MENTAL HEALTH COMMISSION
QUALITY OF CARE COMMITTEE MEETING MINUTES
February 23rd, 2023 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Quality of Care Committee Chair, Cmsr. Barbara Serwin, called the meeting to order @3:38 pm. Members Present: Chair - Cmsr. Barbara Serwin, District II Cmsr. Laura Griffin, District V Cmsr. Joe Metro, District V Cmsr. Rhiannon Shires, District II (left 4:40pm) Cmsr. Gina Swirsding, District I Other Attendees: Cmsr. Douglas Dunn, District III Cmsr. Tavane Payne, District III Cmsr. Pamela Perls, District II Angela Beck Gerold Leonicker Jen Quallick, Supv Andersen's ofc.	Meeting was held via Zoom platform
II. PUBLIC COMMENTS: None.	
III. COMMISSIONERS COMMENTS: • (Cmsr. Griffin) Just wanted to alert everyone on this call to be considering their availability for March 1st in person commission meeting which will be held at 1340 Arnold Drive, Suite 126, Martinez, CA 94553. We have to have seven (7) commissioners in person (at the same location) in order to make quorum. I will be sending out more instructions later today / tomorrow morning on what it means to be absent, how many are allowed, 'Just Cause' (only allowed twice a year for childcare problems, etc.), 'Emergency' which is up to 3 months to be allowed to work remotely. That has to be approved by the commission. These are some really strict rules. These are rules set by the Brown Act and the new teleconferencing rules that were lifted by Governor Newsom. (Cmsr. Serwin) Those are in contradiction with our bylaws. (Cmsr. Griffin) Yes, but we have to abide by the laws. (Jen Quallick) Per your Executive Meeting, Commissioners, I did exchange an email with county counsel Tom Geiger, to find out about the satellite offices and I'm still waiting on that response. Once I have that, I will forward it out. (Cmsr. Griffin) We did get a response from Supv. Gioia that they are not capable of hosting or allowing us to use their offices for committee meetings, Commission yes, committee no. That changes our plan. They can't commit to all the committee meetings during the month, only the main MHC meeting. • (Cmsr. Griffin) the other mention would be that this committee to consider my recommendation that the Site Visit Program, as well as the K-12 project as an 'ad hoc' meetings. The reason is that we could get more done through the ad hoc. Also, if I'm reading the rules correctly, ad hoc committees don't have to abide by these new teleconferencing rules. Per the mandate: "Ad hoc (also called 'work groups') consisting of less than quorum of the covered	

board or it's standing committee with a short term time limited purposes are not covered under these new teleconferencing rules.	
IV. CHAIR COMMENTS – None	
V. APPROVE minutes from the January 19th, 2023 Quality-of-Care Committee Meeting. Cmsr. L. Griffin moved to approve the minutes. Seconded by Cmsr. G. Swirsding. • Vote: 3-0-0 Ayes: B. Serwin (Chair), L. Griffin and G. Swirsding. Abstain: none	**Agendas and minutes can be found at:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VI. DISCUSS Contra Costa school districts and schools most in need of additional behavioral health services and resources, Gerold Loenicker, LMFT, Program Chief, Child & Adolescent Services, Contra Costa Behavioral Health Let's start with bringing your questions into the larger context of the child and youth behavioral health initiative (CYBHI). Some of the statewide initiatives that are currently in planning. Five-year initiative to reimagine and transform how California supports children, youth, and families. There is a lot of money attached to it ($4.7bil in funding). It is not limited to Behavioral Health. It is managed by California Health and Human Services Agency (CalHHS) and spanning several of its departments: ➢ Department of Health Care Services (DHCS) ➢ Dept of Health Care Access and Information ➢ Dept of Managed Health Care (DMHC) ➢ California Department of Public Health (CDPH) ➢ Office of the Cal Surgeon General (Ca-OSG) The goal of the CYBHI is to reimagine they way behavioral health support is provided to all children and youth in California, by bringing together support systems to create an ecosystem that fosters social and emotional well-being and addresses the behavioral health challenges facing children and youth. The initiative will take a whole system approach by creating cross-system partnerships involving stakeholders from the various systems that support children and youth behavioral health to ensure that the reimagined ecosystem is children and youth centered and equity focused. This initiative was started last year and it runs over several years and how the funds are currently being planned and distributed. It initially breaks down into four (4) Key Strategic Areas and these further break down into twenty (20) workstreams that fall under each key area including: ➢ Workforce Training and Capacity ➢ Wellness Coach Workforce (HCAI) ➢ Trauma-Informed Training for Educators (CA-OSG) ➢ Broad Behavioral Health Workforce Capacity (HCAI) ➢ Early Talents (HCAI) ➢ *Behavioral Health Virtual Services Platform and Next Generation Digital Supports (DHCS)* ➢ *Healthcare Provider Training and e-Consult (DHCS)* ➢ *Scaling Evidence-Based and Community-Defined Practices (DHCS)* ➢ *CalHOPE Student Services (DHCS)* ➢ *Mindfulness, Resilience and Well-being Grants (DHCS)* ➢ *Youth Peer-to-Peer Support Program (DHCS)*	Powerpoint presentation screenshared by presenter and emailed to all participants after the meeting.

- Behavioral Health Ecosystem Infrastructure
  - School-Linked Partnership and Capacity Grants (DHCS)
  - Student Behavioral Health Incentive Program (DHCS)
  - Behavioral Health Continuum Infrastructure Program (DHCS)
  - Youth Suicide Reporting and Crisis Response (CDPH)
  - *Behavioral Health Virtual Services Platform and Next Generation Digital Supports (DHCS)*
  - *Healthcare Provider Training and e-Consult (DHCS)*
  - *Scaling Evidence-Based and Community-Defined Practices (DHCS)*
  - *CalHOPE Student Services (DHCS)*
  - *Mindfulness, Resilience and Well-being Grants (DHCS)*
  - *Youth Peer-to-Peer Support Program (DHCS)*
- Coverage Architecture
  - Enhanced Medi-Cal Benefits – Dyadic Services (DHCS)
  - Statewide All-Payer Fee Schedule for School-Linked Behavioral Health Services (DHCS/DMHC)
- Public Awareness
  - Public Education and Change Campaigns (CDPH)
  - ACEs and Toxic Stress Awareness Campaign (CA-OSG)
  - Targeted Youth Suicide Prevention Grants and Outreach Campaign (CDPH)
  - Parent Support Video Series (DHCS)

Building out an ecosystem, because there are new initiatives coming having to do with these workstreams:

- School-Linked Partnership and Capacity Grants
- Student Behavioral Health Incentive Program(SBHIP)
- Statewide All-Payer Fee Schedule for School-Linked Behavioral Health Services

These three will all come into play and transform the school-based behavioral health environment. The school-linked partnership and capacity grants is money that fill go to school districts or local education agencies to build their capacity to partner with health systems. Health Systems and Educational Systems are very different, they have different mandates. Schools have the mandate of educating students and not necessarily in the business of or trained to be health providers, or how to deal with health providers both in the public and private sector. The school-linked capacity grants help build the capacity in how to interact with health systems, how to build billing systems to cover health services provided on school grounds. SBHIP is already on the way and funnels funds through Contra Costa Health Plan (CCHP), not through Behavioral Health Services (BHS) to create partnerships between CCHP, BHS, Office of Education (OE) and the school districts that need more support.

The planning for how these funds are going to be distributed is under the leadership of the health plan. An analysis of where mental health services are needed to be built out. Four districts were identified by the workgroup consisting of CCHP, OE, BHS and representatives of the districts. The data analysis included California Health Kids surveys by the state and included data from which districts had the high percentage of free and reduced lunch. Based on this data, the four districts identified as needing more mental health support were: West Contra Costa Unified School District (WCCUSD), John Swett (JSUSD), Pittsburg (PUSD) and Antioch (AUSD). When I show the data, you will understand why. Together, they represent over 60% of the student body in Contra Costa County.

The districts, if approved for the funding, identified what they would do. Antioch would build out a contract with a provider and win this together to add more clinicians for their elementary school sites. They would fund a district-wide crisis counselor position. John Swett would use the funding to build and equip a new wellness center, as well as fund a wellness center staff positions to coordinate linkage services. Pittsburg would fund (2) Mental Health Clinicians to provide a level 2 tier types of interventions, such as group therapy that focus on anxiety, building social skills and connecting. In WCCUSD would fund behavioral health intervention specialists in middle schools and restorative practice facilitators. That is happening in CCC under SBHIP. It doesn't necessarily fall under behavioral health, but BHS participated in the planning process and providing information.

Coverage Architecture: Statewide All-Payer Fee Schedule for School-Linked Behavioral Health Services is a workstream putting forth an idea that will eventually become a plan (still in the formative stage). The state is thinking about creating a fee schedule for school-linked behavioral health services, which means the local educational agencies, school districts, and schools could either hire or contract mental health providers. Those providers could bill under the fee schedule to whoever the insurance is for each particular child. They would bill, either MediCAL or private insurance for those mental health services identified. The benefits will be defined, and will be a certain number of patients that will be available under the benefit and the therapists could bill any insurance. It sometimes appears that children who have MediCAL have easier access to mental health services than private insurance. This idea should bring school-based mental health services to areas where specialty mental health or MediCAL-based mental health is not available. It will create a broad blanket coverage of mental health services to schools on a wide scale basis. It is a big idea. It is definitely going to put a lot of onus on the districts to find providers, contract with providers and, obviously BHS and CCHP would be quite involved in helping create a system that works.

The free and reduced lunch is an indicator where the 'hot spots' are in terms of poverty, food insecurity and it is often linked to other social determinants of health and an indicator of where the needs are for things like behavioral health intervention also. ***(Screenshare new document of a chart showing the data for all districts, have not received this from presenter as of publishing date)***. Column three shows the free and reduced price meals the number of students on that plan and the percentage is out of the entire population and that is what interests us as well as the total. Example, Acalanes High's percentage is very low and then Antioch is 65%. The CCOE is it's own district but it is county-wide (they serve the needs of those high needs families) and it's at 50%. John Swett is at 64%, a high percentage. Mt. Diablo USD is at 46%, Pittsburg USD is a high percentage and high number. You can see that SVE is a very small district and their percentage is high (61%) but the number is very low because there is really only one high school. WCCUSD with 47% also a high percentage and these numbers can be an indicator for food insecurity, social-economic struggles and probably linked to other factors that have to do with social determinants of health and could be linked to higher incidents of behavioral health problems.

This is in alignment with the SBHIP program came up with. They identified WCCUSD, John Swett, Pittsburg and Antioch as the districts where these funds would go.

Comments and Questions:

- (Cmsr. Serwin) Thank you, Gerold. My take is that this project just did what the is committee was setting out to do, in terms of identification. I was spending some time looking at how we would zoom in on these groups and was looking at the database with percentages of English learners, free/reduced lunch, the amount spent specifically on psychological services per student, behavioral factors (suspensions and dropouts) and it would be interesting to see the data aside from the free lunch. I feel that this has been done already and wonder if you know if the report itself is available? (RESPONSE: Gerold Leonicker) Yes, I would need to ask the SBHIP folks as it is no under my direct jurisdiction. I'd be happy to ask if I can share the report.
- (Cmsr. Serwin) That would be great. One of the goals of the group, in addition to performing the analysis was to bring it to the public eye and to advocate for funding for schools. The funding piece is there.
- (Gerold Leonicker) it is time limited but the SBHIP is a precursor to the larger change that will come with the fee schedule. When that is implemented, it will really provide additional mental health services on a much larger scale.
- (Cmsr. Serwin) So the grant is the $4.7B paying for those 20 workstreams and one is the SBHIP to get it up and running (INT Gerold Leonicker) That's right and then the larger initiative to use the fee schedule. It is a very big initiative that will take some time to plan out and implement but the state is determined to make this happen.
- (Cmsr. Griffin) How is BHS and your department collaborating with WISP and the CCOE? They will be our guest next week, but I was just wondering how you all collaborate and work together. (RESPONSE: Gerold Leonicker) WISP is a product of BHS and the CCOE working together. Together, we applied for the grant and made WISP happen. We meet with WISP to oversee what they are doing and the program really tries to cover both worlds. We have a very close relationship.
- (Cmsr. Perls) The duration of this funding program? When you talk about the school districts, you are looking at the needs but are there any programs in those schools? (RESPONSE: Gerold Leonicker) I believe it's over five years. I can only speak for specialty mental health and there are contracts in place with several providers for school-based mental health, mainly in those districts I mentioned: WCCUSD, PUSD, AUSD, MDUSD, etc. Those contract providers have therapists stationed in schools and the schools are identified by the districts where the hot spots are and there are 'care coordination teams' at the school-level to identify the students who need more support and refer to those school-based programs. There is a good network of providers. The WISP grant program, we were able to expand what we do and able to include two more schools in Antioch to have a therapist on-site.
- (Cmsr. Perls) So there is not a therapist on site in every school. Is there a way to identify the ones that do have? Versus the full range of schools? (RESPONSE: Gerold Loenicker) It is the district that identifies where the 'hot spots' are. There is only a limited amount of funding available. We don't have the funding to cover every school in the county.
- (Cmsr. Perls) You mentioned at the beginning: WCCUSD and John Swett, this time you mentioned MDUSD. (Gerold Leonicker) I mentioned where specialty mental health has a presence now. SBHIP and CCHP is a different animal and have identified additional districts.
- (Question via Chat) What is the dollar amount of the five year grant is? (Gerold Leonicker) All the work streams together is $4.7B.

- (Cmsr. Swirsding) I worked at RPAL (Richmond Police Activity League) and my recollection, when the kids would come, they already had meals at the school. Some of them would still be hungry and we would feed them snacks and (I guess) I don't understand why they are adding this food thing when it already exists. My other point is, did he say this was for middle school, not elementary? (Cmsr. Serwin) That's totally outside what he was speaking about and I don't know anything about the free meal programs at the schools. It's K-12.

VII. REVIEW breakdown of initial tasks for the K12 gap analysis project and DISCUSS assignments, Commissioners Laura Griffin and Barbara Serwin

(Cmsr. Griffin) My understanding and hopes for what we want to accomplish with this committee is to ensure the school districts that needed the most help as far as onsite mental health for children in schools. What type of programs do they have? Do they have a center or some kind of dedicated time or counselor on the grounds to help students. That is where the need is and I think this is where a lot of kids are falling through the cracks. I was just wondering, we have the money and we know they are working towards programs to fund, I know WISP will be presenting on Wednesday at our main commission meeting and it will be good to hear an update. My concern is: are the schools and the school districts that need the help, getting the help they need, as far as behavioral health support for those students?

(Cmsr. Serwin) What occurs to me, is looking at the report and review their methodology for selecting these school districts. As I said, the few things he mentioned were on my methodology. We may agree or find it wanting in some way. We can also look closely at what kind of resources and services are going to be made available onsite. He did mention a wellness center, mentioned onsite staff for therapy / group therapy. The ability to provide services directly through hiring as well as bill through the provider to bill. I'm curious as to what are the limits. When the insurance paid services is eventually rolled out, the insurance plan will define what the limits are. That is out of the public domain unless it's MediCAL. Should we spend the next couple of meetings, should we go through and review in depth to see if it comes up short anywhere or just generates ore questions.

(Cmsr. Perls) I think that part of the difficulty is that this is just dictated by a large number of programs under one funding screen. Those may be the district that need the most help, I don't doubt that but I guess we should get a written copy. Not sure why we couldn't get a copy, why it isn't made public. But the other thing is that he didn't talk about just the general need for behavioral health care, but he talked about was specialty care. That is limited by the statute to a very specific list and didn't even mention schizophrenia (Int. Cmsr. Serwin) Yes he did, toward the end. He said psychosis. (Cmsr. Perls) I'd live to see the rudimentary establishment of behavioral health services in all schools, because so often, it is a troubled kid who doesn't have a diagnosis but one that a teacher might identify as at risk.

(Cmsr. Serwin) Another thing that Gerold pointed out was that there has already been a perception of disparity between kids who are on MediCAL getting more / easier access than kids who either have no insurance and don't qualify for MediCAL or have private insurance that doesn't cover much. I think that is the pocket of kids that don't get anything.

(Cmsr. Swirsding) I would like us to also look into the funding. I don't know if you heard on the news about San Jose's center. Is that part of the state's money?

(Cmsr. Serwin) There is a lot of state funding (in my research) of funding slated that has already underway / been approved to provide huge sums of money and wondering what actually went through (some have already been passed). Is some of it coming from federal sources? Is there federal funding being distributed outside this $4.7B?	
VIII. REVIEW key issues, tasks and establish a timeline for resuming site visits, Commissioner Barbara Serwin (Cmsr. Serwin) <screen share documents> Reviewing the work this group has accomplished over the last couple years regarding site visits and observing the first three (3) site visits we did from start to finish, the first thing that occurs to me is streamlining and simplifying the process, especially: • the initial scheduling of the visit; • coordinating the visit; and, • simplification will be done by dropping the ZOOM Meeting format. Streamlining the report writing by: • enhancing the report template (further building it out); • and maybe establishing some 'good enough' (criteria); • review and streamline the initial documentation, if possible; and, • provide ore guidance on the contract review. We don't really have anything in place to help the commissioner(s) on site visit to evaluate the contracts. That is a big piece of the streamlining. Augmenting the process, we need to add physical site evaluations now. Cmsr. May identified a great international standards document on site visits. All kinds of licensed health facilities (further discussion after these documents have been found). It is important to review the mentors and the site visit liaison roles. They involve work. What are the necessary roles of the mentor and liaison. • Will we always need a mentor? We thought we would the first couple of site visits. Maybe the liaison is the mentor, we aren't sure. • We need to review the communication of reports and the feedback loop. Who should the report go to? And when? We do have protocol in place but it is a bit ambiguous and it had to be thought through each time, so it needs to be more concrete. • We have a lacuna regarding the feedback from BHS. We have sent them three reports and we have never heard back. The whole point is to get it in front of them and reviewed. It is not the sole purpose but it is a key objective. We need to know if they are reviewing it and a confirmation. We need feedback and the site needs feedback. • Another process to deal with is developing the process of documentation specifically for children and transitional age youth (TAY) sites. As part of this, we need to address the HIPAA (Health Insurance Portability and Accountability Act) privacy issue. We need to consider how to best incorporate parent participation. Parent approval and/or participation. • We will need to revise the training module where necessary and establish a timeline for the next site visit(s). Does any commissioner have any additions or comments? **Comments and Questions:** ➢ (Cmsr. Griffin) Having worked these site visits last year, we all did the best we could. We didn't accomplish what I thought we should and the whole process was very slow and bogged down. I am just wondering, last year	*Screenshared docs, sent to participants after the meeting as they were not available at time of publishing.*

Jennifer Bruggeman had suggested possible collaboration with MHSA during their site visits. We would conduct our interviews at the same time. Less set up and much quicker process, as well as the administrative support is doubled. I think it is worth looking into rather than repeating the process. We had a tough time getting commissioners to volunteer. This year we will be going out on site. It just seems there is a lot to it and if we work as a team with MHSA, it could be simplified and get the work done. I feel really strongly about the ad hoc committee with this, as well as the K-12. This would be a really great program to have as an ad hoc committee because it won't fall under the strict in person guidelines and we can meet easier. ➢ (Cmsr. Serwin) What objectives were not met? ➢ (Cmsr. Griffin) We didn't do as many as we wanted to do. We were scheduled to do one per month or every other month. We scheduled one in January and in July we were going to start with the children's sites and ended up only putting out two reports. It was very cumbersome and I'm worried we will fall into that same pattern again this year. And I think the collaboration with MHSA, tag on to their site visits and do our own part. It's really worth looking at. ➢ (Cmsr. Serwin) We can meet with MHSA and discuss. It didn't make sense before but it may now. ➢ (Cmsr. Swirsding) That is what we did before. We were with MHSA. What we are doing now is more detailed than back then but I do remember going with them. I liked that, we were all there at the same time and seemed the staff were much more open when we went together. ➢ (Cmsr. Griffin) and there were issues with the site staff being very skeptical of what we were doing and why. ➢ (Cmsr. Perls) One thing would be to address the hesitancy and skepticism of the staff, we could easily send an introductory letter on our stationary and explaining our oversight responsibilities and asking the administrator to inform the staff. The second thing – do we not have a conflict of interest going out with the MHSA? (RESPONSE: Cmsr. Serwin) Yes, we are looking at sites that are funded, in part, by MHSA.	
IX. Adjourned at 5:05pm.	