Merced County Mental Health Board Meeting

November 4, 2014
3:30 pm – 5:00 pm
1137 B Street, Merced, CA

Present:	Richard Hawthorne, Chair; Iris Mojica de Tatum, Vice-Chair; Vince Ramos, Secretary; Mary Ellis; Sally Ragonut; James Fuller; Keng Cha; Mary Hofmann; Kim Carter; Cora Gonzales; Supervisor Walsh
Absent:	David Baker
Others Present:	Curt Willems; Dr. Manuel; Anthony Prieto; Robert Porta; Cesar Velasquez; Betty Hoskins; Kurt Craig; Sharon Mendonca; Chris Kraushar, PRA; Sharon Jones; Carol Hulsizer, Recorder

MINUTES

I. Call to Order / Flag Salute / Roll Call

Richard Hawthorne, Chair, called the meeting to order at 3:30 p.m. The flag salute was done. Roll call was taken.

II. Mission Statement

Richard read the Mission Statement.

III. Approval of Minutes from October 7, 2014 (BOARD ACTION)

Action/Recommendation: M/S/C (Ragonut / Gonzales) to approve the minutes from October 7, 2014.

IV. Opportunity for *public* input. At this time any person may comment on any item which is not on the agenda.

Discussion/Conclusion: Vince commented on a webinar regarding prescription drug abuse. There was information that doctors are prescribing morphine and other heavy duty prescriptions to the public and not monitoring it. People are going from one doctor to another to fill their prescriptions. Many elderly people are beginning to use morphine and other drugs. Vince also went to the Art Festival in Modesto which is part of their Innovation system they have. They had 457 artists and they were paid $5,810; they get 70% of what they sell. They have 138 hours of volunteer service; they have 175 individuals volunteering. They took their Innovation money and bought a building and then housed all the art and people working there. *Kim commented on Vince's report regarding prescription drug abuse. She stated that anything that is narcotic is done with a triplicate prescription and one copy goes to the State. Those are all reviewed. Richard stated that there is a database that doctors can check; because those in law enforcement, through subpoena, can access that database. This is true in California, but Richard was not sure about other States. Cesar commented that it is a protected database and it is a complicated process of having the providers access the database. Cora stated that in her past-experience, being in the medical community for the past 43 years, the local pharmacy and local medical community have been working very hard to conquer the opiate problem.*

Sally stated that in their Board binders the document showing the Standing Committees is in error. The Executive/By-Laws/Planning Committee information is outdated and needs to be updated with the correct names. Richard stated it would be changed.

Recommendation/Action: Information only

V. CUBE Overview / Program Update – Cesar Velasquez and Betty Hoskins

Discussion/Conclusion: Cesar introduced himself. He is the Mental Health Coordinator with oversight over the CUBE and other programs in the mental health system for the Children's System of Care (CSOC). A brief outline was passed out showing the services offered at the CUBE. Betty Hoskins, Program Manager, then gave a brief overview of the CUBE. Betty invited everyone to come to the CUBE any day between 10:00 and 5:00. Betty explained how the CUBE is set up. They have supervision and other meetings there. There is a washer and dryer for youth to do their laundry. They have a beautiful kitchen and teach the youth cooking, budgeting and how to prepare meals. There is an Advisory Council where the youth decide at the beginning of the week what activities they want to do for the week and what items they will budget, purchase and prepare for their activities. It is a very welcoming environment. They also have celebrations there for Behavioral Health Court. Often they have guest speakers come in. Cesar continued that this is a consumer-driven program. The youth have an agenda on what they want to do, trips they want to take, fund raisers, etc. Staff is there

V. CUBE Overview / Program Update – Cesar Velasquez and Betty Hoskins – con't.

to promote their recovery and wellness. There are peer mentors (all are on their own mental health recovery) there who are a real asset to this program. Their goal over the last two years (FY 12/13) was to have 115 unduplicated participants over the fiscal year; by the end of that year they had 177. Last fiscal year (13/14) they were expecting 200 and they ended up with 397. This year so far they have 137 and Cesar has no doubt they will meet their projected 220 for the year. Some of the challenges are looking at outcomes and data and trying to ensure that the work that is being done really gets represented with the data. Over the last two months they have instituted different measures to capture all this information. Betty stated that a lot of the difficulties in capturing information is because it is not a requirement for youth to be open to mental health services to access the CUBE; this has been an ongoing tracking issue to be able to count their numbers. They recently found out that they had been under reporting during the last couple of years. Cesar continued that by the end of next quarter they will have a lot more accurate numbers based on the data that is in the system. For the most part, they have been meeting all the indicators that are in their plan. Another challenge/concern is transportation – there is always a shortage of vehicles. Gang violence is another issue. It is an open environment and they are forced to deal with this. They do not allow any violence in the CUBE and one safety measure is that gang affiliated colors are not allowed. There have been a few instances of threats of violence and the CUBE was locked down and had a team of staff come in an assist. There have not been any physical assaults within the CUBE. They have put in some measures and it is basically, fairly safe there. Some of the training they are looking at is to assist the staff in being more aware and noticing gang signs and symbols.

Mary H. stated that she has been at the CUBE many times at many times of day and is concerned that she never sees any kids there. There are usually a few – two or three, maybe five or six and most are the same kids. She realizes the CUBE is open to 16-25 year olds but she questioned what ages are actually served because she can't imagine anyone over the age of 18 wanting preferring to go there when they could go to the Wellness Center. Betty said there is a large number of 18 year olds that do come in because it is quieter. She said that Mary was correct in that they don't have as many, but they also do not have as many that are chronically, mentally ill entering the CUBE. They have access to computers and get a little more individualized attention when they come. Often those emancipating out of the foster care system do prefer to "run their own ship" – coming in and accessing the computers, having access to staff to ask individual questions and to feel more one-on-one attention. In the mornings there is not a large amount of kids because most are in school. Mary questioned unduplicated services. Betty stated that when someone first comes in they are a registered member, but if there is no contact in about 6 months they are dropped off. They only count the first day the youth comes in – they are not counted every day. Mary questioned if there is an intent to make this a mental health facility. Betty stated that this doesn't focus specifically on mental illness. Focusing on those emancipating out of the foster care system, whether they are going through an adjustment or may have depression, they may not be where they want to access services but they will get some services while in the CUBE. Often getting peer-to-peer support is enough for them. If there comes a time when they need that linkage and can accept that referral, they are usually walked over to Access. Cesar stated that since October 7th they are actually tracking the number of referrals that the CUBE staff provide to the participants, or to consult with their clinician, or to provide a crisis intervention and connect them with the CSU. Next time they will have a number that is specific to how many mental health referrals were provided and to where. Mary continued as to why people cannot attend the Wellness Center, without having an open case in Mental Health, when we are letting youth enter the CUBE and they do not have to be open to Mental Health Services and yet both are MHSA programs. Curt stated that this question has come up before and it is something that the Department can continue to explore and consider for the community. With the new Director, the Department is looking at the areas that need to be improved. Sharon M. commented that the regulations for the Department of Mental Health, that we have to stand by, is based on our State plan. Our State plan and our agreement with the State is that we will provide services for those indigent and those that have Medi-Cal. That is our job and our role – to meet the needs of that population up to the funds that are available. We cannot just open the doors for everyone. MHSA has its own guidelines as well. It was decided that this subject will be tabled until Curt can talk to the Director. Chris K. questioned how much each of the four Wellness Centers is given. Sharon J. stated that the Merced Adult Wellness Center is given about $1.27 million, the CUBE is given almost $400,000, the Westside Transitional Center is about $200,000, and Dual Diagnosis is about $200,000. All four are under MHSA. Sharon J. continued that every MHSA program has to have three measurable goals, if not more. The Dept. is moving towards not only measuring the goals, but being able to evaluate and analyze those programs in terms of impacts. The MHSA analyst is looking how individuals are enrolled into programs, how they are tracking the data and the activity and making a meaningful explanation from this data.

Recommendation/Action: As noted above

VI. 5150 Requirements – Dr. Manuel

Discussion/Conclusion: Curt introduced the Department's Medical Director, Dr. Isabel Manuel. Dr. Manuel stated that this is her first Mental Health Board meeting and it is quite interesting. She stated that when she had to man the crisis unit for four hours, she was just watching her time and when would her four hours be up. She stated that it is really intensive there. Dr. Manuel went through her PowerPoint presentation and tried to help everyone understand what a crisis evaluation actually entails. The criteria for placing someone on a 5150 hold is: 1. A danger to self, 2. A danger to others, or 3. Being gravely disabled. To meet this criteria it has to be imminent that they are going to hurt themselves. If someone comes in and they say they are not suicidal but they get a call from a family member stating that the person was suicidal last week and was giving away his possessions. Dr. Manuel's tendency would be to go ahead and put this person on a 5150 – giving your belongings away means you are depressed – those are red flags. If Dr. Manuel didn't listen to family members or other information, she doesn't know what the outcome would be. If the person says they are going to kill somebody or hurt somebody, then they are put as a danger to others. If the person gives an actual name of someone they want to hurt, a Tarasoff warning must be given. Dr. Manuel explained what a Tarasoff warning is. Criteria for being gravely disabled means you are not able to provide for food, clothing or shelter. The 5150 is the result of a mental illness or chronic alcoholism. Dr. Manuel emphasized it is hard to meet 5150 criteria.

Mary H. stated that the most common concern of family members reported to NAMI is, "he threatened to kill me", threatened to kill themselves. The individual is taken in and then pulled themself together for 15 minutes and denied the threats. It is very frustrating. Dr. Manuel stated that if there is a single doubt, even in the ER, she says call the family members and get information from them. It is a judgment call at the time the evaluation takes place. It is very hard. Mary then questioned the alcoholism part and has been told that if the person has been drinking, the will not be taken. Dr. Manuel continued that if the individual is a long-term drinker, as opposed to someone who has been drinking for a week, that is a big difference. Dr. Manuel explained the difference and that several things have to be taken into consideration when they do an evaluation.

Dr. Manuel continued that in January 2014 changes were initiated to the 5150. The LPS Act was enacted in 1967 and this is the first time changes have been made. At the same time that the LPS was initiated in 1967, and the changes now, it is still to provide rights to the individual. Dr. Manuel went through the changes briefly. The changes are to provide consistent standards, Statewide, for the protection of personal rights. They must always think about the least restrictive setting when they do an evaluation. They also made changes to some wording - 'mental disorder' to 'mental health disorder', 'mental retardation' to 'intellectual disability'. They can now also evaluate through telemedicine. This occurs more likely in the ER setting, however, if telemedicine is provided, the patient has to consent to being in front of a television. The legal issue is if the patient doesn't consent, then they have a problem. Once someone is on a 5150, they have to continue to provide ongoing assessment and evaluation just to make sure that they continue to meet criteria for a hold. It also says that records can be shared between treating facilities. Another change was making sure that there are training certifications standards (we have to have our clinicians go through training so they can write a 5150 – this is being worked on right now). The police, when they pick someone up on a 5150 hold, they have to safeguard the property and ask the person is things need to be turned off such as the water, appliances, etc. They cannot just take the person. The police also have to ask if the person would like to make a phone call to let someone know what is happening. This is a big change. The individual being picked up also has to be informed they are being placed on a hold and given the choice of where they want to be taken for an evaluation/treatment. The question was asked that when someone is psychotic how can they understand all this. Dr. Manuel replied that sometimes they cannot, but they just try to keep it simple. Dr. Manuel went on to explain what excludes someone from being placed on a 5150 hold. If the person has dementia, however, there is a condition called pseudo-dementia which actually mimics somebody who has dementia and pseudo-dementia is due to depression. Once the depression is treated, they become better and are then not presenting as someone who has dementia. Dr. Manuel continued with exclusions for 5150 hold – developmental/intellectual disabilities, traumatic brain injury, substance use, detox, and medical condition. Curt interjected that in this State a precedent has been set by the Superior Court to actually include brain trauma and some aspects of dementia for placement in the County as conservatorship and we have to take them into our county, serve them and pay for them. They are coming out of the prisons and State hospitals and being assigned back to the county of origin. Dr. Manuel concluded with explaining about the different types of holds. All these hold protect the rights of a patient and all holds will go through a hearing. The hearing officer makes sure that the hold/hospitalization is appropriate; if not, the hearing officer can discharge a patient. In these types of situations, if Dr. Manuel strongly feels that the hearing officer is wrong, she makes them sign a statement that they are being released against medical advice. Patient's rights are always protected. You also always ask them if they would be willing to stay on a voluntary basis.

Recommendation/Action: Information only

VII. Electronic Health Records Update – Anthony Prieto

Discussion/Conclusion: Anthony is the Automation Services Manager for the Department. Anthony went through his presentation with a timeline of what has happened with our electronic health records called Anasazi. Anasazi went live in July 1, 2010. It was very basic; it could do some billing, but not much else. Training was provided by Anasazi; since then they have changed ownership to Cerner Behavioral Health Systems. In the first month over 1,000 services were entered. Three months later the Project Manager left. A new Project Manager was hired and left six months after that. With the Anasazi training, staff expressed their concerns – they didn't like the methodology that Anasazi used to train. It was felt to be ineffective, they didn't learn the product well and because of their doubts they were not sure about Anasazi itself. The development of Anasazi pretty much stalled and staff started using the old system. During this time period a staff member left and only two staff were left. A new Project Manager, Anthony, started and they then assessed where they were with Anasazi right now. The first thing they did was take over the trainings and checking with the staff on what they needed, what they liked, what did they want in the trainings. They came up with new objectives and one core item they changed was better client care. Anthony went over some of the changes that took place. They also took a new approach – we have to be out there where the clients are – where the services are needed. Using secure, remote access through laptops and tablets, service can be provided virtually anywhere – hospital, homes, schools, parks (popular with the PATH grant that does outreach to the homeless). By July 2014 over 11,000 client services were entered into Anasazi – this is ten times the number entered when the system began. Some things to look forward to: clients will be able to remotely access their charts; lab results will be delivered electronically, directly into Anasazi; releases of information will go electronic; and dashboards will give an instant snapshot of data.

Questions: Hub stated that in the past there were presentations that said there were difficulties in charting. Anthony responded that QI staff review the charts and the system will remind you if you have not final approved something; it will remind you if you forget to change the narratives – it will give you warnings. If the clinician decides they do not have to change anything, it will allow them to overwrite this. But it will provide some warnings and alerts that maybe the staff should look at what they are doing.

Mary H. questioned if this is one of several different systems available and is it specifically for mental health or general medical. Anthony replied that this one favors more for behavioral health – it has the AOD, inpatient, and mental health components all in it. Mary asked if the Dept. bought the system or is it something that is paid every year. Anthony replied that the Dept. bought the system and the hardware to house the system. Sharon J. stated that we have to pay for the software each year.

Sally questioned if the client was out-of-county and they were put in the hospital there, is there access to the records here in Merced. Anthony responded that if one of our employees was there, with one of our laptops, they could access back to the system. In the future this is part of the health information exchange that is being developed. There is a Health Information Exchange that all the various counties will join into this. There will be secure access to anybody's system.

Iris questioned if there is a vision to correlate the physical health with the mental health. Anthony stated this will include the primary care aspect. There is a small piece in there now which is called medical conditions. It will track things like diabetes – actual medical conditions. For that integration, this is part of the HI Division – that there will be primary care, county care, etc., all communicating across the network. Vince questioned if someone was seeing a doctor out-of-county and the doctor wanted to access to some of this person's information, is it possible. Anthony stated it is possible through releases of information; if a signed release of information is given to our Dept., they will provide that information to the doctor. It will not go electronically yet, but they can get it.

Recommendation/Action: Information only

VIII. Chair's Reports
a. Bakersfield Meeting
b. CALMHB/C
c. Vision/Mission Statement

Discussion/Conclusion: a. Richard stated that Cora provided information that there will be a Mental Health Board meeting in Bakersfield in January 2015. It is from 10:00-2:00. Richard asked if anyone was interested in attending. Due to distance, nobody seemed too interested. b. Keng reported that there was a meeting on the 16th. October is usually the first meeting of the annual meetings. The CALMHB/C is updating their website; one person has been assigned to design the website. On the second day there was a speaker regarding the conflict in the prisons. The speaker was advocating for reforming the conditions in confinement with mental health disorders in Calif. State prisons. CIMH has changed their name to CIBHS. CIBHS is talking about training mental health – the first training would be on conflict resolution within the Mental Health Boards. The second was responsibility connected to boundary and confidentiality for the local Mental Health Boards. The third Data Workbook will be coming out soon. Lastly, Keng passed out a document that needs to be implemented into the local Mental Health Board. Vince also attended this meeting and he will put this on the next agenda.

VIII. Chair's Reports – con't.

said that Cary Martin was also present. He discussed that all the projects that are coming should be coming to the Board and anything that goes before the boss should be coming to the Board in order to have some evaluation input. There was also discussion on the prudent reserve and the different monies that go into it. C. Richard stated that at the retreat he handed out some samples of visions and missions. He is still waiting for feedback. Richard will put this on the next agenda.

Recommendation/Action: As noted above

IX. Supervisor's Report

Discussion/Conclusion: Supervisor Walsh had to leave prior to giving his report. He will cover today's report at the next meeting.

Recommendation/Action:

X. Director's Report
a. Staffing (new hires)

Discussion/Conclusion: Curt reported that Yvonnia is out of the office this week at a Statewide Planning Meeting through CBHDA. Yvonnia asked Curt to give an update on the building project. This is moving forward; they have gone through some of the feasibility studies and hopefully they will be presenting some possibilities soon to the CEO and BOS. Part of this is the Crisis Residential Unit expansion grant that the Dept. is working on to give another alternative for transitional care at a lower level between hospitalization and the community. Curt applied for an additional $1.9 million; they came back saying it was a little high. Curt then said $1.3 million and they came back and said they would give us $1.5 million. This is on top of the original $2 million that was already awarded. Today Curt was notified that we did receive the extension for the $2 million to continue forward under SB82 funds for the Crisis Residential. If the $1.5 is approved by the CHFFA Executive Committee, we will actually have $3.5 million budget to work on building a Crisis Residential on the first floor of the three-story component. If everything works out, this will be a great facility and this is definitely needed now. Part of this is due to the increase in numbers – Katie A. and the ACA are bringing in many clients. We have over 100,000 individuals in this community that are signed up for Medi-Cal. This will increase the number of mental health clients. With the increase in numbers, people are needing appointments and evaluations, possibly with some confusion because of the new mild to moderate and the SMI population that we serve. Many people with Medi-Cal may have some minor depression, or marital problems, and they call our system of care because we are Medi-Cal. We are taking an enormous amount of calls and refer out to the proper places. It has backlogged our Access department in the past few weeks. Thankfully, we have now addressed this and are now back up to speed where we should be by plugging in people from other parts of the Department to answer phone calls, to call back those that call in and leave a message. For about 2-3 weeks we did have a backlog; part of this also was that one staff member went out for 2 weeks for a physical procedure. That left one person working Access. One of the triage workers was covering but the influx of calls really put everything behind. At this time we are up to speed with all calls and walk-ins. Curt continued that a year ago, in a month's time, urgent calls coming in Access averaged about 9-10 and non-urgent calls were about 180. Now we are seeing from 27-30+ urgent calls and 220-300+ non-urgent calls. This is difficult for two people and the Dept. is building up the Access Team. The ACA and Katie A. brought 12,000 new individuals into our system for children's services. The Department saw this coming but did not realize exactly how many would be hitting us and how it would impact our Access Department. Jeanette Merchant, QI Coordinator, will be overseeing the Access Dept. for a while just so she can get a good handle on the situation. a. A Departmental Management Staff organizational chart was passed out. The chart shows three vacancies, but as of today, Tony Ryland will be the new Program Manager for Adult Services – that leaves only two vacancies. The Department continues to hire and our staffing numbers now are higher than they were five years ago. The Department is in a crunch trying to figure out where to put all the staff that are being hired. Collaboration has begun to work with Mercy Hospital staff to improve response times and shortage of hospital beds for youth, especially those under twelve years of age. It is probably one of the Department's biggest issues right now – trying to find a place for kids. There are seven hospitals in the State and they are all out of county. This is not unique to the County. Right now our State is getting hit in mental health because of the new rules, ACA, new Medicaid – it comes down to more access to care. Curt just wanted everyone to know that this is not unique and it is something being addressed and trying to work towards insuring a continuum of care. Lastly, Curt will be meeting with the Counties Legislative Analysts for the State and Federal government on Thursday, on behalf of Yvonnia, and talking about some of the things for our County – like the 1115 waiver, AB 82, and address housing needs for all ages. Iris stated that she heard about a house that when somebody who is homeless and in the ER, rather than release them back on the street, they would be sent to this house for support and transition back to where they were. Curt stated he has heard bits and pieces of this, but we are not at the table of the organization or coordination of this. The Department is talking to Mercy about collaborative care and integrated care in this way. The Assistant Director at Mercy brought up that they have sixty beds that are available if we could find a way to lobby to

X. Director's Report – con't.

get them to be used for some kind of service other than hospital care; Mercy would love to collaborate with us. The problem is regulations. These are things that have to be changed at a systemic/legislative level. Vince questioned how many line staff the Department has to handle the rural areas, the underserved parts of the County. Will the Department be hiring more? Curt stated that there are more line staff today, and we are not top heavy when it comes to management in providing supervision for these individuals in comparison to past years. There are many more clinicians and mental health workers now than in the past. There are many new positions. The problem is that the Department cannot serve them all; we have to choose and prioritize and that is very hard because who are you going to say 'no' to. One thing we are doing here is the Crisis Residential Unit. The original partnership was with five other counties and now Stanislaus has joined and given their money to this project also. We are now six counties collaborating together in developing this CRU to provide the continuum of care that will be at a lower level than a hospitalization but yet support those that really need the extra support.

Recommendation/Action: Information only

XI. Reports / Updates
a. Executive Committee
b. QIC Report

Discussion/Conclusion: a. Richard reported that the Executive Committee continues to work and design the agendas. This was a packed agenda and he appreciates everyone's patience and the meeting running long. He thinks it is time well spent and everyone is starting to get involved in the process and learning more about what the Board does and the Department does.

Mary E. then reported on the recent Community Partner's meetings in September and October. At the September meeting there was concern about bullying and objectives needed for that part of the social skills program. CalWORKs is doing very well. At the October meeting Jennifer Jones was present and she is the new Clinical Director at Aegis. The Director, Yvonnia, is concerned about the Community Partner's Meeting and the purpose of the meeting. Yvonnia was thinking of joining this meeting with the Ongoing Planning Council meeting because the same groups of people attend both meetings and it would make more sense to combine the two and the participants would only have to attend one meeting instead of two. But concerns were shared about this and it was decided that the Community Partner's Meeting would take place one hour before the Ongoing Planning Council Meeting. Hopefully, this will save some time for those attending both meetings. The December Community Partner meeting will still take place, but will change time in January.

b. Sally stated there was not a QIC meeting to report on. She asked that Carol put QIC on the December meeting and each agenda after that.

Recommendation/Action: Information only

XII. Announcements

Discussion / Conclusion: Iris questioned if the 3-Year MHSA Plan went to the BOS yet. Sharon J. stated that it was scheduled to go to the BOS today but is now scheduled for November 25th. Along with this document the additional positions Curt talked about for Mobile Crisis and technological needs will also go forward.
Sally questioned if the Laura's Law committee needs to continue to meet. Richard stated that he meets with Yvonnia next week and he will bring this up.

XIII. Adjournment

Discussion / Conclusion: The meeting was adjourned at 5:43 p.m. The next meeting is December 2, 2014.

Submitted by: _____
Carol Hulsizer
Recording Secretary

Approved by: _____
Vince Ramos, Secretary
Merced County Mental Health Board

Date: _____

Date: _____