McMillan Stabilization Pilot Project

Funded by the City and County of San Francisco
and the
Hospital Council of Northern and Central California

6-Month Interim Report

August 2003 – January 2004

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I. Project Description

I.A. Project Background

Between 1995 and 2002, diversion rates from emergency departments (EDs) in San Francisco rose more than ten-fold. In response to this disturbing trend, the Board of Supervisors, under the leadership of then-Supervisor Gavin Newsom, established an Emergency Room Diversion Task Force. In November 2002, integrating input from stakeholders that included more than 50 representatives from City departments, community-based agencies, private hospitals and healthcare providers, the Task Force presented a report identifying the key issues and making policy recommendations to address this problem.

A critical finding was that chronic public inebriates, hereafter named homeless alcohol-dependent persons, were placing a significant burden on City EDs—making up more than 20 percent of ED patients, spending almost twice as much time per visit than the average patient, and visiting the EDs with far greater frequency than other populations. The report noted that the city lacked adequate mechanisms to divert homeless alcohol-dependent persons to alternative levels of care, and, while the critical elements of necessary medical and social services were in place, there were gaps in service that needed to be filled. The report also stated that it was necessary to build consensus among the key providers and institutions in order to develop an appropriate system to divert patients to a safe, more effective, and less costly level of care. In response to these findings, the Task Force recommended establishment of a pilot Stabilization Project to provide onsite medically supported sobering services, intensive case management and linkages to a continuum of services for homeless alcohol-dependent persons.

In early 2003, a Medical Advisory Committee and a Project Oversight Committee were convened to continue the work of the Task Force and undertake the planning needed to design and implement the pilot program[1] that would not only reduce demand on the City EDs, but would also more effectively meet the complex psycho-social needs of homeless alcohol-dependent individuals. An unprecedented public/private partnership, members actively involved include a diverse array of stakeholders, including programs of the Hospital Council of Northern and Central California, San Francisco Department of Public Health (SFDPH), the San Francisco Fire Department (SFFD), Citywide Emergency Department physicians, community-based providers, community advocates, and representatives from then-Supervisor Newsom's office and then-Mayor Willie L. Brown's Office.

Through this inclusive and cooperative effort, representatives from public and private sectors reached consensus on the program design and protocols that enabled the San Francisco Department of Public Health to implement the McMillan Stabilization Pilot Project in July 2003[2].

[1] Refer to Attachment A for a list of committees and members.

[2] Refer to Attachments B, C, and D for various protocols developed by the Medical Advisory Committee and Case Management Sub-Committee.

I.B. Project Oversight

A SFDPH-internal Organizational Development Workgroup and a City-wide Project Oversight Committee, comprised of the primary stakeholders who participated in the planning process, provide ongoing oversight of the McMillan Stabilization Pilot Project. In addition to continuing to develop service protocols and program policy, these groups play critical roles in identifying and addressing systemic barriers, gaps in communications, tracking and evaluation needs. The project is supported not only at the highest levels of SFDPH, but by Mayor Newsom's Office and other key City leaders. The SF Health Commission overwhelmingly agreed that such a project is long overdue[3]. Since it's inception, the project has received significant media attention. The San Francisco Chronicle and Examiners have both covered the project[4]; so have local television channels KTVU and KPIX. In addition, the project staff is frequently approached by health providers in other counties and statewide for information on how to initiate such as project.

I.C. Project Partners

McMillan Stabilization Pilot Project is a medically supervised sobering center designed to divert intoxicated persons from the ED to a 24-hour central facility providing medical screening, comprehensive case management services and linkages to a comprehensive continuum of care. The City and County of San Francisco and the Hospital Council of Northern and Central California, a nonprofit hospital and health system trade association representing more than 200 hospitals, provided the funds necessary to implement the pilot project.

In identifying the needs of the target population, key partners were identified that would bring the required medical, social service, alcohol and substance abuse treatment and other relevant expertise to ensure a comprehensive, multidisciplinary approach.

The McMillan Stabilization Pilot Project operates as an integrated continuum of care through the contributions of the following partners:

1. Tom Waddell Health Center, a SFDPH primary care health center and one of the original federally funded Health Care for the Homeless projects begun in 1985, provides medical care;
2. Community Awareness and Treatment Services (CATS), a nonprofit which provides drop-in services for homeless people who are dually diagnosed, provides community case management, transportation services, and the facility space;
3. SFDPH Community Behavioral Health Services Multidisciplinary Case Management Team, including Licensed Clinical Social Workers and other staff, provides intensive psycho-social case and care management services;
4. SFDPH Treatment Access Program staff assess and place individuals into intensive substance abuse treatment services;
5. Baker Places, a community-based substance abuse and mental health non-profit service provider; operates the medical detoxification programs;
6. SFDPH Disability Evaluation Assistance Program team provides SSI/SSDI application assistance and access to consultative exams to homeless adults with

[3] Refer to Attachment H, San Francisco Health Commission Minutes, September 16, 2003
[4] Refer to Attachments E, F and G for newspaper articles.

physical and/or mental disabilities. Also assisting with the SSI/SSDI advocacy is the Homeless Advocacy Project of the Volunteer Legal Services Program, a benefits advocacy and legal assistance program that serves homeless individuals;
7. SFFD Paramedics triage chronic public inebriates on the street; and
8. Emergency Communications Department provides communications support between the EDs and McMillan.

I.D. Program Description

I.D.1. Target Population

The target project population is homeless alcohol-dependent persons in San Francisco; this is a person with a severe alcohol problem who is frequently intoxicated in public. Alcohol abuse is considered the primary problem, though many homeless alcohol-dependent persons have secondary problems with other drugs, mental illness and/or multiple medical problems. Almost all this population is homeless or marginally housed and uninsured.

I.D.2. Sobering Unit

Designed as a means to divert homeless alcohol-dependent persons from ED services, the McMillan Stabilization Pilot Project is a 24-hour, 7-day/week program based at the McMillan Drop-in Center located at 39 Fell Street. Patients are transported to the center by ambulance, the police, or by a Mobile Assistance Patrol (MAP) van, also operated by CATS. A detailed set of medical protocols has been established so that paramedics can triage homeless alcohol-dependent persons to the Stabilization Project at McMillan rather than an ED. The Stabilization Project is defined as 20 beds at McMillan and a multidisciplinary team assigned to ensure that intoxicated clients safely become sober.

I.D.3. Project Goals

At the onset of the project, the Stabilization Project stakeholders identified three goals:
1. To provide better care for homeless alcohol-dependent persons and improve their health outcomes.
2. To decrease the number of inappropriate ambulance trips transporting homeless alcohol-dependent persons to emergency departments.
3. To decrease the number of inappropriate homeless alcohol-dependent persons seen in emergency departments.

I.D.4. Client Entry

1. Clients self-refer and walk into McMillan asking for assistance. If intoxicated, the front desk refers the client to the Stabilization Project.
2. As a critical part of the project, McMillan is linked to the Hospital Administrative Resource Tool (HART) system whereby McMillan informs EDs citywide of their bed availability. EDs may call the MAP van when they receive a patient whom they assess as needing a place to sleep off alcohol intoxication but not immediate medical

attention[5]. Between July and mid-September 2003, the main source of transportation for homeless alcohol-dependent persons to McMillan was the MAP van.

3. From mid-September on-wards, in addition to the services provided by the MAP van to EDs, paramedics were trained on the triage protocol whereby they were advised to transport intoxicated clients with no immediate medical needs directly to McMillan.

I.D.5. Services

Upon arrival to the Stabilization Project at McMillan, medical staff members screen clients guided by nursing protocols developed for the project[6]. Those with medical issues needing immediate intervention are referred to an ED, all others are given a bed or chair (depending on their ambulatory state) to sleep-off their inebriation. As long as the client is present, they are monitored by the medical team during their sobering process to intervene as necessary.

The target population requires a strategy of assertive engagement and outreach. Once the individual has sobered, Community Case Managers screen every individual to identify their immediate needs for community services and refer as appropriate to shelters, hotels, health providers, etc. The Intensive Case Management Team provides oversight and intervenes when medical disabilities and psychiatric disorders impede a client's ability to access services on their own. Equipped to assess, engage, and stabilize gravely disabled clients, the Team places clients into a continuum of services including medical care, housing, benefits advocacy, (medical and social) detox and substance abuse services, and other services available in the DPH system of care. The Team takes a proactive clinical approach to ensure clients are engaged and receive ongoing services until they are stabilized and will often follow the client after they complete treatment[7]. Clients listed as "frequent ambulance users" by the SFFD are automatically prioritized for intensive case management services.

II. Purpose of Report

The purpose of this 6-months report is to review project accomplishments, as well as to identify areas that need to be strengthened as they relate to the project goals.

This report also addresses the outcome measures described in the SFDPH Emergency Medical Section (EMS) pilot program proposal[8]. EMS requested the project team to submit a pilot project proposal to the EMS Operations and Clinical Advisory Committees for review. This request was made because the project is asking paramedics to amend their triage and transportation practice; that is, instead of picking up and transporting a homeless alcohol-dependent person to an ED, the project is requesting the paramedics to triage that person on the street (based on a set of inclusion and exclusion criteria) and determine whether he or she needs to be transported to an ED or the Stabilization

[5] Refer to Attachment B, McMillan Stabilization Project's Inclusion Criteria for hospital instructions to call for MAP Van Transport.

[6] Refer to Attachment C, McMillan Stabilization Project Nursing Protocol.

[7] Refer to Attachment D, McMillan Stabilization Pilot Project: Case Management and Client Transition Protocol.

[8] Refer to Attachment I, McMillan Stabilization Pilot Project's EMS Proposal.

Project at McMillan. This new practice was implemented in mid-September 2003. The EMS Operations and Clinical Advisory Committees will review the work of the pilot project during a trial period and then make a decision on whether to implement an EMS policy change.

Although the project started on July 1, 2003, much of the project data was not captured until August. For consistency, data presented here are for August 1, 2003 to January 31, 2004, unless otherwise noted.

What follows are quantitative and qualitative data that the project team has collected to assess progress against the identified goals. Due to resource limitation, the project implementers made the decision at the start of the project to focus on basic immediate data that they can readily collect with the idea that they will apply for external funding to conduct a more comprehensive project evaluation. SFDPH has subsequently submitted an evaluation proposal to the Robert Wood Johnson (RWJ) Foundation's Substance Abuse Policy Research Program. Some of the evaluation objectives in the proposal are described here.

The data presented in this section are from the following sources: McMillan Stabilization Pilot Project database, SFDPH Emergency Medical Services, SF Fire Department, Emergency Communications Department and the CATS MAP Van.

III. Project Goals and Progress

Data[9] suggest higher utilization of the Stabilization Project than projected. Between August 2003 and January 2004, the Project served 1,261 unduplicated clients with a total of 2,696 encounters. Eighty percent of clients served were male, close to 99% were homeless.

III.A. Goal 1: To provide better care for homeless alcohol-dependent persons and improve their health outcomes

Outcomes:

- Discharge Status: sobered safely; referred to higher level of care; referred to more intensive services, e.g., case management, substance abuse treatment, etc.
- Utilization of Treatment System: retention in the treatment system; usage of acute vs. primary care services; usage of emergency system

III.A.1. Discharge Status

- Of encounters in which outcome data was tracked, the Stabilization Project staff made subjective assessment of clients' health outcomes based on the disposition of clients upon their departure. 40% of clients' health outcomes improved, 22% maintained, 2% worsened, and 36% were unknown.
- Of the total 1,261 individuals served, 26% (329) were assessed for case management services. 21 of these clients accepted ongoing case management services and have been linked with resources, of which 14 were housed (4 in institutional, 2 in permanent and 8 in respite housing).

[9] Refer to Attachment J, McMillan Stabilization Project Six Month Data Summary Report Aug 03 – Jan 04

- Of the 1,261 individuals served, 45 individuals were discharged to medical detoxification and 107 were discharged to social detoxification.
- 5% of total encounters indicated discharge to emergency departments
- Only one client sent to McMillan from an ED was referred back to an ED.
- No deaths occurred at McMillan during the reporting period (Aug 03 to Jan 04).

III.A.2. Client Case Study

The first challenge that homeless alcohol-dependent persons pose to the treatment community is that of engagement. Research indicates that a "sobering center" is an effective engagement and outreach site for this population. The literature also indicates that given the opportunity, most homeless people with serious mental illnesses and/or co-occurring substance use disorders are willing to accept treatment and services voluntarily. Even individuals with the most severe disorders, who are the most reluctant to accept treatment, enrolled in services and showed improved outcomes when served by an outreach team. Through the McMillan Stabilization Pilot Project, a number of the most challenging clients in the system have achieved measured success.

III.A.3. Client Satisfaction

This report does not include a client satisfaction survey. However, the project will participate in the bi-annual DPH Client Satisfaction Questionnaire 8 in May and November. For a two-week period twice each year, clients are asked to complete a standard satisfaction survey at all SFDPH funded mental health and substance abuse treatment clinics. Surveys are typically administered at the conclusion of a client visit or upon discharge from a program. Data are collected, entered and analyzed by the SFDPH Community Behavioral Health Services Section. The results of that survey will be presented in the annual report.

III.A.4. Stakeholder Satisfaction

In addition, the project has submitted an evaluation proposal to RWJ to examine stakeholder satisfaction of the project. Information from stakeholders will be measured through focus group data collected from four primary groups of stakeholders: McMillan Stabilization Project staff, Citywide ED staff and physicians, EMS staff, and staff from mental health, substance abuse, housing and primary care programs that provide services to homeless alcohol-dependent persons.

III.A.5. Predictors of Adverse Outcomes

Determining predictors of adverse outcomes is one of the objectives the RWJ evaluation proposal will address. A premise is even if the intervention led to a decline in utilization of EDs for alcohol intoxication, such a decline would not be desirable if it came at the expense of patient safety. One indication of the safety of caring for apparently intoxicated persons at Stabilization Project and the effectiveness of the triage criteria used in deciding which patients may be transported there is the rate at which patients require ambulance transport from McMillan to the ED. Disposition and types of acute medical problems assessed by McMillan Stabilization Project personnel are recorded in the McMillan Stabilization Pilot Project Database for every admission. Using this database, the study proposes to estimate the proportion of visits requiring ambulance

transport from McMillan Stabilization Project to an ED, to describe the medical problems apparently leading to these adverse events, and to identify and measure characteristics of patients and visits that predict adverse events.

III.A.6. Hospitalizations and Deaths Trends

The RWJ evaluation proposal will also address hospitalizations and death trends of project clientele. If the Stabilization Project is truly safe and effective at improving access to services and breaking the cycle of recurrent public intoxication, the evaluation team expects fewer hospitalizations and deaths among the alcohol-dependent homeless persons who are the primary target of this intervention. City-level data on hospitalizations and deaths are available from the California Office of Statewide Health Planning and Development which maintains a Patient Discharge Data file with links to the National Death Index. The evaluation team proposes to count the number of patients discharged from San Francisco hospitals with a diagnosis of alcohol dependence and a zip code indicating homelessness during the two years before and one year after project implementation; and count the number of deaths occurring in San Francisco (in or out of the hospital) among persons with a history of alcohol-dependence and homelessness.

III.B. Goal 2: To decrease the number of inappropriate ambulance trips transporting homeless alcohol-dependent persons to the emergency department.

Outcomes:

- Appropriate triage and transportation destination of client on the street
- Decrease in total number of hours of ED diversion

III.B.1. Ambulance Transports of Intoxicated Persons

One of the objectives requested in the RWJ evaluation proposal is to track trends in ambulance transport of apparently intoxicated persons. Besides safely decreasing utilization of EDs by intoxicated persons, the proposal finding hopes to show that the centralized multidisciplinary care of alcohol-dependent homeless persons provided at the Stabilization Project and the tailored case management with improved access to detoxification, housing, medical and psychiatric services are effective at breaking the cycle of recurrent public inebriation.

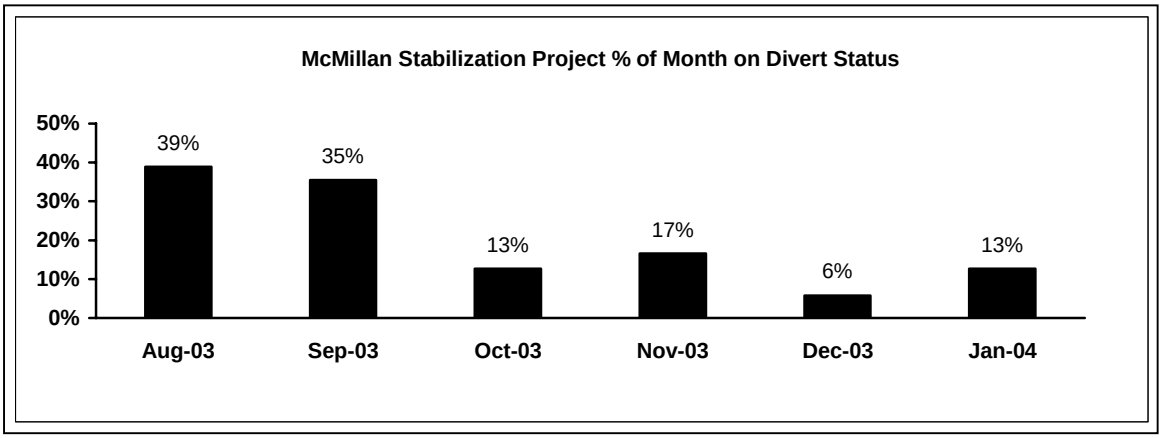
One indication of this might be a decrease in the rate that San Franciscans present intoxicated in public and come to the attention of the Emergency Medical Services (EMS) System. Twenty ambulance units transport approximately 200 patients every day in San Francisco. By randomly selecting one ambulance unit per day, and counting the number of intoxicated persons transported by that ambulance, we will estimate the number of ambulance transports for alcohol intoxication, and analyze the trend before an after project implementation.

III.B.2. Project Diversion Status

The McMillan Stabilization Project has been linked to the Hospital Administration Resource Tool system since the inception of the project. This has allowed hospital EDs

and Emergency Communications Departments to track bed availability at McMillan. Below is a table exhibiting the six-month McMillan divert log report for August 2003 through January 2004.

Thus far, Stabilization staff have been able to move patients from beds (to chairs) as clinically appropriate to handle demand for services and have therefore not needed to place McMillan on divert frequently. Diversions from the Stabilization Program have had more to do with staffing levels. The projects status as a start-up and the challenge of recruiting and hiring new staff to the program resulted in periods in which the project needed to be on divert. Thus, the following numbers showed that the diversion status of the Stabilization Project has been gradually reduced from August 2003 to January 2004 – an indication of increased staff coverage. Staffing coverage at the Stabilization Project has been at greater than 85 percent of 24-hours/7-days per week in recent months.



III.B.3. Hospital Diversion Status

One assumption of the project is that by establishing a Stabilization Project, EDs will be less clogged due to less ambulance drop-offs of homeless alcohol-dependent persons. The hospital monthly percentages of time on divert status from August 2003 to January 2004 does not indicate either an increasing or decreasing trend (see following table). Nevertheless, informants from both St. Francis Memorial Hospital and California Pacific Medical Center have experienced noticeable changes in both the number of inappropriate patients being dropped off at the EDs and number of patients staying at the EDs due to alcohol intoxication.

The SF ER Diversion Task Force identified that there were four hospitals in the Downtown and Mission area of the city that generated 80% of diversion hours. They are: California Pacific Medical Center (Pacific Campus), St. Francis Memorial, San Francisco General and St. Luke's Hospitals. As a result, the McMillan Stabilization Pilot Project would produce the most impact at those four hospitals.

Hospital ED Monthly % of Time on Total Divert Status: February 2003 – January 2004													
Hospital	Feb %	Mar %	Apr %	May %	Jun %	Jul %	Aug %	Sep %	Oct %	Nov %	Dec %	Jan %	Avg
Chinese	21	17	15	12	16	7	13	18	17	13	17	29	16
CPMC(Pac)	17	18	14	12	12	14	17	14	10	15	25	27	16
Davies	8	7	5	3	3	5	6	9	7	8	5	10	6
Kaiser	1	1	0	1	1	0	0	0	0	0	1	0	0
St. Francis	17	15	15	15	15	19	19	23	16	18	25	9	17
St Luke's	7	7	3	3	3	6	4	5	5	4	6	4	5
St. Mary's	2	1	1	0	0	0	1	2	1	1	1	1	1
SFGH	22	20	19	16	16	21	24	20	21	22	26	24	21
UCSF	21	21	19	20	20	14	14	16	16	12	17	20	17
VAMC	13	11	18	17	17	19	24	17	22	19	16	12	18

III.B.4. SFFD Ambulance High User

Prior to the start of the project, SFFD EMS compiled a list of ambulance high users in year 2002, defined by more than ten ambulance rides per year. The Stabilization Project Intensive Case Management Team used this list to identify and engage clients. SFFD and this Team concluded the 2002 criterion of "more than 10 ambulance rides per year" was too long and not specific enough for project needs. The SFFD began to provide the project with a monthly high user list as of December 2003, reflecting a new "high users" criterion of "four or more ambulance pick-ups per month." The list of high user will help the project determine whether they have been successful in reducing the number of ambulance users by homeless alcohol-dependent persons by detecting the degree to which current Stabilization Project clients are no longer EMS High Ambulance Users.

During the first six months, those identified as "ambulance high users" averaged 8.4 encounters with the Stabilization Project, as compared to 1.9 for others.

III.B.5. Paramedics Time on Task

The EMS pilot project proposal requested a measure of paramedics' time on task. This refers to the amount of time EMS responders spend handling homeless alcohol-dependent persons. The SFFD responded that they are not at a point where this can be estimated.

III.B.6. Paramedics Survey

In order to estimate the scope of the public inebriation problem in San Francisco and to pilot the triage criteria that paramedics would use to decide which patients require ED care, the SFFD undertook a month-long survey of all patients transported by SFFD paramedics during July 2003 for whom alcohol inebriation appeared to be a primary factor. For each such patient, paramedics recorded demographic characteristics, location from which the patient was transported, chief complaint, vital signs, Glasgow coma scale score, finger-stick blood glucose level, presence or absence of a number of subjective and objective exclusion criteria, whether or not such a patient officially met criteria for triage to the Stabilization Project, and whether or not they thought such triage

was appropriate[10]. They then brought all such patients to a San Francisco ED per their long-standing protocol.

Patients transported by paramedics in whom alcohol intoxication appears to be a primary factor reflect the population of homeless alcoholics in San Francisco and the United States. They captured 172 transports in 31 days (approximately 5.5 visits/day), but this almost certainly represents an undercount given the non-mandatory nature of the survey, and the tapering the researchers observed in the latter half of the month. If the rate of transports in the first half of the month is applied to the whole month, then the study might expect about 215 transports in 31 days, or 6.9 transports/day, with only about half of those eligible for the Stabilization Project.

The study indicated that the primary reason for failing Stabilization Project criteria was an inability to walk or to say one's name. Coupling this finding with the opinions of paramedics about the appropriateness of triage criteria suggests that the criteria may be too stringent. However, to conclude such requires validating the triage criteria against a better gold standard, such as emergency department follow-up.

III.C. Goal 3: To decrease the number of inappropriate homeless alcohol-dependent persons seen in the emergency room.

Outcomes:

- Decrease in inappropriate ED use (due to sole need to become sober)
- Number of pick-ups by the MAP Van after clearance at participating hospitals

III.C.1. Utilization of EDs by Intoxicated Persons

Preliminary data indicate a decline in the number of visits to San Francisco General Hospital for intoxication following the opening of the Stabilization Project in July 2003.

SFGH ED numbers of alcohol intoxication admits		
Month	2002	2003
October	184	183
November	210	170
December	174	163

As of the writing of this report, Emergency Department (ED) visit rates for patients with uncomplicated inebriation were not available. The evaluation proposal submitted will examine this particular data element. One of the objectives of the RWJ evaluation grant is to examine trends in utilization of San Francisco EDs by intoxicated persons before and after implementation of the project. An assumption is that increases in the number of persons arriving at Stabilization Project by ambulance should theoretically translate to decreases in the number of intoxicated persons visiting San Francisco EDs.

A decrease in the number of emergency department patients who "left without being seen" has been proposed as another measure of success of decompressing EDs by moving inebriates to more appropriate care. This information is not available from emergency departments at this time.

[10] Refer to Attachment K, Report from the SFFD Inebriate Survey, for the complete study write-up.

III.C.2. MAP Van Pick-Ups

The Emergency Communications Department has been tracking the number of calls logged from EDs for MAP van transport from EDs to the McMillan Stabilization Project. A total of 485 MAP van transportations were made in the 6 months period. St. Francis Memorial is the highest user followed by St. Luke's, St. Mary's and Davies Medical Center.

Calls made for MAP van in Hospital EDs from August 2003 to January 2004							
Hospital/Month	Aug	Sep	Oct	Nov	Dec	Jan	Total
San Francisco General	3	6	2	8	9	7	35
California Pacific Medical Center	2	4	3	8	7	4	28
Kaiser Permanente	1	-	-	-	2	2	5
St. Luke's	1	7	8	7	14	23	60
Davies Medical Center	7	9	3	9	12	5	45
St. Mary's	4	10	13	14	8	9	58
University of San Francisco	2	6	4	-	1	6	19
St. Francis Memorial	43	24	44	45	44	35	235
Total	63	66	77	91	97	91	485

The MAP van collects aggregate data on all MAP transports to the McMillan Drop-in Center in general. The sources of MAP van transport to McMillan include: police dispatch, fire dispatch, citizen calls, client calls, patrol contacts by MAP drivers, substance abuse and homeless facilities, and various city agencies and departments. Of the total 3,215, 485 (15%) were from hospital EDs (as above). The MAP Van director also stated that the MAP transport to McMillan has increased by over 50% compared with figures from last year. The director believes the transports from hospitals, as well as increased confidence in McMillan due to the Stabilization Project's nursing staff, played significant roles in this increase.

IV. Conclusion

The McMillan Stabilization Project serves homeless alcohol-dependent individuals…those considered by many as San Francisco's most gravely disabled residents. By assuring their safe sobering and linkage to the continuum of services they need, the Project breaks the cycle of transporting them to the ED, discharging them to the streets once they become sober, only to transport them again to the ED when the next episode occurs.

Toward this, the McMillan Stabilization Pilot Project has achieved much in its first six months of operation…and there is much work still to be done. This section lists some of them in relation to the general operation of the project as well as the goals identified.

Case Story #1

In just 12 months, Mr. X, a 41-year-old Caucasian male, well known to ambulance and ED staff, had been picked up by ambulances 150 times. Mr. X could be found on the streets intoxicated, fallen down, injured, vulnerable, property stolen and sometimes beaten up. The ED became his short-term detox.

Members of his middle-class family no longer consider him part of the family…a result of the pain he has caused them due to his substance abuse and sometimes very embarrassing behavior. Over the years, Mr. X often came close to checking himself in a program, but always changed his mind at the last minute.

Mr. X has been a steady client at McMillan Stabilization. But it took the case managers some time to engage Mr. X. He finally agreed to accept a hotel room and was finally hooked into General Assistance.

Because of his on-going alcohol use, he continues to struggle with his daily activities of living and to find himself in harmful situations. Although Mr. X has been a challenge in the hotel – room sanitation and interpersonal difficulties with other hotel guests – with almost daily visits and assistance with his activities of daily living, the case management team has been able to keep Mr. X housed. Case Managers will continue to try to motivate Mr. X into treatment and help him reduce the harm of his alcoholism until then.

Ambulance pick-ups for this client have been reduced from a monthly average of 12.5 to 2.

IV.A. Project Successes

IV.A.1. Commitment to the goals

There is public and private commitment at every level – from the highest government level to the direct service providers – and across the spectrum of stakeholders in the private sector to address and resolve the problem of ED diversions and the needs of these homeless alcohol-dependent individuals. Then-Supervisor and now-Mayor Gavin Newsom has made homelessness his number one priority issue for the San Francisco. Likewise, the leadership of the Department of Public Health has implemented a policy to prioritize all McMillan Stabilization Project clients in the Department's systems of care.

IV.A.2. Strong project planning and collaboration

As noted in the project background, the project development process involved more than eight organizations. These public and private agencies met intensively for three months to discuss and finalize protocols and planning for the project.

IV.A.3. Development of safe protocols

The protocols, including the inclusion/exclusion criteria, as well as the nursing protocols finalized by the planning teams, have proven to be effective at the Stabilization Project.

IV.A.4. Excellent communication between departments

As a follow-up to the planning process, the public and private agencies continue to meet on a regular basis to openly discuss project issues and identify ways to resolve them.

IV.A.5. Successful integration

In order to address the multiple issues faced by the target population, the City and County of San Francisco has successfully created a citywide, interagency, and multi-disciplinary team. The efforts made to break down bureaucratic barriers and merge the various specialty practices into a population-focused program have been challenging but effective.

IV.A.6. Streamlined access to services

In the interest of providing efficient and effective services to the clients, the project team has addressed a number of barriers to services. One of them is access to medical detoxification services. In addition to there being a high demand for medical detox beds, access has traditionally been lengthy and cumbersome due to the intake and clearance processes. The project team has documented the barriers for each step and proposed workable solutions and works closely with the medical detox staff to try to streamline these processes.

IV.A.7. Staff coverage

Despite the fact the project continues to face staff coverage constraints for a relatively small 24/7 operation, staff coverage has reached 85%.

Case Story #2

Mr. Y, a 40-year-old male who, last year made 35 ambulance calls. Chronically homeless on the streets for years, he had admitted alcohol dependence and multiple encounters with the criminal justice system for minor offenses.

Found intoxicated on the streets, Mr. Y was convinced to come to McMillan where he was stabilized. Mr. Y agreed to go into medical detox at Baker Place's Fremont Street where he stayed for several weeks. After graduating from Fremont, Mr. Y attended Ozanam day treatment program and began going to two AA meetings a day. He has been sober ever since and continues to work his twelve-step program.

The Case Management staff helped him get ID, coordinated and escorted him to appointments, and assisted him in finding housing through the Tenderloin Housing Agency. He is now a resident at Bayanihan House, a supportive housing facility. Mr. Y. is maintaining very well there.

Case managers have been working with City agencies to clear a case pending in SF Superior Court and to prevent his re-entry into the criminal justice system. Mr. Y continues to make all his scheduled appointments and is complying with all court requirements.

Once sober and with the support of case managers, Mr. Y re-established contact with his family in New York City who had assumed he had died from alcoholism. He is currently making arrangements to visit family for the first time in 10 years.

Ambulance and EMS usage has been reduced to zero.

IV.B. Future Work To Be Done

IV.B.1. Increase access to appropriate levels of care

Although the project target population is determined a priority within the SFDPH, the number of slots of services that are available within the delivery system are limited; as a result the target population needs to get on to waiting lists for services such as housing and medical detox slots.

- Action: Stabilization staff to continue to monitor the types of care that is needed by this population. SFDPH and community partners to continue to prioritize direct access to care as indicated.

IV.B.2. Project Support

As seen in the data presented in the earlier section, some of the data collection constraints the project team faces are lack of data that is pertinent to the project performance, lack of personnel to design useful data sets, collect and analyze the data. Inter-agency collaboration also presents another set of data access challenges.

- Action: As the lead agency, the SFDPH recently submitted a proposal to the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program to enhance the project team's capacity to address some of these evaluation issues.

IV.B.3. Outreach and education

As shown by the percentage of EMS drop-offs of project clients at the McMillan Stabilization Project, paramedics are resistant to drop-off clients for a number of reasons. They include fear of liability and a lack of understanding of the purpose of the project. Paramedics are reluctant to drop-off clients at the Stabilization Project because they have not been able to see the advantages of doing so. In addition, some ED physicians have not taken advantage of the MAP van because they have not heard about the project.

- Action: To rectify this, the McMillan Stabilization Project organized a 3-day Open House with the goal of increasing paramedics and ED physician understanding of the project.
- Action: In an attempt to include all stakeholders in client care, the project has convened a monthly client case conference where all stakeholders can discuss the very same clients they have been providing services for.
- Action: As the lead agency, SFDPH has also submitted a project proposal to Frequent Users of Health Services Initiative sponsored by The California Endowment and the California HealthCare Foundation to increase inter-department and agency cooperation and to increase the Stabilization Project's capacity to address the target population's needs through policy development, cross-training and improved systems and communications.

Case Story #3

Mr. Z, a 54-year-old African American male, was well known to the MAP Van and Paramedic staff.

Upon entry to McMillan, Mr. Z's vital signs and mental status were taken according to protocol and were stable. The plan was to monitor his safety under the supervision of the nursing staff over night and move him to a medical detox the next morning. The Nurse Practitioner noticed Mr. Z was quite pale, his gait unstable and he was diaphoretic and tremorous. A full history and physical were done and the patient was found to have orthostatic hypotension and a history of anemia and gastrointestinal bleeding.

The patient was taken by ambulance to St. Francis Hospital ED and was found to have severe anemia (Hematocrit of 10 %). Mr. Z was admitted and kept for five days. His bleeding was stopped and a follow-up appointment was made with a specialist at SFGH. The physician at St. Francis stated that if the patient had stayed out in the streets for one more day he would have died. This doctor praised McMillan staff for saving his life.

Since then, Mr. Z accepted services from the McMillan Case Management Team and was placed at a medical detox. Although he successfully graduated from the medical detox, he has relapsed. Nevertheless, Mr. Z continues to work with his case manager and he is maintaining his appointments and taking better care of himself.

Since being case managed by McMillan Stabilization staff, Mr. Z has not had another hospitalization or ambulance ride.

IV.B.4. Client involvement in continuous improvement

Some of the challenges of client support include the complexity of clients, difficulty in locating them and lack of sufficient consumer involvement in project design.

- Action: In an attempt to improve client support, the project has hired a peer support advisor. This advisor will work with the case managers to implement a variety of activities including convening group meetings.

IV.B.5. Access to public benefits

Due to the severity of the target population, the case managers have found it challenging to assist their clients in getting on public benefits such as SSI/SSDI and County Adult Assistance Programs. Clients experience difficulty in completing lengthy paperwork and often miss critical appointments.

- Action: The proposal to the California Endowment, if funded, will allow the Stabilization Project staff to creatively engage clients and motivate them to work together toward gaining the benefits to which they are entitled.

"This program has saved our Emergency Department's valuable resources. Not only do we have more time to serve other ER patients, public inebriates are now getting the services they need and deserve."

- ED Medical Social Worker

"Thank you for providing a safe and caring environment. This is a very difficult population to deal with and you are doing a great job. Finally, there is a place that can help these folks break the cycle of their substance abuse and get the help they need."

- SFFD Paramedic

IV.B.6. Project sustainability

The project was initially designed as a one-year pilot project. Now that the stakeholders have witnessed the value and success of the project, it is being funded for a second year.

- Action: Project Oversight committee to develop a plan to sustain the gains made and to continue to accomplish the project goals.

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