HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO
Gavin C. Newsom, Mayor

Department of Public Health

MINUTES

HEALTH COMMISSION
COMMUNITY AND PUBLIC HEALTH COMMITTEE
Tuesday, January 19, 2010
2:00 p.m.
San Francisco General Hospital Room 2A6
San Francisco, CA 94110

1) CALL TO ORDER

Commissioner Sako called the meeting to order at 2:05pm.

Present: Commissioner Margine Sako, Chair
Commissioner James M. Illig, Member
Commissioner Catherine Waters R.N., Ph.D., Member

2) FOR DISCUSSION AND GENERAL DISCUSSION OF NEW COMMITTEE POSSIBLE ACTION:

Commissioner Sako welcomed everyone to the newly formed Committee and presented the following as its mission:

Community & Public Health Committee
To assure oversight and review of Departmental policies, programs, and issues that are not addressed through the SF General Hospital or Laguna Honda Hospital Joint Conference Committees. Issues to be addressed, but not limited to, are services provided through Community Programs, public health prevention activities, Healthy SF, Emergency Medical Services Agency, and Jail and forensic health.

- Provide a forum for productive discussion and recommendations to improve DPH program development and service delivery. Community comment and input is strongly encouraged.
- To develop a strong understanding by Commissioners about relevant topics, encourage creative and active input from all interested parties, and provide appropriate guidance and assistance.

- Committee members will hear DPH and community presentations; request additional information where needed; and when suitable, make recommendations.

Commissioner Sako stated that in addition to DPH staff, other community stakeholders, including DPH contractors, are invited to attend the Committee to help give context and input to the topics reviewed and discussed.

Commissioner Sako asked Barbara Garcia, Deputy Director of Health, to assist with creating a twelve month calendar of topics to be presented to this Committee by various DPH divisions. Ms. Garcia will present the Committee with suggested DPH presentations at the next Committee meeting.

3) EMERGING ISSUES

Emergency Medical Services (EMS)

Dr. John Brown, Director of the San Francisco EMS Agency, briefly introduced the Quality Dashboard which uses ten indicators to help assess EMS in San Francisco. Similar Dashboard models have helped other municipalities with their quality initiatives.

He stated that the DPH makes policies and procedures in regard to EMS. The Fire Department is the provider of services; it can make policy on the resources it will spend on EMS and in regard to what entity will be charged for those services.

Currently only two private companies have applied to provide ambulance services. Transport One just completed its corrective action plan steps and Bayshore Ambulance submitted their application. Regardless of whether both of these companies are approved to provide services for the City, Dr. Brown does not anticipate a dramatic change in ambulance services.

Dr. Bob Cabaj, Director of Behavioral Health, stated that the Fire Department is now charging DPH and its contractors for inspections. The DPH charges the Fire Department for Fire and Ambulance Inspections.

Dr. Brown will elaborate on the model and EMS when he makes a full presentation at the February 16, 2010 Community and Public Health Committee meeting.

SF DPH Primary Care Behavioral Health Program

Maria Martinez, Community Programs Deputy Director, Ms. Garcia, and Dr. Cabaj presented the San Francisco Department of Public Health Primary Care Behavioral Health Program (see Attachment 1). The DPH hired the Public Consulting Group to assist with the creation and evaluation of this model.

The model insures that patients have access to both primary and mental health care onsite on the same day; it should reduce loss-to-follow up. The intent is to integrate mental health services into primary care clinics and integrate primary care services into mental health clinics. This enables patients to continue to choose which clinic they prefer; the benefit will be that patients who had previously only received one or the other will be offered both services onsite by providers who will be coordinating care.

An important aspect of the project is how to best maximize federal reimbursement for both primary care and mental health services being provided at the same physical site. Increased effectiveness in patient services will derive from enabling primary care providers to refer those patients needing mental health assessments/services to clinicians onsite; this will enable the primary care providers to see more patients each day. Mental health providers will leave a portion of every hour unscheduled to prepare for seeing patients referred by the primary care providers. The model should also increase the number of clients mental health providers may see each day. Licensed mental health clinicians can bill for every assessment they complete. With increased number of patients seen by both types of providers, the overall amount the DPH will receive in Medi-Cal reimbursement revenue should increase.

The South of Market Mental Health Clinic is currently piloting the model. The Tom Waddell, Silver Avenue, Castro Mission, Housing Urban Health, and Ocean Parkway clinics are being assessed to adopt the model by July 1st, 2010. The execution will proceed differently for each clinic because each has distinct systems and cultures. The goal is to transition all DPH clinics to the model over the next twelve months. Eventually, the San Francisco Clinic Consortium staff will also be trained on the model after it is piloted.

The Committee asked for an update on this issue at the May 18th, 2010 Community and Public Health Committee meeting.

4) PUBLIC COMMENT**

Annie and Hima distributed a letter to the Commissioners outlining issues related to the lack of safety for strippers in clubs that have built private rooms/booths without permits.

Annie stated that the Entertainment Commission has jurisdiction over the clubs. However, they have done nothing to help provide a safer environment for the workers. Because there is a lack of safe work environment and frequent sexual assault of strippers in these booths, she asked the DPH for help to make these clubs safer for the strippers who work there.

Hima stated that she has met with DPH representatives and Health Commissioners in the past but the situation continues to be dangerous for women working in these clubs. She requested that the DPH take action to deal with the lack of health and safety of the strippers at these clubs.

5) ADJOURNMENT

The Committee adjourned at. 3:26pm

_____

Mark Morewitz
Health Commission Executive Secretary

*** Explanatory documents are available at the Health Commission Office, 101 Grove Street, Room #311, telephone 554-2666, or at the Joint Conference Committee meeting. If any materials related to an item on this agenda have been distributed to the Finance Committee after distribution of the agenda packet, those materials are available for public inspection at the Health Commission Office at the address above during normal business hours.**

**** Opportunity for members of the public to address the Joint Conference Committee on items of interest to the public that is within the subject matter jurisdiction of the Joint Conference Committee that are not on the agenda. Additionally, public comments will be taken for each agenda item.**

A majority of the members of the Health Commission may be in attendance at this Committee meeting. However, there will be no discussion of or deliberations on any matter not on this Committee agenda. This matter is being noticed as a meeting of the full Commission in the event that a quorum is present under Sec. 67.3(b)(1) of the San Francisco Administrative Code.

Accessible Meeting Policy

Meetings are held in Room 302,101 Grove Street, in San Francisco, CA. Room 220 is wheelchair accessible through the Grove Street entrance. Take the elevator to the 2nd floor. The closest accessible station for Muni and BART is the Civic Center station. The nearest accessible BART station is Civic Center (Market/Grove/Hyde Streets). Accessible MUNI Metro lines are the J, K, L, M, and N (Civic Center or Van Ness Stations). MUNI bus lines serving the area are the 47 Van Ness, 9 San Bruno, and the 6, 7, 71 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142. For information about MUNI services, call 673-6864. There is accessible parking in the vicinity of City Hall at Civic Center Plaza and adjacent to Davies Hall and the War Memorial Complex. Accessible curbside parking is available on Dr. Carlton B. Goodlett Place and Grove Street and at the southwest corner of Grove and Polk Streets.

American Sign Language interpreters and readers and/or language interpreters are available with advance notice of three business days. The Department of Public Health will make every effort to accommodate requests for sound enhancement systems and alternative formats for meeting minutes and agendas. Please make these requests as far in advance as possible. For all requests contact the Department of Public Health, Equal Employment Opportunity Program, telephone 554-2595 or the Health Commission office at 554-2666. Late requests will be honored if possible.

In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City to accommodate these individuals.

Cell Phone and/or Sound Producing Electronic Device Usage at Hearings

The ringing of and use of cellular phones, pagers and similar sound producing electronic devices are prohibited during public meetings. Please be advised that the Chair/President may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phones, pagers, or other similar sound producing electronic devices (Sunshine Ordinance 67A.1).

San Francisco Lobbyist Ordinance

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance (San Francisco Campaign and Governmental Conduct Code 2.100) to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at: 25 Van Ness Avenue, Suite 220, San Francisco, CA 94102; telephone (415) 252-3100; fax (415) 252-3112; and web site: **www.sfgov.org/ethics**.

Know Your Rights Under the Sunshine Ordinance

The Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's

business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

For information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact Frank Darby by mail to Sunshine Ordinance Task Force, 1 Dr. Carlton B. Goodlett Place, Room 244, San Francisco CA 94102, by phone at (415) 554-7724, by fax at (415) 554-7854 or by email at sotf@sfgov.org Citizens may obtain a free copy of the Sunshine Ordinance by contacting Mr. Darby or by printing Chapter 67 of the San Francisco Administrative Code on the Internet, at http://www.sfgov.org/sunshine.htm.

Attachment 1

San Francisco Department of Health
Primary Care Behavioral Health Program

DPH has made a commitment to ensure that individuals in Primary Care have access to behavioral health services. To this end, as of January 2010, we plan to start a new model in our primary care clinics. Evaluations of similar programs in a variety of cities suggest better clinical outcomes with patients, improvement in primary care provider and patient satisfaction with behavioral health services, and a better value for the health care dollar (citations follow).

At the core of this model, there will be a new provider—the "Primary Care Behavioral Health (PCBH) Provider." The PCBH Provider will focus on a specific problem that the patient and primary care provider identify; e.g., solving a relationship problem, enhancing motivation to change health risk behaviors, changing lifestyle behaviors to prevent illness or improve disease management, learning ways to improve mood and ability to relax, addressing problems with use of medications, improving parenting skills, addressing child behavior problems, establishing stable housing, promoting stability and a higher quality of life for patients with serious mental illnesses, and assisting with the problems of obesity, smoking, alcohol and drug use.

<table>
<tr><th colspan="3">The PC Behavioral Health Provider: A Member of the Primary Care Team</th></tr>
<tr><td>Service:</td><td>Brief Intervention</td><td>Pathways (Chronic Care and Self Care Management)</td></tr>
<tr><td>Role:</td><td>Works to relieve burden of behavioral health problems on PC team, improve patient access to behavioral health services at the time of need (all levels of need)</td><td>Works to improve health outcomes for patients needing sustained behavior change support</td></tr>
<tr><td rowspan="2">Description:</td><td>▪ Located in the heart of the clinic and works out of any available exam room
▪ PCP remains in charge (PCBH Provider makes recommendations, does not have case load)
▪ Open Access Scheduling – Sees patients immediately before / after PC visit. Is available throughout the day, every clinic day of the week, even while seeing patients if need be
▪ Takes all comers – No wrong referrals – Is Generalist
▪ Provides visits that are brief in time and duration, but as needed
▪ Emphasizes problem-solving, education, self-management, skill building
▪ On-going measurement of QOL – Quality of Life</td><td>▪ Identifies "high impact" group (e.g., chronic pain, diabetes, depression, PTSD, ADHD, Homelessness, SMI)
▪ Based on evidence, PCBH Provider and PCP co-develop "pathway program" for patient, share care plan
▪ Often involves monthly self-management classes (lead by PCBH Provider or co-lead by PCBH Provider and PCP), where patients complete outcome measures, learn skills, and in some cases, receive medications. May involve registries, use of telephone
▪ Measures outcomes (utilization, clinical, satisfaction)</td></tr>
<tr><td colspan="2">▪ Charts in medical record
▪ Use evidence-based interventions, including cognitive behavioral therapy, motivational interviewing, mindfulness, etc.
▪ Provides same-day verbal feedback to referring PC providers</td></tr>
</table>

There will be <u>two phases</u> to establish this program:

- <u>Readiness Review</u> (to help clinics prepare for this program)
  Services offered: 2-3 day clinic site review, workshop for PC providers, consultation with clinic leadership, application of practical readiness tool to identify preparation targets
- <u>Implementation</u> (to prepare the PCBH Provider and the PC providers to work as a team)

Services offered: Core competency training for identified PCBH Provider, identification of barriers that PC providers see to success of program, practice support tools for PC providers and PCBH Provider, early morning and/or lunch hour presentations to PC providers based on responses to training interest surveys

Barbara A Garcia, Deputy Director of Health, Director of Community Programs, 415-255-3525
Project Manager: Maria X Martinez, Deputy Director of Community Programs, 415-255-3706
Consultants: Public Consulting Group January 22, 2010

Primary Care Behavioral Health Model – Citations

1. Katon, W., Robinson, P. Von Korff, M., Lin, E., Bush, T., Ludman, E., Simon, G., & Walker, E. (1996). A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry, 53*, 924-932.
2. Katon, W., Von Korff, M., Lin, E., Walker, E., Simon, G.E., Bush, T., Robinson, P., & Russo, J. (1995). Collaborative management to achieve treatment guidelines: Impact on depression in primary care. *Journal of the American Medical Association, 273 (13*), 1026-1031.
3. Meresman, J. F., Hunkeler, E. M., Hargreaves, W. A., Kirsch, A. J., Robinson, P., Green, A., Mann, E. Z., Getzell, M., & Feigenbaum, P. (2003). A case report: Implementing a nurse telecare program for treating depression in primary care. *Psychiatric Quarterly, 74*(1), 61-73.
4. Robinson, P., Del Vento, A., & Wischman, C. (1998). Integrated treatment of the frail elderly: The group care clinic. In Blount, S. (Ed.), *Integrated Care: The Future of Medical and Mental Health Collaboration*, New York: Norton.
5. Robinson, P. (2002). Treating depression in primary care: What are the cost offset opportunities? (pp. 145-166) In N. Cummings, W. O'Donohoe, & K. Ferguson (Eds.), *The impact of medical cost offset on practice and research: Making it work for you.* Reno, NV.: Context Press.
6. Robinson, P. (2003). Implementing a primary care depression critical pathway (pp.69-94). In N. Cummings, W. O'Donohoe, & K. Ferguson (Eds.), *Behavioral health as primary care: Beyond efficacy to effectiveness.* Reno, NV: Context Press.
7. Robinson, P. (2005). *Adapting empirically supported treatments for primary care.* In W. O'Donohoe, N.
8. Cummings, M. Byrd & D. Henderson (Eds.). *Behavioral Integrative Care: Treatments that Work in the Primary Care Setting*. NY: Brunner-Routledge.
9. Robinson, P. (2008). Integrating Acceptance and Commitment Therapy into pediatric primary care. In L. A. Greco & S. Hayes (Ed)., *Acceptance and Mindfulness Interventions for Children, Adolescents and Families*, Oakland, CA: New Harbinger
10. Robinson, P. (2008). Putting it on the streets: Homework in Cognitive and Behavioral Therapy. In W. O'Donohue (Ed.), *Cognitive Behavior Therapy*, Second Edition, Hoboken, NJ: John Wiley & Sons, Inc.
11. Robinson, P., Bush, T., Von Korff, M., Katon, W., Lin, E., Simon, G.E., Walker, E. (1995). Primary care physician use of cognitive behavioral techniques with depressed patients. *Journal of Family Practice, 40* (4), 352-357.
12. Robinson, P., Bush, T., Von Korff, M., Katon, W., Lin, E., Simon, G.E., & Walker, E. (1997). The
13. education of depressed primary care patients: What do patients think of interactive booklets and a video? *Journal of Family Practice, 44*, 562-571.
14. Robinson, P. J., Gould, D., & Strosahl, K. D. (2010). *Real Behavior Change in Primary Care*. Oakland: New Harbinger (available Fall, 2010).
15. Robinson, P., Gregg, J., Dahl, J. & Lundgren, T. (2004). Acceptance and Commitment Therapy in medical settings (pp. 295-314). In S. Hayes, & K. Strosahl (Eds.), *A practical guide to acceptance and commitment therapy*. New York: Springer Science + Business Media.
16. Robinson, P. J. & Reiter, J. T. (2007). *Behavioral Consultation and Primary Care: A Guide to Integrating Services*. NY: Springer.
17. Robinson, P. & Strosahl, K. (2009) The Primary Care Behavioral Health model: Lessons learned. *Journal of Clinical Psychology in Medical Settings,16*, 58-71.
18. Robinson, P. & Strosahl, K. (2000). Improving outcomes for a primary care population: Depression as an example (pp. 687-711). In. M. Maruis (Ed.), *Handbook of Psychological Assessment in Primary Care Settings*, NY: Lawrence Erlbaum Inc.
19. Robinson, P., Wischman, C., & Del Vento, A. (1996). *Treating depression in primary care: A manual for primary care and mental health providers*. Reno, Nevada: Context Press.
20. Strosahl, K. & Robinson, P. (2001). Clinical practice guidelines: A tool for improving the quality of behavioral healthcare. In N. Smelser & P. Baltes (Eds.). *International encyclopedia of the social and behavioral sciences*. London, UK: Elsevier Press.
21. Strosahl, K. & Robinson, P. (2008). *The Acceptance and Mindfulness Workbook for Depression*, Oakland, CA: New Harbinger.
22. Strosahl, K. & Robinson, P. (2007). The Primary Care Behavioral Health Model: Applications to Prevention, Acute Care and Chronic Condition Management. In Kessler, R. (Ed.), *Case Studies in Integrated Care*. NY: Springer