



CONTRA COSTA COUNTY  
MENTAL HEALTH  
COMMISSION

*The Contra Costa County Mental Health Commission has a dual mission: 1) To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and 2) to be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.*

**CONTRA COSTA COUNTY MENTAL HEALTH COMMISSION**  
**MHC/CPAW Capital Facilities Workgroup**  
**Monday • November 2, 2009 • 6:15-8:15 p.m.**  
**MHCC Central County Wellness & Recovery Center • 2975 Treat Blvd., Bldg. C • Concord**

*The Commission will provide reasonable accommodations for persons with disabilities planning to participate in Commission meetings who contact the Executive Assistant at least 48 hrs. prior to the meeting at 925-957-5140.*

**AGENDA**

*Public Comment on items listed on the Agenda will be taken when the item is discussed.*

1. 6:15 **CALL TO ORDER / INTRODUCTIONS**
2. 6:20 **PUBLIC COMMENT**  
The public may comment on any item of public interest within the jurisdiction of the Mental Health Commission. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute maximum time limit (subject to change at the discretion of the Chair). In accordance with the Brown Act, if a member of the public addresses an item not on the posted agenda, no response, discussion, or action on the item may occur. Time will be provided for Public Comment on items on the posted Agenda as they occur during the meeting. Public Comment Cards are available on the table at the back of the room. Please turn them in to the Executive Assistant.
3. 6:25 **REPORT FROM MENTAL HEALTH ADMINISTRATION**
  - A. Children's Proposal-Hear report and written information on exact number of out of County and out of State placements, along with the number of inpatient beds available to children in county, and the budget for all of these expenses.
  - B. Older Adult Proposal
4. 6:45 **ANNOUNCEMENTS**
5. 6:50 **APPROVAL OF THE MINUTES**  
**ACTION** October 19, 2009 MHC/CPAW Capital Facilities Workgroup meeting
6. 7:00 **CHAIR COMMENTS**
  - A. Invite Julie Freestone to assist in facilitating the meeting.**ACTION**
  - B. Request IMD, CCRMC, and all acute hospitalizations Budget for Mental Health.
  - D. Acknowledge receipt of current list of county owned properties.
7. 7:15 **QUESTIONNAIRE/SURVEY DRAFT-Steve Hahn-Smith**
  - A. Report on Questionnaire/Survey timeline delay. Refer to emails.



- B. Review Guidelines for the IT Component (Enclosures 1 and 3) and CCC plan (Component Exhibit 4) submitted to DMH.
  - C. Hear Report and recommendations from Steve-Hahn Smith on survey process and IT data and information.
  - ACTION** D. Questionnaire/Survey Draft: Review, discuss test run of survey, consider both Capital Facilities and IT questions and make final recommendation.
  - ACTION** E. Set new timeline for questionnaire/survey and include plan for an assessment of the Survey results and financial analysis of choices.
8. 7:55 **REPORT INFORMATION ON ANY NEW PROPOSALS FROM STAKEHOLDERS**
- A. Brainstorm on suggested use of Capital Facility Funds and Information Technology funds.
9. 8:05 **HEAR MEETING OUTCOMES and SET NEXT MEETING DATE**
10. 8:15 **ADJOURN MEETING**

*Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the staff to a majority of the members of the Mental Health Commission less than 72 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Ste. 200, Martinez during normal business hours*

**MHC/CPAW Capital Facilities Workgroup Meeting**  
**Date: October 19, 2009, 6:15-8:15 p.m.**  
**Location: Mental Health Consumer Concerns (MHCC)**  
**2975 Treat Blvd., Bldg. C, Concord, CA 94518**

**Minutes - Draft**

**1. CALL TO ORDER/INTRODUCTIONS**

The Workgroup meeting was called to order at 6:20 p.m. by Chairperson Teresa Pasquini.

MHC Capital Facilities Workgroup Members Present:

Teresa Pasquini, District I – Chair, Annis Pereyra, District II, Anne Reed, District II

Absent: MH Commissioner Colette O’Keeffe

Consolidated Planning Advisory Workgroup Members Present:

Brenda Crawford, Kathi McLaughlin, Tony Sanders

Staff Present:

Sherry Bradley, Susan Medlin

Other Attendees:

Audrey Granpal, AAA Mental Health, Richmond

David Kahler, NAMI, Mental Health Commissioner

Charles Madison, NAMI

Sharon Madison, NAMI

Ryan Nestman, Consumer, Family Member, CPAW Member

Karen Shuler, MHS Communication Coordinator

Connie Steers, Patients Rights Residential Advocate with Mental Health Consumer Concerns

Sam Yoshioka, Member of the Public, Mental Health Commissioner

**2. PUBLIC COMMENT**

Sharon Madison mentioned that she and her husband are just getting involved in mental health issues. She stated they have asked questions during the Public Comment period at other meetings they have attended, but have received no answers. Teresa and Kathi explained the Public Comment process to her (comment can be taken on non-Agenda items but only briefly commented on), and suggested that she contact the groups they attended to get their concerns on the Agendas, where there can then be discussion. It was also suggested that she contact Nancy to be placed on the MHC mailing list.

**3. ANNOUNCEMENTS**

- Teresa announced that the Board of Supervisors has an item on their October 20<sup>th</sup> Agenda discussing a sustainability audit of the hospitals and clinics for the county that may be of interest to those present.
- Brenda distributed a flyer about MHCC’s Annual Holiday Party on December 11<sup>th</sup> from 11-2 at the Pleasant Hill Community Center. She said the Party will be the official re-launch of the Contra Costa County Network of Mental Health Clients.

**4. APPROVAL OF THE MINUTES**

A motion was made by Anne Reed and seconded by Brenda Crawford to approve the Minutes from the October 5, 2009 MHC/CPAW Capital Facilities Workgroup meeting.

Discussion: Anne asked that it be notated that Dave Kahler left after giving Public Comment and did not participate in any of the votes. It was pointed out that he was not a member of the Workgroup so could not

vote. There was discussion as to how to format the list of meeting attendees in the Minutes. It was decided that in future Minutes, members of the Mental Health Commission who were not specifically members of this Workgroup would be listed among the "Other Attendees" and be considered members of the public while in attendance. People were asked to state their affiliation for the record. The wording of the membership lists was changed as shown above for future Minutes. There was discussion on who was officially representing CPAW on the Workgroup and it was clarified that Brenda, Kathi and Tony are the CPAW Representatives. The Minutes should be corrected to show David Kahler as an "Attendee" and Susan Medlin as "Staff". Sherry said they would decide at CPAW who another representative would be to reach a balance of four Commissioners and four CPAW Representatives. The Minutes were approved as corrected (the attendance list) with one abstention.

## 5. CHAIR COMMENTS

- A. Report on MHC 10/8/09 meeting (refer to DRAFT Minutes from that meeting). Share public comments heard at the Mental Health Commission Meeting. Refer to letter received from the Diablo Valley Family Coalition.

Teresa referred to the Draft Minutes from the 10/8/09 MHC meeting (included in the meeting packet), and explained that this group requested that the Commission approve our questionnaire minus the IT que ... to basically give us the permission to go forward with our questionnaire process. She stated we didn't want to be held up and have go back to the Commission and so we submitted the questionnaire as it stood that day.

Kathi said that since this has to do with the Questionnaire, it should be discussed under Agenda Item #6, which is an action item.

Teresa responded that she was just going down her Chair Comments and wanted to share the Public Comments from the MHC Minutes, and asked if that should be referred down to the next item as well.

Kathi said it would make more sense and Teresa agreed.

- B. Invite new attendees (Workgroup members only) to state their personal goals for the outcome of this process.

Kathi responded that she was there to ensure that kid's issues are addressed when discussing capital facilities because in Contra Costa County we haven't had much in the way of capital facilities programs or services. She stated our kids have two beds in a room off the Emergency Room and they overflow that on occasion. She said it was her considered concern that we ought to have a separate place for them. In response to a question, she defined children as 18 years of age and under. She stated that by law, children under 18 may not be admitted, but can only be held for 23 hours and we have no appropriate place to hold them for those 23 hours. The holding space this county has is a small room with a couple of lounge chairs.

- C. Report any new developments discussed at 10/15/09 CPAW meeting.

There was nothing to report.

- D. Discuss ways to inform workgroup members, on previous efforts, without reviewing at each meeting. Brainstorn on data compilation and links to previous meetings and documents. Seek ways to inform the workgroups and the public, through a Lean process, that would assist the timeline requests.

Teresa said it wasted time to rehash things at every meeting. It was suggested that new members go to the MHC, Health Services, CPAW and MHSA websites to be brought up-to-date. There has been discussion of getting a separate website for this issue. Anne suggested creating a Facebook page as opposed to waiting for the County IT people to post items to the website. Sherry said it could be done either way. She added that the County has a Facebook page. Susan suggested doing both – posting to the website and to Facebook. She said consumers would check the website first. Brenda stated that MHCC directs consumers to the websites. Kathi made a motion to have all materials from this Workgroup posted to the MHSA website. Annis seconded the motion. The motion carried with one abstention.

- **Recommendation: Have all the MHC Capital Facilities/CPAW Workgroup materials posted to the MHSA website.**

## 6. QUESTIONNAIRE/SURVEY DRAFT

- A. Hear report and recommendations from Steve Hahn-Smith on survey process and IT data and information.

Steve Hahn-Smith was unable to attend.

Sherry referred to the Enclosure 2: *MHSA Capital Facilities and Technological Needs Component Project Proposal Proposed Guidelines for the County's Three-Year Program and Expenditure Plan* (included in the meeting packet). She stated they reviewed the Specific Requirements for Capital Facilities funding when writing up the questionnaire to be sure we were still focusing on what the Guidelines say:

“Capital Facilities funds shall only be used for those portions of land and buildings where MHSA programs, services and administrative supports are provided; consistent with the goals identified in the Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) components of the County's Three-Year-Plan.”

She said they went back to that because a lot of what happens in the way of what is recommended for capital facilities has to be related to the CSS and PEI Plans and it has to be an MHSA service. Sherry said that in our current CSS Plan there are six workplans:

1. Children's Full Service Partners (FSP's) in far east county
2. Adults FSP's in west county (used to be called Powerhouse – now called Bridges to Home)
3. Transition Age Youth FSP's
4. MHSA Housing
5. Older Adults (not full service partners)
6. Systems Development

Sherry also discussed the goals for CSS listed in *Section 1. Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports* (included in the meeting packet), where the core are of needs identified by the community were listed:

### Children/Youth

1. Failure in learning environments
2. Out-of-home placements
3. Involvement in child welfare or juvenile justice systems

### Transition Age Youth

1. Homelessness
2. Incarceration
3. Hospitalization or involuntary care

### Adults

1. Homelessness
2. Isolation
3. Inability to work

### Older Adults

1. Unnecessary loss of functioning
  - a. Frequent hospitalizations
  - b. Frequent emergency medical care
  - c. Inability to work
  - d. Inability to manage independence
  - e. Involuntary care
  - f. Institutionalization
2. Isolation

Sherry then referred to the needs listed under the PEI Plan's *TOP Stakeholder Priority Strategies to Address Target Populations 0-25 Age Group* and *TOP Stakeholder Priority Strategies to Address Target Populations 26+ Age Group* (included in the meeting packet). Sherry said she was going through this because she wasn't sure the information about how these needs came out the way they did had been explained to them. She said it was a long planning process. The first Plan involved about 1100 individuals and the second process was about 900 individuals plus focus groups, surveys, and then out of each of those processes the needs were identified. Sherry explained that if you try to link what the Guidelines say, in terms of being sure that whatever you're doing is going to be some type of an MHSA service, and it has to be true to your CSS Plan and your PEI Plan, it helps to logically do a needs assessment survey with consumers.

Susan said she didn't want to put things on the survey that would lead consumers to think they were going to happen; it would become a token wish list for the consumers and expectations would not be able to be met.

In response to a question about when these surveys were done, Sherry explained that for CSS, the surveys done in 2004-2005 resulted in the 2006 Plan, and cover 05-06, 06-07, 07-08. For PEI, the surveys done in 2007-2008 resulted in the Plan approved in March, 2009.

B. Questionnaire/Survey Draft: Review, Discuss and make final recommendations.

Sherry said that when she and Susan were working on writing this Survey, they struggled with the issue of not putting something on here that was unrealistic, in that the state may not approve it because it was not in our original CSS Plan, or in the PEI process. It also has to be an MHSA service. Lots of things could be listed on the Survey as questions, but due to the guidelines, it might not be realistic to do them.

Rather than having to do all this work again, Anne asked about creating a comprehensive survey that would include non-MHSA funds in case other funding sources come up. Susan replied that it would need to be identified as a non-CSS survey. Tony mentioned the Survey was just a piece of the process, and that building on this has created a wealth of information. Annis mentioned they had been told the CSS Plan could be amended if a need arises. Sherry confirmed this, and added they just wanted to be careful not to put something on the Survey that could not be done to avoid raising expectations. Anne replied that she felt people understood that when they are surveyed, it didn't mean everything was possible. She said she understood this Survey to be a temperature check of what the consumers, family members, and the public think we need in the mental health system and try to take all this and see how it dovetails in this amount of money and the ideas that are floating out there and do it in a quick, efficient manner. She added that now it seems like we're just self-narrowing down everything to just these few things that we may be certain can be funded by MHSA. She added that she didn't think we were taking advantage of the vehicle. Kathi agreed with Susan, saying an expansive survey would raise unrealistic expectations. She added that she doesn't see any other monies coming in. Because of state budget cuts, MHSA funding has become a larger part of the mental health budget than was intended.

Susan stated that, speaking as a consumer and not an advocate, she wants the group to get as much as we can. She said she knows the county isn't going to approve programs or staff that doesn't have a funding stream. Consumers want a "peer-supported, don't-go-to-the-hospital, don't-be-sent-out-of-county" program which can be supported by saving money. Money can be saved if consumers have a place to go in county and not be sent out-of-county. Susan added that we should work with what they want to do and get what we want out of it. Brenda said she supported what Susan said in terms of looking at what's realistic and maybe looking at what can get approved but the county and what can actually get us the biggest bang for our bucks. She added that if we had crisis residential facilities in all three areas of the county, this model has been proven to reduce involuntary commitment in other places

by as much as 25%. She suggested looking at seeing what kinds of services are out there, what kinds of models we can bring that would meet the MHSA guidelines, and look at how these services can bring in all kinds of benefits, which is to reduce out-of-county placement, etc.

Tony mentioned a part of agenda item #5 that had not yet been addressed, which was to refer to a letter received from the Diablo Valley Family Coalition (included in the meeting packet). He said there were concerns raised in that letter and also in Dave's comments last month that we might lose this opportunity if we have to go through the survey process. He added that we might want to move quicker than what the survey process would do.

Teresa said that it sounded like we were going back to the first meeting where the charge of the group was discussed, and that there was now a desire to change the charge of the group. Tony said there were letters expressing a concern about the timeframe.

Kathi mentioned that from the children's perspective, there has never been a receiving center, and according to Children's Mental Health Program Chief Vern Wallace, we are now at an outrageous number of kids in out-of-home placement, including a very large number in out-of-state, not just out-of-county placement, as far away as the east coast. We need a whole system of care, but with only having the little bit of space that we have available, one of the things that has happened is that kids under the education-related AB3632 placement jumped from out-of-home, out-of-county, out-of-state placement at places that are not (in her opinion) that therapeutic. So from the children's perspective, Kathi said they wouldn't want to lose the opportunity to have something here in the county that could help us keep our kids here and address their crisis needs. Kathi also made the suggestion that on the Survey, under ALTERNATIVES TO HOSPITALIZATION: Crisis Residential Facility for Youth Adults, Adults, Older Adults (unlocked) – they need to be separated out because young adult and TAY needs are different, and certainly the older adult piece needs to be pulled out because that's an entirely different population that needs its own services. She added that for the survey purposes it would be helpful to break out the age groups.

Anne asked Tony if he was now questioning whether we should do a questionnaire. She reviewed how at the last meeting, it was her understanding that the workgroup had agreed to do a questionnaire, go to the Commission and get their approval (which they did), and that this meeting was to finalize the questionnaire and get it out ASAP and to establish a timeline -- which allowed us to be sensitive to this, sort of amorphous December 31<sup>st</sup> deadline so that we could get the information out, get it back, compile it and then look at it quickly in order to decide whether we're on the right path with the 20 Allen project, or that we should be on another path – what opportunities there are to use the money in a way that we recommend based on the results of the survey.

Annis said that there was a need to address what the reason for this committee being here was. She said it was created because there was not proper input from the community, and there was no other way that we could function except to go back and get the community input. She added that the workgroup decided they were not going to be deadline-driven – that they can't do what the state requires under the MHSA unless the community is polled and asked.

Tony said that he thought he had heard that the group was going to go back and ask for information about the timeline. Teresa responded that it on the agenda as item #7. He mentioned again the postponement of earlier agenda items.

There were questions regarding the length of time it would take to send the survey out and receive responses back. Sherry responded they would have to be printed, mailed, e-mailed and some delivered manually. Sherry added that when the workgroup develops their timeframe, she will work within that.

Referring to what Kathi had said earlier, Ryan said his son was in a crisis situation recently and he felt the decisions on where to take his son are made on what is available. He felt that if he had had a place to go where he could calm down in this county that wasn't involuntary, it would be better.

Anne asked Ryan if the survey addressed his concern, if it is going to get the information he needs to make a decision. He asked that there be additional space to write comments placed under each topic. Anne suggested adding a space for "Your Ideas" under each topic.

Susan mentioned that "Mental Health and Substance Abuse Services (integrated)" shouldn't have been included on the survey because county mental health can't bill for them. Tony clarified that it can't be billed for if it is the primary focus of their treatment at mental health.

Tony brought attention to questions on the survey that didn't pertain directly to capital facilities, but rather to what services would be desired at facilities. Kathi agreed, saying they sounded like programs or components of programs within the facilities. Sherry said she wasn't sure they belonged there, but she and Susan had put them in there because they didn't want to lose sight of the fact that these things could happen and could be in the setting. Kathi said some of the questions do not appear to be capital facilities-related.

Anne asked for clarification on where the actual survey ended on the documents that were presented to the group. Susan responded that it was a two-page survey and ended following the section entitled "YOUR INTERESTS."

Anne questioned the need for the column entitled "URBAN OR RURAL SETTING" and suggested it be deleted. Sherry explained that in Contra Costa County there were several areas that had received federal designation as being "rural." An example given was the town of Knightsen in far east county. Connie mentioned that many of the county's licensed board and cares are in this rural area and there is no public transportation to get them to community wellness centers. Anne asked why this column is necessary since we are just interested in what part of the county they want it to be in. It was suggested the column be removed. The group agreed to delete the column.

Kathi asked about addressing the issue of transportation, saying she did not see questions regarding transportation.

Susan pointed out question #2 on the survey that asks about transportation needs.

Teresa said we're also going to address IT. Kathi asked Teresa if we're really going to address IT, stating she thought she had read there was a decision not to address IT. Teresa said IT got taken off, that Donna announced that IT was taken out, and so we put it back into the mix because nobody told us, and so since this is back to starting over, we are considering whether that pot of funds should be considered whether the IT system should be back on the table.

Susan asked if Teresa wanted a general question regarding IT put on the survey. Teresa responded that she didn't know.

Going back to transportation, Kathi said part of the issue associated with the location is its being in Central County, where it is hard for people in east and west county to get there, especially after hours. She said she thinks transportation should be addressed as a specific topic, because if we could address the transportation issues, would Central County be an appropriate location? She added that even Antioch wouldn't be appropriate for some of the more rural locations, nor Pittsburg either. 24/7 transportation should be addressed. She asked if the money could be spent for transportation and the response was that it cannot. She then asked if we could potentially spend part of the money that would be saved (by bringing people back from out-of-county placements) to address the transportation piece. The response



was that it can. She clarified that we were concerned about having a central county location because of the transportation issue, so asked that the transportation issue itself be addressed. She said if you live in east county, you're going to want to site it in east county – but where in east county? If you site it in Pittsburg, you're still not going to be able to get there from Brentwood or Antioch.

Teresa said that one of the guidelines was that it has to be on county-owned property, which is one of the things she said she asked for but hasn't gotten yet (a list of county-owned properties).

Brenda said in looking at the survey, non-capital facility issues need to be separated from facilities. Services could be included at some other point. Sherry said they had asked the group to e-mail them with facilities they did not include, but only heard from one person. She asked to be told if a facility has been left off the survey. They asked themselves if these services listed would drive a facility.

Brenda continued that even though December 31<sup>st</sup> is some sort of artificial timeline that we've agreed that we will not have frame this process, we do need a realistic timeline as to when we're going to send this thing out – when do we anticipate getting it back and when do we anticipate looking at the findings.

Teresa said she was hoping we could approve that tonight.

Anne stated her expectations for the survey, saying she is very concerned about the December 31<sup>st</sup> deadline. She said she looks at the survey and asks if the results of the survey are going to allow her to assess whether 20 Allen is the way to go or if we should do something else. She said that the December 31<sup>st</sup> deadline, however nebulous it may be, for a piece of property known as 20 Allen and what we decide to put on that property is still open to debate. The question is: are we going to capitalize on that property or not? She said that to her the most important thing was the column "Location in the County." If we get back responses that a lot of people want services in central county, that says to her certain things about the 20 Allen project or other alternatives to 20 Allen that would be in central county. She said that she considers some of the other questions to be soft things as to the hard building.

Susan said she agreed with Anne, but doesn't think we have to stop at asking for one location – but can ask for what they want.

Anne said she wasn't suggesting that we limit ourselves, but that the date of December 31<sup>st</sup> has to do with a specific location, and in order to assess whether this specific location should be on our list to pursue or not we need to have responses to a questionnaire which is designed to give us relevant information to make that decision.

Annis said we were told that the county was going to buy the property regardless. The December 31<sup>st</sup> deadline was the date they had to decide if they were going to do another retainer or purchase the property. It had nothing to do with the deadline for the psychiatric pavilion. It had to do with the property and they have decided now that they are going to buy the property.

Dave stated that Julie Freestone had sent out an e-mail saying that the longer the property is used for other purposes and the further time goes by regarding the available funding streams, the less likely it is that it will be available for mental health purposes. He added that we have an opportunity, and should act in a timely manner. Susan stated that they want to use it to store stuff while storing our consumers out-of-county.

Teresa stated the need to wrap this item up. She said she's perfectly comfortable with taking a vote tonight, except that it isn't on the agenda. She said if the group wanted, voting on it could be placed on

the next agenda. Annis said that couldn't be done because we haven't collected the input. Teresa said she'd be comfortable making a motion next meeting supporting a children's unit because she thinks Kathi's right. She said she knows the Commission has advocated for years, and when the Commission originally voted on this issue, there were passionate advocates around children's services. She added that it's an unbearable thought to have your child sitting in a little nook, separated when they're at their most vulnerable.

Anne asked to make a motion that with the removal of the right-hand column, Urban or Rural, with Your Ideas being put under each section, that we approve the survey as amended and establish a timeline to get it out the door and back quickly. Brenda seconded the motion.

Discussion:

Kathi asked if the motion includes leaving in the CULTURALLY APPROPRIATE SERVICES and PEER SUPPORT sections that are not capital facilities or if their removal is part of the amended survey. Anne said that she would prefer that they not be in and can add that to her motion so that it is very targeted. In that case, she said her motion would include a suggestion that we have a 48 hour grace period before the final questionnaire for all the members to think about other language for capital facilities and to get it to Sherry within the next 48 hours and empower Sherry with the approval of Teresa to amend the questionnaire and consider it final and go forward with production and implementation. As Brenda had to leave the room, when she came back the amendments made to the motion were explained to her as being eliminating the right-hand column, adding Your Ideas under each of the sections, eliminating everything under Peer Support in Section 1. Brenda seconded the amended motion. It was clarified that the items under ALTERNATIVES TO HOSPITALIZATIONS would be deleted. Tony asked that LOCATION IN COUNTY be revised to provide separate boxes for Central, East, West, and Centralized. Number 2 (Are there needs that should be considered?) would remain.

Teresa asked that the full guidelines be mailed to the workgroup on Tuesday. Sherry said she will take care of it.

There was discussion regarding the LGBTQQI Community. It was decided to spell this out on the questionnaire.

For the purpose of clarity and accuracy, following lengthy discussion, the motion by Anne Reed, seconded by Brenda Crawford, was restated for the record: "To accept the Capital Facilities/CPAW Assessment Survey as presented in draft form with the following changes: One - To eliminate the right hand column from #1; Two - To revise **LOCATION IN COUNTY** to provide separate boxes for Central, East, West, Centralized or All; Three - To delete everything from **CULTURALLY APPROPRIATE SERVICES** below in #1; Four - To add Your Ideas under each of the **ALTERNATIVES TO HOSPITALIZATION**; Five - To increase the space available for #2 "Other" for additional comments; and Six - To allow a 48 hour grace period for CPAW/CapFacilities members to e-mail additional capital facilities language to Sherry for inclusion. At the end of that time the motion assumes that Sherry, with the approval of Teresa, will then be empowered to finalize, produce and distribute according to the timeline that we will approve." Motion carried unanimously.

➤ **Recommendation:**

**To accept the Capital Facilities/CPAW Assessment Survey as presented in draft form with the following changes:**

- 1. To eliminate the right hand column from #1;**
- 2. To revise LOCATION IN COUNTY to provide separate boxes for Central, East, West, Centralized Or All;**

3. To delete everything from CULTURALLY APPROPRIATE SERVICES below in #1;
4. To add Your Ideas under each of the ALTERNATIVES TO HOSPITALIZATION;
5. To increase the space available for #2 "Other" for additional comments; and
6. To allow a 48 hour grace period for CPAW/CapFacilities members to e-mail additional capital facilities language to Sherry for inclusion. At the end of that time the motion assumes that Sherry, with the approval of Teresa, will then be empowered to finalize, produce and distribute according to the timeline that we will approve.

## 7. ESTABLISH BENCHMARK TIMELINE FOR OVERALL PROCESS

- A. Set goals for a timeline that would establish incremental progress demonstrating value of the process to the public and the Health Services Department.

Regarding the timeline, Teresa said she wants to honor the public comments, and the wishes of the Commission. She said the recommendation of Health Services were to go ahead and start over. The indication was that there was no pressure, but added it feels like pressure to her now. She said she still doesn't think this group has enough information to make a decision. She said the group has never been given financial information, and she doesn't think decisions can be made about programs that need to have funding streams attached, when as far as she knows the funding stream attached to this 20 Allen proposal is future CSS funds that haven't gone through the planning process. She said we can either honor the MHSA process or we can not honor it. She said she prefers to honor it and will honor it. She added that she had been told by Julie Freestone that Julie felt that if she could present to Dr. Walker and Mr. Godley some sort of a timeline, some sort of a framework that this workgroup was working on in good faith, then that would make them more comfortable. Teresa said she had been told by Supv. Gioia there had been no decision made on the purchase of this property.

Tony said he respects honoring the system, too. He asked that since we are proceeding with the questionnaire, if a timeline could be established to make things go as quickly as possible. And while that's occurring, he asked if we could be think about proposals to entertain that we know will touched on in the survey so that when data comes in so we can be ready to respond.

Anne suggested that the brainstorming of ideas be an agenda item on the next meeting.

Kathi asked Sherry how long everything would take if we have a 48-hour turnaround time to get comments to her. Sherry said if she got the information by Thursday morning, and Teresa approves the final survey, it can be electronically distributed first thing Friday morning. Getting it printed, depending on their workload, would take the printing services three working days. Then we can start the distribution of the physical copies pretty quickly (copies that have to be physically carried to locations such as libraries). Sherry said the mailing list is pretty much ready to go. She added the only problem they are having is with the clients mailing addresses as in a recent mailing 50% came back as not deliverable. That mailing had cost \$5,000. Our addresses in our system are not correct, although they are now being flagged.

Teresa said as an aside, "Gee, I don't think we need an IT system, do you?"

Sherry offered an option to mailing the surveys to the consumers – to physically take 1,000 copies to each clinic and have them available when the clients come in to register, and you leave it open for a period of two weeks. She said there'd probably be a much better return.

Brenda said we already have a model in place where we put consumers in the centers behind tables and have them fill it out.

Sherry said that's what she would propose. They could be put them in all our physical outpatient clinics. The surveys should also be placed at the Crisis Stabilization Unit and other places as well.

Anne asked if it was realistic to have a return date of November 16<sup>th</sup>. She also asked who was going to compile the information. Sherry said Steve Hahn-Smith has agreed to set up a simple access data base and MHA will provide the clerks to enter the data. A code will be inserted on the survey as a field identifier for entering it into the computer. Brenda asked if we were talking about using the model that had consumers at the center with the surveys and as consumers come in to encourage them to fill it out. Sherry responded that if we do that, we would depend on Brenda and her staff because they did it before. Brenda said then she would have to depend on Sherry to give her money to be able to do it.

Anne asked how long the consolidated report would then take. Sherry said it would take about a week to turn it around.

Because that would place getting the information back during the week of Thanksgiving, it was decided to extend that deadline for compilation to the 30<sup>th</sup>. The information can be distributed electronically on the 23<sup>rd</sup> and the group can meet on the 30<sup>th</sup> to review the findings.

Brenda said again that the most effective way to get the consumer input was to have consumers located at all of our centers encouraging folks to fill these out. Susan suggested having a drawing for a gift basket. Kathi said distributing to family members also needs to be considered.

Kathi made a motion to establish a timeline to get the surveys out by 10/26, to be returned by 11/16, with initial results to the committee by the 11/23 and a final result at some point thereafter, and meet to discuss them on 11/30. Teresa seconded the motion.

Discussion:

Sherry mentioned her experience with surveys in the past and said people mail them in at the last minute, so there may be a delay in getting all the results by the 23<sup>rd</sup>. Anne suggested that we get a preliminary result on the 23<sup>rd</sup> and a final result at some point thereafter.

Tony asked if the \$5,000 we are saving by not mailing to the consumers could be used for the consumer involvement. Sherry said she would have to amend the contract with MHCC. The movement of money to MHCC would take time.

Anne asked that the information about the group approving this timeline be communicated to Dr. Walker. The motion carried unanimously.

➤ **Recommendation:**

**To establish a timeline of:**

**October 26<sup>th</sup> – Getting the surveys out**

**November 16<sup>th</sup> – Deadline for them to be returned**

**November 23<sup>rd</sup> – Initial results sent electronically to the Workgroup**

**November 30<sup>th</sup> – Workgroup meet to review findings.**

**8. REPORT INFORMATION ON ANY NEW PROPOSALS FROM STAKEHOLDERS**

A. Children's Proposal and Older Adult Proposal

Kathi asked that Teresa invite Suzanne or Donna to come to the next meeting to discuss these proposals.

Teresa said she would officially invite Donna to have herself, Suzanne and/or Vern to address these issues.

B. Hear from other attendees on suggested use of Capital Facility Funds.

## 9. NEXT STEPS/SET NEXT MEETING DATE

➤ Next meeting date: Monday, November 2<sup>nd</sup> at MHCC from 6:15-8:15

- Brenda asked to go on record stating the process of getting consumer input was flawed. She added that the clinic staff is not going to be dedicated to get the information out. She said she felt Sherry, Teresa and her need to sit down and talk about how to ensure that the consumer voices are heard.
- Teresa said she also wished to go on record supporting that the consumer voices be heard. Teresa also said she felt the group had already made a decision and a vote could be taken now. Workgroup members disagreed.
- Kathi said ideas about distributing them to families should be sent in to Sherry
- Suggestions were also made to send the survey to contract service providers, county staff, etc.

## 10. PUBLIC COMMENT

In a comment that time should have been provided for on agenda item 6A, Charles Madison said he felt some of the consumers may not understand the terminology of the survey. He also said he felt there were leading questions on the survey. He asked what this committee or the Commission would do if there is a lot of response from Antioch or Pinole wanting the facility there. He said he is very concerned that we have 20 Allen on the plate and it's a pretty good program so long as 4C stays open. We are concerned about what the county is going to do with the property when they buy it. If we have the pavilion and can couple it with a transportation system of some type, they we could get more of the consumers in there.

Teresa said her biggest concern about what he said was "if 4C stays open" because there was nobody she had talked to considers that remotely possible.

Charles said he went to the BOS Finance Committee meeting and when Sharon (Madison) made the comments to the Supervisors about that, they said couldn't lock it in forever but they would keep it off the table, they would keep it open. We're just going to keep a watchful eye and if they ever have a hint of closing 4C, we're going to be up in arms.

## 11. ADJOURN MEETING

The meeting was adjourned at 8:45 p.m. by Chairperson Pasquini.

Respectfully submitted:

Karen Shuler,

MHSA Communication Coordinator

## VACANT COUNTY OFFICE SPACE LIST AS OF 10/23/09

### **2530 Arnold Drive, Martinez (aka Summit Centre) (County Owned Building)**

The Employment and Human Services Department (EHS) has announced that they are transferring 30 employees out of suite 300 and 95 employees out of suite 200 by January 1, 2010. This will create 12,500 square feet of office space vacancy in suite 300 and 24,000 square feet of office space vacancy in suite 200. Under the County's policy of RAMP (Real estate Asset Management Program), the General Services Department (GSD) is evaluating relocating various Health Services and Sheriff-Coroner divisions from leased space in order to occupy this vacant space. At this moment, Health Services is vying for space in suite 200. They have plans to relocate their Personnel, Payroll, AODS unit, and possibly Senior Nutrition. Of the 24,000 square feet available, they would occupy 17,000 to 18,000 square feet. The Sheriff-Coroner is vying for all of suite 300.

**Potential space available = 6,000 – 7,000 square feet**

### **10 Douglas Drive, Martinez (County Owned Building)**

Vacant space was created when the District Attorney relocated from the second floor to their new building at 900 Ward Street, Martinez. With the expansion of Contra Costa TV (CCTV) and Health Services Vital Statistics unit into this space, there are only some small offices available at the western end of the building.

**Potential space available = 1,900 – 2,400 square feet**

### **30 and 40 Muir Road, Martinez (County Owned Buildings)**

These buildings were vacated when EHS relocated to 300, 400, and 500 Ellinwood Drive, Pleasant Hill. Both buildings have been tentatively approved for occupancy for the Department of Conservation and Development (DCD). It is expected that the Board will approve renovation of these two buildings within this fiscal year for DCD.

**Space available = 0 square feet**

### **1330 Arnold Drive, Suite 143, Martinez (Leased Building)**

This suite is leased by the County through November 30, 2011. It is currently occupied by the Senior Mental Health division of the Health Services Department. The division will relocate to 2425 Bisso Lane, Concord upon completion of tenant improvements there, around January 1, 2010 leaving a vacant suite.

**Space available after 01/01/2010= 1,994 square feet**

-----Original Message-----

From: sbradley@hsd.cccounty.us

To: mamap2536@aol.com

Cc: ablades49@yahoo.com; aereed001@hotmail.com; asanders@hsd.cccounty.us;  
bcrawford@mhccnet.org; cokeeffedaphne@yahoo.com; DWigand@hsd.cccounty.us;  
jfreesto@hsd.cccounty.us; kathimclaughlin@comcast.net; STavano@hsd.cccounty.us

Sent: Tue, Oct 27, 2009 3:19 pm

Subject: Re: Survey/Questionnaire

Hello Teresa and Members of the MHC/CPAW Capital Facility/IT Workgroup:

We have all spent many hours working toward the same goal, which is to conduct an open planning process which provides an opportunity for all stakeholders and community members to participate. We have certainly had some starts and stops, and that comes with the territory involved in a true community planning process (CPP). As the MHSA Program Manager, I am here to support the MHSA planning process, and will continue to do so. Indeed, there are some procedural questions that have evolved because the MHC/CPAW Capital Facility/IT Workgroup is covered under the Brown Act and the Better Government Ordinance, and in that matter, I defer to those with the expertise in the Brown Act and Better Government Ordinance.

However, for any errors in the survey that have been caused by my lack of oversight, I am very sorry, and I apologize to all of you. For that reason, because creating and testing a survey is not in my area of expertise, I am unable to give any more time to the development of the survey. I will defer to Steve Hahn-Smith in terms of the structuring of the survey, and in the pre-testing of it for reliability, etc. However, if/when the survey is ready, I am still available to provide the resources to distribute the survey widely as indicated earlier.

I am very hopeful that the Workgroup will formulate recommendations to the Mental Health Commission and to CPAW regarding alternatives and options for Capital Facilities/IT. I am sure that there is still a lot of work to be done, and the survey is just one part of the work you all have to do.

Please know that I am still available to you as you require expertise about CCMH's MHSA Plans, the MHSA Guidelines and Updates from State DMH and the MHSOAC, and current status of anything related to MHSA. For anything beyond that, you will need to seek assistance from Suzanne Tavano or Donna Wigand.

Thank you.

Sherry Bradley, MPH  
MHSA Program Manager  
CCHSD-Mental Health Division  
1340 Arnold Dr. #200, Martinez  
(925) 957-5114 (landline)  
(925) 957-5156 (fax)  
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[sbradley@hsd.cccounty.us](mailto:sbradley@hsd.cccounty.us)

"As we progress in our MHSA planning and implementation, there will be a tendency to want to rely on doing things in familiar ways. We want to respect the expertise we have accumulated over the years. We don't want to 'reinvent the wheel'. But if we only do things in familiar ways, we will only generate familiar plans and programs. We will invent only wheels....and we want more than that."

Mark Ragins, M.D.

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mamap2536@a

ol.com

10/26/2009 06:23

PM

To [sbradley@hsd.cccounty.us](mailto:sbradley@hsd.cccounty.us)

cc [aereed001@hotmail.com](mailto:aereed001@hotmail.com), [ablades49@yahoo.com](mailto:ablades49@yahoo.com), [cokeeffedaphne@yahoo.com](mailto:cokeeffedaphne@yahoo.com),  
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Subj Survey/Questionaire  
ect

Hi Sherry,

As Chair of the MHC/CPAW Cap Facilities/IT Workgroup, I am unable to fulfill my commitment to the motions, supported at the last meeting, on 10-19-09, and the agreed upon Timeline. I do not believe that this questionnaire/survey will be the appropriate tool to capture the public's current temperature on the Capital Facilities **and** Information Technology needs, as required by the DMH Guidelines. The public must have an opportunity to hear the county's decision, to table the IT part of the plan that was submitted to DMH, with the Capital Facility proposal. The public and all stakeholders must understand that this is ONE pot of funds, not two. These two components must be considered jointly.

I listened to the entire 2 1/2 hour tape of the 10/19 meeting and found that the Motion clearly DID NOT include the IT questions. While there were discussions, and I clearly stated that we needed to address IT, I failed to include it in the motion discussion. Therefore, the motion was approved without the inclusion of the IT information. I am a visual learner, so is Annis. Since IT was not on the Draft Questionnaire, we assumed that it could be captured within the 48 hour "grace period" included in the motion. We were wrong.

As a result, **if** this Draft Questionnaire/Survey is distributed, the community will not have an opportunity to weigh in on this important consideration. I believe this would be a failure to inform and receive input. Therefore, I am requesting that the Questionnaire/Survey be held, pending resolution of this issue, at the next scheduled meeting, on November 2, 2009. I have been advised that this is a procedure that is consistent with those employed by the Board of Supervisors on matters of concern. It is prudent to correct a procedural error, if possible, rather than push ahead.

At the 11-2-09 meeting, I will include an agenda discussion and report from Steve Hahn Smith, if he is available. We will provide the DMH 08-09 Enclosures 1 and 3 that refer to Information Technology, in relation to this component. Our Workgroup only received the DMH Guidelines for Capital Facilities, the 08-09 Enclosure 2, at the October 19, 2009 meeting.

Sherry, it is important to state that I do not blame you for this mistake. However, I want to make it very clear, to the workgroup, that Annis had sent an email, on October 9, 2009, requesting that information be placed on the Draft Questionnaire, regarding Information Technology. Yet, it was not included in the Draft, that you provided, at last week's meeting. She feels very upset with herself that she failed to communicate this to the group. She most definitely has not failed. She has devoted hours and hours to this process and was committed to making sure that the commission, and the public, had all of the



relevant information for a balanced discussion and recommendation.

In listening to the tape, Kathi was consistent in talking about Capital Facility needs only. However, at one point, Anne Reed made an objection to the attempt to narrowly focus the questionnaire on only things that are "realistic" and "consistent with the MHSA guidelines, and current CSS and PEI plans." Anne stated that she saw this as an opportunity to "Create a comprehensive survey...." and capture "a breadth of data in case other sources of funding comes up...." She later states that she sees the survey as "...a temperature check of what consumers and family members think we need for the Mental Health System and see how they dovetail into the amount of money available and the ideas floating out there." She didn't want to "self narrow" the focus and prevent the vehicle from serving a wider purpose.

Kathi, stated that she disagreed and did not feel that an "expansive survey" would be good and that she knew of no other funds out there besides MHSA. She suggested a survey process that was expedient and did not raise expectations. Brenda concurred with Kathi and Susan and wanted to be realistic and get the biggest bang for our buck.

While there may be members, of the workgroup, and the public, who will be disappointed, with this delay, I believe there will be a better chance to achieve the fair and balanced process that the group declared as its charge. To proceed with the current motions would create another flawed process and risk **not** capturing the true community needs. I believe the motion was premature and pressured, and that a testing of the questionnaire, as requested by Commissioner Yoshioka, failed to be considered, as well.

I want to state emphatically, again, that I am fighting for a fair public planning process, NOT an outcome. I am committed to a consensus building partnership with all stakeholders. In order to have a true partnership, we must all have the same information at the same time and be able to discuss that information in an open and public process. We must maintain noble intentions, as Brenda Crawford requested, and not allow adversarial, competitive motives to prevail. I appreciate all that you have done to support this process and I am committed to working with you to bring about the transformation of our mental health system.

Sincerely,  
Teresa Pasquini

-----Original Message-----

From: sbradley@hsd.cccounty.us

To: aereed001@hotmail.com; ablades49@yahoo.com; asanders@hsd.cccounty.us;  
bcrawford@mhcnet.org; cokeeffedaphne@yahoo.com; Kathimclaughlin@comcast.net;  
SMedlin@hsd.cccounty.us; mamap2536@aol.com

Cc: jfreesto@hsd.cccounty.us; DWigand@hsd.cccounty.us; STavano@hsd.cccounty.us;  
shahn@hsd.cccounty.us

Sent: Mon, Oct 26, 2009 6:21 pm

Subject: MHC-CPAW Capital Facility Workgroup - Survey Status

Hello Everyone,

This will confirm with you all that I have not sent out the survey. I had connectivity problems at home on Friday, so couldn't do anything (since I was working from home on the laptop to complete other work). As a result, the survey didn't get to Teresa for final approval, so it didn't go to the printer or get distributed electronically.

As it turned out, that's probably a good thing, since it sounded like there were many questions about the survey. I also have a lot of questions about some of the suggestions that I received (for facility questions to be included in survey).

I spent the entire day in meetings today, so just getting around to communicating with you all. It's my understanding that you will go forward with next Monday's meeting (November 2nd) and it also sounded like the survey would be discussed then.

Thank you.

Sherry Bradley, MPH  
MHSA Program Manager  
CCHSD-Mental Health Division  
1340 Arnold Dr. #200, Martinez  
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"As we progress in our MHSA planning and implementation, there will be a tendency to want to rely on doing things in familiar ways. We want to respect the expertise we have accumulated over the years. We don't want to 'reinvent the wheel'. But if we only do things in familiar ways, we will only generate familiar plans and programs. We will invent only wheels....and we want more than that."

Mark Ragins, M.D.

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**Mental Health Services Act (MHSA)  
Capital Facilities and Technological Needs**

**PROPOSED GUIDELINES  
for completing the  
CAPITAL FACILITIES AND TECHNOLOGICAL  
NEEDS COMPONENT PROPOSAL  
of the  
COUNTY'S THREE-YEAR PROGRAM AND  
EXPENDITURE PLAN**

**March 18, 2008**

**Mental Health Services Act  
Capital Facilities and Technological Needs  
Component Proposal**

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## **PART I: PURPOSE AND BACKGROUND**

**Purpose:** The purpose of this document is to set forth proposed guidelines for the submission of the Capital Facilities and Technological Needs Component Proposal that each County mental health department shall submit as part of its Three-Year Program and Expenditure Plan (Three-Year Plan). The Component Proposal encompasses Capital Facilities and Technological Needs together pursuant to direction provided further in this document. The Component Proposal must provide an overview of how the County expects to utilize the available funding and how the Component Proposal supports the goals of the Mental Health Services Act (MHSA) as stated in the County's Three-Year Program and Expenditure Plan. Funding requests to support this Component Proposal will be made via Capital Facilities and/or Technological Needs Project Proposal(s). See Enclosures 2 (Capital Facilities) and 3 (Technological Needs) of this Department of Mental Health (DMH, Department) Information Notice for information regarding the submission of the Project Proposals.

**Background:** The MHSA provides funding for services and resources that promote wellness, recovery, and resiliency for adults and older adults with severe mental illness and for children and youth with serious emotional disturbances and their family members. A portion of the MHSA funds have been specifically set aside for Capital Facilities and Technological Needs pursuant to Welfare and Institutions Code (WIC) Section 5892(a)(2) to promote the efficient implementation of the MHSA. Beginning Fiscal Year 2008/2009, Counties may use a portion of their MHSA Community Services and Support (CSS) funding for capital facilities and technological needs as specified in Section 5892(b).

Each County's Capital Facilities and Technological Needs Component Proposal and the Capital Facilities and/or Technological Needs Project Proposals must support the goals of the MHSA and the provision of MHSA services. The planned use of the Capital Facilities and Technological Needs funds should produce long-term impacts with lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families which promote reduction in disparities to underserved groups. These efforts include development of a variety of technology uses and strategies and/or of community-based facilities which support integrated service experiences that are culturally and linguistically appropriate. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based, less restrictive settings that will reduce the need for incarceration or institutionalization, and the development of a technological infrastructure for the mental health system to facilitate the highest quality, cost-effective services and supports for clients and their families.

The long-term goal of DMH is to develop an Integrated Information Systems Infrastructure where all counties can securely access and exchange information. This infrastructure will provide the local service sites with client demographic information, locations of previous services and critical clinical information for

coordination of care purposes. The infrastructure will allow different County systems to share information across a secure network environment both inside and outside their respective counties. Counties and their contract medical and mental health providers, hospital emergency departments, laboratories, pharmacies, clients and their families could all securely access and exchange information through the infrastructure.

The foundation for an Integrated Information Systems Infrastructure is the Electronic Health Record (EHR) system, which is a secure, real-time, point-of-care, client-centric, information resource for service providers. The goals of MHSA will be achieved as Counties assess their current state of technological readiness and develop and implement roadmaps for technological improvements over time. The *Roadmap* will define the plan, schedule and approach to achieving an Integrated Information Systems Infrastructure. It will include proposed project milestones and cost estimates as well as plans for vendor selection, training, communication, and workflow assessment (see Enclosure 3 for more details on the *Roadmap*).

## **PART II: PLANNING ESTIMATE AND PROPOSAL FUNDING**

WIC Sections 5892(a)(2) and 5892(e) identify the percentage of MHSA revenues reserved for the Capital Facilities and Technological Needs Component Proposal. At this time, the maximum amount of Capital Facilities and Technological Needs funding available to each County is provided in the DMH Information Notice 08-02. County mental health programs must submit a Capital Facilities and Technological Needs Component Proposal (Enclosure 1), which must be approved by DMH in order for DMH to approve a request for MHSA funding under this Component Proposal via Capital Facilities Project Proposal(s) (Enclosure 2) and/or Technological Needs Project Proposal(s) (Enclosure 3). The sum of all project proposal funding requests may not exceed the total Capital Facilities and Technological Needs Planning Estimate identified for each County. Pursuant to Section WIC 5892(h) MHSA funds dedicated to the Capital Facilities and Technological Needs Component Proposal must be used within ten years or they will revert back to the State Mental Health Services Fund (MHS Fund) for redistribution to all participating Counties.

The amount shown in DMH Information Notice 08-02 represents the initial funding amount for the Capital Facilities and Technological Needs Component Proposal based on actual deposits into the State MHS Fund through July 2, 2007. Additional MHSA funding will be identified for the Capital Facilities and Technological Needs Component Proposal in the future based on actual deposits into the State MHS Fund through June 30, 2008. Counties may access the additional Capital Facilities and Technological Needs funding through Project Proposals which serve as updates to the Three-Year Plans. Counties also may request funds from the Community Services and Supports Component for Capital Facilities and Technological Needs beginning in FY 2008-09 provided that the total amount requested for capital facilities and technological needs, workforce education and training needs and the Prudent Reserve does not exceed 20

percent of the average amount of funds allocated to the County for the previous five years (WIC Section 5892(b)).

Capital Facilities and Technological Needs projects that benefit more than only the mental health system must include revenues from other funding sources so that the net cost to the MHSA is reflective of the benefit received by the mental health system. The County should use a reasonable allocation approach to determine the share of a Project's cost related to the MHSA, such as percentage of square feet or the number of clients served within programs (e.g. Mental Health clients versus Primary Health Care). The County must also comply with WIC Section 5891 and Section 3410 of Title 9 of the California Code of Regulations (CCR) addressing County obligations regarding non-supplantation.

### **PART III: CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS COMPONENT PROPOSAL REQUIREMENTS**

Each County will be responsible for submitting a Capital Facilities and Technological Needs Component Proposal. The Component Proposal will provide an overview of future Capital Facilities and Technological Needs projects. The County is expected to draft a Capital Facilities and Technological Needs Component Proposal that will identify the County's capital facilities and technological needs within the overall Capital Facilities and Technological Needs Planning Estimate by reviewing the initial CSS stakeholder process and CSS Component and priorities, including any work done with Prevention and Early Intervention and/or Innovation and CSS One-Time Technology Funding, and the input from the Capital Facilities and Technological Needs Component Proposal stakeholder process. Counties may submit a Component Proposal that addresses both their capital facilities and technological needs or only one segment of the component. Since Counties may begin their Capital Facilities and Technological Needs stakeholder processes at different times, they may later update their Component Proposal as long as they remain within their overall Planning Estimate and submit updates to any impacted project proposals. Project Proposals may be submitted with the Component Proposal or separately as updates to the Three Year Plan.

## **Exhibit Descriptions**

For submission of a complete Capital Facilities and Technological Needs Component Proposal, the County should complete the following exhibits:

### **Component Exhibit 1. Face Sheet**

This exhibit is a signed verification by the County's mental health director that all requirements for the Capital Facilities and Technological Needs Component Proposal have been considered and will be followed. It also provides the name and contact information of the director's designated point of contact for all matters related to this Component Proposal.

### **Component Exhibit 2. Narrative**

Submit a narrative which addresses the following:

#### **1. Framework and Goal Support:**

Submit a brief narrative that provides a conceptual overview of how the County plans to use the Capital Facilities and/or Technological Needs Component funds to support the provision of programs and services to be implemented through the MHSA. Include how the component will produce long-term impacts with lasting benefits that move the mental health system towards the goals of expansion of opportunities for accessible community-based services for clients and their families.

Include a proposed distribution of funds between Capital Facilities and Technological Needs.

#### **2. Stakeholder Involvement:**

Include a description of stakeholder involvement in identification of the County's Capital Facilities and/or Technological Needs priorities in accordance with Title 9 (Sections 3300, 3310, and 3315) of the California Code of Regulations.

### **Component Exhibit 3. Capital Facilities Needs Listing**

Submit a listing of capital facility needs. The listing may include, but is not limited to:

- Types and numbers of facilities needed
- Possible County locations for needed facilities
- MHSA programs and services to be provided or if need administrative offices
- Target populations to be served

### **Component Exhibit 4. Technological Needs Listing**

Submit a listing of the technological needs which meet your goals of modernization/transformation or client/family empowerment as your county moves toward an Integrated Information Systems Infrastructure. Examples are listed in Exhibit 4 and described in further detail in Enclosure 3.



## **PART IV: PLANNING AND SUBMISSION GUIDELINES**

### **Planning**

The comprehensive planning process undertaken by Counties in developing the initial CSS Component of their Three-Year Program and Expenditure Plan should provide the foundation for future planning processes. Counties are encouraged to develop on-going planning and monitoring stakeholder committees, and to use and augment these groups as needed for the particular planning and oversight expertise for each MHSA Component Proposal. Planning processes for new Component Proposals and on-going planning for all Component Proposals should continually augment and strengthen what is already in place. In this way, Counties will be able to develop an informed constituency, while continually reaching out to broaden diversity and expertise.

The local planning for proposed Capital Facilities and Technological Needs expenditures should revisit the priorities and discussions documented in previous MHSA planning processes. As Counties move toward modernization and transformation of their infrastructure and address the goal of increasing client and family empowerment, reducing disparities, and increasing access and appropriateness of care, they should focus upon getting additional input from stakeholders with experience and expertise in these subject areas. The County shall ensure that on-going stakeholder committees and/or key stakeholders are informed and directly involved regarding recommendations for proposed projects.

Consistent with MHSA statutory requirements WIC Sections 5848(a) and (b) and Title 9, CCR Sections 3300 and 3315, each County Capital Facilities and Technological Needs Component Proposal and each Capital Facilities Project Proposal and Technological Needs Project Proposal shall be developed with local stakeholders and made available in draft form and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the documents. Pursuant to WIC Section 5848(b), the local mental health board shall conduct a public hearing on the draft Capital Facilities and Technological Needs Component Proposal. The County shall submit a summary and analysis of any substantive revisions made to their proposed Component Proposal as a result of stakeholder input. No public hearing is required for Capital Facilities Project Proposals and Technological Needs Project Proposals submitted as updates to the approved Three-Year Plan. As noted in DMH Information Notice 06-13, funds are available for technology planning and assessment consultants to assist in the planning process.

### **Submission**

Capital Facilities and Technological Needs Component Proposals should be submitted to the Department electronically, with one unbound paper copy that includes the appropriate signatures. Capital Facilities and Technological Needs Component Proposals will not be accepted via fax. The electronic copy of the Capital Facilities and Technological Needs Component Proposal should be emailed to DMH at the address below. An original of the completed Capital

Facilities and/or Technological Needs Component Proposal should be submitted to:

**California Department of Mental Health,  
Capital Facilities and Technological Needs Component Proposal  
Attn: Child and Family Program  
1600 9<sup>th</sup> Street, Room 130  
Sacramento, CA 95814**

**MHSA-CFTN@DMH.CA.GOV**

Submitted Capital Facilities and Technological Needs Component Proposals must include all four Component Exhibits.

### **Funds Issued After Approval**

DMH Information Notice 08-02 lists a maximum amount of MHSA funding available for the County's Capital Facilities and Technological Needs Component Proposal. To receive funding the Counties must obtain DMH approval for their proposed Capital Facilities and Technological Needs Component Proposal and Project Proposal. The approved amount will be included in the executed MHSA Agreement.

Except for specified pre-development costs, Capital Facility expenditures made prior to Capital Facilities Component Proposal and subsequent Capital Facilities Project Proposal approval are not allowed. The specific, allowable pre-development costs are architectural, engineering, legal and environmental services and costs associated with site control, e.g., security deposit on purchase agreement or lease (rent) to own agreement. These costs will be reimbursable upon Capital Facilities Project Proposal approval and execution of a MHSA Agreement and shall be included in the proposed project budget and overall project cost.

### **Review and Approval**

The review and approval process for the Capital Facilities and Technological Needs Component Proposal will be completed within sixty days assuming the County provides timely response for any additional information requested by DMH. Staff from DMH, with review and comment from the MHSA Oversight and Accountability Commission (OAC), will work closely with County staff to assist with submission, identify any needed additional information, and obtain Plan approval.

If you have further questions regarding these proposed guidelines for the Capital Facilities and Technological Needs Component Proposal, please contact your County Operations Liaison.

**Mental Health Services Act (MHSA)  
Capital Facilities and Technological Needs**

**PROPOSED GUIDELINES  
For completing the  
Technological Needs Project Proposal**

**FOR THE COUNTY'S THREE-YEAR  
PROGRAM AND EXPENDITURE PLAN**

**March 18, 2008**

**Mental Health Services Act  
Technological Needs Project Proposal**

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## PART I. PURPOSE AND BACKGROUND

### ***Purpose***

This document provides proposed guidelines for the submission of the Technological Needs Project Proposal(s) to ensure that the Project(s) achieve the County and Department of Mental Health (DMH, Department) goals for a transformed public mental health system.

### ***Technology Goals***

All County MHSA Technological Needs Projects must be framed within the context of the guiding principles of MHSA and meet the General Standards in Section 3320 of the California Code of Regulations governing the MHSA. The Technological Needs Project Proposal must demonstrate the ability to serve and support the MHSA objectives through cost effective and efficient improvements to data processing and communications. These objectives allow for an overall transformation of processes that will require a phased approach of technology enhancements. DMH will be an active participant in supporting the successful implementation of these local Projects through inception, planning, implementation, and ongoing delivery. DMH will provide needed materials and tools through the DMH website including: County level Project summaries with current status and lessons learned, sample requests for proposals (RFP), Project readiness assessments, sample work plans and templates.

Evaluation and funding approval of Technological Needs Project Proposals will be made within the context of two goals:

- Increase **Client and Family Empowerment** and engagement by providing the tools for secure client and family access to health information that is culturally and linguistically competent within a wide variety of public and private settings.
- **Modernize and Transform** clinical and administrative information systems to ensure quality of care, parity, operational efficiency and cost effectiveness.

### ***Client and Family Empowerment***

Technology solutions have the potential to significantly improve quality of care and health outcomes. This can be accomplished by providing accurate and current information about a client's mental health history to the service provider, the client and his/her family when appropriate. Complete and accurate health information is crucial in reducing medical errors, improving care coordination and increasing client and family mental health literacy. Improved access to information has the potential to improve communication between clients and service providers, resulting in more meaningful client participation in the healthcare process. Having access to such information in a language they understand is empowering, enabling clients to be informed and make sensible choices within the mental health system.

As reported by the National Committee on Vital and Health Statistics, the potential benefits of client accessible health information systems can be applied to behavioral health and include:

- Support wellness activities
- Improve understanding of health issues
- Increase sense of control over health and well being

- Increase control over access to personal health information
- Support timely, appropriate preventive services
- Support healthcare decisions and responsibility for care
- Strengthen communication with providers
- Verify accuracy of information in provider records
- Support home monitoring for chronic diseases
- Support understanding and appropriate use of medications
- Support continuity of care across time and providers
- Manage insurance benefits and claims
- Avoid duplicate tests
- Reduce adverse drug interactions and allergic reactions
- Support convenient online appointment scheduling and prescription refills
- Increase access to providers via e-visits

A successful system of service delivery and coordination of care allows for+ client and family input and communication with their service provider in a culturally and linguistically competent manner. As evidenced throughout the stakeholder discussion process, clients and families have shown overwhelming support for expenditures in computer resources to improve communication. The basis of the relationship between service providers and clients and family is the delivery of high quality care with the utmost respect for client self-reliance and culturally and linguistically competent care. This can only be achieved with the knowledge that information is secure and confidential. The use of uniform policies and procedures to ensure that technology supports the client's privacy and security is essential. Technology can be used to securely provide clients with the ability to view and enter comments or data in their records, and the ability to share their journeys with a family member, friend and service provider as designated by the client.

*A number of Projects that improve client and family empowerment and engagement are described later in this document under Client and Family Empowerment and Engagement Sample Projects.*

### **Modernize and Transform Information Systems**

Information is an essential tool for decision-making at all levels of the public mental health system (e.g. national, state, county, local, family and client). It is employed by service providers to provide appropriate, quality, and evidence-based care; by staff in utilizing resources in the most efficient manner; and by management in developing better methods of providing culturally and linguistically competent services. In a context of increased need, diverse ethnic and linguistic access need, increased geographical locations where care is provided, and changes in mental health treatment and recovery methodology, information is becoming even more important.

Mental health information systems should exist to enable a collaborative decision-making process with service providers, clients and families in all aspects of the mental health system. Information systems are an essential planning tool: they can provide reliable and consistent information about mental health services and clients' needs that are essential for improved client treatment and recovery. These systems can be tools to assist service providers with recording and monitoring the client needs. They can provide a means of reporting the utilized treatments that can be linked to the ongoing improvement of service quality and recovery. In addition, to the extent possible, information systems should have the ability to provide information in the preferred language of the client and family member with support tools available.

Projects that modernize and are transformative are described later in this document under Types of Projects.

### **Standards**

In order to reach the technology goals, mental health information systems must be able to securely share timely and accurate client health and healthcare information. This system capability is possible with the use of technologies that incorporate **uniform standards** to transfer data from one source to another. The achievement of this capability, also known as interoperability, is challenged by dissimilar communication styles, disparate systems for storing and presenting information, differing work flow processes and data languages.

The uniform standards must address the interoperability challenges and emphasize the need for privacy and security of client information. They should support the ethical and legal use of personal health information, in accordance with established privacy laws and rights. Personal health information should be kept confidential and used only for approved purposes, and shared only among authorized individuals with informed consent, in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA); the Information Practices Act of 1977 (Civil Code 1798 et. seq.) and all applicable state law.

To ensure technology is properly configured and coordinated to meet the needs of the county service delivery providers, clients and their families, DMH established the MHSA IT Work Group comprised of state staff, industry experts, County and contract providers, consultants, clients and family members. The group reviews and recommends system requirements, standards, and policies that advance the statewide achievement of the technology goals.

*For all Technological Needs Project Proposals, the County must address the applicable standards noted in the Appendix B when proposing the Projects to DMH.*

## **PART II: FUNDING REQUIREMENTS**

### ***Evaluation and Approval Criteria***

DMH will evaluate and approve Technological Needs Projects within the context of two steps:

#### **Step 1 – Technological Needs Assessment (See Exhibit 2)**

The Technological Needs Project Proposal will be evaluated on the consistency in addressing the significant assessment factors included in the:

- County Technology Strategic Plan
- Roadmap to achieving an Integrated Information Systems Infrastructure
- County Personnel Analysis (Management and Staffing)

Please see Exhibit 2 for detailed instructions on the development of the Technological Needs Assessment. NOTE: Only one Technological Needs Assessment is required regardless if the County proposes multiple Projects.

**Step 2 - Technological Needs Project Proposal (See Exhibit 3)**

The proposed Technological Needs Project(s) must meet the goals of modernization/transformation or client/family empowerment within a framework of an Integrated Information Systems Infrastructure. Counties may work together to submit a comprehensive multi-County Project Proposal using shared resources and with the appropriate level of detail comparable to the level of Project scope and funding. Each proposed Project must be described as detailed in Exhibits 1, and 3 through 6.

Projects meeting these goals include, but are not limited to:

- **Electronic Health Record (EHR) System Projects**
  - Infrastructure, Security, Privacy
  - Practice Management
  - Clinical Data Management
  - Computerized Provider Order Entry
  - Full EHR with Interoperability Components (for example, standard data exchanges with other counties, contract providers, labs, pharmacies)
  
- **Client and Family Empowerment Projects**
  - Client/Family Access to Computing Resources Projects
  - Personal Health Record (PHR) System Projects
  - Online Information Resource Projects (Expansion / Leveraging information sharing services)
  
- **Other Technological Needs Projects That Support MHSA Operations**
  - Telemedicine and other rural/underserved service access methods
  - Pilot Projects to monitor new programs and service outcome improvement
  - Data Warehousing Projects / Decision Support
  - Imaging / Paper Conversion Projects
  - Other

***Types of Projects***

The Department considers the Project types listed below as meeting the goals of modernization/transformation or client/family empowerment within a framework of an Integrated Information Systems Infrastructure. Expenditures must be specific to the proposed Project and cannot be for general technology needs of the County, such as a general increase in desktop computers, PDA's, etc. for new employees.

Once Counties have submitted a Roadmap (as required in the County's Technological Needs Assessment (Exhibit 2) for moving toward an Integrated Information Systems Infrastructure, they may propose Projects in addition to Electronic Health Record (EHR) System Project(s).



### **Electronic Health Record System Projects**

The foundation for an Integrated Information Systems Infrastructure is the Electronic Health Record (EHR) system, which is a secure, real-time, point-of-care, client-driven information resource for service providers. If counties move toward an Integrated Information Systems Infrastructure through EHRs, they, in most cases, will be implementing EHR systems from external software vendors. These purchases could be for complete EHR systems or individual parts, (infrastructure, health record capture, decision support, reporting, data transfer) of an EHR system. DMH has developed minimum statewide standards listed in Appendix B, which Counties must address when purchasing and implementing the parts of an EHR system. These minimum standards, found in Appendix B, which will be promulgated in forthcoming regulations, will be modified periodically to achieve a statewide, fully integrated information system infrastructure.

EHR standards address the ability to access, exchange and assure security in the use of clinical information. The standards are divided into three categories:

- Functional Standards
- Connectivity and Language (interoperability)
- Client Access, Security and Privacy

Counties should evaluate the vendor's ability to meet current standards and commitment to meet evolving national standards prior to the purchase of any EHR related products.

The minimum standards listed in Appendix B are applicable to the individual parts of the County's proposed EHR system. As Counties implement specific parts of an EHR, they must assure compliance with all minimum standards related to the implemented part of the EHR.

### **Client and Family Empowerment and Engagement Projects**

#### **Access to Computing Resources Projects**

Mental health clients and family members need access to computer resources to find current electronic health and wellness information. Access to computer resources will provide clients and family members the ability to access data available through the county, communicate and learn from other client organizations and reference educational sites available through the Internet.

- Computer resources should include computer hardware, software, and broadband Internet connectivity.
- The placement of equipment in a convenient and secure physical environment is essential. These might include "computer labs" within service delivery settings allowing clients and families timely access before or after an appointment, or at housing facilities and wellness centers.
- Computer literacy training must be addressed to afford clients the ability to utilize all available information. This training should include timely and simple methods for clients to

get technical support and information about privacy and security. Note that this training includes client training for the use of PHR s.

### **Personal Health Record (PHR) System Projects**

The PHR system is a tool for collecting, tracking and sharing important, up-to-date information about an individual's health or the health of someone in his/her care through similar information found in a "view" of the EHR. Using a PHR will help clients and family members make better health decisions and improve quality of care by allowing them to access and use information needed to communicate effectively with others about their healthcare.

The Markle Foundation ([www.markle.org](http://www.markle.org)), representing industry leaders, and the Blue Cross Blue Shield Association provided the following proposed principles for the Client Empowerment Breakthrough Initiative under the American Health Information Community, which reports to the United States Secretary of Health and Human Services.

Principles for Personal Health Records:

- Each person controls his or her own Personal Health Record and decides who can access which parts of their PHR
- PHRs contain information for one's lifetime
- PHRs contain information from all health care providers
- PHRs should have data integrity: data sources and age of data should be cited; clients can annotate but are not permitted to destroy or change data electronically supplied by other systems
- Clients and permitted providers can access PHRs at any place and at any time
- PHRs should be portable; one system's PHR should permit easy exchange of information with other systems' PHRs
- PHRs are private and secure; all entities that provide or manage personal health information, whether or not defined as covered entities under HIPAA, should follow the privacy and security rules that apply to HIPAA-covered entities
- PHRs are transparent; clients should be able to view who has accessed which parts of their PHRs
- PHRs permit easy exchange of information; PHRs must comply with interoperability requirements such as those required by certification bodies, such as the Certification Commission for Healthcare Information Technology (CCHIT)

While the definition and scope of a PHR varies, Counties may request funding for PHR Projects that align with the above principles and that follow the applicable standards listed in Appendix B for EHRs.

### **Online Information Resource Projects**

The Network of Care for Behavioral Health is an example of an online information resource for individuals, families and agencies concerned with mental and emotional wellness, substance abuse and developmental disabilities. For most counties, this web resource contains various functions such as: a service directory, a library, simple access to legislation, mental health organizational links, support and advocacy, and a user maintained personal health folder.

Counties may request funding to develop new Web site functions, language access technology or an expansion of information sharing services that improve mental health service delivery through fast and secure access to health information and providers.

### **Other Technological Needs Projects Support MHSAs Operations**

Below is a sampling of "Other" Technological Needs Projects that might be undertaken by the County. These Projects do not have pre-defined requirements and will be evaluated on a case by case basis. As with the above EHR and Client and Family Empowerment Projects, these Other Technological Needs Projects may include funding requests for hardware, software, communications devices and the installation services to install and maintain them.

### **Telemedicine/Tele-psychiatry and Other Rural/Underserved Service Access Methods**

Telemedicine technology is a strategy to improve the accessibility of mental health care, particularly to areas underserved by service providers. Telemedicine, in the form of video, secure e-mail, and phone consultation, is one strategy to improve the accessibility of care in rural and underserved settings. Some benefits include personalized action and treatment plans, easier access without rigid schedules (increases both client and service provider satisfaction), improved visibility into client's needs (leads to better understanding of outcomes) and providing clients better understanding of their conditions, which in turn, requires fewer interventions.

Applications of telemedicine include assessments, support, discharge planning, review, client and family education, case conferencing, emergency consultations, web based applications, interpreter services and translation services.

### **Pilot Projects to Monitor New Programs and Service Outcome Improvement**

Project monitoring follows a cyclical process that begins with monitoring clinical performance to identify successes or issues that influence clinical practice patterns and the causes. Once successes or issues are identified, practice modifications can be recommended and introduced, and the results assessed. Most important, by using the tools and systems to measure outcomes, information can be relayed back to service providers and administrators to improve a system's clinical performance while also addressing issues of accountability. These systems might measure clinical outcomes, including quality of life, relapse and re-hospitalization rates, adverse incidents monitoring and client and family satisfaction surveys.

### **Data Warehousing / Decision Support**

**Data Warehousing** is a process requiring a set of hardware and software components that can be used to better analyze the massive amounts of data that health systems are accumulating to make better operational and/or strategic decisions. The data warehousing process does not consist of just adding data, but also requires the architecture and tools to collect, query, analyze and present information. Data warehousing is a process, not a product, for assembling and managing data from various sources, for the purpose of gaining a single, detailed view of part or all of a business. Data Warehouses can potentially provide numerous benefits to an organization with quality improvement, and decision support by enabling quick and efficient access to information from existing systems and linkage to multiple operational data sources.

**Decision Support** systems record data from various sources that are needed to manage mental health systems effectively. *Population data* describes demographic characteristics, medical and mental health status and level of functioning. *Enrollment data* describes demographic and baseline mental health status of enrollees. *Encounter data* characterizes all users of services (such as health and mental health status, diagnosis, symptoms, functional status), types of services used, and frequency of use. *Financial data* will reflect costs of services, administrative costs and other expenditures.

### **Imaging / Paper Conversion Projects**

These Projects provide the capability to capture, store, manage, retrieve, and route documentation in a secure electronic manner. With document imaging, paper documents, photos, and graphics can be scanned and saved as images, organized into folders, linked to business applications, and retrieved by the users. Benefits of an image system include: ease of search and retrieval, Internet access of scanned images, transfer of images, microfilm replacement, space and storage reduction, and preservation of document integrity.

## **PART III. PLANNING AND SUBMISSION GUIDELINES**

### ***Planning***

The Technological Needs Project Proposal planning process for proposed expenditures should include revisiting the priorities and discussions documented in previous MHSA Community Program Planning Processes (CPP Processes). As Counties move toward modernization and transformation of their information infrastructure and address the goal of increasing client and family empowerment, they should focus upon getting additional input from stakeholders with expertise in this subject area. In addition, each County must address the need for the continued involvement of stakeholder committees and/or key stakeholders regarding recommendations for proposed Projects. Counties may work together to submit a comprehensive multi-County Project Proposal using shared resources and with the appropriate level of detail comparable to the level of Project scope and funding.

Consistent with MHSA statutory requirements WIC Sections 5848(a) and (b) and Title 9 CCR Sections 3300 and 3315(b), each County Capital Facilities and Technological Needs Component Proposal and each Capital Facilities Project Proposal and Technological Needs Project Proposal shall be developed with local stakeholders and made available in draft form and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the documents. Pursuant to WIC Section 5848(b), the Mental Health Board shall conduct a public hearing on the draft Capital Facilities and Technological Needs Component Proposal. If the Component Proposal is submitted along with a Project Proposal, the public hearing must address both. The County shall submit a summary and analysis of any substantive revisions made to its Component Proposal as a result of stakeholder input. No public hearing is required for Capital Facilities and Technological Needs Project Proposals submitted as updates to the approved Three-Year Plan. As noted in DMH Information Notice 06-13, funds are available for technology planning and assessment consultants to assist in the planning process.

### ***County Technological Needs Project Proposal Submission***

Technological Needs Project Proposals should be submitted to the Department electronically, with one unbound paper copy that includes the appropriate signatures. Technological Needs Project

Proposals will not be accepted via fax. The electronic copy of the Project Proposal should be emailed to DMH at the address below.

An original of the completed Technological Needs Project Proposal should be submitted to:

**California Department of Mental Health,  
Technological Needs Project Proposal  
Attn: Child and Family Programs  
1600 9<sup>th</sup> Street, Room 130  
Sacramento, CA 95814**

**MHSA-CFTN@DMH.CA.GOV**

### ***Funding***

Technological Needs Projects that benefit more than only mental health must include revenues from other funding sources so that the net cost to the MHSA is reflective of the benefit received by mental health. The County should use a reasonable allocation approach to determine the share of a Project's cost related to the MHSA, such as percent of total transactions or the number of clients served within programs (e.g. Mental Health clients versus substance abuse clients). The County must also comply with Welfare and Institutions Code Section 5891 addressing County obligations regarding non-supplanting. MHSA funds cannot be used to maintain a system/function already operational on November 2, 2004, but can be used to fully fund systems for mental health services that increase functionality consistent with the County's Technological Needs Assessment. The Budget Summary (Exhibit 4) provides the County with a template to list Project cost and the allocation to MHSA and other funding sources.

Welfare and Institutions Code Sections 5892(a)(2) and 5892(e) identify the percentage of MHSA revenues reserved for the Capital Facilities and Technological Needs component. The initial maximum amount of the Capital Facilities and Technological Needs funding available to each County (i.e., the Capital Facilities and Technological Needs Planning Estimate) is included in DMH Information Notice 08-02 which reflects actual deposits into the State MHS Fund through July 2, 2007. Counties may request less than their maximum funding total. The proposed Projects may not exceed the funding available. Additional funds will be dedicated to the Capital Facilities and Technological Needs component based on actual deposits into the State MHS Fund through June 30, 2008. Finally, Counties also have the ability to request funds from the Community Services and Supports component for capital facilities and technology beginning in FY 2008-09 provided that the total requested for capital facilities and technology, workforce education and training and the Prudent Reserve do not exceed 20% of the average amount of funds allocated to the County for the previous five years (Welfare and Institutions Code Section 5892(b)).

### ***DMH Review Process***

The review process for these proposed Projects and the approval for the funding will be completed within 60 days. DMH headquarters Information Technology (IT) staff will work closely with County staff to assist with submission, identify any needed additional information, and obtain Project approval. The review process will be dependent on a timely response by the County to additional information requests from DMH staff and will include review and comment from the MHSA Oversight and Accountability Commission. DMH headquarters IT staff will also coordinate input review and funding approval.

The Technological Needs Project Proposal will be evaluated in relation to the County's Technological Needs Assessment to ensure that the proposed Projects meet the long-term MHSA goals. If funded, a letter will be sent informing the County that the proposed Project has been funded and will be followed by an amendment to the MHSA Agreement.

Funded Projects are reviewed on an on-going basis in accordance with the Agreement to ensure they are meeting the objectives of the original request. DMH will review periodic County status reports to determine if there are any risks and/or issues that could compromise the success of the Project. If risks and/or issues are identified, additional consultation with the County will be needed to provide guidance, assistance and solicit clarification.

## **PART IV: INSTRUCTIONS AND REQUIRED DOCUMENTATION**

### ***Required Exhibits***

The County Technological Needs Project Proposal and Status is comprised of a series of **six (6) Exhibits** that include the County's Technological Needs Assessment (Exhibit 2), proposed Project and related budget, stakeholder participation and, once approved, Project status. To request funds for a Technological Needs Project, the County must submit a Technological Needs Project Proposal consisting of Exhibits 1, and 3 through 5 for each Project, if more than one Project. A Technological Needs Project Proposal will be evaluated based on the consistency with the Technological Needs Assessment.

Technological Needs Project Proposals must include one Technological Needs Assessment (Exhibit 2) and Exhibits 1, 3, 4 and 5 per Project for evaluation by DMH. Counties may jointly submit a Technological Needs Project Proposal for evaluation.

### ***Exhibit Descriptions***

#### **Face Sheet (Exhibit 1)**

This exhibit is a signed verification by the County's mental health director that all requirements for the Technological Needs Project Proposal have been considered and will be followed. It also provides the name and contact information of the director's designated point of contact for all matters related to this request.

#### **Technological Needs Assessment (Exhibit 2)**

This exhibit will provide to the Department, sufficient background information regarding the County's planned steps toward an Integrated Information System Infrastructure and the link to the proposed Technological Needs Project. This exhibit may be prepared with existing County documents and/or other documents.

DMH engaged the California External Quality Review Organization (CAEQRO) to meet Title 42 CFR, Section 438.2 requirements. Counties may include the results of the CAEQRO Information Systems Capabilities Assessment Report findings when applicable as supporting documentation. Small counties (under 200,000 in population) have the option of submitting a reduced Technological Needs Assessment as described below.

Provide a Technological Needs Assessment which addresses each of the following three elements:

### **County Technology Strategic Plan**

(Small Counties have the option to not complete this section.)

County Technology Strategic Plans will be evaluated on their strategies for reaching the Department's technology goals of modernization / transformation and client / family empowerment through the implementation of an Integrated Information Systems Infrastructure that makes health information available to clients and service providers throughout California. This long-term plan will promote the transformation of county technology operations from a paper based process to a secure, fully integrated, client-driven electronic environment. Successful implementation of individual Projects will be critical to achieving the long-term plan.

This section includes an assessment of the County's current status of technology solutions, its long-term business plan and the long-term technology plan that will define the ability of County Mental Health to achieve an integrated information systems infrastructure over time. Refer to the Template in Exhibit 4.

### **County Technology Roadmap for Achieving an Integrated Information Systems Infrastructure**

The *Roadmap* will define the plan, schedule and approach to achieving an Integrated Information Systems Infrastructure. It will include proposed Project milestones, plans for vendor selection and cost estimates over the life of the planning process.

This section includes a plan, schedule and approach to achieving an Integrated Information Systems Infrastructure.

At a minimum, the Roadmap must include:

1. A proposed implementation timeline with major milestones including; planning, training, communication approach, and systems review
2. An inventory of current systems and proposed purchases for any or all parts of an EHR system as identified in Enclosure 3
3. A proposed workflow assessment plan (Counties may complete this assessment during the implementation of a Project)
4. Criteria for vendor selection (such as a Request for Proposal)
5. Cost estimates associated with achieving the Integrated Information Systems Infrastructure (IISI)

**County Personnel Analysis (Management and Staffing)**

(Small Counties have the option to not complete this section.)

This element includes an assessment of the County's current status, its prior experience with information technology installation and the managerial resources it can bring to bear on the use and control of the technology, for example, Technological Needs Project manager, hardware and software specialists and/or training manager. The County may use the same analysis conducted under the Workforce Education and Training component of the Three-Year Plan to satisfy this requirement.

**Technological Needs Project Proposal Description (Exhibit 3)**

This exhibit is designed to give the Department a comprehensive understanding of the Proposed Technological Needs Project Proposal and how Project(s) relate to the Capital and Technological Needs Component Proposal and the goals of MHSA. This exhibit may be prepared in conjunction with multiple counties using already available, applicable materials such as a Joint Powers Authority (JPA) collaborative planning document, Request for Proposals (RFP's), California External Quality Review Organization (CAEQRO) Information Systems Capability Assessment (ISCA), and other documents developed in consultation with the DMH.

After submission and approval of the Technological Needs Assessment as described above, to receive funding for each proposed Project, the County shall submit a Technological Needs Project Proposal Description (Exhibit 3) with elements about the following categories:

- Project Management Overview
- Project Cost
- Nature of the Project
- Hardware Considerations
- Software Considerations
- Interagency Considerations
- Training and Implementation
- Security Process

County Technological Needs Project Proposal Descriptions must provide a sufficient level of detail to describe the underlying assumptions, feasibility, objectives, alternatives considered, technology environment, and proposed Project to accomplish the proposed solution. *Technological Needs Project Proposals that are for planning or preparation of technology are not required to include hardware, software, interagency, training or security detail.* DMH will review each Technological Needs Project Proposal placing emphasis on the following elements:

1. The quantifiable description of the benefit inherent in the Proposed Technological Needs Project Proposal. This benefit description may be a reference to a description in the Roadmap or other Technological Needs Assessment document.
2. A description of the assumptions used and the expected functionality associated with the proposal that explains how the stated benefits and objectives will be achieved. This description can be provided by a vendor if a technology solution has already been selected.
3. The description of the County's program(s), program objectives and current business processes that will be impacted by the Project.



4. A depiction of how the Project fits into the long-term strategy of the County's programs toward an Integrated Information System Infrastructure.

Each County is responsible for ensuring its Technological Needs Project Proposal meets DMH guidelines described herein. At its discretion, DMH may request additional information from the County.

#### **Budget Summary (Exhibit 4)**

These budget summaries allow the Counties to summarize proposed expenditures for each Project by type of expenditure; for example, personnel, hardware, software, training, support and consulting for each fiscal year. Expenditures for the proposed Technological Needs Project Proposal(s) should be easily identified and related to the Project(s) implementation schedule as defined in Exhibit 3.

Expenditures must be specific to the proposed Project(s) and cannot be for general technology needs of the County, such as a general increase in desktop computers for new employees.

Total estimated costs for the Project(s) minus any funding from alternative sources will equal the total MHSA funding requirement. For Projects providing services to multiple program clients (e.g. Mental Health and Alcohol and Drug Program clients) a description of estimated benefits and Project costs allocated to each program shall be identified.

The total of the Technological Needs Project Proposal funding request(s) plus any request for Capital Facilities funding shall not exceed the total Capital Facilities and Technological Needs Planning Estimate identified for the County in DMH Information Notice 08-02. MHSA funding dedicated to the Capital Facilities and Technological Needs component must be spent within ten years or it will revert to the State for redistribution to all Counties.

#### **Stakeholder Participation Report (Exhibit 5)**

Include a description of stakeholder involvement, including the Community Program Planning Process (CPP Process) and the Local Review Process, in the Technological Needs Project Proposal. The CPP Process may have already been completed through the development of the Capital Facilities and Technological Needs Component of the Plan, as noted in Enclosure 1, in which case, simply attach a copy.

#### **Status Report (Exhibit 6)**

This exhibit describes the required reporting for County Technological Needs Project implementation progress only after the Project has been approved. The current version of this template is available from DMH MHSA Technology website at [www.dmh.ca.gov/Prop\\_63/MHSA/Technology](http://www.dmh.ca.gov/Prop_63/MHSA/Technology).

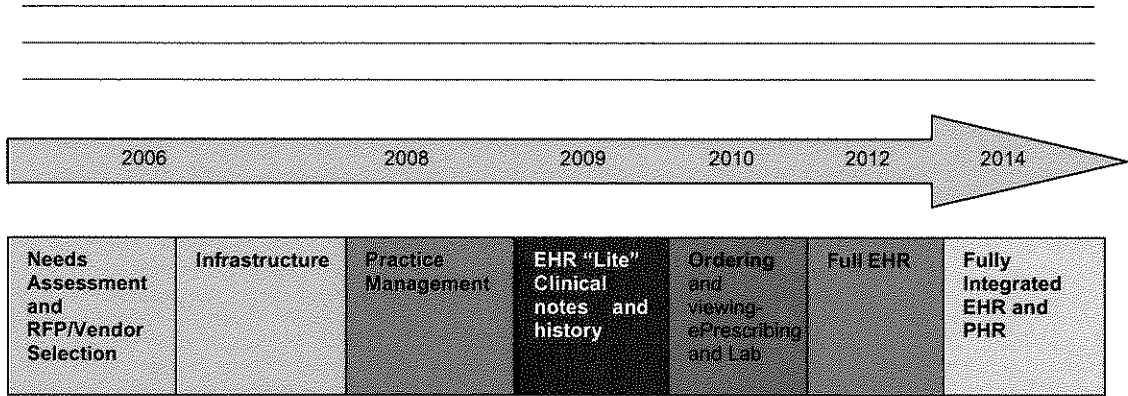
Counties shall submit this report, which may be prepared by the vendor, periodically as required in the Technological Needs Project Proposal. If the County does not submit the required status report information within the established timeframes, the Department may withhold MHSA funds.

**2. Technological Needs Roadmap Template**

This section includes a plan, schedule and approach to achieving an Integrated Information Systems Infrastructure. This Roadmap reflects the County’s overall technological needs.

Complete a proposed implementation timeline with the following major milestones.

- 2.1) List Integrated Information Systems Infrastructure Implementation Plan and schedule or attach a current Roadmap (example below):



- 2.2) Training and schedule (List or provide in timeline format, example below):

Training Schedule for 2008	J a n	F e b	M a r	A p r	M a y	J u n	J u l	A u g	S e p	O c t	N o v	D e c		
Basic System Nav	X													
Admin Staff	X													
Clinicians		X												
Contract Providers			X											
Client Look-Up				X										

## APPENDIX B - EHR AND PHR STANDARDS AND REQUIREMENTS

The minimum standards listed below are applicable to the individual parts of the County's proposed EHR system. As Counties implement specific parts of an EHR, they must assure compliance with all minimum standards related to the implemented part of the EHR. PHR Projects may also have applicable standards as noted below.

### **1. Functional Standards**

County projects **MUST MOVE TOWARDS** an Integrated Information Systems Infrastructure. The foundation for an Integrated Information Systems Infrastructure is a comprehensive Electronic Health Record (EHR) system, which is a secure, real-time, point-of-care, client-centric, information resource for service providers. *The applicable functional requirements a comprehensive EHR **MUST** meet are outlined in the CCHIT Functionality Criteria 2007 ([www.CCHIT.org](http://www.CCHIT.org)). A summary of the attributes of a comprehensive EHR is provided below (Health Care Information Management Services Society (HIMSS) Electronic Health Record Definitional Model Version. 1.1.) ([www.HIMSS.org](http://www.HIMSS.org))*

- Provide secure, reliable, real-time access to client health record information where and when it is needed to support care.
- Function as a centralized and integrated information resource for clinicians during the provision of client care.
- Assist with the work of planning and delivering evidence-based care to individuals and groups of clients.
- Capture data used for continuous quality improvement, utilization review, risk management, resource planning, and performance measurement.
- Support clinical applications such as computerized order entry and decision support tools.
- Summarize via electronic prescribing, prescribed medications from all providers for quality management, coordination of care and for uses in the Personal Health Record.
- Provide compatibility with scheduling, billing and reporting applications as well as personal health record technologies.
- Capture and report California mental health specific cost reporting and performance outcome data.

**User Friendly Interface Standard:** The EHR Project **MUST** meet the following:

- Provide a useful and easy to understand interface, making it easy for clinicians and administrative personnel to operate.

The EHR Project **MUST MOVE TOWARDS** the following:

- Be Internet based, available from any standard web browser, so that consumers or family members may access their PHRs.
- Be able to transmit an approved form of a Continuity of Care Record as applicable.
- Provide ability of the client and family to communicate with the clinician and service provider, especially in the multi-lingual environment.

**Vendor Commitment Standard:** The EHR Project vendor **MUST** meet current industry and government standards. At a minimum, the technology must support current basic standards and the vendor must provide a written agreement to continually upgrade the technology to meet future standards as they become available. The vendor **MUST**:

- Include implementation plans that meet minimum staffing criteria for planning, implementation, conversion/migration, oversight, risk management and quality assurance of the technology.
- Specify how their product meets or is planning to address all State and federal regulations including but not limited to HIPAA regulations.
- Provide the necessary plan for the product to have application interfaces as necessary to meet California mental health reporting and claiming requirements.
- Meet the CCHIT behavioral health criteria within one year of the availability of final CCHIT behavioral health certification criteria.

## **2. Connectivity and Language (Interoperability) Standards**

In addition to the functional requirements, the EHR Project must address the ability of the system to transfer data outside the County clinic. There are two types of data transfer: messaging and record exchange. Messaging is necessary when data is transferred between different systems with different data standards. Messaging requires the use of standardized protocols such as Health Level 7 (HL7). Health Level 7 ([www.hl7.org](http://www.hl7.org)) is one of several American National Standards Institute (ANSI) -accredited Standards Developing Organizations (SDOs) operating in the healthcare arena. Most SDOs produce standards (sometimes called specifications or protocols) for a particular healthcare domain such as pharmacy, medical devices, imaging or insurance (claims processing) transactions. Health Level 7's domain is clinical and administrative data. The format and method of data distribution should be standardized wherever possible. Record exchange can occur where data is transferred between two systems that share a common structural design. Detailed requirements are shown below:

**Connectivity Standard:** *The EHR Project **MUST MOVE TOWARDS** the following:*

- Be compatible with modern local and wide area network technology supporting Internet and intranet communication.
- Be distributed, with "ownership" of the data remaining at both the sending and the receiving ends.
- Use standard protocols that include:
  - Extensible Markup Language (XML), a markup language for documents containing structured information. ([www.XML.com](http://www.XML.com))
  - Simple Object Access Protocol (SOAP) - a protocol for exchanging XML-based messages over computer networks, normally using HTTP. (See the World Wide Web Consortium (W3C) at [www.w3.org](http://www.w3.org).)
  - Security Assertion Markup Language (SAML) - an XML document standard for exchanging authentication and authorization data between an identity provider and a service provider. (See the Organization for the Advancement of Structural Information Standards (OASIS) at [www.oasis-open.org](http://www.oasis-open.org).)
  - Web services used for application programming interfaces
  - Message-oriented middleware (or software that connects two or more software applications so that they can exchange data)

- Other fully documented and highly-supported application programming interfaces as applicable and developed over time

### **Language Standard:**

The EHR Project **MUST** use industry standard coding and classification systems such as:

- International Classification of Diseases (ICD-9)
- Common Procedural Terminology (CPT) or the various nursing terminologies, which set up hierarchical models for specific descriptions of diagnoses, procedures, activities, etc.

The EHR Project **MUST** be able to capture and report:

- California specific cost reporting and performance outcome data

In addition, the EHR Project **MUST MOVE TOWARDS**:

- Standardized clinical nomenclature within structured messages (reference terminologies such as SNOMED (Standardized Nomenclature of Medicine))
- HL7 2.X (with vendor commitment to migrate to HL7 RIM)
- Logical Observation Identifiers Names and Codes (LOINC) as applicable
- Having a cross-mapping of terms from one formal terminology or classification to another consistent with federal, state and DMH standard languages

### **3. Client Access, Security and Privacy Standards**

Technology solutions must also address the need for client access and security. The system must support the ethical and legal use of personal information, in accordance with established privacy principles and frameworks, which may be culturally or ethnically specific. The basis of the relationship between service provider and clients and family is the delivery of high quality care with the highest respect for client self-reliance. This can only be achieved with the knowledge that information is secure and confidential. Detailed requirements are shown below.

#### **Privacy**

**Government Compliance Standard:** The EHR Project **MUST** be continuously updated to comply with current federal and state laws. These include but are not limited to:

- The United States Department of Health and Human Services (DHHS) Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations
- The Information Practices Act of 1977 (Civ. Code 1798 et. seq.)
- The patient confidentiality provisions of section 5328 of the Welfare and Institutions Code
- The Confidentiality of Medical Information Act (Civ. Code 56 et seq.)
- The right to privacy under Article 1, Section 1 of the California Constitution
- All applicable privileges and rules of professional responsibility
- Any other applicable state and federal laws and regulations
- All California rules and regulations pertaining to the privacy and security of mental health and substance abuse information

*Vendor proposals for technology solutions must specify how their product meets or plans to address all state and federal laws including, but not limited to, HIPAA regulations, Clinical Laboratory Improvement Amendments (CLIA), 42 CFR9 (Code of Federal Regulations),*

*Information Practices Act (IPA), California Medical Information Act (CMIA), California Family Code 6920-6929, Title VI of the Civil Rights Act, and the Patient's Access to Health Records Act.*

**Privacy Standard:** The EHR Project **MUST** support the application of prevailing California privacy and confidentiality rules. The technology solution must support the restricting of components or sections of the system to authorized users and/or purposes. This restriction should include restrictions at the level of reading, writing, amendment, verification, and transmission or disclosure of data and records.

- Support privacy and confidentiality restrictions at the level of both data sets and discrete data attributes.
- Support recording of informed consent for the creation of a client record.

**Client Access:** The EHR project **MUST**:

- Address competency and literacy in the use of technology
- Comply with current Americans with Disabilities Act (ADA), Section 508 of the Rehabilitation Act requirements. Section 508 requires that individuals with disabilities, including Federal employees, have access to and use of information and data that is comparable to those without disabilities. To learn more about the regulations governing the accessibility of Federal electronic information, please see: [www.hhs.gov/Accessibility.html](http://www.hhs.gov/Accessibility.html).
- Address cultural and language issues to facilitate access and sharing of data. Many cultures do not support the idea of sharing client information. Others share information and decision making on health matters at the level of the extended family or larger group. Counties must ensure that language translation using technology supports cultural competency and linguistic objectives.

### **Security**

The EHR Project **MUST** follow the security criteria outlined in the CCHIT Ambulatory Security Criteria 2007, as applicable. The criteria include: Access Control, Audit, and Authentication. The general security standards are noted in the sample from International Standards Organization ([www.iso.org](http://www.iso.org)) which is listed below:

- ISO 17799 – Code of Practice for information security
- ISO 27799 – Security Management in health using ISO 17799
- ISO/CD TS 21298 – Health informatics functional and structural roles
- ISO/TS 21091:2005 – Directory services for security, communications and identification of professionals and clients
- ISO/TS 17090-1:2002 – Health informatics – Public Key infrastructure
- ISO 26000 – Standard on Social responsibility (In development – 2008)

A sample from ASTM International originally known as the American Society for Testing and Materials ([www.astm.org](http://www.astm.org)) is listed below. (All of the following standards are American National Standards Institute (ANSI) approved.)

- E1762-95(2003) – Standard guide for electronic authentication of healthcare information
- E1985-98(2003) – Standard guide for user authentication and authorization
- E1986-98(2005) – Standard guide for information access privileges to health information

- E1869-04 – Standard guide for confidentiality, privacy, access and data security principles for health care including EHRs
- E1988-98 – Standard guide for training of persons who have access to health information
- E2147-01 – Standard specification for audit and disclosure logs for use in health information systems

**Access Control Standard:** the EHR **MUST** support measures to define, attach, modify and remove access rights to the whole system and/or sections.

- *Support measures to define, attach, modify and remove access rights for classes of users.*
- *Support measures to enable and restrict access to the whole and/or sections of the technology solution in accordance with prevailing consent and access rules.*
- *Support measures to separately control authority to add to and/or modify the technology solution from the control of authority to access the technology solution.*
- *Support measures to ensure the integrity of data stored in and transferred to and from other systems.*

**Auditing Standard:** The EHR **MUST** support recording of an audit trail of access to, and/or modifications of, data.

- *Support recording of the nature of each access and/or modification.*
- *Support audit capability sufficient to track accountability for each step or task in the clinical or operational processes recorded in the record including but not limited to the standards for e-signature auditing.*

**Authentication Standard:** The EHR **MUST** support two factor authentication and work toward meeting the evolving standards for authentication as they become available.

**Component Exhibit 4****DRAFT****COMPONENT PROPOSAL: TECHNOLOGICAL NEEDS**

Please check-off one or more of the technological needs which meet your goals of modernization/transformation or client/family empowerment as your county moves toward an Integrated Information Systems Infrastructure. Examples are listed below and described in further detail in Enclosure 3. If no technological needs are identified, please write "None" in the box below and include the related rationale in Exhibit 1.

- **Electronic Health Record (EHR) System Projects (check all that apply)**
  - Infrastructure, Security, Privacy
  - Practice Management
  - Clinical Data Management
  - Computerized Provider Order Entry
  - Full EHR with Interoperability Components (for example, standard data exchanges with other counties, contract providers, labs, pharmacies)
- **Client and Family Empowerment Projects**
  - Client/Family Access to Computing Resources Projects
  - Personal Health Record (PHR) System Projects
  - Online Information Resource Projects (Expansion / Leveraging information sharing services)
- **Other Technology Projects That Support MHSAs Operations**
  - Telemedicine and other rural/underserved service access methods
  - Pilot projects to monitor new programs and service outcome improvement
  - Data Warehousing Projects / Decision Support
  - Imaging / Paper Conversion Projects
  - Other (Briefly Describe)



**Contra Costa Mental Health Needs Assessment Survey For Capital Facilities and Information Technology Funding**

**DRAFT**

There is a total of \$10.2 million available to the County from Mental Health Services Act (MHSA) funding that can be spent for capital facilities (such as constructing/renovating buildings, purchasing land for the buildings, etc.) and/or information technology needs (such as electronic medical records, e-prescribing, Personal Health Record, etc), as determined by a public planning process. In February 2009, the draft Capital Facilities and Technological Needs Component Proposal was approved by the State Department of Mental Health. The County proposed to spend \$2 million for information technology needs, and \$8.2 million for capital facilities. Updated research has revealed that purchasing an information technology system will cost between \$5-\$6 million. The County is now interested in determining how stakeholders would like to spend the \$10.2 million, given that it is now more costly to upgrade the technology system.

Please read and answer the following questions based on your experience in working with/receiving services from Contra Costa Mental Health. Your answers will remain anonymous. Your responses will be used to help determine which needs will be funded by Mental Health Services Act (MHSA) Capital Facilities and Technological Needs in order to construct or renovate a building for new mental health services and/or purchasing an information technology system.

1. **If we had the money to construct or renovate a building for mental health services, which of the following services are most important to you? Please rank them in the order of importance to you. (On a scale of 1 through 3, with 3= most important, 2=medium importance, and 1=least important)**

RANK IMPORTANCE	SERVICES NEEDED	LOCATION OF FACILITY Check Location Where You Want the Facility			
		West County	Central County	East County	Centralized in One Location
	Assessment and Recovery Center to include a 24/7 Urgent Mental Health Care Drop-In Center with Crisis Stabilization Services (serves all age groups other than children) [a1]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Centralized Multi-disciplinary Use Mental Health Campus with Adequate Transportation (includes an Assessment and Recovery Center; 16-bed Crisis Residential Facility; Children's Urgent Care Receiving and Assessment Center). [a2]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Contra Costa Mental Health Needs Assessment Survey For Capital Facilities and Information Technology Funding**

	Children's Urgent Care Receiving and Assessment Center [a3]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Co-Location with other Community Services and Supports to Reduce Stigma and Improve Access, Facilitate Community Collaboration, and Provide an Integrated Service Experience for Clients and their Families. [a4]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Crisis Residential Facility for Young Adults. (unlocked) [a5]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Crisis Residential Facility for Adults. (unlocked) [a6]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Crisis Residential Facility for Older Adults. (unlocked) [a7]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dual Diagnosis Residential/Treatment Center Facility [a8]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Contra Costa Mental Health Needs Assessment Survey For Capital Facilities and Information Technology Funding**

	Integrated Mental Health and Primary Care Center Facility [a9]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Peer-Operated Crisis Respite Center (i.e. Peer to Peer, Consumer run alternative to Inpatient Hospitalization, or combination of recovery and clinical-based services) [a10]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Permanent Facility for the Clubhouse [a11]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your Ideas:	[a12]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	[a13]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	[a14]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	[a15]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2. Are there other needs that should be considered? Examples:**

- Transportation to/from Facility [b1]
- Location of the facility [b2]
- Other [b3]

(attach a separate sheet to list other needs to be considered)

**3. A robust computer system that will have a complete electronic medical record, and which will have the future capacity to include a Personal Health Record and electronic prescribing will cost \$5-\$6 million which is 50%-60% of the \$10.2 million allocated to the County.**

**The county has been allocated a total of \$10.2 million that can be spent on Capital Facilities and also on Technology needs. This means that the money available can be "divided up" between Capital Facility expenses and Information Technology/System Replacement**

# Contra Costa Mental Health Needs Assessment Survey For Capital Facilities and Information Technology Funding

**expenses. If you had a choice, how much of the money would you spend on a new Information Technology System that included an Electronic Medical Record, Personal Health Record, and Electronic Prescribing?**

*Please select the statement that best reflects how you feel:*

Yes. I support spending \$5-\$6 million on a new system. [c1] <input type="checkbox"/>	
No. I don't want to spend that much money. [c2] <input type="checkbox"/>	I don't know. (I would need more information to answer this question). [c3] <input type="checkbox"/>

**4. CHECK ALL THAT APPLY:**

<p><b>YOUR EXPERIENCE</b></p> <input type="checkbox"/> Providing Services <input type="checkbox"/> Receiving Services <input type="checkbox"/> Family Member <input type="checkbox"/> Internship <input type="checkbox"/> Advisory Committee <input type="checkbox"/> Advocating <input type="checkbox"/> Volunteering <input type="checkbox"/> Stakeholder	<p><b>YOUR RACE/ETHNICITY</b></p> <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander  Other: _____
<p><b>YOUR INTERESTS</b></p> <input type="checkbox"/> Adult Mental Health Services <input type="checkbox"/> Children's Mental Health Services <input type="checkbox"/> Older Adult Mental Health Services <input type="checkbox"/> Young Adult Services <input type="checkbox"/> Lesbian, Gay, Bisexual or Transgender Community <input type="checkbox"/> Latino Community <input type="checkbox"/> Asian/Pacific Island Community <input type="checkbox"/> Native American Community <input type="checkbox"/> Client Culture Community Other Cultural Communities: _____	<p><b>YOUR GENDER:</b></p> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other  <p><b>YOUR AGE:</b></p> <input type="checkbox"/> Under 18 <input type="checkbox"/> 18-25 <input type="checkbox"/> 26-59 <input type="checkbox"/> 60+
<p><b>YOUR ZIP CODE:</b></p> _____	

**Contra Costa Mental Health Needs Assessment Survey For Capital Facilities and Information Technology Funding**

RETURN THE COMPLETED SURVEY BY 5:00 P.M. ON NOVEMBER 16, 2009 TO:

Contra Costa Mental Health Administration  
Attn: MHSA Facility Need Survey  
1340 Arnold Dr., Suite 200  
Martinez, CA 94553

Or email an electronic copy to: [mhsa@hsl.cccounty.us](mailto:mhsa@hsl.cccounty.us)  
**Thank you!**



## Email Suggestions/Comments for the Draft Capital Facilities/IT Needs Survey

The following are excerpts from emails received from various members of the MHC-CPAW Capital Facility/Information Technology Workgroup, in response to request(s) from staff to review the different versions of the draft. These emails are included in order to provide the Workgroup and the public an opportunity to review all of the input, thus far, for the needs survey, and also to provide information which may be helpful in making final revisions to the survey.

10/26/09:

Do we have a final version?

10/26/09 – 6:23 pm

As Chair of the MHC/CPAW Cap Facilities/IT Workgroup, I am unable to fulfill my commitment to the motions, supported at the last meeting, on 10-19-09, and the agreed upon Timeline. I do not believe that this questionnaire/survey will be the appropriate tool to capture the public's current temperature on the Capital Facilities **and** Information Technology needs, as required by the DMH Guidelines. The public must have an opportunity to hear the county's decision, to table the IT part of the plan that was submitted to DMH, with the Capital Facility proposal. The public and all stakeholders must understand that this is ONE pot of funds, not two. These two components must be considered jointly.

I listened to the entire 2 1/2 hour tape of the 10/19 meeting and found that the Motion clearly DID NOT include the IT questions. While there were discussions, and I clearly stated that we needed to address IT, I failed to include it in the motion discussion. Therefore, the motion was approved without the inclusion of the IT information. I am a visual learner, so is Annis. Since IT was not on the Draft Questionnaire, we assumed that it could be captured within the 48 hour "grace period" included in the motion. We were wrong.

As a result, **if** this Draft Questionnaire/Survey is distributed, the community will not have an opportunity to weigh in on this important consideration. I believe this would be a failure to inform and receive input. Therefore, I am requesting that the Questionnaire/Survey be held, pending resolution of this issue, at the next scheduled meeting, on November 2, 2009. I have been advised that this is a procedure that is consistent with those employed by the Board of Supervisors on matters of concern. It is prudent to correct a procedural error, if possible, rather than push ahead.

At the 11-2-09 meeting, I will include an agenda discussion and report from Steve Hahn Smith, if he is available. We will provide the DMH 08-09 Enclosures 1 and 3 that refer to Information Technology, in relation to this component. Our Workgroup only received the DMH Guidelines for Capital Facilities, the 08-09 Enclosure 2, at the October 19, 2009 meeting.

Sherry, it is important to state that I do not blame you for this mistake. However, I want to make it very clear, to the workgroup, that Annis had sent an email, on October 9, 2009, requesting that information be placed on the Draft Questionnaire, regarding Information Technology. Yet, it was not included in the Draft, that you provided, at last week's meeting. She feels very upset with herself that she failed to communicate this to the group. She most definitely has not failed. She has devoted hours and hours to this process and was committed to making sure that the commission, and the public, had all of the relevant information for a balanced discussion and recommendation.

In listening to the tape, Kathi was consistent in talking about Capital Facility needs only. However, at one point, Anne Reed made an objection to the attempt to narrowly focus the questionnaire on only things that are "realistic" and "consistent with the MHSA guidelines, and current CSS and PEI plans." Anne stated that she saw this as an opportunity to "Create a comprehensive survey...." and capture "a breadth of data in case other sources of funding comes up...." She later states that she sees the survey as "...a temperature check of what consumers and family members think we need for the Mental Health System and see how they dovetail into the amount of money available and the ideas floating out there." She didn't want to "self narrow" the focus and prevent the vehicle from serving a wider purpose.

Kathi, stated that she disagreed and did not feel that an "expansive survey" would be good and that she knew of no other funds out there besides MHSA. She suggested a survey process that was expedient and did not raise expectations. Brenda concurred with Kathi and Susan and wanted to be realistic and get the biggest bang for our buck.

While there may be members, of the workgroup, and the public, who will be disappointed, with this delay, I believe there will be a better chance to achieve the fair and balanced process that the group declared as its charge. To proceed with the current motions would create another flawed process and risk **not** capturing the true community needs. I believe the motion was premature and pressured, and that a testing of the questionnaire, as requested by Commissioner Yoshioka, failed to be considered, as well.

I want to state emphatically, again, that I am fighting for a fair public planning process, NOT an outcome. I am committed to a consensus building partnership with all stakeholders. In order to have a true partnership, we must all have the same information at the same time and be able to discuss that information in an open and public process. We must maintain noble intentions, as Brenda Crawford requested, and not allow adversarial, competitive motives to prevail. I appreciate all that you have done to support this process and I am committed to working with you to bring about the transformation of our mental health system.

10/24/09 – 10:17am

Sherry Bradley requested I forward this message along from Steve Hahn-Smith.

Sherry's comments: "Steve's suggestion is very important in terms of capturing/reporting the survey data, but don't want to change things unless all are ok with that."

Please respond directly to Sherry Bradley.

10/23/09 – 11:19 am

Since this does not change the intent of the survey I am in favor of the additions which as Steve points out will make it easier for people to complete.

10/22/09 – 7:33 pm

This draft does not separate the TAY, Adult, Older Adult as had been discussed and approved earlier--when Anne first made her motion it included a statement (as best I can remember) about including the previously discussed changes and also incorporated the statement about limiting the survey to capital facilities. Adding the IT questions changes the focus and is not what I thought I voted for--therefore I cannot support this as the survey that we approved.



10/22/09 6:05 pm

I believe each should be separate. In terms of the supporting the survey in its current iteration that is not only a process question, but because this committee has been empowered by the MH Commission to make the decision about the survey, and because the inclusion of IT was not discussed and not part of the motion that was approved, to include it will violate both the Brown Act and the Better Government Ordinance and thus be subject to challenge by any member of the public or by any member of the committee.

10/22/09 – 4:28 pm

My concern with Steve's suggestion is the same as the "check all that apply" suggestion - people will put "extremely important" to everything (since we now have nothing), and there will be no way to accurately assess priorities. I am not voting yea or nay, just stating my concern.

10/22/09 – 12:59 pm

One other thing you could do on the survey (that would make it easier on respondents) would be to ask them to rank each option on a scale of 1 to 3 (1=least importance; 2=medium importance; 3=most important...or some other descriptors). This would probably be easier for people to complete than it would to rank the number of options they have now (13?). On the analysis side, it would be easier to analyze b/c we could just do an average score across all surveys for each item and (in the scenario above), low score is most important.

10/22/09 – 12:21 pm

Thank you. I am very comfortable with this survey, as is, but would not object to including Tony's wording below.

10/22/09 – 12:12 pm

If we are going to have question #3--could we add the following:

***[At least 40% (\$4 million) will be required for a Computer System that will have a complete Electronic Medical Record and which will have the future capacity to include a Personal Health Record and Electronic Prescribing.]***

Perhaps we could run this by Steve Hahn-Smith who has been very involved in the selection and pricing of the various IT systems to make sure it is accurate?

10/22/09 – 12:02 pm

I'm having technical difficulties with home e-mail, so I'm working with Cindy to get this draft completed. Please see the attachment, review carefully and let me know if anything was missed.

Please also note that this is still in draft form.

10/22/09 – 10:38 am

I apologize for not responding to your inquiry sooner. As, I mentioned in my email, this suggestion was lifted off of the DMH Guidelines for a possible use of Capital Facilities Funds. I believe it includes a variety of possibilities that might be considered. Any facility that can integrate as many programs and services in one location would serve the county consumer very well.

10/21/09 – 6:31 pm:

I would respectfully request that all correspondence, for this workgroup, be directed to me, Sherry, or Nancy Schott.

Karen Shuler has been working very hard on the minutes from the Monday night meeting and expects to have them completed by tomorrow. She will be forwarding the minutes, to me, when she has them completed. I would request that Karen not be contacted directly and that she not be copied on emails. Karen has graciously been accommodating this workgroup due to the unavailability of the Commission's staff. I do not want to take advantage of her time.

Based on Dorothy's comments, I am leaning towards calling another meeting. I think things are getting missed due to rushing and the timeline pressure. That is not the purpose of this process. The purpose of this process was to ensure that the community planning process includes any steps that were missed during the original process. I think we need to reconvene and reach consensus on the content and distribution of the questionnaire/survey.

I will be asking Nancy Schott to send out a meeting survey to coordinate our schedules. I would prefer that the meeting be dually noticed, however it is not required. I hope that we can find a time, next week, to reconvene and hopefully clarify some of the issues discussed in these emails. I am not comfortable moving ahead with the survey until the group has reached consensus, on a clearly stated process, that is understood by all.

10/21/09 – 2:51 pm

Teresa is correct regarding the sharing of the e-mails being a violation of the Brown act. The best way to avoid a violation is to not include all of the MHC on the e-mails.

As to the survey... The motion made at the Mental Health Commission was fairly generic (see below). It authorized the workgroup to create and send out the survey. Therefore, if a majority of the MHC/CPAW workgroup approves the survey, it does not need to go back to the Commission. Unless the survey is written very clearly and distributed well, the information gathered may not truly represent the feelings of the community. If the survey tool is missing information or unclear, I highly recommend that the group get back together to discuss and come to a consensus.

Motion to authorize the Capital Facility Workgroup to create and send out a survey, to expedite it, to poll the community on the Needs Assessment Survey for Capital Facilities Funding. It would be in some form similar to this survey discussed today. (M-Pereyra/S-Overby/P-Unanimously)

That is my understanding.....

10/21/09 – 12:09 am

Thank you all for your input. I am going to ask that the Commissioners, of this Workgroup, NOT discuss these matters or share these emails with any other Commissioner. I don't believe we have a Brown Act

problem since this is a discussion with less than a quorum of the commission. For future exchanges, the safe thing would be to reply to Sherry or me only to avoid potential serial meetings. While I appreciate the passion and the strong sense of what was and was not decided by the group, I will wait until Karen sends a DRAFT copy of the minutes, from last night's meeting, to be sure of last the motion.

I have reviewed the minutes from the first two meetings and am clear that the group intended to have Information Technology Funding considered in the overall analysis and decision on recommendations for this component. The first meeting held, September 24, 2009, defined the groups charge, with the Commission's 9/3 motion, as its guideline. Since neither Kathi, Anne, or Tony were present for the first meeting, so there may be some confusion as to what the group decided. At the first meeting, the group heard, from Sherry, "...that a robust electronic medical records system would cost around \$5 million and that currently, the Capital Facilities and Information Technology(IT) Component Plan, totaling \$10.2 million, is divided into \$8.2 million for Capital Facilities and \$2 million for IT." The group agreed to review options and alternative for Capital facilities technology needs.

On October 5th, the group reviewed a first draft of a questionnaire that was titled, "Contra Costa Mental Health Needs Assessment Survey For Capital Facilities and Information Technology Funding. However, Sherry noted that she had failed to include an IT question. My memory of our discussion, on October 5th, was that we were going to present a draft of the Questionnaire, to the Commission, to accept and ratify our plan to do a survey of Capital Facilities AND IT needs. During the October 5th meeting, Tony requested that Steve Hahn Smith be invited to address the Workgroup on the IT issues. The motion to take to the commission was for a "range of options" to be included the survey. Sherry stated in the 10/5 minutes that "...we should include IT in the choice of options."

On October 8th the Commission heard a report that included an explanation from Commissioner Perreyra about the Technology Component. Sherry commented to the Commission that she had revised the survey/questionnaire, but that it was missing an IT question(please refer to the Draft Minutes of the MHC meeting that were included in your packets, last night). Now, in reviewing Commissioner Reed's Motion made at the Commission meeting, I note that her motion did NOT include the words IT funding. I don't know if that was intentional or an oversight. I know that I did not realize that the IT component was not included in the motion to the commission. I would not have supported the motion had I realized this omission.

I was not informed that Steve Hahn Smith would not be attending last night's meeting, until the meeting started. I had intentionally set the agenda up to include having his comments heard BEFORE we discussed the survey. I specifically commented during the motion process that we had forgotten to include the Technology question again. My memory was that Commissioner Reed stated that we had 48 hours to make additional recommendations to the survey. I assumed this meant BOTH Capital Facilities and IT questions.

I am going to copy Dorothy Sansoe, on this exchange, to get her opinion and feedback. I am not comfortable moving this survey forward without this matter being clarified, for all members of the group and the public. If necessary, we can convene another meeting to debate and remedy the issue.

10/20/09 – 9:22pm

Good points Anne, thank you for clarifying. My suggestion regarding mental health and physical health were intended to relate to capitol facilities but could have been more clearly stated.

10/20/09 – 9:15 pm

As the one who made the motion, I would suggest that we refer to the meeting minutes for direction. My recollection is that the motion clearly deleted everything that was not related to capital facilities (specifically, everything below “Peer Operated Crisis Respite Center” in Question #1). Therefore, an inquiry about dual diagnosis would need to be phrased as a “dual diagnosis residential center” or “residential center specializing on dual diagnosis” – “center” being capital facilities vs. “program” which could be construed as non-facility related – ie. you can have a program within a center which is not specifically designated for dual diagnosis use. Likewise, information about “mental health” or “physical health” must, under the motion, be phrased in terms of capital facilities.

Under the motion, we have empowered Sherry and Teresa to make final revisions and send out the survey. I trust that they will follow the direction as outlined in the motion as passed and we can all move on to the next phase of our discussions.

Reminder – any capital facilities-related additions to the survey are due to Sherry/Teresa by noon on Thursday. My suggestion is we use “reply” to Sherry/Teresa vs. “reply all” to the entire workgroup, which may lead us into an email discussion with potential Brown Act implications.

10/20/09: - 9:23 pm

I believe that after the meeting, Tony suggested “Centralized multi-???[discipline][use] campus with adequate transportation” as an option. Note that “centralized” still allows respondents to select where in the county they would like a centralized campus to exist. Please consider adding this to the survey.

10/20/09 – 7:44 pm

Teresa's suggestions would make this significantly different than what we voted on and approved at the meeting. I am NOT in favor of including all of this additional information about IT since it was not even discussed, or recommended to be included, at the public meeting. What I thought we decided on is to send out the survey focusing solely on the capital facilities component. Any additions or changes would be related to that--so an entry for a dual diagnosis residential program makes sense (but we still need to find out the feasibility of billing so we can honor what Susan and some of the rest of us said about not including options that would set up unrealistic expectations). In that vein I would also suggest including the information about mental health and primary (or physical) health. This was a publically posted meeting, a decision was made in public, we spent a considerable amount of time clarifying the motion before we voted on it, and to make such significant changes once again leaves the public out of the discussion. If this is indeed a Brown Act meeting then discussing changes via email is a violation since we may be discussing this and making a decision at a future meeting.

Finally, I think including information about the "geography" of the respondent is important, and does not make a structural change that needs to be discussed.

10/20/09 – 5:01 pm

The form has been converted to a template so that folks can just open it, save it, and then type in their responses if they want to send it to us electronically.

We have made the changes you requested, Teresa, but given Tony's question, did not add that facility in the survey (as yet). Will wait for some clarification on that.

I will need some help from you all in how we should phrase any question(s) to get feedback about IT. We did the IT Survey last winter, and focus groups, but I am stuck on how to ask the question.....would this work?:

- The county has been allocated a total of \$10.2 million that can be spent on Capital Facilities and also on Technology needs. This means that the money available can be "divided up" between Capital Facility expenses and Information Technology/System Replacement expenses. If you had a choice, how much of the money would you spend on a new Information Technology System that included an Electronic Medical Record, Personal Health Record, and Electronic Prescribing? Please indicate what percentage of the \$10.2 million you would spend:
- 10% of the money (\$1 million)
- 20% of the money (\$2 million)
- 30% of the money (\$3 million)
- 40% of the money (\$4 million)
- etc., etc.

We could have a box for each percentage. Does this work, or do any of you have a suggestion for how we could phrase this question?

10/20/09 – 3:46 pm

Could you elaborate? That is, "Co-location *{of what type of program/facility}* with other community services and supports to reduce stigma and improve access, facilitate community collaboration, and provide an integrated service experience for clients and their families."

Or, would the person filling in the survey elaborate?

10/20/09 – 3:05 pm

Thank you Sherry for capturing the group's thoughts in this Draft questionnaire. I would like to include the following item which was listed on the "Examples of Potential Use of Capital Facilities Funds:"

- Co-Location with other community services and supports to reduce stigma and improve access, facilitate community collaboration, and provide an integrated service experience for clients and their families.

I would also like to include a separate entry for a Dual Diagnosis Residential Program.

I would also like to capture some new data on an IT system, especially from the providers, clinicians, primary docs who are struggling with the current antiquated IT system that prevents any continuity of care and timely, potential life saving communications. I believe the workgroup clearly wanted IT needs to be included in our assessment and evaluation of the potential use of the 10.2 million dollars of available funding.

Since the original plan to spend 2 million, to update an IT system has been tabled, we need to have some clear idea of how we will address this huge need that is widely accepted as a best practice. I will not be comfortable going forward with a recommendation that has not included an analysis of the IT needs.

Lastly, I would like to suggest that we find a way to capture the zip code, county residence status, or some identifier that will let us know if the results are reflective of the community at large and not coming from one specific part of the county. It would seem that if we distribute this survey to more central, east, or west county locations, then the results could be slanted.

10/20/09 – 2:04 pm

I thought I had mentioned this last night, but I guess I did not.. The description of the Peer run respite services are not clear, and Consumers will not know what you are referring to when you reference the Living Room and Recovery Innovations. We may want to include options that includes words like Peer to Peer, Consumer run, alternative to in-patient hospitalizations or combination of Recovery and Clinical based service. Something that clarifies exactly what we are talking about..

10/20/09 – 1:40 pm

Will you substitute "Lesbian, Gay, Bisexual or Transgender communities" for LGBTQQI?

10/20/09 – 1:24 pm

As per the action taken at last evening's MHC/CPAW Capital Facility/IT Workgroup meeting, I am attaching the final draft of the Capital Facility Need Survey which hopefully captured the desired changes. Please review it, and also the attached State DMH Guidelines, to be sure we haven't left out any facility that might be possible for renovation/remodel/construction with MHSA Capital Facilities funds. Please remember - the list of facilities cannot include that where the purpose of the facility is to provide housing. Be sure to review the list of possible facilities on page 9 of the attached guidelines, and let me know if you believe any of those should be included.

I will need your response by Thursday, October 22, at noon. I will include any suggested revisions, and send them to Teresa for final approval. The survey will then be sent for copying, and then distribution. I will send out electronic copies as soon as Teresa has approved.

10/20/09:

I will look back down the list but know that there are several things we have discussed that didn't make it on that draft:

Dual DX treatment facility

Permanent location for the ClubHouse

I will email other thoughts by tomorrow.

Also, there is absolutely no mention of the fact that the pot of funds included both IT and Cap Facilities. I had suggested that some type of informational blurb precede the questionnaire very clearly stating that there was still time to decide that we would dedicate the (now) \$5 mil to IT to satisfy the Federal mandate for electronic medical records, leaving 5 mil for Cap projects. I think that all involved need to know that they are making a choice to abandon the electronic records by placing more of the pot into Cap. Didn't we discuss that from the previous meeting?

I am also uncomfortable with the heading CULTURALLY APPROPRIATE SERVICES listing as the sole option LGBTQQI education for Families of Youth. Certainly there could be a choice of another cultural service? or was the decision made to drop all of those 3 headings because they were services and not facilities??

10/12/09 – 11:43 am

Although I could not be at the first 2 meetings, if clinical staff (Donna or Suzanne or Vern) had been invited to the meetings then they would have shared this option. Rather than share the option electronically it should be fully discussed at the next meeting so that it can be fully described and so that questions and concerns can be raised.

Kathi

PS: FYI, the Child and Adolescent Task Force has voted its support for the 20 Allen proposal based on its inclusion of this new option for children.

10/12/09 – 10:54 am:

I believe this survey does include the 20 Allen concept, without specifically mentioning 20 Allen, which I am not in favor of doing, on this survey. The program components, of 20 Allen, should each be listed or included in the questionnaire, but not the specific site.

The charge was to start over and analyze all options, including 20 Allen. However, the 20 Allen proposal has been given much scrutiny, over the past 18 months. It was the sole focus of the Capital Facilities Public Forums, Focus Groups, Public Hearing, and various Board and Commission Committees. It was also the sole focus of the Steering Committee convened, by the Mental Health Director, which resulted in those members reporting to the Commission, the Board of Supervisors, and the MHSOAC, that the planning process had been flawed and biased in favor of 20 Allen. This was the basis of the 9/3/09 Special Meeting.

The main charge of this workgroup group is to analyze and prioritize needs, then recommend the options, through the use of the various data sources identified, and the new questionnaire. The group also committed to setting aside personal and preconceived goals. As was mentioned at the two workgroup meeting, and the Mental Health Commission meeting, last Thursday, the charge for all stakeholders is to determine the community needs, not our own personal desires or interests. Of course, this will include the full system of care age groups. It will also be framed within the financial constraints of the the funding sources and financial information that is provided to the group, to best analyze options. These were some of the missed steps in the original planning process.

I am also concerned that this workgroup, the commission, or CPAW have not been informed of this significant new development regarding the ..."Separate Children's Urgent Care Receiving and Assessment Center." While I realize that Kathi McLaughlin could not attend the first two meetings of this workgroup, there have been other opportunities to inform the public of this new development. As Chair of the Workgroup, and acting Chair of the Commission, I would like to request that this information be shared with the entire group electronically, as soon as possible. Lack of transparency was also a concern during the first 18 months of this planning process. In order to overcome that, we need to know when new developments occur and have a chance to debate them publicly.

I would also request that our workgroup receive any information on the IT surveys that have already been utilized and assessed. This will aid us in knowing what has and has not been asked.

I will be working on the next agenda for the October 19th meeting today and tomorrow. I invite all members to send suggested agenda items for the groups consideration. I am committed to making this a group process, driven by the stakeholders including, consumer and family input, in a public meeting.

10/9/09 – 6:13 pm

Sorry I had to miss the last meeting. The survey looks much better--more specific, less general and more questions about children and older adults.

Yes, I do think the survey needs to include 20 Allen, since the original charge of this group was to review all possibilities including 20 Allen. The info about 20 Allen should include the current proposed configuration which includes a separate "Children's Urgent Care Receiving and Assessment Center"--not simply crisis residential. Also, I think that there should either be a question about keeping children separate and older adults separate, or at least separating the older adults from the question about adults and TAY, since they have very special physical as well as mental health considerations.

Will the cover letter indicate the discreet amount of money available for this (in other words there isn't enough money to site facilities in all parts of the county) and also address the difficulties in siting a facility (as all of us remember about Crestwood and the problems with the first attempt on Babel Lane). I know we want people to "dream" and not do things as they have always been done, but we only have a finite amount of money to work with--and in terms of not doing things the way they have always been done, we have never had a separate facility (or wing of a facility) for children.

10/9/09 – 3:59 p.m.

I am attaching the latest version of the Capital Facility/IT Need Survey for your review. At the last Workgroup meeting, it was agreed that you would send me any description of a facility that we should include in the survey. Susan and I came up with the list that's shown in the attached survey - please feel free to make any recommendations for changes/additions/clarifications. After last evening's MH Commission meeting, I realized we will need to do some kind of a "cover document" for the survey, and should include "definitions" of each of the facilities described.

The first question I have for all of you - I have heard folks in the workgroup say we should also include as one of the options the "20 Allen" site and/or project. Do you want to include that in the needs survey? If so, if it's listed as the "20 Allen Project", should we include any reference to the PHF? Or, do we list it as "Psychiatric Pavilion" (which is the term I have also heard used). My concern is that we either include it or not include it.....so please think about that. I am just not sure how you all would want that described on the survey.

The second question - we didn't list an IT Question - but not sure how we would phrase that. CCMH did do an Information Technology Survey that was distributed to mental health consumers and family members, and we had quite a good return on the survey. We also did 4 focus groups on IT, and have good data from that. So.....for the IT question, you aren't really asking about what applications they want.....but I think you are asking how much or what part of the \$10.2 million dollars for "Capital Facilities and Technology Needs".....should be split between Capital Facility needs or Technology needs.

How would you recommend phrasing that?



I would like to get as much input on this survey as possible, prior to the next meeting, and in time to meet the public posting requirements. I want to be able to ask our Planning/Evaluation Manager, Steve Hahn-Smith, to review the survey for us again.

10/9/09

My suggestion is to do a descriptive, simple to read message, detailing the facts that this is a one-time only pot of money, how much it is, and that it needs to be divided between IT and Cap. as dictated by our county needs. Then it should describe what the county would like to do with the IT funds and the approximate cost. Next describe what would be left for Cap, and a brief description of what Cap funds can be used for.

Then it needs to be clear that there will be less for Cap if the full computerized system is put in place, with some examples of what could be done with the remaining funds. Likewise, if we scrap the medical record program, there would be more for other Cap projects.