MENTAL HEALTH COMMISSION
QUALITY OF CARE COMMITTEE MEETING MINUTES
November 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 @3:34 pm. <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, Program Chief, Adult/Older Adult, Behavioral Health Services Kennisha Johnson, Chief of Housing Services, Behavioral Health Services <u>Other Attendees:</u> Angela Beck Jennifer Bruggeman Treva Hadden Teresa Pasquini Lauren Rettagliata	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: • (Lauren Rettagliata) Thank you to past Behavioral Health Administrator and now working with Health Services, Vic Montoya who called our family last night just to check in and say "How are you doing? I know how tough it is to be a family member who doesn't know where there loved one is, what they're up to and doing." It was Vic who brought me to my first bed committee. I was able to see the innerworkings of the bed committee. He held Jan's job many years before moving on to the hospital. I have met so many good people in Behavioral Health Administration and many are on the call today. I have never met anyone who's intentions were no the very best. There are bad things that happen, but those out there with us, the family members, they are using trying their best for ours and I appreciate that.	
III. COMMISSIONERS COMMENTS: • (Cmsr. Leslie May) Report out that I attended Shelter, Inc.'s 35th Birthday Celebration yesterday evening. It was really nice. It was a fundraiser as well. It was a really wonderful experience and Supervisor Michoff presented them with a proclamation from Contra Costa County (CCC) Board of Supervisors (BoS). They received so many different awards. I don't know what their goals in terms of fundraising, but I threw my hat in the ring first. It was really nice. I just encourage everyone to try attend these functions if you get wind of them, you can see what they have actually been doing. There are numerous powerpoints they showed. It moved so quickly but it was really nice.	
IV. CHAIR COMMENTS – None.	

V. APPROVE minutes from the October 21, 2021 Quality-of-Care Committee Meeting. Corrections: Spelling of Sentator Eggman's name correction, BACS (vs) B&Cs, and corrected spelling of Psynergy. • Cmsr. L. May moved to approve the minutes with corrections. 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 status of Site Visit Program ➢ Scheduling ➢ Project Management ➢ Process/Documentations for small board and cares	Moved to SVP Team meeting next week
VII. DISCUSS purpose, organization and operations of the Behavioral Health Services (BHS) Bed Review Committee; Jan Cobaleda-Kegler, Mental Health Program Chief, Adult/Older Adult Behavioral Health, BHS and Kennisha Johnson, Mental Health Program Chief of Housing Services The Bed Review Committee meets weekly. It has multiple agendas. We redesigned the format and still do the same thing but we designed the structure of how we organize it. This new format is more inclusive and involves the whole team. Prior to COVID, Bed review happened in person every week and met up here in Administration in the big conference room. All the managers and supervisors of the Adult system, as well as staff from the hospital. When COVID protocols were put in place, we switched to Zoom and using this format for quite some time. As everyone knows, it has its strenghth and weaknesses. The good thing about Zoom is it allowed us to continue to work together to coordinate care, because that really is the whole purpose. We come together once a week and talk about our clients who have landed in our highest level of care which is the acute inpatient hospital setting. Every morning, we have a morning report that goes out to the members of the bed review committee to notify people who was in PES (Psych Emergency Services) last night, who is on the unit at Contra Costa Regional Medical Center (CCRMC) in 4C/4D and any outside contracted hospitals. This is a rapid phenomena when someone is hospitalized. Some are in the hospital for one or two days and others longer. It is dependent on a variety of reasons. The informaiton is important to be sent out to all the providers in our system of care. That information goes to the clinics and there is a person in the clinic who is responsible to notify providers in the clinic that their client was at PES last night and admitted to 4C this morning or they are not admitted yet, just to give a status to the doctor and to the case manager and/or therapist. So that is a daily morning report. Once a week week, we meet for bed review. We not only changed the format, we went from zoom to Teams (Microsoft Teams) and we meet Thursday mornings (rather than Tuesday mornings). Now the members of the team can log in to the team sight and have access to information that is relevant to that team. We worked as a group to develop a comprehensive system with an excel spreadsheet type of map that has current patients in 4C and those who have been discharged as well as a list of other health insurance patients. Sometime those patients are in different parts of our system (i.e., the insured might have	

an assisted outpatient treatment). We do keep a log of those folks as well as others who may be conserved. We developed this format of sharing information with our partner at the hospital. The psychiatrists, social workers and nurses are providing intensive care for our clients and there is a certain point where it's time for the cients to leave and the hospital needs to coordinate with us to come up with a viable discharge plan. That is really what happens at bed review every Thursday morning. First we review the 4C/4D patients and then review the patients in our outside contracted hospital. It is very intense driven meeting where people are prepared and keep track of the presenting problem, current status and the disposition. That is about an hour and a half to get through all the clients. We also have clients that are more complicated, on the unit where the team needs to take extra time to conference and come up with a viable treatment plan. It is not something that can be done in the five minutes at bed review. Those clients get scheduled in the 'clients for further discussion' file in teams. Those that have complex issues and might need more thoughtful, careful, discharge planning. When we review patients in the outside contracted hospitals. We use John Muir (Concord), Herrick Hospital (Berkeley), and different hospitals in California (Sierra Vista and others in Sacremento), it just depends on where some of our beneficiaries show up in certain emergency rooms where they might need psychiatric care. Sometimes we have clients in a hospital down south. Main contract hospitals we use are John Muir and Herrick. The use of those outside hospitals goes up and down. The planning when we opened the second unit at CCRMC (4D), the hope was to reduce the use of those outside hospitals. However, depending on the community, the need goes up and down. Discharge planning from the hosptial looks at several criteria: What brought the client in? What are their needs? How they doing on the unit? What is the best discharge plan? Many clients want to go home to their families and plan for that. The most important focus is to ensure they have follow up appointments with our clinics so that when they go home, they also have follow up appointments in the clinic. Those need to be seven (7) days from the discharge from the hospital. There are some clients that are not quite ready to go home and that is where crisis residental comes in. We have Nierika House and Hope House that we use for crisis residential purposes. Those are step downs from the hospital and those folks have one to two weeks of time available in crisis residential before they go back out to the community, to a Board and Care placement or to family. There are a handful of clients in the hospital that are waiting to go locked mental health rehabilitation centers (MHRCs), long-term locked care and/or waiting to go to specialized enhanced board and care placements (Psynergy, Everwell, Crestwood Our House, etc.). The challenge with the MHRCs, the locked long-term care facilities is that those are competing with many other counties in the state for those beds and we are always working to get those people into those beds as quickly as we can to make room for people in the hospital so the beds in the hospital stay open. Those in the locked facilities, as they get better, we work on stepping them down to the community back to enhanced board and cares (Kennisha). We are all working together as a team. I chair the meeting with a review of the hospital patients and move on to the next level and check in our crisis residental liaison (Betsy Orme and Hazel Lee) and they coordinate with all these hospitals for all these patients going from those hospitals to those crisis residential facilities, both coordinate going in and	

getting discharged. We can't tackle everything every week, so it has been broken up to the first and third Thursdays of the month and move into reviewing our boar and care patients where we review the large and small enhanced board and cares. Kennisha and Jim Grey oversee that database. That is where we review each board and care, how many beds are open, who is waiting to get in, who has been accepted, etc.

The second and fourth Thursday of the month is reserved for MHRC stepdown list and our detention LPS clients (all clients in conservatorship) and require planning and case management, how are we going step them down, what are our options. That is Joe Ortega is the IMD/MHRC long term care liaison and oversees all the admissions and coordinates with Linda Arzio, the conservatorship manager who both report to Matthew Luu who also attends the meetings.

Also on the first Thursday of the month we include Crestwood Pleasant Hill, they join in on the last part of the board and care meeting to coordinate and collaborate on mutual clients we all share.

(Kennisha Johnson) Just to add a bit more of Jim (Grey's) role and his oversight of the board and cares on a daily basis. Jim Grey is the active housing services coordinator and he is the point person liaison for all the board and care operators and manages all the referrals into board and cares, so he is in bed review every week and responds to questions from management staff, doctors, social workers around availability and program ability to manage the various clients and appropriate placement ideas. He receives referrals every day from the clinics throughout the county. If anyone feels their client is a good fit for a board and care, they send the referral to Jim with all the documentation required and Jim works with the board and care operators and sends the referrals out. There are also referrals from FSP clients that need another level of support and he advocates and coordinates for all those clients in the facilities / programs. He also manages a waiting list on a share drive in our system that all the managers and supervisors have access to it at any point and time, so they don't have to wait until bed review to know what is available.

Questions and Comments:

- (Lauren Rettagliata) Those that may not make it to 4C/4D but are in PES, many who are full service partnership (FSP) between the assisted outpatient treatment (AOT) the emergency room has been cleared up, what about FSPs being notified because of their people being in PES? Many of those in an FSP are not housed in augmented board and cares or in board and cares. The majority are in room and boards and sometimes they are in the coordinated entry system, but many are not. What is happening to those in this category? (RESPONSE: Jan Cobaleda-Kegler) That is a good question. The clients in FSPs are our clients too. When the log goes out in the morning report every day, there is a different clinic, we have FSP liaisons and have rapid access to clinicians in each clinic. That is their job to check the morning report first thing in the morning. Not only do they notify the attendings, psychiatrists and/or person in clinics working with them, but if there is an FSP clients at PES, that FSP gets notified by the clinic. So, at the Concord clinic, that FSP liaison is right away notifying the FSP. They are informed and has to be a phone call. Part of the challenge with our FSPs and CBOs is they finally have the portal access to the emergency health record (EHR); unfortunately, they are still using paper charts themselves.

- (Lauren Rettagliata) I'm glad to hear about the notification process and that it has improved. What about their housing status? Finding out about the room and boards to see why the person is landing in PES. Is that discussed at the bed committee or is that left to the FSP? Do FSP ever contact you about the need for housing people who have fallen into homelessness or room and boards that aren't working for the client? (RESPONSE: Jan Cobaleda-Kegler) There is coordination and communication between the FSPs and our system. For instance, HUME East has client that has bumped up and down, in and out of PES and finally the client is in the hospital and HUME has been coordinating with us concerned, believing that client needs temporary conservatorship. We have been coordinating on that case. Yes, there is coordination and collaboration.
- (Cmsr. Serwin) What are the infrastructure things that are coming down the pike. (Jan Cobaleda-Kegler) Until we acquired an IT Chief, it was really hard to coordinate the data we have to be reviewed. One of the things that Steven (Hahn-Smith) is working on, trying to consolidate all the data to be prepared for when this money comes in to siphon it off in whatever direction it needs to go. So, the details on that, I don't have. I do know we have been working with Steve. There are data projects I am working on with IT to get more accurate data around hospital discharges and our follow up appointments for hospital discharged and how to really have an accurate picture as we can of what is going on with that.
- (Cmsr. Swirsding) If someone is disturbing the peace (in a neighborhood) and homeless. The police pick them up and they go to PES. Where do you place that person? (RESPONSE: Jan Cobaleda-Kegler) PES evaluates that person to determine if they need further hospitalization or not. We assume the police 5150'd them to PES because they appeared to be gravely disabled or troubled and need to go to PES to be evaluated. If they need to be hospitalized, it will be at CCRMC or one of our contacted hospitals.
- (Cmsr. Swirsding) what if they are a danger to the public and themselves? (RESPONSE: Jan Cobaleda-Kegler) It depends on the situation. They might. There are Mental Health Evaluation Teams (MHET) that work with law enforcement and work with individuals that get identified have a lot of interaction with law enforcement due to their behavioral health issues. The MHET would get involved and intervene to carve a path to treatment and help rather than jail.
- (Cmsr. May) When a person is discharged, if it is more of a substance use disorder rather than a severe mental illness, are they sent to an SUD facility? Are they separating them to follow up wherever they are to a stabilization facility and receiving what they need? Second question, when a person has been diagnosed (and we are aware of the 'frequent flyers') if they also have a physical disability and land in PES, once they are stabilized in PES, do they remain in another unit of the hospital for their physical illness? (RESPONSE: Jan Cobaleda-Kegler) Those with SUD issues landing in PES, we have been developing a drug MediCal system of care to provide services to those folks. When they are on PES, if they are showing they could benefit from SUD services, they have to be assessed for level of care needs and then be connected to the right level of care in the community. Now with SUD treatment, it is voluntary and we can't make them go. They have to be willing. If they are in PES and have a positive tox screen are showing co-occurring issues, they can be evaluated and referred. The second question, regarding physical disabilities (Cmsr. May) I am referring to those with

mobility issues (i.e., require use of a scooter or wheelchair, etc.) I understand that Hope House and others will not take anyone with a mobility issue and this is an ADA Compliance requirement. My concern is that whoever you are going to allow to provide services for anybody has severe mental illness, and needs to be in a facility that also are ADA compliant because that is federal law. It is discriminatory and I need to know if this is going to be addressed in the near future or decades? (RESPONSE: Jan Cobaleda-Kegler) I can't give a definitive answer but I agree with you. I'm also amazed, that in our licensing for crisis residential, it prohibits people coming in that have those assisted devices like walkers, wheelchairs and so on. If it has to do with licensing for the facility and for those that have those issues can go are RCFEs (Residential Care Facility for Elderly), like Pleasant Hill Manor, Harmony House where those that have walkers or other assistive devices. This is something we need to work on, I agree. We've had to answer to EQRO on that one. Hope House, for example, it is ADA compliant in certain respects but if you have a walker or wheelchair, you can't be in Hope House and it has to do with safety. If there is a safety issue like a fire, the facility has to be evacuated, those with assistive devices, it would be very hard for them to get out of the building. • (Cmsr. Swirsding) Regarding those with mental health issues that have mobility issues being sent to nursing homes rather than a facility specifically to address their mental health issues. Second, what happens to the people with severe mental illness, homeless and go to PES, where do they go? This is a bed issue. I ask is it makes them not trust the system. (RESPONSE: Jan Cobaleda-Kegler) It is an issue, our homeless services operate shelters in the county and during the pandemic the shelters were closed and are slowly reopening. Some have access but the shelters also require they be vaccinated and some are stubborn and don't want it. Not everyone wants to go to a shelter and choose to not go. If they are 5150'd and go to PES they are evaluated. If they stabilize and reconstitute and don't need to go to a hospital. We don't send them to a hospital if they don't need that. We want to get them to an appropriate level of care. Those that need to be hospitalized get hospitalized. • (Cmsr. May) Who physically goes out and looks at these facilities? Weekly or bi-weekly? Really have eyes on to know where you are allowing to go into. Those that are so vulnerable and usually at the lowest point of their lives, really fragile. Who is assigned to physically go and look at these places? (RESPONSE: Jan Cobaleda-Kegler) Kennisha was speaking about Jim Grey, who routinely goes over to Crestwood Our House for IDT meetings and Crestwood Pleasant Hill for IDT meetings. Betsy and Hazel visit Hope House and Nierika routinely. Betsy might go several times a week depending on medication issues. We also have our own staff that go visit their clients. We expect the case managers to go see their clients and make contact and engage with them at the hospital and at the facilities. During the pandemic, a lot of the congregate care facilities like Crestwood, our staff couldn't just walk in any time they wanted to. Visitor protocol was very strict. It was only at the end of June that family members could visit outside but not inside. Many of those in the small board and cares have case managers in our clinics that routinely go to the facilities. We are trying to get the visits back to pre-COVID levels. • (Teresa Pasquini) Does Jim Grey have everything he needs? When the bed committee meets, is everyone prepared and provides him with all he needs?	

Does everyone get to go to that appropriate level of care in CCC? Do we have any gaps? Sounds to me, that this is our process and we are getting everyone to the right care at the right time and that is just not what is being anecdotally shared. I am wondering, what does your data show on needs? What are our gaps in CCC? Do we know how many board and care beds have been lost? Just in this last year, there was a bill passed, Assembly member Blum's bill that the BH Directors are to be notified when board and cares close, are you getting that report from community care licensing? And if you are, are you sharing that information with the commission and the pubic? How do family's know where to go to get help for their loved ones? Does anyone here think that anybody can provide care on $35 a day (which is the SSI rate)? How can we possibly sustain care for these people when that's all that we are giving these operators? I have heard for so long that we don' have enough. How do we know if we have enough? Do we have enough? Do we have a bed for everyone that needs one, Jan? At the level of care they need? Is there any choice for them? We speak to choice all the time and does a consumer have choice? We speak to the dignity and respect of choice, but I'm just wondering. (RESPONSE: Jan Cobaleda-Kegler) Those are some big questions. The gap, what are our gaps and what are our needs? We have lost beds. We also have increased beds in other areas. We increased our older adult beds, developed a contract with Everwell and we are piecing it together. We still have available beds. It goes up and down. It is not a perfect system.

- (Cmsr. Serwin) Do we know where we are most lacking? Where the log jam happens the most? We shared the San Francisco Bed Optimization paper and they are able to pinpoint which level of care, which types of facilities have the biggest back up. I am wondering, how many fixed beds to we have percentage-wise? What is our total number of patients on average in any point in time? So, we know what the needs are, how many beds are. I know you are trying to track on that through your various data systems. (RESPONSE: Jan Cobaleda-Kegler) Up until recently, we have approximately 500 patients in bed placements. Generally. I am not tracking like I used to but generally it's about 150 people in locked, long-term care facilities and 350 in our enhanced board and cares (larger and smaller). The San Francisco report is really interesting because, I think our problems are parallel to theirs, so we do get quite a big traffic jam with the locked, long-term care facilities and that flow. That moving people out of long-term locked care back to the community or moving them from the community to long-term care. I know we are trying to expand enhanced board and care options so we can move them more fluidly through the system. There are several kinds of options available to people. It isn't a one size fits all.

  (RESPONSE: Kennisha Johnson) Our challenging movement is from the locked facilities and our additional focus has been on adding more enhanced board and care beds so people can step down out of those programs and back into communities. Hopefully, once we have our contract with the one facility being added, A&A, that is in one of our communities in west county, that will work out well so people can be closer to home and have more ability to work with their families and help with the transition whether it is back home or stepping down to a small board and care. They are having a hard time with the rates they are getting. Counties across the state are all having this challenge and everyone is really pushing on how can we pay them more of a daily rate? It has been discussed internally how can we pay them more of a daily rate so that they can survive and we can have more

beds and not losing them on the small board and care side. Some people are able to step out of small board and care beds and move back into the community, whether it's in shared living places or independent living, dependent on the skill building and level of support they have had in the facilities. We don't have the ability to have the fluid movement we would like. We are really trying to identify the best way to maximize what we have and to continue to increase what we have so the clients have a choice.

- (Lauren Rettagliata) I think our BoS and the general public are not aware of the actual cost(s) involved. There was a cost analysis run at the state level that showed the cost is $81,000/year (minimally) to treat someone with a severe mental illness who was incarcerated. That's a lot of money. Now we have those offering services with a realistic price tag to them. A&A services and it sounds really high, but I think we have to realize we are actually saving a life and saving them from incarceration. At $200/day, that works out to $73,000/year. This is what it costs and I think we have to be realistic as to what it costs. Jan can't solve this problem, Suzanne can't solve this problem. Our Board of Supervisors has to take the bigger look and I am hoping you get the ammunition you need to make them realize what it really costs and that we need to actually tap into our county general funds to save lives. We don't have all the funds we need using realignment one, realignment two and MHSA. We have some really good options we have contracted with, one being Psynergy. Before someone goes to Psynergy (or another option) you can't just meet with the bed committee, there has to be lead time in preparation, step down time and coordinating with the providers we do have to be meeting with them at the different levels to step up or step down. This can't be solved in one day and have to be looking in a three week/four week time span on preparing people to go to the right type of placement. When you move from a system of scarcity to abundance, it raises everything higher. It raises the type of care and treatment people are getting. We have to realize it comes with a price tag and we need to pay that price tag in order to keep people well for their dignity and humanity.
- (Lynda Kauffman) One of the things I shared with Kennisha, we work with 26 different county and have the opportunity of seeing a lot of different things happening. One of the more unique things I saw that I really liked was in Sacramento County. They have an open enrollment for augmented board and care and residential treatment. This is attracting board and care operators and that seemed great. It's a struggle to put out an RFP and have all these meetings. Really you want to attract people. Their call to action, open enrollment, if you can meet this need and has the range and what they are looking for. I thought it was impressive and having board and care operators coming to you and asking how they can develop their programs to meet your needs.
- (Teresa Pasquini) Our paper was a call to action, some of our requests have been honored. We now have Kennisha whom we appreciate. We need more but I just don't feel there is a reality of how bad things are. I am concerned that there is not a 'hair on fire' mentality from our community on this topic. I listen to painfully long meetings of the measure X committee speaking to the needs of our community and didn't hear anyone go to the Measure X committee and ask for more funding for board and cares, except for Lauren and I. I know there are a lot of competing needs, but if we don't have anyone actually asking people to understand this issue, and educating them on it, then how can we get out of this crisis? I don't understand how

we can continue to go month after month, year after year and not get to a place of more 'hair on fire' crisis mode. I am frustrated. Lauren and I will be giving our presentation to NAMI CC tonight and will be calling them out for a call to action. I would really like to hear from leadership in this county. What is our plan? I have talked to people we have been partnering with and they don't want to work with our county. They don't want to take our clients based on the experiences they've had. (Cmsr. Serwin) Can I ask what the stated reasons are? They dislike of working with our county. (Teresa Pasquini) Yes, there was no partnership in caring for our client that was taken, a high needs client. It is really time for everyone to get real with this crisis. I wasn't able to be in Doug's last meeting, but I know he is blowing the horn on the crisis from the state hospitals and I joined a BoS meeting and I blew the horn how we are settling for a jail-based crisis training for incompetent to stand crisis in contra costa. Where are all the social warriors for the families like mine? Where is the leadership calling out for the need for this population? I just don't understand. I'm frustrated. I'm going to keep trying to partner, but just feel like there is this status quo mentality that I just don't understand. It has been too long.

- (Cmsr. Swirsding) I just want to say that sometimes it doesn't take a lot to give a person hope.
- (Jan Cobaleda-Kegler) I really appreciate this discussion and hearing from everyone about their concerns. I share these concerns too. These are big issues that are bigger than all of us. If we look at the community and the number of homeless struggling right now in California. There are lot of factors and it is all interconnected that contribute to, say our board and cares closing because they couldn't afford to run them. Who is looking for those things? In children's systems, I know the pain of programs closing. I ran a residential program for girls in juvenile justice (the Chris Adams Girls Center) and, believe me, I was shocked when the BoS decided to close Chris Adams. My heart still hurts from that. That was really hard. That program was developed in the day when there was a lot of good will, coordinated systems of care and many working to put resources together and do this. When it came time to close it, there was a lot of ugliness that happened. We moved on and reconstitute ourselves in different parts of the system and continue to do work to support our clients. I appreciate the advocacy that Teresa and Lauren are taking on. I agree, the BoS, at that level, the cost of care is expensive. We can develop teams to engage with those in the community but the reality is some of our people need housing and it isn't cheap. I think people are so overwhelmed and there's a numbness. At least in our system, we do the best we can with what we have. We have some really amazing awesome staff that throw themselves into the work every day to try to make things better. There's no easy answers on this.
- (Kennisha Johnson) I just wanted to say I appreciate the advocacy and the work you all are putting into this topic and keeping this conversation alive and not letting it go. We all agree there is so much needed in the community and our clients deserve more and need more and we want to give them more. Figuring out the best way to push to make movement. The crisis around housing there is a general crisis but shining a light more on our specific population and the board and care world. All the levels of care we are focused on, not just units. Really keeping it specific to who we want to have served is really important. I thank you and appreciate it. Trying to be thoughtful and rise it where it needs to be and taking advantage of

everything coming down the pike that you all have advocated for. We are starting to see how CCC can be a part of this and participate as best we can.	
VIII. DISCUSS "the "LA County Department of Mental Health Board and Care Initiatives" presentation prepared by Maria Funk, Deputy Director of Housing and Job Development for LA County We attached to the agenda, a presenatation by Maria Funk, the Deputy Director of Housing and Job Development for LA County. There are a few pages, in particular which I will share that I thought were of particular interest. The Board and Care Initiatives of LA County (Item #3) Bed tracking system membership association and capital improvements. It seems that these are relevant to our county and interesting they were able to get movement at the BoS level to fund these efforts. The concern and making a commitment to preserve licensed facilities a priority and developing a real time tracking tool that has realtime information about bed availability in licensed residential faciliities, they are calling it the Mental Health Resource Location Navigator (MHRLN) bed tracking tool. Jan, we know the various systems for tracking, the many parts are paper, spreadsheets and now Teams. Is this the kind of integrated system that you are looking for that Steve Hahn-Smith is thinking about? (RESPONSE: Jan Cobaleda-Kegler) Yes, as a matter of fact, Barbara, Kennisha and I met with Steve Hahn-Smith and some of his staff to start work on this. To see how to consolidate some of this as a real time bed tracking tool in coordination with mental health support people are getting. (Cmsr. Serwin) I find an interesting feature is that facilities are opting in and case managers are opting in. It sounds like, as opposed to the county having to go out and grab people to integrate into the system, it shows they are motivated to get their placements out there and used. (RESPONSE: Jan Cobaleda-Kegler) Exactly, something like the data system will have all that together coordinated in a similar way, like Jim Grey, he holds all this information and knows it all in real time. The rest of us don't have access to his brain and part of having a truly solid data tracking tool like this one developed in LA would be helpful to all of us working in this, as well as the facilities and the providers in the system working with our clients. (Cmsr. Serwin) It seems if we could move the BoS to look at an optimization to look at modeling our system to see where exactly our needs are, the data in terms of the volume, that would be worth while building out this system would be worthwhile. These are actual items in addition to the increase in placement you are working on for the board and cares. This membership association is interesting too. My takeaway here is they are trying to empower board and cares by bringing them together so they can share solutions and lobby together. Is that what this is about? (Teresa Pasquini) Kerry Morrison, Barbara Wilson, Brittany Wiseman (former chair of the LA county Mental Health Commission) all wrote a report a couple years ago that really sparked / put a light under the BoS to act. At the same time, the building of the jails was being discussed and their community came together and said we are not going to build anymore jail beds and we are going to fix this board and care crisis. Even that report they issued, it got some play but not enough. This association was intended to develop a lobbying force. This is in LA County but is a template that I think could be followed here.	

(Lauren Rettagliata) The board and cares do have a group that is a lobbying group and it makes a huge difference. The majority of those that have board and care facilities, they are operated for those with an IDD (intellectual developmental disability). The operators of board and cares who take those with an IDD designation get a supplement of almost $9000/month for those that are severely at that highest, equivalent to our people that have a serious mental illness in our board and cares. Our board and care operators that are licensed to take those with a serious mental illness are going to be raised to $1100/month (maybe $1300/month), there is this huge discrepancy. How the IDD community got what they needed was this huge march on the capital and they go it. There are so few operators, not well organized and don't have this lobbying backing. (Cmsr. Serwin) The last page I will put up is the capital improvement project that were approved by the LA County BoS. I'm unsure on the total amount of funds $11.2mil allocated, plus another $5mil contributed by Cedars-Sinai and administered by the California Community Foundation (CCF). They are doing a physical needs assessment of prioritized facilities which will identify the scope of the needed improvements. This work will prepare LA County for State funding for Community Care Expansion. (Teresa Pasquini) Community Care Expansion is the category of funding coming down from the Behavioral Health structure grant (the $3bil) and they are preparing to go after that money. This is what Lauren and I have been shouting from the rooftops, are we ready? Is CCC ready? LA County has been working on this for two or three years and we are behind the 8-ball.	
IX. Adjourned at 5:24 pm.	