MENTAL HEALTH COMMISSION
FINANCE COMMITTEE MEETING MINUTES
August 18th, 2022 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Chair, Cmsr. Douglas Dunn, District III called the meeting to order at 1:31 pm. Members Present: Chair, Cmsr. Douglas Dunn, District III Cmsr. Leslie May, District V Cmsr. Barbara Serwin, District II Members Absent: Cmsr. Rhiannon Shires, District II Guest Speakers Sam Cavanaugh, Seneca Jessica Donohue, Seneca Other Attendees: Cmsr. Gina Swirsding, District I Angela Beck Jennifer Bruggeman Jen Quallick (Supv. Candace Andersen's ' ofc)	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: None.	
III. COMMISSIONERS COMMENTS: • (Cmsr. May) Unable to attend Executive meeting next week. I wanted to bring to attention that there has been some backbiting and discussion about me, in terms of what I do and say in the meetings and my attendance. I have not exceeded any attendance since I have been attending. If there has been a missed meeting, I notified in advance and for a good reason. In terms of things I say in these committee meetings, I speak from my heart and not because I have an agenda or supervisor or other political figure pushing me to say anything. I say because, what I do here, I do from my heart as it is my passion. In terms of backbiting and discussions, that is other opinions. Being a commissioner is wonderful, I have learned much and remaining on the commission it is my choice unless there is a serious violation and we would have to follow the CALBHB/C rules to have me dismissed. I have not violated any rules and I carry myself as a lady, and a good commissioner and member of the community. This is not my entire life. • (Cmsr. Serwin) I just want to reassure Cmsr. May that any discussions of absences, that is all laid out in bylaws, it is what it is. If you have exceeded absences, that is all it comes down to and not what anyone says. Everyone is on the same level playing field.	
IV. COMMITTEE CHAIR COMMENTS: **None.**	

V. APPROVE minutes from July 21st, 2022, meeting: • Cmsr. Douglas Dunn moved to approve the minutes as written. • Seconded by Cmsr. Leslie May **Vote:** 3-0-0 **Ayes:** D. Dunn, B. Serwin, L. May Abstain: none	**Agendas/minutes can be found at:** http://cchealth.org/mentalhealth/mhc/agendas-minutes.php

VI. REVIEW Behavioral Health Services (BHS) contracts below and ask questions to Program Managers, Jessica Donohue, LCSW, Executive Director, Seneca Contra Costa
<u>Seneca Outpatient Contract</u>
(Jessica Donohue) The Mobile Response Team (MRT) consists of 12 Crisis Clinicians and Counselors (half bilingual), 1 Peer Partner, 1 Program Supervisor, 1 Clinical Supervisor, and 1 Health Information Specialist. We are a team very focused on ensuring our crisis response staff feels very well equipped to handle the calls that come in and focus on very in depth, extensive trainings and service oversight, focused on suicide risk assessment and biopsychosocial factors with a family and community-centered approach, and placement stabilization.
What does the MRT do? The focus is on:
• Crisis stabilization with the aim to use the least intensive interventions, with a collaborative, youth- and family-centered approach
• Coordinate with law enforcement and Psychiatric Emergency Services as needed
• Work with the youth and caregivers to develop a safety plan to limit current and future crises
• Work collaboratively with existing treatment team members
• Link the youth to further mental health services when appropriate such as Wraparound, psychotherapy, support groups, other community services, etc.
• Provide in-person crisis support to families in need between 7am to 11pm Monday through Friday (between 11am and 9pm on the weekends, holidays 9am-9pm); 24 hour phone support
Foster Youth Placement Stabilization
• Family Urgent Response System (FURS):
  ○ 24 hour in-person support is now available to foster youth and former foster youth in the state of California.
  ○ If a youth is FURS eligible they can call the MRT line for phone and in-person support day or night.
  ○ FURS eligible youth can also be connected to MRT by calling the FURS state hotline at 833-939-3877
  ○ For more information on FURS: https://www.cal-furs.org/
• Eligibility:
  ○ Children and adolescents who live in Contra Costa County and have Medi-Cal or are uninsured
  ○ FURS eligible youth
  ○ Families who are privately insured and reach MRT may receive triage, assessment, and referrals to relevant services
• Access to MRT for family and members of the community:	

- Just call our 24 hour support line: 877-441-1089
- Service Providers with non-urgent referrals may email us at MRTReferrals@senecacenter.org
- If you're confused or want to talk about a potential referral, call Lauren Schiff, LCSW: 510-600-2423

- Once MRT is contacted:
  - You'll reach a recorded message, prompting you to choose a language (English or Spanish) and your reason for calling
  - Your call will automatically be routed to an MRT representative
  - You will be asked for identifying information about the youth and the caller's contact information, as well as immediate safety information
  - If in-person crisis support is deemed appropriate a COVID-19 Screening will be completed over the phone with caller
- Referrals from Psychiatric Emergency Services:
  - MRT receives referrals from psychiatric services from youth that are deemed eligible for MRT services
  - MRT is tasked with providing initial assessments, appropriate referrals, and ongoing crisis stabilization
- Families utilize MRT as needed while the youth is eligible
- While families are offered follow up appointments, MRT is a crisis stabilization service and the families determine when and how often they utilize MRT
  - **Crisis Linkage** is a service in which youth and family are referred for individualized support to link with community resources which may support their needs for a longer term
  - **Peer Partner** an individual with lived crisis experience who can, in addition to crisis support, provide youth and families with help to maintain safety plan practices, build coping skills, and process emotions after a crisis
- Not every youth we come into contact with is enrolled, there is a lot of service activity we provide that is not billable.
- Fiscal Year 2021-22 client data logged (all contacts):
  - Suicide threat made/high suicide risk 2284
  - Aggression (Multiple types) 1007
  - Suicidal attempt/gesture 946
  - Other (not specified) 938
  - Self-injurious behavior 923
  - 760
  - Aggression physical 672
  - Depression/non-suicidal 531
  - Runaway risk 492
  - General defiance/oppositional behavior 443
  - Threats of violence 432
  - Aggression, verbal only 396
  - Anxiety 307
  - Aggression property destruction 291
  - Substance use 227
  - Psychosis, general 198
  - Hallucinations, without delusions 179
  - Unknown 154
  - Panic Attacks 80
  - Truancy 61
- Fiscal Year 2021-22 referral/activity type
  - Follow-up call made 1971
  - Referral contact attempts 1208

○ Crisis call	1084
○ Referral received	1057
○ External treatment team collaboration	469
○ Crisis visit	282
○ Client closing	225
○ Referral dead-end	161
○ Administrative call	126
○ Other activity	95
○ Referral initial intake	53
○ Internal Seneca Treatment Team collaboration	30
○ Treatment team meeting	16
○ Follow-up visit made	13
○ Crisis referral	10

Data on clients served by region (listed below) and cities (in presentation), as well as type provided:

East County (2381)
Central County (2188)
West County (1693)
Unknown (538)

- 210 clients served, 215 New enrollments, 227 discharges, and 0.88 avg length of stay (months).

<u>Seneca Therapeutic Behavioral Services (TBS) Contract</u>

(Jessica Donohue) TBS is a behaviorally focused, individualized, intensive, time-limited mental health service for youth struggling with specific behaviors that impact their functioning. TBS is aimed at maintaining long-term behavioral success through the transfer of skills and effective interventions, supporting a youth to change high risk behaviors while emphasizing their strengths. The program is comprised of 6 TBS Specialists and one program/clinical supervisors who oversees all direct services.

The program is behaviorally focused, available to youth ages 5-21 and it is never a stand alone service (adjunctive) and youth always have (at least) another service provider involved and it is not meant to be a therapy model, it is behavioral specific. The goal of TBS is to understand the function of a youth's behavior, understand what need is to be met and teach the youth and their caregiver skills around meeting that need in more functional ways not impacting them in detrimental ways. The goal is (in a period of three-six months) to meet with youth and families intensively. This can mean, up to five-to seven days a week. Generally, we see a couple days a few, a few hours a week or per day that interventions are being provided, but with very targeted and specific behavior. We are one of many providers of TBS in the county and we receive all our referrals directly from the county TBS coordinator. We have little flexibility in terms of outreach or generating referrals. The county coordinator know how many staff is available, how many openings we have and they send us referrals.

A snapshot of our client data: 29 Clients served; 17 new enrollments; 20 discharges; and 7.55 avg length of stay (months). Generally, there is a time limited intervention and a lot of oversight and reporting requirements around progress is going with some clear parameters. When there is progress made in a particular target behave and sustained over a period of several weeks, the TBS intervention is intended to fade out. The goal is really targeted, intervention is very targeted and we have

to get specific approval to have it set beyond six months. That is why you will see (generally) between 6 and 9 months we are actually ending TBS.

We see lots of young kids. Over half our clients are in the 6-10 year old range. Half are in the adolescent 14-17 range. TBS is a fully fee for service program and completely funded by EPSDT (Early and Periodic Screening, Diagnostic and Treatment) billing and there are no other funding sources. It is always a pretty tight budget, maintaining a level of staffing, client referrals, that help us balance our budget. We found that having six (6) TBS specialists with a full client caseload, we are able to manage financially, but it is one of our tougher programs to ensure the funding is sufficient and the revenue generation is sufficient to cover costs for the program.

Comments and Questions:

(Outpatient – MRT)

- (Cmsr. May) Do you have a location out here in East County? (RESPONSE: Jessica Donohue) Yes. Golf Links is our new agency headquarters (our home office), Contra Costa home base is in Concord.
- (Cmsr. May) Regarding weekend services, I find that is when a lot of families need support. Weekdays, if they have school-aged, the children are mostly at school, but weekends when the families are at home and there are incidents there. Are you thinking about increasing or hiring full weekend staff at both locations? Were you thinking of expanding services to have staff full time on the weekends? (RESPONSE: Jessica Donohue) We do have staff available from 11:00am to 9:00pm on Saturday and Sunday. Several years ago, the county approached us regarding what it would take to have MRT available in person 24/7. We did a cross projection and analysis of our calls. Since we're available 24/7, we had some data around our calls (after hours) and we found we were missing a lot of morning callers (before school) and missing calls in the evening. We responded to the county and that we would like to be available, but it is expensive to have staff available and not working so we did a cross analysis and landed on the hours of 7:00am-11:00pm for the weekdays. If we start to miss more calls and there is a change in the trends, we would be able to expand availability.
- (Cmsr. May) Do you respond to the schools, as well? (Jessica Donohue) Yes, we do provide support anywhere a family is comfortable and where the need is. We absolutely are providers in schools as much possible.
- (Cmsr. Serwin) How many requests to you respond to for schools? (RESPONSE: Jessica Donohue) Not as many as expected (did not pull data), less than a fifth. We do report this information on a monthly basis to Gerold (Leonicker), we have an oversight meeting and gather our monthly reports for a fiscal year 2021-22 but have not complied for our annual report, but we could definitely share that if interested. It does show where the calls come from.
- (Cmsr. Serwin) Yes, the Quality of Care committee is looking at coverage of services for K-12, whether the schools are offering directly or through behavioral health services (BHS) and their service wraps around the whole community (all school districts)

(RESPONSE: Jessica Donohue) we were actually just speaking on Monday with Gerold regarding connecting with the county office of education to ensure we are connecting with all the schools we possibly can to ensure they are aware of the service. There is a capacity concern, if every school in the county started to call us, realistically with a team of 12. On any given day, we typically have up to 6 staff on (3 teams), so if we have three teams on and available to respond to crisis. If there are five schools across the district that had a crisis happening simultaneously, we would have to triage and make decisions around urgency or who we could get to. The challenge of opening the flood gates, and if we are not available—they won't call in the future. It can be tricky. We want to be available and make the most use of our team, but how do you get the word out fully, but also not be available (potentially) to meet all the needs.

- (Cmsr. Serwin) With respect to suicide vs. aggression in terms of the data on calls, the aggression has decreased and suicide has increased or has the aggression maintained, and suicide overtaken it? (RESPONSE: Jessica Donohue) I know the ratio has changed but don't know numbers, not sure.
- (Cmsr. Serwin) My last question, if you have a payment limit at $3.3mil, do you feel constrained by that budget or do you feel like you are working amply within it? Or is it one of those things if you can have another team? You could deploy more? Again, the Quality of Care committee is looking at quality of services and availability of service and that is why I ask. (RESPONSE: Jessica Donohue) It is super expensive to pay for people to be available, and not be able to ensure productivity. That is one of the challenges. Speaking to the fiscal balance of this contract, we have a very generous portion of our contract that is EPSDT (Early and Periodic Screening, Diagnostic and Treatment) 'bucket'. We have a really hard time coming anywhere close to maximizing the actual EPSDT side of our contract because you can't generate billable crisis. You can't require families meet with you and there is so much activity we do that is not billable. Several years ago when this contract was created, the county doubled the size of the contract, but it was only the EPSDT side and we can't really do more than we currently are. We have to know our costs will be covered. We are super grateful the county figured out how to cover our costs between general funds and MHSA-funding. We rely on that to build, if we increase by just one team, it will increase costs substantially but it is hard to predict how much more EPSDT revenue generation protentional that would lead to.
- (Cmsr. Dunn) How is the new state program 'FURS' funded? (RESPONSE: Jessica Donohue) Child welfare departments received an annual allocation from the state to be able to implement FURS. Some counties used county staff to develop some type of 24/7 coverage plan, many counties contracted with organizations to become that provider. In our situation, there is an MOU (memorandum of understanding) between child welfare and behavioral health. I believe BHS gets the entire allocation that child welfare receives and passes through to our contract. It is blended into our contract.
- (Cmsr. May) I am thinking, we need to (if you can possibly) meet with Pittsburg, Antioch, and Oakley school districts with brochures and ask

if they can introduce parental agreements at the school. That is a package (offering these services) and most likely they will do is connect you with the principal(s) to let you know who is and IEP/504 – those with severe behavioral issues. It is up to that principal, that's what those designations are. If there is outside resources to help the child at school, that is the law and they are supposed to welcome you with open arms. I would really like to see you expand out in East County. These schools need you. My youngest client is 6 yo and when you hear a client that young saying 'I really wish they had someone here. It's not me and my problems, there are other students and they really need help.' That is a six-year-old's observation, and out of the mouths of babes is where we really need to see through those eyes. If you have the parental agreements, you could start with those kids.

- (Cmsr. Dunn) Can we get a copy of the slides for the MRT presentations? (RESPONSE: Jessica Donohue) Of course.

(TBS)

- (Cmsr. Serwin) Just to clarify what TBS is, is it similar for DBT (Dialectical Behavior Therapy)? (RESPONSE: Jessica Donohue) DBT is skills based for a particular clinical presentation that it is focused on. TBS can target any range of behaviors that may be causing problems in functioning. It is not a specific modality. It is skills and behavior based intervention. Not an evidence-based therapeutic modality.
- (Cmsr. May) The greatest number served ages 6-11. That says a lot about the needs in that age groups. If they can get those services starting from that age, that small block, it really does help. Offering the TBS Services from age 6-11 is vital and it says a lot to where we are seeing the greatest need. It starts in childhood, the earlier intervention, the better.
- (Cmsr. Serwin) Do you feel the pressure of increased demand as you have overall for MRT? Do you feel you are facing unmet demand? Is it the same 'Catch22'? (RESPONSE: Jessica Donohue) It feels like a very different scenario. Knowing we are one of several providers, if we (for whatever reason) have diminished capacity, there are other providers that can take cases. The TBS program, people make referrals and often have a preference request. We try to maintain a diverse staff in all of our programs, but in TBS it tends to be specific requests and we aren't always able to meet all family needs all the time, but if every organization that is providing TBS is approaching their thinking in similar ways, there would be times where the TBS coordinator from the county might know which organization has someone that specializes in a certain area. I, personally, feel let pressure than on the MRT side.
- (Cmsr. Dunn) As we close off the TBS portion, I would like to say to you both, this has been very enlightening and look forward to getting the slides. The summary that Ms. Bruggeman very kindly put together for the June 16 meeting, in which we spoke about from the county perspective, mentioned the TBS involves West Contra Costa Unified School District (WCCUSD), Martinez USD, Mt. Diablo USD and Brentwood. (RESPONSE Jessica Donohue) One clarification on that document, I believe that was summary of our contract overall. TBS is

listed in the same contracts as our other individual contracts so TBS is not actually connected to those other school-based contracts but they are included in the same contract with the county, but as a separate program. • (Cmsr. Serwin) I just want to be achingly clear that TBS is not school-based but individual families, referrals to you. (RESPONSE: Jessica Donohue) Correct, another existing longer-term provider (clinical case manager or therapist, possibly psychiatrist can also refer), would make a referral, not a school-based program. • (Cmsr. May) That is what it makes it better, there is a problem when we have TBS billing medical. You are not overlapping services, it is more of a specialty type of service. • (Cmsr. Dunn) As a 2018 spirit graduate, MRT is where I did my internship. I saw firsthand what you all do.	
VII. RECEIVE high level overview and answer questions regarding 2021-2022 actual and 2022-2023 projected county Mental Health Services Act (MHSA) budget, Jennifer Bruggeman, LMFT, MHSA Program Manager This is a high-level budget update in terms of the MHSA Budget over the past couple of years, related to the current three-year cycle we are in. We are currently, headed into the last year of the 2020-2023 MHSA 3-year program and expenditure plan. • Original budget proposal impacted by COVID -19 o New programming put on hold o Unspent funds used 1x only (FY20-21) to prevent MHSA treatment programs for closing o Original fiscal projections were poor, but ultimately no negative impact to MHSA funding • Three Year Plan is a snapshot in time • Annual Updates reflect budgetary and program changes It has been a pretty wild three year cycle because of COVID. The original budget was pretty much totally scrapped with the onset of COVID in March 2020 and at that time, there was talk and concern around the unspent MHSA funds for our county (and all counties across the state). There was a lot of new programming slated at that time. A decision was made to put the new programming and expansion on hold when COVID hit, which was in the spring, just as we were getting ready to take our plan to the Board of Supervisors (BOS). Some of the changes that happened, with concern of the MHSA Programs that provide higher level intensive service and specialty mental health services, would be at risk of closing or serious financial issues (with stakeholder input), a decision was made to have one-time funding for that year only (2021) of $7mil to fill that gap and help support some of those programs to keep them afloat during that first challenging year of COVID. There were some fiscal projection made by the consultant for the state and they didn't look very goods. We planned very conservatively based on that, ultimately, there wasn't much of a negative impact on MHSA funding and we are now in a position of having more funding than anticipated in term of unspent funds. Just a reminder, the three year plan annual updates are really just a snapshot in time because it is constantly changing.	

Starting with the first year (2021), the breakdown by component, plan budget, actual expenditure and variance:

○ Community Supports and Services (CSS)	$46,933,017	$46,977,262	($44,245)
○ Prevention and Early Intervention	$9,028,430	$10,293,736	($1,265,306)
○ Workforce Education and Training	$2,610,935	$1,609,861	($1,001,074)
○ Capital Facilities Needs and Technology	$500,000	$6,340	($493,660)
○ Innovation	$2,240,330	$1,564,163	($676,167)
○ **TOTALS**	**$61,312,712**	**$60,451,362**	**($861,350)**

Fiscal year 2021-2022, the breakdown by component, plan budget, actual expenditure and variance:

○ Community Supports and Services (CSS)	$40,267,273	$38,407,953	$1,859,320
○ Prevention and Early Intervention	$9,028,430	$10,242,135	($1,213,705)
○ Workforce Education and Training	$2,610,935	$1,970,151	$640,784
○ Capital Facilities Needs and Technology	$250,000	$293,287	($43,785)
○ Innovation	$2,240,330	$964,312	$1,276,018
○ **TOTALS**	**$54,396,968**	**$51,878,336**	**$2,518,632**

We received approval to increase our budget approximately $9mil this year ($63.2mil) and we have spoken to the annual update for this year, a lot is around housing and some of the needs identified pre-COVID. We went back to looking at the areas of expansion we wanted before COVID and which are still a priority and how can we incorporate those to our planning. We don't yet know what all of our expenditures and variance will be but this is the planned budget for Fiscal year 2022-2023, the breakdown by component, plan budget, projected expenditure and variance:

○ Community Supports and Services (CSS)	$47,899,000	$48,149,000	($250,000
○ Prevention and Early Intervention	$9,849,000	$9,849,000	--
○ Workforce Education and Training	$2,943,000	$2,943,000	--
○ Capital Facilities Needs and Technology	$250,000	--	$250,000
○ Innovation	$2,329,000	$2,329,000	--
○ **TOTALS**	**$63,270,000**	**$63,270,000**	

Unspent funds from FY 20-21 $44,972,710
Unspent funds from FY 21-22 $54,825,084
Unspent funds from FY 22-23 $75,420,734

Comments and Questions:

- (Cmsr. Dunn) I am following the care court issue very carefully. The very latest, based on the 13-0 vote in the appropriations committee of the assembly, this is the last committee it goes to before to the senate. It states that beyond the $65mil that Governor Newsom and the legislature put in to pay for care court expenses, they say MHSA funds may be used for other care court costs. I am just sending up the warning signatures the legislature may be looking to. (RESPONSE: Jennifer Bruggeman) Yes, because there are a lot of other costs associated with care court that would fall more under BHS, such as housing and treatment, psychiatry. But no decision has yet been made but I am sure we will be watching very closely.
- (Cmsr. Dunn) I personally disagree using MHSA funds and think there should be more funding elsewhere as there are other very legitimate MHSA needs we need to look at (back to the original budget) with the different needs we have in the county now than we did back then.

VIII. DISCUSS future Agenda items: Round 5 BHCIP competitive funding projects, Commissioner Douglas Dunn

Cmsr. Griffin and I were able to be involved in the BHCIP Round 5 listening session. One of the slides (they are slow getting them out) we found out one of the items that will be available, there are still some youth projects that can be funded, peer respite centers. Also on the adult side, mental health rehabilitation centers for conservatees. Starting next month, after Round 4 closes at the end of this month, I understand Seneca is submitting something in conjunction with the county. Thank you very much. The finance committee will be turning it's attention to Round 5 areas that can be funded, and see what contracts we have in these areas so we know what we are looking at for possible areas to fund for Round 5.	
IX. Adjourned meeting at 3:00 pm	