August 23, 2022

Mental Health San Francisco

Implementation Working Group

San Francisco
Department of Public Health

harder+co community research

Call to Order/Roll Call

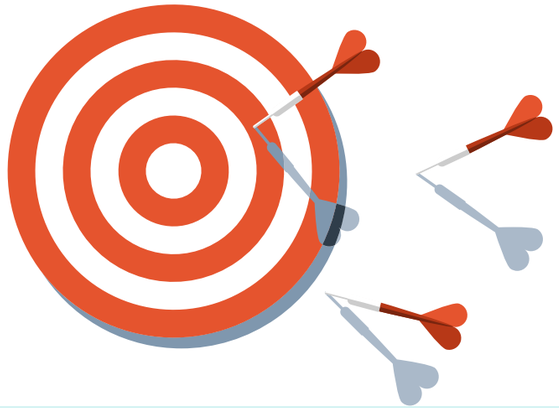
Vote to
Excuse Absent Member(s)

Decision Rule:

- Simply majority, by roll call

Meeting Goals

- Understand and provide comment on the Mental Health Service Center project options and costing from the Controller's Office
- Review and vote on TAY residential recommendations
- Update from the Controller's Office Staffing and Wage project
- Understand A&E data re interim priority populations



All materials can be found on the MHSF IWG website at: https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

Reminder: Mental Health SF Domains

Dr. Hillary Kunins

Mike Wylie

Heather Littleton

Glyins Startz

Jamila Wilson

Oksana Shcherba

Dr. Monica Rose

Wendy Lee

Mental Health SF Domains

Office of Coordinated Care	Street Crisis Response Team	Mental Health Service Center	New Beds and Facilities* (Mental Health and Substance Use Treatment Expansion)
Case Management and Navigation	Pilot Phase	Centralized Access	Expanding Existing Models (Dashboard Updates & Rapid Response)
Overall Care Coordination	Ongoing Implementation	Pharmacy Services	Drug Sobering Center
Marketing / Community Outreach		Transportation	Crisis Unit
Inventory of Programs and Services			TAY

Data and IT Systems | HR Hiring and Pipeline | Equity | Analytics and Evaluation

9:10 AM - 9:15 AM

Discussion Item #1

Remote Meeting Update

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

State and Local Requirements

RESOLVED, as follows:

1. the State of California and the City remain in a state of emergency due to the COVID-19 pandemic. At this meeting, the IWG has considered the circumstances of the state of emergency.

2. As described above, because of the COVID-19 pandemic, conducting meetings of this body and its discussion groups in person would present imminent risks to the safety of attendees, and the state of emergency continues to directly impact the ability of members to meet safely in person

Public Comment for Discussion Item #1

Remote meeting update

Steps:

- Call (415) 655-0001
- Enter access code 2481 671 8132
- Press ‘#’ and then ‘#’ again

Vote on Discussion Item #1

Remote meeting “findings”

Decision Rule:

- Simply majority, by roll call

9:15 AM - 9:25 AM

Discussion Item #2

Approve Meeting Minutes

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

Public Comment for Discussion Item #2

Approve Meeting Minutes

Steps:

- Call (415) 655-0001
- Enter access code 2481 671 8132
- Press ‘#’ and then ‘#’ again

Vote on Discussion Item #2

Approve Meeting Minutes

Decision Rule:

- Simply majority, by roll call

9:25 AM – 9:35 AM

Discussion Item #3

MHSF Director's Update

Dr. Hillary Kunins

All materials can be found on the MHSF IWG website at:
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Public Comment for Discussion Item #3

MHSF Director’s Update

Steps:

- Call (415) 655-0001
- Enter access code 2481 671 8132
- Press ‘#’ and then ‘#’ again

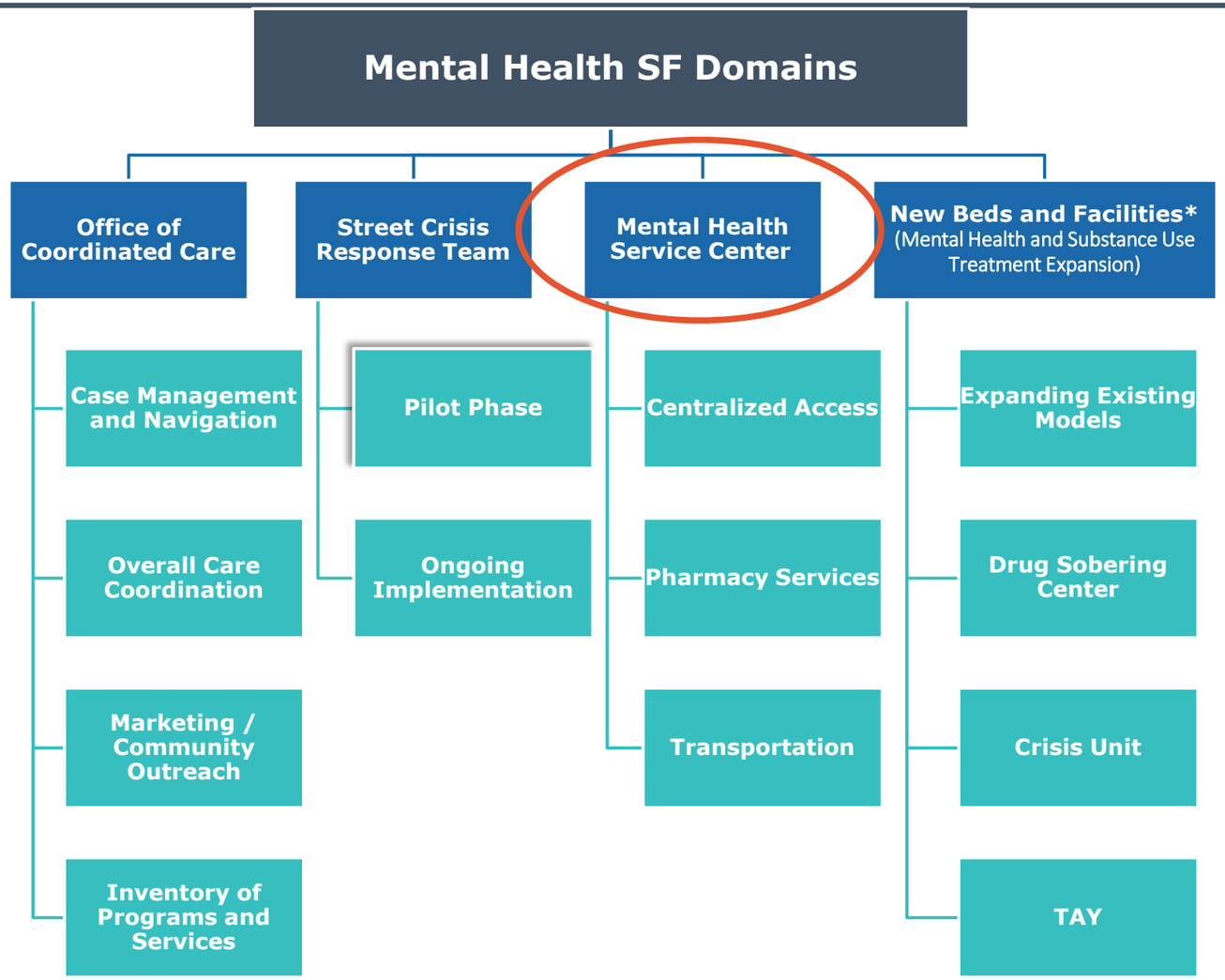
9:35 AM-10:50 AM

Discussion Item #4

Mental Health Service Center Project: Options and Cost Analysis

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

Reminder: Mental Health SF Domains



Mike Wylie

Jamila Wilson

Oksana Shcherba

Data and IT Systems | HR Hiring and Pipeline | Equity | Analytics and Evaluation

Mental Health Service Center

Options and Cost Analysis Discussion

CITY & COUNTY OF SAN FRANCISCO

Office of the Controller
City Performance Unit

Mike Wylie | Jamila Wilson | Oksana Shcherba

Options Analysis Project Deliverables

Planned Deliverables

- *Benchmarking* – Research several other 24/7 service models, including program structure, demand, and key lessons learned.
- *Crosswalk of Existing Services* – Identify current services, remaining gaps compared to the legislation.
- *Equity Assessment* – Work with DPH's equity leads to ensure appropriate criteria are considered in the analysis.
- *Interviews with MHSF Stakeholders* – Share findings and solicit feedback on the analysis.
- *Options + Cost Analysis* – Provide three options for a MHSC roll-out, from a standalone to a virtual center approach. Interview SMEs to provide cost estimates (ranges) for each
  - Preliminary Options Analysis at June 28 IWG meeting
  - Completed Options Analysis at Aug 23 IWG meeting
- *Project Summary* – Summarize project work in a PowerPoint deck.
  - Early Sept Options Analysis summary report

Options Analysis Project – IWG input

IWG Engagement

- Mar 22 IWG meeting on intro to project, current state of MHSC implementation, proposed IWG engagement and discussion
- May 18 Discussion Group on Benchmarking results and Crosswalk of services draft
- May 24 IWG meeting on MHSC legislative requirements, Benchmarking results, Crosswalk of services draft, and discussion
- June 23 Discussion Group on updated Crosswalk and the proposed Options
- June 28 IWG meeting on Crosswalk, preliminary Options review, and discussion
- Aug 23 IWG meeting on final Options and Cost Analysis, with discussion

MHSC Legislative Requirements

The MHSF legislation specifies the Service Center provide 6 key services.

Assessment of Immediate Need
Assess a patient's need for immediate medical treatment refer as necessary and appropriate.

Pharmacy Services
Stock and provide mental health + substance use medications at a reasonable cost 7 days a week.

Transportation
To other service sites.
From Jail and ZSFGH.

Psychiatric Assessment, Diagnosis, Case Management, and Treatment
Provide onsite consultations, diagnosis and/or referral, create a treatment plan, prescribe medications, and assign case mgmt./care.

MH Urgent Care
Clinical intervention for those experiencing escalating psychiatric crisis and require rapid engagement, assessment, and intervention.

Drug Sobering Center (opened)
Clinical support and beds at appropriate level of care for individuals experiencing psychosis due to drug use.
*Center must coordinate services with MHSC, but does not need to be housed in the same building

Controller's Options Analysis

Controller's Options Analysis

Previewing structure of today's presentation:

- For each option:
  - Description: Summary of Services Offered and Staffing
  - Equity Considerations
  - Cost Estimates (staffing, operating, facility costs, totals)
  - Facility Availability & Timing
  - Transportation
  - Caveats

Option 1—Stand-Alone Center

Deliver services required by the MHSF Legislation in one new location. All services outlined in the MHSF legislation will be offered, except for a sobering center which has opened in its own building.

- **Services Offered**—Assessment & Diagnosis, Urgent Care, Pharmacy, Case Management, Treatment Planning, Transportation.
- **Staffing**—24/7 civil service staffing. Includes moving current BHAC to the new location with its staff augmented to cover additional shifts and new service areas.
- **Equity Considerations** —
  - **Cultural Congruency**: Difficult to have multiple cultural presentations with one location.
  - **Workforce Diversity**: May contribute to already scarce staffing between civil service and CBOs. CBOs seen as more connected to underserved communities. Benefits are that civil service positions could provide career opportunities and higher wages to individuals, if hired from the community.
  - **Location/Access**: A central site might not be close to underserved communities; will require clients to travel outside their neighborhood and more transportation options/access. A benefit to a central site is it may reduce complexity of travel once there.
  - **Focus Population**: Some highest need populations may be served well at one location; but for total needs across the city and serving hard-to-reach clients, decentralized sites serve diverse needs/populations.

Option 1—Stand-Alone Center – Cont'd

- **Cost Estimate**—
  - Staffing: $22.1 M
  - Operating costs: $2.4 M
  - Facility cost: Range of $660k- $1.6M to lease (annual), $10M-$31.3M to purchase (one-time). *Based on Sq. Ft. range of 20,000-25,000.*
  - Total: $25.2M to $55.8M
- **Facility Availability and Timing**—Very dependent on the real estate market, the locations available, and condition of building. 1.5-3 years typical for acquiring and moving to a new site. Licensing for a new pharmacy location could take 2-3 years, up to 4 years if including licensure for methadone.
- **Transportation**—Includes the site having a shuttle that would provide transportation *from* the MHSC to offsite treatment programs as well as provide transportation *to* the MHSC for clients exiting SF County Jail and ZSFG PES unit as per legislation.

Option 1—Stand-Alone Center – Cont'd

- Caveats—
  - It has been over 2 years DPH and City Real Estate have been searching for candidate buildings that could house all the MHSC components, but so far this has been unsuccessful.
  - It may be hard to find a site with the exact square footage needed for the stand-alone service center; would likely be housed in a larger site with upper-level office space.
  - Based on SME feedback on feasibility concerns, the stand-alone center would not have a 24/7 full pharmacy. This option would include additional staff that could prescribe medications at all hours and have a stock of medications available to dispense on-site when the BHS pharmacy is not open.
  - With having the capacity to meet a higher service volume, Option 1 needs to include a robust marketing/education campaign.

Option 2—Multi-Location Center

Deliver required MHSC services through several programs and locations already in operation and one new urgent care center. However, no individual site would offer all the MHSC required programs.

- **Services Offered**—Assessment & Diagnosis, Urgent Care, Pharmacy, Case Management, Treatment Planning, Transportation, Drug Sobering Center.
- **Staffing**—Mixed CBO/civil service staffing. Existing sites would need to staff additional shifts to provide 24/7 operations. OCC would need additional case management staff to assist with care coordination between sites. A new urgent care clinic in the community is included in this option.
- **Equity Considerations**—
  - **Cultural Congruency**: Services located in local communities tend to be more culturally congruent and hire diverse staff via community providers.
  - **Location**: Multiple locations support diverse cultural presentations and can benefit focus populations in their neighborhoods. However, multiple locations will require adequate transportation access/options to not impact clients.
  - **Workforce Development:** Impact of this option is mixed/unclear as to reducing wage pressures faced by nonprofit contractors.

Option 2—Multi-Location Center - Cont'd

- **Cost Estimate**—
  - Staffing: $10.3M.
  - Operating costs: $1.3M
  - Facility cost: New urgent care: Range of $154k-$446k to lease (annual) and $2.5M-$9M to purchase (one-time).
    Based on a Sq. Ft. range of 4,680-7,200.
  - Total: $11.8M to $20.6M
- **Facility Availability and Timing**—Hiring additional staff at existing sites would take approx. 1 year. If a new site needed for the additional urgent care location, timeline will be 1-3 years to be acquired, subject to the real estate market (which varies by region) and the building condition in the desired location.
- **Transportation**—A new CBO-operated shuttle would be added to ensure transportation from ZSFG PES and SF County Jail to relevant sites, as well as provide transportation between involved sites. Option 2 would also utilize OCC's Bridge Engagement Services Team and the SOMA Rise Shuttle to coordinate transportation to care and between sites.

Option 2—Multi-Location Center – Cont'd

- Caveats—
  - OCC hiring and location started recently, not fully operational.
  - Effective transportation, and coordination of services from OCC, will be critical.
  - A provider education / PR campaign is needed for clients/staff to experience as a unified system (not included in cost estimate). Including, better publicizing of BHAC as a central access point, internally and externally.
  - Option 2 would not include a 24/hr pharmacy. Participating sites would have Nurse Practitioners available to distribute medications during the night hours.
  - BHAC enhancement of client experience and coordination of services may be hindered or not feasible at the currently leased building.
  - Improved data systems are needed to allow for real-time inventory across the BHS landscape.

Option 3—Virtual Center

Streamline existing MH call lines into one intake line similar to the approach being pursued in New York City. Replicate extensive phone/text/chat system while building off work already underway by the 9-8-8 Workgroup (“Call SF”)

- **Services Offered**—Assessment of immediate need, virtual consultations, linkages to in-person services and case management.
- **Staffing**—Would not need to build new programs, but likely need to hire additional and different staff for call center(s) and provide 24/7 shifts. Such staff projections/estimates for this model are not currently available.
- **Equity Considerations** —
  - **Focus Populations**: A consolidated line with expanded capacity to handle phone/email/text may expand initial access and reduce complexity for clients including the DPH/BHS focus populations. However, the line does not in itself provide increased access to treatment.
  - **Workforce Diversity and Cultural Congruency**: May provide opportunities for hiring from the community and adding multilingual capacity.

Option 3—Virtual Center – Cont'd

- **Cost Estimate**—
  - Total estimate (based on pop): $3.2M
  - New Staffing, Facility, and Operating costs: NA
- **Facility Availability and Timing**—No new program facility needed, but new call center/admin space would be TBD. 2 years is currently planned for the stakeholder coordination/implementation process for 988 and other call lines ("Call SF").

Option 3—Virtual Center – Cont'd

- **Caveats**—
  - More study/analysis would be needed to accurately project this option (i.e., NYCWell model incorporated into current Call-SF plans).
  - Improved capacity for intake and assessment requires sufficient access to treatment/more treatment capacity.
  - Unclear whether effective linkages and ongoing assessments would take place in this model.
  - Improved data systems are needed to allow for real-time inventory across the BHS landscape.

Overall Questions:

- How do the options provide opportunities or challenges toward meeting DPH's and BHS's equity goals?

- Given the equity considerations, estimated costs, and caveats, what are the pros and cons of each option?

MHSC—Summary Table of Options

Option 1-Stand-Alone	Option 2-Multi-Location + Urgent Care	Option 3-Virtual Center
$24.6M to $55.3M	$11.7M to $20.5M	$3.2M
Cost includes all services legislatively mandated to the MHSC except drug sobering center. Biggest cost variable is for a facility.	Additive costs of expanded BHAC, OCC to meet the legislative goals and a new urgent care outpatient clinic.	Estimated cost to emulate the NYC expanded call center approach. A local effort to staff 9-8-8 and coordinate call lines is underway (“Call-SF”).

Next Steps

- Incorporate IWG feedback into an Options Analysis summary
- Brief Sup Ronen and MYR offices (early Sept)
- Publish final summary of the Options Analysis and the feedback received (mid-Sept)

Public Comment for Discussion Item #4

Mental Health Service Center Project: Options and Cost Analysis

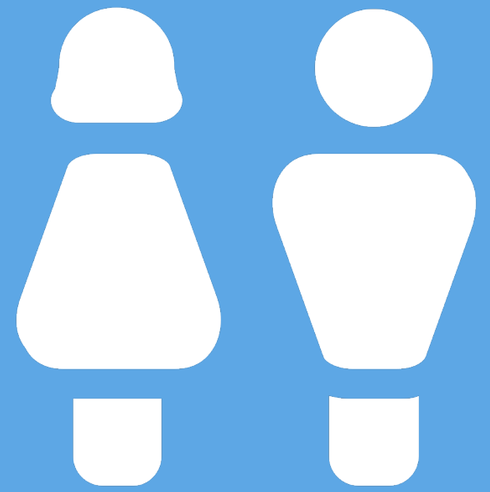
Steps:

- Call (415) 655-0001
- Enter access code 2481 671 8132
- Press ‘#’ and then ‘#’ again

10:50-11:50am

Discussion Item #5

Transitional Age Youth (TAY) Residential: Recommendations Review and Voting



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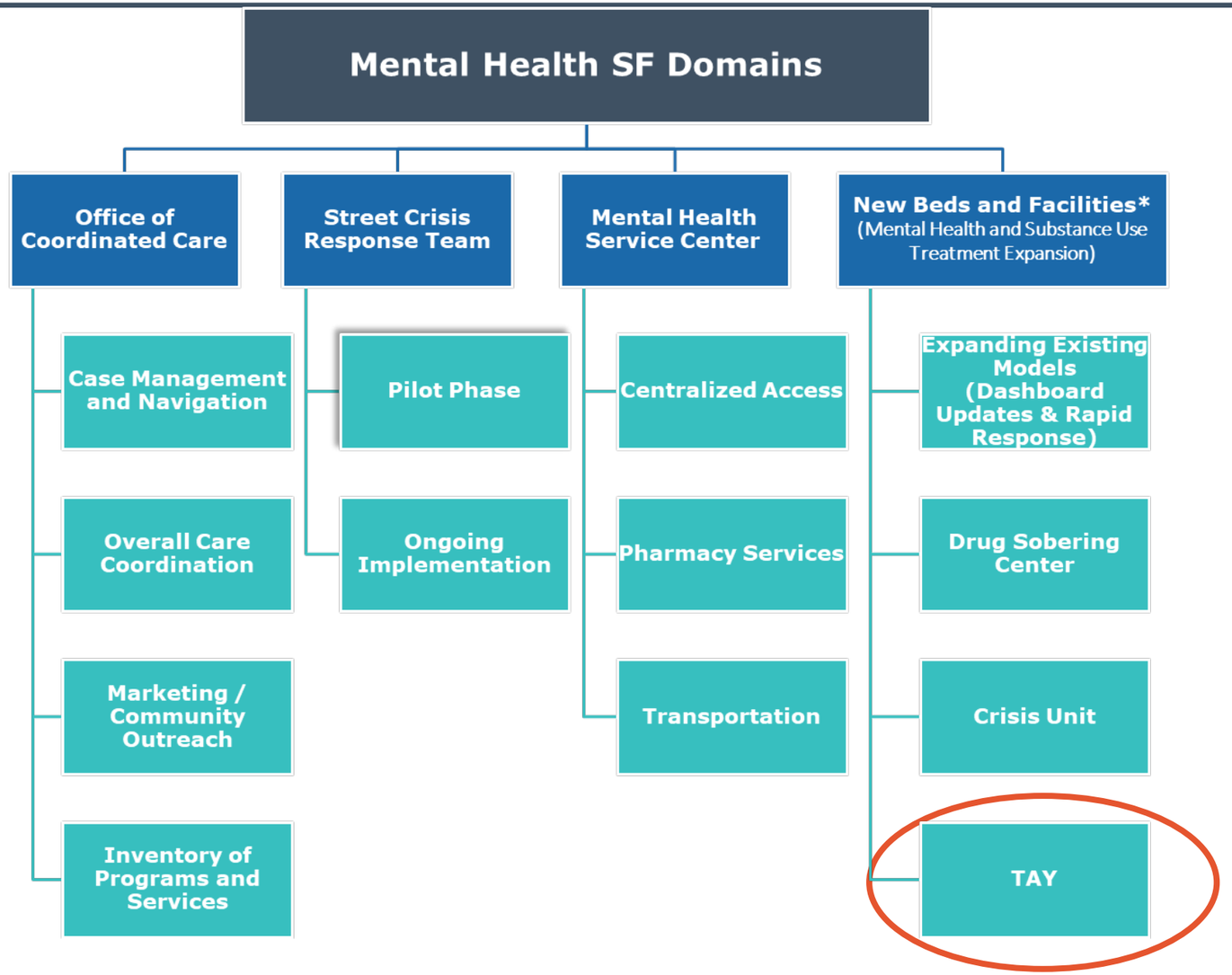
Reminder: Mental Health SF Domains



Data and IT Systems | HR Hiring and Pipeline | Equity | Analytics and Evaluation

Reminder of the Recommendation Roadmap

You are here!

March 22
IWG receives background and discusses*

April 26
IWG engages in white board session to source recommendation ideas*

No discussion group

July 26
IWG reviews Discussion City Planning Team's*

Aug
Discussion Group refines recommendation wording

Aug 23
Review recommendations and vote*

Conflict of Interest key
- = step out
- = be vigilant
- = all can participate

* Occurs during monthly IWG public meetings

TAY Residential Recommendations

Share screen

of recommendations

TAY Residential Recommendations

What is your level of agreement with the current TAY Residential Recommendations?

Public Comment for Discussion Item #5

Transitional Age Youth (TAY) Residental: Recommendations Review and Voting

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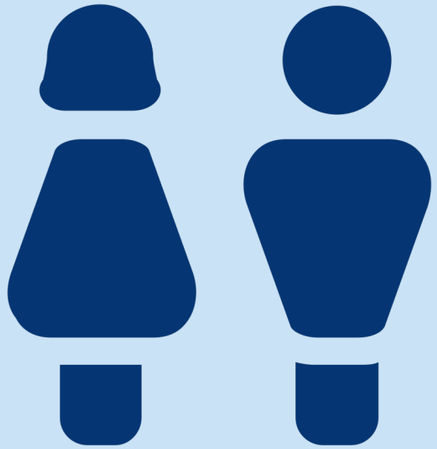
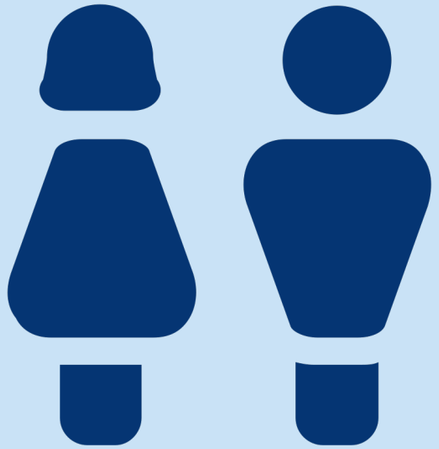


Vote on Discussion Item #5

Vote on TAY Residential Recommendations

Decision Rule:

- Simply majority, by roll call

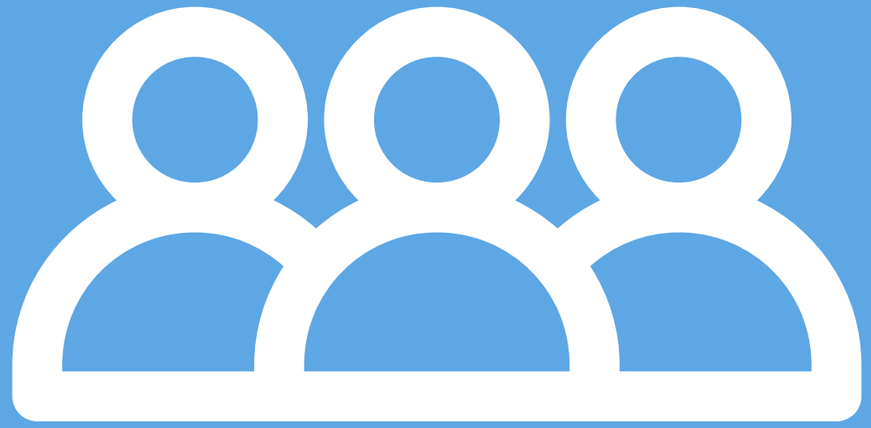



5 Minute Break

11:55-AM- 12:15PM

Discussion Item #6

MHSF Staffing & Wage Project Update



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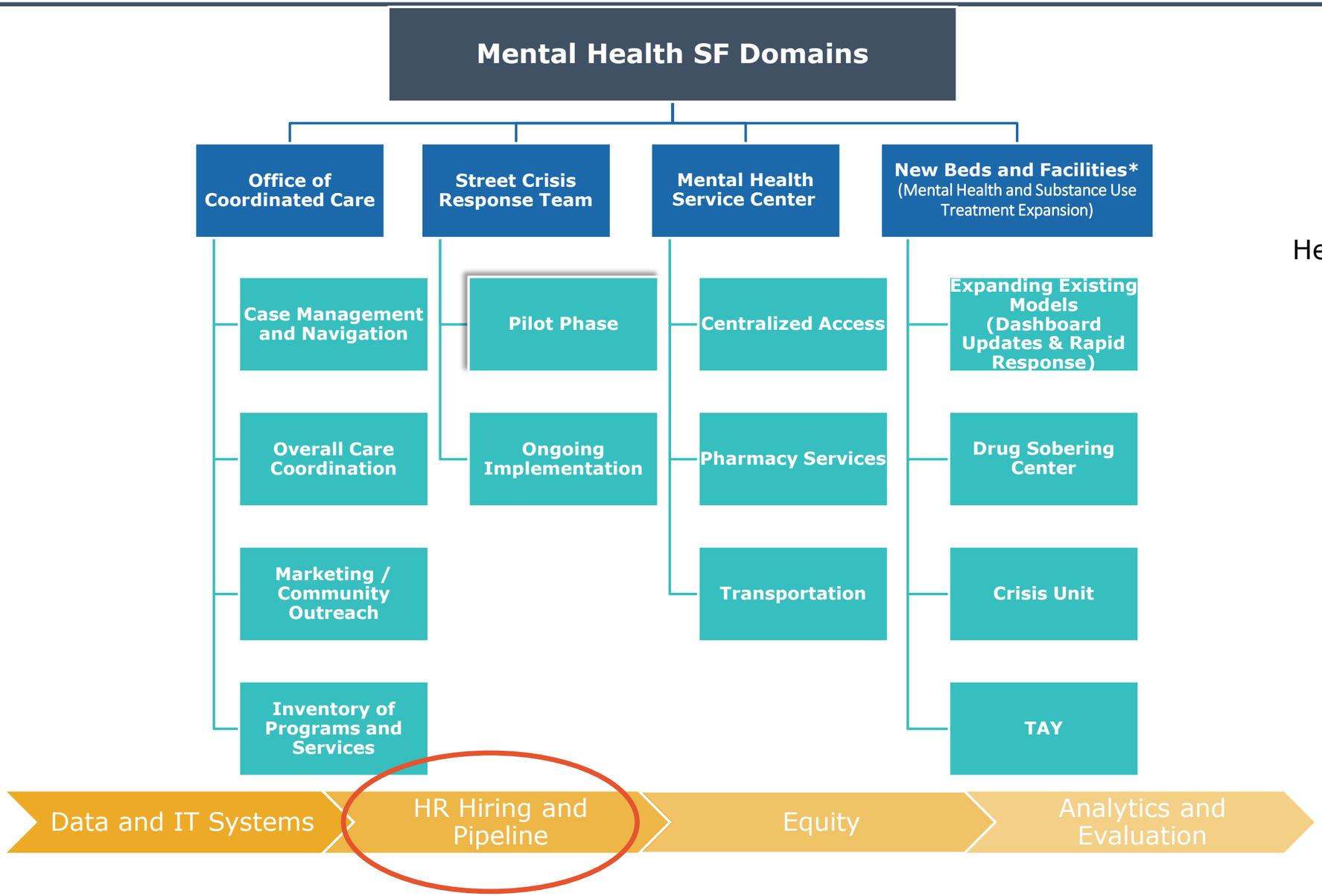
Reminder: Mental Health SF Domains



Heather Littleton

Glynis Startz

MHSF
Staffing & Wage Analysis

Implementation Working Group Update

CITY & COUNTY OF SAN FRANCISCO

Office of the Controller
City Performance Unit

Heather Littleton | Glynis Startz

8.23.22

Mental Health SF Legislative Directive

The Implementation Working Group shall work with the Controller and the Department of Human Resources to **conduct a staffing analysis** of both **City and nonprofit** mental health services providers to determine whether there are **staffing shortages** that impact the providers' ability to provide **effective and timely mental health services**. If the staffing analysis concludes that there are staffing shortages that impact timely and effective service delivery, the staffing analysis shall also include **recommendations regarding appropriate salary ranges** that should be established, and other **working conditions** that should be changed, to attract and retain qualified staff for the positions where there are staffing shortages.

Project Objectives – Phase 1 Priorities

Identify priority staffing gaps and worst service bottlenecks in current system based on existing analysis or data, assess the drivers of gaps, and recommend short to medium run solutions.

- ✓ Provides deeper analysis on root causes of a known staffing challenges.
- ✓ Allows for targeted recommendations in the short-run to bridge the worst gaps affecting immediate implementation and service delivery.
- X Does not provide a full staffing model based on projected demand in ideal state system (e.g., zero wait times, smaller case loads)

Defining “MHSF” through positions and services

- ✓ All Prop C funded MHSF services
- ✓ Services that are identical or materially similar to Prop C funded ones but funded through other sources
- ✓ Direct services, targeted toward and critically serving MHSF populations referred to in the legislation

Areas of Analysis

Identify MHSF Staffing Gaps

- Which City and CBO positions are critical to the delivery of MHSF services?
- Which positions are hard to fill and retain? (*vacancy rates, turnover rates, time to hire*)?
- Which positions are tied to lagging KPIs (unmet *units of service, long wait times, high case loads*)?
- Which of those have equity considerations?

Analyze Root Causes of Staffing Gaps

<u>Hiring</u>

- Where in the process do we lose qualified staff? Why?
- Why did candidates fall out of the 2022 hiring push?
- Where do our new hires come from?

<u>Retention</u>

- Where are they going?
- Why do they leave?
- How often?
- How similar are wages for like positions and conditions (across CBOs and Civil Svc)?
- Skills mismatch, other resources needed?

Develop Wage & Conditions Recommendations

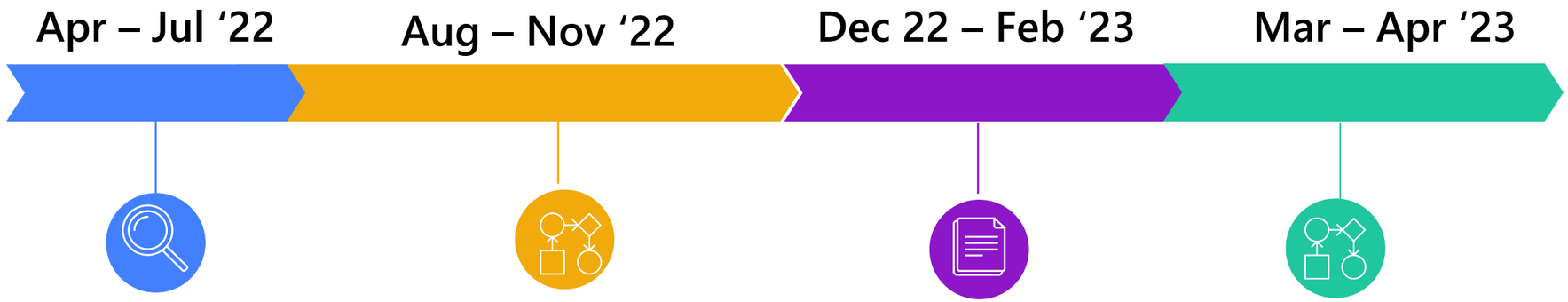
<u>Hiring</u>

- Appropriate pay increases?
- Other incentives? (hiring step increases)
- Process improvements? Improve recruitment pipelines?
- What's an appropriate position redundancy for this job market?

<u>Working Conditions</u>

- Other ways to not burnout staff? Appropriate case loads? Training?
- Appropriate stepdown services (do they have a place to go next?)

Potential Project Timeline



Scoping
Review priorities, data availability and approach

Staffing Gap Analysis
Data scan, data position analysis for key positions , stakeholder/CBO interviews

Root Cause Analysis
Analysis of critical drivers of hiring and retention issues for priority positions

Recs & Final Report
Recommendations development and reporting

Public Comment for Discussion Item #6

MHSF Staffing & Wage Analysis Project Update

Steps:

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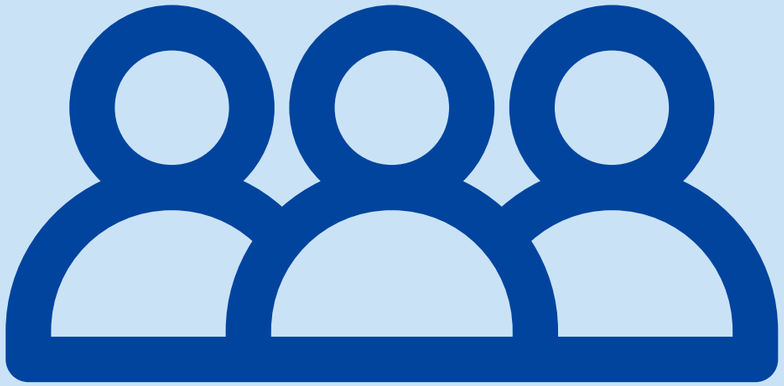

12:15-12:55

Discussion Item #7

Update from Analytics and Evaluation

Monica Rose, MA, PhD
Director, Research & Evaluation
Quality Management
Behavioral Health Services

Wendy Lee
City Performance Unit
Office of the Controller

All materials can be found on the MHSF IWG website at:
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MENTAL HEALTH SF ANALYTICS & EVALUATION

IWG 8/23/2022

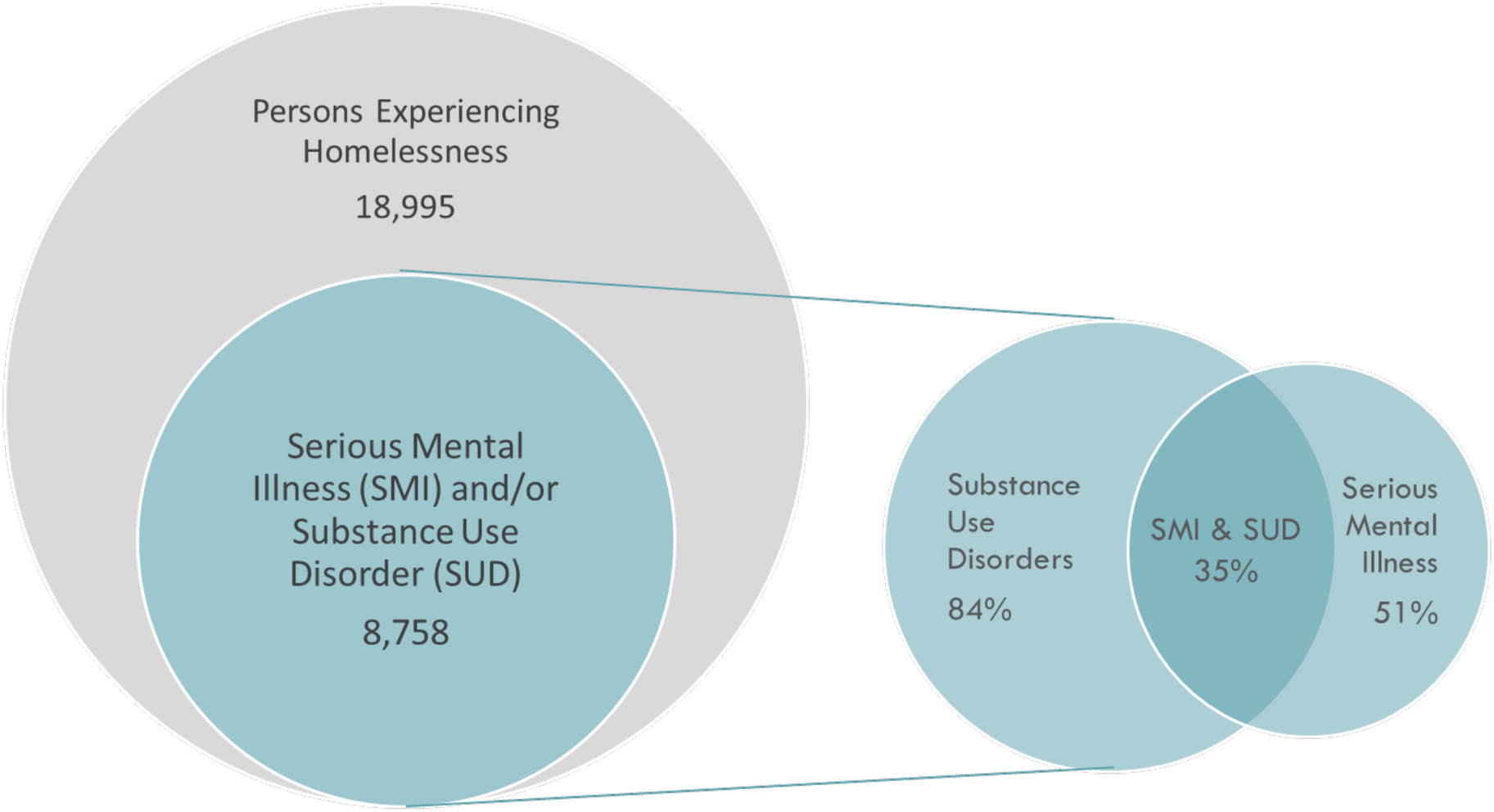
PRESENTATION OVERVIEW

- Description of the Mental Health SF Population
- Mental Health SF Core Metrics
- Estimated timeline of publication of data for the Core Metrics
- Sneak peak of draft data visualizations for wait time data:
  - Intensive Case Management and Mental Health Residential Treatment
- Next steps and challenges
- Feedback, Q&A

MENTAL HEALTH SF POPULATION

Per the Mental Health SF Legislation:

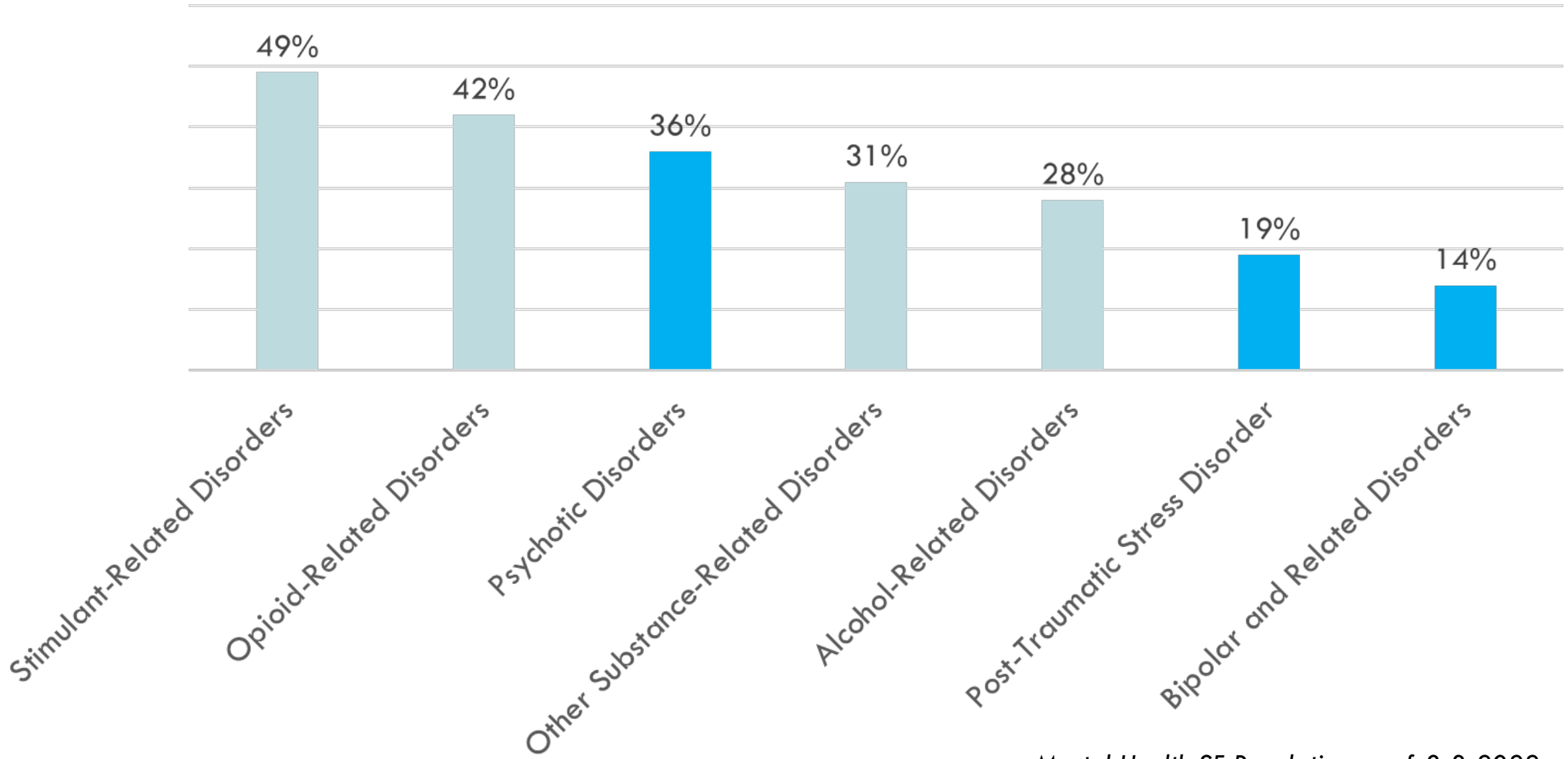
*The primary focus of Mental Health SF is to help people with **serious mental illness** and/or **substance use disorders** who are **experiencing homelessness** get off of the street and into treatment.*



Mental Health SF Population as of 8-3-2022

Data sources: DPH Electronic Health Record Systems (Epic, Avatar); Homelessness and Supportive Housing (ONE)

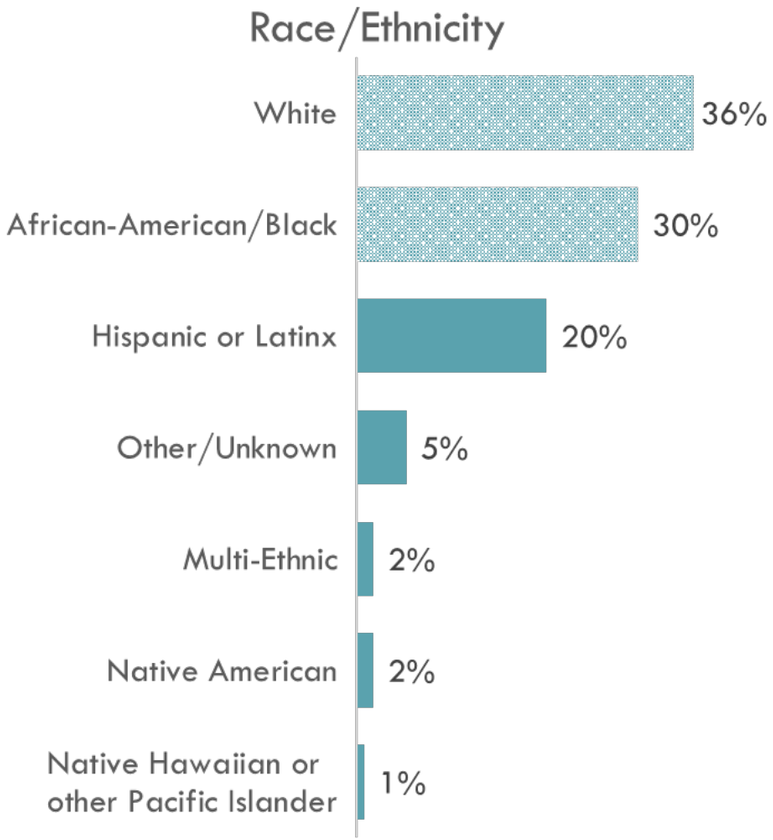
MENTAL HEALTH SF POPULATION:
MENTAL HEALTH AND SUBSTANCE USE DIAGNOSES



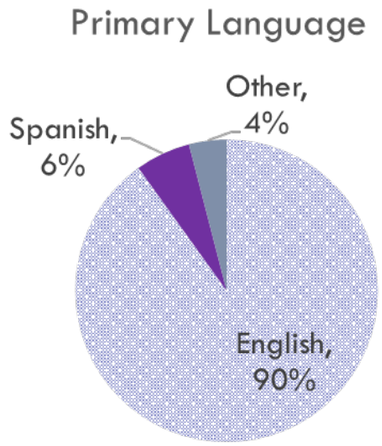
Mental Health SF Population as of 8-3-2022

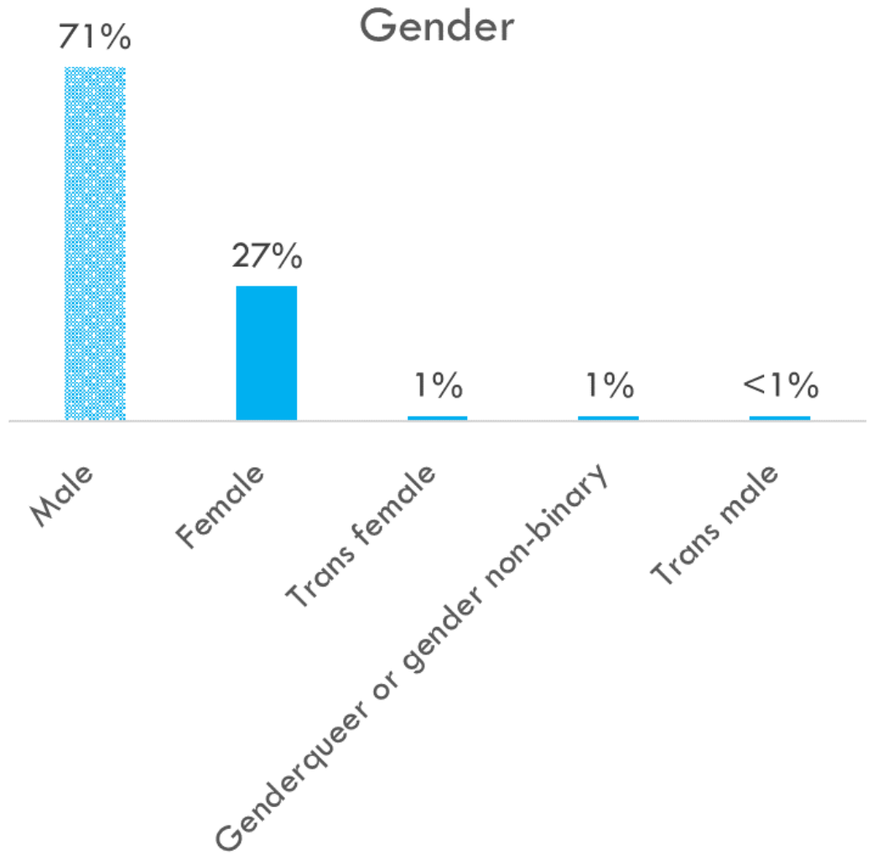
Data sources: DPH Electronic Health Record Systems (Epic, Avatar)

DEMOGRAPHIC PROFILE OF THE MENTAL HEALTH SF POPULATION (N= 8,758)



Mean Age = 44





Mental Health SF Population as of 8-3-2022

Data sources: DPH Electronic Health Record Systems (Epic, Avatar)

MENTAL HEALTH SF CORE METRICS

MENTAL HEALTH SF CORE METRICS

All metrics will be stratified by race/ ethnicity, language, and sexual orientation/ gender identity to identify disparities among groups.

Category		Proposed Metric
HOUSING	1	Increase the percentage of the Mental Health SF population assessed for housing.
	2	Increase the percentage of the Mental Health SF population who are placed in supportive housing
ROUTINE CARE	3	Increase the percentage of the Mental Health SF population receiving routine behavioral health care.
	4	Increase the percentage of the Mental Health SF population receiving routine behavioral health care post 5150 discharge.
WAIT TIMES	5	Decrease wait times for intensive case management services.
	6	Decrease wait times for residential treatment beds.
OVERDOSE RESPONSE	7	Increase the amount of naloxone distributed in the community.
	8	Increase the percentage of persons with opioid use disorders started on buprenorphine or methadone treatment.
	9	Decrease the number of deaths due to overdose.
	10	Decrease the disparity rates in deaths due to overdose.
QUALITY OF LIFE	11	Improve quality of life and functioning for persons in the Mental Health SF population

ESTIMATED DATES *FIRST* METRICS WILL BE PUBLISHED

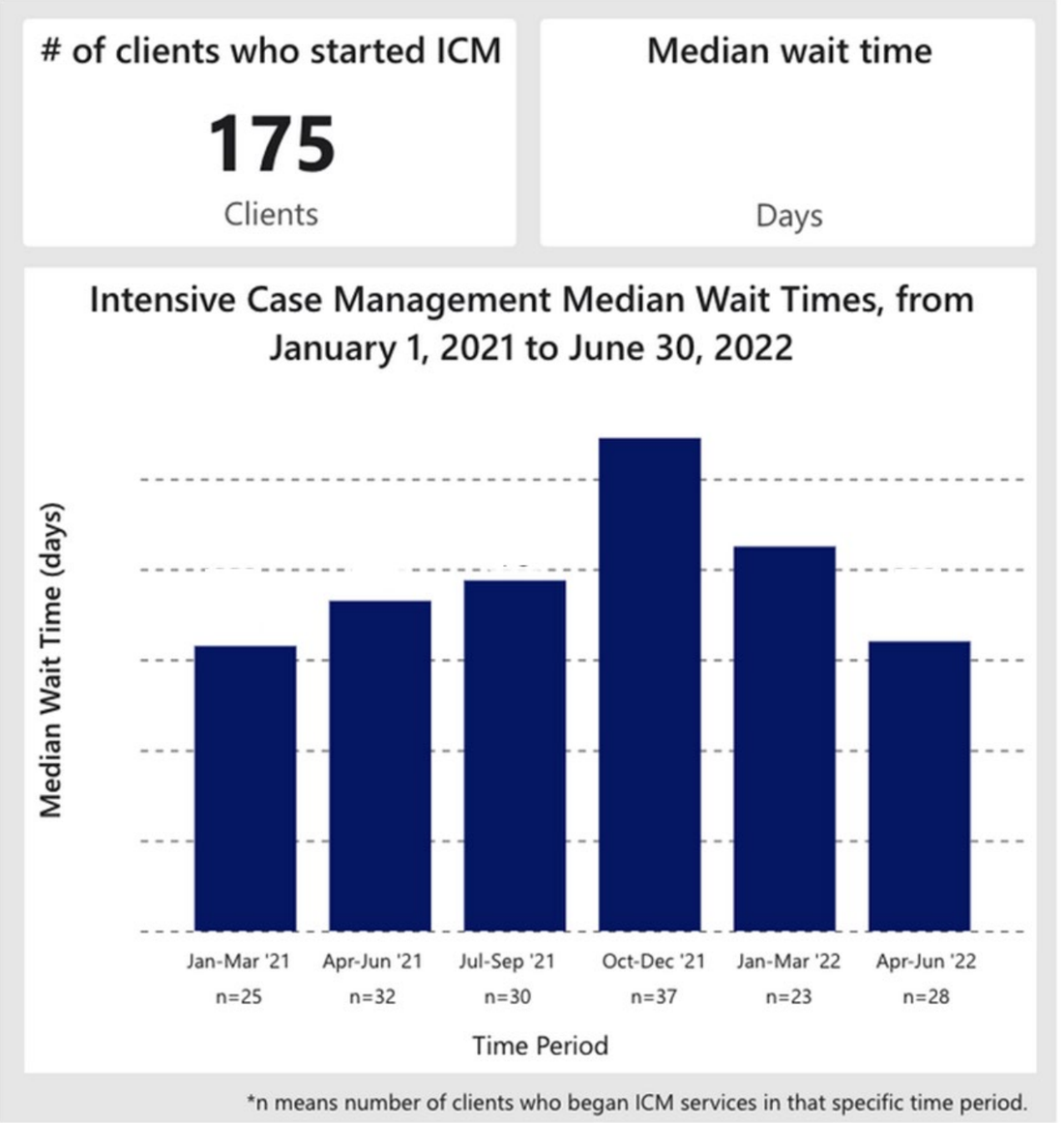
- Wait Times – Sept 2022
- Routine Care – Oct 2022
- Housing – Nov 2022
- Overdose Response – Dec 2022
- Quality of Life – *Pilot 2023*

SNEAK PEAK OF DRAFT DATA VISUALIZATIONS: INTENSIVE CASE MANAGEMENT WAIT TIMES

DRAFT DATA VISUALIZATIONS: INTENSIVE CASE MANAGEMENT

How do we calculate wait times?

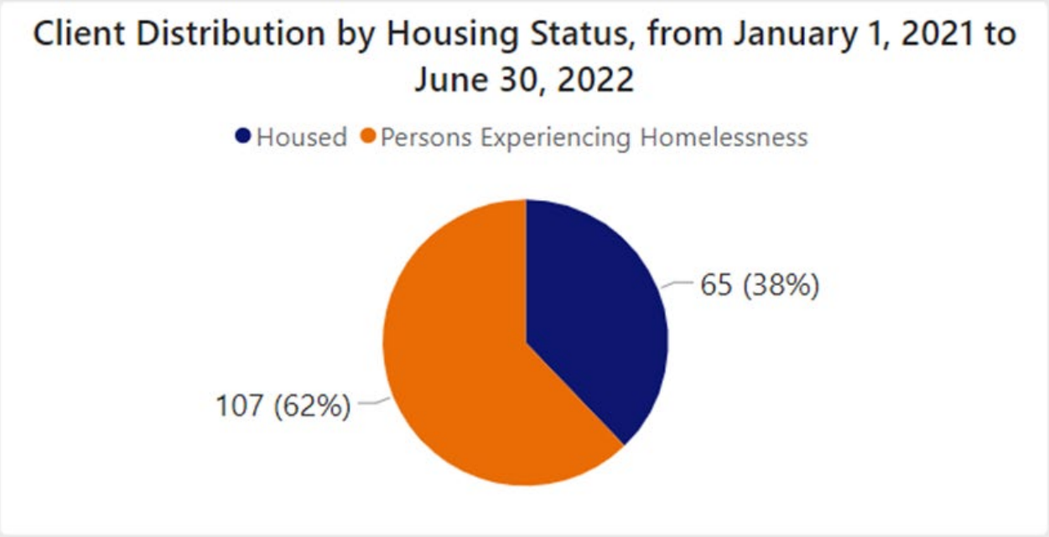
ICM wait time begins the day a client's referral is received by DPH Behavioral Health Services and ends the day a client's ICM treatment episode starts.

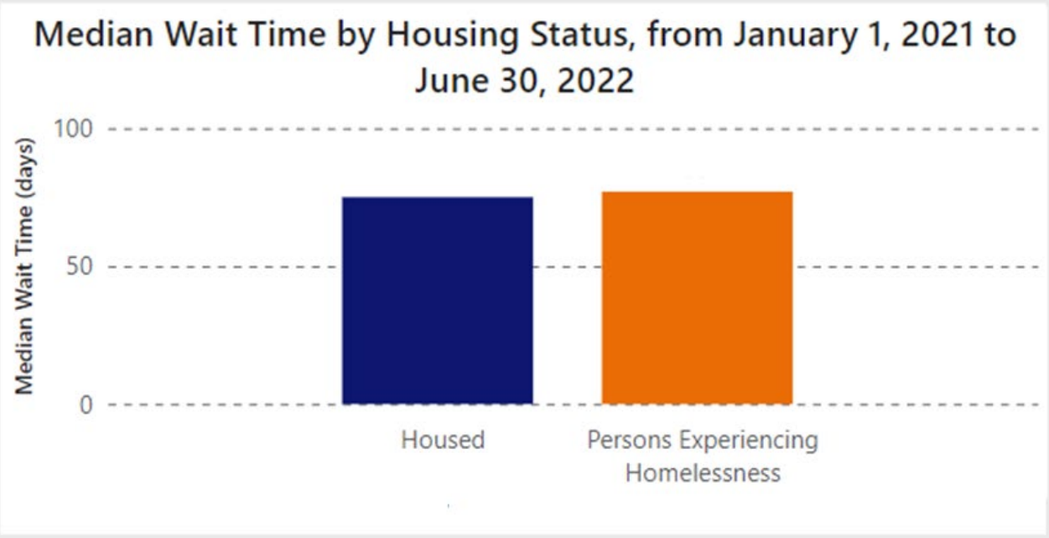


Data sources: DPH Electronic Health Record System (Avatar)
Data has not been finalized and may change

DRAFT DATA VISUALIZATIONS: INTENSIVE CASE MANAGEMENT CONT.

Comparison by Housing Status





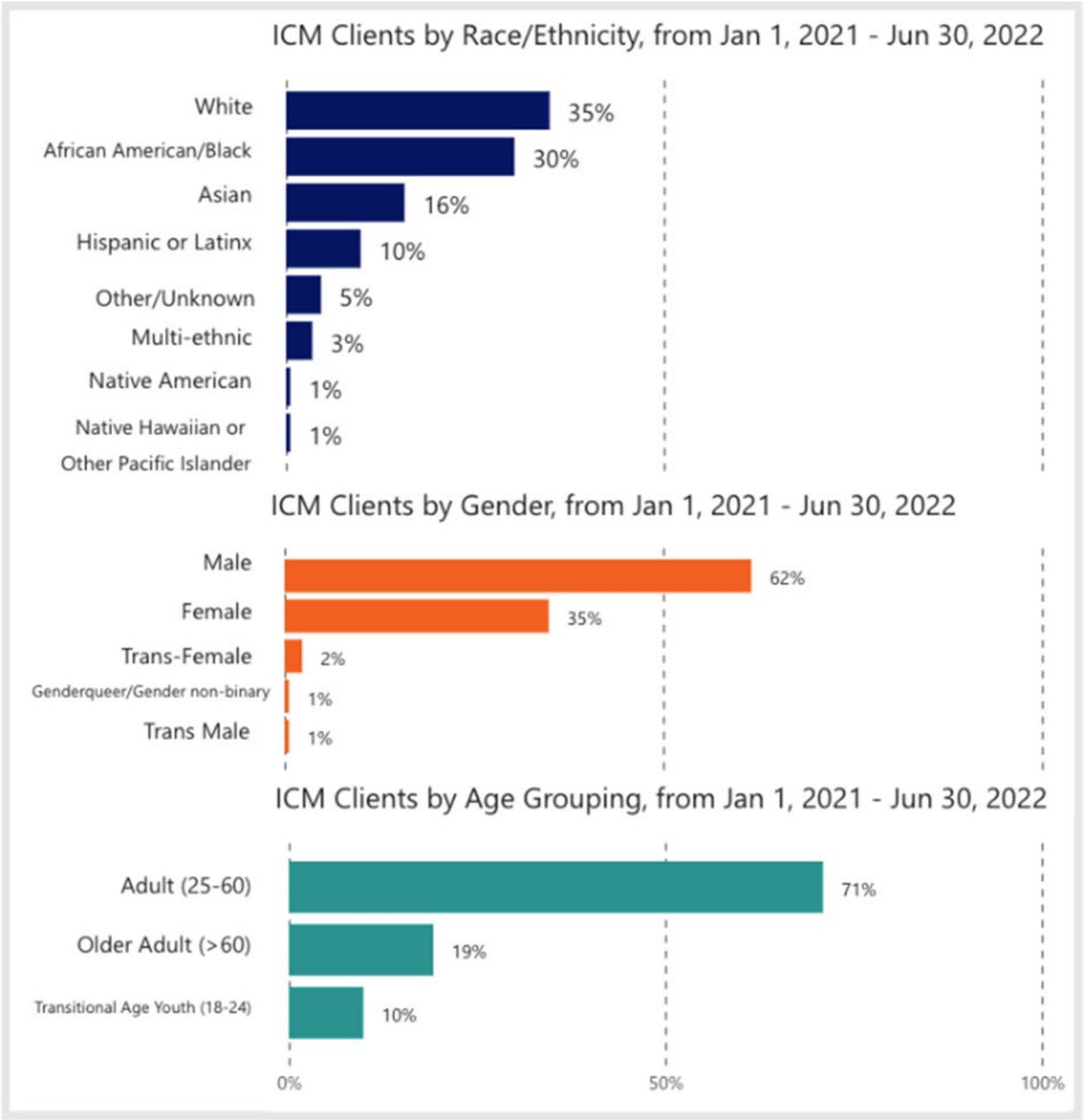
*n equals the number of ICM clients in that category.

City and Count of San Francisco
Data through: 6/30/2022
Last updated: 8/16/2022

Data sources: DPH Electronic Health Record Systems (Epic, Avatar); Homelessness and Supportive Housing (ONE)
Data has not been finalized and may change

DRAFT DATA VISUALIZATIONS: INTENSIVE CASE MANAGEMENT CONT.

Demographic Information



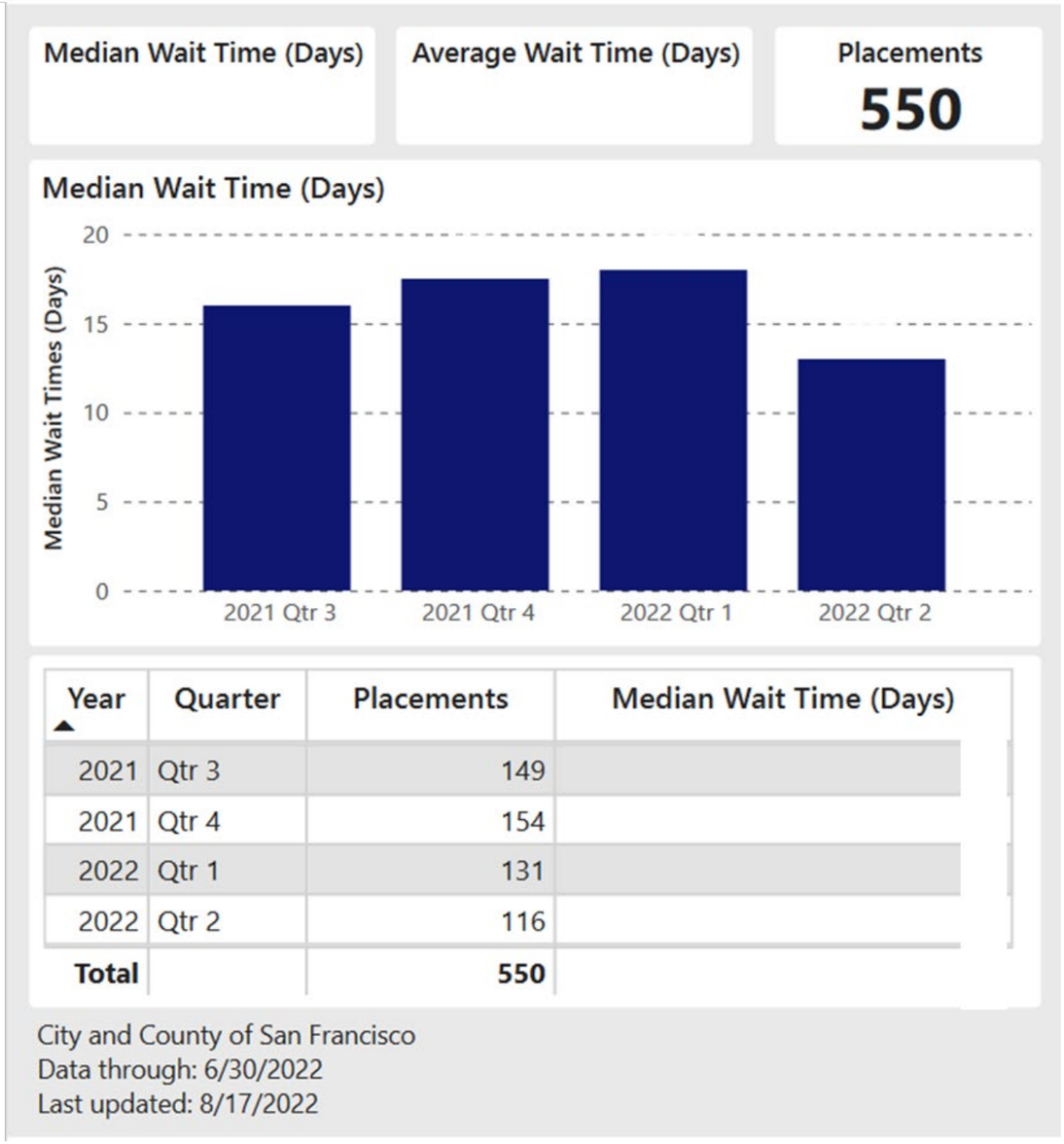
Data source: DPH Electronic Health Record Systems (Avatar)
Data has not been finalized and may change

SNEAK PEAK OF DRAFT DATA VISUALIZATIONS:
MENTAL HEALTH RESIDENTIAL TREATMENT WAIT TIMES

DRAFT DATA VISUALIZATIONS: MENTAL HEALTH RESIDENTIAL TREATMENT

How do we calculate wait times?

Wait time for mental health residential treatment beds begin the day a client's referral is received by DPH Behavioral Health Services and ends the day a client's mental health residential treatment episode starts.



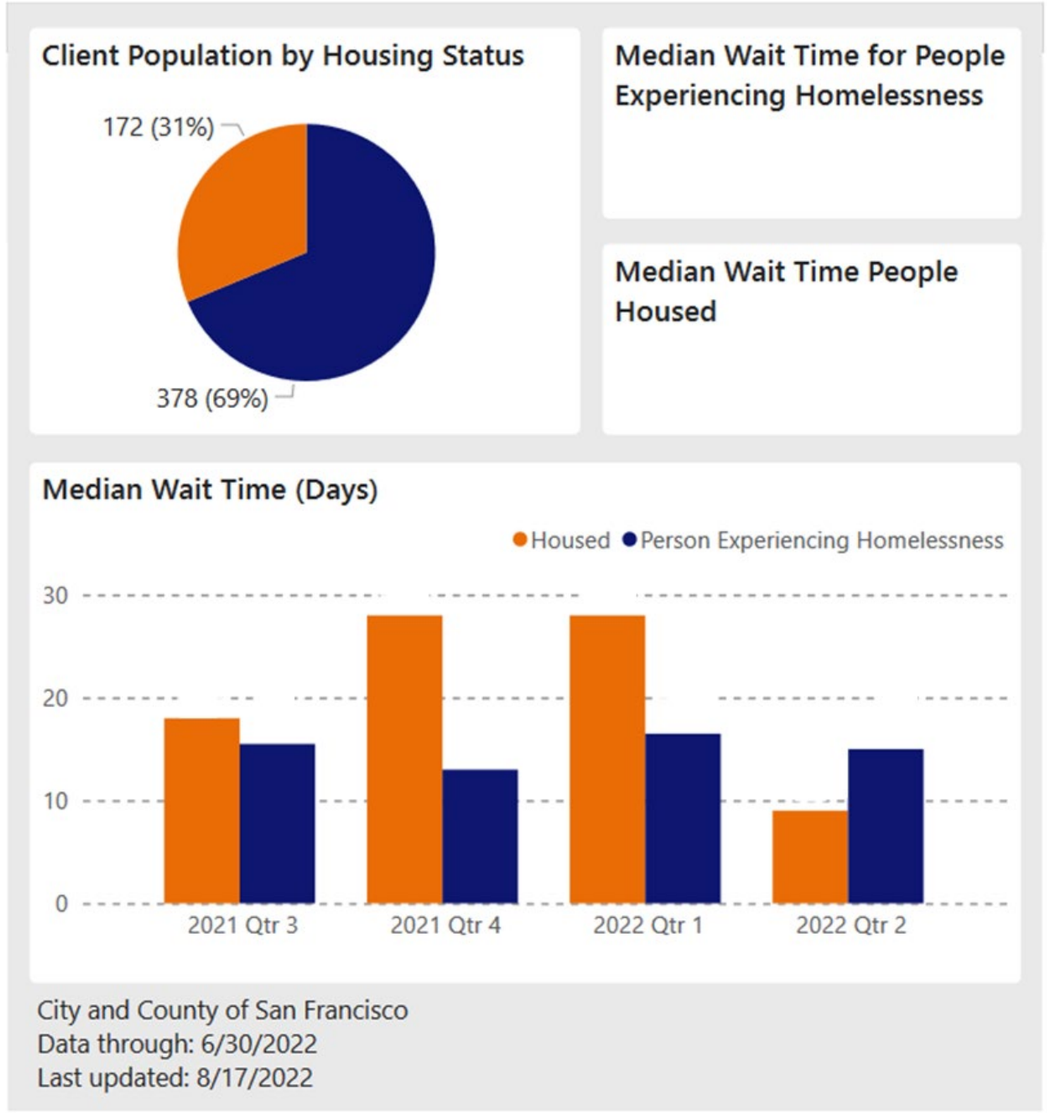
Year	Quarter	Placements	Median Wait Time (Days)
2021	Qtr 3	149	
2021	Qtr 4	154	
2022	Qtr 1	131	
2022	Qtr 2	116	
Total		**550**	

City and County of San Francisco
Data through: 6/30/2022
Last updated: 8/17/2022

Data sources: DPH Electronic Health Record Systems (Epic, Avatar)
Data has not been finalized and may change

DRAFT DATA VISUALIZATIONS: MENTAL HEALTH RESIDENTIAL TREATMENT CONT.

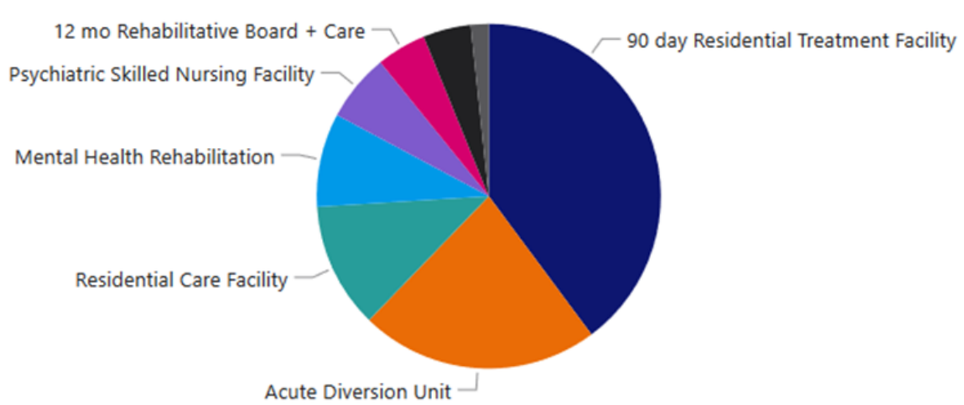
Comparison by Housing Status



Data sources: DPH Electronic Health Record Systems (Epic, Avatar); Homelessness and Supportive Housing (ONE)
Data has not been finalized and may change

DRAFT DATA VISUALIZATIONS: MENTAL HEALTH RESIDENTIAL TREATMENT CONT.

Wait times by Bed Type



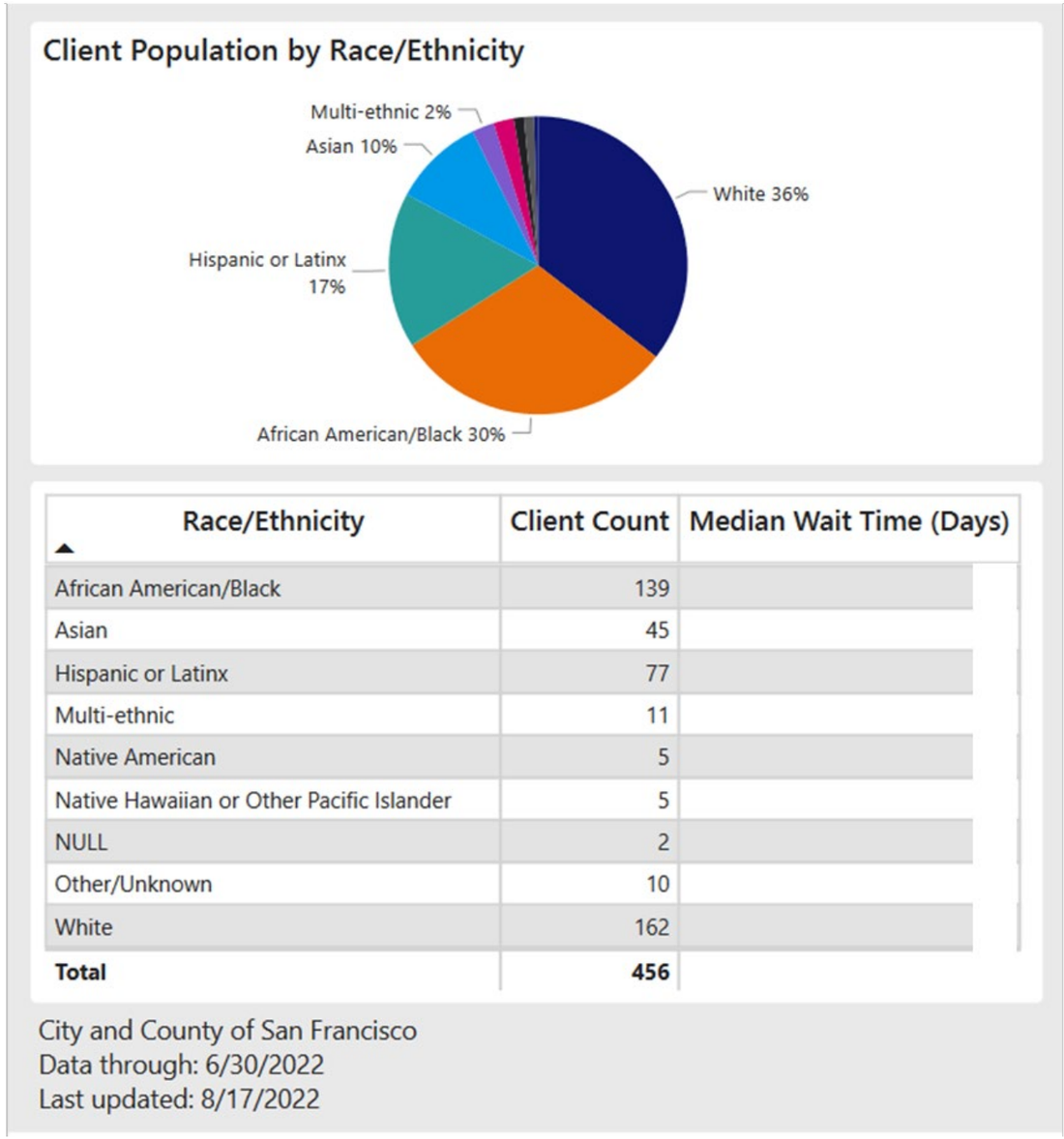
Bed Type	Client Count	Median Wait Time (Days)
90 day Residential Treatment Facility	213	
Acute Diversion Unit	120	
Residential Care Facility	63	
Mental Health Rehabilitation	47	
12 mo Residential Treatment Facility	39	
Psychiatric Skilled Nursing Facility	34	
12 mo Rehabilitative Board + Care	25	
Coops and Supportive Housing	9	
Total	**550**	

City and County of San Francisco
Data through: 6/30/2022
Last updated: 8/17/2022

Data sources: DPH Electronic Health Record Systems (Epic, Avatar)
Data has not been finalized and may change

DRAFT DATA VISUALIZATIONS: MENTAL HEALTH RESIDENTIAL TREATMENT CONT.

Wait time by Race/Ethnicity



Race/Ethnicity	Client Count	Median Wait Time (Days)
African American/Black	139	
Asian	45	
Hispanic or Latinx	77	
Multi-ethnic	11	
Native American	5	
Native Hawaiian or Other Pacific Islander	5	
NULL	2	
Other/Unknown	10	
White	162	
Total	**456**	

City and County of San Francisco
Data through: 6/30/2022
Last updated: 8/17/2022

Data sources: DPH Electronic Health Record Systems (Epic, Avatar)
Data has not been finalized and may change

NEXT STEPS & CHALLENGES

NEXT STEPS

- Complete draft of webpages for intensive case management wait times and mental health residential wait times
- Publish webpages and update quarterly
- Analyze data by demographic factors to identify inequities
- Continue working on the rest of the core metrics
- Work on data to support operations
- Convene stakeholders to begin discussions of measuring “quality of life”

CHALLENGES

- Implementing new protocols for reporting data across multiple electronic health records
- Incomplete, inconsistent data

FEEDBACK? QUESTIONS?

- Any feedback on today's content?
- What further information would you like to see in our next presentation(s)?

Ideas from A&E:

- Share findings from equity analyses
- Discuss how to define and measure "quality of life"

APPENDIX

MENTAL HEALTH SF POPULATION DEFINITIONS

Persons Experiencing Homelessness (PEH)

Individual or family who lacks a fixed, regular, and adequate nighttime residence

Serious Mental Illness (SMI)

Persons 18 years of age and older with a Psychotic Disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, or at least one inpatient visit for a Depressive Disorder

Substance Use Disorder (SUD)

All Substance Use Disorders included except Cannabis*, Nicotine, Caffeine-related Disorders , and Substance Use Disorders in remission (no use in >12 months)

***Time frames**: PEH in the last year, SMI and/or SUD in the last 2 years*

**Cannabis-related disorders with psychotic symptoms are included*

DEVELOPING & CHOOSING "CORE" METRICS

- A select group of metrics to begin working on 1st
- Prioritized thus far based on areas identified by the Mental Health Reform Work, the Mental Health SF Legislation, and stakeholders and SMEs from the Mental Health SF domains, Behavioral Health Services (BHS), Ambulatory Care, and DPH leadership
- Metrics that will enable broad tracking of the impact of Mental Health SF programs and services for the MHSF population
- Metrics that are measurable, meaningful, and actionable
- Feasible based on data that is available or can be collected
- Manageable number of metrics

USING DATA TO IDENTIFY INEQUITIES

Data collection and maintenance → Standardized reporting → Consistent & routine reporting of metrics by key demographic factors → Determine appropriate comparison groups and benchmarks → Ensure data reports and visualizations clearly highlight disparities → Share findings with stakeholders

Public Comment for Discussion Item #7

Update from Analytics and Evaluation

Steps:

- Call (415) 655-0001
- Enter access code 2481 671 8132
- Press ‘#’ and then ‘#’ again

Public Comment for

Any other matter within the jurisdiction of the Committee not on the agenda

Steps:

- Call (415) 655-0001
- Enter access code 2481 671 8132
- Press ‘#’ and then ‘#’ again

Anticipated IWG Meeting Topics 2022

Topic Area	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
IWG Domain												
Street Crisis Response Team					U					U		
New Beds & Facilities (NB&F): Drub Sobering Center						U				U		
NB&F: Crisis Unit	D	D		D	D		D			U		
NB&F: TAY project			D	D			D	D				
NB&F: Minna Project					D	D				U	U	
NB&F: Expansion of Exhisting Models							U					
Office of Coordinated Care (OCC)	D	D	D		U				D	U	U	
Mentla Health Serice Center (MHSC)			U		U	U		D		D		
Analystics & Evaluation	U							U				
Deliverable: IWG Annual Progress report										★		
Deliverables: IWG Implementation Report												★
Other Intersecting Departments/Projects/Briefings												
CON: Citywide Staffing Analysis								U				
HSH: Housing Briefing		U							U			
DPH MHSF Budget Update/ Our City Our Home (OCOH/Prop C) Alignment							U			U		

D=Design U=Update

Housekeeping

- Next Meeting Date and Time
  - 4th Tuesday of the month 9:00AM-1:00PM
  - **September 27, 2022**
  - Note: will send out a scheduler for the holiday months of November and December
- Meeting Minutes Procedures
  - https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
  - Draft minutes in the next two weeks
  - Approved meeting minutes will be posted
  - We plan to migrate the IWG site to the DPH platform after the August meeting
- MHSF IWG e-mail address for public input: MentalHealthSFIWG@sfgov.org

Adjourn

Appendix A: Attendance (since it's become a formal process)

Member	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Amy Wong												
Jameel Patterson	E	E										
[Vacant]												
James McGuigan			E									
Dr. Vitka Eisen												
Steve Fields												
Andrea Salinas												
Dr. Monique LeSarre												
[Vacant]												
Dr. Ana Gonzalez												
Sara Shortt												
Dr Hali Hammer												
Steve Lipton												

E= Excused Absent (unexcused)