"Mental Health Treatment Act"
Measure B Citizens Oversight Committee
AUGUST 29, 2018; 1:00-3:00 PM

MINUTES

APPROVED SEPTEMBER 26, 2018

MENDOCINO COUNTY ADMINISTRATION CENTER
CONFERENCE ROOM C
501 LOW GAP ROAD, UKIAH, CALIFORNIA

1. **Roll Call** was called by Dora Briley, Committee Clerk.

   a. Present: Jenine Miller, Jan McGourty, Carmel Angelo, Ace Barash, Ross Liberty, Mark Mertle, Jed Diamond, Shannon Riley, Thomas Allman, Donna Moschetti.

   b. Absent: Lloyd Weer by prior arrangement.

   c. Quorum was established.

2. **Approval of July 25, 2018 Minutes**

   a. July 25, 2018 minutes were approved with two corrections.

   Motion by Member Moschetti, seconded by Ace Barash.

   Vote was called for by Chair Allman:

Yay	10	Committee unanimously passed the motion.
No	0	
Absent	1	Member Weer

3. **Communications Received and Filed:**

   a. Kemper Consulting Group Report "Mendocino County Behavioral Health System Program Gap Analysis & Recommendations for Allocation of Measure B Revenues". https://www.mendocinocounty.org/community/mental-health-oversight-committee/agendas-and-minutes

   b. CEO August 21, 2018 Report, Page 4 County Counsel Legal Opinion Regarding City of Willits Resolution Relating to Psychiatric Facility Location. https://mendocino.legistar.com/LegislationDetail.aspx?ID=3598907&GUID=C08AA162-29CD-4CB4-9389-79C09F636DF6&Options=&Search=

4. **Public Expression.**

   a. Chair Allman invited public expression for items not on the agenda.

   No one came forward.

   The August 29, 2018 meeting can be viewed at:

   https://www.youtube.com/watch?v=jFZZaXv3GQA&feature=youtu.be

5. **Discussion and Possible Action Items.**

   a. Stepping Up Initiative First Responder Training Syllabus; with Discussion and Possible Action. *Chair Allman*

   1. Chair Allman shared the training will now be in February, March, and April 2019, due to difficulties to have the right instructors come to train. The course will be a 24-hour course, one training per month, for first responders, health providers and those concerned with mental health issues (parents, teachers, etc.) The cost of the training is $15,000 per month. The classes are certified and law enforcement may have some costs reimbursed. A synopsis of the classes will be presented to the committee in December.

   2. Member Miller shared that if you break down the costs of the training per person, it is about $200 per attendee.

   3. Member McGourty shared concerns about the true meaning and purpose of the initiative. The most important issue with Stepping Up being to create a coalition to work together regarding those with mental health illness and who may be incarcerated.

   4. Member Angelo stated that there needs to be a lead for Stepping Up, whether it is the Behavioral Health Department or another one.

   5. Chair Allman stated that the Board of Supervisors in 2015 made Health and Human Services Agency (HHSA) the lead.

   6. Member Miller shared that HHSA has begun a coalition meeting of county partners, while attendance has been sparse, she hopes it will pick up in the future. Another meeting is being planned for September. Working on outreach to attendees.

   b. Kemper's Needs Assessment Report Presentation and Roll Out Timeline; with Discussion and Possible Action. *Member Diamond*

   Mr. Kemper gave an overview of the report, then went through the report with those in attendance.

Mr. Kemper applauded the efforts of the county's voters for passing the tax to bolster mental health efforts in the county.

The report finds the two continuums of care systems in place as incomplete. One for mental health and one for Substance Use Disorders Treatment (SUDT). For substance abuse, there is a small set of services. It is not a continuum of care. A more comprehensive continuum would be the model of an organized delivery system that Medi-Cal is seeking to implement in counties. The report has recommendations for this area.

The mental health continuum is also incomplete. It is missing some key ingredients for residents of the county who need the care. Specifically, the lack of a Crisis Residential Treatment (CRT) facility, the lack of day programs, partial hospital programs and in particular a more robust set of wellness and support services that reach into the various areas of the county.

Much of the current adult services are focused on inpatient services out of the county. There is a lack of an in-county treatment facility and that is noted in the report, this is a key missing element.

The utilization data about mental health came from Redwood Quality Management Company (RQMC) and the dash board reports that they issue on a quarterly basis, specifically data was used from 2016/17 and 2017/18. The data was arrayed in a fashion to show year to year and distinctions of treatment overall. There is a growing level of crisis mental health assessments; this is placing an increasing burden on local delivery systems that are providing the service. Notably the hospital locations and the crisis access points that RQMC operates. The real impact is on the hospitals and this is an area of concern.

In the context of utilization, it is important to note, the level of increasing placements that is occurring in inpatient placements out of county. There is an increase of the average number of people who are in care from 2016-17, 11.7 people to 15.1 people presently. This is a substantial jump in one year, roughly a 29% increase.

Within that context we offer recommendations for how to use the Measure B revenues. In particular we believe the revenues need to be dedicated across the spectrum of services to build out a more comprehensive continuum of mental health care in the county. A goal needs to focus on reducing the need for and the utilization of inpatient psychiatric care whether it is in county or out of county; simultaneously work to have the capacity within the county. Using the increase of 15.1 people in crisis care, the report recommends a goal of reducing that number by 50% over a 5-year period so the number becomes 7.6 people.

With regard to the Substance Abuse Treatment continuum, the report recommends that 10% of the Measure B funds be used to expand the access to services in the county. There are so many steps to be taken in the SUDT area, work needs to get going right away. The county needs to decide on the services organized delivery system, there are many decisions to be made, however it is felt that this an appropriate use of the funds.

Mr. Kemper took the audience to Page 16, Table 3, Overall Mental Health Utilization. The table shows increases seen year after year, this is a difference over what you have seen in the past. It is a substantial change over what you have seen 2 years ago. This is because of the responsiveness of your current contractor intervening in these circumstances. The numbers are going up very fast and should cause concern about the need to balance the system and the strategies that need to be taken to resolve the matter.

Mr. Kemper took the audience to the recommendations at the end of the report, page 43, Key Policies that should be adopted by the county. They are framed as basic good government concepts.

1. Measure B funds should supplement existing sources of funding, these are new resources, new dollars and need to be kept as such. Mr. Kemper noted that sometimes clever maneuvering occurs, these need to be kept as new dollars in the system.

2. A biannual review process of Measure B spending and use of the revenue and expenditures. How are they improving the continuums of care should be measured and reported.

3. A Prudent Reserve needs to be established so that carry over of some of the reserves from the first 5 years into the second 5 years can occur when revenues will be less.

4. Separate Annual Accounting of all Measure B revenues, distinct from the County's Behavioral Health accounting should occur. See page 43, Key Policies, #4 for full details of accountability. Bottom line, Measure B revenues need to be in a separate fund, with a separate identity, so the taxpayers understand where the funds have gone and how they have been used.

5. 10-Year Strategic Financing Plan needs to be established. The report provides a sample is on page 45.

6. Restructure the manner in which data is provided to the Board of Supervisors and public on the populations served across the county so everyone has a better sense of how clients are being served.

Mr. Kemper went over the proposed budget (spending plan) on page 45. He used a ballpark number that is close to the projected incoming funding because it is easier to do the math. Dollar amounts were allocated out per different activities. He went over each activity.

The support services expansion is a way to make the current array of wellness and support services more robust and to expand them more aggressively across the county, such as mobile outreach, more hands on services to individual people and families "where they live". When a service delivery system expects people to come to services, there is a challenge for people when they are suffering certain kinds of mental health issues, substance abuse or health conditions. It is tough to get there. Being able to reach out and touch people where they live is an important component of giving services and the way we want to reach people.

The Full Service Partnership (FSP) expansion is for the folks at the highest level of need, the anything it takes population. There is a real opportunity to expand on this, especially the multiple system users and the multiple users of inpatient psychiatric care.

The Substance Abuse Disorder Treatment (SUDT) component at 10% to be allocated for the plan, we recommend that the Behavioral Health and Recovery Services (BHRS) Director and stakeholders prepare.

The supportive housing pool, is to be used to address the needs of the conserved and homeless mentally ill, as a way to invest dollars in local service delivery and not in out of county services.

There are a variety of things in this report, but this provides you with a base line against your efforts that can be prepared and you can look at the data provided in the report as a base for comparison. We gave you the context of what inpatient psychiatric hospitalization looks like across the Northern California region because these are the things that are contextual for today.

We looked across the system and various facets of the system. What was most compelling was talking with families and consumers about their needs. How they feel so isolated and left alone in their illness. The service system needs to reach this population, the clients and families, in a way that we are not currently doing. There is an incredible amount of opportunity here with these resources and the hope is that the report gives you a foundation to discuss the ideas and come up with what you believe is the best plan.

Member Diamond wrapped up the presentation by stating Mr. Kemper's report is very comprehensive and answered a lot of the questions that the committee and public have had. He acknowledged the high interest in the Ordinance by the public and asked that committee members and the public ask questions they might still have while Mr. Kemper is here.

Questions/Answers

Member Miller thanked Kemper Consultant's for a comprehensive report. She feels it lays a good framework for expanding services in our community. As we look at this and develop a plan, the question is regarding parity across insurance companies, do you have suggestions how we work with the companies for a model of advance services in our community across the insurance companies as we look at Measure B and look at services across our community.

Mr. Kemper asked, what discussions have you had with different health plans in the county, the private sector health plans not necessarily Partnership, as well as some of the third party players?

Member Miller stated they have worked with Beacon and Partnership Healthplan and the clinics. The clinics have come together to talk about our concerns. One of the next steps with the clinics is to come out as a group to talk about our concern as to where we see parity not meeting needs and a next step is to talk with private insurance and Partnership.

Mr. Kemper suggested a two track process. He sees the community clinics as a part of the public assistance side because they are predominately a Medi-Cal/Medi-Care driven population. He suggests to plan out the wellness and prevention components. Both mental health and substance abuse services, the need is to reach out to the private health plans and say "We have a unique opportunity to expand our systems to provide this array of services. We want to talk with you on how to partner the services, how we can deliver complimentary services to the things you are already doing and how to make services you are providing complimentary to what we will be doing." Look for a way to partner with them around the first experience of developing a relationship. If you can develop a relationship around the developing system you can also put on the table your concerns around how the third party system operates and how they interact with our system because services aren't available. There is a hard conversation and an easier one, under take both at the same time. Put the hard things on the table but at the same time you highlight the opportunities. Building trust together is an important ingredient. Parity is hard to quantify, because there is no uniform standard.

Member Angelo thanked Mr. Kemper for an excellent report. Two questions, page 46, Program Development Action Steps, you speak to the CEO doing a Request for Proposal (RFP) process to solicit proposals for a Psychiatric Health Facility (PHF); and in #4 an RFP process to solicit proposals from local hospitals. Will you speak to this; is it your intention we would solicit proposals for both a model where a hospital has four beds and compare that with a stand-alone, is that your intention?

Mr. Kemper replied that was the intention. It was concluded from a funding point of view in terms of the budget, the estimate of what it would cost

after speaking to leaders of a couple of private sector PHF Units in Northern California. There are two ways to expand those psychiatric services in the County, either with a PHF Unit, which would be up to 16 beds and qualify for Medi-Cal or having a wing or beds in a general acute care facility. These facilities differ in terms of structure. With a hospital they would be the owner and the provider of such services; with a PHF facility there are different ways for that to be owned and operated. What is the same is they both expand services to the community. There was interest from both Ukiah Valley Medical Center and Howard Hospital, so ok, then show me. The way to do that is to go through an RFP process. There are decisions that policy makers will have to make first. Where would the facility go? At least have a couple of options. Would they be retrofitting something or tearing something down and building up or building on vacant land? Those are important ingredients in the equation. Ultimately there are two avenues, the revenue for the Federal share of the funds come down through separate mechanisms at the State level but the non-Federal share of the Medi-Cal match always comes from the County and it is always from the Re-Alignment money.

Member Angelo asked, on page 25 Crisis Stabilization Units (CSU), you talk about Nevada County and Napa County, they both operate in the red. Is it possible to run one without being in the red? Without putting General Fund or Measure B funding into the unit?

Mr. Kemper stated in all counties that run a CSU, they have patched together a set of revenues. What has occurred with Nevada and Napa counties, the package of revenues has not been enough. We call attention to that fact because they are relatively new at this and comparable to Mendocino County. A CSU would be a sufficient value, an investment of Measure B funds, to cover the gap and makes sense. It is a good utilization of the new resources, and it creates a change in the dynamic of care that benefits many folks. Your administrator benefits because it centralizes activities and it is close enough to the Crisis Residential Treatment (CRT) facility which makes it a ready access into that venue of care. For law enforcement it is one place to go and you can hand off to a secure setting and it would save time. For people on the coast you would need to set something up in a complimentary way. For the hospitals it means folks are not taking up emergency room beds. We think it is a good investment. But, as you see in the recommendations the contractor will have to put together the process. What is the volume, what is the patient mix, what do the revenues look like, how do you put the final numbers together so you can have a basis to take the next step.

Member Angelo confirmed that for the County to develop a 24-hour PHF without shoring up the whole system of care could possibly lead to failure. It is doable and necessary for the mental health continuum of care but what you are saying is we need to shore up the whole system of care in order for a 24-hour PHF to be successful; along with services in the outlying areas (not just Ukiah centric). We don't have enough services. Do you see a way to break

the isolation factor for clients and families, do we have enough money in Measure B to do everything that is in this report?

Mr. Kemper stated that if you take the numbers in the report for CRT, $5 and $7.5 million, for the CRT and PHF facility and another $2 million for the CSU you are now roughly at $14 million. That is $14 million out of $37 million. What you are hearing is that is a really powerful and important investment. The recommendation is that you put more of the money into the building up of the continuum of care, because a service system that can only respond to crisis will only respond to crisis. Look at the ordering of how we recommend you spend the money; first year priority is the building out of the CRT and CSU facility, then the supportive services expansion, the FSP and supportive housing pool and SUDT, all on the services side. In year 2 and 3, flip from CRT to the PHF facility. You will need time to do the RFP and you aren't going to need all the money until the end of year 3 for final construction costs etc.

It is very important that we haven't told you specifics about the services, more work needs to be done to address how to reach the communities etc. The mobile units are powerful and important but contextually they are very tiny. We found that families need a personal touch for coaching and advice on how to handle their situations. That is a very personalized kind of system vs. people having to come to you. You have an opportunity to take a very good frame work and build upon it, particularly on the adult side.

Member Barash gave an overview of lifting the load from hospitals and law enforcement and the emphasis on the need for a PHF facility. CSU was a plan by RQMC prior to Measure B, but their funding did not come through. Now we have a shovel ready project; my impression is that this would do more to relieve the burden on the hospitals and law enforcement. The locked facility is important but the extent that we have to use such a facility indicates we have already failed. Does it make sense to start with that CSU project?

Mr. Kemper validated Member Barash's statement; that is why it is in the first year expenditure. Because you have already been raising funds through much of 2018, the funds are there and ready to use. We agree the most immediate impact on the need for inpatient psychiatric care would be the CRT center. A CSU is a way to organize and centralize the assessment process to relieve the other places that now handle the high level assessments.

Member Liberty asked if we want to do a single facility for $14 million, such as old Howard Hospital, I don't see a line item for this expenditure.

Mr. Kemper stated that they did not pivot off the estimate on the old Howard Hospital; our estimates were based upon discussions with leadership of two of the California providers delivering PHF services (TeleCare and Heritage Oaks) and their estimate to us on building a new

facility. Based upon the most current facilities they have been working on, the estimate was between $5-6 million dollars. Our estimate took the high end of that range and increased it by 25% of the contingency, that is how we got $7.5 million. The number for the old Howard Hospital renovation was from a separate contractor; in essence it gives you a sense of range. We don't know the cost if you removed the building and used the land vs. a renovation but it could be substantially less than the estimate of the retrofit. We did not try to independently investigate or verify the estimates given to us by the old Howard Hospital developers/contractors, we took them at their word based on talking to high level officials of the companies.

Member Liberty asked if the supporting documentation that supports the numbers is in the report.

Mr. Kemper responded that the information was through verbal interviews with the individuals, the point is you are not seeing where the money is. That money is showing up in the line item for the PHF facility as $7.5 million and if you increase the number, then you need to make a pro-rata distribution or reduction in other areas.

Member Liberty stated that he thought the committee had heard an estimate of $30 million to build a new facility.

Mr. Kemper agreed it was what he heard as well when he was with the committee in April. One of the facilities being built now in Sacramento is coming in at $16 million. It comes down to, what does it cost to build a facility to serve this singular purpose. It is a comparable cost with the new CRT facility being built on vacant land at $4.6 million as a new build. It is a co-located CRT and CSU, (CSU 4 beds, CRT 10 beds). If you are talking that the ground is vacant, then you are looking at $7.5 million. Retro-fit is around $300 a square foot but that estimate is volatile as it depends on conditions; such as, what is the site you are renovating, what are the mitigations you need to address? The fee process we have submitted is a way to test the market on that, in terms of the willingness of someone coming in to build it and the cost to do it.

Member Barash stated that the old Howard Hospital site is much bigger and has room for other services so it is hard to directly compare.

Mr. Kemper stated, that is an important point. The set of assumptions that went into the estimate to build out that building vs. a set of assumptions to build out a 16 bed PHF facility. If there is substantially more capacity for other things then it is not an apple to apple comparison. It is really two different things. As a part of your process the important things for you to know about the old Howard Hospital bid would be:

- What is involved in this particular bid?
- Where would the PHF facility aspect be?
- What are the add-on costs of building other things?
- Are they an essential component of the plan?

There are a variety of good questions to ask to sort through the bid to get good answers.

Member Mertle asked, if you had to prioritize based on funding and we had to make a choice between a CSU, a CRT facility or a PHF facility; with all your investigations, what choice would you make?

Mr. Kemper shared that we have a revenue source coming in for 5 years. The first year gives you $7.5 million. The report tells you by the way we have arranged the dollars in the chart (page 45) that the priorities are the CRT Facility with the CSU. Those are the most powerful and impactful things in the system right now. The PHF is an important ingredient because you still will be placing people in this type of care and it would be better to have one in your county that you can easily access because you have more control of it by the contractor or ownership by the county and it is easier for transport and keeps the services in your county. That's why we put those two pieces together in year one and two and three. In the shoring up, as we state a number of different ways, if you only do crisis then you will only do crisis. You have to build out those front end components so that is why we recommend dedicating those resources. There is a lot of work to be done on what the services should be; we didn't try to be prescriptive with those, other than you need to reach people where they are.

Member Mertle stated that the cost to operate a PHF Unit was between $3-4 million, we don't have the funding to operate one of these facilities. What he is understanding is that maybe we can build one, but we need a contractor to run it.

Mr. Kemper asked the committee to remember that the way you fund an operating facility is the same way you are funding the out of county services now. Those funds that are going out of county would be held here and would be allocated to that PHF facility. This won't be the only facility used by RQMC because a client may need something out of county. The resources from Realignment, General Fund, and the Mental Health Services Act (MHSA) with Federal match would stay here. Similarly on the CRT side, they are using the same kind of dollars, pulling down Federal Medi-Cal match to run the CRT. The dollars used there are dollars that would be used otherwise to send people to a PHF, but the cost is coming in at half of that to run a CRT than what it would cost to put that person in a PHF. They are making savings on those dollars that allow them to reinvest in the CRT or shore up other aspects.

Member Mertle, as a contractor, in reference to the Heritage Hospital and Restpadd, were those estimates based on private companies or public entities.

Mr. Kemper answered they were private companies building them, he did not know the answer if it was under a formal contract with the county.

They end up serving the county but he did not know the answer, he will follow up for the information.

Member Mertle stated based on the numbers in the report he believes it would have to be privately funded. Working in the government sector there are rules around prevailing wages and mandated wages for certain counties. They increase the cost by 2 to 2.5 times over a private entity. If we make a capital investment with Measure B funds we would be paying those wages. As we look at the numbers they are skewed, it will be more than $7.5 million to build. Getting back to Helmer & Sons (contractor who gave estimate on the old Howard Hospital site), they are public work contractors and they have a good handle on the cost to remodel the old Howard Hospital and put it into a square foot number and apply it to the square footage needed for a PHF unit that would be a closer representation but still undervalued because of the size of the building.

Mr. Kemper returned to the prioritizing, if you start with the CRT, and say it costs $12 million vs. $7.5 million, then you would need to come up with the difference and prorate the dollar distribution in years 2 and 3. It doesn't mean you can't do all those things, you have to prorate all the other investments. It should still be your top priority, CRT, CSU, followed by the PHF with concurrent investment in those other areas. The year one dollar amounts will be collected by the end of this year. From a budgeting point of view they will not be budgeted for expenditure until July 1, 2019. You have an extra 6 months of revenue growth. It makes it more maneuverable on how you can move it from one year to another and how to make the investments you want. These dollar amounts are arranged by year so you can think about what kind of investments you want to make. It is not uncommon, particularly in the first year of a program, to have to ramp up to that level of expenditure. You might say our annualized number that we want to hit is $1 million, but in year one we only got ½ way, in year two we got there ¾ of the way and by year three we made it. You just saved your revenues in the first two years and you can move forward into the subsequent years or dedicate them to something else. There are lots of ways to work with the numbers. Do not be daunted that the numbers are higher than the estimates we have laid out. You have running room within the revenue collection.

Member Mertle, if we were to staff a PHF Unit, what proportion of funds would be held locally vs. brought into our services. How much money would we be bringing in vs. paying? The way it looks we have $3 million going out, but the report says we do not have $3 million going out because we will be able to supplement those services by not sending people out of county. What proportion of the budget percentage wise is that?

Mr. Kemper felt he was not in a position to give a hard estimate. He directed all to page 49, PHF hospital dollar amounts listed. Half the revenue is from the County and the other half is from Federal Medi-Cal match. If I send someone to St. Helena Hospital, I'm sending my .50 cents

to St. Helena and the Federal match of .50 cents goes to St. Helena. But if I send someone to a local PHF, my .50 cents goes to the local PHF along with the Federal match. It's a question of where you want to make the allocation.

Member Mertle, looking at the numbers, we will have $2 million coming in when it goes to 1/8 cent sales tax and with this the PHF unit will take $2 million.

Mr. Kemper reminded all that the Measure B funds are on top of the existing mental health system money. By changing the service delivery framework here with the Measure B money you are changing the utilization of money in the base dollars, the existing resources. So those dollars get spent differently. You are not creating a new obligation to yourself out of Measure B money that you can't fund 6 years from now, you are repurposing the way you use the existing resources and moving them into things other than in patient psych services.

Member Mertle stated he is not seeing that. He doesn't want to strap the county with a deficit as you have seen in two other counties with their PHF.

Mr. Kemper pointed out that situation was with a CSU, not a PHF. The concern is right on. You want to be sustainable. These Measure B resources are to supplement not supplant the dollars that are already going to the system. They are additive to, they can change where the base dollars go. The goal is to get more out of the base dollars while you use the Measure B dollars in a strategic way.

Member Diamond, thinking that the CRT/CSU facility is being built at 631 S. Orchard St. in Ukiah, is there a value to having a PHF unit close to the proposed CRT/CSU facility?

Mr. Kemper clarified "close". An hour in bad weather would be hard for someone in crisis, 20-30 minutes would be easier. A CRT/CSU would give you the opportunity to stabilize a person and then transfer them vs. trying to put them somewhere as quick as possible like an emergency room setting might lead you to do.

Member Diamond asked regarding a psych residential facility, options suggested were adding beds to an existing hospital (Ukiah or Willits) or Howard Hospital, were there any other physical facilities that you came across in your study that might work?

Mr. Kemper stated that for the record he did not vet any site. He is not in a position to recommend a location. He has heard of some County owned locations suggested that may be alternatives to the old Howard Hospital, but those are things said in passing.

Member Diamond asked if this is the reason for an RFP that would find out who would want to do something where, correct?

Mr. Kemper shared that the key is to figure out the “where” first. Where is your location before you ask someone to give a bid. There is a deliberative process to do this. But it has to come first.

Member Riley asked, on page five the report talks about Measure B funds going to a supportive housing pool but then it isn’t seen mentioned elsewhere. Can you describe what that is for us?

Mr. Kemper expressed that is correct, it was touched on and then deferred back to BHRS for consideration in the housing authorative recommendations. On page 21, the Lanterman-Petris-Short Act (LPS) Conservatorships, these are people who cannot care for themselves and the government takes care of them. As the section describes, there are a relative small amount of people in this category, approximately 60-70 in Mendocino County. But they cost $2.5 million a year and on the adult side, most are adults, those costs are in addition to all of the other costs you are already seeing in the mental health system. The $2.5 million is a continuing cost for this category. They don’t all stay for a full year, some return home, some expire, but others come in behind them and you have approximately 60 at any given time. Roughly 2/3 of those people are placed in inpatient settings out of the county because we do not have those services in county. Our expectation was that some of the funds could be used for a supportive housing pool to address the needs of this type of population and BHRS, the Public Guardian (PG) and stakeholders would need to sort through the best approaches for this; but develop some of the service delivery capacity that doesn’t exist so those people can stay in the county. Additionally, there is a growing need around the homeless mentally ill. You have some around the county but there is a growing need for some kind of short term location of service and residential care or some type of shelter housing, etc. Some of the resources could be dedicated to this. Again it would need to be sorted out by BHRS, the Public Guardian and the Housing Authority.

Member Riley, do you have an analysis of the staffing? Do you have any sense whether staffing the recommendations in this report is feasible, sustainable for this county. We have difficulty obtaining and maintaining qualified staff. Do you have any insight?

Mr. Kemper asked for clarification, county government staffing, staffing within the hospital system? What venue are you focused on?

Member Riley, we are talking about the addition of services, the PHF for example. Since we are shipping people out of county we would be creating new positions here. What is our ability to recruit and sustain those types of jobs within our county?

Mr. Kemper directed all to page 36. There are two important elements of the framework of a psych facility. First you have to build it. You have to have a qualified contractor, qualified expertise to oversee it and manage it to make sure you come in on budget and on time. That is a suite of skills you will need to have. If you will run the PHF facility you will need to staff it as outlined on page 36. You will need:

- A clinical director
- On call psychiatrist 24/7
- 17 total staff over a 24-hour period that includes 2 licensed mental health professionals, 5 nursing staff and 5 mental health workers
- Licensed Clinical Social Worker (LCSW) to oversee social services
- Registered Nurse (RN) 40 hours per week
- RN, a licensed vocational nurse, or a psychiatric technician awake and on duty in the facility at all times

This is where it gets hard, you as the employer have to make sure you have these staff employed. If a contractor runs it, then they have to handle this part. This becomes a part of your equation, do we owner operate or do we contract out? It is one thing to know and have experience vs. a county starting out after not doing it for 10 years.

Member Moschetti thanked Mr. Kemper for taking seriously the clients and the family members and bringing to the forefront the isolation and loneliness that is felt at one time or another. Names from all around the County, Covelo, Gualala, Willits, Ukiah were shared with Mr. Kemper to contact.

Member McGourty asked if Mr. Kemper had any thoughts about a regional PHF facility, such as the Sutter-Yuba facility. Would it be beneficial for Mendocino County to partner with Lake County?

Mr. Kemper shared that an individual county goes forward with a contract and then brings other counties on board after the fact. It would be a good model for this county. Example, you start with a 16 bed facility even though you only need 14 beds, you contract out with another county for the 2 vacant beds. Your long term goal is to get your number down, so say you get down to only needing 8 beds; now you can contract out the other 8 beds. The reason we shared the chart on acute care psychiatric hospital bed distribution for Northern California (page 33) with you was to show the need in Northern California and what a robust market it would be to fill those additional beds. Our assessment is you start with what you need and as you create a strategy to reduce over time and free up that capacity, have contracts with other counties in your region to fill those beds

according to your terms and conditions. It is like running an airline; you want as many seats filled as possible before you take off. These facility operators want as many people in the beds as possible because each individual is a revenue stream to support the facility. The objective is to provide good care but you still need a business strategy to be successful.

Member McGourty, regarding the supportive housing issues, do you have any examples of any supportive housing projects that are viable within the diminishing availability of such projects in the State?

Mr. Kemper shared that the term “supportive housing” is a broad term, and by design. It could be a small set of aparments where people with certain types of mental illness reside and they have a staff person check on them for their needs. Another type would be vouchers to get them into a short term residential setting where they can stabilize their mental illness or substance abuse issue and get supportive services while they stabilize so they can make decisions on their next steps. Another type could be actual capital construction of units for people who need certain types of mental health or SUDT services. There are a lot of different approaches. These types of supports were noted because there is more to be done here in this county. We gave it a category but deferred it back to BHRS for further discussion. There may be some resources available describing other supportive housing options, you would need to research that.

Chair Allman stated we were looking for a good snapshot of where we are now and the report certainly gives that. On page 45, the budget, the financing plan, can it be assumed that the regional training center was accidentally left out of this? It is approximately 10% of the funds.

Mr. Kemper apologized for overlooking this point. He will re-do the numbers and supply a new chart. In years 6-10 there would be a little less to distribute.

Chair Allman stated that approximately 30% of our citizens live on the coast and according to the chart on page 17, table 4, 25% of all 5150’s originate on the coast. It is fair to say that the coast is far from Ukiah, 1 ½ hours. I didn’t see any new or approved services on the coast, what is your thought?

Mr. Kemper shared that the report, in a global sense, talks about the importance of reaching out across the county which includes the coast. Have we called out specific services, no, but have we talked about wellness and related service expansion and everything it takes, strategy for severely mentally ill (SMI) people and substance abuse services and housing supports. All of those we see as being distributed across the county so they reach where people are. We could not come up with a strategy for a CSU on the coast. You would have to dedicate money to that and not somewhere else. We think there are better strategies to essentially make what is on the coast for 5150 assessments complimentary to the CSU located in Ukiah.

Chair Allman, the coast with all of the beautiful scenery that exists there, would that make sense for a recovery center?

Mr. Kemper asked where do you want to start? I would start with a shovel ready project in Ukiah and incorporate the CSU, build a complimentary structure on the CSU to the Mendocino Coast District Hospital and the crisis center there with RQMC and see how the experience goes with the current CRT in how it alleviates the need for inpatient psych care. Then based upon availability of revenues and the relative determination made at that time, does this make sense on the coast or does something else make sense. Concurrently we are expecting the other kinds of support services to be expanding in the county and on the coast. I would start with what you have and grow into it.

Chair Allman, when you opened today you talked about the mobilization of services and credited the mobile services being offered as being one of the more cost effective ways of treatment that we have in our county. Is it fair to say that if we increase the number of mobile services that we have in our county we would continue to see a decrease of the need of emergency services as well as crisis residential?

Mr. Kemper stated he doesn't remember saying it exactly as stated. What he said was, it is important and relatively small in comparison to everything else. He added that touching the people individually and the way that the mobile team (both outreach and prevention services) is an important ingredient. More of that could help remediate conditions for people suffering mental illness. If we could expand their ability with those services to reach out to people with hours that are not regular business hours; such as in the evenings and the mornings or at times when people find themselves most isolated. A structure that does that, a mobile outreach, could be a component of that. At one time in the recommendations a specific dollar amount for mobile outreach was set aside, but it was felt that was too specific. So we rolled it into the wellness and expansion piece and called it out as something important. We think it is an important ingredient because of its ability to reach people one on one.

Chair Allman, asked about, table 11 on page 23; conservatorship costs are $37,000 per citizen (Mendocino County had 61 people last year) to house them outside of the county (or inside the county); is this the standard throughout the State? Is that a normal cost and is that a normal percentage of people in other counties our size?

Mr. Kemper cannot say that it is the same in other counties, every county has the same responsibility and every county struggles with it. These are very difficult situations, often individuals need a very high level of placement. The number of places in the State who have those types of placements are few and there is great competition for those placements.

Counties all have the obligation and it is also a court ordered process. All counties are under obligation to solve that problem and pay for it. It is complicated. It is included in the report to serve as a reminder to the committee and the Board of Supervisors about this important county responsibility, these individual people and the amount of intervention and costs associated with it. It is not an offshoot item on the side, it is a part of the totality of the mental health delivery system for a specific segment of the population.

Chair Allman asked for public comment on this topic; and asked speakers to share if they read the report and if so, how many times.

James Marmon reminded all that there is a law that requires least restrictive care. In his past jobs working with conservatees it was his job to get people out of locked facilities (not necessarily keep them there). He was always looking for step down facilities, there are at least five different levels, and those are the things we are missing in this county. This is a very complex business and we need to look at all the levels of care. Day care is very important. Reaching out to the people is important. If you bring the body the mind will follow. We need to follow Mr. Kemper's report. If we just do crisis that is all we will do.

Dr. Mills Mattheson, Baechtel Creek Medical Clinic in Willits. He read the report several times. He agrees with the report regarding the first priorities laid out as the CRT and CSU in Ukiah as receiving the first funding. Fort Bragg would greatly benefit from a CSU. This would decrease costs at the Coast Hospital emergency room who needs all the help they can get. He is concerned with the financial liability of a PHF. The last PHF in the county was unfunded. The report does not propose any annual funding for the PHF, it will need Measure B money to keep it running. In June 2018, Tri-County Healthcare District in San Diego closed down its 18 bed PHF because of a $5 million annual deficit. We know about deficits here, like Juvenile Hall. There is tremendous financial risk of a PHF, we should partner with Lake County to share the financial risk. There has been a steady increase in 5150's, we had 107 in 2011, 417 in 2015 and now 645. There is no careful analysis as to why this is happening. Is it a failure of our psychiatric outpatient facilities, are more mentally ill people moving to the county or are we seeing the long term effects of the mass use of speed which creates chronic and acute psychosis?

Eric Cameroff of Willits, read most of the report. There is a breakdown of persons served by region primarily by a PHF for those brought in by law enforcement. 55% in Ukiah and 13% in Willits. What percent of these people are homeless, that may have been picked up in Ukiah but they do not live in Ukiah. Humboldt County's PHF has a 40% homeless rate of people brought in by law enforcement. Do we have a number for our county? (answer: we do not have a number for our county) In light of the fact that 55% of people are from Ukiah, two critical things mentioned by the report, that a PHF be accessed easily and keeping all the services in

the community. There are a tremendous amount of services in Ukiah and few if any in Willits, I would think locating a PHF closer to all the services and to the ability for a community to respond in an emergency situation; Willits has a volunteer fire department who answers over 600 calls a year and struggles to keep up with that and has a small police force and the City is struggling financially. Maybe the consideration is that Willits may not be the best choice to have a PHF.

John Fremont, Fort Bragg, he remembers many years ago when the Talmage State Hospital closed. The argument at the time was that we need to bring people back into the community and treat them where they live rather than ship them somewhere else. It turns out that thought was not true. The problem is we do not have enough employees, jobs that go unfilled, and one of the reasons is the cost of housing. Maybe we could provide housing for a nurse in a housing setting for the mentally ill. The nurse could get housing for next to free while keeping an eye on the occupants of the housing units. This is something that should be considered.

Sherrie Stambaugh, did not read the entire report. The comment about the stats on people who get picked up in Ukiah; I believe the homelessness report by Dr. Marbut for the City of Ukiah stated that all people who get picked up are not all from here. They are from out of town. Even though the stats are true, there is info missing that needs to be looked at.

Arnie Mello, read portions of the report. In the Helmer & Son's report on the old Howard Hospital site, it said it was a 32 bed facility. 16 beds were for a PHF, 16 beds were for mental health rehabilitation. Does the Kemper Report recommend rehabilitation services for the county?

Mr. Kemper stated that the Helmer & Son's report was not considered in the Kemper report. It is one of the areas identified as a gap. Helmer & Son's report was a cost estimate for a combined facility. What would be prudent would be to differentiate between those two items so you can have an apples-to-apples comparison. Contextually, in the finance scheme, we put rehabilitation into the category of services in the other kinds of wellness and supports and deferred it back to the county on the relative need for that service. It is another type of step down service as an alternative to PHF or CRT. If you could provide that to this committee and delineate what it would look like if the PHF was done on its own and what it would look like if the rehab was done on its own and the combined package that would be a very informative report for the committee.

Committee Member Discussion continued:

Member Barash; we have received affirmation through the report of the importance of a CRT project and there is a sense of general agreement, I wonder where we are at as far as how we will move forward.

Chair Allman stated he will report to the Board of Supervisors (BOS) on September 11 on the monthly Measure B Committee meeting and that will include the Kemper Report. The time is now to strike hard and move forward.

Member Barash offered a motion to “recommend moving forward on the RQMC shovel ready project for a CRT, Crisis Access and possible Crisis Stabilization Unit”.

Chair Allman stated that a motion cannot be made for an item not on the agenda. We can put it on the next agenda for discussion and possible action.

Member Riley asked for clarification on the Chair’s statement of “move forward”, what exactly does that mean?

Chair Allman stated that “move forward” means that the BOS move forward on reviewing the Kemper report. We have only asked the BOS to do two things thus far; approve the reimbursement of the ordinance ballot costs and approve the cost of the Kemper contract. We are not asking the BOS to do anything at this point, they have been asked to review the Kemper Report and make notes/comments. At this point this committee has not asked the BOS to make any hard decisions on the Kemper Report. That most likely will be before them in September.

Motion by Member Riley moves that the Committee accepts the amended Kemper Report and move to the BOS for review and comment. Seconded by Member McGourty.

Committee discussion on motion:

Member Diamond asked clarification for Chair’s statement about asking the Board in September for what?

Chair, a review of the Kemper Report will be on the committee’s agenda. Please read the report and come with recommendations. A review of the Kemper Report will also be on the Committee’s agenda in September and bring recommendations.

Member Riley clarified her motion. We are accepting the report agreeing with the contents but we are not making any recommendations.

Member Angelo clarified the motion is to accept the report only, we are not making any recommendations.

Member Riley reiterated that we accepted the report only and we are not advocating for any specific suggestions within the report.

Member Liberty asked about accepting the report as fact because he has questions around the budget figures, so we will accept but not necessarily agree.

Member Riley responded that she agrees. Accepting the report is separate from the RFP process, those processes will flush out some of the actual numbers and answer questions we have. We are accepting the research that was done and the general principles outlaid. Each recommendation is a separate and public and transparent action by the committee.

Motion by Member Riley: The Committee accepts the amended Kemper Report and moves the Report to the Board of Supervisors for review and comment. Seconded by Member McGourty.

Vote was called for by Chair Allman:

Yay	10	Committee unanimously passed the motion.
No	0	
Absent	1	Member Weer

c. Monthly Committee Update to the Board of Supervisors at their First Meeting Each Month, Who will Present and What will be Shared; with Discussion and Possible Action. *Chair Allman*

As discussed earlier, the Chair will give the committee update to the Board of Supervisors on September 11, 2018. The update will include items discussed in today's meeting and the committee's acceptance of the Kemper Report.

d. Committee Member Reports. *Each committee member will have the opportunity to report out on any actions they have performed since the previous meeting.*

Member Miller:
Read the Kemper Report a couple of times and also survived two audits with the State.

Member McGourty:
Attended an Oversight and Accountability Commission meeting, they oversee the Mental Health Services Act funds. She also introduced the NAMI Library that has books to lend that will help you understand the world of mental health.

Member Angelo:
Nothing to report.

Member Barash:
Nothing to report.

Member Liberty:
Nothing to report.

Member Mertle:
Nothing to report but requests that committee members read the Kemper Report thoroughly and come to the next meeting with an agenda of what you think what we

should do first so things can move forward. We need to prioritize what should happen first and put money to that and then move to the next.

Member Diamond:
Agreed with reading the report. Continues to meet with people in his district, Willits City Council (next meeting is September 12) and is open to talk to anyone. Hopes we can come up with some good recommendations that will advance mental health services in our communities.

Member Riley:
Wants to reiterate that the term of “moving this forward, quickly” doesn’t get confused with we have already chosen a location. We have a long way to go. Wants to make sure the public isn’t confused.

Chair Allman:
Nothing to report.

Member Moschetti:
Family to Family classes are starting September 18. It is a NAMI class. Flyers are available to take to your communities. It is an 11 week class. It is for family members only and teaches everything you need to know for right now. It is on the Mendocino County NAMI website for more info. https://namica.org/directory/nami-mendocino-county/

e. Adjournment
Meeting adjourned at 3:02 p.m.

Next meeting is September 26, 2018