Mental Health Commission
Quality of Care Committee Minutes
October 19, 2017 - FINAL

	Agenda Item / Discussion	Action / Follow-up
I.	**Call to Order / Introductions @3:31pm** **Members Present**: Chair- Barbara Serwin, District II (arrived @3:26pm) Gina Swirsding, District I (arrived @3:30pm) **Members Absent**: Meghan Cullen, District V **Others Present**: Sam Yoshioka, District IV Doug Dunn, District III Lauren Retagliatta, District II Victor Montoya, Program Chief for PES Erika Raulston, *submitted application, pending appointment Leslie May *submitted application, pending appointment Jill Ray, Field Rep for District II Supervisor Andersen Priscilla Aguirre, MPP, Quality Management Program Coordinator Dr. Ann Isbell, HS Planner/Evaluator Adam Down-MH Project Manager Liza A. Molina-Huntley, Executive Assistant (EA) for MHC	**Executive Assistant:** • **Transfer recording to computer.** • **Update Committee attendance** • **Update MHC Database**
II.	**Public Comment** • None	
III.	**Commissioner Comments** • Statement regarding concerns with youth having mental breakdowns, how law enforcement assists in the process, what happens before, during and after Juvenile Hall- what services are available to youth, after detention, especially for Foster Care youth.	
IV.	**Chair announcements/comments:** • None	
V.	**APPROVE Minutes from September 21, 2017 meeting** • **Gina Swirsding moved to motion to approve the minutes, without corrections, Barbara Serwin seconded the motion** • **VOTE: 2-0-0** • **YAYS: Gina and Barbara** • **NAYS: 0 ABSTAIN: 0 ABSENT: Meghan Cullen** • Concerns were made regarding certain commission members attending the Family and Human Services meetings. It was clarified that the meetings are closed sessions, by invitation only, and do not violate the Brown Act because only three members attended the meeting, there were not enough members to create a quorum of the commission.	• **Executive Assistant will correct the minutes, finalize and post the minutes on the Mental Health County website.**
VI.	**DISCUSSION regarding an overview and summary of External Quality Review Organization (EQRO) with Priscilla Aguirre, MPP- Quality Management Program Coordinator and Dr. Ann Isbell, Health Services Planner/Evaluator** • EQRO is a federal mandate, required by the United States Department of Health and Human Services, centers for Medicare and Medicaid services (CMS). The review is conducted on an annual basis, to have an independent external evaluation of State Medicaid managed care programs. The state contracts with an agency called "Behavioral Health Concepts". This agency makes annual site visits to review all 56 counties in the state of California. EQRO is an external review and evaluation of access to our services, timeliness of services, and client outcomes. The agency is interested in know whether or not clients are getting better, based on the services that we provide. The agency conducts both staff interviews, as well as focus groups with clients. EQRO is primarily focused on evaluating how the service is being provided to the beneficiaries	• **Include handout from meeting discussion- EQRO report summary** • **EA will ask the Quality Manager- Priscilla Aguirre in JULY/AUGUST for the EQRO report to schedule a presentation at the following meeting**

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under the Mental Health Plan (MHP) • The Behavioral Health Administration serves MHP and other clients that are not specific to the MHP • There are 20 components that Behavioral Health Services Division (BHS) is evaluated on. (provided handout listing components that are evaluated) Three areas are focused on the access to services, some are focused on timeliness and the final section is related to quality. Within each of the three components, there is an abundant amount of requirements • The shared report summary is divided in two columns: EQRO FISCAL YEAR 2015-16 and EQRO FISCAL YEAR 2016-17. The abbreviations are defined as: "FC" for FULLY COMPLIANT, "PC" means PARTIALLY COMPLIANT and "NC" means NON-COMPLIANT. BHS did not receive any "NC's" during the evaluation. In all 20 components, BHS was either fully or partially compliant, in both years. • The document shows that year to year, that there is a trend, for the two years, of being FULLY COMPLIANT in 10 out of 20 components. • The document demonstrates improvements as some components went from partially compliant to fully compliant, in six areas. • Comparing from 2015-16 to 2016-17, the BHS went from being fully compliant in ten areas in 2015-16 to being fully compliant in 16 areas in 2016-17, leaving four areas in partially compliant, out of 20 total. The Behavioral Health Services Division has made strides in a lot of areas. • The four areas that are partially compliant areas, were affected by previous paper billing and charting. Now that BHS is in the process of implementing the Electronic Health Record System (EHR) the areas will should see improvement that were in the partially compliant category • Questions- • What is EQRO actually looking at for evidence of effective communication from BHS and Mental Health Plan (MHP) – this is different from the Mental Health Administration, correct? RESPONSE: Yes, the Mental Health Plan is specific to the beneficiaries of the Mental Health Plan • Will EHR affect Continuum of Care Reform (CCR) and how? RESPONSE: At this moment, it is unknown, due to the fact that the process of the implementation is still in its initial phase of being launched. Cannot answer the question at this time. • Is there a master plan, created by BHS, in what steps will be taken to improve? RESPONSE: This is the initial data of measurement that will best be answered in the following year. There might be different requirements in the future. EQRO is all about improvement, identifying other ways to improve our system to provide better outcomes for the clients • Besides the Electronic Record, was there anything else that BHS was working on to assure that we attain full compliance on the things that we are now partially in compliance? RESPONSE: The question that comes up often is: how do we really now that our clients are getting better? We/BHS are in the planning stages of implementation of other items; for example: CANS (Children and Adolescent needs and Strengths) tool, which has the ability to be used for different levels of care and for treatment planning • When a component is identified as FC, PC or NC- does the process include, a piece that requires BHS to identify what it plans to do? Or does it end there and picks back up again the next year? RESPONSE: It is not linear- one of the things that EQRO does is that they include recommendations based on what was observed during their evaluation. BHS is required to respond to the recommendations. • Will SHARECARE help out in any of the issues, or solely EHR? RESPONSE: For EQRO, the primary focus and improvement will be coming from EPIC (EHR). SHARE CARE is primarily focused on billing. EPIC is focused primarily on documenting, based on the care. • Are the numbers representatives of just the youth in the county or all the population?	

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RESPONSE: the EQRO addresses the entire system of care • There are five key areas of the EQRO report: the first is the performance measurements, (pages 13-20), followed by the performance improvement projects (PIP- two are required to be completed, annually, pages 22-29), the third is Consumer and Family Member focus groups (pages 45-47) , fourth is the Information Systems Review (pages 45-53) and the last section is the RECOMMENDATIONS (on page 56) • In the first section: PERFORMANCE measurements, areas that the state has indicated to measure across counties. There are eight specific areas. (see page 13) • The PERFORMANCE IMPROVEMENT projects (PIPs- see page 22) Two are mandated to be conducted per year, one clinical and one non-clinical. These are projects designed to assess and improve processes. It is up to the county to identify the needs by analyzing internal data. For the clinical performance improvement project it was "Coaching to Wellness," it is a MHSA funded project. The project consists of a peer provider, working with a nurse, to assist those individuals with chronic health conditions. The assistance provided is one-on-one and group work, to help the client identify goals, educate, link the person to resources so that the individual can do better self-management to improve both their health and mental needs. For the non-clinical PIP an appointment adherence was conducted. The county does have a slightly higher than average "no-show" rate, particularly with Psychiatry appointments. It was addressed in multiple ways: it was identified, from feedback provided by a focus group, that a handbook would be helpful to assist in navigating through the system. The county is currently working, with a workgroup, to provide a handbook. The second project is a transportation project to address transportation issues. Some consumers find it difficult to get to their appointments. Approximately one-third of the individuals miss their appointments due to no available transportation. A report was submitted, identifying nine different steps to address, including: forming a committee, define problems, why was the project chosen, research questions, develop indicators to measure impact outcomes data. Coaching to Wellness was rated in both years. For the clinical PIP the overall rate received was 88%, which is considered a high rate, meeting client's needs. For the non-clinical, no-show PIP, at the time of the evaluation, the project had just initiated and was in the launching phase, therefore there was not enough data for the evaluation and received a lower score of 75%. • QUESTIONS- • How long ago was the no-show rate evaluation done and how was the data obtained? • Response: The data on barriers was obtained by conducting focus groups and distributing and collecting surveys from consumers. • Is there a summary of the information? • Response: Yes, there is a finding reports from the improvement surveys • Is there a way to help consumers prioritize their appointments? If consumers have health problems and mental health issues, they can become overwhelmed with appointments and focus on just the health issues and not show up to their psychiatrists or therapists appointments. • Response: we are trying different ways to identify the optimum time to send out reminder calls- one day, two days, same day especially when considering transportation barriers and or other appointments • Where and when were the PIPS done? • Response: The EQRO evaluation is conducted annually in February, so it does not capture the full fiscal year. The data submitted was from November 2016. The sites, where the PIPS were conducted at, are the East and Central adult's clinics. • The results of the focus groups, that were conducted by Behavioral Health Concepts, during the site visit in February of 2017. One focus group is done with adult consumers and the other focus group is done with parents and caregivers of children and youth. A multiple series of questions are asked, themes are noted and recommendations are provided. For adults, consumers seemed aware of how to best access crisis services, if needed. Many noted that staffs were increasingly stressed. The staff involved in "wellness recovery, wraparound services, or action planning groups and in our welcome	

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centers found them very useful and supportive of their treatment. While consumers felt recovery was possible, welcomed more input. The recommendation that came from that particular focus group was to increase opportunities for focus groups to provide feedback, which BHS started to do in 2016 including more survey opportunities. • Where are the welcome centers located? Did they visit all three locations? • We believe that the group was referring to RI International welcome centers. We did ask for clarification and that was what was stated. It was not disclosed if all three locations were visited. • The other recommendation was to have more licensed board and cares facilities in the community and services for the mentally ill, that are homeless, seem limited. It was encouraged to embrace and promote family support as essential for recovery. • Regarding the focus group with parents and caregivers, those who had a longer history of service indicated that consumer progress was made and had improved. And that service provisions were adequately offered in our patient services. Many noted that they had negative experiences with hospital discharge procedures and the parents/caregivers felt that youth were prematurely discharged and follow up support was not provided. Those that were in the Equip, Educated and Support group, as well as First Hope, along with those receiving school based wrap around services found the services to be very helpful. Participants felt supported by each provider, but noted that more staff is needed. Services were available in the preferred language and transportation was available to appointments, including bus vouchers. • Where were the participants talking about being discharged from? PES? Do we know? Most of our youth are not discharged from our county hospital, that are in mental health treatment, that's why I ask the question, because they are discharged from different locations. • Response: details of location were not provided. We conduct our focus groups differently and request more information. The EQRO protocol is different and do not ask the participants to elaborate or to specify, that is their process. We do not get any information in advance to support the focus groups, so the responses are whatever it is, from the clients who chose to participate and their experience that is what is represented in the EQRO summary. • Another recommendation was a more productive transfer of services for transition aged youth (TAY- see pages 46). Additional recommendations were updated communications, using bulletin boards more effectively, having a bilingual person at the front desk, more prompt follow up calls when a request for service is made and consider appointing a benefits support staff for those who need insurance. • The five recommendations were based on what was observed for our county (on page 56) is: standardizing processes and cross-regional referrals for access to care and subsequent services to enhance the seamless and consistent delivery of services. BHS is working on all aspects, including the launch to EPIC, which started on 9/26/17, developing the referral system, by utilizing CCLINK. BHS is making progress in developing this mechanism for referrals cross-regionally. • The other is requesting timeliness matrix request quarterly reports and analyzes for adherence to standards as component of the contractor provider performance measures. An area that we have started to work on, with our new Chief of Operations, Helen Kearns. • The third is utilizing existing equipment to provide tele-psychiatry services in the regions showing the greatest need. BHS is currently piloting tele-psychiatry, tentatively launching on October 31, working with the EPIC team to effectively utilize the system, using a video monitor to communicate with the client and doctor. It will allow a doctor to be at one location and have appointments with patients at various locations. Psychiatry is the area that BHS is currently focused on for the pilot project. There will be a lot to learn, other counties are utilizing the system, which are show success. • Review services designed for TAY and increase for this target population. BHS is working on exploring to partner with an agency to provide a TAY residential program at Oak Grove.	

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• The final recommendation is to develop a communication plan that includes contract providers and a planning and implementation of an electronic inter-operability of EHR data, between systems. At the time of the evaluation, BHS had not started the implementation of the EHR/EPIC, since then, it has launched, internally, and there will be a second phase to include the providers and that will be informed, after it has launched. The new system has only been operating for three weeks and will continue to improve communication and standards, it will take time. • The information provided is summarized in the EQRO Summary report provided * see attached • The state has requested all counties to provide support to the victims of the fire and Contra Costa is doing their best providing support by sending staff to assist. • Approximately 15 Contra Costa County clinicians have done over 25 shifts at the Napa shelter and Sonoma to help the fire victims, individuals and families	
VII. DISCUSS updates from Psych Emergency Services (PES) with PES Program Chief, Victor Montoya • One of the focuses is looking at the services for minors at PES and currently in the process of obtaining clinical data • There is a Health Educator that has initiated the data and refining the data collection system specifically for children • There currently is not an inpatient children/adolescent minor facility in the county and the follow up care is provided and developed at John Muir facilities or send children as far as Sacramento • The ongoing focus might be on the minors that really need hospitalization, that facilities are unwilling or unable to do, due to the minor's acuity status, and will sit at PES for over the allowed 23 hours and the county does not obtain reimbursement, from MediCal, after 23 hours and the county is absorbing the additional costs • With the changes in foster care youth, in providing mental health services, and the reduction of long term group homes being eliminated, there will be greater challenges in providing residential treatment and increase minors homelessness and increase minor ending up in juvenile hall • A lot of foster care parents are unaware of the various court requirements for fostering youth, especially youth receiving medications and the court documentation required to provide medications • Question: Do you think because of the reduction of group homes, more difficult children will now be placed in foster care homes and the foster care parents will need training on how to handles these children- will there be an increase in children in PES? • More than likely, there will be an increase of children in PES. It currently is phasing in. There is a reason why children in long term group homes do not improve. Children need a more family environment. The higher acuity children wind up getting placed out of state, because there is no place for them to go or the facilities refuse them, further from any family contacts.	***Invite PES for the next meeting**
VIII. DISCUSS and REVIEW the committee activities for 2017	***Forward to the November 16 meeting**
IX. DISCUSS potential committee goals for 2018 as follows: **1. Goals not completed or addressed in 2017** **2. Potential new goals for 2018**	***Forward to the November meeting**
X. Adjourned at 4:49 pm	

Submitted by
Liza Molina-Huntley
ASA II- Executive Assistant for MHC
CCHS- Behavioral Health Administration
FINAL minutes approved on 11/16/17