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

MENDOCINO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

November 9 – 10, 2020

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

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

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

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

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Mendocino 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 — Superior

MHP Location — Ukiah

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 2,628

MHP Threshold Language(s) — Spanish

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Network Adequacy

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

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

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

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

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

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

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

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

Status of FY 2019-20 Review of Recommendations

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

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: The MHP is encouraged to select a clinical PIP as soon as possible and begin working on the design and execution.

Status: Met

- The MHP chose a new clinical PIP topic in September 2019 and spent the following five months training staff and developing the details of the PIP. The interventions began in March 2020.
- Due to administrative delays in finalizing the FY 2019-20 report, the MHP had a relatively brief window between receipt of the final FY 2019-20 report and the due date for submissions for the FY 2020-21 review to address the recommendations.

- The MHP is encouraged to seek frequent technical assistance from EQRO in the coming year to support PIP activity.

Recommendation 2: Use of ongoing technical assistance (TA) from the EQRO is highly recommended.

Status: Not Met

- The MHP did not use TA from the EQRO during the year.
- During this review, the MHP agreed to contact the EQRO promptly for TA on both PIPs.

Access Recommendations

Recommendation 3: Assess user-ease of the MHP's website to identify modifications that would support user-friendly access to critical information.

Status: Met

- The MHP worked with beneficiaries through the Behavioral Health Advisory Board to evaluate user ease of the website; and while the suggestion was again offered by stakeholders during this review, the website has been updated and is much more user-friendly.

Recommendation 4: Ensure that locations of wellness centers are easily found on the website.

Status: Met

- A link to the locations of the wellness centers is now easily found on the site.

Timeliness Recommendations

Recommendation 5: Track time from assessment to first follow-up appointment.

Status: Met

- The MHP provided evidence of timeliness reports that include this metric.

Recommendation 6: Track frequency of appointments relative to treatment plans.

Status: Met

- This metric is used for chart reviews and utilization audits.

Recommendation 7: Investigate outliers in data on timeliness for first kept psychiatry appointments and ensure the service delivery process is working as intended.

Status: Met

- The MHP and Redwood Quality Management Company (RQMC), the administrative services organization (ASO), have multiple meetings per month during which they discuss timeliness and utilization at both a system- and individual-level. Outliers are always noted and discussed. The MHP provided evidence of the reports and agendas that reflect this activity.

Quality Recommendations

Recommendation 8: In Quality Assurance/Quality Improvement (QA/QI) and Cultural Diversity Committee(CDC) minutes, identify participants' roles in the system and evaluate the effectiveness of strategies to increase participation.

Status: Met

- Minutes reflect identification of participant roles and organizations
- The MHP provided evidence of discussions in multiple venues related to attendance, including with beneficiaries.
- The final CDC meeting of the fiscal year was held virtually and was the best attended of the year.

Recommendation 9: Analyze those data on high cost beneficiaries that indicate a trend in increased penetration and cost to ascertain appropriateness of services and/or any warranted changes in service delivery.

Status: Met

- The MHP continually reviews appropriateness of care and looked at high cost beneficiaries specifically. They identified specific individuals as well as utilization changes related to RQMC’s assumption of all medication services.

Recommendation 10: Take any indicated action based on the analysis of high cost beneficiaries.

Status: Met

- The ASO has taken steps to refer high cost beneficiaries to the Whole Person Care (WPC) program and has opened crisis respite housing options in partnership with local providers.
- The MHP is building a crisis residential treatment facility they plan to open in November 2021.
- Both the penetration rate and percent of service dollars for high cost beneficiaries dropped significantly in CY 2019-20 from CY 2018-19.

Recommendation 11: Conduct training or in-service that reinforces beneficiary input and collaboration in treatment planning for all psychiatric providers. *(This is a carry-over recommendation from FY 2018-19.)*

Status: Met

- Stakeholders reported that the new medical director has placed an increased focus on beneficiary input, and clinical notes now more frequently include beneficiary preferences (whether accommodated or not).
- Review participants reported no knowledge of collaborative documentation or treatment planning training in the last year.
- The ASO reported having rolled out a collaborative documentation training for their direct service and contractor clinical staff; however, they acknowledged an inconsistent focus on this new strategy. Discussion during the review generated renewed commitment by the ASO to focus on this initiative and elevate its importance in trainings and meetings.
- There was a general consensus that beneficiaries felt they participate in their treatment planning.

Beneficiary Outcomes Recommendations

Recommendation 12: Ensure that results of the beneficiary satisfaction surveys are well-publicized, and that appropriate committees document and share the analyses, including trends over multiple years and quality improvement (QI) initiatives resulting from consideration of the results.

Status: Met

- The MHP reported that the results of the Consumer Perception Survey (CPS) were not made available to the MHP this year. The latest report is 18 months old, and the survey was cancelled this past spring.
- The MHP attempted to do a survey of its own but got few responses.

- With the change in the CPS state-level contract, it is expected that the surveys will return to a predictable schedule once face to face services begin again and that they will yield analyses that will be helpful to MHPs for QI purposes. This recommendation will not be carried forward.

Foster Care Recommendations

Recommendation 13: Brainstorm with Child Welfare Services (CWS) regarding the plan to fill the vacant positions and re-design the tracking process that ensures that all sub-class members are identified and receiving services consistent with the Core Practice Model (CPM).

Status: Met

- The MHP began working with CWS to develop a more effective tracking system; however, they have not consistently applied the new process due to COVID-19.

- Weekly interagency meetings that include probation, education, Family and Children's Services and other stakeholders, as well as the Multi-Agency Committee (MAC) that includes all children's services contractors, review level of care (LOC) and service appropriateness for children in the system, including ensuring that required Child and Family Teams (CFTs) occur.

Recommendation 14: Focus a utilization management (UM) review on foster youth re-hospitalizations, and document and track any plans developed to address the elevated rate at a system level.

Status: Met

- The MHP reviewed these data and identified reasons for the elevated rate. Fewer available Short Term Residential Treatment Program (STRTP) beds and higher acuity has resulted in youth cycling in and out of inpatient services.

- In addition, the rate is based on fewer admissions; in FY 2019-20, only three foster care youth were re-hospitalized, which is a reduction from six in FY 2018-19.

Recommendation 15: Prioritize development of a comprehensive QA/QI system to monitor medication administration per SB 1291, including tracking and trending performance to identify practice improvement opportunities.

Status: Partially Met

- While chart reviews are conducted quarterly by a licensed pharmacist, and the MHP indicated on a checklist that they track SB 1291 and other

Healthcare Effectiveness Data and Information Set (HEDIS) measures, no evidence was provided of that specific tracking.

- During the review, the medical staff acknowledged the need to develop a more comprehensive monitoring and QI system with respect to medication administration practices.

Information Systems Recommendations

Recommendation 16: Install security in both systems that has the capacity to prohibit the use of thumb drives to upload or download data.

Status: Met

- While the MHP has not implemented security to prohibit thumb drive usage, staff have been informed that thumb drives are not be used to upload or download client information.
- The MHP also reported that thumb drives are rarely used by administrative staff, and in such cases are password-protected.

Structure and Operations Recommendations

Recommendation 17: Analyze Mendocino's Provider File to determine which provider's National Provider Identifier (NPI) is not setup correctly and is blocking Medi-Cal billing.

Status: Met

- The MHP is unaware of any issue with the Provider File and/or Avatar billing system issue that is blocking Medi-Cal billing. It is part of the normal operating process of the MHP's Fiscal Department to review, check, and fix claim errors.
- The MHP will review CalEQRO's Network Adequacy document, discussed at the review, which highlights six NPI exception and outlier conditions.

Recommendation 18: Correct the Provider File and/or Avatar billing system; use void/replace transactions to correct the condition.

Status: Met

- The MHP is unaware of an issue with the Provider File and/or Avatar billing system issue.

Recommendation 19: Address the attendance problem at CDC.

Status: Met

- This recommendation duplicates number eight above in Quality.

PERFORMANCE MEASURES

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

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

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

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

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

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

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

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

- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

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

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

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

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

Mendocino MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Beneficiaries	Percentage of Medi-Cal Beneficiaries	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
White	21,198	50.9%	1,664	63.3%
Latino/Hispanic	13,135	31.5%	502	19.1%
African-American	406	1.0%	41	1.6%
Asian/Pacific Islander	735	1.8%	17	0.6%
Native American	2,188	5.3%	167	6.4%
Other	3,974	9.5%	237	9.0%
Total	**41,635**	**100%**	**2,628**	**100%**

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

Table 2 provides details on beneficiaries served by threshold language.

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

Mendocino MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	190	7.2%
Other Languages	2,438	92.8%
Total	**2,628**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

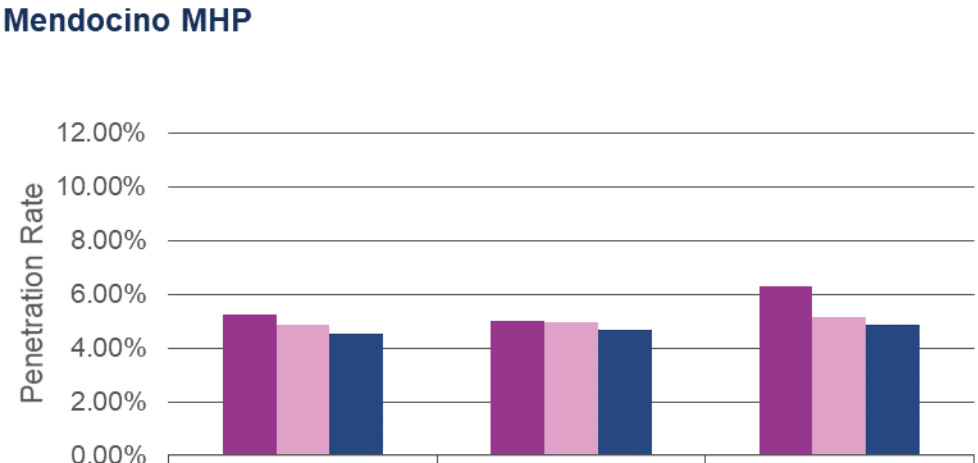
Penetration Rates and Approved Claims per Beneficiary

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

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

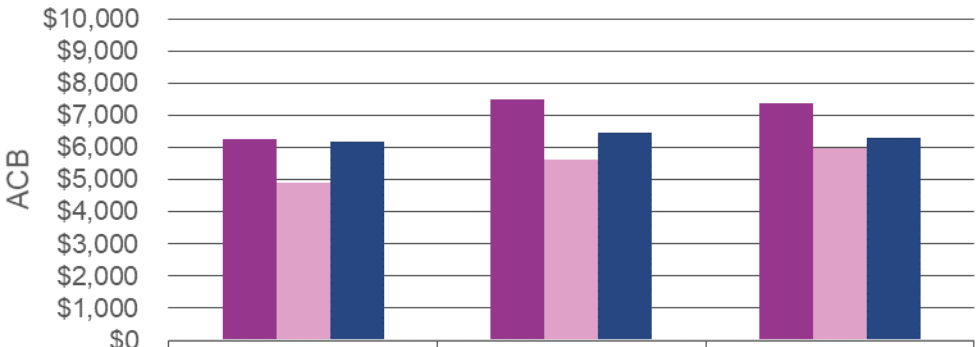
Regarding the calculation of penetration rates, the Mendocino MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	5.23%	5.02%	6.31%
Small	4.87%	4.96%	5.15%
State	4.52%	4.66%	4.86%

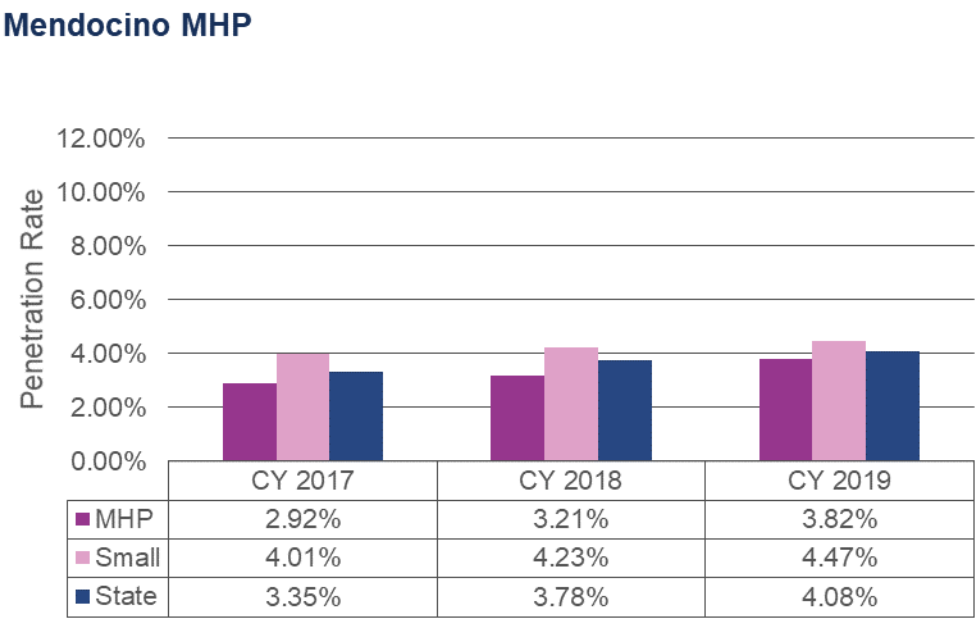
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$6,262	$7,511	$7,354
Small	$4,895	$5,602	$5,982
State	$6,170	$6,454	$6,316

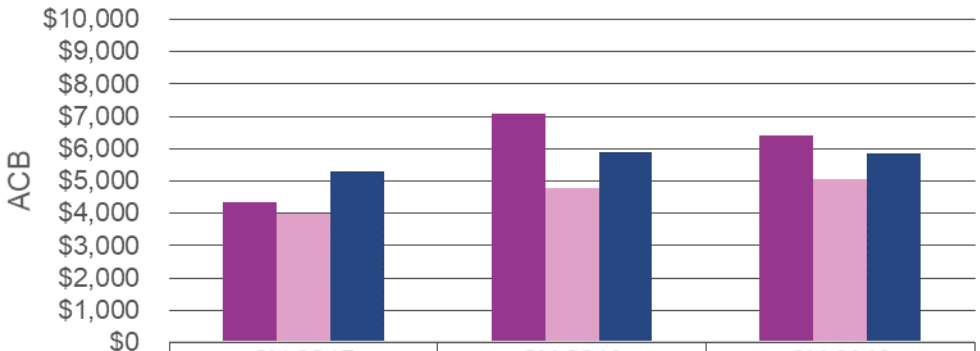
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	2.92%	3.21%	3.82%
Small	4.01%	4.23%	4.47%
State	3.35%	3.78%	4.08%

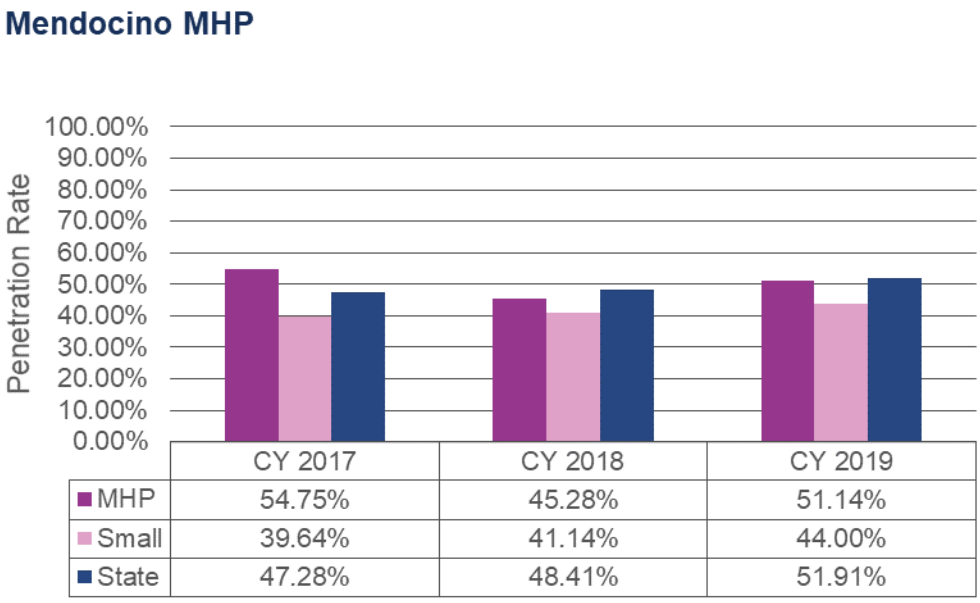
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$4,347	$7,076	$6,389
Small	$3,993	$4,788	$5,040
State	$5,278	$5,904	$5,869

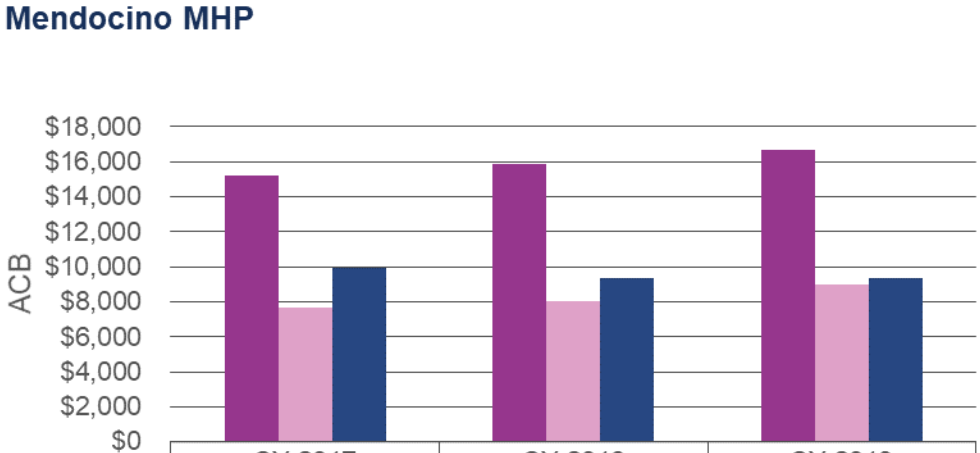
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	54.75%	45.28%	51.14%
Small	39.64%	41.14%	44.00%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

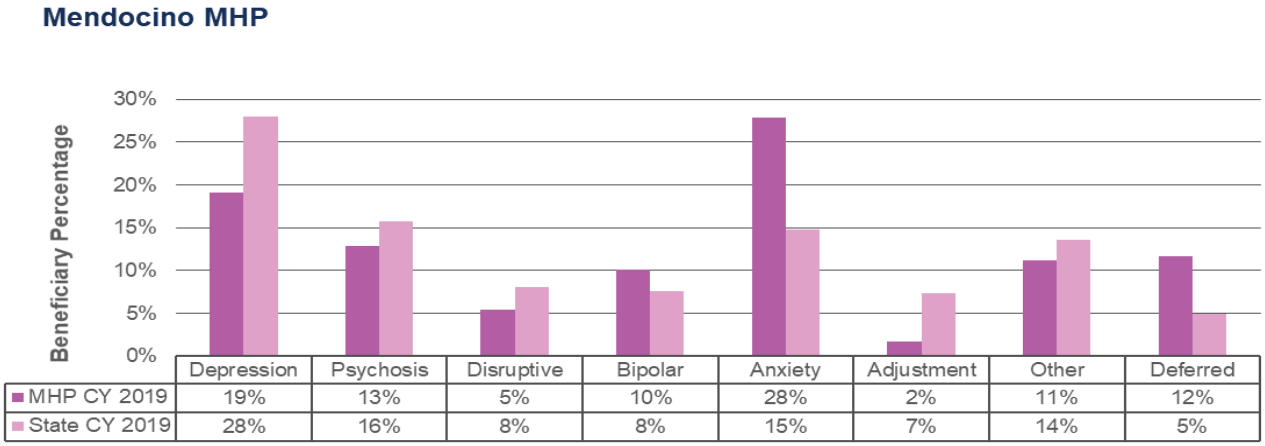


	CY 2017	CY 2018	CY 2019
MHP	$15,216	$15,830	$16,697
Small	$7,671	$8,033	$9,010
State	$9,962	$9,340	$9,360

Diagnostic Categories

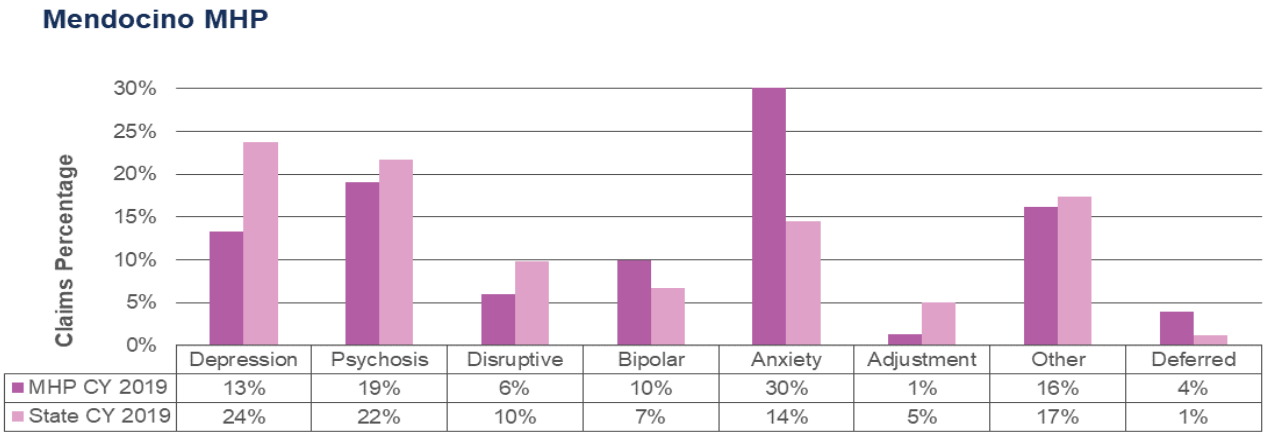
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	19%	13%	5%	10%	28%	2%	11%	12%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

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



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	13%	19%	6%	10%	30%	1%	16%	4%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

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

Table 3: High-Cost Beneficiaries CY 2017-19

Mendocino MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	120	2,628	4.57%	$53,631	$6,435,718	33.30%
	CY 2018	116	2,184	5.31%	$59,320	$6,881,095	41.94%
	CY 2017	83	2,223	3.73%	$54,272	$4,504,553	32.36%

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

Psychiatric Inpatient Utilization

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

Table 4: Psychiatric Inpatient Utilization CY 2017-19

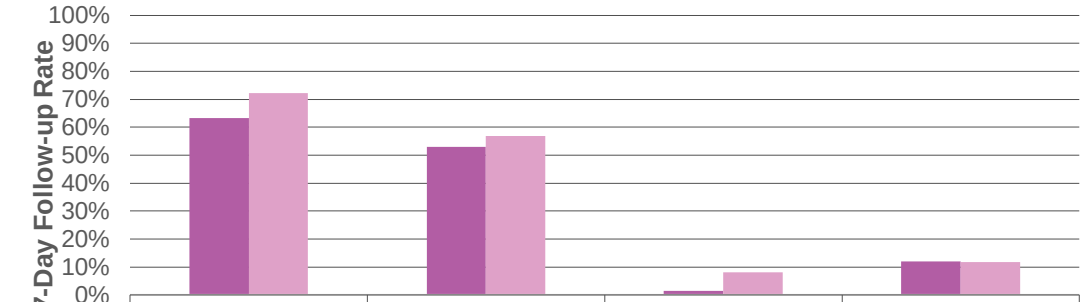
Mendocino MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	286	535	8.63	7.80	$12,197	$10,535	$3,488,376
CY 2018	264	489	8.53	7.63	$17,214	$9,772	$4,544,538
CY 2017	248	548	7.92	7.36	$11,734	$9,737	$2,910,108

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

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

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

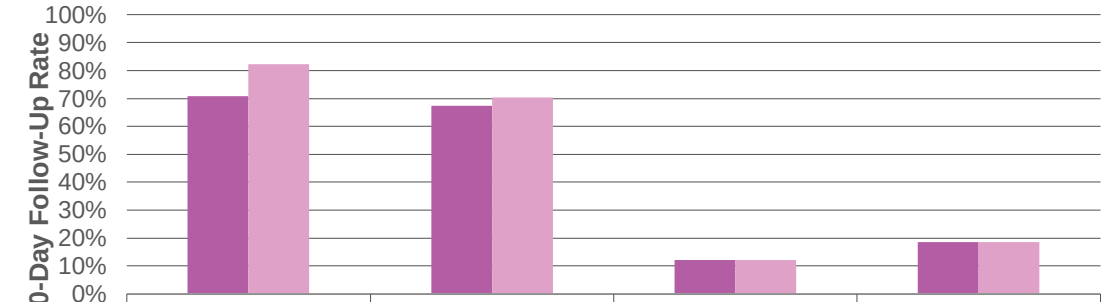
Mendocino MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	63%	53%	1%	12%
CY 2019	72%	57%	8%	12%

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

Mendocino MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	71%	67%	12%	19%
CY 2019	82%	70%	12%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A PIP is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." CMS' EQR Protocol 1: 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.

Mendocino MHP PIPs Identified for Validation

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

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

Table 5 : PIPs Submitted by Mendocino MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Treatment of Anxiety Disorders in Adults
Non-Clinical	1	Appropriate Engagement for Homeless SMH Clients in Ukiah

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Mendocino
PIP Title	Treatment of Anxiety Disorders in Adults
PIP Aim Statement	"Will consistent focused use of short term intensive evidence-based anxiety treatments, over a 4 month period, with adult SMI clients diagnosed with any anxiety disorder, lead to a reduction in anxiety symptoms as reflected in GAD-7 and ANSA scores."
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply):	

MHP Name	Mendocino
☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): n/a ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The MHP defined the population as adult SMI clients, with any anxiety disorder, receiving services through Redwood Community Services' Stepping Stones facility (a transitional housing program for the TAY population).	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The MHP implemented an Evidence-Based Practice (EBP), specifically two elements of Cognitive Behavioral Therapy (CBT), that has been shown to have a positive impact on anxiety.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percentage of adult clients with reduced ANSA scores	80%	**28 of 35**	2019-2020		☒ Yes ☐ No	☒ Yes ☐ No p-value: ☐ <.01 ☒ <.05 Other (specify):
Percentage of reduced GAD-7 scores	**71%**	**25 of 35**	2019-2020		☒ Yes ☐ No	☒ Yes ☐ No p-value: ☐ <.01 ☒ <.05 Other (specify):
Was the PIP validated?				☒ Yes	☐ No	
Validation phase: ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement						

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ Second remeasurement ☐ Other (specify):						
Validation rating: n/a ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence The MHP showed improvement over the 4-month period during which this PIP was implemented. However, the population that received the intervention was small and the likelihood of the same results if/when this is implemented throughout the MHP is still in question. "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: • The MHP should participate in EQRO technical assistance (TA). Although the MHP implemented part of an Evidence Based Practice (EBP), it did not implement the entire EBP, calling in to question the validity of the implementation. • The MHP agreed to develop a new clinical PIP and to use EQRO technical assistance (TA) as they consider topics and plans.						
The TA provided to the MHP by CalEQRO consisted of: • Discussion during the review focused on the MHP's actual intent, which was to promote increased use of an EBP among the contracted providers. The EQRO would like to see more focus on implementation of PIPs from the perspective of the beneficiary. The MHP should focus on the benefits that the PIP brings to the beneficiary, not just to the MHP itself. • As designed, the initiative functioned to re-validate an existing EBP. • The MHP was encouraged to review data related to clinical/quality of life measures to identify improvement opportunities.						

*PIP is in planning and implementation phase if n/a is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Mendocino
PIP Title	Appropriate Engagement for Homeless SMH Clients in Ukiah
PIP Aim Statement	"Can increased connection through a "warm handoff" improve the following among homeless clients with SMI: 1. Decreased amount of time from "warm handoff"/crisis contact to first outpatient contact (increased access to services) 2. Increase the number of outpatient services utilized (increased engagement)?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The study included all adult homeless persons with either Medi-Cal or Indigent status, who accessed crisis or inpatient services.	

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

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): None
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The sole intervention was implementation of a "warm handoff" to a community mental health provider at the time of the person's exit interview at Redwood Community Crisis Center post-discharge from inpatient or following use of community-based crisis services.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): None

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percentage of individuals receiving a "warm handoff" who continue w/ mental health services	The MHP defined a baseline year (FY 2018-19); however, those individuals did not receive a warm handoff, so	A 3-month baseline was established after the intervention was applied (April 1, 2019-June 30, 2019)	July 1, 2019 – June 30, 2020 ☐ n/a*	Sample: 54 Rate: 51 of 54 = 94%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): the

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
	this is not relevant to the indicator	Rate: 8 of 13 = 62%				significance was tested on a different measure – percent improvement (not clear over what)
Percentage of individuals receiving a "warm handoff" who attend first provider appointment within 7 days	Same as above	Same as above Rate: 8 of 8 = 100%	July 1, 2019 – June 30, 2020 ☐ n/a*	Sample: 54 Rate: 46 of 54 = 85%	☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): the significance was tested on a different measure – percent improvement (not clear over what)
Percentage of individuals receiving "warm handoff" who continue with services and average 2 services per week in 60	Same as above	Same as above Rate: 6 of 8 = 75%	July 1, 2019 – June 30, 2020 ☐ n/a*	Sample: 54 Rate: 25 of 54 = 46%	☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
days post "warm handoff"						(specify): the significance was tested on a different measure – percent improvement (not clear over what)

Was the PIP validated? ☒ Yes ☐ No

Validation phase:

☐ PIP submitted for approval

☐ Planning phase

☐ Implementation phase

☐ Baseline year

☐ First remeasurement

☒ Second remeasurement

☐ Other (specify):

Validation rating:

☐ High confidence

☐ Moderate confidence

☐ Low confidence

☒ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

- This PIP has been completed, and the MHP agreed to consult frequently as they develop a new one.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
• The MHP is encouraged to keep the PIP simple and ensure they have clarity regarding definitions of their population, baseline, and indicators.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • It is clear that the MHP wants to know if providing a warm handoff for homeless individuals discharging from inpatient is more effective than no warm handoff in engaging and retaining them in ongoing services. • However, their population definition was stated differently in each section of the study; they did not effectively conceptualize and mathematically/statistically define the performance measures, and they were not clear about establishing a baseline against which to measure their success. • Late in the study they documented performance significantly over a 30 percent improvement target; however, it is not clear to what baseline that 30 percent target applies. • Discussion during the PIP session included all of the above points.						

*PIP is in planning and implementation phase if n/a is checked.

INFORMATION SYSTEMS REVIEW

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

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

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

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

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Mendocino	1.57%	2.30%	2.20%	2.20%
Small MHP Group	N/A	2.95%	3.25%	3.54%
Statewide	N/A	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

- ☒ Under MHP control
- ☐ Allocated to or managed by another County department
- ☐ Combination of MHP control and another County department or Agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☒ Yes	☐ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If no BCP was selected above; the MHP uses an ASP model to host EHR system which provides 24-hour operational support.	☐ Yes	☐ No
The BCP (if the MHP has one) is tested at least annually.	☐ Yes	☒ No
There is at least one person within the MHP organization clearly identified as having responsibility for Information Security.	☐ Yes	☒ No
If no one within the MHP organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

- RQMC assists the MHP in meeting their administrative requirements.

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

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	0%
Contract providers	98.44%
Network providers	1.56%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

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

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	8	1	1	0
2019-20	8	2	1	0
2018-19	7	2	1	0

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

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	5- MHP 12 - RQMC	0	0	0
2019-20	17	0	0	0
2018-19	17	2	1	0

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

- There has been no change in IT or data analytic staffing in the past year.
- The MHP has one IT vacancy, a Department Applications Specialist.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by MHP and does not account for user's log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	20	65	85
Clinical Healthcare Professional	18	210	228
Clinical Peer Specialist	0	18	18
Quality Improvement	3	18	21
Total	41	311	352

While there is no standard ratio of IT staff to support EHR user's, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Small MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	8	5.30
Total EHR Users Supported by IT (Source: Table 17)	352	200.00
Ratio of IT Staff to EHR Users	1:44	1:38

RQMC IT staff is not included in the above calculation. RQMC operates the EHR, Exym, in an application service provider (ASP) model.

Table 19: Additional Information on EHR User Support

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

- Five MHP staff have access to RQMC's EHR, Exym.
- While the Avatar system operated by the MHP for billing, reporting, and a minority of client EHR's does not utilize an ASP for operations, the MHP's ASO, RQMC, does utilize an ASP for operations of the EXYM EHR.

Table 20: New Users' EHR Support

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

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☒ Yes	☐ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No

Ongoing EHR Training and Support	Status	
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

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

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	9
Number of county-operated telehealth sites	0
Number of contract providers' telehealth sites	9
Total number of beneficiaries served via telehealth during the last 12 months	1,816
• Adults	1,021
• Children/Youth	720
• Older Adults	75
Total Number of telehealth encounters (services) provided during the last 12 months:	18,072

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

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

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

- The MHP added individual therapy, group therapy and new client intake and assessment telehealth services due to the COVID-19 pandemic.

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

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

- The MHP also supports American Sign Language (ASL)

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

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

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

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Redwood Quality Management Company	20+ - Clinical Services 3 - Psychiatry

Current MHP Operations

- The MHP continues to use two EHR systems for service documentation and billing. Services delivered by RQMC-contracted providers are documented in EXYM and claims data is electronically submitted from Exym to the MHP via a batch file transfer. MHP and SUD staff enter data directly into Avatar.
- Medi-Cal claims and state data-reporting are produced from the Avatar system.

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

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Avatar PM	Practice Management	Netsmart	17	HHSA IT/Vendor
Avatar CWS	Clinical Workstation	Netsmart	6	HHSA IT/Vendor
EXYM	EHR	EXYM	11	ASO/Vendor

The MHP's Priorities for the Coming Year

- Convert the Avatar EHR system from local hosting to hosting by Netsmart Technologies at one of their Data Centers.
- To encourage social distancing related to the COVID-19 pandemic, continue the implementation of telehealth options for clients.
- Continue to provide devices, virtual meeting software, and training for staff to create and host online meetings and webinars.
- Complete staff orientation on tracking Mental Health Medi-Cal Administrative Activities (MHMAA).
- Complete training and report development to support SUD program in the transition to Avatar.

Major Changes since Prior Year

- To comply with the March 2020 California Shelter in Place order, purchased hardware and set up a virtual private network (VPN) to allow staff to work remotely.
- Completed quarterly submissions of Network Adequacy Certification Tool (NACT) data to DHCS.
- Completed the purchase of large smart boards for group rooms.
- Purchased a portable telehealth cart to expand flexibility in the provision of virtual interpretation services, including ASL.

Other Areas for Improvement

- While the MHP noted plans to implement a beneficiary Personal Health Record (PHR) in prior ISCA tool submissions, the implementation of the myHealthPointe software continues to be a future (more than two years) initiative.

Plans for Information Systems Change

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

MHP EHR Status

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

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts		☒	☐	☐	☐
Assessments		☒	☐	☐	☐
Care Coordination		☒	☐	☐	☐
Document Imaging/Storage		☒	☐	☐	☐

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Electronic Signature—MHP Beneficiary		☒	☐	☐	☐
Laboratory results (eLab)		☒	☐	☐	☐
Level of Care/Level of Service		☒	☐	☐	☐
Outcomes		☒	☐	☐	☐
Prescriptions (eRx)		☒	☐	☐	☐
Progress Notes		☒	☐	☐	☐
Referral Management		☒	☐	☐	☐
Treatment Plans		☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		12	0	0	0
FY 2019-20 Summary Totals for EHR Functionality:		12	0	0	0
FY 2018-19 Summary Totals for EHR Functionality:		11	1	0	0

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

- No enhancements were completed in the past year; RQMC has a fully functional EHR. RQMC providers provide 98.44 percent of services for the MHP.
    - RQMC has implemented Care Coordination and Referral Management functionality in EXYM; however, neither function is available in Avatar.
- Electronic prescribing and lab results functionality are available in EXYM but are not available in Avatar.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

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

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

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not Applicable
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not Applicable
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	92.71%	Weekly
Direct data entry into MHP EHR system by contract provider staff	0%	Not Applicable
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not Applicable
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	7.29%	Monthly

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

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

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

EHR Vendor	Product	Count of Providers Supported
EXYM	Redwood Quality Management Company	Not provided by the MHP.

Personal Health Record (PHR)

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

☐ Yes ☒ No ☐ Implementation Phase

Not Applicable

Expected implementation timeline:

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

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

Table 28: PHR Functionalities

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

PHR Functionality	Status	
Have ability to both send/receive secure Text Messages with provider team.	☐ Yes	☒ No

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

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

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP's SDMC claims.

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

Mendocino MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**85,200**	**$17,705,210**	**559**	**$161,414**	**0.90%**	**$17,543,796**	**$17,182,169**
JAN19	7,108	$1,438,585	22	$6,332	0.44%	$1,432,253	$1,394,677
FEB19	6,696	$1,364,654	29	$14,481	1.05%	$1,350,173	$1,320,133
MAR19	7,761	$1,687,620	27	$16,032	0.94%	$1,671,588	$1,634,363
APR19	8,442	$1,709,025	48	$12,261	0.71%	$1,696,764	$1,673,805
MAY19	10,836	$2,086,481	95	$16,600	0.79%	$2,069,881	$2,046,587
JUN19	7,086	$1,457,648	133	$16,903	1.15%	$1,440,745	$1,416,504
JUL19	6,686	$1,412,733	51	$14,197	0.99%	$1,398,536	$1,368,293
AUG19	6,613	$1,495,732	45	$31,243	2.05%	$1,464,489	$1,418,490
SEP19	6,607	$1,443,321	58	$14,106	0.97%	$1,429,215	$1,401,435
OCT19	6,306	$1,312,215	25	$5,951	0.45%	$1,306,264	$1,288,166
NOV19	5,472	$1,157,480	19	$12,422	1.06%	$1,145,058	$1,103,070
DEC19	5,587	$1,139,714	7	$886	0.08%	$1,138,828	$1,116,645
Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2019 was **2.99 percent.**							

Table 30 summarizes the top five reasons for claim denial.

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

Mendocino MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	338	$84,673	52%
Beneficiary not eligible.	47	$38,952	24%
Medicare or Other Health Coverage must be billed before submission of claim.	15	$12,849	8%
Beneficiary not eligible or non-covered charges.	16	$8,861	5%
Invalid place of service for procedure code.	81	$7,117	4%
Total	559	$161,414	NA
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

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

NETWORK ADEQUACY

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

Network Adequacy Certification Tool Data Submitted in April 2020

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

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

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

Review of Documents

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

Review Sessions

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

Findings

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

The following strategies in place to meet the needs of beneficiaries were discussed during the review:

- The MHP contracts with both Consolidated Tribal Health Clinic and Round Valley Indian Health Center through the Mental Health Services Act (MHSA) for supporting culturally responsive services and has memoranda of understanding (MOUs) to support the continuity of mental health services.
- Specialty mental health service providers offer mobile services to outlying communities such as Covelo, Laytonville, and Point Arena.
- Telehealth services are available through collaboration and contracts with Round Valley Indian Health Clinic, and all specialty mental health providers provide telehealth and telephonic services for individuals preferring to access services from their home.

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

The MHP's Plans of Correction involved administrative issues that have been resolved, e.g., an outdated contract for language services.

Provider NPI and Taxonomy Codes – Technical Assistance

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

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

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	4
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	6
NPI Type 1 number reported is associated with two or more providers	1
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	1
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	0

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

CFM Focus Group One

Table 32 : Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested one culturally diverse group of adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group consisted of Latino/Hispanic and Caucasian men and women over the age of 25 who are English-speaking consumers. Included in this group are also individuals who were contacted by phone, and their responses were incorporated into the findings. The group session was conducted virtually over Zoom.
Total number of participants	Ten
Number of participants who initiated services during the previous 12 months	One
Interpreter used	No
Summary of the main findings of the focus group:	

Topic	Description
Access - new beneficiaries	Only one participant was new to services in the last year.
Access – overall	The participants mostly agreed that access to services was what they needed, including to psychiatrists, therapists, and case managers. Services since the COVID-19 restrictions continue to be provided much the same as before, with face-to-face as well as telehealth and over the phone. Service availability is well-publicized by flyers at the clinic in Spanish and English.
Timeliness	Most participants reported that their appointment schedules with their psychiatrists and therapists were satisfactory, and most get support to ensure they remember their appointments. Some disparity was reported related to the consequences of missed appointments, including rules such as having to wait four months if three appointments are missed.
Urgent care and resource support	Some participants knew how to access urgent care; only two reported knowledge of the Crisis Line. Many described the value of the Whole Person Care program and staff at the wellness centers for providing support between formal appointments. No one was aware of the warm line.
Quality	Most participants reported being involved in their treatment planning; however, no one had a Wellness and Recovery Action Plan (WRAP). Written and verbal information about medications did not appear to be satisfactory.
Peer employment	Only some participants knew about job support services; none have used them.
Structure and operations	Only one participant reported attending meetings related to system issues. Two remembered being asked their opinion about services in a survey but did not remember getting back any results.
Recommendations from this focus group	• Focus group participants perceived the homeless shelter (Building Bridges) to be “short on food and needs therapists or psychiatrists.” • Focus group participants perceived the shelter to be “dirty, needs more cleaning.” • Focus group participants suggested that additional therapists are needed in Ft. Bragg.

Topic	Description
Any best practices or innovations (optional)	None identified

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

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

Access to Care

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

Table 33: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	13
The MHP uses multiple channels for distributing and providing information about services, including the website, which is user-friendly, can be easily accessed in Spanish and other languages, and since COVID-19 changes, makes readily available information about virtual groups that include supports for the constraints of the pandemic. After the COVID-19 restrictions were implemented, the MHP created a warm line, available for all county residents, open between 7:30 am and 6:00 pm, Monday through Saturday. In tracking the use of the line, the MHP has seen a higher-than-expected volume and no discernable impact on the Access Line or Crisis Line. The provider directories are located on the RQMC website, as are the details about services and locations. It is not clear from the MHP website that RQMC manages most of the mental health services, thus finding any of this information is difficult unless one already knows about RQMC.			

Component		Maximum Possible	MHP Score
The Performance Outcomes System (POS) reports are easily located; the most recent report is from 2017, which is the last set of data made available to the MHPs.			
1B	Capacity Management	10	9
The MHP and RQMC meet multiple times per week, including with contract service providers, to evaluate and address capacity needs relative to existing enrollees and those newly entering. While monthly utilization reports, broken out by a range of demographic variables, are reviewed by the QAQI committee, the data would be more useful if provided as clearly-identifiable trends that could be used for capacity management and QI purposes. A full-time medical director was hired in the last year.			
1C	Integration and Collaboration	24	24
The MHP and RQMC work collaboratively with Federally Qualified Health Centers (FQHC's) to ensure that bidirectional referrals are completed. All adult providers have contracts with the Department of Rehabilitation and share assessment and rehabilitation eligibility functions. Services are most frequently provided for the TAY population. The MHP also has an agreement with CalWorks to place a rehabilitation specialist in the one-stop day program to provide services and assess for SMHS medical necessity. The MHP was awarded a No Place Like Home grant for an additional 20 apartment units to be constructed in the Ukiah area.			

Timeliness of Services

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

Table 34: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	16
Ninety-seven percent of all appointments are offered within ten business days, with an average of five days.			
2B	First Offered Psychiatry Appointment	12	12
Overall, first offered psychiatry appointments met the 15-day standard 93 percent of the time, with an average of six days. The MHP agreed during the review that the foster care data provided to the EQRO likely is not complete, reflecting only three referrals for psychiatry, and they planned to take another look and make sure they are capturing all referrals. As described during the session, the referral process appears designed to capture all requests in a timely manner.			
2C	Timely Appointments for Urgent Conditions	18	18
The MHP reports monthly to the QAQI Committee on all timeliness metrics and specifically breaks down urgent requests by time of day. The maximum wait time was three hours; all requests met the 48-hour standard 100 percent of the time. The MHP does not require prior authorization for any requests that are considered urgent.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	10
One hundred percent of all adults and 97 percent of children discharged from inpatient care receive a follow-up service within seven days. The MHP has a robust process that entails collaboration with the hospital during the stay, developing a follow-up plan prior to discharge, and ensuring that required appointments are scheduled in advance of the anticipated discharge date. Crisis staff transport people from the hospital to the previously-scheduled appointments or to the crisis center, and if a case manager is already involved with the person, they participate in the planning at the crisis center. Sixty-day post-discharge crisis plans are implemented for those who are not enrolled in MHP services. Medication Services holds slots for these and other psychiatric emergencies.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The overall readmission rate was 10 percent within 30 days, despite a 33 percent rate for foster youth.			

Component		Maximum Possible	MHP Score
Compared to FY 2018-19, half the number of foster youths were hospitalized in FY 2019-20; the MHP reported that while there has been a decrease in the number of foster youths in residential care, and Short Term Residential Treatment Programs (STRTP) beds have decreased by half, youth who remain in those beds are higher acuity and stay longer, having a harder time finding homes. Hence, they tend to cycle through inpatient more readily.			
2F	Tracks and Trends No-Shows	10	10
The overall average of no-show rates for psychiatrists was nine percent, and for non-psychiatrist clinicians it was ten percent. The MHP reported that the rates began dropping in January or February and have decreased more since more beneficiaries are accessing services virtually or telephonically. In addition, the ASO has implemented multiple strategies to reduce no-shows, including reminder calls, provision of transportation, and coordination with the case manager, who may at times participate in a session with the beneficiary.			

Quality of Care

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

Table 35: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	9
The MHP tracks service utilization by race/ethnicity, language, gender, and geography, reviewing detailed reports provided by the ASO. These reports would be more useful if the data were displayed using line graphs that clearly reflect trends rather than as tables with numbers that don't easily tell a story. The FY 2019-20 update to the Cultural Competence Plan was signed in December 2019, yet it included some progress on goals as of June 2020. Measurable goals include some data regarding increasing participation and attendance at meetings and provision of training; however, most of the definitions of			

Component		Maximum Possible	MHP Score
goals and strategies are written in narrative form and do not include a methodology for measuring their impact or achievement of goals. The MHP has conducted many trainings in the last several years, including during FY 2019-20, aimed at improving staff performance related to cultural competence and to educate an array of stakeholders. Minutes over the last year continue to be spare and do not reflect routine discussion of goals, progress, nor identification of follow-up activity identified.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
The MHP has a well-developed LOC determination system based on Child and Adolescent Needs and Strengths/Adult Needs and Strengths (CANS/ANSA) scores. Beneficiary needs are reviewed in utilization meetings that include contracted providers. Transitions are planned with receiving service providers, involving case manager support, warm hand-offs, and overlapping of open cases. Stakeholders reported satisfactory involvement in their care planning.			
3C	Quality Improvement Plan	10	9
The QI plan includes a combination of routine monitoring activity and measurable targets for the items being monitored, and the annual update measures the extent to which the MHP "complied" with its monitoring targets or met performance goals. Most of the goals are defined as monitoring activity rather than identifying performance measures that can be tracked, reported, and assessed for QI opportunities. Minutes of QAQI meetings reflect standing agendas of review of the same indicators/reports each meeting: Access Line test calls, appeals and grievances, timeliness metrics, crisis services utilization. Minutes also reflect some trending of performance (as narrative documentation) and identification of those measures needing attention, including corrective action plans when appropriate. Much of this activity is in the service of compliance as contrasted with quality improvement. A detailed analysis of disparities is in included in the Cultural Competency Plan.			
3D	Quality Management Structure	14	14
The MHP and ASO collaborate on quality management and improvement activity through multiple joint committees, the Quality Assurance Quality Improvement (QAQI) Committee (comprised of representatives across programs and departments) being the central point of monthly reporting. A monthly Quality Improvement Committee (QIC) includes community and beneficiary stakeholders and is combined with the MHSA stakeholders' meetings. Prior to			

Component		Maximum Possible	MHP Score
COVID-19, this committee met in various parts of the county to encourage attendance.			
3E	QM Reports Act as a Change Agent in the System	10	10
The MHP and ASO routinely review dashboards and other reports related to utilization, penetration, performance on timeliness and other quality of care metrics (monthly, quarterly, annually), in multiple committees. Minutes reflect identification of problems and plans to ameliorate.			
3F	Medication Management	12	7
The MHP reported chart audits of no less than five percent of beneficiaries per year and quarterly specific medication audits of no less than 20 medical charts. All chart audits are reported to be performed by licensed/certified staff. The medication monitoring checklist indicated that most of the HEDIS measures are tracked; however, no evidence was provided that chart reviews specifically track those measures. Chart review reports are presented at Medication Committee, including recommendations for improvement in practice. Developing a methodology to track and trend, over time, performance on specific indicators included in the chart reviews would provide the prescribers and the MHP with data that could be readily analyzed for quality improvement opportunities. Medical staff reported that there is no policy regarding chart reviews nor regarding medication practices. Coordination with primary care has reportedly improved in the last year. The prescribers reported an intent to start routine case conferences about high acuity beneficiaries. Stakeholders agree this would be very helpful.			

Beneficiary Progress/Outcomes

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

Table 36: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	14
The MHP reported tracking and aggregating data from the CANS and ANSA. CANS LOC discussions, training, and other discussions occur in MAC meetings, which occur at least monthly for the youth service providers. An Active CANS and PSC-35 is verified at each treatment plan renewal. These are electronically uploaded to the state. The aggregated CANS report provided for this review is an Excel file with two scores listed; no analytical report was provided. The MHP reported having difficulty re-writing the reporting algorithm after switching to the CANS-50. This had been resolved the month prior to the review.			
4B	Beneficiary Perceptions	10	7
There has been a lag in State reporting of the Consumer Perception Survey (CPS), and the MHP did not have new data available at the time of the review. Results are provided to some leadership groups, contract providers, and the Behavioral Health Board, when available. The MHP reported that providers collect satisfaction surveys of their own and report twice per year at QIC meetings.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
Wellness centers are located in all major population centers of the county, including the coast. All are either peer-run or peer-influenced, and the MHP tracks utilization on a regular basis. Information about the centers is available in Spanish in the schools and other partners in the county as well as in the outpatient clinics.			

Structure and Operations

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

Table 37: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	27
Several programs function as day treatment although the billing is unbundled. A tax measure passed providing funds to build a few psychiatric facilities, including a Psychiatric Health Facility (PHF); an RFP is currently out soliciting bids for an operator.			
5B	Network Enhancements	18	15
The MHP has been discussing possible co-location with several FQHCs; however no clear progress has been made. The FQHCs let the mobile outreach teams use their space when needed.			
5C	Subcontracts/Contract Providers	16	16
The MHP reported that RQMC and its providers served 98.44 percent of beneficiaries in the past year. The MHP and ASO are in close contact with contract providers, meeting regularly to discuss a range of subjects from specific beneficiary needs to system-level issues.			
5D	Stakeholder Engagement	12	12
Stakeholders reported that the MHP has made greater effort this past year to reach out and support participation in various meetings and groups, including providing transportation. Prior to the cessation of in-person meetings, the MHP had made efforts to hold QIC/MHSA stakeholder meetings in various locations throughout the county, and tribal communities were often the co-hosts.			
5E	Peer Employment	8	8
Peer positions are available at wellness centers and in outpatient clinics, some full time with benefits. Roles include case management and rehabilitation support. The MHP reported multiple levels of positions, and one participant reported having promoted someone from peer specialist to case manager, then to supervisor.			

SUMMARY OF FINDINGS

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

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- Due to the state's COVID-19 guidelines for face-to-face interaction, the MHP added individual therapy, group therapy and new client intake and assessment telehealth services.
- A warm line was established to support clients during the COVID-19 pandemic.
- The MHP was awarded a No Place Like Home grant for an additional 20 apartment units to be constructed in the Ukiah area.

Strengths:

- The website hosts an up-to-date calendar, in Spanish and English, of support and therapy groups being held on Zoom.
- The clinical and cultural/language needs of newly-enrolling beneficiaries are captured by the CANS and ANSA and discussed at UM and MAC meetings held weekly.
- All staff meetings include both MH and SUD personnel, furthering the integration and understanding of both sets of clinical issues.
- Willow Terrace, a 37-bed supported housing project for chronically homeless people, had just opened at the time of last year's EQR and has been successful in retaining 64 percent of the original tenants – a strong outcome given the challenges of operating such a housing project.

Opportunities for Improvement:

- The provider directories are located on the RQMC website, as are the details about services and locations. It is not clear from the MHP website that RQMC manages most of the mental health services; thus, finding any of this information is difficult unless one already knows about RQMC.

Timeliness of Services

Changes within the Past Year:

- None noted.

Strengths:

- Overall timeliness performance meets or exceeds the standards on all measures.
- The MHP has a robust and successful process for ensuring that people being discharged from inpatient care are seen within seven days, including those who are not enrolled in services.

Opportunities for Improvement:

- The MHP agreed during the review that the foster care data provided to the EQRO likely is not complete, reflecting only three referrals for psychiatry. They planned to take another look and make sure they are capturing all referrals.

Quality of Care

Changes within the Past Year:

- RQMC hired a full-time medical director in the last year who is committed to promoting current best practices in prescribing medication, particularly with respect to those that are potentially addictive and/or are popular street drugs.

Strengths:

- The MHP has a well-developed and consistently utilized LOC system based on CANS/ANSA scores and clinical discussion at intake and throughout treatment.
- Stakeholders reported being very satisfied with the level of their participation in treatment planning.

Opportunities for Improvement:

- The MHP and ASO would benefit from developing measurable QI goals that go beyond required monitoring activity in order to ensure a focus on those aspects of service delivery and system management that need improvement. Reporting on identified key performance indicators, on a scheduled basis, using trended data, would strongly support that effort.
- Explore and address beneficiaries' concerns about insufficient information when medications are changed.
- The ASO reported having rolled out a collaborative documentation training for their direct service and contractor staff. Conversation during the review generated renewed commitment by the ASO to re-invigorate this initiative and elevate its importance in trainings and meetings.

Beneficiary Outcomes

Changes within the Past Year:

- None noted.

Strengths:

- The MHP and contract providers employ peers in a variety of roles; in some settings peers can move into supervisory roles without additional education.
- Wellness centers are located in all major population areas of the county, including on the coast. They are all peer-led or -run.

Opportunities for Improvement:

- None noted.

Foster Care

Changes within the Past Year:

- The MHP reported that increasingly consistent use of the CANS at intake and periodic reviews has improved their ability to accurately assess beneficiary LOC needs over time.

Strengths:

- A contracted service provider had implemented Treatment Foster Care-Oregon (TFCO) ten years ago, and has been providing a version of therapeutic foster (TFC) care since that time.

- The MHP was more prepared to transition to TFC, as they had an existing system, including Resource Foster Parents and two Foster Family Agencies; however, challenges regarding TFC recruitment remain.

Opportunities for Improvement:

- Continued TFC recruitment efforts are warranted.
- The MHP/ASO does not appear to have policies related to medication administration, nor does it employ a QI process to assess prescribing practices included in SB 1291 and HEDIS measures.

Information Systems

Changes within the Past Year:

- Technical support and equipment were provided to staff to support telehealth services for individual and group therapy as well as new client intake and assessment.

Strengths:

- Despite the use of two IT systems, one for billing and one as the clinical record, this combined system provides staff access to the information they require and produces claim files with low denial rates.

Opportunities for Improvement:

- The implementation of myHealthPointe software for personal health record functionality continues to be a future (more than two years) initiative that lacks prioritization.

Structure and Operations

Changes within the Past Year:

- A tax measure passed that will provide funding for building a psychiatric health facility (PHF). The MHP has put out an RFP for an operator.

Strengths:

- The MHP and RQMC work closely with their contract providers, who expressed satisfaction with the relationships.
- The MHP encourages participation in multiple meetings designed to address system issues, and prior to COVID-19 was scheduling QIC at various locations around the county to facilitate stakeholder participation.

- Stakeholders reported noticing an increased effort by the MHP to promote participation in QIC/MHSA meetings.

Opportunities for Improvement:

- Information on the website about QIC and CDC meetings is very outdated. Stakeholders would benefit from ongoing updates to these pages.

FY 2020-21 Recommendations

PIP Status

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

Recommendation 2: The MHP is encouraged to make frequent use of TA from the EQRO in the development of both new PIPs. *(This is a carry-over recommendation from FY 2019-20.)*

Access to Care

Recommendation 3: Ensure that the MHP's website provides prominent information about accessing RQMC's website for detail about available services.

Timeliness of Services

None noted.

Quality of Care

Recommendation 4: Explore and address beneficiaries' concerns about insufficient information when medications are changed.

Beneficiary Outcomes

None noted.

Foster Care

Recommendation 5: Create and implement policies and procedures for monitoring, tracking, and reporting on EQRO-mandated SB 1291 elements and HEDIS medication administration practices. Ensure that results are incorporated into a QI process. *(This is a carry-over recommendation from FY 2018-19.)*

Information Systems

None noted.

Structure and Operations

None noted.

ATTACHMENTS

Attachment A: Virtual-Site Review Agenda

Attachment B: Virtual-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—Virtual 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

Mendocino MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Clinical Line Staff Group Interview
Program Managers Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Clinical Management and Supervision
Medical Prescribers Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Telehealth
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Harriet Markell, Quality Reviewer
Lisa Farrell, IT Reviewer
Marilyn Hillerman, Consumer/Family Member Consultant

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

Sites of MHP Review

MHP Sites: All sessions were held virtually via Zoom

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Anderson	Dan	COO	Redwood Quality Management Company
Bhandari	Navin	Program Manager	Mendocino County BHRS
Britton	Rebecca	Mental Health Rehab Specialist	Mendocino Coast Hospitality Center
Burtis	Peter	Clinical Director	Mendocino Coast Hospitality Center
Colby	Caitlin	Program Specialist II	Mendocino County BHRS
Craig	B/T	Clinician	Redwood Community Services
Driggers	Melinda	Senior Program Specialist	Mendocino County BHRS
Fine	Heather	Mental Health Clinician	Mendocino County Youth Project
Gillespie	Ceclia	Clinical Director	Mendocino County Youth Project
Glasscock	Jenna	Mental Health Clinician	Mendocino Coast Hospitality Center
Goodwin	Cuyler	Medical Director	Redwood Quality Management Company
Guthry	Libby	Executive Director	MCAVHN
Harris	Carmen	Director TAY and Adult Services	Redwood Community Service

Last Name	First Name	Position	Agency
Jancito	Carols	Senior Program Specialist	Mendocino County BHRS
Johns	Nichole	Clinical Director	Tapestry Family Services
Kaye	Marty	Account Specialist	Mendocino County BHRS
La Delle-Daily	Lois	RQMC Compliance Officer	Redwood Quality Management Company
Landis	Cliff	Mental Health Clinician II	Mendocino County BHRS
Livingston	Sarah	Director	Redwood Community Crisis
Logan	Alicia	Business Administrator	Redwood Quality Management Company
Lovato	Karen	Acting OOC Deputy Director	Mendocino County BHRS
Lower	Danielle	Electronic Health Record Manager	Redwood Quality Management Company
Malone	Tim	Mental Health Clinician	Tapestry Family Services
Miller	Jenine	Behavioral Health and Recovery Services Director	Mendocino County BHRS
Offill	Christina	Clinical Program Manager	Redwood Community Services

Last Name	First Name	Position	Agency
Pallisen	Taylor	Medical Assistant	Redwood Quality Management Company
Peeler	Grace	Mental Health Rehab Specialist	MCAVHN
Power	Angela	Mental Health Rehab Specialist	MCAVHN
Riley	William	Staff Services Administrator	Mendocino County BHRS
Schraeder	Camille	CFO	Redwood Quality Management Company
Schraeder	Tim	CEO	Redwood Quality Management Company
Shems	Sarah	Clinician	Redwood Community Services
Smith	Rendy	Program Manager Substance Use Disorder Treatment	Mendocino County BHRS
Thompson	Dustin	Staff Services Administrator	Mendocino County BHRS
Turchin	Andrea	Fiscal Manager	Mendocino County BHRS
Walsh	Sarah	Data Analyst	Redwood Quality Management Company

Last Name	First Name	Position	Agency
Wilson	Rebecca	WPC Director	Redwood Quality Management Company
Winter	Ian	Mental Health Rehab Specialist	Mendocino County BHRS
Wolf	Sage	Homeless Advocate	Redwood Community Service
Wyant	Billie	Clinical Program Manager	Redwood Community Services
Yovino	Mary	Program Administrator	Redwood Quality Management Company

Attachment C—Approved Claims Source Data

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

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

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

Mendocino MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Small	171,297	8,082	4.72%	$39,384,225	$4,873
MHP	12,870	665	5.17%	$3,845,038	$5,782

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

Table C2: CY 2019 Distribution of Beneficiaries by ACB Range

Mendocino MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	2,395	91.13%	93.31%	$10,123,748	$4,227	$3,998	52.38%	59.06%
>$20K - $30K	113	4.30%	3.20%	$2,767,599	$24,492	$24,251	14.32%	12.29%
>$30K	120	4.57%	3.49%	$6,435,718	$53,631	$51,883	33.30%	28.65%

Attachment D—List of Commonly Used Acronyms

Table D1: List of Commonly Used Acronyms

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

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

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

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