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FY 2022-23
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 8 – 9, 2022

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — August 8-9, 2022

MHP Size — Small-rural

MHP Region — Superior

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	4	1	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	5	4	1
Information Systems (IS)	6	6	0	0
TOTAL	**26**	**21**	**4**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
"Social Supports for Youth"	Clinical	06/22	Implementation	Moderate
"Reducing Wait Time"	Non-Clinical	06/22	Implementation	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	3

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has sufficient capacity to serve monolingual Spanish-speaking beneficiaries, which account for one-third of their beneficiaries.
- The MHP now meets monthly with Interagency Placement Committees. This has improved communication with other agencies regarding foster care (FC) youth.
- The MHP improved its FC penetration rate (PR) by 86 percent from CY 2019 (24.49 percent) to CY 2021 (45.61 percent), now exceeding statewide and small-rural averages.
- The MHP contracted with Kingsview and Traditions Behavioral Health to increase the number of psychiatric providers and hours via telehealth, expanding availability and capacity.
- While the statewide and small-rural PR continued to decline in the second year of the pandemic in CY 2021, Colusa MHP remained the same as CY 2020. The MHP's PR is also 58 percent higher than the statewide PR.
- The MHP has developed, in collaboration with Kingsview, a design that refines the functionality of the Child and Adolescent Needs and Strengths–50 (CANS-50) and Pediatric Symptom Checklist–35 (PSC-35) Dashboards so the appropriate information can be aggregated and evaluated by MHP staff.

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

- The MHP number of eligible beneficiaries has increased over the past three years, and the number served has also increased, while the PR remains at 6.08 percent.
- The standard for urgent appointments, despite initiating performance improvement activities, was met only 50 percent of the time for FY 2021-22.

- The MHP does not have a medication monitoring system in place to track, trend, and use medication data for performance improvement activities.
- The MHP does not track and does not trend Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by the Welfare and Institutions Code (WIC) Section 14197 and Senate Bill (SB) 1291.
- Stakeholders feedback suggests that there is an opportunity for the MHP to improve transparency and communication.

Recommendations for improvement based upon this review include:

- Research and implement ways to continue to increase access, given the MHP's PR remains at 6.08 percent while number of eligible beneficiaries and number served has increased.
- Continue to track effectiveness of the performance improvement activities to increase timeliness for urgent appointments, with a goal of 80 percent or more.
- Continue to support Electronic Health Record (EHR) vendor (Kingsview) implementing a psychiatrist review that provides medication monitoring. Follow-up with contracted psychiatric providers to do the same.
- Investigate best practices and implement a medication monitoring system for the FC system as required by WIC Section 14197 and SB 1291.
- Increase opportunities for beneficiary and family member input, participation in committees, and volunteer positions to improve beneficiary and family member perceptions of the value of their input.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2022-23 findings of the EQR for Colusa County MHP by BHC, conducted as a virtual review on August 08-09, 2022.

REVIEW METHODOLOGY

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

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File; Short-Doyle/Medi-Cal (SDMC) approved claims; and Inpatient Consolidation File (IPC).

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and five summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on FC, transitional age youth, Early and Periodic Screening, Diagnostic, and Treatment, and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Review and validation of each MHP's NA as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Beneficiary perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 12, then "≤11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding PR percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during Coronavirus Disease 2019 (COVID-19) pandemic. The MHP had to close some programs for in-person services in 2020 but did not experience significant staff loss or discontinuation of services. At the time of the CalEQR, the MHP had telehealth, telephone, and some in-person locations as options for beneficiaries to receive services. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- Executed a Memorandum of Understanding between Colusa Behavioral Health, local law enforcement, and the hospital emergency department to improve crisis services.
- Contracted with Kingsview and Traditions Behavioral Health to increase the number of psychiatric providers and hours via telehealth, expanding availability and capacity.
- Contracted with Kingsview Professional Services to support with CalAIM initiatives and other quality assurance and improvement projects.
- Increased capacity by hiring ten new clinical positions and one new Marketing and Administrative Specialist.
- Reopened Safe Haven Wellness and Recovery Center, and opened a new youth center, Bright Vista.
- Opened an innovation program Practical Action Towards Health (PATH). PATH will offer help with social determinants, to include employment, housing, food security, medical access, and transportation.
- Contracted with the California Mental Health Services Authority (CalMHSA) and Streamline Behavioral Health to implement a new EHR in July 2023.
- Onboarded a new MHP Director as of June 1, 2022.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: 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.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Following the retirement of the onsite psychiatrist, the MHP contracted with Traditions Behavioral Health and Kingsview to provide telepsychiatry services. Since doing so timeliness rates have improved to an average of 3.11 days wait with 100 percent of requests meeting the standard.
- Stakeholders reported favorable results of interactions with the telepsychiatry services.

Recommendation 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)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP created a Crisis Team in January 2022. Since doing so the wait time for urgent requests has improved from an average of 120 hours to an average of 72 hours; this showed an increase in the number of requests that meet the 48 hours standard by 20 percentage points to 69.23 percent in Quarter 3.

Recommendation 3: Investigate best practices and implement a medication monitoring system, including monitoring HEDIS measures outlined in SB 1291.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- While the MHP has a contract with a pharmacist for medication monitoring, administrative barriers prevented active monitoring in FY 2021-22.
- The MHP has been working closely with their EHR Vendor and has engaged in monthly Health Impact Assessment (HIA) meetings with an assigned representative who has been designing a Medication Monitoring Dashboard and a SB 1291 (with HEDIS measure items) to make this data more accessible. HIA meetings are ongoing.
- The MHP reports that their EHR vendor has begun medication monitoring of the psychiatrists they provide to the MHP. The MHP plans to request that the second provider of psychiatrists, Traditions Behavioral Health, do the same.
- The MHP is recruiting for a psychiatric technician to monitor HEDIS measures for psychotropic medication per SB 1291.
- This recommendation will be carried forward to allow the MHP to report completion of implementation of medication monitoring systems in FY 2023-24 EQR.

Recommendation 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.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has been working closely with their EHR vendor (Kingsview) and engaging in monthly HIA meetings with an assigned representative.
- This representative has been collaboratively designing and refining the functionality of the MHP's dashboards so that the appropriate information can be aggregated and evaluated by MHP staff. Work has been completed on the CANS-50 Dashboard which now includes Percent of Change from 1st Assessment to Reassessment, Client CANS-50 Details, and is Staff Specific.
- These customized reports allow the MHP to see the overall percentage change, either improvement or deterioration of clients, on each item in CANS, the specific changes on individual clients, and the effectiveness of the clinical staff providing treatment.
- Further work is needed to develop a mechanism/practice to evaluate and disseminate the aggregated CANS-50 data per the Children's Clinical Program Manager request.

Recommendation 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)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has developed a Disaster Recovery Plan. The MHP presented its strategic plan to ensure IT security, operations continuity, and disaster recovery plan. The EHR-related issues are all managed by the IS vendor and the application service provider (ASP).
- The MHP clarified that most non-EHR related security responsibilities are carried out by the county IT.
- With the pending EHR implementation next year, the MHP will need to ensure that the functionalities including claims and billing are transitioned without any break in operations, and that the new vendor has an operations continuity plan (OCP) with the same or better standards and protocols as the current vendor and the ASP.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 95 percent of services were delivered by county-operated/staffed clinics and sites, and 5 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 83 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county provider staff; beneficiaries may request services through the Access Line during the normal business hours and by contractor-operated staff during the after-hours and weekends; 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 (MCP) 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.

[1] CMS Data Navigator Glossary of Terms

As part of CalAIM changes in access criteria are being implemented the MHP is developing an open access system for this coming year. This involves collaboration with the MCP.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 225 adult beneficiaries, 44 youth beneficiaries, and 34 older adult beneficiaries. All telehealth is provided at the county-operated clinic site. Among those served, 50 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

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

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

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

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

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

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

Table 1B: MHP OON, FY 2021-22

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	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 has sufficient bilingual capacity to serve monolingual Spanish-speaking beneficiaries, which is close to a third of the beneficiaries served by the MHP.
- The MHP has expanded capacity for psychiatry services.

ACCESS PERFORMANCE MEASURES

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

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median

differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, the PR of 6.08 is percent is lower than small rural and higher than the state PR with an average approved claim amount of $10,119. While the state PR has fallen over the past three years, the MHP PR has remained more or less constant.

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

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims

Year	Total Eligibles	Beneficiaries Served	PR	Total Approved Claims	AACB
CY 2021	11,132	677	6.08%	$6,850,714	$10,119
CY 2020	10,404	633	6.08%	$6,530,029	$10,316
CY 2019	10,088	670	6.64%	$2,509,392	$3,745

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

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	PR	Similar Size Counties PR	Statewide PR
Ages 0-5	1,334	≤ 11	-	1.45%	1.59%
Ages 6-17	3,254	229	7.04%	7.65%	5.20%
Ages 18-20	683	43	6.30%	7.07%	4.02%
Ages 21-64	4,942	366	7.41%	7.15%	4.07%
Ages 65+	921	-	-	3.18%	1.77%
TOTAL	**11,132**	**677**	**6.08%**	**6.29%**	**3.85%**

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percent of Beneficiaries Served
Spanish	197	29.32%
Threshold language source: Open Data per BHIN 20-070		

Close to a third of the beneficiaries served by the MHP had Spanish as their primary language, the only threshold language in the county other than English.

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

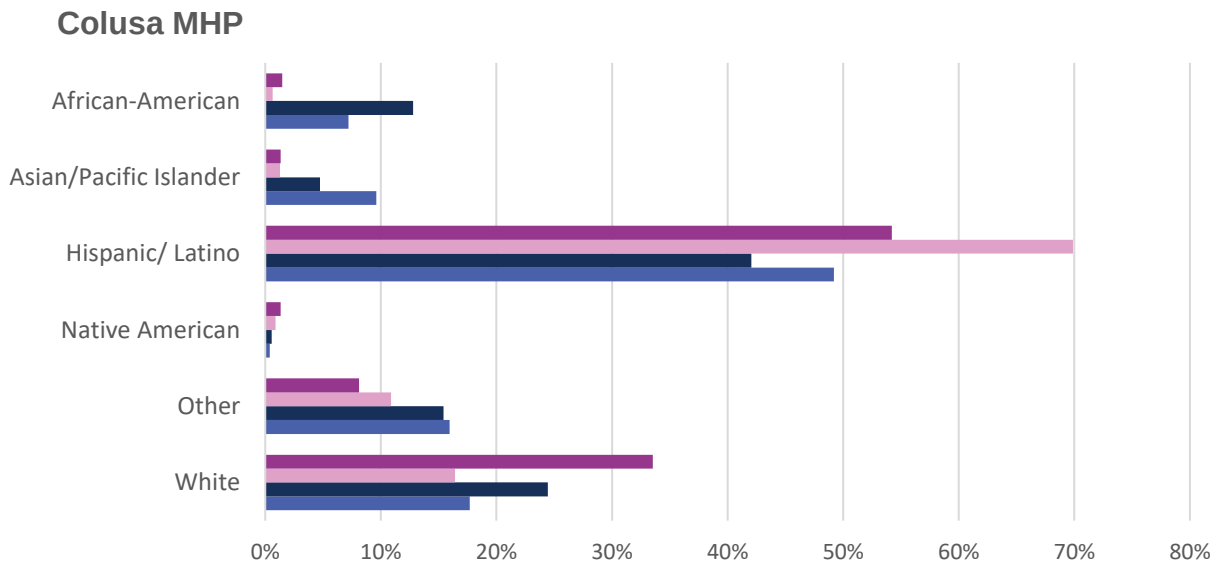
Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	PR	Total Approved Claims	AACB
MHP	2,572	157	6.10%	$1,388,183	$8,842
Small-Rural	35,376	2,077	5.87%	$9,182,717	$4,421
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.

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

Race/Ethnicity	# MHP Served	# MHP Eligibles	MHP PR	Statewide PR
African-American	≤ 11	70	-	6.83%
Asian/Pacific Islander	≤ 11	143	-	1.90%
Latino/Hispanic	367	7,782	4.72%	3.29%
Native American	≤ 11	98	-	5.58%
Other	55	1,213	4.53%	3.72%
White	227	1,828	12.42%	5.32%
Total	**677**	**11,134**	**6.08%**	**3.85%**

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



	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	34%	8%	1%	54%	1%	1%
MHP % Eligibles	16%	11%	1%	70%	1%	1%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

The percentage of Hispanic/Latino Medi-Cal eligibles in Colusa County is 43 percent higher than the statewide rate and constitute 70 percent of the total eligible population. More than half the beneficiaries (54 percent) served by the MHP were Hispanic/Latino.

White Medi-Cal eligible percentage in the county is similar to the state, but the MHP proportionately serves more White beneficiaries, 34 percent versus 24 percent statewide.

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

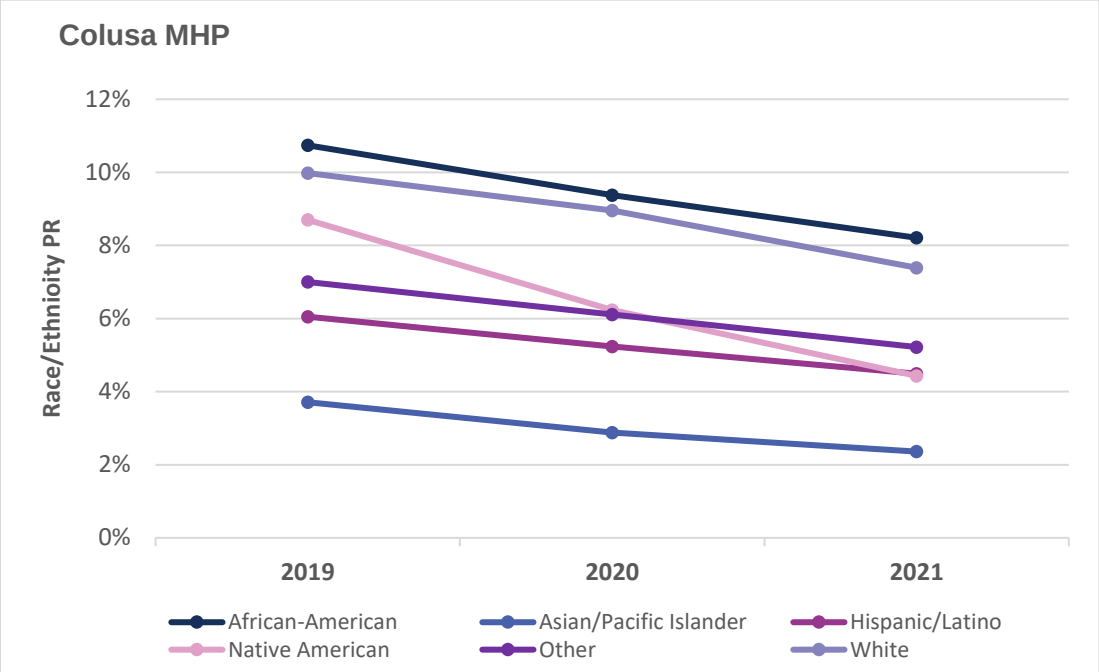


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

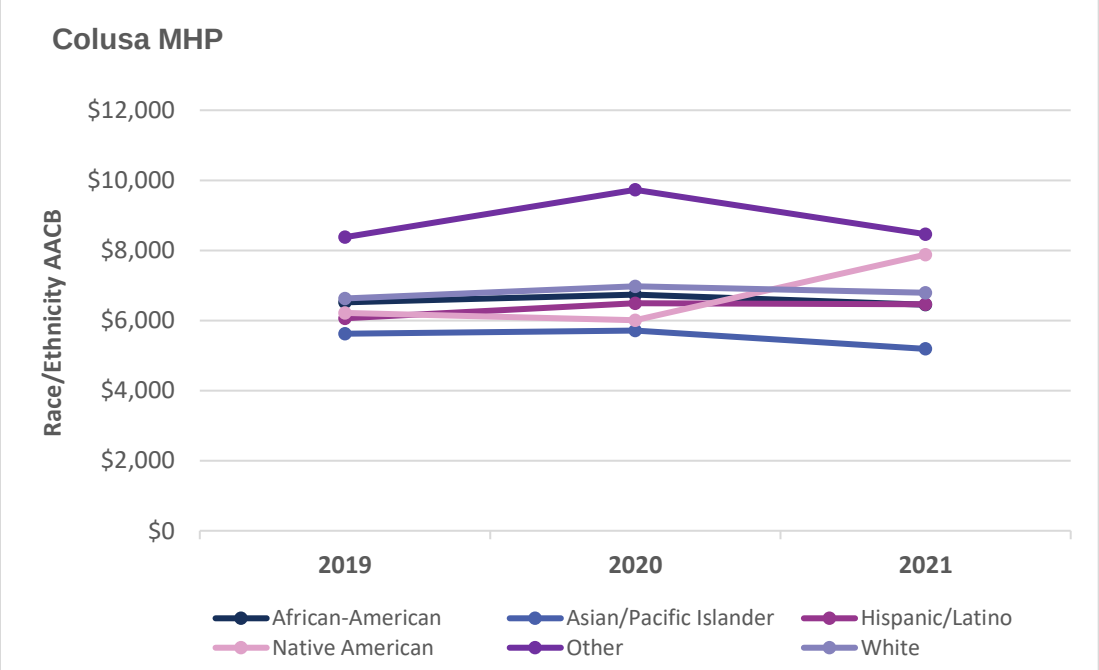
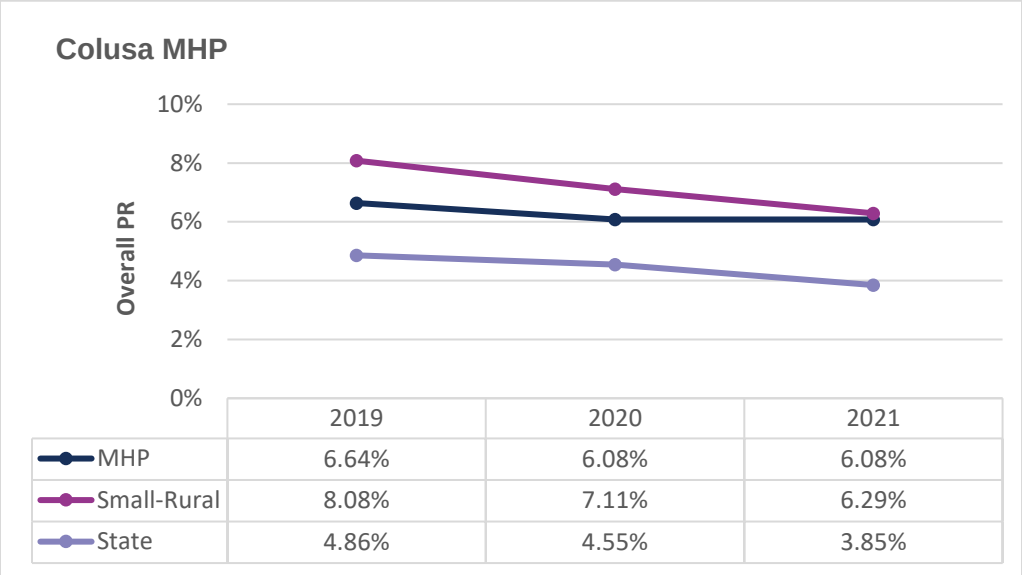


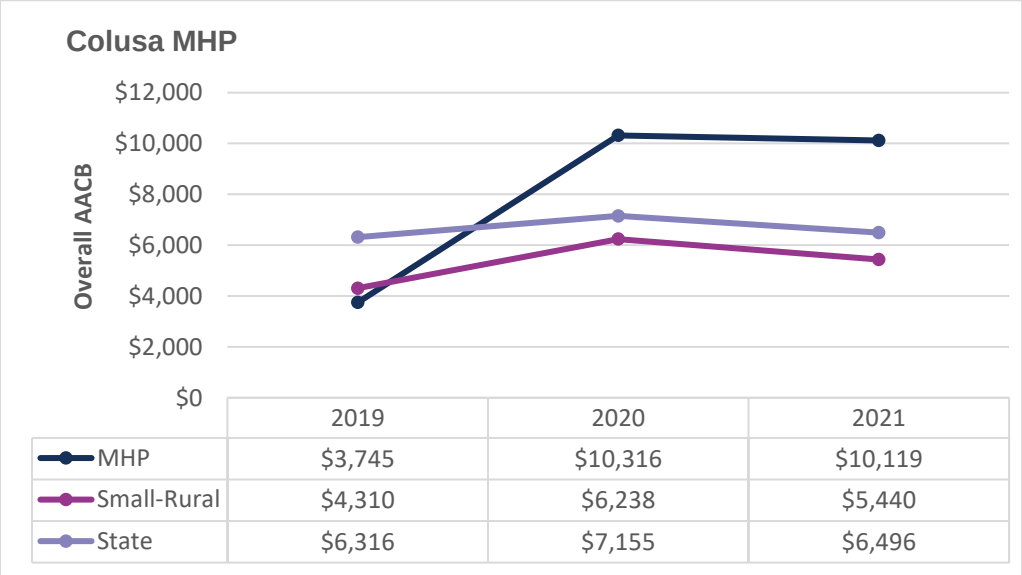
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	6.64%	6.08%	6.08%
Small-Rural	8.08%	7.11%	6.29%
State	4.86%	4.55%	3.85%

Since the onset of the COVID-19 pandemic, statewide, small-rural, and the MHP PRs all declined. However, while the statewide and small-rural PR continued to decline in the second year of the pandemic in CY 2021, Colusa MHP appears to have stemmed the decline, staying the same as CY 2020. It is now close to the small-rural PR which used to be considerably higher. The MHP's PR is also 58 percent higher than the statewide PR.

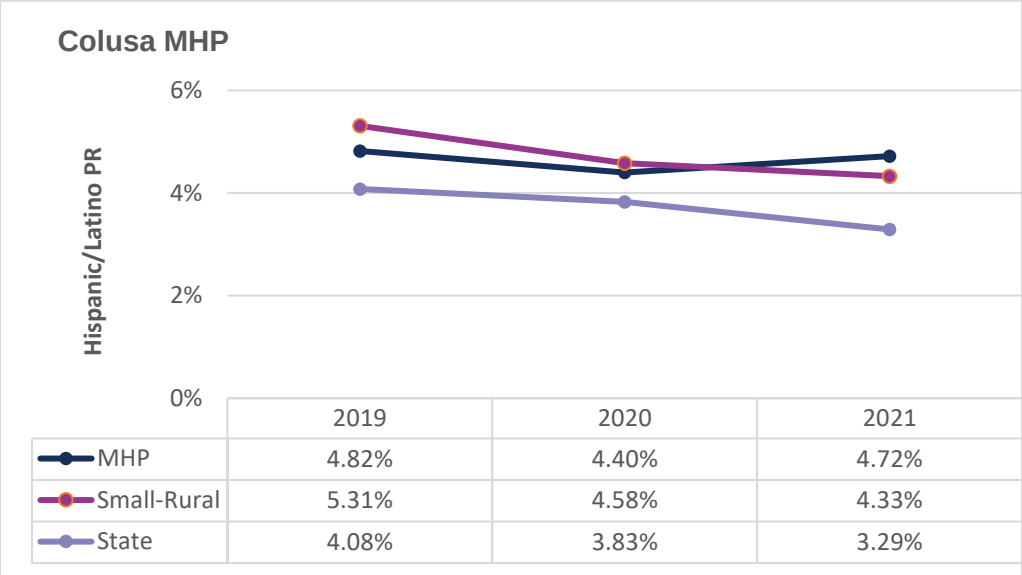
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$3,745	$10,316	$10,119
Small-Rural	$4,310	$6,238	$5,440
State	$6,316	$7,155	$6,496

As noted in the previous year's EQR report, the MHP's AACB increased significantly higher in CY 2020 than the corresponding statewide and small-rural figures. It declined slightly in CY 2021 while the statewide and small-rural AACBs declined more rapidly.

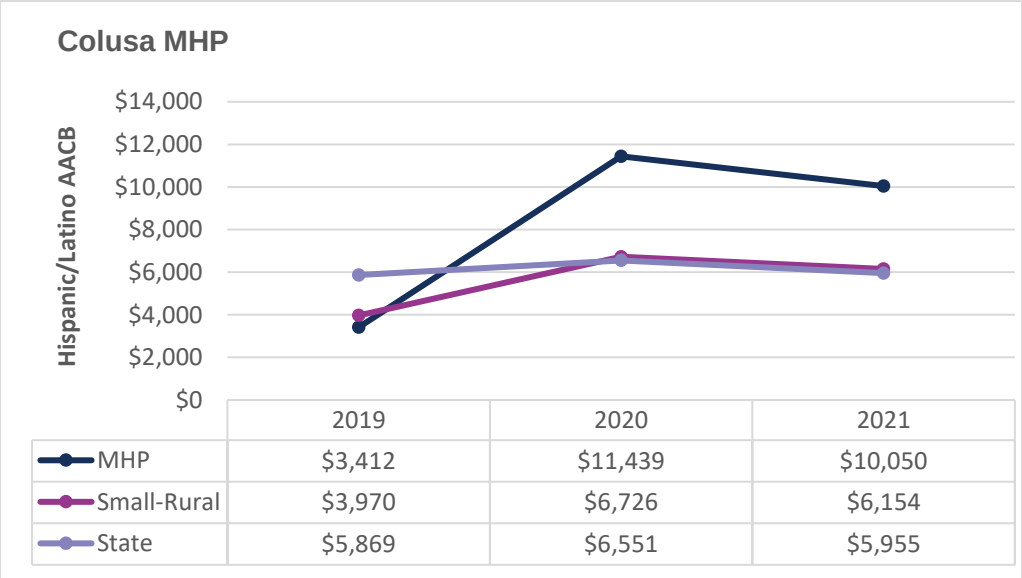
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	4.82%	4.40%	4.72%
Small-Rural	5.31%	4.58%	4.33%
State	4.08%	3.83%	3.29%

The MHP's Hispanic/Latino PR trends are similar to its overall trends with slight variations. The Hispanic/Latino PR increased slightly in CY 2021.

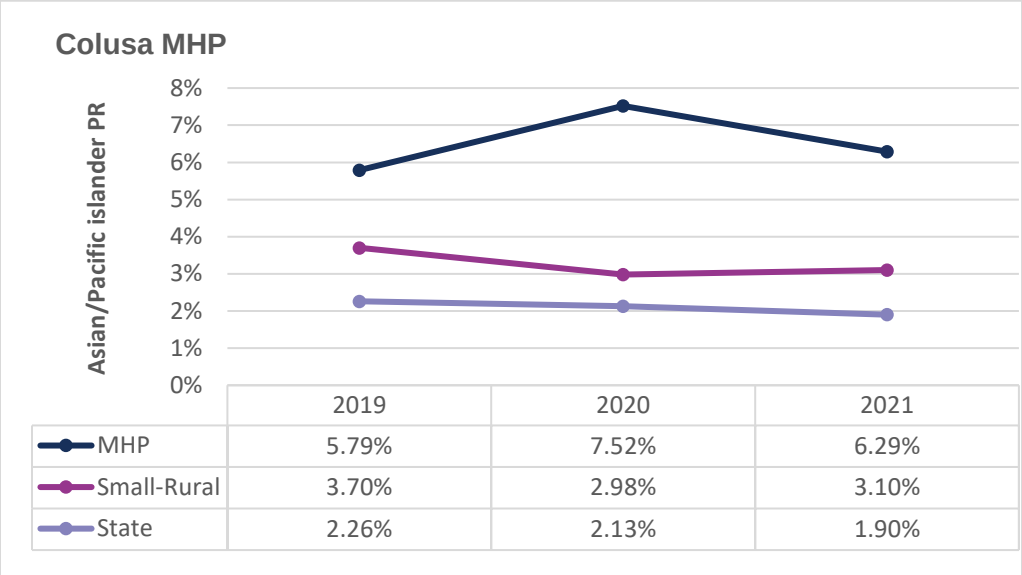
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$3,412	$11,439	$10,050
Small-Rural	$3,970	$6,726	$6,154
State	$5,869	$6,551	$5,955

The MHP's Hispanic/Latino AACB trends are similar to its overall trends with slight variations. The AACB went down by $1,400 dollars but remained two-thirds higher than the statewide and small-rural averages.

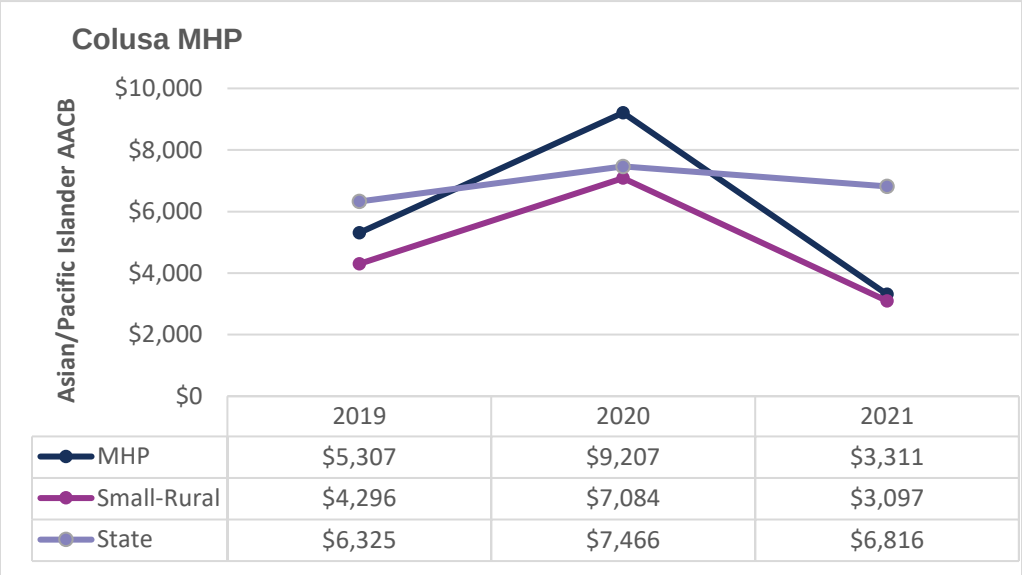
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	5.79%	7.52%	6.29%
Small-Rural	3.70%	2.98%	3.10%
State	2.26%	2.13%	1.90%

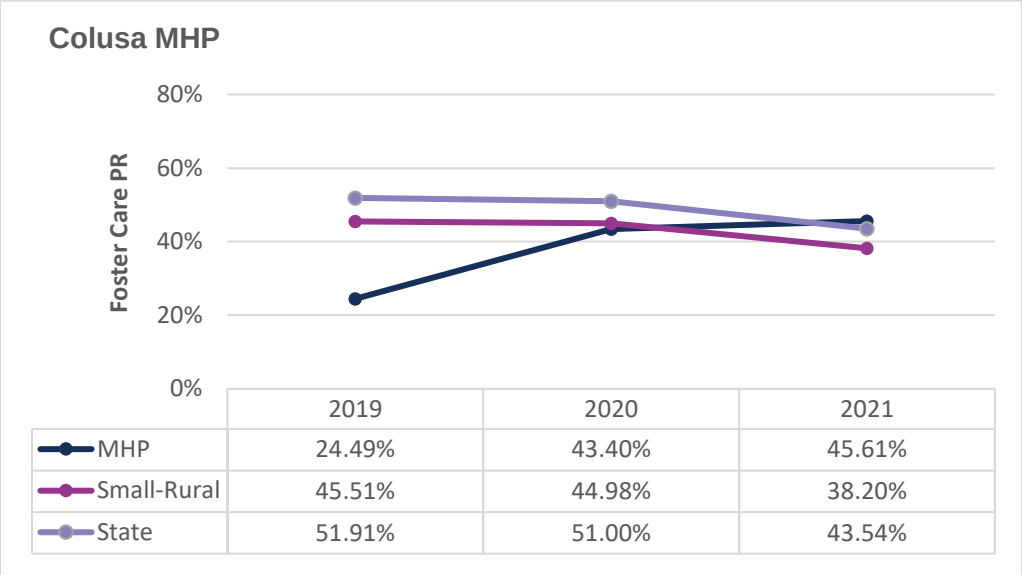
The MHP serves a low number of Asian/Pacific Islander beneficiaries, and this needs to be considered when interpreting the data.

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



	2019	2020	2021
MHP	$5,307	$9,207	$3,311
Small-Rural	$4,296	$7,084	$3,097
State	$6,325	$7,466	$6,816

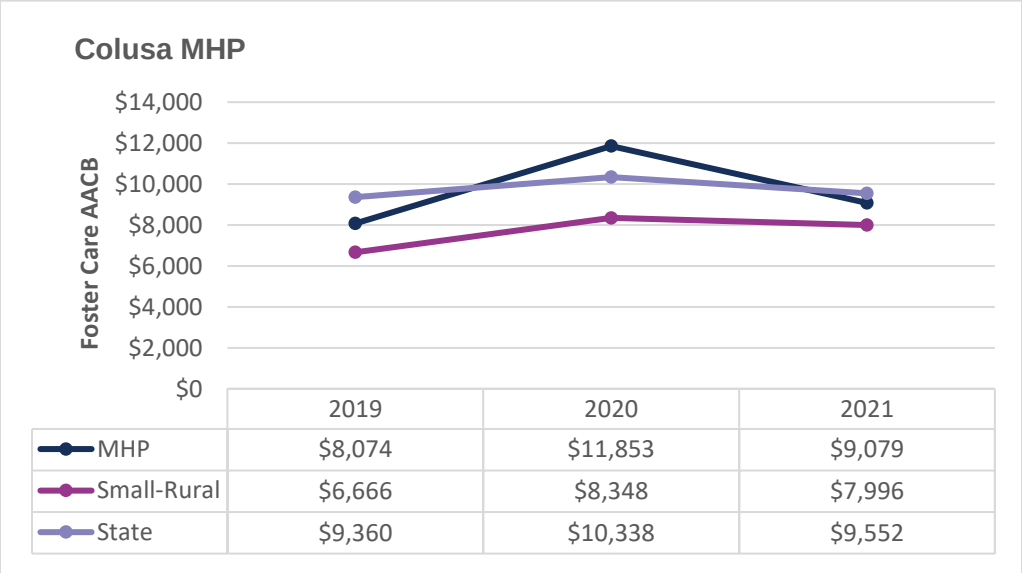
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	24.49%	43.40%	45.61%
Small-Rural	45.51%	44.98%	38.20%
State	51.91%	51.00%	43.54%

The MHP improved its FC PR by 86 percent from CY 2019 (24.49 percent) to CY 2021 (45.61 percent), now exceeding than statewide and small-rural averages. The MHP attributes this improvement, in part, to higher Child Protective Services referrals to the MHP.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$8,074	$11,853	$9,079
Small-Rural	$6,666	$8,348	$7,996
State	$9,360	$10,338	$9,552

The MHP's FC AACB declined much more rapidly in CY 2021 than its corresponding overall AACB and is similar to the statewide average now.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 441				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	≤ 11	-	-	-	10.8%	14	8
Inpatient Admin	≤ 11	-	-	-	0.4%	16	7
Psychiatric Health Facility	≤ 11	-	-	-	1.0%	16	8
Residential	≤ 11	-	-	-	0.3%	93	73
Crisis Residential	≤ 11	-	-	-	1.9%	20	14
Per Minute Services							
Crisis Stabilization	≤ 11	-	-	-	9.7%	1,463	1,200
Crisis Intervention	78	17.7%	166	90	11.1%	240	150
Medication Support	211	47.8%	333	258	60.4%	255	165
Mental Health Services	282	63.9%	985	577	62.9%	763	334
Targeted Case Management	130	29.5%	538	225	35.7%	377	128

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

Service Category	MHP N = 26				Statewide N=33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	≤ 11	-	-	-	4.5%	13	8
Inpatient Admin	≤ 11	-	-	-	-	6	4
Psychiatric Health Facility	≤ 11	-	-	-	0.2%	25	9
Residential	≤ 11	-	-	-	-	140	140
Crisis Residential	≤ 11	-	-	-	0.1%	16	12
Full Day Intensive	≤ 11	-	-	-	0.2%	452	360
Full Day Rehab	≤ 11	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	≤ 11	-	-	-	2.3%	1,354	1,200
Crisis Intervention	≤ 11	-	-	-	6.7%	388	195
Medication Support	≤ 11	-	-	-	28.5%	338	232
Therapeutic Behavioral Services	≤ 11	-	-	-	3.8%	3,648	2,095
Therapeutic FC	≤ 11	-	-	-	0.1%	1,056	585
Intensive Home Based Services	≤ 11	-	-	-	38.6%	1,193	445
Intensive Care Coordination	≤ 11	-	-	-	19.9%	1,996	1,146
Katie-A-Like	≤ 11	-	-	-	0.2%	837	435
Mental Health Services	24	92.3%	1,058	706	95.7%	1,583	987
Targeted Case Management	≤ 11	-	-	-	32.7%	308	114

IMPACT OF ACCESS FINDINGS

- The MHP number of eligible beneficiaries has increased over the past three years, and the number served has also increased, while the PR remains at 6.08.
- The MHP is implementing a walk-in access to outpatient clinics as part of the CalAIM changes in access. This will increase access to services.

- The MHP improved its FC PR significantly between CY 2019 and CY 2020 and continued to improve more gradually in CY 2021. It now has a higher FC PR than statewide and small-rural averages. The MHP attributes this improvement, in part, to increases in Child Protective Services referrals to the MHP.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The MHP sets timeliness standards, tracks and trends related data, and has initiated performance improvement activities when trends indicated below minimum performance expectations for all timeliness measures identified in Table 10.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of, FY 2021-22. This data represented the entire system of care. Table 11 and Figures 12 – 14 below display data submitted by the MHP; an analysis follows.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	6.91 Days	10 Business Days*	82.41%
First Non-Urgent Service Rendered	24.36 Days	15 Business Days **	41.20%
First Non-Urgent Psychiatry Appointment Offered	10.62 Days	15 Business Days*	80.95%
First Non-Urgent Psychiatry Service Rendered	12.19 Days	20 Days**	76.19%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	83.45 Hours	48 Hours*	50%
Follow-Up Appointments after Psychiatric Hospitalization	4 Days	7 Days**	54.84%
No-Show Rate – Psychiatry	9.87%	10%**	n/a
No-Show Rate – Clinicians	10.05%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

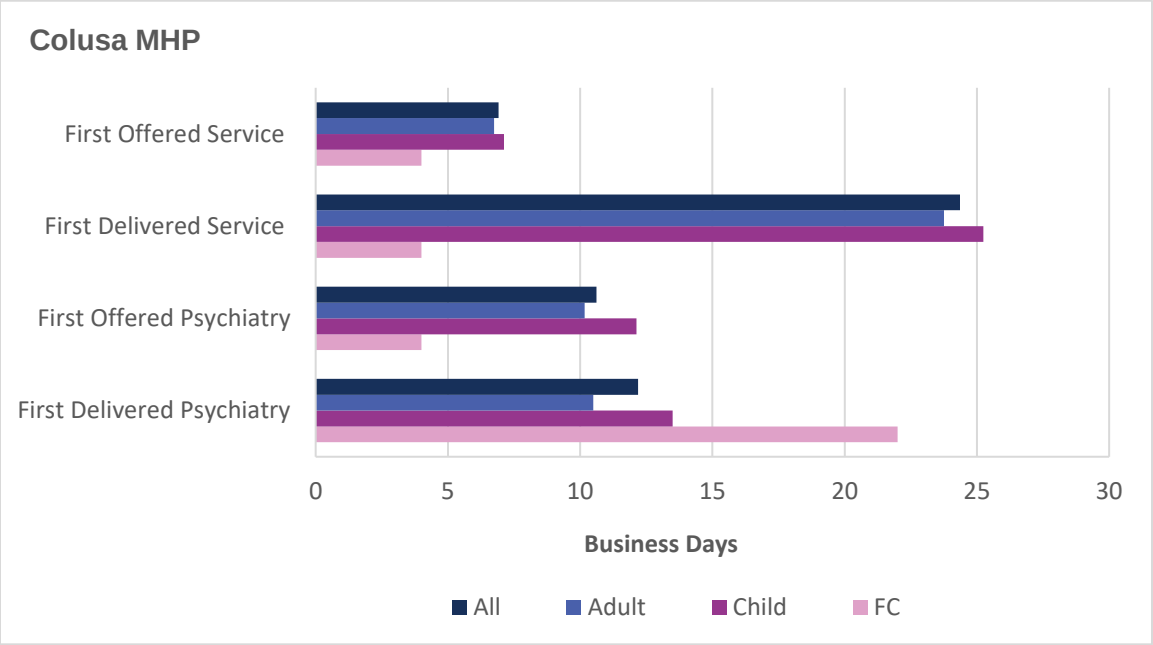


Figure 13: Wait Times for Urgent Services

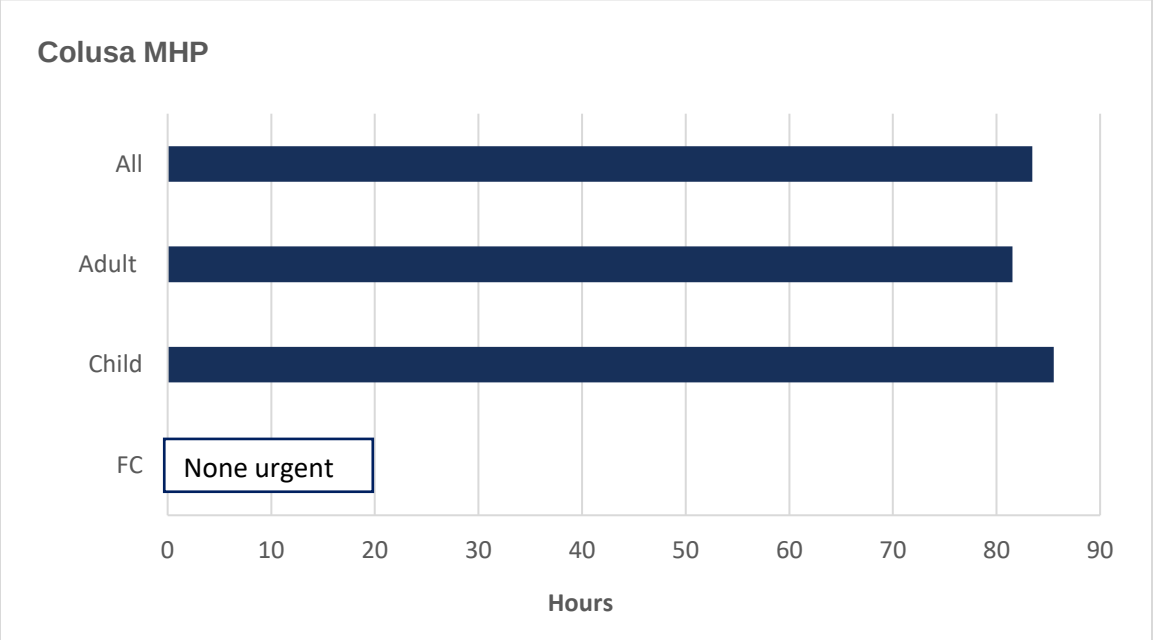
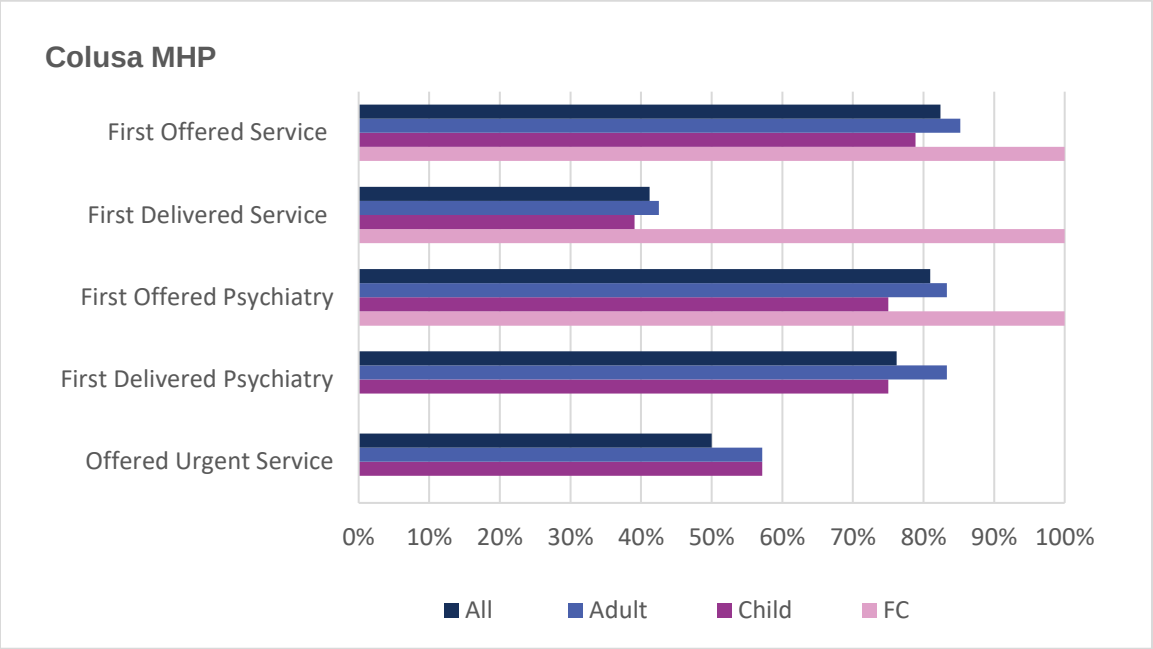


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments.
- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as a beneficiary discharging from an inpatient hospital, a beneficiary who was recently seen in crisis at the clinic, a beneficiary who just moved to Colusa County who is low on psychotropic medication, recent Child Protective Services removal from the home, and other conditions that may pose a risk of decompensation if a beneficiary is not seen as soon as possible.
- There were reportedly 32 urgent service requests with a reported actual wait time to services for the overall population at 83.45 hours.
- The process for psychiatry access as well as the definitions and tracking may differ for adults and children. The MHP has defined psychiatry access in the submission as from the point of first determination of need for both adults and children. Once medical necessity is determined, the psychiatrist reviews the chart for appropriateness and the timeline of “approved request” is established – this process may add additional wait time.
- The MHP reports that their EHR vendor is now starting to have a psychiatrist review the psychiatrists they provide to the MHP for medication monitoring. The

MHP plans to request that the second provider of psychiatrists, Traditions Behavioral Health do the same.

- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 9.8 percent for psychiatrist appointments overall, with 9.41 percent for adults, 13.62 percent for children, and 0 percent for FC. The MHP shows a no-show rate of 10.05 percent for non-psychiatry clinical staff overall, 11.60 percent for adults, 7.78 percent for children, and 13.79 percent for FC.
- MHP met the 48-hour urgent timeliness standard 50 percent of the time for FY 2021-22 and has initiated a process for response to urgent requests through the Crisis Team to improve this performance.

IMPACT OF TIMELINESS FINDINGS

- The MHP has contracted with Kingsview and Traditions Behavioral Health for telepsychiatry. They report 80.95 percent first offered appointment within the 15 days standard. This is in part to address CalAIM implementation on timeliness.
- The MHP reports 31 hospital discharges during FY 2021-22, with 17 receiving follow-up services within 7-days, or 54.84 percent. All 31 are reported to have received follow-up services within 30 days. This indicates that the MHP is involved in tracking hospitalizations and discharges effectively to allow for contact with the beneficiary to facilitate follow-up services. Telepsychiatry is conducted at the MHP, with staff available to help the client check-in online and with any connectivity issues. This has significantly increased their capacity for psychiatry services.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is an agency responsibility undertaken by the Quality Assurance (QA) Clinical Program Manager who is supported by a full-time QA Coordinator. Quality is viewed as a continuous process across systems, with QI embedded in each program.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. 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 54 identified FY 2021-22 QAPI workplan goals, the MHP met or partially met 75 percent. Progress towards the work plan goals is evaluated quarterly in QIC meetings. Annually, the work plan is evaluated to assure the success of the Quality Management program.

The MHP utilizes the following level of care (LOC) tools: Milestones of Recovery Scale (MORS), and CANS-50. All beneficiaries who request treatment are screened using LOC criteria. The MHP tracks reasons for referrals that do not match LOC criteria-based recommendation for placement.

The MHP utilizes the following outcomes tools: Generalized Anxiety Disorder -7 (GAD-7), MORS, PSC-35, CANS-50, Patient Health Questionnaire-9 (PHQ-9)

- The MHP utilizes the MORS to evaluate a beneficiary's status with a focus on engagement and recovery. Their score is used to identify individuals who need increased services as well as individuals who are successfully entering the maintenance phase of their treatment.

- The GAD-7 and PHQ-9 are utilized to assess a beneficiary's current mental status.

- The CANS-50 and PSC-35 are tools utilized to evaluate beneficiaries served by the children's services division. Specifically, areas of impairment from both the

clinician perspective (CANS-50) and the parent perspective (PSC-35). The CANS-50 is used to both guide treatment and demonstrate improvement/outcomes.

- CANS-50 and PSC-35 data are tracked and aggregated through a dashboard. The MHP is working to develop a mechanism/practice to evaluate and disseminate the CANS-50 data gathered per the Children's Clinical Program Manager's request. The MHP is utilizing the overview of data from the PSC-35 Dashboard to monitor improvement in scores from Psychologically Impaired to Not Impaired for their clinical PIP.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Partially Met

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

- The MHP has developed, in collaboration with Kingsview, a design that refines the functionality of the CANS-50 and PSC-35 Dashboards so the appropriate information can be aggregated and evaluated by MHP staff. These customized reports allow the MHP to see the overall percentage change, either improvement or deterioration of clients, on each item in CANS-50, the specific changes on individual clients, and the effectiveness of the clinical staff providing treatment. The PSC-35 Dashboards shows an overview of the data, specific client details on each item in the PSC-35, and a client list that shows the change in score from initial survey to subsequent survey.
- The MHP does not currently have a medication monitoring system in place to track, trend, and use medication data for performance improvement activities. Please note the response to last year's recommendation 3.
- The MHP reviews the results of Beneficiary Satisfaction Surveys, and compares them to former results. MHP leadership uses the surveys as information for development of programs. Stakeholders do not receive survey results.
- Safe Haven and Bright Vista wellness centers are peer driven. At least 50 percent of the employees are peers and/or family members. There does not appear to be a formalized process to inform beneficiaries about peer run programs. Stakeholders reported that they learned from other beneficiaries, flyers posted on walls in clinics, and sometimes case managers.
- Consumer and family members are not listed as being in key roles in the MHP. The MHP is currently working on increasing their peer employee program, and this includes peer certification options.
- The MHP is working with Kingsview to establish a dashboard to monitor items per SB 1291. The MHP is recruiting a Licensed Psychologist Technician to assist with the SB 1291 HEDIS measures.
- The MHP does not track and does not trend the following HEDIS measures as required by WIC Section 14717.5:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)

QUALITY PERFORMANCE MEASURES

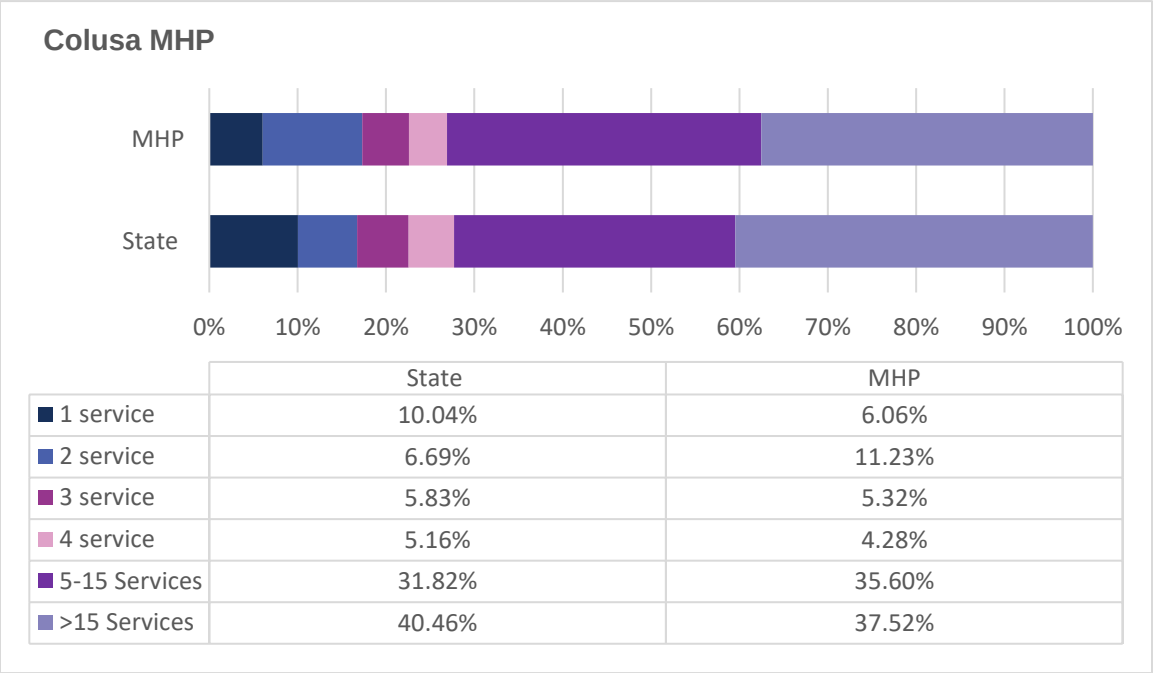
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



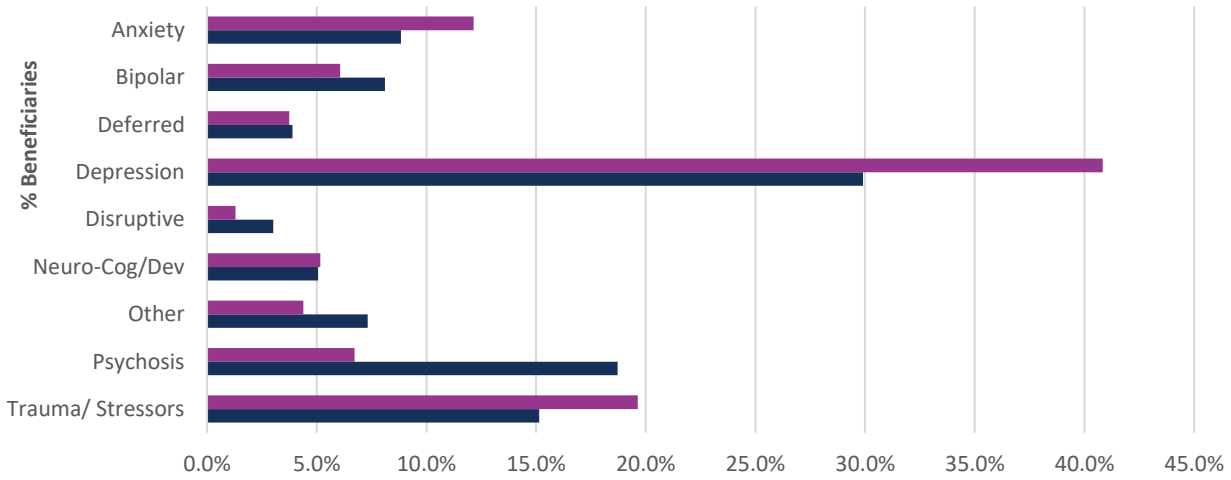
	State	MHP
1 service	10.04%	6.06%
2 service	6.69%	11.23%
3 service	5.83%	5.32%
4 service	5.16%	4.28%
5-15 Services	31.82%	35.60%
>15 Services	40.46%	37.52%

In comparison to the state, more beneficiaries are engaged past a single service at the MHP. Beneficiaries receiving five or more services approximates the statewide average.

Diagnosis of Beneficiaries Served

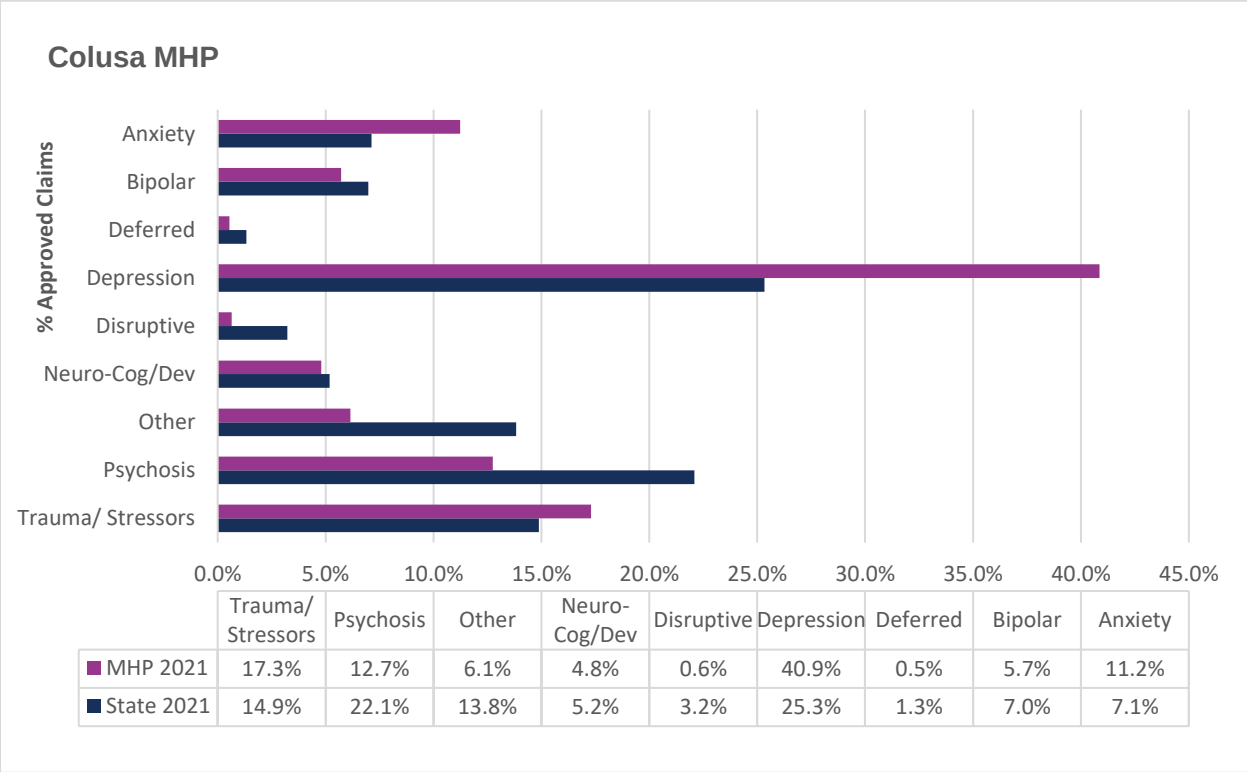
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment.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

Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	19.6%	6.7%	4.4%	5.2%	1.3%	40.8%	3.7%	6.1%	12.1%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

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



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	17.3%	12.7%	6.1%	4.8%	0.6%	40.9%	0.5%	5.7%	11.2%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

The MHP exceeds the state percentage of beneficiaries diagnosed with depression by almost half; the State average is 25 percent, while the MHP reports 41 percent. There are several categories where the MHP is lower than the state averages; these include disruptive, psychosis, and other diagnoses. It would be worthwhile for the MHP to look at how diagnosis is arrived at and if anything is being overlooked.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

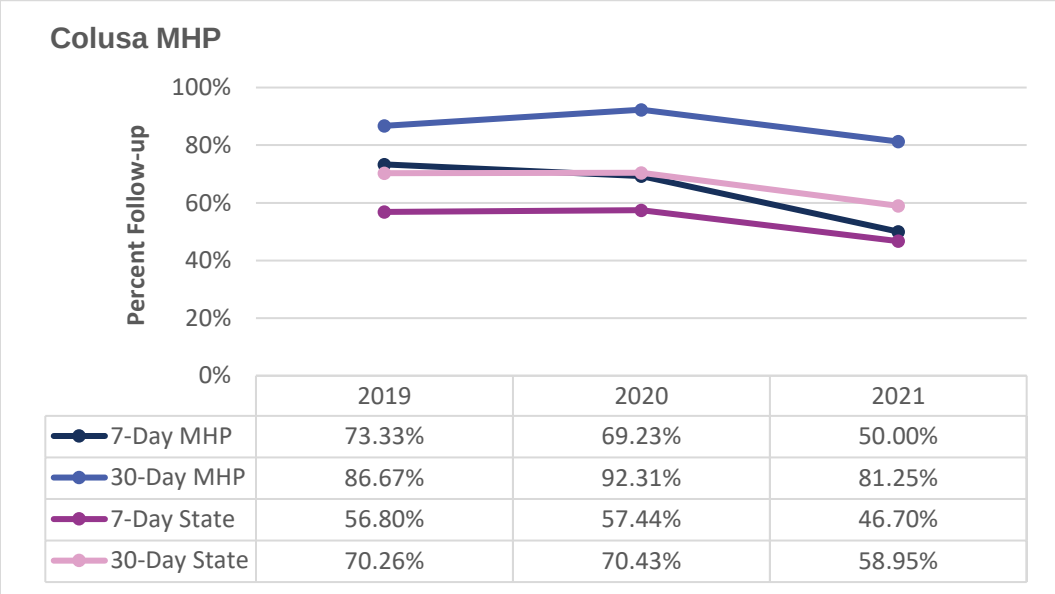
Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	16	18	15.35	8.79	$13,695	$12,052	$219,127
CY 2020	16	16	11.94	8.68	$11,154	$11,814	$178,464
CY 2019	14	16	8.47	7.63	$8,907	$10,212	$124,698

Follow-Up Post Hospital Discharge and Readmission Rates

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

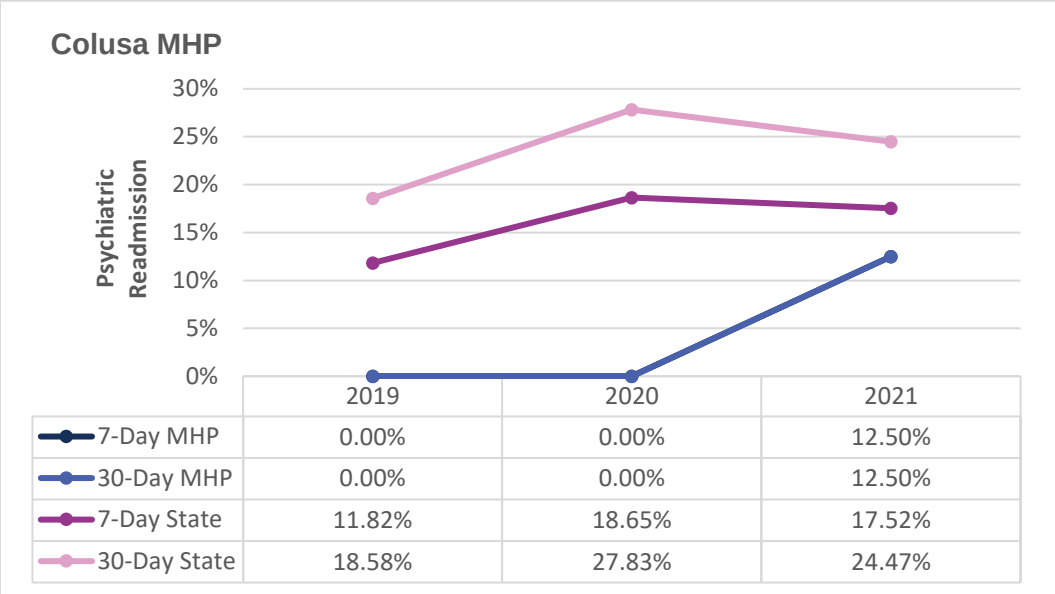
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	73.33%	69.23%	50.00%
30-Day MHP	86.67%	92.31%	81.25%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

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



	2019	2020	2021
7-Day MHP	0.00%	0.00%	12.50%
30-Day MHP	0.00%	0.00%	12.50%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The LOS for hospitalizations in Colusa County has increased over the past three years, from 8.47 in 2019, 11.94 in 2020, and 15.35 in 2021, This is almost twice the state average. The MHP proposes that one cause is a lack of places to which patients can be discharged during the COVID-19 pandemic restrictions.
- All hospitalizations are included in the claims data, regardless of payer source.
- While CalEQRO reports that 81.25 percent of discharges receive follow-up services in CY 2019-20, the MHP reports 100 percent in FY 2021-22. This may be due to different times measured.
- As mentioned earlier, the MHP has success in follow-up services post discharge from hospitalization. Readmissions for 7- and 30– days are well below state average; although they were reported at 0 percent for 2019 and 2020, and are reported as 12.50 percent for both 7- and 30- days readmission in 2021. The MHP reports 12.90 percent readmission rates for FY 2021-22.

High-Cost Beneficiaries

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

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

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

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

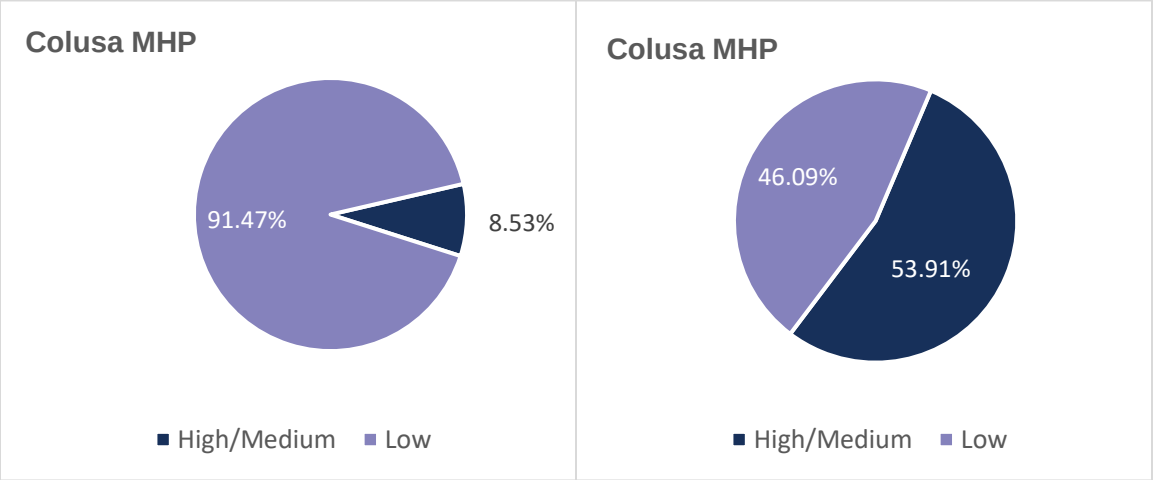
Entity	Year	HCB Count	Total Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	545,147	3.46%	$53,476	$43,231
MHP	CY 2021	44	677	6.50%	$51,757	$39,993
	CY 2020	38	633	6.00%	$53,591	$46,387
	CY 2019	≤ 11	670	-	$50,239	$38,442

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	≤ 11	-	$167,937	6.69%	$23,991	$24,368
Low Cost (Less than $20K)	547	85.97%	$2,090,260	48.58%	$3,177	$4,340

- The MHP’s percentage of HCBs went from under 1 percent in CY 2019 to 6.50 percent in CY 2021, nearly a ten-fold increase in terms of the actual HCB count. Although the actual AACB per HCB remained relatively stable, this higher HCB count may have factored in significantly in the MHP’s overall AACB increase.
- As Figures 20 and 21 demonstrate, only 6.5 percent of the MHP’s beneficiaries accounted for a third of its total approved claims. When combined with the medium-cost beneficiaries, only 14 percent of the beneficiaries accounted for more than half of its total approved claims, while the rest, 86 percent of the beneficiaries, accounted for less than 50 percent of the approved claims.

Figure 20: Proportion of Beneficiary Count and Approved Claims by Claim Amount Category 2021



IMPACT OF QUALITY FINDINGS

- The development of dashboards for CANS-50 and PSC-35 have allowed the Children's System of Care the ability to assess individual beneficiary progress in recovery as well as monitor effectiveness of specific programs.
- MHP is without a medication monitoring system in place and any psychotropic medication monitoring of FC youth. This issue effects quality of care assessments.
- Colusa MHP diagnostic categories show beneficiaries diagnosed with depression at 41 percent. There are several categories where the MHP is lower than the state averages; these include disruptive, psychosis, and other diagnoses. This affects medications prescribed, and it would be worthwhile for the MHP to look at how diagnosis is arrived at and if anything is being overlooked.
- The MHP is developing system changes to prepare for CalAIM being fully implemented. One example is tracking of referrals to lower LOC.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Social Supports for Youth

Date Started: 06/2022

Aim Statement: The youth client will build and rely upon their social supports. Ultimately, using these healthy supports can expedite the treatment process and lead to better treatment outcomes for our youth clients. This tool will be active, June 29, 2022, through December 31, 2023, with a goal of increasing the percentage of child clients (ages 3-17) who receive a collateral service from 39 percent to 60 percent so that clients that initially scored as "psychologically impaired on their PSC-35 move into the "not psychologically impaired" category from a rate of 11.96 percent to 20 percent.

Target Population: All youth clients, 3–17 years old, receiving mental health treatment, regardless of their diagnosis.

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

[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

Colusa County Children's Team would like to increase the number of collateral services provided to their youth clients. Research shows that individuals who actively sought mental health treatment or had a family member seeking help, described the significant role that family plays in the success of the individual's recovery. When youth clients have their social supports involved in their treatment, they are then able to learn how to utilize these supports daily, improving their overall functional status. With overall improved functional status, youth clients are then able to reduce their need for mental health services. The MHP has the goal of increasing the percentage of clients in this population who receive collateral services from 39 percent to 60 percent, with the prediction that clients that initially scored as "psychologically impaired" on their PSC-35 move into the "not psychologically impaired" category.

To support this hypothesis, the intervention of utilizing the My Support Tool was put in place. The improvement strategy/intervention begins with training all clinicians providing services to youth beneficiaries. The training included the definition of the target population, why it is important to implement this intervention and why this tool was chosen. Once clinical staff are trained, they will then begin to utilize the tool and encourage collateral supports to be a part of the client's treatment. The intervention can be applied at any point during treatment. It is preferred to be applied in the first few sessions of treatment and then one to two months later. The PSC-35 will be completed upon intake and every six months thereafter for the length of treatment.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: Credible, reliable, or valid methods were implied or able to be established for part of the PIP; however, the PIP is not yet fully implemented.

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

- Track when intervention is implemented (e.g., first 2 months of treatment etc.)
- Consider tracking rates for those who do have parent support. This would give more comparison for the intervention.
- Research what other barriers, not mentioned, may be preventing those who do want to be involved but have competing priorities (e.g., transportation issues, other children to care for), and if these are issues that the MHP can help resolve.
- Track and report results not less than quarterly.
- Engage in TA support with EQRO early and often.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Reducing Wait Time

Date Started: 06/2022

Aim Statement: The percentage of beneficiaries receiving a therapy appointment within 15 business days post intake will increase from 51.52 percent to 70 percent.

Target Population: All new mental health beneficiaries requesting mental health services between 6/28/2022 and 12/31/2023 who qualify for SMHS who are offered an appointment after intake.

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

Summary

The aim of the PIP is to address stakeholder and staff member concerns regarding number of beneficiaries that experience long wait between intake appointments and starting their therapy services. The average wait days between intake appointment and therapy appointment offered prior to the PIP was 16.18 business days with 51.52 percent receiving an offered therapy appointment within 15 business days.

The PIP is designed to improve timeliness from intake assessment to first offered therapy session. The improvement strategy will include increasing staff time in reviewing new intake cases for approval in ACCESS (renamed to Utilization Management (UM) Team), and assigning cases more frequently by adding one additional day of scheduling initial appointments so that more beneficiaries are offered a first therapy session in a timely manner.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: Credible, reliable, or valid methods were implied or able to be established for part of the PIP; however, the PIP is not yet fully implemented.

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

- The aim statement would be stronger if a timeframe was added (. e.g., The percentage of beneficiaries receiving a therapy appointment within 15 business days post intake will increase from 51.52 percent to 70 percent. In the next 18 months).
- Track and report results not less than quarterly.
- Engage in TA support with EQRO early and often.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an 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 11 years. Currently, the MHP has selected a vendor through CalMHSA and is scheduled to begin its implementation in July 2023.

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 the county administration. The IS staffing and budget percentage remained unchanged from the previous year.

The MHP has 68 named users with log-on authority to the EHR, including approximately 62 county staff and 6 contractor staff. Support for the users is provided by two full-time equivalent (FTE) IS technology positions. Currently all positions are filled.

As of the FY 2022-23 EQR, the only contract providers are the telehealth and after-hours crisis services, and these staff have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Direct data entry into MHP IS by provider staff	☐ Daily ☒ Weekly ☐ Monthly	90%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☒ Weekly ☐ Monthly	10%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP currently does not offer PHR functionality to its beneficiaries but plans to roll it out once the new EHR is implemented.

Interoperability Support

The MHP not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- Colusa MHP reported that it devotes 6 percent of its total budget to IS, which is higher than most comparable MHPs.
- In the past two years, the MHP has improved its data analytical capabilities and in the past year, it has developed a CANS systems-level reporting system that is currently in pilot phase.
- Although the MHP does not have an organizational contract provider, its after-hours crisis services and telehealth are provided by contractors. These contractors have full access to its EHR system.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

For the MHP, it appears that significant claims lag begins in December and likely represents $500,000 in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through December 2021.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	1,202	$640,613	$2,176	0.34%	$638,437
Feb	1,197	$615,944	$3,902	0.63%	$612,042
Mar	1,417	$721,198	$3,826	0.53%	$717,372
April	1,257	$656,275	$2,211	0.34%	$654,064
May	1,171	$636,200	$9,137	1.44%	$627,063
June	1,225	$674,013	$5,496	0.82%	$668,517
July	928	$517,532	$7,592	1.47%	$509,940
Aug	1,059	$572,855	$8,129	1.42%	$564,726
Sept	1,102	$632,850	$6,275	0.99%	$626,575
Oct	928	$531,412	$3,938	0.74%	$527,474
Nov	969	$567,680	$2,176	0.38%	$565,504
Dec	0	$0	$0	0.00%	$0
Total	**12,455**	**$6,766,572**	**$54,858**	**0.81%**	**$6,711,714**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B or Other Health Coverage must be billed before submission of claim	111	$48,009	87.51%
National Provider Identifier related	7	$2,384	4.35%
Service line is a duplicate and a repeat service procedure code modifier not present	7	$2,384	4.35%
Beneficiary not eligible or non-covered charges	9	$2,083	3.80%
Total Denied Claims	134	$54,860	100.00%
Overall Denied Claims Rate	0.81%		
Statewide Overall Denied Claims Rate	2.78%		

Colusa MHP had a very low denial rate. Less than 1 percent of its total claims were denied in CY 2021.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP has finalized its new IS vendor selection. The implementation is scheduled to begin in July 2023. The MHP has relied upon an ASP for many years to manage its EHR. Since the selected EHR will not be managed by the

same ASP, the MHP needs to utilize this time making sure the functionalities and management of the new EHR transition seamlessly without any major difficulties.

- In response to a recommendation from the FY 2021-22 EQR, the MHP has produced an OCP that is largely dependent on the current EHR vendor and the ASP's OCPs. The MHP needs to ensure that the new vendor's OCP will match or exceed these standards and protocols.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

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 and compares the findings to prior data as part of continuous QI. However, it does not appear that this information is provided to beneficiaries in general or those who participated in the survey.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

As part of the pre-review planning process, CalEQRO requested one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each. The MHP collaborated with CalEQRO in sending out invitations to appropriate beneficiaries, exceeding the number needed, requesting that they participate in a Consumer Family Member Group. The MHP also made follow-up calls the day of the group to remind of the 4:00 p.m. meeting and beneficiaries confirmed that they planned to attend the meeting. The perspective participants were provided with written zoom access information. All were given information of the gift card for attending. CalEQRO subsequently discussed with the MHP possible ways to improve attendance at this meeting in future EQRs, and reiterated the importance of beneficiary feedback in assessing quality of MHP services.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of caregivers/parents of youth consumers who initiated services in the preceding 12 months. The focus group was held virtually and included three participants. All consumers/family members participating receive/have a family member who receives clinical services from the MHP.

Due to the small number of focus group participants, feedback is noted as general and not linked to specific participants. The participants who entered services within the past year described their experiences as timely in seeing a clinician; however, there was a

wait of over two months for a psychiatrist appointment. All participants report that they receive reminder calls for their appointments. Also, if they miss an appointment the MHP calls to help them reschedule. All are aware of county interpreters if they or a family member should need one. They note that there are flyers in the clinics informing beneficiaries of this option. The participants were all aware of County provided transportation to appointments. The group was unclear about their mental health provider having a connection with the physical health provider. All participants knew what to do if they felt that a staff person working with them was not a good fit. All psychiatry appointments are telepsychiatry and the group expressed satisfaction with this protocol. The participants were unaware of any results of the CPS or other surveys; however, some reported that surveys were filled out over last year. All agree that information on resources is posted in the outpatient clinics, or they receive information via telephone call from a therapist or case manager. All participants noted and stated a few times that the front desk is helpful and friendly. “The people at the front desk are great! They are friendly, helpful, and listen.” Overall, participants were not aware of an opportunity to volunteer or be paid by the MHP for different positions available to those with lived experience with mental health. Discontinuance of transportation to medical appointments has caused difficulty for some of the participants. The participants voiced that there have been staff changes that have increased their satisfaction with services. They report they feel the children in services have support in the community (e.g., help with school). Overall, the participants reported that the services they receive give them hope for recovery.

Recommendations from focus group participants included:

- The participants reported that at times they are not looking for a therapy session, just an ear to listen. “Sometimes I need to be able to vent and not get suggestions for groups, problem solving, etc.”

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The group in general was satisfied with the services they receive. They are happy with the telehealth and telephone options for receiving services. Some prefer in-person appointments. The feedback they gave suggests there is an opportunity for the MHP to improve transparency and communication. The participants are not involved in any committees, volunteer, or paid work with the MHP, and do not perceive that their input is valued.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP has sufficient capacity to serve monolingual Spanish-speaking beneficiaries, which account for one-third of their beneficiaries. (Access)
2. The MHP meets monthly with Interagency Placement Committees. This has improved communication with other agencies regarding FC youth. (Quality)
3. The MHP improved its FC PR by 86 percent from CY 2019 (24.49 percent) to CY 2021 (45.61 percent), now exceeding statewide and small-rural averages. (Access)
4. The MHP contracted with Kingsview and Traditions Behavioral Health to increase the number of psychiatric providers and hours via telehealth, thus expanding availability and capacity. (Access)
5. While the statewide and small-rural PR continued to decline in the second year of the pandemic in CY 2021, Colusa MHP remained the same as CY 2020. The MHP's PR is also 58 percent higher than the statewide PR. (Access)
6. The MHP has developed, in collaboration with Kingsview, a design that refines the functionality of the CANS-50 and PSC-35 Dashboards so the appropriate information can be aggregated and evaluated by MHP staff. (Access)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP number of eligible beneficiaries has increased over the past three years, and the number served has also increased, while the PR remains at 6.08 percent. (Access)
2. The MHP has initiated performance improvement activities to improve timeliness of urgent appointments, However, the standard was met only 50 percent of the time for FY 2021-22. (Timeliness)
3. The MHP does not currently have a medication monitoring system in place to track, trend, and use medication data for performance improvement activities. (Quality)
4. The MHP does not track and not trend HEDIS measures as required by WIC Section 14197 and SB 1291. (Quality)

5. Stakeholders feedback suggests that there is an opportunity for the MHP to improve transparency and communication. (Quality)

RECOMMENDATIONS

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

1. Research and implement ways to increase access given the MHP's PR remains and 6.08 percent while the number of eligible beneficiaries and number served has increased. (Access).
2. Continue to track effectiveness of the performance improvement activities to increase timeliness for urgent appointments, with a goal of 80 percent or more. (Timeliness)

   (This recommendation is a carry-over from FY 2021-22.)
3. Continue to support EHR vendor (Kingsview) implementing a psychiatrist review that provides medication monitoring. Follow-up with request to second provider of psychiatrists, Traditions Behavioral Health, to do the same.

   (This recommendation is a carry-over from FY 2021-22.)
4. Investigate best practices and implement a medication monitoring system for FC system as required by WIC Section 14197 and SB 1291. (Quality)

   (This recommendation is a carry-over from FY 2021-22.)
5. Increase the perception of beneficiaries and family members that their input is valued by creating opportunities for improved transparency and communication, including involving them in committees and volunteer positions within the MHP. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: CalEQRO Review Agenda

CalEQRO 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 PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
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 MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
Electronic Health Record Deployment
Electronic Health Record Hands-On Observation
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Saumitra SenGupta, Information Systems Reviewer
Walter Shwe, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Alvernaz	Graciela	Children Team Mental Health Specialist	Colusa County Behavioral Health
Amundson	Haley	Marketing and Administrative Specialist	Colusa County Behavioral Health
Arce	Tomika	Medical Billing Specialist	Colusa County Behavioral Health
Billeci	Paul	Case Manager – Crisis Response	Colusa County Behavioral Health
Briscoe	Bonnie	Fiscal Administrative Officer	Colusa County Behavioral Health
Bullis-Cruz	Heather	Compliance Officer	Colusa County Behavioral Health
Davis	Mandi	Adult Forensic Team Therapist	Colusa County Behavioral Health
Hobson	Tony	Director	Colusa County Behavioral Health
Jessup	Tiffany	Full Service Partnership Case Manager	Colusa County Behavioral Health
Madson	Susan	Adult Therapist II	Colusa County Behavioral Health
McAllister	Jennifer	Clinical Program Manager, SUD	Colusa County Behavioral Health
McCloud	Bill	EHR Manager	Colusa County Behavioral Health
McGregor	Mark	Clinical Program Manager, Children	Colusa County Behavioral Health
Piper	Shannon	Clinical Program Manager, Adult	Colusa County Behavioral Health
Puga	Mayra	Mental Health Services Act (MHSA) Coordinator	Colusa County Behavioral Health
Rios	Daisy	Youth Team Therapist	Colusa County Behavioral Health
Rojas	Bessie	Quality Assurance Coordinator	Colusa County Behavioral Health
Rubio	Rocio	Medical Billing Specialist	Colusa County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Scroggins	Jeannie	Clinical Program Manager, QA & MHSA	Colusa County Behavioral Health
Tafolla Martinez	Brizia	Clinical Program Manager, Crisis	Colusa County Behavioral Health
Triggs	Pamela	Certified Peer Support Specialist	Triggs
Uhring	Audrey	Deputy Director	Colusa County Behavioral Health
Whiting	Lynn	Electronic Health Record Coordinator	Colusa County Behavioral Health

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	Credible, reliable, or valid methods were implied or able to be established for part of the PIP; however, the PIP is not yet fully implemented.

General PIP Information
MHP/DMC-ODS Name: Colusa MHP
PIP Title: Social Supports for Youth
PIP Aim Statement: The youth client will build and rely upon their social supports. Ultimately, using these healthy supports can expedite the treatment process and lead to better treatment outcomes for our youth clients. This tool will be active, June 29, 2022, through December 31, 2023, with a goal of increasing the percentage of child clients (ages 3-17) who receive a collateral service from 39 percent to 60 percent so that clients that initially scored as "psychologically impaired on their PSC-35 move into the "not psychologically impaired" category from a rate of 11.96 percent to 20 percent.
Date Started: 06/2022
Date Completed: n/a
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:

General PIP Information
Target population description, such as specific diagnosis (please specify): All youth clients, 3 – 17 years old, receiving mental health treatment, regardless of their diagnosis.
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): My Social Supports Tool - to be completed with the youth beneficiaries to identify their current problem, their social supports, when they would like support, and how they would like to receive that support.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Provide My Social Supports Tool and evaluate.
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): The improvement strategy/intervention will begin with training all clinicians providing services to youth beneficiaries. The training included the definition of the target population, why it is important to implement this intervention, the My Support Tool, how to utilize it and the reason for implementing the tool.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Implement the My Social Supports tool into each youth client's treatment	2022	n/a	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Track when intervention is implemented (e.g., first 2 months of treatment etc.) • Consider tracking rates for those who do have parent support. This would give more comparison for the intervention. • Research what other barrier, not mentioned may be preventing those who do want to be involved but have competing priorities (e.g., transportation issues, other children to care for) and are these issues that the MHP can help resolve. • Track and report results not less than quarterly. • Engage in TA support with EQRO early and often.

Non-Clinical PIP

Table C1: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	Credible, reliable, or valid methods were implied or able to be established for part of the PIP; however, the PIP is not yet fully implemented.

General PIP Information
MHP/DMC-ODS Name: Colusa MHP
PIP Title: : Reducing Wait Time
PIP Aim Statement: The percentage of beneficiaries receiving a therapy appointment within 15 business days post intake will increase from 51.52 percent to 70 percent.
Date Started: 06/2022
Date Completed: n/a
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): This PIP focuses on new beneficiaries who have requested a mental health intake as of June 28, 2022, and qualify for SMHS. This PIP does not exclude beneficiaries due to age or diagnoses.

General PIP Information
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): A member is added to the UM team, training is provided to ensure interrater reliability of reviewing, approving, and assigning intake assessments. The Clinical Program Managers will be a part of the UM Team and will assist all UM Team Members in becoming familiar with their team members' areas of expertise to assist in case assignments.
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): The Access team (renamed UM Team) will offer a therapy service within 15 business days. The intervention will be applied twice weekly, between June 28, 2022 – December 31, 2023, as the UM Team reviews and assigns completed intakes. The second intervention of Clinical Program Managers assigning cases on one additional day of their choosing to accommodate for urgent needs will occur between August 1, 2022- December 31, 2023.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of Access workers reviewing mental health	2022	n/a	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of times a week intakes are assigned to clinicians	2022	n/a	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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:

- Add timeframe to the Aim Statement.
- Track and report results not less than quarterly.
- Engage in TA support with EQRO early and often.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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