CONTRA COSTA
MENTAL HEALTH COMMISSION

CONTRA COSTA
MENTAL HEALTH
COMMISSION
1340 Arnold Drive, Suite 200
Martinez, CA 94553
Ph (925) 313-9553
Fax (925) 957-5156
cchealth.org/mentalhealth/mhc

Mental Health Commission (MHC)

Wednesday, September 7th, 2022, ◊ 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 (10 minutes)

II. Public Comments (2 minutes per person max.)

III. Commissioner Comments (2 minutes per Commissioner max.)

IV. Chair Comments/Announcements (5 minutes)

- **i. Review of Meeting Protocol:**
  - **No Interruptions**
  - **Limit two (2) minutes**
  - **Stay on topic**
- ***ii. October MHC Orientation Topic TBD***
- **iii. Mandatory membership on at least one standing committee (two in the case of Executive Committee members)**
- **iv. Welcome newest Commissioners:**
  - **Welcome Supervisor Karen Mitchoff as Alternate Representative to the commission**

V. APPROVE August 3rd, 2022 Meeting Minutes (5 minutes)

VI. "Get to know your Commissioner" – Cmsr. Gerthy Loveday Cohen (5 minutes)

VII. Presentation: External Quality Review Organization (EQRO) Report, Priscilla Aguirre, MPP, Quality Management Program Coordinator, Quality Improvement & Assurance Unit (20 Minutes/10 Minutes for comments/questions)

(Agenda Continued on Page Two)

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

Mental Health Commission (MHC) Agenda (Page Two)

Wednesday, September 7th, 2022 ◊ 4:30 pm - 6:30 pm

VIII. Presentation: Meeting the Mental Health needs of People with Developmental Disabilities, Liz Walser, Clinical Psychologist, ASD Specialist, Regional Center of the East Bay, and Vi Ibarra, Executive Assistant, Developmental Disabilities Council (20 minutes/10 minutes for comments/questions)

IX. ESTABLISH Election Nomination Committee (10 minutes)

X. Behavioral Health Services Director's report, Dr. Suzanne Tavano (10 minutes)

- **Update on applications for BHCIP grants**
- **Update on diversion housing**

XI. Adjourn

ATTACHMENTS:

A. Election Guidelines for 2023
B. EQRO 2021-2022 Report
C. Developmental Disabilities Council Presentation

Mental Health Commission
Guidelines for Nominating Committee, 2023 Elections

Elections Held For:

- Chair
- Vice-Chair
- Executive Committee (minimum of three members, maximum of five, Chair and Vice Chair are automatic members so need to elect one to three additional members)

Timeline:

- September: Formation of Nominating Committee
- September – October: Develop slate
- November: Announce slate
- December: Hold election

Who Votes:

- Only Commissioners vote – not members of the public

Term:

- One year terms
- Chair and Vice Chair may hold their position for three consecutive years only; they may run again for the same position after not holding it for one year

Process:

- Create Elections Committee from Commissioner volunteers
- Select one person to represent/lead the Committee, e.g. give updates at Commission and Executive Committee meetings, lead the voting process at the Commission meeting
- Develop Slate
    - Objective is to develop a list of candidates for each elected role: Chair, Vice Chair and Executive Board Members
    - Identify potential candidates (excluding Supervisor)
        - Email all Commissioners to request that Commissioners interested in a position contact the Nominating Committee; include a description of roles in the email
        - Ask Commissioners for potential candidates too
        - Identify Commissioners who appear to be strong candidates for a leadership role (e.g. experience with the Commission, engaged with Commission issues and work, collegial, speak up at meetings, engaged in the Community)
    - Divide up list of potential candidates among Nominating Committee members
    - Reach out to each potential candidates and walk through: why they are interested in running, job responsibilities and time commitment (note that this is NOT an interview but more a vetting process and chance for Commissioners to

ask questions and to really reflect on whether the role they want to run for is really a good fit)
    - Aim for at least two candidates for Chair and Vice Chair and four to five candidates for Executive Committee
    - Document candidates
- Announce Slate
    - Ideally, if the slate is ready by one week before the November Commission meeting, provide the slate to the Executive Assistant for inclusion in the meeting packet
    - At the November Commission meeting announce the slate – there will be an item on the meeting agenda for this
- Hold Election
    - For the December meeting election, be prepared with voting materials, method/process for conducting the voting, instructions for Commissioners
    - Since the meeting will most likely be conducted in Zoom, voting materials will need to be a Zoom poll or private Zoom Chat (each Commissioner messages their choices to one member of the Nominating Committee) or other electronic technique that ensures privacy of the voter and ensures that only Commissioners vote (rather than pencil and paper)
    - Tally the votes by entering a break-out room and reviewing the results of the poll or tallying up the votes sent by Chat
    - Winners are selected by simple majority
    - In the case of a tie, ballots may be recast until the tie is broken; if this approach fails to result in a majority winner(s) the vote may be deferred until the next Commission meeting
    - In the event there is only one candidate for the Chair and Vice Chair positions, there is still a vote for these positions; if there is less than three candidates for the Executive Committee slots, there is still a vote for these slots
    - At the end of the vote tallying, announce the winners

Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 402
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2021-22
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

CONTRA COSTA DRAFT REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 19 – 20, 2022

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report.

MHP INFORMATION

MHP Reviewed — Contra Costa

Review Type — Virtual

Date of Review — January 19 - 20, 2022

MHP Size — Large

MHP Region — Bay Area

MHP Location — Martinez

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 15,453

MHP Threshold Language(s) — English, Spanish

SUMMARY OF FINDINGS

Of the seven recommendations for improvement that resulted from the FY 2020-21 EQR, the MHP addressed or partially addressed all seven recommendations.

CalEQRO evaluated the MHP on the following four Key Components that impact beneficiary outcomes; among the 26 components evaluated, the MHP met or partially met the following, by domain:

- Access to Care: 100 percent (three of four components fully met; one partially met)
- Timeliness of Care: 100 percent (three of six components fully met; three partially met)
- Quality of Care: 100 percent (eight of ten components fully met; two partially met)
- Information Systems (IS): 100 percent (five of six components fully met; one partially met)

The MHP submitted both required Performance Improvement Projects (PIPs). The clinical PIP, “Addressing Depression and Anxiety Among Youth,” is in the second remeasurement phase with a moderate confidence validation rating. The non-clinical PIP, “Gain-framed Provider Reminder Calls to Reduce No-Shows to Initial Assessment

Appointments," is in the implementation phase with a moderate confidence validation rating.

CalEQRO conducted two consumer family member focus groups, comprised of a total of eight participants.

SUMMARY OF STRENTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: having a robust Cultural Humility Plan to address disparities; expanding crisis services through its A3 Initiative – Anyone, Anywhere, Anytime; reducing no-shows for non-psychiatrists; a non-clinical PIP focused on expansion of telehealth; and expanding resources for the IS team for California Advancing and Innovating Medi-Cal (CalAIM) preparation.

The MHP was found to have notable opportunities for improvement in the following areas: the underrepresentation of Latino/Hispanic and Asian/Pacific Islander (API) beneficiaries in their use of specialty mental health services (SMHS); having long wait times post-assessment for ongoing services resulting in waitlists; not having the flexibility to emphasize the availability of telehealth services (which results in a strain on staffing resources); the need for more opportunities and more consumer and family member (CFM) participants to provide feedback in system and program planning; and needing to include contractors in the medication monitoring process when the contractor provides related services.

FY 2021-22 CalEQRO recommendations for improvement include: investigate reasons for underrepresentation of Latino/Hispanic and API beneficiaries in the use/receipt of mental health services in Contra Costa County; investigate reasons for long wait times and wait lists for services after initial assessment; clarify with related governing bodies how the presentation of service delivery choice can be made to beneficiaries which increases beneficiary access; investigate reasons for low rate of follow-up post-hospitalization appointments meeting the 7-day standard; and evaluate current opportunities for CFMs to provide feedback related to the MHP system.

INTRODUCTION

BACKGROUND

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs to provide SMHS to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal Mental Health Plan (MHP). DHCS contracts with Behavioral Health Concepts, Inc., the California EQRO (CalEQRO), to review and evaluate the care provided to the Medi-Cal beneficiaries.

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

This report presents the fiscal year (FY) 2021-22 findings of the EQR for Contra Costa County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on January 19-20, 2022.

METHODOLOGY

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

CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files, unless otherwise specified. These statewide data sources include: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File (IPC). CalEQRO reviews are retrospective; therefore, data evaluated are from CY 2020 and FY 2020-21, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data–overall, FC, transitional age youth, and Affordable Care Act (ACA). CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

FINDINGS

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 of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of three elements pertaining to NA: Alternative Access Standards (AAS) requests, use of out-of-network (OON) providers, and rendering provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).
- Summary of MHP-specific activities related to the following four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, and an examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per SB 1291 (Chapter 844).
- Review and validation of submitted PIPs.
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the MHP's quality and operational processes.
- Consumer perception of the MHP's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act (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, with a dash (-) to prevent calculation of initially suppressed data; its corresponding penetration rate percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

In this section, the status of last year's (FY 2020-21) EQR recommendations are presented, as well as changes within the MHP's environment since its last review.

ENVIRONMENTAL IMPACT

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP reported ongoing staffing and service delivery issues. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

MHP SIGNIFICANT CHANGES AND INITIATIVES

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

- Key Staff Changes:
  - The MHP filled the position of Behavioral Health Medical Director on August 1, 2021, along with several other key leadership and management vacancies.
  - A new position was added, the Director of Provider Services and Credentialing, and is in the recruitment process.
  - Current vacancies include various supervisor positions and the QI Coordinator position.
- CalAIM:
  - The Enhanced Care Management (ECM) benefit for Medi-Cal beneficiaries under CalAIM will be administered by Contra Costa Health Plan (CCHP), a managed care plan contracted with DHCS. The MHP has been selected as one of the contracted providers along with the Public Health Department.
  - In August 2021, the MHP convened a workgroup of mental health and substance use lead staff to shepherd these efforts to meet the go-live date of January 1, 2022.
- Peer Certification:
  - On November 19, 2021, the California Mental Health Services Authority (CalMHSA) submitted an implementation plan on behalf of interested counties into the peer certification plan, including Contra Costa.

- The MHP has begun the planning details and phases for implementation. Key workgroups are forming to meet all the federal and state requirements for the certification, implementation, and oversight of peer support specialists (W&I Code 14045.14 (a) (1)).

- Children's Crisis Stabilization Unit (CSU):
  - In May 2021, the MHP's application with California Health Facilities Financing Authority (CHFFA) to fund the remodel of Miller Wellness Behavioral Health into a Children's CSU was approved.
  - The goal is to build a CSU for up to eight minors that are in need of crisis stabilization and evaluation. The projected start date of programming is late Fall 2022.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2020-21

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP met with the lead reviewer on three separate occasions to discuss the status of the clinical PIP and to explore ideas on a new non-clinical PIP. The MHP pursued a non-clinical PIP based on the suggestions made by the lead reviewer.

- In addition, the MHP shared correspondence about the PIPs whenever there were questions or significant developments. The MHP Quality Improvement Quality Assurance (QI/QA) unit also participated in PIP 101 webinar events hosted by CalEQRO during the year.

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 recommendation is a carry-over from FY 2019-20.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP discussed and explored the possibility of using an embedded browser feature for a translation widget onto specific MHP web pages; however, after discussion with the Health Services Community Education and Information Department, the MHP was informed that translation widgets could not be used as they are not deemed as an accurate translation platform.
- As a follow-up, the Reducing Health Disparities committee will review and identify specific MHP webpages and/or materials hosted online and make recommendations to MHP leadership for translation into Spanish language, which is the threshold language. This will be a long-term process and goal.
- In addition, the Contra Costa Health Services (CCHS) Department is undergoing an overhaul to all the division websites. CCHS went through a formal request for proposal process to identify a vendor to contract for the website. A bidder was identified, and an agreement was approved by internal county counsel; however, the vendor declined to sign and accept the agreement. CCHS is now renegotiating and plans to include Spanish links into division content.

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 recommendation is a carry-over from FY 2019-20.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- CalEQRO identified for FY 2019-20 the rate of 38.8 percent for MHP follow-up discharge appointments made within seven days. The MHP improved its overall discharge follow-up appointment rate from 38.8 percent to 48.9 percent for FY 2020-21.
- The MHP worked with Information Technology (IT) to review data and identify gaps impacting the accuracy of timeliness data. The MHP reviewed data related to discharges to out-of-county providers, private insurance providers, and contracted hospitals.

- In summary, the MHP reported that the review of the data did not reveal an explanation for the low rate of hospital discharge follow-up appointments. The data shows that the MHP still maintains an average number of 15 days between hospital discharge and follow-up appointments.
- The MHP plans to work with its new Informatics Chief and IT staff to develop a dashboard containing hospital admission, discharge, and follow-up appointment data.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has taken several steps to better understand the underlying issues contributing to the relatively high no-show rate for non-psychiatric appointments.
- In June 2021, in conjunction with administering the Consumer Perception Survey (CPS), the MHP conducted a Service Improvement Survey (SIS) where participants identified reasons for no-showing. Results indicated that the most commonly selected reasons were: forgot appointment (28 percent), challenges with remote appointments (28 percent), and being sick or caring for sick family members (15 percent).
- In addition to surveying beneficiaries, the MHP incorporated additional demographic data into its quarterly no-show reporting. QI staff have begun discussing these data trends with the MHP's Ethnic Services Coordinator to develop initiatives to address disparities.
- With the offering of video and telephone appointments, the MHP has achieved a consistent 3-4 percentage point reduction in quarterly no-shows among non-psychiatric appointments (16 percent to 17 percent) compared to quarterly no-show rates for these appointments before the pandemic (21 percent).
- The MHP is also actively working on implementing its appointment adherence policy and reminder system. This implementation is expected for early 2022.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- This recommendation was reviewed but not implemented. Instead, the MHP is participating in a CalMHSA project to explore an integrated EHR for the MHP that will satisfy CalAIM requirements and support interoperability with CBOs.

- A possible next step is to replace ShareCare as the MHP's practice management system. As such, the MHP has decided not to invest time and resources to build interfaces to ShareCare until there is more clarity.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- MHP beneficiaries are currently able to electronically sign the Partnership Plan for Wellness and Consent for Psychotropic Medications during in-person visits, either in clinic or in the field, via track pads on provider laptops.
- In the next three to six months, to aid in visits conducted via telehealth, the MHP plans to collect electronic signatures through MyChart for these forms.
- Additionally, the MHP will pilot the use of signature pads for beneficiaries to sign several registration forms as well as for clinical forms. After a period of stabilization and pending adjustments that may be necessary to support CalAIM, the MHP plans to extend the rollout of electronic signature collection to other registration and clinical forms.

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.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP identified and deployed resources to build the Office of Informatics and Technology team. A Chief of Informatics was hired, and the unit started operating in April 2021.
- An external consultant was contracted to do a gap analysis between current system functionalities and what is required to support CalAIM health care reform efforts. This gap analysis will inform the MHP on the IT resources required to support multiple priorities going forward.

NETWORK ADEQUACY

BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All MHPs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

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. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services, for youth and adults. If these standards are not met, DHCS requires the MHP to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports 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 separately and with MHP staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the MHP's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely 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.

FINDINGS

For Contra Costa County, the time and distance requirements are 30 minutes and 15 miles for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over)[1].

Alternative Access Standards and Out-of-Network Providers

The MHP met all time and distance standards and was not required to submit an AAS request. Further, because the MHP is able to provide necessary services to a beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries to access services via OON providers.

Planned Improvements to Meet NA Standards

Not Applicable.

MHP Activities in Response to FY 2020-21 AAS

The MHP did not require AAS in FY 2020-21.

PROVIDER NPI AND TAXONOMY CODES

CalEQRO provides the MHP a detailed list of its rendering provider's NPI Type 1 number and associated taxonomy code and description. Individual TA is provided to MHPs to resolve issues which may result in claims denials, when indicated. The data comes from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. The data are linked to the NPPES using the rendering service provider's NPI, Type 1 number. A summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO will be presented in the FY 2021-22 Annual Aggregate Statewide report.

[1] AB 205 and BHIN 21-023

ACCESS TO CARE

BACKGROUND

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

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

ACCESS IN CONTRA COSTA COUNTY

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 34.8 percent of services were delivered by county-operated/staffed clinics and sites, 51.5 percent were delivered by contractor-operated/staffed clinics and sites, and 13.7 percent were delivered by network providers. Overall, approximately 69.4 percent of services provided are claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: crisis services, schools, hospitals, and psychiatric emergency services. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Typically, most people go through the Access Line for quick screening and then get routed to care depending on their acuity level.

In addition to clinic-based mental health services, the MHP provides telehealth and mobile mental health services. Specifically, the MHP delivers psychiatry and mental health services via telehealth to youth and adults. In FY 2020-21, the MHP reports having served 6,178 adult beneficiaries, 5,255 youth beneficiaries, and 1,600 older adult beneficiaries across 17 county-operated sites and 94 contractor-operated sites. Approximately 2,200 beneficiaries received telehealth services from county providers in a language other than English in the preceding 12 months.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members. Examining

service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

Each access component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 1: Key Components - Access

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

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

- The 2020-2023 Cultural Humility Three Year Plan (Cultural Humility Plan) details a robust plan to address identified language and cultural needs to build equitable care through its Reducing Health Disparities Committee.
- While the MHP monitors system demand and resources to meet capacity, more strategies are needed to address ongoing waitlists for services after initial assessment. Staff retention, hiring, additionally assigned tasks, program/staffing inflexibility, and remote work policies exacerbate the waitlist problem.
- From the MHP's perspective, the MHP has taken steps to reduce no-show rates across the system of care by offering telephone and video appointments in addition to traditional in-person services. While its efforts provide more flexibility in terms of visit format, the MHP is not able to over-offer telehealth, maintaining that the choice be incumbent on the beneficiary. When telehealth is not utilized as a means of main service delivery, more staffing, time, and travel resources are tied up and unavailable for other beneficiaries.

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect access to care in the MHP:

- Total beneficiaries served, stratified by race/ethnicity and threshold language.
- Penetration rates, stratified by race/ethnicity and FC status.
- Approved claims per beneficiary (ACB) served, stratified by race/ethnicity and FC status.

Total Beneficiaries Served

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

Table 2 below shows disparities in the percentage of Medi-Cal eligibles and the percentage of beneficiaries served by race/ethnicity, and Figure 1 presents the same information graphically.

Latino/Hispanics represent 34.1 percent of eligible beneficiaries in Contra Costa but only 25 percent of beneficiaries served.

API are also under-represented in their use of mental health services. Approximately 11 percent of Medi-Cal eligibles are API, but they only account for 4.8 percent of beneficiaries served. Conversely, White beneficiaries represent 16.3 percent of Medi-Cal eligibles, but 25.1 percent of beneficiaries served. African Americans represent 13.3 percent of eligibles, but 18.3 percent of beneficiaries served.

Table 2: County Medi-Cal Eligible Population and Beneficiaries Served in CY 2020, by Race/Ethnicity

Contra Costa MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Eligibles**	**Percentage of Medi-Cal Eligibles**	**Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP**	**Percentage of Medi-Cal Beneficiaries Served by the MHP**
White	44,074	16.3%	3,873	25.1%
Latino/Hispanic	92,066	34.1%	3,860	25.0%
African-American	35,837	13.3%	2,827	18.3%
Asian/Pacific Islander	29,408	10.9%	736	4.8%
Native American	699	0.3%	77	0.5%
Other	67,760	25.1%	4,080	26.4%
Total	**269,844**	**100%**	**15,453**	**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.				

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020

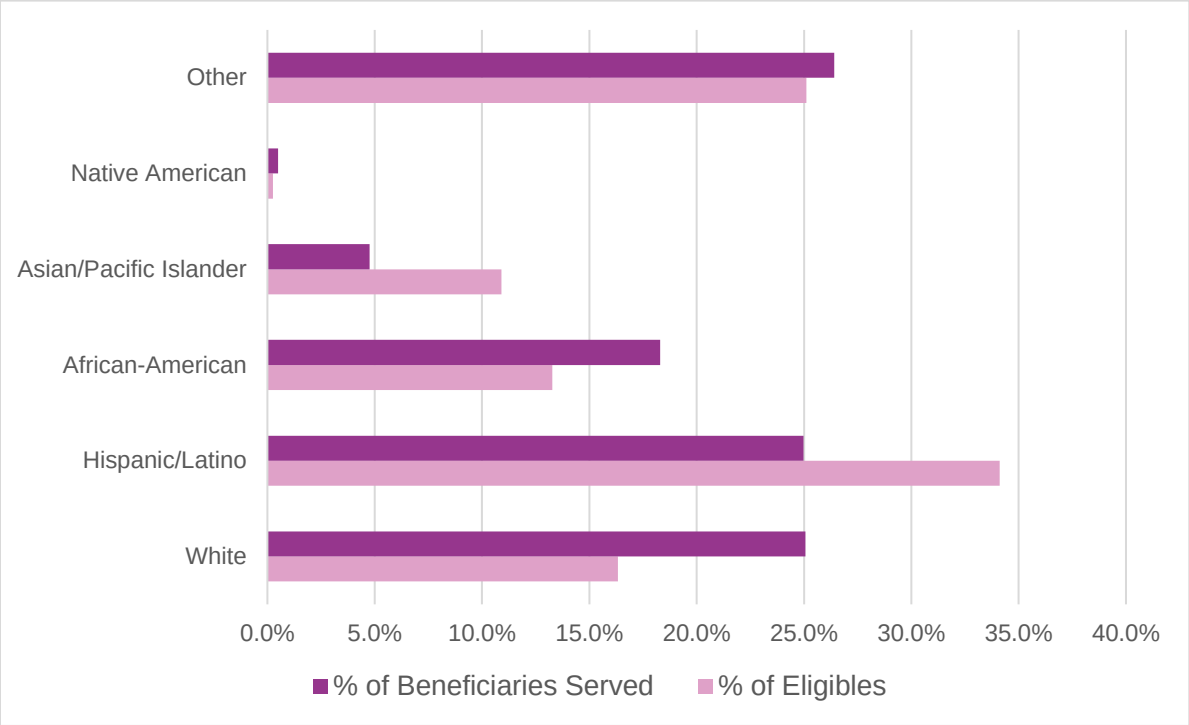


Table 3 below shows 2,281 beneficiaries served by the MHP indicated Spanish as their primary language, which represents 14.9 percent of all beneficiaries served.

Table 3: Beneficiaries Served in CY 2020, by Threshold Language

Contra Costa MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Other Language	12,986	85.1%
Spanish	2,281	14.9%
Total	**15,267**	**100%**

Threshold language source: Open Data per BHIN 20-070; Other Languages include English. The Threshold language count is a total yearly count and not based on the average monthly calculation used for Table 3. Any discrepancy in total number of beneficiaries served between the two tables is attributable to this difference in methodology.

Penetration Rates and Approved Claim Dollars per Beneficiary Served

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The ACB served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. See Table D1 for the CY 2019 ACA penetration rate and ACB.

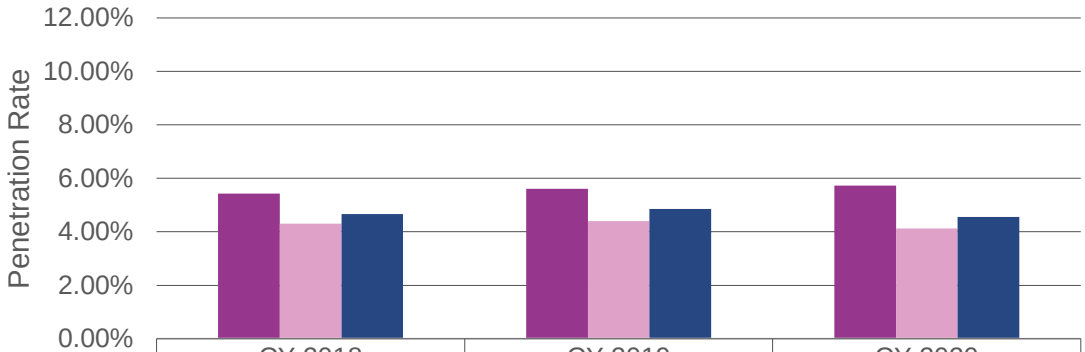
Figures 2 through 9 highlight three-year trends for penetration rates and average approved claims for all beneficiaries served by the MHP as well as the following three populations with historically low penetration rates: FC, Latino/Hispanic, and API beneficiaries.

CY 2020 claims data show that Contra Costa's overall penetration rate and rates for all race/ethnicity subgroups are higher than large counties and statewide averages.

The MHP's overall ACB is also higher than large counties and the state average.

Figure 2: Overall Penetration Rates CY 2018-20

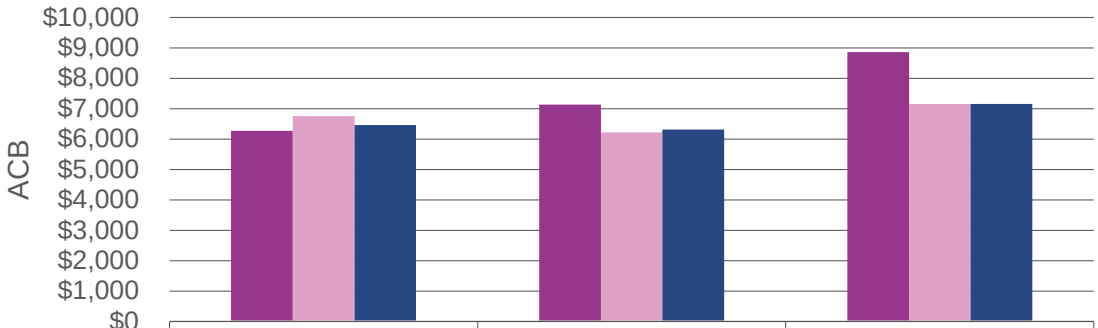
Contra Costa MHP



	CY 2018	CY 2019	CY 2020
MHP	5.43%	5.61%	5.73%
Large	4.31%	4.40%	4.13%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20

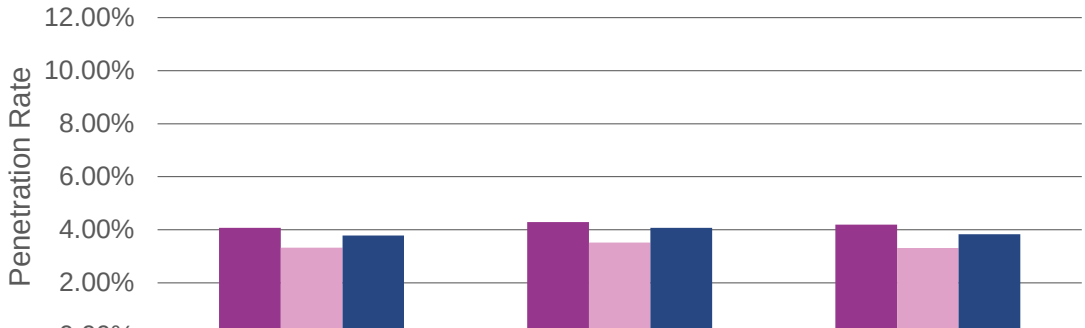
Contra Costa MHP



	CY 2018	CY 2019	CY 2020
MHP	$6,271	$7,138	$8,863
Large	$6,750	$6,219	$7,156
State	$6,454	$6,316	$7,155

Figure 4: Latino/Hispanic Penetration Rates CY 2018-20

Contra Costa MHP



	CY 2018	CY 2019	CY 2020
MHP	4.07%	4.29%	4.19%
Large	3.33%	3.52%	3.31%
State	3.78%	4.08%	3.83%

Figure 5: Latino/Hispanic ACB CY 2018-20

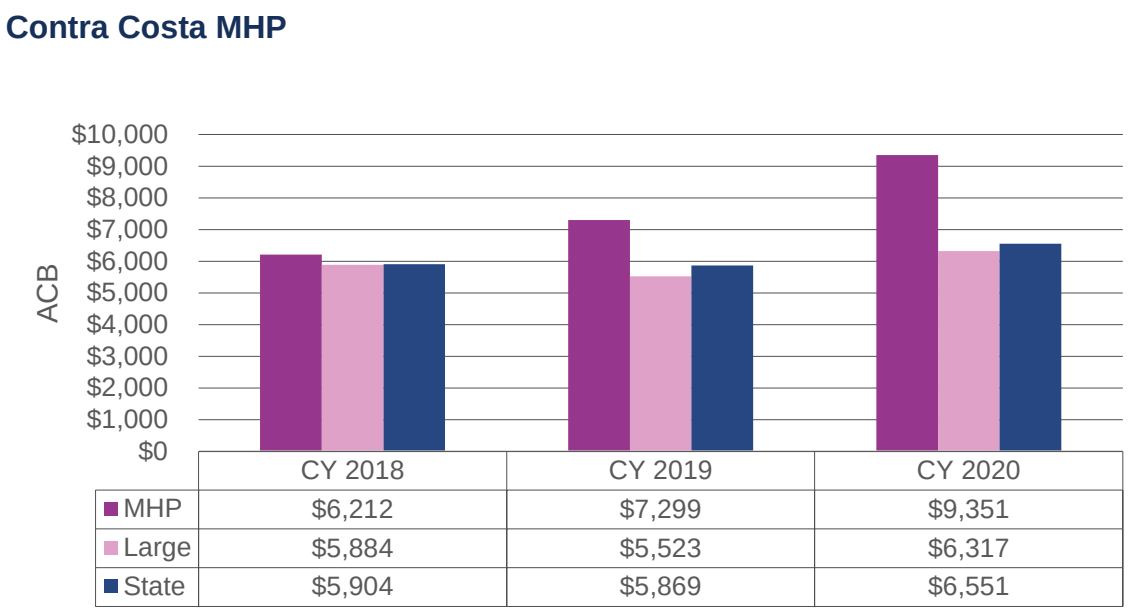


Figure 6: Asian/Pacific Islander Penetration Rates CY 2018-20

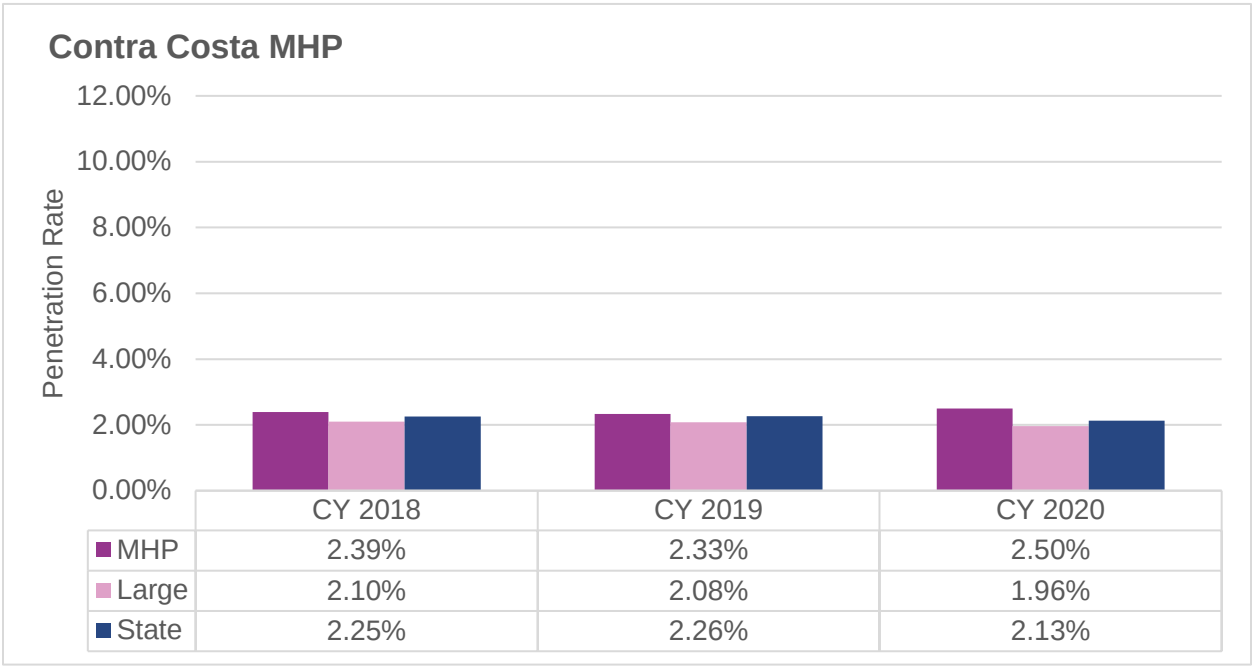
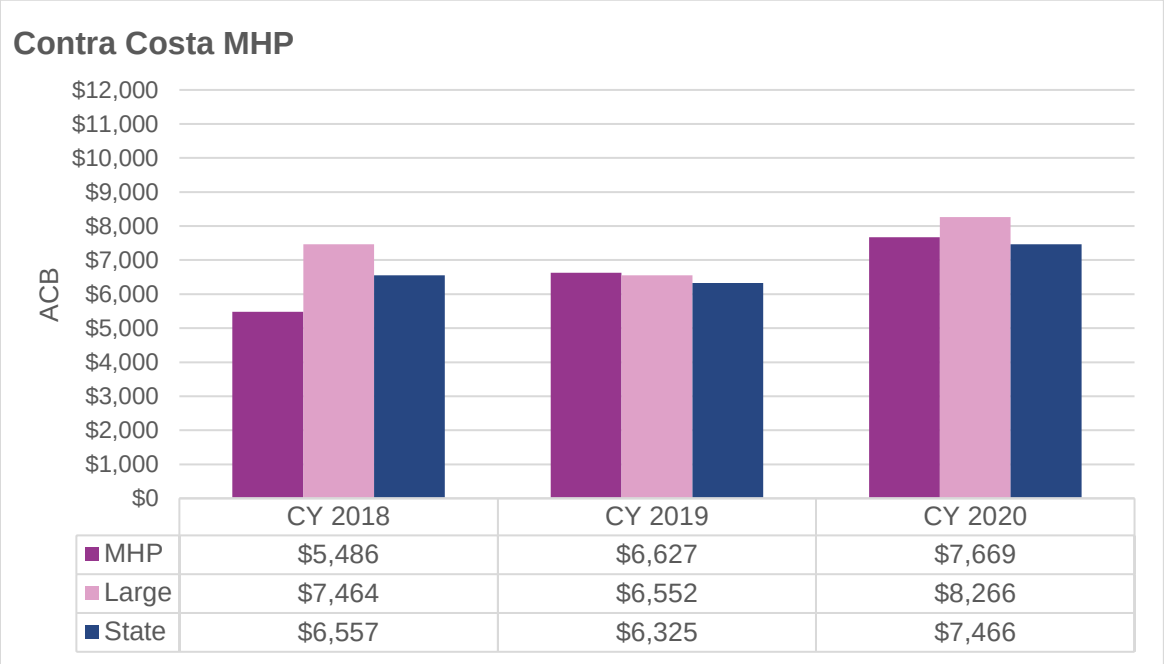
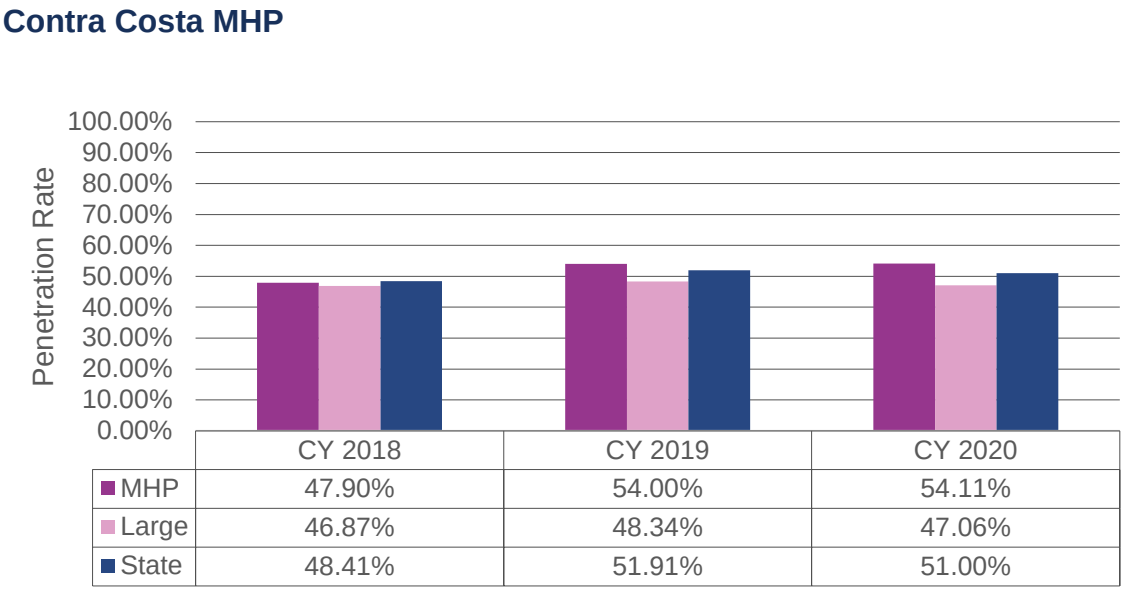


Figure 7: Asian/Pacific Islander ACB CY 2018-20



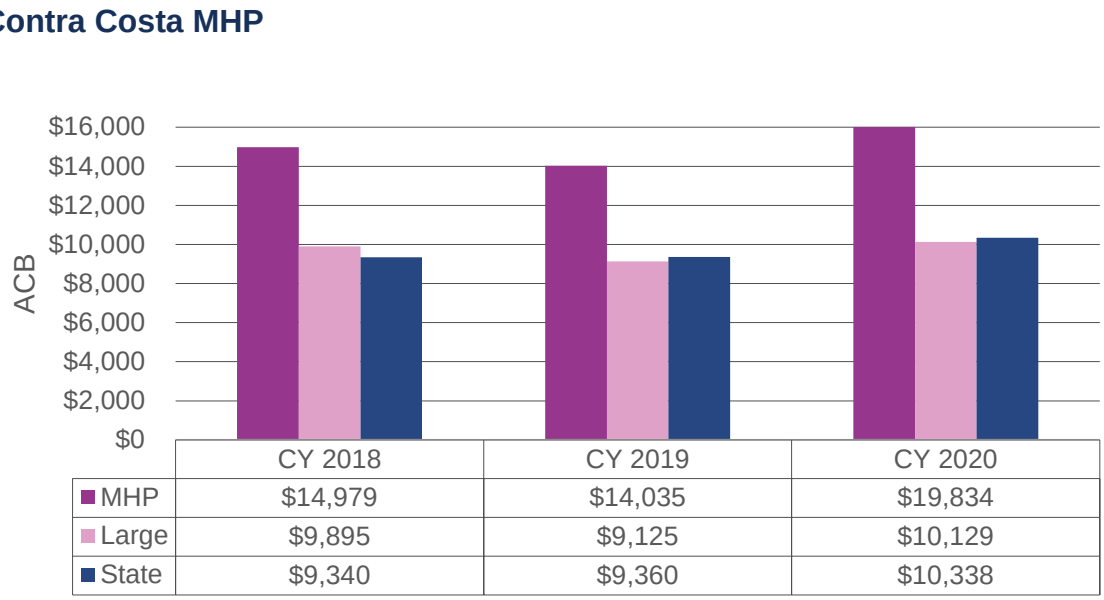
	CY 2018	CY 2019	CY 2020
MHP	$5,486	$6,627	$7,669
Large	$7,464	$6,552	$8,266
State	$6,557	$6,325	$7,466

Figure 8: FC Penetration Rates CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	47.90%	54.00%	54.11%
Large	46.87%	48.34%	47.06%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	$14,979	$14,035	$19,834
Large	$9,895	$9,125	$10,129
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

Latino/Hispanic and API beneficiaries are under-represented in their use of SMHS in Contra Costa County. The MHP may need to formulate strategies to target these populations for outreach and service promotion, including the recruitment of Latino/Hispanic and API clinicians in the system of care.

Contra Costa's overall beneficiary penetration rate is higher than large counties and the statewide average, and the number of beneficiaries who received telehealth services increased 700 percent from 1,854 in FY 2019-20 to 13,033 in FY 2020-21. This increase attests to Contra Costa's successful pivot to telehealth services as a response to barriers and restrictions associated with the COVID-19 pandemic.

TIMELINESS OF CARE

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likely the delay will result in not following through on keeping the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track the timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. CalEQRO uses a number of indicators for tracking and trending timeliness, including the Key Components and Performance Measures addressed below.

TIMELINESS IN CONTRA COSTA COUNTY

The MHP reported timeliness data stratified by age and FC status. Further, timeliness data presented to CalEQRO represented a mix of county-operated services for some metrics and the complete SMHS delivery system for others.

For assessment of timely access reporting, the MHP extracts county clinics' data from its EHR (ccLink) and contracted providers' data from its practice management system (ShareCare).

TIMELINESS KEY COMPONENTS

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

Each Timeliness Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 4: Key Components – Timeliness

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

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

- Through the expansion of telehealth to both psychiatric and non-psychiatric services, the MHP reports that it has achieved a consistent 3-4 percentage point reduction in quarterly no-shows among non-psychiatric appointments (16 percent to 17 percent) compared to quarterly no-show rates for these appointments before the pandemic (21 percent).
- While the MHP reports timeliness for urgent appointments, the usefulness of the data is incomplete due to data being limited to county-operated service data and reporting in days versus hours. For FY 2020-21, the MHP reports that it did not receive any urgent requests for beneficiaries enrolled in FC at the time of initial service request. The MHP's current timeliness policy utilizes a 2-business day standard; however, the MHP plans to revise the policy to be 48 hours in the upcoming year at the time the policy is up for review.
- For follow-up appointments after psychiatric hospitalization, the MHP does track and trend data related to timeliness for follow-up appointments within seven days after a discharge from a psychiatric facility. While there is some analysis, it has not led to initiatives to improve access/timeliness which is reported overall to be 48.9 percent of qualified appointments meeting the standard.

PERFORMANCE MEASURES

Through BHINs 20-012 and 21-023, DHCS set required timeliness metrics to which MHPs must adhere for initial offered appointments for non-urgent SMHS, non-urgent psychiatry, and urgent care. In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Additionally, utilizing

approved claims data, CalEQRO analyzes MHP performance on psychiatric inpatient readmission and follow-up after inpatient discharge.

The following PMs reflect the MHP's performance on these and additional timeliness measures consistent with statewide and national quality standards, including Healthcare Effectiveness Data and Information Set (HEDIS) measures:

- First Non-Urgent Appointment Offered
- First Non-Urgent Service Rendered
- First Non-Urgent Psychiatry Appointment Offered
- First Non-Urgent Psychiatry Service Rendered
- Urgent Services Offered – Prior Authorization not Required
- Urgent Services Offered – Prior Authorization Required
- No-Shows – Psychiatry
- No-Shows – Clinicians
- Psychiatric Inpatient Hospital 7-Day and 30-Day Readmission Rates
- Post-Psychiatric Inpatient Hospital Discharge 7-Day and 30-Day SMHS Follow-Up Service Rates

MHP-Reported Data

For the FY 2021-22 EQR, the MHP reported its performance for FY 2020-21 as follows:

- Average wait time of 5.5 days from initial service request to first non-urgent appointment offered.
- Average wait time of 8.1 days from initial service request to first non-urgent psychiatry appointment offered; the MHP measures this metric from the point of clinical determination of need.
- Average wait time of 36 hours from initial service request to first urgent appointment offered for services that do not require prior authorization.
- The MHP adopted a standard of 15 business days for first non-urgent service rendered and 30 business days for first non-urgent psychiatry service rendered. Against these standards, the MHP achieved 95.3 percent for first non-urgent service rendered and 94.3 percent for first non-urgent psychiatry service rendered.

Table 5: FY 2021-22 MHP Assessment of Timely Access

FY 2021-22 MHP Assessment of Timely Access			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5.5 Days	10 Business Days*	96.4%
First Non-Urgent Service Rendered	6.7 Days	15 Business Days**	95.3%
First Non-Urgent Psychiatry Appointment Offered	8.1 Days	15 Business Days*	92.2%
First Non-Urgent Psychiatry Service Rendered	11 Days	30 Business Days**	94.3%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	36 Hours	48 Hours*	84.2%
Urgent Services Offered – Prior Authorization Required	****	96 Hours*	****
Follow-Up Appointments after Psychiatric Hospitalization	15 Days	7 Days**	48.9%
No-Show Rate – Psychiatry	14.7%	10%**	n/a
No-Show Rate – Clinicians	15.8%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 20-012 ** MHP-defined timeliness standards **** MHP does not separately track urgent services offered based on authorization requirements; all urgent services are held to a 48-hour standard.			
For the FY 2021-22 EQR, the MHP reported its performance for the following time period: FY 2020-21.			

Medi-Cal Claims Data

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post-hospital discharge, as reflected in the CY 2020 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained mental health professionals is critically important.

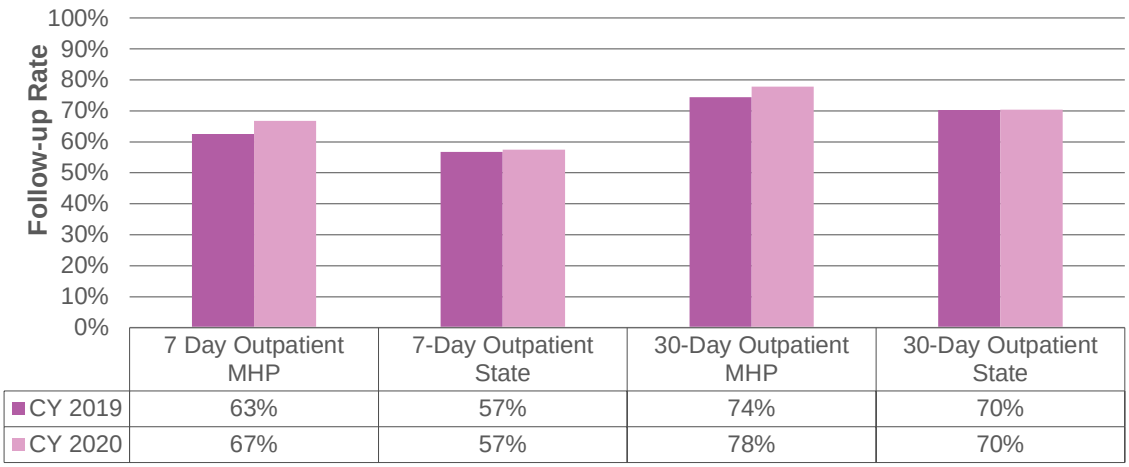
Follow-up post-hospital discharge

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care.

The MHP's 7-day and 30-day post psychiatric inpatient follow-up rates (67 percent and 78 percent) are higher than statewide rates.

In the Assessment of Timely Access Form, the MHP reported lower rates for post-hospital discharge follow-up at 48.9 percent for 7-day and 61.4 percent for 30-day in FY 2020-21.

Figure 10: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-20



	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	63%	57%	74%	70%
CY 2020	67%	57%	78%	70%

Readmission rates

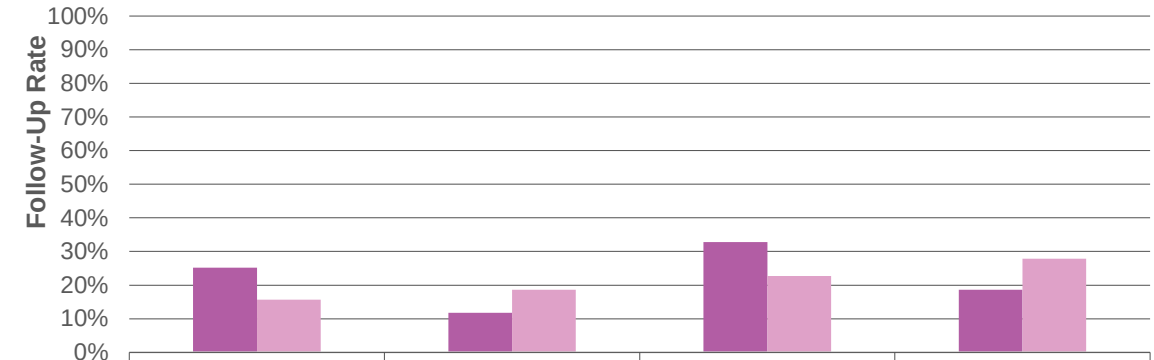
The 7- and 30-day rehospitalization rates (HEDIS measures) are important proximate indicators of outcomes.

Based on approved claims data, the MHP's 7-day psychiatric readmission rate decreased to 16 percent in CY 2020 from 25 percent in CY 2019. Similarly, the 30-day readmission rate decreased from CY 2019's 33 percent to 23 percent in CY 2020. As such, Contra Costa had a lower rehospitalization rate than the statewide average.

The MHP self-reported 7-day and 30-day readmission rates at 3.5 percent and 10.5 percent respectively in the Assessment of Timely Access Form for FY 2020-21.

Figure 11: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-20

Contra Costa MHP



	7-Day Rehospitalization MHP	7-Day Rehospitalization State	30-Day Rehospitalization MHP	30-Day Rehospitalization State
CY 2019	25%	12%	33%	19%
CY 2020	16%	19%	23%	28%

IMPACT OF FINDINGS

According to FY 2020-21 self-reported Assessment of Timely Access data, Contra Costa did well on most timeliness metrics. CY 2020 approved claims data showed the MHP having better performances than large counties and the statewide average on the 7-day and 30-day post psychiatric inpatient follow-up and 7-day and 30-day hospital readmissions measures.

The MHP made serious attempts to address timeliness issues in the last year. The Research and Evaluation Unit trends appointment no-shows and cancellations quarterly by clinic and program, and presents findings to the Quality Management Committee. The Business Intelligence team, in coordination with input from THE MHP administration and the QI/QA team, also developed a comprehensive Client Services Information (CSI) Timeliness report for executives and QI/QA staff to monitor CSI Timeliness for county and CBO programs. In addition, the ccLink team developed a work queue to proactively track beneficiaries whose timeliness for their first offered clinical and/or psychiatric appointments may be at risk, which allows staff to proactively offer beneficiaries earlier appointments or issue a Notice of Adverse Benefit Determination where appropriate.

QUALITY OF CARE

BACKGROUND

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through:

- Its structure and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based knowledge.
- Intervention for performance improvement.

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

QUALITY IN CONTRA COSTA COUNTY

In the MHP, the responsibility for QI resides within the QI unit which includes a research manager and planner evaluators for data analysis and MHP analytics staff assigned for support. A QI/QA coordinator is assigned to monitor important regulatory changes and mandates and communicates this information to management and the executive team.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC minutes list several participants; however, the roles of the participants are not discernable. QIC is scheduled to meet monthly. Since the previous EQR, the MHP QIC met ten times. Of the five identified FY 2020-21 QAPI workplan goals, there were 106 action items, of which the MHP met 60 (56.6 percent). The areas of focus include: Service Capacity, Accessibility of Services, Beneficiary Satisfaction, Cultural and Linguistic Competence, Beneficiary Safety and Medication Practices, Service Delivery and Clinical Issues, and Establishing Beneficiary and System Outcomes.

The MHP utilizes the following Level of Care (LOC) tool: The MHP reports that it does not have an LOC-specific tool, but that outcome tools in general are used to support LOC decisions. Program managers and clinicians meet monthly to review and evaluate LOC for beneficiaries. The MHP is also using CSI reports to determine appropriate care options.

The MHP utilizes the following outcomes tools: The Child and Adolescent Needs and Strengths – 50 (CANS-50) outcome tool and Pediatric Symptom Checklist – 35 (PSC-35) are used as an assessment aid to assist with treatment planning and care coordination. In addition, the Generalized Anxiety Disorder – 7 (GAD-7) assessment, the Patient Health Questionnaire – 9 (PHQ-9), CANS-50, and Adult Needs and Strengths Assessment (ANSA) are used for goal development and outcomes. Results are given to providers for treatment planning, goal setting, tracking improvement areas of life functioning, and to determine level of service needed.

QUALITY KEY COMPONENTS

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

Each Quality Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 6: Key Components – Quality

KC #	Key Components - Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The MHP's PIPs and the A3 Initiative for crisis response (A3 provides timely and appropriate behavioral health crisis services to Anyone Anywhere at Anytime) are good examples of using data to identify and address specific problems with program/process changes.
- While there are several committees and work groups to address specific issues such as inclusion, outreach, and homelessness, CFMs are not visible at the planning and decision-making phase. Minutes from various meetings identify contractors and MHP staff as attendees without CFM representation.
- The MHP reported that they do not include contractors in medication monitoring review. The MHP confirmed that some of the CBOs do have psychiatrists or nurse practitioners. As such, HEDIS measure tracking and trending appears to only be occurring for direct county-operated clinics/programs.
- The MHP faces some barriers in expanding the monitoring of HEDIS measures, including contractors not having access to Epic and not having a single source of labs or medications resulting in utilizing different providers. The MHP is working to resolve these barriers by creating centralized lab orders through Epic.

- The MHP does track and trend the following HEDIS measures as required by SB 1291:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD)
    - The use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC)
    - Metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)
    - The use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP:

- Beneficiaries Served by Diagnostic Category
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay (LOS)
- Retention Rates
- High-Cost Beneficiaries (HCB)

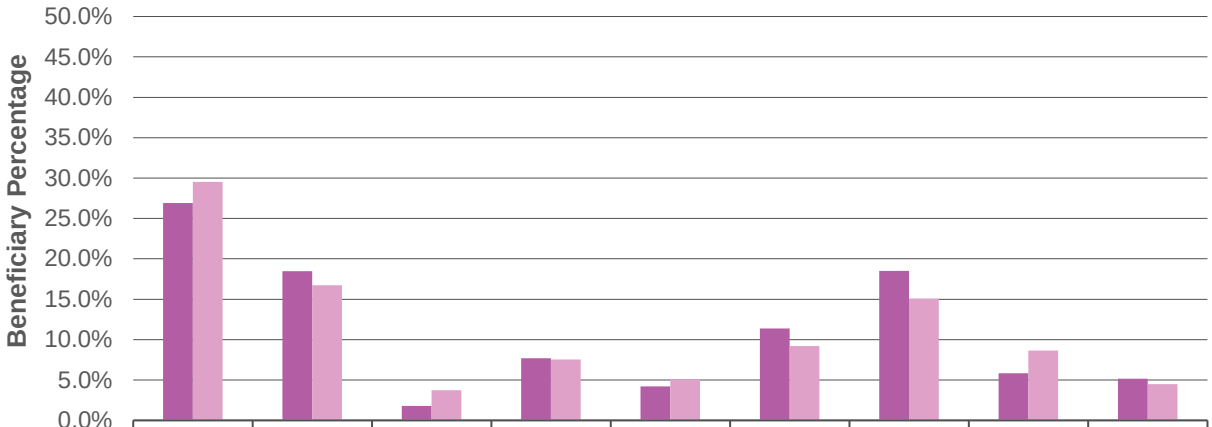
Diagnosis Data

Figures 12 and 13 compare the percentage of beneficiaries served and the total approved claims by major diagnostic categories, as seen at the MHP and statewide for CY 2020.

The MHP served a higher proportion of beneficiaries with psychosis (18.5 percent) and trauma-related disorders (18.5 percent) than the statewide average (16.7 percent and 15.1 percent respectively), and 26.9 percent of beneficiaries served have a diagnosis of depression. Beneficiaries with psychosis accounted for 26.4 percent of Contra Costa's total approved claims in CY 2020.

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020

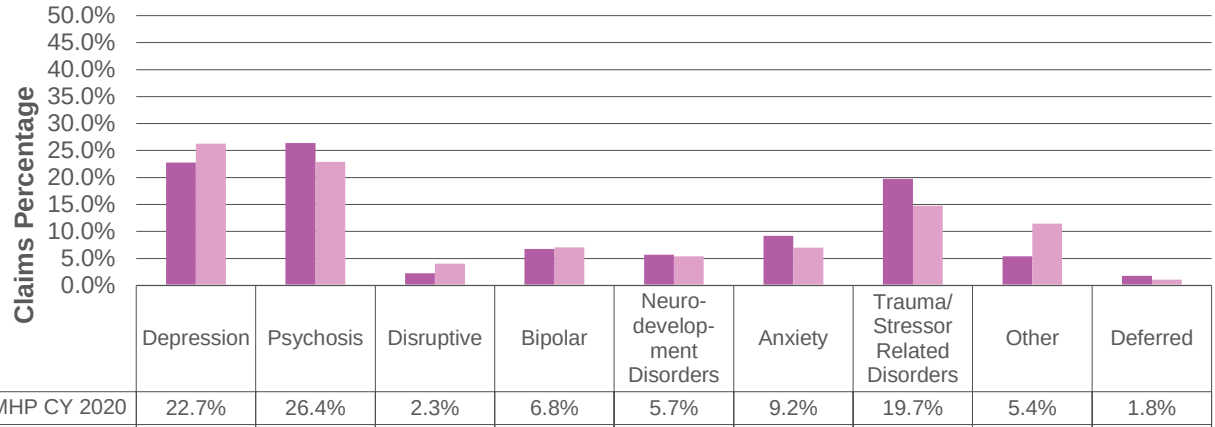
Contra Costa MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-develop-ment Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	26.9%	18.5%	1.8%	7.7%	4.2%	11.4%	18.5%	5.8%	5.1%
State CY 2020	29.5%	16.7%	3.7%	7.5%	5.1%	9.2%	15.1%	8.6%	4.5%

Figure 13: Diagnostic Categories by Percentage of Approved Claims CY 2020

Contra Costa MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-develop-ment Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	22.7%	26.4%	2.3%	6.8%	5.7%	9.2%	19.7%	5.4%	1.8%
State CY 2020	26.3%	22.9%	4.0%	7.1%	5.4%	7.0%	14.8%	11.5%	1.1%

Psychiatric Inpatient Services

Table 7 provides a three-year summary (CY 2018-20) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

The number of Contra Costa beneficiaries who had inpatient psychiatric services decreased in CY 2020 as well as their total number of admissions; however, those who were hospitalized stayed half a day longer than the statewide average and their average claim was higher by $7,500.

Table 7: Psychiatric Inpatient Utilization CY 2018-20

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 2020	979	1,594	9.31	8.68	$19,387	$11,814	$18,980,014
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

High-Cost Beneficiaries

Table 8 provides a three-year summary (CY 2018-20) of HCB trends for the MHP and compares the MHP's CY 2020 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.

Tracking the HCBs provides another indicator of quality of care. High cost of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than the rest of the beneficiaries receiving SMHS. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of

total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

Contra Costa's HCB count showed an increase from 721 in CY 2019 to 1,052 in CY 2020, and the proportion of HCB (6.81 percent) was higher than the statewide rate of 4.07 percent. HCBs accounted for 47.61 percent of Contra Costa's total claims in CY 2020.

Table 8: HCB CY 2018-20

Contra Costa MHP							
	Year	HCB Count	Total Beneficiary County	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
MHP	CY 2020	1,052	15,453	6.81%	$61,981	$65,204,384	47.61%
	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%

See Attachment D, Table D2 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.

Retention Data

In CY 2020, Contra Costa showed a higher percentage of beneficiaries with only one to four services when compared to the state.

Table 9: Retention of Beneficiaries

	Contra Costa			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 Service	1,862	12.05	12.05	9.76	9.76	5.69	21.86
2 Services	1,213	7.85	19.90	6.16	15.91	4.39	17.07
3 Services	1,038	6.72	26.62	4.78	20.69	2.44	9.17
4 Services	924	5.98	32.60	4.50	25.19	2.44	7.78
5-15 Services	4,458	28.85	61.44	29.47	54.67	19.96	42.46
>15 Services	5,958	38.56	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

Relative to the statewide average of 16.7 percent, Contra Costa served more beneficiaries (18.5 percent) with a diagnosis of psychosis in CY 2020, and they accounted for 26.4 percent of total approved claims.

The number of beneficiaries who had inpatient psychiatric services decreased in CY 2020, but they stayed half a day longer than the statewide rate and their average claim was higher by $7,500.

HCBs increased by 300 in CY 2020 at 6.81 percent, which was higher than the statewide rate of 4.07 percent. Also, HCBs accounted for almost half of the county's total approved claims.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Addressing Depression and Anxiety Among Youth

Date Started: October 2020

Aim Statement: Will clients who are referred to and participate in a Cognitive Based Therapy for Depression Group see a reduction of depression symptoms by 15 percent and an increase in self-identified functions by 10 percent?

Target Population: This PIP will focus on youth beneficiaries ages 12 to 18 who are receiving SMHS at East County Children's Clinic who have trauma-related symptoms.

Validation Information:

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

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

The MHP's clinical PIP is in the second remeasurement phase and considered active and ongoing.

Summary

The goal of this PIP is to provide new treatment modalities for Contra Costa MHP beneficiaries who are suffering from depression to help reduce their symptoms. Of the beneficiaries who had completed a PHQ-9 at any point in their treatment at the East County Adult Behavioral Health Clinic, 30.2 percent had a primary diagnosis of depression. When limited to beneficiaries at East County Adult Behavioral Health Clinic who had moderately-severe depression symptoms on their baseline PHQ-9, 41.3 percent of beneficiaries had a primary diagnosis of depression and 43.2 percent of beneficiaries who had severe depression symptoms on their baseline had a primary diagnosis of depression. After this analysis of PHQ-9 data was presented to the Evidence Based Practices Workgroup and the QIC, both committees suggested the adoption of Cognitive Behavioral Therapy for Depression (CBT-D) as an intervention.

To receive the intervention, beneficiaries with a depression diagnosis or severe depressive symptoms are referred to the CBT-D group by their treating clinician and/or psychiatrist. The CBT-D group leaders interview the referred beneficiaries to ensure they are appropriate for the group and to establish group cohesion. Currently, CBT-D is offered at the East County Adult Behavioral Health Clinic; however, The MHP plans to expand the treatment to the other county clinics once additional clinicians are trained to ensure fidelity to the model. The MHP is also working to identify CBOs and contract providers that may also be interested in providing CBT-D.

So far, there has only been one data cycle, which occurred at the conclusion of the first CBT-D module. Of the beneficiaries who completed a PHQ-9 at the end of the first module, none of these clients saw an increase in their total score. The sample size is small and unable to yield significant results.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: although findings showed that changes in PHQ-9 and GAD-7 scores were not statistically significant, it is possible that the small number of participants affected the significance; all groups demonstrated a reduction in depression and anxiety symptoms which is promising.

The TA provided to the MHP by CalEQRO consisted of:

- Ongoing phone, video, and email consultation.
- Guidance on recommencing the PIP, discussing barriers to engagement.

- Discussing concerns regarding population size and expanding participants.

CalEQRO recommendations for improvement of this clinical PIP include:

- The MHP should specify the time period for the PIP in the aim statement.
- It is recommended that the MHP consider administering the CANS at the same interval as the other measures, or at least at the end of the five-week group. Issues could potentially arise before the next sixth month or discharge administration of CANS-50 such as beneficiaries leaving treatment with no contact, or other delays which will result in incomplete CANS-50 data.
- The MHP would benefit from recruiting a larger number of participants for the TF-CBT groups so that there is more data to analyze for statistical significance.

NON-CLINICAL PIP

General Information

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

Date Started: November 2021

Aim Statement: Will providing beneficiaries with a reminder call from their therapist containing a “gain-framed” message significantly decrease no-shows to initial assessment appointments at the East Adult Clinic to be no higher than 15 percent within a year of the launch of the PIP.

Target Population: All beneficiaries receiving their initial assessment appointment at the MHP’s East Adult Clinic.

Validation Information:

The MHP’s non-clinical PIP is in the implementation phase and considered active.

Summary

The Improving Appointment Adherence to the First Appointment project is a systemic approach to improving appointment adherence and ensuring timely access to care for mental health beneficiaries using beneficiary-based interventions. The project focuses on new beneficiaries to provide early engagement with the assessment process through phone outreach to increase attendance to initial assessments. If the beneficiary expresses any ambivalence about attending this appointment, staff will use motivational interviewing (MI) to help the beneficiary work through ambivalence and attend the

appointment. During reminder calls the CSW/FSW will identify any beneficiaries who have transportation barriers and will provide a warm hand-off for transportation assistance in navigating the public transportation system.

Analysis of the data suggests that the PIP did have an impact on appointment non-adherence rates. Overall, there was a statistically significant improvement in the percentage of missed appointments at East Children's Clinic from 35 percent missed appointments to 27 percent missed appointments.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: there is some concern regarding continuity of therapist adherence to the protocol of reminding beneficiaries of their appointments and recording the outcome of the calls.

The TA provided to the MHP by CalEQRO consisted of:

- Ongoing video, email, and phone consultation.
- Discussion regarding fidelity to best practice model and intervention implementation.

CalEQRO recommendations for improvement of this non-clinical PIP include:

- Addressing continuity issues related to therapist adherence to intervention protocols as the success of PIP is contingent upon it.

INFORMATION SYSTEMS (IS)

BACKGROUND

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

IS IN CONTRA COSTA COUNTY

California MHP EHRs fall into two main categories -- those that are managed by county or MHP IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Epic (ccLink), which has been in use for four years. In preparation for CalAIM, the MHP is participating in a CalMHSA initiative to explore an integrated EHR for mental health and substance use disorder (SUD) services that will support interoperability with CBOs.

Approximately two percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is allocated to the MHP but managed by another county department. The FY 2021-22 IT budget is identical to what was budgeted for the previous year.

The MHP has 789 named users with log-on authority to ccLink, including approximately 619 county-operated staff and 170 contractor-operated staff. Support for the users is provided by 11 full-time equivalent (FTE) IS technology positions. Currently all positions are filled and technology staff support that includes both Mental Health and Alcohol and Other Drugs (AOD) Services. The 11 FTE technology positions are three less from the prior year's 14 FTEs.

As of the FY 2021-22 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Line staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the MHP practice management system (ShareCare) as reported in the following table:

Table 10: Contract Providers' Transmission of Beneficiary Information to MHP IS

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
☐	Electronic Data Interchange (EDI) to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☒	Electronic batch file transfer to MHP IS	☒ Daily ☒ Weekly ☒ Monthly	12%
☒	Direct data entry into MHP practice management system by provider staff	☒ Daily ☒ Weekly ☒ Monthly	88%
☐	Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☐	Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
			100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a PHR enhances beneficiaries' and their families' engagement and participation in treatment. Beneficiaries who are CCHS beneficiaries have online access to MyChart, the ccLink electronic patient portal.

Interoperability Support

The MHP is not a member or participant in a Health Information Exchange (HIE). Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information with contract providers, Whole Person Care, Federally Qualified Health Centers, hospitals, and primary care providers.

IS KEY COMPONENTS

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

Each IS Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 11: Key Components – IS Infrastructure

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

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

- In the past year, the MHP has continued to improve its IT infrastructure:
- An IT governance structure was put in place to improve communication with executive staff.
- An Informatics Chief was hired in Spring 2021 to focus on internal governance and leadership within the MHP.
- A dashboard for IT project prioritization was created.
- A process was created to channel system improvement ideas into changes to the IS.
- In response to the 21st Century Cures Act final rule, which included prohibition of information blocking in an EHR, the MHP began sharing the Partnership Plan for Wellness through MyChart in November 2020. In April 2021, the MHP began sharing more information through MyChart that includes clinical notes, discharge summary, network provider services, and CBO services.

- In October 2021, ccLink was upgraded to the latest version which included additional features for the MHP such as a suicide prevention plan. The suicide prevention plan is available to the beneficiary in MyChart after being completed.
- E-signature is available to beneficiaries via MyChart or signature pads for initial registration documents that include the Consent to Services, Advanced Directives, Patient Rights, and HIPAA Notice of Privacy Practices.
- The MHP has made mobile applications for ccLink available to county clinical providers which allows them easier access to beneficiary charts while out in the field. Through the use of Haiku and Canto, providers have the ability to access beneficiary records from their smartphones (Haiku) and tablets (Canto), chat securely, and view and act upon messages in their In Basket.
- In October 2021, the Utilization Review (UR) Unit and three CBOs began a pilot project to streamline the process for CBOs to electronically submit beneficiary paperwork to UR for intake treatment plan review and authorization. New workflows were designed with a goal to reduce total disallowed services due to missing paperwork, improve timeliness of documentation submission, and implement a secure and electronic process where communication and paperwork can be tracked. The MHP plans to roll out the new process for the remaining CBOs in Fall 2022.
- CBOs continue to do double data entry in ShareCare and their own EHRs to record services provided. This practice is a burden on the CBOs, not cost-effective, and prone to data-entry errors.

IMPACT OF FINDINGS

While making strides to improve the IS landscape, the MHP also initiated a number of IT projects in collaboration with CCHS IT that will guide future technology development for both the MHP and DMC-ODS:

- A behavioral health IT consultant (Xpio) who has expertise in the California behavioral health system, regulatory requirements, billing processes, and has worked in multiple counties within the state, was contracted to do a gap analysis to look at current IS and their functionality, and what will be required with CalAIM healthcare reform efforts. This consultant is expected to begin work by January 2022 and provide recommendations by March 2022.

- Contra Costa is a participant in the CalMHSA vendor selection process to assess current functional requirements and anticipated functional requirements under CalAIM, EHR options that are focused on behavioral health, and the different approaches EHR vendors have for meeting the needs of county behavioral health in California.

- MHP and CCHS IT will assess whether ccLink has the required functionality to meet clinical documentation and claims processing for an integrated EHR for mental health and SUD, and support interoperability with mental health and SUD CBOs. Considerations may include choosing a new system for both, replacing the current practice management system, or configuring ccLink to meet MHP goals.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

BACKGROUND

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

CONSUMER PERCEPTION SURVEYS

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

The MHP administers the CPS 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.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

As part of the pre-site planning process, CalEQRO requested two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a culturally diverse group of 10-12 English-speaking caregivers/parents of beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 15 months. The focus group was held via Zoom video conferencing and included three participants; a Spanish language interpreter was used for this focus group. All consumers/family members participating receive clinical services from the MHP.

Assessment services were provided within one to two weeks for new beneficiaries, with psychiatry services taking a few months longer. Participants were not aware of how to access crisis services other than calling 911. All felt they could share feedback with the MHP, though none had received an invitation or were made aware of opportunities.

Recommendations from focus group participants included:

- Make more therapists available.
- Let beneficiaries know if therapist is leaving and if a new one will be assigned.
- Let beneficiaries know about available services and programs.

Consumer Family Member Focus Group Two

CalEQRO conducted a 90-minute focus group with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. CalEQRO requested a culturally diverse group of six to eight Spanish-speaking adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 15 months. The focus group was held via Zoom video conferencing and included five participants; a Spanish language interpreter was used for this focus group. All consumers/family members participating receive clinical services from the MHP.

Assessment services were provided within one to two weeks, with therapy services taking four months. Ongoing services were received at monthly intervals (psychiatry) and every three weeks for therapy services. Participants indicated that frequency was dependent on program, how well they were doing, and provider availability. Participants were aware of several options on how to access crisis services. All felt they could share feedback with the MHP, though none had received an invitation or were made aware of feedback opportunities.

Recommendations from focus group participants included:

- Provide consistent providers so that families do not have to repeat their story again and again.
- Provide a consistent messaging for medications (align with parent) for improved compliance.
- Employ more mentors, especially male mentors, and provide training for mentors on how to approach teens, handle challenging behavior, and improve participation.
- Include more education for parents and teens on safety, especially on human trafficking and the danger of online chats with strangers.
- Provide guidance for mentors on confidentiality.

IMPACT OF FINDINGS

The MHP successfully connects beneficiaries from various cultures to its many services. Mixed feedback regarding timeliness of services indicates a possible disconnect in ease of access and availability of services, warranting the need for a further look at the diversity of beneficiary experience when assessing timeliness.

CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP has a robust Cultural Humility Plan to address disparities in access including language and the identification of cultural needs.

   (Access)

2. The MHP is expanding crisis services through the A3 initiative, which provides timely and appropriate behavioral health crisis services to "Anyone Anywhere at Anytime."

   (Access)

3. The MHP, through the use of telehealth services, reduced no-shows among non-psychiatric appointments from 21 percent to 16 percent.

   (Timeliness)

4. The MHP's non-clinical PIP is aimed at improving no-show rates among non-psychiatry providers through the expansion and use of telehealth.

   (Quality)

5. The MHP expanded staff for the Office of Informatics and Technology team. A consultant completed a gap analysis to prepare for CalAIM and inform on IT needs.

   (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Latino/Hispanic and API individuals are disproportionately less likely to access SMHS in Contra Costa County. In CY 2020, Latino/Hispanic individuals represented 34.1% of the total Medi-Cal eligible population yet comprised only 25% of beneficiaries served. In the same time period, API beneficiaries represented 10.9% of the total Medi-Cal eligible population, yet they represented only 4.8% of beneficiaries served.

   (Access)

2. Improved efforts to expand capacity both at the MHP and contractor level is needed to improve wait times for services post-assessment and reduce ongoing waitlists for service

   (Access, Timeliness)

3. The MHP demonstrates commitment to retain in-person service availability for beneficiaries in addition to continuing to offer telehealth services. While both service modalities are available, the MHP reports it cannot endorse telehealth services over in-person services; stakeholders report concern that this may contribute to reduced flexibility for beneficiaries, decreased staff morale, and increased staff turnover.

   (Access, Timeliness)

4. Fewer than half of all discharged beneficiaries received a follow-up service within 7-days of psychiatric hospitalization.

   (Timeliness)

5. CFM participation and feedback appear limited in time and scope per limited CFM references in meeting minutes and agendas. It is unclear whether CFMs are fully utilized in all aspects of the mental health system.

   (Quality)

6. The MHP does not include contractors in medication monitoring review. The MHP reports barriers in expanding the monitoring of HEDIS measures, including contractors not having access to Epic and not having a single source of labs or medications, resulting in utilizing different providers.

   (Quality)

RECOMMENDATIONS

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

1. Investigate reasons for the disproportionate access to specialty mental health services among Latino/Hispanic and API beneficiaries in Contra Costa County. Take action to ameliorate the gaps in service.

   (Access)

2. Investigate reasons for long wait times and wait lists for services after initial assessment. Take action to improve wait times post assessment to ongoing service and reduce waitlists.

(Access, Timeliness)

3. Continue to promote beneficiary choice in service modality; at the same time, explore and implement strategies to further increase systemwide flexibility and address staffing concerns.

   (Access, Timeliness)

4. Investigate reasons for low rate of follow-up post-hospitalization appointments meeting the 7-day standard. Take action to improve rate of appointments meeting the standard.

   (Timeliness)

5. Evaluate and take action to increase opportunities for CFMs to provide feedback related to the MHP system, including the unduplicated number of CFMs who participate, types of events, and the methods of outreach, and memorialize CFM participation in meeting minutes.

   (Quality)

6. Include contractors in medication monitoring review. Identify solutions to barriers including providing access to Epic where contractor services include medication prescribing or monitoring.

   (Quality)

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: CALEQRO REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

Contra Costa
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, QI and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
CFM Focus Group(s)
Contract Provider Group Interview – Operations and Quality Management
IS Billing and Fiscal Interview
ISCA
Prescribers Group Interview
Peer Employee Group Interview
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Cyndi Lancaster, Lead Quality Reviewer
Olivia Kozarev, Quality Reviewer
Caroline Yip, IS Reviewer
MaryEllen Collins, 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.

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Aguirre	Priscilla	Quality Management Program Coordinator	CC Behavioral Health
Ahad	Terry	Mental Health Program Supervisor	CC Behavioral Health
Andreev	Oleg	Health Services Info Systems Programmer/Analyst	CCHS Info Technology
Ang	JR	Director of Patient Accounting	CCHS Finance
Armstrong	Kerry	Program Supervisor	CC Behavioral Health
Battis	Claire	Health Services Planner/Evaluator	CC Behavioral Health
Bautista	Jessica	Mental Health Clinical Specialist	CC Behavioral Health (First Hope)
Becerra	Marina	Mental Health Clinical Specialist	CC Behavioral Health
Bennet	Cathy	Hospital Liaison for Children's Mental Health	CCHS Info Technology
Bergesen	David	Contractor	Community Options for Families & Youth
Berlingieri	William	Lead Psychiatrist	CC Behavioral Health
Bianchi	Charlene	Katie A. Program Manager	CC Behavioral Health
Blanza	Jennifer	Contractor	Seneca
Blee	Liz	Mental Health Clinical Specialist	CC Behavioral Health
Bruggeman	Jennifer	Program Supervisor	CC Behavioral Health
Burton-Flores	Margie	Mental Health Program Supervisor	CC Behavioral Health
Caldwell	Pete	Contractor	We Care Children
Callaghan	Jim	Contractor	Mental Health Systems, Inc.
Calloway	Vernon	InSyst Support Analyst	CCHS Info Technology
Campbell	Kathleen	Mental Health Clinical Specialist	CC Behavioral Health
Cardenas	Paula	Mental Health Clinical Specialist	CC Behavioral Health
Cathey	Kellee	Mental Health Clinical Specialist	CC Behavioral Health
Celio	Chris	Contractor	Hume Center
Chavez	Beatriz	Mental Health Clinical Specialist	Child Therapy Institute
Chmiel	Denise		CC Behavioral Health
Cobaleda-Kegler	Jan	Adult/Older Adult Program Chief	CC Behavioral Health
Cua-Ang	Jeremiah		CC Behavioral Health
Curran	Brittany	Mental Health Clinical Specialist	CC Behavioral Health
Danko	Adam	Psychiatric Mental Health Nurse Practitioner	CC Behavioral Health
Diaz	Alicia	Mental Health Clinical Specialist	CC Behavioral Health

Last Name	First Name	Position	Agency
Dimidjian	Natalie	Mental Health Program Supervisor	CC Behavioral Health
Dold	Amanda	Integration Services Manager	CC Behavioral Health
Dominguez	Jessica		CC Behavioral Health
Donahue	Jessica	Contractor	Seneca
Down	Adam	Ethnic Services and Training Coordinator	CC Behavioral Health
Eriksson	Gabriel	Contractor	Community Options for Families & Youth
Faramazyan	Alina	Lead Psychiatrist	CC Behavioral Health
Fattah	Hala	Lead Psychiatrist	CC Behavioral Health
Fernandez	Nancy	Manager	CC Behavioral Health
Fuhrman	Beverly	Mental Health Program Manager	CC Behavioral Health
Gallagher	Ken	Research & Evaluation Manager	CC Behavioral Health
Gargantiel	Paolo	Access Line & Care Management Unit Operations Lead	CC Behavioral Health
Gibson	Teresa	Mental Health Program Supervisor	CC Behavioral Health
Girardey	Marina	Mental Health Clinical Specialist	CC Behavioral Health
Girardey	Brigette		CC Behavioral Health
Goss	Sonja	Contractor	Seneca
Grewats	Jennifer	Mental Health Community Support Worker	CC Behavioral Health
Hannah	Elizabeth (Betsy)	Mental Health Clinical Specialist	CC Behavioral Health
Haridas	Arun	Lead Psychiatrist	CC Behavioral Health
Hasenpusch	Colleen	Mental Health Community Support Worker	CC Behavioral Health
Hayes	Warren	Mental Health Program Chief	CC Behavioral Health
Hayes	Amma	Mental Health Clinical Specialist	CC Behavioral Health
Heher	Kirsten	Mental Health Community Support Worker	CC Behavioral Health
Huynh	Winnie	Mental Health Program Supervisor	CC Behavioral Health
Jacob	Jean	Health Services Planner/Evaluator	CC Behavioral Health
Johnson	Jessica	Mental Health Clinical Specialist	CC Behavioral Health
Johnson	Kennisha	Mental Health Program Manager	CC Behavioral Health
Juaregui-Ornelas	Cecilia	Mental Health Clinical Specialist	CC Behavioral Health

Last Name	First Name	Position	Agency
Jun	Jimmy	Mental Health Clinical Specialist	CC Behavioral Health
Kalaei	Susan	Behavioral Health Pharmacist	CC Behavioral Health
Khan-Amirkani	Shereen	Contractor	Early Childhood Mental Health Program (ECMHP)
Koita	Kadiatou	Health Services Planner/Evaluator	CC Behavioral Health
Lau	Edward	Lead Psychiatrist	CC Behavioral Health
Leung	Yat Ming Jude	Program Manager	First Hope
Loenicker	Gerold	Child/Adolescent Services Program Chief	CC Behavioral Health
Lukas	Brian	Contractor	Child Therapy Institute
Luu	Matthew	Behavioral Health Deputy Director	CC Behavioral Health
Madruga	Christine	Mental Health Program Manager	CC Behavioral Health
Marina	Bridget	Mental Health Clinical Specialist	CC Behavioral Health
Martin	Diana	Mental Health Clinical Specialist	CC Behavioral Health
Masadas	Ja-Nel	Mental Health Community Support Worker	CC Behavioral Health
Matal Sol	Fatima	AOD Chief	CC Behavioral Health
Matthews	Zakee	Lead Psychiatrist	CC Behavioral Health
May	Leslie	Mental Health Commissioner	Mental Health Commission
Melendez	Robin	IS Specialist	CC Behavioral Health
Mendoza	Floris	Mental Health Program Supervisor	CC Behavioral Health
Menjivar-Beltran	Gloria	Mental Health Community Support Worker	CC Behavioral Health
Messerer	Mark	AOD Program Manager	CC Behavioral Health
Molina-Huntley	Liza	Administrative Contract Analyst	CC Behavioral Health
Naghshineh	Morvarid	Health Services Planner/Evaluator	CC Behavioral Health
Nasrul	Kimberly	QI Coordinator and Compliance Coordinator	CC Behavioral Health
Navarro	Johanna		CC Behavioral Health
Nawy	Jena	Mental Health Clinical Specialist	CC Behavioral Health
Neilson	Jersey	Health Services Planner/Evaluator	CC Behavioral Health
Nobori	Michelle	Mental Health Project Manager	CC Behavioral Health
Ny	Faye	Health Services Accountant	CC Behavioral Health
Nybo	Erik	Business Intelligence Developer	CC Behavioral Health

Last Name	First Name	Position	Agency
O'Neill	Robin	Mental Health Program Manager	CC Behavioral Health
Orme	Betsy	Mental Health Program Manager	CC Behavioral Health
Otis-Miles	Laura	Contractor	Mental Health Systems, Inc.
Pena	Jorge	Lead PSP/InSyst Support Analyst	CCHS Info Technology
Pierce	Chad	Mental Health Program Manager	CC Behavioral Health
Powers	Karen	Mental Health Program Supervisor	CC Behavioral Health
Quittman	Judy	Mental Health Clinical Specialist	CC Behavioral Health
Ransom	Kelly	Contractor	We Care Children
Rice	Megan	cclink Behavioral Health Project Manager	CCHS Info Technology
Rogers	Kimberly	Mental Health Community Support Worker	CC Behavioral Health
Sanabria	Bernadita	Program Supervisor	CC Behavioral Health
Scannell	Marie	Mental Health Program Manager	CCHS Info Technology
Serwin	Barbara	Mental Health Commissioner	Mental Health Commission
Shah	Maansi	Health Services Planner/Evaluator	CC Behavioral Health
Shah	Bhumil	Assistant IT Director, Analytics and Reporting	CCHS Info Technology
Shirgul	Ellen	Mental Health Program Supervisor	CC Behavioral Health
Siackasorn	Moukdavash	Mental Health Clinical Specialist	CC Behavioral Health
Siliezar	Elizabeth		CC Behavioral Health
Sloan	Jeff	Contractor	ECMHP
Smith	Raymond	Mental Health Community Support Worker	CC Behavioral Health
Spikes	Chet	Assistant Health Services IT Director	CCHS Info Technology
Surio	Blesilda	UR Manager	CC Behavioral Health
Sweeten-Healy	Heather	Mental Health Program Manager	CC Behavioral Health
Tarvins	Denise	Mental Health Clinical Specialist	CC Behavioral Health
Tavano	Suzanne	Behavioral Health Director	CC Behavioral Health
Thigpen	Robert	Mental Health Family Services Coordinator	CC Behavioral Health

Last Name	First Name	Position	Agency
Tiano	Mark	Program Supervisor	CC Behavioral Health
Tuipulotu	Jennifer	Office for Consumer Empowerment Coordinator	CC Behavioral Health
Tupper	Stacey	Project Manager	CC Behavioral Health
Visbal	Kristin	Mental Health Community Support Worker	CC Behavioral Health
Waters	Susan	Mental Health Community Support Worker	CC Behavioral Health
Whalen	Jon	Lead Psychiatrist	CC Behavioral Health
White	Matthew P.	Medical Director	CC Behavioral Health
White	Katy	Access Line and Care Management Unit Program Manager	CC Behavioral Health
White	Vicki	Mental Health Community Support Worker	CC Behavioral Health
White	Matthew P.	Medical Director	CC Behavioral Health
Wintermantel	Heidi		CC Behavioral Health
Wood	Amelia	Mental Health Clinical Specialist	Hume Center
Zesati	Genoveva	Administrative Services Assistant	CC Behavioral Health

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☒ →Moderate confidence ☐ →Low confidence ☐ →No confidence	The MHP should specify the time period for the PIP in the aim statement. It is recommended that the MHP consider administering the CANS-50 at the same interval as the other measures, or at least at the end of the five week group. Issues could potentially arise before the next sixth month or discharge administration of CANS-50 such as beneficiaries leaving treatment with no contact, or other delays which will result in incomplete CANS-50 data. The MHP would benefit from recruiting a larger number of participants for the TF-CBT groups so that there is more data to analyze for statistical significance.
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Contra Costa MHP	
PIP Title: Addressing Depression and Anxiety Among Youth	
PIP Aim Statement: **Will clients who are referred to and participate in a Cognitive Based Therapy for Depression Group see a reduction of depression symptoms by 15 percent and an increase in self-identified functions by 10 percent?**	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify):	

This PIP will focus on youth beneficiaries ages 12 to 18 who are receiving SMHS at East County Children's Clinic who have trauma-related symptoms and agree to participate in an online TF-CBT skills group.

Improvement Strategies or Interventions (Changes in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
1. CBT-Depression at East Adult Click or tap here to enter text.

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)
n/a

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of TF-CBT skills group participants completing group	April 2021	N= 2, 2 out of 3 complete group). Total of 11 sessions completed.	September 2021	N=8, (8 out of 12 complete group). Total of 54 sessions completed.	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent decrease in PHQ-9 scores from pre to post intervention	April 2021	35% decrease (n=2)	September 2021	13% (n=8)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of participants whose PHQ-9 scores decrease	April 2021	50% (n=2)	September 2021	71% (n=7)	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percent decrease in GAD-7 scores from pre to post intervention	April 2021	33% (n=2)	September 2021	10% (n=8)	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of participants whose GAD-7 scores decrease	April 2021	100%	September 2021	50% (n=8)	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Mean PHQ-9 scores pre and post intervention	April 2021	N=2, Mean pre =10, Mean post=6.5	September 2021	N=7, Mean pre=9, Mean post=7.9	☒ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Pre PHQ-9=9.62, Post PHQ-9=8.0 t(12)=1.90, p. =.08
Mean GAD-7 scores pre and post intervention	April 2021	N=2, Mean pre =12, Mean post =8	September 2021	N=8, Mean pre=8.6, Mean post=7.8	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Pre GAD-7 = 9.71, Post GAD-7 = 7.64, t(13)=1.94, p.= .07
Percent of participants whose functioning impact of depression decreases post intervention	April 2021	50% (N=2)	September 2021	14% (N=7)	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of participants whose functioning impact of anxiety decreases post intervention	April 2021	50% (N=2)	September 2021	25% (N=8)	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The MHP should specify the time period for the PIP in the aim statement. It is recommended that the MHP consider administering the CANS-50 at the same interval as the other measures, or at least at the end of the five week group. Issues could potentially arise before the next sixth month or discharge administration of CANS-50 such as beneficiaries leaving treatment with no contact, or other delays which will result in incomplete CANS-50 data. The MHP would benefit from recruiting a larger number of participants for the TF-CBT groups so that there is more data to analyze for statistical significance.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☒ →Moderate confidence ☐ →Low confidence ☐ →No confidence	The biggest issue with PIP implementation currently is therapist adherence to the protocol of reminding beneficiaries of their appointments and recording the outcome of the calls. The MHP has detailed a plan for addressing this issue and the progress of the PIP currently hinges on the success of increasing therapist adherence to protocols. The MHP needs to continue addressing this to move forward.

General PIP Information
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Contra Costa MHP
PIP Title: Gain-framed Provider Reminder Calls to Reduce No-Shows to Initial Assessment Appointments
PIP Aim Statement: Will providing beneficiaries with a reminder call from their therapist containing a "gain-framed" message significantly decrease no-shows to initial assessment appointments at the East Adult Clinic to be no higher than 15 percent within a year of the launch of the PIP.
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): All beneficiaries receiving their initial assessment appointment at the MHP's East Adult Clinic.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) 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) Warm reminder call with "gain-framed" message.

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number and percent of appointments for which a therapist receives a reminder text to provide a reminder call	n/a	n/a	11/18/21-12/2/21	47 reminder texts, 94% of appointments	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number and percent of appointments which are provided a warm call reminder.	n/a	n/a	11/18/21-12/2/21	14 reminder calls made, 28% of appointments received reminder call	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number and percent of beneficiaries successfully reached (therapist talked with direction)	n/a	n/a	11/18/21-12/2/21	4 beneficiaries talked to, 8% of scheduled beneficiaries	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
No-show rate to initial assessment appointment	n/a	n/a	11/18/21-12/2/21	24%	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

The biggest issue with PIP implementation currently is therapist adherence to the protocol of reminding beneficiaries of their appointments and recording the outcome of the calls. The MHP has detailed a plan for addressing this issue and the progress of the PIP currently hinges on the success of increasing therapist adherence to protocols. The MHP needs to continue addressing this to move forward.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Contra Costa					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,835,638	155,154	4.05%	$934,903,862	$6,026
Large	1,859,411	68,297	3.67%	$419,802,216	$6,147
MHP	77,683	3,959	5.10%	$19,776,096	$4,995

Table D2: CY 2020 Distribution of Beneficiaries by ACB Range

Contra Costa								
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	13,717	88.77%	92.22%	$55,138,600	$4,020	$4,399	40.26%	56.70%
>$20K-$30K	684	4.43%	3.71%	$16,610,057	$24,284	$24,274	12.13%	12.59%
>$30K	1,052	6.81%	4.07%	$65,204,384	$61,981	$53,969	47.61%	30.70%

Table D3: Summary of CY 2020 Short-Doyle/Medi-Cal Claims

Contra Costa MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**414,458**	**$156,253,456**	**31,434**	**$6,421,000**	**4.11%**	**$149,832,456**	**$132,599,490**
JAN20	40,618	$11,796,574	3,553	$558,615	4.74%	$11,237,959	$9,670,256
FEB20	38,174	$11,228,805	3,149	$476,049	4.24%	$10,752,756	$9,154,605
MAR20	40,003	$10,971,656	3,754	$637,309	5.81%	$10,334,347	$8,882,599
APR20	38,904	$13,195,430	3,554	$682,367	5.17%	$12,513,063	$10,265,940
MAY20	36,021	$13,616,621	3,109	$648,331	4.76%	$12,968,290	$11,040,973
JUN20	34,128	$13,790,855	3,122	$711,172	5.16%	$13,079,683	$11,845,614
JUL20	32,031	$13,233,330	2,615	$551,795	4.17%	$12,681,535	$11,386,756
AUG20	31,023	$13,162,795	2,134	$554,712	4.21%	$12,608,083	$11,267,448
SEP20	34,022	$14,102,078	1,994	$511,247	3.63%	$13,590,831	$12,301,632
OCT20	33,637	$14,926,403	1,542	$420,743	2.82%	$14,505,660	$13,155,400
NOV20	27,605	$12,944,644	1,460	$349,694	2.70%	$12,594,950	$11,650,617
DEC20	28,292	$13,284,264	1,448	$318,965	2.40%	$12,965,299	$11,977,652

Includes services provided during CY 2020 with the most recent DHCS claim processing date of July 30th, 2021. Only reports Short-Doyle Medi-Cal claim transactions and does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2020 was 3.19 percent.

Table D4: Summary of CY 2020 Top Five Reasons for Claim Denial

Contra Costa MHP			
Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim attachment other documentation that was received was the incorrect document	20,520	$1,950,591	30%
Beneficiary not eligible	1,122	$876,340	14%
Medicare Part B or Other Health Coverage must be billed before submission of claim	2,608	$872,526	14%
Beneficiary not eligible or non-covered charges	1,788	$761,942	12%
Claim/service lacks information which is needed for adjudication	1,374	$671,875	10%
TOTAL	**27,412**	**$5,133,274**	**80%**

Developmental Disabilities Council, Regional Centers & Meeting the Mental Health needs of People with Developmental Disabilities

September 7, 2022

Artist Barry Regan

Overview

Developmental Disabilities Council

Regional Center

Regional Center Eligibility

RCEB funded services

Mental Health needs of DD Population

Services we have access to

Gaps in MH services

Developmental Disabilities Council

Mission: To promote the coordination, improvement, and growth of services and supports to individuals with developmental disabilities and their families. To advocate for the needs of people with developmental disabilities and their families.

The 21 member Board of Directors is a diverse group of self-advocates, family members, and services providers. The Council meets monthly to disseminate information about existing resources, listen to expressed needs, and advocate for the development of services.

Council efforts focus on: employment services, emergency planning, equity issues, transportation, education, healthcare, and support for people across the lifespan.

Regional Centers

Founded in California 1965 due to recognition of special needs of people with intellectual disabilities. Expanded statewide in 1967. Expanded again in 1974 to serve greater variety of consumers.

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

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

Eligibility

To be made eligible for RCEB, a person must apply for services.

Applications for DD are usually completed by family members , advocates, or occasionally the person themselves.

There are 2 programs within the Regional Center:

Early Start and Lifelong Disabilities.

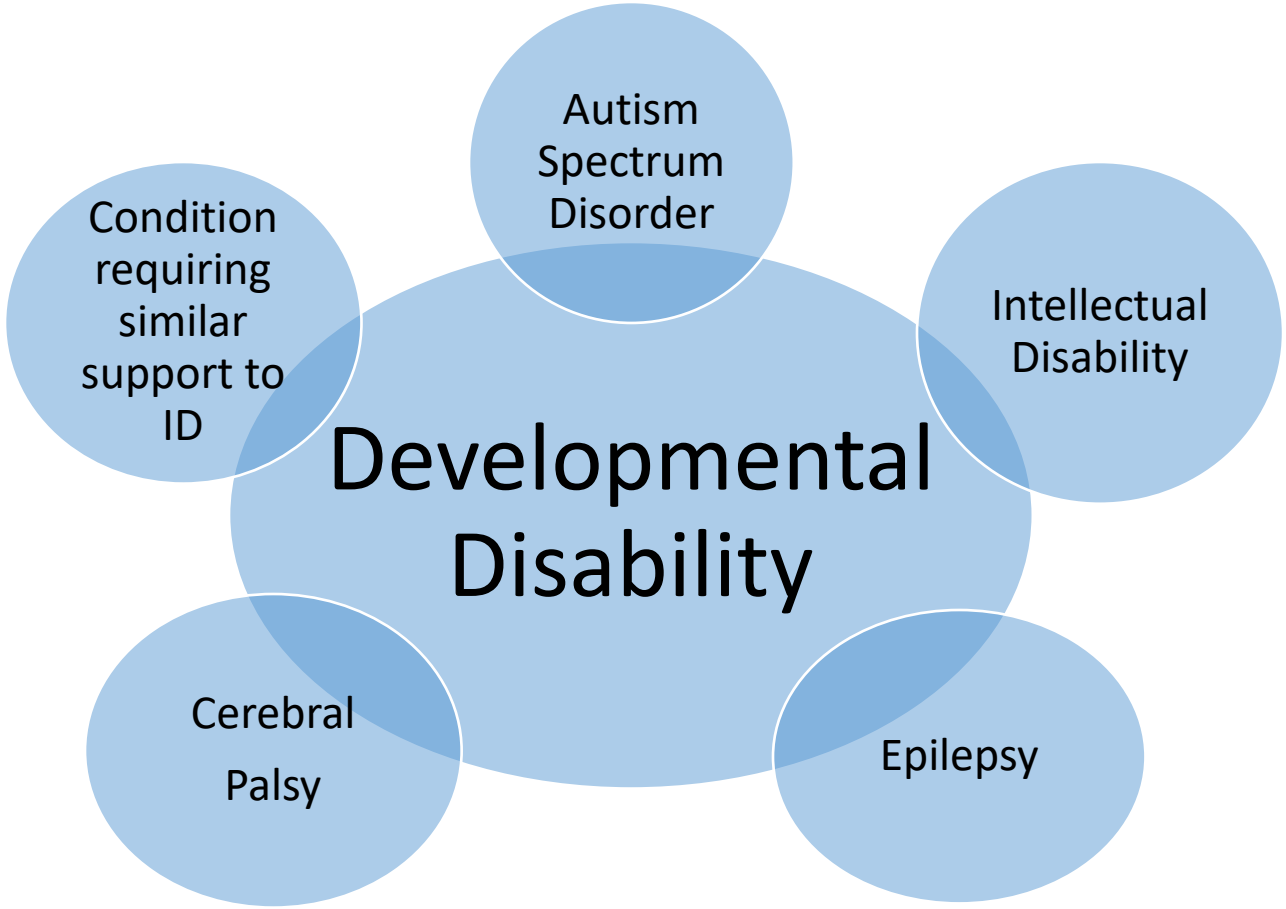
Early Start provides services to children ages 0-3 who demonstrate

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

Lifelong eligibility

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

Who is Eligible



Developmental Disability *and* Substantially Disabled

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

Services

If eligible, Regional Center assigns a Case Managers.

Case Managers are coordinators of services. They meet with the client, families, or other supports to create an Individual Program Plan (IPP).

An IPP contains life details, goals, and services obtained or needed.

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

Regional Centers contract out for services in the community.

The kinds of services provided by Regional Centers are regulated by the law and enforced by DDS.

Services may Include:

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

Generic Resources and Insurance

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

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

--Lanterman Act, WIC 4648(8)

Mental Health and Developmental Disabilities

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

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

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

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

Some Data…

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

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

ADHD occurs in 50-70 %

Depression occurs in 40 % versus neurotypical pop

Anxiety 40% versus neurotypical population

Mood and Psychosis #'s vary, but higher than general population

Why Limited Access

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

Why:

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

But Remember Slide 11!!!

Service Gaps

There are few providers who will assess and treat mild to moderate mental health conditions.

There are few providers of long term therapy for DD individuals who have long term mental health conditions.

Psychiatrists often refuse to see non-verbal clients, and are only willing to advise PCPs on medical treatment of psychiatric conditions.

Psychiatric hospitals do not often provide adequate services. They often turn DD clients away at ER once a disability is discovered.

Clients are sometimes “banned” from hospitals because of behaviors.

Clients are sometimes held in ER inappropriately because hospitals won’t transfer them to appropriate care.

RCEB Funded “Crisis Support”

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

Our crisis services include:

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

Glimmers of Hope

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

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

What is Needed..

Advocate for more public mental health clinics to do intake, proper mental health assessments, and provide treatment.

Training for mental health clinics on meeting the needs of dual diagnoses patients.

Advocacy for psychiatrists to properly serve outpatient dual diagnosis clients even those with limited verbal abilities.

Advocacy for hospitals and Intensive Outpatient Programs to properly serve dual diagnosis patients.

Increase attention to mental health in school age population.

Collaboration around projects, such as the K-12 project, to include dually diagnosed children.