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FY 2022-23
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

CONTRA COSTA FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 18-19, 2023

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Contra Costa" may be used to identify the Contra Costa County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — January 18-19, 2023

MHP Size — Large

MHP Region — Bay Area

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
6	5	1	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	5	1	0
Quality of Care	10	4	6	0
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**16**	**10**	**0**

Table C: Summary of PIP Submissions

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

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	13
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	9

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The Anyone, Anywhere, Anytime (A3) reconfiguration of crisis services shows the promise of having services available at all times.
- Despite vacant positions, the Quality Improvement (QI) program is creative in its focus on quality and service improvements.
- The MHP's method of analyzing Information Technology (IT), ensures projects are implemented efficiently and economically and are able to produce desired outcomes.
- Telehealth delivery is robust across both county and contract provider programs.
- The Access virtual assessment pilot shows the promise of accomplishing rapid intakes and assessments and reducing assessment no-shows.

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

- The MHP continues to be impacted by capacity issues related to recruitment and retention challenges.
- The communication of California Advancing and Innovating Medi-Cal (CalAIM) changes to providers and others in utilization management need to be more comprehensive and consistent.

- The MHP does not yet have a comprehensive, ongoing Senate Bill (SB) 1291 monitoring process for contract providers.
- Claims denial rates are higher than statewide and may result in lost revenue.
- Community-based organizations (CBOs) must perform double data-entry, increasing the chances of errors.

Recommendations for improvement based upon this review include:

- Implement recruitment and retention strategies identified through staff input.
- Develop a clinical and utilization review documentation manual which incorporates recent DHCS findings.
- Develop a comprehensive SB 1291 medication monitoring process for both directly-operated and contract providers.
- Expand use of batch files or direct entry into MHP EHR for CBOs.
- Investigate claim denial reasons and develop a plan to reduce denials and recover lost revenue.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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 SB 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2022-23 findings of the EQR for Contra Costa County MHP by BHC, conducted as virtual review on January 18-19, 2023.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to 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, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, 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, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results 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, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, then "<11" is indicated 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 (PR) percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during/after the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP has experienced a continued loss of staff, difficulties with recruitment and retention of personnel, and required a shift to telehealth and virtual services. 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.

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.

- Filling vacant key program leadership positions has occurred in the past year; however, continued challenges occur with retention and recruitment efforts.
- Implementation of California Advancing and Innovating Medi-Cal (CalAIM) changes, including screening tools, changes to Current Procedural Terminology codes, documentation changes, no wrong-door, and development of memorandums of understanding with Managed Care Plans (MCP) to support data exchange protocols have presented an extensive task.
- The pandemic impact upon business and clinical practices of the MHP has continued the need for telehealth, particularly with psychiatry services and a shift to field-based services, while much of the organization has shifted back to offering in-person care for psychotherapy and other services.
- The redesign of the crisis continuum, which started in Fall 2020, has continued to shift services towards the needs identified by the key stakeholders—those with lived experience, advocates, caregivers, law enforcement, and clinical staff. This brought about the MHP's concept of "A3,": 'Anyone, anywhere, anytime, there is a crisis need, it will be met'. This is not yet a finished project and elements of it continue to be developed, such as the drop-in wellness center. The spirit of accessible and responsive crisis services is imbedded in all A3 services.
- The MHP partners with the Contra Costa Health Plan to administer Enhanced Care Management, the new CalAIM benefit. Various aspects of workflow, documentation, and collaboration are being developed.
- Implementation of the EPIC electronic health record (EHR) provider portal that includes contract provider utilization review (UR) enhancements and supports

electronic submission of required UR documentation has started with a pilot involving three CBOs. The intent is to involve the remaining CBOs once system implementation issues are identified and resolved.

- Automated appointment reminders utilizing the Artera system went live October 2022, supporting phone and text appointment reminders. This system also supports both clinical and non-clinical PIP efforts. Currently, the reminders are provided in English and Spanish. Reminders in Vietnamese, Tagalog, and Greek currently in development and reminders in Mandarin, Cantonese, and Russian are planned for future rollout. Currently, the reminders are scheduled for seven-and one-day notifications.
- Since the Fall of 2021, the MHP has sought to build children's outcome measures in the EPIC ccLink software, with a goal of evaluating the impact of the locally utilized evidence-based practices. In the Spring of 2022, the MHP added measures for Family-Based Treatment for Eating Disorders and the Eating Disorder Evaluation Questionnaire (EDE-Q). Adult measures were already included.
- The MHP is also working on the transition elements required to sunset the Sharecare billing system and transition all claiming to ccLink, which will occur in July 2023.
- The MHP launched an anti-stigma campaign called "I'm not a case," to target the terminology that discourages and stigmatizes individuals with mental health and/or substance use conditions.
- The MHP has worked with a consultant to develop contract templates for CBOs that will align with the changes in rate-setting processes and claiming that will occur in the next six months as part of CalAIM.
- Clinicians will be granted ccLink authorization to schedule appointments following a pilot that started in December 2022, and will result in greater transparency and reduction of redundancy in the appointment workflow.
- The Access Line program will be piloting a virtual assessment process, whereby beneficiaries screened by Access can also be immediately assessed via telehealth, in one call. The MHP hopes this process will reduce or eliminate the no-shows that are common with initial assessments. Furthermore, this process should expedite the provision of treatment services, improving outcomes.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 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 2021-22

Recommendation 1: Investigate reasons for the disproportionate access to SMHS among Latino/Hispanic and Asian/Pacific Islander (API) beneficiaries in Contra Costa County. Take action to ameliorate the gaps in service.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP acknowledges challenges in access for Latino/Hispanic and API beneficiaries.
- The MHP's leadership has engaged staff in discussions to identify root causes of lower access rates for the API and Latino/Hispanic individuals.
- The MHP contends that some of the difference is related to its tracking of race/ethnicity. The MHP reports high percentages of enrolled beneficiaries select "decline" or "unknown" for race/ethnicity questions. The MHP intends to increase efforts to capture this information, emphasizing with staff the importance of accuracy in this area. Without consistent and accurate information, the MHP finds it challenging to determine if further efforts are needed to improve engagement with historically underserved populations.
- Data improvement efforts to assist improving race/ethnicity tracking includes a request for improvements to access line data capture to incorporate race/ethnicity and language information to support analysis of the distribution of access calls.

- One aspect of improvement pursued by the MHP has been to hire individuals with specific linguistic capabilities. In order to maintain these critical staff, some positions have been categorized as protected from the usual seniority provisions, if reduction in workforce became necessary. In addition, the bilingual pay differential was doubled from $100 to $200 per month.
- The MHP is also using educational loan repayment initiatives as a strategy to recruit and retain individuals with relevant linguistic skills.
- While achievement in this area will take time to impact PRs, the course of actions planned should create improvement in this area. For this reason, this recommendation will not be continued for the current review period.

Recommendation 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.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The single most significant factor in extended wait times for treatment is the persistent challenges in recruitment and retention of licensed staff, leaving numerous vacancies and causing high caseload numbers for current staff.
- This staffing issue is compounded in the east part of the county that is a less desirable location for job applicants. East county has even greater staffing challenges, have lost 11 of 14 mental health clinical specialists over a two-year span.
- The MHP has implemented some interventions to facilitate access:
    - Enhanced Wait-List Management: In the adult and children's systems of care (ASOC/CSOC), therapists' outreach to waitlisted individuals every 30 days to re-assess needs. As appropriate, therapists refer individuals to group treatment, network providers, or CBOs. Case management services may also be provided to wait-list individuals to assist them in overcoming barriers.
    - Intensive Caseload Monitoring/Management: Increased supervisor involvement in monitoring of caseloads includes an outpatient attendance policy that has beneficiaries informed of the benefits of regular treatment sessions and the importance of cancelling appointments that they cannot attend. Within the CSOC, staff are directed to close services for beneficiaries who no-show to two Child/Family Treatment meetings, so as to free up slots for others waiting for services. Additionally, clinical staff are directed to consider referrals to other community resources where appropriate. As another aspect of caseload management, the MHP is going to incorporate information from the Child Adolescent Needs and Strengths (CANS), Pediatric Symptom Checklist-35 (PSC-35) and other instruments in the re-determination of need for treatment process.

- Brief Therapy: In both the ASOC and CSOC, brief targeted therapy is being utilized. As an alternative to open-ended treatment, beneficiaries can access focused therapy that is limited in scope but built upon a shared, mutual understanding of the outcome expectations and duration of treatment. Brief therapy helps to open up capacity.

- This recommendation will be carried over in a modified format for this current review year, with an emphasis on resolution of the recruitment and retention of licensed personnel and implementation of the alternate work schedule options identified by leadership.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP noted provision of choice in how services were received was less frequent in the assessment service area, where in some instances only in-person services were offered. Access staff have been coached to offer choice in this area unless issues such as connectivity problems or attention span that may occur with younger beneficiaries are identified.
- The MHP surveyed clients regarding their preferred visit format (in-person, video, or phone) for different visit types. However, this process was limited to hard copy/paper responses, and likely omitted the feedback from those who are exclusively served by telehealth.
- Overall, survey respondents preferred in-person services to a combined phone/video option. The MHP is making efforts to improve access to telehealth options; integration of Zoom with ccLink and MyChart may accomplish this in 2023.
- A more complete analysis of beneficiary modality preferences that includes email/text participation options and online data capture would improve the representation of individuals served virtually in the MHP's analysis.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP's methodology for 7- and 30-day post-hospital discharge follow-up has been more rigorous than the Healthcare Effectiveness Data and Information Set (HEDIS) measure. The MHP has excluded unplanned services such as crisis from this data and includes all individuals served, which lowers the performance results.

- The MHP's EQR 7- and 30-day follow-up rates for the most recent CY 2020 and 2021 periods were higher than the statewide averages for the same timeframe.
- There are considerations for the MHP to modify its internal tracking of this metric to utilize the broader service inclusion of qualifying follow-up services utilized by HEDIS and also report out a parallel metric that only includes planned services.
- Recent exploration of this topic assisted the MHP and the EQRO to consider other approaches to reporting of this HEDIS measure. Since the MHP is currently outperforming the statewide average, and has done so for the past two years, this recommendation is considered addressed and will not be continued.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP identifies the use of townhalls, surveys, and CBO collaborations to receive input from beneficiaries and family members. In addition, there are a number of school-based forums that offer the opportunity for youth to provide input. The Mental Health Services Act process mandates regular, periodic meetings in which the community, beneficiaries and family members are asked for their input. The pandemic caused a pause in these meetings, but the meetings resumed in September 2022. Furthermore, there were five scheduled events that occurred in 2022 where input was sought from the community.
- The MHP also utilized a targeted approach to obtain stakeholder feedback on specific programs that were under development, including the Children's Crisis Services Unit. Stakeholder input was critical to the development and priorities of this program, and the final format addressed the concerns and needs identified by stakeholders.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has established a medication monitoring process for county-operated services, including a weekly chart review with a random sample of ten cases per provider. Results are presented to the MHP medical director. Peer reviews are conducted of line psychiatrist charts monthly.
- Due to involvement with an extensive EHR evaluation process, expansion of this medication monitoring process to the CBOs has yet to occur.

- In order to support the MHP's decision-making process in this area, analysis of service distribution was performed. Medication services were determined to comprise only 0.48 percent of CBO provided services, and 0.32 percent of all MHP services. The MHP acknowledges the importance of providing oversight of medication services, but it plans to improve in this area following the implementation of billing reform in summer of 2023. After the claiming process shift to EPIC occurs and stabilizes, the MHP will look to expand service and clinical data reviews.
- The MHP has shared its medication monitoring practices with CBO prescribers. The medical director, nurse program manager, and pharmacist will meet annually with CBO prescribers to monitor and provide feedback on shared beneficiaries.
- This recommendation is considered addressed and will not be continued.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or 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.[1] 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 PMs addressed below.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 36.89 percent of services were delivered by county-operated/staffed clinics and sites, and 63.11 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 87.80 percent of services provided were 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 the county Access Line staff during standard business hours, and by Optum, a contract provider, after hours. Non-urgent calls are followed up when the MHP Access Line team is back on duty. Beneficiaries may request services through the Access Line as well as through the following system entry points: presenting directly to a regional clinic site. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Urgent and crisis needs are referred to psychiatric emergency services and/or mobile crisis teams for adults and children/youth. Individuals are then screened and referred to services appropriate to their needs.

In addition to clinic-based services, the MHP provides psychiatry and mental health services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 5,872 adult beneficiaries, 11,536 youth beneficiaries, and 1,174 older adult beneficiaries across 22 county-operated sites and 129 contractor-operated sites. Among those served, 866 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

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

Table 1A: MHP Alternative Access Standards, FY 2021-22

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

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

Table 1B: MHP Out-of-Network Access, FY 2021-22

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

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

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to 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 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet 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 MHP monitors, tracks, and evaluates initial service access from test calls and call line data. The MHP broadly posts instructions regarding accessing services in one's preferred language at all points of contact. Automated appointment reminders went live in October 2022, with a seven- and one-day reminder programmed to occur in English or Spanish, as preferred.
- The MHP has developed a flexible and creative approach to resolving transportation barriers, including the use of flex funds for walking shoes, payment of vehicle registration fees, gas cards, and even the purchase of a tire for a beneficiary.
- The MHP utilizes creativity in managing demand and waitlists. Review informants are confident in the MHP's ability to provide initial intake and assessment in a timely manner. The limited input from beneficiaries overall did not significantly contradict this, although a small number reported long delays in accessing care.
- However, once the assessment has been completed there is often insufficient clinical capacity to rapidly initiate individual psycho-social treatment other than for those at the highest risk. This situation can become even more difficult when there is a need for a specialized intervention, such as dialectical behavioral therapy, in which very limited numbers of staff are certified.
- The MHP has developed quite a few strategies for this situation, including: development of group treatment where appropriate: use of a brief therapy model involving five to six sessions, monthly follow-up calls to those who have completed assessments and have yet to be assigned a clinician for therapy.
- Regarding possible solutions to the recruitment and retention issue, the MHP has explored this matter extensively. A survey of staff was conducted, in which the MHP sought to identify non-cash benefits that would improve recruitment and retention. Alternate work schedules and more competitive pay seem to be among the most important areas. Recently, there have been some pay raises, but review

participants cited that pay levels remain below nearby Bay Area counties that compete for the same labor market. While there is approval to utilize alternative work schedules, this option has been very slow to roll-out.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rates, and Average Approved Claims per Beneficiary Served

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) 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. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, the PR is higher than both similar size counties and statewide.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	297,051	14,906	5.02%	$116,430,899	$7,811
CY 2020	269,842	15,453	5.73%	$136,953,041	$8,863
CY 2019	262,957	14,764	5.61%	$105,379,251	$7,138

- Consistent with statewide patterns, the number of eligibles increased and the number of beneficiaries served decreased in 2021, contributing to a PR reduction.

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	30,075	476	1.58%	1.29%	1.59%
Ages 6-17	66,966	4,067	6.07%	4.65%	5.20%
Ages 18-20	15,435	783	5.07%	3.66%	4.02%
Ages 21-64	153,134	8,718	5.69%	3.73%	4.07%
Ages 65+	31,443	862	2.74%	1.52%	1.77%
Total	297,051	14,906	5.02%	3.47%	3.85%

- The PR for every age group, with the exception of ages zero through five, exceeds both the similar size county and statewide rates.

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	2,176	14.74%
Threshold language source: Open Data per BHIN 20-070		

- Nearly 15 percent of beneficiaries served speaks Spanish.

Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	91,746	3,991	4.35%	$21,989,714	$5,510
Large	2,153,582	62,972	2.92%	$387,366,612	$6,151
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- ACA eligibles represent 30.88 percent of the overall Medi-Cal population and the PR exceeds the large county and statewide rate.

The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population

of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served. Table 7 and Figures 1–9 compare the MHP's data with MHPs of similar size and the statewide average.

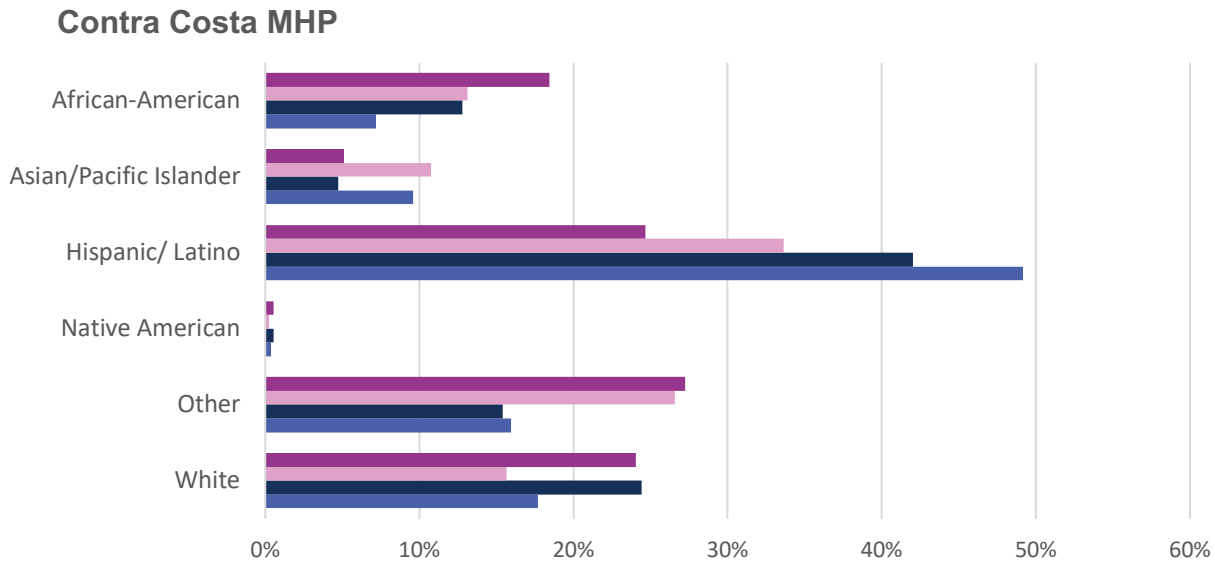
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	38,947	2,746	7.05%	6.83%
Asian/Pacific Islander	31,916	760	2.38%	1.90%
Hispanic/Latino	99,907	3,680	3.68%	3.29%
Native American	749	79	10.55%	5.58%
Other	79,001	4,059	5.14%	3.72%
White	46,534	3,582	7.70%	5.32%
Total	**297,054***	**14,906**	**5.02%**	**3.85%**

* Total Annual eligibles does not equal that of tables 3 and 4 due to rounding of variables in calculating the annual total as an average of monthly totals

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

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021

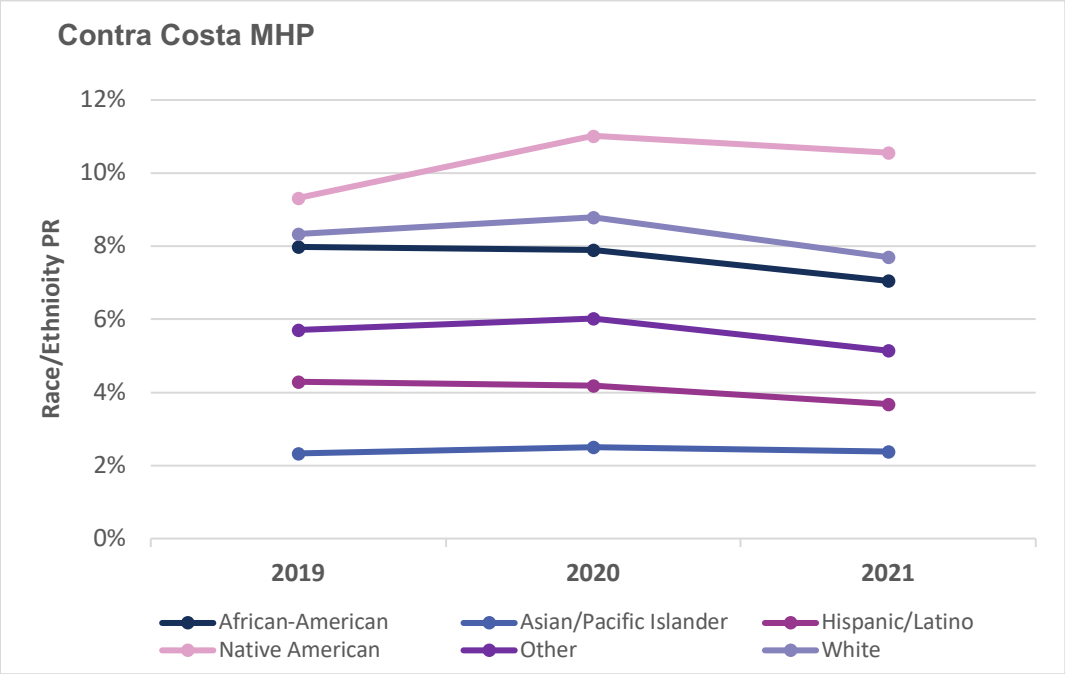


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	24%	27%	1%	25%	5%	18%
MHP % Eligibles	16%	27%	0%	34%	11%	13%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- Commonalities between the MHP and statewide are that the White and African-American groups appear to be overrepresented among beneficiaries served, whereas the Hispanic/Latino and API groups are underrepresented.

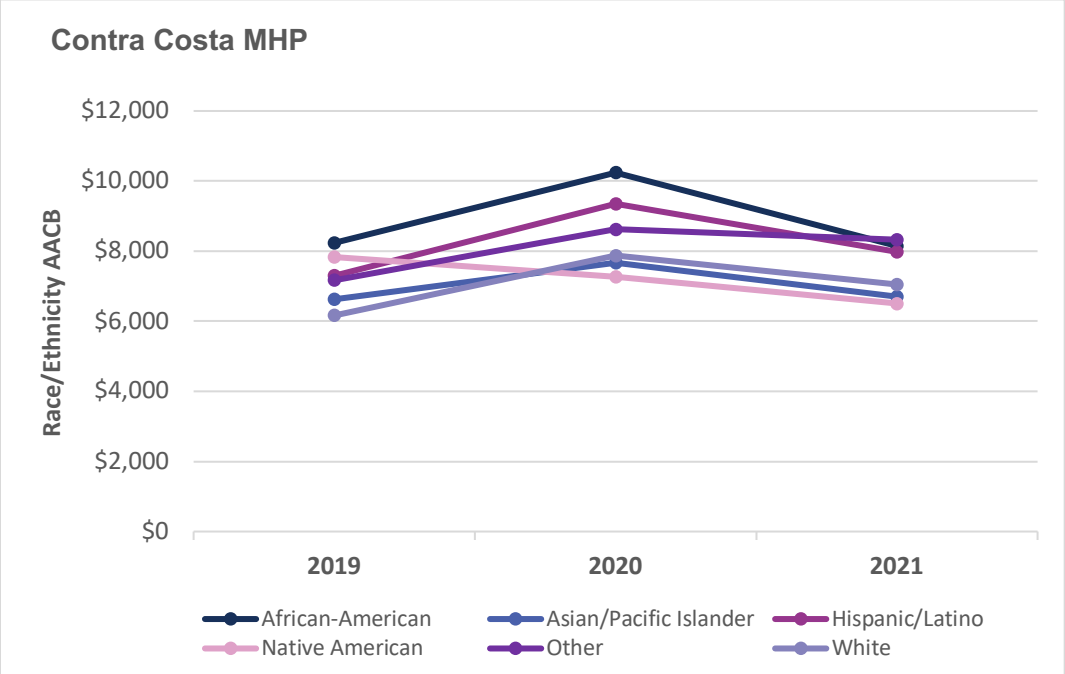
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year trend.

Figure 2: MHP PR by Race/Ethnicity CY 2019-21



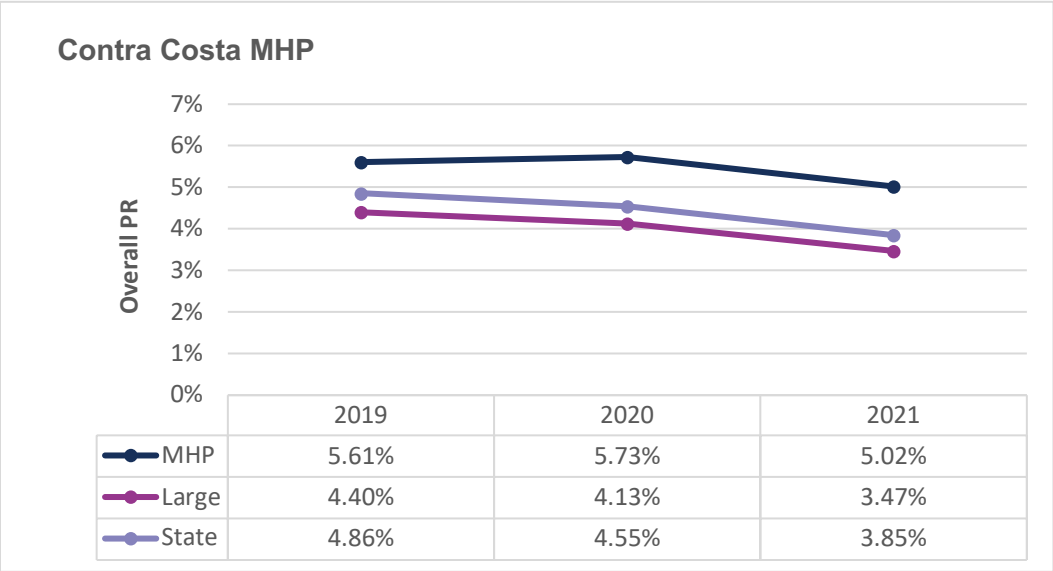
- A downward PR trend is seen across most race/ethnicity categories.

Figure 3: MHP AACB by Race/Ethnicity CY 2019-21



- The AACB has decreased from CY 2020 to CY 2021 across most racial/ethnic categories.

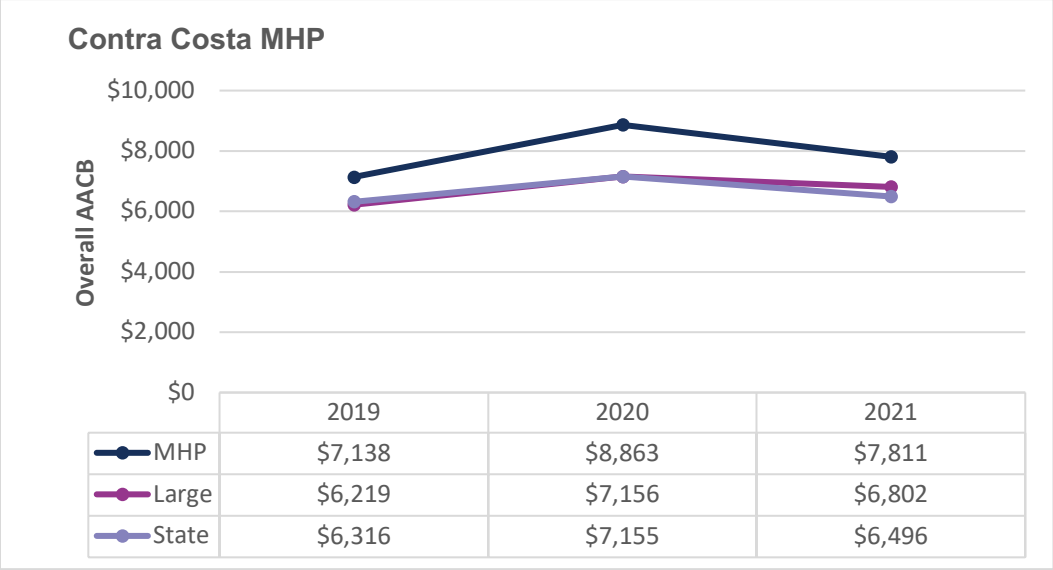
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	5.61%	5.73%	5.02%
Large	4.40%	4.13%	3.47%
State	4.86%	4.55%	3.85%

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

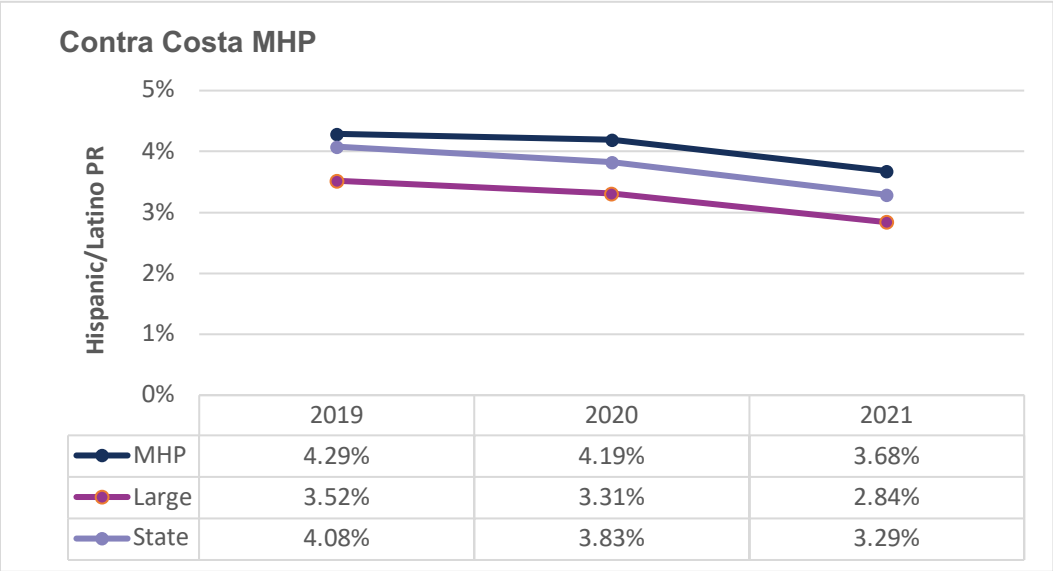
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$7,138	$8,863	$7,811
Large	$6,219	$7,156	$6,802
State	$6,316	$7,155	$6,496

- The MHP's AACB increased in CY 2020 surpassing both large MHPs and statewide. In CY 2021, the AACB decreased but remains higher than large counties and state.

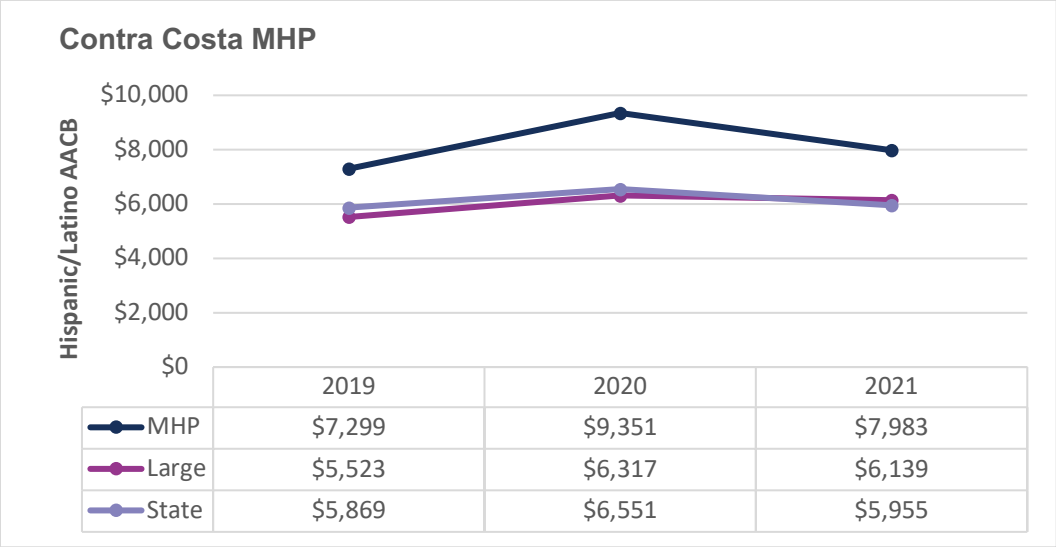
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	4.29%	4.19%	3.68%
Large	3.52%	3.31%	2.84%
State	4.08%	3.83%	3.29%

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

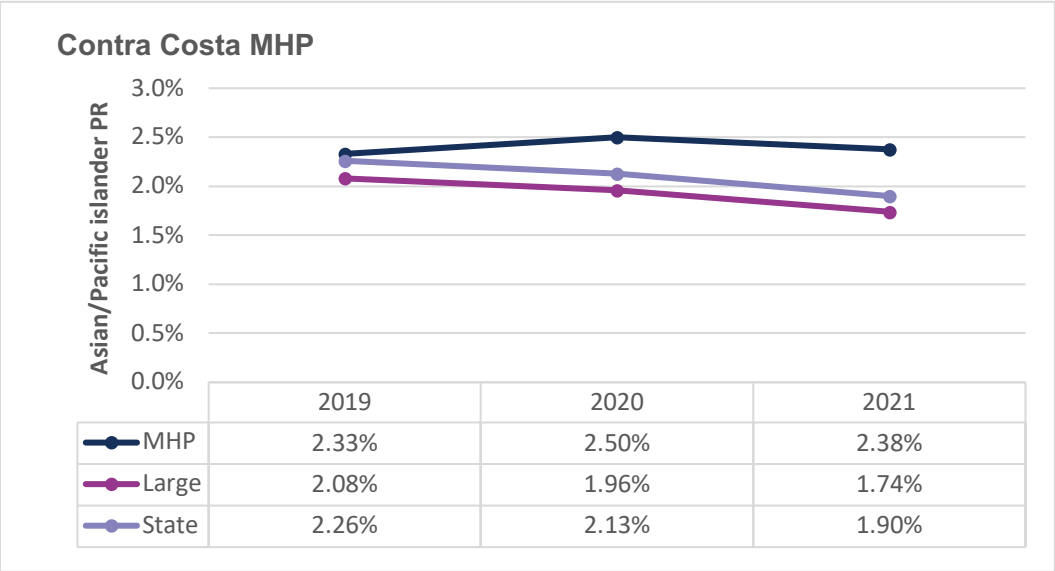
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$7,299	$9,351	$7,983
Large	$5,523	$6,317	$6,139
State	$5,869	$6,551	$5,955

- The MHP's AACB increased approximately 28 percent between CY 2019 and CY 2020, likely due to the higher claim rate during the COVID-19 pandemic and has decreased almost 15 percent in CY 2021. The AACB is consistently higher than similar size counties and statewide.

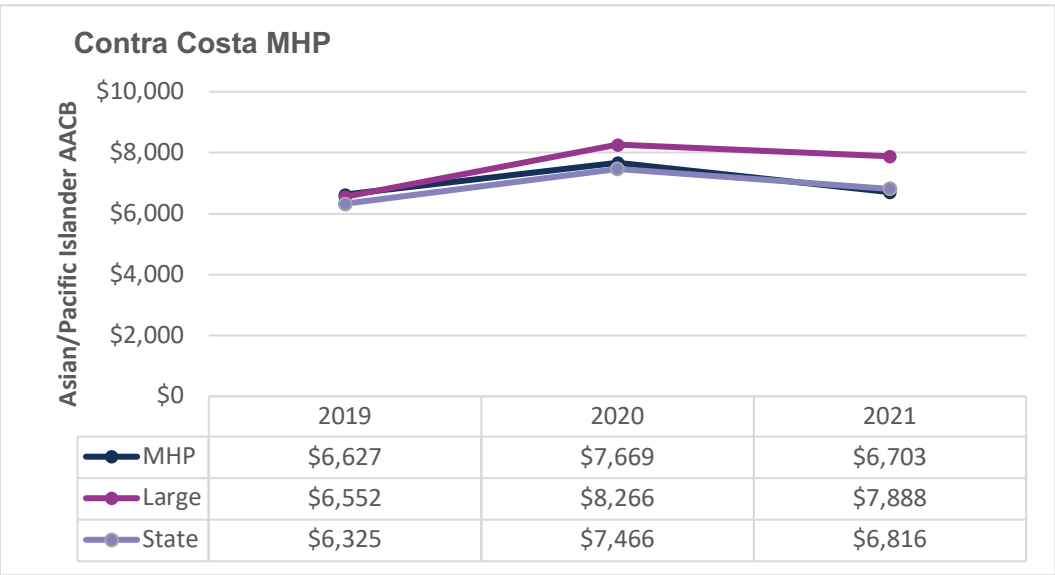
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.33%	2.50%	2.38%
Large	2.08%	1.96%	1.74%
State	2.26%	2.13%	1.90%

- The PR for the API population is on a slight downward trend but has exceeded the large county and statewide PR for the last three years.

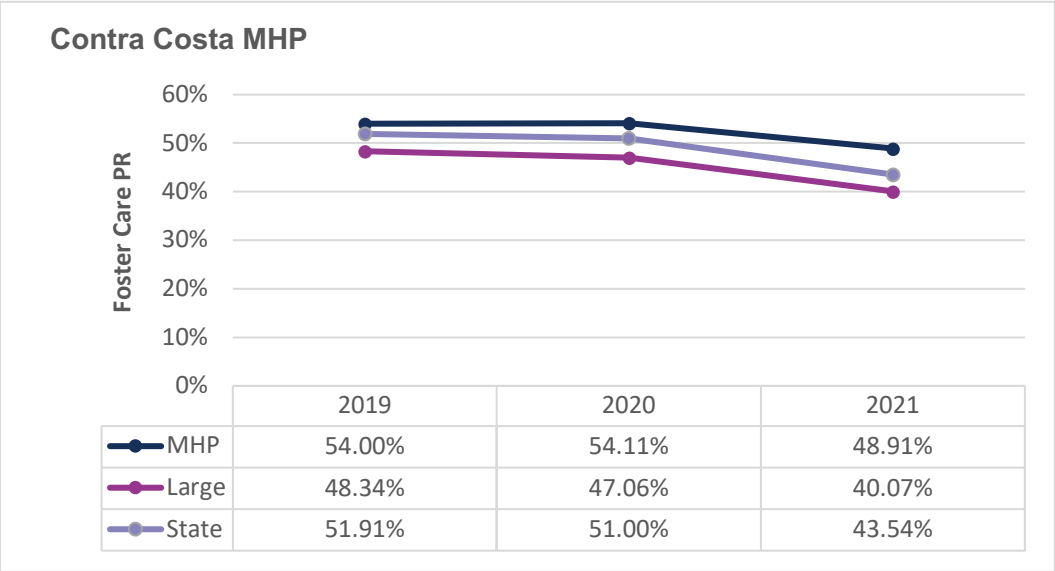
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$6,627	$7,669	$6,703
Large	$6,552	$8,266	$7,888
State	$6,325	$7,466	$6,816

- The AACB increased almost 16 percent in CY 2020, likely due to the higher claim rate during the COVID-19 pandemic and has decreased almost 13 percent in CY 2021.

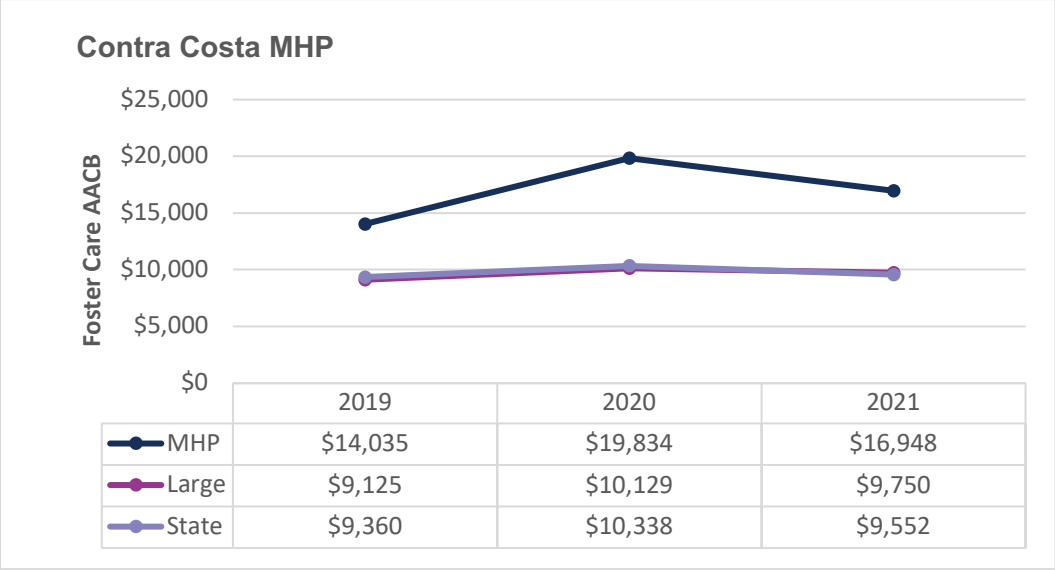
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	54.00%	54.11%	48.91%
Large	48.34%	47.06%	40.07%
State	51.91%	51.00%	43.54%

- The MHP FC PR remained steady between CY 2019 and CY 2020 but decreased in CY 2021. However, the PR exceeds both the large county and statewide PR.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$14,035	$19,834	$16,948
Large	$9,125	$10,129	$9,750
State	$9,360	$10,338	$9,552

- The FC AACB is notably higher than both the large county and state AACB.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 10,367				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	758	7.3%	9	5	10.8%	14	8
Inpatient Admin	144	-	-	4	0.4%	16	7
Psychiatric Health Facility	<11	-	-	-	1.0%	16	8
Residential	38	0.4%	64	39	0.3%	93	73
Crisis Residential	247	2.4%	16	14	1.9%	20	14
Per Minute Services							
Crisis Stabilization	1,927	18.6%	1,783	1,200	9.7%	1,463	1,200
Crisis Intervention	545	5.3%	206	165	11.1%	240	150
Medication Support	6,518	62.9%	264	180	60.4%	255	165
Mental Health Services	4,997	48.2%	611	278	62.9%	763	334
Targeted Case Management (TCM)	1,176	11.3%	384	140	35.7%	377	128

- The percentage of adults receiving Inpatient services is less than statewide and the median units of service is three days shorter than seen statewide.
- The percentage of adult beneficiaries receiving Crisis Stabilization is considerably higher than the statewide percentage and the percentage of beneficiaries receiving Crisis Intervention is considerably lower than the statewide percentage.
- The percentage of adults receiving Mental Health Services is noticeably lower compared to the statewide percentage.
- A much smaller percentage of adults receive TCM services than statewide.

Table 9: Services Delivered by the MHP to Youth in Foster Care

Service Category	MHP N = 495				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	18	3.6%	8	6	4.5%	13	8
Inpatient Admin	<11	-	-	-	<11	6	4
Psychiatric Health Facility	<11	-	-	-	0.2%	25	9
Residential	<11	-	-	-	<11	140	140
Crisis Residential	<11	-	-	-	0.1%	16	12
Full Day Intensive	<11	-	-	-	0.2%	452	360
Full Day Rehab	<11	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	26	5.3%	1,555	1,170	2.3%	1,354	1,200
Crisis Intervention	20	4.0%	163	152	6.7%	388	195
Medication Support	129	26.1%	289	241	28.5%	338	232
Therapeutic Behavioral Services	39	7.9%	4,561	2,936	3.8%	3,648	2,095
Therapeutic FC	<11	-	-	-	0.1%	1,056	585
Intensive Care Coordination	182	36.8%	1,150	707	38.6%	1,193	445
Intensive Home-Based Services	35	7.1%	1,148	494	19.9%	1,996	1,146
Katie-A-Like	<11	-	-	-	0.2%	837	435
Mental Health Services	469	94.7%	2,315	1,245	95.7%	1,583	987
Targeted Case Management	299	60.4%	580	149	32.7%	308	114

- The percentage of FC youth receiving inpatient services is less compared to statewide and the median units of service is two days shorter than seen statewide.
- The percentage of FC youth beneficiaries receiving Crisis Stabilization is higher than the statewide percentage and the percentage of beneficiaries receiving Crisis Intervention is lower than the statewide percentage.

- The percentage of FC youth receiving Mental Health Services is similar to the statewide percentage; however, the median unit of service is higher than statewide.
- A much larger percentage of FC youth receive Targeted Case Management (TCM), and receive more units of service, than statewide.

IMPACT OF ACCESS FINDINGS

- Despite recent decreases in the number of beneficiaries served, the MHP's penetration rates remain above the statewide and large county averages.
- The MHP utilizes crisis stabilization and crisis residential for adults that show a higher percentage of utilization than statewide.
- Managing and adapting capacity to meet beneficiary needs is a complex area.
- While CalAIM changes in access criteria may eventually manifest in the MHP's service data, currently the MHP does not see any significant changes. The distribution of beneficiaries between the MHP and the local MCP seems to track with previous practices.

TIMELINESS OF CARE

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 likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to 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 PMs section.

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

Table 10: Timeliness Key Components

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

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

- The MHP's time to first offered non-urgent psychiatry service reflects first clinical determination of need, and only includes county-operated service data. While the MHP reported overall average of first offered appointment of 12.77 days and first rendered overall averages of 16.27 days, stakeholders from various other

sessions indicated that psychiatry access often takes one month or more to achieve, with exceptions for critical, high-need beneficiaries who receive expedited psychiatry services.

- Urgent service access was reported in days, due to limitations of the EHR. Going forward, the MHP will make efforts to capture this data in hours, as required. The current urgent care data is limited to directly operated services. All urgent services reported fall within the required timeline.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12-14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care, except for urgent services, non-urgent psychiatry services and no-shows which are limited to directly-operated services only. Due to EHR limitations, urgent services are reported in days, rather than the stipulated hours format.

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

Table 11: FY 2021-22 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5.65 Days	10 Business Days*	97.2%
First Non-Urgent Service Rendered	7.96 Days	15 Business Days**	92.7%
First Non-Urgent Psychiatry Appointment Offered	12.77 Days	15 Business Days*	81.9%
First Non-Urgent Psychiatry Service Rendered	16.27 Days	30 Business Days**	87.6%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	37.68 Hours****	48 Hours*	89.3%
Follow-Up Appointments after Psychiatric Hospitalization	16 Days	7 days**	45.8%
No-Show Rate – Psychiatry	15.9%	10%**	n/a
No-Show Rate – Clinicians	14.2%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards **** The MHP reports in days which must be converted to hours			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

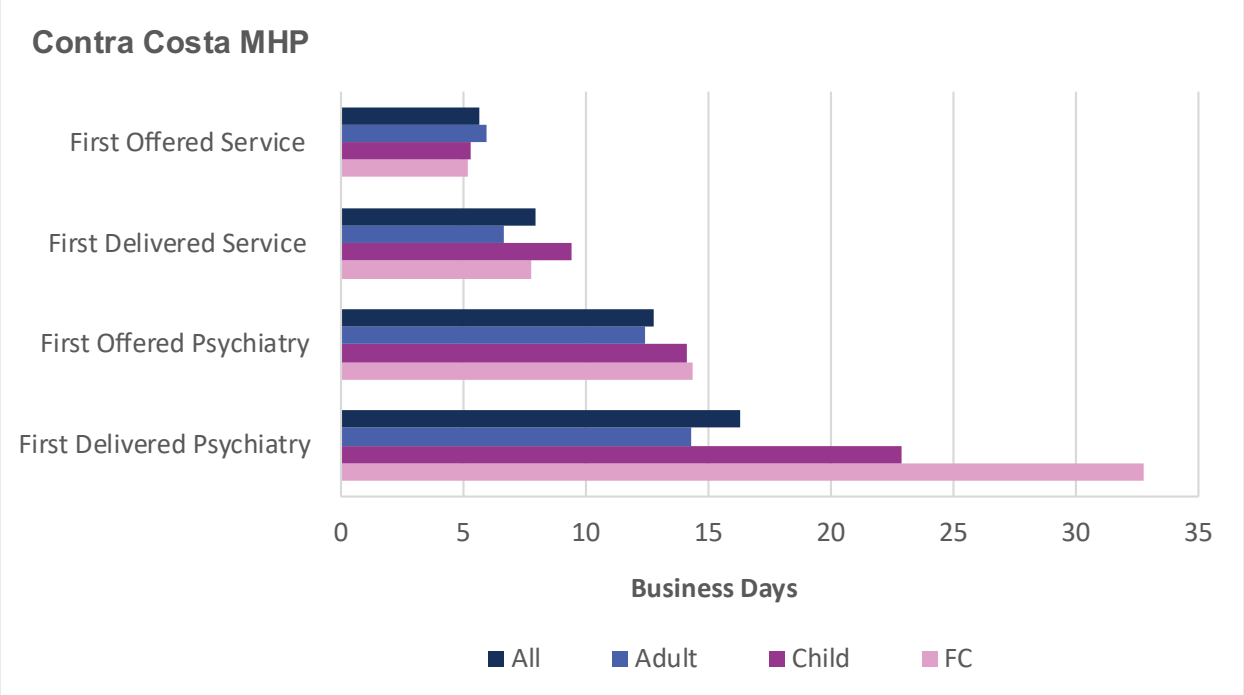


Figure 13: Wait Times for Urgent Services

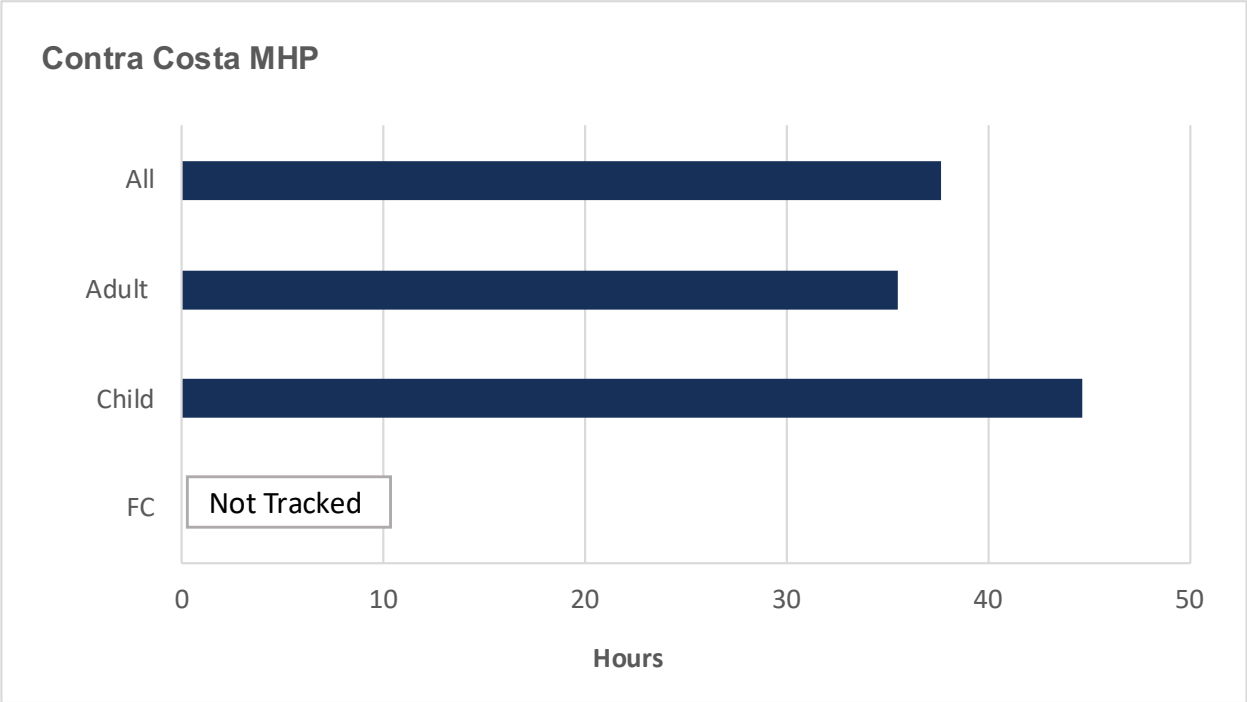
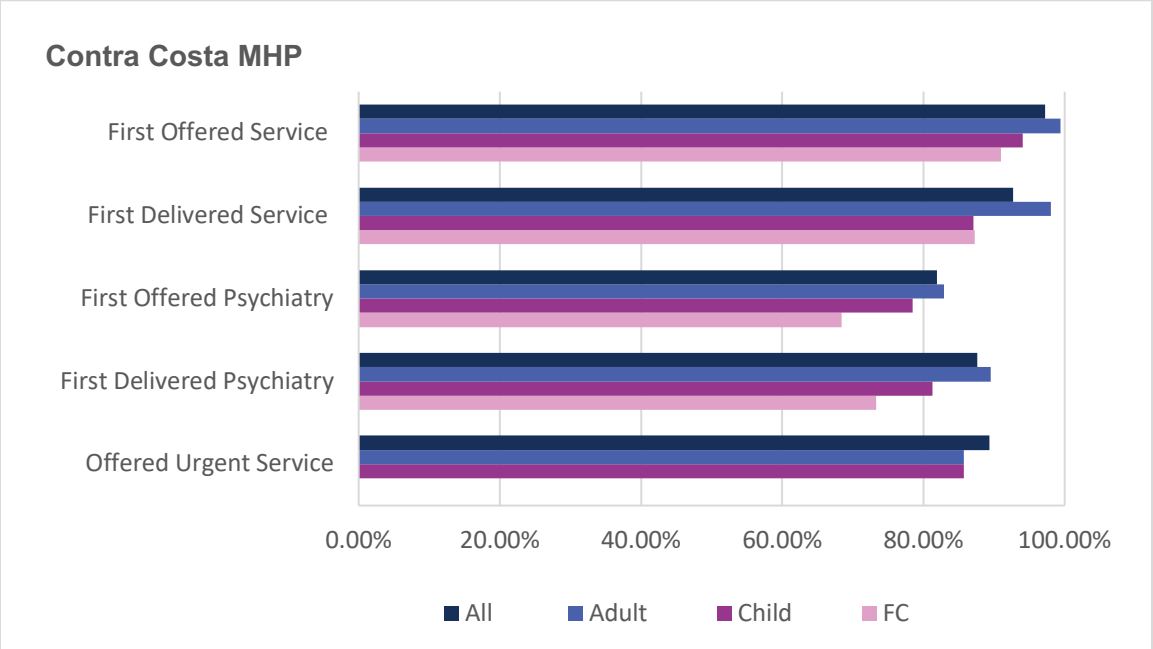


Figure 14: Percent of Services Offered/Delivered that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled and unscheduled assessments.

- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as “Without service within 48 hours, it is likely client may require a psychiatric emergency.”
- There were reportedly 28 urgent service requests with a reported actual wait time to services for the overall population at 37.68 hours (reported as: 1.57 business days). The MHP is in the process of converting the EHR collection of this data from days to hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as from the first clinical determination of need, with a 30-business day standard.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked and represent a subset of directly-operated services only. The MHP reports an overall no-show rate for psychiatry providers of 15.9 percent and 14.2 percent for other clinical staff.

IMPACT OF TIMELINESS FINDINGS

- Currently, there was no mention of CalAIM’s impact upon timeliness; however, there is a sense that in the CSOC there may be greater demand due to the access criteria changes for that population that will eventually appear in the data.

QUALITY OF CARE

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, and the intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI Program for the services furnished to 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 THE MHP

In the MHP, the responsibility for QI is with the Quality Improvement & Quality Assurance (QIQA) unit, led by a Quality Management Program Quality Management Program, with support from another staff who holds a dual role as Quality Improvement and Compliance Coordinator. Quality is viewed as a continuous process across the system.

The MHP monitors its quality processes through the Quality Management Committee (also known as Quality Improvement Committee (QIC)), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of the medical director, chiefs, program managers of the MHP (and DMC-ODS Chief, Program Manager and Planner/Evaluators), community support workers (peers), and QI/QA staff. QIC is scheduled to meet annually ten months out of year. Since the previous EQR, the MHP QIC met five times. The QI/QA unit oversees, by way of the Quality Improvement Workplan, timeliness, satisfaction surveys, penetration/retention, performance improvement projects, service accessibility, evidence-based practices, outcome measures, medication monitoring, beneficiary grievances, appeals, unusual, serious occurrence notification, Health Insurance Portability and Accountability Act (HIPAA) incident reporting investigations, quality of care concern investigations, change of provider trends, notice of adverse benefits and determination compliance, fraud, waste and abuse reporting. Of the 17 goals and 118 actions identified in the CY 2021 QAPI workplan, the MHP partially met 81 percent of its action steps (fully met 65 percent actions and partially met 16 percent actions), while 19 percent of QI actions were not met.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths Assessment, CANS, Difficulties in Emotion Regulation Scale, Suicidal Ideation Questionnaire, Generalized Anxiety Disorder-7, Posttraumatic Stress Disorder Checklist, Patient Health Questionnaire-9, PSC-35, Posttraumatic Stress Disorder Reaction Index, Independent Living Skills Survey, Structured Interview for Psychosis Risk Syndrome, Recovery Assessment Scale, Eating Disorder Examination Questionnaire, and the Parents Versus Anorexia Scale.

A sub workgroup to the overall Quality Management Committee the MHP has an Evidence Based Practice and Outcome Measures workgroup that reviews the implementation of EBPs and Outcome measures implemented in the Adult and Children's system of care. This process is used to drive discussions about quality improvement needed to existing programs and the development of new programs. This data is also used to support and identify potential PIPs.

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 12: Quality Key Components

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

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

- Despite operating with significantly reduced staffing, the MHP operates a sophisticated QI program that demonstrates strong competencies.
- While there are many areas in which administration is seeking to improve communication, the MHP continues to work to increase the opportunities for

beneficiaries and line staff to provide input directly to leadership. The MHP's recent staff survey identified the areas of greatest importance to staff, such as alternative work schedules.

- CalAIM requirements continue to present issues/challenges with interpretation, particularly those impacting QA and UR process, which are conveyed verbally and are not supported by clear, written communication.
- In the area of clinical continuum of care, the MHP has created a comprehensive document that outlines the levels of care in both ASOC and CSOC and describes how each SOC should operate optimally. This is an MHP strength, in an area in which many similar MHPs lack a comprehensive description of system operations.
- The MHP has not adopted specific level of care tools, which could provide more support to decisions level of care determinations. However, the MHP is operating a small CSOC pilot that utilizes a Praed Foundation crosswalk of CANS and PSC-35 scores to LOC. QI/QA is collecting data from participating providers and plans to evaluate the tool's efficacy.
- The MHP has a process for medication monitoring that reviews a sample of charts for all directly operated program prescribers. It has a sophisticated review process that looks at the level of practice and documentation compliance. The MHP acknowledges that there is more work to be done on this due to the difficulties in accessing records of contract provider prescribers and the multiple options of lab work that exist outside of the county-operated system. The MHP has plans for improvement soon that include annual meetings with contract providers to review prescribing trends.
- The MHP's website does not appear to provide posted prescribing guidance and standards, which would be an ideal location for reference for all prescribers whether they are county staff or contracted.
- The MHP reports that it has not received consumer perception survey (CPS) results for 2022 at the time of this review. Typically, this information appears in the QAPI Work Plan. Results are shared and disseminated with the clinics as the findings are presented at both Clerical Operations Workgroup and Quality Management. In addition, results are also shared with contract providers at the Contractors Luncheon meeting. There is currently no process for making the results available to beneficiaries. The most recent information available was from several years ago. Posting to the MHP's website and developing a mechanism to inform stakeholders would provide a benefit to involved parties. Beneficiaries interviewed during this review frequently mentioned participating in this survey, but none were informed of the results. For the last six years the MHP has augmented the CPS process with a local Service Improvement Survey, and utilized its findings to target areas for improvement,
- Peer support specialists do not have other opportunities for growth. It is not clear to the extent that this is planned within the MHP and whether or not certification will connect with greater opportunities for promotion.

- There does not appear to be a standard or formal process of informing beneficiaries about wellness centers, instead relying upon individual determination of need by clinicians and psychiatrists.
- The MHP tracks but does not trend the following HEDIS measures as required by WIC Section 14717.5. The MHP tracks these measures for directly operated youth psychiatry, but not for youth psychiatry through contracted prescribers.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- The MHP is aware of the need to track medication utilization for youth served through CBOs and plans to improve its monitoring in this area.

QUALITY PERFORMANCE MEASURES

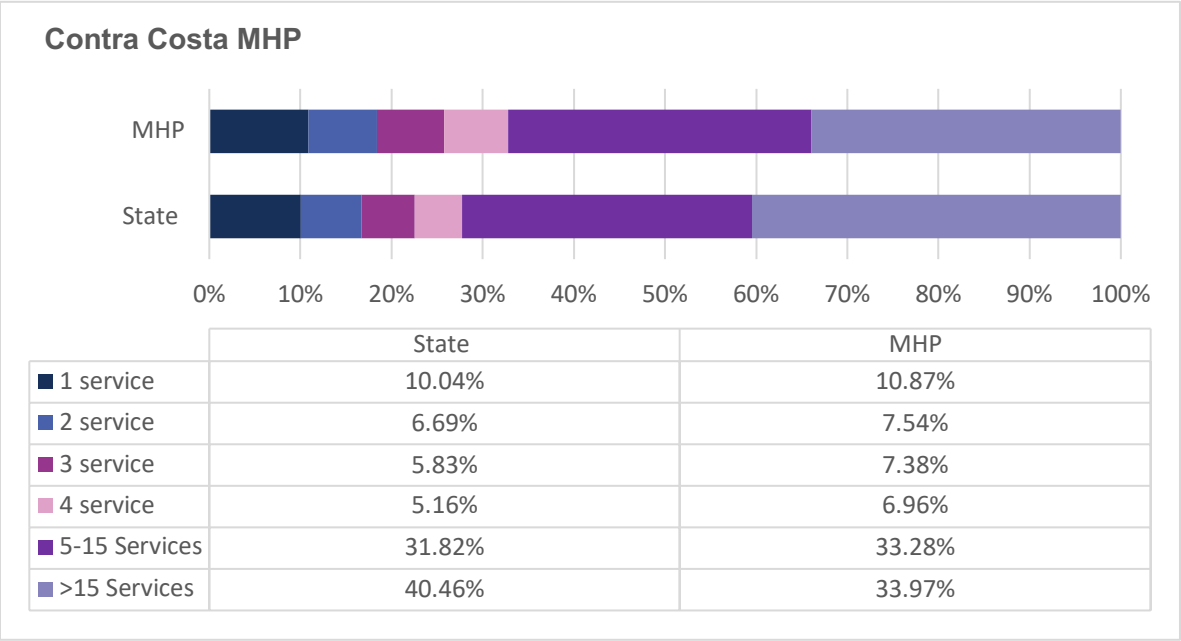
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries served by the MHP to require 5 or more services during a 12-month period. However, this table does not account for the length of stay, as individuals enter and exit care throughout the 12-month period.

Figure 15: Retention of Beneficiaries CY 2021



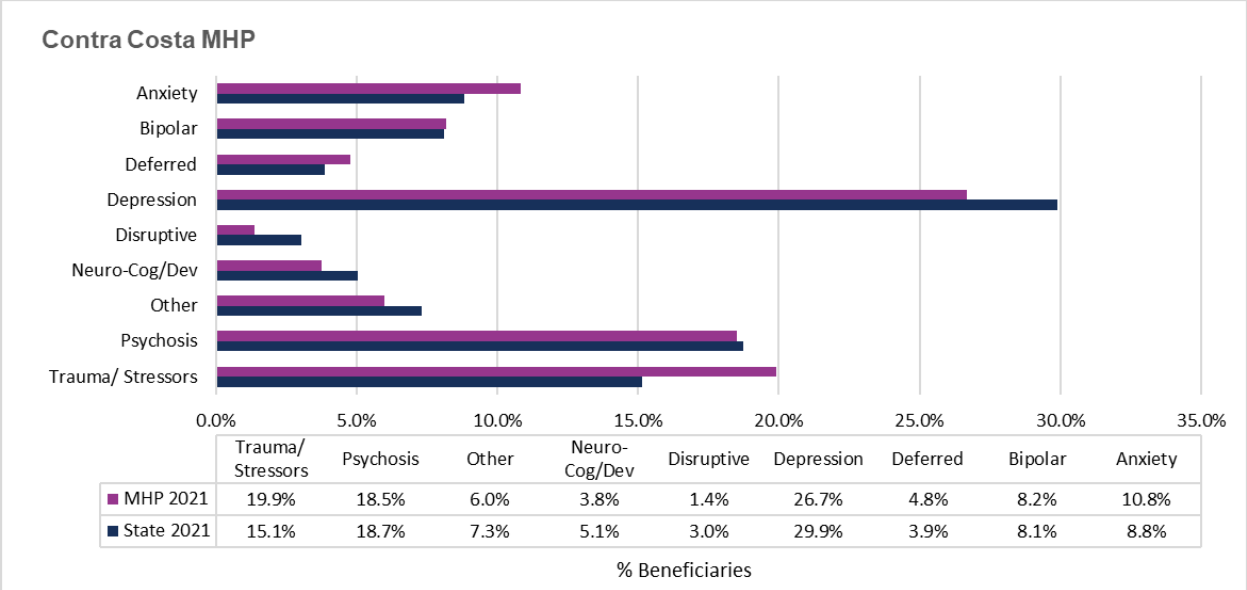
	State	MHP
1 service	10.04%	10.87%
2 service	6.69%	7.54%
3 service	5.83%	7.38%
4 service	5.16%	6.96%
5-15 Services	31.82%	33.28%
>15 Services	40.46%	33.97%

- The percentage of beneficiaries receiving only one service is just slightly higher than the statewide percentage. The percentage of beneficiaries receiving between 5 and 15 services is slightly higher compared to statewide and the percentage receiving over 15 services is approximately 16 percent lower than statewide.

Diagnosis of Beneficiaries Served

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

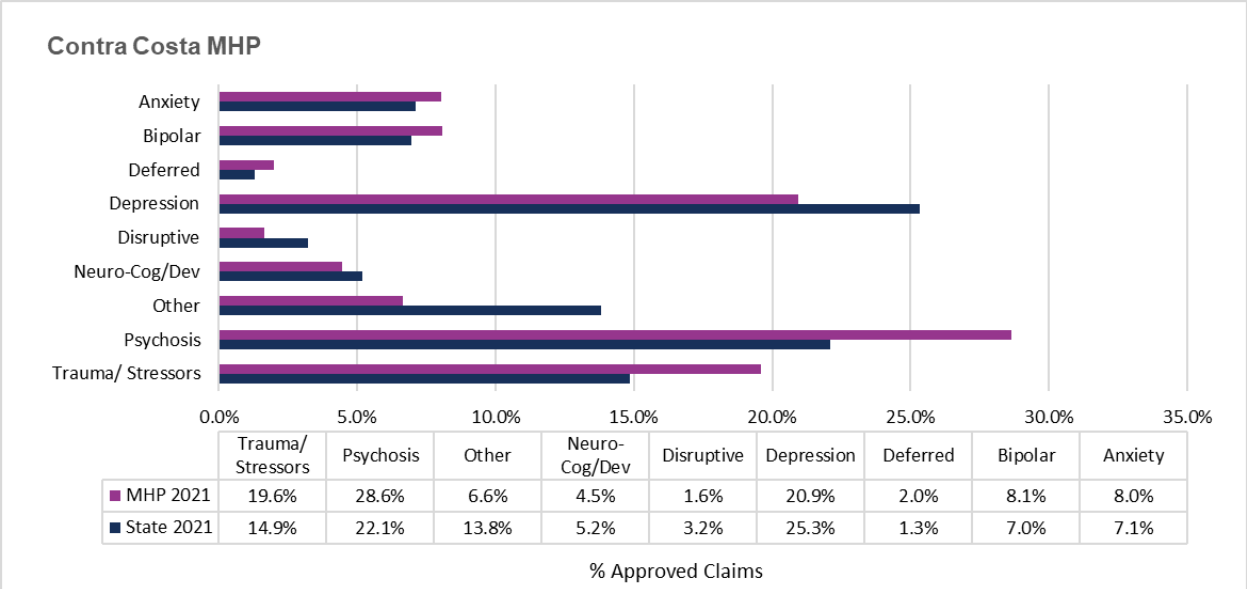
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	19.9%	18.5%	6.0%	3.8%	1.4%	26.7%	4.8%	8.2%	10.8%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- The MHP's leading diagnostic category is depression; the percentage of beneficiaries with a depression diagnosis is lower compared to statewide and the percentage of beneficiaries with a trauma diagnosis is higher compared to statewide. The other diagnostic categories are comparable to statewide percentages with slight variances.

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	19.6%	28.6%	6.6%	4.5%	1.6%	20.9%	2.0%	8.1%	8.0%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- The MHP has a larger percentage of approved claims with trauma and psychosis diagnoses and a lower percentage with depression and other diagnosis

compared to statewide. The distribution of approved claims is congruent with the diagnostic patterns displayed in Figure 16.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay (LOS).

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	1,080	1,618	9.22	8.79	$22,301	$12,052	$24,085,494
CY 2020	979	1,594	9.31	8.68	$19,387	$11,814	$18,980,014
CY 2019	1,011	2,133	7.39	7.8	$13,115	$10,535	$13,259,607

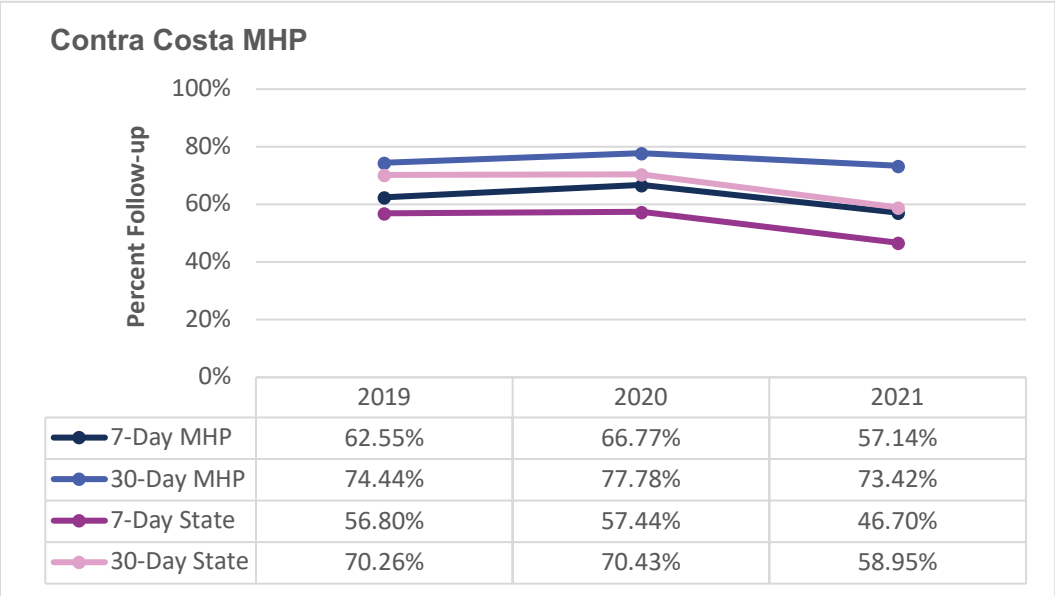
- The MHP has maintained a slightly longer average LOS over the last two years with beneficiaries staying about a half day longer than the statewide average. The number of both unique beneficiaries and inpatient admissions increased in CY 2021. The MHP AACB is notably higher than the statewide AACB. Over 20 percent of total approved claims are for inpatient claims.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2021 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

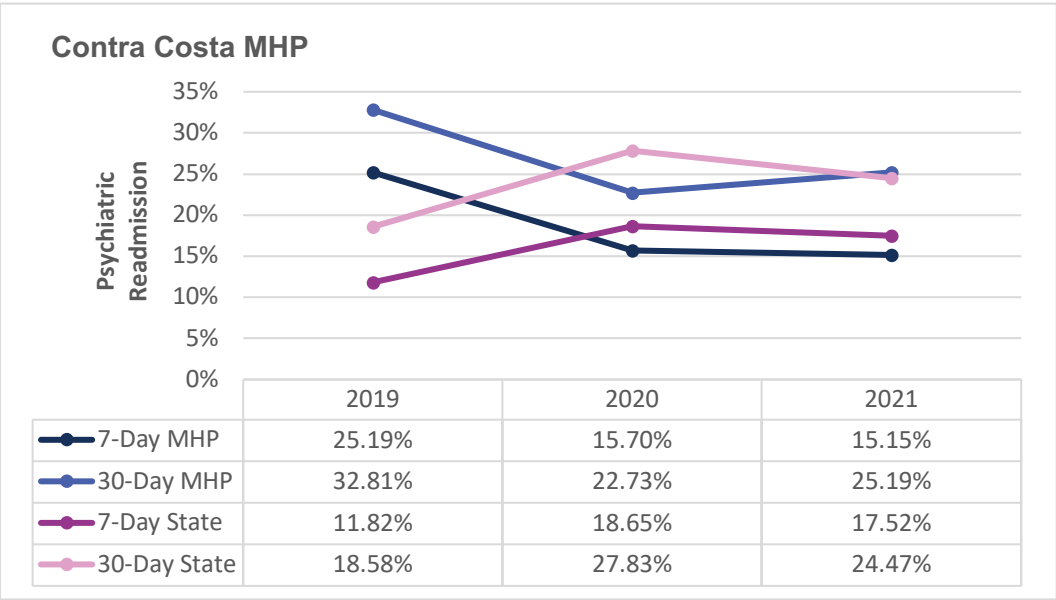
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	62.55%	66.77%	57.14%
30-Day MHP	74.44%	77.78%	73.42%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	25.19%	15.70%	15.15%
30-Day MHP	32.81%	22.73%	25.19%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- Both the MHP's 7-day and 30-day follow-up rate are noticeably higher than the statewide rates.
- The 7-day and 30-day psychiatric readmission rate was notably higher in CY 2019 and has decreased the last two years. The CY 2021 readmission rates are similar to statewide readmission rates.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $6,496, the median amount is just $2,928.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	3.46%	28.46%	$1,007,853,748	$53,476	$43,231
MHP	CY 2021	833	5.59%	43.55%	$50,703,514	$60,869	$47,307
	CY 2020	1,052	6.81%	47.61%	$65,204,384	$61,981	$47,581
	CY 2019	721	4.88%	41.10%	$43,309,899	$60,069	$48,483

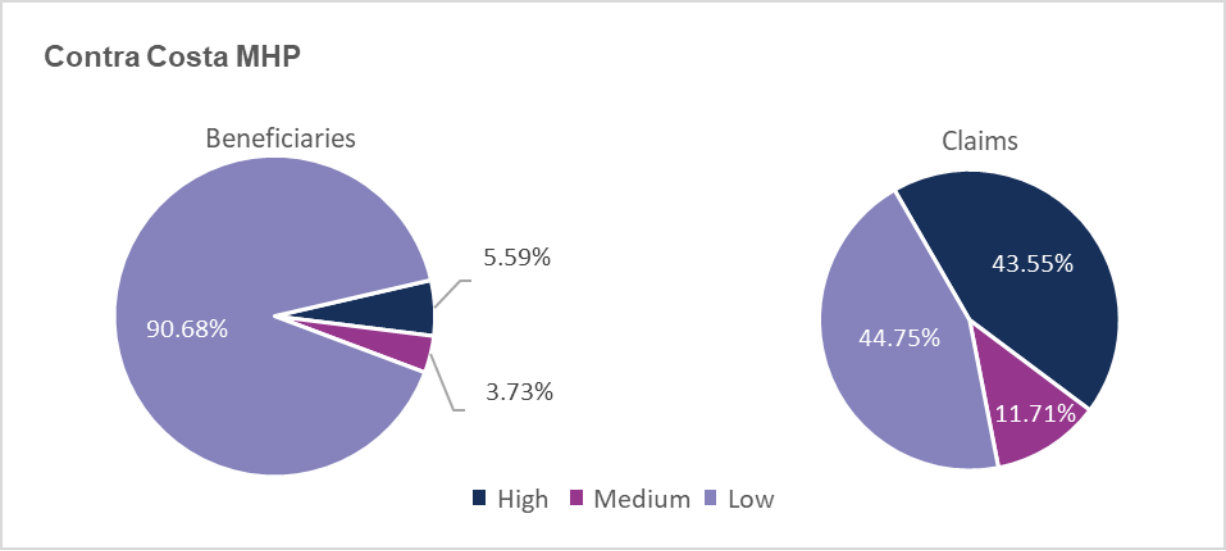
- For the past three years, the percentage of HCB beneficiaries has been higher than the statewide percentage.

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	556	3.73%	11.71%	$13,629,568	$24,514	$23,998
Low Cost (Less than $20K)	13,517	90.68%	44.75%	$52,097,817	$3,854	$2,112

- Most beneficiaries served fall into the low-cost category and had median approved claims of $2,112.

Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021



- HCBs make up 5.59 percent of the beneficiaries served, and over a third of the approved claims were for services rendered to HCBs.

IMPACT OF QUALITY FINDINGS

- The MHP's retention data of those receiving greater than 15 services suggests that there is a process for providing time-limited, focused treatment, which may assist in providing improved capacity to treat new incoming beneficiaries. This is particularly important when there are challenges with filling vacant positions and retaining existing staff.
- The MHP's 7- and 30-day post-hospital follow-up has continued to exceed the statewide average over the past three calendar years, during which time

rehospitalization rates have dropped to levels better than or close to the statewide average, with the exception of the most recent CY 2021 period in which the MHP has slightly increased over the statewide average. This suggests the MHP's follow-up efforts have had an impact on reducing readmission rates.

- The MHP is involved in the development of guidance for staff and contractors regarding the CalAIM documentation and service process changes. The MHP has been working to fill QI/QA vacancies that have faced similar challenges to the filling of clinical positions.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and 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.caleqro.com.

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

CLINICAL PIP

General Information

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

Date Started: 09/2022

Aim Statement: For Medi-Cal beneficiaries with ED visits for mental health conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023.

Target Population: Adult and children who are Medi-Cal beneficiaries and have an ED visit for a mental health condition.

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

Summary

The BHQIP PIP focuses upon individuals with an ED visit for a mental health condition and identification of these individuals and arranging mental health follow-up

[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

appointments. The interventions include the use of a peer navigator in the emergency departments, and follow-up/reminder calls. Another intervention involves the development of a notification process that identifies individuals with ED visits, eventually taking the form of an electronic notification process. At this point, the MHP is finalizing its planning and intervention development, and as yet has no outcome data.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: The essential design and intervention strategies are likely to continue to improve the already good follow-up results of this MHP as reflected in the California Mental Health Services Authority supplied data.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this clinical PIP including:

- There are four other non-county EDs in Contra Costa County. The MHP will likely need to develop specific strategies tailored to these other locations as it seeks to provide navigation assistance for follow-up to ED visits. As well, establishing a quick notification process may need to come directly from those hospitals rather than the managed care plan if the 7-day follow-up rate is to be improved.

NON-CLINICAL PIP

General Information

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

Date Started: 11/2021

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

Target Population: East Clinic Adults

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

Summary

The non-clinical PIP targeted assessment no-show improvement based on clinician reminder calls that emphasized importance of attending appointments through a reminder approach that described potential gains from treatment. In that these appointments were typically dual clinician/psychiatrist appointments for streamlined access, making appointments was very important to the individual beneficiary and

resource management. Issues emerged in the time consumed for these reminder calls. In addition, the linked sessions have been re-evaluated. This PIP has then evolved to using an automated reminder approach, which will be the final intervention adjustment.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the MHP added to the staff-intensive reminder calls an automated reminder process, for seven- and one-day prior to appointments. With the existing vacancies and difficulties with recruitment, the automated reminders may yield a greater improvement of no-show rates, exceeding the current slight improvement of 24 to 22 percent.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this non-clinical PIP including:

- Emphasizing automated reminders was going to be a recommendation for improving this PIP, but the MHP has already incorporated this into the year two revisions.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Epic/ccLink, which has been in use for six years. Currently, the MHP uses ShareCare as the primary billing system and has plans to sunset ShareCare by June 2023 and begin using ccLink to perform billing functions.

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

The MHP has 790 named users with log-on authority to the EHR, including approximately 507 county staff and 171 contractor staff. Support for the users is provided by 13.25 full-time equivalent IS technology positions. Currently, all positions are filled. Additional staff will be hired to support the Epic ccLink billing implementation, but at the time of the review, the number of staff was not determined.

As of the FY 2022-23 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☒ Weekly ☐ Monthly	10.72%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	89.28%
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 Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. MHP beneficiaries have access to medical records using the Epic patient portal, MyChart. The medical records include services provided by county staff only.

Interoperability Support

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

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive 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 17: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Met
4C	Integrity of Medi-Cal Claims Process	Partially 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:

- A solid IT infrastructure exists that includes executive leadership, subject matter experts, program chiefs, and IT staff.
- The MHP has sufficient staffing to support IS operations and has a pool of super users/champions, by discipline and clinic, to train and provide support to end users.
- A mobile device platform is available for staff to access beneficiary records while delivering services in the field.
- While the MHP does have policies and procedures supporting the Medi-Cal claiming process, the MHP claim denial rate (3.25 percent) exceeds the 2.78 statewide denial rate.
- An Operations Continuity Plan exists identifying critical business functions and ensure capability to restore systems following a disruption of service and is tested at least annually.
- CBOs must do double data entry in ShareCare and their own EHRs to record services provided.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

For the MHP, it appears that significant claims lag begins in June 2021 and likely represents $20,852,975 in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through December 2022.

Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	30,164	$13,343,757	$304,144	2.28%	$13,039,613
Feb	30,064	$13,170,571	$251,571	1.91%	$12,919,000
Mar	35,181	$15,211,379	$369,439	2.43%	$14,841,940
April	32,694	$14,967,153	$517,025	3.45%	$14,450,128
May	31,146	$11,575,058	$464,559	4.01%	$11,110,499
June	31,466	$11,080,644	$572,394	5.17%	$10,508,250
July	24,480	$8,956,966	$286,051	3.19%	$8,670,915
Aug	16,650	$5,752,755	$378,839	6.59%	$5,373,916
Sept	28,803	$9,666,814	$418,372	4.33%	$9,248,442
Oct	21,686	$7,149,875	$152,209	2.13%	$6,997,666
Nov	14,744	$4,627,921	$42,277	0.91%	$4,585,644
Dec	1	$502	$0	0.00%	$502
Total	**297,079**	**$115,503,395**	**$3,756,880**	**3.25%**	**$111,746,515**

- A consistent volume of monthly claims contributes to a steady stream of revenue.

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other	2,095	$675,607	17.98%
Medicare Part B or Other Health Coverage must be billed before submission of claim	582	$621,470	16.54%
Beneficiary not eligible or non-covered charges	5,809	$537,184	14.30%
NPI related	491	$325,631	8.67%
Claim/service lacks information which is needed for adjudication	958	$310,243	8.26%
Service line is a duplicate and a repeat service procedure code modifier not present	2,095	$675,607	17.98%
Total Denied Claims	19,804	$3,756,880	100.00%
Overall Denied Claims Rate	**3.25%**		
Statewide Overall Denied Claims Rate	**2.78%**		

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Expanding use of the EHR to implement the billing module of ccLink and sunsetting current billing system should eliminate challenges of operating two separate systems, increase efficiencies by integrating documentation and billing, and decrease the probability of making data entry errors.
- The successful testing and completion of 274 files to DHCS makes sure the MHP meets NACT reporting requirements.
- Developing Client Services Information timeliness electronic work queue's in ccLink identifies missing data elements and ensures new clients are offered timely appointments.
- Expanding lab services to several locations around the county gives beneficiaries the flexibility to schedule and receive lab work at locations of their choice and shortens wait times to receive results.
- Completed the identification and mapping of EHR data elements to lay foundation for health information exchange with healthcare partners and ensuring only appropriate information is released and exchanged.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

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 reviews and circulates CPS data in a number of forums. The 2022 CPS data has not been received from the vendor. The most recent analysis information was from June 2021. The reports were shared with Quality Management, Clerical Operating Group, Mental Health Commission and Contractors Luncheon Meetings. There is not a current mechanism for broad sharing of this data with beneficiaries and caregivers. During the review, there was discussion about other mechanisms of circulating CPS information, such as through MHP website and clinic postings, and providing comparison data over time.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers, the majority of whom initiated services in the preceding 12 months. The focus group was held virtually and included 13 participants. All participating consumers receive clinical services from the MHP.

Few of the participants initially accessed services within the prior 12 months, but they felt access went quickly enough for their needs. Over half of the participants receive appointment reminder calls.

Some mentioned reminders that arrive through the patient portal, MyChart. The MHP advises that these would be for medical appointments, which in the future will include behavioral health appointments. About one-third of the participants were aware of the

MyChart patient portal. BHS clerks record in Epic the beneficiary's preferred mode of service. Starting March 28,2023, beneficiaries will be able to join their BHS appointments through MyChart.

The availability of interpreting services was mentioned as universally offered. Transportation assistance has been furnished by the managed care plan (Contra Costa Health Plan), or by a case manager. Some participants receive services in-house and do not need transportation assistance. None were aware of the crisis phone number.

Some participants indicated that the involvement of families in the treatment process was not offered to them. Physical health care is addressed in various ways, including encouragement to take walks and exercise, particularly as part of the plan to address depression.

Over half of the participants receive psychiatric services, but most were unsure if there is any communication between that practitioner and their primary care provider.

However, a few of the participants felt that they were not given a choice as to how services are provided, as in phone, video, or in-person.

The frequency of psychiatry services varies among these participants, ranging from monthly to every six weeks, and for a smaller number every two months. Psychosocial care varies from weekly to every two weeks. Most reported case management services occurring on a monthly basis, and was easily accessible.

Some participants could recall taking a satisfaction survey, but none recall being informed of the results.

About half of the participants feel a sense of hope, and are optimistic about recovery.

Recommendations from focus group participants included:

- Provide a greater focus on independence and employment, with less emphasis on governmental assistance, which was seen as dependency and reliance on the system.
- Provide more opportunities to give feedback to the MHP as occurred in the focus group.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of caregivers of children and youth, the majority of whom initiated services in the preceding 12 months. The focus group was held virtually and included nine participants; a Spanish language interpreter was used for this focus group. All family members participating have a family member who receives clinical services from the MHP.

Initial access wait times for these caregivers ranged from one day to nearly one year. One participant was informed there were no therapists available, and has not called back. One caregiver's child was released from the hospital and it was over one month to arrange for an intake. One participant has a FC son who is not receiving therapy, and is awaiting an assessment. The FC Child and Family Services worker is located in Fresno.

The majority of these caregivers receive reminder calls. During services, interpreters are always available for the preferred language of either the beneficiary or caregiver. One participant has a Spanish-speaking provider.

In regard to ongoing access to care, some participants use telehealth or in-person services at home. The options for service include telehealth for psychiatry and other services. Therapists often are seen at school and in-person; family therapy is reported as in-person, with generally a blend of in-person and telehealth being offered.

Some use the available transportation services, and one had to drop out from services because of difficulties arranging for the child to reach the appointment. This participant had no recollection for any offer of transportation help.

Physical health is inquired about by both the clinician and, where involved, the psychiatrist.

The frequency of services varies among the participants, ranging from monthly to weekly therapy. Psychiatry occurs monthly or less frequently. Each service type may have a unique frequency that changes as the child progresses.

In the event of a crisis or urgent need, all participants have telephone numbers for mobile response, the clinic, or a hotline. Approximately half of the participants could recall taking a satisfaction survey. None could recall being informed of the results.

Approximately half of the participants have utilized MyChart to obtain information or to schedule appointments related to physical healthcare. Participants mentioned an age cut-off for parental access to MyChart.

Most of the participants relayed that they have a sense of hopefulness regarding recovery for their children.

Recommendations from focus group participants included:

- Reduce the wait times for services when initially accessing care.
- Improve the access to Wraparound services.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

In general, beneficiaries and caregivers are satisfied with services. The areas of dissatisfaction relate to initial timeliness and the MHP's capacity to rapidly provide treatment.

CONCLUSIONS

During the FY 2022-23 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 "A3" (anyone, anywhere, anytime) approach to the development of crisis services shows promise in improving access to crisis care and further decreasing the use of acute hospitalization resources for beneficiaries. (Access, Quality)
2. Despite vacant positions, the QI program is creative in its focus on quality and service improvements. (Quality)
3. The MHP's method of analyzing IT, working collaboratively with program chiefs and subject matter experts, to determine needs ensures projects are implemented efficiently and economically and are able to produce desired outcomes. (IS)
4. Telehealth delivery is robust across both county and contract provider programs and includes capacity for telehealth for non-English speaking beneficiaries. (Access, Quality, IS)
5. The Access virtual assessment pilot shows the promise of accomplishing rapid intakes and assessments, improving engagement and retention of those seeking treatment, as well as reducing assessment no-shows. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP continues to struggle with issues of capacity that are related to recruitment and retention. This results in higher caseload numbers and barriers to providing beneficiaries with the level of treatment they need. These unfilled vacancies impact both clinical and quality areas of care. (Access, Timeliness, Quality)
2. The CalAIM implementation impacts local utilization management, which has yet to be fully codified into a dynamic documentation manual. (Quality)
3. The MHP does not have an ongoing review process for SB 1291 monitoring of contract provider psychiatry prescribing practices. (Quality)
4. The claims denial rate is higher than statewide and may result in lost revenue. (IS)

5. CBOs currently have the burden of performing double data entry of service data into MHP's billing system and their own EHRs, increasing likelihood of errors. (IS)

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

   (This recommendation is a modified carry-over from FY 2021-22.)
2. Develop a documentation and clinical process manual that is regularly updated and reviewed with directly operated and contract provider programs that furnishes clear and specific guidance as to the utilization management requirements. Develop and publish Frequently Asked Questions from discussions of CalAIM changes that is routinely updated and circulated. (Quality)
3. Develop a SB 1291 review process that includes both directly operated and contract provider prescribing practices. (Quality)
4. Expand use of batch files to submit service data claims or provide access for CBO's to directly enter clinical data to eliminate double data entry once the Epic ccLink billing implementation is complete. (IS)
5. Investigate reasons for claim denials and develop a plan to reduce denials and recover lost revenue (IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a public health emergency (PHE) exists. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT F: PM Data CY 2021 Refresh

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Contra Costa MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Satisfaction
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview

CalEQRO Review Sessions – Contra Costa MHP
Information Systems Capabilities Assessment
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Robert Walton, Quality Reviewer
Rita Samartino, Information Systems Reviewer
Pamela Roach, Consumer Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Aguirre	Priscilla	Quality Management Program Coordinator	Contra Costa Behavioral Health (CCBH)
Andreev	Oleg	Health Services Info Systems Programmer/Analyst	CC Health Services Info Technology
Ang	JR	Director of Accounting	CC Health Services Finance
Armstrong	Kerry	Program Director	CBO – Vistability
Blanton	Crystal	Unspecified	CBO-Lincoln Families
Blanza	Jen	Program Director	CBO – Seneca Family Agencies
Bruggeman	Jennifer	MHSA	CCBH
Calloway	Vernon	HS-IT Manager Sharecare Billing System	CC Health Services Info Technology
Cesario	Melissa	Program Director	CBO-Fred Finch
Chavez	Rudy	Business Intelligence Consultant	CC Health Services
Chu-Harris	Tracy	Mental Health Clinical Specialist	CCBH
Corral	Jana	Senior VP Clinical Services & Programs	CBO – Youth Homes
Coy	Michelle	Mental Health Clinical Specialist	CCBH
Curran	Brittany	Mental Health Program Supervisor	CCBH
Diaz (Bertha)	Alicia	Mental Health Clinical Specialist	CCBH

Last Name	First Name	Position	County or Contracted Agency
Donohue	Jessica	Regional Executive Director	CBO – Seneca Family Agencies
Down	Adam	Mental Health Project Manager	CCBH
Escobedo	Alejandra	Mental Health Community Support Worker II	CCBH
Field	Stephen	BHS Medical Director	CCBH
Finch	Linda	Program Director	Peer Connection Center
Fuhrman	Beverly	East County Adult Mental Health Services Program Manager	CCBH
Gallagher	Ken	Research & Evaluation Manager	CCBH
Gargantiel	Paolo	Mental Health Clinical Specialist	CCBH
Giles	Amber	Access Line Mental Health Program Supervisor	CCBH
Go	Sharon	Mental Health Program Supervisor	CCBH
Graham	Warner	Chief Program Officer	CBO-A Better Way
Gray	Casey	Mental Health Clinical Specialist	CCBH
Grewats	Jennifer	Mental Health Community Support Worker Central County	CCBH
Hahn-Smith	Steve	BHS Informatics Chief	CCBH
Hardy	Jennifer	Mental Health Clinical Specialist Forensics	CCBH

Last Name	First Name	Position	County or Contracted Agency
Hunter	Tamara	Executive Director	CBO - Mental Health Connections
Jacob	Jean	Planner/Evaluator	CCBH
Jimenez	Dani	A3 Crisis Services Mobile Crisis Response Team	CCBH
Johnson	Kennisha	Mental Health Program Chief of Housing Services	CCBH
Kersten	Melissa	Quality Improvement Coordinator	CCBH
Kester	Connie	Mental Health Clinical Specialist Housing Services	CCBH
Kuzio	Amanda	Mental Health Clinical Specialist	CCBH
Lam	Daisy	Mental Health Program Supervisor	CCBH
Liggins	Carla	Team Lead – Peer Connection Center	Contra Costa Clubhouses
Loenicker	Gerold	Mental Health Program Chief	CCBH
Luu	Matthew	Deputy Director	CCBH
Matal Sol	Fatima	Alcohol &Other Drug Services Chief DMC-ODS	CCBH
Mendoza	Floris	Mental Health Program Supervisor	CCBH
Messerer	Mark	Program Manager, Alcohol & Other Drug Services	CCBH
Millman	Phoebe	Clinical Director for School Based Services	CBO-Lincoln Families

Last Name	First Name	Position	County or Contracted Agency
Rose	Nate	Mental Health Clinical Specialist Older Adult	CCBH
Ny	Faye	Contra Costa Mental Health Finance Manager	CC Health Services Finance
Nybo	Erik	BI Developer	CCBH
Ojewole	John	Mental Health Clinical Specialist	CCBH
Orme	Betsy	Adult & Older Adult Program Chief	CCBH
Orme	Betsy	Adult & Older Adult Program Chief	CCBH
Owens	Renee	Community Support Worker II	CCBH
Paiste	Nicole	Campus Administrator	CBO-Children and Youth Behavioral Health Initiative
Pedraza	Christopher	Project Manager Behavioral Health Admin	CCBH
Peebles	Heather	Mental Health Clinical Specialist	CCBH
Pena	Jorge	Business Systems Sharecare Support	CCHS Info Technology
Pfanner	Alisa	QA Chief	CBO - Mountain Valley Child & Family Services
Pham	Vivian	QA Coordinator	CBO – Bay Area Community Resource
Pierce	Chad	Mental Health Program Chief	CCBH
Rahimzadeh	Ziba	Director of Provider Relations and Credentialing	CCBH

Last Name	First Name	Position	County or Contracted Agency
Ransom	Kelly	CEO	CBO – We Care Services
Rice	Megan	CCLink Behavioral Health Project Manager	CCBH
Rojas	Jessica	Program Director for School Based Services	CBO-Lincoln Families
Sanabria	Bernadita	Mental Health Program Supervisor	CCBH
Scannell	Marie	Program Chief Forensic Mental Health Services	CCBH
Shah	Bhumil	Assistant IT Director Analytics & Reporting	CC Health Services Info Technology
Shirgul	Ellie	Mental Health Program Supervisor	CCBH
Sikland	Joty	CEO/President	CBO – Hume Center
Spikes	Chet	Assistant Director Business Systems	CC Health Services Info Technology
Stokem	Kim	Mental Health Clinical Specialist	CCBH
Surio	Bles	RN UR Manager	CCBH
Tavano	Suzanne	BHS Director	CCBH
Temeltas	Ates	Assistant IT Director Clinical Systems	CC Health Services
Tuipulotu	Jennifer	Behavioral Health Office for Consumer Empowerment Coordinator	CCBH
Underwood	Kenneth	Mental Health Program Supervisor	CCBH

Last Name	First Name	Position	County or Contracted Agency
White	Katy	Behavioral Health Chief of Managed Care	CCBH
Williams	Dolores	Clinical Director	CBO-Bay Area Community Resource
Williams	Jenna	Recovery Coach	Peer Connection Center
Wilson	Pat	Advisor	CC Health Services
Zamora	Bernice	Community Support Worker II/Family Partner Antioch Children's Behavioral Health	CCBH
Zesati	Genoveva	Workforce Education & Training Ethnic Services Coordinator	CCBH

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 structure described for this PIP appears to present moderate confidence, but with interventions and data collection yet to occur; this may change in time to a higher or lower level of confidence as the data comes in.

General PIP Information
MHP/DMC-ODS Name: Contra Costa County Behavioral Health
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness (FUM)
PIP Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023.
Date Started: September 2022
Date Completed: June 30, 2023
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): Medi-Cal beneficiaries served in an emergency department for a mental health condition.

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): The implementation of a navigator in the emergency department environment to link individuals meeting PIP criteria with a SMHS follow-up appointment, and also providing additional contacts to ensure this follow-up appointment is kept.
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): Development of a notification process. Placement of a navigator at emergency departments.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Increased follow-up of Medi-Cal beneficiaries with ED visits for MH conditions by 5 percent for the 7-day FUM periods.	2021	7-day Total N=1,134 FUM-7 N=528 /47 percent	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
Increased follow-up of Medi-Cal beneficiaries with ED visits for MH conditions by 5 percent for the 7-day FUM periods.	2021	30-day Total N = 1,134 FUM-30 N= 696 61.4 percent	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

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: There are four other non-county emergency departments in Contra Costa County. The MHP likely needs to develop specific strategies tailored to these other locations as it seeks to provide navigation assistance for follow-up. As well, the notification process may need to come directly from those hospitals rather than the managed care plan if notification of relevant events will occur rapidly enough to improve the 7-day and 30-day follow-up metric.

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	Of the tracked metrics, the MHP reported the most significant improvement in the process measure of receiving a warm reminder call from the clinician (28 to 62 percent). The actual PIP outcome performance measure of no-show reduction went from 24 to 22 percent in the last reporting period. With short-staffing, interventions that place an additional burden on clinical staff were likely to see lower compliance, thereby translating into lower performance measure results. However, the recent introduction of an automated reminder process, in addition to the current small improvement has a moderate level of confidence attributed to this PIP. The October 2022 automated reminders did not have sufficient time for the MHP perform a full analysis of the result of this change by the time of the current review.
General PIP Information	
MHP/DMC-ODS Name: Contra Costa Behavioral Health	
PIP Title: Gain-framed Provider Reminder Calls to Reduce No Shows to Initial Assessment Appointments	
PIP Aim Statement: Will providing clients with a reminder call from their therapist containing a "gain-framed" message and providing automated Artera appointment reminders significantly decrease no shows to initial assessment appointments at the East Adult clinic to be no higher than 15% within two years of the PIP launch.)	
Date Started: 11/2021	
Date Completed: 11/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): East clinic adult clients.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Warm reminder calls with “gain-framed” message. 11/18/2021
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Therapists received a reminder text message to make a warm call to scheduled beneficiaries.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Automated Artera reminders 10/4/2022

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Intervention Process Metric PM 1 Number and % of initial assessment appointments for which therapists receive a text reminding them to make a warm call. Target: 85%	(No baseline) First Measurement 11/18/21-12/2/21	(No baseline) First Measurement 47/50 47 reminder texts, 94% of appointments	12/3/21-11/18/22	N=1338 1284/1338 96%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): X^2 (1) = .49, p =.48
Intervention Process Metric PM 2. Number and percent of appointments receiving a warm reminder call made by therapists. Target: 80%	(No baseline) First Measurement 11/18/21-12/2/21	(No baseline) First Measurement 14/50 = 28%	12/3/21-11/18/22	N=1407 871/1407 62%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify): Other: X^2 (1) = 23.41, p <.01 (Note: M2 is improved over M1, but does not meet the 80% target)
Intervention Process Metric PM 3. Number and percent of clients successfully reached with gain-framed therapist call. Target: 30%	(No baseline) First Measurement 11/18/21-12/2/21	(No baseline) First Measurement 4/50 4 clients talked to, 8% of scheduled clients	12/3/21-11/18/22	N=1335 343/1335 26%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify): X^2(1) = 8.25, p = .004
PIP Performance Measure PM 4. No show rate to initial assessment appointment - No higher than 15%	FY 20/21	313/1292 24%	12/3/21-11/18/22	N=1514 331/1514 22%	☒ Yes ☐ No	☐ Yes ☒ No P-value: ☐ <.01 ☐ <.05 Other: X^2(1) = 1.58, p=.21

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Year Two Intervention Process Changes - Below						
Intervention Process Metric PM 5. Number and percent of clients receiving an automated appointment reminder 7-days before the appointment.	(No baseline) First Measurement 10/5/22-10/18/22	(No baseline) First Measurement 1/35 (3%)	10/19/22-11/30/22	10/94 (11%)	n/a Insufficient time to evaluate result	n/a Insufficient time to evaluate result
Intervention Process Metric PM 6. Number and percent of clients receiving an automated reminder 1-day before the appointment.	(No baseline) First Measurement 10/5/22-10/18/22	(No baseline) First Measurement 31/35 (89%)	10/19/22-11/30/22	89/94 (95%)	n/a Insufficient time to evaluate result	n/a Insufficient time to evaluate result

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.

PIP Validation Information
EQRO recommendations for improvement of PIP: The MHP in this second year modified the PIP to focus on automated interventions. Considering the current pressure on staff of increased caseloads this seems like a wise change. The only other modification that might be of assistance is if there was a way to convey a recorded “gain-framed” message about the benefits of treatment in the automated reminder message. This could be a mid-year modification if the automated reminders alone do not result in improved no-show rates.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required to be included in this report.

ATTACHMENT F: PM DATA CY 2021 REFRESH

At the time of the MHP's review, the data set used for the PMs was incomplete for CY 2021. Across the state, most of the approved claims data November and December 2021 was not included in the original data used for this report.

CalEQRO obtained a refreshed data set for CY2021 in January 2023. The PM data with the refreshed data set follows in this Attachment.

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Contra Costa MHP Performance Measures

REFRESHED

FY22-23

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	297,051	16,321	5.49%	$144,346,957	$8,844
CY 2020	269,842	15,453	5.73%	$136,953,042	$8,863
CY 2019	262,957	14,764	5.61%	$105,379,252	$7,138

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	30,075	543	1.81%	1.69%	1.96%
Ages 6-17	66,966	4,410	6.59%	5.40%	5.93%
Ages 18-20	15,435	839	5.44%	4.06%	4.41%
Ages 21-64	153,134	9,593	6.26%	4.24%	4.56%
Ages 65+	31,443	936	2.98%	1.69%	1.95%
Total	**297,051**	**16,321**	**5.49%**	**3.99%**	**4.34%**

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	2,373	14.54%
Threshold language source: Open Data per BHIN 20-070		

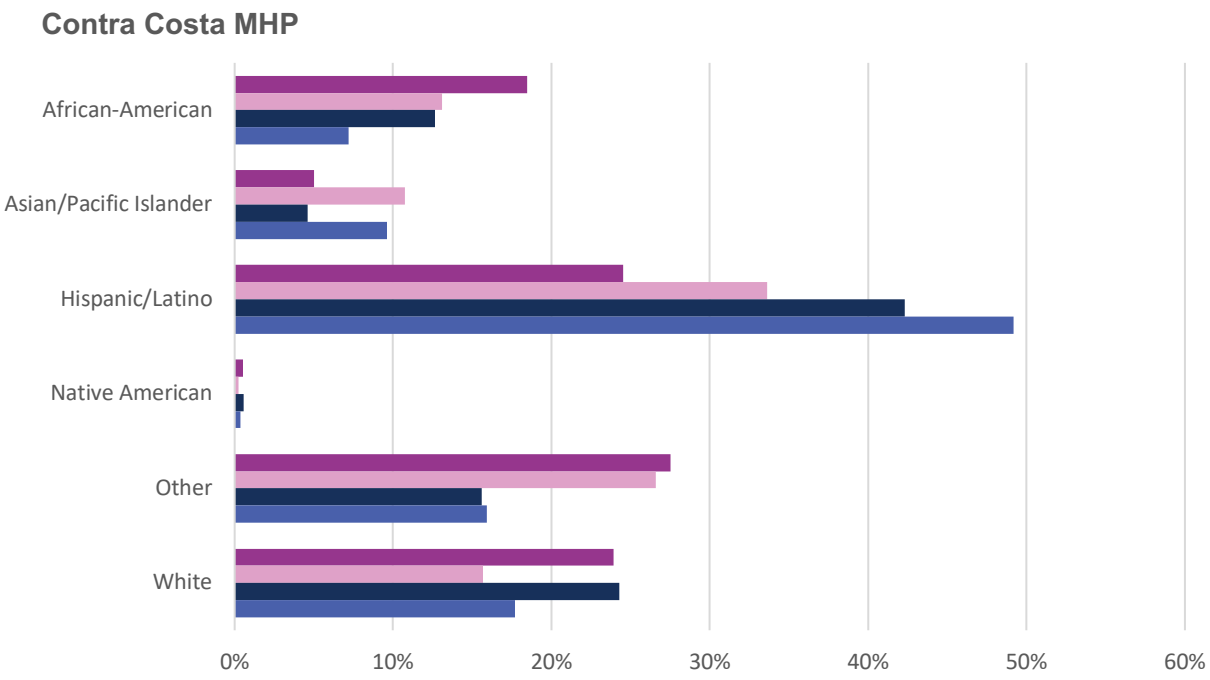
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	91,746	4,513	4.92%	$27,168,260	$6,020
Large	2,150,000	74,042	3.44%	$515,998,698	$6,969
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

Table 7: PR Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	38,947	3,017	7.75%	7.64%
Asian/Pacific Islander	31,916	818	2.56%	2.08%
Hispanic/Latino	99,907	4,004	4.01%	3.74%
Native American	749	85	11.35%	6.33%
Other	79,001	4,491	5.68%	4.25%
White	46,534	3,906	8.39%	5.96%
Total	**297,054**	**16,321**	**5.49%**	**4.34%**

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	24%	28%	1%	25%	5%	18%
MHP % Eligible	16%	27%	0%	34%	11%	13%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

Figure 2: MHP PR by Race/Ethnicity CY 2019-21

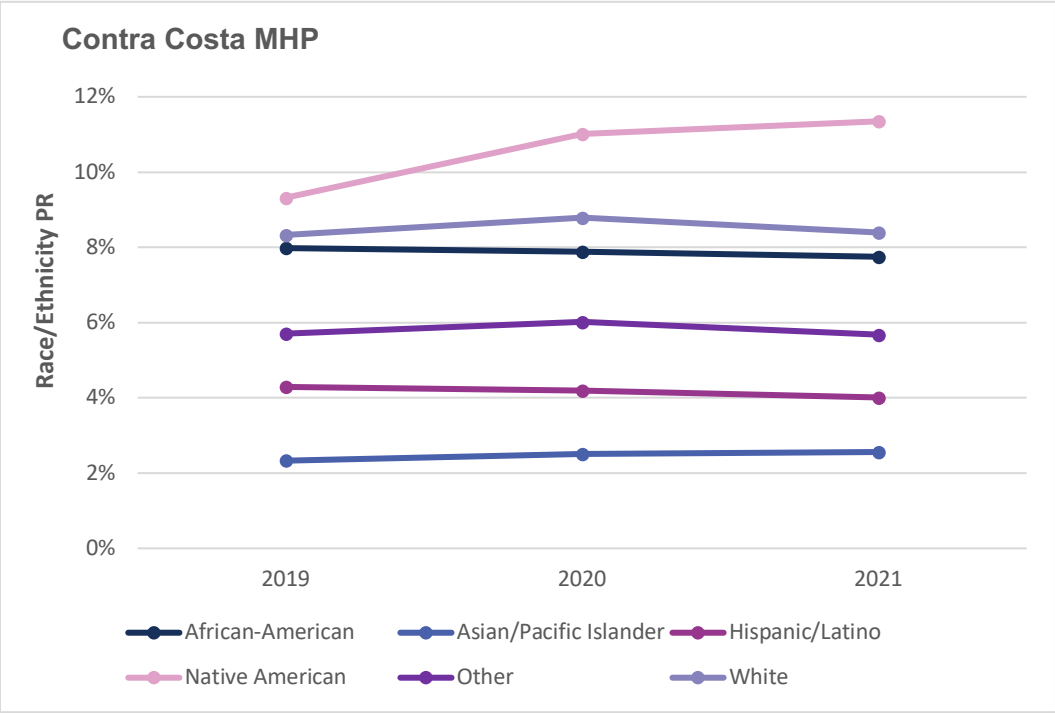


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

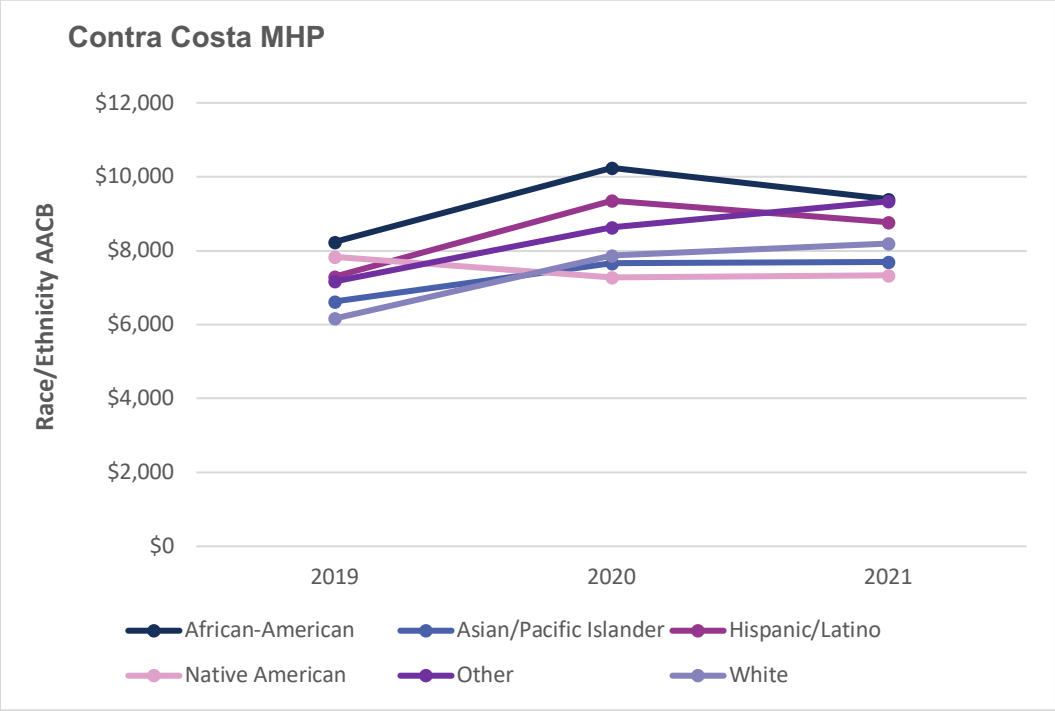
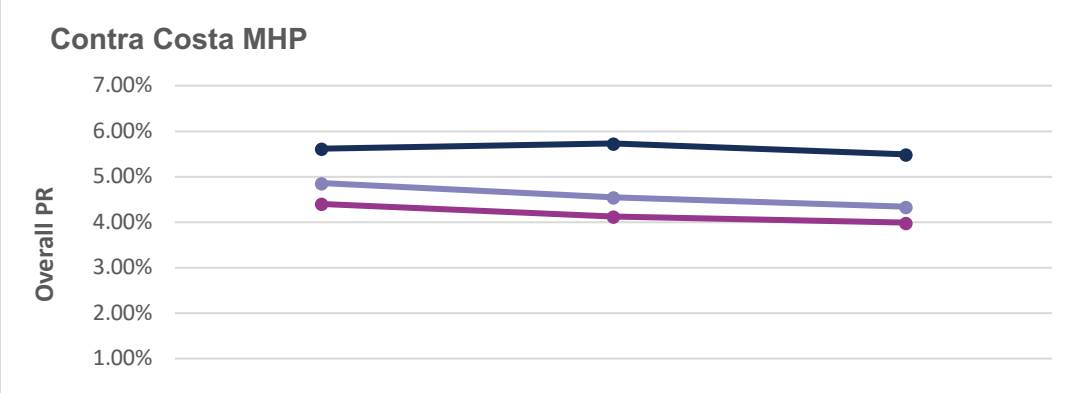
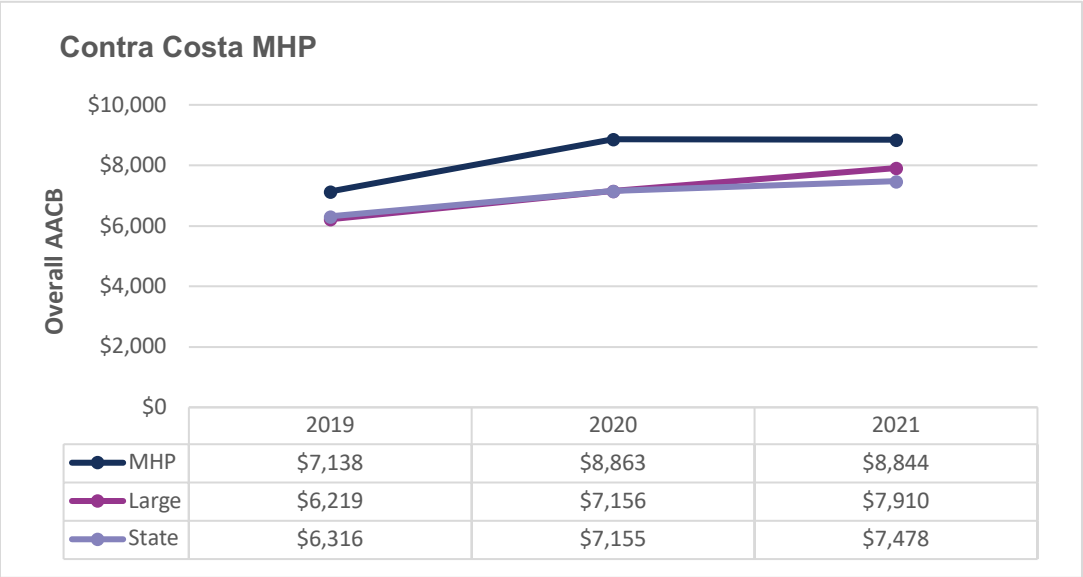


Figure 4: Overall PR CY 2019-21



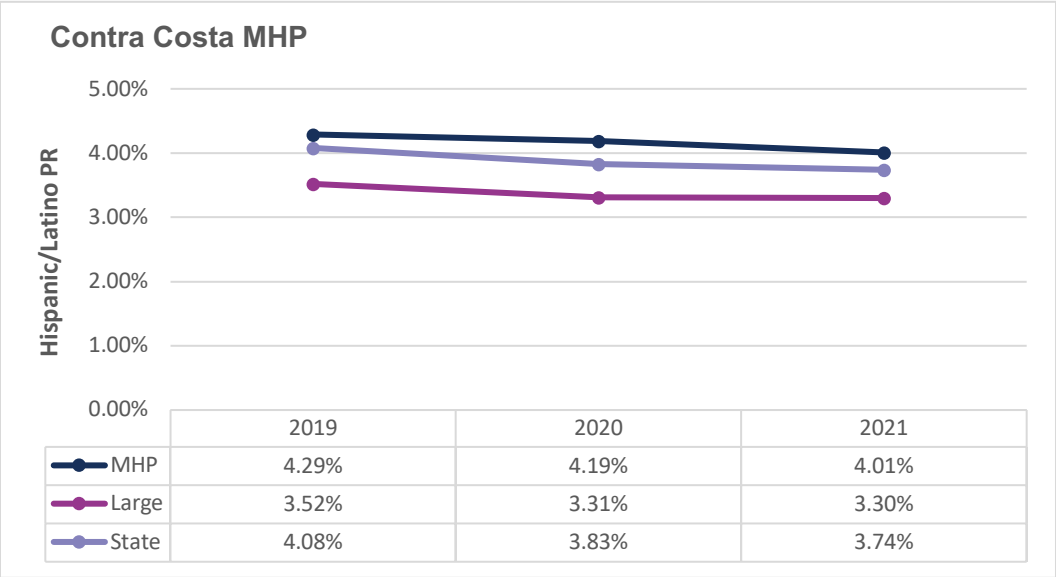
	2019	2020	2021
MHP	5.61%	5.73%	5.49%
Large	4.40%	4.13%	3.99%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



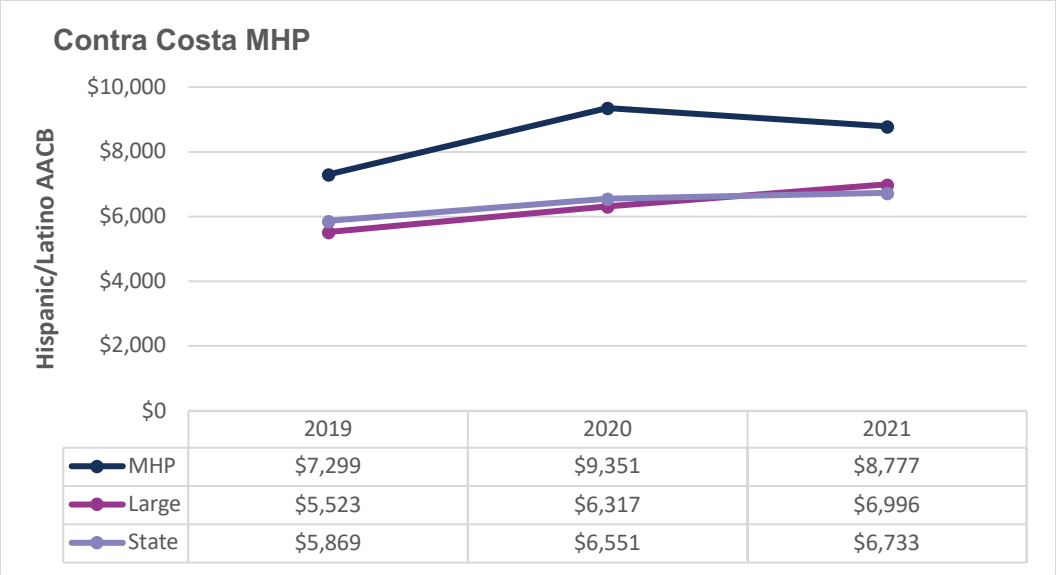
	2019	2020	2021
MHP	$7,138	$8,863	$8,844
Large	$6,219	$7,156	$7,910
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21



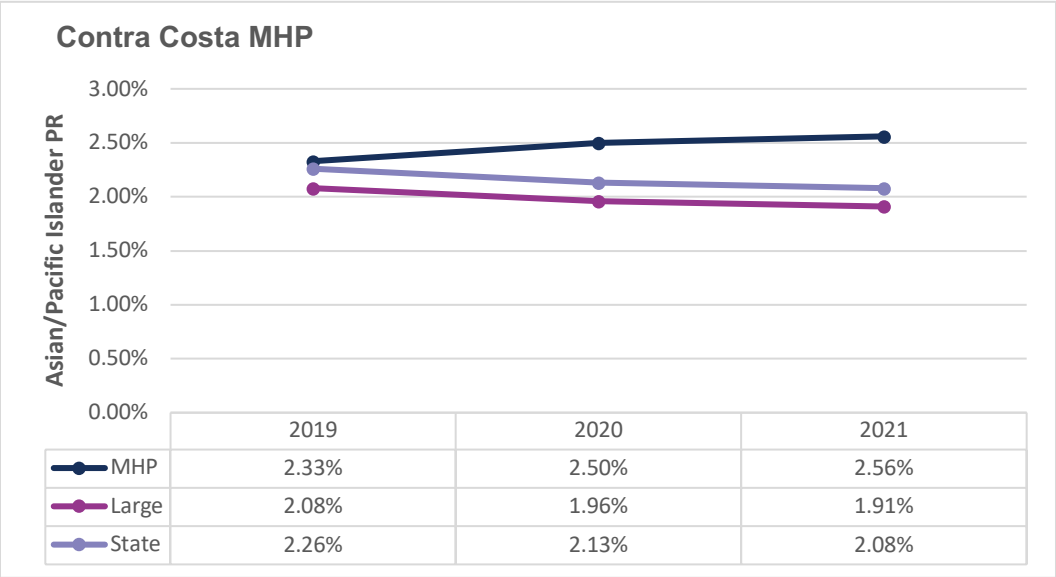
	2019	2020	2021
MHP	4.29%	4.19%	4.01%
Large	3.52%	3.31%	3.30%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21



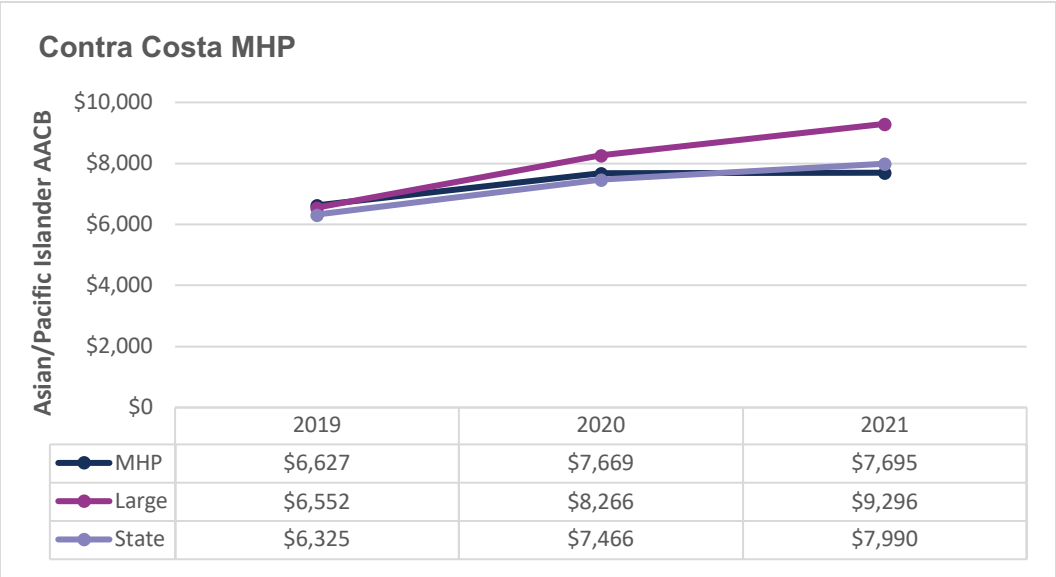
	2019	2020	2021
MHP	$7,299	$9,351	$8,777
Large	$5,523	$6,317	$6,996
State	$5,869	$6,551	$6,733

Figure 8: Asian/Pacific Islander PR CY 2019-21



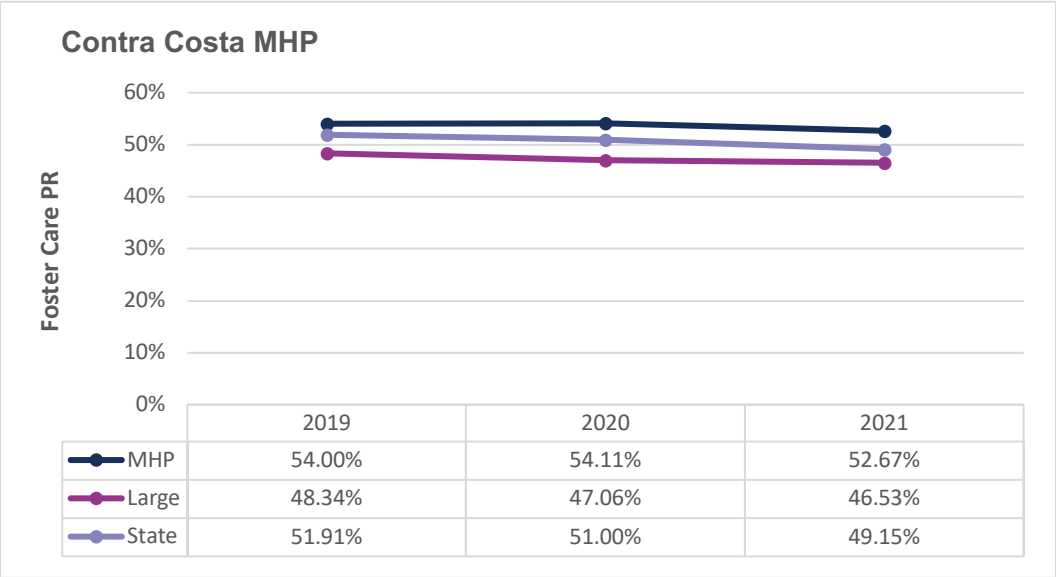
	2019	2020	2021
MHP	2.33%	2.50%	2.56%
Large	2.08%	1.96%	1.91%
State	2.26%	2.13%	2.08%

Figure 9: Asian/Pacific Islander AACB CY 2019-2021



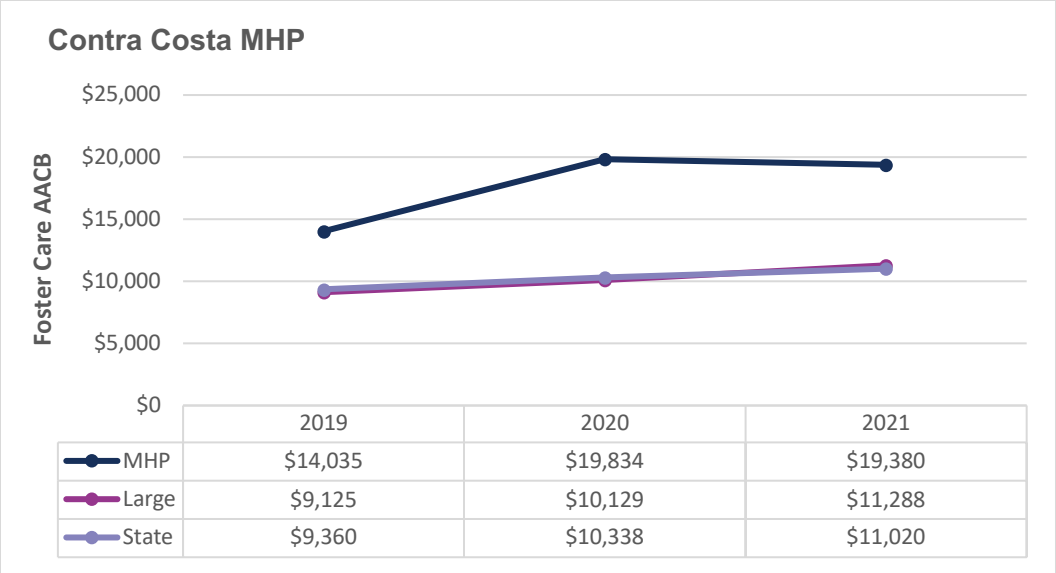
	2019	2020	2021
MHP	$6,627	$7,669	$7,695
Large	$6,552	$8,266	$9,296
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	54.00%	54.11%	52.67%
Large	48.34%	47.06%	46.53%
State	51.91%	51.00%	49.15%

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$14,035	$19,834	$19,380
Large	$9,125	$10,129	$11,288
State	$9,360	$10,338	$11,020

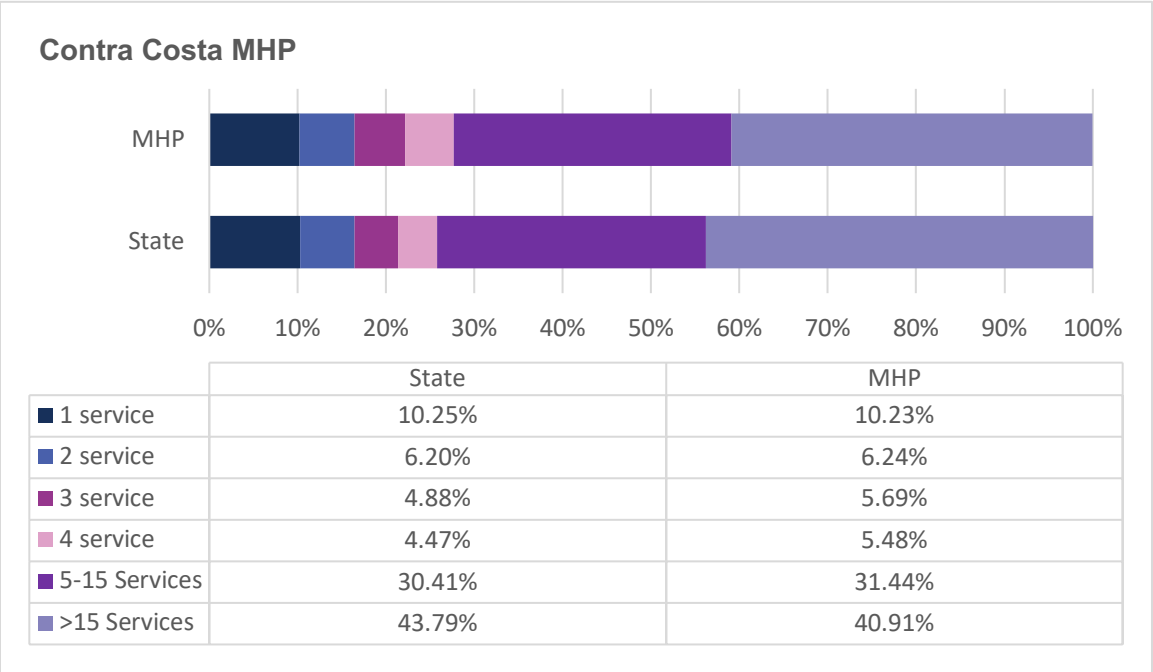
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 11,372				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	988	8.7%	10	5	11.6%	16	8
Inpatient Admin	183	1.6%	13	5	0.5%	23	7
Psychiatric Health Facility	12	0.1%	9	9	1.3%	15	7
Residential	55	0.5%	83	54	0.4%	107	79
Crisis Residential	308	2.7%	17	14	2.2%	21	14
Per Minute Services							
Crisis Stabilization	2,306	20.3%	1,846	1,200	13.0%	1,546	1,200
Crisis Intervention	679	6.0%	217	165	12.8%	248	150
Medication Support	6,994	61.5%	320	225	60.1%	311	204
Mental Health Services	5,750	50.6%	745	346	65.1%	868	353
Targeted Case Management	1,323	11.6%	445	154	36.5%	434	137

Table 9: Services Delivered by the MHP to Youth in Foster Care

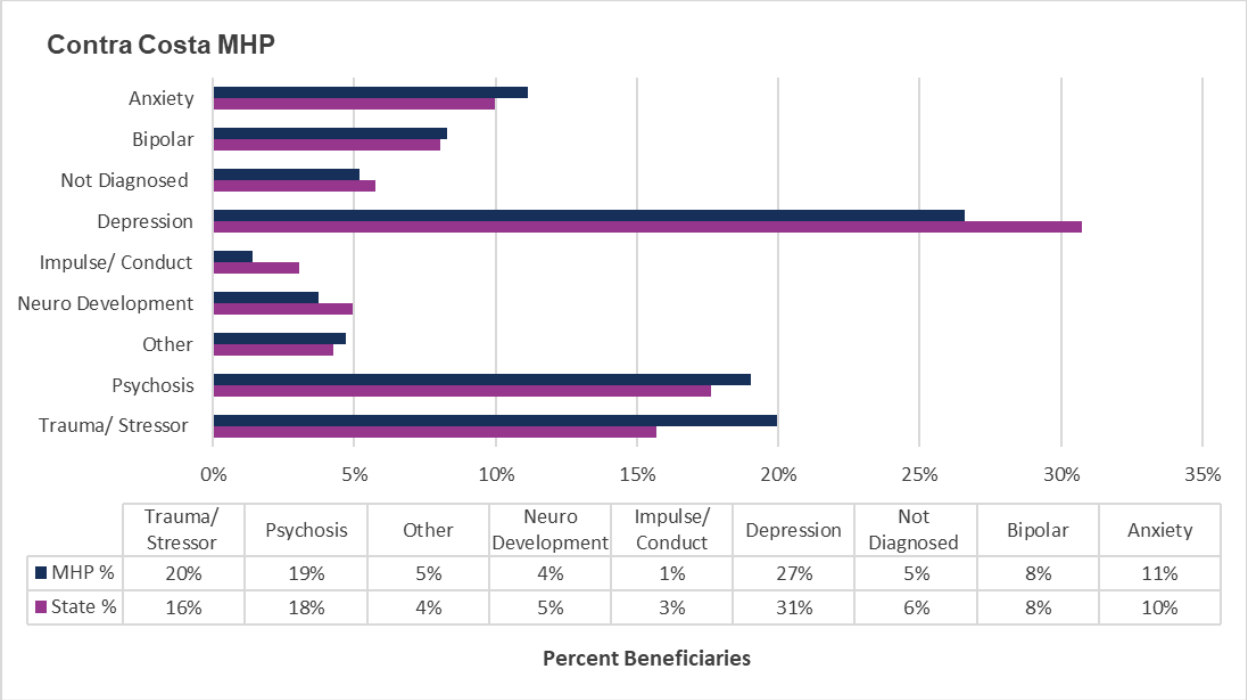
Service Category	MHP N = 533				Statewide N = 37,489		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	20	3.8%	8	5	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	<11	-	66	66	0.3%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	17	12
Full Day Intensive	<11	-	543	543	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	28	5.3%	1,716	1,200	3.1%	1,398	1,200
Crisis Intervention	25	4.7%	188	162	7.5%	404	198
Medication Support	150	28.1%	332	270	28.3%	394	271
TBS	42	7.9%	5,318	3,692	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	195	36.6%	1,390	804	40.0%	1,351	472
Intensive Home Based Services	43	8.1%	1,365	855	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	512	96.1%	2,875	1,416	96.3%	1,848	1,103
Targeted Case Management	331	62.1%	693	160	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



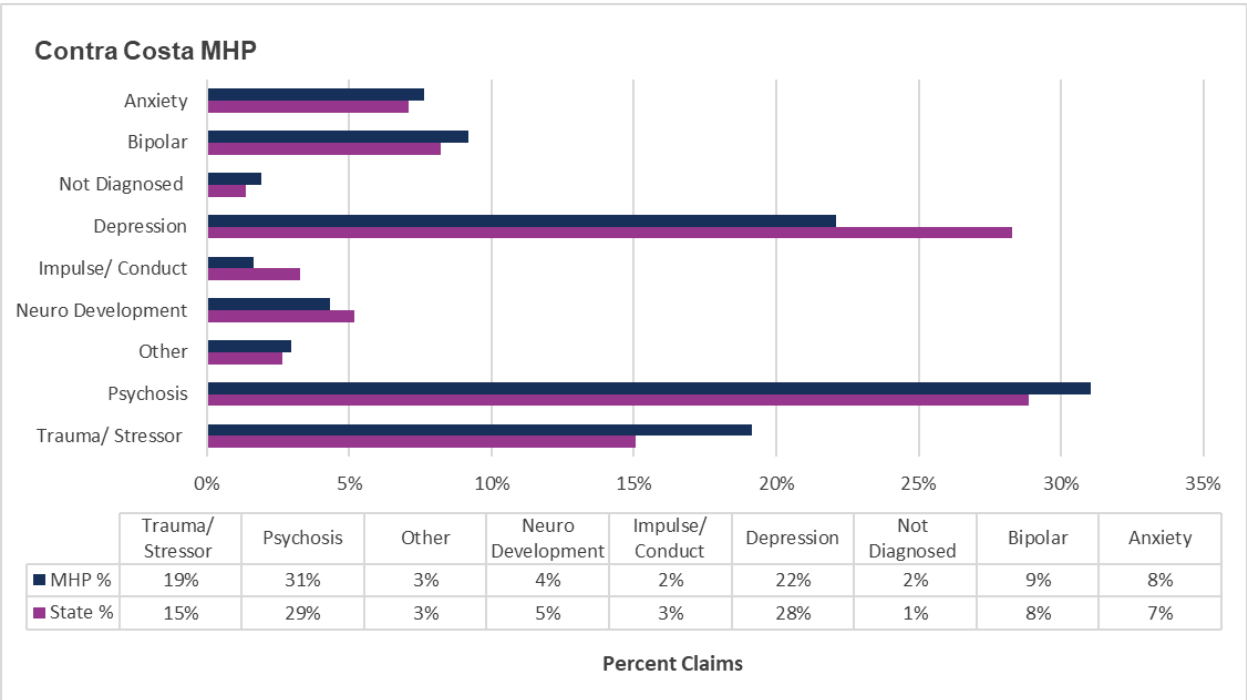
	State	MHP
1 service	10.25%	10.23%
2 service	6.20%	6.24%
3 service	4.88%	5.69%
4 service	4.47%	5.48%
5-15 Services	30.41%	31.44%
>15 Services	43.79%	40.91%

Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	20%	19%	5%	4%	1%	27%	5%	8%	11%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021

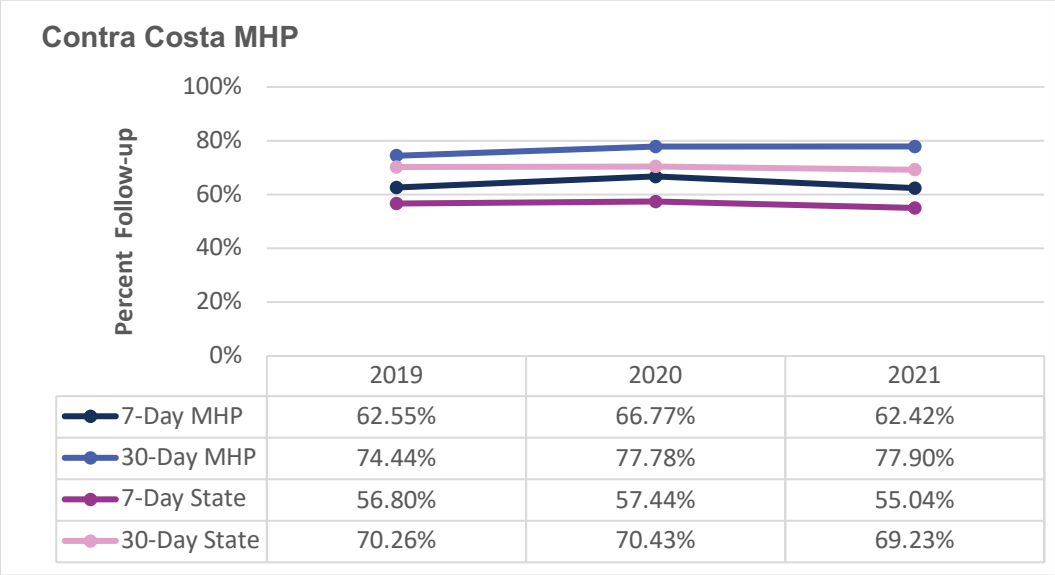


	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	19%	31%	3%	4%	2%	22%	2%	9%	8%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Table 13: Psychiatric Inpatient Utilization CY 2019-21

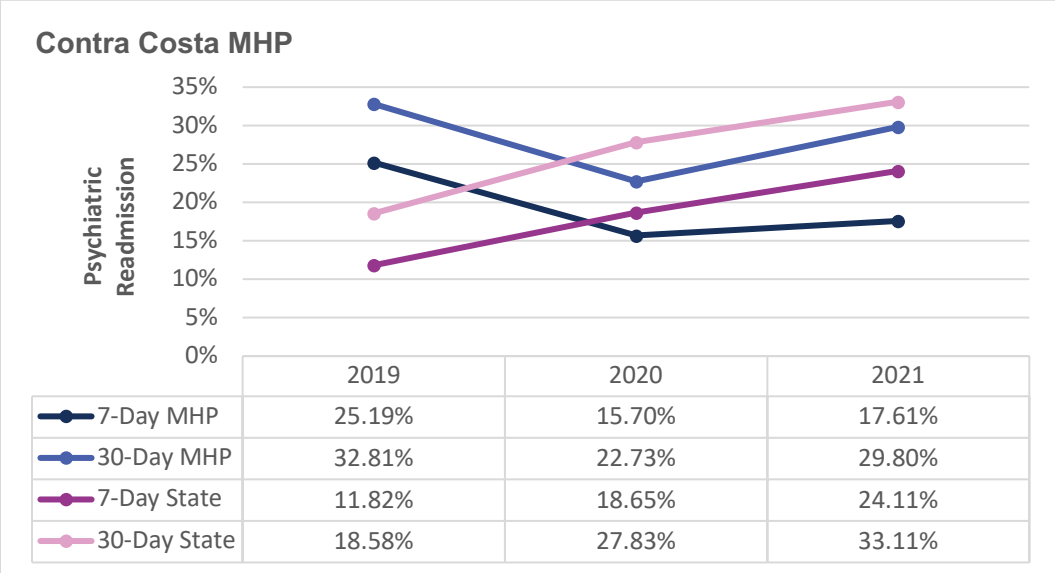
Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	1,320	2,052	10.29	8.86	$25,073	$12,052	$33,096,894
CY 2020	979	1,594	9.31	8.67	$19,387	$11,814	$18,980,014
CY 2019	1,011	2,133	7.39	7.80	$13,115	$10,535	$13,259,607

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	62.55%	66.77%	62.42%
30-Day MHP	74.44%	77.78%	77.90%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	25.19%	15.70%	17.61%
30-Day MHP	32.81%	22.73%	29.80%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	1,115	6.83%	49.70%	$71,742,737	$64,343	1,115
	CY 2020	1,052	6.81%	47.61%	$65,204,384	$61,981	1,052
	CY 2019	721	4.88%	41.10%	$43,309,899	$60,069	721

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	642	3.93%	10.84%	$15,641,805	$24,364	$24,082
Low Cost (Less than $20K)	14,564	89.23%	39.46%	$56,962,416	$3,911	$2,174

Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021

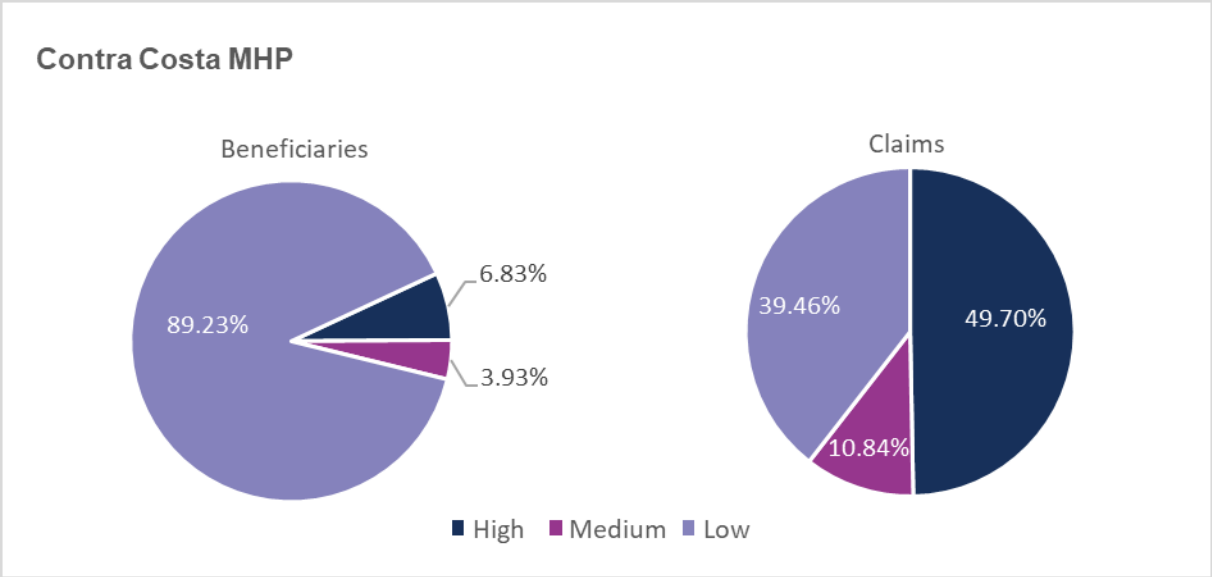


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	31,767	$14,148,642	$183,155	1.29%	$13,111,724
Feb	32,085	$14,347,713	$241,016	1.68%	$13,086,869
Mar	38,156	$16,477,477	$238,550	1.45%	$15,110,964
April	34,777	$16,201,589	$255,902	1.58%	$14,725,044
May	34,131	$13,403,370	$277,631	2.07%	$11,988,736
June	33,755	$12,435,236	$125,980	1.01%	$11,059,609
July	35,058	$13,836,688	$1,528,392	11.05%	$9,986,224
Aug	34,470	$12,701,127	$1,275,361	10.04%	$9,573,273
Sept	33,293	$12,037,545	$150,773	1.25%	$10,656,827
Oct	33,811	$11,714,298	$295,843	2.53%	$10,641,846
Nov	31,548	$11,729,458	$297,801	2.54%	$10,745,594
Dec	25,219	$9,848,795	$432,572	4.39%	$8,834,593
Total	**398,070**	**$158,881,938**	**$5,302,976**	**3.34%**	**$139,521,303**

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Service line is a duplicate and a repeat service procedure code modifier not present	7,667	$2,297,279	43.32%
Late claim	6,476	$887,875	16.74%
Other	7,429	$871,816	16.44%
Deactivated NPI	5,548	$478,471	9.02%
Beneficiary not eligible or non-covered charges	315	$373,735	7.05%
Medicare Part B must be billed before submission of claim	693	$234,741	4.43%
Other healthcare coverage must be billed before submission of claim	174	$154,308	2.91%
Service location NPI issue	25	$4,752	0.09%
Total Denied Claims	**28,327**	**$5,302,977**	**100.00%**
Overall Denied Claims Rate	**3.34%**		
Statewide Overall Denied Claims Rate	**1.43%**		