Yolo County Mental & Behavioral Health Board
Director's Report
December 3, 2018

Pacifico Update- On November 2nd, Karen and Al Rowlett met with some of the parents of residents at Pine Tree Gardens as well as other interested parties to discuss sustainability options for Pine Tree Gardens. We shared the path forward and commitment document that was shared with this board last month and had a rich discussion. One of the operators attended as well. We will continue to meet together regularly and strategize about our path forward.

Navigation and Adult Residential Facility – The Navigation services are open in Davis at the 600 A Street office, Tuesdays, Thursdays and Fridays, 8:30am – 4:30pm. The Pacifico location is still under review and projected timeline will put opening the Navigation Center at the Pacifico site next summer, and the Adult Residential Facility at the Pacifico later in FY1920.

Beamer Street Development – The official ribbon cutting ceremony for the Beamer street development will be on December 11th from 2-3pm. The units are filling up and we are working closely with staff and residents to set clear expectations and ground rules.

No Place Like Home Update – With the passage of Proposition 2, 7% of every county's Mental Health Services Act (MHSA) budget will be reallocated for the purpose of developing permanent housing persons with serious mental illness experiencing homelessness. The County Homeless Strategic Plan is a required element of NPLH applications as well as a requirement for future homeless services funding opportunities from the State. HHSA contracted with HomeBase to complete the community input process and development of the Homeless Strategic Plan, utilizing the existing Strategic Plan and ensuring all No Place Like Home requirements were met. November 13th was the first part of the community input which was a countywide open forum for stakeholders to gain some understanding around the No Place Like Home requirements, give input into needs of the community around homeless issues, and participate in some breakout sessions on key priority topics. Following this, on December 4th and 5th there will be 3 community input summits; one in Davis, Woodland, and West Sacramento. These summits will focus on the 3 key priority issues identified at the November 13th summit and will allow key stakeholders in each community to drill down into these and create action steps and guidance on how to accomplish the key strategies. All of this information will be compiled into a County Homeless Strategic Plan to submit alongside the other No Place Like Home application requirements. HHSA anticipates Woodland and West Sacramento to both submit project applications for No Place Like Home and is working closely with both city's managers and their staff to ensure timely completion of the applications.

Intercept Mapping (Hospital)s - HHSA, the CAO's office, Sutter and Dignity Health have embarked on an intercept mapping process to identify the process of homeless individuals moving in and out of the hospitals in Yolo County. The intercept mapping process allows for a robust analysis of a system as currently structured, while identifying gaps and needs of that system for improvement. HHSA, CAO, and Dignity staff have met twice this far to begin the process, and HHSA, CAO, and Sutter staff had their initial meeting in the beginning of November. All staff are now working together to develop next steps to provide a comprehensive and collaborative process occurs.

Board & Care Study meeting - On October 30, 2018, over 20 people participated in a stakeholder meeting to discuss progress on the Yolo County Board and Care Study Innovation Plan that was approved by the Mental Health Services Oversight and Accountability Commission on July 26, 2017. HHSA partners, Research Development Associates (RDA), facilitated the meeting which included a review of the plan itself, the differences between licensed and unlicensed care facilities and the types of care each provides, Yolo-County specific findings, and a discussion of next steps.

After reviewing quantitative and qualitative data about existing resources and needs for Yolo County residents, RDA concluded the following: 1) there are not enough Board and Care Facilities in Yolo County; 2) due to the limited amount of Board and Care Facilities, Board and Cares are less likely to accept clients with more intensive needs; 3) mental health consumers with the highest needs are placed out of county and away from their homes and families and/or support system.

Discussions followed to examine challenges in both sustaining existing facilities and opening new board and cares, and to explore innovative models in other service delivery systems. Common strategies emerged, including: 1) de-couple owner and operator roles and responsibilities; 2) collaborate within the County as well as with outside investors; 3) creatively fund services to surround consumers in board and cares; and 4) develop a full continuum of care. Recommended actions were to support existing Board and Care operations to stay in business and to look to new, innovative models to meet the growing need.

Davis Services –The official grand opening of our Davis site will be held on December 13th at 9am. The building is being named after our very own Helen Thomson. You are all invited to the ceremony followed by a tour of the entirely remodeled site.

Envisioning the Behavioral Health Delivery System – On November 8th Karen participated in an all-day discussion with California Primary Care Association. Other speakers included Adrienne Shilton from the Steinberg Institute and Kimberly Lewis from National Health Law Program. The participants were from community clinics throughout the State who are interested in increasing their knowledge and care in the realm of behavioral health.

Involuntary Medication resolution – The Board of Supervisors recently approved a resolution that would allow for involuntary medication to occur for in-custody clients who have been found incompetent to stand trial (IST) on a felony charge and are awaiting placement in to Department of State Hospital (DSH) for competency treatment. Yolo Superior Courts, District Attorney, Public Defender, County Counsel, Sheriff Department, California Forensic Medical Group (CFMG) and HHSA staff had multiple meetings and communications around development of this resolution. Yolo County felony IST clients often wait months until a DSH competency bed opens for placement and periodically these clients refuse medication which leads to decompensation. This resolution allows for early onboarding of medication for these clients who otherwise would sit in jail without treatment. In order for involuntary medication to be administered, a court order must be in place first.

HHSA continues to work with CFMG and other partners to finalize the policies and procedures of how the involuntary medication will be administered now that the resolution has been approved.

Mental Health Diversion –Assembly Bill 1810, signed into law in June 2018. AB1810 allows for diversion of clients who have a DSM – V diagnosis, with the exception of pedophilia, borderline personality disorder, and antisocial personality disorder. There are certain requirements to qualify for the diversion: the DSM diagnosis; that their mental disorder played a significant role in the commission of the charged offense; that the clients symptoms would respond to mental health treatment; the defendant agrees to treatment as a condition of the diversion and that the judge is satisfied with the treatment being recommended; the defendant gives up their right to a speedy, public trial; and that the court finds that the defendant does not pose an unreasonable danger to the public. The bill also requires periodic updates to the court showing the clients progress in treatment throughout the 18-month diversion timeline. While the bill is specific in these areas, it is broad in how the accomplish the above. In light of this, Yolo County, like many California counties, are holding meetings between criminal justice partners and HHSA to determine the most effective means of implementing this new diversion bill. Some of the issues that must be determined are who the mental health expert giving their opinion of the diagnosis, whether or not it contributed to their crime, and if it is amenable to treatment will be, but also who would be responsible for the ongoing reports to the courts to ensure clients are engaging in services.

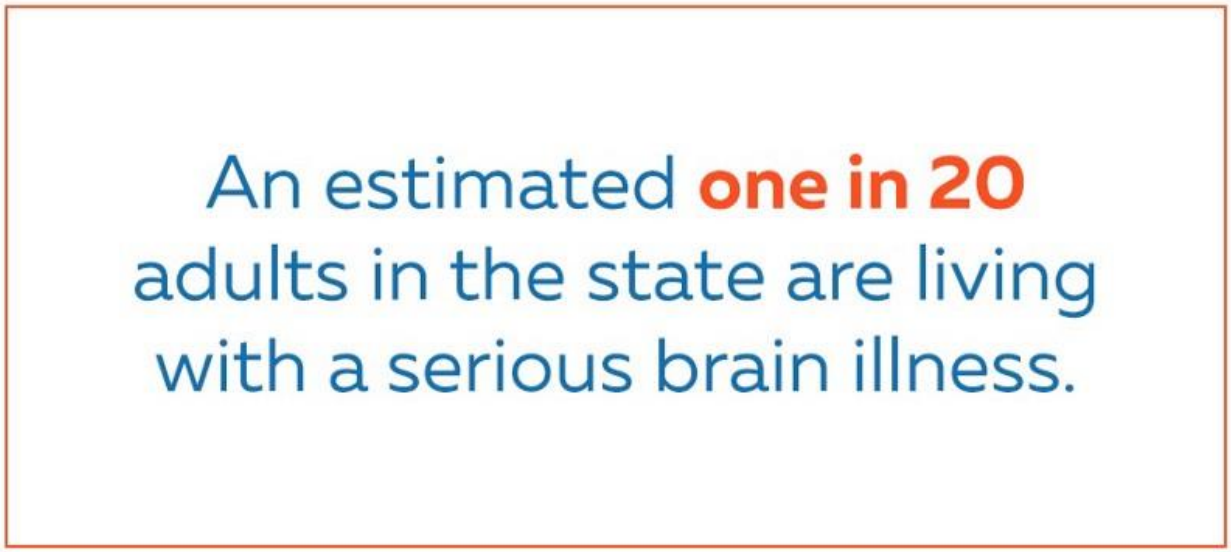
Governor Elect Newsom – See attached platform from Governor elect Newsom regarding behavioral health.

Data – See attached report summarizing trends in inpatient hospitalization from FY15-16 through the first quarter of FY18-19.

Getting Serious About Mental Health

When it comes to healthcare in California, we for far too long have tolerated two different and unequal worlds. I don't mean rural and urban. I don't mean rich and poor. While both those dichotomies are true, I am talking about the fundamental differences in our approach to illness of the body and illness of the brain.

In any given year, one in four families in California deal with a mental health condition. An estimated one in 20 adults in the state are living with a serious brain illness. Each year, thousands of young Californians will experience their first psychotic break, enduring the terrifying delusions and hallucinations that are a hallmark of schizophrenia, bipolar disorder and some forms of depression.



We all know someone, don't we? Whether we're living with brain illness ourselves, or it's a spouse, a child, a sibling, a friend. And more often than not we've heard about their struggles to find quality care: the long wait times for appointments, and shift to cash-only psychiatrists; the shortage in licensed providers and crisis beds; limited insurance coverage; the punishing side effects of medications; the fear that a boss or colleague or neighbor will learn the truth and look at you differently.

Our system of mental healthcare in California falls short, not for lack of funding. We've done the right thing in this state: Thanks to the vision of Sacramento Mayor Darrell Steinberg, we passed a millionaire's tax in 2004 that now funnels more than $2 billion a year into services. We fall short because we lack the bold leadership and strategic vision necessary to bring the most advanced forms of care to scale across the state. We lack the political will necessary to elevate brain illness as a top-tier priority. We lack the unity and fervor needed to rally the medical and research communities around an unyielding search for ever-better diagnosis and treatment.

We're all living with the fallout. As a mayor, I was acutely aware of the many ways untreated mental illness tore at the fabric of community. We moved over 12,000 folks off the streets and into housing with supportive services. Yet still, more than 7,500 people live homeless in San Francisco, and research indicates

about a third of them are dealing with untreated mental illness. Across the state, 134,000 people are living on the streets, a third of them suffering with progressed stages of mental illness.

One-third of the people living behind bars also deal with a brain illness, making our jails de facto asylums. The Los Angeles County Jail actually doubles as the nation's largest mental health facility. Students struggle in silence with depression and anxiety. Our suicide rate hasn't fallen in two decades. Families are ripped apart because they can't get their children the care they need.

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It's not that we don't have the answers. We actually know a lot about treating mental illness. We know how to deliver wraparound services on the back end of care that can transform

lives. And—more importantly—we know how to deliver intensive services on the front-end, treatment that can stem the course of serious brain illness, including schizophrenia, before it becomes disabling. California has model programs in this arena, as does New York. Australia is a global leader in early diagnosis and intervention. Trieste, in northern Italy, offers a showcase for how to replace a system of substandard institutionalized care with humane and effective services delivered through a network of 24-hour clinics integrated into the community.

What we need is a command structure capable of articulating a clear vision for how we strategically spend our mental health resources, and how we partner with county-level providers to bring the best practices to scale. Even as we respect county-level governance, we need to standardize and scale up some core services so every Californian has access to advanced models of care, regardless of ZIP code. And we need statewide systems for measuring and sharing outcomes.

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It starts with leadership: In the 14 years since passage of the Mental Health Services Act, three critical reports have raised questions about the state's failure to direct and oversee spending. Our statewide delivery system is hampered by confusing and overlapping lines of authority, a lack of clear goals, and uncertainty about who wields the power for enforcement. We lack the centralized authority to ensure our investment is spent effectively, on services with measurable outcomes.

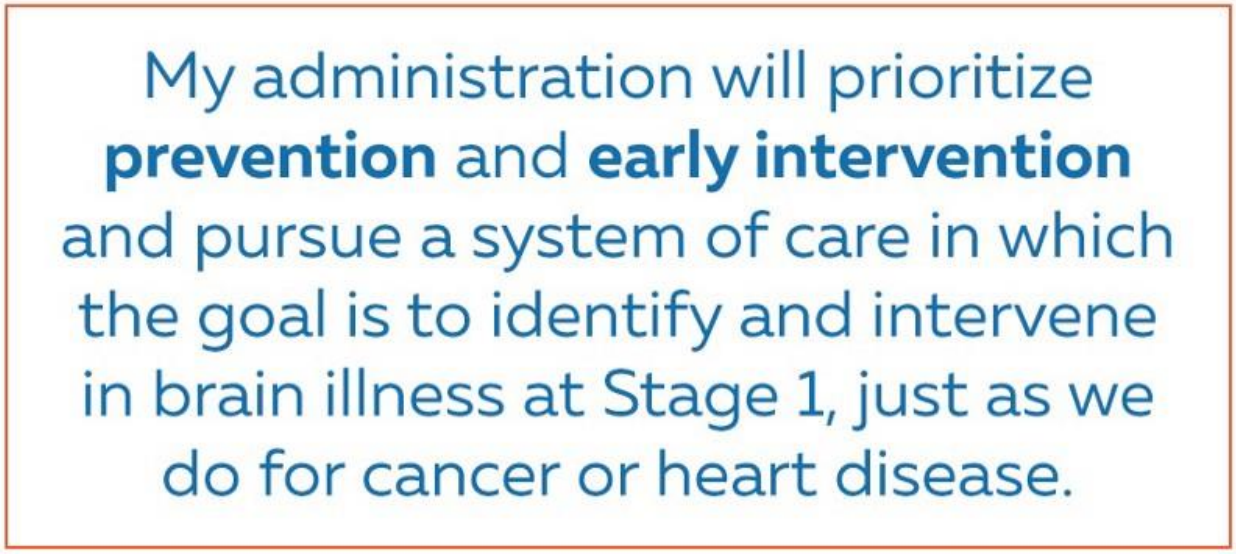
My administration will work with top public policy and research groups to review our delivery system and draw on best practices across the globe to create a more effective leadership structure. Our goal will be a command structure, tailored to California, that has clearly stated objectives and responsibilities, and is vested with the authority necessary to set performance standards, drive strategy for reaching those standards, analyze outcomes, and

enforce mandates. We will articulate a strategic vision for care, and provide the support and oversight needed for counties to meet the objectives. We'll increase our investment in data-collection and analysis, and use these tools to inform our treatment models. We will build on efforts to create public-private partnerships to finance research and technological innovation, with the goal of expanding access to care and advancing our understanding of how to diagnose and treat brain illness.

From Stage 4 to Stage 1: Try to think of another serious illness in this state that we routinely treat at Stage 4? And yet that is the outrageous reality about our approach to mental health treatment. Our system is set up so that the bulk of revenue from the Mental Health Services Act—80 percent—goes into services for people whose mental illness is already seriously progressed. And just 20 percent goes into early diagnosis, prevention and intervention. UC Davis and UCLA are among the research centers that have developed successful models for intervening in the early stages of mental illness and helping young people not only to live with a brain illness but to thrive—but fewer than half our counties offer such services.

My administration will prioritize prevention and early intervention, and pursue a system of care in which the goal is to identify and intervene in brain illness at Stage 1, just as we do for cancer or heart disease. We will work

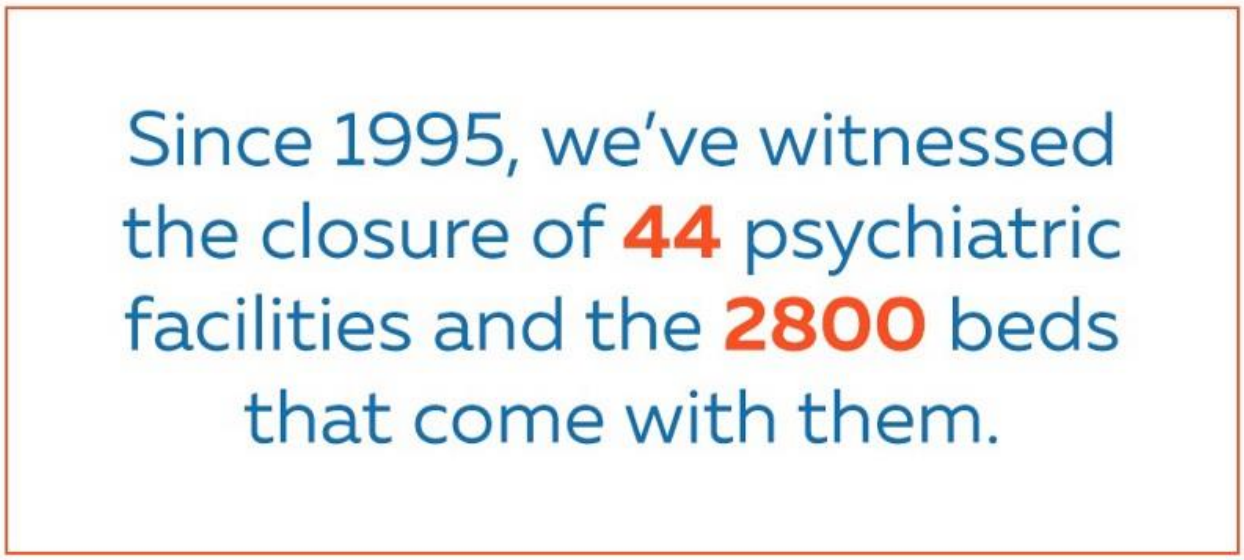
with our public and private partners, and draw on advances in technology and telemedicine, to create a system in which every young person has access to advanced treatment. Integral to this push, we will launch a campaign to train our teachers, counselors, first responders and pediatricians in how to recognize early signs of mental illness.



Seventy-five percent of serious brain illness manifests before age 25, meaning our college-aged youth are at particular risk. **We will work to ensure every public and private college in the state adopts comprehensive strategies for raising awareness of symptoms of mental illness, identifying students at risk, and providing support services.** In addition, we will call on every college to implement evidence-based suicide prevention policies.

Integrate and diversify our healthcare workforce: If we're going to shift the treatment paradigm toward early intervention, we need a more integrated approach to healthcare. That means training primary care doctors—who see the bulk of our patients—in the diagnoses and treatment of minor to moderate brain illness, and how best to refer more serious cases for specialized care. It means creating incentives for provider networks to create collaborative care centers that have the staffing to seamlessly span both brain and body. It means using the powers at our disposal to ensure insurance providers adhere to federal parity rules and adequately compensate for mental healthcare. It means eliminating rules that prevent patients from seeing both primary care and mental health providers on the same day.

America faces a well-documented shortage of psychiatrists that is mirrored in California. Our counties—particularly our rural counties—labor to find psychiatrists willing to work in community health. My administration will tackle this problem head on. We will highlight and grow promising innovations, including expanded roles for nurse practitioners and peer providers. And we will grow the ranks of licensed professionals who elect to work in the community sector through expanded funding for training, scholarships and loan forgiveness.

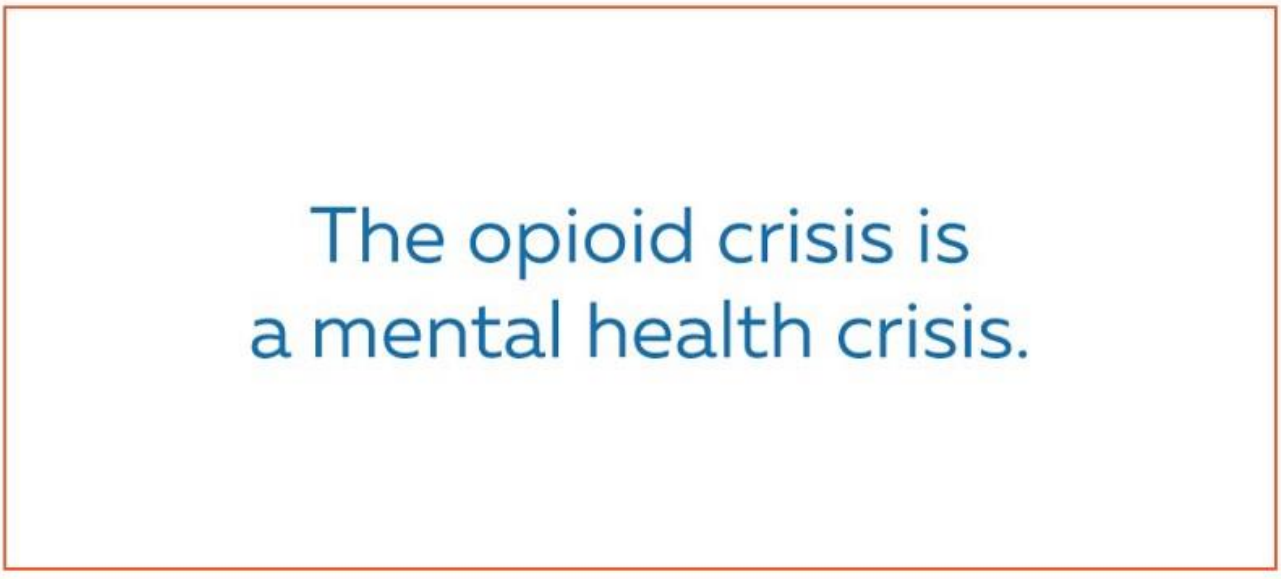


We will also expand the options available for inpatient care. Since 1995, we've witnessed the closure of 44 psychiatric facilities and the 2800 beds that come with them. As hospitals eliminated psychiatric units, the number of acute psychiatric beds per capita fell by 40 percent in California during that time. Rather than lead the nation in this critical aspect of care, we fall well below the national average. My administration will direct both funding and political capital into the effort to revitalize the acute-care system at the community level, pushing through the zoning issues and discrimination that often serve as obstacles to building specialized facilities.

Give law enforcement and courts the training and programs they need: Gaps in our treatment system mean that law enforcement officers are often the first responders for someone experiencing a mental health crisis. Meanwhile, state

correctional officers and jail staff are dealing with tens of thousands of inmates who have been diagnosed with mental illness. It's a reality that can prove debilitating for both law enforcement and the inmates in need of treatment.

Over time, increased investment in early prevention and intervention will help relieve some of this pressure. But we need a more immediate response. My administration will build on existing training for law enforcement officers, dedicating additional resources to instruction in how to de-escalate encounters with people with a mental health issue. We will scale up alternative sentencing options, including successful models of mental health and drug courts. And we will increase resources for specialized mental health units in our prisons and jails, as well as transitional housing that provides support and treatment upon release.



Combat the opioid crisis: The opioid crisis is a mental health crisis. Over 50% of opioid prescriptions are for people with mental illness. Nationally, opioid prescriptions have quadrupled since 1999, as have tragically, opioid-related overdose deaths. Even as the epidemic wreaks havoc on a national scale, California is being hit hard. A more aggressive effort is still needed to combat this overwhelming crisis. We need stricter enforcement of mental health parity laws. We need to curb the eagerness of certain medical providers that write too many prescriptions without fully weighing the consequences. And we need to get more clinicians on the ground and double down on effective treatment and prevention programs.

Bust the stigma: Finally, we will amplify efforts to eliminate the stigma that keeps too many people from reaching out for the care they need. My administration will join efforts to end discrimination in the workplace, encouraging leave policies that mirror those in place for other types of illness and training employers how to accommodate someone living with a brain illness in the workplace so that they have the support they need to live a life with meaning and make a contribution to society. We'll invest in public service campaigns and outreach to educate our communities and normalize discussion of brain illness.

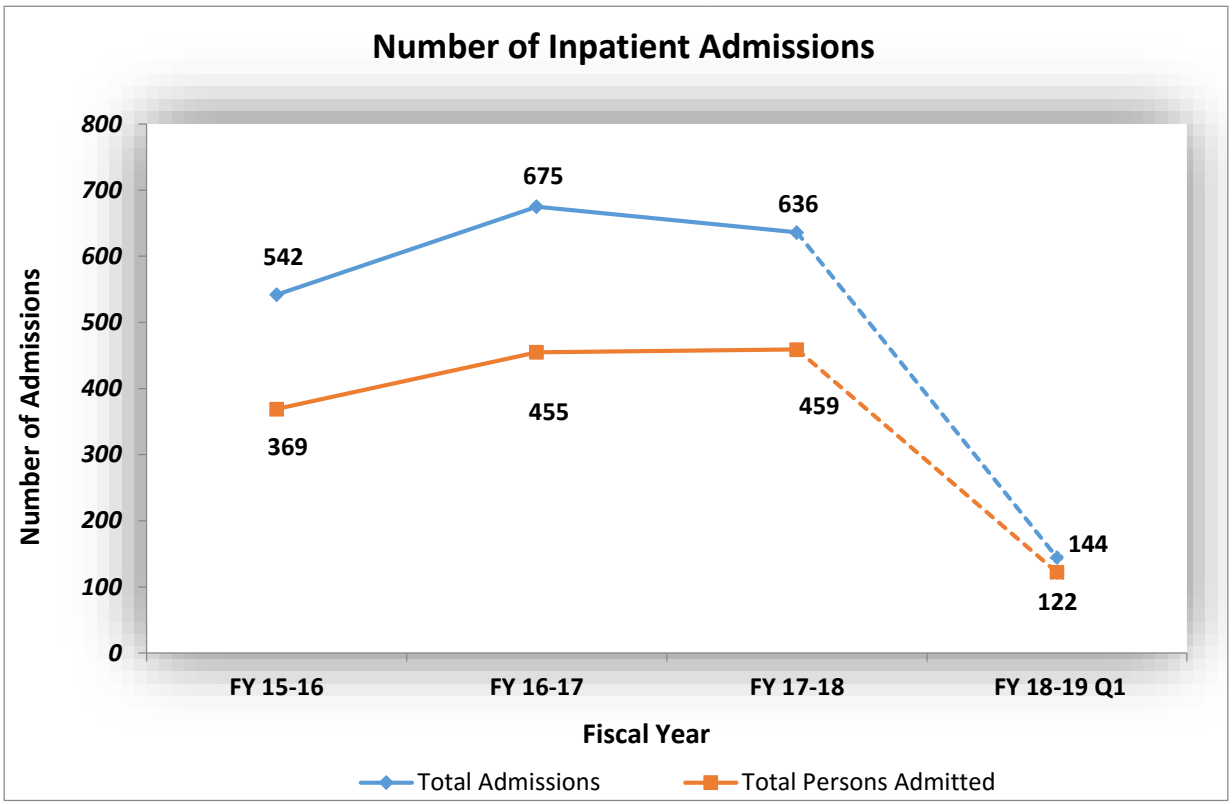
As Governor, I will embrace the mantra that there is no health without brain health. We will usher in the next era of care, and emerge a stronger, healthier California.

Yolo County Hospital Utilization Data Report

For Fiscal Year 2015-16, 2016-17, 2017-18 and 2018-19
Quarter 1 (July thru September 2018)

November 26, 2018

Measure 1: Total number of inpatient admissions



Data Source: TAR log FY 15-16, FY 16-17, FY 17-18 & FY 18-19 Q1

Data summary:

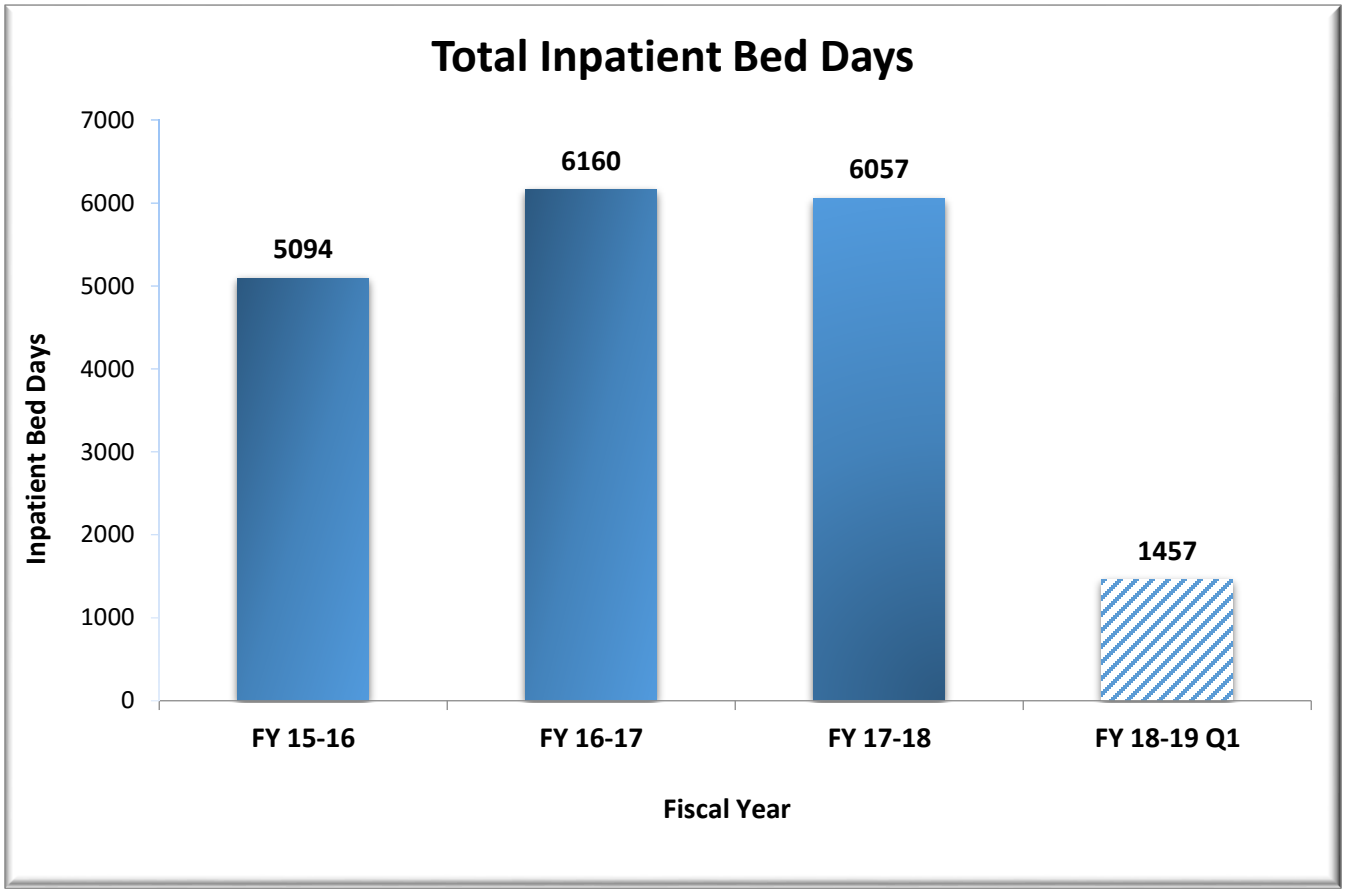
The above data displays the total number of inpatient admissions and total number of person admitted, for Yolo County Medi-Cal beneficiaries across the last three fiscal years and the first quarter of the current fiscal year.

- The total number of inpatient admissions increased by 24.5% from FY15-16 (542) to FY16-17 (675), followed by a 5.7% decrease in FY17-18 (636). FY18-19 Q1 data suggests the downward trend may continue.

- Overall, the total number of inpatient admissions increased by 17.3% across the three years; FY15-16 (542) through FY17-18 (636).

- The total number of persons admitted to an inpatient facility increased by 24.4% from FY15-16 (369) to FY17-18 (459). First quarter data from FY18-19 suggests the increased trend may continue.

Measure 2: Total number of Inpatient Bed Days



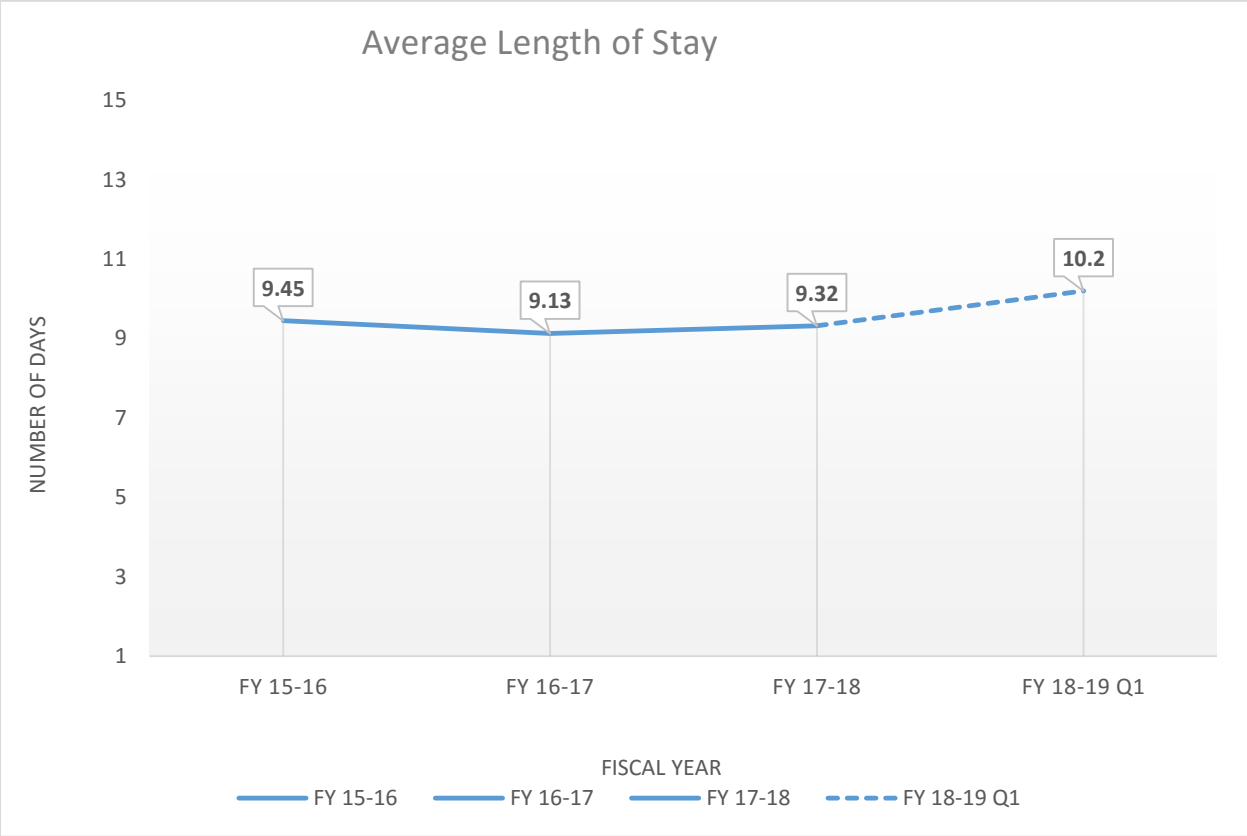
Data Source: TAR log FY 15-16, FY 16-17, FY 17-18 & FY 18-19 Q1

Data summary:

The above data displays the total number of inpatient bed days for Yolo County Medi-Cal beneficiaries across the last three fiscal years and the first quarter of the current fiscal year.

- The total number of bed days utilized increased by just over 20% between FY15-16 (5094) and FY16-17 (6160) with a slight decrease in FY17-18 (6057). FY18-19 Q1 data suggests a downward trend may continue.

Measure 3: Average length of Stay



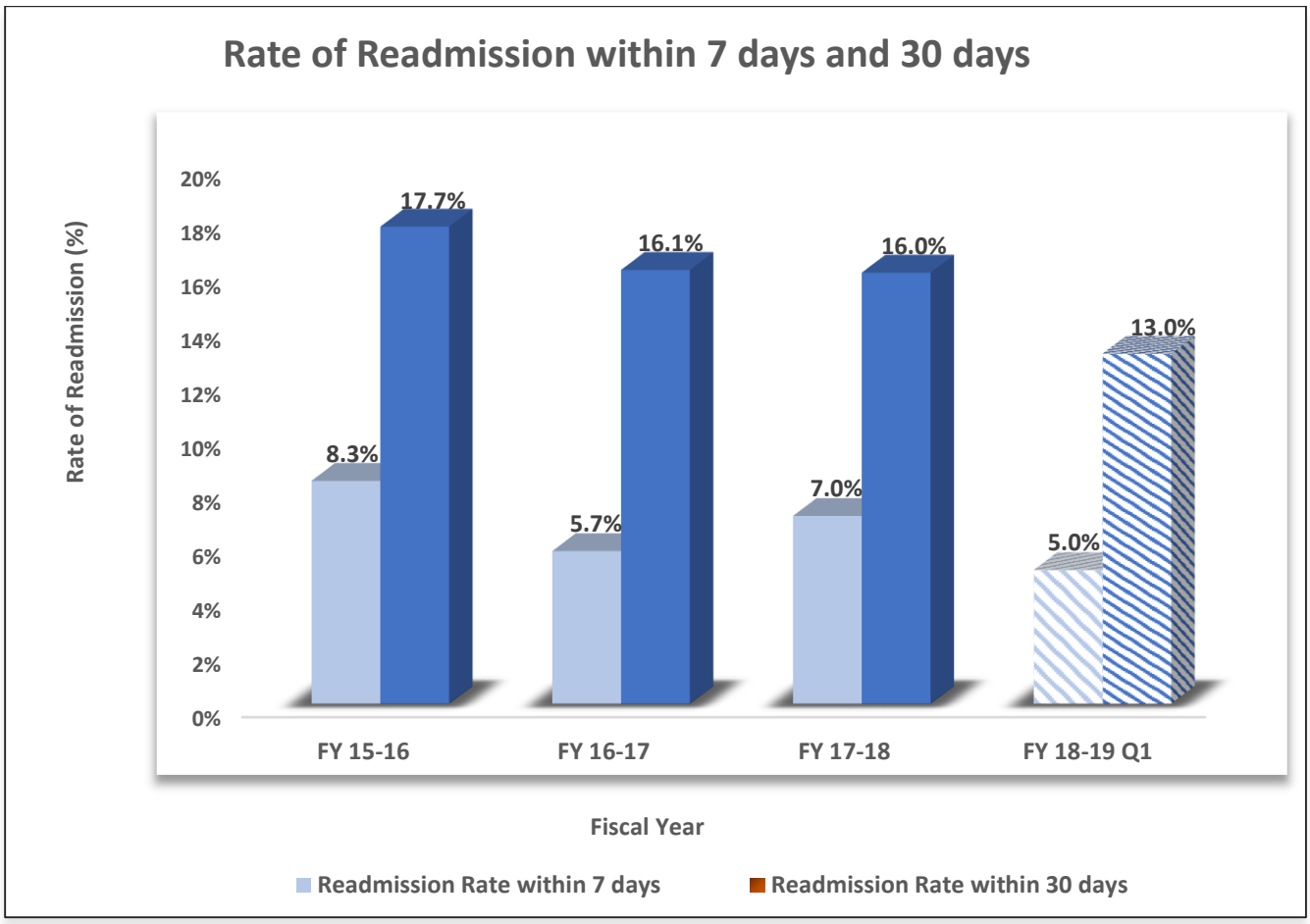
Data Source: TAR log FY 15-16, FY 16-17, FY 17-18 & FY 18-19 Q1

Data summary:

The above data displays the average length of stay among all inpatient facilities for Yolo County Medi-Cal beneficiaries, across the last three fiscal years and the first quarter of the current fiscal year.

- The average length of stay varied slightly (half a day) across fiscal years
- FY18-19 Q1 data suggests the average length of stay may increase

Measure 4: Readmission Rate within 7 days and 30 days



Data Source: TAR log FY 15-16, FY 16-17, FY 17-18 & FY 18-19 Q1

Data summary:

The above data displays the percentage of discharges that resulted in at least one readmission within 7 and 30 days (Rate of Readmission), for Yolo County Medi-Cal beneficiaries across the last three fiscal years and the first quarter of the current fiscal year.

- The rate of readmission within 7 days of discharge has fluctuated across fiscal years, with an overall downward trend of 15.7% between FY15-16 (8.3%) and FY17-18 (7.0%). FY18-19 Q1 data suggests this downward trend may continue.

- The rate of readmission within 30 days of discharge has been steadily declining across fiscal years, showing an overall decrease of 9.6% from FY15-16 (17.7%) to FY17-18 (16.0%) FY18-19Q1 data suggests the downward trend may continue.