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

CONTRA COSTA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 17-19, 2024

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — January 17-19, 2024

MHP Size — Large

MHP Region — Bay Area

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

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

Table B: Summary of Key Components

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

Table C: Summary of PIP Submissions

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

Table D: Summary of Plan Member/Family Focus Groups

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

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

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

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

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

Recommendations for improvement based upon this review include:

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

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

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

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

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

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

REVIEW METHODOLOGY

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

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

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

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

Findings in this report include:

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

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

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

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

SIGNIFICANT CHANGES AND INITIATIVES

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

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

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

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

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

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

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

RESPONSE TO FY 2022-23 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

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

Recommendations from FY 2022-23

Recommendation 1: Implement the recruitment and retention strategies identified from staff survey feedback, such as testing alternate work schedules, so as to stabilize staffing and improve recruitment results for both clinical and quality positions.

(This recommendation is a modified carry-over from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

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

Recommendation 2: Develop a documentation and clinical process manual that is regularly updated and reviewed with directly operated and contract provider programs that furnishes clear and specific guidance as to the utilization management requirements. Develop and publish Frequently Asked Questions from discussions of CalAIM changes that is routinely updated and circulated.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

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

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

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

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

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

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

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

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

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

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

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

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

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

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

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

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

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

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

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

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

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

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

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

ACCESS PERFORMANCE MEASURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

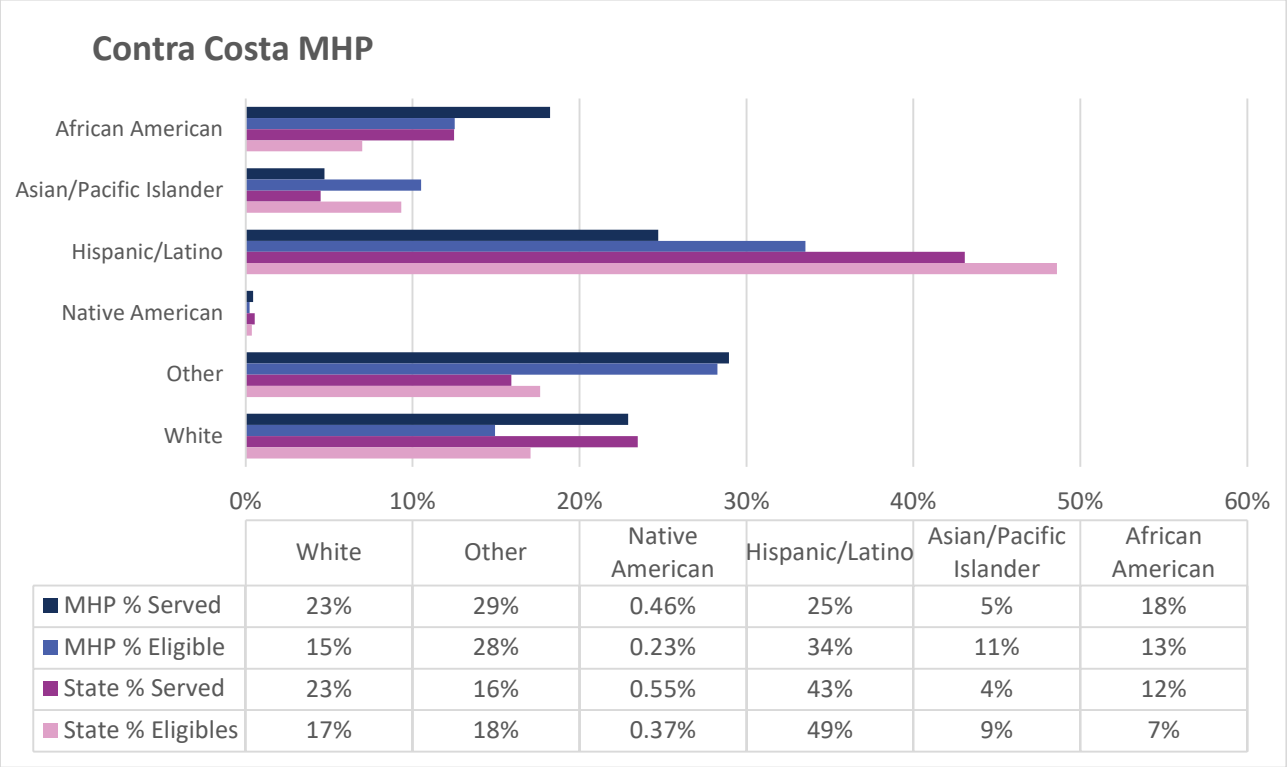
Table 7: Contra Costa MHP PR of Members Served by Race/Ethnicity, CY 2022

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

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

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

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



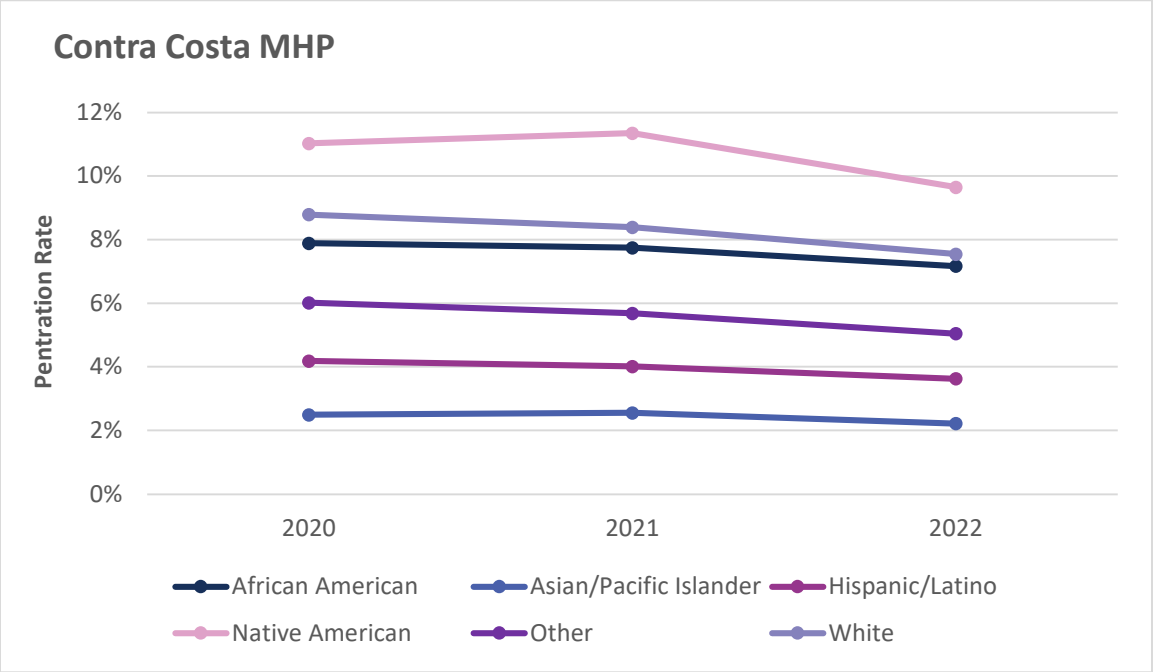
	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	23%	29%	0.46%	25%	5%	18%
MHP % Eligible	15%	28%	0.23%	34%	11%	13%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

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

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

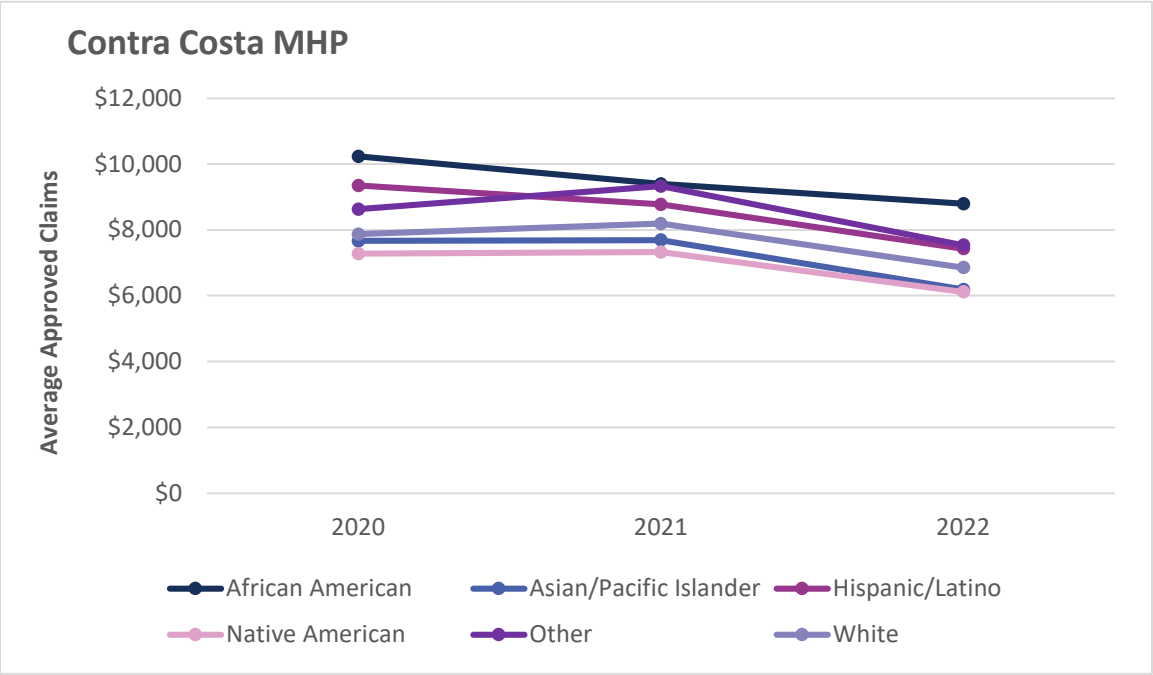
and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year trend.

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



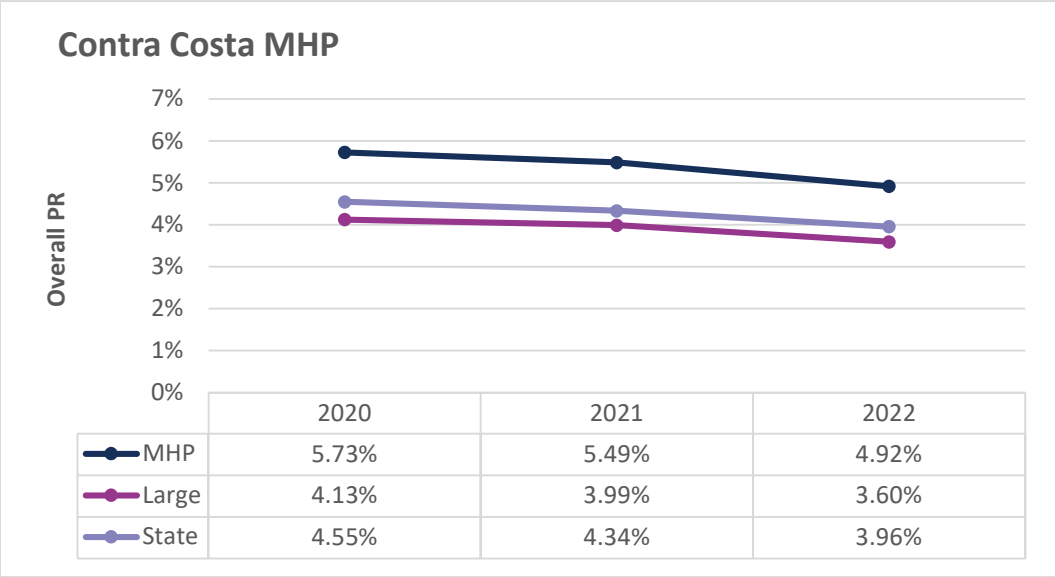
- A downward trend in PRs was seen across all race/ethnicity categories.
- Native American and White PRs were consistently highest over the past three years, and the Asian/Pacific Islander PR has consistently been the lowest in the MHP.

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



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

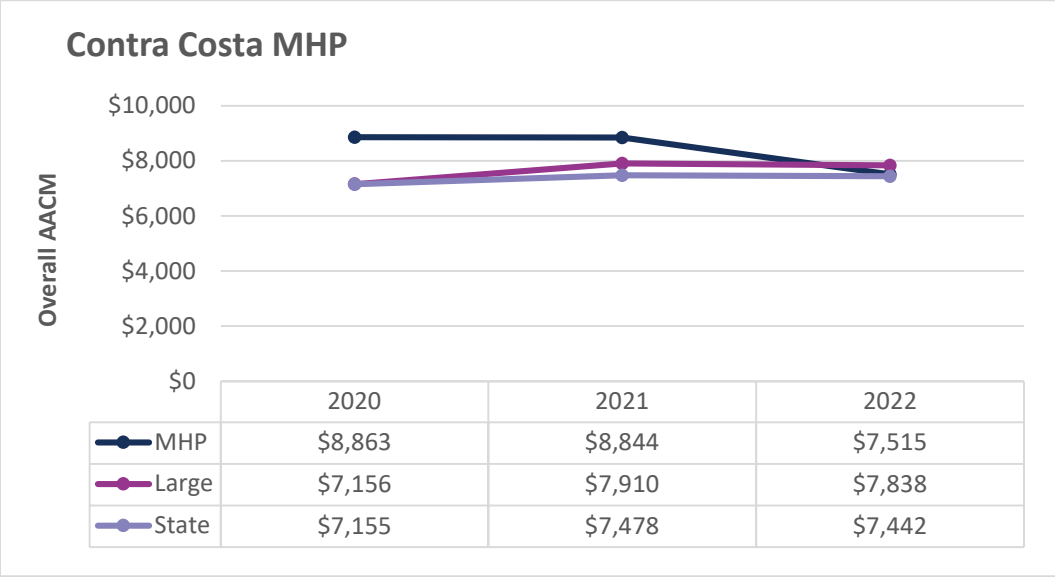
Figure 4: Overall PR CY 2020-22



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

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

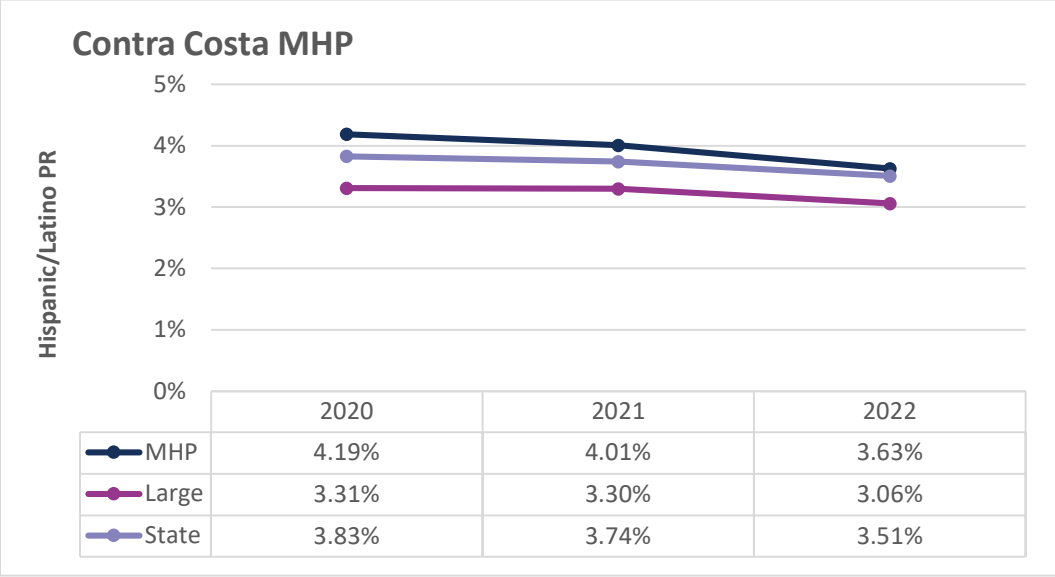
Figure 5: Overall AACM, CY 2020-22



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

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

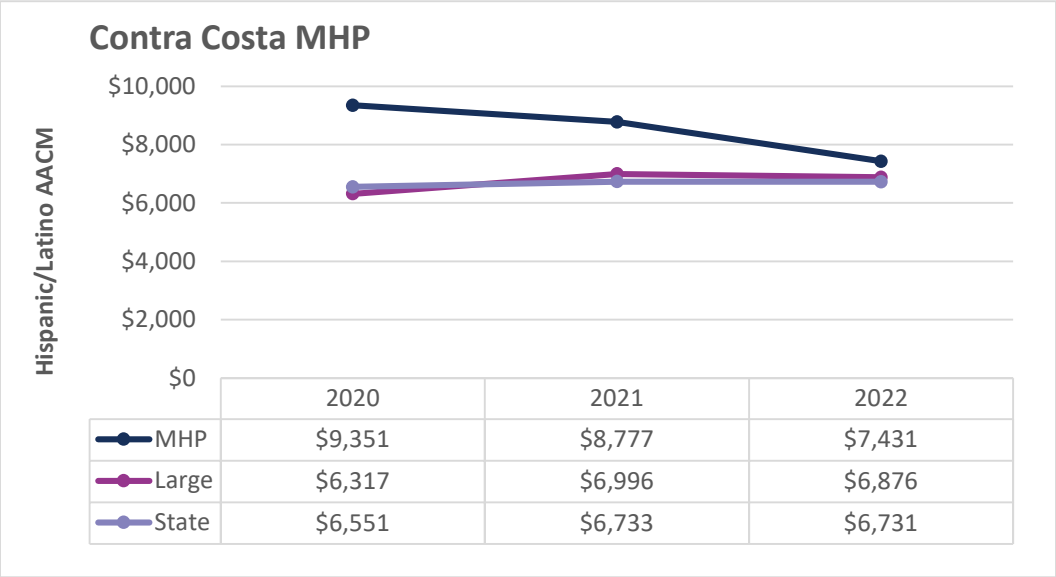
Figure 6: Hispanic/Latino PR, CY 2020-22



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

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

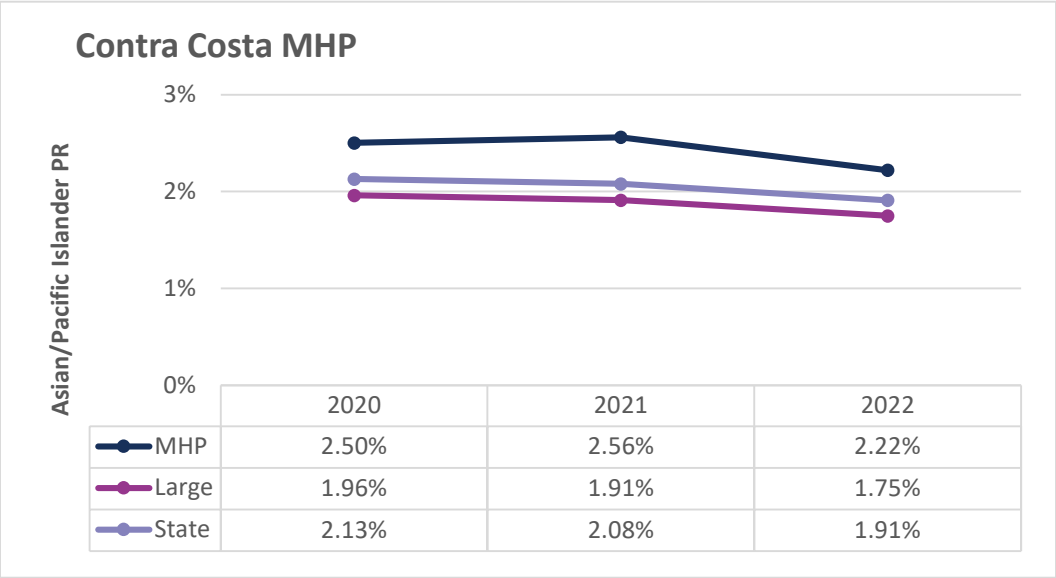
Figure 7: Hispanic/Latino AACM, CY 2020-22



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

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

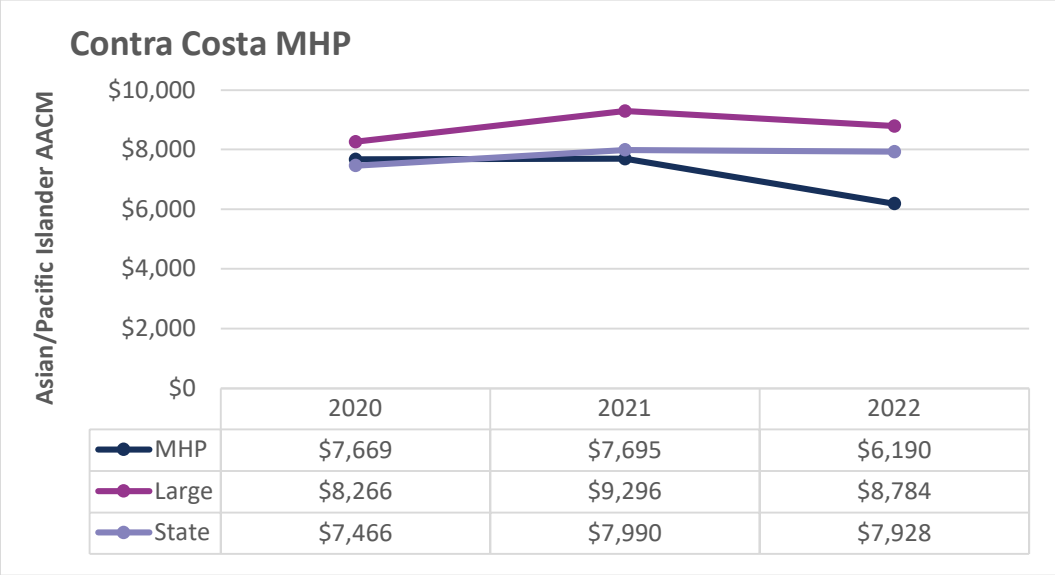
Figure 8: Asian/Pacific Islander PR, CY 2020-22



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

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

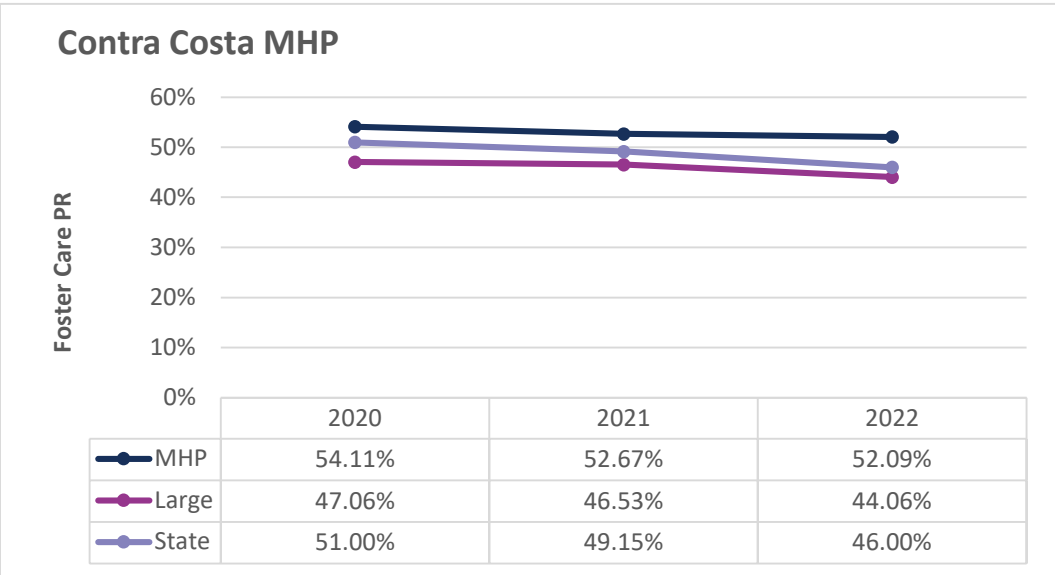
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



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

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

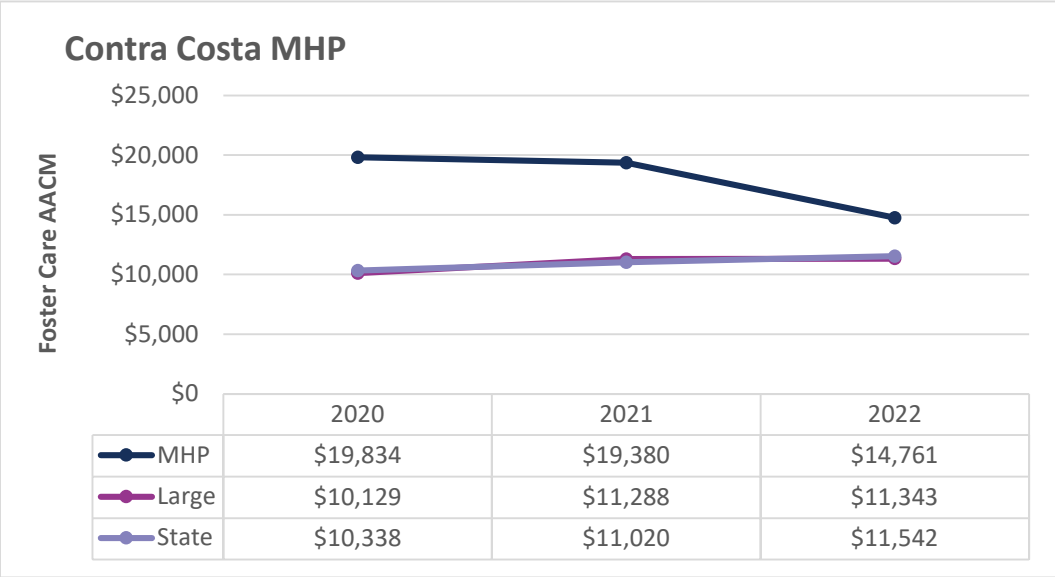
Figure 10: Foster Care PR, CY 2020-22



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

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

Figure 11: Foster Care AACM, CY 2020-22



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

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

Units of Service Delivered to Adults and Foster Youth

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

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

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

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

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

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

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

IMPACT OF ACCESS FINDINGS

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

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

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

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

TIMELINESS PERFORMANCE MEASURES

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

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

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

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

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

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

** MHP-defined timeliness standards

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

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

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

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

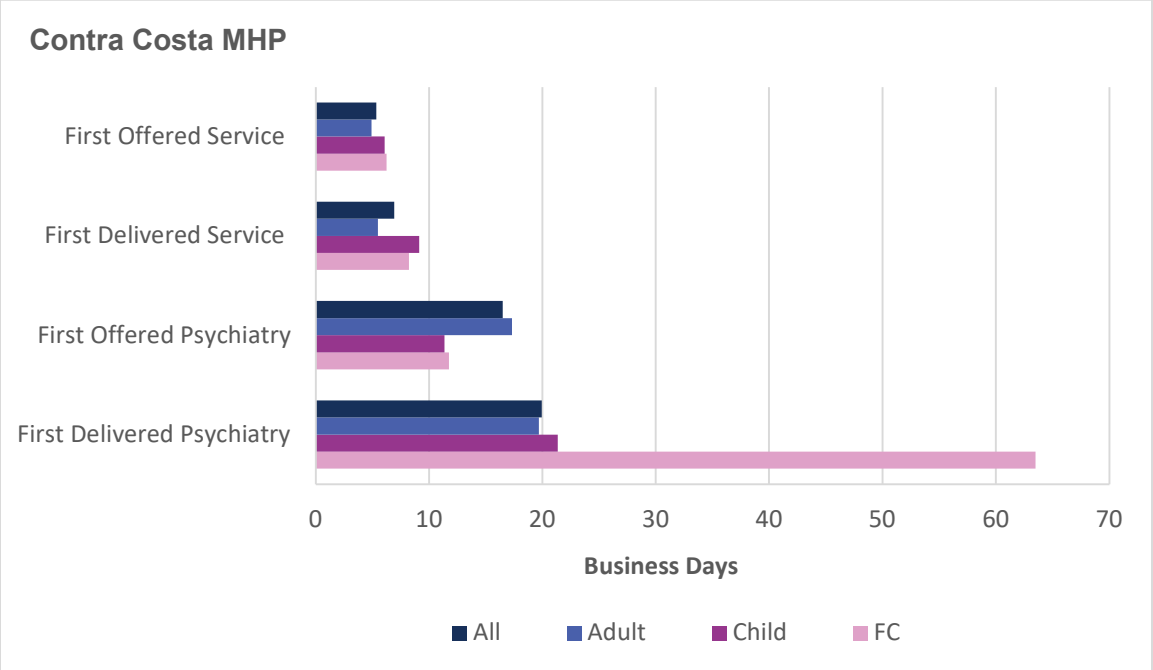


Figure 13: Wait Times for Urgent Services

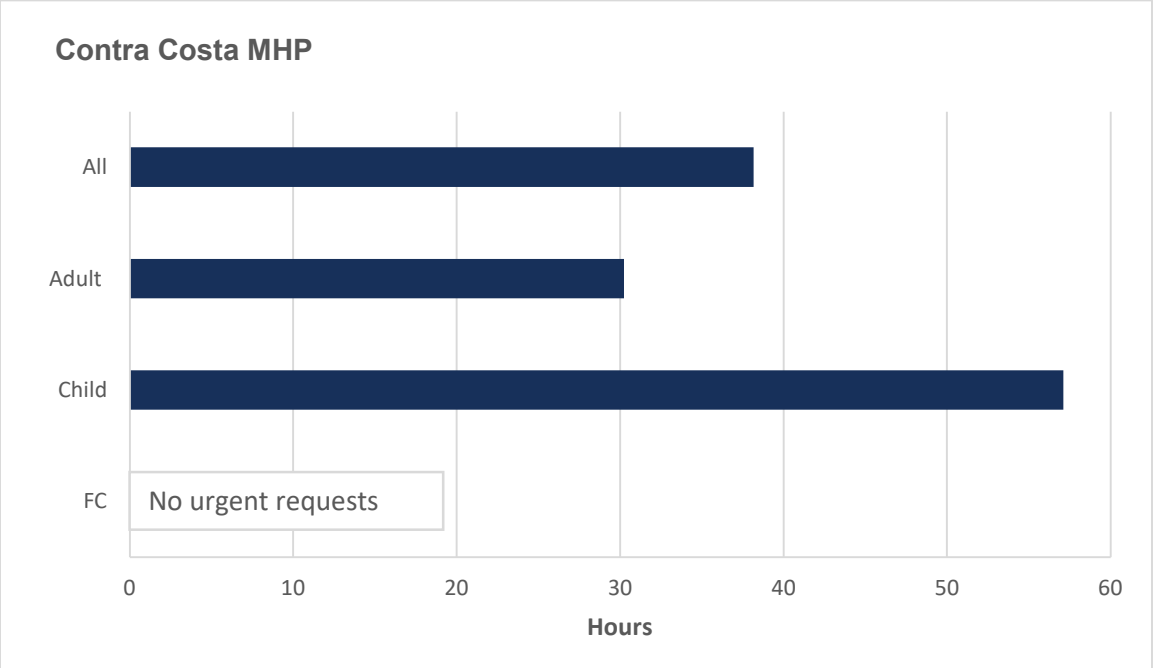
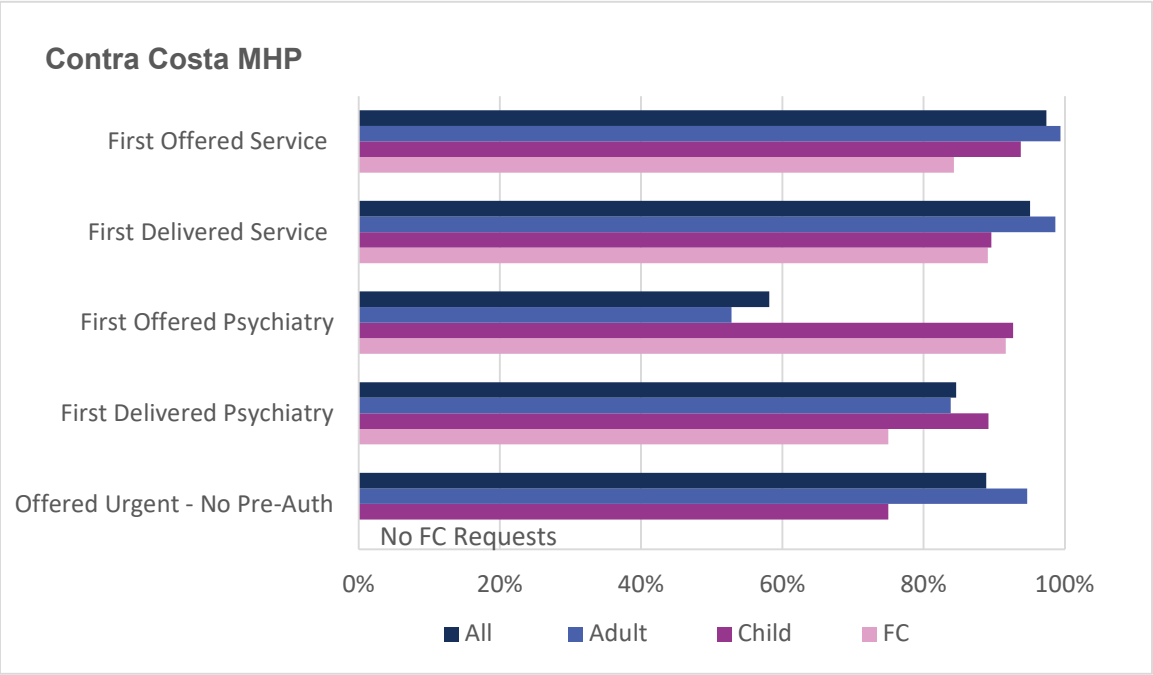


Figure 14: Percent of Services that Met Timeliness Standards



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

IMPACT OF TIMELINESS FINDINGS

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

QUALITY OF CARE

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

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

QUALITY IN THE MHP

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

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

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

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

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

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

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

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

QUALITY PERFORMANCE MEASURES

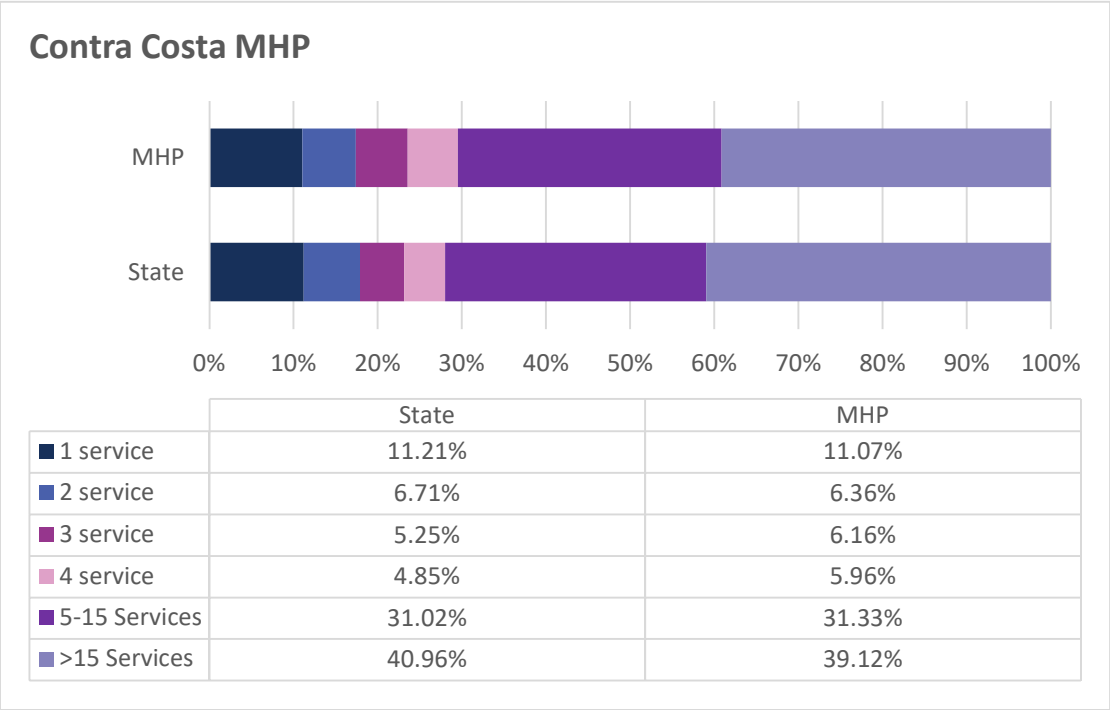
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Members Served, CY 2022



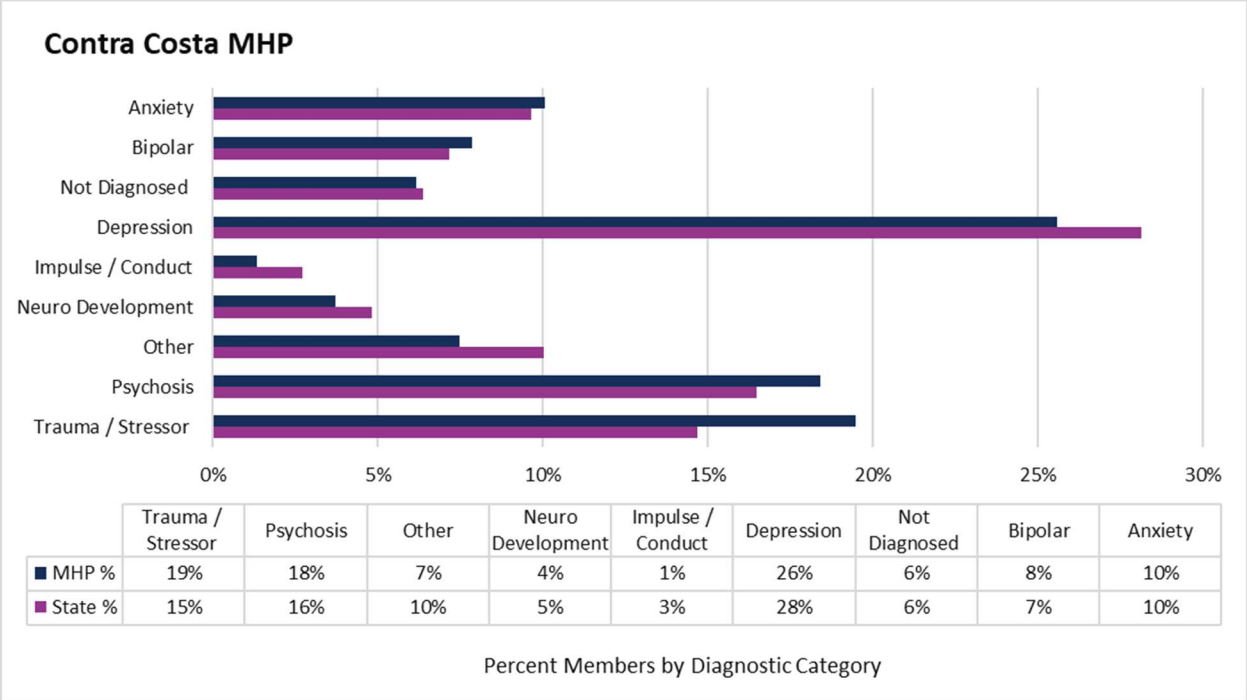
	State	MHP
1 service	11.21%	11.07%
2 service	6.71%	6.36%
3 service	5.25%	6.16%
4 service	4.85%	5.96%
5-15 Services	31.02%	31.33%
>15 Services	40.96%	39.12%

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

Diagnosis of Members Served

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

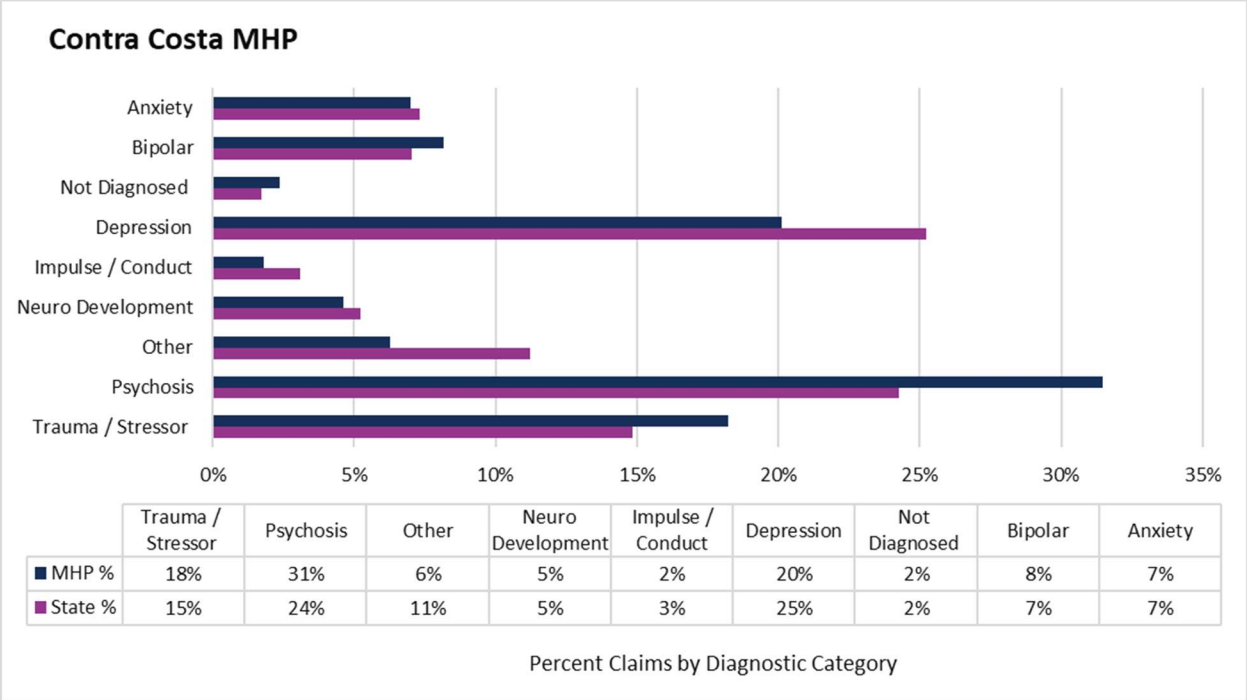
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



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

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

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



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

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

Psychiatric Inpatient Services

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

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

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

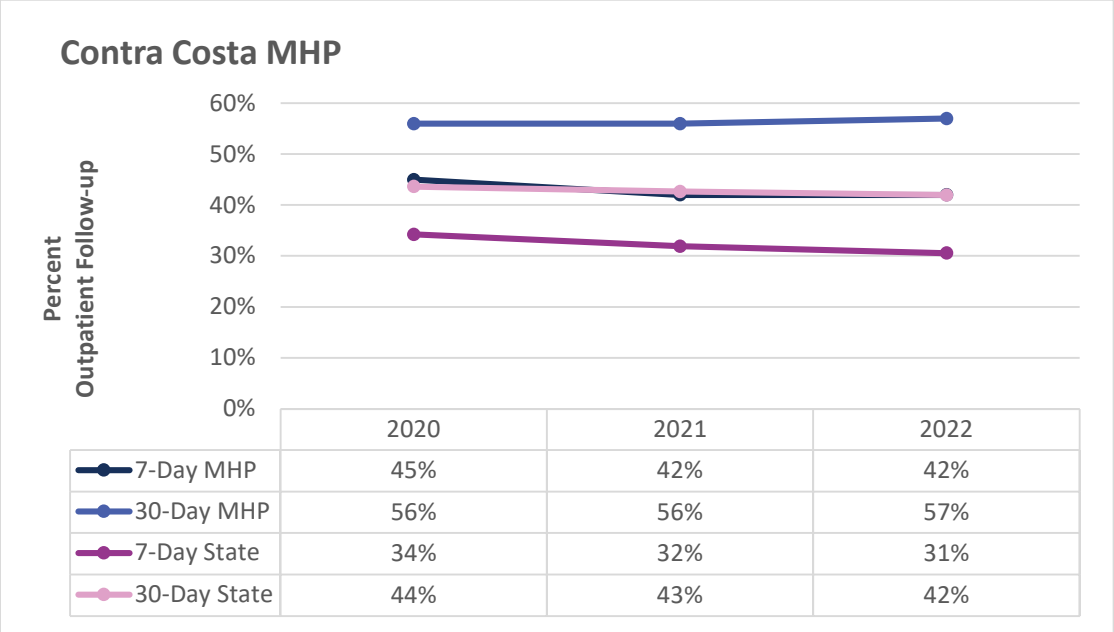
- The MHP has maintained a slightly longer average LOS than seen statewide over the last three years, with members staying about a day longer than the statewide averages. The number of both unique members and inpatient admissions decreased in CY 2022. The MHP inpatient AACM is more than double that of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

Follow-Up Post Hospital Discharge and Readmission Rates

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

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

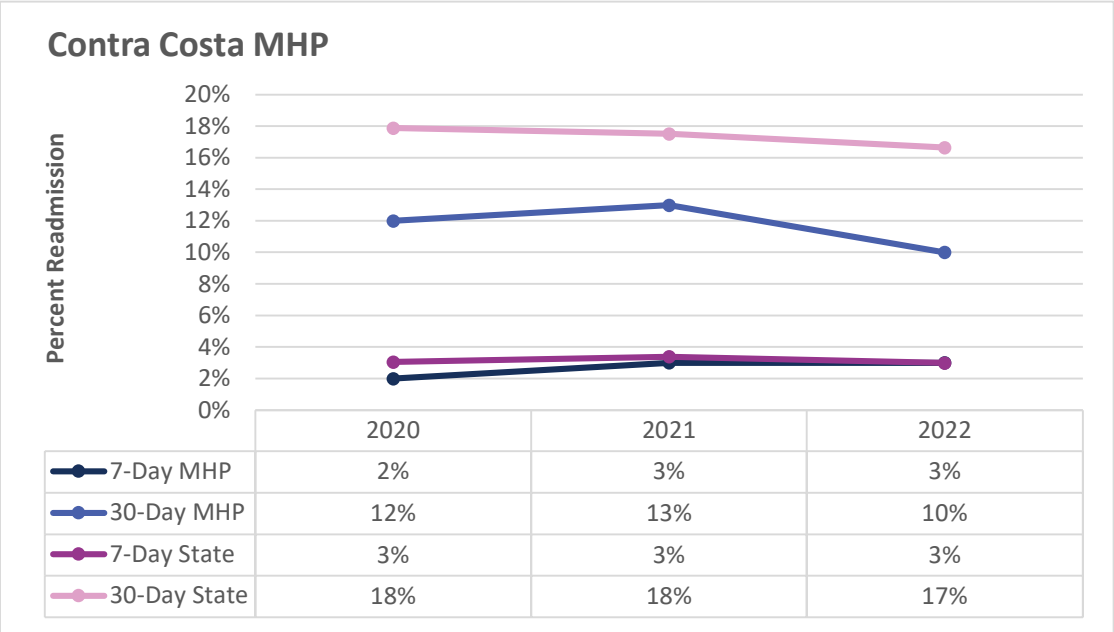
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



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

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

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



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

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

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

High-Cost Members

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

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

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

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

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

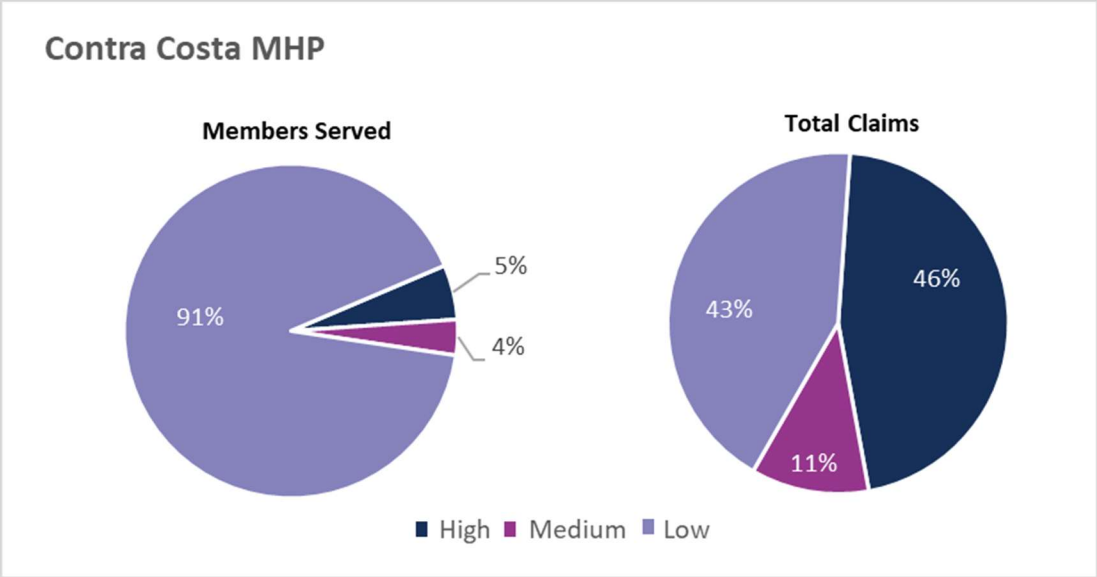
- For the past three years, the proportion of members served considered to be HCMs has been higher than statewide.
- Total HCM approved claims decreased by 24 percent in CY 2022 compared to CY 2021.

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

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

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

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



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

IMPACT OF QUALITY FINDINGS

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

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

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

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

Date Started: 09/2022

Date Completed: In progress

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

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

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

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

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

Summary

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

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

TA and Recommendations

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

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

CalEQRO recommendations for improvement of this clinical PIP:

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

NON-CLINICAL PIP

General Information

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

Date Started: 11/2021

Date Completed: In progress

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

Target Population: East clinic adult clients

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

Summary

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

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

TA and Recommendations

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

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

CalEQRO recommendations for improvement of this non-clinical PIP:

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

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

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

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

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

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

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

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

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

Member Personal Health Record

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

Interoperability Support

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

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

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

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

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

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

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

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

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

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

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

IMPACT OF INFORMATION SYSTEMS FINDINGS

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

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

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

PLAN MEMBER/FAMILY FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

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

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

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

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

Recommendations from focus group participants included:

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

Consumer Family Member Focus Group Two

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

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

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

Recommendations from focus group participants included:

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

SUMMARY OF MEMBER FEEDBACK FINDINGS

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

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

CONCLUSIONS

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

STRENGTHS

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

OPPORTUNITIES FOR IMPROVEMENT

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

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

RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

EXTERNAL QUALITY REVIEW BARRIERS

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

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

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

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

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

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

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

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

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

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

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

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

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

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

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

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

Non-Clinical PIP

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

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

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

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

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

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

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

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

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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