MONTHLY MEETING MINUTES
MENTAL HEALTH COMMISSION (MHC)
October 4th, 2023 – FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Cmsr. L. Griffin, MHC Chair, called the meeting to order @ 4:33pm. Members Present (In-Person): Chair, Cmsr. Laura Griffin, District V Cmsr. Ken Carlson, District IV Cmsr. Gerthy Loveday Cohen, District III Cmsr. Tavane Payne, District IV Cmsr. Pamela Perls, District II Cmsr. Vanessa Rogers, District IV Cmsr. Barbara Serwin, District II Cmsr. Geri Stern, District I Cmsr. Gina Swirsding, District I Members Absent Vice-Chair, Cmsr. Leslie May, District V Cmsr. Rhiannon Shires, District II Presenters: Dr. Suzanne Tavano, Director of Behavioral Health Services (BHS) Priscilla Aguirre, MPP, Quality Management Program Manager Dr. Ruth Fernandez, Ed.D. Executive Director* Wanda Davis, Early Intervention Program Officer* Other Attendees (*in Person): Colleen Awad (Supv Ken Carlson's ofc)* Angela Beck* Jaspreet Benepal Peter Caldwell Gigi Crowder Deborah Cunningham Dr. Stephen Field Ashleigh Goddard (Supv. Diane Burgis ofc) Jessica Hunt Lynda Kaufmann Gerold Loenicker Kim McCarl Jennifer Quallick (Supv. Andersen's ofc) Lauren Rettagliata Jennifer Tuipulotu	Meeting was held at: 1025 Escobar Street, Martinez, CA 94553 and via Zoom platform
II. Motion to request approval for Commissioner Leslie May to continue to participate remotely based on "emergency circumstances" for October 4, 2023 Commission Meeting (In accordance with AB2449 -Teleconferencing options allowed under the Brown Act, dated March 1, 2023)	***Cmsr. Leslie May was not present on Zoom. No vote taken***
III. PUBLIC COMMENT: • (Lauren Rettagliata) I am really looking forward to hearing Suzanne Tavano's report today on the Care Act and I hope she is given enough time to present everything she needs to. There is so much going on in this arena. I would also like to inquire about, how we as a commission, can better facilitate the permitting of needed facilities. I understand the permitting of a facility that was needed for behavioral health ran into the huge road block of the NIMBY (not in my back yard) wall. The permits that should have been easily garnered were not. I hope that, in the future, the commission and the BHA work with all the advocates who	

have come to their aid on so many occasions to permit the Crestwood Pleasant Hill facility, the National Psychiatric Facility in Walnut Creek and who fought very valiantly to get the Knightsen farm that did never materialize. I would also like to make a public comment on conservatorships. My family ran into a huge crisis and one of things I think might have helped is that I believe our conservatorship office and our public guardian must be guided that they fill out a missing person's report once a person who is conserved and deemed a grave danger to themselves or others is found missing, I believe this report should be filed. I would like to ask the Mental Health Commission (MHC) to put forth a motion that this letter go out to the public guardian of record (Anna Roth) and to the guardianship office. I know this is not the first time that families have encountered what our family did go through. I worked very hard with another mother from the Danville community, who also ran into this and had her daughter missing for a long time, out in the Bay Area of California. Let's get this fixed before we find someone that does not make it home. I would like to thank Suzanne Tavano for all her help during the crisis our family encountered. It was luck and heroics , again, that saved someone that we need to have a tighter and better system. Thank you.	
IV. COMMISSIONER COMMENTS • (Cmsr. Swirsding) I ran into an issue with my medications. Going to the pharmacy. I am going to be doing a bit of research, but what the pharmacy was doing was waiting until the last minute to pick up my meds. I have a seizure disorder and cannot do that. I found out the pharmacy was re-running the prescription through if you did not pick up your Rx within two days, and not include the insurance and so the meds would cost $95.00 (normal copay is only $24.00). If you have a lot of meds (like myself) it could get very costly. I complained to the pharmacy and it was corrected. Then, as I stood in line, it was happening to other seniors. So I am going to research. • (Cmsr. Payne) My one comment is just – I would think we need to find out where you are getting your Rx, and what insurance is doing this. • (Cmsr. Perls) We haven't assigned a committee, but I'd like us to investigate Prop 1 – the governor's bond measure and proposal to revamp the Mental Health Services Act (MHSA) and take away an approximate ??% of the funding and moving it to homeless housing for the schizophrenic and psychotic mental health problems. It is a bit more complicated but it is something that will be voted on and I think they will not understand the repercussions.	
V. CHAIR COMMENTS/ANNOUNCEMENTS: ➢ Welcome our new Commissioner Vanessa Rogers, District IV I would like to introduce and welcome our new commission, Vanessa Rogers from District IV. We are so excited to have you join our commission. We look forward to working with you. Angela will be in contact with you with information and you will need. I will touch base with you to talk to you a bit further on the commission, and what committees you might want join.	

VI. APPROVE September 6, 2023 Meeting Minutes • September 6, 2023 Minutes reviewed. **Motion:** T. Payne moved to approve the minutes as is. Seconded by K. Carlson **Vote: 7-0-1** **Ayes:** L. Griffin (Chair), K. Carlson, G. Cohen, T. Payne, P. Perls, V. Rogers and G. Swirsding Abstain: B. Serwin	**Agenda and minutes can be found:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
VII. RECEIVE Presentation External Quality Review Organization (EQRO) Findings - Priscilla Aguirre, MPP, Quality Management Program Manager **<u>External Quality Review Introduction</u>** The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). Behavioral Health Concepts continues to be our External Quality Review Organization. Based in Emeryville, California, Behavioral Health Concepts has conducted reviews of the Mental Health Plan for at least the past five or so years. However, with the onset of CalAIM, the Department of Health Care Services expects to contract with an alternative contract provider to conduct the External Reviews, likely the contractor who reviews the Managed Care Plans, although the date when the transition will occur has not been formalized as of yet. The referenced report in your handout packets was for the review period fiscal year 2022 - 2023. In preparation for the review, all supporting documentation was provided to the EQRO December 2022. Each year my team and I prepare and submit numerous documentation to the EQRO in advance to the site visit based on the requirements. In terms of how we obtain the final EQRO report in your packets, once the onsite review is complete, the EQRO prepares a draft report. The report is sent to the Department of Health Care Services for their review and approval and then EQRO sends it to the county for their review and input. This is a fairly newer process that helps ensure that DHCS and EQRO are aligned in the areas of focus and need for improvement. Once we submit feedback, the EQRO responds to our feedback and then issues the final report. This year's final report was issued in April 2023. **<u>Why is the EQR and its Findings Important?</u>** So why is the EQR and its findings important? Well first of all its Federally mandated but more importantly perhaps is that it helps us evaluate our accomplishments, area of needed improvement and our set of priorities regarding the Mental Health Plan. The review helps us think and plan upcoming programs, and or initiatives keeping in mind a quality lens. The EQRO is fully invested in reviewing the quality of services we provide to our beneficiaries, the access to services and the timeliness of those services. In addition, they 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 extensive about 40 pages in length, their site visit and review of documentation is fairly comprehensive and as you can see	PowerPoint presentation for this agenda item was shared to the Mental Health Commission via screen share. Documentation on this agenda item can be found: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

their corresponding report is rather long but thorough. All the other County Plans participate in the same process.

During my almost 13 years with the county, I have noticed we improve our system of care by way of the feedback/input from the EQRO review team and their findings. Given we are a large county system with a lot of Mental Health Plan mandates, requirements that we have to comply with first and foremost it tends to be challenging to determine which quality improvements to prioritize, EQRO allows us to inform that as well. What has been nice to see over the more recent years is that we tend to align with what the EQRO says we ought to do and are actually making movement towards it. So we are seeing the feedback both internally and from the review process.

The EQRO also gives us another set of eyes to look at us objectively while it also brings us a fresh and current statewide perspective to providing feedback based on the review of the other 55 counties.

Key Areas of the EQRO Report

The makeup of the EQRO report and the content areas of focus within it.

1. Executive Summary (p 6-8)
   Table A: Prior Year (FY 20-21) Responses to Recommendations
   Table B: Key Components
   Table C: PIP Submissions
   Table D: Consumer/Focus Groups
2. Strengths, opportunities and new recommendations
3. MHP Changes and Initiatives (p 12-13)
4. Response to FY 22-23 Recommendations in-depth (p 14-18)
5. Access to Care – Key Components & Performance Measures (p 19-33)
6. Timeliness of Care – Key Components & Performance Measures (p 34-38)
7. Quality of Care – Key Components & Performance Measures (p 39-49)
8. Performance Improvement Project Validation (PIPS) (p 50-52)
9. Information Systems Key Components (p 53-57)
10. Validation of Beneficiary Perceptions of Care (p 58-61)
11. Conclusions, Opportunities, & Recommendations, FY 23-24 (p 62-63)

First is the executive summary, which is nice because it gives you the high level review of how we did in terms of responding to last year's recommendation (Table A*), key components of the review (Table B*), our performance improvement projects both the clinical and non-clinical projects (Table C*), the consumer and caregiver focus groups facilitated by the state with our beneficiaries (Table D*) and the strengths, opportunities and new recommendations.

*See EQRO Report: **https://cchealth.org/mentalhealth/pdf/CAEQRO-Report-2022-2023.pdf**

Prior Years Responses to Recommendations, FY 21-22 (p 14-18)

1. Investigate reasons for the disproportionate access to SMHS among Latino/Hispanic and Asian/Pacific Islander (API) beneficiaries in Contra Costa County. Take action to ameliorate the gaps in service. **(Addressed)**.
2. 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. **(Partially Addressed)**
3. 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. **(Addressed)**
4. 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. **(Addressed)**

5. Evaluate and take action to increase opportunities for beneficiaries and family members to provide feedback related to the MHP system, including the unduplicated number of beneficiaries and family members who participate, types of events, and the methods of outreach, and memorialize beneficiaries and family members participation in meeting minutes. **(Addressed)**
6. Include contractors in medication monitoring review. Identify solutions to barriers including providing access to Epic where contractor services include medication prescribing or monitoring. **(Addressed)**

These are the prior year recommendations for fiscal year 21-22. Out of the six recommendations; we fully addressed five and partially addressed one. Important to note that EQRO deemed none of our recommendations as not addressed.

Regarding the one that were only partially addressed we recognize there is more work that needs to be done. The EQRO took note of our interventions to support and facilitate access however they indicated that the single most significant factor in extended wait time for treatment is the persistent challenges in recruitment and retention of licensed staff in addition to some clinic locations being less desirable job locations to recruit and retain applicants. We have surveyed staff about their concerns and through it we developed a work schedule/WFH pilot that is showing promising results. A committee was assembled to begin addressing how to extend and scale the pilot which will hopefully help with recruitment and retention of clinical staff.

Access to Care – Key Components & Performance Measures (p 19-33)

1A. Service Access and Availability are Reflective of Cultural Competence Principles and Practices **(MET)**
1B. Manages and Adapts Capacity to Meet Beneficiary Needs **(PARTIALLY MET)**
1C. Integration and/or Collaboration to Improve Access **(MET)**
1D. Service Access and Availability **(MET)**

Relevant Performance Measures:
Higher than Statewide Averages

- Beneficiaries Served
- Overall Penetration Rates
- Overall Approved Claims per Beneficiary
- By age groups (except 0-5)
- By ACA Eligible
- Latino/Hispanic and Native American Penetration Rates (although downward trend)
- Latino/Hispanic Approved Claims per Beneficiary
- API Penetration
- Foster Care Penetration Rates
- Foster Care Approved Claims per Beneficiary

The first of the series of component reviews is Access to Care Components. Each access component is comprised of individual subcomponents which are collectively evaluated to determine an overall key component rating of met, partially met or not met. Not met ratings are further elaborated to promote opportunities for quality improvement. Please keep in mind that Contra Costa was able to fully meet or partially meet **all components reviewed under Access, Timeliness and Quality of Care**. With that said, EQRO decided to recommend improvements based on areas we only partially met which from a review perspective is more of a secondary approach to really helping

bring improvements to the system. This is different and unlike not meeting key component areas reviewed by the EQRO which signals a more pointed, significant level of recommendation by the review team to the MHP.

Under the area of Access to Care, Contra Costa did well in meeting the components evaluated by the EQ Review team by fully meeting three of the four components and partially meeting one. The Access to care components were:

1A) Service Access and Availability
1B) Manages and Adapts Capacity to Meet Beneficiary needs
1C) Integration and collaboration
1D) Service Access and Availability

As previously mentioned in the last slide, we are always looking to continue our efforts to recruit, hire and retain staff.

In addition to the key components under Access to Care, there are three major performance measures we are evaluated on by the EQRO:

Total Beneficiaries served
Penetration Rates
Approved Claims per Beneficiary overall, by race/ethnicity, foster care

Some of the key highlights on our performance include claims data show that our overall penetration rate and rates for all age groups (except 0 – 5) are higher than large counties and statewide averages. In case you didn't catch that, higher penetration rates are a good thing as it signals we're serving more of the clients who are eligible for medical compared to other counties throughout the state.

Also our overall approved claims per beneficiary is also higher than large counties and the state average.

EQRO report new: The MHP's PR is approximately 11% higher than the statewide rate for Hispanic/Latino beneficiaries and is 31% higher than the statewide rate for White beneficiaries. The penetration rate for the Native American group is almost double the statewide rate.

Timeliness– Key Components & Performance Measures (p 34-38)

The next Key Component area is Timely Access to Care. Contra Costa also did well in meeting the components evaluated by the EQ Review team. Of the six component areas we fully met five partially met one. The Timeliness to Care Components are:

2A) First Non-Urgent Request to First Offered Appointment
2B) First Non-Urgent Request to First Offered Psychiatric Appointment
2C) Urgent Appointments
2D) Follow Up Appointments after Psychiatric hospitalization
2E) Psychiatric Readmission Rates
2f) No-Show/Cancellations

While we realize we do not offer a first psych appointment within standard 100% of the time, we have been compliant in meeting the threshold established by Department of Health Care Services through the Network Adequacy certification and continue to make efforts to increase the number and portion of psychiatric appointments offered within standard in recruiting/retaining psychiatric staff of which continues to be a national, state and local struggle for mental health plans. However we are making some strides in hiring that has really helped us better ensure we are meeting the standards.

Some of the key highlights in terms of our performance include that Contra Costa outperformed large counties and the statewide averages for both 7-day and 30-day post psychiatric inpatient follow-up as well as the hospital readmissions measures (both 7-day and 30-day). All of these would be considered better than average performance. None the less, we continue to improve on our inpatient follow-up to ensure our clients are connecting with our outpatient services and to find ways to better serve in meeting their needs regarding barriers to attending appointments. The state has also pointed out that while our re-admissions appear similar to that of other counties they believe our efforts locally are helping keep the rates from increasing. **<u>Assessment of Timely Access:</u>** Another look into the Timeliness key components is to the EQROs review of the timeliness measures which according to FY 2021-22 self-reported Assessment of Timely Access data, Contra Costa did well on most timeliness metrics. We have worked diligently to address timeliness issues in the past couple years and have been proactive in addressing any barriers to meeting timeliness. For example, the ccLink team developed a work queue to proactively track beneficiaries whose timeliness for their first offered clinical and/or psychiatric appointments may be at risk, which allows staff to proactively offer beneficiaries earlier appointments or issue a Notice of Adverse Benefit Determination where appropriate. We also developed a comprehensive timeliness report that allows us to monitor timeliness to appointments. If we observe any challenges in monitoring the report we bring it to Quality Management Committee and outreach to the clinics to discuss the barriers and problem solve in order to meet the standards. This has really helped us meet the benchmarks set by Department of Health Care Services around timeliness. Our Follow up appt after psych hospitalization needs improvement and is an area mentioned by our EQRO partners during reviews over the years. This year as a result of an inquiry from the EQRO we really wanted to delve into continuous quality improvement in serving clients d/c from the psych inpatient and so we did a pilot that included a Peer who would support the client discharging and in need of a follow up appt at one of our clinics, by offering transportation if needed and inquiring on any barriers to care to support the client to reach their first appt. The pilot though small has been showing some preliminary success to connecting clients to follow up appts within our outpatient clinics. **<u>Quality of Care – Key Components & Performance Measures (p 39-49)</u>** The largest key component area is Quality of Care, Contra Costa fully met 4 of ten components and partially met six components. There are a lot of subsections to the Quality of Care component so I won't mention all of them however I did want to mention a few things about what EQR liked about our approach to quality and how they along with us recognize that there is more work to do in the area of quality of care. For example 3C Communication from MHP Administration and stakeholder input, involvement in system planning/implementation, we surveyed our staff and they indicated that they wanted more communication from admin. We are currently looking to see what would be most helpful to staff in that communication and how to prioritize the information communicated. We	

re-engaged a BH newsletter this year to share highlights from the Director, key programmatic changes, and to appreciate staff and the work of various departments. We encourage staff to email on content for the newsletter as well. We do hope to get additional feedback on the communication recommendation to push out more impactful communication. Health Services is also redesigning the webpages with the hope to make content more visible, more readable and more helpful to end users like our beneficiaries. Regarding 3D Evidence of Systemic Clinical Continuum of Care the EQRO enjoyed seeing a comprehensive document on our continuum and saw it as a strength. While we have not adopted a specific level of care tool to help decision level of care determinations they highlighted our small level of care pilot in the children's system of care which is based on CANS data and a proprietary algorithm developed by the Praed Foundation (the developers of the CANS/ANSA tools) and how we plan to evaluate the tools efficacy. They also said under 3E Medication Monitoring that while we have good internal medication monitoring practices, prescriber guidance/standards and we track HEDIS measures internally with our county owned and operated facilities/prescribers, we do not monitor these areas among the contract providers. However at the time of the review the EQRO was not fully aware that there are very few prescribers among CBO and even less so when factoring in HEDIS measure outcomes for children/adolescent youth, collectively they make up less than 1% of all services so while we understand the desire it's also a very small amount of clients. Nonetheless we are taking the EQRO feedback into account to meet with CBO prescribers annually to share protocols and review practices to ensure that clients on medication are being monitored using sounds guidelines, set protocol and agency procedures in place. Under 3H Utilized Information from Beneficiary Satisfaction Surveys The EQRO indicated that we should consider a process for sharing survey results with clients. Some of reports over the years have been rather lengthy and could hard to read, even presentations of the data have focus on a lot of percentages and demographic information. While the results have led to some improvement work and performance improvement projects, we recognize the need for something more practical for our clients. As a result and since the EQRO visit my department worked to create a series of 1 page infographics about the MHSIP results from last year, we obtained feedback from Peers and management and have posted them at each of the clinics for clients to read. In this same manner it was pointed out under 3I that we could also do more to formally inform clients about Wellness Centers out in the community for example. The Quality-of-Care Performance Measures reviewed are: Beneficiaries served by diagnosis, & by approved claims Total psychiatric inpatient hospital episodes, costs and avg length of stay High-Cost Beneficiaries Retention Rates Worth Noting - Contra Costa serves a higher proportion of beneficiaries with psychosis and trauma diagnosis than statewide.	

Regarding length of stay and inpatient hospitalizations, in CY 2019 - 2021 the average length of stay was about a half day longer than the statewide average. The number of both unique beneficiaries and inpatient admissions increased in CY 2021. Over 20% of total approved claims are for inpatient claims.

Regarding high-cost beneficiaries these are those who had approved claims of more than $30,000 in a year. Our proportion of HCBs was higher than statewide rate for the past three years.

Regarding retention rates, Contra Costa showed a higher percentage of beneficiaries with only one to four services and a slightly higher percentage for beneficiaries receiving 5-15 services when compared to the state overall.

Performance Improvement Project (PIP) Validation (p 50-52)

The next section of the report and review is the validation of the Performance improvement projects. PIPs often times require us to be very data driven from both a problem perspective and barriers perspective and you have to collect data throughout your planned interventions and those interventions have to be creative but also evidence based which can be challenging to implement in the short period of time using the PIP framework. The PIPs typically run two years and depending on your interventions they may only run one year and then you have to identify new ones to do and study. We are required to have two PIPs (one clinical and one non-clinical) running concurrently every year.

PIP #1 is focused on Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM). This PIP was focused on increasing the percentage of follow-up mental health services with the MHP within 7- and 30-days after ED visits for mental health conditions. This PIP was found to be active and ongoing and, in the planning, and implementation phase with moderate confidence in our methodology. EQRO recommended that we develop strategies to provide navigation assistance for follow up ED visits from non-county EDs. This is also a Quality Strategy metric under CalAIM so we intend on continue to monitor our follow up to emergency room (ER) discharge in the near future.

PIP #2 is focused on reducing no shows to initial assessment appointments using a Gain Framed approach to provider reminder calls. This PIP was focused on improving our no show rate to first appointment by having clinicians contact clients to encourage them to attend their appointment. There is a lot of research that suggests that when clients receive a call directly from their provider it yields greater adherence to appointments. The Gain Frame approach to contacting the client has to do with advising the client of the direct benefits of attending their appointments as an incentive to show up to appointments. Like the first PIP this one was also found to be active and ongoing and in the implementation validation phase. Similarly, to the first PIP, EQRO felt that they had moderate confidence in our methodologies for PIP #2. In this PIP they recommended increasing the therapist adherence to the reminder call protocols.

Information Systems Key Components (p 53-57)

Contra Costa met or partially met all 6 Information Systems key components.

The Key components are:

Investment in IT Infrastructure and Resources is a Priority
Integrity of Data Collection and Processing
Integrity of Medi-Cal Claims Process
EHR Functionality
Security and Controls
Interoperability

This is a newer key component area and there was no performance measures identified in the report.

Validation of Beneficiary Perceptions of Care (p 58-61)

To validate beneficiary perceptions of care the EQ team reviews beneficiary satisfaction survey results as well as conducts their own focus groups during the review with beneficiaries and or caregivers.

EQR conducted two (2) 90-minute beneficiary focus groups, one with adult consumers and one with caregivers of children and youth.

Focus Group #1 – was with a diverse group of adult consumers, the majority of whom initiated services in the preceding 12 months. There were 13 participants, a very good size focus group.

EQRO summarized the findings of the focus group by indicating that the caregivers and parents said that:

- About one-third of the participants were aware of the MyChart patient portal.
- Participants were not aware of the crisis phone number
- Some participants indicated involvement of families in treatment process was not offered to them.
- A few participants felt they were not given a choice on visit format (in person, video, phone)
- Some recall taking a Satisfaction Survey, but none recall being informed of results.

Common Recommendations

1) Provide greater focus on independence and employment, less emphasis on government assistance.
2) Provide more opportunities to give feedback to MHP.

Focus Group #2 – was a diverse group of caregivers of children and youth, the majority of whom initiated services in the preceding 12 months. There were 9 participants including a Spanish interpreter for our Spanish speaking caregivers

The EQRO indicated that participants in this group said:

- Majority of participating caregivers receive reminder calls
- Some recall taking a Satisfaction Survey, but none recall being informed of results.
- One participant had no recollection for any transportation help

Common Recommendations among the focus groups were:

1) Reduce wait times for services when initially accessing care.
2) Improve access to Wraparound services

New Recommendations, FY23-24 (p 62-63)

So in conclusion to the EQRO and the site visit, based on opportunities for improvement here are the new EQRO recommendations for FY 22-23.

This year we have five recommendations total. Earlier I presented last year's responses to the recommendations and how we did on those.

The new list of recommendations will require us to prepare documentation and responses in preparation to our next EQRO visit in 2024.

1. Implement the recruitment and retention strategies identified from staff survey feedback, such as testing alternate work schedules, so as to stabilize staffing and improve recruitment results for both clinical and quality positions.
2. Develop a documentation and clinical process manual that is regularly updated and reviewed with directly operated and contract provider programs that furnishes clear and specific guidance as to the utilization management requirements.
   Develop and publish Frequently Asked Questions from discussions of CalAIM changes that is routinely updated and circulated.
3. Develop an SB 1291 review process that includes both directly operated and contract provider prescribing practices.
4. Expand use of batch files to submit service data claims or provide access for CBO's to directly enter clinical data to eliminate double data entry once the Epic ccLink billing implementation is complete.
5. Investigate reasons for claim denials and develop a plan to reduce denials and recover lost revenue.

Questions and Comments

- (Cmsr. Serwin) Regarding the focus groups, for the outcomes and recommendations are they incorporated into observations and recommendations of this report? Or is that planned for next year? (RESPONSE: Priscilla Aguirre) There are the formal recommendations and then there are areas of improvement that are listed throughout the report and certainly after the section of the focus groups. There is a section on the outcomes of those focus groups. It is really more that they prioritize, anything they observe, the recommendations they made and those are more formal. Responses they want to see the MHP respond to; however, they certainly give us the feedback in the report as a way to perform quality improvement; specifically around what heard in the focus groups. At least in one example, where we are hearing (for example) that they are not hearing results from the satisfaction surveys, that was something I shared, we are now providing infographics that are based at each of the clinics so we are sharing the results in a very friendly way to our clients, which is really a direct result of what we heard in the focus groups, as well as the feedback that the EQRO provided us.
- (Cmsr. Payne) Thank you Priscilla, that was a lot of information. Is there access for the whole report? <Shown link for access that is in the packet attachment to access online as the report itself is too large>
- (Gigi Crowder) As I review counties, more and more are invested in transitional-aged youth (TAY) targeted services, because prevention is important to the county. Does this county have any plans on investing in a system of care specific to TAY, recognizing that it is more often when individual start experiencing their first onset of mental health challenges and many counties have moved in that direction. That might be a questions for Dr. Tavano. (RESPONSE: Dr. T) There is focus on early intervention on psychosis program and largely serving the TAY population. That is one piece already in place. Are you asking about building out beyond that? I would say that with the modernization of

the Mental Health Services Act (MHSA), when we see the final, if the state takes prevention as is planned, that means early intervention. Then there are discussions that 51% of the funding is intended for youth, defined through TAY. There is that piece and what changes might be required for early intervention so it looks about different when we currently do prevention intervention now. If prevention is pulled out moves to the state, that leaves early intervention and the state has been talking about redefining early intervention. We need to see what comes out of that. That is where the majority of funding is in terms of building out specialized services. • (Barbara Serwin) Looking at the broad recommendations presented at the end, it seems the two or three are more technical in nature, where I was hoping under Quality of Care that there is __________ give out point evaluation. I would have hoped to see more of that reflected in the recommendations. • (Wanda Davis) Dr. Tavano, you mentioned 51% of the funding was going to the youth? Is it under 21, or youth? (RESPONSE: Dr. T) I am going to have to take another look. I think it is under 21 as the definition but we will take a look at that.	
VIII. RECEIVE Presentation "Investing in Early Childhood Mental Health" – Dr. Ruth Fernandez, Ed.D, Executive Director and Wanda Davis, Early Intervention Program Officer I want to start by thanking Chair Griffin and all the commissioners for the invitation. It is really a pleasure to be here and to share a little more about First Five's work, specifically in the area of social/emotional development in early childhood mental health. First Five is a public agency that has worked for more than two decades to ensure young children are reaching their full potential by focusing on their most critical years of development – prenatal to five years. First Five was created when voters Prop 10 in the late 1990's. It established 58 First Five county commissions across the state, with a central charge of building and facilitating the implementation of a system of care. Along with that mandate, the mission is to develop a system of care that is connected and integrated to the many other public and private community organizations that are working to serve children in Contra Costa County. Our focus has been on maximizing those first five years of children's lives by helping and working with the adults in the children's lives, which includes families, childcare providers, educators, service providers, pediatricians, mental health providers, everyone in the community in a child's life. Our Mission: To foster the development of our community's children, prenatal through 5 years of age. Our Vision: Contra Costa's young children are healthy, ready to learn, and supported in safe, nurturing families and communities. Core Values: Diversity & Inclusion, Equity, Cultural Humility, and Community Partnership. We actually wear multiple hats out in the community. We are convenor of different agencies. We advocate on behalf of young children in the county, as they cannot advocate for themselves. We are also serve as an incubator for transformational and innovative models of different frameworks and	Documentation on this agenda item can be found: https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

approaches to services that really address system inequities for young children and their families. Lastly, we are also known for being a local funder. We put back out our Prop 10 funding into the community as investments, we fund other community-based organizations and non-profits that are providing direct services to our community. We do everything in partnership to help ourselves, the entire county and our elected officials to better understand the needs of young children. Research shows the importance of interaction between the caregivers and the child in health development and the critical focus on whole family wellness. What we know is that young children's early experiences affect the development of the brain architecture which provides the foundation for all future learning, behavior, and health. During this critical period of a child's first five years, there is a window of opportunity. Prime time. Safe, nurturing relationships, experience and environments really shape, not only build the brains, but really lay the foundation for the competencies that children need. We often get asked what is early childhood mental health? It is all the supports that go into building those conditions prenatal to five years. Building strong relationships and system so that children are cared for and nurtured. We know that healthy growth and development in the first five years almost solely depends on health supportive relationships between a child and their caregivers. Nurturing relationships are an essential ingredient in protecting children against adverse childhood experiences. We know that without buffers to adverse brain development can be compromised and can be negative effects lasting well into adulthood. Adverse childhood experiences that lead to toxic stress before age 18 untreated can manifest into mental illness, poor stress management, unhealthy lifestyles and other negative impacts. So much so, that it has been deemed a public health crisis. One in three children experience toxic stress. In children, this can cause learning challenges, behavioral problems, anxiety, depression, trouble sleeping and can even change DNA long-term. In recent years, we have added a new adversity. The pandemic, an extraordinary stressor on families, particularly our low-income families. Children are experiencing chronic stress at record high levels due to poverty, housing insecurity, violence, abuse, systemic racism and other factors. We wanted to learn more about how families are being impacted and possible solutions. We conducted two family needs surveys in 2020 and, again in 2021. Parents reported the need for improved access to services. They wanted an agile system in mental health support, coupled with concrete support and information that destigmatize mental health. Providers reported the need for more training and help with resource connections. We also know that recently there has also been issue of having adequate reimbursement and staffing shortages across many systems of care. First Five takes a multi-prong upstream approach toward the social and emotional well being of children and families. We work at several levels to strengthen, improve and coordinate services into best practices that are trauma informed and racially just. First Five aligns with the MHSA's prevention and early intervention strategies around prioritizing work to prevent and intervene in early childhood trauma; advancing and instituting early identification practices that promote early detection of social-emotional behavioral and other developmental concerns within early	

childhood settings. Ending the stigma and discrimination through outreach. We support capacity building while offering training. We promote policies and practices that influence policy makers to invest in prevention in young children. We know that each babies potential is unlimited but that the window to provide a child with the foundation of success is not.

Our First Five Centers utilize the protective family protective factor framework to provide concrete supports, like diapers and formula. We also work with providing building relationships so that people have emotional support and social connections. We have classes that increase knowledge of childhood development, positive parenting skills and develop social competencies in children.

When the five protective factors are well established in a family, the likelihood of child abuse and neglect diminishes. We also conduct developmental screenings to help families to better understand their children's development. More importantly, being able to intervene at the earliest signs of concern. We offer healthy growth, development playgroups and specialists to address developmental issues identified through screening. Our First Five staff and health growth coordinators can connect families to additional community resources and help them to navigate our systems of care, which can be very daunting, stressful and confusing to families.

We support and strengthen our community providers by piloting new resource-based practices. We offer training and additional structural support to providers through our common forum capacity buildings, we help providers to prototype trauma informed care and healing practices in their programs. We also offer training on the same subject. We developed the network of care and partnership with alliance to end abuse. It is a community HUB for trauma informed providers where they can connect, learn and access information.

This past September, we've promoted self-care highlighting ways to reduce stress. We have coordinated with a variety of agencies and their staff to gauge in, share wellness activities and to post wellness messages on the Network of Care HUB. They were engaging in yoga, walks, zoom sessions, meditation sessions, stress buster activity and learning session on how to promote wellness in your home and body.

Strengthening Policies and Practices:

- Early intervention and prevention coalition
- First early childhood mental health community forum
- Research Briefs
- Advocacy: SB326 and Measure X

Return of investment, we know the earlier the investment, the greater the return. The unfortunate truth is that even though after three decades or more of brain development research, understanding the importance of the first five years and, now with economists talking about the return of investments from a national workforce development and productivity and efficiency, we are still severely underinvesting in early childhood services across the nation.

Of the 73,100 children, ages 0 to 5 in Contra Costa County, only a very small percentage receive the necessary services and support for optimal development. For example: MediCAL, approximately 500 families with children 0 to 5 currently covered through MediCAL contracts with community organizations that provide specialized early childhood services

that are needed for families with young children. When you think of the 7300, only 500 families. If you think of MHSA funding, we estimate that there is less than two percent of $11.8m in prevention and early intervention MHSA funding that is dedicated specifically for the zero to five population.

We have a great partnership with CCH and the MHSA staff for years and know it has been part of the community input sessions and the zero to five population has been severely underserved for a while. This is not news.

Early Childhood Mental Health Investments:

What are we doing to increase efforts for public partnerships. We cannot do it alone. First Five has been working in CCC for more than two decades developing programs, building coalitions and amplifying families voices about their needs. All in an effort to really improve and maximize their full potential. As a funder, just over the last decade, we have invested over $25m in Prop X funds in early intervention and prevention services focused on children's socio-emotional development. Unfortunately, we have known from our inception that we are part of the syntax. We are the second state in the nation with the highest rate of smoking cessation. The more we stop smoking, and now with Prop 31, where vaping products have been removed from the market, we are on study slope of reduction since 1998.

First Five are taking a conscientious approach in refining what we do and what we focus our resources on. What is clearly written on the campus is that we really have to do this in partnership with others. Other public funds and partners. We believe there are successful funding models that we can replicate to continue to close the gap of critical needs for children. Over the years, we have had other partnerships with the county health department, health and human services, we can do more.

We believe we should be planning for children's services in a more coordinated fashion and to increase the pie for children. With this in mind, we intentionally continue to look for public partnerships that can grow this funding. One of our core strategies is stakeholder advocacy for early childhood investment. Most recently, we have been engaged in a partnership with CCH. One very successful partnership is our expansion of the Triple P-Positive Parenting classes. We have been matching BHS funds with Prop X funds since the beginning about ten years. We are able to provide Triple P parenting classes throughout the county to families.

Locally, we continue to advocate and also increase the understanding of the gaps within community based providers. One example is our engagement with Measure X in the process of informing the community advisory board. My team and other colleagues, come together and have been very involved in informing of what we know from experience and the data we collect on the daily about the gaps in early childhood, including mental health.

Our partners have been providing public comment at the community input meetings that have been offered through the supervisors to, again, speak up about what they are hearing and the critical urgency to invest in early childhood mental health services.

One more example of our advocacy, we have been closely monitoring SB326 – the MHSA modernization act. We understand why the governor is doing this. One of the efforts is to shift the funding to address the needs of other groups like the unhoused. While we know there are other critical needs, we continue to be concerned that there isn't a designated allocation for zero to five investment in the current language. We hope we can continue to elevate

the importance of prevention investment.

Services for young children offer the best return on investment in terms of future savings for mental health care, foster care, patient psychiatric services and all the different things we have heard and talked about just in this meeting today. We believe, right now, given the transitions and new funding we are seeing in our state and county, there is an opportunity to really investing in prevention in the early years. We are interested in continuing to partner with all our public partners and trying to continue to be creative and how to leverage existing resources. Thank you for the opportunity to share our message.

Questions and Comments

- (Cmsr. Stern) My business partner has been on the Board of Directors of Early Childhood Mental Health in Richmond. Do you partner with them? (RESPONSE: Dr. Fernandez) Yes. They are one of our members that gave testimony around challenges they were seeing around childhood mental health at Supervisors Gioia's last session. Many of our partners testified and we continue to speak to the challenges in terms of funding, lack of funding for critical for early childhood mental health systems, for wages that are not sufficient for percentages of funding that's kept by the county rather than in the hands of providers to do the work.
- (Cmsr. Payne) I see the conflict with the cost of living adjustment (COLA) but isn't there also a problem with paying people enough to have them do the job? (RESPONSE: Dr. Fernandez) I think it is a great investment, I mentioned-to clarify- to make it clear that the money allocated through Measure X didn't go to services.
- (Cmsr. Cohen) This brought up a lot of memories when I was getting my bachelor's degree in psychology in Peru, I hated psychoanalysis but they made me read a book, "A Secure Base" by John Bowlby. That book was amazing. With my first son, we had an old school pediatrician and he was of the 'more the merrier' philosophy, my kids are amazing and I don't know if I did something different but I just followed the book and until now, my conversations with my oldest is open and genuine about everything that happens. That book was a life changer.
- (Gigi Crowder) I am a big proponent of prevention, so as early as possible, we should be positioning our staff to provide mental health funding for zero to five, recognizing we need to get a head of the school to prison pipeline. Investment early on will certainly support that so I appreciated the presentation from Ruth and Wanda.
- (Cmsr. Perls) I understand your advocacy and partnerships, but do you actually have employees or staff who run these programs? (RESPONSE: Dr. Fernandez) We don't provide direct service like that, we support the system. In the past we did and we have been in these systems for almost 25 years. We have moved away from direct service slowly. We work very closely with service providers and do the developmental screenings. The most direct is our centers. We have five (5) First Five Centers across the county that are free and open to all families, prenatal to age five.
- (Cmsr. Serwin) Does your organization was able to get a piece of the billions that are being distributed by state?
  (RESPONSE: Wanda Davis) We've done okay. We received two ACES grants, which helped us with a lot of the work around reform of childcare and create a curriculum for support for early childhood and we received approximately $2m for that effort. We did receive in Round 1 with a partnership with <???> additional funding (approx. $400k) to

extend our efforts around Triple P. There have been talks with your managed care plan around possibly doing some partnership with serving children and families together where physicians and behavioral health partner together to create a more holistic approach to serving a child and the family.

- (Cmsr. Serwin) Have you worked with modeled pre-schools? (RESPONSE: Wanda Davis) We work with a lot of early childhood providers. (Dr. Fernandez) We have three areas of focus. Early childhood education and we work with the County Office of Education (COE), Coco Kids, Research/Referral agency and First Five to really increase quality of early learning settings, both at home and family childcare in a private settings. As Wanda said, we do a lot of coaching and have been doing that for years.
- (Cmsr. Swirsding) West County Native American Center (closed?) is one place where parents would bring their young children to and they are directed in the right path. They also work with Building Blocks for Kids. Because it is closed, I had called on someone in the community I know that works with foster kids, about the risks. During the pandemic closure, a lot of the meetings they had were in the schools because parents felt comfortable in that space. In our area we have a lot of shootings and I'm concerned because COVID made things not as available. Have you seen this throughout the county? (RESPONSE: Wanda Davis) You are speaking to two things. One is culturally relevant providers of programs that are really important in terms of people's access and comfortable to be able to go to those services and the other part is, with COVID, a lot of programs did shut down, particularly early childhood education. There are a lot of people who left that field. We are seeing the same thing in our mental health providers. The 'great resignation'
- (Cmsr. Griffin) I just want to thank you both. What can we do as a commission to help advocate? Why is the zero to five the least funded group of kids? What is that? Is it because people don't think they need help? Is it just training society and people to know this is the most important time in kids lives? What is it? Why are they underfunded? (RESPONSE: Wanda Davis) I used to be the Director of the Early Intervention Program, and people used to talk about infant mental health and people would say 'what is that? Baby's like couches?' so I think part of it is people not understanding that young children have social and emotional needs and those needs start early and that the formation and connection to their parents and their parent stressors and them understanding who their child is can make or break a child. I think that is one thing that people aren't really in tune to. The other thing is we often run to the crisis. We run to put money at things are tertiary system. Not thinking about if we start at preventative, then maybe we wouldn't have these tertiary issues.
- (Cmsr. Griffin) How are parents? Do they buy into this? Or do you find they hold back because 'my child doesn't have issues' or not going to have issues? How do you educate the parents? `(RESPONSE: Wanda Davis) Often parents will say 'we don't have a manual' what should we do? I think what parents don't want to see is stigmatized and made to feel they are the problem. Parents don't want to feel they are somehow not being responsible in caring for their children so the way you connect to a parent and build that relationships, all those are central to how they see themselves in the service. I also feel like having services that reach a diverse range of people, we all come

from different cultural backgrounds and needs and we have all had messages. Some messages say mental health is a problem and we don't talk about our business. So recognizing those things and having a workforce of diverse is one way to tackle some of those issues. (Dr. Fernandez) The way it is structure and how children are lumped into a category is elimination at times. There is a big range (zero to 25) so often, prenatal to five can be lost in translation. One might say we provide a gamut of services, but if you don't have the specialized services you need for prenatal to five, it is very easy to be aloof of any focus. That is why it so important that you actually dedicate and call out zero to five and how you budget and invest.	
IX. Nomination Committee Volunteers – Cmsr. Serwin Cmsr. Serwin went through the nomination and voting process as well as the request for volunteers for the committee, the responsibilities and expectations.	
X. RECEIVE Report out: MHSA Advisory Committee Liaison, Cmsr. Perls	***Due to time constraints, this has been tabled for next month***
XI. Committee Report out: Justice Systems and Quality of Care/Finance committees	***Due to time constraints, this has been tabled for next month***
XII. RECEIVE Behavioral Health Services Director's Report, Dr. Suzanne Tavano ➢ Update on Care Court implementation in Contra Costa County ➢ Children's Crisis Center and Psych Emergency Services (PES) Expansion and Invite (Dr. Tavano) The youth Crisis Stabilization Unit (CSU). The doors have been incredible. They should be here now and installed and the building finished by the end of the month. We are hoping the provider would be able to take possession by the middle of November. We are hoping to have a soft opening for a couple of weeks with maybe up to four youths so the provider is used to the operations, the workflows are working and then go to full operations. There are a couple things we are still working with CCRMC about. (1) If a youth experiences a medical emergency and needs to go to the ED, we will have a work flow consistent with other programs on the campus. (2) if there are eight youth in the CSU, there will be a flexible period of time to see what the volume, utilization is, etc. So, it might be that for a period of time, if there are more than eight youth that one or two might to PES. The numbers usually don't go there. We would like to thank Dr. Shaw and Jaspreet for their flexibility. Regarding Care Court, I would like to coordinate a presentation with you to the full commission. As I have mentioned before, for us and our consultants to go to committee meetings and then have to repeat the presentation to the full commission when it is a topic of general interest, there is so much going on and for efficiency's sake, those items that we know are going to be of general interest to the full commission that we do that during the monthly meeting. I think that is when you have your largest attendance from the community. So for Care Court, we are hoping to be able to work with you. Informational "What is Care Court? What are the moving parts? Who is eligible? Who is not eligible? What the expectations are?"	

Our consultant, Roberta Chambers of Indigo will be conducting these informational sessions. We will schedule a series and we are hoping she is available in December if that works for the commissions schedule. I would recommend a significant amount of time be allocated because it is complicated and the presentation will be complicated. A number of you will be receiving an invitation to be part of the planning committee, and it will be a pretty diverse group. I have been communicating with the court system and, as of yesterday, the presiding judge had not yet made an assignment of where Care Court will be located. When that is determined we will, of course, start partnering with the judge to do more of the planning jointly going forward. It would be great to get it scheduled in December; if not, in January.

(Jaspreet Benepal) We shared with our Behavioral Health Care Partnership (BHCP), Dr Shaw came in and shared that Psych Emergency Services (PES) expansion that we been referring to, the three models, we have moved away from that. The reason being, when the experts came to work with us on the Measure X funding, which PES was part of that expansion of those projects, they actually brough different information as part of their expertise to share with us. Having the additional 3k sq ft to the existing 6k is not really going to serve the purpose of what we were trying to accomplish, which is to increase the space to accommodate our increased volume for the past few years.

The recommendation is to increase PES by 19k sq ft. The other aspect they shared was that once we start constructing PES, the services would be majorly restricted and disrupted for almost a year and a half, due to _________ which is OSHPD approvals, etc. This has taken a different turn from our vision. The Measure X funds that is assigned to PES expansion, but we are finding out the expansion will bring a lot of disruption and not accomplish the goal we were hoping. There are several proposals the company (Blue Cottage Cannon Design Company) presented to the steering committee, which was shared with our JCC (joint conference committee) with Supervisor Gioia and Supervisor Glover. We are also presenting at the full Board on November 7. If we are going to expand PES, we would like to expand to the maximum capacity projecting the needs of the community and be able to meet the volume we are seeing today. I can send the link if the commission is interested or I can come back to present the two options that were presented to us.

The discussion going on with the Board, the JCC and with company that presented. Dr. Shaw, our CEO, and the rest of the steering committee were having these presentations at the CCRMC and Health Center Board.

Questions and Comment

- (Cmsr. Griffin) Just for clarification, Jaspreet. Did you say at the November 7th that you will be presenting?
  (RESPONSE: Jaspreet Benepal) Yes, the presentation on Measure X will be presented at the Board of Supervisors meeting and part would be the information regarding the PES expansion and BHS. The company that is engaged in this (Blue Cottage Cannon Design) looking at the community needs and the projection in five years, ten years of mental health needs are saying the 3k sq ft. will not really address the needs of the demand we will have in the community today and moving forward. If we are going to disrupt the services on the third floor, we would really like to have the expansion be to address all future needs, not just a band aid fix.

That presentation will be November 7 in front of the whole Board. • (Cmsr. Griffin) Could you send us the link? Jaspreet Benepal to send. • (Cmsr. Stern) 3k sq. ft. to 19k sq. ft. is a BIG expansion. Is that going to be on the grounds of CCRMC or in another location? (RESPONSE: Jaspreet Benepal) The options presented are on the grounds of CCMRC. They may not be as jointed as PES is now, but will be on the campus. • (Dr. Tavano) Ideally, we would be able to decentralizing some of the services so they are more accessible. But as we started out the meeting and Lauren raised an issue, getting community support for the types of programs we know are needed and we hear the community saying they want, to then get the support of the community to actually establish those types of programs, is part of the challenge. Ideally, start regionalizing access to more of these levels of care would be ideal. • (Jaspreet Benepal) Lauren, the hospital is built on a hill, so if you come from the front lobby, PES is on the third floor, but from the back you go directly into PES as if it is the first floor. In-patient psychiatric unit is on the fourth floor. • (Cmsr. Serwin) When will the design options be presented to stakeholders. (RESPONSE: Jaspreet Benepal) Dr. Shaw started with BHCP and came to present (not the full options) a summary and update. The links were sent to the whole group to look at the designs. If there is a special request, we can present here or at the full Board on November 7. I will definitely send the link. There has been no final decision as to which option. Before the decision is made, that would be the point when we would like to engage community stakeholders more actively than we have to this point. • (Cmsr. Serwin) I feel the commission is often 'Johnny come lately' to these reviews. The BHCP, which is affiliated more with the hospital, seems to consistently have the opportunities and the commission is unaware of the milestones (kept out of the loop). The milestones where it's important for the commission to actually have the opportunity to review and provide feedback, I feel this is something that has gone on for years and I strongly request there to be a mechanism put in place that we (MHC) are give an heads up that these important milestones are coming along and; therefore, have the opportunity to be prepared. We request these presentations at the full commission meetings. • (Kim McCarl) I just wanted to clarify, the presentation that will happen on November 7 is about all the Measure X funding that the department received and not specific to the hospital and will not include a walk through of all the proposals, so Jaspreet, I think we should touch base about that. I think we should discuss a different way to present all the different proposals with this group, because the meeting on the 7th is not likely to be that level of detail. I just wanted to be clear about that. • (Jaspreet Benepal) Perhaps I didn't make myself clear, the presentation is on all the projects related to Measure X, not just PES expansion. It is just part of it. If the commission wants, we can bring those presentations to the commission and go over the options when it is convenient you, Laura. I am happy to have the team come and do the presentation. • (Cmsr. Perls) If we receive a presentation about options, I think what we are interested in is involving the MHC long before you have options to add our expertise. We represent all the different districts and hopefully	

all the different constituents and families requiring mental health treatment. The report we just received about the performance in the county notes multiple times that constituents and users of the system are not consulted. We should be right up with consulting. We should be giving our input at the beginning and not long after the fact of an update. (RESPONSE: Jaspreet Benepal) I agree, the options are not final options but given to us by the company. There is no finalization of any options, definitely we want the decision makers, the community and the commission to be involved in completing the final conclusion. One thing I do want to say is that a lot depends on the dollar amount. There are a couple that are quite expensive and that would be a challenge for us to accomplish, but the company still presented those based on the projections of the needs of the community moving forward. I don't know which month would be good for us to come present. I will be more than happy to do that with my team. I just need to know when it is a convenient time for you all. • (Cmsr. Griffin) I am concerned about Dr. Tavano – she has a time constraint. Do you have a couple more minutes? • (Dr. Tavano) Yes I can. One thing about this, I think it is how the MHC prioritizes its presentations and use of its time. Sometimes it is hard, let me just say if you don't prioritize some of these things, then there is not the time built into the monthly meeting to go over them. Just a thought and a suggestion because sometimes there are presentations that are wonderful but take up a great portion of the meeting, but then there is not enough time to always to present on some of this and have the kind of exchange, which is a bit different in the BHCP because there is more allocated and it is concentrated. Every month we are focusing on issues. I think there is a bit more time for exchange. • (Cmsr. Griffin) Thank you Dr. Tavano. We will see if we can schedule for December, as soon as possible. • (Gigi Crowder) Thank you Dr. Tavano, I am going to echo what you said about BHCP, which is no longer just a focus on PES, we look at the continuum of care and I think Jennifer and I, along with the sponsors have done a great job of being on the pulse of what is important to individuals as it relates to that continuum of care. We build our agenda each month based on trending topics and what people want to hear. We also do so, making sure we allow enough time for the updates and we prioritize the updates. That is the difference between our meeting and it is open to the public so MHC can certainly attend. • (Cmsr. Serwin) I would just respond that my key point is that the Commission is not aware of the key milestones. We are not pushed by BHS and so we don't know how to prioritize those topics when we are not even aware. Often times, we don't find out until we see them being reported to the Board of Supervisors. It is not about how we prioritize our topics meeting to meeting, but having the information to know what to prioritize in terms of where BHS is putting <cut off / talk over by Gigi Crowder, missing dialogue> • (Dr. Tavano) The monthly meeting with the chair and vice chair of the commission, I look to that time to talk about the different things coming up how to prioritize them in discussions with the MHC. That is the opportunity. We can go from there. • (Cmsr. Griffin) Definitely hearing what you are saying and we will take this up at the Executive Committee and see how we can better look into	

the milestones and collaborate with BHS. We will definitely take it up, look at it on our end and see what we can do better on our end as well. • (Dr. Tavano) Chair Griffin, I wanted to acknowledge you. You have been very consistent in our meetings and I know you are being very thoughtful and I want to thank you and let the group know that you are really doing a lot of good work. • (Cmsr. Swirsding) Just echoing to attend NAMI.	
XIII.Adjourned: 6:36 pm	

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External Quality Review Findings

Mental Health Commission

October 4, 2023

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External Quality Review (EQRO) Introduction

- Federally Mandated, MHP Contract
- Annual, independent review of the quality of services provided to Medi-Cal beneficiaries by contracted managed care plan
- California's External Quality Review Organization (EQRO): Behavioral Health Concepts, Inc. (BHC)
- Review Period: FY 2022 - 2023
- Documentation Submission: December 2022
- Onsite Review: January 18 - 19 2023 via Zoom Video
- Final Report Issued: April 2023

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Why is the EQR and its Findings Important?

- 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

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Key Areas of the EQRO Report

1. Executive Summary (p 6 – 8)
   - Table A: Prior Year (FY 20-21) Responses to Recommendations
   - Table B: Key Components
   - Table C: PIP Submissions
   - Table D: Consumer/Focus Groups
   - Strengths, opportunities and new recommendations
2. MHP Changes and Initiatives (p 12-13)
3. Response to FY 22-23 Recommendations in-depth (p 14-18)
4. Access to Care – Key Components & Performance Measures (p 19 - 33)
5. Timeliness of Care – Key Components & Performance Measures (p 34 - 38)
6. Quality of Care – Key Components & Performance Measures (p 39 - 49)
7. Performance Improvement Project Validation (PIPS) (p 50 - 52)
8. Information Systems Key Components (p 53 - 57)
9. Validation of Beneficiary Perceptions of Care (p 58 – 61)
10. Conclusions, Opportunities, & Recommendations, FY 23-24 (p 62 - 63)

1. Prior Years Responses to Recommendations, FY 21-22 (p 14 - 18)

1. Investigate reasons for the disproportionate access to SMHS among Latino/Hispanic and Asian/Pacific Islander (API) beneficiaries in Contra Costa County. Take action to ameliorate the gaps in service.	**Addressed** ☺
2. 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.	**Partially Addressed** ☺
3. 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.	**Addressed** ☺
4. 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.	**Addressed** ☺
5. Evaluate and take action to increase opportunities for beneficiaries and family members to provide feedback related to the MHP system, including the unduplicated number of beneficiaries and family members who participate, types of events, and the methods of outreach, and memorialize beneficiaries and family members participation in meeting minutes.	**Addressed** ☺
6. Include contractors in medication monitoring review. Identify solutions to barriers including providing access to Epic where contractor services include medication prescribing or monitoring.	**Addressed** ☺

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2. Access to Care – Key Components & Performance Measures (p 19 - 33)

	Access to Care Components Evaluated	Rating
1A	Service Access and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Partially Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

Access to Care - Relevant Performance Measures

Higher than Statewide Averages

- **Beneficiaries Served**
- **Overall Penetration Rates**
- **Overall Approved Claims per Beneficiary**
- **By age groups (except 0-5)**
- **By ACA Eligible**
- **Latino/Hispanic and Native American Penetration Rates (although downward trend)**
- **Latino/Hispanic Approved Claims per Beneficiary**
- **API Penetration**
- **Foster Care Penetration Rates**
- **Foster Care Approved Claims per Beneficiary**

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3. Timeliness– Key Components & Performance Measures (p 34 - 38)

	Timeliness Components Evaluated	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No Show/Cancellations	Met

Higher than Statewide Averages

- **7-day post psychiatric inpatient follow-up rates**
- **30-day post psychiatric inpatient follow-up rates**

Similar than Statewide Averages

- **7-day readmission rates**
- **30-day readmission rates**

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3. Timeliness– Assessment of Timely Access (p 36)

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5.65 Days	10 Business Days*	97.2%
First Non-Urgent Service Rendered	7.96 Days	15 Business Days**	92.7%
First Non-Urgent Psychiatry Appointment Offered	12.77 Days	15 Business Days*	81.9%
First Non-Urgent Psychiatry Service Rendered	16.27 Days	30 Business Days**	87.6%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	37.68 Hours****	48 Hours*	89.3%
Follow-Up Appointments After Psychiatric Hospitalization	16 Days	7 Days**	45.8%
No-Show Rate – Psychiatry	15.9%	10%**	n/a
No-Show Rate – Clinicians	14.2%	10%**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033
** MHP-defined timeliness standards
**** The MHP Reports in days which must be converted to hours

For the FY 2022-23 EQR, the MHP reported its performance for the following period: FY 2021-22

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4. Quality of Care – Key Components & Performance Measures (p 39 - 49)

	Quality of Care Components Evaluated	Rating
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	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Met

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4. Quality of Care Con't – Key Components & Performance Measures (p 39 - 49)

	Quality of Care Components Evaluated	Rating
3G	Measures Clinical and, or Functional Outcomes of Beneficiaries Served	Met
3H	Utilized Information from Beneficiary Satisfaction Surveys	Partially Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Consumer and Family Member Employment in key Roles throughout the System	Partially Met

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4. Quality of Care con't - Relevant Performance Measures (p 42 - 49)

Higher than Statewide Averages (worth noting)	• **Percentage of beneficiaries only receiving one service** • **Percentage of beneficiaries receiving between 5 – 15 services** • **Beneficiaries with a trauma diagnosis** • **Percentage of approved claims with trauma and psychosis diagnoses** • **7-day and 30-day *follow up after hospitalization* rates**
Higher than Statewide Averages (-)	• **Inpatient Hospitalization length of stay (LOS)** • **High-Cost Beneficiaries** • **7-day *readmission* rates** • **30-day *readmission* rates**

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5. Performance Improvement Project Validation(p 50 - 52)

PIP Validation	PIP #1 (Clinical) Follow-Up After ED Visit for Mental Illness (FUM)	PIP #2 (Non-Clinical) Gained-Framed Provider Reminder Calls to Reduce No-Shows to Initial Assessment Appointments
PIP Status (Per DHCS requirement)	Active and Ongoing	Active and Ongoing
Validation Phase	Planning and Implementation Phase	Implementation phase
Validation Rating	Moderate Confidence	Moderate Confidence
PIP Recommendations	There are four other non-county EDs in Contra Costa County. The MHP will likely need to develop specific strategies tailored to these locations as it seeks to provide navigation assistance for follow up ED visits. Consider administrating the CANS-50 at the same interval as the other measures The MHP can benefit from recruiting a large number of participants for more data to analyze.	Emphasizing automated reminders was going to be a recommendation but the MHP already incorporated this into year two revisions.

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6. Information Systems Key Components (p 53 – 57)

	Information Systems Key Components Evaluated	Rating
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	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

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7. Validation of Beneficiary Perceptions of Care (p 58 - 61)

Reviewed both beneficiary satisfaction surveys by MHPs and contractors.

Focus Group #1 Adult Consumers (13 participants)

- About one-third of the participants were aware of the MyChart patient portal.
- Participants were not aware of the crisis phone number
- Some participants indicated involvement of families in treatment process was not offered to them.
- A few participants felt they were not given a choice on visit format (in person, video, phone)
- Some recall taking a Satisfaction Survey, but none recall being informed of results.

Common Recommendations

1) Provide greater focus on independence and employment, less emphasis on government assistance.
2) Provide more opportunities to give feedback to MHP.

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7. Validation of Beneficiary Perceptions of Care con’t (p 58 – 61)

Focus Group #2 Caregivers of Children and Youth (9 participants, including Spanish interpreter for Spanish speakers)

- Majority of participating caregivers receive reminder calls
- Some recall taking a Satisfaction Survey, but none recall being informed of results.
- One participant had no recollection for any transportation help

Common Recommendations:

1) Reduce wait times for services when initially accessing care.
2) Improve access to Wraparound services.

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8. New Recommendations, FY23-24 (p 62-63)

	Recommendations
#1	Implement the recruitment and retention strategies identified from staff survey feedback, such as testing alternate work schedules, so as to stabilize staffing and improve recruitment results for both clinical and quality positions. (This recommendation is a modified carry-over from FY 2021-22.)
#2	Develop a documentation and clinical process manual that is regularly updated and reviewed with directly operated and contract provider programs that furnishes clear and specific guidance as to the utilization management requirements. Develop and publish Frequently Asked Questions from discussions of CalAIM changes that is routinely updated and circulated.
#3	Develop a SB 1291 review process that includes both directly operated and contract provider prescribing practices.
#4	Expand use of batch files to submit service data claims or provide access for CBO's to directly enter clinical data to eliminate double data entry once the Epic ccLink billing implementation is complete.
#5	Investigate reasons for claim denials and develop a plan to reduce denials and recover lost revenue

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Q & A
Thank you

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