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

PLACER-SIERRA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 19 – 20, 2021

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INTRODUCTION

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

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

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

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Placer-Sierra 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 — Medium

MHP Region —Central

MHP Location — Rocklin

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 2,488

MHP Threshold Language(s) — Spanish

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Network Adequacy

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

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

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

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

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS BHIN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS reviews these forms to determine if the provider networks meet required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services for youth and adults. If these standards are not met, DHCS requires the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, CalEQRO will review the AAS and ONA information as part of its annual EQR.

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 reviews access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups,

beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.calegro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

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

Status of FY 2019-20 Review of Recommendations

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

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.

Status: Met

- Two PIPs started and completed in the last year were submitted for validation.
- The PIP identified by the MHP as clinical was completed by the MHP, having analyzed data that demonstrated the extreme difficulty of assessing the results of their efforts. Based on the topic, it would not be considered clinical, and based on the methodology, it would not be considered a PIP. It is validated below.
- The MHP worked on both of these projects during the year, most of which was during the pandemic.

Recommendation 2: Because the EQRO did not rate either of the submitted projects, as both were considered not to be PIPs, the MHP is strongly encouraged to use EQRO technical assistance (TA) in the development of two new PIPs for the coming year. *(This is a carry-over recommendation from 2018-19)*.

Status: Partially Met

- The MHP accessed TA regarding both PIPs late in 2020 after addressing the immediacy of the COVID-19 changes in service delivery, the impact of those changes on administrative staff, and a PIP leadership personnel change.
- Earlier use of TA could have resulted in improvements in both projects.

Access Recommendations

Recommendation 3: Review the distribution of Spanish language flyers, instructions, and forms to increase the availability of these documents to the Hispanic/Latino community.

Status: Met

- The MHP distributes all Spanish language flyers and documents to contract providers via email and as soft copy to providers and other members of the Placer Race, Equity, Access, Diversity, and Inclusion Committee (READI) – formerly the Cultural and Linguistic Competency Committee (CLCC), to school liaisons, to the local medical clinics, and routinely presents information to the Latino Leadership Council.

Recommendation 4: Ensure that the Spanish language provider list on the website is up to date.

Status: Met

- The Spanish language provider list on the website was last updated in January 2021.

Timeliness Recommendations

Recommendation 5: Ensure that the necessary data is available, and queries structured to provide required timeliness reports for all agencies requiring reporting. *(This is a follow-up recommendation from 2018-19).*

Status: Not Met

- The Timeliness reports provided do not include the contractor providers' data.

- The MHP indicated that this recommendation was not completed due to competing priorities. As employees of the larger Placer Health and Human Services (HHS) Agency, many staff were deployed throughout the year on essential duties related to public health and in support of the response to the COVID-19 pandemic.

Recommendation 6: Develop a methodology to track first request for service to comply with timeliness requirements.

Status: Partially Met

- The MHP has methodology to document first request for service for adults, children, and foster care (FC).
- The tracking system does not capture time to first offered appointment for children and FC; however, the access system is designed to accommodate all initial assessment requests by the next day. Data regarding kept appointments demonstrates this capacity.
- The MHP's tracking and reporting capabilities continue to fall short of the DHCS requirements to demonstrate capacity to meet the timeliness standards.

Recommendation 7: Ensure that foster care timeliness performance is separated from that of other children.

Status: Met

- FC timeliness information is provided as a separate item for all measures other than first offered assessment in the MHP Assessment of Timely Access (MATA) report provided.

Recommendation 8: Continue to investigate and address barriers to timely access for children, both for first appointments and for psychiatric assessment. *(This is a carry-over recommendation from 2018-19).*

Status: Met

- Children's services timeliness data for initial request to first kept assessment and psychiatry appointments reflect significant improvement from FY 2019-20 to FY 2020-21. Similar improvement is noted in foster care performance.
- For child psychiatry appointments, obtaining important consent, lab, and other medical information is complex and contributes to delays in the provision of psychiatry services. Appointments are not scheduled until the required information is submitted.

- As partial explanation, the MHP pointed to the increased use of telehealth and decreases in no-shows once the pandemic restrictions on in-person services were implemented.

Recommendation 9: Develop and implement a plan for capturing contract provider timeliness data that can be reliably integrated into MHP totals.

Status: Not Met

- The timeliness data reported for FY 2019-20 did not include contract provider data.
- The MHP reported that due to staff redeployment to meet COVID-19 needs, they have not developed a complete plan to capture this information.
- The MHP plans to include a timeliness reporting requirement in the FY 2021-22 provider contracts.

Recommendation 10: Investigate the reasons for the high no-show rate for psychiatry and implement a plan to improve performance.

Status: Met

- Placer reported significantly reduced psychiatry no-show rates in FY 2019-20 for all populations.
- Due to the COVID-19 pandemic, provision of services for one-half of the fiscal year was predominantly via telehealth. While the MHP did not directly attribute the improvement to this shift in service delivery, they reported their intent to continue to utilize telehealth to a much greater extent after the pandemic is over.

Recommendation 11: Establish a standard for no-show rates against which to evaluate performance.

Status: Not Met

- The MHP continues to track no-shows for medical staff, which includes psychiatrists, physicians, and nurse practitioners. They do not track this metric for non-medical clinical staff.
- The MHP has not developed a standard agreed upon no-show rate for use in evaluating performance.

Quality Recommendations

Recommendation 12: Create quantifiable/measurable quality of care goals in the quality improvement (QI) and Cultural and Linguistic Competency (CLC) plans.

Status: Partially Met

- The MHP produces and updates a comprehensive QI and CLC plan annually.
- Much of the FY 2019-20 plan and update is devoted to tracking compliance with monitoring requirements, including some measurable targets, and detailing activities that more closely resemble an annual system-wide workplan.
- The document does not clarify the MHP's key QI and CLC goals.
- The MHP reported that Placer READI is now developing measurable goals.

Recommendation 13: Track, trend, and report performance on CLC and QI plan goals on a periodic basis throughout the year.

Status: Partially Met

- Minutes from monthly Quality Management (QM) Committee and quarterly Quality Improvement (QIC) Committee meetings reflect reporting of chart reviews, medication compliance, contract provider utilization data, and a few other compliance metrics.
- Data in the minutes are displayed as narrative with little or no attendant discussion or analysis documented.
- Reports submitted to the EQRO related to the QI plan were mostly narrative, specific to individual contractors or programs, reflect primarily utilization data, and include no evident trending of key performance indicators (KPIs) over time.

Recommendation 14: Ensure there is meaningful discussion in QI committees about submitted reports and that follow-up needs are identified and pursued.

Status: Not Met

- While attending to the needs of pandemic, redeployment has understandably distracted the MHP from their earlier intentions to improve their QI processes and reporting, there is no evidence that measurable progress was made.

Recommendation 15: Investigate the barriers and develop and implement a plan to improve coordination between psychiatry and primary care providers.

Status: Met

- As a response to continuing difficulties communicating with primary care, the MHP is moving forward on embedding a satellite Federally Qualified Health Center in their largest adult outpatient clinic. Their response to the pandemic has slowed progress on this initiative; however, they are targeting early 2021 to go live.
- In addition, the MHP is working on a few technology solutions for the exchange of information, including gaining access to beneficiary use of the emergency department and the exchange of information among providers.

Recommendation 16: Modify the medication monitoring chart review tool to be more specific and to capture required Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Status: Not Met

- The chart review tool does not capture most of the specific HEDIS and outcome measures required or recommended by DHCS.
- Review participants reported that they do not capture most of the items on the list provided by the EQRO.
- Some questions on the chart review tool may generally capture information related to the measures; however, as phrased, it would depend on the reviewer and the specificity of the documentation.

Recommendation 17: Develop and implement a data-based report on medication monitoring results that allows for tracking, trending, and identification of problematic issues requiring QI follow-up.

Status: Not Met

- Reports provided to QI committees continue to be narrative in style with no ability to track or trend performance over time.
- During the review, participants acknowledged the potential benefits of creating a dashboard-style report that would allow them to identify ongoing issues and make plans for remediation.

Beneficiary Outcomes Recommendations

Recommendation 18: Ensure that results and analysis of the Consumer Perception Survey (CPS), including identification of QI opportunities to pursue, are widely distributed across all stakeholder groups, including internal staff.

Status: Met

- The contract for the CPS scoring and analysis between the California Institute of Behavioral Health Services and DHCS has been discontinued; as a result, the MHP has been unable to obtain the data and analysis they previously received from CIBHS.
- In addition, the new contract establishes a new electronic methodology for completion, which resulted in a very low response rate in the spring; the fall survey period was cancelled by DHCS.
- Because the MHP had no data to share, this recommendation is determined to be met.

Recommendation 19: Investigate and address staff concerns regarding use of the Level of Care Utilization System (LOCUS) and ensure that complete data is being captured timely.

Status: Not Met

- The MHP has trained to this tool and reported provision of related supervision and discussion with the clinical team.
- However, in anticipation of a DHCS decision regarding statewide use of a tool for adult outcomes, the MHP is not planning to invest any further effort in this tool unless it becomes the state standard.
- The MHP reported interest in investigating the extent to which beneficiaries receive the type and amount of service indicated by their LOCUS scores.

Recommendation 20: Develop a plan to aggregate, periodically report, and analyze beneficiary outcomes.

Status: Partially Met

- The MHP reported aggregating and reporting on Child and Adolescent Needs and Strengths (CANS) scores quarterly; however, no reports submitted included CANS data.
- The MHP does not aggregate LOCUS scores.

Foster Care Recommendations

Recommendations are included in Quality section.

Information Systems Recommendations

Recommendation 21: Consult with Netsmart and DHCS representatives to resolve the MHP's inability to successfully upload void and replace transactions to the state system. Escalate this issue as needed to achieve resolution.

Status: Met

- After consultation with Netsmart and DHCS and updates to the EHR, the Void/Rebill process has been corrected.

Recommendation 22: Implement a plan to ensure timely submission of service data by contract providers.

Status: Met

- The MHP indicated that they could not identify a provider with late service data.
- Contract monitors from the MHP work closely with contractors to ensure timely submission. Service data is to be received within 30 days of month-end, per the terms of the provider contract.

Recommendation 23: Develop and implement a plan to achieve a fully functional EHR for county-operated programs.

Status: Met

- The MHP is in the process of implementing CareConnect. An estimate for going live has not been determined.

Structure and Operations Recommendations

Recommendation 24: Ensure that data analysis training is completed, and that affected staff have applied the learning to their reporting processes. *(This is a follow-up recommendation from 2018-19)*.

Status: Met

- The Fiscal Team has reclassified a position to include an analyst to provide data analysis for the HHS fiscal group. The staff person selected for this position had already been completing the tasks and assignments and so did not require additional training. This position is now tasked with training their direct reports.
- All analysts and technicians in the system of care (SOC) are assigned trainings to supplement their skill sets.

Recommendation 25: Refresh the Behavioral Health website to support beneficiaries seeking help and information and to comply with Mental Health and Substance Use Disorders Information Notice (IN)18-020 technical requirements.

Status: Met

- English and Spanish language provider directories are posted on the Placer Mental Health website.

Recommendation 26: Investigate contract provider concerns regarding administrative requirements, IT support, and report feedback as well as general relationship issues.

Status: Met

- The MHP indicates they are not aware of outstanding contract provider concerns.
- Workgroups have been implemented which include provider, fiscal staff, program staff and IT staff to address all issues upon implementation of a contract.
- The MHP hosts quarterly meetings with contractors and solicits agenda items in advance; the MHP reported that attendance at the meetings is very inconsistent.

Recommendation 27: Work collaboratively with the contractors to plan for and implement resolutions to those concerns.

Status: Met

- Contractors report a variety of communication and problem-solving interfaces with the MHP. Initial communication regarding requirements of the contract is intensive and helpful.
- During the review, the MHP agreed that continued efforts to solicit feedback from the contractors would be beneficial.

PERFORMANCE MEASURES

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

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

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

- 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, 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

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

1. 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: https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx
3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and 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
4. 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.

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).
- 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 Suppression Disclosure

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11, and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, 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

Placer/Sierra 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	31,660	52.3%	1,611	64.8%
Latino/Hispanic	10,666	17.6%	257	10.3%
African-American	1,352	2.2%	89	3.6%
Asian/Pacific Islander	3,942	6.5%	49	2.0%
Native American	473	0.8%	38	1.5%
Other	12,452	20.6%	444	17.8%
Total	**60,543**	**100%**	**2,488**	**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 identified in DHCS BHIN 20-070.

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

Placer/Sierra MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	76	3.1%
Other Languages	2,412	96.9%
Total	**2,488**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

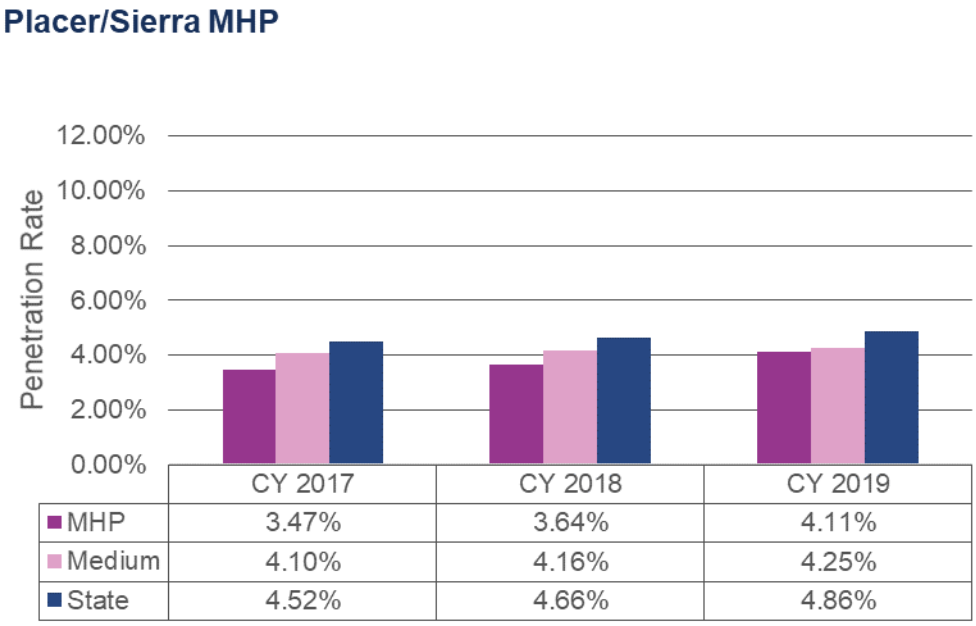
Penetration Rates and Approved Claims per Beneficiary

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

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

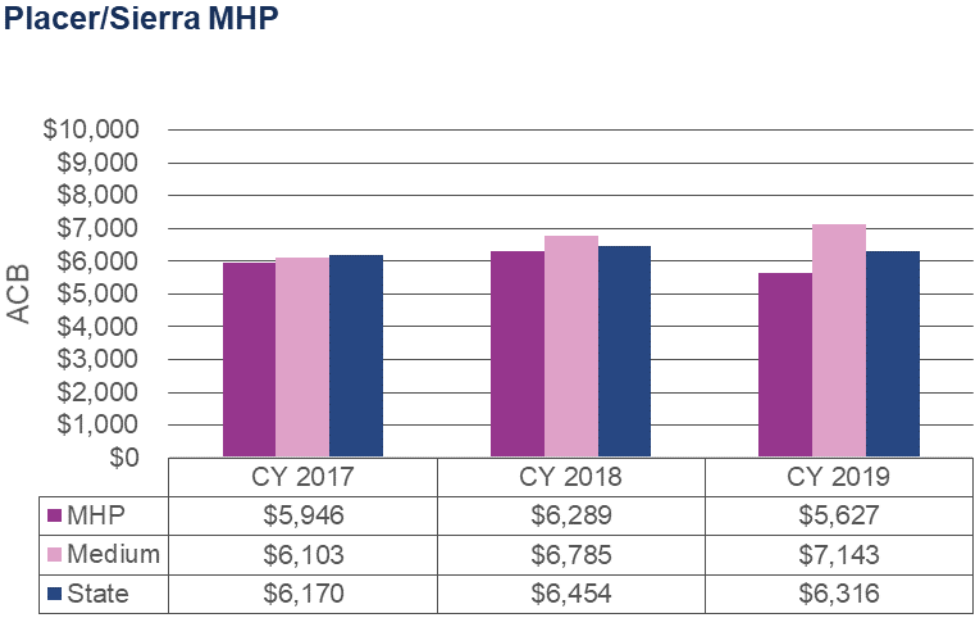
Regarding the calculation of penetration rates, the Placer-Sierra MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	3.47%	3.64%	4.11%
Medium	4.10%	4.16%	4.25%
State	4.52%	4.66%	4.86%

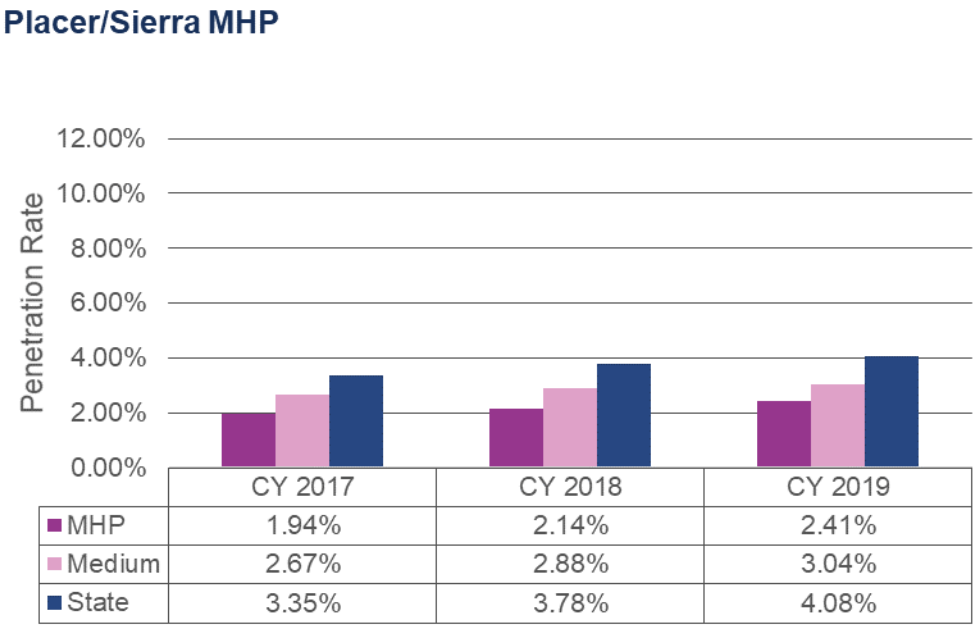
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$5,946	$6,289	$5,627
Medium	$6,103	$6,785	$7,143
State	$6,170	$6,454	$6,316

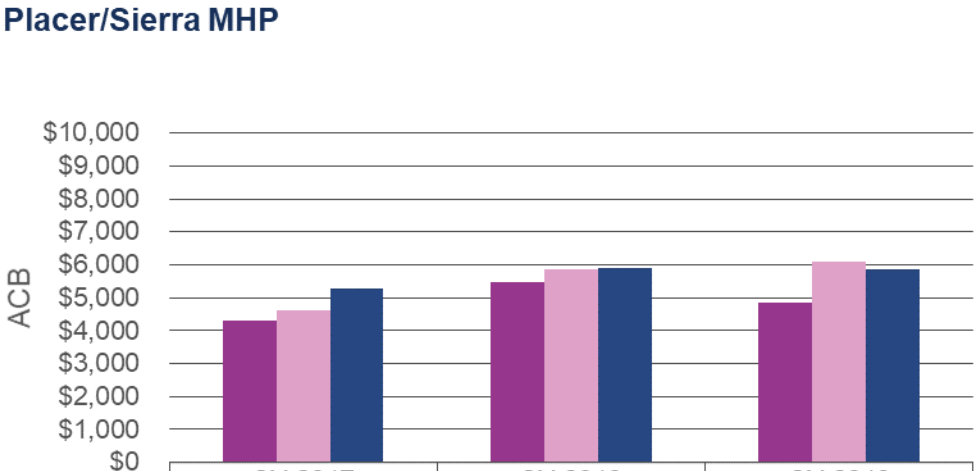
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	1.94%	2.14%	2.41%
Medium	2.67%	2.88%	3.04%
State	3.35%	3.78%	4.08%

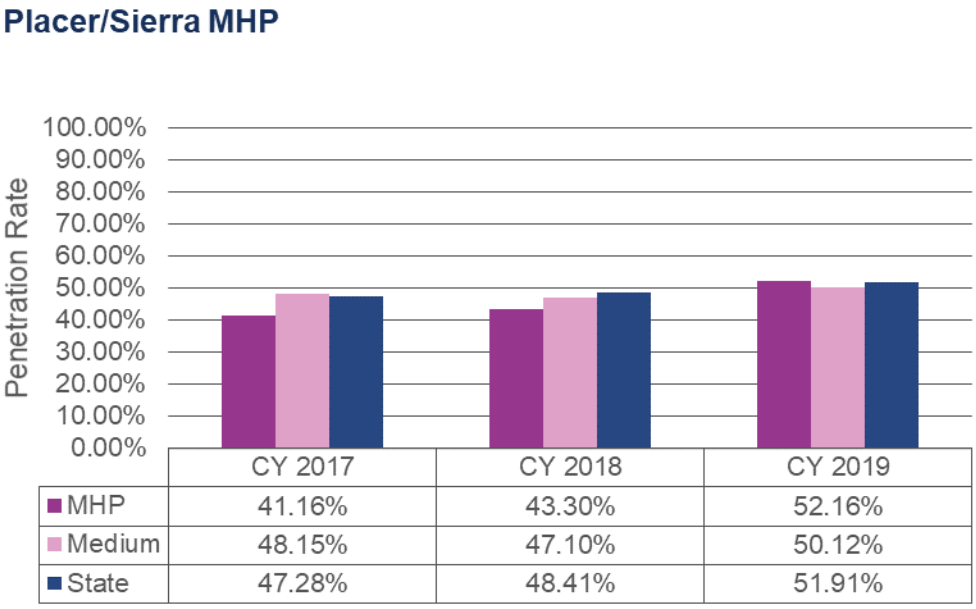
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$4,296	$5,471	$4,851
Medium	$4,622	$5,858	$6,081
State	$5,278	$5,904	$5,869

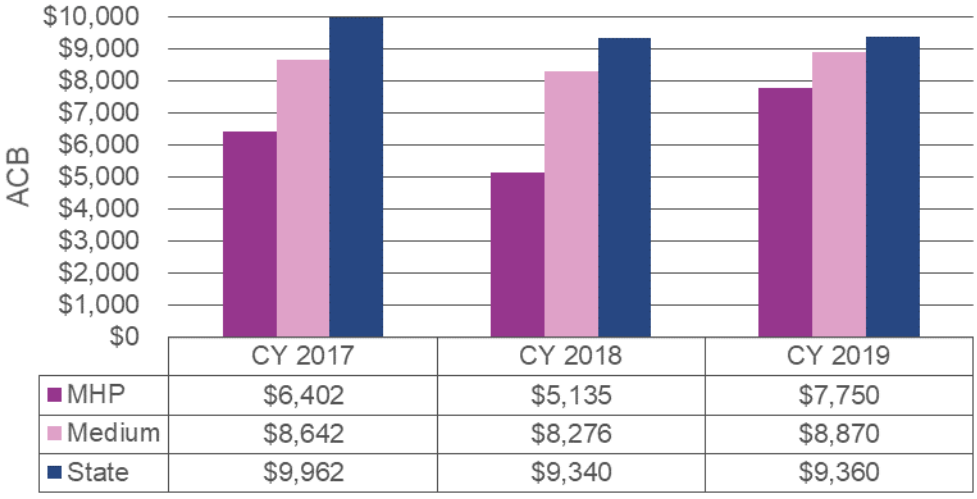
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	41.16%	43.30%	52.16%
Medium	48.15%	47.10%	50.12%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

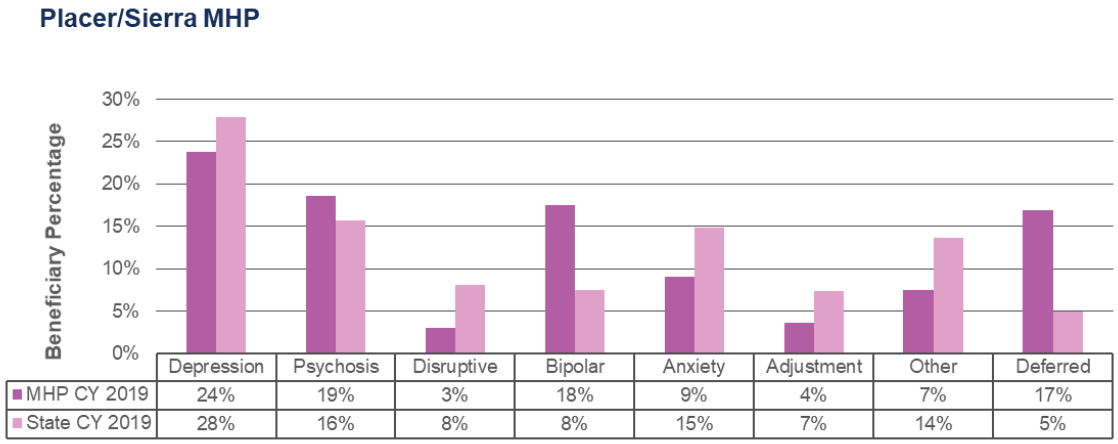


	CY 2017	CY 2018	CY 2019
MHP	$6,402	$5,135	$7,750
Medium	$8,642	$8,276	$8,870
State	$9,962	$9,340	$9,360

Diagnostic Categories

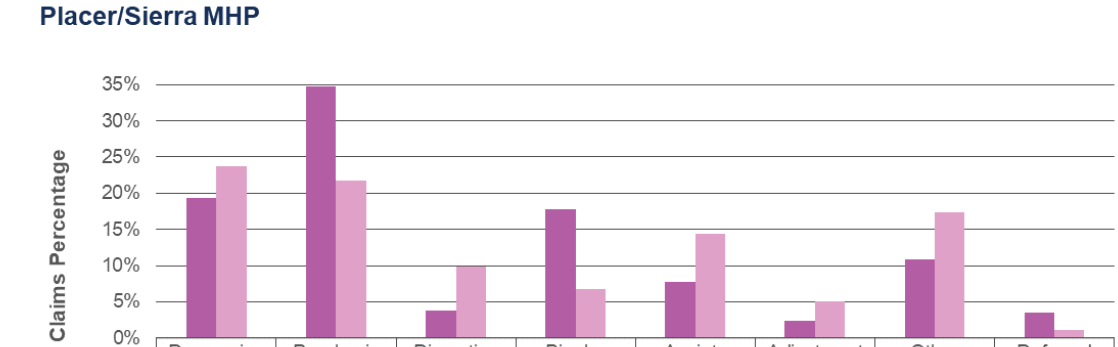
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	24%	19%	3%	18%	9%	4%	7%	17%
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	19%	35%	4%	18%	8%	2%	11%	4%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

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

Table 3: High-Cost Beneficiaries CY 2017-19

Placer/Sierra 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	74	2,488	2.97%	$48,685	$3,602,691	25.74%
	CY 2018	80	2,283	3.50%	$49,870	$3,989,609	27.79%
	CY 2017	84	2,238	3.75%	$47,058	$3,952,881	29.70%

See Attachment E, Table E1 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

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

Table 4: Psychiatric Inpatient Utilization CY 2017-19

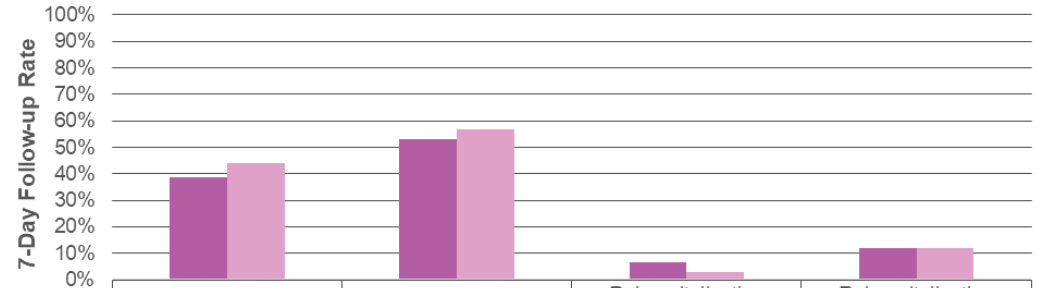
Placer/Sierra MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	403	644	10.61	7.80	$9,828	$10,535	$3,960,797
CY 2018	326	512	10.09	7.63	$11,403	$9,772	$3,717,362
CY 2017	388	724	10.38	7.36	$9,446	$9,737	$3,665,021

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

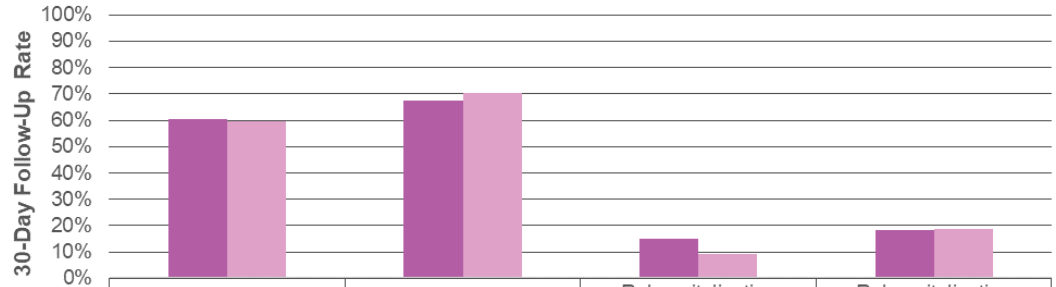
Placer/Sierra MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	39%	53%	7%	12%
CY 2019	44%	57%	3%	12%

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

Placer/Sierra MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	61%	67%	15%	19%
CY 2019	60%	70%	9%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Placer-Sierra MHP PIPs Identified for Validation

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

Table 5: PIPs Submitted by Placer-Sierra MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	"SOAR and its Effect on Homelessness"
Non-Clinical	1	"Aftercare"

- The MHP categorized the SOAR PIP as clinical, although because it does not include clinical interventions, it is not a clinical PIP.

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Placer-Sierra
PIP Title	SOAR and its Effect on Homelessness
PIP Aim Statement	"Will the use of the SSI/SSDI Outreach, Access, and Recovery (SOAR) application process with clients at risk of homelessness improve (decrease) levels of homelessness among homeless/at risk of homelessness adults receiving SMHS over a 12 month period?"
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)	

MHP Name	Placer-Sierra
☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The MHP defined the population as: “Placer Specialty Mental Health clients who are at risk of homelessness or who are homeless, who have completed an application with the SOAR program”; however, the intervention appeared to involve assisting beneficiaries with completion of the application. No further detail was provided. SOAR is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Assistance with SOAR application
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Re-measurement Year	Most Recent Re-measurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Number of clients (*sic*) who have secured housing	Not specified	Not specified	CY2020 ☐ n/a[5]	Results were not available due to lack of available housing information and lack of clarity regarding study population	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Was the PIP validated?				☒ Yes	☐ No	

Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☐ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	
☒ Other, completed one month prior to the current EQR	Completed (The MHP ended this PIP due to inability to access data required to evaluate performance).

[5] PIP is in planning and implementation phase if n/a is checked for all performance measures.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Re-measurement Year	Most Recent Re-measurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ PIP submitted for approval			Concept only, Not Yet Active			
☐ Planning phase						
☐ Other, inactive			Inactive, Developed in a Prior Year			

Validation rating:

☐ High confidence[6]
☐ Moderate confidence[7]
☐ Low confidence[8]
☒ No confidence[9]

Justification for validation rating: Most elements of the PIP lacked the specificity necessary to conduct a valid study, and the MHP concluded at the end, based on the available data, that the intervention was not appropriate for the population.

"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:

- This PIP has ended, and the MHP expressed interest in ongoing TA as they develop a new PIP.

The TA provided to the MHP by CalEQRO consisted of:

- The EQRO provided TA via Zoom on two occasions within two months of the review date.
- The EQRO provided the MHP with an annotated version of this PIP at the time of the TA.

[6] Credible, reliable, and valid methods for the PIP were documented.
[7] Credible, reliable, or valid methods were implied or able to be established for part of the PIP.
[8] Errors in logic were noted or contradictory information was presented or interpreted erroneously.
[9] The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Placer-Sierra
PIP Title	Aftercare
PIP Aim Statement	"Can the no-show rate be reduced by 5% for unestablished Adult Medi-Cal beneficiaries who received a referral to after-care services post psychiatric hospitalization discharge between July 1, 2019 and June 30, 2019 compared to the same 12 month period in the prior year?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): Adults (18+) who had not been engaged in outpatient services prior to receiving psychiatric hospitalization in a location other than the Placer County Psychiatric Health Facility.	

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):

PIP Interventions (Changes tested in the PIP)
1. The MHP aimed to change the follow-up process to increase participation in aftercare; however, the actual intervention was not clearly described in detail.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Re-measurement Year	Most Recent Re-measurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percentage of No-Shows	2017-18	163/553 29.48%	FY 2019-20 ☐ n/a	155/498 31.12%	☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Was the PIP validated?				☒ Yes	☐ No	
Validation phase:			PIP status (per DHCS requirement):			

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Re-measurement Year	Most Recent Re-measurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ Implementation phase				Active and Ongoing		
☐ Baseline year						
☐ First remeasurement						
☐ Second remeasurement						
☒ Other, completed one month prior to the review date				Completed		
☐ PIP submitted for approval				Concept only, Not Yet Active		
☐ Planning phase						
☐ Other, inactive				Inactive, Developed in a Prior Year		

Validation rating:

☐ High confidence[6]

☐ Moderate confidence[7]

☒ Low confidence[8]

☐ No confidence[9]

Justification for validation rating: This PIP does not clearly define the intervention, vacillates about the baseline comparison population/time frame, is not specific about the data being used to evaluate performance, and does not adequately define the population being studied. Measurement data provided was annual, and it was not clear when during those two years the intervention began.

"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:

- This PIP has ended, and the MHP is developing their next non-clinical PIP.

The TA provided to the MHP by CalEQRO consisted of:

- The MHP and EQRO reviewed this PIP once, late in the year prior to the review.

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key 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
Placer-Sierra	7.00%	7.00%	2.40%	2.40%
Medium MHP Group	n/a	3.28%	3.34%	3.01%
Statewide	n/a	3.58%	3.35%	3.34%

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 the BCP status is "No," the MHP uses an Application Service Provider (ASP) model to host the EHR system, which provides 24-hour operational support.	☒ Yes	☐ No
If the BCP status is "Yes," it is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP clearly identified as having responsibility for information security.	☐ Yes	☒ No
If no one within the MHP is identified as having responsibility for information security, the parent 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 county IT department is responsible for system and network security.

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	58%
Contract providers	39%
Network providers	3%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

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

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	2.50	0	0	0
2019-20	2.50	0	0	0
2018-19	5	1.50	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	0	0	0
2019-20	5	0.50	0.50	0
2018-19	6	1.50	0	0

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

- The MHP also receives support from the EHR vendor.

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 the MHP and does not account for users' 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	118	13	131
Clinical Healthcare Professional	158	11	169
Clinical Peer Specialist	11	0	11
Quality Improvement	10	0	10
Total	297	24	321

While there is no standard ratio of IT staff to support EHR users, 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	Medium MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	2.50	7.87
Total EHR Users Supported by IT (Source: Table 17)	321	572.00
Ratio of IT Staff to EHR Users	1:128	1:73

- Netsmart Technologies also provides EHR Support

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

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	2
Number of contract providers' telehealth sites	2
Total number of beneficiaries served via telehealth during the last 12 months	204
• Adults	125
• Children/Youth	72
• Older Adults	*
Total number of telehealth encounters (services) provided during the last 12 months:	679

CalEQRO suppressed values in the report tables when the count was less than or equal to 11, and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries.

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.

- In conjunction with program leadership, IT developed flexible solutions for serving the community during COVID-19. The MHP now has a spreadsheet with the potential platforms and solutions available for use in delivering tele-health services.
- IT assisted county employees with hardware and software requests to support them working at home. Laptops were updated and repurposed for at-home workers.
- The MHP increased meetings and communications with providers and staff to keep all informed.
- Use of telehealth has increased participation and reduced no-shows.

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

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

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
Uplift Family Services	1
Sierra Mental Wellness Group	1

- This information reflects use of telehealth prior to the pandemic. All providers moved to an array of virtual platforms for service delivery once the restrictions on face-to face-contact were implemented.

Current MHP Operations

- Placer continues to use Avatar, hosted and supported by Netsmart technologies, as its EHR. The Avatar system provides practice management, billing, managed care, clinical and medical record support, and state-mandated reporting operations.
- The MHP utilizes various platforms to meet telehealth needs across the county, including Zoom, Skype, and Microsoft Teams.
- Forms were altered to allow for completion in the field. The MHP ensured that the forms could be signed using Adobe PDF.
- To respond quickly to COVID-19 changes, staff initially took their work computers home, and as it became available, staff were supplied with the additional technology required to work more effectively on virtual platforms.
- The Key Performance Indicator module is online. Dashboard training and deployment continue.

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 (SD/MC) 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
Avatar	EHR	Netsmart Technologies	17	Netsmart
LOCUS	Level of Care Utilization	Deerfield Behavioral Health	5	Admin IT

Major Changes Since Prior Year

- Migration to the Netsmart hosted platform for Avatar was completed.
- Appointment Scheduling Phase I was fully implemented.
- Appointment Scheduling Phase II utilizing a single calendar was implemented.
- Automation of authorizations for the Managed Service Organizations (MSO) was completed.
- Six programs were converted from Mental Health Services Act (MHSA)-only funding to Medi-Cal certification and service claiming.

The MHP's Priorities for the Coming Year

- To complete the upgrade of Cache 2017 in preparation for NX platform (next generation of Avatar).
- To complete KPI Dashboard training and deployment.
- To implement Care Connect health information exchange.

Other Areas for Improvement

- Full implementation of Medicare Part B claiming, which has been delayed due to the impact of COVID-19, would reduce claims denials resulting from billing Medi-Cal first.
- The MHP would benefit from maintaining a formal record or log of IS/computer training activities.

Plans for Information Systems Change

- No plans to replace the current system.

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 Pre-sent	Not Rated
Alerts	Netsmart/ myAvatar	☒	☐	☐	☐
Assessments	Netsmart/ my Avatar	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/Storage	Netsmart/ myAvatar	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Netsmart/ Topaz	☒	☐	☐	☐
Laboratory results (eLab)	Netsmart/ OrderCon-nect	☒	☐	☐	☐
Level of Care/Level of Service	Deerfield BH/ LOCUS	☒	☐	☐	☐
Outcomes	Netsmart/ myAvatar	☒	☐	☐	☐
Prescriptions (eRx)	Netsmart/ OrderCon-nect	☒	☐	☐	☐
Progress Notes	Netsmart/ myAvatar	☒	☐	☐	☐
Referral Management		☐	☐	☒	☐

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Treatment Plans	Netsmart/ myAvatar	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		10	0	2	0
FY 2019-20 Summary Totals for EHR Functionality:		10	0	2	0
FY 2018-19 Summary Totals for EHR Functionality:		10	0	2	0

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

- The MHP anticipates implementation of CareConnect in 2021.
- The MHP has a no wrong door policy for referral and as such does not see the need to implement the referral management portion of the EHR.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not Applicable
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not Applicable
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not Applicable
Direct data entry into MHP EHR system by contract provider staff	60%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	35%	Daily
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	5%	Monthly

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

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

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

EHR Vendor	Product	Count of Providers Supported
NextGen	EHR	1
Welligent	EHR	1
FAST	Proprietary EHR	1

Personal Health Record

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

☐ Yes ☒ No ☐ Implementation Phase

Not Applicable

Expected implementation timeline:

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

- The MHP does not have the staffing to manage and support a PHR.

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

Table 28: PHR Functionalities

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

- ☒ Dimension Reports application
- ☐ Web-based application, including the MHP EHR system, supported by vendor or ASP staff
- ☐ Web-based application, supported by MHP or DMC staff
- ☐ Local SQL database, supported by MHP/Health/County staff
- ☐ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP's SD/MC claims.

Table 29: Summary of CY 2019 SD/MC Claims

Placer/Sierra MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**63,435**	**$18,535,252**	**10,361**	**$2,578,758**	**12.21%**	**$15,956,494**	**$12,968,486**
JAN19	5,185	$1,387,623	399	$90,648	6.13%	$1,296,975	$1,178,787
FEB19	4,572	$1,229,385	327	$77,455	5.93%	$1,151,930	$1,043,945
MAR19	5,304	$1,336,249	422	$92,098	6.45%	$1,244,151	$1,108,607
APR19	5,623	$1,397,359	530	$88,638	5.96%	$1,308,721	$1,177,686
MAY19	5,843	$1,528,109	632	$136,309	8.19%	$1,391,800	$1,208,332
JUN19	7,997	$2,716,594	3,208	$707,193	20.66%	$2,009,401	$1,246,161
JUL19	5,523	$1,746,856	944	$285,633	14.05%	$1,461,223	$1,147,958
AUG19	4,975	$1,543,692	874	$241,548	13.53%	$1,302,144	$1,039,421
SEP19	4,769	$1,507,783	821	$230,105	13.24%	$1,277,678	$1,007,999
OCT19	4,852	$1,433,703	797	$217,473	13.17%	$1,216,230	$958,719
NOV19	4,447	$1,370,206	703	$207,100	13.13%	$1,163,106	$939,277
DEC19	4,345	$1,337,693	704	$204,557	13.26%	$1,133,136	$911,594

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

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 MHP's 12.21 percent denial rate is 9.22 percent above the statewide rate of 2.99 percent.
- During the CY 2019 claiming period the MHP received numerous denials due to a processing change at DHCS.

Table 30 summarizes the top five reasons for claim denial.

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

Placer/Sierra MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible or non-covered charges.	3,318	$948,776	37%
Service line is a duplicate and a repeat service procedure code modifier not present.	3,452	$669,173	26%
Medicare or Other Health Coverage must be billed before submission of claim.	1,409	$309,058	12%
NPI, Type 2 credentialing data missing, incomplete, or invalid.	880	$300,331	12%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	649	$195,170	8%
Total	10,361	$2,578,758	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 "Service line is a duplicate and a repeat service procedure code modifier not present" are generally re-billable within the State guidelines.
- The MHP had delays in claiming to Medicare Part B, which increased denials for the reason "Medicare or Other Health Coverage must be billed before submission of claim".

NETWORK ADEQUACY

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

Network Adequacy Certification Tool Data Submitted in April 2020

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

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

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Placer, the time and distance requirements are 60 minutes and 30 miles for mental health services, and 60 minutes and 30 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

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

Review Sessions

Due to the MHP's role in the county's COVID-19 response, an abbreviated and virtual review did not allow for key informant interviews to identify any problems or barriers for the beneficiaries relating to access and timeliness issues.

Findings

There were nine zip codes with approved AAS in Placer/Sierra County. These zip codes (95715, 96140, 96141, 96142, 96143, 96145, 95146, 96148, 96161) were not included in the April 2020 NACT submission due to an error.

The contract for services in the Tahoe Basin had concluded, and interim services were provided by clinical and medical staff who were traveling to the area during this gap period. There is now a new contract in place that includes both outpatient services and psychiatry in this zip code, meeting both time and distance standards. In addition, negotiations are underway with another provider for both outpatient and psychiatry services to begin in the next several months, thereby increasing the MHP's capacity for client care.

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

Not Applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

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

Table 31 below provides a summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	2
NPI Type 1 and 2 numbers are the same	27
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	4
NPI Type 1 number reported is associated with two or more providers	0
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	0
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	4

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted zero focus groups with consumers (MHP beneficiaries) and/or their family members during the review of the MHP. As part of the review planning process, designed to accommodate the MHP's commitments to the county's COVID-19 response, CalEQRO requested one focus group with 10 to 12 participants, the details of which can be found in the section below.

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of TAY beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. Despite the MHP's attempt to convene this group, including receiving confirmation from seven potential participants, no one attended the session. The CFM consultant reached one person by phone and gathered information; however, that information will not be used in this report for both confidentiality reasons and an inability to generalize beneficiary experience from one person's responses.
Total number of participants	N/A
Number of participants who initiated services during the previous 12 months	N/A
Interpreter used	N/A

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

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

Access to Care

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

Table 33: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
Last fiscal year the MHP completed translation of all of their forms, which are available in Spanish in the clinics and on the website.			
1B	Capacity Management	10	10
The MHP has redesigned the CLCC, now called Placer READI, in part to improve data-based reporting that will identify gaps in access and service delivery and measure the impact of strategies for improvement.			
1C	Integration and Collaboration	24	24
The MHP integrates and/or collaborates with all human service, law enforcement, health, and educational systems, including faith-based organizations and the housing authority. Child Welfare (CW) is under the Placer HHS umbrella and works closely with mental health (MH) services as part of the Children's' System of Care (CSOC). CW and CSOC are co-located.			

Component	Maximum Possible	MHP Score
The Family Mobile Team, a pilot program to reduce the number of youth 5150 admissions and the overall number of youth and family crises, is co-located with the Roseville Police Department to facilitate collaboration. The MHP worked with the Placer County Office of Education (PCOE) to establish wellness centers in several schools over the last year. The PCOE employs the clinicians, family advocates and a project coordinator for the wellness centers; one clinical supervisor, who also co-leads the project, is provided by the CSOC and is an HHS employee.		

Timeliness of Services

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

Table 34: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	12
Placer reports on this metric only for the Adult System of Care (ASOC); the access system for children is designed to accommodate next day appointments for all requests. The adult system operates walk-in clinics three days per week, available to all beneficiaries requesting services, also ensuring that everyone can be seen within a day or two. Sierra reports on all timeliness measures separately. For Placer, the average time for first offered appointments for adults is 1.5 days; 100 percent of appointments meet the ten business-day standard. Overall, first kept appointments met the ten-day standard 97.2 percent of the time. Sierra reported an overall average time of 8.4 days, with foster care averaging 18.7 days, including one outlier among four appointments counted. Sierra met the ten business-day standard for initial appointments 83 percent of the time. Placer reports timeliness data quarterly for the CSOC at QM meetings. They plan to create an overall SOC timeliness reporting schedule. Sierra reports these measures annually. Placer's timeliness for all metrics is tracked and reported for the MHP only; Sierra directly provides all services.			

Component		Maximum Possible	MHP Score
2B	First Offered Psychiatry Appointment	12	10
Placer reported on time to first completed appointment. Overall, 47.55 percent of appointments met the 15 business-day standard. Average adult time was 23.65 days; children was 5.88 days; and foster care was 5.33 days. Appointments for children and foster youth are scheduled once the required information packet has been received. Sierra reported overall 83 percent of appointments met the 15 business-day standard, with an average overall of 10.2 days.			
2C	Timely Appointments for Urgent Conditions	18	16
Placer reports this metric from mobile crisis data for ages 16 and up, 5150 crisis assessment data. The reporting includes the entire system. Sierra does not report on this metric, stating that they provide immediate crisis intervention assistance until an appointment is available, within 24 hours. Placer reported 100 percent of all urgent requests met the 48 hour standard, averaging overall just over two hours.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	10
Placer reported an overall average of 10.9 days for follow-up appointments post-discharge, with children averaging 13.2 days at the high end of the range; the MHP reported that 61.1 percent of appointments met the standard. Sierra reported that for the total of six discharges, all met the seven-day standard.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
Placer reported an overall 12.93 percent readmission rate within 30 days of discharge. This reflects an increase for adults and a decrease for children over the previous year. Total discharges increased by 138 (21 percent) in FY 2019-20, and readmissions within 30 days increased by 42 (almost 70 percent). The MHP's seven-day readmission rate in CY 2019 (3 percent) was less than half the rate in CY 2018 (7 percent). Sierra reported no readmissions within 30 days in the last fiscal year. Discussion in the review about these differences focused on the impact of COVID-19 as well as some data clean-up undertaken by the MHP.			
2F	Tracks and Trends No-Shows	10	6

Component	Maximum Possible	MHP Score
Placer reported no-shows only for psychiatrists and nurses. The overall average rate for psychiatrists was 13.2 percent, with children reported as 5.4 percent. For nurses, the overall average was 4.9 percent, with children reported as .4 percent. These metrics reflect a significant decrease over last year; discussions throughout the review reflected on the relationship of telehealth to no-show rates. MHP explanations related to reporting on this metric for non-medical clinicians have varied over the last two years; while the EHR does not have reportable data fields to capture this information easily, creating a tracking system would provide valuable information for the MHP. Sierra reported an overall no-show rate for psychiatrists as 7 percent, and for clinicians other than psychiatrists the overall rate was 5 percent.		

Quality of Care

In Table 35, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 35: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	10
The MHP appears to use the MHSA Three-Year Plan as their locus of data regarding underserved populations and plans to address deficiencies. A variety of committees review data related to service patterns monthly and quarterly; however, it is not clear how that information feeds development of goals and targets for improvement in access, quality, and timeliness. The MHP produced an annual CLC report for FY 2019-20 that assessed performance against their goals. Many of the goals are stated as action plans, such as tracking training attendance and offerings, conducting access line test calls, sustaining a training team, and monitoring adherence to Culturally and Linguistically Appropriate Services (CLAS) Standards. Strategies for improving access for underserved communities do not appear to be the focus of this committee. Staff training is underway to increase awareness of beneficiary needs and improve responsiveness.			

Component		Maximum Possible	MHP Score
The CSOC is working closely with the Sierra Native Alliance and Latino Leadership Council to coordinate beneficiary cultural and linguistic needs and to continue to integrate Native American and Latinx service teams into the CSOC. The MHP reported that the new Placer READI structure is fully integrated across MH, CW, and DMC-ODS. The new committee is in the process of developing more targeted, measurable goals and a structured reporting process. The EQRO did not see any documents that reflect these changes.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
To establish levels of care, the LOCUS is used for adults and a modified Beacon medical necessity tool was developed for children. Youth with milder needs are referred to network providers, and those requiring more intensive services are referred to a contracted agency. Consultation between programs regarding individual beneficiaries is routine as changing needs are identified, and warm hand-offs are facilitated when changes are indicated. The MHP and health plan have a process for consulting on possible transitions across systems, using a jointly-developed screening tool. Collaborative documentation is used with permission from beneficiaries; beneficiary signatures are verified as part of chart reviews. The CANS is used as a collaborative treatment planning tool with children and their families.			
3C	Quality Improvement Plan	10	6
The structure and content of the QI Plan has not changed relative to last year. Goals continue to be primarily compliance-related processes, and it does not include an analysis of disparities. Minutes reflect some reporting on some monitoring activity. The MHP reported that detailed data reports are reviewed most frequently by specific SOC and leadership teams; however, no evidence was provided regarding those meetings. The goals of the CLCC were included in the FY 2019-20 QI Plan update.			
3D	Quality Management Structure	14	13
The quality management structure is both dispersed across and embedded within the systems of care (including CW and DMC-ODS) as well as coordinated, including multiple, function-specific committees and teams that collaborate and coordinate through a QI Committee that oversees all QI activity. Meetings occur weekly, monthly, and quarterly and include all levels of internal staff as well as external stakeholders. Both the Placer READI and the Medication Review committees are part of the QI structure.			

Component		Maximum Possible	MHP Score
The MHP described frequent cross-system meeting attendance and report-sharing that facilitates coordination of QI activities across the entire system. There is no evidence that the QIC routinely reviews progress on QI goals or data beyond some beneficiary safety and compliance requirements.			
3E	QM Reports Act as a Change Agent in the System	10	7
The MHP provided few reports directly related to QI goals, and minutes reflected discussion of a few compliance-related monitoring activities and some timeliness data. CSOC produces quarterly reports detailing penetration rates and utilization across MH and CW, including use of specialty and high intensity services. Data is presented in graphs and charts and for some elements, trended over more than a year. The CSOC Key Data Indicators report also tracks service delivery related to Continuum of Care Reform for both foster youth and other high risk youth being served by the mental health system and Juvenile Justice (JJ). It is not clear how these reports are used.			
3F	Medication Management	12	8
Chart review reports do not reflect tracking of most SB 1291 and HEDIS measures, and staff concurred. Reports are narrative with numbers embedded in text; data-driven, trended reports are not produced; staff acknowledged benefit of tracking performance on key indicators over time. Results of reviews are provided to the medication staff committee and to QI quarterly, and problematic findings are addressed individually.			

Beneficiary Progress/Outcomes

In Table 36, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 36: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	15
The MHP uses the LOCUS, CANS, and the Pediatric Symptoms Checklist (PSC-35) as outcome tools. The MHP reported inconsistent use of the LOCUS and plans to create a report to identify training and support needs. Aggregated reports are reviewed quarterly by the Evaluation Committee.			
4B	Beneficiary Perceptions	10	8
The CPS was not administered during the Fall 2020 due to the pandemic, and the Spring survey yielded minimal response (administration process changed to electronic). There is no evidence that the MHP administers its own survey in addition to the CPS. The MHP also gets input through the MHSA process, the Mental Health, Alcohol and Drug Advisory Board, and multiple cross-system committees in which they are involved.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
Wellness centers are closed due the pandemic; however, they are located in Auburn and Roseville, are mostly peer-influenced, or run, and are open to anyone over the age of 18. The MHP operates youth “wellness centers” in partnership with the PCOE at several schools.			

Structure and Operations

In Table 37, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 37: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	26

Component		Maximum Possible	MHP Score
The MHP expanded the mobile response team, creating a Family Mobile Team located at the Roseville Police Department to respond to situations that do not appear to need law enforcement involvement. The MHP does not offer Day Treatment Intensive nor Day Rehabilitation.			
5B	Network Enhancements	18	16
The MHP is co-located with schools, Probation, and Juvenile Detention as well as being part of an integrated system with CW. Use of telehealth has expanded across the system due to the pandemic; most outpatient services are currently being provided virtually. During the review, several providers indicated they have staff who speak the threshold language.			
5C	Subcontracts/Contract Providers	16	15
Contract providers sit on multiple SOC and quality-related committees, and the MHP hosts a quarterly contractors' meeting to discuss general system issues. The MHP reported that they always solicit agenda items ahead of the meetings and that the meetings are not as well attended as they would like them to be. The MHP has initiated multiple attempts to engage providers in defining the best communication strategies. All contractors are assigned a contract monitor who meets with them at least quarterly but is also always available for any requests or questions. Generally, the contract monitor provides information and updates about such issues as billing, policy, and services; however, the MHP reported that providers are always involved in developing implementation plans for any new requirements defined by the county, state or federal government. During the review, providers raised concerns regarding adequate communication, as they had last year. The MHP recognizes that there may be more they can do to understand the issues and possibly address them.			
5D	Stakeholder Engagement	12	12
The MHP convenes multiple meetings that address system planning, both internally and involving a broad range of community stakeholders. While participation varies, goals in the QI plan and stakeholder report during the review demonstrate the MHP's commitment to inclusive planning. All peer positions are now under one contract. The contractor oversees a Consumer Council that reviews system changes, policies, had input into selection of interpreter service.			

Component		Maximum Possible	MHP Score
5E	Peer Employment	8	8
The MHP has moved to a full peer workforce model (under one contractor), in contrast to peer positions being a steppingstone to other positions requiring additional training and/or education. A Peer Coordinator sits on various committees, including leadership as does the manager of Parent Partners.			

SUMMARY OF FINDINGS

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

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Completed

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- Since the onset of COVID-19 restrictions on interpersonal contact, almost all services have been provided virtually or via telephone.
- Data indicate an increase in hospital admissions and crisis services encounters. In addition, data revealed that, while fewer individuals were being served, the frequency of their services increased.
- Longer stays in residential settings due to COVID-19 have resulted in back-ups in the Emergency Department, as discharge options have dwindled. This situation has prompted the MHP to investigate the possibility of opening a Crisis Stabilization Unit. They are also working with Crisis Now, an initiative of the National Association of State Mental Health Program Directors, to brainstorm strategies.
- Use of telehealth in the CSOC has provided the opportunity for more family and other support people to participate.
- Staff redeployment to deal with the Placer HHS COVID-19 response, as well as family needs, illness, and medical accommodations, have impacted staff morale and availability.

Strengths:

- None noted.

Opportunities for Improvement:

- None noted.

Timeliness of Services

Changes within the Past Year:

- Timeliness metrics have improved significantly: the adult average from request to first kept appointment is two days, and the average for children is 1.9 days, with 1.5 days for foster youth. The MHP hypothesizes this is due to the availability of virtual appointments and the structure of next-day appointments for youth and three days per week of initial appointments for adults.
- There has been a marked reduction in no-shows for psychiatry appointments.

Strengths:

- Sierra is able to schedule initial assessments well within the ten-day standard and urgent requests are accommodated immediately, with an appointment always available within 24 hours.
- The MHP's seven-day readmission rate in CY 2019 (3 percent) was less than half the rate in CY 2018 (7 percent).

Opportunities for Improvement:

- The MHP's timeliness data for multiple measures does not conform to state requirements.
- Data for urgent requests is only captured from mobile crisis data (ages 16 and older) and 5150 assessment data for beneficiaries of all ages.
- Creation of a comprehensive dashboard and (at least quarterly) reporting schedule for timeliness performance for the entire system would provide the MHP with a complete picture, including trends over time.

Quality of Care

Changes within the Past Year:

- The MHP has redesigned the CLCC, rebranding it as the Placer READI committee, with expanded membership and increased clarity of goals and measurement of performance.

Strengths:

- QI and CLC efforts have been better integrated with the creation of Placer READI, including designating the QM manager as the Ethnic Services Manager/chair of the READI committee.

- The MHP has a robust QM structure that allows for cross-system collaboration (including CW and JJ) and information-sharing.
- Reports related to the goals in the QI Plan are distributed and reviewed at multiple levels, in multiple program areas of the system; in addition, the reports are reviewed quarterly at QIC, the main coordinating committee that has a total view of the system.

Opportunities for Improvement:

- QI Plan goals continue to reflect primarily compliance-related monitoring activity and routine activities such as scheduling and tracking training participation.
- Quarterly medication monitoring reports do not track and trend performance on the existing measures and are therefore not conducive to identifying QI opportunities at the system level.

Beneficiary Outcomes

Changes within the Past Year:

- The CPS was administered electronically in spring 2020 and was not rolled out all in the fall. Therefore, the MHP had very little hard data to use during the past fiscal year, although input from beneficiaries and other stakeholders is provided in an array of committees and planning groups such as the MHSA planning process and the Mental Health, Alcohol and Drug Advisory Board.
- Peer employment has been centralized under a single contract and has shifted to a full peer workforce model that provides for multiple types of positions and supervisory and management roles that constitute a career ladder. The contractor deploys positions throughout the SOC.

Strengths:

- Peer positions are both full and part-time, some benefitted, and include supervisory roles. The MHP has taken steps to fully embed peer employees throughout the SOC.

Opportunities for Improvement:

- Consistent use of the LOCUS until a state-defined scale is identified would benefit treatment planning and outcomes for beneficiaries.

Foster Care

Changes within the Past Year:

- The Mental Health Screening Tool was updated to increase the number of CW system-involved youth eligible for MH services.
- Work continued with County Counsel on minimizing the barrier to timely treatment caused by the existing Consent to Treat Policy.
- Some existing foster families are discontinuing their availability until the pandemic is over.
- Five group homes converted to Short Term Residential and Therapeutic Program status, requiring significant training and collaborative meetings to develop processes to ensure adequate monitoring of service provision.

Strengths:

- Foster care data is disagregated in the MATA.
- Because CW is an integrated part of the Placer HHS SOC, coordination with MH, JJ, and DMC-ODS is easily facilitated.

Opportunities for Improvement:

- The specific SB 1291 performance measures are not included in the chart review, hence not reported in QI committees. As per SB 1291 (Chapter 844; Statutes of 2016), this reporting is required.

Information Systems

Changes within the Past Year:

- The Avatar migration to the hosted platform at Netsmart Datacenter was completed.
- Appointment Scheduling Phase II, utilizing a single calendar, was implemented.
- Automation of authorizations for the MSO was completed.
- Six programs were converted from MHSA-only funding to Medi-Cal certification and service claiming.

Strengths:

- None noted.

Opportunities for Improvement:

- Full implementation of Medicare Part B claiming, which has been delayed due to the impact of COVID-19, would decrease denials for the reason “Medicare or Other Health Coverage must be billed before submission of claim”.
- Maintenance of a formal record or log of IS/computer training activities would be helpful in case of necessary personnel action.

Structure and Operations

Changes within the Past Year:

- The number of meetings and communications with both staff and contract providers increased in order to address COVID-19 concerns and responses.
- The MHP expanded housing availability: opened a new 14 bed Single Room Occupancy facility; closed escrow on two MHSA-funded homes, closed escrow on a new board and care in Auburn; began the first housing project in the Tahoe region; and they are working on Housing and Urban Development housing with CW.
- The MHP’s assistance with the county’s response to the pandemic included deploying staff to Public Health functions, thereby exacerbating existing staffing shortages.

Strengths:

- The MHP reported that staff have remained flexible through the challenges that the COVID-19 response has created and have been as supportive and helpful to the community as possible.

Opportunities for Improvement:

- None noted.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: Access technical assistance (TA) from the EQRO early in the process of developing two new PIPs.

Access to Care

None noted.

Timeliness of Services

Recommendation 2: Ensure that a process is in place to gather the necessary data and that queries are structured to provide the required timeliness data (including for contract providers) for all entities requiring reporting. Please refer to BHIN 20-062E. *(This is a follow-up recommendation from FY 2019-20).*

Quality of Care

Recommendation 3: For the next Quality Improvement (QI) Plan, identify key quality of care measures, establish measurable performance goals or targets, ensure the data is available to measure them, and create dashboard reports that are reviewed on a standing schedule in high level QI and leadership meetings. Structure the reports to track and trend performance over time. Major categories could include access, timeliness, quality, and outcomes. *(This is a follow-up recommendation from FY 2019-20)*.

Recommendation 4: Restructure medication monitoring reports as dashboards that track and trend performance on chart reviews over time, and use the information to identify QI opportunities. *(This is a carry-over recommendation from FY 2019-20).*

Outcomes

Recommendation 5: Utilize the LOCUS with fidelity until a state-mandated tool is identified, including ensuring consistent use for individual beneficiaries and aggregating and analyzing system-wide data for QI purposes.

Foster Care

Recommendation 6: As per SB 1291 (Chapter 844; Statutes of 2016), capture specifically all of the SB 1291-required performance measures on the medication monitoring tool.

Information Systems

Recommendation 7: Identify reasons for and implement solutions to decrease denials, particularly for the reason “Medicare or Other Health Coverage must be billed before submission of claim.”

Structure and Operations

None noted.

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.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Data

Attachment D: ACA Penetration Rates and ACBs

Attachment E: ACB Range Distributions

Attachment F: List of Commonly Used Acronyms

Attachment A—Review Agenda

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

Yolo MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Performance Improvement Projects
Clinical Line Staff Group Interview
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Harriet Markell, Quality Reviewer
Leda Frediani, IS Reviewer
Steven Cullen, 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.

MHP Review Sites and Participants

All sessions were held virtually via video conference due to COVID-19 restrictions.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Aberle	Kim	Client Services Practitioner	Placer County Children's System of Care (CSOC)
Abrahamson	Twylla	Director	Placer County CSOC
Bahoh-Javete	Carolyn	Clinical Program Manager	Uplift Family Services
Bell	Rebecca	Administrative Supervisor	Placer County CSOC
Brown	Kaitlyn	Program Supervisor	Placer County Adult System of Care (ASOC)
Budge	Curtis	Program Manager	Placer County ASOC
Burnett	Brenda	Nurse Practitioner	Placer County ASOC
Compton	Sue	Program Manager	Placer County CSOC
Conklin	Lauren	Client Services Counselor	Placer County CSOC
Cook	Jennifer	Assistant Director	Placer County CSOC
Dixon	Matt	Client Services Practitioner	Placer County CSOC
DuChien	Teresa	IT Supervisor	Placer County IT
Duell-Stephens	Deborah	Clinical Director	Lighthouse
Dunbar	Lori	IT Analyst	Placer County IT
Ellis	Amy	Director	Placer County ASOC
Flores	Amy	Associate Director	Uplift Family Services
Franceschini	Jamie	Contract Analyst	Sierra County
Garafolo	Suzanne	Clinical Director	Sierra Mental Wellness Group
Garcia	Lisa	Client Services Practitioner	Placer County CSOC
Garrett	Dr. Brian	Psychiatrist	Placer County ASOC
Garrison	Laura	Supervising Psychiatric Nurse	Placer County ASOC

Last Name	First Name	Position	Agency
Genschmer	Scott	Program Manager	Placer County ASOC
Griffiths	Kevin	IT Analyst	Placer County IT
Hatch	Stephanie	Administrative Clerk	Placer County CSOC
Hildinger	Julie	Client Services Practitioner	Placer County CSOC
Hill	Kathryn	Clinical Director	Sierra County
Holley	Derek	Program Supervisor	Placer County CSOC
Hook	Susan	Psychiatric Nurse	Placer County CSOC
Ignatowicz	Dr. Olga	Psychiatrist	Placer County ASOC
Kauppila	Andrea	Staff Services Analyst	Placer County CSOC
Kellogg	Michele	Executive Director	Yolo Community Care Continuum
Kerschner	Jon	Executive Director	Sierra Mental Wellness Group
Kolster	Kristin	Client Services Practitioner	Placer County CSOC
Leighton	Melissa	Staff Services Analyst	Placer County Health and Human Services (HHS)
Ludford	Jennifer	Staff Services Analyst	Placer County ASOC
McCartney	Debra	Administrator	Cirby Hills Behavioral Health
Medina	Leslie	Program Manager	Placer County CSOC
Miller	Jessica	MH Head of Service	Koinonia
Nguyen	Dr. Mai	Psychiatrist	Placer County CSOC
Oldham	Dr. Robert	HHS Director	Placer County HHS
Osborne	Marie	Assistant Director	Placer County ASOC
Price	Jennifer	Executive Director	Advocates for Mentally Ill Housing, Inc.
Salas	Lea	Behavioral Health Director	Sierra County
Scott	Andrew	Client Services Practitioner	Placer County CSOC

Last Name	First Name	Position	Agency
Shepard	Megan	Program Manager	Placer County HHS
Sira	Beth	Accountant	Placer County HHS
Skinner	Candyce	Program Manager	Placer County CSOC
Smith	Amber	Client Services Practitioner	Placer County CSOC
Snyder	Denise	Administrative Clerk	Placer County CSOC
Soto	Julia	Program Manager	Placer County ASOC
Steer	Jeff	Client Services Practitioner	Placer County CSOC
Washman	Nancy	Administrative Supervisor	Placer County ASOC
Wellenstein	Jennifer	Regional Director	Turning Point
Williams	Ula	Administrative Clerk	Placer County CSOC

Attachment C—Approved Claims 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 (-).

Attachment D—ACA Penetration Rates and ACBs

Table D1 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 D1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Placer/Sierra 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
Medium	519,441	20,353	3.92%	$121,346,017	$5,962
MHP	17,168	858	5.00%	$4,082,463	$4,758

Attachment E—ACB Range Distributions

Table E1 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 E1: CY 2019 Distribution of Beneficiaries by ACB Range

Placer/Sierra 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	2,327	93.53%	93.31%	$8,245,477	$3,543	$3,998	58.90%	59.06%
>$20K - $30K	87	3.50%	3.20%	$2,150,802	$24,722	$24,251	15.36%	12.29%
>$30K	74	2.97%	3.49%	$3,602,691	$48,685	$51,883	25.74%	28.65%

Attachment F—List of Commonly Used Acronyms

Table F1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
AB	Assembly Bill
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
API	Asian/Pacific Islander
ASAM	American Society of Addiction Medicine
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts
BHIN	Behavioral Health Information Notice
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organizations
CBT	Cognitive Behavioral Therapy
CCC	Cultural Competency Committee
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services

Acronym	Full Term
COVID-19	Corona Virus Disease-2019
CPM	Core Practice Model
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CURES	Controlled Substances Utilization Review and Evaluation System
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EDI	Electronic Data Interchange
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
FTE	Full Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Full Term
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HR	Human Resources
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IHBS	Intensive Home-Based Services
IMD	Institution for Mental Diseases
IN	Information Notice
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
KPI	Key Performance Indicator
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care
LOS	Length of Stay
LPHA	Licensed Practitioner of the Healing Arts
MAT	Medication Assisted Treatment
MCO	Managed Care Organizations
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MFA	Multi-Factor Authentication
MHBG	Mental Health Block Grant
MHP	Mental Health Plan
MHSA	Mental Health Services Act

Acronym	Full Term
MHST	Mental Health Screening Tool
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MSO	Management Services Organization
NA	Network Adequacy
n/a	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTP	Narcotic Treatment Program
OON	Out-of-Network
OTP	Opioid Treatment Program
PA	Physician Assistant
PDSA	Plan Do Study Act
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIN	Personal Identification Number
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RFP	Request for Proposal
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration

Acronym	Full Term
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SD/MC	Short-Doyle Medi-Cal
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
STCs	Special Terms and Conditions
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
VOIP	Voice Over Internet Protocol
WET	Workforce Education and Training
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan