SAN FRANCISCO MENTAL HEALTH BOARD

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Adopted Minutes

Mental Health Board
Wednesday, September 17, 2014
City Hall
One Carlton B. Goodlett Place
2nd Floor, Room 278
San Francisco, CA
6:30 PM – 8:30 PM

BOARD MEMBERS PRESENT: Ellis Joseph, MBA, Co-Chair; David Elliott Lewis, PhD, Co-Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Co-Secretary; Terry Bohrer, RN, MSW, CLNC; Andre Moore; Terence Patterson, EdD, ABPP; Harriette Stevens, EdD; and Idell Wilson.

BOARD MEMBERS ON LEAVE: Kara Chien; Vanae Tran, MS; Sgt. Kelly Kruger, and Errol Wishom, Co-Secretary.

BOARD MEMBERS ABSENT:

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of CBHS; Gene Porfido, Tom Waddell Health Clinic Advisory Board; Reuben David Goodman; Toni Parks; Jason Wolfson; Paul Hickman, Family Services Agency; Charles Pontious, Santa Clara County Mental Health Board; Mercedes Crouser; and three additional members of the public.

CALL TO ORDER

Mr. Joseph called the meeting of the Mental Health Board to order at 6:38 PM.

He introduced Charles Pontious from the Santa Clara County Mental Health Board who was visiting our meeting.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

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.

Ms. **Robinson** announced that the first meeting of the Assisted Outpatient (Laura's Law) Care Team met today. The Care Team is composed of members from the Sheriff's department, Police department, City Attorney's office, Public Defender's office, and community behavioral health organizations. Two members of the Mental Health Board are on the Care Team. Dr. David Elliott Lewis represents the Mental Health Board and Ms. Kara Chien represents the Public Defender's office. There will be four more two-hour meetings. Since the Board of Supervisors approved Assisted Out-patient Treatment after the FY 2014-2015 final budget, the implementation will not happen until FY 2015-2016.

Coming out of the Mayor's CARE task force this summer was the peer respite recommendation. San Francisco will offer a hybrid respite model that is composed of both peers and mental health professionals. It is expected that by November 1, 2014, a hybrid peer respite program will be instituted in San Francisco. The facility will be opened for clients/patients to come voluntarily to engage with peers. Additionally, there will be a peer warm line to help people with de-escalation and just to talk with someone.

She announced that from October 7-9 is the Each Mind Matters training event at CCSF Ocean Campus on 50 Phelan Ave in San Francisco at Ram Plaza from 10 am-2 pm.

Ms. Bohrer asked how much money was allocated for the peer respite program.

Ms. Robinson said the peer respite program is well funded by a three-year grant with the amount to be over a million dollars.

1.2 Public Comment

Mr. Goodman wondered how vocational services programs work.

Ms. **Robinson** said the director of the vocational services program will work with programs serving consumers. These programs provide job related training and broaden outreach efforts.

Mr. Hickman is from Family Services Agency (FSA) and commented that he was glad that DPH responded so quickly to implement a peer respite program.

Monthly Director's Report
September2014

1. New Director of Vocational Services Program Manager

We are pleased to welcome Jennie Hua to 1380 Howard who is our new Vocational Services Program Manager. Jennie is coming from the Behavioral Health Center at SF General and has been working as a program manager for 18 years and employed with DPH for over 20 years.

Jennie will be working to enhance and expand the availability of vocational services in both the Adult and Children's System of Care. She will be responsible for planning, coordinating, implementing and evaluating various vocational projects designed to promote the principles of wellness and recovery. Moreover, she will work with a diverse set of stakeholders to support clients to achieve wellness through meaningful activities

such as training, education and employment. One of her primary tasks will be managing the Department of Rehabilitation's Collaborative Contract which includes coordinating a centralized referral process, overseeing the accountability of productivity with providers, and expanding outreach efforts.

Jennie will report to Charlie Mayer, Director of Peer Employment, however, Jennie will report directly to Marlo Simmons, Director of MHSA, while Charlie is out of the office. Jennie will be located in work station 219D. Please welcome her to 1380 Howard.

2. SF Launches Peer-Staffed Phone, Chat Service for Mental Health Support

San Francisco residents seeking emotional support now have access to a free mental health hotline staffed by those who have personal experience with mental health issues.

“Nearly 200 people have called the Mental Health Triage Warm Line since its soft launch Aug. 4”, said Michael Gause, Deputy Director of the nonprofit organization Mental Health Association of San Francisco, which operates the line and is expected to run the service 24 hours a day, seven days a week, by the beginning of next year.

The Warm Line differs from The City's 24-hour Suicide Prevention Hotline and Access Helpline for referrals to mental health services in that it’s staffed by peer counselors who have experienced mental health conditions themselves or among family members. It's the first Warm Line in San Francisco to offer assistance from peers.

"Let's say it's at 10 o'clock at night, and [someone] needs some reassurance, some conversation, a warm voice on the other end to just really listen to them and help them settle down," explained Jo Robinson, director of behavioral health for the Department of Public Health, of how the Warm Line will be used.

"People feel very comfortable talking to someone on the line who may have had a similar experience to them," Gause said.

The Warm Line is operated by the Mental Health Association of San Francisco, and funded by a $1.2 million three-year grant from the state Mental Services Act. It is currently taking calls from noon to 8 p.m., Monday to Friday.

Call if you need help

How to contact the Warm Line and other health resources:

Mental Health Triage Warm Line: (855) 845-7415

Warm Line chat online:

www.mentalhealthsf.org/

Suicide Prevention Hotline: (415) 781-0500

Mental Health Access Helpline: (415) 255-3737

3. 40TH ANNUAL SUICIDE PREVENTION WEEK IS SEPTEMBER 8-14, 2014

EACH MIND MATTERS: CALIFORNIA[1]S MENTAL HEALTH MOVEMENT UNITES CALIFORNIANS IN STATEWIDE SUICIDE PREVENTION MOBILIZATION

Sacramento, CA Each Mind Matters: California[1]s Mental Health Movement is uniting Californians across the state to increase awareness that suicide is preventable and put tools to prevent suicide within reach during the 40th Annual Suicide Prevention Week, September 8th to 14th, 2014.

Each Mind Matters offers Californians the tools to support Suicide Prevention Week throughout the entire month of September:

- Across California, many local communities and county health agencies will host activities that raise awareness about suicide prevention and empower Californians to learn steps they can take to help prevent suicides. **The public can find local events taking place in their communities on the Each Mind Matters Events page (http://www.eachmindmatters.org/events/)**
- EachMindMatters.org will serve as a resource for information on suicide prevention resources that can be used in local communities.
- An online and social media campaign will direct Californians to life-saving resources. Accessing these tools is as easy as following the Each Mind Matters blog and Facebook page.

[3]Suicide Prevention Week is an opportunity to empower every Californian with the knowledge that we are all part of the solution when it comes to preventing suicides,[2] said Maureen Bauman, Director of the Placer County Adult System of Care and Board President of the California Mental Health Services Authority (CalMHSA), which oversees the implementation of Each Mind Matters. [3]Through Each Mind Matters, California counties are partnering to make available the resources Californians need to learn the signs of suicide and take action to get help for themselves, a friend or a loved one in crisis.[2]

Since the passage of the Mental Health Services Act (Proposition 63), a landmark initiative passed by voters in 2004, California has made a significant investment in programs that are intended to prevent suicides, prevent mental illness, promote mental wellness and connect individuals with help before they reach a crisis point. Counties have partnered through CalMHSA to utilize Proposition 63 funding to implement statewide efforts that improve the mental health of Californians with strategies that empower everyone from youth to seniors, with the tools, technologies, resources and crisis support needed to prevent suicide.

Through CalMHSA[1]s efforts,

- Nearly 3,000 Californians have been trained in suicide crisis intervention skills that save lives.
- Ten suicide prevention hotlines across California are answering nearly 23,000 calls per month on average and have been expanded to meet the diverse language needs of Californians.

- Crisis support is now available in some areas through chat or texting, making these resources more available to young people.
- The statewide suicide prevention campaign, Know the Signs (www.suicideispreventable.org), has engaged nearly a half million Californians online, empowering them with information to know the warning signs of suicide, find the words to offer help to someone, and reach out to local resources such as crisis hotlines and support groups that can provide care. Research has found that the Know the Signs campaign has been effective in increasing confidence to intervene and talk with someone who is at risk for suicide.

Suicide Prevention Week comes this year as the world mourns for the loss of Robin Williams. Californians are responding to his death by reaching out to provide care to others and receive support for themselves. In fact, in the weeks following the death of Robin Williams, visits to the Know the Signs campaign website increased ten-fold, and calls to various suicide prevention crisis hotlines significantly increased.

If you or someone you know is having thoughts of suicide, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). The National Suicide Prevention Lifeline can connect you to a trained crisis counselor at your nearest crisis center, 24 hours a day, 7 days a week.

For more information on the suicide prevention efforts underway in California and to get involved, visit www.eachmindmatters.org, www.suicideispreventable.org, www.elsuicidioesprevenible.org

4. Children, Youth and Families (CYF)

CYF Leadership Team met in July to establish 14/15 priorities. Key to the leadership meeting was the intentional process of looking at and integrating the Trauma Informed Systems Principals into our priorities. Leadership utilizing staff feedback chose to focus our work on safety and stability and collaboration and empowerment. These two principles encompassed our intention to improve the way in which we do the work and the way in which we engage our children, youth and families in treatment. Examples of our plan include rolling out a new risk and PURQC process designed to identify areas that clients are challenged and to better support clinical staff with consultation and guidance regarding clinical issues. The full System of Care group including our providers decided to focus on sharing best practices for child, youth and family engagement, clinical supervision and group treatment.

Sadly, July, August and the beginning of September were witness to violence and impacted children and families directly. CYF, Comprehensive Crisis together with CBO partners and city agencies have been collaborating to provide support, coordination, treatment and debriefing for impacted staff and families. We hope to learn from this response so we can better attend to children, youth and families that tragically experience violence and work towards preventing more episodes. Similarly, the city has responded to the humanitarian crisis that has been termed “unaccompanied youth”. Director Garcia asked CYF to take a leadership role in helping coordinate the San Francisco response to youth and families entering the city escaping trauma and violence in their native country and enduring a treacherous and traumatic journey to our city. Max Rocha and Roban San Miguel have been leading the CYF effort.

a) LEGACY (Formerly CSOC)

August has been all about assisting children and families prepare for the upcoming school year. At our August Family Support Night we gave away backpacks, school supplies and uniform shirts to our families. Our speaker for that evening was a representative from SFUSD's Pupil Services who discussed the district's efforts in partnering with parents to respond to conflicts.

LEGACY's Peer Mentorship Program is continuing to look for new mentees. We are looking for youth between the ages 12-17 who are active CBHS consumers, in need of support with achieving mental wellness, identifying and accomplishing goals, and sustaining a positive, healthy lifestyle. For more information on the referral process, please contact: Bonnie Friedman, LCSW, L.E.G.A.C.Y Program Director, Phone: 415-920-7700 or email: bonnie.friedman@sfdph.org

b) Foster Care Mental Health

The FCMH team is averaging approximately 55 new referrals for CANS screening a month! We are very busy providing screening and assessment and direct services, while, at the same time building an Attachment Based, Trauma Informed, Care Coordination Model. We are so pleased to welcome Dr. Ray Cendana and Dr. Karen Finch, our new, Spanish speaking child psychiatrists. Dr. Cendana will be providing psychiatric evaluation and services two days/week at FCMH. Dr. Finch will join our team as a full time child psychiatrist. In addition, FCMH has posted an open, full time 2974, clinical psychologist position. In early September, the FCMH Director will be conducting two SFUSD workshops during the SFUSD CBO Orientation which will focus on the DPH Trauma Informed System of Care Principles. This is an opportunity to continue to create shared language between county systems and departments who serve our children and families.

c) Intensive Services

The Edgewood Crisis Stabilization Unit has opened and is receiving youth for 23-hour crisis stabilization to avoid hospitalizations. They have been successful in diverting most clients from psychiatric hospitalization.

d) Child-Parent Psychotherapy Learning Collaborative

We are pleased to announce that 17 participants from our CYF System of Care will be taking part in an upcoming Child-Parent Psychotherapy Learning Collaborative through San Francisco's Child Trauma Research Project and UCSF. This is an incredible opportunity granted us by Alicia Lieberman, internationally renowned co-developer of the Child-Parent Psychotherapy (CPP) model. CPP is an evidence-based practice that is a relationship-based form of intervention that focuses on the child-parent interaction and on each partner's perceptions of the other. It is an intervention for children from birth through age 5 who have experienced at least one traumatic event (e.g., maltreatment, the sudden death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including PTSD. The Learning Collaborative is an 18-month training program that incorporates seminars, bi-weekly consultations, case presentations, and required readings, and it consists of dozens of clinicians from across the country. Among our 17 participants in this cohort, 15 of them are clinicians or clinical supervisors from Chinatown Child Development Center, Foster Care Mental Health

Program, Family Mosaic Project, Instituto Familiar de la Raza, and RAMS/Fu Yau Project. The remaining two participants will be system of care program managers, Chris Lovoy and Rhea Bailey, who will work with the cohort on systems issues related to treatment implementation and practice sustainability. We are excited at this opportunity to bring CPP into our CYF system of care on such a large scale, and we want to thank the members of our cohort for committing to the 18-month long journey.

e) Mission Family Center

Mission Family Center held its annual retreat during the month of August at Coyote Point. The staff generated an amazing number of ideas as we navigate our way into the next phase of behavioral health care under the Affordable Care Act. During the next few months, we will review the retreat notes and go through a participatory decision making process to prioritize the action items we want to implement over the next two to three years. It was definitely an eventful day. In addition, as August was back to school month, we also saw an increase in the number of referrals as families get acclimated to the new school year. We are gearing up for these new referrals!

5. Changes in CBHS Clinic Medication Room Policy

CBHS is in the process of revising its Clinic Medication Room Policy. In June 2014, Short-Doyle/Medi-Cal released a new protocol applicable to all CBHS and CBHS affiliated clinics that store or maintain medications onsite. The protocol included significant changes to requirements for medication rooms. Additionally, changes to the current policy were needed to comply with the Centers for Medicare and Medicaid Services Preventing Fraud/Waste/Abuse Guidelines, and to provide explicit guidance to meet CA Board of Pharmacy regulations based on findings from Medi-Cal mental health certification/re-certification of medication rooms and occurrence reports related to medications.

Changes to the policy affect every section of the policy. The most significant changes for CBHS pharmacy and CBHS clinics are for receiving medications, handling of clients' own medications and floor stock medications. In order to comply with CA board of pharmacy regulations, clinics will chronologically document the chain of custody of medications- receipt, dispense, administration and/or disposal of every medication. Clinics will now be required to keep detailed logs of medication deliveries from pharmacies and of medications dispensed from floor stock to clients. To comply with federal fraud, waste and/or abuse guidelines, the policy specifies that clinics may not store more than a 6-week supply of clients' medications and that automatic refills may not be utilized. Compliance to the new policy will be the responsibility of all clinic staff, and leadership will be shared by the clinic Medical Director and Program Director. Leadership will designate one staff member to coordinate medication room activities. This staff member will complete a quarterly audit of the medication room and will review the results of the audit with the Medical Director.

The plan for implementation of this new Medication Room Policy is as follows:

1. Presented to CBHS Executive and Contractors Association: August 26th, 2014
2. Presented to CBHS Medical Directors' Meeting: August 27th, 2014
3. Provide training sessions for clinic medical directors, program managers and medical staff:
   a. September 24th, 2014- 9:30am-10:30am at 1380 Howard Street, 4th floor conference room
   b. September 24th, 2014- 10:30am-11:30am at 1380 Howard Street, 4th floor conference room
4. Individual clinic consultations: September-October 2014
5. Request MUIC approval: November 6, 2014
6. Request CBHS Executive approval: November 18th, 2014
7. Policy distribution: November-December 2014

6. Each Mind Matters! City College Outreach Event

The Community Mental Health Certificate, Project SAFE, and the Student Health Center at City College of San Francisco have partnered with Each Mind Matters to offer three days of information regarding Early Intervention, Suicide Prevention, Stigma Elimination, and Peer Education on multiple health issues.

The event will take place at the CCSF Ocean Campus 50 Phelan Ave in San Francisco at Ram Plaza from 10am-2pm on Tuesday, Wednesday, Thursday, October 7, 8,9. (Tues, Wed, Thurs)

Please feel free to visit or stop by for information and resources. Free to the public.

7. *Disability Rights California (DRC) Releases New Mental Health Resource For Law Enforcement Officials*

Because law enforcement is often the first responder when a person is experiencing a mental health crisis, DRC has released a policy paper with recommendations called "An Ounce of Prevention: Law Enforcement Training and Mental Health Crisis Intervention," to ensure this first point of contact is beneficial to all involved. Contact: Margaret Jakobson-Johnson at Margaret.Jakobson@disabilityrightsca.org *or (916) 504-5937.*

***8.* CalMHSA Brings International Stigma Conference to California, Seeks Presentation Proposals**

"Together Against Stigma: Each Mind Matters" is the 7th International Conference on Stigma Research, Policy and Practice and will be held in San Francisco February 18th – 20th, 2015. It is being hosted by California Mental Health Services Authority (CalMHSA), the California Institute for Behavioral Health Solutions (CIBHS), and the World Psychiatric Association (WPA). The international character of this conference underscores the fact that stigma is not exclusive to any one country or culture: it is pervasive, encountered at all levels of society, institutions, among families and within the healthcare profession itself. This conference will be the first to be hosted in the United States.

Confirmed keynote speakers include world renowned experts in stigma and discrimination research, media and journalism, and youth leadership which include

Graham Thornicroft, Professor of Psychiatry and Chair of the WPA Scientific Section on Stigma and Mental Health, Patrick Corrigan, Professor of Psychology and Principal Investigator at the National Consortium for Stigma and Empowerment, Sergio Aguilar-Gaxiola, Professor of Clinical Internal Medicine and Founding Director of the UC Davis Center for Reducing Health Disparities, former U.S. Senator Gordon H. Smith and current President and CEO of the National Broadcasters Association, and Executive Director and founder of Active Minds, Alison Malmon. Please consider submitting a presentation proposal (Due September 26th, 2014). Early registration closes November 14, 2014. Contact: Amanda Lipp at. ?

9. DEA Releases New Rules That Create Convenient But Safe and Secure Prescription Drug Disposal Options

SEP 08 (WASHINGTON) - Today the U. S. Drug Enforcement Administration's (DEA's) Final Rule for the Disposal of Controlled Substances, which implements the Secure and Responsible Drug Disposal Act of 2010, was made available online for preview by the *Federal Register* at https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-20926.pdf. The Act, in an effort to curtail the prescription drug abuse epidemic, authorized DEA to develop and implement regulations that outline methods to transfer unused or unwanted pharmaceutical controlled substances to authorized collectors for the purpose of disposal. The Act also permits long-term-care facilities to do the same on behalf of residents or former residents of their facilities. The Final Rule will be officially published tomorrow and will take effect on October 9.

"These new regulations will expand the public's options to safely and responsibly dispose of unused or unwanted medications," said DEA Administrator Leonhart. "The new rules will allow for around-the-clock, simple solutions to this ongoing problem. Now everyone can easily play a part in reducing the availability of these potentially dangerous drugs."

Prior to the passage of the Act, the Controlled Substances Act made no legal provisions for patients to rid themselves of unwanted pharmaceutical controlled substances except to give them to law enforcement, and banned pharmacies, doctors' offices, and hospitals from accepting them. Most people flushed their unused drugs down the toilet, threw them in the trash, or kept them in the household medicine cabinet.

Unused medications in homes create a public health and safety concern, because they are highly susceptible to accidental ingestion, theft, misuse, and abuse. Almost twice as many Americans (6.8 million) currently abuse pharmaceutical controlled substances than the number of those using cocaine, hallucinogens, heroin, and inhalants *combined*, according to the 2012 National Survey on Drug Use and Health. Nearly 110 Americans die every day from drug-related overdoses, and about half of those overdoses are related to opioids, a class of drug that includes prescription painkillers and heroin. More than two-thirds (70 percent) of people who misuse prescription painkillers for the

first time report obtaining the drugs from friends or relatives, including from the home medicine cabinet.

As a temporary measure, DEA began hosting National Prescription Drug Take-Back events in September 2010. Since then, the DEA has sponsored eight take-back days. Enormous public participation in those events resulted in the collection of more than 4.1 million pounds (over 2,100 tons) of medication at over 6,000 sites manned by law enforcement partners throughout all 50 states, the District of Columbia, and several U.S. territories.

"Every day, I hear from another parent who has tragically lost a son or daughter to an opioid overdose. No words can lessen their pain," said Michael Botticelli, Acting Director of National Drug Control Policy. "But we can take decisive action, like the one we're announcing today, to prevent more lives from being cut short far too soon. We know that if we remove unused painkillers from the home, we can prevent misuse and dependence from ever taking hold. These regulations will create critical new avenues for addictive prescription drugs to leave the home and be disposed of in a safe, environmentally friendly way."

On September 27, the DEA holds its next Take-Back Day. The public may visit www.dea.gov or call 1-800-882-9539 in September to find a nearby collection site. At this time, DEA has no plans to sponsor more nationwide Take-Back Days in order to give authorized collectors the opportunity to provide this valuable service to their communities.

DEA's goal in implementing the Act is to expand the options available to safely and securely dispose of potentially dangerous prescription medications on a routine basis.

- The Final Rule authorizes certain DEA registrants (manufacturers, distributors, reverse distributors, narcotic treatment programs, retail pharmacies, and hospitals/clinics with an on-site pharmacy) to modify their registration with the DEA to become authorized collectors.
- All collectors may operate a collection receptacle at their registered location, and collectors with an on-site means of destruction may operate a mail-back program.
- Retail pharmacies and hospitals/clinics with an on-site pharmacy may operate collection receptacles at long-term care facilities.
- The public may find authorized collectors in their communities by calling the DEA Office of Diversion Control's Registration Call Center at 1-800-882-9539.
- Law enforcement continues to have autonomy with respect to how they collect pharmaceutical controlled substances from ultimate users, including holding take-back events. Any person or entity—DEA registrant or non-registrant—may partner with law enforcement to conduct take-back events.
- Patients also may continue to utilize the guidelines for the disposal of pharmaceutical controlled substances listed by the Food and Drug Administration on their website at http://www.fda.gov/downloads/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingOver-the-CounterMedicines/ucm107163.pdf.
- Any method of disposal that was valid prior to these new regulations being implemented continues to be valid.

Tomorrow when the Final Rule is officially published in the *Federal Register*, it will be viewable at www.regulations.gov. It will also be available for viewing tomorrow on the DEA website at http://www.deadiversion.usdoj.gov.

10. CMS Approves State Plan Amendments Related to SUD Services Expansion

The Centers for Medicare and Medicaid Services (CMS) approved both state plan amendments (SPAs) necessary for California to implement the expansion of substance use disorder services as part of the Medi-Cal expansion. An approved copy of SPA 09-022 to update the rate setting and reimbursement methodologies for Drug Medi-Cal services in now posted to the DHCS website. The effective date of this SPA is July 1, 2009. CBHDA received word just this week that SPA 13-038 has also been approved. SPA 13-038 outlines the additional benefits to be provided under the Drug Medi-Cal program as part of the ACA implementation. This SPA should be effective January 1, 2014. DHCS has indicated that they are working to develop a notice to counties announcing the approval that they hope to disseminate shortly.

11. Blurb on Health Equity Leadership Institute Initiative – San Francisco

In April 2013 the California Institute for Mental Health (CiMH) – now known as California Institute for Behavioral Health Solutions (CIBHS) -- launched their inaugural pilot project of the Health Equity Leadership Institute (HELI), and San Francisco's Department of Public Health (SFDPH) was one of four California counties who participated in this year-long work. The aim of HELI was to support the development of leadership skills of community members and county staff in achieving health equity, reducing disparities and enhancing public behavioral health systems' capacity to track and eliminate disparities at the local level.

From May 2013 through May 2014, the HELI San Francisco team – comprised of two faith-based community leaders, one TAY [Transitional Age Youth] woman, one community leader in mental health support, one retired educator and three SF Department of Public Health staff -- developed an initiative that focused on the social and economic determinants and discrimination that prohibited the African American community of San Francisco's District 10 (Bayview, Hunters Point, Potrero Hill, Visitacion Valley) from experiencing health equity. Pastor Shad Riddick (Metropolitan Baptist Church) and Pastor Andrew Smith, Sr. (Little Bethany Baptist Church) were catalytic in the SFDPH's understanding that employment is a key vehicle in which community members can work toward experiencing health equity (e.g. being employed means having an income to pay for housing, healthy food and health insurance). In its fullest development the HELI SF initiative was the connection of church-based programming (that helps individuals and families with basic needs such as food and clothing) with workforce development and job placement organizations in District 10. To date, this initiative has helped (15) individuals to receive employment readiness skills and/or job placement assistance.

12. California Department of Health Care Services (we have received unofficial notice)

The California Department of Health Care Services has received approval from the federal Centers for Medicare and Medicaid Services (CMS) of their State Plan Amendment that expands MediCal services and eligibility under implementation of the Affordable Care Act (ACA).

This milestone affirms that clients newly eligible for MediCal under ACA will have their care covered 100% by federal funding as of 1/1/2014. Expanded services (such as intensive outpatient substance abuse treatment) will also be covered for all MediCal eligible clients. San Francisco has participated actively in the design of services and systems for the implementation of ACA in California, and will continue to work closely with all providers and clients as these benefits become more widely accessible throughout the county.

We will forward the official notice from DHCS about this initiative as soon as it is available.

11. QM's Dr. Tom Bleecker to Moderate National Conference Session on ANSA

The 10th annual CANS/TCOM* Conference is in Chicago Nov 12-14. The conference usually focuses mostly on the CANS (Child and Adolescent Needs and Strengths), as it is very widely used. This year, Dr. John Lyons, the developer of both the CANS and ANSA (Adult Needs and Strengths Assessment) wanted to make a concerted effort to have more ANSA related activities.

To help accomplish this, Dr. Lyons invited Dr. Tom Bleecker from our Quality Management office to moderate an afternoon session focusing exclusively on the ANSA. Dr. Bleecker has been leading the CBHS Adult/Older Adult System of Care's efforts around the implementation and ongoing use of the ANSA. We're very pleased that Dr. Bleecker is able to help other systems around the country work with the ANSA by sharing the progress we have made and the challenges we have faced.

Total Clinical Outcomes Management*

Tell us your clinic story and we will add it to the upcoming Director's Reports.

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 vita.ogans@sfdph.org

ITEM 2.0 MENTAL HEALTH SERVICE ACT ANNUAL 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 Annual Update: Public Hearing

Ms. **Robinson** commented that the three year MHSA plan was submitted to the Health Commission and was very well received. Furthermore, adding to the mix of the new health commissioner team was a psychiatrist, Dr. David Pating, who has a specialty in treating substance abuse. He also serves on the state MHSA Oversight and Accountability Commission.

Ms. Wilson asked about funding allocation under MHSA.

Ms. Robinson said the details of MHSA funding allocation are available on the DPH website.

2.2 Public comment

No public comments.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

No public comments.

3.2 PROPOSED RESOLUTION Be it resolved that the minutes for the Mental Health Board meeting of July 16, 2014 be approved as submitted

Unanimously approved

ITEM 4.0 PRESENTATION: PSYCHIATRIC EMERGENCY TO A BED IN THE COMMUNITY; HOW DOES IT WORK? JOHN ROUSE, MD, DEPARTMENT OF PSYCHIATRY, PSYCHIATRIC EMERGENCY SERVICES, SAN FRANCISCO GENERAL HOSPITAL AND KELLY HIRAMOTO, DIRECTOR OF PLACEMENT, BEHAVIORAL HEALTH SERVICES, DEPARTMENT OF PUBLIC HEALTH.

4.1 Presentation: Psychiatric Emergency to a Bed in the Community; How does it Work? John Rouse, MD, Department of Psychiatry, Psychiatric Emergency Services, San Francisco General Hospital and Kelly Hiramoto, Director of Placement, Behavioral Health Services, Department of Public Health.

Mr. Joseph welcomed Kelly Hiramoto, Director of Placement for Community Behavioral Health Services and Dr. John Rouse, Psychiatric Emergency Services at San Francisco General Hospital.

The power point presentation is available at the end of the minutes

Ms. Hiramoto provided a brief overview of community placement, and stressed that the department is no longer called the bed committee, but, a division of public health. In essence, community placement provides housing transitions. A coordinating placement team works together to stabilize frequent users of the system in the most appropriate and in the least restrictive environments.

The team oversees the Mental Health Rehabilitation Center (MHRC) and 400 beds in residential care programs in San Francisco; 200 beds in residential care programs outside of San Francisco; 240 locked sub-acute treatment beds and the skilled nursing facility.

Ms. **Virginia Lewis** asked about contract hotels in the system's bed portfolio.

Ms. Hiramoto said a vital part of San Francisco's housing stock is subsidized placement in single room occupancy hotels (SROs) or "residential hotels" for stabilization. Currently, the system utilizes four residential hotels called Belvedere, Mission, Adrian and Crystal.

For clients/patients with mental illness, MHSA also subsidizes room costs for full service partnership clients. It is an aggregate of about 50-60 residential homes.

Dr. Patterson wanted to know about various locations for clients/patients in need of community placement.

Ms. Hiramoto said most stabilization beds are distributed throughout the City with some out-of-county beds.

Ms. Bohrer wanted to know under what circumstances a client get discharged to a homeless shelter.

Ms. Hiramoto explained that after a client/patient achieves stabilization, she/he can voluntarily decline community placement and be discharged to a homeless shelter, if no family members are available to help out.

Ms. Bohrer inquired about respite bed housing stock.

Ms. Hiramoto said only 6-8 respite beds are available.

Ms. James asked if a client/patient initially refused community placement but then decided to re-engage back into the system.

Ms. Hiramoto said there is usually an offer for case management to provide linkage for re-engagement in placement.

Ms. Lewis wanted to know about the housing stock of stabilizations rooms in SRO units

Ms. Hiramoto said there are about 20-30 stabilization rooms in various SRO units and residential hotels. Once clients/patients are stabilized enough, they go into a treatment program.

Unfortunately, affordable housing is a major barrier. It used to be that an SSI check could be "stretched" enough to pay for an SRO room, now that is no longer true due to San Francisco housing scarcity and high rents..

Dr. David Elliott Lewis wanted to know why there is a declining trend of board and care operators in the City.

Ms. Hiramoto said owners and operators of board and care are licensed by the State of California. The decline in board and care operators is partly due to lack of acceptance for clients with mental health, since many board and care places are not set up to accommodate such clients.

Another part of declining housing stock is San Francisco's real estate is becoming too valuable for heirs to continue the board and care program after original founding owners expired.

Ms. James asked about what constitutes elderly status.

Ms. Hiramoto said the elderly are at least 60 years of age and adults are 18-59 years of age.

Ms. Lewis wanted to know more about what happens with placement refusal after initial stabilization.

Ms. Hiramoto said when people dis-engage a placement, many, unfortunately, end up in PES because some people with mental health illness have an overlay of substance abuse.

Ms. Stevens asked about Lanternman Petris Short (LPS) conservatorships.

Ms. Hiramoto said LPS conservatorship is client only. However, family can weigh in, but they cannot over ride LPS regulations. Usually, LPS is for persons with severe mental disorders or with impaired chronic alcoholism.

Mr. **Joseph** asked about conservatorship on finance.

Ms. Hiramoto said finance conservatorship is usually dictated by an advanced healthcare directive.

Ms. **Virginia Lewis** commented that San Francisco NAMI includes in its training an advanced medical directive that a person with mental illness can prepare.

Ms. **James** added that in NAMI trainings, it encourages clients to have three copies of the directive: one for the doctor, one for a family member and one on the person.

Dr. Rouse has worked in psychiatric emergency for 35 years. He provides client-centered treatment in Psychiatric Emergency Services (PES) at San Francisco General Hospital (SFGH). PES operates 24x7 and is the primary provider of adult emergency mental health care in the City and County of San Francisco. Clients/patients served in PES are often dually diagnosed, usually with a major psychiatric disorder as well as addiction-related issues.

5150 cases are brought in by police, case managers, friends, relatives and board and care operators. Approximately 5% are voluntary walk-in patients seeking crisis stabilization.

For example, when a person with acute psychosis brought in by the police under 5150, PES does a complete medical and psychiatric assessment and evaluation, and initial treatment, if appropriate.

The staff, including clinicians work closely with a number of community agencies to develop short and long-term treatment plans. PES triages people with serious psychiatric illness, and about 20% are admitted into in-

patient units in 7B. For the other 80%, PES refers people with less serious psychiatric to DORE Urgent Care or Westside Community Services.

SFGH has different psychiatric units. 7A is closed at the moment. 7B has about 20 acute psychiatric beds and 20 step-down beds for non-conserved clients/patients. 7C is a locked down sub-acute care facility with 41 beds. 7L is an incarcerated unit (or jail unit) for patients/clients with acute psychosis and in police custody. If they get stabilized they go back to jail with follow up care by Jail Psychiatric Services (JPS).

He said recent a MediCal audit found that not enough people are really qualified for acute status. The audit questioned medical necessity and wondered why a person with psychosis could not be treated at a lower level of care. PES weekly meetings involve a transition team to discuss the status of all clients/patient with psychosis.

Dr. **Patterson** asked if people who come directly into PES automatically get assigned to a case manager and directly get connected to services.

Dr. Rouse said PES always does an assessment first. Linkage to case management is not always a necessity due to the patients/clients diagnosis.

Dr. **David Elliott Lewis** asked about why no new psychiatric beds are being added in the building of a new hospital and wondered if the current beds are enough for San Francisco.

Dr. Rouse said he believes that the actual number of acute psychiatric beds currently available could handle the current capacity, provided that there are other beds available after a patient/client stabilized and get discharged from PES.

Ms. **Bohrer** asked if funding for the HOT team (Homeless Outreach Team) was pared down drastically.

Ms. Hiramoto said the contract for homeless services were changed to another organization. But supplemental funds, now, are available to expand services for the HOT team to re-hire back social workers and staff with CAADAC license. The goal is for the HOT team to reach full capacity as before.

Ms. **Virginia Lewis** wondered about the sub-acute designation for people in dire need for psychiatric services.

Dr. Rouse said PES interprets sub-acute designation according to the state mandate. But, an ADU is an Acute Diversion Unit that can do most of what PES can do. This extra service ensures a person in need of help gets services even though the sub-acute designation may not be applicable to that person.

Ms. Robinson added that CBHS has a full spectrum of services to offer people in desperate need of services.

Dr. **David Elliott Lewis** asked if the dropping of almost 50% to 24 psychiatric beds causes any noticeable delays in care.

Ms. Hiramoto said that a person with the least restrictive care should be able to obtain wellness and recovery in the supportive community rather than at costly psychiatric beds at SFGH where they are reserved for patients with the most restrictive care.

4.2 Public Comment

Mr. Ruben David Goodman thanked Ms. Hiramoto and commented that he felt his residential care facility called Buena Vista Manor House has deprived him of healthy sustenance.

He is 63 years of age and shared that he is sober for 4 years and 7 months from being a 20 year crack cocaine addict. He would like her intervention to mediate for his housing stability because the Manor manager started the eviction process after he asserted his rights.

Ms. Hiramoto said she will follow up on his complaint.

Mr. **Porfido** said he personally feels the people who need help the most often fail to get into treatment soon enough. He wanted to know what his options are to help people in need without resorting to calling the police.

Dr. **Rouse** suggested calling the Mobile Crisis Team which does do assessment including 5150s, if warranted.

Mr. **Hickman** works at Family Service Agency (FSA) and commented that the community placement team is a great help

ITEM 5.0 REPORTS

For discussion

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

Ms. **Brooke** reminded the board about the following:

- October 10, 2014 is Suicide Prevention lunch at the City Club.
- October 14, 2014 is Statewide Video Conference on reducing poverty and hunger
- October 24, 2014 is Northern California Suicide Prevention Summit at Samuel Merritt University.

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

The next meeting of the Executive Committee is tomorrow, Thursday, September 18, 2014 at 10:30 AM in Room 424 at 1380 Howard Street.

Mr. **Joseph** said that at the last Executive Committee meeting, the committee decided to form a committee to plan the board retreat for Saturday, December 6th. Dr. Terence Patterson is the Chair.

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.

None mentioned.

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

Ms. **Bohrer** said she attended Mental Health America's 2014 Annual Conference in Atlanta, Georgia.

Mental Health America is dedicated to promoting mental health, preventing mental and substance use conditions and achieving victory over mental illnesses and addictions through advocacy, education, research and service.

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

Ms. **Bohrer** suggested a presentation from Network of Care which provides assistance to veterans and which develops a resource location app to help people locate mental health resources in San Francisco.

Dr. **David Elliott Lewis** suggested a presentation from Terry Bohrer on Mental Health America's 2014 Annual Conference. He also volunteered to do a presentation on AOT Implementation.

5.6 Public comment.

No comments were made.

ITEM 6.0 PUBLIC COMMENTS

No comments were made.

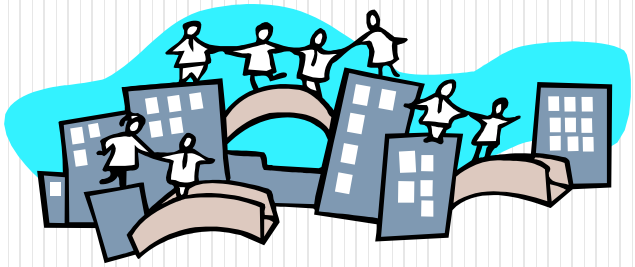
ADJOURNMENT

Meeting adjourned at 8:45 PM.

Ms. Kelly Hiramoto presentation

Community Placement

San Francisco Health Network



Presented by: Kelly Hiramoto, LCSW, Director of Transitions
September 17, 2014

Not the Bed Committee!

Goal of Placement

The goal of the Placement division is to ensure clients are stabilized in the *most appropriate*, least restrictive setting in the most cost effective manner

Who We Are

City and County of San Francisco - Department of Public Health
Placement

SF Health Network

- SF General Hospital
- Laguna Honda Hospital
- Managed Care
- Ambulatory Care

Transitions Director

Kelly Hiramoto, LCSW

Placement

Elayne Hada
Coordinator

Population Health & Prevention

- Community Health & Epi
- STD Prevention
- Emergency Med Services
- TB Control
- Public Health Lab
- Environ Health/Safety
- HIV Research
- HIV Epidemiology
- Health Promo & Prevention
- HIV Prevention

David Sickles

Operations

Valerie Lai

Christina Castro

Marilou Panganiban

Gary Scherer

Hotels/ Stabilization

Harriet Lem

SFGH Psychiatry/ IMD/NB SNF

Lesley Head

Stacey Johnson

Joseph Steward

RCF/Residential Treatment/Jail/ Community Hospitals

Perrie Ancheta

Joe Harris

Annie Shui, MFT

Sharon Singletary

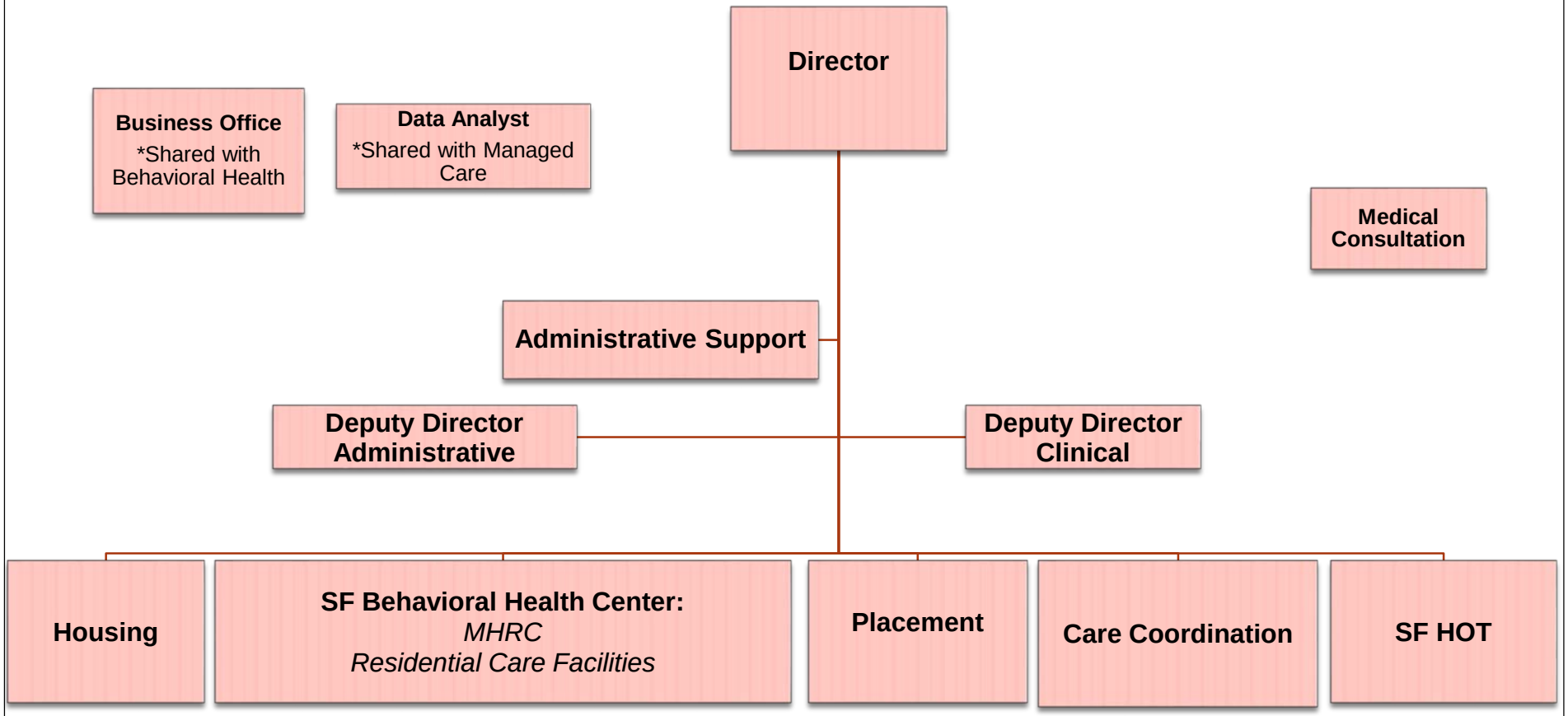
Sana Noble

Adam Udlis (also covers IMD)

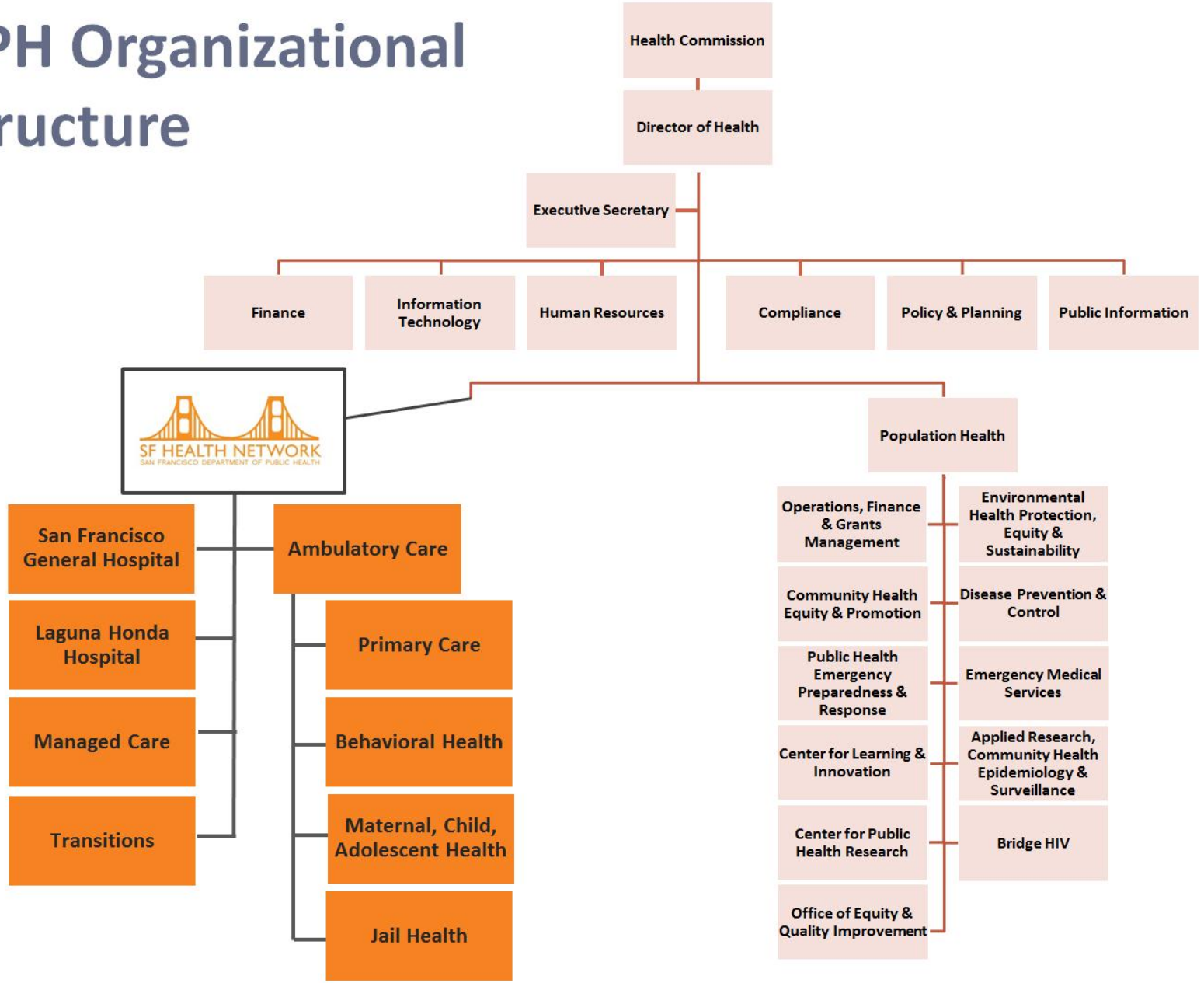
Claire Whaley (also covers IMD)

Rev 02/23/14 Effective date: 02/23/14

SFDPH Transitions Division



DPH Organizational Structure



How It Works

The Lingo

- ADU: Acute Diversion Unit
- LSAT: Locked Sub Acute Treatment
- “L”: Locked setting
- IMD: Institute for Mental Disease
- MHRC: Mental Health Rehabilitation Center
- RCF/E: Residential Care Facility/for Elderly

  (also referred to as “Board and Care”)
- TCM: Targeted Case Management
- LTC: Long Term Care = IMD/MHRC, RCF/E, SNF
- SNF: Skilled Nursing Facility

Identifying Appropriate Referrals

- Low/No income
- Treatment Ready & Willing if not Conserved
- Conserved clients who are Low/No income
- In need of subsidized placement to leave the hospital
- Complex discharges

Where We Do It

- Acute Psychiatric and Medical Units at SFGH and Community Hospitals
- Acute Diversion Units, Residential Treatment (Mental Health, Substance Use and Dual Diagnoses), Transitional Residential
- Residential Care Facilities (Board & Care)
- Locked settings: IMD/MHRC/Neurobehavioral SNF
- Laguna Honda Hospital
- Community Settings
- Jail
- Emergency Departments: Psychiatric & Medical
- State Hospitals

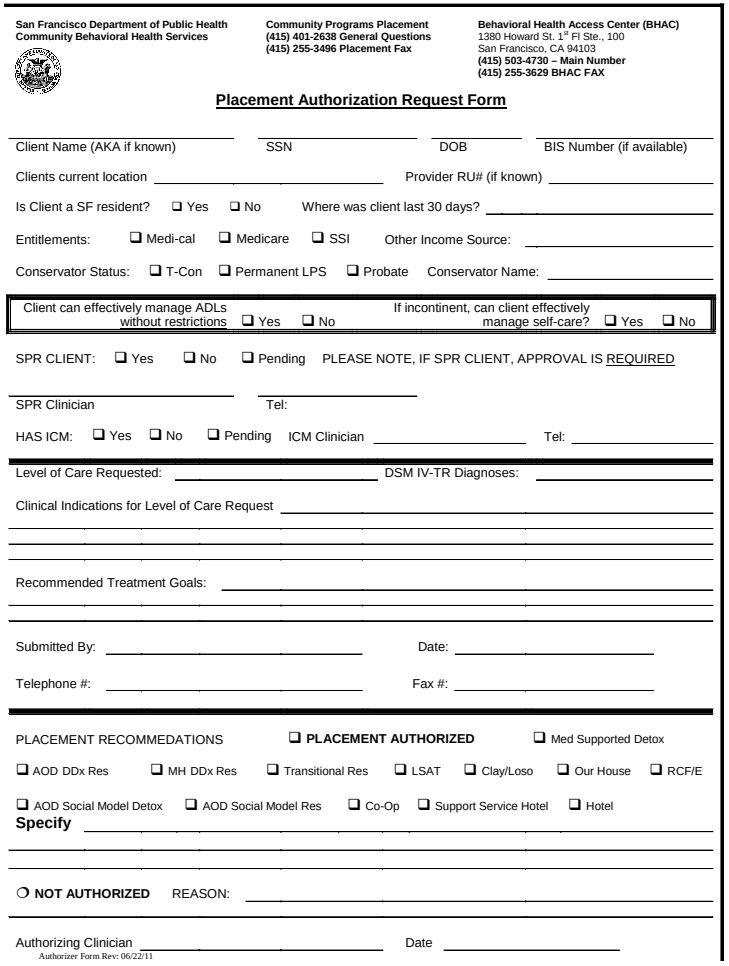
Collaborations

- Baker, Conard, Progress Foundation, HealthRight360
- Canyon Manor
- Crestwood Behavioral Health Services: converted beds in 2 facilities from IMD level of care to Residential Care; established Dialectical Behavioral Therapy in every facility
- Community Behavioral Health Services to link to Care Management and Primary/Behavioral Health Care
- Behavioral Health Access Center: Treatment Access Program
- Jail Re-Entry Services
- Direct Access to Housing

Levels of Care

- Treatment
- Shelter
- Hotel *aka SRO, Stabilization Room*
- Support Service Hotels
- Co-operative Housing
- Direct Access to Housing and Shelter + Care
- Residential Care *aka "Board & Care"*
  - *RCF/ARF: 18 y.o. – 59 y.o.*
  - *RCFE: 60 y.o. and older*
- MHRC/IMD/LSAT
- Neuro-Behavioral SNF
  - *Chronic Inebriate Program*
- Medical SNF
- State Hospital

Placement Authorization Referral



San Francisco Department of Public Health
Community Behavioral Health Services

Community Programs Placement
(415) 401-2638 General Questions
(415) 255-3496 Placement Fax

Behavioral Health Access Center (BHAC)
1380 Howard St. 1st Fl Ste., 100
San Francisco, CA 94103
(415) 503-4730 – Main Number
(415) 255-3629 BHAC FAX

Placement Authorization Request Form

Client Name (AKA if known) _____ SSN _____ DOB _____ BIS Number (if available) _____

Clients current location _____ Provider RU# (if known) _____

Is Client a SF resident? ❑ Yes ❑ No Where was client last 30 days? _____

Entitlements: ❑ Medi-cal ❑ Medicare ❑ SSI Other Income Source: _____

Conservator Status: ❑ T-Con ❑ Permanent LPS ❑ Probate Conservator Name: _____

Client can effectively manage ADLs without restrictions ❑ Yes ❑ No If incontinent, can client effectively manage self-care? ❑ Yes ❑ No

SPR CLIENT: ❑ Yes ❑ No ❑ Pending PLEASE NOTE, IF SPR CLIENT, APPROVAL IS REQUIRED

SPR Clinician _____ Tel: _____

HAS ICM: ❑ Yes ❑ No ❑ Pending ICM Clinician _____ Tel: _____

Level of Care Requested: _____ DSM IV-TR Diagnoses: _____

Clinical Indications for Level of Care Request _____

Recommended Treatment Goals: _____

Submitted By: _____ Date: _____

Telephone #: _____ Fax #: _____

PLACEMENT RECOMMEDATIONS ❑ **PLACEMENT AUTHORIZED** ❑ Med Supported Detox

❑ AOD DDx Res ❑ MH DDx Res ❑ Transitional Res ❑ LSAT ❑ Clay/Loso ❑ Our House ❑ RCF/E

❑ AOD Social Model Detox ❑ AOD Social Model Res ❑ Co-Op ❑ Support Service Hotel ❑ Hotel

Specify _____

❍ **NOT AUTHORIZED** REASON: _____

Authorizing Clinician _____ Date _____

Authorizer Form Rev: 06/22/11

What We Do

- Assessment, Authorization and Utilization Management and Utilization Review at every level of care for placement in the most appropriate, least restrictive level of care to support client flow
- Assist with discharges
- Bridge Care Management to provide transitional care management coverage to facilitate client stability and movement
- Medi-Cal and Short Doyle Authorization for acute hospital payments throughout California

Assessment, Utilization Management & Review

- LOCUS: Level of Care Utilization System
  Deerfield Behavioral Health

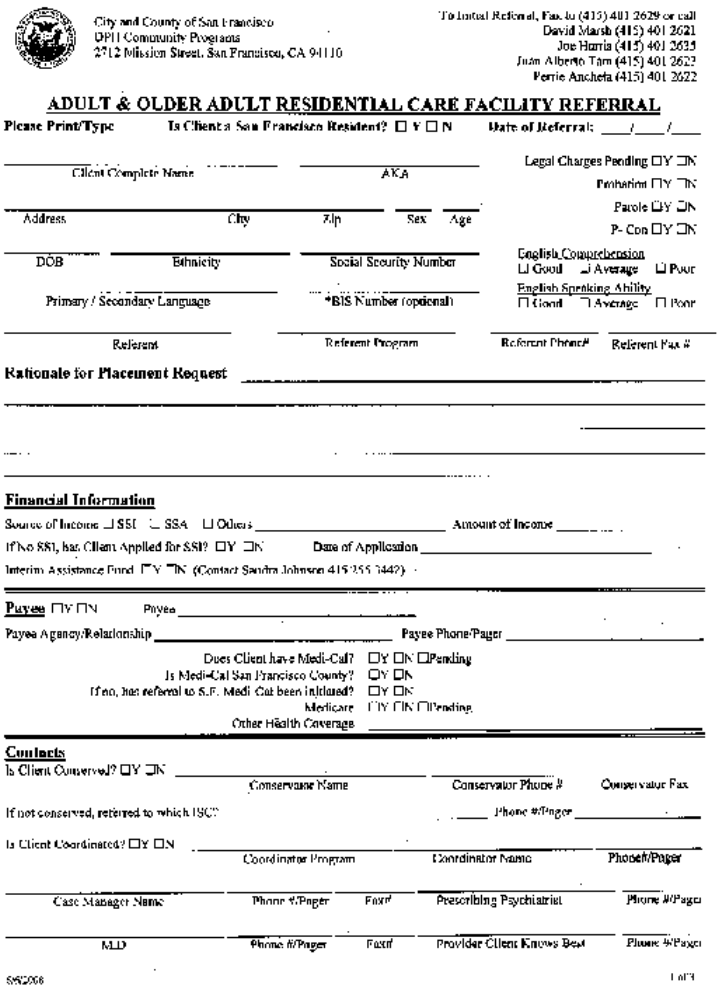
  - Risk of Harm
  - Functional Status
  - Medical, Addictive and Psychiatric Co-Morbidity
  - Recovery Environment
    - Sub-scale: A – Stressors
      B – Supports
  - Treatment and Recovery History
  - Engagement

- Chart Review
- BioPsychosocial Assessment: EMRD90 Form

Residential Care

- 2 types of Facilities:
  - Adult Residential
  - Elderly
- In order to receive DPH subsidy, individuals must have a Representative or Third Party Payee
- Very few non-ambulatory facilities in SF
- Very few delayed egress facilities in SF
- Limiting factors: diabetes management, wound care, oxygen, active substance use, behaviors: aggressive, agitated, intrusive, non-compliance

RCF/E Packet



City and County of San Francisco
DPH Community Programs
2712 Mission Street, San Francisco, CA 94110

To Initial Referral, Fax to (415) 401 2629 or call
David Marsh (415) 401 2621
Joe Hurria (415) 401 2625
Juan Alberto Tam (415) 401 2623
Perrie Ancheta (415) 401 2622

ADULT & OLDER ADULT RESIDENTIAL CARE FACILITY REFERRAL

Please Print/Type **Is Client a San Francisco Resident?** ☐ Y ☐ N **Date of Referral:** ___/___/___

Client Complete Name | AKA | Legal Charges Pending ☐Y ☐N | Probation ☐Y ☐N | Parole ☐Y ☐N | P- Con ☐Y ☐N

Address | City | Zip | Sex | Age

DOB | Ethnicity | Social Security Number | English Comprehension ☐ Good ☐ Average ☐ Poor | English Speaking Ability ☐ Good ☐ Average ☐ Poor

Primary / Secondary Language | *BIS Number (optional)

Referent | Referent Program | Referent Phone# | Referent Fax #

Rationale for Placement Request ___

Financial Information

Source of Income ☐ SSI ☐ SSA ☐ Others ___ Amount of Income ___

If No SSI, has Client Applied for SSI? ☐Y ☐N Date of Application ___

Interim Assistance Fund ☐Y ☐N (Contact Sandra Johnson 415 355 3442)

Payee ☐Y ☐N Payee ___

Payee Agency/Relationship ___ Payee Phone/Pager ___

Does Client have Medi-Cal? ☐Y ☐N ☐Pending
Is Medi-Cal San Francisco County? ☐Y ☐N
If no, has referral to S.F. Medi Cal been initiated? ☐Y ☐N
Medicare ☐Y ☐N ☐Pending
Other Health Coverage ___

Contacts

Is Client Conserved? ☐Y ☐N ___ Conservatee Name | Conservator Phone # | Conservator Fax

If not conserved, referred to which DSC? ___ Phone #/Pager ___

Is Client Coordinated? ☐Y ☐N ___ Coordinator Program | Coordinator Name | Phone#/Pager

Case Manager Name | Phone #/Pager | Fax# | Prescribing Psychiatrist | Phone #/Pager

MD | Phone #/Pager | Fax# | Provider Client Knows Best | Phone #/Pager

8/8/2008 1 of 3

Locked / Secure Placement

LOCKED

- Able to participate in treatment but not demonstrating good insight or judgment regarding safe behaviors in an open setting
- Level of cognitive impairment puts the person at high risk for victimization
- Limiting factors: behaviors: aggressive, agitated, intrusive, non-compliance; 1:1

SECURE

- Wandering
- Level of cognitive impairment puts the person at high risk for victimization
- Limiting factors: behaviors: aggressive, agitated, intrusive, non-compliance; 1:1

LSAT Checklist

LSAT/ STATE HOSPITAL DOCUMENT CHECKLIST

Client: _____**Date:**_____

Referred by:_____**Unit:**_____

Phone:_____**Fax:**_____ **Psychiatrist:**_____

1. CLIENT INFORMATION (include MHS 140)
   a. ☐ Admission Face Sheet
   b. ☐ TB Screening RESULTS within 90 days: ☐ PPD or Quantiferron test result
      IF PPD or Quantiferron test is positive, include:
      ☐ CXR report **and** ☐ documentation of prior treatment/current TB symptom screenir
   c. ☐ Nursing notes – Admit, 1st week AND last 10 days
   d. ☐ Physician notes – Admit, 1st week AND last 10 days
   e. ☐ Social Work notes – Admit, 1st week AND last 10 days
   e. ☐ Admission Psychiatric Evaluation
   f. ☐ PES Notes
   g. ☐ Psych Consult Notes
   h. ☐ Physician Orders – last 10 days
   i. ☐ PSYCHOTROPIC CONSENT FORMS
   j. ☐ PASARR (medicine referrals to SNF)
   k. ☐ Social History

2. LEGAL STATUS
   a. ☐ Conservatorship (or T-Con) Letters
   b. ☐ Conservatorship (or T-Con) Orders
   c. ☐ Riese, Affidavit B, Affidavit A Orders
   g. ☐ 1370 or other court orders
   h. ☐ Felony charges: ☐ Parole ☐ Probation (Must provide documentation with detail
   i. ☐ Registered sex offender: ☐ YES ☐ No
      IF a Registered Sex Offender, include: ☐ registration documentation
      ☐ history and information re the sexual offense

3. MEDICAL CONDITIONS
   a. ☐ Physical Exam and Medical History (most recent) **note if flu symptoms present**
   b. ☐ **Lice, scabies, bedbug, other infestation screening form**
   c. ☐ Complete list of current medications and dosages (routine, prn, last decanoate injection)
      Include MediCal TAR #'s if available
   d. ☐ Ambulatory Status: ☐ Ambulatory (able to self-evacuate in case of emergency, including u
      ☐ Non-ambulatory Specify Limitations: _____
   e. ☐ Medical specialty consultation reports (e.g. oncology, hematology, orthopedics)
   f. ☐ Psychological or Neuropsych testing reports, **if ordered**
   g. ☐ Lab Work
   h. ☐ Test results
   i. ☐ EEG, CT Scan, MRI results, **if ordered**

4. RISK HISTORY ☐ Methadone
   ☐ assault ☐ fire setting ☐ suicidal or self-injurious behavior ☐ AWOL
   ☐ substance abuse ☐ inappropriate sexual behavior ☐ Other: _____

If non-SFGH referral:
☐ current care plans ☐ two most recent weekly summaries
☐ most recent quarterly note

Conservatorship: LPS

- LPS: Lanterman Petris Short Act
- Governed by California Welfare and Institutions Code
- Designed for persons with serious mental disorders, or who are impaired by chronic alcoholism
- Initiated by a 5150 hold that continues as a 5250 hold
- Individuals receive a 5 day notice to contest the application for LPS Conservatorship during the 5250
- After the 5 days, a Temporary Conservatorship (T-Con) can be issued by the court that lasts approximately 30 days
- A Permanent Conservator (P-Con) hearing is then held in court. If issued, the P-Con lasts for 1 year
- Clients have the right to contest the P-Con every 30 days

Conservatorship: Probate

- 2 types
  - *Person only; can also include Dementia Powers*
  - *Estate only*
- Governed by the California Probate code
- Designed for people who are gravely disabled and/or unable to appropriately manage their finances
- Individuals receive notice at least 15 days before the Court Hearing
- If a Temporary Conservatorship is being pursued, the individual must receive notice 5 days before the Court date
- Temporary Conservatorship lasts 30 days
- A Court Investigator interviews the individual prior to the Court Hearing
- Probate Conservatorships are very difficult to remove

Medical Probate

- Governed by the California Probate Code Section 3200
- Allows a “Health Care Institution” to make health care decisions for a client who lacks capacity but is not yet conserved
- Completed by the Doctor and the City Attorney

Conservatorship Information

- http://www.disabilityrightsca.org/pubs/522501.pdf
- http://www.disabilityrightsca.org/pubs/523001.pdf
- http://www.canhr.org/factsheets/legal_fs/html/fs_ProbateConservatorship.htm
- http://www.risk.mednet.ucla.edu/MC1001.pdf
- Superior Court Self-Help Access Center: 551-5880 http://www.sfsuperiorcourt.org/index.aspx?page=202
- San Francisco Department of Aging and Adult Services 355-3555

Substance Abuse Treatment

- Residential
- Outpatient
- Referrals are processed through the Behavioral Health Access Center
- Use the same Placement Authorization Referral Form
- FAX to: 255-3629

Placement Quick Reference

LEVEL OF CARE	LPS	Probate	Payee	Self/Family Sign in	Income	Entitlements	Care Manager	NON-Ambulatory	Incontinence	Cognitive: Mild	Cognitive: Mod	Cognitive: Severe	Disposition Options
24° Supervision Locked/Secure	X	X	X			X				X	X	X	(Involuntary) LSAT: LPS only Axis I, Chronic Inebriate
24° Supervision Locked/Secure SNF	X	X	X			X		X	X	X	X	X	(Involuntary) Secure SNF: LPS or Probate Medically Frail, redirectable TBI
24° Supervision Open Unit SNF			X	X	X	X	X		X	X	X		SNF ** No Assaultive Behaviors **
24° Supervision Residential Care			X	X	X	X	X			X	X		Residential Care Facility 1 facility with Delayed Egress
RN Support				X									Medical Respite
Monitoring: Not 24°				X			X		X+	X	X		Shelter Social Rehab + Stablization Room (if self manages incontinence products)
Independent with Support				X			X		X	X	X		DAH
Independent with Support				X	X	X		X	X	X	X		Hotel/Apt with IHSS Granada Hotel if sufficient income
Independent				X			X		X	X	o		Apartment Hotel Shelter

* not required for LOC: if checked, it can impact the number of options

lack of entitlements limit placement to within SF and very unlikely RCF/E

pending probate limits placement to within SF

Few facilities in SF take wheelchair/non ambulatory

IDDM: client must be able to self inject for unsecured LOC

LTC Looking Forward

- Approach client flow with a long range view to maximize opportunity for stability
- Promote Recovery and Wellness to encourage maximum independence
- Continue to develop relationships with community partners to streamline process and contain costs

CONCLUSION

The Placement Team
thanks you
for your continued support!