



# COUNTY OF YOLO

Health and Human Services Agency

*Karen Larsen, LMFT*  
Director

137 N. Cottonwood Street • Woodland, CA 95695  
(530) 666-8940 • www.yolocounty.org

## Local Mental Health Board

**Regular Meeting: Monday, December 3, 2018, 7:00 PM – 9:00 PM**

Bauer Building, Thomson Conference Room  
137 N. Cottonwood St. Woodland, CA 95695

*All items on this agenda may be considered for action.*

James Glica-Hernandez  
**Chair**

Nicki King  
**Vice-Chair**

Reed Walker  
**Secretary**

**District 1**  
**(Oscar Villegas)**

Bret Bandle  
Martha Guerrero  
Sally Mandujan

**District 2**  
**(Don Saylor)**

Serena Durand  
Nicki King  
Antonia Tsobanoudis

**District 3**  
**(Matt Rexroad)**

Richard Bellows  
Laurie Ferns  
James Glica-Hernandez

**District 4**  
**(Jim Provenza)**

Ben Rose  
Robert Schelen  
Ajay Singh

**District 5**  
**(Duane Chamberlain)**

Brad Anderson  
Reed Walker  
Vacant

**Board of Supervisors Liaison**

Don Saylor

**Alternate**

Jim Provenza

**CALL TO ORDER ----- 7:00 PM – 7:10 PM**

1. Welcome and Introductions
2. Public Comment
3. Approval of Agenda
4. Approval of Minutes from [October 22, 2018](#)
5. Member Announcements
6. Correspondence

**TIME SET AGENDA----- 7:10 PM – 8:10 PM**

7. [Adult Needs and Strengths Assessment Presentation](#) – Kim Narvaez  
CQI/Analyst Department and Children’s Mental Health  
Program Manager, Child, Youth & Family Branch, HHSA
8. [Level of Care Utilization System Presentation](#) – Sandra Sigrist  
Adult and Aging Branch Director, HHSA

**CONSENT AGENDA ----- 8:10 PM – 8:30 PM**

9. [Mental Health Director’s Report](#) – Karen Larsen
  - a. Pacifico Update
  - b. Navigation and Adult Residential Facility
  - c. Beamer Street Development
  - d. No Place Like Home Update
  - e. Intercept Mapping (Hospitals)
  - f. Board & Care Study Meeting
  - g. Davis Services
  - h. Envisioning the Behavioral Health Delivery System
  - i. Involuntary Medication Resolution
  - j. Mental Health Diversion
  - k. Governor Elect Newsom
  - l. Data

**REGULAR AGENDA ----- 8:30 PM – 8:50 PM**

10. Board of Supervisors Report – Supervisor Don Saylor
11. Chair Report – James Glica-Hernandez

**PLANNING AND ADJOURNMENT----- 8:50 PM – 9:00 PM**

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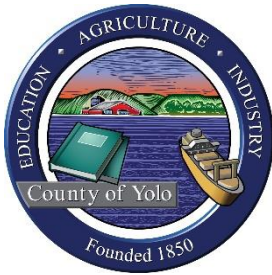
12. Future Meeting Planning and Adjournment – James Glica-Hernandez
  - a. [Current Ad-Hoc Committees and Members](#)
  - b. [Long Range Planning Calendar Discussion](#)
  - c. [Next Meeting Date and Location](#) – January 28, 2019  
from 7:00pm - 9:00pm. AFT Community Meeting Room 1212 Merkeley Ave.  
West Sacramento, CA 95691.

I certify that the foregoing was posted on the bulletin board at 625 Court Street, Woodland CA 95695 on or before Friday, November 30, 2018.



Iulia Bodeanu  
Local Mental Health Board Administrative Support Liaison  
Yolo County Health and Human Services Agency

Item 4. Approval of Minutes from  
October 22, 2018



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## Local Mental Health Board Meeting Minutes

**Monday, October 22, 2018**

**AFT Library, Community Conference Room  
1212 Merkeley Ave. West Sacramento, CA 95691**

- Members Present:** James Glica-Hernandez, Martha Guerrero, Antonia Tsobanoudis, Sally Mandujan, Nicki King, Brad Anderson, Don Saylor, Bret Bandley,
- Members Excused:** Serena Durand, Laurie Ferns, Ben Rose, Robert Schelen, Ajay Singh, Reed Walker, Richard Bellows
- Staff Present:** Karen Larsen, Mental Health Director, HHSA  
Samantha Fusselman, Deputy Mental Health Director and Manager of Quality Management Services, HHSA  
Carol Strung, Deputy to Supervisor Oscar Villegas

### CALL TO ORDER

- Welcome and Introductions:** The October 22, 2018 meeting of the Local Mental Health Board was called to order at 7:00 PM. Introductions were made.
- Public Comment:** None
- Approval of Agenda:** There was no quorum at the start of the meeting, so the approval of the agenda was postponed.
- Member Announcements:** Antonia Tsobanoudis attended the CALBHBC Training and that the training was very good and useful.
- Correspondence:** None

### TIME SET AGENDA

- Substance Use Disorder Presentation** – Karen Larsen, Mental Health Director, HHSA

### CONSENT AGENDA

- Mental Health Director's Report** by Karen Larsen, Mental Health Director, HHSA
  - Pacifico – The Pacifico neighbors came to the Board of Supervisor's meeting and the Davis City Council meeting. HHSA is working closely with the City of Davis to finalize a conditional use permit that will include the items that the Housing Authority and HHSA will do to mitigate the concerns of the neighbors. There will be another public meeting regarding the community concerns.

- b. Beamer Street – Homeless individuals who end up in hospitals are released back into the community and don't have a home, so end up coming back into the hospital. It has come up with our hospital partners to have the possibility of a lower-level of care to recuperate for a limited term.
- c. Homeless Funding Update – Allocations based on homeless point in time count and SMI prevalence rate. There are monthly meetings that HHSA staff are attending with City Managers and Homeless Coordinators to discuss funding opportunities to discuss how to distribute funds in an equitable manner.
- f. MHSA Planning Summit – This event had the best attendance so far. There is great potential for the next round of the three year planning process. Funding and programmatic opportunities are promising.
- j. Pine Tree Gardens Update – HHSA met with Sup. Saylor, Sup. Provenza, the CAO and Al Rowlett from Pine Tree Gardens to discuss guiding principles and follow up items so that Karen Larsen and Al Rowlett are going to meet with the families of those who have clients at Pine Tree Gardens. There will be a visit to Roy's house in Nevada City, a peer run home, which could serve as a potential model for the Pine Tree Gardens residents.

## REGULAR AGENDA

### 8. Board of Supervisors Report – Supervisor Don Saylor

- Supervisor Saylor is looking forward to tomorrow's Board of Supervisor's meeting where a proposal to establish involuntary medication program within the county jail will be presented to the board. This proposal addressed the needs of a focused population of those that are incarcerated. The Public Defender and HHSA have been in discussion. The Board of Supervisors is looking for clarity in protocols and believe that the program can be very helpful as it is the intention to serve those housed in jail but on their way to state hospitals, but cannot be served there at the moment, because of limited capacity. This is a means for their conditions to be treated within the jail.

Supervisor Saylor is very proud of the mental health housing projects recently, namely the Beamer Street Project. Pacifico is going to get there but it is going to take some time to put the pieces together. Pine Tree Gardens is also moving in the right direction. It is going in the right direction. He is also impressed by the UC Davis NAMI group and their involvement with the student population. The Chancellor of UC Davis is looking at student wellness and has made food security, housing and mental health, his areas of focus. There is limited mental health coverage and there is a large need, as well as a means of collaboration among various agencies.

### 9. Chair Report – James Glica Hernandez

- James attended the governing board meeting of the CALBHBC mental health planning council. There was a presentation from MHOAC staff about demographic mapping and fiscal outcome tools. There are a multitude of planning tools using real-time demographics that were presented. NAMI Heritage Plaza event and the service at St. Martin's church was excellent and there has been tremendous growth within the NAMI group. The by-laws regarding the name change is in draft. An ad-hoc committee to edit the bylaws was created with members Bret Bandley, Ajay Singh, Nicki King, Sally

Mandujan and James Glica-Hernandez. Ad-hoc committees have demonstrated greater functionality than standing committees.

**10. Future Meeting Planning and Adjournment:** James Glica-Hernandez

- a. Current Ad-Hoc Committees and Members/Reports: None
- b. Long Range Planning Calendar: LOCUS and Child and Adolescent Survey
- c. Next Meeting Date and Location:

December 3 2018, from 7:00pm - 9:00pm. Bauer Building, Thomson Conference Room Woodland, CA 95695

**Adjournment:** 8:30pm

Item 7. Adult Needs and  
Strengths Assessment  
Presentation



# ANSA OVERVIEW

ADULT NEEDS AND STRENGTHS ASSESSMENT

Kim Narvaez  
December 2018 Local Mental Health Board



# What is the ANSA?

Developed by the Dr. John S. Lyons, Ph.D.

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Multipurpose **information integration tool** that is designed to be the output of an assessment process

Multiple inputs of info may be combined to generate a measurement

A collection of unique items which are integrated into a **collaborative assessment** process.

Framework to **identify and measure** needs and strengths

**Informs** behaviorally-based case plan objectives from identified needs and strengths

Not a self report measure

Not solely a measure of clinical impression

Versions have been developed for other populations

- Transition Aged Youths (TAYs)
- Children and Early Childhood (0-5)
- Client with Developmental Disability
- Juvenile Justice involved

# What are the impacts of the ANSA?

## Effective Communication

- shared vision across all levels of the system
- facilitates the linkage between the assessment process and the design of individual service plans
- supports care coordination and participatory decision-making

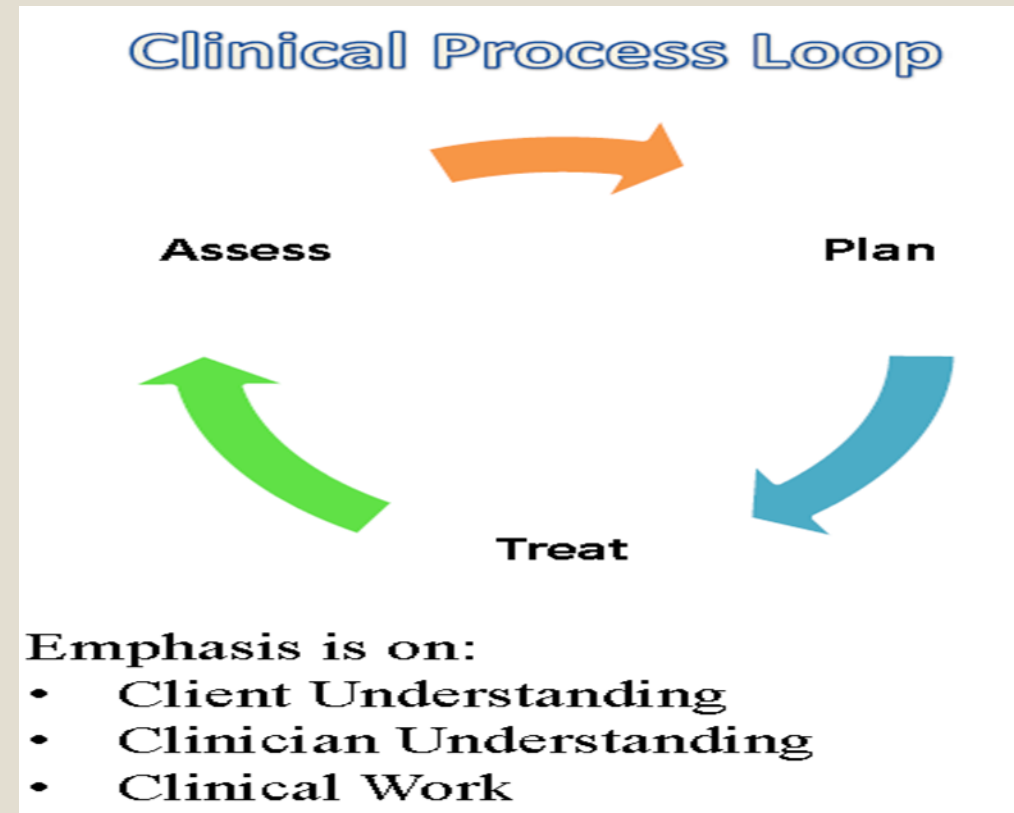
## Supports decision-making

- Level of care
- Intervention and service planning

## Allows for monitoring of clinical and functional outcomes

# Improves the Information Loop

Role of structured assessments in Behavioral Health



# 6 Principles

Items are included because they might impact care planning

Level of items translate immediately into action levels

It is about the individual not about the individual in care

Consider culture and development

It is about the 'what' not about the 'why'

The 30 day window is to remind us to keep assessments relevant and 'fresh'

## Needs Action Levels:

- 0 = No need for action; no evidence of need
- 1 = Watch need carefully to prevent worsening
- 2 = Act; include in plan of care
- 3 = Act immediately/intensively

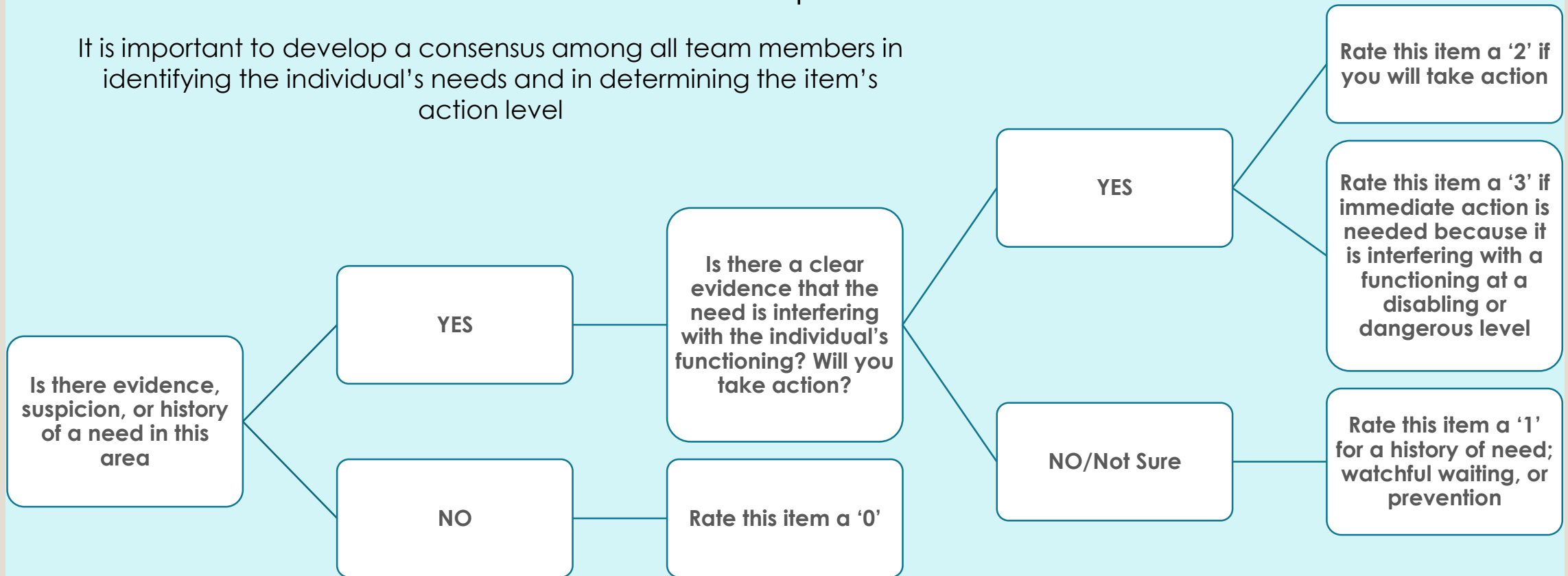
## Strengths Action Levels:

- 0 = Centerpiece strength for plan of care
- 1 = Useful strength for plan of care
- 2 = Identified strength, but needs building
- 3 = No strength identified in this area

# Assessing for Needs

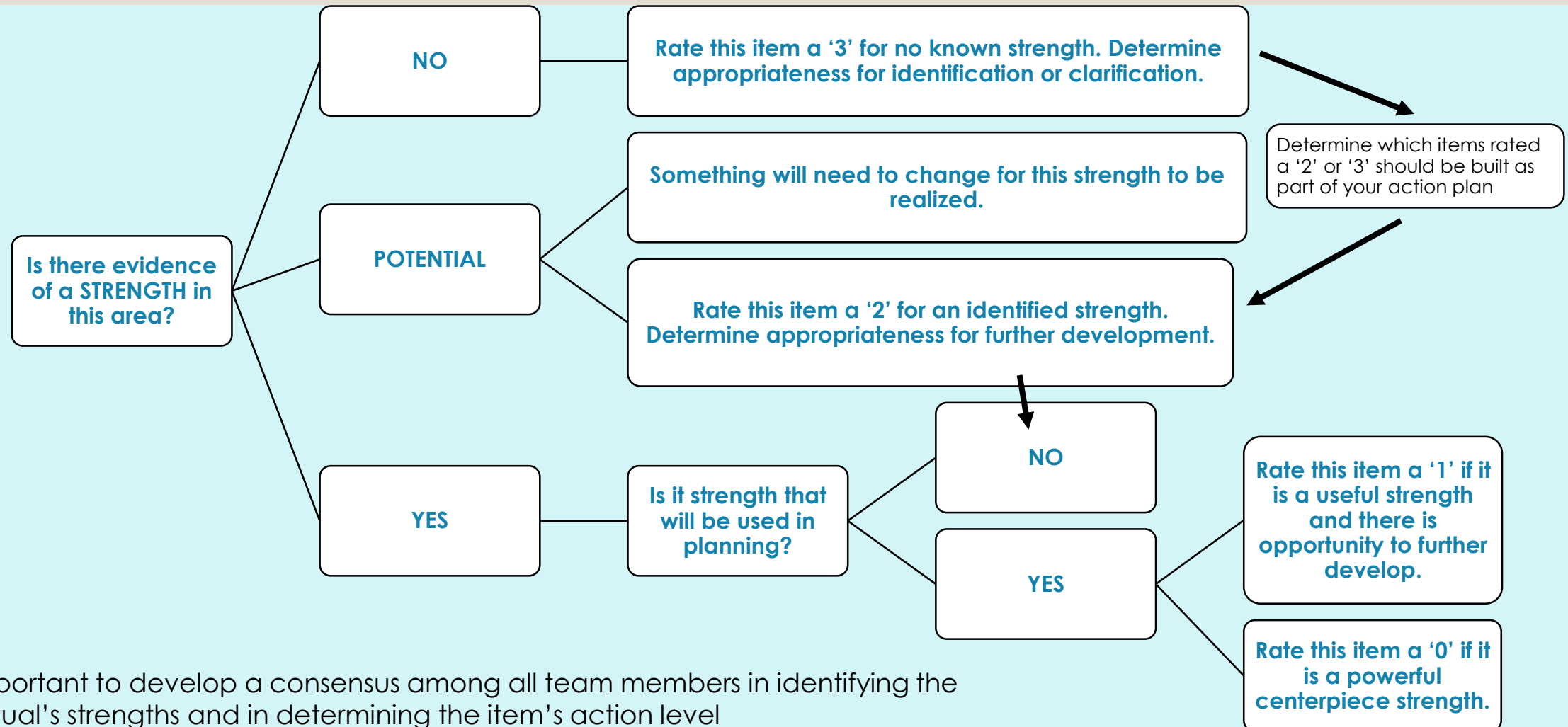
## Decision of whether or not information represents a NEED

It is important to develop a consensus among all team members in identifying the individual's needs and in determining the item's action level



# Assessing for Strengths

Decision of whether or not information represents a STRENGTH



It is important to develop a consensus among all team members in identifying the individual's strengths and in determining the item's action level

# Treatment Planning

Identify the linkage between the ANSA and treatment plan

- Shared vision
- Golden Thread
- Collaboration is interactive and ongoing
- To get from the what to the why
- Transparency and use of data with clients and families
- How does the client/family make sense of these ratings?
- Clinical practices focused on client centered approaches



# Treatment Planning

## START with the 'WHAT'

- describe the circumstance and environment

## CONSIDER the 'WHY' (This is a clinical formulation)

- What are the past trauma, developmental stages and cultural factors?
- Understand what is happening

## DETERMINE the 'HOW' (develop a plan to help)

- Clear need to bundle actionable items into treatment targets
- Help to focus on high impact needs or the most annoying problem.
- Work together to understand the complexity of the needs

# When will it be utilized?

- Yolo County HHSA Mental Health staff are not currently using the ANSA.
- HHSA will implement it as an outcomes measure tool and as a required component of the Steps to Success program.
- If a client is demonstrating poor outcomes with an existing treatment plan, the ANSA will be used as an indicator if service dosage or type of service is off track, and the treatment plan will be revised.

# Thank You

## References:

TCOM, Dr. John Lyons and Dr. April Fernando, UC Davis Extension, Timothy E. Hougen, Ph.D.

## Contact Info:

[kim.narvaez@yolocounty.org](mailto:kim.narvaez@yolocounty.org)

530-666-8513

## Item 8. Level of Care Utilization System Presentation

# LOCUS Overview

Yolo County Local Mental Health Board  
December 2018

# LOCUS – What is it?

- Level of Care Utalization System (LOCUS)
- Developed by the American Association of Community Psychiatrists
- Latest revision—LOCUS Adult 2010
  - Incorporates the “Stages of Change”

# Why the LOCUS?

- Best Practice
- Utilized throughout the United States
- Provides a common language
- Addresses Co-Occurring issues
- Assists in distinguishing needs and appropriate services
- Monitors/Measures change

# Understanding the LOCUS

There are **three** main objectives of the LOCUS:

A system for evaluating the current status of clients and their needs based on six dimension parameters

To describe a continuum of service arrays which vary according to the amount and scope of resources available at each “level” of care

To create a methodology for quantifying the assessment of service needs in order to reliably place a client into the appropriate level of services within the available continuum



# LOCUS: Using the Tool

- The LOCUS is a dynamic instrument and scores are expected to change over time
- Scores are generally assigned on a here and now basis
- Some parameters do take into account *historical* info
- Clinical judgment should prevail in the determination of frequency to reassess
  - Generally reassessments occur more frequently at higher levels of care

# LOCUS: Using the Tool

LOCUS does **not**:

- Direct how to design programs
- Specify treatment interventions- does not treatment plan– but **acts as a service level guide**
- Negate clinical judgment – if Clinician and the score don't agree, then the Clinician is to rely on their **own judgment**
- Limit creativity: although it describes levels of care, there is nothing that requires a Clinician to limit interventions, the focus of services, or the design of a program for unique client needs

# LOCUS: Additional Information

- Most thoroughly completed with all available data considered: history, family, friends, client, prior evaluations, etc.
- The tool does not need to be used in a linear fashion
- Each dimension is rated independently of the others
- If there is not a clear score in any area, the higher score is assigned
- Objectivity is primary
- Clinical judgment is always considered in determining the final level of care recommendation

# LOCUS: When is it utilized?

- Yolo County HHSA Mental Health staff currently utilize the LOCUS when there are indicators that a higher or lower level of service dosage may be appropriate for an existing client
- Some HHSA Contractors utilize the LOCUS at time of Intake and at 6-month or annual intervals to determine appropriate service dosage at that time, in addition to when there are indicators that a higher or lower level of service dosage may be appropriate for a particular client
  - Upcoming: HHSA will incorporate the LOCUS in this way, at time of Intake and at annual intervals

## YCHHSA Adult LOCUS

The Levels of Care are meant to serve as guidelines and are not meant to be static. Although initial placement may begin at a particular level of care, clients may (based upon an updated LOCUS, treatment plan and choice) move to/from different levels of service. Service intensity among the different modalities (psychiatric, therapy, case management, funding assistance) is presented as a guideline. Services at all levels of care must be medically necessary and expected to benefit clients. Recommended hours are not intended to be cumulative across all types of modalities. In some circumstances a consumer may have part of their hours from across all modalities, while others have all their hours from only one modality.

Level	Name	Description	LOCUS Score	Level of Care	Average Service Dosage	Re-Authorization	Clinical Review Criteria for Approval
1	Recovery Maintenance	Person lives independently with mild-to-moderate mental health symptoms	7 to 13	Triage/Screening. May receive 3 - 6 service contacts supporting linkage to outside provider	Up to 6 service contacts per year	None. If additional services requested, Triage/Screening will be repeated.	Repeat engagement -- will consider Level 2
2	Low Intensity Community Based Services	Brief/Intensive services or episodes of care. Mild clinical symptoms, behaviors and/or functional impairments. Demonstrated capacity to engage in routine outpatient treatment.	14 to 16	Medication Monitoring. Annual Medication Plan for services. Triennial Assessment with a Clinician. Primarily office-based visits.	4 to 12 service contacts per year	Annual	Demonstrates insight and responsiveness to medication treatment with a psychiatrist
3	Medium Intensity Community Based Services	Multiple/significant symptoms and functional impairments. Deterioration in at least one life domain due to psychiatric illness.	17 to 19	Medication Monitoring. Annual Client Plan for services. Triennial Assessment with a Clinician. Intermittent Case Management Services to maintain linkage to psychiatry care. Funding support available if needed to remain in the community. Field-based visits available as needed.	4-24 service contacts per year	Annual, or semi-annual if over 24 service contacts per year are necessary to maintain stability and independence in the community	Remains symptomatic with mild-to-moderate impairments in social relationships and other life domains
4	High Intensity Community Based Services	Capable of living independently, but requires intensive management by a multidisciplinary treatment team. Includes Mental Health Court, and chronically homeless individuals with persistent psychiatric symptoms.	20 to 22	Medication Monitoring and regular, frequent case management contact, intermittent Clinician contact and consistent funding needs to maintain community-based placement. May engage after hours and crisis services.	24 - 60 service contacts per year	Semi-annual	Remains symptomatic with moderate to severe impairments in multiple life domains. Uses crisis services and may be hospitalized to maintain community-based independence. May demonstrate problems with engagement in care.
5	High Intensity Wrap-Around Services	Resides in room and board or higher residential setting. Requires intensive, frequent contact, services and funding assistance to remain in the community	23 to 27	Intensive, regular scheduled case management and Clinician contacts, as well as frequent after hours and crisis contacts. Housing is room and board/board and care or higher level, with funding support needed to avoid higher level of care.	60+ service contacts per year	Semi-annual	Remains symptomatic with severe, chronic impairments in multiple life domains. Moving to lower level of care will increase risk. May demonstrate problems with engagement in care. Lack of progress warrants new treatment strategies and decision trees for crisis on a regular basis.
6	Inpatient Care	IMD/SNF. Typical legal status is LPS Conservatee.	28+	N/A	Quarterly to annual Clinician visits at IMD, focused on reviewing treatment progress and ongoing appropriateness for level of care, as well as potential opportunity for step-down	Quarterly to Semi-annual	Repeat hospitalizations due to severe and persistent psychiatric symptoms with related functional impairments.

- Questions?

## Item 9. Mental Health Director's Report

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

**Pacifco Update-** On November 2<sup>nd</sup>, 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 Pacifco location is still under review and projected timeline will put opening the Navigation Center at the Pacifco site next summer, and the Adult Residential Facility at the Pacifco later in FY1920.

**Beamer Street Development** – The official ribbon cutting ceremony for the Beamer street development will be on December 11<sup>th</sup> 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 13<sup>th</sup> 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 4<sup>th</sup> and 5<sup>th</sup> 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 13<sup>th</sup> 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 13<sup>th</sup> 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 8<sup>th</sup> 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 HHS 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.

HHS 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 HHS 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.

An estimated **one in 20**  
adults in the state are living  
with a serious brain illness.

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.

It's hard to think of a public policy issue not impacted by the state of mental healthcare.

It's hard to think of a public policy issue not impacted by the state of mental healthcare.

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.

**As Governor, I will pursue an aggressive agenda to lift California's approach to mental healthcare into a national model.**

As governor, I will pursue an aggressive agenda to lift California's approach to mental healthcare into a national model.

**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.

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.

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.

Since 1995, we've witnessed the closure of **44** psychiatric facilities and the **2800** beds that come with them.

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.

The opioid crisis is  
a mental health crisis.

**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.

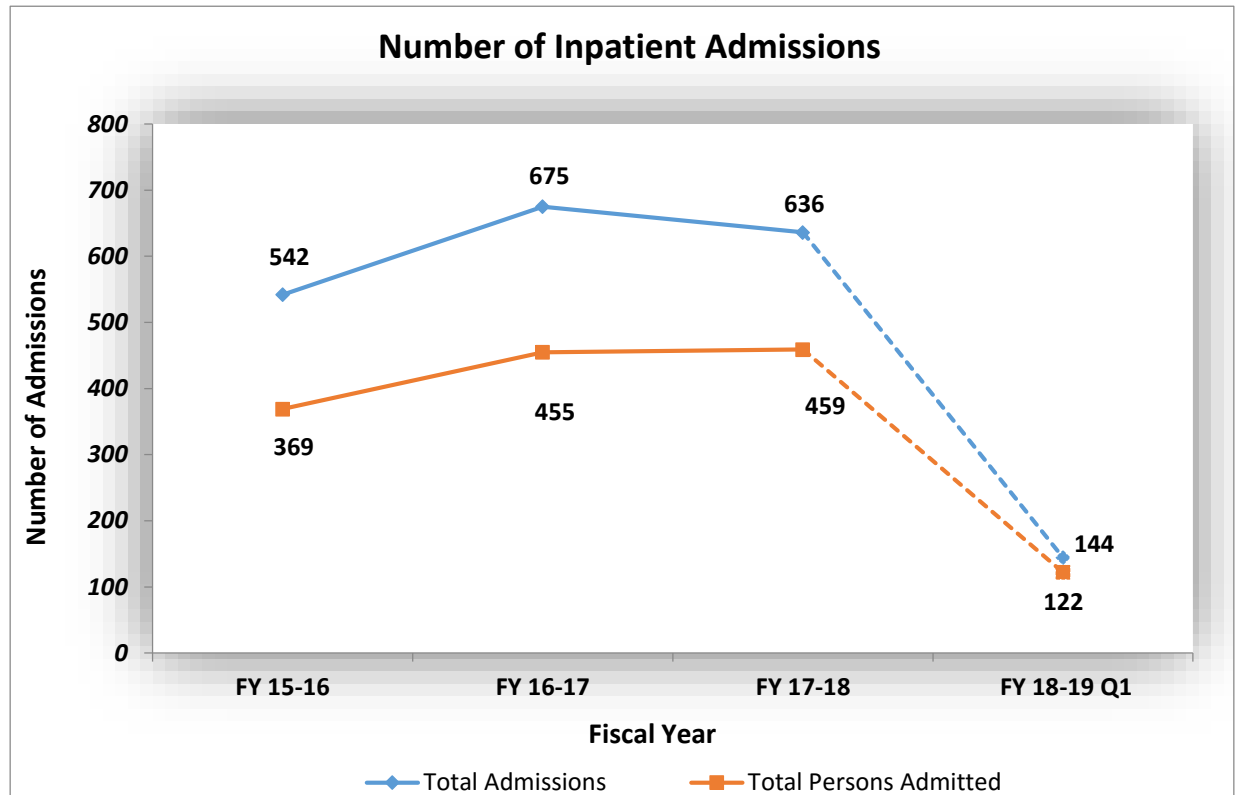
As Governor, I will embrace the mantra that there is no health without brain health. We will usher in the next era of care, and emerge a stronger, healthier California.

# **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



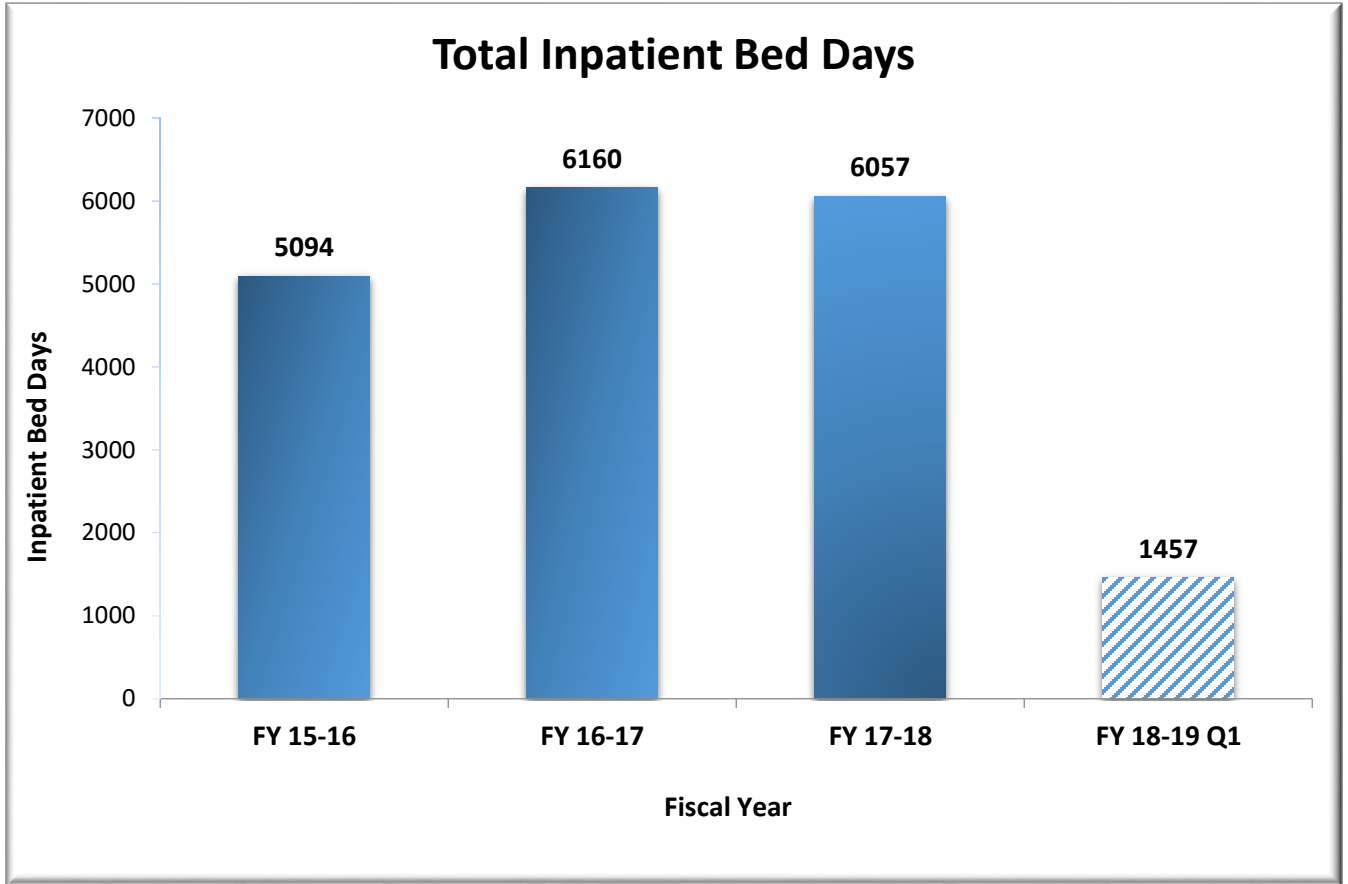
Data Source: TAR log FY 15-16, FY 16-17, FY 17-18 & FY 18-19 Q1

### 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

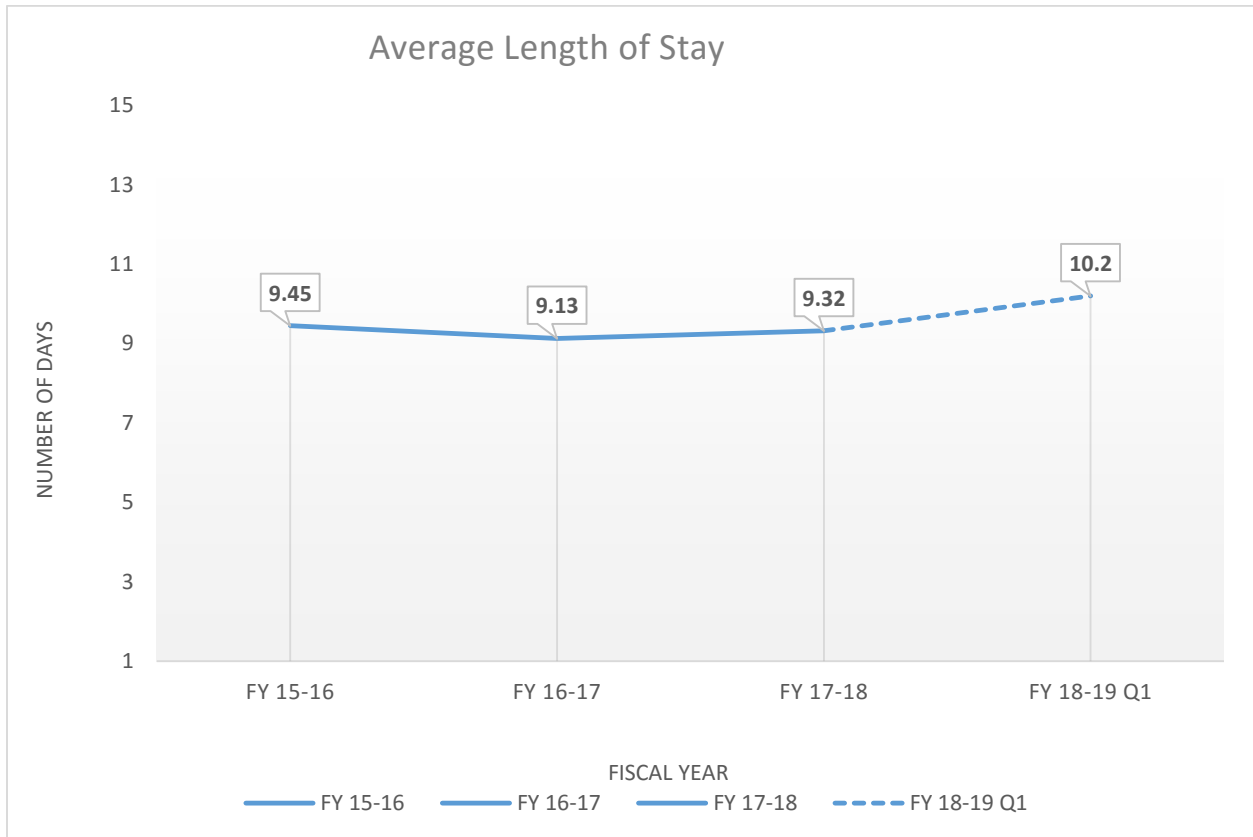
### **Data summary:**

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



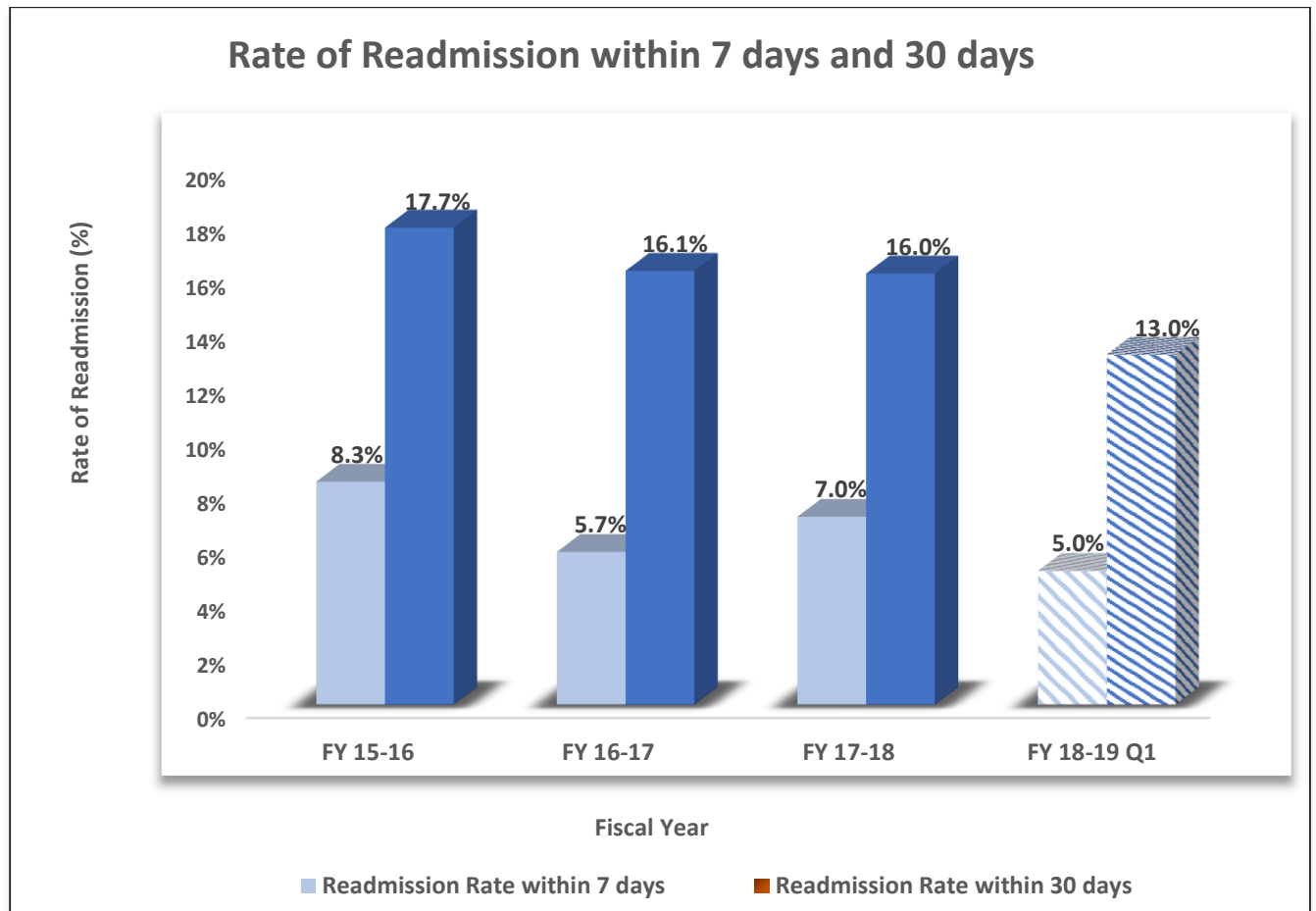
Data Source: TAR log FY 15-16, FY 16-17, FY 17-18 & FY 18-19 Q1

#### **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.

## Item 12.a. Current Ad-Hoc Committees and Members

**Current Ad-Hoc Committees and Members / Reports**

<b>Meeting</b>	<b>Participants</b>	<b>Last Date Met</b>
<i>Data Metrics Ad-Hoc</i>	Samantha Fusselman, James Glica-Hernandez, Nicki King, Richard Bellows	February 20, 2018
<i>Pine Tree Gardens Ad-Hoc/Task Force</i>	James Glica-Hernandez, Martha Guerrero, Brad Anderson, Sally Mandujan, Antonia Tsobanoudis	March 19, 2018 May 21, 2018
<i>West Sac Engagement Ad-Hoc</i>	Sally Mandujan, Martha Guerrero, Robert Schelen	April 10, 2018
<i>Site Visit Ad-Hoc</i>	James Glica-Hernandez, Ajay Singh, Ben Rose	April 16, 2018
<i>Budget and Finance</i>	Nicki King, Bob Schelen, Richard Bellows	April 25, 2018
<i>By-Laws</i>	Bret Bandley, Ajay Singh, Nicki King, Sally Mandujan, James Glica-Hernandez	Have yet to meet

## Item 12.b. Long Range Planning Calendar

**Yolo County Local Mental Health Board  
Long Range Planning Calendar 2018**

Meeting	Agenda Item	Agency/Presenter	Type	Timing
1/29/18	5150 Process Presentation	Harjit Singh Gill, Samantha Fusselman	Presentation	Past
2/26/18	MHSA 3-year Plan Update	Resource Development Associates (RDA)	Presentation	Past
2/26/18	Homeless Presentation	Aurora William, HHSA Homeless Services Manager	Presentation	Past
3/26/18	CCP Presentation	Carolyn West, CAO Senior Management Analyst	Presentation	Past
4/30/18	Annual Report Approval	Executive Committee	Recommendation	Past
4/30/18	Behavioral Health Services Budget Presentation	Connie Cessna-Smith, HHSA Fiscal Administrative Officer	Presentation	Past
5/21/18	Public Guardian Presentation	Laurie Haas, HHSA Chief Deputy Public Guardian	Presentation	Past
5/21/18	Annual Election of Officers	All	Adoption	Past
6/25/18	Maternal Suicide and Depression Presentation	Anna Sutton, HHSA	Presentation	Past
6/25/18	By-Law Review	All	Recommendation	Past
8/27/18	Consumer Perception Survey Data Presentation	Samantha Fusselman, Deputy Mental Health Director and Manager of Quality Management Services, HHSA	Presentation	Past
9/24/18	MHSA Annual Update Presentation	Anthony Taula-Lieras, Project Coordinator, Mental Health Services Act (MHSA)	Presentation	Past
10/22/18	SUD Presentation	Ian Evans, Alcohol and Drug Administrator	Presentation	Past
12/3/18	Assessment Presentation	Kim Narvaez, Program Manager, Child, Youth & Family Branch	Presentation	Past
1/28/19	School District Mental Health Services	TBD	Presentation	Proposed

## Item 12.c. Next Meeting Date and Location

# DRAFT

# 2019

## Yolo County Local Mental Health Board

January						
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Regular Meeting      County Holiday

**JANUARY 28, 2019 - WEST SACRAMENTO**  
 AFT Library, Community Meeting Room, 1212 Merkley Ave. West Sacramento, CA 95691  
 7:00 – 9:00 PM Meeting

**FEBRUARY 25, 2019 - DAVIS**  
 Mary L. Stephens Library, Blachard Community Conference Room, 315 East 14th Street,  
 Davis, CA 95616 7:00 – 9:00 PM Meeting

**MARCH 25, 2019 - WOODLAND**  
 Bauer Building, Community Conference Room, 25 Cottonwood St. Woodland, CA 95695  
 7:00 – 9:00 PM Meeting

**APRIL 22, 2019 - ESPARTO**  
 Esparto Community Library 17065 Yolo Ave, Esparto, CA 956271  
 7:00 – 8:00 PM Meeting

**MAY 20, 2019 - WEST SACRAMENTO**  
 AFT Library, Community Meeting Room, 1212 Merkley Ave. West Sacramento, CA, 95691  
 7:00 – 9:00 PM Meeting

**JUNE 24, 2019 - DAVIS**  
 Mary L. Stephens Library, Blachard Community Conference Room, 315 East 14th Street,  
 Davis, CA 95616 7:00 – 9:00 PM Meeting

**JULY - BOARD RECESS**

**AUGUST 26, 2019 - WOODLAND**  
 Bauer Building, Community Conference Room, 25 Cottonwood St. Woodland, CA 95695  
 7:00 – 8:00 PM Meeting

**SEPTEMBER 23, 2019 - DAVIS**  
 Mary L. Stephens Library, Blachard Community Conference Room, 315 East 14th Street,  
 Davis, CA 95616 7:00 – 9:00 PM Meeting

**OCTOBER 28, 2019 - WEST SACRAMENTO**  
 AFT Library, Community Meeting Room, 1212 Merkley Ave. West Sacramento, CA, 95691  
 7:00 – 9:00 PM Meeting

**DECEMBER 9, 2019 - WOODLAND**  
 Bauer Building, Community Conference Room, 25 N. Cottonwood St. Woodland, CA  
 95695 7:00 – 9:00 PM Meeting