QUALITY OF CARE COMMITTEE MEETING
MINUTES
February 18, 2021 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Quality of Care Committee Chair, Cmsr. Barbara Serwin, called the meeting to order @3:49 P.M. <u>Members Present:</u> Chair- Cmsr. Barbara Serwin, District II Cmsr. Laura Griffin, District V Cmsr. Leslie May, District V Cmsr. Gina Swirsding, District I <u>Presenters:</u> Jan Cobaleda-Kegler, Mental Health Program Chief Joseph Ortega, RN, IMD Liaison <u>Other Attendees:</u> Angela Beck Rebekah Cooke Carolyn Goldstein-Hidalgo Jim Grey Lynda Kaufmann Jeff Landau Akindele Omole Theresa Pasquini Christy Pierce Stephanie Regular Lauren Rettagliata Ruth Schreiber Kristine Suchan	
II. PUBLIC COMMENTS: • (Ruth Schreiber) LPS Conservatorship (State Hospital) comments directed to Jan Cobaleda-Kegler. Sister has been in the mental health system through Contra Costa County (CCC) under LPS Conservatorship, gravely disabled and in the Napa State Hospital. I am speaking as a family member advocating for my sister for the past 40 years. My experience interacting with the office of the public guardian is they are extremely hostile to family members. I can quantify this, which I have to you in the past. There is no doubt, it is not a gray area regarding the hostility. There is a wealth of a gap of information for family members. I conservatorship training mandated by a judge that handles public guardianships in the county, even with that, nothing addressed the LPS conservatorships. Families relinquish involvement/control of the conservatorship to the county, often because (in my opinion) they're in crisis because the family member is so gravely disabled that it is a seemingly insurmountable task, it's an emotional drain and do not know how to navigate the system. I feel there is a serious issue in your department. I have tried for years to	

have my voice heard to advocate for my sister and have been shut down, blocked and treated like I was an 'ignoramus' and told I was difficult, should 'shut up' and stop complaining. I have been blocked access to my sister's records, I've been accused of being litigious and a problem. In the two complaints I have seen where the grand jury investigated the office of the public guardian, I wonder what it takes to get the county to pay attention? Does it take a grand jury? Does it take a lawsuit? This gap is so huge and it is something that should be seriously looked into. Family members shouldn't be left in the dark and shut out. We should not be treated as having no right to know when it is discovered there has been unethical and inappropriate treatment, bordering on abuse, in the state hospital system. The abject apathy on the part of the public guardian's office because they don't want to be bothered. This shouldn't be happening. It has been happening for years. I feel like that it is such a problem that it is eventually going to backfire on the county; just as the case did when I was in the last meeting and told the Yolo County Sheriff's department is being sued for gross maltreatment of women prisoners, mentally ill women prisoner's. That it was such a blatant, vulgar way these women were treatment that it could not be ignored. When family members are out there and do not understand the role the public defender's office plays, and what power/authority the public guardian's office has in the case of an LPS conservatorship and when you try to get information, you are just negated and diminished. It is very unacceptable and feel it is a real issue that should be addressed.

- (Cmsr B. Serwin) Let me interject, the Justice System committee is, in fact, right now doing a deep dive into the LPS conservatorship set of issues / problems. I am so glad you came and shared. Your experiences are being shared by a lot of people, including those in this meeting. I highly recommend that you attend that meeting, would be very welcome there.
- (Jan Cobaleda-Kegler) Ruth, I can see that talking about this is very upsetting to you and feel deeply and strongly what you are sharing today. What I will offer is to contact me. (Ruth Schreiber) I did contact you five years ago to let you know what was happening and you assured me that they had my sister's best interest at heart and that is not what I see. That has not been my experience, but I will contact you again.
  (Jan Cobaleda-Kegler) My door is always open, Ruth. Because of confidentiality and your own privacy, I would rather talk with you offline and address your concerns, okay? (Ruth Schreiber) Okay.
- (Cmsr. L. May) Ms. Schreiber, please look in the comments, someone is giving you their contact information.
- (Theresa Pasquini) sent her contact information. Ruth, my heart goes out to you as the mother of a 38-year-old son that has been conserved by CCC for the last 20 years. Part of that time was at Napa State Hospital, as well, where he was arrested and criminalized and spent four years in jail. He escaped, luckily, and is living free in the community for the first time in 20 years. I don't know your situation, but I know I was crying at this meeting last month so do not apologize for getting emotional. Thank you so much for sharing, I am a former commission and also a local, state, and national advocate. I hear you; I agree with you. I am also working with the Justice Committee. You are absolutely right, there is no excuse for family

members to be in this position. We are not in a position to communicate because of the format, but please reach out to me. I have been begging for oversight of the conservatorship office for years. I personally had a great experience with them but I know others have not and I am very concerned. (Ruth Schreiber) It is more than that. I appreciate you so much. What I have experienced and seen is that there are these huge gaps that their role is limited once a patient is put into the state system and I am dealing with the state hospital and there is no accountability. There is a huge gap at the state level and the laws regarding the protections that are in place for monitoring the quality of care.

- (Stephanie Regular) We spoke at length about a month ago, I am with the public defender's office. Mr. Landau is the attorney representing your sister. I think you recall our role with regards to your sister. (Ruth Schreiber) Yes, I was actually going to contact you two to get a clearer understanding on that again. (Stephanie Regular) Please feel free to reach out to Jeff or me and we'd be happy to speak with you.

III. COMMISSIONERS COMMENTS:

- (Cmsr L. May) I was invited to a meeting this morning I couldn't attend. There was a press conference regarding Angelo Quinto. Angelo Quinto suffered from severe mental illness and stopped breathing/heart stopped while at home under police custody. He was declared dead at the hospital on December 26, 2020. His death is under investigation, and although the family is still awaiting the autopsy results, they believe he died from asphyxiation while in police custody. They held a press conference this morning at their home in Antioch. The incident was on the news last night. I am supposed to speak with Cassandra (the mother) later this evening after 5:30pm. I just want to say this was a young man suffering from severe mental illness. It triggered me and (I don't cry that often, but) last night I cried. My daughter had to comfort me. I was recalling the exact same type of incident happened in my home with my granddaughter in 2018, with the exception of, when the police responded, I refused to let her go. I was on the floor, with my legs wrapped around her, and my arms wrapped around her and was rocking her. I made the police get on the floor with me and talk with her. I calmed them before they interacted with her and held her until the ambulance came and the EMTs were able to walk her out of her own volition. It triggered me, my daughter was at work when this incident occurred and my granddaughter flew to my house running. I just want to share because it could be anyone's child. The mother stated he was dead before he even left her home. I want the commission to be aware of what is occurring in this county and our districts. There is an actual individual that is allowing me to share in the comments to call and speak to individually. This is who we are, this Commission, we need to be involved with these cases, such as Rebekah Cooke. We hear about these cases with law enforcement, but the change is not coming fast enough. We need to let our voices be heard. There is a role we need to do; this cannot continue to happen. (Rebekah Cooke) My observation, it is, to your point Leslie, not happening fast enough. I feel I was getting frustrated because we talked about the smoking ban, we talked about black history month, we talked about many things that are all important; it just seems we are not prioritizing. We

need to get to the beds. We can't have non-smoking facilities if we don't have the facilities. We can't have people of color served if there are no beds. So, at some point it feels like we need to prioritize getting the beds first in order to accomplish all these other aspects. Same thing with the laws. There is AB1194, it is not being recognized. This is going to be a huge thing for my daughters case in a few months because she is going to be able to present herself well. All of this money the county spent on her and all the foundation, she can just walk away. There are some prioritization efforts I would love to see happen. (RESPONSE) (Cmsr. B Serwin) Thank you, very much. I will bring that to the Executive Committee, the desire to see me of a priority established. We do have a number of competing interests, there are so many things going on. Where we are trying to prioritize by setting our goals for 2021 and at our next Commission meeting.	
IV. CHAIR COMMENTS – None.	
V. APPROVE minutes from the Quality-of-Care Committee and Justice Systems Committee Joint Committee Meeting of January 21, 2021 • Cmsr. Leslie May moved to approve the minutes as written. Seconded by Cmsr. Gina Swirsding. • Vote: 4-0-0 Ayes: B. Serwin (Chair), L. Griffin, L. May, and G. Swirsding. Abstain: none	
VI. REVIEW and DISCUSS list of Mental Health Services Act facilities, Behavioral Health Services owned and operated facilities and contracted facilities, including criteria for inclusion, types of sites included, and information tracked about the sites with Jennifer Bruggeman, Program Manager, Mental Health Services Act, and Jan Cobaleda-Kegler, Mental Health Program Chief, Adult and Older Adult Behavioral Health Services and Joseph Ortega, RN, IMD Liaison • (Cmsr B. Serwin) Referring to packet with List of Sites provided by Jan Cobaleda Kegler's team. These lists relate back to the site visit program that the Mental Health Commission's Quality of Care Committee is currently building and working to organize the list of sites related to Behavioral Health Services (BHS) within the MHSA for commissioners to visit. We would like to ensure we have a comprehensive list and understand what these sites are and coordinate our visits with BHS and MHSA, so we are not all showing up at the same time. • (Jan Cobaleda-Kegler) One list contains the Mental Health Rehabilitations Centers (MHRCs) with their name and addresses. MHRCs are locked facilities and added on the Crisis Residential facilities (screen share of lists), runs through list of Board and Cares (BAC). Psynergy is an example of Enhanced-BACs, which tend to be larger facilities with more of a structured program. For example, Our House, The Bridge, Pathway and Psynergy, they are structured and have a program. The small BACs, their staff supports clients with their medications, but do not have as many groups and as developed program as the enhanced BACs. All the residential facilities on the list are all open facilities and not locked. The goal is to help clients, especially in enhanced BACs, once they have	Program and Fiscal Review for the Recovery Innovations International (RII) Program were shared as a PowerPoint presentation during meeting.

completed treatment, to move them to smaller BACs to have a little more independence to come and go. In all of these facilities, there is support with medications and a many of our clients need help with that. Another way to view the housing; at any one time we have approximately 450 people in placement. 150 of those are in the locked settings, which is a general figure (sometimes more or less). Those in locked care, are conserved on LPS conservatorship. We also those in LPS conservatorship that are also out in the community in open settings and are doing quite well, but maintain their conservatorship status. What does the committee want to know? It is a big subject. One thing the BACs all have in common is they are all licensed by community care licensing. Community care licensing has rigorous standards and must answer to CCL (state agency). If there are any infractions, reports are submitted to CCL continuously. Anyone from the public may go to the CCL website to investigate complaints or problems with any particular facility. There are checks and balances to monitor these facilities and how clients are doing. CCL is one of the ways we track.

- (Cmsr. B. Serwin) The list of BACs has some of the enhanced BACs, but not all of them? Would that be fair? (RESPONSE) The list has all the enhanced BACs, what is not listed is Psynergy, or Everwell, which we have started a contract with them. I apologize the list is missing those two.
- (Cmsr. B. Serwin) Please explain Adult Residential Facilities (ARFs). (RESPONSE) The BACs are ARFs. The Older Adult facilities are Residential Care Facilities for the Elderly (RCFE), places like Pleasant Hill Oasis, Harmony House, Walnut Creek Willows. All offer assisted living care for older adults. The RCFEs are really helpful for older adults that have wheelchairs, etc., that need extra care that they will not receive in an ARF.
- (Cmsr. B. Serwin) Can we go over the list of MHRCs. (RESPONSE) MHRCs are all highly specialized environments for our clients, most of them are coming out of the hospital and need long-term locked psychiatric care. Clients in the MHRCs have been in the hospital, not ready to go back into the community, need to be sheltered, contained, stabilized and work on their recovery. Typically, we want them to return to the community. That is the goal. (Joe Ortega) MHRCs are a rehabilitation center, not a housing center. We try to exhaust all lower level, least restrictive before we even consider a locked facility, which is a last resort. My role is, how they come across my desk to start to follow, those that have been placed on LPS conservatorship and are requiring (inpatient acute) or requesting (family members or case managers, providers) requesting or recommending a locked facility that has that level of care for the client. My number one purpose as liaison is to ensure best treatment, best quality of life, given the least restrictive environment. My role is almost a third party. I representant CCC, but I am not going to side with conservatorship because they are county, nor am I going to side with inpatient acute because they are providers. My role is more like a family member in that I choose what is best for the client. There are a lot of clients that do not have families. I follow these clients from inpatient acute into our locked facilities all the way back out to the community. As a liaison in the locked facilities, I represent the county but ensure there is a partnership with conservatorship and our providers are in good standing, as well as family members are very involved, if possible and included in treatment and connected. I ensure the best quality of care and treatment is happening;

referring back to the contract, what was put in writing, regarding services that should be provided and what services are not provided. I monitor all that and medical necessity (psychiatrically, medically, etc.). As we progress within the individual treatment care plans, we try to get people back the community or ready to go back to the community as soon as possible.

- (Cmsr. B. Serwin) I want to know more about your site visit practice or protocols. As said, we are building a site visit program and have developed focused on consumer experience. We are not looking into utilization or accounting. We are looking at interviewing consumers and sharing their experience. We would like to augment with the site reviews we are about to embark on and it would be good to hear about your site reviews. How do you choose the sites you review? How often do you review them? Does that coincide with the contract review?
  (RESPONSE) All good questions. It is not specified in the contract how often we need to visit; it is not that detailed. Before COVID, regular practice was a site review of all locked facilities, at least, every two weeks. There are multiple reasons:
  - Presence is power
  - To build rapport with our clients
  - Gives opportunity to meet one-on-one with clients; wherein some of the more 'official' meetings, they are sometimes limited to share certain things or they are (maybe) under pressure from the conservator. I am able to have those candid conversations.

  My goal prior to COVID was to perform site visits twice a month in every locked facility. Dependent on the locked facility, there are weekly meetings (different names) where the team has a brief meeting with the patient. Often family members are invited to attend those, conservators are invited, myself. However, I follow approximately 150 patients and it is hard to attend all those. In addition to the weekly meetings, I have scheduled a monthly utilization review (UR) meeting with the facility where I meet with attending team and take five-ten minutes to review each client's case; progress, including challenges, needs, etc. The facilities have a quarterly meeting (treatment conference) to review the last three-months with the attending team, social workers and the disciplinary team; conservators are invited and usually present. If there is family involvement, they are definitely encouraged to be present and actively participate in that meeting. With ZOOM, I continue to have UR Monthly meetings with the attending team. It is a little more difficult to meet on ZOOM one-on-one with clients at this point, but definitely participate in a quarterly meeting with the client and have more one-on-one.
- (Cmsr. B. Serwin) The nature of your visits is all client focused. It is not going out to a facility, but client focused.
  (RESPONSE) I need to ensure I walk the facility; everyone knows me by name, I perform checks for hygiene, infection control, safety and such. I asses all that and ensure medical needs are met, annual checks (mammograms, podiatry, etc.). I do check facility standards and ensure Title 22 codes and regulations are being met.
- (Stephanie Regular) You are meeting with the clients every three weeks? Is that just the individuals in the locked facilities? Wondering how you are meeting with 150 people every three weeks. (RESPONSE) I perform site visits (before COVID). In any given facility, there is approximately ten

clients in the facility. When I perform a site visit, I am there two hours; unless I am there for quarterlies, which sometimes takes 20-30 minutes per client. I am performing 10-minute check-ins with the client and is easily done in a site visit. They will let me know if they had visits from family, I encourage them. I ask if they have had contact with their conservator and if not, I make notes and reach out via email to the conservator 'this client is trying to reach out, can you follow up'. On average, I am able to meet with all clients. I just cover locked facilities. Once they step down, they pass to Jim Grey (prior to him it was Jane Yoo). Then they are connected to System of Care, Case Management, FSPs.

- (Stephanie Regular) The list that Jan Cobaleda-Kegler provided, are those exhaustive lists of placements with exception of the state hospitals? Are individuals placed in Room and Boards for conservatorships? (RESPONSE) Yes, save Psynergy and Everwell are missing. We do not place in room and boards because they are not licensed. The distinction of many of our clients out in the community and receiving services in our clinics, many do live in room and boards but we do not place them.
- (Stephanie Regular) How does the community decide how many placements in contracts with? There is a shortage of beds and it is taking a long-time for our clients to step down because there are not enough placement beds and takes a very long time for them to be placed. CCC only contracts with a certain number of facilities, not the entire number of placement facilities within the state. I am wondering how the county makes the decision which facilities it will contract with and whether or not there is ability to place outside in facilities the county does not contract with so that our clients can be placed in a more expeditious fashion. (RESPONSE: Joe Ortega on behalf of MHRCs) I am on a committee with other counties state-wide (Cal-MHSA). Out of the top five largest counties, CCC is probably the number one county that is contracted with the most locked facilities in the state of California (Crestwood, Telecare and some private). I do participate in stepdown from state-level, as well as locked facilities.
- (Stephanie Regular) We have clients who have waited in jail for the whole length of their wait. (RESPONSE) Jail is a whole different issue. There are barriers within the jail that makes it difficult for us (within the county) to place. This has been shared with Jeff Landau in court multiple times, some of the barriers. The problem is these MHRCs, the majority of our clients that come from jail, the recommendation in court is a locked facility or state level. These facilities are privately owned and have their criteria for level of acceptance within that. Not specific, but review, depending on what they see, it is a challenge to get people in and we have not control of that. Many times, within jail systems, there isn't sufficient mental health services provided and, depending on the law, different things can and cannot happen (with refusal of meds). In jail they can refuse meds at times and they are not completely stable in jail and it is a very risky acceptance for someone bring into a facility that they need to be stabilized prior to admission as they spent time in acute care or in the state hospital and step down to a facility, whereas in jail they are not stabilized. There are a lot of barriers. It is dependent on how the client is currently presenting.
- (Stephanie Regular) I understand CCC contracts with more facilities than many other counties, but how does CC decide how it contracts with

facilities and how many? Is there a cost issue? (RESPONSE, Jan Cobaleda-Kegler) The MHRCs we contract with are in California and provide comprehensive care. The BACs are a different issues. We want to use as many BACs as we can that are in CC. When our folks are ready to leave and come home to be closer to their families, we want them to come back to CC, which plays part in how we choose contracts and what kind of services are provided. Unfortunately, in the past few years, some have closed. Many six-bed have closed. There is this constant change influx. (Joe Ortega) On an annual basis, we review a list of all MHRCs in the state and there are very few we are not contracted with but those are very far away. We prefer they be as close as possible for their family and conservators to visit frequently and be active in their care.

- (Jeff Landau) The list of facilities from the state, and the question of how we choose from the overall list. This had been something I have looked into for clients. Each case is unique, but someone who had been in jail and looking for placement to either a state hospital or an MHRC, in that process looked through only those licensed by the state that are locked facilities, which was the only possibility. BAC was not an option for this client. There are more than 100 different locked facilities, but in the No. California Bay Area, there are many dozens, including Psychiatric Health facilities, acute care hospitals, and many others in the locked category. Knowing that we do contract with other counties, how do we choose our list of ten, or so, from the overall list in Alameda, Contra Costa, etc. (RESPONSE Joe Ortega) I would have to say within a proximity of 300 miles from CCC we are contracted with every MHRC. There are no other MHRC than the 12 or so we are contracted with.
- (Jeff Landau) share screen to clarify list. (Joe Ortega) Jeff, I would just like to say that a lot of the counties, their hosting facilities like Crestwood (Bakersfield) they are dedicated to that county. There is a Creekside facility in Santa Rosa we were contracted with but lost the contract because Sonoma went dedicated and took all those beds. You will see facilities on this list, but they are dedicated to where those facilities are hosted. (Jan Cobaleda-Kegler) To add to what they are saying, there are some counties that have contracted with a provider to operate their own MHRC, example San Francisco, Alameda County and so on. The list you are showing is the list we look over annually. There is a cap on those contracts.
    - (Teresa Pasquini) I have been to almost everyone of those MHRCs over the last 20 years and know them intimately well. I have driven to them often. The question how to make that decision is an excellent one. It is the point of the paper that Lauren and I wrote “Housing that Heals” and I have to disagree that if CCC is the ‘gold star’, it is very sad. There is a human logjam created because there is an inadequate number of beds. It absolutely impacts decision making and based on budgets and is NOT about patient centered care. Do we need more beds? Yes. We talk about going from scarcity to abundance. Everyone is working form a place of scarcity in California. It is how decision making is happening. In terms of the list of BACs, the list has been stagnant for years and is the same list in 2006, 2013, and I believe it is the same list in 1994 when there was an assessment made of what was needed. At that point, 47% were living with their family members. Those family members are likely gone and all of us are

getting old. I appreciate the commission doing site visits, I think in order to make an assessment on where to go, we need to know where our people are and how long they have been there. Are they experiencing the issues that wee mentioned by the family member that spoke at the beginning of the meeting? What is the communication with conservatorship? I am concerned about so many layers of the system right now. It is a broken system. It might look good on paper but it isn't working for many people. I appreciate the commission brought forward some motions at the last commission meeting regarding their goals, I wrote public testimony delivered, I have spoken publicly since then to the Board of Supervisors, and other people. There are multiple reports regarding the level of scarcity in this state. I really encourage CCC to come forward with more data and information on how these placements are working, how effective they are. It is not a matter of just placing someone in a bed. What kind of warm handoff are people getting that are living locked facilities that have been traumatized and place out of counties for many years. Is it just whatever bed is open where they are being placed? My son would rather be homeless than go back to a small BAC. When the county is investing all this money, we should know what places are working well? It is unfortunate that Psynergy and Everwell were left off the list. I am unaware of Everwell because we haven't contracted with them long enough. I have personal experience with Psynergy. There are so many providers that don't know we have contracts with them. There is a gatekeeping issue that is happening. This is another issue we asked respectfully to be considered in some sort of Value Stream Mapping event so we wouldn't be in an adversarial place. It is a priority; it has been a priority for 20 years in CCC. I would urge the commission, when Supervisor Anderson says we have other priorities, please remind her of these reports that have come forward. Please remind her that for years the commission and the stakeholders have put housing as the number one priority for our county and we didn't place housing in solitary cells as a priority or in locked facilities. We want a continuum of care. I have tried for years to be respectful and work in partnership. Don't spend a whole bunch of money for these people to be placed in facilities and then have them fall off the cliff when you bring them back into the community. We need to know how well the BACs are working. Some, I would not even think of putting anyone in. I urge site visits and get data on where things are working well and where they are not. I am not seeing the data coming through. That's what we are hoping to get out of the value stream mapping event. (RESPONSE Jan Cobaleda-Kegler) Please don't apologize, I appreciate your passion, advocacy and voice. You are speaking from your own experience and really appreciate what you are saying. These are tough discussions we need to have. We did add a couple of programs to that BAC list a couple years ago and advocating very strongly to increase our resources for older adults, which we did do. We have an older adult population and they need specialized care, not just for their mental health, but physical health.

- (Teresa Pasquini) I speak a lot about my son, but you all should know I also have an older brother in the system and he lives independently

and has been conserved a couple of times and I understand, he is in his late 60s and so he is approaching that age where I will need to be helping him. Obviously, a population I care about. The list we have does not show the number of beds, how they are being utilized, it doesn't show the decision making. It doesn't show anything. It is this big 'secret' which is what was called out in our paper, respectfully. But right now, I am actually kind of pissed off. I have been doing this for too long, for two decades. It is not okay. It is not just my son; I have advocated for other people who have no family. Decisions made to take them out of Crestwood into a small BAC and face down on the street a couple months later. Thank god they had my phone number to call me. Now they are doing better again. Luck and heroics have got to stop being the way we do things. The process is unknown, that is why we are asking for a Value Stream Mapping Event. So, we can peel away the layers and figure it out as a community. We have all lost trust in the system that is not working.

- (Lauren Retaggliata) I would like to thank Teresa for her comments and enforce in double measure. I have visited many of the BACs on the list and would suggest to the commission I did so, many times Joe was with me, with the MHSA Program and Fiscal review that we, as a commission, set up. Remember you might not need to set special visits because you have the ability to go with the MHSA team when they do their site visit. Ensure you coordinate that way. One good way to track these is to look in the MHSA list, as they have everything listed by Regions of the county and what type of facility. I noticed the list is missing those for the transitional age youth (TAY) and youth. When Teresa and I were out we noticed Calli house, and would like the commission to visit. We have also sent people to St. Vincent School for Boys? What about Fred Finch's Avalon? How are they doing? What do these places look like? Teresa and I were deciding where to visit, we decided we wanted to see Anne Sippi Ranch in the Bakersfield area. NAMI Contra Costa visit in 2001 when trying to do a residential farm. I contacted the facility, told her my name and where I lived. She thought I was 'county' and I said, no I'm not from CCC. She stated there was resident from CCC. When we visited, she did verify there has been a CCC resident in Anne Sippi Ranch under the ARF category. People get lost. In an interview with those that run Family Courtyard, they explained that almost all residents that MHSA pays a stipend for, they originated and were placed there by San Francisco County. They get good care in that facility and have lived there a very long time. We need to keep a better list on exactly who we contact with and find some of these 'lost' people and suggest you make sure you make use of the Program and Fiscal review. Make sure you don't duplicate visits.
- (Joe Ortega). I just wanted to comment that I did not state we are the 'Golden Star' within the state of California. I was given data. I agree there is definitely a shortage of bed and availability. I feel like I have been thrown into the adversarial role. This is our first meeting and I would hope as we work together you will learn my passion and my love for my job. I lived with mental illness, my father was bipolar, a Vietnam Veteran. My mother was mentally ill with depression. I have lived that. Hopefully, as we work together, you understand my

passion and love whom I conserve. Yes, throughout California, I totally agree it is a broken system. They are missing a lot in locked facilities. It is why I have been with CalMHSA, the deputies and directors of counties state-wide, on a project for the last six years to develop an alternate to the state hospital because it is a challenge. It is very difficult. Services versus rates and what we are paying for and to justify the care and to monitor because all the state politics. I would like to speak on my behalf. We do need more beds on all levels, it is a challenge. In the past, if I see that our clients in locked facilities are not receiving the appropriate care, I pull our patients out and I've done that with Telecare. I did that for two years with Villa Fairmont, until they received a new administrator and developed another relationship. Crestwood in Vallejo, we pulled everyone out for two years because they were not receiving care. I know you are frustrated Teresa. I love the passion of all the commissioners. I am in the same boat. If we had the funds and availability, I would want to do my own MHRC. We are missing in those facilities by far.

- (Cmsr. G. Swirsding) Two questions/points. I am from District 1. Why are there those in facilities from other counties? If we have a shortage of beds and we are having trouble placing them in our county, why are there those in our facilities from other counties? Second point. We lost a very dear friend. He had schizophrenia and was living in a BAC facility. There is no one to watch over night. There are administrators during the day, but gone at night. This young man walked out, got hit by a car and was killed. Why was there no one to watch him overnight? What are the criteria for placing someone with severe mental illness such as this in a facility with overnight staff versus no overnight staffing? (Jan Cobaleda-Kegler) You are raising a big question; it is a big issue and not easily solved. In BHS, we have access to crisis residential. Before COVID, there were (are) strict rules how long someone can be there. The goal is to get them back to the community and prior to COVID, we used them for people leaving the hospital but could also community placement. Once COVID started, we have not been able to use the crisis residential for people from the community, only from the hospital. Even so, they have to be cooperative taking medication, walk on their own and take care of themselves. They are monitored in those places. There are many facilities that are not licensed or regulated by the state.
- (Lynda Kaufmann) There is no greater in California for BACs than me for the last 18 years. In speaking with consumers during the commission site visits, every fall and spring, the Dept of Health Care Services (DHCS) conducts a Consumer Satisfaction Report. Before you go out, it would be nice if you were able to review those. It is from the clients perspective regarding that particular provider, as well as their quality of life. I don't recall if CCC has that extra addendum for quality of life. It is in three parts: Adult, Older Adult, Quality of Life.
- (Cmsr. L. May) I would like to add that a lot of these facilities do have night staff. However, the night staff are not working. I have had the ambulance company call me stating they have been trying to access the facility for the last 20 minutes and I had to drive to the facility. Once I started to beat on the door, they finally answered. They were back in a lounge in a different part of the facility. This is why there are

people walking out of facilities. There is no one there to monitor. There should be some surprise visits. ▪ (Cmsr. B. Serwin) Back to the issue of the cap on the number of beds we contract with at a given facility. Do we commit to a certain number of beds, whether filled or not? (RESPONSE) It is dependent on the contract. Pleasant Hill Oasis, we contract for 25 beds. There is a waitlist and we work to get people in. Psynergy, there is a specific amount of dollars in the contract that only gives us a certain amount of placement. Crestwood is a large contract with many facilities, different types (MHRCs, Skilled nursing, ARFs) that contract has an amount limit. We work within that amount limit to have a certain amount of beds in every program. We try to keep them close to home; however, they may need to be placed across the state in their other facilities.	
VII. Adjourned at 5:34 pm.	