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FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

COLUSA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 13, 2020

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INTRODUCTION

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

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

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

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Colusa MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Small-Rural

MHP Region — Superior

MHP Location — Colusa

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 670

MHP Threshold Language(s) — Spanish

CalEQRO obtained the MHP threshold language information from the DHCS Information Notice (IN) 13-09.

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed AB 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and INs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard (AAS) and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS IN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS will review these forms to determine if the provider networks met required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services to youth and adults. If these standards are not met, DHCS will require the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, these will be reviewed by CalEQRO as part of their annual quality review process with a structured protocol to assess access and timeliness and validation of the AAS and any plan of correction or improvement of the services to Medi-Cal recipients living in the zip codes requiring an AAS.

CalEQRO reviews the NACT provider files, maps of clinics closest to the AAS zip codes, and distances to the closest providers by type and population. If there is no provider within the time or distance standard, the MHP shall develop and propose an AAS plan, and access to any alternative providers who might become Medi-Cal certified for the MHP. The MHP shall submit a plan of correction addressing the needs to meet the AAS.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO will review grievance and complaint log reports, facilitate beneficiary focus groups, review claims and other performance data, and review DHCS-approved corrective action plans.

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

Recommendation #1: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. The MHP should consult with CalEQRO on a regular basis especially in the early months of PIP planning to ensure that each of the PIP sections are fully developed, with a data-defined problem, a barrier/cause analysis, and appropriate interventions. *(This recommendation is a carry-over from FY 2018-19.)*

Status: Met

- The MHP submitted two PIPs, both a clinical and non-clinical PIP. Both PIPs were validated and determined to be active and ongoing.

Access Recommendations

Recommendation #2: Evaluate staff perspectives/biases, which may unintentionally impact beneficiaries and provide training on mental health, stigma, and bias in the workplace. *(This recommendation is a carry--over from FY 2018-19.)*

Status: Met

- The MHP has asked all staff to participate in the California Institute for Behavioral Health Solutions' Eliminating Inequities in Behavioral Health Care webinars (September 2020).
- Staff were required to attend the webinar "Implicit Bias: Recognizing Its Harmful Impact and Taking Actions to Counter Unconscious Bias." The MHP plans to distribute a pre-test and post-test to gauge learning.
- Clinical staff are encouraged to participate in as many of the webinars in this series to help improve discussions about race and racism with clients, challenge biases, and identify strategies to fostering meaningful change.

Recommendation #3: Prioritize the hiring of Spanish--speaking providers.

Status: Met

- For some time, the MHP's job flyers specified "Bilingual Spanish/English preferred but not required." This continues to be MHP practice.
- Bilingual staff account for 33 percent of the MHP staff; included are two mental health specialists, three clinicians, two extra help on-call staff, and four office staff.
- The MHP's internal psychiatrist is not bilingual in Spanish, but bilingual in Tagalog.

Recommendation #4: Investigate missed opportunities for collaboration with managed care plans for providing transportation to beneficiaries. Develop complimentary transportation solutions to augment limitations to existing transit.

Status: Met

- Beneficiaries arrange transportation with the managed care plans Anthem Blue Cross and California Health and Wellness.
- Reservations for transportation (for beneficiaries who do not have managed care benefits) are arranged two weeks ahead of time through LogistiCare.

If the beneficiary is not in the LogistiCare program or if time is an issue, case managers provide transportation.

Timeliness Recommendations

Recommendation #5: The MHP needs to improve its first offered appointment timeliness in accordance with the state timeliness metric as per Information Notice (IN) 18-011.

Status: Not Met

- During FY 2019-20, the average length of time from first request for service to first offered appointment was 10.44 days for all services, which represents a 21.4 percent increase in wait times from FY 2018-19 (8.6 days). Overall, for FY 2019-20, 57.32 percent of appointments met the standard of ten business days, while in FY 2018-19, 66.89 percent of appointments met the standard.
- Staff were calculating days wait between the time of beneficiary request to the time of the scheduled appointment when it should have been between the request date and first offered date. This issue has since been corrected.
- The MHP's non-clinical PIP includes an intervention to increase the number of intake appointments. Intake appointments are scheduled Tuesday and Thursday afternoons with a rotation of clinical staff.

Recommendation #6: Track and trend timeliness of urgent appointments.

Status: Met

- In January 2020, the MHP began timeliness tracking of urgent appointments. The MHP captures and reports urgent and crisis appointments together.
- The MHP does not delineate between 48-hour and 96-hour services requiring prior authorization but uses the 48-hour standard for timeliness evaluation.
- Overall, 70 percent of its appointments meet the standard, with 100 percent for adults and 40 percent for children. The average length of time for urgent appointments not requiring prior authorization overall is 6.3 days, with 1.5 days for adults, and 11.20 days for children.

Recommendation #7: Investigate the post-hospitalization appointments and identify causes for appointments not meeting the 7-day standard. Correct or implement processes for identifying those beneficiaries in need of post-hospitalization appointments within 7-days.

Status: Partially Met

- The MHP stated that they frequently have beneficiaries hospitalized from outside counties and they are discharged to their counties of residence.
- Disaggregated data is needed to determine the true follow-up rate for Colusa County beneficiaries.

Quality Recommendations

Recommendation #8: Recruit and involve beneficiary participants on the Quality Improvement Committee (QIC).

Status: Met

- A consumer family member (CFM) frequently attends QIC meetings and provides feedback on access to services, timeliness, and wellness center operation.
- The Board of Supervisors (BOS) has a CFM who is a liaison between the BHB and the BOS and attends all the MHP's BHB meetings.

Recommendation #9: Develop employment supports for beneficiaries, both within the MHP and externally. Consider post-secondary schools for additional collaboration or as a resource.

Status: Not Met

- The MHP reports that they have plans to incorporate this recommendation into the MHP's Social Determinants Innovation Project Proposal.

Recommendation #10: Assess effectiveness of current outreach and advertising approaches for beneficiary recruitment for both committees, program planning (wellness center) and system planning. Address any communication gaps.

Status: Met

- A Facebook page was created to inform the community of meetings and events open to stakeholders.
- In October 2019, a fire damaged the MHP's wellness center Safe Haven.

- After the fire, the wellness center was relocated to the MHP's office in a large meeting room. Beginning in March 2020, when COVID-19 began, the wellness center temporarily closed its face-to-face encounters.

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

Status: Partially Met

- A staff survey response indicated that supervisory feedback and monthly all staff meetings were appropriate forums for improving communications.
- Feedback from staff underscored the need for more inclusion, dissemination of information, and performance indicators.

Beneficiary Outcomes Recommendations

Recommendation #12: Execute aggregate reporting for the Milestones of Recovery Scale (MORS), Child Adolescent Needs and Strengths (CANS-50) and the Pediatric Symptom Checklist (PSC-35) outcome tools to assess program outcomes for use in program and capacity planning. (This recommendation is a carry-over from FY 2018-19.)

Status: Partially Met

- The MHP states that it is more difficult to aggregate data for CANS-50 than MORS because CANS-50 has multiple scores across domains. As a result, the MHP does not aggregate the CANS-50 data.
- Both CANS-50 and MORS dashboards were created in February 2019. MORS is used as a level of care tool with aggregated data available. The PSC-35 dashboard has yet to be created by Kings View.
- CANS-50 dashboards and data are filtered and utilized in a variety of interventions/treatments for cultural issues, supervision of clinician treatment effectiveness as well as for school or parental issues.

Foster Care Recommendations

None noted.

Information Systems Recommendations

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

Status: Met

- The MHP distributed 15 laptops and 30 new iPhones to clinicians between April and May 2020. Anecdotal reports from supervisors indicate that these mobile devices have improved connectivity and increased productivity.

Structure and Operations Recommendations

None noted.

PERFORMANCE MEASURES

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

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

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

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

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to: screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social

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for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

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

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:

- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

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

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

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

Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:

  - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
  - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure

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

Total Beneficiaries Served

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

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Colusa MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	1,671	16.6%	255	38.1%
Latino/Hispanic	7,052	69.9%	340	50.7%
African-American	62	0.6%	*	n/a
Asian/Pacific Islander	121	1.2%	*	n/a
Native American	94	0.9%	*	n/a
Other	1,089	10.8%	50	7.5%
Total	**10,088**	**100%**	**670**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

Table 2 provides details on beneficiaries served by threshold language.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

Colusa MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	190	28.4%
Other Languages	480	71.6%
Total	**670**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

Penetration Rates and Approved Claims per Beneficiary

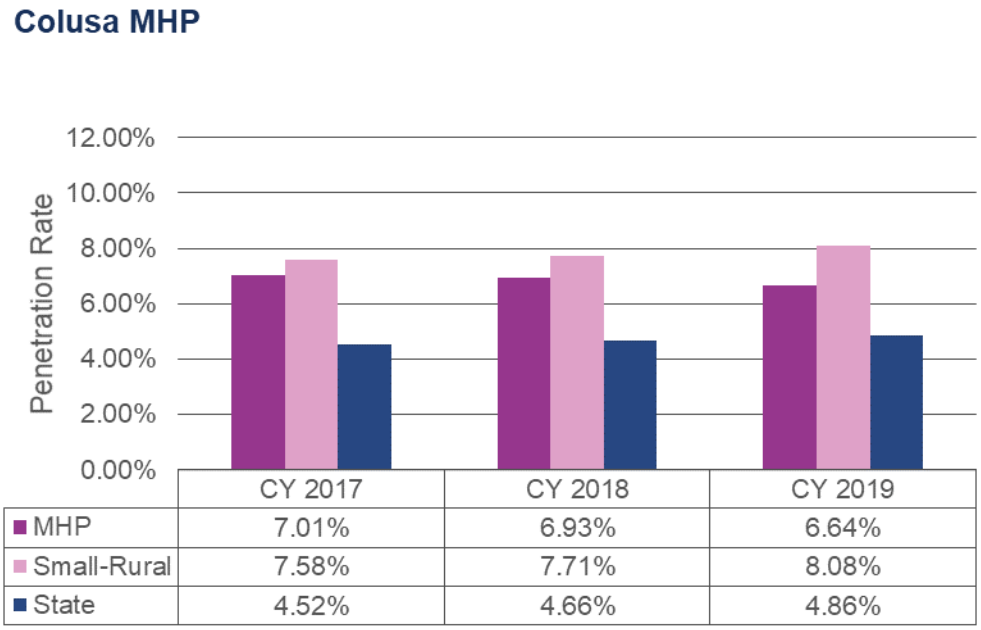
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated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

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2019. See Table C1 for the CY 2018 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Colusa MHP uses the same method used by CalEQRO.

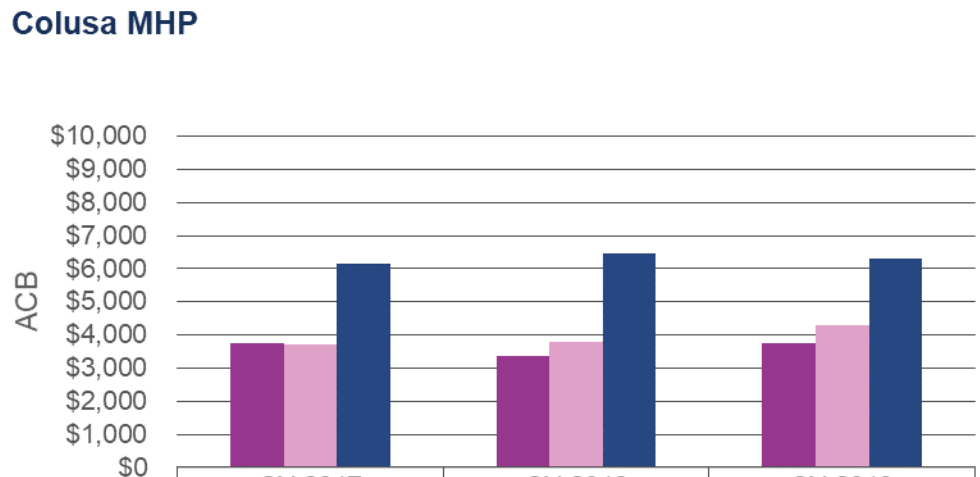
Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	7.01%	6.93%	6.64%
Small-Rural	7.58%	7.71%	8.08%
State	4.52%	4.66%	4.86%

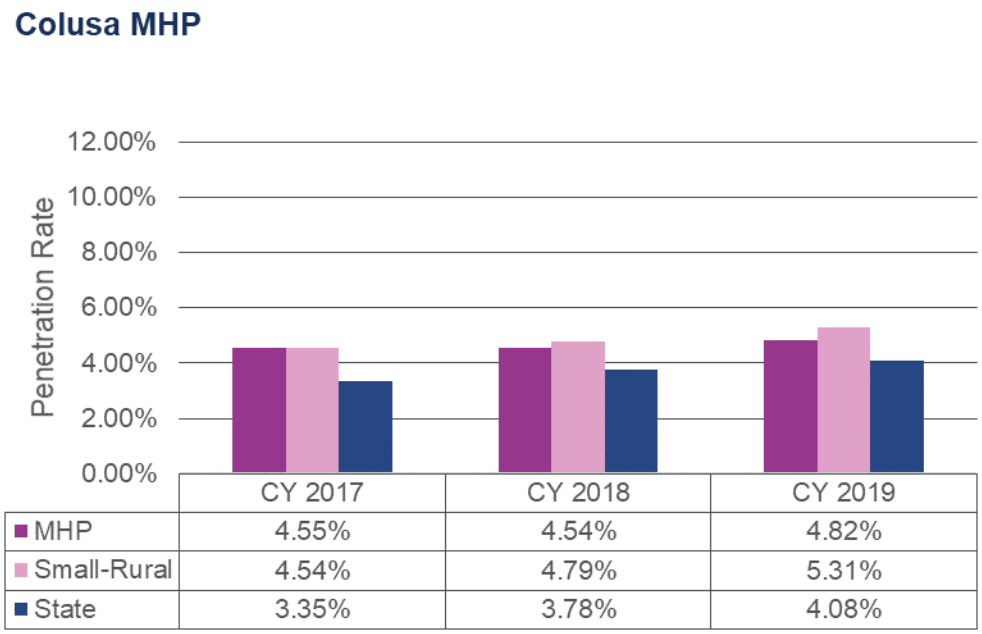
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,735	$3,371	$3,745
Small-Rural	$3,692	$3,794	$4,310
State	$6,170	$6,454	$6,316

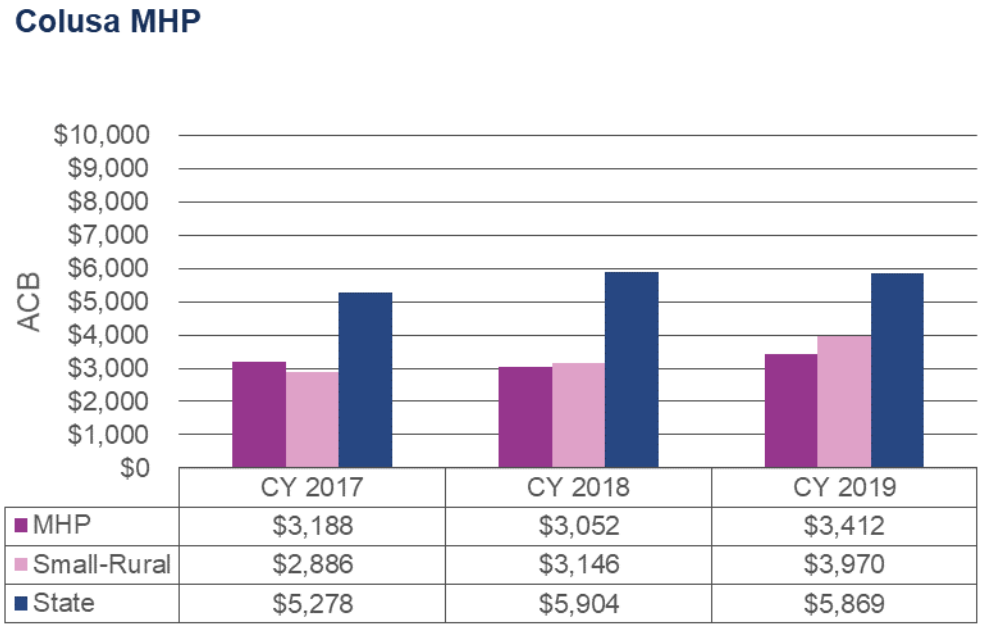
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	4.55%	4.54%	4.82%
Small-Rural	4.54%	4.79%	5.31%
State	3.35%	3.78%	4.08%

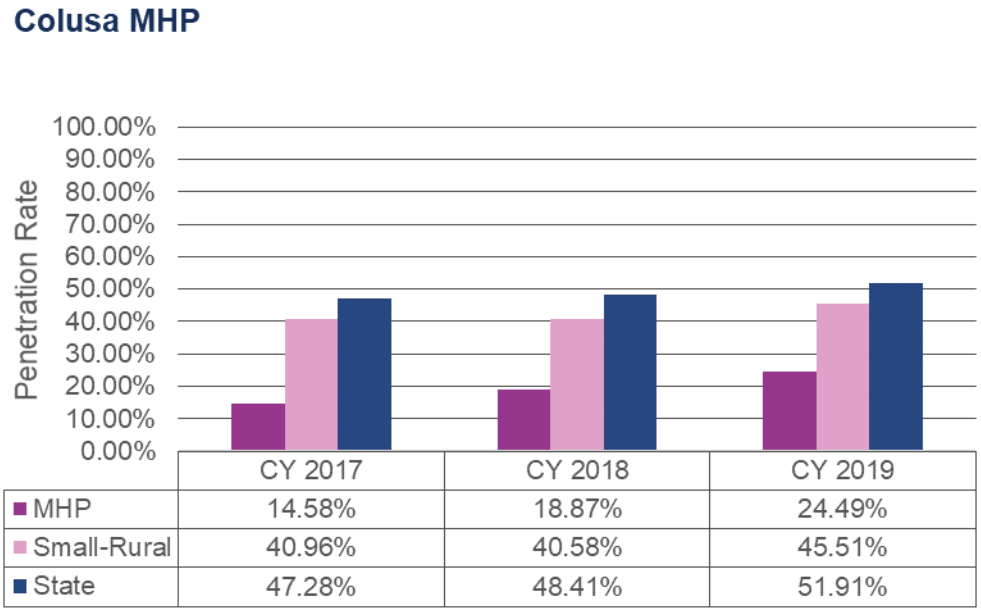
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,188	$3,052	$3,412
Small-Rural	$2,886	$3,146	$3,970
State	$5,278	$5,904	$5,869

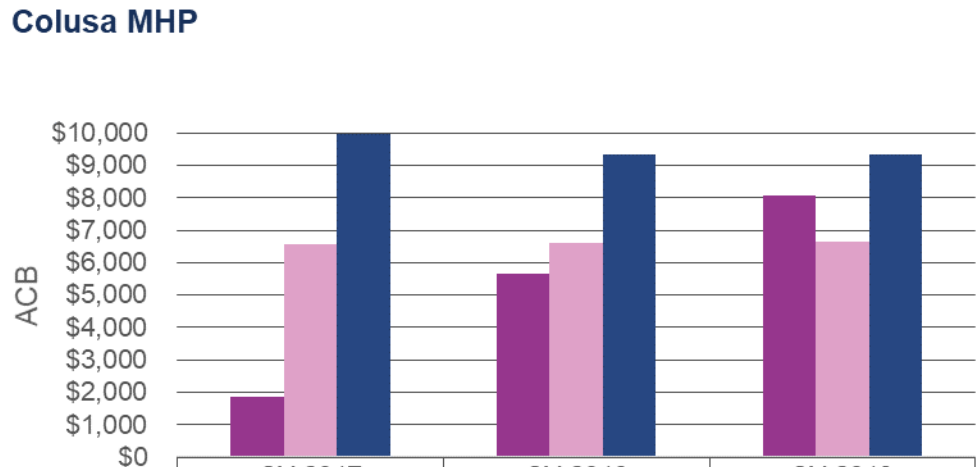
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	14.58%	18.87%	24.49%
Small-Rural	40.96%	40.58%	45.51%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

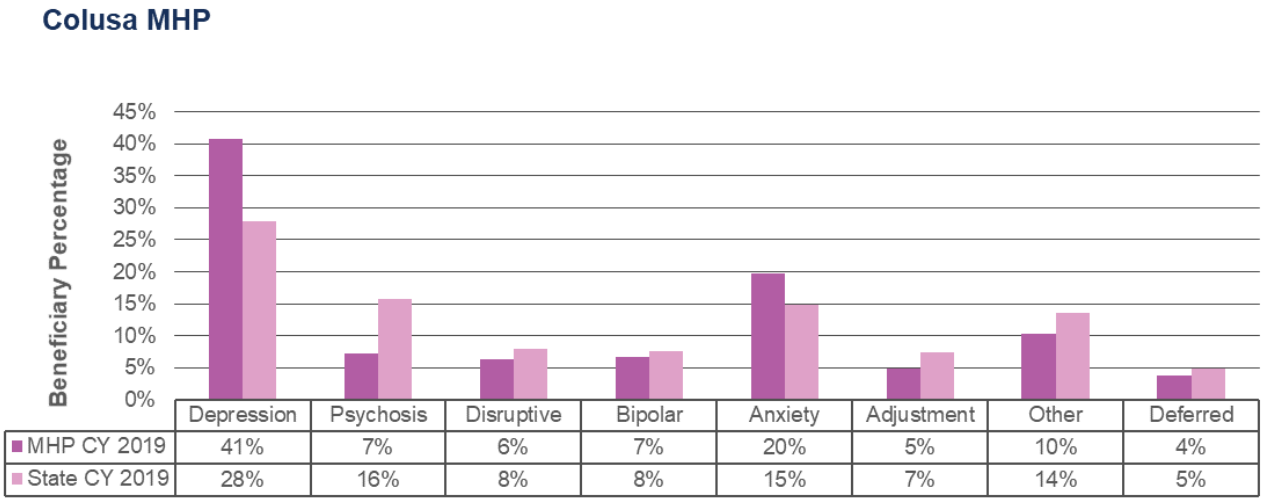


	CY 2017	CY 2018	CY 2019
MHP	$1,875	$5,647	$8,074
Small-Rural	$6,553	$6,630	$6,666
State	$9,962	$9,340	$9,360

Diagnostic Categories

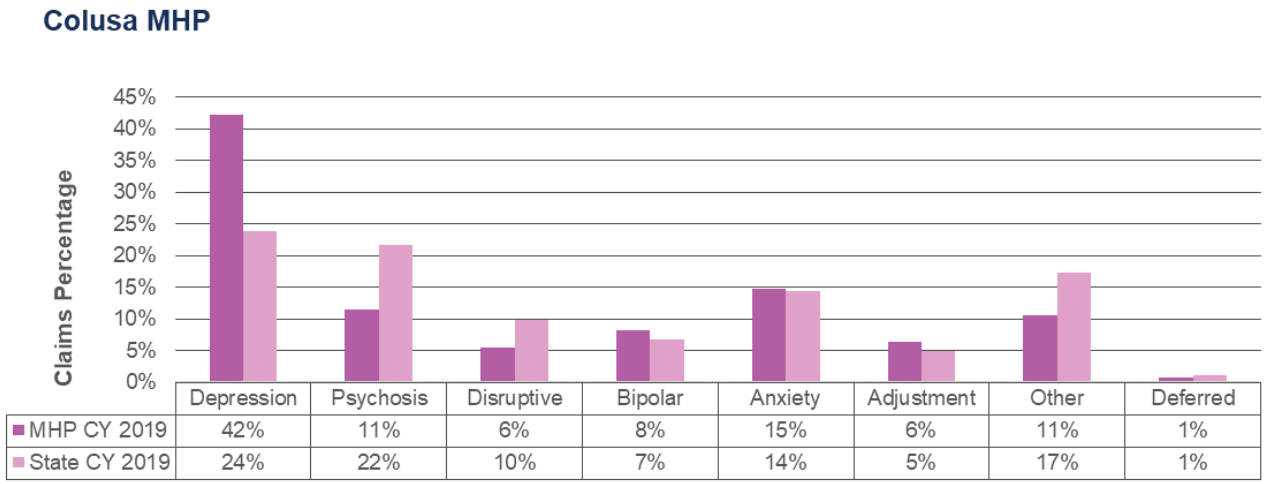
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	41%	7%	6%	7%	20%	5%	10%	4%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	42%	11%	6%	8%	15%	6%	11%	1%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

Colusa MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	*	670	n/a	$50,239	-	n/a
	CY 2018	*	690	n/a	$40,200	-	n/a
	CY 2017	*	665	n/a	$54,318	-	n/a

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

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

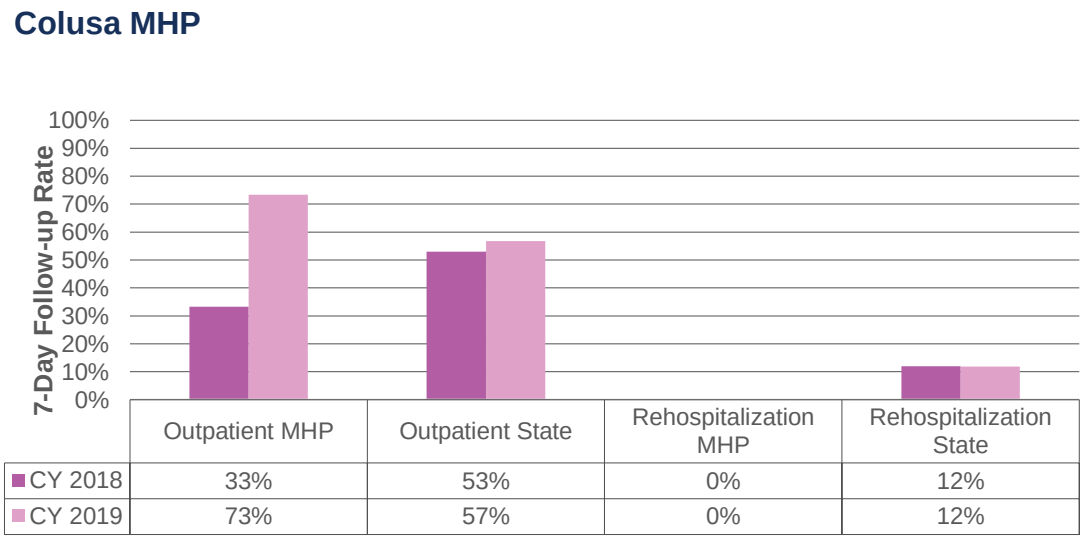
Table 4: Psychiatric Inpatient Utilization CY 2017-19

Colusa MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	14	16	8.47	7.80	$8,907	$10,535	$124,698
CY 2018	16	20	7.50	7.63	$9,965	$9,772	$159,439
CY 2017	12	18	10.87	7.36	$12,314	$9,737	$147,772

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

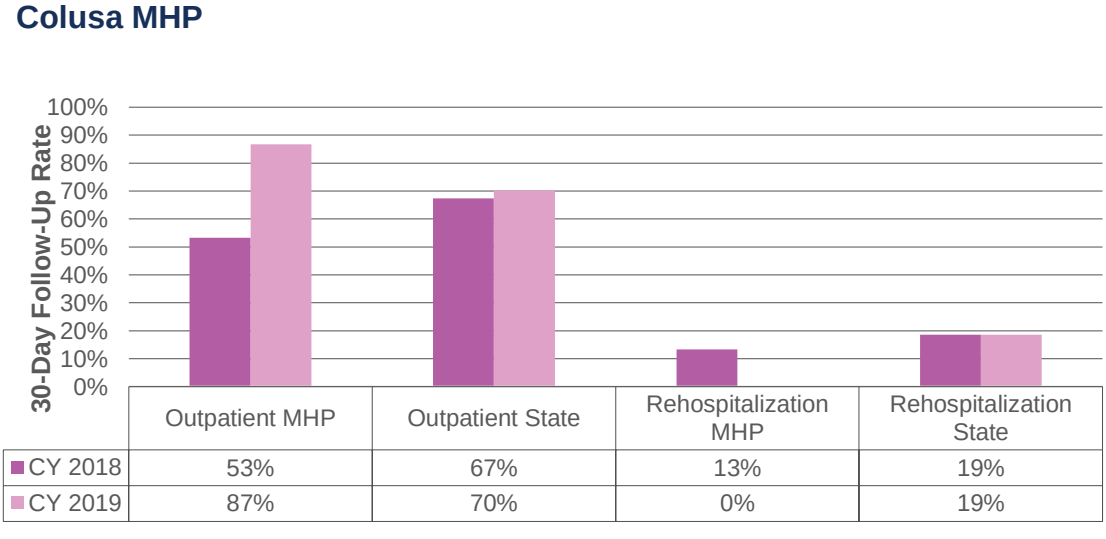
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	33%	53%	0%	12%
CY 2019	73%	57%	0%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	53%	67%	13%	19%
CY 2019	87%	70%	0%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

Colusa MHP PIPs Identified for Validation

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

Table 5: PIPs Submitted by Colusa MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Collateral Support
Non-Clinical	1	Improved Intake Attendance

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Colusa
PIP Title	Collateral Support
PIP Aim Statement	Will prioritizing offering collateral services to our adult beneficiaries increase the number of adult beneficiaries that receive a collateral service and subsequently show an improvement in their mental health functioning indicated by their MORS score?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	

MHP Name	Colusa
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ 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): Adults who are receiving services.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested 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): • Collateral support tool used in clinical way to work with beneficiaries and families.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Collateral support tool used in clinical way to work with beneficiaries and families.
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): n/a

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Base-line Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Collateral received (Goal 20%)	CY 2019	14/313 (4.47%)	1/1 – 3/31 2020	2/183 (1.09%) - 3.38% from baseline. 18.91% away from goal.	☒ Yes ☐ No	☐ Yes ☒ No
Collateral received (Goal 20%)	CY 2019	14/313 (4.47%)	4/1 – 6/30 2020	12/178 (6.74%) + 2.27% from baseline. 13.26% away from goal.	☒ Yes ☐ No	☐ Yes ☒ No
MORS Score Improvement (Goal 80%)	CY 2019	30/73 (41.10%)	1/1 – 1/31 2020	18/38 (47.37%) + 6.27% from baseline. 32.63% away from goal	☒ Yes ☐ No	☐ Yes ☒ No
MORS Score Improvement (Goal 80%)	CY 2019	30/73 (41.10%)	4/1 – 6/30 2020	15/26 (57.69%) + 16.59% from baseline. 22.31% away from goal.	☒ Yes ☐ No	☐ Yes ☒ No
Was the PIP validated?				☒ Yes	☐ No	
Validation phase: ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement						

Performance Measures	Base-line Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
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: • Simplify the aim statement and include time frame (i.e. Will the addition of family collateral services improve adult treatment as measured by their MORS scores over the course of 12 months? • Add discussion and analysis of remeasurement results after data tables. • Provide information on inter-rater reliability – specifically, how will the MHP assure that everyone enters the same data in the same way.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Discussion of the steps needed to establish a firm foundation for a PIP. These include using data to identify problems, causes and/or barriers related to problems, and linked indicators. • Discussion on choosing interventions based on barrier analysis/cause(s) to improve the likelihood of success.						

*PIP is in planning and implementation phase if N/A is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Colusa
PIP Title	Improved Intake Attendance
PIP Aim Statement	Will increasing the number of intake slots and reminder calls decrease the no-show rate at intake as measured by kept assessment appointments?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☒ 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): Children/adults seeking treatment for behavioral health issues.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Urgent vs. Standard Request for appointment (1/1/2020) 2. Intake appointment text/call reminder of scheduled day/time (1/2/2020) 3. Scheduled intake days/times added (5/1/2020) 4. Case management check-in calls until first appointment occurs (scheduled 9/1/2020) 5. Completion of Beneficiary Questionnaire upon intake request (Fall 2020)

PIP Interventions (Changes tested in the PIP)
6. Assurance that beneficiaries will be offered an intake appointment with a provider who speaks their threshold language (Fall 2020).
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Average wait days for standard request	7/2019-12/ 2019	2194/188 = 11.67 days Goal=10 days	5/1 – 6/30 2020	262/42 = 6.24 days	☒ Yes ☐ No - 5.43 days	☐ Yes ☒ No
% of beneficiaries who are offered a standard 10-day timely intake appointment	7/2019-12/ 2019	110/188 = 58.51% Goal= 70%	5/1 – 6/30 2020	34/42 = 80.95%	☒ Yes ☐ No + 22.44%	☐ Yes ☒ No
Intake appointment “no-show” rate	7/2019-12/ 2019	18.45% Goal= 10%	1/1 – 3/31 2020	11/92 = 11.96%	☒ Yes ☐ No - 6.43% from baseline. 1.96% away from goal	☐ Yes ☒ No

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Intake appointment "no-show" rate	7/2019-12/ 2019	18.45% Goal= 10%	4/1 – 6/30 2020	9/63 = 14.29%	- 4.16% from baseline. 4.29% away from goal	☐ Yes ☒ No
% of beneficiary satisfied with intake process	August 2020	18.45%	TBD	TBD	TBD	TBD
Was the PIP validated?				☒ Yes	☐ No	

Validation phase:

☐ 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

☒ Confidence cannot be determined at this time. Data collection methodology needs refining to produce reliable and consistent data. Further, the interventions are not based on barrier/cause analysis.

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

EQRO recommendations for improvement of PIP:

- The aim statement would benefit from including a time period, for example, "over a period of 12 months" along with a stated goal.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
• While this PIP contains basic information such as how often data will be collected and what data are collected, more details are needed to determine whether the data and collection methodology were reliable and consistent. For example, who is collecting the data, what are their qualifications, and what is the analysis plan? What are the considerations for untoward results, etc. • Regarding interventions, intervention one, developing an Intake Data Tracking Log to differentiate between urgent and standard requests for appointments, is not an intervention but rather a step the MHP needed to take so that it could proceed with the PIP. • Intervention five is also not considered an intervention – completion of a beneficiary questionnaire is a data gathering tool. • Intervention six is also not an intervention as assurance to beneficiaries that their appointment will be in their threshold language is already an industry standard (either by using the language line or a bilingual provider). • Finally, a discussion of data, analysis, and meaning is needed following tables of remeasurement data.						
The TA provided to the MHP by CalEQRO consisted of: • Discussion of the steps needed to establish a firm foundation for a PIP. These include using data to identify problems, causes and/or barriers related to problems, and linked indicators. • Discussion on choosing interventions based on barrier analysis /cause of the problem to improve the likelihood of success.						

*PIP is in planning and implementation phase if N/A is checked.

INFORMATION SYSTEMS REVIEW

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

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

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

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Colusa	5.00%	6.00%	6.60%	5.50%
Small-Rural MHP Group	N/A	5.26%	4.17%	3.92%
Statewide	N/A	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

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

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☒ Yes	☒ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If no BCP was selected above; the MHP uses an ASP model to host EHR system which provides 24-hour operational support.	☐ Yes	☐ No
The BCP (if the MHP has one) is tested at least annually.	☐ Yes	☒ No
There is at least one person within the MHP organization clearly identified as having responsibility for Information Security.	☐ Yes	☒ No
If no one within the MHP organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

- Colusa County and the MHP hosts and supports Cerner Community Behavioral Health (CCBH) system locally.

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	98.7%
Contract providers	1.3%
Network providers	0%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	3	1	1	0
2019-20	3	0	0	0
2018-19	3	0	0	0

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	0	0	0	0
2019-20	0	0	0	0
2018-19	0	0	0	0

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

- Data analytics support continues to be provided by Kings View, MHP QI, and technology staff.
- An EHR Coordinator was hired in January 2020 to fill a vacancy. Her role is HIPAA compliance; EHR training; problem-solving and troubleshooting; and to provide CCBH and Kings View liaison and staff with support.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by MHP and does not account for users log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	12	25	37
Clinical Healthcare Professional	32	2	34
Clinical Peer Specialist	1	0	1
Quality Improvement	1	1	2
Total	46	28	74

While there is no standard ratio of IT staff to support EHR user's, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources, they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Small-Rural MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	3	2.16
Total EHR Users Supported by IT (Source: Table 17)	74.00	42.00
Ratio of IT Staff to EHR Users	1:25	1:19

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☒ Yes	☐ No
The MHP utilizes an ASP model to support EHR operations.	☐ Yes	☒ No
The MHP also utilizes QI staff to directly support EHR operations.	☐ Yes	☒ No
The MHP also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☐	☒	☐	☐
Screen workflow and navigation	☐	☒	☐	☐

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

- Kings View provides quarterly training/billing sessions for all staff who perform billing functions.

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	1
Number of county-operated telehealth sites	1
Number of contract providers' telehealth sites	0
Total number of beneficiaries served via telehealth during the last 12 months	
• Adults	N/A
• Children/Youth	N/A
• Older Adults	N/A
Total Number of telehealth encounters (services) provided during the last 12 months:	N/A

- The MHP did not provide the total number or breakdown of beneficiaries served via telehealth during the last 12 months as they just recently began to use telehealth services.

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

☐ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☐ To serve special populations (i.e. children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☐ To reduce travel time for beneficiaries
☐ To support NA time and distance standards
☒ To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- In response to COVID-19, MHP staff began providing telehealth services for 55-minute sessions. HIPAA compliant and State-approved Zoom sessions take place, as well as via FaceTime on their mobile phones.
- A HIPAA consent form is signed by the beneficiary for mobile devices.
- A workstation is available at the MHP for beneficiaries to use if they do not have access to an electronic device enabling interaction with their provider.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☐	Cambodian
☐	Cantonese	☐	Farsi	☐	Hmong
☐	Korean	☐	Mandarin	☐	Other Chinese
☐	Russian	☒	Spanish	☒	Tagalog
☐	Vietnamese				

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☐ Yes ☒ No ☐ Implementation Phase`

The rest of this section is applicable: ☐ Yes ☒ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Sierra Behavioral Health Solutions	1

- Sierra Behavioral Health Services provides after-hours crisis response.

Current MHP Operations

- The MHP purchased and distributed 15 new laptops and 30 iPhones for COVID-19 response to support mobile sessions, field-based work, and increased productivity.
- Four super users provide EHR support.
- The MHP's Provider Directory is updated "as needed – monthly to every two months".
- The MHP monitors, tracks, and trends walk-ins, referrals, and primary care referrals.
- The MHP utilizes Tableau for dashboard reporting.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
CCBH	Client Data System	Kings View	9	MHP
CCBH	Assessment & Treatment Plans	Kings View	9	MHP
CCBH	Scheduling	Kings View	9	MHP
CCBH	Doctor's Homepage System	Kings View	9	MHP
CCBH	ePrescribing	Kings View	9	MHP
CCBH/Tableau	Dashboards	Kings View	2	MHP

The MHP's Priorities for the Coming Year

- Research a new EHR system.
- Collaborate with Kings View staff to continue updating dashboard reporting capabilities for Client Services Index (CSI) data and CANS-50/PSC-35 reporting data.
- Establish protocols and procedures for reporting timeliness (access to services).
- Provide ongoing staff training in the system, account repairs/updates, and training focus sheets.
- Discern and report needed EHR changes to Kings View to accommodate pending certification for DMC.

Major Changes since Prior Year

- Upgraded CCBH EHR system to Promotion 230.06, Hotshots update.
- Both CANS-50 and MORS dashboards were created in February 2019. The PSC-35 dashboard has not yet been created.
- Created initial set of operational dashboards with QIC metrics.
- Produced CSI Assessment to capture reportable CSI initial contact information, used in conjunction with the Access to Services Assessment.
- Completed Meaningful Use/Client Portal for Kings View to move forward.
- Changed server from Citrix to Cerner application for CCBH EHR access.
- MORS staff training was provided in Fall of 2019.

Other Areas for Improvement

- The MHP is dissatisfied with Cerner, stating that the vendor has not fulfilled its contract for the MHP's patient portal, although the MHP has completed their actionable items. Cerner states their current software cannot accommodate a patient portal until Millennium.

Plans for Information Systems Change

- The MHP is considering InSync Systems, Inc. information system and has had several demonstrations and meetings with the vendor.

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts		☒	☐	☐	☐
Assessments		☒	☐	☐	☐
Care Coordination		☐	☒	☐	☐
Document Imaging/ Storage		☒	☐	☐	☐
Electronic Signature—MHP Beneficiary		☒	☐	☐	☐
Laboratory results (eLab)		☐	☒	☐	☐
Level of Care/Level of Service		☒	☐	☐	☐
Outcomes		☒	☐	☐	☐
Prescriptions (eRx)		☒	☐	☐	☐
Progress Notes		☒	☐	☐	☐
Referral Management		☐	☒	☐	☐
Treatment Plans		☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		9	3	0	0
FY 2019-20 Summary Totals for EHR Functionality:		9	3	0	0
FY 2018-19 Summary Totals for EHR Functionality:		8	4	0	0

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

- None noted.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Direct data entry into MHP EHR system by contract provider staff	0%	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	100%	Daily

The rest of this section is applicable: ☐ Yes ☒ No

Some contract providers have EHR systems which they rely on as their primary system to support operations.

Table 27 lists the IS vendors currently in-place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Contract Provider to MHP Data Transmission

EHR Vendor	Product	Count of Providers Supported
Not Applicable.		

Personal Health Record (PHR)

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

☐ Yes ☒ No ☐ Implementation Phase

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☐ Yes	☒ No
View list of current medications through portal.	☐ Yes	☒ No
Have ability to both send/receive secure Text Messages with provider team.	☐ Yes	☒ No

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

- ☐ Dimension Reports application
- ☒ Web-based application, including the MHP EHR system, supported by vendor or ASP staff
- ☐ Web-based application, supported by MHP or DMC staff
- ☐ Local SQL Database, supported by MHP/Health/County staff
- ☐ Local Excel Worksheet or Access Database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP's SDMC claims.

Table 29: Summary of CY 2019 Short-Doyle/Medi-Cal Claims

Colusa MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**13,262**	**$2,549,112**	**186**	**$31,347**	**1.21%**	**$2,517,765**	**$2,412,455**
JAN19	1,032	$189,880	8	$794	0.42%	$189,086	$181,789
FEB19	1,029	$187,337	9	$735	0.39%	$186,602	$179,489
MAR19	1,219	$237,477	17	$3,182	1.32%	$234,295	$222,474
APR19	1,117	$212,410	9	$1,388	0.65%	$211,022	$202,714
MAY19	1,160	$246,242	19	$2,838	1.14%	$243,404	$231,306
JUN19	1,018	$207,343	28	$5,132	2.42%	$202,211	$188,634
JUL19	1,146	$230,365	24	$7,572	3.18%	$222,793	$211,694
AUG19	1,060	$211,165	20	$2,775	1.30%	$208,390	$200,715
SEP19	1,033	$195,794	14	$1,752	0.89%	$194,042	$186,290
OCT19	1,180	$211,655	9	$1,264	0.59%	$210,391	$204,154
NOV19	1,217	$220,121	13	$2,095	0.94%	$218,026	$211,112
DEC19	1,051	$199,321	16	$1,819	0.90%	$197,502	$192,085

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

Colusa MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Medicare or Other Health Coverage must be billed before submission of claim.	137	$17,200	55%
Beneficiary not eligible or non-covered charges.	11	$6,303	20%
Beneficiary not eligible.	31	$5,893	19%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	4	$1,154	4%
Service line is a duplicate and a repeat service procedure code modifier not present.	2	$510	2%
Total	186	$31,347	NA
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

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

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Colusa MHP, the time and distance requirements are 60 minutes and 90 miles for mental health services, and 60 minutes and 90 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted one consumer and family member focus groups, five stakeholder interviews, one staff and contractor interviews, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

The county MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

Not applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	1
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100%	2
NPI Type 1 number reported is associated with two or more providers	0
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	0
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	1

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested both a culturally diverse group of adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months and a culturally diverse group of parents/caregivers of child/youth beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. Working in collaboration with the MHP, CalEQRO decided to combine the groups. The group was consistent with that requested by CalEQRO, who are English-speaking beneficiaries and family members. The group was held via Zoom video conferencing.
Total number of participants	Six
Number of participants who initiated services during the previous 12 months	None
Interpreter used	No If yes, specify language: N/A

Topic	Description
Summary of the main findings of the focus group:	
Access - new beneficiaries	No new beneficiaries attended.
Access – overall	Prior to COVID-19, participants reported that transportation was provided by a peer support specialist. Since COVID-19, services continued by phone or meeting outside on benches. Psychiatry is by telehealth.
Timeliness	Participants felt that services were timely with the switch to phone and outside in-person meetings. Participants were very positive about psychiatry appointments being held through telehealth.
Urgent care and resource support	Participants really miss Safe Haven wellness center.
Quality	All participants reported that they are involved in their own treatment planning. Participants' responses were mixed regarding whether primary care and psychiatry communicate about an individual's treatment. Some participants reporting being asked to participate on the QIC, while others had not.
Peer employment	Participants reported that the hiring of two Peer Support Specialists was positive.
Structure and operations	A few participants attended the Mental Health Board meeting regularly.
Recommendations from this focus group	• Add a virtual dance fitness class. • Open Safe Haven wellness center. • Incorporate regular/ongoing FSP reassessments for easy transition between levels of care. • Provide Zoom groups.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 33 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 33: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
A Facebook page was created to inform the community about services and ongoing meetings, which are open to stakeholders. The MHP provides information to beneficiaries regarding transportation (public transportation vouchers) and collaborates with local community organizations such as Indian Health Services. Referrals are tracked and the MHP arranges for reimbursement from the Indian Health Services. Eligible beneficiaries arrange transportation through Anthem Blue Cross and California Health and Wellness. For non-eligible beneficiaries, reservations for transportation can be arranged two weeks ahead through LogistiCare. Open intake assessment services are offered weekly; however, COVID-19 restrictions and shelter-in-place guidelines altered the delivery of regular non-emergency services. Telehealth is provided by Zoom video conference, but if beneficiaries do not have the necessary technology, they can meet with a doctor via a Zoom workstation provided by the MHP at a different location within the building.			

Component		Maximum Possible	MHP Score
1B	Capacity Management	10	10
The MHP assesses the needs of its eligibles through collection of demographic information and regular reporting in QIC meetings. The MHP monitors staff productivity (at 70 percent) and caseload assignments, which are overseen by supervisors. The MHP has several Spanish-speaking staff members including case managers, mental health specialists, transportation drivers, office staff, coordinators, and therapists. The MHP began tracking sessions in Spanish in August 2020. Staffing challenges are still present with two therapist vacancies, some case manager vacancies, and a most notably difficult-to-fill psychiatric technician vacancy. The MHP continues to advertise the positions and is ready to hire when the right candidate applies. Regarding the impact of COVID-19 on services, the MHP states that it has had an increase in hospitalizations and surges in child, adult, senior, and nursing home beneficiaries' need for services. Additionally, for those already in service, very few have disengaged. Originally, the MHP staffed half days on-site, but they modified the rotation to one day per week on-site. All other business days, the staff provides sessions through mobile devices. An estimate of 90 percent of staff work from home.			
1C	Integration and Collaboration	24	24
The MHP continues to collaborate with local community agencies to offer services in schools and suicide prevention programing. The MHP also has relationships with local medical providers and the local emergency room. The MHP also partners with public health and managed care, child welfare services (CWS), the local hospital, doctors, probation, jail, and schools.			

Timeliness of Services

As shown in Table 34, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 34: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	16
Overall, 57.32 percent of appointments meet the goal of ten business days, 56.59 for adults, 55.45 percent for children and 84.62 percent for FC. The average length of time from first request for service to first appointment (in business days) was 10.44			

Component		Maximum Possible	MHP Score
days overall, 10.31 days for adults, 11.08 days for children, and 7.08 days for FC. The data reported was for the entire system. The MHP is addressing this issue through its PIPs.			
2B	First Offered Psychiatry Appointment	12	10
Overall, 56.25 percent of appointments meet the goal of 15 business days, 60.87 for adults, 37.50 percent for children and 100 percent for FC. The average length of time from first request for service to first appointment (in business days) was 20.09 days overall, 22.65 days for adults and 21.50 days for children. The data reported were for the entire system.			
2C	Timely Appointments for Urgent Conditions	18	13
The MHP submitted data from January 2020 to June 2020. The MHP does not normally track this metric and for this review, the data have been reported in days, not hours. The MHP does not differentiate between those appointments that require pre-authorization versus those that do not, because all urgent/crisis requests are seen for an appointment regardless. Overall, the average length of time for an urgent appointment is 6.3 days overall, 1.5 days for adults, and 11.20 days for children, with one day for FC. The percent of appointments that met the standard of 48 hours was 70 percent overall, 100 percent for adults, and 40 percent for children. The range for adults and children differs greatly– one to two days for adults and 0 to 44 days for children.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	10
Of the total number of hospital admissions and discharges (n=33), 29 had follow-up appointments within seven days, with an average wait time of 0.88 days. Adult and children's data were not reported by CalEQRO due to there being less than 11 people.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
Of the 33 hospitalizations and discharges, there were no re-hospitalizations within 30 days.			
2F	Tracks and Trends No-Shows	10	8
For psychiatrists, the no-show rate was 13.07 percent for all services, 13.10 percent for adults, and 12.75 percent for children. FC was not separated out for this metric. For clinicians, the no-show rate was 10.80 for all services, 8.99 percent for adults, and 12.97 percent for children's services. FC was reported at 11.95 percent. The standard			

Component	Maximum Possible	MHP Score
for both psychiatrists and non-psychiatrists is 10 percent. The MHP is addressing no-shows at assessment through a non-clinical PIP.		

Quality of Care

In Table 35, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 35: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
The Cultural Competence Committee (CCC) is actively meeting monthly by Zoom video conferencing. The MHP worked with the Master of Social Work (MSW) program field instructor from Chico State University to recruit Spanish-speaking interns. Two interns are coming on board in August/September, one of whom speaks Spanish. The CCC reviews the Hispanic/Latino penetration rate to monitor improvement and identify outreach events. The MHP produces a cultural competence plan (CCP) which coordination between the CCC and QIC work plans, activities, and evaluations.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	8
The MHP uses a process to transition beneficiaries between levels of care using a goal system and wraparound approach. The MHP tracks level of care through the medical necessity form or through the MORS scores for adult beneficiaries. Beneficiaries also indicated that they are involved in treatment planning. For adult beneficiaries, the MHP performed data analysis and found a low incidence of MORS completion by staff; subsequently, training for staff was provided on MORS in the Fall of 2019. Of note, although the MHP's policy and procedure on MORS mandates that providers complete a MORS for each beneficiary monthly, some providers state that they are "too busy" to complete them for each beneficiary. For reporting, the CANS-50 and MORS dashboards were created in February 2019. Outcome dashboards are distributed and discussed at quality improvement (QI) meetings, PIP meetings, and leadership meetings. Dashboard data are utilized to			

Component		Maximum Possible	MHP Score
determine effectiveness of interventions; however, the MHP states that the CANS-50 results in multiple scores for an individual and as such, are hard to aggregate for the system as a whole.			
3C	Quality Improvement Plan	10	8
The current work plan contains measurable goals. While the MHP's work plan does not contain an analysis of disparity in services by site/region/population served, the MHP's Cultural Competency Plan does. The MHP's QI Plan does not include trending analysis over time.			
3D	Quality Management Structure	14	13
QI interfaces with other MHP divisions/units/departments for quality improvement coordinator/manager. There are several meetings where information is shared. The QIC meetings are monthly along with compliance meetings. The CCC meets quarterly. All-staff meetings are held quarterly, with supervision weekly. The QIC completed its NA documentation through data collected and reported on through dashboards. The QI coordinator position is a full-time position with IS/IT responsibilities. The Compliance Officer is contracted for 12 hours per week. Another data analyst would be beneficial to meet increasing demands of state mandated reporting and internal needs for data analysis and usage. The MHP hired two part-time extra help peer employees. The peer employees call and connect beneficiaries to resources. The MHP also has an existing full-time peer support specialist. Beneficiary participation, and participation in general, has improved in the QIC meetings. One beneficiary attends regularly and provides feedback and reports on any wellness center issues.			
3E	QM Reports Act as a Change Agent in the System	10	8
Dashboards are used to evaluate data related to timeliness, quality, outcomes, and access. With more dashboards available and an increase in qualitative metrics, the MHP could become a data-driven quality improvement system.			

Component		Maximum Possible	MHP Score
3F	Medication Management	12	2
Medication monitoring is included as a goal in the MHP's Work Plan. Medical records staff are to identify ten medication charts to be reviewed quarterly by a person licensed to prescribe or dispense prescription drugs; however, the MHP has not identified an individual who qualifies to review the prescribing practices of the MHP's psychiatrist. Once a qualifying person is hired, reports will be reviewed in QIC for oversight and needed actions. Regarding capability, the EHR and corresponding subunits allow the MHP to track and trend medication management services. Anasazi, the current EHR record, does not include a code that differentiates antipsychotic medications from other medication management. The MHP reports that it is exploring EHR providers to allow a more customizable platform, enabling the MHP to track and trend medication management.			

Beneficiary Progress/Outcomes

In Table 36, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 36: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	13
The MHP utilizes dashboards for outcome reporting in addition to reporting on access and timeliness. The MORS is used to evaluate outcomes for adult beneficiaries while the CANS-50 and PSC-35 are used for children and youth beneficiaries. The MHP relies on dashboards for aggregated data.			
4B	Beneficiary Perceptions	10	10
The MHP administers the Consumer Perception Survey (CPS) from DHCS; however, they do not enter their own data prior to submission to the State. The MHP also provides its own surveys to beneficiaries.			

Component		Maximum Possible	MHP Score
4C	Supporting Beneficiaries through Wellness and Recovery	12	6
A fire that damaged the location of Safe Haven caused the wellness center to move to a large meeting room at the MHP's office. This Safe Haven site was open from October 2019 to March 2020 when COVID-19 caused temporary closure of face-to-face interactions. The peer employees continue to provide outreach to beneficiaries through Facebook, phone calls, and information packages that are distributed/dropped-off to beneficiaries. Clinical staff have offered and provided groups to Safe Haven members via telehealth and conference calls during COVID-19.			

Structure and Operations

In Table 37, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 37: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	20
The MHP offers several services including mental health, medication support, case management, and crisis intervention. Other services are available through its contractors (i.e., inpatient psychiatric hospitalization and residential treatment). The MHP does offer crisis services within the community; however, the MHP does not receive dedicated funding for a mobile crisis response unit. For after-hours and weekends, the MHP's subcontractor, Sierra Mental Wellness, provides crisis coverage. MHP staff provides rotating coverage during business hours. There is some overlap as a few MHP staff are employed by Sierra Mental Wellness for after-hours crisis.			
5B	Network Enhancements	18	12
The MHP offers telehealth appointments and field-based services. The MHP also partners with HHS on the Whole Person Care initiative. The MHP can provide services in Spanish, the county's threshold language.			

Component		Maximum Possible	MHP Score
5C	Subcontracts/Contract Providers	16	12
The MHP does not have direct service provider contractors except for compliance consultants and Sierra Mental Wellness after-hours crisis. The MHP might consider involving Sierra Mental Wellness on both the PIP work group and CCC.			
5D	Stakeholder Engagement	12	6
Staff feedback indicates that email is the primary way that leadership communicates and that at times, communication is not transparent. For example, monthly staff meetings have decreased from quarterly to none; however, staff did not report a reason. Since the initial draft of this report, the MHP responded that staff meetings were suspended (due to COVID) and that a virtual all-staff meeting was held October 20, 2020. As previously noted, there is an increase in beneficiary participation on the QIC.			
5E	Peer Employment	8	3
The MHP does not have collaboration with the Department of Rehabilitation. There does not appear to be an established career ladder for peer employees (i.e. level I, II, III); however, two peers where hired on a part-time basis before COVID-19 and have since been providing outreach services during shelter-in-place.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Colusa MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

- While the MHP provided two active and ongoing PIPs, both PIPs need improvement to be successful for a second year. Ongoing TA will strengthen them and yield the best possible outcome.

Access to Care

Changes within the Past Year:

- Reservations for transportation (for beneficiaries who do not have managed care benefits) are arranged in advance through LogistiCare.
- The local hospital had approached the MHP to convert a hospital wing into a psychiatric health facility (PHF); however, the hospital decided not to go forward due to high conversion costs to meet compliance standards.
- In the past year, the MHP expanded their Rapid Rehousing Program capacity, acquiring two more properties to meet housing needs for females and families.
- The full-service partnership program was expanded with additional staff coordinators in efforts to stabilize and move them through the program.
- The MHP expanded the Sober Living Program in Chico with three new locations for men, women, and mothers with children.

Strengths:

- None noted.

Opportunities for Improvement:

- None noted.

Timeliness of Services

Changes within the Past Year:

- Walk-in assessments are now offered with delivery modification (i.e. telehealth, Zoom, telephone) due to COVID-19.
- The MHP's non-clinical PIP includes an intervention to increase the number of intake appointments. Intake appointments are scheduled for Tuesday morning and Thursday afternoon with rotation of clinical staff. Additionally, scheduled intake appointments are available throughout the week.
- Timeliness tracking of urgent appointments began in January 2020.

Strengths:

- None noted.

Opportunities for Improvement:

- Overall, 57.32 percent of first assessment appointments met the 10-business day goal. The average length of time from first request for service to first appointment (in business days) was 10.44 days overall, 10.31 days for adults, 11.08 days for children, and 7.08 days for FC.
- Overall, 56.25 percent of first offered psychiatric appointments met the 15-business day goal. The average length of time from first request for service to first appointment (in business days) was 20.09 days overall, 22.65 days for adults and 21.50 days for children. The data reported was for the entire system.
- Overall, 70 percent of urgent appointments met the 48-hour standard with 100 percent for adults, and 40 percent for children. The average length of time for urgent appointments not requiring prior authorization overall was 6.3 days, 1.5 days for adults and 11.20 days for children.

Quality of Care

Changes within the Past Year:

- None noted.

Strengths:

- None noted.

Opportunities for Improvement:

- The MHP plans to develop and incorporate employment supports for beneficiaries within the MHP and externally through their Social Determinants Innovation Project Proposal. This was an unmet recommendation for FY 2019-20.
- Feedback from clinical line staff as well as peer employees, during the review, underscored the need for more staff inclusion, dissemination of information, and performance data. No improvements in bi-directional feedback were reflected.
- The MHP's QI Plan does not include trending analysis over time.

Beneficiary Outcomes

Changes within the Past Year:

- Both the CANS-50 and MORS dashboards were created in February 2019. The PSC-35 dashboard is not yet created.
- MORS staff training was provided in Fall of 2019.

Strengths:

- CANS-50 dashboards and data are utilized in a variety of interventions/treatments to evaluate cultural needs and supervision of treatment effectiveness.

Opportunities for Improvement:

- Not all clinicians are consistent with entering MORS data into the system and state that they have limited time due to seeing beneficiaries.
- The MHP does not have a PSC-35 dashboard.
- The MHP states that the CANS-50 results in multiple scores for an individual and, as such, is hard to aggregate for the system as a whole.

Foster Care

Changes within the Past Year:

- None noted.

Strengths:

- None noted.

Opportunities for Improvement:

- None noted.

Information Systems

Changes within the Past Year:

- None noted.

Strengths:

- None noted.

Opportunities for Improvement:

- None noted.

Structure and Operations

Changes within the Past Year:

- The MHP hired a compliance officer and a new deputy director.
- The MHP hired two bilingual mental health specialists in September 2019 and another MH Specialist in November 2019 for rehabilitation services.
- Mental Health Service Act (MHSA) three-year funds were moved to Capital Facilities, $400,000 last year and another $400,000 this year. A funds transfer had not been done for over five years. A week before the review, the Board approved the three-year plan.
- In November 2019, the MHP created and filled two new part-time peer support specialist positions.
- A fire in October 2019 damaged the MHP's Wellness/Drop-in center, Safe Haven. There have been no repairs and construction done to date. The MHP states reconstruction is the landlord's and insurance company's responsibility.

Strengths:

- None noted.

Opportunities for Improvement:

- None noted.

FY 2020-21 Recommendations

PIP Status

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

Access to Care

None noted.

Timeliness of Services

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

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

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

Quality of Care

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

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

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

Beneficiary Outcomes

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

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

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

Foster Care

None noted.

Information Systems

None Noted.

Structure and Operations

None Noted.

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible, such as conducting on-site beneficiary focus groups.
- The beneficiary/family member focus group did not include beneficiaries new to services within the last 12 months.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment A—On-site Review Agenda

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

Table A1: EQRO Review Sessions

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

Attachment B—Review Participants

CalEQRO Reviewers

Cyndi Lancaster – Lead Quality Reviewer
Judy Toomasson – Information Systems Reviewer
Gloria Marrin – Consumer/Family Member Consultant

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

Sites of MHP Review

MHP Sites

Review was held by video conference due to COVID-19.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Briscoe	Bonnie	Fiscal Administrative Officer	CCBH
Bullis-Cruz	Heather	Compliance Officer	CCBH
Deabel	Donna	Clinical Program Manager, MHSA	CCBH
McAllister	Jennifer	Clinical Program Manager, SUD	CCBH
McCloud	Bill	EHR Manager	CCBH
McGregor	Mark	Clinical Program Manager, Children	CCBH
Piluczynski	Cindy	Patient's Rights Advocate	CCBH
Piper	Shannon	Clinical Program Manager, Adults	CCBH
Puga	Mayra	MHSA Coordinator	CCBH
Rooney	Terence	Director	CCBH
Scroggins	Jeannie	Quality Assurance Coordinator	CCBH
Uhring	Audrey	Deputy Director, Clinical	CCBH
Whiting	Lynn	EHR Coordinator	CCBH

Attachment C—Approved Claims Source Data

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

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

Table C1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Colusa MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Small-Rural	30,108	2,403	7.98%	$8,036,478	$3,344
MHP	2,157	143	6.63%	$614,680	$4,298

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

Table C2: CY 2019 Distribution of Beneficiaries by ACB Range

Colusa MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	658	98.21%	93.31%	$2,090,260	$3,177	$3,998	83.30%	59.06%
>$20K - $30K	*	n/a	3.20%	-	$23,991	$24,251	n/a	12.29%
>$30K	*	n/a	3.49%	-	$50,239	$51,883	n/a	28.65%

Attachment D—List of Commonly Used Acronyms

Table D1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CCBH	Community Care Behavioral Health
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIT	Crisis Intervention Team or Training
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSD	Community Services Division
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services

Acronym	Full Term
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay

Acronym	Full Term
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MCBHD	Medi-Cal Behavioral Health Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NA	Network Adequacy
N/A (alt)	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
ONA	Out-of-Network Access
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PM (alt)	Partially Met
QI	Quality Improvement

Acronym	Full Term
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version