SPECIAL MEETING OF THE
CONTRA COSTA COUNTY MENTAL HEALTH COMMISSION
DRAFT COMMUNITY SERVICES & SUPPORTS 08/09 PLAN
PUBLIC HEARING • APRIL 29, 2009
MINUTES-Approved 5/28/09

1. **CALL TO ORDER / INTRODUCTIONS**
Commission Chairperson Peter Mantas called the meeting to order at 6:18 p.m.

Commissioners Present:
Clare Beckner, District IV
Art Honegger, District V
Dave Kahler, District IV
Peter Mantas, District III
Colette O'Keeffe, District IV
Teresa Pasquini, District I
Annis Pereyra, District II

Commissioners Absent:
Bielle Moore
Supv. Mary Piepho

Other Attendees:
Sherry Bradley, Mental Health Services Act Program Manager
Karyn Cornell, Supv. Piepho's office
Brenda Crawford, Mental Health Consumer Concerns
Cyndi Downing, Mental Health Administration
Al Farmer, NAMI-CC
Ronald Johnson, Family Member
Victor Montoya, Adult Mental Health Program Chief
Mariana Moore, Human Services Alliance
Elvita Sarlis, Mental Health Administration
Dorothy Sansoe, Senior Deputy CAO
Karen Shuler, Executive Assistant to the Mental Health Commission
Suzanne Tavano, Deputy Mental Health Director
Veronica Vale, NAMI-CC, Family Advocate, Consumer
Donna Wigand, Mental Health Director

2. **OPENING COMMENTS BY MENTAL HEALTH COMMISSION CHAIR**
Peter thanked the attendees for coming and said everyone was welcome to give their comments. Attendees were introduced.

3. **PUBLIC COMMENT: NON-AGENDA ITEMS**
There was no Public Comment on non-Agenda items.

4. **DRAFT COMMUNITY SERVICES & SUPPORTS 08/09 PLAN PRESENTATION BY MENTAL HEALTH DIRECTOR DONNA WIGAND, AND MENTAL HEALTH SERVICES ACT PROGRAM MANAGER SHERRY BRADLEY**
Peter introduced MHSA Program Manager Sherry Bradley and Mental Health Director Donna Wigand. Donna welcomed everyone and thanked them for attending. She stated the goal is to get their input and feedback into this Plan. She added they are here to listen to your comments tonight.

Sherry presented a powerpoint of the original Community Services and Supports 3-Year Program and Expenditure Plan. (Copies of powerpoint were distributed.)

Donna: Workplans 1, 2, and 3 were contracted out to our community partners. Each was a collaboration to run the Children, TAY and Adult program. The Older Adult was the one we kept in house because it is integrated into the clinics and our staff will be co-located at the heath care centers. These numbers are for a year ago.
Art: I didn't notice any housing for the seniors.
Vic: Because it's not a full service partnership, housing is not required, but we will take advantage of opportunities as presented such as Villa Vas Consuelas. Also, we've been developing board and cares, including one that is out of county. It's a work in progress.
Sherry: There's a separate pot of MHSA money for CAL FHA to administer.
Vic: When state program 2034 shut down, we used one time money because we had established a relationship with our county housing and attached onto their Notice of Funding Availability to make Villa Vas Consuelas available. We're working with West County on the Lillie Mae Jones project -- 8 multiple use units. Also, Rubicon had the Virginia Apartments that needed to be kept up, and we helped them rehab and save those properties.
Suzanne: We also have community-based teams with the intent of keeping older adults in place so they wouldn't lose whatever housing they had.
Teresa: If you have an older adult consumer living with an elderly relative, your goal would be to still keep them in place? Do you have any examples...I know of people who have older adult consumers living with them and this is not good.
Suzanne: This is new, but there have been some outstanding stories of successes.
Sherry: We have a couple of success stories from Community Servicers and Supports. (Copies of examples of success stories were distributed.)
Sherry next presented an MHSA Community Services and Supports Plan Update for FY 2008-2009. (Copies of powerpoint were distributed.)
Sherry stated Input has been going on since last summer. It's a status quo plan with some expansions.
Art: What are parent partners?
Sherry: In the Children's Mental Health System, we hire parents to be peers or mentors to other parents of children in the mental health system.
Donna: we are also creating additional "Gloria's" – we put one in each region and have them available for the adult system.
Peter asked for a better definition of "wraparound".
Donna: Using wrap facilitators is an evidence-based practice for children and their families. It has been going on across the country for about 10 years. It is a mobile service wrapping services around the family where they are. It pushes the staff out to where the families are. Parent partners, licensed clinicians determine what are the services and supports that family needs to get to a better level of functioning. Wrap facilitators are folks who work with the wrap team -- it's a multidisciplinary team – the facilitator coordinates the team.
Suzanne: The wrap facilitator goes in and has the family at the core and identifies who their support people are in their lives and that team is built around the family. The family identifies strengths and needs and then the wrap team sees how they can help.

Annis: Adult wrap facilitators are offended by the use of wraparound "wrap" facilitators. It can be confusing.
Donna: The service itself is called wraparound.
Annis: But shouldn't be shortened to "wrap" facilitator.
Peter asked about the wellness program.
Suzanne: About 2 years ago we started working on this. There are 2 nurses assigned to each clinic. We have a nurse practitioner who will be brought in to coordinate physical health and mental health. They go to the Wellness Centers and clinics. We want to incorporate people to help with smoking, diet, and physical health's relationship t mental health.
Colette: What about bringing this service to people's homes?
Suzanne: We hope to, but are doing what we can with what we have and want to expand to children and adolescents as well.
Colette: Does the plan show the currently going out, coming in?
Sherry: Current FSP's. The tool we use that is required by the state does not allow for flexibility.
Mariana: Is there an assumption they will stay enrolled?
Sherry: Disenrollment is not shown – it reflects a level of recovery.
Donna: One of the premises is that you don't kick people out of treatment, but people "backslide". The goal is you don't let people drop off the radar.
Colette: Are there any quantitative analysis of achievement?
Suzanne: There are reporting requirements for the state, so all the providers and FSP's are sending them to the state, but the state is not returning anything to us, so at the local level we will have to analyze the data.
Sherry: The state's outcome quality improvement has been disbanded.
Teresa: So we have no county-based performance outcomes that were built in to see how we're doing?
Donna: More than just reports...when we saw early on that the children's and TAY programs had trouble getting people in, we met with the providers and started looking into it. We worked with the provider and said we wanted the numbers to go up as well as the quality. The TAY is struggling because some of the 16-25 year olds refuses to enroll due to stigma. The drop in and outs happens most with TAY's.
Peter asked that comments on the plan be held off until Public Comment period and questions be asked for explanation. Peter said there was a need for qualitative as well as quantitative information.
Vic: Regarding quantitative issues on adults…the number of individuals we are currently servicing are our targets. These are existing organizations that have been working in West County for several years and we know who is in crisis, at the hospital, in locked facilities, etc. The numbers are what they need to be. Also, we've developed a relationship with the public health entity -- so we purchased shelter beds. If we have folks on the street, let's get them off the street. Qualitatively, we will and can go back and do a review of all the FSP's and review the adults and TAY's -- looking at the number of people housed, hospitalizations, living situations, number of incarcerations

before and after being enrolled -- those numbers are going to look very good. We can

look at benefits before and after enrollment, those who work or students, etc. We'll come back and do that for the Commission.
Suzanne: We've been tracking numbers on outreach and engagement. I think we were overlooking the measures we were sending on to the state because we were waiting for information back from the state, but we need to look at them instead of waiting. It's time for us to act by looking at our own data and bring it back here and work with the Commission on what data we have been working on. We feel the personal stories are important, and quantitative, but we have to build in the qualitative.
Colette: I would hope that physical health would be related to mental health.
Vic: As part of the county structure we have a formal health disparities project that reports directly to Dr. Walker. We went back to and looked at consumers and their health disparities. About the TAY...the TAY collaborative was new to West County. The challenges were that these were the proposals that were presented to us -- they had to establish a site, hire program managers, etc. By the time we let out the RFP, we were in less than a 2-year operation -- so it has been challenging, along with developing relationships within that community who were strong in the mental health system. We have looked at some of their strengths and the referral sources. It's a challenge to expand services across the 3 regions. One of the referral programs was GRIP. The positive was that we used one time money for a 12-bed house. We also got Bissell Cottages for TAY's. We have tried to build relationships. Challenges going forward: they are small programs. Philosophical challenge in thinking "we are only serving 60 TAY's". We need to give them credit for the good work they are doing.
Peter: Going forward...part of the plan should include (pursuant to the Welfare & Institutions Code) reports on achievements on performance outcomes established. Along with talking about the programs, we need to have the qualitative and quantitative reports. If you see how you're performing, we can be much stronger.

5. **PUBLIC COMMENT: DRAFT CSS 08/09 PLAN**

Veronica Vale: The challenge will be to ensure that IMPLEMENTATION ACHIEVES THE STATED GOALS OF THE LEGISLATION TO PROMOTE RECOVERY AND REDUCE THE NEGATIVE CONSEQUENCES OF UNTREATED MENTAL ILLNESS, including suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from their homes. These could be outcome measures. The lack of clear policy and guidance on evidence-based practices leaves much uncertainty about potential effectiveness of the strategies adopted by the county. Program success also, will depend on the counties' ability to recruit, hire, train, and retain qualified staff, consumers, and family members who reflect the cultural and linguistic diversity of the consumers and are committed to integrating recovery principles into all aspects of program implementation. Will WET, Workforce Education and Training monies be used do fulfill this promise? Will CBO staff be trained too? We have a great responsibility to make choices that are based on hope, empowerment, self-determination and meaningful roles in society which are the principles most beneficial to

the consumers and the community. The family positions are vague. Which ones are parent partners, which ones are families with children and do these mean children under 18? Which ones will be in the adult clinics and which ones will be in the children's

clinics? Page 9 and 10 do not delineate new positions even though the narrative talks about them? The Office of Consumer Empowerment is now getting more staff again after three years. The county originally paid for this staff. Is this not a supplantation, which is not allowed under the MHSA? Even though it was said there was a hiring freeze. What has changed to make it possible to hire now? Why are not the out-of-county people leaving the Long-term MH hospitals not getting services through FSP's programs? Does the expansion of the far east County include Antioch?
Sherry: It hasn't happened yet.
Donna: There has been discussion with the providers but it hasn't happened yet.
Veronica: The Office of Consumer Empowerment was funded by the county -- how can you use MHSA for this? It was an already-existing position.
Donna: They were contractors and have been gone for 4 years. We are now able to create positions.
Veronica: It looks like you're funding positions that are already there. What about people leaving long term beds out of county?
Teresa read a letter addressed to Peter Mantas, Chair of the Commission, submitted by Mashariki Kurudisha, who was unable to be there. "I am a member of a family which has used the services of the mental health system of Contra Costa County. I have been serving as a member of the Family Involvement Steering Committee for MHSA. I would like this public hearing to include my views of the Community Services and Support (CSS) Program. First, however, I would like to again convey to the MHC the March 26, 2009 letter with attachment from the Family Involvement Steering Committee for MHSA regarding the CSS Program. Please include this letter, the MOC and the March 26 FSC letter with attachments in the MHC consideration and review of the CSS Program. The Family Involvement Steering Committee for MHSA has worked hard to have the voice of families included in the MHSA process in Contra Costa. We work not just for our own families but for all families facing mental illness. Personally, I am disappointed that we have yet to answer the question of what equals support for the mentally ill. This is a question that is not decades from being answered but centuries. I know that today some ones family member left Contra Costa County jail or juvenile detention center not functional and without needed mental health support. The same thing will happen tomorrow. I know that I can go to the streets of this County regardless of the city and find homeless mentally ill. At the same time, CSS waits for the next ill, unsupported soul to request service as a full service partner. The CSS program has not met its youth numbers and the proposed solution is to reduce the number that the program should include. At the same time, 19% of the population today in the County jail is mentally ill and up to 100% of the youth in juvenile detention and their families are in need of mental health support. There is a basic failure here. I see the fights over budget reductions in the County. At the same time, I look at the Council of State Government Justice Center recommendations and I know that reducing the return of the mentally ill to jails and detention centers where most of them receive only enough mental health support to control them is a state, national and international goal. Contra Costa could innovate to insure that the moment a mentally ill client leaves jail, detention, the emergency room, the office of a local non-profit, the door ways of commercial areas, under the freeway, or a family home in need of immediate attention them is a means to have an outreach worker there to guide them into the system of care as a chosen options to beatings and death. That guidance could

include needed paperwork and other supports up to and including those services provided by an ACT Team. Such a response would need to include mobility and flexibility of time and deliver. CSS says it has this but the results speak for themselves. Our County example of a student preparing for an improved life with mental illness was an example of the beating and death experienced in this County by the mentally ill. The CSS program has been envisioned to include supportive housing and supportive services. What we have today is a small step towards what is needed. I believe that our measure of delivery needs to be quantitative and qualitative. We have a program that can only tell us the limited numbers of people served. We cannot tell whether the services were beneficial to the population served. This leaves us without a means to improve serves. The Mental Health Commission must determine what is working as a service and what needs improvement. Best practices for the County need to be defined and then documented. A database of positive treatments, drugs and supports which helped someone achieve some positive outcome would be program dollars well spend in my opinion on mental health. My hope is that by the next program review, we can know that we has at least begun to create such a brain trust of recovery for the mentally ill of Contra Costa."
[Ms. Kurudisha asked to have other materials placed in the record. However, while the above letter was read into the record at the meeting, although other materials were referenced, no copies were available at the meeting nor were they read.]

Peter: What was her basic comment?
Teresa: She wants the Family Steering Committee letters included.
Donna: She suggested an innovative program, similar to assertive community treatment.
Colette: I would want checks and balances to protect consumer's rights
Teresa: We as a Commission need to consider consumer's opinions.
Colette: They should not be considered as an afterthought...
Peter: The measure of delivery needs to be quantitative and qualitative.
Veronica: Evidence-based practices.
Colette: What's the evidence for evidence-based practices?
Mariana: In terms of quantitative and qualitative, one of the things I've heard is making a lot of assumptions that may or may not be based by facts. I would like to caution against assumptions. We should have a rigorous and fair process to look at the facts. I hope to build into the process being thoughtful and include the providers and consumers in the conversation.
Brenda: Regarding the wellness part of the plan -- expand it beyond its present scope -- look at physical and mental wellness and vocational services, making people feel good about themselves. Look to support SPIRIT but other models as well to provide job training.

Al Farmer: Can the capacity of the programs be adjusted as the program approaches capacity with regard to housing, etc.? With regard to MHSA FSC, will its being rolled into CPAW limit our voice?
Ron Johnson: Looking at the number of children in the FSP and the per capita cost, it seems outrageous. What is the source of the children in the program? If we have 50,000 mentally ill in this county, this isn't a sufficient amount of money -- there will be breakdowns in the future.

Peter: On this particular issue, can you address the per capita cost?
Sherry: All counties measure the cost differently. We've been looking to the state to provide a guideline. The cost of FSP's per capita tends to be very high because all services go to these. The state has given us no standards.
Ron: Regarding the graph...what made this thing kick up? There's a much larger population receiving no services. The action you took to make it kick up seems to be a source of real effectiveness.
Donna: I've been troubled because the MHSA has built a two-tiered system. Some get a lot, some get nothing.
Art: Is this written into the proposition?
Donna: Yes. Who gets in and who's allowed to get in.
Teresa: DMH has expanded the definition for next year.
Donna: Requests came to loosen up and allow us to serve more of the populations. I haven't been able to do that for the last 4 years, but will be able to try to do it in the future.
Suzanne: I think in going back to Vic, getting new programs up and going takes time, and at some point we do pause and see if we overestimated in one area and underestimated in another and need to modify.
Peter: Going back to original question, $18,000 for FSP -- what are the top 3 costs and what percentage?
Vic: Staff, staff, staff.
Suzanne: Costs get lower as enrollment goes up. Costs of services to children tend to be higher than for adults.
Peter: A % of capacity would give us a better idea of how much per individual.
Sherry: It's not close for children.
Vic: The other complexity is the state tried to put MHSA side-side with our county Medi-Cal clinics so we have to meet all the trappings of Medi-Cal so Medi-Cal costs are very expensive. Also critical is the caseload ratio. A year and a half isn't enough time.
Ron: The TAY program people will not discuss the issue until his healthy families coverage drops off. The 23 year old thinks he has both. His current providers are not covered by Medi-Cal -- people who have his trust will end.
Vic: We might be able to fix that one.
Ron: It's a tragedy that the good services might end.
Peter: Break in continuum of care -- how can we phrase that?
Vic: We need the details in order to tell. It's too nuanced to develop a program around that.

Suzanne: There's the level of changing health benefits. They turn 18 and they either lose their benefits or they change or they can say "No"
Peter: Can it be part of the CSS plan?
Donna: It's a larger issue. It would take a change in regulation.

6. **CLOSE PUBLIC COMMENT ON THE DRAFT CSS 08/09 PLAN**

Peter called for a motion to close the Public Comment portion.
M-O'Keeffe; S-Beckner. Unanimous.

7. **MHC COMMENT ON THE DRAFT CSS 08/09 PLAN**

Teresa: Going back to the discussion of oversight of providers and being mindful of Mariana's comments about assumptions...all we want are good services. Those missed opportunities can be life-altering events. We need better communication for the sake of people's lives and family member's lives. There's things that are troubling – comments that Steve hadn't been contacted by the county about the plan. The assumption by the public taxpayer is that these conversations are ongoing. It's a struggle in that breakdown of communication and the impact on the consumer. At the MHSA Steering Committee there was conversation about renewing communication. It's very troubling that this plan is just being submitted near the last day of April. That's $16,000 million that's sitting up at the state and not coming down here. A lot of other counties were able to get their plans in. The TAY thing -- there's family members here who get that. We do live stories that would benefit your staff and the providers. It's disappointing that we don't have families in the discussion with the providers. It's troubling there's only 3 family members at the table and not more embracing of this service.

Teresa gave a copy of a Supportive Housing Plan to Sherry.

Colette: Is work being done for the TAY program to decrease the feeling of stigma, so they are more in line with their assessment of their needs? No consumers were invited either to Fred Finch. Regarding outcome analysis -- the consumers should be in there deciding what those goals are to evaluate ourselves.

Clare: In the proposal to expand housing...what is your definition of housing and what are regional housing specialists?

Donna: We should provide a definition in the plan.

Art: What happened to people when beds were closed?

Donna: We bought new beds that were added to the system.

Annis: Back to a comment from Teresa...an older adults living at home when there are no housing services provided because an older adult is not an FSP. The example that is given matches my experience. What are you going to do with someone who is intrusive and delusional and needs to be taken out of the home...what are you going to do for housing?

Suzanne: The FSP's have inherent in them provision for housing...but we find a place for them not under FSP. But part of the planning process should be older adult FSP's.

Dave: Is the Clubhouse supported in the CSS plan?

Sherry: Not in CSS -- in the PEI.

8. **MHC ACTION – DEVELOP LIST OF SUBSTANTIVE COMMENTS**

Items addressed on the flip charts:

- Wellness
    - Taking services to consumer's homes
        - Stop smoking
        - Nutrition
        - Safety in the home (mold, etc.)
- Vocational services
    - Recruit, hire, train and retrain, integrating recovery principles
    - Self-determination
- Evidence-based practices

    - More requirements, outcomes, contracts, ongoing data
    - Quantitative and qualitative data
- Expansion of services to far east county
- Develop a system to avoid break in continuum of care
- Include the Family Steering Committee Memorandums of Concern and the responses in the Plan

Peter: I feel they are all substantive and all should be addressed. I think we should approve all of them as substantive to be addressed in the plan update.
A motion was made to request that all Public Comment received to considered substantive and be addressed in the Plan update.
M-Honegger; S-Pereyra
Brief discussion followed.
Suzanne: A great majority of the comments will have to do with the plan update but some are future issues.
Carried unanimously.

9. **MHC ACTION – MOTION ON RECOMMENDATIONS TO THE COUNTY MENTAL HEALTH ADMINISTRATION AND TO THE BOARD OF SUPERVISORS**

Peter: The plan is behind and we need to move it forward. I'd like to entertain a motion to conditionally approve the plan updates assuming the following:

1) There be balanced representation on CPAW (county staff, mental health staff are at a minimum on CPAW and a significant portion is made up of family and consumer representatives to get more people involved in the decision-making process.
2) There is heavy involvement of family and consumer members not only in discussion but also decision making (CPAW)
3) Mental Health Administration will work with all stakeholders, especially the Mental Health Commission to develop quantitative and qualitative analysis of MHSA program performance by August 31, 2009.
4) All noted substantive comments get addressed in the plan update with Mental Health Commission involvement – for discussion and review before it's

submitted.

Colette: I request that the word consumer would come first at least 50% of the time.
M-O'Keeffe; S-Honegger.
Discussion followed.
Suzanne: Amend the way it's structured in MHSA...make recommendations to Mental Health Director?
Peter: Yes. We put these steps in place so we can sit down and talk. We want to work with everybody to make sure we're discussing these things with everybody
Mariana: Will another meeting of the Mental Health Commission be required?
Teresa: It needs to be discussed at CPAW but I don't want to jeopardize these funds.
Sherry: Point of order...according to the stat sheet...when we make changes that are substantive we have to recirculate the plan so the public knows the changes have been made. I don't think it requires another public hearing.
Donna: In an ideal world it would be nice if everybody was on the same page. I don't

have that expectation that everybody with a special interest will see things the same way. I don't expect everyone to agree at the end of the day.
Peter: We are all on the same page in terms of communication. How do we get involved?
Sherry: There's documentation of all the comments -- name, date, how we responded, what's the change, circulate.
Suzanne: What triggers the whole process is the use of the word "substantive."
Sherry: Most counties consider all comments substantive. Whether or not it leads to a change is contingent on the guidelines. How is "heavy involvement" defined?
Peter: We can figure this out. 51%? The Steering Committee was 90% Mental Health Administration. That needs to change.
Motion carried unanimously.

10. **CLOSE PUBLIC HEARING**
Peter thanked those who attended. A motion was made to close the Public Hearing.
M-Pasquini; S-Pereyra.
Motion carried unanimously.

Respectfully submitted,
Karen Shuler, Executive Assistant
Contra Costa County Mental Health Commission

FLIP CHART #1
Wellness
- Taking it to consumer's homes
- Stop smoking
- Assessing mold in the homes

Challenge to ensure
suicide, enc. unemp., homeless
removal from homes. In home support ser.
- Success, recruit hire rain and retrain

Integrating recovery principles
Hope recovery self-determination

FLIP CHART #2
- Evidence based practices

    - More requirements, outcomes, contracts, ongoing data
- Issues
    - Family positions/explain in regard to children's ages
- Budget
    - Family position Parent Partner? Helpers?
    - Meant more for adult. Nothing in children section states that page 9 & 10
- No position listed
- Families of children will be employed as P.P.
- Expansion Far East. Antioch. Include in update/Areas expansion have been disproportionate with providers

FLIP CHART #3

- OCE funded by CC MHSA $$ of OCE pos? Existing programs?
    - No position with contractors cut.
    - No position to fill are able to contract now. Not existing.
- Update out of county. People leaving mental health beds. Can it be used for partnership for CBO's
- Letter re: Family used services CCC
  serv. as MC Steering Committee CSS
  1. Convey March 26 FSC letter re: CSS
  MOC
  Fis com. Dis what = support
- Leaving out facilities non-functional

FLIP CHART #4

- Family Steering letters included in plan

Suggest specific program

Would like CC move to ACT model where ind is contacted in a timely manner on their way out.

    - Consider civil rights

Consider

FLIP CHART #5

- Measure of delivery

Quantitative and qualitative

- Evidence based practices
    - Look very carefully

MM repres.

- Quantitative and qualitative – making assumptions regarding what goes on with providers
    - Providers measuring up?
    - Rigorous, fair thoughtful process
    - Facts – what are we learning

  Adjust ex MHCC and Rubicon Clinic and Cons. Approach
  Build into (unreadable) measures and process
  Include providers

FLIP CHART #6

- Home wellness – look at expanding and kinds of services, mental and physical plus

vocational for self sufficiency = jobs. WET? Design for con. training. Looking at other models. Example – SPIRIT.

- MHSA funds. Cap be adjusted to serve more programs.

Are they adjustable
FSC rolled with CPAW limit availability on comment/voice
# of children FSP

- Source – in contact with symptoms.

FLIP CHART #7

- Broadening programs
- Per capita FSP's is always high. All counties different.
- Higher population received less services

FSP ½ services ½ in line for service
$51% of CSS money
Definition has been expanded by DMH
DMH issue county directions

- FSP – cost for staff

% of capacity
Not meeting cap in children

FLIP CHART #8

Cons – Healthy family Medi-Cal TAY will not discuss until Health Family cuts off
Providers not concerned medical
Can't use some doctors or existing therapies due to insurance

- How can we avoid break in continuum of care?
- Develop a system to avoid break in continuous care.

Q: can this be part of CSS plan?
A: need a change in regulation

FLIP CHART #9

Oversight of providers
Better communication for people's lives
Comments CPAW communication within agencies. Impact on consumers missing out on services.
Communication Group:
EOM and plan just being submitted.
Dollars sitting at state TROUBLING!!!
Other counties turned plans in
TAY – lived it, have stories to benefit
Should be mandated
Provider
3 family positions on table, should be more of this resource
Stigma with family needs to go away

FLIP CHART #10

No family members at Fred Finch retreat
Housing plan – suggestion
1. Work being done on TAY to decrease stigma
Assessment of needs.
Fred Finch – no consumers invited
2. Outcome analysis – consumer should voice goals
Best practices – have consumers there
Psych services. Voice in evaluation
Housing – diet

FLIP CHART #11
Definition written in plan. specifics on housing spec.
- FSP – beds occ – where did people go?

New beds bought
Comments
Older adults living with family. No services provided
Not FSP
  - What happens when situation doesn't work out?
  - What would be done with an intrusive/dilusional person?
  - Should be part of planning process.

Clubhouse - PEI