



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
Thursday • September 24, 2009 • 3:00 – 5:00 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. 3:00 **CALL TO ORDER / INTRODUCTIONS**
2. 3:05 **PUBLIC COMMENT. [First 5 Submitted]**
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. 3:10 **AGREE ON THE WORKGROUP CHARGE**
For MHC Capital Facilities workgroup members and CPAW members (up to 4) to review options and alternatives (including the 20 Allen site as one option) for capital facilities needs for mental health services in Contra Costa County with an open mind/no pre-conceived ideas. Those options would be brought back to the full Commission for their recommendations to MHA and BOS.
4. 3: 20 **AGREE ON THE OUTCOME OF THE PROCESS INCLUDING PERSONAL OUTCOMES**
 - A. **MACRO OUTCOME:** possible long and short term solutions to the defined consumer-related service needs/gaps.
 - B. **MICRO OUTCOMES:**
 1. Project(s) for the MHSA \$8 million
 2. Project(s) for the Cal HFA funds
 3. Resolution regarding the 20 Allen proposal
 4. Individual personal goals



5. 3:45 **DECIDE ON THE REQUIRED STEPS:**
 - A. Define the problem(s) being addressed
 - B. Gather all questions
 - C. Get answers from MHA
 - D. Review best practices in other counties
 - E. Other steps? (hear input from selected others?)
 - F. Create recommendations
 - G. Get general comments on recommendations
 - H. Return recommendations to MHC
6. 4:10 **REVIEW OF THE QUESTIONS**
7. 4:30 **AGREE ON A TIMELINE**
8. 4:40 **NEXT STEPS/NEXT MEETING**
9. 4:50 **PUBLIC COMMENT. *[Remaining]***

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10. 5:00 **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

**Notes from MHC and MHA Planning Collaboration Meeting
prior to CPAW meeting 9/17/09**

1. Define what the problem(s) are among the option(s): find a use for 20 Allen; identify how to spend MHSA Capital Facilities money; recommend how to address one or more unmet mental health needs that involve capital facilities.
The group agreed it was the latter)
2. Define what outcomes the group hopes for (including personal ones)
3. Identify questions/data needed
4. Identify a timeline (although the group acknowledged that there is some urgency since the 20 Allen property could be designated for another use if too much time passes, it did not want to be driven by that issue)
5. The group agreed the meetings should be open, noticed and with a public comment period. It was also noted that since not everyone has the same knowledge level about this issue, that it would be important to set the stage about parameters (e.g. what MHSA money can be used for) and set a realistic context for the discussions.
6. During the process, additional "voices" might be invited to join specific meetings to get their perspective. There would be a community forum/hearing to allow additional input about recommendations.
7. Staff Support: For the first meeting, the group requested Sherry, acknowledging that for future meetings MHA staff with expertise would be needed to provide input. Julie volunteered to help facilitate if the need arises. A note taker would be needed for all meetings.

Capital Facilities Questions
MHC/CPAW Capital Facilities Workgroup 9/24/09

What are the Needs?

- Where is the needs assessment that objectively evaluates the needs of our clients and determines the gaps between these needs and the services that we have to offer. A population needs analysis would help ensure that the community mental health services better match client need. The analysis should include data on current symptoms, functioning, and service use and needs. The services analyzed should include standard case management, intensive case management and residential care management.
- What are the outcomes on these services in our County? Theoretically, the consumers receiving case management and residential services should be the most stable. Are they? Do we know?
- Has a level of care planning model been applied to any data that suggests that a high percentage of consumers may be receiving too high or too low a level of care, for their needs.
- What is the daily census at CCRMC's CSU and 4 C during 08 and 09? How are decisions made to refer to 4c vs. contract facility. Is payor source a determining factor? Should it be? How many indigent beds are held on 4c per day? How many high acuity beds are held on 4c? Donna stated that 4c is filled to 23-bed capacity before consumers are sent to contract facility? We have heard that this is not true. What is the factual information?
- What analysis has been done on the lack of a comprehensive housing plan and its financial and human impact? For instance, how does the instability of housing complicate and add to acuity, resulting in increased incarceration and hospitalization?
- What analysis was done on the acuity of our population?
- Develop priority list of services, which stakeholders believe are necessary. (This is in addition to those MHA has identified in the Pavilion.)
- What is the roadmap that was followed to develop the current proposal, at 20 Allen? What was the methodology utilized? Where are those stats?
- Was the current proposal based on the fact that psychiatry is draining the hospital financially? What is the profitability of other departments at CCRMC? The ER, Radiology, Surgery?
- What financial analysis has been performed or considered on the health disparities of our clients?
- What are the numbers of consumers who are experiencing complex medical issues that could not be treated in a PHF?

What are the Options/Alternatives?

- Consider collaboration with private hospitals to identify if proposed services are already available. If they aren't available are the private hospitals interested in supporting any or all of said activities? If so, how?
- Are there other choices (besides 20 Allen) to remedy this financial stress (if there is some)?
- We know there is a great disparity, so should we be using the MHSA Capital Funds to integrate primary and behavioral health in all three regions? Example current proposal for Concord. Why are we spreading out services in West County? What planning for psychiatry or behavioral health is taking place with Doctor's Hospital in San Pablo? There is a Joint Powers Authority between the County and that facility. Are we joining with them on creating services for the mentally ill in West County? There is evidence that co locating would prevent or intervene in the treatment of complex medical issues that lead to expensive hospitalization.
- Since there are fewer and fewer acute medical beds in Northern Calif, we would compete with other counties, as well as private insurance, for acute hospital beds. Sacramento County is planning on closing 50 acute beds (See Sacramento Bee article dated August 18th) That will cause people from Sacramento to compete for the same hospitals that CCC contracts for overflow beds. There are very few hospitals that take complex medical cases or the more difficult, hard to control patients. Where will our CCC consumers go when nobody else will accept them? Especially once Ward C is closed, which is the public assumption, if the Pavilion is built.
- During the week of the Kaizen 3 Event, at CCRMC, there were several references to the possibility of re-designing the ER and CSU to allow for the re-opening of the old PES door and re institute immediate entry to the CSU, for psychiatry patients. It was stated that there may have been an over reach on the Title 22 requirements, following the CMS Audit, and that Title 22 does not mandate that the door be closed, but rather, this was an administrative decision. When can the CSU re-open to allow improved access and increased quality of care for our consumers?
- Should there be a protocol or procedure that mandates that payor source is somehow considered, without violating any laws? Should we be sending consumers who have Medical/Medicare to a freestanding facility like John Muir, where there will be no reimbursement from Medical or Medicare, and only county general funds will pay? Is this a prudent use of our limited funds? It would seem that a consumer who has both Medical and Medicare would be a good candidate for a 4C bed before being sent out to an overflow bed. Are we considering the best options for both care and revenues?

How do the Needs Match the Alternatives?

- Does continuum of care mean that all proposed Pavilion services need to be housed in one facility?
- Are all (20 Allen) proposed services needed?
- Should any of these (proposed) services be provided regionally? If so which and where?
- Look at all existing county owned property, including vacancy status, in all regions to match needs with existing property to avoid new construction costs.

What are the Constraints?

- Look at all funding sources not just MHSA.
- How does the county make decisions for capital facilities? How are we using tax payer dollars to create and plan for needed services?
- Are decisions made from a regulatory perspective or an operational perspective?
- Could MHSA Capital Facilities funds be used to re-model the ER/CSU to improve space conditions at the current hospital?
- What is the financial arrangement between MHA and CCRMC regarding payment for beds? Is there any incentive to have the 4c beds filled before sending to another facility? What coordination occurs between MHA and CCRMC's CSU and 4c?

Next Steps:

- The findings should be referred back to County Health Services/MHA for full assessment. The Assessment should address feasibility and should include full financial analysis.
- Updates to MHC and CPAW.
- A presentation to MHC at a Public Hearing or Community Forum for final recommendations.