AGENDA - PUBLISHED

CONTRA COSTA COUNTY Mental Health Commission

Thursday, July 18, 2024 **3:30 PM** **1340 Arnold Drive, Suite 126, Martinez**

https://zoom.us/j/5437776481
Meeting number: 543 777 6481 | Call in: 1 669 900 6833 | Access code: 543 777 6481

Quality of Care Committee

The Committee will provide reasonable accommodations for persons with disabilities planning to attend the Committee meetings. Contact the staff person listed below at least 72 hours before the meeting. Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Committee less than 96 hours prior to that meeting are available for public inspection at 1340 Arnold Drive, Suite 126, Martinez, during normal business hours. Staff reports related to items on the agenda are also accessible on line at www.contracosta.ca.gov. Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

For Additional Information, please contact: Angela Beck (925) 313-9553

I. Call to Order, Roll Call and Introductions

II. Public comments on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to two minutes).
In accordance with the Brown Act, if a member of the public addresses an item not on the agenda, no response, discussion, or action on the item will occur, except for the purpose of clarification.

III. Commissioner comments on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to two minutes).

IV. Chair comments and announcements

V. APPROVE minutes from June 20th, 2024, Quality of Care meeting **24-2132**

Attachments: Quality of Care-Committee Minutes 06.20.2024 DRAFT

VI. DISTRIBUTE the 2023-2026 Contra Costa County Behavioral Health Services (BHS) Cultural Humility Plan to be discussed at August 15th, 2024 Quality of Care meeting **24-2133**

Attachments: Att A_CHP_FINAL

VII. DISCUSS External Quality Review Organization (EQRO) 2023-24 report and compile questions for Behavioral Health Services (BHS) Quality Improvement/Quality Assurance (QI/QA) **24-2134**

Attachments: Att B_Contra Costa MHP FY 2023-24 Final Report CMH 040524
Att C_Quality of Care questions for 2022-2023 EQRO report 1.20.24

VIII. DISCUSS questions for Detention Behavioral Health Services at the West County Jail and the Marsh Creek Jail in preparation for visits to these sites by Commissioners

IX DISCUSS 2024 goals and priorities – complete previous discussion **24-2135**

Attachments: Att D_MHC Quality of Care Committee Projects as of January 2024 3.11.24

The next meeting is currently scheduled for August 15, 2024 @ 3:30pm.

X. Adjourn

1025 ESCOBAR STREET
MARTINEZ, CA 94553

CONTRA COSTA COUNTY

Staff Report

File #: 24-2132 **Agenda Date:** 7/18/2024 **Agenda #:** V.

Advisory Board: Mental Health Commission - Quality of Care Committee
Subject: APPROVE minutes from June 20th, 2024, Quality of Care meeting
Presenter: Cmsr. Barbara Serwin

Minutes from June 20th, 2024, Quality of Care meeting

MENTAL HEALTH COMMISSION
QUALITY OF CARE COMMITTEE MEETING MINUTES
June 20th, 2024 - DRAFT

Agenda Item / Discussion	Action /Follow-Up
I. Call to Order / Introductions Quality of Care Committee Chair, Cmsr. Barbara Serwin, called the meeting to order @3:36 pm • Cmsr. L. Griffin moved to approve the motion requesting approval for Cmsr. Barbara Serwin to participate remotely based on "emergency circumstances" for the MHC Quality of Care Committee meeting today, June 20, 2024 (In accordance with AB2449 -Teleconferencing options allowed under the Brown Act, dated March 1, 2023). Seconded by Cmsr. J. Towle • Vote: 5-0-0 • Ayes: L. Griffin (Chair), Y. Burrell, V. Rogers, G. Swirsding and J. Towle. • Abstain: none • <u>Members Present:</u> Chair - Cmsr. Barbara Serwin, District II* Cmsr. Y'Anad Burrell, District I Cmsr. Vanessa Rogers, District IV Cmsr. Gina Swirsding, District I* Cmsr. Jenelle Towle, District IV *Remote/Zoom <u>Other Attendees:</u> Cmsr. Laura Griffin, District V Angela Beck Alejandra Escobedo, Family Services Coordinator, Adult Mental Health Ellen McDonnell, Public Defender (4:35pm) Lucy Nelson, Family Services Coordinator-Children's Mental Health Jen Quallick, Supv. Andersen's Ofc.	Meeting was held at: 1340 Arnold Drive, Ste 126 Martinez, CA and via Zoom platform
II. PUBLIC COMMENTS: None	
III. COMMISSIONERS COMMENTS: • (G. Swirsding) Discussed prescription refill issues. Problems stemming from AI (Artificial Intelligence software) the pharmacy and insurance is insisting on using instead of human customer service. Prescriptions are being filled one at a time, and alerting the refill is ready; therefore causing multiple trips to the pharmacy. Created problems with MediCare and receiving treatment. Feels it is very important to alert both the pharmacy and medical personnel of the problem. Cmsr. Was able to receive and take all her meds for a week (which is a really big problem). It is not just Walgreens (her pharmacy), but other pharmacy's as well. Her situation is not unique, she is concerned for other seniors and those constituents with mental health medication needs. • (Y. Burrell) Would like to add the Cultural Humility Plan (2023/26) to the agenda to have a conversation on this at the committee meeting in August.	
IV. CHAIR COMMENTS: None	

V. APPROVE minutes from the April 18th, 2024 Quality-of-Care Committee Meeting. Cmsr. G. Swirsding moved to approve the minutes. Seconded by Cmsr. Y. Burrell. • Vote: 4-0-1 Ayes: B. Serwin (Chair), Y. Burrell, V. Rogers and G. Swirsding. Abstain: J. Towle	**Agendas and minutes can be found at:** https://contra-costa.legistar.com/Calendar.aspx
VI. DISTRIBUTE a copy of the External Quality Review Organization (EQRO) 2023-24 report and a copy of questions regarding the EQRO 2022-23 report prepared by the Quality of Care Committee for Behavioral Health Services (BHS) Quality Improvement/Quality Assurance (QI/QA) This External Quality Review Organization (EQRO) Report is performed in every county and is a third party review, organized by the California Department of Health Care Services (DHCS). This report covers MediCal specialty care only on big picture topics such as access to care, who is able to receive and timeliness, how long the wait list, quality of care. There are a couple quality of improvement projects that departments work on every year. Another big topic is information systems performance, measurements and impact on healthcare for the county. We spent the latter part of 2023 reviewing the 2022 EQRO report and developed a host of questions. The April meeting we met with the Quality improvement/Quality Assurance (QI/QA) team and Informatics to receive response to many of our questions. The next meeting, we will dive into the 2023/24 report and begin documenting our questions and hoping to get through that review in the next two meetings and document our questions. We will combine the questions for the new report with any remain 2022 questions. *Please reference Attachment A 'EQRO 2023/24 report' and Attachment B 'Quality of Care questions for 2022-2023 EQRO Report' and the EQRO Report (https://www.cchealth.org/home/showpublisheddocument/28588/638333969768052065)>* Cmsr. Serwin's suggested a place to start would be to review the Executive Summary; Reviewing "Response to 2022 Recommendations" section; comparing that to the "Response to 2023 Recommendations". Each year, the report identifies challenges, strengths and recommendations. It is helpful to jump to the recommendations to see how the department did over the past year. After digesting the recommendations, it is helpful to navigate the review of the full report, as you have an overview of what you will be reading. Cmsr. Serwin went through the packet review. **Questions and Comments** • (Cmsr. Swirsding) Why people on MediCare are not able to participate? (RESPONSE: Cmsr. Serwin) The state offers public services to people with a certain level of need and it that is the group this is focused on. This is a review of public behavioral health services that BHS provides. This is not looking at total private/public insurance. • (Cmsr. Burrell) Page 8, there are listings of opportunities for improvement and recommendations. It looks more focused on career/professional development. One states shortages of 30%, another speaks to working with contracted providers. Drop down to recommendations and it is retention and the third bullet is about review process; it appears to be just in those pages without going through the rest. More professional development focused. The full report may have other information but it is really unfortunate, when looking at it for the overall summary, those two areas focus on professional development and there is no actual quality.	**Agendas and minutes can be found at:** https://contra-costa.legistar.com/Calendar.aspx

Also, Page 7 regarding focus groups (Table D) they have eight or nine participants and it seems excruciatingly low for a yearlong report. We understand the world is different now based on everything that has happened since 2020. There is a lot of trust to rebuild in the health systems and getting individuals to participate. Eight and nine participants is not really representative of such a dynamic report.
(RESPONSE: Cmsr. Serwin) Thank you for those observations. Regarding the second one, I whole-heartedly agree. Recruitment is always difficult and I am unaware of their recruitment process so that is a good question to ask. Regarding the first, also a great question to ask. There are a lot of questions for the past report as to why/how the reviewers prioritize? Some of the prioritization didn't feel what our thoughts on priorities. This is an example of that – in terms of your thoughts about it. Additionally, the work of BHS has definitely been quite compromised by the inability to recruit adequate number of staff and a major reason why there would be a focus on this. Have they done the right things, enough of the right things in the past to meet their requirements. We will want to ask why this is the focus as opposed to other care issues we think are more important.

- (Cmsr. Towle) Just to piggyback, we can read this and take it into consideration but I don't like we don't know, it is a very small sample and don't actually know the composition of the sample. How to they intend on training across cultures? It seems like a great opportunity since they are short staffed to fix that problem.
- (Cmsr. Serwin) We are meant to be an objective viewer of this report. So, before calling into question the number of people in the focus groups, being circumspect about the kinds of conclusions that are drawn from these focus groups is a reasonable thing to do. The question of hiring staff that can work with the various constituencies of the BHS clients. I don't know if this is covered in the report or not. In past there has been some coverage but not a lot.
- (Cmsr. Burrell) Can you define difficult time hiring? (Cmsr. Serwin) Finding enough people that speak Spanish, Farsi, a lot of it is the language competency.
- (Lucy Nelson) If we have questions, should we share them? (Cmsr. Serwin) We will go through the formal process of review and documenting our questions.
- (Lucy Nelson) We are part of the work, providing individuals for the EQRO and have been part of this process for the last year or so and supporting the process. They say we need about 12 members of the community receiving services. They ask for 12, I will invite 20 or more. In the end, we have about eight people show up even providing transportation, etc. (Cmsr. Serwin) That is typical and you need to have certain incentives. Lucy Nelson ran through thru a lit of difficulties in getting people to participate.
- (Cmsr. Burrell) As a former ED, Nonprofit that served TAY (Transitional Aged Youth), one thing we would while in program already, the focus group for them would happen. We would take them out and have them come on Tuesday 3-5 but then come at this date to do this other program. That is where they fell off, so while they were in program and already there, this is was part of the program. We have to get them while we already have them and add another layer of stipend. That is where we get a tremendous amount of participation.

- (Cmsr. Swirsding) Being a registered nurse, I make contact with a lot of them, and also speaking for myself, I am a part of Stanford Health-all of my physicians are of color. The big problem in the health care system is the storage, both in the private and public health center. There has been a definite shift due to the shortage.
- (Cmsr. Rogers) Regarding provider shortages, I am surprised everything was met with that 30% people shortage but still access was 100% met. Unsure how that works but I am excited to learn about that. Second comment, two small focus groups would be able to complete a report like this so I thought there might be a survey and it looks like there is a survey. Consumer perception surveys, being a MediCaL member and my mother also, never have seen a survey before. Do we have access to the survey data? Or is it something we can locate? (Cmsr. Serwin) we can certainly ask. I would be surprised if we couldn't have access. We would ask for that through QI/QA and could be one of our immediate requests.

Questions and Comments

- (Cmsr. Swirsding) I have a concern after reading through all these reports. It bothers me that West County did not receive their funds because they were late because the School District in West County as there was some malfeasance. Now the State of California is overseeing West County's finances. There are a lot of kids that are exposed to gun violence. <point of order, interrupted not on topic with agenda>
- (Cmsr. Burrell) Clarification, is the $4.7B for the SBHIP or $72.3M reduction this year and the $349M reduction next year just specific to the CYBHI? (RESPONSE: Cmsr. Serwin) it's the CYBHI is the larger umbrella project. SBHIP is one of the projects under the CYBHI. No specific information on the SBHIP reduction amounts at this time.

VII. REVIEW Student Behavioral Health Incentive Program (SBHIP) December 2023 (bi-annual) reports from SBHIP school districts

Documentation on this agenda item can be found:
https://contra-costa.legistar.com/Calendar.aspx

Reviewed the semi-annual reports. Quick summary, it is a MediCAL program and managed by the county's public health plan. All counties in the state have their own program so we are speaking only two Contra Costa county. It is all focused on Behavioral Health and Wellness programs. There are four school districts participating, selected to participate in this pilot program: Antioch, Pittsburg, West County, and John Sweet Unified school districts. The projects are interventions being implemented at these schools. Each report has a summary of overall accomplishments and each district is covered separately within each report. Every six months there are ongoing stakeholder status meetings.

The big challenges of the project were hiring staff or contract resources to deliver new behavioral health services and wellness programs.

VIII. DISCUSS potential cuts to the Children and Youth Behavioral Health Initiative (CYBHI) and SBHIP budgets.

Documentation on this agenda item can be found:
https://contra-costa.legistar.com/Calendar.aspx

Discussion from last commission meeting (June 5) regarding the provisional May 2023/24 Budget for next year. One of the items discussed was cuts to the Children and Youth Behavioral Health Initiative (CYBHI). The program we are watching carefully (SBHIP) is a part of CYBHI. The CYBHI is a $4.7B initiative over five years. SBHIP is a three-year program that is a part of the CYBHI. Reviewing the budget reductions (summary provided by CALBHB/C), one of the items was the cuts to the CYBHI was a proposed one-time reduction of $72.3M from the

general fund this year; $349M from the general fund next year; then $5M from the general fund in 2025/26. These are funds for schooling, health partnerships, and capacity grants for higher education institutes, etc. all under the umbrella of the CYBHI. Without doing the math, it is estimated that a little over $400M (close to $425M) so that is a significant cut percentage-wise. So it's about 8% which is significant.
Cmsr. Serwin reviewed the various reports.

There was a lot of interruptions and talking out of turn / commenting not on topic of this agenda item, participant muted and eventually dropped from Zoom call due to point of order being violated multiple times.

IX. DISCUSS 2024 goals and priorities – complete previous discussion

There was not much time to go through the list of projects but There is a long list and we must consider what the priorities are and what we are able to accomplish with only six months of the year left and which we can realistically accomplish. Also consider we will be merging with the AOD Advisory Board and we don't know exactly what will transpire with this committee, whether it will combine with any kind of Quality of Care committee that AOD has or continue to operate as we are. We have been advised to proceed with business as usual and continue with the projects as usual and not get bogged down with what ifs.

(Cmsr. Griffin) They have created a committee in BHS that is putting this all together for us. Basically, they will dismantle the MHC and AODAB and will create a new BHC (Behavioral Health Commission) and there will be a Board Order created and voted on. I was told no one will lose their position and there will be a survey they will send out in the month of September (likely during our commission meeting) and will give us a report out on how it will look, what it encompasses. The survey letters/forms will ask if we want to continue with the new combined Board as well as other questions. We will have to have Veteran, a student (or under 25), someone that works for educational services and a few other categories to touch upon all groups. The Board of Supervisors (BOS) said to continue business as usual until the end of the year. I have been working with Logan Campbell (the chair of AODAB) who has received basically the same information.

(Cmsr. Serwin) Did you say BHS is inventing this or that is the BOS?
(Cmsr. Griffin) The BOS has assigned a group of individuals that are in BHS, not sure who they are, what departments they are in, but it is the BOS calling the shots.
(Cmsr. Serwin) Are you and Logan on this committee?
(Cmsr. Griffin) We were supposed to be an ad hoc committee and work a bit more in depth than what we have been asked to do so far and then it was changed to this new group handling it within BHS. We are volunteers, not county employees but we are kept in the loop.
(Cmsr. Serwin) So I have strong feelings about that the commission should have a role in this and I wonder, is this something we would express as individuals? Is there a way we can express it as a commission? Or do you feel it is a train that rolling and there's no way to stop it.
(Cmsr. Griffin) It's a train that's rolling and emphatically, it will be in place January 1, 2025. The governor is pushing all counties that have not done so yet. Suzanne Tavano and Fatima Matal Sol are the point persons and they would get together with us and give us more detail on what we could do and what feedback they needed from us. At this point, I have not heard anything back yet

except for the surveys going out. They will be creating the board order. They could have went two ways: combine and reorganize; or dismantle and create a new board order. The law states it must be 15 people but with the criteria and combining both the current members are guaranteed to be on and not lose their positions. (Cmsr. Serwin) That's very helpful, I just think another way would be for individual commissioners to speak with their appointed supervisor to express an opinion. There is a concern about conflict of interest with who is doing the reorganization. (Cmsr. Griffin) Colleen Awad (with Supv. Carlson's office) is the point person for the BOS but the one thing they advised is that the strongly urge all commissioners to attend an AODAB meeting to start seeing how their board runs. As I learn more, I will be updating everyone.	
X. Adjourned at 5:04 pm.	ZOOM recording available at: https://zoom.us/rec/share/zqTyP1q1gH9ERDjJTKwikpEwz0QQGho_PHARtMAa-gv9fsd08O6qGE9ulMZzdmde.SSYOPxIKyxjb8FdO [zoom.us] Passcode: kuk65^V7 Passcode: P@8r%6Y%

File #: 24-2133 **Agenda Date:** 7/18/2024 **Agenda #:** VI.

Advisory Board: Mental Health Commission Quality of Care Committee
Subject: Contra Costa Behavioral Health Services Cultural Humility Plan
Presenter: Cmsr. Barbara Serwin and Cmsr. Y'Anad Burrell

ATTACHMENT A:

2023-2026 Contra Costa County Behavioral Health Services (BHS) Cultural Humility Plan

2023-2026 Cultural Humility Plan

Contra Costa Behavioral Health Services

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Cultural Humility Plan Summary

Contra Costa Behavioral Health Services (CCBHS) has ongoing efforts to bolster a system of care that is culturally and linguistically responsive to better meet the needs of the communities served. This Cultural Humility Plan and/or Plan Update details programming in CCBHS to addresses identified disparities. CCBHS recognizes the importance of developing services and working with community partners that are receptive to the cultural and linguistic diversity of the communities served and the need to invest in a quality workforce that supports the cultural and linguistic needs of those served. It is important that systems continue to invest in building services, relationships, policy, and funding for communities which have been historically marginalized; understanding that racism and discrimination is a public health crisis and communities continue to face challenges due to structural racism, discrimination, and inequities.

Focus Areas and Future Goals

CCBHS continues its work in previously identified Focus Areas identified through the CCBHS Reducing Health Disparities (RHD) Workgroup Survey in 2019. Programming has continued to support target population of Latina/o/e/Hispanic, Asian/ Pacific Islander communities, young children, Lesbian, Gay, Bisexual, Transgender, Questioning/Queer, Intersectional, Plus (LGBTQI+) youth; as well as African American/Black communities leveraging more appropriate services in ways that align with client cultural values and linguistic needs. In 2021, the RHD Workgroup further identified Action Items for each Focus Area as recommendations to CCBHS leadership. These discussions, however difficult are ongoing. Outcomes to date have been summarized below.

Focus Area 1.) Continue strengthening dialogue between the CCBHS RHD Workgroup and CCBHS Leadership. Continue to improve and invest in a System of Care that fosters space for healing and difficult discussions, recognizing at times, the complex system complicity of causing harm or distrust in communities that are supposed to be served. Revisit approaches and allow for dialogue to encourage peer/clients/consumers, families, community, and staff to build equity, health, wellness, and trust.

Action Item(s):

a.) Ethnic Services Manager/Ethnic Services Coordinator will at minimum, meet quarterly or more, if necessary, with CCBHS Leadership to update, communicate and identify methods to support equity as it relates to behavioral health and identified action items.

Outcome: Ethnic Services Manager meets quarterly with CCBHS Leadership to communicate equity efforts. Provides regular reports used within CCBHS and larger CCH system.

Focus Area 2.) Build up language access in Spanish, which is this County's threshold language, as well as language access that extends to the changing demography of the community.

Action Item(s):

a.) Start process to interpret key CCBHS links/info on web pages into Spanish to support equity, and based on identified priority population needs, External Quality Review Organization (EQRO) recommendations, threshold language requirements, and disparities identified in Cultural Humility Plan. Recommend starting with the CCBHS Homepage and working on to other key sites.

b.) Recommend also including some basic information on website about Access Line in the languages of Chinese (written and traditional), Tagalog, Punjabi, Farsi, Portuguese, Vietnamese.

Outcome: In late 2023, CCH updated its website. Through these updates, an imbedded interpretation device was established and allows for information to be interpreted into Arabic, Chinese (simplified), Chinese (traditional), Filipino, French, Hindi, Japanese, Korean, Persian, Portuguese, Russian, Spanish, and Vietnamese.

Focus Area 3.) Work to strengthen community engagement and involvement, including peer/client/ consumer and family voices. Track how and where this is happening, to further build healthy equitable relationships.

Action Item(s):

a.) Work to increase number of peer/clients/consumers and family members, specifically from historically marginalized communities, such as BIPOC and LGBTQI+ communities involved in stakeholder committees as a manner to continually move equity forward. Whether consumers are appropriately served in ways that align with their cultural values and linguistic needs is an issue that has been raised by many community stakeholders and advocates and is something that warrants ongoing assessment. Additionally, marginalized populations identified both in quantitative and qualitative data in Cultural Humility Plan are listed below.

- Latina/Latino/LatinX/ Hispanic
- Asian communities – at minimum identified as Chinese and Filipino communities, based off 2020 Census Data, but also in reviewing Language Line calls supported through the County's Linguistic Access Services and through the Health Care Interpreter Network (HCIN), communities which speak Punjabi, Farsi, Portuguese, and Vietnamese
- Families of Children (ages 0-5)
- LGBTQI+ youth
- African American/ Black Communities - although penetration rates show to be serving at minimum or higher rates in this population, stakeholders have voiced the need for more culturally appropriate services specific to the African American/ Black communities.

Outcome: This area has proved challenging, and CCBHS continues to explore methods on how to better encourage engagement.

b.) Work to translate Community Program Planning Process Surveys into languages listed above to gather input from these communities.

Outcome: CCBHS provided surveys to the community in 2022 in other languages, however, other than Spanish, no responses were received. Additionally, the new website features updated in 2023 allow for translation of surveys into other languages. This is a new feature and CCBHS is still exploring its use.

c.) Work within CCBHS to further identify methods to support and engage these groups. Some of the current efforts include the idea to support community defined practices for Asian and African American/Black communities through MHSA-Innovation funds.

Outcome: A CCBHS Innovation project was established to allocate funding to target underserved and inappropriately served communities to support mental health and wellness. As a result, CCBHS did extensive work with community stakeholders to create a Request for Proposal that provided a funding opportunity of $6 million over an estimated three-year period to support Community Defined Practices (CDP). A CDP is a practice reflective of a community or culture and is embraced by that community and supports that community's mental health and wellness. CDPs are rooted in customs, behaviors, values, and beliefs that may be passed down or shared in community, serve as informal system of support which individuals/communities may practice as part of their daily lives. The services may be provided by a qualified practitioner, a peer, promotora, community health worker, trained facilitator, traditional healers, or trusted community member based on that community's definition. Through this process the following 17 agencies were identified as awardees. CCBHS is in process of establishing contracts with the below listed agencies to further community defined practices of mental health and wellness. The population to be served is highlighted in the following table.

Table 1. Community Defined Practices Awardees

	African American / Black	Latino/e/x	AAPI	Children & Youth	Older Adults	LGBTQ	Recent Immigrants	Faith-Based
Being Well				X				
Center for Human Development				X		X		
Contra Costa AAPI Coalition			X					
CoCo Family Justice Alliance	X	X	X					
Early Childhood Mental Health Program	X	X		X				
East Bay Center for Performing Arts	X	X	X	X				
Genesis Church	X							X
International Rescue Committee							X	
James Morehouse Project		X					X	
La Clinica de la Raza		X					X	
La Concordia		X						
NAMI Contra Costa	X	X	X			X		X
One Day at A Time		X		X				
One Accord	X							X
PEERS	X		X					X
Richmond Community Foundation	X	X	X	X				
Village Community Resource Center		X						

Focus Area 4.) Ongoing support of the CCBHS workforce and partner community agencies to support the diverse needs of the community. Support more specified cultural humility, anti-racism, self-care, and trauma informed systems training.

Action Item(s):

a.) Offer following training, based on feedback from Workforce Survey.

- Training in relation to Racial Trauma
- Training in relation to working with the African American/Black Community
- Training in relation to LGBTQ+ Community/ Sexual Orientation/ Gender Identity (SOGI)
- Training in relation to working with the LatinX/ Hispanic Community
- Training in relation with working with undocumented people
- Training in relation to working with immigrants

Outcome: CCBHS has expanded its training, however there are still several areas that need further attention and support. Much of the training focused on cultural groups has not been realized due to several other training demands, specifically State required training due to California Advancing and Innovating Medi-Cal (CalAIM) implementation and other programming.

Focus Area 5.) Promote and invest in professional development programs that support quality staff in CCBHS including contracted CBOs with specific consideration of staff with language capacity and lived experience, systems involvement experience, and cultural responsiveness to serve and meet the identified needs of BHS clients and community.

Action Item(s):

a.) Prioritize CCBHS and contracted CBO staff for student loan repayment program with specific consideration for:

- Language capacity – prioritize Spanish, Chinese languages (Mandarin and Cantonese), Tagalog, Punjabi, Farsi, Portuguese, and Vietnamese
- Cultural responsiveness
- Lived experience

- Systems involvement experience

Outcome: CCBHS is participating in the Greater Bay Area Regional Partnership Loan Repayment Program, which is a State program that provided matching funds to counties which elected to participate in the program through a regional partnership agreement. This allowed CCBHS to offer educational loan repayment to CCBHS staff and CCBHS contracted Community Based Organization (CBO) providers; where the State provided about 67% in funding and participating counties needed to match with an additional 33% of funding. Through participation in this program, CCBHS has been able to award 60 individuals with educational loan repayment. Individuals identified for award may receive up to $10,000 in educational loan repayment in return for a 12-month service obligation, meaning 12-months of completed work. Priority was placed on individuals which could fill a language or cultural need, and those with lived experience. Applicants were surveyed. All individuals had the opportunity to skip some or all questions asked below.

Table 2. CCBHS Loan Repayment Program Survey Responses

Number of Awardees Which Provided Response to Survey Questions	58
Provide Services in Other Language	27
Self-Identified as Having Personal Lived Experience	39
Self-Identified as Client/ Consumer/ Peer	39
Self-Identified as Having a Close Family Member of Someone w/Mental Health Challenges	44
Self-Identified as Previous Systems Involvement (personal or close family member involved in Juvenile Justice System, or Adult Justice System)	22
Self-Identified as Having lived in a foster home or group home at any point during your childhood (0-18 years of age)	11
Self-Identified as First-generation college student/graduate	39
Self-Identified as Military (Active, Reserve, Veteran)	7
County CCBHS Staff	34
CCBHS Contracted CBO Staff	26

Criterion 1: Commitment to Cultural Humility

I. Commitment to Cultural Humility

Contra Costa Health's Mission, Commitment and Statement of Philosophy

The mission of Contra Costa Health (CCH) is to care for and improve the health of all people in Contra Costa County with special attention to those who are most vulnerable to health problems. Its commitment and vision are to:

- Provide high quality services with respect and responsiveness to all.
- Be an integrated system of health care services, community health improvement and environmental protection.
- Anticipate community health needs and change to meet those needs.
- Work in partnership with our patients, cities, and diverse communities, as well as other health, education, and human service agencies.
- Encourage creative, ethical, and tenacious leadership to implement effective health policies and programs.

CCBHS is one of the eight divisions under CCH. Mental Health and Alcohol and Other Drug Services were combined into a single Behavioral Health Services system of care to create CCBHS.

Behavioral Health Services Mission
CCBHS, in partnership with consumers, families, staff, and community-based agencies strives to provide welcoming, integrated services for mental health, substance abuse, and other needs that promote wellness, recovery and resiliency, while respecting the complexity and diversity of the people we serve.

Strategic Plan
CCBHS is committed to strengthening its ongoing efforts in providing a system of care that works to be culturally responsive and linguistically appropriate to the communities served. The CCBHS Cultural Humility Three Year Plan (or Plan Update) details strategies and data illustrating CCBHS's work to improve identified language, and cultural needs to build equitable care. This plan follows recommendations based on the last Department of Mental Health Cultural Competence Plan Requirements Modification[1]. The primary purpose of the Cultural Humility Plan is to evaluate services and workforce needs of the populations CCBHS is intended to serve, while also gauging areas in relation to cultural and linguistic access and need within its system of care. This plan is a working document that has been compiled in collaboration with community stakeholder input and data collected from County systems and other groups.

Policies and Procedures
CCH and CCBHS have standing policies and procedures in place that enable better coordination of care. These policies and procedures are reviewed and revised every few years to better formulate the changing landscape of services and reinforce the National Standards for Culturally and Linguistically Appropriate Services (NCLAS) in Health and Health Care[2]. These policies include, but are not limited to:

<u>Contra Costa Health Department</u>
- CCHS Policy 110-A Dissemination of Information (including Patient Information) to the Public and Media
- CCHS Policy 111-A Mission of Contra Costa Health Services
- CCHS Policy 117-A Service Excellence
- CCHS Policy 127-A Reducing Health Disparities
- CCHS Policy 128-A Non-Discrimination Policy
- CCHS Policy 200-PM Affirmative Action Policy
- CCHS Policy 402-PCS Access to Services for Limited English Proficient (LEP) Deaf and Hearing-Impaired Persons
- CCHS Policy 508-PCC: Filing Complaints

<u>Contra Costa Behavioral Health Services Division</u>
- CCBHS Policy 104: Cultural Competence Plan
- CCBHS Policy 117: Physical Accessibility
- CCBHS Policy 118 Guidelines for Providing Linguistic Access to Limited English Proficient (LEP), Deaf, and Hearing-Impaired Clients in Behavioral Health Services Division
- CCBHS Policy 119: Guidelines for the Distribution of Translated Materials to Consumers in Behavioral Health

[1] California Department of Mental Health (2011). *California Department of Mental Health Cultural Competence Plan Requirements - CCPR Modification.* https://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17_Enclosure1.pdf
[2] US Department of Health and Human Services. (2021, December 15). *National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice.* https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf

- CCBHS Policy 144MH Client, Family Member, and Stakeholder Reimbursements for Participation in Mental Health Services Act Planning and Implementation
- CCBHS Policy 146: Behavioral Health Intern Program
- CCBHS Policy 151-MH: MHSA-Funded Community Based Organization Internship Program Guidelines
- CCBHS Policy 153: Cultural Competence Training
- CCBHS Policy 510: Behavioral Health Access Line Protocols for Routine and Urgent Mental Health Conditions
- CCBHS Policy 704 Behavioral Health Client Rights
- CCBHS Policy 750-MH Behavioral Health Access Line Service Availability and Telephone Call Logs for Mental Health Services
- CCBHS Policy 801: Network Adequacy Standards and Monitoring
- CCBHS Policy 804: Medi-Cal Beneficiary Grievance Procedures
- CCBHS Policy 827 Availability of Beneficiary Brochures and Other Behavioral Health Services Division Medi-Cal Beneficiary Informing Materials

Other Key Documents

The below documents provide information related to behavioral health services.

- Contra Costa County Mental Health Services Act Three Year Program and Expenditure Plan Fiscal Years 2023-2026[3]
- Fiscal Year (FY) 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review Contra Costa Final Report - Mental Health Plan[4]
- Fiscal Year (FY) 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review Contra Costa Final Report - Drug Medi-Cal Organized Delivery System[5]
- Substance Use Disorder Services Strategic Prevention Plan 2018-2023[6]

II. Recognition, Value and Inclusion of Racial, Ethnic, Cultural and Linguistic Diversity Within System

A. Community Services and Supports (CSS) Plan

In 2004, California voters passed Proposition 63, known as the Mental Health Services Act (MHSA)[7]. The Act provides significant additional funding to the existing public behavioral health system to better serve individuals and families affected or at risk of, serious mental health issues. With the goal of wellness, recovery and self-sufficiency, the intent of the law is to reach and include those most in need and have been traditionally underserved. Services are to be client, peer, consumer driven, family focused, based in

[3] Contra Costa Behavioral Health Services. (2023, June) *Contra Costa County Mental Health Services Act Three Year Program and Expenditure Plan Update Fiscal Year 2022-2023.* *https://www.cchealth.org/home/showpublisheddocument/29216/638386819435000000*

[4] Behavioral Health Concepts, Inc. (2023, August). *Fiscal Year (FY) 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review Contra Costa Final Report - Mental Health Plan.* https://calegro.com/data/MH/Reports%20and%20Summaries/Prior%20Years%20Reports%20and%20Summaries/Fiscal%20Year%202022-2023%20Reports/MHP%20Reports/Contra%20Costa%20MHP%20EQR%20Revised%20Final%20Report%20FY22-23%20RW%2004.17.23%20rev%208.23.23.pdf

[5] Behavioral Health Concepts, Inc. (2022, September). *Fiscal Year (FY) 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review Contra Costa Final Report - Drug Medi-Cal Organized Delivery System.* *https://www.calegro.com/data/DMC/Reports%20and%20Summaries/Prior%20Years%20Reports%20and%20Summaries/FY%202022-2023%20Reports/County%20Reports/Contra%20Costa%20DMC-ODS%20EQR%20Final%20Report%20FY22-23%20AC%2011.22.22%20revised%2001.30.23.pdf*

[6] Contra Costa Behavioral Health Services. *Substance Use Disorder Services Strategic Prevention Plan 2018-2023, Alcohol and Other Drugs Services.* https://www.cchealth.org/home/showpublisheddocument/10155/638428254490298810

[7] Department of Health Care Services. *Mental Health Services Act.* https://www.dhcs.ca.gov/services/MH/Pages/MH_Prop63.aspx

the community, culturally and linguistically appropriate, and integrated with other health and social services.

The MHSA is comprised of five components which are Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Workforce Education and Training (WET), Innovation, (INN), and Capital Facilities/Technology (CFTN).[8] CSS refers to service delivery for mental health services and supports for children, transition aged youth- TAY (ages 16-25), adults (ages 26-59), and older adults (ages 60 and over) with a serious emotional disturbance or mental health challenges. CCBHS utilizes MHSA-CSS funding to support Full-Service Partnerships (FSP) and General System Development. It should be noted that for many CSS programming, the total amount of funding is likely a combination of Medi-Cal reimbursed specialty mental health services funds, MHSA funds, and/or other federal or state funding sources. CCBHS's budget has grown incrementally to approximately $81.9 million for FY 2023-24 in commitments to programs and services under CSS. The construction and direction of how and where to provide funding began with an extensive and comprehensive Community Program Planning Process (CPPP) whereby stakeholders were provided training in the intent and requirements of the MHSA and actively participated to identify and prioritize community mental health needs, and develop strategies as service delivery grew with increasing MHSA revenue. The programs and services described are directly derived from the initial CPPP and expanded by subsequent yearly community program planning processes.

Full-Service Partnerships (FSPs)

CCBHS both operates and contracts with partner CBOs to enter collaborative relationships with clients/peers/consumers. Personal service coordinators develop an Individualized Services and Support Plan (ISSP) with each client, and, when appropriate, the client's family to provide a full spectrum of services in the community necessary to achieve agreed upon goals. Children and transition aged youth (16 to 25 years) diagnosed with a serious emotional disturbance or serious mental illness, and adults and older adults diagnosed with a serious mental illness are eligible. These services and supports include, but are not limited to, crisis intervention/stabilization services, mental health treatment, including alternative and culturally specific treatments, peer support, family education services, access to wellness and recovery centers, and assistance in accessing medical, substance abuse, housing, educational, social, vocational, rehabilitation and other community services, as appropriate. Service providers are also available to respond to the client/family, 24 hours a day, seven days a week to provide after-hours intervention. As per current statute requirements, these services comprise most of the CSS budget. Detailed planning and programming under the CSS component can be found in the most recent MHSA Three Year Plan, under the Community Services and Support section. Demographic information for CSS – FSP programs can be found under Criterion II, Section IV of this document. The following is a summarized description of CSS services and goals for FY 2023-2024.

Children's FSPs.

Personal Service Coordinators (PSCs). PSCs are part of the Short-Term Assessment of Resources and Treatment (START) program. Seneca contracts with CCBHS to provide PSCs, a mobile crisis response team, and three to six months of short-term intensive services to stabilize youth in the community and connect them and their families with sustainable resources and supports. Referrals to this program are coordinated by County staff on a countywide assessment team, and services are for youth and their families who are experiencing severe stressors, such as out-of-home placement, involvement with the juvenile justice system, co-occurring disorders, or repeated presentations at the County's Psychiatric Emergency Services.

[8] Mental Health Services Oversight and Accountability Commission. *Prop 63/MHSA*. https://mhsoac.ca.gov/the-act-mhsa/

Mobile Crisis Response. Additional MHSA funding supports the expansion of hours that Seneca's mobile crisis response teams are available to respond to children and their families in crisis. This expansion began in FY 2017-18 and includes availability to all regions of the county. Seneca has two teams available from 7AM until 10PM with on call hours 24/7 and the ability to respond to the field during all hours if indicated and necessary.

Multi-dimensional Family Therapy (MDFT) for Co-occurring Disorders. Lincoln Child Center contracts with the County to provide a comprehensive and multi-dimensional family-based outpatient program for adolescents with a mental health diagnosis who are experiencing a cooccurring substance abuse issue. These youth are at high risk for continued substance abuse and other problem behaviors, such as conduct disorder and delinquency. This is an evidence-based practice of weekly or twice weekly sessions conducted over a period of 4-6 months that target the youth's interpersonal functioning, the parents' parenting practices, parent-adolescent interactions, and family communications with key social systems.

Multi-systemic Therapy (MST) for Juvenile Offenders. EMBRACE Mental Health formerly known as Community Options for Families and Youth, contracts with CCBHS to provide home-based multiple therapist family sessions over a 3–5-month period. These sessions are based on nationally recognized evidence-based practices designed to decrease rates of antisocial behavior improve school performance and interpersonal skills and reduce out-of-home placements. The goal is to empower families to build a healthier environment through the mobilization of existing child, family, and community resources.

Children's Clinic Staff. County clinical specialists and family partners serve all regions of the County and contribute a team effort to full-service partnerships. Clinical specialists provide a comprehensive assessment on youth deemed to be most seriously emotionally disturbed. The team presents treatment recommendations to the family, ensures the family receives the appropriate level of care, and family partners help families facilitate movement through the system.

Table 3. Children FSPs

Program/Plan Element	*County/ Contract*	*Region Served*	*# to be Served Yearly*
Personal Service Coordinators	Seneca Family of Agencies (FSP)	Countywide	75
Multi- dimensional Family Therapy	Lincoln Child Center (FSP)	Countywide	60
Multi-systemic Therapy	Embrace Mental Health (FSP)	Countywide	65
Children's Clinic Staff	County Operated	Countywide	Support for FSPs
Children's Flex Funds		Countywide	TBD
Eating Disorder Treatment		Countywide	TBD
CalAIM Transitional Support Funds		Countywide	N/A

Transition Age Youth (TAY) FSPs.

Eligible youth (ages 16-25) are individuals who are diagnosed with a serious emotional disturbance or serious mental illness, and experience one or more of the risk factors of homelessness, co-occurring substance abuse, exposure to trauma, repeated school failure, multiple foster care placements, and experience with the juvenile justice system.

Fred Finch Youth Center. Located in West County and serves West and Central County. This program utilizes the assertive community treatment model as modified for young adults that includes a personal service coordinator working in concert with a multi-disciplinary team of staff, including peer and family mentors, a psychiatric nurse practitioner, staff with various clinical specialties, to include co-occurring substance disorder

and bilingual capacity. In addition to mobile mental health and psychiatric services the program offers a variety of services designed to promote wellness and recovery, including assistance finding housing, benefits advocacy, school and employment assistance, and support connecting with families.

Youth Homes. Located in Central and East County and serves Central and East County. This program emphasizes the evidence-based practice of integrated treatment for co-occurring disorders, where youth receive mental health and substance abuse treatment from a single treatment specialist, and multiple formats for services are available, to include individual, group, self-help, and family.

Table 4. Transition Age Youth (TAY) FSPs

Program/ Plan Element	*County/ Contract*	*Region Served*	*# to be Served Yearly*
Transition Age Youth FSP	Fred Finch Youth Center	West & Central County	70
Transition Age Youth FSP	Youth Homes	Central & East County	30
County Support Costs (Vehicles)	County	Countywide	N/A
CalAIM Transitional Support Funds		Countywide	N/A

Adult and Older Adult FSPs.

Adult FSPs provide a full spectrum of services and supports to adults over 18 who are diagnosed with a serious mental illness, are at or below 200% of the federal poverty level, are uninsured or receive Medi-Cal benefits. CCBHS contracts with Portia Bell Hume Behavioral Health and Training Center (Hume Center) to provide FSP services in the West and East regions of the County. Prior to COVID-19, the Hume contract was increased to provide enhanced services including housing flex funds as well as serving 40 additional clients. Familias Unidas contracts with the County to provide the lead on full-service partnerships that specialize in serving the County's LatinX population whose preferred language is Spanish.

Table 5. Adult FSPs

Program/ Plan Element	*County/ Contract*	*Region Served*	*# to be Served Yearly*
Adult FSP	Hume Center	Wes County East County	70 (Adult), 5 (Older Adult) 70 (Adult), 5 (Older Adult)
Adult FSP	Familias Unidas	West County	28 (Adult), 2 (Older Adult)
CalAIM Transitional Support Funds		Countywide	N/A
Adult Housing Flex Fund	County	Countywide	TBD
County Support Costs (Vehicles)		Countywide	N/A

*CalAIM Transitional Support Funds. These are temporary funds offered in FY 23-24 to support community-based organizations who provide specialty mental health services as they transition from cost-based to fee-for-service contracts, as part of the statewide California Advancing and Innovating Medi-Cal (CalAIM) effort. These funds were calculated through a cost survey analysis and will be offered on a pay-per-performance basis to qualified agencies to keep them whole during the transition year.

Additional Services Supporting Full-Service Partners. The following services are utilized by full-service partners and enable the County to provide the required full spectrum of services and supports.

Adult Mental Health Clinic Support. CCBHS has dedicated clinicians at each of the three adult mental health clinics to provide support, coordination, and rapid access for full-service partners to health and mental health clinic services as needed and appropriate.

Rapid Access Clinicians offer drop-in screening and intake appointments to clients who have been discharged from the County Hospital or Psychiatric Emergency Services but who are not open to the county mental health system of care. Rapid Access Clinicians will then refer clients to appropriate services

and, when possible, follow-up with clients to ensure a linkage to services was made. If a client meets eligibility criteria for FSP services, the Rapid Access Clinician will seek approval to refer the client to FSP services. Clinic management act as the gatekeepers for the FSP programs, authorizing referrals and discharges as well as providing clinical oversight to the regional FSP programs. FSP liaisons provide support to the FSP programs by assisting the programs with referrals and discharges, offering clinical expertise, and helping the programs to navigate the County systems of care. Community Support Worker positions are stationed at all three adult clinics to support families of clients as they navigate and assist in the recovery of their loved ones.

Table 6. Adult Mental Health Clinic Support

Program/Plan Element	*County/Contract*	*Region Served*	*# to be Served Yearly*
FSP Support, Rapid Access	County Operated	West, Central, East County	Support for Full-Service Partners

Assisted Outpatient Treatment. In February 2015, the Contra Costa Board of Supervisors passed a resolution authorizing $2.25 million of MHSA funds to be utilized on an annual basis for providing mental health treatment as part of an assisted outpatient treatment (AOT) program. The County implements the standards of an assertive community treatment team as prescribed by Assembly Bill 1421, and thus meets the acuity level of a full-service partnership. This program provides an experienced, multi-disciplinary team who provides around the clock mobile, out of office interventions to adults, a low participant to staff ratio, and provides the full spectrum of services, to include health, substance abuse, vocational and housing services. Persons deemed eligible for assisted outpatient treatment are served, whether they volunteer for services, or are ordered by the court to participate. CCBHS contracts with Turn Behavioral Health Services (formerly Mental Health Systems, Inc.) to provide 23 the Assertive Community Treatment (ACT), while CCBHS has dedicated clinicians and administrative support within the Forensic Mental Health Clinic to 1) receive referrals in the community, 2) conduct outreach and engagement to assist a referred individual, 3) conduct the investigation and determination of whether a client meets eligibility criteria for AOT, 4) prepare Court Petitions with supporting documentation and ongoing affidavits, 5) testify in court, 6) coordinate with County Counsel, Public Defender and law enforcement jurisdictions, 7) act as liaison with ACT contractor, and 8) participate in the development of the treatment plan.

Table 7. Assisted Outpatient Treatment

Program/ Plan Element	*County/ Contract*	*Region Served*	*# to be Served Yearly*
Assisted Outpatient Treatment	Turn Behavioral Health Services	Countywide	70 (Adult), 5 (Older Adult)
Assisted Outpatient Treatment Clinic Support	County Operated	Countywide	Support for Assisted Outpatient Treatment

Wellness and Recovery Centers. Mental Health Connections (formerly Putnam Clubhouse) contracts with CCBHS to provide wellness and recovery centers in West, Central and East County to provide a full spectrum of mental health services. These centers offer peer-led recovery-oriented, rehabilitation and self-help groups that teach self- management and coping skills. The centers offer support groups, wellness planning, physical health, nutrition education, advocacy services, training, and arts and crafts.

Table 8. Wellness and Recovery Centers

Program/Plan Element	*County/ Contract*	*Region Served*	*# to be Served Yearly*
Wellness and Recovery Centers	Mental Health Connections, (formerly Putnam Clubhouse	West, Central, East County	200

Hope House - Crisis Residential Center. The County contracts with Telecare to operate a 16-bed crisis

residential facility. This is a voluntary, highly structured treatment program that is intended to support seriously mentally ill adults during a period of crisis and to avoid in-patient psychiatric hospitalization. It also serves consumers being discharged from the hospital and long-term locked facilities that would benefit from a step-down from institutional care in order to successfully transition back into community living. Services are designed to be short term, are recovery focused with a peer provider component, and treat co-occurring disorders, such as drug and alcohol abuse. In addition, CCBHS is in the process of developing a Request for Proposal (RFP) for a second Crisis Residential Center, following the recent closure of Neireka House.

Table 9. Crisis Residential Center

Program	*County/ Contract*	*Region Served*	*# to be Served Yearly*
Hope House - Crisis Residential Center	Telecare	Countywide	200
New Crisis Residential	TBD	TBD	TBD

MHSA Funded Housing Services. MHSA funds for housing supports supplements that which is provided by CCBHS and the County's Health, Housing and Homeless (H3) Services Division, and is designed to provide various types of affordable shelter and housing for low-income adults with a serious mental illness or children with a severe emotional disorder and their families who are homeless or at imminent risk of chronic homelessness. Annual expenditures have been dynamic due to the variability of need, availability of beds and housing units, and escalating cost. Housing supports are categorized as follows; 1) temporary shelter beds, 2) augmented board and care facilities or homes, 3) scattered site or master leased permanent supportive housing, 4) housing continuum and resource development 5) a centralized county operated coordination team.

Temporary Shelter Beds. The County's Health, Housing and Homeless Services (H3) Division operates several temporary bed facilities for adults and transitional age youth. CCBHS has a Memorandum of Understanding (MOU) with the H3 Division that provides MHSA funding to enable individuals with a serious mental illness or a serious emotional disturbance to receive temporary emergency housing in these facilities. This agreement includes 1,638 bed nights per year for the Bissell Cottages, Pomona Street Apartments and McGovern House transitional living programs, staff for the Calli House Youth Shelter, 23,360 bed nights for the Brookside and Concord temporary shelters, and 2,920 bed nights for the Respite Shelter in Concord.

Augmented Board and Care. The County contracts with several licensed board and care providers and facilities to provide additional funds to augment the rental amount received by the facility from the SSI rental allowance. These additional funds pay for facility staff care to enable those with serious mental illness to avoid institutionalization and enable them to live in the community. An individualized services agreement for each person with a serious mental illness delineates needed supplemental care, such as assistance with personal hygiene, life skills, prescribed medication, transportation to health/mental health appointments, and connection with healthy social activities. MHSA currently funds a number of augmented board and care providers to augment clients board and care with additional agreed upon care for persons with seriously mental illness. These providers include, but are not limited to, Divines, Modesto Residential, Oak Hill, Pleasant Hill Manor, United Family Care (Family Courtyard), Williams Board and Care Home, and Woodhaven. An additional provider, Crestwood Healing Center, has 64 augmented board and care beds in Pleasant Hill, and has a transitional residential program, The Pathway, that provides clinical mental health specialty services for up to a year (with a possible six-month extension) for those residents considered to be most compromised by mental health issues. During this three-year period CCBHS will seek to maintain and increase the number of augmented board and care beds available for adults with serious mental

illness. Additional funding is also being allocated to address market competitiveness for rates being paid to small adult residential facilities and to assist older adult clients to maintain the home and placement that they have successfully lived in for many years.

Permanent Supportive Housing: Master Leased and Scattered Site. Shelter, Inc. contracts with the County to provide a master leasing program which adults or children and their families are provided tenancy in apartments and houses in the County. Through a combination of self-owned units and agreements with landlords, Shelter, Inc. acts as the lessee to the owners and provides staff, maintenance and administers County-funded rental subsidies to support individuals and their families to move in and maintain their homes independently. Until 2016 the County participated in a specially legislated state-run MHSA Housing Program through the California Housing Finance Agency (CalHFA). In collaboration with community partners the County embarked on several one-time capitalization projects to create 39 permanent housing units for individuals with serious mental illness. Individuals receive mental health support from CCBHS contracted and county service providers. The sites include Villa Vasconcellos in Walnut Creek, Lillie Mae Jones Plaza in North Richmond, The Virginia Street Apartments in Richmond, Robin Lane apartments in Concord, Ohlone Garden apartments in El Cerrito, Third Avenue (Arboleda) Apartments in Walnut Creek, Garden Park apartments in Concord, and scattered units throughout the County operated by Hope Solutions (formerly Contra Costa Interfaith Housing). The state-run MHSA Housing Program ended in 2016 and was replaced by the Special Needs Housing Program (SNHP). Under SNHP, the County received and distributed $1.73 million in state level MHSA funds to preserve, acquire, or rehabilitate housing units, and added 5 units of permanent supportive housing at the St. Paul Commons in Walnut Creek. The deadline to use SNHP funds was June 30, 2023.

In July 2016 Assembly Bill 1618, or No Place Like Home, was enacted to dedicate in future years $2 billion in bond proceeds throughout the State to invest in the development of permanent supportive housing for persons who need mental health services and are experiencing homelessness or are at risk of chronic homelessness. Local applications for construction and/or re-purposing of residential sites have been developed and submitted to the state. Through the four completed funding rounds Contra Costa has or will add up to 61 permanent supportive housing units.

- Round 1 - Contra Costa was awarded competitive funding in partnership with Satellite Affordable Housing Association (SAHA) in the amount of $1,804,920 for construction of 10 dedicated NPLH units for persons with serious mental illness at their Veteran's Square Project in the East region of the County. During Round 1 County accepted the State's non-competitive funds in the amount of $2,231,574 to be allocated in future funding rounds.
- Round 2 - Contra Costa was awarded funds to construct permanent supportive housing units in the Central region of the County. An award was granted to Resources for Community Development (RCD) in the amount of $6,000,163 for 13 NPLH Units at their Galindo Terrace development.
- Round 3 – Selected RCD as recipient of County's non-competitive funds in the amount of $2,231,574 for 9 units located at 699 Ygnacio Valley Rd in Walnut Creek.
- Round 4 – CCBHS sponsored two additional projects that were awarded funds by the Department of Housing and Community Development (HCD.) The first project is an 8-unit development located in Richmond submitted in partnership with Community Housing Development Corporation and Eden Housing in the amount of $3,718,780. A second County sponsored project was submitted by Resources for Community Development (RCD) which was awarded $13,002,266 for 21 additional units (total of 30 dedicated NPLH units) for the project at 699 Ygnacio Valley Road that had previously been awarded non-competitive dollars during the Round 3 project period.

Housing Continuum and Resource Development. The State and Federal government have and continue to release multiple housing infrastructure-related grant opportunities for Counties. CCBHS has submitted projects under the Behavioral Health Continuum Infrastructure Program (BHCIP), submitted plans to participate the Behavioral Health Bridge Housing (BHBH) program, and intends to submit a plan under the Department of State Hospital Incompetent to Stand Trial and Competency Restoration program. CCBHS has accepted an allocation from Department of Social Services to fund the Community Care Expansion (CCE) Preservation program intended to stabilize existing licensed adult residential facilities and residential care facilities for the elderly. The County intends to apply for other opportunities as they are released. CCBHS recognizes supported housing for people living with a mental health condition as a priority and is committed to leveraging existing resources to meet that need by fortifying our existing housing continuum of care. CCBHS plans to complete proposed projects and provide funding for any potential County required funding match to take advantage of funding opportunities. Additional funds have been allocated to allow CCBHS to locally fund potential projects addressing other gaps in the housing continuum.

In order to better support clients additional funding is being allocated to emergency care funds to support clients at certain facilities while social security benefits are pending. Additionally, this budget allocates funding to support clients and Housing Services staff address the often-unforeseen challenges that arise by creating a housing flex fund. This fund may be used to address small, unplanned and/or temporary financial needs related to maintaining a home.

Coordination Team. The Housing Services Coordination Team provides support to residents, facilitates linkages with other Contra Costa behavioral health programs and services, and provides contract monitoring and quality control. A Chief of Supportive Housing Services oversees the Coordination Team and MHSA funded housing units.

Table 10. MHSA Housing Services

Plan Element	*County/ Contract*	*Region Served*	*# of MHSA Beds/ Units Budgeted*
Shelter Beds	County Operated	Countywide	Estimated 75 beds
Augmented Board and Care*	Crestwood Healing Center	Countywide	80 beds
Augmented Board and Care*	Various	Countywide	335 beds
Master Lease	Various	Countywide	110 units
Scattered Site Housing	Contractor Operated	Countywide	39 units
Community Care Expansion Preservation Match		Countywide	Varies
Behavioral Health Continuum Infrastructure Program/ Infrastructure Program Match		Countywide	Varies
Coordination Team	County Operated	Countywide	Varies
Emergency Care Funds		Countywide	Varies
Housing Flex Funds		Countywide	Varies
Continuum Resource Development	TBD	Countywide	TBD

*Augmented Board and Care facility contracts vary in negotiated daily rate, and several contracts have both realignment as well as MHSA as funding sources. Thus, the budgeted amount for FY 22-23 may not match the total contract limit for the facility and beds available. The amount of MHSA funds budgeted are projections based upon the1) history of actual utilization of beds paid by MHSA funding, 2) history of expenditures charged to MHSA, and 3) projected utilization for the upcoming year. CCBHS will continue to look for and secure additional augmented board and care beds. Annual Three-Year Plan Updates will reflect adjustments in budgeted amounts.

It is estimated that over 1,000 individuals per year are receiving temporary or permanent supportive housing by means of MHSA funded housing services and supports. CCBHS is and will continue to actively participate in state and locally funded efforts to increase the above availability of supportive housing for persons with serious mental illness.

Non-FSP Programs (General System Development)

General System Development is the service category in which the County uses MHSA funds to improve the County's mental health service delivery system for all clients who experience a serious mental illness or serious emotional disturbance, and to pay for mental health services for specific groups of clients, and, when appropriate, their families. Since the CSS component was first approved in 2006, programs and plan elements included herein have been incrementally added each year by means of the community program planning process. These services are designed to support those individuals who need services the most.

Supporting Older Adults. There are two MHSA funded programs serving the older adult population over the age of 60, 1) Intensive Care Management, and 2) Improving Mood: Providing Access to Collaborative Treatment (IMPACT).

1) Intensive Care Management. Three multi-disciplinary teams, one for each region of the County, provide mental health services to older adults in their homes, in the community, and within a clinical setting. The primary goal is to support aging in place and to improve consumers' mental health, physical health, and overall quality of life. Each multi-disciplinary team is comprised of a psychiatrist, a nurse, a clinical specialist, and a community support worker. The teams deliver a comprehensive array of care management services, linkage to primary care and community programs, advocacy, educational outreach, medication support and monitoring, and transportation assistance.
2) IMPACT. IMPACT is an evidence-based practice which provides depression treatment to older adults in a primary care setting who are experiencing co-occurring physical health impairments. The model involves short-term (8 to 12 visits) problem solving therapy and medication support, with up to one year follow-up as necessary. MHSA funded mental health clinicians are integrated into a primary treatment team.

Table 11. Supporting Older Adults

Program	*County/ Contract*	*Region Served*	*# to be Served Yearly*
Intensive Care Management	County Operated	Countywide	237
IMPACT	County Operated	Countywide	138

Supporting Children and Young Adults. There are two programs supplemented by MHSA funding that serve children and young adults: 1) Wraparound Program, and 2) expansion of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

1) Wraparound Program. Countywide program, in which children and their families receive intensive, multi-leveled treatment from the County's three children's mental health clinics, was augmented in 2008 by family partners and mental health specialists. Family partners are individuals with lived experience as parents of children and adults with serious emotional disturbance or serious mental illness who assist families with advocacy, transportation, navigation of the service system, and offer support in the home, community, and county service sites. Family partners participate as team members with the mental health clinicians who are providing treatment to children and their families. Mental Health Specialists are non- licensed care providers, often in successful recovery with lived experience as a consumer or family member, who can address culture and language specific needs of families in their communities. These professionals arrange and facilitate team meetings between the

family, treatment providers and allied system professionals.

2) EPSDT Expansion. EPSDT is a federally mandated specialty mental health program that provides comprehensive and preventative services to low-income children and adolescents involved with Children and Family Services. State realignment funds have been utilized as the up-front match for the subsequent federal reimbursement that enables the County to provide the full scope of services. This includes assessment, plan development, therapy, rehabilitation, collateral services, case management, medication support, crisis services, intensive home- based services (IHBS), and Intensive Care Coordination (ICC). The Department of Health Care Services has clarified that the continuum of EPSDT services is to be provided to any specialty mental health service beneficiary who needs it. In addition, Assembly Bill 403 mandates statewide reform for care provided to foster care children, to include the County's responsibility to provide Therapeutic Foster Care (TFC) services. This significant expansion of care responsibility, entitled Continuing Care Reform (CCR), utilizes MHSA funds as the up-front match for subsequent federal reimbursement that enables the County to provide the full scope of services, adding County mental health clinicians, family partners and administrative support.

Table 12. Supporting Children and Young Adults

Plan Element	*County/Contract*	*Region Served*	*# to be Served Yearly*
Wraparound Support	County Operated	Countywide	Supports Wraparound Program
EPSDT Expansion	County Operated	Countywide	Supports EPSDT Expansion

Concord Health Center. The County's primary care system staffs the Concord Health Center, which integrates primary and behavioral health care. A behavioral health clinician and community support worker (peer) work as a team to provide an integrated response to adults visiting the clinic for medical services who also have a co-occurring behavioral health issues. MHSA funds additional similar positions in the regional behavioral health clinics to provide enhanced support.

Table 13. Concord Health Center

Plan Element	*County/ Contract*	*Region Served*	*# to be Served Yearly*
Supporting all Outpatient Clinics	County Operated	Central County	Support Clients Served by Clinics

Liaison Staff. CCBHS and Contra Costs Regional Medical Center (CCRMC) partner to provide Community Support Worker positions to liaison with Psychiatric Emergency Services (PES) to assist individuals experiencing a psychiatric crisis connect with services to support them in the community. These positions are in the CCBHS Transition Team, and schedule regular hours at PES.

Table 14. Liaison Staff

Plan Element	*County/ Contract*	*Region Served*	*# to be Served Yearly*
Supporting Liaison Staff	County Operated	Countywide	Supports clients served by PES

Clinic Support. County positions funded through MHSA supplement clinical staff implementing treatment plans at the adult clinics. These positions were created in response to identified needs in the Community Program Planning Process (CPPP).

1) Resource Planning and Management. Dedicated staff at the three adult clinics assist consumers with money management and the complexities of eligibility for Medi-Cal, Medi-Care, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) benefits. Money management staff are allocated for each clinic, and work with and are trained by financial specialists.
2) Transportation Support. The CPPP identified transportation as a critical priority for accessing services. One-time MHSA funds were used to purchase additional county vehicles to be located at the clinics.

Community Support Workers have been added to adult clinics to be dedicated to the transporting of consumers to and from appointments.

3) Evidence Based Practices. Clinical Specialists for each Children's clinics have been added to provide training and technical assistance to fidelity of treatment practices that establish evidence that support successful outcomes.
4) Transitions Team Expansion. Funds have been allocated to support a Street Psychiatry initiative to offer field-based nursing and psychiatry services to community members who are unhoused or facing other challenges that prevent them from coming into the clinic. The Transitions Team will also support a new Mental Health Library Initiative with a field-based team (one clinician and one peer support specialist). The team will work with county libraries identified as having a high number of unhoused patrons living with untreated mental health and substance use disorders. The team will provide outreach and engagement, linkage to community supports and services, and support library staff.

Table 15. Clinic Support

Plan Element	*County/ Contract*	*Region Served*	*# to be Served Yearly*
Resource Planning and Management	County Operated	Countywide	Supplements Clinic Staff
Transportation Support	County Operated	Countywide	Supplements Clinic Staff
Evidence Based Practices	County Operated	Countywide	Supplements Clinic Staff
Transition Team Expansion	County Operated	Countywide	TBD

Forensic Team. Clinical specialists are funded by MHSA to join a multi-disciplinary team that provides mental health services, alcohol and drug treatment, and housing supports to individuals with serious mental illness who are either referred by the courts for diversion from incarceration, or on probation and at risk of re-offending and incarceration. These individuals were determined to be high users of psychiatric emergency services and other public resources, but very low users of the level and type of care needed. This team works very closely with the criminal justice system to assess referrals for serious mental illness, provide rapid access to a treatment plan, and work as a team to provide the appropriate mental health, substance abuse and housing services needed.

Mobile Crisis Response Team (MCRT). During the FY 2017-20 Three Year Plan the Forensic Team expanded its mobile crisis response capacity from fielding a mobile Mental Health Evaluation Team (MHET) with law enforcement to fielding a full Mobile Crisis Response Team to respond to adult consumers experiencing mental health crises in the community. Mental health clinicians and community support workers work closely with the County's Psychiatric Emergency Services and law enforcement, if necessary, to respond to residents in crises who would be better served in their respective communities.

The passage of the Measure X sales tax has allowed for further expansion of crisis services in Contra Costa. The adult Mobile Crisis Response Team, formerly funded by MHSA, has now been expanded and moved under the Anyone, Anywhere, Anytime (A3) program, which is a new system for delivering safe, appropriate care to county residents who are experiencing behavioral health emergencies. Once fully brought to scale, the program will offer 24-hour mobile crisis response teams available throughout the county, as well as the comprehensive Miles Hall Crisis Hub where a number of related services will be available to community members.

Table 16. Mobile Crisis Response Team (MCRT)

Plan Element	County/ Contract	Region Served	# to be Served Yearly
Forensic Team	County Operated	Countywide	Support to the Forensic Team

Quality Assurance and Administrative Support. MHSA funding supplements County resources to enable CCBHS to provide required administrative support, quality assurance and program evaluation functions for statutory, regulatory, and contractual compliance, as well as management of quality-of-care protocols, such as fidelity to Assisted Outpatient Treatment and Assertive Community Treatment. County staff time and funding to support the mandated MHSA community program planning process are also included here. County positions have been incrementally justified, authorized, and added each year as the total MHSA budget has increased.

B. Current Involvement Efforts and Level of Inclusion with Underserved Communities

Each year CCBHS utilizes a Community Program Planning Process (CPPP) to accomplish the following:

- Identify issues related to mental illness that result from a lack of mental health services and supports
- Analyze mental health needs
- Identify priorities and strategies to meet these behavioral health needs

CCBHS gathers input from its ongoing community stakeholder bodies, which include clients, peers, consumers, family members, providers, and community members. Engagement is provided through committees, workgroups, community forums, surveys, program visits, and ongoing dialogue. Some meetings are either held virtually, in-person or are a hybrid of both meetings. All meetings are open to the public.

Table 17. Stakeholder Meeting Groups

Meeting	*Purpose*	*Frequency*
MHSA Advisory Council (formerly known as Consolidated Planning and Advisory Workgroup - CPAW Committee)	Opportunity for the public dialogue with the Behavioral Health Director; discuss issues relevant to MHSA, review existing programming, funding, and evaluation. MHSA Advisory Council Membership seats include; Alcohol and Other Drug Services, CBO Service Providers, CCBHS Service Providers, Consumers, Criminal Justice, Education, Faith Based Leadership, Family Members, Family Partner, Youth Family Partner, Health, Housing and Homeless Services, Mental Health Commissioners, Peer Providers, Underserved Populations, and Veterans	Bi-Monthly
MHSA Advisory Council Sub-Committee: Innovation and Systems of Care	Learn, discuss, and provide input on new and emerging MHSA related programs that impact Behavioral Health Services system of care.	Quarterly
MHSA Advisory Council Sub-Committee: Steering	Develop monthly agenda for MHSA Advisory Council main meeting, including identifying presentation & discussion topics	Bi-Monthly
MHSA Advisory Council Sub-Committee: Membership	Review new applications for MHSA Advisory Council Membership	As Needed
Suicide Prevention Coalition	Countywide collaboration responsible for Suicide Prevention Strategic Planning	Monthly
Youth Suicide Prevention Sub-Committee	Collaborative meeting for networking and information sharing around issues related to youth mental health and suicide prevention	Quarterly
CCBHS Reducing Health Disparities Workgroup	Focus on diversity, equity, inclusion and reducing disparities within Behavioral Health Services system of care with ongoing goal of being trauma informed, working against racism, addressing historical barriers to services to promoting wellness, recovery, and resiliency service delivery and workforce. Provides input for annual Cultural Humility Plan.	Quarterly
Assisted Outpatient Treatment (AOT) Workgroup	Discussion and support around the work of County AOT providers, including Forensic Mental Health, Justice Partners, and Community Based Organizations	Quarterly

Other CPPP events involved:

- Presentation to Historically Marginalized Community Engagement (HMCE) Unit - Mental Health Services Act (MHSA) Innovation Project: Supporting Equity through Community Defined Practices Project held June 29th, 2023
- Community Mental Health Forum: Real Talk! Real Voices! Real Solutions held January 21, 2023
- Innovation Community Forum provided an overview of the MHSA with particular focus on the Innovation component. New project ideas were reviewed and input from the community was received through small group listening sessions and was held March 4, 2022.
- Town Hall for Providers was a way to engage in an informational and listening sessions where providers were able to identify priority populations and service needs, as well as staff training needs and was held October 26, 2022.
- Virtual Community Forum Events also allowed participants to learn about the MHSA, engage in listening sessions, small group discussions and provide direct feedback regarding prioritization of future programming and funding related to the MHSA. These events were held November 3, 2022, November 17, 2022, and December 15, 2022.
- Annual MHSA Orientation: Provided to the Service Provider Individualized Recovery and Intensive Training (SPIRIT) class. SPIRIT is a nine-unit accredited college course, taught in collaboration with Contra Costa College and peer providers from the CCBHS Office for Consumer Empowerment.
- Other MHSA presentations include presenting to the Mental Health Commission. MHSA staff regularly attend the Mental Health Commission meetings. Other informational presentations in the year were provided to the Alcohol and Other Drug Services Advisory Board, CCBHS Access Team, School-based Mental Health Providers, and Cal State University East Bay Nursing Students.
- A community survey was launched and distributed to at least 800 community members in November of 2022. The survey was intended to elicit feedback from the community regarding prioritization Cultural Humility Plan Focus Areas. Please see pages 11-14 of the MHSA Three Year Program and Expenditure Plan 2023 – 2026.

C. Lessons Learned

CCBHS has identified Asian and Latino/a/e/X/Hispanic population as being underserved. This is demonstrated through the External Quality Review Organization data, found in the *Medi-Cal Population Service Needs* section of this document. CCBHS is in the process of establishing contracts for Community Defined Practices through the MHSA Innovation component. The Request for Proposal (RFP) and process was created through community collaboration to better support equity in opportunities for funding, as well as supporting culturally and linguistically appropriate practices for mental health and wellness.

A lesson learned through this process was using language that was easily understood and non-clinical in the RFP and utilizing a group of community members and contractor with experience in working with the community to draft the RFP to facilitate language which did not reflect solely clinical terminology. Overall, positive feedback was received as well as a high number of RFP applications.

III. Positions Supporting Cultural Humility

CCBHS has one staff member filling the role of Ethnic Services Manager (ESM) which also holds the role of Training Coordinator and is part of the MHSA team. The acting ESM meets with the CCBHS Director, as needed. The CCBHS Director has open dialogue and is regularly involved with stakeholder meetings and the CPPP.

IV. Budget Resources Targeting Culturally Responsive Activities

Budgeting for culturally and linguistically responsive programming is outlined in detail throughout the *Contra Costa County Mental Health Services Act Three Year Program and Expenditure Plan Fiscal Years 2023-2026.* A summary of the programming and services that support specific cultural niches and offer services in other languages are listed in the following table; which includes agency name, the MHSA component the program is under, a brief description of services, and the most recent allocated budget. Detailed outcome information can be found in the MHSA Three Year Plan – Appendix B on the MHSA page here.

Table 18. Resources Targeting Culturally Responsive Activities for Fiscal Year (FY) 2023-2024

MHSA Component of Community Services and Supports (CSS)	*Funds*
CCBHS Adult Mental Health Clinic Support: CCBHS has dedicated clinicians at each of the three adult mental health clinics to provide support, coordination, and rapid access for full-service partners to health and mental health clinic services as needed and appropriate. Rapid access clinicians offer drop-in intake appointments and screening to clients who have been discharged from the County Hospital or Psychiatric Emergency Services but who are not open to the county mental health system of care. Rapid access clinicians refer clients to appropriate services and, when possible, follow-up with clients to ensure linkage to services was made. If a client meets eligibility criteria for Full-Service Partnership (FSP) services, the rapid access clinician will seek approval to refer the client to FSP services.	$2,477,381
CCBHS Assisted Outpatient Treatment (AOT): CCBHS has dedicated clinicians and administrative support in the Forensic Mental Health Clinic to 1) receive referrals in the community, 2) conduct outreach and engagement to assist a referred individual, 3) conduct the investigation and determinate whether a client meets eligibility criteria for AOT, 4) prepare court petitions with supporting documentation and ongoing affidavits, 5) testify in court, 6) coordinate with County Counsel, Public Defender and law enforcement jurisdictions, 7) act as liaison with Assertive Community Treatment (ACT) contractor, and 8) participate in the development of the treatment plan.	$677,881
CCBHS Children's Clinic Staff: County clinical specialists and family partners serve all regions of the County and contribute a team effort to FSP clients. Clinical specialists provide a comprehensive assessment on all youth deemed to be seriously emotionally disturbed. The team presents treatment recommendations to the family, ensures the family receives the appropriate level of care, and family partners help families facilitate movement through the system.	$603,053
CCBHS Housing Services: The County provides various types of housing supports in the form of shelter beds, augmented board and cares, master lease housing, scattered site housing, Emergency Care Funds, Housing Flex Funds, Behavioral Health Continuum Infrastructure Program (BHCIP) Match, and the CCBHS Coordination Team which provides support to residents in facilities with other County behavioral health programs and services and provides contract monitoring and quality control.	$21,907,598
CCBHS IMPACT: Provides evidence-based practice for depression treatment to older adults experiencing co-occurring physical health impairments in a primary care setting. Model involves short-term (8 - 12 visits) problem solving therapy and medication support, with up to one year follow-up, as necessary. Mental health clinicians are integrated into a primary treatment team.	$ 433,536
CCBHS Intensive Care Management: Provides mental health services to older adults in their homes, the community, or clinical setting through three multi-disciplinary teams for each region of the County. The goal is to support aging in place, improve mental health, physical health and quality of life. Each team is comprised of a psychiatrist, a nurse, a clinical specialist, and community support worker to deliver a comprehensive array of care management services, linkage to primary care or community programs, advocacy, educational outreach, medication support and monitoring, and transportation assistance.	$3,964,286
CCBHS Resource Planning and Management: Staff at the three adult clinics work with and are trained by financial specialists in order to assist clients with money management and complexities of eligibility for Medi-Cal, Medi-Care, Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI) benefits to support clients.	$741,930
CCBHS Transportation Support: The Community Program Planning Process identified transportation as	$158,421

a critical priority in accessing services. MHSA funds were used to purchase county vehicles to be located at the clinics. Community Support Workers are dedicated to transport clients for appointments.	
CCBHS Wraparound Program: Provides intensive, multi-leveled treatment to children and their families from County's three children's mental health clinics and is augmented by family partners and mental health specialists. Family partners have lived experience as parents of children and adults with serious emotional disturbance or serious mental illness who assist families with advocacy, transportation, navigation of services, and offer support in the home, community, and county sites. Family partners participate as team members with mental health clinicians providing treatment to children and their families. Mental health specialists are non-licensed care providers with lived experience, who can address culture and language specific needs of families in their communities. These professionals facilitate team meetings between the family, treatment providers and allied system professionals.	$1,211,646
Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Expansion: EPSDT is a federally mandated specialty mental health program that provides comprehensive and preventative services to low-income children and adolescents involved with Children and Family Services. Services include crisis services, assessment, plan development, therapy, rehabilitation, collateral services, case management, medication support, intensive home-based services, and Intensive Care Coordination. Statewide reform for care to foster care children includes County's responsibility to provide Therapeutic Foster Care (TFC) services. MHSA funds the up-front match for subsequent federal reimbursement enabling the County to provide full scope services, by adding County mental health clinicians, family partners and administrative support through significant expansion of care responsibility entitled Continuing Care Reform.	$761,830
Embrace Mental Health (formerly Community Options for Families and Youth): Multi-dimensional family-based outpatient program for adolescents with a mental health diagnosis experiencing a cooccurring substance abuse issue. These youth are at high risk for continued substance abuse and other problem behaviors, such as conduct disorder and delinquency. This evidence-based practice of weekly or twice weekly sessions conducted over 4-6 months target the youth's interpersonal functioning, the parents' parenting practices, parent-adolescent interactions, and family communications with key social systems.	$1,056,614
Familias Unidas: Serves adults 18+ through Full-Service Partnerships (FSP) providing a full range of services utilizing a modified Assertive Community Treatment (ACT) model consisting of a multi-disciplinary mental health team. Team works together to provide majority of treatment, rehabilitation, and support services to client/peer. Focused FSP services for the County's Latino/Hispanic population.	$297,404
Fred Finch Youth Center: Serves west & central County. Program utilizes the ACT model as modified for young adults; supported through a multi-disciplinary team including a personal service coordinator, peer and family mentors, and psychiatric nurse practitioner. Staff have clinical specialty in co-occurring substance disorder and offer bilingual services. Mobile mental health and psychiatric services are offered as well as services to promote wellness and recovery, including assistance finding housing, benefits advocacy, school and employment assistance, and support in connecting with families.	$1,643,231
Hope House: Provides Crisis Residential Center through contract with Telecare to operate 16-bed crisis residential facility. This is a voluntary, highly structured treatment program intended to support seriously mentally ill adults during a period of crisis to avoid in-patient psychiatric hospitalization. It also serves clients discharged from hospital and long-term locked facilities that benefit from a step-down from institutional care to transition into community living. Services are designed to be short term, recovery focused with a peer provider component, and treat co-occurring disorders.	$2,408,428
Lincoln Child Center: Provides a comprehensive and multi-dimensional family-based outpatient program for adolescents with mental health and co-occurring substance use issues. The youth are considered high risk for continued substance use and other risky behaviors. This evidence-based practice of weekly or twice weekly sessions provided over 4-6 months target the youth's interpersonal functioning, parents' parenting practices, parent-adolescent interactions, and family communications with social systems.	$1,069,956
Mental Health Connections - Peer Connection Centers (formerly Putnam Clubhouse): Provides wellness and recovery centers in west, central and east County. The centers offer peer-led recovery-oriented, self-help and rehabilitation groups that teach self-management and coping skills, Wellness Recovery	$1,100,039

Action Planning (WRAP), physical and nutrition education, training, arts, crafts, and support groups.	
Portia Bell Hume Behavioral Health and Training Center (Hume Center): Provides adult Full-Service Partnership (FSP) services in East and West County.	$4,532,294
Seneca Family of Agencies: Provides Short Term Assessment of Resources and Treatment (START) services, personal services coordinators, a mobile crisis response team, and 3-6 months of short-term intensive services to stabilize youth in the community and connect them and their families with sustainable resources and supports. Referrals are coordinated by County staff on a countywide assessment team. Services are for youth and their families experiencing severe stressors, such as out-of-home placement, involvement with the juvenile justice system, co-occurring disorders, or repeated presentations at the County's Psychiatric Emergency Services. Seneca also provides the Mobile Response Team (MRT). Funding supports the expansion of hours which Seneca's MRT is available to respond to children and families in crisis in all regions of the county. Two teams are available from 7AM-10PM with on call hours 24/7 and ability to respond during all hours if indicated and necessary.	$1,001,479
Youth Homes: Provides services to central and east County. Emphasizes evidence-based practice of integrated treatment for co-occurring disorders. Youth receive mental health and substance abuse treatment from a single treatment specialist. Services include individual, family and group self-help.	$794,041
MHSA Component of Innovation (INN)	*Funds*
CCBHS Cognitive Behavioral Social Skills Training (CBSST): Project aimed to enhance quality of life for those residing in enhanced board and care facilities by incorporating meaningful activity, skills in daily routines to increase overall functional improvement. CBSST is emerging practice with demonstrated positive results for persons with severe and persistent mental illness. CBSST applies therapeutic practice consisting of a licensed clinician and peer support worker to lead CBSST groups at board and care facilities. Adults with serious mental illness learn and practice skills to enable them to achieve and consolidate recovery-based skills, while decreasing need for costly interventions such as psychiatric emergency services. Funds added to expand services to additional board and care residents.	$454,716
CCBHS Room to Overcome, Achieve and Recover (ROAR): Intensive outpatient treatment program offering three levels of care (intensive, transitional and continuing care) to adolescents dually diagnosed with substance use and mental health disorders. Services provided by multi-disciplinary team and include individual, group and family therapy, and linkage to community services. CCBHS recognizes substance use dependence in adolescence negatively affects physical, social, emotional, and cognitive development. Early onset of substance use is one of the strongest predictors of later dependence.	$658,412
CCBHS Supporting Equity Through Community Defined Practices (CDPs): Emerging Innovation project. General idea is to funding mental health and wellness reflective of community defied practices which are culturally and/or linguistically responsive and target underserved or inappropriately served communities.	$1,907,750
Psychiatric Advanced Directives (PADs): Multi-County Collaborative Innovation Project aimed to support treatment decisions for people experiencing a mental health crisis. The project will offer standardized training on the usage and benefits of PADs, development of a peer-created standardized PAD template, provide a training toolkit (in 9 languages) and implement a customized cloud-based technology platform to access and utilize PADs. Unlike an electronic health record, the technology will not be used to store HIPAA protected data. Technology to be developed with peers and stakeholders, rather than for them	$494,646
MHSA Component of Prevention and Early Intervention (PEI)	*Funds*
Asian Family Resource Center (fiscal sponsor Contra Costa ARC): Provides culturally sensitive education and access to mental health services for immigrant Asian communities, focus on Southeast Asian population of Contra Costa. Staff provide outreach, medication compliance education, community integration skills, and mental health system navigation. Early intervention services provided to those exhibiting symptoms of mental illness. Participants assisted in actively managing recovery process.	$164,354
California Mental Health Services Authority (CalMHSA): Through Know the Signs initiatives CalMHSA provides technical assistance to encourage the County's integration of available statewide resources on stigma and discrimination reduction and suicide prevention. CCBHS contracts with CalMHSA to link county level stigma and discrimination reduction efforts with statewide social marketing programs. This	$78,000

linkage expands the County's capacity via language specific materials, social media, and subject matter consultation with regional and state experts to reach diverse underserved communities.	
CCBHS Experiencing the Juvenile Justice System – Supporting Youth: County operated Children's Services mental health clinicians support families experiencing juvenile justice system. Five clinicians support the juvenile probation offices. Clinicians provide direct short-term therapy and coordinate appropriate linkages to services and supports as youth transition back into their communities.	$433,535
CCBHS First Hope: Serves youth showing early signs of psychosis or who have recently experienced a first psychotic episode. Referrals accepted from all parts of the County. Through a comprehensive assessment process, young people ages 12-25, and their families are helped to determine whether First Hope is the best treatment to address the psychotic illness and associated disability. Intensive care is provided by a multi-disciplinary team and consists of psychiatrists, mental health clinicians, occupational therapists, and employment/education specialists. Services are based on the Portland Identification and Early Referral (PIER) Model, and consist of multi-family group therapy, psychiatric care, family psychoeducation, education and employment support, and occupational therapy.	$3,550,789
CCBHS Library Initiative: Provides support to work with county libraries that have been identified as having a high number of unhoused patrons who are living with untreated mental health and substance use disorders. CCBHS staff will work to provide outreach and engagement, linkage to community supports and services, and support to library staff.	$150,000
CCBHS Office for Consumer Empowerment (OCE): OCE staff provides support to reduce stigma and discrimination, develop leadership and advocacy skills among consumers, support the role of peers as providers, and encourages consumers to actively participate in planning and evaluation of services. OCE supports activities designed to educate the community and raise awareness of the stigma of mental illness. The Wellness Recovery Education for Acceptance, Choice & Hope (WREACH) Speakers' Bureau forms connections between people in the community and people with lived experiences, using face to face contact and storytelling of recovery & resiliency, as well as sharing information on health treatment and supports. WREACH activities include producing videos, public service announcements, and educational materials. OCE facilitates Wellness Recovery Action Plan (WRAP) groups providing certified leaders conducting classes in the County. Staff employ evidence-based WRAP system in enhancing the efforts of consumers to promote and advocate for their wellness. The Social Inclusion Committee is a project-based committee and ongoing alliance promoting the inclusion of persons who receive behavioral health services. Projects are designed to increase participation of consumers and family in planning, implementation and delivery of services. Efforts support integration of services for mental health and substance use treatment within CCBHS. Staff assist and support consumers and family in participating in planning committees and sub-committees, Mental Health Commission meetings, community forums, and other opportunities to participate in planning processes.	$248,577
Center for Human Development (CHD): Fields two programs - African American Wellness Group that serves east county community in Bay Point. Services consist of culturally appropriate education on mental health issues through support groups and workshops. Participants at risk for developing serious mental illness receive assistance with referral and access to County mental health services. Second program provides mental health education & supports for LGBTQ youth and their supports in East County to work toward more inclusion and acceptance within schools and in the community.	$176,633
Child Abuse Prevention Council of Contra Costa: Provides 23-week curriculum designed to build new parenting skills. Intended to strengthen families and support healthy development of their children. Program is designed to meet the needs of Spanish speaking families in east and central County.	$192,311
Contra Costa Crisis Center: Provides suicide prevention services operating a certified 24-hour suicide prevention hotline. Callers deemed as vulnerable and at risk of suicide are connected to community resources to enhance safety. Staff conduct lethality assessment on each call, provide intervention and support, and do follow-up calls (with caller's consent) to those deemed at medium to high risk of suicide. MHSA funds additional paid and volunteer staff capacity. Services in Spanish and other languages.	$413,652
Counseling Options Parenting Education (COPE): Uses evidence-based practices of Positive Parenting	

Program (Triple P) to help parents develop effective skills to address common child and youth behavioral issues that can lead to serious emotional disturbance. Focus on families in underserved communities, through seminars, training, and groups in English and Spanish.	$276,720
Fierce Advocates (formerly Building Blocks for Kids under fiscal sponsorship of Tides): Provides education to family and partner communities. Uses peer model of lived experience in outreach and engagement of at-risk families to address family mental health challenges. Individual and group wellness activities assist participants to make and implement plans of action, increase access to community services, and integrate into higher levels of mental health treatment as needed.	$245,428
First Five Contra Costa (First 5): partners with COPE Family Support Center by taking lead on training families who have children up to age five. Provides training in Positive Parenting Program (Triple P) method to mental health practitioners who serve underserved population.	$92,023
Hope Solutions: Provides on-site services to formerly homeless families at Garden Park Apartments in Pleasant Hill, Bella Monte Apartments in Bay Point, and Los Medanos Village in Pittsburg. Services include pre-school and afterschool programs, teen and family support groups, assistance in school preparation, and homework clubs. Services designed to prevent serious mental illness by addressing domestic violence, substance abuse, as well as life and parenting skills.	$421, 221
James Morehouse Project: Provides range of youth development groups designed to increase access to mental health services for at-risk students at El Cerrito High School. Partners with other CBOs, government agencies and local universities. Groups address mindfulness (anger/ stress management), violence, bereavement, societal and environmental factors leading to substance abuse, peer conflict mediation, and immigration/ acculturation.	$115,815
Jewish Family and Community Services of the East Bay (JFCS): Provides culturally grounded, community-directed mental health education and navigation services to Latino, Afghan, Bosnian, Iranian, and Russian refugees and immigrants of all ages. Outreach and engagement services provided in group setting including cultural practice, in non-office settings convenient to individuals and families.	$190, 664
La Clinica de la Raza: Engages at-risk LatinX in central and east County. Provide behavioral health assessments and culturally appropriate intervention services to address trauma, domestic violence, and substance abuse. Clinical staff provide psycho-education groups.	$315,771
Lao Family Community Development: Provides comprehensive and culturally sensitive integrated services for Asian adults and families in west County. Staff provide comprehensive case management services, including home visits, counseling, parenting classes, assistance accessing employment, financial management, housing, and other services offered within and of outside agency.	$214,315
Lifelong Medical Care: Provides isolated older adults in west County opportunities in social engagement, social services, and access to mental health. Group and one-on-one approaches employed in three housing developments provide screening for depression or other health issues with linkage to services.	$147,201
Mental Health Connections (formerly Putnam Clubhouse): Provides peer-based programs for adults in recovery from serious mental illness, includes work focused programming helping individuals develop support networks, career development skills, and self-confidence needed to sustain stable, productive and more independent lives. Provides respite support to family members, peer-to-peer outreach, and special programming for Transition Age Youth (TAY) and young adults	$820,581
People Who Care (PWC): After school program serving underserved youth, youth involved in the juvenile justice system, or youth from other referred behavioral health treatment programs from the communities of Pittsburg and Bay Point. Vocational projects offered on and off site, with select participants receiving stipends to encourage leadership development. Clinical specialist provides emotional, social and behavioral treatment through individual and group therapy.	$391,905
Rainbow Community Center: Provides social support program designed to decrease isolation, suicidal ideation, and depression among lesbian, gay, bisexual, transgender, and/or questioning community. Activities include outreach to community, engaging individuals at risk, mental health support groups that address isolation and stigma and promote wellness/resiliency, and providing mental health treatment.	$853,161
RYSE Center (RYSE): Provides activities that enable underserved youth to cope with violence and	$549,662

trauma in community and at home. Trauma informed programs and services include drop-in, recreational and structured activities across areas of health, wellness, media, arts, culture, education, career, technology, youth leadership and organizing capacity. RYSE facilitates training and technical assistance events to educate community on mental health and mental illness connected to trauma and violence.	
STAND!: Utilizes established curricula to assist youth successfully address the debilitating effects of violence occurring both at home and in teen relationships. Support groups are held for teens throughout County, teachers and other school personnel are assisted with education and awareness to identify and address unhealthy relationships amongst teens.	$150,944
The Latina Center (TLC): Serves Latino parents and caregivers in west County by providing culturally and linguistically specific twelve-week parent education classes to high-risk families utilizing the evidence-based curriculum of Systematic Training for Effective Parenting (STEP). Offers training to parents with lived experience to both conduct parenting education classes and become Parent Partners to offer mentoring, emotional support, and assistance in navigating social and mental health services.	$137,178
Vicente Martinez High School, Martinez Unified School District: Provides career academies for at-risk/underserved youth that include individualized learning plans, learning projects, internships, mental health education and counseling support. Students, school staff, parents and community partners work together on projects designed to develop leadership skills, a healthy lifestyle and pursuit of career goals.	$202,985
We Care Services for Children: Supports families and children from birth to 6 years old in range of early childhood education and mental health programs. Targeted, compassionate, and effective early intervention services are aimed to help young children and their families reach their full potential, regardless of abilities or circumstances. The Everyday Moments/Los Momentos Cotidianos provides programming for families and children in three components: 1) Family Engagement and Outreach; 2) Early Childhood Mental Health Home-Based Support; and 3) Parent Education and Empowerment.	$132,613
MHSA Component of Workforce Education and Training (WET)	*Funds*
CCBHS Loan Repayment Program (LRP): LRP for educational loan repayment to address diversity equity and inclusion, critical staff shortages, such as language need, hard-to-fill, and hard-to-retain positions. Provides potential career advancement for CCBHS staff and contracted CCBHS CBO staff as part of the public behavioral health workforce. CCBHS partners with the California Mental Health Services Authority (CalMHSA) to administer both the County specific LRP, as well as the Workforce Education and Training Greater Bay Area Regional Partnership Loan Repayment Program provided by the California Department of Health Care Information Access (HCAI). Funds have been allocated to CalMHSA for payment to individuals and administration of program is ongoing.	$0
CCBHS Senior Peer Counseling Program: Program in CCBHS Older Adult Mental Health that supports, recruits, and trains volunteer peer older adults to engage other older adults at risk of developing mental illness by providing home visits and group support. Clinical staff support efforts to reaching Latino/X/ Hispanic and Asian American seniors. Volunteers receive extensive training and consultation support.	$144,512
Staff Training: Various staff trainings are funded that support values of the MHSA. CCBHS offers training to CCBHS staff, CCBHS contracted CBO staff, and other community partners. Training is identified through workforce, community and leadership input.	$615,203
National Alliance on Mental Illness (NAMI) Contra Costa: Provides Family Volunteer Support Network to recruit train, and support family members with lived experience as subject matter experts in a volunteer role to educate and support other families in understanding, navigating, and supporting someone with mental health challenges. Family members are provided training and assistance to become natural supports in the recovery of loved ones. Also provide Family Psycho Education Programs such as NAMI Basics, Faith Net, Family-to-Family/De Familia a Familia (offered in Mandarin and Spanish), and Conversations with Local Law Enforcement. The programming offers evidence-based NAMI educational training, relationship building, education on mental health throughout the County to family members, care givers, faith communities, first responders and local law enforcement on what individuals experiencing mental health challenges may encounter. Training programs are designed to support and increase knowledge of mental health issues, navigation of systems, coping skills, and connectivity with	(FVSN) $675,305 (FPEP) $77,142

community resources. Some services offered in Spanish and Mandarin.	
Residency and Internship Programs: Funds paid internship programs for graduate or post-graduate students within CCBHS sites or contracted CCBHS CBOs. Emphasis on recruitment of interns to fill language and cultural needs of communities served, as well as interns with lived experience. Internships for individuals working towards licensure in mental health as Marriage and Family Therapist, licensed Clinical Social Worker, licensed Professional Clinical Counselor, and Clinical Psychologist.	$737,350
Service Provider Individualized Recovery Intensive Training (SPIRIT): SPIRIT is offered through partnership between CCBHS and Contra Costa Community College. SPIRIT is a college accredited recovery oriented, peer led and experiential-based program for individuals with lived experience as a consumer or a family member of a consumer with mental health and/or substance use challenges. Completion of classroom and internship lead to certification accepted as the minimum qualification necessary for employment within CCBHS as a Community Support Worker. Participants learn peer provider skills, group facilitation, Wellness Recovery Action Plan (WRAP) development, wellness self-management strategies and other skills needed to gain employment in a peer provider or family partner position. Some individuals are hired within CCBHS or CCBHS contracted CBOs. This training is offered annually. Monthly peer support groups are offered for individuals hired into CCBHS, as well as support in placement and advancement for SPIRIT graduates consisting with their career aspirations.	$545,336

MHSA programs focus on outreach to underserved communities and serve specific cultural niches or provide services in other languages. Other language access efforts include the Linguistic Access Services office where County staff support interpretation for clients. When interpretation cannot be provided through Linguistic Access Services either the Health Care Interpreter Network (HCIN) or Language Line Solutions are used. Written translation is provided through the United Language Group. CCH provides language differential pay. Parameters and amount are negotiated by union bargaining. In FY 21-22, it is estimated that 90 CCBHS staff received language differential pay, and 39 positions were flagged for bilingual for language needs in Spanish, Chinese (Mandarin and Cantonese), Vietnamese, and American Sign Language.

Criterion 2: Updated Assessment of Service Needs

I. Contra Costa County General Population

Based on the 2020 US Census estimates, the population size in Contra Costa County is about 1,165,927[9]. It's estimated 8% of people in Contra Costa are living in poverty and about 33% of the residents have public health coverage[10]. The population size is expected to grow[11]. In addition, its estimated that 23% of the population are children[12] and 77% are 18 or older, and about a quarter of residents are foreign born. The County is also primarily identified by three geographic regions; each having unique sub-populations. Thes regions are west – including cities of El Cerrito, Richmond, San Pablo, Pinole, Hercules, and the unincorporated communities of Kensington, El Sobrante, North Richmond, Rodeo, Crockett, and Port Costa; central - including cites of Lafayette, Moraga, Orinda, Walnut Creek, Pleasant Hill, Concord, Clayton, Martinez, Danville, San Ramon; and the unincorporated areas of Canyon, Pacheco, Vine Hill, Clyde, Pleasant Hill BART station, Saranap, Alamo, Blackhawk, and Tassajara; and east - including cities of Pittsburg, Antioch, Oakley, Brentwood, and the unincorporated communities of Bay Point, Bethel Island,

[9] United States Census Bureau. (2021, December 15). *Contra Costa County, California.* https://data.census.gov/cedsci/profile?g=0500000US06013

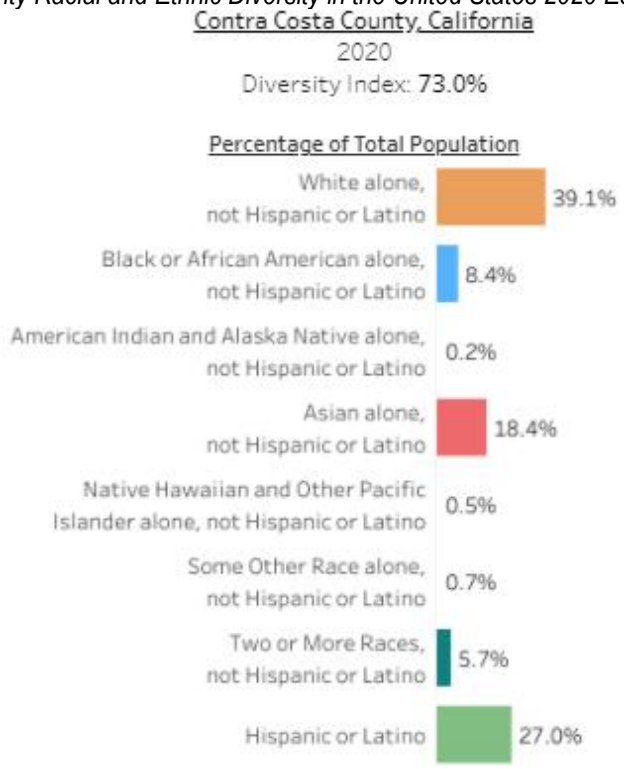
[10] United States Census Bureau. (2021, December 15). *Selected Economic Characteristics.* https://data.census.gov/cedsci/table?q=contra%20costa%20county%20data&t=Health%20Insurance&g=05US&tid=ACSDP1Y2019.DP03

[11] State of California Department of Finance. (2021, December 15). *Projections- Household Projections for California Counties.* http://www.dof.ca.gov/Forecasting/Demographics/projections/

[12] United States Census Bureau. (2021, December 15). *Contra Costa County, California.* /https://data.census.gov/cedsci/profile?g=0500000US06013

Knightsen, Discovery Bay, and Byron.[13] Figure 1 illustrates estimated current racial/ethnic demographics for Contra Costa, based on the 2020 Census Diversity Index.

Figure 1: Contra Costa County Racial and Ethnic Diversity in the United States 2020 Estimated Populations



II. Medi-Cal Population Service Needs

A. County Client Utilization Data

The California Department of Health Care Services (DHCS) requires an annual, independent external evaluation by an External Quality Review Organization (EQRO). The EQRO conducts a review that is an analysis and evaluation of aggregate information including, but not limited to access, timeliness, and quality of health care services. It also requires evaluation on the delivery of services in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care. The EQRO also measures penetration rates for those receiving services. The penetration rate is the number of persons receiving mental health and/or substance use treatment services of the total County Medi-Cal eligible population. Penetration rate data also shows how the County is performing in comparison to other like sized, large counties, and how the county compares to the overall state average performance. There are two separate reports developed, one which evaluates services in relation to mental health and the other evaluates services for substance use treatment.

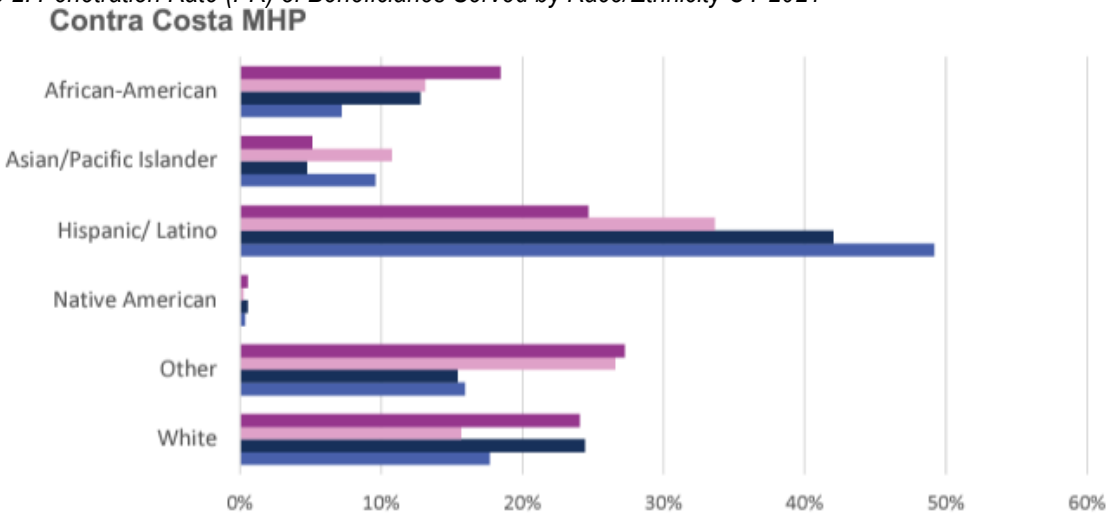
The following figure is from page 25 of the Fiscal Year (FY) 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review Contra Costa Final Report - Mental Health Plan[14]. It shows penetration rates of the

[13] Contra Costa County Community Development. (2004, December 1). *Planning Framework.* https://www.contracosta.ca.gov/DocumentCenter/View/30912/Ch2-Planning-Framework?bidId=

[14] Behavioral Health Concepts, Inc. (2023, August). *Fiscal Year (FY) 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review Contra Costa Final Report.* https://calegro.com/data/MH/Reports%20and%20Summaries/Prior%20Years%20Reports%20and%20Summaries/Fiscal%20Year%202022-

Contra Costa Mental Health Plan (MHP), or services provided to eligible beneficiaries by race/ethnicity. Analysis of services provided through the Contra Costa Mental Health Plan shows Latino/Hispanics and Asian/Pacific Islanders as being underserved. Latinos/Hispanics represented at 34%, however only 25% of mental health services are being provided to that group. Asian/Pacific Islanders (API) represent approximately 11% percent of eligible beneficiaries, but only receive about 5% of services. In contrast, Whites and African Americans seem to be overrepresented in services. Whites represent only 16% of eligible beneficiaries, but receive about 24% of services, and African Americans represent about 13% of eligible beneficiaries, but receive about 18% of those which receive services.

Figure 2: Penetration Rate (PR) of Beneficiaries Served by Race/Ethnicity CY 2021



	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	24%	27%	1%	25%	5%	18%
MHP % Eligibles	16%	27%	0%	34%	11%	13%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

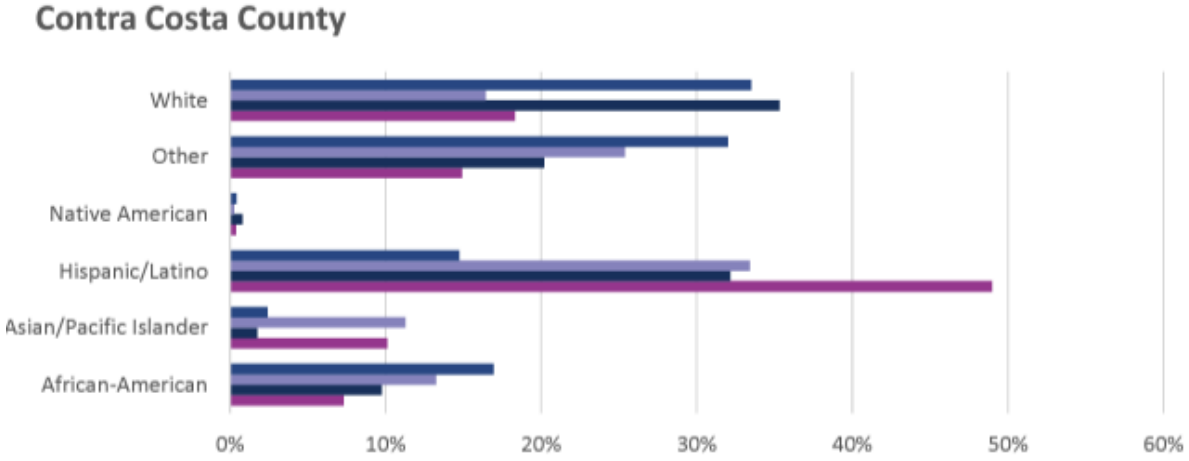
Figure 3 shows penetration rates of the Drug Medi-Cal Organized Delivery System or services provided by CCBHS and its contractors for substance use treatment to eligible beneficiaries by race/ethnicity. It is found in page 22 of the Fiscal Year (FY) 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review Contra Costa Final Report - Drug Medi-Cal Organized Delivery System (DMC-ODS)[15]. The same underrepresentation proves for the Drug Medi-Cal Organized Delivery System (DMC-ODS) which are services for substance use treatment provided through CCBHS. Latinos/ Hispanics represent 33% of eligible beneficiaries but receive only 15% of services for substance use treatment. Likewise, Asian/Pacific Islanders (API) represent about 11% of eligible beneficiaries but receive about 2% of services. In contrast, Whites represent only 16% of eligible beneficiaries, but receive about 33% of services. African Americans represent about 13% of eligible beneficiaries yet receive 17% of services. It should be noted that although

2023%20Reports/MHP%20Reports/Contra%20Costa%20MHP%20EQR%20Revised%20Final%20Report%20FY22-23%20RW%2004.17.23%20rev%208.23.23.pdf

[15] Behavioral Health Concepts, Inc. (2022, September). *Fiscal Year (FY) 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review Contra Costa Final Report - Drug Medi-Cal Organized Delivery System (DMC-ODS).* *https://www.calegro.com/data/DMC/Reports%20and%20Summaries/Prior%20Years%20Reports%20and%20Summaries/FY%202022-2023%20Reports/County%20Reports/Contra%20Costa%20DMC-ODS%20EQR%20Final%20Report%20FY22-23%20AC%2011.22.22%20revised%2001.30.23.pdf*

African Americans/Blacks seem to be overrepresented in both the MHP and DMC-ODS, when looking at where services are received, most receive services in more intensive programs. Low penetration rates for Latinos/Hispanics and Asian/Pacific Islanders have been ongoing.

Figure 3: Percentage of Eligibles and Beneficiaries Served by Race/ Ethnicity, Calendar Year (CY) 2021



	African-American	Asian/Pacific Islander	Hispanic/Latino	Native American	Other	White
County % Served	17%	2%	15%	0%	32%	33%
County % Eligibles	13%	11%	33%	0%	25%	16%
State % Served	10%	2%	32%	1%	20%	35%
State % Eligibles	7%	10%	49%	0%	15%	18%

III. Poverty Estimates Based on 200% Federal Poverty Level

A. Summary of Client Utilization Data

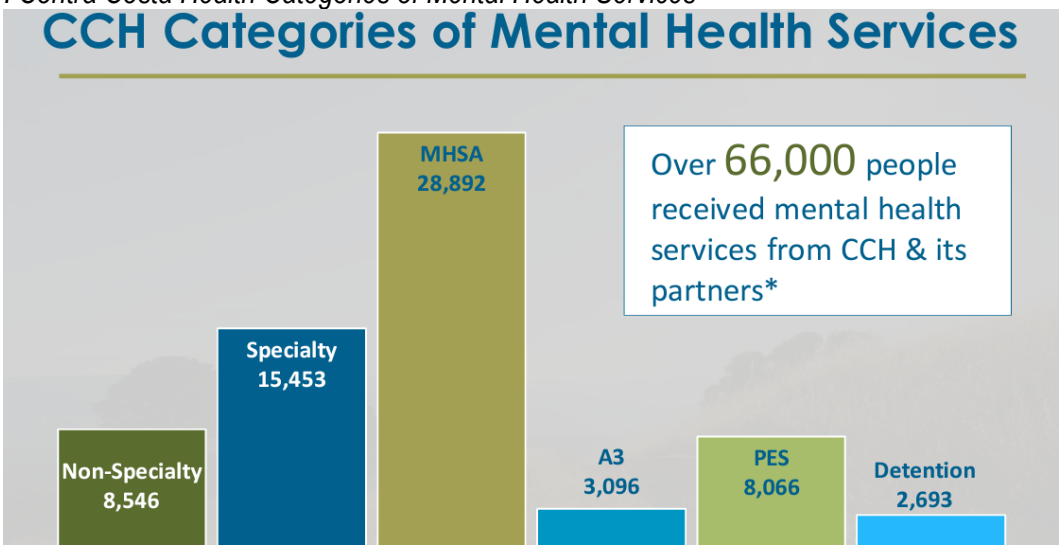
Looking at the overall services needs of Contra Costa, it is estimated that about 33% of the population in the County is insured through public health insurance[16], and another 5.5% of the population does not have health insurance[17], based on 2020 US Census Data. Due to the passing of the Affordable Care Act (ACA) in 2010, more individuals have become eligible for health insurance coverage which has led to higher enrollment in services provided by the County over the years. According to Covered California, for a person to be considered at 200% Federal Poverty Level in 2020, an individual's income would be at or below $24,980[18]. This is the primary population intended to be served through CCH and CCBHS.

B. Analysis of Disparities Identified

To provide more equitable care, CCBHS must continue to invest in culturally and linguistically responsive, community defined practices. A review conducted and presented to the Contra Costa Board of Supervisors on August 16th, 2022, provided data for racial/ethnic estimates of the overall County population, the Medi-Cal eligible population, and the estimated clients served through the County health system, including CCBHS and CCBHS contractors. The Equity in our Mental Health Delivery System presentation data shows the most recent 12-month reporting period at the time.

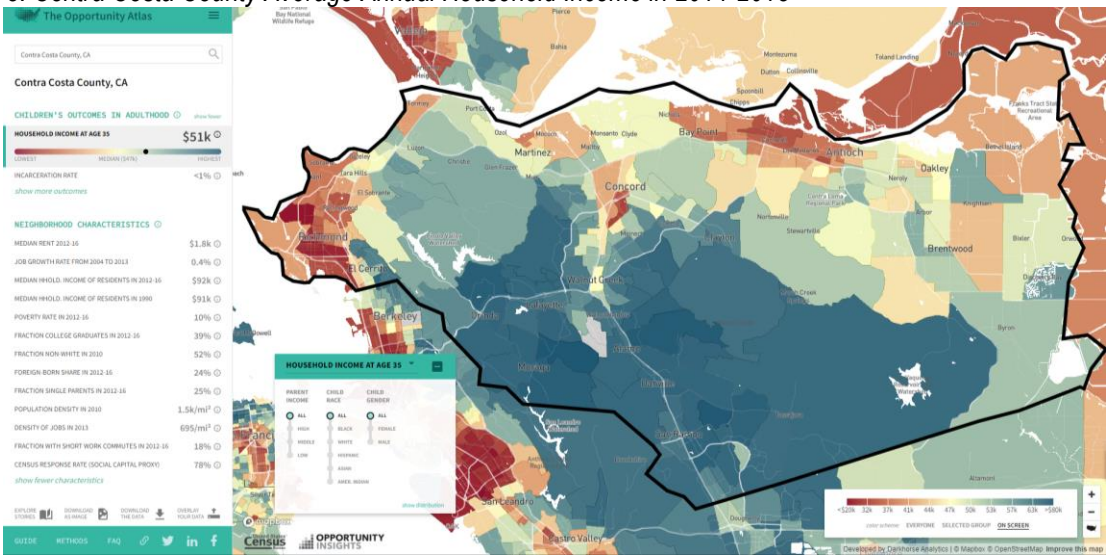
[16] United States Census Bureau. (2021, December 15). *Contra Costa County- Selected Economic Characteristics.* https://data.census.gov/cedsci/table?q=contra%20costa%20county%20data&t=Health%20Insurance&g=05US&tid=ACSDP1Y2019.DP03
[17] United States Census Bureau. (2021, December 15). *Contra Costa County, California.* https://data.census.gov/cedsci/profile?g=0500000US06013
[18] Covered California. (2020, March). *Program Eligibility by Federal Poverty Level for 2020* https://www.coveredca.com/pdfs/FPL-chart-2020.pdf

Figure 4: Contra Costa Health Categories of Mental Health Services



Further data analysis of the County demographic data also shows income disparities, specifically some of the areas with the lowest levels of income in Contra Costa County were in the City of Richmond, the Monument Corridor located in the City of Concord, and parts of the City of Antioch. This is based off information from The Opportunity Atlas, which is an interactive map of social mobility data, compiled through a collaboration between researchers at the Census Bureau, Harvard University, and Brown University[19]. The following figure is a snapshot which outlines Contra Costa County average annual household income in 2014-2015 with the areas shown in the darker brick red having income ranging between $20,000 and $32,000. Areas with darker brick red indicates lowest levels of income, with the yellow and light green being median and the darker green being areas with higher household income.

Figure 5: Contra Costa County Average Annual Household Income in 2014-2015



IV. MHSA Community Services and Supports (CSS) Population Assessment and Service Needs

CCBHS released its 2019 Mental Health System of Care Needs Assessment which draws upon input

[19] United States Census Bureau. (2021, December 15). *Data Equity Tools*. https://www.census.gov/about/what/data-equity/tools.html

received through the Community Program Planning Process, Various stakeholder committees and analyzing data focused on Contra Costa County[20]. Housing continues to be the number need identified throughout the County.

A. CSS Population Assessment

Under the component of CSS, Full-Service Partnership (FSP) programs are a crucial component that assists in recovery and wellness for individuals with a serious mental illness or serious emotional disturbance. An analysis of FSP programs had identified the positive impact FSPs which provide an Assertive Community Treatment (ACT) model have shown to decreasing homelessness, incarceration, and Psychiatric Emergency Service (PES) visits and increased engagement in productive and meaningful activities such as; work, education, vocation/ training programs and volunteerism for individuals with serious and debilitating mental health challenges.
Housing services and support continues to be a key factor for many of the clients being served by FSP programs. CCBHS's strategy to address this is the continuum of housing services to support the FSP programs. MHSA currently funds several housing specific elements, to include permanent supportive housing, master leasing, shared housing, augmented board and care, shelter beds, and the housing specific services and supports to enable clients/consumers to move in and maintain housing most suited to their situation. CCBHS has applied and been awarded No Place Like Home[21] funding intended to house people with serious mental illnesses and continues to explore efforts to support future housing for clients enrolled in FSP programs.

Strategies to reduce identified disparities include cultural and gender-sensitive outreach; services located in racial/ethnic communities with linkages to the full range of supports, such as transportation, services and supports provided at school, in the community and at home. In another example of key strategies, keys to the cultural competency of programs serving transition age youth are the embedding of its outreach/ personal service coordinators in community-based agencies serving communities that are often not reached by county systems.

The data below illustrates rates of change for in-patient psychiatric hospitalization and PES episodes for participants of FSP programs. For FY 2021- 2022 data was obtained for 450 participants served by FSP programs. Use of PES and in-patient psychiatric hospitalization was compared before and after FSP participation, with the following overall results:

- 61.2% decrease in the number of PES episodes
- 69.9% decrease in the number of in-patient psychiatric hospitalizations
- 47.8% decrease in the number of in-patient psychiatric hospitalization days
- 19.7% decrease in productive meaningful activity (average hours per week) – this is usually an increase, however; it should be noted, this is the first full year of data which reflects the pandemic
- 55.5% decrease in number of unhoused

For most participants, FSP programs have also shown to decrease the number of juvenile assessment and consultation services as well as detention facility bookings. The data for FSP clients is listed in the subsequent tables and is listed by order Children, Transition Aged Youth (TAY), and Adults and Older Adults FSP programs. Please reference the following tables for detailed information. The data labels for the

[20] Contra Costa Behavioral Health Services. (December 2019). *2019 Mental Health System of Care Needs Assessment.* https://cchealth.org/mentalhealth/mhsa/pdf/2019-Needs-Assessment-Report.pdf
[21] California Department of Housing and Community Development. *No Place Like Home Program.* https://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml#background

FSP tables are identified below:

- PES episodes - Psychiatric Emergency Services (PES) Episodes
- Inpatient episodes – number of hospitalizations
- Inpatient days - number of days hospitalized
- JACS - Juvenile Assessment and Consultation Services
- DET Bookings – Detention facility bookings

Children's FSP Programming

Table 21. Pre- and post-enrollment utilization rates for 29 Embrace FSP participants enrolled during FY 21-22

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	25	6	0.091	0.045	-50.6%
Inpatient episodes	1	0	0.004	0.00	-100.0%
Inpatient days	4	0	0.014	0.000	-100.0%
JACS Bookings	11	2	0.040	0.015	-62.6%

Table 22. Race/Ethnicity Data for Embrace Children's FSP participants enrolled in during FY 21-22	
Black or African American	3
Latin American	5
Mexican American	9
Mixed Race	1
Other Hispanic	2
Unknown / Not Reported	5
White or Caucasian	4

Table 23. Gender Data for Embrace Children's FSP participants enrolled in program during FY 21-22	
F	10
M	19

Table 24. Pre- and post-enrollment utilization rates for 39 Lincoln Child Center participants enrolled during FY 21-22

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	3	0	0.009	0.010	-100.0%
Inpatient episodes	0	0	0.000	0.000	-0%
Inpatient days	0	0	0.000	0.000	-0%
JACS Bookings	10	12	0.031	0.047	+51.6%

Table 25. Race/Ethnicity Data for Lincoln Child Center participants enrolled in program during FY 21-22	
American Indian	1
Black or African American	16
Filipino	2
Mexican American	6
Mixed Race	3
Other	1
Other Hispanic	1
Unknown / Not Reported	3
White or Caucasian	6

Table 26. Gender Data for Lincoln Child Center participants enrolled in program during FY 21-22

F	11
M	28

Table 27. Pre-and post-enrollment utilization rates for 47 Seneca Start FSP participants enrolled during FY 21-22

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	94	52	0.201	0.169	-15.9%
Inpatient episodes	6	3	0.013	0.010	-23.1%
Inpatient days	31	26	0.066	0.084	-27.3%

Table 28. Race/Ethnicity Data for Seneca START Children's FSP participants enrolled in program during FY 21-22

Asian	1
Black or African American	7
Latin American	5
Guamanian	1
Mexican American	13
Other	1
Other Hispanic	3
Unknown/ Not Reported	2
White or Caucasian	14

Table 29. Gender Data for Seneca START Children's FSP participants enrolled in program during FY 21-22

F	28
M	19

Transition Aged Youth (TAY) FSP Programming

Table 30. Pre- and post-enrollment utilization rates for 33 Fred Finch FSP participants enrolled during FY 21-22

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	% change
PES episodes	27	11	0.082	0.030	-63.4%
Inpatient episodes	13	7	0.039	0.019	-51.3%
Inpatient days	126	154	0.382	0.418	+9.42%
DET Bookings	2	2	0.006	0.005	-16.7%

Table 31. Race/Ethnicity Data for Fred Finch Youth Center TAY FSP participants enrolled during FY 21-22

Black or African American	12
Filipino	1
Laotian	1
Latin American	4
Mexican American	3
Mixed Race	1
Other	2
Other Hispanic	4
White or Caucasian	5

Table 32. Gender Data for Fred Finch Youth Center TAY FSP Participants enrolled during FY 21-22

F	16
M	17

Table 33. Pre- and post-enrollment utilization rates for 33 Youth Homes FSP participants enrolled during FY 21-22

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	131	42	0.358	0.119	-66.5%
Inpatient episodes	36	13	0.098	0.037	-62.6%
Inpatient days	441	181	1.205	0.513	-57.4%
DET Bookings	12	7	0.033	0.020	-39.4%

Table 34. Race/Ethnicity Data for Youth Homes TAY FSP Participants enrolled during FY 21-22	
American Indian	2
Black or African American	9
Chinese	1
Latin American	2
Mexican American	5
Mixed Race	1
Other	1
Other Asian	2
Other Pacific Islander	1
White or Caucasian	9

Table 35. Gender Data for Youth Homes TAY FSP participants enrolled during FY 21-22	
F	16
M	18

Adult and Older Adult FSP Programming

Table 36. Pre-and post-enrollment utilization rates for 20 Familias Unidas FSP participants enrolled during FY 21-22

	No. pre-Enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	% change
PES episodes	22	0	0.094	0.000	-100.0%
Inpatient episodes	6	0	0.026	0.000	-100.0%
Inpatient days	41	0	0.175	0.000	-100.0%
DET	7	4	0.030	0.018	-39.2%

Table 37. Race/Ethnicity Data for Familias Unidas Adult FSP participants enrolled during FY 21-22	
Asian Indian	1
Black or African American	2
Laotian	2
Latin American	6
Mexican American	5
Mixed Race	1
Other Hispanic	1
White or Caucasian	2

Table 38. Gender Data for Familias Unidas Adult FSP participants enrolled in program during FY 21-22	
F	11
M	9

Table 39. Pre- and post-enrollment utilization rates for 68 Hume East FSP participants enrolled during FY 21-22

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	302	72	0.378	0.091	-75.9%
Inpatient episodes	44	16	0.055	0.020	-63.6%
Inpatient days	381	176	0.477	0.223	-53.2%
DET Bookings	22	12	0.028	0.015	-46.4%

Table 40. Race/Ethnicity Data for Portia Bell Hume Center East Adult FSP participants enrolled during FY 21-22

Asian Indian	1
American Indian	2
Black or African American	21
Latin American	2
Mexican American	7
Mixed Race	2
Other Hispanic	3
Samoan	1
Vietnamese	1
White or Caucasian	28

Table 41. Gender Data for Portia Bell Hume Center East Adult FSP participants enrolled during FY 21-22

F	37
M	31

Table 42. Pre- and post-enrollment utilization rates for 47 Hume West FSP participants enrolled during FY 21-22

	No. pre-enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	*96*	*64*	*0.180*	*0.113*	*-37.2%*
Inpatient episodes	*14*	*2*	*0.026*	*0.004*	*-84.6%*
Inpatient days	*145*	*30*	*0.272*	*0.053*	*-80.5%*
DET Bookings	*13*	*2*	*0.024*	*.004*	*-83.3%*

Table 43. Race/Ethnicity Data for Portia Bell Hume Center West Adult FSP Participants enrolled during FY 21-22

Black or African American	24
Filipino	3
Laotian	1
Mexican American	3
Other	1
Other Hispanic	1
Other Southeast Asian	1
Samoan	1
White or Caucasian	12

Table 44. Gender Data for Portia Bell Hume Center West Adult FSP participants enrolled during FY 21-22

F	22
M	26

Table 45. Pre-and post-enrollment utilization rates for 76 Turn BHS Assisted Outpatient Treatment (AOT)/ Assertive Community Treatment (ACT) FSP participants enrolled during FY 21-22

	No. pre-Enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	235	66	0.308	0.076	-75.3%
Inpatient episodes	39	16	0.051	0.018	-64.7%
Inpatient days	514	282	0.675	0.323	-52.1%
DET Bookings	48	37	0.063	0.042	-33.3 %

Table 46. Race/Ethnicity Data for Turn BHS AOT/ACT Adult FSP Participants enrolled during FY 21-22	
American Indian	4
Black or African American	6
Filipino	2
Latin American	3
Mexican American	7
Mixed Race	1
Native Hawaiian or Other Pacific Islander	2
Other	4
Other Asian	1
Unknown / Not Reported	4
Vietnamese	1
White or Caucasian	41

Table 47. Gender Data for Turn BHS AOT/ACT Adult FSP Participants enrolled during FY 21-22	
F	32
M	44

Table 48. Pre-and post-enrollment utilization rates for 59 Turn BHS FSP participants enrolled during FY 21-22

	No. pre-Enrollment	No. post-enrollment	Rate pre-enrollment	Rate post-enrollment	%change
PES episodes	139	65	0.217	0.098	-54.8%
Inpatient episodes	28	15	0.044	0.023	-47.7%
Inpatient days	314	231	0.489	0.347	-29.0%
DET Bookings	20	35	0.031	0.038	+22.5 %

Table 49. Race/Ethnicity Data for Turn BHS Adult FSP Participants enrolled in program during FY 21-22	
American Indian	1
Asian Indian	1
Black or African American	8
Japanese	1
Korean	1
Latin American	3
Mexican American	4
Native Hawaiian	1
Other	2
Other Asian	1
Other Hispanic	2
Unknown / Not Reported	4
White or Caucasian	30

Table 50. Gender Data for Turn BHS Adult FSP Participants enrolled during FY 21-22	
F	17
M	42

B. Analysis of Disparities in CSS

Data analyses supports that the FSP programs are mostly meeting the targeted number of clients intended to be served annually, and that FSP services have shown to support a decrease in psychiatric emergency services episodes, inpatient psychiatric hospitalizations, the number of inpatient hospitalization days, and the number of juvenile assessment and consultation services or detention facility bookings. In reviewing the data available in relation to race/ethnicity for overall FSP clients, there does seem to be an over representation of Caucasian/White under the Adult FSPs. Most of the agencies providing Adult and Older Adult FSP services seem to have a larger percentage of Caucasian/ White population. In some agencies, this population makes up over 50% of the clients served, when roughly 18% of the Medi-Cal Eligible population identifies as Caucasian/White. The aggregate data for race/ethnicity of FSP clients is shown in the following table.

Table 51. Overall Race/Ethnicity Data Available for 2021-2022 FSP Clients

Race / Hispanic Origin	***Num of Clients***	***% of Clients***
White or Caucasian	***146***	***33.0%***
- Hispanic	*12*	*2.7%*
- Not Hispanic	*126*	*28.4%*
- Unknown/Not Reported	*8*	*1.8%*
Black or African American	***105***	***23.7%***
- Hispanic	*1*	*0.2%*
- Not Hispanic	*95*	*21.4%*
- Unknown/Not Reported	*9*	*2.0%*
Mexican American	***61***	***13.8%***
- Hispanic	*58*	*13.1%*
- Unknown/Not Reported	*3*	*0.7%*
Latin American	***29***	***6.5%***
- Hispanic	*28*	*6.3%*
- Not Hispanic	*1*	*0.2%*
Other Hispanic	***16***	***3.6%***
- Hispanic	*13*	*2.9%*
- Unknown/Not Reported	*3*	*0.7%*
Unknown	***12***	***2.7%***
- Hispanic	*1*	*0.2%*
- Unknown/Not Reported	*11*	*2.5%*
Other	***12***	***2.7%***
- Hispanic	*1*	*0.2%*
- Not Hispanic	*7*	*1.6%*
- Unknown/Not Reported	*4*	*0.9%*
Mixed Race	***10***	***2.3%***
- Hispanic	*4*	*0.9%*
- Not Hispanic	*3*	*0.7%*
- Unknown/Not Reported	*3*	*0.7%*
American Indian	***10***	***2.3%***
- Hispanic	*3*	*0.7%*

- Not Hispanic	*6*	*1.4%*
- Unknown/Not Reported	*1*	*0.2%*
Filipino	***8***	***1.8%***
- Hispanic	*2*	*0.5%*
- Not Hispanic	*6*	*1.4%*
Unknown / Not Reported	***6***	***1.4%***
- Hispanic	*4*	*0.9%*
- Not Hispanic	*1*	*0.2%*
- Unknown/Not Reported	*1*	*0.2%*
Laotian	***4***	***0.9%***
- Not Hispanic	*4*	*0.9%*
Other Asian	***4***	***0.9%***
- Not Hispanic	*4*	*0.9%*
Asian Indian	***3***	***0.7%***
- Not Hispanic	*3*	*0.7%*
White	***3***	***0.7%***
- Not Hispanic	*3*	*0.7%*
Native Hawaiian	***2***	***0.5%***
- Not Hispanic	*2*	*0.5%*
Vietnamese	***2***	***0.5%***
- Not Hispanic	*2*	*0.5%*
Samoan	***2***	***0.5%***
- Not Hispanic	*2*	*0.5%*
Native Hawaiian or Other Pacific Islander	***1***	***0.2%***
- Not Hispanic	*1*	*0.2%*
Japanese	***1***	***0.2%***
- Not Hispanic	*1*	*0.2%*
Korean	***1***	***0.2%***
- Not Hispanic	*1*	*0.2%*
Other Southeast Asian	***1***	***0.2%***
- Hispanic	*1*	*0.2%*
Asian	***1***	***0.2%***
- Unknown/Not Reported	*1*	*0.2%*
Guamanian	***1***	***0.2%***
- Hispanic	*1*	*0.2%*
Other Pacific Islander	***1***	***0.2%***
- Not Hispanic	*1*	*0.2%*
Chinese	***1***	***0.2%***
- Not Hispanic	*1*	*0.2%*
Grand Total	***443***	***100.0%***

V. Process in Identifying Prevention and Early Intervention (PEI) Priority Populations

It is estimated that MHSA Prevention and Early Intervention (PEI) programming which primarily do not require Medi-Cal eligibility to receive services provided support to an estimated 31,917 individuals in FY 2021-2022. It should be noted that this data reflects the second year of the pandemic. Despite the challenges faced by COVID-19 and the shelter in place, many agencies continued to serve clients at the same volume. Some limitations that exist in this data is that all programs were not able to collect data, especially with shelter in place challenges that made it difficult for some of the demographic data to be

gathered. During the first year of the pandemic the data did show a slight decrease of those served in PEI programs decreasing by about 3,000 compared to the previous year, but in the second year of the pandemic, it seems agencies were serving individuals almost at the same rate as prior to the pandemic. The identifying data collected represents voluntary information that is self-reported by program participants.

A. PEI Priority Populations

The following table illustrates *primary populations* served related to cultural groups under MHSA-PEI funding. It should be noted that the agency may be more expansive and serving other populations. Detailed planning and programming under the PEI component can be found in the most recent MHSA Three Year Plan, under the Prevention and Early Intervention section.

Table 52. Prevention and Early Intervention Cultural and Linguistic Providers

Provider	*Primary Population(s) Served*
Asian Family Resource Center	Asian
Fierce Advocates (formerly Building Blocks for Kids)	African American/Black, Latino/Latina/LatinX/Hispanic
Center for Human Development	African American/Black, LGBTQI+ Youth Latino/Latina/LatinX/Hispanic
Child Abuse Prevention Council	Latino/Latina/LatinX/Hispanic
Contra Costa Crisis Center	African American/Black, Latino/Latina/LatinX/Hispanic
COPE / First Five	Latino/Latina/LatinX/Hispanic, African American/Black
Hope Solutions	African American/Black, Latino/Latina/LatinX/Hispanic
James Morehouse Project	Latino/Latina/LatinX/Hispanic, African American/Black, Asian
Jewish Family & Community Services of the East Bay	Afghan, Middle East, Russian, and other recent immigrants
La Clínica de la Raza	Latino/Latina/LatinX/Hispanic
Lao Family Development	Asian, and other recent immigrants
Lifelong (SNAP Program)	African American/ Black
People Who Care	African American/ Black, Latino/Latina/LatinX/Hispanic
Putnam Clubhouse	Peer Driven Services
Rainbow Community Center	LGBTQI+ / LGBTQI+ Youth
RYSE	Youth, Asian, Latino/Latina/LatinX/Hispanic, African American/ Black, LGBTQI+ Youth
Stand!	Youth, African American/Black, Latino/Latina/LatinX/Hispanic
The Latina Center	Latino/Latina/LatinX/Hispanic
Vicente Martinez High School	Youth
We Care Services for Children	African American/Black, Latino/Latina/LatinX/Hispanic

All programs under PEI help create access and linkage to mental health treatment, often through community defined practices, as well as providing outreach and engagement to those populations who have been identified as historically marginalized such as black, indigenous, people of color (BIPOC), immigrants and refugees, children, youth, older adults and the LGBTQI+ communities.

The following tables summarize demographic data collected by PEI programs, however a significant number of program participants declined to provide information or data was unable to be collected. Prior to 2020, when MHSA staff were conducting in person program visits, many staff and clients shared that people were hesitant to provide information when receiving services due to the political climate and fear of who would have access to the data collected, specifically relating to immigration challenges and various

laws such as Public Charge[22]. Additionally, with the onset of COVID-19, collecting client data became even further challenging. It should be noted, this data represents the second year of the pandemic.

Table 53. Race Data in PEI Programs	*Numbers Served*
Asian	2,154 or about 7%
African American / Black	4,069 or about 13%
Caucasian / White	8,784 or about 29%
Latino/ Latina/ LatinX / Hispanic	3,578 or about 11%
Native American / Alaskan Native	165 or about .5%
Native Hawaiian / Other Pacific Islander	194 or about less than 1%
More than One Race	507 or about 2%
Other	510 or about 2%
Declined to Respond or Data Not Captured	11,347 or about 36%

Please note, race data may be more than 100% as some individuals identified as more than one race. It is difficult to identify disparities in PEI programs as information is provided at will and a large number of individuals do not respond to all questions.

Table 54. Age for PEI Clients	*Numbers Served*
0-15 years (Child)	1,211
16-25 years (Transition Age Youth – TAY)	2,395
26-59 years (Adult)	10,226
60+ years (Older Adult)	5,040
Decline to State/ Data Not Captured	12,433

The following PEI programs primarily serve children and adolescents ages 0-15: Fierce Advocates, Center for Human Development, Child Abuse Prevention Council, COPE, First Five, Hope Solutions, the James Morehouse Project, Jewish Family and Community Services of the East Bay, La Clinica de la Raza, People Who Care, RYSE, Stand!, Vicente Martinez High School, and We Care Services for Children.

Table 55. FY 2021-2022 Primary Language Spoken for PEI Clients	*Numbers Served*
English	24,324
Spanish	2,118
Other	1,405
Decline to State or Data Not Captured	3,610

Table 56. Current Gender Identity for PEI Clients	*Numbers Served*
Man	8,057
Woman	14,466
Transgender	96
Genderqueer	24
Questioning or Unsure of Gender Identity	10
Another Gender Identity	58
Decline to State/ Data Not Captured	8,581

[22] Contra Costa County Board of Supervisors. (2018, December 7). *Letter from Contra Costa Board of Supervisors to Chief Regulatory Coordination Division, Office of Policy and Strategy U.S. Citizenship and Immigration Services Department of Homeland Security.* https://cchealth.org/insurance/pdf/Public-Charge-Comment-12-7-18.pdf

Table 57. Sexual Orientation for PEI Clients	*Numbers Served*
Heterosexual or Straight	20,926
Gay or Lesbian	214
Bisexual	141
Queer	71
Questioning or Unsure of Sexual Orientation	36
Another Sexual Orientation	68
Decline to State/ Data Not Captured	9,835

Some PEI programs have specific programming supporting the LGBTQI+ and non-binary gender communities, such as the Rainbow Community Center, RYSE, and Center for Human Development.

Table 58. Military Connected Status for PEI Clients - Active Military	*Numbers Served*
Yes	66
No	2,711
Decline to State/ Data Not Captured	22,642
Veteran Status	*Numbers Served*
Yes	124
No	3,650
Decline to State/ Data Not Captured	27,515

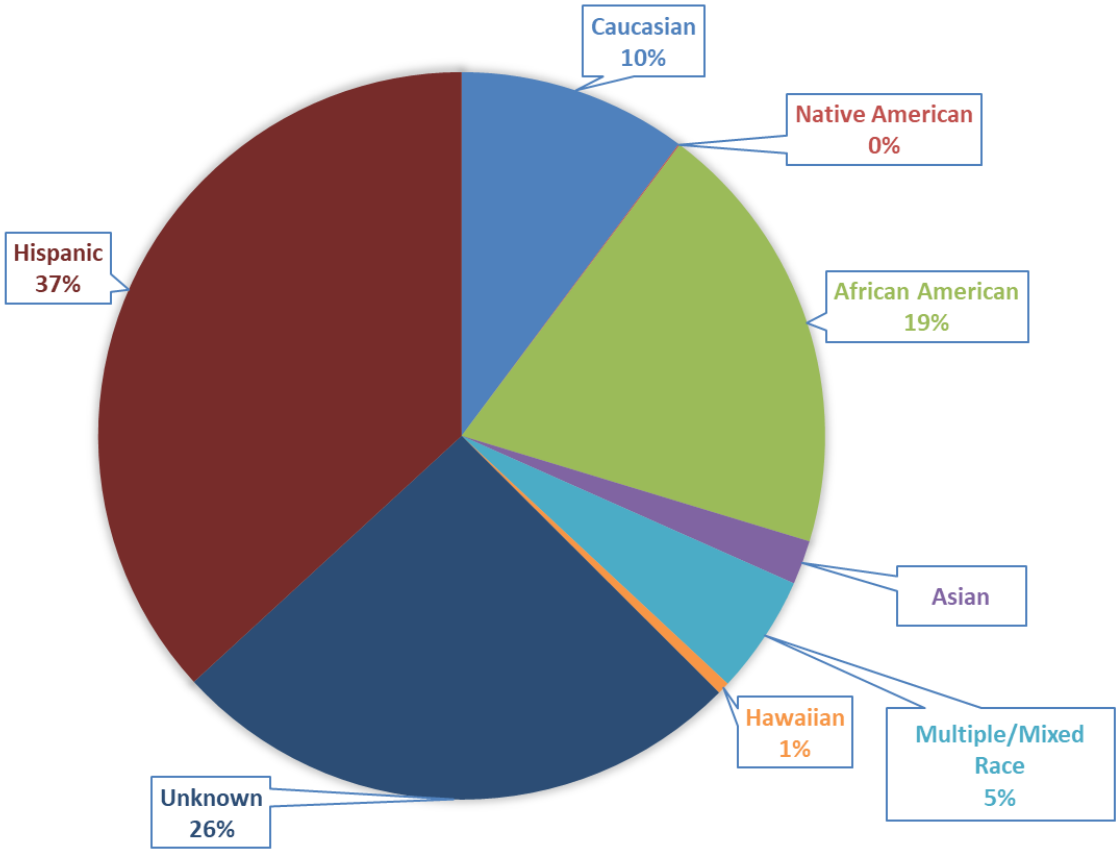
The County does have a local Veterans Affair (VA) Office and VA Hospital located in central Contra Costa County[23]. Additionally, the Regional Veterans Affairs Office is in Oakland[24], in the next county over making.

Table 59. Disability Status for PEI Clients	*Numbers Served*
Yes	557
No	1,375
Decline to State/ Data Not Captured	27,427

Apart from the MHSA PEI programs, CCBHS also contracts with providers under Alcohol and Other Drug Services (AODS) to provide prevention services to clients and the community. The California Department of Health Care Services Primary Prevention SUD Data Service (PPSDS) is a system for counties and providers to report and track prevention services. According to PPSDS, AODS prevention providers served 1836 individuals in 2021; race/ethnicity is shown below. Overall, AODS prevention providers served mainly Hispanic clients, followed by African American and Caucasian. However, there are 26% prevention clients whose race/ethnicity is unknown.

[23] Contra Costa County Veterans Service Office. (2021, December 15). https://www.contracosta.ca.gov/1557/Veterans-Service-Office
[24] United States Department of Veterans Affairs. (2021, December 15). *Oakland Reginal Office*. https://www.benefits.va.gov/oakland/

Figure 6: Race/ Ethnicity of Clients Served by AODS Prevention Providiers (January 1, 2021-December 31st. 2021)



Whether consumers are appropriately served in ways that align with their cultural values and linguistic needs is an issue that has been raised by community stakeholders and advocates and is something that warrants on- going assessment. Specifically, the topic of the need for appropriate and relevant mental health and wellness services through community defined practices for Latino/ Latina/ LatinX/ Hispanic, Asian and African American/ Black communities has been a topic stated throughout many stakeholder and community engagement events. CCBHS must continue to build trusting relationships with communities that have been historically marginalized as well as affected by systemic discriminatory policies. This has become even more relevant during the pandemic, as existing social and racial inequities have been exacerbated.

In analyzing the available data, the identified priority populations are similar to the identified needs in other areas under CCBHS. Priority populations include Latino/Latina/LatinX/Hispanic, Asian communities, children; older adult and LGBTQI+ communities[27]. Additionally, although African American/ Black communities may be showing up as having received services comparable to the percentage eligible, stakeholders have voiced the need for culturally responsive and appropriate community defined practices in relation to mental health and is a well warranted and valid claim, given serious disparities this community has faced[25].

[25] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24

Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural and Linguistic Behavioral Health Disparities

I. Target Populations

CCBHS has identified the following target populations which include Latino/Latina/LatinX/Hispanic, Asian, African American/Black, LGBTQI+ communities, and children ages 0-5. Furthermore, there has been some work done to further identify sub-groups that make up the Asian population. In reviewing data from the updated 2020 Census, the largest ethnic groups which identified as being part of the Asian race were those which identified as Filipino and Chinese[26]. The County also received refugee arrivals from Afghanistan, likely increasing the need for language access. Data continues to be reviewed to gauge language needs. Considering interpretation support calls provided through Linguistic Access Services, the Health Care Interpreter Network (HCIN), and Language Line Solutions for CCBHS clients during FY 2021-2022, the following languages were most utilized in order of highest to least utilized.

Table 60. Non-English Encounters through Linguistic Access Services and HCIN
Spanish
Punjabi
Farsi
Portuguese
Vietnamese
Dari
Arabic
Mandarin
Tagalog
Cantonese

II. Identified Disparities

There are significant language disparities with many of the clients needing support in other languages. Spanish is a threshold language, however penetration rates through EQRO data for Medi-Cal eligible clients, still show there is a gap for providing services to LatinX communities. For clients needing services in other languages, specifically the various Asian languages identified proves challenging. Although some clients may be able to be supported by CCBHS and CBO providers, utilization and penetration rates are low. Additionally, stakeholder feedback provided by clients and staff at CBOs partner agencies state services are not sufficient to meet the needs of the clients, due to challenges in navigation.

Alcohol and Other Drugs Services (AODS) Utilization Data by Race and Ethnicity

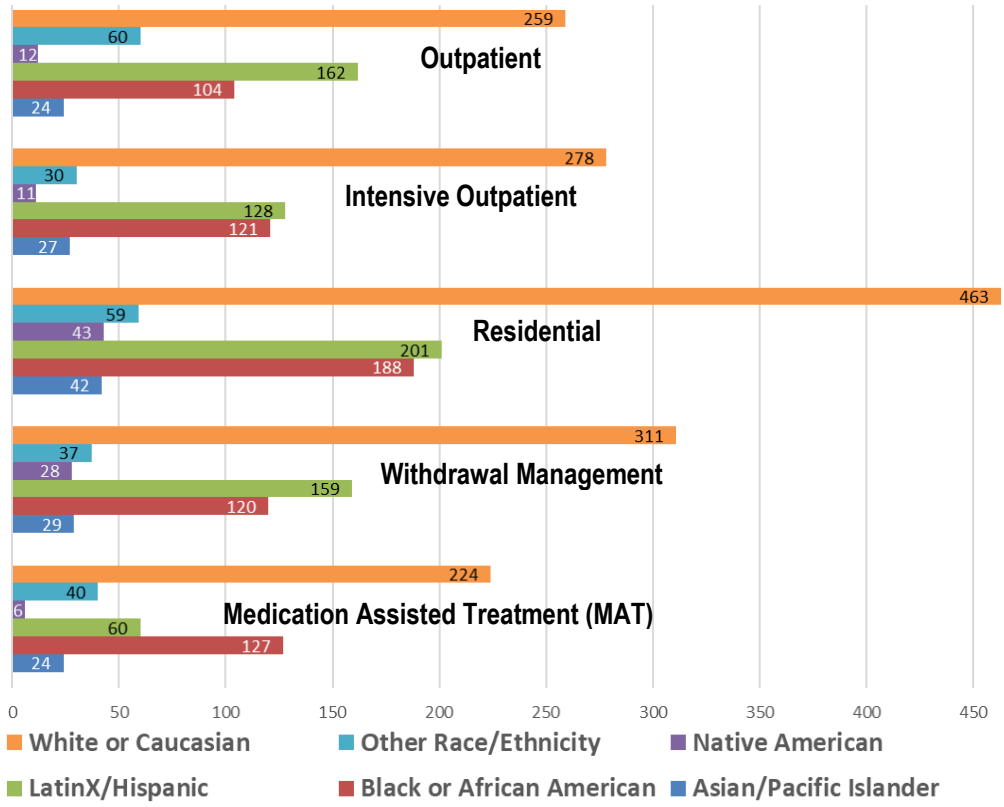
Data collection and integration continues to take place within CCBHS. In 2018, AODS began to develop and implement methodologies to capture, report and incorporate data into primary prevention. In 2019 AODS further increased strategies to collect and use data to inform treatment program planning. Initial efforts to capture data started with each American Society of Addiction Medicine (ASAM) Criteria Level of Care Placement Assessment (LOCPA) that was administered. Beyond LOCPAs data AODS continues to collect data on staff demographics, training, provider network language capacity, opioid response, etc. Disparities in the AODS data mirror disparities identified in mental health, when consider race/ethnicity, however the gap and disparity margin for communities of color, specifically for LatinX and Asian

[26] United States Census Bureau. (2021, December 15). *Contra Costa County, California.* https://data.census.gov/cedsci/table?t=Language%20Spoken%20at%20Home%3APopulations%20and%20People&g=0500000US06013&d=DEC%20Summary%20File%203%20Demographic%20Profile

communities seems to be greater. Overall, AODS is predominantly serving more White/ Caucasian clients which are over-represented in Residential Treatment Programs, followed by LatinX/Hispanic and African American. When compared, there are more LatinX/Hispanic than African American clients in most levels of care, except for Medication Assisted Treatment (MAT). Black/ African Americans are the largest group represented in MAT's Drug Medi-Cal Organized Delivery System (DMC -ODS) services. Similarly, the County's Buprenorphine MAT program also known as Choosing Change served only 14% of Black/African American clients and 62% were White/Caucasian.

Further detailed information may be accessed at the California Overdose Surveillance Dashboard hosted by the California Department of Public Health. County specific data is available and can be filtered by selecting data for Contra Costa.[27] The data demonstrates the need for more targeted outreach to address disparities that may have been compounded by the impact of COVID-19 such as isolation and accessibility of Fentanyl (a synthetic form of Opioid) as well as limited Substance Use Disorder (SUD) treatment resulting from program closures due to quarantine status. For more detailed information, please refer to the Substance Use Disorder Services Strategic Prevention Plan 2018- 2023[28]. The California Outcomes Measurement System Treatment (CalOMS Tx) data system captures each participant's initial admission into Substance Use Disorders (SUD) treatment and any subsequent transfers or changes in service. According to CalOMS data, AODS providers served an estimated 3,377 individuals in 2021.

Figure 7: Racial/ Ethnic Data and Level of Care for Individuals Served by AODS (January 1, 2021-December 31st, 2021)



It should be noted that the category of Asian/Pacific Islander includes Asian Indian, Chinese, Cambodian,

[27] https://skylab.cdph.ca.gov/ODdash/?tab=CTY
[28] https://cchealth.org/aod/pdf/Prevention-Strategic-Plan-2018-2023.pdf

Filipino, Guamanian, Japanese, Korean, Laotian, Native Hawaiian, Other Asian, Other Southeast Asian, Other Pacific Islander, Samoan and Vietnamese. LatinX/Hispanic includes Mexican American, Latin American, and Other Hispanic. Native American includes Alaskan Native and American Indian. The category of Other Race/ Ethnicity includes Mixed, Other, Unknown and Not Reported. The total individual served during the reporting period in Figure 7 was 3,377. Data for race/ethnicity with Level of Care for substance use is outlined in the following figure.

III. Strategies to Reduce Disparities

In examining the data captured above, specifically in County administered programs, it seems there are areas where penetration rates in Medi-Cal eligible services for specific ethnic/racial groups in comparison to other groups are lower, when considering the population percentages of those enrolled. Specifically, penetration rates for the LatinX and Asian communities seem to be disproportionately lower when taking into consideration the eligible percentage of enrollees in these racial/ethnic groups. There also seems to be the same trend in AODS with even greater margins of inequity.

Additionally, community input in various stakeholder meetings have voiced the need for more culturally appropriate services for the African American/ Black community. As previously stated, although penetration rates based on the External Quality Review Organization (EQRO) show African/American Black communities as being overrepresented, stakeholders have voiced a need for more culturally appropriate supports in preventative services.

Ongoing evaluation is warranted in CCBHS's commitment to equity and continuing conversations and assessments in pursuit of better service delivery; recognizing that there must always be work to dismantle systemic racism and discrimination, and review policy which may harm communities intended to be served. Penetration rates in both the EQRO report conducted for and show the Asian and Latino population continue to be underserved, when comparing the percentage of eligible beneficiaries or the population eligible for services. Linguistic needs continue to be voiced from stakeholders. Additionally, factors that likely play into low penetration rates for some communities may be due to fear in immigrants, refugees or families with mixed status due to the political climate that oust or make access to services difficult.

Additionally, communities continue to share concerns with various hate crimes that have been witnessed and experienced by BIPOC and the LGBTQI+ communities. For some communities there is a distrust in government systems. Although Contra Costa County staff and board of supervisors make public statements to voice that services are to be provided to communities regardless of race/ ethnicity, religion, sexual/ gender identity or documentation status; there is a strong challenge in communities feeling safe when accessing the services[29].

CCBHS should continue to partner with trusted CBOs that provide mental health and substance use services. An advantage of the MHSA as it currently stands, is that some CBOs providing PEI services are not required to provide Medi-Cal services, decreasing the need for collection of in-depth personal information. Additionally, CCBHS has now expanded its community crisis response program known as the Miles Hall Pilot Hub[30]. Community advocacy and ongoing discussions in Contra Costa County led to the development of the Anywhere, Anytime, Anyplace (A3) program; with a priority on 1) someone to talk to – a centralized call center (hub) to receive calls for help 2) someone to respond - 24/7 trained mobile crisis teams responding across the county, and 3) a place to go – locations to get care. This program was birthed

[29] https://cchealth.org/insurance/pdf/Public-Charge-Comment-12-7-18.pdf
[30] https://cchealth.org/bhs/crisis-response/

through collaboration with various Health Services divisions, County agencies, community stakeholders, elected officials, and law enforcement to better support community crisis response in connection with behavioral health needs.

As children of ages 0-5 had been previously identified as a target population, this group was further supported through MHSA-PEI funding to support families through a collaborative of 0-5 providers which partner with CCBHS. This came out of stakeholder involvement and community input provided through the Early Childhood Mental Health Community Forum. Specifically, a collaborative multi-agency effort was developed with funding being awarded to We Care Services for Children to support families and children from birth to six years old with wide range of early childhood education and mental health programs. This Cultural Humility Plan reflects the first year of reporting for this program.

In 2021, AODS launched its Nuevos Comienzos or New Beginnings program, in partnership with the Family Justice Center which aims to support Spanish speaking groups for people who may struggle with substance use. AODS has 2 FTE bilingual counselors running 2 groups of clients in Central and East County. Nuevos Comienzos served more than 34 clients with 6 clients successfully graduating from the program. In 2022, AODS plans to add a five-week session of (Substance Abuse and Mental Health Services Administration (S*AMHSA's) Peer Based Recovery Community Dialogues*: El Siguiente Paso as a step down from Nuevos Comienzos to support stabilization and maintenance. El Siguiente Paso will provide a safe venue where mental health needs are discussed in a community setting that embraces culture and traditions. Community resources to support Mental Health and Wellness are provided along with relapse prevention for both conditions.
Women and youth services clearly represent the most underserved populations in the AODS system. In an attempt to address the overall decline on the number of referrals of women into treatment, we engaged the consulting services of Network for the Improvement of Addiction Treatment (NIATx) to work directly with perinatal providers. NIATx assisted our perinatal providers with PDSA cycles to focus on engaging clients in treatment programs. Moreover, our perinatal team worked with the Labor and Delivery unit at Contra Costa Regional Medical Center (CCRMC) to minimize barriers for treatment admissions and help clients impacted by health inequities. Building visibility for Substance Use Disorder (SUD) has included revamping networking and attending case conferences, Perinatal Equity Initiative (PEI) Board meetings, SUD in pregnancy Workgroup meetings, Planned Parenthood and Black Infant Health collaboratives. In 2021, AODS was able to increase the number of women served in AODS by 23% as compared to 2020. As intended, the women services unit developed a Strategic Plan to formulate a road map to ensure women have equal access to services.

To expand Youth Treatment, AODS hired a bilingual (Spanish) Parent Navigator as a strategy to support parents who may call the Access Line, or teachers who may need assistance in using a complicated system. The Parent Navigator provides warm hand-off to youth and parents in need of SUD treatment and linkages to resources in need. We have increased efforts to work in an integrated manner with other systems such as Probation and Continuation/Regular Schools.

AODS will continue ongoing efforts to track and monitor treatment admission data for these populations. Focus areas for AODS will include:

- Initiate the update of the County's Prevention Strategic Plan to comprehensively address gaps and opportunities including a blueprint with goals, objectives and timelines for our prevention services.
- Offer meaningful opportunities for both youth and women to contribute with their input in the development of strategies intended to improve services for these populations, e.g. create an

advisory group, survey implementation, key informant interviews, etc.

Other efforts which provide cultural and linguistic services under AODS include the following:

a. Pueblos del Sol, Residential Services SUD Treatment: Operated by BiBett Corporation, is a 16-bed residential facility that serves monolingual Spanish speakers and bilingual clients whose primary language and preference is Spanish. This facility is in Concord, the Central Region of the county. To support effective transitions of care, in FY18-19 a pathway to outpatient services was created through Nuevos Comienzos and the number of Spanish speaking counselors was increased from 2 to 3FTEs.

b. The Latino Commission, Residential Services SUD Treatment: After years struggling with providing effective treatment support to pregnant and perinatal women in residential services, AODS contracted with the Latino Commission based in San Mateo County. Initially, existing providers were encouraged to hire bilingual staff, but the practice was not always effective at engaging the client work toward more inclusion and acceptance within schools and in the community. The contract supports the cultural and linguistic needs of women with SUD and their children.

c. Driving Under the Influence (DUI) Programs, SUD Intervention/Diversion: DUI diversion programs are offered in both English and Spanish in the East and Central part of Contra Costa. All Spanish speaking groups are well attended.

d. Center for Human Development (CHD) Project Success SUD Prevention: Project Success is a primary prevention program that focuses on education strategies. A component of Project Success, which is an Evidence Based SUD prevention program, aims at educating parents about the risks and protective factors for SUD. There are some geographic areas in the county comprised of prominently monolingual Spanish speaking parents, cultural and linguistical adaptations were made to Strengthening Youth and Families (SYF) in order to effectively serve parents. CHD has been a champion in supporting hiring practices that support the linguistic needs of the parents. Currently, SYF parent education classes are delivered in Spanish. As with all other AOD primary prevention programs, the classes are offered free to the community.

e. AODS launched its SUD Latino Workgroup and has invited Mental Health staff primarily focused on serving Latino beneficiaries due to low penetration rate. The SUD Latino Workgroup developed a Strategic Plan, which included hiring of additional bilingual staff/providers and continued outreach in the community. This included an interview in Richmond Confidential and a local radio station, posters in local grocery stores were placed at visible locations in East, Central and West County. The SUD Latino Workgroup has provided two cultural competence presentations to internal key units in the AOD system of care, so that staff understand the cultural challenges and barriers to access SU services. community to coordinate efforts to better support this community.

f. In June 2021, CCBHS requested funding to expand its successful existing Mobile Crisis Response Teams (MCRTs) to ensure that clients throughout the County receive appropriate, timely, and targeted care in the community; this is due the existing gaps in the county's crisis response system for Spanish speakers. The Latino MCRT was approved early in 2022. Recruitment efforts are underway to secure two teams of Spanish speaking SUD counselors and MH Clinicians.

g. In 2021, AODS received the Residential Substance Abuse Treatment (RSAT) grant from Board of Corrections to fund Crossroads Project with 2 FTE SUD counselors in West County Detention Facility to provide SUD treatment in the jail. Up to date, Crossroads has received more than 200 referrals and successfully linked 42 justice-involved clients into SUD treatment prior to release, this is less than a year. AODS keeps track of demographic data of all clients to ensure equity.

h. Efforts to Elicit Client Input: In June of 2022, AODS assisted the AOD Board with the release of a SUD Community Awareness Survey which is currently underway in English and Spanish about awareness of AODS services. The survey was developed by our AOD Board Chair, AODS staff has assisted with

preparation and dissemination. This is an electronic survey using a QR code and paper surveys are also available and distributed at local outreach fairs.

IV. Metrics for Reducing Disparities

The primary metric to identify change in disparities will be based on penetration rates through the annual EQRO, as well as in reviewing all the data presented within this report. Additionally, stakeholder feedback will serve to inform system analysis as well.

V. Accomplishments and Lessons Learned

Events throughout the Country and this County have been eye opening to some, though not unfamiliar to many marginalized communities. The best approaches and impact come from instances of learning and when County has directed services with community collaboration. If the last few years have served to educate at all, they have also clearly outlined some system shortfalls; specifically the need for services to be representative of community healing.

Criterion 4: Client/Family Member/Community Committee: Integration of the Committee Within the County Behavioral Health System

I. Cultural Humility Committee

A. Description of Cultural Humility Committee

There are several longstanding committees, meetings, advisory boards, and workgroups that support the integration of mental health and substance use services within CCBHS and work together to support equity, however the primary meeting group under CCBHS focused on increasing cultural humility, language access and equity is the Reducing Health Disparities Workgroup (RHD).

This meeting group provides input to the CCBHS Director and is chaired by the Ethnic Services and Training Coordinator, which is part of the MHSA team. Updates are also provided to the MHSA Program Manager and CCBHS leadership to discuss methods to support equity within CCBHS. Input from the RHD group also feeds into other stakeholder groups; such as the Quality Improvement/ Quality Assurance (QI/QA) Committee and is exploring better methods of strategizing efforts. Members of this group also identified the Focus Areas and advocated for increase of community defined practices which support mental health and wellness through MHSA Innovation funding, as well as Measure X. Measure X is a recently passed County tax which was created to generate revenue through ½ cent tax on Contra Costa residents for crucial social services. Mental health was identified as the number one priority in Measure X community planning. RHD Workgroup meetings are open to all.

B. Cultural Humility Committee and Integration with County Behavioral Health System

Other committees and meeting groups which provide input and dialogue with CCBHS leadership are identified below.

<u>The Mental Health Commission</u>

Contra Costa County also has the Mental Health Commission that is comprised of appointees from the five districts. Meetings are regularly attended by the CCBHS Director. The commission has a dual mission:

1. To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and
2. To be the advocate with the Board of Supervisors, the Mental Health Division, and the community on

behalf of all Contra Costa County residents who need mental health services.[31]

There are three appointed Mental Health Commission members for each of the five districts that represent:
1. A Consumer Representative- a person who is receiving or has received mental health services.
2. A Family Member- a person who has a family member who is receiving or has received mental health services.
3. A Member-at-Large- a person who has an interest in and knowledge of mental health issues.[32]

Other Committees, Workgroups, and Meetings

Other meetings, workgroups and committees that meet on an ongoing basis also provide avenues to communicate cultural or language needs:

- Mental Health Services Act (MHSA) Advisory Council formerly known as the Consolidated Planning Advisory Workgroup (CPAW). This meeting group is an advisory committee to the CCBHS Director with sub-committees of Steering, Systems of Care and Innovation, Suicide Prevention, and the Membership Committee.
- This meeting group has largely been connected to providing input on the MHSA, service delivery and system needs. The meeting is regularly attended by the CCBHS Director who also provides regular updates, dialogues with stakeholder.
- Individuals can also make Public Comments and suggest future agenda items
- Other meeting groups that are integrated into the system of care are Social Inclusion, Aging and Older Adults Committee, Health, Housing, and Homeless (H3) Services – Council on Homelessness Meeting, Behavioral Health Care Partnership, Alcohol and Other Drug Services (AODS) Advisory Board.

All meeting groups listed are open to the public. Ongoing effort by method of presentations, information sharing and recruitment for members that represent clients/peers/consumers, family members, Community Based Organizations (CBOs), and the workforce is made to have various voices present in shaping and integrating services and programs. These meetings also support the Community Program Planning Process (CPPP) within CCBHS as a method to identify, address, and inform CCBHS on service needs, and how to build more equitable, and culturally and linguistically appropriate services and serve to communicate input to CCBHS Leadership in evaluating service responsiveness and quality.

A challenge some committees face is having appointed members that participate on a consistent and continual basis from culturally and linguistically underrepresented communities. Further work to address this challenge must be incorporated through all committees and should involve conversation and strategic planning with leadership to identify methods that may lead to increased participation from historically marginalized communities. Additionally, Community Forums are regularly held by the MHSA to engage the community. These events are usually held in partnership with local and trusted CBOs or community agencies to further engage community. Forums allow for several methods to provide input such as small group discussions where input is collected by scribes, a public comment portion and electronic or written input forms are also made available. When forums are held in person, if an individual desired to provide input for the public comment period but did not want to speak in front of a large crowd, people could provide input on a card and a CCBHS staff member would read the comment. Materials were translated into the

[31] https://www.cchealth.org/about-contra-costa-health/leadership/commissions-advisory-groups/mental-health-commission
[32] https://www.cchealth.org/about-contra-costa-health/leadership/commissions-advisory-groups/mental-health-commission/membership

threshold language of Spanish, and an interpreter was onsite for those needing translation in Spanish. Other languages could also be supported through an interpreter with advance request. Prior to the pandemic, forums were in person and have since shifted to a virtual platform.

Criterion 5: Cultural Humility Training Activities

I. Cultural Humility Training

Regularly, CCBHS holds several ongoing and regular trainings throughout the year and requires that all staff, contracted providers, as well as partner community-based organizations complete Cultural Humility Training on an annual basis. Apart from live trainings, CCBHS offers various cultural humility trainings through the Relias Learning Management System, an online platform that provides virtual recorded trainings.

A. Cultural Humility Training Plan

The following table outlines various Cultural Humility trainings that took place during FY 2021-2022. It should be noted that trainings were significantly impacted since the pandemic, as CCBHS pivoted to pandemic response and eventually a large focus for required training through new State requirements.

Table 61. Training Offered through CCBHS for FY 2021-2022

Course Name	*Name of Presenter*	*Description of Training*	*Date of Training*	*Number of Hours*	*Attendees*
Building a Multicultural Care Environment and Other Culturally Responsive Courses Offered through Relias	Relias Learning Management System – Contra Costa Behavioral Health Services Online Platform	Training examines the factors that may contribute to underutilization of healthcare services, as well as ways to improve cultural understanding & competency in healthcare treatment. Covers significance of culture & demographics, as well as individual & cultural diversity factors. This training proposes some helpful conceptual frameworks for embracing cultural considerations in healthcare.	Training completed between the dates of 7/1/2021 through 6/30/2022	596hrs	549
Supervision in Stressful Times: Managing Staff Stress, Vicarious Traumatization, Time Management, Prioritizing Work Tasks, Boundaries w/Working from Home, Telehealth & Challenging Supervisees	Rachel B. Michaelsen, LCSW	Supervisors will learn how to: • identify and address stress and vicarious traumatization in their staff; • address time management and work prioritizing balanced with challenges of working from home; • understand and monitor ethical concerns of telehealth; • intervene with supervisees who may present challenges	8/12/2021	6hrs	45
The Practice of Cultural Humility: Acknowledging Ourselves while Working with	Matthew Mock, PhD	• List imperatives for understanding background of immigrants & refugees' sources of stress • List sources of strength and resilience that can contribute to mental health, wellness, and adjustment	10/20/2021	3hrs	15

Immigrants and Refugees		• Apply specific processes for the effective evaluation of immigrants, refugees & mixed status families • List principles of forming effective working relationships w/immigrant, refugee & other migrant communities			
Cognitive Behavioral Social Skills Training (CBSST)	Granholm Consulting – Eric Granholm, PhD	Building upon two strong and previously validated evidence-based practices, Cognitive Behavioral Social Skills Training (CBSST) combines cognitive behavioral therapy (CBT) and Social Skills Training (SST) to target functional disability in schizophrenia. It is a flexible intervention that teaches cognitive, social, and problem-solving skills to help clients/ consumers achieve their living, learning, socializing & working goals. CBSST targets various multi-dimensional deficits that lead to functional disability in people with Severe Mental Illness (SMI).	10/26/2021 & 10/27/2021	6.5hrs per day	79
Creating Trans-Affirming Behavioral Health Services	Willy Wilkinson, MPH	This training explores breadth of identities associated /trans & gender nonconforming communities, and how to utilize culturally competent language and behavior for working with this population. Participants will; • Increase knowledge of social determinants of health, mental health stressors, substance abuse risk and protective factors for health care access • Receive overview of legal & policy issues that impact trans communities, with emphasis on trans communities of color. • Explore trans-affirming practices & systems for effective service provision w/interactive, solutions-oriented, engagement. • Have opportunities for learning & problem solving at all knowledge levels	11/17/2021	3hrs	19
Youth Mental Health First Aid (MHFA)	Cypress Resilience Project - Brooke Briggance & Jasmine Nakagawa-Wong	Youth Mental Health First Aid (YMHFA) teaches adults how to help & support adolescents (ages 12 to 18) experiencing a mental health or substance use challenge.	2/23/2022, 2/24/2022 & 6/16/2022	8hrs	54
Assessing, Addressing and Preventing Suicide	Rachel B. Michaelsen, LCSW	The Centers for Disease Control and Prevention data shows a steady increase in suicide mortality between 1999 and 2018 with a 1% increase per year from 1999 to 2006 and 2% per year from 2006 through 2018. A recent study showed the percentage of young adults, ages 18 to 24 who have increased their likelihood of seriously considering suicide went up from 10.7% to 25.5% since the pandemic began. Learn how to identify signs of	2/25/2022 & 4/8/2022	6hrs	154

		suicide risk, assess for suicide risk, intervene when there is suicide risk and prevent suicide in children, teens, and adults. In this class participant will have the opportunity to practice performing a suicide assessment and intervening with a suicidal client through role play and case vignettes. They will also have the opportunity to review their case load for sign and symptoms of suicide risk and will discuss intervention and prevention strategies for their cases.			
Culturally Responsive Services through Culturally and Linguistically Appropriate Services (CLAS) Standards: Optimizing Practices of Cultural Effectiveness	Matthew Mock, PhD	This training is crucial for ensuring effective delivery of culturally and linguistically responsive, and competent services. This training furthers ongoing commitment through its cultural competence plan adhering to the National Standards for Culturally and Linguistically Appropriate Standards (CLAS) services. Behavioral health care staff and others continue to serve clients increasingly diverse by culture, class, gender, sexual orientation, immigration standing, different abilities and more. This foundation training provides conceptual and experiential learning furthering understanding of cultural humility through CLAS services.	3/23/2022	6hrs	120
The Assessment of Violence Risk Using the Historical Clinical and Risk Management (HCR-20 Version 3)	Nicole Paglione, PsyD	his training is designed to enhance forensic mental health professionals' ability to identify risk factors of violent behavior, specifically utilizing the HCR-20 Version 3, in order to not only assess for violence risk, but also to aid in treatment planning and supervision through the practice of relevance rating and scenario planning. This training will educate Contra Costa Forensic Mental Health staff on the development of the HCR-20 as a well-respected and highly researched risk assessment tool, the research that guides the use of said tool, and the practical application of said tool on cases indicative of escalating risk.	3/31/2022 & 4/7/2022	3hrs per day	23
Adult Mental Health First Aid (MHFA)	Cypress Resilience Project - Karen Lane & Jasmine Nakagawa-Wong	Mental Health First Aid (MHFA) teaches you how to identify, understand, and respond to signs of mental health and substance use challenges. Topics will include: • Common signs & symptoms of mental illness • Common signs & symptoms of substance use disorders • How to interact with a person in crisis • How to connect the person with help • The "ALGEE" action plan	4/22/2022 & 5/26/2022	8hrs per day	52
Strength and Resilience of Asian	Matthew Mock, PhD	Cultural competency, responsiveness & humility are imperatives in service practices working w/Asian American communities. This means understanding	5/16/2022	6hrs	28

Americans Amid Diversity and Complexity		diversity & complexity of Asian Americans and Pacific Islanders (AAPI), understanding ourselves, and general understanding of world views of mental health. There will be sharing of social movements & relational practices, including those used by therapists. There must be critical social justice in times of racial attacks on AAPI, and impact on wellness of AAPI communities.			
Cognitive Behavioral Therapy (CBT) and Relapse Prevention (RP) Strategies	Integrated Substance Abuse Program (ISAP) - James Peck, PsyD	CBT for Substance Use Disorders (SUD) is an evidence-based SUD treatment which has demonstrated efficacy by itself, and as part of combination treatment strategies. Participants shall be provided detailed overview of CBT and RP strategies, available resources, & use strategies in clinical practice.	6/9/2022	3hrs	42
Crisis Prevention and Response (CPAR)	Sean Krack, Steve Diamond, APCC, Justine King, LMFT	The CPAR model was developed & created by small group of individuals with significant experience providing crisis support services to a variety of populations. Facilitators speak to utilization of CPAR techniques and concepts at all levels of staff; including but not limited to various de-escalation models and collaborative approaches including such as Handle with Care, Crisis Prevention Intervention (CPI), Pro-act, Nonviolent Crisis Resolution, Trauma-Informed Care, and Collaborative and Proactive Solutions. The CPAR model incorporates effective concepts from these models' w/adjustments to enhance approaches to prepare, prevent, respond, reflect in crisis situations, and create an environment of constant growth and learning for staff.	6/15/2022 & 6/16/2022	5hrs per day	14
Creating LGBTQ+ Affirming Behavioral Health Services	Willy Wilkinson, MPH	This training will explore breadth of identities associated w/LGBTQ+ populations, w/focus on non-binary, and gender-expansive communities. Will explore how to utilize culturally competent language & behavior for navigating interactions appropriately. Will also review methods to apologize when mistakes are made. Participants will; • increase knowledge of mental health stressors, substance use disorder risk, protective factors, social determinants of health, health care access, educational settings, and legal and policy issues that impact LGBTQ+ communities. Participants will practice strategies to scenarios they might encounter through interactive, multimodal, solutions-oriented, and engaging training.	6/30/2022	3hrs	59

II. Incorporation of Client Culture Training

Table 62. Training for the Incorporation of the Client Culture through CCBHS for FY 2021-2022

Course Name	*Name of*	*Description*	*Date of*	*Number*	*Attendees*

	Presenter(s)		*Training*	*of Hours*	
PhotoVoice Empowerment Project, Wellness Recovery, Education for Acceptance, Choice and Hope (WREACH), and Wellness Recovery Action Plan (WRAP), Social Inclusion Committee, and SPIRIT	CCBHS Office for Consumer Empowerment SPIRIT Peer Providers and Contra Costa College Professor, Aminta Mickles, Chair of Health and Human Services	The Office for Consumer Empowerment (OCE) provides client culture training & educational opportunities to include personal lived experience of clients, presentations to CCBHS, CBO partners, & other agency partners representing the peer perspective. • The PhotoVoice Empowerment Project enables consumers to produce art that speaks to prejudice & discrimination people with behavioral health challenges face. Photovoice's vision is to enable people to record & reflect their community's strengths & concerns, promote critical dialogue about personal & community issues, & to reach policymakers to effect change. • The Wellness & Recovery Education for Acceptance, Choice & Hope (WREACH) Speakers' Bureau forms connections between the community & people with lived experience & co-occurring experiences, using personal stories of recovery & resiliency & current information on health treatment & supports. Other activities include producing videos, public service announcements & educational materials. • Wellness Recovery Action Plan (WRAP) groups are facilitated by peer certified leaders. Staff employ evidence-based WRAP system enhancing efforts of consumers to promote & advocate for their own wellness. •The Committee for Social Inclusion is an ongoing alliance of members that work together to promote social inclusion of persons receiving behavioral health services. The committee is project based, & projects are designed to increase participation of consumers & family members in planning, implementation, & delivery of services. • Staff provide outreach & support peers & family members to enable them to actively participate in various committee, & behavioral health integration planning efforts. Staff provide mentoring & instruction to consumers who wish to learn how to participate in community planning processes or to give public comments to advisory bodies. • (SPIRIT) is a recovery-oriented peer led class & experientially based college accredited program that prepares individuals to become providers of service. Certification from this program is a requirement for many Community Support Worker positions in CCBHS. Staff provide instruction, administrative & ongoing support to graduates.	Through-out the Year	Varies	It estimated that about 1,329 encounters were provided. It should be noted that some individuals may be duplicate participants throughout various sessions.
National Alliance	NAMI CC	• Family to Family (Mandarin/Cantonese) and De	Through-	Varies	It

on Mental Illness, Contra Costa (NAMI CC)- Family to Family (Spanish, Mandarin, Cantonese), FaithNet, NAMI Basics, and Conversations with Local Law Enforcement	Staff and Volunteers	Familia a Familia (Spanish) help address the unique needs of the specified population, helping to serve Spanish, Mandarin & Cantonese speaking communities to help families develop coping skills to address challenges posed by mental health issues in the family, & develop skills to support the recovery of loved ones. • NAMI Basics provides instruction related to mental health concepts, wellness & recovery principles, symptoms of mental health issues; as well as education on how mental illness & medications may affect loved ones. • FaithNet implements a mental health spirituality curriculum targeting faith leaders & the faith-based communities, who have congregants or loved ones with severe & persistent mental illness. The goals are to implement training to equip faith leaders to have a better understanding of mental health issues; & their roles as first responders at times & replace misinformation about mental health diagnoses, treatment, medication, etc. with accurate information. • Conversations with Local Law Enforcement supports dialogue between local law enforcement & consumers/ families through CCBHS's Crisis Intervention Training (CIT) within the County to enhance learning & dialogue between all groups in response to community concerns & mental health supports. The desired goal is to enhance information sharing & relationships between law enforcement & those affected by mental health. All these trainings are meant to create partnerships with agencies and community to gain general understanding of mental health and learn about family support efforts, ensure connectivity with families of consumers, stay abreast & be adaptive to current & future needs. Training is augmented by utilizing faith centers, CBOs, & community locations to enable access to diverse communities & reach the broadest audiences.	out the Year		estimated that about 1,163 encounters were provided. It should be noted that some individuals may be duplicate participants throughout various sessions.
Crisis Response Team Training (CRTT)	Recovery Innovation (RI) International	The RI created was created by peer support advocate, Lisa St. George, and is based on best practices toolkit provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) as National Guidelines for Behavioral Health Crisis Care, Best Practices Toolkit. Subject matter experts from various behavioral health backgrounds including peers w/lived experience, social service professionals, and medical experts in recovery field aided in curriculum development.	5/18/2022, 5/20/2022, & 5/23/2022	5hrs per day	12

CCBHS Staff may provide input through their supervisors. Managers and supervisors are also able to provide input through the Training Advisory Workgroup (TAW). Additionally, managers and supervisors are able to voice their training needs to executive leadership which also communicate needs to the Training & Ethnic Services Coordinator. CCBHS CBOs and stakeholders may provide input for training via the various stakeholder meeting groups. In 2020, the CCBHS Workforce Survey collected responses from almost 300 County and contracted provider staff to gauge for training interests and needs. The following top five training were identified by County staff as being the most helpful in assisting in staff's work at CCBHS:

1. Trauma-informed care
2. Cultural humility/ cultural responsiveness
3. Implicit Bias
4. Ethics
5. Assessing/ treating suicide risk/ harm

County staff also identified the following top five general trainings they would like to see offered in the future:

1. Self-care/ self-compassion
2. Training to work with people who may have a dual diagnosis (mental health & substance use challenges)
3. Communication with co-workers in a remote setting/ or physically distant setting
4. Training to work with people who may be criminal justice involved
5. Training to work with people who may have borderline personality disorder

The following trainings were identified as the top five training needs in relation to cultural humility/ responsiveness that County staff would like to see offered in the future:

1. Training in relation to Racial Trauma
2. Training in relation to working with the African American/Black Community
3. Training in relation to working with LGBTQ+ Community
4. Training in relation to working with the LatinX/ Hispanic Community
5. Training in relation with working with undocumented people

Contracted community partners were also surveyed and identified the following top five general trainings they would like to see offered in the future:

1. Training in relation to working to work with people who may have anxiety or depression
2. Training to work with people who may have a dual diagnosis (mental health & substance use challenges)
3. Training to work with people who may be criminal justice involved
4. Training in relation to Self-care/ Self-Compassion
5. Training to work with people who may have borderline personality disorder

The following trainings were identified as the top five training needs in relation to cultural humility/ responsiveness by contracted community partners:

1. Training in relation to Racial Trauma
2. Training in relation to working with the African American/Black Community
3. Training in relation to working with the LatinX/ Hispanic Community
4. Training in relation to working with immigrants
5. Training in relation to Sexual Orientation/ Gender Identity (SOGI)

As part of CCBHS commitment to equity and to better facilitate workforce development and systems change, CCBHS plan to utilize the input received from the workforce survey to focus on offering training in relation to the indicated topics.

Criterion 6: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Responsive Staff

I. Recruitment, Hiring and Retention of a Multicultural Workforce

The CCBHS County workforce is culturally diverse. List certified bilingual staff and share challenge in accessing this data.

Alcohol and Other Drug Services (AODS) Primary Prevention and Treatment Workforce Strategies

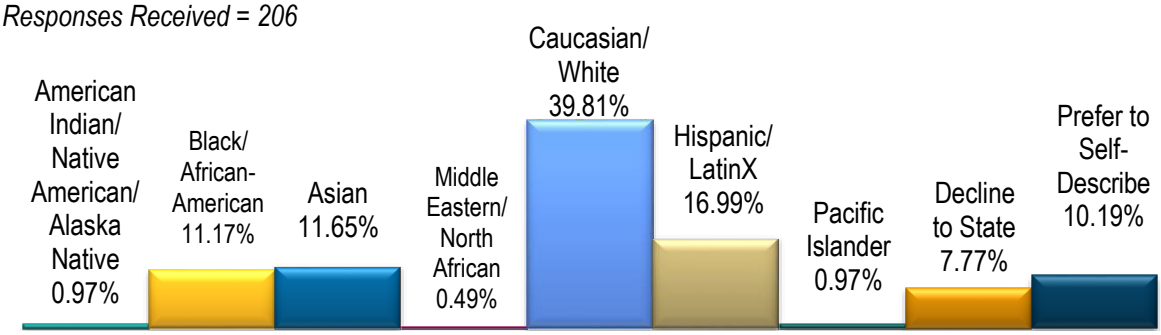
The AODS office under CCBHS continues to implement the following workforce strategies to provide primary prevention and treatment for underserved populations.

Table 63. AODS Workforce Development Strategies

Workforce Staff Support
1. Identified supervisors attend the local community Colleges Advisory Board (Diablo Valley College and Contra Costa College). Most SUD programs including County-run services are hosting Addiction Studies Interns. 2. Maintain and support implementation of Latino Outreach efforts in the community to develop a volunteer network of Latino families to provide support and navigation for family members struggling with SUD. 3. Continue efforts to increase, recruit and hire substance abuse counselors who represent the cultural diversity of Contra Costa with emphasis on hiring bilingual staff. 4. Insert language in contracts with SUD subcontracted providers that requires Culturally and Linguistically Appropriate Services (CLAS) standard implementation and encourage hiring practices of direct service staff who represent Contra Costa's diversity. 5. Ensure promotional material prepared by AODS is regularly translated into threshold language, including all clinical forms signed by clients or prevention participants.
Training and Technical Assistance
6. Continue to offer training opportunities for both county and community-based organizations staff in AODS to enhance CLAS standards and cultural competency. 7. Provide and increase training for both county and community-based organizations staff regarding LGBTQ+ communities.

In the fall of 2020, CCBHS conducted a voluntary workforce survey. The following is a summary of responses received from County staff. A total of 219 County staff that participated in the voluntary anonymous survey, and all individuals had the option to skip questions, or decline to respond. The data collected from the survey illustrated that about 67% of the staff that participated in the survey provide some form of direct service to peers/clients/consumers, about 78% lived in Contra Costa County, and about 50% had at some point in their life either received services or had a close family member receive services through CCBHS or another public mental health system. Additionally, about 50% of the survey participants had a master's degree. About 29% or 60 individuals self-identified as being fluent in another language, but of that number 61% or 37 individuals did not use their other spoken language in their line of work. Of the reasons given for not using their language; 13 stated the other language they spoke was not needed in their line of work, 4 stated they were not in a role where their other language was needed, 3 stated they did not feel comfortable using their other language in their line of work, and 10 declined to respond. The following figure shows race/ethnic data for those that responded to this survey question.

Figure 8. 2020 CCBHS Workforce Survey Race/ Ethnicity of Respondents Self-Reported Ethnicity/ Race of County Workforce Survey Participants Total
Responses Received = 206



Individuals that preferred to self-describe identified as: Human Race, Mexican, European & South American, White & LatinX, Caucasian & Pacific Islander, Hungarian & Japanese, Mix raced assumed white, Asian & Caucasian, Spanish/ Native American/ Irish, Mixed Race, Black/ White/ Hawaiian, Middle Eastern/ Pacific Islander, Bi-Racial, Black & White, and one individual identified as none.

Following tables display the positions of staff that participated in the survey, race/ ethnicity, age, sexual orientation, gender identity and the average length of time worked in CCBHS or any other public mental health system for the CCBHS County staff which participated in the survey. It is important to note that not all individuals responded to all questions.

Table 64. 2020 CCBHS Workforce Survey Participant Responses- County Staff Positions

Position	*Totals*
Executive Leadership	1
Clinical Supervisor	9
Clinical Manager	6
Mental Health Clinical Specialist- Licensed	57
Mental Health Clinical Specialist- Licensed Eligible	11
Administration- Clerical or Secretarial	32
Administration- Supervisor or Manager	16
Administration- Other	11
Community Support Workers- Peer Provider	14
Community Support Worker- Family Support Worker	4
Community Support Worker- Family Partner	3
Mental Health Specialist	11
Family Practitioner (Psychiatric Nurse Practitioner)	1
Psychiatrist	6
Substance Abuse Counselor	13
Registered Nurse	7
Patient Financial Services Specialist	2
MH Employment Placement Specialist	2
MH Rehabilitation Counselor	2
Intern	1
Number of Individuals that Answered Question	*213*
Number of Individuals that Skipped Question	*6*

Table 65. 2020 CCBHS Workforce Survey Participant Responses- County Staff Age Range

Age	*Totals*
18-25 years	0
26-35 years	24
36-45 years	64
46-55 years	55
56-65 years	36
66+ years	12
Decline to State	8
Number of Individuals that Answered Question	*204*
Number of Individuals that Skipped Question	*15*

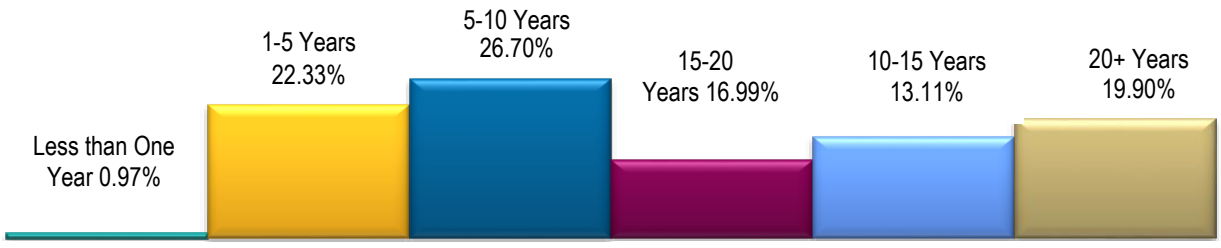
Table 66. 2020 CCBHS Workforce Survey Participant Responses- County Staff Gender Identity

Gender Identity	*Totals*
Female	151
Male	43
Transgender	0
Genderqueer	1
Questioning	0
Decline to State	9
Prefer to self-describe: Her/She	1
Number of Individuals that Answered Question	*203*
Number of Individuals that Skipped Question	*16*

Table 67. 2020 CCBHS Workforce Survey Participant Responses- County Staff Sexual Orientation

Sexual Orientation	*Totals*
Bisexual	5
Gay	5
Heterosexual or straight	167
Lesbian	2
Queer	2
Questioning	0
Decline to State	21
Prefer to self-describe multi-sexual, queer/ bi-sexual	2
Number of Individuals that Answered Question	*205*
Number of Individuals that Skipped Question	*14*

Figure 9. Average Length of Time Working in Public Mental Health System
Total Responses Received = 206



Contracted Community Partners Workforce Data

Contracted providers were also asked to participate in a workforce survey. 77 responses were collected from the voluntary survey. The data collected illustrated that about 55% of the staff that participated in the survey provide some form of direct service to peers/clients/consumers, about 51% lived in Contra Costa County, and only about 39% stated they had at some point in their life either received services or had a close family member receive services through CCBHS or another public mental health system. Additionally, about 52% of the survey participants had a master's degree. About 21% self-identified as being fluent in another language, but of that number only about 10% use their other spoken language in their line of work.

Table 68. CCBHS County Contracted Partner Providers Racial/Ethnic Estimates 2020

Racial/Ethnic Data Estimates	*Staff Employed*
Hispanic/ LatinX	13%
Caucasian/ White	45.5%
Black/ African American	18%
Asian	13%
American Indian/ Alaska Native	1%
Pacific Islander	3%
Middle Eastern/ North African	0%
Decline to State	0%
Prefer to Self-Describe	6.5%

The following tables display information in relation to contracted community provider staff that participated in the survey, and answered questions about race/ ethnicity, age, sexual orientation, gender identity and the average length of time worked in behavioral health or any other public mental health system.

Table 69. 2020 CCBHS County Contracted Partner Providers Workforce Survey - Age Range

Age	*Totals*
18-25 years	1
26-35 years	20
36-45 years	28
46-55 years	14
56-65 years	9
66+ years	4
Decline to State	1
Number of Individuals that Answered Question	*77*

Table 70. 2020 CCBHS County Contracted Partner Providers Workforce Survey - Gender Identity

Gender Identity	*Totals*
Female	60
Male	17
Transgender	0
Genderqueer	0
Questioning	0
Decline to State	0
Prefer to self-describe:	0
Number of Individuals that Answered Question	*77*

Table 71. 2020 CCBHS County Contracted Partner Providers Workforce Survey- Sexual Orientation

Sexual Orientation	*Totals*
Bisexual	5
Gay	6
Heterosexual or straight	59
Lesbian	1
Queer	1
Questioning	0
Decline to State	3
Prefer to self-describe heteroflexible	1
Number of Individuals that Answered Question	*76*
Number of Individuals that Skipped Question	*1*

Table 72. Average Length of Time Contracted Partner Working in Public Mental Health System
Total Responses Received = 76

Length of Time	*Totals*
Less than One Year	0%
1to 5 Years	20.78%
5 to 10 Years	22.08%
10 to 15 Years	19.48%
15-20 Years	10.39%
20+ Years	25.97%

CCBHS will continue to survey its workforce and monitor the number of staff members which receive differential pay for language access.

Criterion 7: Language Capacity

I. Increase Bilingual Workforce

Examples of language access has been identified throughout the Cultural Humility Plan. Efforts that address language access are consideration in staff recruitment for identified language capacity, as well as the loan repayment program offered through CCBHS in partnership with HCAI and California Mental Health Services Authority (CalMHSA). Information and signage are provided in threshold and other languages CCBHS sites where clients are served.

Additionally, the acting Ethnic Services Manger meets with the Linguistic Access Services Program Manager to stay in tune with policies in relation to language access as administered by the State and communicates any challenges encountered by staff when using interpretation services. In FY 2021-22, it is estimated that 90 CCBHS staff received language differential pay, and 39 positions were flagged for bilingual for language needs in Spanish, Chinese (Mandarin and Cantonese), Vietnamese, and American Sign Language.

II. Provide Services to People with Limited English Proficiency (LEP)

Some examples of services for Limited English Proficiency are the CCBHS Access Line, which apart from being a way people can access services, also serves to provide linguistic access. For example, if someone calls the Access Line at 1-888-678-7277 and needs services in other languages, there are recordings in English, Spanish, Vietnamese, Farsi, Tagalog, Cantonese, Russian, and Khmu where people will be instructed to press a number to be connected with someone who can support them in these languages. Other services are supported through the HCIN.

III. Provide Bilingual Staff/Interpreters at All Points of Contact for Threshold Language Clients

There are also postings in all clinics where individuals receive services with information on how to access services through an interpreter which is offered through a video phone service. Between FY 2021- 2022, 4,040 interpretation encounters were facilitated by use of Language Line Solutions (LLS) and another 1,504 calls were facilitated through the Health Care Interpreter Network (HCIN).

IV. Provide Bilingual Staff/Interpreters at All Points of Contact for Clients Not Meeting Threshold Language Criteria

An interpreter is made available to clients who many not fall under a threshold language in the same mananer as other clients, either through a video phone or audio phone. Between FY 2021- 2022 the following languages were the most utilized for calls that were supported either through Linguistic Access Services, HCIN, or LLS. The languages listed are in order of the highest utilized to least utilized for behavioral health services.

1. Spanish
2. Punjabi
3. Farsi
4. Portuguese
5. Vietnamese
6. Dari
7. Arabic
8. Mandarin
9. Tagalog
10. Cantonese

V. Required Translated Documents, Forms, Signage and Client Informing Materials

As previously stated, there are also postings in all clinics where individuals receive services with information on how to access services through an interpreter which is offered through a video phone service. Informing materials can be translated upon request, if not available.

Criterion 8: Adaptation of Services

I. Client Driven/Operated Recovery and Wellness Programs

The Office of Consumer Empowerment (OCE) is comprised of primarily Community Support Workers (CSWs) and a manager. The office is a County operated program that supports CCBHS and offers a range of trainings and supports by and for individuals who have experience receiving mental health services. The staffing has various lived experience and reflect a culturally diverse workforce. The goals of OCE are to increase access to wellness and empowerment for peers/clients/consumers of CCBHS. Detailed information for OCE programs was provided under Criterion 5 of this plan. Additionally, all the PEI programs incorporate some form of culturally and linguistically responsive peer driven/ peer led model. Specific example of peer model programs provided during FY 2021-2022 include the services provided by Putnam Clubhouse under the MHSA components of PEI and CSS.

Putnam Clubhouse provides a safe, welcoming place, where participants (called members), recovering from mental health challenges and illness, build on personal strengths. Members work as colleagues with peers and a small staff to maintain recovery and support prevention through work and work-mediated relationships. Members learn vocational and social skills while doing everything involved in running The Clubhouse and Peer Connection Centers.

Putnam Clubhouse's peer-based programming helps adults recovering from psychiatric disorders access support networks, social opportunities, wellness tools, employment, housing, and health services. The work-ordered day program helps members gain prevocational, social, and healthy living skills as well as access vocational options within Contra Costa. The Clubhouse teaches skills needed for navigating/ accessing the system of care, helps members set goals (including educational, vocational, and wellness), provides opportunities to become involved in stigma reduction and advocacy. Ongoing community outreach is provided throughout the County via presentations and by distributing materials, including a brochure in both English and Spanish. The Young Adult Initiative provides weekly activities and programming planned by younger adult members to attract and retain younger adult members in the under-30 age group. Putnam Clubhouse helps increase family wellness and reduces stress related to caregiving by providing respite through Clubhouse programming and by helping Clubhouse members improve their independence.

Putnam Clubhouse assists the Office for Consumer Empowerment (OCE) by providing career support through hosting Career Corner, an online career resource for mental health consumers in Contra Costa County and holding countywide career workshops. Putnam Clubhouses assists CCBHS in several other projects, including organizing community events and by assisting with administering consumer perception surveys. Putnam Peer Connection Centers also provide peer related services.

During FY 21-22, Putnam Clubhouse established a new contract with CCBHS, expanding as Putnam Peer Connections Centers were provided which served individuals or members experiencing mental and/or behavioral health challenges in west, central and east Contra Costa County. Connection Centers provided a variety of wellness and recovery-related classes and groups which were primarily offered virtually, as well as one-on-connection calls during the pandemic, vocational support and links to community resources. Due to the pandemic, most recreational opportunities were placed on hold during this period. The classes, groups and coaching are recovery-oriented and facilitated by peer providers. Peer providers worked with members towards individualized goals. The Wellness Recovery Action Plan (WRAP) which was part of usual services were also put on hold due to the pandemic, however wherever possible, WRAP skills were practiced; which included establishing virtual and over the phone self-help and coping skills, support networks and a commitment to overall wellness. Members seeking services also helped shape the newly implemented programs through feedback and listening sessions. Peer providers facilitated groups by engaging members to share their own success in recovery through obtaining education, coping skills, self-management and/or sobriety; continually using their lived experience as a strength-based path to recovery.

It should be noted that RI ended services with CCBHS on June 30, 2021, and Putnam Clubhouse took on contracted services that were previously offered by RI International effective July 1, 2021. Putnam Clubhouse was instrumental in providing services to individuals transitioning over from the previous provider. Programming has continued to grow and expand as services have eventually transitioned into a hybrid model offering both in-person and virtual programming.

II. Responsiveness of Behavioral Health Services

Information for accessing services is provided in several ways. This information is found on the CCBHS Homepage, as well as the Behavioral Health Access Line site.

III. Quality Assurance

Quality Improvement and Quality Assurance (QI/QA) works with both the mental health and substance use services to monitor effectiveness, oversight and review of clinics, organizations, and services to clients/consumers. At the moment, CCBHS is exploring better methods the QI/QA team may better

coordinate efforts and shared challenges to further support cultural responsiveness and better access to clients. The Quality Management team performs program development and coordination work to implement, assess and maintain programming that effectively measures and strives to improves the access to, and quality of care and services provided to the County's behavioral health peers/clients/consumers.

Beneficiary Rights

To provide feedback about any experience or resolve an issue, people can receive assistance at one of the CCBHS clinics, find information with the contracted CBO, or may call the Quality Improvement Line or Email CCBHSQualityAssurance@cchealth.org. Assistance is also offered by contacting a Patient Rights Advocate at 925-293-4942 or 844-666-0472. This information is also posted online at Quality Improvement and Quality Assurance (QI/QA) under *Beneficiary Rights*. To file a written complaint/grievance, the information can be found online at Problem Resolution Process under *File A Grievance.*

This document outlines and meets the requirements described in the California Department of Mental Health Cultural Competence Plan Requirements CCPR Modification[33]. Although the California Department of Mental Health no longer exists, CCBHS looks forward to new guidance for the Behavioral Health Equity Plan that is slated to be released by the California Department of Health Care Services (DHCS). Further information on DHCS efforts to reduce behavioral health disparities may be accessed at the DHCS Efforts to Reduce Disparities in Behavioral Health page.

[33] https://www.dhcs.ca.gov/services/MH/Documents/IN10-17_Enclosure1.pdf

File #: 24-2134 **Agenda Date:** 7/18/2024 **Agenda #:** VII.

Advisory Board: Mental Health Commission Quality of Care Committee
Subject: EQRO 2023/24 Report Review and Questions
Presenter: Cmsr. Barbara Serwin

ATTACHMENT B: EQRO 2023-24 report

ATTACHMENT C: Quality of Care questions for 2022-2023 EQRO report

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FY 2023-24
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

CONTRA COSTA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 17-19, 2024

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EXECUTIVE SUMMARY

Highlights from the fiscal year (FY) 2023-24 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Contra Costa" may be used to identify the Contra Costa County MHP.

MHP INFORMATION

Review Type — Virtual

Date of Review — January 17-19, 2024

MHP Size — Large

MHP Region — Bay Area

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	2	3	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	4	2	0
Quality of Care	10	6	4	0
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**19**	**7**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	Clinical	09/2022	Implementation	Moderate
Gain-framed Provider Reminder Calls to Reduce No Shows to Initial Assessment Appointments	Non-Clinical	11/2021	Second Remeasurement	High

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	8
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	9

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Contra Costa appears to be a quality driven organization that is forward thinking and places emphasis on utilizing quality improvement (QI) processes as evidenced by their QI projects.
- The MHP has peer support staff embedded in programs across the system of care, providing an abundance of opportunity for consumers with lived experience.
- Contra Costa's innovative A3 (Anyone, Anywhere, Anytime) crisis program continues to evolve and has made progress since the last EQR. The MHP plans to further expand the program.
- Contra Costa's supervisors and managers expressed dedication to members and assist when needed. For example, supervisors will complete a client assessment when members with urgent issues come in and a clinician is not available.
- Contra Costa has been able to expand Epic to perform billing through payment reform and the MHP is able to bill for services.

The MHP was found to have notable opportunities for improvement in the following areas:

- The MHP continues to have staffing shortages with a 30 percent vacancy rate. Although it has tested work at home for some staff, it appears that more initiatives are needed to ensure adequate staff to serve members' needs.
- Although the MHP has begun to coordinate with contracted providers to assess whether their medication monitoring practices align with the MHP, Contra Costa's California Senate Bill (SB) 1291 review process does not include contracted providers.
- There is a continued opportunity for the MHP to provide access for contracted providers to enter progress notes and claims data in the electronic health record (EHR) system as Epic can share information, but it is not bidirectional.
- The MHP does not have a defined career ladder for peer employment. The Mental Health Specialist minimum qualification position requires an associate degree. Peers may not be able to obtain education without assistance.
- There may be an opportunity for senior leadership to ensure that supervisors and managers are well-supported and receive responses to their requests.

Recommendations for improvement based upon this review include:

- Continue to implement recruitment and retention strategies identified from staff survey feedback, such as testing alternate work schedules, to stabilize staffing and improve recruitment results for both clinical and quality positions.

  (This recommendation is a carry-over from FY 2021-22 and FY 2022-23.)
- Continue to develop the SB 1291 review process that includes both directly operated and contracted providers.

  (This recommendation is a carry-over from FY 2022-23.)
- Expand use of batch files to submit service data claims or provide access for contracted providers to directly enter clinical data to eliminate double entry once the Epic ccLink billing implementation is complete.

  (This recommendation is a carry-over from FY 2021-22 and FY 2022-23.)
- Clearly define a career ladder for peer employment and provide peer support staff with information about county resources/supports to provide advancement opportunities for example, tuition reimbursement.
- Assess and ensure that MHP supervisors and managers receive sufficient communication and responses to questions.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs, comprised of 58 counties, to provide specialty mental health services (SMHS) to Medi-Cal members under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal MHP. DHCS contracts with Behavioral Health Concepts, Inc. (BHC), the CalEQRO to review and evaluate the care provided to the Medi-Cal members.

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per SB 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2023-24 findings of the EQR for Contra Costa County MHP by BHC, conducted as a virtual review on January 17-19, 2024.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to validate and analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, members, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws

upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

CalEQRO reviews are retrospective; therefore, county documentation that is requested for this review covers the time frame since the prior review. Additionally, the Medi-Cal approved claims data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and the Inpatient Consolidation (IPC) File. PMs calculated by CalEQRO cover services for approved claims for calendar year (CY) 2022 as adjudicated by DHCS by April 2023. Several measures display a three-year trend from CY 2020 to CY 2022.

As part of the pre-review process, each MHP is provided a description of the source of the Medi-Cal approved claims data and four summary reports of this data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; transition aged youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of QI and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – summary of the validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5, and also as outlined DHCS's Comprehensive Quality Strategy. Data definitions are included as Attachment E.
- Validation and analysis of each MHP's NA as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems

and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding penetration rate (PR) percentages.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

The MHP did not experience any significant environmental issues affecting its operations.

SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

- The MHP had key staffing changes. A Mental Health Program Chief position was filled for A3 crisis services; 21 Enhanced Care Management program staff were moved from the Public Health Division to the Behavioral Health Division, including two Mental Health Program Managers. Mental Health Program Supervisor positions for the following clinics/programs were filled: MH Diversion, Intensive Care Coordinators, Children's Wraparound, Conservatorship and Guardianship, Central County Children Clinic, and Central County Adult Clinic.

- The Deputy Director of Behavioral Health position was vacated in May 2023 and Contra Costa is conducting interviews to fill the position.

- Implementation of payment reform under the California Advancing and Innovating Medi Cal (CalAIM) plan required changes in billing codes to a Current Procedural Terminology (CPT) code-based billing system. The MHP stopped using ShareCare for mental health services rendered after July 1, 2023, and started using Epic (also known as ccLink locally) for claims.

- The MHP's A3 crisis program had changes since the last EQR that include:
    - Started using inContact phone system during all hours of operation to improve efficiency when answering calls.
    - Placed the crisis triage tool into ccLink and created a dashboard for A3 leadership to utilize.
    - Started building out a crisis assessment tool and safety planning tool.

- The MHP is piloting dispatch software and integrating it with ccLink; they received radios and iPads to improve crisis mobile team dispatch process.

- Contra Costa developed and implemented a comprehensive training strategy to ensure county and contracted providers, supervisors, and utilization review (UR) staff receive training on new policies and procedures adopted under CalAIM. The MHP established a CalAIM steering committee which created a workgroup specifically to coordinate and oversee training. A dedicated email box where staff can pose questions was also created. As part of Contra Costa's overall training implementation strategy, a website was created to serve as a repository for CalAIM materials, including a dedicated section containing training videos and handouts tailored to contract providers.
- As of January 2023, the MHP started implementing the universal screening and transition tools to facilitate access to care and coordinate transitions of care. The Access Line completes the screening tools for members who are not already connected to mental health services.
- In August 2023, Contra Costa opted to develop a peer certification program in accordance with standards developed by DHCS. The MHP has partnered with Contra Costa Community College since 2008 to create a nine-unit college course titled the Service Provider Individualized Recovery Intensive Training. Contra Costa Behavioral Health subsequently applied with California Mental Health Services Authority to become certified as a peer provider training vendor. The MHP was approved as a vendor.
- To optimize the use of licensed clinical staff at the Access Line, staff have initiated a small-scale pilot offering on demand assessments via telehealth for the three regional adult clinics. The goal is to offer an "in the moment" assessment to the client if they are available and interested. This will move clients from screening to assessment in one call, often with the same clinician. The process follows a brief assessment model, and the intention is to maximize the window of opportunity when the client is actively seeking help and services.
- The MHP is actively engaged in data exchange for care coordination. The MHP has successfully met all the Behavioral Health Quality Improvement Project (BHQIP) requirements to date pertaining to data exchange by allowing access to the current EHR.
- The MHP has an interoperability agreement with the managed care plan (MCP), and both are using the Epic EHR. This allows mental health member charts to be visible to the MCP and vice versa.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations not addressed may be presented as a recommendation again for this review. However, if the MHP has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 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.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has been offering alternative work schedules for some employees on a case-by-case basis (e.g., work from home one day per week). This benefit is not available to all employees, and staff who are able to use it cannot select the day to work from home.
- There were other areas identified in the survey, including better communication with staff. It appears that there is more work to be done on staff recruitment and retention strategies. Of Contra Costa's 702 MH positions (30 flagged Spanish), there are 208 vacant positions (two flagged Spanish). The approximate staff vacancy rate is 30 percent.
- This recommendation was partially met and will be carried over.

Recommendation 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.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP published a document guide most recently updated in July of 2023, in conjunction with feedback from contracted and county providers.
- Contra Costa internally published CPT/ Healthcare Common Procedure Coding System (HCPCS) codes and a quick reference guide with crosswalk for county and contracted providers, and an updated documentation training PowerPoint.
- The MHP published frequently asked questions incorporating questions from a dedicated CalAIM email box and the MHP's office hours.

Recommendation 3: Develop an SB 1291 review process that includes both directly operated and contract provider prescribing practices.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has an SB 1291 review process for county provider prescribing practices; however, Contra Costa does not monitor contracted providers.
- Contra Costa has made some progress in this area by providing a checklist to contracted providers to check whether their processes are in alignment with the MHP. A meeting was scheduled to meet with all contract agency prescribers in mid-January to review, discuss, and provide feedback on the checklist, and to start a dialogue on aligning medication monitoring protocols.
- This recommendation was partially addressed and will be carried over.

Recommendation 4: Expand use of batch files to submit service data claims or provide access for providers to directly enter clinical data to eliminate double data entry once the Epic ccLink billing implementation is complete.

(This recommendation was continued from FY 2021-22 and FY 2022-23.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Epic can share information, but it is not able to accept fully bidirectional communication. Not all contract providers have the Information Technology (IT) capability to expand EHR systems to support data exchange.
- MH contract providers can add diagnoses to the Problem List through ccLink and upload documents into the EHR, but they do not currently have the ability to document notes and treatment plans in the EHR. The MHP will be evaluating

future data exchange capabilities and the ability for contract providers to document directly in Epic in the future.

- This recommendation was partially met and will be carried over.

Recommendation 5: Investigate reasons for claim denials and develop a plan to reduce denials and recover lost revenue.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Contra Costa has made significant efforts to reduce errors caused by invalid National Provider Identifiers (NPIs) this past year and to remediate issues and rebill/replace claims where possible. Overall, their denied claims rate was lower than the statewide rate for CY 2022.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or members) are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which members live, equity, as well as accessibility—the ability to obtain medical care and services when needed.[1] The cornerstone of MHP services must be access, without which members are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and PMs addressed below.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 38.68 percent of services were delivered by county-operated/staffed clinics and sites, and 61.32 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 78.84 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24 hours, seven days per week that is operated by the county Access Line staff during standard business hours, and by Optum, a contract provider, after hours. Members may request services through the Access Line as well as through other system entry points by presenting directly to a regional clinic site or contracted provider. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. Calls are identified as routine or urgent by the Access Line and handled accordingly to meet timeliness requirements. Crisis calls are referred to psychiatric emergency services and/or mobile crisis teams for adults and children/youth.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23 the MHP reports having provided telehealth services to 1,387 adults, 2,723 youth, and 277 older adults, across 15 county operated sites and 87 contractor-operated sites. Among those served, 1,526 members received telehealth services in a language other than English.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information in Table 1A and Table 1B.

In December 2022, DHCS issued its FY 2022-23 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Contra Costa County, the time and distance requirements are 15 miles and 30 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 2022-23

Alternative Access Standards	
The MHP was required to submit an AAS request due to time or distance requirements	☐ Yes ☒ No

- The MHP met all time and distance standards and was not required to submit an AAS request.

Table 1B: MHP Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No

- Because the MHP can provide necessary services to a member within time and distance standards using a network provider, the MHP was not required to allow members to access services via OON providers.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to members and family members. Examining service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access, and availability of services form the foundation of access to quality services that ultimately lead to improved member outcomes.

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 QI.

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Member Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

Strengths and opportunities associated with the access components identified above include:

- Contra Costa has an integrated Access Line which serves the MHP, MCP, and Alcohol and Other Drugs Services. The Access Line provides screenings for treatment, referrals to prevention programs, and referrals for mild-to-moderate.
- The MHP has an innovative approach to provide crisis services with its A3 program. Contra Costa has expanded the program in the past year now offering services 24 hours a day, seven days a week, and going from 5 to 22 full time staff (FTE). The MHP plans to expand the program further and is preparing for an A3 Wellness Campus site to include Crisis Call Center, Care on Demand Clinic, and Peer Respite Center (construction to begin in 2024).
- Contra Costa is testing having Access Line staff provide a brief clinical assessment at the time of conducting the universal screening to eliminate the need for clients to attend a separate clinical assessment scheduled at the clinics.
- The MHP may need to further access whether it is providing adequate services in languages other than English. Wait times for services may be longer if members prefer to not use the language line and wait for a clinician who speaks their language. Contra Costa may need to consider additional efforts to recruit and retain bilingual staff.

ACCESS PERFORMANCE MEASURES

Members Served, Penetration Rates, and Average Approved Claims per Member Served

The following information provides details on Medi-Cal eligibles, and members served by age, race/ethnicity, and threshold language.

The PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, Contra Costa demonstrates better access to care than was seen statewide.

Table 3: Contra Costa MHP Annual Members Served and Total Approved Claims, CY 2020-22

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	320,350	15,776	4.92%	$118,556,069	$7,515
CY 2021	297,051	16,321	5.49%	$144,346,957	$8,844
CY 2020	269,842	15,453	5.73%	$136,953,042	$8,863

Note: Total annual eligibles in Tables 3 and 4 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The number of eligibles increased from the prior year, while the number of members served decreased from the previous year.
- The MHP overall PR decreased from the previous year (5.49 percent to 4.92 percent), as did total approved claims and AACM.

Table 4: Contra Costa County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	30,200	566	1.87%	1.50%	1.82%
Ages 6-17	70,246	4,295	6.11%	5.01%	5.65%
Ages 18-20	16,853	848	5.03%	3.66%	3.97%
Ages 21-64	168,581	9,044	5.36%	3.73%	4.03%
Ages 65+	34,473	1,023	2.97%	1.64%	1.86%
Total	**320,350**	**15,776**	**4.92%**	**3.60%**	**3.96%**

Note: Total annual eligibles in Tables 3 and 4 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The PRs for every age group exceed the corresponding similar-size county and statewide rates.

Table 5: Threshold Language of Contra Costa MHP Medi-Cal Members Served in CY 2022

Threshold Language	# Members Served	% of Members Served
Spanish	2,242	14.34%
Threshold language source: Open Data per BHIN 20-070		

- Spanish is the only threshold language, with 14.34 percent of members reporting Spanish as their primary language.

Table 6: Contra Costa MHP Medi-Cal Expansion (ACA) PR and AACM, CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	102,484	4,205	4.10%	$25,679,935	$6,107
Large	2,532,274	76,457	3.02%	$535,657,742	$7,006
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the Affordable Care Act (ACA), their overall PR and AACM tend to be lower than non-ACA members.
- Though lower than its overall AACM, Contra Costa has a higher ACA PR than other large counties and statewide.

The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total members served. Table 7 and Figures 1-9 compare the MHP's data with MHPs of similar size and the statewide average.

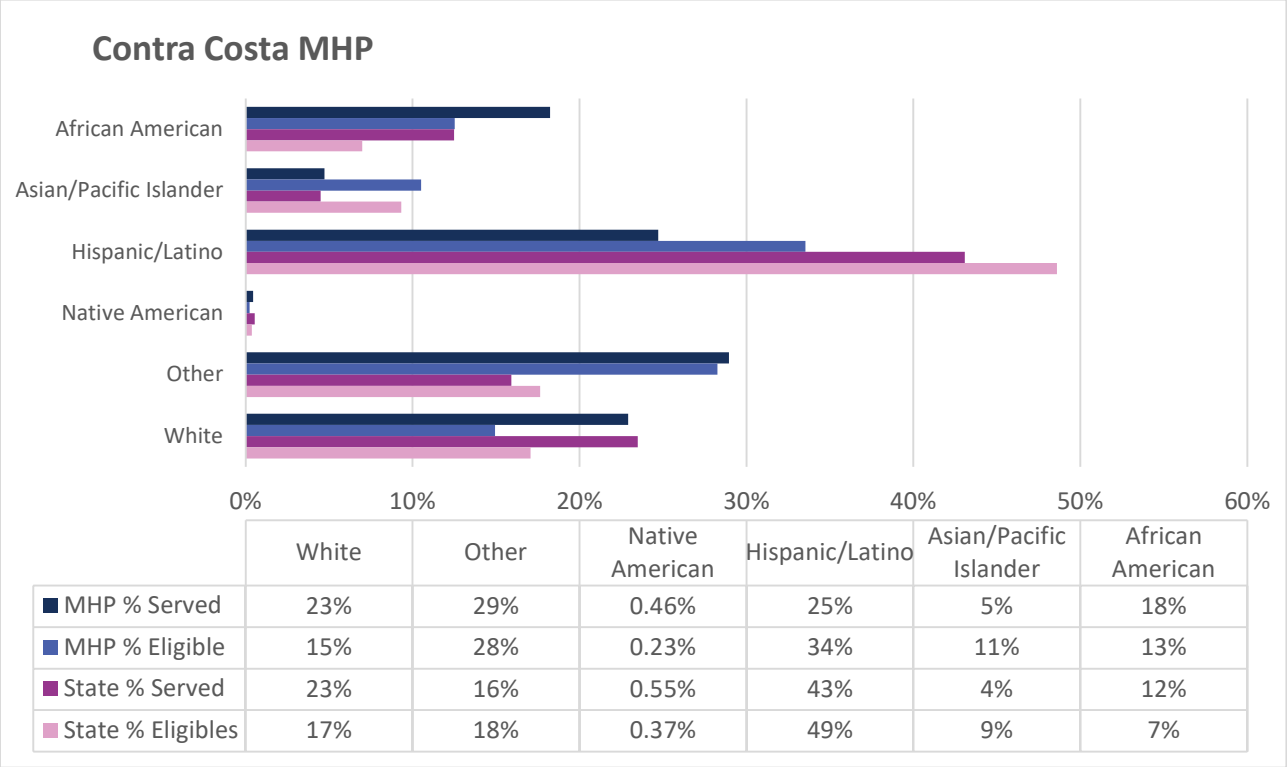
Table 7: Contra Costa MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	40,110	2,877	7.17%	7.08%
Asian/Pacific Islander	33,664	746	2.22%	1.91%

Hispanic/Latino	107,440	3,899	3.63%	3.51%
Native American	746	72	9.65%	5.94%
Other	90,532	4,568	5.05%	3.57%
White	47,861	3,614	7.55%	5.45%

- The MHP's PR is approximately 3 percent higher than the statewide rate for Hispanic/Latino members and is 39 percent higher than the statewide rate for White members. The PR for the Native American group is 62 percent higher than the statewide rate.
- Asian/Pacific Islander members had the lowest PR of any group served by the MHP, though higher than the statewide PR.

Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022



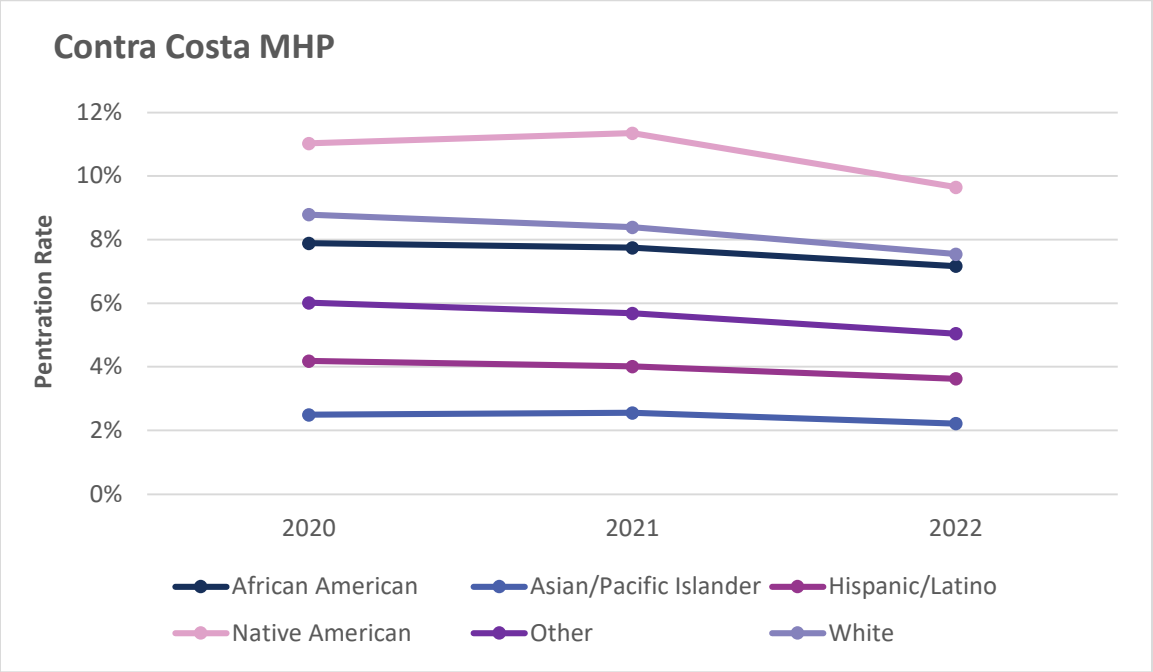
	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	23%	29%	0.46%	25%	5%	18%
MHP % Eligible	15%	28%	0.23%	34%	11%	13%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- Commonalities between the MHP and statewide are that the White and African-American groups appear to be proportionally overrepresented among members served, whereas the Hispanic/Latino and Asian/Pacific Islander groups are underrepresented.

Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander),

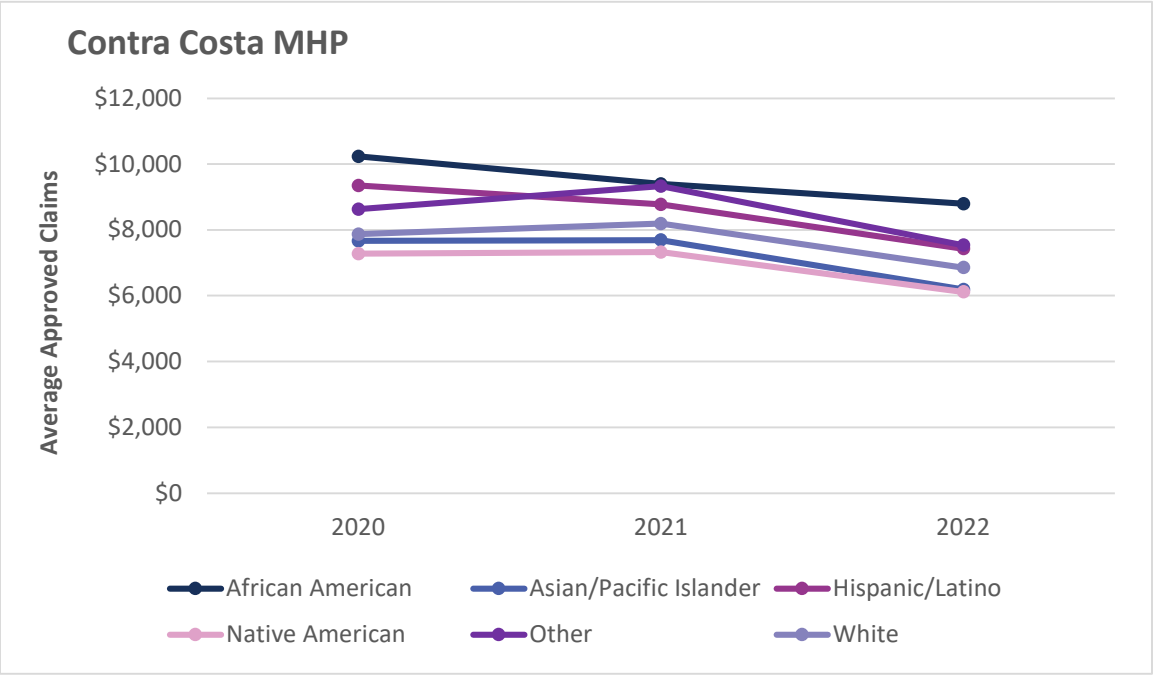
and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year trend.

Figure 2: MHP PR by Race/Ethnicity, CY 2020-22



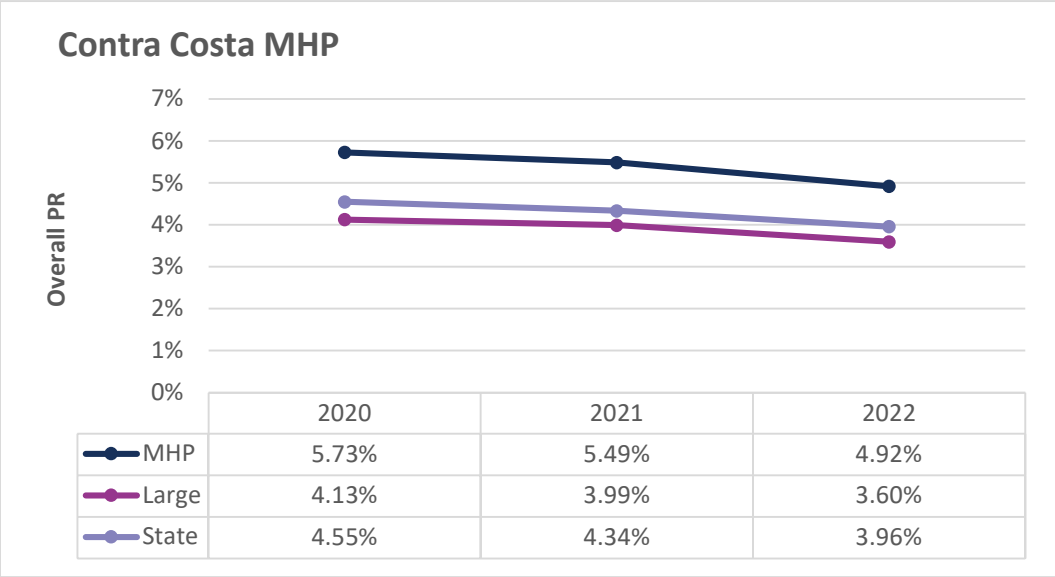
- A downward trend in PRs was seen across all race/ethnicity categories.
- Native American and White PRs were consistently highest over the past three years, and the Asian/Pacific Islander PR has consistently been the lowest in the MHP.

Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22



- The AACM has decreased from CY 2021 to CY 2022 across all racial/ethnic categories.
- The African American racial/ethnic group has consistently had the highest AACMs over the past three years, whereas the Native American group has consistently had the lowest.

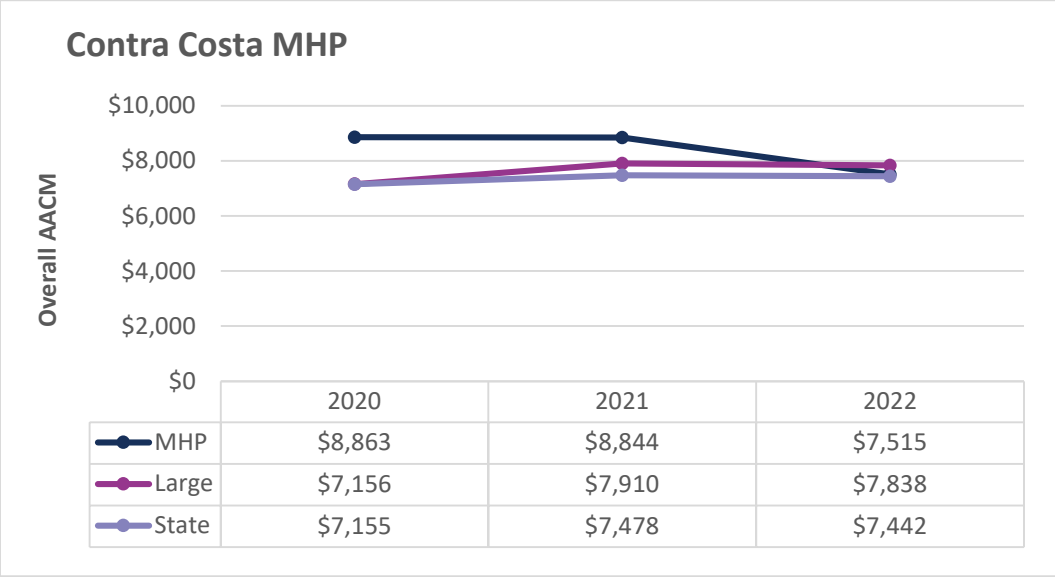
Figure 4: Overall PR CY 2020-22



	2020	2021	2022
MHP	5.73%	5.49%	4.92%
Large	4.13%	3.99%	3.60%
State	4.55%	4.34%	3.96%

- The overall PR is on a downward trend; however, the MHP has consistently maintained a higher PR than other large MHPs and statewide for the last three years.

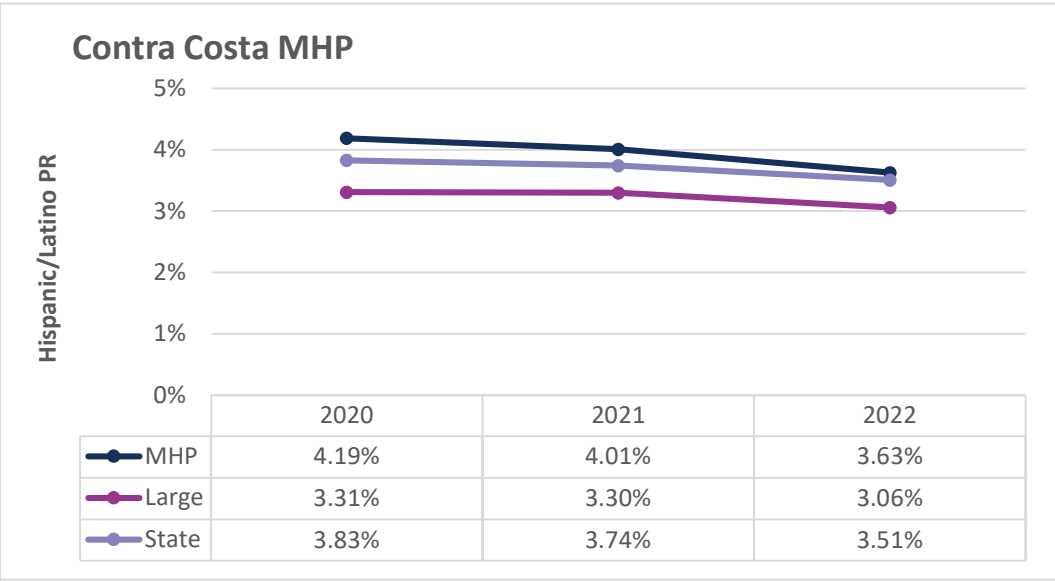
Figure 5: Overall AACM, CY 2020-22



	2020	2021	2022
MHP	$8,863	$8,844	$7,515
Large	$7,156	$7,910	$7,838
State	$7,155	$7,478	$7,442

- The MHPs AACM decreased in CY 2022 and was lower than large county and statewide AACMs for that year.

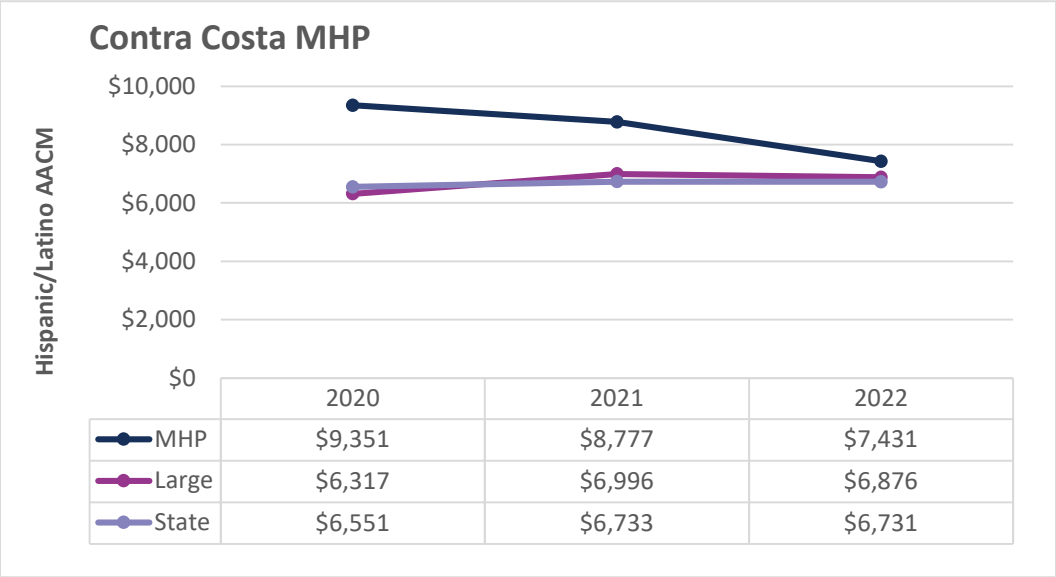
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	4.19%	4.01%	3.63%
Large	3.31%	3.30%	3.06%
State	3.83%	3.74%	3.51%

- The Hispanic/Latino PR has taken a downward trend the last three years and remains consistent with trends in both the large county and statewide PRs; however, the MHP PR for this population has consistently remained higher than the large county and state PR over the last three years.

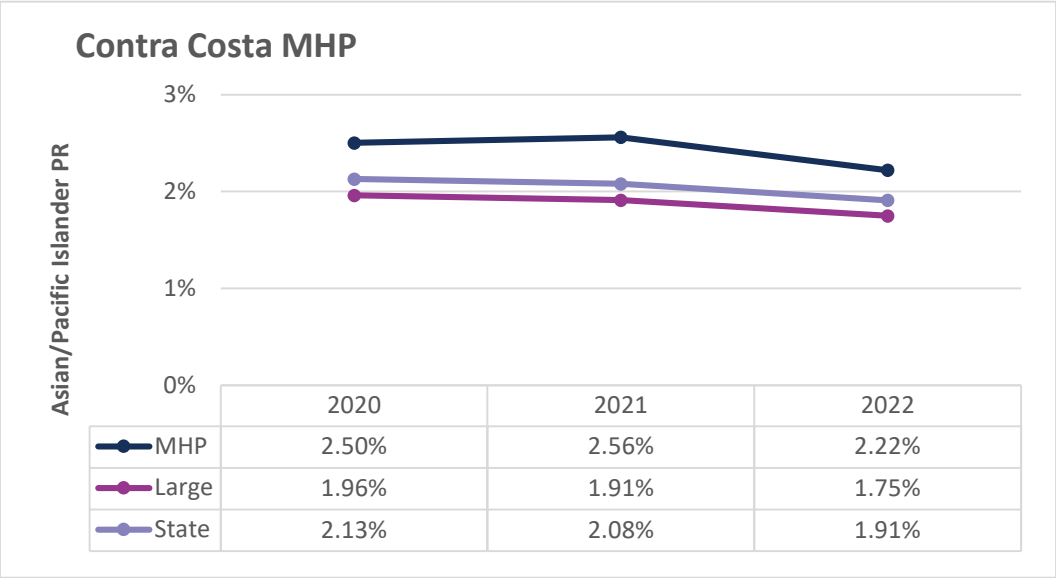
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$9,351	$8,777	$7,431
Large	$6,317	$6,996	$6,876
State	$6,551	$6,733	$6,731

- The MHP's AACM decreased approximately 21 percent between CY 2020 and CY 2022. However, the AACM is consistently higher than similar-size counties and statewide.

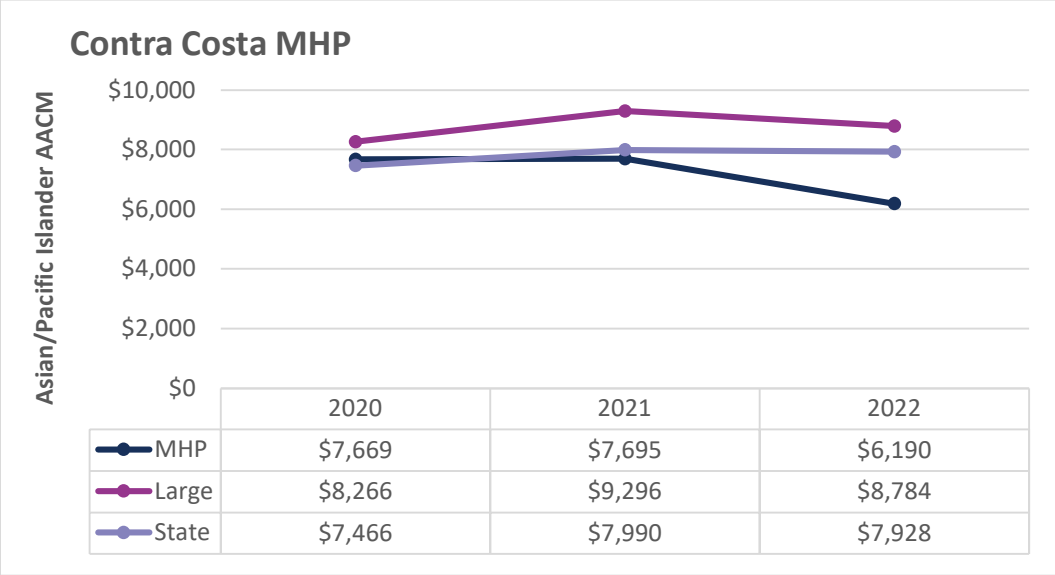
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	2.50%	2.56%	2.22%
Large	1.96%	1.91%	1.75%
State	2.13%	2.08%	1.91%

- The PR for the Asian/Pacific Islander population is on a slight downward trend but has exceeded the large county and statewide PRs for the last three years.

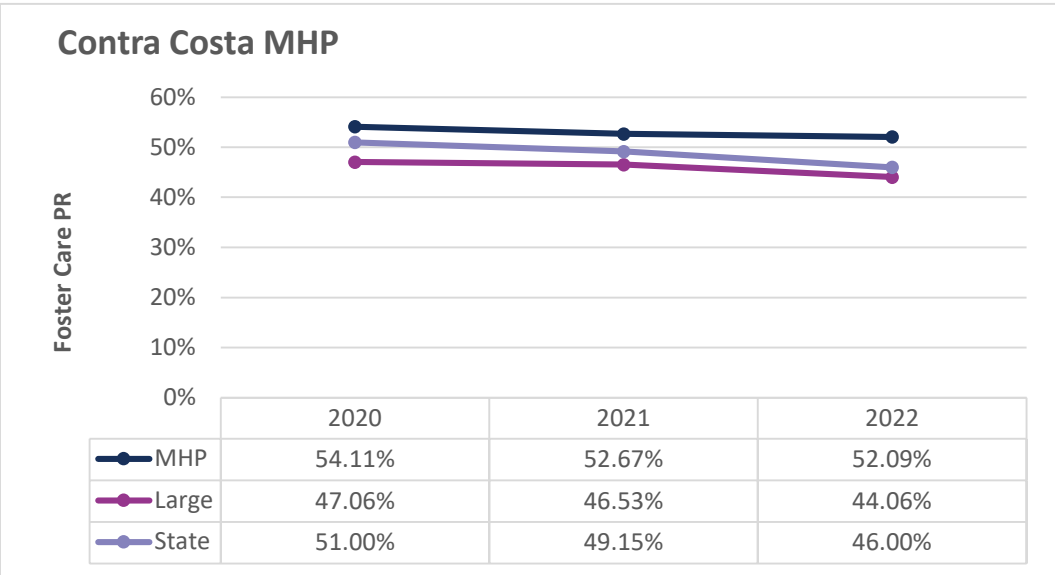
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$7,669	$7,695	$6,190
Large	$8,266	$9,296	$8,784
State	$7,466	$7,990	$7,928

- The AACM for the Asian/Pacific Islander has decreased 20 percent from CY 2020 to CY 2022. The last two years they have remained lower than other large counties and statewide.

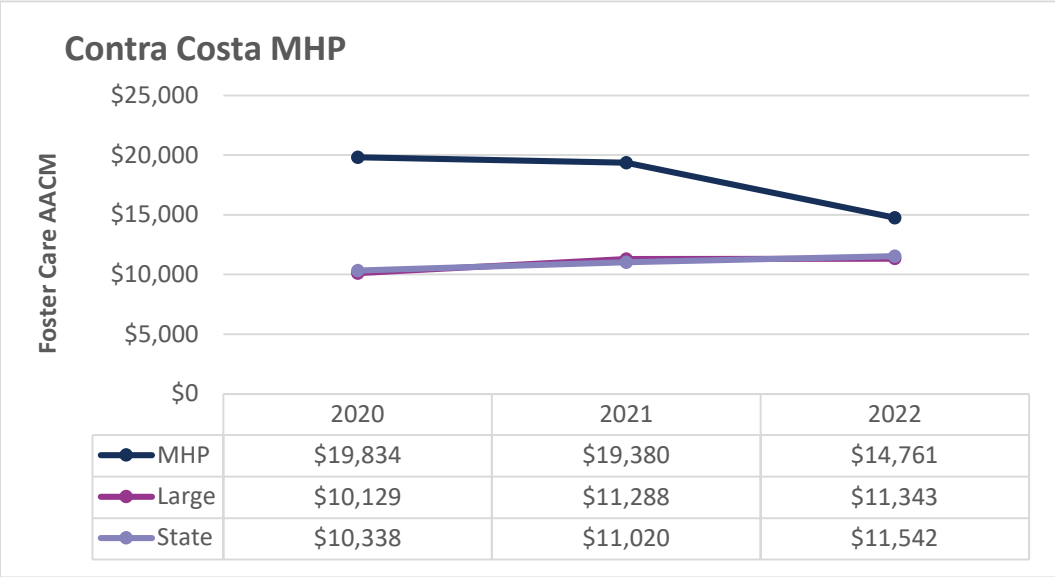
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	54.11%	52.67%	52.09%
Large	47.06%	46.53%	44.06%
State	51.00%	49.15%	46.00%

- The MHP FC PR remained stable between CY 2020 and CY 2022. The MHP PR continues to exceed both the large county and statewide PR.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$19,834	$19,380	$14,761
Large	$10,129	$11,288	$11,343
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years. The MHP FC AACM has decreased 26 percent over the past three years.
- The FC AACM is consistently higher than both the large county and state AACM.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Contra Costa MHP to Adults, CY 2022

Service Category	MHP N = 10,919				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	768	7.0%	10	5	10.3%	14	8
Inpatient Admin	119	1.1%	13	6	0.4%	26	10
Psychiatric Health Facility	<11	-	9	8	1.2%	16	8
Residential	28	0.3%	147	108	0.3%	114	84
Crisis Residential	204	1.9%	15	13	1.9%	23	15
Per Minute Services							
Crisis Stabilization	2,069	18.9%	1,682	1,200	13.4%	1,449	1,200
Crisis Intervention	506	4.6%	192	140	12.2%	236	144
Medication Support	6,786	62.1%	304	210	59.7%	298	190
Mental Health Services	5,504	50.4%	723	306	62.7%	832	329
Targeted Case Management	1,680	15.4%	384	131	36.9%	445	135

- The percentage of adults receiving inpatient services is lower than statewide, with shorter lengths of stay (LOS).
- Residential and crisis residential services were similar to the statewide patterns.
- The percentage of adults with inpatient administrative days is higher than statewide.
- The percentage of adult members receiving crisis stabilization is higher than the statewide percentage, and the percentage of members receiving crisis intervention is considerably lower than the statewide percentage.
- Medication support is utilized at a slightly higher rate than that seen statewide.
- The percentage of adults receiving mental health services is noticeably lower compared to the statewide percentage.
- A much smaller percentage of adults receive targeted case management (TCM) than statewide.

Table 9: Services Delivered by the MHP to Contra Costa MHP Youth in Foster Care, CY 2022

Service Category	MHP N = 485				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	25	5.2%	8	6	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	16	16	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	<11	-	294	294	0.2%	673	435
Full Day Rehab	<11	-	36	36	0.2%	111	84
Per Minute Services							
Crisis Stabilization	23	4.7%	1,521	1,200	3.1%	1,166	1,095
Crisis Intervention	26	5.4%	281	206	8.5%	371	182
Medication Support	139	28.7%	282	225	27.6%	364	257
TBS	37	7.6%	4,622	3,273	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	166	34.2%	1,286	697	40.8%	1,458	441
Intensive Home-Based Services	55	11.3%	1,574	861	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	467	96.3%	2,475	1,312	95.4%	1,846	1,053
Targeted Case Management	326	67.2%	451	129	35.8%	307	118

- The percentage of FC youth receiving inpatient services is slightly higher compared to statewide, and the median unit of service is two days shorter than seen statewide.
- The percentage of FC youth members receiving crisis stabilization is higher than the statewide percentage, and the percentage of members receiving crisis intervention is lower than the statewide percentage.

- The percentage of FC youth receiving therapeutic behavioral services is noticeably higher compared to the statewide percentage.
- The percentage of FC youth receiving mental health services is similar to the statewide percentage; however, the median unit of service is higher than statewide.
- The percentage of FC youth receiving TCM services is noticeably higher compared to the statewide percentage.

IMPACT OF ACCESS FINDINGS

- Contra Costa's PR is 4.92 percent, higher than the statewide PR of 3.96 percent.
- The MHP performs higher than statewide in terms of service utilization for several mental health services provided to FC youth.
- Based on focus group findings, the MHP may benefit from increased communication with contractors. Contractors expressed not being included in decisions, affecting their ability to support members. If not being done already, the MHP should routinely and consistently share and discuss new state and local requirements with contractors to increase understanding and support.

TIMELINESS OF CARE

The amount of time it takes for members to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to members. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved member outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

Each Timeliness 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 QI.

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	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	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

Strengths and opportunities associated with the timeliness components identified above include:

- Contra Costa indicated timeliness is part of ongoing conversations at the MHP and they look at timeliness by program to identify issues.

- Contra Costa initiated a QI project to improve 7-day and 30-day post psychiatric inpatient follow-up and performs better than statewide for both measures.
- The MHP has completed a non-clinical PIP on no-shows and achieved significant improvement in reducing no-shows.
- The MHP tracks non-urgent wait times for psychiatry for county-operated services only; they use a standard of 30 business days for the standard for delivered services, instead of 15 business days, which is the requirement for offered services.
- Contra Costa currently uses two business days as the benchmark for urgent appointments. The MHP plans to change the goal to hours in the coming year.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Counties are also expected to submit the source data used to prepare these calculations. This is particularly relevant to data validation for the additional statewide focused study on timeliness that BHC is conducting.

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care. The MHP reported timeliness for urgent services in units of business days which were converted by the EQRO into hours.

Claims data for timely access to post-hospital care and readmissions are discussed in the Quality-of-Care section.

Table 11: FY 2023-24 Contra Costa MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5.34 Business Days	10 Business Days*	97.4%
First Non-Urgent Service Rendered	6.92 Business Days	15 Business Days**	95.1%
First Non-Urgent Psychiatry Appointment Offered	16.51 Business Days	15 Business Days*	58.17%
First Non-Urgent Psychiatry Service Rendered	19.94 Business Days	30 Business Days**	84.65%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	38.16 Hours***	48 Hours*	88.89%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	11.00 Calendar Days	7 Calendar Days	52.5%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	11.00 Calendar Days	30 Calendar Days	63.6%
No-Show Rate – Psychiatry	14.7%	10%**	n/a
No-Show Rate – Clinicians	12.2%	10%**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033

** MHP-defined timeliness standards

*** MHP data submitted in units of business days, converted by EQRO to hours

**** The MHP does not require pre-authorization for any urgent services

For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23

Figure 12: Wait Times to First Service and First Psychiatry Service

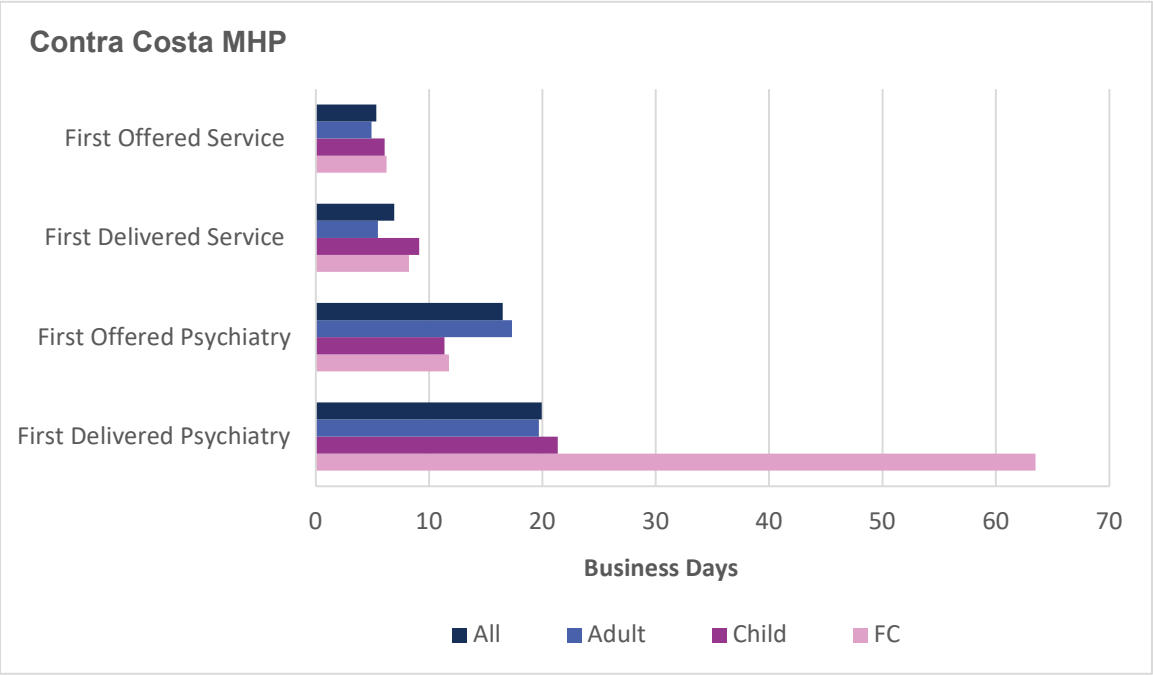


Figure 13: Wait Times for Urgent Services

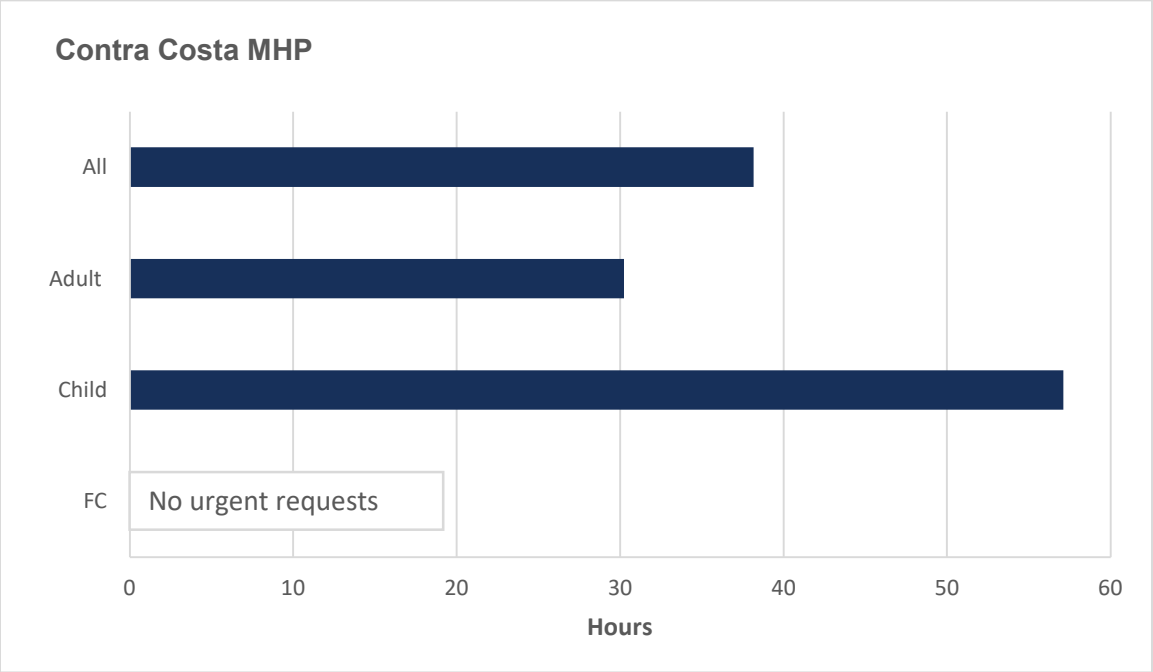
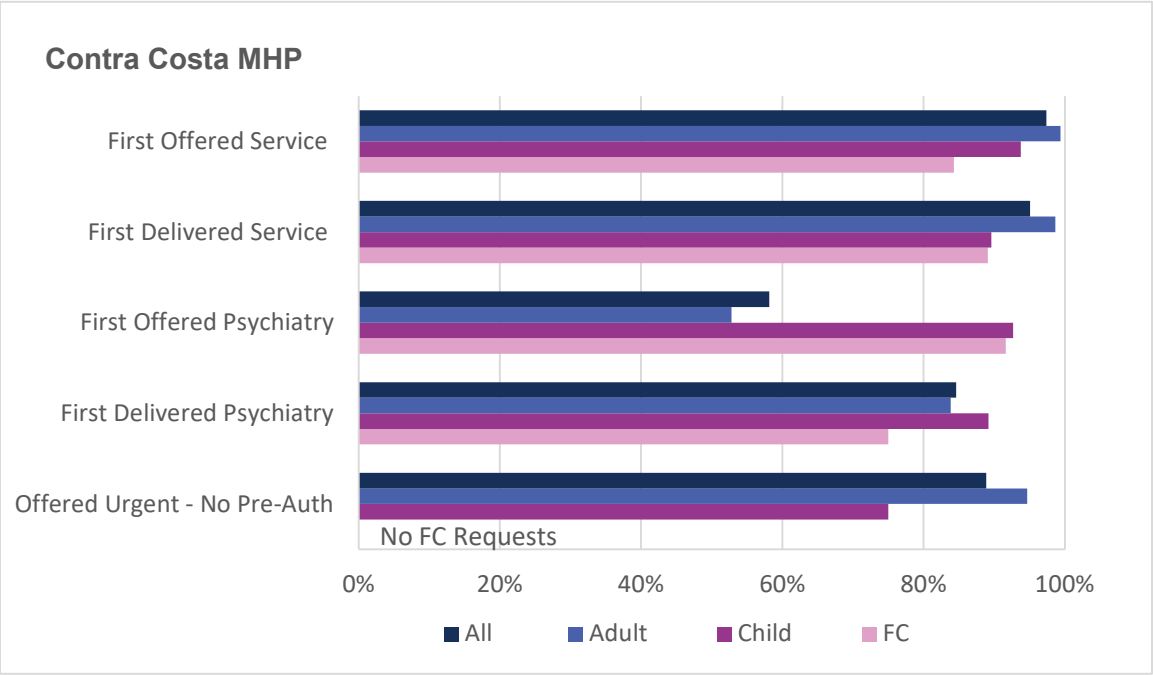


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled and unscheduled/walk-in assessments.
- The MHP defined “urgent services” for purposes of the ATA as a mental health or substance use disorder service that must be provided within 48 hours of the members request in order to prevent a crisis, imminent risk/hospitalization of significant decompensation in functioning. There were reportedly 27 urgent service requests with a reported actual wait time to services for the overall population of 38.16 hours. The MHP does not offer urgent services that require pre-authorization. The MHP currently does not track this metric in hours but is working to implement such tracking in the coming year.
- The MHP defines timeliness to first delivered/rendered psychiatry services as the first completed appointment with a psychiatrist following the date that medical necessity was established, and a psychiatry referral was entered in system after initial request for services at Access Line or County clinics, regardless of whether the client completed an assessment with a non-psychiatrist prior to the psychiatry referral entry date. First delivered psychiatry services were completed within 20 days for all new clients to psychiatry with the MHP’s standard goal being 30 days. The MHP reported 1,264 initial psychiatry services were delivered by the County in FY 2022-23.
- The MHP does track and monitor data for no-shows for county-operated services. The MHP reports a no-show rate of 14.7 percent for psychiatrists and 12.2 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- The MHP has multiple QI projects focused on improving timeliness of care and adheres to evidenced-based performance improvement practices.
- Contra Costa performs well with timeliness to first non-urgent service, both offered and rendered.
- There appears to be an opportunity to examine the results and improve wait time to psychiatry, especially for FC youth.
- Contra Costa should use the DHCS standard for urgent services (48 hours).

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the members through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, and the intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI Program for the services furnished to members. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement."

QUALITY IN THE MHP

In the MHP, the responsibility for QI is with the Quality Improvement & Quality Assurance (QI/QA) unit, led by the Quality Management Program Coordinator with support from another staff member who holds a dual role as Quality Improvement and Compliance Coordinator. Quality is viewed as a continuous process across the system. The Quality Management Committee/Quality Improvement Committee (QIC) is comprised of the medical director, chiefs, program managers, program supervisors, DMC-ODS Chief, Program Manager, and Planner/Evaluators, community support workers (peers), and QI/QA staff. The QIC is scheduled to meet ten months out of the year, and since the last EQR met seven times. The MHP monitors its quality processes through the QIC, the QAPI workplan, and annual evaluation of the QAPI workplan. Of 14 goals in the CY 2022 QAPI workplan, there were 90 actions identified and the MHP fully met 58 percent of actions.

The QI/QA unit oversees timeliness, appointment adherence, satisfaction surveys, penetration/retention, PIPs, service accessibility, evidence-based practices, outcome measures, medication monitoring, member grievances, appeals, serious occurrence notifications, Health Insurance Portability and Accountability Act incident reporting investigations, quality of care concern investigations, change of provider trends, notice of adverse benefits and determination compliance, fraud, waste and abuse reporting.

The MHP does not currently utilize level of care (LOC) tools; however, is participating in a small pilot with the purpose of using the Child and Adolescent Needs and Strengths (CANS) as the basis to informing the LOC tool. The LOC tool is proprietary and factors in local CANS data as the basis of its algorithm in recommending an appropriate level of care. The MHP has considered clinician feedback in the process.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths Assessment (ANSA), CANS, Difficulties in Emotion Regulation Scale, Suicidal Ideation Questionnaire, MacLean Screening Instrument for Bipolar Disorder, Generalized Anxiety Disorder-7, Patient Health Questionnaire-9, PSC-35, Posttraumatic Stress Disorder (PTSD) Reaction Index, PTSD Checklist, Independent Living Skills Survey,

Structured Interview for Psychosis Risk Syndrome, Recovery Assessment Scale, Eating Disorder Examination Questionnaire, Parents Versus Anorexia Scale, Program to Encourage Active, Rewarding Lives for Partners in Aging, and Brief Cognitive Assessment for Schizophrenia.

Current county ANSA data are entered directly into Epic, and contracted providers' data are entered into a web-based portal operated by Objective Arts. CANS and PSC-35 assessment data for county staff are entered into the MHP's EHR, and data from contracted providers are entered into Objective Arts. Contra Costa tracks and analyzes outcomes data over time.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for members. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

Each Quality 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 QI.

Table 12: Quality Key Components

KC #	Key Components – Quality	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 Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Met
3H	Utilizes Information from Member Satisfaction Surveys	Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Member and Member Employment in Key Roles throughout the System	Partially Met

Strengths and opportunities associated with the quality components identified above include:

- The MHP places emphasis on QI and uses data to inform management and guide decisions.
- Contra Costa does not currently use LOC tools; however, it is in the process of establishing a process to use the CANS to be the basis of informing the decision support model (LOC tool).
- Contra Costa oversees prescribing practices for county prescribers, but not for contracted agencies' prescribers. The MHP started the process of ensuring that contract agency processes are in alignment with the MHP's process and is having meetings with the contracted providers.
- Although Contra Costa has an abundance of employment options for peer support staff, it does not yet have a defined career ladder.
- There may be an opportunity for senior leadership to ensure that supervisors and managers are well-supported and receive responses to their requests.
- The MHP tracks the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5 for county prescribers, but not contracted providers.

QUALITY PERFORMANCE MEASURES

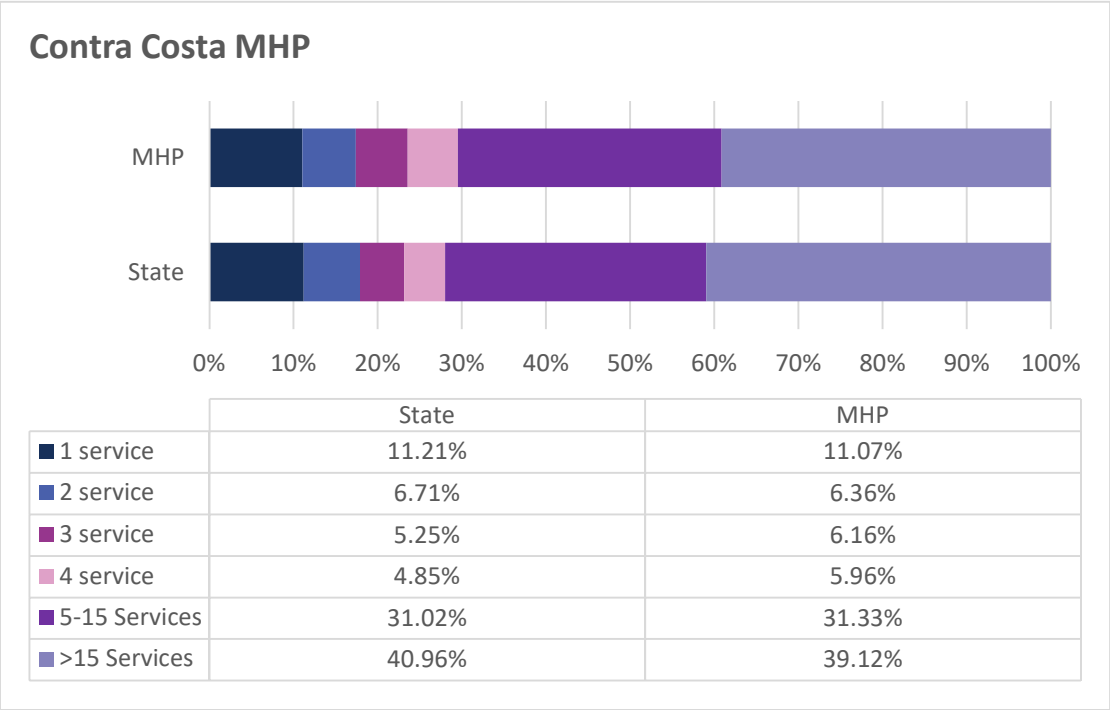
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented in the approved claims:

- Retention in Services
- Diagnosis of Members Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Members (HCMs)

Retention in Services

Retention in services is an important measure of member engagement in order to receive appropriate care and intended outcomes. One would expect most members served by the MHP to require five or more services during a 12-month period. However, this table does not account for the length of stay (LOS), as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Retention of Members Served, CY 2022



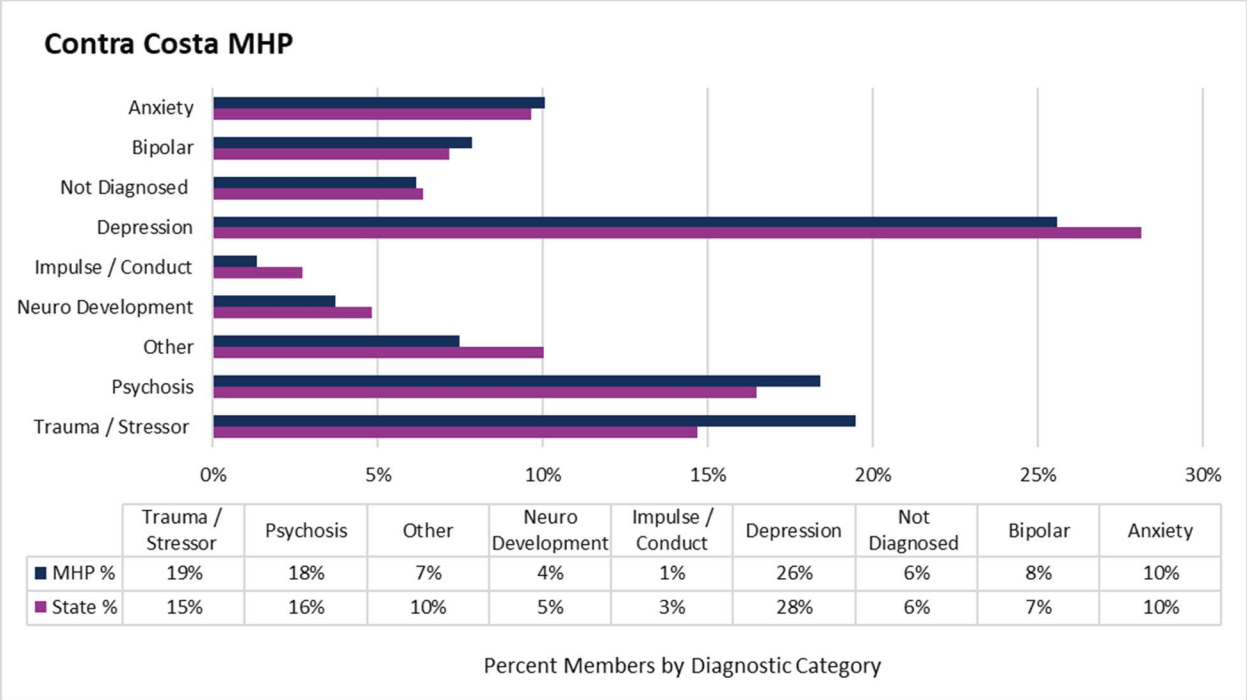
	State	MHP
1 service	11.21%	11.07%
2 service	6.71%	6.36%
3 service	5.25%	6.16%
4 service	4.85%	5.96%
5-15 Services	31.02%	31.33%
>15 Services	40.96%	39.12%

- Overall, the retention of members served is very comparable to that seen statewide.

Diagnosis of Members Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared to statewide. This is not an unduplicated count as a member may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

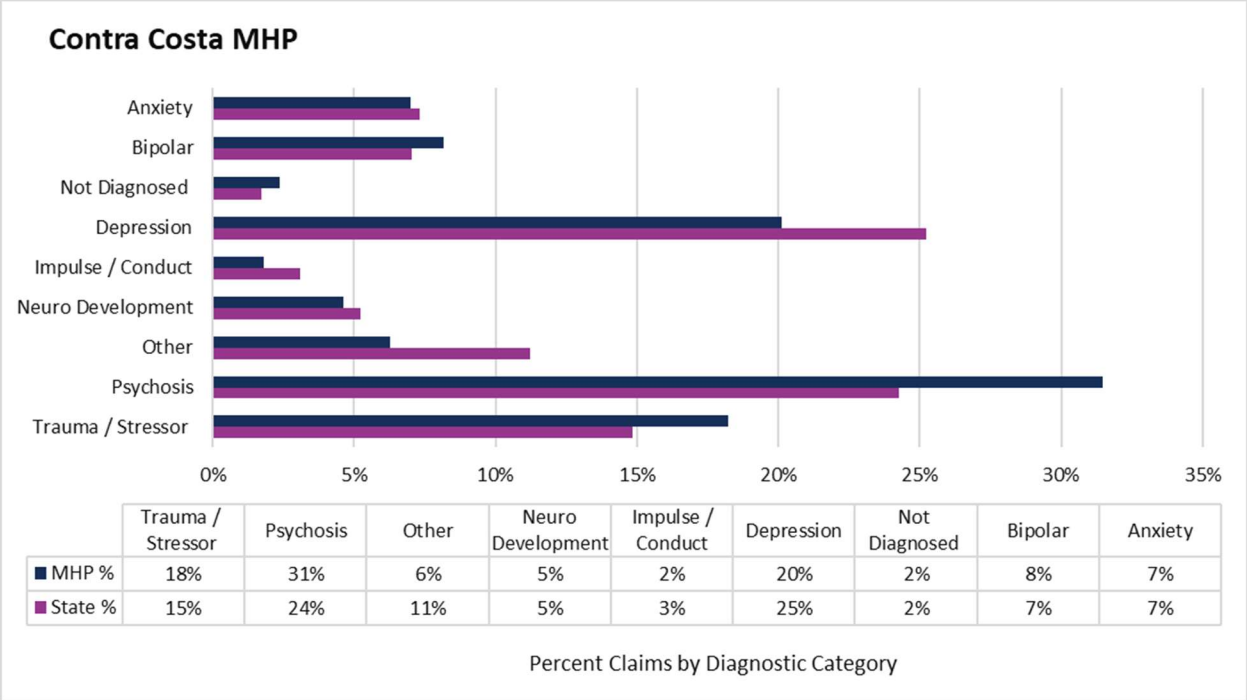
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	19%	18%	7%	4%	1%	26%	6%	8%	10%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- The MHP's leading diagnostic category is depression; the percentage of members with a depression diagnosis is lower compared to statewide, and the percentage of members with either a trauma/stressor or psychosis diagnosis is higher compared to statewide. The "other" diagnostic category is lower than statewide percentages.
- The diagnosis with the most significant difference than that seen statewide is trauma/stressor. The MHP has 19 percent of their members with this diagnosis where statewide it is only seen in 15 percent of members.

Figure 17: Diagnostic Categories by Percentage of Approved Claims, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	18%	31%	6%	5%	2%	20%	2%	8%	7%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- The distribution of most approved claims is fairly congruent with the diagnostic patterns displayed in Figure 16. The MHP has a large number of approved claims being dedicated to those diagnosed with psychosis. This is much higher at 31 percent when compared to the State at 24 percent.
- Depression for the MHP equaled 26 percent of the diagnosis but was only 20 percent of the approved claims.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS. CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

Table 13: Contra Costa MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	1,073	1,120	1.04	10.03	8.45	$26,861	$12,763	$28,821,326
CY 2021	1,320	1,413	1.07	10.29	8.86	$25,073	$12,696	$33,096,894
CY 2020	979	1,082	1.11	9.31	8.68	$19,387	$11,814	$18,980,014

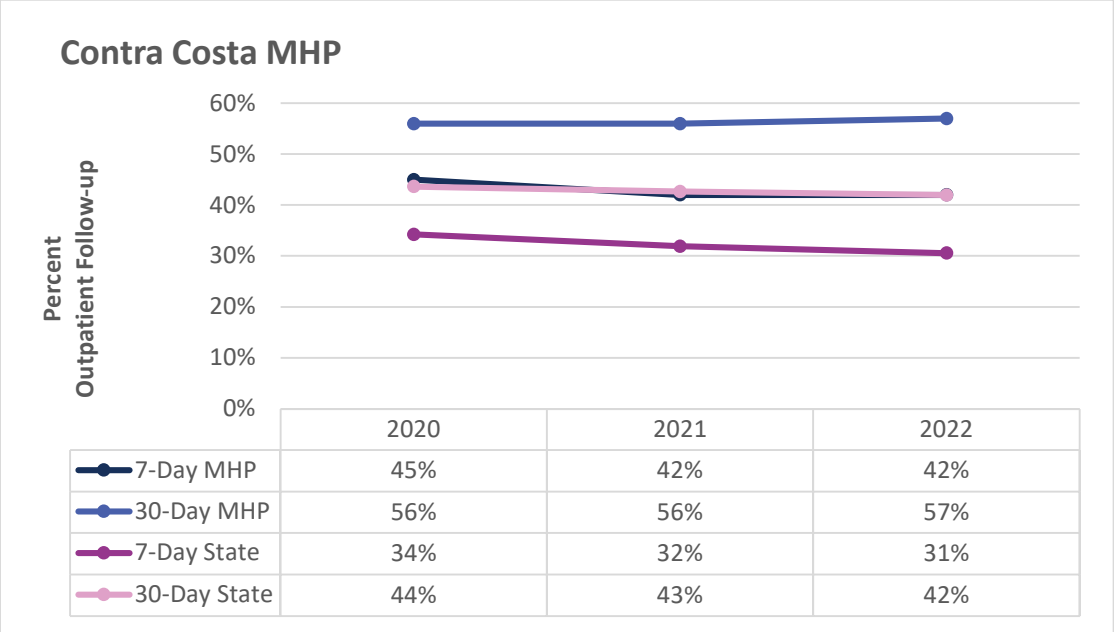
- The MHP has maintained a slightly longer average LOS than seen statewide over the last three years, with members staying about a day longer than the statewide averages. The number of both unique members and inpatient admissions decreased in CY 2022. The MHP inpatient AACM is more than double that of statewide.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and is reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis. As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the current methodology.

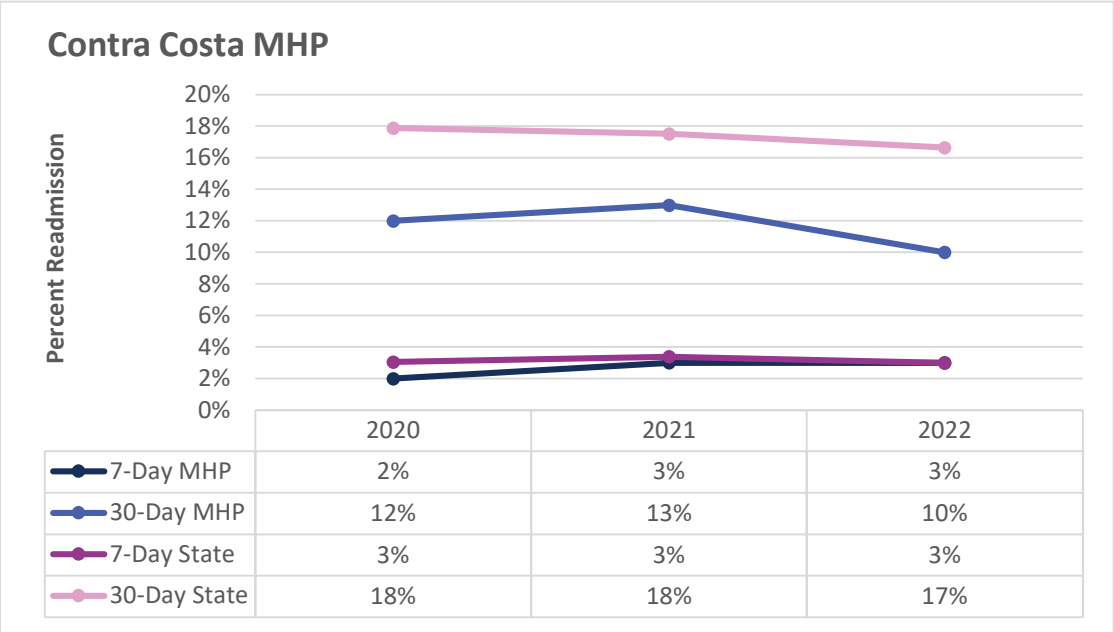
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	45%	42%	42%
30-Day MHP	56%	56%	57%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- Contra Costa continues to exceed the statewide rates for both 7-day and 30-day follow-up services post hospitalization.

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22



	2020	2021	2022
7-Day MHP	2%	3%	3%
30-Day MHP	12%	13%	10%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP has low rates of 7-day psychiatric readmissions. These rates are consistent with that seen statewide at 3 percent. The 30-day readmission rate is

noticeably lower than the statewide rates across all three CYs depicted in Figure 19.

High-Cost Members

Tracking the HCMs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCMs may disproportionately occupy treatment slots that may prevent access to levels of care by other members. HCM percentage of total claims, when compared with the HCM count percentage, provides a subset of the member population that warrants close utilization review, both for appropriateness of LOC and expected outcomes.

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

Tables 14 and 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

Table 14: Contra Costa MHP High-Cost Members (Greater than $30,000), CY 2020-22

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	835	5.29%	46.00%	$54,536,429	$65,313	$48,370
	CY 2021	1,115	6.83%	49.70%	$71,742,737	$64,343	$48,480
	CY 2020	1,052	6.81%	47.61%	$65,204,384	$61,981	$47,581

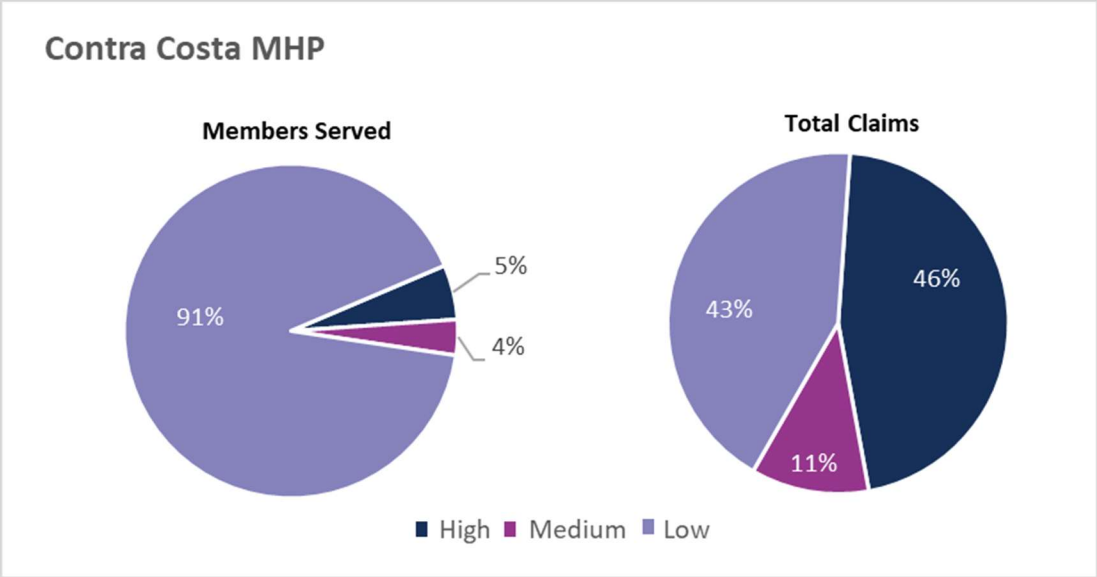
- For the past three years, the proportion of members served considered to be HCMs has been higher than statewide.
- Total HCM approved claims decreased by 24 percent in CY 2022 compared to CY 2021.

Table 15: Contra Costa MHP Medium- and Low-Cost Members, CY 2022

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	543	3.44%	11.20%	$13,281,823	$24,460	$24,246
Low-Cost (Less than $20K)	14,398	91.27%	42.80%	$50,737,817	$3,524	$1,870

- Most of the MHP members are considered to be low-cost (less than $20,000 in claims). Only 11.20 percent of the MHP's services were considered medium-cost (claims totaling $20,000 - $30,000).

Figure 20: MHP Members and Approved Claims by Claim Category, CY 2022



- While 91 percent of members served were considered low-cost, they only accounted for 43 percent of claims. Just 4 percent of members were considered medium-cost, and that group accounted for 11 percent of the county's overall approved claims.

IMPACT OF QUALITY FINDINGS

- The MHP's 7-day and 30-day post-hospital follow-up has continued to exceed the statewide average over the past three CYs, during which time readmission rates have dropped to levels lower than or equal to the statewide average.

- While the MHP currently does not use a LOC tool, the MHP started a pilot using the Praed Foundation's proprietary algorithm LOC with the support of existing CANS data.
- The MHP has used CANS and PHQ-9 results as the basis of data to support federally-required PIPs.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.caleqro.com.

Validation tools for each PIP are located in Attachment C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Follow-Up After ED Visit for Mental Illness

Date Started: 09/2022

Date Completed: In progress

Aim Statement: "The goal of this PIP is to increase the percentage of adults with an MH condition, who are not open to SMHS, who receive a 7-day follow-up appointment following ED discharge from 29.8 percent to 35 percent and increase the percentage who receive a 30-day follow-up appointment from 37.5 percent to 43 percent by September 30, 2023."

Target Population: Adult clients with a MH condition who sought care at Contra Costa Regional Medical Center (CCRMC) or Kaiser Richmond ED who had not received SMHS from the MHP previously.

[2] https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf

[3] https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf

Status of PIP: The MHP's clinical PIP is in the implementation phase.

Summary

The MHP submitted the FUM BHQIP for its clinical PIP. Contra Costa's goal is to improve follow-up in 7 and 30 days for adults seen for mental health in the ED.

The intervention was focused on clients who sought care at CCRMC or Kaiser Richmond and had not received services from the MHP previously. Medical social workers at the hospitals link clients to the Access Line to schedule a follow-up appointment. Social Workers were provided with a prompt hidden in the Access Line phone tree so their call could be prioritized, and they receive a quicker response. The intervention should allow clients to be discharged from the ED with a scheduled follow-up appointment. The MHP started the interventions in September and October 2023. The PIP does not yet include performance measure results.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence. The PIP was recently revised, and results are not yet reported to evaluate whether interventions have a significant impact on the outcomes.

Contra Costa did not request PIP TA outside of the review.

CalEQRO recommendations for improvement of this clinical PIP:

- Track how many clients require interpretation and for what language.
- Investigate and address why not all clients who were eligible were referred to a social worker for linkage to the Access Line.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Gain-framed Provider Reminder Calls to Reduce No Shows to Initial Assessment Appointments

Date Started: 11/2021

Date Completed: In progress

Aim Statement: "Will providing clients with a reminder call from their therapist containing a "gain-framed" message, and providing automated Artera appointment reminders, and offering on-demand clinical assessment by the Access Line, significantly decrease no shows to initial assessment appointments at the East Adult clinic to be no higher than 15 percent within two years of the launch of the PIP."

Target Population: East clinic adult clients

Status of PIP: The MHP's non-clinical PIP is in the second remeasurement phase.

Summary

The goal of this non-clinical PIP is to decrease no shows to first assessment appointments at the MHP's East Adult regional clinic. The PIP interventions included a reminder call from the therapist containing a "gain-framed" message, providing automated Artera appointment reminders, and offering an on-demand clinical assessment by the Access Line.

The PIP demonstrated statistically significant improvement in the no-show rate to initial assessment appointment from a baseline of 24 percent to 16 percent. There was improvement in the percent of appointments a therapist receives a reminder text to provide a reminder call, percent of appointments that are provided a warm call reminder, and percent of clients successfully reached.

TA and Recommendations

As submitted, this non-clinical PIP was found to have high confidence, because the no-show rate was reduced significantly, and the intervention evaluation data demonstrated improvement as well.

Contra Costa did not request PIP TA outside of the review.

CalEQRO recommendations for improvement of this non-clinical PIP:

- Spread the interventions to other clinics/areas, as applicable.

INFORMATION SYSTEMS

Using the Information Systems Capabilities Assessment protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the MHP's EHR, IT, claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Epic, which has been in use for six years. Currently, the MHP has no plans to replace the current system, which is functioning in a satisfactory manner.

Approximately 2 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is allocated to the MHP but managed by Contra Costa Health IT department. The IS allocation remains unchanged since the previous year.

The MHP has 1,001 named users with log-on authority to the EHR, including approximately 707 county staff and 294 contractor staff. Support for the users is provided by 12.15 FTE IS technology positions. Currently all positions are filled. This looks like a decrease of 1.1 FTE from the prior year, however last year the FTE of 13.25 staff included those dedicated to the Drug Medi-Cal Organized Delivery System (DMC-ODS).

As of the FY 2023-24 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit member practice management and service data to the MHP IS as reported in the following table: Contractors have the ability to enter members' services data for billing purposes to the MHP. Contractors do not at this time have the capability to directly enter member progress notes, problem lists, or treatment plans.

Table 16: Contract Provider Transmission of Information to Contra Costa MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☒ Daily ☒ Weekly ☐ Monthly	9.34%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	90.66%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. MHP members have access to medical records using the Epic patient portal, MyChart. The medical records include services provided by county staff only.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with contract providers, Federally Qualified Healthcare Center, substance use disorder providers, hospitals, primary care physicians, and the MCP.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive member outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

Each IS Key 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 QI.

Table 17: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	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	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

Strengths and opportunities associated with the IS components identified above include:

- Although the MHP reports in the ISCA decreased IS staff from (13.35 to 12.15 FTE) this past year, last year's FTE count included those dedicated to DMC-ODS. This year the MHP states they have a total of 17.45 FTE staff supporting the county's IS department, with 12.15 fully supporting the MHP, which appears to be an increase in support.
- The MHP has implemented the payment reform requirements and rate changes. This is a commendable achievement given the amount of staff time required. They currently are billing MHP services.
- The MHP should continue to work with the contract providers to establish fully bidirectional EHR communication and capability to directly enter not only the service data, but also the progress notes, problem lists, and treatment plans.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

For the MHP, Table 18 appears to reflect a largely complete or very substantially complete claims data set for the time frame represented.

Table 18: Summary of Contra Costa MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	32,420	$10,390,040	$556,500	5.36%	$9,833,540
Feb	33,881	$11,215,355	$577,070	5.15%	$10,638,285
Mar	40,699	$12,840,307	$448,072	3.49%	$12,392,235
April	33,998	$11,634,961	$367,771	3.16%	$11,267,190
May	35,985	$12,398,611	$458,223	3.70%	$11,940,388
June	33,193	$11,049,617	$503,445	4.56%	$10,546,172
July	26,962	$9,097,141	$340,621	3.74%	$8,756,520
Aug	33,453	$10,013,797	$373,498	3.73%	$9,640,299
Sept	31,939	$7,597,589	$287,762	3.79%	$7,309,827
Oct	13,660	$4,284,102	$345,033	8.05%	$3,939,069
Nov	25,161	$8,416,032	$369,726	4.39%	$8,046,306
Dec	18,247	$6,045,879	$251,113	4.15%	$5,794,766
Total	**359,598**	**$114,983,431**	**$4,878,834**	**4.24%**	**$110,104,597**

- A consistent volume of monthly claims contributes to a steady stream of revenue. The MHP reported that they have billed services for December 2023.

Table 19: Summary of Contra Costa MHP Denied Claims by Reason Code, CY 2022

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other	23,531	$2,389,710	48.98%
Beneficiary is not eligible or non-covered charges	938	$959,145	19.66%
Medicare Part B must be billed before submission of claim	1,938	$661,494	13.56%
Late claim submission	887	$329,681	6.76%
Other healthcare coverage must be billed first	703	$310,279	6.36%
Service line is a duplicate and repeat service modifier is not present	447	$138,860	2.85%
Deactivated NPI	385	$44,514	0.91%
Service location NPI issue	63	$43,135	0.88%
Place of service incomplete or invalid	1	$2,017	0.04%
Total Denied Claims	**28,893**	**$4,878,835**	**100.00%**
Overall Denied Claims Rate	**4.24%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The overall denied claims rate for Contra Costa (4.24 percent) is lower than statewide (5.92 percent). The most prevalent reasons claims were denied were in the Other category (48.98 percent of the denied dollars), the member not being eligible, or the charges not being covered (19.66 percent of denied dollars), and the service needing to be billed to Medicare Part B prior to submission (13.56 percent of denied dollars).

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP continues to review the LOC tools available and is looking to increase tracking and efficiencies within the current system and other systems available.
- The MHP has incorporated the new billing codes to meet the CalAIM payment reform requirements. They also continue to train the contract providers on the current initiatives and changes. These efforts are time-consuming and require a great deal of staff time. Additional allocations for IS staff may be needed in the future to meet all CalAIM reporting requirements.
- In order to support CalAIM and payment reform the MHP provided a CPT Code Overview Training in May 2023 followed by six CPT code training courses (two for each discipline, clinicians, unlicensed staff, and medical) with more specific information for providers.
- The MHP has been able to get several contract providers on the Epic system for billing purposes only. However, they are not able to enter progress notes or treatment plans and can only see what the county has added to the current system. Epic can share information, but communication is not bidirectional. Not all contract providers have the IT capability to expand EHR systems to support data exchange.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting members' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of members: adult, older adult, youth, and family members. MHPs administer these surveys to members receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS and provides a comprehensive analysis in the annual statewide aggregate report.

Contra Costa administered the annual CPS and developed one-page infographics to display simplified Spring 2022 results for Adults, Older Adults, Youth, and Families to address a recommendation from the FY 2022-23 EQR that indicated Contra Costa did not have a process for making the results available to members. The MHP provided the infographics that are posted on bulletin boards at each county clinic for members. The MHP also posted the Spring 2022 results on their QI/QA website. The infographics included that 91 percent of adults, 97 percent of older adults, 94 percent of families, and 86 percent of youth were generally satisfied with services they received from the MHP.

PLAN MEMBER/FAMILY FOCUS GROUPS

Plan member and family member (PMF) focus groups are an important component of the CalEQRO review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and PMF involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-review planning process, CalEQRO requested two 90-minute focus groups with MHP members and/or their family, containing eight to ten participants each.

Consumer Family Member Focus Group One

The first member focus group was a diverse group of older adult consumers who received MHP services in the preceding 12 months. The focus group was held both in-person and virtually and included eight participants. A Spanish interpreter was made available in the event the focus group included Spanish speaking clients; however, there were no Spanish speaking clients who participated in the focus group. All the consumers participating receive clinical services from the MHP.

The older adult member focus group had all received services for some time; no one was newer in the program. Participants shared an abundance of positive feedback regarding the services they receive from the MHP, including that they overwhelmingly feel supported, and that staff give them a sense of hope for stability and long-term

recovery. Group members indicated they are offered telehealth appointments and if they miss an appointment, it is easy to reschedule. Overall members were aware of transportation options.

An area that seemed to stand out where there may be an opportunity to improve services is member awareness of crisis services and ensuring that members know of any MH committees, they are eligible to participate in. Although members of this group were familiar with the satisfaction survey, they did not recall seeing results from it.

Recommendations from focus group participants included:

- Be able to leave a message at the center in times of crisis, if the call is not answered.
- Members would really enjoy animal therapy.

Consumer Family Member Focus Group Two

The second member focus group was monolingual Spanish speaking caregivers of youth who received services from the MHP in the preceding 12 months. The focus group was held both in-person and virtually and included nine participants. A Spanish speaking interpreter was used for this focus group. All members participating are caregivers who have a family member receiving clinical services from the MHP.

There were three members who started services in the past year. One member waited two months before services started. One caregiver indicated that it was easy to start services for one child, but it was more difficult for her other child. The third caregiver indicated that her son was reluctant to start services; however, he is doing well now.

All caregivers indicated that they are offered services in Spanish and both parents' and youth language needs are accommodated by the MHP. Some parents reported delays in being referred for therapy, and this has led to issues in their child's treatment. All parents were aware of crisis numbers and mobile crisis services. A caregiver indicated that the MHP has made the experience easy to access and staff have been there for her family. She recommends parent support to other members because it has been very helpful. Focus group participants agreed MHP staff give them and their children a sense of hope.

Recommendations from focus group participants included:

- Address parent concerns regarding wait times after assessment for youth therapy services.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Overall, both member focus groups expressed appreciation for MHP services and indicated a sense of hope because of the staff and services received. Participants

spoke highly of the MHP staff and that they feel supported. The older adult group shared that they were provided exceptional support, such as having staff reach out to them to see how they are doing. The focus groups had minimal recommendations for MHP improvement. There may be an opportunity for the MHP to ensure that members are aware of and can utilize information in MyChart.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. Contra Costa appears to be a quality driven organization that is forward thinking and places emphasis on utilizing QI processes as evidenced by their QI projects. (Quality)
2. The MHP has peer support staff embedded in programs across the system of care, providing an abundance of opportunity for consumers with lived experience. (Quality)
3. Contra Costa's innovative A3 (Anyone, Anywhere, Anytime) crisis program continues to evolve and has made progress since the last EQR. The MHP plans to further expand the program. (Access, Timeliness)
4. Contra Costa's supervisors and managers expressed dedication to members and assist when needed. For example, supervisors will complete a client assessment when members with urgent issues come in and a clinician is not available. (Access, Timeliness)
5. Contra Costa has been able to expand Epic to perform billing through payment reform and the MHP is able to bill for services. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP continues to have staffing shortages with a 30 percent vacancy rate. Although it has tested work at home for some staff, it appears that more initiatives are needed to ensure adequate staff to serve members' needs. (Access, Timeliness)
2. Although the MHP has begun to coordinate with contracted providers to assess whether their medication monitoring practices align with the MHP, Contra Costa's SB 1291 review process does not include contracted providers. (Quality)
3. There is a continued opportunity for the MHP to provide access for contracted providers to enter progress notes and claims data in the EHR system, as Epic can share information, but it is not bidirectional. (IS, Quality)
4. The MHP does not have a defined career ladder for peer employment. The Mental Health Specialist minimum qualification position requires an associate degree. Peers may not be able to obtain education without assistance. (Quality)

5. There may be an opportunity for senior leadership to ensure that supervisors and managers are well-supported and receive responses to their requests. (Quality)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the MHP in its QI efforts and ultimately to improve member outcomes:

1. Continue to implement recruitment and retention strategies identified from staff survey feedback, such as testing alternate work schedules, to stabilize staffing and improve recruitment results for both clinical and quality positions. (Access, Timeliness)

   (This recommendation is a carry-over from FY 2021-22 and FY 2022-23.)

2. Continue to develop the SB 1291 review process that includes both directly operated and contracted providers. (Quality)

   (This recommendation is a carry-over from FY 2022-23.)

3. Expand use of batch files to submit service data claims or provide access for contracted providers to directly enter clinical data to eliminate double entry once the Epic cclink billing implementation is complete. (IS, Quality)

   (This recommendation is a carry-over from FY 2021-22 and FY 2022-23.)

4. Clearly define a career ladder for peer employment and provide peer support staff with information about county resources/supports to provide advancement opportunities for example, tuition reimbursement. (Quality)

5. Assess and ensure that MHP supervisors and managers receive adequate communication and timely responses to questions. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

There were no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Contra Costa MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation of Findings for Pathways to Well-Being
Plan Member/Family Member Focus Groups – Older Adults and Spanish Speaking Parents/Caregivers
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Health Plan and MHP Collaboration Initiatives
Peer Employees Group Interview
Contract Provider Group Interview
Information Systems Billing and Fiscal Interview
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Christy Hormann, LMSW, CPHQ, CSSBB, Lead Quality Reviewer
Nathan Lacle, PsyD(c), MPA, MAOL, Quality Reviewer
Sharon Mendonca, MPA, Information Systems Reviewer
Pamela Roach, M.Ed., Consumer/Family Member Reviewer

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-review and the post-review meetings and in preparing the recommendations within this report.

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Aguirre	Priscilla	Quality Management Program Coordinator, QI/QA	Contra Costa County
Ahad	Terry	Mental Health Program Manager, Central Adult Mental Health	Contra Costa County
Alexander	Onna	LCSW	CC Youth Service Bureau
Alexander	Scott	Mental Health Program Supervisor	Contra Costa County
Ang	JR	Director of Patient Financial Services	Contra Costa County
Arevalo	Myrna	Clinical Supervisor	Community Health for Asian Americans (CHAA)
Bal	Rebecca	Program Supervisor, Countywide Wraparound	Contra Costa County
Barcelo	Nicolas	Medical Director, Contra Costa Health Plan	Contra Costa County
Bianchi	Charlene	Child and Family Behavioral Health Specialty Services	Contra Costa County
Blanza	Jennifer	Program Director, Contra Costa Community Based Services	Seneca Family of Agencies
Bruggeman	Jennifer	Mental Health Program Manager	Contra Costa County
Bullard	Clearnise	Program Administrator	Telecare Hope House
Bullock	Kenneth	Program Director, The Pathway	Crestwood Behavioral Health
Calloway	Vernon “Cal”	Health Services – IT Manager	Contra Costa County
Cannavino	Cristina “Tina”	Community Support Worker II, Mental Health	Contra Costa County
Carofanello	Nicholas	Accountant II, Finance	Contra Costa County
Cedermaz	Heather	Family Nurse Practitioner, Public Health	Contra Costa County
Celio	Christopher	Vice President of Clinical Programs and Interim Director of Training	Hume Center
Cesario	Melissa	Director of Outpatient School Based Services	Fred Finch
Chavez	Rudy	Business Intelligence Consultant	Contra Costa County

Last Name	First Name	Position	County or Contracted Agency
Corral	Jana	Chief Clinical Officer	Youth Homes
Darian	Arash	Mental Health Clinical Specialist, East County Adult Mental Health	Contra Costa County
Devlin	Shaunna	Community Support Worker, Mental Health	Contra Costa County
Dold	Amanda	Mental Health Program Chief	Contra Costa County
Down	Adam	Mental Health Project Manager	Contra Costa County
Fairchild	Victoria	Community Support Worker II, Office of Consumer Empowerment	Contra Costa County
Field	Stephen	Medical Director, Behavioral Health Services	Contra Costa County
Fuhrman	Beverly	Program Manager, East County Adult Mental Health	Contra Costa County
Gallagher	Ken	Research & Evaluation Manager	Contra Costa County
Gargantiel	Paolo	Mental Health Clinical Specialist	Contra Costa County
Giles	Amber	Mental Health Program Supervisor	Contra Costa County
Girardey	Brigette	Mental Health Program Supervisor, Central Childrens Mental Health	Contra Costa County
Gonzales	Petra	Mental Health Clinical Specialist, West County Children and Adolescent Mental Health Services	Contra Costa County
Hahn-Smith	Stephen	Behavioral Health Informatics Chief	Contra Costa County
Harvey	Jasmine	Planner/Evaluator – QI/QA	Contra Costa County
Hernandez	Elizabeth	Asst Dir Safety & Perf Improve	Contra Costa County
Huffman	Benjamin	Mental Health Clinical Specialist, Older Adult Mental Health	Contra Costa County
Iacuaniello	Byron	Clinical Director, Community Based Services	Youth Homes

Last Name	First Name	Position	County or Contracted Agency
Jackson	Ryan	Program Director, Bridge	Crestwood Behavioral Health
Jacob	Jean	Mental Health Project Manager, QI/QA	Contra Costa County
Johnson	Kennisha	Mental Health Program Chief of Housing Services	Contra Costa County
Kekuewa	David	Health Services System Analyst I, Alcohol and Other Drug Substance	Contra Costa County
Kersten	Melissa	Quality Improvement Coordinator	Contra Costa County
King	Amber	Community Support Worker II, Central County Mental Health	Contra Costa County
Kuzio	Amanda	Mental Health Clinical Specialist, Mental Health	Contra Costa County
Lam	Daisy	Mental Health Program Supervisor, West County Adult Mental Health	Contra Costa County
Lardner	Matt	Health Services Planner/Evaluator	Contra Costa County
Lee	Hazel	Mental Health Clinical Specialist	Contra Costa County
Loenicker	Gerold	Mental Health Program Chief	Contra Costa County
Matal Sol	Fatima	Alcohol and Other Drugs Program Chief	Contra Costa County
Mendoza	Floris	Mental Health Program Supervisor	Contra Costa County
Messerer	Mark	Program Manager, Alcohol and Other Drug Substance	Contra Costa County
Mudd	Alanna	Community Support Worker I, Forensic Mental Health	Contra Costa County
Newfield	Jennifer	Mental Health Clinical Specialist, Mental Health	Contra Costa County
Ny	Faye	Health Services Reim Accountant	Contra Costa County
Nybo	Erik	Contract Employee, Information Technology	Contra Costa County
Orme	Betsy	Program Chief, Adult and Older Adult Mental Health	Contra Costa County

Last Name	First Name	Position	County or Contracted Agency
Owens	Renee	Community Support Worker II, West County Mental Health	Contra Costa County
Pedraza	Christopher	Mental Health Project Manager	Contra Costa County
Pena	Jorge	Sharecare and PSP/Insyst Support Analyst, Information Technology	Contra Costa County
Perata	Elyse	Mental Health Program Supervisor	Contra Costa County
Peterson	Todd	Health Services Planner Evaluator, Informatics	Contra Costa County
Pleasant	Daphne	Chief Executive Officer	Embrace Mental Health
Rahimzadeh	Ziba	Director – Provider Relations and Credentialing	Contra Costa County
Ransom	Kelly	Director of Mental Health Services	We Care Children
Razon	Danelyn	Accountant III, Finance	Contra Costa County
Rice	Megan	Project Manager, contract employee, Information Technology	Contra Costa County
Robinson	Kirsten	QA Coordinator	Bay Area Community Resources
Rodgers	Kimberly	Community Support Worker II, Mental Health	Contra Costa County
Sanabria	Bernardita	Program Supervisor, East County Adult Mental Health	Contra Costa County
Scannell	Marie	Program Chief, Forensic Mental Health Services	Contra Costa County
Schilling	Lisa	Chief Quality and Integration Officer	Contra Costa County
Shirgul	Ellen	Mental Health Program Supervisor, Older Adult Mental Health	Contra Costa County
Skallet	Maria	HS Education & Training Spec	Contra Costa County
Spikes	Chet	Assistant Director, Business Systems	Contra Costa County
Tameltas	Ates	Assistant IT Director, Clinical Systems	Contra Costa County

Last Name	First Name	Position	County or Contracted Agency
Tavano	Suzanne	Behavioral Health Director	Contra Costa County
Tighe	Thomas	Mental Health Program Manager, Hospital & Health Services	Contra Costa County
Tran	Loan	Mental Health Clinical Specialist, West County Adult Mental Health	Contra Costa County
Tuipulotu	Jennifer	Mental Health Consumer Empowerment Program Coordinator	Contra Costa County
White	Katy	Chief of Managed Care	Contra Costa County
Winschell	Sara	Office Manager	Crestwood Pleasant Hill
Zesati	Genoveva	Workforce Education and Training/Ethnic Services Coordinator	Contra Costa County

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP submitted the FUM BHQIP for its clinical PIP. Contra Costa's goal is to improve follow-up in 7 and 30 days for adults seen for mental health in the ED. The intervention was focused on clients who sought care at CCRMC or Kaiser Richmond and had not received services from the MHP previously. Medical Social Workers at the hospitals link clients to the Access Line to schedule a follow-up appointment. Social Workers were provided with a prompt hidden in the Access Line phone tree so their call could be prioritized, and they receive a quicker response. The intervention should allow clients to be discharged from the ED with a scheduled follow-up appointment. The MHP started the interventions in September and October 2023. The PIP does not yet include data or analysis.
General PIP Information	
MHP/DMC-ODS Name: Contra Costa	
PIP Title: Follow-Up After ED Visit for Mental Illness	
PIP Aim Statement: "The goal of this PIP is to increase the percentage of adults with an MH condition, who are not open to SMHS, who receive a 7-day follow-up appointment following ED discharge from 29.8 percent to 35 percent and increase the percentage who receive a 30-day follow-up appointment from 37.5 percent to 43 percent by September 30, 2023."	
Date Started: 09/2022	
Expected Date Completed: 09/2024	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Adult clients with a MH condition who sought care at Contra Costa Regional Medical Center (CCRMC) or Kaiser Richmond ED who had not received SMHS from the MHP previously.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): ED Social Workers at CCRMC and Kaiser Richmond assist clients not already open with SMHS to connect with Access Line to schedule a follow-up appointment within 7-days. The MHP will ensure Spanish-speaking clients will be able to speak with a Spanish-speaking clinician at the Access Line or receive interpretation services. For speakers of other languages, the MHP will similarly ensure interpretation is available if staff cannot directly meet their language needs.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Number of universal referrals received through the referral tracking system.	8/21/23-11/21/23	n=2	☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2. Number of calls to Access Line from EDs to link clients to follow-up care.	8/21/23-11/21/23	n=2	☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3. Number and percent of appointments scheduled within seven days of ED visit.			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 4. Number and percent of appointments scheduled within 30 days of ED visit.			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 5. Number and percent of ED visits that received a mental health follow-up within 7-days.			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 6. Number and percent of ED visits that received a mental health follow-up within 30-days.			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Track how many clients require interpretation and for what language. • Investigate and address why not all clients who were eligible were referred to a Social Worker for linkage to the Access Line.

Non-Clinical PIP

Table C2: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	The goal of this non-clinical PIP is to decrease no shows to first assessment appointments at the MHP's East Adult regional clinic. The PIP interventions included a reminder call from the therapist containing a "gain-framed" message, providing automated Artera appointment reminders, and offering an on-demand clinical assessment by the Access Line. The PIP demonstrated statistically significant improvement in the no-show rate to initial assessment appointment from a baseline of 24 percent to 16 percent. There was improvement in the percent of appointments a therapist receives a reminder text to provide a reminder call, percent of appointments that are provided a warm call reminder, and percent of clients successfully reached.
General PIP Information	
MHP/DMC-ODS Name: Contra Costa	
PIP Title: Gain-framed Provider Reminder Calls to Reduce No Shows to Initial Assessment Appointments	
PIP Aim Statement: "Will providing clients with a reminder call from their therapist containing a "gain-framed" message, and providing automated Artera appointment reminders, and offering on-demand clinical assessment by the Access Line, significantly decrease no shows to initial assessment appointments at the East Adult clinic to be no higher than 15 percent within two years of the launch of the PIP."	
Date Started: 11/2021	
Expected Date Completed: 03/2024	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): East clinic adult clients.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Warm reminder call with "gain-framed" message.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Therapists received a reminder text message to make a warm call to scheduled members.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Automated Artera reminders, Access Line Clinical Assessments.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Number and percent of appointments for which a therapist receives a reminder text to provide a reminder call.	11/18/21-12/2/21	47/50 47 reminder texts 94 percent of appointments	11/19/22-11/17/23	1006/1045 96 percent	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): *p* =.49

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2. Number and percent of appointments which are provided a warm call reminder.	11/18/21-12/2/21	14/50 14 reminder calls 28 percent of appointments received reminder call	11/19/22-11/17/23	728/1059 69 percent	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify): *p* <.0001
PM 3. Number and percent of clients successfully reached (therapist talked with direction).	11/18/21-12/2/21	4/50 4 clients talked to 8 percent of scheduled clients	11/19/22-11/17/23	343/1335 27 percent	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify): *p* = .003
PM 4. No show rate to initial assessment appointment.	11/18/21-12/2/21	313/1292 24 percent	11/19/22-11/17/23	203/1268 16 percent	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify): *p*=.0001
PM 5. Number and percent of clients getting an automated seven-day reminder.	10/5/22-10/18/22	1/35 3 percent	11/19/22-11/17/23	350/1268 28 percent	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not provided
PM 6. Number and percent of clients getting an automated one-day reminder.	10/5/22-10/18/22	31/35 89 percent	11/19/22-11/17/23	1011/1268 80 percent	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): NA

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 7. Number of clients receiving a clinical assessment at the time-of-service request from Access Line.	11/19/22-11/17/23	2/1268 .2 percent			☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): NA

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First remeasurement ☒ Second remeasurement ☐ Other (specify):

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

- Spread the interventions to other clinics/areas, as applicable.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, PIP Validation Tool, and CalEQRO Approved Claims Definitions are available on the CalEQRO website: CalEQRO website

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required as part of this report.

MEMORANDUM

FROM: Contra Costa Mental Health Commission, Quality of Care Committee

TO: Dr. Suzanne Tavano, Director, Behavioral Health Services
Priscilla Aguirre, Quality Management Program Coordinator, Behavioral Health Services
EQRO Site Review Team

DATE: January 20th, 2024

RE: Questions regarding Contra Costa Behavioral Health Services 2022-2023 External Quality Review Organization Report

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This document presents questions from the Quality of Care Committee of the Mental Health Commission regarding the 2022-2023 External Quality Review Organization (EQRO) report for the Contra Costa Behavioral Health Services (BHS).

- In September 2023, Pricilla Aguirre presented the EQRO report to the Mental Health Commission.
- During October and November of 2023, the Quality of Care Committee reviewed the report more deeply and had several questions, which are provided below.
- During January, 2024, the Committee finished the write-up of the questions.

The Quality of Care Committee would like to receive a written response to the questions, and a follow up committee meeting for clarifications and discussion. We are targeting the Quality of Care meeting on March 21, 2024 for this discussion.

Note that Section I contains questions for BHS whereas Section II contains questions directed to both BHS and the EQRO site visit team.

I. Questions for BHS

1. In the section about Med-Cal claiming, there is a reference to a "claim lag" of $20,852,975. In the accompanying table there is a column on "disallowances" that amounts to $3,756,880. What is this disallowance? (pgs. 55-57)

2. What are BHS targets for Penetration Rate (PR) and Average Approved Claim Benefit (AACB) for 2023? For: Adults, children, foster care, ethnicities. How will BHS achieve these targets? While BHS outperformed other counties this past year, we still need to see the targets for 2023-2024.

3. What are the implications for a higher AACB versus a lower AACB? (pages 22+)

4. In the table on “Units of Service Delivered to Adults” (page 31) there is data showing that BHS underperforms other counties in several ways (see bullet points on page 31-32. What are the causes of the underperformance and how are they being addressed?

5. What is being done to finally implement direct data entry by CBO’s to Electronic Health Records? This effort has been going on for a very long time. (page 8)

6. What is the current tally of total number of hired clinical staff and key management and support staff versus the number of empty slots for each type of staff (e.g. psychiatrists, therapists, psychiatric nurses, department managers) (page 12)

7. Did the Sharecare to ccLink system happen yet (page 13)

8. Have the new CalAIM contract templates and process been developed yet? When will implementation start?

9. How does the Access Line program virtual assessment process work? E.g are there clinical staff on hand to do assessments at any time that the Access Line is open? At what point will a full assessment in person be done? (page 13)

10. What is the thinking behind the notion that a higher percentage of beneficiaries will respond to the race/ethnicity question via the Access Line? Why would someone be more willing to respond in this environment. Because they are not face-to-face? Is there data yet on whether is a higher response rate? (page 14)

11. How is East County operating with only 3 clinical health specialists? What are the typical reasons why staff are leaving? (page 15) Have there been exit interviews for candid feedback?

12. What are the current wait times and wait lists for services after initial assessment? It sounds like a major strategy for decreasing wait times is ongoing reassessment of individual’s needs as they wait. This sounds a little like off-loading and kicking-the-can down the street. What number of individual’s are shifted to another provider or found to be no longer in need of treatment for both adults and children? Don’t other providers have wait lists too? (page 15)

13. How does “brief therapy” affect outcomes compared to BHS standard therapy approach. Does it provide better, same or worse outcomes? The number of brief therapy sessions offered are “five to six”. Can such a small number of sessions be effective? How long are the standard (non-brief) therapy treatments? How long has BHS been using this strategy? (page 16)

14. Why haven’t more financially competitive compensation packages been offered yet? What is the hold up? We are in a crisis that will be improved by appropriate incentives. What is the retention rate for clinical staff? Do we know why staff stay? (pages 16 and 21)

15. Despite the multiple channels of obtaining beneficiary feedback, focus groups show that beneficiaries don't all feel like they have a feedback avenue. MHSA feedback seems to deal more with preferences regarding needs to be addresses, not specific feedback to interactions with the BHS mental health system of care / delivery system. What other more direct ways are being considered? (page 17)

16. BHS indicates that it obtains stakeholder feedback on specific plans under development, including the Mental Health Commission (MHC). The MHC, in fact, did not provide critical input to "specific plans that are underway" during 2022-2023. It hasn't provided meaningful "input and involvement" in System Planning and Administration in this period. It was very rarely (if at all) informed that plans were at a juncture requiring MHC feedback. How will BHS remedy this serious problem? What kind of process can be designed to ensure that the MHC is kept apprised of plan progress and key points of community input? (page 17)

17. Do we know anything more about beneficiaries who are receiving tele-health services other than age range? Do we know why some consumers choose tele-health services? Is it strictly convenience and no drive? (page 19)

18. How does East County have services that meet the network adequacy benchmarks given such factors as low capacity due to difficulty in staffing? A facility may be within driving range, but if they don't have enough capacity, do they really qualify to be in the network? (page 20)

19. To improve access, BHS performs MONTHLY follow up all to beneficiaries that have been assessed but are waiting for treatment. How is this acceptable and doesn't it conflict with the Access Key Component "1D"? (page 21)

20. The responses from focus groups regarding wait times for initial intake and assessments is ambiguous and at times inconsistent with the report narrative. Are these times being tracked on? What is the target benchmark? (page 21)

21. What is the average wait time for receiving treatment (including seeing a psychiatrist where indicated) once assessment is complete? (page 21)

22. Is the list of consumers on a wait-list prioritized e.g. by urgency?

23. Is there a measure for improvements in transportation and the effectiveness of the dollars spent? How much transportation is actually supported and is transportation support managed?

24. How do assessments and treatment occur for people who do not have transportation and cannot or do not want to do tele-health?

25. Why are adult "per minute service" percentages so much lower than state levels for: Crisis Intervention, Mental Health Services and Targeted Case Management? (page 31)

26. Why is the Foster Care percentage so much lower in Intensive Home-Based Services? Why is it so much HIGHER in Targeted Case Management? (page 32)

27. How does BHS sometimes provide planned mental health services prior to the completion of assessment and diagnosis? How does this work?

28. In terms of timeliness measures, the percentage of "met standard" for First Non-Urgent Psychiatry Appointment Offered and Follow-Up appointments after Psychiatric Hospitalization is well below that of the states (81.9% and 45.8% respectively). Is this all due to staffing shortages? Are there no other process/systemic reasons behind these findings? (page 36)

29. Why are wait times for foster care so high (33 days) ? Wait times for other children are not as high, but are high as well. What are the reasons for this? Is this all due staffing of pediatric clinical staff or are there other factors as well?

30. Why are "no show rates" so high for both beneficiaries AND clinicians? (page 36)

31. The CY 2021 quality assessment and performance improvement (QAPI)
fully met 65% of actions, partially 16% and 19% not met. What is being done to improve upon this quality of care effort? (page 39)

32. Staff input was obtained in a recent survey. However, there doesn't appear to be adequate communication throughout the year, particularly during budgeting, that staff input is actively requested/required. How can BHS culture develop more of a flow of ideas from staff to management in operations and provision of services? What kind of input is requested and when; what kind of input is offered; and do staff feel secure enough to speak up? What are the results of the staff survey? (page 40-41)

33. The CBO's are a critical stakeholder group. What kind of quality improvement input is requested and shared with CBOs? What happens at luncheons? Is there any formal mechanism for exchange? How can greater exchange occur? (page 40)

34. What are the plans for improving medication management, including closing the gap with CBO's and labs? (page 41)

35. How will CalAIM processes be seamless with CBO's? Do CBO's have their own CalAIM training?

36. What is BHS doing to continue to decrease the cost of high cost beneficiaries?

37. What is BHS doing to increase claims acceptance / reduce claim denials? What is the target? (page 55)

38. A focus group gave feedback that there be a greater focus on “independence and employment” with less emphasis on “governmental assistance”, which was seen as dependency and reliance on the system. How will BHS respond to this critical beneficiary input? (page 59)

39. Under CONCLUSIONS/STRENGTHS there is a statement about IT, item 3) that is difficult to interpret. How does this breakdown? (page 62)

II. Questions for BHS and EQRO Site Review Team:

40. Summary of Key Components – 10 of 26 not met. How is this acceptable?

41. The IMPACT OF ACCESS FINDINGS section, none of the deficits found in the section are articulated. Why is this?

43. In the QUALITY KEY COMPONENTS section, 6 out of 10 key components are partially met. Why is there not more elaboration of this performance? (page 40)

44. How can there no impact by the unmet standards of the timeliness measures? (page 38)

File #: 24-2135 **Agenda Date:** 7/18/2024 **Agenda #:** IX

Advisory Board: Mental Health Commission Quality of Care Committee
Subject: 2024 Goals and Priorities
Presenter: Cmsr. Barbara Serwin

ATTACHMENT D: Quality of Care 2024 Projects

MHC Quality of Care Committee Projects:
Project Activity and Action Items as of March, 2024

1. Review and advocate for Contra Costa K-12 public school mental health services

    - Work 2023:
        - Background literature review on mental health issues, needs and services in K-12 schools at national and state levels
        - Learning about and tracking on the Student Behavioral Heal Incentive Program (SBHIP) developments
        - Tracking on the Wellness in Schools Program (WISP) activities

    - Work for 2024 and Action Items:
        - Continue literature review
            - Update research with 2023 developments
            - Bullet key findings as a resource
        - Tracking on the Student Behavioral Heal Incentive Program (SBHIP) developments
            - Continue tracking through end of project early 2025
            - Determine objective of advocacy, e.g. for continued funding if needed
            - Determine what to report out and to whom, e.g. update to BHS and BOS
            - Draft report and take advocacy steps (or is this early 2025?)
        - Tracking on the Wellness in Schools Program (WISP) activities
            - Continue tracking and linking in to WISP activities
        - Broaden effort to non-SBHIP K-12 county school districts
            - Determine objectives, contacts, how to research, and action plan

2. Improve protocol and implementation of protocol for finding missing persons/consumers (new project)

    - Work for 2024
        - Review current protocol/process
        - Reach out to stakeholders
        - Identify challenge areas, e.g. understaffing and need for additional training
        - Develop recommendations

3. Continue evolving the MHC Site Visit Program

    - Work 2022 - 2023:
        - Developed purpose, process, and interview questionnaires
        - Obtained inventory of existing county-contracted sites
        - Tested beta program with Hume
        - Conducted three additional site visits: Crestwood Our House, Crestwood Bridge, Hope House
        - Collaborated with MHSA team to conduct and report on student interviews at Vicente High School

- Work for 2024 and Action Items:
  - Assess pro's and con's and best options for continued collaboration with MHSA on research
  - Identify next priority sites
  - Conduct two site visits
  - Refine process for publishing and following up on reports
  - Publish existing reports more broadly, e.g. to BOS, and verify that BHS is reviewing

4. Create plan for routine, annual or semi-annual site visits to Psyche Emergency Services (PES), Children's Crisis Response (CCR), CCRMC Inpatient Psychiatric Services, Martinez Detention (with Justice Committee), West County Detention (with Justice Committee)

   - Work 2023:
     - Visited all sites: Psyche Emergency Services (PES), Children's Crisis Response (CCR) (incomplete and external), CCRMC Inpatient Psychiatric Services, Martinez Detention (with Justice Committee), West County Detention (with Justice Committee)

   - Work for 2024 and Action Items:
     - Decide on frequency of visits, minimum number of Commissioners, purpose/objective, minimum report
     - Schedule, recruit and visit sites

5. Lead review of annual EQRO report

   - Work for 2024 and Action Items:
     - Complete review process for 2023 report
     - Analyze report and develop questions
     - Follow up on questions and any actions taken
     - Host full Commission EQRO report out, with focus on challenges

6. Continue to advocate for adequate capacity of in-patient treatment beds in county-accessible mental health residential facilities

   - Work 2022-2023:
     - Advocated for an inventory of existing placements and a needs analysis
     - Tracked on grant proposals and proposal outcomes
     - Advocated for more resources for grant writing for BHS

   - Work for 2024 and Action Items:
     - Review factors leading to grant proposal performance
     - Track on proposed projects that have funding
     - Track on number of treatment beds actually created
     - Advocate for analysis of assessment of future needs

7. Continue to track on Children's Crisis Response Center

    - Work 2022-2023:
        - Reviewed plans when made accessible – minimal advocacy possible
        - Toured exterior of incomplete facility

    - Work for 2024 and Action Items:
        - Obtain, review and respond to current CCRMC plans for programs and services
        - Track on completion of facility
        - Consider improvements needed once facility launches
        - Track on outcomes once facility opens

8. Track on expansion of Psych Emergency Services (PES)

    - Work to date years up through 2023:
        - MHC has advocated persistently for over a decade for the expansion of PES and a separate area or facility for children's crisis response
        - In 2023 we heard a few brief, sporadic updates on the current expansion; we had no opportunity for input

    - Work for 2024 and Action Items:
        - Organize presentation to full Commission on plans
        - Track on progress through CCRMC
        - Determine desired input and communicate with CCRMC

9. Track on Mobile Crisis Response

    - Work 2023:
        - Heard presentation from A3 at a full Commission meeting

    - Work for 2024 and Action Items:
        - Track on A3 and identify key questions
        - Organize presentation to full Commission