FY 23-24

Annual Report

SF COORDINATED STREET RESPONSE TEAMS

Coordinated Response Division

Department of Emergency Management

FY 23-24

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EXECUTIVE SUMMARY

The SF Coordinated Street Response Teams integrate crisis response, rapid response and planned outreach into a comprehensive strategy that addresses a wide array of behavioral health crisis and homelessness needs on the streets of San Francisco. Nine teams across four departments are covered in this report:

SF COORDINATED STREET RESPONSE TEAMS

A. Department of Emergency Management
    1. Healthy Street Operations Center (HSOC)
    2. Homeless Engagement Assistance Response Team (HEART)
B. Department of Public Health
    3. BEST Neighborhoods (BN)
    4. Street Medicine (SM)
    5. Office of Coordinated Care/Street Crisis Response Team, Triage (OCC-SCRT Triage)
    6. Post Overdose Engagement Response Team (POET)
C. Fire Department/Community Paramedicine
    7. Street Crisis Response Team (SCRT)
    8. Street Overdose Response Team (SORT)
D. Homelessness and Supportive Housing (HSH)
    9. Homeless Outreach Team (HOT)

Each team brings a unique specialty to the work, serving clients in crisis and/or experiencing homelessness in accordance with their mission, funded contractors, and work plans. As well, responsive to city leadership and the public, collectively, we have worked diligently together over the last couple of years to make progress on requested goals:

A. To tighten our cross teams' communication and coordination.
B. To use data to drive our program, operational, and system decisions.
C. To simply all street response teams' information through a unified public awareness and media/communications strategy.
D. To demonstrate progress towards recommendations made by the SF Budget and Legislative Analyst's (BLA) office.

OVERVIEW OF KEY COORDINATION ACHIEVEMENTS

A. Developed top ***tier goal and performance metrics***
B. Built a backend data integration, creating one ***all street teams database***
C. Created an all street response teams', ***by-name client list***
D. Launched a beta version of all street response teams' ***outreach worker tool***
E. Built a wireframe for the ***policy maker dashboard***
F. Designed a mockup of the all street response teams', ***public facing website***

Looking Forward

This FY 23-24 report showcases tremendous progress of SF Coordinated Street Response teams. It's a brightline of the vital work of each team and the steps we have taken together to improve coordination. We share a sense of urgency to answer key questions about our work: What do the teams do; how many people have been served; what client needs are; and most importantly, what are the outcomes of our work.

In FY 24-25 (July 1, 2024 – June 30, 2025), as the above key achievements indicate, there is a foundation to accelerate the compilation of data and outcomes that city leaders and the public want to see. Over the next several months, we'll ensure the accuracy and responsiveness of the integrated, all street teams client data base, a large undertaking that has all teams' full commitment. To memorialize commitments, we'll complete an operational workplan that reflects our top tier goals, performance metrics, services, coordination and reporting, information that will help leaders to answer key questions about the client journey and the collective impact of our work.

LEADERSHIP STATEMENTS

Department of Emergency Management, Executive Director, Mary Ellen Carroll

"The Department of Emergency Management coordinates the SF Coordinated Street Response Program, a multi-pronged effort, at the client-level, to get people safely off the street and linked to available services and at a system level, to strengthen coordination and communication strategies across all participating street teams. To improve conditions for people in need and in our communities at large, we must align around shared policies and practices, and better use data to improve our operations and inform our policies".

Department of Public Health, Director of Health, Dr. Grant Colfax

"Street-based care is an essential part of our public safety net. SFDPH street teams are in the community every day and night working with the City's most vulnerable residents, many of whom have complex medical, mental health and substance use conditions, and trauma that can prevent them from seeking medical care through traditional pathways. SFDPH street teams employ medical and behavioral health professionals, as well as health workers and peer specialists with lived experience. They holistically support clients with the ultimate goal of getting them into ongoing treatment and care, in addition to coordinating with other City systems to meet their basic needs. We continue to evolve our approach and our teams' work to make the greatest impact on individuals and the communities we serve."

San Francisco Fire Department, Chief, Sandy Tong

"The Fire Department has been a leader within San Francisco, California, and nationally in recognizing that we must adapt our 911-based care to meet the evolving needs of our community. Every day in our city we see people who require services and interventions that span traditional departmental boundaries. We also see the positive health outcomes that can happen when we deliver on these complex needs. The Street Crisis Response and Street Overdose Response Teams' successes are evidence of this coordinated approach, and we will continue to build and collaborate on these data-driven models of effective care."

Homelessness and Supportive Housing, Executive Director, Shireen McSpadden

"Effective coordination of outreach and engagement services is crucial in linking individuals with complex health needs to shelter and permanent housing. By building trust and providing consistent support, we can ensure that those who are most vulnerable receive the comprehensive care they need to transition from experiences of homelessness to stable, long-term housing."

Department of Emergency Management (DEM): Coordination, Healthy Streets Operation Center (HSOC), Homeless Engagement Assistance Response (HEART), Joint Field Operations, Ambassador Programs Coordination	**Department of Public Health (DPH):** Office of Coordinated Care (OCC) – SCRT Triage; OCC – BEST Neighborhoods, Street Medicine, Post Overdose Engagement Team
Homelessness and Supportive Housing (HSH): Outreach, shelter, housing placement and housing assistance	**Fire Department/Community Paramedicine (SFFD)** Street Crisis Response Team and Street Overdose Response Team

SF COORDINATED RESPONSE OVERVIEW

History

Outreach and engagement teams were launched nearly two decades ago through the initial establishment of the Homeless Outreach Team in 2004, followed by the launch of Street Medicine several years later, both under the Department of Public Health. In 2016, the Homeless Outreach Team moved to the Department of Homelessness and Supportive Housing.

In 2018, the Healthy Streets Operation Center launched, spotlighting the efficacy of braiding multi-department teams into daily coordinated efforts focused both on linking people in distress to shelter and services and to ensuring that San Francisco's streets and sidewalks were clean and accessible for all.

In 2020, through the establishment of Mental Health SF, the Office of Coordinated Care and crisis response teams were respectively consolidated or created. During the period of 2014 – 2020, coordination was organic to client-level efforts, but a need for more coordination and tighter data sharing was already evolving.

By 2022 when nearly ten street response teams were operating across San Francisco and the homelessness and behavioral health crisis on our streets intensified, there was an increased focus on tighter all street response teams' coordination. The Department of Emergency Management was asked to play a coordination leadership role, beyond the work of HSOC, and work hand in hand with leaders of all teams to simplify messaging about street response work, streamline coordination, instruct the public on how to activate street teams, use data to drive operational and policy decisions and improve collective impact reporting.

A new team, HEART was launched to address a gap in our street response continuum. Collectively, we took first steps all together to de-silo our efforts, and further define strategies for improved coordination, focusing on ways to leverage the unique expertise of teams, reduce duplication of services and support more clear paths to expedited services linkages for clients.

Coordination progress is demonstrated through improved resource commitments made to daily, "direct action" efforts like HSOC, through finetuning a focus on "shared priority clients," people with identified complex health needs, and through the integration of data science and engineering, capacity that has moved the needle on data and reporting improvements.

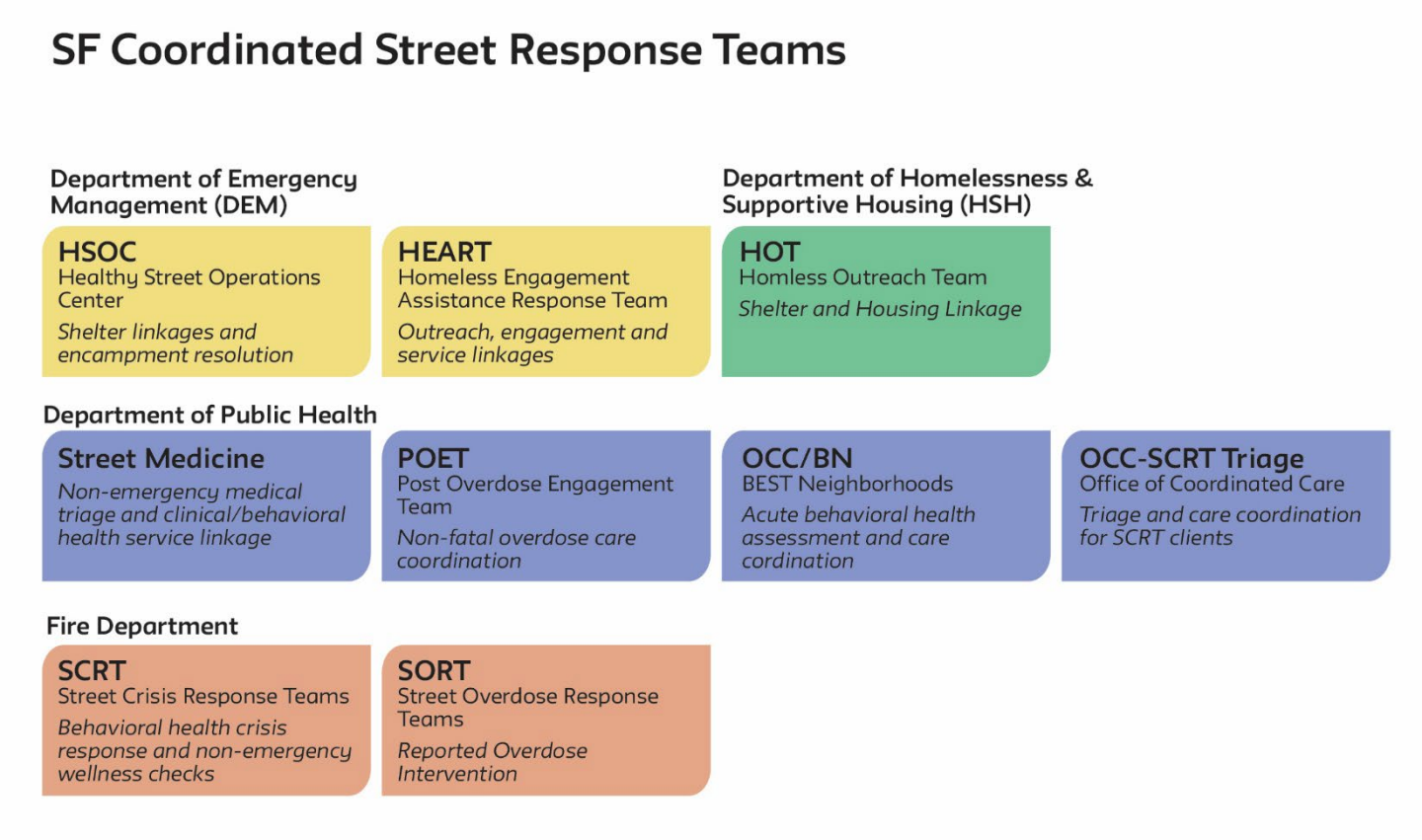
We recognize the urgency of better defining our work and how it both addresses and improves the complex needs in San Francisco. FY 24-25 is the year that we build on the coordination infrastructure established last year and accelerate projects that result in greater clarity on the impact of our collective efforts, results that are a win for people experiencing homeless and San Francisco communities.

Coordination Framework and Underpinnings

San Francisco's Coordinated Street Response effort is built around two pillars:

a. Direct service delivery
b. Inter-team coordination

Teams provide direct services to people in crisis, distress and experiencing homelessness and operate in coordination with each other to expedite linkages to care through direct services action like HSOC and through inter-team, care coordination efforts. A summary of street team services:

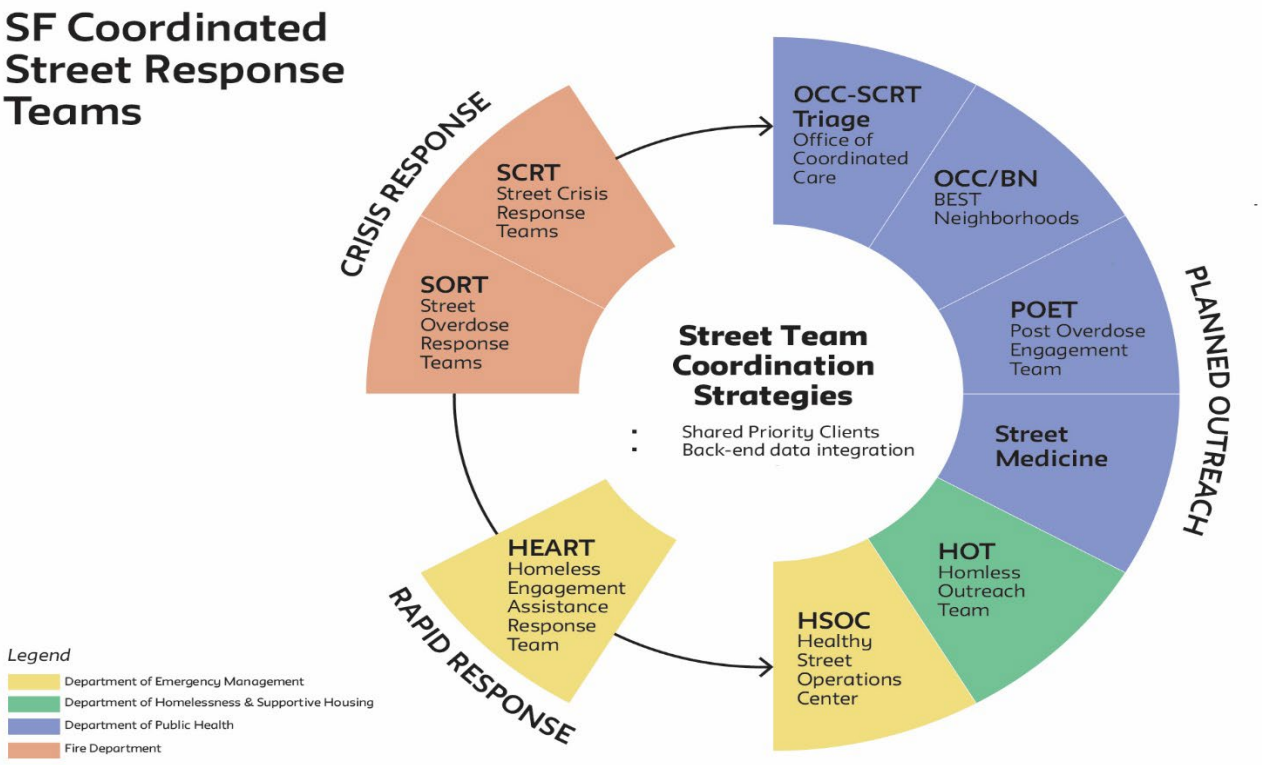


All of these teams also work in close coordination to provide a more comprehensive array of services to meet the needs of our most challenging situations.

The *following* diagram demonstrates a continuum of coordination between street teams that provide an array of services.

It can be interpreted as following:

- "SERVICE TYPES" (the outermost ring) indicates the service types or buckets under which street teams services' belong. As client need demands, all teams may operate out of their identified service type to provide a needed service. For example, the SF HOT team may provide rapid response to address a time sensitive need and the HEART team may conduct planned outreach. The "SERVICE TYPE" reflects the primary function of the team.
- "SERVICES/TEAMS" (the middle ring) illustrates the array of street teams (including HSOC which is both service provider and coordinator/convener) and
- "COORDINATION" (the innermost ring) reflects how the SF Coordinated Response teams work together to meet the complex and dynamic needs of people in distress in San Francisco, efforts focused on shared priority clients and improved data integration. Additional details on coordination strategies are provided throughout this report.



- Crisis response: Responses to 911 calls/needs; address overdoses (SORT) and behavioral health crisis (SCRT).
- Rapid response: Activated by calls to public safety non-emergency and primarily to 311; address unidentified and non-emergency needs of people experiencing homelessness.
- Planned outreach: Operate following a planned schedule or zone or district deployment in areas where identified clients are located and where there are known hotspots; address persistent behavioral health challenges, shelter and housing needs, non-emergency medical needs, non-fatal overdoses, and encampments.

Clients are at the center of our work. Recognizing the deep trauma experienced by the people we serve, we take dignity, safety, and wellness seriously. SF Coordinated Street Response teams complete extensive training around effectively engaging with people experiencing behavioral health disorders and homelessness. Training is tailored to the expertise of the team but includes minimum standards across all teams:

Motivational interviewing	De-escalation Techniques	Client-centered, trauma informed, culturally responsive and strength-based approaches to effective engagement

We recognize that building trust with clients who may be suspicious of institutional systems or who have experienced harm within systems is the backbone to connecting or re-introducing a person to stabilizing resources. While our work seeks to ultimately empower clients to self-determine their connection to offered services, our teams are vigilant about observing when a person's behaviors may be harmful to self or others. When legally and ethically appropriate, teams use California's 5150 law indicating that a person should be detained for assessment, evaluation, and treatment planning. The law outlines a clear and narrow definition for when professionals can legally and ethically activate a 5150. Street teams are both judicious about whether a person meets criteria and keenly aware of the importance of a legal tool that can offer structure that is needed on a complex wellness journey. Teams use every available tool and resource to address the complex needs of our clients. While our work is labor and time intensive, we continue to strategize on ways to scale success.

DEM and all street response team partners collaborated to simplify and tighten up messaging about and improve public understanding of SF Coordinated Street Response.

- Dozens of focus groups and feedback and planning sessions resulted in the creation of a public awareness campaign, "Okay to Call" which included posters, palm cards, advertisements in bus shelters, and a public facing website that raises awareness about street response teams and coordination.
  - The website educates the public on the work of street teams and on how teams collaborate.
  - Importantly, it also details how the public can activate the street team that is best positioned to respond to specific needs observed on the street.
- The public can access the SF Coordinated Street response program by going to: https://www.sf.gov/coordinated-street-response-program.

COORDINATION SUCCESSES – DRIVEN BY DATA IMPROVEMENTS

Our last report spotlighted strategies for improving coordination and accountability. Historically, legal hurdles, proprietary client data bases and data siloes hampered coordination efforts. However, today we are proud to report that significant progress has been made on each of the previously presented recommendations. Over the past year and a half, through a robust partnership with the Mayor's Office of Innovation (MOI), we established a legal framework to support expanded data sharing for SF Coordinated Street Response and incorporated data engineering and data science expertise into our work, two skillsets that were previously unavailable to core street response departments.

This partnership has been a game changer for SF Coordinated Street Response. We will look to build on that technical expertise in the future through expanded capacities in data engineering and data science.

The following table provides a status update of the strategies, followed by additional detail on progress and challenges for each.

Summary of Improved Coordination Strategies

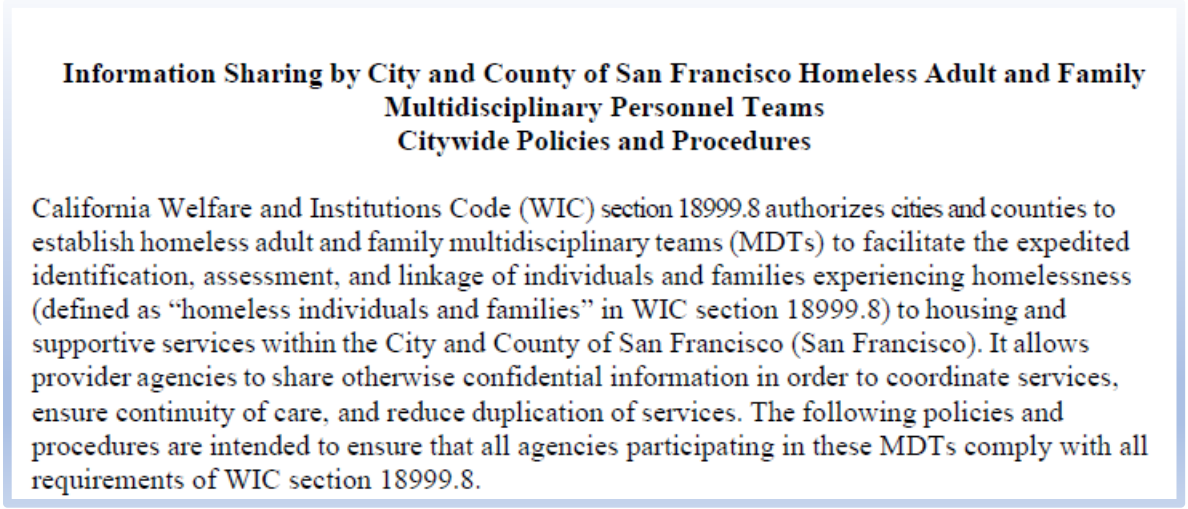
Objective	Update	Status: Active, In progress, Not Started
Structural Coordination		
1.Established a legal framework for data sharing	• Fully operational	• Active
2. Centralized coordination efforts	• Coordinated Street Response division at DEM created in FY 22/23 • Manage an array of client, system and policy meetings	• Active
Data Coordination		
3. Cross department data sharing, Development of a back end data integration and tools for data access	• Integration has been built; continued iteration with expanded data sets and data quality control diligence.	• Active
4. By-name client list, linking siloed client histories and data sets	• Linking completed; IT/analysts continue data quality/integrity due diligence	• Active
5. (NEW) Outreach Worker Tool (OWT)	• Centralized access to client profiles, an internal tool for outreach workers	• Active
Accountability Alignment		
6 and 7. Publishing data	• Creation of a.) the policy maker dashboard and b.) public facing website	• In progress
8. Top line goal and performance metrics and data definition alignment and field inputs.	• Draft details have been circulated and are reflected below. Further review and iteration needed to ensure database is populated appropriately. • Aligning data definitions and field inputs are system FY 24-25 objectives	• In progress
9.Impact Reporting	• Need to continue to finetune back end, all street teams, client database • Finalize goals and performance metrics • FY 24-25 report will include more robust data; information that will be available in advance of next submission through the policy maker dashboard and public facing website.	• In progress

1. Established/Sustained a Legal Framework for Data Sharing

Historically, street team data sharing was allowable through an array of ad-hoc data sharing agreements and memorandums of understanding across different sets of departments which facilitated the sharing of information across some but not all departments providing street response services. Our inability to share data deemed private and confidential, while restricted by well-intended laws, created services delivery and coordination inefficiencies. People in need could be served by multiple street response teams in one day without there being teams awareness of multiple engagements. The sequencing of care coordination goals could be poorly implemented as one team encouraged a linkage that wasn't aligned with another team's assessment of a next step action. As data sat in siloed client management systems unless shared conversationally with a partner or during care coordination meetings, there wasn't streamlined opportunity to centralize and socialize key data that could improve our cross teams care planning and services linkages.

To improve coordination across all street response teams, we had to streamline data sharing at client and system levels.

Foundational to our coordination successes was the leveraging of a state law that allowed municipalities in California to expand the definition of a social services entity to include a broad array of stakeholders for the purpose of creating a multi-disciplinary team (locally called, the SF-HMDT) for the specific purpose of assessing needs and linking people experiencing homelessness to services, shelter, and housing. Homelessness is defined by the SF-HMDT as "an experience of homelessness" in the last year. The Mayor's Office, City Attorney's Office, DEM, and all partners conducted extensive due diligence focused on data privacy, security and accountability and successfully created a formal SF HMDT that would serve as the backbone for data sharing across all city-led street teams. The law includes clear guidance on training of all SF HMDT members to ensure that private and confidential data continues to be rigorously protected and appropriately shared in a way that is consistent with the SF-HMDT law. The SF-HMDT is administered by the Department of Emergency Management, Coordinated Street Response division and closely adheres to the membership, data sharing and accountability requirements of the state law. Current SF-HMDT participating agencies include the Mayor's Office, the Department of Emergency Management, the Department of Public Health, the Fire Department, the Department of Homelessness and Supportive Housing, the Human Services Agency, the Department of Technology and Digital Services Division of the City Administrator's Office. As we leverage the SF HMDT to improve data sharing, SF HMDT leadership will continue to explore the integration of additional agencies that can be valuable to the SF HMDT and our city's comprehensive homeless efforts.



Information Sharing by City and County of San Francisco Homeless Adult and Family Multidisciplinary Personnel Teams
Citywide Policies and Procedures

California Welfare and Institutions Code (WIC) section 18999.8 authorizes cities and counties to establish homeless adult and family multidisciplinary teams (MDTs) to facilitate the expedited identification, assessment, and linkage of individuals and families experiencing homelessness (defined as "homeless individuals and families" in WIC section 18999.8) to housing and supportive services within the City and County of San Francisco (San Francisco). It allows provider agencies to share otherwise confidential information in order to coordinate services, ensure continuity of care, and reduce duplication of services. The following policies and procedures are intended to ensure that all agencies participating in these MDTs comply with all requirements of WIC section 18999.8.

The implementation of this data sharing strategy has propelled the development of coordination tools that will substantially improve the way all street response teams work together and our ability to effectively work with people experiencing homelessness.

2. Centralized Coordination Efforts

In FY 23-24, the Department of Emergency Management's, Coordinated Street Response division continued to play coordination and conductor roles, centralizing program, system and policy level objectives and strategies while the Division of Emergency Communications (DEC), the city's 911 Call Center played a key operational role in ensuring that requests for service that are appropriate for several street response teams are expeditiously routed to the best or most responsive team.

DEM, Coordinated Street Response division provided coordination leadership to "direct action" efforts like HSOC, and infrastructure support focused on identifying, vetting, and mobilizing opportunities to strengthen coordination. In FY 23-24, collectively, we finalized the legal framework for data sharing; strengthened data sharing practices through the partnership with the Mayor's Office of Innovation (MOI), expanded place-based efforts in neighborhoods most impacted by homelessness and behavioral health crisis, developed the underpinnings of a new shared priority client initiative, and improved our communication protocols to expedite information sharing about client needs and coordination requests. Beyond routine program, operational and system meetings and exploratory conversations, DEM also facilitates a coordinated street response policy meeting of executive leadership of all departments. These meetings are important for ensuring continued coordination alignment across departments, improving overall operations, reviewing system friction and resource needs, and promoting accountability.

A key focus of system, operational and policy conversations is to better understand hurdles to more effectively linking clients to stabilizing services. We recognize that there are key communication and resource hurdles that impact our work. For street response teams' work to be effective in the long-run, services linkage offramps must be available to clients at critical moments like when they are in the hospital, psych emergency, shelter and in jail and alignment around service linkage needs must be effectively communicated across key partners. Leadership across all teams is regularly strategizing on ways to mitigate complex challenges. The below is a summary of a couple of key ones.

Challenges and Next Steps

1. There are not enough residential, psychiatric beds for all levels of care for people exiting Psych Emergency Services (PES). DPH updated its bed optimization report in 2024 and is exploring ways to expand services to meet the recommended expansion goal. A developing, operational next step is to create a "shared priority" flag in the public health, client management system, EPIC, an indication of street teams' involvement with a client and a prompt for aligning on care coordination goals. SF Coordinated Street Response leaders will host an operational workgroup of key institutional partners focused on improved communication and care coordination efficiencies and build off already developing strategies.

2. There is not enough dedicated shelter capacity for SF Coordinated Street Response, and specifically non-congregate shelter capacity. Considerations that drive the service gaps are complex: there are an array of priority demands on the shelter system, it's challenging to find locations to open shelters, it's expensive to operate a round-the-clock facility, and there are specific considerations like places that accommodate pets, families, couples, and the needs of people who are disabled. As client needs and motivations for accepting shelter are dynamic, street teams need access to a nimble supply of beds. This is a well-known and discussed topic, one that has a specific impact on street response teams. As next steps, partners will work together to further understand utilization patterns of existing shelter resources and see if there are any new trends that may result in an additional allocation from existing stock. Teams will also take advantage of the partnership with the Mayor's Office of Innovation to leverage data improvement strategies that will help us better understand placement and acceptance rates and overall utilization of shelter by clients served by SF Coordinated Street Response. We recognize that leadership will want to know "how much capacity is actually needed," and we are actively working on a data-driven strategy to answer the question more accurately. Importantly, leadership must rally around the implementation of the city's Home by the Bay, five-year strategic plan. Policy and funding support is needed. Leadership of all street response teams, as part of the operational plan will develop aligned advocacy messaging in support of resources that are needed to open and operate temporary shelter, additional capacity that is also needed by SF Coordinated Street Response.

3. Inter- Department Data Sharing – Creation of an All-Street Teams Client Database

The Mayor's Office of Innovation has built a new database integrating critical client information from the four departments and nine teams making up the SF Coordinated Street Response Program.

Previously, the street response teams working in San Francisco were largely siloed in the way they recorded and accessed data about people experiencing homelessness and crisis. The inability to share data at scale resulted in challenges in aligning around the best care and resources for people experiencing homelessness and crisis: What team is best suited to service this client? What resources are best positioned to guide this client to success?

Inter-departmental coordination can only happen at scale with robust data sharing.

This new database is the result of a widely successful multi-agency collaboration led by the Department of Emergency Management (DEM) and the Mayor's Office of Innovation, and including all departments engaged in street response as well as the Department of Technology and DataSF.

As of today, the database includes all records of street encounters with individuals who have experienced homelessness in the last year. We now have the foundation to begin generating informative insights about the collective work across departments and services. These robust, aggregate data analyses will appear in next year's annual report and be presented publicly before then.

Legally, the all street response teams, client database leverages the SF HMDT framework to ensure client data privacy, security, and accountability measures. Furthermore, the Department of Technology and DataSF are providing additional expertise to ensure robust data protection protocols.

This new, developing, inter-departmental dataset allows us to:

1. Track an individual across departments, which allows us to track what *inputs* lead to the desired *outcomes* in better, more complete ways.
2. Perform data analysis and data science to understand what factors are associated with positive outcomes (such as acceptance of housing), and adjust our system accordingly.
3. Identify high-risk individuals and apply targeted response (such as shared priority list).
4. Empower outreach workers, as appropriate, with more comprehensive client histories, which they can leverage to improve care.
5. Track demographics and equity across our system.
6. Better track progress towards system-level KPIs, coordinate overall goals both for individual clients and the system as a whole.
7. Understand the gaps in our system. Right now, each department publishes their own program reports largely based on their own efforts. By applying an integrated, systems-level approach, we can better illustrate system wide gaps and identify strategies for addressing them.
8. Perform data analysis/data science to understand what isn't working and what should be optimized.

Integrated data is a vital component of a transparent, coordinated, accountable and effective system. It results in ripple effect benefits for individual departments, the coordinated street response system, policy makers and clients.

FY 23-24 was the year for envisioning and designing the new database infrastructure. FY 24-25 will open doors for finetuning: ensuring data cleanliness, integrity, and accuracy; expanding comprehensive team-by-team reporting; and fully developing front-end tools to access the data.

4. By-Name-Client List

The crux of the integrated database is the creation, for the first time ever, of a "By-Name" list of every client encountered by all teams in SF Coordinated Street Response. The Mayor's Office of Innovation (MOI) approached the database construction challenge using an iterative, minimum viable product (MVP) to ensure success for this complex endeavor. MOI started by aggregating records of each encounter from the nine teams over the past year. The team was able to connect client profiles from each department to create comprehensive, cross-department encounter histories for each client. In doing so, we were able to successfully demonstrate that it was possible to do a basic analysis about the population of people served by our street outreach teams – and it also flagged critical data alignment and quality questions that will help drive further improvement.

"By-name" list efforts are currently focused on "Shared Priority 3.0" – a list of clients with complex health needs who are most at risk of overdose and other causes of death, defined by an eligibility criteria that was informed by medical and clinical experts. A list of this kind has never been possible before. But "Shared Priority" is both a list as well as a coordination strategy. Using the list as a touchstone, teams are activating foundational steps like the identification of a lead provider and the development of a care coordination plan, and ensuring key care plan information is socialized across teams, improving a unified, all teams approach to working with clients with complex health needs. While street teams have previously used a shared priority model, the integrated database offers an efficient, scalable solution for creating an objective, eligibility-driven, by-client-name list.

Shared Priority 3.0 Eligibility Criteria – 9.20.24

Data Element	Frequency
Unsheltered	Yes/no
SCRT Contact	SCRT contact 2 times in a 24-hour period in the last month, 4 or more times in last month, or 10 times in last 12-months
EMS Contact	EMS contact 2 times in a 24-hour period in the last month, 4 or more times in last month, or 10 times in last 12-months
5150 Holds	>1 5150 holds initiated (or attempted?) in the last 30-day
Non Fatal Overdose	2 non-fatal overdoses reported in the last 30-days (via EMS)
ER Visit	2 Emergency Room Visits in last 30 days
Hospital Stay	1 hospital admission in the last 30-days

Beyond the above eligibility that is part of the shared priority automation, street teams' clinical and medical staff also consider high medical vulnerability criteria such as: pregnancy status; high risk HIV status, advanced chronic kidney disease cancer diagnosis, and other severe chronic health conditions with high-risk mortality when discerning shared priority status. Shared priority client efforts will be integrated into broader all street response teams' goals and performance metrics, helping us to understand if these efforts result in more expedited linkages to services and spotlighting rich insights around how the complexity of client needs impacts a timeline towards improved stability. There is much to learn as the client journey is far from linear.

A client found safety and comfort in a parking lot. The person was observed with significant mental health needs. The encampment regularly expanded in size. As the area was being cleaned, teams encouraged services connections, but the client returned after the area was cleaned. Teams focused meaningfully on trust building and considered every tool including assessment for involuntary hold – the client did not meet criteria for SB43 or conservatorship. After many services declines, the client began to deepen a trust with the BEST Neighborhoods team and eventually agreed to start taking medication. Teams continued to do outreach. Teams coordinated around appropriate shelter options knowing that the client couldn't thrive in some. A suitable location opened up. They transported the client who several weeks later is still staying inside. Teams are supporting the client as connections to long-term care are completed.

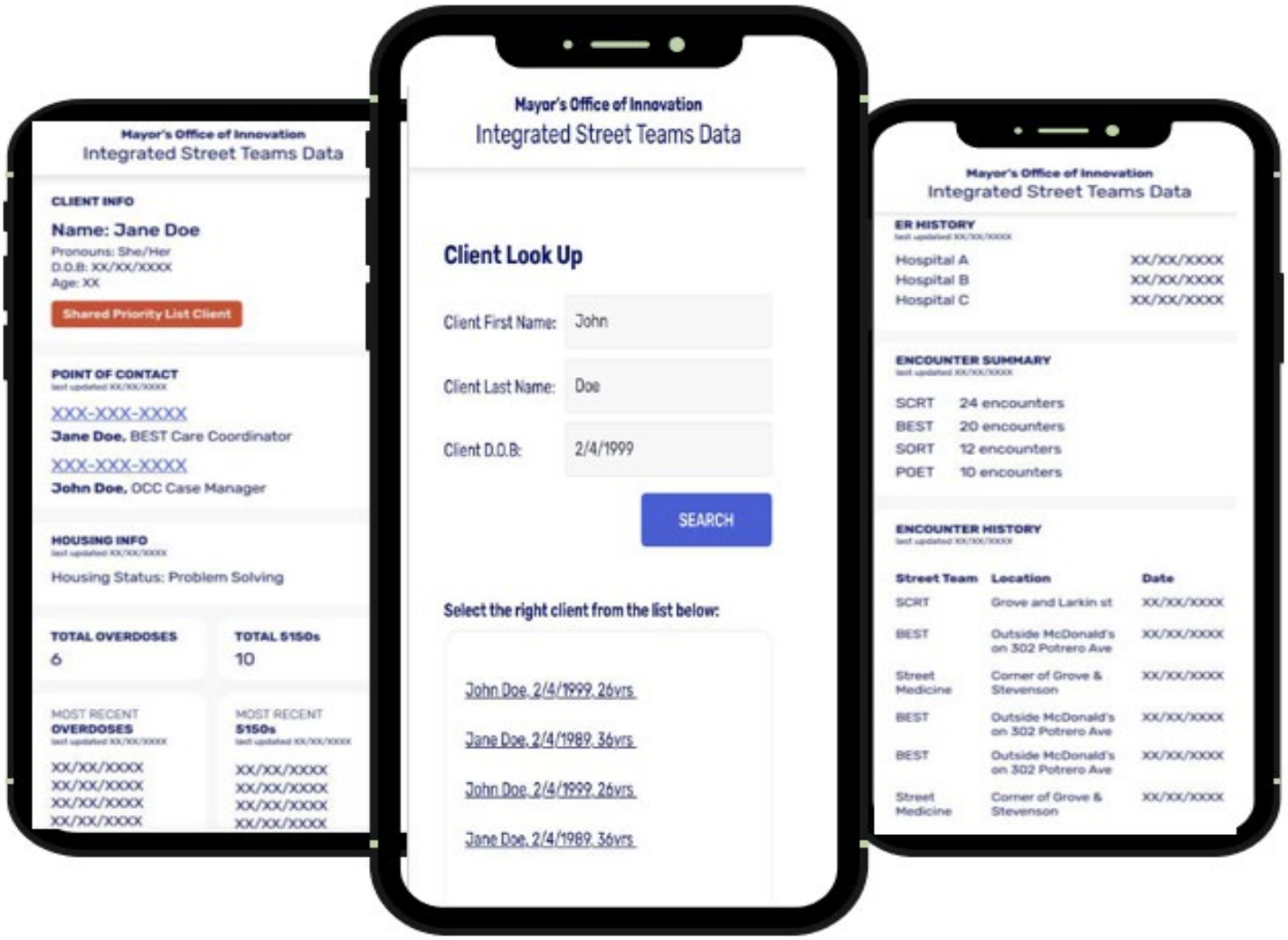
5. Outreach Worker Tool

In addition to leveraging shared data as the foundation for program-level coordination, we are also empowering direct service street teams with access to comprehensive client profiles. The "Outreach Worker Tool" is a mobile app that will bring highly-useful time and information access efficiency to SF Coordinated Street Response Teams.

The pilot launched in late September, and the beta test period will last through October. Like all elements of data sharing among street teams, the tool is governed by privacy and security guidelines of the SF HMDT.

In brief, the Outreach Worker Tool (OWT) centralizes and summarizes key client information in a succinct and digestible format. Instead of logging into multiple platforms to understand key client needs and encounter history, street response teams will be able to efficiently access key client details in one space. OWT is for internal-teams use only and all data in OWT may only be used for purposes aligned with the SF HMDT – to assess the needs of people and expedite linkages to shelter, housing and other support services.

Wireframe Illustrations of the Outreach Worker Tool

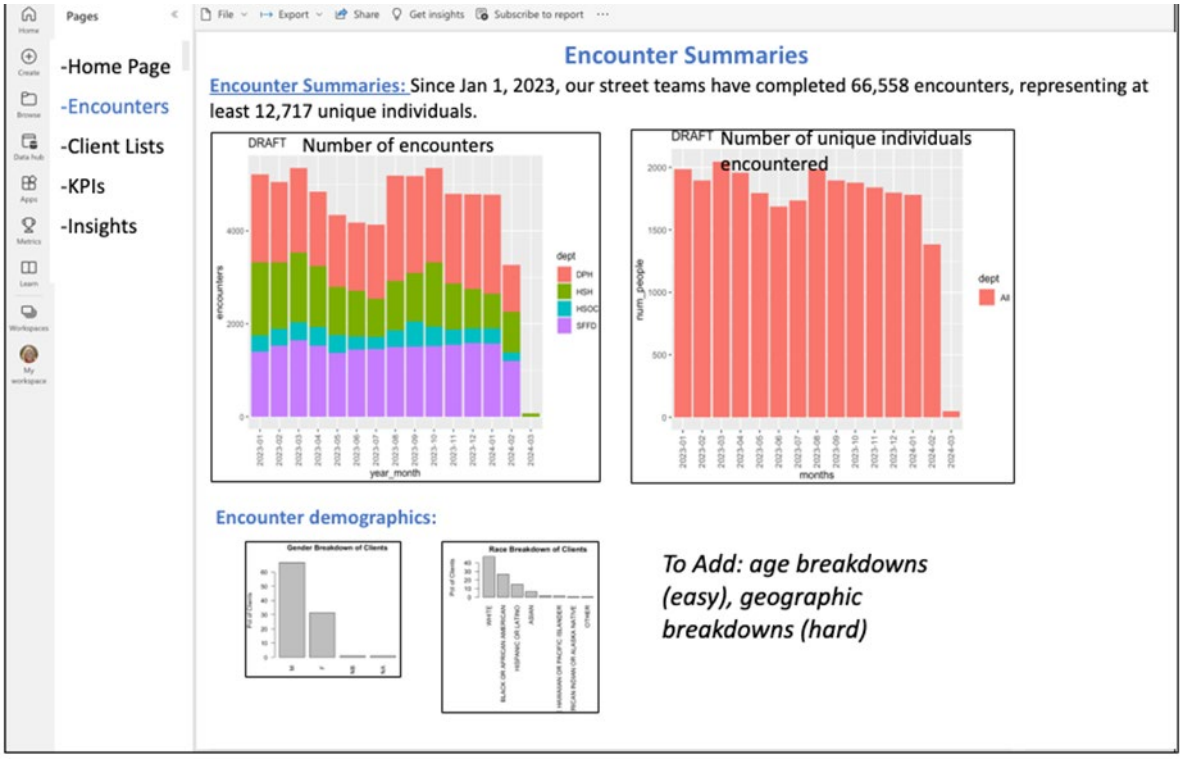


- Initial OWT fields will include identifying client information, lead point of contact, indication of shelter/housing status, overdose history, 5150 history, ER history, by team encounter summary, by team, last location of contact.
- Extensive "user acceptance" evaluation of the tool in the early launch of the OWT will help us understand what parts of OWT are most accessed and what additional data is needed to strengthen the utility of a tool.

6. Policy Maker Dashboard

Currently, SF Coordinated Response Teams outcomes can be reviewed through team specific, public facing dashboards but it's difficult to fully appreciate the volume and diversity of all street response teams efforts and to recognize the broad-based impact of our teams because the dashboards are siloed. The next front end user product that will be built on the integrated database is the policy maker dashboard. The digital interface will be designed to provide policymakers with cross team data insights and visualizations incorporating easy to understand charts, graphs and tables. The dashboard will streamline access to vital information, enabling a data driven understanding of street teams efforts and impact. As we move towards finalizing top tier goals and performance, the dashboard, when fully launched, will be a north star for communicating the progress we are making towards top tier goals.

Policy Maker Dashboard, Early Development (Mock Data)



As good data will tell a robust and compelling story about the work and impact of SF Coordinated Response impact, it is also critical to continue to not lose sight of the individuals, the clients in the numbers. In tandem with strengthening our data driven approaches to better understanding collective impact, we'll continue to ensure that the hard-won successes of our clients are also featured.

A vulnerable person with significant psychiatric distress created a makeshift living space with cardboard and blankets near the curb of a sidewalk. The person exhibited erratic behaviors consistent with untreated needs. Businesses, community members, and city leadership called on street teams to help. Over a period of a few months, street teams outreached, engaged, and coordinated efforts. Trust was built through consistency. Eventually a team was able to administer needed medication in the community. This was a huge win. The person showed signs of openness to conversations about safety, wellness, and services. The person accepted an offer of shelter. The person stayed inside for a short time and unfortunately returned to the sidewalk. Teams kept going back to the known location on the street and supported the person's return to shelter. This person transitioned from shelter to permanent supportive housing and is continuing to stay inside and manage medication with the help of long-term case management support.

7. Public Facing Website

SF Coordinated Response Teams currently maintain program specific websites driven by program level data. While the dashboards showcase the extremely valuable work of street response teams, they can't tell the story of the collective impact. As is reflected in this report, the backend, client database has become a springboard to an array of new tools, including a public facing website which more effectively spotlights the unique work of each team while educating the public on our collective impact. We expect the first version of this website to launch by Q3 FY24-25. A website, mockup design follows.

Nearly 4,400 people sleep in San Francisco's streets on any given night.

Source: Point in Time (PIT) Count 2022

Each of these people has a diverse array of needs: physical and mental healthcare, access to food and water, access to shelter or residential care, financial support, and more. Through the Coordinated Street Response System, San Francisco's various street teams identify, engage, and provide assistance to individuals experiencing crisis.

In 2023, Coordinated Street Response teams engaged with over 10,000 unique individuals.

The **Coordinated Street Response System** includes multiple street teams dedicated to addressing one or more of these needs. It leverages a data-driven approach to align efforts across teams and ease individuals' paths to stable care and housing.

Source: Integrated data from DPH, DEM, SFFD, HSH

How does the Coordinated Street Response System work?

4 City departments and 9 street teams address an individual's immediate medical needs, direct them to stabilizing medical care, and offer shelter and pathways to long-term housing.

Fire Department (SFFD)

Street Crisis Response Team (SCRT)
Street Overdose Response Team (SORT)
Emergency Medical Services (EMS-6)

Department of Public Health (DPH)

Bridge Engagement Service Team (BEST)
Post-Overdose Engagement Team (POET)
Street Medicine

Department of Homelessness & Supportive Housing (HSH)

Homeless Outreach Team (HOT)

Department of Emergency Management (DEM)

Healthy Streets Operation Coordination (HSOC)
Homeless Engagement A Response Team (HEART)

8. Top Tier Coordination Goals and Performance Metrics

In Spring 2024, leadership from all street team departments came together with the goal of establishing a top tier goal to serve as a north start to guide our collective work which led to continuing conversations with teams around performance metrics. The initial meeting resulted in a working definition of a top tier goal:

> ***"The Coordinated Street Response Teams will work collaboratively to reduce distressing street behaviors with urgency and improve the quality of life of all residents of San Francisco."***

This goal serves as a guide star for the system's performance as a whole, but it must also be broken into measurable parts for it to be effective – both for internal management purposes ("how are we doing?") and for external accountability and communication ("here is what we are trying to do and how we are doing").

To effectively measure progress towards this goal we will need to track and present two main elements:

1. Indicators of "distressing street behaviors."
2. Client outcomes pursued by the street teams.

Our goal in presenting these elements is to illustrate the needs of people being served through SF Coordinated Street Response, the efforts that address the needs and the impact of those efforts on clients. This work is complex and multi-faceted – just like the challenges faced by individuals on our streets.

The overall system goal will be broken into two high-level "encounter outcome" segments:

1. Addressing the immediate "stabilization" needs through an array of interventions and
2. Getting people into shelter, housing, and other supportive/residential programs.

We are currently focusing on refining the "stabilization encounter outcomes" and ensuring that the requisite data is available in the integrated database.

Distressing behaviors are the complex needs faced by our clients, and stabilization outcomes are indicators of progress towards street teams' connections, linkages to public health and shelter services, and indications of more controlled wellness. As street teams increasingly achieve stabilization outcomes, distressing street behaviors are reduced (as are observations of street-level distress), thereby improving quality of life for all San Franciscans, both housed and unhoused.

The below list reflects developing elements of key needs (distressing behaviors) and stabilization encounter outcomes.

Distress

1. Clinical observation or diagnosis of mental health disorder
2. Clinical observation or diagnosis of substance use disorder
3. Chronic homelessness (homeless for at least a year or repeatedly while struggling with a disabling condition (mental illness, substance use disorder or physical disability)
4. Involuntary holds
5. Non-fatal overdose
6. Shared Priority 3.0 Clients – meets defined eligibility criteria

Stabilization Encounter Outcomes

1. Completion of care coordination plan
2. Uptake of medications for opioid disorder and mental illness
3. Referral/ linkage to key services: Substance use disorder, mental health, medical.
4. Public benefits services
5. Conservatorship assessment, acceptance
6. Linkage to intensive case management
7. Linkage to IHSS
8. Naloxone distribution
9. Relocation services
10. Shelter placement
11. Other housing assistance: Access point, problem solving, housing navigation

Data Definitions

Data definition incongruity and commonality across teams has been identified.

Aligning data definitions for terms like referral, engagement, encounter, linkage, placement, etc. is part of the goals and performance metrics project.

SF Coordinated Street Response shares the vision and objectives of many city leaders and the public to:

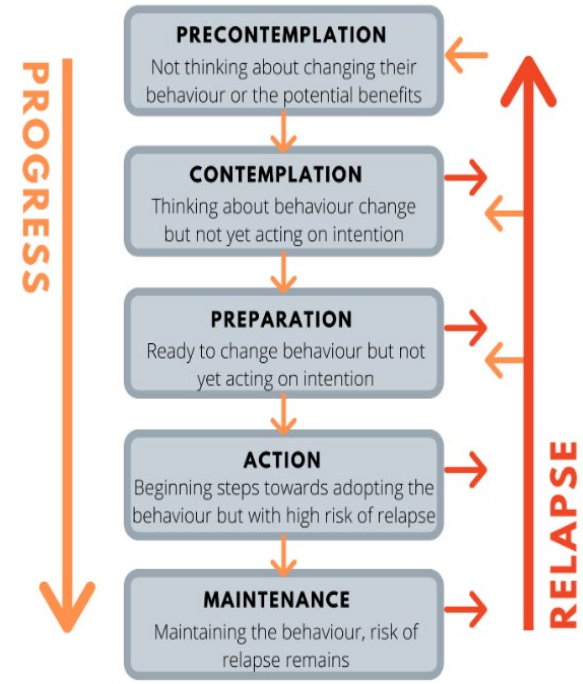
- Implement an outcomes focused services model, marked by a set of logical stages and interventions,
- Track key data over a realistic period of time, and
- Produce the outcomes that we all want to see – healthy and well people and safe, clean, and vital streets and communities.

This "a+b=c" type of framework, as indicated above by our commitment to a top tier goal and performance metrics, is a north star for SF Coordinated Street Response. ***An ideal outcomes journey:***

However, the reality of executing these steps on a standardized timeline, to use a Transtheoretical Theory of Change reference, requires a person is beyond pre-contemplation and contemplation and demonstrating signs of responsiveness to a personal call to action.

In the precontemplation stage of change, a person may not recognize a problem or be aware that their behavior is unhealthy. In that moment, they are not interested in or motivated to change their behavior, sometimes because they are already in the relapse stage of change and/or simply fear the difficulty that lies ahead.

Transtheoretical Theory of Change



"Future Learn, 9.20.24, https://www.futurelearn.com/info/courses/eduweight/0/steps/256186"

SF Coordinated Response was created to address acute needs on San Francisco streets. **Teams are often meeting people in the relapse, precontemplation and contemplation stages of the model**, addressing untreated serious mental illness, medical needs and alcohol and substance use disorder, complex needs that are not addressed on a linear timeline.

Our dedicated and experienced teams spend extensive time with clients **in an unmarked and often unrecognized space to the left of the above "Needs Assessment" arrow**, *working diligently to build trust that results in progress towards "preparation" and "action" in the Theory of Change*.

In a pre-contemplative phase, there are voluminous care coordination plan disruptions, unexpected pivots, and staggered opportunities for interventions. We continue to identify strategies for improving re-connection and efficiently expediting linkages. Projects like Shared Priority 3.0 and the Outreach Worker Tool will help.

The mentions of Theories of Change aren't intended to undercut an urgency to do everything possible to enroll a person with a very complex medical and behavioral health history in stabilizing services. Teams work diligently to build a foundation of trust and consistency that is needed for our clients to take steps towards services connections. They are highly knowledgeable about how to activate the right resources. The reality is that the outcomes journey of our clients is time and labor intensive which also impacts data collection and reporting. Clients aren't coming into an office every Wed. at 11am for treatment planning after which time outcomes and notes are logged. We are finding them in the community, sometimes regularly, sometimes not, working in chaotic environments on the street, addressing unexpected medical and other circumstantial needs, and quickly capitalizing on unpredictable moments when a person is able to follow through on a service goal that has been in development for weeks or longer – a linkage process that can take hours from start to finish; doing all of that while also being committed to data entry and capturing encounter and services linkages information.

As we move towards finalizing a top tiers goal and performance measurements framework, we'll continue to tighten data collection, alignment and sharing strategies. Our collective progress will be spotlighted in the policy maker dashboard and public facing website.

From "Okay to Call," public awareness campaign

SFHOT team member talking to person in the community

9. Impact Reporting – an early on data summary

As underscored throughout this report, our past siloed client databases made it extremely complicated to demonstrate the collective impact of our efforts. Through the establishment of the backend data integration, an all street response teams client database, we are positioned to provide annual impact reports in the future that are data-driven, and client centered. While the FY 24-25 report will include more robust data insights on the work of SF Coordinated Street Response, data findings will be available earlier in the policy maker dashboard and public facing website, products that will be launched before we submit the next annual report. At this early time, please see a summary of all teams' encounter information.

Teams:

Crisis Response
- SCRT
- SORT

Rapid Response
- HEART

Planned Outreach
- HSOC
- SFHOT
- OCC-Triage and BEST Neighborhoods
- POET
- Street Medicine

Services provided during encounters:

- Outreach and engagement
- Trust building and de-escalation
- Resources education and navigation
- Distribution of hygiene supplies, clothing and food
- Naloxone administration
- Suboxone prescriptions and starts
- Array of assessments – medical, behavioral health, shelter and housing, 5150 and conservatorship
- Referral and linkage to stabilization services – clinics, primary care, medication management, intensive case management, drug, alcohol and mental health treatment, shelter and housing, and housing assistance
- Transportation

***Total FY 23-24 encounters: 79,557**

***AVG total monthly encounters: 6,629**

***Service types and engagement summary:**

Crisis Response Services	**Rapid Response Services**	**Planned Outreach Services**
2 teams	**1 team**	**6 teams**
20,154 calls for service	15,246 tickets	597 resolutions (HSOC only)
15,514 encounters	5,717 encounters	58,326 encounters

***Summary Outcomes**

Crisis Response

1. 6,090 connections to hospital and non-hospital, stabilizing services settings

Rapid Response

2. Nearly 80% - Regularly responded to nearly 80% of calls from the public regarding the non-crisis/emergency needs of people experiencing homelessness, calls that historically were routed to the police department.

Planned Outreach

1. 17,780 – Referrals made to medical, mental health and SUD treatment services
2. 6,328 – Linkage to shelter and housing and related assistance
3. 2,484 – Linkages to medical, mental health and SUD services, ICM, care coordination
4. 1,082 – Suboxone prescriptions and documented suboxone administration (88). Team reports provide more information.

***Considerations:**

1. There is duplication across encounter and summary outcomes updates. Through the backend integration, we'll be able to parse out unduplicated contacts. This summary draws from numbers included below in team reports.
2. Encounter and summary outcomes data across service types is not an "apples to apples' comparison. Outreach type, team size, resource availability and length of each engagement episode all impact encounter volume.
3. HSH administers all shelter allocations and SFHOT manages all shelter placements. Direct placements into shelter are made by SFHOT with HSOC managing a dedicated allocation. Other teams coordinate closely with SFHOT on possible placements of clients encountered by a broader array of teams. All teams play an important role in supporting the transition of people from the street and into shelter and housing.

Department	Division/Team
Emergency Management	Coordinated Street Response **Healthy Street Operations Center (HSOC)** **Homeless Engagement Assistance Response Team (HEART)**
Homelessness and Supportive Housing	Outreach and Engagement and Shelter and Housing Placement **Homelessness Outreach Team (HOT)**
Fire Department	Community Paramedicine **Street Crisis Response Team (SCRT**), **Street Overdose Response Team (SORT)**
Public Health	Behavioral Health and Medical Interventions **Office of Coordinated Care (OCC): SCRT-Triage, BEST Neighborhoods (BN)** **Whole Person Integrated Care (WPIC) - Street Medicine, Post Overdose Engagement Team (POET)**

Department of Emergency Management (DEM)

HSOC-Overview

HSOC is a broad based, direct-action, coordinated effort that leads with services-first to get unsheltered San Francisco residents housing solutions and the social services they need to achieve long-term stability. For residents with particularly complex needs, HSOC uses all available resources to get them the appropriate assistance and on the pathway to recovery. For people exhibiting harmful behavior, or continually refusing assistance, we will use every tool we have to support their welfare, ensure the safety of our neighborhoods, and get them into care.

HSOC operates through a tight collaboration of more than eight Departments within CCSF and regional partners.

1. **Department of Emergency Management (DEM):** Manages and directs HSOC and its many partners. Other areas of daily focus include responding to constituent needs, conducting citywide scouting, collecting encampment reports via email, 311, 911, and community channels, and active participation in community and stakeholder meetings. HSOC's success, in part, is because of strong internal support from the DEM/Department of Emergency Communications which includes dedicated 911 staff serving as a coordination liaison between the 911 Call Center and HSOC efforts.
2. **Department of Public Health (DPH):** Led by BEST Neighborhoods team, DPH provides pre-resolution services focused on understanding needs and offering mental health and substance use disorder services, referrals and connections.
3. **Homelessness and Supportive Housing (HSH):** HSH's outreach program, SFHOT and SFHOT's senior outreach team, the "Encampment Resolution Team" or ERT provides professional client engagement services overseen by a clinical case manager. ERT's complement DPH's effort, providing pre-resolution outreach and resolution noticing, assessing specifically for shelter needs and helping to facilitate placement into shelter beds that are dedicated to HSOC efforts. HSH also has a dedicated HSOC operations support team that manages the HSOC client database which includes information on daily shelter allocation and tracking of shelter placements. HSOC publicly posts data related to daily engagement and placement efforts.
4. **Fire Department:** The Fire Department staffs an Incident Commander or "IC" at HSOC. This position provides resolution oversite and safety, ensuring orderly and structured engagements and inter-departmental coordination of paramedic and as needed medical support services.
5. **Department of Public Works**: The Department of Public Works provides packers, dump trucks, professional street cleaning and repair crews to HSOC and leads efforts to address landscaping fixes that are needed and secure areas with breached fending.
6. **Recreation and Parks:** Recreation and Parks, park rangers specifically collaborate with HSOC to address encampments within their jurisdiction.

7. **Police Department**: The Police Department provides on-scene safety, can run warrants, issue citations and make arrests when necessary.
8. **Municipal Transportation Agency**: Vehicle and traffic enforcement.
9. **San Francisco Port, National Parks, and Caltrans**: The partners, similar to Recreation and Parks, collaborate with HSOC to address encampments within their respective jurisdictions.

HSOC Data

Primary Goal: HSOC's goal is to end unsheltered homelessness and to promote clean and safe neighborhoods. The approach is "all-hands-on-deck" and requires rigorous inter-departmental coordination.

Description of performance metrics:

1. *Shelter Placements*: HSOC outreach workers confirmed client wanted shelter, administrative staff sent the shelter referral, referral was accepted, and transport staff brought the person to the shelter with a warm hand off.
2. *Refusing services*: Unhoused person refuses to engage with the team or they engage and give us their name but refuse shelter.
3. *Already Housed or sheltered*: People who are at the site and tell us they are already sheltered, or outreach workers know from very recent referrals that they are already sheltered, or from looking the person up in the ONE System that they are already in shelter or PSH. Teams expedite a reconnection to the placement.
4. *Other*: Individuals sent in an ambulance to the hospital or to one of DPH's support services or residential programs, and accounts for a small margin of error in data counting.
5. *Total people onsite at start:* The denominator for all other sub-outcomes in this dataset.
    a. Please note that outreach workers are highly skilled at effectively engaging with people with complex needs, but San Francisco takes a low barrier approach to services engagement and linkages.
    b. People don't need to provide their names or identifications during outreach efforts.
    c. As a result, teams can document total number of people onsite at the start of an effort, but if they don't provide name or other requested information, HSOC can't capture 100% of people across the metrics.

HSOC Data Highlights – HSOC data is also publicly posted here. This table reflects a summary of HSOC engagement outcomes.

Metric:	**#**	**%**
Shelter Placements	1725	37%
Engaged but Refused Offers[1]	999	22%
Declined Engagement [2]	1886	41%
Other (EMS Transport, DPH programs, other)	27	.01%
Total or People on Site at Start[3]	**4,637**	**100%**
Resolutions	**597**	

Notes:

1. Sum of encounters where individual engages with the outreach workers but declines residential placement that day.
2. Sum of encounters where individual refuses to give outreach workers their name or any identifying information, therefore refusing residential placement that day.
3. Figures include repeat individuals because outreach workers cannot obligate individuals to divulge their names, so team cannot de-duplicate or calculate repeat encounters.

* 1,667 unique individuals encountered from 7/1/23 – 6/30/24.

HSOC – Progress Towards BLA Audit Recommendations

A. Collaborate on improvements to track HSOC shelter availability, referral, and placement data for HSOC clients, with the goal of increasing shelter referral uptake among HSOC and other street team clients.

The HSOC team is an active participant in the back end data integration, All Street Teams Client Database, the partnership with the Mayor's Office of Innovation. There is concerted focus being put on how to leverage technology to scale data collection around shelter uptake across all teams, data that can help inform policy and operational decisions. As we look towards a scaled, data-driven solution, the HSOC team has taken steps to integrate strategies that illustrate shelter placements and preferences. Anecdotal and available data underscore a known reality – the majority of the adult population that we serve prefer a place that is non-congregate, single room with a bathroom. A single room is not always the safest option for someone, contingent on their needs and scaling single rooms with bathrooms to meet the breadth of needs is complicated. Please see below for more information on HSOC's early-on findings.

HSOC -Shelter Acceptance, Distribution Table

Shelter Name:	# of Allocations	Acceptance Rate:	Shelter Type:
The Cova Hotel (Winter Shelter)	25	120%	Non-Congregate
The Monarch	38	118%	Non-Congregate
The Adante Hotel (Winter Shelter)	13	115%	Non-Congregate
Gough Mini Cabins	46	78%	Non-Congregate
Mission Cabins	34	71%	Non-Congregate
The Baldwin	55	56%	Non-Congregate
Division Circle Nav	236	55%	Navigation Centers
711 Post	169	54%	Non-Congregate
Embarcadero Nav	62	52%	Navigation Centers
Bayshore Nav	79	49%	Navigation Centers
Bayview Navigation Center	69	46%	Navigation Centers
Central Waterfront	32	34%	Navigation Centers
685 Ellis	81	28%	Congregate
Next Door Shelter	5	20%	Congregate
MSC South	143	7%	Congregate
Sanctuary Shelter	0	0%	Congregate

Notes:

1. Shelter acceptance rates vary greatly depending on the individual's personal circumstances, preferences, pets, partners, families, weather, and many other factors.
2. Data above shows > 100% acceptance rate because the raw acceptance rates that include couples exceed the number of rooms allocated.

As mentioned above, anecdotal feedback from the teams underscores that clients requested non-congregate shelter and cabins (which are private cabin/rooms) and occasionally there are requests for vehicle triages spots for vehicle/RVs.

Both in response to BLA Audit and city leadership requests, and as part of a civic innovation project, the HSOC team took on the task of better understanding when people at a resolution decline shelter and if shared, what shelter preference was indicated. In Q4 FY 23-24, the HSOC team launched a pilot to track for this purposes. The pilot was successful in creating a foundation for incorporating "preference" questions into a robust array of engagement topics and questions. The below table reflects outcomes of the pilot.

HSOC Pilot – Shelter Preferences

Preferred Shelter/Housing	#	%
Non-Congregate Shelter	62	80%
Specific Navigation	8	10%
Permanent Housing	5	6%
VTC	3	4%
# of clients declined with shelter preference	**78**	**100%**
Note: HSOC started asking which shelters clients would like mid-2024.		

Further validating indications in the HSOC shelter acceptance distribution table, is the data from the shelter preferences pilot. Non-congregate settings which include hotels and cabins are preferred. For congregate settings, navigation sites were consistently selected. As well, we are also seeing increased requests for locations that accommodate couples.

HSOC both as a direct services effort and as part of the broader project with MOI, will continue to build on these results and be part of collective thinking on strategies for scaling this data collection across additional teams.

HEART-OVERVIEW

The Department of Emergency Management (DEM), through a competitive procurement, selected Urban Alchemy to operate the Homeless Engagement Assistance Response Team (HEART), a police alternative effort that filled a services response gap in the SF Coordinated Street Response Program. Urban Alchemy has been a responsive and responsible partner and provides invaluable support to people in need and our city at large. HEART responds to a wide array of third-party calls from the public regarding the non-emergency needs of people experiencing homelessness, calls that historically were routed to the police board at the 911 Call Center. HEART calls primarily originate from 311 and the public safety non-emergency number which is managed by the 911 Call Center. The Department of Emergency Communications of DEM has dedicated dispatch staff that provide invaluable support to HEART and HSOC.

HEART responds to an array of calls related to people experiencing homelessness:

1.) 919 – Unknown needs of individuals experiencing homelessness
2.) 916 – Suspicious vehicle
3.) 915 – Encampments
4.) 914 – Suspicious person
5.) 415 – Noise complaint
6.) 601 – Trespassing
7.) 921 – ADA non-compliance/Blocked Sidewalks

In response to every call, HEART's objective is to serve people who are experiencing homelessness and leverage resources of SF Coordinated Response, the citywide effort to link people to stabilizing services. Many of HEART's team members are formerly homeless or incarcerated, and/or have experience as a consumer of San Francisco's public health and homelessness services. They bring an informed and caring perspective to their work, successfully building trust with clients and empowering steps towards service linkages. While HEART doesn't have dedicated shelter or other resources capacity, they are tenacious about collaboration and partner coordination and turn every stone to try and link clients to needed services.

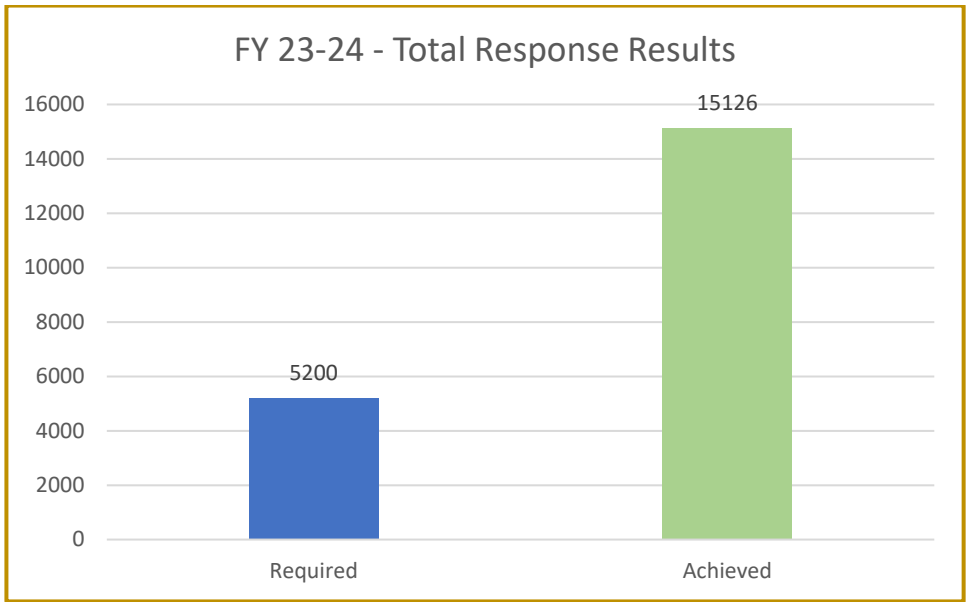
HEART team members undergo an extensive training program that's essential to the effective outreach and engagement. Aligned with the minimum standards for all SF Coordinated Response Teams, HEART teams buttress their training with effective communication, trust building, conflict resolution & de-escalation, gender informed training, trauma informed training, adult mental health first aid training, HMIS compliance training, SF HMDT training, 911/311

dispatch and communications training, and culturally responsive strategies. The team members' personal experiences combined with rigorous professional training makes HEART uniquely qualified to succeed in this work.

HEART operates citywide, seven days a week, M – F, 7am- 7pm and S/S 7am – 3:30pm. HEART currently deploys up to 5 teams of practitioners per day, fewer on the weekends. A communications and dispatch team receives, sorts, and organizes daily, high call volume, and dispatches HEART teams. HEART is also equipped with care coordination services that work in harmony with the practitioner teams to follow up people who need additional support in getting personal identification and navigating steps to access support services, treatment, shelter and housing.

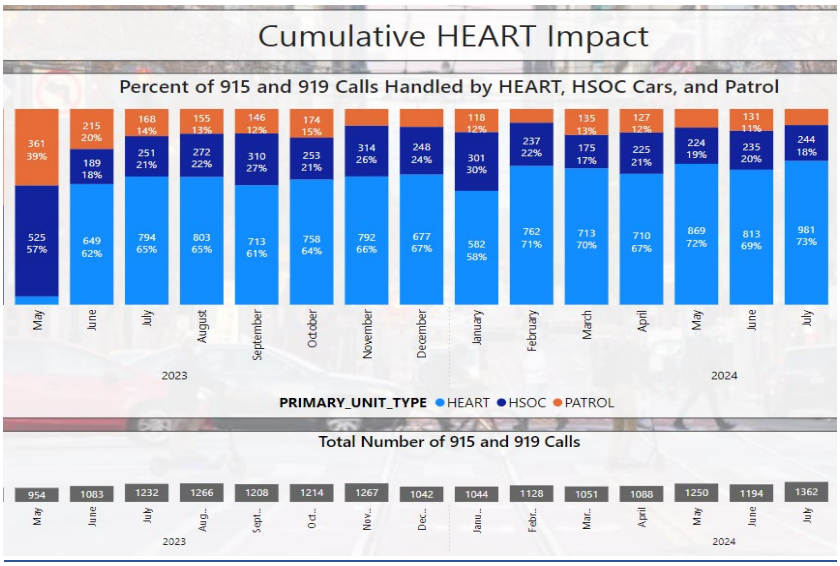
Goals/results

1.) Reduce law enforcement responses to non-emergency calls related to people experiencing homelessness.
   a. Overachieved initial response requirements by nearly 200%. HEART demonstrated a firm commitment to filling a gap in SF Coordinated Response, efforts that are illustrated by the results.
2.) Successfully address the needs of people experiencing homelessness.
   a. HEART approaches outreach and engagement with compassion and dignity, seeking an appropriate services solution and providing continuous follow up. Their teams completed over thirty assessments per week, identifying behavioral health needs, navigating services linkages, and referring people to internal care coordination services. However, people aren't required to complete a formal assessment to receive HEART services. An area for data collection improvement is capturing needs data more broadly.



A person was living in a structure on a busy, touristy corner for a long while during and well beyond COVID and became very comfortable with the location. City leadership requested HEART team engagement with the person. The person was identified as a high utilizer of coordinated street response team services. HEART returned multiple times, strengthening trust, and empowering the person to envision a life off of the streets. They assured the person they would provide support every step of the way to get the person in shelter. HEART collaborated with HSOC/HOT to identify shelter and the client accepted. Fast forward several months and the person is on the pathway to permanent housing. A HEART care coordinator continues to check in with the person.

HEART Data Snapshot – System Impact



FY 23-24

This table represents a total of all calls from the public regarding 915 (encampments) and 919 (unknown homeless need) concerns which are calls most associated with the needs of people experiencing homelessness, and HEART's response to the requests for service.

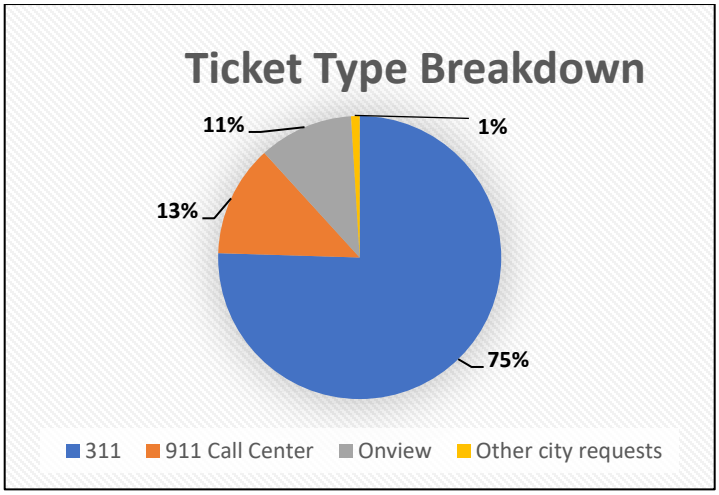
HEART responded to a majority of these calls, broadening collaborative and service linkage opportunities clients, and freeing up law enforcement capacity.

HEART Data Snapshot – Program Impact

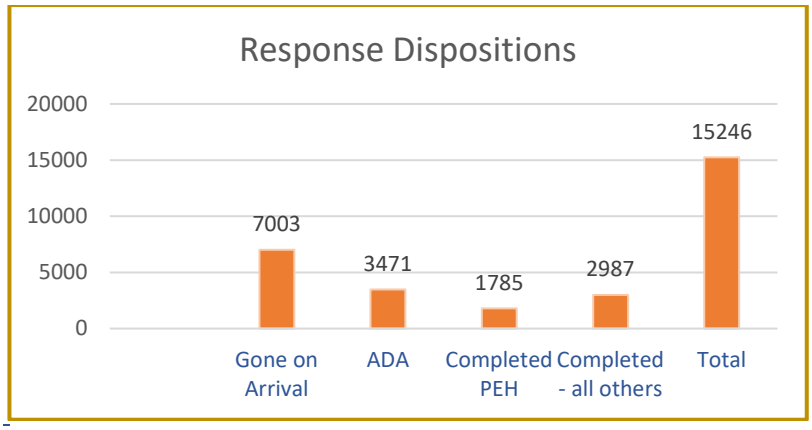
FY 23-24 Monthly Responses

July	1169
August	1206
September	1319
October	1471
November	1317
December	1147
January	1160
February	1202
March	1159
April	1223
May	1506
June	1367
Total	15246

FY 23-24 Ticket Types



Disposition Highlights



Disposition Descriptions:

"Completed – all others":
- Request for additional public service.

"Completed – PEH":
- Completed needs assessment/prioritization for clients.

"ADA":
- Addressed Americans with Disability Act compliance.

"Gone on Arrival":
- A response to a service calls results in obsolete need.

HEART Progress Towards BLA audit Recommendations

A. Ensure ongoing monitoring of HEART staffing, in-service ratios, and calls for service, ensuring that contractor HEART has met contracted staffing obligations

Since the launch of HEART, DEM and HEART have met weekly to review and troubleshoot operational issues that may impact services delivery. As well, HEART has submitted a monthly program report summarizing services activities and results for the previous month. Lastly, HEART submits a detailed monthly invoice of expenditures. To date, HEART is contract compliant.

Along with the monthly program report, HEART also submits a daily deployment schedule and a monthly (by day) team and staffing deployment accounting. HEART has not had any problems meeting service level requirements and as indicated earlier, far exceeded initial response expectations.

Sample - Accounting of HEART Monthly Teams Deployment

Ticket created - Date	SF - Unit #	# Teams Deployed	# of Team Members
2024-06-01	HEART 1	1	3
	HEART 3	1	2
	HEART 3	1	3
	Total Team and Staff	3	8
2024-06-02	HEART 1	1	2
	HEART 3	1	2
	Total Teams and Staff	2	4
2024-06-03	HEART 1	1	2
	HEART 2	1	2
	HEART 3	1	2
	Total Teams and Staff	3	6
2024-06-04	HEART 1	1	4
	HEART 2	1	3
	HEART 3	1	4
	Total Team	3	11

HOT – Overview

SFHOT works to engage and stabilize the most vulnerable unsheltered individuals by voluntarily placing them into shelter and housing or connecting with other available resources. To make these placements, SFHOT works seven days a week to provide outreach and case management to people experiencing homelessness living on the streets of San Francisco. Services are provided by small, skilled teams with expertise in the complex issues that are barriers to stability for this population. For individuals who are not ready to accept the services HSH has to offer, SFHOT continues to outreach and build motivation to ensure services are available when they are needed.

Case Management, with a specific focus on preparation for and placement in housing, is the second largest component of SFHOT services. SFHOT is the only outreach street team that is directly connected to in-house case management. SFHOT case managers support clients to gather all necessary documentation to qualify and apply for housing. This includes supporting clients navigating complicated federal housing appointments that usually require multiple appointments prior to qualification. Case managers also connect clients to social supports and income benefits for long-term success and stabilization once in housing. On average, clients work with case managers for nine months, and can continue to support clients for up to three months after they have been placed into housing.

SFHOT provides outreach and engagement to people experiencing unsheltered homelessness through a few key initiatives:

- **District Teams:** Placed-based outreach teams organized by police district. Focus on building relationships with people experiencing unsheltered homelessness and connecting them to resources or other street teams and resources as appropriate. By having the same team members consistently in one area, they are better able to work with clients to understand and address their unique needs.
- **HSOC Encampment Resolution Team:** Services-first approach to the city's encampment resolution work.
    - Dedicated teams funded by the State's Encampment Resolution Fund support encampment resolution work in the highly impacted Mission and Tenderloin neighborhoods.
- **Street Crisis Response Team (SCRT):** SFHOT partners with the San Francisco Fire Department to respond to non-urgent 911 calls
- **Case Management:** Case managers escort clients to get public benefits (CAAP, SSI, MediCal, CalFresh, VA, etc.), take them to medical appointments, work with them on strategies to address behavioral health or other challenges etc. SFHOT case managers are supported by an HSH team of licensed behavioral health clinicians who assist in diagnosing clients and developing specialized care plans for clients. Clinicians leverage relationships with multi-disciplinary teams (including Street Medicine, BEST, the Conservators Office) to address the complex needs of clients.

In addition to the initiatives above, SFHOT also works collaboratively with the Department of Public Health's Street Medicine team and other Street Response Teams to address medical and behavioral health needs, using an individualized approach that includes wrap-around services and promotes harm reduction and stability-based recovery.

Outreach Success Story: *SFHOT encountered a couple living in their vehicle that were feeling hopeless and out of options. SFHOT immediately sent in a referral to the Rapid Rehousing Program. The couple qualified, and SFHOT supported their search and eventual move into housing 2 months later.*

HOT – Performance Highlights

SFHOT had a number of program highlights from FY 2023-24, including but not limited to the following.

1. Expanded Housing Placement Opportunities

In FY 23-24 SFHOT expanded direct housing placement programs and successfully placed 132 clients directly into permanent housing from the streets. The initiatives below are examples of how SFHOT is able to support lower-barrier and faster housing processes for people with complex needs.

- Rapid Rehousing: SFHOT was allotted 40 rapid rehousing (RRH) subsidies through a new initiative launched in March 2024. The initiative is targeted to support housing placement for people experiencing unsheltered homelessness. In the program, SFHOT identifies eligible clients from their outreach, transports them to a Coordinated Entry Access Point to enroll in the RRH program, and then case managers support them navigate the housing process, including getting document ready. Between March and June 2024, SFHOT recruited 21 clients, 6 of which successfully moved into housing before June 30, 2024. We anticipate SFHOT using all allotted subsidies by the end of the calendar year.

- Street to Home: The Street to Home program was launched in June 2023 and is one of the successful strategies HSH has employed to reduce vacancies in supportive housing and move people into housing more quickly. Through Street to Home, SFHOT outreaches to eligible clients on the street, invites them to view a unit, sign a lease and move into a long-term home. In FY23-24, SFHOT placed 58 clients into permanent homes through the Street to Home program.

- Case Management: SFHOT case management work with clients to apply for, navigate the housing process and stabilize in housing once placed. In FY 23-24, SFHOT case management supported 68 direct placements into permanent housing.

2. Increased Linkages to Services through the SFHOT Public Phone Line

SFHOT has long had a 24/7 public phone line that people experiencing unsheltered homelessness could call and leave a message with their information and services they were seeking. Upon receipt of the voicemail, SFHOT would deploy a team to engage the person in the community.

An analysis conducted by SFHOT in Spring 2024 found that 26% of calls responded to by SFHOT teams in the community were unsuccessful due to clients being gone upon arrival. In response to this data, SFHOT implemented a new practice of returning phone calls for anyone who provided contact information in addition to deploying teams. Encounters have increased due to SFHOT's ability to problem solve, refer and offer services to clients over the phone that previously may have been difficult to find on the streets.

3. Expansion of Relocation Assistance Options

As one of the City's Street Response Teams, SFHOT participated in training in FY23-24 for the Journey Home Relocation Assistance Program that supports people to reunite with family and friends outside of San Francisco. In FY23-24, SFHOT referred 23 clients to the program, 18 of which were successfully reconnected to their communities.

Outreach Success Story: The Tenderloin HOT team had worked with Sam for many years. During an engagement, Sam* said that his mother was ill and it "was time to go home". The problem was, they didn't know where she was living. The team spent 2-3 hours with Sam on their phones looking on Facebook, Google and the white page to find and locate his mom - they even messaged Sam's sibling on Facebook! They finally located Sam's mother and Sam was able to connect with her over the phone and she welcome him home. HOT immediately set Sam up with a referral to Journey Home, transported him to the bus station and sent him home to his mother.

San Francisco has received a total of $17,309,916 through two rounds of Encampment Resolution Fund (ERF) state funding that supports outreach and shelter projects in highly impacted areas.
In January 2024, SFHOT launched the state-funded ERF teams in the Tenderloin and Mission. These dedicated outreach positions support highly-impacted neighborhoods with regular outreach and engagement.

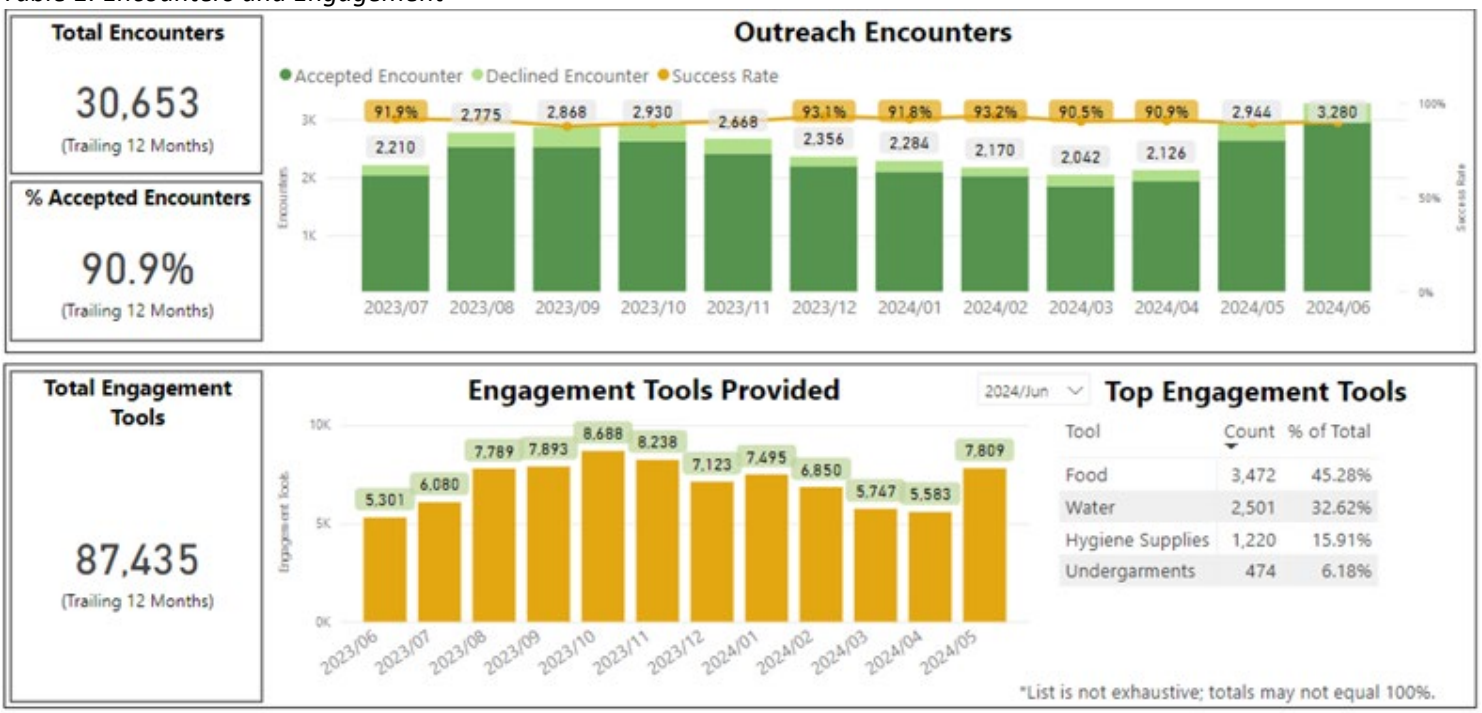
- Tenderloin: 4 FTEs (2 teams of 2) provide dedicated outreach and engagement to the Tenderloin, including the Lower Polk Alleys and surrounding areas.
- Mission: 4 FTEs (2 teams of 2) provided dedicated outreach and engagement to the Mission. These teams supported engaging and referring unsheltered individuals to the Mission Cabins temporary shelter program that opened in Spring 2024.

HSH has applied to the third round of the State's ERF Grant to support outreach and shelter in the Bayview.

5. Performance Data

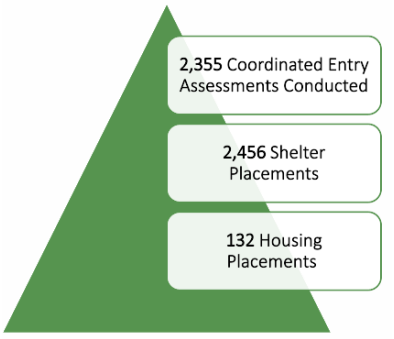
In FY 2023-24, SFHOT conducted over 30,600 encounters with people experiencing homelessness. 90.9% of these encounters were accepted, meaning SFHOT teams actively engaged – offering resources, connecting to services or continuing to build relationships and understand unique needs of unhoused neighbors. During the same time period, over 87,400 engagement tools were provided, with the top three being food, water and hygiene supplies.

Table 1: Encounters and Engagement



SFHOT's primary goal is to connect and place people into stable resources including shelter and housing. The encounters and encounter tools referenced above are critical for engagement and trust building with the goal of placement and service connection.

In FY 2023-24, SFHOT made 2,456 placements to shelter, conducted 2,355 Coordinated Entry assessments, and placed 132 clients from the streets into permanent housing.



Additional data highlights from FY 2023-24 include:

- 208 connections to public benefits (direct assistance to support clients apply for CAAP, SSI, SDI, CalFresh or VA);
- 116 medical care connections including urgent and non-urgent care for physical health or dental care, including transportation to appointments or clinics;
- 52 mental health connections – helping clients access services for mental health symptoms or disorders;
- 24 connects to substance use services – accessing programs like SomaRise, Treatment Access Point (TAP) or referral to medical detox; and
- 18 successful Journey Home referrals.

HOT – Progress Towards BLA Audit Recommendations

August 2024 Updates: BLA Recommendations
2.2: DEM and HSH should collaborate on improvements to track HSOC/ERT shelter availability and referral data for HSOC/ERT clients with the goal increasing shelter referral uptake among HSOC and other street team clients.
DEM and HSH are working collaboratively to strengthen HSOC data, including measures to address this recommendation such as: • Working to connect all homeless outreach data sets from four City departments through a back end data integration project, a partnership with the Mayor's Office of Innovation and DEM which has resulted in the first-ever, by-name client list across departments so that we can better understand engagement each client has within the entirety of our system. • The back end data integration will also be a springboard to creating a policy level dashboard and developing an end-user tool for street teams to access limited data. These tools will communicate outcomes and client level data across all street engagement teams. • DEM/HSH are beginning to analyze shelter uptake as it pertains to projected daily allocations in order to determine whether the number of allocations received per day are sufficient and which allocations are most readily accepted. • There currently exists an HSOC outcomes dashboard (internal to City partners) which aggregates HSOC outcomes per HSOC shift. This tells us how many people were sheltered per day and / or are already housed, refused placement, or refused to provide any information at all. • There is also a quarterly tent, structure, and vehicle count conducted by HSOC to assess increases or decreases in homelessness. This can help provide insight into HSOC's ability to reduce tents, structures, and vehicles across the City. Qualitative feedback from SFHOT continue to indicate the most desired shelter resource is non-congregate shelter. In FY 2023-24, HSH has continued to leverage local and state funding sources to maintain and open new non-congregate shelter options, including 60 new non-congregate cabins in the Mission district.

4.4: HSH's Director of Outreach and Temporary Shelter should: Address Heluna Health's staffing challenges for SFHOT in the next contract monitoring report by working with Heluna Health to develop an SFHOT staffing plan.

Heluna Health has made significant progress towards meeting the goal of maintaining 90% staffing, in part due to the implementation of a Recruitment and Retention Plan in November 2023.

- As of August 20, 2024, SFHOT is at an overall staffing rate of 87%, with 89% staffing for outreach and 80% for case management staff. Vacant positions (3 outreach and 3 case management) are all in the interview process. Despite regular staffing turnover in FY23-24, Heluna Health successfully hired 18 new outreach and case management staff and increased the outreach staffing rate by 22% from March to July of 2024 to support the Encampment Resolution Fund (ERF) outreach expansion in the Mission and Tenderloin / Lower Polk Alleyways.

- In FY23-24 Heluna Health executed a subcontract with Code Tenderloin, a local community-based organization for additional Outreach positions in order to meet the City's needs. These partner staff were deployed in the community starting in April 2024. The goal is to maintain and scale up the partnership moving forward, that will support existing outreach efforts and potentially provide a staff recruitment tool to support overall SFHOT staffing moving forward.

5.2: HSH's Director of Outreach and Temporary Shelter should: work with SFFD to identify placement options for street team clients who request shelter placement outside of normal shelter intake hours.

HSH has expanded our evening and weekend access to Temporary Shelter and Crisis interventions over the last few years to support placements from other street teams outside normal shelter intake hours.

- **Street Crisis Response Team (SCRT):** Receives 4 beds on weeknights for placements 4pm – 8am (next day), in addition to daily allocations provided through SFHOT for SCRT daytime placements.
- **San Francisco Police Department (SFPD):** Receives 5 beds on weeknights and weekends for placements 4pm – 8am (next day). Placements made by HOT officers or SFPD HSOC officers.
- **SUD Shelter and Stabilization Pilot Program:** Starting in March 2024, HSH in collaboration with DPH, San Francisco Community Health Centers and Code Tenderloin launched the SUD Shelter and Stabilization Pilot Program as part of the city's DMACC initiative. The SUD Shelter and Stabilization Pilot Program provides supports of unsheltered people experiencing homelessness and who have substance use disorders to stabilize and connect to recovery and treatment resources.
    - This program started with 9 non-congregate units in March 2024, and expanded to 20 units by July 2024.
    - Placements are made by Night Navigators (staffed by Code TL) 7pm – 3am.

August 2024 Updates: Other BLA recommendations in which HSH is named as a supporting agency.

4.3: DPH, DEM and HSH should: conduct, at minimum, mid-year reviews or evaluations of contractor performance toward contract obligations of all new street team contractors for the first three years of the contract.

While HSH is named in this recommendation, Heluna Health is not a new contractor with the city or for outreach services through SFHOT. Heluna Health was selected through RFP # to continue to provide SFHOT services under a new contract starting in January 2024. This contract was approved by the Board of Supervisors in December 2023.

HSH conducts annual performance reviews of Heluna Health's SFHOT contract as noted in the BLA report. FY22-23 Monitoring was completed in November 2023. The monitoring confirmed that overall, Heluna was meeting and exceeding all service outcome objectives.

5.3: The Board of Supervisors should prioritize funding needs identified in HSH's Home By the Bay Strategic Plan to expand the capacity of the homelessness response system by adding 1,075 new shelter beds and to add new shelter, transitional housing or other options in a variety of settings and models, including after-hours and weekend placement options for street team clients.
HSH released the citywide strategic plan to prevent and end homelessness in May 2023. The Plan identified the need to add 1,075 new shelter beds along with 3,250 new housing units and 4,300 slots of prevention in order to reach the Plan's goals, including a 50% decrease in unsheltered homelessness. The FY 2024-26 adopted budget included key investments to maintain and expand shelter options, including but not limited to: 1. Capital and operational support for Jerrold Commons, a new shelter program opening in early 2025 that will provide a mix of non-congregate cabins and safe parking in the Bayview; 2. Leverage State HHAP grant dollars to support continued operations of nearly 300 units of non-congregate shelter hotels, including the Adante Hotel which is the home to the RESTORE pilot program with DPH; and 3. Expand emergency shelter hotel vouchers to serve an additional 600 families over the next 1.5 years and expand capacity at the Buena Vista Horce Mann (BHVM) Family Stayover Program to address the increased need of families experiencing homelessness.

SCRT and SORT – OVERVIEW

Program	Goal	Core Metrics

SCRT	Alternate response to 911 activations for individuals experiencing mental or behavioral health emergencies, or those requiring low-acuity wellbeing checks.	• Number of Encounters
		• Distribution by Call Origin
		  ○ Dispatch
		  ○ Other (inc. on-views)
		• Distribution by Disposition
		  ○ Against Medical Advice/ Patient Declined Transport
		  ○ Non-Ambulance Transport
		  ○ Ambulance Transport to Hospital
		  ○ Community Paramedic Initiated Encounter (CP Encounter)
		  ○ Office of the Medical Examiner (OME)
		  ○ Unable to Locate
		  ○ Walked Away
		• 5150 Reasons*
		  ○ Grave Disability
		  ○ Harm to Others
		  ○ Self-Harm
		• Police Requested
		• Police Request Reasons*
		• Disposition of Engaged Encounters
		  ○ Ambulance Transport to Hospital
		  ○ Non-Ambulance Transport
		  ○ Remained in Community
		• Average Response Time
		• Average Time on Call
		• Average Turnaround Time
		
		*Multiple selections allowed

SORT	Respond to overdose survivors within the 911 system and provide connections to Suboxone (buprenorphine), shelter, treatment and follow-up care.	

SCRT Performance Metrics

Metric	SCRT
Number of Encounters	
Encounters	13881
Distribution by Call Origin	
Dispatch	11712
Other	2169
Distribution by Disposition	
Against Medical Advice	115
Ambulance transport to hospital	2322
CP Encounter	1847

OME	7
Patient Declined Transport to Hospital	6559
UTL	2782
Walked Away	249
5150 Reasons*	
Grave disability	119
Harm to others	47
Self-harm	193
Police Requested	
PD Arrived Without Request	39
PD On Scene Before SFFD	246
PD Requested	110
SCRT/SORT Special Called by PD	2626*
Police Requested Reason*	
Assist with Restraint	21
Assist with Restraint:Imminent Threat to Self or Others	5
Assist with Restraint:Imminent Threat to Self or Others:	5
Assist with Restraint:Scene Management	1
Imminent Threat to Self or Others	37
Imminent Threat to Self or Others:Scene Management	5
Scene Management	59
Disposition of Engaged Encounters	
Ambulance transport to hospital	2322
Non-Ambulance transport	2683
Remained in Community	5845
Average Response Time (Mins)	
	17.0
Average Time on Call (Mins)	
	45.6
Average Turnaround Time (Mins)	
	29.8

*SCRT/SORT Special Called by PD from CAD Data

5150's written by Community Paramedics in 2023/24 Fiscal Year**: 306**

SCRT – Progress Towards BLA Audit Recommendations

A. Update on monthly training of SCRT teams

- In-service trainings are conducted weekly and facilitated by community paramedic captains and RAMS supervisors. Trainings consists of scenario-based practice, review in small groups, and lectures, which may be virtual and in person by subject matter experts. All members of the team participate: community paramedics, EMTs, and peer support specialists. Topics reviewed this year include Roles and Responsibilities, De-escalation and Self Preservation, Safety Procedures, Resources, 5150 Review, SORT in service, orientation for new members and trainings by Street Medicine and Project Lily on SUD and Reproductive Health. Our members have also conducted site-visit based training sessions with staff from Dore Urgent Care Clinic (DUCC) and the San Francisco Sobering Center. These drills are in addition to the core ongoing Fire Department policy and protocol trainings.

B. Indication of increased sense of belonging and support across teams

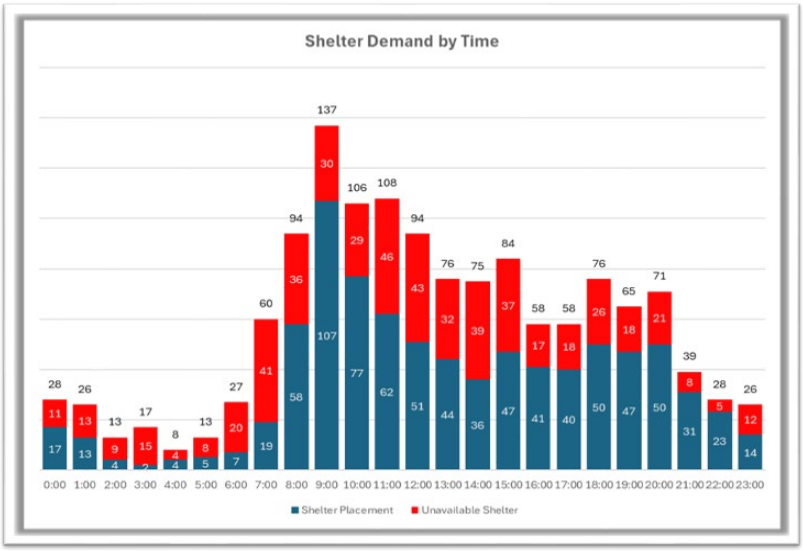
The Fire Department has initiated and continued numerous programs to support crew wellness and belonging. These include:

1. Weekly Crew Meals: Funded by a grant from the National Science Foundation, funds support two (2) crew meals per week for all street response team members. This program, started in March, will continue through December 2024. This intervention (sponsored meals) has brought together teams that are frequently posted in different areas of the city and contributed to ongoing positive moral, wellness and retention.
2. EMS & Community Paramedicine Cross-Division Ride Alongs: Members of the EMS Division are riding along with Community Paramedicine Division units with the goal to better understand their work.
3. Resource Fair: A multi-agency resource fair is in the planning stages and will be schedule for late October. The Fire Department is partnering with numerous resource providers and non-EMS street teams to allow for SFFD members to embed with these partners for informational and relationship building purposes. After these embeds occur, SFFD members and our partner agencies will gather to share information, reinforce relationships and recognize the community of providers involved with our clients' care.
4. ADC Station visits: Fire Department Assistant Deputy Chiefs representing the Community Paramedicine Division as well as our Diversity, Equity, and Inclusion Chief, have been systematically visiting all SFFD Fire Stations to answer questions about Community Paramedicine and signal leadership support for continued integration into Department culture.
5. Daily Division Meetings: Community Paramedic Captains are attending daily Division meetings. Led by one of two on-duty SFFD division chiefs who supervise FD operations City-wide, these daily meetings include all Battalion Chiefs and are a source of information dissemination and feedback for the entire Department. Participation has supported continued integration of community paramedicine into regular Department operations.
6. Police Department Line-ups: Community Paramedicine Section Chief of Operations April Sloan continues to attend SFPD line-ups to bridge information gaps and answer front-line officers' questions directly about our programs, ongoing issues observed in the community, and areas identified by our quality improvement process. These lineups began January 2024 in coordination with the SFPD Crisis Intervention Team (CIT) and resulted in all 10 SFPD stations receiving informational visits. Informational line-up visits will begin again in October 2024 to increase interagency cooperation around supporting individuals who are conserved or gravely disabled and placed on involuntary mental health holds
7. Peer Support Conversations: Initiated in April of 2024, this has proven to be a powerful intervention supporting crew well-being. These facilitated sessions are designed as a preventative mental health measure ("the gym for your mind"), allowing teams to share the successes and challenges they confront daily. These sessions are held weekly and open to all team members and have received broad positive feedback from crew

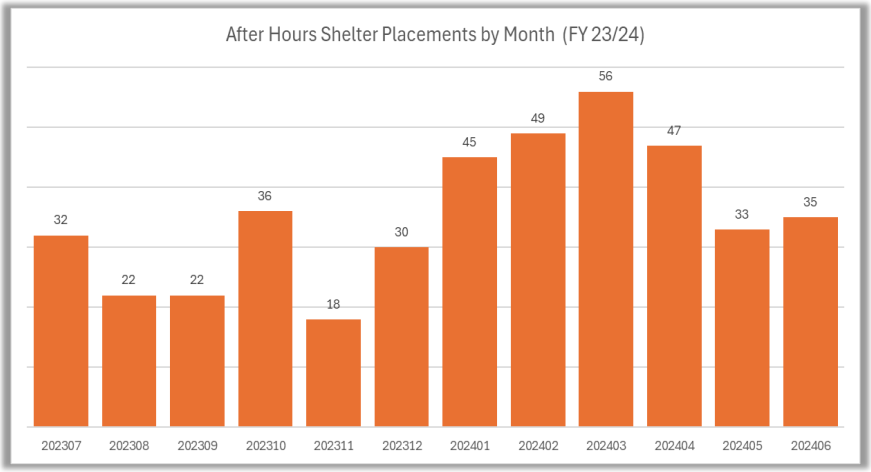
C. Shelter: Identify shelter availability resource gaps for SCRT. Below table reflects shelter availability/unavailability during "after hours" anytime outside of 0800 – 1600. Time is determined by the initial incident call for service time.

Summary

- Shelter placements (blue) = 849 (61% avail)
- Unavailable shelter (red) = 538 (39% unavailable)



Indication of SCRT dedicated shelter improvement/evening drop offs



D. Indication of SCRT staffing levels and if they are adequate to meet needs; what's needed to meet staffing needs.

- During the FY 23-24 time period, SCRT units received **17,146** calls for service[1]
- Of those over 17,146 calls, **2,626** were special calls from the San Francisco Police Department

- The percentages below indicate how often SCRT units are available to respond to specific call types, which are a subset of the 17,145 calls for service in FY24. These call types were chosen as they best represent incidents which would have previously received a law enforcement response and include only incidents to which SCRT units are dispatched solo (alone), without other Fire Department or law enforcement resources.

Final Call Type	CP Dispatched	Total Calls	Percentages
25A1C	5017	5185	96.76%
32B1	332	533	62.29%
32B3	253	401	63.09%
32D1	1342	1932	69.46%
Total	6944	8051	86.25%

[1] A call for service is defined as a 911 activation. Data sourced from Department of Emergency Management CAD.

The percentages above indicate how often SCRT units are available to respond to specific call types.

- **25A1C:** This call type is for behavioral health emergencies that would previously have received a police response. SCRT units respond alone to this call type, which will pend up to 30 minutes awaiting an available team.
- **32B1, 32B3, 32D1:** These call types are for wellbeing checks that would previously have received a police response. If no SCRT unit is available to respond immediately, these incidents are assigned an ambulance response.

E. Report on progress towards the "health outcome database" to support longitudinal understanding of suboxone administration.

- The Fire Department has supported and championed the back end integrated dataset, All-Street Teams Client Database, a project which is meeting the need to connect disparate data sets and provide longitudinal insights into the impacts of our collective care and services. In addition to this major effort, the Department is in different stages of operationalization for the following health outcome data efforts:
    - **Buprenorphine Utilization Performance Evaluation (BUPE) Registry:** The SFFD, in coordination with the California Paramedic Foundation, have successfully applied to the California Department of Health Care Services to receive funds to support creation of a registry to track health outcomes from pre-hospital buprenorphine administrations. This database will link pre-hospital (EMS) buprenorphine administration data with hospital health and discharge data, providing a more comprehensive understanding of the impacts of paramedic-initiated buprenorphine. This registry will be launched and piloted in San Francisco and has the potential to scale on a state or national level if successful. The project award was announced in July 2024, and we expect a 1-year implementation timeline before initial launch.
    - **Continued Integration with EPIC:** Community Paramedicine Division electronic patient care reports (ePCRs) are automatically imported into EPIC, the centralized health information exchange utilized by the majority of San Francisco hospitals, and into which non-EPIC hospital data is imported.

SORT Performance Metrics

Metric	SORT
Number of Encounters	
Encounters	1633
Distribution by Call Origin	
Dispatch	1428
Other	205
Distribution by Disposition	
Against Medical Advice	77
Ambulance transport to hospital	956
CP Encounter	115
OME	8
Patient Declined Transport	319
UTL	141
Walked Away	17
5150 Reasons	
Grave disability	2
Harm to others	
Self-harm	8
Police Requested	
PD Arrived Without Request	2
PD On Scene Before SFFD	15
PD Requested	5
SCRT/SORT Special Called by PD	58
Police Requested Reason	

Assist with Restraint	2
Assist with Restraint:Imminent Threat to Self or Others	
Assist with Restraint:Imminent Threat to Self or Others:	
Assist with Restraint:Scene Management	
Imminent Threat to Self or Others	5
Imminent Threat to Self or Others:Scene Management	1
Scene Management	20
Disposition of Engaged Encounters	
Ambulance transport to hospital	956
Non-Ambulance transport	129
Remained in Community	390
Average Response Time (Mins)	
	10.3
Average Time on Call (Mins)	
	30.1
Average Turnaround Time (Mins)	
	34.0

In FY 23-23, SORT responded to 2,088 calls

SORT – Progress Towards BLA Audit Recommendations

A. Suboxone Administration

Provider	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Grand Total	% of Grand Total
AMR				1		1	0	0	0	0	0	0	2	2%
King American	2	1	1		1		0	2	0	0	0	0	7	7%
SFFD	4	4	8	9	10	10	4	11	10	9	6	3	88	91%
Grand Total	6	5	9	10	11	11	4	13	10	9	6	3	97	100%

While SORT was directly responsible for 20% of all pre-hospital Suboxone inductions in San Francisco, they were involved with 44% of all inductions (meaning SORT unit was on-scene or consulted by the medic unit). We interpret this as an indicator of their influence and modeling of best practices to other EMS providers.

Since EMS providers in San Francisco joined this Suboxone pilot, San Francisco has surpassed all other participating counties, even those that started several years prior.

Bupe Starts: Start date -August, 2024

County	Start Date	Total bup admins since start date
Alameda	July 2023	69
San Francisco	April 2023	129
Contra Costa	September 2020	123
Monterey	May 2023	7
San Benito	July 2023	1
Santa Cruz	July 2023	10
San Diego	October 2023	2
Yolo	July 2023	3
	Total	344

B. Indication of SORT staffing levels and if they are adequate to meet needs; what's needed to meet staffing needs.

SORT's capture rate (a percentage figure defined by the instances where SORT was available and on scene for a confirmed opioid overdose) is 31%. In other words, SORT was able to respond to 31% of all opioid overdoses known to the Fire Department. This metric is influenced by several factors: the volume of overdoses the Department is seeing, SORT unit availability and SORT staffing.

C. Optimizing SORT Impact

SORT's greatest area of impact is connecting individuals to Suboxone, shelter and treatment services. While SFFD is leading the state in pre-hospital Suboxone inductions, we continue to seek areas of opportunity. In FY23/24, available SORT units were dispatched to all overdoses in addition to an ambulance and a first response unit (engine or quick response vehicle). Given the volume of overdoses, and the time required to successfully engage individuals who are contemplating change, SORT members were operationally challenged by this response framework. Beginning FY25, SORT units will self-dispatch to 911 overdose incidents, with the goal to allow for enough engagement time on individual incidents and clients to support our collective aim of increasing referrals directly into treatment.

Department of Public Health (DPH)

Whole Person Integrated Care (WPIC)-Street Medicine – Overview

Street Medicine is a multidisciplinary team which offers care in the areas of medical, mental health, substance use, and cognitive concerns. The model is mobile, low barrier, and includes both direct outreach and connecting to individuals identified by internal and external referrals.

Services include engagement and trust building for individuals out of care and suspicious of the healthcare system, assessment of need for emergency care, episodic care for acute medical conditions and exacerbations of chronic conditions to the extent that care can be delivered safely in the outreach setting.

Street Medicine is not set up as a crisis response team although we have capacity to offer care for urgent problems when they arise. Building and sustaining longitudinal therapeutic relationships is a core component of our Street Medicine work. Our initial outreach encounter will usually be a mobile evaluation by a health worker and registered nurse. Depending on the situation, a psychiatrist, psychiatric nurse practitioner, primary care nurse practitioner or physician may also respond. The individual will be assessed for risk and vulnerability and any immediate needs. Once a care plan is developed, we work to build a therapeutic relationship, stabilize, and connect the individual to needed services and care over time.

Services are delivered wherever our patients need them, including encampments, streets, parks, etc. While engagement often starts on the street, it does not end there. Street Medicine teams actively link patients to 4-walls clinics, including the Maria X Martinez Health Resource Center which offers urgent care, transitional primary care, integrated behavioral health care, dental care, podiatry, and addiction medicine.

Street Medicine includes a CalAIM Enhanced Care Management (ECM) team, including nurses, health workers, and behavioral health clinicians, who are able to provide high-touch, longitudinal care management for patients identified by their managed care plan as having complex medical needs. Standard ECM data elements are reported to Managed Care Plans.

Street Medicine has a contract with the Community Based Organization RAMS to employ Peer Health Workers who are integrated into multidisciplinary Street Medicine teams. Peers bring a unique skill set and background to Street Medicine work, improving our ability to build trusting relationships with the communities we serve.

WPIC-Street Medicine – Progress on BLA Recommendations and Summary Goal and Data Highlights

A. Street Medicine, which has existed since 2016, does not track any metrics or post any data on its outputs or outcomes publicly.

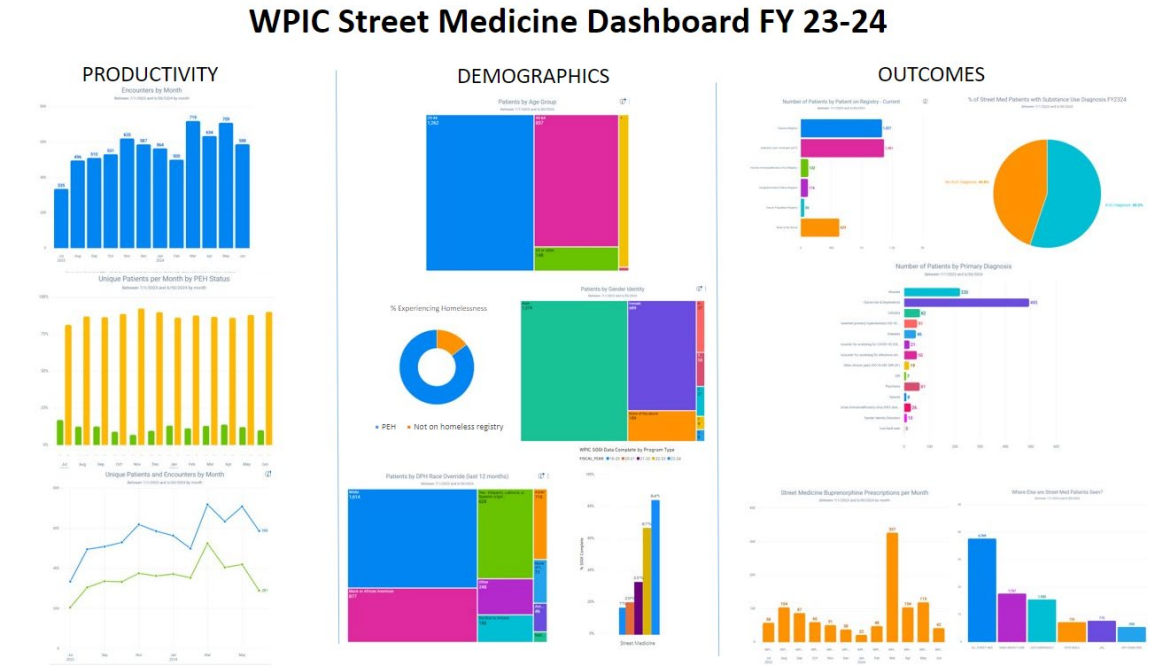
For FY 2023-24, Street Medicine identified and tracked the following performance objectives:

Objective	Rationale	Goal for FY 2023-24	Outcome	Met/Unmet?
Street Medicine will meet defined threshold for total number of Face to Face Encounters each year.	Maximize patient engagement	2000 encounters	*6,793*	MET ✔
Street Medicine will serve a defined minimum number of unduplicated clients each year	Maximize patient engagement	1000 unique clients	*2,355*	MET ✔
At least 60% of people served by the program each year will be People Experiencing Homelessness.	Reach target population	60% PEH	85%	MET ✔
At least 500 patients with Opioid Use Disorder seen by a Street Medicine provider at a WPIC site will have at least one prescription for buprenorphine each year.	Decrease overdose risk and improve outcomes for Opioid Use Disorder	500 patients prescribed buprenorphine	994	MET ✔
At least 30 clients annually will be enrolled in low barrier Hepatitis C treatment.	Eliminate Hepatitis C	30 clients enrolled	89 clients	MET ✔
At least 60% of people served by the program will have Sexual Orientation Gender Identity status documented.	Improve quality of care for LGBT and Gender Diverse patients.	60% SOGI status documented	84%	MET ✔
At least 70% of Street Medicine HIV Transitional Primary Care patients will have a viral load < 200 copies/ml which will indicate viral suppression and treatment adherence.	Decrease HIV transmission and morbidity/mortality for People Experiencing Homelessness	70% virally suppressed	67%	UNMET

All FY 2023-24 objectives were met by Street Medicine teams with the exception of missing our 70% goal for HIV viral load suppression by 3%. Of note, our HIV viral suppression rate of 67% is higher than the rate of viral suppression for People Experiencing Homelessness in San Francisco as a whole. We will continue improvement efforts to meet the 70% goal.

Street Medicine has made significant progress over the last year in improving documentation and using data to improve care. Where performance targets were exceeded for FY 23-24, Street Medicine is adjusting goals for FY 24-25 with a goal of continuous quality improvement. Street Medicine has developed a clinical dashboard utilizing data from the Electronic Health Record to continually track demographics and patient outcomes.

Graphic: Street Medicine 2023-24 Dashboard



All Street Medicine contracts currently have outputs/outcomes in scopes of work and protocols in place for regular evaluation of contractor performance. As RAMS contractors work as part of an integrated multidisciplinary Street Medicine teams, objectives for RAMS are reported as part of the work of Street Medicine teams.

Whole Person Integrated Care- POET – OVERVIEW

The Post Overdose Engagement Team (POET) launched in August 2021 to offer street-based support for people experiencing homelessness with a recent non-fatal overdose. Following an immediate response by the Street Overdose Response Team (SORT) at the time of an overdose, the Post Overdose Engagement Team (POET) provides ongoing follow up, continuing to offer engagement, care coordination, and access to treatment, including medications. The multidisciplinary POET team includes health workers, peers, social workers, nurses, and medical providers.

POET – Performance/Data Highlights

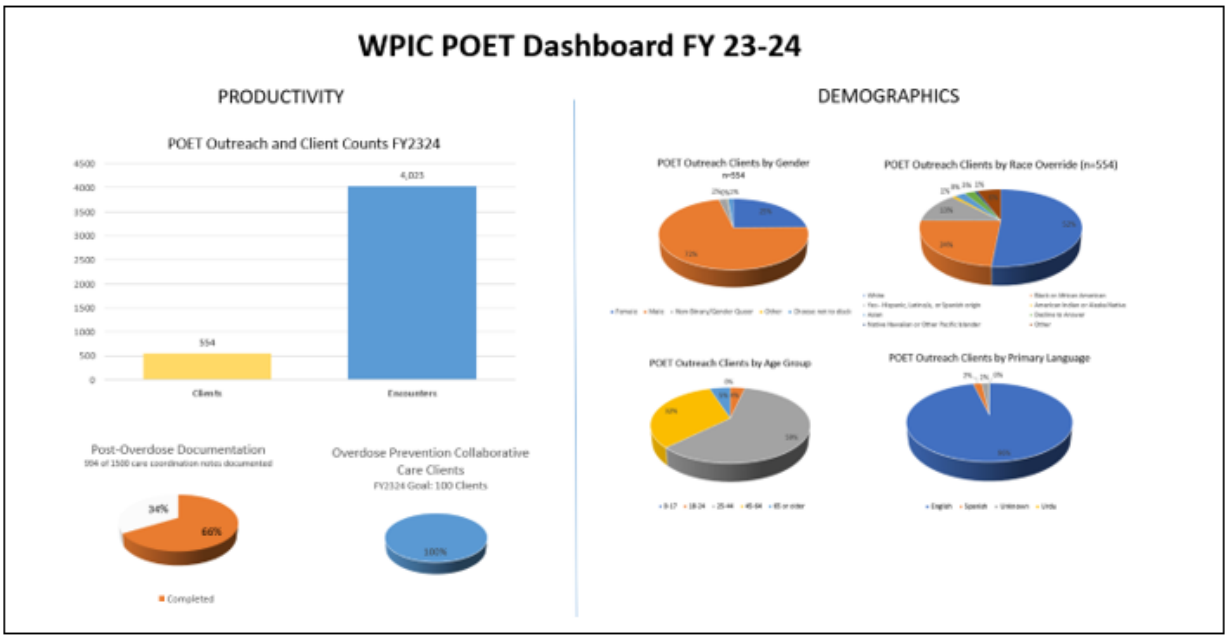
For FY 2023-24, POET identified and tracked the following performance objectives:

Objective	Rationale	Goal for FY 2023-24	Outcome	Met/Unmet?
Program will meet defined threshold for total number of successful outreach engagements which include the provision of standardized overdose prevention counseling each year.	Maximizing patient engagement.	2000	4,023	MET ✔
Program will serve a defined minimum number of unduplicated clients each year.	Maximizing patient engagement.	500	554	MET ✔
At least 1500 people who have experienced a non-fatal overdose will have post-overdose care coordination documented in the electronic health record.	Decrease risk of future fatal overdose	1500	994	UNMET
At least 100 people who have experienced a non-fatal overdose will receive ongoing intensive multidisciplinary overdose prevention collaborative care.	Decrease risk of future fatal overdose	100	100	MET ✔

Of note, all FY 2023-24 objectives were met by POET teams except post-overdose documentation in the electronic health record, meant to aid with care coordination. We have developed standardized workflows that provide reportable data into our electronic health records beginning in late 2023, so we can report a more complete dataset and expect to meet the goal

of 1,500 annually for FY 2024-2025. Where performance targets were exceeded for FY 23-24, POET is adjusting goals for FY 24-25 with a goal of continuous quality improvement. POET is in the process of developing a clinical dashboard utilizing data from the Electronic Health Record to continually track demographics, referrals made and patient outcomes.

Graphic: POET 2023-24 Dashboard Draft



POET – Progress Towards BLA Audit Recommendations

A. Absence of executed contract

The one-time barriers that caused the SORT Community Based Organizations contract to be delayed have been since addressed. All SORT/POET contracts currently have outputs/outcomes in scopes of work and protocols in place for regular evaluation of contractor performance. Contractors (Felton Institute and RAMS) work as part of the integrated multidisciplinary POET team and objectives for contractors are reported as part of the work of the POET team.

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

We have continued to refine the service model for the POET team using an iterative, data driven process with the goal of using resources efficiently and with highest impact. A key accomplishment over the last year has been to better integrate the work of San Francisco overdose response teams, including SORT, POET, and the HOPE team (a UCSF team providing post-overdose support to housed individuals.) This year, SORT, POET, and HOPE, in collaboration with DEM, participated in the Civic Bridge Collaboration through the Mayor's Office of Innovation. Over 12 weeks, we worked with ZS consultants to understand the responder journey, including care gaps, for SORT, POET and HOPE, and to propose and implement feasible changes for response teams which were tested during an implementation phase.

Currently the POET team prioritizes the following high impact activities:

- Documentation of the overdose event and available support resources in a care coordination note in the Electronic Health Record where the information can be viewed when the person presents to an ER or other care site.
- Outreach to unhoused people who we have a clear way to find and connect with, utilizing a "warm hand off" approach from other teams including Street Medicine and SORT wherever possible.
- Linkage to treatment and initiation of medications including methadone and buprenorphine.
- Longitudinal care coordination for people at high risk for recurrent overdose, including a cohort of people who have had multiple overdoses.

OCC- OVERVIEW

The Behavioral Health Services (BHS) Office of Coordinated Care (OCC) supports connection to mental health and substance use services across the City's behavioral health system, with services ranging from centralized behavioral health access points and eligibility services to community-based care coordination services, which have a significant focus on people experiencing homelessness.

OCC plays a role in the city's Coordinated Street Response in two key ways: 1) via the BEST Neighborhoods (Bridge & Engagement Services Team: Neighborhoods) teams, which provide outreach, engagement and connection to care for people who are unhoused and have significant behavioral health needs and 2) by providing follow-up triage for Street Crisis Response Team (SCRT) referrals.

OCC- SCRT Triage does not represent a specific street team or dedicated OCC program. Triaging of SCRT clients is part of a much broader OCC-Triage scope of work. Future reports will show "OCC-Triage" with outcomes for a sub-population, SCRT clients served by OCC-Triage.

OCC- SCRT Triage

When the Street Crisis Response Team reconfigured in 2023, follow-up triage for SCRT referrals was also reconfigured and incorporated into the larger OCC organizational structure. OCC now determines follow-up needs and plans for individuals who have had a behavioral health crisis contact with the Street Crisis Response Team.

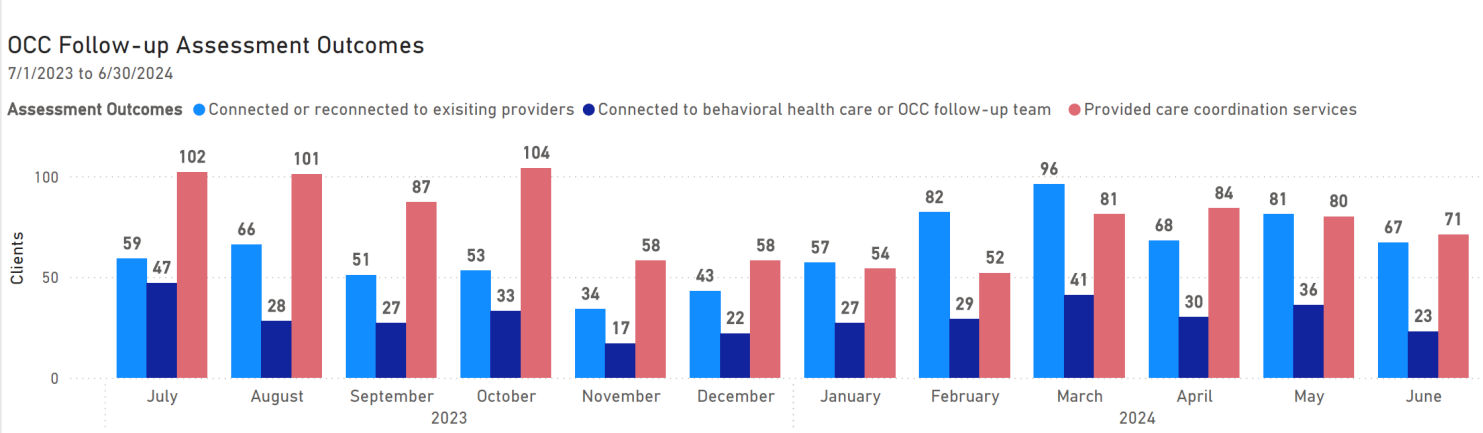
Each day, OCC's Triage team receives and reviews the list of clients with SCRT encounters for behavioral health crisis and identifies follow-up needs. The team triages and identifies needs for all individuals on the list for whom there is identifying information, with special focus on individuals for whom SCRT initiated a 5150 or transported to the hospital, those transported to SoMA RISE, those transported to Dore Urgent Care, as well as those with multiple SCRT or other system contacts. OCC identifies follow-up steps and provides care coordination with the goal of reconnecting or connecting those people in particular to behavioral health resources including to OCC's community-based follow-up teams.

General follow-up steps can include:

- Identifying current or needed service connections
- Coordinating follow-up plans with hospitals, emergency departments, existing providers, and community-based teams
- Deploying additional outreach and follow-up support to engage, stabilize and connect to health care services such as behavioral health care, primary care, case management, and housing.

OCC's goal is to ensure individuals who have had contact with SCRT for a behavioral health crisis have follow-up needs identified and appropriate care coordination or service connection steps taken. In FY 23-24 OCC triaged and determined follow-up needs for **2049** contacts referred from SCRT. Follow-up steps included care coordination and re-connection with existing providers as well as connection to OCC or other DPH community-based teams for additional outreach, engagement and service connection.

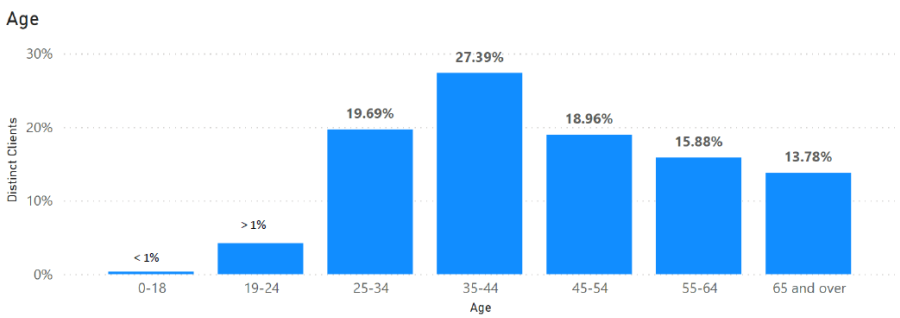
FY 23-24 Outcomes – Bar Chart and Distribution Tab



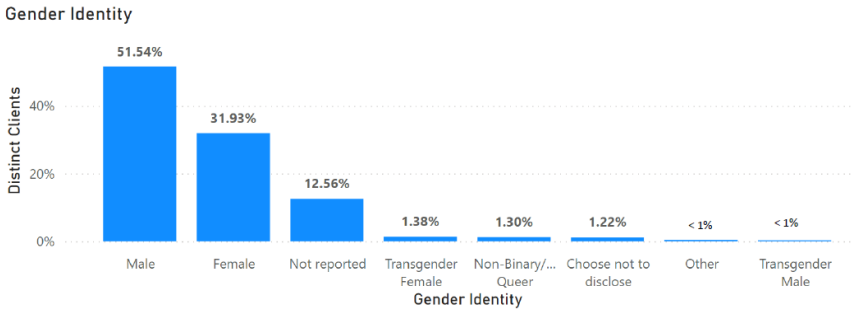
Year	Connected or reconnected to exisiting providers	Connected to behavioral health care or OCC follow-up team	Provided care coordination services	Total
2023	**306**	**174**	**510**	**990**
July	59	47	102	**208**
August	66	28	101	**195**
September	51	27	87	**165**
October	53	33	104	**190**
November	34	17	58	**109**
December	43	22	58	**123**
2024	**451**	**186**	**422**	**1059**
January	57	27	54	**138**
February	82	29	52	**163**
March	96	41	81	**218**
April	68	30	84	**182**
May	81	36	80	**197**
June	67	23	71	**161**
Total	**757**	**360**	**932**	**2049**

When there is sufficient client identifying information, OCC creates or documents a referral (episode) in the public health, client management database, EPIC each time there is a contact with SCRT necessitating OCC triage/follow up. Annual data may include multiple referrals/episodes for the same individual. SCRT may also refer people who do not disclose ample identifying information for documentation into EPIC. In this instance, SCRT will include descriptive information of the client and the specific location of the SCRT encounter. An OCC team will outreach to the specific location, although re-connection success is an identified challenge as the referred person (through description only) may not remain in the location of the SCRT encounter. This challenge will hopefully, in part, be mitigated through the Outreach Worker Tool which will catalogue all teams' encounters with "shared" clients, increasing knowledge of where clients are around the city, hopefully improving opportunities for reconnection. The below information is for clients referred from SCRT who have profiles in EPIC.

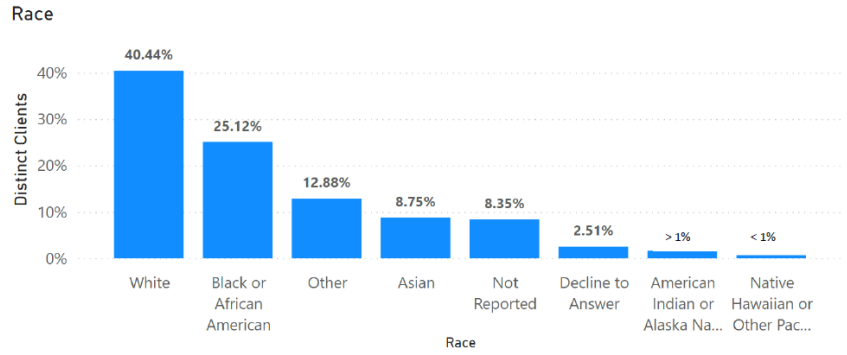
Age distribution

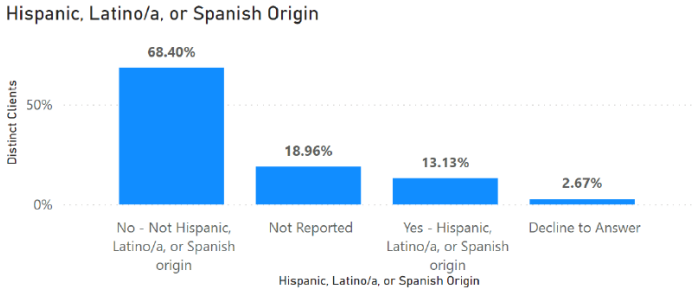


Gender Distribution



Race Distribution





OCC's SCRT follow-up triage data are published on a monthly basis to the public SCRT dashboard (https://www.sf.gov/street-crisis-response-team). Additional metrics updates are being planned for this year, which will include cumulative follow-up data.

OCC – SCRT Triage – Progress Towards BLA Audit Recommendations

A. Modify/fine tune service models to improve the success rate and cumulative follow-up rate for referred clients.

As noted, DPH made significant changes to the SCRT follow up model as part of the SCRT reconfiguration. As of March 2023, follow-up for SCRT is integrated into the larger Office of Coordinated Care (OCC) organizational structure. OCC provides care coordination and follow-up for people who have multiple points of contact across systems, including people exiting involuntary holds (5150), transitioning out of acute care settings, following crisis contacts, and leaving jail.

This approach ensures OCC can identify, follow, and provide strategic intervention for people who have contacts across multiple places in the system and who need strong system coordination. It also ensures that the follow-up response is focused and tailored to the individual's needs.

SCRT follow-up is also integrated into Coordinated Street Response. The coordinated and shared approach to SCRT follow-up centers shared priority clients, which ensures individuals with the highest level of need receive the level of services and focus commensurate with that need. It also leverages BEST Neighborhoods' neighborhood-based and planned outreach as well as the communication and coordination between all street response teams to support follow-up.

OCC-BEST Neighborhoods – OVERVIEW

As part of the reconfiguration of SCRT, BEST Neighborhoods was established in March 2023 to play an important role in the city's Coordinated Street Response. BEST Neighborhoods both expands and focuses DPH services that provide outreach, engagement, and connection to care for individuals experiencing homelessness with significant behavioral health needs.

BEST Neighborhoods teams work with people experiencing homelessness with highly complex needs who face significant barriers to access or engage with needed care and who may experience ongoing crisis. The teams focus on follow-up for individuals with SCRT encounters, shared priority clients (clients who are prioritized for care based on city health and emergency services data), and individuals identified during planned outreaches in the community. The teams provide time-limited, focused and phased interventions to support clients with the transition to ongoing care and supports.

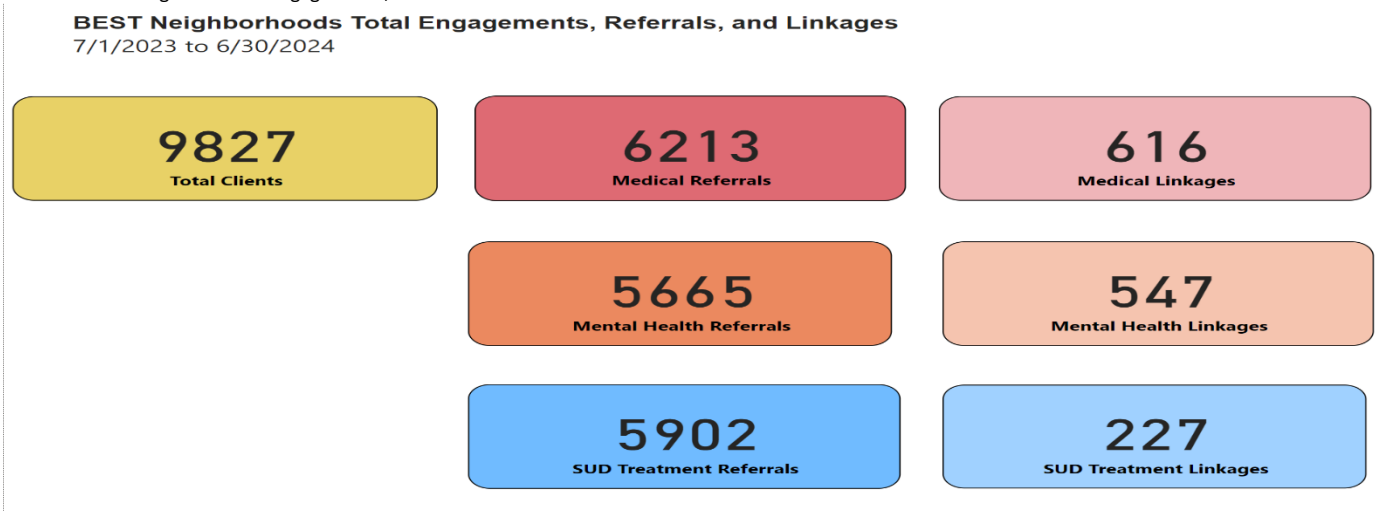
BEST Neighborhoods is staffed by civil service staff as well as via a contract with RAMS, a community-based organization with special expertise in employing peer counselors and integrating them into multidisciplinary behavioral health teams. RAMS peer counselors play core roles in BEST Neighborhoods daily outreach, engagement and connection to care.

The BEST Neighborhoods multidisciplinary teams are made up of behavioral health clinicians, health workers, peer counselors, registered nurses and psychiatrists who work together to outreach, engage, stabilize, and connect people experiencing homelessness who have significant behavioral health needs to necessary health and other services.

BEST Neighborhoods teams work 6 days a week in assigned neighborhoods, allowing the teams to become familiar with and knowledgeable about specific neighborhood needs, residents and businesses. BEST Neighborhoods has teams that respond to and focus on areas of need citywide, as well as teams focused in the Tenderloin, Mission/Castro, and Bayview/Ingleside. The teams also provide support and connection to behavioral health services to encampments as part of the Healthy Street Operation Center (HSOC) pre-resolution outreaches.

OCC- BEST Neighborhoods, Performance Highlights

FY 23-24 BEST Neighborhoods Engagements, Service Referrals & Connections to Care



Conclusion

SF Coordinated Street Response works with an urgency to address the needs of people in crisis who experience homelessness in San Francisco. Our most complex work is with people who are not yet intrinsically motivated, for an array of reasons, to take advantage of stabilizing services. Teams use every resource and tool available in support of stabilization and wellness of clients, but the bottom line is that the work is time and labor intensive.

At a system-level, we recognized that the siloed nature of our work was a barrier to positively impacting our shared clients and the San Francisco community at large. Together, we are strengthening strategies for coordination, recognizing that effective and streamlined communication and appropriately sharing information increases opportunities for expedited services linkages. We made tremendous progress in FY 23-24 and will build on it in FY 24-25.

Key next steps include:

1. Completing an SF Coordinated Street Response Operational Plan
2. Finalizing top tier goal and performance metrics
3. Operational commitments to Shared Priority clients
4. Full integration of the outreach worker tool into our business practices
5. Launching of the policy maker dashboard and public facing website
6. Continuing advocacy around resource need

Our next report will be submitted in September 2025.