

SAN FRANCISCO MENTAL HEALTH BOARD



Mayor Edwin Lee

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Harriette Stallworth Stevens, Ed. D., Co-Chair

Ulash Thakore-Dunlap, MFT, Vice Chair

Idell Wilson, Vice Chair

Gene Porfido, Secretary

Terezie "Terry" Bohrer, RN, MSW, CLNC

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Judith Klain, MPH

Carletta Jackson-Lane, JD

Gregory Ledbetter

Susan Page

Toni Parks

Angela Pon

Richard Slota, MA

Marylyn L. Tesconi

Njon Weinroth

Benny Wong, LCSW

ADOPTED MINUTES

Mental Health Board Meeting

Wednesday, **October 18, 2017**

City Hall, 2nd Floor, Room 278

One Carlton B. Goodlett Place

San Francisco, CA

6:30 PM – 8:30 PM

BOARD MEMBERS PRESENT: Harriette Stevens, EdD; Co-Chair; Idell Wilson, Vice Chair, Gene Porfido, Secretary; Terry Bohrer, RN, MSW, CLNC; Judy Zalazar Drummond, MA; Judith Klain, MPH; Gregory Ledbetter; Susan Page; Toni Parks; and Marylyn Tesconi; Njon Weinroth; and Benny Wong, LCSW.

BOARD MEMBERS ON LEAVE: Ulash Thakore-Dunlap, MFT, Co-Chair, Carletta Jackson-Lane, JD; Angela Pon; and Richard Slota, MA.

BOARD MEMBERS ABSENT. **None.**

OTHERS PRESENT: Helynna Brooke (Executive Director); Loy M. Proffitt (Administrative Manager); Kavooos Ghane Bassiri, LMFT, LPCC, CGP, Director of Behavioral Health Services; Dr. Deborah Borne, MD, Medical Director for the HIV Homeless Outreach Mobile Engagement Team; Scott Carlisle; David Elliott Lewis, PhD; Liza Murawski; Seth Roger and **two** members of the public.

CALL TO ORDER

Dr. Stevens called the meeting of the Mental Health Board to order at 6: 30 PM.

Members of the Public:

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

None.

ITEM 1.0 REPORT FROM BEHAVIORAL HEALTH SERVICES DIRECTOR (See Attachment A)

The full director's report can be viewed at the end of the minutes or on the internet.

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

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

Mr. Ghane Bassiri shared about the heat advisory in SF in the month of September. High temperatures had reached 106 Fahrenheit in San Francisco. The City created several cooling centers. Several BHS staff were deployed to be at the designated Cooling Centers to provide support. BHS Staff even went door-to-door at single-occupancy residents (SRO's) to see if people needed help.

The hepatitis A outbreaks are occurring in San Diego, Los Angeles, and cases have been identified in Santa Cruz but none in San Francisco so far. The Department of Public health is taking preventative measures to protect high-risk populations in San Francisco, and staff are vaccinating people identified within the high risk population for free. People who are homeless and/or drug users are at risk for hepatitis. According to research, the first dose of hepatitis A vaccine is 90% effective. San Francisco's current effort is making us ready if a hepatitis outbreak were to happen.

North Bay fires impacted the SF Bay Area. SF County has stepped up in a big way with about 100 staff identified from the behavioral health department ready to volunteer (Civil Service and Contractors) as counselors as well as disaster workers. Many staff have already been deployed and helping those impacted by the wildfires in the North Bay. As requested, SF has sent many bilingual Spanish-speaking staff. This is a City system-wide operations that was activated from various departments, police to firefighters, to environmental health/Department of Public Health.

He made a couple of short announcements. The California Board of Behavioral Science (BBS) appointed Jonathan Maddox, LMFT, BHS Training Coordinator, to its board. SFDPH has published two RFPs, posted and sent out to the community, both for Children, Youth and Families (CYF) System of Care, one to provide Mental Health Treatment Support and Training Services to specified CYF clients, programs, and public agency partners and the other to provide Substance Use Disorder Prevention (SUD-Prevention) services.

He has been meeting with different business groups and community stakeholders who have shared concerns about the homelessness issue in San Francisco. DPH has been actively engaged

in various efforts and coordinating services to address the needs of those who are homeless and have a mental health condition and/or substance use disorder. More outreach & engagement specialists are going to be added throughout the City where the needs are. These specialist are in addition to what is provided by the Homeless Outreach Team (HOT-SF).

Ms. Bohrer asked about data, monthly measurable outcomes, such as the number of clients going to the clinics and the waiting time to see a therapist.

Mr. Ghane Bassiri said he had done two presentations for the Health Commission that included some data & metrics. He will forward the slides to the Mental Health Board. He also stated that he can share more data and demographics at the meetings, based on the latest that is available.

Ms. Bohrer asked if the City is coordinated with the American Red Cross in responding to a disaster.

Mr. Ghane Bassiri said “Yes,” we coordinate response services. Red Cross efforts are locally based & coordinated and BHS efforts are coordinated through State/Counties mutual aid process.

Ms. Wilson asked who makes the final decision for the 2018 film contest (youth-focus activity shared about at the meeting), since older adults 65 appeared to be excluded from the process.

Mr. Ghane Bassiri said that he would raise the need for inclusion of this population as well with the California Mental Health Services Authority (CalMHSA) and for future activities.

Public Comment

Dr. Lewis asked for Hummingbird updates.

Mr. Ghane Bassiri explained that there are already four (4) beds available, and they are ramping up for a total of fifteen (15) beds soon. Also, the program operates 24 X 7. There is coordination between Psychiatric Emergency Services (PES) as well, and PES has been sending people there. People have been staying as short as several hours to several days. Positive Resource Center/Baker Places is the operating agent for Hummingbird. SFPD can also drop people at Hummingbird.

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

Mr. Ghane Bassiri said the Board of Supervisors approved the three-year MHSA Plan that was presented to the MHB board in September, and once signed, it will be distributed & posted online. He shared information about two separate community activities/events, funded by MHSA, and highly encouraged board members to attend the upcoming MHSA Awards Ceremony on Thursday, October 26, 2017.

2.2 Public Comment

Dr. Lewis shared that the 7th MHSA Award ceremony on Thursday, October 26, 2017. I believed recovery is a heroic journey, and it is worth celebrating.

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 September 20, 2017 be approved as submitted.

Unanimously approved.

ITEM 4.0 PRESENTATION: HIV HOMELESS OUTREACH MOBILE ENGAGEMENT, ISSUES AND EXPERIENCE, DR. DEBORAH BORNE, MEDICAL DIRECTOR, SCOTT CARLISLE, CONSUMER.

4.1 Discussion: HIV Homeless Outreach Mobile Engagement, Issues and Experience, Dr. Deborah Borne, Medical Director, Scott Carlisle, Consumer.

Dr. Stevens introduced Dr. Deborah Borne, Medical Director for the HIV Homeless Outreach Mobile Engagement Team.

Dr. Borne said Scott Carlisle was unable to attend the meeting with her. However, she brought Miguel Ibarra who is Program Supervisor at Asian & Pacific Islander Wellness Center (APIWC). Miguel Ibarra oversees intensive case management (ICM).

She shared that the HIV Homeless Outreach Mobile Engagement (HHOME) is funded by Health Resources and Services Administration (HRSA) and the Special Project of National Significance (SPNS) initiative. HHOME provides medical care, addiction medicine to the hardest-to-reach HIV (human immunodeficiency virus) population with the following characteristics:

- Experiencing active substance use
- Not adherent to or prescribed HIV Medicine
- Living with mental illness
- Living on the street or in HRSA -defined unstable housing
- Not currently engaged in primary medical care
- Transwomen of color

Model of Care emphasizes the holistic approach to serve individuals who are experiencing homelessness and living with HIV through mobile integrated care: case management, navigation, HIV primary care, mental health and substance use treatment, and housing support.

The AIDS national average is about 1%, but the disease burden is 3% higher in the homeless population. People who are homeless often have undiagnosed trauma. The consumers of HHOME do not fail; it is the system that fails them. There is no one-size fits all for people. People have a variety of needs for integrated care.

Mr. Wong inquired how much information is needed to refer someone to HHOME.

Mr. Ibarra said the HHOME project is the integration model in mobile engagement and differs from prior mobile team models in that it explicitly focuses on individuals experiencing homelessness who are the most difficult to engage and retain in care, namely those facing complex, multiple comorbidities and barriers who have not previously been successfully involved in housing and/or HIV treatment.

Ms. Klain asked how HHOME can be incorporated into the system of care.

Dr. Borne responded that we help people gain purpose and meaning out of life. There is a low barrier to services and programs to connect people with HIV to integrated care. Women with HIV are in need of help for trauma, navigating services, and vocational services.

Ms. Parks said that lots of times we have helpers, but then they are gone. How do we sustain good providers?

Mr. Ibarra said that workplace retention needs to address the issue of paying rent in this city. Management can advocate on behalf for frontline workers with expert coaching, and self-care encouragement. Frontline providers are taught to recognize when caring becomes a stressor and when caring is satisfaction.

Ms. Tesconi asked about how much the role of policy plays in providing the best care and will there be any system-wide changes.

Dr. Borne said learning how to navigate policy and billing is a challenge.

Mr. Porfido asked about care for people with severe mental illness (SMI).

Dr. Borne said humility and respect people for their self-determination. She believed an integrated care approach makes a big difference.

Mr. Ibarra said he is persistent and relentless in his approach to reach out to people with SMI.

Ms. Page asked about how many transitional age youths (TAY) receive HHOME services.

Dr. Borne said the system of care for TAY is separate from HHOME, but they are trying to get more youth into the system.

Mr. Weinroth said about the PrEP program.

Mr. Ibarra shared more PrEP access is needed.

4.1 Public Comment:

A Member Public member asked about funding budget since the AIDS office has data showing about \$250,000.

Dr. Borne emphasized her budget is \$225,000 per year. It is a minimal budget.

Dr. Lewis asked about sanctuary trauma.

Dr. Borne said HHOME is about how to meet people where they are at in life. Little things can make a change to improve wellness.

ITEM 5.0 REPORTS

5.1 Report from the Executive Director of the Mental Health Board. Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

Ms. Brooke mentioned the following items:

- MHSA Awards Ceremony Thursday, October 26th from 10 – 1:30.

5.2 Report of the Chair of the Board and the Executive Committee.

Dr. Stevens mentioned that there are lots of meetings and events on the calendar. The Wellness Van Committee meets next Monday, October 23rd at 5:00 PM. The Executive Committee meets the following day, Tuesday, October 24th at 10:00 AM and the Senior Committee meets Thursday, October 26th at 5:00 PM.

The following week, the Board is hosting its Meet and Greet at the San Francisco Public Library in the Hispanic Room on Saturday, November 4th from 10:00 AM – 12:00 Noon. Please post this event on your social media. Brunch will be served. Finally, the Annual Board retreat is Saturday, December 2nd from 9:00 AM – 4:00 PM.

5.3 Committee Reports

Dr. Stevens asked each committee chairperson to give a three sentence report on their committee that briefly highlights accomplishments.

- Mobile Wellness Van Committee: Richard Slota, Co-Chair
- Youth Committee: Judy Drummond, Co-Chair
- Senior Committee: Terry Bohrer, Chair

Dr. Lewis said he would email out the report of upcoming meetings.

Ms. Drummond said many Youth Committee members were affected by the North Bay fires on the last meeting date.

Ms. Bohrer said the 2017 Data Notebook is focusing on senior needs and mental health care.

5.4 People or Issues Highlighted by MHB: Suggestions of people and/or programs that the board believes should be acknowledged or highlighted by the Mental Health Board.

None.

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

Ms. Tesconi shared her program review at Horizons Unlimited serving youth between 15-25 years of age. She was very impressed with the program which connects closely with nine other local programs. She found Horizons Unlimited staff were very joyful at the program. The program has a strong support system and training to assist staff with vicarious trauma and self-care resulting from serving youth struggling with trauma.

Mr. Porfido was selected to speak at the Jewish Community Center several weeks ago.

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

Ms. Klain suggested looking at innovative models around the world.

Ms. Wilson suggested a presentation on an update to the Hummingbird program.

5.7 Public Comment

Dr. Lewis suggested the board consider a presentation on safe injection sites.

6.0 PUBLIC COMMENT

Dr. Lewis suggested the board look at the issue of marijuana when it becomes legal for recreational use in January 2018.

Adjournment

Adjourned at: 8:31 PM



Mayor Edwin M. Lee

Behavioral Health Services Monthly Director's Report October 2017

1. COMMUNITY RESPONSE

Heat Advisory in San Francisco

In September, during the days where San Francisco experienced extremely hot weather, number of cooling centers were announced for public use. BHS OMI Family Center (at 1701 Ocean Avenue) was identified as one of the Cooling Center, in that particular neighborhood, on the designated days. Also, during the weekend, BHS staff were deployed and provided onsite support, at various designated cooling center sites throughout the City. BHS truly appreciates the dedicated staff who volunteered to help.

Hepatitis A Vaccination Campaign to Reduce the Risk of Outbreak

In light of the Hepatitis A outbreaks elsewhere in California, San Francisco has been taking a proactive approach to reduce the risk of a similar outbreak. "The at-risk populations for Hepatitis A infection are homeless and drug using communities," said Barbara Garcia, San Francisco Director of Health. "We are directly reaching out to these populations to provide vaccinations to ensure that we reduce the risks of a Hepatitis A outbreak in San Francisco."

The Hepatitis A vaccine is safe and effective and the best strategy to reduce the chance of an outbreak here while protecting the at-risk population. The vaccine is free and being made widely available thanks to collaboration with health care providers, community based organizations, homeless shelters, navigation centers and employees and volunteers who work with the population at-risk.

In October, the SFDPH and community partners will be escalating efforts with a series of pop-up vaccination clinics and an increase in street outreach, along with a continuation of the activities already underway. BHS has been actively involved & coordinating efforts, and various BHS related sites (Civil Service and Contractors) have been identified to offer & administer the vaccines. Behavioral Health Access Center, located at 1380 Howard, is also a designated site for this purpose, operating from 9:00am to 4:00pm, Monday through Friday.

Get more San Francisco information here: <http://www.sfdcp.org/preventhepA.html>

North Bay Fires Disaster Response

SFDPH Behavioral Health Services (BHS) quickly activated in response to the disaster mental health support needs of evacuees from the wildfires that erupted in the North Bay counties. Since evacuation shelters were opened up in the affected areas, with about 100 staff members ready & on stand-by, BHS has already sent approximately 30 disaster mental health workers from BHS programs (Civil-Service and Community Based Organizations/Contractors) to provide support to the people who are impacted &/or suffered losses, including to families and children. The majority of the disaster mental health workers that BHS deployed thus far are bilingual Spanish-speaking, as Spanish was the identified language in greater need. BHS continues to line up disaster mental health workers to deploy into work shifts (including overnights), currently & into the coming week(s), to both Napa and Sonoma counties where the fires had the most devastating impact. BHS is courting its disaster mental health support via the Statewide EMS authority for coordinating County Mutual Aid. SFDPH BHS is grateful to all the mental health workers who were already deployed and to the many staff who have signed up & expressed their willingness help out. BHS will facilitate *debriefing sessions* for staff upon returning from volunteering.

2. MENTAL HEALTH SERVICES ACT (MHSA)

2nd Annual BHS Art Show at the Main Library

On Tuesday, October 3, 2017, UCSF's Citywide Employment Program teamed up with MHSA to present the 2nd Annual BHS art show in the Latino Room of the Main Library in San Francisco. Over eighty pieces of art were received from mental health consumers from all over San Francisco spanning genres from paintings, dioramas, airbrush art, wood carvings to beaded bottles and more. From these submissions, the panel of judges narrowed it down to twenty pieces that were shown at the opening. With over 100 guests in attendance, Mr. Imo Momoh (MHSA Director) and BHS Director gave brief speeches to further support the artists and inspire. Artists also spoke about their lives, challenging experiences & accomplishments and explained the motivations and “theories” behind their art. Attendees enjoyed food catered by UCSF Citywide’s own Slice of Life (vocational training program). A special recognition was given to two of the artists. High quality reproductions will be on display in the third floor rotunda in the Main Library until the end of the calendar year. Please visit and enjoy the art!

6th Annual Directing Change Program & Film Contest 2018

The California Mental Health Services Authority (CalMHSA) – a proud partner of San Francisco’s Department of Public Health: Behavioral Health Services, Mental Health Services Act -- is pleased to announce its 6th Annual Directing Change Program & Film Contest 2018 (directingchange.org) that invites young people ages 14 to 25 to create 30-second and 60-second films about suicide prevention for their peers. This program gives youth and young adults the chance to produce films that support the awareness, education and advocacy of suicide prevention and mental health; and these films will ultimately be used for social change on the contestants’ school campuses and their communities. The capstone for this program will be a red carpet award ceremony, where the young filmmakers will be recognized for their creativity and artistry. For more information about Directing Change 2018, please visit:

<http://www.directingchange.org/submission-categories/>.

[Submission Categories - Directing Change](#)

3. TRANSITIONAL AGE YOUTH (TAY)

BHS Vocational CO-OP, Occupational Therapy Training Program-SF, and the IPS Implementation

Occupational Therapy Training Program (OTTP-SF) serves at-risk youth in a multitude of mental health, educational, and vocational programs and strives to engage them in meaningful activities that result in positive goal fulfillment. In April 2016, OTTP-SF responded to California State Department of

Rehabilitation’s invitation to do a pilot study on implementing the Individual Placement and Support (IPS) model in its work with youth ages 15-24 with a primary mental health diagnosis. Some of the core principles of IPS include rapid job search, attention to client preferences, and time unlimited support. In addition, IPS supported employment is integrated with the treatment team with competitive employment as the goal. The IPS pilot program started with 13 clients from OTTP-SF’s outpatient programs and the one year pilot yielded outcomes as listed below.

	IPS	Non-IPS
Time it takes for clients to get first job from referral to program	109 days	188.5 days
Percentage of clients who obtain at least one job while in program	77%	54%
Time it takes to make first face-to-face contact with employer from referral to program	82 days	92 days

In addition to these positive outcomes, they have also received significant positive feedback from the participants. Clients have obtained a wide variety of positions in areas they are truly interested in. One of the IPS clients recently received her ideal job as an office assistant. According to the client’s Vocational Specialist, Nikki Mathews, MS, OTR/L, it has been amazing to observe her transformation; “She has made so much progress in the last couple of months managing her anxiety, and searching for a job has really increased her confidence. When I first met her, she had a hard time holding a simple conversation; however, after her first interview, she walked out of the room like she owned the place!” Another of Nikki’s client recently went on his first job interview. He has difficulty managing anxiety and typically does not show/express his emotions; however after an interview at a tech company, his *dream* job, he said, “I was so excited for my interview, I was telling everyone. I think I told my mom six times!”

For additional information about OTTP-SF and how to enroll your clients in the BHS/DOR Vocational CO-OP, please contact Rachel Pechter at (415) 551-0975 or Rachel.pecher@ottp-sf.org.

4. FORENSIC/JUSTICE INVOLVED BEHAVIORAL HEALTH SERVICE

The Community Justice Center (CJC) is a community-based collaborative court program that partners with the San Francisco Superior Court, the San Francisco District Attorney’s Office, the San Francisco Public Defender’s Office, Human Services Agency and the San Francisco Adult Probation Department. SFDPH staff provide case management services to people who are charged within the geographic area of the Tenderloin, Civic Center, parts of the South of Market neighborhood, and Union Square. SFDPH staff provide services on site and linkage to social services agencies; community resources; and primary, behavioral health and substance use disorder treatment programs.

The SFDPH staff at CJC host a variety of groups, one of which is being highlighted and is led by Dalicia Nance. In March of 2017, the Community Justice Center and the Demonstration Gardens at UC Hastings run by Kasey Asberry, forged a relationship. Clients have been coming to the Demonstration Garden on Wednesday mornings for what it's currently calling the *CJC Coffee Hour*. Coffee and snacks are provided and participation occurs in a variety of ways. People can participate in a conversation, do projects, sit quietly at a table & draw, or explore. One theme that has emerged out of the conversations is the memories linked to a grandparent, grandmothers especially. This theme is going to be the focus of a larger project that clients are going to create. Additionally, Kasey is working diligently to find funding to support this effort and see about stipend payments for CJC clients who want to be a gardener trainee. The hope is that with this training, clients will be able to obtain work where they would be able to use their gardening skills. To share, a quote from one of the newest members: "Most peaceful hour...Enjoy the peace of mind...Mind can shut off and refocus on other things".

BHS appreciates the wonderful & impactful recovery oriented work that is being done at the Community Justice Center!

5. ANNOUNCEMENT

California Governor Edmund G. Brown Jr. Announces Board of Behavioral Sciences Appointment

SFDPH is pleased to announce that BHS Training Coordinator, Jonathan Maddox, LMFT, has been appointed to the California Board of Behavioral Sciences. Mr. Maddox is a Licensed Marriage and Family Therapist, who has been the training & internship coordinator at BHS since 2014, where he has also served in several positions since 2006, including program director and clinical supervisor. Additionally, Mr. Maddox has maintained a private practice since 2004. He was a mental health consultant for Contra Costa County Mental Health Services from 2005 to 2006, a therapist at the East Bay Agency for Children from 1998 to 2000, and a military police officer in the U.S. Army from 1989 to 1992. Mr. Maddox earned a Master of Arts degree in marriage and family therapy from Oral Roberts University.



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



The Homeless Health Outreach and Mobile Engagement (HHOME) Project



Asian & Pacific islander
Wellness center

This program is funded by HRSA
Special Project of National Significance
(SPNS) initiative

“Building a Medical Home for Multiply
Diagnosed HIV Positive Homeless
Populations Initiative”

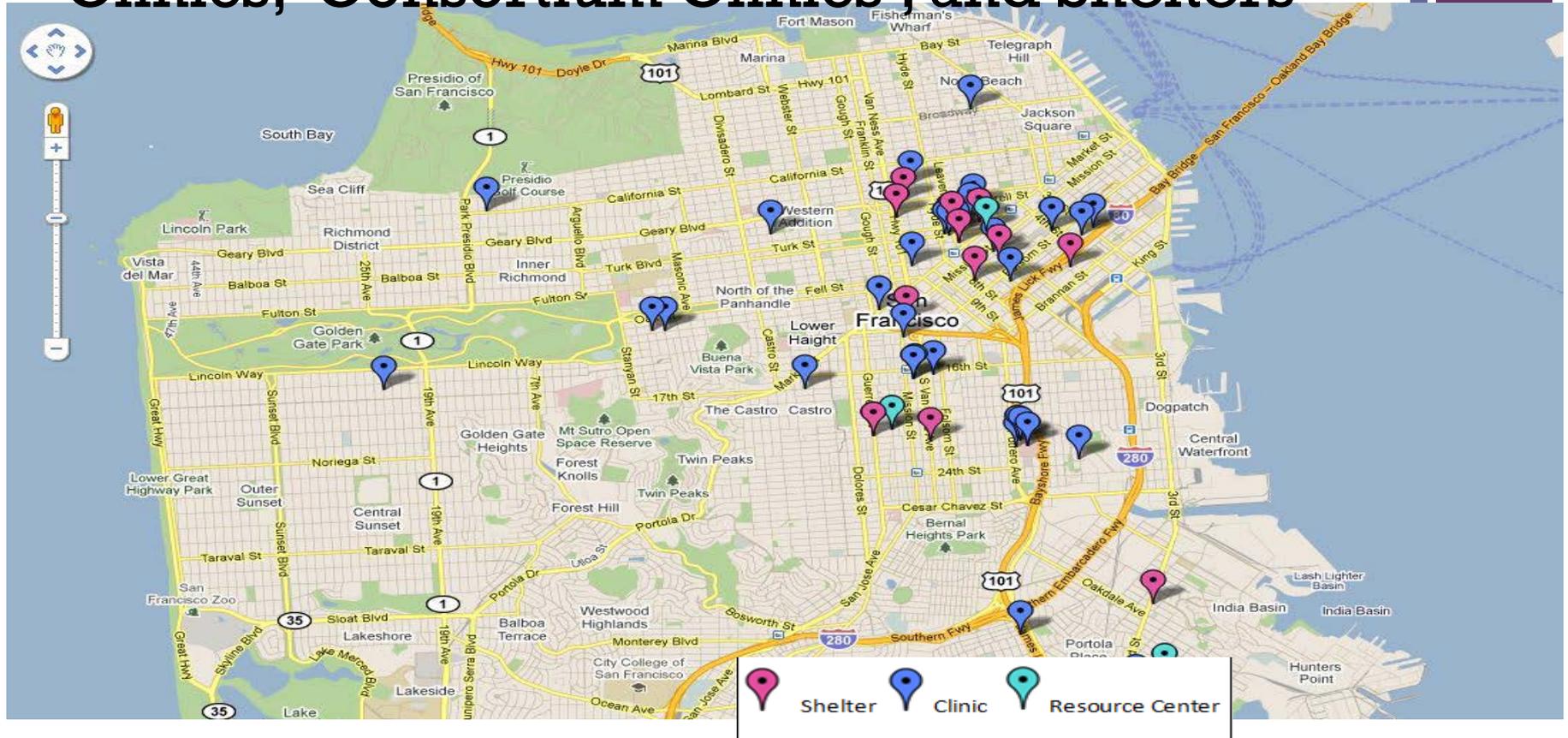


SFDPH

DEBORAH BORNE, MSW, MD
*MEDICAL DIRECTOR,
TRANSITION'S DIVISION*

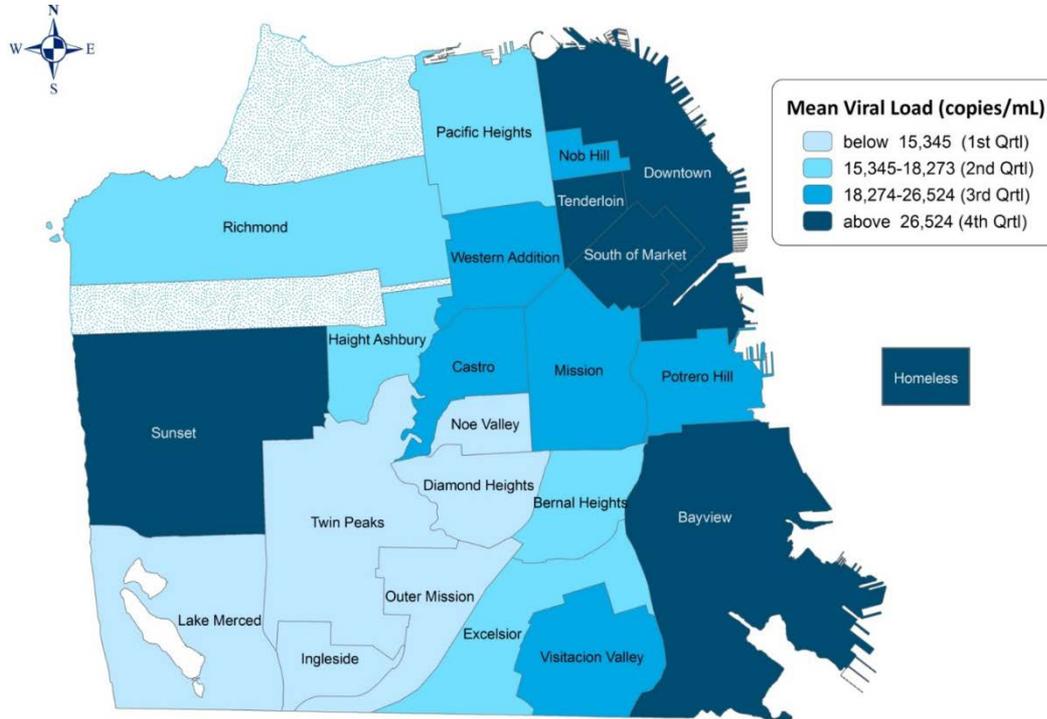
SCOTT CARLISLE, CONSUMER

+ SF Department of Public Health medical Clinics, Consortium Clinics, and Shelters





Spatial Distribution of Mean CVL by Neighborhood, 2005-2008



Homelessness is an independent risk factor for elevated Viral Load

+ Homelessness in San Francisco

Average age of death for someone
Experiencing Homelessness:
43

70 % have a Chronic Illness:
Medical or Behavioral Health Issue

2015 Homeless Count people who are
chronically homeless

55% Mental Health Condition

35% Post Traumatic Stress Disorder

62% Have Substance Abuse

43% Chronic Health Problems



Data from HUD Funded San Francisco
Homeless Count – 2009,2011,2015

DPH FY 14-15 Homeless Client Data

	Homeless	Homeless > 10 Years	TAY 18-24	Women	Age 60+	Top 1-5% High Utilizers
Total Number	9,975	3,272	631	2,403	1,304	1,234
% HIV	7.5%	12.3%	2.7%	5.3%	6.6%	13.3%
	(5)	(403)	(17)	(127)	(87)	(173)

DPH FY 14-15 Coordinated Case Management System (CCMS) Homeless Client Data individuals who have 'touched' system in Fy14-15



**Challenges to Engagement
and Retention**

Trauma: Homelessness and Sanctuary Trauma

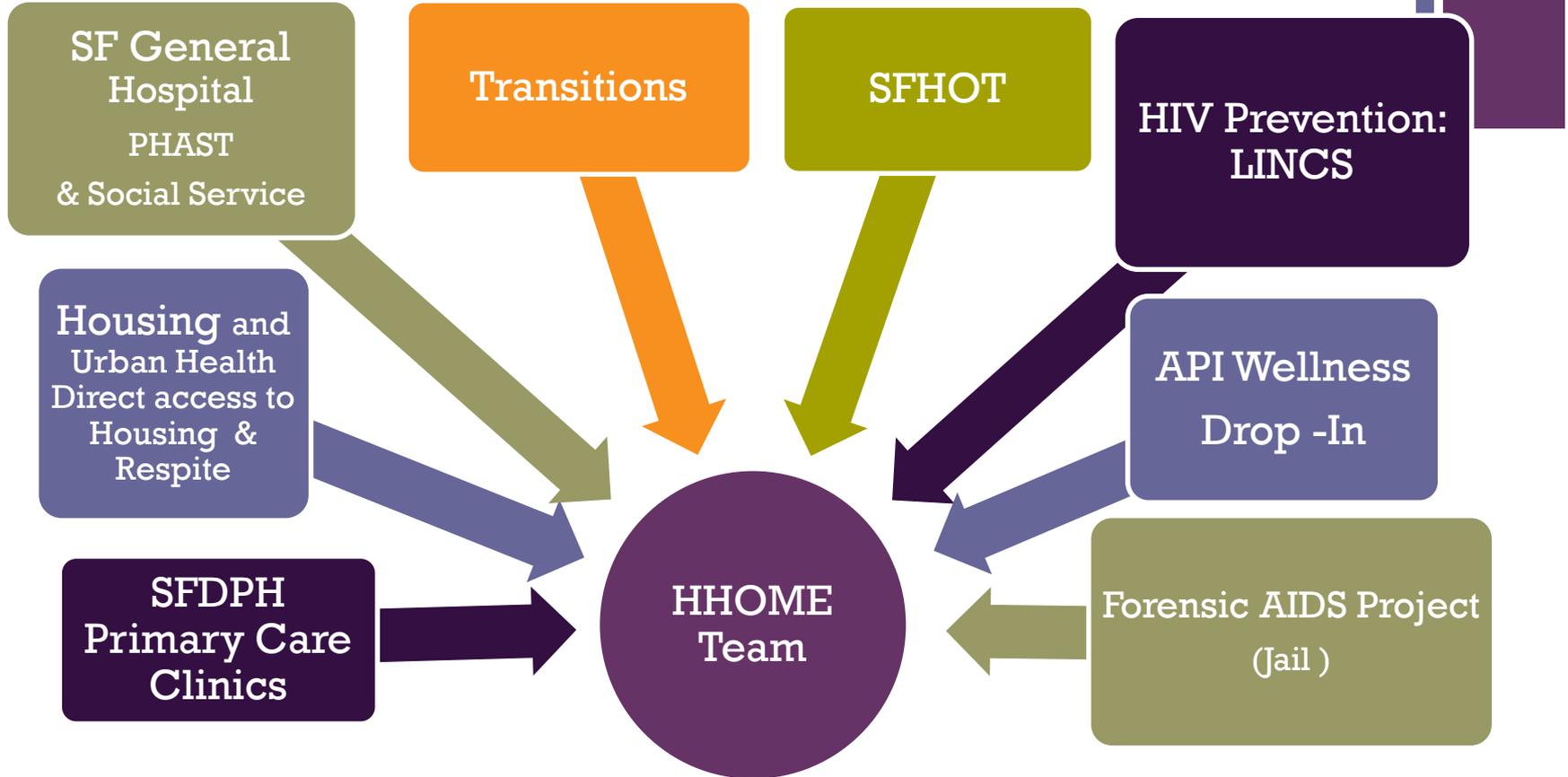




How Does Our Program Work



+ SF HHOME PARTNERS





SYSTEM WRANGLER

Gap in Service

Goal of Integrated Mobile Care for Hardest to Reach HIV Positive Homeless Individuals

Mobile Medical
Case Management

Stabilization Room
and Respite Access

Mobile Integrated
Primary Medical
Care

Mobile RN Care
Coordination and
Adherence

City Wide
Evaluation for Level
of Care for Clients

Coordination of
community partners
and services
available to clients

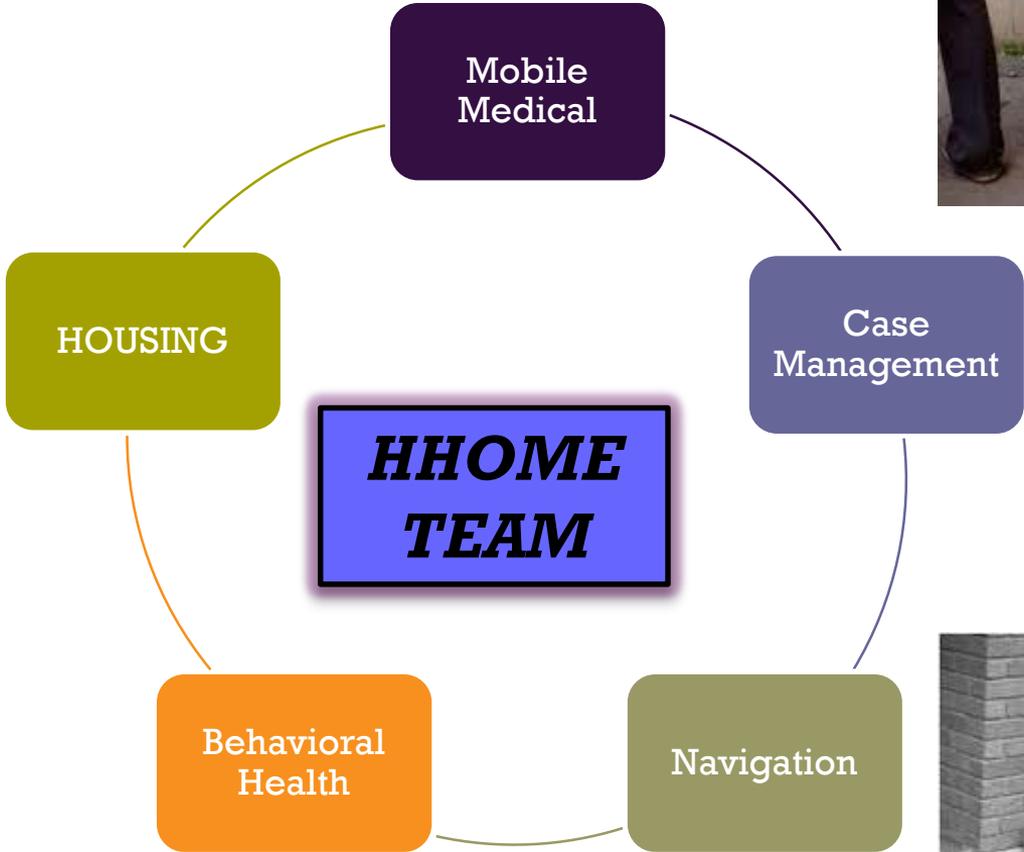
Access to all city
Supportive Housing
(outside of DPH)

Hospital Discharge
directly to SFHOT
Services

Fully Utilize Peer
Navigators as part
of care team

Services improved by SPNS Grant

Acuity and Chronicity Assessment



Levels of Support for PLWHA Experiencing Homelessness

Homeless

Navigation

PHAST

Clinic based
Social Work

LINCS-CHW

*COE-Ryan
White center
of Excellence*

Case management and BH
care

**Homeless
Outreach
Team**

**Intensive
Case
management**

Mobile Medical

HHOME

Engage
in Primary
Care:
Undetectable
Viral Load!

Referrals

Hospital

Community



Medical

Psychiatric

Emergency Room

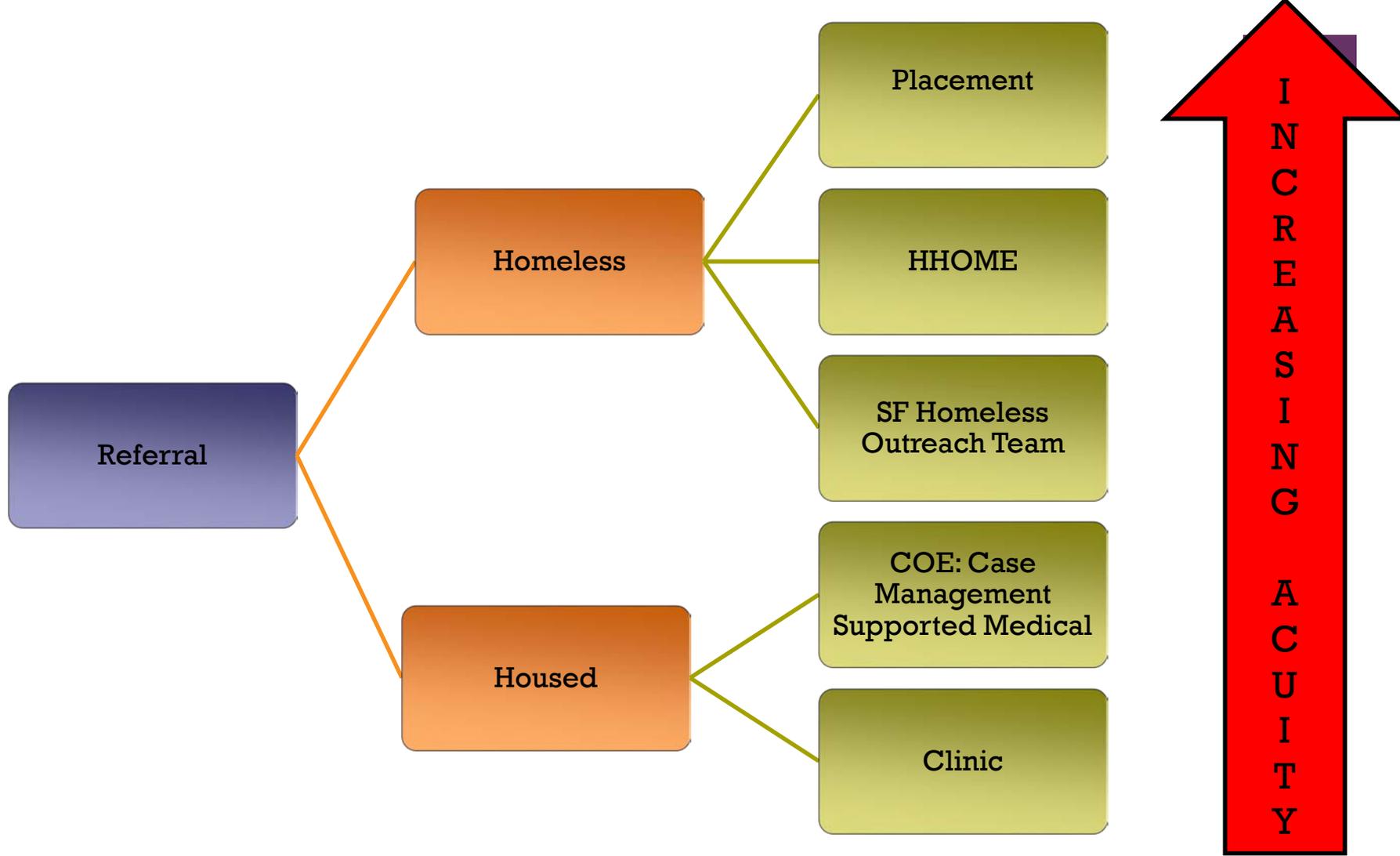
Long and Short Term Care Facility

Primary Care

Urgent Care

'Street': Police, Shelter and Homeless Outreach

Jail



Medical Acuity Long Version

Area of Functioning <i>Current Acuity Level</i>	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self-Management (0)	Predicted Chronicity
Medical Care and Treatment Adherence					
Care Adherence <i>Acuity Level:</i>	<input type="checkbox"/> Missed 4 or more medical appointments in the last 6 months or has not been seen in the last 6 month <input type="checkbox"/> Severe medical illness w/o capacity for treatment adherence <input type="checkbox"/> Unable to tolerate 4-walls clinic or has received denial of service > 1 clinic	<input type="checkbox"/> Missed 3 medical appointments in the last 6 months or has not been seen in the last 3 months <input type="checkbox"/> Multiple physical conditions w/ low treatment adherence <input type="checkbox"/> Able to tolerate 4-walls clinic with an escort and redirection <input type="checkbox"/> Can self-direct to open-access clinic or drop-in	<input type="checkbox"/> Missed 3 medical appointments in the last 12 months <input type="checkbox"/> Engages w/ clinic to address physical conditions with support <input type="checkbox"/> Able to attend 4-walls clinic with intensive reminders; may need navigation to appt, but navigator doesn't need to stay	<input type="checkbox"/> Engages in clinic w/ standard appointment reminders only (phone, text, email) <input type="checkbox"/> Engages w/ clinic independently to address physical conditions	
Current Health Status <i>Acuity Level:</i>	<input type="checkbox"/> Detectable VL, CD4 < 200, and/or refuses ART, OI in the last month <input type="checkbox"/> Current acute medical issues not treated or well controlled <input type="checkbox"/> Hospitalized in the last month for acute disease <input type="checkbox"/> High risk pregnancy	<input type="checkbox"/> Detectable VL, CD4 200-350, and/or refuses ART, OI in the last 6 months <input type="checkbox"/> Current acute medical issue being treated <input type="checkbox"/> Hospitalized in the last 6 months <input type="checkbox"/> Pregnancy	<input type="checkbox"/> Detectable VL but on ART, no OI in the last 6 month or on treatment for OI <input type="checkbox"/> Acute medical issues in the last 6 months resolved <input type="checkbox"/> No hospitalizations in the last 6 months	<input type="checkbox"/> Virally suppressed, no OI in the last 12 months <input type="checkbox"/> No current acute medical issues <input type="checkbox"/> No hospitalizations in the last 12 months	
Chronic Illness <i>Acuity Level:</i>	<input type="checkbox"/> > 2 visits to the ER in the last month to treat illness or 1-2% high utilizer of single or multiple system in the last year <input type="checkbox"/> Meets palliative care definition (health condition likely result in death 2 years) <input type="checkbox"/> Complex coordination between multiple medical providers and medically focused agencies	<input type="checkbox"/> > 2 visits to the ER in the last 2 months or current 3-5 % high utilizer in the last year== <input type="checkbox"/> Multiple poorly controlled medical illnesses <input type="checkbox"/> Not flourishing medically in current level of care <input type="checkbox"/> Active coordination between multiple care providers	<input type="checkbox"/> 1 or more visits to the ER in the last 3 months or prior 1-5 % high utilizer in the last 2-3 years <input type="checkbox"/> Illness is chronic, but taking medication and stable medically with support from wrap-around care	<input type="checkbox"/> 0 visit to the ED in the last 6 months <input type="checkbox"/> No history of high utilization <input type="checkbox"/> Chronic condition is managed through current treatment and no wrap-around support is needed <input type="checkbox"/> Empowered for self-care of chronic illness	



Area of Functioning <i>Current Acuity Level</i>	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self-Management (0)	Predicted Chronicity
Medical Care and Treatment Adherence (continued)					
Function: <ul style="list-style-type: none"> • Physical • Cognitive • Impulse control/decision making • Accommodations <i>Acuity Level:</i>	<input type="checkbox"/> Challenges in various areas of physical function with severe impact <input type="checkbox"/> Challenges with thinking that has severe impact on functioning <input type="checkbox"/> Screening MoCa < 17 <input type="checkbox"/> Diagnosed dementia <input type="checkbox"/> Impulse control or decision-making ability impairing health and life functions <input type="checkbox"/> Despite accommodations, persistent inability to function, impairing health and ADLs/IADLA	<input type="checkbox"/> Challenges with ambulation, moving, or senses, impairing 1 or more life functions <input type="checkbox"/> Challenges with memory impairing one or more life functions <input type="checkbox"/> MoCa between 18-22 <input type="checkbox"/> Impulse control or decision-making impairing 1 or more life functions <input type="checkbox"/> Accommodations not fully effective or available	<input type="checkbox"/> Occasional unexplained ability to ambulate <input type="checkbox"/> Occasional inability to follow through due to cognitive impairment <input type="checkbox"/> History of TBI, ETOH, substance use or medical condition associated with cognitive impairment <input type="checkbox"/> MoCa 22-26 <input type="checkbox"/> Impulse control or decision making occasionally impairing life functions <input type="checkbox"/> Accommodations meet needs	<input type="checkbox"/> No conditions commonly associated with mobility and sensory impairment <input type="checkbox"/> No conditions associated with cognitive impairment <input type="checkbox"/> MoCa >26 <input type="checkbox"/> Impulse control or decision making does not impair any life functions <input type="checkbox"/> No accommodations needed	
Medication Adherence <i>Acuity Level:</i>	<input type="checkbox"/> Misses doses daily <input type="checkbox"/> Requires DOT or other intensive adherence support, cannot self-manage medicines <input type="checkbox"/> < 30% adherent <input type="checkbox"/> Not taking ART or other life-saving medication	<input type="checkbox"/> Misses doses weekly <input type="checkbox"/> New to ART or lifesaving regimen <input type="checkbox"/> Missed treatment or prescription refill in the last month <input type="checkbox"/> Takes some chronic disease medications but is unable to take all medications daily <input type="checkbox"/> 30-60 % adherent	<input type="checkbox"/> Misses doses monthly <input type="checkbox"/> Missed treatment or prescription refill in the last 3 months <input type="checkbox"/> 60-90% adherent	<input type="checkbox"/> Rarely misses treatment <input type="checkbox"/> 90-100% adherent	



Panel Management

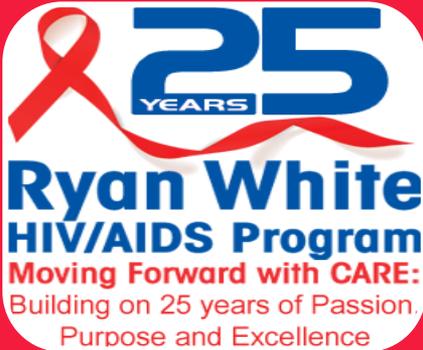
Appointment reminders

Missed visit follow-up

Routine review of panel to ensure engagement

clinic-based standard

LEVEL 'O'



Centers of Excellence (CoEs)

Focus on mental health, substance use, stigma, and other barriers

Longer-term; Primarily clinic-based

LEVEL 1



ICM

GTZ ICM, Westside ACM, HOT

Intensive support with medical & psychosocial;

Long-term (except HOT); Community-based

LEVEL 2



Mobile Medical and Case Management

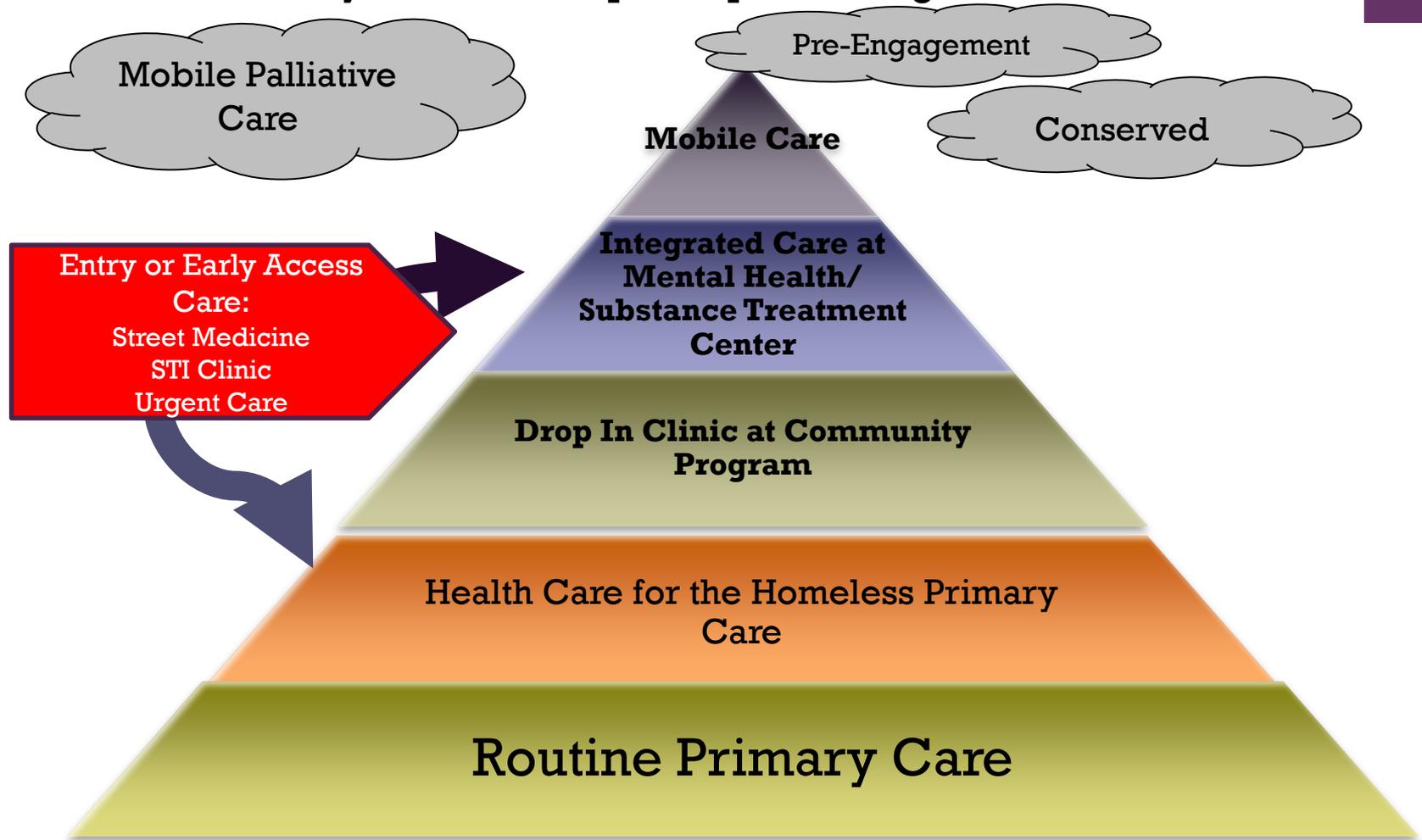
Directly Observed Therapy program
HHOME & Health at Home

Short-term; Community-based

LEVEL 3

HIV Care Navigation: Out-of-care HIV+ clients; re/connect with care & treatment, insurance, benefits, and other support based in individual needs; usually mobile; often time-limited

Levels Of Primary Care for People Experiencing Homelessness





+HHOME Team

Linking an

SF Homeless Outreach
Shelter Beds/Stabilization
Rooms
Permanent housing

Mobile Care Culture

Transitions

Placement
Stabilization Rooms

Structure to Complexity

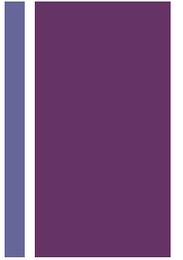
SF DE
Medical
Medicine/Supplies
Insurance Support

**HCH Culture: One
stop for Medical,
Addiction
Medicine, Mental
Health Tx**

HHOME TEAM
Consumer
'Captain' of
Team

API
Drop in Clinic
Drop in Center

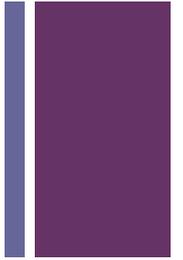
**Community Based
Culture**



+HHOME: Targeting the hardest to service

To be considered for enrollment, a HHOME client must be at minimum:

- PLWH not currently engaged in HIV treatment or failing the current level of care, with a detectable viral load, CD4 < 200;
- Active substance abuse disorder;
- Diagnosed with severe mental illness, or mental health condition impairing functioning;
- Experiencing homelessness



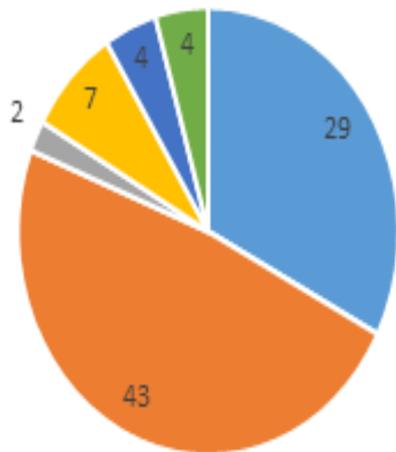
+ Population we serve: Community added..



- HIV-positive pregnant women
- HIV-negative partner of HIV-positive individual; partner meets HHOME criteria and needs PrEP
- Transitional Age Youth (TAY), ages 18-25 and young adults ages 25 – 30 aging out of TAY
- Newly diagnosed with HIV
- Eminent risk of eviction.

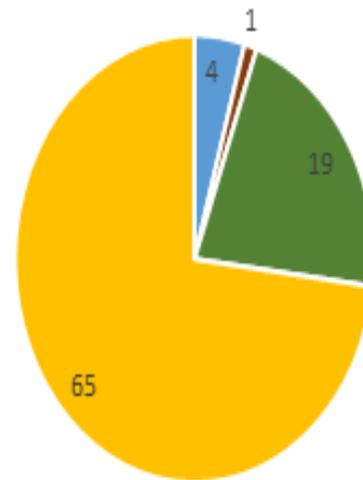
Baseline Data for Enrolled Participants (n=61)

HHOME by RACE/ETHNICITY



■ African/Black American ■ White ■ API ■ Latino ■ Native American ■ Other

HHOME by GENDER IDENTIFICATION

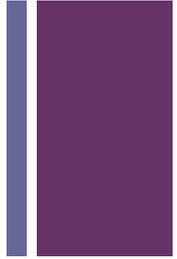


■ Trans-Woman ■ Two-Spirit ■ Woman ■ Man

+ PSYCHOSOCIAL FACTORS at BASELINE *Study population (N=61)*

- 72.1 % reported having experienced sexual or physical trauma
- 72.1% had a CES-D Score of ≥ 10 , which indicates depressive symptoms
- 95.0% had a mental health diagnosis prior to enrollment. Of those clients,
 - 84.0% had a substance use diagnosis
 - 47.4% had a depression diagnosis
 - 40.4% had a bipolar or mood disorder diagnosis
 - 36.8% had a schizophrenia or psychotic disorder diagnosis
- 46.7% had used injection drugs within the past 3 months, 75% lifetime

Our Approaches

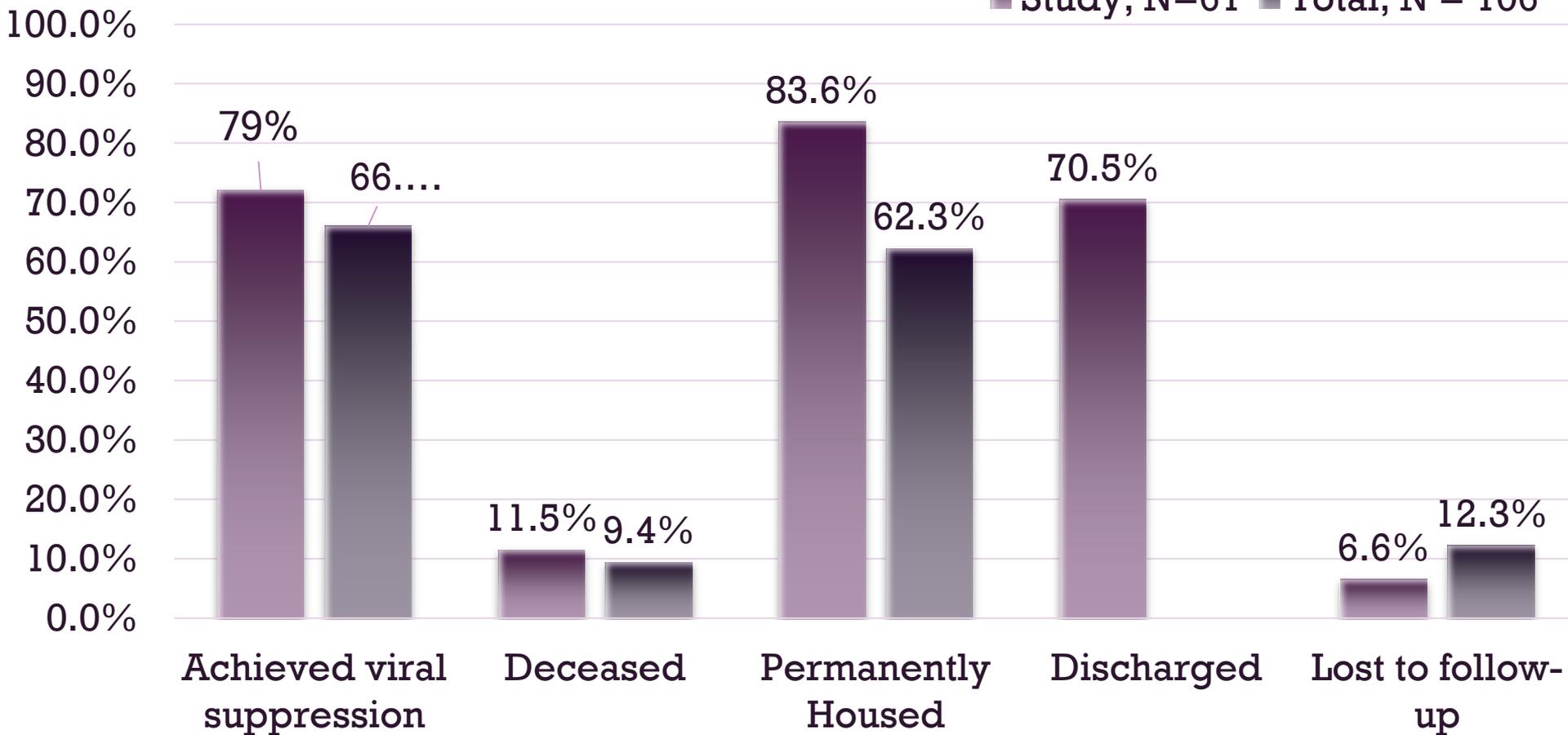




VARIABLES	STUDY PARTICIPANTS N =61	ALL HHOME CLIENTS <i>including those unable to consent to study</i> N =106
VIRAL SUPPRESSION at 12 MONTHS achieved viral load suppression at 12 month chart review	32 (60.4%)	N/A
VIRAL SUPPRESSION EVER at 12 MONTHS achieved viral load suppression at least once during intervention by 12 month chart review	42 (79.25%)	70 (66.0%)
RETENTION IN CARE at 12 MONTHS retained in care with the program by 12 month chart review	51 (83.6%)	N/A
STABLE HOUSING from intervention stably and independently housed or linked to the appropriate level of supportive-living	51 (83.6%)	66 (62.3%)
PERMANENT HOUSING acquired permanent housing; signed lease	45 (73.8%)	57 (53.8%)
SUCCESSFUL DISCHARGE successfully discharged to standard level of medical care and less intensive support services	43 (70.4%)	N/A
LOST-TO-FOLLOW-UP lost to HHOME team and/or study, either due to disengagement or relocation	4 (6.6%)	13 (12.3%)

HHOME Metrics

■ Study, N=61 ■ Total, N = 106



+Housing CM and Peer Navigation

“Never Give
up
Never Surrender” - *Siotha King-Thomas*



Peer Navigation



“Its not going to work if you’re doing more for the client then they are doing for themselves” – Jason Dow



Never Give up on Anyone

+ WHAT IT CAN LOOK LIKE



It can take
many
weeks to
many
months
for clients
to adjust
and then
thrive
indoors





+

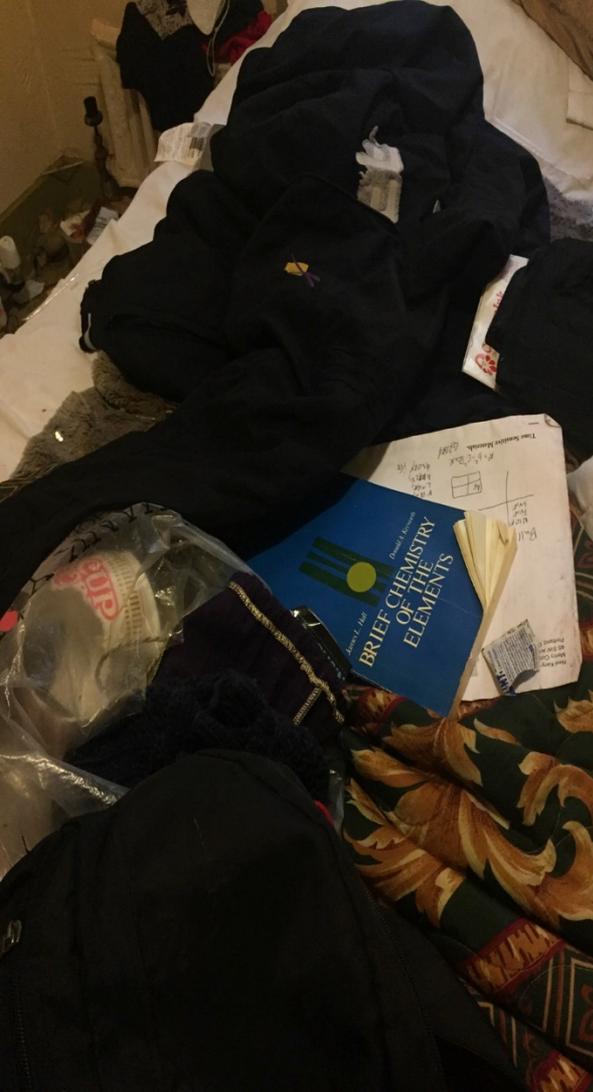
Consumer Voice....



Successes and Challenges







Challenges: Program

- ◆ Not enough Peer Navigation or RN time
- ◆ Data Issues:
 - ◆ Referral process is not centralized nor computerized
 - ◆ We have different data systems
- ◆ Applying “QI” principles to a moving target is tricky
- ◆ Maintaining calm focus in the midst of chaos
 - ◆ “If we weren’t meditating before this, we certainly meditate now.” -*Janell*
- ◆ Addressing short term goals and long term goals simultaneously



Challenges: System

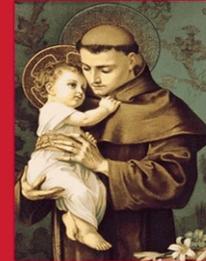
- ◆ Not Enough Stabilization or Supportive Housing
- ◆ Lack of Trauma Informed Programs and Providers.
- ◆ Communication between hospital–hospital and hospital-community
- ◆ Not enough medical CM programs to ‘step down’ to.- especially Palliative Care
- ◆ Political environment constantly changing

What Works

- ◆ Care: Trauma Informed
 - ◆ Client Centered
 - ◆ System Supported -System-Wide Coordination
- ◆ Flexible Treatment plans
- ◆ Cross training of team-Integrated, team-based navigation
- ◆ Starting treatment any where, any time
- ◆ Team Communication
- ◆ Community Pharmacy
- ◆ Support of Lead Agencies
- ◆ Courage of consumer and team



Help To Find **Lost**
things and people ...

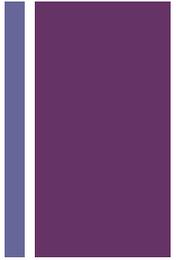


Saint
Anthony is
the Patron
Saint of
LOST things
and people.

*Call on
him now!*

+ Unexpected Successes

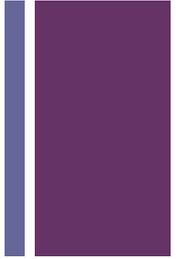
- ❖ System-Wide Coordination
 - ❖ Creation of the SF HIV Care Continuum Task Force – insures that system-wide referrals and linkages for PLWHA are timely and appropriate
- ❖ Championing palliative care and advanced care planning
- ❖ Recognized as a leader in trauma-informed medical care in SF
 - ❖ Training medical students, residents, and fellows



+ SPIN-OFFS:

- ❖ New Getting to Zero intensive case management programs
- ❖ HHOME Life Skills – peer led program designed to retain PLWHA in housing
- ❖ Encampment Health – program providing low barrier PrEP, STI testing, and HIV testing and Rapid treatment for encampment communities in SF
- ❖ Pregnant women Mobile Care
- ❖ Social Determinants of Health Consult

+ Partnerships Built



- ❖ Safety net medical clinics
- ❖ Medical and psychiatric emergency rooms and inpatient hospitals
- ❖ Surveillance and linkage organizations
- ❖ SF county jail health program
- ❖ HIVE – services for pregnant women living with HIV/AIDS and/or discordant couples
- ❖ Project Open Hand – nutritional services and meal delivery for people living with disabilities and/or chronic illnesses



The HHOME Model proves the hypothesis that systems fail, not the patient.

A HHOME clients' success comes their resiliency
- coupled with pooling resources, integrating care between agencies, and clearly defining and addressing system gaps





+ Humans Are Amazing

