MENTAL HEALTH COMMISSION
QUALITY OF CARE COMMITTEE MEETING MINUTES
October 19th, 2023 - FINAL

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Quality of Care Committee Chair, Cmsr. Barbara Serwin, called the meeting to order @3:33 pm. Members Present: Chair - Cmsr. Barbara Serwin, District II Vice-Chair, Cmsr. Laura Griffin, District V Cmsr. Pamela Perls, District II Cmsr. Rhiannon Shires, District II Cmsr. Gina Swirsding, District I Other Attendees: Angela Beck Ashleigh Goddard, Supv. Burgis' Ofc. Jen Quallick, Supv. Andersen's Ofc. Marina Ramos, MHSA AC Rep	Meeting was held at: 1340 Arnold Drive, Ste 126 Martinez, CA and via Zoom platform
II. PUBLIC COMMENTS: None	
III. COMMISSIONERS COMMENTS: • (Cmsr. Shires) Reminder of the CALBHB/C quarterly meeting and training is this Friday (October 20). For those who haven't done the Implicit Bias Training, there will have this from 3:15 - 5:45pm, as well as community engagement training. It is Saturday from 9am-12noon. It is how to be an effective MHSBH Board member/commission member. I think all of us should attend. • (Cmsr. Perls) I am planning to attend, not sure about Friday (Cmsr. Shires) you can attend virtually, in person it is at the Airport Embassy Suite in Burlingame. <cross talk by several commissioners, unable to hear> • (Cmsr. Swirsding) Update on the Walgreen's prescription billing and possible fraud issues. I called MediCARE and, believe it or not, they sent me to the Quality of Care division. They stated they are very concerned, it is not only happening there, but also wide-spread and wanted to let you all know it is happening at other pharmacy's and they are aware of it. I'm concerned about the seniors and the confusion they are causing.	
IV. CHAIR COMMENTS: None	
V. APPROVE minutes from the August 17th, 2023 Quality-of-Care Committee Meeting. Cmsr. G. Swirsding moved to approve the minutes. Seconded by Cmsr. R. Shires. • Vote: 5-0-0 Ayes: B. Serwin (Chair), L. Griffin, P. Perls, R. Shires and G. Swirsding. Abstain: none	**Agendas and minutes can be found at:** https://cchealth.org/mentalhealth/mhc/agendas-minutes.php

VI. DISCUSS EQRO report, focus on 1) evaluating Behavioral Health Services (BHS) plans for improvements; and 2) understanding what improvements were made during 2021 to 2022. Develop list of questions for BHS

Our job is to develop a list of questions for BHS. This was presented at the last commission meeting and it was a very fast presentation and there was no time for questions and some commissioners had mentioned about the link to the full report. This is why I put the agenda on the Quality of Care committee agenda. The idea is to develop a list of questions and we will pass those over to Quality Improvement/Quality Assurance (QI/QA) with BHS requesting responses to our questions.

I did develop some question but let's start with other commissioners (other than myself), let's take questions and we will have these minutes to develop the list.

Questions and Comments:

- (Cmsr. Swirsding) Many clients with behavioral health problems have a hard time going to the doctor. I remember mention of something having to do with kids and wanting to have a psychiatrist. Is this the right question to be asking here? (RESPONSE: Cmsr. Serwin) If it is in the EQRO, yes. (Cmsr. Swirsding) I just feel there needs to be addressed. I'm concerned there are kids on medications and not having a psychiatrist to monitor. Going to a crisis center, needing the medication and there is no psychiatrist to evaluate and monitor. Is there a protocol under development? I'm concerned the crisis center has no designated psychiatrist on staff. Question is, if a kid is needing to be evaluated for medication, are they referring them to psyche emergency services (PES) or after it is opened, the children's crisis stabilization unit (CCSU)? Are they looking into this if the CCSU doesn't have a psychiatrist. (RESPONSE: Cmsr. Serwin) Just to clarify, I am not familiar with the overall process. Cmsr. Griffin and I went on the tour of the new PES building and some of the process and staffing seem to be a bit unclear still. We were told that there is a physical health component of it and the psychiatrist not staffing it. I'm not sure who does the assessment. It may start with those physical health doctors. I think if they have psych issues, they will pass them over to the psychiatric staff.
- (Cmsr. Perls) I thought the psychiatrist was going to be supplied by the general intake staff
- (Cmsr. Griffin) I think they will do the same for the crisis center. I just wanted to mention that I have been working really hard to get Suzanne Tavano and the team for PES to give us a presentation like they did at the Behavioral Health Care Partnership (BHCP). She had promised me in November, I contacted Mary Shepard with Pacific Clinics (the county contracted provider for CCSU), so I contact Mary to see if she could do a presentation like they did. It was a great presentation. We want to stay involved and that was the reasoning by NAMI CC (National Alliance on Mental Illness Contra Costa) being there, too and of course they wanted to be involved. So I was intercepted and Mary told me that I needed to speak with Dr. Tavano and Dr. Tavano said she would coordinate it for me and I'm still waiting. I have been very politically nice and trying to ask her, but she is out of town and won't be back until right before the meeting.
- (Cmsr. Shires) Doesn't she have a backup? (RESPONSE: No) <Jennifer Bruggeman did reply and stated Dr. T would be back before the MHC deadline>

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

- (Cmsr. Shires) I still believe Dr. Tavano needs to put her summary report in writing. I think it's too much information. It is hard to process during the meeting and I cannot even come with appropriate questions. There is no time to digest or research. There is a lot of things you do with information to handle it in an intelligent way and, you may not be in agreement with me but I need to speak up because I keep bringing it up and having it on record. (Cmsr. Serwin) I have asked multiple times, as well. Just like she kept bringing up and talking about CalAIM and once I brought it up with Jennifer, the next meeting she stopped speaking on it and addressing our questions. Of course they have a new format for the contract and they are all standardized with a standardized process. It is a huge deficit for us right now. I'd like to have her more accountable. (Cmsr. Shires) If we have it in writing, it is also (to me) more helpful to have the information in front of us to thoughtfully process and ask intelligent questions. On the other board, Fatima writes out a whole summary for us every month.
- (Cmsr. Griffin) I totally agree with you. How realistic is it? Have you ever asked her for that? (RESPONSE: Cmsr. Serwin) I don't feel it is highly realistic, she has so little time for the commission. We should definitely ask. I am just trying to think how, it would be nice to ask, send her the two or three questions and her have a written response.
- (Cmsr. Swirsding) The MHSA Advisory Committee (MAC), they would do a review also with what is going on and this would help her with other meetings to do just one report. (Cmsr. Shires) And just to note on record that most all people do that, she (Suzanne) is the only one that does not.
- (Cmsr. Serwin) I think asking one on one in the leadership meeting might be healthy because it is not in a public forum.
- (Cmsr. Shires) If we're a consensus, we can say as the Mental Health Commission is requested and we are all in agreement that this would be beneficial for us and for you (Suzanne).
- (Cmsr. Griffin) I have it down as an action item to follow up with her. You are right, our meetings are just all over the place and, when it comes to her? First of all, I can never hear on that speaker. Here is the deal though…she will not be available to meet with me in October and she is also out of town.
- (Cmsr. Serwin) How many meetings has she made this year?
- (Cmsr. Griffin) Maybe we have met 5 or 6 and, by myself, I might add. The other thing, then of course, December we likely won't meet because we usually meet the last Friday of the month. We are going to have new leadership in January and that is something we are going to take up. The other question is, can the Executive Members attend that leadership meeting? Food for thought and I don't think we will get anywhere the rest of this year. Whoever is in leadership next year can pick this up.
- (Cmsr. Serwin) One thing I know about the Executive Committee, that is the opportunity where you have the opportunity to talk under less pressure and more directly. (Cmsr. Griffin) I don't mean the Executive committee meeting, I mean the executive members attend the leadership meeting.
- (Cmsr. Serwin) I mean, how is the transparency? If you had another partner there then you would have help. <example if the vice chair couldn't attend with the chair, perhaps another executive member could attend in that person's stead>
- (Cmsr. Serwin) Back to the EQRO discussion, looking at the report to see if there are questions to pass on to QI/QA. Those presentations tend to focus

only on the positives and, unfortunately we don't have the opportunity to do what we are supposed to be doing, which is to probe where there are opportunities for improvement and ask how those improvements are meant to happen. Some of these are smaller ticket items than others and not prioritized yet.

- One thing, as I have the questions I'd like to ask, not so much of BHS but more for the EQRO team. The summary of key components (timeliness, quality of care, access and all those things rolled together) ten out of 26 are not met, yet there was no focus on this. There was an analysis, to some extent (that summary), but there wasn't a bullet point for each one of those items that were not met. So, I'd like to ask: How is this possible? How is this acceptable?
- The second question I would direct to the EQRO Team, which has not been done before and probably wouldn't make people happy, but I think that is who we need to put the question to, because they did the review. The question is: Under the impacted access findings, none of the deficits found in this section are actually articulated. You see in the table that they are not fully met but you don't learn about why not.
- In the quality key components section, only six out of ten components are partially met. Why is there not more elaboration at this performance?
- How can there be no impact by the unmet standards of the timeliness measures (pg 38)? There is a list of time to provide assessment, first psychiatric appointment, post hospitalization psychiatric appointment and all the time it takes to get those. We don't meet all the standards. There is just no follow up in the discussion.

- Questions for BHS they could clarify for us:
  - They talk about penetration rate and average approved claim benefit for 2023 and that is for adults, children, foster care and the range of ethnicities that we serve. There are no targets set. Everything is set up against the State's benchmark (I don't know if you noticed that in all these tables). It just seems like 'Is the aim just to beat the state? Or do you have a target? That's the only thing measurable. (Cmsr. Shires) You are saying state benchmarks? So they are not looking at our county? (Cmsr. Serwin) What I mean to say (pg 36) there is a timeliness measure (will come back to this), the main thing is there is no stated goals. Have we met the county's standard or the average for the state (all counties)? So we are comparing ourselves to other counties and the state average. The questions is, is that what we want? Meeting the state average or surpassing? In many ways we do surpass, but there are ways in which we don't.
  - Regarding the CBOs (Community-based organizations) connection to the electronic health records of beneficiaries that they serve for the county / on behalf of the county. Right now they don't have access and they don't have the ability to update the electronic health record of their beneficiaries. They can't type in data directly, so it is either double enter or (it's hard to tell) it's sent over in batches, which is inefficient. They can look up information but they can't enter it and there is a lag for some BHS staff can't see the information for certain beneficiaries and vice versa. This effort has been going on for a long, long time. It is still stated as something that will be done. What is being done to finally

implement the direct data entry for CBOs to the electronic health records?

- We have been told over and over that the shortage of psychiatric staff across the board (all positions) is really a holdback for implementing services, projects, improving on the wait time situation. State this lack of staff available to be hired. What I'd like to know, what is the current tally of the total number of hired clinical staff and key management staff, vs. the number of empty slots for each type of staff. How many people do we have? How many slots are empty?

- (Cmsr. Shires) And what are they doing to recruit?
- (Cmsr. Serwin) We have been told a bit in this report, but not fully. One of the questions kicked around a lot, flexible scheduling. The second thing is looking at non-cash incentives. I asked at the last commission meeting about that… what are we doing to improve our compensation packages to make them competitive with other counties. In the EQRO report, it just says it is being explored. It's been explored as long as I've been on the commission. What are the barriers to that?
- (Cmsr. Shires) I'd like to know what the present non-cash incentives are? What does the package look like beyond the salary? What are they offering right now? That could be the reason they have a shortage, not just how much they pay, but <interrupted by Cmsr. Serwin> I've seen it and to me it's not enough to draw someone that has a 30% more difference between other counties. (Cmsr. Perls) I think that's an endless excuse. It's their excuse for health carriers, every department-crisis management, etc. It's just the condition of everything. Either you pocket up or you do something to reach further and recruit.
- (Cmsr. Shires) There are two things, either results or excuses. They have to give something up because we are losing on so many fronts because we are trying to do the same stuff with not enough people. Whatever they are doing isn't working and they have to go into the infrastructure and figure out what exactly isn't working because we are not getting results.
- (Cmsr. Swirsding) The problem, throughout the medical field, there is a shortage everywhere. Evin the pharmacy I am dealing with. It is the problem, they haven't enough workers. And they are running around over worked.
- (Cmsr. Griffin) This comes out yearly? When was the last time we reviewed it? (Cmsr. Shires) Last year. (Cmsr. Griffin) So it is for us to review each year?
- (Cmsr. Serwin) Lauren Rettagliata had a good suggestion, doing it at Quality of Care. She suggested Executive committee but don't think that group is turned in, these are primarily quality issues. We can explore at both.
- (Cmsr. Perls) Is there a different person that can give this report? Does it fit under any particular department?
- (Cmsr. Serwin) The director is the captain of it and there is a department (QI/QA) that is very involved in managing the process and working with the EQRO team from the state and going through all the utilization, financials and all the quality data, the delivery services, etc. It is a state mandated review process. I would expect the team hasn't changed that much, although different people might be assigned to different counties.
    - There is a share care system that has been meant to sunset and transfer over to a ccLink system. The function of that system is billing. Again, this

is one of those things that has just been going on forever. I bring up because it is just delayed functionality and inefficiencies, plus it's expensive to do this work. We have some people on board from Epic, the software used, and there are a lot of consultants and that is expensive.

- Another pet peeve: the new CalAIM contract template hasn't been developed yet. I saw comments that were at various stages in the CalAIM process. It makes sense, it is a tremendous amount of work but it is one question I'd like the answer to.
- How does the access line virtual assessment process works. Is it being done remotely? Is that what they mean by virtual? Or do they mean there is software that runs you through some questions and determines whether or not you need certain services? How does that program work? Then the other piece: they are able to take the call, have them assessed and then, if need help, have them speak with a psychiatric staff member – clinical or psychiatrist (dep. on their need) right away. Instead of being two appointments-the assessment appointment and then the second appoint (sometimes quite a long wait time), they are trying to do this in one appointment. It is hard to imagine how this works. Psychiatrists and psychiatric nurses are not available on demand and in short supply, so I want to learn about how that works. (Cmsr. Shires) Is it possible to get a copy of your notes with the pages? I'd like to take it home and really dig in and research through. I think you pinpointed some excellent issues and now we need to take a further look.
- Penetration of race beneficiaries. It seems to be low. Why is it low? BHS says it is hard to really know because so many people don't indicate their race ethnicity. Definitely fair or not, some of that percentage might be undocumented workers or other. So their response has been that we need to look more into how can we better record this information. One thought (because it isn't being filled out on the paper forms) was to have the access line workers ask their race and ethnicity. Why would someone be willing to tell you that straight up if they won't write it on a piece of paper? I don't now if, it doesn't seem like a strategy that will get to the bottom of it.
- East county was pointed out as particularly difficult to staff due to potential candidates are not as interested in living in East County. That is what they threw out, but said they lost 10 or 11 of 14 staff over the last two years. It sounds like they haven't backfilled because they didn't state they had. I would just like to know how is East county operating with only three clinical health specialists right now.
- Wait times and wait lists: I was trying to get a handle on services after initial assessment. What are the current wait times and the wait lists. This is something that really threw me off. It sounds like a major strategy for decreasing wait times. An ongoing reassessment of the individuals as they wait. Waiting to get an appoint, but instead of waiting, they are checking in to see if you have gotten any better? Who do you need to talk with now? They may have thought initially to send them to a psychiatrist, but now think you can speak with? They are also shifting people to other providers and those other providers have wait lists too and it is like getting passed around.
- Another strategy is brief therapy engagements where there is a stated goal, stated number of sessions. A lot of insurances require. They don't

support open-ended therapy. I wonder how that is effecting outcomes? How long has this been going on? (Cmsr. Perls) Screening is different from assessment. Are they doing any screening? Screen online and then (you have to decide what you are assessing). (Cmsr. Serwin) I'm not sure with the access line, I don't know the terminology usage is. • Despite the multiple channels of obtaining beneficiary feedback, focus groups show they don't feel like they have a feed back out of it. BHS made a claim that they get it in the form of MHSA feedback engagement with the MHC and BHCP. I just felt like (1) MHSA feedback seems to deal more with preferences regarding needs to be addressed and not specific feedback to interactions with the mental health care system (so quality concerns). What are other more direct ways being considered. • BHS indicates that it obtains stakeholder feedback on specific plans under development, including the MHC as a stakeholder. It says 'critical input' specifically plans under way and I said we <u>didn't</u> provide 'critical input' in plans in 2020-2023 and that we haven't provided 'critical input and involvement' in system planning and administration for the period. We were very rarely, if at all, that we were informed that plans were at a juncture, requiring MHC feedback. I asked how will BHS remedy this serious problem? What kind of process can be designed to ensure the MHC is kept apprise of plans, progress and key points of community input? • What are the percentages of beneficiaries that are receiving telehealth services? How does East county have services that meet the network adequacy benchmarks (30 min or 15 miles from a beneficiary)? Apparently, the county does meet the network adequacy benchmark set by the state and I'm wondering how they heck East county do this when it is so sparsely staffed? • To improve access, BHS performed monthly follow up on all beneficiaries that include _____ and are waiting for treatment. How did they follow up? How is this acceptable? Doesn't it conflict with the access key component 1D "BHS is confident in its ability to provide initial intake and assessment in a timely manner." Basically, if you are following up every month on someone, that means the waitlist is long, the wait time is long. If you have to wait 30 days, that is a long time. If you have to wait multiple months… that I didn't have <trailed off> This is all beneficiaries waiting for services.	
VII. DEVELOP questions for November Commission meeting presentation by BHS and Indigo Consulting on what has been learned regarding the Behavioral Health Continuum Infrastructure Program (BHCIP) and Behavioral Health Bridge Housing (BHBH) grant development and submission process	***Agenda Item tabled.***
VIII. UPDATE on Vicente High School Site Visit taking place on October 27, 2023 (Cmsr. Griffin) We need to settle meeting date. Jennifer didn't realize we were planning on meeting with MHSA again with them. I had to clarify with Jennifer. Our site visit is next Friday (a week from tomorrow). We need to decide what we are doing as far as questions. Are we meeting together as an ad hoc and develop the questions and when? Are we meeting again with MHSA? (Cmsr. Serwin) We need to do both. I wouldn't be surprised if the ad hoc comes together the week before.	

(Cmsr. Griffin) According to Jessica Hunt, we need to get them an agenda prior to, they are waiting for an agenda. Why is that? (Cmsr. Serwin) We just fit in, we don't drive the agenda. Let's go through the agenda right away to see where commissioners would like to attend: the site walk-thru, the meeting with the program manager at the beginning of the day (principal). They should be driving the times. It will be Cmsr. Perls, myself and Cmsr. Payne. Cmsr. Griffin is back up. (Cmsr. Griffin) We really need to meet. Discussion of time frames available to meet on Monday, 10/23 @ 3:00pm for an hour and a half. Cmsr. Griffin to send out the meeting invite to just the ad hoc committee. Meeting with MHSA folks Tuesday, 10/24 @ 2:00pm (just before the Executive Meeting in person in Suite 126).	
IX. Adjourned at 4:58 pm.	