



City and County of San Francisco

# Local Homeless Coordinating Board Shelter Monitoring Committee

## Shelter Enrichment Report

### Executive Summary

#### *Process Overview*

The Shelter Enrichment process began on February 14, 2008, when Mayor Newsom held a press conference announcing his interest in transforming the two largest City owned emergency shelters, Next Door and Multi Service Center South (MSC), through expanding the medical respite program and placement of on-site supportive services, similar to the one-stop model of Project Homeless Connect. The Local Homeless Coordinating Board and the Shelter Monitoring Committee began a community process to get feedback on the medical respite and supportive service model proposed. Five community meetings and five on-site shelter meetings were held over a six week period to gather recommendations on medical services, supportive services, and access to the City & County of San Francisco shelter system.

#### *Recommendations*

Throughout the process, the community highlighted key recommendations in all four areas, the overall system, medical services, supportive services, and access. Below are the general themes stated throughout the process:

- *Do not reduce the number of sleeping units in the emergency shelter system for both single adults and families*
- *Increase medical services for homeless shelter residents, however do not replace general access sleeping units with medical respite beds*
- *Increase services for homeless people and make the on-site services accessible to all people, not just those staying at the shelter the services are located*
- *The current way shelter sleeping units are accessed needs to change [clients stated on multiple occasions that they had to wait in line 5-8 hours a day to access a one-day reservation]*
- *Solutions must be client focused and the only way to create client focused and guided solutions is to get client input*
- *All recommendations should be alignment with Continuum of Care Five Year Strategic Plan and the Shelter Standards of Care.*

A full list of all recommendations can be found within the appendices of this report.

The product of this process holds many donated hours of client, provider, and community time. We would like to thank everyone who contributed to the Shelter Enrichment Process.

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## Shelter Enrichment Report

### Shelter Enrichment Proposal

On February 14, 2008, Mayor Gavin Newsom held a press conference at St. Vincent de Paul's Multi Service Center South (MSC) to "pledge [his] commitment to improve the shelter system in San Francisco through expanded access to medical respite and on-site supportive services." By invitation from the Mayor's Office, the Local Homeless Coordinating Board (LHCB) and the Shelter Monitoring Committee (SMC) began a six week community outreach effort to get recommendations on Mayor Newsom's proposal of a "specific redesign components [that] will focus on two areas: expanded medical respite and placement of on-site supportive services similar to the one-stop model of Project Homeless Connect." At their March meetings, both the LHCB and SMC approved an outreach proposal drafted by staff to begin a Shelter Enrichment process. At the first of five community meetings on March 19, 2008, it was clear from community feedback received that a shelter redesign would need to expand past the two large shelters indicated on February 14, 2008, MSC South and Next Door, and the two areas, medical respite and on-site supportive services.

### Shelter Enrichment Process

LHCB Policy Analyst Ali Schlageter and SMC Policy Analyst Bernice Casey planned the first Town Hall meeting on March 19, 2008. Facilitated by LHCB Member Dr. Christine Ma, the meeting drew over 80 participants. The focus of the first meeting was to get feedback on the proposal of improving the shelter system through expansion of medical respite, on-site supportive services, and access. The meeting provided an opportunity for representatives from the LHCB, SMC, Ten Year Plan Implementation Council (TYPIC), Human Services Agency (HSA), Department of Public Health (DPH), and the Mayor's Office to discuss the previous community work completed on homeless policy, specifically the creation of the Ten Year Plan to End Homelessness, the Continuum of Care Plan, the Standards of Care, and to hear from policy makers on how terms such as "respite" are defined within the City & County of San Francisco. By providing a base of what work the City & County of San Francisco had already accomplished, the goal of this meeting was to identify what types of supportive services consumers and providers would like to see in the system, utilizing a Project Homeless Connect (PHC) approach [services at one site; utilization of a large volunteer base; and financial and resource based support from the private sector], the need for an increase in medical services on-site, including respite beds, and the manner in which all services, including shelter, could be accessed within the shelter system.

At this meeting and the four meetings that followed, as well as the five shelter-specific meetings that were held, the following system recommendations were raised repeatedly:

- **Do not reduce the number of sleeping units in the emergency shelter system for both single adults and families**
- **Increase medical services for homeless shelter residents, however do not replace general access sleeping units with medical respite beds**
- **Increase services for homeless people and make the on-site services accessible to all people, not just those staying at the shelter the services are located**

- **The current way shelter sleeping units are accessed needs to change [clients stated on multiple occasions that they had to wait in line 5-8 hours a day to access a one-day reservation]**
- **Solutions must be client focused and the only way to create client focused and guided solutions is to get client input**
- **All recommendations should be alignment with Continuum of Care Five Year Strategic Plan and the Shelter Standards of Care.**

There were four community meetings held after March 19, 2008. On April 3, 2008, a medical services workgroup meeting was held. The group identified 20 recommendations to improve client access to medical and health services. On April 9, 2008, a supportive services workgroup meeting was held. The group identified 29 recommendations to improve client access to services in the shelter system. On April 23, 2008, an access workgroup was held. The group identified 20 recommendations to improve client access to the shelter system as a whole. The community reconvened on April 28, 2008, to identify the key recommendations to be forwarded to the LHCB and the SMC for their review before being sent on to the Mayor's Office and the Board of Supervisors.

### **Shelter Enrichment Recommendations**

#### *Medical Services*

At all the community meetings, it was noted that additional medical services are needed to meet the health needs of clients. If the answer is respite beds, the respite beds should be provided in addition to current units, not with the replacement of any sleeping units at shelters. Many spoke of the need for extended health clinic hours, more clinicians on-site, more mental health services, the use of a medical roving team, and health training for both staff and clients.

The following are the five key recommendations for medical services. A complete list of Medical Recommendations is located in Appendix 1 of this report.

- **Have a roving medical team or van that comes to the site on a regular and consistent basis.**
  1. Mental health and counseling should also be a part of the roving service.
  2. A mobile health van would allow for service to be offered at the shelters opened only at night.
- **Expand current on-site medical clinic hours.**
  1. For larger shelters, the clinic expands to five days per week at convenient times, particularly evening hours.
  2. At resource and drop-in centers, clinic hours correspond [and if needed, expand] to when clients are making [and waiting for] reservations.
- **Have medical staff train and educate both clients and staff on chronic health issues, how to ensure a healthy environment, and provide basic treatment for a variety of common health conditions [as listed below]**
  1. Request that DPH develop curriculum for shelter staff that would review triage techniques for wound care, epilepsy, asthma, pain management, occupational therapy, tuberculosis, hepatitis, and sexually transmitted diseases.

2. In addition, utilizing existing printed resource from National Health Care for the Homeless, distribute and post pamphlets regarding chronic health issues at resource and drop-in centers and shelters.
- **Increase “rest-beds”**
    1. A “rest-bed” [or health bed] is a medical step-down from more acute medical care as well as a step-up in care from a general shelter bed.
    2. The purpose of a “rest-bed” is to prevent [re-] hospitalization and to meet the need of non-acute care.
    3. Client should be referred to “rest-beds” from the hospital, urgent care, respite centers, out-patient clinics, and/or case manager at the shelter and resource and drop-in center.
  - **Use a low threshold model to ensure that all medical services are easily accessed and to minimize the unnecessary hurdles for that clients trying to access sites and services.**

### *Supportive Services*

Before the first Town Hall meeting, services providers were asked to identify the services offered at their site. Given the February 14, 2008 proposal of providing on-site support services, Project Homeless Connect model proposed by Mayor Newsom, a survey was distributed to service providers to assess which of the services offered at the December 2007 Project Homeless Connect were offered at their site. Only one single adult shelter provided over 60% of those services. For details of on-site supportive services currently offered by service providers and data of the use of the services provided at the December 2007 Project Homeless Connect, please review Appendix 2.

The April 9, 2008 Support Services workgroup meeting also discussed utilizing a resource center model for on-site service delivery. The Mission Neighborhood Resource Center model was presented.

The following are the 14 key recommendations for supportive services. A complete list of the Supportive Services Recommendations is located in Appendix 3 of this report.

- **Provide 24-hour access to mental health services**
  1. Employ a therapist for each site and/or program, available Monday-Friday
  2. Provide access to a mental health professional after hours and on weekends
  3. Provide mental health training to staff
- **Create an assessment tool which measures clients’ needs [upon intake] from mental health, nutrition, physical health, employability, and housing**
- **Create and maintain system-wide, stream-lined housing data base which is updated, complete, and easy for case managers to use**
- **Create a senior specific shelter**
  1. Create a shelter for Golden Age clients 55 years and older
  2. Provide intensive case management services, similar to those provided through the Homeless Outreach Team
  3. Identify clients 65 years and older who may need additional services
- **Provide services at one site but let all clients access those services**

- **Provide training for case managers** [and other shelter staff] **to ensure that all case managers** [and other shelter staff] **have the same information on resources and services for clients**
- **Create an employment program on-site at the shelters in partnership with a day labor program**
- **Provide more educational programs, including literacy, General Education Development (GED), computer skills, and vocational programs**
- **Create a client satisfaction survey that can assist in determining if services are being provided successfully**
  1. Provide incentives to clients for completing the surveys
  2. Provide assistance and encouragement for completing the surveys
  3. Provide an alternate form of delivery so that clients can send their comments directly to the City & County of San Francisco
- **Provide specific services for undocumented clients, particularly housing and employment**
- **Establish better client to staff ratios**
  1. Suggested Ratios: Case Management 25:1 and Floor Monitors 20:1
- **Raise hiring standards for staff**
  1. Provide training for existing staff
  2. Provide annual trainings for staff
  3. Emphasis on conflict prevention resolution training and other training options by removing security guards from sites and use those funds to train staff [NOTE: when this item was discussed in the larger group, some clients requested that there be additional security guards at sites]
  4. Provide higher wages for staff
  5. The City & County of San Francisco should provide hiring guidelines to all shelters
- **Create a shelter for women only**
  1. Create more sleeping units for women; while there is a need for more sleeping units for men, there needs to be more units for women that correspond to the population size of homeless women of San Francisco.
  2. Create a women-only shelter in the Winter Shelter System
- **Have General Assistance (County Adult Assistance Program) workers on-site at the shelters**

### *Access*

At the community meetings, through community discussion and client's comments, it was clear that access to San Francisco's shelter system needs to be improved. In particular, people were concerned with the difficulty for seniors and those with disabilities accessing beds, the long daily waits people encounter when getting a reservation, and the fact that empty beds are in the system each night.

The following are the seven key recommendations for improving client access to the shelter system. For a complete list of all the recommendations, please review Appendix 4.

- **Analyze the Care Not Cash (CNC) programs**
  1. The analysis should focus on the number of CNC beds unoccupied each night.

- **Track what type of sleeping unit is vacant each night**
  1. The analysis would define the access point to that vacant sleeping unit: CAAP, CAAP Pending, case management, etc.
  2. Track where, which sites, vacancies occur
  3. Track at what times sleeping units become “vacant” in the Coordinated Homeless Assessment of Needs and Guidance through Effective Services (CHANGES)
- **Increase the number of sleeping units that the resource center has access to make reservations.**
  1. Currently the resource centers have access to 38% of the total units in the shelter system.
- **All turn-aways should be tracked each day and night at the resource centers and at the individual shelters.**
  1. A turn-away is defined as an individual attempting to make a reservation at any time during the day or night and not being able to access a sleeping unit at that time.
  2. Types of turn-away are classified in two ways, a) an individual is unable to make a reservation at X time as there no sleeping units available in the system and b) an individual is unable to make a reservation at X time as the shelter they are requesting does not have an available sleeping unit [personal choice].
  3. The tracking mechanism would note whether the turn-away was based on personal choice or the availability of a sleeping unit. The mechanism would be used at the site throughout the day, note if the individual was unable to make the reservation based on availability, and at what time a sleeping unit was made available within CHANGES.
  4. Clients should have the option to fill out a survey documenting the time they were turned away, which shelter they could not access, and the reason.
- **Sleeping unit reservations should be able to made on-site at shelters**
  1. The Standards of Care City Requirements Section 20.403 (a) Ensure 24-hour client access to a shelter and provide on-site shelter reservations for current shelter clients.
  2. Allow sleeping unit reservations and reservation extensions to be made on-site at shelters, not just at resource centers.
- **Drop available sleeping units at an earlier time**
  1. It was reported that some shelters drop “vacant beds” as late as 11:00 PM, midnight, and the early morning hours.
- **Use the SF 311 free phone line as another way that someone can make a shelter reservation 24 hours a day.**

### **Community Process**

The most consistent complaint about the community process was the lack of client involvement in the meetings. Ms. Casey and Ms. Schlageter held five community meetings at shelter sites, Hospitality House, Dolores Street Community Services, MSC South, Next Door, and Sanctuary. In addition, throughout the process, the Local Homeless Coordinating Board and the Shelter Monitoring Committee received e-mails and calls about the process. Two community organizations, Human Services Network and the Coalition on Homelessness, submitted written recommendations on the Shelter Enrichment process. Both letters can be found in Appendix 5.

### **Continuum of Care Plan and the Standards of Care**

In recognition of the community efforts that have already taken place, it is important to recognize the cross over between the recommendations within the Shelter Enrichment, Continuum of Care Plan, and Standards of Care legislation. In Appendix 6, there is a breakdown of the medical, services, and access recommendation intersections.

### **Budget Constraints**

On April 15, 2008, Mayor Gavin Newsom submitted to the Board of Supervisors a Resolution declaring it to be official City policy that no new set-asides or other mandatory appropriations be added to the City Charter unless the measure also identifies or provides a specific, adequate new source of funds. The issue of funding was a concern throughout this process. To respect the community process, the key recommendations for medical, services, and access should go forward. The Human Services Agency, Department of Public Health, and other policy bodies should work with the Mayor's Office and the Board of Supervisors to identify appropriate funding, if possible. The following recommendations are being proposed as low cost or no cost; however, a budget analysis would need to be conducted by the City departments identified below to determine the cost:

- **Have medical staff train and educate both clients and staff on chronic health issues, how to ensure a healthy environment, and provide basic treatment for a variety of common health conditions**  
*Implementation: a) Utilizing National Health Care for the Homeless free trainings; b) DPH could work in partnership with local university health programs to provide a curriculum- based training to all employees*
- **Increase "rest-beds"**  
*Implementation: Access to bed rest is mandated within the Standards of Care legislation*
- **Create an assessment tool which measures clients' needs [upon intake] from mental health, nutrition, physical health, employability, and housing**  
*Implementation: HSA and the DPH could create a standardized assessment tool, in partnership with the Shelter Directors, incorporating existing tools*
- **Create and maintain system-wide, stream-lined housing data base which is updated, complete, and easy for case managers to use**  
*Implementation: Working in partnership with the HSA, DPH, and community housing organizations, create a web accessible list that can be accessed by the community.*  
*Need: Identify an existing staff within HSA or DPH to take the lead.*
- **Have General Assistance (CAAP) workers on-site at the shelters**  
*Implementation: A pilot program at a large shelter, e.g. MSC South or Next Door, where a CAAP worker will work on-site 20 hours a week [minimum] and track outcomes.*
- **Provide training for case managers [and other shelter staff] to ensure that all case managers [and other shelter staff] have the same information on resources and services for clients**  
*Implementation: Employing a similar model for training staff [listed above], HSA and the DPH, will provide annual trainings.*

*Need: An analysis of training needs identified through HSA's monthly Shelter Director's meetings and the incorporation of the nine training areas required by all staff within the Standards of Care.*

- **Create a client satisfaction survey that can assist in determining if services are being provided successfully**

*Implementation: Local Homeless Coordinating Board and the Shelter Monitoring Committee will work with community groups and clients to identify incentives.*

*Need: Self-addressed envelopes to the contract monitor agency should be provided with each survey. The LHCB and SMC can provide an analysis of each site's responses.*

- **Track what type of sleeping unit is vacant each night**

*Implementation: This information is already available through HSA.*

*Need: A report should be done on a monthly basis and that information provided to the LHCB and SMC.*

- **All turn-aways should be tracked each day and night at the resource centers and at the individual shelters.**

*Implementation: Local Homeless Coordinating Board and the Shelter Monitoring Committee will do quarterly turn away checks. In addition, contract monitors should work with agencies to provide a tracking tool. For example, the Human Services Agency has provided sites with a tracking sheet to record turn aways.*

- **Increase the number of sleeping units that the resource center has access to make reservations.**

*Implementation: After completion of the above analysis, the Human Services Agency should reassess resource center access allocation.*



# **Appendix 1**

## **Medical Services Recommendations**

## Shelter Enrichment Recommendations Medical Services

### Background:

At all the community meetings it was noted that medical services are needed to meet the health needs of our clients. If the answer is respite beds, the respite beds should be in addition to current units, not replacement of any sleeping units at shelters. Many spoke of the need for extended health clinic hours, more clinicians on-site, the use of a medical roving team, and health training for both staff and clients.

At the April 28, 2008 meeting, the group identified 5 priorities areas of the 20 recommendations that were presented during the community process:

### **Here are the top recommendations for medical/health services:**

- **Have a roving medical team or van that comes to the site on a regular and consistent basis.**
  1. Mental health and counseling should also be a part of the roving service.
  2. A mobile health van would allow for service to be offered at the shelters opened only at night.
- **Expand current on-site medical clinic hours.**
  3. For larger shelters, the clinic expands to five days per week at convenient times, particularly evening hours.
  4. At resource and drop-in centers, clinic hours correspond [and if needed, expand] to when clients are making [and waiting for] reservations.
- **Have medical staff train and educate both clients and staff on chronic health issues, how to ensure a healthy environment, and provide basic treatment for a variety of common health conditions [as listed below]**
  3. Request that DPH develop curriculum for shelter staff that would review triage techniques for wound care, epilepsy, asthma, pain management, occupational therapy, tuberculosis, hepatitis, and sexually transmitted diseases.
  4. In addition, utilizing existing printed resource from National Health Care for the Homeless, distribute and post pamphlets regarding chronic health issues at resource and drop-in centers and shelters.
- **Increase “rest-beds”**
  1. A “rest-bed” [or health bed] is a medical step-down from more acute medical care as well as a step-up in care from a general shelter bed.
  2. The purpose of a “rest-bed” is to prevent [re-] hospitalization and to meet the need of non-acute care.
  3. Client should be referred to “rest-beds” from the hospital, urgent care, respite centers, out-patient clinics, and/or case manager at the shelter and resource and drop-in center.
- **Use a low threshold model to ensure that all medical services are easily accessed and to minimize the unnecessary hurdles for that clients trying to access sites and services.**

**Below are all the recommendations made regarding medical/health services:**

- Make medical services available at the “night only” shelters
- Free transportation should be provided to medical appointments if on-site services are not available
- Have a roving medical team or van that comes to the shelters on a regular and consistent schedule
- There should be made available free, set aside, medical detox slots that the shelter staff can refer their residents to
- Have special screenings at the shelters for specific health conditions, e.g. diabetes care
- Have shelter staff use a medical questionnaire that can direct clients for appropriate referrals
- Expand current on-site medical clinic hours
- Clients suffering from a mental illness should be able to stay in a unit longer and not have to go from shelter to shelter
- Each homeless person should have the option of having a guide that helps them navigate through the services in the system; the guide would not be connected to any particular shelter (e.g. UK community case worker or PHC navigator)
- Use a low threshold model
- Have medical staff train and educate both clients and staff on chronic health issues, and how to treat health conditions
- “Re-tool” the intensive case management model that DPH uses and make it more like a “guide” or navigator
- Have health education classes at the shelter (group settings)
- In alignment with HIPPA rules, client’s medical histories should be tracked so when they change service providers or shelters they can be served more effectively
- There should be set-aside, long-term, medically case managed beds
- Increase “rest-beds”
- Increase the number of Tom Wadell nurse practitioners or health workers on-site at the shelters
- Medical services should be continued even if a client has to leave the shelter where they first accessed those services
- Have more linkages with primary care doctors in the community that will serve homeless clients
- Clients should have small cards, that they carry with them, that outline their medical histories, medical needs, etc. The clients can share these cards when they think it is appropriate
- Increase partnerships between the city and local universities that will result in more student nurses, etc. volunteering in the shelters

## **Appendix 2**

# **Employing a Project Homeless Connect Service Model**

### Service Provider Survey Findings

- **87% of services provided at the December 2007 PHC event are provided by at least one shelter and/or resource center**
- **85% of services provided at the December 2007 PHC event are provided in-house at least one shelter location**
- **5 services offered at the December 2007 PHC event are not provided at either a shelter or resource center: chiropractic care, on-site Veterans Administrative or Swords to Plowshares support, veterinary services, eye exams and glasses, and wheelchair repair**

#### Site by Site Breakdown-Shelters Only/On-site

- **A Woman's Place provides 31% of the services at the December 2007 PHC event**
- **Hospitality House provides 41% of the services at the December 2007 PHC event**
- **Lark Inn provides 62% of the services at the December 2007 PHC event**
- **MSC South provides 49% of the services at the December 2007 PHC event**
- **Next Door provides 54% of the services at the December 2007 PHC event**
- **Sanctuary provides 46% of the services at the December 2007 PHC event**
- **Providence provides 36% of the services at the December 2007 PHC event**

According to the SF Connect website, the five most provided services for 2007 at all PHC events were:

- **CAAP/PAES/GA/Food Stamps/SSI/SSDI information**
- **Employment Services, e.g. job training, resume development, etc.**
- **Meals**
- **Housing Information**
- **Phone Calls**

**These services are provided, in some form, by all 7 shelters and 2 of the 3 resource centers that participated in the survey.**

#### *Information about the Survey*

*This survey does not encompass all services provided at PHC events or at shelters and resource centers. For example, PHC provides family services at its events; that data was not included as this data collection is for the Adult Shelter system. Shelter providers such as Lark Inn and MSC South provide youth focused services. Resource Centers such as Mission Neighborhood Resource Center offer NARCAN training and distribution (for drug injectors), homeopathy and homeopathic medicine. For suggestions or questions, please contact Ali Schlageter or Bernice Casey.*



City and County of San Francisco  
**Local Homeless Coordinating Board**  
**Shelter Monitoring Committee**

**Service Provider Summary**

<b>Service Offered at PHC*</b>	<b>Service Offered at Shelter**</b>	<b>Service Offered at Resource Center***</b>	<b>Providers-Shelters Listed</b>	<b># of People who requested service at PHC for all of 2007****</b>
Social Activities (e.g. movies, crafts, etc.)	<b>6 of 7 shelters provide on a daily basis</b>	<b>100% of Resource Center provide, 2 of the 3, daily and 1 of 3, weekly</b>	<b>A Woman's Place Hospitality House Lark Inn MSC South Next Door Sanctuary</b>	<b>Information not provided</b>
Acupuncture	<b>Not provided</b>	<b>2 of the 3 sites, 1 site provides twice a week and 1 site provides weekly</b>	<b>Not Provided</b>	<b>93 treatments were given</b>
Adult Probation	<b>3 of 7 shelters provide</b>	<b>Not provided</b>	<b>Lark Inn Next Door Sanctuary</b>	<b>39 service connections were made, at one event, PHC 19</b>
Banking Services	<b>3 of 7 shelters provide</b>	<b>Not provided</b>	<b>Lark Inn Next Door Sanctuary</b>	<b>133 banking service consultations were given</b>
Substance Abuse Services	<b>6 of 7 shelters provide daily</b>	<b>2 of 3 sites provide, 1 site weekly and 1 site daily</b>	<b>A Woman's Place Lark Inn MSC South Next Door Providence Sanctuary</b>	<b>702 Behavioral Health, Substance Abuse, or Methadone connections were made</b>

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<b>Service Offered at PHC*</b>	<b>Service Offered at Shelter**</b>	<b>Service Offered at Resource Center***</b>	<b>Providers-Shelters Listed</b>	<b># of People who requested service at PHC for all of 2007****</b>
Mental Health, provided by a licensed clinician	<b>5 of 7 shelters provide, 2 sites, Monday- Saturday, 3 sites weekly</b>	<b>2 of 3 sites provide, 1 site daily and 1 site, 2xs a week</b>	<b>Lark Inn MSC South Next Door Providence Sanctuary</b>	
CAAP/PAES	<b>2 of 7 sites provide</b>	<b>1 of 3 sites provide daily</b>	<b>Hospitality House MSC South</b>	<b>1709 people received information about CAAP/PAES/GA/food stamps/SSI/SSDI/Medical</b>
Food Stamps	<b>3 of 7 sites provide</b>	<b>Not provided</b>	<b>Hospitality House Next Door Sanctuary</b>	
SSI/SSDI/Medical, at a minimum have the capacity to fill out applications	<b>7 of 7 sites, daily or as needed</b>	<b>2 of 3 sites provide daily</b>	<b>A Woman's Place Hospitality House Lark Inn MSC South Next Door Providence Sanctuary</b>	
Chiropractic	<b>Not provided</b>	<b>Not provided</b>	<b>Not provided</b>	<b>47 treatments were given at one event, PHC 19</b>
Dental Treatment	<b>1 of 7 sites provide</b>	<b>2 of 3 sites provide, 1 site, weekly and 1 site, daily</b>	<b>MSC South</b>	<b>600 screenings performed</b>
California Identification Cards	<b>3 of 7 sites provide</b>	<b>1 of 3 sites provide, daily, in the form of waives</b>	<b>Hospitality House Lark Inn Providence</b>	<b>970 identification cards were issued</b>

<b>Service Offered at PHC*</b>	<b>Service Offered at Shelter**</b>	<b>Service Offered at Resource Center***</b>	<b>Providers-Shelters Listed</b>	<b># of People who requested service at PHC for all of 2007****</b>
Employment Services (e.g., job training, resume development, interview techniques, etc.)	<b>3 of 7 sites provide</b>	<b>1 of 3 sites provide, daily</b>	<b>Lark Inn MSC South Providence</b>	<b>1200 employment interviews and services were given</b>
Free postal services	<b>2 of 7 sites provide, as needed</b>	<b>1 of 3 sites provide, as needed</b>	<b>Hospitality House Lark Inn</b>	<b>359 mailings were sent by clients</b>
Flu shots and other vaccinations	<b>5 of 7 sites provide, seasonally</b>	<b>2 of 3 sites provide, seasonally</b>	<b>A Woman's Place Lark Inn MSC South Next Door Sanctuary</b>	<b>Information not available</b>
Food distribution, not meals	<b>1 of 7 sites provide, daily</b>	<b>All sites provide, 1 Monday- Friday, 1 daily, and 1, MWF</b>	<b>Lark Inn</b>	<b>Per person data not available, 68,244 lbs. of groceries were provided</b>
Meals	<b>7 of 7 sites provide daily</b>	<b>2 of 3 sites provide, 1 twice a day and 1 once a week</b>	<b>A Woman's Place Hospitality House Lark Inn MSC South Next Door Providence Sanctuary</b>	<b>9525 lunches were provided</b>
Haircuts	<b>1 of 7 sites provide, as needed</b>	<b>1 of 3 sites provide, weekly</b>	<b>Hospitality House</b>	<b>422 haircuts were provided</b>



<b>Service Offered at PHC*</b>	<b>Service Offered at Shelter**</b>	<b>Service Offered at Resource Center***</b>	<b>Providers-Shelters Listed</b>	<b># of People who requested service at PHC for all of 2007****</b>
Health Insurance referrals, e.g. Healthy Families	<b>2 of 7 sites provide, as needed</b>	<b>1 of 3 sites provide, daily</b>	Lark Inn Providence	<b>Information not available</b>
Hearing Screenings	<b>1 of 7 sites provide, as needed</b>	<b>Not provided</b>	Lark Inn	<b>Information not available</b>
Homeward Bound, e.g. referral to the Homeward Bound program	<b>6 of 7 sites provide, daily and as needed</b>	<b>2 of 3 sites provide, daily</b>	A Woman's Place Lark Inn MSC South Next Door Providence Sanctuary	<b>120 trips were arranged</b>
HIV Rapid Testing	<b>4 of 7 sites provide, 2 sites as needed/daily, 2 sites, 2xs a year</b>	<b>2 of 3 sites provide, 1 weekly and 1 daily</b>	Lark Inn MSC South Next Door Sanctuary	<b>188 HIV tests were performed</b>
Hygiene Kit, minimum of socks, shampoo, and body soap	<b>4 of 7 sites provide, 3 of 7 sites provide shampoo and body soap</b>	<b>3 of 3 sites provide, 1 site, as needed, 1 site, daily, and 1 site, weekly</b>	A Woman's Place Hospitality House Lark Inn MSC South Next Door Providence Sanctuary	<b>Information not available</b>
Legal Services, at a minimum on-site attorneys who can address and mitigate minor warrants and tickets; access an	<b>2 of 7 sites provide legal services, 1 of 7 sites has monthly Community Court</b>	<b>2 of 3 sites, 1 site offers Clean Slate services and 1 site offers immigration services</b>	MSC South Next Door Providence	<b>718 legal meetings were conducted</b>

Service Offered at PHC*	Service Offered at Shelter**	Service Offered at Resource Center***	Providers-Shelters Listed	# of People who requested service at PHC for all of 2007****
individual's legal/criminal status				
Massages	1 of 7 sites offer weekly	2 of 3 sites offer weekly, 1 site is for woman only	Hospitality House	368 massages were performed
Medical Services, at a minimum provide acute care, schedule follow up appointments	5 of 7 sites offer, at least once a week, most more	2 of 3 sites offer, 1 site, daily, and 1 site, 20 hours a week	A Woman's Place Lark Inn MSC South Next Door Sanctuary	933 service interactions were made, many connecting clients with primary care providers
Podiatry, at a minimum examine, assess, clean, and provide urgent treatment	3 of 7 sites offer, weekly	2 of 3 sites, 1 site, monthly, and 1 site, as needed	Lark Inn MSC South Next Door	193 podiatry treatments were given
Needle Exchange, at a minimum safely dispose of used needles and provide new needles	2 of 7 sites offer, weekly	2 of 3 sites, 1 site weekly for women, and 1 site twice a week	Next Door Sanctuary	Information not provided
Phone calls, local calls	7 of 7 sites provide	3 of 3 sites, daily	A Woman's Place Hospitality House Lark Inn MSC South Next Door Providence Sanctuary	2450 phone calls were made
Service Offered at PHC*	Service Offered at Shelter**	Service Offered at Resource Center***	Providers-Shelters Listed	# of People who requested service at PHC for all of 2007****

Phone calls, long distance, national calls	<b>4 of 7 sites provide, as needed</b>	<b>3 of 3 sites, 1 site, daily and 2 sites, as needed</b>	<b>A Woman's Place Hospitality House Lark Inn MSC South</b>	<b>2450 phone calls were made</b>
Senior Services, at a minimum qualification for SSI, senior housings, and Medi Care	<b>5 of 7 sites provide, daily</b>	<b>Not provided</b>	<b>Hospitality House MSC South Next Door Providence Sanctuary</b>	<b>Information not provided</b>
Housing Information, at a minimum provide a list of housing referrals	<b>7 of 7 sites, daily</b>	<b>3 of 3 sites, daily</b>	<b>A Woman's Place Hospitality House Lark Inn MSC South Next Door Providence Sanctuary</b>	<b>1096 housing information counseling meetings were conducted</b>
Storage, at a minimum all of the clients' belongings are stored during their stay	<b>4 of 7 sites, daily</b>	<b>1 of 3 sites, as needed</b>	<b>Hospitality House Lark Inn Next Door Sanctuary</b>	<b>Information not provided</b>
Transportation, at a minimum provide tokens and MAP van access	<b>7 of 7 sites provide, daily or as needed</b>	<b>3 of 3 sites provide</b>	<b>A Woman's Place Hospitality House Lark Inn MSC South Next Door Providence Sanctuary</b>	<b>Information not provided</b>
<b>Service Offered at PHC*</b>	<b>Service Offered at Shelter**</b>	<b>Service Offered at Resource Center***</b>	<b>Providers-Shelters Listed</b>	<b># of People who requested service at PHC for all of 2007****</b>
Veterans (on-site VA or Swords to Plowshares	<b>Not provided</b>	<b>Not provided</b>	<b>104 Veterans service connections were made</b>	<b>104 Veterans service connections were made</b>

staff)				
Veterinary Services	<b>Not provided</b>	<b>Not provided</b>	<b>169 veterinary care and pet sitting served dogs, cats, and other pets</b>	<b>169 veterinary care and pet sitting served dogs, cats, and other pets</b>
Vision, at a minimum provide “readers glasses”	<b>Not provided</b>	<b>Not provided</b>	<b>371 eye exams were conducted and 1200 pairs of eyeglasses distributed</b>	<b>371 eye exams were conducted and 1200 pairs of eyeglasses distributed</b>
Voicemail	<b>2 of 7 sites provide</b>	<b>2 of 3 sites provide, daily</b>	<b>Lark Inn Providence</b>	<b>626 voicemail accounts were opened</b>
Wheelchair Repair	<b>Not provided</b>	<b>Not provided</b>		<b>Information not provided</b>

**Notes:**

\*These services were offered at the December 2007 Project Homeless Connect

\*\* Two of the Adult Shelters were unable to participate in the survey, Dolores Street Community Services & Ella Hill Hutch Community Center. Other participants were asked to complete a survey and submit back to the Town Hall organizers.

\*\*\* The Resource Centers that participated in the survey are Tenderloin Health, Mission Neighborhood Resource Center, and United Council Bayview Resource Center.

\*\*\*\* Data found at <http://www.sfconnect.org/>; this data includes all 6 PHC 2007 events.



# Local Homeless Coordinating Board Shelter Monitoring Committee

## Appendix 3 Supportive Services Recommendations

Shelter Monitoring Committee  
1380 Howard St., 2<sup>nd</sup> Floor  
San Francisco, CA 94103  
(415) 255.3642  
[www.sfgov.org/sheltermonitoring](http://www.sfgov.org/sheltermonitoring)

Local Homeless Coordinating Board  
1440 Harrison St., 2<sup>nd</sup> Floor  
San Francisco, CA 94103  
(415) 558.1825  
[www.sfgov.org/lhcb](http://www.sfgov.org/lhcb)

## Shelter Enrichment Recommendations Support Services

### Background:

At the community meetings it was apparent through community discussion and client's comments that the sites could provide additional services. Both clients and staff would like to see more services at sites; however, individuals wanted to see equal access to services regardless of where services are located, in the shelter or out of the shelter.

At the April 28 meeting, the group identified 14 priorities areas of the 29 recommendations that were presented during the community process:

- **Provide 24-hour access to mental health services**
  1. Employ a therapist for each site and/or program, available Monday-Friday
  2. Provide access to a mental health professional after hours and on weekends
  3. Provide mental health training to staff
- **Create an assessment tool which measures clients' needs [upon intake] from mental health, nutrition, physical health, employability, and housing**
- **Create and maintain system-wide, stream-lined housing data base which is updated, complete, and easy for case managers to use**
- **Create a senior specific shelter**
  1. Create a shelter for Golden Age clients 55 years and older
  2. Provide intensive case management services, similar to those provided through the Homeless Outreach Team
  3. Identify clients 65 years and older who may need additional services
- **Provide services at one site but let all clients access those services**
- **Provide training for case managers [and other shelter staff] to ensure that all case managers [and other shelter staff] have the same information on resources and services for clients**
- **Create an employment program on-site at the shelters in partnership with a day labor program**
- **Provide more educational programs, including literacy, General Education Development (GED), computer skills, and vocational programs**
- **Create a client satisfaction survey that can assist in determining if services are being provided successfully**
  1. Provide incentives to clients for completing the surveys
  2. Provide assistance and encouragement for completing the surveys
  3. Provide an alternate form of delivery so that clients can send their comments directly to the City & County of San Francisco
- **Provide specific services for undocumented clients, particularly housing and employment**
- **Establish better client to staff ratios**
  1. Suggested Ratios: Case Management 25:1 and Floor Monitors 20:1
- **Raise hiring standards for staff**
  1. Provide training for existing staff
  2. Provide annual trainings for staff

3. Emphasis on conflict prevention resolution training and other training options by removing security guards from sites and use those funds to train staff [NOTE: when this item was discussed in the larger group, some clients requested that there be additional security guards at sites]
  4. Provide higher wages for staff
  5. The City & County of San Francisco should provide hiring guidelines to all shelters
- **Create a shelter for women only**
    1. Create more sleeping units for women; while there is a need for more sleeping units for men, there needs to be more units for women that correspond to the population size of homeless women of San Francisco.
    2. Create a women-only shelter in the Winter Shelter System
  - **Have General Assistance (County Adult Assistance Program) workers on-site at the shelters**

**All Recommendations Presented Throughout the Community Process:**

- 24 hour access to mental health services, through the use of Mental Health Access and a licensed therapist on staff
- All shelter sites should use a standard assessment tool that measures a client's array of needs; the information can follow client if they so choose
- Create an assessment tool which measures clients' needs from mental health, nutrition, physical health, employability, housing,
- Have a stream lined housing data base that the shelter case managers can use for information
- Have a senior specific shelter
- Increase the number of sleeping units for women
- Have General Assistance (CAAP) workers on-site at the shelters
- Increase the staff to client ratios, case managers and floor monitors
- Provide haircuts on-site
- Provide social programs that engage the clients
- Have phone and voicemail services
- Provide services at one site but let all clients access those services
- Case managers should have joint trainings so they all hold the same information
- City should be in charge of hiring all shelter staff
- Create an employment program on-site at the shelters in partnership with day labor program
- Educational programs, including literacy, GED, and computer skills, and vocational programs
- Create a client satisfaction survey that can assist in determining if services are being provided successfully
- Specific services for undocumented clients, particularly housing and employment
- Transportation services, access to tokens and para transit
- Aid in getting benefits, e.g. SSI, SSDI
- *Staff, including client to staff ratios*
- Better client to staff ratios, particularly for seniors
- Better staff ratios, suggestions, Case Management, 25:1 and Floor Monitors, 20:1

- Higher wages for staff
- Additional training for staff
- Emphasize conflict prevention resolution training and other training options by removing security guards from sites and use those funds to train staff
- Staff programs
- Raise hiring standards
- Case managers should have joint trainings so they all hold the same information
- City should be in charge of hiring all shelter staff
- More Veteran focused services in the shelters



## **Appendix 4 Access Recommendations**

## Shelter Enrichment Recommendations Access

### Background:

At the community meetings it was apparent through community discussion and client's comments that the access to San Francisco's shelter system needs to be improved. In particular people were concerned with the difficulty for seniors and those with disabilities accessing beds, the long daily waits people encounter when getting a reservation, and the fact that empty beds are in the system each night.

At the April 28 meeting, the group identified 7 priority areas of the 20 recommendations that were presented during the community process:

- **Analyze the Care Not Cash (CNC) programs**
  1. The analysis should focus on the number of CNC beds unoccupied each night.
- **Tracks what type of sleeping unit is vacant each night**
  1. The analysis would define the access point to that vacant sleeping unit: CAAP, CAAP Pending, case management, etc.
  2. Track where, which sites, vacancies occur
  3. Track at what times sleeping units become "vacant" in the Coordinated Homeless Assessment of Needs and Guidance through Effective Services (CHANGES)
- **Increase the number of sleeping units that the resource center has access to make reservations.**
  1. Currently the resource centers have access to 38% of the total units in the shelter system.
- **All turn-aways should be tracked each day and night at the resource centers and at the individual shelters.**
  1. A turn-away is defined as an individual attempting to make a reservation at any time during the day or night and not being able to access a sleeping unit at that time.
  2. Types of turn-away are classified in two ways, a) an individual is unable to make a reservation at X time as there no sleeping units available in the system and b) an individual is unable to make a reservation at X time as the shelter they are requesting does not have an available sleeping unit [personal choice].
  3. The tracking mechanism would note whether the turn-away was based on personal choice or the availability of a sleeping unit. If possible, the tracking mechanism would be used at the site throughout the day and note, if the individual was unable to make the reservation based on availability, at what time a sleeping unit was made available within CHANGES.
  4. Clients should have the option to fill out a survey documenting the time they were turned away, which shelter they could not access, and the reason.
- **Sleeping unit reservations should be able to made on-site at shelters**
  1. The Standards of Care City Requirements Section 20.403 (a) Ensure 24-hour client access to a shelter and provide on-site shelter reservations for current shelter clients.
  2. Allow sleeping unit reservations and reservation extensions to be made on-site at shelters, not just at resource centers.
- **Drop available sleeping units at an earlier time**

1. It was reported that some shelters drop “vacant beds” as late as 11:00 PM, midnight, and the early morning hours.
- **Use the SF 311 free phone line as another way that someone can make a shelter reservation 24 hours a day.**

**Below is the list of all the recommendations made:**

- Sleeping units should be “dropped” earlier, e.g all sleeping units should be dropped at 8:00 PM
- Resource Centers should have access to more sleeping units to make reservations for clients
- Each client who receives a reservation for Ella Hill Hutch or Providence should receive token transportation to and from the shelter
- A resource center, for both men and women, should be open 24 hours so shelter reservations can be made at any time in person
- An analysis needs to be conducted to determine which type of beds are vacant, why they are vacant, and how to get people in those beds
- Utilize the City’s 311 to make shelter reservation, similar to Alameda County’s 211 system
- To get a more accurate vacancy rate, all turn aways [defined as someone attempting to access a reservation at X time and being told to come back at X time]
- Resource centers should have access [to make reservations for a client at] any respite beds or medically supported beds
- There should be coordinated times of service delivery which would make it easier to navigate the system and access needed services and shelter, e.g. sleeping units should become available at one time during the day and resource centers should be able to place a client immediately
- Streamline the reservations system
- Shelter reservations should be made on-site at the shelters, not just the resource centers
- Seniors should not have to wait until the night to access beds
- Seniors should have a separate shelter; seniors should not be sleeping on mats
- The Access piece should be taken out of the Shelter Enrichment process and should become a separate discussion
- Access challenges illustrate a need for additional sleeping units
- Reduce one-night reservations by placing a cap of 150 on Care Not Cash sleeping units in the system
- Americans with Disability Act (ADA) access needed at each shelter
- A mechanism needs to be in place for service animals to get certified to access shelter with owners
- Create a blog to continue the discussion [of Shelter Enrichment]
- Clients should be able to access housing from the shelters [not have to go from shelter to shelter]
- There should be additional sleeping units for women

## **Appendix 5 Community Input**

April 14, 2008

Christine Ma, M.D.  
Chair, Shelter Enrichment Community Process  
Local Homeless Coordinating Board  
C/o Ali Schlageter  
P.O. Box 7988  
San Francisco, CA 94120

Dear Dr. Ma:

On behalf of the San Francisco Human Services Network (HSN), we are writing to comment on proposed changes in the City's shelter system. HSN is an association of over 110 health and human service nonprofits, dedicated to ensuring that community-based organizations play a role in developing and implementing solutions to issues that impact our sector. The shelter redesign process raises policy and planning implications for our members and those we serve.

HSN joins with our member organizations that work with homeless families and individuals in support of the Shelter Enrichment Community Process, examining how to best enhance shelter program services in order to meet client needs, with particular attention to the work at San Francisco's two largest shelters, MSC-South and Next Door.

It is HSN's position that the current effort should be rooted in the "*Five-Year Strategic Plan of the San Francisco Local Homeless Coordinating Board 2008-2013*," recently passed by the Board of Supervisors as our City's "*Continuum of Care Plan*." That plan, itself a product of broad and intensive community study and input, recognizes as a priority that the City "provide interim housing in shelters to support access to permanent housing until such time as permanent housing is available." It calls for integrated, wrap-around shelter services addressing residents' physical health, mental health, substance abuse, educational, vocational, income maintenance, and other needs and challenges.

The Plan states: "Although permanent housing is the primary goal for people who are homeless, interim housing is a necessity until the stock of housing affordable to people with extremely low incomes can accommodate the demand. Interim housing should be available to all those who do not have an immediate option for permanent housing, so that no one is forced to sleep on the streets. Interim housing should be safe and easily accessible and should be structured to provide services that assist people in accessing treatment in a transitional housing setting or permanent housing as quickly as possible."

Specifically, HSN urges the following:

*That there be no further reduction in shelter bed availability until there is demonstrated decrease in need.* The Continuum of Care Plan calls for assessment when vacancy rates exceed 20%. The single adult shelters are currently running at about 90% occupancy, with near full occupancy at certain periods of the month. According to the 2007 San Francisco Homeless Count, there has been a reduction of 326 beds in the citywide shelter system since January 2005, leaving only 1,182 currently in the system. We understand an

additional 100 beds will be eliminated with the close of the Ella Hill Hutch Shelter in June. Further, the de-funding of Buster's Place just a few days ago will impact other shelter utilization. This is not the time to reduce again the number of shelter beds.

*That services be enriched at all shelters, affording homeless persons increased opportunity to meet their physical and mental health, substance abuse, educational, vocational, income maintenance, and other challenges, with a goal toward assisting them in achieving permanent housing placement.* Creation of a "Project Homeless Connect"-type shelter, as suggested by the Mayor, has definite appeal. It should be acknowledged also that many, though certainly not all, of those service elements are already in place in the shelters and that service enhancement should be extended to all shelters in San Francisco, not only to the two largest shelters. In addition, some of our emergency shelter and resource center community-based providers have models that are as relevant as Project Homeless Connect, and therefore worth considering as different model options for distinct populations and neighborhoods (e.g. youth, immigrants, and women).

*That any expansion or enhancement of the shelter system be accomplished in addition to rather than instead of existing services in our system of care.* The City has floated a plan to increase the number of medical respite beds for medically complex homeless individuals being discharged from hospitals. We support the plan, but we do not believe that this should be achieved by reducing existing services now available to vulnerable San Franciscans.

*That the City increase its commitment to the development of affordable housing.* The Mayor's Office of Housing projects about 330 additional units of supportive housing to become available next fiscal year. We anticipate that shelters will remain needed until there are sufficient exits to decent and affordable housing with support services for San Francisco's homeless population. These 330 units will provide valued opportunities for shelter users, but elimination of beds should await realization of the impact of new housing.

Thank you for your leadership in the Shelter Enrichment Community Process. We appreciate your commitment to ensuring that this important decision-making process impacting the shelter system incorporates the expertise of shelter residents, service providers, and others in the community.

Sincerely,

Sherilyn Adams  
HSN Co-Chair

Steve Fields  
HSN Co-Chair

Debbi Lerman  
Administrator

## Recommendations from the Coalition on Homelessness

### MAJOR SHELTER ACCESS ISSUES

“It’s now a system-wide lottery and the beds often go to those people who can wait in line the longest.” Unidentified Provider

#### Summary Solutions

1. Increased Access Equity: Cap the number of CNC beds at 150.
2. Track turnaways from shelters
3. Simultaneously, the city should do a fact based independent analysis of empty beds, and compare vacancies against availability, and identify what kind of bed each vacancy occurs.
4. The city needs to take corrective action, track down and fix all system errors occurring in the CHANGES system.
5. Increase Budget for Bus Tokens, Improve Reliability of CATS VAN, and make accommodations for people in wheelchairs riding van.
6. Moratorium on shelter closures until that day that the need ceases.
7. Ensure 24-hour drop-in center that has adequate capacity of at least 100 men and woman, and, which is a place of healing and movement into health care, treatment, benefits and housing.
7. Simplify Case Management bed access, especially at Next Door, and move portion of Next Door case management beds over to CHANGES system.
8. Mayor’s Office on Disability develop comprehensive recommendations on shelter accessibility and HSA/DPH implement those recommendations.

#### Issue # 1: Time Consuming Access

“Some nights, getting into the shelter is like a full-time job.”

-African American man (age unknown)

For homeless men and women seeking emergency shelter, one of the central barriers is obtaining a reservation.

Although referrals can ostensibly be made at some Resource Centers at any time during the day, there are few vacant beds to which people can be regularly referred. There are two times of day when beds are likely to be available in the system: early in the morning, when the Resource Centers open, and in the late evening, after most Resource Centers (bed reservation-sites) close and the shelters re-allocate unfilled reserved beds. These are the only times that vacancies appear in the centralized system and can be given out to the men and women waiting at the Resource Center. Thus, well in advance of both periods, homeless men and women line up at the Resource Centers in hope of getting one of the desirable vacant beds – perhaps at one of the shelters known for their friendly staff, or where the length of stay is seven days instead of one, or where there is Spanish-speaking staff. But, particularly in the morning, few beds are given out, so many of the people lined up must return in the evening and wait again. This process is time-consuming and frustrating. Waiting in line for shelter reservations makes it difficult to accomplish other

necessary activities such as making or getting to health care appointments, going to work or obtaining other necessities of life.

Solution: Currently only 39% of beds are available through resource centers. The rest are either Care not Cash beds, which are frequently empty, or case management beds. We recommend capping the number of CNC beds at 150. Currently CNC recipients have favored status in the shelter system – they have guaranteed access as opposed to competing with all others for shelter beds. This would mean increased equity for people with disabilities, working homeless people, senior's veterans, alongside CNC recipients. It would also greatly decrease the number of beds released on a one night only basis and beds sitting empty.

Issue # 2: number of empty beds greatly exaggerated

On nights when the City's Human Services Agency claims that the shelters beds are unoccupied, Resource Center staff report that no vacant beds are show up in the system. As one provider pointed out, "even if there are vacancies, what good do they do if Resource Center workers can't reserve them?"

During two weeks this past winter, shortly after the City released a statement encouraging the homeless to come in from the streets to a supposed 100 vacant shelter beds, the Coalition on Homelessness tracked the number of people turned away at three central city shelter reservation sites. With information gathered from Resource Center staff, we learned that close to 50 per day were turned away.

Solution:

In the past, SF tracked shelter turn-aways. This provided consistent information on the needs of the homeless population with regards to shelter. In addition to increasing portion of beds available to resource centers, the city should start tracking turnaways from shelters.

Simultaneously, the city should do a fact based independent analysis of empty beds, and compare vacancies against availability, and identify what kind of bed each vacancy occurs.

Issue #3: CHANGES Error Prone

As a result of system problems, many of the City's homeless return to the streets every night, while shelter beds may sit empty. Other difficulties reported by homeless men and women include being told by staff at a Resource Center that a reservation had been made for them at a shelter, only to learn upon arriving at that shelter that there was no reservation. Irrespective of the source of these problems, it is clear that the computerized reservation and referral process for the shelters is error prone, and many homeless men and women are left out in the cold.

Solution:

The city needs to take corrective action, track down and fix all system errors occurring in the CHANGES system.



#### Issue # 4 Transportation To Shelters Lacking

Depending on where a shelter reservation is made, getting to that bed can be a problem and constitutes a significant barrier. Although most of the City's Resource Centers and shelters are located in the central parts of the city, e.g., the Tenderloin or South of Market, some are in the Bayview and less centrally located areas. For the homeless men and women referred, to the Bayview from a Resource Center in the Mission or the Tenderloin, transportation presents a significant problem. Homeless men and women describe the difficulty of getting to the Bayview late at night: reporting cases in which no bus tokens were provided; others describe waiting and waiting for buses that are not running any more or that refuse to stop; and numerous people report safety concerns with arriving in an unfamiliar neighborhood encumbered with their belongings in the middle of the night.

Various providers describe incidents where as many as twenty people have been stranded at the Resource Centers at night waiting for a van that never arrived. For the elderly and people with physical disabilities, the need for a reliable transportation system between resource center and shelter is crucial – even for sites that may be relatively close to one another.

#### Solution:

Increase Budget for Bus Tokens, Improve Reliability of CATS VAN, and make accommodations for people in wheelchairs.

#### Issue #5: Shelter Operations Shrinking

According the Shelter Monitoring Committee, 364 sleeping units in shelters have been lost between July 2004 and December 2006. Another 100 mats will be lost this summer with Ella Hill Hutch closing, and 7 family rooms will be lost at St. Joseph's.

#### Solution:

Moratorium on shelter closures until that day that the need ceases.

#### Issue # 6: Lack of Low Threshold Access

Low threshold services are those in which virtually no barriers to entry exist, and which there are no requirements or "strings" to receiving services. Low-threshold services are designed to ensure that the most disabled and impaired individuals are able to receive services. Ideally, this modality is coupled with intensive non-judgmental services that engage people in health based solutions. In San Francisco, almost all low threshold services for homeless people have been eliminated, with the exception of some community and resource centers. There are no longer any low-threshold shelters. Nighttime low threshold access is almost obsolete, with the closure of Buster's Place, and the temporary, much smaller, male only, replacement slated for closure in just a few months. What is most apparent is that with all these closures, people with disabilities are at a severe disadvantage in accessing simply a place to be if they have nowhere to call home.

#### Solution:

Ensure 24 hour drop-in center that has adequate capacity of at least 100 men and woman, and, which is a place of healing and movement into health care, treatment, benefits and housing.

#### Issue #7 -Shelter System Fails People with Disabilities

For the hundreds of homeless men and women with physical or mental disabilities, these barriers are even more obstructive. While waiting in line twice a day or moving back and forth between Resource Centers and shelters is frustrating and exhausting for almost everyone, these tasks can be excruciating or physically impossible for people with disabilities. The Mayor's Office on Disability reports additional problems. These include the frequent referral of people with physical disabilities to top bunks or to shelters where there are just mats on the floor; the unreliability of the MAP van for transporting people to and from the shelters; and insufficient accommodations in showers or bathrooms.

It is crucial to note that these are not simply isolated incidents experienced by a handful of people. Of the 215 shelter residents surveyed by the Coalition, 50% reported having a physical or mental disability. Of these, more than half (59%) state their disabilities are not accommodated in the shelter in which they're staying.

For individuals with mental disabilities, more problems arise, many of which come from the general lack of awareness and insensitivity about the nature of mental disabilities. As described by one provider, the structure of the system is a barrier to people struggling with mental illness. Many describe unsympathetic staff, who not only question whether or not mental illness is a disability, but who frequently interpret the behavior of people with mental illness as violent or disruptive. There are, tragically, reports of staff engaging in provocative, client-escalating behavior, which then use their response as a basis to eject that person for being disruptive. The Mayor's Office on Disability reports that, instead of working with people with mental illness to de-escalate situations that arise, shelter staffs frequently punish them for "acting out" or "breaking rules."

**Solution:**

Simplify Case Management bed access, especially at Next Door, and move portion of Next Door case management beds over to CHANGES system.

Mayor's Office on Disability develop comprehensive recommendations on shelter accessibility and HSA implement those recommendations.

**Appendix 6  
Continuum of Care  
Shelter Standards of Care**

Shelter Enrichment Community Process  
*Continuum of Care Five Year Strategic Plan*  
&  
*Shelter Standard of Care*

What is said in the Continuum of Care Plan

The following strategies are presented in the Local Homeless Coordinating Board Continuum of Care Five Year Strategic Plan Towards Ending Homelessness. They are categorized below as Medical, Services, and Access. The entire Plan is available at [www.sfgov.org/LHCB](http://www.sfgov.org/LHCB)

**Medical:**

Priority Two:

- A) *Increase the number of respite beds for persons who need continued medical assistance after discharge, prior to placement in permanent housing.*
- ▶ Educate social workers within hospitals about the resources available to provide and support housing at discharge.
  - ▶ Charge a “respite advisory group” to create a plan to coordinate services/beds and enhance relationships with homeless services providers to increase respite care.
  - ▶ Provide respite at 24-hour shelters by dedicating beds with appropriate medical support, e.g. visiting nurse care.
  - ▶ Maintain right to case-managed shelter beds during period of hospitalization. Until sufficient respite beds are available, dedicate IHSS Homecare workers to each shelter site based on existing need.
- B) *Provide timely medical treatment and services to people who are homeless to minimize their entry into the emergency medical system.*
- ▶ Bring to scale the work of the Emergency Medical Services High User group to identify and engage frequent users of EMS in order to address their needs and minimize 911 and emergency department usage.
- C) *Provide services in shelters that lead to accessing and maintaining permanent housing.*
- D) *Provide specialized shelters or set-aside sections in general population shelters to accommodate the need for:*
- ▶ People in crisis needing an unstructured, low-threshold shelter with minimal requirements for residents, consistent with maintaining standards for client safety and hygiene.
  - ▶ Respite beds
  - ▶ Elderly
  - ▶ Victims of domestic violence
  - ▶ Immigrants
- E) Need for assessment tool either at point of discharge and/or intake at shelters.

**Services:**

Priority Three:

1. *Provide services in shelters that lead to accessing and maintaining permanent housing.*
  - a) Services provided to individuals and families in emergency shelters should focus on increasing housing stability, including:
    - ▶ Housing placement
    - ▶ Economic literacy, including money saving
    - ▶ Accessing income benefits
    - ▶ Child care
    - ▶ Housing retention skills.
2. *Provide services in coordination with other community service providers.*
  - a) Coordinate with Resource Centers and other community service providers to increase involvement in community activities and access to social, psychosocial and medical services.

Priority Four

1. *Improve access points and provide wraparound support services that promote long-term housing stability for those in permanent housing, transitional housing settings and for those yet to be housed.*
  - a) Continue and expand outreach through Project Homeless Connect and engage new individuals and businesses as volunteers to increase the volunteer hours and private funds being directed to ending homelessness.
2. *Increase the availability of community drop-in and Resource Centers.*
  - a) Provide additional, dedicated resources for community drop-in and Resource Centers to offer site-based services to people living on the streets and in emergency shelters.
  - b) Provide a comprehensive range of services through community drop-in and Resource Centers, including housing placement services as well as access to basic services, crisis intervention, and referrals to other social services, mainstream benefits, safe day space off the streets, and interim housing as appropriate.

**Access:**

*Priority Three: Initiative I:*

- Maintain sufficient number of emergency shelter beds until there is a demonstrated decrease in need
- Expand shelter hours to provide 24 access and adjust rules to increase number of hours that people are permitted to sleep to improve/maintain health

*Priority Three: Initiative III:*

- Provide specialized shelters or set-aside sections in general population shelters that accommodate the need for: people in crisis needed an unstructured, low threshold shelter with minimal requirements for residents; respite beds; elderly; victims of DV; immigrants; and teen-aged youth

*Priority Four:*

- Enhance access points for support services and housing through outreach to and engagement of people experiencing homelessness

### **What is said in the Standard of Care**

The following are pieces of the Standard of Care legislation that relate to medical, services, and access. The entire legislation is available at [www.sfgov.org/sheltermonitoring](http://www.sfgov.org/sheltermonitoring)

#### **Medical:**

- Ensure all City-funded shelter operators meet minimum standards of care in the shelter system, and that all shelter clients are treated with dignity and respect and are provided with clean, healthy, and safe shelter stay.

#### **Services:**

- Ensure all City-funded shelter operators meet minimum standards of care in the shelter system and that all shelter clients are treated with dignity and respect and are provided with clean, healthy, and safe shelter stay, specifically compliance with Americans with Disabilities Act (ADA), adherence to environmental safety standards, nutritious meals to meet dietary health needs, access to toiletries, access to first aid kits, CPR masks, disposable gloves, and as otherwise listed Section 20.204 of the Standards of Care for City Shelters legislation.

#### **Access:**

- Ensure 24-client access to a shelter and provide on-site reservations for current shelter clients and provide at least one 24-hour emergency drop-in center
- Provide shelter services in compliance with the Americans with Disabilities Act (ADA), including but not limited to: the provision of accessible sleeping, bathing, and toilet facilities.
- Locate an alternative sleeping unit for a client who has been immediately denied shelter services after 5:00pm, unless the denial of services was for acts or threats of violence.
- To the extent not inconsistent with Proposition N, passed by the voters on November 5, 2002, ensure that all single adult shelter reservations be for a minimum of seven nights.