**MONTHLY MEETING MINUTES**
**MENTAL HEALTH COMMISSION (MHC)**
**September 7th, 2022 – FINAL**

| Agenda Item / Discussion | Action /Follow-Up |
|---|---|
| **I. Call to Order / Introductions**<br>Cmsr. B. Serwin, Mental Health Commission (MHC Chair, called the meeting to order @ 4:31 pm<br><br>Members Present:<br>Chair, Cmsr. Barbara Serwin, District II<br>Vice-Chair, Cmsr. Laura Griffin, District V<br>Cmsr. Kerie Dietz-Roberts, District IV<br>Cmsr. Douglas Dunn District III<br>Cmsr. Gerthy Loveday Cohen, District III<br>Cmsr. Leslie May, District V<br>Cmsr. Joe Metro, District V<br>Cmsr. Karen Mitchoff, District IV (alternate)<br>Cmsr. Tavane Payne, District IV<br>Cmsr. Rhiannon Shires, District II<br>Cmsr. Yanelit Madriz Zarate, District I<br><br>Members Absent:<br>Cmsr. Geri Stern, District I<br>Cmsr. Gina Swirsding, District I<br><br>Presenters:<br>Priscilla Aguirre, MPP, Quality Improvement & Assurance Unit (QI/QA)<br>Vi Ibarra, Developmental Disabilities Council<br>Rebecca Sterling, Regional Center of the East Bay<br>Liz Walser, Regional Center of the East Bay<br><br>Other Attendees:<br>Colleen Awad (Supv. Karen Mitchoff's ofc)<br>Guita Bahramipour<br>Angela Beck<br>Jennifer Bruggeman<br>John Gallagher<br>Jessica Hunt<br>Marianne Iversen<br>Lynda Kaufman<br>Anna Lubarov<br>Teresa Pasquini<br>Pamela Perls<br>Christy Pierce<br>Jennifer Quallick (Supv. Candace Andersen's ofc)<br>Stephanie Regular<br>Lauren Rettagliata<br>Rebecca Sterling<br>Stephanie Taddeo | Meeting was held via Zoom platform |
| **II. PUBLIC COMMENTS**<br>• (Lauren Rettagliata) I would like to thank Hope Solutions, along with our Behavioral Health Administrators, Adam Down and Betsy Orme, for going out at meeting with the pastor at Clayton Presbyterian Church who was very concerned about the people living at Kirker Court. This was a 1994 development that so many families (along with Herb Putnam, a few | |

| | |
|---|---|
| others) and NAMI CC (National Alliance on Mental Illness, Contra Costa) founded this wonderful development that is still with us today; but through the years many of the supportive services that were supposed to be provide have fallen wayside. We have been very fortunate to have both Eden Housing, along with the board members of Hope Solutions, to work on bringing back services needed. Thank you to all who went out with me to help get them back on track.<br>• (Pamela Perls) I just wanted to say that Vi Ibarra and another member of our council when out to see Fred Finch (schools, residential, short-term residential and crisis response programs) in Alameda. It might be an interesting model for us. It is a very high reach, but a very good model.<br>• (Teresa Pasquini) Quickly wanted to mention a couple things. I would like to let the commission know, since you all have been supporters of the Housing that Heals mission and vision since releasing our paper in 2020; I have spent the last year working with stakeholders in LA County and Senator Henry Stern on a bill (SB1446). This started as a right to treatment and right to housing that heals bill, but it seems no one is interested in giving anymore rights out these days, so the bill was amended to be more symbolic. It prioritizes the SMI (behavioral health) population. We think it as a complimentary bill to care court. Without housing, people will not do well in care court. It has passed, it is awaiting signature of the governor and hoping he will sign.<br>Secondly, there is a national Housing that Heals initiative being launched with various partners, working in DC and more to come on that. Lastly, I would like to give a shout out to Adam and our Behavioral Health Services (BHS) staff. We had a really great meeting of the Behavioral Health Continuum Infrastructure Program (BHCIP) Steering Committee last week. As you all know, Lauren and I worked hard with our state partners, bringing forward all that and we are excited to see how that will develop in our county. There are some exciting / promising things coming. | |
| **III. COMMISSIONER COMMENTS**<br>• (Cmsr. Rhiannon Shires) Potential Liaison reports. I know Alcohol and Other Drug (AOD) Advisory Board, we have liaison reports from Contra Costa Council on Homelessness, the Tobacco Prevention Project, I do a little report on the Mental Health Commission and the Meds Coalition. Just a suggestion that I would be willing to do a liaison report from the AOD advisory board, since a lot of our work concurs.<br>(RESPONSE: Cmsr. Serwin) Thank you. I'd like to agendize that topic because in the past we have had commissioners formally appointed to other commissions and/or advisory boards and it has been very helpful.<br>• (Cmsr. Leslie May) In terms of being presenters on here, I was unable to hear. Is there a conflict if we are on this commission and another commission or advisory board not linked to the county? Is there a conflict of interest? (RESPONSE: Cmsr. Serwin) Regarding the Liaison, lets agendize the question along with that topic for the next meeting. | |

| | |
|---|---|
| **IV. CHAIR COMMENTS/ANNOUNCEMENTS:**<br>i. Review of Meeting Protocol:<br>➢ No Interruptions<br>➢ Limit two (2) minutes<br>➢ Stay on topic<br>ii. October MHC Orientation Topic is tentatively "Financing Mental Health Services" – We are still working on what this topic should be and still working on the Finance Orientation. I would like to do a tally of how many new commissioners have attended the new commissioner/introduction to the commission orientation and how many have participated in the orientations by the Director of Behavioral Health Services (BHS) and the other chiefs of major programs in BHS. We will send out an email (through our EA) and please let us know what you have signed up for to choose the best topic to present next.<br>iii. Mandatory meeting attendance for full Commission meetings and Committee meetings<br>iv. Mandatory membership on at least one standing committee (two in the case of Executive Committee members) – We still need more signups for the newest commissioners. Please contact the committee chairs to ask questions about what work they are doing and past projects so that you can choose your committee<br>v. Welcome Supervisor Mitchoff. Thank you for introducing yourself. A robust welcome to you and we are really glad to have you on board. | |
| **V. APPROVE July 6th, 2022 Meeting Minutes**<br>• September 7th, 2022 Minutes reviewed. **Motion:** D. Dunn moved to approve the minutes. Seconded by L. May.<br>**Vote: 10-0-0**<br>**Ayes:** B. Serwin (Chair), L. Griffin (Vice-Chair), K. Dietz-Roberts, D. Dunn, G. Loveday Cohen, L. May, J. Metro, K. Mitchoff, R. Shires, Y. Zarate<br>Abstain: None | **Agenda and minutes can be found:**<br>https://cchealth.org/mentalhealth/mhc/agendas-minutes.php |
| **VI. "Get to know your Commissioner" – Commissioner Gerthy Loveday Cohen**<br>Today I was talking to one of my students and said "Today, I have to introduce myself to the Commission" and thinking how I cannot believe that I have been in Mental Health for 34 years, since I was 16 and submitted to University in my country (Lima, Peru). I studied, became a clinical psychologist, certified in Peru by the time I was 22. I started to working in the Public Hospital and where I wanted to stay in my career. However, circumstances moved me to the United States. I attended the University of New Mexico, received my master's in counseling and a school was opening. I was hired to be a school counselor in middle school. I stayed in that position for 20 years. I was part of the crisis team and responded to homicides, suicides, accidents. I worked with first responders to help them deal with situations they were responding to. My husband got a job in San Francisco and we moved here.<br>When I moved there, I first worked for an agency, the Center for Human Development in their Beyond Violence program. I was the intensive case manager for victims of gun violence. It was my dream job and I loved it. Always it was inside me to be a school counselor. I can prevent youth from becoming victims of gun violence. Now I am a counselor at Freedom High | |

| | |
|---|---|
| School. I am thinking of starting my PhD soon, but unsure if I want PhD, an EDD, or a _____. I am bilingual and can be a clinician and help different populations and just trying to decide which direction I want to go.<br><br>I decided to get involved with the Commission at my oldest son's prompting. He is a youth commissioner with Brentwood, he is 16. He told me "Mom, you have all this training in mental health, but not your doctorate yet. You have so much training and experienced so much, why don't you apply and join?" It was his urging that motivated me to apply. I am also certified on all the FEMA (Federal Emergency Management Agency) courses that you can possibly imagine: logistics if there is a major crisis, how to organize the center for logistics, in case we need the media, etc. I have all the certifications and I am also a crisis prevention trainer for the QPR (Question, Persuade, and Refer) Institute. I can train nationally and was certified last year. I was working on my LMHC (licensed mental health counselor) in New Mexico, but we moved her to California. I am deciding if I want to get my clinical license and then do my doctorate in education. My youngest son is on the Autism Spectrum. He can communicate some things, some things he cannot. He attends Freedom (my other son attends Heritage) High School and he is doing wonderful in school. The program is amazing for them. My life is taking care of my kids, my parents who live with me. My husband helps take care of all of them, as well.<br><br>The meetings with the commission is part of my self-care, I get to meet people, talk to others, hear about others and be part of the community. This is something I have a passion for and I tell my son, 'people are homeless' Homelessness, what can we do to transition them back into the community? What services do they need? All this started in New Mexico because part of my training was practicing hours at a Veteran's Hospital and there were a lot of patients with PTSD (Post-Traumatic Stress Disorder). They would come to the clinic, which was a room with now windows, so I would take them outside to dance and conduct therapy. Their willingness and what they wanted was to continue their lives and not be homeless. At that time, there was not many resources in New Mexico and I was so involved with my career and finish my degree but I did not continue pursuing. I have also worked with gangs and have been to every single training you can possibly imagine and have a lot of success stories. I was able to get a lot of youth out of the streets.<br><br>(Cmsr. Serwin) That is a lot and I am so inspired. I am exhausted but very inspired by your story. I am so happy to have you to provide so much experience with the work we are doing. Thank you very much. | |
| **VII. Presentation: External Quality Review Organization (EQRO) Report, Priscilla Aguirre, MPP, Quality Management Program Coordinator, Quality Improvement & Assurance Unit**<br><br>The United States Department of Health and Human Services (US DHHS) Centers for Medicare and Medicaid services requires this annual, independent external evaluation of state Medicaid Managed Care programs by an external quality review organization. That has been behavioral health concepts and continue to be the external quality review organization for the mental health plan (MHP) and are based in Emeryville, California. Behavioral Health Concepts has conducted reviews of the MHP the past five years. | Documentation on this agenda item were shared to the Mental Health Commission and included as handouts in the meeting packet and is available on the MHC website under meeting agenda and minutes: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php |

You should all have a copy of the EQRO final report in your packets. The review period was fiscal year (FY) 2021-2022. In preparation for the review, all supporting documentation was provided to the EQRO in December of 2021. Each year, my team and I submit approximately 2,000 pages of documentation to the EQRO, it is very expensive. The continuation of the pandemic, all EQRO site visit sessions occur via Zoom on January 19th through the 20th. Once the review is complete, the EQRO prepares a draft report and sent to the Department of Health Care Services for their review and approval and then the EQRO sends it to the county for their review and input. Once we submit feedback, the EQRO responds to our feedback and issues the final report. This year, the final report was issued in May 2022.

Why is the EQR and the findings important?

- Areas of Strength/Accomplishments – It helps us evaluate our accomplishments, area of needed improvement and our set of priorities regarding the MHP.
- Fully invested in reviewing the quality of services provided to our beneficiaries, the access to services, and the timeliness of those services.
- Just to consider our internal infrastructure, as well as IT support, to provide the services and support needed by beneficiaries and staff. Their protocol for the review is pretty extensive and the corresponding report is quite lengthy and very thorough.

During my (almost) 12 years with the county, I have noticed many of the improvements efforts have come as a result of the EQRO findings. In a large county like ours, where we have a lot of requirements, it tends to be challenging to determine which quality improvements to prioritize. The EQRO gives us another set of eyes to look objectively while bringing a fresh and current state-wide perspective to providing feedback based on the review of the other 55 counties and helps us prioritize our improvement efforts.

Key Areas of the EQRO Report (new update layout this year):

1. Prior Year (FY 20-21) Responses to Recommendations (p 11-14)
    - Seek ongoing and regular technical assistance from CalEQRO in the continued implementation of its Performance Improvement Projects (PIPs) -- ADDRESSED
    - 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 -- PARTIALLY ADDRESSED
    - 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 -- ADDRESSED
    - Investigate the reasons for high no-show rates starting with clinician no-show rates -- ADDRESSED
    - Automate the service interface between community-based organization (CBO) electronic health records (EHR) to Sharecare to eliminate double data entry – PARTIALLY ADDRESSED
    - Complete the EHR's implementation of the Electronic signature for MHP beneficiaries -- ADDRESSED
    - Evaluate whether resources are sufficient for the successful recruitment and retention of the Office of Informatics and Technology staff. Augment when gaps are identified -- ADDRESSED

2. Access to Care: Key Components & Performance Measures (p 17-26)
   Components Evaluated (Ratings):
   - (1A) Service Access and Availability (Met)
   - (1B) Manages and adapts capacity to meet beneficiary needs (Partially Met)
   - (1C) Integration and collaboration (Met)
   - (1D) Service Access and availability (Met)

   Relevant Performance Measures:
   Higher than statewide averages in:
   - 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
3. Timeliness of Care: Key Components & Performance Measures (p 27-32)
   Components Evaluated (Ratings):
   - (2A) First non-urgent request to first offered appt. (Met)
   - (2B) First non-urgent request to first offered psychiatric appt. (Met)
   - (2C) Urgent Appts. (Partially Met)
   - (2D) Follow-up Appts. After psychiatric hospitalization (Met)
   - (2E) Psychiatric Readmission rates (Partially Met)
   - (2F) No-Show/Cancellations (Partially Met)

   Relevant Performance Measures:
   Higher than statewide averages in:
   - 7-day post psychiatric inpatient follow-up rates
   - 30-day post psychiatric inpatient follow-up rates

   Lower than statewide averages in:
   - 7-day readmission rates
   - 30-day readmission rates

   Assessment of timely access:

| Timeliness Measure | Average | Standard | % That Meet Standard |
|---|---|---|---|
| First Non-Urgent Appointment Offered | 5.5 Days | 10 Business Days* | 96.4% |
| First Non-Urgent Service Rendered | 6.7 Days | 15 Business Days** | 95.3% |
| First Non-Urgent Psychiatry Appointment Offered | 8.1 Days | 15 Business Days* | 92.2% |
| First Non-Urgent Psychiatry Service Rendered | 11 Days | 30 Business Days** | 94.3% |
| Urgent Services Offered (including all outpatient services) – Prior Authorization not Required | 36 Hours | 48 Hours* | 84.2% |
| Urgent Services Offered – Prior Authorization Required | **** | 96 Hours* | **** |
| Follow-Up Appointments after Psychiatric Hospitalization | 15 Days | 7 Days** | 48.9% |
| No-Show Rate – Psychiatry | 14.7% | 10%** | n/a |
| No-Show Rate – Clinicians | 15.8% | 10%** | n/a |

4. Quality of Care: Key Components & Performance Measures (p 33-40)
   Components Evaluated (Ratings):
   - (3A) Quality assessment and performance improvement are organizational priorities. (Met)
   - (3B) Data is used to inform management and guide decisions. (Met)
   - (3C) Communication from MHP administration, and stakeholder input and involvement in system planning and implementation (Partially Met)

- (3D) Evidence of a systemic clinical continuum of care (Met)
- (3E) Medication monitoring (Partially Met)
- (3F) Psychotropic medication monitoring for youth (Met)
- (3G) Measures clinical and/or functional outcomes of beneficiaries served (Met)
- (3H) Utilized information from beneficiary satisfaction surveys (Met)
- (3I) Consumer-run and/or consumer-driven programs exist to enhance wellness and recovery (Met)
- (3J) Consumer and family member employment in key roles throughout the system (Met)

Relevant Performance Measures:

Higher than statewide averages in:

- Inpatient hospitalization length of stay (LOS)
- High-cost beneficiaries
- Retention rates (only 1-4 services)

Other notable higher averages:

- Beneficiaries served with psychosis, trauma related orders and depression
- Percentage of approved claims for beneficiaries with psychosis

5. Performance Improvement Project (PIP) Validation (p 41-44) typically run two years and are very data driven, depending on intervention may only run one year. We are required to have two PIPS running concurrently every year and are following:
   PIP #1 (clinical) – Addressing depression and anxiety among youth. We learned of some data that suggested a large percentage of clients had anxiety, depression and trauma diagnosis and are in need of more support. We are providing CBT (Cognitive behavior therapy) for depression as the intervention in this PIP and it is active and ongoing. We are entering the second remeasurement phase and active. The validation rating has to do with how confident the EQRO is in our methodology (moderate confidence). EQRO recommended we specified the time period for the PIP in the aim statement; consider the CANS-50 at the same interval as other measures; and increase the number of beneficiaries to the intervention to be able to analyze more data and determine the level of success.
   PIP #2 (non-clinical) – Gained-framed provider reminder calls to reduce no-shows to initial assessment appointments. This was focused on improving our no-show rates of first appointment by having clinicians contact clients in person to attend the appointment. There is a lot of research that shows when clients receive a call directly from their provider it yields greater adherence to appointments. This is active and ongoing and in the implementation phase (moderate confidence). This recommendation was to increase therapist adherence to the reminder protocols.
6. Information Systems Key Components (p 45-49)
   Components Evaluated (Ratings):
   - (4A) Investment in IT infrastructure and resources is a priority. (Met)
   - (4B) Integrity of data collection and processing. (Met)
   - (4C) Integrity of Medi-Cal claims process (Met)
   - (4D) Electronic Health Record (EHR) Functionality (Met)
   - (4E) Security and controls (Met)
   - (4F) Interoperability (Partially Met)

7. Validation of Beneficiary Perceptions of Care (p 50-52) – Both beneficiary satisfaction surveys by MHPs and contractors were reviewed.
   <u>Focus Group #1 English-speaking caregivers and parents of beneficiaries</u>
   - Assessments were timely; however, psychiatry took longer to initiate
   - Participants were not aware of how to access crisis services
   - Felt they could give feedback but just hadn't received invitations or made aware of opportunities

   <u>Focus Group #2 Spanish-speaking adult beneficiaries</u>
   - Assessments were timely; however, therapy services took much longer to initiate
   - Participants were not aware of how to access crisis services
   - Felt they could give feedback but just hadn't received invitations or made aware of opportunities

   <u>Common recommendations:</u>
   - Make more therapists available
   - Communicate with beneficiaries about any changes in providers
   - Communicate about available services and programs
8. Conclusions/Recommendations, FY 22-23 (p 53-55)
   i. Investigate reasons for the disproportionate access to specialty mental health services among Latino/Hispanic and Asian-Pacific Islanders (API) beneficiaries in Contra Costa County (CCC). Take action to ameliorate the gaps in service.
   ii. Investigate reasons for long wait times and wait lists for services after initial assessment. Take action to improve wait times post assessment to ongoing service and reduce waitlists.
   iii. Continue to promote beneficiary choice in service modality; at the same time, explore and implement strategies to further increase systemwide flexibility and address staffing concerns.
   iv. Investigate reasons for low rate of follow-up post-hospitalization appointments meeting the 7-day standard. Take action to improve rate of appointments meeting the standard.
   v. Evaluate and take action to increase opportunities for children and family members (CFM) to provide feedback related to the MHP system, including the unduplicated number of CFMs who participate, types of events, and the methods of outreach, and memorialize CFM participation in meeting minutes.
   vi. Include contractors in medication monitoring review. Identify solutions to barriers including providing access to Epic where contractor services include medication prescribing or monitoring

**Questions and Comments**

- (Cmsr. May) How long has Behavioral Health Concepts been the contracted review? (RESPONSE: Priscilla Aguirre) They have been under contract approximately five (5) years to perform the EQROs for our county.
- (Cmsr. May) It seems as though the county, in terms of the Latino/Hispanic populations. The 2010-2013, when I was working for the county, this was a hot topic and where they were supposed to be reaching out. That population was increasing rapidly in CCC, there were a lot of discussions why, not important, but there was a need to address this population. Here we are ten years later and still lacking. There seems to be some disconnect with actually getting out and ensuring

these community members are accessing and receiving services. It is too hard for me they are not trying to do so.
Secondly, falling back with long wait times and that nature. We have been going through this the same time period and it seems like is getting worse, not better. It is to the point that people are now seeking service in other counties by using addresses there or however they need to obtain services more quickly than the county they live. To me that encourages people to break the law, commit fraud. It has been occurring for over a decade. There was a partial improvement when Dr. Tavano had hired more psychologists as we were severely lagging behind. In terms of getting the appointments for services, to see their doctors and therapists in order to get their prescriptions filled, it seems we are still following so far behind.
It was also mentioned regarding the psychosis. Yes we have intense psychosis because this area is immersed in methamphetamine and other drugs, the numbers are going up because (as I've been screaming at every meeting, but falls on deaf ears as the upper administration and supervisors ignore), we have a lot of patient dumping, and it is being posted with officers pulling up and dropping off patients (still in their clothing from the hospital) around the county. We need the supervisors to address that issue and this patient dumping needs to stop. It is running our numbers up for our homeless population, for Psych Emergency Services (PES), and it is too much taxing our resources and they are not actual residents of our county. I really hope that you can go back and share that information and it will be heard and considered by the supervisors. I will forward the rest of my comments as we do not have enough time. (RESPONSE: Priscilla Aguirre) To keep in mind, as Dr. Tavano has stated, there has been a lot of effort into timely access. We meet the standards, well over 90% at this time. We have made such a concerted effort with enhanced monitoring and additional reporting that was created in order for us to really see what is going on and to troubleshoot and strategize on meeting those standards. One thing to note is that the standards for California do only focus on the first. There will be new State requirements surrounding follow-up. More will come with ensuring timeliness of follow up appointments we are already going to focus on internally. The focus has been around the first offered clinical and/or psychiatric versus ongoing appointments. There are no standards around that.

- (Cmsr. Dunn) Has COVID-19 protocols resulted in fewer psychiatric inpatient services admissions? If not, why not? If so, how? (RESPONSE: Priscilla Aguirre) At this time, I would not be able to answer that question, it is not my area of expertise but I am happy to follow up if that is, perhaps a question in inpatient could respond to.
- (Cmsr. Dunn) What factors caused the jump from 650 to 721 High Cost Beneficiaries (2018 to 2019) and then from 721 to 1051 (from 2019 to 2020)? (RESPONSE: Priscilla Aguirre) I am unable to share what factors led to that increase. I can tell you, overall, high cost beneficiaries-one of the major areas that contributes to the high cost beneficiaries: in approximately 8 counties, that actually provide wrap-around services and not all counties provide those services. Those services are heavily needed in this county and others. Counties have advocated for wrap around services which bring together some very in-need populations for a group / team will come to together to support a youth in great need

| | |
|---|---|
| and to provide structure and essentially wrap those services around that client. Those services do tend to be more expensive and not all counties actually offer those services. It makes it really tough because it looks at any beneficiary with services over $30k and that group of counties who do have wrap around services are being compared with everyone else who do not. That is one of the factors. I wish we were taken out and given the counties specific with wrap around services and you might see the difference. Certainly, the fact we are also in the Bay Area that makes it another factor in terms of services.<br>• (Cmsr. Dunn) Why do high-cost beneficiaries account for 47% of all CCC claims in 2020? (RESPONSE: Priscilla Aguirre) I am unable to answer that question fully but happy to provide a response after the meeting.<br>• (Cmsr. Serwin) Unfortunately our Director of BHS, Dr. Tavano and Deputy Director, Matthew Luu, are not available tonight to answer these questions. It's a lot and these areas are not Priscilla's area of focus. I would like to compile a list of these questions and send them to Dr. Tavano for a response. I will hold off on my questions to put in the list, in the interest of time.<br>• (Priscilla Aguirre) I will be happy to take all of the questions and follow up, I just ask all of them to be sent in one, through the executive assistant.<br>• (Cmsr. Serwin) Yes, we will compile the questions and send on to you and Dr. Tavano. | |
| **VIII. Presentation: Meeting the Mental Health needs of People with Developmental Disabilities, Liz Walser, Clinical Psychologist, ASD Specialist, Regional Center of the East Bay (RCEB), and Vi Ibarra, Executive Assistant, Developmental Disabilities Council**<br>(Liz Walser) Developmental Disabilities Council overview we will cover:<br>➢ Developmental Disabilities Council<br>➢ Regional Center<br>➢ Regional Center Eligibility<br>➢ RCEB funded services<br>➢ Mental Health needs of the Developmental Disability (DD) Population<br>➢ Services we have access to<br>➢ Gaps in Mental Health services<br>Our ***Mission:*** To promote the coordination, improvement, and growth of services and supports to individuals with developmental disabilities and their families. To advocate for the needs of people with developmental disabilities and their families.<br>***The 21 member Board of Directors*** is a diverse group of self-advocates, family members, and services providers. The Council meets monthly to disseminate information about existing resources, listen to expressed needs, and advocate for the development of services.<br>***Council efforts focus on:*** employment services, emergency planning, equity issues, transportation, education, healthcare, and support for people across the lifespan.<br>Regional Centers were founded in California 1965 due to recognition of special needs of people with intellectual disabilities. Expanded statewide in 1967. Expanded again in 1974 to serve greater variety of consumers. | Documentation on this agenda item were shared to the Mental Health Commission and included as handouts in the meeting packet and is available on the MHC website under meeting agenda and minutes: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php |

The AB 846 Lanterman Act provides services for people with developmental disabilities.

Regional Centers are private, not for profit entities, overseen by the Department of Developmental Services. RCEB serves people in Contra Costa and Alameda Counties.

Eligibility: To be made eligible for RCEB, a person must apply for services. Applications for DD are usually completed by family members , advocates, or occasionally the person themselves.

**There are 2 programs within the Regional Center:**
**Early Start and Lifelong Disabilities.**

**Early Start** provides services to children ages 0-3 who demonstrate

1) a developmental delay
2) an established risk condition
3) are in a high risk category for developmental delay

To be eligible for long-term Regional Center services beyond the age of 3, the law says that a client must demonstrate a developmental disability that presented before the age of 18 and they must be substantially disabled. The onset of these conditions had to have been prior to age 18; continues, or can be expected to continue indefinitely and constitutes a substantial handicap for the individual.

Who is eligible? Those with Developmental Disabilities including: Autism Spectrum Disorder (ASD); Cerebral Palsy; Epilepsy; Intellectual Disability; and any condition requiring similar support to intellectual disabilities (ID).

<u>Developmental Disability *and* Substantially Disabled</u>

- Self-Care: significant limitations in the ability to acquire or perform basic self-care skills
- Expressive and Receptive Language: significant limitations in both the comprehension and expression of verbal and/or nonverbal communication resulting in functional impairments
- Learning: substantially impaired in the ability to acquire and apply knowledge or skills to new situations even with special intervention
- Mobility: substantially impaired in the ability to acquire and apply knowledge or skills to new situations even with special intervention
- Self-Direction: significant impairment in the ability to make and apply personal and social judgments and decisions
- Capacity for Independent Living: unable to perform age-appropriate independent living skills without the assistance of another person
- Economic Self-Sufficiency: lacks the capacity to participate in vocational training or to obtain and maintain employment without significant support

<u>Services</u>

If eligible, Regional Center assigns a Case Managers. Case Managers are coordinators of services. They meet with the client, families, or other supports to create an Individual Program Plan (IPP). An IPP contains life details, goals, and services obtained or needed.

*Beyond service coordination, Regional Centers are prohibited by law from providing any direct services themselves.*

Regional Centers contract out for services in the community. The kinds of services provided by Regional Centers are regulated by the law and enforced by DDS.

Services may include:

- Early Intervention and Prevention Services (under age 3)
- Behavioral Support
- Day Programs
- Independent Living Services
- Supported Living Services
- Residential Service
- Nursing Services
- Respite
- Durable Medical Equipment
- Social and Recreational Services (new)

Generic Resources and Insurance

RCEB does not fund any services that are required by law to be funded by another agency or that can be accessed through a generic resource. For example, medical care and dental services are provided through health insurance. Speech therapy is provided through education programs and sometimes through insurance. Transition services are provided in schools.

***"Regional Center funds shall not be used to supplant the budget of any agency that has a legal responsibility to serve all members of the general public and is receiving public funds for providing those services."***

***--Lanterman Act, WIC 4648(8)***

Mental Health and Developmental Disabilities

People with disabilities are a part of the general public and they should be provided access to psychiatric care, therapy, and emergency psychiatric services.

People with developmental disabilities often have co-occurring mental health conditions such as:

- Depression
- Anxiety
- Obsessive Compulsive Disorder (OCD)
- Executive Functioning Disorders (like ADHD)
- Bipolar Disorder
- Psychotic Disorders
- Substance Use Issues

DD Clients often demonstrate their symptoms physically and they may need help to otherwise articulate what is happening.

The GAIN Study, which is a longitudinal study of older adults and **Alzheimer's**, found that 70 percent of older adults with autism also had a mental health condition.

**Trauma**: CDC data shows that the 2 highest risk factors for child abuse or neglect are: 1) being age 4 or younger; 2) having a disability. Therefore, many of our adult clients are survivors of childhood trauma.

**ADHD** occurs in 50-70 %
**Depression** occurs in 40 % versus neurotypical population
**Anxiety** 40% versus neurotypical population
**Mood and Psychosis** numbers vary, but higher than general population

Why limited access?

***Despite civil rights protections, people with developmental disabilities are regularly turned away from standard mental health services and sent back to Regional Centers for care.***

Some reasons why:

- Misperceptions related to the role of Regional Centers.
- A belief that people with ASD, ID, or language impairments cannot benefit from therapy or hospitalizations.
- A belief that the behavior of people with DD is the only thing that can be addressed and this cannot be done in psychiatric settings.
- An idea that the distress exhibited is simply a result of the disability.

Service Gaps

- There are few providers who will assess and treat mild to moderate mental health conditions.
- There are few providers of long term therapy for DD individuals who have long term mental health conditions.
- Psychiatrists often refuse to see non-verbal clients, and are only willing to advise PCPs on medical treatment of psychiatric conditions.
- Psychiatric hospitals do not often provide adequate services. They often turn DD clients away at ER once a disability is discovered.
- Clients are sometimes "banned" from hospitals because of behaviors.
- Clients are sometimes held in ER inappropriately because hospitals won't transfer them to appropriate care.

Regional Center of the East Bay Funded "Crisis Support":

Regional Centers have a few contracts for providers to give crisis support to clients and families. The crisis services are usually over the telephone, they are often not timely, and the providers cannot physically intervene. They have waitlists. They are not long term and do not include hospitalizations.

Our crisis services include:

- Crisis Response Project (CRP)
- System, Therapeutic, Assessment, Resources, Treatment (START)
- Crisis Assessment Stabilization Team (CAST)

Glimmers of Hope:

For clients with DD and severe mental health concerns, there are a few programs in CCC where DD clients are not turned away.

- A Step Forward provides forensic services for DD clients
- First Hope accepts clients with ASD and IQ's above 80 who may be early in psychosis.
- The Hume Center has committed to accepting dual diagnosis clients when the clinic has openings with designated therapists through MediCal or contract with RCEB.
- Some private practices are expanding to serve DD clients.

What is Needed:

- Advocate for more public mental health clinics to do intake, proper mental health assessments, and provide treatment.
- Training for mental health clinics on meeting the needs of dual diagnoses patients.
- Advocacy for psychiatrists to properly serve outpatient dual diagnosis clients even those with limited verbal abilities.
- Advocacy for hospitals and Intensive Outpatient Programs to properly serve dual diagnosis patients.

- Increase attention to mental health in school age population.
- Collaboration around projects, such as the K-12 project, to include dually diagnosed children.

**Questions and Comments**

- (Cmsr. May) I really appreciate this presentation, as some of my clients have received services. I hear a lot of complaints and now I know the reason and I can advise why, because it isn't offered. One client was stating her child needed to see a speech therapist. They were refused to be seen in the office and now I see that the child needs to be referred out. Second, you touched upon being diagnosed before age 18 to have life-long services. You went on to say later on in your presentation that, there are a lot of people that have had trauma and have happened to folks. I am seeing more 20 and 30 year old's that really need these services but for some reason were passed over. They really have the learning ability of an 8 or 9 year old where the parents neglected to get them the help and now we have these adults that have no way to apply for these services later in their 20's and 30's that are completely intellectually delayed because the did not get diagnosed. Is that correct? (RESPONSE: Liz Walser) No, but thank you for asking that question, Cmsr. May. I really appreciate it. The first question, around the speech therapy, in our early intervention program (0-3), we do pay for speech therapy for those out in the community. That population is contracted out. Whatever their rules are on providing the therapy is how they do it. If the family is unhappy with that and want to see a speech therapist in person, they can switch therapists and the RCEB will go along with that. We are not super rigid about that. After the age of three, we don't pay because it is supposed to be paid for by insurance and the school district. If we are asked, we are not allowed to provide that.
  The second question regarding testing by age 18. It is not that they have to be diagnosed before the age of 18, it is that there has to be sufficient evidence in their record that the disability they are presenting with was present before the age of 18.
- (Cmsr. Dunn) I heard that RCEB government funding is seven times higher for persons with severe mental health challenges; however, I have also seen extended news reports of RCEB's major staff turnover issues, low salaries, etc. Can you please explain how this continues to occur and how it can be resolved? (RESPONSE: Rebecca Sterling) The budget we get for purchases of services and what we can spend on clients is totally different than our operational budget. Operational budget is what we are allowed to spend on ourselves and staff which has been woefully low for a very long time. One of the things noted in a recent state audit is that the Department of developmental services (DDS) who we have our contract with has a very outdated ratio for determining case manager salaries that doesn't match case load expectations. In terms of our service budget, that is in the high millions and the reason is that it covers some pretty expenses services including residential care, transportation and day programming or work programs.
- (Cmsr. Dunn) I am personally aware of the major funding divides caused by the artificial insurance and legal redline 'blocked walls' distinction between mental illnesses and intellectual developmental disabilities. How can these walls and redlines at least be lowered, improving streams

globally speaking for both types of challenges?
(RESPONSE: Liz Walser) I don't have any ideas on that and would really need to ponder that, and talk about it with my colleagues to give you some semblance of a coherent answer.

- (Teresa Pasquini) I think the funding disparities and discrimination between the two populations exists and it sort of creates a competition in disabilities. My son was determined to be gravely disabled for the last 20 years as an LPS conservatee and yet, he has no right to treatment for those disabilities. Private insurance didn't provide enough, etc. I hear you, in our white paper we called out the discrimination for realignment, the IMD exclusion, etc. and we advocated locally, statewide and nationally for those to change. I mentioned SB 1446 started out as a right to treatment bill, it was called for to be some consideration of these disparities at the LPS hearing that was held on December 15th last year at the state legislature that I testified. I am only raising this because I do think we are natural allies and saw the list that my son checks all that criteria. We are constantly worried about what will happen when we are gone? The residential services and entitlements aren't available to our population. I just wanted to raise it because we straddle both lines. Some people don't know the difference between LPS and Lanterman Act. And there are differences. I just wanted to raise that up in this conversation, not to compete but in hopes to form partnerships. We all do need the same for our clients and loved ones.
(RESPONSE: Liz Walser) I agree, part of my job is to consult on cases with mental health needs and have worked in Mental Health for many years before, when I was a social worker prior to being a psychologist. That was my focus, adult mental health. It breaks my heart too, when I assess people and see their primary diagnosis is a mental illness and don't fit into one of our diagnostic categories. I hate that. I totally agree with you and can be allies.
- (Lauren Rettagliata) Thank you for your presentation and coming to the commission. We need to ask our county to make this a legislative priority. A county has to step up. We, as a mental health commission, can ask our county to step up and make this a legislative priority that is dealt with. This is a state legislature problem. Four years ago, I met with the Executive Director, Lisa Kleinburg(?) and we were working on this, but then COVID happened, I was no longer a member of the mental health commission. If we could merge the two—the housing component that those in the RCEB get. If there is someone with a severe disability, they get over $9000/month for their housing and our people a left with a pittance of (maybe) $1000. There is this disparity that members of the RCEB and other regional centers are not getting the psychiatric care they need. This needs to be dealt with at the state level and it needs to be a legislative priority that we direct our county to put forward in order for us to work on this at the state level. This dichotomy has to stop. We have to work together so both the DD and those with SMI are not pitted against each other in legislation but have legislation that works together to solve the problem. (RESPONSE: Liz Walser) I agree.
- (Cmsr. Serwin) I have a clarification to ask. The funding that your clients receive; is the funding broken down for different services? Is funding available for mental health services? Or is it all one big pot that can be used as determined is necessary for a given client?

| | |
|---|---|
| (RESPONSE: Liz Walser) We have services available to us that we can make use of if the client's case demonstrates it is a necessity. So, if it is a young adult and has fallen off the cliff, school services have ended and is 22 years old and the pandemic hit and is now stuck at home and not doing anything. We determine he needs independent living skill services and mental health services. We can pay for his independent living skills services for our budget. We can't pay for his mental health services because that is supposed to be covered by the generic resource of insurance. Are you asking if there is a finite amount available in a POS budget for a person? Is that what you are asking? (Cmsr. Serwin) for any particular category and whether or not, wasn't sure if mental health services were outside of that. (Liz Walser) It is outside of that.<br>• (Cmsr. May) So, by that example, you have this person that already has delays, you have been working with him and now he goes to school and someone slips him something and he ends up with a diagnosis of schizophrenia as well as the ID, he should still remain at the RCEB but would have to get psychiatric services through the county or his parents insurance? (RESPONSE: Liz Walser) Correct | |
| **IX. ESTABLISH Election Nomination Committee**<br>Create committee from commissioner volunteers with the main objective to develop the slate of a list of candidates for each elected role: Chair, Vice Chair and the Executive Committee members. That involves reaching out to potential candidates, walking them through what the job is, learning why they may be interested in running, job responsibilities, time commitment. It is not an interview, it is just to get potential candidates to reflect on the role and whether or not they want to run and are a really good fit. This all needs to be done before the November meeting when the slate is announced and this committee actually oversees the actual election.<br>Do we have any volunteers for the nominating committee? I would say that we need at least one or two people who have some history with the commission, know the various commissioners and understand what the roles are. We do have a description of the roles. Of course, new faces are very welcome. Do have any volunteers?<br>Commissioners Leslie May and Laura Griffin have volunteered for the election nomination committee. Would like one more volunteer. It is a short term commitment. | |
| **X. RECEIVE Behavioral Health Services Director's Report, Dr. Suzanne Tavano**<br>➢ Update on applications for BHCIP grants<br>➢ Update on diversion housing | ***BHS could not report out: Director and Deputy Director of BHS were unavailable/unable to attend.*** |
| **XI. Adjourned at 6:33 pm** | |