Contra Costa Mental Health Commission
Monthly Meeting
December 10, 2009
Minutes – Approved 1/14/10

1. CALL TO ORDER/INTRODUCTIONS

Chair Mantas called the meeting to order at 4:35 pm and requested Vice Chair Pasquini chair the meeting.

Introductions around the room were made.

Commissioners Present:
Dave Kahler, District IV
Carole McKindley-Alvarez, District I
Colette O'Keeffe, MD, District
Peter Mantas, District III, Chair
Floyd Overby, MD, District II
Annis Pereyra, District II
Anne Reed, District II
Teresa Pasquini, District I, Acting Chair
Sam Yoshioka, District IV

Commissioners Absent:
Art Honegger, District V-Excused
Bielle Moore, District III-Excused
Scott Nelson, District III – Excused
Supv. Piepho, Dist. II – Excused

Attendees:
Gita Baronimipour
Brenda Crawford, MHCC
Al Farmer, NAMI
Lynda Gayden CCR Health Foundation
John Gragnini, Local 1
Steve Grolnic-McClurg, Rubicon
Robert Heaston, Jr.
Mariana Moore, Human Services Alliance
Connie Steers, MHCC
Janet Marshall Wilson, JD, MHCC

Staff:
Dr. Karen Burt, CCRMC
Susan Medlin, MHA
Donna Wigand, MHA
Suzanne Tavano, MHA

2. PRESENTATION ON INTEGRATIVE HEALTH CENTER-Dr. Karen Burt

She has been with CCC for 13 years, most recently as a primary care physician in Brentwood. Dr. Burt's vision for integrative health care comes during a time of debate on national healthcare on a in which many things are being discussed about what needs to change about healthcare. "The current system is broken and really needs to get fixed."

Her proposal discusses how to create and expand the integrative health services group medical visits and health education in the CCC health system. The types of services focus on prevention and self-management; key components of any revised health care system. One component is group medical visits where a group of patients see a doctor in a group setting. CCC has several of these groups already: pain management, prenatal visits, well-baby visits, diabetes groups and possibly heart failure groups in the future. The other component is health education, fitness and wellness, including incorporating alternative medical services including acupuncture when appropriate. A part of this is behavioral health services. As a primary care provider, she spent a great deal of time talking to her patients about the issues in their lives ad a majority of them had to do with mental health and substance

abuse issues. She was frustrated she didn't have access to mental health services for her patients and filled the gap as best as she was able.

Integrative healthcare is collaborative between family and patient, more collaboration between all aspects of health care, collaboration between different County divisions, collaboration between community agencies and community health workers. It really focuses on the patient and empowers them toward self-management within the healthcare system.

It represents a paradigm shift from current, conventional healthcare crisis and disease-oriented system set up (unsustainable) vs. a new model of self-healthcare (sustainable). In the unsustainable model, the medical, mental health and substance abuse teams are separated making care for the "total" patient difficult. In the sustainable model, people are taught to care for themselves then when disease does strike, to help self-manage their care. Disease management will always be required, but not at the center of the system. Behavioral health services would be expanded in the program from severe mental illness to stress management.

Switching to this type of model is a big transition for both providers and patients, requiring a willingness to change. Community health workers can be a key link between communities and families and acting as patient educators.

The services she discussed already have seeds being sown from this integrative approach within CCC health system. She has been in contact with Dr. Ferman, Ambulatory Care, who will be bringing in behavioral health services, both in one-on-one and group treatment situations. The beneficiaries of this system include patients, providers and the entire healthcare system: patients' fundamental needs addressed (including more empowered and enthusiastic patients), new models for handling chronic pain, chronic issues, mental health issues and behavioral health issues, new productive successful venues for providers to deliver care and healthcare system balanced/costs reduced. When the different parts of the healthcare system collaborate, it will result in a better range of treatment for the patient. In a system where patients take care of their own health care, we will see less acute illness.

(The slides from the PowerPoint presentation follow these minutes.)

Robert Heaston asked what would it take to implement the new system. Dr. Burt said "buy in" from all parties. So far everyone she has spoken to has been positive, including Dr. Walker and Pat Godley. She has various ideas about how to implement it. She introduced Lynda Gaydon, director of Contra Costa Regional Health Foundation, who be supporting it by writing grants. There are several new health centers being considered over the next few years; hopefully they will be built according to this model: integrating both physical and behavioral health care needs.

Commissioner Yoshioka asked if a single existing facility could be used as a pilot site and if the concept had been run by the County financial people. Dr. Burt has spoken to the CEO and CFO and hopes within 2 years to have a pilot site. Lynda Gaydon said so much of the revenue streams are a function of billing issues and who is able to bill for services. Currently only a physician, nurse practitioner, licensed clinical psychologist or LCSW is able to bill; many of these positions were eliminated due to budget constraints. Suzanne Tavano said they are looking at space on Willow Pass with Concord Adult Mental Health to use as an integrative pilot site and it looks fairly positive, if the building can be modified. Donna Wigand clarified that space would be a slightly different model than Dr. Burt is talking about.

The Concord clinic would involve placing a health clinic within the 4 walls of a mental health clinic for patients with some physical health care needs but moderate to high mental health needs. It would be the first time health care would be introduced into a mental health care clinic. Lynda Gaydon clarified Integrative Health Services is a much large picture; looking at Behavioral Health Services (ie. the Concord clinic) is a component of that broader picture.

Vice-Chair Pasquini asked if consumers in the room had any comments. None from members of the public, but Commissioner O'Keeffe asked if we are integrating physical health services into the mental health services, what will the model be: the old physical health model vs. a more holistic approach given the limited budgets? Dr. Burt wasn't sure, but it is a great question. Suzanne Tavano said in the Concord clinic by placing a separate physical health clinic inside (but separate) from a mental health clinic, they will be able to bill under a separate billing system and avoid the issues of same day billing. So much is billing driven.

Vice-Chair Pasquini read about the new County facility in San Pablo and not having a mental health clinic co-located within the new clinic. Donna Wigand said she understands there will continue to be psychiatrists attached to the clinic, but West County Mental Health Services clinic will not be placed within the new clinic. Vice-Chair Pasquini is disappointed the integrative approach is not being considered at the new clinic as it was in 38th St. clinic.

Commissioner Yoshioka presented 2 articles: the first about the new Richmond Health Center and the second about a San Pablo outpatient health center to be opened in July 2010 for commissioners' review. *(The articles follow these minutes)*

3. PUBLIC COMMENT

A. Robert Heaston gave an account of his 25 year-old daughter's treatment when she was in crisis and taken to the CSU at CCRMC on 10/2/09. She was separated from her mother and very little was done to evaluate her medically before moving her to CSU that was filled with patients being held on 5150's. When he went to pick up his daughter at CSU he was treated with disrespect by staff and told to wait in the ER as there is no waiting area by CSU. After 4 weeks, he requested a report from the County and was told they were waiting for reports from 2 doctors. He is very frustrated with the doctors at CSU and their lack of response to his requests for follow-up information on the inadequate care his daughter received. In a follow-up call to the CSU Director shortly after the incident, Mr. Heaston was told his daughter could be seen for an appointment in a month or so. She saw several doctors during the next few weeks and felt there was no integration of care; she felt they had not even read her file based on discussion/suggestions of medications she was already taking or had not previously worked for her. She was told if she saw a non-County doctor, the County wouldn't be able to work with her. Julie Kelly and Gloria Hill have been the only ones to provide real assistance and he appreciates their help. He attempted to contact the Director of Health Services (emails and phone calls) without a response; he spoke at the 12/1/09 BOS meeting about the incident. He distributed a handout including a letter written by his daughter. He would like to see family in the process and patient advocates. There is no accountability of personnel CSU and conflicts of interest within the system.

Vice-Chair Pasquini thanked Mr. Heaston for attending and bringing the issue to the attention of the MHC. Chair Mantas suggested Mr. Heaston stay connected and communicate with the MHC.

4. ANNOUNCEMENTS

A. 1/14/10 MHC abbreviated meeting/public hearing at 651 Pine Street, Room 101, 4:30 – 7:30 pm, on the MHSA FY 2009/2010 Annual Update to the three year program and expenditure plan. Each Commissioner received a hard copy of the plan today to review prior to the meeting and it is also posted online.

B. MHCC Holiday Party-Dec.11, 11 am – 2 pm at the Pleasant Hill Community Center, 320 Civic Center: A celebration for consumers.

5. APPROVAL OF THE MINUTES

- **ACTION: November 12, 2009 MHC Monthly Meeting – Motion made to approve minutes as corrected to include the motion made to have the MHC meet on 11/16/09 at the County Planning Commission public hearing on the application from Bonita House. (M-Pereyra/S-Overby/P-Kahler, McKindley-Alvarez, O'Keeffe, Overby, Pasquini, Pereyra, Yoshioka,7-0; Commissioners Mantas and Reed abstained.)**

(After listening to the tape recording of the 11/12/09 meeting, it was confirmed a motion was not made or required for the MHC to post a meeting notice to attend the Bonita House application hearing on 11/16/09. No correction to the minutes is necessary; they stand as submitted.)

6. VICE CHAIRPERSON'S COMMENTS

A. Update on New Commissioner Orientation – Nancy Schott to coordinate; please make attendance a priority. Commissioners need to view Brown Act/Better Government videos as well as the AB1234 Ethics online video. Nancy Schott to send out website information.

B. Report on 11/30/09 meeting at Mental Health Consumer Concerns Wellness Center with Supv. Gioia: See the Report on pg. 15 of the agenda packet for her

Public Comment by Connie Steers: She thanked Vice-Chair Pasquini and Supv. Gioia for coming to the Center and listening to the consumers' comments. The opportunity for consumers to have their voices heard was greatly appreciated.

Vice-Chair Pasquini would like to consider if the MHC should send a letter to the BOS requesting a copy of the investigation report on the West County consumer suicide or is that action necessary?

Commissioner Reed asked if the MHC did receive the report how heavily redacted would it be for confidential information and would it be of any value? Donna Wigand said by law any identifying patient information would have to be redacted. She feels MHA feels they have a history of sharing appropriate information and still maintaining confidentiality.

- **ACTION: Motion made to request the report be distributed to the Commission (M-Mantas, S-McKindley Alvarez/P-Kahler, Mantas, McKindley-Alvarez, O'Keeffe, Overby, Pasquini, Pereyra, Reed, Yoshioka, 9-0)**

Discussion:
Commissioner Reed stated that although all Commissioners are bound by the confidentiality agreement, not all Commissioners have signed the agreement yet. It is usually signed at the New Commissioner Orientation, but Nancy Schott will send out agreements to everyone who has not signed them prior to the Planning Retreat on 1/8/10.

Chair Mantas said the Commission must get to the point where it is understood what type of information is available to us. There have been incidents in the past brought to the MHC and although details are not required, we need to determine what is going on to fix those problems in order to make recommendations to the BOS.

Vice Chair Pasquini also would like to receive the report and use a learning document in order for the MHC to perform due diligence. Also schedule David Cassell to come as soon as possible and make that presentation a priority; we discuss prioritizing guests at the Planning Retreat. Also invite someone from CCRMC as Victor Montoya suggested at the 11/12/09 meeting.

C. MHC Planning Retreat will be held on 1/18/10 4:00 – 7:30, location to be determined. Julie Freestone invited to facilitate. The proposed agenda guideline is in the meeting packet. Any agenda suggestions should be submitted to Nancy Schott by 12/28/09.

- **ACTION: Motion made to have a retreat on 1/8/10, 4:00 – 7:30, location tbd, using the proposed agenda guideline (to be finalized) and Julie Freestone as facilitator. (M-Reed/S-Pereya/P-Kahler, Mantas, McKindley-Alvarez, O'Keeffe, Overby, Pasquini, Pereyra, Reed, Yoshioka)**
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D. 2009 Annual Report Update: The report is being prepared and will be discussed at the Planning Retreat.

E. Rose King Whistleblower Complaint: Rose King is the co-author of MHSA. See complaint in the packet. The complaint raises the possibility of repercussions and whether Prop. 63 has been circumvented with fragmented implementation of the state guidelines. She believes the MHC must consider the complaint as part of it's due diligence and it will possibly be considered at a future meeting.

7. MHC COMMITTEE/WORKGROUP REPORTS

A. MHC-CPAW Cap Facilities/IT Workgroup – Chair Pereyra

1. Update from Donna Wigand regarding current status on the 20 Allen St. parcel: the original proposal from MHA to HSD to use that parcel for new mental health programs. The original proposal included up to 4 levels of care in 3 buildings: Bldg. 1) 16 bed locked acute psychiatric health facility for adults, Bldg. 2) 16 bed unlocked crisis residential facility for adults, and Bldg. 3) program of 5150 involuntary receiving area for all age groups and voluntary urgent care outpatient clinic for anyone to use anytime. Both MHC and CPAW have ideas for use under review and a survey is being taken now for more ideas for use of Capital Facilites and IT money available under MHSA.

HSD has decided to purchase the land whether or not it is used for mental health services. Dr. Walker and/or Pat Godley will address the purchase of the property is an item on next week's

BOS agenda. In further discussion with HSD, 2 of the 4 services are no longer on the table for consideration at this time: 16 bed locked acute facility for adults and 5150 receiving center for adults. The only programs to be considered at this time are: 1) 16 bed unlocked crisis residential facility for adults and 2) an urgent care walk-in center for adults/urgent care walk-in clinic and 5150 receiving center for children.

Adults coming in to 5150 will still need to go through Emergency Room at CCRMC. HSD has decided no matter what gets approved or not, until a decision is made as to what MHA wants to do with the site, HSD will be opening up the site as storage and additional parking because those services are desperately needed. She hopes those decisions do not preclude any new mental health programming from going to that site. Went from 2.25 mill to 1.9 million; will

Commissioner O'Keefe asked if a lower price had been negotiated for the property. Donna Wigand said the cost went from 2.25 million to 1.9 million; it will be noted on the BOS agenda item.

Commissioner Reed asked if any money would be required to get the site ready to use for storage and parking? Donna Wigand said she was not sure. The building on site where HSD used to be located, can probably store medical records in its current condition. She's not sure about the parking.

Commissioner Yoshioka asked what the thought process was for eliminating the PHF and ARC and keeping only the crisis residential facility? Donna Wigand said her perception is there is already a 16 bed facility in hospital and a 5150 receiving center for adults in ER. There is more of a willingness to move forward with programs that don't already exist in the hospital. She stressed she is not speaking for HSD. Commissioner Yoshioka is concerned that the PHF was going to be the sole entry point into the mental health system. In a county as large and diverse as ours, why does that have to be a single entry point in Martinez? Donna Wigand doesn't agree with that statement. Currently people can access the system at various points in the county (ie. Antioch and Pittsburg clinics). If there are multiple points of entry, why can't parts of the ARC be located in out in the outpatient clinics for better access. We should be working toward that goal. Dr. Walker discussed unbundling services from the inpatient acute care to an outpatient model. The proposal seemed to be re-bundling the services back into the ARC in a central location. Donna Wigand stated CCC has 6 outpatient clinics; intake and crisis management are available at each clinic and suggested commissioners visit clinics. Commissioner Yoshioka prefers upgrading the outpatient clinics to offer more services in the different areas of the counties.

Vice-Chair Pasquini said the clinics are outstanding and she would like to the MHC visit clinics next year.

Commissioner Reed confirmed adult 5150's will still come through the ER; Donna Wigand agreed. Commissioner Reed wondered if there will be an opportunity during the assessment of any new facility to address some of the procedural issues the MHC has heard about regarding adults coming in to the existing ER at CCRMC? Vice Chair Pasquini said this is not Donna

Wigand's area, but discussions are being held at CCRMC and she will be working on the issue through the Healthcare Partnership.

Commissioner Pereyra asked if the RFP's be resent out with the change of programs? Donna Wigand said that may be necessary given the new focus on the ARC for children. There was only 1 children's provider who applied.

Chair Mantas asked how many of the unlocked beds will be available for adolescents vs. adults? Donna Wigand said it must be licensed for one or the other; it will be for adults (over 18).

Commissioner Yoshioka asked if a contractor or County would run the ARC? Donna Wigand the County will run the assessment center/urgent care clinic/children's 5150 center and a contractor will run the adult crisis residential. There is now more acceptance of county staff needing to run the assessment center.

Commissioner Overby asked if the County running the program will exclude Medicare and private insurance? Donna Wigand said it will not exclude patients with Medicare and privately insured patients usually go to their private insurance hospital. John Gragnini said the County has certain contracted hospitals for Medical and not all of those are all Medicare. Suzanne Tavano clarified 4C and CSU are under hospital administration, but the contracts with private hospitals are held by us and managed by Mental Health. MHA.

2. Update on Needs Assessment Survey

Commissioner Pereyra referenced the MHC-CPAW Capital Facilites/IT Workgroup handout. Suzanne Tavano and Steve Hahn Smith presented at the 11/16/09 meeting and provided more information than had been received at the CPAW meeting regarding IT. Steve Hahn-Smith was there as well and added his information. She felt there was a much better understanding of IT after the meeting. A questionnaire has been sent out to County Staff (600) and results are due back 12/11/09. The information will be reviewed, the results input into a database and a formalized report generated.

Commissioner Yoshioka asked if the commissioners could take the survey today? He feels the MHC perspective could be viewed in relation to the public one. Vice Chair Pasquini said it is not on the agenda and there is not time today. It could have been recommended at the Workgroup level at an earlier time. Commissioner Yoshioka asked about taking it at the Planning Meeting. Chair Pereyra said the report should already be prepared by the Planning Meeting. Commissioner Reed said from her point of view it would be better to have each Commissioner fill out the survey and then compare it to the tabulated results and report as a learning tool.

3. Hear update from 12/3/09 CPAW meeting

Part of the Workgroup splintered off, went out and came back to CPAW with information that was collected. She isn't sure if that was supposed to be in place of the survey the Workgroup is doing. They were trying to move along toward a vote on whether to accept the proposed facility at the CPAW meeting, but CPAW did not vote at the time. A new workgroup has been formed; her understanding from listening to the meeting is the group will be from

CPAW to get input from consumers and families as to the services to be provided at the new facilities, whatever the capital facilities end up being. After the meeting, there was another CPAW member who volunteered to join the Workgroup. She understands people have resigned from the Workgroup, but she has not seen any resignations, so she is not sure if they are on it. She doesn't know if the Workgroup can still be run if there are only Commissioners on it. Vice-Chair Pasquini said the surveys need to be received and possibly the joint Workgroup will revert back to the MHC Capital Facilities/IT Workgroup. Brenda Crawford said she has not resigned at this point, but she is still unsure of the Workgroup's charge.

Chair Mantas clarified CPAW's charter is only MHSA projects. The MHC is a W&I based commission that reports to the BOS on all matters of mental health services related. The chair of the Workgroup should still drive the meetings even if CPAW members do not participate. Chair Pereyra said it was presumed after the Workgroup receives the surveys and the research is completed on the information previously completed from other sources, the Workgroup will make a recommendation to the MHC and end as the charge will have been completed.

Commissioner Overby asked when the report will come back to the MHC? Chair Pereyra said the survey has been sent out with results coming back tomorrow. Commissioner Overby asked what background do the survey recipients have to provide us information? Chair Pereyra clarified the survey went out to County clinic rather than consumers as originally discussed. Vice-Chair Pasquini reminded Commissioners who haven't been part of the Workgroup process to respect those who have participated and be aware how much effort has gone into ensuring the various voices within the system (family, consumer, provider, MHC commissioners).

Brenda Crawford said consumers do not want the comments gathered through the MHCC-facilitated process negated. Vice-Chair Pasquini said those comments were heard at the Workgroup which the MHC charged with gathering information and issuing a recommendation back to the MHC.

Commissioner Kahler said we need to acknowledge the Workgroup has been a failure.

Commissioner Reed said the survey isn't the only piece of information available to the Workgroup. There have been previous surveys done that focused on the consumer. Before making a recommendation, the Workgroup will consider all the other information sources. The survey was sent to staff because their voices hadn't been included yet in the process.

Chair Mantas requested comments should be directed to the Chair not other commissioners. There are people doing lots of work on behalf of the MHC. The MHC needs to wait for the Workgroup to come back with their findings; be a little more patient.

Commissioner Overby apologized if anyone was offended. He went to several Workgroup meetings and heard interest in gaining more input from the consumer. Commissioner Yoshioka also attended the meeting and thought the survey was distributed to get consumer input.

Chair Pereyra said it was the Workgroup's opinion that input hadn't been collected across the board from the community, from staff, from families, from consumers . It was determined the

questionnaire wasn't a good tool to use for consumers and families and it was decided to send to staff only. CBO's were also interested in having their voices heard.
Chair Mantas clarified there has been information collected from consumers and families; Chair Pereyra confirmed yes.

Vice Chair Pasquini confirmed the joint MHC-CPAW effort from the MHC's perspective is over, but she and and Commissioner Pereyra have joined the CPAW Cap Fac/IT workgroup as MHC liaisons. The Workgroup will be advising Donna Wigand. Vice-Chair Pasquini would like someone to explain to both the MHC and CPAW the differences in the charges in both group's charges. Although CPAW reports to Donna Wigand and the MHC reports to BOS, she feels there are more likeness than differences. Chair Mantas confirmed Vice-Chair Pasquini's definitions and added the MHC has statutory W&I guidelines and CPAW does not. CPAW does have W&I mandates that CPAW has to follow in the course of doing business. Vice-Chair Pasquini is not sure if it clear to CPAW members and would like it communicated.

4. Consider information available regarding any proposals for the use of 20 Allen St. and take appropriate action

Chair Mantas said the MHC does not have enough information to take action on this item and suggests it is tabled until the report is received from the Workgroup. Vice-Chair Pasquini said the goal is to have survey report presented at the 1/14/10 MHC meeting. She asked Julie Freestone to check if Dr. Walker would consider waiting for the report and she said she thought he would. We don't know if the BOS will approve the land purchase until the 12/15/09 BOS meeting. **The Motion was tabled.**

5. Consider recommention 4C remain open an a permanent basis as it is a key component on the mental health continuum and if HS begins discussions to alter or close 4C, they will inform the MHC and all Community Stakeholders.

- **<u>ACTION:</u> Motion made to recommend 4C remain open on a permanent basis as it is a key component on the mental health continuum and if Health Services begins discussions to alter of close 4c, they will inform the MHC and all Community Stakeholders. (M-Mantas/S-Pereyra/P-Pereryra,O'Keeffe, Kahler, Overby, Reed, Mantas, Pasquini, 7-0/abstain McKindley and Yoshioka)**

Discussion:
Commissioner Yoshioka uneasy about keeping 4C open on a permanent basis. Why have a psychiatric patient without any medical issues in a 4c unit instead of a psychiatric unit of equal quality? Now there is a proposal for a PHF that is a better solution for an acute psychiatric patient without medical issues.

Commissioner O'Keeffe it is unusual to be in 4C without medical issues with the patient population we serve; it is not a good idea to switch them to less acute types of care.

Commissioner Reed said she would rather have the permanent status with notification of changes. Commissioner Yoshioka seems to be talking about the types of patients in 4C rather than the facility itself.

Chair Mantas said we have approx. 40 beds in a county of over 1 million citizens. The need and demand are huge; the supply is limited. This motion is more of a statement to the BOS requesting the hospital take the permanent position to not shut down 4C.

Vice-Chair Pasquini feels very strongly about keeping 4C open; it is commonly known there is a shortage of psychiatric beds in the county, state and country. The medical complications are also rising.

6. Consider Health Services initiate a study to develop a plan that could fill the gaps in the transportation system that serves the hospital.

Commissioner O'Keeffe said the type of facilities are yet to be determined so we don't know what type of transportation will be required. It sounds like we are taking on the transportation study for the entire hospital that is too large a scope for the MHC. Vice-Chair Pasquini clarified the motion is for Health Services not the Mental Health Commission to initiate a study.

Commissioner Kahler said this does motion addresses the issue of transportation to the entire hospital. HS has been remiss in not developing a transportation plan for years and it's only with the advent of the 20 Allen St. property that people suggest the transportation issues to a PHF? Putting a building in Brentwood is just as inaccessible as Martinez for someone. The solution isn't building more buildings, but to address transportation to the hospital and fill the gaps.

Commissioner O'Keeffe said there have already been major cutbacks to pubic transportation and the cuts will continue; the solution may come from a taxi/voucher system.

- **Motion: Consider HS initiate a study to develop a plan that could fill the gaps in the transportation system that serves the hospital (M-Kahler/S-Mantas/F-Yes: Pereyra, Kahler, Overby, Mantas, N0: O'Keeffe, Reed, Yoshioka, Pasquini, Abstain-McKindley -Alvarez) Motion failed.**

Discussion:
Commissioner O'Keeffe said it is a grandiose gesture; too big a task. Vice-Chair Pasquini is not sure it is an appropriate study for the hospital or HS.

Commissioner Kahler said this is just a study.

Chair Mantas thinks it is appropriate since the hospital is being used as a service hub. If HS can't do it, they will come back and let us know. We can ask the question.

Commissioner O'Keeffe said there won't be any help from the County Connection system and asking HS to do this will not have a positive outcome.

Chair Mantas agrees with Commissioner O'Keeffe, but still wants to pose the question and get a response.

8. REPORTS: ANCILLARY BOARDS/COMMISSIONS

A. Mental Health Coalition – Vice-Chair Pasquini: They are going to visit the BOS next year.
B. Hospital Community Forum - none

C. Human Services Alliance - none

D. Local 1: John Gragnani – completed the evaluation of MHA; submitted to Donna Wigand and Dr. Walker for in-house meetings to discuss results; report will be sent to MHC and NAMI early next year.
Vice-Chair Pasquini said she received a phone call from a Local 1 member regarding the survey. She may receive a survey. Chair Mantas asked the method of distribution. John Gragnani said After the in-house meetings are held, short and long terms goals on how to improve the system will be discussed. The report will then be distributed to the MHC and others.

E. Mental Health Consumer Concerns (MHCC) -Brenda Crawford - 300 rsvp's to holiday party. She thanked Dave Kahler/NAMI and Donna Wigand for their donations. Each consumer will receive a gift bag at the party. The West County facility greatly appreciated Supv. Gioia and Commissioner Pasquini's visit in November. They now have a wellness nurse who visits once a week, a dual diagnosis group meeting once a week and a case manager available to call for assistance in navigating the system for any of their clients. There were system failures, but positive things have happened since then.

F. National Alliance on Mental Illness (NAMI) – Al Farmer - At the last NAMI board meeting; voted to approve the proposal as they understood it with the assumption 4C would remain open. They will do whatever they can to support the consumer and add services.

G. Mental Health Services Act (MHSA) Consolidated Planning Advisory Workgroup (CPAW) - Annis Pereyra- there continues to be a conflict of interest between some of the voting membership of CPAW as they have vested interest in outcomes. It goes back to the Rose King complaint. It's difficult for unbiased information to come out of that body and she encourages anyone from MHC to come to CPAW meeting for themselves.
Vice-Chair Pasquini agrees. The conflict of interest/self-interest is a statewide issue in the MHSA implementation process. Part the solution may be a neutral facilitator. Interviews were held and a second round of interviews is next week. The goal is to have the facilitator in place by the February 2010 meeting.

Brenda Crawford brought up the beginning of the Aging and Adult Workgroup. Vice-Chair Pasquini said that issue would be brought up at the Planning Retreat.

10. FUTURE AGENDA ITEMS

FUTURE AGENDA ITEMS

Any Commissioner or member of the public may suggest items to be placed on future agendas.

A. Suggestions for January Agenda ***[CONSENT]***
None.

B. List of Future Agenda Items:
1. Case Study
2. Discussion of County Mental Health Performance Contract & Service Provider Contract Review.
3. Presentation from The Clubhouse
4. Presentation from the Behavioral Health Court.
5. Discuss MHC Fact Book
6. Review Meetings with Appointing Supervisor
7. Creative ways of utilizing MHSA funds
8. TAY and Adult's Workgroup
9. Conservatorship Issue

10. Presentation from Victor Montoya, Adult/Older Adult Program Chief
11. Presentation from Crestwood Pleasant Hill
12. Proposed MHC 2010 Legislative Platform, presentation by Dorothy Sansoe
13. Report on Behavioral Health Unit – Dr. Johanna Ferman
14 Presentation from Health Services Department on the policies and procedures surrounding sentinel events using Vic Montoya's suggestions on the different reporting structures.
15. A planning retreat will be held to determine 2010 goals; date TBD.

Robert Heaston would like the BOS to respond to his letter. He would like to see something positive come out of this. People at CCRMC are scared of losing their jobs and do not report incidents. Vice-Chair Pasquini will consider adding it as an action item at a future meeting.

11. 6:30 **ADJOURN MEETING**

- **ACTION Motion to adjourn (M-Reed, S-Yoshioka/P-unanimously, 9-0)**

The next scheduled meeting will be Thursday, January 14, 2010 at 651 Pine Street, Room 101; 4:30 pm.

Integrative Health Center Proposal

Karen Burt, M.D.
Director, CCRMC Integrative Health Program
Coordinator, CCRMC Group Medical Visits

2009

In an Historic Time of National Healthcare Reform:

Create and Expand:

Integrative Health Patient Services
Group Medical Visits
Health Education

Integrative Health Centers

Services:

Focus on Prevention / Self-Management

- **Group Medical Visits**
- **Health Education, Wellness and Fitness Classes**
- **Complementary and Alternative Medical (CAM) Services**
- **Integrative Health Clinic**: Individual providers and CHW's for 1:1 care
- **Behavioral Health Services**: SA/ MH
- **Training Center**: Patients Staff Outside providers
- **Evaluation**: Quality improvement

Integrative and Collaborative

- **Integration: Holistic approach** The Whole Person
- **Integration with CAM**
- **Collaboration with Patients and families:**
  Self- management = decreased unnecessary reliance upon acute care facilities
- **Collaboration within Health Care System – build upon existing services**
  DFM PH MH Admin
- **Collaboration with other County divisions / agencies**
  Adult Education EHSD Parks and Recreation
- **Collaboration with members and agencies of the Community**
  Community Health Workers Community Agencies Community Advisors

Integrative Health Centers
Location

- **Dedicated space:** within major Health Centers for groups, classes, CAM
- **Three centers:** PHC, MTZ, and RHC → No exclusion of any population
- **Positive Common Environment:** Supporting the mission

Current Conventional Medical Paradigm

Not Sustainable

Technology

Evidence Based ? Skyrocketing costs

Unequal Distribution - Health Disparities

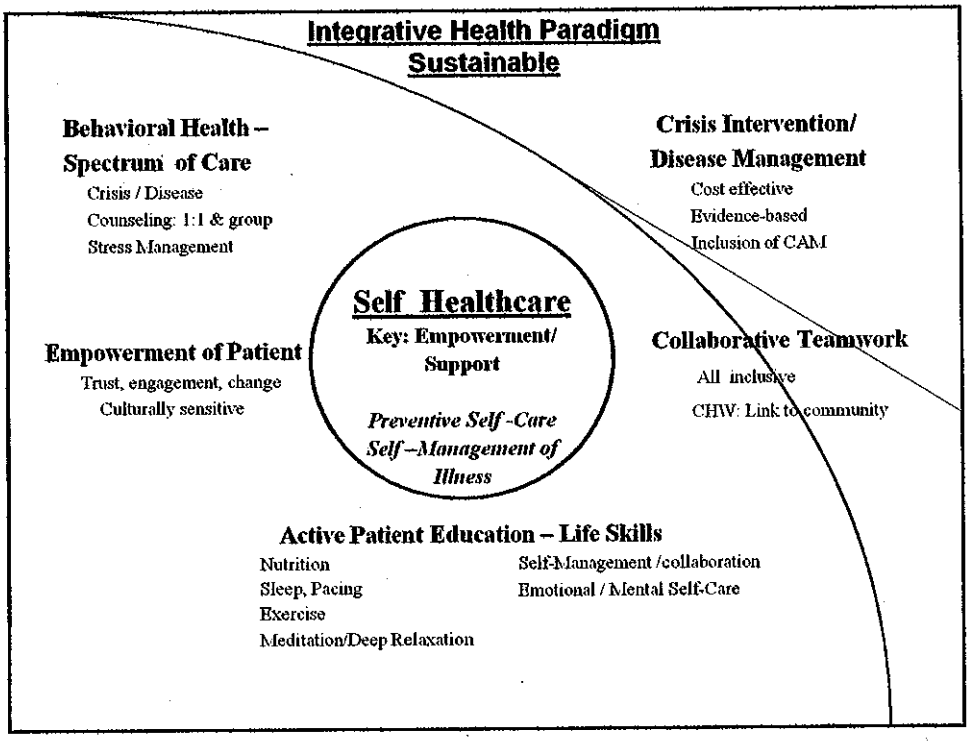
Compliance Education
to participate in preventive screening and disease management

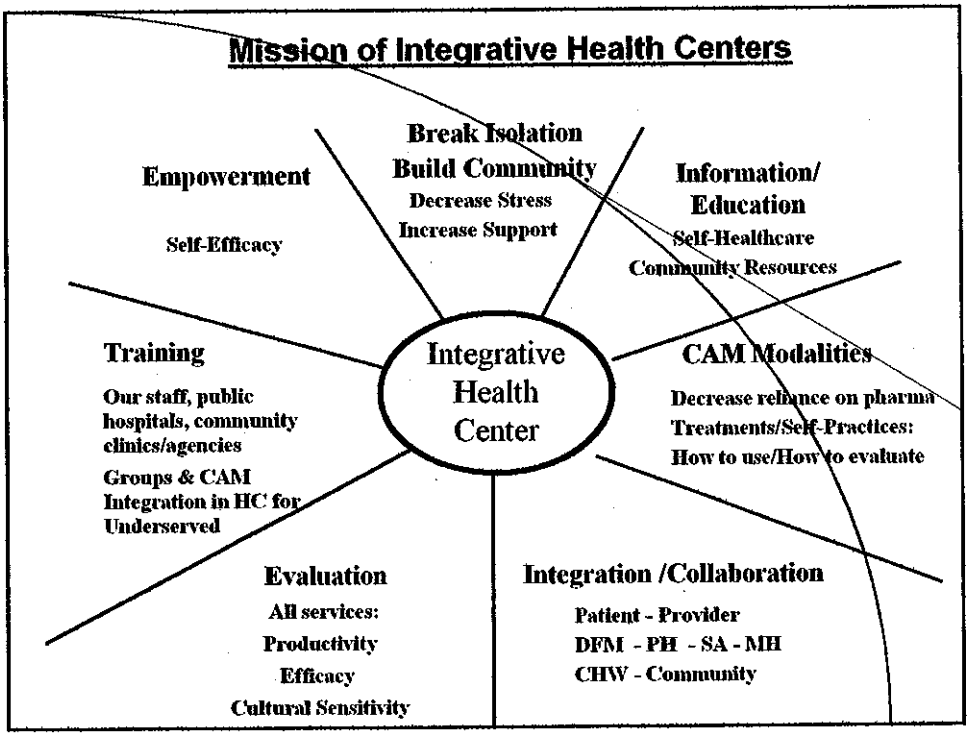
Heart:
Crisis Intervention/ Disease Management

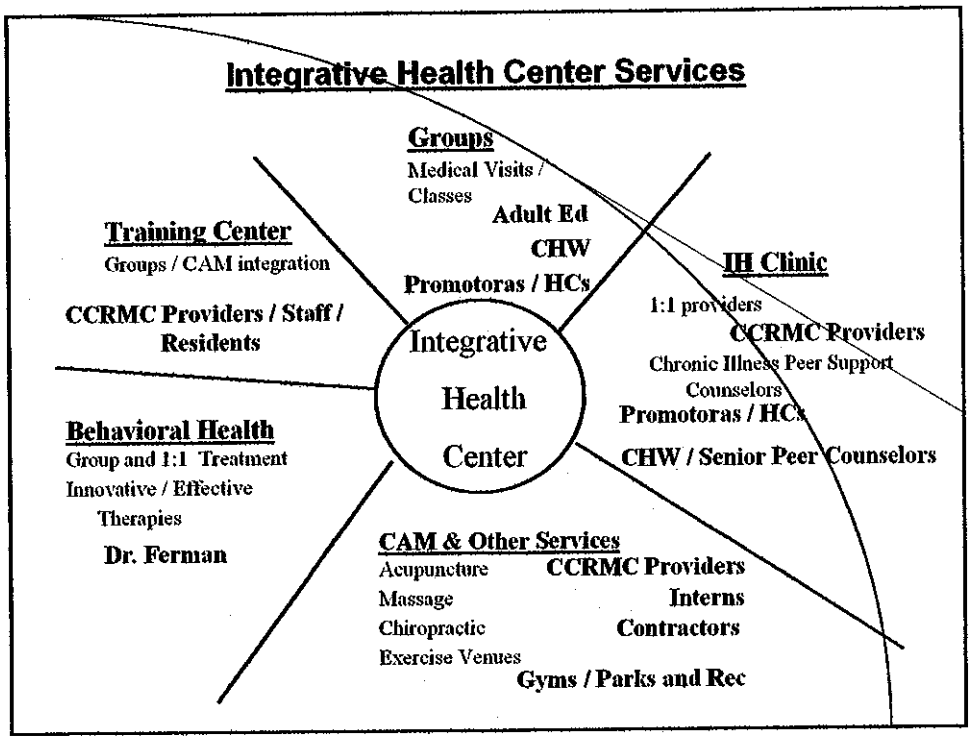
Key:
Technology

Team
MD, Nurse, OT, PT, SW, Admin., etc.

Marginalized: MH / SA / PH / Community


Integrative Health Paradigm
Sustainable
Behavioral Health –
Spectrum of Care
Crisis / Disease
Counseling: 1:1 & group
Stress Management
Crisis Intervention/
Disease Management
Cost effective
Evidence-based
Inclusion of CAM
Self Healthcare
Key: Empowerment/
Support
Preventive Self-Care
Self–Management of
Illness
Empowerment of Patient
Trust, engagement, change
Culturally sensitive
Collaborative Teamwork
All inclusive
CHW: Link to community
Active Patient Education – Life Skills
Nutrition
Sleep, Pacing
Exercise
Meditation/Deep Relaxation
Self-Management /collaboration
Emotional / Mental Self-Care


Mission of Integrative Health Centers
Empowerment
Self-Efficacy
Break Isolation
Build Community
Decrease Stress
Increase Support
Information/
Education
Self-Healthcare
Community Resources
Integrative
Health
Center
Training
Our staff, public
hospitals, community
clinics/agencies
Groups & CAM
Integration in HC for
Underserved
CAM Modalities
Decrease reliance on pharma
Treatments/Self-Practices:
How to use/How to evaluate
Evaluation
All services:
Productivity
Efficacy
Cultural Sensitivity
Integration /Collaboration
Patient - Provider
DFM - PH - SA - MH
CHW - Community



Evaluation

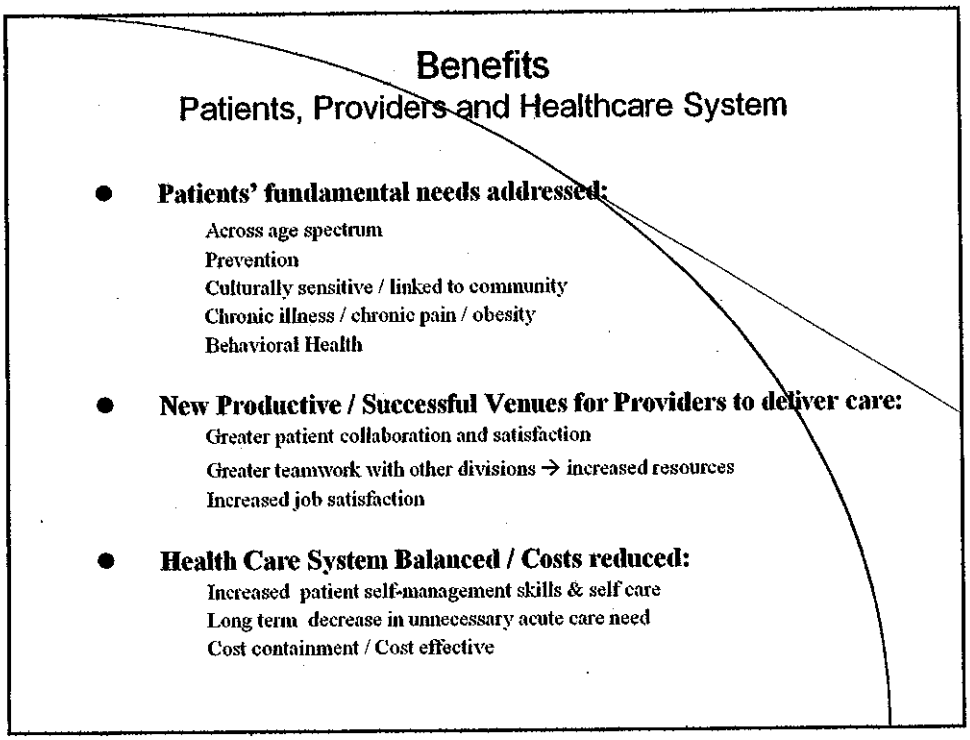
- **Every Program Evaluated:**

1. Measurable parameters of health and illness
2. Productivity
3. Patient and provider satisfaction
4. Patient and provider perception of patient progress

- **Programs that are not successful will be terminated after quality improvement measures fail.**

- **Collaborate with experts in program / service evaluation**

  e.g.: PH - CHAPE
  UCB School of Public Health
  UCSF Osher Center for Integrative Medicine


Benefits
Patients, Providers and Healthcare System
Patients' fundamental needs addressed:
Across age spectrum
Prevention
Culturally sensitive / linked to community
Chronic illness / chronic pain / obesity
Behavioral Health
New Productive / Successful Venues for Providers to deliver care:
Greater patient collaboration and satisfaction
Greater teamwork with other divisions → increased resources
Increased job satisfaction
Health Care System Balanced / Costs reduced:
Increased patient self-management skills & self care
Long term decrease in unnecessary acute care need
Cost containment / Cost effective

From Commissioner Yoshioka

CONTRA COSTA TIMES
ContraCostaTimes.com

$12 million allocated to replace Richmond Health Center

By Tom Lochner
Contra Costa Times

Posted: 12/09/2009 10:56:25 AM PST

Updated: 12/09/2009 05:41:18 PM PST

A new health center for West Contra Costa County, to be built on the campus of Doctors Medical Center, San Pablo, took a big step closer toward reality Wednesday with a $12 million infusion of federal economic stimulus funds.

The center will replace the venerable but obsolete county-run Richmond Health Center, which has logged more than 1 million patient visits since it opened in 1967, according to health officials.

"We've tried for years to provide high quality care in an aging, dysfunctional building in a Contra Costa community with some of the highest health needs," said Dr. William Walker, the county's health services director. "We'll finally be able to realize our dream by building a state of art building to match the high quality of care we've always delivered."

The Richmond Health Center, one of eight run by Contra Costa County, provides primary and specialty care, well-baby visits, immunizations and other critical services. The center, at 38th Street and Bissel Avenue in Richmond, has 50,000 usable square feet, which is described as inadequate; and elevators, air conditioning and other utilities that break down frequently, according to the office of U. S. Rep. George Miller, D-Martinez, which, along with the office of Contra Costa Supervisor John Gioia, announced Wednesday's award.

Some Richmond residents vocally opposed a move to San Pablo, arguing at community meetings over the last two years that the current location is convenient and well-served by mass transit. Opposition subsided somewhat after officials made the case that the new center would be centrally located near the Richmond city line and be accessible by public transit, and that it would be able to serve far more people than the approximately 10,000 who receive health care annually at the current center.

The award to Contra Costa County is one of 85 construction and renovation grants to community health centers and networks nationwide and one of 11 in California in a $508.5 million cycle of funding announced by President Barack Obama at the White House, and part of the greater $787 billion American Recovery and Reinvestment Act he signed earlier this year.

The grants are supposed to help the health centers institute electronic record-keeping as well as promote jobs and provide health care to more than a half-million additional people in underserved communities, according to the White House.

"This is the culmination of a partnership between the county and the community," said Gioia, who attended the midday award ceremony in Washington. "The community has wanted this and supported the health department's replacement efforts for years. This is an incredible opportunity to link the Richmond Health Center and Doctors Medical Center -- two public health systems -- to give the community the health services they need and deserve, and to create badly needed jobs."

CONTRA COSTA TIMES
ContraCostaTimes.com

Elsewhere in the Bay Area, the Solano County Health and Social Services Department will receive almost $ 2.2 million; Petaluma Health Center Inc. in Petaluma, $8.9 million; Santa Clara Valley Health and Hospital System in San Jose, $2.64 million; and San Mateo County Health Services Agency, $1.77 million. The maximum amount of the grants awarded Wednesday was $12 million.

Miller, in a news release, said: "This is a huge shot in the arm for our communities as they work to provide much needed health care services."

He called the move to the San Pablo hospital campus "a win for our entire community."

"Patients will have access to comprehensive services at the hospital and health center, medical staff will be able to share resources and the community will have better access to the facility," Miller said. "Community health centers, like this one, are key to developing a national plan for comprehensive health care."

Under the guidelines of the awards, the new center must open within two years, said Gioia, who also is the board chairman of the Doctors Medical Center Management Authority, a joint powers agency of the West Contra Costa Healthcare District, which owns the hospital, and Contra Costa County.

Officials hope to have a timeline and a complete financing package in place in January, he said.

Reach Tom Lochner at 510-262-2760.

From Commissioner Yoshioka

CONTRA COSTA TIMES
ContraCostaTimes.com

San Pablo hospital outpatient center could open in July

By Tom Lochner
Contra Costa Times

Posted: 12/09/2009 02:53:23 PM PST

Updated: 12/09/2009 02:53:24 PM PST

An outpatient center planned for a former fitness salon at a shopping center is on track, if not quite on schedule, and could open in July, Doctors Medical Center officials told the San Pablo City Council this week.

In October, the hospital's board finalized a lease at $26,000 a month, or $312,000 a year, with landlord San Pablo Retail Partners LLC for 12,000 square feet at Town Center formerly occupied by 24-Hour Fitness. The hospital intends to sublet part of the space to Alliance Medical Group for $10,000 a month.

The new outpatient center would offer the full complement of ancillary and diagnostic services, including a laboratory draw station, X-rays, physical therapy, occupational therapy, cardiac rehabilitation, echocardiography, electrocardiography, preoperative testing and wellness services.

DMC and Alliance would share the waiting room, check-in and registration and other common functions.

The move reflects a nationwide trend in the hospital industry, a shifting emphasis from inpatient to outpatient services, DMC's CEO Joseph Stewart told the council. DMC is behind that curve, with only 30 to 35 percent outpatients compared with 50 to 60 percent nationwide, he said. The new facility would serve about 20,000 patients between the two providers, DMC and Alliance, said the hospital's director of government and community affairs, Gisela Hernandez.

Outpatient services can be delivered more economically than inpatient services, and the new center would make a small profit as early as the first year, increasing to $600,000 by the fifth year, according to an estimate provided by the hospital.

Factoring in "pull-through" business — new revenue for the hospital as a result of referrals to hospital-based services not offered at the outpatient center, such as magnetic resonance imaging, positron emission tomography or computerized tomography scanning — DMC's bottom line would improve by just over $300,000 the first year and by more than $950,000 the fifth year, according to the estimate.

Putting the clinic in a retail center is a deliberate "shopping mall strategy" that reflects consumer preference for easy access combined with ample parking, Stewart said. Town Center is near the Interstate 80-San Pablo Dam Road interchange.

The new outpatient center would coexist noncompetitively with a planned Contra Costa County medical clinic to be located on the DMC campus. The county clinic would serve "the most needy population," while the hospital's outpatient clinic would cater to patients with medical insurance, said DMC Chief Operating Officer David Ziolkowski.

The hospital's delegation asked the San Pablo City

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ContraCostaTimes.com

Council for a loan to help fund the $600,000 estimated cost of construction and $1.5 million in tenant improvements. The council said it would consider the issue but did not commit to any funding.

Reach Tom Lochner at 510-262-2760.

Handout from Robert Heuston regarding his daughters Emergency Room experience at CCRMC 10/2/09.

October 6, 2009

Contra Costa Emergency Room Experience

The following is my best interpretation of what happened to me and the events that took place around me on Friday October 2nd. I understand that I was in a very fragile state due to my heightened anxiety; however, I am an extremely high functioning individual and I am able to recognize unprofessional conduct.

As I entered the ER my mother was told she was not allowed to come inside because she was not going to be allowed into the psychiatric ward. I was sat down in a chair in the hallway of the ER by a nurse and asked a series of questions. "Do I want to hurt myself? others?" My answer was "No" and she continued to ask me about the symptoms I was experiencing. Meanwhile, she was writing down notes on a chart as I spoke. I said that I have extremely high anxiety which I think is linked to my chronic migraines. My medications might be off because I feel extremely manic, my thoughts are racing, I can't concentrate on anything, my mind seems to just go and go nonstop, I can't sleep at night, I cry all the time, I break out in rashes all over my neck and chest, and my feelings build and build up inside. (These are my symptoms, whether or not I told her every one at that specific moment I am not sure, my memory isn't that precise) The nurse then told me she'd get me some help and left me sitting there crying where I waited for about 5 minutes.

Then a Doctor came over and it was round two. She asked me the exact same questions as the nurse did. So I gave her all the same answers. She just stood over me in the hallway as I sat in the chair. She didn't take any vital signs or touch me at all. After taking some notes, she said she'd send me to psych; told me to wait, and walked away.

By now I was even more anxious. Where were they taking me? Were Doctors going to even be there? The original nurse came back and told me to follow her as we walked through a few doors and around a corner. She dropped me off, handed a file to a lady at the psych desk, and left. Nothing was said to me and I was standing in a large room with many people wandering around with no shoes. Some people were yelling, others looked sedated, and one woman was strapped to a chair. ARE YOU SERIOUS!?!?! Why am I here! What did I do!? I never said I wanted to hurt anyone or hurt myself!!! I continued to cry.

A tall white woman, brown hair, with glasses told me to sit on a chair/bench and wait. I looked at the chair and it was covered with what appeared to be vomit. I continued to stand. She said sorry and wiped down the chair with a wet wipe. This same nurse took my bag, my belt, and would have taken my shoes except they were uggs and had no laces. She then placed all my belongings into a large white bag which would be searched through later and inventoried without my knowledge or permission. She then told me to sit and wait. During this entire initiation process, an Asian man was running around with a magazine pretending to take notes on the cover and yelling at the nurses about how they were treating him poorly. He was also pretending that his lawyer was on the phone (maybe his lawyer was on the phone, but I doubt it) and was claiming he would sue. All of a sudden there was a loud horn and it was something like "Honk! Honk! Code! Code!" The nurses told us to go into the dormitories and I had no idea what was going on, I had been in there for less than 10 minutes. In the "dormitory" there were 4

small cots. An older Hispanic woman gave me a blanket and said, "Don't worry, you will be safe if you stay in here." What was happening? The nurses and people from other units did a restraint on the Asian man...I didn't see him again for the rest of my stay.

When we were allowed to come out of the dorm, I sat for a while and did nothing until I was called to see my therapist and Doctor. I did try to go to the bathroom and realized all the doors were locked. When I politely asked the nurse if I may please go, she asked if I had given a urine sample. A urine sample? Since when am I being drug tested? I grab the cup and went to the bathroom. I couldn't believe this reality. I was a sick patient that needed help, not a drug addict that needed to be contained. Why wasn't I in a hospital room? I should've gone to John Muir or UC Davis....

My anxiety was continually rising and I'm feeling worse and worse. I'm crying constantly and no one has allowed me to see a doctor nor has anyone administered medication. I sat on a bench by myself away from everyone else crying and trying to breath to calm myself down. Finally they are ready to see me. Unfortunately I do not know the names of my night doctor, therapist, and nurse. (This information should be on the chart which is comforting because all I remember about the Doctor is his thick Russian(?) accent, the female therapist was heavyset with short brown hair, and the female nurse was Asian and petit.)

Once again I am asked why I am here. This is now the fourth time I have had to tell this story. Once to the triage nurse in admitting, once to the nurse in ER, once to the doctor in ER, and now I'm trying to tell it again. I'm exhausted. I explain some of my history as well and tell him that I'm not pleased with the treatment I've received from Dr. Hamilton, my county psychiatrist. The Psych Doctor's response is, "Dr. Hamilton is a FANTASTIC doctor! He is great! He does a wonderful job!" Now I completely feel like I'm in hell. I tell the Psych Doctor some diagnoses other doctors have given me (like my college Psych whom I still talk to) and before I'm done with my sentence he cuts me off and says, "No, no, no. You don't have that, you don't have that either..." I have to defend myself and this man has only known me for 5 minutes! The therapist asks me questions like "Do you hear voices?" "Do you want to hurt yourself or others?" I began by saying that I'm not a schizo and once again I'm not going to hurt anyone. Does this hospital know how to treat high functioning patients? Or only people who are on the verge of suicide?

The Psych Doctor then looks at me in the face and says word for word, "What do you want me to do?" What do you think? I want you to HELP ME. I need help! Obviously whatever medicine I'm taking isn't working and my body is out of whack! I need help! My anxiety is sky high!

*To update the reader of this document, I currently take 100mg of Seroquel (a drug I've taken for over 3 years) and 1mg Klonopin at bedtime (a drug I have taken for 5 days).

The Psych Doctor continues by saying, "We are going to do a little experiment. I am going to give you 300mg of Seroquel and we are going to do a sleep study of you without any Klonopin." My initial reaction in my mind was to explode. The reason why I am here is for my ANXIETY and the Klonopin is NOT working and I need help! So your reaction is to give me Seroquel which has nothing to do with anxiety and give me absolutely nothing for anxiety??? What kind of Doctor are you!?? Then I ask where I would be sleeping IF I agreed to the sleep study. He said I would be in the women's dormitory with all

the other women. THAT IS NOT A SLEEP STUDY. I was crying so hard. What am I supposed to do? The Psych Doctor says that the Seroquel should knock me out so I won't even feel my anxiety or know I'm surrounded by other people. And if I wake up in the night, he'll give me a Klonopin.

This is so confusing. This is all by FREE WILL. I said that by sleeping in the dorms my anxiety would go up even further, I'm SCARED! This doesn't seem professional; this doesn't seem like a real sleep study. Then the Psych doctor said, "This is something Dr. Hamilton can't do, but I CAN. You don't want our help? If you want our help and if you want treatment then stay, but if you leave, they we won't help you at all." I was sick, in need of medicine, and vulnerable. I was blackmailed into staying, which is disgusting, especially when I got absolutely nothing positive out of the treatment.

They gave me 300mg of Seroquel and because the pharmacy was closed I was unable to take my nightly 100mg of Topamax (even though there was some inside my purse and the nurse was informed and knew).

I laid in the fold out chair which were the beds used in this ward and each time someone walked by my bed, they kicked my feet. The 250lbs+ woman to my right snored so loud I never fell fully asleep even though I was heavily drugged. My sister tried to come see me and my therapist came into the dorm and woke me up to tell me my sister was here. I told the therapist to tell my sister to leave. In my groggy state I got up and went into the hall to look for the therapist to see if my sister was still there. The Therapist then said she wasn't sure and that if I go see her I have to leave because there are no visitors. Then why did she come wake me up to tell me that my sister was here? For the hell or it? To tease me? If I can't see her then why tell me? Why wake me up? Why disturb my "therapy" and my "sleep observation".

I got back into my cot and continued to not sleep well due to snoring, and continual loud speaker announcements "Code Code!"...etc. I had nightmares and horrible dreams that woke me up with a racing heart constantly. I wondered why my sleep study was done with no one around to observe me. There were no monitoring machines and I was given one blanket that I shivered under while wearing my jeans and the rest of my street clothes. Don't hospital patients normally wear gowns or patient garments? Around 3 or 4am I couldn't take it anymore, and I got up and told a night nurse my anxiety was way too high. The Russian Psych Doctor walked out with a smile and said, "Ooook, we give you Klonopin". I told him that I wasn't going back into the dorms so he allowed me to sleep in one of the small cells that lock from the outside. The nurse took my blood pressure and tossed a blanket in the new cell. I asked if he could please turn the air conditioning down and he laughed. After not offering to get me another blanket, I went back in the women's dorm and took my old one.

I finally slept for a few broken hours until I heard some screaming which I suppose meant the food was there. Once everyone had their food, I approached the cart and stood there for a few minutes. I didn't know how things worked around here so I didn't want to do anything rash and get into trouble. The nurses paid no attention to me waiting there patiently. Was that a sign I could serve myself? I waited longer. One of the patients eating said "What are you waiting for? Take a box." I took a box and walked towards somewhere to sit and a nurse yelled at me and asked what I thought I was doing touching the

food. I explained that I waited, got no help, and that a patient told me the protocol. The patient agreed she said it was ok and the nurse yelled at me again and told me to sit down and eat. Is it really necessary to yell at patients in a psych ward when nothing dangerous is going on? That nurse was just asking for a conflict.

One of the women in my old dorm was not cooperating for whatever reason and there was another "Code! Code!" and we all had to retreat while people from other units ran in to restrain her. Because of this incident, we were told the Doctors were busy and we'd have to wait longer to talk to them before we could be released. My nurse that morning was Pat W., she is thin, older, wears glasses, blondish-gray hair, and refused to make eye contact unless she wanted to teach me a lesson or prove a point. I used the most polite tones and expressions with her and she wouldn't give me the time of day. I take morning meds, which I reported to the triage nurse and they were in my bag. Pat held up a clip board in my face and circled Seroquel, Topamax, and Klonopin and said "THESE are the only meds you are cleared for, got it?" I take Wellbutrin XL, Topamax, and Birth Control in the morning; if I was in a regular unit in the hospital would I have been denied my regular medications?

The doctor was ready to see me now. Oh...new doctor. It was truly amazing, in under 5 minutes, he knew everything about me. He also thought Dr. Hamilton was an amazing doctor and commented on how his specialty is drug abuse and addiction. Hmmm....I am neither a drug abuser nor am I an addict. I guess this would explain as to why Dr. Hamilton wouldn't renew my Ritalin prescription from my old Doctor's prescription for me because he told me Ritalin is addictive. Moving on....the new morning doctor's name is Dr. P. Kumar and he told me that I can change my doctor but until then he'll give me some new prescriptions. Dr. Kumar says he'll write me a prescription for Seroquel 100mg tablets and to take 1-3 at bedtime. So basically up to 300mg of a drug I'm already taking. Then he wrote a prescription for Wellbutrin XL for 300mg once daily, which is a drug I already take and don't even need a new prescription for. There is no reason he needed to write this prescription and was never asked to write a new one for it either. Then we discus Klonopin and he initially says 30 tablets and I wonder if I can get addicted, so he says he'll give me 15 instead. Then I ask if he can give me 30 and I can just take as needed and not every night. He agrees that will work best. So in the end of my intense and miraculous "sleep study," what did I get? THE EXACT SAME DRUGS I ALREADY HAVE. I already take Wellbutrin XL, Topamax, Seroquel, and just recently Klonopin. I went in for help, and what did Contra Costa give me? NOTHING, YOU TOOK FROM ME. I'm in worse shape now than I was before.

While waiting for my meds to be written up a new patient was brought into the unit. He looked sickly and I think I overheard something about him hearing voices. He was immediately put into one of the quiet cells but the door was cracked open. He was an older white male and his ear was cut and bandaged. He was hungry but all the food was gone and nothing was available at the moment. He was asking questions but for the most part being ignored by the staff. He kept asking for something to eat and one of the LVNs said jokingly that a nurse went down to the kitchen to make something special for him. She was laughing silently to herself. He was saying, well I want to go home, how long will the food take? If I can go home first then cancel the order. And then the LVN said "oh you want to cancel the food?" and laughed again with her colleagues. The patient had no idea what was going on. It was cruel.

Finally, as my nurse Pat W. transcribed my meds onto a chart, I saw the 1-2 100mg tablet prescription for Seroquel. Dr. Kumar told me to take up to 300mg a night. When I noticed the mistake I politely told the nurse and asked if she could double check with the doctor. Pat W. said "No, I'm a nurse, I know how to read a prescription" Luckily the doctor walked by and I asked him about how he said he wanted me to take 300mg of Seroquel but he wrote 1-2 tablets. His response was, "Oh yea, take 3, it doesn't matter" Can he not do math? Does he not realize the pills will run out and the insurance won't refill the prescription? Then I saw that he wrote the Klonopin for 14-1mg tablets when he said he'd write it for 30. I told the nurse that she is my advocate and she is supposed to help me and support me and go to the doctor for me and ask questions on my behalf. Pat didn't respond, except with a smug look. When I told her she was disrespectful and that she treated me poorly she said it wasn't true and that it was all in my head.

After leaving the hospital and at the local pharmacy, my Dad called the hospital to talk to Dr. Kumar and told him how upset he was about my treatment including his mistakes on the prescriptions. Dr. Kumar said that BY LAW he could not give more that 14-1mg pills of Klonopin to a patient out of the ER. We then had the pharmacist call Dr. Kumar because we needed her to clear up some discrepancies. As soon as she got off the phone with him, she let us know that she was going to fill a 300mg month supply of Seroquel and 30-1 mg pills of Klonopin. Interesting...the doctor lied directly to my father.

I'm sorry this letter is so long. I'm sorry I endured this treatment and that it's necessary to write this letter. Merely writing this letter has caused anxiety and increased my stress and therefore hindered further progress in my treatment but it must be done. I'm not writing this letter out of hate but to defend my own ethical rights. In addition, I want to ensure the security of the rights of other patients who aren't capable, like myself, to defend themselves.

Unfortunately I'm sure that I will continue to remember additional details over time. Currently, I still need help just as I did October 2nd. How does Contra Costa Health Care help people? How do they think what they are doing is ok? How did I end up in a psych ward? I received NO help. I can't even believe that I can actually say that....I received NO help at all. My horrifying experience in your hospital will now donate memories to my racing thoughts and nightmares and my fits of anger.

A success story? I think not.

My name is Charlene Heaston and I can be reached at 31 West Park Ct. Walnut Creek, CA 94597. My email is: heaston84@gmail.com and if absolutely necessary, my cell phone is: 925-324-1566

Thank you for reading my story. I know this isn't YOUR fault, but please understand my pain.

Signed,

Charlene Heaston

WILLIAM B. WALKER, M.D.
HEALTH SERVICES DIRECTOR

JEFFREY V. SMITH, M.D.
Executive Director
MEDICAL CENTER
HEALTH CENTERS

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HEALTH SERVICES

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Martinez, California 94553-3191
Ph (925) 370-5000

November 13, 2009

Ms. Charlene Heaston
31 West Park Ct.
Walnut Creek, CA 94597

Dear Ms. Heaston:

I am writing in response to a complaint received on October 6, 2009 regarding your interactions with the Contra Costa Regional Medical Center's Emergency Department and Crisis Stabilization Unit. Thank you for bringing this matter to our attention. Dr. David Goldstein, Chief of the Emergency Department; Ms. Mary Murphy, RN and Nurse Program Manager for the Emergency Room; Mr. Todd Paler, Medical Social Services Program Manager; Dr. Charles Saldanha, Chief Psychiatrist for the Crisis Stabilization Unit; and Ms. Sandra Vernell, RN and Nurse Program Manager for the Crisis Stabilization Unit, have investigated this complaint and provided responses. Please be assured that appropriate administrative action and follow-up has occurred regarding your complaint.

According to Dr. Goldstein, Dr. Riley did not intend to make you feel more anxious or uninformed. Ms. Murphy states that the nurse in the emergency room could have confirmed your understanding of the plan of care. Ms. Murphy agrees that the communication of the plan of care must be clear and should address the needs of the patient; therefore, Ms. Murphy has discussed your concerns with staff to make improvements.

You were concerned that the CSU (Crisis Stabilization Unit) staff did not effectively communicate to you the plan of care. You state that no one would address your concerns during the long wait to see a doctor. Dr. Saldanha appreciates you taking the time to notify us of your concerns. He states that staff could have been more informative and responsive to your concerns and needs. You mentioned that staff explained that you would be involved in a sleep study. We apologize if this was misleading to you in any way, as the CSU does not conduct sleep studies but did provide you with medication to help you sleep. You also stated that you were unable to take your 100 mg of Topamax. Staff could have explained more clearly, why the medication was unnecessary or inappropriate at that time. In terms of your concerns about your father calling Dr. Kumar regarding your prescriptions, Dr. Saldanha states that Dr. Kumar could have been clearer in his communication to you and your family and his intentions were not for you to feel like he was lying.

Mr. Todd Paler states that the therapist awoke you and explained that your sister was outside and when you declined, your sister left the grounds. When you woke up about 10 minutes later and changed your mind, the therapist explained that your sister was not in the CSU anymore but that you could call her if you wanted to.

According to Ms. Sandra Vernell, the care environment in the Crisis Stabilization Unit is frequently noisy and other patients can be in urgent crisis. This can affect the patient's perception of the unit. She agrees that early interventions, anticipation of patient's needs and patient education can help present the unit in a more positive way. She appreciates that you shared all your nursing concerns and has reviewed them all with staff.

In closing, please know what an impact your letter had on our CSU and Psychiatry staff. Your eloquent, articulate letter very clearly describes an experience fraught with fear, and confusion sparked by ineffective communication. Our goal of Service Excellence revolves around the expectation to provide optimal care to all patients in a professional, safe, and caring environment. CSU and Psychiatry staff is committed to incorporate additional ways to better interact with patients and are committed to ongoing improvements. We do apologize for your unpleasant experiences and hope that any future visits reflect our expectation to provide you with excellent, professional, and compassionate care. If in the future you experience problems, please make sure to ask for a supervisor who can assist you. If you have further concerns, please contact me at 925-370-5144, and again, we thank you for bringing this issue to our attention.

You have the right to file this complaint with the California Department of Health Services at 850 Marina Bay Parkway, Building P, 1st Floor, Richmond, CA 94804-6403, (510-620-3900).

Sincerely,

Tulita Ochoa
Patient Relations Services Coordinator

Dear Ms Ochoa

I am very concerned that this very carefully constructed letter does not address most of the treatment addressed in my daughter's letter. I would like a letter that addresses EVERY incident in my daughter's letter. I would be happy to meet with each doctor ,nurse and aid involved.

Just a few of the items that are were omitted. 1) That Charlene was told by an unnamed employee that my other daughter was there to see her. ***But it was omitted that she was told that if she left and talked to her sister she would not receive treatment and have to leave.***
2) NOTHING WAS DONE FOR HER ANXIETY,,,, like adavan, or any other type of medication or care normally given to someone complaining of extreme anxiety..
3) That a Doctor DID tell her she be part of a sleep study,,, and that they had to observer her,,, before any action or medication could be taken. She told them what medication she was on and they gave her the same ones she was already taking. In other word,,,, THEY GAVE HER NO CARE!

These are only three examples of what happened, and either minimized or not addressed.

Too much time was given to construct this fabrication. As of Nov 5 when I talked with Cindy Abram, 2 of the individuals that were involved still had not responded in writing.

How much time should there be given to employee to get together and fabricate a response. My daughter's response was timely even thought traumatized by your personnel.

So many items were not addresses. Is it ok for your personnel to make fun of patients? When nurses are asked to confirm questions with a doctor they till the patient NO. It goes on and on. This letter does not address them.

Please address all of the concerns in the letter!

AS I said I would be happy to meet with Dr. Saldanha and each of the personnel in the unit. Dr Saldanha said this incident would be used to help teach and improve care I the ward. This letter shows nothing of that! It appears as a cover up with not a single person taking responsibility for their actions.

Robert Heaston
31 West Park Ct.
Walnut Creek, CA. 94597

Phone
925-935-7722
925-324-0150

CPAW Report by Annis Pereyra.

At the 12-3-09 CPAW meeting, a report was delivered by Tony Sanders on the joint MHC/CPAW Capital Facilities/IT Workgroup. Mr. Sanders presented his perceptions of the combined efforts of the MHC and CPAW Capital Facilities/IT Workgroup. Mr. Sanders reported that a sub group of previous members and attendees of that combined workgroup had met to formulate recommendations. Those CPAW representatives that met in an unnoticed, non public session were: Kathi McLaughlin, Ryan Nestman, Susan Medlin, and Tony Sanders. Their recommendations to CPAW were the following:

- Establish an ongoing Capital Facilities/IT Workgroup with the charge of bringing the peer and family perspective to the program design for both components, including increased access to services. ***This item was accepted by CPAW and the 4 CPAW members volunteered to serve on this new Workgroup. Annis Pereyra and Teresa Pasquini, both CPAW and MHC Liaisons also volunteered to serve on this CPAW workgroup.***
- Recognizing the importance of both components, we recommend the IT/Capital Facilities split be modified to approximately 50/50.***CPAW did NOT support this recommendation at this meeting.***
- CPAW strongly supports best practical alternatives to hospitalization and therefore recommends that the property at 20 Allen contain the following psychiatric services:
    1. Crisis Assessment and Recovery services for children and youth.
    2. Voluntary Crisis Assessment and Recovery services for adults.
    3. Voluntary Crisis Residential for Adults.
    4. We also recommend that discreet older adult services be included.

CPAW did NOT support this recommendation at this meeting.

A discussion considered the following:
-No documentation or evidence was presented to CPAW in advance of the meeting in order to make an informed decision. Mr. Sanders and Ms McLaughlin reported that they had, "talked to staff" to assist with their recommendations. Commissioner Pereyra reported that the Surveys that the Workgroup had been working on for several weeks were in the process of distribution to county staff, CBOs, and a variety of providers. Mr. Sanders expressed that he did not think this had been agreed upon by the workgroup. Commissioner Pereyra reminded Mr. Sanders that she had sent out an email to all workgroup members asking for input. Commissioner Pereyra proceeded with the survey in light of the public, MHC, and CPAW pressure for action.
-Questions were raised by Steven from Rubicon about the employment status of the CPAW reps. Tony Sanders and Susan Medlin acknowledged being staff of MHA. Kathi McLaughlin stated she was not county staff, however it should be noted that she is a School Board Member for the Martinez School District, who is a recipient of MHSA PEI funding. Also, it should be noted that Ryan Nestman has previously mentioned that he is seeking employment, under MHSA funding, as a Parent Partner. **This might raise issues of self interest and conflict of interest which is an ongoing concern of MHSA Stakeholder process throughout the State and clearly identified in Rose King's Whistleblower Complaint to the State Auditor. This is a topic that the commission might consider in its planning session.**

It appeared that adversarial posturing has prevented the two groups from collaborative debate. There are claims that the charges of the two groups are different. While they have different reporting structures, their charges are not in conflict. It is unfortunate that the two groups could not reach consensus through this partnership effort.

It should be noted that Commissioner Pasquini has requested clarification on the distinction in roles, process, and ethical concerns for the two bodies and also requested some form of mediation to unite purpose and effort.

Report prepared 12-08-09 by Mental Health Commissioners Pereyra and Pasquini