Joint San Joaquin-Mother Lode/Stanislaus-Merced Sections
Meeting Agenda
Wednesday, May 16, 2018
12:00 – 2:00 p.m.
Health Plan of San Joaquin
7751 S Manthey Road
Pacific Conference Room
French Camp, CA

Meeting Objectives:
1. Decide the preferred geographic scope of the Health Sector Partnership (workforce development)
2. Determine optimal role for local hospitals in addressing problem of homelessness
3. Discuss progress of discussions to improve behavioral health services

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<tr>
<th>Time</th>
<th>Description</th>
<th>Page #</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>12:00 pm</td>
<td>I. Welcome</td>
<td></td>
<td>Paul Rains, Section Chair</td>
<td>None</td>
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<td>12:10 pm</td>
<td>II. Call to Order, Introductions</td>
<td>4</td>
<td>Paul Rains</td>
<td>None</td>
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<td>III. Review of Agenda/Request for Additions</td>
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<td>Paul Rains</td>
<td>None</td>
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<td>IV. Approval of March 14, 2018 Meeting Minutes</td>
<td>8</td>
<td>Paul Rains</td>
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<tr>
<td>12:15 pm</td>
<td>V. Health Sector Partnership Update</td>
<td>14</td>
<td>Brian Jensen, Daniel Wolcott, Lita Wallach</td>
<td>Yes</td>
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<td>Presentation: Brian Jensen, RVP, Hospital Council; Daniel Wolcott, CEO, Adventist Health Lodi Memorial; and Lita Wallach, Director, CHLC</td>
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<td>Discussion Questions:</td>
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<td>1. How should workforce development efforts be integrated across counties in the region?</td>
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<td></td>
<td>2. What should be the geographic scope of the San Joaquin Area Health Sector Partnership?</td>
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<td>12:35 pm</td>
<td>VI. Homelessness</td>
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<td>Brian Jensen</td>
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<td>Presentation: Brian Jensen, RVP, Hospital Council</td>
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<td>Discussion Questions:</td>
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<tr>
<td></td>
<td>1. What is hospitals’ role about homelessness today, and what should it be moving forward?</td>
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</table>
2. How can/should the hospital industry position itself as leaders on this issue?

1:00 pm  VII. Behavioral Health Improvement
*Presentation:* Brian Jensen, RVP, Hospital Council; Paul Rains, CEO, St. Joseph’s Behavioral Health Center; Corwin Harper, SVP/Area Manager, Kaiser Permanente Central Valley

*Discussion Questions:*
1. How can we improve behavioral health across the San Joaquin/Stanislaus system?

1:25 pm  VIII. Political Advocacy
*Presentation:* Brian Jensen, RVP, Hospital Council

1:30 pm  IX. Federal and State Advocacy Report
*Presentation:* Art Sponseller, Pres, Hospital Council

*Issues:*
1. AB 1795
2. AB 3087
3. SB 1152
4. President Transition Plan

1:45 pm  X. CEO Round Table

*Discussion Questions:*
1. Share innovations or announcements.
2. What emerging trends are you seeing?
3. What challenges can benefit from this group’s collective support?

2:00 pm  XI. Adjournment

2018 CALENDAR OF EVENTS

- **San Joaquin-Mother Lode and Stanislaus-Merced Section Meetings**
  - Nov. 2, 2018, 12-2 p.m., Kaiser Manteca Medical Center
  - [https://www.hospitalcouncil.org/san-joaquin-mother-lode-meetings-events](https://www.hospitalcouncil.org/san-joaquin-mother-lode-meetings-events)

- **Developing, Measuring & Documenting Employee Competence**
  - May 18, 2018, Sutter Sacramento

- **LEAD Academy**
  - [http://www.hospitalcouncil.org/lead-academy](http://www.hospitalcouncil.org/lead-academy)

- **Hospital Council 2018 Summit**
  - September 26-28, 2018
  - Portola Hotel and Spa at Monterey Bay
  - [https://www.hospitalcouncil.org/annual-summit](https://www.hospitalcouncil.org/annual-summit)

- **Healthcare Administrative Professionals Conference**
  - October 19, 2018
  - [https://www.hospitalcouncil.org/administrative-professionals-conference](https://www.hospitalcouncil.org/administrative-professionals-conference)
ANTITRUST STATEMENT
HOSPITAL COUNCIL OF NORTHERN AND CENTRAL CALIFORNIA

The Hospital Council of Northern and Central California’s mission is to help our members to provide high quality health care and to improve the health status of the communities they serve. Consistent with our mission, it is the policy of the Council to comply with all applicable laws, including federal and state antitrust laws.

Because our meetings and activities bring competing members together, it is important that all communications are conducted with sensitivity to antitrust considerations. Members should avoid discussing certain topics – both at formal meetings and in informal contacts with other members: Topics to avoid include: prices, fees, rates, profit margins, or other matters of competitive sensitivity; allocation of markets; or refusals to deal with suppliers, customers or other third parties.

Antitrust laws are not violated by collective efforts to obtain governmental action, such as lobbying. However, it is important that such efforts remain confined to obtaining results through the government rather than directly through members’ coordinated conduct in the marketplace itself.
SAN JOAQUIN / MOTHER LODE SECTION MEMBERSHIP

Adventist Health Lodi Memorial  
Daniel Wolcott, President/CEO  
975 South Fairmont Avenue  
Lodi, CA  95241-1908  
Phone 209-339-7560 Fax 209-339-7654  
E-mail: wolcotda@ah.org  
Assistant: Joanne Kerans  
E-mail: keransjc@ah.org

Adventist Health Sonora  
Michelle Fuentes, President  
1000 Greenley Road  
Sonora, CA  95370-4819  
Phone 209-536-5012 Fax 209-536-3500  
E-mail: michelle.fuentes@ah.org  
Assistant: Keri Gunter  
E-mail: keri.gunter@ah.org

Dameron Hospital  
Lorraine Auerbach, Chief Executive Officer  
525 West Acacia Street  
Stockton, CA  95203-9989  
Phone 209-461-3100 Fax 209-461-7578  
E-mail: lauerbach@dameronhospital.org  
Assistant: Ruben Geronimo 209-461-3172  
E-mail: r.geronimo@dameronhospital.org

Doctors Hospital of Manteca  
Brandon May, Chief Executive Officer  
1205 E. North Street  
Manteca, CA  95336  
Phone 209-239-8361 Fax 209-239-8329  
E-mail: brandon1.may2@tenethealth.com  
Assistant: Margaret Miller  
E-mail: margaret.miller@tenethealth.com

Kaiser Permanente Manteca Medical Center  
Corwin Harper, Sr. VP/Area Manager, Modesto/Manteca Area  
1777 W. Yosemite Avenue  
Manteca, CA  95337  
Phone 209-735-4146 (Modesto)  
E-mail: corwin.n.harper@kp.org  
Assistant: Felicia Perez 209-735-4159  
E-mail: felicia.m.perez@kp.org

Mark Twain Medical Center  
Robert Diehl, President/CEO  
768 Mountain Ranch Road  
San Andreas, CA  95249  
Phone 209-754-2515 Fax 209-754-2626  
E-mail: robert.diehl@dignityhealth.org  
Assistant: Amy Molson  
E-mail: amymolson@dignityhealth.org

St. Joseph’s Behavioral Health Center  
Paul Rains, President  
2510 North California Street  
Stockton, CA  95204  
Phone 209-461-2000 Fax 209-467-8107  
E-mail: paul.rains@dignityhealth.org  
Assistant: Jo Martinez 209-461-2021  
E-mail: jo.martinez@dignityhealth.org

St. Joseph’s Medical Center of Stockton  
Donald J. Wiley, President  
1800 North California Street  
Stockton, CA  95204  
Phone 209-467-6384 Fax 209-461-3299  
E-mail: donald.wiley@dignityhealth.org  
Assistant: Diane Bertilacchi 209-467-6512  
E-mail: diane.bertilacchi@dignityhealth.org
San Joaquin General Hospital
David Culberson, Chief Executive Officer
500 West Hospital Road
French Camp, CA 95231
Phone 209-468-6600 Fax 209-468-6136
E-mail: dculberson@sjgh.org
Assistant: Anna Zabala 209-468-6600
E-mail: azabala@sjgh.org

Sutter Amador Hospital
Anne Platt, Chief Executive Officer
200 Mission Boulevard
Jackson, CA 95642-2132
Phone 209-223-7510 Fax 209-223-7509
E-mail: platta@sutterhealth.org
Assistant: Donna St. Clair 209-223-7513
E-mail: stclaid@sutterhealth.org

Sutter Tracy Community Hospital
David Thompson, Chief Executive Officer
1420 North Tracy Boulevard
Tracy, CA 95376
Phone 209-832-6042 Fax 209-832-6091
E-mail: thompsdm@sutterhealth.org
Assistant: Teresa Alonzo
E-mail: alonzot@sutterhealth.org

Brian Jensen, Regional Vice President
(916) 552-7564, e-mail: bjensen@hospitalcouncil.org
Donna Astrinidis, Regional Office Coordinator
(916) 552-7656, e-mail: dastrinidis@hospitalcouncil.org
Hospital Council of Northern and Central California
1215 K Street, Suite 730, Sacramento, CA 95814
STANISLAUS / MERCED SECTION MEMBERSHIP

**Doctors Medical Center**  
*Warren Kirk, Chief Executive Officer*  
1441 Florida Avenue  
Modesto, CA 95350  
Phone 209-576-3754 Fax 209-576-3680  
E-mail: warren.kirk@tenethealth.com  
Assistant: Wendy Zollinger 209-576-3758  
E-mail: wendy.zollinger@tenethealth.com

**Emanuel Medical Center**  
*Lani Dickinson, Interim CEO*  
825 Delbon Avenue  
Turlock, CA 95380  
Phone 209-664-5090 Fax 209-634-9336  
E-mail: lani.dickinson@tenethealth.com  
Assistant: Colleen de Bruyn 209-664-5005  
E-mail: colleen.debruyn@tenethealth.com

**HealthSouth Rehabilitation Hospital of Modesto**  
*Tina Pollack, Chief Executive Officer*  
1303 Mable Avenue  
Modesto, CA 95355  
Phone: 209-857-3421  
E-mail: tina.pollack@healthsouth.com  
Assistant: Victoria Mendoza 209-857-3422  
E-mail: victoria.mendoza@healthsouth.com

**John C. Fremont Healthcare District**  
*Matthew Matthiessen, Interim CEO*  
5189 Hospital Road / P.O. Box 216  
Mariposa, CA 95338  
Phone 209-966-3631 ext. 9  
Fax 209-966-3776  
E-mail: matthew.matthiessen@jcf-hospital.com  
Assistant: Kym Brownell  
E-mail: kymberly.brownell@jcf-hospital.com

**Kaiser Permanente Modesto Medical Center**  
*Corwin Harper, Sr. VP/Area Manager, Modesto/Manteca Area*  
4601 Dale Road  
Modesto, CA 95356  
Phone 209-735-4146  
E-mail: corwin.n.harper@kp.org  
Assistant: Felicia Perez 209-735-4159  
E-mail: felicia.m.perez@kp.org

**Memorial Hospital Los Banos**  
*David Thompson, Chief Executive Officer*  
520 West I Street  
Los Banos, CA 93635  
Phone 209-826-0591 ext. 316  
Fax 209-826-1943  
E-mail: thompsdm@sutterhealth.org  
Assistant: Margie Lagmay  
E-mail: lagmaym@sutterhealth.org

**Memorial Medical Center**  
*Linda Horn, Interim Chief Executive Officer*  
1700 Coffee Road  
Modesto, CA 95355  
Phone 209-572-7289 Fax 209-569-7417  
E-mail: hornl@sutterhealth.org  
Assistant: Beth McKinsey  
E-mail: mckinshb@sutterhealth.org

**Mercy Medical Center Merced**  
*Chuck Kassis, President*  
333 Mercy Avenue  
Merced, CA 95340  
Phone 209-564-5001 Fax 209-564-5096  
E-mail: chuck.kassis@dignityhealth.org  
Assistant: Marty Nambatac  
E-mail: marty.nambatac@dignityhealth.org
Joint San Joaquin-Motherlode/Stanislaus-Merced Sections

Minutes

Wednesday, March 14, 2018
12:00 – 2:00 p.m.

Kaiser Manteca Medical Center
1783 West Yosemite Avenue
Tahoe Building, Room A
Manteca, CA

Meeting Objectives:

1. Share challenges, emerging trends, and suggestions for collective action
2. Prioritize public policy efforts for 2018
3. Prepare to engage county and other stakeholders to improve behavioral health services in 2018

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<tr>
<th>Time</th>
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<tbody>
<tr>
<td>12:00 pm</td>
<td><strong>I. Welcome</strong> – Chair Corwin Harper and Hospital Council RVP Brian Jensen</td>
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<td>12:10 pm</td>
<td><strong>II. Call to Order, Introductions</strong> – Chair Corwin Harper called the meeting to order at 12:05 p.m. All attendees introduced themselves. Corwin encouraged all to follow his lead and write a check to CHPAC.</td>
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<td><strong>III. Review of Agenda/Request for Additions</strong> – Add discussion of phone conference with Modesto Junior College scheduled for tomorrow regarding funding of nursing program by area hospitals. Also – addition of Item VII.</td>
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<td><strong>IV. Approval of October 24, 2017 Meeting Minutes</strong> – Correction requested in Section V to Stanislaus County (not San Joaquin County). Motion for minutes to be approved as corrected was made, seconded and approved.</td>
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| 12:15 pm      | **V. CEO Round Table**
What challenges can benefit from this group’s collective support?
Don Wiley, St. Joseph’s Medical Center Stockton: Payer issues with Health Plan of San Joaquin (HPSJ), and now Med Corp Health Plan. He may be largest provider in the room with those plans and is having to work extra hard to get paid.
Any others experiencing the same? John McCormick, Oak Valley: Is having major problems HPSJ they are trying to fix.  

Discussion – Brian asked if more conversation about this is needed re denial rates, or other issues.  Don will work with Brian if they’re the only ones experiencing these issues.  

Brian described his function on the HPSJ board and asked all to engage with him about any HPSJ issues so he can address with the board.  

Health Information Exchange (HIE) John indicated he would like to have the exchange in place for purposes of competition.  He would like to know what options are available for behavioral health – how many counties have HIEs?  San Joaquin General Hospital (SJGH) has HIE, and Dave Culberson named the participants in San Joaquin and Stanislaus Counties.  San Joaquin Behavioral Health is interested in moving ahead.  SJGH is in as a sponsor but not active in it.  Mark Ellson – Intrepid Ascent – has contacts around the state.  Linked up with Inland Empire HIE, which merged with CAHIE.  Mark is the contact to bring everyone up to date.  Sustainability and usability are always an issue.  

Daniel Wolcott, Adventist Lodi Memorial: Is interested in participating at a higher level of data if going down that road.  He needs to be enough info to make things different for his physicians.  

Brian described the Sacramento Health Information Partnership (SHIP) and working with Rim Cothren of the California Health Information Exchange (CAHIE).  CAHIE is a clearinghouse for protocols, agreements, process, provides some services in some cases.  

SHIP is using a different approach – HIE means a structured entity.  Because of Sac County circumstances, there has been resistance to that.  Many spent millions on HIEs and are still onboarding.  There is latent interoperability, figuring out how to connect with use case and purpose.  Sac conversation regards the alternate destinations pilot project – need the data piece to support it, and decided rather than set up another HIE (unsustainable), with first responders they are building interoperability working through a vendor that can connect the patient care records with hospital EHR.  CAHIE recommends this path: start narrow, prove the value, it grows organically from there.  Does this group want a deeper dive on this?  

John: It’s mentioned as a strategy in the Behavioral Health Task Force report.  

Daniel likes picking a use case, operationalizing, and asked if the area hospitals are willing to make the investment to make it work.  Would need compelling enough use case to make it work.  

Paul Rains, St. Joseph’s Behavioral Health Center: There are regulatory barriers around what information can be shared.  On Jan. 1, CMS changed the rules that EDs can communicate with anyone as long it’s among them, i.e., ED to ED only.  Cannot share between behavioral health providers and EDs.  Need to improve regulations re patient info sharing.  

Is there a regulatory solution needed?  

Corwin – maybe there’s a use case around opioids / narcotics issue that would put a different spin on it for hospitals to partner with pharmacists and pharmacies.  These patients are difficult to manage and hard to staff.  Mentioned violence against staff.  Angle around opioids and drugs.  HC do research on these use cases and see if there’s energy to build on it.
Brian referred to the previous section meeting when there was a presentation on opioid abuse prevention. Senses there is interest in stepping into HIE.

Corwin – third potential use case – taking on diabetes, highest health problem.

Daniel – if we had data, what positive way would it be used to change care? How would changes be made with EHR and integrate into workflow? What about a patient bringing a paper record with them – portable records – perhaps a more feasible way to get it done.

“What keeps you up at night?”
Corwin: the economy and growth for this area. Population suffers from lower Medicare reimbursement rates compared to others. Is watching more people being forced into this area. High cost of housing / gentrification – not sure how prepared the area hospitals are to deal with the onslaught of patients. Lots of residents are not the usual Central Valley people. They’re from the Bay Area. Need to help more organic businesses come to the area. How do we support / build infrastructure for this area?

Bob Diehl: AB 2024 – new way hospitals can hire doctors directly. It was introduced as an experiment. His hospital started using it. CHA said track when they use it and how they use it, and outcomes. Got to CMA and got 7 years to try it out, and they’re in the second year to see if it’s a good way to recruit physicians without “upsetting the apple cart.” For certain physicians, it works. 5 years from now it could be a chink in armor – all hospitals start hiring physicians like the rest of the nation.

Brian: For non-critical access hospitals – is this helpful? Michelle asked how this will impact tax strategy. New tax laws will be more advantageous for physicians to be on 1099 instead of W-2.

Regulatory environment around this is burdensome and archaic (Daniel). Would be good to do something about regulations.

Bob: Watch and see how hospitals are doing with it and act accordingly.

Corwin: Delivery system and payer mix trumps tax.

Brian: Tecap: HIE/ record sharing around opioid / diabetes; concern re how to prepare for and encourage economic growth in the region, how to brace for meeting health needs. Tracking employment model for physicians.

Corwin – at some point need to know how the collective voice here impacts DC. Need to be a voice of reason around economic development.

1:00 pm  VI. Behavioral Health Task Force Report
Presentation: Brian Jensen, RVP, Hospital Council; Paul Rains, CEO, St. Joseph’s Behavioral Health Center
Brian recapped the process of how the report came to be, and how to use the report. Behavioral Health (BH) is top concern of the membership. Described the Behavioral Health Task Force team. Report is the result of that work – identifying common problems / issues / gaps / shortcomings / potential solutions. Not meant to be prescriptive. Second half of effort is to determine best fit for the health care provider reality. How to roll this out with collaborating parties in your county with county partners. Each community is different.

What in the report stood out to you? How would you apply collective wisdom to local circumstances?
Paul – some recommendations in this document restate recommendations from over some years. Some of the models have been tried. Mentioned the successful BH paramedicine pilot in Stanislaus county. Goal – seem to be moving in a direction with more substantive conversations in trying to bring the right people to the table to get something done.

Brian: what are your BH challenges? Avg BH patients in an ED is 7-8 on a daily basis. Hospitals are trying to not put them in an inpatient bed.

Don: It seems like the community believes hospitals are the last resort for placing a BH patient and hospitals are expected to deal with it. It is a systemic issue due to lack of available psychiatric care. This area is one of the worst. Need scaffolding for this population of people.

Foothill counties – what’s happening? Bob Diehl described “hot potato” drop off to his hospital.

John: In Orange County (OC) a study showed that law enforcement is not very well trained to deal with the BH populations. Training shifted to paramedics. What stood out in the OC report was putting more pressure on the counties to fulfill their obligations.

Brian described Rideout’s innovation that got them the Innovation Award at the Summit for their solution in getting BH patients through the hospital and county systems. Working with County Behavioral Health, BH staff is located in the hospital ED, available for immediate patient assessment and disposition. Rideout helped County BH with the concept that every person who comes into the ED is an emergency, with the same assessment and disposition requirements as a patient with emergency medical needs. No medical patient is boarded in an ED for days, and it should be the same for BH patients. The system has been successful. They have very little BH patient backlog in their ED.

Brian: CA Behavioral Health Directors Assn. embraced the BHTF report and gave feedback. The report is helping co-convening with the counties. San Joaquin and Stanislaus were identified as counties for additional research. For smaller counties, a toolkit was created to model solutions.

How to move forward with Stanislaus County leaders? Contact county people, be sure they have the report and start a dialog. There are technological solutions in the report that can start conversations around real solutions / what we can do.

In Stanislaus County there is a meeting with county and stakeholders to define gaps.

Paul: real plans with real solutions are needed. Resources in the community are lacking. Brian asked if there should be a San Joaquin / Stanislaus bi-county meeting for this. Yes, have them both together.

Dave Culberson mentioned Whole Person Care in San Joaquin county. MHSA – new activity, new money. There are unspent funds in all the counties.

Corwin: Determine needs in the county and use the money to create the resources. Who needs to be in the room from the county? County administrators, county mental health directors – make a list of people that will convene. Corwin Harper offered to facilitate.

Brian: if doing this as 2-county approach, will require commitment from hospitals to drive this. CEO or designee is committed to the process with decision-makers at the table.
to inform the problems and solutions. Be there as one part of the community instead of owning it.

2-county task force? Yes – all concurred. Corwin will find meeting space. Brian will share the BHTF Report Tool Kit with Michelle Fuentes (Adventist Sonora).

MAKE ASK CLEAR. Corwin will frame up the request.

1:25 pm VII. **Health Sector Partnership Update**

**Presentation:** Brian Jensen, RVP, Hospital Council and Daniel Wolcott, CEO, Adventist Health Lodi Memorial

Brian gave history of the workforce partnership and making workforce development a priority. Last year a proposal was made to Health Sector Partnership. It got off the ground. Funding was made available. It’s clear everyone in this room has openings for nurses, psych techs, etc., obvious this needs to be worked on. Community College funded much of Health Sector Partnership, so education partners are at the table. More to report at April 23 meeting for hospital CEOs – “go / no go” decision on this. June will be final meeting to commit or not. Things are moving along, dozens of health care leaders and education leaders have been working on this for months.

Corwin: San Joaquin County is talking about doing infrastructure funding. Then other counties come on board.

Brian: Start and expand over time, or start with both counties?

Corwin mentioned Modesto Junior College losing 1/3 of its nursing program funding because Tenet backed out of the next funding cycle. Infrastructure is needed. How to keep MJC program going? Need to decide.

Brian gave history of MJC funding, which was discussed at October 2017 meeting.

1:40 pm VIII. **Political Advocacy**

Brian Jensen, RVP, Hospital Council

CHPAC – political advocacy includes financial support. It’s part of the process of electing people supportive of healthcare. Discussed CHPAC donation stats on the front page of the agenda. If want to continue to having ammunition needed to deter CNA, SEIU, etc., contribute to CHPAC. Hospital Council’s Board of Directors made 100% commitment to participate. Now the same request is being made at section level. Sac Sierra agreed to do this at section level via motion.

Corwin: after sitting on the CAHHS Board for 6 years and watching Duane Dauner’s navigation through the political arena with legislators, he can’t help but give. There were many strategy meetings about when to use / how to avoid using funds. Corwin noted his name tent card showing CHPAC donation level - gave his form today and encouraged all to do the same. Brian talked about CHPAC Coordinator role at the hospitals. HC will send info.

Corwin: Make next 6 months the transition time to help people understand the value of giving to CHPAC.

Brian indicated he will send minutes from today’s meetings, forms to contribute, and coordinator form, and will ask who to talk to about their CHPAC goals.
Transition this year – Art Sponseller is retiring as Pres/CEO. Plan for succession is in place. Same search firm for Duane Dauner’s replacement, Executive Search, is working for Hospital Council. Corporate assessment is going on for what members want, and search for new President/CEO. Job description will be out in spring; it is anticipated a new CEO will be in place in the fall. Art will be available but not in the building after hire of new person.

2:00 pm X. **Adjournment** – The meeting adjourned at 2:00 p.m.
### Decision Points:

- **Funding**
- **Regional Scope**

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<tr>
<th>Hospital Council of Northern and Central California Information for Decisions on Funding and Regional Approach to the San Joaquin Area Health Sector Partnership</th>
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<tbody>
<tr>
<td>This document is in response to a request for information on the following:</td>
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<tr>
<td>1. What would be in our collective best interest for funding a health sector partnership? <strong>Funding</strong>: At what level?</td>
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<tr>
<td>2. How can the San Joaquin Area Health Sector Partnership ‘embed and expand’ to meet the micro geographic needs of Stanislaus County and the surrounding region?</td>
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### Historical Perspective

**Perspective: San Joaquin County**

The Executives Council of the San Joaquin Area Health Sector Partnership identified a ‘next step’ action step to consider the following:

- Maximize resources between academia and hospitals to address healthcare workforce shortages.
- Commit to a July 1, 2018 launch of the partnership.
- First year deliverables shall begin with the RN Pipeline Pilot (acceleration pathway model). Other pilots now developing.
- Increase salary for Executive Director (add cost for health benefits for Executive Director and one Administrative Staff).
- Initiative partnership with an Interim Director and hire permanent staff no later than January 2019.

**Perspective: Stanislaus County**

Stanislaus Community Foundation and Stanislaus County Workforce Development have requested the San Joaquin Area Health Sector Partnership to consider a regional approach (see Stanislaus RFI handout).

### Potential Shared Principles and Core Values

**Principles and Core Values:**

- Equitable governance of the partnership
- Well managed and cost effective organizational structure and staffing of the partnership
- Collective advocacy and synergy – collaborate across geographic boundaries and funding silos
- Metrics-based decision-making
- Accountability
The organizational structure demonstrates the relationship and communication among the partners, staff and stakeholders. This is a preliminary concept than can be adapted to accommodate new partners and expanded stakeholders.
## Partnership Timeline:

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<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>2016</td>
<td>Initiate Health Sector Partnership Exploration and Feasibility</td>
</tr>
<tr>
<td>2017</td>
<td>Executive Council formed (Strategic Planning Funding Committed: SJDC $100K; Hospitals $68K)</td>
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<tr>
<td>2018</td>
<td>April 23, 2018 SJAHSP Executive Council – preliminary approval of partnership (funding/staffing). Hospital partner members agree to discuss funding at the May 16, 2018 Hospital Council meeting. May 16, 2018 Hospital Council quarterly meeting June 14, 2018 SJAHSP Executive Council meets for final approval for the San Joaquin Area Partnership June TBD Regional perspective exploratory meeting July 1, 2018 San Joaquin Area Health Sector Partnership launches (TBD: Consider name change)</td>
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## Budget

<table>
<thead>
<tr>
<th>Revised after 4/23/18 Executives Council Meeting:</th>
<th>Proposed Annual Budget (July 1, 2018 – June 30, 2019)</th>
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<tr>
<td>Executive Director</td>
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<td><strong>Total</strong></td>
<td><em><em>$271,500</em>/year</em>*</td>
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*Executives Council 4/23/18 meeting directed SJAHSP Project Staff to:
- Increase Executive Director salary from $110k to $150k and to add amount for providing health benefits.
- Consider commitment for 3/year funding with an evaluation in year 4.

## Contact:

Lita Wallach / [lita.wallachconsult@gmail.com](mailto:lita.wallachconsult@gmail.com) / 209.210.8898

*Coming together is a beginning; keeping together is progress; working together is success*

*Edward Everett Hale*
DATE: April 6, 2018

TO: Member CEOs

FROM: Art Sponseller, President/CEO

SUBJECT: Homelessness

SUMMARY

Homelessness has emerged as an increasingly severe problem throughout California. The issue of homelessness and safe discharge from hospitals has triggered strong reactions from state and local elected officials. In March, Sen. Ed Hernandez (D – Los Angeles) introduced Legislation (SB 1152 – Hospital patient discharge process: homeless patients) which would place new burdens on hospitals and create additional negative attention about a perceived lack of hospital support for homeless patients.

The Sac Bee is running a series on “homeless patient dumping” by hospitals and has gone as far as promoting a LA like ordinance for Sacramento. Significant advocacy with the Sacramento City Council, the Mayor’s Office and the County Board of Supervisors is underway. Hospital are working together to standardize and strength discharge protocols and to improve hand-off communication with shelters. Politicians in Santa Clara and Alameda counties are highly engaged on the homelessness issue and have yet to target hospitals.

Hospitals and systems participate in many local collaboratives addressing homelessness and invest community benefit funds in programs to address homelessness. As you consider your responses to the discussion questions for the meeting, please consider the following:

- Are there other ways to frame the issue and hospitals’ role in addressing homelessness?
- Is homelessness a co-morbidity like other chronic disease?
- Do hospitals want to play a visible community-wide (statewide) role in addressing the issue? And, if yes, in what manner?

REQUESTED ACTION

Provide guidance to Hospital Council staff to develop a policy for discussion at the July board meeting and at the April CHA Board of Trustees meeting.

DISCUSSION

With respect to homelessness, the hospital community is being painted by some as the problem, especially regarding discharges of homeless individuals.
1. What is hospitals’ role about homelessness today, and what should it be moving forward?
2. How can/should the hospital industry position itself as leaders on this issue?

BACKGROUND

In recent months, there have been several news stories alleging improper hospital discharges of homeless individuals. CHA and the Regional Associations have been anticipating state legislation that will require hospitals to develop discharge protocols for homeless individuals. State Senator Hernandez has introduced SB 1152 which, if passed, will require hospitals to implement a homeless discharge plan and process, require hospitals to obtain a written confirmation from the homeless shelter receiving the patient before being discharged, and ensure the patient is clothed in weather appropriate clothing, released in the daytime hours and with appropriate medication. Hospitals would also be required to create a written plan for coordinating services and referrals of homeless patients with the county behavioral health agency, health and social services agencies in the region, health care providers and nonprofit social services providers.

South Bay
At the last section meetings, members directed RVP Jo Coffaro to create a Discharge Planning Task Force in both Santa Clara and Santa Cruz Counties. The purpose of these groups is to review hospital discharge plans to identify commonalities and gaps. Once this work has been done, the hospitals will meet with the local shelters, non-profits, and homeless advocates to explore ways all these organizations can work together to better meet the needs of this population.

Alameda
Board of Supervisors Homeless Solutions Summit on February 22. RVP Rebecca attended the morning session of this Summit, which brought together County and City leaders, policy makers, homeless advocates, and a few hospitals and other community leaders. In the morning, Summit participants heard from elected leaders and advocates regarding challenges and best practices, as well as from individuals currently experiencing homelessness. Participants then brainstormed ideas to address homeless encampments, housing and displacement, as well as opportunities for greater regional collaboration.

Sacramento
Media coverage of homelessness in the Sacramento Bee began to focus on hospital discharge practices in early January 2018. Allegations of patient dumping led members of both the Sacramento City Council and Sacramento Board of Supervisors to express interest in a local ordinance to stop it. The Hospital Council has organized the health systems in the county to engage and educate local elected leaders on the reality of the situation. The effort seems to have redirected focus from regulation and punitive action to partnering on additional programmatic improvements. Hospital Council members continue to meet aggressively to advance government relations and media relations strategies.

Attachments:
January 8, 2018 Sac Bee article
February 14, 2018 Sac Bee article
It was a scary thing.’ Hospital dumps senior at homeless shelter. He’s not the first

Arlan Lewis, 77, sits in Friendship Park in Sacramento. Lewis said on Dec. 11 he was released from a Woodland hospital and dropped off at the Union Gospel Mission in Sacramento. The shelter had no bed for Lewis and he had no family he could call. “It was a scary thing for me,” he said. Randy Pench rpench@sacbee.com

By Cynthia Hubert
chubert@sacbee.com
January 08, 2018 04:00 AM

Arlan Lewis, nearly 78 years old and hobbled by arthritis in his right hip, remembers feeling disoriented when a taxi dropped him in front of Sacramento’s Union Gospel Mission one afternoon last month.

He had just been discharged from Woodland Memorial Hospital, about 20 miles away, where he had spent more than a week undergoing psychiatric evaluations after sheriff’s deputies picked him up in Carmichael as a potential danger to himself or others.

Lewis, a former cook who recently had become homeless after his Social Security check no longer covered his rent, had not asked to be taken to the mission. Standing in an unfamiliar place where dozens of grizzled men were sprawled along the sidewalk waiting for one of the agency’s 60 shelter beds, he approached swing shift supervisor Bobby Chatman.

“I have a reservation,” Chatman recalled Lewis saying. Chatman said Lewis showed him his hospital paperwork, which directed he be sent to the mission. But the shelter had no bed for Lewis. It does not take reservations.
“It doesn’t work that way here,” Chatman told Lewis. “We’re first come, first served.” He said no one from Woodland Memorial Hospital had called the shelter in advance. He also noted that Lewis had not undergone a tuberculosis test, a requirement for admission to the shelter, nor would his achy legs be able to navigate the building’s staircase to its dorm room.

With no identification, no phone and no family he could call, Lewis wandered the mission’s campus until late that night, when he sat in its “warming center” for a few hours, he said. In the morning, with the help of a sympathetic stranger, he made his way to Loaves & Fishes homeless services complex on North C Street, where staffers went to work to find him a board and care home.

He is safe now, having found a place to live in the Valley Hi neighborhood, he said. But he is baffled about the circumstances surrounding his discharge from the Woodland hospital, operated by Dignity Health.

“I was outside with this big, huge crowd of homeless people,” Lewis, tall and thin with expressive blue eyes and a missing-tooth smile, recalled on a recent afternoon. “It was a scary thing for someone my age. I didn’t know what to do. Why would they send me there when they didn’t even have a bed for me?”

Robin Oliver, vice president of communications for Dignity Health, declined to address Lewis’ case specifically. She issued a statement saying that Dignity is “committed to providing the basic needs of any patient identified as homeless.”

Lewis’ situation is hardly uncommon, said administrators of shelters and other nonprofit groups that serve homeless clients. They refer to the behavior as the “dumping” of patients who are poor or homeless, and said it is occurring with increasing frequency as the Sacramento region’s homelessness crisis deepens.

Local hospitals face a common dilemma as they cope with a growing number of homeless patients. Where do they send people who have no permanent address when they are ready to be released from care? Shelters can be an acceptable option, but only if prior arrangements are made for lodging and care, health specialists said. In many cases, shelter plans are never made or fall by the wayside, administrators and others said.

“Unfortunately, it happens all the time,” said George Kohrummel, assistant director of Friendship Park, the primary gathering place at Loaves & Fishes, which serves meals and provides a variety of other services to some 700 homeless men and women each weekday. At least once a week, a medical transport van, taxi, Lyft or Uber will drop off a newly discharged hospital patient to the complex, he said.

Sometimes, the patients are still in their hospital gowns and slippers, he said. Some are dropped off after Loaves has closed for the day, and arrive without needed wheelchairs, canes and prescriptions. Many are too frail to navigate the streets.

Loaves has no overnight beds, Kohrummel said. “If I see something like this happening, I’ll have the ambulance or the taxi take them right back to the hospital.” He is unsure what happens to them after that, he said.

Joan Burke, advocacy director for Loaves, said the system for serving an estimated 2,000 homeless people in Sacramento County “is over-saturated. But hospitals have a moral and legal duty to discharge people to a suitable place.”

Brian Jensen, regional vice president of the Hospital Council of Northern and Central California, agreed. But if some people fall through the cracks, “it’s not for a lack of good intentions or effort,” he said.

California’s Health and Safety Code requires hospitals to have a discharge policy for all patients, including those who are homeless. Hospitals must make prior arrangements for patients, either with family, at a care home, or at another appropriate agency, the code says. But the task is easier said than done for health
professionals dealing with people who have no place to live and may have mental illnesses and other complicated problems, said Jan Emerson-Shea, vice president of external affairs for the California Hospital Association.

“Hospitals try to do a ‘warm hand-off’ if possible,” Emerson-Shea said. “But if the person is homeless, who do the hospitals call? There are only so many shelter beds. It’s a huge problem in California.”

Sometimes, homeless patients insist on being taken to specific shelters or agencies, or simply released to the streets, she said. In some communities, such as Los Angeles, patients are sometimes dropped off on skid row “because that is, in fact, where the services exist in that area for homeless people.”

But the failure of some hospitals in L.A. to make prior arrangements for homeless patients has spurred a rash of lawsuits alleging “dumping” of poor people. In 2016, a Hawaiian Gardens hospital agreed to pay $450,000 to settle a lawsuit filed by the city for sending a homeless woman to skid row with no identification and wearing only paper pajamas. The settlement was part of a crackdown by the city attorney’s office on such practices.

The Sacramento City Attorney’s Office did not respond when contacted with questions about patient dumping and whether the city was investigating the issue.

Lewis said he became homeless about two months ago, after the rent on his apartment in Carmichael rose dramatically and he no longer was able to survive on his $1,500 monthly Social Security check. Before he was picked up by sheriff’s deputies in early December, he said, he slept behind a big-box store in the neighborhood. Sheriff’s deputies took him into custody on a psychiatric hold after they received a call about him knocking on doors and looking into windows. Lewis said he was seeking help after he had been mugged and robbed of his belongings.

Lewis said he had never been homeless before. He has been to prison for drug infractions, records show, but has had no significant brushes with the law in 20 years.

The Sacramento County Sheriff’s Department confirmed they detained him on Dec. 5 and took him to nearby Mercy San Juan medical center, where he said he was held for about a day before being taken by ambulance to another Dignity Health facility, Woodland Memorial Hospital, for further psychiatric evaluations. He was there about a week, he said, before he was told by hospital personnel that “my ride” was waiting for him outside. He was happy to leave the facility, he said, but never was told where he was going. When he entered the cab, the driver informed him he was being delivered to the Union Gospel Mission.

That evening he met a local homeless activist, Tom Armstrong, who notified Loaves & Fishes and others about Lewis’s plight. Loaves & Fishes staffers contacted various nonprofit groups and housing agencies, and the organizations managed to find a board and care home for Lewis within a day.

Oliver, of Dignity Health, said the hospital group helps patients who need transportation and lodging after they are released from inpatient care. Those plans are specific to each person, and “may include providing transportation and determining bed availability at shelters,” she said.

She noted that Dignity Health works with community partners to provide services to homeless people, including mental health outreach and interim care for those recently released from the hospital.

Officials at Sutter Health, which is considered a local leader in innovative programs for homeless people, said hospitals have an obligation to make sure all patients are released to a safe setting.

Sutter’s staffers prepare detailed “transition of care” plans for homeless patients who remain frail but are well enough for release from the hospital. The plan might include respite care at one of about three dozen
beds at Volunteers of America and Salvation Army for recently released homeless patients, said Keri Thomas, vice president of external affairs for Sutter Health Valley Area. Depending upon their needs, patients can receive “wraparound” services including substance abuse treatment and help with finding housing and resolving insurance issues, Thomas said.

“The goal is to give them that warm hand-off instead of putting them in taxis,” she said. “It’s something our hospitals take very seriously.”

The respite beds are available to patients released from hospitals throughout the city, Thomas said. But they often are occupied, or patients refuse to accept them. If homeless patients want to be discharged elsewhere, “it is imperative” that hospitals contact the receiving agency to make arrangements, Thomas said.

Kaiser Permanente, another large hospital group in the area, said it employs similar practices. “While we can provide a patient with options regarding shelter when discharged, if the patient is deemed mentally stable and capable of making his or her own decisions, we must comply with the patient’s preferences,” said Sandy Sharon, senior vice president and area manager for Kaiser Permanente Sacramento.

Sometimes, patients decline help and “opt to leave on their own,” said UC Davis Medical Center spokeswoman Karen Finney. In such cases, a case manager or social worker will attempt to contact the wayward person “as long as there is a way to communicate” with him or her.

Wellspace Health, which oversees a network of clinics that provide health care for poor people, works with all of the area’s hospitals to ensure that homeless patients are discharged safely. CEO Jonathan Porteus said the collaborative system works well. “This is (bewildering) to me,” he said of the “dumping” allegations. “We have a robust mechanism for people who are homeless being discharged from hospitals, so I can’t imagine how this would happen.”

“There are lots of reasons that hospitals want to make sure that patients transition to a safe place,” Porteus said. Those include “a sense of what is the right thing to do, legal reasons, public relations reasons. I’m truly surprised that this would occur.”

Chatman at Union Gospel Mission, where Lewis wound up after his release from Woodland Memorial, said the shelter had no information about him before his arrival in the late afternoon of Dec. 11. “It put me in a tough place,” he said. “It kind of broke my heart that we couldn’t take him.”

Similar scenarios play out at the shelter “probably two or three times a month,” said Pastor Tim Lane, director of the mission. “We’ve had people come in by taxi in night clothes, telling us the hospital sent them here. Sometimes they’re in the middle of convalescing, and are in no position to be out on the streets.”

Michele Steeb, CEO at St. John’s Program for Real Change, recalled an incident in July in which a taxi delivered a homeless, mentally ill woman to the agency without advance planning. The woman arrived in pink pajamas carrying a Cabbage Patch doll and a diaper bag filled with baby bottles and other items for infants, Steeb recalled.

St. John’s, which runs a shelter and job preparation program for homeless women and children, is consistently full, and not equipped to treat severe mental illness, Steeb said.

When the woman arrived, “I approached the cab driver, and I asked, ‘Who ordered her here?’ ” Steeb said. “He showed me paperwork from the Stanislaus County Department of Behavioral Health.”
Steeb fired off a note to Sacramento County health authorities, with the subject line reading “Dept of Behavioral Health of Stan Cty dumped one of their clients on our doorstep today ... ” Sacramento County administrators said they would investigate.

Richard DeGette, director of the Stanislaus County agency where the woman’s paperwork showed she received care, told The Bee he was unable to talk about specific cases because of privacy concerns. But he emphasized that patients can choose their destinations once they are released from county care. “If an individual who is not on conservatorship requests to go somewhere else, they’re able to move freely to that location,” DeGette said. “If the individual decides to accept a taxi voucher from our agency, we will provide that.”

However, he said, “our goal is to maintain services within the county.”

Tara Cryderman, a therapist who works at St. John’s, said she evaluated the Stanislaus County patient shortly after her arrival.

The woman, who The Bee is not identifying by name, “was not able to have a conversation that was cohesive,” Cryderman said. “She was seeing things that weren’t there.” The woman told Cryderman that she had schizophrenia, and wanted to go to a psychiatric hospital, the therapist said. St. John’s helped her get admitted.

“It was a horrifying situation,” Steeb said. “This is not how we should be treating human beings.”

Kohrummel of Loaves & Fishes said he fears for the lives of some people who end up at the agency following hospital stays. “What are we going to do with someone who is not stable and they’re dropped off?” he said. “People like that can die from exposure out here.”

Sometimes, in desperation, Kohrummel said, he has taken people who are too ill or weak to be outside to a fire station on the Loaves campus. “I’ll tell the paramedics, ‘She’s having a hard time breathing,’ ” he said, knowing that the words are code for the need for emergency care. “She has to go back to the hospital.”

Forcing city paramedics and ambulances to transport homeless patients back and forth “is a poor use of taxpayer money,” Kohrummel acknowledged. “It’s a vicious cycle. But in some cases I feel I have no choice.”

Last month, said Kohrummel, a medical transport van pulled onto the Loaves campus with an elderly homeless woman who had just left a Sacramento hospital. She was missing a leg, he said, but “she had no wheelchair, no walker, no prosthetic. Yet she said the hospital instructed them to bring her here, and they were putting her out on the sidewalk.”

“I told the driver to turn around and return her to the hospital,” Kohrummel said. He said he could not recall which hospital had cared for her. “There are so many of these situations,” he said. “I lose track.”

Lewis said his brief time on the streets has made him even more grateful for a warm place to sleep. But he still has flashbacks about the nights when he was without shelter, ever wary of strange places and sounds.

“When you’re out there in the dark, you close your eyes but you never sleep,” he said. “It’s the scariest thing ever.”

Cynthia Hubert: 916-321-1082, @Cynthia_Hubert

“I was outside with this big, huge crowd of homeless people,” said Arlan Lewis, recalling the recent December day when he released from a Woodland hospital and dropped off at Sacramento’s Union Gospel Mission. “I didn’t know
what to do. Why would they send me there when they didn’t even have a bed for me?” Randy Pench
rpench@sacbee.com

Read more here:
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Lara Woods, 46, underwent cancer surgery at UC Davis in January. A social worker told her she had a recovery bed at the Salvation Army, she says. But when she arrived, she was turned away and wound up sleeping in her car. Randall Benton The Sacramento Bee

Dumping patients at homeless shelters ‘a systemic issue’ in Sacramento, new survey says

BY CYNTHIA HUBERT

chubert@sacbee.com

February 14, 2018 12:01 AM
Updated February 15, 2018 09:05 AM

Days after her double mastectomy surgery late last month, Lara Woods still had drainage tubes dangling from her chest when a ride-share car delivered her from UC Davis Medical Center to the Salvation Army building near downtown Sacramento.

Woods, fighting a second bout of potentially deadly breast cancer, had been told by a UC Davis social worker that a respite bed was awaiting her at the homeless shelter upon her discharge that day, she said. But when she arrived, staffers told her that no prior accommodations had been made for her, and the agency’s beds were all occupied.

She ended up walking to a friend’s house nearby, she said. The friend helped her retrieve her car, and that’s where Woods slept that night. Weeks later, she continues to live out of her Kia.

To homeless advocates, Woods was a victim of what’s known as “patient dumping,” or the discharge of poor people from hospitals and other health care providers to shelters or the streets without advance planning.
The Salvation Army did not return calls Tuesday asking for comment on the matter. UC Davis declined to address the specifics of the Woods case, citing patient privacy, but spokesman Charles Casey said the hospital system makes every effort to secure housing for homeless patients upon discharge.

“UC Davis Medical Center and its care teams are deeply committed to the health and well-being of every patient we see and treat, regardless of the patient’s background or circumstances,” he said in a statement.

Data released this week by a nonprofit advocacy group, the Sacramento Regional Coalition to End Homelessness, suggest that the practice of sending patients to shelters without advance notification is not uncommon.

The organization recently surveyed agencies that serve the poor in the Sacramento area about whether homeless people recently had been dropped off at their organizations – by ambulance, cab or ride share – immediately following discharge from a health care provider and without prior notification. The results were startling, said executive director Bob Erlenbusch.

Thirteen of 20 service providers responded to a poll asking about the practice, Erlenbusch said. Seven of the 13 agencies answered that recently released patients had been delivered to their campuses. One agency reported the practice occurring two or three times a week, and three facilities said it happens about once a week. One said it occurs about every other week, and two estimated that it happens once or twice a year.

In most cases, the agencies said, patients were wearing hospital gowns upon arrival. Many arrived in wheelchairs or on walkers. Some had open wounds.

The facilities or agencies discharging patients included major hospital groups in the Sacramento area and government organizations, according to the survey respondents.

Erlenbusch launched the survey in response to a Bee story about Arlan Lewis, 78, who was discharged in December from a Woodland Hospital to the Union Gospel Mission in Sacramento, which turned him away because he did not qualify for a bed there. The results of the new poll “paint a horrifying picture of homeless patient dumping,” he said.

“Our report underscores that this is a systemic issue for our community, and not a few isolated incidents by a few ‘bad actors,’” Erlenbusch said.

Stephen Watters of First Step Communities, a nonprofit group that among other things runs the winter sanctuary shelter, in which people are transported to rotating churches to have meals and sleep, said the practice “seems to be happening more and more” in Sacramento.

“I am not in any way callous,” Watters said, “but I’m to the point that I’m not shocked anymore because these things happen so often.”

Watters said the staff has learned to be on high alert when a vehicle pulls up to drop someone off. “We try to go in and see who is coming to us, who is sending them and what is going on,” he said. “Are we the right place for them to be?”

In many cases the answer is no, he said. Recently, a ride share service deposited a discharged hospital patient “who could barely stand, much less walk,” and therefore was not a candidate for the sanctuary program, Watters said.
“Almost once a day, I hear from a hospital asking if we can take someone,” Watters said. “That’s OK. We just need a heads up to understand whether the person can succeed in our environment.”

California’s Health and Safety Code requires hospitals to have a discharge policy for all patients, including those who are homeless. Hospitals must make prior arrangements for patients, placing them either with family, at a care home or at another appropriate agency, the code says. But in a recent interview with The Bee, an official with the California Hospital Association said the task is sometimes difficult for health professionals dealing with people who have no place to live. The problem can be compounded if a patient has mental health issues.

Erlenbusch said he understands the pressures on medical discharge planners who may have few housing options for men and women who are homeless and recovering from injuries and illnesses. But, he said, “it remains immoral and unconscionable to release homeless people to recuperate, sometimes from major surgery, on the streets.”

He said he will be asking the city and county to respond with strict enforcement of laws designed to prevent illegal “patient dumping,” including hefty fines and possible jail sentences for those responsible.

Mayor Darrell Steinberg, who has made Sacramento’s growing homelessness crisis a centerpiece of his administration, said what happened to Woods “should not be the standard in our community. It’s just not acceptable.”

He said government leaders should review existing laws and hold hospitals accountable for improperly discharging poor people. “These stories should be used as a catalyst for change,” he said.

“The ultimate answer to this very complex problem is, of course, more housing for people who need it, and a system that is seamless” in helping people who are without stable housing and recovering from serious medical problems, Steinberg said.

Woods, who said she has been homeless off and on for the past decade because of various issues including health challenges, generally praised UC Davis and its doctors and nurses for the cancer care she has received since 2015. “But I question the actions of the people who discharged me” in January, she said. “This is about accountability.”

Her medical records, which she provided to The Bee, show that Woods was discharged from UC Davis on Jan. 22, four days after undergoing mastectomies on each of her breasts. Her discharge papers urge her to “keep wound clean, dry and intact,” and to use small pumps attached to tubes in her chest to drain fluids from the surgical area. Her papers also included a list of agencies that provide meals and shelters to homeless people.

Woods said she left UC Davis in a ride-share car called by the hospital. The car took her to the Salvation Army, but she was turned away, she said.

With no place to go, in pain from her surgery and with her drainage tubes still in place, Woods walked over to Quinn Cottages, a nearby homeless services agency, and sought help from a friend who lives at the facility.
“When I saw her and heard her story, I was sick to my stomach,” said Sarah Allen, a Quinn Cottages staffer. “I thought, ‘This is a complete failure. How could she be in this position, given the intensity of her surgery?’”

Two days after her arrival at Quinn Cottages, while spending “scary” nights in her car outside the building, Woods was taken by ambulance back to UC Davis with cardiac symptoms, she said. Her medical condition stabilized. When she told hospital workers about her situation, they pitched in and secured a hotel room for her for a week, she said.

She spent a couple of days with a daughter who lives in Corning, but wants to live in Sacramento where she soon will undergo chemotherapy, she said. During the day, she has been meeting with housing advocates. She has taken showers at her friend’s apartment at Quinn Cottages, and sleeps in her Kia.

Woods said she is on track to get housing in the near future, and has hopes of once again working as a neighborhood advocate or as an ambassador for cancer prevention. Next month, she is scheduled to return to UC Davis for 18 weeks of infusions of cancer-fighting drugs.

“I have had a very hard life,” Woods said. “Right now, I’m just trying to survive and trying to make the next half of my life as good as it can possibly be. But the fact is, I’m living in my car. At the moment there are no other options for me.”

Cynthia Hubert: 916-321-1082, @Cynthia_Hubert

Lara Woods sits in her car in Sacramento on Tuesday. Woods, who is homeless, said she was “dumped” to the streets after undergoing double mastectomy surgery at UC Davis Cancer Center. The hospital put her in a cab just days after her surgery, she said, and sent her to the Salvation Army, which had no bed for her. She was forced to live in her car. Homeless services agencies regularly see fragile people discharged by health care agencies to the streets. Randall Benton rbenton@sacbee.com
In 2014, approximately 1,400 Stanislaus County community members experienced homelessness, and thousands more showed signs of risk for becoming homeless. Although there are over 30 programs and hundreds of concerned citizens who help people access housing, shelter, and other basic life necessities, we know that we can do much more to prevent homelessness from actually occurring. Focus on Prevention will not just work to improve the existing homeless services system, but rather address the root causes and develop strategies to intervene early to prevent homelessness.

Instead of isolated and interventions of the past, multiple homelessness services agencies and community partners in Stanislaus County have come together, aligning their efforts and forming partnerships that have resulted in the Homelessness Community System of Care. In March 2017, the new Community System of Care (CSOC) Leadership Structure was formed. The new 25-member CSOC provides overall guidance for the Homelessness Community System of Care, working across multiple sectors to sustain the vision, energy, and commitment to think and act in new innovative ways to reduce and prevent homelessness.
This Community System of Care in which all sectors have a role and are contributing to the desired results acknowledges that service providers and partners can accomplish much more working together rather than separately. The importance – and potential – of this alignment, shared results and learning has become crystal clear.

The system of care incorporates four core strategies:

1. Outreach and Engagement: Improving community-based outreach and engagement strategies with a focus on identifying individuals who are not currently connected to services, and as trust is established, those individuals are introduced and connected to a variety of health, housing and community services and supports.

2. Coordinated Access: Developing a countywide coordinated access system that integrates all public- and community-based services and community supports.

3. Housing: Improving access to temporary, transitional, and permanent supportive housing.

4. Supportive Services: Increasing the availability, effectiveness and alignments of homelessness services and community supports that help people escape from and stay out of homelessness.
Sacramento Hospitals: Collaborating with the Community to Ensure Safe, Respectful Care for Homeless Residents

More than 500,000 people across the country are homeless, according to the U.S. Department of Housing and Urban Development. And nowhere is the problem more acute than in California. The Golden State has an estimated 134,000 people who are homeless – more than any other state and 25 percent of the nation’s total homeless population. In recent years, Sacramento County has seen an approximate 1/3 increase in the nightly homeless to about 3,655 individuals. Of these, approximately 2,052 are unsheltered and sleeping outdoors, an 85 percent increase from just two years earlier.

The reasons for homelessness are multi-faceted and complex. Some individuals suffer from addiction or behavioral health issues. Others find themselves on the streets as a result of broken families, lost jobs and/or the high cost of housing. Whatever the cause, people who are homeless are at risk for a variety of illnesses or injuries that may result in the need to seek hospital care.

Every person who comes to a hospital emergency department (ED) receives safe, medically appropriate care regardless of their life circumstances. A critical component of the patient care process involves the appropriate planning for the patient’s eventual discharge. This process generally starts upon a patient’s admission to the hospital and evolves over the course of the person’s hospital stay.

When a patient is homeless, the discharge planning process becomes even more critical. Hospitals do everything possible to coordinate and facilitate the patient’s discharge to appropriate area shelters or other community-based services. Hospital staff routinely communicate with their community partners in order to find the most appropriate destination for these patients. The goal is always “a warm handoff” between the hospital and a community partner. In 2017, hospitals in Sacramento County discharged 138,960 patients according to these practices.

It is important to remember, however, that some homeless patients may choose to leave a hospital on their own terms, without accepting assistance from anyone. Every person has the right to make their own decisions, and no organization can force a person to accept help against their will. When these situations occur, hospitals must respect the desires of the patient.
KEY MESSAGES

RESPECT: Hospitals treat all patients with dignity while respecting their individual rights and personal goals.

- Hospitals are committed to the safe discharge of all patients, while being respectful of an individual’s rights and personal choices.

- There is no “one size fits all” process for a discharging homeless patient. Hospital professionals work diligently with each patient and appropriate community-based partners to ensure that each individual’s specific post-hospital needs are best served.

- The discharge plan for a homeless patient cannot infringe on that person’s rights. The goal is to create a post-treatment plan that is consistent with the person’s wishes.

- Despite the best efforts of trained hospital personnel, some homeless patients refuse assistance when they are ready to leave the hospital. Some patients even leave the hospital against medical advice. When that happens, hospital staff do their best to provide appropriate resources and guidance, but they ultimately must respect the wishes of the patient.

SAFETY: Hospitals strive to ensure a safe and appropriate “warm handoff” when a homeless patient is discharged into a community setting.

- Every hospital has specific patient discharge protocols. While these protocols vary by hospital, the overall goal is to ensure that every patient, including those who are homeless, is discharged to a safe and appropriate environment.

- Care doesn’t end when a patient is discharged. Hospital discharge planners know that recovery continues after a patient is released from the hospital. This means helping each patient find a safe environment to return to, regardless of their individual circumstances.

- The overall effectiveness of these efforts depends on the resources available in the community and the individual’s willingness to take advantage of the support.

COMMUNITY: In local communities throughout the state, hospitals have played leadership roles in to address the challenges of homelessness.

- The issue of homelessness is one of the great societal challenges of our time. More than 134,000 Californians are currently homeless – that’s more than any other state and 25 percent of the nation’s total homeless population.

- At some point, every homeless person will likely seek care in a hospital. People who are homeless are at risk for a variety of illnesses or injuries that may result in the need to seek medical care.
Hospitals have long been leaders in their communities in the efforts to provide appropriate care and secure ongoing services for homeless individuals. Across the state, hospitals have forged strong partnerships with homeless shelters, community providers, non-profit groups, local governments, faith-based organizations and other groups dedicated to addressing the needs of the homeless. Sacramento hospitals support many worthy programs, including:

- Pathways to Health + Home
- Interim Care Program
- Triage, Treat, Transport (T3)
- Joshua’s House
- Sacramento Steps Forward
- Street Nurse Program
- Sacramento Regional Coalition to End Homelessness
- River City Food Bank
- Sacramento Housing Alliance
- Saint John’s Program for Real Change
- St. Vincent de Paul
- Salvation Army
- Lutheran Social Services – Housing with Dignity

Ensuring that homeless patients receive appropriate care and services once they are ready to be discharged from a hospital is a shared responsibility between hospitals and their community partners. Collaboration is key.

# # #
April 26, 2018

Board of Supervisors
County Administration Building
Stockton, CA 95202

Dear Board Members:

**Adopt Recommendations of the**
**San Joaquin County Homelessness Task Force**

**Recommendation**

It is recommended that the Board of Supervisors adopt the following recommendations made by the San Joaquin County Homelessness Task Force (HTF) and supported by the County Administrator:

1. Support programs that deflect/divert homeless individuals from the criminal justice system, and support efforts to prevent the criminalization of homelessness and solutions that provide appropriate alternatives to incarceration and punishment.
   
   a. Probation – Pretrial Services
   
   b. Homeless Court

2. Adopt policies and procedures for law enforcement officers when individuals with mental health needs are booked into the County Jail.
   
   a. Mobile Crisis Units
   
   b. Behavioral Health Services co-located at the County Jail as a future goal. Due to lack of funding, the current plan for the new jail facility does not include a dedicated mental health facility.

3. Prioritize Community Development Block Grant (CDBG) and Home funds for the creation of additional permanent housing. On March 6, 2018, your Board received the recommendations from the Community Development Department that included Community Development Block Grant monies for the addition of 40 new beds at the Gospel Center Rescue Mission (B-18-153), and HOME Investment Partnership Program funding for the provision of affordable housing options for first time homebuyers (B-18-152).
4. Continue to engage with HUD to assist with the restructuring of the San Joaquin Continuum of Care (CoC) and the establishment of goals and objectives.

   a. Develop county-wide Strategic Plan to address homelessness and a local CoC plan.
   b. Facilitate continued county-wide collaboration and strategic planning.
   c. Acknowledge the strong inter-city collaboration happening throughout the county.
   d. Continue collaboration with cities and encourage greater partnership in the CoC.

Reason for Recommendation

On November 14, 2017 your Board received the final annual report of the San Joaquin County Homelessness Task Force. Among the many achievements of the Homelessness Task Force and the County Administrator's Office are:


2. Creation of a robust collaborative community of stakeholders including, cities, county agencies, and community based organizations working together to address homelessness throughout San Joaquin County.

3. Creation of a new County position to oversee and continue the momentum established by the HTF. The County Administrator has filled the position effective April 2, 2018.

4. Health Care Services Agency has secured funding of $18.5 million (over five years) for the Whole Person Care Pilot; $4.0 million for the acquisition, construction, and renovation of housing units; $6.5 million in pending funding (over five years) for creation of rehabilitative housing for adults with co-occurring disorders; and $6.0 million of Proposition 47 funding to support withdrawal management services, with an additional $8.2 million in pending funding (over five years) for an Assessment and Respite Center component.

5. The County has been awarded 200 hours of Technical Assistance from Housing & Urban Development (HUD) for the transition of the HTF to a reenergized San Joaquin County CoC.

6. In March 2018, the County Administrator's Office hosted two days of meetings with the HUD Technical Assistance Team. This effort was the result of the award of a 200 hours Technical Assistance grant from HUD. The meetings included two workshops designed to provide the HTF with detailed information regarding the structure and governance of a CoC, federal priorities for planning, and analysis of the County’s transition from the Homelessness Task Force to a re-
energized CoC. In addition to the meetings mentioned above, the HUD Technical Assistance Team met with leaders from Stockton, Lodi, and Tracy regarding those cities ongoing efforts to address the needs of the homeless population within their respective cities.

The second onsite visit from our HUD Technical Assistance Team is planned for May 2018. The agenda for that visit will include a meeting with Manteca officials regarding their efforts to address homelessness issues; and a meeting with the entire CoC to take the next steps toward development of a revised CoC Charter, and to begin discussions regarding a strategy for the January 2019 Point-in-time count.

7. Since 2015-2016 the Human Services Agency (HSA) and First 5 have contributed a total of $224,287 toward the budget of 2-1-1 San Joaquin, which is operated by the Family Resource and Referral Center. For 2018-2019, HSA plans to contribute $98,783, and First 5 plans to contribute $27,750 to this vital partner providing all County residents, including the homeless with referrals to appropriate service providers within the community.

8. The County Administrator’s Office has secured $379,641 in funding which will cover in excess of two years of costs associated with the new Program Administrator-Homeless Initiatives position. The $379,641 in funding commitments includes contributions from the Cities of Stockton in the amount of $50,283, and Lodi in the amount of $11,417. The City of Stockton’s funding is contingent upon coming to an agreement on a Memorandum of Understanding.

9. Ready To Work (RTW) is a local non-profiorganization that has fostered a public-private partnership with the County to bring housing and job training resources to men with a history of homelessness or involvement in the criminal justice system. The County has been instrumental and worked collaboratively with RTW to leverage existing County resources as follows:

   a. On October 24, 2017, your Board approved a lease agreement (B-17-669 and  
      A-17-398) for RTW to occupy Honor Farm Barracks J, K, and L for a term of  
      ten years at the annual rate of $1.

   b. On December 12, 2017, your Board approved and authorized the submission  
      of a grant proposal (R-17-167) by the District Attorney (DA) on behalf of the  
      DA and RTW to operate a Community Based Transitional Housing Program.  
      In April 2018, the County was notified that an award of $1.5 million was  
      approved by the State for the period of May 1, 2018 through September 30,  
      2019. Approximately $700,000 of the grant award will be provided to RTW as  
      the facility operator. RTW would spend its resources to enhance the security  
      of the housing campus, renovate the housing campus for its new use, provide  
      direct services to clients, and provide staff to deliver those direct services.
The balance of approximately $800,000 will remain in the DA’s budget to provide services to RTW.

c. On January 3, 2018, your Board approved a Memorandum of Understanding (B-18-63) between RTW and the Sheriff’s Office for the provision of supplies and services allowing the Sheriff’s Office to offer RTW food, clothing and personal items at cost.

In addition to the achievements highlighted in the HTF annual report of November 14, 2017, the HTF made several recommendations. The County Administrator’s review of the HTF’s recommendations took into consideration costs, available funding resources, and whether the recommendation is already being accomplished. After careful analysis, the County Administrator is in support of the HTF recommendations as listed above, and recommends them for adoption by your Board.

Fiscal Impact

The ongoing cost of these recommendations are the existing resources and funding used for the annual Homelessness Point-in-time count. Additional costs associated with diversion services, mental health services, and grant writing activities from Behavioral Health Services, Public Works, Community Development Department, and the County Administrator’s Office.

Action to be Taken Following Approval

Following adoption by your Board, the County Administrator will distribute adopted recommendations to all stakeholders, including, non-County organizations involved in providing services to the homeless population, all cities located in the County, and all County department heads.

As the San Joaquin County Homelessness Task Force concludes its important and strategic work, the enhanced San Joaquin County Continuum of Care and County departments will look to the Coordinated Strategic Priorities, and these adopted recommendations to provide guidance and inform all decisions related to addressing the needs of the homeless and potentially homeless populations in the communities we serve.

Sincerely,

Monica Nino
County Administrator

MN:CJH
c: Community Development
   Public Works
   Chief Probation Officer
   Behavioral Health
   Clerk of the Board for 5/08/2018 Agenda

BL01-05

Reviewed by County Counsel’s Office:

J. Mark Myles, County Counsel 4/26/2018
Before the Board of Supervisors
County of San Joaquin, State of California

MOTION:

Adopt Recommendations of the
San Joaquin County Homelessness Task Force

THIS BOARD OF SUPERVISORS DOES HEREBY adopt the following recommendations made by the San Joaquin County Homelessness Task Force (HTF) and supported by the County Administrator:

1. Support programs that deflect/divert homeless individuals from the criminal justice system, and support efforts to prevent the criminalization of homelessness and solutions that provide appropriate alternatives to incarceration and punishment.
   a. Probation – Pretrial Services
   b. Homeless Court

2. Adopt policies and procedures for law enforcement officers when individuals with mental health needs are booked into the County Jail.
   a. Mobile Crisis Units
   b. Behavioral Health Services co-located at the County Jail as a future goal. Due to lack of funding, the current plan for the new jail facility does not include a dedicated mental health facility.

3. Prioritize Community Development Block Grant (CDBG) and Home funds for the creation of additional permanent housing. On March 6, 2018, your Board received the recommendations from the Community Development Department that included Community Development Block Grant monies for the addition of 40 new beds at the Gospel Center Rescue Mission (B-18-153), and HOME Investment Partnership Program funding for the provision of affordable housing options for first time homebuyers (B-18-152).

4. Continue to engage with HUD to assist with the restructuring of the San Joaquin Continuum of Care (CoC) and the establishment of goals and objectives.
   a. Develop county-wide Strategic Plan to address homelessness and a local CoC plan.
   b. Facilitate continued county-wide collaboration and strategic planning.
c. Acknowledge the strong inter-city collaboration happening throughout the county.
d. Continue collaboration with cities and encourage greater partnership in the CoC.

I HEREBY CERTIFY that the above order was passed and adopted on [date] by the following vote of the Board of Supervisors, to wit:

AYES:

NOES:

ABSENT:

ABSTAIN:

MIMI DUZENSKI
Clerk of the Board of Supervisors
County of San Joaquin
State of California
San Joaquin County Emergency Services Task Force
April 12, 2018, 2017, 1:00 – 2:30 p.m.
Minutes

Attendees:
Ken Johnson (Chair), Stockton Fire; Anne Baird, California State Assembly Staff; Brian Beenes, Doctors Hospital of Manteca; Amber Brackett, St. Joseph’s Behavioral Health Center; Chuck Bryan, Dameron Hospital; Greg Diederich, San Joaquin County Health Care Services; Mark Duerr, Stockton Fire; Kathy Hannah, San Joaquin County Behavioral Health; Barbara Johnson, Valley Mountain Regional Center; Paul Rains, St. Joseph’s Behavioral Health Center; Deana Reese, Lodi Memorial Hospital; Jonathan Truelove, Sutter Tracy Medical Center; Tony Vartan, San Joaquin County Behavioral Health; Brian Jensen, Hospital Council; Donna Astrinidis, Hospital Council

Welcome
The meeting was convened at 1:05 p.m. by Chair Ken Johnson.

Self-Introductions
All in attendance introduced themselves.

Review of Minutes / Approve Agenda – The February 15, 2018 minutes were approved.

Behavioral Health Task Force Report – Brian gave an overview on the establishment of the behavioral health task force and mentioned that the final task force report was made part of the meeting packet. He also stated that the report is intended to provide ideas, i.e. toolbox, for local communities and sections to consider and utilize.

Paul commented on how best practices recommendation was beginning to take off – transporting people to the right place and alternate locations to best serve patients. Partnership with Stanislaus and San Joaquin counties is working well.

Brian asked the group to identify the top 1-2 issues to discuss and try to improve/leverage resources in a different way. A summary of what the group discussed is noted below.

1. Integrated Health Information Exchange
   The group discussed connecting Medi-Cal population to the HIE framework – allow to track people abusing children/taken to multiple EDs by interfacing the EDIE system with electronic health record. Being able to share critical patient information enhances communication by providing a robust exchange of information (i.e. diagnosis, medications, labs), shows cost savings and speeds up care. There was also consensus amongst the group that there is a need for real time connectivity – i.e. HIE connectivity with CURES database.
2. **5150 Inconsistencies**

The group discussed how the LPS Act – authorizes law enforcement or clinicians to involuntary confine behavioral health patients into care. Hospitals have become a place to receive patients with behavioral health issues. Kathy stated that CRISIS is who is designated to receive patients with mental disorders in San Joaquin County. She also advised that there are adequate mobile crisis units to meet the needs of the community in San Joaquin County.

There was a comment that there needs to be an assessment on who writes 5150s. It is critical that law enforcement know how to write a 5150 correctly in order to help EMS. However, officers say they do not get proper training. Without proper information, EMS has no grounds to hold patient. There was a comment that San Joaquin County provides CIT training 4 times a year where one learns how to write a 5150.

3. **Behavioral Health Dispatch**

Ken advised that many behavioral health crisis are not dispatched because they do not meet the criteria and individuals walk away. He also mentioned that an ambulance is not dispatched if an individual does not want to go to the hospital. Ken mentioned a time when Fire was held up at a scene with a behavioral health patient for 34 hours because law enforcement was busy – situation was low on the list of priorities.

Ken stated that it is a burden to the hospital and patients when a patient is transported to the ED rather than a behavioral health facility. The group discussed how counties and hospitals are pushing to authorize local EMS to allow trained paramedics to transport patients who meet specific criteria to a local behavioral health treatment facility – AB 1795. Existing state law requires paramedics to transport people including those who do not have a medical emergency but are suffering from a behavioral health crisis to an ED in response to a 911 call.

There was a comment that transporting a 5150 to an ED does not give capability to care for patient and that transporting to ED system is not set up to deal with patients effectively or passionately. These patients could be treated more appropriately if transported directly to a behavioral health facility. However, there was also group consensus that mental health patients are patients, that it is good practice having law enforcement transport a 5150 to an ED, and that having law enforcement make a medical decision is out of scope of their practice.

The group also discussed how regulations has taken away ability to apply common sense and delays care for patient that requires mental care. If a patient has insurance, care gets delayed because of regulations.

Paul stated that a psychiatric ED is the answer – like sobering centers in San Francisco. It was also mentioned that Florida has designated psychiatric ED where patients are receiving the treatment and counseling they need.
SJC Community Paramedic Program & Alternative Ambulance Destinations – This agenda topic was not discussed – ran out of time.

TeleHealth Update – This agenda topic was not discussed – ran out of time.

Data Collection Subcommittee Report – The group discussed the need to map out the mental health transport process to see where patients come from and identify the bottlenecks. Each stakeholder has their own set of metrics to identify where to target next steps. The data will determine if there is a need to invest for additional resources, reallocate resources or fund resources to do X. A few data elements to consider include number of patients – how many psychiatric; average number of times patients sits in ED; number of patients admitted/discharged; time patient medically cleared – time of day/day of week, etc.

There was group consensus that establishing a data collection subcommittee is necessary to determine a standardized way to gather and collect behavioral health data that may require an evaluation or change in process. Brian asked who from the group was willing be part take in the subcommittee. Kathy Hannah, Deana Reese, Tony Vartan, Paul Rains, Chuck Bryan and Ken Johnson volunteered. The subcommittee will need to define what elements to look for, determine what the data is telling us, etc.

Ken Johnson agreed to lead and organize offline subcommittee meetings. Chuck Bryan to co-chair. Donna will provide Ken/Chuck with a list of those who previously volunteered in 2017. Ken/Chuck will send Donna a final list of individuals who will represent the new data collection subcommittee for 2018.

Debrief Meeting – Kudos and Criticisms - This agenda topic was not discussed – ran out of time.

Adjourn – The meeting adjourned at 2:30 p.m.
DEVELOPING, MEASURING & DOCUMENTING
EMPLOYEE COMPETENCE

When: Friday, May 18, 2018
Registration: 9:00 AM
Program: 9:30 AM – 2:30 PM
Cont. Breakfast and Lunch Provided

Where: Sutter Sacramento
Buhler Specialty Pavilion
First Floor – Classroom #2 & 3
2800 L Street
Sacramento, CA  95816

Who Should Attend?
Ancillary Support Managers and
Directors, Nurse Managers and
Directors

Registration Fee:
$295/Hospital Council Member
$350/Non-Acute Stakeholder
Class size limited to 35 people
4 BRN CEUs provided CEP#14560

Contact:
Lisa Brundage O’Connell
Education Manager
loconnell@hospitalcouncil.org
925-746-0728

An Education Program
Provided by:

Stay on target with The Joint Commission competency requirements for meeting patients’ needs.

This intensive one-day workshop, presented by the Hospital Council of Northern and Central California provides in-depth explanations of The Joint Commission competency assessment standards, detailed examples of compliance, and opportunities for managers to develop and redesign the content of their department competency tools.

Course Objectives
- Define the components of the competency assessment and measurement process.
- Compare competency skills against the essential duties of a job description.
- Differentiate between competency and a job-specific duty.
- Develop the high-risk, low-volume, or problem-prone competencies for each job description.
- Implement measurement and documentation tools that will meet The Joint Commission requirements.

About the Speaker – Emelda Latham, RN, MS
Emelda Latham, MS, RN provides human resources consulting services for medium to large hospitals and health care systems in the areas of human resources strategic planning, human resources operations management, merger management, management training, Joint Commission and human resources legal compliance. She has more than 30 years of combined health care experience in human resources management, administrative and clinical nursing and management training.
For Newly Appointed, Recently Hired Health Care Managers And Supervisors

Central Valley
Saint Agnes Medical Center – The Plaza Building
1111 East Spruce Ave., Martin Room – 2nd Floor, Fresno
Sessions: June 5, July 17, August 21, September 11, October 9, November 13
8:00 am - 5:00 pm

LEAD Academy Trains Managers To Be Successful Leaders

LEAD Academy empowers recently hired, newly appointed or previously untrained health care leaders to better understand and use their strengths. Designed for health care supervisors and managers, LEAD is built on the underlying principle that effective leadership requires productive relationships to support excellence in patient care, sustainable business objectives and a safe patient environment.

LEAD Academy utilizes innovative tools and experiential learning, over a comprehensive six-session, 12-module course, to provide a safe environment to practice newly learned skills and align work goals and actions to support the broader vision of the organization. Engaging activities guide participants through the process of understanding differing leadership styles and overcoming the distinct challenges of being a leader.

Specific program focus areas include:
• Self-development
• Supporting the development of others
• Managing and developing a successful organization

Registration Fees
Hospital Council Members
Entire Track (six sessions): $1,950

Non-acute Stakeholders (post-acute facilities, community clinics)
Entire Track (six sessions): $2,500

Questions
If you have questions about this program, please call Constance Cheong at (925) 746-1552 or email ccheong@hospitalcouncil.org.

Register Today, Space is Limited!
www.hospitalcouncil.org/lead-academy
**Agenda**

**Wednesday, September 26**

- **10:00 am – 6:00 pm** Summit Registration
- **11:00 am – 1:30 pm** Rural Healthcare Center Advisory Board Meeting
- **5:00 pm – 7:00 pm** Summit Welcome Reception and CHPAC Presidents’ Club Reception

**Thursday, September 27**

- **7:00 am – 5:00 pm** Summit Registration
- **7:30 am – 9:00 am** Networking Buffet Breakfast
- **9:00 am – 9:30 am** Welcome and Opening Session
- **9:30 am – 10:30 am** The Fallacy of Impossible
  - Mick Ebeling, CEO & Founder, Not Impossible
- **10:30 am – 11:00 am** Networking Break with Sponsors, Book Signing and Techbar
- **11:00 am – 12:15 pm** Innovation Challenge Breakout Sessions
- **12:15 pm – 2:00 pm** Sponsor Showcase Luncheon
- **2:00 pm – 3:15 pm** Innovation Challenge Breakout Sessions
- **3:30 pm – 4:30 pm** The New Normal?
  - Carmela Coyle, CHA President/CEO
- **6:00 – 8:00 pm** Dinner Reception
  - Honoring Art Sponseller, President/CEO, Hospital Council

**Friday, September 28**

- **7:00 am – 9:00 am** California Critical Access Hospital Network (CCAHN) Breakfast
- **8:00 am – 9:00 am** Summit Breakfast
- **9:00 am – 10:00 am** Pave the Way for Breakthrough Performance at Your Hospital
  - Bonnie St. John, Author
- **10:00 am – 11:15 am** Making Mental Health Essential Health
  - Patrick Kennedy, US Representative, Co-Founder One Mind Research
  - Adjournment

**Keynote Speakers**

**Carmela Coyle**  
CHA President/CEO

**“The New Normal?”**
Carmela Coyle began her tenure as President & CEO of the California Hospital Association in October 2017. Previously, Coyle led the Maryland Hospital Association for nine years, where she played a leading role in reframing the hospital payment system in Maryland and moving to a value-based methodology. Maryland is now considered a national leader in health care policy and innovation.

**Patrick Kennedy**  
US Representative, Mental Health Advocate

**“Making Mental Health Essential Health”**
Patrick Kennedy served 16 years in the US House of Representatives, and is predominantly known as author and lead sponsor of the Mental Health Parity and Addiction Equity Act of 2008. After leaving congress in 2010, Rep. Kennedy co-founded One Mind, a national coalition seeking new treatments and cures for neurologic and psychiatric diseases of the brain. He is considered one of the world’s leading mental health advocates.

**Bonnie St. John**  
Author

**“Pave the Way for Breakthrough Performance at Your Hospital”**
Despite having her right leg amputated at age five, Bonnie St. John became the first African-American ever to win medals in Winter Olympic competition. Bonnie is the author of six books and served in the White House as a Director of the National Economic Council during the Clinton administration. NBC Nightly News called Bonnie, “One of the five most inspiring women in America.”

**Mick Ebeling**  
CEO, Not Impossible

**“The Fallacy of Impossible”**
A recipient of the Muhammad Ali Humanitarian of the Year Award, named one of Wired’s “Agents of Change” and listed as one of the most influential creative people by The Creativity 50’s, Mick Ebeling has sparked a movement of pragmatic, inspirational innovation. As founder and CEO of Not Impossible, Ebeling harvests the power of technology and storytelling to change the world. He founded Not Impossible on the premise that nothing is impossible.

Hear creative, innovative solutions to the challenges hospitals face every day. Member hospitals competed for an opportunity to present their innovative projects. Those selected will present to their peers during Innovation Challenge Breakout Sessions at the 2018 Summit.

**For more information visit**
www.hospitalcouncil.org/annual-summit

#HC2018Summit @NorCalHospitals
Emerging Trends • Effective Practices

Sharpen your skills and knowledge while sharing your experience and ideas!

You are invited to join us for this, one-day program, all about YOU!

At this conference you will:

- Refresh your current skills and master new ones
- Increase your ability to collaborate up, down, and across the organization
- Focus your leadership skills and renew your sense of purpose
- Provide an opportunity to learn from and network with others in similar professions

Who Should Attend

Hospital Administrative Professionals to include Executive Assistants, Administrative Managers and Coordinators, Office Assistants and Project Coordinators

When: Friday, October 19, 2018
Registration: 8:30 AM
Program: 9:30 AM – 3:15 PM

Where: Embassy Suites, 100 Capitol Mall, Sacramento

Registration Fee: $325

Contact:
Constance Cheong
Phone: 925.746.1552
Email: ccheong@hospitalcouncil.org

Register online at www.hospitalcouncil.org/Administrative-Professionals-Conference

See Conference Agenda on reverse side

The Hospital Council of Northern and Central California is the unified voice of our members. As an advocate and convener we bring hospitals together to resolve local issues affecting patient care and hospital operations. Hospital Council also provides high quality education and business services to anticipate and meet hospital needs, overcome operational challenges and improve patient care.
8:30 – 9:30 AM  Registration/Continental Breakfast

9:30 – 10:00 AM Welcome/Health Care Update
Jeanne McAuliffe, Executive Office Coordinator and
Arthur Sponseller, CEO, Hospital Council of Northern and Central California

10:00 – 11:30 AM  The Invaluable Assistant
Sandy Geroux, MS, WOWplace International, LLC

Your competence makes you “indispensable”. Beyond that, there are mindsets, attributes and skill sets that executives prize in their closest support professionals, and that move you from “indispensable” to “invaluable”. Knowing what your leader is looking for by anticipating needs, attending to things, they overlook, and acting with the agility and adaptability demanded of executives is as critical to your success as it is to theirs. This program is designed to give you over 30 hard-hitting tips and ideas for serving your executive teams at a higher level as well as tools and templates to help polish your proactive and critical thinking skills.

11:30 – 12:15 PM  Networking Luncheon

12:15 – 1:30 PM  Apps to Boost Personal & Professional Productivity
Tara Thomas, Co-Founder and Editor, The Meeting Pool

We are constantly being asked to do more with less. Luckily, technology is advancing in multiple ways to help us get organized and efficient, all while being more communicative, collaborative and connected. The speaker will share a legion of ready-to go apps to help you get rid of manual processes, automate your workflows and see a measurable difference in the way you manage your life and work time.

1:30 – 3:00 PM  Leading Without Rank and Maximizing Your Value
Sandy Geroux, MS, WOWplace International, LLC

Since the title was invented, Administrative Professionals have been vested with great power and unofficial leadership. Frequently asked to serve on and lead various teams and projects at work and have responsibilities and deliverables, but often no real organizational authority. Accomplishing those duties requires strong skills and knowledge of informal leadership processes that allow you to lead without formal rank. This interactive program will help you unlock leadership abilities using relationships, and feedback and team-building skills. You will learn to:

- Think and act more like a leader by focusing on the benefits they provide versus the tasks performed
- Communicate more assertively and effectively
- Delegate more effectively by recognizing the correct mix of delegation and empowerment
- Bring more credibility and raise the reputation of the entire administrative team

3:00 – 3:15 PM  Wrap-up and Next Steps - All

Register online at
www.hospitalcouncil.org/administrative-professionals-conference