MENTAL HEALTH COMMISSION
MONTHLY MEETING MINUTES
June 2nd, 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. Laura Griffin, District V Cmsr, John Kincaid, District II Cmsr. Kathy Maibaum, District IV Cmsr. Leslie May, District V Cmsr. Joe Metro, District V Cmsr. Alana Russaw, District IV Cmsr. Geri Stern, District I Cmsr. Gina Swirsding, District I Members Absent: Cmsr. Douglas Dunn District III Presenters: Priscilla Aguirre (Quality Management Program Coordinator) Jennifer Bruggeman (Program Manager, Mental Health Services Act) Matthew Luu (Deputy Director of Mental Health) Other Attendees: Grace Ash Guita Bahramipour Angela Beck Y'Anad Burrell Theresa Comstock Gigi Crowder Amanda Dold Lisa Finch Carolyn Goldstein-Hidalgo Jessica Hunt Lynda Kaufmann Karen Lai Theresa Pasquini Pamela Perls Christy Pierce Dom Pruett (Supv. Candace Andersen's ofc) Stephanie Regular Lauren Rettagliata Rhiannon Shires Marissa Shaw Joni Spears	Meeting was held via Zoom platform
II. PUBLIC COMMENT: • (Lauren Rettagliata) Continuum of Care. What are we going to do and how are we going to accommodate those that are being sent back to the counties from the state hospitals? This is likely to happen. This may not be the worst thing that could happen if we were prepared for it. It might be a very good thing to have people who need and could receive the treatment and care they needed in our	

county, rather than sending them off to the larger state hospitals. We need to really take a deep look at that and expand our continuum care and our ability to have secured settings for those who are severely mentally ill.

- (Pamela Perls) I just presented an update on AB-988 to the East Bay Legislative Coalition which is a committee of Contra Costa and Alameda Developmental Disability Counsels, which I am associated with. I just wanted you to know what is left in California State Assembly member Rebecca Bauer-Kahan 's bill is just the Mental Health Crisis line. What they have stripped out is the Mobile Crisis Response Team (MCRT), which is very unfortunate. Just wanted to update you.
- (Gigi Crowder) I am grateful for what Lauren brought up. I am working with the Rapid Improvement Effort and I am on the Alternative Destination team, we are looking at Gap Analysis and it is really horrific that we have to go outside of the county to look for some of the programming we should have in this county for people who are most impacted by mental health. We are looking at a way to avoid PES (Psyche Emergency Services), which is the last option to look at – aka '5150'. I was reminded that two years ago today (right around this time), Tuan Hall called for enforcement to come and support her son, but the day before she had actually called to see if there was anything else that could have been put in place before Miles decompensated as much as he had. I am really optimistic about the AB-988, which legislation took out some of the language but are trying to put it back. It still has the very robust information regarding what we need to have in a HUB, which I am hoping will be called the Miles Hall Wellness HUB. Not crisis, but wellness, because we need to look more preventatively. We have a lot of great things happening her in Contra Costa County and I hope it has full support from, not just the Commission, but the Supervisors. I just want to say his name loudly! I can't even imagine the pain his mother is in today, losing her beautiful son, just because he lived with a mental illness and we did not the options available for her to get him support earlier. Say his name: MILES HALL.
- (Marissa Shaw) My name is Marissa Shaw; I am a member of the LGBTQ community and I have several other minority distinctions. I am also a person with a physical disability, as well as a diagnosis of depression. I applied to be a member of the MHC. I met with my supervisor and was never brought in front of the mental health commission to decide whether I could be placed. I looked up today that I applied three years ago and, basically, after speaking to my supervisor, nothing ever happened, no follow up. I speak to that because I know you all have a full agenda, but I am speaking to that because it is an item on your agenda, I believe it is Agenda Item X. I want to bring to your attention that I applied and there was no follow up. My understanding, if your website is correct, there are several other vacancies and would still like to apply if the opportunity presents itself but wanted to tell you what actually happened when I applied three years ago.
  (Cmsr. Wiseman) Thank you very much for sharing that Ms. Shaw. Each district supervisor is the one responsible for appointing people to the commission, so I encourage you to continue that discussion with your supervisor, to share your passion, continue attending our meetings and let them know that you are someone in the community who really wants their voice heard. That is the process. We do not pick who is on the commission, it comes through the supervisor. We can recommend people, and if we have your application, I am sure we can recommend. Which district are you in? Which supervisor do you have? (Marissa Shaw) John Gioia, District 1. (Cmsr. Wiseman) There is an opening in that district. I would recommend you speaking again to your supervisor. Supervisor Andersen, is there anything you would like to add to Ms. Shaw's comment? (Supervisor Andersen) No. Other than, each supervisor has their own process with all of their advisory body appointments. Typically (and I hope in your case) that someone on that supervisor's staff, at least, got back to you to say that there has been a selection after considering all the applicants. For me, I always interview everyone, but also follow up after to let people know they have not been selected. Often times, let them know of other opportunities

they may want to apply for as well. I am sorry if that didn't happen in your case. Each supervisor has their own process. In July, we will be discussing the process for appointing mental health commissioners, what is in the bylaws and a bylaw change based upon some input from another supervisor, before our internal operations (IO) committee, a subcommittee of the Board of Supervisors). You are certainly welcome to attend that meeting. If you would like to email my office (SuvervisorAndersen@bos.cccounty.us), we can give you the date of that IO meeting and you are welcome to attend and provide additional input.

- (Y'Anad Burrell) I wanted to follow up on the comment Marissa made, as well. I am also in District 1 and applied approximately a year or so, ago. Also never received a response, multiple emails to my supervisor and to the leads there. When the position was filled, there was never any follow up that it was filled. So, it is open again. I will try this again and definitely will put an application forward. It is beyond a passion for me, it is my life's work, something I have been a part of for many years. Particularly focused on children and youth in this this space. We will do this again. I just heard something new, Graham, where you said a commissioner could recommend? I did not know that. I will be reaching out to one of the commissioners here and hopefully get some support. Thank you.
- (Theresa Comstock) Hi, Theresa Comstock with the California Association of local Behavioral Health Boards and Commissions. One of your members had reached out to me to connect today, I think because of this issue. I just wanted to remind the members of the commission, most of the supervisors around the state have probably 40 or more boards and commissions to fill. So, it is terrific when you have a process of vetting and inviting people, connecting with them, and finding those to help with the diversity and including people that intersect all the various of sectors that are associated with mental health. I just wanted to encourage you that way.

III. COMMISSIONER COMMENTS

- (Cmsr. Gina Swirsding) Continuing on to Lauren Rettagliata's comment, regarding the homeless. It is also my focus as there are a number of homeless veterans and I am very involved with veterans' services. I am also concerned with older adults. There are more and more older adults and veterans with mental illness, plus they are homeless. Some have lost their Medicare. The Veteran's Administration added Medicare to their package. Because of their disability and the rules of Medicare, they lost their Medicare, as a result, many have become homeless. I just want to make that clear. I wish we had something involving this. I am involved with the homeless in my area (my district) but not with the commission. I am extremely concerned when there are older adults and severely mentally in these homeless camps because some are abused.
- (Cmsr. John Kincaid) Just wanted to briefly address the commission. This is my last full commission meeting. I wanted to say goodbye and speak to how impressed I am with the dedication, the knowledge, the life experience that I have seen on the commission and that I have seen among community members, prior commissioners and, really it has been quite an impressive experience. I wanted to thank you all. (Cmsr. Wiseman) Thank you very much, Commission Kincaid. You are not going to get off that easily. We will certainly miss you, again the depth of knowledge, the ability to wordsmith what we are thinking into the written word is unmatched. We will sorely miss you on the MHC. Thank you for all the time you have been with us and hope you will continue to contribute a member of the public as we go forward.
- (Cmsr. Gina Swirsding) There are a lot of consumer seats that are empty. I am in District I; it is really hard to get consumers on the commissioner. It is difficult to understand why a consumer can't cross over to another section to fill seats. We have had long months of not enough consumers on the board. (Cmsr. Andersen) There is nothing that precludes another supervisor for making an out of district appointment. We do it all the time and, often times, if a consumer has a family

member who has mental illness and experience with it, they might also qualify from that perspective if the consumer seat is already occupied. Definitely that is a great option, and I was just going to say, in light of Dr. Kincaid's retirement from the commission, I am looking for a family member seat. We will be talking a little more about the appointment process, but I really encourage anyone on the commission that knows someone who is a family member, interested in serving on the commission, to reach out to my office and fill out an application. • (Cmsr. Gina Swirsding) I have another question, I am a health professional, in reality I am a consumer, but I can also be a member-at-large; Is it possible to change over? (Cmsr. Andersen) Typically, there are many different roles the commissioners can fill. In some ways, it is nice not to pick people to fill a certain role, it is really state law that does have a seat and you have to ensure there is fair representation of all sectors to get that perspective.	
IV. CHAIR COMMENTS/ANNOUNCEMENTS: • The final comment I have is regarding the Rapid Improvement Event. I attended one of the meetings and, honestly, was quite concerned by what I saw going on. The process, for me coming from the private sector, the first question I asked was what was the budget? The answer was whatever we want to spend. That is not the correct approach to have when building any kind of program. I was disappointed, a little surprised and now I am questioning the value of that entire process if its approach is we have all the money we want to spend. That is the feedback I was receiving. It is also somewhat disappointing to hear that our sister county (Alameda) already has a process in place, Los Angeles already has process in place, and we have decided to ignore and start from square one. That is my comment on what I observed at the Rapid Approvement Event.	
V. APPROVE May 5th, 2021 Meeting Minutes • May 5, 2021 Minutes reviewed. **Motion:** L. May moved to approve the minutes as written. Seconded by J. Kincaid. **Vote: 10-0-0** **Ayes:** G. Wiseman (Chair), B. Serwin (Vice-Chair), L. Griffin, J. Kincaid, K. Maibaum, L. May, J. Metro, 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) Commissioner Graham Wiseman (District II) – The reason Commissioner Wiseman chose to serve on the MHC is that in 2013 he lost his son Colin to suicide. He was 15 years old and a sophomore at Acalanes High School. It was a devastating event for him, his family and all those that knew Colin. His funeral was attended by almost a 1000 people and he had no idea that he had that much connection with the community because he felt so alone. Commissioner Wiseman took that pain and turned it to a purpose of working to provide support for mental health in our county and beyond. He was successful in working with two other parents and getting mental health wellness centers in the Acalanes USD so that all campuses (Campolindo, Acalanes, Miramonte, Los Lomas and the independent study campus) have wellness centers now, to help kids as they experience crises. This could be anything from a breakup to a severe mental break. That process led him to champion that a small group of people dedicated with a good solution can make a difference. He contacted Supervisor Andersen's office when there was an opening to make a difference. His life has been all over the world. He was born in Iran, lived in London (where his parents are from), Ghana, Nigeria, Boston, Vancouver B.C., Sydney, and Cambria Australia. This has given him the opportunity to look at other cultures and how they deal with mental health and youth supporting youth. He hopes to bring some of that	

wisdom to the MHC. He is also very active in corporate sales, in an environment that most do not actually thrive in. If you don't sell, you don't eat. It drives him to the view of 'why are you still talking about this three months later, we should have acted' and tries to control that perspective, but it does come out often. His purpose of serving on the MHC is to serve youth, be a voice for parents that have kids struggling with mental health issues and make improvements in our county, not just for his community, but for the entire county and beyond. Commissioner Leslie May (District V) – The reason Commissioner May chose to serve on the MHC, she has family members (a child and grandchild) that has severe mental illness, as well as 10 of 14 cousins (all siblings) with mental illness. They lived in Bay Area and she would observe her mother work with all these older cousins. When her mother passed away in 2004, prior to her passing, she told Commissioner May that it was her turn to take care of her cousins because they all have mental illness. She did not realize it when she was younger. She is from New York. Her ethnicity is Black and Irish (maternal) and Native American (paternal). She was the first black infant born in Lebanon Hospital in the Bronx, New York. When she was a year old, they moved to Berkeley as she was born with severe physical disabilities (everything from her waist down was turned the opposite direction). As a young black girl growing up in Berkeley she was accepted; however, once the family relocated to Oakland, she was not accepted and bullied. She suffered severe depression and was sent to Oregon to live with her grandparents and within one year, she was well and came back to California and continued her education. Through all the turmoil, being subjected to constant bullying and abuse, and suffering from depression, she sought to work with others with physical disabilities and mental health issues. She volunteered and worked with BAS for many years throughout Alameda County. Once Commissioner May relocated to Contra Costa County, as a retired teacher, she started a new career in the mental health field as a psychotherapist to help heal those that did not have the support and opportunity to heal as she did. She loves what she does and serving all populations of the community and is fulfilling her purpose as she works in the mental health field.	
VII. RECEIVE Presentation of External Quality Review Organization (EQRO) Report, Priscilla Aguirre, MPP, Quality Management Program Coordinator, Quality Improvement & Assurance Unit, Behavioral Health Services (BHS) Contra Costa County External Quality Review Organization (EQRO) Report for FY 2020-21 Introduction. The US Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) requires and annual independent external evaluation of State Medicaid managed care programs by an external quality review organization. Behavioral Health Concepts (BHC) is the external quality review organization that has been reviewed the Mental Health Plan the past four years, and are locally based in Emeryville, California. This review period was for FY 2020/21. In preparation for the review, all supporting documentation was provided to the EQRO in January 2021. Each year, my team and I submit approximately 2,000 pages of documentation to the EQRO. This year, because of the pandemic, our counties were consulted to determine the best course of action for conducting the EQRO site visit. Onsite review was scheduled for February 2-4, 2021; however, with the county still in the purple tier and months away from seeing the impact needed from vaccination, it was decided to work with BHC and conduct the review as a desk audit only. As a result, there was no onsite meetings and/or focus groups conducted by the EQRO this year. The report is drafted by the EQRO and approved internally, it is sent to the DHCS for their review and approval. The EQRO then sends to the county to review the draft report. After the draft report has been reviewed, we are given a short deadline to provide feedback on the draft report. Once we submit feedback, the EQRO responds	The EQRO Report Presentation to the Mental Health Commission was shared as a PowerPoint Presentation during the meeting. The EQRO Report for FY 2020-21 was included as a handout in the meeting packet and is available through the QI/QA Unit.

to our feedback and then issues the final report. This year's final report was issued earlier this month.

Why is the EQRO and its Findings Important?

One of the exercises we go through as a division as part of the EQRO is to review significant changes and initiatives that occur through the year and summarize those efforts to the EQRO. This gives us a sense of:

- Areas of Strength / Accomplishments
- Opportunities to improve / areas of deficiencies, make our system of care better
- Provide better quality, access and timeliness of the services provided to beneficiaries/consumers
- Incremental transformation of our system of care

Key Areas of the EQRO Report

- Prior Years Recommendations, FY 19-20 (p 10 - 15)
  - Access to services:
    - ◊ Spanish language translation to the mental health pages of the county website – Not Met
    - ◊ Investigate the bilingual pay differential to like-sized counties and adjust accordingly – Met
  - Timeliness:
    - ◊ For children, 64.78 percent of first offered appointments meet the 10-business day standard – Met
    - ◊ Include contractor data in timeliness reports and use of aggregate reporting – Met
    - ◊ Improve the FY 2018-19 rate of 43.1 percent of psychiatric appointments offered within 15 business days – Met
    - ◊ Improve the current rate of 41.8 percent of follow-up hospital discharge appointments that are within 7-days – Not Met
  - Beneficiary Outcomes:
    - ◊ Prioritize and implement aggregate reporting for the Adult Needs and Strengths Assessment (ANSA), Pediatric Symptom Checklist (PSC- 35), and Child and Adolescent Needs and Strengths (CANS-50) – Met
  - Foster Care:
    - ◊ Prioritize credentialing for Community Based Organizations (CBO) offering children's services to allow for expanded access for FC youth – Partially Met
    - ◊ Finalize and implement the draft tool which specifically evaluates the fidelity of Intensive Care Coordination (ICC) and In-home Based Services (IHBS) in accordance with the Integrated Core Practice Model (ICPM) – Met
  - Information Systems:
    - ◊ Explore options to create interfaces with CBO EHRs to support electronic transmission of service data into ShareCare. This will eliminate the double data entry CBOs have to support to record services in both their own EHRs and the MHP's billing system – Not Met
    - ◊ Provide ShareCare training to CBO users on a regular monthly basis to increase their competence level working in the application – Met
    - ◊ Ensure the CBO Authorizations Work Group reviews the utilization review workflow of approving/denying/pending CBO intake treatment plans for process improvement to reduce the likelihood of services entered by CBOs in ShareCare being flagged as unauthorized – Met
  - Structure and Operations:
    - ◊ Strengthen the IT unit by either hiring or appointing an appropriate staff member to an IT leadership position within the MHP. Increase Behavioral Health Systems (BHS) leadership presence and participation on both the IT Steering and Data Governance committees – Met

- ◊ Implement a mechanism to track CBO communications and feedback along with MHP responses. Evaluate past attendance at bimonthly contractor meetings and improve attendance and/or increase participation – Met
- ◊ Identify and replace antiquated credentialing processes and implement a mechanism which holds credentialing staff accountable to best practices which do not delay direct service staff from providing services to beneficiaries – Met

- Performance Measures (p 16 - 26)
  - Higher than Statewide Averages
    - ◊ Overall Penetration Rates
    - ◊ Overall Approved Claims per Beneficiary
    - ◊ Latino/Hispanic Penetration Rates
    - ◊ Latino/Hispanic Approved Claims per Beneficiary
    - ◊ Foster Care Penetration Rates
    - ◊ Foster Care Approved claims per Beneficiary
  - Above Statewide Averages
    - ◊ Percentage of high-cost beneficiaries
- Performance Improvement Projects (PIPS)(p 27 - 36)
  - Federally, we are mandated to have two PIPS running concurrently throughout the year. One clinical and one non-clinical PIP.
    - ◊ PIPS often times require us to be very data driven from both the problem perspective and a various perspective. Data must be collected throughout you plan interventions. Interventions must be creative and evidenced base, which can be challenging to implement in the short period of time using the PIP framework.
    - ◊ PIPS typically run two years. Depending on interventions may only run one year. Then you must also identify new ones to study.
      PIPS in this year's submission, as some of the changes in the EQROs methodology.
- Information Systems Review (p 37 - 52)
  Focuses on changes related to our IT systems and also discusses billing and claims processing.
  - Changes:
    - ◊ Implemented Provider Portal for all MH and AODS CBOs.
    - ◊ Began sharing medical information and MH partnership plans with beneficiaries through MyChart in support of ONC 21st Century Cures Act.
    - ◊ Implemented ANSA in ccLink and Objective Arts.
    - ◊ Implemented Zoom telehealth video conferencing, same day assessment tools and screening in response to COVID-19.
    - ◊ Completed CANS-50 improvements.
    - ◊ Implemented physician navigation and assessment documentation improvements and utilization review checklist improvements.
    - ◊ Implemented ccLink production upgrade to three times a year.
    - ◊ Upgraded to current ShareCare production version 8.15.5.
    - ◊ Contra Costa County MHP CalEQRO Report Fiscal Year 2020-21
    - ◊ Implemented clinician-facing productivity dashboards.
  - Next Priorities:
    - ◊ Client Services Information (CSI) timeliness documentation and reporting.
    - ◊ •Timely production upgrades for ccLink three times a year.
    - ◊ • Maintain current ShareCare upgrades.
    - ◊ • Information blocking – ONC 21st Century Cures Act.
- Performance Key Components (p 58 – 64)
  This is all the areas of the EQRO review and how we are evaluated based on the

EQRO scoring system.

Components Evaluated in the MHP	FY 19/20	FY 20/21	Max Poss
• Access to Care Components			
◊ 1A Service Access and Availability	13	10	14
◊ 1B Capacity Management	10	10	10
◊ 1C Integration and Collaboration	24	24	24
• Timeliness of Services			
◊ 2A First Offered Appointment	10	16	16
◊ 2B First Offered Psychiatry Appointment	9	11	12
◊ 2C Timely Appointments for Urgent Conditions	8	13	18
◊ 2D Timely Access to Follow-up Appointments after Hospitalization	8	8	10
◊ 2E Psychiatric Inpatient Rehospitalizations	6	6	6
◊ 2F Tracks and Trends No-Shows	6	6	10
• Quality of Care			
◊ 3A Cultural Competence	NA	12	12
◊ 3B Beneficiary Needs are Matched to the Continuum of Care	12	12	12
◊ 3C Quality Improvement Plan	10	10	10
◊ 3D Quality Management Structure	14	14	14
◊ 3E Quality Management Reports Act as a Change Agent in the System	10	10	10
◊ 3F Medication Management	12	12	12
• Beneficiary Progress/Outcomes			
◊ 4A Beneficiary Progress	12	12	16
◊ 4B Beneficiary Perceptions	10	10	10
◊ 4C Supporting Beneficiaries through Wellness and Recovery	4/4	10	4/12
• Structure and Operations			
◊ 5A Capability and Capacity of the MHP	26	26	30
◊ 5B Network Enhancements	18	18	18
◊ 5C Subcontracts/Contract Providers	12	12	16
◊ 5D Stakeholder Engagement	2	12	12
◊ 5E Peer Employment	8	8	8

- Summary of Findings including Recommendations, FY 20-21 (p 65 - 71)
  - Performance Improvement Project (PIP) Status:
    - ◊ Opportunities for Improvement: N/A
    - ◊ Recommendations: Seek ongoing and regular technical assistance (TA) from CalEQRO in the continued implementation of its PIPs
  - Access to Care:
    - ◊ Opportunities for Improvement: The MHP's website does not include Spanish language translation to the mental health pages which could be remedied through an embedded browser feature or by providing Spanish language links to services with descriptions and contact information. *Recommendation from FY 2019-20.*
    - ◊ Recommendations: Include Spanish language translation on the mental health pages of the county website through an embedded browser feature or by providing Spanish language links to services with descriptions and contact information. *Carry over from FY 2019-20.*
  - Timeliness of Services (2):
    - ◊ Opportunities for Improvement: The MHP's timeliness data on hospital discharge follow-up appointments appears inconsistent, as the MHP reports that 38.8 percent of appointments meet the 7-day standard while the reported wait times average eight and ten days for adults and

children, respectively. This relates to a FY 2019-20 recommendation to improve the then-current rate of 41.8 percent.
    - ◊ Recommendations: Improve the FY 2019-20 rate (38.8 percent) of post-hospitalization follow-up appointments meeting the 7-day standard, while ensuring accuracy of the data. *Carry over from FY 2019- 20.*
    - ◊ Opportunities for Improvement: With an overall no-show rate of nearly 20 percent, the MHP's no-show rates fail to meet its 10 percent standard by a large margin.
    - ◊ Recommendations: Investigate the reasons for high no-show rates starting with the clinician no-show rates..
- Information Systems (3):
    - ◊ Opportunities for Improvement: The MHP's capacity to evaluate would benefit from implementation of behavioral health dashboards and the migration of custom databases.
    - ◊ Recommendations: Automate the service interface between community-based organization (CBO) EHRs to Sharecare to eliminate double data entry. *Carry over from FY 2019-20.*
    - ◊ Opportunities for Improvement: The MHP's ability and efficiency to focus on service delivery would improve by completing the service interface of CBO EHRs to ShareCare.
    - ◊ Recommendations: N/A
    - ◊ Opportunities for Improvement: The MHP plans to complete the EHR's implementation of the Electronic Signature for MHP Beneficiaries and will consult with other counties for resolution of roadblocks.
    - ◊ Recommendations: Complete the EHR's implementation of the Electronic Signature for MHP beneficiaries.
- Structure and Operations (3):
    - ◊ Opportunities for Improvement: Display prominently the crisis/suicide hotline phone number on the MHP's main webpage.
    - ◊ Recommendations: N/A
    - ◊ Opportunities for Improvement: Additional resources are needed for the successful recruitment and retention of the Office of Informatics and Technology staff.
    - ◊ Recommendations: Evaluate whether resources are sufficient for the successful recruitment and retention of the Office of Informatics and Technology staff. Augment when gaps are identified.
    - ◊ Opportunities for Improvement: The MHP continues to rely on a hybrid medical record chart.
    - ◊ Recommendations: N/A

Comments and Questions:

- (Cmsr. G. Wiseman) Thank you, very much. That was an 80+page document and you really summarized it very well and want to congratulate you on that. It looks like, despite all the traumas we have gone through with COVID, your department did really well. Are pleased and feel good about the review you received? (RESPONSE: Priscilla Aguirre) I am very pleased because it was a very tough year for everyone. I am sure everyone in this meeting can attest to it being a very hard year. We were very thankful to see the results, but we also know that it was very stressful time for everyone.
- (Cmsr. L. May) This report is from the programs that received MHSA funding, is this all Medi-Cal, where are these numbers coming from? (RESPONSE: Priscilla Aguirre) The EQRO is primarily focused on Medi-Cal beneficiaries. That is who they are obligated to review. In the past, MHSA had more involvement, a section around MHSA documentation. However, there have been numerous structural changes how the mental health plans are reviewed. Their focus is on Medi-Cal beneficiaries. There are organizations funded by MHSA that do serve Medi-Cal beneficiaries and are part of this data set.

- (Cmsr. L. May) There needs to be inspection and accountability within these agencies, from what I understand and have first-hand knowledge (in some cases), the number of people served, especially during 2020, was very low. I am hearing from quite a few sources that they were really underserved. Wondering where more funding is available. You stated there were recommendations were made in 2020, where they effected or different during covid. It seems the numbers should have gone up, due to people not having to worry about transportation. It was basically virtual counseling, and it seems to me the people that are on Medicaid, there should have been or services provided to them in reality than have been reported. What really happened, why did the numbers not go up?
- (Cmsr. J. Kincaid) I would like to echo what Commissioner Wiseman said. The data looked really good over the year with COVID. I am concerned about people who present with acute symptoms or problems and are not getting in to be evaluated soon enough. It has been a chronic problem. Not sure if it is your department's role to try to address or recommend solutions, but I hope that is something we can tackle in the near future.
- (Cmsr. B. Serwin) I am wondering how the PIPs are selected. You may have already covered this, so forgive me if you have. (RESPONSE: Priscilla Aguirre) Typically, the PIPs come by way of data. It is data driven. We are required to review a variety of data in our quality management committee and the data is one of the challenges. In some cases, we know of problems anecdotally, and know there are problems we hear from a variety of stakeholders; however, for a PIP to line up with the methodology for the EQRO, it has to be heavily data driven. We DO have a lot of data, but we also have some that actually doesn't show there is a problem necessarily. For example: the satisfaction survey that are done twice a year, typically a lot of counties do look to their satisfaction surveys to see if the beneficiaries are indicated certain areas they are experiencing (greater) dissatisfaction; some of those results have stayed consistent. That makes it hard, from the standpoint of a PIP to utilize that data and put an intervention in place to see if the scale will tip and experience change in the results. They tend to be consistent. This is something to where we would like to use other tools that are more actionable, particularly around PIPs because they do need to be heavily data driven. This cannot be a small percentage; it has to actually be a problem that is very pervasive across a system of care.

VIII. RECEIVE Behavioral Health Services Director's Report, presenting on behalf of Dr. Suzanne Tavano: Matthew Luu, Deputy Director of Mental Health and Jennifer Bruggeman, Program Manager of Mental Health Services Act (MHSA)

(Matthew Luu) There are two specific items that were requested to be passed on. One is regarding COVID vaccine doses being administered through the county. The second is the plan for the county employees to return to in-person work, as there were concerns over clients being served in person.

- COVID update: As of today, per the website, the County has administered an approximate total of 1,334,200 vaccines to this county. Out of that, there are approximately 736,200 partially vaccinated individuals. This is approximately 74.5% of total. Those fully vaccinated are 639,993, which represents approximately 64.8% of the county. The total number being administered exceed the number of residents. That is due to helping those who work in Contra Costa and we do vaccinate, not just residents, but those who actually work in Contra Costa. The numbers look very encouraging.
- Return to in-person services/work: Dr. Tavano has made a huge effort with management staff the last month (6-weeks) planning for our BHS workers to return to work in person. Many of you know we are anticipating for the governor on June 15 that most, if not all, businesses will be returning to normal, and most restrictions will be lifted. In preparation, our Director has worked with clinical and administrative units to have staff work three (3) days a week in person at minimum. During the Pandemic, the number of services being rendered through

telehealth and telephone skyrocketed. This is good. We were able to reach out clients, as they were fearful being seen in person. There is also a certain population that still require in person service. Knowing this, we are planning for more in person transition. If all restrictions are lifted by June 15th, we may have all staff working in person five days a week. Effective June 1 (yesterday), all clinic and administrative staff are working three (3) days a week in person (minimally), two (2) days remote. Due to clients dropping from care due to transportation issues and fear of COVID.

(Jennifer Bruggeman) There are just two items to update on the MHSA side. One is the annual plan update and the second is two recent Request for Proposals (RFPs) we have through MHSA.

- First, the MHSA Program and Expenditure Report – just completed the 2021/22 Annual update. That is posted on the CCHealth.org/MHSA website. It is in draft form right now. It is available and open for public comment. Folks can go to that site to review and drop off a comment, either through the comment card on the website or contacting us directly. The next MHC Meeting (July 7th) we are having the Public Hearing for the plan. Traditionally do this time of year. Next month's commission meeting will be an overview of the changes, highlights of anything new, and then the opportunity for more public comment on the plan. I encourage everyone to come if you can.
- Second, we just recently had two RFPs. The first was for an Early Childhood Mental Health Program. This would be 0-5 ages, targeting children and their family members (ages 0-5). Both RFPs, we had approximately 3-4 applicants for each one. A panel was assembled, the applications were reviewed, applicants interviewed and recently selected for the early childhood mental health, Early Childhood Prevention, and Intervention Coalition (ECPIC), it consists of several providers in the community. Many of you would be familiar with, WeCare is going to be the lead on this and there is First Five, COPE, Early Childhood Mental Health, and Vistability (or the Lynn Center, as well. The idea behind this one, they have come up with a proposal for a program called "Everyday Moments". It has three components. One is a family outreach and engagement. The second component is an in-home support program. Physicians will come into people's homes and provide up to ten (10) family sessions. I thought was really unique and interesting. The third component is around parent education and empowerment and will be led by COPE and will do parenting classes for targeting that age group.

  The second RFP is for a suicide prevention program and awarded to the Contra Costa Crisis Center. Their proposal is for a suicide prevention follow up call program. This is really exciting, through the suicide prevention coalition, we have learned and spoke to other counties that have come in and shared presentations. Other counties have had a lot of great success with this type of a program. It is based on research around the understanding that immediately following a hospitalization, whether it is inpatient or PES; folks are very vulnerable, particularly if it is for suicide attempt or suicide ideation . The idea behind the program is that, before the person leaves the hospital, they would work with the staff, the program would be introduced, and if the person is interested, they sign a consent form. Within 4-8 hours of their discharge, someone from the Crisis Center will contact by phone and continue to contact them at regular intervals for up to a year, possibly longer if indicated. It is really just to provide active listening, emotional support and help identify additional resources that might be useful to them. We are hoping both these will be able to start at the beginning of the fiscal year.

Comments and Questions:

- (Cmsr. G. Wiseman) Jennifer, I don't know if you remember Tom Tamura from the Crisis Center was sharing what percentage of people released from 5150 holds we actually lose to suicide. It was a high number. Do you remember what

that was? (RESPONSE: J. Bruggeman) I don't recall, but I do remember him sharing that and it was alarming. It was quite high. I believe that was behind this. (Cmsr. G. Wiseman) Was it like 60%? (J. Bruggeman) I think that was right around that percentage, yes.

(Cmsr. G. Wiseman) I bring it up because it is really an exciting development, it is what the Crisis Center is patterning this service after. It is a similar program I saw in Sacramento that took it from 60% to zero. They have lost no-one to suicide after they have gone into this program. I think it is an excellent first step for our county.

- (Teresa Pasquini) A comment for Mathew Luu. As a family member of someone who is conserved and living out of county, I am curious when conservators will start seeing their conservatees out of county, visiting them and interacting with them more (or a case manager), is there a plan for that? I also wanted to share good news I just received. I was hoping that Director Tavano would have been here and give us an update on the budget, I just received a notice and thought you would want to know. The LPS trailer bill was rejected by both houses of legislature and joint budget deal. The advocy push by both the Behavioral Health Directors Association and NAMI and many family members pushing back on the Department of State Hospitals plan has been rejected. I think that is good news and have more time to plan around that. (RESPONSE: M. Luu) You are correct to the extent, most case managers do not necessarily follow clients outside of the county; however, it is still a mandate for the conservators' office, under the court order, to see their client a minimum number of times per given year. That is one venue we keep up on what is going on with the client placed outside of the county. The second process in place is under utilization review process. Joe Ortega, our UR Nurse coordinator is in touch with / keeping track of these clients outside the county. Prior to COVID, he actually physically visits the facilities outside our county to meet with the clients and doctors, staff and assess where they are at and review treatment plan, are they targeting the goals needed to work on and how is the client improving to promote the person getting well; and eventually get the client back to Contra Costa County. During the Pandemic, however, many facilities have stopped allowing visitors or anyone not staff. However, the treatment planning meetings still happen through zoom. We are hoping many facilities are starting to allow our staff to go back in to interview client and doctors over there.
- (Lauren Rettagliata) My question is also directed to Mathew Luu. I am so thankful for the advocacy that all put forth on the LPS and on the Department of State Hospitals. I think that was a warning shot across the bow. I would like to know from Mathew. They are wanting this to happen too fast, but we need to realize that 90% of our state hospitals are full of forensic patients and sending people who are not forensic into the state hospitals is likely not the best situation. Are we going to have and executive team? Are we developing a team within the Behavioral Health information to help correct the continuum of care so that we are able to keep those who need secured treatment and care within our and not send them out of county to a state hospital? Are we doing that? Is there a plan afoot because we need to be prepared? We cannot be caught. It will cost people their lives. (RESPONSE: M. Luu) Most definitely. I think you know what Suzanne emailed me earlier. The usual wanting me to convey to you all that the California Behavioral Health Director's Association, in concert with many entities, such as California State Association of Counties (CSAC) to voice their opposition, which Theresa just mentioned that advocy helped stop this on time. Over the years, many counties, including our county, have relied on the state hospital system to treat most gravely mentally ill. They are the only 'game in town' / monopoly. I know that the last couple of years, Cal-Mesa has been floating an idea (proposal) to look at alternative venues to enable all the counties to come up with suggestions for vendors to transition away from the state hospital system. How far along they are, I do not know. I do know it has been an ongoing conversation and know that in the LA county area, there is talk about

some facilities in Southern part of the state and some in the Northern part of the state and have a vendor come in from Florida to do this. This may have changed but that was spoke about in the past. Reliance on that single system (the state hospitals) is problematic. Suzanne continues to be part of the larger group with the Behavioral Health Director's Association to have ongoing dialogue to resolve these issues.	

IX. RECEIVE Presentation on Site Visit Program, Commissioner Laura Griffin, Commissioner Leslie May, and Commissioner Barbara Serwin, Quality of Care Committee
 	
The program is all about Commissioners visiting programs and services to improve the client experience. There are very important commitments for commissions in order to make this a successful program. As we discussed last year when developing goals, site visits will be mandatory for commissioners. Two (2) per year is our target and we would like to target eight (8) to 12 site visits per year.
• A Qualitative approach:
  • Based on the San Francisco MHC model (we did our homework!)
  • A focus on INTERVIEWING to get the perspective of clients
  • We hear client stories, insights, and "magic wishes"
  • We see from the client's eyes how well the site is serving their needs
  • We are NOT reviewing finances, licensing, utilization charts – we're leaving this for BHS and state reviews to do
• Purpose of the Site Visit:
  • To help programs improve their level of success
  • To better assist Behavioral Health Services (BHS), Contra Costa Regional Health Center (CCRMC) and Mental Health Services Act (MHSA) in making program and system decisions, including continuation of funding
  • To deepen Commissioners' knowledge of BHS programs and system of care and thereby help Commissioners to be more informed and effective advocates
• What is the site visit process?
  • Choose site
  • Schedule
  • Visit Site/Interview
  • Write Report
  • Share Out
• What do we do BEFORE we visit a site?
  • Schedule the site visit with the MHC Executive Assistant –- put aside one day or one long afternoon
  • Research site: Website, MHSA review if existing, online search
  • Receive and review Site Review packet (site review instructions, site information, blank questionnaires, report instructions and template)
  • Review Commissioner instructions
 	
What do we do DURING a site visit?
  • Take a basic TOUR of the site, checking for cleanliness, quality of food and food choices, state of furnishings and flooring, impact of spaces and furnishings on mood, adequate spaces for therapy, etc.
  • INTERVIEW Clients
  • INTERVIEW Program Director and staff members
• What do we do AFTER we visit a site?
  • DEBRIEF with partner Commissioners on site strengths and challenges, big aha's, plan of action if concerns
  • Draft report using report template
  • Share draft with Program Director and incorporate comments
	The SVP Presentation to the Mental Health Commission was shared as a PowerPoint Presentation during the meeting. And was included in the handouts provided with the Meeting announcement packet.

- Share draft with Chair, Vice Chair and BHS Director and incorporate comments
- Share draft with Full Commission

- The Hume Center Test
  - Participated in the design of the program and volunteered early on to be our test site
  - End-to-end test in April 2021 including scheduling, recruiting clients, interviews, and reporting
  - Report included in meeting packet
- How do we CHOOSE SITES to visit?
  - Creating master lists of Adult Sites and Children's Sites
  - All County operated and contracted out programs and services
  - Includes County Clinics, PES, Crisis Residential, Board & Cares
  - Small and large
  - Priorities: Large contracts, contract up for review, not reviewed in a long time, sites with challenges
- List of sites was shared during this presentation: Adult, Children's, as well as MHSA's List of Programs and Services.
- The Adult Questionnaire was shared.
- SVP Status / Schedule:
  - Summer 2020: Tested adult interview questions with SPIRIT Team Members
  - April 2021: Tested overall process, end-to-end, with Hume Center
  - June 2021: Updating program documentation based on Hume Center test results
  - June 2021: Finalizing Site Lists -- Need contract dollar amounts and dates of last review data
  - July 2021: Commissioner site sign-up through remainder of year
  - August 2021: First site visit

Comments and Questions: None.

- Requested all questions / comments be listed in chat. None listed.

X. DISCUSS and VOTE on objection letter to Supervisor Candace Andersen, RE: proposed by-law changes in Section 4. VACANCIES AND RECRUITMENT, by Commissioners Graham Wiseman and Leslie May

Upon review of the bylaw changes to Section 4. Vacancies and Recruitment proposed by Supervisor Candace Anderson, under subsections 4.4 and 4.5. The commission would like to have an active role. According to *Best Practices for the Local Mental/Behavioral Health Boards and Commissions 2020* rev. 1 (pg. 24, Best Practices 2020); written by the California Association of Local Behavioral Health Boards and Commissions; they speak to how candidates for positions on the commission should be chosen and the role of the MHC in that process, as well as the strategies on how to recruit, places to recruit. One of the strategies, Ethic, Racial, and Sexual orientation, which leads into the Executive Order 13985 signed into law by President Joseph R. Biden, Jr. on January 20, 2021 on *Advancing Racial Equity and Support for Underserved Communities through the Federal Government.* To sum up the particular importance – the term equity means the consistent and systemic fair just and impartial treatment of all individuals, including individuals belonging to underserved communities that have been denied such treatment to include: black, latino, indigenous, Native-American, Asian-American, Pacific Islanders and other persons of color, members of religious minorities, LGBTQ+ persons, those with disabilities (mental and physical), those in rural areas and other persons otherwise adversely affected by persistent poverty or inequality.

The commission should be active in the process that is listed in this recruitment. It states under 3. Process, Board, Commission Chari and/or executive committee receives redacted applications from staff for follow up interviews. What I would like to see and am asking the commission to vote on, is to include language that covers all

of the areas I spoke of, in terms of people representing the clients and population in this county. That the Board of Supervisors (BoS) allow the MHC to be involved in this process that is laid out in these documents I have just listed.

(Cmsr. G. Wiseman) To summarize this is a letter asking for Commissioner Andersen to carry to the next meeting that the MHC would like to have some interaction on the selection; mainly we want to ensure it is representative of our community. There be some kind of meeting between applicants and the chair or vice-chair of the MHC just to explain the roles and responsibilities. This has been a major reason we have lost three commissioners this month is due to informing them of their roles and responsibilities that they were unable to meet and all voiced concern that it was not properly explained to them by their supervisor.

Comments and Questions:

- (Cmsr. G. Swirsding) One thing that needs to be mentioned, this is a MHC and many of those that are mentally ill are discriminated against. Just because they are mentally ill, that they are not intelligent enough to be able to participate. I want to ensure that is included, there will be consumers on the commission and there should not be any discrimination against them.
- (Cmsr. Russaw) I would like to add to Cmsr. Swirsding's comment. In all reality, if this current commission would have met me face-to-face, I do not know if I would have been chosen. Realistically, I feel that would have been in regard to race or having an off day. I am really very torn regarding this decision and put a lot of thought into this. I was previously a part of the juvenile justice commission and it was a wonderful acceptance from them. I had lunch with the current commissioners and were able to speak with me. It was informal and comforting experience to know I was chosen from the people on the commission; however, I appreciate having to go under the tutelage of Supervisor Mitchoff. I thank you, Leslie and Graham to bringing this to our attention. I do think this is something that needs much more discussion. (Cmsr. G. Wiseman) Thank you very much and to be clear, all members of the MHC are appointed by their Supervisor. The Commission can meet and talk with applicants, but we do not appoint.
- (Theresa Comstock) I am the Executive Director for California Association of Mental Behavioral Health Boards and Commissions. I believe Commissioner Leslie May referred to our best practices document. We have some guidance in terms of recruitment of board members in that document and those are just suggestions. We try to give you the tools you need to do your work. I just wanted to comment that, I think, changing bylaws is not really the route I would suggest going and would be glad to meet with members and talk about what kind of recommendations I would have for you all, if you want to increase your capacity in terms of the recruitment piece and working with county staff, the county clerk's office, and supervisors to do that. I am happy to spend some time with you to speak about that.
- (Cmsr. K. Maibaum) I am very new and green in this whole process. I can share my experience. Angela welcomed me and provided me a packet of information, but I am still trying to get my bearings on it and try to learn. Just listening, I am happy to be here and really want to contribute more and am sorry to hear about the others who have had a not-so-great experience. It is sad because I think we would do better, to be honest. I am hoping it is going to change. Leslie, I appreciate all the work you have put in and really admire you and hope to be one day like you. I just want to thank everyone for allowing to even sit here and listen. I am still a bit nervous to put in my two cents because I feel it is a lot and want to ensure I am understanding the process. If there is training, that would be great. I would appreciate training to be more informed and a better commissioner. (Cmsr. G. Wiseman) Thank you and there is training. COVID shook things up a bit, but there is definitely is a training program and look forward to you participating in that. In fact, all of us that have not gone through the full six segments to do that.

• (Cmsr. J. Kincaid) Would you entertain a motion that would allow us to table this for further discussion to allow for other input? (Cmsr. G. Wiseman) One of the difficulties is we do have a meeting in July, in which the Internal Operations (IO) committee will be reviewing so there is a bit of a hurry to get this letter in. • (Cmsr. C. Andersen) If you would like me to jump in with the process and respond a little, I think it would be helpful to understand that every member of the BoS works very hard to try to have a broad spectrum of diversity on every board and commission. It is something each of us do and, as many of you know, we are in the process of creating and Office of Equity and Inclusion and will continue to look at these issues. Right now, it is important to note we do welcome and want the input of the commission as we are out recruiting applicants. You see in the chat; we do have openings. Even in the proposed bylaws, and changes that went out, there is a strong desire to really have each of you as commissioners encourage qualified applicants to apply for this commission. You are doing very important work; you are getting this done and making important proposals. We want you to be part of that. I think the issue that came up is one supervisor felt very strongly that she wanted to make that final decision and didn't want other commissioners weighing in on who she was going to appoint. That comes down to, at what do we really need a strong orientation, understanding of what the commission does: Does that come pre- or post-appointment. From your letter, what you are suggesting is that it should be pre-appointment. This is something we will take up in internal operations and will be brought before the full BoS for full discussion, but in no way is it to minimize the role the commission plays from the perspective of myself, it is to reflect on how we have been doing things, at least the last five years, if not longer. We have not had a separate ad hoc committee advising the BoS as to who they should appoint. That said, we want your input and out there recruiting. Many of you, through your work in the community know people who would be really good for this commission and encourage you to help them sign up. Again, when a supervisor can not find someone in their own district to fill a particular seat, they can look outside the district, as well. • (Cmsr. G. Wiseman) We are four minutes over and we do need to adjourn the meeting. I would like to encourage you all to think about whether or not we want to include the letter or the discussion we have already had with the supervisor can be carried t that IO meeting is sufficient. • June 6, 2021 Objection letter to Supervisor Candace Andersen re: proposed by-law changes in Section 4. VACANCIES AND RECRUITMENT. **Motion:** B. Serwin moved to approve the motion. Seconded by L. May. **Vote: 4-2-3 Motion APPROVED** **Ayes:** B. Serwin (Vice-Chair), L. Griffin, L. May, G. Swirsding **No:** G. Wiseman (Chair), K. Maibaum **Abstain:** C. Andersen, J. Kincaid, A. Russaw	
XI. DISCUSS and VOTE on proposed new By-law on excused absence from MHC meeting due to unforeseen, extraordinary circumstances, Commissioner Leslie May, Contra Costa County Mental Health Commission PROPOSED LANGUAGE (Added as Section 2.1b in **bold**): *Section 2.1b is proposed language for a new by-law regarding excused absences from Commission meetings. It is in red font. The other text is pre-existing by-law language for context.* *2.1 Attendance requirements* *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*	**Due to time constraints, this Agenda Item will be added to the July 7 Meeting Agenda**

resigned from the Commission. In such event the former Commission member 's status will be noted at the next scheduled Commission meeting and shall be recorded in the Commission 's minutes. The Chairperson shall, without further direction from the Commission, apprise the Board of Supervisors of the member 's resignation and request the appointment of a replacement *ii) Each Commissioner will ensure that when s/he attends Commission-sponsored meetings (excluding Commission and Commission Committee meetings) or activities representing her/himself as a Commissioner, s/he expresses only those views approved by the Commission.* ***b) A Commissioner's absence from a regularly scheduled Commission meeting may be excused in the case of an unforeseen, extraordinary circumstance, including but not limited to major illness, natural disaster, or civil unrest. Commissioners shall obtain consent from the Chair at least one day prior to the meeting that will be missed for any planned absence. Excused absences will be recorded in the meeting minutes as "excused absence".***	
XII. Adjourned: 6:38 pm	