

# Mental Health SF Implementation Working Group Draft Meeting Minutes

November 9, 2021 | 9:00 AM – 12:30 PM

This meeting was held by WebEx pursuant to the Governor's Executive Orders and Mayoral Emergency Proclamations suspending and modifying requirements for in-person meetings. During the Coronavirus Disease (COVID-19) emergency, the Mental Health San Francisco Implementation Working Group will convene remotely until it is legally authorized to meet in person.

Note: The agenda, meeting materials, and video recording will be posted at the Mental Health SF Implementation Working Group website:

<https://www.sfdph.org/dph/comupg/knowcol/menthlth/Implementation.asp>

## 1. Call to Order/Roll Call

The meeting was called to order at 9:07 AM.

*Committee Members Present:* Dr. Scott Arai, Psy. D., Kara Chien, J.D., Dr. Vitka Eisen, M.S.W., Steve Fields, M.P.A., Ed.D, Dr. Ana Gonzalez, D.O., Dr. Hali Hammer, M.D., Philip Jones, Dr. Monique LeSarre, Psy. D., Andrea Salinas, L.M.F.T., Sara Shortt, M.S.W.

*Committee Members Excused Absent:* Shon Buford, Jameel Patterson, Amy Wong.

*Committee Members Unexcused Absent:* None

## 2. Welcome and Review of Agenda

Dr. Monique LeSarre, IWG Chair, opened the meeting and reviewed the meeting goals and agenda. Chair LeSarre also reviewed the main presenters for today's MHSF domains. Chair LeSarre briefly reviewed the group agreements and encouraged IWG members who do not usually speak to step forward and participate actively during the meeting.

## 3. Discussion Item #1: Approve October 2021 Meeting Minutes

Member Hali Hammer highlighted Item #6 regarding public commenters being identified as a comment made during a previous IWG meetings and not during October 2021 meeting. Member Hammer asked for that to be removed. Member Chien asked that Chair LeSarre's name spelling to be corrected on Page 6, 3<sup>rd</sup> paragraph from the bottom.

Member Hammer made a comment regarding the Board of Supervisors hearing and suggested informing the IWG of future board meetings that have to do with MHSF in order for there to be IWG representation. Chair LeSarre requested Heather Littleton inform the IWG of board hearings in the future. Heather Littleton agreed.

## 4. Public Comment for Discussion Item #1

No public comment.

## 5. Action on Discussion Item #1

Member Vitka Eisen moved to approve the October 2021 minutes as amended; Member Hammer seconded the motion. The resolution was approved by the IWG.

Dr. Scott Arai, Psy. D. - Yes

Shon Buford - Absent  
Kara Chien, J.D. - Yes  
Dr. Vitka Eisen, M.S.W. - Yes  
Steve Fields, M.P.A., Ed.D - Yes  
Dr. Ana Gonzalez, D.O. - Yes  
Dr. Hali Hammer, M.D. - Yes  
Philip Jones - Yes  
Dr. Monique LeSarre, Psy. D. - Yes  
Jameel Patterson - Absent  
Andrea Salinas, L.M.F.T. - Yes  
Sara Shortt, M.S.W. - Yes  
Amy Wong - Absent

## **6. Discussion Item #2: New Beds and Facilities: Crisis Diversion Discussion and Recommendation**

Chair LeSarre reminded the IWG of the MHSF Domains and briefly reviewed the Recommendation Roadmap. Jenna Bilinski, Director, Health Operations, Social Medicine, Lean Performance Improvement at Zuckerberg San Francisco General Hospital, informed the IWG that New Beds & Facilities is one of the ways the county is addressing racial health equity. She also reviewed the continuum of the current mental health crisis care services and the key differences between them. Director Bilinski stated that Dore Urgent Care is the model for crisis services and informed the IWG of the effect that model has on potential enhancement of services. She identified where the Crisis Diversion services would fall on the continuum and addressed the IWG's questions from the October meeting.

Member Chien inquired whether there were overlapping services between Crisis Diversion (CD) and Drug Sobering Center (DSC) and expressed concern regarding duplicating services. Director Bilinski referred the DSC question to Dr. David Pating. Dr. Pating replied that DSC is a non-medical social model where individuals can sober from intoxication and is based on a shelter model. He acknowledged that Crisis Diversion has a small overlap with DSC, but CD is a medical program. He also stated that DSC is the lowest level of service and, ultimately, supports a continuum of care so that individuals can access the appropriate level of services.

Member Eisen inquired if there is a contemplation for a medical detox for more complex withdrawal issues. She expressed their belief that medical detox is a service that is missing in San Francisco's crisis services and response to substance use disorder. Dr. Pating stated that Crisis Diversion is worded specifically to ensure that there is no "wrong door" to receiving services. He also stated that the Joe Healy Alcohol and Detox Center is available for more severe detox. Member Eisen expressed that she would like to see hospital-based programs for people who need a higher level of care and that there is an outstanding gap in the service.

Member Salinas inquired if the intended population for Crisis Diversion are individuals seeking services within the Emergency Department and asked for clarification of the typical presentation that the police or ambulance will refer to Crisis Diversion. Director Bilinski reminded IWG that there are models that are being taken into consideration when determining the intended population. She stated that the ideal population will be experiencing mild to moderate crisis – either intoxication or withdrawal, in addition to a mental health concern or physical health concern. She informed the IWG that the goal is to reduce revisit rate to emergency psychiatric services and moving people away from higher level of care. Member Salinas asked about the rate of individuals that stayed for services of the New York model, given that it isn't a locked facility. Director Bilinski replied that individuals experiencing crisis were treated effectively and that conversations would continue with those non-local experts regarding the design of the facilities.

Facilitator Jennifer James introduced the whiteboarding activity. IWG participated in the Jamboard (whiteboard). Below are screen shots of the final virtual whiteboards:

# As we begin planning for expanding crisis services, what advice or recommendations do you have for DPH?



# Are there other models we did not discuss that we should consider?

a model with a lot of peer support built in would be good

it would be good to see what else is out there, explore best practices and innovative, creative models that have worked in other cities.

the more we can get to a "home-like" setting vs an institutional one the better

Include a roadmap for the continuum of care - where do the users of the Crisis Center go after being stabilized.

I think is here a way to follow up if people leave?

I am wondering about models that utilize for nature engagement have come up?

also using Native practices that I have witnessed - ceremony and spirituality - using Ed Durans models around addiction?

Is there a model that uses community to support the client while engaging in multiple levels of care?

Abstinence based drug treatment

Instead of going out and bringing clients in - is there a model similar to Lavamae where crisis services are brought out to the community

Addressing crisis that happen indoors

what are cultural models in Asia and API communities around substance?

Facilitator James informed the IWG that these suggestions from the whiteboard will be forwarded to the Discussion Group. She informed the IWG that there is currently only one member who has signed up to be part of that Discussion Group and encouraged others to sign up. Dr. Pating indicated that he would do some research of the models that the IWG noted in the whiteboard. Facilitator James indicated that the Jamboard will be available for the IWG until the end of the week to add suggestions at their convenience.

Facilitator Ashlyn Dadkhah reiterated that the brainstorm will be drafted into recommendations by the Discussion Group and invited IWG to sign up both as members and as a "captain" for the Discussion Group.

## **7. Public Comment for Discussion Item #2**

No public comment.

## **8. Discussion Item #3: Office of Coordinated Care Discussion and Recommendation Brainstorm**

Chair LeSarre introduced the Office of Coordinated Care (OCC) discussion by reminding IWG of the MHSF domains and introducing Deputy Director Marlo Simmons. Deputy Director Simmons indicated that implementation has been slow because of challenges with hiring. She reviewed the current components of the OCC and the corresponding goals and stated that the component names are still a work in progress.

Deputy Director Simmons introduced the Care Coordination and Transition Management (CCTM). This name is temporary until a better one is identified. CCTM is a mobile field-based team who will address the challenges with connecting and navigating services. She briefly reviewed the core elements of the CCTM model and what success will look like. She reviewed the CCTM workflow and acknowledged that some individuals may not be appropriate for services under OCC and will be referred to the correct level of service. She identified that the goal would be to connect individuals to an ongoing support system and that those individuals will not exit until CCTM is certain that the individual has been connected to that service.

Deputy Director Simmons posed questions to the IWG for both OCC and CCTM.

Facilitator James invited the IWG to ask Deputy Director Simmons questions on the presentation.

Member Arai inquired if there was a hierarchy or strategy to roll out the components of OCC. Deputy Director Simmons stated that they are all priorities, and it is pending staff hiring. Member Arai asked if there was a plan in place of when this work will begin moving forward or a deadline. Deputy Director Simmons acknowledged that the hiring process is complex, and they are not provided a list of candidates until the job posting closes.

Chair LeSarre expressed her concerns about the CCTM Workflow where the individual either does or does not meet referral criteria. She also stated that there is a lack of a prevention component to the workflow and integration with public defender or school system. Chair LeSarre suggested she would like to see partnering with community-based organizations. Dr. Simmons addressed the concerns and indicated that the CCTM workflow is for individuals who have many barriers to accessing services or who have refused services. She provided examples of when the OCC would address certain issues and how they would refer to CCTM.

Member Eisen asked for clarification around what referral criteria needs to be met. Deputy Director Simmons acknowledged that there are no referral criteria set yet. Member Salinas commented that working with these populations take a lot of resources, a lot of services cannot be billed for, and inquired if civil servant staff would not have similar constraints. Deputy Director Simmons stated that there could be funds leveraged to allow staff flexibility in providing services. Member Salinas also shared her experience where a program in outreach may be able to provide flex funds for potential members but that once transferred to permanent care providers, the same funding flexibility is not available and they cannot continue the work in the same manner. Deputy Director Simmons acknowledged that those best practices need to be expanded across the system.

Member Chien inquired if DPH knows what the national care coordination model is. She expressed concern that individuals who do not work in the field are not aware of the level of engagement and services required to help people and the current system is quick to put a band-aid. She commented that providers should take more of an oncologist approach and brought up the model called Trieste. Deputy Director Simmons stated that there is not a specific model being considered and that she is open to suggestions once the OCC is fully staffed. Chair LeSarre acknowledged Member Salinas for the work that she does. Chair LeSarre stated that there needs to be education provided to Board of Supervisors and the community to what the work really entails and to address "unrealistic expectations." Facilitator James introduced the OCC whiteboard activity.

See next page for screenshots of the virtual whiteboard.

OCC General:

need to make sure that the funding is flexible enough to provide across whole system of care and cbo's etc

should the OCC consider

need specific anti black racism strategy

conceptual design

Need to consider in hiring developing culturally competent providers. It is more difficult to hire for persons with additional languages. May need to offer work visas particularly from API countries

Need to consider safety concerns in program design as many folks may present highly intoxicated with violence history

coffee  
tea  
food

Strive to have one meta case manager assigned to individuals who will follow through all levels of care.

transparency to the public - how's it working and where is it not

culturally congruent and language accessibility services

Parity pay, because it can never be said too often!

...s successful, how will we sustain capacity, given how hard it is to hire in the DPH and the shortage of behavioral health clinicians?

Training for the OCC staff and a resource bank.

drop in circles

Call to ACTION to Community - really being a village - volunteering, peers etc

peers

other service providers linkage obsite

time. need to be able to consistently and persistently connect with people even if just playing cards or drinking coffee, without pressure for an outcome. be able to build rapport and forge relationships, which might take a

retention to build capacity for new clts. Parity between CBO and Civil service. How can BHS help minimize administrative and billing documentation/ paper work that takes up a lot of time for the OCC programs and existing

flexibility in linkage/treatment modalities including telehealth

expand call center to include warm lines and crisis/suicide hotlines

Public Health Campaign

plan for patients that don't link

what will medication support look like while in the linkage stage?

temporary storage of client belongings

PT.2 work that takes up a lot of time for the OCC programs and existing OP services, or factor this into caseload size.

in person function

text function

welcoming, inviting, casual, low barrier environment with food, coffee, maybe some entertainment (magazines, games, TV), charging stations...things that make it alluring for people to come by. then in doing so they

OCC should consider that perhaps the capacity at the OP & ICM level should be built up ahead of increasing demand for services that will be created by the creation of the CCTM team

Appropriate provider to client ratio

transport ith ambassador to higher level of care if needed

age flexibility all ages must be served

staff need to be diverse and reflect the backgrounds of those they are serving

email function or app based

# OCC General: Who are our key stakeholder groups to engage in planning and implementation?



# CCTM Specific: What services and supports should this team provide to promote wellness and recovery?



# CCTM Specific: Suggestions for client engagement strategies?

Workforce development and/or volunteering opportunities

management demonstrates that people are very motivated by actual money. Provide incentives such as \$ for clean utox, gift cards for actually making appointments, or completing important goals ie making

Staff knowledge of Stages of change - different stages have different goals that define what success is

High touch for people transition from setting where we know people are high risk: jails, PES, hospitalization, street crisis.

Have goodies/ incentives

Provide services out of the office/ on the street or in other settings

Pt.2 or completing important goals ie making medical appts

Work with people they already know/ trust

Have some ESA animals. a lot of people really relate to them

Bring in community and family support, food, gift cards, and housing.

cell phones for clients to be able to text/telehealth

Have respite spaces where they can be seen/ provided services so that they come for the break

peer navigators/counselors

Use peers

opportunities for low barrier contact

public service and communications and anti-stigma campaign

at the risk of stating the obvious--judgment free and welcoming connections.

use multiple modalities of social media and tv print media bill boards town halls etc

service pets

low barrier (minimal paperwork, drop-in, no appointments) services

Facilitator Dadkhah identified that Chair LeSarre and Members Arai, Chien, Eisen, and Salinas all expressed interest in participating for the OCC Discussion Group. Facilitator James inquired if any of those members require any clarification on the brainstorm ideas that were identified by IWG members.

Member Eisen requested clarification about whether OCC is considered a service or a location. Deputy Director Simmons replied that OCC is a general umbrella of services and listed the services that it will be contained within that umbrella. She suggested that the brainstorm feedback involving physical location be addressed as the Behavioral Health Access Center (BHAC) and questions about services be addressed as OCC.

Facilitator James reminded IWG members that there is one more spot available for the OCC Discussion Group. She reviewed the recommendation roadmap for this item and reminded IWG that the Discussion Group will require IWG members to be vigilant about conflicts of interest and suggested members check in with City Attorney, Jon Givner.

#### **9. Public Comment for Discussion Item #3**

No public comment.

#### **10. Discussion Item #4: Street Crisis Response Team (SCRT) Discussion Group Report Back**

Chair LeSarre provided updates on the recommendations from the SCRT Discussion Group. Member Salinas reported that there was a conversation regarding improving coordination with providers. Chair LeSarre also highlighted the recommendation of equity in pay. Member Arai expanded on Member Salinas point regarding coordinating with providers and how just entering an individual's name can help find which services they are connected to. He also addressed the recommendation regarding transportation and SCRT connecting individuals to other services.

Chair LeSarre reviewed the next steps for SCRT. She also reminded everyone that SCRT does not address crises that happen inside building, only out in the open.

#### **11. Public Comment for Discussion Item #4**

No public comment.

#### **12. Discussion Item #5: Housekeeping**

Facilitator James reviewed the anticipated IWG meeting topics. She reminded the IWG about the mayoral policy requiring that all public body members to be fully vaccinated by 12/15/21. Chair LeSarre suggested eligible members to get a booster shot and inquired if the requirement will include the booster shot. Facilitator Dadkhah inquired if members will be required to submit proof again if they have already submitted vaccine status. Heather Littleton will confirm the responses to these questions and include the responses in the email. Facilitator James reviewed the next dates for the MHSF IWG meeting.

#### **13. Public Comment for Discussion Item #5**

No public comment.

#### **14. Discussion Item #6: Public Comment on any matters within the Working Group's jurisdiction not on the agenda**

No public comment.

#### **15. Adjourn**

Member Chien motioned to adjourn the meeting and Member Hammer seconded the motion. The next meeting will be on Tuesday, December 14, 2021 from 9:00 AM- 1:00 pm. Meeting adjourned at 12:30 PM.