**MEMORANDUM**

FROM: Contra Costa Mental Health Commission, Quality of Care Committee

TO: Dr. Suzanne Tavano, Director, Behavioral Health Services
Priscilla Aguirre, Quality Management Program Coordinator, Behavioral Health Services
EQRO Site Review Team

DATE: January 20th, 2024

RE: Questions regarding Contra Costa Behavioral Health Services 2022-2023 External Quality Review Organization Report

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This document presents questions from the Quality of Care Committee of the Mental Health Commission regarding the 2022-2023 External Quality Review Organization (EQRO) report for the Contra Costa Behavioral Health Services (BHS).

- In September 2023, Pricilla Aguirre presented the EQRO report to the Mental Health Commission.
- During October and November of 2023, the Quality of Care Committee reviewed the report more deeply and had several questions, which are provided below.
- During January, 2024, the Committee finished the write-up of the questions.

The Quality of Care Committee would like to receive a written response to the questions, and a follow up committee meeting for clarifications and discussion. We are targeting the Quality of Care meeting on March 21, 2024 for this discussion.

Note that Section I contains questions for BHS whereas Section II contains questions directed to both BHS and the EQRO site visit team.

**I. Questions for BHS**

1. In the section about Med-Cal claiming, there is a reference to a "claim lag" of $20,852,975. In the accompanying table there is a column on "disallowances" that amounts to $3,756,880. What is this disallowance? (pgs. 55-57)

2. What are BHS targets for Penetration Rate (PR) and Average Approved Claim Benefit (AACB) for 2023? For: Adults, children, foster care, ethnicities. How will BHS achieve these targets? While BHS outperformed other counties this past year, we still need to see the targets for 2023-2024.

3. What are the implications for a higher AACB versus a lower AACB? (pages 22+)

4. In the table on “Units of Service Delivered to Adults” (page 31) there is data showing that BHS underperforms other counties in several ways (see bullet points on page 31-32. What are the causes of the underperformance and how are they being addressed?

5. What is being done to finally implement direct data entry by CBO’s to Electronic Health Records? This effort has been going on for a very long time. (page 8)

6. What is the current tally of total number of hired clinical staff and key management and support staff versus the number of empty slots for each type of staff (e.g. psychiatrists, therapists, psychiatric nurses, department managers) (page 12)

7. Did the Sharecare to ccLink system happen yet (page 13)

8. Have the new CalAIM contract templates and process been developed yet? When will implementation start?

9. How does the Access Line program virtual assessment process work? E.g are there clinical staff on hand to do assessments at any time that the Access Line is open? At what point will a full assessment in person be done? (page 13)

10. What is the thinking behind the notion that a higher percentage of beneficiaries will respond to the race/ethnicity question via the Access Line? Why would someone be more willing to respond in this environment. Because they are not face-to-face? Is there data yet on whether is a higher response rate? (page 14)

11. How is East County operating with only 3 clinical health specialists? What are the typical reasons why staff are leaving? (page 15) Have there been exit interviews for candid feedback?

12. What are the current wait times and wait lists for services after initial assessment? It sounds like a major strategy for decreasing wait times is ongoing reassessment of individual’s needs as they wait. This sounds a little like off-loading and kicking-the-can down the street. What number of individual’s are shifted to another provider or found to be no longer in need of treatment for both adults and children? Don’t other providers have wait lists too? (page 15)

13. How does “brief therapy” affect outcomes compared to BHS standard therapy approach. Does it provide better, same or worse outcomes? The number of brief therapy sessions offered are “five to six”. Can such a small number of sessions be effective? How long are the standard (non-brief) therapy treatments? How long has BHS been using this strategy? (page 16)

14. Why haven’t more financially competitive compensation packages been offered yet? What is the hold up? We are in a crisis that will be improved by appropriate incentives. What is the retention rate for clinical staff? Do we know why staff stay? (pages 16 and 21)

15. Despite the multiple channels of obtaining beneficiary feedback, focus groups show that beneficiaries don't all feel like they have a feedback avenue. MHSA feedback seems to deal more with preferences regarding needs to be addresses, not specific feedback to interactions with the BHS mental health system of care / delivery system. What other more direct ways are being considered? (page 17)

16. BHS indicates that it obtains stakeholder feedback on specific plans under development, including the Mental Health Commission (MHC). The MHC, in fact, did not provide critical input to "specific plans that are underway" during 2022-2023. It hasn't provided meaningful "input and involvement" in System Planning and Administration in this period. It was very rarely (if at all) informed that plans were at a juncture requiring MHC feedback. How will BHS remedy this serious problem? What kind of process can be designed to ensure that the MHC is kept apprised of plan progress and key points of community input? (page 17)

17. Do we know anything more about beneficiaries who are receiving tele-health services other than age range? Do we know why some consumers choose tele-health services? Is it strictly convenience and no drive? (page 19)

18. How does East County have services that meet the network adequacy benchmarks given such factors as low capacity due to difficulty in staffing? A facility may be within driving range, but if they don't have enough capacity, do they really qualify to be in the network? (page 20)

19. To improve access, BHS performs MONTHLY follow up all to beneficiaries that have been assessed but are waiting for treatment. How is this acceptable and doesn't it conflict with the Access Key Component "1D"? (page 21)

20. The responses from focus groups regarding wait times for initial intake and assessments is ambiguous and at times inconsistent with the report narrative. Are these times being tracked on? What is the target benchmark? (page 21)

21. What is the average wait time for receiving treatment (including seeing a psychiatrist where indicated) once assessment is complete? (page 21)

22. Is the list of consumers on a wait-list prioritized e.g. by urgency?

23. Is there a measure for improvements in transportation and the effectiveness of the dollars spent? How much transportation is actually supported and is transportation support managed?

24. How do assessments and treatment occur for people who do not have transportation and cannot or do not want to do tele-health?

25. Why are adult "per minute service" percentages so much lower than state levels for: Crisis Intervention, Mental Health Services and Targeted Case Management? (page 31)

26. Why is the Foster Care percentage so much lower in Intensive Home-Based Services? Why is it so much HIGHER in Targeted Case Management? (page 32)

27. How does BHS sometimes provide planned mental health services prior to the completion of assessment and diagnosis? How does this work?

28. In terms of timeliness measures, the percentage of "met standard" for First Non-Urgent Psychiatry Appointment Offered and Follow-Up appointments after Psychiatric Hospitalization is well below that of the states (81.9% and 45.8% respectively). Is this all due to staffing shortages? Are there no other process/systemic reasons behind these findings? (page 36)

29. Why are wait times for foster care so high (33 days) ? Wait times for other children are not as high, but are high as well. What are the reasons for this? Is this all due staffing of pediatric clinical staff or are there other factors as well?

30. Why are "no show rates" so high for both beneficiaries AND clinicians? (page 36)

31. The CY 2021 quality assessment and performance improvement (QAPI)
fully met 65% of actions, partially 16% and 19% not met. What is being done to improve upon this quality of care effort? (page 39)

32. Staff input was obtained in a recent survey. However, there doesn't appear to be adequate communication throughout the year, particularly during budgeting, that staff input is actively requested/required. How can BHS culture develop more of a flow of ideas from staff to management in operations and provision of services? What kind of input is requested and when; what kind of input is offered; and do staff feel secure enough to speak up? What are the results of the staff survey? (page 40-41)

33. The CBO's are a critical stakeholder group. What kind of quality improvement input is requested and shared with CBOs? What happens at luncheons? Is there any formal mechanism for exchange? How can greater exchange occur? (page 40)

34. What are the plans for improving medication management, including closing the gap with CBO's and labs? (page 41)

35. How will CalAIM processes be seamless with CBO's? Do CBO's have their own CalAIM training?

36. What is BHS doing to continue to decrease the cost of high cost beneficiaries?

37. What is BHS doing to increase claims acceptance / reduce claim denials? What is the target? (page 55)

38. A focus group gave feedback that there be a greater focus on “independence and employment” with less emphasis on “governmental assistance”, which was seen as dependency and reliance on the system. How will BHS respond to this critical beneficiary input? (page 59)

39. Under CONCLUSIONS/STRENGTHS there is a statement about IT, item 3) that is difficult to interpret. How does this breakdown? (page 62)

**II. Questions for BHS and EQRO Site Review Team:**

40. Summary of Key Components – 10 of 26 not met. How is this acceptable?

41. The IMPACT OF ACCESS FINDINGS section, none of the deficits found in the section are articulated. Why is this?

43. In the QUALITY KEY COMPONENTS section, 6 out of 10 key components are partially met. Why is there not more elaboration of this performance? (page 40)

44. How can there no impact by the unmet standards of the timeliness measures? (page 38)