QUALITY OF CARE COMMITTEE MEETING
MINUTES
August 19, 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 @3:33 pm. Members Present: Chair- Cmsr. Barbara Serwin, District II Cmsr. Laura Griffin, District V Cmsr. Leslie May, District V Cmsr. Gina Swirsding, District I Other Attendees: Cmsr. Alana Russaw, District IV Angela Beck Carolyn Goldstein-Hidalgo Lynda Kauffman Lucy E. Nelson Teresa Pasquini Lauren Rettagliata	Meeting was held via Zoom platform
II. PUBLIC COMMENTS– None.	
III. COMMISSIONERS COMMENTS – None.	
IV. CHAIR COMMENTS – None.	
V. APPROVE minutes from the August 19, 2021, Quality-of-Care Committee Meeting. • Cmsr. Leslie May moved to approve the minutes as written. Seconded by Cmsr. Laura Griffin. • Vote: 4-0-0 Ayes: B. Serwin (Chair), L. Griffin, L. May and G. Swirsding. Abstain: none	**Agendas and minutes can be found at:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. DISCUSS Site Visit Program updates and upcoming steps: ➢ Commission site assignments: Everyone has been assigned, refer to Site Visit Assignment email, dated 8/6/2021 5:32PM. ➢ Commissioner site visit training on September 1st, 2021: Commissioner Site Visit Training will be held before the next Commission meeting on September 6th (3:00pm). Angela, Cmsr May, Griffin and I spent quite a significant amount of time working through the table of contents for the training. It is worked out on a detailed level; most content is developed and some must be written from scratch. We are in process of preparing the presentation for training. ➢ Prioritization of proposed site visit elements, including site visit client perspective, staff perspective, family member perspective, evaluation of	

grievances, evaluation of contracted objectives and targets, scope to include non-licensed board and cares, children's / adolescent site visits:
There are enough sites and commissioners to match all sites up and we are in a good place. Right now, it is about prioritizing additional features of the site visits. We started out with a total consumer perspective. We were going to really limit the goal to interviewing the consumer and, in the case of children and adolescent, also the family member. Moving forward in that process, we decided we should interview the program director and a few program staff and kept going back to the idea of touring the site. It feels like we can't do a site visit without touring the site. This sounds obvious, but San Francisco's program (which we modeled this program after) did not really speak to facility tours. We have evolved from the consumers to adding the program staff members and a physical site tour. Since then, there has been a lot of other elements that have been raised by other commissioners and members of the public. We need to decide if we want to cover these elements and how do we prioritize them.

The most recent we have committed to are the evaluation of the contracts, the objectives and targets in the contracts and that seems to come up over and over again, as a high priority. The others that have come up (in no particular order) are family member perspectives (i.e., evaluation of grievances), researching of those grievances before going to the site and taking into account outstanding grievances. There is a website that Commissioner May has brought to our attention where people can file grievances at the state level. You go to this database, input the site to receive any outstanding grievances and how want to build that in as a step.

Do we want the scope to include non-licensed Board and Cares (BAC), as we have many clients living in non-licensed BACs? We have the question of children and adolescent site visits. This has always been considered something we would roll out the same time we were doing adult sites. The Site Visit Planning (SVP) Team met with Gerold Leonicker, Program Chief of Children/Adolescent Division, BHS and he raised several issues we really need to think through/figure out best way to approach in terms of privacy, etc. There are a lot of elements to consider. We decided to put it aside temporarily, we are still committed to this, but we are going to roll out the adult program first.

We have committed to, but not written documentation for (or fully thought through), evaluation of contracts. We do have it in our current plans and in our training program TOC. What I would like to do in this meeting, is take a few minutes after we have spoken to priorities and go through/create a checklist for contract reviews. List of the top five things we are looking for in the contract review. We are fully committed to this, and these other issues: the evaluation of grievances; the scope to include non-licensed BACs; family member perspective. What do people feel about the relative priorities? These are all important, it is just the order we tackle these items.

- (Cmsr. Leslie May) My first comment is regarding speaking with Gerold Leonicker and bringing up that there are so many issues with this. I don't believe there is. I have worked at places with youth where we received permission from the primary care giver (parent, step- or foster parent, whomever it was) that signed on stating the youth could be in the survey. I really of tired of this whole thing (playing games), when those flags come and raise issues like that, it makes me think "What are you hiding"

and I want to see the kids rolled at the beginning of the years. This is ridiculous. We want to focus on children.

My second issue is unlicensed care. I did not realize the county gives money for unlicensed care. If that is the case, I must protest against that, because if you are unlicensed, you don't have to follow anyone rules but your own. I am thinking to a lot of these care homes where elderly have dementia and Alzheimer's. I think many are unlicensed. We just recently had little man missing from here (East County) and said he was in wheelchair. We all looked for him. The last time he was seen was 7:30am. The ended up finding him three or four days later in Los Angeles. How did he get to Los Angeles?
(RESPONSE: Cmsr. Serwin) This may be me having misspoken, but you are right, these are non-licensed BACs and the county has stated we don't contract with them and we have no influence over the situation in these BACs. At the same time, we know we have a lot of people there. So, does the commission have an interest in visiting any of them? And if so, what is our interest and hope to accomplish with visiting.
(Lauren Rettagliata) I understand where Cmsr. May is coming from and it is so sad so many people are placed in BACs. There are some very good BACs for six people. Community Care Licensing (CCL), the people that come out and look, they are just looking to see if the refrigerator has food, hot running water, they are not getting to the heart of the matter of people with mental illness or behavior health problems. It is entirely different. Adult residential facilities are different and I don't have the guidance you need on this. I would spend your time where you think you have the absolute guidance. Possibly getting information from Gerold. I just don't know how large of a problem this is on the children's end and it sounds like Leslie has a lot more information that I do. My understanding is for adults and those facilities.

(Cmsr. May) Are they even accredited by CARF (Commission on Accreditation of Rehabilitation Facilities)? It just seems to me they can't be accredited by them if they are not licensed. (RESPONSE: Cmsr. Serwin) I hear what you are saying about the Children/Adolescent site visits being important and wanting to take a second look at the barriers and, if in fact, we have the ability to work around them.

(Lauren Rettagliata) In regard to the Children/Adolescents, can you go target the provider? It is a larger provider, and that provider is who would provide entry into visiting and request that you see what you would like to verify: housing, childcare. I would assume visits are targeted to your larger providers.

(Lucy Nelson) I have had a question, my role as a family services coordinator in Children's mental health and is this the meeting I should be involved in? (Cmsr. Serwin) There is a full commission meeting once a month (first Wednesday of the month) and covers a broad range of issues currently with the MHC, which is of general interest to everyone. The topics change and there may or may not be a children's issue on the agenda, but that would be the meeting you want to attend. Then there are standing committees, one regarding finance, another is Justice Systems and this one – Quality of Care. There used to be committees based on age (older adults, adults and children and adolescents). We are no longer organized that way. If we were, then obviously you would want to go to that children's standing committee meeting. Each committee will

address children's issues, but not necessarily every month. As a site visit, we will be visiting a children's center, or Justice Systems is looking at issues at juvenile detention. It really depends on the issue each committee is addressing that month. The best thing to do is to take a look at the agenda when posted to see if there is a topic of interest. You can always reach out to the committee chair or the chair of the commission to ask about particular issues or inquire on issue we could bring to a meeting.

(Cmsr. Swirsding) The older adult and children was through CPAW, not the commission. (RESPONSE: Cmsr. Serwin) I thought quite a long time ago, we also had committees designed that way.

- (Cmsr. Griffin) I think it is really important for us to pick up on the children site visits, I agree with Cmsr May, at the beginning of the year. That should be our priority. As far as the priorities, issues sited regarding what we should tackle or add to our evaluation when conducting site visits, I think the evaluation of grievances, in addition to the contract valuations, is really important. It would be great to go in and know ahead of time if there are contract issues or any grievances filed.

  (Cmsr. Serwin) Let's spend a few minutes on contracts. There are two things I would like to get everyone's input on. One is a contract checklist, initial brainstorming. Also, a checklist for the actual physical site visit. If you were a commission going into a site visit, and you have a checklist of what to look for, what would they be?

<u>Contract Checklist</u>

What are they contracted to do? What is the scope of their work? If there are any matrices associated with the work: number of clients to serve, or anything that is spelled out (data), the amount of the contract. What would be important to have on that list?

(Cmsr. Griffin) If the contract is expired, what the calendar term is of the contract. How often the contract is reviewed. If the contract shows the services to be provided. (Lauren Rettagliata) The contracts are quite boiler plate for everyone and you can view them anytime as a commissioner. If you go the agenda for the Board of Supervisors, they will have the contracts there. Sometimes the contracts are lumped together. Example: Crestwood, you will find $8mil-$9mil as the contract will have a number of different locations on that contract. Once you review the contracts, you will see they are 'boiler plate' and many are extended for twelve months and read it is extended for another six months. I don't believe you will need to worry about any working on an expired contract, because our county will not pay out money, unless the contract is in place. What the agency does with the money after receiving, that is an entirely different question and that is where you will find out, the question isn't really between the county and the provider, it is looking at their accounting of where they are spending their money. They are granted a specific amount of money and look at their budget and the accounting of where they are spending that money.

(Cmsr. Serwin) This group is specifically carved out the licensing, utilization, financials as something we are not addressing. We are leaving that to the state and the county. We are looking at the contract, more from a quality-of-care perspective. This is what is stated you will provide, are you really providing these services? I this provider doing what they said they would do for this client?

- (Cmsr. May) I just attended a meeting by Congressmen DeSaulnier and spoke to mental health, but also spoke to children receiving services. Children are the most affected by COVID and the shutdown, etc. We need to start thinking ahead. This is what is being pushed for with the $3bil, pushing for more integration of children with mental disorders. We need to plan ahead, as it is coming down the pipeline.
  (RESPONSE: Cmsr. Serwin) this will be a good topic of discussion at our retreat.

<u>Physical Site Visit Checklist:</u>

- (Cmsr. May) The condition of the facility: the type of floor, furnishings. Is it clean? Is the furniture worn, the floors safe? How many people to a room? That is really important (privacy, adequate physical space) and the conditions of the rooms because most of these facilities, they have clients/patients are supposed to straighten and clean up their rooms every day. If you get a room that you can tell hasn't been cleaned, we want to look at these things. Look at the condition of the kitchen, the refrigerator, the stove, as well as the laundry area and appliances. Clean and in good working order. Heating and Air condition (HVAC) system is it working and in good condition?

  Bathroom, kitchen, bedrooms, common areas – cleanliness, light and air quality.
- (Lauren Rettagliata) I was thinking you should have a simpler checklist and you could actually use the adaption of the Institute of Medicine (IOM) checklist, and it is in the Housing That Heals paper and there are six items that you look at when you evaluate a facility (i.e., Is it safe? Is it secure? Is it family / patient oriented?). Lynda Kauffman (Synergy) may have a checklist, as well. They have to ensure their facilities meet all the guidelines.
- (Lynda Kauffman) I could email you the checklist that the CCL looks for because I don't expect your visits going around with a temperature gauge to ensure you are between certain degrees and things such as that, but I think it is good to use as a baseline. Know what the standards are that we are expected to meet and take it from there. I will send the checklists to you.

➢ Preparing administratively for initial site visits:
Blessed Care Home is the first site we are visiting in Pittsburg. We need to get this set up with all the flyers and notices. The Site Visit team is slated to be Commissioner Russaw and Commissioner Metro with Commissioner May as the Mentor.

VII. DISCUSS questions regarding aspects of treatment beds in the County system, including where they are located, how many there are, how they are assigned.

We need to brainstorm who we need to be talking to and what questions do we need to ask in order to ensure our county has access to an adequate number of appropriate in patient treatment beds and housing placements for our seriously mentally ill population. This is a huge issue that Teresa Pasquini and Lauren Rettagliata have been working on for a very long time and really brought to the foreground through the Housing That Heals paper they wrote and the paper the MHC voted to support in any way we can. We are at a point where we are not rolling off the site visit programs but have gotten far enough along that we can

continue and start off another major project. This is the project we should be working on. I want to start this out by brainstorming our line of questioning.

(Document shared on screen by Commissioner Barbara Serwin).
To give some structure to what it is we are trying to accomplish and our possible strategy, I have put together this document and would like to start building a list of questions to research, staff to interview and non-staff as well. Then I have a couple of important emails from Lauren Rettagliata, with some history, and additional questions. Along with an email that was sent to Dr. Tavano in August of 2019 asking the same questions, which we still do not have answers to yet. This challenge of a problem statements, I am curious if there is anything we should modify for accuracy and to accomplish our objectives. I focus on that we have access to an adequate number of appropriate beds and housing placements but not commenting on the adequate numbers. Maybe there is a quality aspect, but it seems to be when I hear people speaking to this, we don't have enough.

We need to ensure our problem statement ensures it really is what we are after.

The committee, as part of this commission, has the unique opportunity to interview county staff and other people responsible for managing the county's network of inpatient treatment beds and housing placements. They need to come and talk with us. They may not want to, but they need to, so we could ask those questions they may ignore if they received from the public. In terms of scope, I want to point out we are addressing inpatient treatment beds and housing placements in acute to sub-acute facilities and homes. We are talking about the entire continuum.

We want to map out all treatment beds and housing placements used by the county. Then determine where all the clients who use specialty mental health services are housed. Which placements do we use and where is everyone? What isn't there is clients that need these services and beds and aren't housed.

- How do we identify individuals who need a bed?
- How do we select which individuals will actually get a bed, including establishing criteria and trade-offs?
- How do we define/determine what kind of bed (level of service) that they need?
- How do we determine which bed individuals will actually be assigned to as they move through the continuum of care, including establishing criteria?
- How do we decide how long an individual will stay in a given bed, including establishing criteria?
- How do we determine how many beds the county will have access to -- county owned and operated and contracted out?
- What are all of the beds currently in use?
- What beds to we have access to or available that we currently don't make use of?
- What are the key barriers to providing an appropriate bed to every individual who needs one at any given point in time?
- Who is accountable for each of the decisions that are made in providing a bed with treatment to individuals?

There is a group of people determining this, they have a system for deciding who is going where and how long they are staying, but it not crystal clear to anyone I have ever spoken to. From this, we need to understand the county's current deficit and needs and its future needs for these beds and placements. We know

there is a deficit and how are we going to determine this? How will we project the future needs?

Broader questions:

- How do we best organize to optimally provide Housing That Heals?
- How much Housing That Heals are we lacking?
- How can we grow Housing That Heals to keep up with demand?

STAFF to interview:

- Director of BHS
- Deputy Director of Behavioral Health (over Conservatorship at present)
- Chief of Adult Division
- Chief of the Children's Division
- New Housing position – Kennisha Johnson
- CFO of BHS
- There's a role(s) at PES -- I don't know the name of it
- Chief psychiatrists for 4C and 4D
- Program Directors at Hope House, Niereka House, Crestwood, etc.
- Who else at the hospital?
- Who else has a role?

Ultimately, CBO's to interview:

- Directors
- Staff

Questions and Comments:

- (Teresa Pasquini) I love all the work you have done and the thought you put into this. This is a great start. It is up to the committee to decide the approach, but I would like to go back to those reports and have the committee ground itself in some history on this and remind the committee of these reports over the years. When you are speaking to mapping out all the treatment places, knowing where they are…I will remind you we had a slide that shows a placement tree the county was using a couple of years ago. We still have this, but how much has it changed? Has it changed at all? This is another question to ask.

  Quality is critical. I know those of you that some of the pictures sent out recently, this points to lacking quality. Cockroaches in bathrooms and kitchens are ongoing and not acceptable. For me, it is not just a bed, it is a bed that you would want to put your loved one. We can't ignore quality. The Housing that Heals vision is about both. I would ask that be added.

  We pride ourselves on being data driven and quality improvement driven, but this is a very non-transparent process and it always has been. I assume no one wants the light shined on this because I don't see a lot of willingness to participate. I just want to thank you for pushing through and agree with all your opening comments. This is something we have to talk about and find out where are people going? I was stunned when I read minutes from the innovation committee recently. There were four or five BACs have closed or are about to close in Contra Costa County. Those were from May. I don't recall that information coming forward to the commission in any committee meeting. I was stunned as I was reading those minutes. That is everything we have been talking about is beds closing, losing beds. What is happening to those people?

  One last thing, there was work done by San Francisco. I almost positive we cited in our paper, but we can get you a link and a bed optimization

report. It is just a really good report to look at what San Francisco (SF) hired analysts for, to do a very in-depth report, and the outcome of that report. I remember getting it and being impressed and sending it off to our county leaders and not hearing anything back. This was done by Dr. Antone Bland, the former chief psychiatrist at Contra Costa Regional Medical Center (CCRMC) and he is now in SF and was the czar that Mayor Breed appointed to lead their transformation (pre-COVID), but this report was done. You have to be crystal clear on the target population you are focusing on this. Otherwise, it will be too large. We targeted in on the specialty mental health population. Those going to IMDs, on conservatorship, sitting in jail waiting for state hospital beds.

- (Cmsr. Gina Swirsding) Pre-COVID, I would visit homeless camps. Some of these patients lost their benefits due to not cooperating, being on drugs, not following the rules where they were placed. As a consequence, they lost their benefits and they wouldn't take you if you had an addiction. (T. Pasquini) Specialty mental health used to exclude primary substance use and that is not the case anymore. There is an historical lack of services and beds for that population. I think we acknowledge that in our paper. What is the need?
- (Cmsr. Serwin) We can get a concise list of historical and current documents/reports we should review and I can take a pass and get input on the key things we need to look at. (Teresa Pasquini) My concern the committee getting blocked and months of inviting people and no one showing up to answer these questions. I remember going through the this, Cmsr. Stern pushed pretty hard trying to get some answers and there being roadblocks. (Cmsr. Serwin) I suspect there will be, I have already received my first one. That was when I asked Dr. Tavano and Kennisha Johnson to attend this meeting to do the brainstorming, I was told they are very busy with public health and grant applications. I have been thinking about my response to that and public health is very important, but so is mental health and that is our number one priority. (Teresa Pasquini) This population is one of the highest risks in public health. This is one of the greatest health disparity populations. We can't wait for everything to get fixed before we continue to ask these questions. So again, thank you for pursuing it and I do think it is important to think how to get information.
- (Cmsr. Serwin) what I do want to add is a section of what we do know, what we do have information on, so we are not reinventing the wheel. (Teresa Pasquini) That was the one document we used that shows the arrows going every which way. I know we have added Synergy, Everwell, but it gave an impression of what happens at the bed committee every Tuesday or whatever day they do it now. That was a visual to start with and we use it in all of our PowerPoint presentations, we used it when we presented to Kern County last night.
- (Cmsr. Griffin) We need this so badly. It is focused on adults. Have we ever looked at the children/adolescents on this? Beds for children in our county. I know that is a big problem. (Teresa Pasquini) We focused only on adults. We all know the children's beds are a big issue too - locally, statewide and nationally. Other than what the children's committee and the work done around PES, I know there was a report in the last couple of years regarding the bed optimization for children, but our report did not focus on children.

- (Cmsr. Swirsding) I know some of our patients, from this county, go to Herrick and have an inpatient for children. I am aware of this. They have a whole children section and I did ask if they were CCC population. I do know the population and the program at Herrick has increased. What about at John Muir? (Teresa Pasquini) Yes.
- (Cmsr. Griffin) This is something we should take a look at. It is critical/crucial for us to look into this. I do know those at John Muir get sent right back to PES if they don't have insurance. They do not take MediCAL, they get sent back to PES and held there. I think it is dire and we really need to do something about the kids, in addition to the adults. (Cmsr. Serwin) We can start with the Adults and then probably would be in a much better position to move into the kids. (Teresa Pasquini) I agree with you wholeheartedly, and I think children is the focus of local, state and national. Everyone is focused on kids right now and prevention and all that, and I totally agree with that but Lauren and I really wanted the commission to recognize – we have literally heard people in state meeting state, 'well there isn't anything we can do about this generation' and that is unacceptable. Sorry, but our kids are NOT throw away kids.
- (Cmsr. Leslie May) What is the rate of recidivism? How many times? Some of these places, it is revolving doors. Someone leaves and two days later, they are back. Someone leaves, three days later, a week later they are back. What is the recidivism rate? We want to know because a lot of these clients don't want to go to places like Hope House because there is structure (and rules), so they are refusing to go to Hope House and just send them to BACs or somewhere because they refuse to go to these other places. We need someone at the state level, a congress person, to lobby for that because this is ridiculous that a person can choose where they want to go and go in for a 'hot minute' and keep going back. If you have someone that has been in two different places a total of fourteen times in three months, then there is an issue there. How much they are taking up a bed for someone that really needs it. (Teresa Pasquini) I agree completely. That's what we wanted to know. Are people getting placed it the right places? Are they just going to any open bed? How successful is it? How many successful placements are we having? We talk about client choice, but they don't have a choice.
- (Lauren Rettagliata) They already have this data. I don't know why they aren't getting it to you right away because it is already there. They actually know how many people are at the state hospital, how many people are each of the IMDs, and have been sent to the different contracted providers. They know this. The last physical read out I have is from 2015. I believe Cmsr. Dunn has one that is quite recent about where everyone is, how long they have been there and how much it costs per day. It will have Napa, Metro, Atascadero, Villa Fairmont, California Psychiatric Transitions, Crestwood, Angwin. It will have all those, how many people we have there and how long they have been there and how much it costs. They have the information and can get that to you. Laura, I really would ask you to contact Gerold Loenicker and talk to him. He will definitely speak to you. He is the head of Children's MH. There are laws that have changed recently for children. They used to be able to stay in these larger facilities but now the state has changed the laws and how we house children, where they cannot stay with a family or with a foster family, the type of housing they can be in…that has all changed. We do have some contracts out there with some larger facilities such as

Saint Vincent's Boys Home. Gerold knows where the children are. If they don't have that information, maybe this committee will actually be the committee that gets them to document it so there is a document that readily shows the number of children diagnosed and where they are. (Cmsr. Griffin) Is that something I can pursue? Thank you.

- (Teresa Pasquini) The bed committee convenes (I am unaware who is on this any longer) but they get calls from the hospitals and are told which patients need what type of bed and services, there are case managers and conservators, make pitches/present their case on each client and the services and level of care they need. They look at all these patients, their needs, where they have been and how long/how many times. As well as if they have asked facilities to take the patient and if they refused, where can this person go? Where is the patient now and for how long? Are they at a level of care they no longer needs? How long have they been waiting? How expensive is that? Who is paying for that? What is the cost of not having access to the correct bed? How much are we spending for inappropriate or non-action? Also, the out of county placements, how many people are out of county? How far are they going? How far are their families going? Especially the children.
- (Lauren Rettagliata) If we want to know where people are being placed and housed, along with Hope House and Niereka House, to ask our FSP where their people and our AOT providers and where their people are, as these are the larger contracts we have in our county. Now with Project Home Key, we have over 250 plus people, many are seriously mentally ill, where is the case management? Where are these peoples next step? We have Project Room Key, Project Home Key and we also need to ask about the shelters? We have shelters that are county run, we have Trinity and faith-based run. People are actually in our specialty mental health system but 211 may have placed them at Trinity Shelter in Walnut Creek, that's not a county run, but we probably need to be looking at coordinated entry through 211 and where they are going. (Teresa Pasquini) The email with this information is pulled up and it is a comprehensive list. (Cmsr. Serwin) Does this email jog any questions? If there anything we need to add?
- (Cmsr. Serwin) Let's end the meeting with the list of documents and reports we need to gather. (Lauren Rettagliata) At the end of the last finance meeting they had asked BHS for a request for knowledge on items and had given them a few weeks and did not answer them. They actually put it in a motion that will go to the Executive Committee that will become a motion of the MHC, so that you can get this list to be presented at the Executive Committee meeting, it can be placed as a motion to the MHC and do a formal ask. (Cmsr. Serwin) That's very interesting. I don't like that idea. We shouldn't have to do that. Absolutely not. By doing that, it is like pulling out a bigger gun and we shouldn't have to have any guns out. I will work on that one.
  (Lauren Rettagliata) I agree. Maybe another month, at what point do we get an answer? (Cmsr. Serwin) My perspective, is breaking it down, getting these questions organized so that it is broken down and doing it bite by bite. I think we are not going to get a big complete report, we will be getting pieces of this information to put together.
- (Teresa Pasquini) I agree. I was on the IST group and Doug made a public comment, I know his focus is on that population, which is critical. So there is time urgency. Not that there isn't time urgency here, but I do

think that whatever data is being gathered in that committee, there should be some collaboration. I know Doug's public comment was to expect 100 or so, I'm unaware but he has some data that should be shared. Also, what run charts, what reports are being used? We know from the Value Stream Mapping that there is access to data, this is county is not completely flying blind and someone has access to this information. If they don't, what are we missing? It is frustrating, again, I made this list with Lauren and this was two years ago. I have a few emails I will cull through to see if there are further questions I can share. These are questions that have been asked, and we showed the timeline in our PowerPoint. We have a timeline of key reports for over 20 years, I believe. The SF report was a template that any county can use and we shared it with the top level of the health administration. Said "Wow, look at this" and crickets. I will get a list together for you after the meeting. There is data because they have to provide it to the state. What reports are going to the state? What are we getting? I would remind you all, there was a very important meeting that Justice Systems held with Linda Arzio (Manager of Conservatorship) and she gave a pretty good report to Cmsr Stern's meeting, ten pages of notes, giving a lot of good information. It wasn't data, but it was pretty thorough. That is another document to look at.	
VIII. Adjourned at 5:30 pm.	