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

MARIPOSA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 25, 2020, August 31, 2020, September 8 and 11, 2020

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

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

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also considers the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and 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 Mariposa MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Small-rural

MHP Region — Central

MHP Location — Mariposa

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 556

MHP Threshold Language(s) — No Threshold Languages

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).

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

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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.

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 one 60-minute focus group with beneficiaries 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 three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

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

Status of FY 2019-20 Review of Recommendations

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

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

None

Access Recommendations

Recommendation 1: The MHP should explore transportation barriers and identify local solutions to improve beneficiary access to services.

Status: Met

- Mariposa County Health and Human Services expanded transportation countywide using Mariposa County Transit (Mari-go), which is a General Public Dial-a-Ride, curb-to-curb service.

- The MHP has contracted with Anthem Blue Cross and California Health and Wellness for transportation reimbursement of beneficiaries using non-medical transport.

Recommendation 2: The MHP should take steps to expand the wellness center hours beyond the current schedule to better accommodate beneficiary needs.

Status: Met

- Prior to COVID-19, the MHP had increased the Wellness Center hours to every Monday through Wednesday from 1 p.m. to 5 p.m.
- In response to COVID-19, the wellness center is closed. The wellness center peer specialist provides outreach in the field and telephone contact to participants.

Timeliness Recommendations

Recommendation 3: The MHP should identify and implement solutions to meet the ten-day state requirement more routinely regarding timeliness from initial request to first offered appointment as per Information Notice (IN) 18-010.

Status: Met

- The MHP implemented a continuous quality improvement (CQI) approach to improve the screening process, which resulted in a decrease in length of time from initial request to the first offered appointment from 10.8 calendar days in FY 2019-20 to 6.4 calendar days in FY 2020-21.
- The MHP added more assessment appointment slots; incorporated centralized scheduling; and improved clinician flexibility with scheduling assessments in their calendars.
- The MHP has experienced some setbacks with the turnover of medical records staff; however, Mariposa County Behavioral Health and Recovery Services (MCBHRS) is currently recruiting for open positions.

Recommendation 4: Identify the root causes for not meeting the timeliness standard from request for service to first psychiatry appointment and develop an action plan to have appointment time availability/capacity conform to the MHP standard.

Status: Met

- The legacy EHR measured timeliness data in calendar days instead of business days to better ensure adherence to the state standard though this algorithm most assuredly lowered the ratings reported in FY 2019-20.
- MCBHRS expanded the role of the nurse practitioner (intern graduated June 2020) from 0.32 FTE to 0.80 FTE allowing for increased psychiatric intake appointments.
- The MHP canceled its contract with the previous telehealth provider (Kings View) and now contracts with Jackson and Coker Locum Tenens as of January 2020. The contractor provides four telehealth hours per month for children and adult beneficiaries.
- The MHP Medical Director currently provides psychiatry services in-person for one day, and one day via telehealth. Two licensed vocational nurses provide medication support.
- The MHP tracks initial requests and offered appointments for psychiatry in real time; office staff notify supervisors if the appointment is made outside of the timeliness standards.

Recommendation 5: The MHP should take steps to identify a mechanism to track urgent request by the hour to assure compliance with this state timeliness metric as per Information Notice (IN) 18-010. (*This recommendation is a carry-over and follow-up from FY 2017-18 and FY 2018-19.*)

Status: Met

- The MHP records urgent request information; however, due to the low volume of requests, they do not track and trend this data.
- The EHR hosted by Kings View did not have the ability to track urgent requests in hours; however, the MHP reports that the new EHR (InSync) will allow for tracking in hours and minutes rather than in minutes only.

Recommendation 6: The MHP should work towards the establishment of a formal data governance protocol to record and transparently disseminate reporting data sources, assumptions, baselines, methodologies, and findings for its clinical quality improvement (QI) data analytics reporting. This will make it much easier for the MHP to document how it is taking these findings and using them to improve programs and treatment. (*This is a carry-over recommendation from FY 2018-19*.)

Status: Partially Met

- The MHP's Quality Assurance (QA) unit is being trained in Lean Six Sigma (LSS) to be completed in September 2020.

- The MHP has hired an experienced Staff Services Analyst who will focus on data analytics.
- The MHP is implementing a new EHR which has reporting, and data analytics built into the system for real-time clinical information for staff and supervisors.
- When the LSS training is complete (September 2020), the MHP will review Tableau and other data analytics programs for selection.

Quality Recommendations

Recommendation 7: The MHP should explore and implement the necessary steps to electronically report on prescribing patterns.

Status: Met

- The MHP's legacy EHR does not offer an effective mechanism to electronically report on prescribing patterns.
- The MHP states that the new EHR has the capability to electronically track and trend prescribing patterns.

Recommendation 8: Continue to provide resources to identify, develop and implement the DHCS required PIPs but ensure a launch timeframe within the review cycle that allows them to be considered active.

Status: Partially Met

- MCBHRS completed a non-clinical PIP to address the low rate of co-occurring disorder diagnoses and implemented clinical use of the DSM-5 level 2-substance use cross cutting tool for adults during initial assessment.
- The MHP had preliminary clinical PIP discussions regarding the improvement of beneficiary length of stay in treatment by implementing the LOCUS (Level of Care Utilization System) during assessment. The MHP decided to not pursue this PIP topic due to the complex variables.
- The start of the COVID-19 pandemic created barriers for the MHP to resume the PIP planning process.
- The MHP should engage with the technical assistance (TA) offered by CalEQRO on a regular basis to incorporate the recommendations in the PIP section and apply that TA to the PIP process and write- ups.

Beneficiary Outcomes Recommendations

Recommendation 10: The MHP should include contract providers in the use of their screening and assessment tools such as the Patient Health Questionnaire (PHQ-9) and Crisis Triage Rating Scale (CTRS) to be more uniform in the delivery of its standard of care.

Status: Partially Met

- MCBHRS has been coordinating with contract providers to use the appropriate screening and assessment tools including Functional Assessment Screening Tool (FAST) reporting; however, the MHP reports roadblocks with adherence due to lack of integration in the EHR.
- The MHP met with contract providers to reiterate the expectation of uniformity in the delivery of its standard care.
- The MHP should enhance contract language in with network providers to mandate the use of the appropriate screening and assessment tools to be more uniform in the delivery of its standard of care.

Recommendation 11: MHP should prioritize its aggregated reporting and analytic capabilities within clinical outcome tools by expediting the selection of data mining software.

Status: Partially Met

- MCBHRS replaced the legacy EHR with InSync due to its built-in reporting and data analytics functions allowing for real-time clinical information to be shared with staff and supervisors.
- The MHP's QA unit is being trained in LSS to be completed in September 2020. The MHP will review Tableau and other data analytics programs for selection upon training completion.
- The MHP should select and begin using data mining software to discover data trends for its clinical QI data analytics reporting and CQI efforts.

Foster Care Recommendations

Recommendation 12: The MHP should explore and implement the necessary steps to electronically track, trend and routinely report on prescribing patterns and other SB 1291 requirements. *(This recommendation is a carry-over from FY 2019-20.)*

Status: Partially Met

- The MHP's legacy EHR did not allow for electronic tracking, trending and routine report production on prescribing patterns and other SB 1291 mandates.
- The new EHR (InSync) will allow for electronic tracking, trending and routine report production of prescribing patterns and other SB 1291 requirements.
- The MHP canceled its contract with Kings View and contracts now with Jackson and Coker Locum Tenens for psychiatry services leading to increased compliance with monitoring prescribing patterns and SB 1291 requirements.
- The MHP should build electronic tracking, trending and routine report production on prescribing patterns and other SB 1291 mandates into the new EHR (InSync).

Recommendation 13: The MHP should explore with Child Welfare Services (CWS) the causal factors pertaining to the marked decrease in subclass member enrollments and identify if there are areas in which performance improvement or QI actions are indicated.

Status: Met

- The MHP had a significant increase in number of identified subclass members from 31 in FY 2018-19 to 69 in FY 2019-20.
- The MHP has a Continuum of Care Reform (CCR) policy and procedure operating in draft form to improve coordination of resources and services to promote greater uniformity between MCBHRS and CWS.
- MCBHRS clinicians and CWS social workers are required to collaborate and attend Child and Family Team Meetings (CFTM) as per most recent edition of the Core Practice Model requirements.
- The legacy EHR was not capable of monitoring and tracking screenings, assessments, and disposition of FC youth. The MHP plans to implement these features into the new EHR.

Recommendation 14: The MHP should take steps to secure access to a youth Crisis Stabilization Unit (CSU) level of care by locating a contract provider.

Status: Met

- MCBHRS is collaborating with Central Star Crisis Residential Unit (CRU) in Merced and submitted the following licensing documents:
    - Provider File Update form to obtain provider number for the CRU for Mariposa County.
    - Medi-Cal Certification and Transmittal form 1735 to DHCS for approval in June 2020.
    - License and DHCS certificate to California Department of Social Services to certify Central Star as a Short Term Residential Therapeutic Program (STRTP).
- The MHP has contracted with JDT Consulting for Therapeutic Behavioral Services (TBS) to provide short-term intensive services for youth at risk of psychiatric hospitalizations or group home placement.
- A STRTP facility is now contracted through Sierra Quest Human Services to provide short-term intensive care and supervision to children and nonminor dependents.

Recommendation 15: Continue to convene discussions with probation and CWS the certifying of a local Therapeutic Foster Care (TFC) with parties interested.

Status: Partially Met

- The MHP, CWS and Juvenile Probation partners have not developed an estimate of how many Therapeutic Foster Care (TFC) parents are needed for the county.
- The MHP has a Mental Health Aide placed at probation and informal discussions occur regarding FC youth.
- Sierra Quest Human Services Foundation submitted a program statement for TFC services which is currently in review by MCBHRS QA team.
- MCBHRS should resume discussions with probation and CWS and finalize the TFC certification process of the local TFC with parties interested.

Information Systems Recommendations

Recommendation 16: Develop systemwide outcome reports for internal MHP use by program, child, and adult, for the Children and Adolescent Needs and Strengths (CANS-50), Pediatric Symptom Checklist (PSC-35) and Milestones of Recovery Scale (MORS).

Status: Partially Met

- The legacy EHR did not have the ability to produce systemwide outcome reports for CANS-50, PSC-35 and MORS.
- The MHP is in the process of reevaluating the use of the MORS due to the lack of training capacity from the parent program.
- The MHP has hired an experienced Staff Services Analyst who will focus on data analytics.
- The MHP reports that they are implementing a new EHR which has reporting and data analytics capability built into the system for real-time clinical information for staff and supervisors.

Recommendation 17: Obtain internal IT staffing expertise to provide support for Cerner Community Behavioral Health (CCBH) technical issues and assure effective bidirectional communication with Kings View technical support. *(This recommendation is a follow-up from FY 2018-19.)*

Status: Met

- The MHP determined that it was necessary to establish a new EHR to provide the level of service and support that it requires.
- MCBHRD entered a contract with InSync Healthcare Solutions in December 2019.
- This recommendation will be closed as the MHP is in transition to a new EHR with different reporting protocols.

Recommendation 18: The MHP should continue its efforts to secure qualified staff and import consultant or subject matter expertise to ensure needs are met and system capability correctly assessed. (*This recommendation is a follow-up from FY 2018-19.*)

Status: Met

- The MHP determined that Kings View and CCBH EHR were unable to address the agency's concerns; it was determined that a new EHR vendor would be pursued.

- The MHP reports that the new EHR (InSync) will provide full reporting capability for CANS-50 and PSC-35 outcomes; additional reporting capabilities on many demographic and program levels will also be available.
- The MHP is in the process of reevaluating the use of the MORS due to the lack of training capacity from the parent program.

Recommendation 19: To secure a functional forum to discuss its needs pertaining to the EHR, meetings with Kings View should occur routinely, be calendared, and have targets with action areas identified in any associated minutes. (*This recommendation is a follow-up from FY 2018-19*.)

Status: Met

- The MHP determined that Kings View was unable to address the agency's concerns; therefore, a new EHR vendor was obtained.
- The MHP entered a contract with InSync in December 2019 for the implementation of a new EHR.

Recommendation 20: The MHP should work towards the establishment of a formal data governance protocol to record and transparently disseminate reporting data sources, assumptions, baselines, methodologies, and findings for its clinical QI data analytics reporting. (*This recommendation is a carry-over from FY 2018-19*.)

Status: Met

- The MHP's QA unit is being trained in Lean Six Sigma (LSS) to be completed in September 2020.
- The MHP has hired an experienced Staff Services Analyst who will focus on data analytics.
- The MHP reports that they are implementing a new EHR which has reporting and data analytics built into the system for real-time clinical information for staff and supervisors.
- The MHP will review Tableau and other data analytics programs for selection when the LSS training is complete in September 2020.

Structure and Operations Recommendations

Recommendation 21: The MHP should identify and formalize within its QI plan a logic model for its initiatives.

Status: Met

- The MHP's QA team has completed Lean Six Sigma green belt training. It will now review and update the QI work plan with this new formatting and logic model.

Recommendation 22: The MHP should make filling of vacant positions a priority and consider use of temporary or consultant time as an interim step to ensure that all quality management activities are sufficiently resourced.

Status: Partially Met

- The MHP had a fully staffed QA unit with four FTE and four 0.50 FTE positions prior to the pandemic.
- The pandemic, staff turnover and reassignments has had a significant impact on the interviewing, hiring, and training of staff. The MHP is now re-focusing resources on dealing with the community's response to COVID-19.
- The MHP is waiting to see the full fiscal impact of the pandemic prior to filling vacancies.

PERFORMANCE MEASUREMENT

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 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:
- 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

- 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).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).

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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.

- 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

Mariposa 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	3,680	74.3%	451	81.1%
Latino/Hispanic	758	15.3%	69	12.4%
African-American	25	0.5%	*	n/a
Asian/Pacific Islander	40	0.8%	*	n/a
Native American	136	2.7%	*	n/a
Other	318	6.4%	24	4.3%
Total	**4,955**	**100%**	**556**	**100%**

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

Table 2 provides details on beneficiaries served by threshold language.

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

Mariposa MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
No Threshold Languages	*	n/a
Total	**556**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

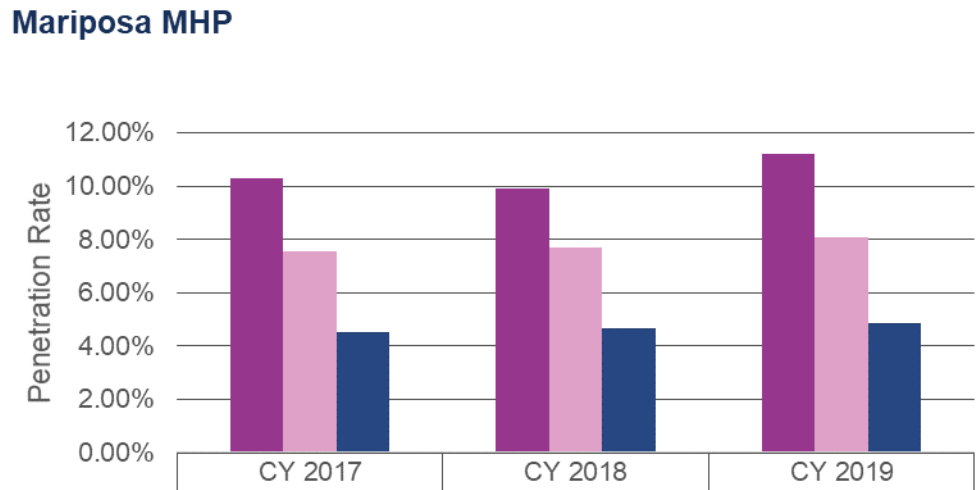
Penetration Rates and Approved Claims per Beneficiary

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.

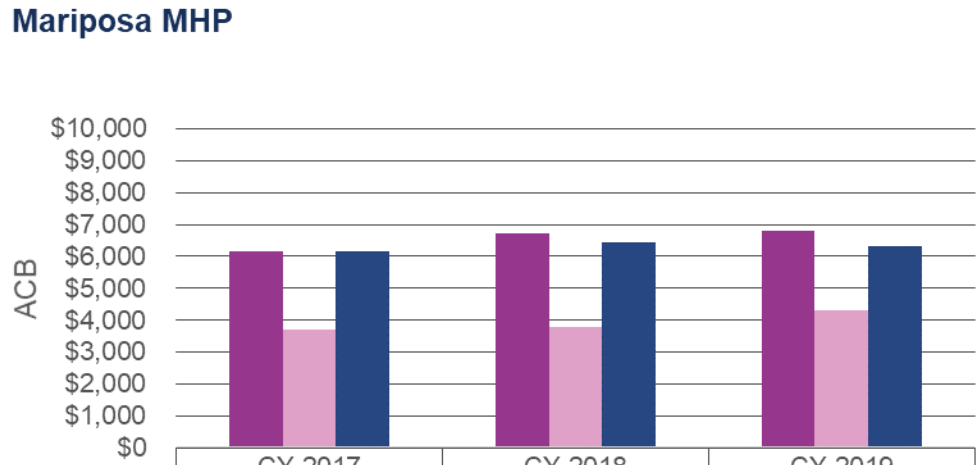
Regarding the calculation of penetration rates, the Mariposa MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	10.28%	9.91%	11.22%
Small-Rural	7.58%	7.71%	8.08%
State	4.52%	4.66%	4.86%

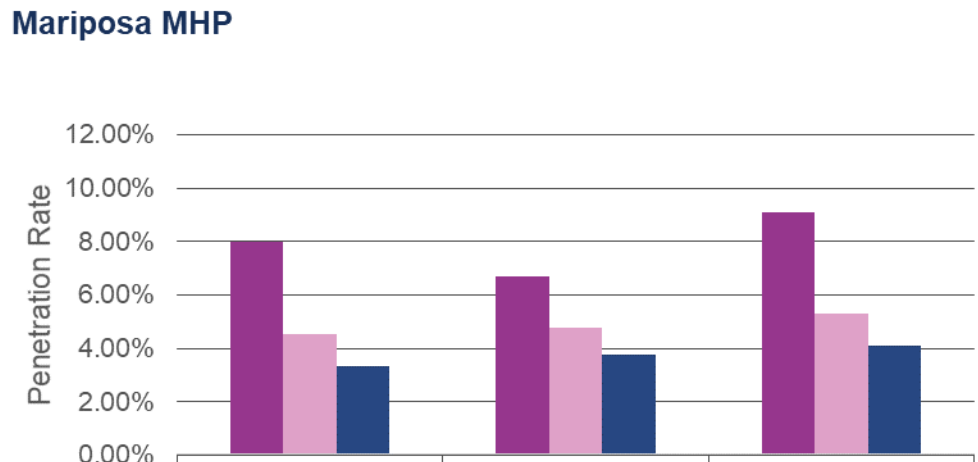
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$6,169	$6,737	$6,786
Small-Rural	$3,692	$3,794	$4,310
State	$6,170	$6,454	$6,316

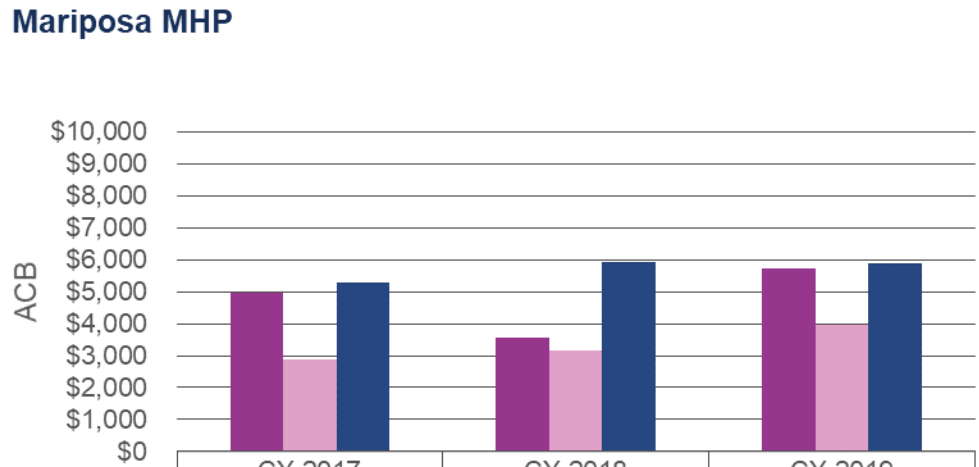
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	8.00%	6.70%	9.10%
Small-Rural	4.54%	4.79%	5.31%
State	3.35%	3.78%	4.08%

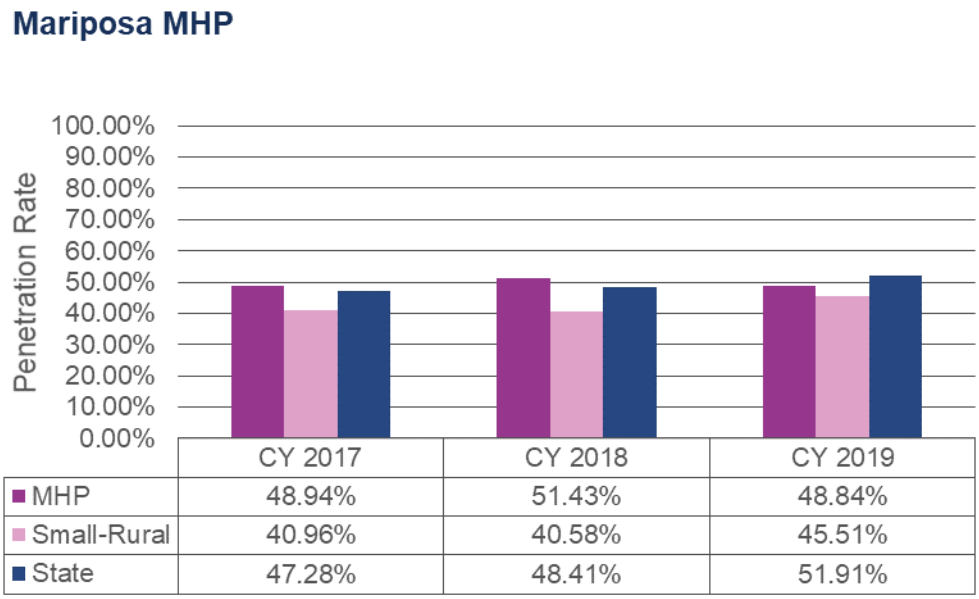
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$4,964	$3,542	$5,707
Small-Rural	$2,886	$3,146	$3,970
State	$5,278	$5,904	$5,869

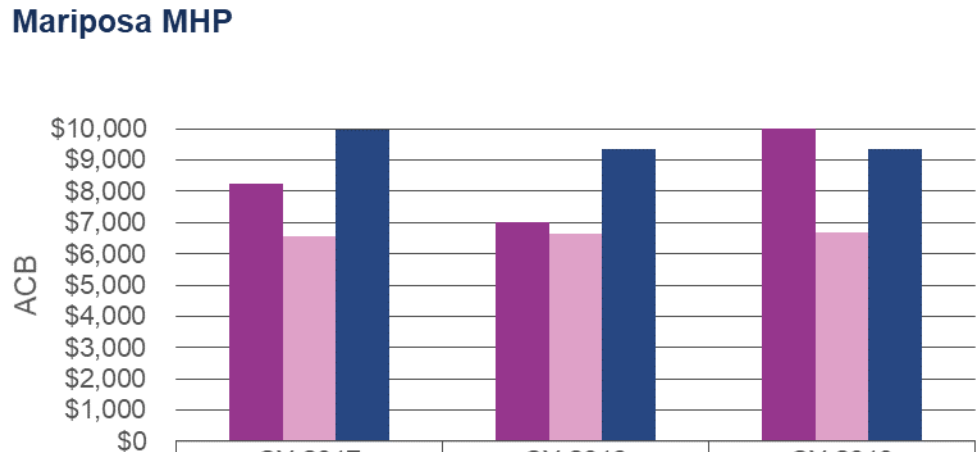
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small-rural MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	48.94%	51.43%	48.84%
Small-Rural	40.96%	40.58%	45.51%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

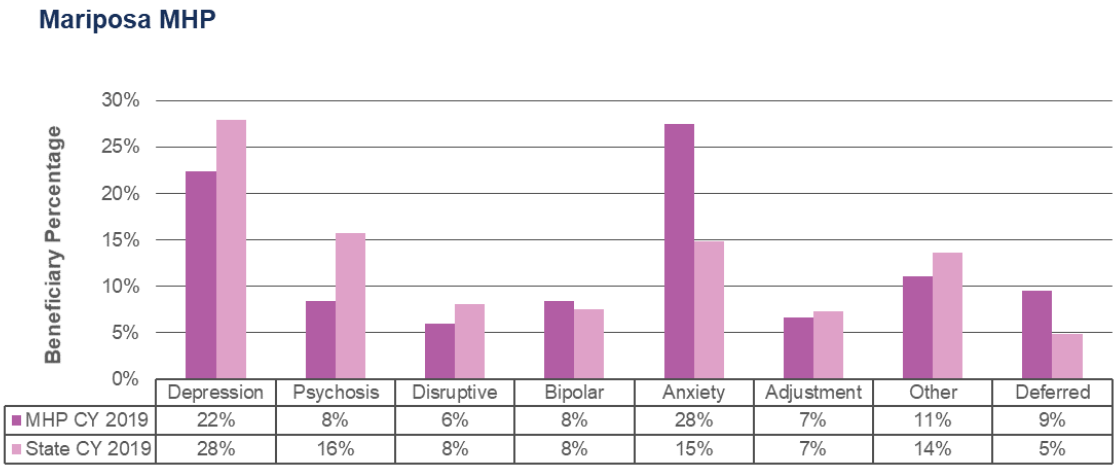


	CY 2017	CY 2018	CY 2019
MHP	$8,227	$7,030	$12,478
Small-Rural	$6,553	$6,630	$6,666
State	$9,962	$9,340	$9,360

Diagnostic Categories

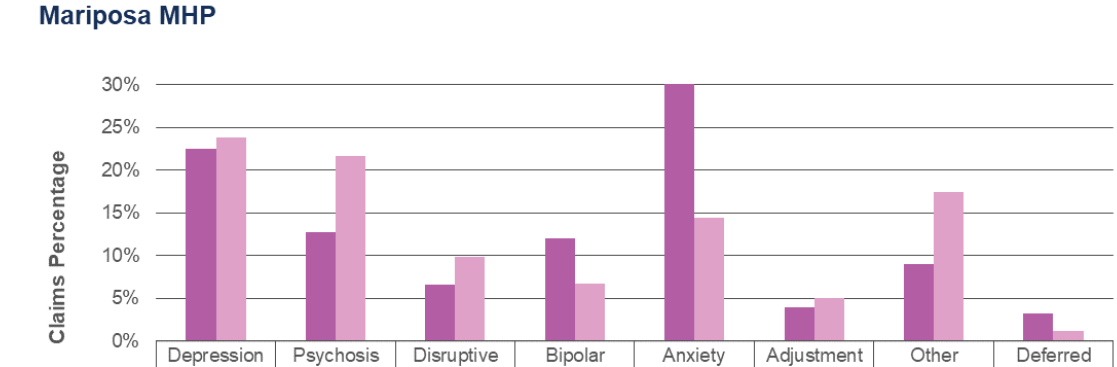
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	22%	8%	6%	8%	28%	7%	11%	9%
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	22%	13%	7%	12%	30%	4%	9%	3%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides the three-year summary (CY 2017-19) MHP HCBs and compares the statewide data for HCBs for CY 2019 with the MHP's data for CY 2019, as well as the prior two years. 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

Mariposa 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	22	556	3.96%	$48,138	$1,059,041	28.07%
	CY 2018	19	493	3.85%	$53,589	$1,018,197	30.65%
	CY 2017	13	507	2.56%	$45,347	$589,514	18.85%

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 the 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

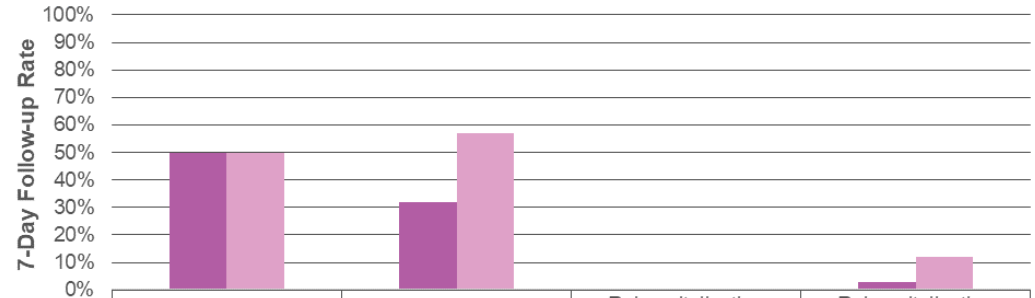
Mariposa MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	29	33	7.39	7.80	$7,039	$10,535	$204,142
CY 2018	20	33	14.85	7.63	$23,087	$9,772	$461,746
CY 2017	16	37	7.26	7.36	$10,453	$9,737	$167,254

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

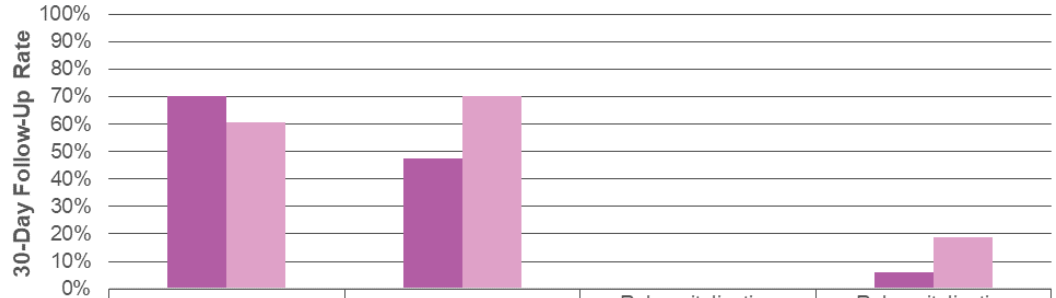
Mariposa MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	50%	32%	0%	3%
CY 2019	50%	57%	0%	12%

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

Mariposa MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	70%	48%	0%	6%
CY 2019	61%	70%	0%	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.

Mariposa 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 one PIP, as shown below.

Table 5 : PIP Submitted by Mariposa MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	0	Levels of Care (determined not to be a PIP)
Non-Clinical	1	Substance Use Disorder (SUD) Screening Tool

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Mariposa MHP
PIP Title	Levels of Care (determined not to be a PIP)
PIP Aim Statement	The MHP did not pursue the PIP topic
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): Not applicable.	

MHP Name	Mariposa MHP
☐ 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: Not applicable.	
Target population description, such as specific diagnosis (please specify): Not applicable.	

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): Not applicable.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Not applicable.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The MHP selected the PIP topic after TA provided during the CalEQRO FY 2019-20 review. Data showed that beneficiaries were remaining in treatment for either very brief periods of time (e.g. less than one year) or very extended periods of time (e.g. more than two years). The MHP realized that beneficiaries whose length of stay fell between the two timeframes were being missed. The PIP team hypothesized that the gap in treatment may be caused by improper level of care placement. The MHP hoped to improve beneficiary length of stay in treatment by implementing the LOCUS (Level of Care Utilization System) during assessment. The MHP decided to not pursue this PIP topic due to the complex variables in determining level of care placement in relation to beneficiary length of stay in treatment.

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
Not applicable.			☐ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Not applicable.			☐ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Not applicable.			☐ NA*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Was the PIP validated?				☐ Yes	☒ No	
Validation phase:						

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
☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): The MHP did not submit a clinical PIP.						
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: • To assist the MHP with identifying the PIP variables and performance measures, especially in the early planning phase, the PIP team should participate in frequent TA (e.g. monthly or quarterly) to stay on the pre-determined study timeline.						
The TA provided to the MHP by CalEQRO consisted of: • Reviewing the data gathered to define the scope and depth of a problem, and a barrier analysis to determine the cause(s) of the problem. • Reviewing the connection between identified barriers and selecting appropriate beneficiary centered interventions, which are likely to have the greatest impact. • The MHP should complete work on selecting a clinical PIP topic. The CalEQRO Quality Reviewer plans to meet with the PIP team in one month to discuss the MHP's progress toward implementation of two new PIPs.						

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

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Mariposa MHP
PIP Title	SUD Screening Tool
PIP Aim Statement	"Would implementation of a substance use screening tool result in an increase of co-occurring diagnosis of clients over the age of 18 from 12 percent to 60 percent"?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The identified PIP population are adult beneficiaries over the age of 18 that are receiving mental health services; however, the PIP aim statement should further describe the population such as new versus on-going beneficiaries.	

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): Interventions for this PIP are provider-focused to improve screening for co-occurring diagnosis during intake assessment.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The MHP identified the following PIP interventions: (1) clinicians complete the SUD screening tool at intake alongside the beneficiary; (2) clinician's greater ability to identify SUD conditions; and (3) clinicians provide appropriate level of care referrals to SUD programs.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The MHP aimed to change the beneficiary intake process by adding in the SUD screening tool to every new assessment and providing appropriate referrals to those who screened positive for co-occurring disorders.

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Number of beneficiaries screened for SUD during intake	2018	0/0=0%	2020 ☐ NA*	129/186= 69%	☒ Yes ☐ No	☐ 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
						NA
Number of screening assessments which indicated a SUD referral	2018	0/0=0%	2020 ☐ NA*	81/129= 63%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): NA
Number of referrals to the SUD program	2018	0/0=0%	2020 ☐ NA*	25/81= 31%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): NA
The MHP overall rate of co-occurring diagnoses	2018	12%	2020 ☐ NA*	76/264= 29%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): NA
Was the PIP validated?	☒ Yes	☐ No				

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Validation phase: ☒ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): The PIP was completed in May 2020.						
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: The PIP has the potential to significantly impact beneficiary health, functional status, and satisfaction. To improve this PIP, feedback from beneficiaries should be included. The MHP should modify their aim statement by defining the improvement strategy, population, and time period of the study. It should be clear, concise, measurable, and answerable. The PIP development should clearly identify the interventions; describe the intervention implementation period; further describe when the SUD screening tool will be used; expand upon the PIP population description (new versus on-going beneficiaries) and participation timeframe; and utilize achievable outcome goals.						

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
The variables for this PIP are adequate to answer the PIP aim statement; however, independent variable number two (clinician's greater ability to identify SUD conditions) should be reworded. The MHP's actual focus in this instance is clinicians reviewing the SUD screening tool with the beneficiary. The purpose of this is to increase the client's strength in identifying SUD conditions. Furthermore, the MHP did not obtain a baseline measurement for beneficiaries who received a SUD referral prior to the implementation of this PIP. This is valuable information that would assist the MHP in answering the aim statement. The PIP variables can be measured over time and should be on at least a quarterly basis. The MHP should include literature and/or research that explains how the selected performance measures are grounded in proven methods pertinent to the study topic. The data collection plan did link to the data analysis plan; however, the PIP team should have measured rate of co-occurring disorders more frequently. The MHP began the planning phase of this PIP in November 2018 and a month-long pilot of the SUD screening tool was applied in March 2019. Modifications were made to the study and interventions resumed July 15, 2019; therefore, only ten months of data collection was available. The MHP did not present the results of these remeasurements. The PIP study design intended to collect the data every two months; however, the MHP measured the baseline of the dependent variables (number of beneficiaries screened for SUD during intake; number of screening assessments indicating a SUD referral; number of SUD program referrals; rate of co-occurring diagnoses) in July 2018 and did not document a remeasurement until May 2020. The impact of the pandemic on the PIP study is understandable; however, it is unclear why the PIP team did not document the remeasurements that the study design implied prior to COVID-19. The MHP should provide more detail in the data collection plan to ensure that reliable and valid data was collected (e.g. who, what, where, when, why). MCBHRS should make the following modifications to improve the PIP data collection procedures: conduct more frequent QA activities to ensure data collection is occurring as planned; provide more detail of QA measures taken; measure rate of co-occurring disorders more frequently such as quarterly; provide more detail on data collection personnel and procedures; create and maintain PIP timeline to ensure study benchmarks are being met.						
The TA provided to the MHP by CalEQRO consisted of discussions involving the MHP's plan to end the PIP and begin a new non-clinical PIP. The MHP was also encouraged to consult with EQRO early and often during the development of new						

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
PIPs. Recommendations for new PIPs include utilizing a simple, straight-forward aim statement which identifies the problem, intervention, and outcome measures; thus, the aim statement would prove to be more answerable. The new PIP should include more in-depth data evaluation and barrier analysis, to ensure that interventions are related to problem causes. The MHP should complete work on selecting a non-clinical PIP topic. The Quality Reviewer plans to meet with the MHP in one month to discuss the MHP's progress toward implementation of two new PIPs.						

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

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's Information System (IS) 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
Mariposa	4.82%	6.79%	7.31%	7.87%
Small-rural MHP Group	N/A	5.26%	4.17%	3.92%
Statewide	N/A	3.58%	3.35%	3.34%

- MCBHRS budgeted approximately 4.8 percent in FY 2020-21 dedicated to supporting IT operations which represents a 39 percent decrease since FY 2017-18; however, the current budget remains above the statewide average (3.58 percent), and slightly below the small-rural MHPs (5.26 percent) for FY 2019-20.
- The FY 2020-21 IT budget reduction is worthy of attention as the MHP is in the process of implementing a new EHR.
- The MHP's IT staff have been transferred to the County IT division so that the costs are now addressed annually but have not yet been processed.
- The MHP's contract for their new EHR costs significantly less than their contract with their legacy EHR (Kings View).

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 Application Services Provider (ASP) model to host EHR system which provides 24-hour operational support.	☒ Yes	☐ No
The BCP (if the MHP has one) is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP organization clearly identified as having responsibility for Information Security.	☒ Yes	☐ No
If no one within the MHP organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☐ Yes	☒ No

- The MHP has both a county level Information Security officer and an agency level Information Security officer.

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	80.25%
Contract providers	19.75%
Network providers	0%
Total	**100%***

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

- The MHP increased the use of contract providers from eight percent in FY 2019-20 to 19.75 percent in FY 2020-21.

Summary of Technology and Data Analytical Staffing

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

Table 15: Technology Staff

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

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

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	5.1	.1	2	1
2019-20	5	3	2	2
2018-19	1	1	0	2

The following should be noted regarding the above information:

- MCBHRS has half of the county's IT users, and the MHP's IT staff have been transferred to a centralized county IT division. The IT team remains funded by the MHP; however, they have moved to a new location with a new chain of command.
- The purpose of centralizing the IT division is to maintain the same amount of ticket support and access to technology as before the reassignment of staff.
- The MHP's data analytics staff have now taken over day-to-day EHR and IT support responsibilities previously maintained by IT staff. Most staff are assigned to the Fiscal Unit, while the QA division has 1.5 FTE.

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	12	2	14
Clinical Healthcare Professional	22	12	34
Clinical Peer Specialist	1	0	1
Quality Improvement	4	0	4
Total	39	14	53

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)	5.1	2.16
Total EHR Users Supported by IT (Source: Table 17)	53	42.00
Ratio of IT Staff to EHR Users	1:10	1:19

Table 19: Additional Information on EHR User Support

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

Table 20: New Users' EHR Support

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

Table 21: Ongoing Support for the EHR Users

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

- The MHP will train staff who are new users of the EHR using InSync's University Webinar Video Library and superusers who understand the new workflows.

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

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

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	4
Number of county-operated telehealth sites	1
Number of contract providers' telehealth sites	3
Total number of beneficiaries served via telehealth during the last 12 months	107
• Adults	51
• Children/Youth	46
• Older Adults	10
Total Number of telehealth encounters (services) provided during the last 12 months:	1472

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.

- Telehealth was used primarily for psychiatry prior to the COVID-19 pandemic, and since then most services are provided via telehealth.
- The MHP was awarded a Rural Utilities Service (RUS) grant for $1.1 million during FY 2019-20 and expanded telehealth sites from four to seven including: Health & Human Services Agency (HHSA) North County; Yosemite Clinic; the local Jail; John C. Fremont Medical Center; Mariposa County High School; HHSA Community Health Center; and the HHSA Family Services Center.
- The RUS grant allowed the MHP to train their staff on the use of telehealth equipment, creating a smooth transition of services from in-person to telehealth post COVID-19.
- The MHP utilized the RUS grant funds to provide laptop computers to staff, allowing them to continue providing services while working from home.
- The MHP contracted with Zoom (cloud platform for video) for user licenses to allow for the efficient delivery of telehealth services, and to ensure that confidentiality requirements are met.

Identify from the following list of California-recognized threshold languages that are 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
Quest Counseling	1
Compass Counseling	1
Ranchos Counseling	1

Current MHP Operations

- The MHP transitioned to the new EHR provider InSync, in August 2020 as an Application Service Provider (ASP).
- The MHP seamlessly transitioned most services to telehealth since the beginning of the COVID-19 pandemic.
- The MHP will continue to use Kings View for CCBH back billing through the Fall and will then discontinue their working relationship.
- The MHP uses unmet needs data to determine where and what kind of services need to be provided. It was awarded a RUS telehealth grant to expand services for specialty services in remote areas.

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

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
CCBH	EHR	Cerner	13	Kings View
InSync	EHR	InSync Healthcare Solutions	New	InSync

The MHP's Priorities for the Coming Year

- Launch and configuration of new EHR (InSync).
- Secure vendor via Request for Proposal (RFP) to ensure successful installation, staff training, and support of new technology purchased under RUS grant.
- Selection of a Community Informaton Exchange (CIE).
- Implement Electronic Prescriptions for Controlled Substances (EPCS).
- Ensure clean claims and state reporting.

Major Changes since Prior Year

- Client Services Information (CSI) reporting functionality became available in August 2019.
- Achieved Functional Assessment System Tracking (FAST) reporting.
- Deployment of RUS telehealth grant equipment in July 2019.
- Identificiation and inventory of new computer equipment.
- Deployment of Zoom telehealth platform in response to COVID-19.
- Deployment of upgraded laptops and iPads with videoconferencing capabilities.

Other Areas for Improvement

- It is unknown if InSync's system design and workflow processes will adequately capture and support California state-mandated data reporting requirements directly from the EHR system.
- The MHP lacks sufficient numbers of subject matter experts and county operations to support standing-up a new-to-California EHR system.
- The MHP did not share InSync's project plans with tentative timelines or milestones.
- The MHP did not provide sufficient details regarding EHR system cut-over strategy to ensure that data is submitted in a timely manner to the state.

Plans for Information Systems Change

- The MHP ended ASP services with Kings View, and transitioned to the new EHR (InSync), which is also an ASP implementation; the new EHR began roll-out in August 2020.
- Mental health and SUD contract providers will have direct access to the new EHR.

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	Cerner CBH	☒	☐	☐	☐
Assessments	Cerner CBH	☒	☐	☐	☐
Care Coordination	Cerner CBH	☒	☐	☐	☐
Document Imaging/ Storage	Cerner CBH	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Cerner CBH	☒	☐	☐	☐
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service		☐	☐	☒	☐
Outcomes		☐	☐	☐	☒
Prescriptions (eRx)	Cerner CBH	☒	☐	☐	☐
Progress Notes	Cerner CBH	☒	☐	☐	☐
Referral Management	Cerner CBH	☒	☐	☐	☐
Treatment Plans	Cerner CBH	☒	☐	☐	☐
Summary Totals for EHR Functionality:					

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
FY 2020-21 Summary Totals for EHR Functionality:		9	0	2	1
FY 2019-20 Summary Totals for EHR Functionality:		6	3	3	0
FY 2018-19 Summary Totals for EHR Functionality:		6	1	5	0

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

- The MHP's official Chart of Record is a combination of paper and electronic forms with several vital forms continuing on paper: Release of Information; Laboratory Results; Medication Consents; and Hospital Release Documents.

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

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

Some contact providers have EHR systems which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in-place to support transmission of beneficiary and services information from contract providers to the MHP.

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

EHR Vendor	Product	Count of Providers Supported
Not applicable.		

Personal Health Record (PHR)

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

☐ Yes ☒ No ☐ Implementation Phase

Expected implementation timeline:

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

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

Table 28: PHR Functionalities

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

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

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP's SDMC claims.

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

Mariposa MHP							
Service Month	**Number Submitted**	**Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Dollars Adjudicated**	**Dollars Approved**
TOTAL	**10,780**	**$3,709,235**	**44**	**$26,151**	**0.70%**	**$3,683,084**	**$3,583,059**
JAN19	1,091	$327,925	3	$6,944	2.07%	$320,981	$310,869
FEB19	850	$246,799	4	$3,550	1.42%	$243,249	$236,801
MAR19	1,145	$354,421	13	$4,927	1.37%	$349,494	$329,855
APR19	959	$316,275	15	$5,706	1.77%	$310,569	$291,468
MAY19	1,077	$324,518	3	$2,699	0.82%	$321,819	$305,589
JUN19	687	$208,838	1	$140	0.00%	$208,698	$205,501
JUL19	930	$357,343	0	$0	0.00%	$357,343	$353,452
AUG19	853	$331,759	0	$0	0.00%	$331,759	$328,496
SEP19	798	$323,737	1	$140	0.04%	$323,597	$318,714
OCT19	951	$357,027	2	$493	0.14%	$356,534	$352,313
NOV19	697	$274,052	0	$0	0.00%	$274,052	$271,551
DEC19	742	$286,400	2	$1,552	0.54%	$284,848	$278,451

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

- The MPH's denied claims rate of 0.70 percent is significantly lower than the 2.99 percent statewide average.

Table 30 summarizes the top five reasons for claim denial.

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

Mariposa MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible or non-covered charges.	7	$11,989	46%
Beneficiary not eligible.	22	$7,443	28%
Medicare or Other Health Coverage must be billed before submission of claim.	12	$3,422	13%
Missing or incomplete or invalid codes.	3	$3,297	13%
Total	44	$26,151	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 reasons 'Medicare or Other Health Coverage must be billed before submission of claim' and 'Missing or incomplete or invalid codes' are generally re-billable within the State guidelines.

NETWORK ADEQUACY

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

Network Adequacy Certification Tool Data Submitted in April 2020

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

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

The time to get to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Mariposa, the time and distance requirements are 90 minutes and 60 miles for mental health services, and 90 minutes and 60 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two 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.

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.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's Network Adequacy 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[5]
NPI Type 1 number not found in NPPES	1
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 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

[5] Data Sources:
1. MHP's NACT Rendering Providers, Exhibit A.3 worksheets
2. Health Care Provider Taxonomy, version 20.0, January 2020 ©2020 AMA
3. NPPES Link: https://nppes.cms.hhs.gov/#/
4. PAVE Portal: https://pave.dhcs.ca.gov/sso/login.do

Description of NPI Exceptions	Number of Exceptions[5]
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 60-minute focus group with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested one focus group with 10 to 12 participants each, the details of which can be found in each section below.

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

CFM Focus Group One

Table 32 : Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. In response to COVID-19, the group was held via videoconference. Due to the low number of participants, information is suppressed to protect confidentiality.
Total number of participants	One
Number of participants who initiated services during the previous 12 months	Values are suppressed to protect confidentiality of the individual(s) in the group.
Interpreter used	No
Summary of the main findings of the focus group:	
Access - new beneficiaries	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality

Topic	Description
	of the individual(s) in the group.
Access – overall	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality of the individual(s) in the group.
Timeliness	Feedback was obtained regarding timeliness to services. Information is suppressed to protect confidentiality of the individual(s) in the group.
Urgent care and resource support	Feedback was obtained regarding urgent care and resource support. Information is suppressed to protect confidentiality of the individual(s) in the group.
Quality	Feedback was obtained regarding quality of services. Information is suppressed to protect confidentiality of the individual(s) in the group.
Peer employment	Feedback was obtained regarding peer employment. Information is suppressed to protect confidentiality of the individual(s) in the group.
Structure and operations	Feedback was obtained regarding structure and operations. Information is suppressed to protect confidentiality of the individual(s) in the group.
Recommendations from this focus group	Recommendations from this group are suppressed to protect confidentiality of the individual(s) in the group.
Any best practices or innovations (optional)	Best practices from this group are suppressed to protect confidentiality of the individual(s) in the group.

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 35 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 MCBHRS website is user friendly and is easy for beneficiaries to find information. The MHP maintains an Access and Services Policy and Procedure which outlines mental health services, access, and delivery. The MHP offers printed materials in languages other than English and is accessible on the website. The provider directory is up-to-date, and beneficiaries can access clinical and recovery services using the beneficiary handbook. These resources are also available in electronic form on the website. The beneficiary handbook and MHP website provide information on how to access services in threshold languages. MCBHRS maintains a 24/7 Access Line Policy and Procedure, and data is recorded in the Access Log, including beneficiary requests for an interpreter. After-hours calls are handled under a contract provider and test calls occur each month. The MHP tracks and trends data on requests for services by walk-ins, calls, mail, and a wide range of referral sources. Mariposa County HHSA expanded transportation countywide consisting of dial-a-ride service for non-medical transport. MCBHRS			

Component		Maximum Possible	MHP Score
collaborated with Anthem Blue Cross and California Health and Wellness to be reimbursed for beneficiary transportation for non-medical transport. The MHP should expand transportation services to wellness center participants. MCBHRS has one bi-lingual staff member, proficient in reading and writing in Spanish. All staff are trained to access the tele-interpreter services.			
1B	Capacity Management	10	10
The Cultural and Linguistic Competence Plan (CLCP) CY 2020 outlines MCBHRS' commitment to improving services, expanding access, improving quality of care and outcomes. The Cultural Responsiveness Committee (CRC) membership includes leadership, line staff, community members, and beneficiaries, and it reports directly to the QIC. The goals of the CLCP are aligned with the Mariposa County MHSA Three Year Plan and include objectives to provide culturally and linguistically appropriate services to individuals in the community. Culturally relevant trainings are planned semi-annually. System demand is routinely part of the quality management efforts as evidenced by recent adjustments to address increased demand in the North County by expanding use of telehealth and other mental health services in this remote area. Satellite offices are established in Coulterville and Yosemite National Park, and beneficiaries may access mental health and psychiatry services at these locations. The MHP FY 2019-20 QIC Workplan contains objectives to track and trend beneficiary demographics, location, types of services, and diagnosis, and reports are reviewed quarterly. While the MHP has identified three under-served subgroups (those in poverty, the elderly, and veterans), it should advance its efforts to address disparities in access for these populations beyond awareness training for staff.			
1C	Integration and Collaboration	24	24
Mental Health and substance abuse services are integrated along with those of the child welfare system in one super agency with the Agency Director overseeing all aspects of the three divisions. MCBHRS has an agreement for healthcare services with John C. Fremont Healthcare District Hospital to provide acute care to individuals admitted with mental health emergency needs. The Connections Emergency shelter provides 16 beds and is adjacent to the Mariposa County HHSA building.			

Component	Maximum Possible	MHP Score
For outreach and engagement, the MHP collaborates with several community-based organizations including: MiWu-Mati Healing Center; Alliance for Community Transformations who operate Ethos (drop-in center for homeless youth) and the Mariposa Heritage House (SUD support services. MCBHRS focuses programs on older adults and outreach at the Senior Center and provides supportive services in the home. MCBHRS collaborates with the Mariposa County School District to provide weekly groups at the county alternative high school using the Seeking Safety curriculum for the 2020-21 school year. MCBHRS funds 5.5 positions within the school district to assist with prevention and early intervention of mental health issues, and contracts with a local non-profit provider to operate the Primary Intervention Program for youth. The Mariposa County Department of Human Services is managing a Subsidized Employment program called Mariposa Works that provides jobs for the unemployed, supports business, and helps motivated job seekers gain new skills. The MHP collaborates with Anthem and California Health and Wellness (MCOs) for individuals with mild to moderate impairment resulting from a mental health disorder. The MHP collaborates with the Mariposa County Adult Detention Facility (MCADF) and operates the Jail Based Competency Training (JBCT) Restoration and Competency (ROC) program. The program is dedicated to individuals charged with a felony and deemed incompetent to stand trial.		

Timeliness of Services

As shown in Table 36, 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 current EHR does not provide the capability to track timeliness in business days; therefore, all data is reported in calendar days. This issue should be remedied with the August 2020 launch of the new EHR system. The MHP has a standard of ten business days for length of time from initial request to first offered appointment and met the standard approximately 84 percent of the time			

Component		Maximum Possible	MHP Score
with a mean of six days (87 percent for adults, 81 percent for children, and 78 percent for FC youth). Compared to last year, the MHP met the ten-business day standard more of the time, and the overall mean decreased by 4.8 days. The MHP does not currently segregate the adult population to track or report these standards for older adults. While the MHP reports that they rarely receive written requests for service, the requests are held to the same timeliness standards as walk-ins and calls. MCBHRS tracks and reports all first offered appointment data for the entire system of care on a frequent basis (e.g. monthly, quarterly, semi-annually, and annually), including the number of days, percentages of times the standard is met, and the range. Data is also shared at quarterly QIC meetings.			
2B	First Offered Psychiatry Appointment	12	12
The current EHR does not provide the capability to track timeliness in business days; therefore, all data is reported in calendar days. This issue should be remedied with the August 2020 launch of the new EHR system. The MHP does not currently segregate the adult population to track or report these standards for older adults. The MHP has a standard of 15 business days for length of time from initial request to first offered appointment and met the standard approximately 71 percent of the time with a mean of 12 days (70 percent for adults, 71 percent for children, and 75 percent for FC youth). MCBHRS expanded the role of the nurse practitioner (intern graduated June 2020) from 0.32 FTE to 0.80 FTE, allowing for increased psychiatric intake appointments. MCBHRS tracks and reports all first offered psychiatry appointment data for the entire system of care on a frequent basis (e.g. quarterly and annually), including the number of days, percentages of times the standard is met, and the range. Data is also reviewed at quarterly QIC meetings.			
2C	Timely Appointments for Urgent Conditions	18	11
The MHP has a policy and procedure requiring adherence to service requests for urgent appointments timeliness metrics. MCBHRS records both types of urgent appointments (e.g. 48 hour and 96 hour); however, they do not track or trend urgent requests data due to low volume of requests. The data is limited in value as their EHR does not have the ability to track in hours, thereby rendering the reporting times in days. The EHR urgent encounter tracking issue should be remedied with the implementation of the new EHR system in August 2020.			

Component		Maximum Possible	MHP Score
The MHP has a standard of 48 hours from service request for urgent conditions to actual encounter for appointments that do not require a prior authorization, and met this standard 35 percent of the time with a mean of 3.8 days (4.3 days for adults and five days for children). There were no identified urgent requests for FC youth nor any urgent requests that required prior authorization for FY 2019-20. The MHP has a contracted vendor to provide after-hours screening for urgent condition requests. The MHP should initiate performance improvement activities with time-limited goals to meet the state standards.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	8
The MHP has a standard of seven calendar days for follow-up appointments post-psychiatric inpatient discharge with a mean of 10.8 days (12.5 for adults and 2.2 for children). There were no FC youth hospitalized in FY 2019-20. The percent of appointments that meet the standard has decreased from 50.77 percent in FY 2019-20 to 40.38 percent in FY 2020-21. MCBHRS QM team meets on a weekly basis to review hospitalizations and to ensure follow-up activities are performed within the seven-day standard. MCBHRS did initiate a promising PIP which was completed in July 2018 to increase engagement in follow-up services post psychiatric hospitalization. MCBHRS data is reflective only of Medi-Cal beneficiaries, including beneficiaries that were presumptively transferred to Mariposa County. The data excludes beneficiaries who were admitted prior to July 2019 and those admitted that continue to be in the hospital during the reporting period.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The overall hospital re-admission rate within 30 days for the entire system of care is approximately 5.8 percent. The MHP reports that of the 45 adults admitted to the hospital, three were readmitted within 30 days, representing 6.67 percent. There were no hospital re-admissions for children, and no FC youth hospitalizations for FY 2019-20. MCBHRS data is reflective only of Medi-Cal beneficiaries, including beneficiaries that were presumptively transferred to Mariposa County. The data excludes beneficiaries who were admitted prior to July 2019, and those admitted that continue to be in the hospital during the reporting period.			
2F	Tracks and Trends No-Shows	10	8

Component	Maximum Possible	MHP Score
The MHP reports that it does track no-shows for psychiatrists across its entire system; the data reported for clinicians reflects only county operated services. FC youth no-show data for psychiatrists was not disaggregated from children's no-show data. The MHP does track type of staff no-shows and monthly cancellations, and beneficiary no-show/cancellation rate is reviewed during quarterly QIC meetings. The MHP has a no-show standard of ten percent for psychiatrists, and an overall no-show rate of approximately 14.5 percent (14.9 percent for adults and 10.9 percent for children's services). The no-show rate for psychiatrists has increased 32 percent since FY 2018-19. The MHP has a no-show standard of ten percent for clinician's other than psychiatrists and an overall no-show rate of approximately 12 percent (12.9 percent for adults, 9.9 percent for children, and 9.2 percent for FC youth). QIC meeting meetings reflect that performance improvement activities have been initiated to reduce the overall no-show rates, such as providing appointment reminder calls. The MHP expects the new EHR (InSync) will more accurately reflect the no-show percentage.		

Quality of Care

In Table 37, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 35: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
The MHP has an updated CLCP (December 2019) with current data reflecting the population in Mariposa County. MCBHRS Cultural Responsiveness Committee (CRC) includes members from leadership, line staff, Behavioral Health Board, Mariposa County HHSA, contract providers (Mariposa Safe Families), community members and beneficiaries. The CRC is responsible for overseeing the ongoing assessment of the county and MHP demographics, penetration rates, and indicators of disparity.			

Component		Maximum Possible	MHP Score
The MHP maintains a policy and procedure for the CRC, and the committee reports directly to the QIC. The CLCP was developed in collaboration between the CRC and QIC to address equity and disparities using specific goals and objectives, actions implemented to ensure cultural competence, and recommendations to enhance cultural competence. Collaboration between the two committees is reflected in quarterly CRC meeting minutes. The CRC is also responsible for integrating National Standards for Culturally and Linguistically Appropriate Services (CLAS) in all MCBHRS staff and unit meetings, including trainings and other forms of communication. The MHP has a designated Cultural Competence Responsiveness Committee chair who has direct access to the Deputy Director of Behavioral Health Services.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
The MHP has an established levels of care flowchart which outlines the intake and assessment processes using a clinical lens to determine the most appropriate level of care for beneficiaries. Assessment and re-assessment are completed for adults using MORS and the PHQ-9. The CANS-50 and PSC-35 are used with children. MCBHRS uses a transition of care tool for adults and children to assess individuals who may need to step down or up levels of care. The MHP uses a bi-directional transition form to refer individuals who meet medical necessity to a contract provider when the MHP is at capacity. Individuals who do not meet medical necessity for Serious Mental Illness (SMI) are referred to an MCO. The MHP confirms that the beneficiary has an appointment prior to transfer and follows-up within 30 days. The quality management team performs monthly utilization chart reviews to ensure clinical compliance with level of care assignments. Discussions regarding levels of care are part of the coordination meetings held at the clinic sites.			
3C	Quality Improvement Plan	10	10
The MHP has an updated QI work plan aligned with their CLCP; it reflects a variety of initiatives that are assigned quantified goals and objectives with both process and outcome indicators. MCBHRS produced an annual QI report evaluating effectiveness and progress towards goals and objectives. The QIC meeting minutes reflect discussion of progress toward the QI work plan goals, and meetings are held quarterly at a minimum.			
3D	Quality Management Structure	14	12

Component		Maximum Possible	MHP Score
The QA team is comprised of a Supervising Administrative Analyst, three Staff Services Analysts, a System Support Analyst (vacant) and a part time Office Assistant (vacant). The QA staff are fully integrated with the leadership team, and there is a direct line of communication with administration. The MHP plans to have the QA team trained in Greenbelt Lean Six Sigma by Purdue University in September 2020, and once the training is completed, the team will review Tableau and other analytic software for selection. The QIC meeting minutes reflect discussion of progress toward the QI work plan goals, and meetings are held quarterly at a minimum. The QIC oversees the activities of the PIP Committee, Compliance Committee, Cultural Competence Committee and Primary Care Provider (PCP) sub-committee. Meeting attendees include MCBHRS Deputy Director, QA Supervisor, clinical supervisors, MHSA Coordinator, QA staff, committee chairs, beneficiaries, Mental Health Board members, community service and contract providers, and other MHP leadership and direct provider staff.			
3E	QM Reports Act as a Change Agent in the System	10	10
The MHP utilized its QIC to review data from the QI work plan goals such as the monitoring of service delivery capacity. That has resulted in the addition of a satellite office located in the North County Health and Human Service Center in Coulterville, a town previously assigned minimal resources. MCBHRS is currently conducting a non-clinical PIP focused on more accurately diagnosing co-occurring disorders by using a standardized SUD screening tool during assessment. The MHP is currently exploring clinical PIP topics. The MHP hired a Staff Services Analyst in June 2020 who has experience in data analytics, and QA staff are currently receiving training in the data driven QA philosophy, Lean Six Sigma. The QA team plans to research and select an analytic platform (e.g. Tableau) following completion of the Lean Six Sigma training. The MHP reports that the new EHR (InSync) features adequate reporting and data analytics built into the system that allows for real-time clinical information to be provided to staff and supervisors.			
3F	Medication Management	12	11
The MHP offered two days per week (main clinic and Coulterville office) of in-person psychiatry services prior to COVID-19. The MHP Medical Director currently provides psychiatry services in-person for one day, and a second day via telehealth. Two licensed vocational nurses provide medication support. The MHP psychiatric nurse			

Component	Maximum Possible	MHP Score
practitioner provides three half days (25 hours) of psychiatry services (via telehealth) and is shared with Mariposa County Public Health. Beneficiaries may meet with a MCBHRS psychiatrist every first Friday of the month from 8:00 am to 9:30 am to ensure coordination of care and answer any medication questions. The MHP canceled its contract with the previous telehealth provider (Kings View) and now contracts with Jackson and Coker Locum Tenens as of January 2020. The contractor provides four telehealth hours (reduced from eight) per month for children and adult beneficiaries. This change has led to increased compliance with monitoring prescribing patterns and other SB 1291 requirements; however, the MHP was not able to track and trend this data with the previous EHR (Kings View). MCBHRS reports that InSync is capable of reporting on prescribing patterns and will be built into reporting by QA to meet regulatory expectations. The new EHR also allows beneficiaries to directly contact their psychiatrist through the patient portal. The MHP has an established medication services flowchart which outlines level of care transitions and bi-directional communication between prescribers and primary care physicians. The MCBHRS Medical Director, Utilization Management (UM) Committee, QA supervisor and QIC are all responsible for the monitoring the safety and effectiveness of medication practices. QI activities include: 1) audits on 5 percent of active charts; 2) audits of nurse practitioner and telehealth charts by MCBHRS Medical Director; 3) report production of prescribing practices and trending HEDIS measures for the UM Committee; and, 4) chart audits by available pharmacist or psychiatrist. MCBHRS is currently working with surrounding counties to develop a MOU to share medication chart reviews. The MHP met with Inyo County Behavioral Health in June and July of 2020 and plans to move forward in the upcoming year. The MHP has established a detailed medication consent policy and procedure for all beneficiaries to ensure that informed consents are obtained prior to the prescription of medications. Staff are expected to adhere to the chart review schedule, obtain informed consent for each change in medication or dosage, and review the chart findings in QA meetings. The MHP holds a weekly medication support team meeting, and medication prescribing practices are tracked monthly, reviewed semi-annually, and are included on the QI work plan.		

Beneficiary Progress/Outcomes

In Table 38, 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	15
The MHP has adopted use of several standardized tools designed for measuring beneficiary progress. Assessment and re-assessment are completed for adults using MORS, PHQ-9, and Crisis Rating Scale (as needed). The CANS-50 and PSC-35 are used with children. MCBHRS completed a non-clinical PIP to address the low rate of co-occurring disorder diagnoses and implemented clinical use of the DSM-5 level 2-substance use cross cutting tool for adults during initial assessment. Beneficiaries are assessed at the beginning of treatment, and adults are reassessed within one year of the initial assessment to ensure they continue to meet medical necessity and/or meet the target population. Beneficiaries who are in step down services may be assessed every two years, as appropriate. Results for all the tools are found in the EHR. The MHP reports that quality management chart reviews include not just compliance checks but content as well. The new EHR (InSync) will allow for system wide reporting in FY 2020-21. The MHP reports that CANS-50 utilization training has been added as part of MCBHRS clinical onboarding process. MCBHRS states that beneficiary outcome reports are shared during QIC and Utilization Management meetings; however, documents submitted for this review do not reflect routine sharing of results.			
4B	Beneficiary Perceptions	10	10
MCBHRS administers the Performance Outcomes Quality Improvement survey (POQI) twice annually. The MHP began collecting the Consumer Perception Survey (CPS) data electronically in November 2019 and completed electronic data entry for all CPS outcomes for the June 2020 submission. Survey results are shared twice annually with leadership, line staff, beneficiaries and stakeholders. The Mariposa County MHSA Three Year Plan (CY 2017-2020) stakeholder feedback indicates the following areas of need: 1) increased outreach and engagement for local veterans, homeless, and isolated older adult populations; 2) increased peer support; 3) assistance with navigating county services; 4) increased school based counseling; and 5) increased targeted wellness center activities for SMI population. The MHP CRC is addressing these areas of concern with outreach, trainings, and collaborations with CBOs. The QI Work Plan includes an initiative to increase the number of			

Component		Maximum Possible	MHP Score
beneficiaries who complete it along with a goal to improve overall satisfaction by 3 percent over last years' POQI results.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
The MHP has a single wellness center, located in the main town of Mariposa approximately one mile (new location) from the Mariposa County HHSA building. The wellness center is open every Monday thru Wednesday from 1 p.m. to 5 p.m. prior to COVID-19; the center is currently closed until further notice. The center is staffed by one benefited Mental Health Aide (peer) who currently provides outreach to beneficiaries via telephone and site visits (e.g. supported living). Prior to the pandemic, participants met monthly to determine which activities/groups are to be scheduled such as: outings; meditation; healing drum circle; cooking; gardening and art. Transportation is limited but may be provided if arranged in advance. New wellness center participants receive an orientation, and group/activity attendance is tracked. The MHP provides information about the wellness center in the beneficiary handbook, wellness center calendar and MCBHRS website. The MHP should expand transportation services to wellness center participants.			

Structure and Operations

In Table 39, 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	30
The MHP has a full range of services available, and consistently reviews its capacity to provide the necessary services as outlined in its contract. Services are provided in the main population center of Mariposa as well as in the north county town of Coulterville and within the national park at Yosemite Medical Clinic in Yosemite Valley. Most SMHS are provided by the MHP; however, they contract with the following five providers: Sierra Quest Human Services for STRTP; Mountain Mental Health; Quest Community Counseling; Ranchos Counseling; and an independent licensed clinician. The MHP is currently coordinating TBS with JDT Consultants. MCBHRS has been in			

Component		Maximum Possible	MHP Score
contact monthly with Sierra Quest Human Services regarding provision of TFC services; however, the collaboration is currently on hold. Crisis services are available in Mariposa County 24 hours a day, seven days a week. The Triage Response and Access to Care (TRAC) team provides crisis response to incidents in the community, jail, schools, hospitals, and other areas as needed; the Crisis Stabilization Unit (CSU) is located at the Mariposa Community Health Center. The MHP has a Memorandum of Understanding (MOU) with John C Freemont Hospital to provide treatment for psychiatric patients in the emergency department. MCBHRS collaborates with Mountain Crisis Services for domestic violence assistance.			
5B	Network Enhancements	18	18
The MHP has utilized or coordinates with several entities to access adjunct services such as Whole Person Care, telehealth, a wellness center, and the local homeless shelter project. The MHP's TRAC team offers 24-hour crisis response with both a local and 800 telephone number. Additionally, the MHP is integrated with various departments and is co-located with other agency divisions such as public health and CWS at its main office in Mariposa. The MHP is co-located with the Community Health Center (October 2019) and began providing psychiatry services in July 2020. MCBHRS contracts with Jackson and Coker Locum Tenens for telehealth psychiatry services, and the MHP transitioned most services to telehealth in response to COVID-19. MCBHRS currently operates telehealth services in four sites (one county and three contract providers) and served approximately 107 beneficiaries during the last 12 months. The MHP joined with San Benito and Plumas Counties to establish the Whole Person Care (WPC) Pilot program as part of the Small County Whole Person Care Collaborative (SCWPCC).			
5C	Subcontracts/Contract Providers	16	13
The MHP holds quarterly combined MOU meetings with MCBHRS and Mariposa County Public Health covering updates, issues and concerns, care coordination, and follow-up items. The designated MHP liaison is a single point of contact for all providers, and communications are weekly or as needed to share information, make adjustments, or problem solve. The MHP uses a bi-directional transition form to refer individuals who meet medical necessity to a contract provider when the MHP is at capacity. Individuals who do not meet medical necessity for SMI are referred to an MCO. The MHP confirms that the beneficiary has an appointment prior to transfer and follows-up within 30 days.			

Component		Maximum Possible	MHP Score
Community and contract providers are invited to attend all Cultural Competency trainings, QRC and QIC meetings; however, it appears that the MHP struggles with gaining consistent attendance from those entities. Documents submitted for this review do not reflect reports and data analyses obtained from contract and network providers. There are no contract providers active in Performance Improvement Projects (PIP) with the MHP.			
5D	Stakeholder Engagement	12	7
Active participation by manager, supervisors, clinical and support staff is evident in various system planning and development work groups or committees. Beneficiaries are asked for their input through the consumer surveys conducted by the MHP and as noted earlier, they provided examples where adjustments have been made based on beneficiary input. There is stakeholder input into the QIC with membership that includes a local behavioral health advisory board representative. Beneficiary and family involvement in the QIC are desired but remains a challenge. The MHP county website has a detailed page on the activities of the QIC and allows for public questions or input. The MHP posts a variety of up-to-date performance dashboards about the department, allowing consumers and stakeholders to review reports on service levels and other areas of interest. The MHP should take the necessary steps to follow the Request for Proposal (RFP) process when procuring goods (e.g. InSync), services (e.g. foundational programs) and supplies, rather than non-competitive, single-source purchasing.			
5E	Peer Employment	8	6
The MHP currently has 1.5 FTE positions designated for peers (Mental Health Aide). The one FTE benefitted Mental Health Aide position manages the Wellness Center in Mariposa and can provide support to the Full Service Partnership (FSP) program as needed. The peer may naturally progress to the Mental Health Aide I (after one year of service), II, and III levels; however, these positions are competitive and not limited to peers. There are at present no supervisory or management positions for peers. The remaining 0.50 FTE peer position is vacant and currently being advertised. The Mariposa County MHSA Three Year Plan (CY 2017-20) reports lack of supervisor and staff preparation, investment, recruitment, and appropriate oversight of the peer program. To assure readiness, Mariposa County teamed up with Workforce Integration Support and Education (WISE) a program of NorCal Mental Health America, and all supervisors have been trained with WISE Peer Support 101 for Supervisors. The county staff will be trained by WISE prior to bringing on the peers as			

Component	Maximum Possible	MHP Score
a strategy to successfully integrate the workforce. Mariposa county plans to support interested and ready individuals to receive training in the WISE U Peer Support Program and subsequently hire peer specialists through this pool of candidates.		

SUMMARY OF FINDINGS

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

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: No PIP submitted (not rated)

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- Acquisition of the RUS grant to expand use of telehealth and other mental health services at the North County Office in Coulterville and additional satellite offices (e.g. Yosemite National Park).
- Installation of RUS grant equipment completed in July 2020.
- Collaboration with Anthem and California Health and Wellness for reimbursement of non-medical transport to increase beneficiary access to transportation.
- Oversight of the emergency homeless shelter (Connections) transferred to Alliance for Community Transformations.

Strengths:

- The MHP's overall penetration rate of 11.22 percent is more than twice the state average of 4.86 percent; the Latino/Hispanic penetration rate is 9.10 percent, almost twice the state average of 4.08 percent.
- The MHP's current initiative for FY 2020-21 is to continue adding Medi-Cal certified sites in North County, inpatient psychiatric facilities, and for the Native American population (MiWu-Mati).

Opportunities for Improvement:

- Approximately 33 percent of beneficiaries receive less than five services indicating a potential challenge with retention.
- The MHP should investigate and focus on remediable barriers to increase beneficiary retention.

- The MHP has experienced significant staffing changes and vacancies over the last CY which have impacted timeliness of access and retention rates.

Timeliness of Services

Changes within the Past Year:

- The MHP reports that the implementation of the new EHR (InSync) will allow for accurate timeliness data collection and report production not previously available with the legacy EHR.
- Expansion of the nurse practitioner role from 0.32 FTE to 0.80 FTE, allowing for increased psychiatric intake appointments.

Strengths:

- The percent of initial requests to first offered appointment which met the 10-day standard improved from 62.53 percent last year to 84 percent of the time this year.
- The overall hospital re-admission rate within 30 days for the entire system of care is 5.77 percent.

Opportunities for Improvement:

- The length of time from request for urgent conditions to actual encounter is provided within 48 hours only 35.29 percent of the time.
- The percent of initial requests to first offered psychiatry appointment is provided within the 15-day standard only 70.75 percent of the time.
- The percent of follow-up appointments post-psychiatric inpatient discharge that meet the seven-day standard is only 40.38 percent.
- The no-show rate for psychiatrists (32 percent increase) and clinicians (72 percent increase) has steadily increased since FY 2018-19.
- The MHP should initiate performance improvement activities with time-limited goals to meet the state timeliness standards.

Quality of Care

Changes within the Past Year:

- The MHP reports that they are implementing a new EHR which has reporting and data analytic capability built into the system for real-time clinical information for staff and supervisors.

- The QA team completed training in Greenbelt Lean Six Sigma (QI philosophy) by Purdue University in September 2020.
- The MHP hired a Staff Services Analyst in June 2020 who has experience in data analytics.

Strengths:

- The QA staff are fully integrated with the leadership team, and there is a direct line of communication with administration.
- The MHP has an updated CLCP with current data reflecting the population in Mariposa County.
- The MHP has an updated QI work plan aligned with their CLCP and reflects a variety of initiatives assigned quantified goals and objectives with both process and outcome indicators.

Opportunities for Improvement:

- The MHP will prioritize the use of the new EHR (InSync) to extract and analyze data pertaining to access, timeliness, quality, and outcomes.
- Beneficiary, family member and peer participation are not reflected in FY 2019-20 QIC meeting minutes.
- The MHP's percentage of beneficiaries diagnosed with Anxiety disorders (28 percent) is almost twice the statewide average (15 percent).
- The MHP should ensure the methodology for assigning diagnoses is accurate and consistent among all clinicians.

Beneficiary Outcomes

Changes within the Past Year:

- Completed non-clinical PIP to address low rate of co-occurring disorder diagnoses and implemented clinical use of the DSM-5 level 2-substance use cross cutting tool for adults during initial assessment.
- Began collecting CPS data electronically in November 2019 and completed electronic data entry for all CPS outcomes for June 2020 submission.
- The MHP states that the new EHR (InSync) will allow for system wide beneficiary outcomes reporting in FY 2020-21.

Strengths:

- The wellness center Mental Health Aide (peer) is performing outreach to beneficiaries via telephone and field visits.

Opportunities for Improvement:

- The MHP does not include contract providers in use of their standardized screening tools.
- Stakeholder feedback in Mariposa County MHSA Three Year Plan (CY 2017-20) indicated:
    - Lack of supervisor and staff preparation, investment, recruitment and appropriate oversight of the peer program.
    - Need for outreach and engagement for veterans, homeless and older adult populations.
    - Need for increased school-based counseling, and targeted wellness center activities for SMI population.

Foster Care

Changes within the Past Year:

- A STRTP facility is now contracted through Sierra Quest Human Services to provide short-term intensive care and supervision to children and nonminor dependents.
- MCBHRS is currently in the licensing process with Central Star Crisis Residential Unit (CRU) in Merced to provide CSU level of care.

Strengths:

- The MHP had a significant increase in number of identified subclass members from 31 in FY 2018-19 to 69 in FY 2019-20.
- MCBHRS reports that the new EHR (InSync) will allow for electronic tracking, trending and routine report production of prescribing patterns and other SB 1291 requirements.
- The MHP has a CCR policy and procedure operating in draft form to improve coordination of resources and services to promote greater uniformity between MCBHRS and CWS.
- MCBHRS clinicians and CWS social workers are required to collaborate and attend Child and Family Team Meetings (CFTM) per most recent edition of the Core Practice Model requirements.

Opportunities for Improvement:

- CCR meeting minutes reflect that staff from CWS are invited to discuss shared assignments, policies, procedures and to review monthly reports; there is inconsistent CWS attendance at these meetings.
- The MHP should add a goal to the QI workplan with process and outcome indicators to monitor SB 1291 requirements and add a standing agenda item to the quarterly QIC meetings to allow for a deeper discussion of these mandates.
- MCBHRS should identify areas in which performance improvement or QI actions are indicated and take the necessary steps to ensure that SB 1291 requirements are being met.

Information Systems

Changes within the Past Year:

- The MHP is transitioning from their long-term EHR, CCBH, and ASP relationship with Kings View as they implement a new EHR with InSync.
- The MHP increased its use of telehealth by: (1) growing from one site in CY 2019 to four sites this year, and (2) increasing contract provider telehealth use from zero last CY to three this year.
- The MHP upgraded from their previous on-line video conferencing provider by obtaining sufficient licenses for all staff to use Zoom from their home-based offices.

Strengths:

- The MHP obtained a RUS grant allowing them to bring multiple sites up on telehealth and provided resources to obtain laptops and other technology for their staff.
- Despite having numerous vacancies in both leadership and line-staff, the MHP has benefited from the experience of multiple long-employed senior staff to provide stability and focus to the agency.

Opportunities for Improvement:

- The MHP will demonstrate how its new EHR (InSync) meets California state regulatory reporting requirements.
- The MHP would benefit from subject matter experts and could consider consulting with the County Behavioral Health Directors Association (CBHDA) IT forum to ensure successful implementation of their new EHR.

- MCBHRS will closely monitor and report on the implementation timeline and personnel resources allocated to the InSync implementation; this is to ensure that it will be robust, timely, and effective.
- The MHP will confer with other small counties who have begun to implement new-to-California SDMC billing EHRs (e.g. Lassen County) to share lessons-learned.

Structure and Operations

Changes within the Past Year:

- Significant staffing changes occurred in the past year including:
    - New Deputy Director of Behavioral Health in December 2019; now vacant as of May 2020.
    - Vacant HHSA Director as of May 2020.
    - County Health Officer currently acting as HHSA Director.
    - TRAC supervisor vacant as of April 2020.
    - Vacant System Support Analyst
    - Two vacant Office Assistant II positions in Medical Records.
    - Four vacant Mental Health Clinician positions (FSP and CCR programs).
    - Two Mental Health Assistant II and one AOD Specialist positions vacant in SUD and services program.
    - The 0.5 FTE peer position is vacant and currently being advertised.
- The MHP has increased the use of contract providers from 8 percent in FY 2018-19 to 19.75 percent in FY 2019-20.
- The MHP became co-located with the Community Health Center in October 2019 and began providing psychiatry services in July 2020.
- MCBHRS contracted with Jackson and Coker Locum Tenens for telehealth psychiatry services in January 2020 and transitioned most services to telehealth in response to COVID-19.
- The first STRTP facility is now contracted through Sierra Quest Human Services.
- The MHP contracted with JDT Consulting for TBS.

Strengths:

- The MHP experienced a smooth transition at the beginning of the COVID-19 pandemic and is providing most services via telehealth.
- The MHP improved access to service by increasing contract providers using telehealth from zero in FY 2019-20 to three in FY 2020-21.
- The MHP's knowledge, claims payment policies and practices for reviewing and processing denials is highly effective as demonstrated by the low denial rate of 0.70 percent, a quarter of the state's average of 2.99 percent.

Opportunities for Improvement:

- There are no contract providers involved as active stakeholders in the MHP's PIPs.
- Community and contract providers are invited to attend all Cultural Competency trainings, QRC and QIC meetings; however, it appears that the MHP struggles with gaining consistent attendance from those entities.
- MCBHRS should dedicate resources to obtain a second RUS grant which will bring approximately one million dollars of new technology to the agency.
- The MHP should take the necessary steps to follow the Request for Proposal (RFP) process when procuring goods (e.g. InSync), services (e.g. foundational programs) and supplies, rather than non-competitive, single-source purchasing.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: Continue to provide resources to identify, develop, and implement the DHCS required PIPs as per Title 42, CFR, Section 438.330, and ensure a launch timeframe within the review cycle that allows them to be considered active.

Access to Care

Recommendation 2: Develop and implement evaluation methods for determining the impact of QI activities on increasing engagement in mental health and substance use disorder (SUD) services, resulting in improved retention rates.

Recommendation 3: Continue to monitor and analyze the changes intake staffing and their long-term impact on timely delivery of services and beneficiary retention rates.

Timeliness of Services

Recommendation 4: Build electronic tracking, trending, and routine report production of urgent requests by the hour into the new EHR (InSync) to ensure compliance with state timeliness metrics as per Information Notice (IN) 18-010. (*This recommendation is a follow-up from FY 2017-18, FY 2018-19, and FY 2019-20.*)

Recommendation 5: Identify and implement solutions to meet the 48-hour state requirement of length of time from request for urgent conditions not requiring prior authorization to actual encounter to ensure compliance as per Information Notice (IN) 18-010.

Recommendation 6: Monitor all no-show metrics and implement streamlined strategies where needed to remove access barriers.

Recommendation 7: Implement Continuous Quality Improvement (CQI) strategies to meet the seven-day hospitalization discharge follow-up more routinely as per Information Notice (IN) 18-010.

Quality of Care

Recommendation 8: The MHP should establish a formal data governance protocol to record and transparently disseminate reporting data sources, assumptions, baselines, methodologies, and findings for its clinical QI data analytics reporting. (*This recommendation is a follow-up from FY 2018-19 and FY 2019-20.*)

Recommendation 9: The MHP should optimize the use of the new EHR (InSync) to capture clinical quality data and generate ongoing data reports to summarize prescribing patters. (*This recommendation is a follow-up from FY 2019-20.)*

Recommendation 10: Develop and monitor a formal governance framework to ensure the new EHR (InSync) is implemented in an effective and sustainable manner, while allocating sufficient personnel resources to accomplish this task.

Recommendation 11: Select and begin using data mining software to discover data trends for its clinical QI data analytics reporting and CQI efforts. (*This recommendation is a follow-up from FY 2019-20.)*

Recommendation 12: Through continuous monitoring of diagnostic patterns, explain MHP variations from statewide averages and determine if further intervention is necessary.

Beneficiary Outcomes

Recommendation 13: Enhance contract language with network providers to mandate the use of assessment tools such as Child and Adolescent Needs and Strengths (CANS-50) and Patient Health Questionnaire (PHQ-9) to be more uniform in the delivery of its standard of care. (*This recommendation is a follow-up from FY 2019-20.)*

Recommendation 14: Provide supervisor and staff preparation, investment, recruitment, and appropriate oversight of the peer program to promote wellness and recovery.

Foster Care

Recommendation 15: Resume discussions with probation and Child Welfare Services (CWS) and finalize the Therapeutic Foster Care (TFC) certification process of the local TFC with parties interested. (*This recommendation is a follow-up from FY 2019-20.)*

Recommendation 16: Add a goal to the quality improvement (QI) workplan with process and outcome indicators to monitor SB 1291 requirements and include a standing agenda item to Quality Improvement Committee (QIC) meetings to allow for a deeper discussion of these mandates.

Recommendation 17: Identify and implement strategies to improve engagement in Continuum of Care Reform (CCR) meetings between Child Welfare Services (CWS) and the MHP to ensure provision of quality care for foster care (FC) youth.

Information Systems

Recommendation 18: Work closely with the new EHR provider to ensure accurate and full implementation of a California Short-Doyle/Medi-Cal (SDMC) billing module, conferring with CBHDA and other peer InSync agencies and counties for technical assistance (TA).

Recommendation 19: Ensure that the new EHR (InSync) system offers state mandated technology capability, functionality, and security standards.

Recommendation 20: Maintain a working relationship with ASP/Cerner to ensure ongoing and successful monthly billing of services until such time as the new EHR is capable of doing.

Structure and Operations

Recommendation 21: Identify and implement strategies to improve outreach and engagement of contract providers and community-based organizations (CBOs) as stakeholders on the PIP team, Cultural Competence Committee (CRC) and Quality Improvement Committee (QIC).

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.
- The Creek Fire began on September 4, 2020 in the surrounding areas of Mariposa which greatly impacted the review; several MHP staff had to prepare for evacuations.
- The CFM focus group had one participant via videoconference. The CFM focus group is an important component of the CalEQRO review process. Feedback was obtained regarding quality, access, timeliness, and outcomes; however, specific information is omitted to protect confidentiality.
- There was insufficient information provided to assess the viability of the new EHR system.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment A—Review Agenda

The following sessions were held during the MHP desk and videoconference review, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

Mariposa MHP
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
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Consumer and Family Member Focus Group
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Telehealth

Attachment B—Review Participants

CalEQRO Reviewers

Angela Kozak-Embrey, Quality Reviewer
Lamar Brandysky, Information Systems Reviewer
Deb Strong, 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

Not applicable

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Glenn	Laura	Staff Services Analyst II	MCBHRS
Ridenhour	Randy	Senior Administrative Analyst	MCBHRS
Rumfelt	Lynn	Admin Analyst I	MCBHRS

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

Mariposa 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	1,661	183	11.02%	$1,162,083	$6,350

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

Mariposa 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	519	93.35%	93.31%	$2,372,965	$4,572	$3,998	62.89%	59.06%
>$20K - $30K	15	2.70%	3.20%	$341,000	$22,733	$24,251	9.04%	12.29%
>$30K	22	3.96%	3.49%	$1,059,041	$48,138	$51,883	28.07%	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
ASP	Application Services Provider
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

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

Acronym	Full Term
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MCBHD	Medi-Cal Behavioral Health Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NA	Network Adequacy
NA (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

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