

Current (2018) Members of the Contra Costa County Mental Health Commission

Barbara Serwin, District II (Chair); Duane Chapman, District I (Vice Chair); Supervisor Diane Burgis, BOS representative, District III, Geri Stern District I; Gina Swirsding, District I; Diana MaKieve, District II; Lauren Rettagliata, District II; Douglas Dunn, District III; Julie Ann Neward, District III; Sam Yoshioka, District IV; Michael Ward, District V; Leslie May, District V; Joe Metro, District V;  
Candace Andersen, Alternate BOS Representative for District II

**The Mental Health Commission  
Hosts a Public Hearing for the Mental Health Services Act (MHSA) Three Year Plan \*updates  
Wednesday, June 6, 2018 from 4:30pm-6:30pm  
At: 550 Ellinwood Way, Pleasant Hill, CA**

**I. Call to order/Introductions**

**II. Public Comments:**

\*Please note that all members of the public may comment on any item of public interest within the jurisdiction of the Mental Health Commission, in accordance with the Brown Act, if a member of the public addresses an item, not on the agenda, no response, discussion or action on the item may occur. Time will be provided for public comment on the items on the agenda, after commissioner's comments, as they occur during the meeting.

**III. Commissioner Comments-**

**IV. Chair Announcements/Comments-**

**V. APPROVE Minutes from the May 2, 2018 Meeting**

**VI. RECEIVE Behavioral Health Services report-- Dr. Matthew White, Behavioral Health Services Acting Director**

**VII. FORM ad hoc committee to define MHC information needs regarding key indicators of consumer and overall mental health system outcomes-- Barbara Serwin, MHC Chair**

**VIII. DISCUSS MHC Retreat plan-- Barbara Serwin, MHC Chair**

**IX. Report on Commission membership vacancies and Committee membership needs- Liza Molina-Huntley, MHC Executive Assistant**

**X. Adjourn**

**\*\*The Public Hearing will follow the Commission meeting**





- I. **Call to order-Public Hearing on the Mental Health Services Act Three Year Plan \*updates**
- II. **Opening Comments by the Mental Health Commission Chair:**
  - A. Review of authority for Public Hearing, Welfare & Institutions Code 5848 (a) (b).  
A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans. The Mental Health Commission shall conduct a public hearing on the draft plan and annual updates at the close of the 30 day comment period. The Mental Health Commission shall review the adopted plan or update and make recommendations to the County Mental Health Department for revisions.
  - B. Review of Public Hearing purpose to confirm and complete the process.
- III. **Fiscal Years 2017 to 2020 Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan- by Warren Hayes, MHSA Program Manager.**

The plan is available for review at: <http://cchealth.org/mentalhealth/>
- IV. **Public Comment regarding the Plan-**

Members of the public may comment on any item of public interest within the jurisdiction of the Mental Health Commission.

**Public Comment cards** are available on the table at the back of the room; please give your card to the Executive Assistant of the Mental Health Commission.

In the interest of time and equal opportunity, speakers are requested to **please adhere to a 3 minute time limit, per person.** In accordance to the **Brown Act**, if a member of the public addresses an item not on the agenda, no response, discussion or action on the item will occur, except for the purpose of clarification.
- V. **Commissioner Comments-**

Members of the Commission may comment on any item of public interest within the jurisdiction of the Mental Health Commission.

**Commissioner Comment cards** are available at your seats. Please give your card to the Executive Assistant of the Mental Health Commission.

**In the interest of time and equal opportunity, speakers are requested to please adhere to a 3 minute maximum time limit, per person. In accordance with the Brown Act**, if a member of the public addresses an item not on the agenda, no response, discussion or action on the item will occur, except for the purpose of clarification.
- VI. **Develop a list of Comments and Recommendations to the County Mental Health Administration (MHA) and to the Board of Supervisors (BOS)**
- VII. **Adjourn- Public Hearing**

**MENTAL HEALTH COMMISSION  
MONTHLY MEETING MINUTES  
Wednesday May 2, 2018 – First Draft  
At: 550 Ellinwood Way, Pleasant Hill, CA**

Agenda Item / Discussion	Action /Follow-Up
<p><b>I. Call to Order / Introductions</b> Commission Chair Barbara Serwin called the meeting to order at 4:42pm</p> <p><u>Members Present:</u> Chair- Barbara Serwin, District II Supervisor Diane Burgis, District III Diana MaKieve, District II Douglas Dunn, District III (arrived @4:45pm) Gina Swirsding, District I Lauren Rettagliata, District II Leslie May, District V Mike Ward, District V Sam Yoshioka, District IV</p> <p><u>Commissioners Absent:</u> Duane Chapman, Vice Chair, District I Geri Stern, District I Patrick Field, District III</p> <p><u>Other Attendees:</u> Erika Jenssen, Assistant to Health Services Director for Contra Costa Count Jaspreet Benepal, Interim Chief Executive Officer for CCRMC and Detention Mental Health Dr. Matthew White, Chief Psychiatrist, Medical Director for BHS and Interim Director for BHS Dr. William “Mario” Berlingieri, Chairman of the Department of Psychiatrist and Psychology for Contra Costa County Health Services Mark Goodwin, Chief of Staff for District III Jill Ray, Field Representative for District II, Supervisor District II Miriam Rosa- CCCHS- Assistant to Health Services Director Tasha Kamagai-Kuradi Vic Montoya, Administrator Chief with Hospitals and Health Centers Joe Metro, (pending District V) Warren Hayes, MHSa Program Manager Genoveva Zesati, ASA III/MHSA program Stephanie Regular, Deputy Public Defender Christy Pierce, Public Defender Morvarid Naghshineh, Planner Evaluator Adam Down, MH Project Manager (arrived @5:28pm) Robert Thigpen, Adult- Behavioral Health Family Services Coordinator Theresa Pasquini, family member Erika Raulston, family member April Langro- RI International/Chair of Behavioral Health Care Partnership Kassie Perkins, ANKA Lauren Coley, Samuel Merritt University-Psych Clinical Liza A. Molina-Huntley, EA for MHC</p>	
<p><b>II. Public Comments:</b></p> <ul style="list-style-type: none"> <li>• None</li> </ul>	
<p><b>III. Commissioner Comments:</b></p> <ul style="list-style-type: none"> <li>• Supervisor Burgis announced that May is Mental Health Awareness Month and the presentation of the proclamation will be on the Board of Supervisor’s agenda for May 8. Encourages attendees to be present on May 8, for the presentation from the Mental Health Commission and the Office of Consumer Empowerment (OCE). A short video will be shown by OCE.</li> <li>• Gina- requested minutes be forwarded from the April 20, Assisted Outpatient Treatment (AOT) meeting.</li> <li>• Lauren- noted that not all MHC members were on the email distribution list for the AOT meeting notifications. Requests that list be updated to include all members.</li> <li>• Doug- announced that are two new updates from the California legislature AB1971,</li> </ul>	<p><b>Interested in serving as a volunteer on the Mental Health Commission? Apply online at:</b> <a href="https://ca-contracostacounty2.civicplus.com/6408/Boards-and-Commissions-Database">https://ca-contracostacounty2.civicplus.com/6408/Boards-and-Commissions-Database</a></p> <p><b>*MAY 8: Presentation by MHC and OCE at the Board of Supervisors Chambers to honor May Mental Health Awareness Month at 9:30am, located at: 651 Pine Street in Martinez</b></p>

<p>regarding conservatorships, in addition to SB1206. Encourages everyone to review both bills, previously stated.</p> <ul style="list-style-type: none"> <li>• Leslie- encourages attendees to advocate for new legislation, to protect the safety of all staff members, serving in the mental health care field</li> <li>• Chair- would like the item to be agendized in the future, to allow for further discussion</li> </ul>	<p><b>*Chair will agendize the item, in the future, regarding advocating for new legislation to protect the safety of professionals, working in the mental health care field</b></p>
<p><b>IV. Chair Announcements/Comments</b></p> <ul style="list-style-type: none"> <li>• Encourages viewing the website for the organization called “Mental Health America”. Not all present, agreed on the views of the organization.</li> <li>• OCE will be presenting a video from the PhotoVoice participants; along with an art gallery exhibit called, “See Me For Who I Am,” that is currently displayed in the hallways of the Board of Supervisors Chambers.</li> <li>• Provided an update, on behalf of the Director of Contra Costa County Health Services (CCCHS), Anna Roth, RN MS MPH. Regarding the process for recruitment on the permanent Behavioral Health Director, in her words: “Since there is a requirement for the MHC to review candidates, I wanted to request input from the Commission, on how the MHC might want to accomplish this? I also plan to reach out to the County’s Behavioral Health’s Director Association, for best practice models of how counties have engaged the MHC and other interested stakeholders in this important recruitment. If the MHC has any written protocol, preferred model or other examples they feel should be considered, I would welcome the opportunity to review and provide these to our Personnel Director for consideration. I would like to have a proposed process in the next few months; to share with the MHC and other interested stakeholders. “</li> <li>• Chair- I personally will be checking in with the California Association of Local Behavioral Health Advisory Boards and Commissions (CALBHBC) for best practices for examples of how Commissions engage in the hiring process in other counties. If any other Commissioner has any specific ideas on how we can engage, or specific concerns, please forward them to the EA and the Chair and Director of CCCHS, will include submissions in the discussion on the hiring process</li> </ul>	<p><b>* The Chair and Director of CCCHS will collaborate regarding the hiring process, for a permanent Behavioral Health Director</b></p>
<p><b>V. MOTION to APPROVE minutes from April 4, 2018 meeting</b>  <b>Sam Yoshioka moved to motion, Douglas Dunn seconded the motion</b>  <b>*correction noted by Lauren Rettagliata: stated on page 9, to correct spelling of “triennial”</b>  <b>VOTE: 9-0-0</b>  <b>YAYS: Supervisor Diane Burgis, Barbara Serwin, Diana MaKieve, Mike Ward, Leslie May, Sam Yoshioka, Gina Swirsding, Doug Dunn, and Lauren Rettagliata</b>  <b>NAYS: none ABSTAIN: none ABSENT: Duane Chapman, Patrick Field</b></p>	<p><b>*Post final corrected minutes to MHC website at:</b>  <a href="http://cchealth.org/mentalhealth/mhc/agendas-minutes.php">http://cchealth.org/mentalhealth/mhc/agendas-minutes.php</a></p>
<p><b>VI. DISCUSS next MHC Retreat: date, format, and potential topics—Barbara Serwin, MHC Chair</b></p> <ul style="list-style-type: none"> <li>• Chair- retreat is typically held in August, would like to provide options for the 2018 retreat and asks that members provide feedback via email. The details will be finalized at the next MHC meeting on June 6.</li> <li>• The date options are: August 4, 18 and 25 all dates are on a Saturdays.</li> <li>• Would like to continue with the all-day meeting, with a break for lunch</li> <li>• As for content, would like to provide a refresher on the rules and responsibilities of Commissioners, by Susan Wilson, from the California Association of Local Advisory Boards and Commissions. An opportunity for an extended Q&amp;A would be included, for more involved questions.</li> <li>• Additional options are: a high-level overview of the programs and facilities that make up the county’s mental health system, as well as the people who direct our system of care.</li> <li>• Warren Hayes, the MHSA Program Manager, has previously provided great visuals that map items out</li> <li>• The second option is a high-level overview of the mental health system’s financing</li> </ul>	<p><b>*MHC members forward preferences in retreat dates and provide input regarding options to the EA/Chair of MHC</b></p>

<ul style="list-style-type: none"> <li>• The third idea came from Adam Down, Ethnic Services Manager &amp; Training Coordinator, schedule the trauma informed training program, developed by the County. It is an engaging and interactive training, that would be best scheduled in the afternoon</li> <li>• Gina- Would like the overview of the mental health system, to be provided separately, at Commission meetings, from the staff providing the services. Does not believe the overview to be feasible to do in one day.</li> <li>• Chair- Warren has a schematic visual, laid out for each area of the county, providing an integrated view of the system of care. A high-level presentation, instead of a detailed presentation</li> </ul>	
<p><b>VII. DISCUSS new “Motion Tracker” tool for tracking and reporting on motions made by the Commission</b></p> <ul style="list-style-type: none"> <li>• <b>Chair-</b> referred to attachment in meeting packet, spreadsheet listing all the motions passed by the Commission and all four Committees, since the beginning of 2017 to present.</li> <li>• <b>Chair-</b> the purpose of the tool is to enable the Commission and Committees, to better manage its motions. Members will be able to refer/review/view the motions quickly, rather than digging through minutes, to see if actions set by the Commission/Committees have been completed or not, and identify the person(s) responsible</li> <li>• <b>Chair-</b> the overall goal is to help members to be more accountable, to their commitments, and thereby be more effective.</li> <li>• <b>Chair-</b>There are a lot of motions that have not been acted on at all, or are partially done.</li> <li>• <b>Chair-</b> the motion states the date, the language of the actual motion, and the status of whether it’s complete, in progress or incomplete, who made the motion, passed, and any special comments. They are in order by date and by status</li> <li>• <b>Chair-</b> as for the process, the motion will be updated after the meeting. The motions can be just pulled out and plugged into the tracker, instead of waiting for the minutes to be created. The tracker can be reviewed by the entire Commission and Committees, and will be made available to the Chairs as soon as it is updated. This process will allow the Chairs to review and start working on their commitments and not have to wait for the minutes to be created, providing a prompt tool for tracking. The tool will be made available to any Commissioner who wants to see it.</li> <li>• <b>Chair-</b> in time, the Chairs will figure out, how the tracker best fits into the workflow.</li> <li>• <b>Chair-</b> uncertain if the tracker will be used by the Chairs, to discuss with their Committee, presented monthly, or quarterly</li> <li>• <b>Joe Metro-</b> the tracker appears to be well laid out, does or will it have “action items, or assigned” members to the items?</li> <li>• <b>Chair-</b> had contemplated the idea, while revising the tracker, does agree that it should have its own field. The approval of minutes will not be noted in the motion tracker.</li> </ul>	<p><b>* see attachment provided in meeting packet for May 2, 2018 meeting</b></p>
<p><b>VIII. RECEIVE Behavioral Health Services report—Dr. Matthew White, Behavioral Health Services Acting Director and Medical Director</b></p> <ul style="list-style-type: none"> <li>• <b>Dr. White-</b> shared his thoughts pertaining to the framework of his new role, changes and where efforts will be concentrated within the Behavioral Health Services Division.</li> <li>• the focus will be on access to care, quality of care, the recognition that mental health includes divisional ownership of mental health issues, including the social and physical determinants of health, with substance abuse and housing stability as part of the pieces of mental health and builds towards mental health</li> <li>• Specific areas of interest are most urgently access to care, access to psychiatrist, access to health care and clinics and other locations</li> <li>• The physician workforce is clear and a priority</li> <li>• As of 5/3/18, there will be a salary increase for the contract physicians in</li> </ul>	<p>*</p>

the clinics, which equivalent to two-thirds of the workforce in the clinics, this will help to retain physicians and encourage physicians to increase their individual hours that they are working and hopefully to recruit other physicians as well

- In the physician workforce, there is a child psychiatrist, Dr. Zakee Matthews, working now full time in the West County Children's clinic
- There is 1.5 Tele-Psychiatrists working in East County and another part-time psychiatrist will start in May, it is not a substitute for in-person evaluations, it is helping to provide services to patients
- On July 1, another adult psychiatrist will be added, Dr. Grant Coast. Additional attempts to hire more psychiatrist are being made
- Pertaining to access to care, is having the workforce be effective and efficient, everyone included in the system
- Behavioral Health Services Division will implement the same process done for detention mental and health care services, in our own clinics, starting on the second week of June. The Value Stream Mapping Event will start at the East County Adult Clinic, followed by Rapid Improvement Events happening over the summer.
- We will be bringing some of the same expertise, critical self-examination, looking for areas of improvement, both short and long term.
- Another key area of interest is measuring how we are doing? The hospital has a dashboard to easily access information, because the hospital has been on Epic for four years and Behavioral Health Services has been on Epic for only four months. Now that we do have Epic, we will be adopting a different and more sophisticated billing software package in July. One of my priorities is to have the ability to have a dashboard, within our system, so that we can access the information, as leadership, as the public and as stakeholders actually see how we are doing. **It is a priority to develop a unified data analytics team, to help build the dashboard.**
- Moving forward, as we become more sophisticated, capture satisfaction and experiential data about the patient and provider experience, in terms of how much is the actual volume of the experience as well
- Another area of importance is levels of care; are patients getting the right kind of care, the right location and level of care
- Identify where the impacted parts are, in this area, where there issues are in the supply and demand of the kind of housing and facilities that we are providing for people, considering the following: A) is there a financial issues and B) the larger discussion would be a needs assessment. What is the needs assessment for housing at all different levels; from inpatient to other types of community based housing
- We need to identify what the needs are and what are the models of care, once the needs are identified, this can be done simultaneously
- Financially, getting what we can and doing what we can to maintain revenues and to seek other revenue sources and grants
- Communication needs to be worked on, with stakeholders, staff, system of care, clinics, service providers
- The last piece, there are a lot of ways that stakeholders and systems align and what we want. We want to strengthen our working relationship with the consumers, with their loved ones, to mutually inform our goal setting, our decision making. There are areas of shared advocacy that we can move forward with that align in both ways
- Sam- Isn't there a need for an East County Psychiatric hospital service, to provide total comprehensive mental health services. Originally there was a plan for four crisis residential, planned for both children and adults. Wondering if there is a need for a children's psychiatric services, because people are being sent out of county because we are not able to take care of people in our county
- Dr. White- that would be part of the assessment
- Doug- there is money in the budget for a TAY crisis residential facility at

<p>Oak Grove, the facility is not adequate for housing a program. What are the plans to move the process forward, either demolishing the property or starting over, what is the process to get this badly needed facility in the community, and not just die.</p> <ul style="list-style-type: none"> <li>• Lauren- yesterday we learned at the homeless meeting, that Jenny Robbins and Jaime Jenett facilitated, they said that they were overwhelmed by a number of transitional aged youth (TAY) grants that are available for planning and for funding TAY. Because there was poor planning, no one did an assessment of the property, before the request for proposal (RFP) was put out. They put the cart before the horse. There are an abundant of grants and H3 seems to be overwhelmed with how they are going to process and get to these</li> <li>• Dr. White- I will document, maybe Warren can provide a more sophisticated answer</li> <li>• Warren- I am aware of the advocacy of the MHC, regarding the TAY project, the areas articulated fit into putting staff resources to moving forward and making sure that the entire system, from locked to independent living, are properly assessed in terms of their need versus what we have, so we can actually have a comprehensive plan for where we need to put resources in the future. We need to assess what is out there, in terms of resources that we can access and address what are needs are</li> <li>• Theresa- asked why the Oak Grove-TAY project is not feasible. Housing has been the number one priority, since 2001 and it has not changed.</li> </ul>	
<p><b>IX. RECEIVE update regarding Detention Rapid Improvement events- Erika Jenssen, Assistant to Health Services Director of Contra Costa County</b></p> <ul style="list-style-type: none"> <li>• Erika- has been working on the improvement endeavor in detention mental health since its initiation.</li> <li>• The department partnered with the Sheriff's Office, during the process. The work done could not have been possible without the full participation of the Sheriff's Office, Custody Services Bureau. Would also like to acknowledge Jaspreet Benepal, Interim Chief Executive Officer for Contra Costa Regional Medical Center (CCRMC), Health Centers and Detention Mental Health, could not have done this work without her.</li> <li>• The topics for the January Rapid Improvement Event, a week-long event, with a team of 12 to 15 people that go into the detention facility. The team of the individuals figures out how the process works and tries to figure out how to make the system better. Initially, the group looks at data, does some preliminary testing, and finally a public report out. The report outs are available online on the website at: <a href="https://cchealth.org/video/2018-0323-dh-report-out.php">https://cchealth.org/video/2018-0323-dh-report-out.php</a></li> <li>• The Rapid Improvement Event in January was focused on specialty care and group activities</li> <li>• The Rapid Improvement Event in March was focused on reentry</li> <li>• The work initiated in August of 2017, with the Value Stream Map. During this event, a team of people collaborated for a week, and visited both the Martinez and West County detention facilities. The group mapped the experience of being incarcerated and the health care that people receive, from the point of view of a patient, mapping out the entire process from intake to release. During this time, communication patterns and how long the processes take are observed and noted by the group.</li> <li>• The current state, notes the current process for the patient.</li> <li>• The future state, is the ideal process for the patient to receive all the care that they need in the most efficient way, which provided less steps than the current process</li> <li>• The principles, for all the work, were to think about three things: dignity, privacy and safety. These principles are not just for the patient, it is also for the staff. Does the staff have enough resources to do their job with dignity too, do they have privacy to meet with patients, and is staff safe; and the same principles for the patients. We are thinking about these</li> </ul>	<p><b>* See attachments in meeting packet for May 2, 2018</b></p> <p><b>*View video on the Rapid Improvement Event at:</b>  <a href="https://cchealth.org/video/2018-0323-dh-report-out.php">https://cchealth.org/video/2018-0323-dh-report-out.php</a></p>

principles, while we are thinking of improvements and testing

- The driver diagram (\*see attachment) a logic model, a way to think about what are the changes that need to be made, in order to arrive to the desired goals for the patients in detention. To provide high quality care, for patients, addressing all the mental, physical and psycho-social needs, in a timely, trauma informed, culturally sensitive, and respectful.
- The team came up with the aim, during the first week of the Value Stream Map, and then the aim is held along with the principles of dignity, privacy and safety; while thinking about the system and the improvements that can be made
- After the Value Stream Map, it is reviewed and figure out the areas that require more focus towards improvements
- During the intake, Rapid Improvement Event week, one week was focused on urgent health care, particularly mental health issues
- More Rapid Improvement Events are planned, that will start in the fall of 2018, to allow enough time for the implementation process, from the earlier improvement events
- The theory of the Rapid Improvement Events is that small tests are done, towards implementing change, known as PDSA (Plan, Do, Study, Act). PDSA is a methodology about thinking about what needs to be changed, doing the change and actually looking to see if the change is working and later review to see if the change worked and figure out what adjustments maybe needed. The changes are done on a small scale, tested on one provider and one patient; if the change works, then it can be expanded
- During the specialty care groups, the following was discussed: access to capability to receive specialty care, scheduling and transportation (a large issue while the patient is in detention), and therapeutic groups that are provided to people with mental health needs in particular. Referring to care and specialty care is as follows: dental services, optometry, ophthalmology, looking at the levels of people being referred to the type of services, from the providers in detention. The wait times and access issues were studied to obtain specialty services. Some of the services, previously mentioned, are offered within detention. Some of the services are offered off site and people need to be transported from the detention facility, to the Contra Costa Regional Medical Center and/or Health Center, to receive the service. Depending where the services are located, there may be additional logistical considerations.
- Before transporting a patient, the length of time of the appointment and where the appointment is located, needs to be arranged through the Sheriff's Office
- There is one clerk in detention that does a lot of the scheduling
- Additional staff is required in different areas to be more efficient
- Obtaining authorizations was noted as a lengthy process
- In reference to the M module, is for all genders, requiring additional mental health needs. There is a multidisciplinary team that works, in the M module, including: specially trained deputies, clinicians, nurses. The team wanted to figure out how to provide more therapeutic groups for the patients in the M module. The groups are to provide tools and information, to the patients, as they transition back into the community and to improve coping skills and distress. It is a great opportunity to work with the patients that are there, both therapeutically and to provide some structured activities for those patients
- Patients were really interested in the evening groups, clinicians did want to offer evening groups, but other urgent priorities prevented the evening group activity to come to fruition. The team noted a "next step" process, to be able to provide the evening group. At all events, the patients were asked: what types of groups did they want, what they were interested in, what had they experienced that they really liked. Some quotes were provided, from several patients. The preferred length of time for groups



was 60 minutes and patients liked WRAP services, which are now implemented in detention, involving more patient participation.

- As part of the test given to patients, they were asked to identify depression symptoms and what they liked about the group experience. The patient's comments were positive.
- The accomplishment for the current week, for specialty care and groups was appointment availability was increased for detention patients. Requested a block of time set aside for detention patients, from CCRMC and the Health Centers. For example, optometry blocked appointment times; the dental flow was made more efficient, designed and improved workflows for scheduling and transportation. It was important that different departments participated in the event, to witness what each job task entailed. Staff members from the Sheriff's Office participated in the week-long event as well. The process deepened the teams understanding regarding the patient's choices and to think more about what questions need to be asked to gain more clarity regarding the patient's wants.
- Improvements were made towards documentation for clinicians, to streamline the process and to be able to facilitate the groups
- Members from the Sheriff's Office were part of the team, along with staff members that work in detention and staff that works outside of detention, to review collectively the process and identify where the improvements were needed
- The March event was focused on pre-release planning and reentry, due to the complexity of the process; for the person entering and for the hosts of service providers. The first week focused on the team learning about the different services, to become more acquainted with all the services being provided and be more efficient. From a health perspective, reentry is the largest vulnerable of the populations in our community. The reentry population has a higher risk of death in the first two weeks. There is an opportunity to address the high risk, most vulnerable population, to effect what happens after reentry into the community and help these individuals make the transition sooner. The Martinez detention facility processes approximately 1000 releases per month. The West County detention facility processes approximately 900 releases per month. The days and time for release varied (see attachment); considerations of available staffing and workflows were reviewed, to be available to provide services during peak release times. Recognizing peak times, brought to light the services available during non-business hours. Improvement teams focused on assessing, finding out what the individual's needs are, before the person is released. How to provide a 30 day supply of medications upon release, and continue to take their medications after release. How to link and connect released individuals to benefits and services. Ask individuals if they have housing or a place to stay, health coverage, require substance abuse treatment, after they are released. Detention Mental Health, the County Office of Education and other departments are becoming more involved in doing prerelease planning, for reentry to the community.
- Housing, employment and food are a higher priority, upon release; health care is a lower priority. MediCal benefits are suspended during the incarceration period. Staff is assisting individuals to reapply for MediCal so that their benefits can be reinstated, to follow up with health and mental health care appointments and be able to obtain a refill on their medications. The process to reapply for MediCal benefits was previously unclear and cumbersome, for individuals in detention. Out of the 18% of incarcerated patients, that are receiving medications, only 3% are released with medications. This is due to approximately on 25% of those incarcerated have a projected release date it is difficult to plan if the release date is unknown to staff members. How can staff provide medications for individuals being released and what system can be implemented so that unplanned releases, can receive their medications

too. The patient must communicate to the staff, their release date, and submit a request for their medications to be ready at the time of release. The process was reviewed and assessed to find alternatives to streamline the process. Prior to the new system, individuals being released were receiving a 14 day supply of medications; the new system increased the supply to provide a 30 day supply of medications, in case there is a delay in reinstating the person's MediCal benefits. Medications were placed with the individual's, locked belongings. Often times, staff were not made aware that the individual's medication were placed in the bin, with the person's belongings, therefore medications were not given or seen when releasing personal belongings to the individual. Custody staff, involvement in the team assessment process, assisted in the implementation of changing the process.

- Another identified issue is telephone access and privacy. Postings pertaining to services were not posted near the phones in detention, making accessibility not feasible. The unavailability to adequate phone access, made it difficult for incarcerated individuals to schedule or access services, post release. Phone calls are limited to 12 minutes per individual and if they were placed on hold for an extended period of time, they would have to drop the call and reattempt at a later time. Some phone numbers to services, such as dialing 211, is not accessible while in detention.
- While interviewing released individuals, it was noted that a bus schedule is not provided at the bus station or in the release lobby area. A BART ticket is given to release individuals, for a fixed amount in most cases the amount is insufficient to people's needs. The resources provided at release are inadequate. No free phone access, the phones in the lobby area cost money and no money is given to access the phones. Many individuals do not have a plan or a place to go to upon release, no phone access and no money to get them reconnected to their families or loved ones. The team studied how to make the process better for people, the most vulnerable and largest population. One person informed staff that in the San Francisco detention, people being released are met by individuals that are able to assist or provide services.
- The Transition Clinic is a service, provided by Health Services, offering outpatient and support group services. The referral process, from detention health to the transition clinic, was assessed and changes will be implemented to offer a more streamlined process. During the support group, at the Transition Clinic, it was noted that 70% of the individuals did not have any emergency room visits, 61% were not rearrested during the timeframe and most patients kept their outpatient treatment appointments. To summarize, having a clinic that provided support services, provided better health outcomes. There are two Transition Clinics, one at the West County Health Center and another facility at the Pittsburg Health Center.
- During the Rapid Improvement Event, it was resolved to obtain approval, to standardize the process and be able to provide patients with a 30 day supply of medications, upon release.
- The CORE team was called, for some of the individuals being released, met the individuals and transported the individuals to a CARE Center and connected the people to their families. The CORE met with individuals at various times and during the evenings as well. A person being released was very pleased that the CORE team was present and gave the staff person a big hug, stating that they did not require services but was happy to see someone present, to meet them after being released.
- The team was comprised of the Martinez and West County Detention staff of custody and health, subject matter experts, sponsors are Anna Roth, Director of Contra Costa County Health Services (CCCHS), and Matthew Schuler, the Assistant Sheriff and the Leadership Support Advisory Team, who provided added input for focus.

- Gina- asked if DBT group therapy was being provided- Erika will refer question to the Chief of Detention Mental Health Services, David Seidner
- Leslie- is the issue of insufficient staffing being addressed and hired quickly to be able to respond to the patient's needs? Erika = Yes, the issue is being addressed
- Lauren- According to a previous report received, the ACCESS Line received an outstanding review in the triennial audit, but according to your statements, it was not the case when those in detention tried to use the ACCESS Line. Is the Behavioral Health Director aware that the ACCESS Line is not working, the way it was reported to be working?
- Erika responded: The Acting Behavioral Health Director was aware of the issue, before today's presentation. Keep in mind that the tests done were for a short period of time, only for a one week period.
- Lauren- the other question is regarding MediCal- if you as Behavioral Health and health providers, have worked and asked the Sheriff, maybe it's actually a legislative issue; the poor, who are not convicted of any crime yet, are in our jails they are awaiting trial, they are not convicted, yet do they also lose their MediCal/Medi-Care benefits just by the fact that they are awaiting trial? They have not been convicted, some may not be convicted. That's a question that maybe we as a society need to ask ourselves about; if a person is wealthy and can get bail, while awaiting trial, they keep all their benefits. If a person is poor, then they don't. Then on the slide that said, pertaining to the M module, "with more significant mental health and medical needs". The presentation was wonderful, but the one thing as a mental health advocate, that I would like to point out is that mental illness and mental health are medical needs. To write down, "mental health and medical needs," it seems as if the statement reads that mental illness isn't a medical need. It is as much a medical need as anything else. I have received comments from the public that there is a problem with the ACCESS Line, but apparently it didn't show up in the triennial audits and in the EQRO's. The public itself is experiencing problems with the ACCESS Line.
- Erika- I agree and I will make sure that the wording gets changed.
- Doug- What are steps are being looked at in the horizon and how are they being looked at, for when the West County Detention facility, the new expansion and the M Module and most of Detention moves over to the new facility. What steps and how is your group looking to incorporate those, into the system of care, three or four years out.
- Erika- on behalf of the detention and health leadership, the improvements are being done now, before the new West County facility, especially the reentry units opens that the improvements are in place.
- Jaspreet- there is a lot of work that needs to happen before decisions are made pertaining to the implementation of the changes and prior to the opening of the new facility. We will be looking at other workflows and more into the needs of our patients in detention and out of detention. It will take two to three years to successfully implement the new processes; this is why we are starting the work now, before the new facility is built.
- Sam- when describing detention, are you combining both the Martinez and West County facilities? What is the average census for Martinez and for West County? Erika- When we discuss about detention, we do combine them as a whole. There are approximately 1500 in the adult detention, at both facilities.
- Public member- Is there a possibility of having additional staff, at the detention facilities, assisting patients in completing the MediCal form? In the past, if someone was in the detention facility and needed psychiatric care hospitalization, the county had an arrangement with a different county which had an inpatient clinic and they no longer have that relationship. I am wondering if there is available psychiatric hospitalization for people who do require hospitalization and happen to be in a detention

<p>facility.</p> <ul style="list-style-type: none"> <li>• Dr. White- there has been a lot of discussion regarding this issue and there are many issues administratively, administering medications involuntarily, it is an area of focus</li> <li>• Jaspreet- there is discussions regarding connecting staff member’s workflow to the needs of the patients, including providing assistance in filling out the MediCal form. We have hired an additional psychiatrist for detention. We are also looking into training our staff in assessments and medication management. There is a lot of work happening and a lot of discussions, the team is meeting almost every other day, to look at how do we best provide services to our patients, who need mental health care in detention</li> <li>• Joe- What protocols and procedures have changed to ensure that the sustainability of that process keeps and maintains its current state?</li> <li>• Erika- that is exactly why we paused and postponed the Rapid Improvement Events until the fall, because we are putting in place all the policies, procedures, standard workflow and training the staff</li> <li>• Teresa-we all know that we loss the access to Santa Clara County, and why, we are not the only county that was impacted. I am concerned about our patients in detention that require a higher level of care and that are being placed in safety cells and individuals picking up extra charges for the lack of available treatment at in detention. I am doing a shout out to the Commission to work with this process and not to forget the patients that lack capacity to voluntarily ask for things/treatment, for those who are suffering in detention. We need to use all the tools in our tool box.</li> <li>• Dr. White- I agree, we need to have the same level of care in detention as we have in our community environment, we are all aware of it and placing a lot of effort towards that issue</li> <li>• Jaspreet- we are looking into making a lot of changes, including trying to catch behaviors, before they escalate to where the person loses the capacity. We are picking pieces off the entire process and studying the pieces and making changes where they are needed. We all want what is best for our patients.</li> </ul>	
<p><b>X. DISCUSS proposal to advocate to law enforcement for always requiring a medical evaluation at PES of people when they possess a weapon and/or who pose harm to self/others at the scene of a call for an involuntary hospitalization (5150)-Lauren Rettagliata, MHSA/Finance Chair and Commissioner for District II</b></p> <ul style="list-style-type: none"> <li>• <b>Lauren-</b> this request is for the Health Services Director to issue a letter to all law enforcement officers about how important this is</li> <li>• <b>Gina-</b> Can this be discussed further at the Justice Systems Committee?</li> <li>• <b>Chair/Lauren:</b> agreed</li> </ul>	<p><b>* Forwarded to the next Justice Systems Committee meeting on 6/26/18</b></p>
<p><b>XI. DISCUSS motion to communicate our support for the Behavioral Health Administration’s efforts to collaborate with the Regional Center of the East Bay to ensure the best quality of care for patients who are dual diagnosed with severe mental illness and emotional illness and developmental disabilities—Lauren Rettagliata, MHSA/Finance Chair and Commissioner District II</b></p> <ul style="list-style-type: none"> <li>• <b>Lauren-</b> this is very timely and the meeting will take place this Friday, 5/4/18 or 5/11/18. The Region 4, advisory board is really backing a collaborative effort between Behavioral Health Administration and the Regional Center of the East Bay. This is about sending out a letter, in support of the collaborative work that they are doing to meet the needs</li> <li>• <b>Diana-</b> Can you please explain what the letter of support will do? What are we trying to accomplish?</li> <li>• <b>Lauren-</b> it became evident in the Quality of Care meetings and in the Mental Health Services Act Program and Fiscal Reviews,</li> </ul>	

	<p>especially Fred Finch, I mentioned it in Assisted Outpatient Treatment, that they were having extreme difficulty meeting the needs of those people that have both a developmental disability and a severe mental illness and needed the collaboration of both agencies, to decide how to best care for these individuals. As a Commission, we have not submitted a letter of support. The group is trying to obtain collaboration across all areas</p> <p><b>MOTION MADE BY GINA SWIRSDING, TO CREATE AND SUBMIT A LETTER, TO ENCOURAGE AND SUPPORT THE EFFORTS STATED PREVIOUSLY, SECONDED BY DOUGLAS DUNN</b></p> <p><b>VOTE: 8-1-0</b></p> <p><b>YAYS: Supervisor Diane Burgis, Barbara Serwin, Diana MaKieve, Mike Ward, Leslie May, Gina Swirsding, Doug Dunn, and Lauren Rettagliata</b> <b>NAYS: Sam Yoshioka</b> <b>ABSTAIN: none</b></p> <p><b>ABSENT: Duane Chapman, Geri Stern, Patrick Field</b></p> <ul style="list-style-type: none"> <li>• Leslie- I have worked with clients and the Regional Center of the East Bay, they will not work with anyone that has only mental health issues. I feel the letter will fall on deaf ears</li> <li>• Sam- I have reservations with the motion, the fact that we don't have anyone from the Behavioral Health Administration to inform us of what they would want us to support, not as it is stated in the item's heading</li> </ul>	
<p><b>XII.</b></p>	<p><b>DISCUSS goal for improving recruitment, training, mentoring engagement and retention of new Commissioners—Barbara Serwin, MHC Chair</b></p>	<p><b>*Forwarded to the next meeting on 6/6/18</b></p>
<p><b>XIII.</b></p>	<p><b>RECEIVE Commission liaison reports:</b></p> <ol style="list-style-type: none"> <li>1) AOD Advisory Board- Sam Yoshioka –</li> <li>2) CPAW General meeting-Douglas Dunn-</li> <li>3) AOT Workgroup Meeting- Lauren Rettagliata</li> </ol> <p>Lauren- will provide report read, to EA to attach to minutes</p>	<p><b>*Forwarded to the next meeting on 6/6/18</b></p> <p><b>**Lauren Rettagliata will email report to EA to attach to minutes</b></p>
<p><b>XIV.</b></p>	<p><b>Adjourned Meeting @6:32pm</b></p>	

# 2018 Commission and Committee members

Mental Health Commission (MHC)	MHSA/Finance Committee (FIN)	Quality of Care Committee (QC)	Justice Systems Committee (JS)	EXECUTIVE Committee (EC)	BYLAWS Task Force
1 <sup>st</sup> Wednesday 4:30--6:30 pm (full membership-16 + 1 BOS alternate)	3 <sup>rd</sup> Thursday 1:00--3:00pm (3 to 5 members)	3 <sup>rd</sup> Thursday 3:15--5:00 pm (3 to 5 members)	4 <sup>th</sup> Tuesday 2:00 to 3:30 pm (3 to 5 members)	4 <sup>th</sup> Tuesday 3:30 to 5:00 pm (3 to 5 members- vote)	(3 to 5 members)
<b>1- Chair Barbara Serwin Consumer District II</b>	<b>Chair- Lauren Rettagliata</b>	<b>Chair- Barbara Serwin</b>	<b>Chair- Diana MaKieve</b>	<b>Chair- Barbara Serwin</b>	<b>Duane Chapman</b>
<b>2- Vice Chair Duane Chapman Member-at-Large District I</b>	<b>Vice Chair- Douglas Dunn</b>	<b>Gina Swirsding member</b>	<b>Vice Chair Gina Swirsding</b>	<b>Vice Chair- Duane Chapman</b>	<b>Sam Yoshioka</b>
<b>3- Supervisor Diane Burgis District III</b>	<b>Sam Yoshioka member</b>	<b>Leslie May member</b>	<b>Geri Stern member</b>	<b>Diana MaKieve member</b>	<b>Gina Swirsding member</b>
<b>4- Alternate BOS rep Supervisor C. Andersen District II</b>	<b>Leslie May member</b>	<b>(VACANCY)</b>	<b>Duane Chapman Pro tem member</b>	<b>Michael Ward member</b>	<b>Leslie May member</b>
<b>5- Gina Swirsding Consumer District I</b>	<b>(VACANCY)</b>	<b>(VACANCY)</b>	<b>(VACANCY)</b>	<b>(VACANCY)</b>	<b>(VACANCY)</b>
<b>6- Geri Stern Family Member District I</b>					
<b>7- Diana MaKieve Member-at-Large District II</b>					
<b>8- Lauren Rettagliata Family Member District II</b>					
<b>9- Douglas Dunn Member at Large District III</b>					
<b>10-Julie Ann Neward Family member District III</b>					
<b>11-Consumer District III (vacant)</b>					
<b>12-Sam Yoshioka Family Member District IV</b>					
<b>13-Consumer District IV (vacant)</b>					
<b>14-Member-at-large District IV (vacant)</b>					
<b>15-Mike Ward Consumer District V</b>					
<b>16-Leslie May Family Member District V</b>					
<b>17-Joe Metro Member at Large District V</b>					

# Mental Health Services Act (MHSA) Three Year Plan Update for FY 2018-19

## OUTLINE OF DRAFT PLAN UPDATE

# FY 18-19 Plan Update Summary

- The Three Year Plan proposes to set aside \$50.5 million for fiscal year 2018-19 to fund 85 programs and plan elements. This is no change from the budget authority authorized by the Board of Supervisors in June 2017.
- The Plan Update continues the Board approved strategy to spend down an average of \$6 million annually from the County's MHSA unspent fund balance.
- To avoid reversion to the State the Plan Update contains a plan to spend PEI and WET dollars by 2020 that were identified by the State as subject to reversion
- It is anticipated that current total budget spending authority will not need to be reduced in order to fully fund MHSA programs and plan elements in the foreseeable future.



# Plan Outline Summary

- Introduction
- Table of Contents
- Vision
- Community Program Planning Process
- The Plan
- The Budget
- Evaluating the Plan
- Acknowledgements
- Appendices
  - Mental Health Service Maps
  - Program and Plan Element Profiles
  - Glossary
  - Certifications, Funding Summaries
  - Public Comment and Hearing
  - Board Resolution

# Introduction

- Describes MHSA, MHSA values, statutory and regulatory requirements
- Highlights updates to the current Three Year Plan
  - A description of this year's Community Program Planning Process
  - Outcome indicators for FSP programs and PEI categories
  - Emerging programs and initiatives
  - Updated program profiles to reflect outcomes for FY 2016-17 for MHSA funded programs
  - Funding levels to allow for programs' increased cost of doing business

# Vision

We intend to utilize MHSA funding to assist Contra Costa Behavioral Health Services in addressing three key areas:

- Access – improve assistance with eligibility, transportation, shorten wait times, increase availability after hours, provide services that are culturally and linguistically competent
- Capacity – take the time to partner with the individual and his/her family to determine the level and type of care needed, coordinate necessary health, mental health and other needed resources, and then successfully work through challenging mental health issues
- Integration – work with our health, behavioral health and community partners as a team to provide multiple services coordinated to a successful resolution.

We need to continually challenge ourselves to improve our response to individuals and their families who need us the most, and may have the most difficult time accessing care.

# Needs Assessment

- In 2016 CCBHS conducted a data driven assessment of public mental health needs to complement the planning process.
- Prevalence and penetration rates were used to determine that the County is proportionally serving all three regions as well as by race/ethnicity, age group and identified gender. Asian/Pacific Islanders, Latina/os, children ages 0-5 and the elderly are slightly underrepresented. All service rates exceed state averages.
- Expenditure data indicate significant services available at all levels of care, with an oversubscription of funds paying for locked facilities.
- Workforce analysis indicate a critical shortage of psychiatry time, with an underrepresentation of Latina/os in the CCBHS workforce.

# Community Program Planning Process

- Describes the process
- Describes the Consolidated Planning and Advisory Workgroup and ongoing stakeholder participation
- Describes and summarizes results of the recently completed Community Program Planning Process for FY 2018-19
- Links prioritized needs to MHSA funded programs, projects and plan elements contained in the Three Year Plan

# Community Program Planning Process Highlights (1)

- CPAW planned and hosted three community forums
- 280 individuals attended forums in Richmond (West), Martinez (Central), and Brentwood (East)
- Attendees self identified:
  - 24% as a consumer
  - 23% as a family member
  - 38% as a service provider
  - 17% as a community member
- Small group discussions addressed topical questions developed by consumer, family member and service provider representatives
- Attendees prioritized identified mental health needs

# Community Program Planning Process Highlights (2)

## Prioritized Needs:

	Last Year
1. More housing and homeless services	1.
2. Getting care in my community, my culture, my language	9.
3. More support for family members	2.
4. Improved response to crisis and trauma	6.
5. Finding the right services when you need it	5.
6. Better coordination of care	3.
7. Getting to and from services	11.
8. Intervening early in psychosis	8.
9. Children and youth in-patient and residential beds	4.
10. Serve those who need it the most	13.
11. Support for peer and family partners	7.
12. Increased psychiatry time	unranked
13. Care for homebound frail and elderly	12.
14. Assistance with meaningful activity	10.
Unranked - Help moving to a lower level of care as one gets better	14.
Unranked - Better program and fiscal accountability	15.

# The Plan

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Innovation (INN)
- Workforce Education and Training (WET)
- Capital Facilities and Technology (CF/TN)

Each component leads with a short description of the component and categories within the component, and then lists and describes each program or plan element, cost allocated, and number to be served.



# Community Services and Supports

\$36.8 million to fund programs and plan elements that provide services to approximately 2,000 individuals - children who are seriously emotionally disturbed, transition age youth (TAY), adults and older adults who are seriously mentally ill.

- **Full Service Partnerships** (\$22.6m):
  - 9 Full Service Partnership Programs serving all age groups and all county regions
  - Assisted Outpatient Treatment
  - FSP support staff at all children and adult clinics
  - 3 Wellness and Recovery Centers
  - Hope House (transitional residential center)
  - MHSA funded housing services (temporary, supported or permanent)
- **General System Development** (\$14.2m):
  - Children's Wraparound and EPSDT expansion
  - Older Adult Program
  - Clinical staff at the Miller Wellness Center, Concord Health Center
  - Clinic support and liaison staff to PES and CCRMC
  - Administrative support and quality assurance staff

# Prevention and Early Intervention

\$8.9 million to fund 24 MHSAs programs that provide prevention and early intervention services to approximately 26,000 individuals. All are designed to prevent mental illness from becoming severe and debilitating, and 1) creates access and linkage to mental health services, 2) reduces stigma and discrimination, and 3) provides outreach and engagement to underserved populations. All programs are in the following 7 categories:

1. Seven programs provide Outreach for Increasing Recognition of Early Signs of Mental Illness (\$1.1m)
2. Five programs provide Prevention Services that reduce risk factors and increase protective factors (\$1.7m)
3. The First Hope program provides Early Intervention Services for youth at risk of or who are experiencing early onset of psychosis (\$2.7m)
4. Three programs provide Access and Linkage to Mental Health Services (\$.9m)
5. Six programs Improve Timely Access to Mental Health Services for Underserved Populations (\$1.6m)
6. The Office for Consumer Empowerment (OCE) provides leadership and staff support that addresses efforts to Reduce Stigma and Discrimination (\$.4m)
7. Contra Costa Crisis Center and County staff address Suicide Prevention (\$.5m)

# Innovation

\$2.2 million in FY 2017-18 to fund new or different patterns of service that contribute to informing the mental health system of care as to best or promising practices that can be subsequently added or incorporated into the system.

- 3 projects are approved and will be in operation for FY 18-19 (\$1.4m):
  - Coaching to Wellness. Adding peer wellness coaches to the adult clinics
  - Partners in Aging. Support for frail, homebound older adults
  - Overcoming Transportation Barriers. Assisting consumers overcome transportation barriers to accessing services
- 2 projects are in development, and are expected to be in operation during the Three Year Plan (\$.8m – estimated):
  - CORE – multi-disciplinary treatment team to serve youth with mental health and substance use disorders
  - CBSST – bringing cognitive behavioral social skills training to clients living in augmented board and care facilities

# Workforce Education and Training

\$2.6 million annually from Contra Costa's MHSAs unspent funds to recruit, support and retain a diverse, qualified paid and volunteer workforce. The five WET categories are:

1. **Workforce Staffing Support.** (\$1.23m) Funds the county operated senior peer counseling program, a new NAMI operated family volunteer support network, and WET administrative staff
2. **Training and Technical Assistance.** (\$.23 m) Funds Mental Health First Aid, Crisis Intervention Training, NAMI Basics/Faith Net/de Familia a Familia and various county and contract staff trainings
3. **Mental Health Career Pathway Programs.** (\$.5m) Funds the college accredited SPIRIT course where approximately 50 individuals yearly are trained as peer providers and family partners
4. **Internship Programs.** (\$.35m) Provides approximately 75 graduate level clinical intern placements in county and contract operated community mental health programs to increase workforce diversity
5. **Financial Incentive Programs.** (\$.3m) Establishes a locally administered loan repayment program to address critical workforce shortages, such as psychiatrists, and supports upward mobility of community support workers

# Capital Facilities and Information Technology

This component enables counties to utilize MHSA funds on a one-time basis for major infrastructure costs necessary to implement mental health services and supports, and to generally improve support to the County's community mental health service system. For FY 17-20:

- **\$52,000 projected to be remaining for FY 18-19 of MHSA funds to complete and integrate Behavioral Health Services' electronic records system with the Epic system currently in use by the County's Health Services**
  - Completion forecasted for FY 18-19
  - As per the provisions of the 2010 proposal any costs that exceed the originally approved \$6 million will be born by the County's Health Services Department

# The Budget

- Provides estimated available funds, revenues, expenditures and projected fund balances by component for Fiscal Years 18-19 and 19-20
- Projected fund balances will be updated in FY 19-20 MHSA Plan Update as revenues and expenditures actualize
- Projected revenues include state MHSA Trust Fund distribution, interest earned, and federal financial participation (Medi-Cal reimbursement)
- The County maintains a prudent reserve of \$7,125,250 to ensure that services do not have to be significantly reduced in years in which revenues are below the average of previous years. This is in addition to available unspent funds from previous years.

## The Budget (2)

- \$7.8m in unspent CSS funds from previous years is transferred to the WET component in order to finance the proposed WET category expenditures for the three year period
- The \$1.7m received in 2016 for the Special Needs Housing Program has been added to the CSS budget for FY 17-18. Any of these funds not spent during FY 17-18 will be carried over to the FY 18-19 budget
- A collective increase in budget authority for FY 18-19 and 19-20 allows for an increase in the cost of doing business. Subsequent Three Year Plan annual budget authority will be reviewed based upon actual costs and adjusted, if appropriate, for Board of Supervisor review and approval
- It is projected that the requested total budget authority for the Three Year Plan period enables the County to fully fund all proposed programs and plan elements while maintaining sufficient funding reserves (prudent reserve plus unspent funds from previous years) to offset any reduction in state MHSA Trust Fund distribution or federal financial participation (Medi-Cal reimbursement)

# Evaluating the Plan

- Describes a program and fiscal review process with written report to determine whether MHSA funded programs:
  - Meet the letter and intent of MHSA
  - Support the needs, priorities and strategies identified in the community program planning process
  - Meet agreed upon outcomes and objectives
  - Are cost effective
- Includes a quarterly MHSA financial report to enable ongoing fiscal accountability.



# Acknowledgements

A thank you to individuals who shared their stories, provided input, and who are working to make the system better.

# Appendix A - Mental Health Service Maps

Provides six one page pictorials of all Contra Costa Mental Health's services broken down by the following:

- East County adult, older adult and transitional age youth
- East County Children's
- Central County adult, older adult and transitional age youth
- Central County Children's
- West County adult, older adult and transitional age youth
- West County Children's

# Appendix B - Program Profiles

Provides a profile of each MHSA funded program or plan element according to the following outline:

- Organization contact information
- Brief organization description
- Title(s) and brief description(s) of MHSA funded program or plan element
  - Total MHSA funds allocated
  - FY 16-17 outcomes
- Contains an alphabetized Program and Plan Element Profile Table of Contents

# Appendix C - Glossary

Provides an alphabetical listing and definition of terms and acronyms used in the document.

# Appendix D – Certifications

## Appendix E - Funding Summaries

- County Behavioral/Mental Health Director Certification
- County Fiscal Accountability Certification
- MHSOAC required funding summaries

# Appendix F - Public Comment, Hearing

## Appendix G – Board Resolution

- Will include evidence of Public Comment period and Hearing, and summary of public comments.
- Mental Health Commission’s review of draft plan and recommendations.
- Contra Costa Behavioral Health Service’s response to public comments and Mental Health Commission recommendations.
- Board of Supervisor Resolution

# Plan for Spending Funds Subject to Reversion

- The State has determined \$2 million in unspent PEI funds distributed to Contra Costa in FY 09-10 are subject to reversion back to the State, and \$167K in WET funds distributed in FY 06-07 are subject to reversion
- AB 114 and DHCS Info Notice gives counties until June 30 to submit a Board approved plan to spend the money by 2020
- Draft Reversion Plan earmarks the following MHSA funded programs to fully spend funds subject to reversion:
  - Expansion of PEI First Hope Program to add treating youth experiencing first psychotic episode
  - New WET Loan Repayment Program
- Reversion Plan to accompany Three Year Plan Update

# Timeline

- **APR 4/5** - 1<sup>st</sup> DRAFT Three Year Plan Update, to include Reversion Plan, shared with CPAW/MHC for input
- **APR 20 – MAY 20** - 2D DRAFT Three Year Plan Update posted for 30 day public comment period
- **JUN 6** - Mental Health Commission (MHC) hosts Public Hearing on Three Year Plan Update
- **JUN 11** – Public Comment, Hearing and MHC recommendations addressed - Three Year Plan Update submitted to County Administrator for inclusion on Board of Supervisors' (BOS) agenda
- **JUNE 19** – BOS considers Three Year Plan Update
- **JUNE 30** - Plan Update to include Reversion Plan sent to the State



# Your Input Is Most Welcome!

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