# Minutes for Yolo County Mental Health Board
## Monday, October 22, 2007

Members Present: Chairwoman Marilyn Moyle; Millie Braunstein; Peter Brixie; Robert Canning; Martha Flammer; Helen Thomson, County Supervisor; Guille Libresco; Carolyn Reiff; Irma Rodriguez; Rev. Hank Scherer; Marilyn Schwartz; Mike Summers

Members Absent:

Members Excused: Vice-Chairman Robert Schelen; Anne Breault-Darling; Joanne Welty

Others Present: Richard DeLiberty, ADMH Interim Director; Christina Hill-Coillot, Deputy Director; Mark Bryan, Deputy Director; Mike Tucker, Deputy Director; Rudy Arrieta, QM/Data Administrator; Joan Beesley, ADMH Program Manager (MHSA); Kevin Rosi, Child Psychiatrist; Leigh Harrington, Adult Psychiatrist; Jon Caldwell, Psychiatrist; Tawny Yambrovich, ADMH Secretary; Don Meyer, Probation; Pat Leary, Assistant County Administrator; Diane Sommers, Director, Suicide Prevention; June Forbes, NAMI-Yolo; Walter Shwe, client; Delilah Schelen (representing Bob Schelen)

Location: Training Room, Families First, 2100 Fifth Street, Davis, CA 95618

I. Meeting called to order by Chairwoman Marilyn Moyle at 7:01 P.M.
Introductions:

a. Dr. Caldwell, Interim Medical Director–Came to Yolo County in August of last year. Irma Rodriguez was instrumental in getting the designation for Yolo County so we could participate in the NHSC Scholarship program, which allowed Dr. Caldwell to come here.
b. Leigh Harrington, NHSC scholar also. Adult psychiatrist, trained at Stanford University. She is very principled; enjoys doing the right thing for the right reason. Has had a lot of training in Cognitive Behavioral Therapy; will be training clinicians in group and individual therapy.
c. Kevin Rosi, child and adolescent psychiatrist, trained at Stanford also. Will be working 2 days in West Sacramento and 2 days in Woodland, under the guidance of our seasoned child psychiatrist, Harvey Tullin.
d. Delilah Schelen – taking notes tonight for Bob Schelen, who is at a School Board candidate's forum.
e. Rudy Arrieta–Quality Management Data Administrator; came to us from San Joaquin County; expert in data and quality management. Involvement with the community and as an advocate. Disraeli (former prime minister of England) said there are "Lies, damn lies, and statistics." We're moving forward. Rudy will be managing the CA EQRO audit process.

II. Approval of Agenda; Minutes.

Approval of Meeting Agenda: *Motion was made by Robert Canning and seconded by Irma Rodriguez to approve agenda; carried.*
Approval of Meeting Minutes: *Motion was made by Carolyn Reiff and seconded by Robert Canning to approve minutes as amended of September 24, 2007 meeting; carried.*

III. Announcements:

a. Robert Canning announced that he and Martha Flammer will be making a trip on Thursday down to Marin County to observe their STAR court, which is their mental health court. They will be visiting with the court while they do their work. He invites any board members and interested parties to attend.

IV. Public Comment

a. None

V. Report: Board of Supervisors–Helen Thomson

a. Wants to note that the Board will be hearing the same report tomorrow that Richard is sharing with the LMHB tonight: the first quarterly financial report.

VI. Report: LMHB Chairperson–Marilyn Moyle

a. Has had a number of phone calls in the last few weeks expressing concerns about what's going on in the department. Would like to go forward in a manner that provides support; support for Richard, support for the staff that is working hard to continue to provide service during hard economic times. It's important to get through this budget crisis in as positive a way as we can. It's important that we keep the lines of communication open and work together. Everybody's foundation is shifting, and, like it or not, some people are bound to fall through the cracks.
b. Irma: Can't support the staff without sufficient information. When concerns are brought to the board, wants to make sure that not all information is treated as rumors, without doing fact-finding first.
c. Marilyn M.–those on the smaller committees have gotten a clearer understanding of what is going on in the department, and hope that the committee reports can make things clear to the larger board.
d. June F. – Hears first person stories from people and their families about problems; what bothers her is that she never hears explanations from the department, or what the department is planning to do about it.
e. Millie: If there is an individual situation, Christina and Richard have said at previous meetings that they can be called and they will try to address the problem.
f. Marilyn M: Will be asking for reports from YCCC, Pinetree Gardens, and the ACT teams.
g. Irma: Think these issues should be addressed by the Board, rather than as a series of 17 individual phone calls. As a board, we can be a powerful force for change, but if we each take action individually, we lose continuity. Fears that, as we lose some of those community based services, we can't get them back.

VII. Report: ADMH Interim Director–Richard DeLiberty

a. Interviewed for Medical Director last Friday; two very strong candidates–hope to make an offer in the next few days
b. Recruiting for Staff Development Manager, budgeted with MHSA training and education funds
c. Recruiting for a permanent director

d. Still having significant difficulties with the budget; still trying to move people out of residential programs.
e. Bringing on a new supervising clinician for Adult Forensics; developing another team that can help with moving people out of facilities. Combined Prop 36 and ConRep programs and moved 3 staff from other programs.
f. Trying to direct our resources to helping the most severely ill population
g. Working on increasing productivity, completing paperwork
h. Q: Irma – Moving someone from prevention into medical services is a very different scope of service; what kind of training is being provided?
   A. Richard: Staff will not be doing medical work, rather will be spending more time completing paperwork so physicians won't have to. We are creating new positions and developing a new team, with the supervisor coming in, working with them and figuring out how they will work together. Don't want to make the plans too specific until the team gets together and see how they work and meld. We're doing new things.
   Irma: The lack of specificity may be adding to the anxiety that staff are feeling.
i. Richard: we are going to lose a minimum of $2.3 million if we continue as we are now. The Board of Supervisors will not allow this. Plan B is to move people to brace up those areas. So far we have continued without curtailing services. Plan C will involve cutting services; we will start having those planning meetings and discussions very soon. We will be talking with the unions. We are trying to preserve services, preserve jobs.
j. Martha: The Forensic committee would appreciate being informed of these changes, because the board should have some discretion over programmatic changes; the ability to review the process. This should not be done in secret. We would appreciate being informed in advance of such major changes.
k. Irma: Q: How are individuals taking their funding with them? Are you trying to build a continuum with existing funding?
   Richard: A: Yes, I think that's all being taken into consideration.
l. One of the issues is that we have been moving slower than we thought getting people out of locked facilities and into the community. Safe Harbor, in some cases, was more expensive, but provided an opportunity for the ACT team to spend intensive time with clients while trying to return them to the community. ADMH was informed on Friday that Safe Harbor did not have the staffing levels that would satisfy their licensure, so clients had to be moved until Safe Harbor had legal staff-to-patient ratios.
   June F.: Horrified that someone would be moved from 24/7 care to a motel. Believes that relapse is unavoidable if someone goes from a completely regulated life to living alone with no company and no assistance.
   Marilyn M.–When people are stepped down from an IMD, they are given assistance 24/7 from the ACT team.
   Irma: no one is taken out of 24-hour care unless they no longer meet medical necessity for that level of care.
   Christina: ACT provides continuous case management, multiple contacts per day, transportation to medical appointments, access to a nurse and a psychiatrist. It's very individualized care.
   Richard: YCCC was being used as emergency housing. ACT supplies case management services, support, medication, groups.

Robert: recommends going to spend some time with the ACT team.
Christina: the ACT team has a meeting every morning at 8:00 A.M. that is open to members of the community who would like to have questions answered. The ACT team helps clients shop; reintegrate with family members that they haven't seen in years; teaches activities of daily living.

Richard: ACT team census is lower than expected because we have been working through the process in Yolo County to get clients placed.
Mike Summers: Is the ACT team an intake source?
Richard: No, the clients are only taken as direct referrals from the department; primarily those people coming out of 24-hour settings.
Richard: The bottom line is that we are still looking at a significant shortfall. Our new financial system is letting us take a better look at it.
Robert: Are we bleeding money from services, or not taking in income?
Richard: 2 places primarily that we are missing our budget, and 1 more potentially. 1) 24-hour and locked facilities; 2) our acute-care stays run 9-10 days (Woodland Memorial–need some guidelines and parameters); length-of-stay at Safe Harbor is 10-11 days. 3) Need more billable hours (face-to-face services are only being provided 30-35% of the time); revenue coming in from providers is complicated; some of it is services not being provided, some of it is billing and claiming problems.

VIII. Budget Report: ADMH Deputy Director–Mike Tucker

a. Expenditures and revenues; make them match.
b. Mental Health funding is so convoluted, it IS rocket science.
c. The budget assumes 10% salary savings/year; right now we have 20%, because we can't get people in the door fast enough
d. Contracts: have to guess what level of services, and who will be providing the care–those are all estimates, but since treatment is individualized, those numbers are moving targets
e. If you don't provide enough services, you don't get Medi-Cal reimbursement
f. If you don't have the staff to provide services for grants, you won't receive the grant payments
g. Department Financials: "point-in-time" estimate; doesn't have all the payments in yet, but has identified several problems in how we do accounting. We have data that isn't accurate; we are correcting it. We know that there are revenues that have not been posted to Gen Led (the general ledger).
h. If we looked straight ahead, without changes, we would end the fiscal year $4.4 million in the hole. Management team has put together a plan to reduce expenditures
i. Revenue projections are extremely low: some of our contracts are not in place, so we are not capturing Medi-Cal billing. Some staff are not in place for grants. We have an over $2 million revenue problem.
j. To increase revenue: we could increase the Medi-Cal eligible services provided.
k. Deficit in Contracts should read $1 million

Richard: there has been a freeze on a couple of positions (i.e. the Director's position), but largely the salary savings have come due to positions vacant during

turnover, or new positions that haven't been filled. MIOCR positions are being held because we don't know how to staff that for 1 year, without knowing how we will go forward. Positions that have been held were not revenue-generating positions.
Irma: what kind of training is the staff receiving to increase their billable hours? What is the no-show rate? How can we decrease the no-show rate?
Richard: Extra person reassigned to Woodland office to increase Physician's billable time (non-revenue generating person moved to help medical staff increase productivity).

l. Mike: There are basically three ways to get out of the hole: 1) reduce length of stay and provide more aggressive treatment so that clients don't end up in acute care and IMDs. Billing is receiving training so that billing errors are caught up front and not discovered years down the line as a denial in the audit process 2) We have to decide who we WILL serve, and who we WON'T serve (for cost containment). We may have to limit or decrease services; create waiting lists. If someone who has insurance doesn't have a prior authorization to be seen, we aren't paid for services. If they have exhausted their eligibility, we don't get paid. 3) Prioritize services.

There are a number of options, none of them particularly good. Budget units are directly related to funds.
505-7 was created specifically so we could keep track of MHSA funding. Our planning was more aggressive than what we implemented; it is difficult to get staffing without competing with core mental health for providers. We are only going to spend $3.5 million of the $5.9 million we have budgeted this year. ACT contract got started later than planned. State wants us to have a reserve equal to ½ of our MHSA budget. Next year AIM, MIOCR, and one time monies for planning go away, so under-spending this year might be a good thing.
Every action has a reaction in the Mental Health budget. If you eliminate positions, you lose revenue that you had budgeted by not generating enough Medi-Cal units to draw down Medi-Cal units as planned.
Irma: Is a reduction in Children's services leading to decreased revenue? Send clinicians to children's services which are 95% Medi-Cal reimbursable?
Robert: Treating kids costs more now, but gives you "more bang for your buck." Early intervention for kids is clearly proven to prevent more expensive treatment down the road.
Richard: at this point, we haven't cut services to kids. Serving children now is very cost effective, but we have a budget deficit now.
Irma: you are dedicating more services to adult residential care than in the past.
Marilyn: If we start hearing that there is a reduction in children's services, we need to address that. We need to see the big picture, and be fair to every one who needs services. In the six years I have been on the board, the financial picture has gotten more and more grim. As we go through this year, and continue getting these reports, we need to listen to the community and our constituents. You can't make people get well any faster than they can get well.

IX. Report: WRAP Training–Marilyn Schwartz: not done.

X. Report: Legislative Review–Martha Flammer

a. Vetoed legislation will likely not be reintroduced

b. House Mental Health Parity bill: has passed the Energy and Commerce committees.
c. New Perry Communications Training: will be on Strategic Planning, and working with key stakeholders. To be held Thursday, November 8, from 7:00 – 9:00 P.M. in the Walker room.

XI. Committee Reports:
a. Executive: none
b. Budget: none
c. Forensic
i. CIT Training Update–Mike Summers: Has concerns for interaction of local law enforcement with the mental health community. CIT is a 40-hour course including instruction on signs and symptoms of mental illness, PTSD, de-escalation, and understanding and preventing suicide. Out of 1100 attendees at the CIT conference, only 9 attendees were from CA: 2 from San Diego, 6 from Modesto, and Mike. West Sacramento, Woodland, and Davis police departments will all be sending representatives to the 2-day CIT seminar put on by CIMH in Sacramento.
ii. Martha F: Long Term Plan, taking into consideration budget issues and delegating more groundwork, timeline is maybe a year longer to institute mental health court. Will still be bringing in folks to speak with, and visiting other programs.
d. Program – Millie Braunstein: have focused a lot on the budget, which is important since you can't have programs if you don't have money, but need to look also at whole system transformation, to set up supports so that clients can do well in the community. This model will cost less in the long run, and there is good evidence that it works. We need a whole cultural shift; a different way of thinking, that clients can have quality of life in the community.
There has been more transparency in the last year, and we need to compliment staff on their accessibility. Patients are getting a higher quality of care than if they were in a locked facility taking pills.
Community drop-in center is scheduled to open January 1.
Consumer-run business in the lobby of the Health Department will open soon.
MHSA prevention and early intervention guidelines are online; we have a consultant on-board to facilitate that process.
MHSA housing monies are also going to be available, and we are working with the Yolo County Housing Authority on how to best utilize those funds.
Program and Budget Committees will meet on November 19, from 3:30 – 5:00 P.M.
e. Legislative Advocacy

XII. Adjournment – 9:39 P.M.