Mental Health Commission
Quality of Care Committee Minutes
April 20, 2017- FINAL

Agenda Item / Discussion	Action / Follow-up
I. Call to Order / Introductions The meeting was called to order by Committee Chair Barbara Serwin at 3:34 p.m. **Members Present**: Chair- Barbara Serwin, District II Gina Swirsding, District I **Members Absent**: Connie Steers- District IV **Others Present**: Bernadette Banks, Director of Office of Patient's Rights for CCC Jennifer Tuipulotu, Coordinator for Children's Family Services and interim Coordinator for Office of Consumer Empowerment and Co-Chair for the Children's Teen and Young Adult's Committee Kathi McLaughlin, CPAW- Children's committee/MHSD Marilyn Franklin, WCCAS/CCC-Children's Mental Health clinician Douglas Dunn, District III Susan Horrocks, Family member Dee Pathman, Family member Lauren Rettagliata, District II Adam Down, Behavioral Health Administration (left @4:06pm) Liza A. Molina-Huntley, Executive Assistant for MHC	**Executive Assistant:** • **Transfer recording to computer.** • **Update Committee attendance** • **Update MHC Database**
II. Public Comment • None	
III. Commissioner Comments • **Gina-** There was a shooting last year regarding a child that died at the Hilltop Mall in Richmond. I am concerned about people that live in the area where there is gun violence. Gina did attend a seminar, on Tuesday-4/18/17, presented at the City of Richmond Police Department, for "Victims of Gun Violence," to help those who have suffered from gun violence, families were invited as well. It is difficult for victims and families of victims of gun violence, to find government assistance. These families need help and I want to find a way to help these families.	
IV. Chair announcements/comments: • None	
V. APPROVE Minutes from March 16, 2017 meeting • **MOTION VOTE: 2-0-0** • **Gina moved to motion and Barbara seconded the motion** • **YAYS: 2 NAYS: 0 ABSTAIN: 0** **Present: Barbara, Gina** **Absent: Connie Steers**	• **Executive Assistant will correct the minutes, finalize and post the minutes on the Mental Health County website.**
VI. DISCUSS –Grievance advocacy for consumers by guest- Bernadette Banks, program Director for the Office of Patient's rights in Contra Costa County o **Barbara-** We are very fortunate to have Bernadette here, to speak with us about how grievance advocacy works for consumers. The reason this Committee has decided this year to look at the various types of patient's advocates/advocacy available on patient's rights, patient's advocacy and	• **Attachment received by BB- PowerPoint from Consumer's Self Help Center**

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study the issue and to see if there are any gaps, or other ways for improving our system. We are inviting others and trying to piece together what all the different elements are in our system and feel that you are an important piece of it. • **Bernadette**- I brought some handouts, (see attachment). I have been a patient's right advocate in this county for 22 years. I have been the program director since **Consumer Self Help** took over the contract for **Mental Health Consumers Concerns** in 2013. Our main office is in Sacramento, I am located in the 1350 building on Arnold Drive, in Martinez, next to Behavioral Health Administrative offices. Our agency has four counties: Sacramento, San Joaquin, Yolo and Contra Costa. • **Barbara**- When the Mental Health Consumers Concerns closed, were all of the functions previously provided transferred over to Consumer Self Help? • **Bernadette**- **Recovery Innovations (RI)** took over the centers and brought me in through the county to assist with patients' rights, it is State mandated in every county. There are some things that did not carry through because RI works differently from the previous program, the two are different programs • **Doug**- to add to what you are saying Bernadette, I at various CPAW meetings this issue came up regarding what things were dropped, for example- if a person is discharged from the hospital, they may get into a housing situation that is not ideal, that is one of the responsibilities that got dropped in the new contract. Contracted County housing facilities there is no advocacy to make sure that problems are rectified and that rights are being followed. • **Barbara**- Are there any other obvious things that were dropped? • **Bernadette**- I would say that the whole main concept of what the clients received from Mental Health Consumers Concerns is completely different from the concept of Recovery Innovations. Previously, the clients were given a lot of attention. I am trying to get my team trained to be "hands on" out in the field and I do want to get the new program, in the future, able to operate as well as the previous program, it will take some time. • **Gina**- Do you help people with their conservatorship process? • **Bernadette**- when the County files for a temporary conservatorship, if there is a family member that does not want the services, the person has the right to go to court to bring the consumer home to take care of them. I do know how to complete the application and I am willing to help people fill it out. There are some changes. I have two new staff members that never have been advocates and they are in training. I am currently out in the field, training the staff. It is taking our office a little longer to help consumers and their families, if the person is patient, we will help them. Jocelyn and Paul are the two new staff members and they are really nice and helpful. • **Lauren**- do you go to the RI centers? • **Bernadette**- at times. On Mondays and Thursdays we are in the facilities: CCRMC (Contra Costa Regional Medical Center) and at John Muir Behavioral Health Center, looking at certifications that the doctors have placed on the client that is entitled to a legal hearing. The staff preps for the hearings on Mondays and Thursday s, for the hearings held	

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every Tuesday and every Friday. • **Lauren-** I am very familiar with that. There is concern from family members and the patient's advocate. When you go in to speak with a patient, who is in the hospital, are you allowed to see their medical records? Do you see information that the family has sent over? Because that's a concern of mine. • **Bernadette**- yes. A person always has the right to send over information. The difference regarding legal rights and medical needs are completely opposite. Patient's rights is an expressed interests, the patient has the right to have "due process" and not to be locked up. That is what patient's rights are there for. When information is sent, the hearing officer who comes into the facilities to the hearings, he listens to what the hospital is presenting. If there is a conflict between the information sent by the family and what the hospital's information states, the patient has to show symptoms that demonstrate enough probable cause to continue a hold on a patient against their will. • **Lauren**- what I am asking you is – do you sit down with the patient and prep for the hearing, beforehand? • **Bernadette**- Yes, we do. We prep on Mondays and Thursdays. Every week we go into the hospitals and obtain a "sensor" sheet. The sensor sheet tells us what patients are in the hospital and what their status is and we pre-prep and visit the patient and fully explain the process to them and what they need. • **EA/Liza**- Can we allow Bernadette to finish her presentation; it may clarify some more questions. • **Bernadette-** As I was trying to say, all patients have rights. From children to adults. We help with all ages. John Muir has a children's and adolescent unit with 10 beds for children's ages 4 to 12 and 24 beds for ages 13 to 17 years old. The adult unit is 18 years old and up. Our County hospital is the designated psychiatric facility for Contra Costa. What that means is that most of the people sent to PES (Psych Emergency Services), may be on an up to 72 hour hold, or it might be decided that the person needs further hospitalization. That is when the search for beds starts to see where there is available space and where the person will be accepted. I do assist consumers with their 5250 (up to a 14 day hold) hearings, if the person is being released from John Muir but if they are released from PES, they all have a hearing at PES. Other facilities will not take a patient unless the legal hold is still active or the patient has had a hearing. For both, 5150 or 5250 the person has to be a danger to themselves, or a danger to others or gravely disabled that they cannot provide food, clothing or shelter for themselves due to a mental disorder, as defined in the Welfare and Institutions Code book. Only CCRMC is defined as a designated psych facility in Contra Costa County, a consecutive 5150 or 5250 cannot be done on any patient at this facility, because it is a form of incarceration. I understand the family member's point of view but I must follow the protocol to protect the patient's legal rights and their need for medical care. Most of the time I will ask the hearing officer to ask the patient how they are feeling, the patient will most of the time talk themselves into staying at a facility. By law, the patient has to be given the option to sign "voluntarily," they must be given the option. If the family member commits to caring for their loved one that is considered "third party assistance," then the	

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patient is no longer able to lawfully be on hold. • **Gina-** if a person attempts suicide and they are taken to John Muir, after the person has recovered or voluntarily go can that person be held under a 5150? • **Bernadette-** Any ambulance will not transfer a person unless they are being held under a 5150 legal hold. If the person decides that they want to stay at a private hospital, the hospital will sign the person in as a voluntary hold. But, in order to transfer, the patient must be held under a legal hold or the ambulance will not transfer the patient. Most patients are released if it is a first occurrence; if not, then the possibility of being held is greater especially if there is a pattern of frequent 5150 holds. • **Lauren-** what about the patient's history? Many people are under a deep psychosis can be very convincing and have convinced themselves and present themselves a being sane and rational but they are not telling anyone the truth, including the hearing officer. • **Bernadette-** I understand and hear what you're saying; the main thing is what the Psychiatrists states in the patient's chart. The hearing officer cannot see the patient's chart because it would be a HIPPA violation, he must be unbiased. • **Lauren-** What if the Psychiatrist is not there to step forward to state if someone should stay placed on a 5250 hold and it's the Social Worker's day off, then what you have happening is that you have a person who is not well, who is not dealing in reality going before the hearing officer. There are a lot of people not dealing in reality that make a very good presentation. • **Bernadette-** With that being said, regardless if it is the weekend, the final decision is made by the Psychiatrist, there must be one at every hearing. A hearing cannot be held without the Psychiatrist, Hearing Officer, the patient and the Patient's rights representative. • **Lauren-** But if the Psychiatrist has only known the patient for 15 minutes he doesn't know. • **Bernadette-** The Psychiatrist has to look at the history and read the patient's chart. • **Doug-** two questions: Lauren asked about the history of the patient- is your office aware of the language in AB1194? What about the issue of being released against medical advice? Where the Psychiatrist recommends that the patient be held, based on their medical criteria, but the patient is released against medical advice and the Hearing Officer releases the patient. • **Bernadette-** As I said earlier, legal rights and medical needs can be opposite of each other. Hospital staff is speaking on medical needs, our office is for legal rights, that's where the confusion is because the patient does have legal rights of not being held against their will. Ideally, it is best for people to be a part of their own treatment plan. • **Lauren-** If the person is in a deep psychosis they can't be. The problem is that there are people that have very serious mental illnesses that are very hard and without the history available to the Hearing Officer it is almost impossible to get these consumers into the longer extended treatment that they need. They end up in a revolving door of PES, Homelessness and jail. It is very disheartening to families when they do end up in 4C and after they have had a period of time of stabilization and	

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are appearing to be doing better, and the Hearing Officer does not know the history or the Psychiatrist of record, then the patient is released too soon. You as the patient's rights person, people also have the right to be treated, more important than their right to not be incarcerated is their right to treatment. If there is some way that we could advocate that the Patient's Right's office understand that these people hit this revolving door because their right for treatment is not first. Their real will isn't there and they are so ill they really don't have free will at the point because of their illness has incapacitated them, like any other debilitating illness. • **Bernadette-** To wrap it up- if a family member has any information, they need to make sure that the information gets in the patient's record. I also advise people when the child or patient is at their best, have them sign a release to give the family member authorization to go into their records. The authorization is good for a year; otherwise the family member will be told that they cannot be given any information because it is a HIPPA violation, unless a release of authorization is signed. Now if it is an under aged child, only the parent can sign them in and out, it is up to the parent. The parent signs the child in involuntarily. Parents can contact our office for assistance, toll free, at: 844-666-0472. Our office has flyers everywhere: in PES, in all the hospitals. • **Gina-** That is great to know. I know a lot of kids that are released and sent back to school and they are still in the crisis mode and they wind up in juvenile hall because they wound up in school too soon while they were still in crisis mode. It is hard for kids to express that they need help and hard for the parents because they are working and don't know what to do, especially if there is a language barrier. If they do ask for help and they don't get the help, the lose trust and won't ask again and wind up in trouble. • **Barbara-** given the new year and your staffing level, what do you feel are your biggest challenges? If things breakdown, where do they breakdown? • **Bernadette**- My biggest challenge is when family members want to talk about the patient and we can't talk about it, unless there is a released signed. I can listen but I explain that we cannot discuss anything without a release signed. It's the law, have the patient sign the consent form authorizing to release information. • **Lauren**- Do you explain that to the families? • **Gina**- Can we have you come back Bernadette? • **Barbara**- Once we have cycled through all the different services and have a better handle on what is there and what we perceive to maybe not be there it would be great to have you come back to educate us some more. • **Bernadette-** I would suggest that everyone read the handout that I gave and write down your questions and send them to me, so when I come back, we can get right to answering your questions.	
VII. DISCUSS- Mission and goals for Children's (TAY) Transitional Age Youth and Young Adults by guests: Jennifer Tuipulotu and Kathi McLaughlin • **Barbara-** This is the first time that we are able to sit down with the Children's, TAY and adolescent's Committee and we are happy to have	• **Gina would like the SPIRIT program to present at the Mental Health Commission meeting**

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both of you here. Both of these groups, children's and TAY are in need of inpatient facilities. We really don't have placement here in our county**.** Both groups have been working on advocacy for how to address this problem. The first step for us would be for you to tell us about the committee, what your mission is and what are the things that you're working on and where are you to date with your efforts regarding advocacy for a treatment center facility. • **Jennifer**- I am passing around the agenda of our last meeting shows the mission of the committee**: "To decrease stigma and improve outcomes for youth and their caregivers throughout Contra Costa County. "** The committee has been active for four years; we meet the second Thursday of each month, from 11am to 1pm., usually in a conference room at our Administrative offices. The high point that I think of in terms of this meeting is that Vern is always on the agenda and present at the meetings because the folks that come from the community and providers, who may not see him very often, are able to ask him questions at the meeting. Vern gives us accurate information regarding what is going on with children's programs, standards and regulations. • **Barbara-** Can I ask about the make-up of the committee and how it relates, what is the link? • **Kathi-** the Children's Committee of CPAW originally was just the Children's Committee basically and it grew out of a task force. The Child and Adolescent Task Force committee started meeting with Vern because Vern wanted an opportunity to meet with the community and for him to talk to community advocates regarding what is important and going on in the Children's system of care. It has a long history linked to the commission, due to my previous involvement with the commission, about 25 years. When CPAW was created, to make recommendations to the Mental Health/Behavioral Health Directors, the Children's committee was a part of CPAW and ran in the same manner it currently is. A couple of years ago the Board of Supervisors discussed having the committee's adhere to the "Brown-Act," but since the committee is not as well established as the commission or it's committee's and we wanted the ability to work more nimbly so if something was coming up, it was on the agenda and allow anyone to bring up any discussion as well. This is the reason why the two groups divided. It was set up as a way for the age related committees and social inclusion to be able to respond quickly to anything of interest and allow anyone to attend, it is an open committee and it is not subject to the Brown Act. Because of the shortage of beds more and more places that use to take our kids have closed or are no longer taking the younger kids or accept the application for our kids. Unfortunately, every facility has the right to refuse anyone and it is a primary reason we have so many problems. We had hoped that the George and Cynthia Wellness Center was going to be a diversion from PES. But, because it is a federally qualified health center, it cannot accept children or adults that are mild to moderate, moderate or severe. Basically, if a person has already been to PES, then they do not fit the criteria to go to the Miller Wellness Center due to being a federally qualified health center. The money from the Mental Health Services Act for capital facilities went in, it was not enough money to build a free standing place, to save money, we went in with physical help and	

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ambulatory care to create a federally qualified health center to obtain federal reimbursement. Unfortunately, we were not aware that it would limit the criteria. PES is not a place for kids and there isn't really a place for kids. That is why we started to look at different options and started to put a plan together to move 4D to a kids unit. • **Lauren-** After reading the letter, I am not clear; will 4D become the psych emergency for children too? • **Kathi**- No, it's not going to be a psych emergency, it gives a place to put kids that need a longer treatment plan than 23 hours. By law, children are not allowed to be held longer than 23 hours in PES. When they do stay beyond the 23 hours the county gets absolutely no reimbursement. Not to mention the fact that there is no place for the kids in the center. • **Lauren-** Have we done a study on the utilization and review of the average number of children entering PES monthly, to see if there utilization and review, on their exit is to a full hospital? • **Kathi-** I am certain that Vern has done that study because the numbers I have, I got from him. • **Lauren-** Vern said that the figures did not correlate with Pat Godley's figures, his figures had less. When we did ask the question at our last meeting, they said that they didn't know and I think that if to go forward, I think it's a good thing to know so that when you present your proposal to the Board of Supervisors and to Pat Godley you can say, on the discharge from PES, this number of children have been discharged without a place to go- the discharge has to be very specific. • **Kathi-** that would be better information for Vern, than for me, because I am not a clinician and I would not know anything about that. • **Barbara- as opposed to what else?** • **Lauren**- No, we need to know. What is going on in my head is that a lot of these children that are there for a long time, many of them would not qualify to go to an inpatient hospital. The placement that they were looking for would be a possible- "super foster family care" but this is recent and not a lot of them are available. There are some young people that are so ill that they need even more than that- they are falling into this crevice between hospitalization and an intensive care facility • **Kathi-** what we are looking at is a high level group home but unfortunately more are closing than being created, there is not a place for these kids to go because of the **Community Care Reform.** • **Lauren-** I would like to know what the utilization review is saying- are they saying that we've got 7 kids, 12 kids, how many kids every month? • **Kathi-** I think we need to ask that question to Vern. What Pat Godley said is that the figures didn't pencil out because we could not get a contract from other counties, committing to a certain amount of beds. We don't do that; no one is going to do that. But the fact still remains that we do not have enough space in any kind of a hospital setting at all and we really don't have any space at all for the kids that are 5 to 12 years old. • **Barbara-** Going back to why they won't commit- is it an issue of: "The other county knows that they will need the beds, but will not commit upfront, because in the possibility that they don't need a bed, then the county would still be liable to pay for it." • **Kathi-** Correct! We, as a county, don't do that either. Yet, we are always	

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looking for space for our kids, outside the county, because there isn't any available space along with other counties. • **Barbara-** If that is a known practice, then we know how many beds are exchanged. • **Kathi-** That is why Vern and Warren had put together a proposal to look at the possibility utilizing 4D for children. This started about a year ago, I actually wrote a letter, a year ago, I have revised it since then- we all thought that Pat Godley was onboard with the proposal- • **Barbara- what made you think that?** • **Kathi-** because he kind of indicated to Vern and Warren, over a year and half ago, that he was on board and he did think that the figures were going to pencil out, plus we were going to be using Mental Health Services Act Funds to deal with the physical plant. We cannot provide (meaning MHSA) staffing or money for staffing to anything that is a locked facility. Then more than a year ago, Mr. Godley said no, that the project didn't pencil out. Vern does believe that it would, especially because there is a need and so few places for the little ones that many counties would come to us asking for available space. Aside from everything else, I don't think that all of the costs are being included. 4D has been used as a cafeteria for more than a year; it was previously a psychiatric unit for adults. So the county could afford to convert it to a cafeteria but not for a unit for kids? I am sorry, that just doesn't make any sense. The number of stays beyond 23 hours that were not reimbursed at PES, there were 175 children in 2015, 148 children in 2016. I believe I remember Vern said the drop was due to the mobile response team? Those are just the kids that stay beyond the 23 hours that means that they are not able to receive services that are going to be reimbursed. We cannot keep them there but those services are at the county's expense, not reimbursed in any way shape or form. I know of one child that stayed 77 days and I want to say that another child stayed 50 days, this year, these were the longest stay. • **Gina-** and it costs approximately $2000, per day, per child? • **Kathi-** that is correct, approximately. The additional costs in serving kids that are placed out of our county, then we also have to provide supervision to them and there is a lot of down time in that, costs our county approximately $150,000. The services at PES costs about $75,000, it did drop to about $60,000. However, children staying over a week, still need to be connected with their school and their families. That does not work when they are sent out of the county or when they are in PES. There is not a safe place for kids in PES, nor is there a quiet place. The school district will not send teachers to PES for home and hospital teaching, those kids are not getting any educational services during the amount of time that they're there. That compounds there problems when they go back to school because the kids get way behind in school. The reason being is that there isn't a place for the teacher to meet with the student. The school might wait until the child goes home, before the send a home and hospital teacher. The kids lose their connection with the district. It is a civil rights violation. It is against the law to hold these kids in PES past the 23 hours. This does put the county at risk for being sued. I don't think anybody is taking this into account the fact that this is not acceptable programing. It is a patient's rights issue and a civil rights violation. If you haven't visited PES, look at where the kids are. It	

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is an alcove with two dental chairs that's where they stay. • **Gina-** the other part is that they're there against their will, there are people screaming inside PES, that can be scary for adults, it's even worse for the kids. • **Doug-** to get back to the finances Kathi, at the last meeting, I took apart the financial piece and emailed it to you both- Warren made a statement using averaging the costs per day, Pat Godley countered – originally they had stated that the actual records and they actually only paid out "X" and they said that there was a $1.6 million difference of what they had estimated on an average cost per day basis and what was actually paid. If you can show that the doctor recommended a hospital stay and that's not happening, that is a civil rights issue and plus there is also a cost factor that Mr. Godley might not be taking into account. • **Kathi-** So you are talking about kids that should come back to PES, should be hospitalized, should have a more restrictive environment, some don't come back after the first time that they are there • **Doug-** it would be interesting to know if those kids wind up in jail, or where the recidivism continues. They drop out of the system because they are under aged. You can show that there is at least a "break even" because the other counties would want to use the space, if they are not full with our own kids and have the availability. • **Kathi-** 110 kids are processed through PES every month and 51% of those are from East County. There is a dearth of services in East County as well. I do find that it would be appropriate to address the civil rights violation, it is not just a dollar and cents issue, this is a civil rights and treatment issue. There is an older/aging adults program, under Innovation from the MHSA, that is called "Partners in Aging" and they were going to set up at PES to help divert older adults because they are vulnerable too and there is no space at PES for them. I suggested that there is space at the Miller-Wellness and they were told that there is no space for them there either. It is an issue, over and above; that I think that CPAW and the Commission needs to start looking at. We put in $3 million dollars into the center: we put in 75% of the money and have maybe 25% of the space at the Center? My intention with this is to set up a meeting with a Family and Human Services and the Board and have that discussion there first and see what happens? If anyone has any interest in signing my letter, let me know, and I will be happy to put your name on it. I am in the process of revising the letter. • **Barbara-** Has any one talked about reworking the financial analysis, broadening it? When I look at the situation, I see at first pass an analysis that Adam and Vern both stressed that they had limited information in many different ways. In some ways it shouldn't be incumbent on advocates and non-finance staff to do that analysis. From a commission stand point, there is information that we could demand to have from the Finance department. • **Kathi-** that would be a better role from you all, than from CPAW. • **Lauren-** it's because we don't have the numbers from the hospital. To make this real numbers we have to have the real numbers from the hospital finance. We can think of numbers and put an estimate of what the costs are but they have the actual numbers/costs. Whether the child stays 1 day or 23 days, there is not that costs that they're saying there is.	

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When I spoke to Victor Montoya, he said that actually it doesn't costs them that much more to hold the child and it's the right thing to do because if there is no place for the child to go, better to keep the child in a safe environment than to exit the child to a non-safe environment. But the costs that we're saying that we are attributing to them being there really is not the true cost. There is only a certain amount of beds in psych emergency and children do get top priority, and they stay there longer because there is no place for them to go. • **Kathi-** what Vern is talking about is that he will not allow the child that stays at PES not to get some sort of treatment and support and just sit there without help. Vern is sending his staff over and that is where those costs are that are not shown in the hospital costs. • **Lauren-** We would have to know too, how many days will they be allowed to stay in 4D unit? • **Kathi-** That would be determined by the Psychiatrists. There are a lot more factors that determine the stay, depending on the treatment plan. • **Barbara-** maybe we can do some brainstorming as a next step • **Doug-** if I can add, we probably better do it sooner rather than later, because there is stuff going on at the federal level. • **Barbara-** Liza/EA, just for the record- I/we would like to request to do some brainstorming around- what is the best way to move forward in terms of we are looking at the perspective of how do we show the need for 4D, as a children's treatment facility. And we need to obtain a more detailed analysis to be done regarding the costs advocating for a children's facility, whether it be converting 4D or another treatment care facility for children. Note that Kathi did state that the Children's Committee is planning a visit to the Miller-Wellness Center and if we can piggy back and join them during their visit. We need to make sure we get a hold of Jennifer Tuipulotu. • **Jennifer-** What I was actually thinking was to hold the Children's Committee meeting at the Center at their very nice large conference room, although parking is an issue and have a tour while we are there. I will follow up and let you know.	
VIII. DISCUSS the Behavioral Health Service's development of an action plan to support Children's, (TAY) Transitional Age Youth and Young Adults inpatient treatment facilities by guests: Jennifer Tuipulotu and Kathi McLaughlin	• **Postponed due to insufficient time.**
IX. DISCUSS and CREATE Action Plan for 2017	• **CHAIR MOVED ITEM to the MAY agenda and will email EA the goals for 2017**
X. Adjourned at 5:16 pm	

Respectfully submitted,
Liza Molina-Huntley
ASA II- Executive Assistant for MHC
CCHS- Behavioral Health Administration
Final minutes approved on May 18, 2017