MENTAL HEALTH COMMISSION
MONTHLY MEETING MINUTES
May 5th, 2021 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Cmsr. G. Wiseman, Mental Health Commission (MHC-Chair, called the meeting to order @ 4:31 pm Members Present: Chair- Cmsr. Graham Wiseman, District II Vice-Chair, Cmsr. Barbara Serwin, District II Cmsr. Candace Andersen, District II Cmsr, Douglas Dunn, District III Cmsr. Laura Griffin, District V Cmsr, John Kincaid, District II Cmsr. Kate Lewis, District I Cmsr. Kathy Maibaum, District IV Cmsr. Leslie May, District V Cmsr. Joe Metro, District V Cmsr. Kira Monterrey, District III Cmsr. Alana Russaw, District IV Cmsr. Geri Stern, District I Cmsr. Gina Swirsding, District I Members Absent: Cmsr. Michael Coyle, District IV Presenters: Dr. Suzanne Tavano, (Director, Behavioral Health) Aisha Banks (Improvement Advisor, Clinical Informatics) Mardy Beggs-Cassin Amanda Dold Steve Hahn-Smith Kennisha Johnson Other Attendees: Colleen Awad Guita Bahramipour Angela Beck Jennifer Bruggeman Y'Anad Burrell Angie Dobson Lisa Finch Jessica Hunt Vi Ibarra Lynda Kaufmann Enid Mendoza Carlyn Obringer Pamela Perls Monique Perry Dom Pruett (Supv. Candace Andersen's ofc) Stephanie Regular Rhiannon Shires Jacqueline Villalobos Tamisha Walker	Meeting was held via Zoom platform

II. PUBLIC COMMENT:

- (Guita Bahramipour) I also serve on the Board of Crisis Center (211) and the question we have (quite frequently) is if someone calls from the community (parents) with a mental issue, typically dementia. The adult children are trying to figure out how to handle their parent, while there are children and grandchildren in the house. Which of these phone calls assures the community to reach out for someone that can help their parents with the delusional thoughts? How can they help them with their therapy and medication? What is CCC doing for those with dementia and their needs? (RESPONSE: Dr. Suzanne Tavano) This is an important issue the county raises with the State regularly. The way the Medi-Cal benefits are divided up, those with organically based disorders such as dementia, Alzheimer's, Traumatic Brain Injury (TBI), etc. fall into the excluded diagnosis list. They are not included in who we are to serve under the Medi-Cal program. The care is supposed to occur is through the managed care plan (the health care plan), but that is for the physical health aspects. What we have been bringing forward to the state (for years) is there is a big gap in services for people with neuro-cognitive disorders, because they are excluded from our behavioral health services unless they also have another mental health condition diagnosed prior to the onset of the organically based condition. The state has set up all very complicated rules that, for the most part, exclude us from serving that part of our community. The physical health needs are to be addressed by CCHP and BlueCross, but it remains silent on who should provide (and where the money would come from) the service you are speaking to. This is definitely a state-wide issue that has not been resolved.
- (Jacqueline Villalobos) May is Mental Health Awareness month. I have been thinking a lot about the youth in the community, especially in high schools. One aspect I was thinking towards is: How are teens made aware of the resources available? I asked my brother (who is High School) if he is aware of any mental health resources, and sadly most high schoolers, the answer is "I don't know" and is one thing I would like to point out. Another mention is the idea of having mental health ambassadors in high school bringing awareness on the high school level by having funding to give high school age youth an opportunity for a job bringing awareness within their own campus. It is something I would like to advocate for considering May is mental health awareness month.

III. COMMISSIONER COMMENTS

- (Cmsr. John Kincaid) I wanted to ask Dr. Tavano to clarify something she just said because it is shocking. Someone with dementia or organicity, even if they have a co-morbidity that meets criteria for a mental health diagnosis, if that diagnosis doesn't pre-exist, the neurological problem, then it is not eligible for funding and treatment. If that is true, that is a big gap. How does Medicare deal with that? Is it the same or different?
  (Dr. Tavano) There is so much history, I won't go into it, but basically, a list of included diagnosis was constructed and anyone with those diagnosed conditions falls into our realm but have a list of excluded diagnosis where we can provide the service but cannot get reimbursed for the services. The state doesn't tell us 'you shall not do it' just that we will not get reimbursed for the care. The other added provision is, if we do treat someone with an organically based disorder, there is some substantiation that their mental health condition existed prior to the onset of the organic condition. It is both in the outpatient and inpatient where this plays out. There are certainly those hospitalized on psychiatric units that are suffering from dementia, TBI, etc. and what is being treated are the behaviors, not the underlying condition. The Medicare program is a completely different issue. The commercial plans and Medicaid program, there are all sorts of regulations about accessed care, for specialty mental health and drug Medi-Cal organized delivery system. There are very tight requirements where someone must be seen within ten days of request by a clinician, within 15 days of request

for a psychiatrist and within seven days post hospital discharge, but there aren't those rules for Medicare and there aren't a lot of providers in the county that are just independent Medicare providers. It creates access issues. Many with Medicare get enrolled in a managed care plan (Blue Cross, CCHP, etc.) so there is some access to more services than if they weren't assigned to a managed care plan. For county BHS, when one has both Medi-Cal and Medicare, we provide the full range of services. We do see some (inpatient and outpatient) that have Medicare only and tend to be those who require frequent high levels of care and want to provide case management and other supportive services. Medicare only pays for certain provider types and types of services. Community BH offer multi-disciplinary teams with the whole continuum of care. Many are not considered Medicare benefits so there is no reimbursement. It is a very complicated issue and explanation. It is how it all flows in terms of the state and federal rules and how money is assigned to provide care for those individuals. We try to serve as many Medicare only patients as we can, but our primary charge is the Medi-Cal population and then it becomes a resource availability issue.

- (Cmsr. G. Swirsding) I belong to a PTSD Group and many are military and have problems with helicopters. In our area, we have Medi-Cal or law enforcement helicopters constant overhead (low flying and back and forth, constant traffic). They become paranoid and listen to police dispatch. They want to know what is happening with west county (Kaiser/John Muir) to central county, like Medi-Cal helicopters? Is this a regular route? It is affecting a lot of people within that PTSD group. Where can we get some information to answer the question.
  (Dr. Tavano) Yes, for many of those that have served in the military, it is a very common reaction within the PTSD realm that the sound of helicopters overhead really triggers a lot of very strong feelings. That I do know. I do know John Muir is the designated trauma center that has the heliport, but beyond that I do not have any information on what the pattern or schedule is or where they might be going or how to find out. Possibly the EMS director might have that information.

IV. CHAIR COMMENTS/ANNOUNCEMENTS:

- May is Mental Health Awareness Month. We really do want to focus on what is going on, what we can do, how we can help our constituents in our community on mental health. Really focus on what are some opportunities for us to make some positive changes.
- There was a discussion at the Executive Committee Level regarding by-law updates regarding replacements and appointments to the Commission. That item has been moved on to the Board of Supervisors (BoS) and will be having an internal operations committee meeting on this. Any commissioners interested in commenting on that policy are welcome to join the next meeting on June 14th, but it is expected this item will come up on the July 12th meeting. If you have any questions or comments regarding how people are assigned to the commission, that is the place to take it.
- There is another item regarding subcommittees inviting speakers from county offices to their meetings. At this time, we would like to get clarification that those requests go through the chair and we will pass them on to county BHS so that we do not inundate BHS personnel with requests for additional needs. I hope to have more information on that for our next meeting.

V. APPROVE April 7th, 2021 Meeting Minutes

- April 7, 2021 Minutes reviewed. **Motion:** D. Dunn moved to approve the minutes as written. Seconded by K. Maibaum.
  Vote: 14-0-0
  Ayes: G. Wiseman (Chair), B. Serwin (Vice-Chair), C. Andersen, D. Dunn, L. Griffin, J. Kincaid, K. Lewis, K. Maibaum, L. May, J. Metro, K. Monterrey, A. Russaw, G. Stern, G. Swirsding Abstain: None

Agenda and minute can be found at:
https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

VI. "Get to know your Commissioner" – Introducing our two newest commission members: Graham Wiseman (District II) and Leslie May (District V)	**Due to time constraints, this Agenda Item will be added to the June 2 Meeting Agenda**

VII. RECEIVE update on the first Crisis Intervention Rapid Improvement Event (RIE), Aisha Banks Improvement Advisor, Clinical Informatics, Kennisha Johnson, East County Child and Adolescent Services, Commissioner Barbara Serwin, Mental Health Commission
 	
Rapid Improvement Event 2 (RIE2), last meeting included a presentation from the first RIE presentation. Presenters today include the co-facilitator of the RIE, Aisha Banks, Mardy Beggs-Cassin, Amanda Dold, Kennisha Johnson and Barbara Serwin
 	
Speaking on the debriefing from the Rapid Improvement Event #2 (RIE2)-*Aisha Banks*:
 	
The theme around the RIE2 was testing and developing solutions, the first theme in RIE1 was just getting started, ensuring all of the data pieces are brought together. This iteration is all about testing and developing solutions. The third event will be putting it all together.
 	
AIM Statement: "*Anyone in Contra Costa County can access timely and appropriate behavioral health crisis services anywhere, anytime."*
 	
What was done differently this time around was to bring real-time feedback with the voice of the community into the design process during the week. With that said, we had approximately seven (7) speakers who were either those with lived experience or family members of those with lived experience. A couple of those, (1) a family-member and (1) was a person with lived experience who was actually a part of some of the sub workgroups of the process.
• **Josue** (Lived Experience): Josue discussed his experience with homelessness as a minor, lack of resources and its impacts on his mental health. He was part of the Mobile Crisis Collaborative Response Team, also known as the non-police team.
• Continued focus on four priority improvement AIMS of:
  • Incorporating a single phone number
  • 24/7 availability
  • Non-police mobile crisis team – the name was changed to the mobile crisis collaborative response team to be inclusive of all those who will be participating on the team.
  • Alternate destinations (facilities other than PES or the emergency room)
 	
Continued areas of improvement / issues to resolve:
• Long travel times to other regions
• Not everyone receives a referral or gets connected to follow up services
• Redundant intake interviews
• The correct people are not sent to help the person or family in crisis.
 	
Over the course of the week, the team developed the following proposed model of a collaborative integrated response (Slide 12 flow chart). This starts with someone from the county who will call a Behavioral Virtual Hub. We are operating on the 'no wrong door approach' and this Behavioral Virtual Hub will have a single number that can be accessed directly. Given that there are multiple entry points, if the person called 911 or 211 or another county agency, they would be routed to the Behavioral Virtual Hub with a warm handoff between their entry point to the mobile health crisis hub.
• The team will also examine, identify and triage based on crisis, using a triage tool that was also developed. Determined need for:
  • Physical presence
  • Team will be mobilized.
  • Teams could have different configurations potentially having either a mental health clinician with peer support or an ENT. Only trying to use law enforcement in case of emergency situations (weapon, safety, crime)
• Calls answered by a trained mental health professional
	The Crisis Intervention Rapid Improvement Event 2 Update presentation to the Mental Health Commission was shared as a PowerPoint presentation during meeting.

- Based on the Substance Abuse and Mental Health Services Administration (SAMHSA) Best Practices
- Offers air traffic control (ATC) quality coordination of crisis care in real-time
- The HUB will provide seamless coordination from the customers crisis entry to follow up care

Crisis Assessment Triage co-response model presented by *Amanda Dold*

This particular event, started to dive more into what will be our future state.

- Co-response model including three variations responding to a crisis in the community (Slide 8 flow chart):
  - Law enforcement only (crimes, weapons, clear danger to others)
  - Co-response (mental health clinician, peer support worker and police officer) This is currently exists with the Mobile Crisis Response Team (MCRT) and we are working with them to test some of these new responses out.
  - Non-police presence responding to community crisis (mental health). The ideal would be to respond to most incidents that are not violent in nature.

We continue to define the criteria for each team and what they would need. The team continues to recognize that the work is just beginning. It is a very complicated effort with many people involved. What are our short-term and long-term aspirations? Between this event and the next event in June.

- Short-term goals:
  - At least 25 Mental Health only responses before next Rapid Improvement Event
  - Pilot use of police radios for clinicians for improved immediacy of response and communication among team members
  - Analyze data from responses
  - Consistently administer follow up surveys:
    - ◊ Law Enforcement
    - ◊ Clinicians
    - ◊ Community Support Workers
- Long-term goals:
  - Pilot option of having an EMT as team member
  - Further refinement of triage assessment
  - Pilot use of crisis support worker (mental health specialist)
  - Law Enforcement be a member of c-response team ("task force" model)
  - Streamlined transportation modalities

Behavioral Health Virtual Hub Team (formerly the Single Phone Number 24/7 Team) discussion by *Kennisha Johnson*

During this event we focused on testing the idea of the 'warm hand off' and seamless transitions to the Hub. Regardless of where the calls are originating 'no wrong door' we are able to transfer the calls into the Hub, if the agency feels there is an in-person behavioral health response needed. The example in this workflow (Slide 12 flow chart) if the call is coming in from another agency or 911/211, the calls are able to be transferred into the Hub. Continual testing of the warm handoffs, we learned is that some agencies are not able to provide a warm hand off and some agencies are able to do so. We are focused on how to apply the ability to transfer into the Hub, how to make that capability available to all agencies with the information coming in.

Next steps: A trained clinician should be taking the call. The person taking the call would be the holder of all the information learned from the caller and use the triage form to refer/pass off to the best team to take the call. A three-way call to the team in the field would be placed. The idea is to keep the caller on the line the entire time as they move forward in order to continue to provide information and stay engaged and know in real time what the situation is as it evolves and to provide continued support to the person in crisis, as well as the team responding.

All information gathered will be entered into a shared software tool. We have been evaluating several different software applications to best communicate and

coordinate. One program (ArcGIS) is currently in use in the county. It has an app function enabling staff to type information in real time, communication flows back and forth between staff online with caller and the team in the field. We are looking at programs that would meet the need of sharing communication in real time to prevent the breaks that are happening. The Hub would be deploying the team out.

The Behavioral Health Hub Team is focused on having the trained clinician answering phones and have been relying on Best Practices of SAMSHA and their crisis intervention model and using an air-traffic control model.

Crisis Assessment Triage Model update by Commissioner *Barbara Serwin*.

Triage Crisis Assessment consists of asking questions about the situation, assessing, and deciding how to best respond. In a mobile response triage situation, questions are asked about the nature of the crisis, the caller's behavior, and safety questions (if there is a weapon). Once enough information is obtained, decisions will be made whether to make a field visit or escalate and involve EMS or if law-enforcement is needed for support, or what expertise is needed within the Team that is sent to out. A clinician or peer support worker, EMT and the various models Amanda was speaking of. My team is working on the triage protocol that consists of short set of essential questions and a decision tree (Slide 15 flowchart) indicating a measure of decision made by the call responder. In the diagram, orange means 'yes', green means "no'. Starting with "is this a mental health crisis" – if the answer is YES, we ask if it is an emergency, if so, 911 or local law enforcement is called. We also ask if it is a good candidate for a field visit, if YES, we ask the caller if he/she wants MCRT. If so, is law enforcement required? There are several series of questions following to assess what the response team should consist of when responding in field.

Next steps: Test and time the triage tool to be utilized for Virtual Hub and Collaborative Mobile Responses.

Future State Alternate Destinations Model discussed by *Aisha Banks*

The following list of alternate destinations, at a high level, the team is just thinking about creating different types of facilities (Slide 18 Flow chart), ensuring there is a no wrong door approach and the virtual hub still continuing with the caller to pass to another hand to ensure there is appropriate aftercare.

- Co-Occurring Treatment facilities
- Crisis Residential
- Crisis Receiving and Stabilization Center
- Drop-in Clinic/In-Home Support
- Sobering Center
- Respite
- Shelter

Next steps: Expand and Create Children and Adult services in all regions:

- Peer-Operated Respite
- Sobering Center
- Crisis Stabilization Unit
- Crisis Residential Facilities
- Co-Occurring Treatment facilities
- Shelter and safety for those living with Mental Illness
- Drop-in Clinic/In-Home Support

Addressing the data measurements, the following are some proposed data measures we want to incorporate to ensure the measurement of quality of service and what process measures in terms of the response time and satisfaction of service:

- The percentage of HUB calls answered, screened, and routed to the appropriate source within 3 min
- Mobile Crisis Collaborative Response Team answers all calls within 30 min

- Reduce avoidable 5150s by 25%
- Community Satisfaction and Customer Experience targeted at the 75th percentile
- Reduce cost per crisis by 20%
- 80% of all crises have follow up care services (wrap-around)
- Team Satisfaction targeted at 80% (satisfied – very satisfied)

Data Trends and Source collection discussed by *Steve Hahn-Smith*

Addressing the data trends is a very data intensive process the team is going through MCRT call trends (Slide 22 graph) and the sources of calls to MCRT (Slide 23 chart). The calls the MCRT has received, it is a fairly new program that started in 2018. Tracking the number of calls per month, we see there is a study growth and a spike in November (around the time of the Value Stream Mapping). MCRT takes calls across the whole county, open eligibility any one can call (it is not just tied into the health plan) the graphs show the frequency distribution – family being the highest number of calls into the MCRT line, and Family/self and from the Police Department, followed by the Mental Health Access Line. Three are approximately 30 sources of calls incoming, with the highest number being family.

Comments and Questions:

- (Cmsr. D. Dunn) What is meant by the term 'Alternative Destinations'? (RESPONSE: Mardy Beggs-Cassin) It is something that is not an emergency department, not Psych emergency and not jail. The list provided is what we thought best would meet the needs of what people in crisis could do outside of in an emergency department or jail. (Kennisha Johnson) It is based on the SAMSHA guidelines addressing alternatives to psyche emergency or jail. The team Mardy is co-leading is working on what other resources we have in the county the client can be referred to in crisis, as they may not necessarily need PES or to be 5150'd, but aware these venues will handle someone while in crisis.
- (Cmsr. L. May) Can anyone call for help for someone, for example, if you see someone on the street, can you call? (RESPONSE: Aisha Banks) What we are proposing is anyone in CCC would be able to call, even if on the street. That our future work of having anyone within the county can call.
- (Cmsr. L. May) The next to the last slide (sponsorship/leadership), I did not see any agencies from East County. I am wondering why East County is not represented – Pittsburg, Antioch, Oakley, Brentwood, Discovery Bay, etc.? (RESPONSE: Aisha Banks) We are working with the City Manager from Pittsburg, in the previous slide. Additionally, the City Manager from Antioch just joined and will be a part of the group. We do have on our team, law enforcement representatives from Antioch working on the mobile crisis collaborative response team. We do have east county representation, but they are listed in the sponsorship / leadership roles.
- (Cmsr. G. Swirsding) During the presentation, you mentioned not using EMS for transporting. I am wondering if EMS is not being used, what kind of service is used to transport a client? (RESPONSE: Aisha Banks) To clarify, I believe what you are referencing is the MCRT having the configuration of EMS / EMT being a part of the team. Part of the models we are discussion (other counties), may not necessarily use an ambulance or a police car to transport clients, but rather other types of vehicles such as SUVs or vans. The team was looking into using other vehicles for transport aside from an emergency vehicle, which can add to a heightened situation if someone is crisis. Rather trying to look at alternate modes of transportation.
- (Cmsr. L. Griffin) This RIE is just focused on adults, correct? No youth/children? How are they handled? Are they a part of this or will there be a separate event for them? (RESPONSE: Aisha Banks) The model is looking at both youth and adults. The MCRTs would have a dispatch either way.
- (Cmsr. K. Maibaum) How many are in a team? And how long is the training? (RESPONSE: Aisha Banks) The team compositions are currently still in progress with the MCRT configurations. This would depend on the response needs and

were looking to have a community crisis worker that would have lived experience and would have training based on the SPIRIT program, but it is still yet to be defined. There are still cost configurations regarding who should and what be on the team. The configurations are still being worked through and do not necessarily have this set yet. We are working on models using calculations to determine how many teams are needed per county region in order to have enough for the different regions. Multiple county models are being looked into as examples for input in our set up. We have Seneca mobile response on the team to help work on the configuration for the MCRT and other Best Practices. • (Cmsr. G. Wiseman) I have a two-part question (a) It is my understanding the MCRT misses approximately 80% of the calls that come in (unanswered). Secondly (b) when we looked at the assessment tool, is this a county-wide standard assessment tool? (RESPONSE: Part (a) Steve Hahn-Smith and Part (b) Cmsr. B. Serwin) MCRT is a rather new program and small. Not having enough resources is one of the big issues going on here. Being able to respond as a team of four (4) when it is two teams of two (2) and they are out on a response and people are calling, they are already out. It is a resource issue and that is part of the goal, to build up number of teams that can go out. (Kennisha Johnson) As we are thinking of future ideas, we are requesting to have dedicated call takers who can answer phone calls and provide the escalation or deploy a team. We are also looking at call volume within our system to understand how many are outreaching to MCRT; then using those numbers to configure how many teams would be needed to effectively respond to demand in the future. We do not have enough currently. Most calls are handled by not going out, but handled over the phone and through providing information, and de-escalating over the phone. So, approximately 25% of the calls actually go out in the field. There is a whole cross-section we need further research. • (Y'Anad Burrell) I was curious, when the calls come in, actually identifying the level of response needed. How do we work with those who are identified as an actual call to then dispatch and ensure an effective support team responds? (RESPONSE: Aisha Banks) This was covered by Cmsr. Serwin discussion on the triage tool. The triage tools help to standardize what the call looks like, so it helps to inform the person on the call, what the response should be based on criteria. The group is still working on this triage tool and reviewing/incorporating these criteria. (Cmsr. B. Serwin) That was pretty complete. The triage protocol is meant to standardize the process. The established criteria for making these decisions (e.g., 5150 or safety issues).	
VIII. RECEIVE update on Hume site visit test and work on building a site list, Commissioner Laura Griffin and Commissioner Barbara Serwin, Quality of Care Committee	**Due to time constraints, this Agenda Item will be added to the June 2 Meeting Agenda**
IX. VOTE on proposed by-law change regarding mandatory attendance of Mental Health Commission meetings CURRENT LANGUAGE: *a) "Regular attendance at Commission meetings is mandatory for all Commission members."* *i) "A member who is absent from four (4) regularly scheduled Commission meetings in any calendar year shall be deemed to have resigned from the Commission."* PROPOSED LANGUAGE (IN BOLD): *a) "Regular attendance at Commission meetings is mandatory for all Commission members."*	

i) *"A member who is absent from four regularly scheduled full Commission meetings in any **consecutive twelve-month period~~, as opposed to calendar year~~**, shall be deemed to have resigned from the Commission."*

Comments and Questions:

- (Cmsr. L. May) The changed language, I still do not agree. Also, what we put before the Board, I believe it is time for us to wait until we receive feedback from them because there is information about this missed meeting and mandatory meetings, there is information regarding that, and we need to wait until we get feedback. This just defeats our proposal we put before the BoS.
- (Cmsr. J. Kincaid) We have been talking about this for months. The problem is that if there is an absent member routinely, we have problems with quorum. It changes the number if we have commissioners that don't attend, it is a real problem. Also, there is the distribution of the workload if someone simply doesn't attend. In terms of the concept, this is in our existing bylaw which were approved. I have always wondered about our ability to do this when commission members are appointed by members of the BoS. It has been in the bylaws all along, so I guess we can, but in terms of language, I would like to say that I would remove the words 'as opposed to calendar year' because they are redundant. If you are going to redefine it as consecutive 12-month period. You do not need to reference 'as opposed to calendar year'. The point is, you want to see someone attending regularly and not missing more than a third of the meetings. As a concept that seems pretty reasonable.
- (Cmsr. D. Dunn) Commissioner Kincaid, you covered the comments I wanted to make.
- (Supervisor Andersen) On this specific topic, there are other committees and commissions where attendance requirements are also respected. If the bylaws are amended to request a commissioner be removed for failure to attend, I am quite certain my colleagues would agree. We want active commissioners. That is why we appoint people because we want them involved. With this bylaw amendment, if this is what the majority of commissioners think will ensure the best way to have this commission work smoothly, have engagement, and not have undue burden on others, I would recommend this be passed on to the internal operations committee and put it on the same agenda as we also talk about the appointment to the commission bylaw change and put both items on the IO (internal operations). Once it goes through IO, we do take public comments and everyone is welcome to come, we weigh in and have county counsel look at it to ensure there aren't any irregularities. Then it just goes before the full board on a consent.
- (Cmsr. B. Serwin) As Commissioner Kincaid pointed out, attendance being mandatory is already part of the bylaws. This is simply changing the way the absences are tracked. Right now, a commissioner can miss up to three meetings in a calendar year. The fourth, they are considered resigned. So, they can miss a meeting in October, November, and December. The calendar year starts in January and they could miss January, February and March and still be fine. Meaning they can miss six meetings in a row with the language as it is. The new language provides that it is a rolling twelve month. Within a 12-month period there is a maximum of four meetings that can be missed.
- (Cmsr. G. Stern) I'd like to address the Zoom meeting issue. We have been able to meet with significantly more attendees during this pandemic because it is on Zoom. That, alone, has provided us with way more participation than we have ever had in the past. I understand there is the Brown Act regulation that requires physical participation during normal times, but I'd like to propose we change that regulation to continue on Zoom for more participation and make it easier to attend.

  (Supervisor Andersen) It is really important to note that the Brown Act isn't just a county or commission rule, it is a State Law. We also have the Better Government Ordinance for Contra Costa County. Right now, there are three

different bills pending in the state legislature that would allow commissions to continue to meet remotely, or partially remotely, and we do not know the outcome of these. We are very supportive on the BoS, as we recognize there is much greater attendance when you can meet remotely. We are just waiting to see what the legislature does. We, of course, have to be compliant with the Brown Act. There are things we can do, now that we have the technology set up, where even under the old version, as long as you had a majority of the commission within CCC, other members can participate remotely via Zoom or phone, but would need to list where they were on the minutes. The BoS is supportive but we will need to wait to see what the State legislature passes.

- (Cmsr. G. Swirsding) One of the reasons I joined the commission is to get out of the house. I feel isolated and would like to attend in person. I hope we can have meetings to meet together.

- May 5, 2021 By-law change re: mandatory attendance. **Motion:** D. Dunn moved to approve the motion with corrections. Seconded by J. Kincaid.
  Vote: 11-1-2
  Ayes: G. Wiseman (Chair), B. Serwin (Vice-Chair), C. Andersen, D. Dunn, L. Griffin, J. Kincaid, K. Lewis, K. Maibaum, J. Metro, K. Monterrey, G. Stern
  No: L. May **Abstain:** A. Russaw, G. Swirsding

X. VOTE on proposed new By-law change regarding mandatory Committee membership and attendance

a) "Regular attendance of one standing Commission Committee, with the exception of Executive Committee, is mandatory for all Commission members."

i) "A member who is absent from four (4) regularly scheduled Commission Committee meetings in any calendar year shall be deemed to have resigned from the Committee. In such event the former Committee member's status will be noted at the next scheduled Committee meeting and shall be recorded in the Committee's minutes. The resigned member shall choose a different Committee on which to serve."

PROPOSED CHANGES (IN BOLD):

*i) "A member who is absent from four (4) regularly scheduled Commission Committee meetings in any **consecutive 12-month period,** shall be deemed to have resigned from the Committee. In such event the former Committee member's status will be noted at the next scheduled Committee meeting and shall be recorded in the Committee's minutes. The resigned member shall choose a different Committee on which to serve."*

Comments and Questions:

- (Cmsr. B. Serwin) This proposed bylaw addresses the need for an adequate number of committee members to get the work of the commission accomplished. Ever since I have been part of the commission (and speaking to others that have served longer than I have) we all believe membership on a committee was mandatory. It his how things work and run. I am unsure what brought it up, but we finally figure out this was not the case. This bylaw is being tendered to ensure everyone is participating in the commission at a hands-on level and that we have enough people to actually do the work we are charged with doing, as well being evenly distributed across all commission members. That is the nature of this suggested bylaw.
- (Cmsr. L. May) Once again, this bylaw like the last one, seems a way to 'go around' the proposal I wrote on February 24th, 2021. The mental health commission bylaw amendment. It is a way to change things before this takes place. I was on several committees when I took a job in October and I will miss two (at most three) meetings and will be back. When I did return, someone had

taken my position on the committees. I was kicked off and not given the respect when I did announce to everyone that I was taking this particular job and would be absent for a set amount of time. Both of these proposals seem to be a way to get around the bylaw amendment that I have proposed, which has to do with unplanned absences, such as catastrophes or family emergencies/illnesses.
(RESPONSE: Cmsr. B. Serwin) This proposed bylaw, which is really about making membership of a committee mandatory, this was voted on by the Executive committee over a year ago. It precedes the proposal you have put forward by many months. It is my understanding, the proposal you put forward has begun discussion in the Executive committee level and will continue next month. There is no relationship between the two.
(RESPONSE: Cmsr. G. Wiseman) Thank you Commissioner May. Actually, this has been discussed numerous times at the Executive committee level and voted on, and we finally have it here for the full commission to hear and vote. The bylaw proposal that you submitted for excused absences (what mandates and absence) has not cleared Executive committee in time to be put on this agenda. It does not, in my mind conflict, but is open for discussion on the next Executive committee meeting, and hopefully the full MHC meeting next month. Hopefully, that answers your questions on this.

- (Cmsr. D. Dunn) Do we want to seek out and modify this motion to agree with the previous agenda Item "consecutive 12-month period" as opposed to a calendar year period. For consistency, do we want to sync up this so that the language agrees with the previous agenda item.
- (Cmsr. J. Kincaid) I would say, yes, make consistent.
- (Cmsr. G. Swirsding) One of the committees I am on, we are interviewing people. For me, at this time, I just cannot. Most of the time, I am able to do anything, but I am having a very hard time speaking to anyone I do not know. What do we do about that aspect? If I want to participate but I am unable to?
  (Cmsr. B. Serwin) You must be referring to the SVP, there is a difference between attending the monthly committee meeting and extra committee work that people volunteer for. So, there is no requirement that we go above and beyond that monthly meeting attendance. You are not required to unless you have signed up for. If you would like to participate on the committee or you are on the committee and it is difficult for you to make the meeting times, it is up to the committees to determine when they are going to meet. The only request is it be consistent. So, if that has been prohibitive and there is a committee you are interested in and can't make it when they meet, let the chair know and they can work on that.
- May 5, 2021 By-law change re: mandatory committee membership and attendance. **Motion:** J. Kincaid moved to approve the motion with corrections. Seconded by D. Dunn.
  Vote: 11-1-2
  Ayes: G. Wiseman (Chair), B. Serwin (Vice-Chair), C. Andersen, D. Dunn, L. Griffin, J. Kincaid, K. Lewis, K. Maibaum, J. Metro, K. Monterrey, G. Stern
  No: L. May **Abstain:** A. Russaw, G. Swirsding

XI. RECEIVE Behavioral Health Services Director's Report, Dr. Suzanne Tavano

May is Mental Health Awareness month. We discussed whether or not we would move forward a proclamation this year and decided to wait and do a bigger event next year but do want to let everyone know that the Putnam Clubhouse is hosting a 'Sweep Away Stigma' virtual event on May 14th. I will forward the information to Ms. Beck and she can make it available to all of you. Again, it is on May 14th from 1:00pm to 4:00pm.

- COVID update: At this point, there has been 1.1 million doses of vaccine administered within Contra Costa County. Currently, over 68 percent of our community has been partially immunized and over 46 percent have been fully immunized. This is based on data from the end of last week, so the numbers are actually a bit higher, there is a very high availability of the vaccine. If you know of anyone within the county (or even outside the county) who has not yet been vaccinated, please let them know to go to the CCHealth.org website and they will be able to make an appointment. Walk-in sights are opening, as well. The county has a very ample supply of vaccine. We are trying to pivot from the general population and start looking at the parts of our community members that are hesitant or have been rejecting, and how we can perform better outreach and education.

  We are particularly concerned with the young adults, many of whom have not been wanting to get vaccinated and we are seeing a rise in cases with that population and increased hospitalization. How do we encourage our younger adults to join in cause to get vaccinated? That is our focus. We are looking at who else in our population that has not been vaccinated and to better conduct outreach and education. Youth 16 and above are able to be vaccinated and anticipate in the very new future, those 12 and above will be eligible for vaccination. This will be widely publicized, public health has already been working on a plan for mobile vans go to school sites and, with guardian approval, vaccinate kids right there on site at the school. We really trying to reach deeply into our community now to get the remaining residents vaccinated. That is the best protection, and we are still advising masks. There has been a bit of confusion with conflicting guidance. We are still paying a lot of attention and enforcing guidance.
- Right now, we are finishing a project of identifying all of the clients that receive behavioral health services with us, those who have vaccinated and those who haven't been, we are going to bring it down to the program level so clients in various programs we will know to perform very targeted outreach to them. We are considering reopening the out-clinic vaccination sites at the three regional mental health clinics. We are looking at the data to determine if it is feasible to reopen and serve a purpose. We are still making calls to get clients into external sites as much as possible.
- May, 14 months post, looking at what has been happening with utilization of our services. Initially, the first several months was a decrease in PES, decrease in the number of hospitalization and a decrease in calls to the MCRT and the MRT. As we moved into the summer, late summer we started to see some small increases and we are seeing a steady increase in all those areas. Just as we were concerned about underutilization, we are keeping track of the high-level services (PES, hospital, and mobile crisis). This may or may not have a correlation to some of the data, we suspect it does. Pre-COVID our services break down as:
  - 45 percent - in person (in clinics)
  - 1.7 percent - telehealth (Zoom)
  - 2.5 percent – phone

  This is not going to total 100 percent because in these numbers, I am not including field visits that occur (either) out in the community or in homes. As you know, last March, we pivoted very quickly. What we are seeing now is:
  - 18 percent - in person (in clinics)

- 11 percent - telehealth (Zoom)
- 33 percent – phone

When people speak about remote services, they tend to just think remote services, but we are looking at this a bit more discreetly. Telehealth is distinctly different than telephone. Telehealth they are having a live interaction where they see each other. With the telephone, you are on the phone and do not visualize the other person. I am concerned we are missing important information by not being able to have eyes on clients. This is an important part of knowing how they are doing in the world. We are now in the process of pivoting back to providing more in person visits with all the workforce coming back (not at same time/same day). Even if they are still providing some services remotely but starting to bring people back into the workplace and increasing our in-person visits. As Commissioner Swirsding mentioned earlier, social isolation is not good for anyone and we have worked so hard to decrease social isolation for those we serve and to really build social inclusion. With the pandemic and everyone staying away, those two important goals have really been impacted and how do we come of this and safely start seeing people in person to better meet their needs.

- In 2019, we served about 21,300 individuals. In 2020, it went down to 20,479. On one hand, that is almost 1000 individuals. It is significant and we shouldn't be losing track and losing contact with people. Moving back, we should be able to re-engage with those we have lost contact with during this past year.
- Fortunately, we are seeing a downward trend in suicide over the past year. That is a positive. The negative is that it was still over 90 members of our community who committed suicide over the past year. The trend line is down from previous years, but we are still paying attention to it. We did release a request for proposals for some more intensified suicide prevention work in the community. We have not yet announced who that award is going to but are working on that and should be announced soon.
- The number of people in our community who died from intentional opioid overdose, that number exceeds the number of people who intentionally committed suicide. 117 opioid related deaths which is an increase for our county, and we are definitely looking. Very few have been receiving substance use services. Those who had been receiving substance use services, did not fall into that overdose group. It means our services are effective, we just need to re-engage so they are receiving services.
- Addressing fentanyl and methamphetamine treatments and looking into a number of new services.
- There was a decrease in specialty services, now the number is starting to go up significantly. Those who did not seek services previously are now requesting services, predominately anxiety and depression.
- Grant updates: From last month, we received the initial reward from CHFFA (Cal Health Facilities Financing Authority), $2.3 million to establish a youth crisis stabilization unit. We are hoping to go before the BoS on May 18th regarding CHAFEE Grant. Last Thursday (4/29) we went before the CHFFA board and received our full award notification. It is official and will be going to the BoS for their consideration for us to accept. If we can accept, we have already been conducting some preliminary planning work and will bringing forward some of the conceptual ideas to the MHC in the near future.
- Federal earmarks came back this year and submitted two proposals to Congressman DeSaulnier and received positive feedback. The staff will be forwarding our proposals to the full legislature appropriations committee for consideration. Congressman DeSaulnier wanted all of you to know that he is very interested in this whole area of behavioral health. The two proposals submitted were (1) to Revitalize the Oak Grove campus so it can be fully utilized and

potentially become the crisis HUB; and (2) Expansion of our MCRT. We had 3.5 for a very large county, which is not enough. We also included addition of substance use counselors to the teams. • Today, we submitted the proposals through Senator Feinstein's portal, so she can also be considering them, if they move to include the senate. • We continue to look for every grant possible. **Comments and Questions:** None.	
XII. Adjourned Meeting at 6:34 pm	