CONTRA COSTA
MENTAL HEALTH COMMISSION

CONTRA COSTA
MENTAL HEALTH
COMMISSION
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Mental Health Commission (MHC)

Wednesday, June 2nd, 2021 ◊ 4:30 pm - 6:30 pm

VIA: Zoom Teleconference:

https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195
Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

AGENDA

I. **Call to Order/Introductions**

II. **Public Comments**

III. **Commissioner Comments**

IV. **Chair Comments/Announcements**

V. **APPROVE May 5th, 2021 Meeting Minutes (5 mins)**

VI. **"Get to know your Commissioner" (5 mins)**
- **Commissioner Graham Wiseman, District II**
- **Commissioner Leslie May, District V**

VII. **RECEIVE Presentation of External Quality Review Organization (EQRO) Report, Priscilla Aguirre, MPP, Quality Management Program Coordinator, Quality Improvement & Assurance Unit, Contra Costa County (25 mins)**

VIII. **RECEIVE Behavioral Health Services Director's Report, presenting on behalf of Dr. Suzanne Tavano: Matthew Luu, Deputy Director of Mental Health and Jennifer Bruggeman, Program Manager of Mental Health Services Act (MHSA) (15 mins)**

IX. **RECEIVE Presentation on Site Visit Program, Commissioner Laura Griffin, Commissioner Leslie May, and Commissioner Barbara Serwin, Quality of Care Committee (15 mins)**

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Mental Health Commission (MHC) Draft Agenda (Page Two)

Wednesday, June 2, 2021 ◊ 4:30 pm - 6:30 pm

X. DISCUSS and VOTE on objection letter to Supervisor Candace Andersen, RE: proposed by-law changes in Section 4. VACANCIES AND RECRUITMENT, by Commissioners Graham Wiseman and Leslie May (10 mins)

XI. DISCUSS and VOTE on proposed new By-law on excused absence from MHC meeting due to unforeseen, extraordinary circumstances, Commissioner Leslie May, Contra Costa County Mental Health Commission (10 mins)

PROPOSED LANGUAGE (Added as Section 2.1b in **bold**):

Section 2.1b is proposed language for a new by-law regarding excused absences from Commission meetings. It is in red font. The other text is pre-existing by-law language for context.

2.1 Attendance requirements

a) Regular attendance at Commission meetings is mandatory for all Commission members.

i) A member who is absent from four (4) regularly scheduled Commission meetings in any calendar year shall be deemed to have resigned from the Commission. In such event the former Commission member 's status will be noted at the next scheduled Commission meeting and shall be recorded in the Commission 's minutes. The Chairperson shall, without further direction from the Commission, apprise the Board of Supervisors of the member 's resignation and request the appointment of a replacement

ii) Each Commissioner will ensure that when s/he attends Commission-sponsored meetings (excluding Commission and Commission Committee meetings) or activities representing her/himself as a Commissioner, s/he expresses only those views approved by the Commission.

b) A Commissioner's absence from a regularly scheduled Commission meeting may be excused in the case of an unforeseen, extraordinary circumstance, including but not limited to major illness, natural disaster, or civil unrest. Commissioners shall obtain consent from the Chair at least one day prior to the meeting that will be missed for any planned absence. Excused absences will be recorded in the meeting minutes as "excused absence".

XII. Adjourn

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FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

CONTRA COSTA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

February 2 – 4, 2021

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INTRODUCTION

The United States Department of Health and Human Services (HHS), 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). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO 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 Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review, or a desk review, of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also considers the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Contra Costa MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

MHP Information

MHP Size — Large

MHP Region — Bay Area

MHP Location — Martinez

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 14,764

MHP Threshold Language(s) — Spanish

CalEQRO obtained the MHP threshold language information from the DHCS Behavioral Health Information Notice (BHIN) 20-070.

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

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

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed Assembly Bill (AB) 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and BHINs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out-of-Network-Access (ONA), Alternative Access Standards (AAS), and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS BHIN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS reviews these forms to determine if the provider networks meet required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services for youth and adults. If these standards are not met, DHCS requires the MHP to improve the network to meet the standards or submit an AAS request. If approved by DHCS, CalEQRO will review the AAS and ONA information as part of its annual EQR.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

Validation of State and MHP Beneficiary Satisfaction Surveys

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed

definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met 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 Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2019-20

PIP Recommendations

- None.

Access Recommendations

Recommendation 1: Include Spanish language translation to the mental health pages of the county website through an embedded browser feature or by providing Spanish language links to services with descriptions and contact information.

Status: Not Met

- The MHP has discussed the embedded browser translation feature with the Contra Costa Health Services (CCHS) Office of the Director's

Webmaster but has decided that further information is needed before this can be implemented.

- The MHP offers printed translated materials to beneficiaries along with language access services offered through behavioral health staff, the county's language line and interpreter services, and community partner agencies.

Recommendation 2: Compare the offered bilingual differential to like-sized counties and adjust upwards to match industry standards.

Status: Met

- The MHP did a comparison with other Bay Area counties finding that Contra Costa County is close to industry standards.
- Bilingual differentials are documented in the memorandums of understanding between the labor unions and the MHP, the rate is not decided at a division or department level.

Timeliness Recommendations

Recommendation 3: For children, 64.78 percent of first offered appointments meet the 10-business day standard. The MHP must comply with the DHCS timeliness metric as per BHIN 18-011.

Status: Met

- The MHP adjusted staffing in the regional children's clinics and reorganized staff schedules so that 99.4 percent of beneficiary appointments met the 10-day timeliness requirement.
- Clinic managers receive bi-weekly reports on timeliness and availability of appointment slots allowing them to adjust schedules to meet standards.

Recommendation 4: Include contractor data in timeliness reports and demonstrate use of aggregate reporting for capacity management.

Status: Met

- The MHP created a report tracking timeliness of services so that providers can engage in corrective action to improve timeliness standards. The report is used as a performance measure to determine whether funding needs to be adjusted (to create additional capacity) or what other actions need to be taken to improve timely access to care.

Recommendation 5: The MHP should improve the FY 2018-19 rate (43.1 percent) of psychiatric appointments offered within 15 business days as per BHIN 18-011.

Status: Met

- The MHP met the standard of timely psychiatric appointments using a variety of interventions: increasing internal capacity and support, shifting and reviewing caseloads by stepping beneficiaries down to make room for new beneficiaries, utilizing tele-psychiatry, establishing a single case agreement with comprehensive psychiatric services to provide on demand psychiatric support to new beneficiaries, and providing a 20 percent compensation increase for independent contractor psychiatrists.

Recommendation 6: The MHP should improve the current rate (41.8 percent) of follow-up hospital discharge appointments that are within 7-days.

Status: Not Met

- The MHP analyzed 267 hospital discharges for FY 2019-20 and found inadequacies and gaps within their data.
- The MHP plans to work with IT to develop a mechanism that addresses the data gaps preventing accurate reporting of timeliness of hospital follow-up discharge appointments.

Quality Recommendations

- None noted.

Beneficiary Outcomes Recommendations

Recommendation 7: Prioritize and implement aggregate reporting for the Adult Needs and Strengths Assessment (ANSA), Pediatric Symptom Checklist (PSC-35), and Child and Adolescent Needs and Strengths (CANS-50).

Status: Met

- The MHP implemented an electronic data management system called Objective Arts for all contract providers completing the CANS-50 and PSC-35 so that providers now have immediate access to CANS-50 and PSC-35 reports for their programs.
- The MHP combines CANS-50 and PSC-35 data from its EHR (ccLink) with Objective Arts provider data producing a comprehensive report of all CANS-50 and PSC-35 assessments.

- The implementation for ANSA reporting was extended to December 2020 due to COVID-19.

Foster Care Recommendations

Recommendation 8: Prioritize credentialing for Community Based Organizations (CBO) offering children's services to allow for expanded access for FC youth.

Status: Partially Met

- The MHP convened a workgroup to address problems with the credentialing process. The workgroup compared the MHP's credentialing application forms with the forms of Alameda County, reviewed obstacles frequently cited by providers, reviewed requests by providers for accommodations due to COVID-19, and addressed some of the identified improvement opportunities.

- Provider Services reviewed application packets submitted between July 2019 and December 2019. Nearly half of all packets were incomplete. The workgroup had planned an intervention and improvement test in Spring 2020; however, shelter-in-place orders interrupted the testing project. Provider Services continued its regular communication practices with providers on best practices.

Recommendation 9: Finalize and implement the draft tool which specifically evaluates the fidelity of Intensive Care Coordination (ICC) and In-home Based Services (IHBS) in accordance with the Integrated Core Practice Model (ICPM).

Status: Met

- The MHP drafted a survey tool for beneficiaries, primary caregivers, and family members participating in Child Family Team (CFT) meetings and receiving ICC and IHBS. The survey is an opportunity to provide subjective feedback and information regarding the effectiveness of ICC services and CFT meetings.

- While responding to this recommendation the MHP reevaluated the survey tool deciding it was too lengthy. The newest version of the ICC/CFT survey tool is being reviewed by stakeholders to ensure that it's user friendly and reflective of the ICPM.

- The new survey tool will be implemented twice per year via mail with return postage. Additionally, an online version will be sent out via email. The initial implementation date is set for February 2021.

Information Systems Recommendations

Recommendation 10: Explore options to create interfaces with CBO EHRs to support electronic transmission of service data into ShareCare. This will eliminate the double data entry CBOs have to support to record services in both their own EHRs and the MHP's billing system.

Status: Not Met

- The MHP is pausing efforts on an interface between CBOs and the ShareCare billing system and will reevaluate after further analysis of the anticipated payment reform.
- This goal is closed and will not be carried forward.

Recommendation 11: Provide ShareCare training to CBO users on a regular monthly basis to increase their competence level working in the application.

Status: Met

- The MHP offers ShareCare training twice per month for both the MH and Alcohol and Other Drugs Services (AOD) systems of care. Due to the COVID-19 pandemic, trainings are now performed remotely via Zoom sessions. When it is safe to return to in-person trainings, the sessions will be offered at county training rooms with workstations for the end-users.

Recommendation 12: Ensure the CBO Authorizations Work Group reviews the utilization review workflow of approving/denying/pending CBO intake treatment plans for process improvement to reduce the likelihood of services entered by CBOs in ShareCare being flagged as unauthorized.

Status: Met

- The MHP formed a workgroup with CBO representatives to better assess problem areas, devise strategies for improvement, and implement corrective action steps.
- The MHP has created a frequently-asked-questions memo for CBO's to maintain clarity and consistency.

Structure and Operations Recommendations

Recommendation 13: Strengthen the IT unit by either hiring or appointing an appropriate staff member to an IT leadership position within the MHP. Increase Behavioral Health Systems (BHS) leadership presence and participation on both the IT Steering and Data Governance committees.

Status: Met

- The MHP was granted approval to hire a contractor who was hired and reports to the MHP Director. This person is a member of the leadership team and started in February 2021.
- The MHP currently hosts weekly ccLink executive sponsor meetings as well as quarterly steering committee meetings with members of IT and BHS to provide updates on meeting priority targets as well as to prioritize IT projects.

Recommendation 14: Implement a mechanism to track CBO communications and feedback along with MHP responses. Evaluate past attendance at bimonthly contractor meetings and improve attendance and/or increase participation.

Status: Met

- The MHP has weekly virtual meetings with providers to maintain continuity of communication and support. Attendance fluctuates between 40 and 50 participants. Meeting invites are sent via email, along with minutes from the prior meeting.

Recommendation 15: Identify and replace antiquated credentialing processes and implement a mechanism which holds credentialing staff accountable to best practices which do not delay direct service staff from providing services to beneficiaries.

Status: Met

- The MHP and a contracted consulting firm, FluidEdge, interviewed prospective individual and organizational candidates to serve as the credentialing software vendor.
- Due to COVID-19, the credentialing project was placed on hold. The MHP has resumed the contracting process expecting to finalize a contract with FluidEdge.

PERFORMANCE MEASURES

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to screenings, assessments, home-based mental health services, outpatient services, day treatment, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. SB 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf
2. EPSDT POS Data Dashboards: https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx
3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
   - 5A (1&2) Use of Psychotropic Medications
   - 5C Use of Multiple Concurrent Psychotropic Medications
   - 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure
4. AB 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as a presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf
5. *Katie A. v. Bonta*:
   The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act Suppression Disclosure

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

Table 1 provides details on beneficiaries served by race/ethnicity.

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Contra Costa MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	45,517	17.3%	3,790	25.7%
Latino/Hispanic	92,508	35.2%	3,973	26.9%
African-American	36,926	14.0%	2,946	20.0%
Asian/Pacific Islander	29,413	11.2%	684	4.6%
Native American	719	0.3%	67	0.5%
Other	57,876	22.0%	3,304	22.4%
Total	**262,957**	**100%**	**14,764**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

Table 2 provides details on beneficiaries served by threshold language identified in DHCS BHIN 20-070.

For FY 2020-21 CalEQRO utilized data from the DHCS Mental Health Services Division Information Notice 13-09, which was considered current policy on threshold languages. On December 14, 2020, DHCS issued BHIN 20-070 which utilizes more current Medi-Cal eligibility data to determine threshold languages. The MHP experienced no change in threshold languages during this period.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

Contra Costa MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	2,376	16.1%
Other Languages	12,388	83.9%
Total	**14,764**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

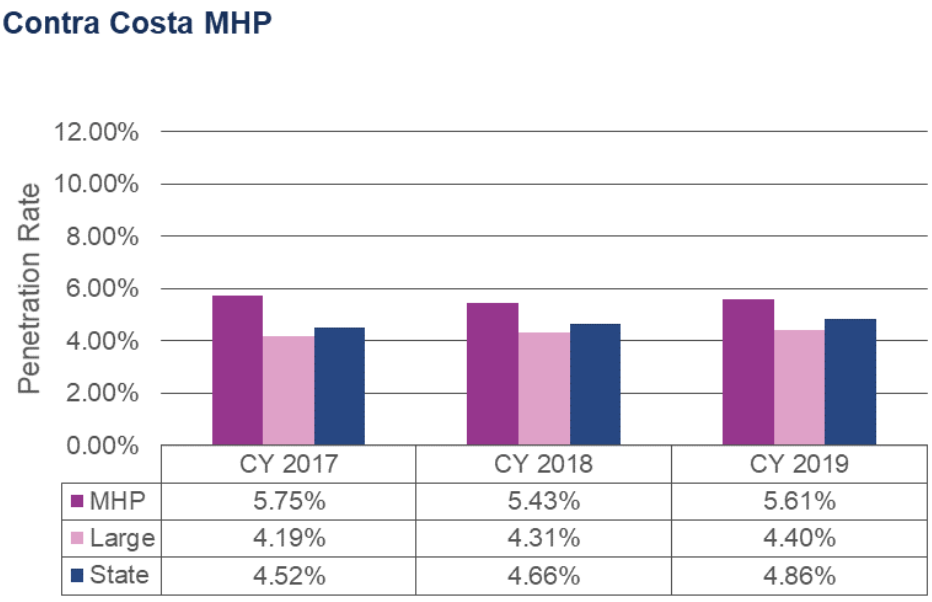
Penetration Rates and Approved Claims per Beneficiary

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2019. See Table D1 for the CY 2019 ACA penetration rate and ACB.

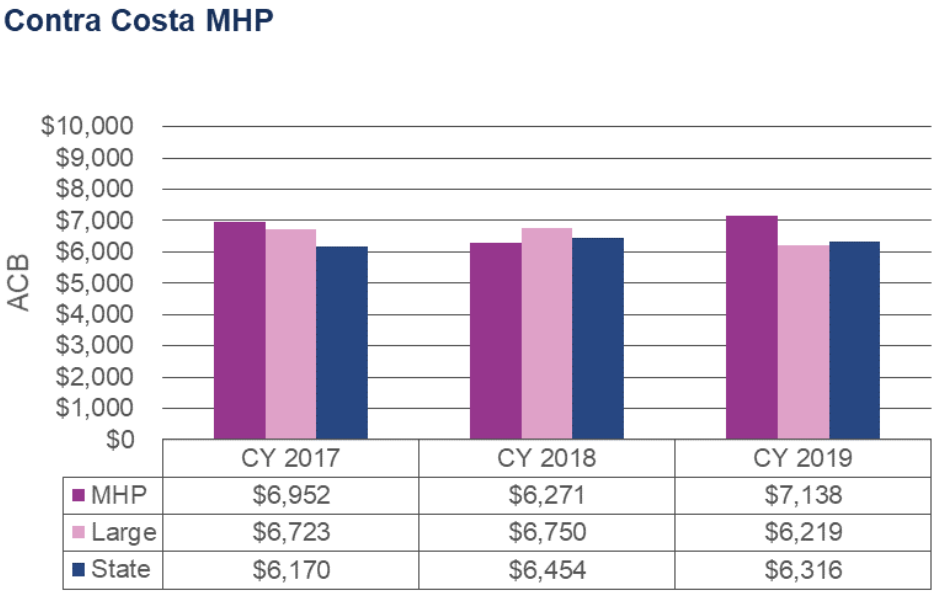
Regarding the calculation of penetration rates, the Contra Costa MHP uses the same method used by CalEQRO. Also, the MHP includes unbilled and unapproved claims. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	5.75%	5.43%	5.61%
Large	4.19%	4.31%	4.40%
State	4.52%	4.66%	4.86%

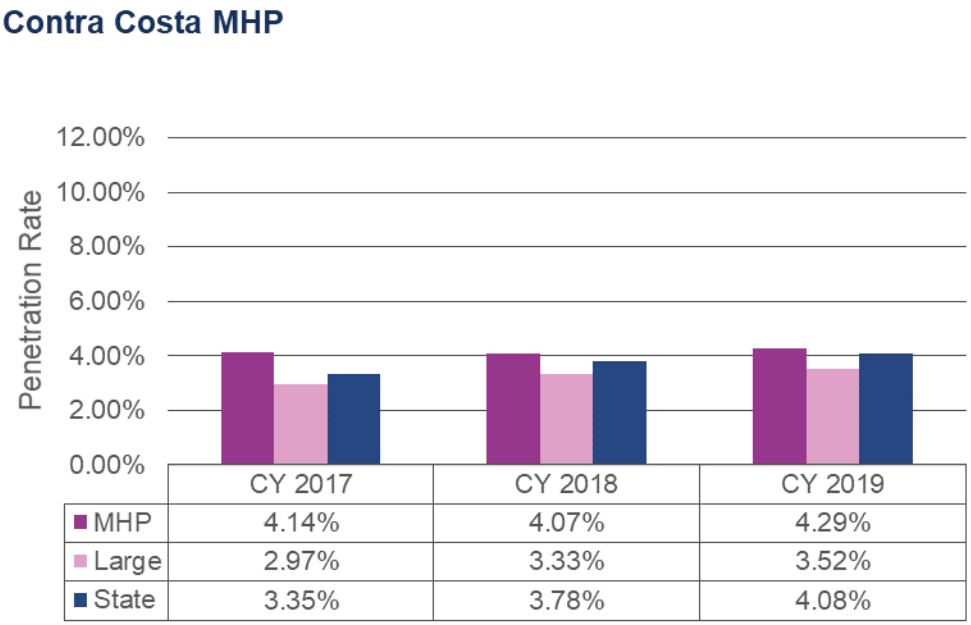
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$6,952	$6,271	$7,138
Large	$6,723	$6,750	$6,219
State	$6,170	$6,454	$6,316

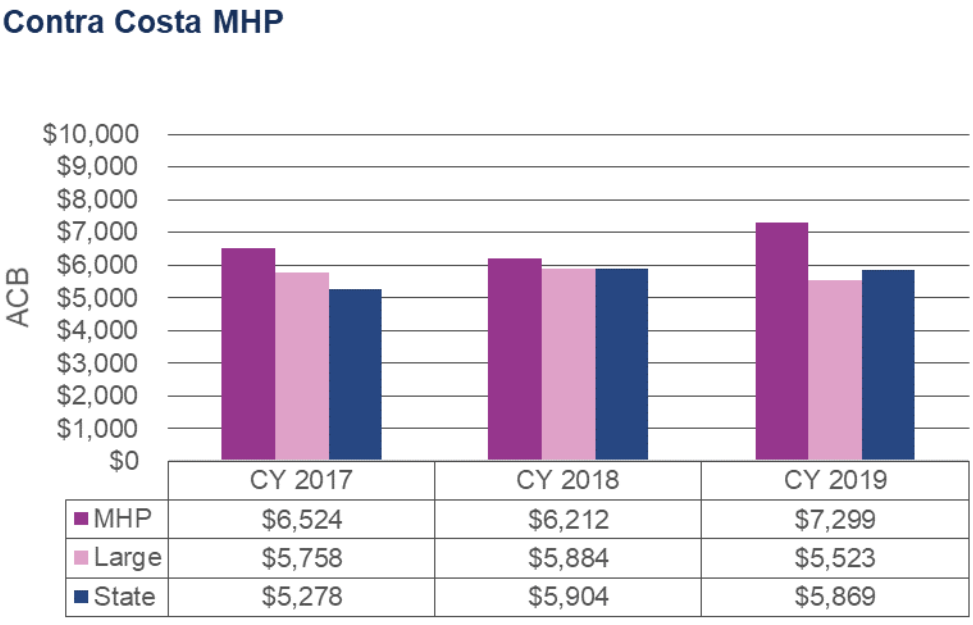
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	4.14%	4.07%	4.29%
Large	2.97%	3.33%	3.52%
State	3.35%	3.78%	4.08%

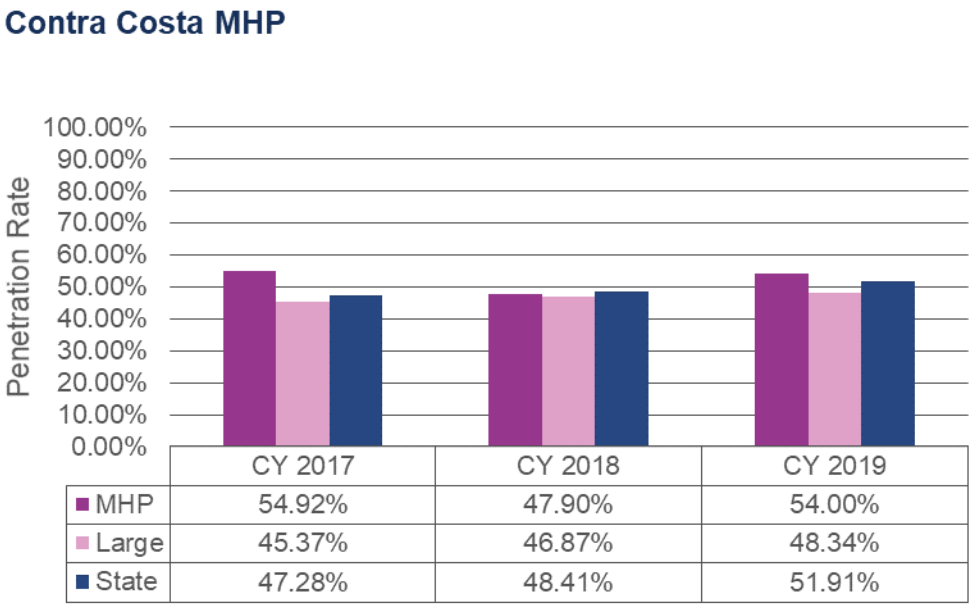
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$6,524	$6,212	$7,299
Large	$5,758	$5,884	$5,523
State	$5,278	$5,904	$5,869

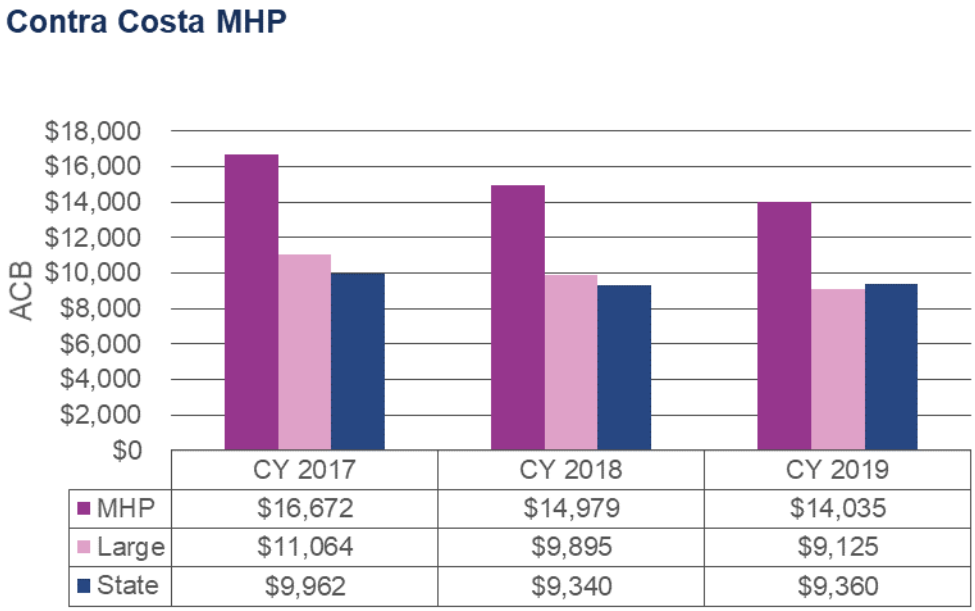
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	54.92%	47.90%	54.00%
Large	45.37%	46.87%	48.34%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

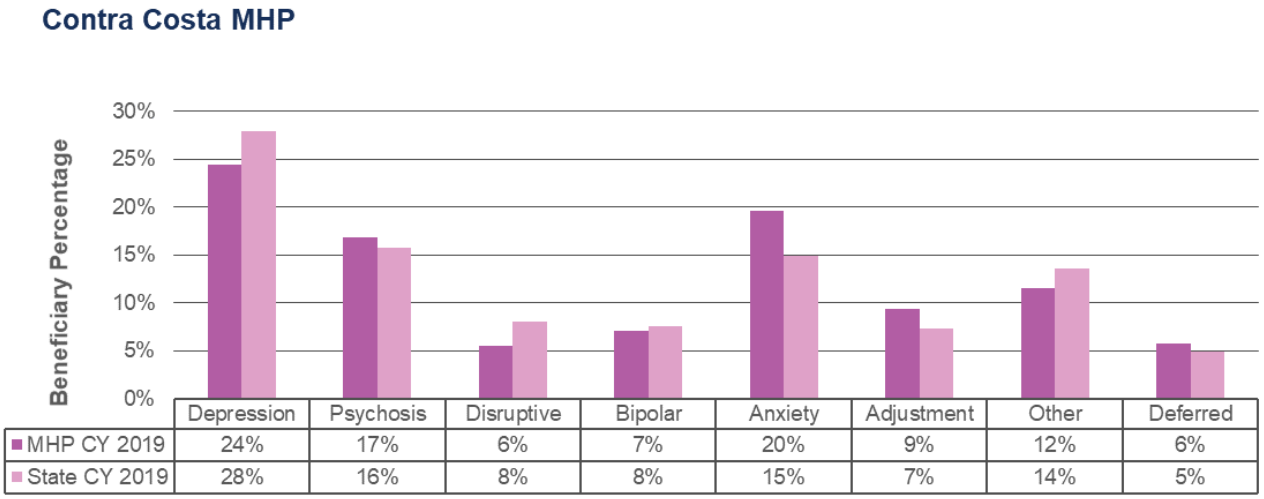


	CY 2017	CY 2018	CY 2019
MHP	$16,672	$14,979	$14,035
Large	$11,064	$9,895	$9,125
State	$9,962	$9,340	$9,360

Diagnostic Categories

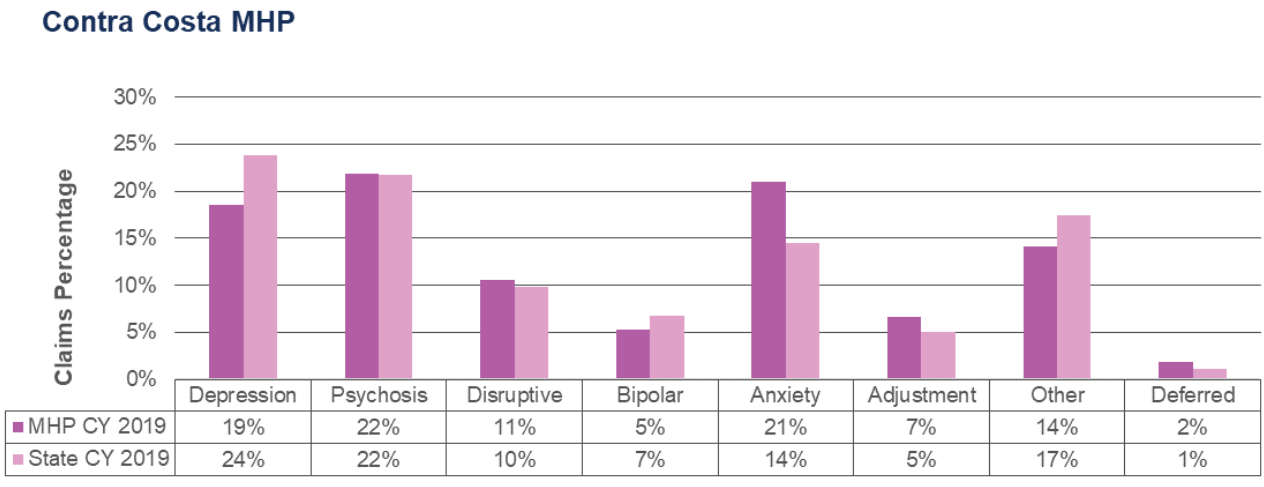
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	24%	17%	6%	7%	20%	9%	12%	6%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	19%	22%	11%	5%	21%	7%	14%	2%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

Contra Costa MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	721	14,764	4.88%	$60,069	$43,309,899	41.10%
	CY 2018	650	14,645	4.44%	$58,112	$37,772,499	41.13%
	CY 2017	840	15,883	5.29%	$56,388	$47,366,301	42.90%

See Attachment E, Table E1 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

Table 4: Psychiatric Inpatient Utilization CY 2017-19

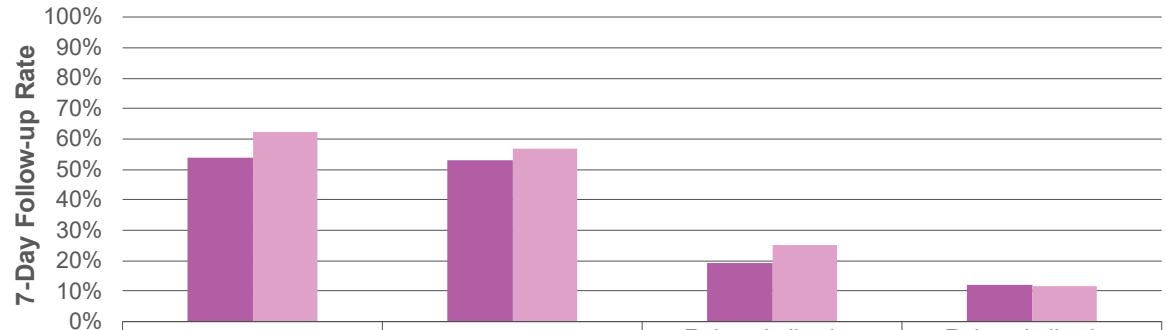
Contra Costa MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	1,011	2,133	7.39	7.80	$13,115	$10,535	$13,259,607
CY 2018	979	1,561	7.36	7.63	$14,497	$9,772	$14,192,149
CY 2017	947	1,941	6.23	7.36	$14,090	$9,737	$13,343,302

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19

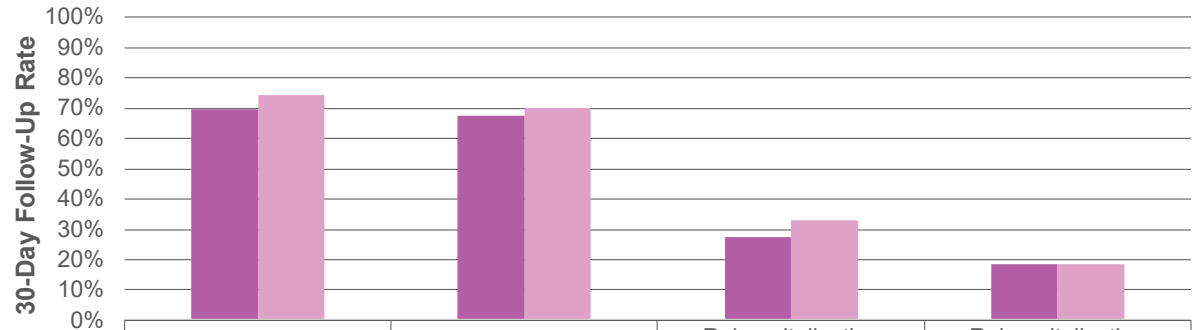
Contra Costa MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	54%	53%	19%	12%
CY 2019	63%	57%	25%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19

Contra Costa MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	70%	67%	27%	19%
CY 2019	74%	70%	33%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A mandatory EQR-Related activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

Contra Costa MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs and validated two PIPs, as shown below.

Table 5: PIPs Submitted by Contra Costa MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Addressing Depression and Anxiety Among Youth
Non-Clinical	1	Maintaining Client Services During a Pandemic and Shelter-In-Place Orders

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Contra Costa
PIP Title	Addressing Depression and Anxiety Among Youth
PIP Aim Statement	Will youth who participate in a Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) group via telehealth see a reduction of depressive symptoms by 15 percent and anxiety symptoms by 15 percent?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	

MHP Name	Contra Costa
Target age group (check one): ☒ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☐ 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): This PIP will focus on youth beneficiaries ages 12 to 18 who are receiving specialty mental health services at County operated clinics and have a trauma related diagnosis, such as post-traumatic stress disorder (PTSD), as well as a need in depression or anxiety as indicated by their most recent CANS-50 assessment." The MHP will be using the Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder Assessment (GAD-7) to evaluate depression and anxiety.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested 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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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): TF-CBT Group (03/2021) CANS-50 Tickler Report (11/2020)

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
% of beneficiaries who improve on depression score as indicated by: CANS-50 PHQ-9 % of beneficiaries who resolve need in depression at discharge	October 2018-October 2020	n=320 39.2% 42.4%	PIP is in Planning or implementation phase, results not available ☒ n/a[5]		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
% of beneficiaries who improve on anxiety score as indicated by: CANS-50 GAD-7 % of beneficiaries who resolve need in anxiety at discharge	October 2018-October 2020	n=320 34.1% 40.7%	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
% of beneficiaries who improve on social functioning score % of beneficiaries who resolve need in social functioning at discharge	October 2018-October 2020	n=320 25.6% 23.8%	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

[5] PIP is in planning and implementation phase if n/a is checked for all performance measures.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
					☐ No test of statistical significance	
Average difference between total needs at first CANS-50 and most recent CANS-50	October 2018-October 2020	0.58 average needs	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	

Was the PIP validated?	☒ Yes ☐ No

Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☐ Baseline year	
☒ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in __ months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☐ Planning phase	
☐ Other, inactive	Inactive, Developed in a Prior Year

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Validation rating:						
☐ High confidence[6] ☒ Moderate confidence[7] ☐ Low confidence[8] ☐ No confidence[9] Justification for validation rating: The PIP adheres to acceptable methodology; however, the parameters for beneficiary inclusion in groups is prohibitive if the beneficiary does not identify their experience(s) as trauma. Group members are required to have a trauma diagnosis. Also, long wait times for youth to gain access to group services and long periods of time between CANS-50 assessment may not yield a large sample size. The number of planned groups over the PIP's lifetime remains unclear. "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: • Broaden the parameters of the group to include beneficiaries who may not have a trauma-related diagnosis, but still experience mood or trauma related symptoms. • Specify and set goals for the number of groups held to achieve a representative population size.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: CalEQRO is in the process of scheduling a TA session to provide feedback on the submitted PIPs. As this was a desk review, a live session for PIP review was not held.						

[6] Credible, reliable, and valid methods for the PIP were documented.
[7] Credible, reliable, or valid methods were implied or able to be established for part of the PIP.
[8] Errors in logic were noted or contradictory information was presented or interpreted erroneously.
[9] The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Contra Costa
PIP Title	Maintaining Client Services During a Pandemic and Shelter-In-Place Orders
PIP Aim Statement	The aim of this PIP is to maintain the overall number of appointments (139,813scheduled appointments in 2019) at County-operated clinics during the COVID-19 pandemic.
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☒ 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): This PIP focuses on the entire population of the MHP. All beneficiaries will be offered their choice of appointment format.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested 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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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): Telehealth expansion 03/2020 Staff survey 7/2020 Beneficiary survey 7/2020 CCHS Vaccination Clinics 12/2020 All beneficiaries who receive services at County-operated clinics will be given the choice of having an in-person visit, a telephone appointment, or a video appointment via Zoom.

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Appointment volume	2019	Q1 33,885 Q2 36,146 Q3 35,363 Q4 34,419	2020 ☐ n/a	Q1 34,511 Q2 29,515 Q3 32,819 Q4 32,460	☐ Yes ☒ No -7.5%	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
						☒ No test of statistical significance

Appointment adherence	2019	Youth Canceled 14.80% No-show 16.40% Completed 68.80% Adult Canceled 19.20% No-show 21.90% Completed 58.80% Older adult Canceled 17.80% No-show 13.40% Completed 68.80%	2020 ☐ n/a	Youth Canceled 13.7% No-show 16% Completed 70.3% Adult Canceled 14.3% No-show 17.5% Completed 68.1% Older adult Canceled 13.5% No-show 10% Completed 76.4%	☒ Yes ☐ No Youth – number of completed appt -0.4 % Youth – completed appointment rate percent difference +2.2% Adult – number of completed appt +3.9% Adult – completed appointment rate percent difference +15.8% Older Adult – number of completed appt +1.6% Older Adult – completed appointment rate percent difference +11.0%	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): ☒ No test of statistical significance

Was the PIP validated?	☒ Yes ☐ No
Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☒ Baseline year	
☒ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in ___ months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☐ Planning phase	
☐ Other, inactive	Inactive, Developed in a Prior Year
Validation rating:	
☐ High confidence[6] ☒ Moderate confidence[7] ☐ Low confidence[8] ☐ No confidence[9] Justification for validation rating: PIP methodology was acceptable. A comparison of beneficiary choice in treatment modality would provide additional information on barriers to attendance. "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: For beneficiary choice, consider: • Track and report fidelity of appointment offer. Is this truly a beneficiary choice or is it impacted by staff preference, tool availability, or other factors? • Track, report and analyze cultural, gender and age choice differences.	

• Track choice by diagnostic group. • Track if beneficiaries are stable in appointment type preference. For service duration and frequency, consider: • Consider tracking if service duration changes from baseline across the choice options. For clinical outcomes, consider: • Incorporate thematic feedback from surveys in Plan Do Study Act (PDSA) quality approach or other processes. • Compare clinical outcomes such as psychiatric hospitalization, suicide risk factors and rates, and psychosis with appointment type.
The TA provided to the MHP by CalEQRO consisted of: • CalEQRO is in the process of scheduling a TA session to provide feedback on the submitted PIPs. As this was a desk review, a live session for PIP review was not held.

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system (IS) is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key ISCA Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site review.

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software licenses, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Contra Costa	2.00%	0.20%	0.10%	1.10%
Large MHP Group	n/a	2.81%	2.59%	2.88%
Statewide	n/a	3.58%	3.35%	3.34%

- Oversights in the FY 2019-20 report which listed the IT budget as 0.20 percent, and in the FY 2018-19 report as 0.10 percent when they should have been listed as 2 percent and 1 percent, respectively.
- The MHP's IT budget at 2 percent is lower than last year's Statewide average of 3.58 percent. This level of funding is an impediment to utilizing the IS systems in a manner that may provide robust data governance for management.

The budget determination process for information system operations is:

☐ Under MHP control
☒ Allocated to or managed by another county department
☐ Combination of MHP control and another county department or agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☒ Yes	☐ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If the BCP status is "No," the MHP uses an Application Service Provider (ASP) model to host the EHR system, which provides 24-hour operational support.	☐ Yes	☒ No
If the BCP status is "Yes," it is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP clearly identified as having responsibility for information security.	☒ Yes	☐ No
If no one within the MHP is identified as having responsibility for information security, the parent agency or county IT assumes responsibility and control of information security.	☐ Yes	☒ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☐ Yes	☒ No

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	29%
Contract providers	58%
Network providers	13%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	14	3	3	1
2019-20	15	0	2	2
2018-19	22	0	1	1

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	8	0	0	0
2019-20	8	0	2	2
2018-19	20.50	5	2	4.50

The following should be noted regarding the above information:

- The MHP org chart indicates that while there was a vacant Informatics position that would report to the BHS Director, an independent contractor has been hired who will start half-time in February 2021 and will transition to full-time later.
- There has been no change in IT and analytical staff staffing patterns.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by the MHP and does not account for users' log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	108	100	208
Clinical Healthcare Professional	516	87	603
Clinical Peer Specialist	39	0	39
Quality Improvement	11	0	11
Total	674	187	861

- The MHP is unable to differentiate CBO quality improvement staff from administrative staff; therefore, the numbers for administrative staff may include quality improvement staff.

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Large MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	14	37.85
Total EHR Users Supported by IT (Source: Table 17)	861	2084.00
Ratio of IT Staff to EHR Users	1:62	1:55

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☒ Yes	☐ No
The MHP utilizes an ASP model to support EHR operations.	☐ Yes	☒ No
The MHP also utilizes Quality Improvement (QI) staff to directly support EHR operations.	☒ Yes	☐ No
The MHP also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☒	☒	☐	☒
User profile and access setup	☒	☒	☐	☒
Screen workflow and navigation	☒	☒	☐	☒

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

The MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	136
Number of county-operated telehealth sites	10
Number of contract providers' telehealth sites	126
Total number of beneficiaries served via telehealth during the last 12 months	1,854
• Adults	1,012
• Children/Youth	691
• Older Adults	151
Total number of telehealth encounters (services) provided during the last 12 months:	5,905

- There were 866 telehealth services in languages other than English provided in the last 12 months.

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☒ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☐ To serve special populations (i.e., children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☐ To reduce travel time for beneficiaries
☐ To support NA time and distance standards
☒ To address and support Corona Virus Disease-2019 (COVID-19) contact restrictions

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐ Arabic	☐ Armenian	☐ Cambodian
☐ Cantonese	☐ Farsi	☐ Hmong
☐ Korean	☐ Mandarin	☐ Other Chinese
☐ Russian	☒ Spanish	☐ Tagalog
☐ Vietnamese	☐ n/a	

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Children and Adolescents	105
Adults and Older Adults	12
All Age Groups	9

Current MHP Operations

- Contra Costa uses a hybrid of ShareCare, Epic/ccLink hosted by CCHS IT. The MHP's CBOs use their own distinct EHRs.
- The MHP's EHR is Epic/ccLink for clinical documentation. It uses both Epic/ccLink and ShareCare for billing and state reports.
- The planning branch developed real-time dashboards to track in-person and virtual staffing, and personal protective equipment supplies being provided and used at BHS sites around the county.
- In September 2020, the MHP began a weekly Information Blocking Committee to develop a plan and timeline to meet the November 2020 deadline of sharing electronic health information with beneficiaries per the 21st Century Cures Act Final Rule and the Office of the National Coordinator (ONC) Health IT Certification Program regulations.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SD/MC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Epic/ccLink/Tapestry	Epic EHR and Tapestry Managed Care module	Epic	5	CCHS IT
ShareCare	BHS System of Care claims billing and payment posting for MH and AOD	The Echo Group	2	CCHS IT

- The MHP ended its support of The Echo Group's legacy product, Insyst/PSP, as it successfully transitioned to their ShareCare product to process billing.

Major Changes since Prior Year

- Implemented Provider Portal for all MH and AODS CBOs.
- Began sharing medical information and MH partnership plans with beneficiaries through MyChart in support of ONC 21st Century Cures Act.
- Implemented ANSA in ccLink and Objective Arts.
- Implemented Zoom telehealth video conferencing, same day assessment tools and screening in response to COVID-19.
- Completed CANS-50 improvements.
- Implemented physician navigation and assessment documentation improvements and utilization review checklist improvements.
- Implemented ccLink production upgrade to three times a year.
- Upgraded to current ShareCare production version 8.15.5.

- Implemented clinician-facing productivity dashboards.

The MHP's Priorities for the Coming Year

- Client Services Information (CSI) timeliness documentation and reporting.
- Timely production upgrades for ccLink three times a year.
- Maintain current ShareCare upgrades.
- Information blocking – ONC 21st Century Cures Act.

Other Areas for Improvement

- Provide sufficient resources to improve recruitment and retention of informatics and technology staff.
- Complete implementation of BH dashboards and the migration of custom databases.
- Display prominently the crisis/suicide hotline phone number on the MHP's main webpage.
- Improve access for beneficiaries by assuring that the webpage is presented in threshold languages (Spanish).

Plans for Information Systems Change

- A new system is in place (systems installed in past five years).

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	ccLink	☒	☐	☐	☐
Assessments	ccLink	☒	☐	☐	☐
Care Coordination	ccLink	☒	☐	☐	☐
Document Imaging/Storage	OnBase/ Hyland and Epic are Integrated	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	ccLink	☐	☐	☒	☐
Laboratory results (eLab)	ccLink	☒	☐	☐	☐
Level of Care/Level of Service	ccLink	☒	☐	☐	☐
Outcomes	ccLink	☒	☐	☐	☐
Prescriptions (eRx)	ccLink	☒	☐	☐	☐
Progress Notes	ccLink	☒	☐	☐	☐
Referral Management	ccLink	☒	☐	☐	☐
Treatment Plans	ccLink	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		11	0	1	0
FY 2019-20 Summary Totals for EHR Functionality:		11	0	1	0
FY 2018-19 Summary Totals for EHR Functionality:		11	0	1	0

Progress and issues associated with implementing an EHR over the past year are summarized below:

- The MHP is working to add components to the EHR: coordinated care management, care plans and beneficiary goals.
- The MHP will integrate CANS-50 and ANSA from Objective Arts into ccLink.
- The MHP continues to rely on a hybrid (paper and electronic) medical record model.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	12%	Weekly
Direct data entry into MHP EHR system by contract provider staff	88%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used

Type of Input Method	Percent Used	Frequency
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	0%	Not used

- Network Provider claims are processed through the ccLink Tapestry application and then services are interfaced to ShareCare for billing.
- CBO's do direct data entry (CSI demographic data) into the ShareCare billing system via a secure virtual private network connection.

The rest of this section is applicable: ☒ Yes ☐ No

Some contract providers have EHR systems, which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Data Transmission from Contract Provider to MHP

EHR Vendor	Product	Count of Providers Supported
Azalea Health Harmony	Azalea EHR	1
Clinivate	Clinitrack	1
Oregon Community Health Information Network	Epic	1
Exym	Exym	1
Formstack	Formstack	1
Seneca Family of Agencies	Seneca Intranet	1
Seneca Center	Beneficiary Database EHR	1
Welligent	Welligent	3

- Some primary care providers within CCHS share the same EHR as the MHP: Epic. Medical information is exchanged between CCHS and other

Epic customers through CareEverywhere; however, MH information is not exchanged.

Personal Health Record

The beneficiaries have online access to their health records through a personal health record (PHR) feature provided within the EHR, a beneficiary portal, or a third-party PHR.

☒ Yes ☐ No ☐ Implementation Phase

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☒ Yes	☐ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☒ Yes	☐ No
View list of current medications through portal.	☒ Yes	☐ No
Have ability to both send/receive secure text messages with provider team.	☐ Yes	☒ No

- The MHP reports that 4,281 beneficiaries have access to their PHR: MyChart, which is an Epic product.
- The PHR is a web-based application, so beneficiaries may access it both from all CCHS sites and by using their personal smartphone, tablet, or computer.
- The PHR has a feature that sends text messages to beneficiaries upon checking in for their appointment so they may more easily sign up for MyChart accounts.

Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

- ☐ Dimension Reports application
- ☐ Web-based application, including the MHP EHR system, supported by vendor or ASP staff
- ☒ Web-based application, supported by MHP or DMC staff
- ☒ Local SQL database, supported by MHP/Health/County staff
- ☐ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☒ Clearinghouse

Table 29 summarizes the MHP's SD/MC claims.

Table 29: Summary of CY 2019 SD/MC Claims

Contra Costa MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**373,251**	**$120,620,813**	**17,229**	**$5,194,927**	**4.13%**	**$115,425,886**	**$99,966,515**
JAN19	33,783	$10,540,206	1,113	$390,269	3.57%	$10,149,937	$8,801,144
FEB19	31,234	$9,820,897	1,045	$315,425	3.11%	$9,505,472	$8,228,436
MAR19	35,530	$10,681,436	1,237	$345,585	3.13%	$10,335,851	$9,150,874
APR19	30,106	$9,570,771	1,100	$304,326	3.08%	$9,266,445	$8,059,258
MAY19	37,031	$11,644,360	1,212	$414,709	3.44%	$11,229,651	$9,638,144
JUN19	28,392	$9,623,059	1,343	$447,157	4.44%	$9,175,902	$7,743,550
JUL19	26,551	$8,702,960	780	$260,618	2.91%	$8,442,342	$7,466,661
AUG19	27,847	$9,296,352	1,523	$467,326	4.79%	$8,829,026	$7,648,069
SEP19	34,627	$12,140,661	5,173	$1,455,968	10.71%	$10,684,693	$8,436,035
OCT19	34,543	$10,917,165	1,460	$368,848	3.27%	$10,548,317	$9,350,817
NOV19	27,127	$8,875,179	656	$223,519	2.46%	$8,651,660	$7,739,067
DEC19	26,480	$8,807,767	587	$201,176	2.23%	$8,606,591	$7,704,461
The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments from Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.							
Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2019 was **2.99 percent.**							

- The MHP's denial rate of 4.13 percent is 1.14 percent greater than the state's average of 2.99 percent.

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

Contra Costa MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible or non-covered charges.	5,328	$1,557,387	30%
Medicare or Other Health Coverage must be billed before submission of claim.	4,405	$1,395,059	27%
Beneficiary not eligible.	2,468	$1,033,043	20%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	1,961	$607,992	12%
Service line is a duplicate and a repeat service procedure code modifier not present.	1,272	$304,558	6%
Total	17,229	$5,194,927	NA
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

- Denied claim transactions with reasons “Medicare or Other Health Coverage must be billed before submission of claim.” and “Service line is a duplicate and a repeat service procedure code modifier not present.” are generally re-billable within the State guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS request would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Contra Costa, the time and distance requirements are 30 minutes and 15 miles for mental health services, and 30 minutes and 15 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed all relevant documents and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO was not able to conduct key informant interviews during the desk review process due to the Covid-19 pandemic.

Findings

The county MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

Not Applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	10
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	52
NPI Type 1 number reported is associated with two or more providers	2
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	2

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services.	1

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

Due to COVID-19, for FY 2020-21 CalEQRO did not conduct any focus groups with consumers (MHP beneficiaries) and/or their family members as this was a desk review of the MHP due to staff reassignments and shortages.

The consumer and family member (CFM) focus group is an important component of the CalEQRO review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFM focus group participants.

CFM Focus Group One (Not Held)

Table 32: Focus Group One Description and Findings (Not Held)

Topic	Description
Focus group type	n/a
Total number of participants	n/a
Number of participants who initiated services during the previous 12 months	n/a
Interpreter used	n/a If yes, specify language: Click or tap here to enter text.
Summary of the main findings of the focus group:	
Access - new beneficiaries	n/a
Access – overall	n/a
Timeliness	n/a
Urgent care and resource support	n/a
Quality	n/a

Topic	Description
Peer employment	n/a
Structure and operations	n/a
Recommendations from this focus group	n/a
Any best practices or innovations (optional)	n/a

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 33 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 33: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	10
The MHP's website is functional and user friendly and has an updated provider directory in both English and Spanish; however, language translation is not available on the website. The website has a surplus of information and links to resources. The MHP has a variety of informing materials available on its website, e.g., regarding transportation; moreover, efforts included the implementation of the "Overcoming Transportation Barriers" initiative to increase access by improving public transit navigation. For FY 2020-21, service provision was focused on increasing and maintaining beneficiary access to behavioral health services during COVID-19. The MHP rapidly increased its use of telehealth to provide beneficiaries phone, Zoom video conference, and traditional telehealth services. For beneficiaries experiencing homelessness and those housed in hotels/motels throughout the county, staff provided mental health support and linkages to resources and a referral hotline.			

Component		Maximum Possible	MHP Score
The MHP also focused on expanding crisis services and improving ease of access to medications through mobile crisis and prescription delivery, respectively. To decrease overcrowding and wait times for hospital admissions for adults, a new acute in-patient ward was opened to increase access to acute services while improving infection prevention practices.			
1B	Capacity Management	10	10
The MHP assesses cultural, ethnic, racial, and linguistic needs through the initial CSI which tracks demographics. Additional information is gathered on an ongoing basis, during initial assessment, and subsequent services. The MHP has several bilingual clinicians and pays an additional stipend for bilingual services. The MHP monitors caseloads and productivity. Beginning in early Spring 2020, service delivery for all types of services shifted to telehealth, while some in-person services remained available for beneficiaries who were not able to access telehealth-type services. The MHP implemented a supportive transportation program as part of its non-clinical PIP.			
1C	Integration and Collaboration	24	24
The MHP collaborates with several community-based providers and has an active Mental Health Services Act (MHSA) stakeholder process. The MHP also collaborates with the National Alliance on Mental Illness, law enforcement, schools, and Public Health.			

Timeliness of Services

As shown in Table 34, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 34: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	16
First offered appointments are defined as those offered by the Access Line to a new beneficiary for an initial assessment. Reported data includes the entire system of care. For first offered appointments, 92.3 percent overall met the 10-business day standard, with 95.3 percent for adults, 87.7 percent for children, and 73.5 percent for FC. Average timeliness overall was reported as 5.79 days, with 4.81 days for adults, 7.31 days for children, and 12.56 days for FC.			

Component		Maximum Possible	MHP Score
2B	First Offered Psychiatry Appointment	12	11
First offered psychiatry appointments are defined as the earliest of a first offered or first scheduled appointment with a psychiatrist following the date that medical necessity was established and a psychiatry referral was made. Reported data is limited to county operated clinics. For first offered psychiatry appointments, 89.1 percent overall met the 15-business day standard, with 92.6 percent for adults, 69.1 percent for children and 80 percent for FC. Average timeliness overall was reported as 8.12 days, with 6.70 days for adults, 16.36 days for children, and 12.8 days for FC.			
2C	Timely Appointments for Urgent Conditions	18	13
The MHP believes that its urgent appointments appear to be inflated due to clinics not always changing referral priority after assessing beneficiaries who are initially assessed as “urgent.” During summer of 2019, the MHP developed a procedure for referring children with urgent needs to the County Clinics and added this procedure to Access Line Policy 750. For adult urgent services, 94.6 percent of appointments meet the standard of 48 hours, with an average of 1.57 days. The MHP currently measures in days, not hours. The MHP does not have appointments that require prior authorization.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	8
Of the 565 hospital discharges overall, 219 (38.8 percent) had follow-up appointments within seven days. The average length of time for follow-up was eight days for adults and seven days for children. For adults and children, 38.3 and 57.1 percent respectively met the 10-day standard.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
Of the 565 hospital discharges, 36 were readmitted within 30 days equaling a readmission rate of 6.5 percent for adults. No children were readmitted.			
2F	Tracks and Trends No-Shows	10	6
For county operated services, the MHP reports the average no-show rate for psychiatrists as 16.5 percent, 16.7 percent for adults, and 15.1 percent for children. The average no-show rate for clinicians is 19.9 percent overall, 20.5 percent for adults, and 18.9 percent for children. The goal is 10 percent for both.			

Quality of Care

In Table 35, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 35: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
The MHP has a comprehensive Cultural Competence Plan which includes both goals and strategies to identify and increase access for underserved populations. The MHP has programs focused on serving immigrant communities, communities of color, young children, the Lesbian, Gay, Bisexual, Transgender or Questioning population and the elderly. The MHP collaborates with its community partners, the African American Health Conductors, and Promotores, to outreach to African American and LatinX beneficiaries. For evaluation, the MHP developed reporting requirements that include outcomes, surveys, the PHQ-9, and program specific evaluation tools.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
The MHP uses the ANSA and CANS-50, among others, to assign beneficiaries to an appropriate level of care. Program managers and clinicians meet monthly to review and evaluate level of care for beneficiaries. The MHP is using CSI reports, as well, to determine appropriate care options. Capacity management is accomplished through staffing adjustments to allow for expanded appointment slots.			
3C	Quality Improvement Plan	10	10
The QI unit produces an annual work plan including measurable goals. Monthly Quality Improvement Committee (QIC) meeting minutes document progress towards goals and tasks. QI efforts are supported by a research manager and planner evaluators for data analysis. Projects include preparation for the triennial review, PIPs, timeliness and NACT reporting, compliance, policies and procedures. The MHP generates quarterly penetration rates based on services provided.			
3D	Quality Management Structure	14	14
The QI unit includes a research manager and planner evaluators for data analysis and MHP analytics staff assigned for support. Important regulatory changes and mandates are disseminated and communicated by QI to management and the executive team.			

Component		Maximum Possible	MHP Score
3E	Quality Management Reports Act as a Change Agent in the System	10	10
Claims data, timeliness data, outcome data, productivity data, fiscal data, and clinical data are used by the leadership, management, IS, and QIC to evaluate systems' operations. Additionally, the MHP utilizes both the Plan Do Study Act and Lean Six change management approaches.			
3F	Medication Management	12	12
The pharmacist conducts weekly chart reviews for each medical caseload in a random sample using the Medication Monitoring Tool. The pharmacist then presents the results to the medical director for evaluation; furthermore, once a month the pharmacist, the medical director, the lead psychiatrist, and selected line staff review charts together to conduct peer reviews. The MHP also monitors beneficiaries who have been on an antipsychotic medication for one year, the physician who prescribed the medication, and whether the beneficiary has had the recommended cholesterol and glucose screenings. If the patient has not had the recommended labs, the psychiatrist ensures that labs are ordered.			

Beneficiary Progress/Outcomes

In Table 36, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 36: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	12
The MHP chose the ANSA to measure beneficiary functioning and outcomes. Weekly training was slated to begin February 2020. The implementation deadline for the ANSA in the Adult System of Care was extended to December 2020 due to COVID-19. County providers will complete the ANSA in ccLink while contract providers will use Objective Arts. The MHP has already drafted an aggregated ANSA report that will merge data from both systems and be deployed after providers begin			

Component		Maximum Possible	MHP Score
submitting data in December 2020. For children's services, the MHP rolled out a new electronic data management system called Objective Arts to all contract providers completing the CANS-50 and PSC-35 in May 2020. Through Objective Arts, providers now have immediate access to CANS-50 and PSC-35 reports for their programs, as well as the ability to export raw data for their own reporting needs.			
4B	Beneficiary Perceptions	10	10
The MHP administers the Client Perception Survey biannually. The MHP regularly reviews and compares data to prior surveys. The MHP is addressing an identified transportation problem through its non-clinical PIP. Progress and results are shared with staff at various meetings.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	10
The MHP's wellness centers are run by its contractor RI International and are in each of the three county regions. Wellness centers are staffed by beneficiary employees. Beneficiaries are informed about the wellness centers via the website and directory of services for each of the three regions. In 2020, wellness centers saw a 12 percent decrease from 2019 in numbers of unduplicated clients served.			

Structure and Operations

In Table 37, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 37: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	26
The MHP offers the standard array of mental health services, medication support, case management, and crisis intervention. The MHP also pair clinicians with law enforcement for mobile crisis response. Day treatment and rehab are not present.			
5B	Network Enhancements	18	18
The MHP has several psychiatrists. In response to COVID-19, telehealth was expanded to include clinical therapy, case management, and medication support services.			

Component		Maximum Possible	MHP Score
5C	Subcontracts/Contract Providers	16	12
The MHP implemented weekly virtual meetings with contract providers to support ongoing collaboration and address challenges related to COVID-19 and service delivery. The weekly meetings have been attended by representatives from CBOs and MHP administration. Attendance fluctuates between 40 and 50 participants. The MHP provides updates regarding a variety of topics including administrative updates, Utilization Review Unit updates, Provider Services Unit Updates, CBO portal, ShareCare/IT, and Quality Improvement/Quality Assurance Unit updates such as CANS-50, ANSA, beneficiary feedback, and HIPAA regulatory procedures pertaining to breaches, and providing time for contract agency staff to raise their concerns.			
5D	Stakeholder Engagement	12	12
While beneficiaries and family members are mentioned in planning activities (MHSA, Cultural Competency Plan, Strategic Plan), CalEQRO was unable to validate actual involvement; however, the MHP's Office of Consumer Empowerment Manager is part of the Executive leadership and is charged with providing lead support to staff on a variety of different initiatives. All its staff are beneficiaries. Under the restrictions and challenges of the pandemic, Zoom meetings have taken the place of those meetings formerly held on-site. As a desk review, CalEQRO was unable to validate the quality of communication with stakeholders.			
5E	Peer Employment	8	8
For FY 2020-21, the current organizational chart serves as validation that county positions are peer-designated with some being imbedded in programs, clinics, and at contract agencies. There are roughly 60 peer positions within the County including at contractor agencies. There are only two levels of Community Support Workers, I and II. There is a 9-unit vocational program at Contra Costa College, Service Provider Individualized Recovery Intensive Training (SPIRIT), that prepares people with lived experience for careers as service providers. The SPIRIT Vocational Program also assists SPIRIT graduates with job retention activities and career development assistance.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Contra Costa MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

- While both PIPs are active, the quality of the PIPs could be improved with TA and collaboration with CalEQRO.

Access to Care

Changes within the Past Year:

- During outbreak of the pandemic, the MHP expanded their service model to include increased telehealth and phone appointments, in addition to in-person field visits. The MHP provided 33 percent more services overall during March to September 2020 as compared to the six months prior. Similarly, the Mobile Crisis Response Team also experienced a 24 percent increase in calls.

Strengths:

- The MHP was able through its contract with a local pharmacy to provide prescription delivery services to beneficiaries at their residences. Additionally, as part of this contract, medication delivery was also secured for those beneficiaries who were being housed at hotels/motels throughout the county.

Opportunities for Improvement:

- The MHP's website does not include Spanish language translation to the mental health pages which could be remedied through an embedded browser feature or by providing Spanish language links to services with descriptions and contact information. This was a recommendation from FY 2019-20.

Timeliness of Services

Changes within the Past Year:

- The MHP implemented same-day assessment tools for staff providing services to beneficiaries at alternative care sites. The new tools allow staff to document services regardless of whether the beneficiary is open to specialty MH, receiving a wellness check, or being screened for opening to specialty MH.

Strengths:

- The MHP improved its timeliness of both offered and kept first assessment appointments, and adult offered psychiatry appointments.

Opportunities for Improvement:

- The MHP's timeliness data on hospital discharge follow-up appointments appears inconsistent, as the MHP reports that 38.8 percent of appointments meet the 7-day standard while the reported wait times average eight and ten days for adults and children, respectively. This relates to a FY 2019-20 recommendation to improve the then-current rate of 41.8 percent.

- With an overall no-show rate of nearly 20 percent, the MHP's no-show rates fail to meet its 10 percent standard by a large margin.

Quality of Care

Changes within the Past Year:

- To decrease overcrowding and wait times for hospital admissions for adults, a new acute in-patient ward (4D) was opened to increase access to acute services while improving infection prevention practices.

- The MHP participated in a quality improvement event to assess Behavioral Health and Public Health's response to community crisis events. The project aims to identify metrics for improvement, proposed actions, and a timeline of subsequent rapid improvement events addressing response to crises.

- In December 2020, the MHP adjusted the productivity standards for staff from 55 to 60 percent to improve timely access to care and align with NA standards. A productivity dashboard was developed for program managers, supervisors and clinicians to monitor real-time productivity and review needed administrative paperwork like CANS-50 and utilization review forms.

Strengths:

- The MHP utilizes an evidence-based practice (EBP) enrollment tracking and monitoring report for both the children's and adult system of care. This report captures beneficiaries enrolled in various EBPs and provides alerts when beneficiaries are missing data.

Opportunities for Improvement:

- None noted.

Beneficiary Outcomes

Changes within the Past Year:

- ANSA 101 trainings started in July 2020 via Zoom; currently 92 staff are certified in the tool. In October 2020, the MHP implemented its first monthly joint CANS-50 and ANSA 101 training for staff.

Strengths:

- The MHP is now in its third year of CANS-50 and PSC-35 implementation. As of November 2020, 8,740 CANS-50 and 7,870 PSC-35 forms have been submitted to DHCS.
- The MHP is using aggregate data from the CANS-50 to assess key areas of needs and strengths among children as well as treatment outcomes by looking at differences in CANS-50 scores between intake and discharge.

Opportunities for Improvement:

- None noted.

Foster Care

Changes within the Past Year:

- The MHP updated the Katie A./Pathways to Well Being policy and the ICC eligibility screening tool, and provided refresher trainings to all CBOs, partnering school districts and clinic staff members.
- The MHP reports a 40-50 percent decrease in FC MH referrals since COVID-19 (March 2020-current). The MHP is working with Children and Family Services to identify causes.

Strengths:

- The MHP tracks and trends data on use of singular and multiple concurrent psychotropic medications for children and adolescents as well as prescribed Attention Deficit Hyperactivity Disorder medications.

Opportunities for Improvement:

- None noted.

Information Systems

Changes within the Past Year:

- The MHP implemented a Provider Portal for all MH and AODS CBOs.
- The MHP began sharing medical information and MH Partnership Plans with beneficiaries through MyChart in support of ONC 21st Century Cures Act.
- Zoom telehealth video conferencing was implemented along with same-day assessment documentation tools and screening in response to COVID-19.
- Physician navigation, assessment documentation and utilization review checklist improvements were made.
- The MHP implemented clinician-facing productivity dashboards.

Strengths:

- The MHP's EHR, Epic/ccLink, is a web-based application that integrates both physical health and MH records in one system allowing beneficiaries to access both via smart phone, tablet, or computer.

Opportunities for Improvement:

- The MHP's capacity to evaluate would benefit from implementation of behavioral health dashboards and the migration of custom databases.
- The MHP's ability and efficiency to focus on service delivery would improve by completing the service interface of CBO EHRs to ShareCare.
- The MHP plans to complete the EHR's implementation of the Electronic Signature for MHP Beneficiaries and will consult with other counties for resolution of roadblocks.

Structure and Operations

Changes within the Past Year:

- The MHP developed real-time dashboards to track in-person and virtual staffing and personal protective equipment supplies being provided and used at BHS sites around the county.
- The MHP began a weekly Information Blocking Committee to develop a plan and timeline for sharing electronic health information with beneficiaries per the 21st Century Cures Act Final Rule and the ONC Health IT Certification program regulations.
- There was a hiring freeze between June and September 2020. The MHP is currently interviewing for a Mental Health Program Chief. In November and December 2020, the MHP hired a Mental Health Program Supervisor for Education-Related Mental Health Services and the Mental Health Program Supervisor for Prevention and Early Intervention will be filled.

Strengths:

- The MHP provided on-site wellness support to staff by setting up a phoneline to call when/if they needed someone to talk to with availability from 8 a.m. to 6 p.m. seven days per week.
- The MHP developed a self-care team with the purpose of “healing the healers.” It has a self-care webpage that consolidated a variety of resources for staff, county memos and health orders, telehealth training materials, and self-care resources such as activities, tip sheets, and apps.
- The MHP began self-care sessions available to all staff and contract providers. These 20-minute sessions occurred every Monday, Wednesday and Friday over Zoom and featured a different guided self-care activity such as mindfulness meditation, gratitude practice, or expressive arts.

Opportunities for Improvement:

- Additional resources are needed for the successful recruitment and retention of the Office of Informatics and Technology staff.
- The MHP continues to rely on a hybrid medical record chart.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: Seek ongoing and regular technical assistance (TA) from CalEQRO in the continued implementation of its Performance Improvement Projects (PIPs).

Access to Care

Recommendation 2: Include Spanish language translation on the mental health pages of the county website through an embedded browser feature or by providing Spanish language links to services with descriptions and contact information. (*This is a carry-over recommendation from FY 2019-20*.)

Timeliness of Services

Recommendation 3: Improve the FY 2019-20 rate (38.8 percent) of post-hospitalization follow-up appointments meeting the 7-day standard, while ensuring accuracy of the data. *(This is a carry-over recommendation from FY 2019-20.)*

Recommendation 4: Investigate the reasons for high no-show rates starting with the clinician no-show rates.

Quality of Care

None noted.

Beneficiary Outcomes

None noted.

Foster Care

None noted.

Information Systems

Recommendation 5: Automate the service interface between community-based organization (CBO) EHRs to Sharecare to eliminate double data entry.

Recommendation 6: Complete the EHR's implementation of the Electronic Signature for MHP beneficiaries.

Structure and Operations

Recommendation 7: Evaluate whether resources are sufficient for the successful recruitment and retention of the Office of Informatics and Technology staff. Augment when gaps are identified.

SITE REVIEW PROCESS BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Data

Attachment D: ACA Penetration Rates and ACBs

Attachment E: ACB Range Distributions

Attachment F: List of Commonly Used Acronyms

Attachment A—Review Agenda

The FY 2020-21 review was a desk review due to the COVID-19 pandemic. No sessions were held.

Table A1: EQRO Review Sessions (Not Held; Desk Review)

Contra Costa MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Clinical Directors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Medical Prescribers Group Interview
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Forensics and Law Enforcement Group Interview
Community-Based Services Agencies Group Interview

Contra Costa MHP
Supported Employment Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Electronic Health Record Hands-On Observation
Telehealth
Access Call Center Site Visit
Wellness Center Site Visit
Contract Provider Site Visit
Crisis Stabilization/Psychiatric Health Facility Site Visit
Jail Mental Health Services Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Cyndi Lancaster, Quality Reviewer
Saumitra SenGupta, Quality Reviewer
Lamar Brandysky, Information Systems Reviewer
Deb Strong, Consumer/Family Member Consultant

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-site and the post-site meetings and in preparing the recommendations within this report.

MHP Review Sites and Participants

MHP Sites

Contra Costa County Behavioral Health Services
1340 Arnold Drive, Suite 200
Martinez, CA 94553

The FY 2020-21 review was conducted as a desk review due to COVID-19 restrictions.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
The FY 2020-21 review was conducted as a desk review due to COVID-19 restrictions. No sessions were held.			

Attachment C—Approved Claims Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Attachment D—ACA Penetration Rates and ACBs

Table D1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table D1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Contra Costa MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Large	1,791,890	69,726	3.89%	$372,190,347	$5,338
MHP	73,820	3,301	4.47%	$14,020,858	$4,247

Attachment E—ACB Range Distributions

Table E1 shows the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Table E1: CY 2019 Distribution of Beneficiaries by ACB Range

Contra Costa MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	13,507	91.49%	93.31%	$49,011,009	$3,629	$3,998	46.51%	59.06%
>$20K - $30K	536	3.63%	3.20%	$13,058,343	$24,363	$24,251	12.39%	12.29%
>$30K	721	4.88%	3.49%	$43,309,899	$60,069	$51,883	41.10%	28.65%

Attachment F—List of Commonly Used Acronyms

Table F1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standards
AB	Assembly Bill
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
API	Asian/Pacific Islander
ASAM	American Society of Addiction Medicine
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts
BHIN	Behavioral Health Information Notice
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organizations
CBT	Cognitive Behavioral Therapy
CCC	Cultural Competency Committee
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services

Acronym	Full Term
COVID-19	Corona Virus Disease-2019
CPM	Core Practice Model
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CURES	Controlled Substances Utilization Review and Evaluation System
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FTE	Full Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Full Term
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HR	Human Resources
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IHBS	Intensive Home-Based Services
IMD	Institution for Mental Diseases
IN	Information Notice
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
KPI	Key Performance Indicator
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care
LOS	Length of Stay
LPHA	Licensed Practitioner of the Healing Arts
MAT	Medication Assisted Treatment
MCO	Managed Care Organizations
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MFA	Multi-Factor Authentication
MHBG	Mental Health Block Grant
MHP	Mental Health Plan
MHSA	Mental Health Services Act

Acronym	Full Term
MHST	Mental Health Screening Tool
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MSO	Management Services Organization
NA	Network Adequacy
n/a	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTP	Narcotic Treatment Program
OON	Out-of-Network
OTP	Opioid Treatment Program
PA	Physician Assistant
PDSA	Plan Do Study Act
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIN	Personal Identification Number
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RFP	Request for Proposal
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration

Acronym	Full Term
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SD/MC	Short-Doyle Medi-Cal
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
STCs	Special Terms and Conditions
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
VOIP	Voice Over Internet Protocol
WET	Workforce Education and Training
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan

CONTRA COSTA
MENTAL HEALTH COMMISSION

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MENTAL HEALTH
COMMISSION
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Martinez, CA 94553
Ph (925) 313-9553
Fax (925) 957-5156
cchealth.org/mentalhealth/mhc

June 2, 2021

Dear Supervisor Candace Andersen,

We respectively ask the Internal Operations Committee of the Contra Costa County Board of Supervisors to read and consider the Mental Health Commission's suggestion to the bylaw regarding Section 4. VACANCIES AND RECRUITMENT.

The following language presents 1) the text that you are requesting; and 2) the text that the Mental Health Commission is requesting as an alternative (note: highlighted text is what differs).

Text Proposed by Supervisor Candace Andersen, District II

SECTION 4. VACANCIES AND RECRUITMENT

4.1 Role of the Commission

The role of the Commission in recruitment of new commissioners is at the discretion of and to the extent requested by the Board of Supervisors.

4.2 The Commission is encouraged to help identify and recruit qualified applicants to apply for any vacancies on the Commission.

4.3 Commission Identification and Recruitment of Applicants

a) Pursuant to Article IV, section 1.2, the Commission shall, to the extent possible, identify and encourage applicants who will assist the County in complying with the ethnic and demographic mandates in the Welfare & Institutions Code.

b) To the extent possible, the Commission shall identify and encourage applicants who have experience and knowledge of the mental health system, preferably in the County

4.4 Each County Supervisor will encourage any applicant being considered for the Mental Health Commission to attend a Commission meeting prior to their appointment.

4.5 Upon appointment, the Chair and Executive Committee of the Mental Health Commission shall coordinate appropriate training and orientation of all new commissioners.

Text Proposed by the Mental Health Commission:

SECTION 4. VACANCIES AND RECRUITMENT

4.1 Role of the Commission

The role of the Commission in recruitment of new commissioners is at the discretion of and to the extent requested by the Board of Supervisors.

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a) Pursuant to Article IV, section 1.2, the Commission shall, to the extent possible, identify and encourage applicants who will assist the County in complying with the ethnic and demographic mandates in the Welfare & Institutions Code.

b) To the extent possible, the Commission shall identify and encourage applicants who have experience and knowledge of the mental health system, preferably in the County

4.4 Each County Supervisor will encourage any applicant being considered for the Mental Health Commission to attend at least one Commission meeting prior to their appointment. Applicants are required to meet with the MHC Chair, MHC Vice Chair and/or ad-hoc committee prior to accepting position to ensure full understanding of the roles, responsibilities, and restrictions of being a Mental Health Commissioner.

4.5 Upon appointment by the District Supervisor, the Chair and Executive Committee of the Mental Health Commission shall coordinate appropriate training and orientation of all new commissioners.

Will you please honor the fact the Commission is currently not reflective of the diversity of the client population in the county? We would like to ensure we are following the guidelines of Executive Order No. 13985 *Advancing Racial Equity and Support for Underserved Communities through the Federal Government* (pg 7009 - 7013), signed into law January 20, 2021 by President Joseph R. Biden Jr., as well as the Recruitment of Board/Commission Members, WIC 5604 (a) (1), and *Best Practices for Local Mental/Behavioral Health Boards and Commissions 2020*, rev.1 (pg. 24, Best Practices, 2020).

We realize that the Board of Supervisors is inundated with responsibilities of the county and Mental Health Commissioners are ready and willing to take on the task of recruiting, orienting/interviewing, and making recommendations to the Board of Supervisors for candidates to fill open seats on this Commission.

Sincere Regards,

Contra Costa County Mental Health Commission

Mental Health Commission
Proposed By Law

Meeting Date: June 2, 2021

Motion (original):

XI. DISCUSS and Vote proposed potential by-law on "excused absences from Mental Health Commission meetings due to unforeseen, extraordinary circumstances", Commissioner Leslie May, Contra Costa County Mental Health Commission

Section 2.1b is proposed language for a new by-law regarding excused absences from Commission meetings. It is in red font. The other text is pre-existing by-law language for context.

2.1 Attendance requirements

a) Regular attendance at Commission meetings is mandatory for all Commission members.

i) A member who is absent from four(4) regularly scheduled Commission meetings in any calendar year shall be deemed to have resigned from the Commission. In such event the former Commission member 's status will be noted at the next scheduled Commission meeting and shall be recorded in the Commission 's minutes. The Chairperson shall, without further direction from the Commission, apprise the Board of Supervisors of the member 's resignation and request the appointment of a replacement

ii) Each Commissioner will ensure that when s/he attends Commission-sponsored meetings (excluding Commission and Commission Committee meetings) or activities representing her/himself as a Commissioner , s/he expresses only those views approved by the Commission.

b) A Commissioner's absence from a regularly scheduled Commission meeting may be excused in the case of an unforeseen, extraordinary circumstance, including but not limited to major illness, natural disaster, or civil unrest. Commissioners shall obtain consent from the Chair at least one day prior to the meeting that will be missed for any planned absence. Excused absences will be recorded in the meeting minutes as "excused absence".

Hume Center Site Interview Report (draft)

Authored by the Contra Costa County Mental Health Commission

Quality of Care Committee Site Visit Program Test

Date of Interviews: April 23, 2021

Date of report: May 27, 2021

Reviewed Programs: Contra Costa County Concord Out-patient and Partial-Outpatient Programs

Interviewers: Commissioners Laura Griffin, Leslie May and Barbara Serwin

Version: This version incorporates comments from the Program Director of Hume Center from her review of a first draft of the report. The next draft will incorporate answers to outstanding questions and will be the final draft.

Notes:

- **This report is the result of a Site Visit Program test conducted in April – May, 2021. Hume Center was the test site.**
- **Hume was visited virtually during COVID when visits to facilities were not permitted. Instead of a physical site visit, Commissioners interviewed clients and staff via Zoom.**

I. Brief Summary

Hume Center in Contra Costa County serves as a bridge between in and out-patient hospitalization. People go to Hume instead of hospitalization or as a step down. The people treated by Hume are truly those in greatest need: Those who are gravely mentally ill, possibly indigent, and with no other access to services.

Hume's Partial Hospitalization Program (PHP) can serve up to 20 adults, who are Medicare recipients. Since it is a PHP where individuals reside in the community, they do not have beds.

The PHP is supervised by a Licensed Psychologist and is staffed daily by doctoral interns, and graduate level practicum students. PHP also employs a Psychiatrist, a psychiatric Nurse Practitioner, a Registered Nurse, and receives administrative support from the clinic's operations assistant.

One other item of note is the extent to which Hume embraced working with the Quality of Care Committee of the Mental Health Commission throughout development of the Site Visit Program starting in Spring of 2020. When the design phase began, Hume immediately volunteered to be the test site of the new Site Visit. Through-out the test, Hume was enthusiastic, open and supportive and its participation was invaluable.

II. Consumer Perspective

Number and type of interviewees: 5 female adults

Strengths

1. Hume patients have considerably lengthy stays e.g. 6 months for more thorough treatment. According to one patient: *"At John Muir you are limited to four weeks then they cut you off. I needed something longer term until I was well. I can sustain my progress with the Hume program."*

2. Overall, patients reported that they were getting better. According to one patient: "Yes. I was able to prepare for an upcoming court date – being in front of the judge, navigating the process. I was nervous. I'm now at peace – not anxious like a "9 or 10" (scale) constantly – I'm more like a "1 – 2". No more (very few) night terrors."

3. Patients most commonly mentioned the following services as strengths: One-on-therapy; group therapy; psycho-education; classes on mindfulness, breathing exercises and art therapy; making friends and a sense of community. According on one client: "They care. My counselor wouldn't ask me to do anything that he wouldn't do himself. Amazing suggestions. The therapists give a lot of knowledge. We have peer group therapy to advise each other. I take more what they say. They are high-functioning and can give advice."

4. Except for one patient, patients reported that staff asked for input re: their services.

5. Patients were in agreement that the program provides social opportunities and therapeutic activities.

6. Overall, patients are happy with most aspects of medication management.

7. Overall, patients have easy time getting an appointment.

8. Patients are able to read and understand the formal documentation at intake, e.g. HIPPA document.

9. Patients know their rights at Hume, such as confidentiality.

10. All patients knew what a patient's rights advocate is and how to contact one.

11. Hume allows clients to see their external providers for therapy and medication management. According to one client: *"The program is so much better than John Muir. I've been in John Muir, which is medication-focused; John Muir wanted to control meds and wouldn't let me see an outside doctor. This program (Hume) lets me see my normal psychiatrist and therapist with who I have the bonds."*

12. Hume has a grievance process that seems to work for clients. Although one client found the documentation off-putting, four patients used the grievance process to successfully resolve their issue.

Challenges

1. Hume clients are pre-dominantly indigent, middle-age, Caucasian and Black females – a population over-represented across all mental health sub-populations. However, at the time of the Hume site interviews date, Hume had only one male client and the rest were females. The only non-Caucasian was a Black female client who said: *"I am the only African American in the program. There are no African American men in the program, no Hispanic, no Native American, no Middle Eastern in the program. They are all Caucasian women and one man in the program."* Attaining a more gender and racially/ethnically diverse client population is a challenge. While the Hume board of directors is diverse, it is not necessarily reflective of all of the community that it serves.

   Note: According to the Program Director, while Hume has had more diversity in the past -- more men and more ethnic minorities, such as African Americans, Asians, Hispanics and Indigenous People), the current makeup of the patient population doesn't truly reflect that. This is mainly because the census is low and therefore it is not a representative sample of Hume's usual population. They think it is a function of their limited ability to outreach to the community in person and the technology barriers that people are facing to access services due to COVID. The words of the client who expressed concern about diversity are powerful and speak to her experience. It has been challenging for Hume to outreach during this period, and as a team, Hume staff is working together to address these issues.

2. One patient described the place as much too small and too dark. This sentiment was echoed by staff.

3. While one client was provided education for working with the legal system, and one was told about resources, other clients didn't engage this service of Hume. One person was never asked if she needed other services. Hume can provide an important benefit by sharing resources weekly with everyone.

4. Three clients did not have an advanced directive. One patient got hers elsewhere. A fifth patient didn't know what an advanced directive is.

5. One client was concerned about security. She believes that there are no security checks and told a story about a man threatening to kill someone a year and a half ago. Note: According the Program Director, in the past few weeks, Hume has installed a doorbell at the main entrance so that only staff, visitors and clients can enter. This has helped Hume control who has access to their waiting room to protect patient safety and privacy.

Other Observations

1. Most patients believe that staff help them use their personal strengths, skills, and capabilities in recovery.

2. A few patients believe that the services are adjusted to their specific needs, e.g. ethnicity. However, one patient pointed out that the lack of diversity did not meet her needs.

3. For patients with a medical issue(s), the issue was accounted for in their treatment program.

4. Although Hume has a peer provider (a SPIRIT intern), patients reported that they didn't have one.

5. People feel safe in the neighborhood. Three clients use the van transportation – Hume could publicize this for other people too. Note: According to the Program Director, prior to COVID, transportation was the biggest barrier to attending service. Hume has therefore been providing transportation to PHP patients since the inception of their program.

6. Only one patient is a care-giver for her mother, who has mental illness, and Hume gives her space to process her feelings around being the care-giver.

7. One client spoke of the need for everyone to be required to attend group therapy every day. She likes Hume for its social opportunities and feels that lack of consistent attendance compromised her group therapy experience.

Client Magic Wishes

- Two clients emphasized their desire to meet in person. Zoom was helpful, said one, but not as beneficial.
- One client wished for a spacious, sunny and light facility.
- One client wished for diversity.
- One client wished for everyone to be required to attend group therapy every day.

III. Staff Perspective

Number and type of interviewees:

- 1 Psychology doctoral intern
- 1 Nurse Practitioner
- 1 Program Director

Strengths

1. The program staff works very well together and there is respect and a strong sense of community.

2. Staff members feel fulfilled by their work.

3. Clients can refer themselves to Hume, which seems like a significant strength in an environment of highly controlled access to beds. Clients can also be referred to Hume by Access Line, John Muir, social workers, family members, case managers

4. Hume emphasizes measuring the progress of its clients through the evaluation and tracking components of its programs.

5. Hume employs evidence-based-practices in several therapeutic areas.

6. Hume has a formalized grievance policy and has a compliance department to review grievances.

Challenges

1. Hume is working significantly below capacity (7 to 8 patients recently versus 20 capacity). Despite awareness efforts, including a lot of presentations e.g. to board and cares and other providers, Hume's PHP is not well enough known.

2. COVID-related:
   - Hume has experienced lack of access to technology.
   - Hume clients have experienced isolation and less access to services.
   - If clients are triggered in the moment, staff is unable to provide intimate face-to-face contact with that client.
   - Staff do not feel that Tele-health is as effective as in-person and it has taken a long time to get into a new routine.
   - Clients must be trained how to use the smart phone and tablet/lap top to communicate via Zoom

3. Two staff members were not trained on incident reporting.

Other Observations

1. In addition to providing treatment, Hume is a teaching and hands-on training facility and a research program. This seems unique outside of a teaching hospital affiliated with an academic or research institution. It would be instructive to know Hume's philosophy and how the treatment of clients is prioritized. On the Hume website home page, these core functions are presented with equal weight. As a result, it is not clear whether treatment is the top priority.

2. While limited in the use of peer supports due to payment by Medicare and Medical, Hume does host a SPIRIT intern each year.

3. Hume uses a master treatment plan approach, with check-ins on client goals and progress at least every two weeks.

Program Improvement Needs

1. PHP needs case management e.g. for funding, referral connection and housing resources. This lack of a basic need gets in the way of treatment. Other Hume programs than PHP, however, can provide case management services.

2. Hume needs access to technology as long as Telehealth is being used.

3. Hume needs more opportunities for staff and volunteers to help with outreach.

Staff Magic Wand Wishes

1. Hume would accept anyone with any type of diagnosis regardless of their insurance.

2. Hume would have more patients – its census is low. According to one staff member: "*There are people out there that need help."*

3. Hume needs a larger facility with open windows and fresh air. Plastic dividers are needed for COVID-distancing. Note: Per the Program Director, because clients have been meeting virtually since COVID began, they have not yet seen that Hume has changed the room where the PHP will resume in-person services. Once services resume, the main room that PHP will utilize for daily services will now have better ventilation, light, and a large space.

IV. Recommended Areas for Action Plans

This section lists suggested areas of improvement, including some ideas for strategies.

Training on Incident Reporting

- Ensure that all employees are trained on incident reporting. Note: Per the Program Director, based on our site visit recommendations, Hume will increase how often this training is provided to incoming staff and trainees.

Raise Awareness of Hume Client Treatment Programs

- Consider more social media presence, perhaps through volunteer or SPIRIT support.
- Consider what the Hume web site communicates. Treatment is not front and center -- the web-site home page is not client-focused and client-friendly. Hume is a multi-faceted organization and needs multiple pathways into its web-based information. However, the web-site home page is what needs to greet whoever approaches the site. Note: The Program Director says that Hume is working on a plan to update the website in order make it more client treatment oriented.
- Ensure that program presentations are likewise focused on the client and treatment.
- Consider ways to leverage staff and volunteers in the outreach effort; this may require additional funding. While current trainees have taken on this challenge in the last couple of weeks in addition to their regular responsibilities, this should not be a long term solution and could lead to staff burn-out and decreased quality of services.

Technology Access and Training

- Consider prioritizing obtaining and managing technology for essential Tele-health and for continued delivery of online classes, groups and therapies that worked well during COVID and remain a viable option. Note: As per the Program Director, technology access will continue to be a focus as Hume reconsiders how to deliver services and provide a hybrid program of in-person and virtual services.
- Consider developing a training program to teach clients of all ages to use the smart phones, tablets and laptops necessary for therapeutic purposes and case management when in-person therapy or services are not accessible. Note: Per the Program Director, last year, because of shelter in place restrictions Hume developed a training manual individualized to each patient, which was given to them with a loaned a smart phone. The training was done by phone due to COVID restrictions. This year, however, they will definitely consider in-person training.

CONTRA COSTA MENTAL HEALTH COMMISSION

CLIENT SATISFACTION SURVEY

1. How long have you been in this program?

   _____

   _____

   _____

2. Do you feel that you are getting better and that your quality of life is improving?

   _____

   _____

   _____

3. Are there ways in which this program is different for you than other programs you have participated in? How is different?

   _____

   _____

   _____

4. Tell me a few things about this program that you like the best.

   _____

   _____

   _____

5. In respect to making this program better, are there any recommendations that you would make to improve this program?

_____

_____

_____

6. Does the staff ask you for your input on services that you might need?

_____

_____

7. Does the staff help you use your strengths, skills, and capabilities in your recovery? (e.g., your leadership abilities, compassion for others, artistic talents, computer skills)

_____

_____

_____

8. Do you feel the services you receive are adjusted to your specific needs (e.g., gender, ethnicity, disability, language)?

_____

_____

9. Does the program provide or connect you with meaningful social opportunities or therapeutic activities? Are there any other types of activities that are important to you?

_____

_____

10. Do you attend group therapy? How often do you attend? Did you sign a confidentiality agreement? What do you like or dislike about your group therapy?

_____

_____

_____

11. Are you comfortable with us asking you questions about your behavioral health medications? Yes □ No □

    Are you taking medications? (If "Yes," go to question "11a". If "No," skip remaining medication-related questions.)

    Yes □ No □

    a. Did a doctor or staff person talk to you about what the medications are for?
       Yes □ No □
       _____

    b. Did a doctor or staff talk to you about the medications' side effects, including interaction with other medications you are taking?
       Yes □ No □
       _____

    c. Did a doctor or staff talk to you about alternatives to medication such Cognitive Behavioral Therapy, Acupuncture, Yoga, or Mindfulness?
       Yes □ No □
       _____

    d. Did the doctor or staff answer all your questions about your medications?
       Yes □ No □
       _____

    e. Do you feel the medications are helping you?
       Yes □ No □
       _____

    f. If you had a problem with your medications, did the doctor or staff listen to your concerns? What did they do about your concerns?
       Yes □ No □

       _____

g. (***For female clients***): Did a doctor talk to you about the impact of medication on your hormones, menstrual cycle, menopause, pregnancy, or sexual function?
   Yes □ No □

_____

h. (***For male clients***): Did a doctor talk to you about the impact of medication on your hormones or sexual function?
   Yes □ No □

_____

i. Where do you get your prescriptions filled? Is it convenient for you?

_____

j. Did you sign any papers agreeing to take the medications at admission?
   Yes □ No □

_____

k. Did you understand the papers you signed at admission?
   Yes □ No □

_____

12. How is your physical health? Do you have access to physical health treatment and support that you need? Is your physical health accounted for in your treatment plan?

_____

_____

_____

13. Does any of your family members, caregivers, friends, or other advocates participate in your program? Are services provided to support them?

_____

_____

_____

14. Do you have a Peer Provider? (*See description) What services or support do you receive from peer providers in this program?

_____

_____

_____

15. (Inpatients Only) Do you like your accommodations and your meals here? What about the common areas and therapy spaces or any other aspects of the facility?

_____

_____

_____

16. How do you get to and from this program? How long does it take you to get here from where you live?

_____

_____

_____

17. Do you feel safe in this program's neighborhood? Do you feel the premises are secure?

_____

_____

_____

18. Is it easy to get appointments with your doctor, therapist, social worker, or whoever else you want to meet with? Can you get appointments within a reasonable time frame?

_____

_____

19. Do you have children, elderly parents, or anyone else whom you are responsible to care for? What are some ways that this program helps you manage your caregiving needs? (E.g., providing toys and a play space for children?)

_____

_____

_____

20. Does this program provide you with other services, such as legal help, housing services, financial resources, medical expense resources, educational services, SNAP benefits (food assistance program known as CalFresh in CA), or other services?

_____

_____

_____

21. Consider the intake documents you signed for Hume, such as HIPPA notice (privacy), financial responsibility, and patient rights. Did you read them? Did you understand them?

_____

_____

_____

22. Do you know your rights as a participant in this program? Confidentiality is a right, for example. Do you feel your rights are respected?

_____

_____

_____

23. If you have ever had a concern or grievance with your treatment or some other aspect of the program, have you been able to address your concern successfully? What process did you follow? Did you use a grievance form?

_____

_____

_____

24. Do you know what a Patient's Rights Advocate is? (**See description) Do you know how to contact one?

_____

_____

25. Do you have a Mental Health Advanced Directive, also known as a Psychiatric Advanced Directive? (***See description)

_____

_____

26. If you had a magic wand and could change anything about this program, what would that be?

_____

_____

_____

* PEER PROVIDER
A peer provider is someone who draws on their own lived experience of disability, along with training and professional support, to provide services like counseling and coaching to people with the same type of disability.

** PATIENTS RIGHT ADVOCATE
An individual, such as an attorney, friend, nurse, ombudsman, physician, or social worker, who pleads for and preserves a patient's rights to health care. Patient advocates address many com mon and important health care issues, including the right to access a health care provider, the ri ght to obtain confidential care, and the right for the patient to work after diagnosis or treatment.

*** MENTAL HEALTH ADVANCED DIRECTIVE: Document developed voluntarily by a person with a mental health condition when the person is doing well to ensure that during periods when the person lacks the capacity to make an informed decision about mental health care, their choices regarding treatment and services shall be carried out. The benefits of Mental Health Advance Directives include increasing treatment collaboration by improving communication between the individual and his/her treatment team; allowing for consumer- centered care and treatment planning; expediting crisis interventions; preventing unnecessary guardianship procedures; and promoting individual autonomy and empowerment in the recovery from mental illnesses.