Mental Health Association of San Mateo County Presents: Navigating the Mental Health System

Friday, May 24, 2019
8:30 a.m. to 4:30 p.m.

The Sobrato Center for Nonprofits
350 Twin Dolphin Drive, Redwood Shores

www.mhasmc.org
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@springstreetmha

Mentalhealth Association of San Mateo County

@mentalhealthassociationofsmc
An estimated 26% of Americans ages 18 and older - - about 1 in 4 adults - - suffers from a diagnosable mental disorder in a given year. Many people suffer from more than one mental disorder at a given time.

Mental Health Disorder Statistics – Johns Hopkins Medicine
Studies of non-compliance among mental health consumers show the following reasons for not taking medication:

• Side Effects – side effects can begin well before signs of improvement.
• Denial about illness.
• Cost.
• Fear and Procrastination.
• Fear of giving up personal autonomy.
• Symptoms rarely go away completely.
• Because they feel better and assume that they are cured.

Approximately 50% of adults are non-adherent with their medication for physical conditions. The main reasons for not taking medications include:

• Side effects: they don’t like them.
• There is no immediate relief.
• Medication is too costly.
• Medication makes them feel less in control.
• Medication doesn’t seem to be working and symptoms are not going away.
• Symptoms have resolved and they figure they no longer need it.
Multiple studies have found that mental health diagnoses varied significantly by race and ethnicity.

- Native American/Alaskan Native patients had the highest rates of diagnosis (20.6%)
- Asians had the lowest rates (7.5%)
- In general, the study found that patients from most racial and ethnic minority groups had much lower rates of mental health diagnosis compared to non-Hispanic white patients, ranging from 64% lower for Asian patients to 28% lower for Hispanic patients.

Nauert, Rick, Ph.D., “Race/Ethnicity Influence Diagnosis & Treatment of Mental Illness”; PsychCentral; 8 Aug 2018.

Differential conceptualization of emotional well-being has implications for the assessment and diagnosis of mental health issues in this population.

Urban Indian Health Institute, Seattle Indian Health Board. (2012). Addressing Depression Among American Indians and Alaska Natives: A Literature Review. Seattle, WA: Urban Indian Health Institute.

Students from India, Nigeria and Thailand plainly said there was no concept for “depression” in their native culture and many felt their parents “would not allow” them to accept medication for — or the labeling of — their condition as “depressive.”

Boles, David; October 14, 2008 No Word for Depression
There is nothing I can do to help someone living with a mental illness.
Agenda

• What is Integrated Behavioral Health?
  • Integrated Behavioral Health delivery at SMMC
  • Results
Integrated Behavioral Health brings mental health services to primary care populations

The goal of Integrated Behavioral Health is to increase access, reduce stigma, and improve patient outcomes.
One-third of patients with medical conditions have co-occurring mental health issues

Percentage of Adults with Mental Health Conditions and/or Medical Conditions

- 29% of Adults with Medical Conditions Also Have Mental Health Conditions
- 68% of Adults with Mental Health Conditions Also Have Medical Conditions

Top conditions seen in Primary Care

- Skin disorders
- Osteoarthritis, joint disorders
- Back problems
- Cholesterol problems
- Upper respiratory problems

- **Anxiety, depression, and bipolar disorders**
  - Chronic neurologic disorders
  - Hypertension
  - Headaches, including migraine
  - Diabetes

Primary care is the *de facto* mental health system in the US

Mental Health comorbidity leads to worse health outcomes

Source: Melek SP, Norris DT, Paulus J. Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. April, 2014
Primary Care typically underdiagnoses and treats behavioral health issues

- 28-yo Latina
- PCP visit for headaches, insomnia and back pain
- 2 kids, no partner
- History of domestic violence and depression
- Completed early childhood education degree
- DACA status expires May
- Feeling sad, anxious, lonely

“Luz”  
(composite patient with stock photo)

Dr. Kalra, PCP

- Median PCP appt time is 15.7 min
- 3-4 medical topics raised in most visits
- Median patient talk time is 5.3 min and PCP is 5.2 min
- Time share of topics in visits:
  - 79% Biomedical
  - 4% Mental health
  - 4% Personal habits
  - 9% Psychosocial
  - 1% Pt-PCP relationship
  - 2% Others

Agenda

• What is Integrated Behavioral Health?

Integrated Behavioral Health delivery at SMMC

• Results
Annual depression screening administered yearly for all adult primary care patients

PRIME MD PHQ-2

Over the past two weeks, have you lost interest or pleasure in things you usually like to do?

Yes  No

Over the past two weeks, have you felt sad, down, depressed, or hopeless?

Yes  No

• Free
• Empirically validated
• Widely adopted
• Integrated with EHR
Behavioral health specialists embedded in primary care augment care seamlessly

- Crisis interventions
- Functional Assessment
- Triage
- Brief intervention
- Referral to patient wellness classes
- Clearance for groups (CBT, Mindfulness, Diabetes, Depression, Insomnia)
- Referral to other SMC services, e.g., AOD care
- Schedule intake for therapy and psychiatry
Integrated Care
One clinic, one chart, one tx team

In-visit (Warm handoffs)
• Crisis interventions
• Meet & greet
• Brief interventions

Group Treatment
• Skills-based
• Mind & body
• Social activities

Individual Psychotherapy
• Evidence-based
• Short-term
• Brief & traditional visits

Outreach & Education
• Weekly wellness classes
• Patient handouts
• Peer counseling

Medication Evaluation
• Curbside consultation
• Ongoing follow-up
• Pharmacy support

Referrals
• AOD, SMI
• Long-term treatment
• Social Work/Case Mgt
• Social support

Context:
• Culturally-sensitive
• Trauma-informed
• Patient-centric

SMMC offers a broad array of behavioral health services in primary care clinics
Educational materials normalize behavioral health care as part of medical care.
Agenda

• What is Integrated Behavioral Health?

• Integrated Behavioral Health delivery at SMMC

Results
Integrated Behavioral Health at SMMC is touching close to 2,000 lives yearly

Patient Volume

- 10,000 depression screens in 2018 (~15% positives)
- Higher behavioral health service utilization (up to +40%) due to reduced stigma and greater access
- Over 8,000 individual appointments in 2018
- Patients efficiently linked to follow-up care, if any
- 30 workshops per quarter
- 9 therapy groups quarterly
- Expanding to other clinics

Source: SMMC data
Strong positive feedback from PCPS

I am no longer afraid of opening a Pandora’s box by asking my patients about their emotional health. Having Behavioral Health readily available in the clinic has been vital - and now I can’t imagine primary care without it!

[PCP]

I used to be primary care provider, mental health counselor, and psychiatrist...but now I feel supported!

[PCP]

Having Integrated Behavioral Health in the clinic is a critical component of the workflow. We feel really well supported!

[Nurse]
Questions?

• Katherine Shadish, PhD
  – kshadish@smcgonv.org
Navigating the Mental Health System 2019
Selma Mangrum
BHRS Access Call Center
Screening & Referral for:

**Mental Health:**

**County Clinics**
- case management, Medication support, Therapy, Groups, referrals to higher levels of care

**Private Provider Network**
- Therapy
- Medication

**Substance Use Treatment**
- Outpatient
- Intensive Outpatient
- Residential
- Detox
- Medication Assisted Treatment
Access to care:

24-hour Access-Screening
Referrals/information

Insurance Types:
Health Plan of San Mateo
• Medi-Cal
• Care Advantage/Cal Medi-Connect
• Healthy Kids
• Health Worx
• ACE
When you or anyone in need calls we will ask:

“How can we help you?”

“How long have you or your family member been feeling / thinking / behaving like this?”

“How do these issues affect your daily life?”
We will also ask:

- **Diagnoses: Current, past**
- **Medications--current, past, need?**
- **Risk—Harm to self or others**
- **Treatment History**
- **Substance Use History**
BHRS REGIONAL CLINICS

1. North County:
2. North-East and North-West
3. South County
4. Coastside
5. East Palo Alto
6. Central County
PRIVATE PROVIDER NETWORK

Approximately 200 providers throughout San Mateo County

MFT’s LCSW’s, PsyD/PhD’s, MD’s, NP’s; Individuals and Agencies

Available languages: Spanish, Cantonese, Mandarin, Russian, Farsi, Tagalog;

Taxi vouchers available from HPSM to get to your appointments
SUBSTANCE USE SERVICES

• Referral to Outpatient services in your neighborhood or

• Referral to the Residential Treatment Team for evaluation
For Residential Treatment
Your Rights as a Beneficiary:

Timely Decisions about your requests for services

Change of provider Requests

Grievance and Appeal if you are not satisfied
Questions?
Regional Clinics

Mariana Rocha, LCSW
Clinical Services Manager
Regional Clinic Services serve individuals with a Serious Mental Illness (SMI).

SMI is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

*Definition by The National Institute of Mental Illness: www.nimh.nih.gov*
Regional Clinics

North County Adult & Youth Clinic
375 89th Street
Daly City, CA 94015
650-301-8650

Coastside Adult & Youth Clinic
225 South Cabrillo Highway, Suite 100A
Half moon Bay, CA 94019
650-726-6369

Central Adult & Youth Clinic
1950 Alameda de las Pulgas San Mateo, CA 94403
650-573-3571

South Adult Clinic
802 Brewster Ave Redwood City CA, 94063
650-363-4111

South Youth Clinic – Shasta Clinic
727 Shasta Street Redwood City CA, 94063
650-599-1033

East Palo Alto Adult & Youth Clinic
2415 University Ave, Suite 301 East Palo Alto, CA 94303
650-363-4030
How to access Regional Clinic Services?

BHRS ACCESS Call Center
(800) 686-0101

Walk in Hours
9:30-11:30am & 1:30-3:30pm
Same Day Assistance (SDA)

SDA is a brief evaluation/screen appointment regarding care and treatment needs.

Individuals will get to talk to a clinician about their concerns, services they are requesting and the services that the clinic can provide.

Based on the brief screen an individual will be given treatment options which may include care at the clinic or other more appropriate referrals for other services.
Same Day Assistance (SDA)

What is helpful to bring for an SDA appointment:

- ID
- Insurance Card
- Current Medications or Empty Pill Bottles
- Any Mental Health Records available
Same Day Assistance (SDA)

If an individual is eligible for Regional Clinic Services they will get an appointment for an assessment with a mental health clinician or a psychiatrist.

If there is an urgent need for medication/meds refills the psychiatrist on duty will be consulted but this may not result in a prescription being filled.

Wait times to see a psychiatrist can range from 10-30 days.
Regional Clinic Services

The Regional Clinics offer an array of services from:

- Psychiatric assessment
- Medication evaluation/Monitoring
- Rehabilitation counseling
- Clinical case management Services
- Counseling/Therapy Services
- Peer Support Services
- Psychoeducation
- Collateral support
- Referrals to Employment Support Services/Educational programs/Social Rehabilitation programs/ Co-occurring substance use services/and others
Referrals for Higher Level of Care

Clients with serious mental illness who are identified by their treatment providers to need more support than what the regional clinics can offer will be referred to either Intensive Case Management Services (ICM) or Full Service Partnership team (FSP)

FSP: Full Service Partnerships Criteria:
• Three or more PES/ED visits in the last 60 days AND/OR
• Two Inpatient psychiatric hospitalizations in the last 6 months with most recent hospitalization in past 30 days AND /OR
• Transitioning out of a locked/secure facility (i.e MHRC, Secured SNF, Jail, or Out of County Placement) AND/OR
• Loss of current support system that would potentially result in hospitalization, incarceration, or other form of locked placement without FSP level services based on past history.
Other BHRS Programs

OASIS: Older Adult System of Integrated Services Provides services to older adults 60+ who are SMI and homebound.

PUENTE: A specialty clinic working with Golden Gate Regional Center to provide mental health services to adults with intellectual disabilities.

AOT: Assisted Outpatient Treatment team reaches out to people with a severe mental illness who are not connected to services and are challenged to live safely and stably in our community.

*Referral to these specialty programs can happen via Access Team if the client is not connected to a regional clinic or by the clients treatment team.
Questions
Psychiatric Emergency Services (PES)
What is PES?
ER for mental health and behavioral emergencies
Our Services

We provide:

- acute psychiatric evaluation
- crisis intervention
- referral services
- and are the gateway to acute inpatient admissions
What to Expect

Every patient is under the care of a psychiatric registered nurse and a psychiatrist at all times. The psychiatrist will complete an evaluation, make a diagnosis and determine a plan of care. Care plans may include:

- Crisis intervention with follow-up services as appropriate, either behavioral health or substance abuse
- Medication and stabilization, or medication and subsequent hospitalization for further stabilization
- Evaluation and determination of a discharge plan will be as prompt as possible within a 23-hour period
Who we serve: Adults, Seniors, and Youth who

- Voluntarily seek psychiatric assistance during a crisis
- Or those detained involuntarily (5150) for psychiatric evaluation
Populations Served in 2018

- 11yo and under: 62; 2%
- 12 - 17yo: 445; 14%
- 18 - 59yo: 2494; 75%
- 60yo and over: 312; 9%
Presenting Legal Status

- Voluntary: 39%
- 5150: 56%
- Other: 5%
Services (generally) NOT Provided

- Services best provided by outpatient treatment and resources
- Medication adjustments and management
- Medication refills
- Housing and shelter
- Group therapy and activities
Referrals to PES in 2018

- Voluntary; 1031; 31.1%
- Med-ED; 617; 18.6%
- Law Enforcement; 1102; 33.2%
- Outpatient Clinic; 89; 2.7%
- Residential/SNF; 25; 0.8%
- Outside Hospitals; 9; 0.3%
- Shelter; 12; 0.4%
- ETOH/Drug Tx; 14; 0.4%
- Jail/Probation; 55; 1.7%
- Other; 305; 9.2%
- Cordilleras; 60; 1.8%
- Outside Hospitals; 9; 0.3%
How to Access Services

• Call PES at (650) 573-2662 for 24 hour advice from a psychiatric registered nurse

• 24 hour voluntary evaluations at San Mateo Medical Center

• Call 911 or local law enforcement for assistance regarding a mental health crisis and request a CIT officer
Discharge Locations in 2018

- Home/Self care: 55.3%
- Other: 4.9%
- AOD Treatment: 5.0%
- Inpatient (3AB): 8.7%
- Inpatient (Other): 21.2%
- Residential/B&G/CF/SNF: 3.3%
- Probation/Custody: 1.7%
- Other: 4.9%
CONTACT US

Psychiatric Emergency Services
San Mateo Medical Center, 1st Floor
222 W. 39th Ave
San Mateo, CA 94403

650-573-2662 T
650-573-2489 F
smchealth.org
QUESTIONS?
Landscape of Digital Medicine for Mental Health
## Digital Health: The Perfect Storm

<table>
<thead>
<tr>
<th>Human Needs</th>
<th>Tech Advances</th>
<th>Business/Regulatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Existing systems of intervention are not working</td>
<td>• Installed base of devices</td>
<td>• Shortage of clinicians</td>
</tr>
<tr>
<td>• Addiction Issues</td>
<td>• VR/AR ready for prime time</td>
<td>• Costs MUST be controlled</td>
</tr>
<tr>
<td>• Chronic Diseases</td>
<td>• Sensors and data</td>
<td>• Regulatory easing and expedition</td>
</tr>
<tr>
<td>• Aging Populations</td>
<td>• AI and ML advances</td>
<td>• ACO and capitation</td>
</tr>
<tr>
<td>• Prevalence of Mental Health Issues</td>
<td>• Tools and Techniques tested and available</td>
<td>• New payer models</td>
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<tr>
<td></td>
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<td>• Venture and Investments</td>
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</table>
Human Needs
Paradigm Shift in Care Needs

Acute to Chronic Care Management

- “Life Threat” to Disease Process
- Existing systems of care not designed to accommodate new paradigm
- 80% of all deaths and 90% of all morbidity
- $2.4 Trillion is spent on chronic lifestyle diseases
- Global burden ~$47T
CNS: Huge Unmet Need

U.S. Economic Burden¹ for CNS disease, 2016

<table>
<thead>
<tr>
<th>Condition</th>
<th>Adults With Mental Illness (Millions)</th>
<th>Percent of Adult Population</th>
<th>Equivalent State Adult Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Psychiatric Disorder</td>
<td>43.6</td>
<td>18.7%</td>
<td>Texas, New York, and Georgia</td>
</tr>
<tr>
<td>Serious Psychiatric Disorder</td>
<td>9.8</td>
<td>4.2%</td>
<td>Illinois</td>
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<tr>
<td>Major Depressive Disorder</td>
<td>15.7</td>
<td>6.7%</td>
<td>Florida</td>
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<tr>
<td>Schizophrenia</td>
<td>2.6</td>
<td>1.1%</td>
<td>Connecticut</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>6.1</td>
<td>2.6%</td>
<td>Oregon and Oklahoma</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>2.3</td>
<td>1.0%</td>
<td>Utah</td>
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<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>8.2</td>
<td>3.5%</td>
<td>Georgia</td>
</tr>
<tr>
<td>Panic Disorders</td>
<td>6.3</td>
<td>2.7%</td>
<td>Virginia</td>
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<tr>
<td>Dysthymia</td>
<td>3.5</td>
<td>1.5%</td>
<td>Louisiana</td>
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<tr>
<td>Autism</td>
<td>2.4</td>
<td>1.0%</td>
<td>Iowa</td>
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<tr>
<td>Neurodegenerative Disorders</td>
<td>5.8</td>
<td>2.5%</td>
<td>Washington</td>
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<tr>
<td>Alzheimer's</td>
<td>5.1</td>
<td>2.2%</td>
<td>Massachusetts</td>
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<tr>
<td>Parkinson's Disease</td>
<td>0.6</td>
<td>0.3%</td>
<td>North Dakota</td>
</tr>
<tr>
<td>Total</td>
<td>50.9</td>
<td>21.8%</td>
<td>California and Texas</td>
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</tbody>
</table>

Estimated U.S. economic burden of common brain-related illnesses exceeds $1.5 trillion per year and worldwide burden exceeds $6 trillion per year by 2030

Global patient pop. for CNS disease

Billion patients

Approximately 80% of the world market for brain related treatments is currently either underserved or underserved

*Information Technology and Innovation Foundation (ITIF), 2016
Source: NeuroInsights, Office of Nat’l Drug Policy, American Psych. Assoc., Cost of Brain Disorders Europe
Costs and Consequences: Mental Illness and Addiction

**Mind-blowing**


<table>
<thead>
<tr>
<th>Disease Type</th>
<th>0</th>
<th>3</th>
<th>6</th>
<th>9</th>
<th>12</th>
<th>15</th>
<th>18</th>
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<tbody>
<tr>
<td>Mental illness</td>
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<tr>
<td>Cardiovascular diseases</td>
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<tr>
<td>Cancers</td>
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<td>Chronic respiratory diseases</td>
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<tr>
<td>Diabetes</td>
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</tbody>
</table>

Cause of disability-adjusted life-years*
High-income countries, people under 70, 2012

- Mental-health disorders 17.4%
- Cancers 15.9%
- Cardiovascular diseases 14.8%
- Respiratory diseases 4.4%
- Musculoskeletal diseases 9.2%
- Injuries 12.9%
- Other 21.7%

Sources: World Economic Forum; Harvard School of Public Health; Mental Health Atlas; WHO; The Economist

Economist.com
In 2015 only 11% of the estimated 22.7 million Americans in need of treatment for SUD received any formal treatment.

Over $740B in annual costs from healthcare, productivity and crime.

Addiction and overdose have surpassed car accidents as a leading cause of death in young men.

91 people a day are overdosing and deaths > 2 jets a week crash landing.

Health impacts are profound and include abscesses, cellulitis, pneumonia, heart failure, HIV and Hep C.

High rates of comorbidities – causative or reflective directionality.
Digital Therapies are Needed

Current State of Care

- Diagnosis occur too late
  - Jail, hospital, death
- Stigma and shame
- Expensive, not available and not scalable
  - Deserts of care for all mental health
- High friction for patients
  - Removed from home, work, stressors and triggers
- Inconsistent treatment

Digital Treatment

- Digital can allow exploration and early intervention
- Private – apps are all HIPAA secure and CFR-42 compliant
- Effective, available and scalable
  - BYOD – patients already online
- Always on and always available
  - 168 hours in the week
- Consistent approach that is gamified and engaging and can be personalized
Tech Advances
Patients Ready and Tech Ready

90% of Americans Use Digital Health Tools

<table>
<thead>
<tr>
<th>Consumer ownership of connected devices in the U.S.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Smartphone</td>
<td>78%</td>
</tr>
<tr>
<td>Tablet</td>
<td>55%</td>
</tr>
<tr>
<td>Streaming device</td>
<td>32%</td>
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<tr>
<td>Home automation</td>
<td>27%</td>
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<tr>
<td>Smart speaker</td>
<td>24%</td>
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<tr>
<td>Fitness tracker</td>
<td>18%</td>
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<tr>
<td>Smartwatch</td>
<td>13%</td>
</tr>
<tr>
<td>VR headset</td>
<td>9%</td>
</tr>
<tr>
<td>Personal drone</td>
<td>7%</td>
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</tbody>
</table>

SOURCE Walker Sands 2017 Future of Retail survey
George Petras/USA TODAY
Sensors and Networks Connecting Every Device
Data, Analytics and AI

Advancing Data Developments:

- Massive advances in AI
- Huge amount of $ pouring in
- FDA clear Viz.AI and follow ons
- “Light Touch” and 21st Century Cures

People willing to share data >50% already do.

“Machines will be capable, within twenty years, of doing any work a man can do”
Business/Regulatory
Advancing Regulations:

- Digital Tx approved by FDA
- Accelerated Reviews – Around the World: Pre-Cert Program and EAPs/European Medicine Agency Fast Track
- RWD accepted in clinical trials and expansion indications
- No regulation of the “practice of medicine”
- FDA exempts a broad range of digital tools
Payers Increasingly Interested in Digital Medicine

New Payers/Mindset on the Scene

- Self Insured Employers/A-B-JPM
- New Entrants: Oscar, Collective, Clover
- Traditional Insurers Investing Heavily
Private Funding Increases
LET’S GET DIGITAL
Digital Health Delivers

High Value:

◆ Available 24/7

◆ Scalable and Affordable

◆ Consistent and Safe

◆ Fully Integrated into Care Paradigms

◆ Engaging and Positive Reinforcement

Hundreds RCTs have shown positive results
Behavior Modification and Neuroplasticity

Requirements
• Expert framing and education
• Intensive coaching and attention
• 24/7 access and support
• Feedback loops
• Rewards and recognition
• Holistic

Issues
• Expensive
• Not scalable
• Friction points: travel; time from work and home
• “Specialists” and lack of trained clinicians
• Non standardized care
Why Digital Apps for Mental Health?

- **Active Involvement**: provides patients with immersive experiences that make them feel more involved in their care.
- **Feedback**: behavior is reinforced by direct, immediate and relevant feedback that reinforces positive behavior.
- **Engaging and Motivating**: gives patients something to control and can provide immediate rewards. (Contingency Management)
- **Social Connections**: provide and enhance social resilience. (Social Physics)
- **Dose Response**: games prolong the effect of therapy while reducing face-to-face contact.
Emotional Drivers

**Traditional Emotional Motivation**

Apprehension, uncertainty, waiting, expectation, fear of surprise do a patient more harm than any exertion.

Florence Nightingale
Notes on Nursing 1859

**Game/App Approach**
Engagement Drives Outcomes

92% of patients said improving consumer experience should be a top goal when deploying digital health tools.

• Non-adherence causes ~ 125,000 deaths, 10% of hospitalizations and costs up to $300 billion a year
• Patients that are more engaged have better outcomes
• Data Access is Key

Annals of Internal Medicine, 2017
Legacy Systems are just too far behind to ever get you there.
Update on Co-Occurring Disorders: The Bad, the Good, and the In-Between

Anna Lembke, MD
Stanford University
May 2019
Disclosures

I have been retained as a consultant on behalf of plaintiffs in the federal multidistrict litigation (MDL) against opioid manufacturers, distributors, and other defendants. I have also been retained on behalf of the state of Washington in the opioid litigation against Purdue Pharma.
The Bad News
Gateway Hypothesis
Runway Hypothesis
Risk factors for addiction

Nature

Nurture

Neighborhood
Simple access to drugs is a risk factor for addiction
Link between opioid prescribing and opioid deaths
The second wave of the epidemic

Overdose Deaths Involving Opioids, United States, 2000-2016
The hidden epidemic – benzodiazepines: 7-fold increase in overdoses between 1999-2015

[Graph showing overdose deaths in the United States involving benzodiazepines, 1999 through 2015. From the National Institute on Drug Abuse.]

The pill generation

Prescription/Over-the-Counter Drugs Account for 8 out of 14 of the Most Frequently Abused Drugs

Prevalence of Past Year Drug Use Among 12th Graders

Source: The Monitoring the Future study, University of Michigan
Cannabis: Potency

Average THC and CBD Levels in the US: 1960 - 2011

Daily cannabis use going up

Daily marijuana use rises sharply

Percent of marijuana users who use the drug at least 300 days out of the year.

Source: National Survey on Drug Use and Health
WAPO.ST/WONKBLOG
Tobacco access has increased worldwide
Increased access means increased consumption

![Figure 1](image)

Per capita consumption of different forms of tobacco in the United States, 1880-1995


ms of tobacco consumption (Burns et al., via US Department of Agriculture)
E-cigarette use is going up

E-cigarette use trends
U.S. high school students' usage of e-cigarettes increased 900 percent between 2011 and 2015.

Source: CENTER FOR DISEASE CONTROL & PREVENTION
DRU BERRY, Missourian
Super potent nicotine delivery systems
The Internet, social contagion, and behavioral addictions
Global delivery supply chain, depositing drugs on our doorstep
The technology itself is addictive
We are inundated with dopamine!
If you’re not addicted yet, it’s coming soon to a website year you.
The Good News
Medical schools now training doctors to detect and intervene for substance use problems
IN THE HOUSE OF REPRESENTATIVES

Ms. Clark of Massachusetts (for herself, Mr. Rogers of Kentucky, Mr. Sarbanes, and Mr. Guthrie) introduced the following bill; which was referred to the Committee on ________

A BILL

To amend the Public Health Service Act to authorize a loan repayment program for substance use disorder treatment employees, and for other purposes.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

4 This Act may be cited as the “Substance Use Dis-
5 order Workforce Loan Repayment Act of 2018”.
INPATIENT ADDICTION
CONSULT SERVICE

Hospitalization is a critical opportunity to offer addiction diagnosis, treatment, and linkage to outpatient care. Addiction consult services decrease substance use, improve treatment adherence, and reduce readmissions.

Evaluation and Diagnosis
in patients with concern for substance misuse (i.e. drug-seeking, chronic high dose opioids, illicit drug use).

Pharmacotherapy for Addiction
initiated inpatient with bridge prescriptions to outpatient follow up. Assistance with tapers for risky opioid and benzodiazepine use.

Motivational Interviewing & Counseling
with education on treatment options, harm reduction, overdose prevention.

Linkage to Outpatient Addiction Care
through coordination with outpatient providers, collaboration with social work, and discharge to outpatient programs.

Consult Addiction Medicine (or page #14826)
Available 8am - 5pm Monday - Friday
Medications to treat addiction: Naltrexone
Buprenorphine

“The provision of opiate substitution therapy for addicted individuals has strong evidence of effectiveness”
Buprenorphine
Transcranial magnetic stimulation (TMS)

TMS Therapy for Depression
Might Also Treat Addiction Too

Transcranial Magnetic Stimulation stimulates the brain's limbic system which regulates emotions & behavior
Peer recovery counselors
Telehealth
Monitoring devices
Virtual reality
In-Between News
Gastric bypass surgeries
Post gastric bypass alcohol addiction

From 2000–2014, the average per study is 21% of WLS patients are gaining new addictions each year.

Doctors now think Gastric Bypass changes how alcohol is metabolized, increasing its rate of absorption & making it more addictive.

Essentially, drinking alcohol after Roux-en-Y is like having an Alcohol IV.

Can't regulate how quickly it gets into your bloodstream. Rather than it taking 30 minutes for alcohol to get through the stomach, the effects are almost instant.

Greater risk of addiction if no awareness or support is sought regarding addictive behaviour.

As a result you get drunker faster & stay drunker longer.
Ketamine for depression?

FIGURE 1. Change in Depression Severity Over Time in Patients With Treatment-Resistant Major Depression Given a Single Infusion of Ketamine or Midazolam

Ketamine is addictive

Relapse on ketamine followed by severe and prolonged withdrawal: A cautionary case and review of potential medical therapies

Matthew P. Prekupec¹, Rachel S. Sussman², Yelizaveta Sher², and Anna Lembke²

¹ Department of Internal Medicine, University of Nevada Las Vegas School of Medicine, Las Vegas, Nevada, USA. ² Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, California, USA

Ketamine is a non-competitive N-methyl-D-aspartate receptor antagonist used medically as a dissociative anesthetic. It has been used recreationally since the 1970s. In recent years, ketamine has been investigated in the treatment of depression and chronic pain. Given ketamine’s addictive potential, increasing medical use poses the risk of misuse or addictive use following medical exposure. This risk may be higher in patients with co-occurring substance use disorders (SUD). We present the case of a patient with opioid use disorder well-controlled on buprenorphine who was exposed to ketamine in the emergency department (ED), then relapsed by misusing ketamine. He procured it from the darknet to “self-medicate his depression.” After using heavily for 15 days, he experienced debilitating withdrawal syndrome requiring intensive care unit admission. Ketamine...
Thanks for listening!
Access to Homeless Services
The Human Services Agency

• Collaborative Community Outcomes - Center on Homelessness
  • Partners with Community Providers for Safety Net and Homeless Services
  • Continuum of Care Lead Agency
  • Role in Coordinating Homeless System
Coordinated Entry System

Pre CES

Post CES
## Core Service Agencies

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Address</th>
<th>Phone Number</th>
<th>Area Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daly City Community Service Center</td>
<td>350 90th St., Daly City</td>
<td>(650) 991-8007</td>
<td>Daly City, Broadmoor, Colma</td>
</tr>
<tr>
<td>YMCA Community Resource Center</td>
<td>1486 Huntington Ave., South San Francisco</td>
<td>(650) 276-4101</td>
<td>Brisbane, San Bruno, South San Francisco</td>
</tr>
<tr>
<td>Pacifica Resource Center</td>
<td>1809 Palmetto Ave., Pacifica</td>
<td>(650) 738-7470</td>
<td>Pacifica</td>
</tr>
<tr>
<td>Coastside Hope</td>
<td>99 Avenue Alhambra, El Granada</td>
<td>(650) 726-9071</td>
<td>Montara, Moss Beach, El Granada, Half Moon Bay</td>
</tr>
<tr>
<td>Fair Oaks Community Center</td>
<td>2600 Middlefield Rd., Redwood City</td>
<td>(650) 780-7500</td>
<td>Redwood City, North Fair Oaks, Portola Valley, Woodside, Atherton</td>
</tr>
<tr>
<td>SAMARITAN HOUSE</td>
<td>4031 Pacific Blvd., San Mateo</td>
<td>(650) 347-3648</td>
<td>Belmont, Burlingame, Foster City, Hillsborough, Millbrae, San Mateo, San Carlos</td>
</tr>
<tr>
<td>Puente de la Costa Sur</td>
<td>620 North St., Pescadero</td>
<td>(650) 879-1691</td>
<td>La Honda, Loma Mar, Pescadero, San Gregorio</td>
</tr>
<tr>
<td>Samarian House South</td>
<td>1852 Bay Rd., East Palo Alto</td>
<td>(650) 294-4312</td>
<td>East Palo Alto, Menlo Park</td>
</tr>
<tr>
<td>Puente de la Costa Sur</td>
<td>620 North St., Pescadero</td>
<td>(650) 879-1691</td>
<td>La Honda, Loma Mar, Pescadero, San Gregorio</td>
</tr>
</tbody>
</table>

Rental Assistance

Presented by
Housing Authority of the County of San Mateo

May 24, 2019
Housing Authority of the County of San Mateo

- Provides rental subsidies to low-income households
- Provides financial supports in preservation of existing, and development of new, affordable housing units

Housing & Community Development

- Facilitates development and preservation of affordable housing through local, state, and federal funding
- Supports public service agencies
Programs Overview

- All rental assistance programs are funded by U.S. Department of Housing and Urban Development (HUD)
- All programs share similar general eligibility criteria but some programs may have additional requirements
- Each program may have different and additional reporting requirements
Programs Overview

- Close to 4,700 Household Served
- > 9,700 Adults and Children
- Close to 1,700 Participating Landlords
- > 10,000 Applicants on Various Waiting Lists
- > $100 Million Annual Housing Assistance Budget
Programs Overview

Rental Assistance

- Voucher (90% via waitlist)
- Permanent Supportive Housing (CES)
Permanent Supportive Housing

- Funded by HUD through the Continuum of Care Program
- Promotes communitywide commitment to end homelessness
- Serves chronically homeless individuals who have severe mental or other disabilities
- Based on Housing First model
Permanent Supportive Housing

Grant recipients are required to provide a minimum 25% “in kind” supportive services match for the amount of the award.

Examples of supportive services include:
- Homeless outreach
- Housing search and counseling
- Case management
- Job training
- Health services
Permanent Supportive Housing

Accessible through the County’s Coordinated Entry System (CES)

No waiting list!

Prioritization will be based on:
- Length of homelessness
- Severity of the disability
- Other vulnerability factors
SMC Coordinated Entry System

Household
With Homeless Service Need

Core Service Agencies
Entry points for coordinated entry to homeless services. Core Service Agencies also provide safety net services such as food, clothing, utility assistance, & other basic needs

Assessment and Diversion
Trained Coordinated Entry Staff work with the household to identify alternative housing options. For households who don’t have alternative housing options, Coordinated Entry Staff complete a standardized assessment tool.
SMC Coordinated Entry System

- Referral to Community Resources
- Housing Options
- Shelter Placement
- Rapid Re-Housing
- CORA
- PSH
- HUD-VASH
SMC Coordinated Entry System

1. Each week HACSM will report to HSA (CES lead) the number of openings its homeless programs can serve
2. HSA will match households using CES assessment tool
3. HSA will notify HACSM through CES of the matched households
4. HACSM will retrieve referral packages from CES and start eligibility process
Pathway to Other Housing Programs

1. Waitlist for the 5-year time-limited Moving-To-Work voucher program is open. Selection is by lottery
   
   www.smchousingwaitlist.org

2. Visit HACSM website www.smchousing.org often for other waitlists opening

3. For homeless veterans, contact the local VA office
   
   ✷ San Bruno VA Clinic
   ✷ Palo Alto/Menlo Park VA Medical Center
Questions

Any questions?

Jennifer Rainwater  jrainwater@smchousing.org
Cindy Chan         cchan@smchousing.org
Housing Scenarios
Bill

- 50 year old male, long time county resident, living in encampments or on the streets for 10+ years
- Not connected to any mental health or shelter services but well known to ERs, law enforcement and food pantries
- Repeatedly approached by outreach teams over the years but refused services due to fear of government
- On recent visit to ER which Bill often used to get out of the rain, was diagnosed with serious illness, later determined to be cancer
- Bill finally wants to explore different housing options in part because his Oncologist knows his chemo and radiation treatments he is scheduled for will be very difficult to handle living outside
Jackie

- 37 year old female long time county resident, lived most of the past 4 years moving from friends’ houses, family, hotels, and common shelter stays
- Before that she lived with her boyfriend for over 8 years
- She never stays very long at a shelter
- Common practice is to get her SSI check the first week of the month, she will stay at a SRO or motel for as long as her $ holds out, then tries to crash with old boyfriends, sister, adult son and failing those, she will try and get referral to Spring Street shelter
- She is seriously mentally ill, getting services through NCBHRS
- In addition to carrying SMI, she has a long history of methamphetamine abuse which causes some behavior problems living in a shelter setting
- She is in the MH system and only ever stays at Spring Street, she has never had a CES assessment
- Most recent time she comes to Spring Street, she finally wants to end her cycle and find appropriate housing
Frida

- 30 year old female long time county resident has lived the past year with assistance from the Rapid Rehousing Program, and that $ is running out
- She cannot pay her rent next month. During the year of RRH, she not only lost her job, but was diagnosed with a SMI after a long hospitalization
- She gets services through CCBHRS
- Her SSI has just come in, but is far less than her rent of $2200/month
- She has asked for extensions from the RRH program and received a couple, but the final request was rejected
- She will be homeless this Friday
MHA PROPERTIES
WHO DO WE SERVE?

- SINGLE ADULTS
- AGES 18-80+
- ALL SERIOUSLY MENTALLY ILL
- ALL FORMERLY HOMELESS OR FORMERLY AT RISK OF HOMELESSNESS
- ALL LIVE WELL BELOW 30% OF AREA MEDIAN INCOME
- MANY HAVE A CO-OCCURRING DISORDER
- NEARLY ALL OF OUR CLIENTS ARE LIVING ON SOME HOUSING SUBSIDY IN SAN MATEO COUNTY
WHAT ARE OUR SERVICES

• HOUSING CASE MANAGEMENT
  • HOUSING LOCATION
  • LANDLORD MEDIATION
  • ENSURE CLIENTS ARE COMPLIANT WITH RULES/REGULATIONS FOR HOUSING AND DOH

• SUPPORT SERVICES

• OCCUPATIONAL THERAPY

• PUBLIC HEALTH NURSING PROGRAM
VILLA TERRACE HOUSE
*OPENED 1992
*6 ROOM SHARED HOUSING
*NO WAITLIST
*FILL VACANCIES WITH CES AND DOH ASSISTANCE
HURLINGAME HOUSE
*OPENED 1993
*6 ROOM SHARED HOUSING
*ON SITE MHA OFFICE
*NO WAITLIST
*FILL VACANCIES WITH CES AND DOH ASSISTANCE
BURLINGAME APARTMENTS
*OPENED 1998
*5 UNITS/8 BEDROOM APARTMENT BUILDING
*NO WAITLIST
*FILL VACANCIES WITH CES AND DOH ASSISTANCE
BELMONT APARTMENTS
*OPENED 2005
*24 UNITS
*ON SITE MHA OFFICE
*NO WAITLIST
*FILL VACANCIES WITH CES AND DOH ASSISTANCE
CEDAR STREET APARTMENTS
*OPENED 2012
*14 STUDIO APARTMENTS
*ON SITE MHA OFFICE
*WAITLIST PROPERTY
*NOT ADMINISTERED THROUGH DOH OR CES
WAVERLY PLACE APARTMENTS
*OPENED 2018
*15 UNITS
*ON SITE MHA OFFICE
*NO WAITLIST
*FILL VACANCIES WITH CES AND DOH ASSISTANCE