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

SHASTA MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 29 – 30, 2020

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INTRODUCTION

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

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 3,099

MHP Threshold Language(s) — No Threshold Languages

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Network Adequacy

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

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

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

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

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS 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, timeliness, and validation of the AAS and any plan of correction or improvement of the services to Medi-Cal recipients living in the zip codes requiring an AAS.

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

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

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

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 video conference 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: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.

Status: Not Met

- The non-clinical PIP from FY 2018-19 began in April 2018. The focus was reducing the 30-day rehospitalization rate; the PIP was completed in September 2019.
- The clinical PIP from FY 2019-20 began in December 2018 (projected end date of June 2020). The PIP focused on preventing unnecessary psychiatric hospitalizations. The MHP experienced high staff turnover

and the PIP was abandoned prior to completion; documentation of PIP results was not provided for this review.

- The MHP did not submit a clinical or non-clinical PIP for FY 2020-21 and did not clearly identify a PIP team during this review.

Recommendation 2: Continue work on the development of a non-clinical PIP. Reach out to CalEQRO early and often in this process.
(This recommendation is a follow-up from FY 2018-19.)

Status: Not Met

- The Quality Improvement Committee (QIC) meeting lacks a standing agenda item to allow for a deeper discussion to ensure PIP processes are meeting quarterly benchmarks.

- The MHP did not participate in regular PIP TA in FY 2020-21.

Recommendation 3: For future PIPs, determine and state improvement goals and study questions to be quantitatively measured so an assessment can be done as to the extent of success of the PIPs. *(This is a follow-up from FY 2018-19.)*

Status: Not Met

- PIP TA was provided during this video conference review includes: PIP committee formation; topic identification; creating a study timeline; collecting baseline data; intervention selection; measuring performance indicators; and data analysis.

- PIP TA is scheduled for the beginning of January 2020 to discuss progress toward the implementation of a clinical and non-clinical PIP.

Access Recommendations

Recommendation 4: Investigate increasing psychiatrist capacity through telemedicine.

Status: Met

- During the last EQRO review, it was identified that psychiatric capacity was an issue for the MHP with lengthy wait times and lack of availability for initial psychiatric appointments.

- In FY 2020-21, the Adult Services Branch (ASB) increased their psychiatric capacity to a total of four locum tenens telepsychiatrists, and the Children's Services Branch (CSB) increased to two telepsychiatrists.

Timeliness Recommendations

Recommendation 5: Set a standard and begin tracking no-show rates for clinicians. *(This is a follow-up recommendation from FY 2018-19.)*

Status: Partially Met

- No-show rates for clinicians are now tracked; however, a standard has not been established.

Recommendation 6: Set a standard for no-show rates for psychiatrists.

Status: Not Met

- A no-show standard for psychiatrists has not been established.

Recommendation 7: Investigate reasons for the large deviations for the post-inpatient follow-up standard. *(This is a carry-over recommendation from FY 2018-19.)*

Status: Met

- The MHP began following Healthcare Effectiveness Data and Information Set (HEDIS) measures so that beneficiaries discharged from a hospital are followed up within seven days.
- Large deviations in post-inpatient discharge follow-up in FY 2019-20 resulted from: (1) including non-Medi-Cal beneficiaries in previous data; (2) beneficiary-based reasons interfering with timely scheduling; and, (3) inability to track follow-up for beneficiaries who received crisis services, but are not MHP beneficiaries.
- Discussions were initiated with MCOs to obtain data of beneficiaries who were discharged from the hospital and their ability to schedule a follow-up appointment within seven days.

Quality Recommendations

Recommendation 8: Develop and implement a process to identify the rate of co-occurring mental health and substance abuse diagnoses more accurately.

Status: Not Met

- Submitted documents and discussions during this review did not provide evidence that a process has been created to accurately diagnose and identify the rate of co-occurring diagnoses.

Recommendation 9: Review deferred diagnosis data to identify trends and assure diagnosis updates are entered into the system in a timely manner to reduce the rate of deferred diagnosis.

Status: Partially Met

- A draft notice as implemented to remove unspecified diagnosis (R69) and replace with encounter for observation for other suspected diseases and conditions ruled out (Z03.89).
- The MHP is yet to continuously monitor diagnostic patterns to determine variations from statewide averages.
- The MHP is yet to determine if further interventions are necessary to reduce the rate of deferred diagnosis.

Recommendation 10: Increase stakeholder involvement in program development by implementing a process to share outcomes data more transparently with clinical supervisors and contract providers.

Status: Partially Met

- Outcomes data is shared internally with supervisors during weekly meetings, and line staff during monthly meetings.
- The MHP reports that Quality Improvement (QI) and data outcome reports are discussed at quarterly meetings with contract providers; however, QIC meeting minutes do not reflect consistent attendance by contract providers and QIC meetings have not occurred as regularly scheduled.

Beneficiary Outcomes Recommendations

Recommendation 11: Provide routine internal outcome reporting (quarterly at a minimum) to stakeholders for children and adult programs (Child and Adolescent Needs and Strengths (CANS-50) and Milestones of Recovery (MORS)).

Status: Partially Met

- The MHP reports that beneficiary outcomes are reviewed during quarterly QIC meetings; however, meeting minutes do not reflect that outcome reports are discussed.
- The QI workplan does not contain any goals to track and report on adult, children, and FC youth (CANS-50 and MORS) outcomes nor include it as a standing QIC agenda item.

Recommendation 12: Provide stakeholders-to include clinical supervisors, contract providers, and beneficiary groups-results of beneficiary satisfaction surveys at the program level.

Status: Partially Met

- The MHP reports that beneficiary satisfaction surveys are shared during weekly supervisor meetings and monthly direct line staff meetings.
- Consumer Perception Survey (CPS) results are posted on the agency website; however, the most recent results are from CY 2015.
- Feedback from stakeholders in EQRO focus groups reflect that beneficiary surveys were not provided to them.

Foster Care Recommendations

Recommendation 13: For each of the timeliness metrics tracked, the MHP should break them down for the FC beneficiaries to determine if there are specific timeliness issues related to them. *(This is a carry-over recommendation from FY 2018-19.)*

Status: Met

- Timeliness metrics are currently tracked and disaggregated for FC youth.

Information Systems Recommendations

Recommendation 14: Assure technological barriers to Medicare claims submission are remediated to submit Medicare claims currently being held.

Status: Partially Met

- The MHP indicated that they remain in contract negotiations with a Medicare approved clearinghouse as of September 2020.
- The MHP has not consolidated the negotiation process with the Medicare clearinghouse, nor planned the timeframe and steps to implement the agreement.

Structure and Operations Recommendations

Recommendation 15: Complete contract with chosen vendor to institute a comprehensive staff survey that seeks input from staff on a wide range issues that have direct impact on the line staff. In addition to training, the survey should include questions on communication, workload and productivity, and staff turnover and incentives. *(This is a follow-up recommendation from FY 2018-19.)*

Status: Met

- Shasta County HHS contracted with CPS HR Consulting (CPS-HRC) to conduct a comprehensive staff engagement survey in October 2019 to elicit feedback regarding employee work experience, leadership, organizational culture, training, teamwork, and overall engagement.
- Survey results were shared throughout the organization, and focus groups were created in each branch of Shasta County HHS to elicit feedback from staff and leadership.
- It was identified that improvement was needed in the area of senior leaders valuing ideas from employees, and that employees need to feel safer in challenging ideas. In response, management personnel are currently discussing ways to improve communication opportunities for the line staff as part the continuous quality improvement (CQI) endeavors.

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 HEDIS measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

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

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

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

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

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure

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

Total Beneficiaries Served

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

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

Shasta 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	43,396	68.9%	2,236	72.2%
Latino/Hispanic	6,371	10.1%	260	8.4%
African-American	1,067	1.7%	91	2.9%
Asian/Pacific Islander	2,362	3.8%	62	2.0%
Native American	1,775	2.8%	72	2.3%
Other	8,005	12.7%	378	12.2%
Total	**62,974**	**100%**	**3,099**	**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

Shasta MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
No Threshold Languages	*	n/a
Total	**3,099**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

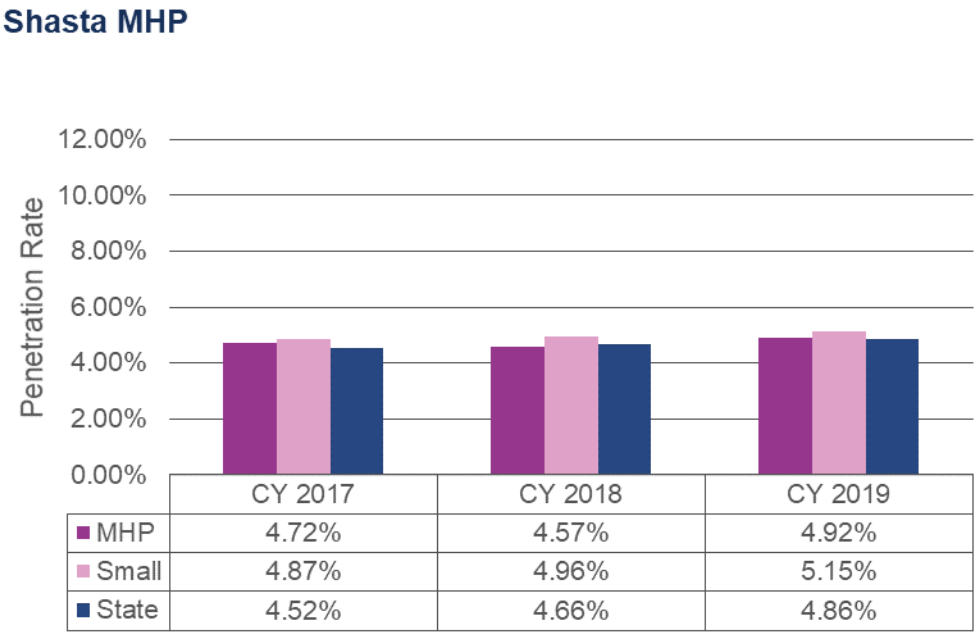
Penetration Rates and Approved Claims per Beneficiary

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

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

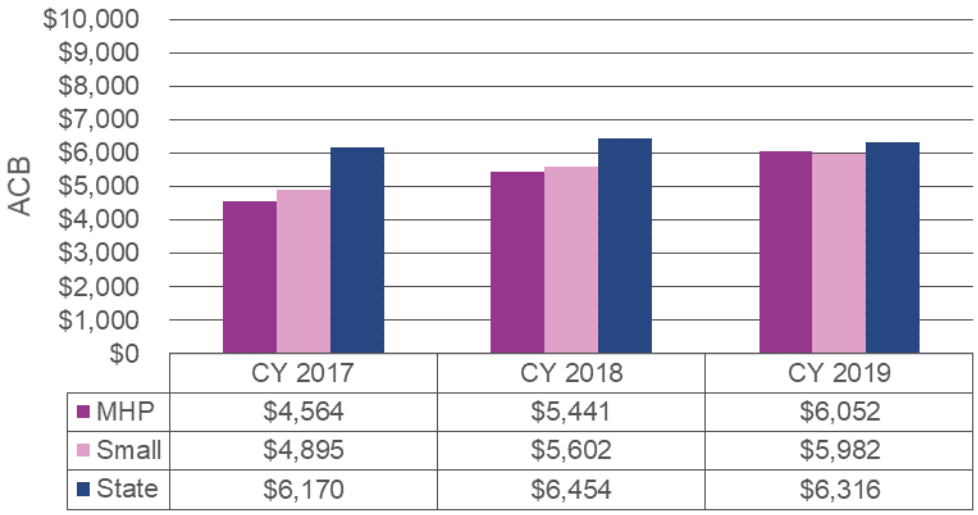
Regarding the calculation of penetration rates, the Shasta MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	4.72%	4.57%	4.92%
Small	4.87%	4.96%	5.15%
State	4.52%	4.66%	4.86%

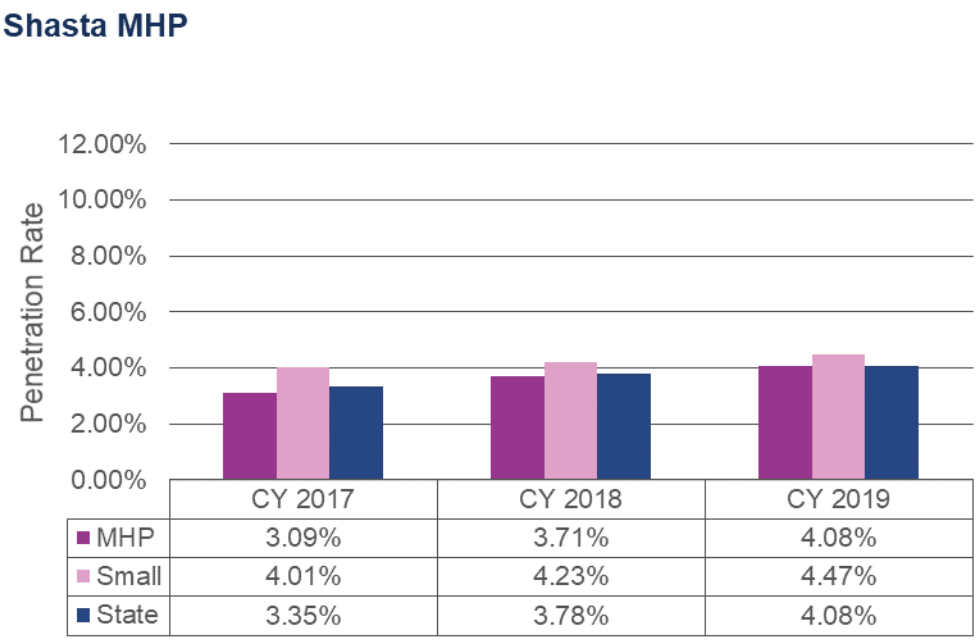
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$4,564	$5,441	$6,052
Small	$4,895	$5,602	$5,982
State	$6,170	$6,454	$6,316

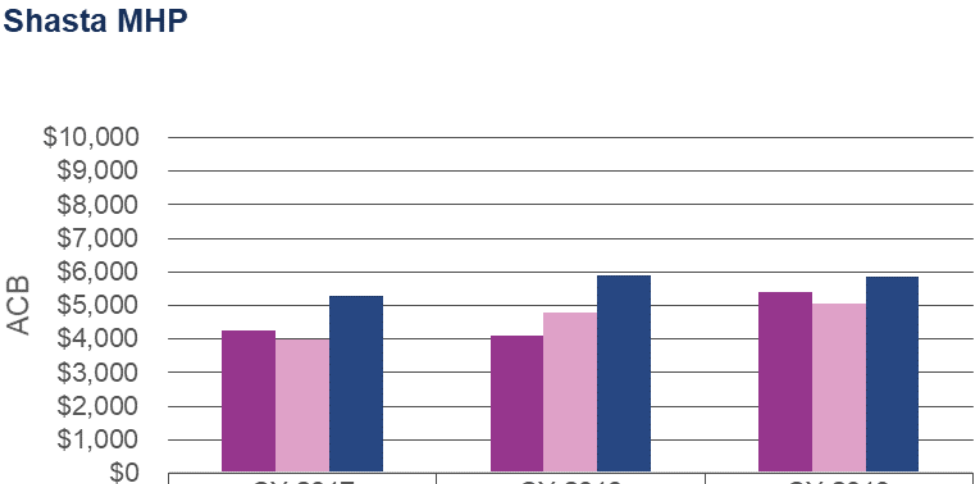
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	3.09%	3.71%	4.08%
Small	4.01%	4.23%	4.47%
State	3.35%	3.78%	4.08%

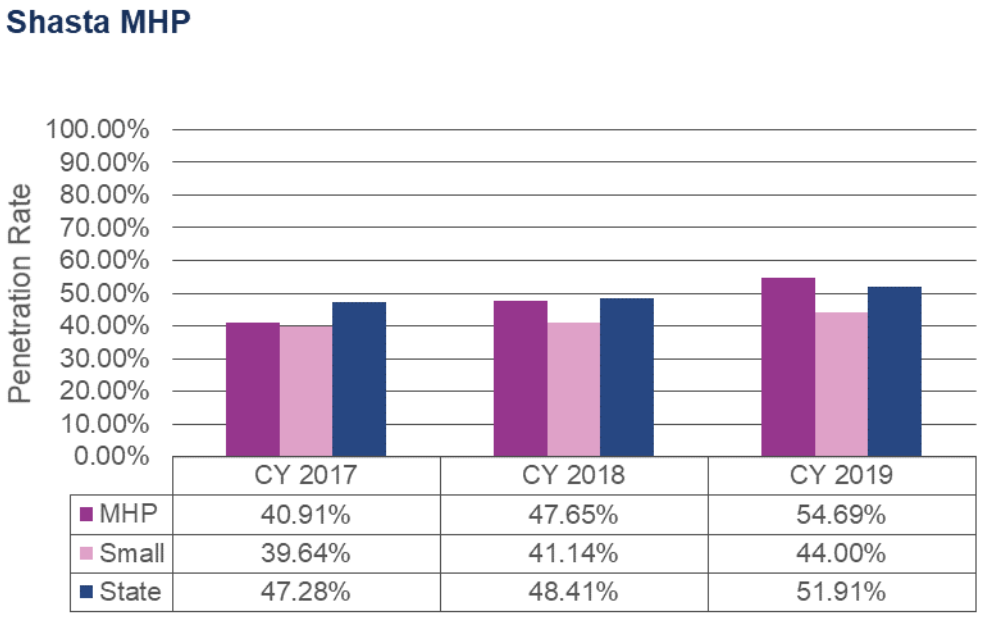
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$4,261	$4,094	$5,415
Small	$3,993	$4,788	$5,040
State	$5,278	$5,904	$5,869

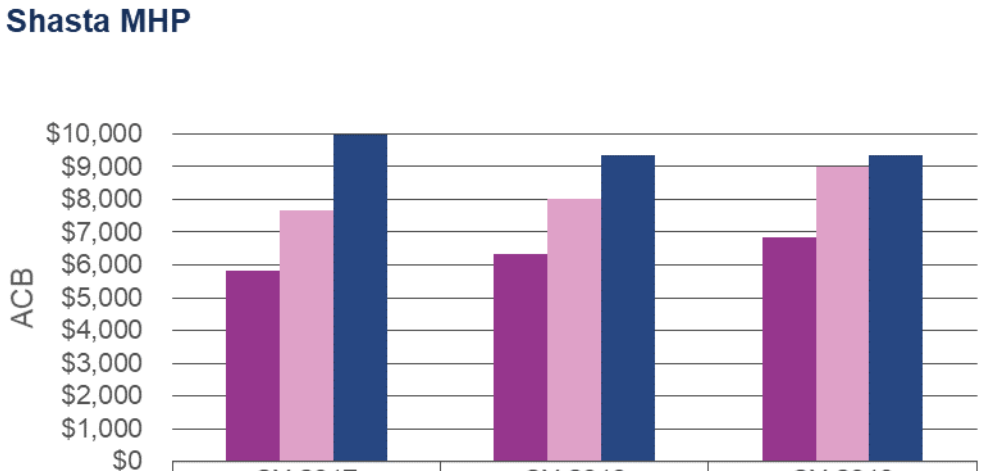
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	40.91%	47.65%	54.69%
Small	39.64%	41.14%	44.00%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

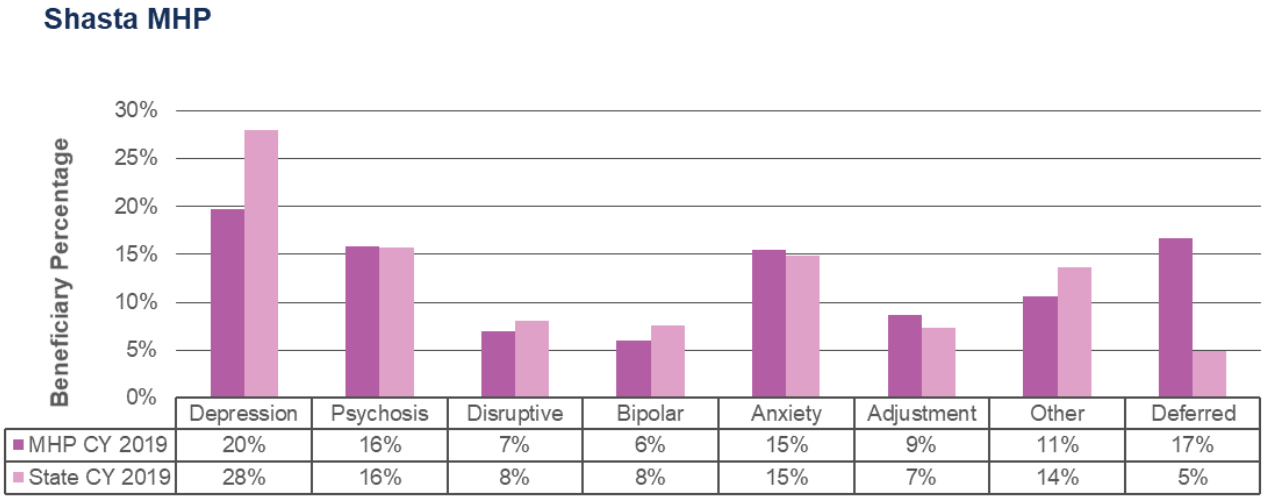


	CY 2017	CY 2018	CY 2019
MHP	$5,831	$6,322	$6,852
Small	$7,671	$8,033	$9,010
State	$9,962	$9,340	$9,360

Diagnostic Categories

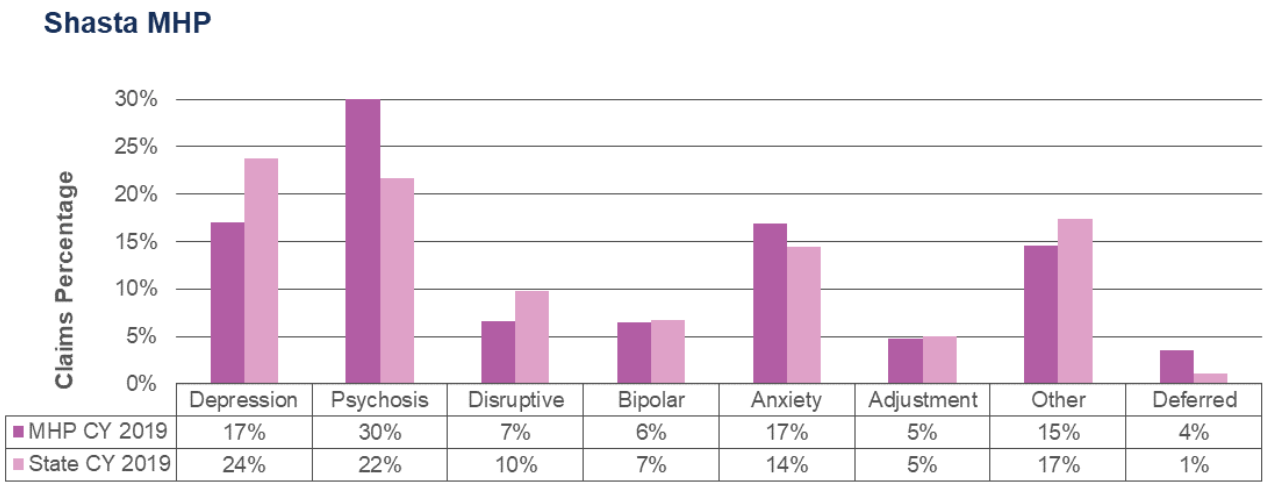
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	20%	16%	7%	6%	15%	9%	11%	17%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

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



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	17%	30%	7%	6%	17%	5%	15%	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

Shasta 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	118	3,099	3.81%	$50,580	$5,968,474	31.82%
	CY 2018	99	2,922	3.39%	$48,685	$4,819,805	30.32%
	CY 2017	76	3,039	2.50%	$44,365	$3,371,716	24.31%

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

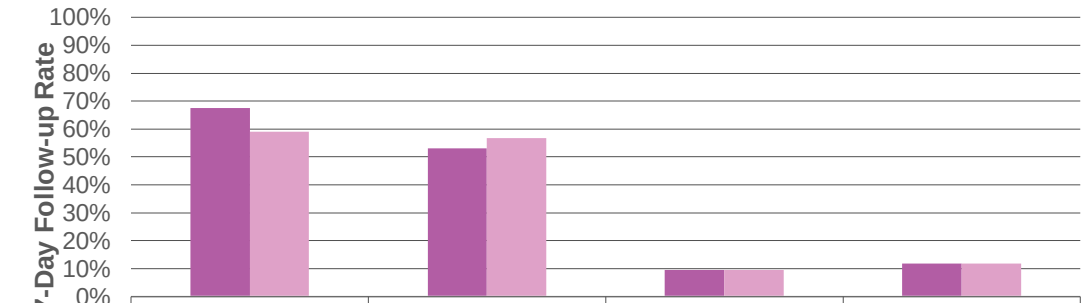
Shasta MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	455	888	8.60	7.80	$10,717	$10,535	$4,876,077
CY 2018	383	661	8.63	7.63	$10,225	$9,772	$3,916,152
CY 2017	377	667	8.82	7.36	$9,556	$9,737	$3,602,544

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

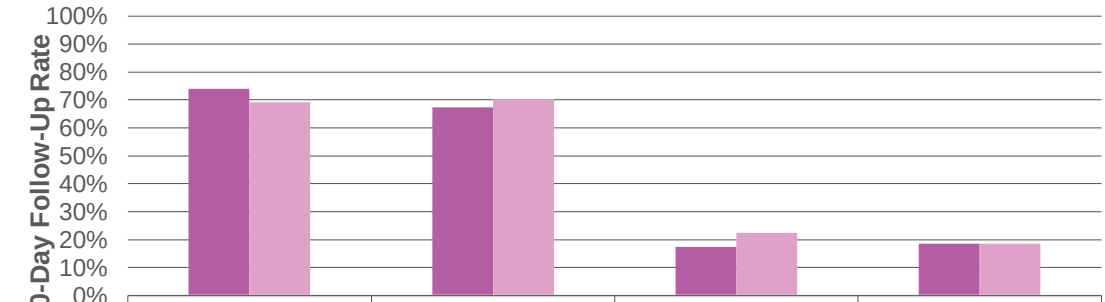
Shasta MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	67%	53%	9%	12%
CY 2019	59%	57%	10%	12%

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

Shasta MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	74%	67%	17%	19%
CY 2019	69%	70%	22%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Shasta MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. The MHP did not submit any PIPs for this CalEQRO video conference review.

Table 5 : PIPs Submitted by Shasta MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	0	not applicable (n/a)
Non-Clinical	0	n/a

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Shasta
PIP Title	The MHP did not submit a clinical PIP.
PIP Aim Statement	n/a
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) n/a ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☐ MHP choice (state allowed MHP to identify the PIP topic)	

MHP Name	Shasta
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): n/a	

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): n/a.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a.

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
n/a.			☐ n/a*		☐ 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 ☐ Second remeasurement ☒ Other (specify): The MHP did not submit a clinical PIP.						

Validation rating: n/a. ☐ 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: • A PIP committee should be formed with clear role descriptions throughout the study timeframe. • The QIC should implement a standing agenda item to allow for a deeper discussion and to ensure PIP processes are meeting quarterly benchmarks at a minimum.
TA provided to the MHP by CalEQRO consisted of: • TA provided during the review included discussions of forming a PIP committee, selecting a study topic, and engaging with EQRO early and often. • Future PIP TA was scheduled during this review.

*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	Shasta
PIP Title	The MHP did not submit a non-clinical PIP.
PIP Aim Statement	n/a
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) n/a ☐ 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): n/a	

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): n/a

PIP Interventions (Changes tested in the PIP)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
n/a			☐ n/a*		☐ 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 ☐ Second remeasurement ☒ Other (specify): The MHP did not submit a Non-Clinical PIP						

Validation rating: n/a ☐ 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: • A PIP committee should be formed with clear role descriptions throughout the study timeframe. • The QIC should implement a standing agenda item to allow for a deeper discussion and to ensure PIP processes are meeting quarterly benchmarks at a minimum.
TA provided to the MHP by CalEQRO consisted of: • TA provided during the review included discussions of forming a PIP committee, selecting a study topic, and engaging with EQRO early and often. • Future PIP TA was scheduled during this review.

*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 video conference 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
Shasta	2.00%	1.58%	1.77%	3.01%
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

- The HHS Technology Program Manager is responsible for system and network security.

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

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	61.4%
Contract providers	38.3%
Network providers	0.3%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

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

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	5	1	1	1
2019-20	5	1	1	0
2018-19	5	1	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	8.5	1.5	2	0
2019-20	7	2.5	2	0
2018-19	6	2	2	1

The following should be noted regarding the above information:

- The MHP added data analytical staff due to increased workload.

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	55	4	59
Clinical Healthcare Professional	118	0	118
Clinical Peer Specialist	3	0	3
Quality Improvement	13	0	13
Total	189	4	193

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

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

Type of Staff	MHP FY 2020-21	Small MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	5.00	5.30
Total EHR Users Supported by IT (Source: Table 17)	193.00	200.00
Ratio of IT Staff to EHR Users	1:39	1:38

Table 19: Additional Information on EHR User Support

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

Table 20: New Users' EHR Support

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

Table 21: Ongoing Support for the EHR Users

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

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

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

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	6
Number of county-operated telehealth sites	2
Number of contract providers' telehealth sites	4
Total number of beneficiaries served via telehealth during the last 12 months	n/a
• Adults	n/a
• Children/Youth	n/a
• Older Adults	n/a
Total Number of telehealth encounters (services) provided during the last 12 months:	576

- MHP provided data for all services (including telehealth).

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.

- Staff are generally working from home, using various methods to stay in contact with beneficiaries including phone calls and Zoom.
- The wellness centers remain "open". The wellness center websites are active, providing information on COVID-19 and service delivery to the beneficiary community.
- The wellness centers provide some group services, via Zoom, with beneficiaries using a large meeting room to maintain distance.
- Staff are using creative ideas to adjust to remote service delivery (e.g., outdoor meetings).

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).

The MHP does not have a threshold language.

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

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

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

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

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
North Valley Catholic Social Services	n/a
Remi Vista	n/a
Victor Community Support	n/a
Lilliput (Wayfinder Family Services)	n/a

- The MHP did not provide count of contract provider sites.

Current MHP Operations

- Prior to COVID-19, in-person and telepsychiatry services for ASB and CSB were provided; in response to the pandemic, all psychiatry services are provided via telehealth, telephone calls, and in-person as needed with beneficiaries.
- The MHP continues to use the CCBH system (software promotion 230) to support EHR functionality, billing, and state-mandated reporting.

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

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Cerner Community Behavioral Health (CCBH)	EPCS	Cerner	4	MHP
CCBH	CHP	Cerner	8	MHP
CCBH	DHP	Cerner	7	MHP
FileBound	EDMS	Upland	13	MHP

The MHP's Priorities for the Coming Year

- Continue the implementation of the Health Information Exchange (HIE).
- Upgrade to Cerner PW231.
- Review HIE options for Patient Portal.
- Fully implement Client Services Information (CSI) Assessments and adjust reports as needed.
- Evaluate CCBH replacement options.

Major Changes since Prior Year

- Served as Cerner Test Partner STP230.
- Began transmitting HIE in July 2019.
- Implemented enhanced CSI Assessment functionality in CCBH to meet mandated requirements.
- The MHP worked to provide expanded telehealth services. IT support worked to obtain additional equipment for staff working from home by purchasing additional equipment, utilizing equipment on hand, and negotiating with other departments within HHS.

Other Areas for Improvement

- There is no internal operations manual or other documentation for production of claims to support new staff training.
- Per DHCS IN 18-020, the provider directory should be updated monthly.
- The MHP remains unable to bill Medicare due to prohibition of dial-up modems by Medicare fiscal intermediary.

Plans for Information Systems Change

- Considering a new system, but no formal project plan in place or project team assigned to accomplish.

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	CCBH	☒	☐	☐	☐
Assessments	CCBH	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/ Storage	File Bound	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	CCBH	☒	☐	☐	☐
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service	AJW Inc.	☒	☐	☐	☐
Outcomes	AJW Inc.	☒	☐	☐	☐
Prescriptions (eRx)	CCBH	☒	☐	☐	☐
Progress Notes	CCBH	☒	☐	☐	☐
Referral Management		☐	☐	☒	☐
Treatment Plans	CCBH	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		9	0	3	0
FY 2019-20 Summary Totals for EHR Functionality:		9	0	3	0
FY 2018-19 Summary Totals for EHR Functionality:		8	0	4	0

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

- There are no current plans to implement additional modules of CCBH pending the MHP decision of whether to move forward with Cerner Millennium.

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 used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Direct data entry into MHP EHR system by contract provider staff	0%	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	40%	Monthly
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	60%	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
Cerner	Cerner	NVCSS
Cerner	Cerner	Remi Vista
NetSmart	Avatar	Victor
Welligent	Welligent	Lilliput

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

n/a

Expected implementation timeline:

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

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

Table 28: PHR Functionalities

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

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

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

- The last Medicare Part B claims submitted occurred in July 2019. The MHP is currently working to resolve claim submission issues with the clearinghouse.

Table 29 summarizes the MHP's SDMC claims.

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

Shasta MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**57,026**	**$18,236,973**	**882**	**$395,093**	**2.12%**	**$17,841,880**	**$16,990,312**
JAN19	5,027	$1,629,084	75	$44,497	2.66%	$1,584,587	$1,464,351
FEB19	5,644	$1,722,336	94	$37,324	2.12%	$1,685,012	$1,612,193
MAR19	5,155	$1,716,522	85	$33,354	1.91%	$1,683,168	$1,561,473
APR19	4,992	$1,481,398	76	$21,909	1.46%	$1,459,489	$1,414,421
MAY19	5,150	$1,651,803	82	$51,895	3.05%	$1,599,908	$1,509,349
JUN19	4,246	$1,385,718	78	$19,503	1.39%	$1,366,215	$1,313,032
JUL19	4,867	$1,523,751	86	$26,044	1.68%	$1,497,707	$1,416,384
AUG19	4,431	$1,367,180	63	$15,345	1.11%	$1,351,835	$1,319,339
SEP19	4,547	$1,498,296	72	$60,951	3.91%	$1,437,345	$1,362,280
OCT19	4,939	$1,569,112	97	$32,244	2.01%	$1,536,868	$1,486,320
NOV19	4,054	$1,358,933	40	$29,055	2.09%	$1,329,878	$1,284,376
DEC19	3,974	$1,332,841	34	$22,972	1.69%	$1,309,869	$1,246,793

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

Shasta MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Medicare or Other Health Coverage must be billed before submission of claim.	546	$115,690	29%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	83	$91,432	23%
Beneficiary not eligible or non-covered charges.	59	$91,112	23%
Beneficiary not eligible.	135	$83,014	21%
Service line is a duplicate and a repeat service procedure code modifier not present.	50	$11,135	3%
Total	882	$395,093	NA

The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.

- Denied claim transactions with denial reason description "Medicare or Other Health Coverage must be billed before submission of claim" and "ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete or invalid" are generally re-billable with the State guidelines.

NETWORK ADEQUACY

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

Network Adequacy Certification Tool Data Submitted in April 2020

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

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

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Shasta, 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.

Video Conference Review Sessions

CalEQRO conducted two consumer and family member focus groups, 12 staff and contractor interviews, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

There were three zip codes (96028, 96056, 90676) identified in Shasta County which required AAS for youth (up to 20 years old) psychiatry providers. The MHP asked for approval for these zip codes and is waiting for DHCS response. The rural zip codes 96056 and 96028 are situated between Shasta Trinity and Lassen National Forests; these areas are mountainous and remote Northern areas of the county. Zip code 96076 is in the remote Southwestern area of the county. These areas of the county are located far from urban centers and were not meeting time or distance standards for psychiatry services for youth. The other zip codes for the MHP for youth psychiatry services met time and distance standards as required by DHCS.

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

The MHP contracts with Mountain Valley Health Center (zip code 96009) to provide telehealth services to all beneficiaries living in the identified zip codes. This provider is approximately 41 miles and 90 minutes from zip code 96028 and 36 miles and 60 minutes from zip code 96062. The need for this resource has not been needed; however, this resource is available should the need arise. Mobile crisis services are provided through a contract with Hill Country Health and Wellness Center. The Mobile Crisis Outreach Team (MCOT) responds to urgent mental health needs to beneficiaries 16 and older. MCOT can provide crisis services in rural areas of the county in certain circumstances. The MHP contracts with two youth psychiatry locum tenens telehealth providers to reach beneficiaries residing in remote locations of the county.

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. The MHP investigated and resolved the identified exceptions shortly after the EQR.

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	1
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	2
NPI Type 1 number reported is associated with two or more providers	8
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	0
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	1

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

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

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

CFM Focus Group One

Table 32 : Focus Group One Description and Findings

Topic	Description
Focus group type	The Zoom group consisted of a culturally diverse group of adult beneficiaries, including new beneficiaries, who have initiated/utilized services within the past 12 months.
Total number of participants	Eight
Number of participants who initiated services during the previous 12 months	Three
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group	
Access - new beneficiaries	New beneficiaries reported that services were prompt, and they felt satisfied with initiating services.
Access - overall	Beneficiaries reported being satisfied with access; however, they reported feeling dissatisfied with psychiatric access due to large psychiatry turnover.

Topic	Description
Timeliness	Long-term beneficiaries reported feeling overall satisfied with the timeliness of their services; however, one beneficiary reported inconsistency with their therapist appointments, with frequent cancellations.
Urgent care and resource support	Beneficiaries reported being knowledgeable of the crisis line and are aware of who to call for resource support.
Quality	Beneficiaries reported being involved in their treatment. Several participants stated that they receive less services due to COVID-19. Beneficiaries were unaware if their psychiatrist communicated with their primary care provider. The wellness centers were cited as an integral part of treatment.
Peer employment	Beneficiaries reported that there are job opportunities available; the first step is a volunteer position with the Shasta Triumph and Recovery (STAR) program. Beneficiaries are proud to be included in STAR and reported an informal career ladder. Some beneficiaries reported that they act as a peer volunteer, but do not receive a stipend.
Structure and operations	Beneficiaries reported a lack of involvement in MHP committees.
Recommendations from this focus group	• Increase number of on-site psychiatrists and improve transitions among providers. • Increase number of mental health advocates. • Provide stipend for peer volunteers.
Any best practices or innovations (optional)	• The STAR program appears to empower beneficiaries and motivate them to participate in their treatment.

CFM Focus Group Two

Table 33 :Focus Group Two Description and Findings

Topic	Description
Focus group type	The Zoom group consisted of a culturally diverse group of parents/caregivers who have initiated/utilized services within the past 12 months.
Total number of participants	Two
Number of participants who initiated services during the previous 12 months	Zero
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group	
Access - new beneficiaries	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality of the individuals in the group.
Access - overall	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality of the individuals in the group.
Timeliness	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality of the individuals in the group.
Urgent care and resource support	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality of the individuals in the group.
Quality	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality of the individuals in the group.
Peer employment	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality of the individuals in the group.
Structure and operations	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality of the individuals in the group.

Topic	Description
Recommendations from this focus group	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality of the individuals in the group.
Any best practices or innovations (optional)	Feedback was obtained regarding access to services. Information is suppressed to protect confidentiality of the individuals in the group.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

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

Access to Care

Table 34 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 34: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	11
The Shasta County HHSA website contains information for individuals to access services, to include the 24/7 access line, crisis phone numbers, and how to access services in English and Spanish. The beneficiary handbook provides information on how to access language assistance and auxiliary aids (e.g., large print materials). Access venues include access line, walk-in, primary care, schools, and other provider referrals. The MHP maintains a directory of services and providers, which is also available on the website; however, the provider list is not user friendly, and the MHP should add the ability to filter for provider type, population served, specialties, etc. The directory has not been updated since April 2020 and should be updated monthly as per IN 18-020. Flyers are available in all locations where beneficiaries are provided services to inform them of resources available. Outreach flyers are also posted to engage individuals of different populations such as the Mien community, older adults, and veterans. Beneficiaries reported knowledge of these pamphlets during the CalEQRO CFM focus			

Component		Maximum Possible	MHP Score
groups. While the MHP does not have a threshold language, it offers interpretation services for beneficiaries requiring language assistance. The MHP reports that transportation is made available to beneficiaries through bus passes, taxis, and case managers who transport as needed; however, CalEQRO focus group participants reported difficulties with finding transportation, especially in remote parts of the county.			
1B	Capacity Management	10	9
The MHP QIC monitors the number and type of services by geographic area, race, ethnicity, gender, and age, and adjusts the service delivery when appropriate to maintain adequate capacity. The penetration rates are calculated on an annual basis. The MHP staff work with Shasta County Veterans Services, courts, probation, jail, the Good News Rescue Mission, emergency departments, and other community resources to provide outreach and case management to eligible homeless or hard-to-reach individuals. For FC youth, the MHP would benefit by adding a standing QIC agenda item to monitor penetration rates. The STAR program is a full-service partnership (FSP) serving all age groups and is staffed by a clinician, peer support specialist, parent partner and assistant social worker. Prior to the pandemic, the STAR team provided outreach with local law enforcement at homeless encampments and is tasked with engaging individuals from various underserved ethnic groups. The MHP continues to do outreach in the field; however, it has been limited due to the pandemic. The MHP provides outreach and engagement to individuals and leadership in the LatinX community to improve access to services (e.g., eligibility assistance). Shasta County has seven recognized Native American tribes and provides outreach to this population in various ways such as POW WOWs and psychoeducation; however, it appears that engagement with this population remains a struggle. The MHP has three bilingual (Spanish) clinicians; two clinicians fluent in Mien and Laotian; and one clinician fluent in American Sign Language (ASL). In response to COVID-19, the MHP is offering several groups for beneficiaries via video conference such as Stand Against Stigma; suicide prevention; and virtual community meetings. The MHP reports that supervisors review their team member's productivity and caseload; clinicians have the capability to review their productivity as needed. Documents submitted for this video conference review do not provide verification of clinician caseloads and productivity. Stakeholder feedback in CalEQRO focus groups suggest challenges in high staff turnover, retention difficulties, and higher caseloads which worsened with the onset of the pandemic.			

Component		Maximum Possible	MHP Score
1C	Integration and Collaboration	24	24
For outreach and engagement, the MHP collaborates with several community-based organizations in and out of the county including: Northern Valley Catholic Social Service (Shasta Counseling); Catholic Charities; Charis Youth Center; Mountain Valleys Child and Family Services; Psynergy; Sequoia Psychiatric Treatment Center; TLC Child and Family Services; Valley Teen Ranch; and Youth for Change. The MHP collaborates with several hospitals and medical clinics throughout the region including Shasta Regional Medical Center; St Helena Hospital; Hill Country Community Clinic; Mountain Valleys Health Center; Shasta Community Health Center; and Shingletown Medical Center. The MHP participates annually in the Redding/Shasta Homeless Continuum of Care Council, and also connects beneficiaries to the Woodlands permanent supportive housing complex. This complex consists of 55 units, 19 of which are designated for people who are eligible for FSP services. A HHSA case manager and peer support specialist provide case management, links to community resources and more for people in the Mental Health Services Act (MHSA) funded apartments.			

Timeliness of Services

As shown in Table 35, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 35: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	15
The MHP has a ten-business-day standard for the length of time from initial request to first offered appointment for the entire system of care and met this standard approximately 95.4 percent of the time (99.4 percent for adults, 91.2 percent for children and 98.7 percent for FC youth). The average length of time from first request for service to first offered appointment is 2.08 business days (0.32 business days for adults, 3.93 business days for children, and 1.47 business days for FC youth). The most recent QIC workplan from FY 2019-20 reflects that the initial request (start date) for services is tracked as the date of first contact recorded (e.g., call into access line) on the CSI; however, if the initial request is not recorded, the MHP uses the start			

Component		Maximum Possible	MHP Score
date as the day that the CSI assessment is initiated. The MHP does not identify how many initial contact dates are recorded as the CSI assessment initiation date. The length of time to first appointment is then calculated by using the earliest date of several different options: 1) first offered date on CSI assessment; 2) a scheduled assessment appointment in scheduler; and 3) an assessment service listed in service report. This methodological issue could present an artificially high percent of initial requests meeting the ten-day standard, and an artificially low timeliness metrics for the length of time from initial request to first offered appointment. The MHP does not need to abandon its current system of tracking percentages that met its own standard; however, it should refine the timeliness measures to include those who may not receive their first appointment within the first 60 days. Furthermore, the MHP should identify how many of the initial requests are documented as the initiated CSI assessment date. The MHP reports that changes and vacancies of front-end staff over the last CY resulted in various clinical staff filling in for these duties, which may have led to inaccurate data collection. The new front-end staff have access to the scheduler and call clients with appointment reminders.			
2B	First Offered Psychiatry Appointment	12	10
The MHP has a 15-business-day standard for the length of time from first request for service to first offered psychiatry appointment, and met this standard 86.8 percent of the time (94.3 percent for adults, 66.7 percent for children, and 71.4 percent for FC youth) for the entire system of care. The average length of time from first request for service to first offered psychiatry appointment is 6.48 business days (4.65 business days for adults, 11.41 business days for children, and 14.58 percent for FC youth). Prior to the pandemic, psychiatry services were provided in-person and via telehealth. In response to COVID-19 ASB has four locum tenens telepsychiatrists, and the Children Services Branch currently has two telepsychiatry providers. The most recent QIC workplan from FY 2019-20 reflects that the initial request for psychiatry services is tracked as the date that the appointment was entered into the scheduler versus the date of first request. As noted in previous year's EQRO report, the MHP's denominator includes only those assessed within 60 days. As such, the assumption is that all requests are met within 60 days and noted as the upper limit of the range provided. This methodological issue could present an artificially high percent of initial requests meeting the fifteen-day standard, and an artificially low timeliness metrics for the length of time from initial request to first offered psychiatry appointment. QIC meeting notes from March 2019 reflect that including all beneficiaries in the timeliness calculations would result in poorer outcomes. The MHP does not need to abandon its current system of tracking percentages that met its own standard;			

Component		Maximum Possible	MHP Score
however, they should also refine their timeliness measures to include those who may not receive their first psychiatric appointment within the first 60 days. The MHP reports that changes and vacancies of front-end staff over the last CY resulted in various clinical staff filling in for these duties, which may have led to inaccurate data collection. The new front-end staff have access to the scheduler and call clients with appointment reminders.			
2C	Timely Appointments for Urgent Conditions	18	15
The MHP has a 48-hour standard for the length of time for urgent appointments that do not require prior authorization and met this standard 100 percent of the time for adults, children, and FC youth. The length of time for urgent appointments has an overall range from zero to 36 hours. The average length of time for urgent appointments is 0.4 hours for adults, children, and FC youth. Urgent appointment data is tracked for the entire system of care and is reported on quarterly. The starting point for this timeliness metric is the evaluation date or medical clearance date and time; if this time was not recorded, the emergency room arrival date and time are considered the starting point. Beneficiaries who were admitted into the hospital are not included in this metric. The time recorded will be the earlier time of in-person evaluation or first in-person service recorded in Cerner. The MHP does not need to abandon its current system of tracking urgent requests that do not require prior authorization; however, they should also refine their timeliness measures to include those beneficiaries who were hospitalized, and implement QI activities to ensure that all urgent requests are being tracked to ensure data fidelity. Timeliness metrics for length of time for urgent appointments that do require prior authorization were not presented during this video conference review. The MHP states that its EHR does not have the capability to track this type of appointment. Urgent requests that require prior authorization are held to the 48-hour standard.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	9
The MHP has a seven-day standard for timeliness of follow-up appointments post psychiatric inpatient discharge for all hospitals; follow-up data is only for county operated programs. The MHP met the standard 68.4 percent of the time (68.1 percent for adults, 76.9 percent for children, and 60 percent for FC youth). The average length of time for a follow-up appointment after hospital discharge is 5.7 days (6.1 days for adults, 4.8 days for children, and 6.2 days for FC youth). The percent of appointments that met the seven-day follow-up standard has decreased from 71.9 percent in FY 2019-20 to 68.4 percent in FY 2020-21. The MHP states that large deviations in post-inpatient discharges in FY 2019-20 resulted from: (1) inclusion of non-Medi-Cal beneficiaries in previous data; (2) beneficiary-based reasons interfering with providing timely scheduling;			

Component		Maximum Possible	MHP Score
and, (3) inability to track follow-up for beneficiaries who were evaluated by the crisis team, but are not MHP beneficiaries and have an outside provider. The MHP began following HEDIS measures so that beneficiaries discharged from a hospital are followed-up with a mental health practitioner or prescriber within seven days. The MHP began discussions with MCOs to obtain data of beneficiaries who were discharged from the hospital and their ability to schedule a follow-up appointment within seven days; the status of these discussions is unknown.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The MHP tracks psychiatric readmission rates within 30 days for all hospitals and reported a 14.1 percent readmission rate (14.9 percent for adults, 11.1 percent for children, and 13.3 percent for FC youth). The data is reviewed during quarterly QIC meetings. The MHP completed a clinical PIP in FY 2019-20 aimed at reducing rehospitalizations for youth beneficiaries by connecting them with supportive services post discharge.			
2F	Tracks and Trends No-Shows	10	8
The reported no-show rates include only county operated programs. The average no-show rate for psychiatrists is 34.3 percent (31.7 percent for adult, 38.8 percent for children, and 38.9 percent for FC youth). The average psychiatry no-show for FC youth has increased from 11.4 percent in FY 2019-20 to 38.9 percent in FY 2020-21. The average no-show rate for clinicians other than psychiatrists is 43.6 percent (33.7 percent for adults, 56.8 percent for children and 56.6 percent for FC youth). In FY 2019-20, the MHP did not track no-show rates for clinicians; however, the no-show rates for psychiatrists was tracked and broken down into adults, children, and FC youth. The MHP reported that beneficiary no-shows pose challenges (e.g., lack of staff control) which negatively impacts their ability to create a no-show standard; therefore, a standard no-show rate for psychiatrists and clinicians has not been established. Trainings have been provided to show staff how to properly use Cerner scheduling; however, the MHP reports that the pandemic created issues to continue this QI activity. An established no-show goal may provide additional information which could contribute to enhanced capacity strategies.			

Quality of Care

In Table 36, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the QI

efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 36: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	11
The MHP presented its Cultural Competency Plan for FY 2019-20; an updated plan was not submitted for this CalEQRO video conference review. The Cultural Competency Committee (CCC) meeting minutes demonstrate that Shasta County Mental Health and Drug (SCMHAD) provides outreach to underserved communities such as veterans, older adults, Latin and Native American (e.g., Wintu tribe at Redding Rancheria) communities through efforts such as informational flyers, wellness fairs, newsletters, videos, and coordination with community leaders to provide cultural trainings to MHP staff. Cultural competency staff trainings are provided on topics such as interpretative services, microaggressions, Black History Month, and local Native American tribes. SCMHAD has adjusted their cultural competency trainings and outreach activities to ensure safe COVID-19 precautions are in place. SCMHAD should update their CCP to include measurable process and outcome indicators to ensure cultural competency principles are embraced throughout the entire system of care. To increase CCC stakeholder participation, the MHP should continue their outreach and engagement efforts to obtain committee membership from staff and individuals in the local community.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
The MORS is used to establish level of care for adults. The CANS-50 is used to establish level of care for children and FC youth. Both serve as outcome tools in evaluating beneficiary progress. The current QI workplan shows that 58.7 percent of all adult beneficiaries received a MORS assessment in FY 2019-20 quarter one, and 57.8 percent in quarter two (quarters three and four not reported). Data was not presented for FY 2020-21. The MHP has established a recovery based spectrum of care which utilizes the beneficiaries MORS assessment score to place them into the following categories: 1) extreme risk; 2) unengaged; 3) engaged but not self-coordinating; 4) self-responsible; and, self-supporting. Services are adjusted to meet the beneficiaries' needs in the least restrictive environment. The ASB and CSB both have processes in place to support beneficiaries with level of care transitions. Cases are reviewed regularly in care coordination meetings and during clinical supervision to review medical necessity; annual biopsychosocial assessments evaluate treatment plans and progress toward goals. Bi-directional			

Component		Maximum Possible	MHP Score
referral forms are used for beneficiaries switching to their primary care provider for medication management, and for referrals to Beacon Health Options for mild-to-moderately mentally ill beneficiaries. The rate of beneficiaries who received a deferred diagnosis has decreased from 27 percent in CY 2018 to 17 percent in CY 2019; however, it remains significantly higher than the statewide average of 5 percent.			
3C	Quality Improvement Plan	10	5
The MHP is utilizing the QI workplan from FY 2019-20 in draft form with a revision documented in January 2020; the plan contains measurable goals and objectives. The MHP monitors direct services provided to beneficiaries SCMHAD and contract providers, and reports on the residential location and penetration rates, age, gender, ethnicity, FC youth and TAY (Transitional Age Youth) data. QIC meetings minutes submitted for this review appear to show four meetings have been convened in the CY 2019 and CY 2020 (March 2019, June 2019, June 2020, and September 2020).Documents submitted for this review demonstrate that the QI workplan annual evaluation correlated to quarters one through three in FY 2019-20; however, the most recent data presented in the evaluation is from FY 2018-19.			
3D	Quality Management Structure	14	11
The Utilization Management, Compliance, Quality Management (QM), and IT units are structured under the Business and Support Services Branch; this may not provide the clinical oversight necessary to best coordinate functions between the clinical QI initiatives and the data analyst needs. The Compliance and QM team was newly established in FY 2019-20, and consists of the QI Coordinator, two Staff Analysts II, one Mental Health Clinician II (vacant) and one office assistant. The current QI Coordinator was promoted to this position in June 2020. The MHP reports significant staffing changes in the QM department which worsened when COVID-19 began. Staff can access mental health programs data on an internal intranet dashboard. QIC meetings minutes submitted for this video conference review appear to show that only four QIC meetings have been convened in the CY 2019 and CY 2020 (March 2019, June 2019, June 2020, and September 2020). QIC participants include MHP staff from various departments and contract providers; no beneficiary or family members were present.			
3E	QM Reports Act as a Change Agent in the System	10	6

Component		Maximum Possible	MHP Score
Documents submitted for this video conference review appear to demonstrate that compliance was the primary focus of staff and the QM function needed more resources to address to quality and performance improvement activities. The most recent QI workplan is from FY 2019-20, and the annual evaluation is based on the FY 2018-19 workplan. The MHP did not submit a clinical or non-clinical PIP. It appears that the pandemic and staffing changes contributed to the difficulties in change management efforts for CY 2020; however, the cause of difficulties prior to the pandemic is unclear. Staff training was offered in February 2020 to improve accuracy of tracking no-show rates in Cerner to improve data integrity; however, the MHP has not set a standard no-show rate for psychiatrists and clinicians, and it is not included in the QI workplan. In response to the CalEQRO FY 2019-20 recommendation to improve diagnostic patterns among clinicians, the MHP implemented a draft IN to remove unspecified diagnosis (R69) and replace with encounter for observation for other suspected diseases and conditions ruled out (Z03.89). This resulted in a slight improvement in rates of deferred diagnosis (27 percent in FY 2019-20 versus 17 percent in FY 2020-21); however, this percentage continues to remain well above the state average of 5 percent.			
3F	Medication Management	12	10
The Managed Care, Compliance and QM departments are responsible for the established medication monitoring policy and procedure for all beneficiaries, and random chart audits are performed monthly; a consulting psychiatrist performs the monitoring of these audits. CSB has a dedicated Public Health Nurse (PHN) who oversees and monitors a caseload of dependent children and youth who take a psychotropic medication. The dedicated psychotropic medication PHN reviews all applications for psychotropic medications (JV220) with the assigned PHN before the doctor's orders go to the presiding judge. Prior to the COVID-19 impact, CSB held two in person staff meetings per month with the social worker and mental health clinician. The staff meetings have been suspended due to the pandemic; however, oversight remains with the PHN and future virtual staff meetings are intended to resume shortly. The MHP Child Welfare Analyst reviews and analyzes reports quarterly on SafeMeasures and the University of California, Berkeley's California Child Welfare Indicator Project (CCWIP); the findings are shared with the supervising PHN. Semiannual meetings are held with the Clinical Division Chief, dedicated psychotropic medication nurse, supervising PHN, assigned JV-220 Office Assistant, and the analyst to discuss the reports, findings, and CQI activities. Documents for this review indicate that youth who receive medications are tracked individually; however, overall medication monitoring for all children and youth is not			

Component	Maximum Possible	MHP Score
tracked. Focus group feedback shows that beneficiaries are unaware if there is routine communication regarding medication management between the MHP and primary care providers.		

Beneficiary Progress/Outcomes

In Table 37, 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 37: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	10
The Outcomes Planning and Evaluation (OPE) team provides CANS-50 data reports at intake, every six months, and at discharge. The MHP also utilizes the 35-item Pediatric Symptoms Checklist (PSC-35) for children and FC youth. The MORS assessment is conducted on adult beneficiaries and the frequency is dictated by the mental health team; the STAR team administers it monthly and the outpatient teams administer it every three months. The CSB contracted organizational providers submit monthly outcome reports which are also discussed at quarterly meetings with those providers. PSC-35 and CANS data for the MHP and contract providers is entered into an online database developed through a contracted provider to improve reporting and outcome monitoring. Beneficiary outcomes are reviewed during quarterly QIC meetings; however, the MHP stated that the outcome reports on MORS data results have not been produced in quite some time. The MHP is in the process of switching to the new MORS assessment format; this has been placed on hold due to COVID-19. The QI workplan shows that 58.7 percent of all adult beneficiaries received a MORS assessment in FY 2019-20 quarter one, and 57.8 percent in quarter two (quarters three and four not reported). The QI workplan does not demonstrate tracking and monitoring of children and FC youth outcome measures such as the CANS-50 and PSC-35. Data was not presented for FY 2020-21. While there are standards as to			

Component		Maximum Possible	MHP Score
when to utilize tools, CalEQRO did not see reports submitted that verify that tools are consistently meeting timeliness standards. The MHP posts the CPS results on their website. This is disaggregated to performance outcomes for adult and older adult, youth and family, children, and youth mental health, respectively.			
4B	Beneficiary Perceptions	10	7
The FY 2019-20 workplan includes a goal with process out outcome indicators to increase the percentage of consumers who completed the CPS; the results are reviewed during quarterly QIC meetings. The survey is administered on a bi-annual basis, and participation has continually declined every CY as follows: 68 adult participants in May 2017, 49 in May 2018, and 18 participants in May 2019; 115 youth or family members in May 2017, 111 in May 2018, and 63 respondents in May 2019. CPS results are posted on the agency website; however, the most recent results are from CY 2015. Beneficiaries in focus groups reported feeling satisfied with their services, and CPS scores generally reflect this; however, youth and family member CPS results show decreasing participation in the survey and decreased satisfaction in receiving as much help as they needed (69.4 percent in May 2018, 62.7 percent in November 2018, and 57.0 percent in May 2019). The FY 2019-21 QI workplan includes a goal to implement its own survey of its beneficiaries, family members, organizational providers, supervisory and management staff. The survey has been formulated but has since been placed on hold due to COVID-19. The MHP is working on an alternative plan. Beneficiaries in the CalEQRO focus groups did not report receiving a satisfaction survey. Beneficiary satisfaction surveys are shared at weekly supervisor meetings, and with clinical line staff during the CSB monthly meeting. For the ASB program, results are shared with direct supervisors through weekly meetings, and with other program staff at weekly team meetings.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
The MHP has two beneficiary-run wellness centers – Olberg Wellness Center in Redding, and Circle of Friends in Burney. Both wellness centers are open to all beneficiaries and their family members and offer a variety of groups and other activities. In response to COVID, the wellness centers are closed, peers are providing outreach to beneficiaries on the telephone, and groups are being reintroduced using Zoom.			

Structure and Operations

In Table 38

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

Table 38: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	28
The MHP is a part of the HHSA which has a vertically integrated structure for adult and children programs separately; there is a range of services from least restrictive to inpatient level of care. SCMHAD collaborates with several specialty mental health providers such as: Star View Adolescent Center; Aurora Behavioral Health Care Santa Rosa; Butte County Behavioral Health; El Dorado County Psychiatric Health Facility; Heritage Oaks Behavioral Health Center; North Valley Behavioral Health; Restpadd Red Bluff; Sierra Vista Hospital Behavioral Health Center; Sutter Center for Psychiatry; and Sutter Yuba Mental Health Services. The Crisis Residential and Recovery Center provides services for up to 30 days to people 18 years of age and older. The Hill Country Counseling and Recovery Engagement Center provides urgent outpatient mental health services and is operated by the Hill Country Health and Wellness (Shasta County HHSA and MHSA funded). Child Welfare, Probation and the MHP have discussed and reviewed the need for Therapeutic Foster Care (TFC) on an ongoing basis. Local foster family agencies (FFAs) have been contacted to assess interest; however, no agencies have shown interest. The MHP has completed two requests for proposals (RFP) for TFC and delivered it to all local FFAs who have not applied. At this time, no FFA partners have shown interest in becoming TFC providers. SCMHAD utilizes Intensive Services Foster Care (ISFC) and Short-Term Residential Therapeutic Programs (STRTP) to meet the needs of eligible foster youth.			
5B	Network Enhancements	18	18
Most services are provided via telehealth in response to the pandemic; in-person appointments are scheduled as needed. ASB has four locum tenens telepsychiatrists, and the Children Services Branch currently has two telepsychiatry providers. The Hill Country MCOT provides on-the-spot urgent mental health services to individuals suffering with severe mental illness (SMI). Clinical staff are co-located in Redding's two emergency rooms allowing for rapid psychiatric assessments. Shasta County is part of the Whole Person Care Pilot,			

Component		Maximum Possible	MHP Score
a joint effort between Shasta County HHSA, Shasta Community Health and Wellness Center, Hill Country Health and Wellness Center and Partnership Health Plan. Field-based nursing services is provided to assist beneficiaries with case management issues or establishing their own medication systems. Shasta County HHS CSB is integrated with both child welfare and mental health services for children under the same branch director. Child welfare staff and children's mental health staff are co-located and have access to shared systems. A clinician has been co-located at the juvenile rehabilitation facility.			
5C	Subcontracts/Contract Providers	16	12
All clinical staff from HHSA Children Services Branch, Northern Valley Catholic Social Service, Victor Community Support Services, Kings View Behavioral Health and Remi Vista have been trained in the use of the CANS-50 and are inputting their data into an online database. Feedback in CalEQRO focus groups demonstrate positive relationship with contract providers who provide FC youth services; however, meeting with organizational providers to gather FC data has been an ongoing issue. Contract provider participation is not reflected in CCC meeting minutes or the PIP committee.			
5D	Stakeholder Engagement	12	8
Shasta County HHSA contracted with CPS-HRC to conduct a comprehensive staff engagement survey in October 2019 to elicit feedback regarding employee work experience, leadership, organizational culture, training, teamwork, and overall engagement. The survey demonstrated that: (1) improvement is needed in senior leaders valuing ideas from employees, and (2) employees need to feel safer in challenging ideas. Survey results were shared throughout the organization, and focus groups were created in each branch of Shasta County HHSA to elicit feedback from staff and leadership. Meeting minutes for the QIC and CCC do not reflect beneficiary or family participation.			
5E	Peer Employment	8	8
The MHP through MHSA offers a free 65-hour training program designed to equip individuals with the education, skills, and experiences necessary to prepare them for an entry-level career into the public mental health field and/or equip them to become peer mentors or peer support specialists. The peer support specialist is a newer classification; there are six out of eight vacant peer positions in the ASB (eight total positions). Stakeholders in the peer focus group experienced an easy hiring process, feel supported by supervisors, have an informal career ladder, and feel valued in the work they provide. Through MHSA, the MHP offers a free 65–hour training program (the academy) designed to equip individuals with the education, skills, and experiences necessary to prepare them for an entry level career in the public mental			

Component	Maximum Possible	MHP Score
health field and to become a peer mentor. The Workforce Education and Training (WET) program is a MHSA volunteer program which provides mental health career development opportunities for Shasta College students, and promotes employment of consumers and family members; it establishes a career pathway in the public mental health workforce capacity.		

SUMMARY OF FINDINGS

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

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: No PIP submitted (not rated)

Non-clinical PIP Status: No PIP submitted (not rated)

Access to Care

Changes within the Past Year:

- Most services are provided via telehealth in response to COVID-19; in-person appointments are available on an as needed basis.
- Shasta County HHSA implemented a COVID-19 Incident Action Plan to develop strategies to manage long-term response and support community recovery efforts.
- In response to COVID-19, the Shasta County Board of Supervisors approved the spending plan for Coronavirus Aid, Release and Economic Security (CARES) Act which provided for the creation of a Crisis Stabilization Unit (CSU) which opened in September 2020 to support local emergency rooms.

Strengths:

- SCMHAD increased its Latino/Hispanic penetration rates from 3.09 percent in CY 2017 to 4.08 percent in CY 2019.

Opportunities for Improvement:

- Focus group feedback suggest challenges in high staff turnover, retention difficulties, and higher caseloads which worsened with the onset of the pandemic.
- Feedback from stakeholders in focus groups indicate difficulties referring individuals to the new CSU located at the Shasta County Residential and Recovery Center; this creates extended wait times for hospitalized individuals.

- CalEQRO focus groups report difficulties with finding transportation, especially in remote parts of the county.
- Stakeholder feedback suggests COVID-19 precautions have stopped most in-person services to beneficiaries in residential care; this has led to a major influx of service requests which staff struggle to balance with existing caseload.
- The provider directory should be updated monthly as per DHCS IN 18-020.

Timeliness of Services

Changes within the Past Year:

- The MHP began disaggregating timeliness metrics for FC youth.

Strengths:

- Most beneficiaries in CalEQRO focus groups report timely access to services.
- The percent of appointments that met the 15-day standard for the length of time from first request for service to first offered psychiatry appointment increased from 30.4 percent in FY 2019-20 to 66.7 percent in FY 2020-21.

Opportunities for Improvement:

- Timeliness tracking should be enhanced to measure average number of business days from initial request to first assessment date (versus CSI assessment initiation date), as well as from assessment to first treatment visit for children, adults, and FC youth.
- The MHP should differentiate the individuals whose initial request was listed as the date that the CSI assessment was initiated versus those whose initial request for services was recorded properly during initial contact; this will help to improve data integrity.
- SCMHAD should track the number of business days from request to initial psychiatry assessment for both children, adults, and FC youth; the timeliness measures should include those individuals who did not receive their first psychiatric appointment within the first 60 days.
- The percent of appointments that met the seven-day standard for post-hospitalization discharge follow-up has decreased from 71.9 percent in FY 2019-20 to 68.4 percent in FY 2020-21.
- The average no-show rate for psychiatrists is 34.3 percent (31.7 percent for adult, 38.8 percent for children, and 38.9 percent for FC youth).

- The average no-show rate for clinicians other than psychiatrists is 43.6 percent (33.7 percent for adults, 56.8 percent for children and 56.6 percent for FC youth).
- It would benefit the MHP to establish a no-show goal for psychiatrists and clinicians; this may provide additional information which could contribute to enhanced capacity and CQI strategies.

Quality of Care

Changes within the Past Year:

- The current QI Coordinator was promoted to this position in June 2020; significant QM staffing changes worsened with the onset of COVID-19.
- The MHP implemented a draft notice to remove unspecified diagnosis (R69) and replace with encounter for observation for other suspected diseases and conditions ruled out (Z03.89).

Strengths:

- The MHP provides outreach to underserved communities such as the LatinX and Native American (e.g., Wintu tribe) communities through efforts such as informational flyers, newsletters, videos, and coordination with community leaders to provide cultural trainings to MHP staff.
- The ASB and CSB both have processes in place to support beneficiaries with level of care transitions; a recovery-based spectrum of care is used throughout the MHP.
- The MHP offered training to its CSB staff in February 2020 to improve accuracy of tracking no-show rates in Cerner.

Opportunities for Improvement:

- The CCP does not include measurable process and outcome indicators to ensure cultural competency principles are embraced throughout the entire system of care.
- The QI workplan does not reflect process and outcome indicators and include an annual evaluation of QI activity effectiveness.
- QIC meetings minutes submitted for this review appear to show only four meetings have been convened in the CY 2019 and CY 2020 (March 2019, June 2019, June 2020, and September 2020).

- The rate of beneficiaries who received a deferred diagnosis has decreased from 27 percent in CY 2018 to 17 percent in CY 2019; however, it remains significantly higher than the statewide average of 5 percent.
- Documents submitted for this review reflect that the MHP has not developed and implemented a process to identify the rate of co-occurring mental health and substance abuse diagnoses more accurately.
- The MHP does not track and trend prescribing practices for the entire system of care, including county and contract providers.
- The MHP does not have a standard no-show rate for psychiatrists and clinicians; these metrics are not included in the QI Workplan or a QIC standing agenda item.
- The structure between the clinical requirements and the technical data collection aspects may be inadvertently affecting the intended results the MHP seeks. This is evidenced by the lack of PIP submission, out-of-date and incomplete documents submitted for this review.

Beneficiary Outcomes

Changes within the Past Year:

- None noted.

Strengths:

- Beneficiaries in focus groups reported feeling satisfied with their services, and CPS scores generally reflect this.
- Stakeholders in the peer focus group experienced an easy hiring process, feel supported by supervisors, have an informal career ladder, and feel valued in the work they provide.

Opportunities for Improvement:

- There are six vacant peer support specialist positions in the ASB.
- The CPS results are posted on the agency website; however, the most recent results are from CY 2015.
- Youth and family member CPS results show decreasing participation in the survey and decreased satisfaction in receiving as much help as needed (69.4 percent in May 2018, 62.7 percent in November 2018, and 57.0 percent in May 2019).

- Beneficiaries in the CalEQRO focus groups did not report receiving a satisfaction survey.

Foster Care

Changes within the Past Year:

- The MHP began collaboration with Child Welfare Services (CWS), behavioral health, probation, education, and the Regional Center on implementing AB 2083 (Foster youth: trauma-informed system of care); AB 2083 requires county-level and state-level MOUs between agencies directly responsible for FC youth.
- The MHP trained all mental health and CWS staff in September 2020 on the integrated presumptive transfer policy and procedures.
- The MHP trained all staff and worked collaboratively with mental health and welfare to have a policy in line and now able to develop integrated policy and procedures within programs.
- Intensive Services Foster Care (ISFC) was transferred to an organizational provider in FY 2020-21.
- The MHP began disaggregating timeliness metrics for FC youth.

Strengths:

- The MHP has improved its FC youth penetration from 40.91 percent in CY 2017 to 54.69 percent in CY 2019.
- The MHP provided additional training from University of California, Davis for supervisors to support use of CANS-50 in CWS and the Children Services Branch within the Integrated Core Practice Model (ICPM).
- CSB has a dedicated PHN who oversees and monitors a caseload of dependent children and youth who take a psychotropic medication.
- The MHP holds semiannual meetings with the Clinical Division Chief, dedicated psychotropic medication nurse, supervising PHN, assigned JV-220 office assistant, and the analyst to discuss the reports, findings, and CQI activities.
- SCMHAD does not offer TFC services; however, ISFC and STRTPs are used to meet the needs of eligible FC youth. Two RFPs have been initiated and ongoing discussions continue between the MHP, CWS, and probation.

Opportunities for Improvement:

- The average psychiatry no-show for FC youth has increased from 11.4 percent in FY 2019-20 to 38.9 percent in FY 2020-21.
- The average no-show rate for clinicians other than psychiatrists for FC youth is 56.6 percent.
- Only 60 percent of FC youth are followed-up within seven days post hospitalization discharge.
- The MHP does not review presumptive transfer information in regular intervals to confirm that out-of-county transfers were executed and if connection to specialty mental health services was completed.
- The MHP should pursue development of local TFC resources, which involves working with local agencies and those within neighboring counties that may be inclined to expand into Shasta County.
- Focus group observations reflect that meeting with FC youth organizational providers to gather data has been an ongoing issue.
- Stakeholder feedback in focus groups suggest communication difficulties in coordinating care for FC youth since COVID-19 began; these delays in timely service have exacerbated beneficiary decompensation.

Information Systems

Changes within the Past Year:

- Expansion of telehealth services due to COVID-19.
- IT staff secured additional laptops to allow staff to work remotely in response to the pandemic; beneficiaries benefited from the additional equipment as well (e.g., iPads brought to homeless shelter).

Strengths:

- In response to COVID-19, Central IT swiftly expanded capacity, internet bandwidth and modified staff laptops to allow remote access to continue providing services.

Opportunities for Improvement:

- The Cerner Millennium project is on hold while the MHP reviews additional CCBH replacement options.
- The MHP should resolve contract issues between Shasta County Counsel and the clearing house, Ability, to resume Part B Medicare billing.

- Lack of an operations manual or other documentation for production of claims impacts the onboarding training of new staff.

Structure and Operations

Changes within the Past Year:

- Significant staffing changes occurred in the past year including:
    - Data analytic capacity increased by 1.5 FTE.
    - High staff turnover in Business and Support Services Branch.
    - The ASB Director retired in February 2020; a new Director was hired March 2020.
    - A new ASB Deputy Branch Director was hired in March 2020.
    - Two new ASB Clinical Chief positions were filled.
    - Two new ASB Clinical Program Coordinator positions were filled.
    - The chief psychiatrist position is vacant; filling of the position is currently on hold.
    - There is high clinician and case manager staff turnover in ASB.
    - There are two CSB vacancies in the Access/Clinical program (Mental Health Clinician and Community Mental Health Worker).
    - There are two CSB vacancies in Nursing/Clinical program (Mental Health Clinician and Nurse Practitioner II).
    - There are three CSB vacancies (Mental Health Clinician, Social Worker and Social Service Aide) in the Intensive Services/Wraparound program.

Strengths:

- The MHP contracted with CPS-HRC to conduct a comprehensive staff engagement survey in October 2019; results were shared throughout the organization, and focus groups were held for staff and leadership feedback.
- ASB has four locum tenens telepsychiatrists, and CSB currently has two telepsychiatry providers.
- Field-based nursing has allowed services to continue for difficult-to-engage populations.

- The Hill Country MCOT provides on-the-spot urgent mental health services to individuals suffering with severe mental illness (SMI).
- Clinical staff are co-located in Redding's two emergency rooms allowing for rapid psychiatric assessments.

Opportunities for Improvement:

- Employee satisfaction survey results show that: (1) improvement is needed in senior leaders valuing ideas from employees, and (2) employees need to feel safer in challenging ideas.
- Stakeholder feedback in focus groups suggest variations in supervisor communication regarding system level changes and leadership decisions which impact services delivery.
- Staff turnover, increased caseloads, lack of bi-directional communication with supervisors, unclear workers' objectives and key accountabilities appear to have caused adverse effects on staff morale, which worsened with the onset on the pandemic.
- Stakeholder feedback in CalEQRO focus groups suggest challenges in high staff turnover, retention difficulties, and higher caseloads which worsened with the onset of the pandemic.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: Continue to provide resources to identify, develop, and implement the DHCS contractually required PIPs as per Title 42, CFR, Section 438.330. *(This is a follow-up recommendation from FY 2017-2018, FY 2018-19, and FY 2019-20.)*

Access to Care

Recommendation 2: Investigate and remediate denied referral requests to the new COVID-19 CSU to promote diversion of beneficiaries entering a higher level of care.

Recommendation 3: Investigate COVID-19 challenges faced by staff providing mental health services to adult and youth beneficiaries in residential care facilities and develop innovative strategies to provide outreach and engagement in these settings.

Timeliness of Services

Recommendation 4: Set a standard for no-show rates for psychiatrists and clinicians to provide additional information which could contribute to enhanced capacity strategies. *(This recommendation is a follow-up from FY 2018-19 and FY 2019-20.)*

Recommendation 5: Investigate issues with reliably tracking time of first beneficiary contact to first offered appointment and develop an effective solution to accurately track and monitor timely access to services for the entire system of care. *(This recommendation is a follow-up from FY 2017-18 and FY 2019-20.)*

Recommendation 6: Explore current psychiatry timeliness tracking methodology and implement an effective solution to accurately report on beneficiary request to initial psychiatry assessment for the entire system of care.

Recommendation 7: Investigate high psychiatry and clinician no-show rates for adults, children, and FC youth, and implement CQI activities (i.e. patient centered communication and PIPs) to ensure timely access to services, quality of care, and beneficiary retention.

Quality of Care

Recommendation 8: Develop and implement a process to identify the rate of co-occurring mental health and substance abuse diagnoses more accurately. *(This recommendation is a carry-over from FY 2019-20.)*

Recommendation 9: Review deferred diagnosis data to identify trends and assure diagnosis updates are entered into the system in a timely manner to reduce the rate of deferred diagnosis. *(This recommendation is a carry-over from FY 2019-20.)*

Recommendation 10: The MHP should actively engage contract providers in system planning, routinely share outcomes data, and promote increased participation in CQI activities such as the PIP committee, QIC, and CCC. *(This recommendation is a follow-up from FY 2019-20.)*

Beneficiary Outcomes

Recommendation 11: Provide routine internal outcome reporting (quarterly at a minimum) to stakeholders for children and adult programs (CANS-50 and MORS)*. (This recommendation is a carry-over from FY 2019-20.)*

Recommendation 12: Increase beneficiary participation in satisfaction surveys, and provide stakeholders (clinical supervisors, contract providers, and beneficiaries) groups-results of the surveys at the program level. *(This recommendation is a follow-up from FY 2019-20.)*

Foster Care

Recommendation 13: Improve bi-directional communication between MHP leadership, direct line staff and community agencies providing services to FC youth to promote integrated core practices (ICPM) and behaviors.

Information Systems

Recommendation 14: Work towards the establishment of a formal data governance protocol to record and transparently disseminate reporting data sources, assumptions, baselines, methodologies, and findings for its clinical QI data analytics reporting.

Recommendation 15: Advocate and resolve contract issues between Shasta County Counsel and the clearing house, Ability, to resume Medicare Part B billing. *(This recommendation is a follow-up from FY 2019-20.)*

Recommendation 16: Consult with other CCBH organizations on EHR selection, system implementation, optimization, and adoption.

Structure and Operations

Recommendation 17: Create an open line of communication for staff to provide honest feedback to leadership, while improving employee morale and engagement to help drive organizational change. *(This recommendation is a follow-up from FY 2018-19.)*

Recommendation 18: Provide clear and consistent job responsibilities, policies, and procedures to eliminate staff confusion and role ambiguity; this will help to promote employee engagement, satisfaction, and retention. *(This recommendation is a follow-up from FY 2018-19.)*

SITE REVIEW PROCESS BARRIERS

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

- Several documents submitted for this video conference review were not up-to-date or were missing information.
- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible.

ATTACHMENTS

Attachment A: Video Conference Review Agenda

Attachment B: Video Conference Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment A—Video Conference Review Agenda

The following sessions were held during the MHP the video conference review, either individually or in combination with other sessions.

Table A1: EQRO Video Conference Review Sessions

Shasta MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Performance Improvement Projects
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Angela Kozak-Embrey, Quality Reviewer
Leda Frediani, Information Systems Consultant
Steven Cullen, Consumer Family Member Consultant

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

Sites of MHP Review

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

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Abbott	Brian	Clinical Program Coordinator, CSB	HHSA
Bastaros	Andrew	Staff Services Analyst II, Managed Care	HHSA
Bowman	Robin	Deputy Director, ASB	HHSA
Carpenter	Joseph	Staff Services Analyst II, OPE	HHSA
Cassidy	Katie	Program Manager, ASB	HHSA
Castaneda	Kiley	Clinical Program Coordinator, CSB	HHSA
Chao-Lee	Mey	Clinical Program Coordinator, ASB	HHSA
Condrey	Amber	Program Manager, CSB	HHSA
Conti	Michael	Program Manager, BSS Tech	HHSA
Dorney	Megan	Deputy Director, BSS	HHSA
Field	Melissa	Senior Staff Services Analyst, OPE	HHSA
Greene	Paige	Branch Director, ASB	HHSA
Hilton	Adam	Clinical Program Coordinator, ASB	HHSA
Hoke	Katrina	Staff Services Analyst II, Managed Care	HHSA
Jacoby-Sheldon	Jennifer	Clinical Program Coordinator, CSB	HHSA
Krtek	Misty	Clinical Program Coordinator, CSB	HHSA
Larson	Justina	Clinical Program Coordinator, Managed Care	HHSA

Last Name	First Name	Position	Agency
Marvin	Peter	Clinical Program Coordinator, ASB	HHSA
McCullough	Katie	Executive Director	Victor Community Support Services
McKinney	Kimberly	Clinical Program Coordinator, ASB	HHSA
Restivo	Genell	Clinical Division Chief, ASB	HHSA
Rodriguez	Miguel	Deputy Director, CSB	HHSA
Ruiz	Rosalie	Clinical Program Coordinator, ASB	HHSA
Schuette	Kerri	Program Manager, AOD	HHSA
Scott	Wendy	Clinical Program Coordinator, CSB	HHSA
Shelton	Doug	Clinical Division Chief, CSB	HHSA
Shuffleton	Leah	Clinical Program/QI Coordinator, Managed Care	HHSA
Stapp	Laura	Clinical Program Coordinator, CSB	HHSA
Steele	Lori	Clinical Division Chief, CSB	HHSA
Stout	Lisa	Clinical Program Manager	Northern Valley Catholic Social Service
Taylor	Jonathan	Program Manager, Managed Care	HHSA
Tedder	Tracy	Branch Director, BSS	HHSA
Van Ausdall	Jeff	Epidemiologist, OPE	HHSA
Wolfer	Margaret	Clinical Program Coordinator, ASB	HHSA
Zumalt	Monteca	Clinical Division Chief, ASB	HHSA

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

Shasta 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	16,109	624	3.87%	$3,431,769	$5,500

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

Shasta 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	2,874	92.74%	93.31%	$10,221,505	$3,557	$3,998	54.50%	59.06%
>$20K - $30K	107	3.45%	3.20%	$2,566,657	$23,987	$24,251	13.68%	12.29%
>$30K	118	3.81%	3.49%	$5,968,474	$50,580	$51,883	31.82%	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