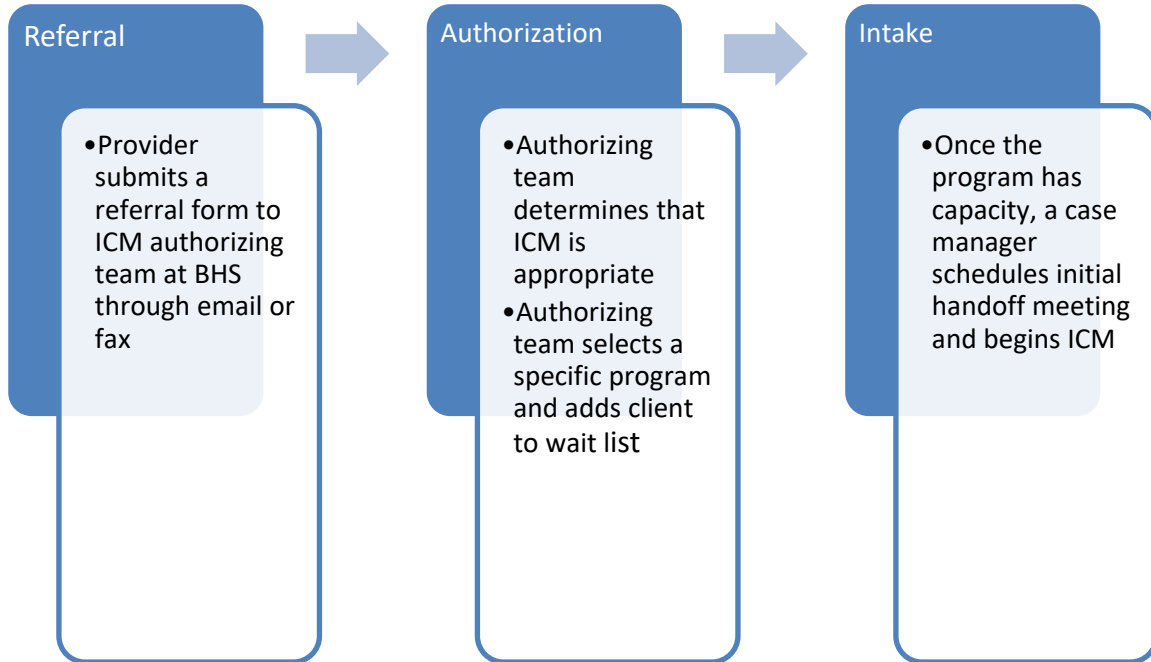
Behavioral Health Services provides funding to 16 programs offering ICM services. These programs vary in size and staffing ratios, and some focus on serving a particular demographic group. Four programs are civil service programs operated by the Department of Public Health, and 12 are operated by community-based organizations. Of these 16 programs, half are categorized as Full-Service Partnerships and are funded through Medi-Cal and the Mental Health Services Act, a statewide law providing funding to counties for mental health services[7]. The other eight programs are funded through the County General Fund, including funding from Proposition C, and through Medi-Cal reimbursement.

The Referral Process

Several types of providers make referrals to ICM, including clinicians in both inpatient and outpatient settings, Jail Health clinicians, public defenders, the office of the Public Conservator, and community agencies. Regardless of where a referral originates, it generally follows the same process, shown in Exhibit 7 below.

---

[7] FSPs are a core component of MHSA implementation, accounting for 55 percent of all estimated County MHSA expenditures in FY 2020-21. Source: San Francisco Mental Health Services Act Annual Update, 2021-2022.

Exhibit 7: A Completed Referral to Intensive Case Management

Referral	Authorization	Intake
•Provider submits a referral form to ICM authorizing team at BHS through email or fax	•Authorizing team determines that ICM is appropriate •Authorizing team selects a specific program and adds client to wait list	•Once the program has capacity, a case manager schedules initial handoff meeting and begins ICM

STAGE ONE: REFERRAL

A referring clinician completes a four-page referral request form for ICM, outlining the reasons for the referral[8]. The referrer sends the completed form by either fax or email to an inbox managed by BHS' ICM program management team.

STAGE TWO: AUTHORIZATION AND WAIT LIST PLACEMENT

Next, ICM program management staff review the completed form to determine whether the client meets the eligibility criteria for ICM. To be eligible, clients typically need to have a mental health diagnosis causing significant functional impairments or symptoms, as well as an imminent risk of decompensation without treatment. Clients generally must also meet one of several additional qualifying categories: two or more hospitalizations within the past year, three or more crisis episodes in the last 60 days, discharge from a locked facility, criminal justice involvement within the past year or risk of future criminal justice involvement.

---

[8] The form is called the Referral Request for TAY, Adult, & Older Adult Intensive Case Management & Full-Service Partnership Services.

If ICM is appropriate**,** program management staff next determine which of the 16 clinics best fits the client, taking into consideration the language and demographic focuses of each clinic, program size and staffing ratios, current wait lists, and other factors**.**

After determining that ICM is appropriate and selecting the best program for services, the ICM program management staff place the client on that program's waitlist. They then work with the referrer to link the client to interim outpatient services while the client waits to begin ICM.

Program management staff typically complete this authorization and placement on the selected program's waitlist within five days.

STAGE THREE: INTAKE

Once the selected program has an opening for the client, the program initiates the intake process. This process typically includes a "warm handoff," or a meeting that includes a clinician whom the client already knows and the new case manager. This clinician whom the client already knows might be the person who referred the client to ICM, or it might be someone who has seen the client in the time since the referral, such as an interim case manager or staff at a residential program. These initial meetings take place in a range of settings, including at residential programs and in the community.

After completing its intake process, the ICM program changes the client's status from "referral" to "open" in Avatar, a behavioral health electronic records system, making it possible for BHS program management staff to see that the client has started ICM.

ICM Staffing and Wait Times

Lengthy wait times for ICM have been a concern for years, and in an audit published in 2018, our office found that clients had been waiting up to 10 months on ICM program wait lists. The audit identified several factors contributing to these waits, including an insufficient number of intensive case managers and the fact that nearly one in two case management clients were staying in Intensive Case Management at least five years. Between Fiscal Year 2012-13 and Fiscal Year 2016-17, the audit found, the city averaged 232 more referrals to Intensive Case Management each year than discharges from case management.

Four years after our audit, significant wait times remain. According to department staff:

- In 2021, the median time period between referral to ICM and the beginning of ICM treatment was just under three months.

- As of early March 2022, the combined wait list for Intensive Case Management included about 150 people.

Sufficiency of Case Management Staffing

According to Department staff and providers, vacancies and staff turnover have been issues for years at ICM clinics, contributing to high caseloads and burnout among intensive case managers. The pandemic has compounded these stressors: At the same time that behavioral health needs intensified for many clients amid disruption to daily routines and support networks, case managers likely also experienced increases in stress and responsibilities outside of work.

Compensation discrepancies between civil service and community-based clinics complicate efforts to fill these vacancies. According to a preliminary Department review, annual license-track civil service intensive case manager salaries, which start at $95,000, outpace both license-track position and licensed positions at community-based organizations, which typically start at $60,000-$70,000 and $70,000-$85,000, respectively. As the City and community-based organizations compete for the same skilled staff, these pay inequities undermine efforts to increase overall network case management capacity.

Beyond filling vacancies, Department staff have also identified a need to increase baseline staffing levels for case management, include hiring new categories of case managers to provide lower-frequency and higher-frequency care, respectively, than intensive case managers.

Delays in Stepping Clients Down from ICM

In addition to increasing staff, another opportunity to create capacity to accept new clients for Intensive Case Management services is graduating or stepping down eligible clients from ICM to a lower level of care. As noted in our 2018 audit report, one half of ICM clients stayed in Intensive Case Management for five years or more. According to department staff and providers, several factors complicate the step-down process, including:

- **Limited capacity at outpatient clinics** for ICM clients ready to step down can mean a wait time for outpatient treatment at a convenient clinic that meets a client's needs.

- There are still **few options for mental health care in between Intensive Case Management and traditional outpatient mental health care,** despite efforts to address this gap**.** This can result in intensive case managers and BHS program staff being reluctant to step some clients down even after they no longer need twice weekly visits from an intensive case manager. In other cases, some clients are discharged from ICM but return not long after, having been unable to maintain their progress through traditional outpatient mental health care.

- **ICM does not have a dedicated utilization management team** with responsibility for identifying candidates for step-down. Instead, that function falls to a two-person placement team that is already responsible for authorizing new ICM services, reviewing

requests to extend services[9], and matching new clients with a clinic that will meet their needs. This stands in contrast to the Residential System of Care, where a utilization management team is responsible for authorization and case reviews, and a placement team is responsible for matching authorized clients with specific facilities.

Ongoing Action to Reduce ICM Wait Times

According to the Director of Health's response to the Budget and Legislative Analyst's 2018 audit report, BHS was already working to address many of these factors at the time of our audit. The Director of Behavioral Health Services reported to the January 20, 2022 Government Audit and Oversight Committee that wait times for Intensive Case Management are "extremely concerning," and the Department continues to work on several fronts to address wait times.

Addressing Vacancies and Turnover

Under the Tenderloin Emergency declaration, the Department has sought to fill civil service vacancies related to Intensive Case Management and throughout BHS. The Department is also creating new case management positions, including:

- Approximately 35 civil service case management positions. Most of these positions will be dedicated to **critical case management**, intended for highest-acuity case management clients, and **outpatient case management**, designed to support clients transitioning out of ICM.

- Approximately 22 contracted staff at community-based organizations to support case management, including approximately 12 intensive case managers.

To improve hiring and retention of intensive case managers at CBOs, BHS has started working to increase the starting salary for certain intensive case manager positions at community-based clinics. BHS will also work with the Controller's Office to study these pay discrepancies, and options for addressing them, in greater detail. As of early March, BHS staff expected project scoping would begin in March and said the target for a final report was the end of December 2022.

Improving Step-Down from ICM

To facilitate step-down of ICM clients, BHS is creating new teams of case managers based at outpatient mental health clinics, intended to provide care at a level in between Intensive Case Management and traditional outpatient services. Staffing will include 12 FTE civil service staff.

---

[9] ICM must be reauthorized after an initial 12-month period, and every six months after that.

To improve its identification of candidates for step-down, BHS also plans to combine utilization management of all Intensive Case Management and residential placement into one unit, which would review ongoing cases in addition to screening new requests. Planning for this unit was interrupted by the pandemic, but BHS intends to resume the process this fiscal year and complete implementation in 2023.

Improving Tracking of Wait List Information

According to DPH staff, following the 2018 Behavioral Health Services audit by the Budget and Legislative Analyst, BHS created a centralized mechanism in Avatar for tracking ICM referrals to track referral source, approval status, program assignment, and ability to see lists of who has been assigned but not yet opened for any given ICM program. This centralized tracking allows the larger BHS system to see if someone has been approved/assigned to an ICM program but not yet opened and to track the mean ICM wait times. BHS is also working on utilizing best available referral-to-service data within Avatar and Epic, in collaboration with DPH IT and key Mental Health SF staff. Staff are working to develop wait time reports that include improved ICM wait time tracking and wait times for mental health residential placements.

Residential System of Care

Overview of the City's Residential System of Care

The City's Residential System of Care program serves clients whose complex behavioral health needs cannot be met through outpatient services alone. This system includes both short-term and long-term residential programs, and it encompasses several levels of care that range in restrictiveness and the specific services offered. Facilities in the Residential System of Care are operated by private, nonprofit and state entities that are not a part of the City of San Francisco, except for the Behavioral Health Center on the Zuckerberg San Francisco General Hospital campus. The City may supplement daily rates paid by Medi-Cal to the residential providers or may fully fund services not reimbursed by Medi-Cal or other payors. Behavioral Health Services staff provide centralized authorization and placement services for referring clinicians, working to match clients with facilities that will meet their needs in the most appropriate and least restrictive setting possible. As of May 2022, the Residential System of Care included approximately 2,300 beds, including approximately 145 beds added as part of Mental Health SF.

Placement staff also facilitate additional short-term placements in the City's two Hummingbird Place Peer Respite sites, voluntary facilities providing beds for up to several weeks. Crisis and emergency care are managed by Psychiatric Emergency Services at Zuckerberg San Francisco General Hospital and Trauma Center and Dore Urgent Care Clinic. Appendix II describes these crisis stabilization facilities and the placement process for the Hummingbird sites.

Levels of Care

The Residential System of Care includes several levels of care, including:

- **State Hospitals:** Locked facilities providing mental health care in an inpatient setting to the most severely mentally ill individuals; waitlists to state hospitals are managed by the State.
- **Locked Sub-Acute Treatment:** Locked facilities providing care in a less-restrictive setting than state hospitals to clients who have been placed in a conservatorship or on a court-ordered hold. Within this category, some facilities designated as Skilled Nursing Facilities can provide additional care for non-behavioral medical needs. [10]
- **Residential Care Facilities, also known as Board and Care facilities:** Unlocked facilities providing nonmedical care, including meals, personal care assistance, and storage and distribution of medication.
- **Residential Treatment Program:** These include longer term residential placements with treatment, including (a) 12-month programs, such as Clay Street House and Loso House operated by the nonprofit Progress Foundation, which provide care designed for individuals who have recently exited a long-term locked sub-acute facility; (b) 90-day residential treatment programs providing voluntary mental health or substance use disorder treamtent, including treatment for individuals with a dual diagnosis; and (c) crisis residential treatment (also called "acute diversion"), which is short term treatment up to two weeks for individuals experiencing a mental health crisis.
- **Co-Op:** Cooperative living settings for clients with behavioral health diagnoses.
- **Services in Supportive Housing:** Supportive housing settings with wraparound behavioral health services.
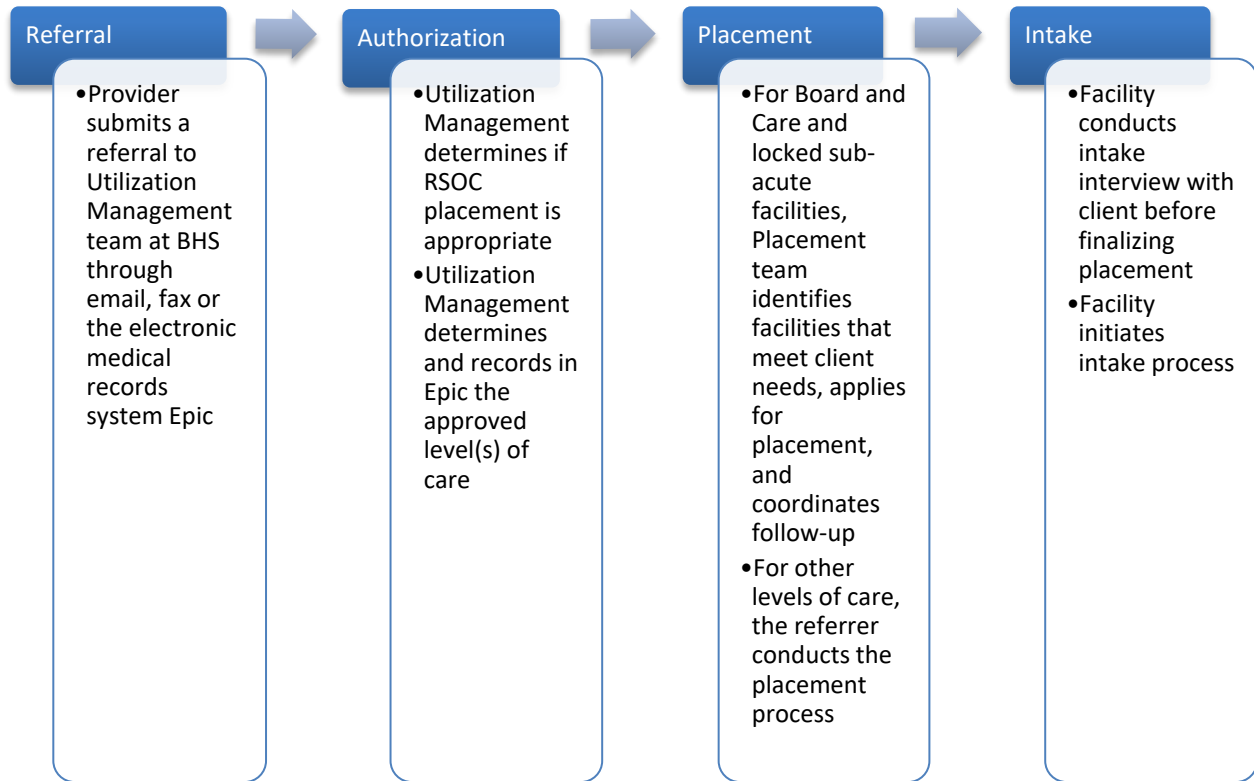
The Referral Process

Clients enter the RSOC through a range of entry points, including emergency and crisis care, jail discharge and ICM. When someone is referred for residential care, the Department's Utilization Management (UM) team first confirms whether the client meets basic eligibility requirements, whether residential care is medically necessary, and if so, which level(s) of care can meet the client's needs in the least restrictive setting possible. For Board and Care and locked sub-acute facilities, the Department's Placement team then works to match the client with a specific facility within the authorized level(s) of care. In some cases, clients will move between facilities and levels of care as behavioral needs shift; each request for a new level of care will follow the above process.[11] Exhibit 8 below shows a completed referral to the RSOC.

---

[10] Sub-categories within the Locked Sub-Acute Treatment level of care include Institutions for Mental Disease (IMD) and Mental Health Rehabilitation Centers.

[11] Utilization Management is responsible for authorizing placement for residential treatment (including 12-month, 90-day, and acute diversion or crisis residential services), Co-Ops, Board and Care, and locked sub-acute facilities (including locked sub-acute, psychiatric skilled nursing, and state hospital placement). The Placement team refers to Board and Care and locked sub-acute placements.

Exhibit 8: Typical Completed Referral to a Mental Health Care Facility in the Residential System of Care

Referral	Authorization	Placement	Intake
•Provider submits a referral to Utilization Management team at BHS through email, fax or the electronic medical records system Epic	•Utilization Management determines if RSOC placement is appropriate •Utilization Management determines and records in Epic the approved level(s) of care	•For Board and Care and locked sub-acute facilities, Placement team identifies facilities that meet client needs, applies for placement, and coordinates follow-up •For other levels of care, the referrer conducts the placement process	•Facility conducts intake interview with client before finalizing placement •Facility initiates intake process

(OPTIONAL) PRE-CONSULTATION

The Utilization Management and Placement teams meet weekly with providers from the psychiatric unit at Zuckerberg San Francisco General Hospital and Trauma Center and other referring entities to discuss specific clients whom these practitioners expect to refer for residential care. In some cases, a care team will ask UM staff for guidance on which level of care is appropriate given a client's needs; these conversations sometimes extend beyond the weekly meeting into additional correspondence.

STAGE ONE: REFERRAL

A referring clinician submits a request for residential placement to UM staff. Clinicians can submit this referral by email to a secure inbox, by fax, or through a notification in the electronic medical records system Epic.

STAGE TWO: AUTHORIZATION

After receiving a request, UM staff assess the client's eligibility for the program and whether the requested level of care is appropriate:

Budget and Legislative Analyst

- To assess the client's eligibility, UM staff review Medi-Cal's medical records system to determine if the client has established residency in San Francisco and meets Medi-Cal's eligibility requirements.
- To assess whether the requested level of care is necessary and sufficient to meet the client's needs, UM staff review medical records in Avatar and Epic. In some cases, UM staff follow up with clinicians for assessment notes or additional information.
- When authorizing for levels of care that require clients to contribute to the costs of care, UM staff will also review the ability to pay.

If UM staff determine that approval is appropriate, they approve the request in Epic.

STAGE THREE: PLACEMENT

For Board and Care and locked sub-acute facilities, BHS' Placement team then begins the placement process. After reviewing the submitted paperwork, this team will identify a list of facilities that meet the client's needs. In some cases, the Placement team will contact the referrer to learn more about the client's placement preferences regarding facility size, location, and other characteristics.

Placement staff will then request placement with approximately five facilities, submitting required documentation about the client and following up as needed. In some cases, a facility will set conditions or targets for accepting the client, such as the client complying with their medication regiment for 14 days or going 14 days without an assault. In these cases, Placement staff will work with the care team, conservator, facility and client throughout this process.

For other levels of care, such as 90-day or 12-month residential treatment, the referrer conducts the placement process after UM authorizes placement.

STAGE FOUR: INTAKE

If one of the facilities considers accepting the client, the facility conducts an interview with the client before making a final acceptance decision and placing the client on a wait list or proceeding with the move-in process.

Mental Health Bed Wait Times

Waits for residential care long-term care continue to pose challenges for clients and BHS staff. When clients cannot be promptly placed, they must stay longer in acute inpatient, Acute Diversion Units and other crisis stabilization settings, even when other facilities would better support their care. In addition to the impact on these clients, prolonged stays in these settings limit space available for others in crisis. They can also force the Department to incur avoidable

financial costs when insurance will not reimburse the City for a level of care that is not medically necessary[12].

According to the Department:

- For July 2021 through December 2021, the average wait time for Locked Sub-Acute Treatment was 45 days.

- For July 2021 through December 2021, the average wait time for Psychiatric Skilled Nursing Facilities was 37 days.

- The above times represent improvements from Fiscal Year 2018-19, when wait times for Locked Sub-Acute Treatment and Psychiatric Skilled Nursing Facilities were 62 days and 121 days, respectively.

The Department was not able to provide wait time data for other levels of care, including Residential Care Facilities (Board and Care facilities).

In some cases, waits for placement are the result of factors outside of the Department's control, such as a lack of in-county residency or application denials by residential facilities.

Eligibility Requirements

To qualify for residential placement by BHS, a client must have established residency in the County of San Francisco, which presents a barrier for some clients who have established residency or enrolled in Medi-Cal elsewhere. In order to establish residency for the purposes of placement in BHS's Residential System of Care, clients must demonstrate evidence of living in San Francisco for at least 30 days. Clients must also be enrolled in Medi-Cal or another insurance program to qualify for placement by BHS in certain levels of care, including locked facilities and Residential Care Facilities (Board and Care facilities).

Denials or Delays by Contracted Facilities

Residential Care Facilities set their own admission guidelines and select clients for admission based on their own criteria and State regulations set by their licensing board. In some cases, clients that UM staff approve for placement are rejected by most or all facilities within the approved level of care for reasons such as histories of violent behavior, non-behavioral medical conditions, and failure to maintain a medication regimen.

---

[12] As stated in the Department's 2020 Bed Optimization Report, the Department cannot bill Medi-Cal for Inpatient Psychiatry stays when a lower level of care would be appropriate.

In some cases, contracted facilities will require a prospective client to meet a specific behavioral target, such as medication adherence or no violent behavior for a specific time period, in order to be accepted, prolonging the placement process. Since the beginning of the pandemic, facilities also have enacted Covid-19 protocols that sometimes result in temporary pauses of new admissions.

Impact of Lack of Mental Health Beds on Wait Times

A key factor in waits for residential treatment is a shortage of treatment beds across the RSOC. In its Behavioral Health Bed Optimization Project, DPH reported in 2020 that four levels of care routinely had wait times due to limited capacity – and each had a capacity-related wait of more than 40 days. Exhibit 9 below shows the average wait times for four levels of care documented in the 2020 Bed Optimization Project, based on utilization in FY 2018-19, as well as the project's recommended bed increases. The authors acknowledged that their estimates were likely undercounting the true need for additional capacity. Given the impact of the pandemic on the entire social service network, needs for residential treatment have also likely increased over the past two years.

Exhibit 9: Average Wait Times and Recommended Bed Increases, 2020 Bed Optimization Project

	Average Wait Due to Capacity (Days)	Recommended Bed Count Increase for Zero Wait	Bed Count Increase for 50% Wait Time Reduction
Locked Sub-Acute Treatment	62	31	20
Psychiatric Skilled Nursing Facilities	121	13	8
Residential Care Facility, aka Board and Care	60	31	13
Residential Care Facility for the Elderly	44	22	9

Source: Behavioral Health Bed Optimization Project: Analysis and Recommendations for Improving Patient Flow. San Francisco Department of Public Health, 2020.

Competition With Other Counties

San Francisco has a limited number of dedicated beds, such as the San Francisco Healing Center – a 54-bed facility operated by Crestwood and located at St. Mary's Hospital. While San Francisco has contracts with out-of-county facilities, these contracts are not for dedicated beds and the City competes with other counties for placements, complicating placement efforts. Many of the facilities in the Residential System of Care contract with multiple jurisdictions, and when beds

become available, these jurisdictions are competing against each other to place clients. For a facility that can choose among clients, acuity and complexity of behavioral issues are barriers to acceptance of the individual.

Limited Supportive Housing Capacity

As explained in the 2020 Bed Optimization Report, the limited availability of long-term housing for unhoused San Franciscans can slow the discharge of unhoused clients out of temporary behavioral health placements and decrease the likelihood that discharged clients will maintain progress made during residential treatment. The report therefore recommended complementing investments in temporary bed capacity with significant investments in Permanent Supportive Housing (PSH) and other permanent housing placements[13]. This recommendation is consistent with a 2016 report from our office, "Impact of Supportive Housing on the Costs of Homelessness," which showed that the city spent less on services provided to a group of unhoused individuals after placing them in PSH, even after accounting for the costs of providing the housing.

Department Plan to Add Beds

In response to the Bed Optimization Report and as part of Mental Health SF, the Department created a New Beds and Facilities team, and in July of 2021, the Department and Mayor London Breed announced plans to make available approximately 400 additional behavioral health treatment beds. As of May 5, 2022, BHS had made approximately 145 of these beds available, including:

- 28 beds at Hummingbird Place – Valencia

- 30 beds at an out-of-county 12-month Rehabilitative Board and Care facility[14]

- Approximately 31 beds at an out-of-county Locked Sub-Acute Treatment facility[15]

- Approximately 13 beds at out-of-county Psychiatric Skilled Nursing Facilities[16]

- 10 beds for providing medical supervision for clients with chronic alcohol dependency

---

[13]The Bed Optimization Report also included Residential Care Facilities when describing permanent placements. Although RCFs are part of the Residential System of Care, the report distinguished between them and temporary settings within the RSOC when emphasizing the need to invest in housing options designed for long-term and permanent stays.

[14] The Department's dashboard says that client placement varies.

[15]The Department's dashboard lists this number as an estimate and says that client placement varies.

[16]The Department's dashboard lists this number as an estimate and says that client placement varies.

- 12 beds at the Minna Project, a transitional care facility for justice-involved individuals with both a mental health and a substance abuse diagnosis

- 23 beds at a Residential Care Facility

According to Department officials, the Department expects to increase that total to 282 beds by the end of 2022. The additional beds expected to open in 2022 will include:

- 20 estimated beds at SOMA Rise, a drug sobering center for people experiencing homelessness

- 63 additional beds at the Minna Project

- 46 additional beds at Residential Care Facilities

- 6 estimated beds at a cooperative living setting for people with a chronic mental health and/or substance abuse diagnosis

Gaps and Inefficiencies in Data Collection

The Mental Health SF ordinance calls for a data-driven approach to the City's mental health overhaul. According to DPH staff, BHS is centralizing Mental Health SF data and analytics work within BHS to ensure coordination with BHS Quality Management and Mental Health SF. The ordinance requires gathering sufficient data for DPH, the Board, and the Mayor to prioritize resources in order to reduce wait times and other barriers. Implementation of the Office of Coordinated Care and coordinated data collection and analysis has been delayed. Between December 2021 and May 2022, the Department moved forward in implementing the Office of Coordinated Care, appointing a director to this office in February 2022 and implementing the hiring process for 35 civil service case managers before announcing the opening of the office on May 6, 2022.

Insufficiency of Existing Systems to Track Referrals

Behavioral Health Services does not have sufficient systems to collect data on and track referrals to care. In both Intensive Case Management and the Residential System of Care, inefficient processes increase the administrative work required of authorizing and placement staff, and they contribute to gaps in data collection. These issues include: multiple electronic records systems, multiple methods for communicating referrals to the same service, continued use of non-digital forms, and different authorization units for ICM and RSOC.

Multiple Electronic Records Systems

BHS uses two medical records systems, Avatar and Epic, to track client services and data:

- **Avatar** is an electronic health record software specific to behavioral health care, including meeting billing requirements, which clinicians in the BHS systems of care have used for years to log clinical developments and look up patient history. BHS has added capacity to capture referral information, but the workflows are not standardized across systems of care.

- **Epic** is an electronic health record software used across all types of health care, which clinicians in health care settings across the city use to log clinical developments, look up patient history, and bill insurers for medical services.

Multiple Methods for Communicating and Use of Non-Digital Referral Forms

In the RSOC, providers submit referrals for placement by **email**, **fax** and **through Epic.** In ICM, providers submit referrals for placement by **email and** by **fax.** In addition, both ICM and the RSOC use non-digital forms for referral requests. While providers can submit these forms electronically by email or fax, the information they contain is not automatically captured by software such as Avatar or Epic.

Different Authorization Units for ICM and the RSOC

The teams reviewing referrals for ICM and for the RSOC are separate. Requests for placement in emergency stabilization beds that do not require authorization, including the Hummingbird Place sites, are reviewed by a third team (the RSOC's Placement team).

Department Actions to Increase Efficiency in the Referral Process

To address the inefficiencies and data analysis challenges of using two software systems, the Department plans to phase out Avatar and ultimately use only Epic. The Department has recently started initial planning for this transition and has not set a firm timeline, though BHS officials expect the process to be completed in 2024.

To improve authorization processes, the Department plans to create a single utilization management team responsible for authorizing new and continued services across both ICM and the RSOC. It expects to complete this process in 2023.

As the Office of Coordinated Care staffs up, it will also be assessing opportunity to improve data collection regarding wait times and other issues.

Policy Considerations

Access to timely, high-quality mental health care can be life-changing for anyone, and for people experiencing homelessness with mental illness, it can mean the difference between a path to recovery and failing to meet basic needs. Where wait times or other barriers to access exist, they

take a particular toll on these unhoused individuals, who are overrepresented among the city's mental health clients and who face challenges to navigating the city's behavioral health services network.

For these reasons, understanding the experiences of unhoused people referred for mental health services is essential to the success of Mental Health SF. Yet significant gaps in Behavioral Health Services data continue to make it difficult to obtain even summary statistics in key areas such as referral totals and wait times, or to assess whether client experiences are improving. By closing these gaps, BHS can make possible new analysis that will support its efforts to eliminate wait times and expand access to mental health care for the City's most vulnerable residents.

Behavioral Health Services does not track referrals for mental health services in a comprehensive, reliable way.

Although BHS keeps data on services provided, comprehensive data on referrals themselves is also necessary to analyze subjects such as:

- The percentage of referrals that are authorized across different systems of care
- The percentage of clients referred for services who ultimately receive services
- Wait times for authorization
- Demographic data about clients referred for services, which could then be compared to demographic data about clients who receive services

To address this issue, BHS officials are working to develop comprehensive data collection processes for referrals to Intensive Case Management (ICM) and the Residential System of Care (RSOC). The agency is still considering options for tracking similar data across outpatient services, which would require significantly more resources than tracking referrals to ICM and the RSOC.

> **Recommendation:** The Board should request the Director of BHS to present an update by December 31, 2022 on planned changes to referral data collection, including:
>
> - Tracking of referral data for Intensive Case Management and the Residential System of Care
> - Assessing whether it is feasible to track referral data for outpatient services

Clients continue to face waits for ICM and the RSOC due to lack of capacity.

In ICM, a shortage of intensive case managers and barriers to stepping clients down into lower levels of outpatient care continue to contribute to wait times that BHS officials acknowledge are unacceptable. In the RSOC, a shortage of available beds and the entry criteria of specific facilities continue to keep some clients in temporary stabilization settings while they wait for long-term placement. These issues are well-known to the Department, and BHS is working to address them

by hiring more case managers, creating a single utilization management unit serving both systems of care, and expanding the city's network of new beds and facilities.

According to BHS, its current goal is to reduce the ICM waitlist by the summer of 2022 and eliminate it by the fall of 2022. BHS has not set a measurable goal for wait times for the RSOC, beyond placing clients in an appropriate level of care as soon as possible[17].

> **Recommendation:** The Board should request the Director of BHS to present an update by December 31, 2022 on progress toward eliminating the wait list for Intensive Case Management, including whether the agency is on track to eliminate the waitlist by Fall 2022.

> **Recommendation:** The Board should request the Director of BHS to present an update by December 31, 2022 on placement in the RSOC that includes establishing measurable department goals for wait times, as the department has done for ICM and for urgent and crisis residential care.

> **Recommendation:** The Board should request the Director of BHS to present an update by December 31, 2022 on progress toward combining authorization units into a single utilization management unit, including whether the department is on track to complete this process in 2023.

Efforts to gather data about mental health services are complicated by the use of multiple medical records systems, multiple methods of submitting referrals, and non-digital referral forms.

These inefficiencies add to the administrative work required of authorizing and placement staff. They also make it more difficult to track and analyze data that could be used to identify and address systemic problems.

To streamline data collection, BHS has started planning an eventual phase-out of Avatar, a change the agency projects will likely take two years to plan and execute. In the meantime, BHS is working on ways to improve data-sharing between Avatar and Epic and between these two systems and outside systems, such as those of hospitals and the Department of Homelessness and Supportive Housing.

> **Recommendation:** The Board should ask the Director of BHS to present an update by December 31, 2022 on planned changes and possible improvements to data collection methods affecting the referral, authorization and placement processes of providing mental health services. This should include:

---

[17] BHS also shared goals for urgent care (clients seen the same day or the following day) and crisis residential services (clients admitted within 24 hours), services that were not a focus of this report.

- An update on phasing out Avatar in order to streamline recordkeeping under a single software system (Epic).

- An assessment of the feasibility of creating a single, software-based referral process for Intensive Case Management and one for the Residential System of Care as part of the transition to Epic and creation of a single utilization management unit.

Work to centralize wait time data for mental health services remains incomplete.

The summary wait list statistics provided by BHS leave important questions unanswered, including wait times at Residential Care Facilities, trends in wait times for ICM over the course of 2021, and wait times by specific program. While some of these details may be available to specific analysts and program managers, the lack of a single wait time database makes it burdensome for staff to respond to policymakers and the public.

Regarding ICM specifically, as of 2018, the department was creating an electronic database of monthly ICM waitlists[18]. The fact that only summary statistics were readily available in response to our questions suggests a continued need to improve data infrastructure in this area. Department staff agree that improved tracking of wait time data can help efforts to improve the referral process.

> **Recommendation:** The Board should ask the Director of BHS to present an update by December 31, 2022 on the Department's efforts to improve tracking of wait times for ICM and the RSOC, including:
>
> - Details about what data BHS plans to track regarding wait times.
>
> - An update on the Department's efforts to create an electronic database of monthly ICM waitlists.

---

[18] BHS stated in its response to our 2018 audit that "BHS is in the process of creating an electronic database of the monthly ICM waitlists and will begin trending the number of clients on the waitlists and wait times and reviewing them quarterly along with other service timeliness metrics."

Appendix I: Case Studies

Department staff provided a verbal step-by-step description of four placements, from which we constructed the summaries below. The four placements, which the department selected, involved referrals received between October of 2021 and February of 2022.

Client A

At the end of Client A's yearlong stay with a 12-month residential program, the program initiated a referral for longer-term care at a Residential Care Facility. Program staff submitted the referral via secure email. Utilization Management (UM) staff then reviewed Medi-Cal records to confirm Client A's residency in San Francisco, and they reviewed records in Epic and Avatar to confirm the medical necessity of placement. UM staff then authorized placement in Epic and scanned Client A's referral documents to add them to Client A's Epic file. UM staff also notified the referring staff at Client A's program that UM staff had authorized placement. UM staff completed each of these steps the day of the referral.

After being notified through Epic of the authorized referral, Placement staff reached out to the referring program to ask about Client A's placement preferences. From this conversation, Placement staff learned that Client A preferred a larger setting, wanted to stay in San Francisco, and hoped to live in a facility where Client A could smoke cigarettes frequently. Placement staff then identified a facility that seemed like a fit, a process that included confirming with the client and the facility that Client A would be able to meet Client A's smoking preferences consistent with the facility's smoking policy. The facility interviewed Client A 10 days after the referral and accepted Client A the day after the interview. Client A moved in six days later.

Days from referral to move-in: 17.

Client B

Client B had self-reported to Dore Urgent Care Clinic and was then transferred to an Acute Diversion Unit (ADU). The ADU subsequently initiated a referral for placement at a 90-day residential treatment program. When UM staff worked to verify Client B's residency, they determined the client was enrolled in Medi-Cal through Los Angeles County, not San Francisco County, and was therefore ineligible for placement. UM denied this placement request.

Subsequently, a clinician worked with the Placement team to transfer Client B to one of the Hummingbird Place respite sites. Hummingbird Place staff helped Client B disenroll from Medi-Cal in Los Angeles County and reenroll in San Francisco County, thus making Client B eligible for placement following 30-day proof of residency. Hummingbird Place staff then faxed UM a new referral for placement in a dual diagnosis program.

After reviewing records from Medi-Cal, Epic and Avatar, UM staff approved this second request three business days after receiving it, authorizing Client B for either a dual diagnosis program or residential treatment. This concluded the Department's involvement in placement, as the Placement team does not manage placements in these levels of care; instead, the referring entity reaches out to programs directly to secure placement on a waiting list and ultimately into a program. According to DPH staff, the client was placed in a residential treatment program 57 days after UM staff authorized placement.

Days from Referral to Move-In: 62 from second referral; 117 from first referral

Client C

During a weekly meeting with Zuckerberg San Francisco General Hospital and Trauma Center and other partners, UM received an informal request for guidance on the most appropriate level of care for Client C, who was in the hospital's inpatient psychiatric unit. Following this meeting and additional discussion, UM received a formal referral five days later through Epic for placement in a Locked Sub-Acute (LSAT) facility. UM staff reviewed the client's records the following day and authorized the request the day after.

Placement staff received Client C's "LSAT packet," a lengthy combination of records, one day later. The same day, they submitted referrals to four facilities. Four days later, Placement staff received denials from two of these facilities. Each facility had denied the client for three reasons: assaultive behaviors, medical conditions, and a wound. Two days later, a third facility also denied placement, citing Client C's assaultive behaviors. The following day, the fourth facility denied placement as well, citing Client C's lack of adherence to Client C's medication regiment. This fourth facility added, however, that if it would reconsider if Client C could demonstrate 14 days of adherence to medications and with no assaults.

Placement staff provided updates throughout this process during weekly meetings with the psychiatric unit treating Client C. They also received updates from this unit about Client C's progress, which they relayed back to the LSAT facility that had indicated a willingness to consider placement. Approximately six weeks after the referral to UM, Client C demonstrated 14 days of adherence to medication and no assaults, and this facility accepted the client the same day. Shortly after, the facility went into Covid protocols, delaying move-in, but Client C continued to demonstrate adherence to medication throughout this period, and the facility moved Client C in approximately three weeks later.

Days from Referral to Move-In: 69

Budget and Legislative Analyst

Client D

A clinical team at San Francisco General Hospital's inpatient psychiatric unit referred Client D via Epic for placement in a locked facility. Client D was being referred for placement due to behavioral challenges and did not have skilled nursing needs. UM staff reviewed Client D's records and approved placement in a Mental Health Rehabilitation Center the same day.

Placement staff received Client D's "LSAT packet" from the hospital the following day. When Placement staff submitted referrals to five facilities, all five denied the client, citing Client D's lack of compliance with Client D's prescribed medication. All five facilities wanted to see medication adherence for 14 days before they would consider placement.

During this time, Client D started making rapid improvements, including becoming adherent to their medication regimen. During weekly meetings, the Residential System of Care team discussed whether a locked setting was necessary and whether they should consider a lower level of care. When they approached Client D with this idea, Client D was very interested, according to Department staff. Clinical staff then submitted a new request for a lower, unlocked level of care, which staff subsequently authorized. After receiving Client D's referral packet, Placement staff identified a Residential Care Facility that the client had previously lived in. Five days after Placement staff received the referral, this facility interviewed Client D in the hospital. The facility accepted Client D approximately one week later, and it moved Client D in approximately two weeks after that.

Days from Referral to Move-In: 29 from second referral; 65 from first referral

Appendix II: Crisis Stabilization

Several facilities in San Francisco provide emergency care for clients experiencing an acute psychiatric crisis. For clients with the most acute needs, Zuckerberg San Francisco General Hospital and Trauma Center provides crisis care in a locked, inpatient setting through **Psychiatric Emergency Services.** The Progress Foundation's **Dore Urgent Care Clinic** provides voluntary crisis care for stays of up to 23 hours, and it also manages a network of **Acute Diversion Units,** which provide voluntary, around-the-clock crisis care out of residential homes for up to two weeks. The city's two **Hummingbird Place Psychiatric Respite** sites also serve voluntary clients in need of a short-term, around-the-clock facility for up to several weeks, often following a discharge from Psychiatric Emergency Services[19] and/or during a wait for placement in a residential facility.

PES and Dore Urgent Care manage their own intake processes, and they were not a focus of our analysis. BHS manages referrals to Hummingbird Place, through the Placement team for the Residential System of Care. Providers making a referral to a Hummingbird Place site, such as clinicians on Street Crisis Response Teams, reach out directly to the Placement team to refer a client. The Placement team then initiates intake at one of the Hummingbird sites, and clients are often placed the same day of the referral, according to Department staff. Exhibit 10 below shows the process of a completed placement at a Hummingbird Place site.

Exhibit 10: Completed Placement at Hummingbird Place Peer Respite
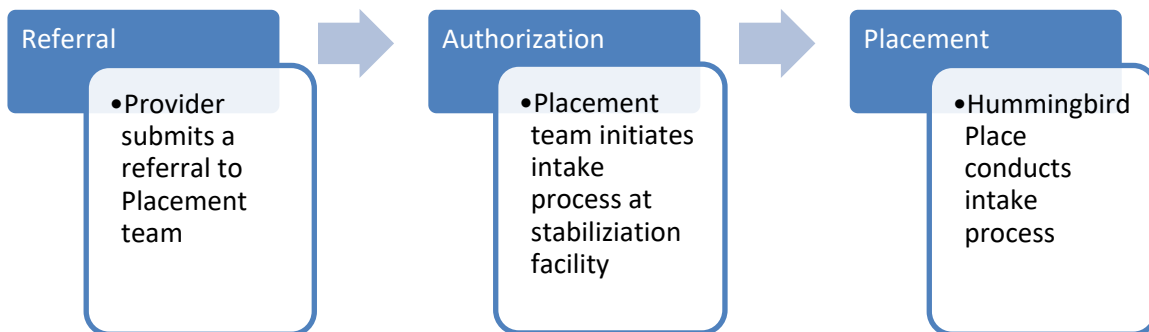
As part of Mental Health SF, the Department is also exploring the creation of an additional **Crisis Stabilization Unit,** which could provide up to 23 hours of voluntary crisis care in a less restrictive setting than PES and a locked hospital unit. The Department proposes a unit with 16 beds that offers mental health, substance abuse and physical care and that accepts walk-in clients as well as clients dropped off by Street Crisis Response Teams and other emergency response units.

---

[19] Hummingbird Valencia is a partnership between the Department, PRC/Baker Places, The Salvation Army, and Tipping Point Community. Hummingbird Potrero, located at Zuckerberg San Francisco General Hospital and Trauma Center, is a partnership between the hospital, the Department and PRC/Baker Places.