MENTAL HEALTH COMMISSION
FINANCE COMMITTEE MEETING MINUTES
October 20th, 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 1:39 pm. <u>Members Present:</u> Chair, Cmsr. Douglas Dunn, District III Cmsr. Rhiannon Shires, District II <u>Members Absent:</u> Cmsr. Gerthy Loveday Cohen, District III Cmsr. Leslie May, District V <u>Guest Speakers</u> Kennisha Johnson, LMFT, Mental Health Program Chief of Housing, Contra Costa Behavioral Health Services (CCBHS) <u>Other Attendees:</u> Cmsr. Barbara Serwin, Chair, District II Cmsr. Laura Griffin, Vice-Chair, District V Angela Beck Jennifer Bruggeman Adam Down, Projects Manager, CCBHS Susan Horrocks – NAMI (National Alliance for Mental Illness) Teresa Pasquini Jen Quallick (Supv. Candace Andersen's ' ofc)	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: • (Susan Horrocks) One of the biggest problems is housing. I looked at your notes and received a summary of your notes from the last session for the BHCIP (Behavioral Health Continuum Infrastructure Program), it looks as though there is money in Round 5 and you are all talking about replacing (or getting money to replace/remodel) the properties we lost (Niereka/Nevin House). They were very valuable to those who are ill and need a place to go after they have been discharged from the hospital. We need more of those. I want the committee to hear that, as a family member. I also understand the AOT (Assisted Outpatient Treatment) program has seven (7) people who are unhoused at the moment and they also have a large percentage (30-40%) of the people in the AOT program are actually living with their parents or a family members. That is an issue that not necessarily help them on their way to recovery. The last thing I want to speak to is the $70m of unspent MSHA money, it was a lot less just a few months ago and it needs to be spent on housing. That is my piece, I don't know a lot about this. I am just a family member, but I see people suffering, I get calls and I don't know what to say to them. We just don't seem to have housing needs covered, particularly supported housing.	
III. COMMISSIONERS COMMENTS: None.	
IV. COMMITTEE CHAIR COMMENTS: **None**	

V. APPROVE minutes from September 20th, 2022, meeting: • Cmsr. Douglas Dunn moved to approve the minutes as written. • Seconded by Cmsr. Rhiannon Shires **Vote:** 2-0-0 **Ayes:** D. Dunn, R. Shires Abstain: none	**Agendas/minutes can be found at:** http://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. RECEIVE and Discuss Presentation from Kennisha Johnson, LMFT, Contra Costa Behavioral Health Services (CCBHS) Program Chief of Housing and Adam Down, CCBHS Projects Manager, regarding: ➢ Current Mental Health Rehabilitation Centers (MHRCs) contracts for LPS Conservatees ➢ Plans to apply in either Round for a 45-bed MHRC facility in West County in Behavioral Health Continuum Infrastructure Projects (BHCIP) Rounds 5 or 6 competitive funding rounds ➢ Any plans to apply for a 16-bed replacement Adult Residential Facility (ARF) in West County and a 16-bed Crisis Residential Facility (CRF) in East County in either of the remaining BHCIP Rounds 5 or 6 competitive funding rounds Introduction by Commissioner Dunn: To begin this presentation on conservatorships and mental health rehabilitation centers (MHRCs) and other facilities that come under the institute of mental diseases (IMDs) I have the following comments: Up to now, in our finance committee meetings, all Contra Costa Behavioral Health Services (CCBHS) contracts reviewed, show they are funded by both state MediCAL and a dollar for dollar match with the federal portion called 'federal financial participation' (FFP); however, with these particular contracts with this meeting, this is not the case. Briefly, here is why: The financial costs fall under for these MHRCs, skilled nursing facilities with special treatment programs (STPs) fall under the IMD reimbursement medical exclusion for persons 24 to 64 years of age and facilities with more than 16 beds that are not physically connected to a larger non-psychiatric facility. This exclusion is one of the very few examples of MediCare, MedicAID, MediCAL law that prohibits the use of federal financial participation for medically necessary care furnished by licensed mental professionals to enrollees based on health care setting providing the services. Congress established this exclusion in 1965 when it began MediCare and MedicAID to avoid paying for the large state hospital care of the mentally ill (then approximately 350,000 persons nationwide) as a result, MediCAL does not pay for the costs of this particular locked facility care. With the closure of state hospitals, the reason for this cost burden of the federal government no longer exists. Nevertheless, this financial exclusion continues. For California, IMDs facilities are the following: MHRCs for individuals 18-59 yrs of age that are ambulatory; skilled nursing facilities (SNFs) for individuals 60 yrs of age and older; STPs for individuals 60 yrs and older that need this level of physical/mental health care. Conservatorships: Individuals only go to one of these facilities if they are civilly, legally judged to be gravely disabled, per Welfare and Institutions	Documentation on this agenda item were shared to the Mental Health Commission and included as handouts in the meeting packet and is available on the MHC website under meeting agenda and minutes: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

Code (WIC) 5008.2, they are unable to provide either food, clothing, or shelter for themselves and have been unable to voluntarily agree to treatment. As a result, CCBHS has regularly opted in to have this level of care provided for our most vulnerable citizens, and thus hopefully avoid the becoming involved in the criminal justice system. BHS pays for this civil locked facility care strictly through the use of state provided, 1991 realignment funds, based in vehicle licensing fees and dedicated sales tax revenues--when the California economy declines, these revenues also decline. LPS Conservatorships: These do involve the conservator that does mandate, mandatory psychotropic medications. Conservatorships are either temporary, 30 days to 6 months, or 'permanent' (1-year renewable at a time).

(Kennisha Johnson) Thank you for that wonderful introduction. I will be giving a general overview (high level) of what is going on in the IMDs.

In terms of conservatorship, I would first like to state that I do not oversee the conservatorship office, so I would not be able to answer detailed questions regarding the conservatorships.

<u>IMD Contract Overview and review of contracted facilities:</u>

CCBHS contracts with facilities under the IMD category: MHRCs and SNF/STPs. The list of facilities we currently contract with (included as Attachment D) is a list of SNF/STPs including payment limits. This list shows if it is an MHRC, SNF, or STP and the count that is as of the beginning of October. The numbers in the facilities change often, due to discharges from the facilities. We do not have dedicated beds in these facilities and depending on where the facility is, the review of the admissions coming, the decisions on whether or not they can manage the current presentation for the consumer all factor into how many people we have in any facility at any given time. The numbers do change month to month.

<u>IMD Referral Process:</u>

1. MHRC Referral Process / Referrals from the Hospital:
    a. Temporary or Permanent Conservatorship
    b. IMD Request
        i. Psychiatrist/ inpatient team
    c. Transition Team
        i. Registered RN assesses client to determine level of care
            1. Evaluate current presentation
            2. Make recommendation - IMD or community placement
    d. IMD liaison reviews assessment and determines
        i. Recommends facilities based on age and/or medical conditions
        ii. Current presentation
    e. If referred to the community
        i. Work with outpatient team on community placement
            1. IMD liaison provides the names of the facilities to send referral to
            2. Hospital discharge planners have to send out a referrals
            3. Hospital discharge planners call IMD daily to check on referral status-
                a. per State MediCAL regulations – daily documentation regarding placement is needed for MediCAL reimbursement
2. MHRC – Referrals from Jail:

a. Court order of investigation for gravely disabled
b. The conservatorship – assess client and make a recommendation
c. If conservatorship recommends placement
d. IMD liaison receives a referral/reviews
    i. Makes facility recommendations and then sends referrals to various facilities
e. Clients can move from Jail to MHRC

3. Napa State – Step Down. Our IMD liaison is involved in the process when a client is ready to step down, there is constant contact with the client and the conservator is as well. Most of the time, they are stepping down to an MHRC.
4. Lateral move. From MHRC to MHRC. The most common is from MHRC to SNF/STP. Clients turn 60 and may have medical needs, so that transition happens.

Monitoring:

1. By Conservator and IMD Liaison
2. IMD Liaison
    a. Performs the utilization review
        i. Review charting/course of treatment
        ii. Managing level of care
3. Attends quarterly IDT's
    a. Case conference
4. Site visits and checks in with client

Discharge Planning:

1. Conservator/ IMD Liaison/Community Case Manager
   Challenges:
    a. Getting a client conserved is not automatic
    b. Wait for the MHRC beds varies greatly
    c. Do not always have the right placement at the right time

(Adam Down) Update on the BHCIP.

Round 5 was originally focused on crisis services. They have softened the requirements a bit after hearing back from counties. There is a lot of complaints from counties about the requirement for needs assessment. We did the needs assessments, we developed projects for the needs of our community and, yes crisis is important for our county but many others did not see it that way. Whatever these other communities have stated their communities need, they have relaxed their requirements on Round 5 and the guidance they are putting out. The request for application (RFA) has not been issued yet. I think the state is getting a lot of feedback from counties the program officers at Department of Health Care Services (DHCS) to relax these timelines a little bit as they are really tough for counties to meet the timelines. They have slowed down on what was a very aggressive timeline. Again, there is still no RFA out. Originally it was October and we had planned on seeing one before now. I have now seen some guidance on the website offering a webinar on November 2nd which indicates to me that they are looking to release the RFA in the last week of October or right at the beginning of November with 90 days to submit after. We are not changing our timeline.

We are working away on several different projects, the most pertinent to this discussion is the Brookside MHRC that is a county owned property near

the Brookside shelter (Wet County Shelter). It is 45-beds. We have sent a schematic over to get a cost for price estimating to get a cost to put a grant application together. We will be ready for that to go in Round 5 definitely. It is a very exciting opportunity. Our process has been to get it on paper, get the drawings, meet the grant requirements and get a reasonable cost estimate to move this forward. Before we come back for any final design, we will make sure we are communicating with the community on what that looks like and go from there. The West County social rehab facility we are looking at. Social rehab is a type of facility that can be both adult residential treatment (like Pathways) or a crisis residential facility (like Hope House). It is the community care license for this type of facility and then through DHCS for the type of treatment license. We are working on a project there and were at the facility yesterday with Capital Projects from Public Works and a whole group of trades inspecting the building. It is a building we would be purchasing and it is something we haven't finalized yet and are working to do that and I can not share the name of the property. We are close to being ready to submit an application for that as well. It would be crisis residential, possibly an urgent care and/or small outpatient clinic as a part of that facility (in the building) and the new discussion is that there is an adjacent property owned by the county that could, and may be written in, for a community wellness center which would also be funded under this grant. One grant with three types of services under one project. And it is adjacent to an H3 project that is for permanent supportive housing. There is a really a great vision for that property and we are hoping more comes of it. I would like to be more detailed but we are in negotiations and can't. The third project we are looking at and moving forward with is the county owned property on Pacheco, adjacent to Discovery House. It is currently being used as a long-term sober living environment. That would be used as a replacement dual diagnosis program with some medical capacity. That will be a Round 6 project. We are focusing on the first project and there is work being done on all these projects but pushing harder on a couple areas. This is project is looking to a Round 6 submittal. There is a LOT challenge on that site, as there is a future road re-routing happening on Pacheco and some other things, so it will take some design. There are architects on all these projects to do the design work. The fourth project is the purchase of a site with the capacity for multiple programs and it is in central county. Again, it is not on the market (private sale) and not on contract (in negotiations). There are appraisals now and real estate is moving forward with trying to get an agreement in place to allow us to show we have site control for the project as we move forward and would also give us the ability and license to do the environmental work we need to do, the studies, etc. I would like to also add that Gigi Crowder reached out to some of the BHS leadership with the City of Antioch and we have met with the to show us a few properties that they are currently in control of and would be interested in service and working to find the right fit / to needs. It's a fluid situation, what is left on our needs assessment, what is specifically with these properties, the due diligence that needs to happen and these are a bit late in the game but we are working and assessing. They will be Round 6 projects, and well into next year.	

Comments and Questions:

- (Cmsr. Dunn) As far as the jail referrals, do they involve persons with misdemeanor or any felonies? I am asking is that if it gets into felonies, it raises the possibility of Murphy conservatorship. What level of criminal justice involvement is referred to when you say 'jail referrals for LPS conservatorship facility? (RESPONSE: Kennisha Johnson) My understanding is they are not felony/not Murphy. There was a distinction that Mr. Ortega was saying they are a different process <cut off>.
- (Cmsr. Dunn) As for Attachment D, MHC list, great spreadsheet, very helpful. Is the (almost) $8.7mil contract paid for by 1991 realignment funds? I imagine it is but checking to confirm. (RESPONSE: Kennisha Johnson) That is my understanding, can you confirm that, as well? (Adam Down) I am pretty certain (98%).
- (Cmsr. Dunn) Based on my research preparing these questions, per the Department of Healthcare Services (DHS), they state in the IMD writeup that MediCAL funds are not used for IMD, so that would have to mean the 1991 realignment. Comparing Attachment D (Mental Diseases contracts) and Attachment E (LPS conservatorship information as of 10/1/22), I noticed there are a 114 persons currently in IMDs, 34 persons temporarily conserved (TCon), and 182 on renewable LPS conservatorships, of which 146 have been conserved. With that background information, my question is: are 100 to 102 of these persons residing in unlocked residential facilities? (RESPONSE: Kennisha Johnson) I would say yes. I can confirm that with the conservatorship office. The clients have to live in a licensed facility.
- (Cmsr. Dunn) This next question is from a racial equity lenses. What are the self-identified ethnic and linguistic make up of CC's LPS population? (RESPONSE: Kennisha Johnson) I asked the conservatorship office your question and they do not have that information readily in a report and this could be a discussion with Matthew Luu and Linda Arzio to get this for you at a later date. They did not have it to just pull the information quickly.
- (Cmsr. Dunn) What I am after, for a variety a reasons, lived experience, etc. and involvement with NAMI CC, I get a lot of referrals from family with loved ones involved in the criminal justice system and you would be shocked at how many are very close to or can be legally considered Felony incompetent to stand trial (FIST) and there is a high percentage that are younger African American males of color, well over half of the population. I am just wondering the mix and if persons are in the conservatorship is as high in the same ethnicity or lower vs. criminal justice involvement in IST. That is an involved question that can't be answered today, but that is where I will be pursuing going forward.
- (Cmsr. Dunn) Attachment F – California Psychiatric Transitions (CPT) Contract: I see in this particular contract, there are multiple levels of services payments. That raises questions: Are there CC clients in the disruptive behavioral unit program? Are there CC clients in the IST program? If so, how many in each? (RESPONSE: Kennisha Johnson) I don't have the numbers of which people are in, but we do have clients in the DBU, verified there are three.
- (Cmsr. Dunn) Have there been instances where CCBHS has had to authorize (there is a special part in the contract) care for a 24-hr period,

has that involved any CC clients? If so, how many and how often has that had to be used? I am aware that CPT is one of the highest level MHRC IMDs contracts that BHS has with MHRCs.
(RESPONSE Kennisha Johnson) Yes, we do have to use this from time to time. Not just at CPT. That is also something the liaison monitors closely and works with the facility, because we don't want to have someone on a one on one longer than needed. I am just taking over the contracts since Jan left and I don't know all the history of how often and how much it is used. I do know that it is used in multiple facilities as needed. The request comes from the facilities. When behaviors get to a point they feel others may be harmed in the facility, they request a one to one and it is approved on an individual as needed basis. The liaison approves with documentation and conversations.

- (Cmsr. Dunn) Attachment G – Crestwood. How many CC client have needed what is called the PATCH Intensive Treatment Program (ITP) Services? What Crestwood facilities? (RESPONSE: Kennisha Johnson) That information isn't readily available and I would have to go to different people to try to get that answered.
- (Cmsr. Dunn) How many CC clients have gone away without leave (AWOL) at Crestwood facilities? How many CC clients within the Crestwood contracts have required SNF services? (RESPONSE: Kennisha Johnson) I don't have the information for the AWOL question but I will research. The chart we provided, we can figure out how many are in the SNF/STP – looks to be 57.
- (Cmsr. Dunn) Telecare Contract. There is a dollar amount for the Gerontology services. How many CC Telecare clients have required gerontology services? Have there been instances where CCBHS has had to authorize contracted hourly payment charges for DBU in Telecare facilities? And if so, how often? (RESPONSE: Kennisha Johnson) We will have to research these questions. <Cmsr. Dunn to send questions>
- (Cmsr. Dunn) The Helios Healthcare contract, there is a piece that talks about geriatric psychiatric services and I know the number of clients in Helios are quite low, but how many have received geriatric psychiatric services? (RESPONSE: Kennisha Johnson) Research.
- (Cmsr. Dunn) Mental Health Management (Canyon Manor) Contract – the phrase 'persons can't be sent back to in county inpatient psychiatric care' which raises the question, Has there been situations in the past FY in which a client psychiatric needs have required them to be returned to CCRMC inpatient care from Canyon Manor? If so, how often? (RESPONSE: Kennisha Johnson) Research. I will say in general terms, it has happened, it may not have been from this facility, but Canyon Manor calls it out. It does exist in, I believe, all the facilities. If someone gets to the point they are unable to manage them, they do want a working relationship with the CCRMC or the hospital in the county of residency to be transferred back for re-stabilization.
- (Teresa Pasquini) I greatly appreciate the presentation, but it makes it look like a smooth, simple flow, moving from here to there. When the client is ready, they get to choose. Respectfully, I know from experience that it actually not true. I just want to call that out because I feel there is a definitely a human log jam in CC, but not just our county as it is all across the state. I just want to make sure the commissioners who have not experienced this level of care understand that, on any given day, we

have people sitting in acute levels of care that are ready for step down that are not being able to be moved because there are not available beds. That goes back to the MHC work (in the Justice Systems Committee) with Alex Bernard's research that you all looked into. I just wanted to call that out and there is data to be mined. Knowing how many people are sitting and waiting in a higher level of care that are ready for step down but there is no stepdown ready for them.
The other comment, I was actually surprised about the referrals from the courts. I guess that is because of SB317? I actually have personal experience from that, and it was shocking. I wanted to briefly share that it was actually a situation I have shared in the past for various reasons. We have a grandmother living in one of our apartments in Richmond and her grandson had been living on the streets of the apartment for up to two years. We had been working with the quarantine and various people on this individual trying to get him help before he landed in jail or the hospital. It went on for two years and eventually he ended up assaulting his grandmother and then arrested. I then started working with detention staff, giving them information. We were surprised to find out after several months that he was back living on the streets of our apartment, yet we found out that he was actually conserved. We were told he was let out even though he was conserved because there was no place for him to go. I had information, wrote to some people and this young man ended up having to be 5150'd, taken to the hospital and is now sitting on 4C or 4D waiting for a bed. As luck and heroics would have it (and I have emails), I did some outreach and got immediate support and help. That's great but this young man had to go through this process with 4 or 5 officers called, it was just a shocking situation for me that happened recently. I just wanted to bring that story forward and call out the fact that this happens to be (an African American) gentleman that we did everything we could to prevent him from going behind a jail door/locked door, from anyone being hurt and it still happened. Now he is conserved and getting care. I just want everyone to understand that getting the right care at the right time and the right place isn't happening every time. The flow chart we just saw is not telling the whole story.

- (Kennisha Johnson) Thank you Teresa. I would say correct on the point. That is our process and it is not smooth. The log jam definitely happens at the MHRCs, so in terms of the waiting it is a long part of it. The referrals go out and there is a wait for beds to open up. People on the inpatient unit wait for beds to open. That wait can vary greatly. Some have waited for a couple weeks, or a month for beds. The hope with all of the BHCIP funds that many counties want their own MHRCs to help with this log jam. As well as board and care beds. There are people sitting on a discharge waiting list waiting on B&C beds because facilities don't have the right beds at the right time.
- (Teresa Pasquini) Is there any chance the commission could do some sort of request for capturing the cost of that? I know we have our needs assessment that has been absolutely amazing. I have always wanted to be able to show how much it is costing us to provide the wrong care at the wrong time and the wrong place. I just want to throw that out. This is the finance committee, I think there is a lot of money being wasted and I think that is important information to have when we go to try to

prove the need for the full continuum of care to be funded and provided in CCC. (Cmsr. Dunn) That is something we will look in to and pursue moving forward. (Adam Down) Are you talking about the cost of appropriate care on an inpatient unit; or an IMD situation. But you are talking about trying to capture that cost of the gap when they should be off the inpatient unit and in an MHRC. (Teresa Pasquini) Yes, how much are we losing on admin days at the hospital for those individuals? How much is it for someone staying at CPT that might be ready to step down but there isn't an opening. That is why I am so passionate about Psynergy's model. They have a work around with MediCAL billing that allows for almost the same level of care as a locked IMD. How many are staying in adult residential facilities (ARFs) that might be able to step down but no access to permanent supportive housing?

- (Cmsr. Serwin) The conservators are called upon to assess their clients, at various points in the process. Moving down from CRT to a lower level of care. What is the qualifications of the conservators to make assessments. We hear the families say that their adult child was allowed to leave or recommended to leave a level of care when they weren't. It always comes back to 'what are their qualifications' for making these assessments? (RESPONSE: Kennisha Johnson) I don't know the answer to that question. (Teresa Pasquini) I went to the AOT conference in San Diego and I came home to conservatorship papers, so I know the process after 21 years and having an amazing relationship with my son's conservator. The law requires two doctors to certify for a renewal. That is due to having an amazing Doctor who knows the patient. There are some that know the patient well versus some IMDs that have doctors that stop by once a week and don't really know the level of expertise. Between that and the county's utilization and review process for conservatees. There has to be two doctors for the process to begin but it doesn't mean it will happen. If you don't have good clinical assessment (I think is the case with most of these incidents), then it doesn't happen. It is another example why we need to have strong clinical supports for this population.
- (Cmsr. Serwin) I'm noticing the monitoring piece of the process that goes on where the IMD liaison and conservator are listed as a part of that monitoring process and it doesn't make sense, it made me wonder why and how much of a role does the conservator have in actually assessing? (RESPONSE: Kennisha Johnson) There are folks specifically around step downs and placements in the IMDs and the treatment teams consist of mostly the staff in the facility and the psychiatrist. The treatment team, IMD liaison and the conservator participate in that. It is a team decision that is made in terms of a step down. They are not making a decision in terms of ongoing, it is related to the treatment while there. They do go through a process more similar to what Teresa just described while there.
- (Teresa Pasquini) Just want to thank Adam on his leadership and work. It has been a pleasure walking through all this with you. I am so grateful for all your efforts and thank you.
- (Cmsr. Serwin) The due diligence in all that happens with the county. The county has a budget for this? Does the grant money, if awarded, covered in that? (Adam Down) Some of it can be. Some of it, the county will eat, they are making an investment in this for sure. Where we can

roll in costs, we will roll into the grant application. Some, like the environmental studies and surveying, if it is on a property we are buying, it can be rolled into a future requirement for it but we still have to pre-invest in it and if we don't win the project, we will be out the money. Health services finance has signed off, they see the value in the investment, even if we go in and do this, and don't win the project but win a $30mil MHRC but lose a couple smaller, we are still way ahead with the county for resources brought in. I think everyone has realized that and have been really helpful working with us to make it happen.	
VII. Adjourned meeting at 3:02 pm	