Contra Costa Mental Health Commission
Special Meeting
September 3, 2009
Minutes – Approved 10/8/09

1. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order at 4:35 pm by Vice Chair Teresa Pasquini.

Commissioners Present:

Supv. Mary Piepho
Art Honegger, District V
Dave Kahler, District IV
Peter Mantas, District III
Carol McKindley-Alvarez, District I
Colette O'Keeffe, MD District IV
Floyd Overby, MD, District II
Annis Pereyra, District II
Anne Reed, District II
Teresa Pasquini, District I

Commissioners Absent:
Bielle Moore, District III – Excused
Scott Nelson, District III – Excused

Attendees:

Julie Freestone, Contra Costa Health Svcs.
Sherry Bradley, Contra Costa Health Svcs.
Cindy Downing, Contra Costa Health Svcs.
Pat Godley, Contra Costa Health Svcs.
Suzanne Tavano, Contra Costa Health Svcs
William Walker, MD, Contra Costa Health Svcs.
Donna Wigand, Contra Costa Health Svcs.
Dorothy Sansoe, County Adminstrator's Office
Nancy Schott, MHC Staff
Suzette Adkins, Supv. Bonilla's office
Karyn Cornell, Supv. Piepho's office
Brenda Crawford, Mental Health Consumer Concerns
Al Farmer, Nat'l Alliance on Mental Illness
Marian Guglielmo, Nat'l Alliance on Mental Illness
Mariana Moore, Human Services Alliance
Sam Yoshioka, Nat'l Alliance on Mental Illness
Anne Heavy, Nat'l Alliance on Mental Illness
Ralph Hoffman, Nat'l Alliance on Mental Illness
Rollie Katz, Local 1
Sandy Kleffman, Contra Costa Times
Ron Johnson
Sharon Madison
Katherine Meid
Violet Smith

Chair Mantas would like to yield the chair responsibilities for today's meeting to Vice Chair Pasquini. Vice Chair welcomed Chair Mantas back. Nancy Schott was introduced as the new Clerk to MHC and Vice Chair Pasqini thanked Julie Freestone, Sherry Bradley, Cindy Downing and Karen Schuler for their assistance during the transition.

Commissioners, Supervisor Piepho, Health Services and County staff and members of the public introduced themselves.

Vice Chair Pasquini noted an error on the agenda noticed by Dorothy Sansoe. In the past several meetings, the first 5 public comments were taken at the beginning of the meeting and all others heard at the end. The additional public comment agenda item was left off this meeting's agenda, but any remaining public

comments will be heard at the end of the meeting, as long as they are within the jurisdiction of the Mental Health Commission.

2. PUBLIC COMMENT

Sam Yoshiyoka requested to be caught up on what's been been going on and requests a a mission statement related to the new proposal. He would like an explanation as to whether the inpatient unit will be closed or remain open.

Ralph Hoffman made two proposals of national significance: 1) Would like to re-name the Affordable Health Choices Act being considered by Congress the Senator Edward Kennedy Health Choices Act and 2) Change the term mental illness to creative maladjustment. He described a number of well-known people who suffered from mental illness (incl. Buzz Aldren and Thomas Eagleton).

3. PROPOSED PSYCHIATRIC FACILITY

A. Contra Costa Health Services: Current Plan and Alternatives

Dr. Walker – Overview of the Plan

This isn't a brainstorm but an effort to review how Health Services arrived at the final proposal and how they wanted to take advantage of an opportunity that presented itself. 20 Allen was his office but not owned by the Health Department. It was contiguous to the hospital emergency room and when it became available to purchase, there was the opportunity to consider the option for use by Mental Health Services. Health Services has listened to the concerns of the Capital Facilities Work Group Committee, focus groups, committees, etc. and would like to hear additional thoughts/concerns about the proposal and be open minded about where things are headed.

Donna Wigand and Sherry Bradley presented alternatives for different types of care referencing the Chart of Capital Facilities Alternatives, dated 8/20/09. The Chart shows levels of care in a particular type of facility, the options (including pros and cons) for that level of care and where the current proposal matches up to that level of care.

Acute psychiatric facility options:

- The county hospital would retain 20 inpatient beds adjacent to the proposed campus.
- One option would be to expand – we had 43 beds that were closed about three years ago. (There are contracts with John Muir and five private hospitals outside the county. In a month, there are 14-15 beds being contracted out – 2 children per day on average). The CCRMC 23 bed license capacity is used before contracting out to other facility.
- Propose to construct 16 additional beds in the Psychiatric Health Facility (PHF) there is a difference between a PHF and an acute inpatient facility (at CCRMC) although both are locked. Most patients in both types of facilities are in on involuntary hold. Psychiatric Health Facilities are free standing and outside the four walls of a hospital. About half the counties in California have them. Most are run by contract providers whose business it is to provide this kind type of care. If a facility goes over 16 beds, MediCal/Medicaid cannot be billed. There are 24/7 nurses and doctors, but also a multi-disciplinary team with consumers and families as support.

- Acute inpatient units tend to be a medical model since they are inside a hospital; for individuals with co-occurring serious medical and psychiatric problems an inpatient unit is the ideal place to be. The average length of stay statewide in both levels of care is a week. There are longer-term locked facilities where people can go if they need an extended period of care.
- Institutional Facility (IMD) – CCHD contracts that out.
- Crisis Residential Facility (CRF) – currently there is one, Nierika, in Concord. One option is to add another CRF adjacent to CCRMC. A central facility may not be as accessible, but there could be two of these in different areas of the county. Two locations might not be as cost effective.
- Residential Treatment: there are two types for adults in CA: One is crisis residential and other is transitional residential. Crisis residential care is where someone moves coming out of a locked level of care into an unlocked but highly supervised setting. Usually people stay there about a month or two until they are stabilized and can move to a lower level of care, transitional residential. We have one crisis residential facility (Nierika) and two transitional. (Richmond and Nevin House). They are each 16 beds because of MediCal/MediCaid billing limits.

(Commissioner O'Keeffe asked if Nevin House was only for patients with co-occurring diagnoses. Donna Wigand said Nevin House staff were trained to provide services to both types of patients and she thinks they any facility should be able to do both)

- Crisis Stabilization 5150 receiving center: there are 3 options: 1) could be a component of CCRMC ED that can result in long waits for mental health clients. 2) could have its own separate entrance at CCRMC and 3) relocate it to a separate facility providing 24/7 urgent care. One option is to construct a 24/& Assessment and Recovery Center (ARC) on the PHF campus. It would be more accessible, but could be more difficult to get to.
- Crisis Stabilization (CSU): currently inside CCRMC and technically part of ED: it's the psychiatric wing of the ED so it has to "walk and talk" like the ED. When the auditors come in, all the services must look like the ED and be staffed like an ED with doctors and nurses In the past, there was a psychiatric emergency staffed differently with a multi-disciplinary team. After a series of regulators inspected, they said it had to be staffed like the ED.

(Commissioner Honegger asked why a person can't go to directly to the CSU if his/her issue is obviously a mental health issue? Donna Wigand said she imagines it is because the CSU is located with the ED, but that she is not really the proper person to answer the question fully. Vice Chair Pasquini asked if someone from HSA would be able to address that question tonight. Dr. Walker said yes.

- There are no voluntary urgent care centers. The idea was to have 24/7 urgent care, voluntary walk- in service for people who need medication, etc. That is the proposed ARC. She acknowledges Commissioner O'Keeffe's concern that transportation is a issue to get there during off hours.
- One idea would be to open the new ARC for the voluntary people and leave the crisis stabilization unit at CCRMC for 5150s.
- We're talking about a continuum of care with different regulations: 4C at CCRMC is hospital; crisis residential is voluntary – it's diversion from and transition out of the hospital. The CSU is a receiving center where people can only stay for 23 hours and 59 minutes (involuntary) per state regulation. If someone stays longer, the State Department of Mental Health must be notified the hospital is out of compliance. In Santa Clara they were out of compliance so often that the

State threatened to close them down and they had to change the structure of service and staffing.

Housing Options:

- The options shown in the Chart are not treatment facilities and MHSA Capital Facilities money cannot be used for housing unless the person is a Full Service Partner. There is other MHSA funding available for housing and California has other types of funds that can be used for a number of things related to housing.

In considering alternative uses for the MHSA capital funds, MHA did a gap analysis. Some alternatives were included on the Chart and some were not because people didn't seem interested in those types of projects (ie. building a new mental health administrative office).

Commissioner Reed wanted to know who was involved in the development of the proposal. Donna Wigand explained 5 years ago when they were trying to determine with the original stakeholders how to spend the original MHSA Capital funds in the county, housing kept coming up…housing with treatment. When 20 Allen became vacant Dr. Walker, Pat Godley, Sherry Bradley, Suzanne Tavano and others thought there was a perfect storm: land, MHSA Capital money, capital to grow a continuum of care with five levels instead of two. Consumers/family members were not included specifically in the finding of the 20 Allen site because it just came up when the Health Department moved out.

Commissioner Honegger brought up the ability to purchase foreclosed properties for crisis residential sites. Donna spoke about the Babble Lane experience 11 years ago and that a year was spent acquiring a house in Concord. It blew up because of NIMBY (Not In My Backyard) in spite of limiting it to six beds. Later, they were successful in opening Crestwood Patterson in Pleasant Hill with several levels of care. Donna also spoke about Ventura County's difficulties in acquiring land for housing even though they have had the funds for the past 5 years. Regardless of the size of the facility, certain regulatory issues (a state license and notice to the public) still preside over crisis residential properties even with fewer than 6 people. It's a complicated process and difficult to site mental health treatment facilities. 20 Allen was an opportunity in terms of land availability and the convenience of being right across the sidewalk from CCRMC. Donna stated she believes that a county of 1 million people needs a residential facility in each of the 3 regional areas and she'll enlist Commissioner Honegger's assistance in finding that space in East County.

Commissioner O'Keeffe wondered if a location next to the hospital is illusory because an ambulance ride is required to transfer between facilities. Donna Wigand said unless someone is unconscious, an ambulance would not be required. Vice Chair Pasquini stated she had been told by Miles Cramer that an ambulance was required.

- **<u>TO DO:</u> Vice Chair Pasquini requested clarification on whether it takes an ambulance to transfer from CCRMC to a separate facility.**

Commissioner Pereyra is concerned that although she has heard many times, as justification for siting the new facility, there will not be any NIMBYism from Martinez, she feels there will a serious response/backlash . Vice Chair Pasquini agreed NIMBYism is rampant; Bonita House is experiencing it now. Vice Chair Pasquini said Contra Costa County is sited online as combating NIMBYism in siting housing in Pleasant Hill.

Dr. Walker mentioned this proposal is not a done deal; it's been a study from the beginning to see if the 20 Allen site was feasible and if there were bids from CBO's who could run it. CCHSA is not entirely sure that it makes financial sense yet.

B. Mental Health Commissioners' Input: Alternatives and Issues

Vice Chair Pasquini discussed her conversation and correspondence with Patricia Coyle from the DMH regarding the Commission's letter to the Board of Supervisors regarding transparency on this project. Patricia Coyle said she felt confident about the County's commitment to be transparent and DMH is looking for evidence the MHSA Capital Facilities proposal reflects what the community needs, not what the County desires. DMH will be issuing a letter to finalize the issue. The Commission has performed due diligence for many months seeking information on the Capital Facilities proposal and she requests all commissioners be mindful of the focus to provide input regarding alternatives and to overcome previous flaws in the stakeholder involvement process as mentioned in letter. At a recent BOS meeting, regarding state budget issues impacting Contra Costa County, Supv. Bonilla said everyone would like their perspective heard, to receive full information about fiscal impacts and options for consideration – a common desire for all community stakeholders. Funds are limited and we must insure we spend every dollar wisely. The Commission has identified gaps in service including dual diagnosis beds, crisis residential beds, crisis mobilization services, and all forms of housing. These are all consistent with original stakeholder forums. The commission has encouraged more dialogue and she believes they need more analysis to determine the use of MHSA Capital Facilities funds.

Vice Chair Pasquini reviewed Capital Facilities Proposals from other counties (Nevada, Ventura, Riverside, Santa Clara, Tuolumne, Sonoma and San Francisco); they provided priorities, choices and alternatives, as identified by their stakeholder process. They had list of priorities for how funds should be spent including types and numbers of facilities needed: four, five or even 10 examples of priorities. Contra Costa County had only one. It's not an accurate assessment of our capital facilities needs. She was waiting for the opportunity to discuss alternatives. She appreciates the fact the land became available, but she been looking for the connection to the transformation of the county system including how the gaps in East and West are are being addressed in this process. She also has examples of potential uses of Capital Facilities Funds from CDMH. It was proposed in April 2008 to the BOS by Dr. Walker. She does not recall these alternatives being given to the Commission at the original meeting where 20 Allen was discussed. She wants to encourage more dialogue.

Vice Chair Pasquini requested a break to introduce Carole McKindley-Alvarez as new member-at-large commissioner from District I. Commissioner McKindley-Alvarez will give an introduction at next month's meeting.

Commissioner Overby wanted to know why Crestwood Patterson was only Board and Care only; was it because a lack of support from the County. Donna Wigand said there are two levels of care with 16 transitional beds each: adult residential and transitional residential. They let go of a mental health rehabilitation center (similar to IMD); they've worked to get away from those kind of beds. County dollars would have to be used instead of MediCal funding. People can stay as long in that level of care. Suzanne Tavano mentioned different levels of care.

Commissioner Overby asked if there were statistics on how many patients are sent out of county and how long they stay there.

- **<u>TO DO</u>: Donna Wigand to obtain statistics on the number of patients sent out of county and length of stay.**

Commissioner Overby asked who checks to see if the services are provided according to contract. Donna Wigand said there are people who "ride the circuit" as a full time job checking that services are being properly provided.

Commissioner O'Keeffe brought up "accessibility" in general, not just relating to transportation. Is there any option to have a 24 hour call-in crisis line, similar to Kaiser, to get people started on asking for care. Possibly that could also be a source for issuing transportation vouchers. A crisis mobilization team could come out and visit. Is there any discussion about that to make it a true 24/7 assessment facility. Donna Wigand stated the staff at the 24/7 Urgent Care facility would have some mobile capacity, but not available to go anywhere, scatter shot. A consumer might go to a private emergency room and the mobile team called to perform a psychiatric assessment.

Commissioner O'Keeffe asked about assessment where a person is living: a call-in line directly to the 24/7 Urgent Care Facility so the person could make a connection and be transitioned by the same staff person upon arrival. The current access line is pretty impersonal. Donna Wigand said the center is called the Assessment and Recovery Center because the patient has more time with the staff for a fuller assessment.

Commissioner Honegger asked if there would be vehicles available to pick up someone in need of urgent services. Commissioner O'Keefe asked about taxi vouchers for someone who isn't sick enough to require an ambulance. Suzanne Tavano is trying to work out access for the different levels of care. Donna Wigand said the county does not have the ability to send vehicles out at this point and realizes we need to figure out the transportation issue.

Commissioner Honegger asked if Donna Wigand could guarantee transportation from different parts of the county to the new facility. She responded that she can't assure there will be a vehicle available, but she is aware transportation to a central facility is an issue. Currently the County does not have capacity for urgent physical health care transportation except for ambulances used for emergencies; the same applies to urgent mental health care transportation. Commissioner Honegger said transportation issues are different for a person in crisis with a mental health issue. Commissioner O'Keeffe thought it would be wasteful to have a 24/7 Urgent Care Facility unless people have a way to get there. Sherry Bradley said MHA has been talking to Commissioner O'Keeffe, chair of a transportation work group. Commissioner O'Keeffe is recruiting people for the work group and MHA will be working with them to develop solutions.

Commissioner Reed asked if the $25.1 million is for the construction, land and equipment, where does the staffing funding come from and might the current budget climate impact the design of the proposal? Pat Godley stated he didn't know at this time. RFP's were sent out based on the current proposal to assist with financial evaluations. CCHS is evaluating the CBO responses for financial viability. We've asked for more clarification and are evaluating it and cannot tell if it's financially viable yet. He provided BOS Finance committee a few months ago with numbers that seemed to be financially feasible, but those numbers are being validated.

Commissioner Reed wanted to confirm the RFP that was sent out was based on the proposal shown today. It presumed a certain mix of patients. Is the thought that if the number crunching shows it's viable and you

nail down what it will be, will there be another RFP (with the new proposal) issued to CBO's? Pat Godley says the current vendors would be the vendors that this would move ahead with.

Commissioner Reed wanted to confirm consumers, family member and Commissioners would be involved in the selection of the Provider: deciding on services to be provided and how to be involved in monitoring the services. Is that reasonable? Donna Wigand said that yes, RFP's have been shared with Capital Facilities Workgroup members as part of the review panel; anyone interested can see the RFP's.

Commissioner McKindley-Alvarez wanted to confirm that she heard consumers were not involved in the planning process. Donna Wigand said the 20 Allen proposal is one proposal that may or may not be viable. For the entire project there will be consumers, family members, etc. will be on the review panel; this is just a feasibility study. She suggested an ongoing review/oversight body for this campus if this project every happens.

Commissioner McKindley-Alvarez questioned if consumers had been involved from the very beginning would transportation have been integrated in the dialogue all along rather than an issue to be explored after the fact as it is now. Access should be presented at the same time as the facility proposal. ?? Asked if MHSA funds could be used to purchase a van. Donna Wigand said Capital Facilites money could not be used, but other MHSA funds could. Susanne Tavano mentioned there has been a year long consumer input process and there is more history than just what presented today.

Chair Mantas spoke regarding the inclusive nature of the process. Although stakeholders were involved, the Commission has made it clear the process wasn't up to par. In the last few months, he's seen a change in the Commission's inclusion/involvement and it's been an extremely positive transition.

- A continuum of care doesn't mean all services must be in one facility. It means all the services are available and that the client is transitioning efficiently, effectively and that the quality of the transition is better. (He spoke about his recent experience at Kaiser and although the service was phenomenal, the transitions from ICU to the surgical bed to discharge "stunk.") Someone can be doing a great job, but the communication and the hand off isn't good enough. The lack of communication is causing significant problems for the clients we serve. We're destabilizing people and wasting money. He feels it's critical this proposal look at transitions between services and transportation options.
- CSU and ED are dysfunctional at the immediate moment; how do we handle clients going from ED to CSU? He hopes someone is planning assessments of that process. Why can't a person go directly to CSU? (He describes a situation where someone wasn't seen in a timely way, left the hospital, killed his father several hours later and is now in jail). People with mental health issues are not being serviced in a timely fashion and we need to deal with triaging people who come to the ED.

➢ **<u>TO DO:</u> Chair Mantas requested Dr. Walker look into ED to CSU situation to improve performance in that area and update the Commission on his findings once completed.**

- Have we worked with private hospital providers to see if there are alternative ways to provide these services, even if not in one facility? It's important that those folks be involved. Also the ambulance issue? Why take a consumer to CSU if they need to go to a private hospital? He

believes CCRMC should sit down with the other hospitals and determine how to deal with that issue.

Supv. Piepho apologized that she had to leave the meeting. She thanked CCHS for encouraging the dialogue. Things are getting worse; look at this project as an opportunity to meet a growing need in these hard times.

Commissioner Honegger asked Pat Godley if any progress had been made with regard to modifying the numbers and the amount bonded as discussed at one of the meetings. Nothing as been changed at this point; everything is contingent upon reviewing the RFP responses.

Commissioner Honegger asked about several million dollars in CSS Mental Health funds; when is that pot coming in and when we will be looking at it. Donna Wigand responded it would have to be next year and could not be used to operate the PHF. She confirmed the uses for these funds still must go through the public process. CSS funding has risen annually in the past, but for '09-'10 $20 million is available and the projections for '11-'12 indicate a drop in available funds. There are unexpended funds because we haven't expanded the original CSS program and a prudent reserve has been built up which should offset lower funding in '11 –'12. The prudent reserve is accessed through applying to the state, but the state has already come out in writing that every county in the state will have to access their prudent reserve. Commissioner Honegger asked how will state budget cuts may impact the prudent reserve. Donna Wigand stated these funds are not subject to raiding by the state.

Commissioner Reed wanted to confirm that as Chair Mantas and Commissioner O'Keeffe mentioned there are things not included on the Capital Facilities Alternatives matrix because it only refers to 1 of the 6 pots of MHSA funds. (ie. A transportation voucher proposal is not shown because it is not a capital facilities expenditure.) She asked about the time line for purchasing property: Dr. Walker indicated the option to purchase must be exercised by 12/31/09. Although we don't have to have the final proposal in place by 12/31/09, we do need to know we want to have a proposal including the 20 Allen property by that date.

Chair Mantas clarified his position that although some of the items he has mentioned are not included in the Capital Facilities matrix because they are not capital facilities items, they are issues consumers and stakeholders have brought up (ie. the ambulance ride issue). Possibly they could be included on a separate matrix as an addendum to Capital Facilities matrix to insure these items are addressed and people know how we are moving forward.

Vice Chair Pasquini asked if Dr. Walker would make a comment about the transition between ED and CSU situation. Dr. Walker said we're looking at how processes work throughout the hospital, including issues of transitions. He feels a little bit ahead of the curve because of the Lean process we're going through. There is no time line at this point.

Vice Chair Pasquini recalled there was a discussion 3 years ago that it wasn't possible to "open the door" (to allow direct admission to CSU rather than being screened first by the ED) due to Title 22 regulations. Her understanding now is there may be a potential loosening of that; is that accurate? Dr. Walker indicated the relationship between CSU and ED, funding availability and staffing issues are being reviewed. If a mental health patient arrives by ambulance, the process of being screened in the ED then moved to CSU should move pretty quickly, but it doesn't always work out that way. The ER staff is overwhelmed and it will get worse when the flu season comes. Commissioner Pereyra reminded the public that the discussions of admitting mental patients directly to CSU rather than through ED have been ongoing.

Commissioner Kahler spoke of the Kaizen process that was introduced to CCRMC as an outgrowth of the Lean process. The hospital received a grant and ran orientation for the entire staff to energize them to address the problem of transition among other issues. Kaizen, an expression meaning continuous incremental improvement, advocates individuals identifying a problem and determining who is responsible the solving it, rather than forming a committee. He described how last night volunteers from a non-profit group who will serve as transition support for family members/friends of patients entering CSU/4C served dinner to the psychiatric staff. This gave the volunteers an opportunity to let staff know their goal of assisting family members understand what is happening, provide mental health resources and that their loved one is being treated by caring professionals. The new CEO, Anna Roth, is very committed to the Lean process and trying to turn things around. This is a giant step in the right direction.

C. **Possible Modifications:** covered under B. Mental Health Commissioners' Alternatives and Issues

D. Public Comment

Ann Heavy - She knows how hard the stakeholder groups worked to come up with ideas to help the consumers. She was concerned when she worked on the MHSA steering committee that good ideas presented would not get past the talking session at the meeting. At least constructive things were said tonight. She brought up several issues: 1) the ability to place modulars, currently available in the County, on the hospital grounds to be used for classes for mental health patients. She referenced Kaiser's cognitive thinking class and how there isn't anything similar offered in the County system. 2) Transportation has been an issue since 2004 when MHSA funds became available. What would it take to run 10 vans to take people where they need to go. 3) With all the foreclosed properties available, the County should be looking at those and using some of the MHSA money to purchase several houses. Possibly NIMBYism could be combated if properties were considered in areas where the houses aren't so close together. Also possibly engage Habitat for Humanity. We talk about a lot of stuff, but nothing ever comes to a conclusion. Discussed the inefficiencies of the County Connection bus system.

Commissioner O'Keeffe shared she heard at an Operations and Scheduling Committee meeting the philosophy of public transportation: voters voted for a bus system for school transportation and emergency evacuation; other needs weren't relevant. The needs of people unable to drive were not considered in the development of the system.

Marianna Moore - A question regarding process: She hopes that there is a clear representation of what the next steps are, who is involved and other alternatives being considered after this meeting. She would like to learn more about possible alternatives based on more regionally sited facilities. Will there be a similarly rigorous process to explore those other options including RFPs, feasibility studies, numbers crunching and political issues. What are the needs of community members and how they can or cannot be better addressed by regionally sited facilities. What happens in the next several months?

Brenda Crawford – MHCC is the oldest consumer run organization. She went to Phoenix last week and looked at their continuum of care model built on peer run services. Since formation of The Living Room, their peer run lower level of care organization, the number of involuntary commitments has dropped drastically. Peers work on their psych wards. She came inspired around the power of peer-to-peer services and how it should be integrated into the overall mental health services. They have a model similar to the

PHF: acute care, lower level run by peers, 24/7 hour assessment center and a warm access line; the number of people committed involuntarily and being restrained in 4 point restraints has fallen. MHCC primary concern is to keep people out of hospitals, get people into recovery and that there are options. Incidents of 4 point restraints in Phoenix has also fallen. She saw the power of mental health system when it's inclusive, both peer run services and clinical services. She is not specifically endorsing the PHF, but advocating changing this system so it really reflects a continuum of care model with the consumer as the primary focus. The model is changing people's lives and they are recovering.

Sharon Madison – She endorses the PHF concept but has four concerns: 1) $25 million is a lot of money: Only one proposal has been presented and there is nothing to compare it against. It will be a tear down with new construction vs. a remodel of a vacant property in this low cost real estate/lending market; is that the best course. 2) The location of the PUF: She imagines the hospital would really like that piece of property because of it's accessibility, but wouldn't the logical solution be to put the PUF somewhere else on the bus line rather than Martinez which is hard to get to. 3) The 23 beds at the hospital: The original proposal to close them was rescinded, but she is concerned with budget issues they may not be open for very long. If they were closed we'd be in a very sad state. We have an existing, local 23-bed facility that works very well. To put a PHF right next to the existing beds, there's nothing to keep that PHF there. 4) Finances and the level of care at the PHF: Finances are a big issue, but she's seen other PHF's and you get what you pay for so it will definitely have to be monitored.

Rollie Katz – He is concerned the matrix shows pros with very few cons. He asked if the capital work funding would all be from MHSA. Donna Wigand stated MHSA funding is only for voluntary, unlocked facilities. There's a pay mix and that's the same for the staffing. Pat Godley stated it is all related to looking at the CBO response. We are already spending the money for 15 people going to private hospitals. 4D had more capacity than we needed. If 20 counties out of 58 have psychiatric inpatient units, either public or private. Are they the larger counties? How many counties have PHFs and inpatient? What is the plan for CSU staffing? If CSU is outside the hospital, does the staffing model change from the medical model to more of a multi-disciplinary approach? Donna Wigand said the medical staffing model can change only outside the 4 walls of a hospital.

- **<u>TO DO</u>: Donna Wigand to provide information on what larger counties have PHF's and how many counties have both PHF's and inpatient.**

Sam Yoshioka: Feels there is a lack of anaylsis for these alternatives. If 30 counties have PHF, how many are next to a hospital? How many are out away from hospitals? More importantly how effective are the PHF's? How effective are the options for crisis residential, crisis stabilization, and urgent 274/7 facilities? Information was presented, but we have no idea how effective the options are. Are there any studies on what is the best practice? Donna Wigand responded there are studies in the packet that address his questions on best practices and offered to speak with him later specifically about the studies.

Ron Johnson – If health care reform is passed on a national level, some aspects of this program may be changed for the better. He also spoke about trying a multi-county group together to get some of the regulations that hamper the County changed. Donna Wigand let him know that most of the regulations he spoke of (ie. hours, billing) are federal regulations and very difficult to get changed from the County level.

E. Next Steps

Chair Mantas listed a number of recommendations:

- Request a meeting between County and private hospital providers to review the plan and see if alternatives can be developed. (Suzanne Tavano explained that Medi-Cal cannot be drawn down from private hospital services)
- Develop a definite plan regarding ambulance transfers
- Transportation issues be resolved
- Continued communication and request for more housing – an addendum to the plan
- Look at other locations more central to public transportation
- Delineation of how many beds can be used for children and adolescents

Commissioner Reed said the process should consider other pots of money and recognize there are no money machines and what the impact of request are; are they reasonable or is it just pie in the sky. An example: there is money for buildings but not for transportation.

Brenda Crawford said there should be specific language that talks about peer run services and the role consumers/peers will play in the process

Commissioner Pereyra suggested we need to take a step back. If we had a perfect world, with a variety of services, this would be a nice addition. We should bring CPAW and service providers together to explore other alternatives. This proposal is very institutional. She feels crisis intervention belongs in the community rather than in a central location. Is one central facility vs. more regional sites truly a better use of $20 million in MHSA funds?

Vice Chair Pasquini suggested combining efforts with CPAW, Capital Facilities Workgroup and possibly others. She encouraged all commissioners to go to the CPAW, MHSA and the County websites and read all the information available. Being interested in the next steps she would like to entertain a motion that CPAW and Capital Facilities Work Group join forces to consider alternatives and report back to the Commission to then make a recommendation to the BOS. This discussion might be influenced by budget considerations to be announced Sept. 15, 2009 which will require working quickly with Health Services staff to identify possible cuts and how they may impact this proposal and any suggested alternatives.

Vice Chair Pasquini noted she and Commissioner Reed are CPAW members as well as Capital Facilities Work Group members. In addition, The Capital Facilities Work Group members include Commissioner Honegger as chair and Commissioners O'Keeffe and Pereyra.

- **<u>ACTION:</u> Commissioner Reed made a motion requesting the Capital Facilities Workgroup join forces with CPAW members to analyze the options and alternatives and bring a list of priority needs back to the full Commission for a final recommendation to the BOS. This discussion might be influenced by budget considerations to be announced Sept. 15, 2009 which will require working quickly with Health Services staff to identify possible cuts and how they may impact this proposal and any suggested alternatives. Also concerns voiced at the 9/30/09 Public Forum would be incorporated. Commissioner Kahler seconded the Motion. (The Motion was tabled by Chair Mantas while he made another motion-see below. He explained that procedurally the Commission needed to develop a list of alternatives**

to be assessed. Once these alternatives are approved then Commissioner Reed's motion would be discussed and voted on. After discussion his Motion was withdrawn.)

Discussion:

- Chair Mantas stated with the information provided today to Health Services and Mental Health Administration, they should be able to do some more assessments to bring back to the Commission and they should launch activities with CPAW to reach that point. He would like to focus on the public forum on 9/30/09 to hear these assessments and then take the next step. The public forum is appropriate to hear more consumer voices, other options, costs of other options and hopefully get private hospital service providers involved in the process for ideas. Would like to request Commissioner Reed's motion request be reconsidered.

- Suzanne Tavano suggested as alternatives are considered, we be mindful of private providers and the programming for which Medical dollars can and cannot be used.

- Chair Mantas feels that a meeting should take place to bring different people with common interests and their ideas together. The meeting should include private hospital and other service providers. The Welfare and Institution Code requires that before any County initiative goes forward to build a new facility the private options as well as other public options be assessed. In his opinion, this assessment has not taken place. He believes collaboration between public and private providers will bring great results.

- Commissioner Honegger, as Chair of the Capital Facilities Workgroup, said he didn't have enough information regarding finances to do this work without assistance from the County.
- Commissioner Reed stated that additional resources other than Capital Facilities Work Group and the Commission, including the County, could be utilized in forming the alternatives brought back to the Commission.

- Julie Freestone was concerned the 3 weeks until the public forum on 9/30/09 wasn't sufficient time to prepare a comprehensive of list of alternatives.

- Commissioner Reed thought the 9/30/09 public form was an educational meeting similar to today's where current options are presented and other ideas/input (including from consumers) are solicited to form a list. Priorities and financial feasibility would be reviewed then the list presented to the Commission.

- Vice Chair Pasquini is not convinced the 9/30/09 public form is necessary, but is committed to being inclusive of the public. Having CPAW and Capital Facilities Workgroup work together to debate the alternatives would achieve the same goal.

- Chair Mantas stated that in order for recommendations made by him and others earlier in the meeting to be assessed, a motion is needed to require those alternatives be considered.

- **ACTION: Chair Mantas made a Motion to adopt the recommendations given by the commissioners and the public for County Health Services and Mental Health Services to explore alternatives. These alternative include:**
  - **-Work with private hospitals and other service providers to look at alternative methods of providing the referenced services**
  - **-More housing**
  - **-Are there alternative locations**
  - **-Develop a definite plan regarding ambulance transfers**
  - **-Transportation issues be resolved**
  - **-Continued communication and request fore more housing – an addendum to the plan**
  - **-Look at other locations more central to public transportation**
  - **-Delineation of how many beds can be used for children and adolescents**

After discussion Chair Mantas withdrew his Motion in order to reconsider Commissioner Reed's motion. He requested the language be kept in case the Motion needs to be reconsidered. The Motion was not voted on.

Discussion:

- Dr. Walker stated the Commission may be feeling some time pressure that is not there. County Health Services/the County has an interest in the land because of its location next to the hospital, but if there is not agreement, the group can start the entire planning process again.
- Commissioner Pereyra commented she was unclear why a motion itemizing specific alternatives to be explored was necessary.
- Chair Mantas said the consideration of alternatives was the reason for the meeting. The Commission can decide separately whether or not to have a public forum on 9/30/09. The Commission can al decide it has heard enough discussion to move forward with the process or it would like to see alternatives presented in a public forum to the public for comment at some point.
- Commissioner Reed thought her motion was to get the Capital Facilities Workgroup to prioritize all the options. Chair Mantas' option is not addressing the same issue and the motions are not working together.
- Vice Chair Pasquini sees MHA as being at the table at CPAW.
- Donna Wigand sees the County's role as presenting information/consultation not working directly with CPAW and Capital Facilities Workgroup committee.
- Commissioner Honegger feels the Capital Facilities Workgroup needs the county's assistance with information to prioritize effectively. With these suggestions, what is the proper time limit?
- Chair Mantas feels CPAW, the Family Steering Committee and MHC have come up with suggestions for alternatives. The only new idea is for private hospital provider involvement. It's time to assess the alternatives (and have a public forum if the Commission wishes it) then move forward. He doesn't wish to create additional work for the Capital Facilities Workgroup and CPAW.
- Commissioner McKindley-Alvarez requested clarification on the two motions. After discussion Chair Mantas withdrew his Motion.
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- **ACTION: REPHRASED MOTION: Commissioner Reed made a motion to designate CPAW and the Capital Facilities Workgroup to analyze the options and alternatives and**

assist in bringing a list of priority needs back to the full Commission for a final recommendation to the BOS. This discussion might be influenced by budget considerations to be announced Sept. 15, 2009 which will require working quickly with Health Services staff to identify possible cuts and how they may impact this proposal and any suggested alternatives. Also concerns voiced at the 9/30/09 Public Forum, if there is one, would be incorporated. Commissioner Kahler seconded the revised Motion. The Motion was passed 8-1 with Chair Mantas dissenting.

- **ACTION: Commissioner Reed made a motion to table the public forum tentatively scheduled for 9/30 until further work was completed. Commissioner McKindley-Alvarez seconded the Motion. The Motion was passed unanimously.**

Vice Chair Pasquini announced due to the unavailability of MHA staff the 9/10 MHC meeting was cancelled and that the next regularly scheduled Commission meeting would be 10/8 at the Concord Police Station.

4. **ADJOURN MEETING**

- **ACTION: Chair Mantas made a motion to adjourn meeting. Commissioner McKindley-Alvarez seconded the Motion. Motion was passed unanimously. The meeting adjourned at 7:25 pm.**

(Note: Supervisor Piepho had to leave the meeting before its conclusion and was not present for any Motion votes.)

Respectfully submitted,
Nancy Schott, Executive Assistant
Contra Costa County Mental Health Commission