



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Unadopted Notes

Mental Health Board

Wednesday, September 11, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

San Francisco, CA

BOARD MEMBERS PRESENT: Ellis Joseph, MBA, Co Chair; David Elliott Lewis, Ph D, Co Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Secretary; Terry Bohrer, RN, MSW, CLNC; Kara Chien, JD; Terence Patterson, EdD, ABPP; Alphonse Vinh, MS

BOARD MEMBERS ON LEAVE: Melody Daniel, MFT; Lena Miller, MFT

BOARD MEMBERS ABSENT: Marlene Flores, Sgt. Kelly Kruger, Errol Wishom

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Ken Epstein, PhD, LCSW, Director of Children, Youth & Families (CYF) System of Care (CBHS); Deborah Sherwood, Ph.D. Director, Office of Quality Management Community Programs San Francisco Department of Public Health; Wendy Yu; Michael Gause, MHA-SF assistant director; and two members of the public.

CALL TO ORDER

Mr. Joseph called the meeting of the Mental Health Board to order at 6:45 PM.

The board took a moment of silence to acknowledge victims of September 11, 2001.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 DIRECTOR'S REPORT

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Dr. Ken Epstein, Director of Children, Youth and Families System of Care gave the director’s report on behalf of Jo Robinson.

Dr. Epstein said that CHBS is being trained on implementation of the Affordable Care Act (ACA). He has developed a Trauma Informed Care initiative for CBHS and has been conducting focus groups and presentations to providers. The initiative will be rolled out in January 2014. Next Tuesday there will be a meeting to share this plan with 130 providers. CBHS has also been working on developing a response to the Katie A lawsuit. This lawsuit mandated that all foster youth will be assessed for mental health service qualification. The lawsuit started in Los Angeles’s foster care system and found that many children in foster care suffered multiple traumas. San Francisco anticipated the mental health issues in foster care and has been proactive and was already providing mental health screening and services to children and youth in foster care.

1.2 Public Comment

Ms. Dale Milfay said that late onset mental health issues can occur and wanted to know if extra services are provided. She said that some youth with schizophrenia are not diagnosed early enough.

The diagnosis is often anxiety and depression and trauma. There are some youth with schizophrenia. Services dollars are scarce to meet the needs of San Francisco youth.

Monthly Director’s Report
September 2013

City and County of San Francisco
Department of Public Health
COMMUNITY HEALTH CARE



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Monthly Director’s Report
September 2013

1. Inspire USA Asks Teens ‘How Do U ReachOut?’ for Suicide Prevention Week

ReachOut.com is launching a campaign for Suicide Prevention Week to raise awareness around self-care and to de-stigmatize help-seeking behavior. “How Do U ReachOut?” consists of Facebook and Twitter profile picture takeovers, an Instagram photo competition, and encouraging e-cards to send to friends. ReachOut’s youth will also attend outreach events to raise awareness about services

within each of the newly established ReachOut California chapters. For more information email Liz Crampton at liz@inspire.org.

2. CA State Senate Select Committee on Mental Health Holds Informational Hearing on Suicide Prevention

On Tuesday, September 24th, from 1:00pm-3:00pm, CA State Senator Jim Beall and members of the CA Senate Select Committee on Mental Health will hold an important informational briefing to discuss the future of suicide prevention in California. “Every Life Matters: Implementing Effective Suicide Prevention Strategies in California” will include guest speakers Kevin Hines, who will speak about living mentally well after a failed suicide attempt, along with other national, state and local officials. To stay updated on this hearing, visit the Committee's homepage, or call Diana Traub at (916) 651-4015.

3. The Walk In Our Shoes Campaign is Coming to a School Near You

Stigma and Discrimination Reduction contractor RS&E recently released the Walk In Our Shoes campaign, aimed at 9-13 year olds, which includes a statewide school-based performance tour kicking off in Sacramento on Monday August 26th. View the tour schedule for the next nine weeks at www.walkinourshoes.org. 8/26 – 9/1: Sacramento Region; 9/2 – 9/8: Greater Chico Area; 9/9 – 9/15: Shasta/Redding Area; 9/16 – 9/22: Eureka/Sonoma; 9/23 – 9/29: Bay Area; 9/30 – 10/6: Fresno/Bakersfield; 10/7 – 10/13: Riverside/San Diego; 10/14 – 10/26: Orange County/LA. Contact Kayla Hansen at khansen@rs-e.com to learn more about bringing a performance to your area.

4. Dr. Juan Ibarra to Present at Cultural Competence and Mental Health Northern Region Summit

California Institute of Mental Health’s (CiMH) Cultural Competence and Mental Health Northern Region Summit has accepted a presentation titled, “Holistic Wellness – Engaging Cultural and Linguistic Traditions to Improve Community Resiliency” proposed by Juan Ibarra, DrPH, MPH, MSW, of the Office of Quality Management. Dr. Ibarra, an epidemiologist and evaluator of MHSA-funded projects, completed a multi-site evaluation of the Holistic Wellness program, part of Prevention and Early Intervention, in 2012. MHSA funded Holistic Wellness activities at Instituto Familiar de la Raza (IFR), Central City Hospitality House, Bayview YMCA, and Native American Health Center, and included culturally appropriate efforts to outreach into these communities, decrease isolation, increase social connectedness, and connect underserved community members to behavioral health services. Congratulations Dr. Ibarra.

The summit will take place in Modesto, California, October 2-3, 2013 and will focus on “Cultural Competency and Workforce Development: The Bridge to Health Care Reform.” Cultural competence skill building workshops and discussions will provide a forum for promoting and advancing cultural competence throughout organizations and systems in order to more effectively meet the needs of individuals and families from diverse communities.

5. State MHSA Audit Critical of State Oversight Agencies; Generates Significant Media Attention

The long anticipated release last week of an audit of the Mental Health Services Act (MHSA) <http://www.bsa.ca.gov/> conducted by state auditor Elaine M. Howle was particularly critical of the state entities charged with evaluating the effectiveness of MHSA programs. It said, for example, that “None of the entities charged with evaluating the effectiveness of MHSA programs – Mental Health, the Accountability Commission, or a third entity – have undertaken serious efforts to do so.” The Auditor also audited four counties – Los Angeles, San Bernardino, Santa Clara and Sacramento. While she issued no findings indicating the counties had improperly spent MHSA funds, the auditor did report that “each of the four county departments we reviewed used different and inconsistent approaches in assessing and reporting on their MHSA programs, and the county departments rarely developed specific objectives to assess the effectiveness of the programs.” The audit also found, however, that the state Department of Mental Health “did not provide explicit direction to counties on how to evaluate their programs effectively... When the responsible state entities do not provide guidance to counties for effective program evaluation, the public cannot be sure that MHSA programs are achieving their intended purposes.”

The audit report has generated significant media attention, and resulted in at least one state legislator’s call for annual state audits of each county. Assemblyman Dan Logue (R-Marysville), who is vice chairman of the Assembly Health Committee, says he “will introduce legislation seeking annual audits to show how California counties are spending billions of dollars in voter-approved money for mental health programs, after a state audit found there has been little oversight to ensure the money is going to those who need it most.” According to Logue, “Regular, intensive audits of all 58 counties are needed to ensure they are complying with all aspects of Proposition 63.” Senate Pro Tempore Darrell Steinberg (D-Sacramento) also responded to the audit report with a written statement, which said, in part, “These evaluations have been long overdue. It is vital that investments are held accountable, through objective reviews of their efficacy so that they can be justified, or adapted where improvements are needed.”

CMHDA released its own statement on the day the audit was released. The statement by CMHDA President Jerry Wengerd and Executive Director Patricia Ryan said that “California’s counties have always welcomed the opportunity to demonstrate the value of the community mental health services we provide through the Mental Health Services Act, and are pleased to find that we agree with the findings of the State Auditor today. At the local level, counties have monitored and are proud of the difference our programs are making in individuals’ and families’ lives. Counties have achieved significant reductions in our clients’ levels of homelessness, hospitalization, and incarceration, using Prop. 63 funds. We agree with the Auditor that state oversight agencies must develop an effective and standardized evaluation method so that we can tell these county-by-county stories on a statewide basis. We will continue to participate actively in any Department of Health Care Services and Oversight & Accountability Commission efforts to establish methods for measuring program outcomes, and hope the Auditor’s recommendations in this area will be implemented in a meaningful and cost-effective manner.”

After receiving a request from Senator Steinberg, the MHSOAC has released a six-page MHSA evaluation plan, which has also been circulated with the CMHDA MHSA Committee.

6. CMHDA Sends Letter to HHS Region IX Director Regarding Medicaid “Inmate Exception” Issue

Following the lead of the National Association of Counties (NACo) and the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD), CMHDA Executive Director Patricia Ryan today sent a letter to Health and Human Services Region IX Director Herb Schultz regarding county Mental Health Plan (MHP) concerns about the effect the so-called Medicaid “inmate exception” rule will have on continuity of care for those individuals who are incarcerated but have not been adjudicated in county jails. The letter requests that CMS “(1) harmonize the definition of “inmate” for Medicaid purposes with the ACA “incarcerated pending disposition” provision, (2) clarify that jail officials may submit Medicaid enrollment applications on behalf of persons in custody, and (3) require that states stop terminating eligibility for persons in custody pending disposition.” Go to: [http://www.cmhda.org/go/Portals/0/CMHDA Files/Breaking News/1308 Aug/CMHDA Inmate Exception Letter Herb Schultz \(8-23-13\).pdf](http://www.cmhda.org/go/Portals/0/CMHDA%20Files/Breaking%20News/1308%20Aug/CMHDA%20Inmate%20Exception%20Letter%20Herb%20Schultz%20(8-23-13).pdf)

7. Opioid Overdose Prevention Toolkit

The Opioid Overdose Toolkit educates first responders, physicians, patients, family members, and community members on ways to prevent opioid overdose. The toolkit also explains how to use a drug called naloxone to prevent overdose-related deaths.

Anyone who uses opioids for long-term management of cancer pain or noncancer pain is at risk for overdose, as are those who use heroin. The good news is we now know that the drug naloxone can be used as an antidote to opioid overdose and can prevent opioid-related deaths when naloxone is administered in a timely manner.

Inside the toolkit are five separate booklets, each designed for a specific audience.

- Patients can learn how to minimize the risk of opioid overdose.
- Prescribers can understand the risks of opioid overdose, as well as clinically sound strategies for prescribing opioids, and educating and monitoring patients.
- First responders will find five steps to use in responding to an overdose, including how to use naloxone and provide other life-saving assistance.
- Community members can view facts about opioid overdose that can help local governments, community organizations, and private citizens develop policies and practices to prevent overdoses and deaths.
- Survivors and family members can gain information and support through the information provided in this booklet.

(Attachments 1 – 5)

8. 39th Annual National Suicide Prevention Week

The 39th Annual National Suicide Prevention Week is almost here! Suicide Prevention Week offers an opportunity to inform the public about great strides in addressing this public health issue through prevention.

Thanks to the Mental Health Services Act (Prop. 63), a landmark initiative passed by voters in 2004, California has made a significant investment in programs that prevent mental illness, promote mental health, and connect individuals with help before they reach a crisis point. Guided by the California Strategic Plan on Suicide Prevention - <http://www.mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf> - and funded by counties through the voter-approved initiative, California is implementing comprehensive suicide prevention programs. These programs empower everyone from youth to seniors with the tools, resources, and crisis support needed to prevent suicide.

Suicide Prevention Week puts a focus on the extraordinary efforts to prevent suicide underway in communities across California. New coalitions have been formed and partnerships strengthened to promote the message that suicide is preventable throughout California's diverse communities. Training opportunities and events are ongoing with the goal of raising awareness of suicide prevention tools and resources.

More than 120 Suicide Prevention Week events, sponsored by counties and community partners, have been compiled in a calendar and organized by different types of events. The calendar, which is available at <http://goo.gl/Mmuve7>, demonstrates the breadth and depth of the suicide prevention activities in California – we encourage you to join a local event and spread the word through your networks. Please refer to the attachments of this report to see a few examples of events planned in San Francisco for Suicide Prevention Week and throughout the month of September.

(Attachment 6)

9. Medications and the Elderly: Growing Needs for Coordinated Care

The U.S. Census Bureau projects that the population over the age of 65 in this country will grow from its current 13.7% to nearly 22% by the year 2060. In the year from 2007-2008, nine out of ten older adults were taking at least one prescription drug and 37% were taking five or more.

Medication treatment presents particular challenges in the older patient. As people age, their bodies change in ways that affect how drugs are handled: lean muscle mass and total body water decreases, resulting in a relative increase in total body fat; kidney and liver function can decline; and receptors may become more sensitive to medications. Ultimately, these changes increase the risk of side effects. Moreover, older people tend to have more medical conditions, take more medications and be prone to more memory impairment.

Many providers are familiar with the Beers Criteria, a list of medications that may be considered inappropriate for use in the elderly. This list was updated in 2012 by an interdisciplinary panel with support from the American Geriatrics Society. Here are some of the highlights of the 2012 Beers List as it relates to psychiatric prescribing:

Medication or Class	Concern for the Elderly	Recommendation
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Antiparkinson Medications (Cogentin, Artane)	Highly anticholinergic—may cause confusion, constipation, urinary retention, dry mouth. Not recommended for prevention of EPS from antipsychotics	Avoid in elderly
First generation antihistamines (Benadryl, Atarax)	Highly anticholinergic, as above; tolerance develops when used as a sleep aid	Avoid in elderly
Certain tricyclic antidepressants (amitriptyline, imipramine, doxepin)	Highly anticholinergic, as above; , sedating and may cause orthostatic hypotension (dizziness and drop in blood pressure on standing)	Avoid in elderly
Antipsychotics (conventional and atypical)	Increased risk for stroke and mortality in the elderly demented	Avoid in the elderly*
Benzodiazepines (lorazepam, diazepam, temazepam, clonazepam, etc.)	Increased sensitivity, slower metabolism increase risks for these agents, including cognitive impairment, delirium, falls, fractures and motor vehicle accidents.	Avoid for treatment of insomnia,** agitation or delirium
Non-benzodiazepine sleep agents (Ambien, Lunesta, Sonata)	Adverse effects similar to benzodiazepines (see above). Minimal improvement for sleep disorders involving difficulty falling asleep or reduced overall amount of sleep.	Avoid chronic use (>90 days)**
Most antidepressants, antipsychotics and carbamazepine	May cause or worsen a condition that can lower blood sodium levels, which may cause confusion, muscle weakness or seizures	Use with caution (monitor sodium levels closely when starting or increasing doses)

*Although Beers Criteria state to avoid in the elderly regardless of diagnosis, these agents may be considered for treatment of psychotic illnesses in non-demented elderly. **Treatment of insomnia in the elderly should always involve non-pharmacological interventions such as addressing sleep hygiene.

Ideally, the older patient has one provider who has primary oversight of all medications, whether prescribed or over-the-counter, and who can evaluate medication therapy with criteria such as the Beers List in mind. A periodic “brown bag review” of everything the patient is taking can be eye-opening. Open and frequent communication between different providers caring for the same patient is essential, and systems to facilitate this should be promoted. Coordinated systems and support of geriatric care can minimize harm from medications, reduce duplication and other wasteful medication practices, and optimize and simplify regimens to provide the ideal care for our vulnerable elderly patients. With the growth of the older adult population in the coming years, these practices must be a priority.

10. DSM-V

Effective January 1, 2014, San Francisco CBHS will require all of its providers to use DSM-V diagnosis codes in Avatar. DSM-V is the fifth edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders. The DSM-V codes are already available in Avatar, and can already be used even now, but by January 1, 2014, all CBHS providers are required to use DSM-V diagnosis codes (and no longer DSM-IV). The DSM-V codes are already able to be cross-walked to the ICD-9 codes for Medi-Cal billing purposes.

11. First Impressions - Introduction to the Construction Trades Vocational Training

(Attachment 7)

12. CBHS Outcomes Presentation to Health Commission Community and Public Health Committee

CBHS Quality Management staff gave an update on outcomes and practice improvement activities to the Health Commission Community and Public Health Committee on August 20, 2013 (powerpoint presentation is attached). The first half of the presentation focused on the behavioral needs and strengths identified at intake using the Adult Needs and Strengths Assessment (ANSA), and the percentage of clients who have achieved improvement in at least one domain of need or strength. The second half of the presentation focused on efforts within the Children, Youth, and Families System of Care to better understand and disseminate what practices are effective in our local context.

Dr. Monica Rose, Director of Research and Evaluation for CBHS, presented an overview of the Adult and Older Adult System of Care outcomes. An analysis of initial ANSAs indicated that the top Behavioral Health Needs were Depression (70% of clients), Anxiety (59%) and Adjustment to Trauma (39%). The top Life Domain Functioning Needs were Residential Stability (46%), Social Functioning (45%) and Family Functioning (44%). The highest rated Strength was Involvement in Recovery, whereas the lowest Strength was Community Connection. Over half of clients (57%) had Substance Use identified as an actionable need, and within this group, 21% used alcohol or drugs daily. An analysis of Actionable Needs (those that require action or immediate, intensive action) indicated that there was a positive correlation between the number of actionable needs and the level of care where the client was being served; that is, clients with more needs were being served in higher levels of care, as is appropriate. We also analyzed change over time, from the initial ANSA measurement to the most recent ANSA. Of the 9,297 client episodes of care where there were at least two ANSAs, we found that 68.8% of client episodes showed reliable change in at least one ANSA domain.

The second half of the presentation was lead by Dr. Nathaniel Israel, who reviewed practice improvement methods within the Children, Youth, and Families System of Care using the Child and Adolescent Needs and Strengths Assessment (CANS). CANS data have been provided to programs in the form of pivot charts so that programs can examine the data in a variety of ways (e.g., by demographics, by clinician, etc.). Each program was asked to write their "theory of change," that is, why they believe their services will produce change in the areas of greatest need for their clients. Programs that have succeeded in producing change over time are then asked to identify specific actions they take in response to the needs for which they have successfully achieved improvements.

Dr. Israel is then looking for patterns of successful practice across programs, which can be shared as best practices for other programs who have clients with a similar need profile.

The Health Commission Committee responded favorably to the presentation. CBHS will continue to provide updates to the committee as we learn more from our outcome and practice improvement analyses.

(Attachment 8)

13. Children, Youth and Families

CYF has initiated a process to improve and transform access and client flow within an equity lens. The goal is to ensure that all children, youth and families qualified for specialty mental health services receive the right services in the right place in a timely manner. The CYF providers, county clinics and administration met in July to identify barriers and priorities. A work group has been established that will meet four times to forward a proposal that is inclusive of providers and meets the objective of immediate access and quality services. The plan will involve changes at the provider level, the practice level together with policies that support the desired outcome. The proposal will be presented to the provider group and CBHS administration late in 2013. This initiative is consistent with best practice, the Affordable Care Act but most importantly with the needs of children, youth and families.

14. Tri-Annual Compliance Review of San Francisco CBHS Mental Health Plan

As required by Welfare and Institutions Code, Section 5614, the Department of Health Care Services (DHCS) has informed county Mental Health Plans (MHP) of their respective dates for their tri-annual Program Oversight and Compliance annual review in Fiscal Year (FY) 2013-2014. San Francisco CBHS's tri-annual review is scheduled for April 28, 2014, with San Francisco General Inpatient (psychiatric) taking place earlier on October 7, 2013.

In accordance with oversight authority contained in the California Code of Regulations, Title 9, Chapter 11, Section 1810.380, DHCS reviews the program and fiscal operations of each MHP to verify that medically necessary services are provided in compliance with State and Federal laws and regulations and/or the terms of the contract between DHCS and the MHP. If during the onsite review DHCS determines that an MHP is out of compliance, DHCS will provide a Plan of Correction that includes: description of the finding(s), a description of any corrective action(s) required by DHCS, and the time limits for compliance.

DHCS will also review a random sample of client charts, from across CBHS providers, to determine if medical necessity criteria were met, and recoup Federal Financial Participation (FFP) dollars in accordance with the FY 2013-2014 Reasons for Recoupment, which is available online at: <http://www.dhcs.ca.gov/formsandpubs/Documents/Enclosure%204%20Reasons%20for%20Recoupment%20FY%202013-14.pdf>

The random sample of Non-Hospital Services CBHS charts to be reviewed on April 28, 2014 will be drawn from the most recent 90-day period for which paid claims data are available or from a specified time period as determined by the Department.

CBHS encourages all CBHS providers to strengthen your ongoing quality assurance and utilization review of client medical records. For your reference, the CBHS Mental Health Documentation Manual is available online at: http://www.sfdph.org/dph/files/CBHSdocs/SFDPHDocumentationManual_REVISED_121112.pdf

15. CBHS Peers and Counselors Trained to Implement "Illness, Management and Recovery Groups"

About 50 individuals from across 23 CBHS mental health and substance abuse treatment providers were intensively trained for two days in August 2013 on facilitating "Illness, Management and Recovery" (IMR) groups for clients at their programs. IMR is an evidence-based practice that emphasizes personal goal-setting and actionable strategies toward behavioral health wellness and recovery. The training was conducted by Lucinda Dei Rossi and Debra Brasher of Inspired at Work. The IMR trainees expressed great satisfaction with the training, and enthusiasm is high to apply what they learned.

CBHS will soon regroup all those who were trained for a follow-up discussion on the implementation of the IMR groups at their programs, and the infrastructure that CBHS will put into place to support the implementers, and remove barriers towards successful launching of the IMR groups. Learning for Action, a consulting firm, has also been engaged by CBHS to provide outcomes evaluation support. For information about this IMR Groupwork Project, please contact John Grimes, MFT, Deputy Director, CBHS Adult and Older-Adults Systems-of-Care, at (415) 255-3444, or at john.grimes@sfdph.org.

16. Harm Reduction Coalition

The California Senate and Assembly voted unanimously yesterday for AB 635, carried by Assembly member Ammiano, to decrease overdose fatalities in California by increasing the distribution of an opioid overdose antidote, naloxone. Drug overdoses are now the leading cause of accidental death in the United States, surpassing motor vehicle crash deaths.

Overdose prevention programs distribute the life-saving drug naloxone (also known as Narcan®), which reverses an opioid overdose from drugs like heroin, oxycodone, morphine, or methadone by restoring an overdosing person's breathing and heart rate. The state's longest-running overdose prevention program, the Drug Overdose Prevention and Education Project (DOPE) in San Francisco, a program of the Harm Reduction Coalition, has provided over 3600 take-home naloxone prescriptions since 2003 in collaboration with the San Francisco Department of Public Health, with over 1000 lives saved. In addition, clinicians at SFDPH public health clinics started co-prescribing naloxone with prescription opioids this year to their patients. According to a Centers for Disease Control report, overdose prevention programs distributing naloxone in the US have trained over 50,000 laypersons to revive someone during an overdose to date, resulting in over 10,000 overdose reversals using naloxone. However, many licensed health care practitioners still fear prescribing

take-home opioid antagonists like naloxone to their patients because of potential civil and criminal liability.

This legislation will protect doctors and other licensed health professionals who prescribe and distribute naloxone to those who need it, including at-risk illicit or prescription drug users and potential bystanders to an overdose. It also clarifies that treatment providers and other non-medical personnel are able to distribute the prescription antidote under a doctor's "standing orders". This practice translates into significant cost savings for individuals and taxpayers. Additionally, the bill will encourage health care providers to begin prescribing naloxone to patients on chronic opioid pain medications in order to address the prescription drug overdose epidemic.

Harm Reduction Coalition (HRC), bill co-sponsor with the California Society of Addiction Medicine, applauded the legislature. "In California, overdose prevention programs have operated in a handful of cities and counties, but have had limited reach in terms of addressing the overdose issue statewide because of potential legal concerns," explained HRC California Director, Hilary McQuie. "We trust that Governor Brown will join this bipartisan consensus to protect the programs already operating, remove the obstacles for those that want to start, and clarify that clinicians may employ the 'best practice' of prescribing naloxone to those at greatest risk for having or witnessing an overdose."

The Harm Reduction Coalition (HRC) has been working since 1995 to reduce drug-related harm among individuals and communities by initiating and promoting local, regional, and national harm reduction education, interventions, and community organizing. HRC maintains offices in New York City, NY and Oakland, CA and conducts trainings nationwide. For more information about HRC, visit <http://www.harmreduction.org>.

17. "Remembering" Memorial Lunchtime Concert

You are invited to a "Remembering" Memorial Lunchtime Concert on Friday, September 13th from 12:30 pm - 1:00 pm at Yerba Buena Park Amphitheater. This concert is in memory of friends and family members that have been lost to suicide. Everyone is invited to attend, including those who have not lost anyone to suicide but would like to stand in solidarity and hope. Please pass along this information and flyer to your staff and clients. This concert is free and open to the public. The music and messages of memory and hope are in observation of the National Suicide Prevention Week: September 9-13.

For more information, please contact:
Michelle Thomas
Development & Communications Director
SF Suicide Prevention
Tel: 415/984-1900 ext. 117
Fax: 415/227-0247
P.O. Box 191350, San Francisco, CA 94119-1350
<http://www.sfsuicide.org>

18. Celebrating a Decade of Behavioral Health Court

Behavioral Health Court will celebrate its tenth anniversary this year. In 2003, the San Francisco Superior Court created a program to redirect clients with mental illness out of the jails and into community based mental health treatment. The court started with a modest goal of helping 10-20 people in the jail that were incarcerated for showing signs of untreated mental illness in public.

Ten years later, the court has a capacity of 150 clients and the program is a fully integrated and necessary part of the criminal justice system in San Francisco. Behavioral Health Court has been the subject of numerous research studies and has become a leader in the movement to decriminalize mental illness, reduce violence, and spend precious mental health resources more effectively.

For more information, please contact: (415) 597-8077 or bhcevent@gmail.com.

Past issues of the CBHS Monthly Director's Report are available at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>

To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates: Mental Health Services Act Annual Update

Dr. Epstein stated that the update is the completion of MHSA statewide audit.

3.2 Public comment

No public comment.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

No public comment.

3.2 PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of July 10, 2013 be approved as submitted.

No vote was taken because there was not quorum.

ITEM 4.0 PRESENTATION: OVERVIEW OF QUALITY MANAGEMENT AND OUTCOMES MEASUREMENT FOR COMMUNITY BEHAVIORAL HEALTH SERVICES. DEBORAH SHERWOOD, PH.D. DIRECTOR, OFFICE OF QUALITY MANAGEMENT COMMUNITY PROGRAMS SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

4.1 Presentation: Overview of Quality Management and Outcomes Measurement for Community Behavioral Health Services. Deborah Sherwood, Ph.D. Director, Office of Quality Management Community Programs San Francisco Department of Public Health

Dr. Sherwood's power point is at the end of this document.

Dr. Sherwood said that she has been the Director of Quality Management for the past five years. Prior to this position she did research on children. The Quality Management Department measures how programs meet their outcomes, analyzes the Client Satisfaction Surveys and has the role of Risk Management. They also manage data on the assessment tools, the Child and Adolescent Needs and Strengths (CANS) tool for children and youth, and the Adult Needs and Strengths Assessment (ANSA) for adults. Her department also pilots new ideas with smaller groups. For example, at Mission Mental Health, clients and clinicians are working together on the computer to summarize sessions and goals.

The transition to the Avatar Computer system has been challenging and some of the clinicians are not entering full information, making outcome reports difficult.

We have an Annual Quality Improvement Plan:

1. Improve transitions in care
2. Wellness and recovery
3. Concurrent documentation
4. Improving data quality and reliability
5. Improving productivity
6. Improving medication services

Ms. Virginia Lewis asked if QMO is a self measurement report and how many staff are in the department.

Dr. Sherwood explained that QMO is obtained from clinician outcome measuring reports that come from directly conversational anecdotes that clients report. Monica Rose is the Research Director and she has three staff members. Nate Israel oversees children's research and Tom Bleeker adults. There are three staff with MHSA data and three others on evaluation. Risk Management has two people. The Quality Improvement Coordinator position is currently vacant.

Dr. David Elliot Lewis asked about the milestone of recovery scale (MORS)

Dr. Sherwood explained that clients self identified with collaboration from clinicians as well.

Ms. Virginia Lewis wanted to know about substance abuse if it's self reporting or from toxicology screening.

Dr. Sherwood said that substance use is self reported. She explained that this month director's report provided programs' top issues from depression and anxiety. The report aggregates how effective each program's services are that can be shared with other programs. This peer learning approach has been going on for about six months.

The adult system has been working on identifying best practices for the past two years and the children system has been identifying best practices for about three years.

Programs are also learning from each other to identify best practices.

Some programs have specific outcomes such as Multisystemic Therapy, which involves intensive 24/7 treatment that involves the whole family to prevent recidivism. Also used are harm reduction, Seeking Safety and Triple P Parenting, which is a positive parenting program that is 9 – 12 weeks of intensive training for parents. Research has shown it to be very effective. We also look at re-hospitalization rates.

Terry Bohrer asked about the number of grievances.

Dr. Sherwood said that last year there were 200 and this year only 120.

Dr. David Elliott Lewis asked for average statistics because he has heard requests for services can take months

Dr. Sherwood explained that it is generally 24 – 48 hours before a patient is first seen and time to get services started is about two weeks. The first psychiatric appointment can be a month or two. The time from leaving the hospital to the first outpatient appointment is seven days.

Wellness and recovery does strength based assessments. For example, OMI and Sunset Mental Health and Mission Mental Health are using strength-based assessments. Recovery in mental health means identifying the client's preferred treatment goals, and clinicians work collaboratively with clients to meet the client's self expectation through the use of client's strengths.

Ms. James asked about evaluation for a senior who participates in the recovery model.

Dr. Sherwood shared that recovery might be a day treatment program to prevent seniors from self isolation. Helping seniors overcome their anxiety so seniors can attend day-programs and connect with the outside world. Working from client's strength yield better outcomes for senior clients as well.

Clinicians sometimes get frustrated with Avatar because it can take over 30 minutes to pull up a client's treatment plan. Dual record/notes like a paper copy and an electronic copy is disallowed.

4.2 Public Comment

Mr. John Stetson commented about the 60% reduction in use for patients with substance use, but after clients leave they can't be tracked.

Dr. Sherwood stated that longitudinal analysis of substance abuse is needed.

Mr. John Stetson wondered about the issue on client misreporting their issues

Dr. Sherwood stated that there are no measurements of clients' lack of truthfulness.

Ms. Milfay has 20 years of experience with San Francisco's mental health service system and wanted to know why there isn't more coordination with primary care. Clients with severe mental illness have difficulty accessing acute care beds in San Francisco.

Dr. Sherwood stated that with the Affordable Care Act (ACA), care coordination is important to keep clients engaged with primary care providers. Every client will have a care manager.

Ms. Crystal with Westside asked about major barriers in implementing recovery, because she has seen that many clinicians did not believe in recovery but she feels strength assessment is another tool in their toolkit.

ITEM 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke made the following announcements

- We were recently approved to provide Continuing Education Units to RN's and psychologists attending our Trauma Training Series
- Bayview Foot Print newspaper publication September 6, 2013 is in your packet
- Hyde Street Community Service celebration of its 10th Anniversary on October 3, 2013
- The 6th Annual Family Health Fair at the Southeast Community on October 26th, 2013 from 10 am – 2 pm.

5.2 Report from the Chair of the Mental Health Board and the Executive Committee.

Mr. Joseph reminded the board that the 2013 board retreat will be December 7, 2013 although we do not yet have a venue for it.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

Ms. Chien would like to honor the Lyon Martin Transgender Program.

5.4 Report by members of the Board on their activities on behalf of the Board.

Dr. David Elliott Lewis attended two program reviews: Progress Foundation Dore Urgent Care on Monday, August 26th, 2013 and Residential Care on Friday, September 6th, 2013.

He was very impressed with both programs.

Dr. Patterson attended the recent National Asian Political Summit. He also attended the Affordable Care Act conference.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Dr. David Elliott Lewis suggested Behavioral Health Court, the Peer Response Team and the Mental Health Association Hoarding and Cluttering program.

Ms. Virginia Lewis suggested the Night Ministry which has been operating for 50 years. It is the only social service available from 10:00 PM to 3:00 AM, 24/7.

5.6 Public comment.

Mr. Michael Gause, Deputy Director of MHA-SF talked about SB 82, as proposed by California Senator Steinberg to provide a new source of revenue for mental health programs. Peer crisis respite is an evidence based practice, which is going on in Santa Cruz, to provide a safe space for people in acute crisis. He asked the board for support.

A member of the public stated that she attended the Asian Forum and learned about health disparities in the Asian American community.

ITEM 6.0 PUBLIC COMMENT

Ms. Parks thanked the board for helping her when she had an acute psychiatric breakdown.

ADJOURNMENT

Meeting adjourned at 8:34 PM.

Dr. Deborah Sherwood's Powerpoint

CBHS QUALITY MANAGEMENT OVERVIEW

SAN FRANCISCO MENTAL HEALTH BOARD
SEPTEMBER 11, 2013

DEBORAH SHERWOOD, PH.D.

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WHAT DO WE DO?

Measure Client (Adult, Youth & Family) Outcomes

Measure Program Performance

Measure Client Satisfaction

**Use Data to Understand What's Working (Organizational
Learning and Practice Improvement)**

Use Data to Identify Where We Need to Improve

Coordinate Quality Improvement Activities

Ensure Client and Staff Safety (Risk Management)

CLIENT OUTCOMES MEASUREMENT

Clinical and Functional Outcomes:

- **CANS** (Child and Adolescent Needs and Strengths Assessment)
- **ANSA** (Adult Needs and Strengths Assessment)
 - **Behavioral Health Needs:** Psychosis, Depression, Anxiety, Adjustment to Trauma, Impulse Control, Interpersonal Problems, Substance Use
 - **Life Domain Functioning:** Physical/Medical, Family Functioning, Living Skills, Social Functioning, Residential Stability, Employment
 - **Risks:** Danger to Self, Danger to Others, Self-Injurious Behavior, Grave Disability, Exploitation, Criminal Behavior
 - **Strengths:** Optimism, Community Connection, Spiritual/Religious, Involvement in Recovery/Motivation for Treatment
 - **Other:** Cultural Stress, Medication Adherence

MHSA FULL SERVICE PARTNERSHIP “DCR” OUTCOMES

Clients served in Full Service Partnerships (FSPs) receive intensive, recovery oriented services, often accompanied by transitional or permanent housing

Outcomes are measured quarterly and/or at the time of any significant change in:

- Living Situation
- Education
- Employment
- Legal Issues
- Emergency Interventions (medical and psychiatric)
- Presence of Co-occurring Substance Use Disorder
- For older adults, Assessment of Activities of Daily Living and IADLs

MILESTONES OF RECOVERY SCALE (MORS)

A clinician-rating of a client's level of recovery, completed monthly in all Intensive Care Management Programs, Assertive Community Treatment Programs, and Full Service Partnerships.

The MORS is a single rating on an 8-item continuum of

- Risk
- Engagement in Services
- Skills and Supports

Data are used to identify clients who may be ready to move to a higher level of recovery, or to identify clients who may not be improving with their current array of services.

SUBSTANCE USE OUTCOMES - CALOMS

Outcomes measured annually and/or at discharge from services

Last 30 Days:

- Frequency of primary drug use
- Number of drugs used
- Alcohol use
- Binge drinking
- IV drug use
- Primary care emergency room visits
- Reduction in overnight hospital stays (primary care)
- % of clients not in workforce who are in school or job training
- Number of arrests
- Days incarcerated (jail/prison)
- Days of family conflict
- Days of paid work

EVIDENCE-BASED PRACTICES

**Multi-Systemic Therapy (juvenile probation-involved youth
and their families)**

Triple-P Parenting Groups

Seeking Safety Groups

Illness Management and Recovery

PROGRAM PERFORMANCE

Performance Objectives

- Rehospitalization rates
- Clinical and Functional Improvement
- Reduction in Substance Use
- Physical Health Screening
- Timeliness of Documentation (assessments and treatment plans)

PROGRAM PERFORMANCE CONT'D

Chart Audits – Quality of Documentation

Timely Access to Care

- Time from request for services to first appointment
- Time from request for services to first psychiatry appointment
- Time from hospital discharge to first outpatient appointment

Client Satisfaction

Child and Family Engagement Survey

QUALITY IMPROVEMENT

Annual Quality Improvement Workplan

Performance Improvement Projects (PIPs)

- Improving Transitions in Care
- Spreading Wellness and Recovery Practices
- Concurrent Documentation
- Improving Data Quality & Reliability
- Improving Productivity
- Improving Medication Services

Using outcome data to understand and share effective practices

Training program staff to conduct rapid tests of change

CLIENT AND STAFF SAFETY (RISK MANAGEMENT)

Investigate Client Grievances

Review and Respond to Incident Reports from Clinics

**Conduct Critical Incident Reviews (typically client suicides
or homicides)**

Identify System Improvement Needs