**Mental Health Commission**
**Quality of Care Committee Minutes**
**September 21, 2017- FINAL**

<table>
<tr><th colspan="2">Agenda Item / Discussion</th><th>Action / Follow-up</th></tr>
<tr><td>I.</td><td>Call to Order / Introductions @3:28pm<br><br><u>Members Present</u>:<br>Chair- Barbara Serwin, District II<br>Gina Swirsding, District I<br>Meghan Cullen, District V<br><br><u>Members Absent</u>: none<br><br><u>Others Present</u>:<br>Margaret Netherby, NAMI member<br>Teresa Pasquini, NAMI member<br>Doug Dunn, District III<br>Lauren Retagliatta, District II<br>Victor Montoya, Program Chief for PES<br>Erika Raulston, *submitted application for MHC appointment<br>Leslie May *submitted application for MHC appointment<br>Jill Ray, Field Rep for District II Supervisor Andersen<br>Duane Chapman, District I<br>Adam Down, BHS Admin<br>Liza A. Molina-Huntley, Executive Assistant (EA) for MHC</td><td>Executive Assistant:<br>• Transfer recording to computer.<br>• Update Committee attendance<br>• Update MHC Database</td></tr>
<tr><td>II.</td><td>Public Comment<br>• None</td><td></td></tr>
<tr><td>III.</td><td>Commissioner Comments<br>• None</td><td></td></tr>
<tr><td>IV.</td><td>Chair announcements/comments:<br>• None</td><td></td></tr>
<tr><td>V.</td><td>APPROVE Minutes from July 20, 2017 meeting<br>• Gina Swirsding moved to motion to approve the minutes, without corrections, Meghan Cullen seconded the motion<br>• VOTE: 3-0-0<br>• YAYS: Gina, Meghan and Barbara<br>• NAYS: 0 ABSTAIN: 0 ABSENT: none</td><td>• Executive Assistant will correct the minutes, finalize and post the minutes on the Mental Health County website.</td></tr>
<tr><td>VI.</td><td>REVIEW and DISCUSS updates on the Family and Human Services committee meeting regarding the Grand Jury –Barbara Serwin<br>• Chair informed that Duane Chapman, Barbara Serwin, Teresa Pasquini and Lauren Rettagliata are attending a series of meetings, with the Behavioral Health Division Director and staff, regarding the Grand Jury Report and other meetings regarding the White Paper. With respect to the Grand Jury, with Family and Health Services (FHS), Behavioral Health Services (BHS) is collaborating with the Mental Health Commission (MHC) mentioned representatives, to negotiate cooperative terms, moving forward, to achieve common ground. Behavioral Health Services has provided updates regarding recent changes that are in progress. The changes do explain, some of the differences, in regards to obtaining a greater understanding of the current status within the division's programs. Another meeting is scheduled, regarding the Grand Jury Report with FHS, in October. The White Paper will be presented at</td><td>•</td></tr>
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| the same meeting in October, with FHS. The expectation is that the MHC will work with the BHS Administration to update the White Paper and reflect mutual understanding of the status quo of the main issues identified in the document. The goal is to have all of the representation, from the MHC, BHS and PES, assuring that there is full representation. Focusing on the issues related to children and beyond. Various meetings are scheduled to meet with BHS and PES, to update the information and either the MHC agrees with BHS or not. MHC will try to maintain an objective viewpoint, in respect to BHS Administration's perspective. The MHC is unclear regarding the number of Psychiatrists, currently on staff, and expects further updates and clarification, to come from BHS Administration; including the name of the current Medical Director and the names of the Psychiatrists at each program. Behavioral Health will respond to all of the inquiries, from the Commission, accordingly in a comprehensive report, as agreed.<br>• Other participants, with family members in the mental health system, have been invited to participate in the process and will be involved in tracking progress<br>• The bulk of the attention has been on the children's system of care and will cover other areas as well. | |
| **VII. DISCUSS updates from Psych Emergency Services (PES) with PES Program Chief, Victor Montoya**<br>• Currently involved with hospital services, at Contra Costa Regional Medical Center (CCRMC), with PES, for the last two years; and was previously the Program Chief for Adults and Older Adults for 15 years, in Behavioral Health Services and has worked for other counties as well, in a variety of levels, including Alcohol and Other Drugs (AOD) Administrator.<br>• Focused on 4C and the operational structure of the inpatient unit, identifying gaps and working in Psych Emergency Services that runs 23 hours a day, seven days a week.<br>• Several months ago started working with the hospital Social Workers on the medical units with the goal to look at the consumers that are high users, across systems, rather than one system at a time.<br>• One of the opportunities and changes is the development of cross systems approaches. Identifying gaps and discovering how to increase communication and coordination across different departments and units.<br>• The subject matter is vast and will need to be carried out beyond several meetings. PES is not a single subject matter.<br>• A questionnaire was distributed, amongst consumers, to obtain information regarding their experiences with the services they received and to identify gaps and areas of need.<br>• PES is licensed for 18 beds; four beds are assigned for children and adolescents. There is a designated medical clearance room, a family room and interview rooms. There is a pod, where the clinicians and the doctor's work and a separate nurses station. There are two adult dorms, separated by gender, ages range from 18 years old to 74 years old.<br>• Regarding service, service delivery and intervention. Due to the large range of needs and services, a greater range of skills sets is required and different forms of approaches are required.<br>• Some individuals that use the services have different forms of insurance and are private pay, Kaiser, Blue Cross, Medi-Cal, VA, uninsured and Medi-Cal from outside counties and that process alone, can complicate the process for providing services<br>• There are various forms of treatment, not just stabilization, engagement in | ***Invite PES for the next meeting** |

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| discharge planning; if the person is homeless then other considerations need to be addressed. Insurance can dictate discharge planning. Establishing relationships with providers on going care is crucial for ongoing care and placements can be difficult in coordinating planning.<br>• Teams of Social Workers try to do coordination of families, of care, of placement, providers and helping individuals hopefully find the skill set to reduce recidivism, by providing better placements and care.<br>• The goal is to provide better discharge planning, with the patient, to obtain better treatments and outcomes.<br>• The population, coming into PES, has changed dramatically in the last five years; 60% to 65% of the utilization was open to the county and the remaining amount was either privately insured or not open. Now, the population being received at PES has reversed roles.<br>• PES is most recently working with Health, Home and Homelessness (H3) to obtain shelter placement upon discharge, taking a more multidisciplinary approach to care<br>• The Medi-Cal, limiting 23 hour constraint, makes providing adequate care and placements difficult, the search for placement begins upon admission<br>• Over 10,000 individuals are being seen, per year, at PES.<br>• PES is doing a better job at treatment planning at the beginning and working more efficiently, moving consumers into appropriate placement faster due to proactive planning, the stay time has reduced to 12 to 13 hours, on average. Working cooperatively with H3 and discharging into the hospital, not leaving consumers out on the streets, are all actions that are helping services and care.<br>• PES is looking into creating changes to the vestibule, to improve it and make it more inviting and conducive for waiting families. Currently, PES shares the entrance with incoming ambulances, minimum space and no seating area<br>• A performance improvement project was done, with the aid of Vicky White, to identify needs better and improve operations<br>• The Program Chief of Children's and Adolescents, Vern Wallace, hired a new clinician for children and adolescents, full time, which has helped a lot with the challenges. Most children admitted are between 10 years old to 17 years old. The current location for children, under 18, requires more effort to obtain placement after discharge. A lot of family work/therapy is done initially.<br>• Children have multiple pair systems; if the child has insurance through Kaiser, then Kaiser will take responsibility regarding placement. PES cannot do placement planning with Kaiser insured patients. A lot of children are from out of county and due to the changes in legislation; many group homes have closed, or are in the process of closing and have to go into Foster Family Agencies. Level 14 is the highest level of group homes for children with extreme need of care, are closing rapidly.<br>• There has been an increase in children coming from outside the county, which provides additional challenges. If the incoming, out of county children, do not have what is known as a JV220, which is defines and awards responsibility to provide psychotropic medications. A court order must be obtained and a physician declaration also is required, which is sent to a judge for signature (JV220) in order for the county to administer the medications needed for an underage patients. The process is very challenging.<br>• In the Children's Unit, once the 23 hours have been expired, there is not a reimbursement of costs is received for the County services provided or for staffing. The County must absorb all costs and staff requirements are more stringent for children. | |

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| • There is consideration, towards proposing a separate, protected, pace for children and adolescents that will have to be both cost effective, within the premises and with minimal initial investment.<br>• PES is a different certification than an inpatient unit and by regulation; Medi-Cal pays for both children and adults, up to 23 hours. It affects children more due to the small current unit. Children treatment is a priority. Children that are coming in, that do not need acute care, but need extended period of time waiting for the group home to become available. PES allows the child to remain, until the child can be placed, which is difficult, due to the closing of group homes. The hoped outcome is to strive towards wrap around care.<br>• The process is in a conceptual phase, at the moment, analyzing where the ideal areas are, with the least amount of potential startup costs that does not affect or disrupt the flow of the hospitals services. Finding funding streams is part of the process as well. The next step is defining the space, creating a cost analysis, funding streams, develop a formal proposal with architectural drawings, staffing, everything will need to be in accordance to safety, fire and building codes<br>• Attendees agreed that PES is not an appropriate unit for children<br>• Attendee asked if there is aggregate data available regarding PES that is broken down.<br>• Recently, a Quality Assurance data staff has been hired to start the task of creating data that captures more current information. More information will become available in the future. There are some limitations that will be improving in the near future. | |
| **VIII. DISCUSS Contra Costa County Regional Medical Center's programs for consumer advocacy, grievance resolution and empowerment**<br>. | ***invite Quality Assurance rep, from CCRMC, to discuss process-** |
| **IX. Adjourned at 4:58 pm** | |

Submitted by
Liza Molina-Huntley
ASA II- Executive Assistant for MHC
CCHS- Behavioral Health Administration
FINAL MINUTES APPROVED 10/19/17