MENTAL HEALTH COMMISSION
MONTHLY MEETING MINUTES
October 6, 2021 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Cmsr. G Wiseman, Mental Health Commission (MHC Chair, called the meeting to order @ 4:30 pm Members Present: Chair, Cmsr. Graham Wiseman, District II Vice-Chair, Cmsr. Barbara Serwin, District II Cmsr. Candace Andersen, District II Cmsr. Douglas Dunn District III Cmsr. Laura Griffin, District V Cmsr. Michael Hudson, District IV Cmsr. Kathy Maibaum, District IV Cmsr. Leslie May, District V Cmsr. Joe Metro, District V Cmsr. Alana Russaw, District IV Cmsr. Rhiannon Shires, District II Cmsr. Geri Stern, District I Cmsr. Gina Swirsding, District I Presenters: Dr. Stephen Field (Medical Director of Behavioral Health Services) Steve Hahn-Smith (Chief of Informatics, Behavioral Health Services) Charmaine Hoggatt (Director, HealthRIGHT 360) Dr. Suzanne Tavano (Director of Behavioral Health Services) Other Attendees: Colleen Awad Angela Beck Jennifer Bruggeman Y'Anad Burrell Rebekah Cooke Gigi Crowder Lynda Kaufmann Marilyn (Chachola) Lucey Carolyn Obringer Theresa Pasquini Pamela Perls Christy Pierce Jennifer Quallick (Supv. Candace Andersen's ofc) Arturo Salazar, Visiony Compromiso Baylee Wechsler	Meeting was held via Zoom platform
II. PUBLIC COMMENT: • (Rebekah Cooke) I would like to make a comment regarding my daughter who was conserved and at Angwin for six months, stable and if you speak with her today, she will say she is very grateful and would have never done this on her own. She graduated to Pathways and did not get the stability and structure. She started using again as there was a liquor store and for her, she needed a better stepdown program than Pathways had to offer. Gray haven has the counseling and structure she needs and has been there for approximately two months and is showing progress. She doesn't like it, she doesn't like structure. We are very grateful she is in a program that is structured and getting the help she needs. Unfortunately, her conservator left and she has a new conservator. My concern is	

that he spoke to her one time, in his opinion she is not gravely disabled and presents herself well. She is articulate and has a plan, but given the chance to go, she immediately gets drunk and has drunk a bottle of hand sanitizer, that doesn't sound like she is stable. She has made great strides but still has more to go. She does have a good plan, but her plan is to go to a homeless shelter in Mendocino with her social security, which is going from lockdown to nothing. I am wondering if there is an AOT program or if he can read the reports at each of the facilities in Contra Costa to see that she has been diagnosed with bipolar, etc. I was told by him that being an alcoholic or addict isn't illegal or gravely disabled. Unfortunately, with her, there is a dual diagnosis and it needs to be handled otherwise she goes off her medication and we start the process over. (TIME/Cmsr. Wiseman asks if one of the commissioners has some personal experience they can share or what is your hope?) Hoping there is a solution and that someone can help me with a continuum of care so we don't go from all to nothing. I am trying to understand "What Next?" There has to be something between A and Z. (Cmsr. Wiseman) Thank you for sharing. I know that is a personal story and each of us has faced our own personal stories and hope one of the commissioners would like to reach out to help you directly. Cmsr. Dunn will reach out to you.

- (Gigi Crowder) I wanted to make this group aware of the fact that the two calls I received this week from young people who live with mental illness who tried to get 5150'd from the sheriff's, I just learned now that one of the young men passed. His mother wanted me to let you all know that she will starting to attend these meetings because whenever we lose someone when seeking help, it is always a tragedy and we can do better. I also think it is very helpful if I can share the information that the mother gets a phone call of condolences, because I know we don't always get it right, but from what I have heard from some of the parents, is no one called to offer sympathy for what happened with their child. That is just compassion and I wish we could have a process in place where someone from the commission or someone recognizes the family. This young man grew up in Walnut Creek but was living with his father in Alamo and his father found him no longer breathing. He was only 28 years old and I knew the family tried to work with him and not in enough time. His name was Joshua. (Cmsr. Wiseman) I would like to speak with you offline regarding this if we could. That is really terrible news.
- (Teresa Pasquini) I wanted to share that a new bill was just signed by the Governor (SB 507) that does allow conservatees (people on conservatorship) to step down from conservatorship into AOT and that offers a continuity of care. It is something I have raised at our AOT meetings before and worked with Senator Edmonds office and was just offering that information for Ms. Cooke whose daughter (I believe) was in AOT prior to being conserved. Just wanting to raise to the commission, while that law may not be in effect right now, this is the kind of thing our system has to think about. We can't just say "they have a plan to go to Mendocino and live in a homeless shelter and that's a good enough plan for us." I just wanted to highlight to the commission, this is the reason people fall off the cliff and come back and we cannot continue to allow this to happen when we are all working so hard to get programs in place to prevent this.

III. COMMISSIONER COMMENTS

- (Cmsr. Leslie May) I wanted to speak on an article I read today. It is a proposed change on mask mandate for Walnut Creek by Dr. Ori Tzvieli and it is very disturbing to me because it reeks of nepotism/favoritism/cronyism. At this time, we don't need that. Ms. Pamela Perls spoke at our last meeting about COVID now being listed as a disability under ADA Section 504, the Rehab Act and Section 1557 of the patient protection and affordable care act. I haven't researched it much but I believe that is also falls under civil rights and I will check tomorrow with the Department of Health and Human Services (DHHS). (INTERRUPTED by

Cmsr. Anderson unable to hear Commissioner May) May I address that for you, Leslie. I was present at the Board of Supervisors (BoS) meeting when Dr. Ori Tzvieli (Commissioner May requesting to reclaim her time to finish her comment). My feeling is there are people that are recovering from COVID, right now that are 'long haulers' and also those that haven't had it and fear getting it. This, because of the new variants, it is going to propose a large problem. To say 'Okay people in this city can relax on the mask mandates' because, as we know, people from that city travel to other cities. I don't want to come face-to-face with someone or be in a store or direct contact with someone without a mask. (Interrupted by Cmsr. Wiseman to ask for a summary statement, Cmsr. May stated that was her summary and will be contacting the federal government). • (Cmsr. Candace Andersen) I think, Leslie, the reporter covering that erroneously said he was talking about Walnut Creek. All of our health orders in Contra Costa County (CCC), and Dr. Ori Tzvieli is one of our deputy health officers, apply to the entire county. What he said yesterday is that CCC is working with other counties within the bay area to come up with some matrix that we collectively (each county) look at to start lifting masking ordinances. At no time did he say it would be city specific, but county-wide. We hope by Friday, we will understand what those metrics are and it should be based on hospitalizations, cases per 100K, spread of disease and absolutely not specific for a community. Throughout this pandemic, we have had people say from Lafayette or Danville or other community where they have had a lower case count say 'why are we being restricted? Just worry about those communities where it is a higher case count.' You are absolutely right. People travel through different parts of the county, some of our front line workers in Lafayette, Danville where they have lower case counts were from disadvantaged communities and it is a county-wide spread. So, there is nothing that will be going forward to specific cities, only county-wide, uniformly applied. We did have a wonderful update yesterday by our health equity officer talking about the great progress we have been making in those populations where we have had lower vaccination rates and higher COVID rates and we're making very good progress. I want to assure you that would not happen in this county and Dr. Ori Tzvieli did not indicate anything of that kind and the report tweaked the information the wrong way. • (Cmsr. Douglas Dunn) I am heavily involved with the state level incompetent to stand trial (IST) workgroup. I would like thirty (30) minutes of the commissions time at the December meeting, as by that time all the workgroup meetings will have wrapped up and the suggestions that will be made will be forwarded to the California DHHS to forward on to the legislature to implement per AB 133. These suggestions will have major impact on the IST, as well as the conservatorship population in this county and will definitely affect (especially) persons of color. I will have a complete update December 1st and would like to give a brief 'heads up' what is involved at the December commission meeting.	
IV. CHAIR COMMENTS/ANNOUNCEMENTS: • Absences: For commissioners, if you are unable to attend any commission or committee meetings, please be sure to notify the Chair and Vice-chair and cc'ing the Executive Assistant. Currently, many are notifying Ms. Beck who is the county clerk and not the proper way to notify the commission. So, just to remind everyone, if you will be missing a meeting, please let us know. • Retreat: We had to reschedule the MHC Retreat and has been moved to November, in place of our regular meeting, it will be earlier and end at the same time. • Orientation: We have also rescheduled our first orientation training and that will start in January. The reasoning is the cycle is every six month and it is much easier to track on the calendar year than to start on an off month.	

• New Commissioner: I would also like to take a moment to introduce our new commissioner, Dr. Rhiannon Shires. Please take a moment to share who you are, where you are from and what motivated you to join the commission. • (Cmsr. Shires) I started out by getting my degrees at Boston University, relocated to California in the 70's. I have worked in hospitals, schools, social service agencies. I have been in private practice for 30+ years in Danville and have done a lot of work in mental health; not just in organizations and private practice, but a lot of grass roots advocacy type of work. I also serve on the advisory board for alcohol and other drugs (AOD), I am on the local boards for our school district, for equity inclusion and diversity. One of my loves is theater and choir so I serve on those boards for our local school. The reason I wanted to serve on the MHC is that I feel I have lot of background and it is time to give back. I feel I have a lot of information and passion, so I felt this would be a good place to serve.	
V. APPROVE September 1, 2021 Meeting Minutes • (Cmsr. D. Dunn) One correction on Page 9, change $35 mil to $75 mil • September 1st, 2021 Minutes reviewed, one correction. **Motion:** L. May moved to approve the minutes with correction. Seconded by D. Dunn. **Vote: 12-0-0** **Ayes:** G. Wiseman (Chair), B. Serwin (Vice-Chair), C. Andersen, D. Dunn, L. Griffin. M. Hudson, K. Maibaum, L. May, J. Metro, R. Shires, G. Stern, G. Swirsding Abstain: None	**Agenda and minute can be found at:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. "Get to know your Commissioner" (Commissioners Barbara Serwin / Douglas Dunn **Commissioner Kathy Maibaum (District IV)** This is my first time participating to help my community officially. I am happy to be here. The reason I was motivated to volunteer to serve on the commission is I have a family member, an adult son, who is living with me and currently stable but it was a rollercoaster. I was never exposed before to this, no history in our family, it was all new territory for all of us in my family. I discovered NAMI (or NAMI discovered me) and going through their steps and advocating was something I felt, once things were settled, I saw this opportunity and I wanted to give back. Again, this all new, I am still learning and I can see there is still a lot of work to be done, but it is much better than before. **Commissioner Gina Swirsding (District I)** I am a consumer on the Board. One of the reasons why I started on the commission, Supervisor John Gioia asked if I would like to serve on the board as I was very active in Richmond getting help for people who have been victims of gun violence. In 2006, I was shot at and knew nothing about guns and the person aimed a laser at me (automatic) and shot at me. It was a drug ring in our neighborhood. After that, I was in a bit of denial for a long while and went through a huge anger stage where I wanted revenge (I had the thoughts but never acted on it), I was that angry. I started chasing after people on methamphetamine and went all over California (now I know the whole trade). As a result of three years of that until the police sat me down and said that they were now following me. I went to Supervisor Gioia a lot as there wasn't much support for victims who experienced this. I met quite few people in West County with this experience and as a result (two years prior to COVID), I found a group where everyone has been shot at, and some sexually assaulted (as was I). There is no therapist, it is a consumer run group and it one of the best things to happen to me. A lot of people don't understand these things unless they have experienced it. Some people in the group are military and officers (still active) and to be able to hear their shared experience and, them to be able to hear from us is very helpful. What cured me was using a gun. I now know a lot about guns, I would never own one, but I do go shoot. It has helped me overcome the trauma. I recognize	

gunfire and know what it is. I was working as a Registered Nurse in 1989 and was assaulted by a patient. I have recovered a lot from that, was returning to work and then was shot at. I did attempt suicide many times at the beginning and in an AOT program for three years. What stopped that pattern is the program believed in me and that they cared. I feel that is very important. People need to feel that they matter and are cared for. (Cmsr. G. Wiseman) Volunteers for next month (December)?	
VII. UPDATE on September through December 2021 Site Visits, Angela Beck, Executive Assistant to the Mental Health Commission We are set for Niereka House in October with Cmsr. Serwin, Cmsr. Stern and Cmsr. Griffin are on that site visit team. There are 18 CCC Beds and since there are two mentors on this team, we have no assigned mentor. I don't have an update on the dates as I received the information to reach out. Cmsr. Serwin and I will need to coordinate reaching out with the introduction letter that needs to be finalized.	
VIII. UPDATE by Nominating Committee, Commissioner Barbara Serwin I am going to turn this over to Cmsr. May. We recently met as a nominating committee and decided Cmsr. May would be the face of the nominating committee. (Cmsr. May) The nominating committee met Tuesday, October 5th at 10:00 a.m. Present were Cmsr. Serwin, Griffin, Maibuam, Hudson and May. The nominating committee met to discuss the election timeline and the guidelines, as well as the roles and responsibilities of the chair, vice-chair and executive committee members. Our schedule is as follows: • October we are soliciting commissioners who want to run for an office and walking them through the time involved and responsibilities involved, in order for them to understand the commitment. • November we will announce the slate of commissioners who are running for office. • December we will hold the elections at our December meeting via zoom. (Cmsr. Serwin) The only thing to add to that report is that the committee will be sending out an email tomorrow (if not Friday) soliciting commissioners interested in running for an office. We will start with email and have a quick turnaround for that mid-next week and would appreciate commissioners watching for that and responding as soon as possible if they are interested in running or if there are any questions about the election or the offices.	
IX. UPDATE on open seats, Angela Beck, Executive Assistant to the Mental Health Commission There are three empty seats: District I Member-at-Large District III Consumer District III Member-at-Large	
X. RECEIVE Behavioral Health Services Director's Report, Dr. Suzanne Tavano, PhD., Director of Behavioral Health Services Dr. Stephen Field has joined me today. We are very focused on getting Behavioral Health Services (BHS) staff fully vaccinated. Our goal is to keep the workforce healthy so they can be available to provide services to clients. We are at 96% of our BHS staff	

are vaccinated and the remaining 4% either have medical or religious exemptions and are being tested weekly. • We are looking into trying to identify some new strategies with the clients we are currently serving who have not yet been vaccinated. We know the names and the programs they are in and are going back to the drawing board to get these clients vaccinated. If anyone has any ideas, we are welcoming your input on how to best engage these clients. We have a couple new strategies we will be trying in the near future. • Staff is increasing-back to providing in person services to the extent clients want to be seen in person. The goal is to have those services available in person to everyone who wants them, at the same time honor the preference to be seen remotely. • Commissioner Dunn is our star taking on the Felony IST as well as public defender Christy Pierce is on the call as well and staying abreast of this. It is not that we are overlooking this in anyway. Many of you know we already have a felony IST diversion grant with the State. We are eligible to expand, but in a limited capacity. So, as Cmsr. Dunn has reported before, the State is offering $140,000 per person that is diverted from state hospitals and it looks as though we can apply for three additional people that we are already serving. The State seems to be very focused on getting more counties participating in the diversion program. Those counties such as ours who are already participating in diversion, they allowed some expansion. Likely not as great as we would like but we will certainly go after it. We have been speaking to the State about how housing needs to be factored into having people return to the community and we will keep you updated as we move forward. • We were able to get approval for additional funding for enhanced board and cares (BACs) and alternative to MHRCs (Mental Health Rehabilitation Center) and looking at high need areas, strong performing programs. If we get some additional funding, we will be investing it in those beds. • There are no numbers for you tonight but we are seeking additional funds and still waiting for a final word on what those projections are. I am happy to say what we were bracing for last year did not come to pass and we are hoping (when CPAW meets) I hope to have this conversation there. It is getting a concrete number of how much additional money we have on the MHSA and taking another look at the plan and hopefully move forward with some of the expansion we have been hoping for. Not sure how much but feeling positive. • Our realignment funds seem to be slated to come in. • The 2-year MHSA Plan we all worked on together was the one we had to pull back and scale down last year. We will go ahead and implementing the 3% COLA (cost of living adjustment) across the board as we possibly can. • Crisis continuum work. I consider the new crisis stabilization unit as part of that continuum. We have been meeting on this every two weeks for the last ten months (if not longer) and we are now at the point that we have a couple of architectural renderings (not plans). The two possibilities we have before us, we just got these yesterday and rather than wait another month, I'd like to share them now. We applied for and received the CHAFFE grant for approximately $2.3mil. This gave us the funds to remodel and build a separate crisis stabilization for youth. • The plan is to repurpose the behavioral health side of Miller Wellness Center (MWC). Some members of the community had been using MWC (after hours) for med refills and drop-ins. There will be a bit of interruption in that service but we are thinking of alternatives to that for the interim. The youth crisis stabilization unit (screen shared renderings) will be up to 9 youths and will be rooms rather than dormitory setting. Dr. Tavano discussed the layout in detail.	
XI. Public comment and questions regarding BHS Director's Report	

Comments and Questions:

- (Cmsr. L. May) I would like to know if it is possible for you to email the plans (renderings) the plans you showed. (RESPONSE: Dr. Tavano) Angela will share via email.
- (Cmsr. L. May) The employees being tested, is that a regular test or the rapid tests. The rapid tests are very faulty. What testing are you using? (RESPONSE: Dr. Tavano) Given that 96% of the staff are immunized, we are using the Binex which is considered the very good one of the rapid testing that is being used by Health Services at the hospital. Our nursing staff are trained and doing the testing ourselves. Before the person walks in, if they are due to be tested, they are tested at the door.
- (Cmsr. L. May) Last question, it is getting near holiday time so I would suggest gift certificates to the grocery stores are a visa, it might encourage some people to get vaccinated.
- (Teresa Pasquini) I just wanted to say how pleased I am to hear about the enhanced funding for enhanced BACs. I do remember MWC and thinking this is not what the community wanted. But it is a good thing, as someone who helped redesign Psych Emergency Services (PES) to reopen the door, it was always a heartbreak to have those children still embedded in that unit so I am really grateful for the work being done. It is an ideal location and great news.
- (Cmsr. G. Wiseman) I know we were looking at the three options to the existing PES facility that there was quite an extensive timeline associated due to hospital construction. Is there an estimate? One year? Ten years? When can we expect? (RESPONSE: Dr. Tavano) That year of work is done and now we are the point of choosing between the two footprints and start moving forward. I was told last week (by next fall we will be ready to open doors.
- (Cmsr. L. Griffin) I want to thank you so much for the exciting news about PES and the new entry for youth and the more beds. I have been an advocate so many years for PES to be better acclimated for children, after touring a couple years ago, it was heartbreaking. I want to thank you we have gotten this far and am very proud of the work we have in front of us. (RESPONSE: Dr. Tavano) Thank you to all of you because it was really all the advocacy from within the community that made a huge difference.

XII. INTRODUCE HealthRIGHT 360, Charmaine Hoggatt, Director, HealthRIGHT 360

I am Charmaine Hoggart and I am the program manager for HealthRIGHT 360 overseeing our programs in Contra Costa and Solano counties. HealthRIGHT 360 (formerly known as Walden House). Walden House was located in San Francisco and provided services to individuals who were homeless as well as runaway adolescent teens who experiencing substance use disorder. Over the years we have evolved and continued to grow. In 2011 Haight Ashbury free clinic merged with Walden House, becoming HealthRIGHT 360. We believe health care is a right, not a privilege. We are in 11 counties in California including: Alameda, Contra Costa, Imperial, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, Solano and Ventura and provide services to over 40,000 individuals annually.

The services we provide are in:

- Social support and re-entry – which include educational, employment and housing services.
- Substance use Disorder treatment – assisting in substance abuse disorder treatment for adults, youth, families which include outpatient, residential, sober living environments and case management.
- Primary medical care – there are a few facilities in SF to provide medical care and evaluation and treatment of mental issues and integrated primary care and

Documentation regarding this agenda item were shared to the Mental Health Commission as a screenshare during the meeting: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

behavioral health services, routine check ups and follow up, as well as women's health. • Mental health services – most all programs offer on-site mental health services including assessment, individual and group therapy. Field training, crisis intervention, all of our programs have therapists who are on-site and provide intervention and support to assist clients and family to better cope to life stressors. Our doors are open to all individuals and encourage family to be a part of treatment and everyday living as a way to reconnect the families to collaborate, educate and support. Since 1996 we have ben collaborating with the California Department of Corrections and Rehabilitation where we have provided substance use disorder treatment to individuals who have been incarcerated. In CCC, we have a reentry program called "HeathRIGHT360 Contra Costa Reentry Network" It works with individuals who are incarcerated, their families and those who have transitioned and reintegrated back into the community. We work with men and women, as well as transitional aged youth (TAY) to provide them with holistic linkage, including peer mentoring, educational and vocational opportunities, employment support, housing, mental health, substance use treatment. We work with those individuals who fall under the AB 109 funding and get our referrals from the central or east CC probation, as well as individual referrals as well as the community-faith providers we work with, such as Shelter Inc, Rubicon, GenderForward, Bay Area Legal aid to name a few. We host monthly seminars and workshops. We encourage participation. We have an incentive program. Based on participation we do provide incentives pertaining to clothing and other items. We provide gift cards for food, clothing, transportation and personal care. We want to ensure the clients we serve in CCC know they have the support they need from our agency to be able to be successful as they transition back into the community. We have three field office operations coordinators who receive referrals. From the start of referral, they contact the individual, perform assessments and create an individual treatment plan based on the needs of the client. As the client progresses through program and complete goals, they receive incentives, as well. There is no real time frame and is based on the individual and their motivation and drive. It is a collaborative partnering effort. The new program starting soon is the California Re-investment grant from the Governor's office. It is a three year grant that provides mental health services, in addition to substance use disorder services. There will be clinician on-site to provide the mental health aspect of the treatment and will be available on client schedule. The clinician will provide individual and group sessions and will be certified (alcohol and drug certification) and work with clients on their treatment plan. In Solano County we have two in custody programs - substance use disorder and a case management program.	
XIII. DISCUSS data resources for Behavioral Health Services and Substance Use Disorder, Steve Hahn-Smith, Behavioral Health Services Chief of Informatics My background is research and approximately six years ago, I left the county and worked for a couple contractors (CBOs) and am back in a brand new position. This position walks the line between BH and the Program needs, System Needs, Data Needs and IT within the county. (Screenshared slide showing an organizational flow chart). The flow chart on screen shows how things work between BHS and IT where all the data is an speak on the systems we use. Behavioral Health Infomatics is pretty small. We have a dotted line to the IT directors and there is one for business systems and clinical systems. The champions and superusers are referencing the EPIC system and the on site help for those that need	Presenter shared slides via screenshare during meeting.

help with EPIC. It has been the big project Health Services started several years before Behavioral Health (2017). There has been a lot of work done, lots of progress but still a lot to do. Our group has a connection to the Executive Level group in BHS (Program chiefs, Director, Deputy Director). This is our link, decision making and prioritizing between us and the IT group.

EPIC/CC Link is where all the documentation and patient data is held and where we have an interface portal for the CBOs to view but are not on the system fully. The billing system is different and makes it quite complicated. It is due to the way we bill that there are some systems we are hoping to move away from. Moving forward, with CalAIM, one of the big changes will be payment reform. We will be moving to more of a typical healthcare billing using CPT codes instead of the archaic system we are currently stuck with until we go live with CalAIM. We have to do the analysis to see what our best options are for BHS overall, including Alcohol and Drug who are currently not on EPIC. We are at a big juncture right now with the payment reforms is in July 2023. The two main systems -- ShareCare (which is billing) and EPIC. Internally, there are a lot and some are better than others. We really didn't have any HR until EPIC and a lot of databases and spreadsheets evolved and many need to be moved over to EPIC so that it is on a more stable platform and we don't have duplicate entries, etc. We are in a period change due to multiple requirements.

Comments and Questions:

- (Cmsr. B. Serwin) I am curious about the (when you speak to) various 'home grown' systems internal to BHS and if you could explain what the adult division collects or the crisis intervention group tracks on and how much cross-record reporting you can do (demographics) and cross over data from detention, reporting on diagnosis, and those things really specific to operations of the division but as well as the Behavioral Health attributes and services. (RESPONSE: Steve Hahn Smith) It depends on the database, such as the mobile crisis data. That is a small program that will probably build out pretty quickly. As Suzanne mentioned, there is a lot of money available for infrastructure (like vehicles) but also for IT. We want to move that triage tool to a platform that is connected to the rest of the medical records (or if they don't have a medical record, it will be created). We have to do things that are not in the traditional health record and in a different system/database but can connect. It is difficult to tell which is the most accurate or up-to-date? Which do we use for a report? The Business Intelligence (BI) Group that we would formally request a report for that, once it is in a system of record (EPIC) it would be much easier to run a report. Our goal is to put everything in a more robust environment, model it the way we need, including the triage piece and call center software for all the incoming calls and how long the call took, where it came from and what city, who was the caller and is there a call back number – then that can be integrated with the triage system. Once it is there, there would be a connector, typically the medical record number (MRN).
- (Cmsr. M. Hudson) I see a tremendous opportunity to streamline information and pull reports, to get the information to the right place, person, group at the right time. Curious the security of that information and how we are safeguarding that? Are there work streams assigned to these specific roles? Is there a breakdown or a general safeguarding system? (RESPONSE: Steve Hahn-Smith) It is pretty heavy IT security system that I am personally not the one to ask but protocol for protecting PHI (personal health information) then we are pretty tight because it is the medical record of the client and have no choice. Reporting would be a higher level that wouldn't be identified to an individual.
- (Cmsr. L. May) When I left the county, we had rolled out EPIC in the clinics and all of us had training and became trainers. Why has it taken so long for it to go from clinics to the hospital to expand like this? Did you not have this infomatics team? Where was the disconnect between the clinics and the hospital?
  (RESPONSE: Steve Hahn-Smith) I wasn't around and don't know. My suspicion is that the project started with the hospital and there was a lot of money to

incentivize and BHS was only eligible for a small potion because it was based MDs/NPs and BHS did not have all that many or possibly scope? It's speculation. (Dr. Tavano) It goes back to funding availability and the number of MDs and RNs. The other part of it is that EPIC really wasn't being used in any BHS and we have been essentially building the ship as we have been flying it. • (Cmsr. B. Serwin) This is more of a case study, I think. The Quality of Care committee is working on the question of demand for treatment related beds and the supply and how we get these things to sync up. So there a lot of data related questions we have and what I don't know, what we do have and is relevant and what is on electronic? what's on paper? What's not even documented? And how many treatment beds does the county contract for? How many does it own? How many clients do we currently have in beds? Where are they located? What are the demographics of the clients utilizing treatment beds? What has been the demand for beds over the past five years? How many dual diagnosis clients do we have? These are examples of questions that we are deeply concerned with. This requires unpacking a lot and going tough it one by one. But how would we approach taking a situation like that and looking for the data? (RESPONSE: Steve Hahn-Smith) I think some of it should be fairly accessible because it's in the EPIC system but I don't know if all the beds are all in the EPIC system, which would men someone is tracking it. (Dr. Tavano) We have a lot of freestanding databases, in fact Steve went around and identified every freestanding database we have and they are still there and a lot of them. There is a lot of data and it is complicated and time consuming to get it all into EPIC so that it is shop place. It takes a fair amount of work for us to put the different info in together. However, it turns up all the beds we're purchasing (master easing, BACs, etc.). I actually wanted to know that and had to go to a bunch of different people to get thein formation and now we have it all in one place. • (Cmsr. L. May) Perhaps we can set a future date that we can get this data? Maybe the first of the year to get some answers to the data you asked for and come to the Quality of Care meeting and do a report out on that sort of thing. Maybe with Dr. Tavano? Those are questions being asked by those coming to the meetings. • (Teresa Pasquini) I might one of those people. I just wanted to say hello and it's good to have you back. I'm happy to see the progress and the org chart, plugged in. It has been a long time coming and we just have to get up to speed with this data. We can't say we are data driven or following the data if we aren't following it, all of it.	
XIV. Adjourned at 6:30 pm	