Contra Costa County Emergency Medical Services 5150 Summit

After Action Summary

On February 22, 2017 Contra Costa Emergency Medical Services held the first 5150 Summit in collaboration with the Contra Costa County Emergency Medical Care Committee and Contra Costa Behavioral Health Services bringing together stakeholders, patient advocates and subject matter experts to support a greater collective awareness.

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5150 Summit Planning Committee	
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Derek Krause, Contra Costa Fire Chief Association Representative to EMCC	Assistant Chief, San Ramon Fire Protection District, EMCC Committee Member
Patricia Frost, RN, MS, PNP Director Emergency Medical Services	Contra Costa Health Services and Staff to EMCC
Anna Roth, RN,CEO Contra Costa Health Services	Contra Costa Regional Medical Center, Detention and Ambulatory Care
Cynthia Belon, LCSW, Director Behavioral Health Services	Contra Costa Health Services

This report was compiled by the Contra Costa Emergency Medical Services. Questions and comments about the Summit may be addressed to:

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General Overview

This After Action report is a result of the first 5150 Summit held February 22, 2017 at John Muir Medical Center Walnut Creek in Walnut Creek California. The Summit was conducted on behalf of the Contra Costa County Emergency Medical Care Committee, an advisory committee for Emergency Medical Services appointed by the County Board of Directors. The Summit was hosted with the support of Contra Costa Behavioral Health and Contra Costa Health System Leadership.

The Summit was designed to support a dialogue that promotes a greater collective awareness and comprehensive understanding of 5150 related issues facing patients, families and stakeholders representing various disciplines. Individuals were invited from:

1. Fire First Responders and Ambulance Providers
2. Representatives Contra Costa Board of Supervisors
3. Contra Costa Fire Executive Chiefs
4. Patient and Family Mental Health Consumers and Advocates
5. Hospital Council Leadership
6. Contra Costa County Hospital and Nurse Executives
7. Alameda and Contra Costa County Medical Association (ACCMA)
8. Alameda EMS Agency Leadership
9. Contra Costa Health Services (CCHS) Public Health
10. Contra Costa Non-Emergency Ambulance Community
11. Emergency Department Physician and Nurse Emergency Department Directors
12. Behavioral Health Leadership and Subject Matter Experts
13. Contra Costa County Counsel
14. Contra Costa County Sheriffs and Law Enforcement Agencies
15. Emergency Ambulance Providers and Subcontractors
16. Field Paramedics and EMTs
17. Base Hospital MICNs
18. Contra Costa County Mental Health Commission Members
19. CCHS Homeless Program
20. CCHS Psychiatric Emergency Services
21. Sutter and Kaiser Local and Regional Leadership

Planning Guidance was offered by the Executive Committee of the Emergency Medical Care Committee and Contra Costa County Health Services Executive Leadership Team. Over 80 individuals registered for the event and a total of 69 attended with at least one representative from each of the invited groups.

The conference featured subject matter experts, EMS System field responders from fire, law and hospitals who addressed the summit objectives through presentations, panel discussions and group exercises exploring the barriers and opportunities to support this challenging population.

Objectives: By the end of the Summit participants will be able to:

1. Understand the countywide frequency and impact of use of 5150 holds on the community.
2. State the legal requirements and responsibilities associated with voluntary and involuntary holds.

3. Recognize the special challenges associated with 5150 of individuals with substance abuse, dementia or when youth are involved.
4. Explore how inter-disciplinary collaboration across the EMS System is important to this complex population.

Agenda for the Day

Time	Topic	Speaker(s)
8-8:30 am	Registration and Continental Breakfast	
8:30-8:40 am	Welcome and Introductions	Kacey Hansen RN, BSN, MBA Chair EMCC
		Pat Frost RN, MSN, PNP, EMS Director
8:45-10:00 am	5150 by the Numbers: Brief Presentations reviewing data from the community	
	County LEMSA Data	Joe Barger MD, Contra Costa Health Services
	Hospital Data	Rebecca Forbes RN,MSN,CEN, Emergency Department Director, John Muir Medical Center Concord
	CCRMC/PES Data	Kristina Serrano LMFT,
	Law Enforcement Data	Lt. Denton Carlson, San Ramon Police Department
	Q & A	
10-10:15	BREAK	
10-11 am	5150 Legal and Clinical Roles and Responsibilities: Speakers to describe law, review legal requirements, provide some "myth busting", review challenges associated with legal, regulatory and clinical responsibilities associated with 5150 and involuntary holds	
	5150 Legal Requirements	Steven Rettig, Contra Costa Deputy County Counsel
	5150 Clinical Regulatory Requirements	Anton Bland MD, Chief Psychiatrist Contra Costa Regional Medical Center
	Q and A	
11-12 noon	5150 Impact Panel: Law, EMS, PES, Hospital, Patients/Family. Speakers share from various disciplines the field, provider and patient experience.	
	Law	Lt Denton Carlson, San Ramon Police Department
	PES provider	Kristina Serrano LMFT, CCHS Mental Health Program Supervisor
	ED provider	Rebecca Forbes RN, MSN, CEN, Director of Emergency Services, John Muir Health Concord Campus

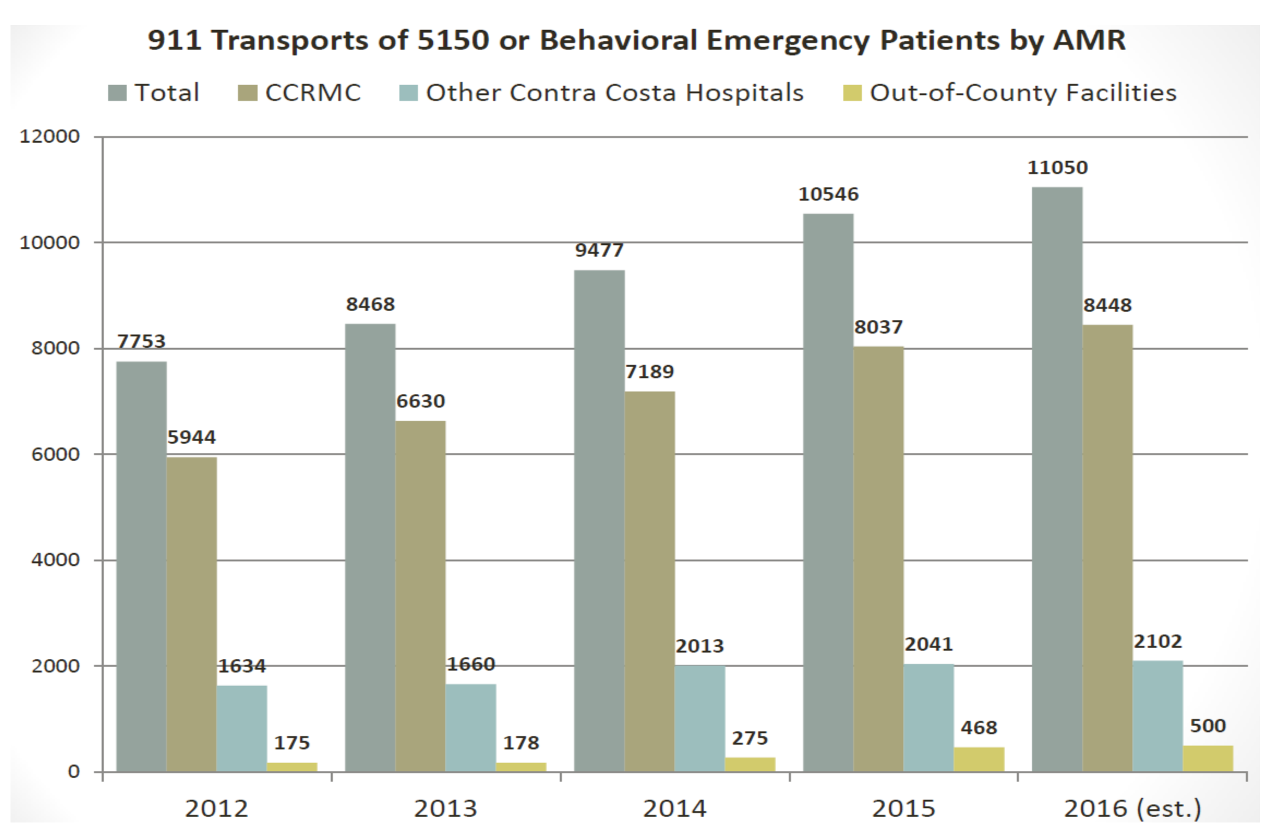
	EMS provider	Battalion Chief John Duggan, San Ramon Fire Protection District
	Patient/Family	Robert Thigpen, CCHS Behavioral Health
	Q&A	
12-1pm	Lunch and networking	
1-2pm	Table Top Group Activity: Each table to explore one of 3 cases	Pat Frost EMS Director & David Goldstein EMS Medical Director
2-2:15 pm	BREAK	
2:15-4:15 pm	Options for 5150/Evolving programs: Behavioral Health/CCHS Program Presentations	
	CCHS/Law Enforcement Pilot	Kristina Serrano LMFT, CCHS Mental Health Program Supervisor
	Assisted Outpatient Treatment	Honorable Judge Stephen Austin, AOPT Program
	Homeless Programs	Jenny Robbins LCSW, H3 Program Manager CCHS
	Whole Person Care	Dan Peddycord, RN, MS, Public Health Director, CCHS
	Contra Costa EMS Agency	Patricia Frost RN, MS, PNP Director Contra Costa Health Services
	Q&A	
4:00-4:15pm	End of Day Summation: Learnings and Partnerships Going Forward	Kacey Hansen EMCC Chair
4:15-4:30pm	Program Evaluation and Post-test	Pat Frost and EMS staff

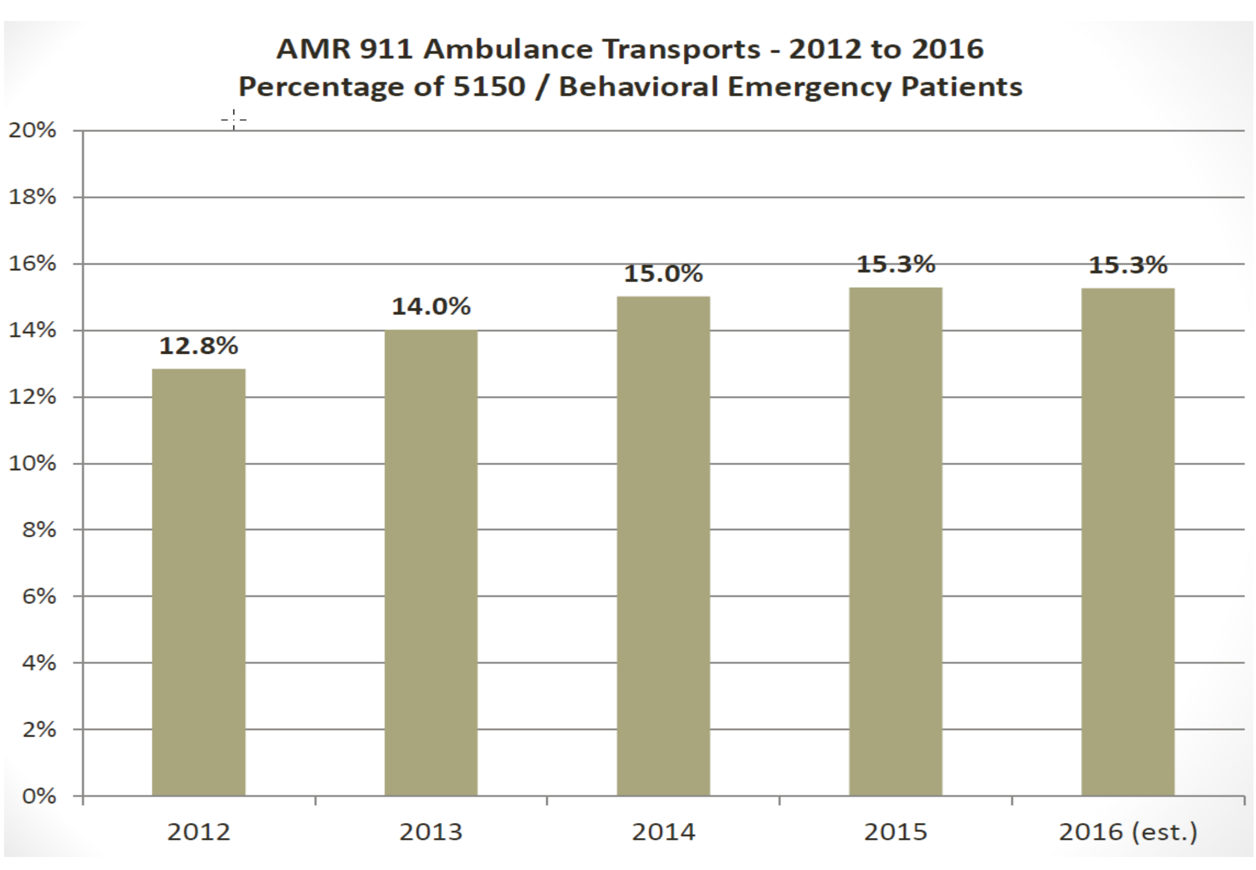
Summit Overview: 5150 by the Numbers

In the first presentation, Dr. Joseph Barger from Contra Costa EMS presented the historical data on the frequency of Behavioral/Psych transport to Contra Costa Regional Medical Center Psychiatric Emergency Services by EMS Ambulance Provider American Medical Response between 2008 and 2015. The data represents 92% of the 9-1-1 ambulance transport volume in Contra Costa and does not include San Ramon Valley Fire or Moraga Orinda Fire. However it is important to note that even though the overall numbers transported by those agencies may appear small they have a significant impact on ambulance deployment.

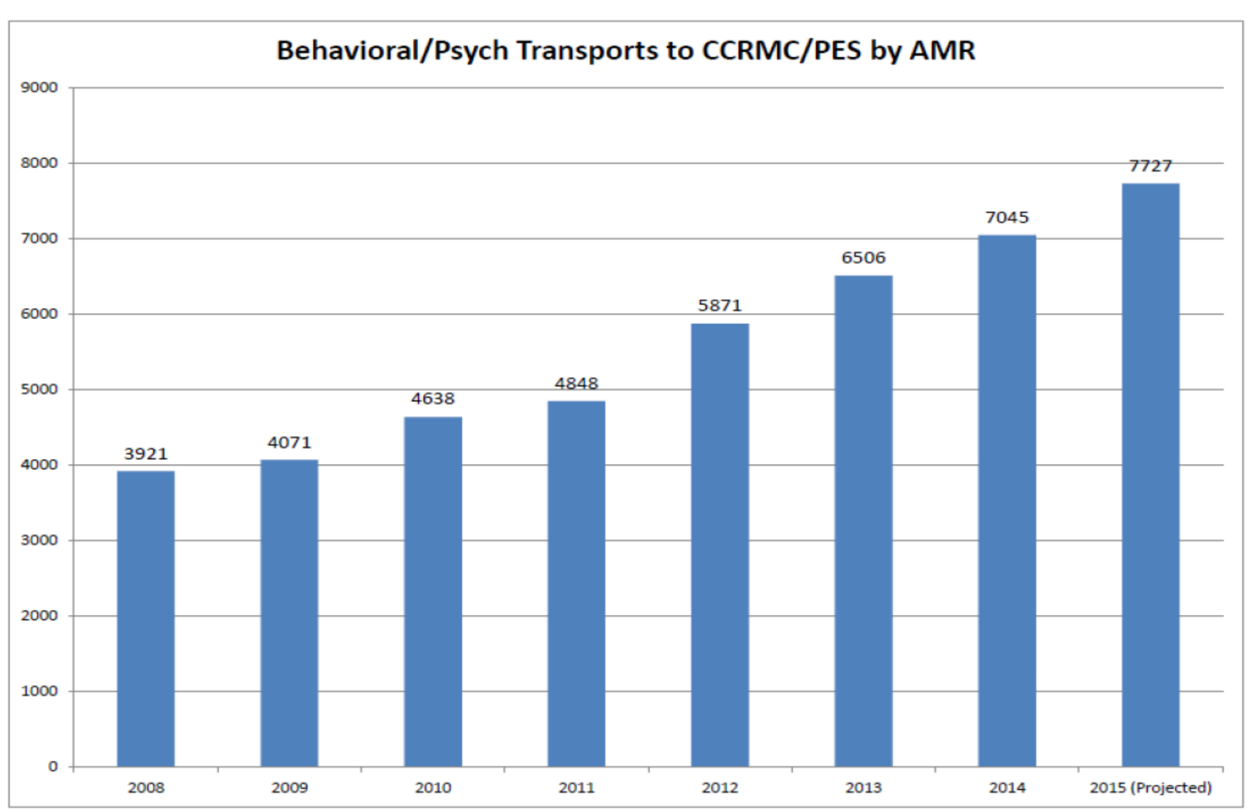
The data presented from a 2012-2016 study includes patients where the prehospital paramedic primary impression was Behavioral Emergency or involuntary transport (5150) as noted on the patient care record. Dr. Barger reported that prehospital documentation is incomplete in many cases and was not available prior to 2012 due to how data was entered into the prehospital electronic medical record.

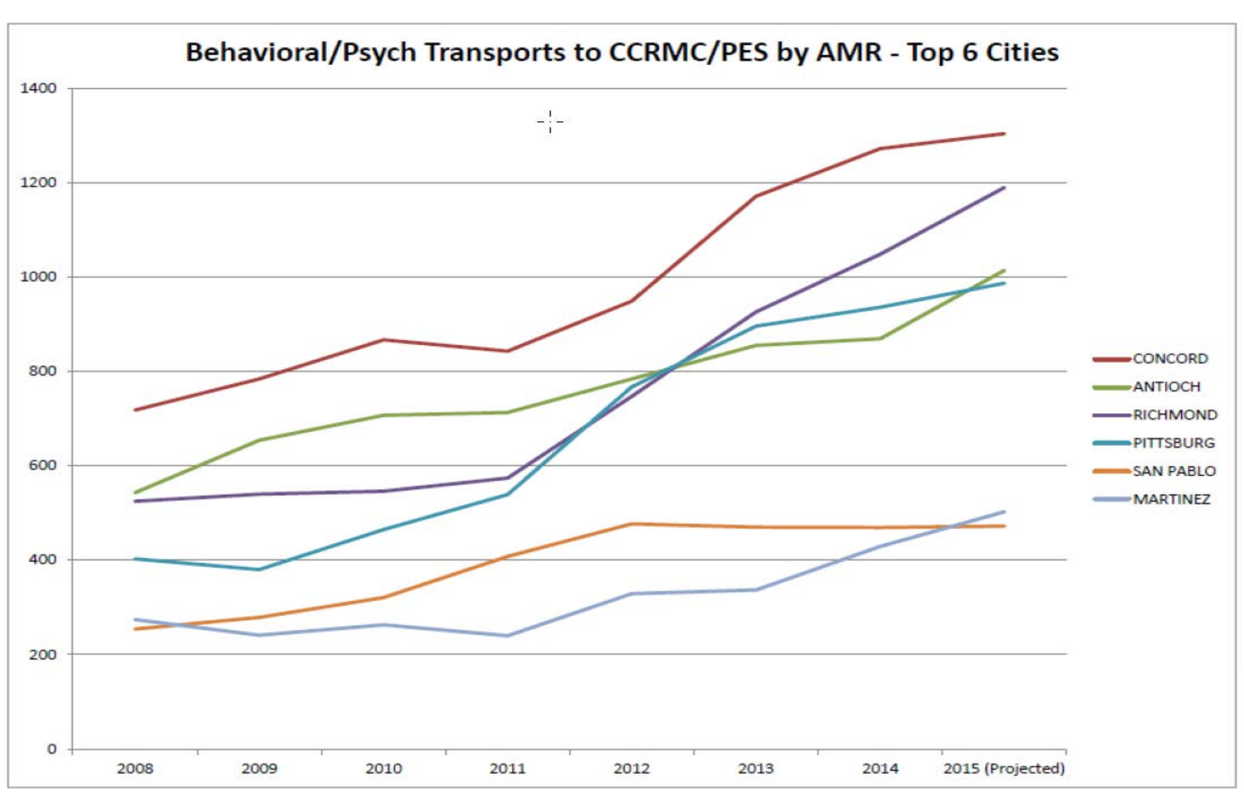
Data includes 911 transports from field settings only involving paramedics and does not include interfacility transports (IFTs) provided by numerous private non-emergency ambulance providers. Currently no data is available for IFTs.

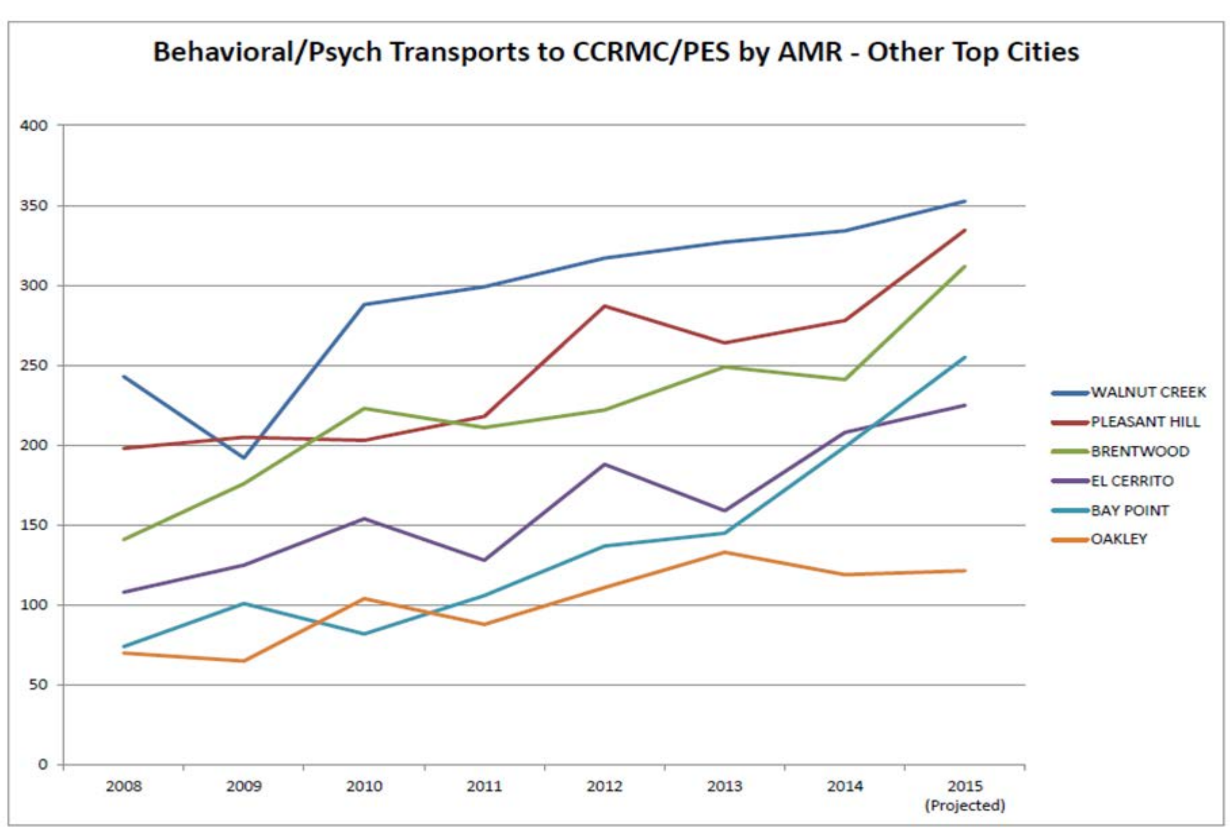

911 Transports of 5150 or Behavioral Emergency Patients by AMR
Total
CCRMC
Other Contra Costa Hospitals
Out-of-County Facilities
12000
10000
8000
6000
4000
2000
0
7753
5944
1634
175
8468
6630
1660
178
9477
7189
2013
275
10546
8037
2041
468
11050
8448
2102
500
2012
2013
2014
2015
2016 (est.)


AMR 911 Ambulance Transports - 2012 to 2016
Percentage of 5150 / Behavioral Emergency Patients
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
12.8%
14.0%
15.0%
15.3%
15.3%
2012
2013
2014
2015
2016 (est.)

AMR Transport Data						
	2012	2013	2014	2015	2016 (est.)	Increase 2012 to 2016
Total Transports	60369	60423	63118	69015	72388	20%
5150 or Behavioral Emergency Transports	7753	8468	9477	10546	11050	43%
Percentage 5150 or Behavioral Emergency	12.8%	14.0%	15.0%	15.3%	15.3%	




Behavioral/Psych Transports to CCRMC/PES by AMR - Top 6 Cities
1400
1200
1000
800
600
400
200
0
2008
2009
2010
2011
2012
2013
2014
2015 (Projected)
CONCORD
ANTIOCH
RICHMOND
PITTSBURG
SAN PABLO
MARTINEZ


Behavioral/Psych Transports to CCRMC/PES by AMR - Other Top Cities
400
350
300
250
200
150
100
50
0
2008
2009
2010
2011
2012
2013
2014
2015
(Projected)
WALNUT CREEK
PLEASANT HILL
BRENTWOOD
EL CERRITO
BAY POINT
OAKLEY

5150 Data by the Numbers: Community Hospitals

This data reflects the total impact of Mental Health and Substance-Related disorders affecting the Health Care System in Contra Costa County. The data was obtained by the Hospital Council from the Office of Statewide Health Planning and Development (OSHPD) and shared with Summit participants as a handout. Hospital and health care data to date is still unable to identify involuntary hold 5150 patients.

Contra Costa County
Hospital Data 2013-2015
Emergency Department Usage for
Mental Health and Substance-Related Disorders

Contra Costa County ER Visits for Mental Disorders	2013	2014	2015
Contra Costa Regional Medical Center	8,838	9,773	10,063
John Muir Medical Center - Concord Campus	2,185	2,343	2,479
Kaiser Foundation Hospital - Walnut Creek	1,453	1,594	1,611
Sutter Delta Medical Center	1,061	1,212	1,502
Kaiser Foundation Hospital - Antioch	941	1,096	1,206
John Muir Medical Center - Walnut Creek Campus	1,024	1,140	1,188
San Ramon Regional Medical Center	456	424	435
Doctors Medical Center - San Pablo	1,229	1,095	185
TOTALS	19,200	20,691	20,684

Contra Costa County Admits from ER for Mental Disorders	2013	2014	2015
Contra Costa Regional Medical Center	832	801	709
Kaiser Foundation Hospital - Walnut Creek	103	115	122
John Muir Medical Center - Walnut Creek Campus	96	101	111
John Muir Medical Center - Concord Campus	76	69	101
Sutter Delta Medical Center	82	93	89
Kaiser Foundation Hospital - Antioch	32	35	62
San Ramon Regional Medical Center	51	64	32
Doctors Medical Center - San Pablo	38	35	4
TOTALS	3,323	3,327	3,245

5150 Data by the Numbers: Emergency Department

In this presentation, Rebecca Forbes of John Muir Medical Center Concord Emergency Services shared data associated with the John Muir Health System experience. A summary of her data presentation follows:

True numbers of mental health patients seen in the Emergency Department (ED) proved elusive to capture. An analysis of the 5150 patients transferred from the Concord (CC) and Walnut Creek (WC) EDs was as follows:

Campus	Month	Year	Volume
CC and WC	December	2016	59
CC and WC	November	2016	65
CC and WC	October	2016	85
CC and WC	September	2016	79
CC and WC	August	2016	71
CC and WC	July	2016	66
CC and WC	June	2016	67
Total			**492**

Campus	Month	Year	Volume
CC and WC	December	2014	79
CC and WC	November	2014	73
CC and WC	October	2014	76
CC and WC	September	2014	77
CC and WC	August	2014	91
CC and WC	July	2014	72
CC and WC	June	2014	58
Total			**526**

As the numbers show, despite a 20% increase in the number of total patients seen in the ED between 2014 and 2016, there was a slight decrease in 5150 volume. This does not mirror the trend in the Psychiatric Emergency Services (PES) numbers and explanations can vary ranging from a change in transportation practices by paramedics, a decrease in the number of 5150 holds placed on mental health patients, to an increase in admissions of 5150s (the numbers above reflect only transferred patients).

5150 Impact Panel: ED Provider

Boarding 5150 patients in the ED occurs very rarely. Juxtaposing our experience with an academic, 66-bed ED in Sacramento County where 8,000 patient-care hours are spent on 5150 holds per month, I feel we are fortunate to be in this county with a PES that does not refuse transfers at any time. The biggest impact to the ED in Concord is the emotional and spiritual strain the 5150 patient population places on staff. ED staff do not feel they are equipped to provide optimal psychological care and are challenged to

provide a therapeutic environment while caring for their other patients. Staff members also feel unsafe at times when patients manifest verbal abuse and violent outbreaks.

Summit Overview: Legal Roles and Responsibilities

In the first presentation, County Counsel Steven Rettig reviewed the law and legal aspects of 5150 emphasizing the legislative intent of the Lanterman-Petris-Short (LPS) Act was to end the inappropriate, indefinite and involuntary commitments of people with mental health disorders and provide them with prompt evaluation and treatment. Each county is responsible for implementing this 5150 process within the resources of the community. The law requires time-specific legal hold periods and some measure of due process.

Under the LPS Act the following persons are authorized to detain under 5150:

- Peace officers
- Professional person in charge of a facility designated by the county for evaluation and treatment or a member of attending staff
    - Designated Treatment and Evaluation Facilities in Contra Costa County
        - Contra Costa Regional Medical Center
        - John Muir Behavioral Health Center
- Professional staff of a private medical facility as designated by the Local Mental Health Director
    - Designated staff include ED physicians, psychiatrists, psychologists and LCSWs **who have been authorized by the facility approved by the Mental Health Director and received 5150 training.**
    - The medical facility must have a Memorandum of Understanding with the Mental Health Director on file.

Criteria for 5150 Detention Upon Probable Cause: When a person as a result of a mental health disorder is a danger to others, danger to self or gravely disabled. Danger to self or others are not defined nor are these terms clearly defined in the law; however, in order to find probable cause that a person is a danger to self or others, there is no legal requirement that the person have an intent to harm themselves or others. Case law in this area has supported the use of 5150 based on information that would lead any person of ordinary care and prudence to believe that the individual as a result of a mental disorder was a danger to themselves.

Criteria for 5150 Associated with Grave Disability is defined as a condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing or shelter. However, a person is not gravely disabled if that person can survive safely without involuntary detention with the help of responsible family, friends or others who are both willing and able to help provide for the persons basic personal needs for food, clothing or shelter. A distinction is made for minors who as a result of a mental disorder are unable to use the elements of life which are essential to health safety and development, including food, clothing and shelter even though provided to the minor by others.

5150 statutory and liability issues were also reviewed. Each organization must consult with their legal counsel for guidance on liability issues related to 5150. Information presented at the Summit is for educational purposes only.

Summit Overview: Clinical Roles and Responsibilities

In this presentation, participants were introduced to the clinical responsibilities and requirements associated with 5150 detainment. The phases of Involuntary Psychiatric evaluation were reviewed as follows:

- Application completion and review by the designated receiving facility e.g. PES
- Evaluation and Treatment in PES (5152)
    - Interview and assessment by psychiatrist
    - Offer for medications and/or therapy as needed
- Decision to Admit, Transfer or Discharge

The importance of field and law enforcement documentation was emphasized and examples of probable cause were presented. Participants were then given information on what occurs during a 5150 patient care encounter at PES. The following important points were then summarized:

- Evaluation does NOT require one to involuntarily hold the individual for 72 hours and the 5152 process (referring to the required mental health evaluation) can be discontinued anytime within the first 72 hours.
- The 5152 evaluation is not predictive of what the patient will do.
- Despite suffering from signs of mental illness consumers have the right to refuse treatment or be treated in a less restrictive setting.
- Patient documentation provided by Law and EMS is important to the PES evaluation for patients placed on an involuntary hold.

Slides from both of these presentations are available as an addendum to this report.

Summit Overview: Tabletop Discussion

The tabletop discussion involved three cases that were designed to stimulate discussion between stakeholders. The cases captured elements associated with potential 5150 patients that are known to be challenging to address. Each table of stakeholders representing various points of view were asked to discuss each case and answer the following three questions:

Questions

Is this in the best interest of the patient?
What alternatives were available for those involved?
Who benefits from having the patient 5150 and why?

15 y/o male with Autism

Developmentally delayed 15 year old boy with a diagnosis of Autism; Lives in a group home setting with four other adolescents. Followed by Case Worker from Regional Center. Verbal but with moderate communication challenges. Suffers from anxiety as well as sensory sensitivities to noise and touch. Tends to bite arm when agitated and can be verbally loud when over stimulated but generally compliant with directions from staff and amenable to redirection. Attends a special education day program during the day. No medical issues, no history of seizures. Takes Risperdone daily and Ativan as needed.

Today, new staff member did not know patient's routine around access to video game console. Patient became increasingly agitated and began biting himself. Staff member attempted to restrain patient from self injury which precipitated increasing agitation. Staff felt physically at risk and called 911. Police responded and became concerned that patient's behavior was unsafe. 5150 place for danger to self and others. Patient transported by EMS to Psychiatric Emergency Department without incident.

42 y/o male intoxicated at BART

Patient discovered in Antioch BART station at 1AM 'asleep' on a bench. Police ask him to leave. Patient becomes belligerent and after brief physical altercation is placed in hand cuffs. Patient admits to alcohol use. Unstable on his feet. Denies medical problems. States most recently resides in shelter in San Francisco as well as living on the street. No family available. Patient tells BART police he wants to kill himself. 5150 placed, transported by EMS to Sutter Delta Emergency Department as patient is clinically intoxicated and 'unable to walk'. Patient ultimately cleared medically after 6 hours of observation, reaches clinical sobriety with stable gait, and persists in expressing suicidal thoughts. He transferred by ambulance to Contra Costa County PES in Martinez for further evaluation of Suicidal Ideation and 5150.

77 y/o female with Dementia

Per patient's husband, patient has been increasingly agitated and difficult to manage over the last several months. Awake at night roaming the house. Has been agitated, yelling at spouse, occasionally violent. Has left the house and become lost wandering in the neighborhood, returned by police and neighbors on two occasions in the last month. Increasingly fearful of taking her medications and no longer recognizing family friends. Husband with chronic medical conditions and recently more ill making it difficult to take patient to doctor's appointments. Physician has recommended placement in a memory care facility but husband has been resistant and financial resources are an issue.

Diagnosed with Alzheimer's Dementia two years prior. Baseline with short term memory challenges and episodic agitation. History of Hypertension, Coronary Artery Disease, n multiple medications.

No known substance abuse. No hallucinations. No acute medical complaints.

Today, 911 called by neighbor who witnessed patient striking her husband. When police arrived husband resisted their attempts to intervene and denied event. Patient became agitated and began yelling at officers to leave her alone and swung a fist at the officer.

Patient placed on 5150 for Danger to Others, Gravely Disabled and transported by EMS to the Medical Emergency Department in Martinez at CCRMC for Evaluation.

Summit Overview: Options for 5150 and Evolving Programs

In this session, presentations highlighting various new and pilot programs were featured. All programs emphasized the importance of collaborative partnerships between behavioral health, law, homeless programs, Public Health and EMS.

CORE Outreach: The CORE Outreach Program stands for Coordinated, Outreach, Referral and Engagement, and is the newest program to be implemented in our homeless system of care. CORE provides day time and evening outreach Monday through Saturday in small multidisciplinary teams that work collaboratively to engage and stabilize homeless individuals and families who are living outside. CORE delivers health and basic need services with the ultimate goal of linking chronically homeless individuals to permanent housing.

Currently we have two day time teams and one evening team that cover the entire geography of Contra Costa County, from west county to far east county. Services and support include but is not limited to delivering basic needs supplies such as socks, hygiene kits, and emergency food. CORE teams will also complete housing assessments, facilitate the completion and submission of benefits applications (CalFresh, MediCal) as well as link consumers to shelters and other housing programs. In addition, CORE works in collaboration with Healthcare for the Homeless (HCH) to ensure that we are providing a direct linkage to services for those accessing their care who are in need of housing.

The central access point for CORE is 211, and once calls are transferred from 211 to our CORE line, dispatch staff screen and assess each call to determine the most appropriate and timely response. Stay tuned for a formal communication launch from the Health, Housing and Homeless (H3) Division that will provide additional information and details regarding CORE, as well as other significant changes in our county's homeless system of care.

San Ramon Police Department PES Pilot: The San Ramon Police Department has partnered with Contra Costa County Health Services to create and implement a 5150 Pilot Program. As a community based law enforcement agency, we felt service from the San Ramon Police Department should not stop when the ambulance doors close and the patient is transported to the County P.E.S. facility in Martinez. As a result, we have implemented a 5150 Pilot Program, which began on January 1st, 2017.

This program ensures the patient and/or family members associated with any incident involving someone being placed under a 5150 hold for evaluation are contacted within a few days by an Officer from the San Ramon Police Department. Our goal is to provide additional resources and possible avenues for further care to the family and patient. They need support after this type of incident, and our goal is to provide that support. By working side-by-side with County Health Services, we are able to recommend the most applicable and helpful resources for those who need further assistance and treatment.

Assisted Outpatient Program (AOT): Information on Contra Costa Assisted Outpatient program established under Laura's Law was presented. The program is for people with severe and persistent mental illness to prevent substantial deterioration of their condition and who may pose a risk to themselves or others. It was emphasized that this program is voluntary and allows counties to use the civil court system to supervise care. The honorable Judge Stephen Austin presented information on his role in the program. AOT is not for crisis intervention. More information about the program is available on the county health services website at https://cchealth.org/mentalhealth/lauras-law.php.

Community Connect: The session ended with an overview of Community Connect, the new Contra Costa Health Services Whole Person Care Program designed to support wrap around services for those requiring intensive case management due to homelessness, mental illness, substance abuse, two or more chronic health conditions, multiple hospital/ED visits. Community Connect will also target foster youth being treated with psychiatric medications and adults on probation or scheduled for release from jail. The Whole Person Care presentation is included as an addendum to this after-action.

Opportunities for Improvement and Next Steps

Recommendation	Responsible Agency
Establish consistent Way of Capturing 5150 data across the EMS and Health Care System	Hospitals, Behavioral Health, EMS, Public Health, Law, PES
Repeat the Summit periodically	EMS, EMCC
Establish Sobering Centers	Hospitals, Behavioral Health, EMS, Public Health, Law, PES
Educate field providers on mechanisms to alert and address frequent 5150 9-1-1 users	EMS, Law, Behavioral Health, Hospitals
Promote training of field providers e.g Crisis Intervention	EMS, Law, Behavioral Health, Hospitals
Promote partnerships to increase efficiency between providers involved in serving the 5150 population	Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families
Improve coordination of care for 5150 frequent users	Behavioral Health, H3, Public Health, EMS, Hospitals
Improve access to 9-1-1 and other educational resources for patients and families e.g. NAMI, Discovery Center	Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families, NAMI
Recognize that regional center and schools may need to be included in mitigating 5150 with youth	Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families
Increase partnerships with families through outreach and engagement. Recognize the importance of family in assisting in mitigation of 5150.	Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families, NAMI
Recognize the role of housing to support stability of at risk 5150 populations who are homeless	H3, Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families, NAMI
Increase awareness of the role of Mental Health	Behavioral Health, Law, EMS

Crisis Teams in the Field	
Make NAMI resources more widely available	NAMI, EMS, Behavioral Health
Integrate families in supporting case management through follow-up	Hospitals, Behavioral Health, EMS, Public Health, Law, PES, Mental Health Commission, Patients and families
Clarify role of 5150 for EMS providers after Law leaves the scene	EMS, County Counsel
Consider adding more designated individuals to support 5150 evaluation in non CCHS setting such as community emergency departments in the EMS System.	Hospitals, Behavioral Health, EMS, Public Health, Law, PES
Explore 5150 Designation for EMS	EMS, County Counsel, EMS Medical Director, Behavioral Health

Summit Evaluation Summary and Comments

Summit Evaluation Summary					
Instruction	Very Poor	Poor	Good	Very Good	Excellent
Instructor Presentation			2	12	18
Instructor Communication			1	10	22
Instructor Knowledgeable			2	8	22

Course Satisfaction	Very Poor	Poor	Good	Very Good	Excellent
Course Format			4	12	15
Course Content			5	10	16
Pace of class			4	14	14
Overall Course Satisfaction			4	12	16

Not all participants completed their evaluations

Comment Summary: “Comments reflected significant engagement.”

Question	Participants Comments
Name one fact that you learned today about 5150 issues.	• That there are several arrest challenges with 5150s. Placement and lack of resources continues to be an issue. Need a sobering center for those that are appropriate • PD impact • There is no easy way to collect 5150 data points across all stakeholders • Other stakeholder roles • A complete overall vision of 5150 • Core Teams • Legal definition of 5150 • Other patient rights • Not so much a single fact but I did not realize some of the legal and other issues shared by ambulance crews during 5150 • Complexity • Judge involved in AOPT program, sobering center • Need for sobering center • EMS staff are not designated staff (to authorize 5150) • During one of the case studies (tabletop portion) understanding the diagnosis of certain illnesses and conditions can be helpful to first responders when responding (ie: autism, epilepsy etc) • 85-90% of 5150 holds are created via law enforcement • Resources available • Recommend speaker from NAMI on family to family. Cross over with domestic violence. Bay area crisis nursery: where children can go if caregiver is hospitalized • I learned to appreciate different perspectives concerning roles and county resources • Learned the incredible value that county resources add to our system • Challenge that EMS has with 5150 holds if law enforcement leaves the scene • 3rd party assist • Patient family perspective • Clarification of criteria to qualify for 5150 detention • 5150 transfers are on the rise • Mental disorder alone is not sufficient for 5150 under gravely disabled • Clearer understanding of requirement for a legal 5150 • EMS challenge if police leave the scene • The definition of section 5150, legal aspects, who has authority to determine 5150, procedure and process • Over impact of jails • Increase in 5150, decrease in voluntary 5150

Question	Participants Comments
Name one fact that you learned today about 5150 issues.	• Every perspective brings value and sheds light on our seemingly broken system. Can we do this better? • Concern of EMD regarding transporting individual on 5150 holds after peace officer has left the scene • Crash course NAMI Contra Costa • That the county is implementing MHET team in order to provide resources for those that don't always require 5150 hold
Name a program that could help support solutions associated with 5150 patients.	• Need more strong family support programs • MHET program • Field ready crisis intervention teams • Share the ideas, conclusions and concerns with county BOS. Call for annual goals and summits • Training across all Health Services • Sobering center vs PES-4C admission • Increased opportunity for treatment. From 911 side process to transport to alternative destinations. Expand San Ramon follow-up program • Family advocacy representatives provided great resources from the community perspective • San Ramon Community resource division • Mobile Health Evaluation Teams (MHET) • More connection between EMS and MHET, Sobering Centers • County mobile crisis unit • MHET • MHET, Information to provide family members with contact information and resources available • NAMI • Sobering Center, San Ramon Pilot Project • 5150 Pilot project and core team, MHET and Whole Person Care • Laura's Law • EMS triage of patients • Whole Person Care Community Connect • Assistive Outpatient Treatment (AOPT) • I would love to see more outreach team response to potential 5150 • Community Connect may assist with case management for medical patients (sobering facility) • MHET, sobering center with evaluation capabilities. • Psychiatric Emergency Services (PES) • They are multifactorial, high cost, high resource consumers

Question	Participants Comments
What comments if any do you have about the summit positive or negative?	• Awesome. Please continue to have this summit periodically until we improve the challenges discussed today. • Sobering centers • Excellent. I think it achieved its goal of making all stakeholders aware of the issues and impacts of each other's perspectives • This forum provided a great opportunity for different agencies and disciplines to come together with a primary goal to not only highlight overall gaps in 5150 cases but to also provide solutions and educational awareness • Very good start to an important conversation • Good source of information to raise current issues and to consider future action to be taken • Poor execution of break out session. Should not herd all groups together • MHET and CIT (Crisis Intervention Training) • Please add the consumer impact. There was no consumer representation and little discussion of the role • Excellent. Very organized, very informative, interesting to hear challenges faces by other branches of the system • We have a long road ahead of us. Together we must certainly improve the care to our 5150 patients • Great way to develop more awareness • This was a great way to open the discussion on a problem that needs more funding and field direction • Great opportunity to bring a 360 perspective to one room so that all • Great Job, Nicely done • Stakeholders can gain new perspective and begin to develop new strategies • Need to do this yearly. System very fragmented. A summit like this helps to network and increase access • Excellent summit, speakers are fantastic • I'm very pleased to see the number of disciplines working on this • Excellent collaboration • More police presence. San Ramon is small represents a very small portion of the county. Police are indeed still using 5150 inappropriately. More advocacy at state level to change. • I valued networking with the county individuals • It was a great forum. Perspectives from all sides was very critical, tabletop discussion was great. Thank you for putting this summit on. It was very helpful • A little too long consider half day program next time • I would have like the presented stat's and numbers in PowerPoint form. A lot of great info was presented that I would have like to take with me • PowerPoint over paper of all presentations

Question	Participants Comments
What comments if any do you have about the summit positive or negative?	• Should do annual • Great Start • Good first step • Dialogue is vital to partner with all entities involved in the process: therefore finding the best solutions for patient care

List of Web Resources related to Behavioral Health and Emergency Medical Services

Mental Health Crash Course: http://www.mhcrashcourse.org/

National Alliance of Mental Illness (NAMI): Contra Costa County: http://www.namicontracosta.org/

Assisted Outpatient Treatment: https://cchealth.org/mentalhealth/lauras-law.php

Homeless Program: https://cchealth.org/homeless/

Mental Health Crisis Services: https://cchealth.org/mentalhealth/crisis-services.php

Contra Costa Crisis Center: http://www.crisis-center.org/

Whole Person Care: Community Connect: https://cchealth.org/care/

Contra Costa Emergency Medical Services: http://cchealth.org/ems/

Mental Health Services: http://cchealth.org/mentalhealth/#simpleContained6

Mental Health Evaluation Team: http://cchealth.org/press-releases/2015/1027-Psychiatric-Emergency-Calls.php

Alcohol and Other Drugs: http://cchealth.org/aod/

Detention Upon Probable Cause

Welfare and Institutions Code § 5150

Steven P. Rettig

Assistant County Counsel

5150 in a nutshell:

"When a person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services."

W & I Code § 5150 (a).

Legislative Intent of the Lanterman-Petris-Short (LPS) Act

- To end the inappropriate, indefinite and involuntary commitments of people with mental health disorders and to provide them with prompt evaluation and treatment. W & I Code 5001 (a) and (b).

In order to achieve this, the LPS Act includes time-specific legal hold periods with some measure of due process attached to each type of hold. Section 5150 is the first of these legal holds and can last up to 72 hours.

Persons authorized to detain under § 5150

- **Peace officers**
- **Professional person in charge of a facility designated by the county for evaluation and treatment or a member of attending staff**.

  Contra Costa County's designated treatment and evaluation facilities are the Contra Costa Regional Medical Center at 2500 Alhambra Avenue in Martinez and the John Muir Behavioral Health Center at 2740 Grant Street in Concord.

Persons authorized to detain under § 5150

- **Professional staff of the Contra Costa Health Services Department as designated by the Local Mental Health Director**

'Professional staff' includes: licensed psychiatrists, licensed psychologists, LCSW's (licensed clinical social workers), MFT's (marriage and family therapists), RN's, psychiatric technicians and ambulatory care psychiatrists. Their authority to detain is limited to their role and responsibilities as a county employee at the specific service site where the employee is located.

Persons authorized to detain under § 5150

- **Professional staff of a private medical facility as designated by the Local Mental Health Director.**

Designated professional staff include emergency department physicians, psychiatrists, psychologists, and LCSW's **who have been authorized by the facility, approved by the Mental Health Director, and have received 5150 training.**

The medical facility must have a Memorandum of Understanding with the Mental Health Director on file.

Criteria for a § 5150 detention **upon probable cause**

- When a person, **as a result of a mental health disorder** is a:

1. Danger to others;
2. Danger to self; or
3. Gravely disabled.

Probable cause defined:

- **A state of facts must be known that would lead a person of ordinary care and prudence to believe, or to entertain a strong suspicion**, that the person to be detained is mentally disordered and is a danger to self, others, or is gravely disabled.
- In justifying the detention, the officer (or other authorized person) must be able to point to specific facts which, together with rational inferences, reasonably warrant the belief or suspicion. (*People v. Triplett* (1983) 144 Cal. App. 3d 283, 288.)

Mental health disorder:

- The term "mental health disorder" is defined in the California Administrative Code as any of the mental disorders set forth in the current edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM").
- The peace officer or other authorized person is not required to make a medical diagnosis of mental disorder. "**It is sufficient if the officer, as a lay person, can articulate behavioral symptoms of mental disorder, either temporary or prolonged … mental health disorder might be exhibited if a person's thought process, as evidenced by words or actions or emotional affect, are bizarre or inappropriate for the circumstances**." (*People v. Triplett* (1983) 144 Cal. App. 3d 283, 288.)

Information about the historical course of a person's mental disorder shall be considered:

- "When determining if probable cause exists to take a person into custody … [the authorizing person] **shall consider available relevant information about the historical course of the person's mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental disorder.**" (Welfare and Institutions Code Section 5150.05, subdivision (a).)

Danger to self or others

- Section 5150 does not define **danger to self** or **danger to others**, nor are these terms clearly defined in case law; however, in order to find probable cause that a person is a danger to self or others, there is no legal requirement that the person have an intent to harm himself or others.

Examples of possible danger to self or others

Danger to others:

- Acts or attempts to harm others.
- Statements of intent or plan to harm others.
- Behaviors that are dangerous to others.
- Symptoms that create the likelihood of dangerousness.

Danger to self:

- Acts or attempts to harm self.
- Statements of intent or plan for self-harm.
- Behaviors that place a person in harms way.
- Symptoms that increase the likelihood of dangerousness.

Sufficient evidence of danger to self:

- "In the case before us, it was reasonable for the officer to infer from appellant's intoxication and tearful condition that she was at least temporarily disordered. Her intoxication and weeping standing alone would not justify a detention under section 5150. But these symptoms coupled with obvious physical signs of a recent suicide attempt would lead any person of ordinary care and prudence to believe that appellant as a result of mental disorder was a danger to herself." (*People v. Triplett* (1983) 144 Cal. App. 3d 283, 288.)

Grave disability defined:

- "A condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter." (Welfare and Institutions Code Section 5008, subdivision (h)(1)(A).)
- Exception: Third party assist. A person is *not* gravely disabled if that person can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs for food, clothing, or shelter. (Welfare and Institutions Code Section 5250, subdivision (d)(1).)

Examples of grave disability:

- In making the determination of grave disability, it is not necessary that a person be unable to provide for all three basic needs. **Inability to provide for one of the three basic needs –food, clothing, or shelter– is sufficient**.
- Signs of malnourishment/dehydration.
- Inability to articulate plan for food, clothing, or shelter.
- Irrational beliefs about food, clothing , or shelter. i.e. food is poisoned, clothing is bugged.

Gravely disabled minor:

- "'Gravely disabled minor' means a minor who, as a result of a mental disorder, is unable to use the elements of life which are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others." (Welfare and Institutions Code Section 5585.25.)

Statutory requirements upon detaining individual:

- **Safeguarding personal belongings.** (Welfare and Institutions Code Section 5150, subdivision (f).)
- **Advisement upon being detained.** (Welfare and Institutions Code Section 5150, subdivision (g)(1).)
- **Advisement upon being detained at home.** (Welfare and Institutions Code Section 5150, subdivision (g)(2).)
- **Documentation of factual basis for detention.** (Welfare and Institutions Code Section 5150.2.)

Personal belongings: safeguarding

- "At the time a person is taken into custody for evaluation, or within a reasonable time thereafter, unless a responsible relative or the guardian or conservator of the person is in possession of the person's personal property, the person taking him or her into custody shall take reasonable precautions to preserve and safeguard the personal property in the possession of or on the premises occupied by the person …" (Welfare and Institutions Code Section 5150, subdivision (f).)

Advisements upon being detained: Section 5150, subdivision (g)(1)

- At the time of detention, the person authorizing the detention must provide verbally or in writing, in a language or modality accessible to the person, the advisement: My name is _____________. I am a (peace officer, mental health professional, doctor, nurse). You are not under criminal arrest, but I am taking you for an examination by mental health professionals at __________________ (name of designated facility). You will be told your rights by the mental health staff." (Welfare and Institutions Code Section 5150, subdivision (g)(1).)

Advisements upon being detained at home: Section 5150, subdivision (g)(2)

- "If taken into custody at his or her own residence, the person also shall be provided the following information: You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken." (Welfare and Institutions Code Section 5150, subdivision (g)(2).)

Documentation of factual basis for detention:

- "The documentation shall include detailed information regarding the factual circumstances and observations constituting probable cause for the peace officer to believe that the individual required psychiatric evaluation under the standards of section 5105 (sic –should read 5150)." (Welfare and Institutions Code Section 5150.2.)

Liability for detaining person: non-LPS facility.

- Health and Safety Code Section 1799.111, provides immunity from civil or criminal liability under specific circumstances, when a person is detained at a non-designated LPS facility. The specific circumstances include that the person is not detained beyond 24 hours and there is probable cause for the detention. (Health and Safety Code Section 1799.111.)
- If transferred to a LPS facility the amount of time detained under section 1799.111 is deducted from the 72 hours allowed for evaluation and treatment.

Liability for persons exercising authority:

- Welfare and Institutions Code Section 5278 provides that "Individuals authorized under this part to detain a person for 72-hour treatment and evaluation … shall not be held either criminally or civilly liable for exercising this authority **in accordance with the law**." (Welfare and Institutions Code Section 5278.)

Maximum period for detention: Section 5151

- "If the facility designated by the county for evaluation and treatment admits the person, it **may detain him or her for evaluation and treatment for a period not to exceed 72 hours**. … the professional person in charge of the facility or his or her designee **shall assess the individual in person to determine the appropriateness of the involuntary detention**." (Welfare and Institutions Code Section 5151.)

Clinical Aspects of the 5150 Referral

D. Anton Bland, M.D.
Chief Psychiatrist
Contra Costa Regional Medical Center

Disclosures

- I have no commercial interests to disclose.

This is NOT an Objective

Objectives

- Describe the process of evaluation and management of individuals on a legal hold.
- Identify the signs/symptoms of a mental disorder required for involuntary detention.
- Discuss the conditions for release from a legal hold.

The Phases of Involuntary Psychiatric Evaluation

- **Application Completed and Reviewed**
- Evaluation and Treatment in PES (5152)
  - Interview and Assessment Completed by Psychiatrist
  - Offer for medications and/or therapy as needed
- Decision to Admit/Transfer/Discharge

Essential Components of 5150 Legal Documentation

- Legible Names/Signatures/Date
- Statements made on the form need to be anchored in **observable, describable behavior** that substantiate a finding of probable cause to believe the person is a DTS, DTO, or is GD because of a mental disorder.

Example: Statements of Probable Cause

- "Called by person's brother to assess a client that was running naked in the street,"
- "Call from patient's mother saying son was suicidal, isolating, and hasn't slept in 3 days"
- "Called by school principal to assess student who stated she is cutting herself and said she didn't care if she died to her school counselor,"

Example: Statements of Probable Cause

- "Called by roommate because client threatened him to stop projecting his thoughts into client's mind,"
- "Told by therapist at County mental health clinic that well-known client just called saying 'it was all over, and people were going to be sorry.'"

The Phases of Involuntary Psychiatric Evaluation

- Application Completed and Reviewed
- **Evaluation and Treatment in PES** (5152)
  - Interview and Assessment by Psychiatrist
  - Clinical Observation
  - Offer for medications and/or therapy as needed
- Decision to Admit/Transfer/Discharge

What happens in the PES?

- Evaluation consist of multidisciplinary analyses of a person's medical, psychological, social, financial and legal conditions as may appear to constitute a problem
- Focus is on relieving the acute crisis, not comprehensive psychiatric evaluation – much like medical emergency departments, treat the presenting problem.

The Mental Status Examination

- A multifaceted analyses of a person's medical, psychological, social, financial and legal conditions as may appear to constitute a problem.
  - Emphasis on assessment for hallucinations, delusions, impaired judgment.

Clinical Consideration

- Danger to self or others without a mental disorder does not meet the standard.
  - Mental retardation, epilepsy, or other developmental disabilities, alcoholism or other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental health disorder.[1]
- Likewise, inability to provide food, clothing and shelter without a mental disorder is not enough.

1. 35 W&I Code section 5585.25

Clinical Consideration

- Assessing Hallucinations
  - Are they commanding the person?
  - Are they telling the person to hurt self or others?
  - Has the person heard the voices in the past?
  - If so, did the person act on the voices or did the voices cause the person to do anything?
- Assessing Delusions
  - How do you know that it is a delusion?
  - Is the delusion such that it would lead the person to cause harm to self or others?
  - Has the person had the delusion in the past and has it caused the person to do anything?
  - Does the delusion prevent the person from providing for food, clothing and/or shelter? If so, how?

Clinical Consideration

- Assessing level of grave disability
  - Are they eating and drinking adequate amounts of food while on the unit?
  - Is the patient wearing clothing?

Danger to Self

- Words or actions showing intent to commit suicide or bodily harm.
- Words or actions indicating gross disregard for personal safety.
- Words or actions indicating a specific plan to suicide.
- Means available to carry out suicide plan (i.e. pills, firearms present or available).

Danger to Others

- Threats against particular individuals.
- Attempts to harm certain individuals.
- Means available to carry out threats or to repeat attempts (i.e. firearms, or other weapons).
- Expressed intention or attempts to engage in dangerous activity

Gravely Disabled

- Signs of malnourishment or dehydration.
- Inability to articulate a plan for obtaining food.
- No food available in the house or at hand if not in a house.
- Irrational beliefs about food that is available (i.e. it's poisoned, inedible, etc.).

Gravely Disabled

- Destruction or giving away of clothing to the point where the person cannot clothe themselves.
- Inability to formulate a reasonable plan to obtain shelter.
  - Homelessness alone does NOT constitute GD. Skills/abilities test, not means test.

Treatment during Involuntary Detention

- Process should be *collaborative*, *non-coercive* care involving a therapeutic alliance when possible, with voluntary treatment in the least-restrictive setting as the goal.
- Consumers may be offered medication management during the evaluation process.
  - However, they have the *right to refuse* all medical interventions.

The Phases of Involuntary Psychiatric Evaluation

- Application Completed and Reviewed
- Evaluation and Treatment in PES
  - Interview and Assessment Completed by Psychiatrist
  - Offer for medications and/or therapy as needed
- **Decision to Admit/Transfer/Discharge**

What happens afterward?

- A 5152 can be discontinued by a psychiatrist or psychologist at any time within the first 72 hours.
- The 5152 Evaluation is not a predictive process.
  - Most experienced clinicians are “moderate” at best at predicting violence.[2]

2. Teo, et al. Psychiatr Serv. 2012 Nov;63(11):1089-94. doi: 10.1176/appi.ps.201200019.

What happens afterward?

- Treatment occurs in the PES with discharge in first 24 hours for 75% or more of patients.
  - A significant proportion of consumers (1 in 2) may suffer with an addictive disorder which leads to involuntary detainment during intoxication that is not sustainable post-intoxication.
- Referrals can be made for follow up appointment with ongoing provider of the client’s choice, primary care provider, or mental health professionals.

Summary

- The 5150 offers an opportunity for a humane approach to the assessment of individuals with mental health issues for safety in the community.
- Clinicians are observing for evidence of how a consumer with mental illness continues to meet criteria for involuntary detention due to DTS, DTO, and/or GD.
- Despite suffering signs of mental illness, consumers have a right to refuse treatment and to be treated in the least restrictive setting.

Questions?

D. Anton Bland, M.D.

1

2

Overview

- **Whole Person Care** is a Medi-Cal waiver pilot program
  - Overall goal is to increase coordination of health, behavioral health and social services for vulnerable Medi-Cal recipients **such to address underlying social & behavioral determinants of health.**
  - Focus on reduction of inappropriate utilization & improved health
- CCHS received approval in October 2016 for $40M annually over 5 years
  - Program duration 2016-2020
  - One of 19 CA County Systems participating
- CCHS has termed the program "**CommunityConnect**"
  - DHCS grant is termed "Whole Person Care"

3

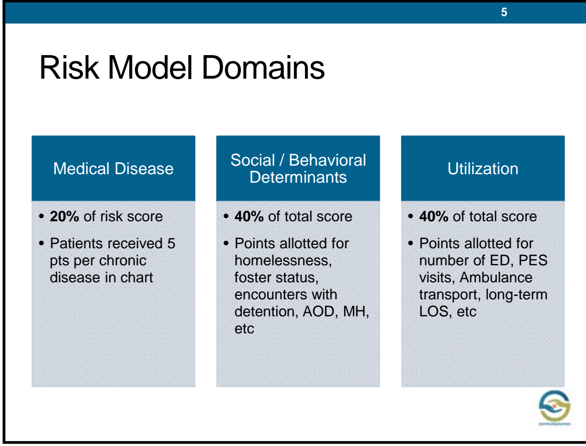
Target Population for WPC

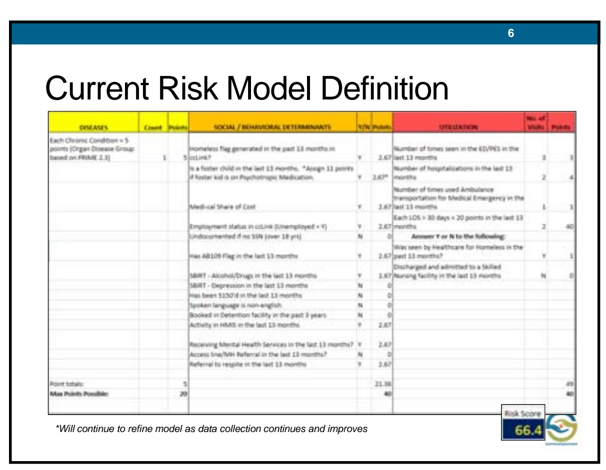
- Approximately 28,000 of the ~257K Medi-Cal members in Contra Costa County, divided into two tiers, based on level of need. We have **planed for ~ 1/2 to participate**. Participation in entirely voluntary.
- Eligibility Criteria includes:
  - **Experiencing homelessness**
  - **Multiple hospital/ED visits in the last year**
  - **On probation or scheduled for release from jail**
  - **Serious Mental Illness and/or Substance Use Disorder**
  - **Two or more chronic health conditions**
  - **Foster Youth being treated with psych meds.**

4

Patient Eligibility & Risk Stratification

- Developed data-driven risk model to identify target population
  - Pulled data from 5 different systems into data warehouse to develop algorithm
  - Compared with current programs (Substance Abuse, Targeted Case Management) to validate data
- Applied Risk model to all Medi-Cal patients (~257k)
  - Threshold of 11 on 100pt scale for initial program eligibility
  - 28,000 patients met criteria, of which 1982 cared for by network providers
  - Assigned to Tier I or Tier II based on – assessment of how **medically & socially fragile** the individual presents as.





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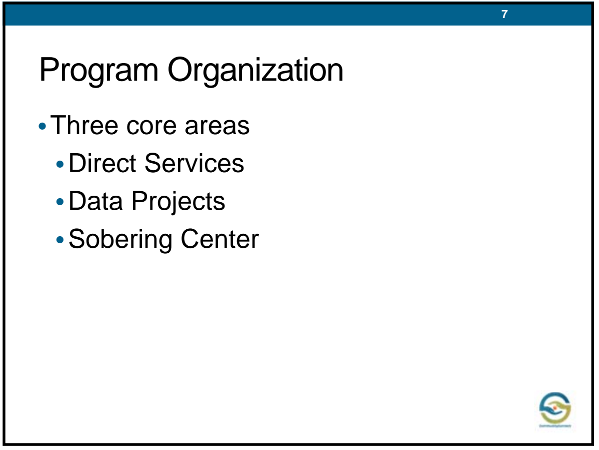
Current Risk Model Definition

DISEASES	Count	Points	SOCIAL / BEHAVIORAL DETERMINANTS	Y/N	Points	UTILIZATION	No. of Visits	Points
Each Chronic Condition = 5 points (Organ Disease Group based on PRIME 2.3)	1	5	Homeless flag generated in the past 13 months in ccLink?	Y	2.67	Number of times seen in the ED/PES in the last 13 months	3	3
			Is a foster child in the last 13 months. *Assign 11 points if foster kid is on Psychotropic Medication.	Y	2.67*	Number of hospitalizations in the last 13 months	2	4
			Medi-cal Share of Cost	Y	2.67	Number of times used Ambulance transportation for Medical Emergency in the last 13 months	1	1
			Employment status in ccLink (Unemployed = Y)	Y	2.67	Each LOS > 30 days = 20 points in the last 13 months	2	40
			Undocumented if no SSN (over 18 yrs)	N	0	**Answer Y or N to the following:**		
			Has AB109 Flag in the last 13 months	Y	2.67	Was seen by Healthcare for Homeless in the past 13 months?	Y	1
			SBIRT - Alcohol/Drugs in the last 13 months	Y	2.67	Discharged and admitted to a Skilled Nursing facility in the last 13 months	N	0
			SBIRT - Depression in the last 13 months	N	0			
			Has been 5150'd in the last 13 months	N	0			
			Spoken language is non-english	N	0			
			Booked in Detention facility in the past 3 years	N	0			
			Activity in HMIS in the last 13 months	Y	2.67			
			Receiving Mental Health Services in the last 13 months?	Y	2.67			
			Access line/MH Referral in the last 13 months?	N	0			
			Referral to respite in the last 13 months	Y	2.67			
Point totals:		5			21.36			49
Max Points Possible:		20			40			40

Risk Score 66.4

*Will continue to refine model as data collection continues and improves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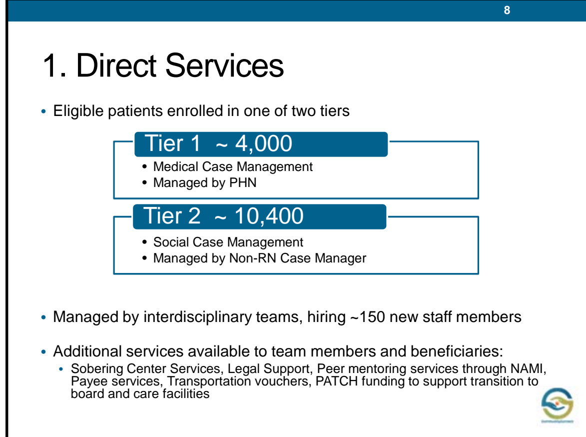
Program Organization
• Three core areas
• Direct Services
• Data Projects
• Sobering Center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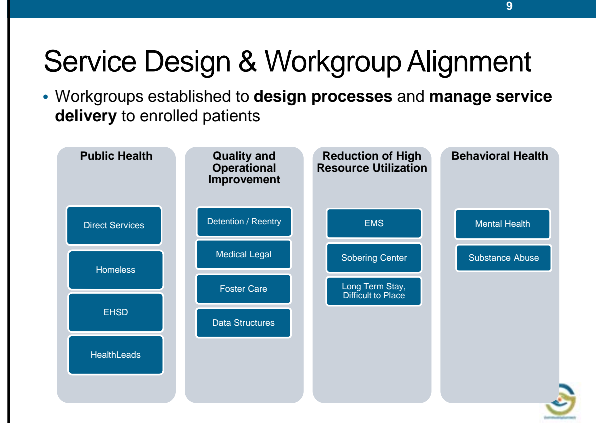
1. Direct Services
• Eligible patients enrolled in one of two tiers
Tier 1 ~ 4,000
• Medical Case Management
• Managed by PHN
Tier 2 ~ 10,400
• Social Case Management
• Managed by Non-RN Case Manager
• Managed by interdisciplinary teams, hiring ~150 new staff members
• Additional services available to team members and beneficiaries:
• Sobering Center Services, Legal Support, Peer mentoring services through NAMI, Payee services, Transportation vouchers, PATCH funding to support transition to board and care facilities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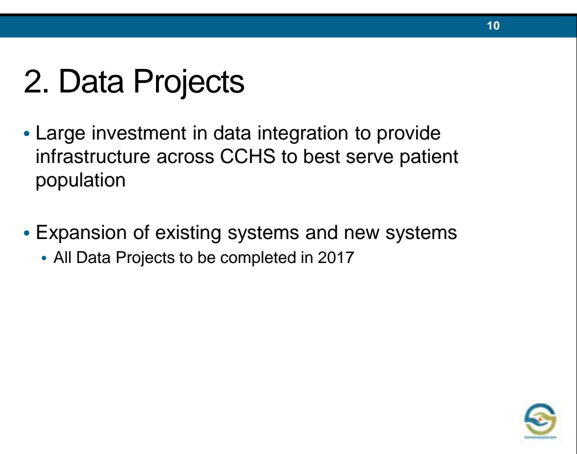
Service Design & Workgroup Alignment
• Workgroups established to design processes and manage service delivery to enrolled patients
Public Health
Direct Services
Homeless
EHSD
HealthLeads
Quality and Operational Improvement
Detention / Reentry
Medical Legal
Foster Care
Data Structures
Reduction of High Resource Utilization
EMS
Sobering Center
Long Term Stay, Difficult to Place
Behavioral Health
Mental Health
Substance Abuse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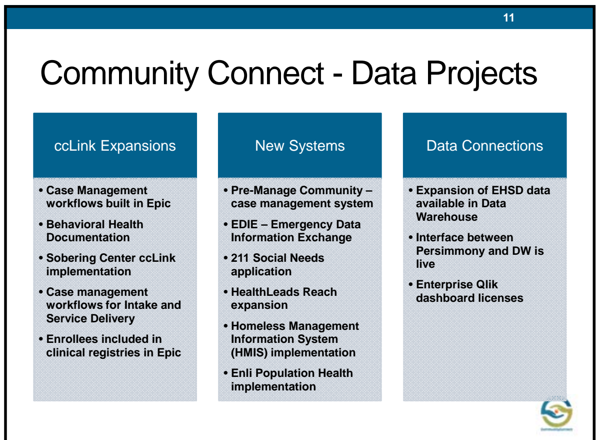
2. Data Projects
• Large investment in data integration to provide infrastructure across CCHS to best serve patient population
• Expansion of existing systems and new systems
• All Data Projects to be completed in 2017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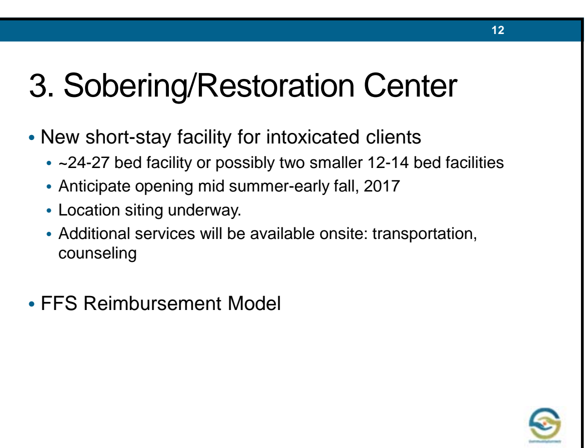
Community Connect - Data Projects
ccLink Expansions
• Case Management workflows built in Epic
• Behavioral Health Documentation
• Sobering Center ccLink implementation
• Case management workflows for Intake and Service Delivery
• Enrollees included in clinical registries in Epic
New Systems
• Pre-Manage Community – case management system
• EDIE – Emergency Data Information Exchange
• 211 Social Needs application
• HealthLeads Reach expansion
• Homeless Management Information System (HMIS) implementation
• Enli Population Health implementation
Data Connections
• Expansion of EHSD data available in Data Warehouse
• Interface between Persimmony and DW is live
• Enterprise Qlik dashboard licenses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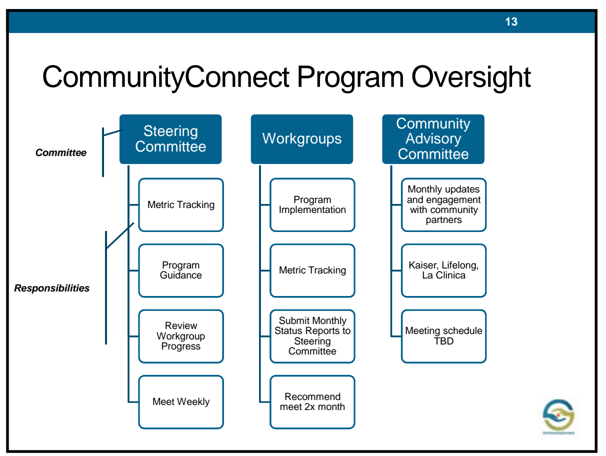
3. Sobering/Restoration Center
• New short-stay facility for intoxicated clients
• ~24-27 bed facility or possibly two smaller 12-14 bed facilities
• Anticipate opening mid summer-early fall, 2017
• Location siting underway.
• Additional services will be available onsite: transportation, counseling
• FFS Reimbursement Model



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Program Administration Team

- Sue Crosby RN, CommunityConnect Director
  - Responsible for overall program success and implementation
- Rachael Birch, Administrative Manager
- Emily Parmenter, Program Manager
  - Responsible for program organization and structure, data project tracking
- Ashley Carrion, Quality Improvement Manager
  - Responsible for tracking of quality measures and workgroup implementation