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FY 2019-20
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

EL DORADO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to 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 takes into account 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) 2018-19 findings of an EQR of the El Dorado MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Small

MHP Region — Central

MHP Location — Diamond Springs

MHP Beneficiaries Served in Calendar Year (CY) 2018 — 1,404

MHP Threshold Language(s) — Spanish

Threshold languages are listed in order beginning with the most to least number of eligibles. This information is obtained from the DHCS/Research and Analytic Studies Division (RASD), Medi-Cal Statistical Brief, September 2016.

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.

Validation of State and MHP Beneficiary Satisfaction Surveys

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

CalEQRO had planned to conduct a 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries. In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, no on-site focus group was conducted as part of CalEQRO's desk review of El Dorado MHP this year.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, DC: Author.

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

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with key staff informed 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.

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, no on-site focus group was conducted as part of CalEQRO's desk review of El Dorado MHP this year.

Consequently, the scope of validation for EQR activities and resulting recommendations were limited.

PRIOR YEAR REVIEW FINDINGS, FY 2018-19

In this section, the status of last year's (FY 2018-19) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2018-19 Review of Recommendations

In the FY 2018-19 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2019-20 desk review, CalEQRO reviewed the status of those FY 2018-19 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2018-19

PIP Recommendations

Recommendation 1: Title 42, CFR, §438.330 requires two PIPs. The MHP is urged to meet this requirement going forward.
(*This recommendation is a carry-over from FY 2016-17*.)

Status: Met

- The MHP submitted two PIPs, both of which were validated and found to be active/completed within the last year.

Access Recommendations

Recommendation 2: Establish communications with County Human Resources (HR) and Chief Administrative Officer (CAO) office to research and formulate innovative and effective solutions for recruiting and retaining staff as well as the most efficient utilization of existing staff. Proceed with a proactive stance on resolving staffing issues.

Status: Met

- The MHP reports that it has worked with the Health and Human Services Agency (HHSA) Director who was also serving as the Acting Behavioral Health Director before a Mental Health Director was hired in April 2020.
- The MHP identified two reasons that were frequently reported by staff leaving employment, namely salaries and work schedule flexibility. For non-competitive salaries, the HHSA Director worked with HR in completing an updated analysis of like and surrounding counties for comparison. The MHP is awaiting the outcome of this updated study. For alternative work schedules, the MHP received approval to authorize alternative work schedules for staff beginning in January 2020. Clinicians and supervisors will begin the pilot project with mental health workers to follow. An implementation date was not provided.
- Additionally, the HHSA Director has noted that HR has a one-time funding source to entice individuals to come to the county. However, since the MHP has not used this practice for anyone recently hired, the MHP did not feel it would be appropriate to start in the middle of its recent hiring phase but will consider using it for the next hiring round.
- The MHP has also taken steps to improve staff education and morale through implementing cross-training and job sharing. Cross-training and job sharing have been implemented to offer staff more diversified work assignments, based upon their preferences and to increase staff knowledge base of clinical programs and services.

Recommendation 3: Research expanding nursing roles and provide training to encompass medication support.

Status: Partially Met

- The MHP continues to struggle with retaining psychiatric technician staff. However, due to the way DHCS calculates full time equivalents (FTE) for non-psychiatrist medication support providers under Network Adequacy, the MHP will continue to explore an expansion of its nursing roles to allow their FTEs to count towards Network Adequacy.

Timeliness Recommendations

Recommendation 4: Track timeliness of children's services, including foster care, Katie A. subclass, and other children's services.

Status: Met

- Two tools were developed to track timeliness data related to children involved in Child Welfare Services (CWS). First, the MHP has created a report specifically for referrals originating from CWS. Additionally, the MHP's EHR (Avatar) can now gather the data on which appointments are offered, scheduled and attended, and in a manner that can be easily queried.

- For this report, the MHP noted that data before February 2020 was tracked through a manual process.

Recommendation 5: Develop accurate methodologies for tracking urgent appointments to capture all requests for urgent services.

Status: Met

- The MHP provides reminders to its clinic support team and Access team staff regarding the use of the "urgent" label when opening a pre-admit request for services. The "Request for Service Discharge Report" from Avatar now contains not only the date but also the time a request for service was made and the time the request for service was completed.

Recommendation 6: Train staff system-wide on entering no-show data, including capturing cancellations by provider separately from cancellations by beneficiary. Monitor staff performance quarterly to ensure compliance and consistency.

Status: Met

- The MHP's supervisors and managers have been receiving reports showing the appointment status for their practitioners. Information was provided on how to mark an appointment status in Avatar along with expectations going forward. For appointments from July 1, 2019 to December 31, 2019 and the first six weeks of 2020, the number of appointments without an appointment status dropped from 22 percent to 16 percent.

- The review process also revealed an Avatar issue related to group appointments and closed beneficiaries that the MHP's South Lake Tahoe program coordinator and system analyst are correcting.

Quality Recommendations

Recommendation 7: Provide training to service providers on entering co-occurring diagnoses correctly, and track, monitor, and report diagnostic patterns quarterly. Provide reports to supervisors for further training opportunities as needed.

Status: Partially Met

- The MHP provides quarterly training on documentation and co-occurring diagnoses. Beginning in December 2019, the MHP provided the training to its staff on multiple occasions, at different times and days to accommodate staffing schedules.
- The MHP continues to track its co-occurring rate; however, they do not yet have an in-depth report to track and trend the nuances of the co-occurring rate.

Recommendation 8: Complete recommendations that are carried forward from the last EQRO review to level of met.

Status: Met

- The MHP continues to evaluate and work on implementing appropriate actions as a result of EQRO recommendations.

Beneficiary Outcomes Recommendations

Recommendation 9: Continue collaborative efforts with Netsmart to remediate the Child Adolescent Needs and Strengths (CANS-50) outcome tool and Pediatric Symptom Checklist (PSC-35) data extraction problems.

Status: Met

- The MHP's systems analyst worked with Netsmart on the technology necessary for this process; however, the solution would not be made available in a timely manner to the MHP. Therefore, the systems analyst developed custom reports and charts to capture and report the data in the required format to the State. The MHP has been submitting this data since May 31, 2019.

Recommendation 10: Develop an improved training program for the Adult Needs and Strengths Assessment (ANSA). Contact other small counties to get feedback on trainers' performances, and schedule system-wide training accordingly. Develop and execute an implementation plan.

Status: Met

- The MHP has provided staff with two ANSA trainings and is in the process of purchasing licenses for the online certification training offered by the Praed Foundation (for both the CANS-50 and ANSA). The MHP has entered 37 ANSAs into Avatar since September 2019, and the expectation is that number will

continue to grow to the expected 100 percent once each practitioner completes the online certification training.

Foster Care Recommendations

Recommendation 11: Collaborate with Netsmart to extract data for foster care to meet SB 1291 criteria.

Status: Met

- The MHP stated it is unclear if Netsmart would develop an enhancement related to tracking FC data. As such, the MHP has assumed responsibility for capturing and reporting FC data to meet SB 1291 requirements.
- A new report to obtain penetration rate data is currently being tested. The MHP hopes to have a more streamlined process in calendar year 2020.
- Two tools have been developed to track timeliness data related to children involved in CWS. First, the MHP has created a report specifically for referrals originated from CWS. Second, the MHP's EHR system (Avatar) now has the ability to gather the date appointments are offered, scheduled and attended in a manner that can be easily queried.
- Additionally, client legal status (such as dependent of the court) is also being entered into the MHP's EHR, but a report of this information is not yet available.
- Until such time, the MHP utilizes a manual process to track data for FC.

Recommendation 12: Provide training to staff on SB 1291 elements and timeliness.

Status: Met

- Training has been provided to all children's contract providers on SB 1291's intent to improve the ability to oversee SMHS for FC and youth and to track outcomes related to such services.
- Specific training has been provided on the Pathways to Well Being Checklist, Dependency Status, CANS-50, Child and Adolescent Level of Care Utilization System (CALOCUS), PSC-35 and Adverse Childhood Experiences (ACEs) data.
- Trainings are provided to each contract provider in a monthly collective forum and with the individual contract provider weekly as needed.

Recommendation 13: Develop and implement a Memorandum of Understanding (MOU) for information sharing between CWS and the MHP.

Status: Partially Met

- The MHP is working with CWS to comply with the All-County Letter (ACL) No. 19-116/ Behavioral Health (BH) Information Notice (IN) No. 19-053 which requires MOU Implementation. The MOU was due to the State by July 1, 2020; however, the date is now set to be determined at a future date.

- The County Board of Supervisors appointed a new Youth and Family Commission. The MHP plans to work with the Commission to improve outcomes for youth and families and in that effort, will be establishing an MOU that covers information sharing between the Commission, the MHP and CWS.

Information Systems Recommendations

Recommendation 14: Work with Netsmart to address system slow connectivity and apportion users' time and system loads.

Status: Partially Met

- The MHP's system analyst has been working with County IT and Netsmart to determine if the connectivity issue is caused by the County network or software (EHR) performance. Review results suggested the slow connectivity does not appear to be a Netsmart issue, but rather a County infrastructure issue. The County's internet connection to Victory Mine in Diamond Springs uses a WiFi signal delivered from the County's main offices in Placerville. Currently, there is no plan to improve the WiFi signal due to the County's migration to a virtual desktop infrastructure; however, County IT is still working with the MHP to determine functionality of the EHR in the virtual desktop environment.

Recommendation 15: Provide data lookup and entry capabilities in Avatar system, with training, to Summitview Child and Family Services.

Status: Partially Met

- In the latter part of 2019, the MHP worked with Summitview Child and Family Services ("Summitview") to identify the number of new licenses that would be required for Summitview to come online in the MHP's Avatar system. At the time, there were an insufficient number of licenses available under the current contract to offer the full number of licenses requested by Summitview.

- El Dorado County beneficiaries receive 38 percent of Summitview services. As of September 2019, there were 46 Summitview practitioners billing El Dorado County for SMHS. Of the 46, only 16 practitioners provided an average of 20 or more service hours per month to El Dorado County SMHS beneficiaries. Additionally, 29 practitioners provided less than 20 service hours per month to El

Dorado County SMHS beneficiaries. Enough licenses are available for the 16 practitioners who provide 20 or more service hours per month.

- The MHP offered Summitview the maximum number of licenses currently available, and suggested perhaps a restructure of who would need licenses based on past billing history (i.e., centralize the team of practitioners who provide services to El Dorado County beneficiaries rather than all practitioners offering those services, some of whom do so very infrequently). Summitview declined to accept those immediately available licenses or centralize a team of El Dorado County providers, preferring to wait until all requested licenses be provided.

- The MHP continues to work on a contract amendment with Netsmart for additional Avatar licenses and will proceed down that path once funding availability in the current fiscal year is confirmed. The MHP will also continue to work with Summitview to verify the number of requested licenses necessary based upon current and future business practices.

Recommendation 16: Provide contract provider staff members quarterly or semi-annual Avatar trainings on documenting progress notes and treatment plans.

Status: Met

- The MHP's Documentation Manual was provided to contract providers in September 2019, and ongoing documentation training is discussed during chart review and monthly provider meetings. Additionally, the MHP's systems analyst has provided, and continues to be available to provide, Avatar training to contract provider staff.

Recommendation 17: Include all contract providers in timeliness data extraction and reporting.

Status: Met

- Netsmart developed a form for collecting the required Client Services Information (CSI) Assessment data related to timeliness of offered appointments. This form has been rolled out to contracted providers, as well as implemented within the MHP's clinics in January 2020.

- Additionally, new widgets and reports have been developed for contract providers in Avatar so that they may also monitor their staff's timeliness. Also, Summitview (a children's provider not yet entering data directly into Avatar) will begin tracking timeliness data for its psychiatry services, which will include the date a psychiatry appointment is requested and the date the first appointment is offered and the date the client is actually seen.

Structure and Operations Recommendations

Recommendation 18: Establish regularly scheduled meetings between leadership and contract providers for mutual goal sharing, bi-directional communications, and collaboration.

Status: Met

- Key MHP Leadership (including Assistant Director, Deputy Director, and Managers) meets monthly with Telecare Corporation staff (Site Administrator, Director of Social Services, Director of Nursing, Psychiatrist) regarding operations of the El Dorado County Psychiatric Health Facility (PHF). Between meetings, urgent issues are addressed via phone calls or emails.

- Monthly meetings with children's contract providers have been occurring since at least January 2019. These monthly meetings provide an opportunity to engage in goal setting and sharing, bi-directional communications, collaboration, and training. Additionally, chart review time is scheduled with children's contract providers on a weekly basis, as needed, to review charts, discuss audit findings, provide service authorizations, and improve collaboration on meeting the needs of the Medi-Cal beneficiaries in El Dorado County.

Recommendation 19: Provide data and analysis on performance elements to administration, in particular for children's programs' service delivery and outcomes.

Status: Partially Met

- The MHP tracks CALOCUS, LOCUS, ANSA, CANS-50 and PSC-35 scores over time on an individual basis to monitor treatment outcomes.

- Utilization review information on beneficiary and types of service are tracked, CSI Assessment and demographic information, as well as outcome measures. Aggregate reporting on outcomes for system-level quality improvement is needed.

Carry-over and Follow-up Recommendations from FY 2017-18

Recommendation 20: The MHP needs to have two active Performance Improvement Projects (PIPs). The current submission of a non-clinical PIP did not meet the qualifications of active PIP status. Last year's recommendation was due to both PIPs being rated Concept Only. The MHP discontinued those PIPs, stating lack of staff to implement. The EQRO continues to offer ongoing technical assistance (TA) to assist the MHP in meeting this recommendation. (This recommendation is a carry-over from FY 2016-17.)

Status: Partially Met

- The MHP submitted two PIPs for FY 2018-19. Both PIPs were active and then completed within the last year. Though the MHP did not seek ongoing or regular TA, the MHP did seek TA from CalEQRO in preparation for the review and the write-up of its Non-clinical PIP.

Recommendation 21: To reverse or stabilize the trend of increasing High Cost Beneficiaries (HCBs), conduct an in-depth analysis of current HCBs and implement interventions as indicated by the analysis. Include analysis by age, diagnosis, and timeliness of service. The EQRO is available to provide TA for this research and analysis if requested. This recommendation was not addressed last year. The EQRO supports that an analysis of the HCBs' services could offer opportunities to address issues that might diminish the frequency of need for such services for some beneficiaries.

Status: Partially Met

- The MHP continues to review HCBs. The MHP is in a small county and as such, allows for the Quality Assurance/Utilization Review (QA/UR) team to become familiar with client names and needs and anticipate the need for additional support. A review of HCBs reveals that they generally fall into these categories:
    - New beneficiaries with high acuity.
    - Lanterman-Petris Short (LPS) Conservatees.
    - Beneficiaries who experience multiple inpatient psychiatric hospitalizations prior to stabilization.
    - Beneficiaries who the MHP is trying to prevent from placement in a locked psychiatric facility.
    - Older beneficiaries, often with co-morbid conditions (e.g., serious mental illness and dementia; serious mental illness and cancer).
- As it has said in prior reviews, the MHP is recruiting an analyst for its QA/UR team to provide further analysis and assist the MHP in identifying and implementing interventions to reduce the number of HCBs.

Recommendation 22: Prioritize Medicare Part B certifications for eligible service sites and healthcare professionals to maximize revenue. Seek consultation from Butte and Solano MHPs, which also use the Avatar system and have significant operational experience processing Medicare-Medi-Cal billing. The MHP did not address this recommendation last year. The EQRO reminded the MHP and shared DHCS MHSD IN11-04, Subject: Dual-eligible (Medicare/Medi-Cal) claiming in Short-Doyle Phase II. The MHP acknowledged the IN 11-04; however, professes that it is a heavy lift to apply for Medicare certification. The EQRO offered TA by telephone consult to discuss this issue. The EQRO also recommends that the MHP begin a discussion with DHCS regarding its concerns about the utility of Medicare certification to the El Dorado MHP. (This recommendation is a carry-over from FY 2016-17.)

Status: Partially Met

- The MHP's Medicare Part B non-compliance has been ongoing for more than five years during which CalEQRO has repeatedly offered support and TA.
- The MHP has performed the initial research into how to submit an application to get certified for Medicare Part B services and will explore this option further as soon as staffing allows.
- Moving forward, the MHP will be contracting with an outside consultant to review its services and provide additional information on incorporating Medicare Part B services into the service delivery model.
- In response to this recommendation, the MHP reported that it performed an analysis of the benefits of applying to be a Medicare Part B provider. The result of that analysis showed that the MHP would have to restructure its service provision and job classifications to support the effort, netting an approximate $100,000 in revenue. The MHP purports that the costs for the necessary facility upgrades would be significant.
    - Editorial Comment: The above explanation is deemed inaccurate and may reflect the MHP's inability to understand the application process for enrollment in the Medicare Part B program and the revenue that would be derived. This is an ongoing trend spanning the last few years.

Recommendation 23: Continue to work toward peer stipends or salaries for peers working in the wellness centers. To encourage peer leadership, create a position description with level of responsibilities, with stipends or salaries reflecting the level of responsibility of the named position. This recommendation was reviewed by the MHP, and a draft Request for Proposal (RFP) was developed, although not yet released as of the date of the EQRO review, to encourage contract providers to increase peer participation and input into wellness center programs. No movement was made on creating a position description that includes level of responsibilities for that position. (This recommendation is a carry-over from FY 2016-17.)

Status: Partially Met

- The MHP issued an RFP for operation of its West Slope Wellness Center, which was to include administration of the peer program, including salaries/stipends for peers.
- Since there was only one response to the RFP, the MHP halted the procurement process and continues to operate the Wellness Center directly. The MHP continues to explore other means of providing Peer salaries/stipends.
- This last year, the MHP contacted the local National Alliance on Mental Illness (NAMI) chapter with the opportunity to collaborate to provide salaries/stipends for the peer program. Under the proposal, the MHP would contract with NAMI for management of the peer program. NAMI would invoice the MHP for those services, and NAMI would be the employer of record for the Peers. Unfortunately, the local NAMI chapter is unable to contract with the MHP for these services because it lacks the administrative capacity to advertise, interview, train, employ, report, and supervise the peers, and the program would not be revenue neutral for NAMI.

PERFORMANCE MEASUREMENT

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

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of 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 services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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

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

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

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following.
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure:

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

Total Beneficiaries Served

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

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity El Dorado MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	23,201	60.5%	934	66.5%
Latino/Hispanic	7,196	18.8%	160	11.4%
African-American	332	0.9%	19	1.4%
Asian/Pacific Islander	989	2.6%	15	1.1%
Native American	272	0.7%	15	1.1%
Other	6,341	16.5%	261	18.6%
Total	**38,329**	**100%**	**1,404**	**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.				

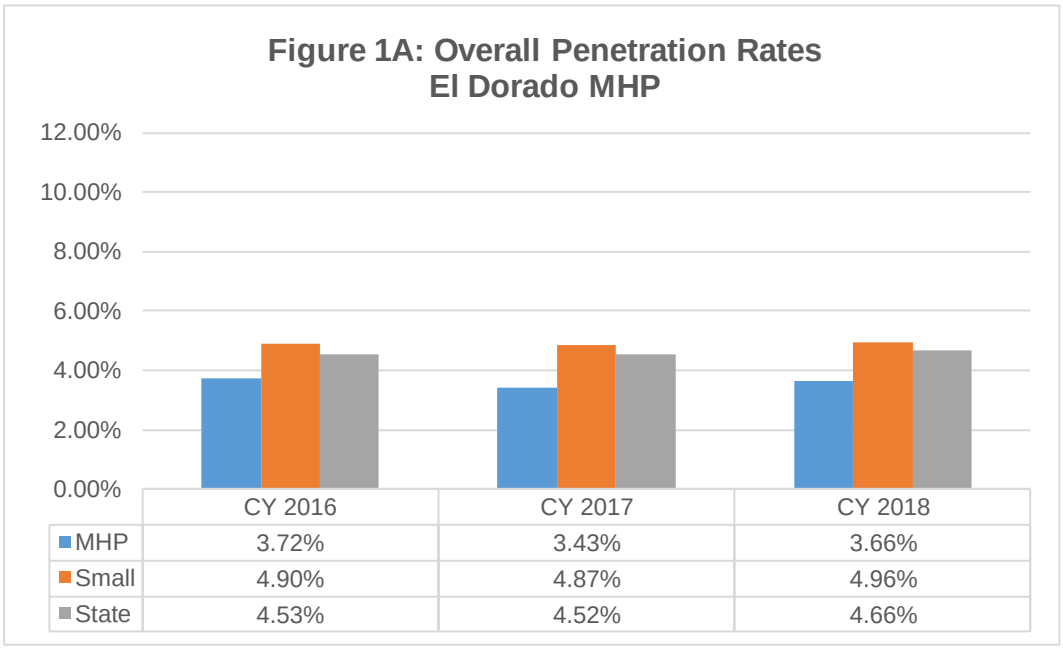
Penetration Rates and Approved Claims per Beneficiary

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.

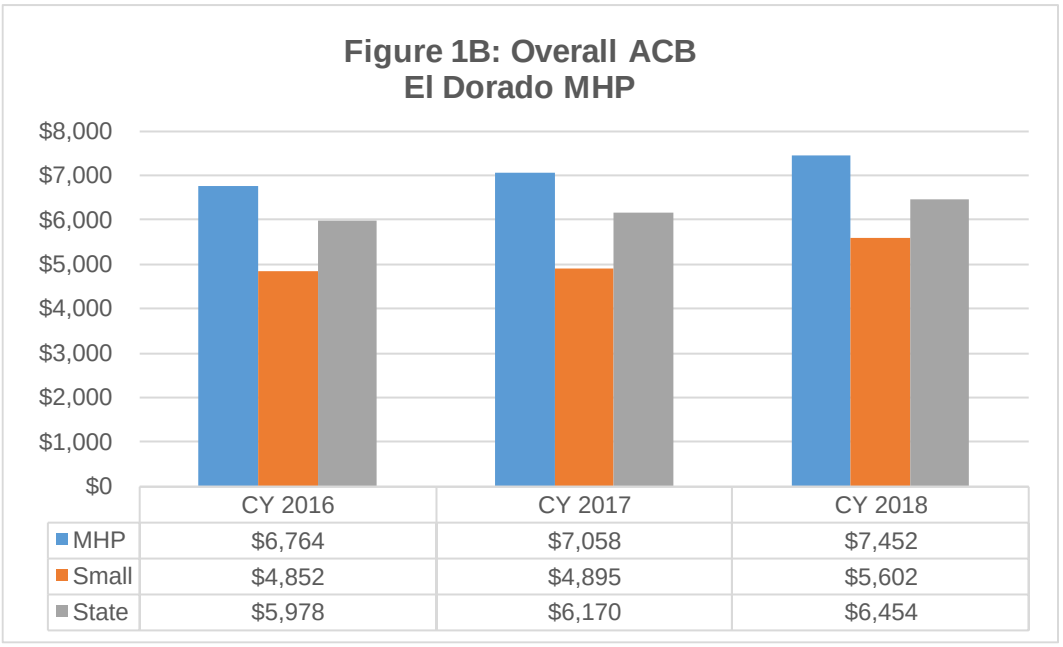
CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2018. See Table C1 for the CY 2018 ACA penetration rate and ACB.

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

Figures 1A and 1B show three-year (CY 2016-18) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small MHPs.



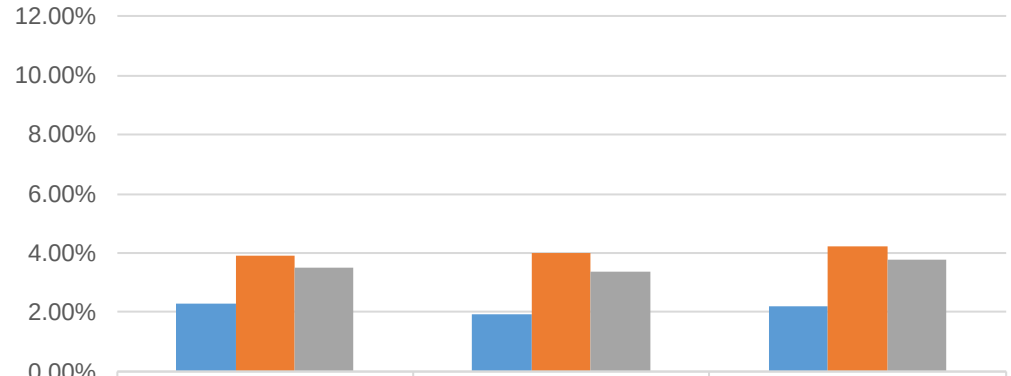
	CY 2016	CY 2017	CY 2018
MHP	3.72%	3.43%	3.66%
Small	4.90%	4.87%	4.96%
State	4.53%	4.52%	4.66%



	CY 2016	CY 2017	CY 2018
MHP	$6,764	$7,058	$7,452
Small	$4,852	$4,895	$5,602
State	$5,978	$6,170	$6,454

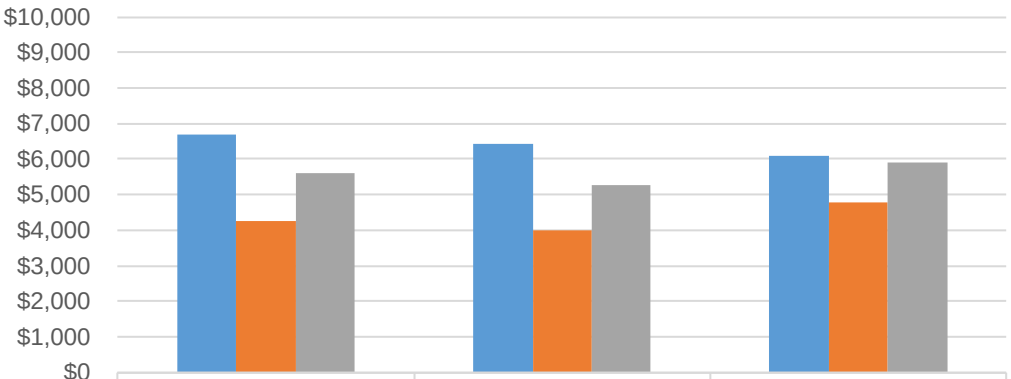
Figures 2A and 2B show three-year (CY 2016-18) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

Figure 2A: Latino/Hispanic Penetration Rates
El Dorado MHP



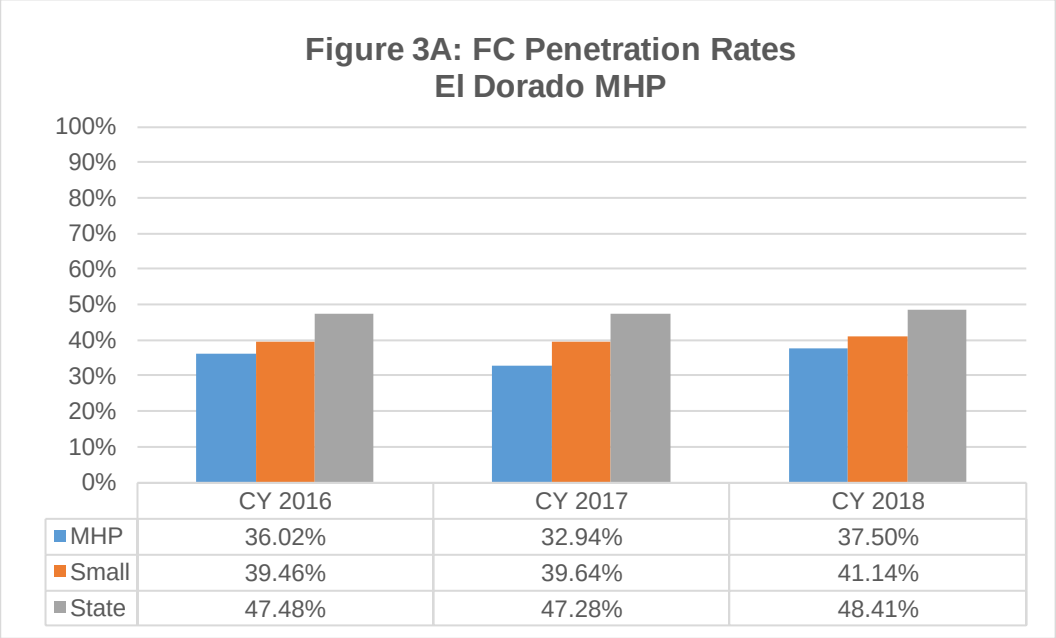
	CY 2016	CY 2017	CY 2018
MHP	2.29%	1.95%	2.22%
Small	3.92%	4.01%	4.23%
State	3.51%	3.35%	3.78%

Figure 2B: Latino/Hispanic ACB
El Dorado MHP

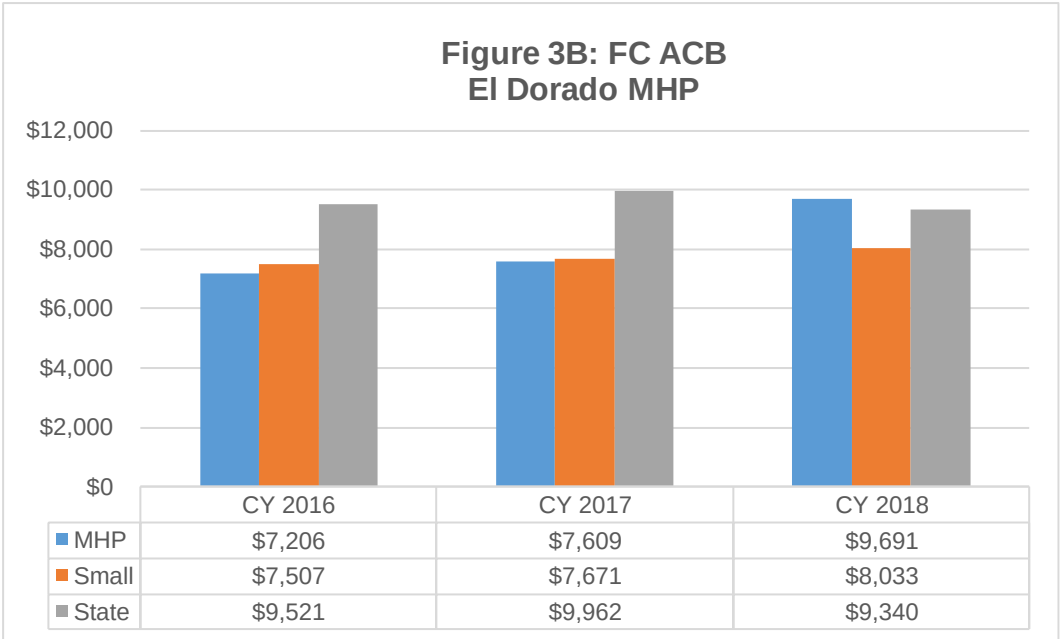


	CY 2016	CY 2017	CY 2018
MHP	$6,690	$6,435	$6,088
Small	$4,243	$3,993	$4,788
State	$5,588	$5,278	$5,904

Figures 3A and 3B show three-year (CY 2016-18) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small MHPs.



	CY 2016	CY 2017	CY 2018
MHP	36.02%	32.94%	37.50%
Small	39.46%	39.64%	41.14%
State	47.48%	47.28%	48.41%



	CY 2016	CY 2017	CY 2018
MHP	$7,206	$7,609	$9,691
Small	$7,507	$7,671	$8,033
State	$9,521	$9,962	$9,340

High-Cost Beneficiaries

Table 2 provides the three-year summary (CY 2016-18) MHP HCBs and compares the statewide data for HCBs for CY 2018 with the MHP's data for CY 2018, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 2: High-Cost Beneficiaries
El Dorado MHP

MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2018	23,164	618,977	3.74%	$57,725	$1,337,141,530	33.47%
MHP	CY 2018	75	1,404	5.34%	$61,091	$4,581,821	43.79%
	CY 2017	62	1,349	4.60%	$55,840	$3,462,091	36.36%
	CY 2016	66	1,461	4.52%	$61,410	$4,053,028	41.01%

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

Psychiatric Inpatient Utilization

Table 3 provides the three-year summary (CY 2016-18) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

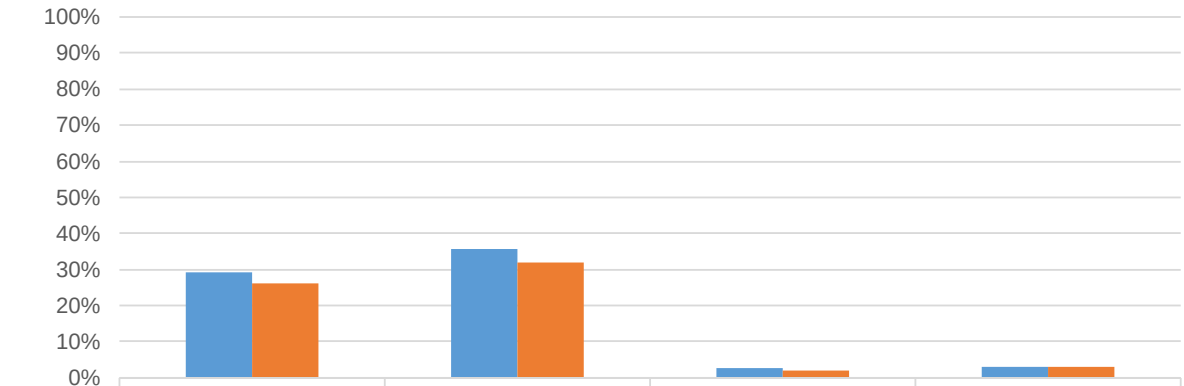
Table 3: Psychiatric Inpatient Utilization - El Dorado MHP

Year	Unique Beneficiary Count	Total Inpatient Admissions	Average LOS	ACB	Total Approved Claims
CY 2018	252	393	9.02	$12,720	$3,205,438
CY 2017	243	379	8.74	$9,145	$2,222,327
CY 2016	249	407	6.92	$7,575	$1,886,242

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

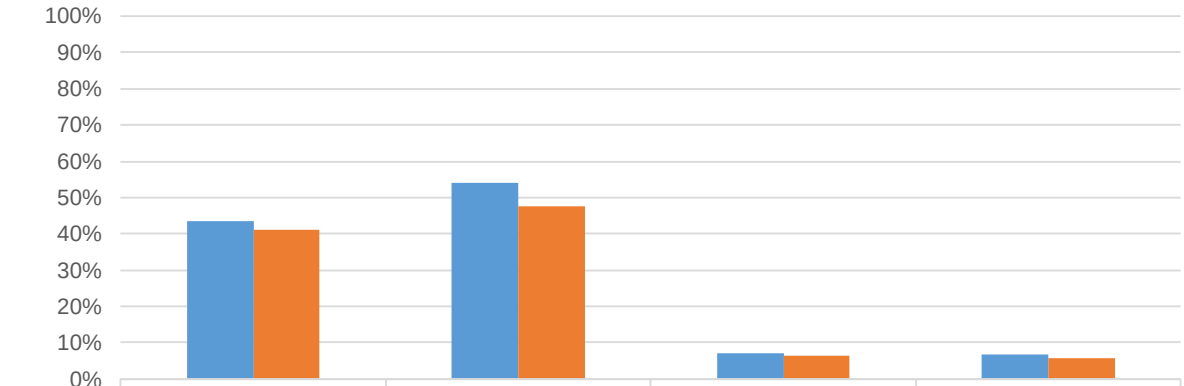
Figures 4A and 4B show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2017 and CY 2018.

Figure 4A: 7-Day Post-Psychiatric Inpatient Follow-up
El Dorado MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	29%	36%	3%	3%
CY 2018	26%	32%	2%	3%

Figure 4B: 30-Day Post-Psychiatric Inpatient Follow-up
El Dorado MHP



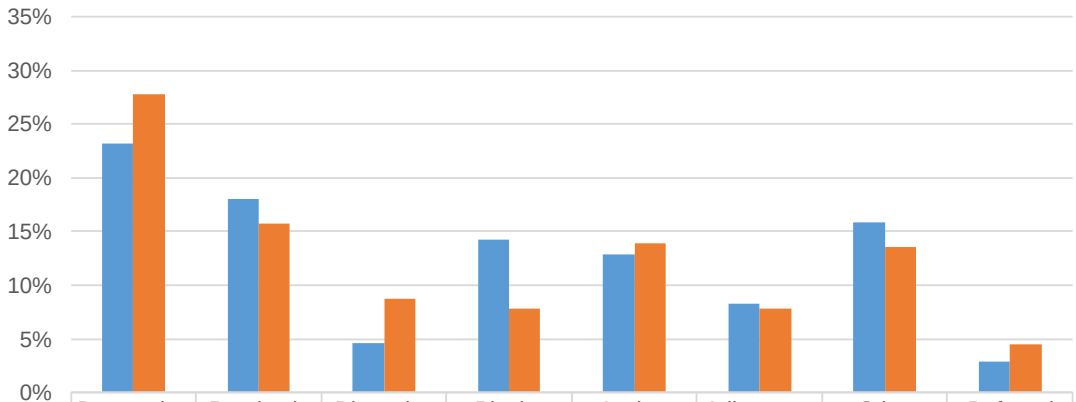
	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2017	44%	54%	7%	7%
CY 2018	41%	48%	6%	6%

Diagnostic Categories

Figures 5A and 5B compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2018.

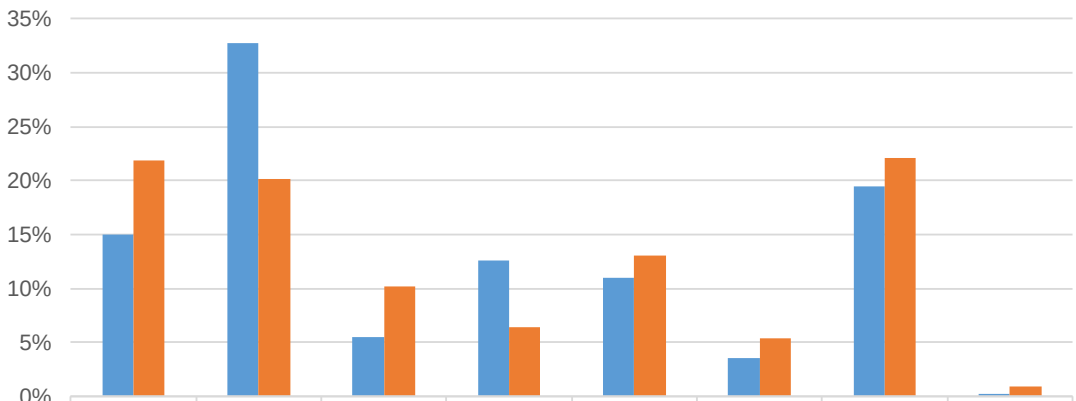
The MHP's self-reported percent of beneficiaries served with co-occurring (i.e., substance abuse and mental health) diagnoses: 40 percent.

Figure 5A: Diagnostic Categories, Beneficiaries Served
El Dorado MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	23%	18%	5%	14%	13%	8%	16%	3%
State CY 2018	28%	16%	9%	8%	14%	8%	14%	5%

Figure 5B: Diagnostic Categories, Total Approved Claims
El Dorado MHP



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2018	15%	33%	5%	13%	11%	4%	19%	0%
State CY 2018	22%	20%	10%	6%	13%	5%	22%	1%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

El Dorado 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 4 lists the PIPs submitted by the MHP.

Table 4: PIPs Submitted by El Dorado MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Pathways to Well Being
Non-clinical PIP	1	Request for Services Process Change – Direct Intake Scheduling

Clinical PIP—Pathways to Wellbeing

The MHP presented its study question for the clinical PIP as follows:

"Will implementing a standardized screening tool to determine eligibility for Intensive Care Coordination-Child and Family Team (ICC-CFT) services, Intensive Care Coordination (ICC-KTA) services, and Intensive Home-Based Services (IHBS), as well as Katie A. subclass members, improve stabilization of placement, reduce symptomology and restore functioning?"

Date PIP began: October 2018

End date: January 2020

Status of PIP: Completed

This PIP aims to ensure that beneficiaries who are eligible for ICC, CFT and IHBS are receiving those services and are identified as Katie A. subclass members when criteria is met. The MHP identified the need for improved screening to allow for proper linkage to services. The need for a standardized, comprehensive screening system came to the

attention of the MHP after receiving collateral information from community partners that ICC and IHBS services did not appear to be occurring at the expected frequency. After review of billed services, the MHP was able to confirm the need for better screening.

This PIP was submitted last year with the same interventions and date of application. No new interventions have been added.

The MHP remeasured monthly for all indicators and results were provided in table/grid format without discussion. While data collection and analysis went through January 2019, the PIP formally ended in January 2020; however, data through January 2020 was not included.

Suggestions to improve the PIP: A more substantial planning effort and evidence base was needed for this PIP. The role of beneficiaries and family members was not specified. While the MHP based its PIP on billing and service data, it did not explain its methodology of defining and capturing the data, nor did it include a barrier and/or causation analysis. Regarding the study question, it should include information on how progress or improvement will be measured. Of note, the question was not improved to include a baseline per last year's feedback. Also, the numerous indicators, similar in name, will likely be difficult to track consistently. Regarding the data analysis plan, information was needed on how and when data was to be collected and analyzed. Overall, further narrative of the data analysis plan would have made the project more robust.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

During the preceding year, the MHP made little contact with CalEQRO to seek TA. For this year's submission, feedback was provided on improving the last sections (in general) and adding detail in the findings section.

Non-clinical PIP—Request for Services Process Change – Direct Intake Scheduling

The MHP presented its study question for the non-clinical PIP as follows:

A question was not provided, though it could be implied. The purpose of the PIP was clearly set out in the introduction. The implied question is:

"Will a new scheduling process improve timeliness of initial assessments as measured by tracking days to disposition through requests for services and a scheduler?"

Date PIP began: March 2019

End date: March 2020

Status of PIP: Completed

The overarching goal of this PIP is to reduce the duration of time elapsed from the initial request for SMHS to the intake screening assessment. By reducing this wait time, requests for services will be dispositioned more expediently and beneficiaries will be referred to an appropriate level of care/resources earlier and have needs addressed promptly, thereby likely reducing functional impairments. The MHP gathered data on the length of time from initial contact to first assessment service and found that there were delays in timeliness due to difficulty contacting beneficiaries. The MHP identified "phone tag" in initial scheduling as the causative issue; however, a further barrier analysis was not provided and would have been helpful in providing more information on possible interventions.

Suggestions to improve the PIP: The PIP could be improved with more detail in the narration. Overall, the sections are incomplete and invite the reader to make inferences, only to find the answers in another section. In Section 6, on the data analysis plan, it does not specify how often the data is collected and analyzed; however, Section 8 on data analysis contains this information. The plan defined the study period but not the intervals within for data remeasurement. The EHR as the source for data was specified, as well as staff qualifications; however, it did not describe contingencies for untoward results.

The MHP reports it has confidence in its reports that are generated in Avatar but details on how they know this was not provided. More information on the methodology is needed to determine if all requests for service are in the EHR. Also missing is the statistical method by which the data was evaluated (confidence).

Remeasurement indicates that the intervention is a success. Although the MHP did not provide a narrative on its preliminary conclusions, the information provided in the table shows improvement in all indicators except for tracking outreach hours, which is to be determined. There was improvement but CalEQRO is unsure which conclusions to draw since there is no Section 9 write-up by the MHP.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The TA provided to the MHP by CalEQRO consisted of telephone discussion and advisement to provide more detail in the lasts sections to explain the significance of the findings. To date, no follow-up has occurred.

Table 5, on the following pages, provides the overall rating for each PIP, based on the ratings: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

Table 5: PIP Validation Review					
				Item Rating	
Step	PIP Section	Validation Item		Clinical	Non-Clinical
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	PM	M
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	PM	M
		1.3	Broad spectrum of key aspects of enrollee care and services	M	M
		1.4	All enrolled populations	PM	M
2	Study Question	2.1	Clearly stated	PM	NM
3	Study Population	3.1	Clear definition of study population	M	M
		3.2	Inclusion of the entire study population	M	M
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	PM	M
		4.2	Changes in health states, functional status, enrollee satisfaction, or processes of care	M	M
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NA	NA
		5.2	Valid sampling techniques that protected against bias were employed	NA	NA
		5.3	Sample contained sufficient number of enrollees	NA	NA
6	Data Collection Procedures	6.1	Clear specification of data	M	M
		6.2	Clear specification of sources of data	M	M
		6.3	Systematic collection of reliable and valid data for the study population	UTD	PM

Table 5: PIP Validation Review					
				Item Rating	
Step	**PIP Section**	**Validation Item**		**Clinical**	**Non-Clinical**
		6.4	Plan for consistent and accurate data collection	PM	PM
		6.5	Prospective data analysis plan including contingencies	PM	PM
		6.6	Qualified data collection personnel	PM	M
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	PM	M
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	M	PM
		8.2	PIP results and findings presented clearly and accurately	M	PM
		8.3	Threats to comparability, internal and external validity	UTD	PM
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NM	NM
9	Validity of Improvement	9.1	Consistent methodology throughout the study	M	UTD
		9.2	Documented, quantitative improvement in processes or outcomes of care	UTD	PM
		9.3	Improvement in performance linked to the PIP	UTD	UTD
		9.4	Statistical evidence of true improvement	UTD	NM
		9.5	Sustained improvement demonstrated through repeated measures	UTD	PM

Table 6 provides a summary of the PIP validation review.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	9	12
Number Partially Met	9	8
Number Not Met	1	3
Unable to Determine	6	2
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**54%**	**64%**

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 response to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the desk review.

Table 7 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, and IT staff for the past four-year period. For comparative purposes, we have included similar size MHPs and statewide average IT budgets per year for prior three-year periods.

Table 7: Budget Dedicated to Supporting IT Operations

	FY 2019-20	FY 2018-19	FY 2017-18	FY 2016-17
El Dorado	1.00%	2.00%	2.00%	2.00%
Small MHP Group	N/A	3.20%	3.50%	3.70%
Statewide	N/A	3.4%	3.3%	3.4%

- The MHP noted that while the IT budget has been reduced, it is mostly related to hardware purchases. In fact, the MHP has more staff supporting the EHR in FY 2019-20 than the previous year.

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

Table 8 shows the percentage of services provided by type of service provider.

Table 8: Distribution of Services, by Type of Provider	
Type of Provider	**Distribution**
County-operated/staffed clinics	55%
Contract providers	45%
Network providers	0%
Total	**100%***

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

Table 9 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 9: Contract Providers Transmission of Beneficiary Information to MHP EHR System		
Type of Input Method	**Percent Used**	**Frequency**
Direct data entry into MHP EHR system by contract provider staff	45%	Daily
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	25%	Monthly
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	20%	Daily
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	10%	Weekly
Health Information Exchange (HIE) securely share beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used

Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ In pilot phase

Number of county-operated sites currently operational: Two

- Number of contract provider sites currently operational: Two

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

- Telehealth services are available with English speaking practitioners (not including the use of interpreters or language line).
- No telehealth sessions were conducted in non-English speaking languages.
- County-operated sites are located at Diamond Springs and South Lake Tahoe.
- Total telehealth encounters provided in the last twelve months: 911
- Total beneficiaries served in the last twelve months: 502
- Contract provider telehealth sites are located at the PHF operated by Telecare Corporation and Summitview Child and Family Services. Both locations are in Placerville.

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 10.

Table 10: Technology Staff				
Fiscal Year	**IT FTEs (Include Employees and Contractors)**	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2019-20	2	1	0.5	0
2018-19	2.5	2	0.5	1
2017-18	.8 FTE (HHSA)	0	0	0

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 11.

Table 11: Data Analytical Staff				
Fiscal Year	**IT FTEs (Include Employees and Contractors)**	**# of New FTEs**	**# Employees / Contractors Retired, Transferred, Terminated**	**Current # Unfilled Positions**
2019-20	3.5	0	0	0
2018-19	3.5	0.5	0	0
2017-18	3	0	2	1

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

- The EHR (Avatar) is hosted by Netsmart who provides 24/7 Data Center support.
- El Dorado HHSA/Behavioral Health IT staff support both Mental Health and Substance Use Disorder Services.
- In FY 2019-20, one IT staff was hired but a 0.5 FTE position was eliminated, resulting in a net increase of 0.5 FTE.
- 3.5 FTEs represent the total number of staff who provide data analysis and supports but they are not 100 percent dedicated to analytics work.

- County IT supports hardware, software and network infrastructure for all County systems.

Current Operations

- The MHP is working with the El Dorado Community Health Clinic (CHC) to implement a Health Information Exchange. The plan is to send client referrals to and from both agencies, along with the necessary documentation (e.g., treatment plans, assessments, medication).
- Referral data is currently shared with Anthem Blue Cross and California Health & Wellness via bi-directional faxes.
- Telecare Corporation, operator of the PHF, and Sierra Child and Family Services have full access to the MHP's EHR. Four children and youth services contract providers have to use secured email/fax to submit billing and clinical data.
- The MHP implemented a number of Avatar newer features since CalEQRO prior year review that improves EHR functionality and interoperability to include: CareManager, CareConnect and ePCS OrderConnect components.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 12: Primary EHR Systems/Applications				
System/Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
AvatarCal-PM	Practice Management	Netsmart	13	MHP/Netsmart
AvatarCWS	Clinical Documentation	Netsmart	7	MHP/Netsmart
Order	ePrescribing	Netsmart	7	MHP/Netsmart

Table 12: Primary EHR Systems/Applications				
System/Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
Connect				
ePCS	ePrescribing	Netsmart	>1	MHP/Netsmart
CareConnectInb	Health Information Exchange (HIE)	Netsmart	>1	MHP/Netsmart

Table 12: Primary EHR Systems/Applications				
System/Application	**Function**	**Vendor/Supplier**	**Years Used**	**Operated By**
ox				
CareManager	Tracking Frequently Encountered Individuals Not Receiving Services	Netsmart	>1	MHP/Netsmart

The MHP's Priorities for the Coming Year

- Preparing for Avatar NX Launch: Cache 17 database updates, Java dependency loss, move to a fully web-based platform built on modern web stack, web-service, external server integration changes. Intensive testing schedule throughout.
- Creating an Avatar video learning series, this will be a long-term item and likely be built along-side testing of the new NX system in mid to late 2020.
- Assisting County IT with migration to Virtual Desktop Infrastructure (VDI) in regard to the Avatar system.
- Update/Re-create/Remove outdated reports, forms, widgets, etc.
- Develop and launch new user widgets, dashboards, forms, and reports. As new workflows are created, current workflows change.
- State required reporting development: CSI Assessment, Functional Assessment Screening Tool (FAST), (X12) 274 transaction standard.

Major Changes since Prior Year

- Substance Use Disorder (SUDS) Drug Medi-Cal Organized Delivery System (DMC-ODS) Development/Launch.
- CareManager System Launch.
- ePCS OrderConnect Integration.
- CareConnect Inbox Avatar Integration.
- Sierra Child and Family Services Service Authorization Dashboard.

Other Areas for Improvement

- The MHP lacks resources to timely implement some complex SUDS Information Notices which has resulted in the need to respond to Corrective Action Plans.
- The South Lake Tahoe clinic continues to experience ongoing EHR response time issues and will do so until network improvements are made.
- El Dorado HHSA and County IT should explore opportunities to obtain federal or state grant awards to implement fiber-optic network countywide to improve connectivity for remote towns and small communities.

Plans for Information Systems Change

- The MHP has no plans to replace current system (in place more than five years).

Current EHR Status

Table 13 summarizes the ratings given to the MHP for EHR functionality.

Table 13: EHR Functionality					
		Rating			
Function	System/Application	Present	Partially Present	Not Present	Not Rated
Alerts	Avatar	X			
Assessments	Avatar	X			
Care Coordination	-			X	
Document Imaging/ Storage	Avatar	X			
Electronic Signature—MHP Beneficiary	Avatar	X			
Laboratory results (eLab)	-			X	
Level of Care/Level of Service	Avatar	X			
Outcomes	Avatar	X			
Prescriptions (eRx)	Order Connect	X			
Progress Notes	Avatar	X			
Referral Management	Avatar	X			
Treatment Plans	Avatar	X			
Summary Totals for EHR Functionality:					
FY 2019-20 Summary Totals for EHR Functionality:		10	0	2	0
FY 2018-19 Summary Totals for EHR Functionality*:		9	1	2	0
FY 2017-18 Summary Totals for EHR Functionality:		9	0	3	0

*Two new EHR functionalities were added to the list beginning in FY 2017-18.

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

- Implemented CareConnect Inbox Avatar integration in support of Health Information Exchange.

- Launched CareManager to track frequently encountered individuals not receiving services.
- Implemented ePCS OrderConnect Integration to add electronic prescribing of controlled substances to the existing electronic prescription system.
- Several changes were made to capture offered and kept appointments data.

Personal Health Record (PHR)

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

☐ Yes ☐ In Test Phase ☒ No

If no, provide the expected implementation timeline.

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

Dimension Reports

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☐ Clearinghouse

☒ MHP not Medicare Part B certified

Table 14 summarizes the MHP's SDMC claims.

Table 14: Summary of CY 2018 Short Doyle/Medi-Cal Claims El Dorado MHP							
Service Month	**Number Submitted**	**Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Dollars Adjudicated**	**Dollars Approved**
TOTAL	**49,304**	**$10,056,259**	**436**	**$114,207**	**1.14%**	**$9,942,052**	**$9,129,832**
JAN18	4,449	$894,061	187	$24,624	2.75%	$869,437	$816,760
FEB18	4,277	$793,428	12	$3,407	0.43%	$790,021	$748,197
MAR18	4,337	$805,377	26	$7,475	0.93%	$797,902	$758,099
APR18	4,233	$837,640	25	$14,220	1.70%	$823,420	$771,152
MAY18	4,379	$884,974	31	$14,930	1.69%	$870,044	$822,099
JUN18	3,784	$793,056	18	$6,890	0.87%	$786,166	$751,104
JUL18	4,034	$856,971	13	$3,461	0.40%	$853,510	$762,450
AUG18	4,918	$1,018,689	27	$11,907	1.17%	$1,006,782	$891,960
SEP18	3,946	$864,383	19	$2,927	0.34%	$861,456	$775,325
OCT18	4,348	$957,158	39	$15,083	1.58%	$942,075	$839,251
NOV18	3,343	$685,130	0	$0	0.00%	$685,130	$603,760
DEC18	3,256	$656,110	0	$0	0.00%	$656,110	$589,676

Includes services provided during CY 2018 with the most recent DHCS claim processing date of June 7, 2019.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2018 was **3.25 percent.**

Table 15 summarizes the top three reasons for claim denial.

Table 15: Summary of CY 2018 Top Three Reasons for Claim Denial El Dorado MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible, or Emergency services or pregnancy indicator must be "Y" for this aid code.	212	$41,241	36%
Payment denied - prior processing information incorrect. Void/replacement condition.	90	$38,318	34%
Medicare or Other Health Coverage must be billed before submission of claim.	63	$14,657	13%
TOTAL	436	$114,207	N/A
The total denied claims information does not represent a sum of the top three reasons. It is a sum of all denials.			

- Denied claim transactions with reason 'Beneficiary not eligible, or Emergency services or pregnancy indicator must be "Y" for this aid code' are generally re-billable within the State guidelines.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, no on-site beneficiary focus group was conducted as part of CalEQRO's desk review of El Dorado MHP this year.

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.

Access to Care

Table 16 lists the components that CalEQRO considers representative of a broad service delivery system that provides 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 16: Access to Care Components

	Component	Maximum Possible	MHP Score
1A	Service Access and Availability	14	12

Despite the MHP's Health Disparities Latino Outreach Project, the Hispanic penetration rate remains lower than the small county average and ranks among the lowest in the state; however, through its Prevention Early Intervention program, New Morning Youth and Family Services and the South Lake Tahoe Family Resource Center provide outreach via its Promotoras to address the needs in the Spanish-speaking or limited English-speaking Latino adult population and youth populations. All Promotoras staff are bilingual or bilingual/bicultural. The MHP has four bilingual and/or bilingual/bicultural mental health staff who are available as an interpreter as needed. The County offers a one-dollar per hour incentive for existing and newly hired bilingual Spanish-speaking staff.

The MHP reports that all requests for services are entered into the EHR. The MHP maintains data on each separate type of request for services depending upon the source of the referral. Information on services is provided to beneficiaries through printed materials posted at emergency departments, Marshall Medical Center, Public Health, senior services, schools, law enforcement, and community-based organizations. The MHP's website is not user friendly nor intuitive. The provider directory on the website is in English only and missing provider license and national provider identification (NPI) numbers.

Table 16: Access to Care Components			
Component		**Maximum Possible**	**MHP Score**
1B	Capacity Management	10	6
The MHP's Quality Improvement (QI) Work Plan measures and monitors cultural and linguistic competency. Specific MHSA programs address locally underserved groups such as the Native American population, and the Hispanic population. Outcome measures are part of the MHSA funded programs. Outcome measures guide next steps in the program as the MHP adapts its capacity. The MHP has measured its own penetration rates manually; however, it recently acquired the capability for automating the calculations within the EHR. Currently the MHP is working out the data and reporting bugs. Staffing remains an issue. Three of the four Access staff positions are filled. This is one less vacancy than last year in the Access department. Last year, the MHP had slightly less than 50 percent of its authorized clinical positions filled. This year, approximately 30 percent of its clinical positions are vacant (according to the organizational chart). Variation is dependent on the definition of "clinical" and would increase if other classifications were included, i.e. mental health worker or aide.			
1C	Integration and Collaboration	24	22
The MHP has a strong history of collaboration with a variety of entities including community-based services. The MHP partners with the South Lake Tahoe Family Resource Center and Sierra Child and Family Services which allows for a presence in schools and increases access for children. Also involved are Summitview Child and Family Services, Stanford Youth Solutions, New Morning Youth and Family Services, and Tahoe Youth and Family Services. The MHP also collaborates with the Sheriff Office's Crisis Intervention Team and the Community Mental and Behavioral Health Cooperative in South Lake Tahoe. The MHP implemented CareConnect Inbox Avatar Integration in support of Health Information Exchange.			

Timeliness of Services

As shown in Table 17, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
2A	First Offered Appointment	16	8
Starting in April 2019, the MHP implemented a PIP to improve timely access to services. An appointment with an Access Clinician is set when the beneficiary requests services. Additionally, until February 2020, the MHP considered the date of determination of medical necessity as the "first offered appointment". In February 2020, the MHP can now capture appointments offered due to a change in the Electronic Health Record software. Therefore, the data below represents the time from request for service to determination of medical necessity, not time to the first offered appointment. For July 1, 2019 through January 31, 2020, the MHP reported that 97 percent of its total appointments (request for service to determination of medical necessity) met the standard of 10-business days.			
2B	Assessment Follow-up and Routine Appointments	8	4
The MHP implemented the CSI Assessment in February 2020 for collecting various timeliness, demographic and other beneficiary data. Aggregate system-wide reporting is not yet being performed.			
2C	First Offered Psychiatry Appointment	12	10
The MHP reports that 90 percent of its first psychiatric appointments overall meet the 15-business day standard. For adults, 91 percent meet the standard, for children, 82 percent meet the standard and for FC, 100 percent meet the standard. The MHP's Electronic Health Record does not currently have the functionality to track the first offered psychiatry appointment. Also, the MHP does not currently have a mechanism in place to capture the timeliness of contract provider psychiatry appointments but is exploring how it can capture this data going forward.			
2D	Timely Appointments for Urgent Conditions	18	11
There was a great deal of confusion among staff regarding the definition of the term "urgent," resulting in inaccurate coding of urgent services. From September 2018 to July 2019, there were only 18 "urgent" requests.			

Table 17: Timeliness of Services Components			
Component		**Maximum Possible**	**MHP Score**
The MHP reported that 39 percent of urgent services were provided in 48 hours with a mean of 101.18 hours. For urgent services with authorization, 50 percent of the appointments met the standard of 96 hours. The average was also 101.18.			
2E	Timely Access to Follow-up Appointments after Hospitalization	10	5
Of the 300 hospital admissions, there were 309 discharges. The MHP reports that the differing numbers are due to whether a patient is admitted prior to the start of a new fiscal year, but discharged in the new fiscal year. This process resulted in more discharges than hospital admissions for FY 2018-19. The MHP's hospital admissions data includes both county and contract hospitals. The follow-up data is county only. For discharge appointments, 66 occurred within the 7-day standard. The percentage of appointment meeting the standard is reported as 69 percent and an average of 7.29.			
2F	Tracks and Trends Data on Rehospitalizations	6	6
The MHP's readmission rate, based on 436 hospital discharges, is 11 percent overall, 12 percent for adults and 4 percent for children.			
2G	Tracks and Trends No-Shows	10	7
The MHP reports that in FY 2018-19, 31.8 percent of the clinician appointments and 1.8 percent of psychiatry appointments did not have an attendance status entered. As a result, the MHP is focusing on increasing compliance and documenting attendance status. The MHP only reported county operations data in the timeliness self-assessment. The MHP reports that for psychiatrists, the no-show rate is 12 percent overall. The standard is 10 percent. For clinicians, the no-show rate is 20 percent. A standard has not been set.			

Quality of Care

In Table 18, CalEQRO identifies the components of an organization that is 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 18: Quality of Care Components			
Component		**Maximum Possible**	**MHP Score**
3A	Beneficiary Needs are Matched to the Continuum of Care	12	8
The MHP created a flow sheet which outlines various levels of care and SMHS in El Dorado County and the criteria for transitioning between them. The MHP uses CALOCUS and CANS-50 for children and Level of Care Utilization System (LOCUS) and ANSA for adults. Outcome/LOCUS tools are completed at intake, every six months, and at discharge. Also, the CSI Assessment information tool is completed at the time of intake and annually. The MHP works with primary care, therapists and psychiatrists for both adult and transitional age youth (TAY) outpatient services. A medication management team is also available. The MHP also offers Full Service Partnership (FSP)/Intensive Case Management/Transition Treatment Program. Higher levels of service include assisted outpatient treatment and LPS conservatorship. The MHP reports a co-occurring diagnosis rate of 40 percent; however, due to inconsistent data entry by staff, the rate may be inaccurate.			
3B	Quality Improvement Plan	10	10
The MHP submitted its FY 2019-20 QI Work Plan and evaluation from FY 2018-19. The plan has measurable goals and objectives. The quality improvement committee (QIC) meets quarterly, with leadership staff meetings between QIC meetings. Progress towards goals is charted in minutes and the evaluation of the previous year's plan. Two PIPs were submitted, and both are considered active. The MHP also has a Cultural Competency Plan (CCP) which includes analysis of disparities in services. The MHP partially met or met all of their recommendations from the FY 2018-19 EQRO Review.			
3C	Quality Management Structure	14	12
The QIC utilizes data analytics and reporting. Utilization review information on beneficiary and types of service are tracked, CSI Assessment and demographic			

information, as well as outcome measures. Aggregate reporting on outcomes for system-level quality improvement is needed. All staff meetings are used for policy and procedure roll out as well as provide more general MHP announcements. The MHP holds regular meetings with various stakeholder groups including contractors, beneficiaries, telehealth staff, and with community-based organizations and groups.			
3D	QM Reports Act as a Change Agent in the System	10	8
The CANS-50 assessment is present in the Avatar system and used to assess children. The ANSA is present in the Avatar system and is used to assess individual adults. Information on aggregate reporting was not provided. While the MHP uses both the CANS-50 and ANSA to evaluate outcomes, it does not appear to be used to evaluate services on the programmatic level. Contract providers perform 45 percent of the MHP's services, but they provided feedback that performance measures are discussed informally without data available. While the MHP uses outcome tools for beneficiaries on an individual level, it is unclear if the MHP employs aggregate reporting. The MHP's PIPs were validated. Both PIPs were completed this last year.			
3E	Medication Management	12	12
The Medication Support Team ensures continuity and monitors communication through a medication support services referral. The MHP provided a sample progress note which is used to document medication and clinician collaboration. The MHP holds a quarterly medication monitoring committee where psychiatry and nursing staff participate in a chart review. The MHP reviews 28-30 charts quarterly for consents, labs, multiple medications and need.			

Beneficiary Progress/Outcomes

In Table 19, CalEQRO identifies the components of an organization that is 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 19: Beneficiary Progress/Outcomes Components			
Component		**Maximum Possible**	**MHP Score**
4A	Beneficiary Progress	16	15
The MHP uses the PSC-35, CANS-50 and ANSA on a clinical level. Although the MHP reports outcomes for its FSP beneficiaries, it does not report out and use aggregate data for system-wide improvement. The MHP stated they lack confidence in their reported 40 percent co-occurring diagnosis rate, citing a staff data entry			

challenge for distinguishing between MH and SUD services. The MHP estimates that the actual number of beneficiaries with co-occurring mental health and substance abuse diagnoses is much higher than the reported 40 percent. Concerns about data integrity were reported last year. The MHP began training in December 2019 to correct the data entry issue. Also, the MHP launched care manager software to track frequently encountered individuals not receiving services.			
4B	Beneficiary Perceptions	10	5
The MHP administers the Consumer Perception Survey (CPS) twice yearly. The MHP reports that they normally analyze and compare results with previous years. The results are shared within the MHP but not with contract providers. This year, the MHP did not have sufficient analyst staff to prepare the survey reports for review or distribution. The MHP is in the process of hiring an analyst. The Pathways to Well-Being program administers a satisfaction survey to families involved in those services on a routine basis. The results are used to address individual treatment issues.			
4C	Supporting Beneficiaries through Wellness and Recovery	4	2
The programs at the wellness center are diverse, with some groups being beneficiary-run. Last year, the MHP issued an RFP, however the MHP halted the procurement process since there was only one response to the RFP.			

Structure and Operations

In Table 20, CalEQRO identifies the structural and operational components of an organization that is facilitates access, timeliness, quality, and beneficiary outcomes.

Table 20: Structure and Operations Components			
Component		**Quality Rating**	
5A	Capability and Capacity of the MHP	30	18
The MHP provides a variety of services including mental health services, medication support services and case management. Crisis intervention is available through children's service or adult service teams. The MHP also has a Psychiatric Emergency Response Team (PERT), a sheriff and a MH clinician, which responds to calls 40 hours per week in addition to crisis services. The MHP has two adult residential treatment facilities, one in county and one out of county, through a contract with Psynergy.			

5B	Network Adequacy	18	14
South Lake Tahoe Behavioral Health (both SUD and MH) are co-located with Adult Protective Services (APS), In-Home Supportive Services (IHSS) and the Public Guardian. West Slope is co-located with a Public Guardian as well. There is also an eligibility worker stationed at the West Slope Clinic. Attempts were made (including a drafted MOU) to allow an MHP Access clinician to be co-located at the Federally Qualified Health Center (FQHC) in Placerville/Cameron Park, but the FQHC determined they did not have enough room to proceed with the co-location. The MHP does not have access to psychological testing nor is it part of the Whole Person Care program. The MHP does utilize telehealth, mobile crisis and field-based services.			
5C	Subcontracts/Contract Providers	16	14
The MHP meets with its contractors monthly but also on an as-needed basis for chart reviews. Its contractors include New Morning Youth and Family Services, Sierra Child and Family Services, Stanford Youth Solutions, Summitview Child and Family Services, Tahoe Youth and Family Services and Telecare Corporation PHF; however, communication could be improved. The results of the CPS are not shared with contract providers.			
5D	Stakeholder Engagement	12	12
The MHP holds weekly staff meetings for individual units and outpatient services, and periodically will have an all staff meeting. In 2015, staff morale was low when some services were contracted out for the PHF with Telecare Corporation. Some anxiety remains each year when the MHP considers outsourcing in its management decisions.			
5E	Peer Employment	8	0
The MHP does not offer stipends or salaries to peer volunteer staff. A beneficiary focus group was not held during this EQRO desk review; therefore, beneficiaries were not interviewed regarding their experiences and perceptions of opportunities for peers to work within the MHP.			
5F	Peer-Run Programs	10	4
Although programs at the Wellness Center are diverse and peer driven, no beneficiary-run programs exit. The MHP reports that they continue to consider this opportunity. The MHP issued an RFP, a key component of which was the requirement that proposals identify how that organization will include more staff opportunities for peers in wellness center operations, including leadership of groups/classes provided. However, there was only one response to the RFP; the MHP halted the procurement			

process and continues to operate the Wellness Center directly. The MHP continues to explore other means of providing peer salaries/stipends.

5G	Cultural Competency	12	6

The MHP has four Spanish-speaking staff – extra help clinician on crisis, two mental health workers (MHW) and a mental health aide (MHA), and office support staff.

The MHP leverages its MHSA programs to outreach and provide services to veterans, the Latino and Native American communities.

The MHP does calculate its penetration rates but it is a manual process which is completed quarterly to every six months. The MHP is working towards moving this process to Avatar.

The MHP does not have a cultural competence committee. The MHP did have a Latino work group for a year, but due to staffing issues, the work group disbanded.

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2019-20 review of El Dorado MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Completed

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- The MHP recently acquired the capability to automatically run its own penetration rate reports. Currently, the reports are being tested for accuracy.
- The MHP implemented CareConnect Inbox Avatar Integration in support of Health Information Exchange.

Strengths:

- The MHP indicates that it has strong collaborative relationships with its community partners. In its work with children, the MHP partners with Sierra Child and Family Services, Summitview Child and Family Services, Stanford Youth Solutions, New Morning Youth and Family Services, and Tahoe Youth and Family Services.
- The MHP has four bilingual and/or bilingual/bicultural mental health staff who are available as an interpreter as needed.

Opportunities for Improvement:

- The MHP continues to show low beneficiary penetration rates when compared to small counties and the statewide average. The penetration rate for its Latino/Hispanic population also reflects a similar trend.
- The MHP does not have a Cultural Competence Committee (CCC) but rather its QI Workplan measures and monitors cultural and linguistic competency.
- The MHP's website is not user friendly or intuitive. The provider directory on the website is in English only and missing providers' CA license and NPI numbers.

Timeliness of Services

Changes within the Past Year:

- The MHP made several changes to capture offered and kept appointments data.
- The MHP implemented the CSI Assessment in February 2020 for collecting various timeliness, demographic and other beneficiary data. Aggregate system-wide reporting is not yet being performed.

Strengths:

- The development of timeliness tracking tools allows for more detailed timeliness tracking for the children's system of care, especially for foster care youth.

Opportunities for Improvement:

- The MHP reviewed urgent requests for services and felt staff require additional training in the identification and classification of urgent requests along with proper documentation.
- Until February 2020, the MHP did not track first contact to first offered assessment appointment. The MHP provided data on the percentage (97 percent) of its total requests for services that were discharged within ten days.
- Although the 90 percent of the MHP's first psychiatric appointments (kept) meet the 15-business day standard, the MHP’s EHR does not currently have the functionality to track the first offered psychiatry appointment for either the MHP or for contractors.
- Thirty-nine percent of urgent services were provided within 48 hours with a mean of 101.18 hours. For urgent services with authorization, 50 percent of the appointments met the standard of 96 hours. Inaccurate coding issues may partially be to blame for the low percentage.
- Two thirds of the follow-up appointments after hospitalization occurred within the 7-day standard.
- The MHP reported a 31.8 percent no-show rate for clinician appointments, with psychiatry no-shows at 1.8 percent.

Quality of Care

Changes within the Past Year:

- Beginning in December 2019, the MHP implemented ongoing documentation and co-occurring diagnoses training for staff.

Strengths:

- The MHP is co-located with several community partners including APS, IHSS, and the Public Guardian.

Opportunities for Improvement:

- Utilization review information on beneficiary and types of service are tracked, CSI Assessment and demographic information, as well as outcome measures. However, aggregate data reporting is not performed.
- The MHP reports a co-occurring diagnosis rate of 40 percent; however, due to inconsistent data entry by staff, the MHP has reservations about the accuracy of the rate.
- The MHP did not utilize the results of the November 2019 CPS due to a lack of staffing. The May 2019 surveys were lost in the mail prior to arriving at the California Institute for Behavioral Health Solutions (CIBHS). The MHP is in the process of hiring an analyst.
- The MHP does not have a beneficiary-run wellness center. While some of the classes are led by beneficiary volunteers, the MHP does not have a specific peer job classification.
- Staff anxiety surfaces when the MHP considers outsourcing in its management decisions. Morale may be impacted and may contribute to staffing retention issues.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP trained its staff on the ANSA outcome tool. The tool is being used with adult beneficiaries. Additional training and certification are being planned.

Strengths:

- The MHP utilizes a variety of level of care/outcome tools to inform treatment including CALOCUS, LOCUS, ANSA, CANS-50 and PSC-35 scores.

Opportunities for Improvement:

- The MHP does not utilize aggregate reporting for system-wide evaluation.

Foster Care

Changes within the Past Year:

- The MHP is working with CWS to develop a joint MOU that will be submitted to the State by the due date, which will be set by the California Health and Human Services Agency (CHHS) at a future date.

Strengths:

- The MHP, while it does not have therapeutic foster care, does have two therapeutic group homes which serve FC youth.

Opportunities for Improvement:

- The MHP can track medication services for FC youth receiving SMHS through its contract providers and clinic via the JV220 process and its EHR; however, the MHP is unable to track medication services outside of their system for mild-to-moderate FC youth.

Information Systems

Changes within the Past Year:

- Implemented CareConnect Inbox Avatar Intergration in support of Health Information Exchange.
- Launched CareManager to track frequently encountered individuals not receiving services.
- Implemented ePCS OrderConnect Intergration to add electronic prescribing of controlled substances to the existing electronic prescription system.

Strengths:

- The MHP increased IT staffing by 0.5 FTE.

Opportunities for Improvement:

- The MHP lacks resources to timely implement some complex SUDS Information Notices which has resulted in the need to respond to DHCS Corrective Action Plans.
- The South Lake Tahoe clinic continues to experience ongoing EHR response time issues and will do so until network improvements are made. Structure and Operations

Structure and Operations

Changes within the Past Year:

- The MHP eliminated the assistant director position and recruited a Mental Health Director who was hired in April 2020.

Strengths:

- The MHP contracted with Innovative Development and Evaluation Associates (I.D.E.A.) Consulting to evaluate the MHP and provide recommendations for system improvement. I.D.E.A. Consulting is in the process of analyzing data and interviewing key stakeholders. The report is expected in the summer.

Opportunities for Improvement:

- The MHP is not yet certified to bill Medicare Part B services. The MHP should pursue next steps to obtain Medicare certification information through Noridian Medicare Portal, the Part B fiscal intermediary for California providers.
- Staffing is a longstanding challenge for the MHP. Approximately 30 percent of its clinical positions are vacant (according to the organizational chart). The MHP is aware of this and is working with HR and a consultant to evaluate compensation.

FY 2019-20 Recommendations

PIP Status

None noted.

Access to Care

1. Expand telehealth and mobile services to remote areas to improve beneficiaries' access to services, in particular to the Latino/Hispanic population.
2. Establish and maintain a formal Cultural Competency Committee (CCC) which meets regularly with minutes kept and which works closely with the Quality Improvement Committee (QIC) and has beneficiary representation.
3. Evaluate the usability of the website from the perspective of a beneficiary. Update the provider directory to include license and National Provider Identification (NPI) numbers and provide the directory in both English and Spanish.

Timeliness of Services

4. Provide training for staff on the identification and classification of urgent requests in relationship to network adequacy and required documentation. Include evaluation of training.
5. Comply with Information Notice (IN) 18-011. Track and offer a first assessment appointment within ten business days.
6. Comply with Information Notice (IN) 18-011. Track and offer a first psychiatric appointment within 15 business days.
7. Investigate and identify barriers to providing (or accurately tracking) urgent services within 48 hours. Implement interventions which directly address the barrier(s) identified.
8. Investigate and identify barriers to providing follow-up hospital discharge appointments within the 7-day standard. Implement interventions which directly address the barrier(s) identified.
9. Investigate and identify the cause of the high no-show rate for clinicians. Implement interventions which directly address the cause(s) identified.

Quality of Care

10. Prioritize and implement aggregate reporting for outcome tools and Client Service Information (CSI) Assessments.

11. Investigate methodology for determining rate of co-occurring diagnosis including compliance with related policies and procedures. Implement solutions to improve accuracy of data which include ongoing training.

12. Implement the hiring of at least one designated peer employee whose duties also include sharing in the management/running of the wellness center.

Beneficiary Outcomes

13. Implement a method to report and/or share survey results and service evaluation with contractors and MHP staff.

Foster Care

None noted.

Information Systems

14. Work with the County to improve network connectivity for the South Lake Tahoe clinics centrally and located at other remote towns and small communities. Explore opportunities such as obtaining a federal or state grant award to implement a fiber-optic network countywide.

Structure and Operations

15. Complete Medicare Part B provider enrollment application and submit to Noridian for site certification processing in order to bill services for Medicare/Medi-Cal eligible beneficiaries; and to comply with DMH Information Notice 11-04 policy guidance. (This recommendation is a carry-over from FY 2016-17.)

SITE REVIEW PROCESS BARRIERS

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

- Documents provided were incomplete, making it challenging to assess and validate progress.
- 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 El Dorado MHP. Consequently, some areas of the review were limited, and others were not possible, such as conducting beneficiary focus groups.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment E: PIP Validation Tools

Attachment A—On-site Review Agenda

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

Table A1—EQRO Review Sessions – El Dorado MHP
Review was conducted as a desk review.
Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)

Attachment B—Review Participants

CalEQRO Reviewers

Cyndi Lancaster, LMFT, LPCC, Lead Quality Reviewer
Caroline Yip, Information Systems Reviewer

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

Sites of MHP Review

No sites were visited for this review.

Attachment C—Approved Claims Source Data

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

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

Table C1: CY 2018 Medi-Cal Expansion (ACA) Penetration Rate and ACB
El Dorado MHP

Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,807,829	152,568	4.01%	$832,986,475	$5,460
Small	176,396	7,578	4.30%	$35,058,406	$4,626
MHP	12,364	377	3.05%	$2,010,883	$5,334

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

Table C2: CY 2018 Distribution of Beneficiaries by ACB Cost Band
El Dorado MHP

ACB Cost Bands	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	1,285	91.52%	93.16%	$4,815,373	$3,747	$3,802	46.03%	54.88%
>$20K - $30K	44	3.13%	3.10%	$1,065,056	$24,206	$24,272	10.18%	11.65%
>$30K	75	5.34%	3.74%	$4,581,821	$61,091	$57,725	43.79%	33.47%

Attachment D—List of Commonly Used Acronyms

Table D1—List of Commonly Used Acronyms	
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment

Table D1—List of Commonly Used Acronyms	
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NP	Nurse Practitioner
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment

Table D1—List of Commonly Used Acronyms	
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Attachment E—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19 CLINICAL PIP	
GENERAL INFORMATION	
MHP: El Dorado County	
PIP Title: Pathways to Well Being	
Start Date: 10/01/18 **Completion Date**: 01/31/20 **Projected Study Period** (#of Months): 15 **Completed**: Yes ☒ No ☐ **Date(s) of Desk Review**: 03/18/20 **Name of Reviewer**: Cyndi Lancaster	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☒ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☐ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): This PIP aims to ensure that beneficiaries who are eligible for ICC, CFT and IHBS are receiving those services and are identified as Katie A. subclass members when criteria is met. The MHP identified the need for improved screening to allow for proper linkage to services. The need for a standardized, comprehensive screening system came to the attention of the MHP after receiving	

collateral information from community partners that ICC and IHBS services did not appear to be occurring at the expected frequency. After review of billed services, the MHP was able to confirm the need for better screening.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	A multi-functional team consisting of the MHP's Access/Utilization Review/Quality Assurance (QA/UR) Clinicians, the QA/UR Program Coordinator, and Children's Contracted Providers of Specialty Mental Health Services (SMHS) developed the study topic, utilizing information provided to these individuals by beneficiaries and their family members, and through collateral contacts such as Child Welfare Services, Probation, and the El Dorado County Office of Education. Additional input and support were provided by the QA/UR Managers. The role of beneficiaries and family members was not specified.

1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? The MHP wrote: This need for a standardized, comprehensive screening system came to the attention of the MHP after receiving collateral information from community partners that ICC and IHBS services did not appear to be occurring at the expected frequency; reviewing services billed and noting ICC and IHBS were being significantly under billed; attending CIBHS conferences in which the focus was the service provision of Katie A/Pathways to Well-Being Services; and participating in the DHCS System and Chart Review. Early data reviewed was monthly invoices in which a lack of billing was noted for CFTs and low billing for ICCs and IHBS…There was concern that children needing intensive case management and services may not be receiving the necessary services.	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While the MHP based its PIP on billing and service data, it did not explain its methodology of defining and capturing the data, nor did it include a barrier and/or causation analysis. The overarching goal of the PIP is to ensure that eligible beneficiaries are receiving the medically necessary services of ICC-CFT, ICC-KTA, and IHBS.

Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☒ Care for an acute or chronic condition ☒ High risk conditions	*Non-clinical:* ☐ Process of accessing or delivering care

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This PIP is designed to implement a screening of all children seeking Specialty Mental Health Services or being re-assessed for further Specialty Mental Health Services, to identify children eligible for ICC-CFT, ICC-KTA and IHBS, and to ensure that they are receiving the appropriate level of services.
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The interventions have the potential to impact the mental health, functional status, and satisfaction of beneficiaries by providing thorough assessment to provide Specialty Mental Health Services that will lead to more vulnerable children receiving an intensive level of service, which will likely improve the stabilization of placement, reduce symptomology, and restore functioning. From last year's review: EQRO questions - Where is the data that these are lacking? What are the data for stabilization? Where are the symptomology data? Restore functioning? How many kids aren't functioning or at what level are they functioning? Beneficiary level data is needed to show an issue for beneficiaries.
	Totals	**1** Met **3** Partially Met

STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Will implementing a standardized screening tool to determine eligibility for Intensive Care Coordination-Child and Family Team (ICC-CFT) services, Intensive Care Coordination (ICC-KTA) services, and Intensive Home-Based Services (IHBS), as well as Katie A. subclass members, improve stabilization of placement, reduce symptomology and restore functioning?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	More information is needed regarding how the MHP plans to measure improved stabilization of placement, reduced symptomology and restored functioning. Add "as measured by…." Question was not improved over last year's feedback: Question is to improve stabilization from what to what, reduce symptomology from where to where, restore function from what to what? There is no baseline provided to show the level of issue.
	Totals	**1** Partially Met
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☒ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	This study includes all children who request services or re-authorization of services. In 2018, there were 463 children for whom requests for services were made. As of January 31, 2019, there were 35 children/youth enrolled as Katie A. subclass members and 83 children had received at least one ICC-CFT, ICC-KTA or IHBS service in January 2019.

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☒ Other: EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The primary data source for this PIP is the MHP's EHR system, "Avatar Clinical Workstation".
	Totals	**2** Met

STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Completion of the Eligibility for Pathways to Well-Being and Katie A. Subclass Services form. 2. The number of children eligible as a Katie A subclass member 3. The number of children enrolled in a Katie A episode 4. The number of children eligible for ICC and IHBS 5. Delivery of ICC-CFT (Service Code 307) to eligible children at least once every 90 days. 6. Delivery of ICC-KTA (Service Code 308) to eligible children 7. Delivery of IHBS to eligible children 8. CALOCUS Score level of care needs of the eligible children 9. CANS-50 Score how children are responding to services 10. PSC-35 Score 11. Duration in Program 12. Number of psychiatric hospitalizations for children receiving ICC-CFT, ICC-KTA and/or IHBS	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The study indicators are clearly defined. Numbers 8 – 12 measure impact of interventions. Number 12 needs a baseline number for measurement of improvement. The numerous indicators, similar in name, will likely be difficult to track consistently and draw useful inferences. Some of the indicators should have been included in defining the problem and its causes first before elevating it to the level of a PIP. For example, if a code is not consistently used by staff and services are misidentified, how would it be known that the services in question were not already being provided.

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	Use of a code and use of a form are not client-focused indicators, but rather, they would be part of the evaluation process to determine root causes of the problem [underused Katie A. services].
	Totals	**1** Met 1 Partially Met
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP is not using a sampling method. The MHP is applying this PIP to all children for whom SMHS are requested or for whom re-authorization of continued services is requested.

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP is not using a sampling method. The MHP is applying this PIP to all children for whom SMHS are requested or for whom re-authorization of continued services is requested.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	The MHP is not using a sampling method. The MHP is applying this PIP to all children for whom SMHS are requested or for whom re-authorization of continued services is requested.
Totals	**3** NA	
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP will track the total number of children authorized for services and the outcome of the screening tool. It is the expectation that the screening tool will be utilized for 100 percent of the children authorized for services. Also, the MHP will collect data on the number of children who have actually received ICC and IHBS services, including Child and Family Team Meetings.
6.2 Did the study design clearly specify the sources of data?	☒ Met ☐ Partially Met	The Eligibility for Pathways to Well-Being and Katie A. Subclass Service form utilizes a series of “Yes” or

Sources of data: ☒ Member ☐ Claims ☐ Provider ☒ Other: EHR	☐ Not Met ☐ Unable to Determine	"No" questions to determine eligibility for ICC and IHBS services. The same form is used by the MHP during the initial assessment for services and by the contracted providers during the provision of services, making for consistent data collection. Hard data is then pulled from the EHR to compare the total number of beneficiaries deemed eligible for ICC and IHBS services and the total number of beneficiaries receiving those services and at what level those services are provided. Secondly, data pulled from billing invoices is used to track the actual provision of the ICC and IHBS services to individuals identified as eligible.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☐ Partially Met ☐ Not Met ☒ Unable to Determine	Information needed on how often data would be collected, by whom, as well as how often the data would be analyzed and by whom.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other:	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Information outlining how staff use the form, and the method used by the PIP team to ensure that staff are correctly using the form is needed.

6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	Further narrative of data analysis plan is needed. In the event of untoward results, the PIP Team will review the issue, identify potential actions to take to address the issue and roll the needed change out to the PIP Team for implementation.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Title: Role: *Other team members:* Names:	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	While the team was listed, descriptions did not include their respective qualifications.
	Totals	**2** Met **3** Partially Met 1 UTD
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:*	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	This PIP was submitted last year with the same interventions and date of application. No new interventions have been added.
	Totals	**1** Partially Met

STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Findings for CALOCUS, CANS-50 and PSC-35 was incomplete though notes were provided: Decrease in level of care from previous scores (CALOCUS) Increased stability from previous scores (CANS-50) Increased stability from previous scores (PSC-35)

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: ____percent _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The MHP remeasured monthly for all indicators. Results were provided in table/grid format without discussion. Data and analysis went through January 2019. Data through January 2020 should be included.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	Results were provided in table/grid format without discussion.
Totals	**2** Met **1** Not Met **1** UTD	

STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Data was collected monthly for children through the screening tool and forms.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☐ Yes ☒ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	The MHP did not provide data past January 2019, though the PIP ended January 2020.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Missing data after January 2019.

9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Missing data after January 2019.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	Missing data after January 2019.
Totals	**1** Met 4 UTD	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

This PIP was submitted last year with the same interventions and date of application. No new interventions have been added.

The MHP remeasured monthly for all indicators and results were provided in table/grid format without discussion. While data collection and analysis went through January 2019, the PIP formally ended in January 2020; however, data through January 2020 was not included.

PIP Validation	#s
Met	9
Partially Met	9
Not Met	1
UTD	6
# Not applicable	3
Score	54.00%
total items in rating	28

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS
Recommendations: A more thorough "setting up" was needed for this PIP. The role of beneficiaries and family members was not specified. While the MHP based its PIP on billing and service data, it did not explain its methodology of defining and capturing the data, nor did it include a barrier and/or causation analysis. Regarding the study question, it should include information on how progress or improvement will be measured. Of note, the question was not improved to include a baseline per last year's feedback. Also, the numerous indicators, similar in name, will likely be difficult to track consistently. Regarding the data analysis plan, information was needed on how and when data was to be collected and analyzed. Overall, further narrative of the data analysis plan would have made the project more robust. EQRO remains available for TA for the development of future PIPs.
Check one: ☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible ☒ Confidence in PIP results cannot be determined at this time

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY 2018-19
NON-CLINICAL PIP

GENERAL INFORMATION

MHP: El Dorado County

PIP Title: Request for Services Process Change – Direct Intake Scheduling

Start Date: 03/15/2019

Completion Date:

Projected Study Period (#of Months): 12

Completed: Yes ☒ No ☐

Date(s) of Desk Review:

Name of Reviewer: Cyndi Lancaster

Status of PIP (Only Active and ongoing, and completed PIPs are rated):

Rated

☐ Active and ongoing (baseline established and interventions started)

☒ Completed since the prior External Quality Review (EQR)

Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.

☐ Concept only, not yet active (interventions not started)

☐ Inactive, developed in a prior year

☐ Submission determined not to be a PIP

☐ No Non-clinical PIP was submitted

Brief Description of PIP (including goal and what PIP is attempting to accomplish):

The overarching goal of this PIP is to reduce the duration of time elapsed from the initial request for SMHS to the intake screening assessment. By reducing this wait time, requests for services will be dispositioned more expediently and beneficiaries will be referred to an appropriate level of care/resources earlier and have needs addressed promptly, thereby likely reducing functional impairments.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component/Standard	**Score**	**Comments**
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	A multi-functional team of stakeholders were part of the PIP committee.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP gathered data on the length of time from initial contact to first assessment service and found that there were delays in contacting beneficiaries. The MHP identified "phone tag" for initial scheduling as the causative issue. A further barrier analysis would have been helpful in providing more information on possible interventions.

Select the category for each PIP: *Non-clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☐ High risk conditions	*Non-clinical:* ☒ Process of accessing or delivering care

1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	All beneficiaries coming into the system.
	Totals	**4** Met
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:*	☐ Met ☐ Partially Met ☒ Not Met ☐ Unable to Determine	No question was provided, though it could be implied. The purpose of the PIP was clearly set out in the introduction. "Will a new scheduling process improve timeliness of initial assessments as measured by tracking days to disposition through requests for services and a scheduler?"
	Totals	**1**Not Met

STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The beneficiary population included in the indicated PIP include a variety of individuals requesting Specialty Mental Health Services. The ages of the beneficiary population requesting specialty mental health services are 0 and up.
3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☒ Utilization data ☒ Referral ☐ Self-identification ☒ Other: EHR	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**2** Met
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* •	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	

4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☐ Health Status ☐ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☒ No Are long-term outcomes implied? ☒ Yes ☐ No	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The indicators measured processes of care with strong associations with improved outcomes.
	Totals	**2** Met
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Sampling not used.

5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:*	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Sampling not used.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable ☐ Unable to Determine	Sampling not used.
Totals	**3** NA	
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider	☒ Met ☐ Partially Met ☐ Not Met	

☒ Other:	☐ Unable to Determine	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	How do you know you have all of them requests for services? In the plan, it does not specify how often the data is collected and analyzed; however, Section 8 does contain this information. The MHP reports it has confidence in its reports that are generated in Avatar but details on how they know this was not provided. Also missing is the statistical method by which the data will be evaluated (confidence).
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☒ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☒ Other:	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	More information on the methodology is needed to determine if all requests for service are in the EHR.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☒ Partially Met ☐ Not Met ☐ Unable to Determine	The plan was minimal. It defined the study period as a whole but not the intervals within for data remeasurement. The EHR as the source for data was specified, as well as staff qualifications, however it did not describe continencies for untoward results.

6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: Title: Manager of Mental Health Programs Role: UR/QA Clinician *Other team members:* Names:	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	
	Totals	**3** Met **3** Partially Met
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* •	☒ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The intervention is the application of the new scheduling process. Everything else is what the MHP is doing to support the intervention. Interventions are direct with the client.
	Totals	**1** Met
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Remeasure indicates that the intervention is a success. Although the MHP did not provide a narrative on its preliminary conclusions, the information provided in the table shows improvement in all indicators with the exception of tracking outreach hours, which is to be determined.

8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☒ Yes ☐ No Are they labeled clearly and accurately? ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____monthly_____ Indicate the statistical analysis used: simple percentage, no statistics. Indicate the statistical significance level or confidence level if available/known: ____percent x Unable to determine	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	No information on statistical significance was provided.

8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* *Conclusions regarding the success of the interpretation:* *Recommendations for follow-up:*	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	
Totals	**3** Partially Met 1 Not Met	
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☒ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☒ No Clinical significance: ☒ Yes ☐ No	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	No discussion was provided.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☒ Unable to Determine	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☒ Moderate ☐ Strong	☐ Met ☐ Partially Met ☒ Not Met ☐ Not Applicable ☐ Unable to Determine	There was improvement but not sure which conclusions to draw since there is no Section 9 write-up.

9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	Over the course of the year, there appears to be improvement. However, the MHP did not provide any additional information on this.
Totals	**2** Partially Met **1** Not Met 2 UTD	

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)		
Component/Standard	**Score**	**Comments**
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☒ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Conclusions:

The MHP gathered data on the length of time from initial contact to first assessment service and found that there were delays in timeliness due to difficulty contacting beneficiaries. The MHP identified “phone tag” in initial scheduling as the causative issue; however, a further barrier analysis was not provided and would have been helpful in providing more information on possible interventions.

Although there was no formal research question within the PIP, it could be implied. The purpose of the PIP was clearly described in the introduction. The MHP appears to be answering the question, “Will a new scheduling process improve timeliness of initial assessments as measured by tracking days to disposition through requests for service?”

The PIP could be improved with more detail in the narration. Overall, the sections are incomplete and invite the reader to make inferences, only to find the answers in another section. In Section 6, on the data analysis plan, it does not specify how often the data is collected and analyzed; however, Section 8 on data analysis contains this information. The plan defined the study period but not the intervals within for data remeasurement. The EHR as the source for data was specified, as well as staff qualifications, however it did not describe contingencies for untoward results.

PIP Validation	#s
Met	12
Partially Met	8
Not Met	3
UTD	2
# Not applicable	3
Score	64.00%
total items in rating	28

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS

Recommendations:

The MHP reports it has confidence in its reports that are generated in Avatar but details on how they know this was not provided. More information on the methodology is needed to determine if all requests for service are in the EHR. Also missing is the statistical method by which the data was evaluated (confidence).

Remeasurement indicates that the intervention is a success. Although the MHP did not provide a narrative on its preliminary conclusions, the information provided in the table shows improvement in all indicators except for tracking outreach hours, which is to be determined. There was improvement but EQRO is unsure which conclusions to draw since there is no Section 9 write-up by the MHP.

Check one:

☐ High confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results

☒ Confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible

☐ Confidence in PIP results cannot be determined at this time