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

CALAVERAS MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

November 12, 2020

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

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 non-minor 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 Calaveras 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 — San Andreas

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 2021

MHP Threshold Language(s) — Spanish

CalEQRO obtained the MHP threshold language information from the DHCS Behavioral Health Information Notice (BHIN) 20-070.

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Network Adequacy

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

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

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 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.

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, 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 virtual review, 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 ensure that the methodologies defined within the projects are appropriate to determine if the goals of various interventions are achieved. The MHP should maintain contact with CalEQRO to secure ongoing technical assistance (TA) as outlined in the PIP section of this report. *(This recommendation is a carry-over from FY 2018-19.)*

Status: Partially Met

- The MHP did not engage in regular PIP TA in FY 2019-2020; TA is now scheduled to occur in January 2020.
- Calaveras County Behavioral Health Services (CCBHS) conducted a beneficiary survey beginning in July 2020 regarding beneficiary perceptions of psychiatry services and the corresponding appointment modality (clinic, telephone, and Zoom appointments).

- The MHP reports that the pandemic created a barrier to fully implementing the new non-clinical PIP (psychiatry no-show rates) in a timely manner.
- The overall psychiatry no-show rate improved from 24 percent to 13 percent since the last EQRO review; however, the MHP hypothesized the improvement resulted from switching from telehealth in the office, to telehealth from the beneficiaries' homes (COVID-19 response) rather than PIP interventions.
- Detailed recommendations are included in the PIP validation section of this FY 2020-21 EQRO report.

Access Recommendations

Recommendation 2: The MHP should regularly review penetration rate data as a clinical and administrative/Quality Improvement Committee (QIC) team to identify potentially underserved beneficiaries, track trends, and create actionable, measurable plans to address disparities. *(This recommendation is a carry-over from FY 2018-19.)*

Status: Met

- The MHP receives monthly penetration data from Kings View which is reviewed monthly by management staff and quarterly in the QIC and Cultural Competence Committee (CCC) meetings.
- CCBHS is in the final contracting phase with El Concillio (community-based non-profit) to provide telehealth services to Spanish-speaking beneficiaries to address access disparities.

Recommendation 3: The MHP should offer specific trainings on co-occurring Substance Use Disorder (SUD) assessment and treatment that augment clinicians' training received through formal education and clinical experience. This would be especially helpful for new staff.

Status: Not Met

- The MHP reports that the Drug Abuse Screening Test (DAST-10) will be implemented during the first quarter of CY 2021; staff training to utilize the tool was not identified during this review.
- The MHP has yet to offer specific trainings on co-occurring SUD assessment and treatment.

Recommendation 4: The MHP should explore the possibility of more frequent in-person cultural competence training, in addition to the current online trainings, that addresses the specific needs and demographics of Calaveras County.

Status: Met

- In response to COVID-19, all cultural competency trainings are provided to staff online.
- Training attendance is monitored by the MHP; 150 staff registered for the annual cultural competence training in August 2020.
- An implicit bias training was scheduled (December 2020) for staff through the Tri-County Cultural Competence Committee (Calaveras, Amador and Tuolumne).
- MHP staff provide input on relevant cultural competency trainings, and funding is made available when possible.

Recommendation 5: The MHP should use a combination of Consumer Perception Survey (CPS) data and other evaluation activity to monitor walk-in and other access points to identify opportunities for improvement, such as beneficiary knowledge of services, satisfaction, and timeliness.

Status: Met

- The MHP administers the CPS twice per year; 80 beneficiary surveys were returned this year (mailed due to COVID-19).
- The non-clinical PIP incorporated a beneficiary survey to assess provider satisfaction; 77 surveys have been collected and analyzed.
- The CCBHS Mental Health Services Agency (MHSA) steering committee met bi-monthly prior to COVID-19 to gather beneficiary feedback regarding services during focus groups; the committee included 12 beneficiaries.
- CCBHS obtains stakeholder feedback (including leadership) from the National Alliance on Mental Illness (NAMI) Gold Country and the Mental Health Advisory Board (MHAB) focus groups.
- QIC meeting minutes from January 2020 reflect progress toward creation of the next beneficiary survey focused on psychiatry services via telehealth.

Recommendation 6: The MHP should add the behavioral health services provider directory to the CCBHS website.

Status: Met

- The provider directory is accessible on the CCBHS clinic website; the directory was updated in September 2020.

Timeliness Recommendations

Recommendation 7: Develop and implement procedures to correctly track re-hospitalization rates to improve the current system of manual entry on a spread sheet so that individuals who are not Medi-Cal eligible do not confound timeliness tracking accuracy.

Status: Met

- The crisis and hospitalization tracking sheet was re-designed to reflect a live spreadsheet differentiating in-county Medi-Cal beneficiaries from out-of-county Med-Cal beneficiaries; all crisis service requests are included in the tracking log.
- The crisis case manager oversees the input of all crisis and hospitalization data into the spreadsheet; clinical line staff also update the log.
- The crisis spreadsheet is reviewed weekly by leadership, and the QIC has a standing agenda item to assess post hospitalization follow-up timeliness metrics to identify trends and outliers.

Recommendation 8: Conduct staff training and institute a formal accountability process to conduct a weekly audit to ensure that everyone is getting a Client Services Information (CSI) assessment so that data entry is consistent, and errors can be fixed quickly.

Status: Met

- CCBHS is re-designing the on-boarding process for new staff that will include CSI assessment training.
- The medical record technician is tasked with oversight of CSI assessment completion and follows-up with providers based on beneficiary activity.
- Management staff review CSI assessment records to verify completion as necessary.

Recommendation 9: The MHP needs to ensure that timeliness tracking data includes contract provider data to support reporting of entire system of care metrics.

Status: Partially Met

- CCBHS reports that all contract provider users have access to the MHP EHR.
- The MHP states that their largest contract provider, Sierra Child and Family Services, requires additional staff training on entering and reporting on timeliness data—especially now with a newly hired team.
- Contract providers are excluded from certain timeliness tracking metrics for services which they do not provide (i.e. initial appointments, urgent services); it would benefit the MHP to distinctly provide this information in the methodology explanation.
- CCBHS states that contract provider timeliness tracking and reporting requirements will be included in future contract renewals.

Recommendation 10: While waiting on DHCS to implement the second phase of the CSI assessment record, work with the EHR vendor to collect psychiatry timeliness data fields into the current CSI assessment record form to ensure that the MHP complies with the state timeliness metric for initial contact to first offered psychiatric appointment and timelines of service request for urgent appointments as per Information Notice (IN) 18-011. *(This recommendation is a carry-over from FY 2018-19.)*

Status: Partially Met

- The MHP is collecting timeliness data utilizing a CSI form built into the EHR; however, psychiatry timeliness data is not built into the CSI form.
- Kings View (EHR vendor) is in the process of updating the MHP's system and plans on adding an electronic CSI psychiatric timeliness form when completed.

Recommendation 11: The MHP should complete a barrier/cause analysis for psychiatry visits, as recommended in the non-clinical PIP TA section, to remove barriers and improve services based on the analysis of the data problem. *(This recommendation is a carry-over from FY 2018-19.)*

Status: Met

- CCBHS conducted an on-line beneficiary survey (77 returned) in September 2020 and identified the following trends:
    - 81.58 percent strongly agreed their psychiatry appointment was easy to schedule.
    - 20 beneficiaries (26 percent) reported that it was difficult to schedule/re-schedule their appointment citing no appointments available for their personal schedule.
    - 67 beneficiaries (87 percent) responded that they were able to attend their psychiatry appointments; transportation availability was cited as the main reason.
    - Beneficiaries who could not attend their appointment, stated lack of transportation as the largest cause followed by "other"—further investigation would be extremely helpful to the MHP.
    - 50 beneficiaries (74.63 percent) responded that reminder calls greatly helped with attending their appointments.

Recommendation 12: The MHP's reported percentage of follow up service appears incorrect in the MHP Assessment of Timely Access (MATA). In discussion, the MHP explained that the data includes all hospitalization regardless of payer source, which may confound the results and skew the percentages.

Status: Met

- The crisis and hospitalization tracking sheet was re-designed to reflect a live spreadsheet differentiating in-county Medi-Cal beneficiaries from out-of-county Med-Cal beneficiaries; all crisis service requests are included in the tracking log.

Quality Recommendations

Recommendation 13: The MHP is recommended to lay out the Quality Improvement (QI) and CCC plans with quantifiable goals and objectives, and evaluation of those objectives (outputs and outcomes), plus a quarterly review of data.

Status: Partially Met

- The FY 2020-21 Quality Assurance Program Improvement (QAPI) plan includes measurable goals with outlined process indicators; however, the QAPI annual evaluation was not completed.

- The CCC plan is not updated and does not reflect quantifiable goals and objectives nor process outcome indicators.
- The QAPI and CCC work plan goals are discussed during quarterly QIC meetings.

Recommendation 14: In keeping with best practices in supported employment, the MHP should implement an assessment during initial intake that assesses beneficiary interest in supported employment and education services, rather than leaving this up to clinician judgment or relying on beneficiary responsibility to raise the issue.

Status: Met

- A designated supportive employment case manager collaborates with the Adult System of Care (ASOC) and clinical staff to connect beneficiaries to the supportive employment program.
- Beneficiaries are assessed during their initial appointment for employment and educational interests; referrals are provided when requested.

Recommendation 15: The MHP should investigate a process for assigning beneficiaries to appropriate levels of care that considers the cultural, ethnic, racial, and linguistic needs of beneficiaries to facilitate beneficiary transitions between levels of care (LOC).

Status: Met

- CCBHS's CCC plan incorporates on-going efforts to design, implement, and evaluate services to ensure cultural and linguistic appropriateness.
- The CCBHS consumer survey summary report (October 2019) stated that 87 percent of respondents felt that staff are sensitive to cultural backgrounds.
- CCBHS maintains policies, procedures, and practices that reflect a commitment to beneficiaries and their families in development, implementation, and monitoring of all programs and services.

Recommendation 16: The MHP should assess the current perceptions of its telehealth services among beneficiaries, either through a survey, rating tool, or focus groups.

Status: Met

- The majority of services were transferred to telehealth in response to COVID-19 beginning in March 2020.

- CCBHS conducted a beneficiary online survey in July 2020 and obtained baseline data regarding beneficiary perceptions and satisfaction of services and the corresponding appointment modality (clinic, telephone, and Zoom appointments).
- Survey results from September 2020 reflect that out of 32 beneficiaries who had a Zoom therapy appointment, approximately half (16 respondents) liked the modality.
- The September 2020 survey results showed that 16 out of 24 beneficiaries (66.7 percent) like their psychiatry services via Zoom, and 37 out of 46 (80.43 percent) like the appointment via telephone.

Recommendation 17: Continue to implement the community needs assessment survey by zip code, age, and ethnicity. Implement strategies such as surveys in Spanish and Spanish-speaking staff involvement in outreach that ensures that the community needs assessment process include pockets of Spanish speaking beneficiaries and eligibles in Valley Springs and Angels camp.

Status: Met

- CCBH employs a designated a case manager to provide outreach, peer support, and advocacy to Latino/Hispanic families in Calaveras County (including Valley Springs and Angels Camp); the case manager linked 60 families to behavioral health and community services in FY 2019-20.
- The continued implementation of the community needs assessment survey was adversely impacted by shelter-in-place restrictions from COVID-19.

Recommendation 18: The MHP should formally appraise the interest of clinical staff in training opportunities, and their feasibility and associated costs and design an orientation process for new clinical staff regarding documentation and licensure.

Status: Partially Met

- The MHP provides standard trainings throughout the year (i.e. documentation, CSI assessment, cultural competency); staff can bring their training interests to leadership, and funding for training may be approved if relevant and available.
- CCBHS is currently in the process of re-designing the new employee on-boarding process, which will include new trainings.
- CCBHS has not administered a formal appraisement of clinical staff training interests—including feasibility and associated costs—nor designed a training process regarding licensure.

- The MHP reports that the impact of COVID-19 and staffing issues created barriers to providing consistent clinical supervision to clinicians working toward licensure.

Recommendation 19: The MHP should create a policy that communicates to clinical staff that they should use their expertise to maintain a SUD diagnosis (for beneficiaries they believe meet criteria) secondary to a primary mental health disorder diagnosis, even if a psychiatrist does not include this secondary diagnosis in the chart.

Status: Not Met

- CCBHS does not have a formal policy and procedure establishing the standards for the engagement, assessment, and treatment of beneficiaries with co-occurring disorders.

Recommendation 20: The MHP should institute a formal diagnostic assessment of SUD for clinicians to identify underserved beneficiaries, moving beyond the current standard of assessing self-perceived impact of substance use problems, for clinicians to use in potential cases of co-occurring disorders.

Status: Not Met

- CCBHS does not have a formal policy and procedure establishing the standards for the engagement, assessment, and treatment of beneficiaries with co-occurring disorders.

Beneficiary Outcomes Recommendations

Recommendation 21: Begin system-wide use including collecting, analyzing, and reporting aggregate data from the California Integrated Practice Child Assessment of Needs and Strengths (CA IP-CANS) and Pediatric System Checklist (PSC-35) that provides insight into beneficiary outcomes and areas in need of attention. *(This recommendation is a carry-over from FY 2015-16, FY 2016-17 and FY 2018-19).*

Status: Partially Met

- The MHP collaborated with their EHR vendor (Kings View) to create a CA IP-CANS dashboard that will be unveiled CY 2021.
- CA IP-CANS assessment training for clinical staff was provided in October 2020.
- CA IP-CANS assessments—in conjunction with PSC-35 results—used informally to drive treatment planning and beneficiary interventions.

- CCBHS reports that discharge CA IP-CANS assessments are not routinely completed; the MHP plans to create a formal process to address the issue.
- The PSC-35 outcomes are tracked; however, the MHP does not analyze or trend the data.

Recommendation 22: Train staff and begin system-wide use of the Milestones of Recovery Scale (MORS). System-wide use is demonstrated through collection and use of aggregate data. *(This recommendation is a carry-over from FY 2015-16 and FY 2016-17 and FY 2018-19).*

Status: Partially Met

- The MHP collaborated with the MORS vendor to create a training agreement which was subsequently delayed due to COVID-19 restrictions.
- The MORS vendor now offers virtual training and CCBHS plans to schedule training in January 2021.

Foster Care Recommendations

Recommendation 23: Begin collecting and aggregating CA IP-CANS data in FY 2020-21 in collaboration with Child Welfare Services (CWS).

Status: Partially Met

- CCBHS administers intake CA IP-CANS assessment for all new FC youth.
- Collaboration with CWS has improved since the last EQRO review; however, CWS experienced staff turnover resulting in issues with the sharing of CA IP-CANS data with CCBHS.
- CA IP-CANS results are used informally to drive treatment planning and interventions; however, discharge assessments are not routinely completed, potentially creating issues with tracking overall beneficiary progress.
- The newly designed CANS-IP dashboard does not have the capability to disaggregate FC youth.

Recommendation 24: The MHP needs to ensure that timeliness tracking data includes contract provider data to support reporting of entire system of care metrics, including children and FC youth.

Status: Partially Met

- Please refer to Timeliness Recommendation number nine.

Information Systems Recommendations

Recommendation 25: Finish implementing the Generalized Anxiety Disorder (GAD-7) assessment into the EHR workflow and train staff on their appropriate use. *(This recommendation is a carry-over from FY 2018-19.)*

Status: Met

- Staff training was provided on the use GAD-7 and the Patient Health Questionnaire (PHQ-9); these assessment tools have been used since September 2019 during beneficiary intake assessment.
- The PHQ-9 has been added to the EHR; however, the GAD-7 has not been added due to complications; the MHP is collaborating with Kings View to locate a new EHR provider.

Recommendation 26: Demonstrate practical use and analysis of the data accumulated from the PSC-35 outcomes tool (*This recommendation is a carry-over from FY 2018-19*).

Status: Not Met

- The MHP reports that analysis of PSC-35 data has not been implemented since the last EQRO review.

Recommendation 27: Add remaining fee-for-service (FFS) providers' access to the EHR and update the manual, as necessary.

Status: Met

- FFS providers have direct access to the EHR since the last EQRO review; Sierra Child and Family Services (organizational provider) are trained and entering services into the EHR.
- The EHR manual is not updated; however, staff are trained on how to use the EHR.

Structure and Operations Recommendations

Recommendation 28: Investigate and implement effective strategies for community awareness and stigma-reduction that can help address the housing shortage and relocation process.

Status: Met

- CCBH is a partner in the Calaveras County five-year strategic plan (updated May 2019) to end homelessness; the plan includes stakeholder feedback, strategies to reduce homelessness, and stigma reduction in the county.

- The strategic plan to end homelessness includes the following: coordinating data collection and planning; increasing emergency, bridge, and permanent housing; enhancing and expanding housing support services; strengthening community collaborations; and pursuit of emerging opportunities.
- Calaveras County created a housing and community program—staffed by a program manager and housing navigator—to focus on meeting the five-year strategic plan goals.
- CCBHS case managers continue to build relationships with local landlords and property management companies to secure housing for beneficiaries.

Recommendation 29: Investigate the causes of increased costs for inpatient psychiatry.

Status: Met

- CCBHS discovered—in collaboration with community partners—between 20 to 25 percent of beneficiaries are hospitalized more than once in a year.
- The MHP found that none of hospitalized beneficiaries had a Wellness and Recovery Action Plan (WRAP) plan; only nine percent were receiving Full-Service Partnership (FSP) services.
- The MHP attributed the high incidence of repeat hospitalizations to lack of coordination of care with mental health services; rural community stigma; minimal public transportation; and lack of affordable housing.
- The current clinical PIP (MHSA funded Enhancing the Journey to Wellness) is focused on increasing beneficiary connection to mental health services, peer support, and housing resources to reduce psychiatric hospitalizations.

Recommendation 30: Consider instituting a process to communicate administrative decisions that impact practice, such as change of providers, as well as changes in policies, to clinicians that emphasizes transparent communication and opportunities for learning.

Status: Met

- The CCBHS Interim Deputy Director, clinicians, and case management staff meet regularly (mental health authorization meeting) to discuss NACT requirements, service authorizations, change of provider requests, Notice of Adverse Benefit Determination (NOABD), and beneficiary strengths and needs.
- Policy and procedures are reviewed annually (or as needed) and policy origination, additions or revisions are uploaded into PowerDMS (cloud-based

software) for distribution; read receipts confirm staff have reviewed the policies.

- Daily emails are exchanged between staff to communicate up to date capacity and timeliness metrics; appointment slots are made available when necessary.
- Staff feedback on policy modifications and updates are collected by management and presented during quarterly QIC meetings.

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 re-hospitalization 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 non-minor dependents in foster care, including the number of Medi-Cal eligible minor and non-minor 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 non-minor 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 non-minor dependents in FC.
- Utilization data for Medi-Cal eligible minor and non-minor 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).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

- 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.

- 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 non-minor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and non-minor 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 non-minor 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

Calaveras 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	9,069	74.8%	702	76.2%
Latino/Hispanic	1,672	13.8%	118	12.8%
African-American	111	0.9%	*	n/a
Asian/Pacific Islander	125	1.0%	*	n/a
Native American	173	1.4%	*	n/a
Other	984	8.1%	74	8.0%
Total	**12,132**	**100%**	**921**	**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

Calaveras MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	19	2.1%
Other Languages	902	97.9%
Total	**921**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

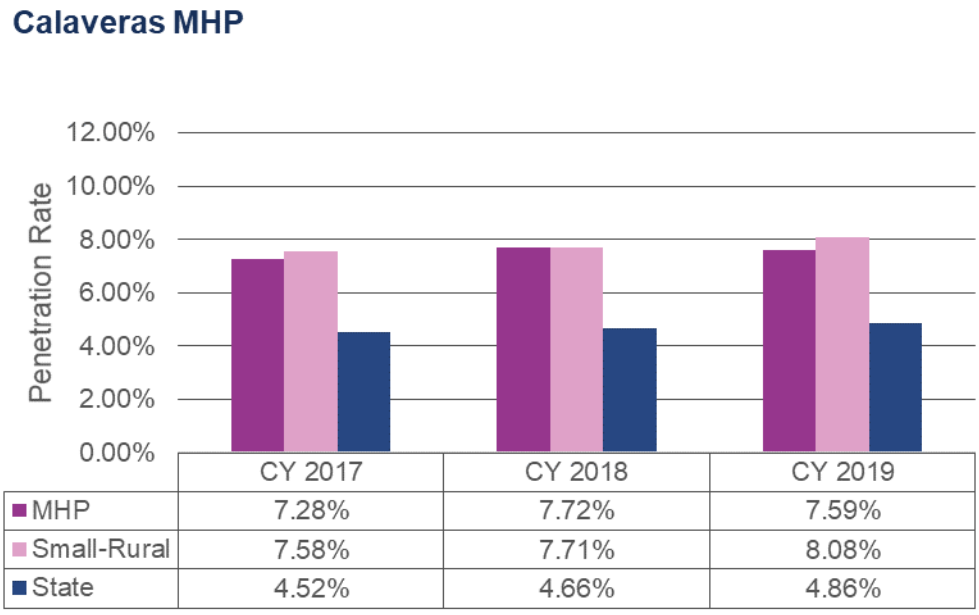
Penetration Rates and Approved Claims per Beneficiary

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 2019 ACA penetration rate and ACB.

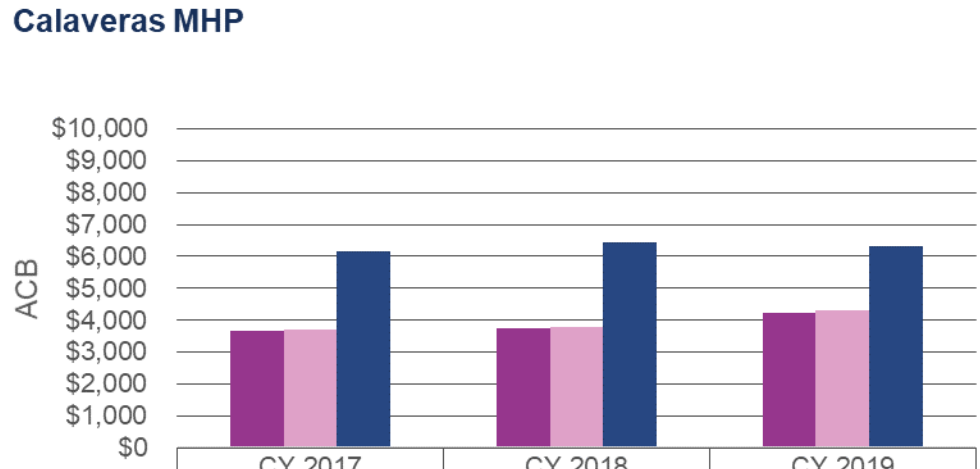
Regarding the calculation of penetration rates, the Calaveras MHP uses a different method than that used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	7.28%	7.72%	7.59%
Small-Rural	7.58%	7.71%	8.08%
State	4.52%	4.66%	4.86%

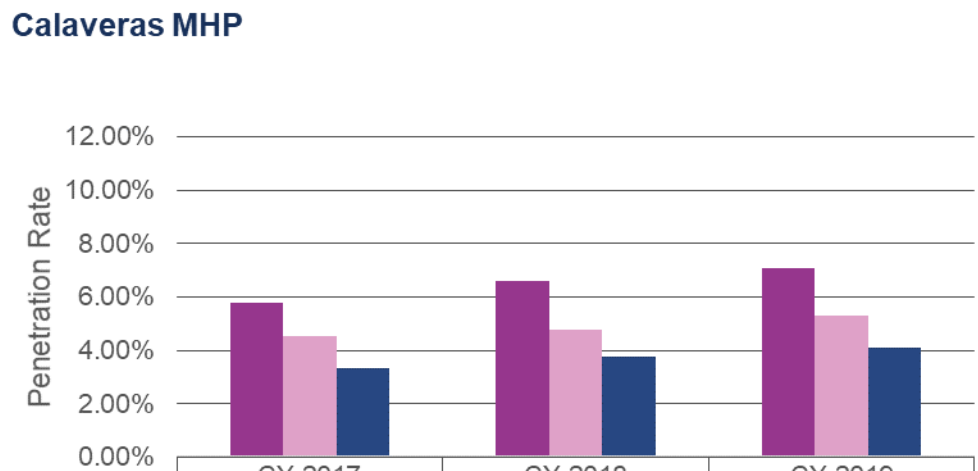
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,674	$3,753	$4,230
Small-Rural	$3,692	$3,794	$4,310
State	$6,170	$6,454	$6,316

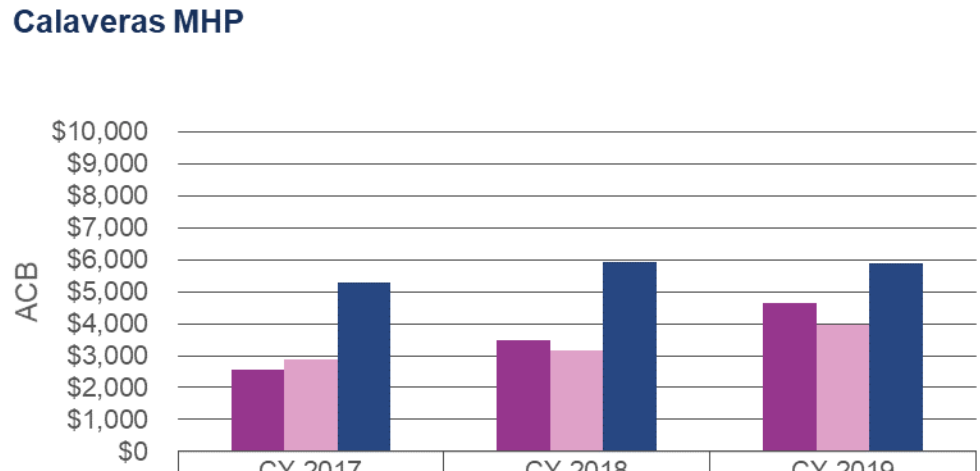
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	5.78%	6.59%	7.06%
Small-Rural	4.54%	4.79%	5.31%
State	3.35%	3.78%	4.08%

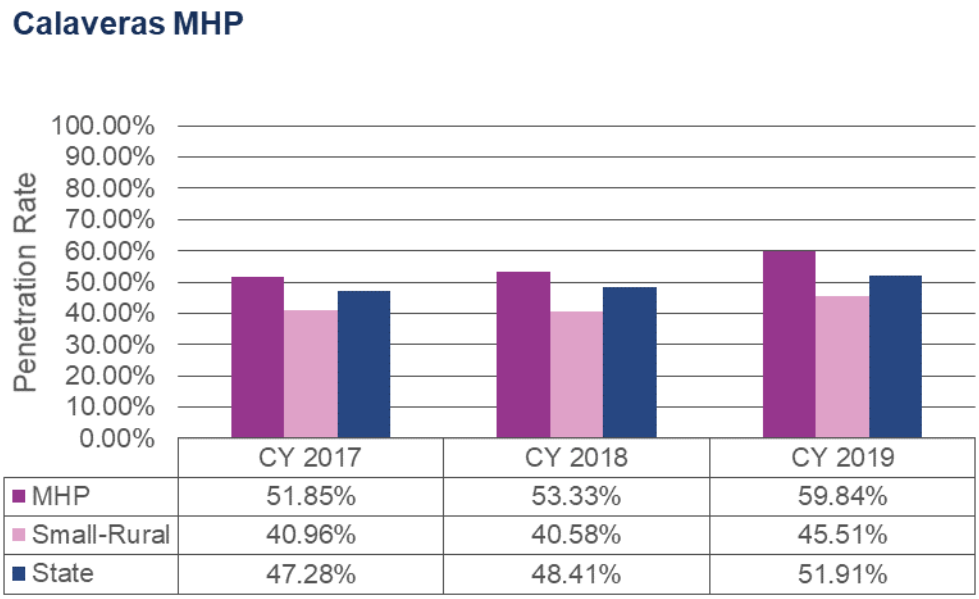
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$2,546	$3,467	$4,629
Small-Rural	$2,886	$3,146	$3,970
State	$5,278	$5,904	$5,869

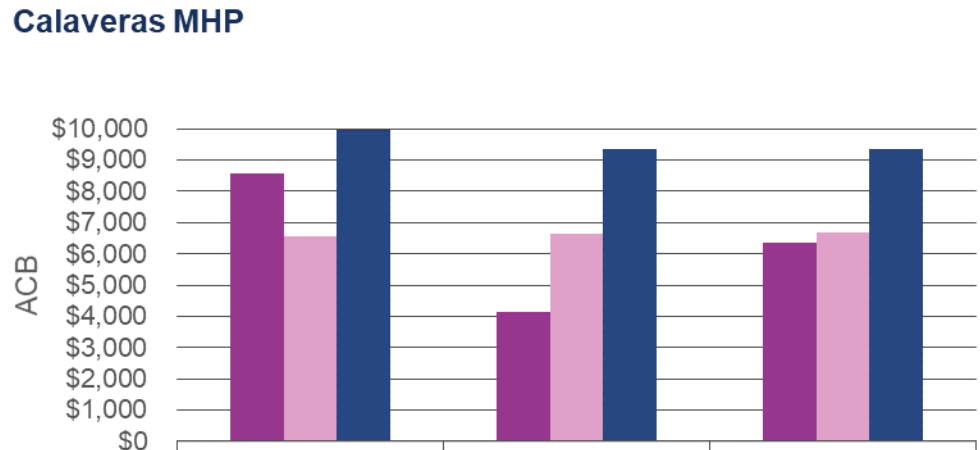
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	51.85%	53.33%	59.84%
Small-Rural	40.96%	40.58%	45.51%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

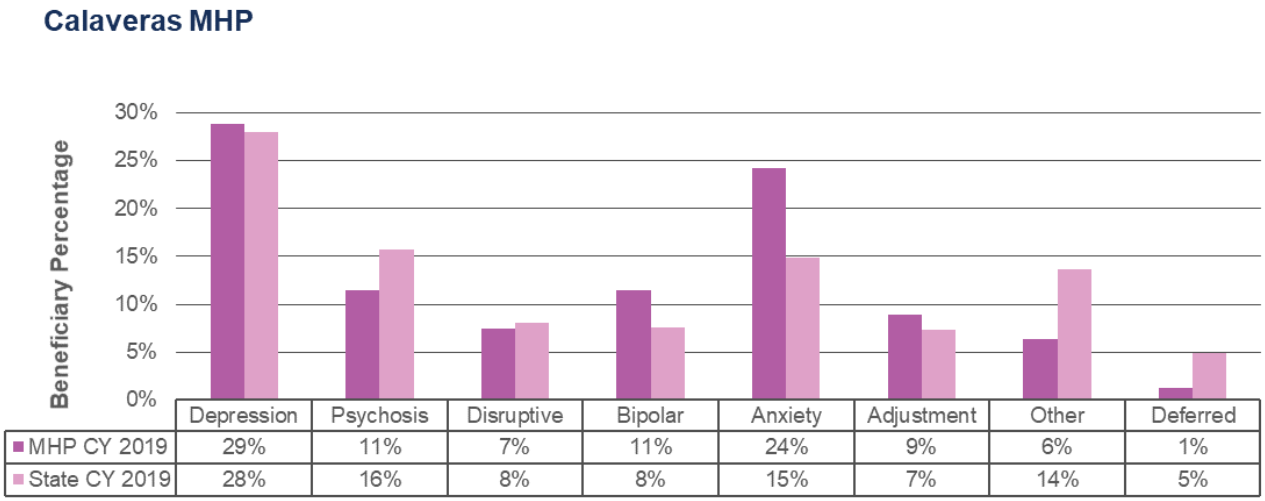


	CY 2017	CY 2018	CY 2019
MHP	$8,560	$4,148	$6,339
Small-Rural	$6,553	$6,630	$6,666
State	$9,962	$9,340	$9,360

Diagnostic Categories

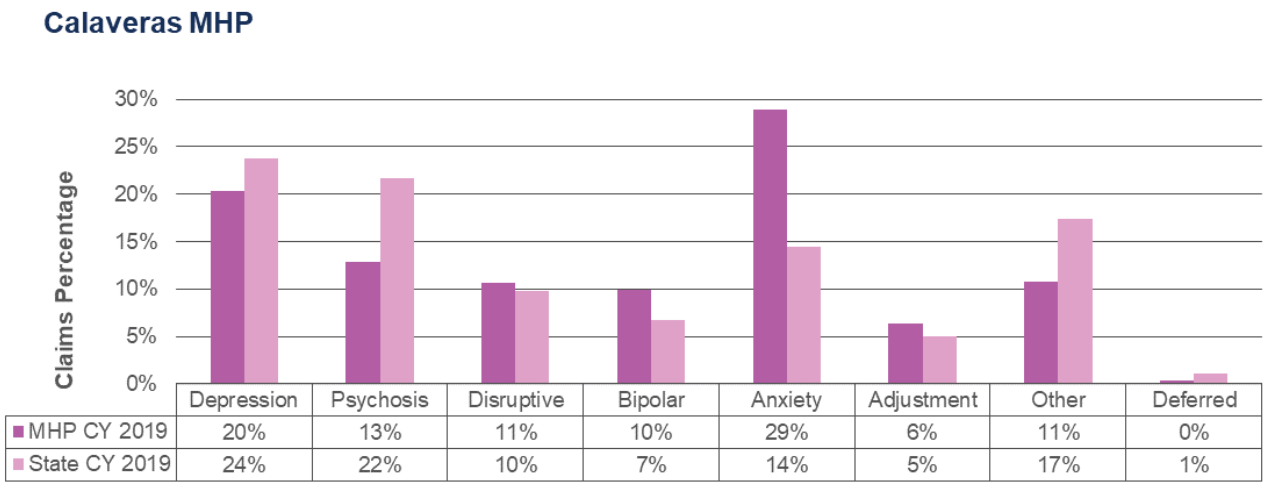
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	29%	11%	7%	11%	24%	9%	6%	1%
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	20%	13%	11%	10%	29%	6%	11%	0%
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

Calaveras 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	16	921	1.74%	$44,688	$715,009	18.35%
	CY 2018	*	942	n/a	$60,339	-	n/a
	CY 2017	13	905	1.44%	$51,710	$672,226	20.22%

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

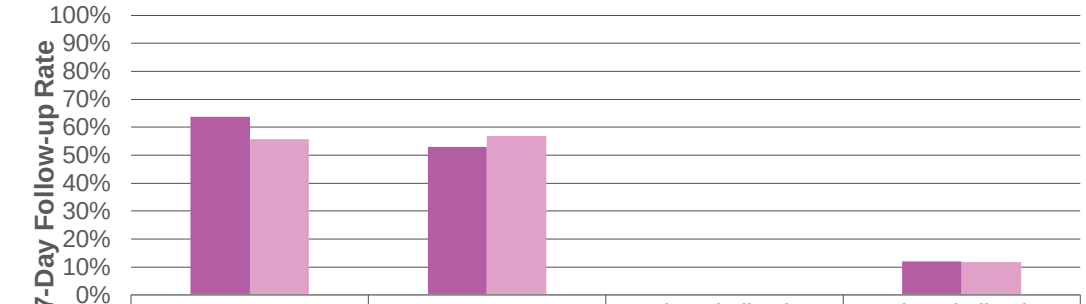
Calaveras MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	46	72	7.00	7.80	$8,562	$10,535	$393,840
CY 2018	49	76	8.85	7.63	$15,035	$9,772	$736,738
CY 2017	44	80	9.86	7.36	$10,241	$9,737	$450,593

Post-Psychiatric Inpatient Follow-Up and Re-hospitalization

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

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

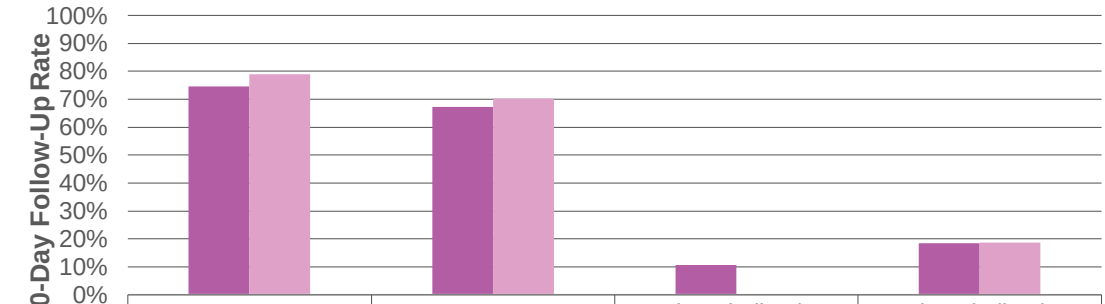
Calaveras MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	64%	53%	0%	12%
CY 2019	56%	57%	0%	12%

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

Calaveras MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	74%	67%	11%	19%
CY 2019	79%	70%	0%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Calaveras MHP PIPs Identified for Validation

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

Table 5 : PIPs Submitted by Calaveras MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Enhancing the Journey to Wellness
Non-Clinical	1	Decreasing Psychiatric No-Shows

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Calaveras MHP
PIP Title	Enhancing the Journey to Wellness
PIP Aim Statement	Will a peer specialist benefit consumers who experience repeat hospitalizations, by helping individuals engage in behavioral health services, reduce hospitalizations over the next three years?
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) Enhancing the Wellness Journey is a MHSA funded innovation project (initiated September 2019) whose primary purpose is to increase access to	

MHP Name	Calaveras MHP
mental health services to underserved populations. The PIP's overarching goal is to increase resilience, promote recovery, and improve wellness for hardest to serve beneficiaries. The MHP will ensure increased access to mental health, provided to CCBHS eligible and non-eligible individuals, and community support services through timely post-hospitalization supports provided by the peer specialist case manager This PIP provides a continuum of behavioral health care services including peer support recovery groups, creation of a WRAP, FSP services, housing supports, wellness center activities, and a range of co-occurring disorder services. The peer specialist case manager will reinforce the Journey to Wellness message, promoting a recovery-oriented environment, reducing stigma, and increasing the likelihood of participation in services and reducing the probability of re-hospitalization. Engaging beneficiaries in community support services will help to ensure assistance is provided to promote independency and safety upon community re-entry.	
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: n/a	
Target population description, such as specific diagnosis (please specify): All beneficiaries who have experienced multiple psychiatric hospitalizations over a 36-month period.	

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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The clinical PIP includes the following peer specialist interventions: • Engage beneficiary within seven days post-hospitalization discharge. • Assess and provide housing support within one week of discharge. • Participate in weekly MHP authorization committee meeting to assess client needs; identify supportive resources (i.e. mental health, food, primary health care, etc.).

PIP Interventions (Changes tested in the PIP)
• Connect and/or refer beneficiary to FSP case manager. • Assist FSP case manager with case management services (i.e. group therapy, medication support, Integrated Dual Diagnosis Treatment (IDDT) services, financial supports, wellness center socialization, etc.). • Assist beneficiary with creating a WRAP to include crisis and treatment planning (i.e. goals). • Provide daily and/or weekly support to beneficiary. • Engage family and provide psychoeducation on mental health issues and coach on problem solving. • Maintain connection with beneficiary through follow-up appointments and referral checks.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Re-measurement Year	Most Recent Re-measurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Re-hospitalization rate (MHP eligibles)	11/2019 to 07/2020	N=65 15.4%	11/2019 to 07/2020 ☐ n/a*	N=55 12.7%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other: n/a
Was the PIP validated?				☒ Yes	☐ No	
Validation phase: ☐ PIP submitted for approval ☐ Planning phase						

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Re-measurement Year	Most Recent Re-measurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ Implementation phase ☐ Baseline year ☒ First re-measurement ☐ Second re-measurement ☐ Other (specify):						
Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence Justification for validation rating: The MHP appeared to have difficulties adhering to the data collection plan as evidenced by inconsistent tracking of FSP referrals and duplicative data entry and tracking). "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: • Explore how the wellness case manager may support individuals who are not currently eligible for CCBHS services. • Focus on enrolling more beneficiaries in FSP programs and improve tracking of FSP referrals. • Expand WRAP planning support services for beneficiaries once they are stabilized (i.e. wellness center support). • Revisit data collection and tracking tools to modify and streamline (i.e. reduce duplicative data entry and tracking.). • Engage in a deeper exploration of the program structure (i.e. embed wellness case manager in the crisis team or with other case managers.). • Explore program components and adjust as needed to ensure beneficiary access to the most needed services. • Engage in frequent TA offered by CalEQRO to ensure successful implementation of interventions.						
TA provided to the MHP by CalEQRO consisted of:						

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Re-measurement Year	Most Recent Re-measurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
• Review of current PIP progress, and duties of the wellness case manager. • Review of the PIP write-up process in the new format.						

*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	Calaveras MHP
PIP Title	Decreasing Psychiatric No-Shows
PIP Aim Statement	Will using telehealth or phone for psychiatry services over the next fiscal year (2020-2021) increase the rate at which beneficiaries attend their appointments improve compliance with treatment and medication services thus decreasing the MHP's no-show rate?
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) The aim of this PIP is to reduce psychiatric no-shows by providing reminder calls and assisting beneficiaries with utilizing telehealth services (i.e. case manager provides home support). CCBHS recognizes that internet services are not accessible throughout the county due to its rural countryside. In response, the MHP collaborated with five libraries throughout the county to offer WiFi hotspots in the parking lot. Beneficiaries without internet access may conduct their psychiatry appointment over the telephone when preferable. Prior to COVID-19, beneficiaries used telehealth services in the clinic setting (MHP provided computer)—clinic appointments continue on an as-needed basis. In response to the pandemic, most services transitioned to telehealth services from the beneficiaries' location (i.e. personal computer and/or cell phone). CCBHS hopes to reduce the psychiatry no-show rate by 50 percent by the end of this study—this PIP was initiated in June 2020	
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):	

MHP Name	Calaveras MHP
The PIP population will consist of all Medi-Cal beneficiaries scheduled, attending, re-scheduling, cancelling, and no-showing for a psychiatry appointment through the MHP.	

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): • Coaching beneficiaries on how to use telehealth services (Zoom). • Connecting beneficiaries to local WiFi hotspots.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Psychiatry services provided via telehealth. • Psychiatry services provided via telephone.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Re-measurement Year	Most Recent Re-measurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Child psychiatry no-show rate	FY 2019-20	7.5%	☒ n/a*		☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other: n/a
Adult psychiatry no-show rate	FY 2019-20	17%	☒ n/a*		☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other: n/a
Was the PIP validated?				☐ Yes	☒ No	

Validation phase:

☐ PIP submitted for approval

☐ Planning phase

☒ Implementation phase

☐ Baseline year

☐ First remeasurement

☐ Second remeasurement

☐ Other (specify):

CCBHS states the interventions began in June 2020; however, provision of telehealth services began in April 2020 in response to the pandemic. The PIP implementation timeframe should be further clarified. Baseline no-show data was

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Re-measurement Year	Most Recent Re-measurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
extracted from FY 2019-20, and the interventions reportedly began in June 2020; however, no-show rate remeasurements were not provided during this review.						
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. The MHP appeared to have difficulties adhering to the data collection plan as evidenced by inconsistent data remeasurements and inconsistent data entry and tracking.						
EQRO recommendations for improvement of PIP: • Provide clear description of PIP timeframe (i.e. beginning and end date, data collection, remeasurements, data analysis, etc.). • Conduct performance remeasurements on at least a quarterly basis. The results from the planned remeasurement in November 2020 was not provided during this review. • The MHP should provide a clear indication whether reminder calls are included in the PIP interventions; measurements were not provided for this process indicator. • Engage in frequent TA offered by CalEQRO to ensure successful implementation of interventions.						
The TA provided to the MHP by CalEQRO consisted of: • Review of the PIP write-up process in the new format, and inclusion of data in the development tool. • Discussion of internal and external threats to data validity. • Analysis of the barriers encountered during intervention implementation, and potential solutions to address the barriers.						

*PIP is in planning and implementation phase if NA 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 virtual 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
Calaveras	4.70%	5.40%	5.20%	4.70%
Small-rural MHP Group	n/a	5.26%	4.17%	3.92%
Statewide	n/a	3.58%	3.35%	3.34%

- The MHP's FY 2019-20 budget included funding for replacement of PC's and laptops required by Central IT.

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 Program Manager is responsible for system and network security.
- The MHP utilizes the County IT department's strategic plan, due to CCBHS' small size.

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	71%
Contract providers	3%
Network providers	26%
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	4	0	0	0
2019-20	3	1	0	0
2018-19	1	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	1	0	0	0
2019-20	1	0	0	0
2018-19	1	0	0	0

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

- There were no changes in staffing since the last EQRO review.

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	14	0	14
Clinical Healthcare Professional	30	13	43
Clinical Peer Specialist	0	0	0
Quality Improvement	1	0	1
Total	45	13	58

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)	4.00	2.16
Total EHR Users Supported by IT (Source: Table 17)	58.00	42.00
Ratio of IT Staff to EHR Users	1:15	1:19

- CCBHS' staff ratio of 1:15—versus small MHP average of 1:19— is consistent with the IT budget noted (table 12) for a central region county.
- Refer to tables 19-21 for additional information on IT staffing level.

Table 19: Additional Information on EHR User Support

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

Table 20: New Users' EHR Support

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

Table 21: Ongoing Support for the EHR Users

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

- The MHP provides FFS providers direct access to the CCBHS EHR, and provides training and 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	4
Number of county-operated telehealth sites	1
Number of contract providers' telehealth sites	3
Total number of beneficiaries served via telehealth during the last 12 months	530
• Adults	386
• Children/Youth	127
• Older Adults	17
Total Number of telehealth encounters (services) provided during the last 12 months:	3024

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 public health emergency on beneficiaries and mental health provider staff.

- The MHP set up telehealth services within three weeks of the beginning of COVID-19 public health emergency.
- MHP staff worked from home during the onset of the COVID public health emergency; however, they returned to the clinic in August 2020 to provide telehealth services from the office.
- The Wellness and Recovery Center holds weekly Zoom sessions and provides information to beneficiaries through multiple formats.

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

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

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

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

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

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Sierra Child and Family	1
Asha Brock	1
Matt Johnson	1

Current MHP Operations

- The MHP continues to use CCBH as its EHR.
- Kings View provides ASP support but does not host the system.

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

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Cerner Community Behavioral Health (CCBH)	EHR	Cerner	7	Cerner
ADM	DUI	Alcohol and Drug Management System	20	MHP IT

The MHP's Priorities for the Coming Year

- Identify a new EHR vendor.
- Implement Short Term Residential Therapeutic Program (STRTP) billing process.
- CCBHS should consult with California Mental Health Services Authority (CALMHSA) to create a presumptive transfer portal; this will allow the MHP to review and verify transfer requests, issue requests for fund transfers for services, and to allow timely payments.
- Update FFS manual.

Major Changes since Prior Year

- Provided all FFS providers with EHR access.
- Implemented LEAPS software system for access to public guardian information.
- Completed Medicare certification process and began claim processing.
- Completed data migration between CA DHCS ITWS system to local Calaveras County network.
- Improved timeliness monitoring.
- Developed a series of dashboard reports in collaboration with Kings View.

Other Areas for Improvement

- The provider directory should be updated monthly as per DHCS IN 18-010; the directory should be available in English and Spanish.
- Medicare Part B submitted claims do not crossover properly to MediCal; claims crossover directly to MCOs for reimbursement resulting in erroneous payments to the MHP.
- Clinical and functional outcome reports, such as CA IP-CANS and PSC-35 data, should be compiled and shared on a routine basis to inform CQI activities.
- The CSI assessment record should be formatted to capture psychiatry timeliness metrics.

Plans for Information Systems Change

- The MHP is collaborating with Kings View to secure a new system; a project team and plan has been created.

MHP EHR Status

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

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts		☐	☐	☒	☐
Assessments	CCBH	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/Storage	CCBH	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	CCBH	☒	☐	☐	☐
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service		☐	☐	☒	☐
Outcomes	CCBH	☒	☐	☐	☐
Prescriptions (eRx)	CCBH	☒	☐	☐	☐
Progress Notes	CCBH	☒	☐	☐	☐
Referral Management		☐	☐	☒	☐
Treatment Plans	CCBH	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		7	0	5	0
FY 2019-20 Summary Totals for EHR Functionality:		6	1	5	0
FY 2018-19 Summary Totals for EHR Functionality:		6	1	5	0

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

- Fully implemented the outcomes module of the CCBH system.

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 Applicable
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not Applicable
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not Applicable
Direct data entry into MHP EHR system by contract provider staff	90%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not Applicable
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	10%	Monthly

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
Exym	Exym	1

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

Not Applicable

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
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

Calaveras MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**17,702**	**$4,153,762**	**273**	**$62,345**	**1.48%**	**$4,091,417**	**$3,615,292**
JAN19	1,661	$325,410	25	$4,983	1.51%	$320,427	$295,476
FEB19	1,453	$293,759	21	$8,962	2.96%	$284,797	$258,728
MAR19	1,624	$332,550	23	$5,444	1.61%	$327,106	$302,500
APR19	1,752	$347,921	18	$3,312	0.94%	$344,609	$320,759
MAY19	1,497	$303,978	16	$3,259	1.06%	$300,719	$278,956
JUN19	1,301	$279,429	22	$4,625	1.63%	$274,804	$253,161
JUL19	1,319	$302,765	10	$1,692	0.56%	$301,073	$293,409
AUG19	1,381	$317,833	21	$5,976	1.85%	$311,857	$301,400
SEP19	1,530	$321,094	25	$2,875	0.89%	$318,219	$310,590
OCT19	1,404	$471,340	49	$10,708	2.22%	$460,632	$357,908
NOV19	1,417	$412,568	22	$3,107	0.75%	$409,461	$309,962
DEC19	1,363	$445,115	21	$7,402	1.64%	$437,713	$332,441

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.**

The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments by Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.

Table 30 summarizes the top five reasons for claim denial.

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

Calaveras 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.	187	$32,423	52%
Medicare or Other Health Coverage must be billed before submission of claim.	49	$14,264	23%
Beneficiary not eligible or non-covered charges.	11	$6,852	11%
Beneficiary not eligible.	10	$3,219	5%
Service line is a duplicate and a repeat service procedure code modifier not present.	9	$2,774	4%
Total	273	$62,345	NA

The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.

- Denied claim transactions with reason “ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid” and “Medicare or Other Health Coverage must be billed before submission of claim are generally re-billable within the State guidelines”.

NETWORK ADEQUACY

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

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing TA 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 Calaveras, the time and distance requirements are 90 minutes and 60 miles for mental health services, and 90 minutes and 60 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 groups: youth (birth to 20 years old), and adults (21 years old and older).

Review of Documents

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

Review Sessions

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

Findings

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

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

Not Applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

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

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

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	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

Description of NPI Exceptions	Number of Exceptions
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	2

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 virtual review of the MHP. As part of the pre-review 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 who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO.
Total number of participants	Three
Number of participants who initiated services during the previous 12 months	Two
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group:	
Access-new beneficiary	Participants received services in a timely manner; the experience was positive for them.
Access – overall	Participants feel supported and experienced a positive process.

Topic	Description
Timeliness	Participant's needs are being met in a safe manner. There is both positive and negative experiences with telehealth since COVID-19 began.
Urgent care and resource support	Participants know who to call and what to do in emergency situations. Beneficiaries may access the warm line if needed.
Quality	The participants received limited information on available services. All participants are involved in their treatment.
Peer employment	Participants are aware of peer employment; however, they choose not to participate in those services.
Structure and operations	Participants expressed limited involvement in community services planning.
Recommendations from this focus group	• Additional therapists and case managers are needed. • More affordable housing and resources for the homeless population are needed.
Any best practices or innovations (optional)	• Improved interaction with local law enforcement and the homeless population. • Crisis response mobile outreach has improved relationship between the MHP, local law enforcement, and beneficiaries. • Improved rapport with mental health providers.

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	11
CCBHS provides printed information about other county programs on waiting room bulletin boards, and participants in the focus group reported knowledge of this. The Medi-Cal Beneficiary Booklet as well as access materials and grievance information is available in English and Spanish. Bulletins regarding the availability of interpreter services and language line are posted in all clinics. The agency website is not user friendly. The MHP has a 24-hour phone line with statewide toll-free access that has linguistic capability and are contracted to provide language interpretations in all languages as needed. When bilingual staff are unavailable or for calls where there is no staff who can act as interpreters for a particular language, BHS uses AT&T Language Line. The MHP utilizes a test caller program to monitor the efficiency and accuracy of the 24-hour access line and the clinic main phone line. CCBH monitors access through walk-ins or other referrals. The MHP should update the provider directory on a monthly basis and should be available in English and Spanish.			

Component		Maximum Possible	MHP Score
1B	Capacity Management	10	9
CCBHS collaborated with five local libraries, in response to COVID-19 to provide WiFi access to beneficiaries living in in each county district (especially rural areas), ensuring provision of telehealth services via Zoom platform. The MHP's standards for system demand and capacity are reportedly assessed on a clinician-by-clinician basis. CCBHS would benefit to regularly review and discuss penetration rates by location in addition to age and ethnicity to address potential access issues for beneficiaries residing in hard to reach locations. The MHP has a standing QIC agenda item to begin tracking to identify beneficiaries by zip code; however, this process is in the planning phase at the time of this EQRO review.			
1C	Integration and Collaboration	24	24
The MHP has developed integrated and collaborative programs with partners and community-based organizations, including child welfare, education systems, law enforcement, and employment supports. CCBHS provides vocational training and supportive employment as part of the Health and Human Services Agency (HHSA) Cal-Works program. The Grandparents Program is contracted through the Calaveras County Office of Education to provide groups and individual consultation to grandparents and other caregivers raising relatives' children with serious emotional or behavioral disorders. The MHP collaborates with students, parents, school staff, employers, faith-based and spiritual leaders, community-based service staff to provide suicide prevention trainings target a broad range of individuals. An adult triage case manager (sheriff liaison), a children triage case manager, and a children triage peer specialist are part of the CCBHS HHSA Crisis and Outreach Unit; services are available to provide crisis interventions in the community. CCBHS HHSA division received $900,000 in funds from the State of California Housing and Community Development (HCD) with the Stanislaus Housing Authority in January 2019. The funds will be used to build five units of permanent supportive housing located in San Andreas, CA. The MHP continues to partner with the Stanislaus Regional Housing Authority for the second grant opportunity to request additional funds to build up to ten units of permanent supportive housing in Valley Springs.			

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 has a ten business-day standard from the length of time from initial request to first offered appointment for county operated programs only, and met this standard 93 percent of the time (93 percent for adults, 96 percent for children, and 92 percent for FC youth). The average length of time is five business days (five business days for adults, children, and FC youth). The MHP does not include contract provider data in this metric; however, MHP reported that all initial appointments take place through the MHP, and contract providers only serve children. CCBHS reviews all timeliness reports during weekly leadership meetings, monthly QIC meetings, and quarterly mental health board meetings. MHP clinical and administrative staff are alerted via email at the end of each business-day when timeliness standards are not being met; additional intake slots are made available if scheduling begins to approach the seven-to-eight-day mark. Timeliness of service entry is reported on the managed care quarterly dashboard and presented to HHSA management at the mental health performance measures meeting; action is taken when warranted.			
2B	First Offered Psychiatry Appointment	12	10
The MHP has 1.0 FTE divided amongst two adult telepsychiatrists offering 30 hours of psychiatry services per week; there is 0.60 FTE telepsychiatrists for children and FC youth offering approximately 20 hours per week. Collaborative meetings and case reviews are held on a weekly basis between the MHP and psychiatrists. CCBHS has a 15 business-day standard for the length of time from initial request to first offered psychiatry appointment, and met this standard 15 percent of the time for county operated programs only (14 percent for adults, 17 percent for children, and 18 percent for FC youth). The percent of appointments that met the 15 business-day standard has increased from nine percent in FY 2019-20 to 15 percent in FY 2020-21; however, it remains well below the timeliness requirements. The MHP now tracks psychiatry timeliness metrics in the CSI assessment record. The average length of time from initial request to first offered psychiatry appointment is 32 business days (31 business days for adults and children, and 43 business days for FC youth). The overall range of initial psychiatry request to first offered			

Component		Maximum Possible	MHP Score
appointment was from 5 to 139 business days (5 to139 business days for adults, 6 to 79 business days for children and 9 to 97 business days for FC youth). CCBHS cited beneficiary no-shows and a long authorization process (approximately five days) as barriers to meeting the 15 business-day standard. The MHP reported that they have sufficient intake appointments available; however, the 1.0 FTE telepsychiatrist positions work four days per week and only offer one assessment slot per day. The current non-clinical PIP is focused on decreasing the psychiatry no-show rate by offering telehealth appointments for beneficiaries.			
2C	Timely Appointments for Urgent Conditions	18	18
CCBHS has a 48-hour standard from the length of time from service request for urgent appointment to actual encounter and met this 100 percent of the time for adults, children, and FC youth; there are no urgent pre-authorization requirements. The MHP provides services for all urgent requests. The MHP beneficiaries in CalEQRO focus group(s) report knowledge of the crisis line and are confident that they can connect with their case manager or front-desk office staff for urgent conditions; the majority of participants stated that the warm line had limited hours.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	10
CCBHS has a seven-day follow-up standard post-psychiatric inpatient discharge for the entire system of care and met this standard 78 percent of the time (67 percent for adults, 95 percent for children, and 100 percent for FC youth). The average length of follow-up post hospital discharge is five days (six days for adults, and three days for children and FC youth). The reported follow-up timeliness metrics reflect only Medi-Cal beneficiaries who were hospitalized. The MHP re-designed their crisis and hospitalization log to track individual incidents more accurately and to differentiate in-county Medi-Cal beneficiaries from out-of-county Medi-Cal beneficiaries; the log is maintained by the crisis case manager. The current clinical PIP (MHSA funded Enhancing the Journey to Wellness) is focused on reducing re-hospitalizations by connecting beneficiaries with the crisis case manager within 72-hours post hospital discharge to receive intensive care coordination.			
2E	Psychiatric Inpatient Re-hospitalizations	6	6
The MHP's re-hospitalization rate was nine percent overall (seven percent for adults and fourteen percent for children and FC youth) for contract hospitals. Timely follow-up after hospitalization to reduce re-hospitalization of adults is the subject of the MHP's current clinical PIP.			

Component		Maximum Possible	MHP Score
2F	Tracks and Trends No-Shows	10	10
The MHP follows the standard of 10 percent for no-shows for both clinicians and psychiatry. The overall no-show rates for psychiatrists is 13 percent (16 percent for adults, eight percent for children and FC youth) representing a 48 percent decrease since CY 2018. The average no-show rate for clinicians is eight percent (nine percent for adults, and six percent for children and FC youth), indicating a 60 percent decrease since CY 2018. No show/cancellation data was reported for county operated programs only; however, children's services are provided by contractors.			

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 is a member of the CCC—comprised of Calaveras, Amador & Tuolumne Counties—creating a Tri-County CCC. The committee pursues strategies of assessing the cultural needs of beneficiaries in its unincorporated rural areas. The MHP's FY 2020-21 cultural competency plan (CCP) demonstrates noticeable disparities in Hispanic/Latino penetration rates (utilizing projected and estimated population growth).The Tri-County CCP and CCBHS will use this data going forward to recruit and sustain staffing and find creative ways to outreach and engage the Hispanic population. The CCC plan is not updated and does not reflect quantifiable goals and objectives nor process outcome indicators. CCBHS reports that the older adult penetration rate is low due to individuals' reluctance to seek mental health assistance. The MHP provides outreach and engagement using the senior peer program and volunteers to go into the community. In-home visits have been impacted by COVID-19.			

Component		Maximum Possible	MHP Score
CCBH employs a designated a case manager to provide outreach, peer support, and advocacy to Latino/Hispanic families in Calaveras County (including Valley Springs and Angels Camp); the case manager linked 60 families to behavioral health and community services in FY 2019-20. The MHP provides cultural competence training four times per year for all mental health staff including management, clinical and support staff.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	5
CCBHS utilizes the CA IP-CANS, PSC-35, GAD-7 and PHQ-9 to determine beneficiary medical necessity and LOC during intake assessment. The GAD-7 has not yet been added to the EHR; however, the PHQ-9 has been added. PSC-35 outcomes are tracked; however, the MHP does not analyze or trend the data. The MHP does not have a formal policy and procedure for LOC transitions. Calaveras County is now looking for another EHR provider with the assistance of Kings View (EHR vendor). CA IP-CANS assessments, in conjunction with PSC-35 results, are used informally to drive treatment planning and beneficiary (children and FC youth) interventions. Collaboration with CWS has improved since the last EQRO review; however, CWS experienced staff turnover resulting in issues with the sharing of CANS-IP data with CCBHS. The MHP reports that discharge CA IP-CANS assessments are not routinely completed; the MHP plans to create a formal process to address the issue. CA IP-CANS assessment training for clinical staff was provided in October 2020. The MHP collaborated with Kings View to create a CA IP-CANS dashboard that will be unveiled CY 2021. The newly designed CA IP-CANS dashboard does not have the capability to disaggregate FC youth. CCBHS collaborated with the MORS vendor to create a training agreement which was subsequently delayed due to COVID-19 restrictions. The vendor now offers virtual training and CCBHS plans to schedule training in January 2021. Clients who do not meet medical necessity for SMHS may be referred out to the MCOs, California Health and Wellness or Anthem Blue Cross. It would benefit the MHP to track referrals to MCOs (i.e. 30 and 60-day follow-up) to ensure that individuals do not have a gap in service potentially leading to mental health decompensation. Stakeholder participants in focus groups report being involved in their treatment care and planning.			
3C	Quality Improvement Plan	10	8
The FY 2020-21 QAPI plan includes measurable goals with outlined process indicators; however, the QAPI annual evaluation was not completed. The QAPI			

Component		Maximum Possible	MHP Score
should include analysis of disparity in services by the county regions served. The QAPI and CCC goals and objectives are aligned and are discussed during quarterly QIC meetings. It would benefit the MHP to complete an annual QAPI evaluation to ensure that the goals and objectives are reflected in data collection and continuous quality improvement (CQI) activities.			
3D	Quality Management Structure	14	13
CCBHS has a dedicated QA unit and appears to interface with other programs and system of care. Stakeholders in review sessions report that obtaining the resources to accomplish initiatives is not always possible.			
3E	QM Reports Act as a Change Agent in the System	10	6
CCBHS QM reporting reflect timeliness baselines and improvement goals. The MHP has two PIPs focused on reducing psychiatry no-shows (non-clinical) and reducing psychiatric re-hospitalizations (clinical). It appears that the MHP does not utilize established change management strategies to track whether QI efforts lead to intended outcomes. It would benefit the MHP to routinely share QM reports throughout the system. CCBHS staff would benefit with training to interpret and use the new EHR dashboards for CQI.			
3F	Medication Management	12	5
The MHP has a Medication Services policy and procedure to improve the monitoring of psychotropic medications used by adults, children, and FC. The public health nurse (PHN) collaborates with the CCBHS, CWS, and probation for FC youth. The PHN provides medication oversite for all FC youth prescribed psychotropic medications. CCBHS does not track and trend Healthcare Effectiveness Data and Information Set (HEDIS) and other national measures for performance improvement purposes. The contract child psychiatrist does track and trend prescribing practices; however, the MHP does not. Beneficiaries in focus groups report signing a release of information for the MHP to collaborate care with their primary care provider; however, they were unaware if the collaboration occurred. The MHP does not track psychotropic medication monitoring for FC youth as per SB 1291 requirements.			

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	10
CCBHS utilizes the CA IP-CANS, PSC-35, GAD-7 and PHQ-9 to determine beneficiary medical necessity and LOC during intake assessment. The MHP reports that discharge CA IP-CANS assessments are not routinely completed; the MHP plans to create a formal plan to address the issue. Stakeholders in focus groups report that aggregate clinical and functional beneficiary outcomes are shared with management but not with line staff. It would benefit the MHP to compile and present reports routinely with stakeholders (at least annually) to address potential gaps among subpopulations and identify groups in most need of QI. These reports should also be shared throughout the agency and contract providers.			
4B	Beneficiary Perceptions	10	10
The CCBHS non-clinical PIP (reducing the psychiatric no-show rate) included a beneficiary survey asking basic questions about the ease of accessing psychiatric appointments, and difficulties accessing their appointments. The MHP conducts the Consumer Perception Survey twice a year. Due to COVID-19, most surveys were mailed to beneficiaries with pre-stamped envelopes to return the survey. Surveys were also hand delivered by case managers. The MHP received over 80 returned surveys this CY.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
Beneficiaries in focus groups report knowledge of the wellness center (The Wellness Cabin) and stated that they were beneficial to their health and wellness. Information about the wellness center is posted in the clinic lobby. The wellness center is open to anyone in the community. The MHP facilitates employment opportunities in the community through job training and skill development and partnership with job placement programs. The MHP monitors the utilization of peer-run programs during			

Component	Maximum Possible	MHP Score
the monthly Calaveras County Mental Health Board meeting. Wellness centers are currently closed due to COVID. Group sessions are held via Zoom in lieu of in-person classes.		

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	15
The MHP provides a broad range of mental health services to beneficiaries, including outpatient, targeted case management, crisis intervention and triage. The MHP does not have a crisis stabilization unit (CSU) nor a psychiatric health facility in county; when a person requires psychiatric hospitalization, crisis workers locate a psychiatric hospital bed in another county and arrange ambulance transportation to such facilities, sometimes across great distances. The crisis residential treatment program is a multi-county collaborative based in Merced. CCBHS does not have an adult residential treatment; however, there is transitional housing (Vision House) for people experiencing homelessness, as there are no shelters. Homelessness has become a much more prominent issue as the result of the 2015 fires and lack of affordable housing. CCBHS does not have a county operated therapeutic foster care (TFC); however, the MHP has a total of two county contracted STRTPs (recently contracted with Rite of Passage). CWS actively recruits resource families as well as collaborates with local foster family agencies in search of TFC homes. Thus far, the community response to this form of FC has been limited to no interest. The families willing to consider, eventually decline due to the level of training, oversight, and potential need of the children to be placed. The MHP, probation and CWS continue to recruit for possible TFC homes. CCBHS collaborates with CWS to provide intensive care coordination services.			
5B	Network Enhancements	18	10
The MHP has a number of means to deliver services. Most services are provided via telehealth since the beginning of the pandemic; telephone and in-person appointments are available on a case by case basis. The MHP does not have co-located services, but they collaborate with local schools, Mark Twain Hospital, and law enforcement on mobile crisis and field-based services. The MHP has one wellness center and no behavioral health/medical homes. The MHP provides outreach and engagement using the senior peer program and volunteers to go into the community. In-home visits have been impacted by COVID-19.			
5C	Subcontracts/Contract Providers	16	10

Component		Maximum Possible	MHP Score
Children and Spanish-speaking adults receive services from a MHP contracted provider. Documents submitted for review do not reflect a formal process to review, discuss and communicate LOC transitions. CCBHS reports and data analysis do not provide all data from contract providers. There are no contract providers as part of the MHP's PIPS. It does not appear that the MHP convenes regular meetings with contract provider management service access and quality (i.e. meeting minutes, strategic plan).			
5D	Stakeholder Engagement	12	12
MHP line staff and supervisors are involved in the QIC and the CCC. Contract providers are included in trainings such as cultural competency and CA IP-CANS; however, they are not in the CCC. The MHP reports that beneficiaries are involved in the Wellness Cabin and the homeless task force. Beneficiary and staff feedback in focus groups reflect participation in CCBHS committees. Several MHP committees are not holding in-person meeting due to the COVID public health emergency, although the MHAB meeting is held via Zoom. National Alliance on Mental Illness (NAMI) groups have been canceled due to COVID-19.			
5E	Peer Employment	8	8
There are eight designated peer positions, where lived experience is required. There is one management level peer position who is included in the leadership team. The MHP is planning on creating a career ladder for Peer Specialists I, II, III plus keeping other positions. The Wellness Cabin is peer driven. The Cabin Director and the staff are individuals with lived experience. Focus group participants were aware of the cabin; however, it is currently closed due to the COVID public health emergency.			

SUMMARY OF FINDINGS

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

- CCBH HSS was awarded the $2.5 million Mental Health Student Services Act (MHSSA) grant, in partnership with local educational entities, to increase access to mental health services in local elementary schools.
- The majority of services are provided via telehealth in response COVID-19.

Strengths:

- CCBH collaborated with five local libraries, in response to the pandemic, to provide WiFi access to beneficiaries living in in each county district (especially rural areas), ensuring provision of telehealth services via Zoom platform.
- The MHP has a designated case manager who conducts outreach into the Spanish-speaking community by liaising with community support groups in different areas throughout the county.
- CCBH improved the Latino/Hispanic penetration rate from 5.78 percent in CY 2017 to 7.06 percent in CY 2019; this rate is higher than other small-rural MHPs penetration rates averaging 5.31 percent (CY 2019).

Opportunities for Improvement:

- The provider directory is not updated on a monthly basis and made available in English and Spanish.
- CCBHS would benefit to regularly review and discuss penetration rates by location in addition to age and ethnicity to address potential access issues for beneficiaries residing in hard to reach locations.

- The MHP should consider updating the agency website to be more user friendly.

Timeliness of Services

Changes within the Past Year:

- The MHP re-designed their crisis and hospitalization log to track individual incidents more accurately and to differentiate in-county Medi-Cal beneficiaries from out-of-county Medi-Cal beneficiaries (improved data integrity).
- The overall no-show rates for psychiatrists is 13 percent (16 percent for adults, eight percent for children and FC youth) representing a 48 percent decrease since FY 2018-19. The average no-show rate for clinicians is eight percent (nine percent for adults, and six percent for children and FC youth), indicating a 60 percent decrease since FY 2018-19.

Strengths:

- The current non-clinical PIP is focused on reducing the psychiatric no-show rate; the clinical PIP is focused on reducing the re-hospitalization rate.
- The ten business-day standard for the length of time from initial request to first offered appointment improved from 83 percent in FY 2019-20 to 93 percent in FY 2020-21.

Opportunities for Improvement:

- The percent of first offered psychiatry appointments that meet the 15 business-day standard has increased from nine percent in FY 2019-20 to 15 percent in FY 2020-21; however, it remains well below the timeliness requirements.
- Inclusion of contract provider data in the MHP Assessment of Timely Access (MATA) reports is necessary to provide a full picture of the MHPs status regarding timeliness.

Quality of Care

Changes within the Past Year:

- The MHP collaborated with Kings View to create a CA IP-CANS dashboard that will be unveiled CY 2021.

Strengths:

- Beneficiaries in focus groups reported satisfaction with their services.

Opportunities for Improvement:

- The MHP did not continue the community needs assessment survey since the last EQRO review; it is unclear how the assessment was impacted by COVID-19.
- It would benefit the MHP to expand staff access to Tableau data analytical reports to provide guidance with treatment, aggregate data for system QI, and to inform LOC development.
- It would benefit the MHP to track referrals to MCOs (i.e. 30 and 60-day follow-up) to ensure that individuals do not experience a gap in service.
- The MHP did not complete a QAPI evaluation to ensure that the goals and objectives are reflected in data collection and CQI activities.
- The MHP is recommended to lay out the QAPI and CCC plans with quantifiable goals and objectives, and evaluation of those objectives (outcomes), plus a quarterly review of data.
- CCBHS does not track and trend HEDIS and other national measures.

Beneficiary Outcomes

Changes within the Past Year:

- Clinical line staff have begun to use the PHQ-9 and GAD-7 assessment tools to determine medical necessity and LOC placement.

Strengths:

- Utilization of peer-run programs are regularly reviewed during Calaveras MHAB meetings.

Opportunities for Improvement:

- The MHP reports that discharge CA IP-CANS assessments are not routinely completed.
- It would benefit the MHP to compile and present reports routinely with stakeholders (at least annually) to address potential gaps among subpopulations and identify groups in most need of QI.

Foster Care

Changes within the Past Year:

- CCBHS is currently in the process of working with CWS on a collaborative MOU for AB 2083 (building trauma informed care for FC youth); the MOU will

allow for both agencies to work towards sharing information without a release of information when appropriate.

- The MHP has a total of two county contracted STRTPs (recently contracted with Rite of Passage).

Strengths:

- The FC penetration rate has improved from 51.85 percent in CY 2017 to 59.84 percent in CY 2019; this is considerably higher than other small-rural MHP's average penetration rate of 45.51 percent (CY 2019).

Opportunities for Improvement:

- The MHP does not track psychotropic medication monitoring for FC youth as per SB 1291 requirements.

Information Systems

Changes within the Past Year:

- CCBH provides EHR access to all fee-for-service providers.
- The MHP completed the Medicare certification process; healthcare claims are submitted for reimbursement now.
- The MHP created an improved tracking document to accurately capture timeliness metrics; the user guide is updated.
- CCBH developed a series of robust and dynamic dashboard reports—in collaboration with Kings View (EHR provider)—which provide improved monitoring of services.
- The outcomes module is fully functional in the Cerner primary practice and clinical system.

Strengths:

- CCBH completed a comprehensive Cerner EHR Implementation report, comprised of team feedback (issues and concerns), in collaboration with Kings View (EHR vendor).

Opportunities for Improvement:

- The provider directory is not updated monthly as per DHCS IN 18-020; the directory should be available in English and Spanish.

- Medicare Part B submitted claims do not crossover properly to MediCal; claims crossover directly to MCOs for reimbursement resulting in erroneous payments to the MHP.
- Clinical and functional outcome reports—such as CA IP-CANS and PSC-35 data—are not compiled and shared on a routine basis to inform CQI activities.
- The CSI assessment record is not formatted to capture psychiatry timeliness metrics.

Structure and Operations

Changes within the Past Year:

- CCBH has experienced significant staffing changes related to resignations and leave of absences since the start of COVID-19, including the following vacancies:
    - Two FTE mental health clinicians
    - One case manager
    - One clinical supervisor
    - CCBH Behavioral Health Deputy Director
    - One alcohol/substance abuse counselor
    - Living Room Wellness and Recovery Cabin program coordinator
    - One clinical nurse
    - One CCBH HHSA program coordinator
- CCBH hired a new medical director in July 2020 for the substance abuse program; the director participates in case reviews and verification of medical necessity for beneficiaries receiving substance abuse services.

Strengths:

- CCBH expanded staffing recruitment opportunities since the last EQRO review to include collaboration with local colleges, attending job fairs (prior to COVID-19), and expansion of recruiting websites.
- Approval of psychiatric technician position (currently recruiting) to focus on youth and FC children; the technician works directly with the beneficiaries' psychiatrist.

Opportunities for Improvement:

- Key informant interviews suggest challenges in bi-directional communication between management and line staff that may negatively impact staff retention and burnout.

FY 2020-21 Recommendations

PIP Status

Access to Care

Timeliness of Services

Recommendation 1: Offer initial psychiatry appointments within 15 business days, as per DHCS Mental Health and Substance Use Disorder Services (MHSUDS) IN 18-020.

Quality of Care

Recommendation 2: Ensure the methodology for assigning and coding co-occurring diagnoses is accurate and consistent among all clinicians. Train all staff on methodology, policies, and procedures. Track and review the co-occurring rate at least quarterly *(This is a follow-up recommendation from FY 2019-20.*).

Recommendation 3: Complete an annual evaluation of QAPI work plan activities.

Beneficiary Outcomes

Recommendation 4: Demonstrate practical use and analysis of the data accumulated (aggregated and disaggregated) from the beneficiary outcome tools (i.e. PSC-35, CA IP-CANS, PHQ-9) and report findings to stakeholders (*This recommendation is a follow-up from FY 2015-16, 2017-18, 2018-19 and FY 2019-20*).

Foster Care

Recommendation 5: Track psychotropic medication monitoring for FC youth as per SB 1291 requirements.

Information Systems

Recommendation 6: Complete analysis of the new dashboard performance measure reports to identify needed modifications and to improve quality improvement activities.

Recommendation 7: Resolve incorrect crossover of Medicare claims to MCOs to prevent erroneous payments to the MHP.

Structure and Operations

Recommendation 8: Institute regular meetings with supervisory and line staff as a first step to improving bi-directional communication and as a forum to address growing concerns regarding staff retention and burnout.

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible, such as conducting in-person beneficiary focus groups.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment A—Review Agenda

The following sessions were held during the MHP video conference review, either individually or in combination with other sessions.

Table A1: EQRO Video Conference Review Sessions

Calaveras MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Angela Kozak-Embrey, Quality Reviewer
Leda Frediani, Information Systems Consultant
Marilyn Hillerman, Consumer Family Member Consultant
Steven Cullen, Consumer Family Member Consultant
Valerie Garcia, Consumer Family Member Consultant

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

Sites of MHP Review

n/a

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Alt	Wendy	ASOC Supervisor / Interim Deputy Director	HHSA CCBH
Bitler	Christine	Medical Billing Specialist	HHSA CCBH
Burns	Leeann	Administrative Services Manager	HHSA CCBH
Chua	Ryan	Technical Training Specialist	HHSA CCBH
Dillard	Rolan	CSOC Supervisor	HHSA CCBH
Gonzales	Monique	ASOC Clinician II	HHSA CCBH
Hall	Julie	CSOC Clinician II	HHSA CCBH
Johnson	Dianne	QM Specialist	HHSA CCBH
Meily	Stacey	Program Manager	HHSA CCBH
Mitchem	Heidi	MH Clinic Clinician II	HHSA CCBH
Morch	Margarite	DRC Clinician II	HHSA CCBH
Sells	Susan	MHSA Business Analyst	HHSA CCBH
Stranger	Kristin	HHSA Director	HHSA
Turner	Laurell	Jail Clinician II	HHSA CCBH
Turzai	Jason	Case Manager	HHSA CCBH
Yount	Daryle	CSOC Clinician II	HHSA CCBH

Attachment C—Approved Claims Source Data

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

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

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

Calaveras 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	3,809	275	7.22%	$812,962	$2,956

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

Calaveras 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	887	96.31%	93.31%	$2,757,769	$3,109	$3,998	70.78%	59.06%
>$20K - $30K	18	1.95%	3.20%	$423,372	$23,521	$24,251	10.87%	12.29%
>$30K	16	1.74%	3.49%	$715,009	$44,688	$51,883	18.35%	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
ACB	Approved Claims per Beneficiary
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
CCC	Cultural Competence Committee
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

Acronym	Full Term
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
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

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

Acronym	Full Term
PM (alt)	Partially Met
QI	Quality Improvement
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