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

COLUSA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of
Health Care Services (DHCS)

Review Dates:

August 18-19, 2021

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EXECUTIVE SUMMARY

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

MHP INFORMATION

MHP Reviewed — Colusa

Review Type — Virtual

Date of Review — August 18-19, 2021

MHP Size — Small-Rural

MHP Region — Superior

MHP Location — Colusa

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 633

MHP Threshold Language(s) — English, Spanish

SUMMARY OF FINDINGS

Of the ten recommendations for improvement that resulted from the FY 2020-21 External Quality Review (EQR), the MHP addressed or partially addressed nine recommendations and did not address one recommendation.

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

- Access to Care: 100 percent (four of four components)
- Timeliness of Care: 100 percent (six of six components)
- Quality of Care: 80 percent (eight of ten components)
- Information Systems (IS): 100 percent (six of six components)

The MHP submitted both of the required Performance Improvement Projects (PIPs). The clinical PIP, “Collateral Support”, was found to be active with a moderate confidence validation rating. The non-clinical PIP, “Reducing wait time between intake assessment and offered therapy appointment”, was found to be active with a high confidence validation rating.

CalEQRO conducted one consumer family member focus groups, comprised of three participants.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: program expansion for beneficiaries; MHP staff expansion by 20 percent with salary adjustments; timeliness to first offered intake appointment; bi-directional communication and collaboration within the MHP; and rapid deployment of telehealth equipment to staff during the Corona Virus Disease-19 (COVID-19) pandemic in order to swiftly meet beneficiary needs.

The MHP was found to have notable opportunities for improvement in the following areas: timeliness to first offered psychiatry appointment; timeliness to first offered urgent appointment; medication monitoring; Child and Adolescent Needs and Strengths – 50 (CANS-50) data aggregation; increase in inpatient length of stay (LOS) and costs; and the search for a new electronic health record (EHR).

FY 2021-22 CalEQRO recommendations for improvement include: timeliness to first offered psychiatry appointment; timeliness to first offered urgent appointment; medication monitoring; CANS-50 data aggregation; increase in inpatient LOS and costs; and developing an IS strategic plan.

INTRODUCTION

BACKGROUND

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

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

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

This report presents the fiscal year (FY) 2021-22 findings of the EQR for Colusa County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on August 18-19, 2021.

METHODOLOGY

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

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

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

FINDINGS

Findings in this report include:

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data; its corresponding penetration rate percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

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

ENVIRONMENTAL IMPACT

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic that has continued through the quality review on August 18-19, 2021, in Colusa County. The MHP lost staff, shifted clinical services to telehealth/telephone for the majority of the FY, and has been offering regular in-person services again as of March 2021. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

MHP SIGNIFICANT CHANGES AND INITIATIVES

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

- The previous MHP director resigned in March 2021 and a new interim director was contracted shortly thereafter.
- Communication within the MHP has improved drastically since the prior review.
- Collaboration with sister agencies and community organizations has strengthened.
- There has been a large expansion of programs within the MHP.
- The MHP is in the process of expanding clinical positions by 20 percent.
- The MHP is looking at a new EHR system.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2020-21

Recommendation 1: Consult with CalEQRO for ongoing and regularly scheduled TA for support implementing the recommendations outlined in this report.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP consulted with CalEQRO for PIP TA on two occasions to prepare for the review.
- The MHP implemented the guidance suggested for both PIPs and currently has two active PIPs.

Recommendation 2: Comply with the state timeliness metric as per Information Notice (IN)18-011 and offer first assessment appointments within ten business days.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP completed a Corrective Action Plan for Network Adequacy in April 2020 and noted that they discovered a data reporting error that inflated their number of days; this was due to miscommunication with office support staff counting days from request to scheduled appointment instead of to first offered appointment.
- Since identifying and correcting this error, for FY 2020-21 the MHP reported an average of 4.01 days for first offered appointment with 97.93 percent of beneficiaries meeting the 10-business day standard.
- The MHP also updated their policy and procedure to ensure that any offered appointments that fall outside of the state standard are brought to a manager's attention in real time so that an earlier appointment can be identified.

Recommendation 3: Comply with the state timeliness metric as per IN 18-011 and offer first psychiatry appointments within 15 business days.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- For FY 2020-21 the MHP reports meeting the 15-business day standard 38.64 percent of the time with an average of 17.05 days; timeliness for this metric has worsened from the prior FY 2019-20.

- The MHP reports efforts to improve first offered psychiatry timeliness via contracting with a new vendor to add eight hours of psychiatry as of July 2021; the MHP plans to contract for eight more hours of psychiatry this FY.

Recommendation 4: Investigate the cause of the delay in service for children's urgent appointments. Implement interventions which bring the average number of hours/days within the 48-hour goal as well as increase the percentage of children's appointments meeting the goal.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP investigated the delay in service for children's urgent appointments and discovered an administrative error where urgent requests were cancelled, then rescheduled; however, instead of creating a new entry with new request date and new offered appointment date, the original entry date was used.
- Front desk staff who enter urgent appointment data have been retrained on the data entry process.
- Although this data entry error has been corrected, the MHP is still below timeliness standards with meeting the 48-hour standard for 54.55 percent of children's appointments for FY 2020-21; it is noted that this is an improvement from the prior FY 2019-20 which was at 40 percent.

Recommendation 5: Develop and incorporate employment supports for beneficiaries within the MHP and externally through the MHP's Social Determinants Innovation Project.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The Social Determinants Innovation Project is designed to examine, identify, support, and stabilize key life domains to improve the quality of life for persons with mental health issues in rural counties.
- The innovation project was recently approved by the Oversight and Accountability Commission with the first planning meeting taking place in July 2021.
- One case manager and two mental health specialists will be responsible for linking beneficiaries to employment supports as part of the project.
- Although the project was not fully operational as of the EQR, concrete steps have been taken for implementation this FY.

Recommendation 6: Routinely report MHP timeliness, outcome, and MHP quality performance data to staff and create an opportunity/forum for bi-directional discussion and staff participation.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP routinely reports timeliness, outcome, and performance data to staff through the following avenues: all staff can attend quarterly Quality Improvement Committee (QIC) meetings where the information is discussed, QIC meeting minutes are disseminated to staff via email, information is periodically posted on a public staff bulletin board, and information technology (IT) runs a data entry timeliness report which is regularly shared with supervisors and addressed with staff as needed.
- Opportunities for bi-directional discussion are promoted through meetings, monthly newsletters, an open-door policy for staff to speak with QI and executive staff, as well as staff supervision meetings.
- Overall, stakeholders reported a strong improvement in bi-directional communication and collaboration.

Recommendation 7: Include trending analysis over time in the quality improvement (QI) work plan.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The QI work plan includes measurable goals that are tracked throughout the FY via the QIC meeting minutes.
- Trending analysis is regularly completed within the minutes and funneled into an evaluation meeting to complete the QI work plan evaluation at the end of the current FY and to prepare the subsequent FY's plan.
- Validation of the QIC minutes demonstrates routine, organized, and robust analysis over time which links clearly to the QI work plan without the need for its inclusion within the plan itself.

Recommendation 8: Establish expectations for all clinicians as well as policy and procedure for completion of Milestones of Recovery Scale (MORS) documentation for all adult beneficiaries.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has created a policy and procedure for completing MORS monthly for adult beneficiaries who are open to mental health services with the expectation that the clinician will meet with the beneficiary's treatment team to determine the appropriate MORS score.
- The MHP intends to set up alerts in the EHR this FY so that MORS due dates can be easily tracked and used to inform staff to complete as needed.

Recommendation 9: Prioritize the implementation of the Pediatric Symptom Checklist – 35 (PSC-35) dashboard.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has collaborated with its EHR vendor to implement the PSC-35 dashboard as of August 2021.
- The MHP has been entering PSC-35 data for all new children/youth intakes since October 2018, resulting in several years of data that the MHP can now track and trend.

Recommendation 10: Consult with Kings View and implement a method to aggregate CANS-50 data for the system.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP is still in the internal process of determining which CANS-50 domains would be useful to track; therefore, consultation with Kings View on implementing a method to aggregate CANS-50 data has not been completed as of the EQR.
- The MHP is encouraged to determine CANS-50 domains relevant to the MHP in monitoring its beneficiaries so that steps towards data analysis at an aggregate level can occur.

NETWORK ADEQUACY

BACKGROUND

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

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

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services, for youth and adults. If these standards are not met, DHCS requires the MHP to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews separately and with MHP staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the MHP's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

FINDINGS

For Colusa County, the time and distance requirements are 60 minutes and 90 miles for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over)[1].

[1] AB 205 and BHIN 21-023

Alternative Access Standards and Out-of-Network Providers

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

Planned Improvements to Meet NA Standards

Not Applicable.

MHP Activities in Response to FY 2020-21 AAS

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

PROVIDER NPI AND TAXONOMY CODES

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

ACCESS TO CARE

BACKGROUND

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

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

ACCESS IN COLUSA COUNTY

SMHS are delivered by both county-operated and contractor-operated. Regardless of payment source, approximately 95 percent of services were delivered by county-operated/staffed clinics and sites, and approximately 5 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 85 percent of services provided are claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is staffed by county-operated staff during the normal business hours and by contractor-operated staff during the after-hours; beneficiaries may request services through the Access Line as well as through the following system entry points: walk-ins and telephone requests through the MHP clinic. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The assessment process begins with a beneficiary requesting an appointment with the MHP, being offered an initial appointment date and time, and attending the initial appointment where medical necessity is determined. If the beneficiary does not meet medical necessity for SMHS, the MHP provides referrals and links the beneficiary to their Medi-Cal managed care plan for services. If the beneficiary does meet medical necessity for SMHS, their assessment is completed at the initial appointment, the ACCESS Team ensures that all Medi-Cal documents are completed and approves the chart. A clinical program manager receives the chart and assigns the beneficiary to a clinician or treatment team, then the assigned clinician or team contacts the beneficiary to schedule the next service appointment.

In addition to clinic-based mental health services, the MHP delivers psychiatry and mental health services via telehealth to youth and adults. In FY 2020-21, the MHP reports having served 84 adult beneficiaries, 85 youth beneficiaries, and fewer than 11 older adult beneficiaries across one county-operated site and zero contractor-operated

sites. Among those served, 39 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

ACCESS KEY COMPONENTS

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

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

Table 1: Key Component – Access

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

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

- The MHP is expanding staffing by 20 percent which will contribute to improved capacity for beneficiary services.
- There has been a large expansion of programs and initiatives such as: purchasing an adult residential facility in Williams with a request for proposal expected in November 2021; No Place Like Home location identified and land purchase in process; memorandum of understanding drafted for crisis response with law enforcement and the local emergency department; and new youth center development.

PERFORMANCE MEASURES

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

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

Total Beneficiaries Served

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

The Latino/Hispanic population constitutes over two-thirds of the Medi-Cal beneficiaries in Colusa County and about one-half of the beneficiaries served by the MHP. Whites constitute about one-sixth of the Medi-Cal beneficiaries, but account for more than one-third of those served by the MHP. The only other race/ethnicity category that has any significant numbers is the Other category which consists of those with no specific racial or ethnic identity known to the system, or with more than one racial/ethnic identity.

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

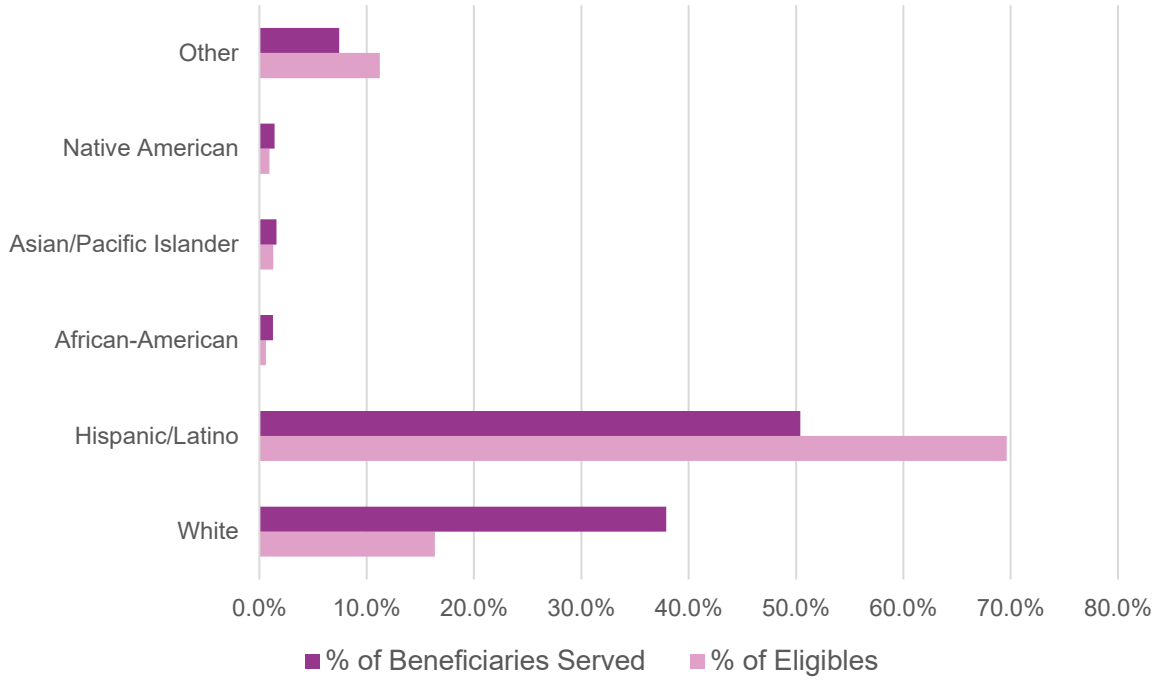
Colusa MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	1,701	16.3%	240	37.9%
Latino/Hispanic	7,245	69.6%	319	50.4%
African-American	63	0.6%	*	n/a
Asian/Pacific Islander	133	1.3%	*	n/a
Native American	96	0.9%	*	n/a
Other	1,167	11.2%	47	7.4%

Colusa MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Total	**10,405**	**100%**	**633**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

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

The disparity in access to mental health services for Latino/Hispanic beneficiaries is more clearly demonstrated in Figure 1.

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



More than one-quarter of the beneficiaries served by the MHP in CY 2020 had Spanish as their primary languages. English accounted for most of the other languages spoken by beneficiaries.

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

Colusa MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	171	27.1%
Other Languages	460	72.9%
Total	**631**	**100%**
Threshold language source: Open Data per IN 20-070 Other Languages include English		

Penetration Rates and Approved Claim Dollars per Beneficiary Served

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

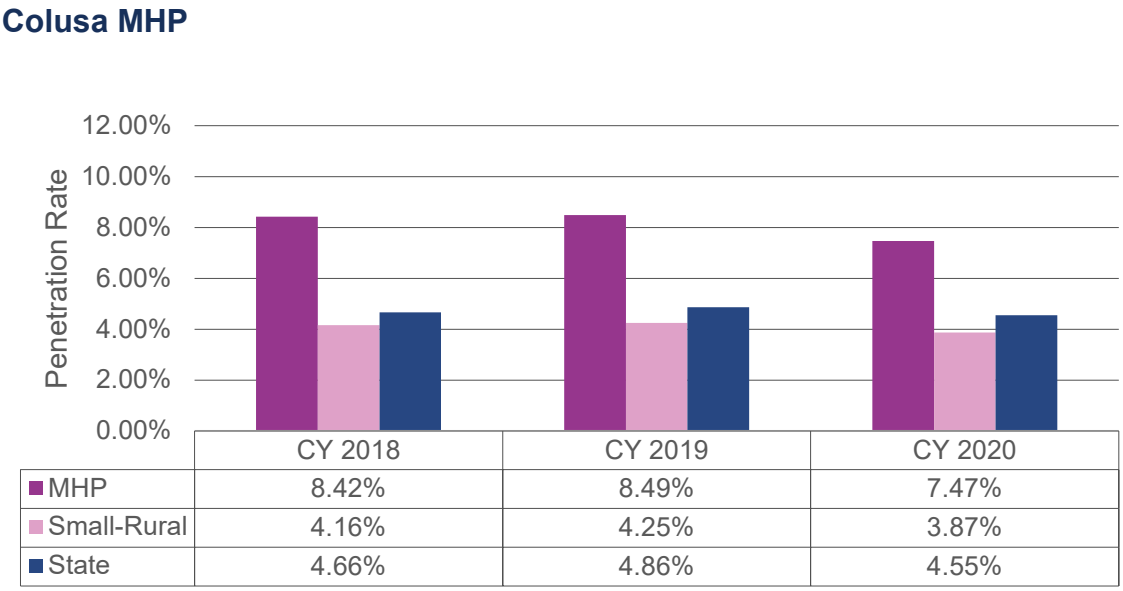
CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. See Table D1 for the CY 2019 ACA penetration rate and ACB.

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

The MHP's penetration rate declined slightly in CY 2020, reflecting similar declines among small-rural MHPs and statewide. However, the MHP had almost twice the average penetration rate of the small-rural MHPs and significantly higher penetration rate than the statewide average. Although its Latino/Hispanic penetration rate was lower than its overall and Asian/Pacific Islander penetration rates, it was still significantly higher than the corresponding statewide and small-rural MHP averages.

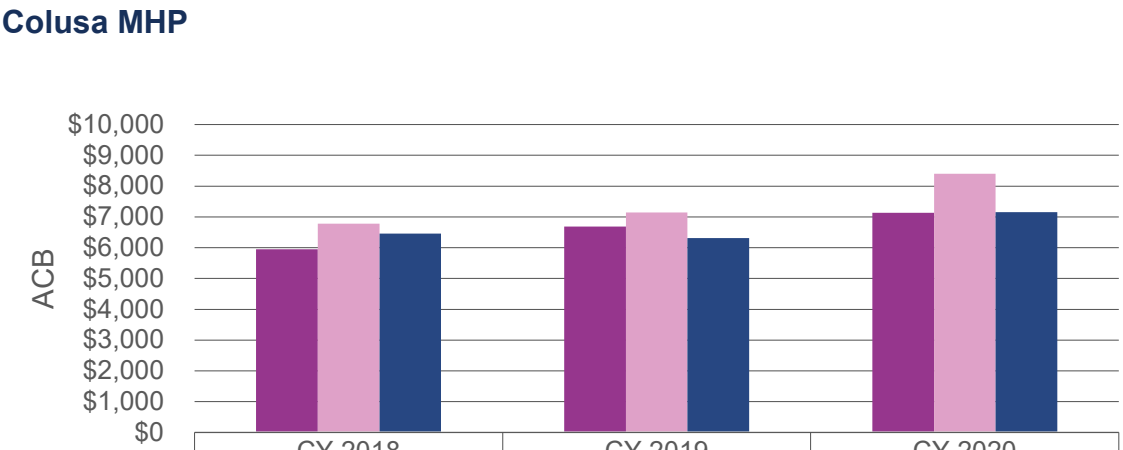
The MHP's ACB increased significantly during CY 2020; however, it reflected a similar increase in the statewide ACB. The MHP fiscal staff attributed the higher ACB to higher rates that went into effect during COVID-19.

Figure 2: Overall Penetration Rates CY 2018-20



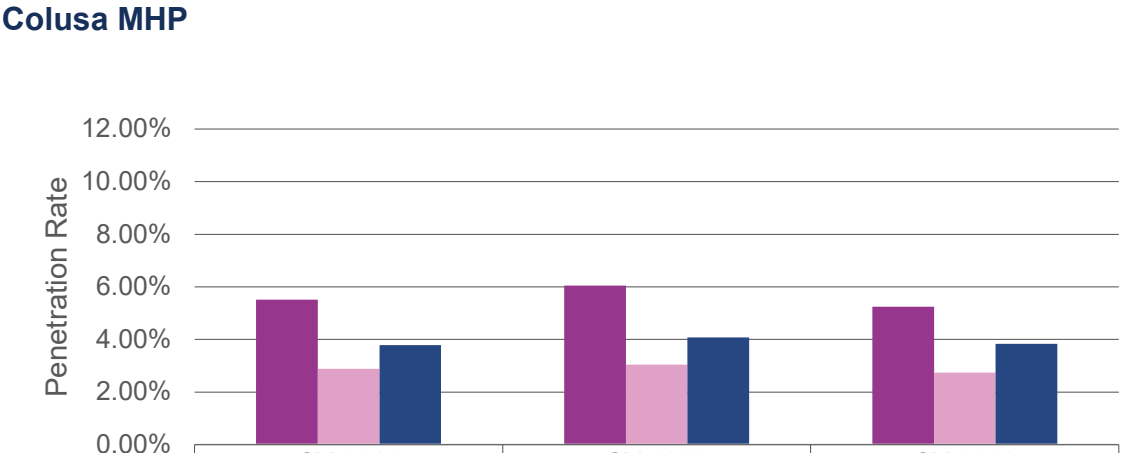
	CY 2018	CY 2019	CY 2020
MHP	8.42%	8.49%	7.47%
Small-Rural	4.16%	4.25%	3.87%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20



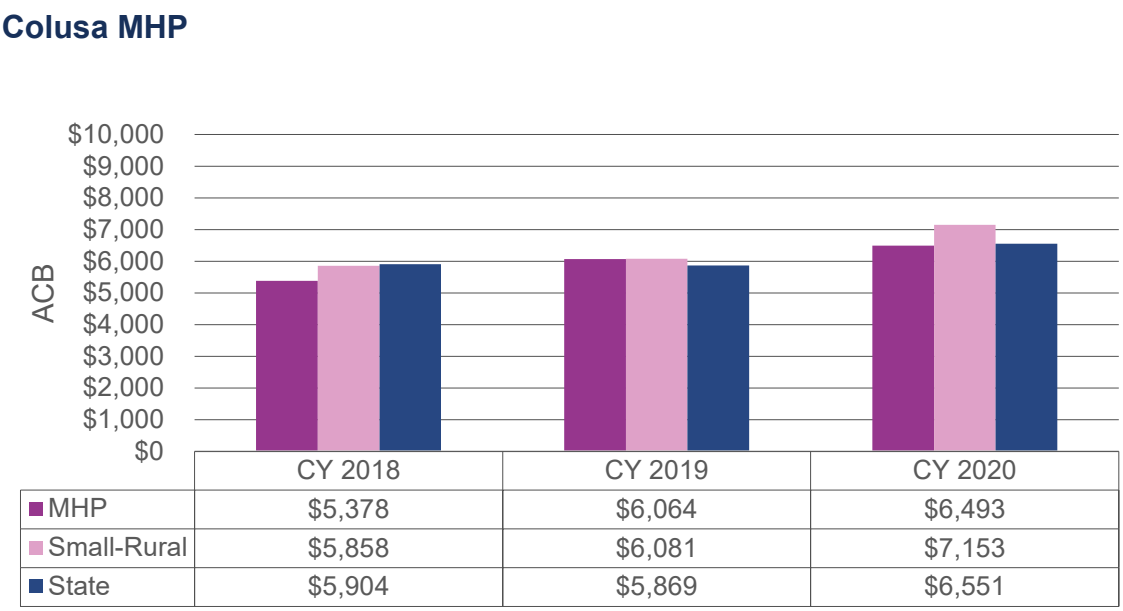
	CY 2018	CY 2019	CY 2020
MHP	$5,946	$6,687	$7,136
Small-Rural	$6,785	$7,143	$8,399
State	$6,454	$6,316	$7,155

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



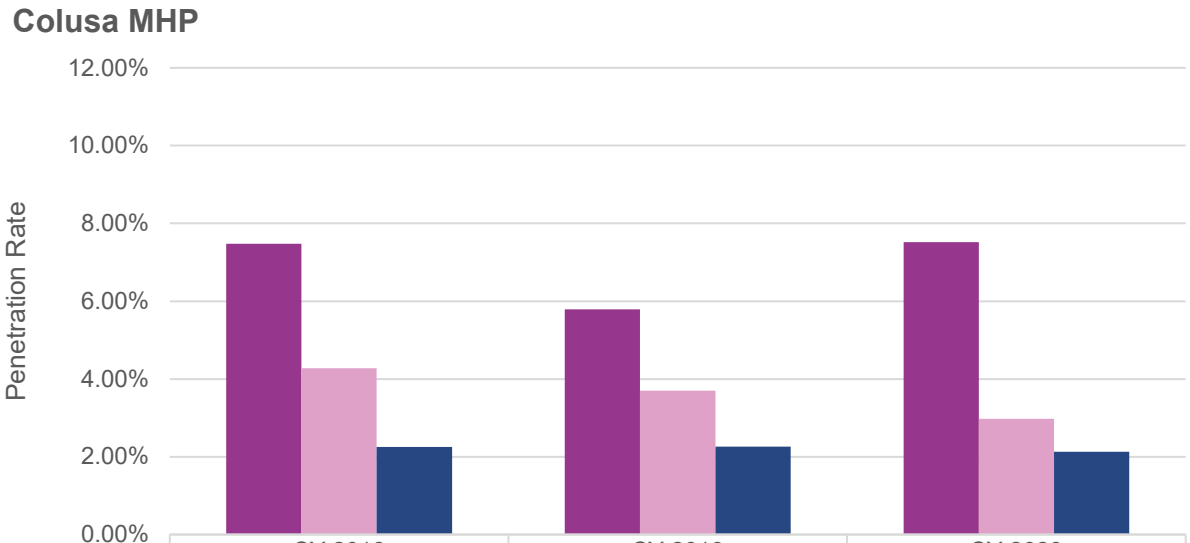
	CY 2018	CY 2019	CY 2020
MHP	5.51%	6.05%	5.24%
Small-Rural	2.88%	3.04%	2.74%
State	3.78%	4.08%	3.83%

Figure 5: Latino/Hispanic ACB CY 2018-20



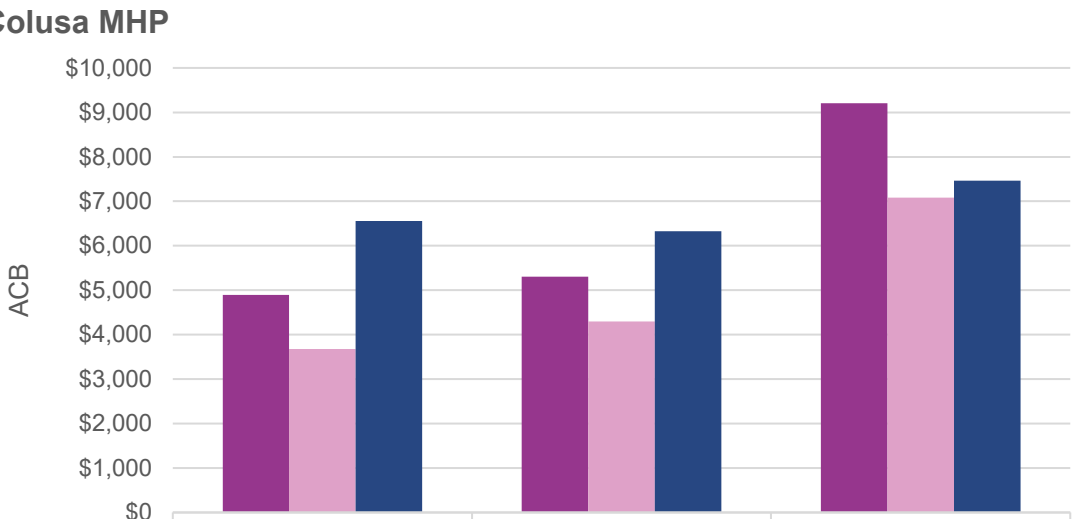
	CY 2018	CY 2019	CY 2020
MHP	$5,378	$6,064	$6,493
Small-Rural	$5,858	$6,081	$7,153
State	$5,904	$5,869	$6,551

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



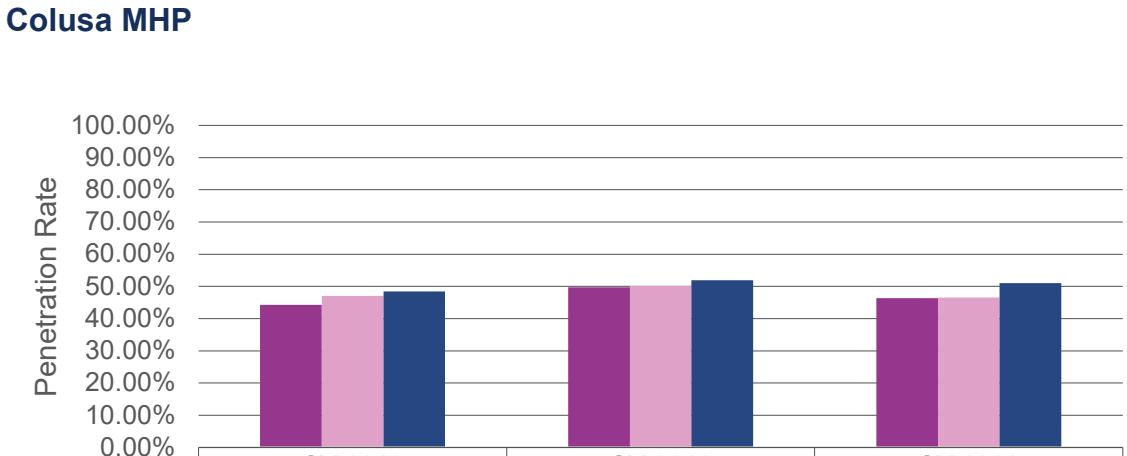
	CY 2018	CY 2019	CY 2020
MHP	7.48%	5.79%	7.52%
Small-Rural	4.28%	3.70%	2.98%
State	2.25%	2.26%	2.13%

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



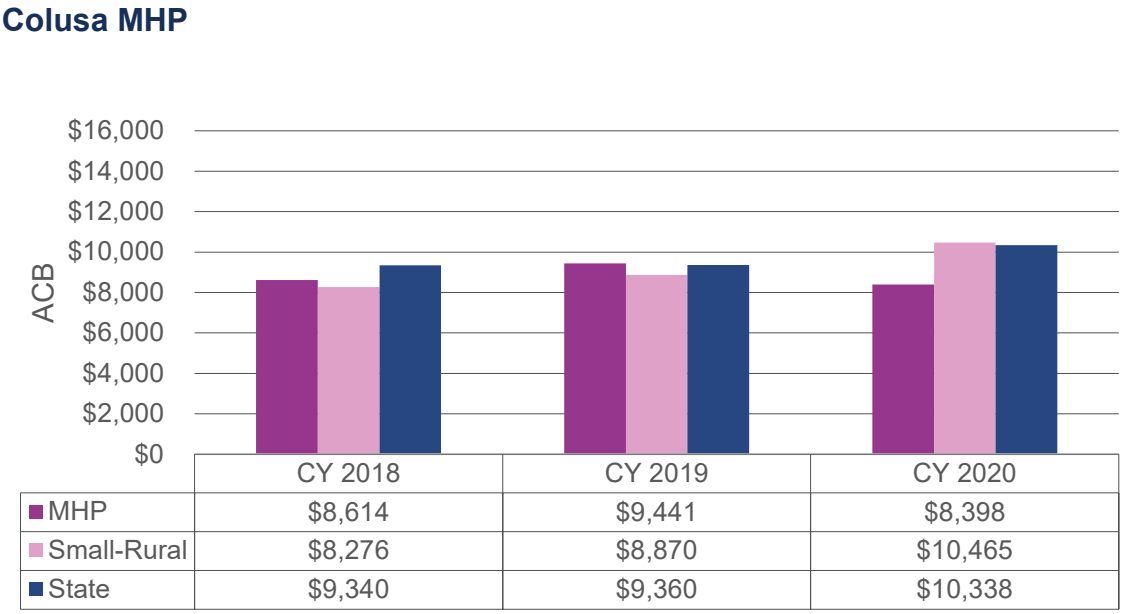
	CY 2018	CY 2019	CY 2020
MHP	$4,893	$5,307	$9,207
Small-Rural	$3,681	$4,296	$7,084
State	$6,557	$6,325	$7,466

Figure 8: FC Penetration Rates CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	44.26%	49.77%	46.33%
Small-Rural	47.10%	50.12%	46.59%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	$8,614	$9,441	$8,398
Small-Rural	$8,276	$8,870	$10,465
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

The MHP has significantly higher penetration rates than similar-sized MHPs and statewide; this is also seen in its Latino/Hispanic penetration rate. Discussions during the virtual review indicate a high unemployment rate in Colusa County, potentially contributing to the penetration rates seen. The higher ACB in CY 2020 may be a temporary increase during COVID-19.

TIMELINESS OF CARE

BACKGROUND

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

TIMELINESS IN COLUSA COUNTY

The MHP reported timeliness data stratified by age and foster care status. Further, timeliness data presented to CalEQRO represented the complete SMHS delivery system.

TIMELINESS KEY COMPONENTS

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

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

Table 4: Key Component – Timeliness

KC #	Key Component – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met

KC #	Key Component – Timeliness	Rating
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- The MHP offers beneficiaries an intake appointment within the standard 10-business days 97.93 percent of the time.

PERFORMANCE MEASURES

Through BHINs 20-012 and 21-023, DHCS set required timeliness metrics to which MHPs must adhere for initial offered appointments for non-urgent SMHS, non-urgent psychiatry, and urgent care. The following PMs reflect the MHP's performance on these and additional timeliness measures consistent with statewide and national quality standards, including Healthcare Effectiveness Data and Information Set (HEDIS) measures:

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

MHP-Reported Data

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. For the FY 2021-22 EQR, the MHP reported its performance for FY 2020-21 as follows:

The MHP offers its first appointment for non-urgent services in four days on average and meets its 10-business day standard more than 97 percent of the time. The MHP only meets the 15-business day standard for first offered psychiatry appointment 38.64 percent of the time, citing an increase demand in psychiatry services during the majority of the pandemic and being unable to add additional psychiatry hours until recently; to address timeliness for psychiatry appointments the MHP has now contracted with a new vendor for eight hours of psychiatry and will be adding eight more hours later this FY; these hours supplement the one full time psychiatrist that the MHP currently employs. The MHP is not able to meet the 48-hour standard for urgent services for 55.56 percent of those needing it; the MHP is currently engaged in the implementation of a crisis unit in order to address this issue.

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

FY 2021-22 MHP Assessment of Timely Access			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	4.01 Days	10-Business Days	97.93 %
First Non-Urgent Service Rendered	10.03 Days	15 business days	82.53 %
First Non-Urgent Psychiatry Appointment Offered	17.05 Days	15-Business Days	38.64 %
First Non-Urgent Psychiatry Service Rendered	17.43 Days	20 business days	56.82 %
Urgent Services Offered – Prior Authorization not Required	64.31 Hours	48-Hours	55.56 %
Urgent Services Offered – Prior Authorization Required	*** Hours	96-Hours	*** %
Follow-Up Appointments after Psychiatric Hospitalization	7 Days	7 days	64 %
No-Show Rate – Psychiatry	8.75 %	10%	n/a
No-Show Rate – Clinicians	12.07 %	10%	n/a

*** MHP does not separately track urgent services offered based on authorization requirements; all urgent services are held to a 48-hour standard.

Medi-Cal Claims Data

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

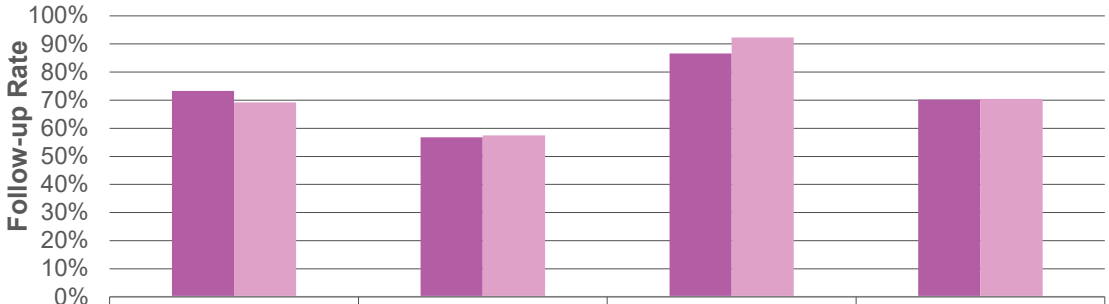
Follow-up post hospital discharge

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

The MHP has a higher post-inpatient 7- and 30-day follow-up rate than the state. Although its 7-day follow-up rate decreased slightly from CY 2019 to CY 2020, its 30-day follow-up rate increased to 92 percent. The MHP's own reported 7-day rate for FY 2020-21 was 64 percent while CalEQRO calculated this for CY 2020 to be slightly higher at 69 percent.

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

Colusa MHP



	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	73%	57%	87%	70%
CY 2020	69%	57%	92%	70%

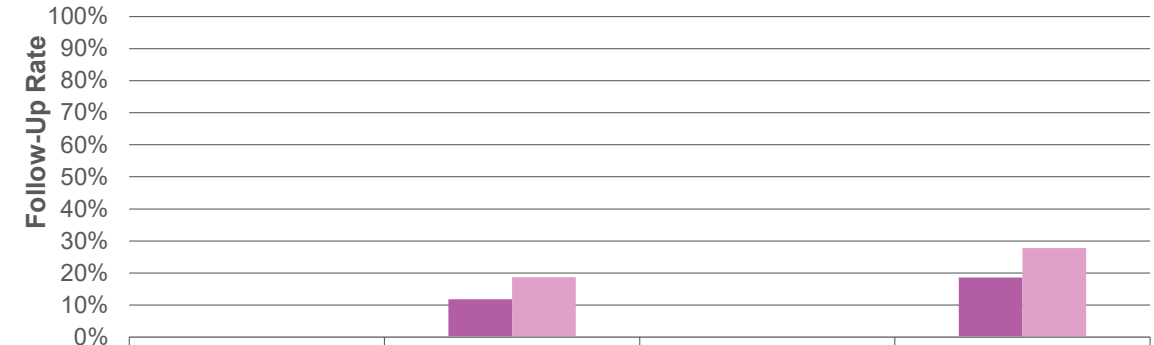
Readmission rates

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

The MHP did not have any rehospitalizations in CY 2020.

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

Colusa MHP



	7-Day Rehospitalization MHP	7-Day Rehospitalization State	30-Day Rehospitalization MHP	30-Day Rehospitalization State
CY 2019	0%	12%	0%	19%
CY 2020	0%	19%	0%	28%

IMPACT OF FINDINGS

The average time to first offered psychiatry appointment is longer than DHCS standards, resulting in beneficiaries being delayed in receiving medication support for their mental health conditions. This may have a trickle-down effect to other parts of the system, such as increase in crisis or emergency department access due to the need for more immediate care which has been intensified by long outpatient wait times. With the data on first offered urgent appointments also showing average times longer than DHCS standards, it would be beneficial for the MHP to continue exploring ways to address these metrics and evaluate whether identified solutions (e.g. adding psychiatry hours and expanding crisis services) will improve timeliness and beneficiary outcomes.

QUALITY OF CARE

BACKGROUND

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

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

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

QUALITY IN COLUSA COUNTY

In the MHP, the responsibility for QI is an agency responsibility undertaken by the Quality Assurance (QA) Clinical Program Manager who is supported by a full-time QA Coordinator.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the Quality Assessment and Performance Improvement (QAPI) work plan, and the annual evaluation of the QAPI work plan. The QIC, comprised of executive-level staff, program managers, program supervisors, clinical line staff, peer support specialists, and beneficiaries, is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met four times. Of the 38 identified FY 2020-21 QAPI work plan goals, the MHP met or partially met 28 of them. The majority of unmet goals related to timeliness to services, as indicated earlier in this report.

The MHP utilizes the following LOC tools: MORS, CANS-50.

The MHP utilizes the following outcomes tools: PSC-35, Generalized Anxiety Disorder -7, Patient Health Questionnaire - 9.

In October 2019, a fire damaged the MHP's only wellness center, Safe Haven. It was temporarily relocated to a conference room at the MHP building, but then in March 2021, the operations were forced to temporarily close for safety concerns due to the COVID-19 pandemic. A new location for Safe Haven has been identified within a five-minute walk from the MHP building, allowing for easy access for beneficiaries. A lease has been signed for the new location with plans to fully implement programming and

operations by November 2021, when beneficiaries can access full wellness center services at the new location.

The MHP supports peer employment through one full-time peer support specialist position, two extra help peer positions, and two pending part-time/benefited peer positions at the new youth center. Although the MHP employs peers in its system, there does not appear to be a career ladder nor supervisory positions available specifically for peers.

QUALITY KEY COMPONENTS

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

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

Table 6: Key Component – Quality

KC #	Key Component - Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not Met

KC #	Key Component - Quality	Rating
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Not Met

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

- A full array of stakeholders regularly participate in the quarterly QIC meetings, allowing for varying perspectives and areas of feedback to better inform QI initiatives.
- The QIC meeting minutes are clearly documented, organized, succinct, and contain useful data analysis and trending.
- Bi-directional communication and collaboration within the MHP has drastically improved from previous EQRs with an overwhelming majority of stakeholders from all levels of the MHP, from beneficiaries to executive level staff, stating such. A positive shift in MHP culture was clearly seen during the EQR.
- The MHP does not currently have a medication monitoring system in place to track, trend, and use medication data for performance improvement activities.
- Although the MHP employs peers in its system, there does not appear to be a career ladder nor supervisory positions available specifically for peers.
- The MHP does not track and trend the following HEDIS measures as required by SB 1291:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD)
    - The use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC)
    - Metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)

- The use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)

PERFORMANCE MEASURES

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

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

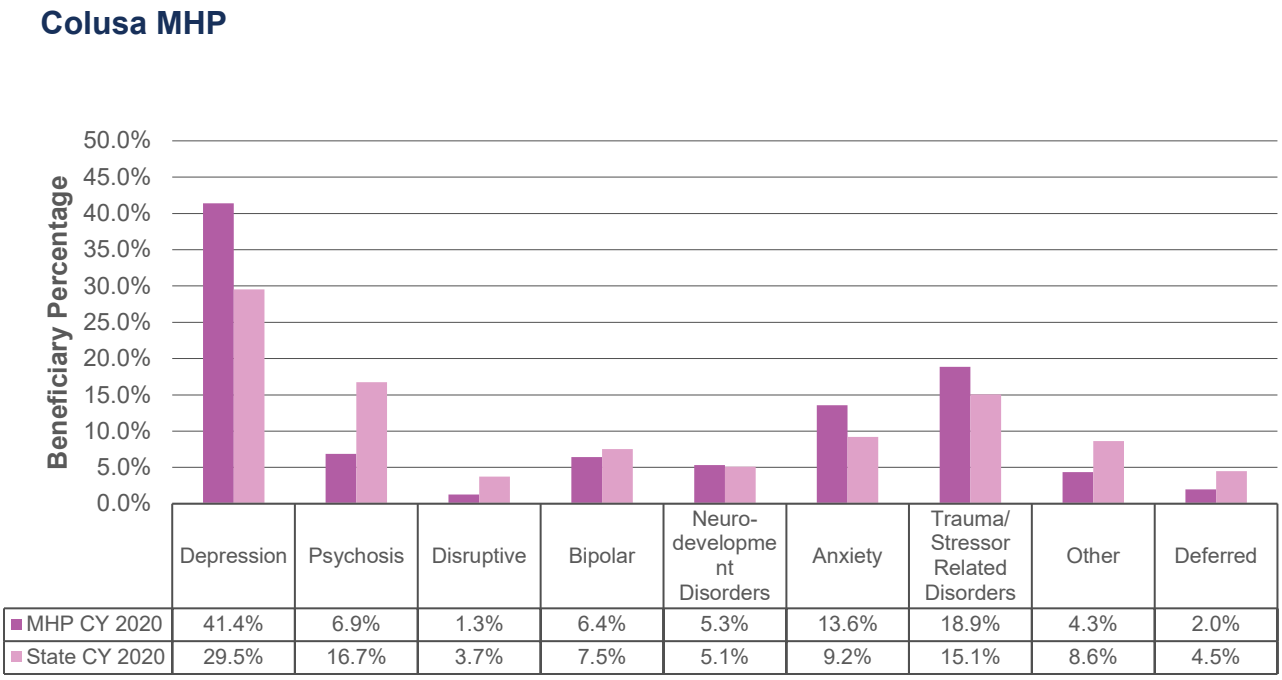
Diagnosis Data

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

The MHP's diagnostic patterns for depression and psychosis are significantly different from the statewide patterns for the same. The MHP's psychosis diagnosis rate is less than half that of the state, while the depression diagnosis rate is 12 percentage points higher than the state. A similar pattern is seen in the ACBs for the two diagnostic categories as well. The MHP has very little deferred diagnoses.

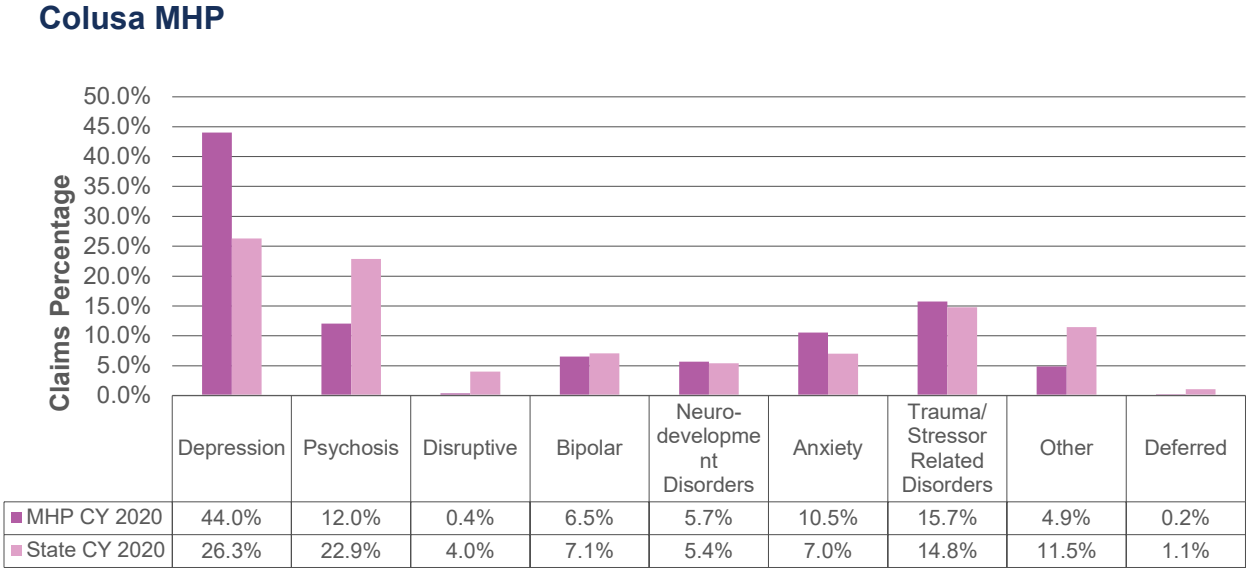
The MHP indicates that the pattern of higher depression and lower psychosis diagnoses accurately reflect the county demographics as most young adults leave the county to pursue employment or schooling activities elsewhere; this potentially lowers the psychosis diagnosis rates in Colusa as the young adults may be residing in other counties at the time that they are most likely to be diagnosed.

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	41.4%	6.9%	1.3%	6.4%	5.3%	13.6%	18.9%	4.3%	2.0%
State CY 2020	29.5%	16.7%	3.7%	7.5%	5.1%	9.2%	15.1%	8.6%	4.5%

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



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	44.0%	12.0%	0.4%	6.5%	5.7%	10.5%	15.7%	4.9%	0.2%
State CY 2020	26.3%	22.9%	4.0%	7.1%	5.4%	7.0%	14.8%	11.5%	1.1%

Psychiatric Inpatient Services

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

The MHP's count of beneficiaries who required inpatient treatment and the number of admissions have remained stable over the three-year period between CY 2018 and CY 2020. However, during the same period, the average LOS and the corresponding ACB and total cost for hospitalization have all gone up significantly, most likely as a result of the increase in the average LOS.

Table 7: Psychiatric Inpatient Utilization CY 2018-20

Colusa MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2020	16	16	11.94	8.68	$11,154	$11,814	$178,464
CY 2019	14	16	8.47	7.80	$8,907	$10,535	$124,698
CY 2018	16	20	7.50	7.63	$9,965	$9,772	$159,439

High-Cost Beneficiaries

Table 8 provides a three-year summary (CY 2018-20) of HCB trends for the MHP and compares the MHP's CY 2020 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

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

After two years of no beneficiaries in the HCB category, in CY 2020, the MHP had 38 HCBs with approved claims of over $30,000 each, and accounting for 6 percent of all the beneficiaries served.

Table 8: HCB CY 2018-20

Colusa MHP							
	Year	HCB Count	Total Beneficiary County	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
MHP	CY 2020	38	633	6.00%	$53,591	$2,036,440	31.19%
	CY 2019	*	670	--	$50,239	--	--
	CY 2018	*	690	--	$40,200	--	--

See Attachment D, Table D2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Retention Data

The MHP's service retention pattern is similar to the statewide pattern. Most beneficiaries receive 5 to 15 services in a year or more, accounting for more than 80 percent of the MHP beneficiaries.

Table 9: Retention of Beneficiaries

	Colusa			STATEWIDE			
Number of Services Approved per Beneficiary Served	**# of beneficiaries**	**%**	**Cumulative %**	**%**	**Cumulative %**	**Minimum %**	**Maximum %**
1 Service	36	5.69	5.69	9.76	9.76	5.69	21.86
2 Services	39	6.16	11.85	6.16	15.91	4.39	17.07
3 Services	25	3.95	15.80	4.78	20.69	2.44	9.17
4 Services	24	3.79	19.59	4.50	25.19	2.44	7.78

	Colusa			STATEWIDE			
Number of Services Approved per Beneficiary Served	**# of beneficiaries**	**%**	**Cumulative %**	**%**	**Cumulative %**	**Minimum %**	**Maximum %**
5-15 Services	225	35.55	55.13	29.47	54.67	19.96	42.46
>15 Services	284	44.87	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

The MHP has had significant increases in inpatient LOS and cost accompanied by an increase in the overall ACB and the number of HCBs. The MHP can begin to investigate these anomalous patterns from the previous years by examining the rising inpatient LOS and factors that may be contributing to more severe beneficiary conditions. It would be worthwhile to investigate if the increased LOS may connect to the slowed first offered psychiatry timeliness and the urgent care response mentioned previously.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

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

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

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

CLINICAL PIP:

General Information

Clinical PIP Submitted for Validation: Collateral Support

Date Started: January 2020

Aim Statement: "Will prioritizing offering collateral services to our adult beneficiaries increase the number of adult beneficiaries that receive a collateral service and subsequently show an improvement in their mental health functioning indicated by their MORS score?"

Target Population: The target population for this PIP includes all adult beneficiaries ages 18 and over.

Validation Information:

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

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

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

Summary

The clinical PIP is focused on increasing collateral services for adult beneficiaries in order to promote improved beneficiary outcomes as measured by increasing MORS scores from 41.10 percent to 80 percent, over the period of January 2020 through December 2021. The MHP's interventions include: having providers use the National Alliance on Mental Illness (NAMI) "ESPERANZA Family Guide" with beneficiaries and collaterals for psychoeducation on mental health disorders, use of a collateral support tool, use of a beneficiary questionnaire given at intake and reassessment sessions to include statements/questions about the beneficiary's natural support system, use of a collateral questionnaire, and an update to the MORS assessment in Anasazi to capture whether or not clinical staff are offering collateral sessions to a beneficiary that month. Two performance measures were tracked: collateral services received and MORS scores.

The most recent remeasurement period of January 1, 2021, to June 30, 2021, demonstrated a rate of 6.56 percent of collateral services received (with baseline of 4.47 percent) and 44.59 percent for MORS scores (with baseline of 41.10 percent). Overall, both performance measures have shown some increases over time.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: the majority of the interventions were applied as uniformly as possible by all clinical staff, with the exception of the collateral support tool intervention which was made optional for staff to utilize. Since not all staff were using this tool, it is possible that the results from the PIP may be skewed; nevertheless, the use of this optional tool would likely have increased collateral involvement in beneficiary services rather than detract from it. Due to this inconsistency and considering the other clearly applied interventions, the PIP is rated with moderate confidence.

The TA provided to the MHP by CalEQRO consisted of:

- Two TA sessions provided by CalEQRO prior to the scheduled review.
- TA provided by CalEQRO during the PIP session of the virtual review.

CalEQRO recommendations for improvement of this clinical PIP include:

- Beneficiaries should be included at the PIP development stage in order to incorporate the target population's feedback into the foundation of the PIP and ensure that the correct issues/interventions are being targeted.
- The current aim statement can be improved by adding the study time period and including specific baseline and improvement target numbers to make the statement measurable.
- It is recommended that all procedures for the PIP are made as clear and consistent as possible so that clinicians are doing the exact same things with

each beneficiary each time. Optional tools should not be present as this may affect the results of the PIP. All interventions need to be done the same way to reduce the possibility that the results are coming from external variables.

- Data personnel were indicated (QA Coordinator), but not their relevant qualifications; include their qualifications in future write-ups.
- As this PIP is still ongoing, full data analysis has not yet occurred. Once the PIP study period ends later this CY, the MHP will need to complete a full data analysis and interpretation of results along with the data that they have already provided.

NON-CLINICAL PIP:

General Information

Non-Clinical PIP Submitted for Validation: Reducing wait time between intake assessment and offered therapy appointment

Date Started: March 2021

Aim Statement: "The timeliness between intake appointment and first offered therapy session will decrease from 19.51 business days to 15 business days or less for 70% of beneficiaries (currently 33.53%), by June 30, 2022."

Target Population: The target population includes all new beneficiaries who have requested a mental health intake as of March 1, 2021, and qualify for Specialty Mental Health Services.

Validation Information:

The MHP's non-clinical PIP is in the first remeasurement phase and considered active.

Summary

The non-clinical PIP is focused on reducing the wait time between intake assessments and first offered therapy appointments from 19.51 average business days to 15 business days or less, improving the average number of beneficiaries being offered a timely appointment from 33.53 percent to 70 percent, via changes to the intake and appointment assignment process. The MHP's timeframe for this PIP is from March 2021 through June 2022. The MHP's interventions include: adding an access worker and adding an additional day of assignment per week. One performance measure was tracked: number of days between intake and first offered therapy appointment.

The MHP completed its first remeasurement in June 2021 and demonstrated a 15.41 business day average wait time between intake and first offered therapy appointment with 55.17 percent receiving an offered therapy appointment within 15 business days.

The preliminary data shows promising improvement in timeliness to the first offered therapy appointment.

TA and Recommendations

As submitted, this non-clinical PIP was found to have high confidence, because: the methodology and interventions for the PIP are clear, concise, and being implemented as stated. There does not appear to be external variables affecting the preliminary results.

The TA provided to the MHP by CalEQRO consisted of:

- Two TA sessions provided by CalEQRO prior to the scheduled review.
- TA provided by CalEQRO during the PIP session of the virtual review.

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

- The MHP would benefit from including direct beneficiary input/feedback during the PIP topic development phase.
- The aim statement needs to be revised to also include the improvement strategy, population of study, and the full time period for the PIP.
- Indicate the relevant qualifications of data personnel.

INFORMATION SYSTEMS (IS)

BACKGROUND

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

IS IN COLUSA COUNTY

California MHP EHRs fall into two main categories, those that are managed by county of MHP IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner-Anasazi, which has been in use for ten years. The systems is operated by an ASP, Kings View. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years. However, the MHP is keeping its options open at this time and expects that next year it will need to look more seriously for a replacement EHR.

Approximately 6 percent of the MHP budget is dedicated to support the IS (County IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency. The MHP has had stable IS staffing with additional new staff in the past year assigned to fiscal and analytics.

The MHP has 47 named users with log-on authority to the EHR, who are all county staff. The contract provider which manages the after-hours crisis line has look-up access to essential EHR functions. Support for the users is provided by two full-time equivalent (FTE) IS technology positions. Currently all positions are filled and there has been no change in IT staffing in the past year.

As of the FY 2021-22 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. The MHP does not have any contract provider offering regular outpatient mental health services. Line staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 10: Contract Providers' Transmission of Beneficiary Information to EHR

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

*Only applicable to after-hours crisis line operator with no significant percentages to report. These claims are submitted by the provider as needed.

Beneficiary Personal Health Record

The 21st Century Cures Act (Cures Act) of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a PHR enhances beneficiaries' and their families' engagement and participation in treatment. The MHP estimates a two-year horizon for PHR implementation alongside when it selects and implements a new EHR.

Interoperability Support

The MHP is not a member or participant in a Health Information Exchange (HIE). Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult.

IS KEY COMPONENTS

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

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

Table 11: Key Component – IS Infrastructure

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

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

- Since the onset of COVID-19, the MHP was able to rapidly equip all clinical and line staff with new laptops in order to facilitate telehealth sessions. During the past year, the MHP also increased its contract amount for the ASP. Together, the MHP and Kings View provided special trainings on telehealth billing codes for the staff.
- The MHP also created a special telehealth equipped private room in the clinic where beneficiaries who lack smart mobile devices can connect to their therapists and doctors.
- The MHP increased its staffing for billing and eligibility determination.
- Although the MHP has a functional EHR at present, the vendor's last update is likely to be its final one, as Kings View has determined that this EHR will not serve the needs of California's SMHS going forward.
- At this time, the MHP is keeping its options open regarding what replacement EHR Kings View will choose, while also monitoring what similar size MHPs with the same current vendor are doing. This will be critical since the current update will not be serving the MHP's needs beyond the end of CY 2022.

IMPACT OF FINDINGS:

Overall, the MHP successfully ramped up its telehealth capacity during COVID-19 that allowed it to maintain its services similar to the pre-pandemic levels after a drop in its claims in the first months of the pandemic (Table D.3).

The MHP's HCB count jumped from none to 38 in one year alongside its overall ACB and inpatient LOS and episode costs. However, it appears that the increase in ACB can be attributed to interim rate increases during COVID-19 that may not be permanent.

The phasing out of its current EHR by the end of CY 2022 presents an opportunity for the MHP to examine other vendors' functionality and track record in California, as well as their ability adjust to the new 1915 (b) waiver slated to begin next year.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

BACKGROUND

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

CONSUMER PERCEPTION SURVEYS

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

The MHP administers the CPS twice a year with the Fall 2020 survey being cancelled due to the pandemic. The MHP reported difficulties in obtaining the aggregated CPS data from prior survey administrations; thus, the MHP has not been able to compare most recent CPS findings with past results.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

As part of the pre-site planning process, CalEQRO requested one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members, containing 6 to 8 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers with the majority having initiated services in the preceding 12 months. The focus group was held via videoconferencing software, but all participants joined by audio-only mode and included three participants; although a Spanish interpreter joined initially, her service was not needed as all participants were bilingual. All consumers participating receive clinical services from the MHP.

The participants expressed that it was easy and quick to get an initial intake appointment with the MHP, but that there was a long wait to see the psychiatrist. Participants mostly felt that MHP staff have been helpful and supportive. Participants

are aware of the Behavioral Health Advisory Board meetings and feel comfortable sharing feedback there directly or through board representatives.

Recommendations from focus group participants included:

- Increase outreach to current Latino/Hispanic beneficiaries and to the Latino/Hispanic general public to provide psychoeducation and information them of MHP services.
- Simplify the process to obtain health records.
- Improve timeliness to psychiatric appointments.

IMPACT OF FINDINGS

Overall, beneficiaries had positive feedback about the provision of care and services at the MHP and felt that their needs were being addressed. Feedback about the long wait times for a psychiatry appointment echo the timeliness data for first offered psychiatry appointment discussed earlier in the report; further exploration of this issue is warranted and the MHP is encouraged to closely monitor if the addition of psychiatry hours through Traditions Behavioral Health will adequately address this issue or if further action is necessary.

CONCLUSIONS

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

STRENGTHS

1. The MHP is expanding its programs and enhancing collaboration with partner agencies. (Access)
2. The MHP is expanding its staffing by 20 percent and making salary adjustments to both retain current staff and recruit new staff. (Access)
3. Timeliness to first offered intake appointment meets the DHCS standard for 97.9 percent of all services. (Timeliness)
4. Bi-directional communication and collaboration within the MHP has drastically improved from previous EQRs, contributing to a positive shift in MHP culture. (Quality)
5. The MHP allocates sufficient resources to its information systems and was able to rapidly deploy new equipment for all clinical staff to ramp up its telehealth services; this enabled the MHP to meet beneficiary access and treatment needs during the COVID-19 pandemic. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP meets the timeliness standard for first offered psychiatry appointment only 38.64 of the time for all services. (Timeliness)
2. The MHP meets the timeliness standard for first offered urgent appointment only 55.56 percent of the time for all services. (Timeliness)
3. The MHP does not have a system in place to monitor medication practices for the entire system nor track or trend HEDIS measures for youth as outlined in SB 1291. (Quality)
4. The MHP is still deciding on how to aggregate CANS-50 data so that the information can be useful for clinical staff and quality improvement activities. (Quality)
5. The MHP experienced an increase in its inpatient LOS and costs alongside a significant increase in its HCBs during CY 2020. (Quality, IS)
6. The phasing out of its current EHR by the end of CY 2022 presents an opportunity for the MHP and a good timeline to examine other vendors'

functionality and track record in California, as well as their ability adjust to the new 1915 (b) waiver slated to begin next year. (IS)

RECOMMENDATIONS

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

1. Evaluate obstacles and implement strategies to adhere to state timeliness standards for first offered psychiatry appointments within 15 business days. (This recommendation is a carry-over from FY 2020-21) (Timeliness)
2. Evaluate obstacles and implement strategies to adhere to state timeliness standards for urgent appointments that do not require prior authorization within 48 hours. (Timeliness)
3. Investigate best practices and implement a medication monitoring system, including monitoring HEDIS measures outlined in SB 1291. (Quality)
4. Consult with the EHR vendor and implement a method to aggregate CANS-50 data. (This recommendation is a carry-over from FY 2020-21) (Quality)
5. Develop an IS strategic plan that will at a minimum incorporate the desired EHR functionalities, IT security, operational continuity and disaster recovery plan, and staff training needs. The IS strategic plan development should incorporate line staff and beneficiary voices. (IS)

SITE REVIEW BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site EQR of the MHP. Consequently, some areas of the review were limited.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: Review Agenda

The following sessions were held during the EQR, 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
PIPs
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
ISCA
EHR Deployment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: Review Participants

CalEQRO Reviewers

Olivia Kozarev, Quality Reviewer

Saumitra SenGupta, Information Systems Reviewer

MaryEllen Collins, Consumer/Family Member Consultant

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Arce	Tomika	Medical Billing Specialist	Colusa County Behavioral Health
Briscoe	Bonnie	Fiscal Administrative Officer	Colusa County Behavioral Health
Bruno	Susan	Therapist	Colusa County Behavioral Health
Bullis-Cruz	Heather	Compliance Officer	Colusa County Behavioral Health
Davis	Mandi	Therapist	Colusa County Behavioral Health
Gomez	Patricia	Case Manager	Colusa County Behavioral Health
Hall	Anthony	Therapist	Colusa County Behavioral Health
Martinez	Ivan	Therapist	Colusa County Behavioral Health
McAllister	Jennifer	Clinical Program Manager, Substance Use Disorders	Colusa County Behavioral Health
McCloud	Bill	EHR Manager	Colusa County Behavioral Health
McGregor	Mark	Clinical Program Manager, Children	Colusa County Behavioral Health
O'Neill	Noel	Interim Director	Colusa County Behavioral Health
Osbourn	Walter	Behavioral Health Board Member	Colusa County Behavioral Health
Piluczynski	Cindy	Patient's Rights Advocate	Colusa County Behavioral Health
Pina	Jayro	Fiscal Analyst	Colusa County Behavioral Health
Piper	Shannon	Clinical Program Manager, Adult	Colusa County Behavioral Health
Puga	Mayra	Mental Health Services Act Coordinator	Colusa County Behavioral Health
Ramirez	Jose	Mental Health Specialist	Colusa County Behavioral Health
Rodrigues	Daisy	Therapist	Colusa County Behavioral Health
Rojas	Bessie	QA Coordinator	Colusa County Behavioral Health

Last Name	First Name	Position	Agency
Rubio	Rocio	Medical Billing Specialist	Colusa County Behavioral Health
Scroggins	Jeannie	QA Coordinator	Colusa County Behavioral Health
Shields	Angela	Family Specialist	Colusa County Behavioral Health
Stirling	Valerie	Peer Support Specialist	Colusa County Behavioral Health
Uhring	Audrey	Deputy Director	Colusa County Behavioral Health
Vasquez	Veronica	Financial Eligibility Coordinator	Colusa County Behavioral Health
Whiting	Lynn	EHR Coordinator	Colusa County Behavioral Health
Wilson	Robert	Behavioral Health Board Member	Colusa County Behavioral Health

ATTACHMENT C: PIP Validation Tool Summary

Clinical PIP

Table C1: Overall Validation and Reporting of PIP Results

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☒ →Moderate confidence ☐ →Low confidence ☐ →No confidence	Beneficiaries should be included at the PIP development stage in order to incorporate the target population's feedback into the foundation of the PIP and ensure that the correct issues/interventions are being targeted. The current aim statement can be improved by adding the study time period and including specific baseline and improvement target numbers to make the statement measurable. It is recommended that all procedures for the PIP are made as clear and consistent as possible so that clinicians are doing the exact same things with each beneficiary each time, as much as possible. Optional tools should not be present as this may affect the results of the PIP. All interventions need to be done the same way to reduce the possibility that the results are coming from external variables. Data personnel were indicated (QA Coordinator), but not their relevant qualifications. As this PIP is still ongoing, full data analysis has not yet occurred. Once the PIP study period ends later this CY, the MHP will need to complete a full data analysis and interpretation of results along with the data that they have already provided.

General PIP Information
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Colusa County Department of Behavioral Health
PIP Title: Collateral Support
PIP Aim Statement: **"Will prioritizing offering collateral services to our adult beneficiaries increase the number of adult beneficiaries that receive a collateral service and subsequently show an improvement in their mental health functioning indicated by their MORS score?"**
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): All adult (age 18+) Medi-cal beneficiaries.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) 1. Made available NAMI's ESPERANZA Family Guide for providers to use with beneficiaries. The ESPERANZA Family Guide provides psychoeducation on mental health disorders and includes the value of familismo. 2. Use of Collateral Support Tool 3. Updated Beneficiary Questionnaire that is given at Intake and Reassessment sessions to include statement/question about the beneficiary's natural support system. 4. Use of Collateral Questionnaire
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) N/A

MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

1. Updated MH MORS assessment in Anasazi to capture data as to whether or not a CCBH Clinical Staff offered Collateral session to the beneficiary that month

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Collateral Service Received	CY 2019	14/313 = 4.47%	1/1/20 – 3/31/20 4/1/20 – 6/30/20 At 7/1/2020, all staff are working from home due to COVID-19. Very little collateral sessions were being conducted due to telehealth and phone sessions. At this point, it was determined by the PIP Team to gather data every 6 months due to COVID-19 barriers. 7/1/20 – 12/31/20 1/1/2021 – 6/30/2021	2/183 = 1.09% 12/178 = 6.74% N/A 17/254 = 6.69% 17/259 = 6.56%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): no significance testing conducted

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
MORS Score	CY 2019	30/73 = 41.10%	1/1/20 – 3/31/20 4/1/20 – 6/30/20 At 7/1/2020, all staff are working from home due to COVID-19. Very little collateral sessions were being conducted due to telehealth and phone sessions. At this point, it was determined by the PIP Team to gather data every 6 months due to COVID-19 barriers. 7/1/20 – 12/31/20 1/1/2021 – 6/30/2021	18/38 = 47.37% 15/26 = 57.69% N/A 32/64 = 50.00% 33/74 = 44.59%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): no significance testing conducted

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- Beneficiaries should be included at the PIP development stage in order to incorporate the target population's feedback into the foundation of the PIP and ensure that the correct issues/interventions are being targeted.
- The current aim statement can be improved by adding the study time period and including specific baseline and improvement target numbers to make the statement measurable.
- It is recommended that all procedures for the PIP are made as clear and consistent as possible so that clinicians are doing the exact same things with each beneficiary each time, as much as possible. Optional tools should not be present as this may affect the results of the PIP. All interventions need to be done the same way to reduce the possibility that the results are coming from external variables.
- Data personnel were indicated (QA Coordinator), but not their relevant qualifications; include their qualifications in future write-ups.
- As this PIP is still ongoing, full data analysis has not yet occurred. Once the PIP study period ends later this CY, the MHP will need to complete a full data analysis and interpretation of results along with the data that they have already provided.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☒ →High confidence ☒ →Moderate confidence ☐ →Low confidence ☐ →No confidence	The MHP would benefit from including direct beneficiary input/feedback during the PIP topic development phase. The aim statement needs to be revised to also include the improvement strategy, population of study, and the full time period for the PIP. Indicate the relevant qualifications of data personnel.

Perform Overall Validation and Reporting of PIP Results

General PIP Information
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Colusa County Department of Behavioral Health
PIP Title: Reducing wait time between intake assessment and offered therapy appointment
PIP Aim Statement: **"The timeliness between intake appointment and first offered therapy session will decrease from 19.51 business days to 15 business days or less for 70% of beneficiaries (currently 33.53%), by June 30, 2022."**
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:

Target population description, such as specific diagnosis (please specify): All new beneficiaries who have requested a mental health intake as of March 1, 2021, and qualify for Specialty Mental Health Services.

Improvement Strategies or Interventions (Changes in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)

N/A

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)

N/A

MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

1. Adding Access Worker
2. Adding another day of assignments per week

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
# of days between day of intake to first offered therapy appointment	3/1/2020 to 2/28/2021	19.51 business wait days with only 33.53% receiving offered therapy appointment within 15 business days	6/30/2021	15.41 business days average wait time between intake appointment and therapy appointment with 55.17% receiving offered therapy appointment within 15 business days	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): no significance testing conducted

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- The MHP would benefit from including direct beneficiary input/feedback during the PIP topic development phase.
- The aim statement needs to be revised to also include the improvement strategy, population of study, and the full time period for the PIP.
- Indicate the relevant qualifications of data personnel.

ATTACHMENT D: Additional Performance Measure Data

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

Colusa MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,835,638	155,154	4.05%	$934,903,862	$6,026
Small-Rural	31,253	2,174	6.96%	$12,033,576	$5,535
MHP	2,277	135	5.93%	$1,341,096	$9,934

Table D 2: CY 2020 Distribution of Beneficiaries by ACB Range

Colusa MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
<$20K	547	86.41%	92.22%	$3,307,714	$6,047	$4,399	50.65%	56.70%
>$20K-$30K	48	7.58%	3.71%	$1,185,875	$2,918	$24,274	18.16%	12.59%
>$30K	38	6.00%	4.07%	$2,036,440	$53,591	$53,969	31.19%	30.70%

Table D 3: Summary of CY 2020 Short-Doyle/Medi-Cal Claims

Colusa MHP Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
TOTAL	16,557	$6,900,385	470	$205,775	2.98%	$6,694,610	$6,447,180
JAN20	1,315	$248,251	7	$572	0.23%	$247,679	$244,620
FEB20	1,191	$216,748	14	$1,342	0.62%	$215,406	$210,738
MAR20	1,307	$518,373	11	$1,370	0.26%	$517,003	$512,270
APR20	1,629	$495,354	88	$30,111	6.08%	$465,243	$433,213
MAY20	1,295	$475,666	19	$5,511	1.16%	$470,155	$464,402
JUN20	1,420	$562,973	8	$2,644	0.47%	$560,329	$556,389
JUL20	1,445	$747,733	10	$5,210	0.70%	$742,523	$734,968
AUG20	1,445	$750,306	8	$5,550	0.74%	$744,756	$733,967
SEP20	1,439	$747,297	90	$46,829	6.27%	$700,468	$648,085
OCT20	1,504	$780,643	72	$35,977	4.61%	$744,666	$702,247
NOV20	1,282	$688,189	66	$34,500	5.01%	$653,689	$615,049
DEC20	1,285	$668,851	77	$36,158	5.41%	$632,693	$591,231

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

Table D 4: Summary of CY 2020 Top Five Reasons for Claim Denial

Colusa MHP			
Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible or non-covered charges	326	$159,328	77%
Medicare Part B or Other Health Coverage must be billed before submission of claim	140	$44,804	22%
Service line is a duplicate and a repeat service procedure code modifier not present	2	$1,581	1%
Beneficiary not eligible	2	$61	0.03%
TOTAL	**470**	**$205,713**	**100%**