Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

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

AMADOR MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

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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 Amador 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 — Central

MHP Location — Sutter Creek

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 773

MHP Threshold Language(s) — None at this time (Spanish according to the old IN cited below)

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)

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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 1. 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.

and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

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: The MHP needs to initiate a clinical PIP with interventions in place prior to next CalEQRO review.

Status: Met

- The MHP started a new clinical PIP to improve engagement through wellness and recovery action plan (WRAP) and peer-run groups in December 2019.
- Due to coronavirus disease 2019 (COVID-19) pandemic, the MHP had to postpone the implementation plans for the above PIP which required group activities.

- Instead, in consultation with CalEQRO, the MHP started a time-limited clinical PIP to bolster the declining penetration rate and service hours due to COVID-19 restrictions using telehealth services.
- At the time of the review, the MHP was preparing to restart group sessions using teleconferencing software, and planning to reactivate the originally planned PIP later in 2020.

Recommendation 2: Upon completion of its non-clinical PIP, the MHP needs to initiate a non-clinical PIP with interventions in place prior to next CalEQRO review.

Status: Partially Met

- The MHP started a new non-clinical PIP in November 2019 to improve service retention rate for beneficiaries who receive only one to three services in a year. This topic was identified through a review of CalEQRO's PM findings.
- Although there are several reasons for low retention rate, the MHP has focused on ameliorating a distal cause, staff satisfaction.
- At the time of the review, the MHP was in the process of full implementation after having been temporarily sidetracked by COVID-19 impacts.

Access Recommendations

Recommendation 3: Continue to explore ways to improve licensed clinician retention rate including providing housing incentives.

Status: Met

- The MHP stated that housing incentives are not an option to improve licensed clinician retention rates due to budgetary restrictions.
- Clinicians' feedback who have left the MHP had suggested implementing an internal support group and providing additional training opportunities for improving retention and preventing clinician burnout.
- The MHP is currently researching a contract to provide a monthly support group and additional training opportunities.
- Strategies for improving staff satisfaction have become the interventions in the MHP's current non-clinical PIP.
- The MHP has become fully staffed over the past year, providing consistency and stabilization internally as well as for beneficiaries.

Recommendation 4: Consider ways to systematically evaluate the numerous cultural initiatives for their effectiveness and identify changes or strategy modifications that may be needed.

Status: Met

- Promotores provided individual assistance and resource support to 181 community members, a 12 percent increase since FY2018-19.
- The MHP meets quarterly with the local Promotores. The Spanish speaking clinician attends these meetings, along with the MHP director and MHSA coordinator.
- The MHP's Latino/Hispanic calendar year penetration rate was 6.31 percent in 2017, 5.81 percent in 2018 and 7.58 percent in 2019. Its penetration rate for 2019 was higher than both statewide and small-rural averages, 4.08 percent and 5.31 percent respectively.
- Latino/Hispanic outreach and engagement has expanded in the past year. The MHP aims to increase the number of crisis calls that are handled in Spanish in order to improve access to SMHS by Spanish-monolingual Medi-Cal beneficiaries.
- Due to COVID-19 distancing, Native American Round Table meetings were suspended temporarily, but have resumed in September. The MHP is working to make this meeting take place consistently. However, the scheduling of these meetings is beyond the MHP's control.

Timeliness Recommendations

Recommendation 5: Track the attempts to reach new beneficiaries by frequency and the total time they take. This will improve the understanding of the first offered appointment timeliness.

Status: Met

- In November 2019, the Quality Improvement (QI) staff met with the MHP's support staff for retraining on collection of timeliness data and utilizing the Access to Service form.
- The MHP does not use its EHR, Cerner Community Behavioral Health's (CCBH) Access to Services Journal but they created a workaround with an Access to Service form and track the data manually.
- For most first offered appointments, the MHP logs in when a new beneficiary calls for service. According to the MHP, this is the most commonly utilized pathway to SMHS. The same procedure is followed for walk-ins. However, for referrals coming in from outside agencies such as

primary care, the support staff will log in the time when they initiated a call, and the time the first appointment slot is available. The MHP has found that sometimes it takes as long as a week for the potential service recipient to call back, and the new procedure eliminates the errors that were generating in MHP's first offered appointment timeliness calculations.

Recommendation 6: Separately track adult, child, and FC no show rates.

Status: Partially Met

- No show rates for FC are not tracked. The MHP's administrative service provider (ASP), Kingsview (KV) has informed the MHP that tracking FC no show data separately is not electronically possible. The MHP can count the FC no-shows, but not the appointments. As a result, it is unable to determine the no-show percentages at this time for FC.
- The MHP is working on electronic tracking of FC appointments with KV. As KV is currently engaged in the selection of a new EHR, the MHP expects that this issue may not be resolved in the short term until a new EHR is in place.
- While the MHP is not able to separate out the FC no-show rates, it is able to calculate the overall, adult, and children's no-show rates for clinicians and psychiatrists.

Quality Recommendations

Recommendation 7: Examine co-occurring diagnosis rates for the adult beneficiaries.

Status: Met

- After reviewing the low co-occurring diagnosis rates, the MHP determined the need to address the rates in its FY 2019-20 QI plan.
- Co-occurring diagnoses and related diagnoses reports has now become a standing agenda item for monthly utilization review (UR) meetings.
- The MHP reported an increase in co-occurring diagnosis rate from 21 percent in FY 2018-19 to 25 percent in FY 2019-20.

Recommendation 8: Establish face-to-face psychiatry quality monitoring through peer review.

Status: Met

- The MHP is conducting 16 peer reviews each year – 8 each for both the internal full time and part time psychiatrists. The MHP's compliance officer monitors all those reviews and sign off on the findings.
- Participants in the EQR beneficiary session reported having difficulty in psychiatry sessions over the phone, and the causes for these and identification or remedies can become part of the peer review process.

Beneficiary Outcomes Recommendations

None noted.

Foster Care Recommendations

Recommendation 9: Monitor all timeliness metrics for the FC beneficiaries

Status: Met

- The MHP now tracks and monitors all timeliness metrics except no-show rates for FC beneficiaries.

Recommendation 10: Coordinate with Child Welfare Services (CWS) and Juvenile Probation to restart the process of identifying FC beneficiaries who may need Therapeutic Foster Care (TFC).

Status: Partially Met

- The MHP met twice in FY 2019-20 to collaborate with Juvenile Probation and Social Services to discuss trauma informed care and to complete a memorandum of understanding (MOU).
- The MHP has been preparing a request for proposal (RFP) for TFC services. However, the MHP also noted that so far it has not found any agency in or near the county willing to take on the responsibility of complying with the TFC regulations.
- At present, the MHP, Juvenile Probation, and Social Services support FC beneficiaries who need higher levels of care through Intensive Treatment Foster Care (ITFC).

Information Systems Recommendations

Recommendation 11: Seek technical assistance with the State and existing fiscal consultant on share of cost policy, collection, and billing procedure.

Status: Met

- The MHP reached out to multiple peer MHPs to get feedback on their share of cost policies and strategies, and verified this feedback with its DHCS liaison who confirmed findings.
- Based on its findings, the MHP has revised its share of cost policies and procedures.
- The MHP began billing for share of cost in January 2020 including the previous six months' services.

Recommendation 12: Commence billing beneficiaries monthly for any outstanding share of cost.
(This recommendation is a carry-over from FY 2018-19.)

Status: Met

- The MHP has started doing this from January 2020.

Recommendation 13: Establish policy and procedure, train and monitor clinicians and billing staff on guidelines for billing for co-facilitators in group therapy sessions. Seek technical assistance from the State in accordance with IN 18-002.

Status: Partially Met

- EHR vendors have had difficulty with their software incompatibility to meet the co-facilitator billing requirements for IN 18-002.
- Since the time of the review, DHCS has released IN 2020-060 with revised guidelines for billing for co-facilitators, and CalEQRO has shared it with the MHP.

Recommendation 14: Collaborate with both KV and the county Health and Human Services Agency (HHSA) in establishing a disaster plan.

Status: Partially Met

- The MHP does not have an internal disaster plan but is utilizing KV's disaster plan.
- The MHP has obtained sample disaster plans from other MHPs, and was in the process of working with Public Health to develop its own internal plan. This is currently on hold due to COVID-19.

Structure and Operations Recommendations

Recommendation 15: Investigate whether the MHP is fully submitting claims for all its Medi-Cal beneficiaries' inpatient episodes.

Status: Met

- In January 2020, the MHP began billing for fee for service providers and facilities.
- Quarterly inpatient billing is monitored and balanced for charge capture and accuracy.
- The MHP has experienced some delays in getting discharge summaries and documentation from providers. However, it reported that the system is working.

Recommendation 16: Perform short-term and long-term needs assessment for internal reporting and analysis as well as for mandated reporting to the state to support funding for new data analyst position. (*This is a follow-up recommendation from FY 2018-19.*)

Status: Partially Met

- The MHP has listed all its short-term and long-term reporting and data analysis needs.
- Short-term needs for internal reporting and analysis are as follows:
    - Routine daily reports for charge capture
    - Timely documentation
    - Missing Progress Notes
    - Milestones of Recovery (MORS) and Child and Adolescent Needs and Strengths (CANS) monthly reporting
    - Timely access to services reporting
    - Annual assessments and treatment plan renewals
    - Grievance tracking
    - Test call tracking
- Long-term needs for internal reporting are as follows:
    - CANS-50 and Pediatric Symptoms Checklist (PSC-35) outcomes data
    - NACT timeliness data
    - Client Service Information (CSI) timeliness

  - PIP data
  - Staff recertification
  - Annual policy tracking

- All the reporting tasks above are currently distributed amongst the QI/UR coordinator, fiscal supervisor and the compliance officer.
- At the time of the review, an offer had been made for an administrative assistant applicant. The hiring process would be finalized within two weeks.
- The new administrative assistant would run some of the above listed reports. The position would be .25 FTE running reports and .25 FTE fee-for-service billing.
- The new administrative assistant's role will not include data analytics.
- Due to likely budget impacts post-COVID-19, the MHP does not expect its requests for a data analyst position will be granted in the near future.

Recommendation 17: Comply with DHCS IN 19-020 data reporting guidelines for Phase One data elements.

Status: Met

- The MHP has complied with Phase One data elements. However, initially there were some errors during FY 2019-20.
- KV provided correction of those errors and provided training to the QI coordinator.

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]

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

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

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

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

- 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 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).

- 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.

    - 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

Amador 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	5,743	72.3%	606	78.4%
Latino/Hispanic	1,016	12.8%	77	10.0%
African-American	63	0.8%	*	n/a
Asian/Pacific Islander	101	1.3%	*	n/a
Native American	162	2.0%	*	n/a
Other	855	10.8%	62	8.0%
Total	**7,938**	**100%**	**773**	**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

Amador MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	*	n/a
Other Languages	*	n/a
Total	**773**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

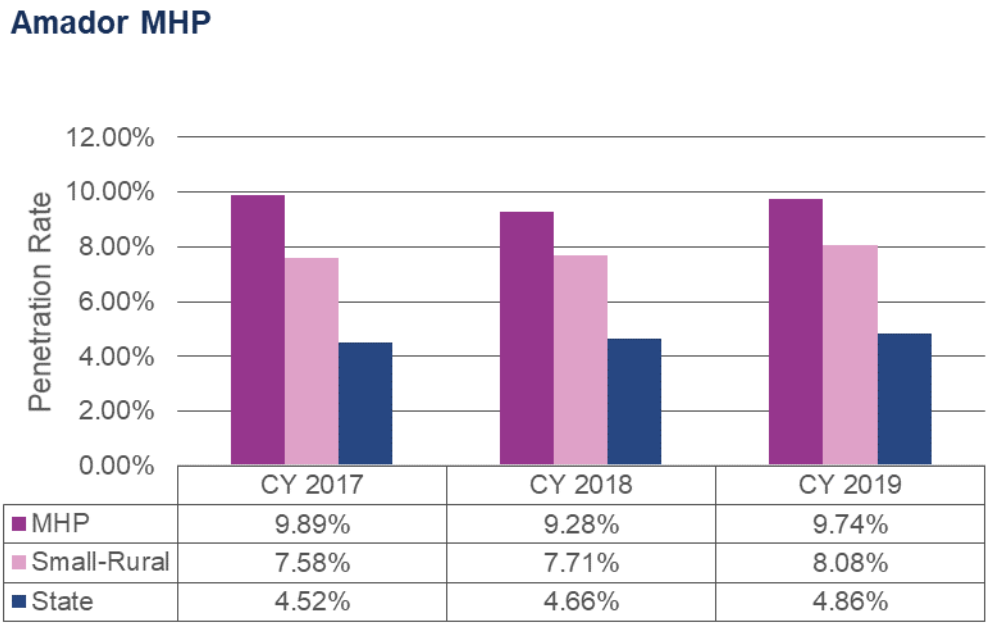
Penetration Rates and Approved Claims per Beneficiary

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.

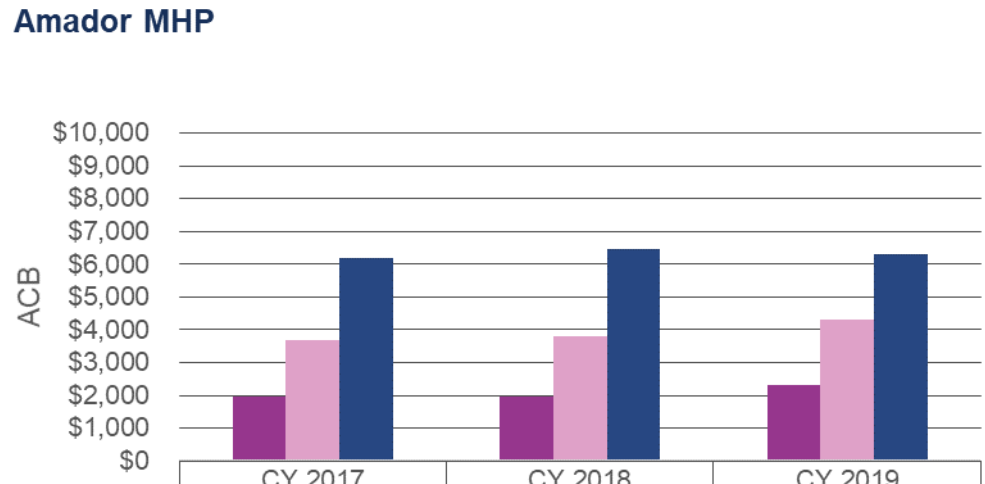
Regarding the calculation of penetration rates, the Amador MHP uses a different method than that used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	9.89%	9.28%	9.74%
Small-Rural	7.58%	7.71%	8.08%
State	4.52%	4.66%	4.86%

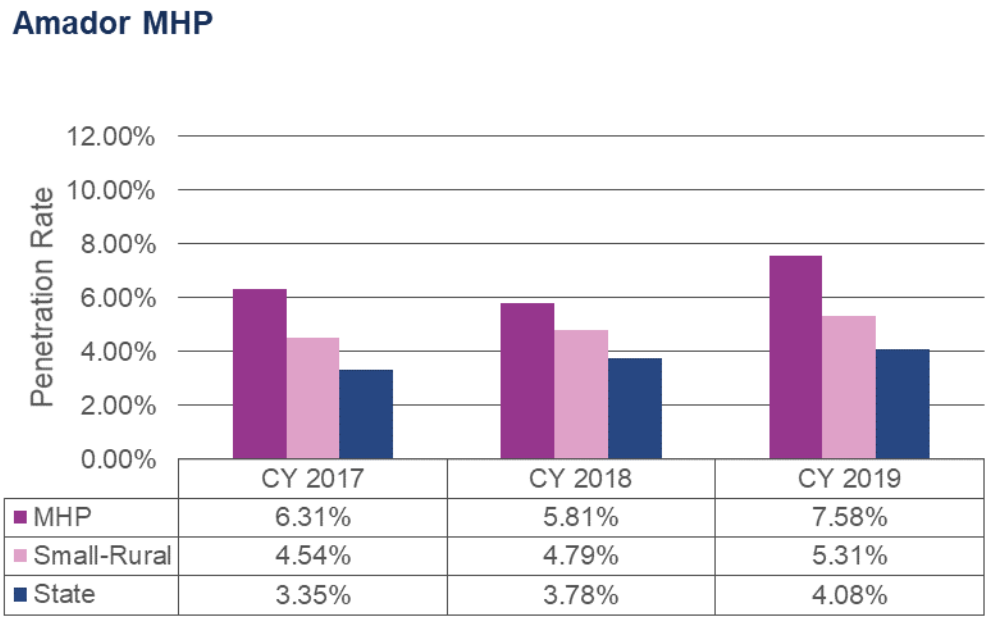
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$1,957	$1,983	$2,321
Small-Rural	$3,692	$3,794	$4,310
State	$6,170	$6,454	$6,316

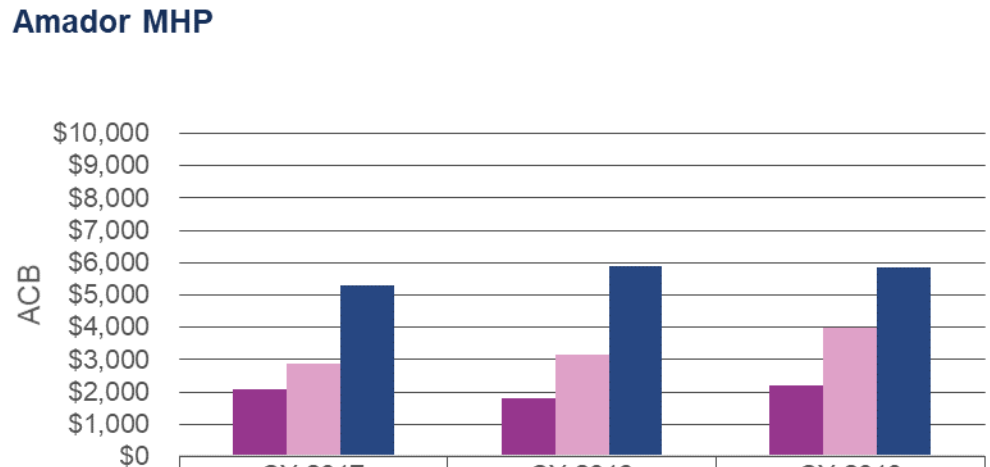
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	6.31%	5.81%	7.58%
Small-Rural	4.54%	4.79%	5.31%
State	3.35%	3.78%	4.08%

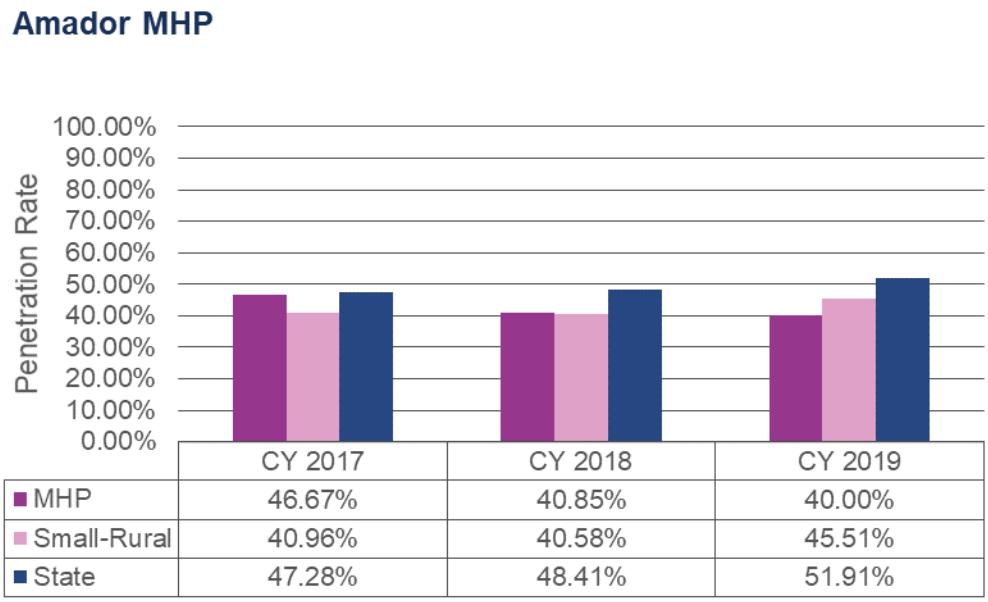
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$2,067	$1,787	$2,201
Small-Rural	$2,886	$3,146	$3,970
State	$5,278	$5,904	$5,869

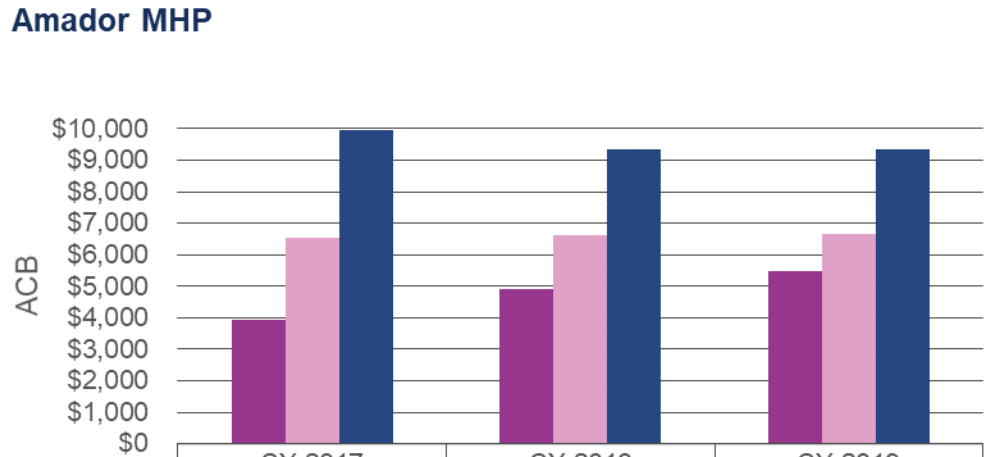
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	46.67%	40.85%	40.00%
Small-Rural	40.96%	40.58%	45.51%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

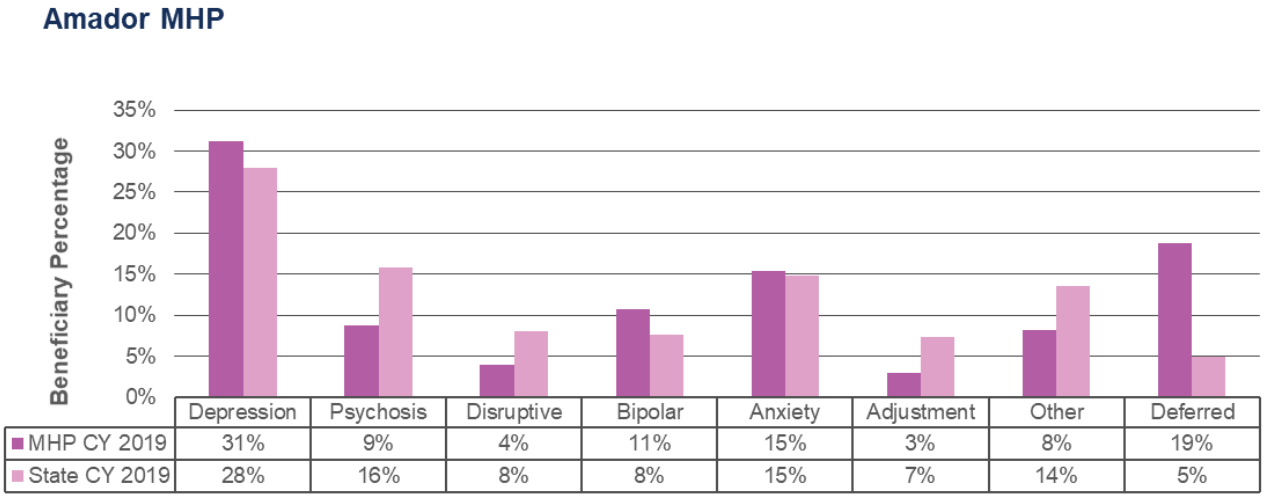


	CY 2017	CY 2018	CY 2019
MHP	$3,928	$4,897	$5,468
Small-Rural	$6,553	$6,630	$6,666
State	$9,962	$9,340	$9,360

Diagnostic Categories

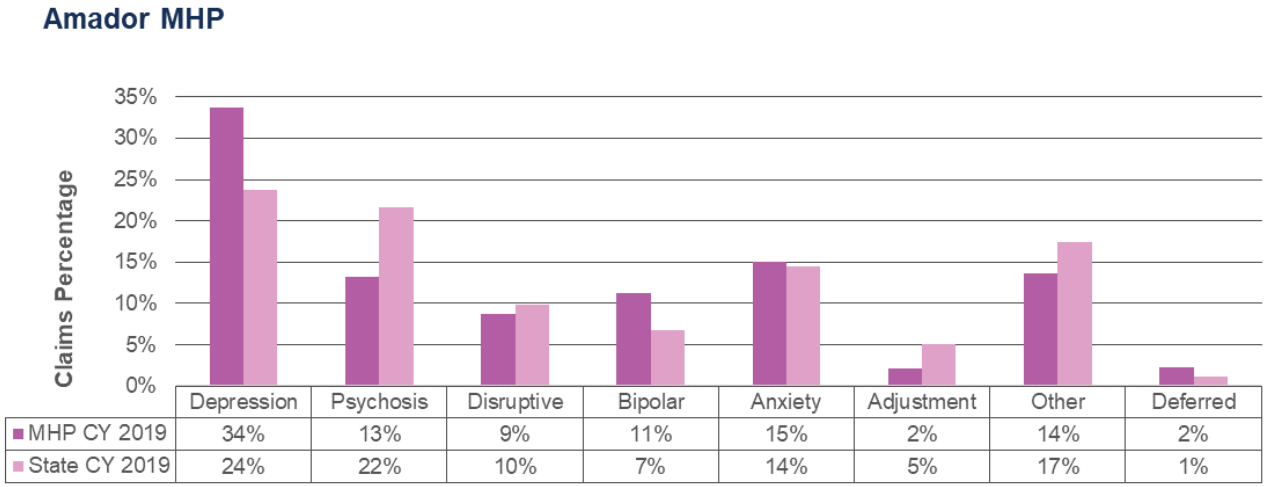
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	31%	9%	4%	11%	15%	3%	8%	19%
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	34%	13%	9%	11%	15%	2%	14%	2%
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

Amador 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	*	773	n/a	$35,733	-	n/a
	CY 2018	*	765	n/a	$41,576	-	n/a
	CY 2017	*	834	n/a	$46,540	-	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

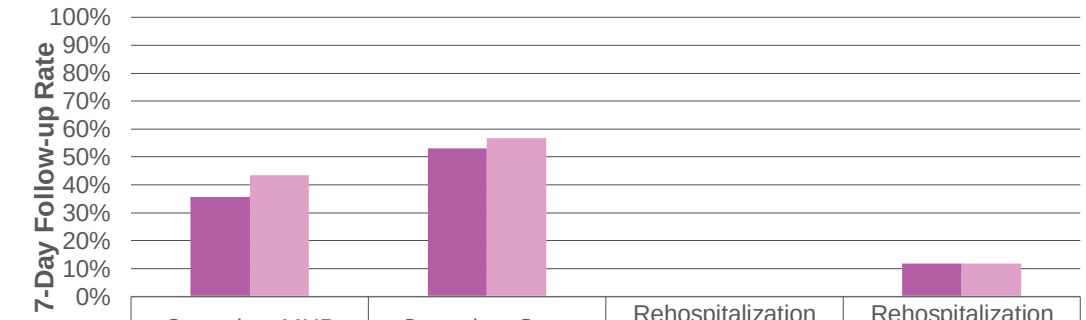
Amador MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	40	58	7.02	7.80	$7,674	$10,535	$306,942
CY 2018	29	35	6.72	7.63	$8,771	$9,772	$254,348
CY 2017	28	58	6.44	7.36	$8,861	$9,737	$248,098

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

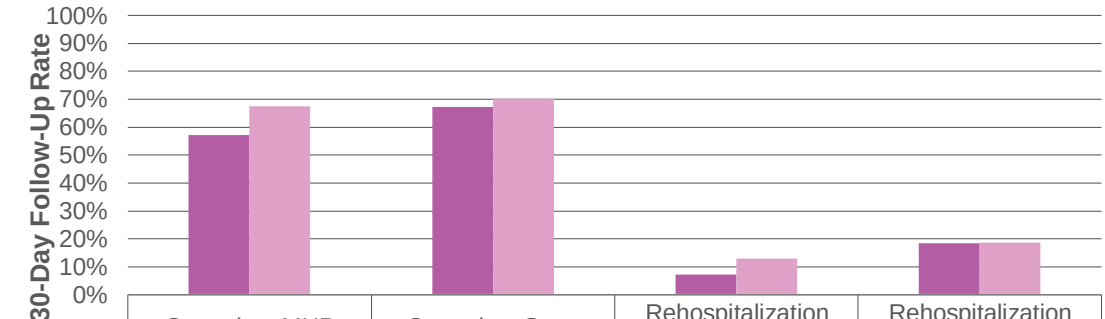
Amador MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	36%	53%	0%	12%
CY 2019	43%	57%	0%	12%

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

Amador MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	57%	67%	7%	19%
CY 2019	67%	70%	13%	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.

Amador MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review.

Table 5 : PIPs Submitted by Amador MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Services during COVID-19 Pandemic
Non-Clinical	1	Low Service Retention Rate

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Amador
PIP Title	Services during COVID-19 Pandemic
PIP Aim Statement	Will the use of Telehealth with behavioral health patients during the COVID-19 Pandemic improve the penetration rate of clients over a 4-month period (May through August 2020) increasing it to the pre-pandemic rate of 4.3 percent?
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	Amador
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): The PIP focused on all beneficiaries served by the MHP without regards to any demographic or clinical characteristics.	

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): The primary intervention was an MHP focused intervention, but it required beneficiary outreach and coaching.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The primary intervention was an MHP focused intervention, but it required staff training.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The MHP implemented telehealth services in order to shore up its declining penetration rate, service duration, and intensity due to COVID-19 pandemic. Telehealth services allow the provider and beneficiary to see and speak to each other on the computer. The beneficiary can access telehealth services using a desktop computer, laptop, tablet device, or cell phone. The way the beneficiary accesses the telehealth appointment is either by email or text link.

Table 8: Performance Measures and Results – 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
Number of telehealth services	January/February 2020	0	July/August 2020 ☐ n/a*	112	☒ Yes ☐ No	☒ Yes ☐ No p-value: ☒ <.01 ☐ <.05 Other (specify):
Number of total appointments	January/February 2020	1,772 Then dipped to 1,538 in March/ April at the beginning of COVID-19	July/August 2020 ☐ n/a*	1,755	☒ Yes ☐ No Improved therapy session count	☒ Yes ☐ No p-value: ☒ <.01 ☐ <.05 Other (specify):
Duration of appointments	January/February 2020	1,487 hours Then dipped to 1,119 hours in March/ April at the beginning of	July/August 2020 ☐ n/a*	1,414 hours	☒ Yes ☐ No For therapy and case management	☒ Yes ☐ No p-value: ☒ <.01 ☐ <.05 Other (specify):

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
		COVID-19				

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

"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:

- Stratify data by demographic variables in order to identify any challenges faced by specific beneficiary groups.
- Focus on treatment hours, not penetration rate which is not likely to be affected by this PIP.

The technical assistance (TA) provided to the MHP by CalEQRO consisted of:

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
• CalEQRO provided input into defining the intervention and variables when the MHP approached with its drop in service delivery at the beginning of the pandemic.						

*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	Amador
PIP Title	Low Service Retention Rate
PIP Aim Statement	Will improving staff satisfaction and retention improve client success and retention, resulting in a decrease of clients receiving only 1-3 services to less than 12%?
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): The MHP included all beneficiaries, children, adult, and older adult who had one to three services in a 7-month period at the start of the PIP.	

MHP Name	Amador

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):
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Quarterly Clinical Burnout Support and Trainings • Contracted Clinical Supervision • Annual Relias Burn Out Training (both staff and Leadership) titled "Stress Management for Behavioral Health Professionals" • Self-care Section and staff story at All Staff • Quarterly Office Newsletter and interactive activities
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):

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
Number of beneficiaries who had three or less services in the previous 12-month period.	2019	653; 16%	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01

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
(excluding those who did not meet medical necessity) Note: For the PIP, the MHP used the previous seven-month period to identify the population.						☐ <.05 Other (specify):
Staff Satisfaction (feeling valued)	2020	28; 7%	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Staff Satisfaction (connected to co-workers)	2020	27; 22%	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Staff Satisfaction (provided needed supervision and support)	2020	27; 22%	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01

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
						☐ <.05 Other (specify):
Staff Satisfaction (Work-Home life Balance)	2020	27; 15%	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
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						

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
"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: • Incorporate regular direct beneficiary feedback or survey into the PIP. • Clarify the actual interventions in the PIP aim statement. • The PIP will benefit from inclusion of indicator(s) of beneficiary health or functional status in order to assess true beneficiary level outcomes. • Ensure that the collection and reporting of the process measures are spelled out in greater details.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • The MHP will need to consider a sampling plan and/or redefine the performance indicator for quicker data collection and analysis. The performance indicator can be collected on a rolling average basis to enable monthly or quarterly collection rather than annually as currently planned. • Make one of the interventions more time limited in order to improve the internal validity of any findings.						

*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
Amador	4.00%	5.00%	5.00%	5.00%
Small-Rural MHP Group	n/a	5.26%	4.17%	3.92%
Statewide	n/a	3.58%	3.35%	3.34%

- During the review, the Fiscal Supervisor provided clarification for the drop in IT operation FY 2020-21 budget. The prior three years were estimated whereas the FY 2020-21 budget allocation was calculated.

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

- The MHP's compliance officer has the responsibility and control for information security.

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	85%
Contract providers	12%
Network providers	3%
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	0	0	0	0
2019-20	0.25	0	0	0
2018-19	0.25	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	0.5	0	0	0
2019-20	0.25	0	0	0
2018-19	0.25	0	0	0

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

- The QI coordinator and compliance officer provide the majority of internal reports. The fiscal supervisor and compliance officer also provide some as well.

- KV continues to host the CCBH system and provide support, along with canned reports which are not reflected in Tables 10 or 11 staffing information.

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 user's 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	8	0	8
Clinical Healthcare Professional	19	11	30
Clinical Peer Specialist	4	0	4
Quality Improvement	1	0	1
Total	32	11	43

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)	0	2.16

Type of Staff	MHP FY 2020-21	Small-Rural MHP Average FY 2019-20
Total EHR Users Supported by IT (Source: Table 17)	43	42.00
Ratio of IT Staff to EHR Users	0:43	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

Ongoing EHR Training and Support	Status	
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

- The MHP's Super Users provide technical support.

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	146
• Adults	103
• Children/Youth	43
• Older Adults	n/a
Total Number of telehealth encounters (services) provided during the last 12 months:	228

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.

- During March and April 2020 at the beginning of COVID-19, the MHP's operating hours went down, session duration decreased, and some beneficiaries disengaged from services. But since telehealth was implemented, services have been trending upwards.
- Reduced public transportation routes, and a lack of ride hailing services in the area also contributed to the need for telehealth services.
- The internal full-time psychiatrist performs the initial visit on telehealth and then follows-up via telephone.
- The MHP employs a psychiatric technician who was trained to provide technical support and to assist the psychiatrist during telehealth sessions.

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
n/a	n/a

Current MHP Operations

- The provider directory is reviewed monthly and updated by the compliance officer.
- The MHP's EHR is hosted by KV.

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 revenues; 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	Scheduler, Clinician's & Doctor's Home Page, ePrescribing	KV	7	KV

- Number of years used for the system/application was not provided by the MHP.

The MHP's Priorities for the Coming Year

- Implement Drug Medi-Cal (DMC) services and DMC billing in November 2020.
- Offer telehealth services for all levels of care.
- Review EHR IS system alternatives due to sunsetting of CCBH.
- Implement sexual orientation and gender identity (SOGI) data collection practices to comply with Prevention and Early Intervention (PEI) requirements.

Major Changes since Prior Year

- The MHP has improved its timeliness of documentation for services. All documentation is reviewed by the QI coordinator and reports of outstanding documentation issues are monitored. Since implementation of the report, suspended billing has decreased from approximately 500 outstanding unresolved issues to 130.
- In June 2020, the MHP provided MORS training and as a result have seen some improvement in regular usage over the past two months.
- The MHP began billing for 5150s in January 2020.

Other Areas for Improvement

- FC appointments cannot be separated in the scheduler application.

Plans for Information Systems Change

- The MHP is considering a new system but no formal project plan is in place and no project team assigned to accomplish it.

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	CCBH	☒	☐	☐	☐
Assessments	CCBH	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/ Storage	CCBH	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	CCBH	☒	☐	☐	☐
Laboratory results (eLab)	CCBH	☒	☐	☐	☐
Level of Care/Level of Service	MORS	☒	☐	☐	☐
Outcomes	MORS, CANS	☒	☐	☐	☐
Prescriptions (eRx)	CCBH	☐	☒	☐	☐
Progress Notes	CCBH	☒	☐	☐	☐
Referral Management	Quartet	☐	☒	☐	☐
Treatment Plans	CCBH	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		9	2	1	0
FY 2019-20 Summary Totals for EHR Functionality:		9	2	1	0
FY 2018-19 Summary Totals for EHR Functionality:		8	0	4	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	97%	Daily
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	1%	Weekly
Paper documents are faxed to MHP IS	2%	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
KV	CCBH	11

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

Expected implementation timeline:

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

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

PHR Functionality	Status	
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

Amador MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**8,510**	**$1,710,005**	**67**	**$19,479**	**1.13%**	**$1,690,526**	**$1,624,013**
JAN19	792	$142,590	3	$663	0.46%	$141,927	$137,399
FEB19	638	$101,472	6	$600	0.59%	$100,872	$96,414
MAR19	752	$150,305	5	$4,048	2.62%	$146,257	$137,272
APR19	840	$148,543	2	$220	0.15%	$148,323	$142,256
MAY19	772	$155,190	9	$1,287	0.82%	$153,903	$146,962
JUN19	637	$129,407	8	$990	0.76%	$128,417	$121,447
JUL19	840	$176,601	7	$1,065	0.60%	$175,536	$169,744
AUG19	772	$181,246	7	$7,247	3.84%	$173,999	$163,550
SEP19	620	$134,911	6	$1,315	0.97%	$133,596	$129,265
OCT19	596	$130,794	3	$342	0.26%	$130,452	$128,418
NOV19	638	$138,071	6	$915	0.66%	$137,156	$133,156
DEC19	613	$120,875	5	$787	0.65%	$120,088	$118,131

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

Amador MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	40	$8,366	43%
Beneficiary not eligible or non-covered charges.	2	$6,521	33%
Medicare or Other Health Coverage must be billed before submission of claim.	18	$3,276	17%
Beneficiary not eligible.	4	$603	3%
Late claim denial.	2	$512	3%
Total	67	$19,479	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 denial reason description "Medicare or Other Health Coverage must be billed prior to submission of claim" are generally re-billable within the state claim resubmission 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 travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Amador MHP, the time and distance requirements are 75 minutes and 45 miles for mental health services, and 75 minutes and 45 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 group, two stakeholder interviews, one staff and contractor interview, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

Amador 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

- Disable population access needs – The MHP contracts with an agency to provide sign language interpretation. Its informational materials are available in audio format, if needed. The MHP also has a therapy and counseling room right off the lobby for beneficiaries with significant mobility concerns.
- Transportation – The two managed care plans (MCPs) in the county both contract with the same agency, Logisticare, to provide transportation to Medi-Cal beneficiaries for mental health services appointments. It requires advance notice from the beneficiaries for scheduling of transportation. In addition, the MHP's peer services coordinators (PSCs) also provide transportation to beneficiaries, if needed. The MHP has a transportation officer position which is currently vacant following the previous incumbent's retirement in the past year.
- Telehealth – Due to COVID-19, the MHP has rapidly implemented telehealth services. Its current short-term clinical PIP is testing the implementation of telehealth.
- Mobile services – The MHP has a mobile team consisting of a licensed social worker and a PSC. This team provides crisis services in order to reduce hospitalizations and arranging for community-based alternatives. The team also carries a caseload for those needing mobile mental health services and support on an ongoing basis.

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	0
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 percent	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	0

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 a culturally diverse group of adult beneficiaries and parents/caregivers of child/youth beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The focus group was held by online meeting software.
Total number of participants	Six
Number of participants who initiated services during the previous 12 months	Four
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group:	
Access - new beneficiaries	Participants reported different sources of information about the MHP services, including referrals from primary care and previous service experience from another MHP.

Topic	Description
	The new beneficiaries described their therapy and case management services as excellent.
Access – overall	All participants were pleased with their experience with access to services and information available from the MHP on accessing other ancillary services. All participants reported receiving appointment reminder texts from the MHP.
Timeliness	All participants reported getting a first appointment within three days. The participants receive services at different frequency from once-a-week to once-a-month. The group therapy sessions were suspended due to COVID-19. However, the participants reported hearing from the MHP that these will restart using Zoom.
Urgent care and resource support	All participants reported that they would call their case manager or the MHP office if they experience crisis or need urgent care.
Quality	The participants were satisfied with the regular therapy and other outpatient services, but reported difficulty with psychiatry services over the telephone. Most participants were expressed that just the telephone calls alone, not telehealth, are a good communication vehicle with the psychiatrist. This is particularly hard for the new beneficiaries who had started services during the pandemic and never had a face-to-face session with the psychiatrist before. One participant with experience receiving mental health care from the Veterans' Administration (VA) health services described the MHP provided services to be far superior. The participants all reported having a voice in their treatment planning, but no one has done a Wellness and Recovery Action Plan (WRAP). All participants knew about the wellness center, but only two had experience going there.
Peer employment	The participants reported that their case managers help them connect with any employment or educational support systems.
Structure and operations	Participants reported receiving sufficient information from the MHP about the happenings in their care system. There

Topic	Description
	is an email list that anyone can join by requesting the MHSA coordinator or one of the PSCs. One participant reported having attended the Quality Improvement Committee meeting as an observer a few times. But no one in this group was a member of the QIC.
Recommendations from this focus group	• All participants would prefer face-to-face, or at least telehealth appointments with the psychiatrist.

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	13
The beneficiary focus group participants were all satisfied with service access. The MHP's website is mostly easy to navigate and obtain the basic information. The MHP maintains its current provider directory on the website. The MHP's crisis and urgent care information is not clearly or prominently displayed on the website.			
1B	Capacity Management	10	10
The MHP strategically leverages its MHSA funded programs to enhance and extend its Medi-Cal funded services. The PSCs provide outreach to the MHP beneficiaries, as needed. The MHP uses promotores for reaching out to its Spanish-speaking beneficiaries. The promotores work in close collaboration with a bilingual therapist in the community support groups.			

Component		Maximum Possible	MHP Score
The clinical line staff reported that all staff rotate in providing crisis care and intake appointments. They reported that this system works better in their view than having designated access and crisis staff.			
1C	Integration and Collaboration	24	23
The PSCs and the leadership team members play a vital role in collaborating with various partner agencies and community groups. One of the PSCs act as the liaison with primary care to facilitate physical health access and check-up for the MHP beneficiaries. The MHP director is a member of a public health preparedness coalition and the MHP is co-located in the same building as public health which allows for easy bi-directional referrals. The MHP also has quarterly meetings with the two MCPs that operate in Amador county to monitor bi-directional referrals. The PSCs provide outreach to local schools to provide information on and educate about mental health signs, symptoms, and how to get help. The MHP uses MHSA dollars to partially fund the College Connect program that allows eligible and interested beneficiaries to work toward and earn an associate's or bachelor's degree in human services. College Connect partners with five community colleges across the state and one out-of-state university to make this program completely online. The MHP attends a faith-based task force to disseminate information about available services and resources. In addition, the MHP has made presentations to various faith community partners to address unmet mental health needs in the community. The MHP reported that the leadership changes in the human services and CWS are likely to positively impact its collaboration with them.			

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	15
The MHP's EHR is not able to report in business days. As a result, the MHP goes with a conversion factor of 14 calendar days to determine the number of new beneficiaries being offered their first appointment within 10 business days. Using this conversion,			

Component		Maximum Possible	MHP Score
the MHP reported an average of 4.5 business days for first offered appointment, with 93 percent meeting the 10-business-day standard. The figures are similar for both adult and children. The significant exception is for FC beneficiaries for which the MHP meets the standard 76 percent of the times. The MHP reported that at the time of this review, it was tallying the FC timeliness data manually as the EHR was in the process of being set up for the capability to separate out FC data.			
2B	First Offered Psychiatry Appointment	12	10
During FY 2019-20, the MHP reported meeting the standard of 15 business days for first offered psychiatry appointment only 61 percent of the time with an average of 19 days of wait time. This was primarily during the first half of FY 2019-20 when the MHP's only full-time psychiatrist was on leave. The MHP reported that it has seen the timeliness for this metric improve in the second half of the FY. The de-identified raw data provided by the MHP lends support to this reasoning. In addition, there were a few big outliers that skewed the average as well.			
2C	Timely Appointments for Urgent Conditions	18	18
The MHP has a 48-hour standard for all urgent appointments. During FY 2019-20, the MHP addressed all urgent care requests during regular hours within 20 minutes maximum. For after hour crisis, the adjudication time was less than two hours, often much shorter.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	7
Depending on the hospital, the MHP has experienced some delays in getting discharge documentation including discharge date which has affected timely follow-up, reporting, and billing. This is particularly true for beneficiaries with private insurance. The MHP met their standard of 7-day for post-hospitalization follow-up only 50 percent of the time. However, this is partly due to the fact that the discharge date is missing for a number of beneficiaries.			
2E	Psychiatric Inpatient Rehospitalizations	6	3
Discharges are tracked by admissions instead of documentation. A better system for receipt of discharge documentation is needed for follow-up, and accurate and timely reporting.			
2F	Tracks and Trends No-Shows	10	8

Component	Maximum Possible	MHP Score
The MHP reported that both staff and beneficiary-initiated cancellations spiked since COVID-19 hit. Prior to that, in the first part of FY 2019-20, there were higher psychiatrist-initiated no-shows due to leave of absence. The reported no-show rates include both no-shows and cancellations. The MHP is unable to track FC no-shows. This because of the way FC is tracked in the EHR. The actual no-shows can be seen, but scheduling for FC beneficiaries cannot be determined, and hence the percentage of FC no-shows cannot be reported.		

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 MHP has a current cultural competency plan completed in December 2019. Two years prior to this, while developing its annual cultural competency plan update in 2017, the MHP determined that the system was needed greater cultural awareness before embarking on accomplishing true cultural competency. Accordingly, the plan was called the cultural sensitivity plan. The MHP reported having made significant accomplishments that can lead to the plan being called a cultural competency plan. The plan was developed with significant feedback from the cultural competency committee and community engagement. The FY 2019-20 objectives included: • Engagement with and access for the Spanish-speaking beneficiaries. • Suicide prevention. • Native American engagement. • Isolated rural communities. • Veterans. • Homelessness. • Single and working parents.			

Component		Maximum Possible	MHP Score
• Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) access. For each of these focus areas, the MHP provided the activities that happened during the past fiscal year, current status, lessons learned, and the type of interventions or events that are needed to implement its strategies.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	10
The UR team reviews all assessment results and clinician recommendations based on the level of care needs. The MHP tries to start services at the least restrictive level of care or service intensity, and adjusts according to beneficiary progress and needs. On the adult side, the MHP has implemented MORS and reported that the completion rate varied by clinician. In June 2020, the MHP conducted a training after which the MORS completion rate is improving. On the children's side, the MHP is completing CANS-50 and PSC-35 for all beneficiaries as required by DHCS. The MHP has identified data analytics needs for these instruments as a priority. At this time CANS-50 and PSC-35 are used for individual beneficiary treatment planning and determination of progress. The MHP provides a number of trainings to the clinical line staff who reported that they were very pleased with the level of training they receive and how it helps with beneficiary assessment and level of care assignment.			
3C	Quality Improvement Plan	10	10
The MHP has a current QI plan for FY 2020-21, and submitted its FY 2019-20 QI plan evaluation. The MHP has monthly QI meetings, and all QI and UR issues are discussed routinely including status of trainings, outcomes, satisfaction surveys, and disparities.			
3D	Quality Management Structure	14	12
The QI committee includes the PSCs who represent those with lived experience. The director and the QI coordinator receive input from and shares findings with the only major contract provider for the MHP. Additionally, the QI members are present at the cultural competency committee, MHSA steering committee, and peer members' meetings to share information and obtain feedback. The QI coordinator's position is now dedicated to QI and UR functions. This is a change from the previous EQR when she was also managing a case load and working as a clinical supervisor. However, the MHP still lacks adequate data analytics support. At the time of the review, the MHP was in the process of bringing in an			

Component		Maximum Possible	MHP Score
administrative analyst who would help part-time in data collection and management so the QI coordinator can devote more time to analytics.			
3E	QM Reports Act as a Change Agent in the System	10	9
The PIPs are the MHPs main tool or vehicle for changes in the system. All three current PIPs are the results of findings from QI data analyses. While not all PIPs lead to desired outcomes, the MHP noted that the findings from the PIPs are always used for further systems improvement purposes.			
3F	Medication Management	12	9
The MHP has follows a medication monitoring protocol that is informed by psychiatrist peer review. During the past year, the MHP had planned for greater collaboration between the psychiatrist and individual PCPs of the beneficiaries. Due to COVID-19, this plan was put on hold but the MHP noted that it intends to restart this process as soon as possible after the COVID-19 restrictions are lifted. The MHP tracks most of the SB 1291 specified HEDIS measures for FC beneficiaries through a tracking sheet and data from JV-220 forms. The two measures that the MHP has not been able to measure to-date are metabolic monitoring first line of psychosocial care for children who are prescribed antipsychotics. The MHP plans to incorporate these in its workflow for tracking the other HEDIS measures specified by SB 1291.			

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

Component		Maximum Possible	MHP Score
The MHP does MORS on a monthly basis. It noted that the instrument was not being used consistently by all clinicians. To remedy this the MHP offered a training in June 2020. Since then MORS is being used more consistently. The MHP administers CANS-50 and PSC-35 to all children and youth. The instruments are primarily used for individual treatment planning and assessment of beneficiary progress. The MHP lacks any aggregation at the systems level at this time. The findings are discussed in supervision and QI meetings as needed.			
4B	Beneficiary Perceptions	10	10
The MHP has done extensive analysis of Consumer Perception Survey (CPS) and presents the findings in QI meetings. Through its MHSA planning and information dissemination efforts, as well as through the PSCs, the MHP has regularly gathered feedback and information from beneficiaries and family members.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
The MHP has a robust system to help beneficiaries through wellness and recovery. It employs two PSCs with lived experience who are active in the community, primary care, and with individual beneficiaries keeping them informed of opportunities for greater access to health care, education, and employment. In addition, the MHP has other peer employees through a contract provider that runs the wellness center. The wellness center is another venue which provides groups to aid in wellness and recovery. The MHP makes it a regular practice to keep its staff informed of potential opportunities for beneficiaries that can help self-sufficiency and recovery. As described in 1C, the MHP uses MHSA dollars to partially fund College Connect that allows beneficiaries to get degrees from a consortium of colleges.			

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	29
The MHP provides services in all modalities either directly or through contract with agencies in or out-of-county. The out-of-county services are primarily residential and crisis stabilization. The MHP does not have TFC yet. It is working on a multi-county RFP for TFC services. In the meantime, it is providing ITFC to FC beneficiaries who need more intensive level of care.			
5B	Network Enhancements	18	14
Due to COVID-19, the MHP has made network enhancements through very rapid deployment of telehealth for psychiatrist and clinical line staff. Initially, as the pandemic hit, the MHP worked with telephones. But then started moving to telehealth as it noticed a significant drop in service hours. This is the current clinical PIP of the MHP. The MHP does not have a health home model as such, but it works very closely with primary care and MCPs. Although the MHP does not have a threshold language, it has capabilities to arrange for services to be provided by a Spanish speaking clinician. The MHP has started working on a Whole Person Care (WPC) implementation plan in collaboration with the social services side.			
5C	Subcontracts/Contract Providers	16	16
The MHP has one large organizational contract provider, Sierra Child and Family Services (SCFS). The MHP has a good bi-directional communication with SCFS with respect to QI activities, Network Adequacy, performance improvement, and compliance related matters. The MHP director and the QI coordinator hold regular meetings with SCFS every month.			
5D	Stakeholder Engagement	12	11
After years of staff turnover and resulting vacancies, the MHP has been able to recruit new staff during the past year and maintain a stable workforce. This has resulted in greater staff morale and care continuity for the beneficiaries. The line staff noted their appreciation of the open-door policy of the MHP director that promotes easy access to the leadership. The line staff further reported having been on different MHP committees such as the cultural competency and MHSA steering committees.			

Component		Maximum Possible	MHP Score
The beneficiaries reported having access to MHP information through MHP newsletter and emails. The beneficiary focus group participants noted being able to easily join the MHP email list by requesting the PSCs or the MHSA coordinator.			
5E	Peer Employment	8	8
The MHP employs two full-time benefitted PSCs with lived experience. In addition, its contracted wellness center program also has peer employees. In order to facilitate peer employment, the MHP utilizes the MHSA funded contract with CalVoices for training of beneficiaries interested in becoming peer support employees. These individuals to go through the peer support certification program offered by the Workforce Integration, Support, and Education University (WISE U) – a program that prides itself as created by peers, taught by peers, and for peers. The MHP reported having created four peer employee positions in various MHSA funded programs since 2018.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Amador 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

Access to Care

Changes within the Past Year:

- Due to COVID-19 the MHP's site remains closed to the public unless it is necessary for a face-to-face session with a beneficiary. Precautions are taken for safety of those face-to-face encounter participants when they occur.
- The MHP's MHSA contract providers are augmenting services for severely mentally ill beneficiaries during COVID-19.
- The MHP is tracking crisis calls and is moving towards increasing calls spoken in Spanish to promote access for Spanish speaking beneficiaries.
- The MHSA funded Aspire program using the Brief Risk Reduction, Interview and Intervention (BRRIIM) school-based early intervention model was highly successful. The program served 94 students, conducted 70 family conferences and made 277 community referrals since October 2017. Funding has expired and moved to the school's funding source.
- Amador County's county seat Jackson has experienced a high level of homelessness. In response, the MHP used a portion of its Homeless Mentally Ill Outreach and Treatment Program (HMOIT) funds to create the Homeless Outreach and Peer Engagement (HOPE) program to address upcountry homelessness.
- The Amador County Behavioral Health (ACBH) has started providing DMC services which will enhance access and quality of care for the MHP beneficiaries with co-occurring mental health and substance use diagnoses.

- The MHP's only full-time psychiatrists was on leave for an extended period during the first half of FY 2019-20. During this time, the MHP managed with telepsychiatry and its other part-time psychiatrist.

Strengths:

- The beneficiary focus group participants expressed satisfaction with service access and the information the MHP provides about its services.
- The MHP has worked with promotores to extend services to the Spanish-speaking population in the county.
- One of the peer PSCs created and monitors an email list for beneficiaries informing them of activities and resources during COVID 19.
- Through its No Place Like Home initiative, the MHP has completed a homeless plan, a housing and needs study, and a site feasibility study. It is now working with local cities and nearby counties to pursue Permanent Local Housing Allocation (PLHA) funds to help MHP beneficiaries obtain affordable housing.
- The MHP's full time psychiatrist visits the jails once a week, or a member of the crisis team visits once a week.

Opportunities for Improvement:

- The MHP's transportation officer retired in 2019. Because of COVID-19 and site closure, recruitment has been suspended temporarily. Three PSCs, mobile crisis staff and case managers assist when transportation is needed.

Timeliness of Services

Changes within the Past Year:

- In November 2019, the QI staff retrained the MHP's support staff on collecting timeliness data and utilizing the access to service form.

Strengths:

- The MHP is able to provide first offered appointment in less than 5 days on average and meeting its 10-business day standard more than 90 percent of the time.
- The MHP provided urgent care within 20 minutes of case presentation during FY 2019-20.

Opportunities for Improvement:

- The MHP's first offered psychiatry appointments took 19 days on average and only 61 percent met its 15-business day standard. The MHP attributed this to the psychiatrist's extended leave during the first half of FY 2019-20, and reported that this is not an issue any longer.
- The MHP does not receive discharge information from all out-of-county discharging hospitals. This adversely impacts its timeliness calculations for 7-day follow-up and 30-day rehospitalization rates.

Quality of Care

Changes within the Past Year:

- The QI coordinator's position is now dedicated to QI and UR functions. This is a change from the previous EQR when she was also managing a case load and working as a clinical supervisor.

Strengths:

- The MHP has a current cultural competency plan that pays close attention to cultural groups and their issues specifically in the context of Amador County. For each of these focus areas, the MHP provided the activities that happened during the past fiscal year, current status, lessons learned, and the type of interventions or events that are needed to implement its strategies.
- The MHP provides a number of trainings to the clinical line staff who reported that they were pleased with the level of training they receive and how it helps with beneficiary assessment and level of care assignment.

Opportunities for Improvement:

- The beneficiaries reported that the psychiatry sessions by telephone are not as helpful as face-to-face sessions.
- The MHP still lacks adequate data analytics support. At the time of the review, the MHP was in the process of bringing in an administrative analyst who would help part-time in data collection and management so the QI coordinator can devote more time to analytics.

Beneficiary Outcomes

Changes within the Past Year:

- On the adult side, the MHP has implemented MORS and reported that the completion rate varied by clinician. In June 2020, the MHP conducted a training after which the MORS completion rate is improving.

Strengths:

- The MHP has a robust system to help beneficiaries through wellness and recovery. It employs two PSCs with lived experience who are active in the community, primary care, and with individual beneficiaries keeping them informed of opportunities for greater access to health care, education, and employment.

Opportunities for Improvement:

- Although CANS-50 and PSC-35 are collected on all children and youth beneficiaries, and used for individual treatment planning and monitoring progress, the MHP lacks a mechanism to aggregate findings at a systems level for trends and opportunities.

Foster Care

Changes within the Past Year:

- A new Social Services director assumed her new position in September 2020. The MHP expects its collaboration with CWS will improve with this change in leadership based on their past work together when the new director was a program manager.

Strengths:

- The MHP currently tracks five of the seven SB 1291 measures.

Opportunities for Improvement:

- The MHP continues to work on releasing an RFP for providing TFC services to the FC beneficiaries in the county who need that level of care. At this time, the MHP has made arrangements to provide ITFC until TFC can be provided.
- The MHP cannot track the no-show rate for FC beneficiaries due to IS technical limitations.

- The MHP is yet to implement monitoring of two SB 1291 measures.

Information Systems

Changes within the Past Year:

- The MHP has complied with Phase One (IN 19-020) data elements. However, it found some errors initially during FY 2019-20. KV has corrected the errors and provided training to the QI coordinator.

Strengths:

- The MHP regularly receives various data reports from KV.

Opportunities for Improvement:

- The full-time psychiatrist has had technical difficulties with the telehealth equipment and signing on.

Structure and Operations

Changes within the Past Year:

- Due to COVID-19, the MHP has made network enhancements through very rapid deployment of telehealth for psychiatrist and clinical line staff. Initially, as the pandemic hit, the MHP worked with telephones. But then started moving to telehealth as it noticed a significant drop in service hours. This is the current clinical PIP of the MHP.
- The MHP has reduced turnover and acquired a full staff over the past year, providing stability and consistency internally as well as for beneficiaries' treatment experience.
- In January 2020, the MHP began inpatient billing for fee for service providers and facilities. Quarterly inpatient billing is monitored and balanced for charge capture and accuracy.
- The MHP began billing for 5150s in January 2020.
- The MHP has started working on a WPC implementation plan in collaboration with the social services side.

Strengths:

- Through its non-clinical PIP interventions, the MHP is focusing on improving staff job satisfaction and morale.
- The MHP has improved its documentation timeliness and resolution process for claims. The QI coordinator routinely monitors and reports on

outstanding documentation issues. Since implementation of close monitoring and reporting, suspended billing has decreased from approximately 500 outstanding unresolved issues to 130 in the past year.

Opportunities for Improvement:

- The MHP does not have a dedicated data analyst position to fully meet internal reporting and data analytic needs.
- The MHP is experiencing lag times in receiving discharge documentation in many instances which has delayed inpatient reporting and billing.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: Explore suitable indicators of beneficiary health or functional status for the current non-clinical PIP.

Access to Care

Recommendation 2: Begin the recruitment process for replacement of the transportation officer at the time the MHP clinic reopens and face-to-face services resume.

Timeliness of Services

Recommendation 3: Explore ways to consistently obtain timely discharge information for beneficiaries coming out of psychiatric inpatient hospitalization (see recommendation 9 for further details).

Quality of Care

Recommendation 4: Ensure that psychiatry sessions are provided by telepsychiatry whenever feasible until face-to-face sessions can resume.

Beneficiary Outcomes

Recommendation 5: Investigate best practices for reporting systems level aggregate findings on CANS-50 and PSC-35 data.

Foster Care

Recommendation 6: Implement routine tracking and monitoring of the remaining SB 1291 indicators.

Information Systems

Recommendation 7: Provide in depth instruction and technical support for telehealth equipment to the full-time psychiatrist. If sign-on problems persist, consult with KV for remedial action.

Structure and Operations

Recommendation 8: Closely monitor and remedy any remaining gaps in data analytical capacity after the new administrative analyst starts with designated functions to help assist the QI coordinator.

Recommendation 9: Collaborate with all local hospitals to identify and resolve barriers that prevent obtaining discharge information within 24 hours.

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

Amador
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
Peer Employee/Parent Partner Group Interview (included in line staff group)
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal (questions and MHP response by email)
Information Systems Capabilities Assessment (ISCA)
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Saumitra SenGupta, Quality Reviewer
Deb Strong, Consumer Family Member Reviewer
Judith Toomasson, Information Systems Reviewer

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

Sites of MHP Review

MHP Sites

All sessions conducted using teleconferencing software due to COVID-19 restrictions.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Compton	Vanessa	Peer PSC	ACBH
Cranfill	Melissa	MHP Director	ACBH
Garner	Tammy	Clinician III	ACBH
Grau	Angie	Compliance Officer	ACBH
Hess	Stephanie	MHSA Coordinator	ACBH
Hixon	Amy	SUD Supervisor	ACBH
Hodson	Megan	QI/UR Coordinator	ACBH
Vaughn	Karen	Fiscal Officer	ACBH
Padgett	Angelica	PSC	ACBH
Navarrete-Smith	Catherine	Clinician I	ACBH
Morton	Cherie	Clinician I	ACBH
Raimondo	Lisa	PSC	ACBH
Stojic	Nenad (Nash)	Crisis Counselor II	ACBH
Blank	Randall	PSC	ACBH
Carroll	Rea	Clinician II	ACBH
Newlun	Sylvia	Clinician II	ACBH
Mitchell	Jacquelyn	Clinician I	ACBH

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

Amador 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	2,306	257	11.14%	$510,159	$1,985

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

Amador 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	765	98.97%	93.31%	$1,530,079	$2,000	$3,998	85.29%	59.06%
>$20K - $30K	*	n/a	3.20%	-	$28,401	$24,251	n/a	12.29%
>$30K	*	n/a	3.49%	-	$35,733	$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	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