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

GLENN MHP DRAFT REPORT

Prepared for:

California Department of Health Care Services (DHCS)

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INTRODUCTION

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

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

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

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

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

MHP Information

MHP Size — Small-Rural

MHP Region — Superior

MHP Location — Willows

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 882

MHP Threshold Language(s) — Spanish

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Network Adequacy

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

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

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

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

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

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

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

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

Status of FY 2019-20 Review of Recommendations

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

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: Title 42, CFR, §438.330 requires two PIPs; the MHP is urged to meet this requirement going forward.

Status: Met

- The MHP has two active PIPS, both a clinical and non-clinical PIP, with active interventions in the current year.

Recommendation 2: The MHP added interventions to its clinical PIP; however, interventions were not beneficiary focused. For multi-year PIPs, a new intervention needs to be included. (This recommendation is a carry-over from FY 2018-19.)

Status: Met

- The training referenced in the Clinical PIP was part of a larger beneficiary-focused intervention, to review Child Adolescent Needs Strengths (CANS-50) scores with beneficiaries as a communication tool as part of the therapeutic process, and to eventually be shared at Child Family Team (CFT) meetings as part of the clinical process.

Recommendation 3: The MHP did consult on occasion with CalEQRO; however, the MHP would have benefited from ongoing consultation with CalEQRO for PIP improvement as well as new PIP development.

Status: Met

- The MHP sought in-depth technical assistance (TA) during the month of July 2020. As a result, their PIPs were amended to meet the needed criteria and qualify as active PIPs. Since then, the MHP has kept in regular contact with CalEQRO to discuss issues that may have an impact on the success of the PIP, including Corona Virus Disease 2019 (COVID-19).

Access Recommendations

Recommendation 4: Evaluate current transportation resources to determine any gaps. Implement a plan to improve identified gaps.

Status: Met

- The MHP is partnering with LogistiCare, a managed care organization, to provide transportation to any Behavioral Health (BH) appointment or event.

- Transportation is managed by the MHP, as LogistiCare has a 4-hour request window that is not always feasible for beneficiaries. The MHP has begun to bill LogistiCare for transportation that the MHP has provided to LogistiCare clients.

Recommendation 5: Evaluate current after-hours care options to determine areas for improvement and/or expansion. Implement a plan to remedy shortfalls.

Status: Met

- Prior to COVID-19, the MHP was in the process of contracting with Sierra Mental Wellness Group (Sierra Wellness) to support after-hours care options. Due to budgetary concerns, the MHP no longer contracts with Sierra Wellness.

- The MHP is covering after-hours crisis response services with its own staff, by utilizing a rotating schedule. Most supervisors and clinical staff cover this work.

- The agreements between the hospitals and emergency rooms (ER) and the MHP have changed. Prior to the change, BH staff had to stay with beneficiaries in crisis until they were placed at another facility for ongoing care. Now, BH staff complete the evaluation and make one round of placement calls before turning over responsibility for the beneficiary to the hospital staff.

Recommendation 6: Perform or access a needs assessment for the local homeless population. Provide outreach and supportive services as identified through the need assessment.

Status: Met

- The MHP contributed to a community needs assessment in partnership with the Community Action Department. The needs assessment resulted in a 10-year plan to end homelessness in Glenn County.
- The plan acknowledged needed services and barriers and laid out a framework for making use of BH's No Place Like Home Mental Health Services Act (MHSA) funds.
- The MHP MHSA Coordinator and the Compliance and Quality Improvement (QI) Manager are now participating in the county's housing committee.

Timeliness Recommendations

Recommendation 7: Track and trend timeliness of assessment follow-up and routine appointments.

Status: Met

- The MHP reports that it tracks timeliness of assessment, medication referrals, and timeliness of urgent response on a quarterly basis and has for some time. Reports are utilized at Quality Improvement Committee (QIC) meetings.
- The MHP recently implemented a process to track follow-up appointment timeliness on a routine basis with the new Client and Service Information (CSI) data reporting requirements. The MHP has not yet formally included this information in its timeliness self-assessment but has tracked the information for program planning and changes.
- The MHP is meeting the requirements of this metric.

Recommendation 8: The MHP must offer a psychiatric appointment within 15 business days. The MHP should comply with the state timeliness metric as per Information Notice (IN) 18-011.

Status: Partially Met

- The MHP has developed a contract with locum tenens to bring on an additional full-time psychiatrist: however, the MHP has not been able to bring the person on board due to COVID-19 restrictions.
- Once the locum tenens person is in place, the MHP expects that there will be a marked improvement in the time to first offered psychiatric appointment which is in line with the State's requirement.

Recommendation 9: Track and trend timeliness of urgent appointments in hours, 48 for those who do not need preauthorization and 96 hours for those requiring preauthorization.

Status: Met

- The MHP does not define urgent appointments any differently than its crisis response, which is a one-hour response time that is tracked and trended. The MHP has a dedicated a day-crisis team who responds to all urgent requests for services, crisis or not, during business hours.
- Services that require preauthorization are authorized immediately upon request rather than according to the 96-hour allowance. Authorization tools are built within the Medi-Cal necessity screening tool so that authorization from a program manager is obtained as soon as services are requested.

Quality Recommendations

Recommendation 10: Track and trend prescribing practices and medication on an aggregate level.

Status: Partially Met

- Medication monitoring is conducted manually on a monthly basis and results are reported quarterly at the QIC. The MHP does not have current capability with its EHR to track medications on an aggregate level short of reviewing each psychiatrist progress note and documenting results manually. The MHP has started discussion with its EHR vendor about using the EHR to note current prescriptions. This would allow the MHP to monitor medications on an aggregate level.

Beneficiary Outcomes Recommendations

Recommendation 11: Research evidence-based practice outcomes tools to consider implementing for adult beneficiaries. (This recommendation is a carry-over from FY 2018-19.)

Status: Met

- The MHP continues to use an in-house Risk and Resiliency tool, as a standardized adult outcome tool has not yet been identified for California MHPs.
- Staff use outcome measures such as the Patient Health Questionnaire (PHQ-9) for depression and the Generalized Anxiety Disorder outcome tool (GAD-7) on an individual basis. These outcome tools can be scanned into the EHR. The MHP is also working on a data dashboard within the EHR for the Risk and Resiliency tool.

Recommendation 12: Implement an evaluation for each staff training to determine the effectiveness and usefulness of training topics (i.e., pre/post training surveys).

Status: Met

- This recommendation was made in error. Staff training evaluation was noted as a strength of the MHP during last year's review. For each training, the MHP tracks and trends pre-test and post-test learning with quantitative chart review outcomes data. During the last fiscal year, the MHP also piloted some pre-test and post-test questionnaires with trainings and plans to make this a standard practice.

Foster Care Recommendations

Recommendation 13: Collaborate and explore consent options with county counsel to develop a consent process that eliminates the delay in accessing treatment.

Status: Met

- Despite the MHP's continued advocacy, Child Welfare Services (CWS) is not agreeable to considering other consent options; however, CWS has since implemented a more streamlined process for obtaining consent from parents when making referrals.

Information Systems Recommendations

Recommendation 14: Conduct periodic chart reviews on dually diagnosed beneficiaries against data reports to assess if the co-occurring under-reporting problem has been rectified.

Status: Met

- The MHP has made substance use diagnosis a standard feedback item with their chart review forms and provide feedbacks to staff when they missed this item or a substance use diagnosis. The MHP is noting when an assessment indicates a referral to substance use services if one was not made. Using their chart review outcomes, they have seen an improvement in this area.

Structure and Operations Recommendations

Recommendation 15: Expand management opportunities for peer employees and incorporate management/supervisory position within career ladder for beneficiaries.

Status: Partially Met

- The MHP indicates that a system is in place. Many of the staff began as peer employees and have moved up the career ladder through case management positions and then on to clinical and supervisor positions. The MHP also supports those with lived experience to attend college at California State University (CSU) Chico's School of Social Work.

- The MHP utilizes the Case Manager III position for those with lived experience to gain supervisory experience. The MHP also offers other leadership opportunities through the Health and Human Services Agency (HHSA) Core Teams.

Recommendation 16: Investigate the potential benefit and need for wellness centers in more rural areas of the county. Where appropriate, develop a plan and timeline for wellness center site expansion.

Status: Met

- Due to budget constraints, the MHP reports that it is not able to open another wellness center. In fact, the MHP reports difficulty maintaining current staffing and the associated costs of the existing wellness center through MHSA, Community Services and Supports (CSS), and Prevention and Early Intervention (PEI) funds. Transportation is provided to the centers and where possible, the MHP assists with transportation.

PERFORMANCE MEASURES

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

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

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

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

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

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

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

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to: screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - 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 nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure

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

Total Beneficiaries Served

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

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

Glenn 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	4,504	35.3%	476	54.0%
Latino/Hispanic	6,765	53.1%	303	34.4%
African-American	85	0.7%	*	n/a
Asian/Pacific Islander	439	3.4%	*	n/a
Native American	250	2.0%	18	2.0%
Other	703	5.5%	57	6.5%
Total	**12,745**	**100%**	**882**	**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.				

During CY 2019, the MHP experienced claims submission delays that resulted in a significant number of claim transactions not being included in the analysis below for CY 2019 results.

Table 2 provides details on beneficiaries served by threshold language.

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

Glenn MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	120	13.6%
Other Languages	762	86.4%
Total	**882**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

Penetration Rates and Approved Claims per Beneficiary

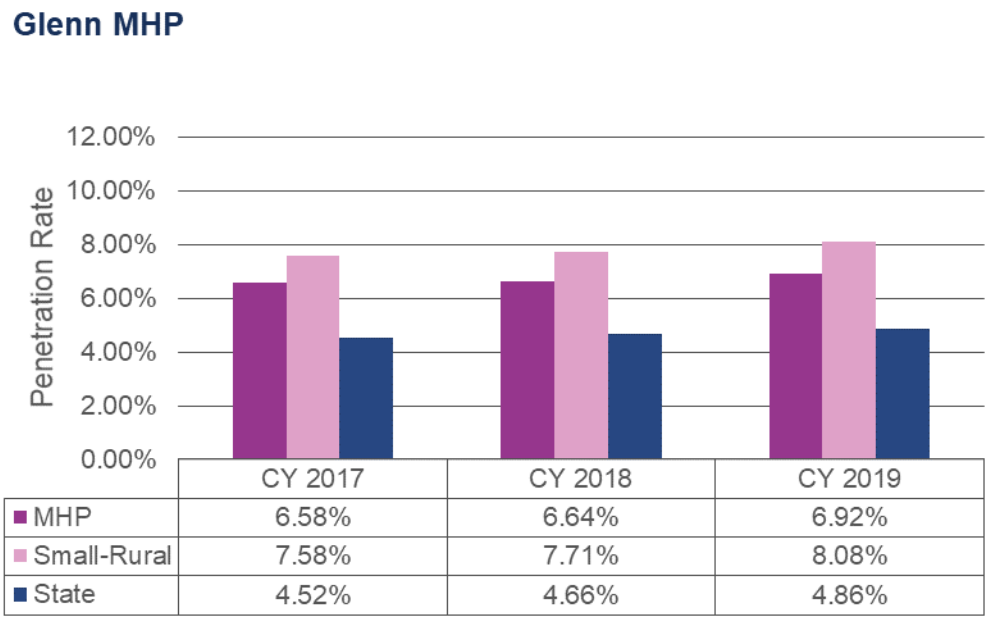
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated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

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

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

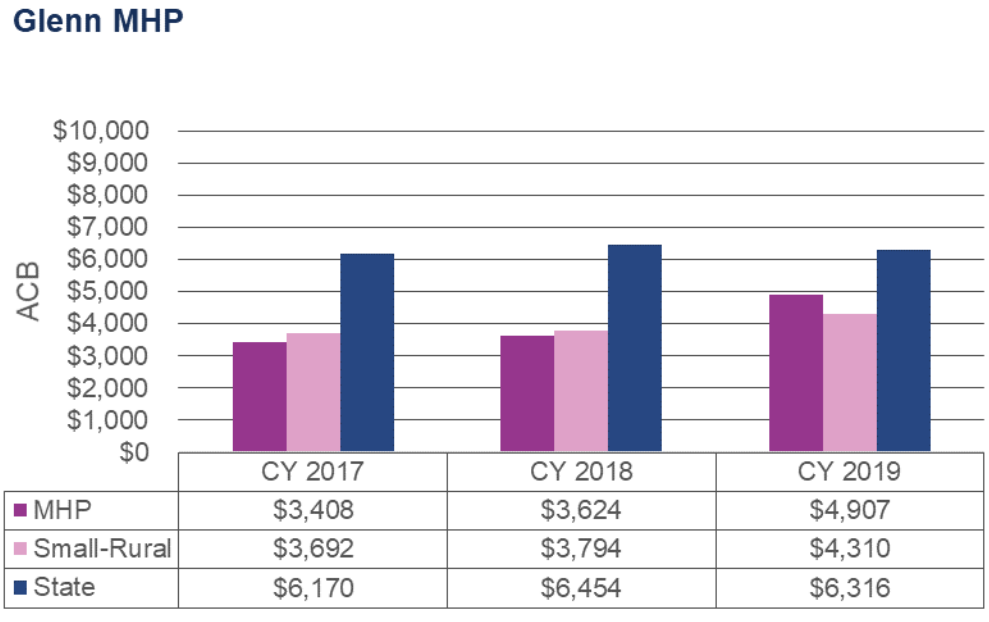
Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	6.58%	6.64%	6.92%
Small-Rural	7.58%	7.71%	8.08%
State	4.52%	4.66%	4.86%

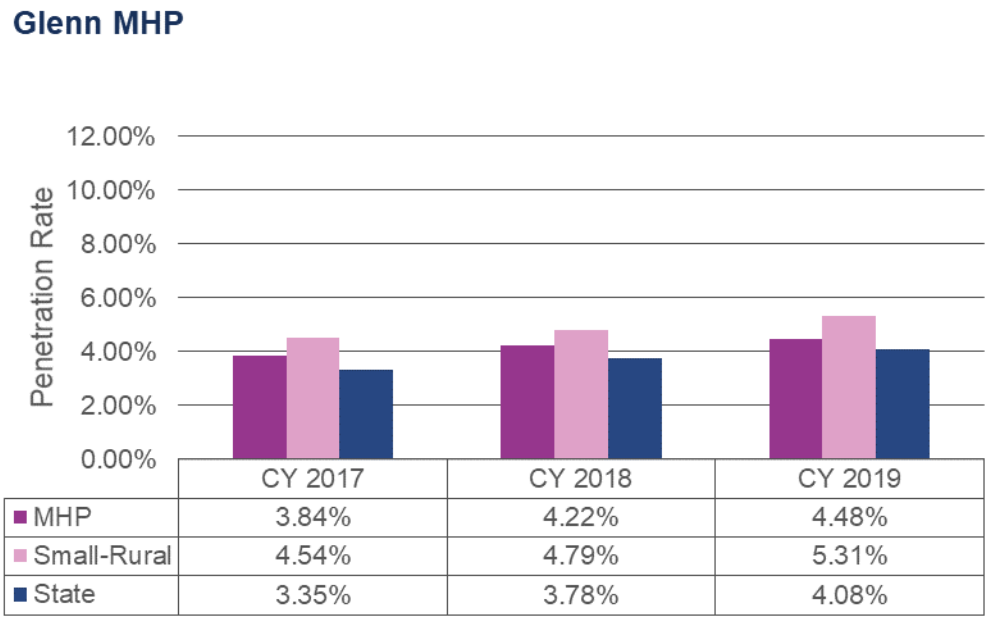
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,408	$3,624	$4,907
Small-Rural	$3,692	$3,794	$4,310
State	$6,170	$6,454	$6,316

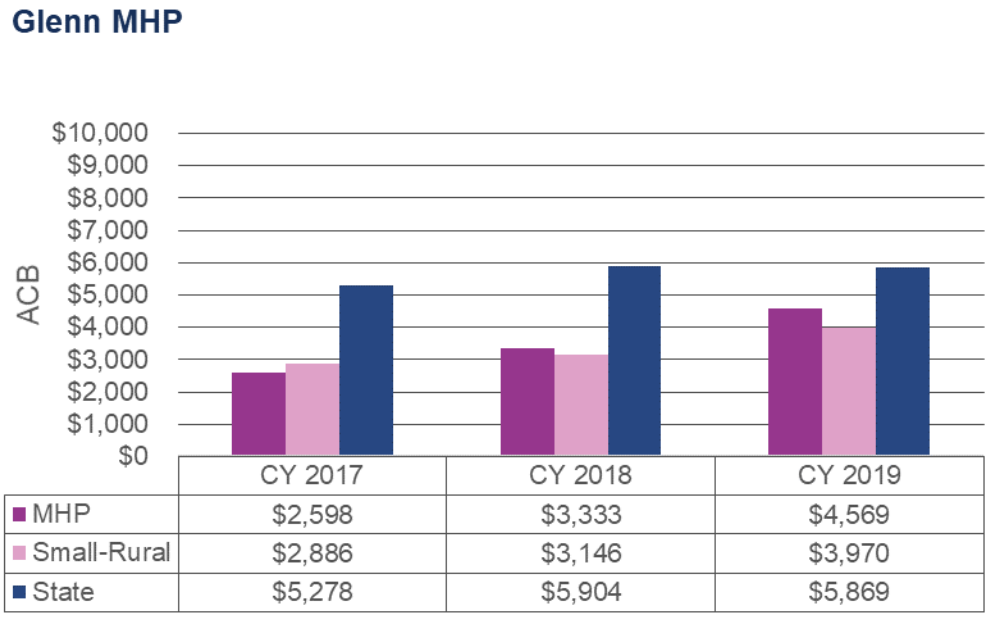
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	3.84%	4.22%	4.48%
Small-Rural	4.54%	4.79%	5.31%
State	3.35%	3.78%	4.08%

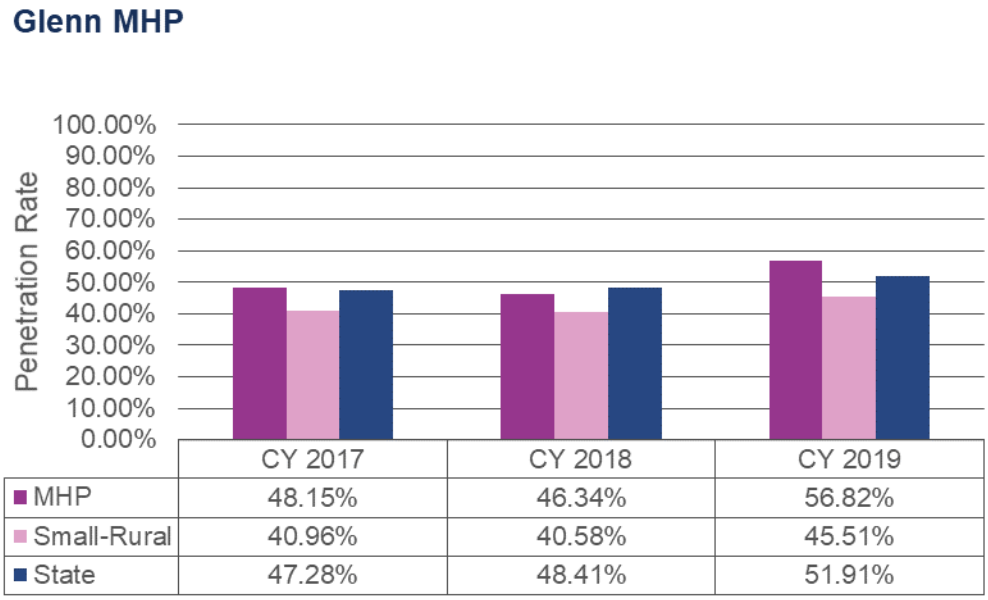
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$2,598	$3,333	$4,569
Small-Rural	$2,886	$3,146	$3,970
State	$5,278	$5,904	$5,869

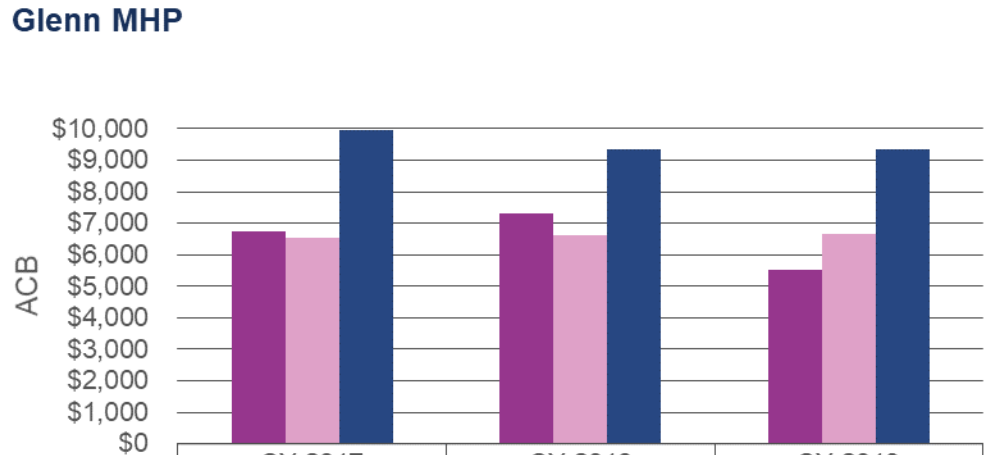
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	48.15%	46.34%	56.82%
Small-Rural	40.96%	40.58%	45.51%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

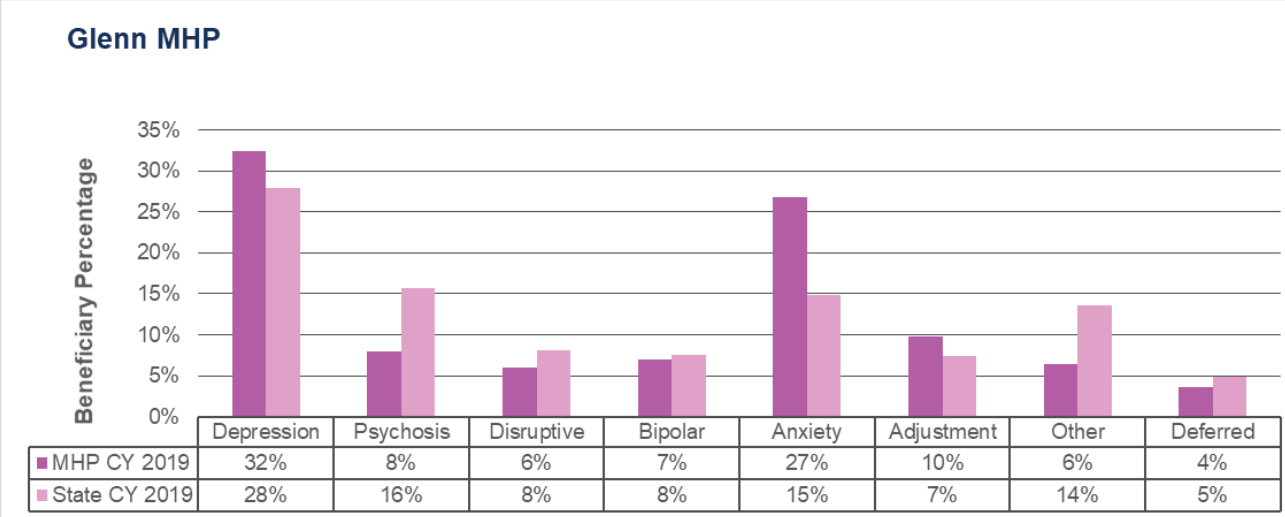


	CY 2017	CY 2018	CY 2019
MHP	$6,723	$7,310	$5,520
Small-Rural	$6,553	$6,630	$6,666
State	$9,962	$9,340	$9,360

Diagnostic Categories

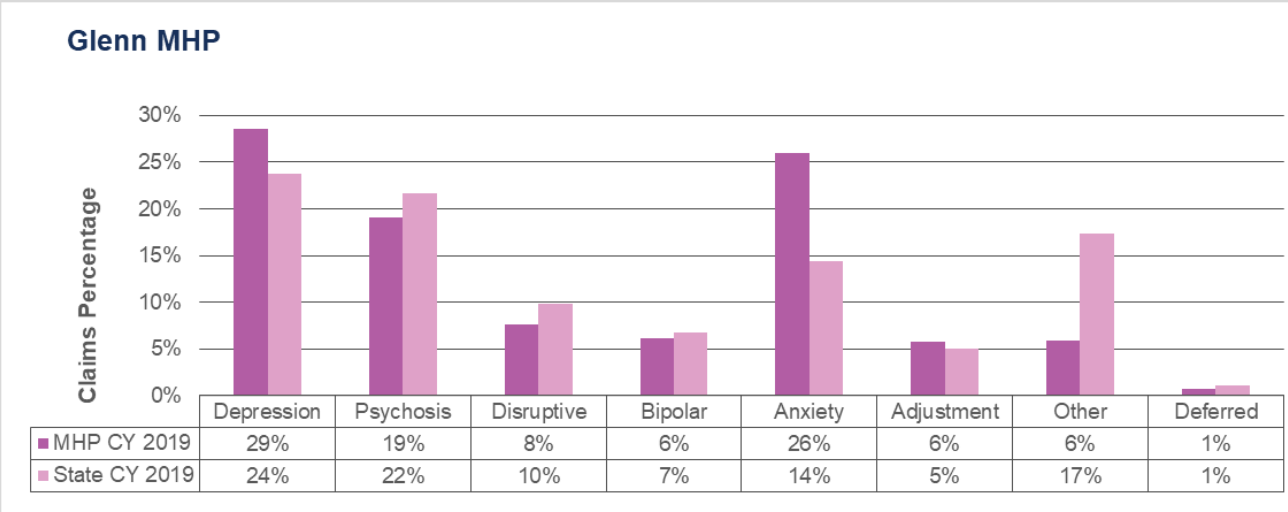
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	32%	8%	6%	7%	27%	10%	6%	4%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

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



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	29%	19%	8%	6%	26%	6%	6%	1%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

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

Table 3: High-Cost Beneficiaries CY 2017-19

Glenn 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	13	882	1.47%	$50,976	$662,690	15.31%
	CY 2018	*	846	n/a	$39,863	-	n/a
	CY 2017	*	842	n/a	$40,032	-	n/a

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

Psychiatric Inpatient Utilization

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

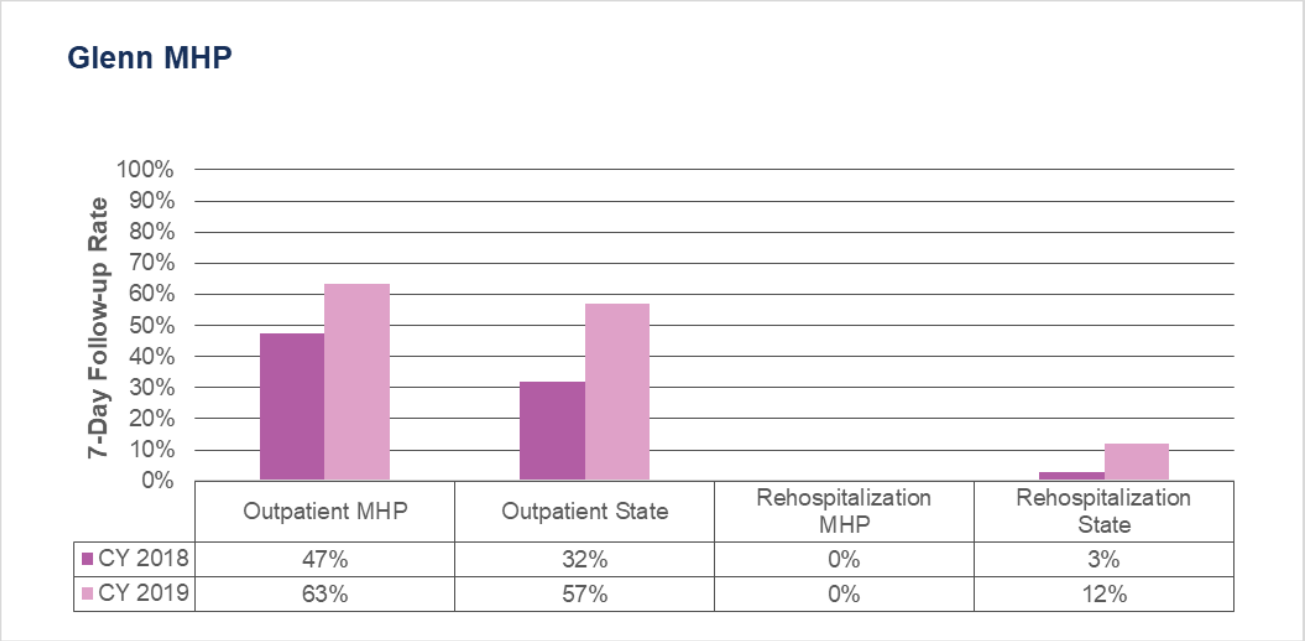
Table 4: Psychiatric Inpatient Utilization CY 2017-19

Glenn 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	44	59	10.71	7.80	$11,578	$10,535	$509,434
CY 2018	36	45	10.88	7.63	$11,426	$9,772	$411,351
CY 2017	36	48	14.38	7.36	$11,344	$9,737	$408,385

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

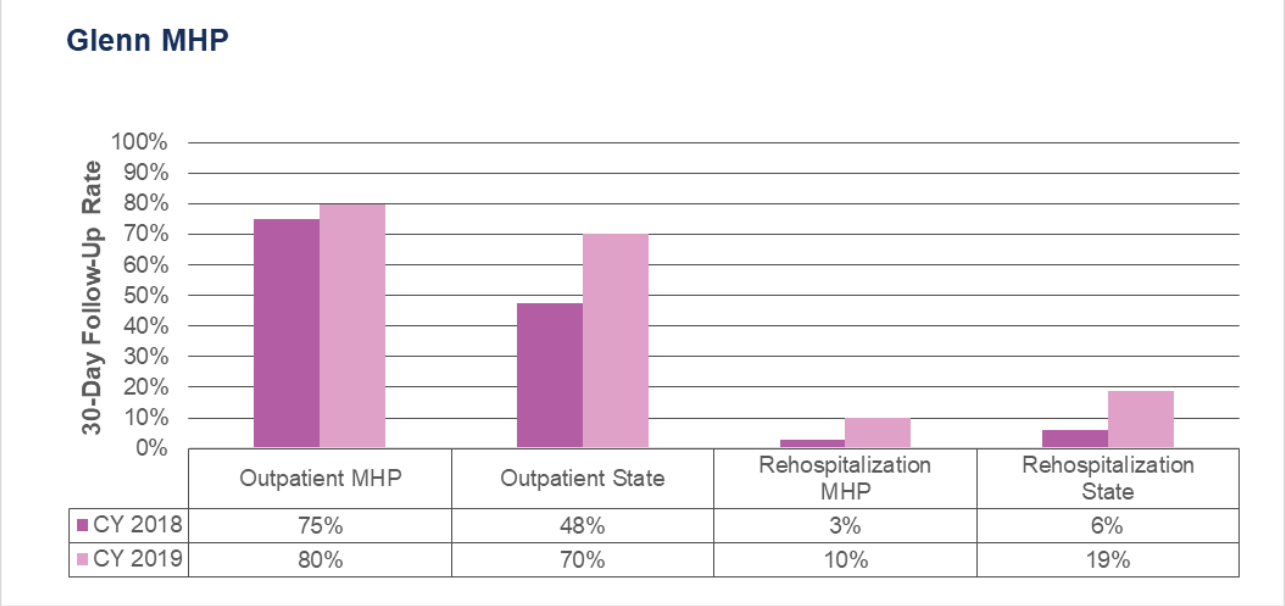
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	47%	32%	0%	3%
CY 2019	63%	57%	0%	12%

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	75%	48%	3%	6%
CY 2019	80%	70%	10%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." CMS' EQR Protocol 3: Validating Performance Improvement Projects mandates that the EQRO validate one clinical and one non-clinical PIP for each MHP that were initiated, underway, or completed during the reporting year, or featured some combination of these three stages.

Glenn 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 Glenn MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Family Functioning
Non-Clinical	1	Access to Mental Health Services at Harmony House

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Glenn
PIP Title	Family Functioning
PIP Aim Statement	Will increasing family engagement, evidenced by at least 32 percent of overall services for children and youth up to age 20 including a family member or significant support person present, improve outcomes for youth clients and their families as evidenced by at least a 10% overall improvement in Family Function scores on the CANS-50?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	

MHP Name	Glenn
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): All children receiving services.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Caregivers and/or support persons are present for the initial treatment planning 2. Implement unit-wide use of the Dyadic Developmental Psychotherapy (DDP) model of psychotherapy 3. Expand telehealth services to increase parent engagement opportunities and access
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Standardize use of CFT meetings 2. Implement unit-wide use of the DDP model of psychotherapy 3. Expand telehealth services to increase parent engagement opportunities and access
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 Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percent of services for children and youth (ages 0- 20) that include a family member or other support person present	June 2019	Services that include a family member or other support person present. 2,008 / 7,122= 28.2%	March 2020	2,319 / 6,845= 33.9%	☒ Yes ☐ No 20.2%	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of Collateral services delivered to children and youth (ages 0-20)	June 2019	Number of collateral services 314 / 7,122=4.4%	March 2020	417 / 6,845= 6.1%	☒ Yes ☐ No 38.6%	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of children and youth with a score of 2 or more who improved their score on the Family Functioning section of the CANS-50	June 2019	Number of improved Family Functioning Scores on CANS-50 6 / 26= 23.1%	March 2020	20 / 83 = 24.1%	☒ Yes ☐ No 4.3%	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Was the PIP validated?				☒ Yes ☐ No		
Validation phase: ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): Recently completed.						
Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: • Meet regularly with CalEQRO for TA for development of new PIPs. • For its next PIP, the MHP should develop a methodology which ensures the integrity of the data and the accuracy of the analysis and conclusions drawn.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Monthly call with MHP is currently being scheduled.						

*PIP is in planning and implementation phase if NA is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Glenn
PIP Title	Access to Mental Health Services at Harmony House
PIP Aim Statement	Will improving outreach, engagement, and referral to specialty mental health services for persons attending Harmony House improve access to mental health services as evidenced by at least 60 percent of persons attending Harmony House being open to mental health services?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): Adults attending Harmony House	

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

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Harmony House Peer Coach staff to make mental health referrals directly. 2. Warm handoff process/appointment attendance.

PIP Interventions (Changes tested in the PIP)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 3. Peer Coach staff assesses and track consumer housing. 4. Coaches call to schedule an initial assessment appointment.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): N/A

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percent of persons accessing Harmony House who are also receiving mental health services	June 2019	56 / 110= 50.9%	March 2020	274 / 456= 60.1%	☒ Yes ☐ No 18.1%	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of consumers experiencing Homelessness who attend Harmony House and are receiving mental health services	June 2019	9 / 19= 47.4%	March 2020	19 / 38= 50%	☒ Yes ☐ No 5.5%	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
						(specify):
Percent of persons attending the drop-in center who are referred by Harmony House staff and are opened to mental health services	June 2019	0 / 0= 0%	March 2020	15 / 17= 88.2%	☒ Yes ☐ No 100%+	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Was the PIP validated?				☒ Yes	☐ No	
Validation phase: ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): Recently completed. March 2020.						
Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence						

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: • Meet regularly with CalEQRO for TA for development of new PIPs. • Going forward, PIPs should be developed using statistical analysis and include methodology for interrater reliability.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Monthly call with MHP is currently being scheduled.						

*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 site review.

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

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Glenn	3.88%	3.62%	4.42%	2.85%
Small-rural MHP Group	N/A	5.26%	4.17%	3.92%
Statewide	N/A	3.58%	3.35%	3.34%

- After three consecutive years of growth, the budget for the current FY decreased and is now less than the Small-rural MHP Group.
- The change in budget from FY 2019-20 to 2020-21 was due to the following factors:
    - The MHP paid a down payment for the Millennium EHR product upgrade in FY 2019-20. Since this product is no longer being pursued by the EHR vendor, Kings View, the MHP has stopped payments and will apply payments already made to the future product they select..
    - FY 2019-20 included a slight increase in the budget for the Kings View ASP contract.

- The MHP believes that the FY 2019-20 budget amount mistakenly includes the Kings View psychiatric services contract amount.
- Collectively, these factors would have contributed to a much higher budget amount in FY 2019-20, which was corrected/reduced for FY 2020-21.

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

- County IT department is responsible for system and network security.
- Kings View provides ASP model support but does not host the system.
- There is no formal training on cyber resiliency to address potential compromise situations; however, the IT department sends out informational emails about how to avoid malware or other potentially harmful cyber transactions.

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	91.03%
Contract providers	8.97%
Network providers	0%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

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

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	.54	0	0	0
2019-20	2	0	0	0
2018-19	2	0	0	0

- MHP indicated that their previous counts were inflating the FTEs. The MHP corrected their methodology in the current EQR. All IT FTEs are partial FTEs from several people.

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	.5	0	0	0
2019-20	8	0	0	0
2018-19	7	1	0	0

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

- MHP shared that their previous counts were inflating the FTE. The MHP corrected their method for the current EQR. IT FTEs are all partial FTE from several people.

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	24	0	24
Clinical Healthcare Professional	51	2	53
Clinical Peer Specialist	0	0	0
Quality Improvement	4	0	4
Total	79	2	81

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)	.54	2.16
Total EHR Users Supported by IT (Source: Table 17)	81	42.00
Ratio of IT Staff to EHR Users	1:150	1:19

Table 19: Additional Information on EHR User Support

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

Table 20: New Users' EHR Support

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

- Contract Provider, Youth for Change deploys Local Super Users.
- Staff telehealth trainings are provided, through Relias, some of which had in-depth sections on confidentiality.

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

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	6
Number of county-operated telehealth sites	6
Number of contract providers' telehealth sites	0
Total number of beneficiaries served via telehealth during the last 12 months	369
• Adults	202
• Children/Youth	154
• Older Adults	13
Total Number of telehealth encounters (services) provided during the last 12 months:	1521

- For telehealth security the MHP purchased HIPAA certified Zoom accounts and promoted the use of Doxy.me (a free web-based HIPAA compliant telehealth application).
- All telehealth is being conducted on county-owned equipment which is programmed with all standard electronic data safeguards that the MHP uses.
- A contract exists between the MHP and Kings View to provide psychiatrists who work at MHP locations in the provision of telehealth. The services are provided and recorded at MHP sites and are included above.

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

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

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

- The MHP and the county are in the process of purchasing Wi-Fi to put in a trailer by the Native American reservation to promote technology access in that area. The Office of Education is partnering with the MHP on this project.
- Youth beneficiaries are having a harder time adopting to the new methods of service delivery.
- Several offices have been opened for the use of beneficiaries who do not have technology access. Ten smart phones were purchased and distributed to beneficiaries.
- Purchase of additional Zoom licenses is in process, both to expand telehealth services and for the anticipated longer period of use.
- Staff are using creative ideas to "see" their clients. The staff member who works with conservatees calls the beneficiary and has them take their phone outside to "walk" together while they have their session.

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
Not applicable.	

Current MHP Operations

- The MHP uses CCBH as its EHR with Promotion 230.1.
- The MHP is focused on reviewing meds-only beneficiaries for potential step-down. They would be referred to the FQHC, which would relieve the overall service delivery system.
- The MHP is expanding telehealth in response to COVID-19 restrictions. The MHP was providing telepsychiatry only services prior to COVID-19. With the onset of COVID-19 all outpatient services are being provided via telehealth or telephone.

- The MHP is implementing claiming changes related to COVID-19 and telehealth which has added a significant burden to staff involved in the process. New service coding, new modifiers and new rates have all had to be updated. Due to these changes, the department has been unable to complete all of these changes in order resubmit their March 2020 replacement claim.

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	8	Cerner

The MHP's Priorities for the Coming Year

- Continue to assess the need to further improve client access through telehealth services and increase IT resources as needed.
- Continue to develop Data Dashboards, among them: Billing by Payor and Timeliness to Service.
- Create an EHR Contact Log.
- Review new EHR systems.

Major Changes since Prior Year

- The MHP worked diligently to improve telehealth services. IT support allows staff to work from home and engage with community members and partners. There have been significant investments in technological resources to provide expanded telehealth service for the beneficiaries.
- The MHP is teleconferencing all outpatient services as a result of COVID 19 pandemic.

- The MHP implemented geo-mapping.
- The MHP implemented CSI Timeliness Reporting.
- The MHP developed CANS-50 reports.
- Children's Services moved to co-locate with CWS as part of the HHSA Integration and Management Plan.

Other Areas for Improvement

- There is a lack of IT and data analytical staff and resources to support the system.
- Much of the equipment deployed to staff are displaying frequent issues with connectivity and communication, which also affects Zoom connectivity.
- The online Provider Directory shortly before the review was outdated and should be updated per DHCS information Notice 2018-020, which requires it be updated at least monthly. The directory was updated shortly after the review.

Plans for Information Systems Change

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

MHP EHR Status

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

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts		☐	☐	☒	☐
Assessments	CCBH	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/ Storage	CCBH	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	CCBH	☒	☐	☐	☐
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service	CCBH	☒	☐	☐	☐
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:		8	0	4	0
FY 2019-20 Summary Totals for EHR Functionality:		8	1	3	0
FY 2018-19 Summary Totals for EHR Functionality:		8	1	3	0

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

- Installing Alerts, through Millennium, was part of the plan in last year's implementation plan. As a result of Kings View halting Millennium project the Alert functionality was discontinued.

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%	N/A
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	N/A
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	N/A
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 HER system	2%	Monthly
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	8%	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 providers to the MHP.

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

EHR Vendor	Product	Count of Providers Supported
Netsmart	Avatar	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

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 your EHR system, supported by Vendor or ASP Staff
- ☐ Web-based application, supported by DMC-ODS or DMC staff
- ☐ Local SQL Database, supported by DMC-ODS/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

Glenn MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**15,303**	**$5,080,997**	**134**	**$50,836**	**0.99%**	**$5,030,161**	**$4,222,091**
JAN19	1,186	$342,732	11	$2,390	0.69%	$340,342	$246,785
FEB19	1,065	$297,108	1	$82	0.03%	$297,026	$214,298
MAR19	1,277	$413,441	3	$1,184	0.29%	$412,257	$307,249
APR19	1,335	$448,972	16	$5,226	1.15%	$443,746	$325,782
MAY19	1,343	$451,165	25	$7,527	1.64%	$443,638	$324,691
JUN19	1,035	$337,876	9	$2,554	0.75%	$335,322	$244,092
JUL19	1,290	$444,600	13	$12,069	2.64%	$432,531	$384,996
AUG19	2,523	$834,711	16	$5,436	0.65%	$829,275	$775,889
SEP19	1,150	$437,943	11	$4,474	1.01%	$433,469	$404,937
OCT19	1,333	$474,254	29	$9,893	2.04%	$464,361	$429,606
NOV19	908	$318,979	0	$0	0.00%	$318,979	$300,931
DEC19	858	$279,215	0	$0	0.00%	$279,215	$262,835

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.**

During CY 2019 the MHP experienced claims submission delays which resulted in number of claim transactions for November and December not being included in table 29 results.

Table 30 summarizes the top five reasons for claim denial.

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

Glenn MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible.	89	$25,413	50%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	9	$10,604	21%
Medicare or Other Health Coverage must be billed before submission of claim.	25	$9,459	19%
Beneficiary not eligible or non-covered charges.	2	$2,372	5%
NPI, Type 2 credentialing data missing, incomplete, or invalid.	4	$2,104	4%
Total	134	$50,836	NA
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

- Denied claim transactions with denial reason description “NPI, Type 2 credentialing data missing, incomplete, or invalid” and “Medicare or Other Health Coverage must be billed before submission of claim” are generally re-billable with 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 Network Adequacy as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

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

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

Review of Documents

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

Review Sessions

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

Findings

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

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

Not applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHPs 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	0
NPI Type 1 number reported is associated with two or more providers	0
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	0

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	0

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

CFM Focus Group One

Table 32 : Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested both a culturally diverse group of adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months and a culturally diverse group of parents/caregivers of child/youth beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. Working in collaboration with the MHP, CalEQRO decided to combine the groups. The group was consistent with that requested by CalEQRO, who are English-speaking beneficiaries and family members. The group was held via Zoom video conferencing.
Total number of participants	Seven
Number of participants who initiated services during the previous 12 months	Four

Topic	Description
Interpreter used	No
Summary of the main findings of the focus group:	
Access - new beneficiaries	All beneficiaries were referred through traditional channels: wellness centers, community-based organizations, self-referral and probation.
Access – overall	All beneficiaries had positive experiences.
Timeliness	All beneficiaries reported minimal wait times.
Urgent care and resource support	Participants were aware of how to access care after-hours.
Quality	Participants were not aware of the QIC or opportunities to participate in ongoing QI activities. All were interested.
Peer employment	Participants did not provide information on employment.
Structure and operations	Beneficiaries had not participated on committees but would like to, as above.
Recommendations from this focus group	• Open Harmony House in-person or by Zoom video conference. • Offer Zoom therapy/groups. • Increase the number of places to get sober/clean and offer more beds in the existing places, especially for younger people. • Increase collaboration between domestic violence shelters, alcohol and drug treatment services and the MHP; coordinate care for all three issues. • Hold an anti-stigma campaign for MH and SUD to reduce shame in getting help.
Any best practices or innovations (optional)	• None noted.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

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

Access to Care

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

Table 33: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
The MHP provides information on accessing services and transportation on its website. The MHP's website is reasonably functional, however, the cover-page does not have a direct link to Behavioral Health (BH) but rather, access is gained through departments and then to BH. The BH main page has links to its 24-hour crisis line, its welcome line during business hours, and links to many other services, including information on COVID-19. The MHP provides some transportation on its own as well as working with LogistiCare. Both the online and printable provider directory is available in English and Spanish and provide information on other languages spoken. Pamphlets and other resources are available on the website in both English and Spanish. CalEQRO was unable to verify on-site the presence of brochures, flyers and other information at the main office; however, the MHP reports that it does provide			

Component		Maximum Possible	MHP Score
information in this way, as well as at the adult drop-in center at Harmony House and the Transition Age Youth (TAY) Wellness Center.			
1B	Capacity Management	10	10
The MHP runs reports annually of all services to ascertain the needs for the coming year and to set goals. Caseloads fluctuate between 15-30 depending on the clinician's department and the severity of symptoms. Productivity is set at 70 percent. In March 2020, the MHP hired a clinician who speaks Hmong. The MHP has several initiatives to expand/improve access. In collaboration with the Office of Education, the MHP is installing a trailer with Wi-Fi service near the Native American reservation to allow better Wi-Fi access in that area. The MHP developed a system to provide Wellness Team meetings to adult Full-Service Partnership (FSP) consumers with intensive needs and have expanded this to include Substance Use Disorder Services (SUDs) clients with complex needs. Prior to COVID–19, the MHP was contracted with Sierra Wellness and prepared to contract out after-hours crisis services to better support staff. Due to budget concerns, the MHP no longer contracts with Sierra Wellness. The MHP re-organized the day-crisis team and began the roll-out of an Innovation program – Crisis Response and Community Connections.			
1C	Integration and Collaboration	24	20
The MHP maintains several relationships within the community to facilitate beneficiary access to services. The MHP has a new agreement with the local hospital for beneficiaries in crisis. Prior terms required that a BH staff person remain with the beneficiary until a successful transfer to another facility was made. The current agreement, because of COVID-19 and the availability of telehealth, is that BH staff complete the crisis evaluation of the individual and make the first round of calls for placements; thereafter, the hospital/ER continues placement efforts. Other approaches to integration include collocating children's services with Child Welfare Services, working with the Office of Education on a suicide prevention campaign, and a partnership with community agencies to address homelessness. Being part of a superagency and in the wake of COVID-19, the MHP frequently works closely with HHSA and Public Health. Information on work with faith-based organizations and the Department of Rehabilitation was not provided.			

Timeliness of Services

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

Table 34: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	16
The MHP reports the average length of time from first request to first offered assessment services as 5.7 days overall, 5.2 days for adults, 6.6 days for children and 8.2 days for FC youth. The standard of 10 business days is met 91.4 percent overall, 94.1 percent for adults, 87 percent for children and 71 percent for FC. The MHP reports the average length of time from first request to first kept appointment as 8.5 days overall, 7.5 days for adults, 9.7 days for children and 9.4 days for FC youth. The standard of 10 business days is met 73 percent overall, 79.6 percent for adults, 64.1 percent for children and 60 percent for FC. The MHP reports that the process for consent for FC youth is a timeliness barrier.			
2B	First Offered Psychiatry Appointment	12	10
The MHP reports the average length of time from first request for first offered psychiatry services as 16.9 days overall, 17.1 days for adults, 16.2 days for children and 15 days for FC youth. The standard of 15 business days is met 51.1 percent overall, 51.1 percent for adults, 51.5 percent for children and 66.7 percent for FC.			
2C	Timely Appointments for Urgent Conditions	18	14
The MHP reports that it defines all urgent appointments as crisis appointments and that all are seen within 48 hours.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	6
Of the 85 hospital admissions and discharges, there were 70 with follow-up appointments within 7 days. 95.9 percent of the post-hospitalization appointments fall within seven days. The MHP obtains hospitalization data for out of county hospitals (85 admissions) and counts in-county follow-up services only (70 discharges). The disposition of the remaining 15 is unknown. The MHP indicated that they only count psychiatric discharges when the beneficiary has made a follow up appointment rather than counting all psychiatric discharges as			

Component		Maximum Possible	MHP Score
the denominator to determine the percentage of appointments which meet the standard.			
2E	Psychiatric Inpatient Rehospitalizations	6	3
Of the 85 hospitalizations, seven were readmitted within 30 days, equaling a rate of 8.2 percent.			
2F	Tracks and Trends No-Shows	10	6
For psychiatrists, the MHP reports a no-show rate of 14.5 percent with a standard of 10 percent. For clinicians, the no-show rate is 11.3 percent with a standard of 10 percent.			

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 annual report of all services is used to conduct analysis on cultural, ethnic, racial, and linguistic needs and identify gaps in service. The Cultural Competence Committee (CCC) and Ethnic Services Committee meet regularly. Currently, communication centers around COVID-19 and having a larger online presence. The MHP uses social media having both a Spanish and an English page to convey information about services and its wellness centers - Harmony House and TAY. The MHP has a staff member whose role is media integration and to monitor content for advertising and outreach. The MHP also has Spanish-speaking staff who provide services to Spanish-speaking beneficiaries.			

Component		Maximum Possible	MHP Score
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
The MHP uses built-in screenings on its medical necessity form to look at intensity of symptoms and function. Each week, cases are evaluated and assigned to staff based on need, insurance and availability of staffing. Outcome tools like the CANS-50 are provided formally at intake and every 6 months. For children, CFTs are held every 90 days. Adults are evaluated using the Risk and Resiliency tool at assessment and annual treatment plan updates. Spanish-speaking clients are provided Spanish-speaking service providers.			
3C	Quality Improvement Plan	10	10
The MHP completes a QI workplan with the previous year's findings. Goals are measurable and contain objectives. The plan includes an analysis of disparities in services and identifies underserved populations. QIC minutes were provided.			
3D	Quality Management Structure	14	12
The QIC meets quarterly. Monthly, the MHP holds system improvement meetings. The MHP will attend the peer drop-in center for beneficiary feedback. The QIC could benefit from regular peer attendance at meetings related to quality improvement. The MHP has two active PIPs.			
3E	QM Reports Act as a Change Agent in the System	10	8
The QIC meets quarterly and every month the MHP holds system improvement meetings. The QI workplan is revised quarterly and the MHP reviews service delivery goals, PIPs, chart review summaries, analysis of all grievances, appeals, medication monitoring, and provider analysis. The MHP has not adopted a formal change management practice.			
3F	Medication Management	12	5
The MHP does not formally track Healthcare Effectiveness Data and Information Set (HEDIS) or other national measures. Metabolic monitoring in general is performed by Public Health. A Child Welfare nurse is performing metabolic monitoring. Medication monitoring is performed by a pharmacist every two weeks, five to seven charts each time. Telehealth is provided through Kings View.			

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	16
The MHP uses the CANS-50 and Pediatric Symptom PSC-35 outcome tools for children and the Risk and Resilience report for adults. The outcome tools are administered at assessment and at six months (for the children's tools) and annually during treatment plan update. Data for these tools is aggregated allowing for both individual treatment planning and program evaluation.			
4B	Beneficiary Perceptions	10	10
The MHP obtains beneficiary feedback through the Consumer Perception Survey (CPS), the MHSA stakeholder feedback process, and its own targeted surveys. Results are posted on the MHP's website and discussed at the MH Advisory Board meeting.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	10
There are two peer-driven wellness and recovery centers located in Glenn County - Harmony House, an adult drop-in center, and the TAY Center. Both centers are temporarily closed due to COVID-19. Before the closure, the centers both offered wellness and recovery programming and with peer involvement in program planning and delivery. Currently, outreach is provided to beneficiaries through social media, drive-by drop-offs of information packets, activity packets and increased calls from case managers. TAY has been able to stay connected through online videos and text.			

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	28
The MHP provides a variety of services including mental health services, medication support services and case management. Crisis intervention is available through children's service or adult service teams. Crisis residential is through Willow Glenn and Yuba City Sequoia. The MHP utilizes two adult residential treatment facilities, through a contract with North Valley Behavioral Health, Restpad, Shasta Regional, Sierra Vista and Woodland Memorial. The MHP does not have Therapeutic Foster Care (TFC), but they are working with the local foster family agency to develop TFC.			
5B	Network Enhancements	18	18
The MHP utilizes Kings View for telehealth. There are two wellness centers; however, they are currently closed due to COVID-19. The MHP is working on the Whole Person Care project with HHSA as well as having an MOU with the Indian Health Center.			
5C	Subcontracts/Contract Providers	16	11
The MHP has very few contractors who provide direct service in-county. County-operated clinics provide 91.03 percent of services. Contract Providers (CBOs) provide 8.97 percent of services. Contract providers include Youth for Change out of Butte County and Kings View for psychiatry.			
5D	Stakeholder Engagement	12	12
Staff report that they are included in discussions which result in program change and that communication is bidirectional. The MHP meets with its contractors as well as beneficiaries to receive feedback, primarily through the MHSA process. Beneficiaries feel included and that there is an open-door policy for exchange of information. Beneficiaries and family members are able to provide feedback through Consumer Voice meetings at Harmony House.			
5E	Peer Employment	8	6
The MHP works with peer employees to return to college and obtain degrees the allow them to compete for higher level positions.			

SUMMARY OF FINDINGS

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

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Completed

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- The MHP no longer contracts with Sierra Wellness for after-hours crisis services.
- The MHP improved the process of scheduling interpretation services by providing schedulers an availability calendar of Spanish-speaking staff.

Strengths:

- The MHP expanded the Ethnic Services Committee to include a newly hired Hmong-speaking clinician.
- Crisis coverage is provided on a rotating basis after-hours and by a day-crisis team during business hours.

Opportunities for Improvement:

- A Locum Tenens contract was developed for one full-time additional psychiatrist; however, the MHP has not been able to on-board the hire.

Timeliness of Services

Changes within the Past Year:

- The MHP began utilizing a text service to remind beneficiaries and confirm telepsychiatry and initial intake appointments.

Strengths:

- CSI Timeliness tracking and reporting were implemented along with geo-mapping.

Opportunities for Improvement:

- For hospital discharge follow-up appointments, the MHP counts only discharged clients who have a follow-up appointment. Beneficiaries who did not receive a follow-up service are excluded.
- For timeliness of first offered psychiatry appointments, overall, 51.1 percent of appointments meet the 15-business day standard.

Quality of Care

Changes within the Past Year:

- The MHP trained all new staff and many community partners in Dyadic Developmental Psychotherapy, an evidenced-based practice.
- In July 2020, the MHP reinstituted multidisciplinary team (MDT) meetings with the goal of making sure each beneficiary is receiving all services for which they are entitled.

Strengths:

- Of the 16 FY 2019-20 recommendations, 13 were “Met” and the remaining three were “partially met.”
- In July 2019, the MHP provided secondary trauma training to staff and began joint BH/CWS meetings to address secondary trauma and to improve collaboration between departments.

Opportunities for Improvement:

- The MHP does not formally track HEDIS or other national measures.
- QIC meetings do not have regular peer attendance or representation.

Beneficiary Outcomes

Changes within the Past Year:

- In February 2020, the MHP began aggregated data reporting for the CANS-50.

Strengths:

- The MHP aggregates data from its adult and children's outcome tools for program and system evaluation.
- There are two peer-driven wellness and recovery centers located in Glenn County - Harmony House, an adult drop-in center, and the TAY Center.

Opportunities for Improvement:

- Although there are two peer-driven wellness and recovery centers, they are currently closed due to COVID-19, leaving a significant gap in peer connection.

Foster Care

Changes within the Past Year:

- The MHP had initiated the process to contract with Redwood Children Services for TFC homes; however, due to budget constraints and economic downturn associated with COVID-19, the MHP put this contract on hold.

Strengths:

- Glenn County Mental Health currently partners with a FC Public Health nurse. Through this collaboration they track and discuss trends regarding FC who are prescribed Attention-deficit/hyperactivity disorder (ADHD) and psychotropic medication.
- Through its collaboration with the FC Public Health nurse, the MHP receives information on metabolic monitoring, bloodwork, and other lab tests. A pharmacist reviews the associated FC charts.

Opportunities for Improvement:

- The MHP is now reviewing options to provide TFC in-house utilizing Glenn county's resource family agency unit.

Information Systems

Changes within the Past Year:

- COVID-19 triggered a system-wide change with services now being provided via telehealth and staff working from home.
- The MHP developed a CANS-50 dashboard and related reports.
- The MHP is also in the process of developing a dashboard for the Risk and Resiliency adult outcome tool.

Strengths:

- The MHP invested in technology to provide expanded telehealth service.

Opportunities for Improvement:

- Additional IT and data analytical staff and resources are needed.
- The MHP should ensure that the online Provider Directory is updated per DHCS information Notice 2018-020, which requires it be updated at least monthly.

Structure and Operations

Changes within the Past Year:

- In March 2020, the MHP co-located Children's Services, Child Welfare, CalWORKs and Eligibility staff in the new Children System of Care Building.
- Adult MH staff are now housed back with TLC staff and SUDS.
- The MHP re-organized the day crisis team and began the roll out of the new Innovation program, Crisis Response and Community Connection.
- All Case Managers were trained to administer the CANS-50.
- A Case Manager was assigned to work half-time in probation doing assessments and providing intensive services for the AB109 population.

Strengths

- The MHP increased housing resources with MHSA housing funds to purchase a bed at a crisis residential unit, at an emergency shelter and pay for housing costs for beneficiaries with co-occurring disorders.
- Since the original COVID-19 shut-down, several offices have reopened for beneficiaries to access technology Behavioral Health appointments. The MHP also purchased ten smart phones for beneficiaries.

Opportunities for Improvement:

- Staff report frequent challenges with connectivity and communication when using telehealth equipment, including during Zoom sessions.
- There is a need for additional IT staff, either temporary or permanent, to install and maintain existing and new equipment especially as it relates to field service and connectivity.

FY 2020-21 Recommendations

PIP Status

None.

Access to Care

Recommendation 1: Finalize the Locum Tenens contract and onboard the new psychiatrist as soon as reasonably possible.

Timeliness of Services

Recommendation 2: When calculating the timeliness of follow-up appointments for post-hospital discharge appointments, include all discharged beneficiaries.

Recommendation 3: Offer a psychiatric appointment within the 15-business day standard identified in DHCS Information Notice 18-011. (*This is a carry-over or follow-up recommendation from FY 2018-19.*)

Quality of Care

Recommendation 4: Develop a mechanism or process to track HEDIS or other national measures for Glenn County beneficiaries, including metabolic monitoring (e.g., regular review of Public Health reports or other collaboration.)

Recommendation 5: Obtain beneficiary attendance and ongoing involvement in the QIC through outreach and invitations to provide feedback.

Beneficiary Outcomes

Recommendation 6: Wherever possible, support beneficiary and peer efforts to replace connections that were made at the wellness centers (e.g., offer video conferencing groups or host socially distanced wellness and recovery events, as permitted by the State and social distancing orders.)

Foster Care

Recommendation 7: Further develop local options for the provision of Therapeutic Foster Care (TFC) in partnership with the local resource family agency and include a timeline for implementation.

Information Systems

Recommendation 8: Review all deployed equipment related to telehealth and COVID-19 for replacement or rehabilitation.

Recommendation 9: Hire additional IT staff, either temporary or permanent, to install and maintain existing and new equipment, especially as it relates to field service and connectivity.

Structure and Operations

Recommendation 10: Ensure that the online Provider Directory is updated monthly per DHCS information Notice 2018-020.

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 beneficiary focus groups.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1: EQRO Review Sessions

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

Attachment B—Review Participants

CalEQRO Reviewers

Cyndi Lancaster – Lead Quality Reviewer
Leda Frediani – Information Systems Reviewer
Gloria Marrin – Consumer/Family Member Consultant

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

Sites of MHP Review

MHP Sites

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

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Alvarez	Nancy	Staff Services Specialist	GCBH
Arnold	Amber	Compliance and QI Coordinator	GCBH
Baillergeon	Roxann	Program Manager	GCBH
Bobadilla	Dago	Staff Services Specialist	GCBH
Callahan	Nancy	Consultant	IDEA Consulting
Confer	Mickie	Sr. Mental Health Counselor	GCBH
Enriquez	Brenda	Administrative Services Analyst	GCBH
Hallett	Joe	Compliance and QI Manager	GCBH
Hanni	Tami	Administrative Analyst/HIPAA Officer	GCBH
Jones	Eloise	Program Manager	GCBH
Lindsey	Amy	Behavioral Health Director	GCBH
Pfyl	Calley	Case Manager III	GCBH
Prose	Ellen	Program Manager	GCBH
Ross	Cindy	Senior Program Coordinator	GCBH
Rust	Stephanie	Program Manager II	GCBH

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

Glenn MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Small-Rural	30,108	2,403	7.98%	$8,036,478	$3,344
MHP	2,884	225	7.80%	$946,441	$4,206

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

Glenn 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	849	96.26%	93.31%	$3,199,445	$3,768	$3,998	73.92%	59.06%
>$20K - $30K	20	2.27%	3.20%	$466,050	$23,303	$24,251	10.77%	12.29%
>$30K	13	1.47%	3.49%	$662,690	$50,976	$51,883	15.31%	28.65%

Attachment D—List of Commonly Used Acronyms

Table D1: List of Commonly Used Acronyms

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

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

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

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