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

COLUSA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 8, 2019

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INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on 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 Colusa 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 — Small-rural

MHP Region — Superior

MHP Location — Colusa

MHP Beneficiaries Served in Calendar Year (CY) 2018 — 690

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:

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[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.calegro.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: Measure results of interventions at least quarterly. This allows the opportunity to adjust PIPs if barriers to success are discovered.

Status: Met

- The MHP collected and analyzed PIP data monthly. Both PIPs utilized this approach and provided remeasurement data.

Recommendation 2: Clinical PIP: Add narrative analysis of what the PIP findings mean. Strengthen connections between engagement and clinical outcomes for the beneficiary in the initial description of the PIP. Provide more information on the limitations of the study, conclusions reached regarding the success of the interpretation of the PIP, and recommendations for follow-up.

Status: Met

- The PIP contains narrative analysis; furthermore, the MHP provided a literature review, which delineates the relationship between engagement, retention and positive impacts on beneficiaries. Limitations were also described.

Recommendation 3: Non-clinical PIP: Review the purpose of the PIP in terms of the beneficiaries. The purpose of the PIP is to correctly diagnose and therefore treat beneficiaries. This is a quality of care issue, not a process of care issue. Consider that this may be a clinical PIP. Add more description of how the interventions are accomplished. Increase the frequency of application of the measurements.

Status: Not Met

- The MHP submitted the Non-clinical PIP as a Clinical PIP; however, new interventions were not implemented, resulting in a rating of "inactive, developed in prior year." The MHP plans to continue this PIP for another 90 days for maintenance before ending the PIP and creating a new PIP.

Recommendation 4: Consult with EQRO early and often during the continuation of both PIPs.

Status: Partially Met

- The MHP consulted with CalEQRO in February 2019 and in May 2019 to discuss the possibility of a new Administrative PIP and to transition the current Administrative PIP to a Clinical PIP. The MHP did not develop any new PIPs.

Access Recommendations

Recommendation 5: Implement the new access system and track and report results, including improved timeliness and need for system adjustments.

Status: Met

- The new Access to Services Assessment (ASA) allows for automated reporting. The MHP worked diligently with Kings View to customize interfaces between them, completing the process in January 2019. Staff were trained in February 2019 and use of ASA was implemented in March 2019.
- The ASA allows for more accurate appointment tracking and assists the MHP with completion of the network adequacy compliance tools.

Recommendation 6: Collaborate with the Colusa Medical Center for the future psychiatric health facility (PHF) and opportunity to leverage psychiatry services through contracting time with psychiatrist that is employed by the PHF.

Status: Met

- The Colusa Medical Center has made a business decision not to pursue the PHF development. Initially, the hospital had approached the MHP for collaboration on a hospital wing conversion; however, it later decided not to go forward.

Recommendation 7: Continue working on the rapid rehousing program with training and continuation of the three to five years plan. The MHP invested in early training for Rapid Rehousing and now have two residents there who are Lanterman-Petris-Short Act (LPS) conservatees. The goal is to create a continuum of housing for beneficiaries leading to permanent housing.

Status: Met

- The MHP continues to develop the rapid rehousing program in accordance with the three-year plan and is looking into developing a new site for shared living for female beneficiaries.
- The MHP sent staff to multiple trainings regarding the development of housing continuums, entered into agreements with the local Housing Authority and placed multiple consumers in housing. The MHP acquired an additional property to address appropriate capacity challenges.

Timeliness Recommendations

Recommendation 8: Follow up with implementation of the Access to Services Assessment tool to facilitate the ability to track access to services and aggregate for review by the quality assurance (QA) committee.

Status: Met

- This recommendation of the ASA was addressed above in Recommendation 5.

Quality Recommendations

Recommendation 9: Develop bi-directional communication opportunities with staff that includes their voice in program decisions.

Status: Partially Met

- The MHP surveyed staff to identify communication preferences. Staff indicated that all-staff meetings and existing meeting groups were appropriate for updates; while departmental issues should be discussed in supervision. Staff are also encouraged to attend the Mental Health Board meetings. Peers and staff are also welcome to attend quality improvement (QI) meetings. The MHP continues to hold beneficiary leadership meetings at the peer drop-in center on a weekly basis; staff are invited to this meeting as well.
- Stakeholder feedback indicates that improvement is still needed and that meetings do not occur as scheduled.

Recommendation 10: Administer trainings for staff, specifically designed to increase awareness of staff stigma, lending to beneficiary recovery and a beneficiary-run wellness center. Create and administer a pre-test and post-test with remedial training as needed.

Status: Not Met

- The MHP administered a survey to its beneficiaries over a one-week period to gauge the degree that beneficiaries felt stigma was present in services and among staff. Of the 36 beneficiaries surveyed, the MHP did not find information that further supported CalEQRO's findings.
- While the survey is an initial step, the MHP did not administer trainings to staff nor evaluate staff perspectives/biases, which may unintentionally impact beneficiaries.

Outcomes Recommendations

Recommendation 11: Execute aggregate reporting to assess program outcomes for use in program and capacity planning.

Status: Partially Met

- The MHP uses customized dashboards to gather and aggregate data related to access and timeliness of services. The MHP uses the Milestones of Recovery Scale (MORS) outcome tool for adults and the Child Adolescent Needs and Strengths (CANS-50) and the Pediatric Symptom Checklist (PSC-35) for children. The MORS dashboard is currently available; however, the CANS-50 and PSC-35 dashboards are not. The MHP is planning to develop these dashboards.

Recommendation 12: Research the viability and usefulness of adding peer staff and/or clinical staff to the wellness center programs.

Status: Met

- The MHP relocated its wellness center, Safe Haven, to an improved location and workspace, allowing for more staff and peer one-on-one interaction or in a group setting. Five MHP staff members visit Safe Haven weekly to engage with beneficiaries. One staff member provides intake assessments on site. The MHP also has two new peer staff positions it plans to fill within the next few months.

Foster Care Recommendations

Recommendation 13: Research data to evaluate causes of the decline in Foster Care (FC) penetration rates over the past three years.

Status: Met

- The MHP investigated the decline in FC penetration rates and determined that the decline is attributable to a 45 percent increase in the number of FC eligibles over the past three years. This number does not account for presumptive transfer beneficiaries, Assembly Bill (AB) 1299, who may be receiving services from the MHP at any given time.
- In response to the higher number of beneficiaries, Department of Health and Human Services (DHHS) has chosen to hire their own therapists to respond to the immediate need for counseling for children in their care. The MHP continues to receive Katie A. and Child and Family Team (CFT) referrals for children with more significant behavioral health needs.

Recommendation 14: Develop the capability to enter Katie A. and AB 1299 information into the EHR.

Status: Met

- Within the EHR, the MHP added the capability to track beneficiaries who qualify for Katie A. mental health and/or medication services. The MHP can also track FC and/or presumptive transfer data. The MHP is now able to track with specificity all data related to timeliness and access to services.

Recommendation 15: Collaborate with Child Welfare Services (CWS) and Probation in trainings on joint Katie A. FC topics to include the Katie A. Core Practice Model (CPM).

Status: Met

- The MHP and CWS continue to have joint trainings related to behavioral health clinical issues including the CPM services and treatment outcomes.
- The MHP also reviews CPM concepts in group supervision, individual supervision and treatment team meetings. Staff also have an electronic copy of the CPM manual.

Recommendation 16: Continue to work with DHHS as they identify and determine foster family agencies (FFA) that will serve as therapeutic foster care (TFC) agencies.

Status**:** Met

- DHHS continues to act in this capacity as there are no local FFAs. There are also no local TFC facilities available for FC placement. CWS recruits through a Resource Family Approval (RFA) program. They outreach in the community using billboard signs. They do not currently use social media or radio to advertise.

Information Systems Recommendations

Recommendation 17: Begin to extract aggregate data for MORS to analyze program successes.

Status: Partially Met

- The MHP created a policy and procedure for MORS submissions to ensure that data is available to analyze. Currently, there is not a large enough sample size to analyze for program success based upon MORS. The Clinical Program Manager in adult mental health services has agreed to provide a MORS training to clinical staff to maintain the validity of the measurement.

Recommendation 18: Complete development and implementation of electronic extraction of referrals to Anthem Blue Cross, FC youth and their medications, Katie A., and AB 1299.

Status: Met

- This recommendation is also addressed above in Recommendation 14. The MHP now has the ability to track FC youth, Katie A. and AB 1299 presumptive transfer referrals.
- The MHP uses the ASA to track referrals back to Anthem Blue Cross and California Health and Wellness. Cerner has not moved forward with creating a beneficiary portal and the MHP is unable to use the portal as intended to make referrals to other healthcare providers.

Recommendation 19: Resolve missing data issue with the Access to Services Assessment and implement use. Train staff once assessment is reconfigured and the remediation has been completed.

Status: Met

- This recommendation was previously addressed above in Recommendation 5.

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

Recommendation 20: Analyze no-shows for both psychiatry and clinical appointments to assess reasons for no-shows. Initiate interventions to resolve these issues. Track success rates in order to reassess and improve appointment rates. Utilize new Kings View dashboards to facilitate pulling this information.

Status: Partially Met

- The MHP utilized its EHR dashboard to track and trend data on psychiatry and clinical no-shows for the month of June 2019. Transportation issues were identified as a contributor to no-shows. The MHP is considering transportation support for psychiatric appointments as well as scheduling reminder phone calls and letters for clinical appointments.

Recommendation 21: Design and administer trainings for staff, specifically to increase awareness of stigma they may bring to the beneficiaries, lending to beneficiary recovery and a beneficiary-run wellness center. Create and administer a pre-test and post-test with remedial training as needed for all staff.

Status: Not Met

- This recommendation was previously addressed under Recommendation 10.

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 Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

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

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, day treatment 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.

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[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 Colusa MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	1,700	17.1%	270	39.1%
Latino/Hispanic	6,981	70.1%	317	45.9%
African-American	63	0.6%	13	1.9%
Asian/Pacific Islander	107	1.1%	*	n/a
Native American	102	1.0%	*	n/a
Other	1,002	10.1%	70	10.1%
Total	**9,953**	**100%**	**690**	**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.				

Penetration Rates and Approved Claims per Beneficiary

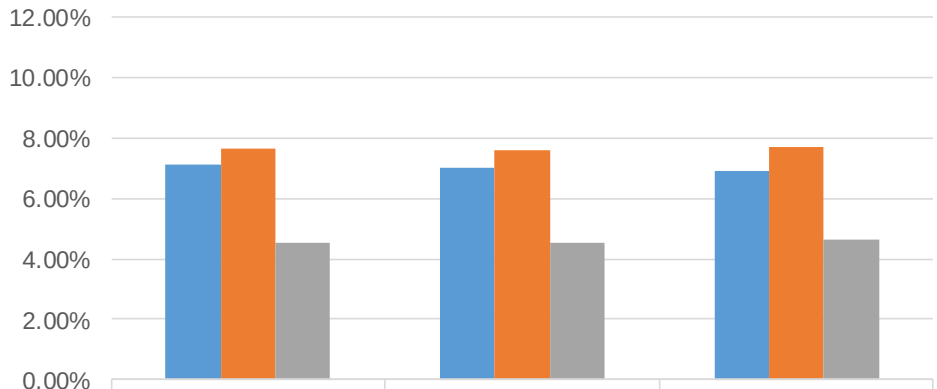
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated 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 Colusa MHP uses a different method than that used by CalEQRO.

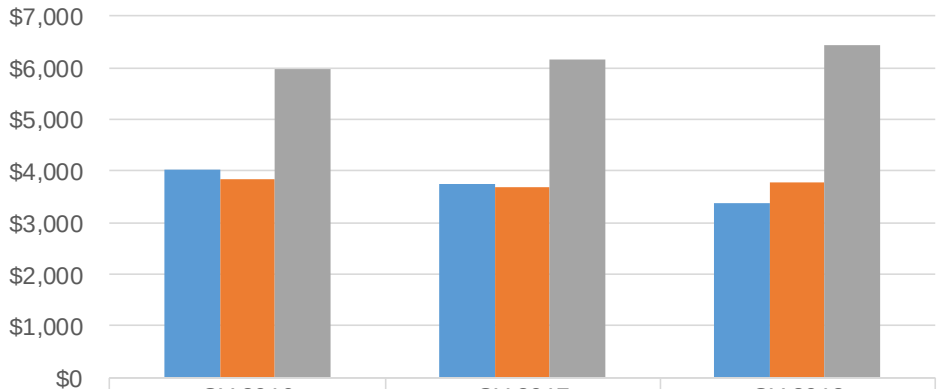
Figures 1A and 1B show three-year (CY 2016-18) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 1A. Overall Penetration Rates
Colusa MHP



	CY 2016	CY 2017	CY 2018
Colusa	7.12%	7.01%	6.93%
Small-Rural	7.66%	7.58%	7.71%
State	4.53%	4.52%	4.66%

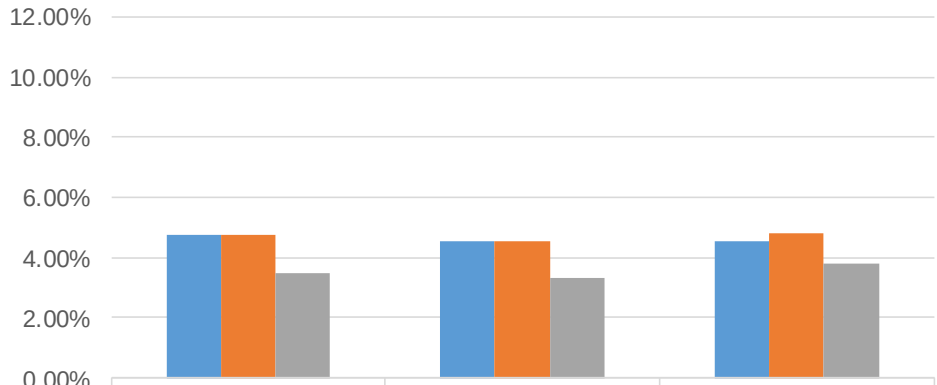
Figure 1B. Overall ACB
Colusa MHP



	CY 2016	CY 2017	CY 2018
Colusa	$4,036	$3,735	$3,371
Small-Rural	$3,845	$3,692	$3,794
State	$5,978	$6,170	$6,454

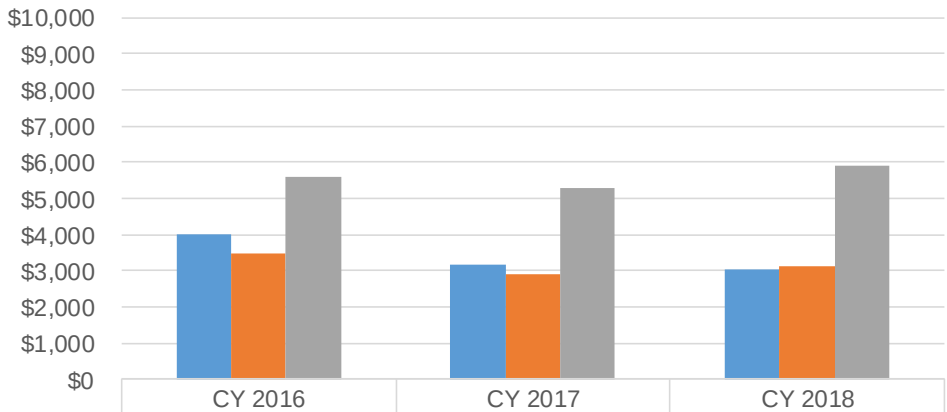
Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 2A. Latino/Hispanic Penetration Rates
Colusa MHP



	CY 2016	CY 2017	CY 2018
Colusa	4.76%	4.55%	4.54%
Small-Rural	4.77%	4.54%	4.79%
State	3.51%	3.35%	3.78%

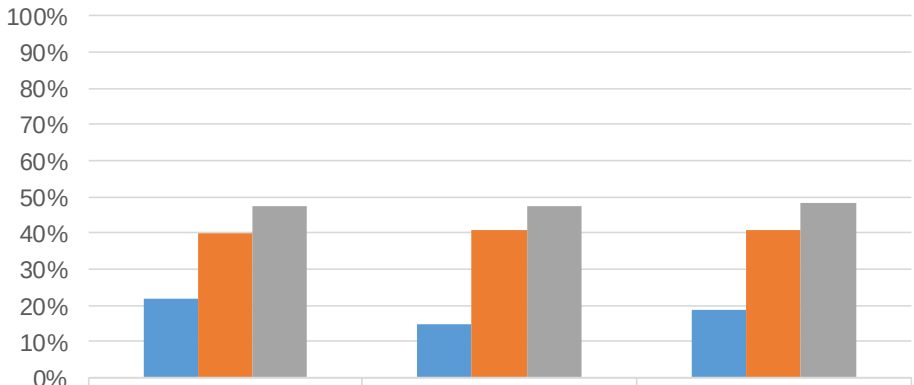
Figure 2B. Latino/Hispanic ACB
Colusa MHP



	CY 2016	CY 2017	CY 2018
Colusa	$3,990	$3,188	$3,052
Small-Rural	$3,499	$2,886	$3,146
State	$5,588	$5,278	$5,904

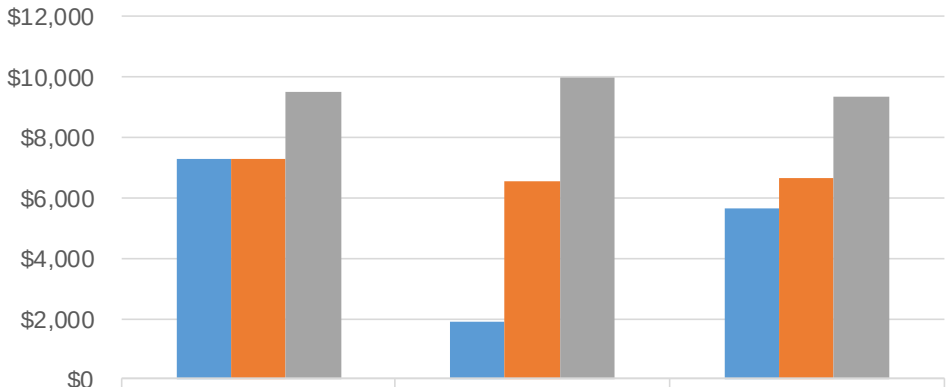
Figures 3A and 3B show three-year (CY 2016-18) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 3A. FC Penetration Rates
Colusa MHP



	CY 2016	CY 2017	CY 2018
Colusa	21.62%	14.58%	18.87%
Small-Rural	39.90%	40.96%	40.58%
State	47.48%	47.28%	48.41%

Figure 3B. FC ACB
Colusa MHP



	CY 2016	CY 2017	CY 2018
Colusa	$7,278	$1,875	$5,647
Small-Rural	$7,290	$6,553	$6,630
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
Colusa 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	*	690	n/a	$40,200	-	n/a
	CY 2017	*	665	n/a	$54,318	-	n/a
	CY 2016	*	669	n/a	$55,796	-	n/a

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.

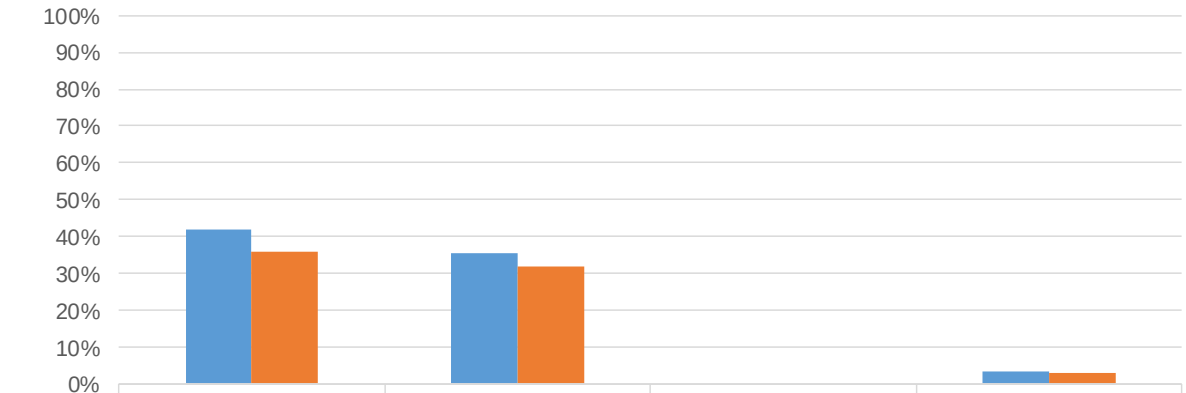
Table 3. Psychiatric Inpatient Utilization - Colusa MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2018	16	20	7.5	$9,965	$159,439
CY 2017	12	18	10.87	$12,314	$147,772
CY 2016	14	16	10.8	$11,593	$162,296

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

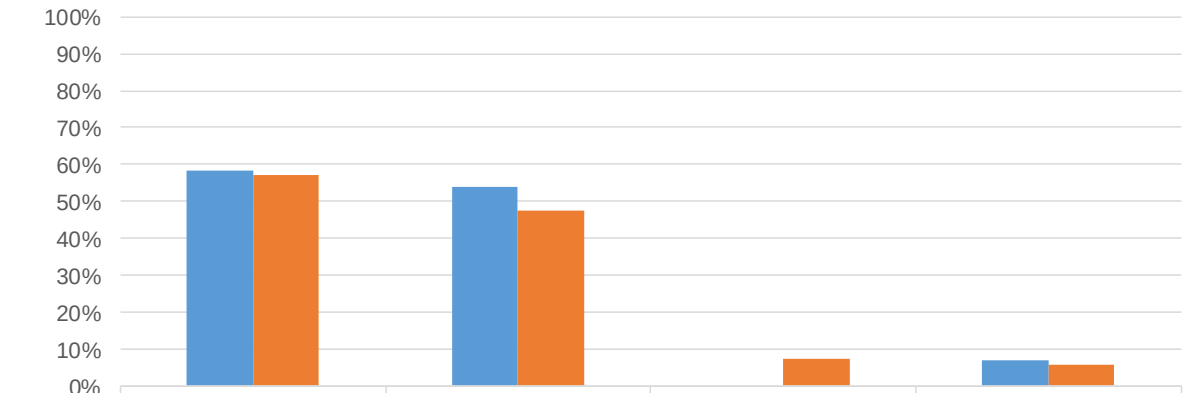
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2017 and CY 2018.

Figure 4A. 7-Day Post-Psychiatric Inpatient Follow-up
Colusa MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	42%	36%	0%	3%
CY 2018	36%	32%	0%	3%

Figure 4B. 30-Day Post-Psychiatric Inpatient Follow-up
Colusa MHP



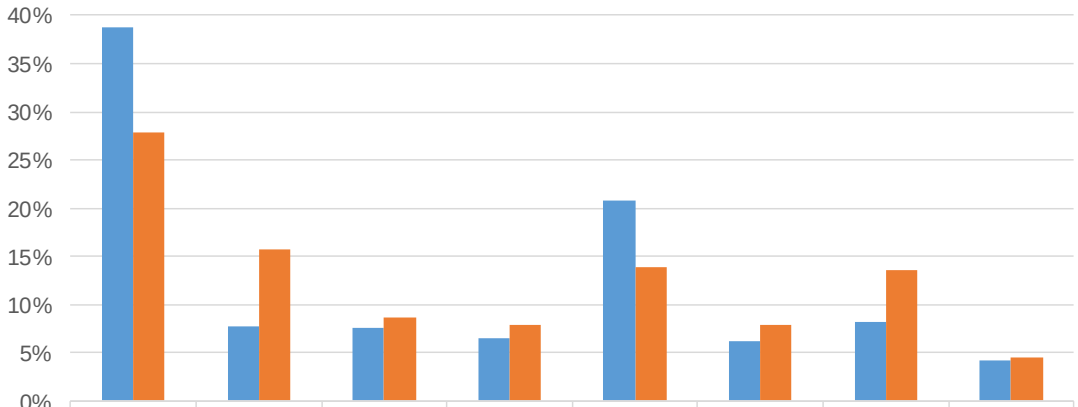
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	58%	54%	0%	7%
CY 2018	57%	48%	7%	6%

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.

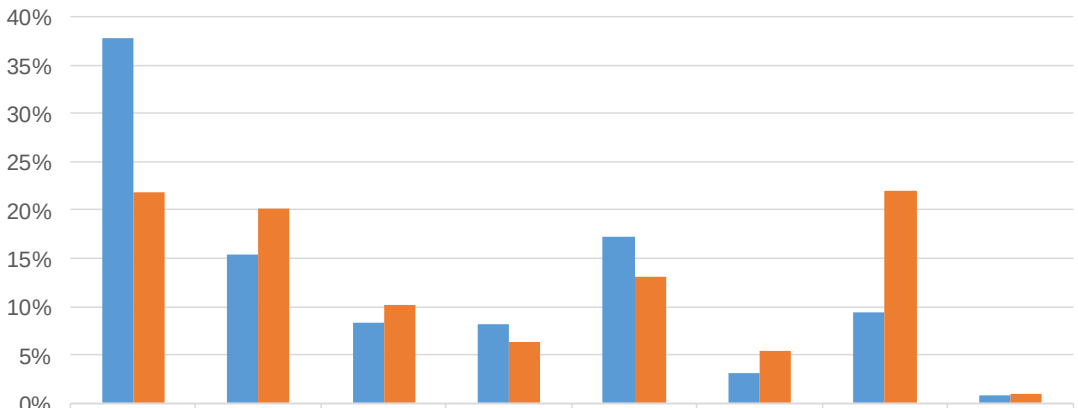
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 30 percent.

Figure 5A. Diagnostic Categories, Beneficiaries Served
Colusa MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	39%	8%	8%	7%	21%	6%	8%	4%
State CY 2018	28%	16%	9%	8%	14%	8%	14%	5%

Figure 5B. Diagnostic Categories, Total Approved Claims
Colusa MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	38%	15%	8%	8%	17%	3%	9%	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.

Colusa 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 one PIP, as shown below.

Title 42, CFR, §438.330 requires two PIPs; the MHP is urged to meet this requirement going forward.

Table 4 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 4: PIPs Submitted by Colusa MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Co-occurring Disorders
Non-clinical PIP	1	Engagement

Clinical PIP—Co-occurring Disorders

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

"Will enhanced focus on the diagnosis of co-occurring disorders increase the percentage of such diagnoses from an average of 16 percent to an average closer to the nationwide average of 40 percent?"

Date PIP began: May 2018

Projected End date: December 2019

[5] 2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.

Status of PIP: Inactive, developed in a prior year (not rated)

This PIP was originally a Non-clinical PIP. Upon review of the interventions, CalEQRO determined that it would be better classified as a Clinical PIP. This Clinical PIP focuses on increasing the accuracy of diagnosis, in particular, diagnoses related to co-occurring disorders. This PIP was developed over one year ago and was presented at the last EQRO review as a Non-clinical PIP. No new interventions were implemented. At that time, recommendations were made to strengthen the PIP; however, the MHP did not incorporate the recommendations moving forward. Recommendations included framing the PIP in terms of improved outcomes for beneficiaries and change the PIP from Non-Clinical to Clinical to reflect the quality of care issue; furthermore, clear indicators, which measure beyond the co-occurring rate, would be useful to gauge the impact on beneficiaries. The MHP was encouraged to consult with EQRO early and often during the continuation of this PIP.

Suggestions to improve the PIP: This PIP would benefit from a barrier/cause analysis with the results used to identify and select an appropriate clinically focused intervention to improve outcomes.

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 by CalEQRO consisted of outlining the steps needed to establish a firm foundation for a PIP. These include using data to identify problems, causes and/or barriers related to problems, and linked indicators.

Non-clinical PIP—Engagement

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

“Will changes in our engagement process increase the percentage of beneficiaries who remain engaged in treatment beyond three clinical sessions from the current average of 75 percent to an average of 85 percent?”

Date PIP began: March 2017

{Projected} End date: Not stated.

Status of PIP: Active and ongoing

This PIP was originally a Clinical PIP. Upon review of the interventions, CalEQRO determined that it would be better classified as a Non-clinical PIP. This PIP was conceptualized in March 2017, and then became active in 2018. The MHP identified that an average of 25 percent of beneficiaries drop out of care before the third post-intake clinical session. This PIP used interventions that correlate with increased engagement, intending to accomplish better treatment outcomes. The goal is to increase the percentage of beneficiaries that remain in treatment beyond three clinical

sessions from 75 percent to 85 percent. Initially, the MHP implemented telephone calls, an engagement survey, and thank you letters.

For this last year, new interventions included sending post cards and offering transportation (October 2018) to beneficiaries and tracking referrals. Also, in October 2018, the MHP began using a data-tracking log, which was restructured and organized, and guided staff during initial interactions with beneficiaries. The MHP created a call-script to follow when contacting beneficiaries who did not remain engaged in treatment beyond 60 days (December 2018). In March 2019, staff were trained and began using the ASA which allows the MHP to track beneficiary postcards and transportation offers.

Suggestions to improve the PIP: Ultimately, the new interventions did not have a positive impact. A barrier analysis is needed to determine the causes of the problem, and in-turn, identify the most appropriate intervention, with a high probability of success; furthermore, statistical methods should be reviewed and employed for future PIPs. The PIP needs additional analysis and an explanation regarding the findings and clinical impact on beneficiaries. Beneficiary stakeholder participation is needed both at the onset of planning and throughout the process as well. A barrier analysis would provide information to select interventions which would have a high probability of succeeding. More information is needed on limitations of the study described, conclusions reached regarding the success of the interpretation of the PIP and recommendations for follow-up.

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

The TA provided to the MHP by CalEQRO consisted of discussion on interventions and choosing interventions based on barrier/cause analysis to improve the likelihood of success.

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	NR	PM
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	M
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	M
		1.4	All enrolled populations	NR	M
2	Study Question	2.1	Clearly stated	NR	PM
3	Study Population	3.1	Clear definition of study population	NR	M
		3.2	Inclusion of the entire study population	NR	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	M
		4.2	Changes in health states, functional status, enrollee satisfaction, or processes of care	NR	PM
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	NA
		5.2	Valid sampling techniques that protected against bias were employed	NR	NA
		5.3	Sample contained sufficient number of enrollees	NR	NA
6	Data Collection Procedures	6.1	Clear specification of data	NR	M
		6.2	Clear specification of sources of data	NR	M
		6.3	Systematic collection of reliable and valid data for the study population	NR	M

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

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	0	14
Number Partially Met	0	6
Number Not Met	0	4
Unable to Determine	0	1
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	28	25
Overall PIP Ratings ((#M*2) +(#PM))/(AP*2)	**0%**	**68%**

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
Colusa	6.00%	6.60%	5.50%	7.20%
Small Rural MHPs	N/A	4.20%	3.70%	3.80%
Statewide	N/A	3.40%	3.30%	3.40%

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

The budget determination process for information system operations is:

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	99.5%
Contract providers	0.5%
Network providers	0.0%
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 EHR system by contract provider staff	0%	Not used
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 EHR system	100%	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

- The MHP does not utilize contract providers that serve beneficiaries within the county service area to provide outpatient services locally in a clinic/program setting. The MHP reports that there are no contract providers available in the area.

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☐ Yes ☒ No ☐ In pilot phase

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	3	0	0	0
2018-19	3	0	0	0
2017-18	3	0	0	0

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	0	0	0	0
2018-19	0	0	0	0
2017-18	0.38	0	0	0

The following should be noted with regard to the above information:

- The three technology FTEs are MHP staff.
- Data analytics support is provided by Kings View, MHP QI and technology staff.

Current Operations

- The MHP's EHR is Cerner Community Behavioral Health (CCBH) with Promotion 229.03.
- Kings View hosts CCBH as an Application Service Provider (ASP).
- The EHR also captures services provided to beneficiaries in jail.
- PSC-35 and CANS-50 have been implemented and are being utilized.
- Tableau is used to create the MHP's dashboards.
- The MHP utilizes Sierra Mental Wellness for after-hours support.

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
CCBH	Client Data System	Cerner	8	Kings View
CCBH	Assessment Treatment Plans	Cerner	8	Kings View
CCBH	Scheduling	Cerner	8	Kings View
CCBH	Doctor's Homepage	Cerner	8	Kings View
CCBH	ePrescribing	Cerner	8	Kings View

The MHP's Priorities for the Coming Year

- Establish protocols and procedures for reporting timeliness.
- Work with Kings View to train MHP management staff on using dashboards and fine-tuning the specific reporting capabilities of existing dashboards.
- Discerning and reporting needed EHR changes to Kings View to accommodate pending certification for DMC.
- Ongoing staff training in system, account repairs, training focus sheets.

Major Changes since Prior Year

- Upgraded CCBH to Promotion 229.03.
- Completed initial set of dashboards and use of data for the Quality Improvement Committee (QIC). In the last year, the MHP focused on developing tools to track timeliness reporting and to present aggregated beneficiaries/services data via dashboards. Dashboards are available for Mental Health, Substance Use Disorders and Dual Diagnosis. Live dashboards include Demographics, Case Assignment, MORS and Service Entry. Dashboards in development include CANS-50, PSC-35 and Productivity
- Implemented custom Access to Service Assessment to capture data for initial contact, initial appointment, Access, Psychiatric Services and Therapy Services.
- The MHP developed a Transition of Care Assessment to track referrals to Anthem Blue Cross and California Health and Wellness Health Plans; however, they are not able to use this tool until a beneficiary portal is developed on the Millennium platform.
- In response to a 2018-19 recommendation on declining Katie A. penetration rates, the MHP added capability in the EHR to track six Katie A. sub-units for better data collection and reporting.
- Completed MHP responsibility for beneficiary portal set-up.
- Developed Network Adequacy reporting.

Other Areas for Improvement

- CY 2018 claims data show that the MHP continues to have a lower Katie A. penetration rate than Small-Rural MHPs and Statewide, and this has been the trend for the last several years.
- Providers used to have laptops to support field-based work, but laptops are no longer available to them. Documentation and notes written will then be entered

into the EHR when they return to the clinic. Staff return to the office at least daily, if not multiple times per day. The lack of devices to support field-based work has compromised providers' productivity.

Plans for Information Systems Change

- The MHP has been in discussions with Kings View to upgrade to Cerner Millennium when the system is operational at a future date.

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	Cerner/CCBH	X			
Assessments	Cerner/CCBH	X			
Care Coordination	Cerner/CCBH		X		
Doc. Imaging/Storage	Cerner/CCBH	X			
Electronic Signature—MHP Beneficiary	Cerner/CCBH	X			
Laboratory results (eLab)	Cerner/CCBH		X		
LOC/LOS	Cerner/CCBH	X			
Outcomes	Cerner/CCBH	X			
Prescriptions (eRx)	Cerner/CCBH	X			
Progress Notes	Cerner/CCBH	X			
Referral Management	Cerner/CCBH		X		
Treatment Plans	Cerner/CCBH	X			
Summary Totals for EHR Functionality:					
FY 2019-20 Summary Totals for EHR Functionality:		9	3	0	0
FY 2018-19 Summary Totals for EHR Functionality*:		8	3	1	0
FY 2017-18 Summary Totals for EHR Functionality:		8	1	2	1

*Two new EHR functionalities were added to the list beginning in FY 2017-18.

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

- Implemented beneficiary electronic signature pads.

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

If no, provide the expected implementation timeline.

☐ Within 6 months	☒ Within the next year
☐ Within the next two years	☐ Longer than 2 years

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Web-based application, with support from Kings View.

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 Colusa MHP							
Service Month	**Number Submitted**	**Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Dollars Adjudicated**	**Dollars Approved**
TOTAL	**11,755**	**$2,384,091**	**155**	**$21,309**	**0.89%**	**$2,362,782**	**$2,221,622**
JAN18	1,071	$217,744	26	$2,752	1.26%	$214,992	$201,507
FEB18	965	$192,903	28	$2,690	1.39%	$190,213	$176,164
MAR18	1,140	$225,759	11	$2,360	1.05%	$223,399	$209,321
APR18	1,048	$213,212	7	$582	0.27%	$212,630	$199,461
MAY18	1,042	$236,289	11	$1,123	0.48%	$235,166	$215,741
JUN18	918	$182,369	9	$914	0.50%	$181,455	$170,889
JUL18	937	$191,229	16	$2,539	1.33%	$188,690	$178,010
AUG18	1,101	$212,878	7	$807	0.38%	$212,071	$201,062
SEP18	928	$190,992	11	$919	0.48%	$190,073	$179,909
OCT18	1,045	$185,519	11	$1,223	0.66%	$184,296	$176,622
NOV18	899	$187,499	12	$4,909	2.62%	$182,590	$168,888
DEC18	661	$147,697	6	$490	0.33%	$147,207	$144,047
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.**							

Table 15 summarizes the top three reasons for claim denial.

Table 15. Summary of CY 2018 Top Three Reasons for Claim Denial Colusa MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Medicare or Other Health Coverage must be billed before submission of claim.	138	$14,457	68%
Invalid procedure code and modifier combination OR single service exceeds maximum minutes per day.	1	$3,990	19%
Beneficary not eligible. OR Emergency services or pregnancy indcator must be "Y" for this aid code.	9	$1,680	8%
TOTAL	155	$21,309	N/A
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

CONSUMER AND FAMILY MEMBER FOCUS GROUP

CalEQRO conducted one 90-minute focus group 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 originally requested two focus groups with 10 to 12 participants each, the details of which can be found in each section below. Through collaborative planning, the MHP and CalEQRO mutually decided that one focus group was sufficient.

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.

CFM Focus Group One

CalEQRO requested a culturally diverse group of adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. As mentioned above, the review moved forward with one group. Group attendees included both adult males and females, who identified as either Hispanic/Latino or Caucasian. The focus group was held at Colusa County Behavioral Health, 162 E. Carson St., Colusa, CA. 95932.

Number of participants: Eight

There were no participants who entered services within the past year. Participants described their experience as the following:

- Participants first learned about services through the wellness center Safe Haven, the Friday Night Live youth program, school, television or church.
- Participants felt well-informed regarding community mental health through the MHP offices, the wellness center and through case managers.
- Participants received weekly, bi-weekly and monthly therapy. All felt that the frequency of services was sufficient to improve functioning.
- For the few who receive psychiatry services on a monthly basis, participants were satisfied with the frequency and level of care. For those who receive medications, they indicated that medication information was provided to them.
- All participants were aware of how to access urgent/crisis services.
- All participants felt that they were involved in their own treatment plan.

Participants' recommendations for improving care included the following:

- Improve communication between staff and upper management to decrease trickle down into the system of care for beneficiaries.
- Provide other transportation options aside from public transportation vouchers.
- Increase and invite beneficiaries to be more involved in system planning.
- Bring back the Wellness Recovery Action Plan (WRAP) group.

Interpreter used for focus group one: 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	14
Service access is supported through collaboration, transportation and expanded services. The MHP collaborates with Cachil Dehe Band of Wintun Indians of the Colusa Indian Community through a memorandum of understanding (MOU), and has a system in place for tracking referrals. Transportation for beneficiaries is provided through the MHP in public transportation vouchers. In April 2018, the MHP added a second day for "open intake" that now includes both Tuesdays and Thursdays.			
1B	Capacity Management	10	10
Demographic information is collected at intake, and reports are run on a monthly basis and discussed in QIC meetings. The MHP monitors productivity and provides monthly reports to staff. Case assignments are monitored by program managers. Program managers monitor capacity through dashboards. Currently there are no vacancies in adult services, with six of the seven direct service staff being licensed. There are two vacancies in the children's services. Currently, there are four filled positions, two are licensed. The MHP offers Spanish-speaking parents coping skills classes so they can support their children while waiting for treatment; however, due to staff turnover, there is currently only one Spanish-speaking service provider.			

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
1C	Integration and Collaboration	24	24
The MHP actively collaborates with other community agencies. They provide counseling services in schools and provide the Friday Night Live youth program for teens. They are also working on a suicide prevention program, which includes varied programming for preschools, elementary schools and high schools. The MHP also provides services at the local emergency room daily. More currently, the MHP is working on a disaster preparedness plan with Public Health. While the MHP meets monthly with its managed care organizations, it does not have a contract and instead, uses single case agreements.			

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	14
The MHP began capturing first offered appointment data in February 2019. 66.89 percent of appointments meet the goal, 71.65 percent for adults, and 56.45 percent for children. The MHP also reported on FC first offered appointments, but the number of beneficiaries was low. The MHP has not initiated performance improvement activities with time-limited goals when the DHCS standard is not consistently met. The MHP has developed forms in the EHR to capture timeliness data related to initial request, assessment and first appointment. Reporting client and service information (CSI) and timeliness assessment information is its system priority.			
2B	Assessment Follow-up and Routine Appointments	8	4
Average length of time between assessment appointment and first offered treatment session is 15.22 days. Data was not separated out by system component or special population; however, the MHP will be tracking in the future.			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
2C	First Offered Psychiatry Appointment	12	12
Overall, 78.26 percent of appointments meet the standard (73.33 percent for adults, 85.71 percent for children). FC data was provided, but the sample size is too small to include here.			
2D	Timely Appointments for Urgent Conditions	18	8
The MHP does not differentiate between an urgent request for service and a crisis service. They are treated the same. The MHP's standard is to respond to and engage the beneficiary within ten minutes. They also do not screen for pre-authorization requirements due to these services being an urgent/crisis request. The MHP reports that 100 percent of urgent appointments are responded to within 48 hours. The MHP has an internal process between on-call crisis workers and reception staff who check for authorization requirements in less than 96 hours (reportedly). This is not tracked.			
2E	Timely Access to Follow-up Appointments after Hospitalization	10	8
The MHP met the 7-day follow-up standard for two-thirds of its inpatient discharges. The MHP needs to look into ways to increase the numbers of appointments that meet this standard.			
2F	Tracks and Trends Data on Rehospitalizations	6	6
The MHP reported an annual 30-day readmission rate of 8.33 percent, similar to what CalEQRO calculated for CY 2018.			
2G	Tracks and Trends No-Shows	10	10
The MHP has set a standard of no more than 20 percent no-show rates for both clinicians and psychiatrists. Its own assessment showed 10.42 percent and 15.05 percent no-show rates for clinicians and psychiatrists respectively. The MHP should examine how it can reduce its psychiatry no-show rates.			

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
Beneficiaries in the EQRO focus group expressed being very involved in their treatment planning and care. QA reviews medical necessity scores and coordinates case assignment. Locally, there is one board and care facility. The MHP has 15 slots for Full-Service Partnership (FSP) beneficiaries. There is a plan to step down beneficiaries to less intensive care when goals are met. Goals are defined by life domains.			
3B	Quality Improvement Plan	10	6
The MHP produced an annual evaluation of its work plan. The current work plan contains minimally measurable goals and does not contain analysis of disparity in services by site/region/population served.			
3C	Quality Management Structure	14	11
The MHP has a designated Quality Management (QM) unit that interfaces with other MHP divisions/units/departments with a designated Quality Improvement Coordinator/Manager. There are several meetings where information is shared. The QIC meetings are quarterly along with compliance meetings. The Cultural Competence Committee (CCC) meets quarterly. All-staff meetings are held quarterly, with supervision weekly. The QIC completed its network adequacy through data collected and reported on through dashboards. Beneficiary participation in the QIC meetings is lacking.			
3D	QM Reports Act as a Change Agent in the System	10	7
The current work plan contains minimally measurable goals. The new ASA allows for automated data collection for reporting. QA can now rely on this data to evaluate timeliness and access. The MHP has one active PIP. The other PIP was developed in a prior year, with no new interventions in the last year.			

3E	Medication Management	12	7
The MHP monitors medication for FC children using the court/social services forms (JV 220 and 221). There is a designated nurse at CWS who tracks and informs FC parents and caregivers. For medication prescribing patterns, the MHP relies on concurrent review. Psychiatry's medication management team tracks due dates and lab tests for everyone.			

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	15
The MHP utilizes dashboards for outcome reporting in addition to reporting on access and timeliness. The MORS is used to evaluate outcomes for adult beneficiaries while the CANS-50 and PSC-35 is used for children and youth beneficiaries. Currently, the MORS dashboard is available; while CANS-50 and PSC-35 dashboards are in the development process. Program Managers have access to the dashboards to better manage treatment teams and make staffing decisions to optimize capacity.			
4B	Beneficiary Perceptions	10	10
The MHP administers the Consumer Perception Survey (CPS) from DHCS; however, they do not enter their own data prior to submission to the State. The MHP also provides its own surveys to beneficiaries. In March 2019, the MHP provided a survey on welcoming environments. As a result, an improvement project is in the works.			
4C	Supporting Beneficiaries through Wellness and Recovery	4	4
The MHP's wellness center, Safe Haven, moved to an improved location in April 2019. The building is smaller and located in town. Beneficiaries like the open concept group room and kitchen with better light and wood floors. Therapists can provide			

services onsite. This last year, the MHP shifted to a program-driven wellness center model and discontinued the drop-in peer support component. Safe Haven's Leadership Committee meets to make decisions for their center and peer staff meet monthly to plan programs. The MHP will be hiring two more part-time peer support specialists.

Structure and Operations

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

Table 20: Structure and Operations Components			
Component		**Quality Rating**	
5A	Capability and Capacity of the MHP	30	17
The MHP provides a variety of services: 1) mental health; 2) medication support; 3) case management; 4) crisis intervention and daytime crisis stabilization. Intensive Care Coordination, Intensive Home-Based Services, Therapeutic Behavioral Services, and TFC are also provided. The MHP does not provide day treatment or rehabilitation, nor do they have a psychiatric health facility or inpatient hospital. The MHP contracts with hospitals in Sacramento, Red Bluff and Redding. The MHP has a vehicle for mobile crisis response; however, it lacks funding for a mobile crisis response team. On-call crisis workers respond to crises via phone, face-to-face in office, to the county hospital emergency room, and in the field by mobile crisis. The MHP has contracted with Sierra Mental Wellness to provide crisis response after-hours, on the weekends, and on holidays.			
5B	Network Adequacy	18	9
The MHP utilizes its wellness center and behavioral health home to support its services. They do not utilize telehealth or have other network/contract providers.			
5C	Subcontracts/Contract Providers	16	0
The MHP reports that it does not have subcontract or contract providers.			
5D	Stakeholder Engagement	12	4
Line staff indicated the need for increased transparency and improved communication from leadership/management. For example, there used to be monthly staff meetings, which were reduced to quarterly, and now are not scheduled. Communication is			

primarily through email.

Beneficiaries received information from the MHP through a variety of means, including flyers, website, case managers and therapists. Most had participated in EQRO before and a few had participated on committees or other feedback venue. For those who had not, the consensus was that they would like the opportunity to participate on committees.

5E	Peer Employment	8	3

While there are limited peer employee positions, there is no career ladder or opportunity for advancement apart from individuals getting an advanced degree. Also, the MHP does not have collaboration with the Department of Rehabilitation as the nearest office is out of county.

5F	Peer-Run Programs	10	9

Safe Haven Wellness and Recovery Center is located at 517 Oak Street in Colusa. Operational hours are Monday- Saturday 9:00 a.m. – 4:30 p.m. It is a peer-run center open to everyone age 16 and older. Counseling, Support groups, activities, arts and crafts and social activities as well as life and job skills are offered. Beneficiaries are informed about the center through brochures, flyers, calendars located at the MHP office, through case managers, therapists and the Colusa County website.

5G	Cultural Competency	12	8

The MHP provides outreach and engagement in Spanish in outlying areas of the county (Arbuckle, Williams, Colusa).

The MHP has a demographics dashboard. A comprehensive penetration report is reviewed regularly; however, an example of how the metrics are used to improve service delivery and access was not.

Cultural competency was addressed in the Annual Work Plan with the goal of providing training to staff on various cultures and outreaching the Hispanic community.

SUMMARY OF FINDINGS

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

MHP Environment – Changes, Strengths, and Opportunities

PIP Status

Clinical PIP Status: Inactive, developed in a prior year (not rated)

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

- Staff turnover has led to a net loss of Spanish-speaking providers. At the time of the review, there was one Spanish-speaking clinician supporting both the adult and children systems of care.

Strengths:

- The MHP has received county General Funds to hire four Mental Health Specialists.

Opportunities for Improvement:

- As recommended last year, the MHP did not administer stigma related trainings to staff nor evaluate staff perspectives/biases, which may unintentionally impact beneficiaries.
- The MHP lacks Spanish-speaking providers.
- Colusa county has a transit service that runs limited routes and only operates until 5:00 PM. Stakeholders indicated that some beneficiaries had missed appointments due to lack of transportation.

Timeliness of Services

Changes within the Past Year:

- The MHP implemented the custom ASA to capture data for initial contact, initial appointment, Access, Psychiatric Services and Therapy Services.

Strengths:

- First psychiatry appointments are in-line with network adequacy standards.

Opportunities for Improvement:

- 66.89 percent of first offered assessment appointments meet the 10-day goal. The MHP has not initiated performance improvement activities with time-limited goals when the DHCS standard is not consistently met.
- The MHP does not differentiate between an urgent request for service and a crisis request for service, nor are they tracked. The MHP states that all requests are responded to within ten minutes.
- 66.67 percent of follow-up appointments after hospitalization meet the 7-day standard. Further information and possibly a process change is needed to increase the numbers of appointments that meet this standard.

Quality of Care

Changes within the Past Year:

- The MHP is creating several multidisciplinary treatment teams to begin service in September 2019.
- Safe Haven, the wellness center, moved locations to a more open and accessible building (April 2019).

Strengths:

- The MHP has a full time in person psychiatrist who sees both adults and children.

Opportunities for Improvement:

- QIC meetings lack any beneficiary participation.
- There are limited peer positions, with no career ladder nor connections to the Department of Rehabilitation.
- Beneficiaries expressed interest in participating on committees and program planning but did not know how to get involved.
- Stakeholders indicated the need for improved communication between leadership/management and direct service staff that results in delayed receipt of information.

Beneficiary Outcomes

Changes within the Past Year:

- Clinical staff received training on CANS-50 and PSC-35.

Strengths:

- The Wellness Center, Safe Haven, relocated to a better downtown location and it is open six days/week.
- The MHP built a MORS dashboard that presents aggregated data and plans to use it to measure adult programs efficacy.

Opportunities for Improvement:

- The MHP is able to aggregate MORS data but does not due to small sample size; further, it is not able to aggregate CANS-50 and PSC-35 data for system-wide program evaluation.

Foster Care

Changes within the Past Year:

- The MHP added capability in the EHR to create “assignments” in the EHR for clients who qualify as Katie A., need medication, or are who are receiving services under presumptive transfer/AB1299.

Strengths:

- The MHP and CWS are jointly under the DHHS which facilitates collaboration.
- CWS employs a FC nurse who tracks medication follow-up and provides information to parents.

Opportunities for Improvement:

- CY 2018 claims data show Colusa continues to have a lower Katie A. penetration rate than Small-Rural MHPs and Statewide.

Information Systems

Changes within the Past Year:

- Implemented Beneficiary Electronic Signature by installing signature pads.
- Completed an initial set of dashboards to produce aggregated data for program evaluation and planning.
- Improved on tools to capture data for timeliness measures.
- Clinical staff were trained on CANS-50 and PSC-35.

Strengths:

- The MHP has added forms and sub-units in the EHR to support reporting needs and improve data collection on FC beneficiaries.

Opportunities for Improvement:

- Providers need laptops to record documentation and notes when they work in schools and other community settings. Not having devices to support their work in the field has significantly impacted their productivity.

Structure and Operations

Changes within the Past Year:

- The treatment team staffing and hiring budget was expanded by one million dollars for rehab services through General Service funds. This is to align with MHSA efforts.
- The MHP created new positions and are hiring now for four rehab specialists (mental health specialists).
- The MHP was recently denied certification for Drug Medi-Cal. They plan to reapply.

Strengths:

- Data analytics support is provided by Kings View and MHP QI and technology staff.

Opportunities for Improvement:

- None noted.

Recommendations:

- None noted.

FY 2019-20 Recommendations

PIP Status

- **Recommendation 1:** As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. The MHP should consult with CalEQRO on a regular basis especially in the early months of PIP planning to ensure that each of the PIP sections are fully developed, with a data-defined problem, a barrier/cause analysis and appropriate interventions.

Access to Care

- **Recommendation 2:** Evaluate staff perspectives/biases, which may unintentionally impact beneficiaries and provide training on mental health, stigma and bias in the workplace. *(This recommendation is a carry-over from FY 2018-19.)*
- **Recommendation 3:** Prioritize the hiring of Spanish-speaking providers.
- **Recommendation 4:** Investigate missed opportunities for collaboration with managed care plans for providing transportation to beneficiaries. Develop complimentary transportation solutions to augment limitations to existing transit.

Timeliness of Services

- **Recommendation 5:** The MHP needs to improve its first offered appointment timeliness in accordance with the state timeliness metric as per Information Notice (IN) 18-011.
- **Recommendation 6:** Track and trend timeliness of urgent appointments.
- **Recommendation 7:** Investigate the post-hospitalization appointments and identify causes for appointments not meeting the 7-day standard. Correct or implement processes for identifying those beneficiaries in need of post-hospitalization appointments within 7-days.

Quality of Care

- **Recommendation 8:** Recruit and involve beneficiary participants on the QIC.
- **Recommendation 9:** Develop employment supports for beneficiaries, both within the MHP and externally. Consider post-secondary schools for additional collaboration or as a resource.
- **Recommendation 10:** Assess effectiveness of current outreach and advertising approaches for beneficiary recruitment for both committees, program planning (wellness center) and system planning. Address any communication gaps.

- **Recommendation 11:** Implement a system which promotes bi-directional communication between all levels of staff that provides for dissemination of ideas and information, with follow-up communication on final outcomes, i.e., monthly staff meetings. *(This recommendation is a carry-over from FY 2018-19.)*

Beneficiary Outcomes

- **Recommendation 12:** Execute aggregate reporting for MORS, CANS-50 and PSC-35 outcome tools to assess program outcomes for use in program and capacity planning. *(This recommendation is a carry-over from FY 2018-19.)*

Foster Care

- None noted.

Information Systems

- **Recommendation 13:** Make laptops available to providers when they do field-based work to improve their productivity.

Structure and Operations

- None noted.

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 - Colusa MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Clinical Line Staff Group Interview
Consumer and Family Member Focus Group(s)
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Wellness Center Site Visit
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Cyndi Lancaster, Quality Reviewer
Caroline Yip, Information Systems Reviewer
Gloria Marrin, 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

Colusa County Behavioral Health
162 E. Carson Street, Suite A
Colusa, CA 95932

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Arce	Tomika	Medical Billing Specialist	Colusa County Behavioral Health
Deabel	Donna	Clinical Program Manager, MHSA	Colusa County Behavioral Health
Dennis	Donna	Program Manager	Colusa County Department of Health and Human Services
Fitch	Jason	Therapist	Colusa County Behavioral Health
Gomez	Patty	Case Manager	Colusa County Behavioral Health
Hall	Anthony	Therapist	Colusa County Behavioral Health
Madson	Susan	Therapist	Colusa County Behavioral Health
Martinez	Brizia	Therapist	Colusa County Behavioral Health
McAllister	Jennifer	Clinical Program Manager, SUD	Colusa County Behavioral Health
McCloud	Bill	EHR Manager	Colusa County Behavioral Health
McCord	Elaine	EHR Coordinator	Colusa County Behavioral Health
McGregor	Mark	Clinical Program Manager, Children's	Colusa County Behavioral Health
Morgan	Janet	Deputy Director, Clinical	Colusa County Behavioral Health
Pallow	Lisa	Therapist	Colusa County Behavioral Health
Puga	Mayra	MHSA Coordinator	Colusa County Behavioral Health
Rooney	Terence	Director	Colusa County Behavioral Health
Scroggins	Jeannie	Quality Assurance Coordinator	Colusa County

Table B1—Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
			Behavioral Health
Shields	Angie	Case Manager	Colusa County Behavioral Health
Shields	Kevin	Case Manager	Colusa County Behavioral Health
Stirling	Valerie	Peer Support Specialist	Colusa County 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 penetration rate and ACB for just the CY 2016 ACA Penetration Rate and ACB. Starting with CY 2016 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1. CY 2018 Medi-Cal Expansion (ACA) Penetration Rate and ACB
Colusa 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
Small-Rural	31,091	2,287	7.36%	$6,904,894	$3,019
MHP	1,748	157	8.98%	$399,135	$2,542

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
Colusa 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	676	97.97%	93.16%	$1,877,079	$2,777	$3,802	80.71%	54.88%
>$20K - $30K	7	1.01%	3.10%	$167,221	$23,889	$24,272	7.19%	11.65%
>$30K	7	1.01%	3.74%	$281,402	$40,200	$57,725	12.10%	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: Colusa	
PIP Title: Co-occurring Disorders	
Start Date: 05/22/18 **Completion Date**: 12/31/19 **Projected Study Period**: 19 Months **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: 08/08/19 **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: The Clinical PIP focuses on increasing the accuracy of diagnosis, in particular, diagnoses related to co-occurring disorders. This PIP was developed over one year ago and was presented at the last EQRO review. No new interventions were implemented. At that time, recommendations were made to strengthen the PIP; however, the MHP did not incorporate the recommendations moving forward. Recommendations included framing the PIP in terms of improved outcomes for beneficiaries. The purpose of this PIP is to correctly diagnose and therefore treat beneficiaries. The MHP did change the PIP from Non-Clinical to Clinical, to reflect the quality of care issue; furthermore, clear indicators, which measure beyond the co-occurring rate, would be useful to gauge the impact on beneficiaries.	

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 NON-CLINICAL PIP	
GENERAL INFORMATION	
MHP: Colusa	
PIP Title: Engagement	
Start Date: 03/07/17 **Completion Date**: Not provided. **Projected Study Period**: Not provided. **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review**: **Name of Reviewer**:	**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 MHP identified that an average of 25 percent of beneficiaries drop out of care before the third post-intake clinical session. This PIP used interventions that correlate with increased engagement, intending to accomplish better treatment outcomes. The goal will be to increase the percentage of beneficiaries that remain in treatment beyond three clinical sessions from 75 percent to 85 percent. Initially, the MHP implemented telephone calls, an engagement survey, and thank you letters.

New interventions include sending post cards and offering transportation (October 2018) to beneficiaries and tracking referrals. Also, in October 2018, the MHP began using a data-tracking log which was restructured and organized and guided initial interactions with beneficiaries. The MHP created a call-script to follow when contacting beneficiaries who did not remain engaged in treatment beyond 60 days (December 2018). In March 2019, staff were trained and began using the Access to Services Assessment (ASA) which allows the MHP to track beneficiary postcards and transportation offers. Unfortunately, the new interventions did not have a positive impact. A barrier analysis is needed to determine the causes of the problem, and in-turn, identify the most appropriate intervention; furthermore, statistical methods should be reviewed and employed for future PIPs.

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	Initial and ongoing beneficiary input is lacking.
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 QIC and PIP committee based the PIP on data, through long wait times between intake and first clinical appointment they noted the significant dropout rate of beneficiaries before attending three sessions.

Select the category for each PIP: *Non-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	The goal of the PIP is to increase engagement (as measured by three appointments) of beneficiaries who are new to Behavioral Health services.
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	The PIP addresses the entire population of beneficiaries that are new to Behavioral Health 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 changes in our engagement process increase the percentage of beneficiaries who remain engaged in treatment beyond three clinical sessions from the current average of 75 percent to an average of 85 percent?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While the study question is clear in outcomes desired, it lacks connection to clinical results for the beneficiary.

	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	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
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: <Text if checked>	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Individuals who attend more than three post intake appointments within 60 days of intake.	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The interventions identified are focused on efforts that are believed to be effective in increasing beneficiary engagement.

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 consumer 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	Although the MHP has presupposed that engagement is a proxy for projection of positive treatment outcomes, it is implied and not tracked in this PIP.
	Totals	**1** Met **1** Partially 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	The data to be collected - number of visits post intake for new beneficiaries.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☒ Other: Standard reports from the EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ 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 MHP will analyze retention rates monthly as reported from the EHR.

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: EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
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	
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* *Name:* *Jan Morgan* *Title:* *Deputy Director, Children's Services* *Role:* *Project Leader* *Other team members:* □ *Names: Quality Assurance Coordinator (Jeannie Scroggins) will collect data from the EHR with assistance from the EHR Coordinator (Elaine McCord).*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**5** Met **1** Partially Met
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data	☐ Met ☒ Partially Met	A barrier analysis is needed to identify the causes of the problem, and to better inform interventions.

analysis and QI processes undertaken? *Describe Interventions:* 1. Call to newly assigned beneficiaries on the day they are assigned to a clinician by the Access Team 2. Sending a “thank you for coming” letter to new beneficiaries 3. Training clinicians to revise helping inform beneficiaries that they are the assigned clinician and would like to schedule an appointment (when the beneficiary doesn't answer the telephone call but has given the department permission to leave a voice message) from merely asking the beneficiary to call back to schedule an appointment to expecting the clinician state in his telephone message a specific time that the clinician is set-aside for the meeting with the beneficiary to begin treatment. 4. An engagement survey was utilized to identify beneficiary barriers to engagement. 5. Telephone calls to beneficiaries who have been identified as not engaged (individuals who have not attended three sessions within 60 days of intake) in order to identify causal factors of failure to engage. New 6. “Post card completed and sent” and “offered transportation options” were added to the new Access to Services Assessment (ASA) to help track these engagement interventions. 7. Intake Data Tracking Log was restructured and organized to account for the information that we now	☐ Not Met ☐ Unable to Determine	

know we need since EQRO 8. Created a call script to follow when contacting beneficiaries who did not remain engaged in treatment beyond 60 days 9. Access to Services Assessment (ASA) was trained and went live so we can now track postcards being sent and transportation being offered.		
	Totals	**1** Partially 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?	☒ 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: _Monthly May 2018 through April 2019_ Indicate the statistical analysis used: ___none_____ 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	MHP requires additional assistance to determine statistical significance, confidence, etc.
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	The MHP calculated the numbers and compared them to the baseline. Overall, they were below baseline; however, a statistical approach was not used.
Totals	**2** Met **1** Partially Met **1** Not Met	

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? Monthly* *Were the same sources of data used? EHR* *Did they use the same method of data collection? yes* *Were the same participants examined? No, not an individual study* *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	The MHP's concluded that there were many outside variables which impacted engagement. Unfortunately, the MHP did not meet its goal and fell below baseline.
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	Staff turnover, system demand and changes in process and program management impacted engagement.

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	
	1 Met **3** Not Met **1** UTD	

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:

PIP Validation	#s
Met	14
Partially Met	6
Not Met	4
UTD	1
# Not applicable	3
#applicable	25
total items in rating	28
Score	68.00%

Recommendations:

The PIP needs additional analysis and an explanation regarding the findings and clinical impact on beneficiaries. Beneficiary stakeholder participation is needed both at the onset of planning and throughout the process as well. A barrier analysis would provide information to select interventions which would have a high probability of succeeding. More information is needed on limitations of the study described, conclusions reached regarding the success of the interpretation of the PIP and recommendations for follow-up.

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