Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

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

FY 2019-20
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

CONTRA COSTA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

February 4 – February 6, 2020

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

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

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

This report presents the fiscal year (FY) 2018-19 findings of an EQR of the Contra Costa MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Large

MHP Region — Bay Area

MHP Location — Martinez

MHP Beneficiaries Served in Calendar Year (CY) 2018 — 14,645

MHP Threshold Language(s) — Spanish

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

---

[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, DC: Author.

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2018-19

In this section, the status of last year's (FY 2018-19) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2018-19 Review of Recommendations

In the FY 2018-19 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2019-20 site visit, CalEQRO reviewed the status of those FY 2018-19 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2018-19

PIP Recommendations

Recommendation 1: For the clinical PIP, the MHP should expand the intervention to additional sites, as well as identify and implement new interventions, i.e., increasing telehealth time.

Status: Met

- Since January 2019, the MHP has hired nine psychiatrists for a total of seven full-time equivalents (FTE). Three of these new physicians (2.5 FTEs) primarily provide telehealth.
- The MHP expanded telehealth to the Central Children's clinic in November 2018, East County Child And Adolescent Services in April 2019, and to the West County Adult Mental Health in July 2019. The increase in psychiatry capacity has resulted in improved timeliness to first psychiatry appointments, which was the primary goal of the clinical PIP.

- The MHP has chosen not to expand the co-visit model for initial intake, a primary intervention in the clinical PIP, to other adult clinics due to challenges resulting from the pilot implementation at the East Adult clinic.

Recommendation 2: For the non-clinical PIP, the MHP should complete a formal barrier analysis to further inform the selection of new interventions. The MHP should collect data on when the reminder calls are made, to help identify the best practice for warm reminder calls.

Status: Met

- The MHP completed a formal barrier analysis on appointment adherence. The multidisciplinary non-clinical PIP workgroup analyzed data from call logs and a November 2019 Service Improvement Survey (SIS). Lastly, the MHP developed a predictive model for no-shows to first assessment appointments to identify the strongest predictors.

- From the barrier analysis, the non-clinical PIP workgroup also identified the need to implement a more robust transportation intervention for beneficiaries attending co-visit appointments, particularly at the East Adult clinic. The workgroup is planning a pilot ride share program to provide rides to clinic appointments.

Access Recommendations

Recommendation 3: By the next EQRO review, fully investigate the high percentage of high-cost beneficiaries (HCB) and identify relevant actions that show potential for impacting that population. *(This recommendation is a carry-over from FY 2018-19.)*

Status: Partially Met

- The MHP initially investigated HCB issues in 2016. In partnership with Public Health, the MHP research and evaluation team plans to study the HCB population.

- An HCB workgroup was re-convened in October 2019 after a Mobile Crisis Response Team (MCRT) was established to reduce 5150s and lessen unnecessary psychiatric hospitalization.

- The HCB workgroup determined that the Level of Care Utilization System (LOCUS) assessment was inadequate as a level of care tool. As a result, the Adult Needs and Strengths Assessment tool (ANSA) was selected for the adult system of care in 2020.

Recommendation 4: Continue to prioritize hiring psychiatrists and increase the number of psychiatrists capable of delivering telehealth services in Spanish.

Status: Met

- Contra Costa Behavioral Health Services (CCBHS) has continued to prioritize hiring psychiatrists, including those with Spanish-speaking ability, as available. Since January 2019, Contra Costa has hired nine psychiatrists including one bilingual in Spanish for a total of seven FTEs. Three of these new physicians (2.5 FTEs) work primarily via telehealth.

- Telehealth has expanded to fill system needs from the original East Adult pilot clinic to a total of four clinic sites, adding Central Child, East Child and the West County Adult Mental Health.

- The MHP has added a ten-dollar hourly incentive to recruit and retain Spanish-speaking independent psychiatrist contractors.

Recommendation 5: Continue to prioritize hiring psychiatrists, especially those who are Spanish-speaking.

Status: Met

- See response in Recommendation 4.

Recommendation 6: Evaluate potential accessibility barriers at crisis residential treatment facilities and prioritize correction and/or implement workarounds so that all facilities are Americans with Disabilities Act (ADA) compliant and are accessible by all persons.

Status: Partially Met

- The MHP operates two crisis residential facilities for adult beneficiaries. Telecare Corporation, a contractor, operates Hope House in Martinez, CA and Bay Area Community Services (BACS), operates Nierika House in Concord, CA.

- Both crisis residential facilities are licensed as “ambulatory only” facilities by DHCS to provide services as a “short-term crisis residential treatment social rehabilitation program.” Under this license, the facility is not permitted to accept beneficiaries who are in wheelchairs or have other limitations that would prevent them from evacuating the facility without assistance.

- Structurally the facilities are “ADA compliant,” meaning they are wheel-chair accessible and bathrooms are compliant with ADA codes; however, due to licensing restrictions, those in wheelchairs and those who need aids to ambulate cannot reside at these facilities.

- Alternative placements for non-ambulatory beneficiaries is still needed since the process for transfer to a board and care is lengthy; further, for homeless persons, respite and emergency shelters are the remaining option.

Recommendation 7: Evaluate and identify gaps in transportation for beneficiaries. Implement strategies to improve transportation and inform beneficiaries of updated transformation services that are newly available.

Status: Met

- Overcoming Transportation Barriers (OTB), an Mental Health Services Act (MHSA) funded committee, collected feedback from beneficiaries who used OTB for services. Additionally, a stakeholder focus group was held during the transportation subcommittee.

- Several Commute Navigation Specialists (CNS) were hired in the Office for Consumer Empowerment (OCE) to provide a range of services from peer support, mapping bus routes, and providing links to resources, including fare information. In addition, the CNS provides support in accessing discount/disabled transit Clipper cards, Regional Transit Connection (RTC), senior/youth cards and paratransit. Beneficiaries can access these services by calling the dedicated phone line for transportation assistance.

- The OTB workgroup provides funding to cover a one-time transportation related cost. For example, flexible funding could cover the cost of a new tire for a vehicle. Also, the OTB workgroup will be providing training to beneficiaries on the use of public transportation. Implementation is planned for 2020.

- The OTB Team informs beneficiaries of updated transportation services through committees and workgroups, clinic staff meetings, community events, peer newsletters, email announcements, and brochures.

Recommendation 8: Evaluate available activities for parents, caregivers, children and Transition Age Youth (TAY). Implement additional activities including children's groups, TAY groups and parenting support groups where gaps are identified.

Status: Met

- The MHP conducted focus groups with caregivers in 2018. Members indicated a desire for more groups including social skills groups for children and parent/family events or activities; however, the MHP reports that in its biannual state Consumer Perception Survey (CPS), the majority of youth stated that they are satisfied with services as-is, but with additional social activities. In these surveys, parents expressed the helpfulness of groups such as Dialectical Behavior Therapy (DBT), family groups, and parent partners.

- While the focus groups did not specifically identify gaps (because the services or group were already being offered), improved communication with beneficiaries is needed, specifically on how to access adjunctive supports. Even with the schedules in each clinic and referrals to groups provided by clinicians, there is a need for less formal supports, i.e. drop-in parent groups, youth activities.

Recommendation 9: Provide one-on-one peer assignment for both adult and children's clinics, to educate and help beneficiaries navigate the system, including Spanish-speaking peer staff.

Status: Met

- In the children's mental health (MH) clinics, the MHP has 12 Family Partner positions, four at each of the three clinic sites. Currently, there are five Spanish-speaking Family Partners.
- The MHP is adding a Mentor Program to its clinics. Mentors will provide direct services to children and youth, including help with system navigation.
- Additionally, many of the MHP's contract providers have peer providers who support beneficiaries in accessing services. A recent survey of providers showed that contractors employ 13 peer providers/family partners, two of which are Spanish-speaking.
- In the adult clinics, there are 37.5 FTE Community/Family Support Worker (CSW, FSW) positions spread across three clinics. They provide peer counseling support, independent living skills training, and general support to adults and older adults.

Timeliness Recommendations

Recommendation 10: Implement process as soon as practical that automates the electronic exchange of service transactions from ccLink to ShareCare to eliminate manual data entry and the need to review reconciliation reports.

Status: Partially Met

- While there are still plans to implement service integration to minimize manual data entry into ShareCare, the MHP is focusing on Client Service Information (CSI) timeliness reporting, the community-based organization (CBO) provider portal, eSignature and ongoing maintenance of the EHR.
- In addition, services can only be entered into ShareCare after an admission has been entered and ShareCare does not currently have tools available to accept an admission interface. Until the admission interface is addressed, admissions will continue to be manual.
- CCBHS is in discussion with the Echo group, the vendor of ShareCare, to create an interface that imports ccLink data to ShareCare to eliminate the manual data entry.

Recommendation 11: Investigate the low rate of offered assessment appointments within the 10-day standard for older adult services through a formal barrier analysis to determine causes/barriers to attendance. Identify and implement interventions specific to the causes identified.

Status: Partially Met

- The Intensive Care Management (ICM) Program is a field-based program for which the access line does not schedule initial intake appointments. Appointments are made directly through the ICM program.
- For all the county clinics combined, 74.3 percent of older adult beneficiaries were offered an assessment appointment within ten business days; however, contractor data is not included.
- For the November 2019 CPS, the MHP added a supplemental one-page SIS to gather additional information on barriers to attendance. Beneficiaries reported transportation barriers. Staff reported that they had difficulty getting in touch with beneficiaries.
- For now, they are considering implementing reminder calls for the ICM Program in addition to providing home visits.

Recommendation 12: Investigate the rate of both offered and kept psychiatry appointments for the system overall, as well as East and West County clinics for both adults and children's services. Through a formal barrier analysis, identify the causes/barriers to attendance of the offered appointment as well as the kept appointment. Identify and implement interventions specific to the causes identified.

Status: Met

- The MHP’s barrier analysis included data from a November 2018 Access line, PIP call logs, and a predictive model for no-shows. The MHP found that the reasons identified by the highest percentage of beneficiaries included forgetting (29 percent) and transportation (19 percent).
- In the East Adult clinic, the MHP implemented a transportation-specific call to beneficiaries eight days before a scheduled co-visit to provide transportation resources and an additional reminder call at five days before the appointment.
- The MHP also implemented a new policy which establishes operational definitions for no-shows, beneficiary cancellations, and missed appointments. The policy establishes procedures for documenting and following-up with beneficiaries for no-shows. Training on the new procedures will begin in 2020.

Recommendation 13: Begin tracking and reporting on the timeliness for urgent services for children's service.

Status: Partially Met

- The MHP previously utilized Miller Wellness Center and the MCRT for urgent referral situations. The MHP established a procedure to get urgent referrals into the clinics and updated the access line policy. This allows the MHP to facilitate urgent referrals to its regional clinics while tracking timeliness.

- The MHP ensures data capture of urgent appointments for children's services by marking calls to the access line with a referral priority of "urgent" and to be scheduled within 48 hours; however, the data does not include contractor data. Calls are also marked for follow-up within two hours of scheduling to confirm or redetermine priority.

Recommendation 14: Track and trend the causes of timeliness barriers for post-hospitalization follow-up appointments which fall outside the 10-working day goal. Identify and implement interventions specific to the causes identified.

Status: Met

- Recommendation 14 mistakenly states that the standard for post-hospitalization follow-up as ten-working days; the correct standard based on the HEDIS measure is seven calendar days.

- As previously indicated in last year's EQR report, the MHP's outpatient MHP 7-day follow-up rate of 56 percent is higher than the DHCS average of 35 percent. Also, the MHP post-hospitalization follow-up rate is higher than its neighboring large counties.

- The MHP is working on interventions which address timeliness of post-hospital follow-up. These include developing a plan to have hospital social workers avoid scheduling appointments based on projected length of stay and instead schedule based on actual confirmed date of discharge. The MHP inpatient transition team is working to connect first-time beneficiaries who are discharging from the hospital to follow-up services.

Recommendation 15: Track and trend the causes of timeliness barriers for initial contact to first assessment. Identify and implement interventions specific to the causes identified.

Status: Partially Met

- The MHP implemented CSI timeliness reporting in June 2019. With the support of DHCS and enhanced monitoring throughout 2019, the children's system of care tracked timeliness of first appointments on an ongoing basis and added additional assessment slots to meet network adequacy standards. As of May

2019, the children's system of care was in full compliance in meeting the standards; however, contractor data is not included.

- In the adult system of care, the MHP has experienced long wait times due to therapist staff vacancies from retirement and transfers, and delays in personnel hiring practices. In 2019, wait-time issues for therapists were addressed. The MHP redistributed staffing resources across its system, performed regular caseload review for step down referrals, and scheduled assessment blocks for staff.

Quality Recommendations

Recommendation 16: Given the long time it takes to access services, and the reported extraordinary documentation requirements for staff, review and amend documentation requirements with an eye towards a minimum necessary approach, consistent with quality of care, as an opportunity to increase service delivery capacity.

Status: Met

- The MHP is revising its Utilization Review (UR) forms and process; including a redesign of the physician's assessment forms and treatment plan.
- Currently, the MHP, in collaboration with the medical team, is focused on updating the Doctor's Billing interface. Design and function are being evaluated and then streamlined.
- In April 2020, an UR committee will begin the process of redesigning the clinical assessment and treatment plan by reducing the number of pages needed for service authorization while still meeting required standards. An UR work group is tentatively scheduled for May 2020.

Recommendation 17: Evaluate the process for accessing Psychiatric Emergency Services (PES) from the beneficiary perspective. Include the Office of Empowerment Coordinator in all aspects of this evaluation and identify both major and minor contributors to negative experiences. Identify and implement interventions which improve beneficiary experience.

Status: Met

- The MHP formed an ad-hoc group consisting of community members, staff from the OCE, and PES and BHS leadership to learn about concerns regarding PES from the beneficiary and family perspective.
- In June 2019, a community forum was hosted by the local National Alliance on Mental Illness (NAMI) to provide a platform for beneficiaries to voice and listen to concerns about PES.
- Identified interventions include the need for more immediate access for voluntary beneficiaries, better communication from PES staff, a more family-friendly waiting

area, a need for greater privacy at initial triage, and improvements to the physical space, most notably for minors accessing PES services.

- The MHP implemented immediate triage and entry into PES for voluntary walk-in beneficiaries, better signage and options to alternate services in an urgent care unlocked setting (Miller Wellness Center). Also, in implementation are plans for staff to attend training on warm, welcoming customer service.

- Regarding the facility at large, while physical improvements to the PES are supported, major issues such as funding, design, and approval processes remain.

Recommendation 18: Evaluate and identify gaps in communication with beneficiaries. Implement strategies to improve communication and inform beneficiaries of services that are available with clear and simple instructions on how to access services. Update the website regularly with service information.

Status: Met

- The MHP provides informing materials to all its beneficiaries at first contact and thereafter upon request. Contractors (CBO or fee-for-service network) provide informational materials, posters and the provider directory in their waiting rooms in both English and Spanish. Informational materials include the beneficiary handbook, beneficiary grievance review request, appeal or expedited appeal request, request for change of provider, suggestion form, and advance directive. These materials are also available on the website https://cchealth.org.

- To improve communication, the MHP tested the effectiveness of its communication. Stakeholders reported differing messages between departments. To remedy this, the MHP created short 30-second videos for its website addressing frequently asked questions (FAQ) covering topics relevant to the beneficiary and accessing services. Videos are available in English and Spanish with closed captioning and involve a staff member providing clarifying information in both audio and visual formats. The videos are scheduled to go live in March 2020.

- The OCE continues to employ several methods to engage face-to-face with community members throughout the year. OCE staff have teamed up with peers and family members to outreach at NAMI events, health and safety fairs, and mental health awareness events.

Recommendation 19: Evaluate the results of expanded children's crisis services to determine if the need for a crisis stabilization unit for that population should be revisited, furnishing a safe, effective, family and child/youth friendly environment in which crisis events may be safely resolved outside of an emergency department environment. (This recommendation is a carry-over from FY 2017-18.)

Status: Met

- Since 2000, the MHP has contracted with Seneca Family of Agencies to operate the MCRT which provides mobile crisis response for youth and their caregivers. The program was expanded in 2018 to provide increased hours of in-person response, staffing, and Spanish-speaking capacity.
- In FY 2018-19, MCRT received 941 crisis calls, and performed 475 crisis assessments. The numbers of crisis calls have increased as well as the numbers of in-person responses, successful crisis intervention, and referrals for psychiatric holds.
- An analysis of PES, a unit at Contra Costa Regional Medical Center (CCRMC) which serves both adults and youth, indicates that MCRT expansion has not decreased the number of PES referrals of youth. In fact, PES referrals of youth have slightly increased. This corresponds with an increased length of stay of minors at PES.
- The MHP and CCRMC have evaluated the feasibility of expanding PES to create a separate area for children and youth; however, cost and space issues remain barriers to expansion.

Beneficiary Outcomes Recommendations

Recommendation 20: Investigate the causes for the increasing number of inpatient visits per beneficiary in 2017, including determining if the trend continued into CY 2018. It is possible that a small number of HCBs could be driving this, in which case implement a focused intervention which may be effective in lowering the number of visits per beneficiary; however, if the increase is more broadly based, look into access to care following inpatient services for possible reasons for recidivism. Address accordingly.

Status: Met

- The MHP reviewed the hospital admissions data. When the MHP compared the EQRO data, the data did not match. The MHP's business analytics team asserts that the data was incomplete due to an upgrade in the billing system from Echo's Inyst/PSP (the legacy system) to Echo's ShareCare billing platform. This upgrade may have led to an inability to capture complete data.
- The MHP reviewed its hospital admissions and determined that conservatorship status, diagnosis and symptom impairment were key factors in repeat hospitalization. The MHP identified the need to expand outpatient services to

better support beneficiaries and avoid hospitalization. The MHP is considering an expansion of its Assertive Community Treatment (ACT) program, an evidence-based treatment program.

- The Institutional Care Committee identified the need to better coordinate discharge planning with existing outpatient service providers; arrange for outpatient services not already connected to providers; and facilitate timely enrollment in a Full-Service Partnership (FSP) program when indicated. This identification process is being integrated into the weekly BHS Bed Review Committee.

Recommendation 21: Take steps to automate the process of receiving outcome data from contractors, i.e., develop and implement a mechanism for secure information exchange, eliminating the use of paper forms.

Status: Met

- Objective Arts (OA) is an electronic data management system and a tool that the MHP will be using for CBOs to send Child Adolescent Needs Strengths (CANS-50) outcome tool and Pediatric Symptom Checklist (PSC-35) forms to the MHP.

- Two CBOs have been participating in a pilot project since November 2019. The remainder of the CBOs will be trained for a go-live date in February/March of 2020.

- An automated data exchange between OA and ccLink has been planned to improve the integration and standardization of county and contract provider data.

Foster Care Recommendations

Recommendation 22: Evaluate current capacity and scope of contracts for Katie A. services along with the referral process, to identify barriers to implementation and access. Address barriers within the referral process and create flexibility within the contracts so that qualifying beneficiaries have unfettered access.

Status: Met

- The MHP created three new contracts specifically serving foster youth, each with an interagency agreement with Child Welfare Services (CWS). Each agency provides a range of services including Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS), individual and family therapy. Two of the three agencies provide field-based therapy as well.

- The MHP has a streamlined referral process. For foster youth, it starts with the Mental Health Liaison (MHL) and Social Worker (SW) completing the mental health screening tool (MHST) and acuity tool which is sent to the County Wide Assessment Team (CWAT) or the Emergency Foster Care (EFC) unit for assessment/CANS-50 and ICC screening. Both units can provide field-based services and are supervised/managed by the same manager who tracks all the

MH referrals and assigns as appropriate. The referrals are generally assigned within 24 hours of receiving the referral.

- For out-of-county foster youth placed in county, the MHP has a designated Point of Contact (POC) and a specific Presumptive Transfer (PT) email address (AB1299@cchealth.org) where the notifications and additional PT documents are sent. Referral information is sent to CWAT and EFC to manage, track and assign to services.

Recommendation 23: Investigate the low rate of kept assessment appointments within the 10-day standard for foster care services through a formal barrier analysis to determine causes/barriers to attendance. Identify and implement interventions specific to the causes identified.

Status: Met

- The MHP analyzed the assessment team's call logs and documentation regarding reasons that may delay initial assessment appointments from taking place within ten days. In addition, the MHP met with Court Appointed Special Advocates (CASA) for foster youth to discuss potential barriers.

- Communication issues with caregivers/parents was identified as a barrier. To address communication issues, the MHP began entering call log information on scheduling attempts in ccLink. The MHP staff increased collaboration with social work team members for assistance in contacting hard-to-reach beneficiaries; further, the MHP is exploring what can be done to increase cell phone accessibility for those families who need access.

- Another barrier is transportation. The MHP created three new MH contracts with MH agencies to increase capacity. Two of them provide field-based services to mitigate transportation issues. In addition, the CWAT, EFC, ICC, IHBS, Wraparound teams and Therapeutic Behavioral Services (TBS) are all offering field-based services.

- In response to delayed notification for PTs, the MHP started PT sub-regional meetings with 9-12 neighboring counties. The MHP created the first PT/waiver notification form, and a PT rescind notification form. They meet every three months and rotate locations county-to-county. To address shortfalls in assessment (beneficiaries not meeting medical necessity but shortly thereafter they do), the MHP is working so beneficiaries do not slip through the cracks. The MHP has educated the CASAs and explained that beneficiaries can contact the access line for MH services at any time and that CASA workers can contact MH staff when they have concerns for a beneficiary.

Information Systems Recommendations

Recommendation 24: By the next EQRO, initiate the planned Rapid Improvement Event (RIE) focused on processes that directly impact beneficiary access to and timeliness of services and CBO provider operational efficiency and cost of service delivery. The scope should include site certification, clinician credentialing, and service authorization processes. Include CBO representatives in all aspects of the process.

Status: Met

- In February 2019, a group of BHS and CBO stakeholders began meeting weekly to take an inventory of the current state of collaboration between CBOs and BHS, including identifying waste and redundancy that interferes with beneficiaries receiving timely access to care.
- In April 2019, the stakeholder committee held a CBO Improvement Kick-off event to launch a collaborative improvement process aimed at improving administrative processes that slow credentialing, authorization, and site certification.
- In August 2019, BHS and CBOs held a joint all-day improvement event and focused discussions on three areas for improvement: 1) CBO provider credentialing; 2) enhanced collaboration and communication between CBO and BHS; 3) BHS, Alcohol and Other Drug Services (AOD), and the Network Adequacy Certification Tool (NACT).
- Some improvements to the provider credentialing process have occurred including an updated website with user friendly links, and handouts related to codes and National Provider Identifiers (NPI); however, BHS staffing issues exist which may impact improvement efforts. Policies and procedures will need to be in place to ensure use and accountability.
- The credentialing workgroup is also developing a technological solution to significantly reduce the paperwork burden to CBOs and the turnaround time for credentialing by developing streamlined forms.
- As a result of the RIE, the county is exploring purchasing credentialing software to provide a definitive software-based solution to streamline the entire process, thus improving time to credentialing and, therefore, ability to serve beneficiaries more readily.

Recommendation 25: Develop a plan to support data interoperability for those CBOs who have local EHR systems that meet MHPs minimum standards to eliminate double data entry into ShareCare. The MHP to include CBOs throughout the planning and technical specification phase to create and support a collaborative working environment.

Status: Partially Met

- The MHP reported that many of their contract providers still operate on paper documentation.

- In 2019, the MHP started a project to support the electronic submission of CANS-50 and PSC-35 forms from the CBOs. Currently, these forms are submitted on paper. Objective Arts will be pilot-tested in February/March 2020 to support this effort.

Recommendation 26: By the next EQRO review, begin collecting and reporting timeliness data from all CBOs without increasing the double data entry burden they already face for claims submission to ShareCare. This is an essential first step in addressing the reported wait lists and long wait-times to begin treatment.

Status: Partially Met

- The MHP began collecting CSI timeliness data from CBOs in June 2019 and so could not include CBO data in the FY 2018-19 timeliness report provided to CalEQRO.
- The MHP organized a kick-off event in May 2019 with the CBOs to clarify any questions on CSI data definitions and to provide training on data entry into the CSI timeliness screen in ShareCare, which CBO providers already access. The MHP also established a BHS timeliness inbox for CBOs to directly ask the CSI timeliness team any questions they have regarding CSI data entry or data definitions.
- Despite the MHP's efforts to ease the CSI Timeliness data collection, CBOs enter timeliness data in ShareCare manually the same way as they enter services data.

Recommendation 27: By the next EQRO, improve the level of ShareCare expertise on the Help Desk and the responsiveness to contract provider ShareCare issues. Document all calls, and the resolution of each ticket opened so that trends can be identified and addressed at the source.

Status: Met

- Contra Costa MHP did the following to improve Help Desk support on ShareCare issues:
    - The ShareCare support team added a Support Analyst to the team.
    - The Service Desk team received training in August 2019 on problem identification, priority assignment, security access and responsibility, and user perceptions.
    - The Service Desk has a direct ring down line to the ShareCare support team where any available ShareCare Analyst can respond to customer issues.

- To further expand training and system awareness, the ShareCare support team provides quarterly newsletters, information bulletins and tips sheets regularly to improve customer experience.
- Any issues reported by customers to the service desk is logged and issued a tracking ticket.

Structure and Operations Recommendations

Recommendation 28: Institute policy and procedure changes by providing to CBOs in writing in advance of the implementation date, ideally after CBO involvement in the decision-making process (when possible).

Status: Met

- The MHP appointed an UR Liaison to act as a go-between the UR unit and CBO and county-operated clinics.
- In October 2018, a Utilization Review Communication Plan (URCP) was implemented to provide guidelines for communicating key initiatives and updates to services providers and partner agencies.
- The UR Liaison regularly issues UR memos to inform providers of upcoming UR changes that impact the authorization process.
- UR Liaison also attends a variety of meetings to disseminate information. Some of these include clerical operations, line staff, provider services and documentation trainings.

Recommendation 29: Develop a consistent practice of clear messaging to stakeholders which is consistent and timely delivered.

Status: Met

- See also Recommendation 28.
- The MHP developed a communication plan in order to improve relaying important information to county staff and CBOs. The communication plan includes the dissemination of UR memos on a regular basis which allows providers to find important information and, or changes in writing. In addition, UR obtained approval to add four new full-time licensed clinicians to the UR department who will be embedded at the MHP's clinics. These four clinicians will be providing unified support across the system of care.
- The Quality Improvement Quality Assurance (QIQA) unit is regularly checking the DHCS Information Notice website to download new information notices that are released. Information is shared with BHS executive members, at the BHS managers meeting, the quality management meeting and contractors luncheon

meeting. The QIQA added a hyperlink to its department website so that staff may bookmark the website and new information notices of relevance.

Recommendation 30: As soon as possible, clarify in writing to the CBOs whether cost reporting is required for FY 2018-19.

Status: Met

- Since the MHP implemented ShareCare in July 2018, fee-for-service contracts for most MH contracts went from a cost reconciliation process to a final units of service reconciliation process that would reconcile total payments with approved Medi-Cal claims. The MHP communicated the change to CBOs within each contract but also in its contractor meeting every other month. Ongoing support is provided on how to monitor approved medical units.

Recommendation 31: Deliver contract renewal documents with enough time for CBO review and well in advance of their effective date.

Status: Partially Met

- The MHP began processing contract renewals for FY 19/20 starting in April 2019; nevertheless, there were delays due to the change from fee-for-service to final units of service structure. Most contracts, however, include an automatic extension period in which half of the overall contract payment limit is made available for contractors to continue to invoice and be reimbursed by the county.

- The MHP is working to prepare a comprehensive policy and procedure document that will outline the general timelines for the overall contracting process; however, contractors are experiencing significant delays with the credentialing process resultant in their staff sitting idle, unable to provide services.

Recommendation 32: Evaluate MHP and CBO salaries and benefits relative to organizations competing for the same resources.

Status: Met

- The MHP reviewed four surrounding Bay Area counties to compare salaries of licensed clinicians and identify any shortfalls. The counties compared were Alameda, Solano, Marin, and San Francisco.

- The MHP found that within comparable classifications of licensed clinicians, for Contra Costa, the starting salary at the first step for a Mental Health Clinical Specialist is significantly lower than other Bay Area counties (-23.3 percent). Likewise, the highest step is almost 10 percent below the average highest step for clinicians.

- As a result, the MHP is competing for clinicians with other counties. In addition, the private sector hospitals are more likely to offer better wages for similar positions.

- The MHP is currently analyzing reimbursement rates for contract providers. Preliminary results indicate that contracted rates renew lower than other MHPs despite a 3 percent rate increase in FY 2020-21.

Recommendation 33: By the next EQRO, the MHP should work with its county counsel to address current policy and practice that do not promote stable wellness upon release from conservatorship and lead to unnecessary recidivism. Develop policies and procedures that facilitate a supportive transition from conservatorship to independent living.

Status: Met

- In November of 2016, Conservatorship Services was moved to BHS, under the supervision of Adult/Older Adult services.
- The MHP convened a large multi-disciplinary work group to review and update the existing policy and procedures governing the referral, admission, and discharge of beneficiaries.
- The MHP work group updated the policy on institute for mental diseases and mental health rehabilitation center admission, referral, and discharge, and an addendum to policy–roles and responsibilities: conservators and clinic case managers.
- The MHP began a stakeholder process in October 2019 to review FSP programs and their capability of providing ACT. The goal is to provide beneficiaries the supportive care needed for transition from locked settings outpatient services, including housing supports.

Recommendation 34: Institute a rapid process improvement effort with defined performance indicators to quickly improve authorization timeliness.

Status: Partially Met

- At the East Adult clinic, the MHP implemented the "co-visit" pilot model for the initial beneficiary intake interview. During the initial intake, the beneficiary meets with a physician and a clinician and receives a streamlined authorization process. The co-visit model was an intervention for the MHP’s clinical PIP last year and continues.
- In February 2019, MHP and CBO stakeholders began meeting weekly to take an inventory of the redundancies and non-value-added activities that interfere with successful collaboration.
- In April 2019, the stakeholder committee held a CBO rapid improvement effort to launch a collaborative process for improving the relationship and processes between the MHP and CBO providers.

- In August 2019, the MHP and CBOs reconvened to discuss CBO provider credentialing, enhanced collaboration and communication between CBO and BHS, and the AOD NACT. Contractor and staff feedback indicate that the momentum has since waned, citing frustrations with credentialing staff.

Recommendation 35: Institute a rapid process improvement effort with defined performance indicators to quickly improve credentialing timeliness.

Status: Partially Met

- See Recommendation 34.

Carry-over and Follow-up Recommendations from FY 2017-18

Recommendation 36: Evaluate the results of expanded children's crisis services to determine if the need for a crisis stabilization unit for that population should be revisited, furnishing a safe, effective, family and child/youth friendly environment in which crisis events may be safely resolved outside of an emergency department environment.

Status: Met

- See Recommendation 19.

Recommendation 37: By the next EQRO review, fully investigate the high percentage of high-cost beneficiaries and identify relevant actions that show potential for impacting that population.

Status: Partially Met

- See Recommendation 3.

PERFORMANCE MEASUREMENT

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

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

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

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

---

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

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

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

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

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

Total Beneficiaries Served

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

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity Contra Costa MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	48,947	18.1%	3,929	26.8%
Latino/Hispanic	95,652	35.4%	3,889	26.6%
African-American	38,169	14.1%	2,931	20.0%
Asian/Pacific Islander	30,669	11.4%	734	5.0%
Native American	733	0.3%	60	0.4%
Other	55,708	20.6%	3,102	21.2%
Total	**269,876**	**100%**	**14,645**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

- The MHP experienced claims submission delays that resulted in a significant number of December 2018 service transactions not being included in the analysis below for CY 2018 results.

Penetration Rates and Approved Claims per Beneficiary

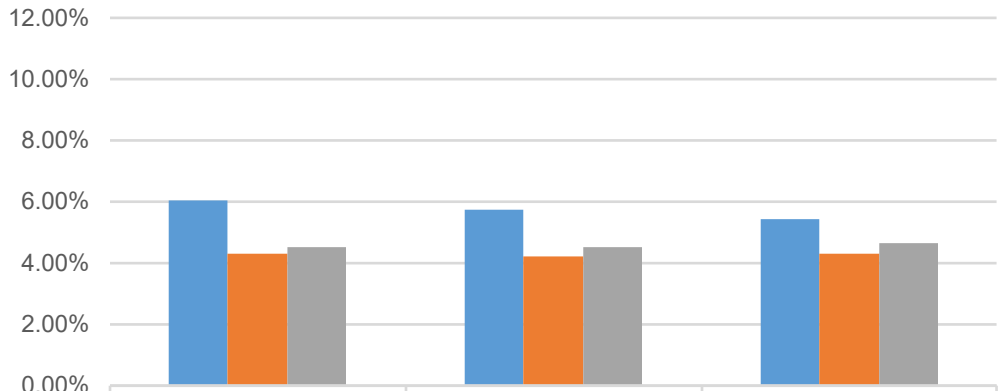
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated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

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2018. See Table C1 for the CY 2018 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Contra Costa MHP uses a different method than that used by CalEQRO. CalEQRO uses approved Medi-Cal claims, while the MHP uses all services provided regardless of whether they are billed or approved.

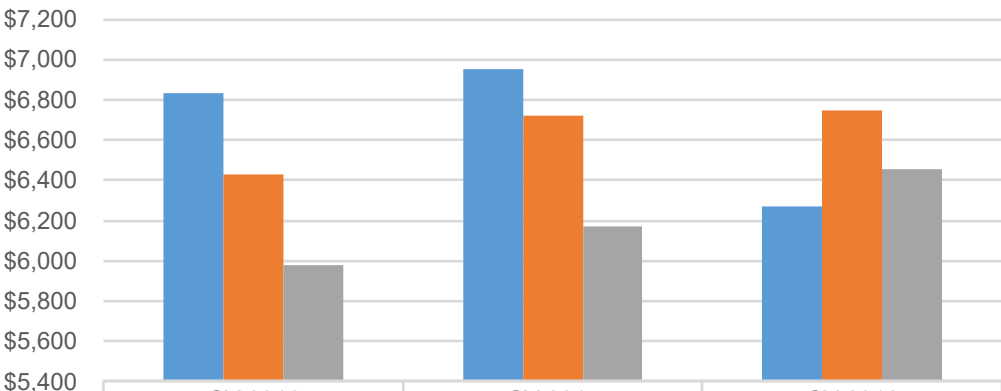
Figures 1A and 1B show three-year (CY 2016-18) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1A: Overall Penetration Rates
Contra Costa MHP



	CY 2016	CY 2017	CY 2018
MHP	6.02%	5.75%	5.43%
Large	4.30%	4.19%	4.31%
State	4.53%	4.52%	4.66%

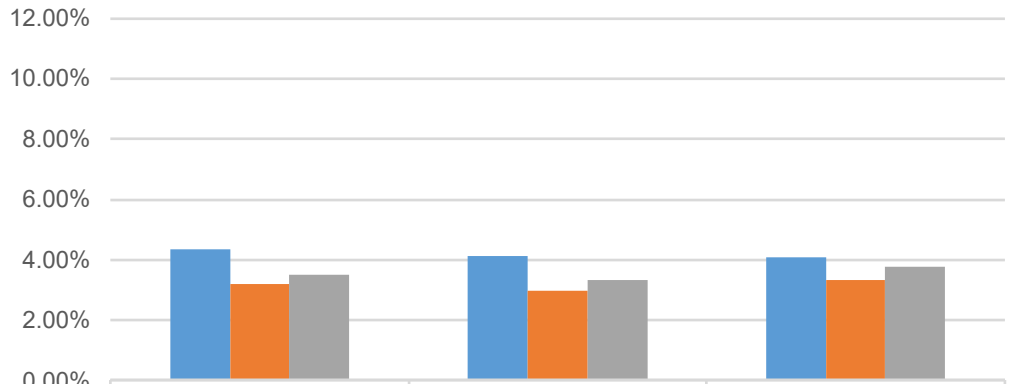
Figure 1B: Overall ACB
Contra Costa MHP



	CY 2016	CY 2017	CY 2018
MHP	$6,835	$6,952	$6,271
Large	$6,430	$6,723	$6,750
State	$5,978	$6,170	$6,454

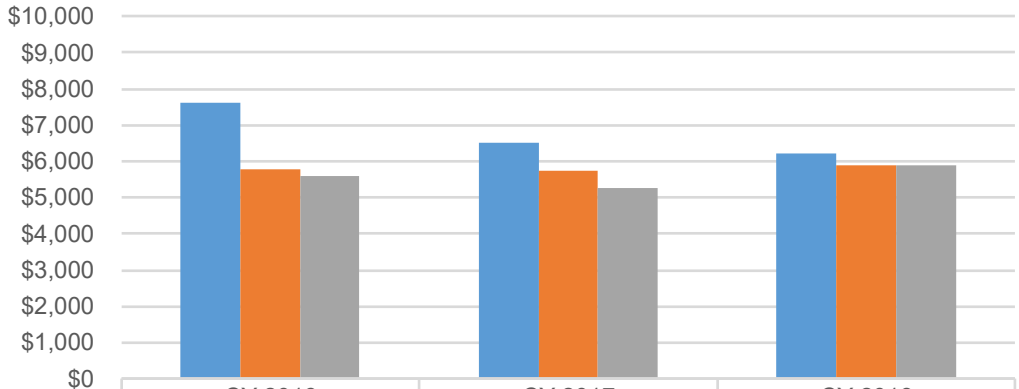
Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 2A: Latino/Hispanic Penetration Rates
Contra Costa MHP



	CY 2016	CY 2017	CY 2018
MHP	4.33%	4.14%	4.07%
Large	3.21%	2.97%	3.33%
State	3.51%	3.35%	3.78%

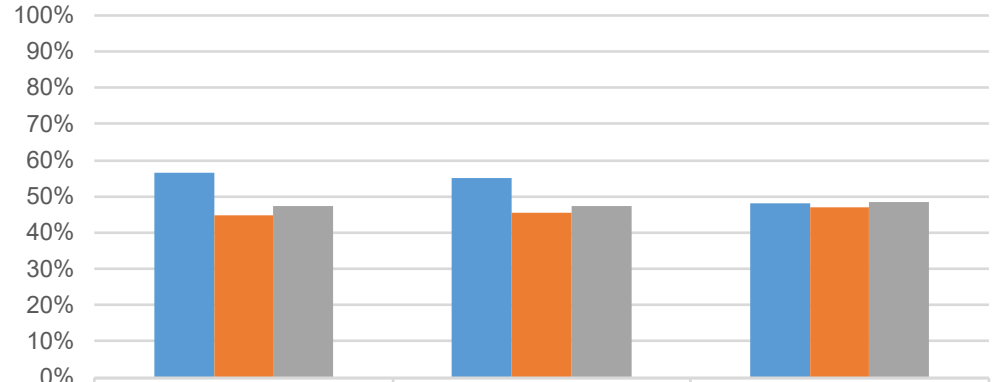
Figure 2B: Latino/Hispanic ACB
Contra Costa MHP



	CY 2016	CY 2017	CY 2018
MHP	$7,612	$6,524	$6,212
Large	$5,785	$5,758	$5,884
State	$5,588	$5,278	$5,904

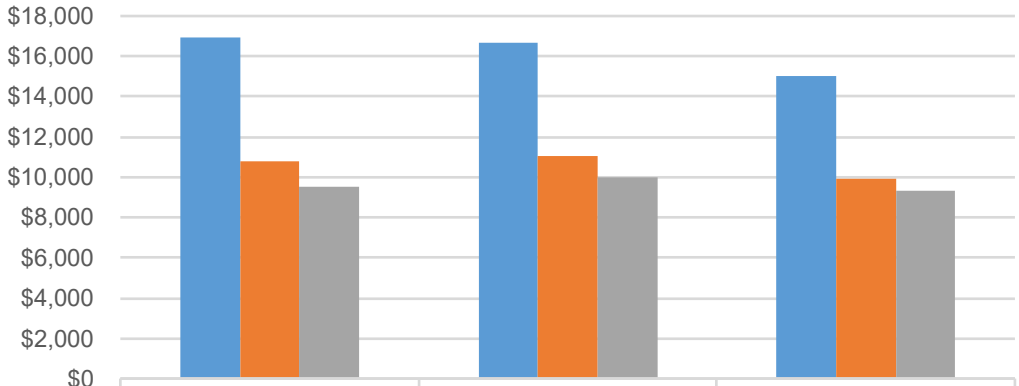
Figures 3A and 3B show three-year (CY 2016-18) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 3A: FC Penetration Rates
Contra Costa MHP



	CY 2016	CY 2017	CY 2018
MHP	56.33%	54.92%	47.90%
Large	44.78%	45.37%	46.87%
State	47.48%	47.28%	48.41%

Figure 3B: FC ACB
Contra Costa MHP



	CY 2016	CY 2017	CY 2018
MHP	$16,940	$16,672	$14,979
Large	$10,805	$11,064	$9,895
State	$9,521	$9,962	$9,340

High-Cost Beneficiaries

Table 2 provides the three-year summary (CY 2016-18) MHP HCBs and compares the statewide data for HCBs for CY 2018 with the MHP's data for CY 2018, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2: High-Cost Beneficiaries
Contra Costa MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2018	23,164	618,977	3.74%	$57,725	$1,337,141,530	33.47%
MHP	CY 2018	650	14,645	4.44%	$58,112	$37,772,499	41.13%
	CY 2017	840	15,883	5.29%	$56,388	$47,366,301	42.90%
	CY 2016	883	16,930	5.22%	$60,247	$53,198,211	45.97%

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2016-18) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

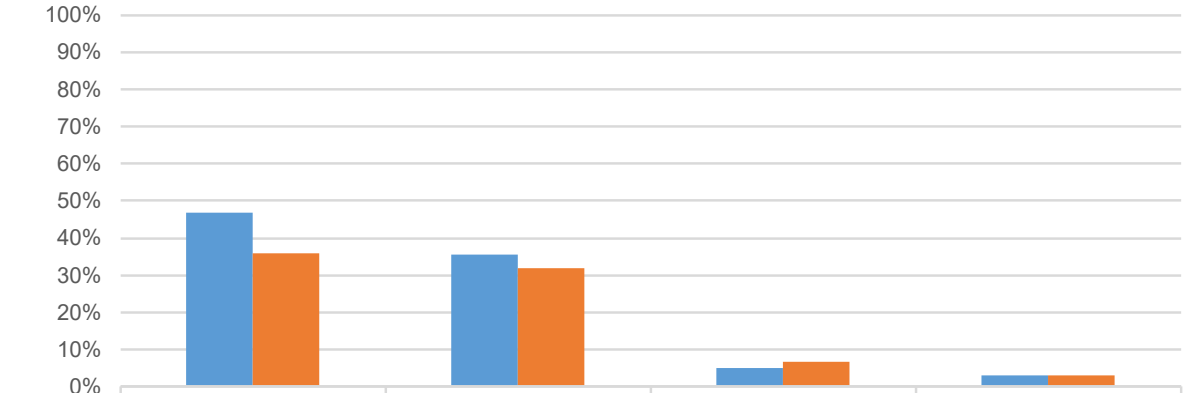
Table 3: Psychiatric Inpatient Utilization - Contra Costa MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2018	979	1,561	7.36	$14,497	$14,192,149
CY 2017	947	1,941	6.23	$14,090	$13,343,302
CY 2016	941	1,664	6.58	$13,819	$13,004,040

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

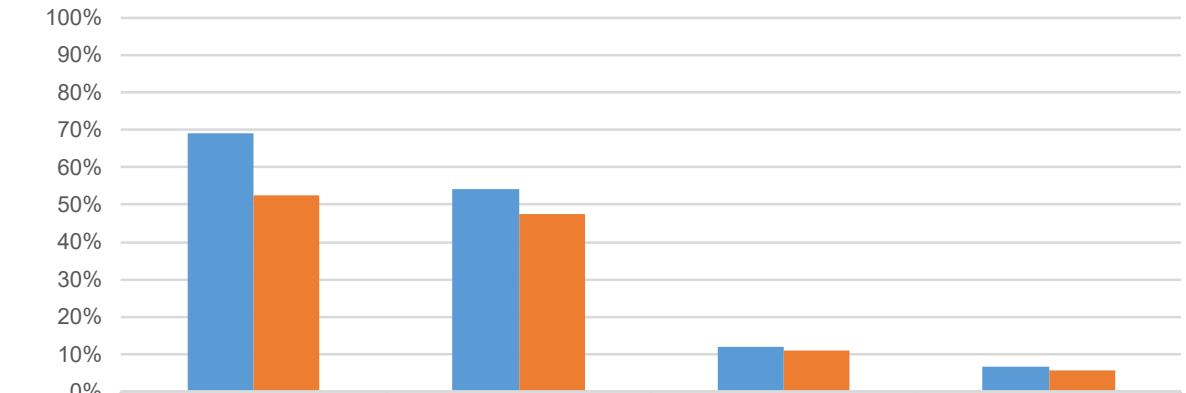
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2017 and CY 2018.

Figure 4A: 7-Day Post-Psychiatric Inpatient Follow-up
Contra Costa MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	47%	36%	5%	3%
CY 2018	36%	32%	7%	3%

Figure 4B: 30-Day Post-Psychiatric Inpatient Follow-up
Contra Costa MHP



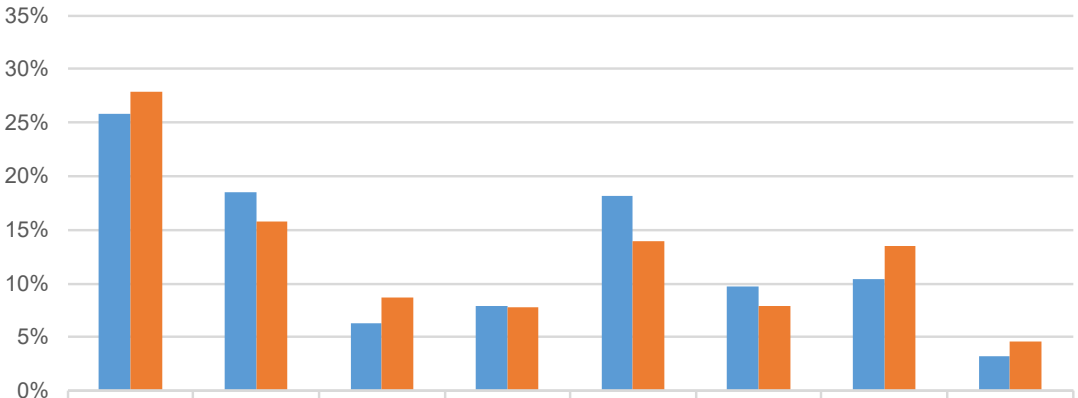
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	69%	54%	12%	7%
CY 2018	53%	48%	11%	6%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2018.

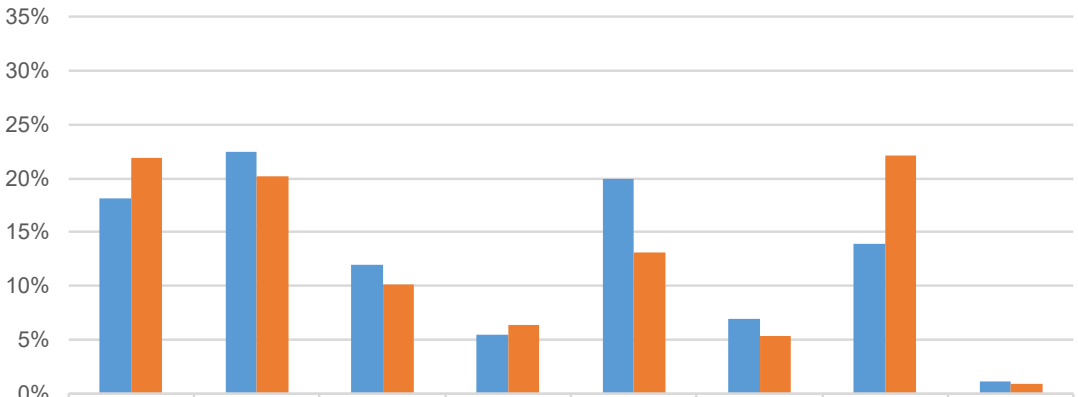
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 22 percent.

Figure 5A: Diagnostic Categories, Beneficiaries Served
Contra Costa MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	26%	19%	6%	8%	18%	10%	10%	3%
State CY 2018	28%	16%	9%	8%	14%	8%	14%	5%

Figure 5B: Diagnostic Categories, Total Approved Claims
Contra Costa MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	18%	22%	12%	6%	20%	7%	14%	1%
State CY 2018	22%	20%	10%	6%	13%	5%	22%	1%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Contra Costa MHP PIPs Identified for Validation

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

Table 4 lists the PIPs submitted by the MHP.

Table 4: PIPs Submitted by Contra Costa MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	CBT-Depression
Non-clinical PIP	1	Improving Appointment Adherence to the First Appointment

Clinical PIP—CBT/Depression

The MHP presented its study question for the clinical PIP as follows:

"Will beneficiaries who are referred to and participate in Cognitive Based Therapy (CBT) for Depression Group see a reduction of depression symptoms by 15 percent and an increase in self-identified functions by 10 percent?"

Date PIP began: November 2019

Projected End date: November 2021

Status of PIP: Active and ongoing

Brief Description of PIP (including goal and what PIP is attempting to accomplish):

The goal of the clinical PIP is to improve outcomes for beneficiaries who are suffering from depression. The MHP identified that many beneficiaries are diagnosed with a depressive disorder or experience severe depressive symptoms. According to performance measures provided by CalEQRO for CY 2018, 27 percent of beneficiaries

have a diagnostic category of depression and those beneficiaries make up 20 percent of approved claims. In January 2018, the MHP implemented a pilot program at its East Adult Clinic to determine the feasibility and utility of having beneficiaries complete a 9-Item Patient Health Questionnaire (PHQ-9) and 7-Item Generalized Anxiety Disorder (GAD-7) assessment at each clinic visit. When limited to beneficiaries at the East Adult clinic who have moderately severe depression symptoms on their baseline PHQ-9, 41.3 percent of beneficiaries had a primary diagnosis of depression.

The MHP also inquired with beneficiaries which additional services they would like. A depression support group was the highest ranked selection, with one of three respondents (136/351, 38.7 percent) indicating they would like this service, while one of five respondents (77/351, 21.9 percent) selected group therapy. The PIP Committee selected CBT, an evidence-based practice, for the intervention. The intervention is designed to help beneficiaries manage their depression by lessening the intensity of feelings, shortening the duration, and teaching prevention. CBT teaches beneficiaries skills to help them change their thoughts and behaviors and helps them break the downward spiral; further, the MHP elected to use the PHQ-9 to monitor depression symptoms throughout treatment.

Suggestions to improve the PIP: The clinical PIP was based on the CY 2018-19 report which stated that 27 percent of the MHP's beneficiaries have a diagnostic category of depression. There was no analysis of causes of depression. For the pilot clinic in this PIP, the depression rate is 41.3 percent at the East Adult Clinic per the PHQ-9. Once beneficiaries with a depression diagnosis are referred by their treating clinician and/or psychiatrist, they are assigned to an appropriate group; however, a standardized method of assessment and subsequent referral process was not utilized. To ensure that all who qualify were captured, more information is needed on the integrity of the referral process.

Each CBT group is comprised of eight to ten beneficiaries. Currently, two groups are being run at the same time. Sample size is limited by this factor; moreover, significantly higher numbers are needed for this to be applicable to the system at large. Regarding fidelity to the evidenced based practice (EBP) CBT model, the MHP plans to have clinicians utilize a manual; however, a process to assure that the manual is being used to fidelity was not provided.

So far, the MHP has experienced positive results reflected in the PHQ-9 and mixed results on the functional outcomes measures, likely due to small sample size.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance (TA) provided to the MHP onsite by CalEQRO consisted of discussion on standardization. The MHP should develop ways to standardize assessment, diagnosis and referrals to groups to ensure that beneficiaries are not missed. While it may not be possible to ascertain each beneficiaries' cause for depression, examining the process by which staff assign and code the diagnosis would

confirm depression rates. The MHP should also increase its sample size to achieve numbers which are high enough for this PIP to be applicable to the system at large.

This MHP's PIPs over the years have demonstrated the theme of piloting and use of an intervention at one location in its system, i.e. a clinic. This practice poses issues with sample size but also in duplicability because ultimately, the MHP does not have the manpower, budget or timing to duplicate its multipart interventions across whole system, no matter the success at the pilot level. A better approach would be to simplify its PIPs and apply singular interventions to the whole system for real and timely change to occur.

Non-clinical PIP—Improving Appointment Adherence to the First Appointment

The MHP presented its study question for the non-clinical PIP as follows:

"Will implementing Direct Client Outreach defined by CSWs/FSWs calling clients 0 to 5 days in advance* of their initial outpatient mental health appointment to engage clients, address ambivalence, answer questions, and refer clients to needed resources, decrease the percentage of missed initial assessment appointments from 41 percent at the MHP's East Adult clinic, and from 35 percent at the MHP's East Children's clinic, to 25 percent?"

Date PIP began: December 2017

End date: December 2019

Status of PIP: Completed

The overarching goal of this PIP is to increase appointment adherence rates to first appointments and reduce wait times for initial assessment among beneficiaries who receive services. This is the final year of this PIP. To improve appointment adherence, the MHP implemented beneficiary outreach practices that incorporate MI for beneficiaries attending initial outpatient mental health appointments at the East Adult and East County Child and Adolescent Services. MI is used to address any ambivalence about attending the appointment. Beneficiaries (or parent/guardian) were contacted one to five days in advance of their appointment. For the second year, the MHP will have an FSW call beneficiaries eight days in advance of their appointment to assess their transportation barriers and make referrals to an appropriate service, i.e., clinic services, Kaiser, or Blue Cross transportation benefit. The analyses for this project occurred every five to six weeks at the start of data collection for appointment adherence rates, rates of new beneficiaries contacted, and referrals to navigation specialists, and then at least quarterly.

For beneficiaries of MHP's East Adult Clinic, there was a non-statistically significant reduction in the percentage of missed appointments; however, for beneficiaries of MHP's East County Child and Adolescent Services, there was a statistically significant reduction in missed appointments. For beneficiaries of the MHP's East Adult clinic,

there was a statistically significant relationship between being successfully contacted and attending the first appointment. Among those who were successfully contacted, 68 percent attended the appointment whereas among those who were not contacted, 58 percent attended the first appointment. For beneficiaries of the MHP's East County Child and Adolescent Services, the relationship between being successfully contacted was not significantly related to attending the first appointment. Of beneficiaries who were successfully contacted, 73 percent attended the first appointment compared to 74 percent for those not successfully contacted.

Suggestions to improve the PIP: The largest issue impacting the comparability of initial and repeat measures is the use of different reports to determine the rate of first scheduled outpatient mental health missed appointments at baseline and subsequent periods. The use of a different report to capture results was necessitated by changes in workflows over the course of the PIP.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The TA provided to the MHP onsite by CalEQRO consisted of discussion of the barrier analysis performed by the MHP to provide better information upon which to base interventions; however, it did not make more measurable changes to the days the calls were made (not a range) to allow for comparison and duplication elsewhere, as previously recommended.

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	M	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	M	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	PM	M
2	Study Question	2.1	Clearly stated	M	PM
3	Study Population	3.1	Clear definition of study population	M	PM
		3.2	Inclusion of the entire study population	UTD	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	M	M
		4.2	Changes in health states, functional status, enrollee satisfaction, or processes of care	M	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
		6.3	Systematic collection of reliable and valid data for the study population	PM	M
		6.4	Plan for consistent and accurate data collection	M	M
		6.5	Prospective data analysis plan including contingencies	M	M
		6.6	Qualified data collection personnel	M	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	M	M
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	PM	M
		8.2	PIP results and findings presented clearly and accurately	M	M
		8.3	Threats to comparability, internal and external validity	PM	M
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NA	M
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NA	M
		9.2	Documented, quantitative improvement in processes or outcomes of care	NA	M
		9.3	Improvement in performance linked to the PIP	NA	PM
		9.4	Statistical evidence of true improvement	NA	M
		9.5	Sustained improvement demonstrated through repeated measures	NA	M

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	14	22
Number Partially Met	4	3
Number Not Met	0	0
Unable to Determine	1	0
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	19	25
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**84.21%**	**94%**

INFORMATION SYSTEMS REVIEW

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

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

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

Table 7 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, and IT staff for the past four-year period. For comparative purposes, we have included similar size MHPs and statewide average IT budgets per year for prior three-year periods.

Table 7: Budget Dedicated to Supporting IT Operations

	FY 2019-20	FY 2018-19	FY 2017-18	FY 2016-17
Contra Costa	0.2%	0.10%	1.10%	<2.00%
Large Size MHP Group	N/A	2.70%	2.88%	2.72%
Statewide	N/A	3.40%	3.30%	3.40%

- The MHP is reviewing the 0.2 percent reported for IT budget as it is uncharacteristically low compared to large size MHPs over the last three-year period.

The budget determination process for information system operations is:

☐ Under MHP control
☒ Allocated to or managed by another County department
☐ Combination of MHP control and another County department or Agency

Table 8 shows the percentage of services provided by type of service provider.

Table 8: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
County-operated/staffed clinics	27%
Contract providers	60%
Network providers	13%
Total	**100%***

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

Table 9 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 9: Contract Providers Transmission of Beneficiary Information to MHP EHR System		
Type of Input Method	**Percent Used**	**Frequency**
Direct data entry into MHP billing system by contract provider staff	80%	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to MHP for data entry input by MHP staff into billing system	20%	Daily
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

- Number of county-operated sites currently operational: Four
- Number of contract provider sites currently operational: One

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

☒ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☐ To serve special populations (i.e. children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☐ To reduce travel time for beneficiaries

- Telehealth services are available with English and Spanish-speaking practitioners (not including the use of interpreters or language line).
- Approximately 44 telehealth sessions were conducted in Spanish at county sites.
- County telehealth is provided at East Adult clinic, East County Child and Adolescent Services, West County Adult Mental Health and the Central Children's clinic. The contract provider telehealth site is operated by Bay Area Community Services in Concord.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff				
Fiscal Year	**IT FTEs (Include Employees and Contractors)**	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2019-20	15	0	2	2
2018-19	22	0	1	1
2017-18	23	16	0	1

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 11.

Table 11: Data Analytical Staff				
Fiscal Year	**IT FTEs (Include Employees and Contractors)**	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2019-20	8	0	2	2
2018-19	20.50	5	2	4.50
2017-18	11.50	4	3	4.50

The following should be noted regarding the above information:

- Technology FTEs are Health Services Department (HSD) staff who manage all Behavioral Health Services applications including their maintenance, upgrades and support.
- Analytical FTEs include staff from the BHS Research and Evaluation Unit and the HSD Business Intelligence Unit.
- Technology and analytical FTEs support both MH and AOD programs.

- In 2017, BHS implemented ccLink as its EHR and in 2018, BHS implemented ShareCare to replace its legacy practice management system InSyst. Technology and analytical FTEs were increased in those years to support the two projects mostly through contract staffing.

Current Operations

- Contra Costa BHS uses Epic as its EHR which has been branded as ccLink. ShareCare is BHS' practice management system primarily used for billing and state-mandated reporting. The two systems are not integrated.
- County clinic providers enter beneficiaries' services and clinical data in ccLink and clerical staff manually enters service data into ShareCare to bill Medi-Cal and other insurances and to meet state-mandated data reporting requirements.
- Since contract providers do not have access to ccLink, they VPN (secure network connection) to ShareCare and enter services directly.
- Network providers have access to ccLink's Provider Portal.
- ShareCare data is imported to ccLink as encounter notes to give County providers a more comprehensive view of services provided to their beneficiaries.
- CSI data is collected for County services in ccLink and for CBO services in ShareCare. Both sets of data are pulled into a data warehouse to support state-mandated reporting requirements.
- Currently, CBOs send paper CANS-50 and PSC-35 forms to the MHP.
- HSD Business Intelligence Unit creates dashboards, data extracts and reports for the MHP and the BHS Research and Evaluation Unit do further analyses to support projects and special studies.
- An IT Steering Committee comprised of County executives (Chief Operations Officer, Chief Information Officer, Chief Medical Information Officer, Chief Nursing Information Officer, Chief Analytics Officer and other department heads as required) is charged with approving and prioritizing county projects.
- BHS and HSD IT created a Data Governance Committee in 2019 to prioritize ShareCare billing updates and ccLink project updates to support BHS Division operations.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 12: Primary EHR Systems/Applications

System/ Application	Function	Vendor/Supplier	Years Used	Operated By
Epic/ccLink Tapestry	Epic EHR and Tapestry Managed Care Module	Epic	4	Health Services IT
ShareCare	BHS System of Care with Claims Billing and Payment Posting for Mental Health and AOD.	Echo Group	1	Health Services IT
OnBase	Enterprise Scanning and Document Archiving and Management System	Hyland Software Inc.	2	Health Services IT
Panoramic Software	Public Guardian – Conservatorship	Panoramic Software Inc.	8	Health Services IT
InSyst	BHS System of Care with Claims Billing and Payment Posting for Mental Health and AOD. (Legacy)	Echo Group	17	Health Services IT

The MHP's Priorities for the Coming Year

- Continue with CSI timeliness documentation and reporting to capture CSI timeliness data for other points of entry including detention, foster youth, hospital discharges, etc.
- Implement the CBO Provider Portal. The ccLink Provider Portal is an online tool that allows contract providers the ability to view a beneficiary's ccLink EHR.
- Conduct continuous quality improvement efforts as it relates to the MHPs overall No-Show Performance.
- Improve CANS-50 reporting through integration from Objective Arts to ccLink. Objective Arts is an electronic data management system and a tool that CBOs will be using to send CANS-50 and PSC-35 forms to the MHP.
- Implement dashboards and migration of custom databases. In partnership with Contra Costa's Mental Health Commission, BHS leadership is in the process of developing data and information reporting on a quarterly basis to enable a common understanding of the state of BHS operations.
- Upgrade ccLink to the 2020 version.
- Collaborate with the Echo group, the vendor of ShareCare, to create an interface that imports ccLink data to ShareCare to eliminate manual data entry by clerical staff.

Major Changes since Prior Year

- Upgraded ccLink to the May 2019 version.
- Implemented CSI Timeliness workflows for CBOs in ShareCare and County access line to BHS clinics in ccLink.
- Implemented electronic Medication Consent and eSignature for Medication Consent and Partnership Plan for Wellness in ccLink.
- Implemented the Care Team feature in ccLink which allows specialty mental health providers to add themselves to a beneficiary's care team.
- Implemented additional features in ccLink MyChart patient portal for BHS beneficiaries.
- Piloted a new UR reminder system in ccLink for West County Adult Mental Health.

Other Areas for Improvement

- CBOs continue to do double data entry in ShareCare and their own EHRs to record services provided. This practice is a burden on the CBOs, not cost-effective and prone to data-entry errors.
- Contract providers have expressed continued struggles with ShareCare and indicated that more training and hands-on assistance would be beneficial.
- UR's process of approving/denying/pending CBO intake treatment plans and entering the disposition status in ShareCare should be reviewed. A delay in entering the treatment plan review status in ShareCare will cause associated services entered in the system to be flagged as unauthorized.
- CBOs reported some ShareCare reports have inaccurate information but the onus to identify the cause of discrepancies appears to fall on the providers which could be a very time-consuming undertaking.
- CANS-50 and PSC-35 data have been collected since October 2018 but the MHP stated not all providers understand their significance as outcome measures. The MHP has performed two system wide reports as well as program level reports for each County-operated clinic site. Due to the time involved in scanning and entering data from paper CANS-50 and PSC-35 forms, the MHP has not been able to perform regular analysis; however, with the implementation of Objective Arts to collect this data, providers will have access to reports immediately.
- There is no identified IT leadership position, or direct-report position from HSD IT in the BHS organizational chart.

Plans for Information Systems Change

- The MHP has no plans for a system change; they continue to use and update the systems in place (ccLink and ShareCare).

Current EHR Status

Table 13 summarizes the ratings given to the MHP for EHR functionality.

Table 13: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Alerts	ccLink	X			
Assessments	ccLink	X			
Care Coordination				X	
Document Imaging/ Storage	OnBase	X			
Electronic Signature—MHP Beneficiary	ccLink	X			
Laboratory results (eLab)	ccLink	X			
Level of Care/Level of Service	ccLink	X			
Outcomes	CANS-50, PSC-35, RAS, ILSS, PHQ-9, GAD-7	X			
Prescriptions (eRx)	ccLink	X			
Progress Notes	ccLink	X			
Referral Management	ccLink	X			
Treatment Plans	ccLink	X			
Summary Totals for EHR Functionality:					
FY 2019-20 Summary Totals for EHR Functionality:		11	0	1	0
FY 2018-19 Summary Totals for EHR Functionality:		10	0	2	0
FY 2017-18 Summary Totals for EHR Functionality:		8	1	3	0

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

- The after-visit summary, a summary of a beneficiary's visit, including relevant patient instructions, upcoming appointments, relevant contact numbers and references, went live in May 2019.
- An electronic medication consent form also went live in May 2019 which allows psychiatrists to complete the consent for psychotropic medication in ccLink rather than on paper. In addition, this feature allows providers to see the history of medications that have been consented.
- In August 2019, a tickler reminder system was repaired and linked for CANS-50 and PSC-35 to discharge forms.
- In November 2019, the MHP went live with the ability to electronically sign the medication consent form and the partnership plan for wellness form.
- An electronic referral process was implemented in November 2019 for MH programs to refer beneficiaries to AOD counselors co-located in the mental health clinics.

Personal Health Record (PHR)

Do beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or third-party PHR?

☒ Yes ☐ In Test Phase ☐ No

ccLink MyChart

- Additional features were implemented for beneficiaries through the MyChart patient portal on May 1, 2019. Those features include the ability to cancel appointments, request medication refills, and view their after-visit summary.

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

ShareCare and BHDECOR (Behavioral Health Denial Corrections Database)

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14: Summary of CY 2018 Short Doyle/Medi-Cal Claims Contra Costa MHP							
Service Month	**Number Submitted**	**Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Dollars Adjudicated**	**Dollars Approved**
TOTAL	**318,974**	**$100,154,583**	**9,153**	**$3,264,117**	**3.26%**	**$96,890,466**	**$85,187,496**
JAN18	37,300	$11,429,183	1,567	$436,094	3.82%	$10,993,089	$9,872,740
FEB18	35,442	$10,667,967	898	$280,962	2.63%	$10,387,005	$9,231,460
MAR18	40,139	$12,128,517	954	$318,030	2.62%	$11,810,487	$10,476,004
APR18	36,613	$11,156,388	958	$376,297	3.37%	$10,780,091	$9,477,205
MAY18	41,535	$12,199,749	1,149	$448,006	3.67%	$11,751,743	$10,362,441
JUN18	30,432	$9,460,628	880	$315,606	3.34%	$9,145,022	$8,089,889
JUL18	22,329	$7,698,110	714	$283,075	3.68%	$7,415,035	$6,408,345
AUG18	21,149	$7,388,531	578	$261,830	3.54%	$7,126,701	$6,054,184
SEP18	19,425	$6,564,636	511	$191,868	2.92%	$6,372,768	$5,428,914
OCT18	18,778	$6,316,381	611	$245,579	3.89%	$6,070,802	$5,266,229
NOV18	14,852	$4,617,959	315	$82,910	1.80%	$4,535,049	$4,147,288
DEC18	980	$526,533	18	$23,859	4.53%	$502,674	$372,798
Includes services provided during CY 2018 with the most recent DHCS claim processing date of June 7, 2019. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2018 was **3.25 percent.**							

- During CY 2018, the MHP experienced claims submission delays which resulted in a significant number of December service/claim transactions not being included in Table 14 results.
- The MHP implemented a new billing system in 2018 and as of February 2020, has recorded $6M open claims that have not been adjudicated.

Table 15 summarizes the top three reasons for claim denial.

Table 15: Summary of CY 2018 Top Three Reasons for Claim Denial Contra Costa MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Medicare or Other Health Coverage must be billed before submission of claim.	5,454	$1,572,211	48%
Beneficiary not eligible, or emergency services or pregnancy indicator must be "Y" for this aid code.	2,030	$1,009,396	31%
Payment denied - prior processing information incorrect. Void/replacement condition.	577	$227,811	7%
TOTAL	9,153	$3,264,117	N/A
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- Denied claim transactions with reason "Medicare or Other Health Coverage must be billed before submission of claim" are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted four 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested four focus groups with 10 to 12 participants each, the details of which can be found in each section below.

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

Focus Group 1: Parents/Caregivers of Children (West)

CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries who receive services in West County and who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The group was held at West County Children's Mental Health Clinic, 303 41st Street, Richmond, CA.

Number of participants: Nine

The four participants who entered services within the past year described their experiences as the following:

- Participants were referred to services through family members, adoption services, and primary care.
- Most reported lengthy wait times for psychiatry and counseling services.
- Some relayed some difficulty getting set up with services, through the access line or their doctor.

Participants' general comments regarding service delivery included the following:

- All were aware that services were available in Spanish and that written materials were provided in multiple languages.
- Most received therapy on a weekly basis and a saw a psychiatrist ranging from weekly to once per month.
- All had received reminder calls and texts.
- In an urgent situation, participants called Seneca, law enforcement and mobile response.

- Most participants were involved in their treatment planning; however, they were unsure whether the psychiatrist and primary care physician (PCP) communicate.
- While some people had been asked for ideas on improving services, none were aware of any committees they could participate in.

Participants' recommendations for improving care included the following:

- Provide more places for intake so families can avoid escalation in problems or behavior and while going through the 5150 process.
- Provide more options other than 5150 for children/youth, to avoid having to call the police.
- Provide MH services for children/youth who have autism.

Interpreter used for focus group one: No

Focus Group 2: Adults (West)

CalEQRO requested a culturally diverse group of adult beneficiaries who receive services in West County and who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The group was held at RI International, 2101 Vale Road, San Pablo, CA.

Number of participants: Eight

The two participants who entered services within the past year described their experiences as the following:

- There were long wait times to begin services, over three months.

Participants' general comments regarding service delivery included the following:

- Participants learned about services through a variety of means – AOD program, hospitalization, and an outpatient clinic.
- Transportation resources are inconsistent.
- All were aware that services were available in other languages.
- Most saw a therapist on a regular basis, while others are having to shift and wait reassignment due to the closure of Rubicon, a CBO which provided wraparound services.
- Most receive psychiatry services and are satisfied with services.
- Missed appointments with the psychiatrist are "horrible" causing a wait time of two to three months.

- Some receive group therapy; none receive family therapy.
- Urgent care outside of crisis services was not seen as available.
- No one had heard of committees or other opportunities to provide feedback on services.

Participants' recommendations for improving care included the following:

- Provide services as if doing it for a family member.
- Aid with navigating Social Security, Department of Rehabilitation and other external resources.
- Improve doctors' interactions with beneficiaries. Some are nicer than others.

Interpreter used for focus group two: Yes Language(s): Spanish

Focus Group 3: Parents of Children & Youth (East)

CalEQRO requested a culturally diverse group of parents/caregivers of child/youth beneficiaries who receive services in East County and who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held at East County Children's Behavioral Health clinic, 2335 Country Hills Drive, Antioch, CA.

Number of participants: 14

The four participants who entered services within the past year described their experiences as the following:

- Referrals for service came from a variety of places including clinics, hospitals and foster care.
- Average wait times were from two weeks up to four months.

Participants' general comments regarding service delivery included the following:

- Participants reported mixed responses regarding transportation. Some said it was a barrier, while others said there were resources.
- Participants confirmed that materials were available in other languages, as well as services.
- Most participants reported that children/youth received weekly services.
- Psychiatry appointments were provided monthly to every six weeks. Collaboration between psychiatry and primary medical doctors needs improvement.

- A few received family therapy; however, most did not know about it. Some had participated in support groups.
- Participants reported issues with crisis services – long waits or not very helpful.
- Participants reported that they are involved in treatment planning, though the staff seem overwhelmed.
- Participants had not heard of opportunities to be on committees or provide feedback.

Participants' recommendations for improving care included the following:

- Expedite services, particularly when a child is in crisis.
- Hire more staff.
- Hire more psychiatrists.
- Expand services in the schools.
- Include a legal component in services so those who have a need for legal advice could get help.
- Add more MCRTs. Contra Costa needs its own MCRT.
- Hire more staff for existing MCRTs.

Interpreter used for focus group three: Yes Language(s): Spanish

Focus Group 4: Adults (East)

CalEQRO requested a culturally diverse group of adult beneficiaries who receive services in East County and who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held at East County Adult Mental Health, 2311 Loveridge Road, Pittsburg, CA.

Number of participants: Three

Participants' general comments regarding service delivery included the following:

- Participants were referred to services in a variety of ways – clinics, primary care, and insurance.
- Most were satisfied with services.
- Most participated in support groups.
- Interactions with peer staff was positive.

Participants' recommendations for improving care included the following:

- Provide more supportive and listening doctors.
- Provide better therapy rooms. Currently they are too open.

Interpreter used for focus group four: No

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

Access to Care

Table 16 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
1A	Service Access and Availability	14	13
The MHP has a variety of materials available on its website, in its lobbies and at its community provider locations. The MHP's website is functional and user friendly; however, it is only in English. The directory is up to date in both English and Spanish. While some focus group participants reported not having difficulty with initial access, others reported long wait times and difficulty establishing services. In June 2019, the MHP implemented tools to track CSI timeliness for beneficiaries referred from the access line to the BHS clinics. The access line and the Health, Housing and Homeless (H3) program began a pilot to coordinate care and streamline access to mental health services to allow for a "no wrong door" approach. In April 2019, access line staff trained other BHS staff on the referral process. The MHP granted clinic access to the electronic referrals and appointment scheduling system. This allowed the H3 clinicians to screen the beneficiaries and schedule directly, bypassing the access line.			
1B	Capacity Management	10	10
Through the newly implemented CSI functionality, the MHP can track beneficiary linkage to service by demographics. Regarding language, the MHP is working with CBOs to identify their language needs. An internship program for bilingual therapists is available. Additionally, the MHP flagged the mental health clinical specialist positions for a Spanish pay differential of $100 per month; however, clinical staff			

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
feedback indicates that the differential is not sufficient and that the increase in language duties, both formal and informal, acts as a barrier for them to complete the original tasks within their scope of work. Also, BHS is revising the minimum 55 percent productivity time upward to 60 percent. Analysis of the access line data and data from the non-clinical PIP has shown that transportation is one of the most frequently identified barriers to appointment adherence. To help address beneficiaries' transportation needs, the MHP is planning to pilot a new transportation intervention, providing beneficiaries rides to clinic appointments using round-trip Lyft. The MHP is working on implementing this intervention with beneficiaries who are scheduled for a co-visit appointment at the East Adult clinic, the clinic with the highest no-show rate and most limited transportation options. The pilot is scheduled to begin in early 2020.			
1C	Integration and Collaboration	24	24
In September 2019, the Behavioral Health Care Partnership (BHCP), a consortium of health-related providers and businesses, reconvened as the primary forum for BHS and hospital leadership to collectively discuss community issues and develop solutions. Collaborations occur on a bimonthly basis. Also, the MHP continues to partner with NAMI, faith-based organizations, and a variety of community organizations and providers.			

Timeliness of Services

As shown in Table 17, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
2A	First Offered Appointment	16	10
Based on FY2018-19 data, for county operated services, 72.6 percent of the 1,415 offered appointments overall met the 10-business day standard. For adults, 75.9 percent met the standard and for children, 64.78 percent met the standard. FC was also reported, though the numbers are too small to include here (n<11).			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
For first kept appointment, 83.4 percent of appointments overall met the 10-business day standard, with 84.3 percent for adult services and 81.3 percent for children. The MHP does not track time to first offered assessment for walk-ins. CBO data was not included as the MHP started collecting data for CBOs in June 2019.			
2B	Assessment Follow-up and Routine Appointments	8	6
In Q4 FY 2018-19, the mean days to a routine appointment was 10.9, with 53 percent of routine appointments falling under ten days. The MHP tracks county services only.			
2C	First Offered Psychiatry Appointment	12	9
The MHP should offer a psychiatric appointment within 15 business days. The MHP reported that based on FY2018-19 data, 43.2 percent of its psychiatry appointments met the 15-business day standard overall. For adults and children respectively, 37.4 percent and 78.4 percent of its psychiatry appointments met the standard. For FC, 75 percent of the appointments met the standard.			
2D	Timely Appointments for Urgent Conditions	18	8
Based on FY2018-19 data, for adult urgent services, 42.9 percent of appointments meet the standard of 48 hours. The MHP currently measures this metric in days. The MHP does not have appointments that require prior authorization, nor do they track in minutes. The MHP's data did not include contractor data. Improvement projects have not been initiated. The MHP believes that its urgent appointments are inflated due to clinics not always coding a lower referral priority when an urgent appointment is assessed as non-urgent. Also, the MHP refers children with urgent appointment requests to the Miller Wellness Center, for immediate service needs.			
2E	Timely Access to Follow-up Appointments after Hospitalization	10	8
Based on FY2018-19 data, for the 1,097 hospitalization discharges, 41.8 percent of the follow-up appointments fell within the 7-day standard. For adults, 36.4 percent of appointments met the standard while 60.1 percent of the children's appointments met the standard. For FC, 62.5 percent met the standard.			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
2F	Tracks and Trends Data on Rehospitalizations	6	6
Based on FY2018-19 data, for its hospital readmission rate, the MHP reported a rate of 7.6 percent overall, 6.6 percent for adults, and 10.9 percent for children. FC numbers were provided but are not included here due to n<11.			
2G	Tracks and Trends No-Shows	10	6
Based on FY2018-19 the, the standard for the MHP's no-show rate is 10 percent for both adults and children. The MHP reports the average no-show rate for psychiatrists as 17 percent, 18 percent for adults, and 17 percent for children. The average no-show rate for clinicians is 19 percent overall, 21 percent for adults, and 16 percent for children. The MHP is addressing no-show rates through its non-clinical PIP.			

Quality of Care

In Table 18, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 18: Quality of Care Components			
Component		**Maximum Possible**	**MHP Score**
3A	Beneficiary Needs are Matched to the Continuum of Care	12	12
The MHP assigns beneficiaries to different levels of care using the ANSA. To date, it was piloted with staff and the TAY population and will be rolled out system-wide in May 2020. The MHP also uses the CANS-50 to assign beneficiaries to specific services, depending on diagnosis and profile. The MHP uses CSI reports for timeliness reporting and adjusts increase capacity when needed. Beneficiaries are involved in treatment planning, as was confirmed in the CFM focus groups.			

3B	Quality Improvement Plan	10	10

The QIQA unit produces a work plan with measurable goals and an annual evaluation. Quality Improvement Committee (QIC) meeting minutes document progress towards goals. QIQA efforts are supported by a research manager and planner evaluators for data analysis. Projects include PIPs, timeliness reporting, other required reports, compliance, policies and procedures. The MHP generates quarterly penetration rates based on services provided.

3C	Quality Management Structure	14	14

The QIQA unit has a research manager and planner evaluators for data analysis. The MHP has an analytics team of report writers and programmers, who design mechanisms to extract data for the QIQA unit to perform analysis. The MHP uses claims data, timeliness data, outcome data, productivity data, fiscal data, and clinical data.

The QIQA coordinator provides and disseminates QIQA memos for important regulatory changes and mandates. A snapshot of info notices released by DHCS are shared with the executive team, at the managers meeting, the quality management meeting and the contractors luncheon meeting. QIQA also added a hyperlink to the QIQA department website so that staff/contractors may bookmark the website and further expedite the handling of new information notices.

The MHP does have beneficiary representation on the QIC. However, no focus group participants were aware of the QIC.

3D	QM Reports Act as a Change Agent in the System	10	10

CSI timeliness reporting for both County BHS clinics and CBOs began in August 2019 with June data. The MHP will continue to capture CSI timeliness in ccLink for other points of entry including detention, FY, hospital discharges, and drop-ins.

The CANS-50 and PSC-35 Implementation Team, which formed in 2017, continues to meet monthly to support the use of system tools. In August 2019, the MHP began bimonthly “Meaningful Use of the CANS” trainings to educate providers on how to use the CANS-50 to engage beneficiaries, collaborate with other stakeholders, and develop treatment plans. As of September 2019, over 2,400 CANS-50 and 3,400 PSC-35 forms have been collected system-wide.

3E	Medication Management	12	12

The pharmacist continues to work with physicians to monitor medication use patterns and provide guidance on pharmacy policy and procedures. The MHP works with public health nurses, psychiatrists, and social workers to track concurrent medications within 90 days.

The MHP is working on several projects that utilize HEDIS/National measures for tracking performance and quality. The MHP is running a pilot project in West County on the use of Esketamine. The MHP is looking to expand access by either arranging for transport or setting up other clinics as a resource. The timeline for this project is estimated to be six to twelve months.

The MHP is also working on an initiative to increase appropriate clozapine adherence and reduce resistance to traditional blood draws. To streamline access to clozapine for the receiving beneficiary, the MHP has contracted with Athelas, a company that provides finger-stick blood testing.

The MHP collaborates with University of California Davis on improved training for PCPs in managing psychiatric diagnosis and medication. The MHP is also working on co-location—placement of psychiatrist in primary care clinics as a model for integration.

Beneficiary Progress/Outcomes

In Table 19, CalEQRO identifies the components of an organization that is dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 19: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	12
The MHP chose the ANSA to measure adult beneficiary functioning and outcomes. The ANSA Implementation Team was formed beginning in April 2019 and includes a multidisciplinary team of clinical lead staff from various county clinics, CBO representatives, managers and planner/evaluators. Five clinical staff have been certified as ANSA trainers and will begin offering weekly trainings starting in February 2020. The ANSA will be rolled out in two phases, beginning with county providers in May 2020 and contract providers in July 2020. In October 2018, the MHP rolled out the PSC-35 and the CANS-50 to measure child and youth functioning. The MHP is also in the initial stages of developing a level of care algorithm in order to match CANS-50 scoring to service need.			
4B	Beneficiary Perceptions	10	10

The MHP administers the Consumer Perception Survey (CPS) biannually. The MHP regularly reviews and compares data to prior surveys. The MHP is addressing an identified transportation problem through its non-clinical PIP. Progress and results are shared with staff at various meetings.			
4C	Supporting Beneficiaries through Wellness and Recovery	4	4
The MHP's wellness centers are run by its contractor RI International and are in each of the three county regions. They are open Monday through Friday, during regular business hours. Wellness centers are staffed completely by beneficiaries and peer employees.			

Structure and Operations

In Table 20, CalEQRO identifies the structural and operational components of an organization that is facilitates access, timeliness, quality, and beneficiary outcomes.

Table 20: Structure and Operations Components			
Component		**Quality Rating**	
5A	Capability and Capacity of the MHP	30	26
In addition to standard offerings of mental health services, medication support, case management and crisis intervention, the MHP has a ride along service, pairing clinicians with law enforcement, which goes to all regions from 7:00 am to 11:00 pm and on weekends. Day treatment and rehabilitation are not present.			
5B	Network Adequacy	18	18
Since January 1, 2019, Contra Costa has hired nine psychiatrists for a total of seven FTEs. Three of these new physicians (2.5 FTEs) are primarily via telehealth. (Contra Costa has employed a model where new telehealth hires spend one week per month in-person.) Telehealth has expanded to fill system needs from the original East Adult pilot clinic to a total of four clinic sites, adding Central Child, East Child and the West County Adult Mental Health.			
5C	Subcontracts/Contract Providers	16	12
Joint meetings are held every other month; however, CBOs report that county leadership participation is not consistent.			

Regarding collaboration, in February 2019, a group of BHS and CBO stakeholders began meeting weekly to take an inventory of the current state of collaboration between CBOs and BHS and its impact on beneficiary access and timeliness. In April 2019, the stakeholder committee held a CBO Improvement kick-off event to launch a collaborative improvement process aimed at improving the relationship and processes between BHS and CBO providers; however, since then, momentum has waned due to credentialing issues.

The MHP implemented CSI timeliness workflows for which CBO stakeholders were involved. Some reporting includes contractor data; however, aggregate reporting is scheduled to launch in Spring 2020 (timeliness).

In January 2019, the MHP began biweekly planning meetings with Objective Arts to begin design of the Contra Costa system. Some contract providers piloted the software, which communicates with the EHR, and provided feedback on user testing.

5D	Stakeholder Engagement	12	2

County leadership participation in the bimonthly CBO meetings is lacking.

CBOs report issues with credentialing and feel that some of the information being solicited is unnecessary, i.e., a high school diploma when there is a higher education degree or licensure. Long credential times result in newly hired CBO staff sitting idle and not providing services.

With the implementation of CSI timeliness, CBOs often feel threatened about being out of compliance. Terms are not clearly defined. All system changes have a significant cost to CBOs; however, it is not factored into their operations. Additionally, CBOs report that they received little Objective Arts guidance. SC reports are not accurate, but the burden is on CBOs to sort out the errors.

The MHP engages line staff/supervisors in work groups and pilot projects to test out initiatives; however, many of these are not well understood, e.g. the Health, Housing and Homeless Services program. Some line staff have heard about it, but others have not. Even with a lot of resources available, they are not well-understood by line staff. Communication does not seem to be filtered down. When a change is introduced, there is little support or follow-up on the change impact.

For West County beneficiaries, when compared to Central and East counties, the consensus is that African American beneficiaries feel left out of outreach activities and having a say in services. Information flow and inclusion are needed.

CFM focus groups participants had not participated on any committees nor heard of opportunities to provide feedback; however, participants in the CFM Employee session reported being on the Behavioral Health Care Partnership workgroup.

5E	Peer Employment	8	8

There are roughly 60 peer positions within the County including at contractor agencies. There are only two levels of Community Support Workers, I and II. The person in charge of the OCE is a beneficiary, but her job title is Consumer Program Coordinator. No one in the focus groups mentioned a formal collaboration between the MHP and Department of Rehabilitation. The MHP could improve knowledge of career ladder navigation.

Supervisor level/management position is present in the executive team, in the OCE. Vocational services are available to diverted beneficiaries who receive services through the Assertive Community Treatment program; however, they are not available system-wide. BHS has contracted with NAMI Contra Costa to recruit, train and develop family members with lived experience to act as subject matter experts in a volunteer capacity to educate and support other family members in understanding, navigating and participating in the public mental health system.

5F	Peer-Run Programs	10	6

The MHP's wellness centers are run by its contractor RI International and are in each of the three county regions. Wellness centers are staffed completely by beneficiaries and peer employees. The OCE is also peer run. It is unclear how the MHP informs beneficiaries about peer run programs or whether they monitor utilization of the wellness centers separately from RI International.

Peer Providers in the Adult System of Care work under the classification of Mental Health Community Support Worker (MHCSW) and are employed to work in the three adult regional BHS clinics, as well as with older adults, housing innovations, forensics services, the MCRT, PES, and the Miller Wellness Center. MHCSWs provide peer counseling support, independent living skills training, and general support to adults and older adults.

5G	Cultural Competency	12	12

Cultural competence inclusion strategies and goals are outlined in the cultural competence workplan. The Reducing Health Disparities Workgroup is currently drafting surveys to identify barriers for underserved populations.

Populations identified were Immigrant communities, communities of color, children ages zero to five, and the elderly. For its senior programs, peer counseling in English, Mandarin, and Spanish is available.

To outreach African American beneficiaries and Latinx beneficiaries, the MHP partnered with the African American Health Conductors and a Promotores program. These programs are related to health services in general; however, the MHP will be linking with peer providers and expanding to provide mental health services.

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2019-20 review of Contra Costa MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- In November 2019, an electronic referral was implemented in ccLink for MHP programs to refer beneficiaries to AOD counselors co-located in the mental health clinics.

Strengths:

- AODS has placed a Substance Abuse Counselor on a full-time basis at each of the three adult and three children's outpatient mental health clinics throughout the county. All seven counselors are supervised on weekly basis by an AOD Program Manager.

Opportunities for Improvement:

- The MHP's website is functional and user friendly; however, it is only in English.
- The Spanish pay differential of $100 per month seems insufficient to attract and retain bilingual staff.

Timeliness of Services

Changes within the Past Year:

- Since January 1, 2019, Contra Costa has hired nine psychiatrists for a total of seven FTEs. Psychiatry expansion, including telehealth, supports the MHP in meeting its network adequacy requirements.
- The MHP implemented CSI timeliness reporting in June 2019.

Strengths:

- Enhanced monitoring by DHCS supported the MHP in tracking timeliness of children's first appointments on an ongoing basis, bringing about added assessment slots to meet network adequacy standards.

Opportunities for Improvement:

- For children, 64.78 percent of first offered appointments meet the 10-business day standard. The MHP must offer an assessment appointment within 10-business days.
- Timeliness data does not include contract providers.
- 43.2 percent of the MHP psychiatry appointments met the 15-business day standard overall. The MHP must offer a psychiatric appointment within 15 business days.
- For adult urgent services, 42.9 percent of appointments meet the standard of 48 hours. Urgent services timeliness is measured in days, not minutes.
- 41.8 percent of the follow-up hospital discharge appointments fell within the 7-day standard.

Quality of Care

Changes within the Past Year:

- The MHP began revision of its utilization review forms and processes. To date, the MHP redesigned the physician's initial and reassessment forms. Next, the MHP plans to address the assessment and treatment plan.

Strengths:

- The MHP boasts a strong QIQA unit comprised of an analytics team and programmers. With the support of leadership, its multidisciplinary team allows the MHP to meets its quality improvement goals and conduct adjunctive extra performance improvement projects.

Opportunities for Improvement:

- None noted.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP chose the ANSA to measure adult beneficiary functioning and outcomes. Implementation is in the planning process and aggregate reporting is not yet in use. Two aggregate reports were developed for the CANS-50 and PSC-35, and aggregate reporting will be completed on a more consistent basis as contract providers transition onto Objective Arts.

Strengths:

- In April 2019, the MHP formed an ANSA Implementation Team and certified five clinical staff as ANSA trainers for the ANSA implementation planned for May 2020.

Opportunities for Improvement:

- The MHP chose the ANSA to measure adult beneficiary functioning and outcomes. Implementation is in the planning process and aggregate reporting is not yet in use, nor is it in use for the PSC-35 and CANS-50.

Foster Care

Changes within the Past Year:

- The MHP contracted with three new MH agencies to provide both Katie A. and children's services. Field-based services are available, including emergency foster care, intensive case coordination, in-home based services, therapeutic behavioral services and wraparound services.

Strengths:

- The MHP has staff collocated at the CWS district offices. With MH staffing stable and CWS filling over forty vacancies, the strong collaboration is a resource for beneficiaries.

- The MHP has an emergency foster care team in place which can expedite services when a FC beneficiary is at risk of losing placement.

Opportunities for Improvement:

- The MHP awarded three providers the contract to provide services to Katie A. subclass members. Two of the three agencies are operational and providing services to this population. The third agency is finishing up the staff credentialing process; however, there are barriers to efficient credentialing within the MHP.

- The MHP's research and evaluation and IT departments have been collaborating with CWS to share data and monitor trends. Due to the prioritization of the

CANS-50 implementation, the drafted tool to specifically evaluate the fidelity of ICC and IHBS services in accordance with the ICPM has not been finalized.

Information Systems

Changes within the Past Year:

- Several optimizations were made to the MHP EHR ccLink, such as implementing After Visit Summary, Care Team, electronic Medication Consent and e-Signature for Medication Consent.
- Implemented CSI Timeliness workflows for CBOs in ShareCare and County access line to BHS clinics in ccLink.

Strengths:

- Additional features were implemented in the patient portal, MyChart, to support appointment scheduling/cancellation, medication refills, etc. for Behavioral Health beneficiaries.

Opportunities for Improvement:

- CBOs must do double data entry to record services in their own EHRs and the MHP billing system. Interfaces that allow transmission of service data into ShareCare are needed.
- CBO users need regular ShareCare training to increase their competence level while working in the application.
- Oversight and accountability of the CBO Authorizations Work Group for process improvement is needed to review the UR workflow of CBO intake treatment plans and to reduce the likelihood of services being flagged.
- CBO need ShareCare report training to help CBOs trouble-shoot data discrepancies between ShareCare and their systems.

Structure and Operations

Changes within the Past Year:

- In June 2019, Dr. Suzanne Tavano was appointed by the Contra Costa County Board of Supervisors as the new Behavioral Health Director. The MHP also hired one Mental Health Program Chief, one Mental Health Program Manager, and three Mental Health Program Supervisor positions.

Strengths:

- The MHP held multiple events with CBOs to collaborate and identify improvements than were needed. The events were well attended and generated several avenues for collaboration.

Opportunities for Improvement:

- There is no identified IT leadership position, or direct-report position from HSD IT in BHS organizational chart. Not apparent that either IT Steering or Data Governance committees include senior BHS leadership participation.
- CBOs continue to do double data entry in ShareCare and their own EHRs to record services provided. This practice is a burden on the CBOs and not cost-effective and prone to data-entry errors.
- Communication is an ongoing issue between CBOs and the MHP, inclusive of the need for leadership to attend bimonthly meetings and the provision of guidance and consideration to the CBOs when implementing change.
- Stakeholder feedback across the system report significant barriers with both the credentialing process and credentialing personnel.

FY 2019-20 Recommendations

PIP Status

- None.

Access to Care

1. Include Spanish language translation to the mental health pages of the county website through an embedded browser feature or by providing Spanish language links to services with descriptions and contact information.
2. Compare the offered bilingual differential to like-sized counties and adjust upwards to match industry standards.

Timeliness of Services

3. For children, 64.78 percent of first offered appointments meet the 10-business day standard. The MHP must comply with the DHCS timeliness metric as per Information Notice (IN) 18-011.
4. Include contractor data in timeliness reports and demonstrate use of aggregate reporting for capacity management.
5. The MHP should improve the FY 2018-19 rate (43.1 percent) of psychiatric appointments offered within 15 business days as per IN 18-011.
6. The MHP should improve the current rate (41.8 percent) of follow-up hospital discharge appointments that are within 7-days.

Quality of Care

- None noted.

Beneficiary Outcomes

7. Prioritize and implement aggregate reporting for the ANSA, PSC-35, and CANS-50.

Foster Care

8. Prioritize credentialing for CBOs offering children's services to allow for expanded access for FC youth.
9. Finalize and implement the draft tool which specifically evaluates the fidelity of ICC and IHBS services in accordance with the ICPM.

Information Systems

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

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

12. Ensure the CBO Authorizations Work Group review the UR workflow of approving/denying/pending CBO intake treatment plans for process improvement. To reduce the likelihood of services entered by CBOs in ShareCare to be flagged as authorized.

Structure and Operations

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

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

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

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: PIP Validation Tools

Attachment A—On-site Review Agenda

The following sessions were held during the MHP on-site review, either individually or in combination with other sessions.

Table A1—EQRO Review Sessions – Contra Costa MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Performance Improvement Projects
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employee/Parent Partner Group Interview
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Wellness Center Site Visit
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Cyndi Lancaster, Quality Reviewer
Saumitra SenGupta, Quality Reviewer
Neal Adams, M.D., Consulting Psychiatrist
Caroline Yip, Information Systems Reviewer
Walter Shwe, Consumer/Family Member Consultant

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

Sites of MHP Review

MHP Sites

Contra Costa Behavioral Health
1340 Arnold Drive, #200
Martinez, CA 94553

Antioch Children's Behavioral Health Clinic
2335 Country Hills Drive
Antioch, CA 94509

East County Adult Mental Health
2311 Loveridge Road
Pittsburg, CA 94565

West County Children's Mental Health Clinic
303 41st St.
Richmond, CA 94805

Contract Provider Sites

RI International
2101 Vale Rd.
San Pablo, CA 94806

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Aguirre	Priscilla	Quality Mgmt. Program Coord.	CC Behavioral Health
Ahad	Terry	MH Program Supervisor	CC Behavioral Health
Andreev	Oleg	HS Info Systems Progr./Analyst	CCHS Info Technology
Ang	JR	Director of Patient Accounting	CCHS Finance
Ayzenberg	Alexander	Executive Assistant	CC Behavioral Health
Battis	Claire	HS Planner/Evaluator	CC Behavioral Health
Bautista	Jessica	MH Clinical Specialist First Hope	CC Behavioral Health
Becerra	Marina	MH Clinical Specialist	CC Behavioral Health
Bennet	Cathy	Hosp. Liaison for Children's MH	CC Behavioral Health
Bergesen	David	CEO	Community Options
Bianchi	Charlene	Katie A. Program Manager	CC Behavioral Health
Blanza	Jennifer	Program Director	Seneca
Bruggeman	Jennifer	Program Supervisor	CC Behavioral Health
Burton-Flores	Margie	MH Program Supervisor	CC Behavioral Health
Calloway	Vernon	Lead PSP/InSyst Support Analyst	CCHS Info Technology
Campbell	Kathleen	MH Clinical Specialist	CC Behavioral Health
Cardenas	Paula	MH Clinical Specialist	CC Behavioral Health
Castillo	Candelario	MH Clinical Specialist	CC Behavioral Health
Cathey	Kellee	MH Clinical Specialist	CC Behavioral Health
Celio	Chris	Director of Clinical Programs	Hume Center
Chavez	Beatriz	MH Clinical Specialist	Child Therapy Institute
Chmiel	Denise	Program Manager	CC Behavioral Health
Cobaleda-Kegler	Jan	Adult/Older Adult Prog. Chief	CC Behavioral Health
Cua-Ang	Jeremiah	Student Intern	CC Behavioral Health
Curran	Brittany	MH Clinical Specialist	CC Behavioral Health
Danko	Adam	Psych. MH Nurse Practitioner	CC Behavioral Health
Dimidjian	Natalie	MH Program Supervisor	CC Behavioral Health
Dold	Amanda	Integration Services Manager	CC Behavioral Health
Dominguez	Jessica	Commute Navigation Specialist	CC Behavioral Health

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Down	Adam	Ethnic Serv. & Training Coord.	CC Behavioral Health
Eriksson	Gabriel	COO	Community Options
Faramazyan	Alina	Lead Psychiatrist	CC Behavioral Health
Fattah	Hala	Lead Psychiatrist	CC Behavioral Health
Fernandez	Nancy	Manager	CC Child and Family Services
Fuhrman	Beverly	MH Program Manager	CC Behavioral Health
Gallagher	Ken	Research & Evaluation Mgr.	CC Behavioral Health
Gibson	Teresa	MH Program Supervisor	CC Behavioral Health
Girardey	Brigette	MH Clinical Specialist	CC Behavioral Health
Goss	Sonja	Interim Executive Director	Seneca
Hanna	Elizabeth	MH Clinical Specialist	CC Behavioral Health
Hayes	Warren	MH Program Chief	CC Behavioral Health
Hayes	Amma	MH Clinical Specialist	CC Behavioral Health
Hernandez	Rusty	Accountant	CC Behavioral Health
Huynh	Winnie	MH Program Supervisor	CC Behavioral Health
Jacob	Jean	HS Planner/Evaluator	CC Behavioral Health
Johnson	Kennisha	MH Program Manager	CC Behavioral Health
Jun	Jimmy	MH Clinical Specialist	CC Behavioral Health
Kalaei	Susan	BH Pharmacist	CC Behavioral Health
Khan-Amrikani	Shereen	Clinical Administrator	ECMHP
Koita	Kadiatou	HS Planner/Evaluator	CC Behavioral Health
Lau	Edward	Lead Psychiatrist	CC Behavioral Health
Leung	Yat Ming Jude	Program Manager	CC Behavioral Health
Loenicker	Gerold	Program Chief CSOC	CC Behavioral Health
Lukas	Brian	Executive Director	Child Therapy Institute
Luu	Matthew	BH Deputy Director	CC Behavioral Health
Madruga	Christine	MH Program Manager	CC Behavioral Health
Martin	Diana	MH Clinical Specialist	CC Behavioral Health
Matal Sol	Fatima	AOD Chief	CC Behavioral Health
Melendez	Robin	Information System Specialist	CC Behavioral Health
Mendoza	Floris	MH Program Supervisor	CC Behavioral Health
Messerer	Mark	AOD Program Manager	CC Behavioral Health
Molina-Huntley	Liza	ASA-III/Contract Analyst	CC Behavioral Health
Naghshineh	Morvarid	HS Planner/Evaluator	CC Behavioral Health
Nasrul	Kimberly	QI and Compliance Coord.	CC Behavioral Health
Nawy	Jena	MH Clinical Specialist	CC Behavioral Health

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Neilson	Jersey	HS Planner/Evaluator	CC Behavioral Health
Nobori	Michelle	MH Project Manager	CC Behavioral Health
Ny	Faye	HS Accountant	CCHS Finance
Nybo	Erik	Business Intelligence Dev.	CCHS Info Technology
O'Neill	Robin	MH Program Manager	CC Behavioral Health
Orme	Betsy	MH Program Manager	CC Behavioral Health
Otis-Miles	Laura	Sr. Vice President	MH Systems, Inc.
Pena	Jorge	Ld. PSP/InSyst Support Analyst	CCHS Info Technology
Pierce	Chad	MH Program Manager	CC Behavioral Health
Powers	Karen	Intensive Care Coord. Sup.	CC Behavioral Health
Quittman	Judy	MH Clinical Specialist	CC Behavioral Health
Ransom	Kelly	Director	We Care Children
Rice	Megan	Cclink BH Proj Manager	CCHS Info Technology
Sanabria	Bernadita	Program Supervisor	CC Behavioral Health
Scannell	Marie	MH Program Manager	CC Behavioral Health
Serwin	Barbara	MH Commissioner	MH Commission
Shah	Bhumil	Asst. IT Dir., Analytics & Rep.	CCHS Info Technology
Shirgul	Ellen	MH Program Supervisor	CC Behavioral Health
Siliezar	Elizabeth		CC Behavioral Health
Sloan	Jeff	Executive Director	Early Childhood MH Prog.
Spikes	Chet	Asst. HS IT Director	CCHS Info Technology
Sweeten-Healy	Heather	MH Program Manager	CC Behavioral Health
Tarvins	Denise	MH Clinical Specialist	CC Behavioral Health
Tavano	Suzanne	Behavioral Health Director	CC Behavioral Health
Thigpen	Robert	MH Family Services Coord.	CC Behavioral Health
Tuipulotu	Jennifer	OCE Coordinator	CC Behavioral Health
Tupper	Stacey	Project Manager	CC Behavioral Health
Waters	Susan	MH Comm. Support Worker	CC Behavioral Health
White	Matthew P.	Medical Director	CC Behavioral Health
White	Katy	Access & Care Mgmt. Mgr.	CC Behavioral Health
Wintermantel	Heidi	Social Work Supervisor II	CC Behavioral Health
Wood	Amelia	MH Clinical Specialist	Hume Center
Zelan	Soul	Psychiatrist	CC Behavioral Health
Zesati	Genoveva	Admin. Services Assistant	CC Behavioral Health

Attachment C—Approved Claims Source Data

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

Table C1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table C1: CY 2018 Medi-Cal Expansion (ACA) Penetration Rate and ACB
Contra Costa MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,807,829	152,568	4.01%	$832,986,475	$5,460
Large	1,833,373	69,835	3.81%	$406,057,927	$5,815
MHP	75,986	3,227	4.25%	$12,761,872	$3,955

Table C2 shows the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000, and above $30,000.

Table C2: CY 2018 Distribution of Beneficiaries by ACB Cost Band
Contra Costa MHP

ACB Cost Bands	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	13,581	92.73%	93.16%	$43,921,508	$3,234	$3,802	47.82%	54.88%
>$20K - $30K	414	2.83%	3.10%	$10,146,206	$24,508	$24,272	11.05%	11.65%
>$30K	650	4.44%	3.74%	$37,772,499	$58,112	$57,725	41.13%	33.47%

Attachment D—List of Commonly Used Acronyms

Table D1—List of Commonly Used Acronyms	
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment

Table D1—List of Commonly Used Acronyms	
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NP	Nurse Practitioner
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment

Table D1—List of Commonly Used Acronyms	
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2019-20 CLINICAL PIP	
GENERAL INFORMATION	
MHP: Contra Costa Behavioral Health Services	
PIP Title: CBT-Depression	
Start Date: 11/6/2019 **Completion Date**: 11/30/2021 **Projected Study Period**: 24 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 02/04/-02/06/20 **Name of Reviewer**: Cyndi Lancaster	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☒ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish):
The goal of the clinical PIP is to improve outcomes beneficiaries who are suffering from depression and to reduce their symptoms. The MHP identified that many beneficiaries are diagnosed with a depressive disorder or experience severe depressive symptoms. According to performance measures provided by CalEQRO for 2018, 27 percent of beneficiaries have a diagnostic category of depression and those beneficiaries make up 20 percent of approved claims. In January 2018, the MHP implemented a pilot program at its East Adult clinic to determine the feasibility and utility of having beneficiaries complete a 9-Item Patient Health Questionnaire (PHQ-9) and 7-Item Generalized Anxiety Disorder (GAD-7) assessment at each clinic visit. When limited to beneficiaries at East County Adult who had moderately-severe depression symptoms on their baseline PHQ-9, 41.3 percent of beneficiaries had a primary diagnosis of depression; and 43.2 percent of beneficiaries who had severe depression symptoms on their baseline had a primary diagnosis of depression. The MHP also inquired with beneficiaries which additional services they would like. A depression support group was the highest ranked selection, with one of three respondents (136/351, 38.7 percent) indicating they would like this service, while one of five respondents (77/351, 21.9 percent) selected Group Therapy. The PIP Committee selected Cognitive Based Therapy for Depression (CBT-D), an Evidence Based Practice (EBP), for the intervention. The intervention is designed to help beneficiaries manage their depression by making the feelings of depression less intense, making the time that they are depressed shorter, and teaching ways to prevent getting depressed again. CBT teaches beneficiaries skills to help them change their thoughts and behaviors and helps break the downward spiral. Further the MHP elected to use the PHQ-9 to monitor depression symptoms throughout treatment.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments

1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP Committee is comprised of the Contra Costa Behavioral Health Quality Improvement Program Coordinator, the Adult/Older Adult Services Program Chief, the Office for Consumer Empowerment (OCE) Coordinator, a Health Services Planner/Evaluator, the East County Adult Behavioral Health Services Program Manager and Supervisor, and the clinicians facilitating the group. The Adult/Older Adult Services Program Chief and the Quality Improvement Program Coordinator are working to identify any community-based organizations (CBOs) or contract providers that may be interested in expanding the PIP to their programs. Members of the PIP committee were chosen based on their subject matter expertise and their ability to implement any improvement activities.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The 2018-2019 MHP External Quality Review report details that system-wide, 27 percent of the MHP's beneficiaries have a diagnostic category of depression and those beneficiaries make up 20 percent of approved claims. Analysis of causes of depression not present, esp. if system is 27 percent and 41.3 percent at East County per the PHQ-9. Not necessarily required, but it is a point of interest.

Select the category for each PIP: *Clinical:* ☒ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☐ High risk conditions		*Non-clinical:* ☐ Process of accessing or delivering care
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other Limited to adults at East County Child and Adolescent Services	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Limited to adults at East County Child and Adolescent Services.
	Totals	**3** Met **1** Partially Met

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will beneficiaries who are referred to and participate in a Cognitive Based Therapy for Depression Group see a reduction of depression symptoms by 15 percent and an increase in self-identified functions by 10 percent?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**1** Met
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Medi-Cal beneficiaries with a depression diagnosis or severe depressive symptoms are referred to the CBT-D group by their treating clinician and/or psychiatrist. The CBT-D group leaders interview the referred beneficiaries to ensure they are appropriate for the group and to establish group cohesion.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☒ Referral ☐ Self-identification ☐ Other:	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	A standardized method of assessment and subsequent referral was not provided (to ensure that all who qualify are captured; more information needed on the integrity of the referral process).
	Totals	**1** Met 1 UTD

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* • Change in PHQ-9 Score • Change in Functional Domains - Family Relations • Change in Functional Domains – Employment/School Performance • Change in Functional Domains – Recreational/Leisure Activities • Change in Functional Domains – Food/Shelter • Change in Functional Domains – Social Relations • Change in Functional Domains – Physical Health • Change in Functional Domains – Substance Use • Change in Functional Domains – Activities of Daily Living	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	1. PHQ-9 scores – the primary indicator in this PIP will be beneficiary PHQ-9 scores. The PHQ-9 is a widely utilized reliable and valid tool to diagnose and measure the severity of depression. 2. Functional Domains – the secondary indicator will be the beneficiary's self-assessment of their functioning in eight domains: Family Relations, Employment/School Performance, Recreational/Leisure Activities, Food/Shelter, Social Relations, Physical Health, Substance Use, and Activities of Daily Living. The beneficiaries are asked to rate their level of functioning on a scale corresponding from very impaired to very good.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**3** NA	
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data to be collected include PHQ-9, beneficiary self-assessment of functional outcomes in eight life domains, primary diagnosis, the number of group sessions attended, and demographics (age, race, gender).
6.2 Did the study design clearly specify the sources of data? *Sources of data:*	☒ Met ☐ Partially Met ☐ Not Met	The PHQ-9 is completed by the beneficiary at every clinical visit and is reviewed and entered in the EHR by the clinicians conducting the group.

☒ Member ☐ Claims ☐ Provider ☐ Other:	☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The total PHQ-9 scores are extracted by a report created by Business Intelligence (BI) and validated for accuracy. The BI report validation process includes BI peer-review of the code and an end user acceptance test of a representative sample of charts. This report also captures the beneficiary's primary diagnosis and demographic information. Using a vetted report will allow the PIP committee to ensure these data are reliable and valid. It is unclear if the entire population is included in the analysis. See 3.2 above.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☒ Outcomes tool ☐ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The functional outcomes assessment is completed by the beneficiaries at their initial session and then at the end of each module. The forms are then scanned using Teleform, a data capture software that allows for the automatic transmittal of data from paper forms to a database. Teleform was chosen to reduce the likelihood of data entry related errors and ensure data quality.

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data will be analyzed at the conclusion of each 4-session module to determine any changes in average total PHQ-9 score and average scores in the functional domains. If a beneficiary drops out before the conclusion of a module, their last PHQ-9 score will be compared to their initial score. Paired t-tests will be used to determine if the changes in average score are statistically significant. If any untoward results are uncovered, they will be brought to the larger PIP committee. The PIP committee will discuss these results and how they should be handled. In addition, the data will be used to inform the pilot and determine whether there are any changes that should be made to enhance the success of the project before it is expanded to other clinics.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Priscilla Aguirre Title: Quality Management Program Coordinator Role: Chair	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PHQ-9 and functional outcomes assessment are self-administered tools completed by the beneficiaries. The clinicians conducting the CBT-Depression group review all forms for completeness and the PHQ-9 for any critical responses. The Health Services Planner/Evaluator is analyzing the data and disseminating the results to the PIP committee. Their qualifications include a Master of Public Health degree and eight years of experience conducting health services research.
	Totals	**5** Met **1** Partially Met

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* CBT-Depression at East Adult (11-6-19)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	In order to maintain fidelity to the CBT-D EBP, the clinicians facilitating the group will utilize the accompanying manual. The PIP committee will check-in with the facilitators at the end of each module to discuss the status of the project and consider any lessons learned.
	Totals	**1** Met
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	For PHQ-9 outcomes, initial remeasurements are promising but the sample size is too small. For functional outcomes, results have been mixed. While some domain scores have increased, others have decreased slightly or have had no change. In a paired t test, none of the domains achieved statistical significance, likely due to small sample size and small difference in means. It is unclear if the entire population is included in the analysis. See 3.2 above.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: __11/6-12/11/2019_____ Indicate the statistical analysis used: _paired T test _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Initial and one remeasurement, at a little over one month. Need larger sample size for meaningful data.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Too early to determine.
Totals	**1** Met	**2** Partially Met 1 NA

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**5** NA	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☐ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

The clinical PIP was based on the CY 2018-19 report which stated 27 percent of the MHP's beneficiaries have a diagnostic category of depression. There was no analysis of causes of higher incidence of depression. For the pilot clinic in this PIP, the depression rate is 41.3 percent at East County per the PHQ-9. Once beneficiaries with a depression diagnosis are referred by their treating clinician and/or psychiatrist, they are assigned to an appropriate; however, a standardized method of assessment and subsequent referral was not utilized (to ensure that all who qualify are captured; more information needed on the integrity of the referral process).

Beneficiaries will attend the 4 session module groups and receive CBT interventions. Depression status will be measured by the PHQ-9 along with a functional outcomes assessment. Each group is comprised of eight to ten beneficiaries. Currently, two groups are being run at a time. Sample size is limited by this factor; moreover, significantly higher numbers are needed for this to be applicable to the system at large. Regarding fidelity to the EBP CBT-D model, the MHP plans to have clinicians utilize the accompanying manual.

So far, the MHP has experienced positive results reflected in the PHQ-9 and mixed results on the functional outcomes measures, likely due to small sample size.

PIP Validation	#s
Met	14
Partially Met	4
Not Met	0
UTD	1
# Not applicable	9
Score	84.21%
total items in rating	28

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Recommendations: The MHP should develop ways to standardize assessment, diagnosis and referrals to groups to ensure that beneficiaries are not missed. While it may not be possible to ascertain each beneficiaries' cause for depression, examining the process by which staff assign and code the diagnosis could lead to more accurate data on depression rates. The MHP should also increase its sample size to achieve numbers which are high enough for this PIP to be applicable to the system at large. This MHP's PIPs over the years have demonstrated the theme of piloting and use of an intervention at one location in its system, i.e. a clinic. This practice poses issues with sample size but also in duplicability because ultimately, the MHP does not have the manpower, budget or timing to duplicate the intervention across whole system, no matter the success at the pilot level. A better approach would be to simplify its PIPs and apply interventions to the whole system for real and timely change to occur.
Check one: ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☒ Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Contra Costa County	
PIP Title: Improving Appointment Adherence to the First Appointment	
Start Date: 12/01/2017 **Completion Date**: 12/31/2019 **Projected Study Period**: 24 Months **Completed**: Yes ☒ No ☐ **Date(s) of On-Site Review**: February 4, 5 & 6, 2020 **Name of Reviewer**: Cyndi Lancaster	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Non-clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): The overarching goal of this PIP is to increase appointment adherence rates to first appointments and reduce wait times for initial assessment among beneficiaries who receive services. This is the final year of this PIP. To improve appointment adherence, the MHP implemented improved beneficiary outreach practices that incorporate piloting the use of Motivational Interviewing (MI) for beneficiaries attending initial outpatient mental health appointments at the East County Adult Mental Health Services and the East County Child clinics. MI is used address any ambivalence about attending the appointment. Beneficiaries (or parent/guardian) were contacted one to five days in advance of their appointment. For the second year, the MHP will have a family service worker call	

beneficiaries eight days in advance of their appointment to assess their transportation barriers and make referrals to an appropriate service, i.e., clinic services, Kaiser, or Blue Cross transportation benefit. The analyses for this project occurred every five to six weeks at the start of data collection for appointment adherence rates; rates of new beneficiaries contacted; and referrals to Navigation Specialists, and then at least quarterly. For beneficiaries of CCMHP's East Adult clinic, there was a non-statistically significant reduction in the percentage of missed appointments; however, for beneficiaries of CCMHP's East County Child And Adolescent Services, there was a statistically significant reduction in missed appointments. For beneficiaries of the MHP's East Adult clinic, there was a statistically significant relationship between being successfully contacted and attending the first appointment. Among those who were successfully contacted, 68 percent attended the appointment whereas among those who were not contacted, 58 percent attended the first appointment. For beneficiaries of the MHP's East County Child And Adolescent Services, the relationship between being successfully contacted was not significantly related to attending the first appointment. Of beneficiaries who were successfully contacted, 73 percent attended the first appointment compared to 74 percent for those not successfully contacted.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Contra Costa Mental Health Plan has assembled a multidisciplinary team to provide oversight of the proposed Timeliness intervention. Stakeholders involved include: Deputy Director of Behavioral Health Services (Matthew Luu), Quality Management Program Coordinator (Priscilla Aguirre), Research and Evaluation Manager (Ken Gallagher), Planner/Evaluator (Jean Jacob), Adult Program Chief (Jan Cobaleda-Kegler), Behavioral Health Access & Care Management Unit Program Manager (Katy White), Adult/Older Adult Mental Health Program Managers, Children/Adolescent Mental Health Program Managers, Adult Family Services Coordinator (Robert Thigpen), Office for Consumer

		Empowerment Coordinator (Jennifer Tuipulotu), Overcoming Transportation Barriers (OTB) Navigation Specialists, access line operations lead (Paolo Gargantiel) Health Service IS Specialist (Robin Melendez), and Community/Family Support Workers. This multidisciplinary team reflects MHP and clinic leadership, practitioners, quality improvement/assurance personnel, beneficiaries and family members.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP completed a comprehensive, formal barrier analysis to learn more about reasons for missed appointments. The barrier analysis included analyzing data from a Service Improvement Survey administered in November 2018 to identify reasons beneficiaries missed behavioral health appointments.

Select the category for each PIP:

Non-clinical:

☐ Prevention of an acute or chronic condition
☐ Care for an acute or chronic condition
☒ Process of accessing or delivering care
☐ High volume services
☐ High risk conditions

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The overarching goal of this PIP is to increase appointment adherence rates to first appointments and reduce wait times for initial assessment among beneficiaries who receive services system-wide. A key strategy that is being implemented involves more direct contact with new beneficiaries (or parents/guardians for those under 18 years) prior to their first outpatient mental health appointment using MI as the overarching methodology. Use of this evidence-based practice can help determine what barriers beneficiaries may be experiencing that keep them from acting, in this case, following through with scheduled appointments.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**4** Met

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will implementing Direct Client Outreach defined by CSWs/FSWs calling clients 0 to 5 days in advance* of their initial outpatient mental health appointment to engage clients, address ambivalence, answer questions, and refer clients to needed resources, decrease the percentage of missed initial assessment appointments from 41 percent at the MHP's East Adult clinic, and from 35 percent at the MHP's East Children's clinic, to 25 percent? *Note that the MHP's statistical analysis shows no significant impact on the number of days beneficiaries receive timely access to mental health services? are called in advance of their appointment so this range allowed CSWs/FSWs to call beneficiaries who were scheduled for next day appointments and those scheduled out further.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Last year, the MHP was advised to make calls on specific days, i.e. 5th day before appt., 3rd day before appt. and track which interval was more effective. This recommendation was not incorporated. It remains that the question would be more measurable if the calls to beneficiaries were made on a specific day (not a range), and possibly compared, to provide information to allow for success to be duplicated elsewhere. The PIP mentions that a statistical analysis of the specific days for calling did not indicate which days would be best; however, no details of that analysis were provided.
	Totals	**1** Partially Met

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☒ Other: Clinic Location The study population includes all beneficiaries scheduled for initial assessment appointments at the MHP's East Adult and East County Child And Adolescent Services. These clinics were selected for this intervention because beneficiaries of these clinics had the longest waits to initial assessments and had high rates of no-shows to these appointments.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP has identified the East County region as the primary focus for initial interventions. Both East County Adult and East County Children; however, information on how the study will address the entire beneficiary population, or a specific sample of that population was not provided in this section, nor information on how inclusion of all members will occur.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☐ Referral ☐ Self-identification ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**1** Met 1 Partially Met

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* • First Scheduled Outpatient Mental Health Missed Appointment Rate • Business Days from Referral to First Completed Routine OP Appointment (mean) • Rate of New Beneficiaries Contacted for Initial Appointment Engagement • Rate of Completed Appointments among Successful Contacts • Percent of Beneficiaries referred to Commute Navigation Specialists (Overcoming Transportation Barriers resource)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be beneficiary-focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Indicators measured processes of care with strong associations with improved outcomes.
	Totals	**2** Met

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	
Totals	**3** NA	

STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data for this project include data extracted from the MHP's EHR and data collected by CSWs/FSWs that are recorded on the project-developed Beneficiary Timeliness Call Log. Data to be collected Datapoints used in these reports for this project include: • Earliest patient communication/referral date; • Referred to department; • Appointment offered and scheduled dates; • Appointment completed dates; • Appointment status/disposition.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Timeliness and missed appointment data from the EHR are extracted from CCMHP's timeliness reports that have been created by the County's Business Technology Team. These reports integrate data from Tapestry and Cadence, two Epic scheduling modules. Scheduling data is contained in the reports are logged real-time by staff at the access line and clerical staff members at each program location. Approximately 60 staff members bear responsibility for data entry at different points of patient contact (initial contact, appointment check-in, follow-up scheduling, etc.). Staff members received between 3-6 hours of training as part of staff orientation to Tapestry or Cadence.

		As Cadence is a new system (introduced January 2017), the MHP continuously monitors reports to assess reliability of the output. CCMHP worked with Contra Costa Health Services Business Technology staff to develop an error report to verify the validity of data input into the EHR. Project data are run quarterly to determine the impact of the proposed interventions. on each of the project indicators (specified above).
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Data about the Direct Outreach calls are recorded on the CCMHP-developed beneficiary Timeliness Call Log, which is completed by CSWs/FSWs when they make the direct outreach calls and to record beneficiaries' appointment status (e.g., completed, cancelled, no-show). This log is also used to calculate: percentage of appointments missed, percentage of beneficiaries successfully contacted, percentage of beneficiaries successfully contacted who miss appointments, and percentage of beneficiaries referred to OTB. CSW/FSWs maintain tracking logs to record and monitor their outreach efforts. Data collected on beneficiaries is cross-referenced with Business Intelligence developed reports to identify any data discrepancies. The Planner/Evaluator assigned to the project reviews logs on a biweekly basis for completeness and inconsistencies and notifies staff of any data discrepancies.

6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	It was determined a priori that reports would initially be run every 5- 6 weeks and then consistently run on a quarterly basis, and be reviewed by the PIP committee. To calculate timeliness to first assessments, data were extracted from the existing Cadence report and then SPSS syntax was run to ensure consistency in measurement. T-tests were performed to determine whether number of business days from referral to completion was reduced. Similarly, existing Cadence reports and beneficiary Timeliness Tracking Logs were used to extract data for missed appointments. Rate of missed appointments was calculated as described above for indicator one. Chi square analysis was performed to determine whether changes in proportions of missed appointments were statistically significant.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Overall data quality issues and data consistency issues are discussed at biweekly PIP Committee meetings. It was determined a priori that data from the logs would be analyzed every 5-6 weeks initially, and then quarterly, to assess rates of missed appointments, successful contact of beneficiaries, and referrals to OTB. The team reviewed Tapestry/Cadence data along with project tracking logs completed by the CSW/FSW. Chi square analysis was run to determine whether missed appointments were significantly reduced and whether beneficiaries who were successfully contacted were significantly less likely to miss appointments than those not contacted.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Priscilla Aguirre Title: Quality Management Program Coordinator Role: Chair *Other team members:* Names: Planner/Evaluator (Jean Jacob) Research & Evaluation Manager (Kenneth Gallagher)	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Project data were collected and maintained by Planner/Evaluator (Jean Jacob) and the Research & Evaluation Manager (Kenneth Gallagher). The individuals identified are full-time staff with CCMHP. Any untoward results identified in data analysis were first reviewed by the Research & Evaluation unit to determine possible factors that may have contributed to the discrepancy (e.g. data entry errors). In the event that the untoward result could not be accounted for, data were presented to the PIP Committee to discuss possible adjustments to the intervention and/or data collection processes, taking into consideration data obtained from CSWs and FSWs regarding barriers to beneficiaries' attendance and documentation about calls listed on Timeliness Call Logs.
	Totals	**6** Met
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* • CSW/FSW calls New Beneficiaries between one to five days in advance of the initial outpatient Mental Health appointment to remind the beneficiary of their initial intake assessment appointment and provide the beneficiary with more information	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This last year, the MHP performed a barrier analysis for appointment attendance from a survey provided in November 2018. On this survey, 29 percent of respondents endorsed that they forgot about the appointment, the most frequently selected item. Transportation was the second most frequently endorsed response with 19 percent of beneficiaries selecting that as one of the reasons they missed an appointment. Similarly, data from the Project's Tracking Logs found that when

about the appointment (what to expect, length of appointment, etc.). Additional calls are made to the beneficiary as deemed necessary by CSW/FSW staff to provide an additional reminder of appointment, if necessary, such as for those with cognitive functional limitations, or to follow-up on resources needed to overcome barriers to attending appointment. • If beneficiary expresses any ambivalence about attending this appointment, the CSW/FSW will use MI to help beneficiary work through ambivalence and attend appointment. • The CSW/FSW will identify any beneficiaries who have transportation barriers and will provide a warm hand off to OTB for transportation assistance in navigating the public transportation system or for referrals for transportation vouchers. • The FSW will call beneficiaries eight days in advance of their appointment to assess their transportation barriers and make referrals to CCHP, Kaiser, Blue Cross transportation benefit, clinic CSWs, OTB, etc. to help beneficiaries access transportation resources.		CSWs/FSWs called beneficiaries who no-showed to appointments, at the East Adult clinic transportation barriers was the most common reason followed by forgetting. At the East County Child And Adolescent Services, beneficiaries reported forgetting as the most frequent reason for no-showing followed by family emergency. From the beneficiary self-reported data, interventions geared toward helping beneficiaries remember appointments and addressing transportation barriers may help to reduce the MHP's missed appointment rates. Similarly, part of the barrier analysis conducted by the MHP was predictive modeling of no-shows, which also showed that successfully reaching beneficiaries with a warm call was a protective factor for no-showing to first assessment appointments.
	Totals	**1** Met

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: 1/3/2017 through 11/22/2017 1/24/2018 through 11/30/2018 1/29/19 through 11/30/2019 Indicate the statistical analysis used: Paired T test Indicate the statistical significance level or confidence level if available/known: Calculated within PIP submission for each indicator.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* None *Conclusions regarding the success of the interpretation:* Analysis is detailed and thorough. *Recommendations for follow-up:* None	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals	**4** Met	
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated?	☒ Met ☐ Partially Met	Data measurement was repeated every 4-6 weeks and reviewed by the PIP committee.

Ask: At what interval(s) was the data measurement repeated? *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☒ Yes ☐ No Clinical significance: ☐ Yes ☐ No *First Scheduled Outpatient Mental Health Appointment Adherence:* At the East Adult clinic, the rate fell three percentage points from 41 percent to 38 percent, a 7 percent decrease; however, among those successfully contacted, the decrease was statistically significant. For the East County Child And Adolescent Services, the appointment non-adherence rate fell significantly. The non-adherence rate was reduced eight percentage points from 35 percent to 27 percent, a 23 percent decrease. Although decreases were observed for both clinics, the MHP did not achieve its goal of no more than a 25 percent missed appointment rate at either clinic, but the East County Child And Adolescent Services narrowly missed this goal by two percentage points.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	*Rate of New Beneficiaries Contacted for Initial Appointment Engagement:* For the East Adult clinic, 40 percent of beneficiaries scheduled for initial appointments were successfully contacted. At the East County Child And Adolescent Services, 65 percent of beneficiaries scheduled for an initial appointment were successfully contacted. For 9 percent of beneficiaries, the CSW was unable to leave a message, 3 percent of whom were scheduled for the same day or next day appointments so there was no time to leave a message. Neither clinic reached the goal of successfully contacting 80 percent of beneficiaries scheduled for an initial appointment. *Rate of Completed Appointments among Successful Contacts:* At the MHP's East Adult clinic, the rate of completed appointments among those who were successfully contacted was 68 percent vs 58 percent who were not successfully contacted. At the MHP's East County Child And Adolescent Services, the rate of completed appointments for those successfully contacted was 73 percent, compared to 74 percent

Business Days from Referral to First Completed Routine OP Appointment: Neither the East Adult clinic nor the East County Child And Adolescent Services decreased the number of business days from referral to first completed outpatient appointment. The mean number of days from referral to completion of the first assessment appointment increased at the East Adult clinic from 18 days to 23 days, an increase of 5 days. At the East County Child And Adolescent Services, the number of business days from referral to completion remained constant at 20 days. Neither clinic achieved the established goal.		for those not successfully contacted. The MHP's goal for this indicator was 75 percent; neither clinic met the goal. *Beneficiaries referred to Commute Navigation Specialists:* Referrals from the MHP's adult clinic were 14 percent and referrals from the children's clinic were only 2 percent. It should be noted that the actual number of beneficiaries who accepted the referral was just 31 beneficiaries from both clinics. Only 17 beneficiaries (54.8 percent) called for transportation assistance.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☒ Fair ☐ High	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP has some concerns about overall data quality for the appointment non-adherence indicator. For the period of July 1, 2018-September 30, 2018, 10.3 percent of cancellations for all appointment types were due to clerical errors, and not actual cancellation of appointments by providers or beneficiaries. Although the MHP has no reason to believe that the number of errors varied systematically from the time baseline data were calculated to when other calculations were performed, this issue does increase the overall amount of random error associated with these measures. The MHP will be working on excluding clerical errors from the reporting of canceled appointments.

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	*First Scheduled Outpatient Mental Health Appointment Adherence Rates:* For beneficiaries of CCMHP's East Adult clinic, there was a non-statistically significant reduction in the percentage of missed appointments (X2(1) = 1.3, p =.25). However, for beneficiaries of CCMHP's East County Child And Adolescent Services, there was a statistically significant reduction in missed appointments (X2(1) = 5.0, p = .03). *Rate of Completed Appointments among Successful Contacts:* For beneficiaries of the MHP's East Adult clinic, there was a statistically significant relationship between being successfully contacted and attending the first appointment X2 (1) = 11.19, p < .00. Among those who were successfully contacted, 68 percent attended the appointment whereas among those who were not contacted, 58 percent attended the first appointment. For beneficiaries of the MHP's East County Child And Adolescent Services, the relationship between being successfully contacted was not significantly related to attending the first appointment (X2(1) = .02, p = .89). Of beneficiaries who were successfully contacted, 73 percent attended the first appointment compared to 74 percent for those not successfully contacted.

9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The observed improvement in appointment adherence was sustained over each quarter of observation. The decrease in business days from referral to completed first appointment demonstrated an immediate improvement over the first quarter after implementing the PIP, and this improvement was sustained over the course of the PIP.
Totals	**4** Met 1 Partially Met	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions: Analysis of the data suggests that the PIP did have an impact on appointment non-adherence rates, but the impact was different for East Adult and East County Child And Adolescent Services. Overall, there was a statistically significant improvement in the percentage of missed appointments at East County Child And Adolescent Services from 35 percent missed appointments to 27 percent missed appointments. At this clinic there was not a significant relationship between successfully contacting a beneficiary and whether they attended the appointment. Also, there was not a statistically significant relationship between whether staff were able to leave a message for beneficiaries and appointment attendance. In fact, 74 percent of beneficiaries for whom a staff member was not able to leave a message reminder attended the appointment compared to 73 percent of beneficiaries for whom a staff member was able to leave a message; however, those beneficiaries who did not receive a message reminder no-showed at a higher rate than those who did (22 percent vs 16 percent) but had a higher cancellation rate (4 percent vs 10 percent). It is important to consider that

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

17 percent of beneficiaries for whom a staff member was unable to leave a message was due to the appointment being a same day appointment.

The largest issue impacting the comparability of initial and repeat measures is the use of a different report used for analysis of Rate of First Scheduled Outpatient Mental Health Missed Appointments for baseline and results. The use of a different report to capture results was necessitated by changes in workflows over the course of the PIP, in addition to identification of data integrity issues with the existing report.

PIP Validation	#s
Met	22
Partially Met	3
Not Met	0
UTD	0
# Not applicable	3
Score	94.00%
total items in rating	28

Recommendations

In response to CalEQRO feedback, the MHP performed a current and formal barrier analysis would provide better information upon which to base interventions; however, it did not make more measurable changes to the days the calls were made (not a range) to allow for comparison and duplication elsewhere.

Check one:

☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results

☒ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

☐ Confidence in PIP results cannot be determined at this time