Contra Costa Mental Health Commission
Monthly Meeting
Date 7/8/10
Minutes – Draft

1. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order at 4:35 pm by Chair Mantas. Introductions were made around the room.

Commissioners Present:
Dave Kahler, District IV
Peter Mantas, District III
Carole McKindley-Alvarez, District I
Floyd Overby, MD, District II
Teresa Pasquini, District I
Annis Pereyra, District II
Sam Yoshioka, District IV

Commissioners Absent:
Colette O'Keeffe, MD, District IV
Supv. Gayle Uilkema, District II

Attendees:
Quentisha Davis
Norbert Dickson
Brenda Crawford, MHCC
John Gragnani, Local 1
Lori Hefner
Lynda Kaufmann, Psynergy Programs
Peggy Kennedy
Mariana Moore, Human Services Alliance
Janet Marshall Wilson, MHCC
De'shawn Woolridge

Staff:
Donna Wigand, MHA
Anna Roth, CCRMC
Suzanne Tavano, MHA
Sherry Bradley, MHA
Julie Kelley, CCRMC
Dorothy Sansoe, CAO
Suzette Adkins, Supv. Bonilla's office
Nancy Schott, Staff to MHC

2. PUBLIC COMMENT.

Janet Marshall Wilson stated she is a family member of a consumer who is a full service partner in Santa Clara receiving special services for 90 days in crisis residential. She is grateful services are in place and available in other counties. She passed around a photo of herself and her family member.

To ensure an orderly meeting, Chair Mantas reviewed that anyone attending the meeting today agrees to abide by Meeting Decorum guidelines posted at the handout table.

3. ANNOUNCEMENTS

A. 7/24/10 Data Outcomes Training: Bisso Lane Conf. Room, 10:00 am – 4:00 pm.

B. 8/2/10 IOC meeting: 651 Pine St., Room 101, 10:30 am if interested in participating. There is a chance the meeting will be moved to 8/9/10.

C. Reintroduction of the Task List Tracking Form: It will be brought back up at next meeting with updates. Please be prepared at the next meeting to provide comments. The colors on the original made the black and white copy in the packet unreadable; they will be removed for next month. Donna Wigand and Suzanne Tavano will be working with us to provide item updates.

4. **CONSIDER APPROVAL OF MINUTES**

- **ACTION: Motion made to approve the June 10, 2010 Monthly Meeting minutes: (M-Kahler/S-Overby/Passed, 6-0-1, Y-Kahler, Mantas, McKindley-Alvarez, Overby, Pasquini and Yoshioka/A- Pereyra (not at 6/10/10 meeting).**

5. **REPORT: CEO, Contra Costa Regional Medical Center - Anna Roth**

CCRMC Update: She has worked with Dave Kahler and Teresa Pasquini, family members of The Healthcare Partnership. The Partnership began the process that is changing the face of CCRMC and inpatient behavioral health care services. She hopes the changes are reaching into the community and the entire mental health system. She first met Dave and Teresa during the process to review the care of heart failure patients. They discovered many people in the CCRMC system with heart failure also had depression, substance abuse challenges and pre-existing co-morbidities with mental health issues. They decided to bring patients and family members together on a Design Team and also powerful advocacy voices such as mental health advocates. Mental health advocacy has an established presence most other constituencies utilizing CCRMC services do not have. Within 2 days, the Design Team challenged CCRMC to create a central place for patients and family members to get information to navigate the hospital system and be linked up to outpatient/family services. Although the Information Center didn't endure, the work and team bonds formed grew in ways they did not imagine at the time.

After that, the Design Team formed the Healthcare Partnership. Areas CCRMC targeted for improvement included traditional medical issues such as surgical and the Emergency Room. It was the Healthcare Partnership, led by Teresa Pasquini, Dave Kahler, Colette O'Keeffe and Brenda Crawford, who challenged CCRMC to focus on behavioral health patient concerns. Taking on behavioral health issues was daunting due to previous history, lots of different parts, and the involvement of several divisions. There were also multiple stakeholder groups CCRMC did not have connections with including the MHC, clinic structures, Detention Division and other community partners that make up the CCC mental health system. CCRMC was merely hosting behavioral health patients through the system rather than understanding how to learn from them.

This led to a series of rapid improvement events or Kaizen (to tear down and put back together in Japanese) events. They took Toyota production methodology and applied it to behavioral health to drive a disciplined improvement effort. CCRMC began a series of Kaizen events; each event begins with a dream session or Value Stream Mapping. Rona Consulting was brought in to facilitate the Kaizen process and they commented they had never seen so many patients and family members on a Planning Team.

When faced with a crisis several years ago, CCRMC made a policy decision to lock the doors of the CSU to both ambulance entry and foot traffic and redirect mental health patients to the ER for admission. Rather than redesign the system, the patients were made to work around the

existing system. Through the Value Stream Mapping process, the Planning Team was challenged on this issue; users of the system would rather enter CCRMC directly through the CSU. Around this same time period (Fall 2009), she was in attendance at a BOS meeting (having been CEO for approx. 60 days) and during public comment heard the heart wrenching story of his daughter's ER/CSU experience from her father. From their family's perspective, the experience was a series of unfortunate, low quality and uncaring events. What this family really wanted was to be together during their ER visit and there was a no visitation policy in place in CSU at the time. There was also testimony from 2 other families dealing with the same no visitation policy concerns, including children in restraints. The BOS meeting took place on a Tuesday morning and these issues were brought to The Healthcare Partnership at that afternoon's meeting. They responded with the charge to change the visitation policy. The doors to the CSU were opened up to the Design Team and the visitation policy was changed to adapt to the family member's perspective. It was huge step.

Although she receives a lot of credit for leading the LEAN effort, it's a team effort including Julie Kelly, Program Chief of Psychiatric Services. CCRMC has a team fully committed to this new culture. They work collaboratively with Donna Wigand, Suzanne Tavano and MHA as well as other community partners. After a series of traditional Rapid Improvement Events, The Healthcare Partnership appointed Teresa Pasquini and Brenda Crawford to the Executive Team for Hospital Operations Planning. They attend all the hospital planning meetings. All CCRMC Improvement Teams have been challenged to include patients and family members at their meetings for the next 30 days. There will be a Report Out available at the end of that time that can be brought back to the MHC next month.

At the spring strategy session, reopening the CSU door to ambulance traffic was discussed again. It's important to understand the evolution of where CCRMC has been and where it is now. Opening up the CSU doors was suggested for mid-July and patients and family members let CCRMC know summer was too far away. Patients and family members have been waiting for years for the doors to reopen and improve the quality of care. CCRMC Administration, she and Julie Kelly met with legal counsel to review the regulatory issues of the process while other teams, lead by patients and family members, began to deal with the logistic of opening the doors and physically changing the look of the entry to make it more welcoming. Dave Kahler and Brenda Crawford led the effort to remove the No Visitors sign and replace it with "Welcome" in large letters. Teams were then sent out simulating ambulance runs (engaging law enforcement, EMS and patient/ family member advocates). There have been both gains and back sliding, but forward movement continues. (This process of reopening the CSU doors was included in Kaizen #1 May 10 – 14, 2010.)

Kaizen #2 (June 14 - 18, 2010) focused on redesigning processes inside the CSU. The Kaizen #2 Opening Event was a momentous day, with largest group of stakeholders she's ever seen and an amazing contrast from a year ago when she was disheartened and ashamed to hear stories of the type of care being provided at CCRMC at the BOS meeting. Representatives from law enforcement, EMS, community providers and other counties were in attendance. Great improvements have been made and the foundation has been laid for the work to keep going. She gives all the credit to the staff, patients and family members. Other CCRMC Teams (including surgery suites, medical units and clinics) in the hospital are looking to Behavioral Health to be

leaders for improvement and transparent patient-centered care. She thanked the MHC for its support and invites everyone to attend the Report Outs. Kaizen #3 (beginning July 26 with Report Out on July 31); will focus on discharge issues from CSU to home. *(Kaizen #1 and #2 Event Summaries follow minutes)*

Chair Mantas asked about the culture change before and after the introduction of the LEAN process (focusing on staff's acceptance of constructive criticism before and after the process was set in motion). Anna Roth responded it's hard for people to take constructive criticism and not get defensive. She feels the culture was one where the staff was afraid if something came up they would get in trouble and it would be held against them. The staff always came to work dedicated to doing the right thing, but the leadership didn't have a methodology to enable that type of process. We didn't know what we didn't know. The leadership culture changed to allow staff to feel more comfortable in bringing up issues and not fear negative consequences; less fearful of failure. Healthcare professionals are not trained to do things wrong and they feel badly when they do. Historically, the medical field has looked for bad apples when something goes wrong rather than looking at the system itself. CCRMC is experiencing a paradigm shift to allow for system change; going the extra mile to put patient first. Julie Kelley said she notices people bring up problems more easily and willingly now.

Donna Wigand said the process has gone to the next level: Dr. Walker and Pat Godley have been looking at the process happening at the CCRMC. Not just the dollars spent to bring in the program, but the effectiveness, and in the long run, how much it saves financially and in quality of care. Dr. Walker is interested in expanding the LEAN process to other divisions. Mental Health has been discussing being the first division to follow up on the LEAN process. She has discussed it with Rollie Katz of Local 1 what LEAN would look like for the Mental Health Division. Although there is a bit of hesitancy, things are moving forward. She has also discussed with her managers the Mental Health Division will decide as a group, from the ground up, what will be addressed first in terms of system change. Lots of conversations are taking place.

As an example of the positives that can come out of a creative and open environment, Chair Mantas asked Anna to share the story of terminally ill patient with family in Philippines who was going to pass away shortly and wished to communicate with his loved ones. Within 3 hours, a resident called upon Information Systems to set up Skype on a laptop in the patient's room and connected to in his family in the Philippines allowing him to say goodbye and die with dignity. It was an example of going the extra mile for a patient.

De'shawn Woolridge asked how the community is able to get involved, possibly as interns or volunteers. With budget cuts, volunteer labor is a great deal. Anna Roth said there are many ways to get the community involved, and asked if Brenda Crawford could speak for the community voice as Brenda has much more experience in that realm. Brenda replied MHCC consumers have felt empowered through this process of decision making and change centered on their needs and care. She gave an example of working with consumers and family members as they designed, planned and painted the new entrance to CSU; it was life altering for some of them.

De'shawn Woodridge said our challenge is to make community members, who are not involved day to day, care about these issues. Los Medanos College has a nursing program with volunteers who might be interested in getting involved. (Brenda provided him with business cards.)

Vice Chair Pasquini said she has been invited in to CCRMC and her input is valued. Bringing everyone together to share ideas and brainstorm is critical. With dwindling resources, all the different cultures should embrace the LEAN concepts because they work. She would like Local 1 staff to experience the positives CCRMC staff has experienced through the process.

Commissioner Yoshioka would like to see structural and cultural changes; but asked how can the changes be sustained. Are we developing a training curriculum for the entire system and the rank and file staff to keep the changes going? Anna said the training and education structure is being reviewed and combined into the improvement and operations structure. Her intention is for CCRMC to become a living, learning lab as well as to innovate and find best practices. Her goal is to set an example and push those innovations out into the system, the community and beyond.

Commissioner Kahler said Anna Roth is the primary force in keeping the process moving forward.

Chair Mantas requested De'shawn Woolridge document any ideas he had about getting Los Medanos college volunteers involved and email to Nancy Schott. She will pass them along to the appropriate person.

6. REPORT: MENTAL HEALTH DIRECTOR – Donna Wigand

She referenced the handout "Shared Democratic Principles for Finalizing Budget". *(handout follows minutes)* It outlines areas of agreement between the Senate and Assembly Democrats on their response to the Governor's budget proposal. She met in Sacramento today with reps from other counties and DMH. The Counties feel even without a budget, not all cash flow should stop and the State agrees. MHSA funds should continue to flow as of 7/1/10 until a budget is settled. The State disagrees on other critical issues. Specifically, Counties assert even if the state portion is of a MediCal claim is withheld, federal funds for MediCal services for adults should not be withheld from the counties. As of today, the issue going up to State Dept of Healthcare Services and State Department of Finance. This issue is critical, especially for smaller/mid size counties, who don't have cash flow to keep services going if the State withholds all funds.

A. Funding of Community Mental Health: Role of Realignment – Suzanne Tavano Mental Health Funding 101.

Donna Wigand said Community Mental Health funding has gotten more complicated over the years, even before MHSA was passed. There have been different pots of funding with different regulations and rules.

Suzanne Tavano gave the presentation including information on the history of mental health funding and realignment. *(PowerPoint slides included in agenda packet, pages 39-51)*

For MediCal beneficiaries, funding comes from a combination of county money and federal money.

If Contra Costa is over the SMA (state maximum allowance), the County must overage with our own funds. Peggy Kennedy asked how CA's SMA (state maximum allowance) compares to other states. Donna Wigand said other states do not set this limit and they are cost reimbursed based on services billed. Peggy Kennedy asked why CA has this limit. Donna Wigand feels the state in the past has not wanted to maximize the federal dollars for mental health.

For uninsured adult consumers, federal funding is not available and county funds are used, primarily from realignment funds. MHSA funding allows for more flexibility in providing services to the uninsured. Other funding sources include SAMSHA and PATH grants.

Realignment Funding is divided into 3 categories: 1) State Hospitals (11 consumers in 2008-2009 down from 50 patients 10 years ago even though the County population has grown), 2) MHRC (otherwise known as IMD's 40 consumers in 2008-2009 down from 200+ 10 years ago) and 3) SNF (Skilled Nursing facilities - 110 consumers. Crestwood Patterson Pleasant Hill has contributed to the County's ability to reduce the number of MHRC beds by working to convert locked beds to residential beds and SNFs..) If more than 50% of the numbers of consumers in a SNF are being treated for mental health issues, federal money is not available and the County must cover the full cost of care.

Janet Marshall Wilson stated IMD (institute for mental disease) is a very offensive term. Suzanne Tavano agreed. (It is still used by the state and federal agencies.)

Contractors are paid for the services they provide; the SMA is built in to the way they operate. For county owned and operated facilities, it has not been built up that way. When they went over the SMA, county money was taken for the overage that could have been used to provide services. The way to come at or under the SMA is to manage revenues and costs. MHA didn't want to cut staff or programs, but rather to increase the number of services provided (and billed). Productivity standards were implemented in 2008 and for 2009-2010 Adult Services, the ratio of actual cost to SMA revenue should be almost even (in 2007-2008 was 114.6%). For Children's Services, the ratio of actual cost is still over the reimbursed SMA amount, but improvements continue to be made (from 177.2% over in 2007-2008 to 122.4% over projected for 2009-9010).

Annis Pereyra requested clarification on several abbreviations: JAS- Juvenile Assessment Services and MRG-Mobile Response Team (provided by Seneca).

Mental Health Division does not administer the CCRMC CSU and Ward 4C services (CCRMC is not contracted, but provides the services), but MHD is responsible for the costs of all services for MediCal and uninsured patients for both areas.

The majority of County dollars go toward funding CSU/4C. The balance goes toward outpatient services.

Lori Hefner asked about the SNF budget amount on page 9 of the handout. In touring the SNF's she feels they are problematic due to lack of mental health services being offered. Donna Wigand clarified that most of the SNF's include STF's (special treatment programs for psych). Lori Hefner will follow up with Suzanne Tavano directly.

Suzanne Tavano passed out Mental Health Matters newsletter that highlights MHA staff and clinics and the work they accomplish for the county. She hopes to prepare something similar for contract providers in the future.

B. Understanding the Governor's May Revise Impact – Donna Wigand

Regarding how budget cuts may affect the ability to provide services, one of the Governors' proposals was to cut 60% of Realignment funding to county. For example, if Contra Costa received $36 million from the state, which would result in a $21,600 million cut in funding, basically devastating the system. Realignment money is used to match to bill for services; without the match, we cannot bill. For the adult system of care; the system would begin to crumble. She doesn't think the Assembly and Senate feel that is feasible.

Health Services has put together a Healthcare Reform Task Force and Mental Health has been invited to participate. Dr. Walker will be inviting people in as needed. There are lots of changes between now and 2014 to put in place. There is still a question of how much Behavioral Health and Alcohol/Drugs will actually be included in federal healthcare reform.

7. MHC COMMITTEE / WORKGROUP REPORTS

A. MHC Capital Facilities and Projects/IT Workgroup –Annis Pereyra

At 6/25/10 Joint Cap Facility and Quality of Care Workgroup meeting, it was recommended the MHC would use the "Ask Yourself" questions from the Handbook for Conservators and MHC site visit form. She would like to consider using the Contract Evaluation–Adult Mental Health Programs form instead because it includes Review Standards and a Scorecard (pg. 53-66 in the meeting packet). She would like to request we use this form (not including the 2 day schedule on pg. 67-68 as it was discussed our site visits would be half a day) exclusively for one visit. After the visit, the Handbook for Conservators could be reviewed in case there are quality of care issues to be included on future site visits. The first site visit will be an experiment on the use of the site evaluation tool which can then be reviewed for effectiveness. She would also like to have a defined amount of time in discussion directly with consumers during site visits for input on how things are working and how they could be improved.

Chair Mantas clarified Commissioner Pereyra would like to table the recommendation approved at the joint meeting and use the new document instead at an initial site visit. Commissioner Pereyra agreed.

- **<u>ACTION:</u> Motion made to table the motion from the Joint Cap Facilities and Quality of Care Workgroup meeting and use the Contract Evaluation-Adult Mental Health Programs form (excluding the 2 day schedule). (M-Pereyra/S-McKindley-Alvarez/Passed, 6-0-1, Y- Mantas, McKindley-Alvarez, Overby, Pereyra, Pasquini,**

Yoshioka/A-Kahler) (Commissioner Kahler not part of either Workgroup and did not vote)

- **ACTION: Motion to adopt the Contract Evaluation-Adult Mental Health Program Annual Site Review Standards and Score Card evaluation tools for use at adult site evaluations. (M-Pereyra/S-Pasquini/Passed, 7-0-0, Y-Kahler, Mantas, McKindley-Alvarez, Overby, Pasquini, Pereyra, Yoshioka)**

Discussion:
Donna Wigand asked if Commissioner Pereyra proposed to use this form for all mental health site visits or just adult programs. Commissioner Pereyra said since she proposes to visit 2 adult sites this year, we'll start with this one and adjust as necessary.

Commissioner Yoshioka asked if there is a record using this form in the past. Sherry Bradley said it had been used by past Commissions in the late 1990's or early 2000's.

Commissioner McKindley-Alvarez asked if this same form was used for adults, older adults and children. Sherry Bradley recalled this form was only for adults and once the site visit report was finished, the Commission met with the Mental Health Director and then the Contractor for follow-up. Commissioner McKindley-Alvarez suggested since we voted to use the other tools at the joint meeting, could both tools (1/2 of group uses the tools originally recommended at the joint meeting and 1/2 uses the new tool) and discuss afterwards which was most effective. Commissioner Pereyra considered that idea, but thought it would be difficult to use different tools at the same time. She would prefer to use the new tool for the first site visit. Commissioners could keep the questions from the original tool in mind as they are talking to residents.

Commissioner McKindley suggested the Handbook for Conservators questions could be part of site visit training to keep the thoughtful flavor of the questions in mind.

Brenda Crawford asked what types of agencies were evaluated using this tool in the past. Were they only agencies that provide billable services or were community based contracted agencies involved as well? Sherry Bradley thought they were billable services agencies. Brenda Crawford asked were the tools or questions based on consumer driven services. Sherry Bradley didn't know. Brenda Crawford is concerned billable services agencies provide very different services than those provided than by consumer driven service agencies and there should be a separate evaluation tool.

Commissioner McKindley-Alvarez would also like to make sure different tools are developed for children's and older adult facilities. Commissioner Pereyra said the two sites scheduled for visitation this year are Crestwood Patterson Pleasant Hill and Crestwood Angwin.

Brenda Crawford would like to make sure contracted consumer driven services are not excluded from evaluation and a separate, more applicable evaluation tool is developed.

Commissioner Yoshioka asked if consumer driven services are explicitly noted in the contract. Brenda Crawford said yes.

Chair Mantas suggested Commissioners should be prepared for site visits by reading the documents the Cap Fac Workgroup has provided. After the site visit, thoughts on the evaluation tool and the actual site will be discussed and evaluated.

Commissioner Pereyra would like input for scheduling the site visit from Commissioners: days of the week and time of day (morning to include lunch or afternoon to include dinner). Email Nancy Schott with availability.

Chair Mantas clarified the Quality of Care workgroup handed off responsibility for site evaluations to Cap Facilities and Projects/IT. Cap Facilities is responsible for the site visit process and Quality of Care can provide feedback.

B. Quality of Care Workgroup – Carole McKindley-Alvarez

The Workgroup did not meet on 6/25 so a report is not available. They are meeting 7/9 with Vic Montoya and Vern Wallace on adult and children's services. They will meet on 7/23 to discuss the presentations from 7/9.

Chair Mantas said the Bylaws Workgroup is waiting for the IOC to review the Bylaws. No further work for now. Once the Bylaws are ratified, work on Policies and Procedures will begin. With 3 new Commissioners hopefully being appointed, he will ask for additional participation on the Diversity Workgroup.

8. REPORTS: ANCILLARY BOARDS/COMMISSIONS

-Feedback from 6/15/10 Regional Training for Local Mental Health Board & Commission Members

Commissioner Overby said he didn't find the training very useful: the start time was listed incorrectly and the presentations weren't very useful for work Commissioners do. The most useful session was LMHC/B Roles and Responsibilities. The best chance for action is to unite on specific issues, consult with MH Administration and take those issues to the BOS.

Commissioner Yoshioka thought the self-management of mental illness session was useful. The presenter, Conard House, based their program on a Stanford book based on self-management of chronic medical conditions he thought contained good information. He looked up a study from from the University of Illinois, the study on mental illness and self-management using WRAP (wellness recovery action planning) and thought it worthwhile. He sent both references to Nancy Schott; contact her if interested. He also thought the LMHB/C Roles and Responsibilities presentation would be very helpful to include in new commissioner training. Chair Mantas said materials had been requested from CiMH and would be distributed when available.

Chair Mantas said the experience of meeting other Commissioners, discussing common challenges and learning about best practices was more valuable than the presentations. Many counties (with the exceptions of San Bernardino, Santa Cruz and San Mateo counties) seem to have similar challenges as Contra Costa does, except for. The California Association of Mental Health Boards/Commissions (statewide organization of mental health boards/commissions) Board had a meeting at the end of that week meeting. He participated and was elected a director

(1 of 5) from the Bay Area Region (1 of 4 statewide regions). The Board agreed to focus on: 1) CiMH should make presentations to state and local mental health directors and local Boards of Supervisors on the statutory responsibilities of Mental Health Boards/Commissions, 2) a membership person from CAMH/B should communicate with local Boards/Commissions and develop stronger regional relationships (including regional meetings to discuss best practices), 3) get up to date contact information from each local Mental Health Commission/Board and 4) establish regional meetings every quarter or at least every 6 months

A. Mental Health Coalition – Teresa Pasquini – none

B. Human Services Alliance – Mariana Moore – The Contra Costa Funders Forum has been having conversations around the safety net provided by mental health, other health services and social services and how the government funding of services is declining. Interaction Associates has been hired by the Funders Forum to create a community-wide conversation around creating the type of community we would like to see in a time of diminishing resources focusing on how could non-profits, government, private and regular citizens could work together in new ways to provide the necessary services. She feels there would be a role for either the Commission as a whole or commissioners individually. She'll provide updates as available.

C. Local 1 – John Gragnani- He discussed mental health services at the Martinez detention facility. He passed out a CC Times article on a County staffed yoga and meditation group conducted in the mental health unit at the jail *(article follows minutes)*. The jail has a mental health module for more extreme inmates/patients. It is usually full and overflow inmates/patients are cared for in the general population. The approx. number of inmates/patients on medication is 250; County staff provide services including initial screenings and assessments for anyone on medication or with mental health and/or suicidal history, care for suicidal inmates (ranges from safety cells to less restrictive care options), overflow inmate transportation between jails, crisis calls from deputies (inmates with a serious diagnosed mental illness is not a mandated to be on medication so they are typically placed in the least restrictive setting if they are behaviorally manageable), review of judges orders for mental health screenings and calls from the public. There is a psychiatrist on site during the week and on call coverage is available on the weekends. Mental health staff is also available on call during the weekends. At one point contracting out jail mental health services was considered, but the proposal was not executed.

Commissioner Kahler asked what the total population of jail? John Gragnani said 600; 200 inmates either with mental health diagnosis or taking meds (approx. 40%).

Suzanne Tavano said the Detention mental health care is under CCRMC not MHA.

Vice Chair Pasquini suggested the community (possibly through a different group than the MHC) start a justice committee as it's an important issue. Jail is the one place a person guaranteed health care; it's a de facto place of care. Chair Mantas suggested John Gragnani provide any thoughts to Commissioner Mc-Kindley-Alvarez for Quality of Care Workgroup for possible action. Vice Chair Pasquini suggested also bringing to Julie Kelly of CCRMC.

D. Mental Health Consumer Concerns (MHCC) - Brenda J. Crawford- MHCC going through its own rapid improvement processes. Last year her focus was external, trying to establish/maintain a place at the policy table. This year it's been internal. Staff began a training process (July-Dec.) 4 hours training per week by CASRA (California Association of Social Rehabilitation Agencies); training open to any Community Support Workers and County staff. The management team is undergoing training as of 8/1/10 to increase effectiveness. The Board of Directors will also be trained in September, including a focus on increasing diversity. Their personnel policies and job descriptions are undergoing revision to reflect the changes that occur when an organization goes from being volunteer run to fully funded. An FSP Recovery Specialist has been hired in Richmond 30 hours a week; FSPs are now fully integrated at MHCC in Richmond. Daily attendance has increased and the facility is too small. MHCC will be offering limited scholarships (for consumers only) to the Alternative Conference in September. MHCC will be sending 2 staff members to Mary Ellen Copeland approved training WRAP. MHCC will be one of the few Northern California agencies with the ability to certify other WRAP facilitators. She handed out flyers for MHCC activities that allow for interaction between consumers, family members and providers leading to community connections. Activities include an anti-stigma poster contest, choir, softball team and peer support group for mood disorders). *(handouts follow minutes)*

E. National Alliance on Mental Illness (NAMI) – none

F. MHSA CPAW – Annis Pereyra -Housing Report – No action item now, but need to have future action items regarding Vic Montoya's request for authority regarding purchase of new properties due to current conditions of the real estate market and the need to make purchasing decisions quickly. ANKA is being fast tracked for approval from the state to allow them to move quickly when a property becomes available. If the MHC is interested in having the opportunity for more review of housing purchases, we must make our feelings known now. Chair Mantas suggested the Cap Facilities and Projects/IT Workgroup meet, develop a plan and bring recommendations to MHC for action. If timing is critical, a special MHC meeting can be called. It is not an agenda item today.

Vice Chair Pasquini asked which Workgroup is responsible for Housing issues. Chair Mantas replied yes it has always been Cap Facilities and Projects/IT Workgroup. At the January Planning Meeting, splitting up Quality of Care Workgroup's (included Housing issues at that time) duties into 2 separate Workgroups was discussed but not acted upon. The Quality of Care Workgroup recommended and the MHC voted to move the responsibility for housing/site visits to Cap Facilities and Projects/IT Workgroup. He feels once more Commission seats are filled, the work can be more evenly divided.

Commissioner Pereyra feels very strongly support services should be located close to housing. At this point there is no allocation of MHSA funds for supportive services in conjunction with MHSA funded housing.

Chair Mantas suggested this is an example of why a process should be developed to allow the MHC to be integrated into the planning process rather than decisions being made through CPAW and brought to the MHC late in the process. Sherry Bradley said a funding availability

notice was posted several months ago for 30 day input for the approx. $9 million MHSA housing funding.

a. Authority of the MHC liaisons to CPAW

Vice Chair Pasquini referenced Anna Roth's blog, http://safetynethospital.blogspot.com, and a recent posting by Anna and John Stenger on ethics beyond right and wrong. Conflicts of interest discussions are being held statewide. The IOC meets in August and the BOS has suggested a conflict of interest policy be developed and presented to them. She thinks it's important the MHC also have a conflict of interest position in place prior to the meeting. At the IOC and CPAW there were references to the First Five Commission to consider as a model for CPAW. She would like CPAW and MHC to avoid a grand jury report similar to the one included in the packet as well as the email from San Diego (documents on First Five Grand Jury Report and San Diego County included in the packet pg. 97 - 107).

Vice Chair Pasquini is already a member of the CPAW Planning Committee and the position she is requesting may be temporary as the Planning Committee has been given 3 more months.

- **ACTION: Motion made to authorize Teresa Pasquini to represent the MHC at CPAW Planning Committee and bring any MHC approved priorities to its attention for consideration. Teresa will report on CPAW Planning Committee meeting at the next available MHC meeting for consideration. The MHC authorizes Teresa to vote as an individual member of the Committee. (M-Pasquini/S-Pereyra/Passed, 6-0-1, Y-Kahler, Mantas, McKindley-Alvarez, Pasquini, Pereyra, Overby/A-Yoshioka)**

Discussion:
Chair Mantas clarified no individual Commissioner can represent the MHC as a whole at another group; anyone participating in other groups will be voting as an individual.

Vice Chair Pasquini said she and Commissioner Pereyra haven't been voting at CPAW meetings to avoid the perception of conflict of interest. They have been trying to represent the MHC position, but it's also important for there to be voting members of CPAW. She would be a family member representative when voting at CPAW.

Chair Mantas MHC representatives cannot represent the MHC position on any advisory body because the MHC's position is not known until it takes action. The MHC's position will be finalized when the representatives come back to the MHC, present their findings and ask for the MHC to take a position via vote. Once taken the representative will take the position back to the advisory body.

Commissioner Yoshioka said due to receiving CPAW report so recently, he has not had time to digest it; he will abstain.

Vice Chair Pasquini said in trying to reach out to CPAW offered to attend a meeting to discuss the MHC's role. There was some discussion at the CPAW Planning Committee meeting about whether or not the MHC had authorized Peter Mantas to attend. She would like to formalize his

authority to go to CPAW if it acceptable to the CPAW Planning Committee and an invitation is extended.

- **ACTION: Motion made to authorize Chair Mantas to attend a future CPAW meeting to advise MHC roles and responsibilities as outlined by the CiMH training manual ("training manual" refers to the Local Mental Health Board/Commission's Roles and Responsibilities presentation from the 6/15/10 Bay Area Region Training, pg. 83 – 92 in the 7/8/10 MHC Meeting packet). M-Pasquini/S-Overby/5-0-1, Y-Kahler, Mantas, Pasquini, Overby and Pereyra/ A-Yoshioka (Commissioner McKindley-Alvarez had left the meeting and did not vote.)**

Discussion: None.

b. Reports on CPAW workgroups and monthly meeting of July 1

Vice Chair Pasquini said there was discussion at the last CPAW meeting about Donna Wigand's discomfort with the appointment process. There was discussion of an appointing committee, but one has not yet been formed. She would like to recommend the MHC has a liaison to any interview group. She withdrew the motion until an interview Workgroup may be formed.

c. MHC Position on Conflict of Interest

- **ACTION: Motion made to recommend to the BOS IOC at their August Meeting, that a written policy on conflict of interest be developed for CPAW which supports the Grand Jury Recommendations #1 and #2, on the First Five Commission, as follows: 1. CPAW members shall not be affiliated with agencies most likely to be awarded significant funding, thereby minimizing perceptions of impropriety. 2. CPAW members having financial interests in MHSA contracts shall recuse and physically remove themselves from meetings where their programs are under consideration. Also, Ethics/Conflict of Interest violations as defined by State Fair Political Practices Commission AB1234 and Government Code 1090 should be considered for CPAW members as they are for MH Commissioners. MHC recommends that Ethics trainings be provided to CPAW members. (M-Pasquini/S-Pereyra/Passed 5-1-0, Y-Kahler, Mantas, Pasquini, Pereyra, Overby, N-Yoshioka.)**

Discussion:
Donna Wigand read public comment composed by Donna Wigand and Sherry Bradley regarding item 8.F.c:
"My public comment is regarding the inclusion of two items in the agenda packet for this evening's meeting, specifically regarding Item 8-F-c, which is being used to support the Mental Health Commission's position on Conflict of Interest. Those two items are: an enclosure on First Five Commission, and an "example" from San Diego County.
We applaud the Mental Health Commission in its work to develop a recommendation to the Board of Supervisors IOC regarding conflict of interest as it pertains to any mental health stakeholder planning group. We are, however, respectfully urging you to consider carefully whether or not you would use the documents included in your packet as those which you would

use as a platform upon which you build your position on conflict of interest (as it pertains to CPAW).

In the first instance, First Five Commission is an independent, stand-alone, decision making agency which is established by Contra Costa County Ordinance. This is a body that itself awards contracts, has its own budget, employs its own staff, etc. Government Code Section 1091.3, and California Govt. Code 1090, is partially inapplicable to this body because it is not an "entity of the county". The conflict of interest issues they have been encountered are based upon the existing statutes noted. Strictly advisory volunteer stakeholder workgroups, such as CPAW, are not required to make attestations to the government codes on financial conflict of interest, because they do not, in and of itself, award any contracts, employ staff, etc.

True, there was a Grand Jury Report issued on a number of matters where there was concern, and not just on conflict of interest. However, they found there was no wrongdoing, and acknowledged that positive changes had been made based upon their interviews with the agency. In the second instance, the memorandum from Shirley Bard to San Diego County Department of Mental Health, dated June 29, 2010, has just been sent to them. There's been no opportunity for San Diego County to respond to the complaint. The memorandum is one person's opinion of perceived wrong doing, accusing county staff of not complying with existing State Fair Political Practices Commission AB1234 and Government Code 1090.

This same matter has been raised by Ms. Bard on three separate occasions (this being the fourth time) and according to Alfredo Aguirre, San Diego County's Mental Health Director, and also Dr. Phillip Hanger, San Diego County's Executive of the MHSA Team, there is no basis to the claim, and the charges are, according to both parties, unfounded. The accusations have been tested in the past, internally by review, then by the State (Fair Political Practices Commission), then by the San Diego County Grand Jury, which most recently said that there was no conflict. I am providing you with a copy of the San Diego County Grand Jury Report titled "Proposition 63 – Mental Health Services Act", filed by the Grand Jury on May 20, 2010.

We don't oppose having conflict of interest guidelines in place for volunteer mental health stakeholder planning groups, such as CPAW. We would, however, like to see the Mental Health Commission do more due diligence in gathering information which would be more suitable to consideration of the present situation.
Thank you."

Mariana Moore said she echoes much of what Donna said. Although Human Service Alliance supports guidelines and ethics training, CPAW is different from the First Five Commission. She feels it is very important to have all stakeholders at the table and something would be lost if those stakeholders went away. She acknowledged she is speaking from a position of self interest on behalf of the Alliance members, but she is very concerned about the process as well. She urges more examination of other sources and consider another path.

Vice Chair Pasquini appreciated the comments and wondered about some of the same issues. Not being an attorney or having a research staff, she took a stab. She agrees the richness of the stakeholder body is important, but feels the MHC has almost a fiduciary responsibility to the tax

payers to make sure funds are spent properly. Advisory body or not, CPAW's recommendations matter to the community. Some of the public comments attached to the CC Times articles were inflammatory (she did not discuss them), but several stated "this doesn't pass the smell test." She feels the bottom line is although efforts are being made and have been made recently, to clear up the perceptions of conflicts of interest, they need to continue.

Chair Mantas said this motion is a recommendation and can be revised in the future based on feedback from Donna Wigand, Sherry Bradley or others. The Commission is requesting a transformation in the process of how CPAW engages with the MHC. It should not be taken as a negative. Something may have been overlooked, but it is a good first step. The make-up of CPAW should be reviewed along with potential undue influence issues. He hopes a process is developed by CPAW that can be reviewed by MHC and everyone can move forward as the process is streamlined.

Vice Chair Pasquini suggested removing the motion language referring to the requirement for Ethics Training since it cannot be mandated per information in Donna Wigand's public comment. Chair Mantas suggested leaving it in as it can be removed at a later date if necessary. She agreed to leave in.

9. CHAIRPERSON'S COMMENTS – Peter Mantas

A. Consider holding a public hearing on the revised MHSA draft Technological Needs Project Proposal

Chair Mantas has taken the MHC position that every plan submission or plan update goes through a public hearing. As there are no substantive changes to the plan for this revision, he recommends not holding a public hearing. The only plan change is the County will house the data rather than outsourcing it to a vendor; the rest of the plan remains the same.

- **ACTION: Motion made not to hold a public hearing for the MHSA draft Technological Needs Project Proposal. (M-Yoshioka/S-Pasquini/Passed, 6-0-0, Y-Kahler, Mantas, Pasquini, Overby, Pereyra and Yoshioka. (Commissioner McKindley-Alvarez had left the meeting and did not vote.)**

Discussion: None

B. Clean-up and Prioritize Future Agenda Item List – moved to next meeting

C. Appoint Workgroup to Develop MHC Fact Book (to be used in review meetings with appointing Supervisors)

Chair Mantas requested Commissioner Kahler chair a temporary workgroup to develop a Fact Book for use between Commissioners and their appointing Supervisors. Commissioner Kahler agreed. Once the Fact Book is developed, Nancy Schott to physically create them. Anyone interested in being a part of the Workgroup contact Commissioner Kahler directly and let Nancy Schott as well.

Chair Mantas confirmed the MHC is still interested in having Dave Cassell present at the next meeting. Donna Wigand said she would confirm he is available.

Donna Wigand requested Steve Hahn Smith attend the next meeting as well to discuss the new Data Request Form and memo issued today. Nancy Schott will forward both documents.

10. FUTURE AGENDA ITEMS

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

A. Suggestions for August Agenda ***[CONSENT]***

1. Presentation from Health Services Department on the policies and procedures surrounding sentinel events – David Cassell

B. List of Future Agenda Items:

1. Rose King Presentation on MHSA
2. Behavioral Court Presentation
3. Case Study
4. Discussion of Service Provider Contract Review.
5. Presentation from The Clubhouse
6. Creative ways of utilizing MHSA funds
7. TAY and Adult's Workgroup
8. Conservatorship Issue
9. Presentation from Victor Montoya, Adult/Older Adult Program Chief
10. Presentation from Crestwood Pleasant Hill
11. Presentation on Healthcare Partnership and CCRMC Psych Leadership
12. Presentation on non-traditional mental health services under the current PEI MHSA programs

C. List of Future Action Items: Next meeting

1. Develop MHC Fact Book to be used in review meetings with appointing Supervisors
2. Review Meetings with appointing Supervisors

Chair Mantas requested Commissioners consider having commission meetings 3 hours rather than 2 hours at the next meeting.

11. ADJOURN MEETING

- **ACTION: Motion made to adjourn the meeting at 7:47 pm (M-Pasquini/S-Pereyra/Passed, 6-0-0, unanimous)**

The next scheduled meeting will be Thursday, August 12, 2010 from 4:30- 6:30 pm. Location to be determined.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the staff to a majority of the members of the Mental Health Commission less than 96 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours

Meeting Handouts

The following documents were presented at the 7/8/10 MHC monthly meeting (and not included in the meeting packet).

For all other materials reviewed and discussed at the 7/8/10 meeting, please see the agenda packet on the MHC Meeting Agendas and Minutes webpage at

http://www.cchealth.org/groups/mental_health_com/agendas_minutes.php

KAIZEN EVENT SUMMARY

CRISIS STABILIZATION UNIT (CSU) – INTERVIEW THROUGH DISPOSITION

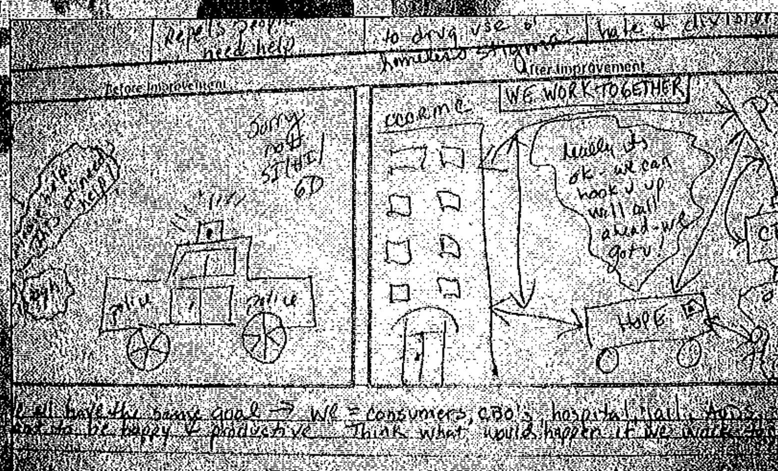
WEEK OF JUNE 14-18 2010

BEHAVIORAL HEALTH KAIZEN #2

Friday, May 18th marked the end of the second Kaizen week focusing on the processes and flow of patients within the Crisis Stabilization Unit (CSU). This Kaizen was a huge milestone in the CCRMC System Transformation process. [illegible] half of the team members [illegible] outside CCRMC. Multiple stake[illegible] organizations were represented, as well as families, advocates and students from the UC Berkeley School of Public Health.

In her introduction to Behavioral Health (BH) Kaizen #2, Anna Roth [illegible] *great moment [illegible] the second [illegible] consumer [illegible] represent[illegible] [illegible]* [illegible]

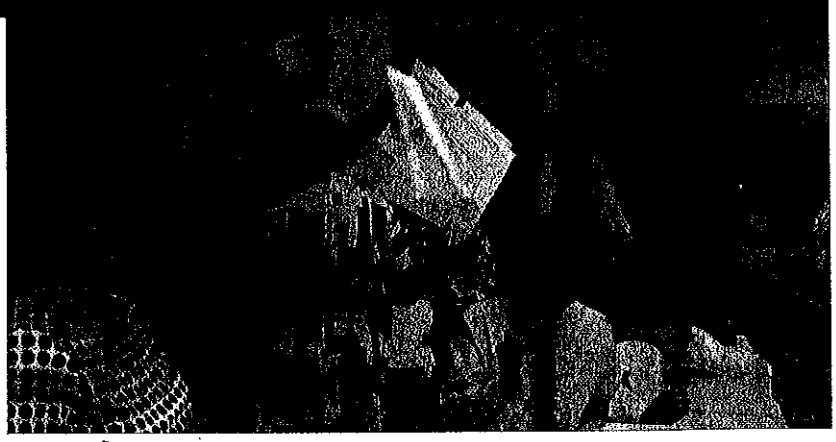
[illegible] of BH [illegible] happens to the [illegible] they have been [illegible] of the same [illegible] their expertise [illegible] In add[illegible] the [illegible] spoke with [illegible] they had [illegible] their



KAIZEN EVENT SUMMARY

CRISIS STABILIZATION UNIT (CSU) – INTERVIEW THROUGH DISPOSITION

WEEK OF JUNE 14TH 18, 2010



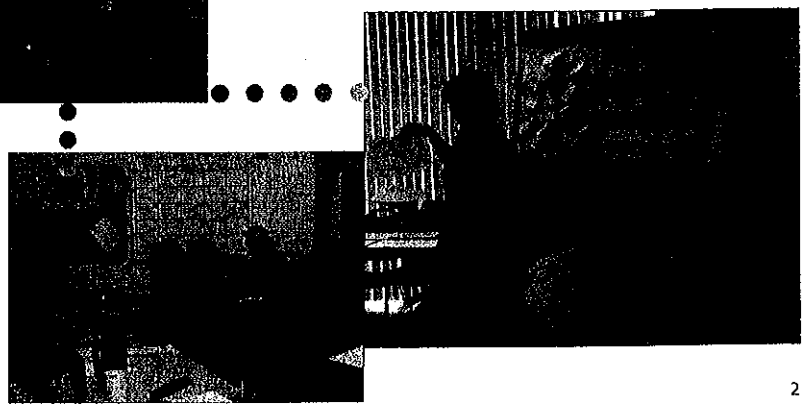
FOLLOW UP ON KAIZEN #1

Work continues. After the front entrance to the CSU opened, the number of patients went up noticeably before leveling off. Staff have applied the Standard Work, and over the past weeks, have recommended changes to address variations in patient volume and staffing levels. There has been a definite decrease in patient agitation attributed to the initial greeting by the multidisciplinary team. Family members have been really responsive. The Safety Checks are going very well, with patients responding to the increased privacy and staff appreciative of the consistent training and reinforcement. Metrics to measure success of Standard Work throughout the unit is under development. Stand-up meetings to follow up on the Kaizen Action Bulletin are held weekly.

The 20+ Kaizen team first spent time in the CSU watching the flow of work and interviewing staff. The observations inspired dozens of ideas that were divided into four teams to observe, analyze and improve specific areas/processes.

NEXT STEPS

Utilizing the continuous improvement structure established after the first BH Kaizen #1, the Standard Work, issues and additional recommendations will be reviewed weekly. Team members will be invited to participate, although the responsibility for implementation of Standard Work and completion of the items on the 30-Day Action Bulletin rests with the Process Owners. In addition, everyone will be gearing up for the next Kaizen the week of July 26th which will focus on Discharge to Home/Community. To stay updated on CCRMC Lean efforts, please feel free to visit Anna's blog at safetynethospital.blogspot.com or our website www.cchealth.org/medical_center/lean



"Kaizen is not a home run. It's a series of hits. You won't get a grand slam this week...but you will in a year."
—*Mike Rona, Rona Consulting*

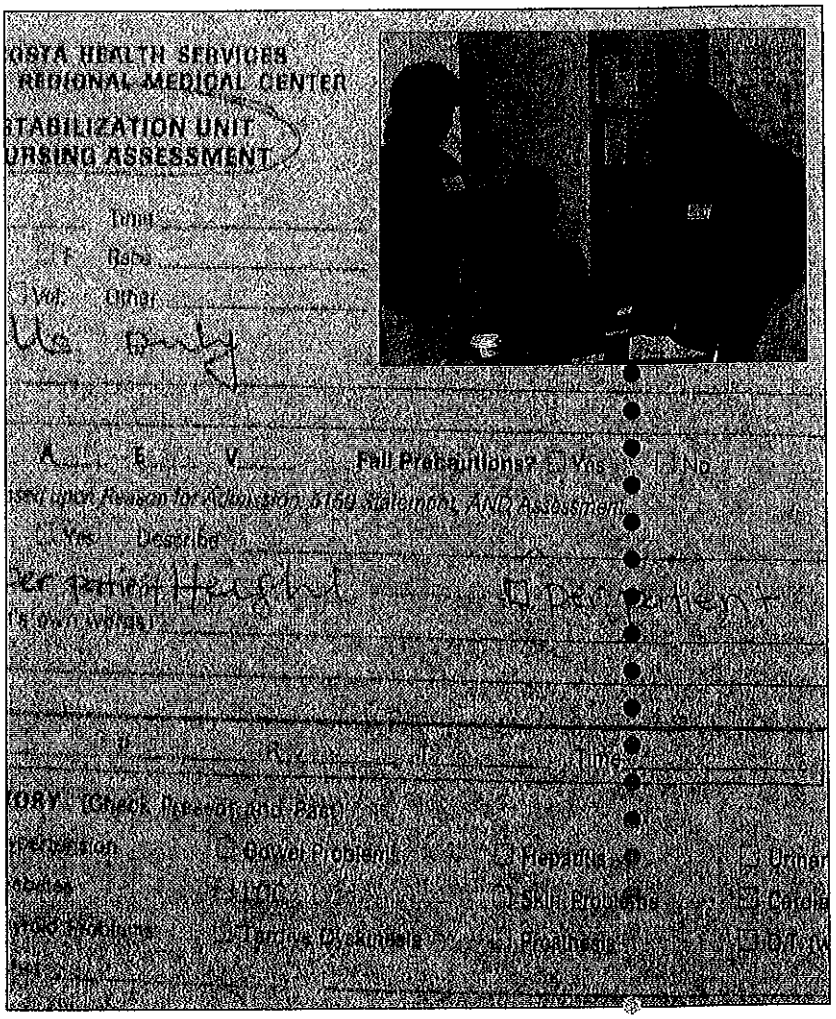
KAIZEN EVENT SUMMARY

CRISIS STABILIZATION UNIT (CSU) – INTERVIEW THROUGH DISPOSITION

WEEK OF JUNE 14 – 18, 2010

WORK TEAM 1—DOCUMENTATION: FORM CONSOLIDATION, BELONGING MANAGEMENT, DISCHARGE PAPERWORK, NURSE ASSESSMENT

- The goal is to nurse people, not paperwork, without sacrificing necessary information.
- Approximately 61.13 hours of staff time will be freed from belongings documentation to spend with patients and families (plus decreasing the potential loss of items by making bag tampering far more evident).
- Three different and repetitive nurse assessment forms have been consolidated into 1.
- Streamlined form to move away from "Discharge" to Inpatient Psychiatric (4C) to "Transfer", eliminating multiple unnecessary forms and reducing processing time from a high of 4 hours to an average of 5 minutes.



Participants: Marianne (Innovation Council), Baraka (QM), Amber (4C), Ann (CSU)

"Respect is a key value in Lean. Time cannot be replaced, so doing a Kaizen, taking time out of our normal work, is a big sign of that respect."

— Patti Chrome, Rona Consulting

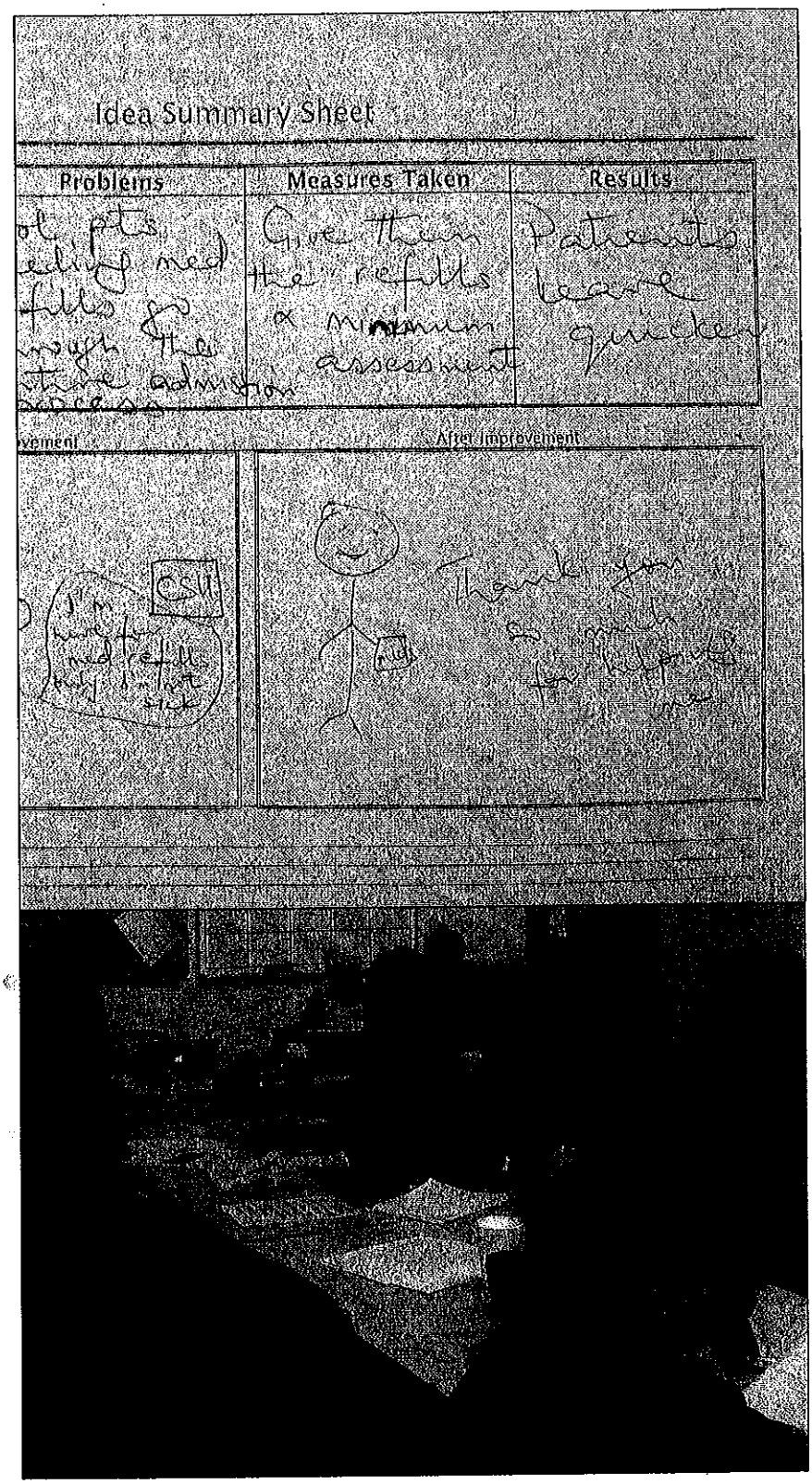
KAIZEN EVENT SUMMARY

CRISIS STABILIZATION UNIT (CSU) – INTERVIEW THROUGH DISPOSITION

WEEK OF JUNE 14–18, 2010

WORK TEAM 2–PATHWAY: DOCTOR/THERAPIST HUDDLE, ROLE OF SOCIAL WORKER, MEDICATION ADMINISTRATION, INTAKEIMPROVEMENT, SCRIPT FOR SHIFT CHANGES

- Psychiatrist schedules have been slightly changed to make it easier to get an MD. Additionally, there is now a process to call an Administrative Psychiatrist when necessary.
- There used to be only one person that could give a final approval, and with cross-training, that has been expanded.
- Red Star system implemented for priority signaling & new process developed to identify patients at high risk for readmission for not filling discharge medication.



Helena (ICU/IMCU), Nadia (Pharmacy), Cheryl (Student Intern), Vernita (CSU), Charles (Psych)

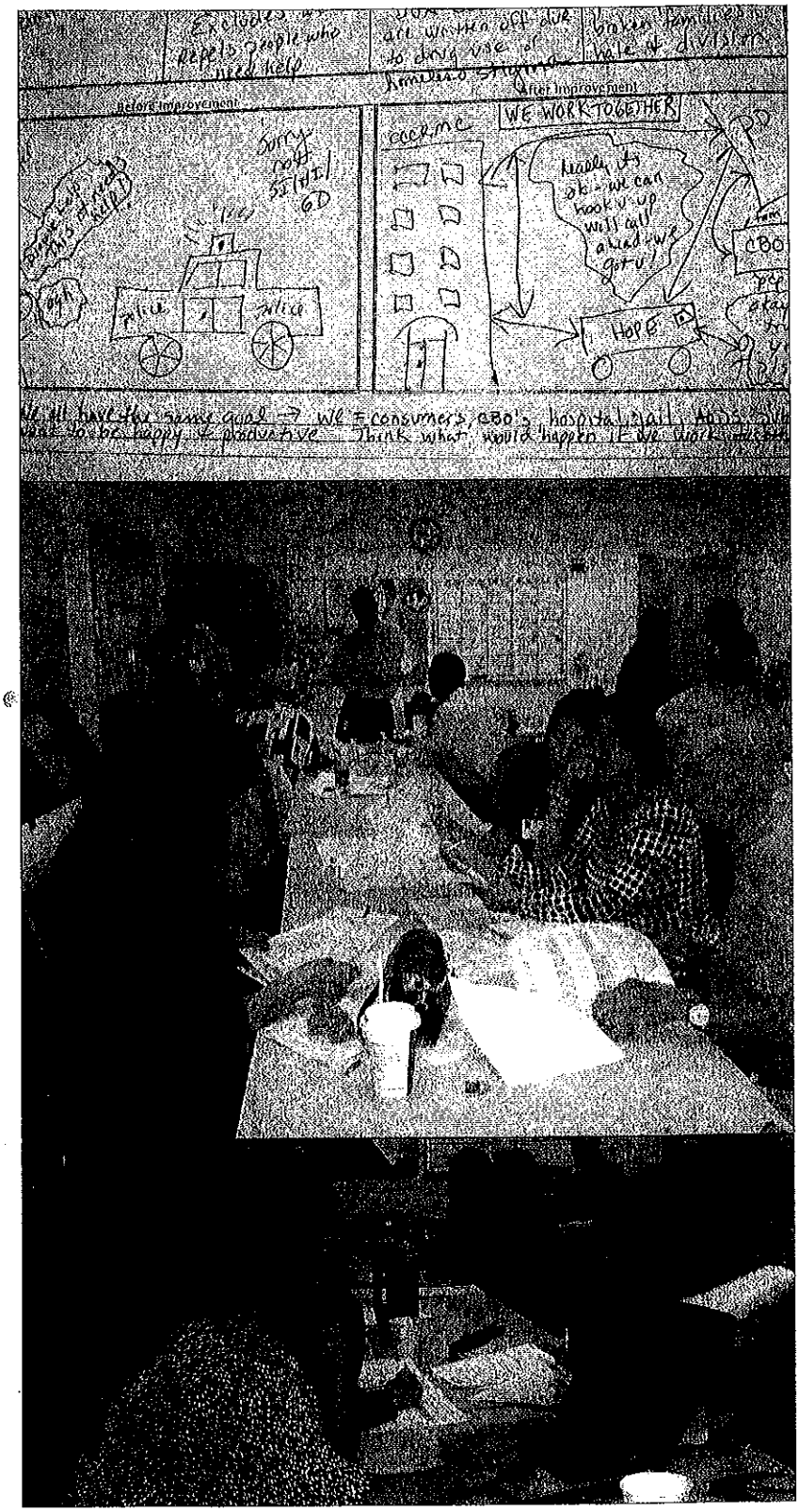
KAIZEN EVENT SUMMARY

CRISIS STABILIZATION UNIT (CSU) – INTERVIEW THROUGH DISPOSITION

WEEK OF JUNE 14 – 18, 2010

WORK TEAM 3 – STAY: FAMILY ENGAGEMENT, PATIENT COMMUNICATION OPTIONS, DUAL DIAGNOSES WITH ALCOHOL AND OTHER DRUGS

- *"From the family's standpoint, it is a critical step forward to be able to email the Psych Emergency (CSU) directly. It is the only method that can beat the ambulance to the CSU and to get the information into the hands of the staff. It is a meaningful and significant step!"*—David Kahler
- Standard Work proposed for early family involvement and education, including CSU Orientation Packet.



Dave (NAMI), Brenda (Anka), Fatima (AODS), Yvonne (CSU), Katherine (Student Intern)

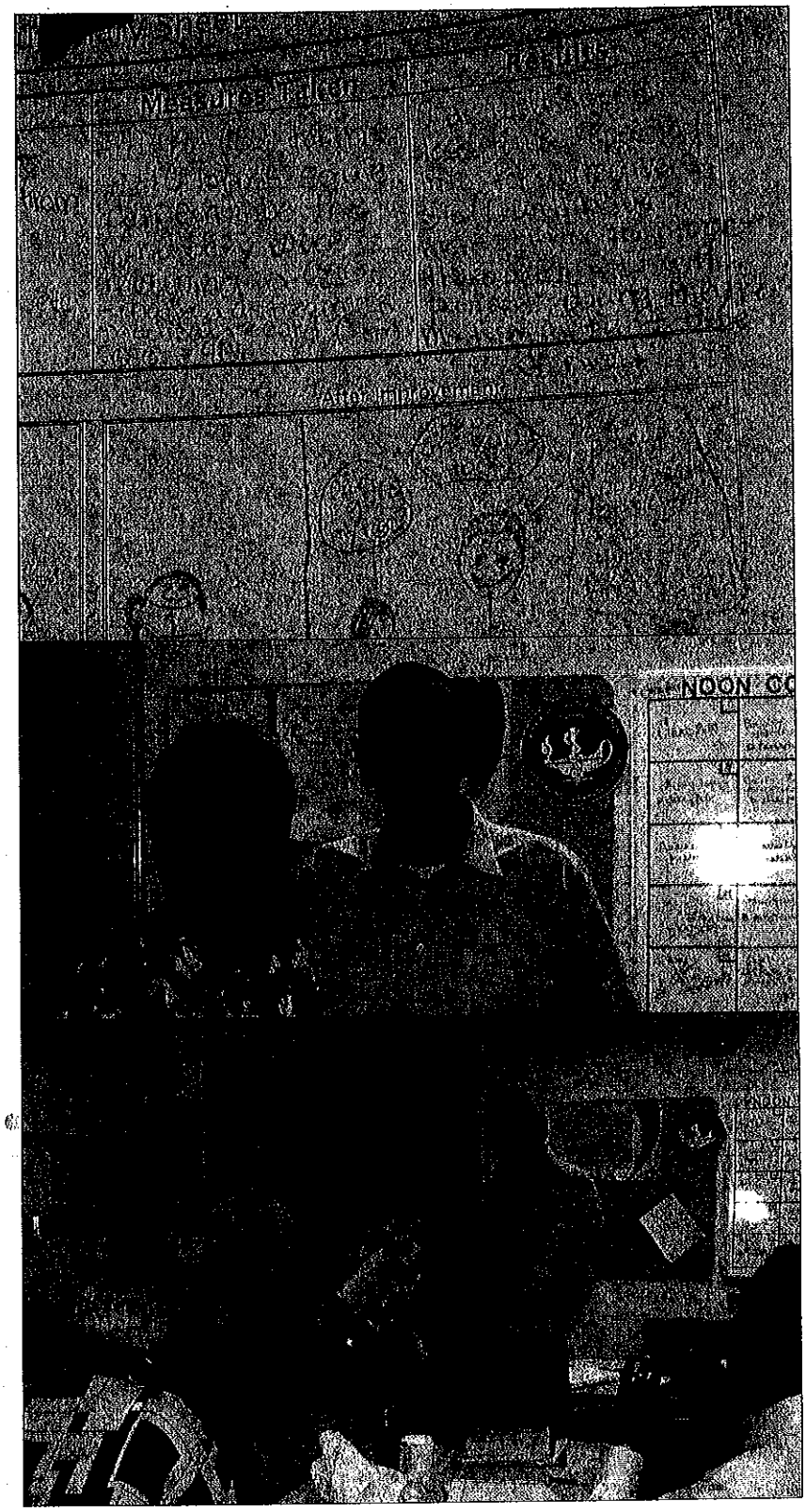
KAIZEN EVENT SUMMARY

CRISIS STABILIZATION UNIT (CSU) – INTERVIEW THROUGH DISPOSITION

WEEK OF JUNE 14 - 18, 2010

WORK TEAM 4 – DISPOSITION: TUBERCULOSIS TESTING, SOCIAL SERVICE REFERRAL FORMS, STREAMLINE DISCHARGE TO NIERIKA/4C, MEDICATIONS FOR DISCHARGE

- *"This is really going to change things for our clients. I think we're getting there."* — Bernadette
- Streamlined form to move away from "Discharge" to Inpatient Psychiatric (4C) to "Transfer", eliminating multiple unnecessary forms and reducing processing time from a high of 4 hours to an average of 5 minutes.
- *"My team turned over every rock we found, and when they found something, they were like bulldogs and didn't let it go!"* — Haven Fearn, Director, Alcohol and Other Drug Services
- Bed availability list from Nierika now goes to CSU (not just 4C)
- TB test can be ordered upon admission to reduce time waiting for result before discharge



Haven (AODS), Teresa (Family member), Bernadette (Patients' Rights), Avi (Nierika), Patti (CSU)

KAIZEN EVENT SUMMARY

CRISIS STABILIZATION UNIT (CSU) – INTERVIEW THROUGH DISPOSITION

WEEK OF JUNE 14 – 18, 2010

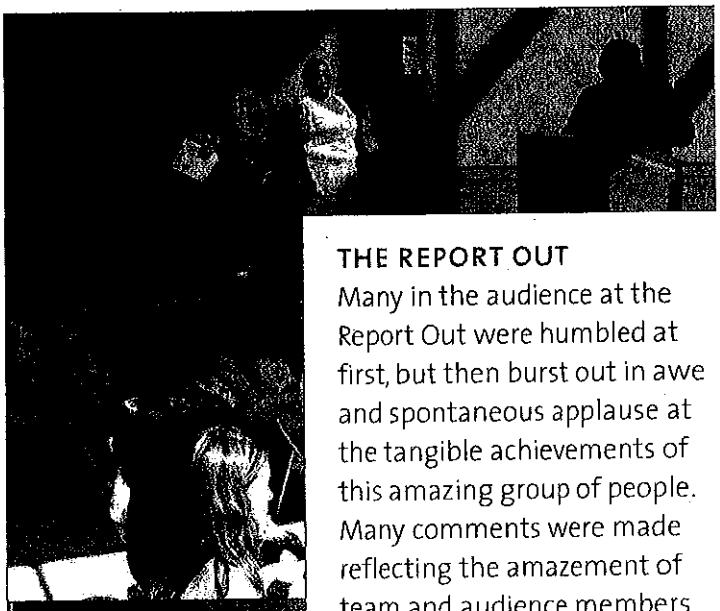
THE PATIENT/ FAMILY MEMBER EXPERIENCE

The Behavioral Health Kaizen 2 event was another opportunity to change a broken system that is characterized by complexities and infected with despair. It was another chance to tuck values into the layers of bureaucracy that choke the life out of the patient, the family, the staff/provider. It was a chance to re-write policies, procedures and break down barriers using science. It was another opportunity to catch a little hope.

The Kaizen process teaches us to think big, blow up the box, but to remember that it is small incremental tests of change that we are trying. We are told to keep taking hits, get on base, and let the next hitter, move us forward to score. It is a difficult process for those of us who love Grand Slams and lack the patience to sit through an entire baseball game.

I went home a couple of nights feeling the weight of so much systemic variation and how it brings harm. But, I returned the next morning because there is no crying in baseball and quitting is not an option since people's lives are depending on us. Plus, I trust the Kaizen process and the leadership of Contra Costa Regional Medical Center.

The support of the hospital leaders to look in every dark corner and shine the biggest light on their system, in hopes of making it better for the line staff to help the patient, is a gift of true transformation. Friday's Report Out was a Grand Slam and I will keep taking those hits in order to sustain the changes. —Teresa Pasquini



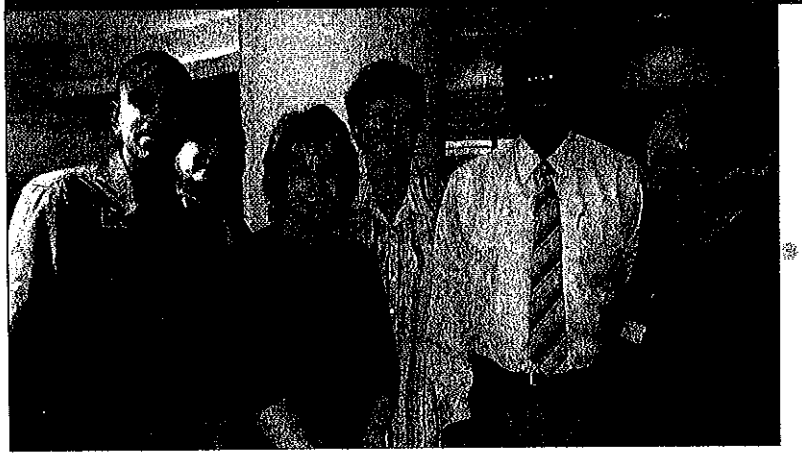
THE REPORT OUT

Many in the audience at the Report Out were humbled at first, but then burst out in awe and spontaneous applause at the tangible achievements of this amazing group of people. Many comments were made reflecting the amazement of team and audience members alike that measurable change can happen, even in a large and complex organization like ours. Thanks to this team and all the staff that will turn their ideas into reality, CCRMC is ever-closer to our Behavioral Health Future State to the benefit of our staff, partners, patients and their families.

KAIZEN EVENT SUMMARY

CRISIS STABILIZATION UNIT (CSU) – INTERVIEW THROUGH DISPOSITION

WEEK OF JUNE 14 - 18, 2010



This picture alone reflects the enormous change our system has experienced. Representatives from our partner organizations stand side-by-side with our staff to show our united cause and how together we can improve the lives of the people in our community more than just any one of us alone.

CONSUMER PICNIC

Staff had a special treat right after the Report Out, as everyone was invited to the Mental Health Consumers & Family Annual Picnic in Pleasant Hill. Everyone had a great time and really enjoyed meeting the people who benefit from an improved, more integrated system of Behavioral Health Care in Contra Costa County.

Staff and partners pose under the NAMI banner. (From left to right, Charles Saldanha, Tess O'Riva, Anna Roth, Suzanne Tavano, Teresa Pasquini, Marianne Bunce-Houston, David Kahler)

Anna addresses the crowd, acknowledging the tremendous work of all our partners and CCRMC's role in supporting the shared goal of consumer recovery.

Student Intern Katherine Lao proves that every moment is an educational moment.

Victor Montoya (Contra Costa Mental Health) cooks up a storm.

DAILY KAIZEN UPDATE

CONTINUOUS INFORMATION FOR CONTINUOUS IMPROVEMENT

FRISDAY
JUNE 18, 2010

Behavioral Health Kaizen #2
June 14 through 18

THE KAIZEN FINAL STRETCH

With every Kaizen event, CCRMC gets better and better. The tangible results from all the hard work of the team and participation by the staff are just inspiring. Thursday morning saw the finalization of Standard Work in many areas, as roadblocks were identified and key decision makers brought in to cut through the red tape. By 3:30 they were done and started preparing for the big Report Out Friday morning.

Each work team focused their efforts on specific projects with the potential for huge impact to reduce patient lead time.

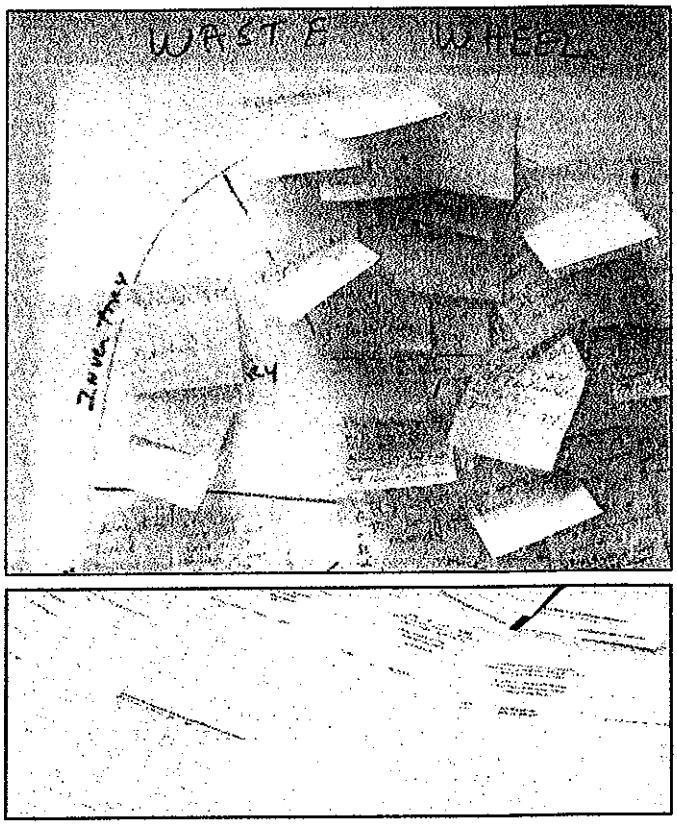
Work Team 1 – Documentation: Form Consolidation, Belonging Management, Discharge Paperwork, Nurse Assessment

Work Team 2 – Pathway: Doctor/Therapist Huddle, Role of Social Worker, Medication Administration, Intake Improvement, Script for Shift Changes

Work Team 3 – Stay: Family Engagement, Patient Communication Options, Dual Diagnoses with Alcohol and Other Drugs

Work Team 4 – Disposition: Tuberculosis Testing, Social Service Referral Forms, Streamline Discharge to Nirika, 4C/Bed Control Issues, Medications for Discharge

Friday morning the team members will report not only on their accomplishments, but also on their experience. These events change not just the way work is done, but the people who work. Partnering outside CCRMC to include not just other Health Services divisions, but even our community partners, reflects a new era of cooperation and seamless care integration for those we serve. And this team is making a promise to not only improve things for this week, but to continue the momentum to sustain these changes and help make CCRMC a continuously improving organization.



KAIZEN TERMS

Standard Work—The "Best Practice" as agreed upon by the people actually doing the work. Team members that do not work in a target area make recommendations from a fresh perspective, but it is up to the staff doing the work to test it and confirm it will do what we want it to: improve the patient experience.

Takt Time—The pace or beat of work: A German word taken from the name of an orchestra conductor's baton. Takt Time is based on patient demand, so higher census hours have a different takt time than low census hours.

Lean—Our adopted management system that emphasizes reducing waste, challenging the status quo and looking at the entire organization from the perspective of the patient.

Kaizen—Continuous Improvement.

For Comments & Questions, call Lynnette Watts at 370-5403 or lwatts@hsd.cccounty.us To view past Kaizen updates and the history of System Transformation at CCRMC, visit http://cchealth.org/medical_center/lean/

DAILY KAIZEN UPDATE

CONTINUOUS INFORMATION FOR CONTINUOUS IMPROVEMENT

THURSDAY
JUNE 17, 2010

Behavioral Health Kaizen #2
June 14 through 18

WHAT IT MEANS TO BE ON A KAIZEN TEAM

Wednesday was intense. So many ideas were generated Tuesday that the team had to put all their energy into testing, updating and testing again the Standard Work. Their tangible progress is reviewed at the end of every day at the daily Report Out. But that's not the half of it. Every morning is the Hansei, where you hear how the process is affecting the people involved.

Hansei means relentless reflection. It is how the team starts their day. They talk about where they are personally with this process, their concerns and how they feel about what is happening. These people, supported by their managers, are taken out of their daily jobs for an entire week and immersed in this intense process that challenges the status quo. They are told again and again that nothing is set in stone...nothing is sacred. Everything can start to change with the end goal of the Future State Map. They are given permission, support and authority to make things better for the patient. And they feel it.

Some of the comments expressed their excitement (some are even losing sleep) at all of the changes that they are making possible. The work teams are turning over every stone (like a CSI show, said one participant), finding something that doesn't work and grabbing onto it "like bulldogs", not letting go until a solution is found. Besides being tired yet optimistic, many people expressed wanting more time this week. They feel so personally invested in the improvements for our patients that they want to do more, test all the ideas, and make sure that the changes are sustainable. And remember that patients are still being served in the CSU while all this is going on. So we must honor the trust that the CSU staff have placed in the team, taking risks to fearlessly point out what doesn't work in their own processes.

So it is not just the Standard Work that is changing. And really, it's not just the people on the team. The commitment of this organization to continuous improvement is starting to change the entire culture. People receiving the daily updates want more information about what is happening in CSU. Many requests to learn more about Lean and Kaizen are coming in. Take note...change is here.

CCRMC....It's about the patient.

Download
Behavioral Health
map

KAIZEN TERMS

Heijunka — Leveled production: Appropriate use of staff per their skill level.
Jidoka — Automation for safety/"Mistake Proof": Acknowledges the importance of Standard Work, since without standards there can be no improvement. It also emphasizes that 99.9% in health care is unacceptable, as that .1% means unsafe care for too many patients.
Kaizen — Continuous Improvement.

For Comments & Questions, call Lynnette Watts at 370-5403 or lwatts@hsd.cccounty.us To view past Kaizen updates and the history of System Transformation at CCRMC, visit http://cchealth.org/medical_center/lean/

DAILY KAIZEN UPDATE

CONTINUOUS INFORMATION FOR CONTINUOUS IMPROVEMENT

WEDNESDAY
JUNE 16, 2010

Behavioral Health Kaizen #2
June 14 through 18

KAIZEN TEAM NOTES

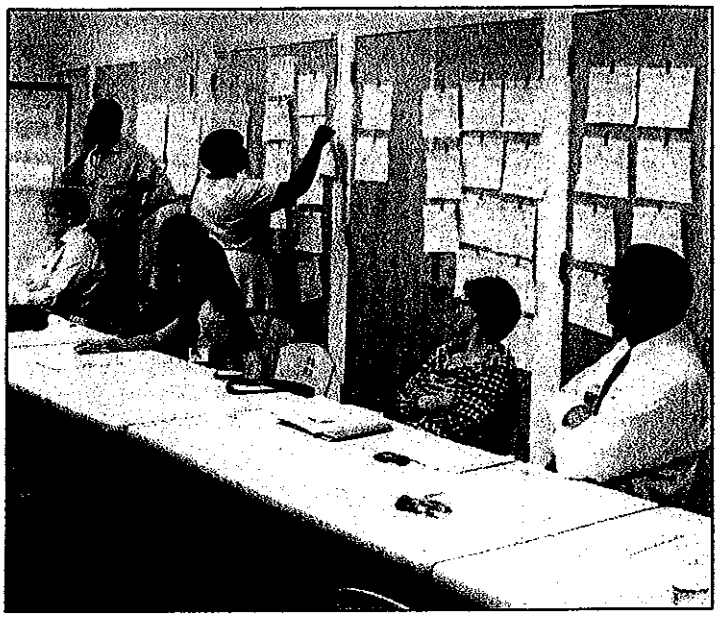
Tuesday saw a lot of hard work, especially with such a large team. After observing the staff in action on the Crisis Stabilization Unit (CSU), each team member was required to come up with three (3) ideas on how to improve a process or workflow. All of these ideas were put up around the room, then grouped into similar categories to define the work teams. The four resulting work teams will focus on:

1. *Documentation:* Multiple repetitive forms were identified, although coordination with Mental Health is necessary to ensure all information needed for billing is collected.

2. *Fast Track Model:* Discussion of the possibility of streamlining triage and treatment options based on acuity level for voluntary patients. This could free up resources (staff and space) for higher-need patients.

3. *Stay:* What patients need during the time they are in the CSU as far as counseling, activities and visitation.

4. *Disposition:* Exploring patient options for leaving the CSU, and what is needed to facilitate the transition.



Download
Behavioral Health
A3-T form

KAIZEN TERMS

Hoshin Kanri—Policy implementation in alignment with the overall strategy so that the culture change resulting from Kaizen events permeates the entire organization.

5 "S"—The equipment and supplies you need, when you need it, in order to do your job well.

Kaizen—Continuous Improvement.

For Comments & Questions, call Lynnette Watts at 370-5403 or lwatts@hsd.cccounty.us To view past Kaizen updates and the history of System Transformation at CCRMC, visit http://cchealth.org/medical_center/lean/

DAILY KAIZEN UPDATE

CONTINUOUS INFORMATION FOR CONTINUOUS IMPROVEMENT

TUESDAY
JUNE 15, 2010

Behavioral Health Kaizen #2
June 14 through 18

KAIZEN CONTINUES

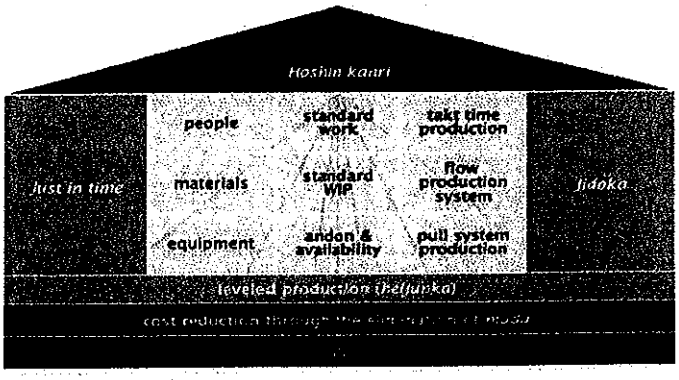
Last month, a Kaizen team representing emergency services, staff and consumers spent an entire week looking at the patient experience from pre-arrival to assessment in the Crisis Stabilization Unit (CSU). As a result, the front entrance doors have opened, staff have been trained on how to consistently perform safety checks, and existing space is not being used differently, to name a few successes.

This week looks at the next step in the patient experience, and brings a whole host of integral partners onto the team. Monday saw the opening comments and initial training for the team, which Anna Roth started by having everyone introduce themselves. The mix was astounding. In addition to our dedicated staff from multiple hospital units and professional levels, also represented were Alcohol and Other Drug Services, Mental Health, Employment and Human Services, consumer advocates, family members and even representatives from the community facilities and agencies that often help our patients after they leave the CSU.

This list of participants is a milestone for CCRMC. Whereas just a year ago the need to take a closer look at our Behavioral Health services was made obvious, and the necessary participation of these stakeholders was identified, we had no idea how to do it. And yet, one year later, here is everyone in the room, ready to roll up their sleeves and see how we can all work together to make things better for the patient. We can't wait until this Friday's full Report Out!

KAIZEN DEFINED

KAI
break apart
ZEN
bring together in a better way
KAIZEN
continuous improvement



KAIZEN TERMS

A3—As used in Lean Healthcare, this term has two meanings. It originally referred to the size of paper that the Kaizen Team Charter is printed on, listing the problem, target, analysis, actions and accountability on one sheet of ledger-sized paper. It also means Access to Appropriate care that we are Accountable for.
Just-In-Time—The equipment and supplies you need, when you need it, in order to do your job well.
Kaizen—Continuous Improvement.

For Comments & Questions, call Lynnette Watts at 370-5403 or lwatts@hsd.cccounty.us To view past Kaizen updates and the history of System Transformation at CCRMC, visit http://cchealth.org/medical_center/lean/

Item 5

KAIZEN UPDATE
CONTINUOUS INFORMATION FOR CONTINUOUS IMPROVEMENT

CONTRA COSTA REGIONAL MEDICAL CENTER

CONTRA COSTA HEALTH SERVICES

Kaizen Event Summary MAY 10 - 14, 2010

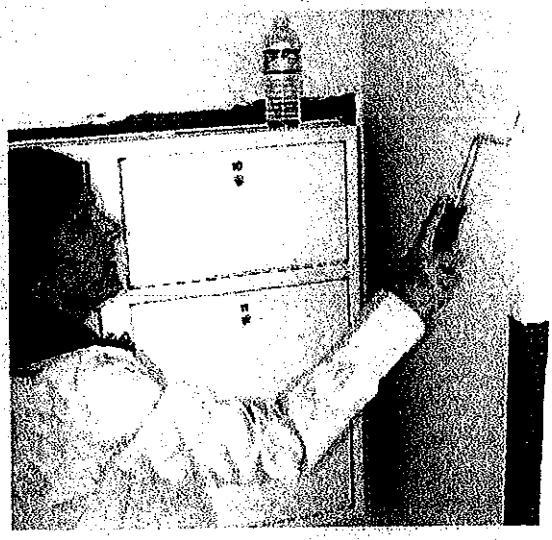
Crisis Stabilization Unit (CSU) - Intake and Initial Assessment

BEHAVIORAL HEALTH KAIZEN #1

Friday, May 14th, marked the end of an intense week that humbled and encouraged participants and observers alike. The audience watched as the team of over a dozen people representing patients, families, emergency services, doctors, nurses and other staff presented the meaningful changes that had happened that week at the speed of Lean.

From a training overview Monday morning, through idea generation, a full simulation of those ideas in practice, documenting Standard Work, training staff and updating the work environment by Thursday afternoon, the CSU is not the same place it was just a week before. It is more organized, more safe and staff feel like they can meet the patients' and families' needs better. "It just feels different" said one team member.

CCRMC is proud to have sponsored such a dynamic and dedicated team. They have shown that change *can* happen, and that the Future State *will* become a reality.



On May 5th, Anna Roth, CCRMC Chief Executive Officer, spent part of her birthday helping paint the redesigned CSU Entrance.

The community has been providing input into the improvement efforts of Behavioral Health for over a year. Here, community members take a break from painting to be recognized for this amazing collaboration.

Carol Lucido
Education and Training Specialist

As my first active participation in a Kaizen event, I felt so very privileged to work with our patients, family members and staff. It was truly a humbling experience for me. I learned very quickly that some of our assumptions regarding what makes the patient feel safe were wrong... and the family members and patient advocates I worked with called me on these assumptions. I valued this entire experience to the fullest extent. Teresa and Connie are so committed and caring; they have taught me so much.

TEAM FOCUS AREAS

Pre-arrival/Notification
Initial Arrival/Greeting
Mobilization Plan
Intake Process
Safety Checks
Facility Configuration

For Comments & Questions, call Lynnette Watts at 925-370-5403 or lwatts@hsd.cccounty.us

To become an effective team, the group must not only focus on their common goal, to improve the patient experience, but they must also have strong sponsorship.

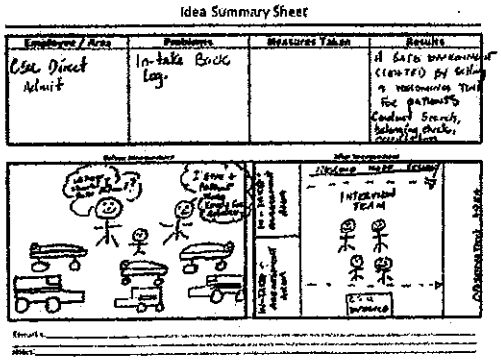
KAIZEN TEAM IN ACTION

The first step was to go to the unit and observe what goes on every day. Team members observed staff in action and tried to identify ways to make processes easier for staff and better for patients. While all this was going on, the CSU staff continued to serve the needs of behavioral health patients, providing feedback on proposed Standard Work wherever possible. At the end of the story, it is our caring staff that will make all these ideas a reality.

Every team member submitted up to 3 ideas they thought would improve the patient experience. No idea was too small or too big. Almost 40 ideas were presented for discussion/simulation.

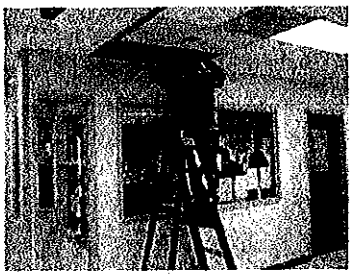
The simulations were eye opening for everyone. American Medical Response provided an ambulance and staff for the exercise, and staff and consumer representatives alike learned what patients experience.

Sample Idea Summary Sheet from the team.



The team was trained on the appropriate procedures for Safety Checks by law enforcement personnel.

As an example of just how fast things can get done, the idea to move a video camera was proposed on Wednesday and completed on Thursday. Thank you, Department of Information Technology!



The charge nurse's office was converted to an exam room to provide privacy for patient safety checks.

Staff practice the Standard Work for Safety Checks with a "patient" in a gurney.

KAIZEN WEEK REPORT OUT

Team members stand ready to give their presentations at the Report Out.

The audience listens to the impressive Report Out of all the team's accomplishments for the week.

Donna Wigand, Director of Mental Health Services and Julie Kelley, CCRMC Mental Health Program Chief show their support for the Kaizen process.

"Where once there was a sign that said 'No Visitors', there is now a team of people to greet patients and make sure they and their family feel welcome."
– Anna Roth

Behavioral Health Kaizen #1 Team Members

Teresa Pasquini,
Family Member

The Behavioral Health Kaizen #1 was a very personal journey. As a family member who heard from consumers and families how difficult it was to experience the Emergency Room, during a psychiatric crisis, this event was a chance for quality of care and access to care improvement. With family members, consumers, patient's rights advocates, law enforcement, psychiatrists, therapists, nurses, EMTs, clerical and administrative staff working hard and fast, we became a team of change agents. In one week, we challenged the status quo and our fears to design a process that maintained the medical standard and the safety of the consumers and staff. Every patient is now given a welcoming, hopeful, recovery based entry into the Crisis Stabilization Unit. This is meaningful and significant!

The staff at the Contra Costa Regional Medical Center is wonderfully special. They have opened their doors, their minds, and their hearts to improving the Behavioral Health Care experience. I was honored and proud to work by their side and I will continue to passionately support their work and their service to our community.

"I've seen it - the way it makes a difference to welcome and greet people up front. It goes a long way to building trust." -*CSU Nurse*

NEXT STEPS

Although the first Behavioral Health Kaizen event has come to an end, the work has just started. Process Owners will use checklists to confirm that Standard Work is fully implemented, weekly meetings will follow the progress of the 30-Day Action Bulletin of ideas still in progress and everyone will be gearing up for the next Kaizen the week of June 14th. To stay updated on CCRMC Lean efforts, please feel free to visit Anna's blog at safetynethospital.blogspot.com or our website www.cchealth.org/medical_center.

Consumer Feedback

"It's wonderful to know that my work will provide hope and healing for all mental health consumers who come through these doors."

"To be asked to be a part of change is a wonderful thing."

"It felt good to be respected rather than restrained."

"They really said 'Welcome' to me."

Although Emergency Services personnel and law enforcement will follow their current procedures, the symbolism of the redesigned entrance combined with the real work within to improve the patient experience takes us farther down our road to improve behavioral health services for our community.

"The joint Health Care Partnership epitomizes the best of consumer/health care provider partnership. This process is what consumer/patient-driven services is really all about." - *Brenda J. Crawford, Executive Director, Mental Health Consumer Concerns, Inc.*

Ngozi Emenalon
CSU Program Manager

I was really humbled when a patient said, "They really said 'Welcome' to me." That was a powerful statement and reinforced that we are on the right track with the changes taking place in CSU.

I also had staff members that thanked me for the opportunity to be a part of a team that created Standard Work that is being used to add value to the care we give, reduce repetition of questions and decrease the wait time for patients. Staff are definitely willing to participate in other Kaizen events now.

Department	Name
Executive Sponsors	Anna Roth, Joe Barger
Innovation Council	Mitch Applegate, MD
	Marianne Bunce-Houston, RN
Human Resources	Karen Jovan
Emergency Department Nurse	Kathy Brandt, RN
ED CSU Nurse	Joy Mendoza, RN
Mental Health Division	Karen Pratt
CSU Educator	Carol Lucido
Social Service	Yvonne Lopez-Tomko, Christine Cole
Line Nurses PM, Night Shift	Tsige Metagesha, RN
CSU Unit Clerk	Vernita Travis
CSU Physician	Josh Niclas, MD
Resident Physician	Rebecca Lee, MD
Patient / Consumer	Connie Steers
Family Member	Teresa Pasquini, Dave Kahler
Law Enforcement - MPD	Officer John Stretch
Emergency Medical Response	Damon Richardson
Patient's Rights	Christine Lopez
Fellows	Lynnette Watts, Renee Nuñez

UPDATE

CONTINUOUS INFORMATION FOR CONTINUOUS IMPROVEMENT

FRIDAY
MAY 14, 2010

Kaizen Event MAY 10-14, 2010

Crisis Stabilization Unit (CSU) - Intake and Initial Assessment

KAIZEN TEAM NOTES

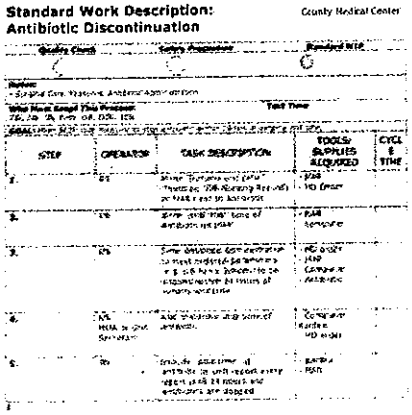
Thursday was about bringing it all together. All the identified processes that do not add value to the patient experience were examined. Standard work procedures were developed. Proposals that could not be done by Monday were added to the Kaizen 30-day Action Bulletin. And of course, there was all the discussion and preparation for the Report Out.

The Report Out does more than provide an end point for the week's work. It demonstrates respect for the process and highlights the team's successes. Bringing together a team, training them, observing work processes, generating ideas to improve things, trying them out and deciding what will work in one week is an amazing feat. The Report Out ***celebrates*** the culmination of this intense process, allowing sponsors and observers alike to see what the team has accomplished in just 5 days and their commitment to Kaizen.

Staff training started Thursday and will continue throughout the weekend in preparation for the front doors into CSU opening on Monday. Friday's Report Out will be everyone's opportunity to be amazed at what has happened in just one week, thanks to the dedication and hard work of the team, the staff, and the sponsors.

KAIZEN TEAM IN ACTION

Documentation of *new* standard work



Standard Work Description:
Antibiotic Discontinuation

County Medical Center

The A3 process

KAIZEN TERMS

Hansei – Relentless reflection: It emphasizes individual accountability to to acknowledge our own mistakes and to pledge improvement. Kaizen cannot exist without Hansei, and with Hansei, we never stop learning and improving.

Kanban – Sign card: A signal or "pull" mechanism that triggers action, like an empty bin or colored sign.

Kaizen – Continuous improvement

REMINDERS

Join us Monday morning at 10 in front of the CSU entrance for the ribbon-cutting ceremony to mark its official reopening.

Stay tuned for an in-depth report of this week's Kaizen due out next week!

For Comments & Questions, call Lynnette Watts at 370-5403 or lwatts@hsd.cccounty.us

IPDATE

THURSDAY
MAY 13, 2010

CONTINUOUS INFORMATION FOR CONTINUOUS IMPROVEMENT

Kaizen Event MAY 10-14, 2010

Crisis Stabilization Unit (CSU) - Intake and Initial Assessment

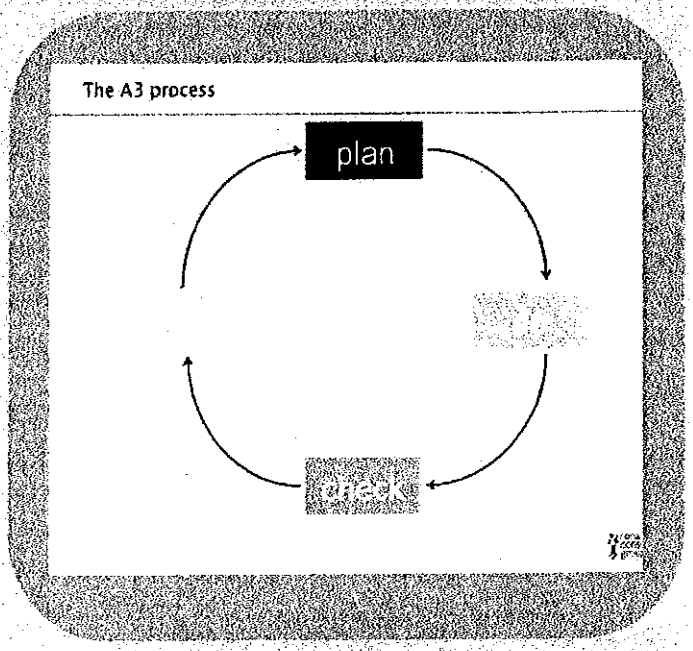
KAIZEN TEAM NOTES

Wednesday was the day for testing ideas. The team went through multiple simulations of intake and initial assessment. To start, a mock call came into the Emergency Department (ED) Phone Triage Nurse. A participating ambulance pulled up to the CSU Ambulance Bay and brought in a gurney with a team member acting as a patient. Later, another team member rang the front doorbell and went through the full initial intake and assessment process. Various ideas were tested, refined, and tested again.

Standard Work Processes have been developed for the pre-arrival phone calls from Emergency Services Personnel (ambulance, police, or sheriff). Another is being developed for Safety Checks, and staff training will begin Thursday.

One of the most exciting things is the feedback the team is getting from staff, consumers and each other! They have gone from feeling really challenged on Monday, through the idea generation process and "just try it" mentality, to the belief and enthusiasm that they can make the Future State a reality.

KAIZEN TEAM IN ACTION



KAIZEN TERMS

Gemba – Grasping the actual situation: Going to the place of work and actually observing what's happening as it's happening.

PDCA – Plan, Do, Check, Act: A systematic approach to problem-solving and a cornerstone of continuous improvement.

Kaizen – Continuous improvement

REMINDERS

This Friday, the Kaizen team will present the Report Out of this week's work. Come to the CCRMC lobby at 10 am to see the results!

You can also join us Monday morning at 10 in front of the CSU entrance for the ribbon-cutting ceremony to mark its official reopening.

For Comments & Questions, call Lynnette Watts at 370-5403 or lwatts@hsd.cccounty.us

DAILY KAIZEN UPDATE

CONTINUOUS INFORMATION FOR CONTINUOUS IMPROVEMENT

WEDNESDAY
MAY 12, 2010

Kaizen Event MAY 10-14, 2010

Crisis Stabilization Unit (CSU) - Intake and Initial Assessment

KAIZEN TEAM NOTES

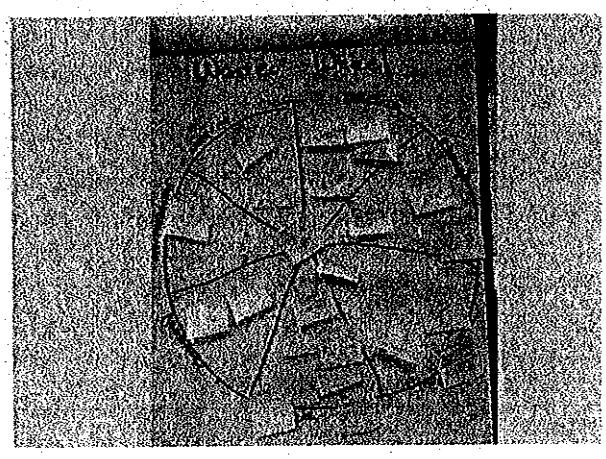
Tuesday was full of testing various patient scenarios in order to generate ideas to improve patient flow and identify non-value added process steps.

Dozens of ideas were presented by the doctors, nurses, consumers, program leads and other team members to improve patient care and streamline processes.

Wednesday will see many of these ideas in action, as the team goes for a full simulation from a request for service (call from an ambulance or emergency service provider) through the completion of the intake and initial assessment process.

The intention is to test whether these ideas will work in practice so it can become "standard work". Standard Work is an agreed upon set of work procedures that establish the best method and sequence for each process.

KAIZEN TEAM IN ACTION



7 Areas of Waste (Muda)

KAIZEN TERMS

Muda – Area of WASTE; any activity, service or supply that consumes time, money and other resources, but creates no value.

Waste walk – Observing the production of a product or service to identify value-added vs. non-value added processes.

Kaizen – Continuous improvement

REMINDERS

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DAILY KAIZEN UPDATE

CONTINUOUS INFORMATION FOR
CONTINUOUS IMPROVEMENT

TUESDAY, MAY 11, 2010

Kaizen Event MAY 10-14, 2010

Crisis Stabilization Unit (CSU) - Intake and Initial Assessment

INTRODUCTION TO KAIZEN

Kaizen is a process for continual, incremental improvement. It is putting the power of making things better for the staff and patients in the hands of the staff and patients. Of course, it takes some dedicated time and resources to step outside of providing patient care every day to objectively observe the overall process. That's where the Kaizen Team comes in.

Staff have been working hard to get up to speed on the philosophy and methods behind the Kaizen quality improvement process, a tool of Lean methodology. Lean is our adopted management system that focuses on doing better with existing resources and is grounded in respect for everyone's contribution. It is a common sense approach to management, focusing on eliminating waste and the obstacles to a smooth patient flow.

Kai = break apart

Zen = bring together in a better way

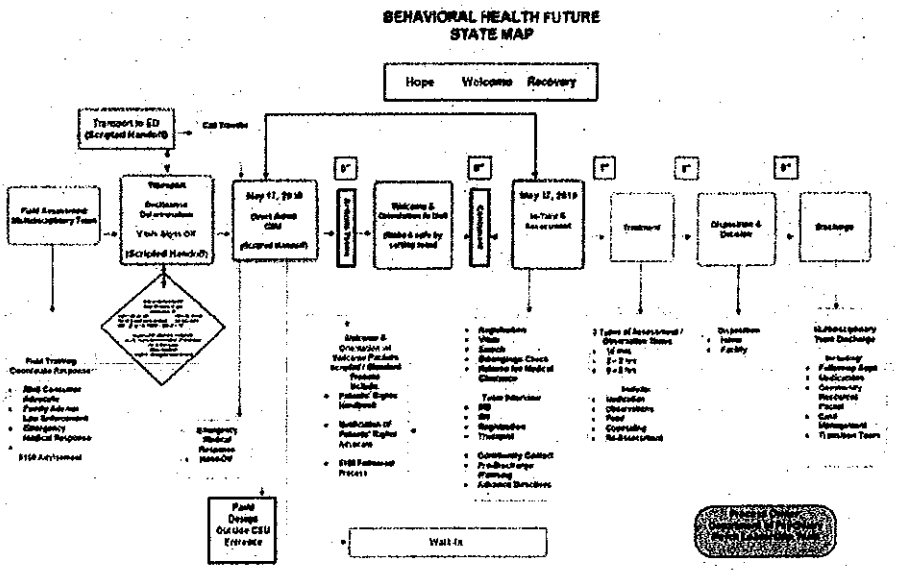
Kaizen = continuous improvement

KAIZEN DEFINED

LATEST NEWS

Monday morning the sponsors, process owners & team members met to review Kaizen methods and tools and lay out their strategy for the week.

In the afternoon the team went to the gemba (place where the work is done) on a "waste walk" looking for defects, non-value added activity and inventory. They ended with a robust idea generation session. The team also listed the expectations & concerns they and some of their colleagues have, for the week.



This week's main targets are to reduce the time it takes to receive care in the Emergency Department and the Crisis Stabilization Unit, as well as to provide the right care at the right time.

Tuesday afternoon the team will simulate several scenarios to test their ideas.

Watch for Wednesday's update, and we'll see you at Friday's Report Out in the CCRMC Lobby at 10 AM.

More soon...

For Comments & Questions, call Lynette Watts at 370-5403 or lwatts@hsd.cccounty.us

Shared Democratic Principles for Finalizing Budget:
Improving Government and Protecting Jobs

Senate President Pro Tem and Assembly Speaker

As the Pro Tem and Speaker continue crafting the budget and holding budget discussions, the leaders are united in their views of how to close the budget and the principles that must guide the negotiations.

Those principles are outlined below.

Education funding:

- Fund schools in accordance with Proposition 98 and provide the highest level of funding possible to protect the quality of education and to minimize teacher layoffs.
- No reneging on last year's deal on repayment of Maintenance Factor.

State-Local Relationship:

- Recognize that the current state-local fiscal relationship is broken, and a final budget deal must begin the process of devolving more services and revenues to counties—the place where the services are delivered and are closest to the people.

Jobs:

- Recognize that the Governor's budget proposals, if enacted, would result in hundreds of thousands of job losses.
- Make sure that all final budget proposals consider the impact on jobs and California's already-high unemployment levels, and make sure that the final budget prevents or minimizes further job losses.
- Recognize the importance of government investment to maximize job growth in both the private and public sectors, and ensure that final budget includes such investment.

Health and Human Services "Safety Net":

- No further erosion of the critical services for vulnerable children, the disabled, the elderly, and the ill, including proposals that call for elimination of CalWORKs, child care, community mental health, and the draconian reductions in IHSS and Medi-Cal.

Out-years:

- Recognize that California will continue to have budget struggles in future years.
- Enact budget proposals that take the long-view, including budget solutions that start a multi-year "workout" plan.

No New Programs and No New Tax Breaks:

- With the state facing multi-year budget shortfalls, now is not the time to implement major new programs or to implement new tax breaks.
- Necessary revenue increases should be focused on closing loopholes---like the oil drilling loophole, and maintaining existing tax rates that will not negatively impact the economy. And new revenues should be tied to specific restructuring and job protection proposals.
- Recognize that spending levels are at historic lows at a time when demand for government services by Californians is at a record high due to the recession.

State employees:

- During these tough budget times, state employee contracts need to be in place to provide certainty to employees and the budget. The leaders continue to believe that the way to achieve certainty and budget savings is through the collective bargaining process. Recent completion of bargaining agreements demonstrates that this process works.
- Recognize that California's fundamental budget problems (and the problems in every other state) are largely due to the collapse of the economy, and reject the scapegoating of state employees and the implication that they are the cause of our budget problems.

One-time solutions:

- Recognize that, given the size of the deficit, we will likely need some additional one-time solutions that are not currently included in any of the budget plans under consideration (Governor's, Senate's, or Assembly's).
- Avoid cynical "hidden borrowing" temporary solutions that simply delay spending until reversed by the courts or that simply shift costs to local governments or other state programs.
- To the extent that budgetary borrowing is required, minimize the borrowing in order to reduce out-year fiscal pressures.

Timing and Transparency:

- The budget must be completed quickly, must be honest and credible, and the process should be as open and transparent as possible.

Ultimatums:

- Finally, the Governor and Republican leaders have issued several ultimatums on the budget, listing provisions that must be included or excluded from any final budget deal.
- Although the Democratic leaders do not think that ultimatums are helpful in coming to budget resolution, both the President Pro Tem and Speaker will never support a budget package that eviscerates education or the "safety net", leads to more job losses, and does not begin to address the broken structures of state government finance.

KARL MONDON/STAFF PHOTO

Psychotherapist David Ezra leads a qigong class May 10 at County Jail in Martinez. Qigong involves meditative breathing and movement.

Liberating practice behind bars

Contra Costa County Jail guard says qigong classes have reduced fights, suicide attempts, stress

By Roman Gokhman
rgokhman@bayareanewsgroup.com

MARTINEZ — The qigong meditative class begins with instructor David Ezra asking the participants if they have any worries this week.

A burly man with tattoos running down his arms speaks up.

"Any little thing will set me off," Sonny Mitchell says.

Ezra tells Mitchell to control his emotions and then instructs all the men in orange jumpsuits to stand in two rows of five or six. He turns on a portable CD player, which plays soothing melodies.

Several feet away, Deputy Frank Oathout, a guard at County Jail in Martinez, watches to ensure the inmates behave while they're performing their slow movements and controlled breathing techniques.

Mitchell was arrested on suspicion of stealing a car and leading police on a high-speed chase. He also faces a charge of possessing stolen property and violating parole. The 36-year-old Antioch resident has a trial scheduled for May 24, and this has him stressed.

To cope with the stress, as well as the anger he often feels, he joined the weekly qigong (chee-KUNG') and meditation class in his jail module. Ezra, a psychotherapist with Contra Costa

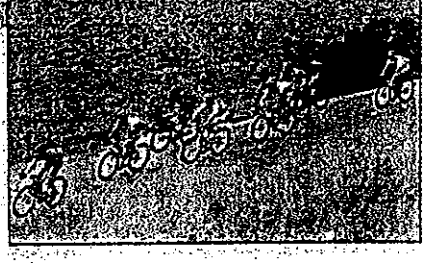
See INMATES, Page 13

An inmate participates in an exercise May 10 led by Ezra during a meditative qigong class at County Jail in Martinez. Qigong classes are offered once a week.

5/20/10

IN SPORTS

Cyclists cruise through East Bay before heading to Southern California



WEATHER
Sunny
H: 70s
L: 50s
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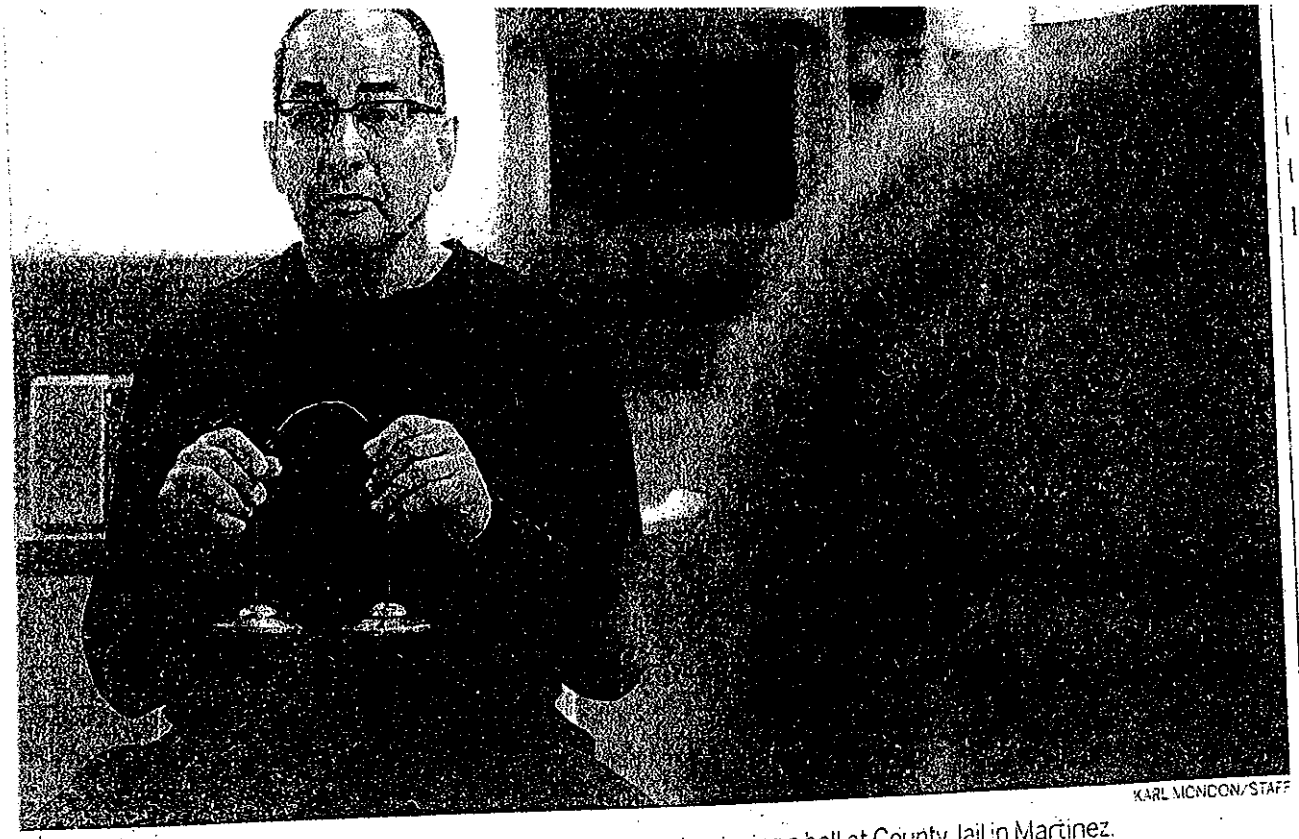
Item 8C

From John Gragnani



KARL MONDON/STAFF

Psychotherapist David Ezra prepares to end his qigong session by ringing a bell at County Jail in Martinez.

Inmates

From Page 1

Health Services, teaches several of these classes to inmates each week.

Oathout said he has seen a decrease in the number of fights among inmates in the cellblocks. Suicide attempts and medical emergencies have also decreased, Ezra said.

"It helps me relax and stay grounded," Mitchell said. "I wish this class was more than once a week. I look forward to it."

Ezra works at the county's detention facilities. He assesses the mental states of inmates when they are booked and provides suicide prevention and intervention services, among other duties.

For 30 years he has taught yoga and qigong — a holistic system of breathing techniques and exercises with postures and slow movements that require concentration. He got the idea to teach qigong to inmates after he saw that many of them respond better to nonverbal communication.

"Talking to people in anxious states doesn't work very well," he said. "Some of these people have poor verbal skills ... or are suffering from mental illnesses. They have poor impulse control."

When he met inmates having anxiety attacks, he would show them how to breathe slowly and stretch to calm them down.

In 2003, he was allowed to teach qigong to one group of inmates. Since then, his workload has increased to about five groups each week, including one in the mental health module in the Martinez jail and a class at West County Jail in Richmond.

The inmates begin with a salute, in a stance similar to that of a martial artist greeting his opponent. But instead of fighting, the qigong participants slowly rise, lower and rotate their arms as Ezra guides them with directions such as: "Bring heaven to earth" and "Let go of all the stress you are holding."

Ezra tells them to practice restraint.

"Think with your mind, not your emotions," he says. "Think of yourself as an eagle looking down over your life."

At the end of the exercise, the inmates put their hands together and bow. They take their seats on chairs brought from their cells, and Ezra has them close their eyes to meditate.

"Situations rise, last for a moment and pass away," Ezra says. "Feelings are temporary."

Inmates get no perks for taking part. To apply, they send a letter to Ezra. He meets with them, where they have to convince him they will take the classes seriously. He has turned away inmates he thought would be a distraction. Inmates commit to attending 20 classes unless they have to attend court or are released.

"If they don't come every week, I kick them out," he said. "I have 50 people on a waiting list."

In return, they develop a sense of community with other participants and get instruction on lowering stress.

"I've always had anger issues," said inmate Casey Moore. "I found (the class is) an easy way to let go of my anger, rather than trying to bottle it up like I have."

Moore has been an inmate at the jail for six months and is facing five counts of lewd and lascivious acts on a child. He is jittery because his trial has been pushed back.

"Where I'm at, here — most of it is due to my anger," he said. "It hasn't gotten me anywhere good. I may as well try and do something the positive way."

Roman Gokhman covers public safety. Contact him at 925-945-4780. Follow him at Twitter.com/romithewriter.

Poll

in their ballots ahead of the June 5 election.

Race tightens

paign. Poizner has contributed $24.2 million to his efforts

Mental Health Consumer Concerns, Inc.

MHCC

Come One Come All

<u>It's time to play softball</u>

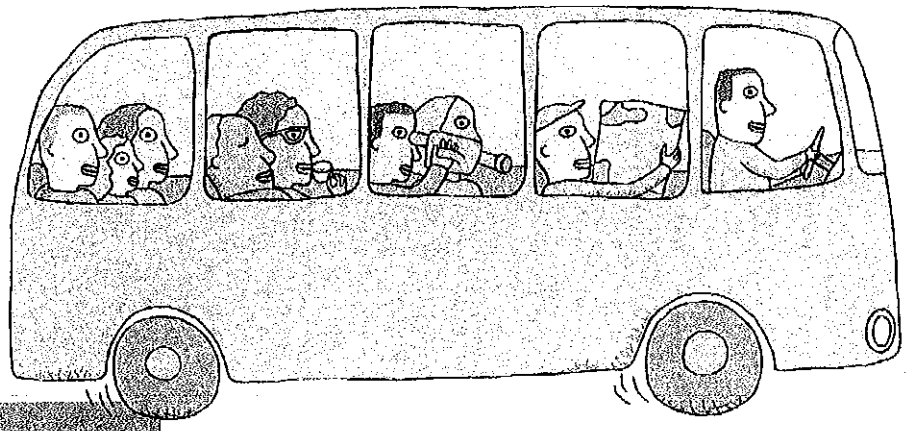
MHCC is putting together a coed softball team

Practice on Fridays and times of practice to be announced

The more the merrier

No prior playing experience necessary

Interested ? call Peggy at 521-1230 between Tues through Friday 2-4 pm



MHCC

MENTAL HEALTH CONSUMER CONCERNS, INC.

"Empowerment. Confidence. Success."

MHCC is Sponsoring a **Wellness and Recovery Anti-Stigma Poster Campaign**

We are looking for your artistic expressions of your Wellness and Recovery Journey!

We need your drawings, paintings, sketches and talented ideas for our community poster contest!

1st Prize is $100.00

2nd Prize is $50.00

3rd Prize is $25.00

All entries need a Title

All entries will be judged by Mental Health Consumers

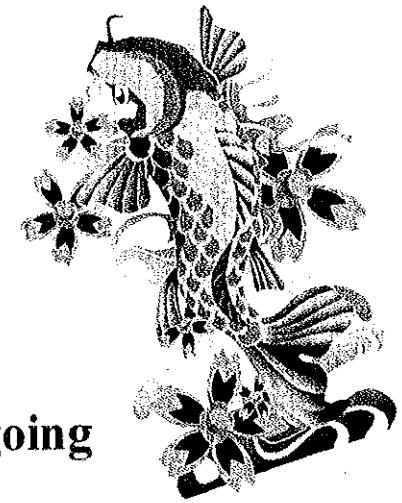
Deadline for entries is July 31st at 5:00 p.m.

Free art materials are available through Joy at 925-521-1230

All prize winners will need to sign a release form giving MHCC permission to reproduce the artwork.

Many Moods

Peer Support for persons recovering from Bipolar Disorder



Are You Looking For An Ongoing Peer Support Group?

- Many moods provides a safe atmosphere for consumers to share their experiences with mental health and recovery

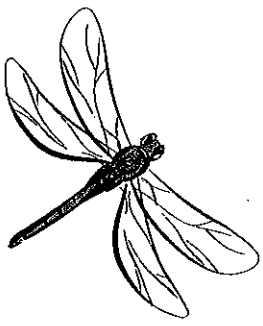
- Many Moods can provide consumer with an opportunity to create a support network.

Date: **Every Thursday Beginning July 1, 2010**

Time: **6:00 PM - 7:30 PM**

Place: **MHCC**
2975 Treat Boulevard,
Building C
Concord, CA 94518

For more information
please call
925-521-1230



"Recovery is Real"

MHCC

MENTAL HEALTH CONSUMER CONCERNS, INC.

"Empowerment. Confidence. Success."

MHCC Choir Call

15 members +

Songs include spiritual, rock, blues

Practice one day a week on Thursdays
at the **Concord Wellness & Recovery Center**
10:00 am to 11:00 am

Contact: **Joy Witt**
Activity and Art Coordinator
for more information
925-521-1231

We Need <u>You</u> to Make This Happen

Item 8D

CPAW meeting Report -7-1-10
Prepared by Commissioner Pasquini

The meeting was convened at Bisso Lane. The meeting opened with introductions with each member expressing their intention for the meeting's process. This is a good way to personalize and set a tone for our meetings and it allows team building. CPAW has never been given a chance to "know" the other members on a personal level. Some of us have deeper connections, but many members are left with only 30 to 60 second sound bites in a meeting. We need to develop relationships in order to collaborate and build trust.

Our new facilitators are establishing a safe process that will allow that trust to grow beyond identity politics which will assist system transformation. The meetings are being planned and organized through a Planning Committee of which I am a member. Other members include Kathi McLaughlin, Marianna Moore, Brenda Crawfore and John Gragnani. Sherry Bradley and Mary Roy are staff members. The Planning Group meets to help provide support to the Facilitators, help them understand context and issues, determine priorities, make process recommendations, and ensure that the CPAW work plan and work flow are followed. **CPAW supported this planning group continuing in its current configuration for an additional 3 months.**

Recommendation to MHC: Consider priority items from MHC Workgroups and MHC monthly meeting to take to the CPAW Planning Committee for consideration on CPAW, s agenda. This would allow the MHC to influence the CPAW process/decisions. I also recommend that the Commission authorize Chair Mantas to attend a future CPAW meeting to inform and advise CPAW of the MHC role and responsibilities. This might help clarify our duties and aid communication between the two advisory bodies.

- **Consider authorizing Teresa to represent MHC at Planning Committee and bring any MHC approved priorities to its attention for consideration. Teresa will report on CPAW Planning Committee meeting at the next available MHC meeting for consideration. The MHC authorizes Teresa to vote as an individual member of the committee.**
- **I move that The MHC authorizes Chair Mantas to attend a future CPAW meeting to advise of MHC roles and responsibilities as outlined by the CIMH training manual.**

Advisory vs Planning and Authority of CPAW: There was lengthy discussion on CPAW's decision making process which included Donna addressing the voting of county staff. There were new green colored name plates for some county staff which indicated that they were NOT voting members. Donna commented that there needed to be discussion about how/why some county staff are voting and others are not. For example: John Gragnani, Candace Tao, Tony Sanders, John Hollender, and Susan Medlin are all current county staff and did not have green name tags and are therefore voting members. There was no conversation about funded contractors (examples: Brenda Crawford, Steven Grolnic-McClurg, Molly Hamaker, Peggy Harris, Beatrice Lee, Susanna Marshland, Connie Steers) in voting positions. No decision was made.

There were some expressed frustrations around decisions being made outside of the CPAW Committee structure which ignore or exclude the stakeholder input. An example was the use of the CalLocus qualitative program tool that was NOT recommended by the CPAW Data Committee. Comments made included, "Why is this tool being recommended now?" "Why are we meeting?" and "This recommendation is not in the best interest of my agency." It was stated that the CalLocus is being recommended by the State as a uniform tool. Another example

discussed was the MHA decision on using Anka for the remaining housing funds which was NOT brought to the Housing Committee for vetting.

Donna informed CPAW of her discomfort with the current and past process of appointing CPAW members. She discussed that the process was for a stakeholder to come to Sherry Bradley and request a seat on CPAW. If that person represented a vacant stakeholder position, they were usually appointed. Donna suggested that CPAW should be in charge of the future appointments, not her.

- **I move that the MHC recommends that a MHC Liaison is included on the CPAW Interview Workgroup.**

Recommendation to MHC on Conflict of Interest:

- **Consider** Draft Conflict of Interest Guidelines adopted by CPAW at its May 6th and June 3rd meeting. Consider Direction of the IOC's May and June meetings on considering Conflict of Interest.
- **Consider** Grand Jury Report and CC Times articles on First Five Commission Conflicts of Interest. Consider supporting the Grand Jury Recommendations to the BOS on the First Five Commission, as they compare to CPAW.
- **Consider** San Diego County email on conflict of interest.

Consider motion: I move that the CCC MHC recommends, to the BOS IOC at their August Meeting, that a written policy on conflict of interest be developed for CPAW which supports the Grand Jury Recommendations #1 and #2, on the First Five Commission, as follows:
1. CPAW members shall not be affiliated with agencies most likely to be awarded significant funding, thereby minimizing perceptions of impropriety. 2. CPAW members having financial interests in MHSA contracts shall recuse and physically remove themselves from meetings where their programs are under consideration. Also, Ethics/Conflict of Interest violations as defined by State Fair Political Practices Commission AB1234 and Government Code 1090 should be considered for CPAW members as they are for MH Commissioners. MHC recommends that Ethics trainings be provided to CPAW members.

Consider motion: With the recent appointments of Sam and Dave to CPAW, there is potential for consensus building outside of a posted meeting. This was brought to Sherry and Donna's attention and they are consulting County Counsel. **I move that any further appointments of Mental Health Commissioners to CPAW are discussed with the MHC Chair.**

MHSA CONSOLIDATED PLANNING & ADVISORY WORKGROUP (CPAW)
DRAFT
CONFLICT OF INTEREST GUIDELINES

ADOPTED AT THE MAY 6TH AND JUNE 3RD, 2010 CPAW MEETINGS:
(Adopted by consensus)

The Contra Costa Mental Health MHSA Consolidated Planning Advisory Workgroup (CPAW) has discussed how conflict of interest can impact discussions and decision making which result in recommendations made regarding MHSA planning, plan updates, etc. As such, the following principles were discussed and adopted at the May 6, 2010 CPAW meeting, and they were further clarified and adopted at the June 3, 2010 meeting.

MHSA Planning and Conflict of Interest:

At the May 6, 2010 CPAW meeting, members engaged in preliminary discussions of conflict of interest. The consensus was that the MHSA planning process should be more collaborative and participatory, but must consider sorting out issues of conflict of interest. In order to frame a background to define conflict of interest, CPAW members described a more collaborative and participatory process which would include the following:

- Building trust;
- Improved engagement of participants;
- Letting go of the past and moving forward in the future;
- Building connections with the external world.

Guidelines to Ascertain and/or Determine Conflict of Interest:

At the June 3, 2010 CPAW meeting, members reached consensus on the following in order to provide some guidelines in determining conflict of interest:

1. When offering an opinion or perspective, the individual speaking will start by declaring who/what they represent:
   - Personal opinion or life experience.
   - Professional opinion, representing your job experience.
   - Perspective of constituency you represent and have heard from on this topic.
   - Perspective of a system thinker, looking for the good of the whole system rather than one sub-group.

2. When decision making is needed, the following factors must be taken into consideration by each CPAW member OR the group as a whole:
   - The risk must be managed (i.e., risk to the individual or organization by participation in a decision that may be a conflict).
   - Each individual is responsible to determine their level of conflict;
   - The conflict of interest or potential conflict of interest will be declared up front;

- If a conflict of interest is determined, the individual is excluded from the voting/consensus process;

3. During a discussion which could result in a recommendation to the Mental Health Director, CPAW members will aim to include and disclose any information that may result in an increasing understanding of their perspective, and information as needed.

Daniel Borenstein: BART outreach meetings fiscally irresponsible
MediaNews columnist
Posted: 07/04/2010 12:01:00 AM PDT

FOR A CASE STUDY of a government bureaucracy run amok, consider BART's attempts to comply with federal requirements that it solicit input from minority, low-income and limited-English-speaking residents.

It's reasonable for the U.S. Department of Transportation to insist that, in exchange for federal dollars, which will exceed $160 million this year, BART officials consider the effects of its projects on often-overlooked communities. If the transit district doesn't reach out, it is likely to miss the concerns and needs of a key segment of society.
It's more than good policy. It's the law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin in programs and activities receiving federal financial assistance.
In 2007, the Transportation Department issued its latest guidelines for complying with the act, requiring that agencies receiving federal funds "seek out and consider the viewpoints" of minority, low-income and limited-English persons. The following year, the federal agency sent notice to BART that it would be auditing its compliance. In December 2009, the agency found that BART lacked an adequate outreach plan.
It all came to a head two months later, when BART was denied $70 million in federal stimulus funding for a rail connector to the Oakland Airport in part because it had failed to seek out and consider the viewpoints of minority and low-income residents. BART directors desperately want federal money to help build this ill-conceived $480 million people mover.
Suddenly, BART got religion. Of course, there's nothing like the zeal of the converted. The district launched a $1.2 million outreach program.
District officials say they were complying with the demands of the Transportation Department's Federal Transit Administration. Dave Longo, spokesman for the federal agency, insists that the transit administration only issues broad guidelines, but does not micromanage.
The truth is probably somewhere in between, but the result is an outreach process that's out of control, apparently with little regard for its cost.
The first phase was development of a "Public Participation Plan," for which 29 community meetings were held. "The purpose of the meetings was to determine how BART could best provide information and receive public input on transportation issues," according to the report by the consultant. (When in doubt, hire a consultant.) In other words, the district held meetings to seek input on how it should seek input.
The result: A 40-page "BART Public Participation Plan," which was accompanied by a 20-page report, with eight appendices, summarizing the process used to develop the plan. The plan is to be used to solicit feedback on major service changes, fare changes or construction projects.
The next question is, what constitutes a "major service change?" To figure that out, the district held —- you guessed it — another set of outreach hearings, 18 this time. While they were talking with folks, they also asked about the transit board's plan to temporarily reduce fares by 3 percent — an election-year ploy that will use up a small surplus the district should be saving to cover budget shortfalls that are almost certain next year.
The next phase was six outreach meetings on the airport connection, an idea the district will never let die no matter how costly it might be.
Thus, all told, 53 meetings so far, using up about half of the $1.2 million. The costs include translators for 10 languages, food and baby-sitting services for the meetings. The consultant moderated the meetings, collected and transcribed the comments, and tallied and analyzed meeting evaluation responses. In addition, the district hired three temporary workers to assist with the effort.
There's more to come. Hearings are planned on the eBART extension in East Contra Costa and the Warm Springs extension in Fremont, and to further determine how best to reach out to limited-English-speaking residents.
Seeking public participation by minorities, low-income and limited-English residents is laudable. But BART officials have turned this into an extravagantly wasteful process.

Consider this: BART officials estimate the first 29 meetings cost about $300,000. They also estimate about 800 people showed up for the meetings. Do the math: That's $375 a person.
One wonders if anyone, at BART or the federal government, asked if there was a cheaper way to do this.
Borenstein is a staff columnist and editorial writer. Reach him at 925-943-8248 or dborenstein@bayareanewsgroup.com.

Public Comment from Donna M. Wigand, LCSW, Mental Health Director, and Sherry Bradley, MPH, MHSA Program Manager, to Mental Health Commission, Thursday, July 8, 2010, re: Item 8-F-c

My public comment is regarding the inclusion of two items in the agenda packet for this evening's meeting, specifically regarding Item 8-F-c, which is being used to support the Mental Health Commission's position on Conflict of Interest. Those two items are: an enclosure on First Five Commission, and an "example" from San Diego County.

I applaud the Mental Health Commission in its work to develop a recommendation to the Board of Supervisors IOC regarding conflict of interest as it pertains to any mental health stakeholder planning group. I am, however, respectfully urging you to consider carefully whether or not you would use the documents included in your packet as those which you would use as a platform upon which you build your position on conflict of interest (as it pertains to CPAW).

In the first instance, First Five Commission is an independent, stand-alone, decision making agency which is established by Contra Costa County Ordinance. This is a body that itself awards contracts, has its own budget, employs its own staff, etc. Government Code Section 1091.3, and California Govt. Code 1090, is partially inapplicable to this body because it is not an "entity of the county". The conflict of interest issues they have been encountered are based upon the existing statutes noted. Strictly advisory volunteer stakeholder workgroups are not required to make attestations to the government codes on financial conflict of interest, because CPAW does not, in and of itself, award any contracts, employ staff, etc.

True, there was a Grand Jury Report issued on a number of matters where there was concern, and not just on conflict of interest. However, they found there was no wrongdoing, and acknowledged that changes had been made based upon their interviews with the agency.

In the second instance, the memorandum from Shirley Bard to San Diego County Department of Mental Health, dated June 29, 2010, has just been sent to them. There's been no opportunity for San Diego County to respond to the complaint. The memorandum is one person's opinion of perceived wrong doing, accusing county staff of not complying with existing State Fair Political Practices Commission AB1234 and Government Code 1090.

This same matter has been raised by Ms. Bard on three separate occasions (this being the fourth time) and according to Alfredo Aguirre, San Diego County's Mental Health Director, and also Dr. Phillip Hanger, San Diego County's Executive of the MHSA Team, there is no basis to the claim, and the charges are, according to both parties, unfounded. The accusations have been tested in the past, internally by review, then by the State (Fair Political Practices Commission), then by the San Diego County Grand Jury, which most recently said that there was no conflict. I am providing you with a copy of the San Diego County Grand Jury Report titled "Proposition 63 – Mental Health Services Act", filed by the Grand Jury on May 20, 2010.

I don't oppose having conflict of interest guidelines in place for volunteer mental health stakeholder planning groups. I would, however, like to see the Mental Health Commission do more due diligence in gathering information which would be more suitable to consideration of the present situation.

Thank you.

PROPOSITION 63
Mental Health Services Act

INTRODUCTION

The 2009/2010 San Diego County Grand Jury received a complaint alleging that the San Diego County Department of Mental Health Services (MHS) has deficiencies in its organization, including potential conflicts of interest and ethics code violations in its volunteer advisory committees. It was also alleged that MHS administration exploited one of these committees by unduly influencing its advisory vote on Mental Health Services Act funded programs/contracts. These issues prompted a Grand Jury investigation which included a focused audit on the County's administration of its Mental Health Services Act funding.

Proposition 63, known as the Mental Health Services Act (MHSA or the Act), was enacted on January 1, 2005. The MHSA imposes a one percent income tax on personal income in excess of $1 million in order to increase funding, personnel, and other resources to expand service programs and monitor progress toward statewide goals for serving children, transitional age youth, adults, older adults, and families with mental health needs.

In summary, Proposition 63:

- Provides funds to counties to expand services and to develop innovative programs and integrated service plans for mentally ill children, adults and seniors.
- Requires the State to develop mental health services programs including prevention, early intervention, education and training.
- Creates a commission to approve certain county mental health programs and expenditures.

The MHSA requires that each county mental health program shall, with involvement of stakeholders, prepare and submit a three-year Program and Expenditure Plan for approval by the California Department of Mental Health (DMH).

The Act directs the DMH to establish a program to prevent mental illness from becoming severe and disabling and to reduce negative outcomes such as suicide, incarceration, school failure, unemployment, prolonged suffering, homelessness and removal of children from their homes. The DMH determines the amount of funds available, establishes and communicates the county plan requirements, and allocates the funds among the counties. Distributions are only made to Counties that have an approved plan in place.

The five MHSA core components administered by San Diego County are the following:

- The Community Services and Supports (CSS) are the programs, services, and strategies that are being identified by MHS through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating

disparity in access and improving mental health outcomes for racial/ethnic populations and other unserved and underserved populations.

- Workforce Education and Training (WET) targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.
- Capital Facilities and Technological Needs (CFTN) addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and the Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs. Although there is one DMH allocation, CFTN is divided into two functions: Capital Facilities, and Technological Needs.
- Prevention and Early Intervention (PEI) supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations.
- Innovation (INN) is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and to promote interagency collaboration.

The two components administered by the State are the following.

- PEI State Administration is administered by DMH in collaboration with the Mental Health Services Oversight and Accountability Commission (OAC) and the California Mental Health Directors Association (CAMHDA). The County of San Diego agreed to participate in the PEI Statewide Projects and transfer the assigned funds to DMH. These funds are used to administer three PEI Statewide Projects: Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction.
- MHSA Housing is administered by DMH in collaboration with California Housing Finance Agency (CAHFA). CAHFA administers the real estate aspects of the MHSA Housing Program for DMH. The program provides funding for the capital costs and operating subsidies to develop permanent supportive housing for persons with serious mental illness who are homeless, or at risk of homelessness, and who meet the MHSA Housing Program target population criteria.

DMH has allocated about $481 million to San Diego County. The population of San Diego County is about 8.1% of State population and about 8.1% of MHSA funding has been allocated to San Diego County. About $316 million of the funds allocated to San Diego County have been approved. The $165 million balance of the funds allocated to San Diego County is accounted for in the trust fund, including the $65 million that is unapproved.

INVESTIGATION

The Grand Jury reviewed:

- Applicable sections of the Welfare and Institutions Code,
- Applicable provisions of the Revenue and Taxation Code, and
- San Diego County Community Program Planning Structure and Processes.

The Grand Jury also obtained and considered numerous other sources of information, including:

- The testimony of professional, auditing and lay witnesses;
- The testimony of appointed officials;
- The testimony of members of advisory councils for the Mental Health Services Act;
- Analyses, websites and other sources of information; and
- Reports of auditors, professional organizations and consultants.

DISCUSSION

Complaint Resolution

The Grand Jury investigated a complaint concerning possible conflicts of interest of members of the three advisory councils for implementation of the MHSA. Some of the volunteer members of these councils are employed by non-profit agencies which are receiving or applying for MHSA funding. The complaint also alleged that these councils merely "rubber stamp" projects favored by MHSA program administrators.

Testimony revealed that conflicts of interest do not exist; advisory council members customarily recuse themselves when the body is considering a project that would benefit their employers. Advisory council members benefit the outreach process by bringing their expertise in mental health programs and do not consider themselves as rubber stamping any proposals brought forth for their consideration.

MHSA Funded Programs

In the course of other investigations, the Grand Jury encountered examples of programs funded in whole or in part by the Mental Health Services Act. Among these are:

- *Homeless in San Diego*: mental health counseling at temporary shelters; outreach for programs for homeless veterans; three approved supportive housing programs.
- *Transitional Age Youth*: wraparound services for children aging out of foster care.
- *Juvenile Detention*: mental health counseling for wards with follow-up after their release to the community.
- *Adult Justice System*: Behavioral Health Court to hear cases dealing with mentally ill people who are accused of committing crimes or have been adjudicated and are awaiting sentencing.

FACTS

Fact: DMH determines the amount of funds available, establishes and communicates Plan requirements, and allocates funds to each County based on MHSA requirements. Distributions are only made to Counties that have an approved Plan in place.

Fact: Through February 2010, about $5.9 billion of MHSA funding has been allocated among the counties. $481 million, or 8.1% of that funding, has been allocated to San Diego County.

Fact: The population of San Diego County is about 8.1% of the population of the State.

Fact: About $381.6 million has been allocated to San Diego County core components; $65.2 million is unapproved; $30.9 is designated Prudent Reserve; and the balance of $4.5 million is shown as interest income.

Fact: The allocations to San Diego County core components are:

- Community Services and Supports (CSS), $217.1 million;
- Workforce Education and Training (WET), $17.3 million;
- Capital Facilities and Technological Needs (CFTN), $37.3 million;
- Prevention and Early Intervention (PEI), $58.4 million; and
- Innovation (INN), $11.6 million.

Fact: The San Diego County allocations to State administered funds are:

- MHSA Housing, $33.1 million; and
- Prevention and Early Intervention (PEI), State Administration, $6.8 million.

Fact: Although $3 million was approved for a Technological Needs (TN) project, MHS has submitted no proposals for approval of Capital Facilities (CF). A balance of $34.4 million, or 92%, of the CFTN allocation is not approved, according to MHS, due to current economic conditions and liability risk of property ownership.

Fact: About $2.5 million, or 21% of the INN allocation, is not approved.

Fact: About $24 million, or 73% of the State administered MHSA Housing allocation, is not approved.

Fact: Through FY 2009, $100.4 million has been spent on the SDMHSA five core components.

Fact: MHS has used about $24 million of CSS funding for children, youth, transitional age youth and families through FY 2009.

Fact: MHSA reversion policy specifies that funds allocated to a County which have not been spent for their authorized purpose within three years shall revert to the State.

Fact: A March 2010 audit concluded that there is no current risk of reversion of MHSA funds allocated to San Diego County.

Fact: The March 2010 audit, requested by this Grand Jury, was the first audit of the San Diego County MHSA program since its inception in 2005.

FINDINGS

Finding 01: San Diego County's proportion of MHSA funding is commensurate with its proportion of the population of the State.

Finding 02: The State allocation of $27.9 million (FY 2010) Prevention & Early Intervention was double counted in Capital Facilities &Technological Needs and in

Prevention & Early Intervention, which inflated the Capital Facilities & Technological Needs allocation amounts in the State MHSA agreement and internal tracking report.

Finding 03: The State approved $1.5 million (FY 2010) for Innovation was double recorded under Prevention & Early Intervention and Innovation in the State MHSA agreement and the County internal tracking report. Also, State documentation understated the Prevention & Early Intervention service approval amount by $2.2 million.

Finding 04: As of March 2010, the County has no funding at risk of reversion to the State.

Finding 05: About $65.2 million, or 17% of the funds allocated to San Diego County are not approved.

Finding 06: MHS has submitted no proposals for approval of Capital Facilities (CF). A balance of $34.4 million, or 92%, of the CFTN allocation is not approved, according to MHS, due to current economic conditions and liability risk of property ownership.

Finding 07: About $24 million of the funds allocated to San Diego County for MHSA housing development but administered by the State are not approved.

Finding 08: About $9.1 million of the MHSA funds allocated to San Diego County for MHSA housing development but administered by the State has been approved; $18.9 million is in the pre-development pipeline; and $5 million of other possible projects are under consideration.

Finding 09: Implementation of proposed MHSA projects is often delayed due to the lengthy public outreach process, lack of effective coordination, and labor intensive processes requiring extensive administrative tasks.

RECOMMENDATIONS

The 2009/2010 San Diego County Grand Jury recommends that the Chief Administrative Officer of the County of San Diego direct the Director of the Health and Human Services Agency and the Director of Mental Health Services to:

10-47: **Proceed now, during the economic downturn, with CFTN projects so as to take advantage of lower costs.**

10-48: **Enhance the Mental Health Services Act web site to improve transparency of the program. Such enhancements should include:**

- **a listing of all of the County's Proposition 63 funded activities,**
- **how much funding is allocated to each program,**
- **the target population for each program,**
- **a brief summary of each program's function,**

- **the duration of each program,**
- **the name and contact information for each program's lead person, and**
- **the deliverables for each program.**

10-49: **Report to the Grand Jury on the resolution of findings #2 and #3 as stated above regarding double counting.**

10-50: **Advocate with the State Department of Mental Health to streamline the approval process to allow for a timelier implementation of approved projects.**

The 2009/2010 San Diego County Grand Jury recommends that the Chief Administrative Officer of the County of San Diego direct the Chief Financial Officer to:

10-51: **Audit the Mental Health Services Act at least once in every three year cycle.**

COMMENDATIONS

The 2009/2010 San Diego County Grand Jury commends:

- County Mental Health Services for the fact that currently the County has no funding at risk of reversion to the State.

- The new Behavioral Health Court for the creative manner of using the Innovation component of Proposition 63 funding to deal with mentally ill people accused of committing crimes or have been adjudicated and are awaiting sentencing.

REQUIREMENTS AND INSTRUCTIONS

The California Penal Code §933(c) requires any public agency which the Grand Jury has reviewed, and about which it has issued a final report, to comment to the Presiding Judge of the Superior Court on the findings and recommendations pertaining to matters under the control of the agency. Such comment shall be made *no later than 90 days* after the Grand Jury publishes its report (filed with the Clerk of the Court); except that in the case of a report containing findings and recommendations pertaining to a department or agency headed by an elected County official (e.g. District Attorney, Sheriff, etc.), such comment shall be *within 60 days* to the Presiding Judge with an information copy sent to the Board of Supervisors.

Furthermore, California Penal Code §933.05(a), (b), (c), details, as follows, the manner in which such comment(s) are to be made:

(a) As to each grand jury finding, the responding person or entity shall indicate one of the following:

(1) The respondent agrees with the finding

(2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

(b) As to each grand jury recommendation, the responding person or entity shall report one of the following actions:

(1) The recommendation has been implemented, with a summary regarding the implemented action.

(2) The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.

(3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This time frame shall not exceed six months from the date of publication of the grand jury report.

(4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

(c) If a finding or recommendation of the grand jury addresses budgetary or personnel matters of a county agency or department headed by an elected officer, both the agency or department head and the Board of Supervisors shall respond if requested by the grand jury, but the response of the Board of Supervisors shall address only those budgetary or personnel matters over which it has some decision making authority. The response of the elected agency or department head shall address all aspects of the findings or recommendations affecting his or her agency or department.

Comments to the Presiding Judge of the Superior Court in compliance with the Penal Code §933.05 are required from the:

Responding Agency	Recommendations	Date
Chief Administrative Officer, County of San Diego	**10-47 through 10-51**	8/18/10