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

SOLANO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

May 11 – 12, 2021

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INTRODUCTION

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

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

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

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Solano MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

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

MHP Information

MHP Size — Medium

MHP Region — Bay Area

MHP Location — Fairfield

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 4,821

MHP Threshold Language(s) — Spanish

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Network Adequacy

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

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these

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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.

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

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

Validation of State and MHP Beneficiary Satisfaction Surveys

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

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

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

Status of FY 2019-20 Review of Recommendations

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

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: Both MHP's PIPs were completed before this current review occurred. Conversations between the EQRO and MHP staff included encouragement to immediately pursue development of clinical and non-clinical PIP topics. MHP staff were advised of the EQRO's technical assistance (TA) availability. As per Title 42, CFR, Section 438.330, DHCS contractually requires two active PIPs.

Status: Partially Met

- Since the prior review, the MHP engaged in the development of a new clinical and non-clinical PIP.

Access Recommendations

Recommendation 2: Complete review of the website design and develop a more beneficiary friendly and focused structure. Suggestions include relocating the provider directory to a more prominent position and with enhanced search capabilities, prominent identification of wellness center resources, and regular, periodic testing of links, which will ensure that key resources have active links.

Status: Partially Met

- The MHP has made some improvements to its website, updating some content and adding new pages for Access to Services, subpages under Diversity and Equity Efforts for Asian/Pacific Islander (API), Hispanic/LatinX, Lesbian, Gay, Bisexual, Transitioning and Questioning (LGBTQ), and Native Americans, which provide additional information for beneficiaries.

- Information has been added to the website that describes the Wellness and Recovery Unit, but there is no information related to the Wellness and Recovery Centers. Beneficiaries and family members interested in locating information about wellness centers must first know that Caminar operates these programs and perform a related web search.

- Provider directory information is located under the Quality Improvement (QI) option on the Solano County Behavioral Health (SCBH) website home page. QI is the 15th of 18 options on the list. Having this information under QI does not seem at be an intuitive location for the beneficiary community.

- The MHP reports limitation to changes exist due to the requirement that the department adhere to the County Administrator's approved business plan. This imposes some restrictions of modifications.

- The MHP has a social media workgroup, meeting monthly, reviewing materials and providing recommendations for improvements.

Timeliness Recommendations

Recommendation 3: Improve the tracking and reporting of initial psychiatry service timeliness to include the percent of time the standard is met and the data range, per Information Notice 18-011.

Status: Partially Met

- A newly created "Referral for Psych Services" form will support tracking for child psychiatry, with new fields for "offered" and "accepted" dates.

- The MHP reports adult psychiatry is the standard of care for that service.

- At the time of this review the MHP was unable to provide any data as to the psychiatry service access results. The MHP noted that determination of need for psychiatry services was not currently captured and pending implementation.

Recommendation 4: Improve the capture of data for service delivery sites that are currently entering partial or no data into Avatar, to provide more complete assessment timeliness reporting.

Status: Partially Met

- The MHP identifies training of all sites in use of the Access Screening Tree. The MHP reports data as collected in the Timeliness Self-Assessment.

- On further review of the timeliness document, FC data for first offered is captured. Psychiatry first offered has no data for any population. Post hospital discharge follow-up has no FC data, also no FC inpatient readmission rate data, nor clinician no-show. Whether this is due to the absence of events or to challenges in capture of this information is not clear.

Recommendation 5: Obtain consultation from DHCS liaison to determine if the current practice of restricting urgent tracking to intake/assessment is acceptable. Consider expanding the tracking of urgent service needs beyond the assessment window to other times during the treatment process. Update the 3-day standard and reporting to the 48/96 hour, non-preauthorized and pre-authorized requirements.

Status: Not Met

- The MHP did not review this issue with its DHCS assigned liaison.

- This recommendation was not continued in that it is a technical matter that does not merit continuation in the presence of larger impact issues. In addition, DHCS is aware of this issue and will provide clarity if they feel it is important.

Quality Recommendations

Recommendation 6: Continuously add data to the Quality Assessment Performance Improvement (QAPI) plan through the course of the year as updates and relevant data are received and reviewed. This supports this document being an active source for tracking progress throughout the year.

Status: Not Met

- Solano MHP provides quarterly QIC PowerPoint presentations containing updated QAPI workplan data that are shared with stakeholders and inform annual workplan updates.
- This recommendation is not continued for the FY 2020-21 review period due to the fact the MHP does create informative documents from each QAPI meeting.

Recommendation 7: Develop a mechanism to ensure that new information related to Consumer Perception Surveys (CPS) and other system data is posted to the website and a communication strategy is employed. This may include posting messages for beneficiaries and caregivers at clinics and email notifications containing links to other stakeholders.

Status: Met

- The quality improvement team created a communication strategy that involves a flier containing a Quick Response (QR) code that is sent to stakeholder organizations to draw attention to SCBH beneficiary survey results.
- The flier includes a QR code that links to SCBH's outward facing website and the beneficiary survey results. Circulation of fliers can be through electronic media as well as hard copy. Programs are encouraged to post fliers in easily accessible locations.
- The most recent posted results were from 2019, as the 2020 survey was cancelled.

Recommendation 8: Renew efforts towards the developing and implementing a plan to integrate physical health care with the adult behavioral health (SCBH) outpatient clinics, to assist in serving a population that often has multiple poorly managed physical health conditions.

Status: Not Met

- The pandemic focused physical health care providers on managing COVID-19 related issues. Staffing has been inadequate to divert attention to integrative activities with behavioral health.
- This remains a future priority for the MHP.
- This recommendation is not continued for the FY 2020-21 review period due to the scale of such integration and related challenges with recovery from the COVID-19 pandemic. This will be revisited with CalAIM.

Beneficiary Outcomes Recommendations

Recommendation 9: Complete the implementation of the Reaching Recovery (RR) instruments and apply the results to informing assessments and level of care determinations (*This recommendation is a carry-over from FY 2018-19).*

Status: Partially Met

- SCBH began implementation of RR, a clinical toolset comprised of four separate instruments, with the Recovery Needs Level (RNL) level of care tool. This instrument is incorporated with assessments and level of care transition determinations.
- All SCBH programs are rated and grouped by level of care in descending order. These levels are aligned with ranges of RNL scores This process supports matching individual needs with program capacity. The general schema aligns higher level programs such as assertive community treatment and inpatient with higher RNL scores; alternatively, medications-only beneficiaries are at lower RNL scores.
- The implementation process involved training of all clinician and psychiatry staff in the methodology for scoring beneficiaries across all programs. Baselines have been established, and a RNL is required for changes in level to higher levels from the weekly Transitions in Care (TIC) clinical meeting.
- As of this review, baseline for all beneficiaries is still in progress.

Recommendation 10: Continue tracking the supported employment results provided by the Caminar contract expansion, including beneficiary satisfaction with services.

Status: Met

- The Caminar Individual Placement and Support (IPS) team provides supported employment services. It includes a supervisor, employment specialists, peer employment mentors, and offers job development, job club, and peer support.
- In August 2020, this program expanded to provide these services to transitional age youth (TAY) served by full-service partnership (FSP) programs.
- During FY 2020-21, the IPS Supported Employment program through Caminar Jobs Plus served 126 clients and made 56 placements. Thus far, 60 percent of job seekers maintained a job for at least 90 days and 71 percent maintained a job for over 120 days.

Recommendation 11: Begin the process of developing a masterplan for the inclusion of individuals with lived experience in all aspects of MHP service delivery.

Status: Not Met

- The MHP's response to this recommendation focused on the inclusion of peers/advocates in committees and input groups. While this type of involvement is important to assure that beneficiaries' voices are heard, the recommendation focused on a master plan for inclusion of peers/advocates in various aspects of the workforce, for example from FSP, and crisis through outpatient.
- This recommendation is not being continued in that the MHP is engaged in the training and expanded use of lived experience individuals, and time to make progress in this area should be provided before making this a recommendation again.

Foster Care Recommendations

Recommendation 12: The MHP to develop a comprehensive reporting process that targets SB 1291 FC prescribing standards, including metabolic monitoring, which is reviewed with prescribers and program clinical staff on a periodic basis throughout the year. This report should include action steps, such as: further investigatory pursuits when the data is unclear, and/or actions taken when standards are not met.

Status: Met

- The Mental Health (MH) Medical Director reviews an expanded Report 339C that includes weight, vitals, and lab work related to metabolic monitoring. This information is included in the peer review process, and with the Clinical Quality Review Committee. There is a foster care flag and includes all children on psychiatric medications.

Recommendation 13: All timeliness metrics are to be monitored separately for FC beneficiaries.

Status: Partially Met

- In the data for the current review (FY 2019-20) the MHP did not report FC first offered psychiatry services, access, urgent care response time, follow-up post psychiatric hospital discharge, or 30-day FC psychiatric inpatient unit rehospitalization rates.
- The MHP developed a special flag for FC youth in the "special populations" screen in Avatar. This supports addition of this element to

Avatar reports. Currently this has occurred with the timeliness and inpatient reports.

- It is important to add this capability to timeliness and rehospitalization tracking reports that are reviewed quarterly within the QAPI meeting format.

Information Systems Recommendations

Recommendation 14: The MHP to continue efforts to improve the IT and data analytics staffing capacity to effectively maintain and move the department forward. The inability to complete critical projects and initiatives based on established timelines is evidence of this need.

Status: Met

- The Solano County Department of Information Technology (DoIT) is currently in the process of restructuring their services and support for all county departments/units. There will be movement of more repetitive tasks to the County Help Desk. This will allow the remaining staff to focus on developing skills and working on higher level more complex tasks and projects.

- DoIT is actively recruiting for 3 Data Engineers, which will move the department forward in implementing a data warehouse and provide a stronger reporting and analytics platform.

- The MHP has hired a Planning Analyst who has been developing dashboard and other reports to inform the system.

Recommendation 15: The MHP to review the totality of Information Technology/Information Systems (IT/IS) priority listings and assess for each the need to remain on the priorities list and how moving forward can be accomplished.

Status: Met

- Each year SCBH QI and DoIT review and determine priorities for the year.

- The MHP completed six or the seven priorities from last year, with the seventh priority eliminated due to its low priority status for SCBH.

Recommendation 16: The MHP to complete the following recommendations from the prior year: (1) Implement 270/271 Eligibility Checking in Avatar; (2) Improve and implement new Console Widgets in Avatar; (3) Implement Mental Health Services Act (MHSA) Data Collection in Avatar. *(These are carry-over recommendations from FY 2018-19.)*

Status: Partially Met

- The fiscal team had developed an alternative, preferred process for eligibility checking and has elected not to move forward with the 270/271 implementation.
- Solano County DoIT has created multiple console widgets and demonstrated them with the clinical user group. DoIT is currently building console views to roll out to users.
- SCBH QI and DoIT are currently working on make the necessary changes to meet the data collection needs for MHSA. MH Client Demographic form need to collect additional data has been built and will be deployed in production soon.

Structure and Operations Recommendations

Recommendation 17: Continue the process to secure a provider for mobile crisis services.

Status: Met

- The MHP contracted with Uplift Family Services to operate a mobile crisis service. The launch date was slated for late April 2021, with hours from 10 am to 11 pm. Hours may change according to service demands.
- Initially, the coverage will include two Solano County cities. Expansion will occur after several months of testing and will be extended to the entire county.
- Coverage hours may expand to 24/7, as determined by demand. Analysis of dispatch data, and experiences of neighboring MHPs suggest the currently planned coverage hours will include 80 to 90 percent of calls for service. Calls outside of coverage will either wait for the mobile team's return or be served by the local Crisis Stabilization Unit (CSU).

Recommendation 18: Identify the barriers to workforce stability and develop a comprehensive plan to address these factors, including strategies related to recruitment and retention.

Status: Partially Met

- The MHP's response focused on the issues relating to IT staff and retention of related personnel. The focus of this recommendation was intentionally on retention of clinical staff, who are often lost to neighboring counties and other providers creating difficulties with continuity of care.

- The MHP did indicate that it was supportive of staff having some level of alternate work schedule, that could include work-from-home time. The decision, however, is reliant on overall county administration to set policy in this area. This is one area that could improve staff retention when salary increases are not on the table.

PERFORMANCE MEASURES

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

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

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

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to screenings, assessments, home-based mental health services, outpatient services, day treatment, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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

1. SB 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf
2. EPSDT POS Data Dashboards: https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx
3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
    - 5A (1&2) Use of Psychotropic Medications
    - 5C Use of Multiple Concurrent Psychotropic Medications
    - 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure
4. AB 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf
5. *Katie A. v. Bonta*:
   The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

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

Health Information Portability and Accountability Act Suppression Disclosure

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

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

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

Solano 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	23,612	20.1%	1,418	29.4%
Latino/Hispanic	36,440	31.1%	878	18.2%
African-American	21,664	18.5%	1,131	23.5%
Asian/Pacific Islander	14,086	12.0%	277	5.7%
Native American	589	0.5%	58	1.2%
Other	20,820	17.8%	1,059	22.0%
Total	**117,209**	**100%**	**4,821**	**100%**

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

Table 2 provides details on beneficiaries served by threshold language identified in DHCS BHIN 20-070.

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

Solano MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	372	7.7%
Other Languages	4,449	92.3%
Total	**4,821**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

Penetration Rates and Approved Claims per Beneficiary

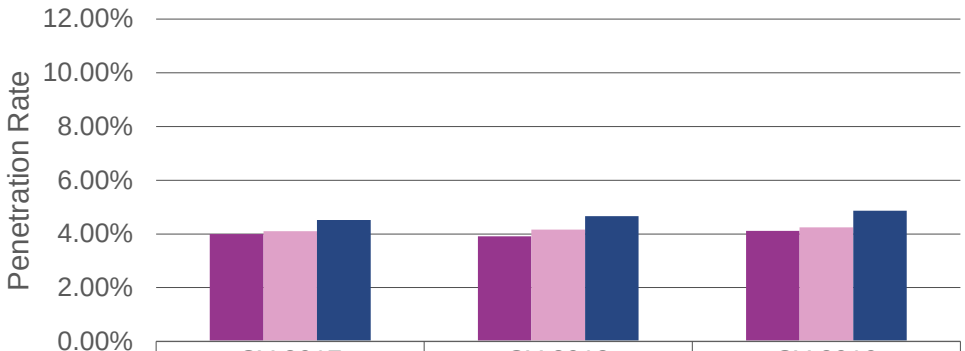
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated 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 D provides further ACA-specific utilization and performance data for CY 2019. See Table D1 for the CY 2019 ACA penetration rate and ACB.

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

Figure 1: Overall Penetration Rates CY 2017-19

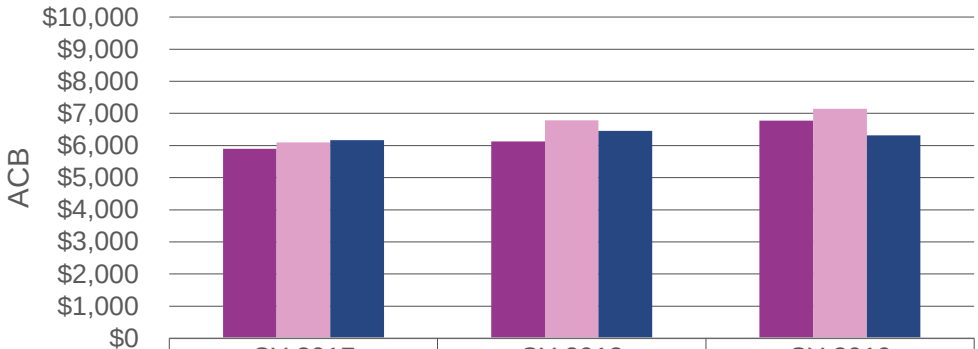
Solano MHP



	CY 2017	CY 2018	CY 2019
MHP	3.99%	3.91%	4.11%
Medium	4.10%	4.16%	4.25%
State	4.52%	4.66%	4.86%

Figure 2: Overall ACB CY 2017-19

Solano MHP

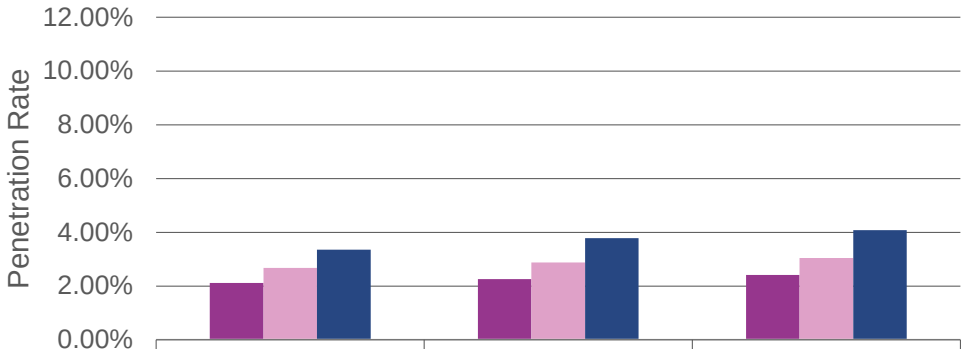


	CY 2017	CY 2018	CY 2019
MHP	$5,894	$6,129	$6,772
Medium	$6,103	$6,785	$7,143
State	$6,170	$6,454	$6,316

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

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

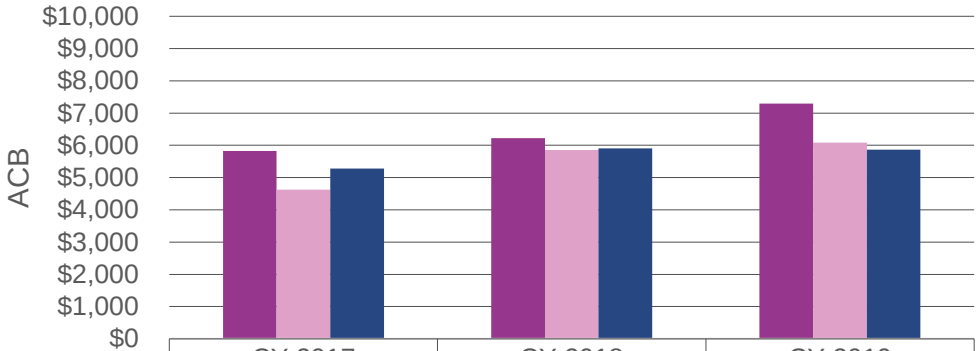
Solano MHP



	CY 2017	CY 2018	CY 2019
MHP	2.11%	2.26%	2.41%
Medium	2.67%	2.88%	3.04%
State	3.35%	3.78%	4.08%

Figure 4: Latino/Hispanic ACB CY 2017-19

Solano MHP

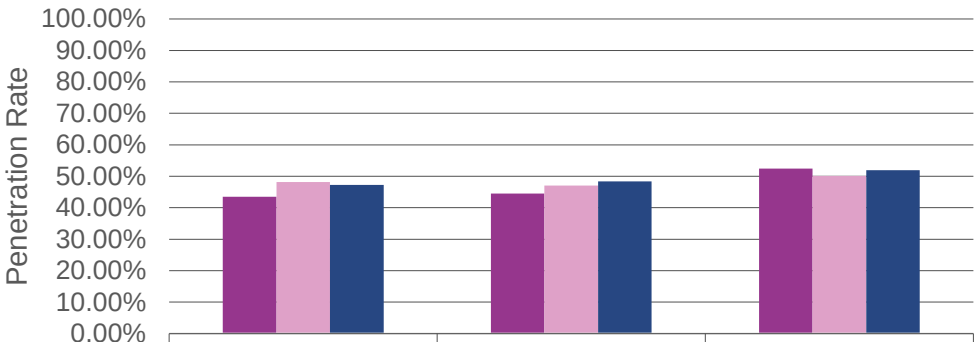


	CY 2017	CY 2018	CY 2019
MHP	$5,821	$6,219	$7,291
Medium	$4,622	$5,858	$6,081
State	$5,278	$5,904	$5,869

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

Figure 5: FC Penetration Rates CY 2017-19

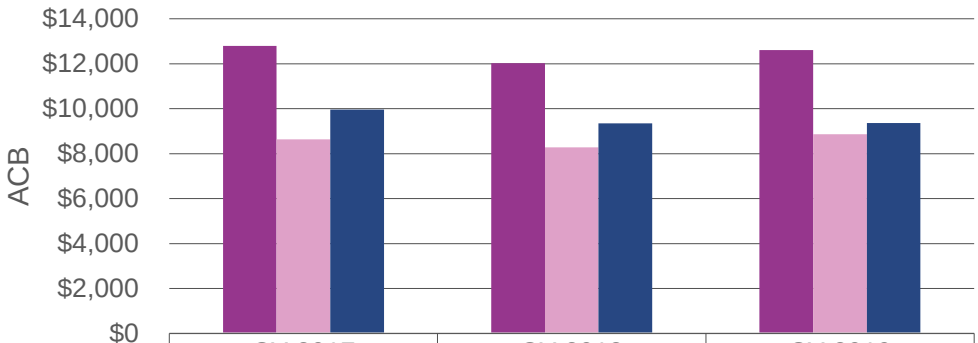
Solano MHP



	CY 2017	CY 2018	CY 2019
MHP	43.51%	44.49%	52.46%
Medium	48.15%	47.10%	50.12%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

Solano MHP

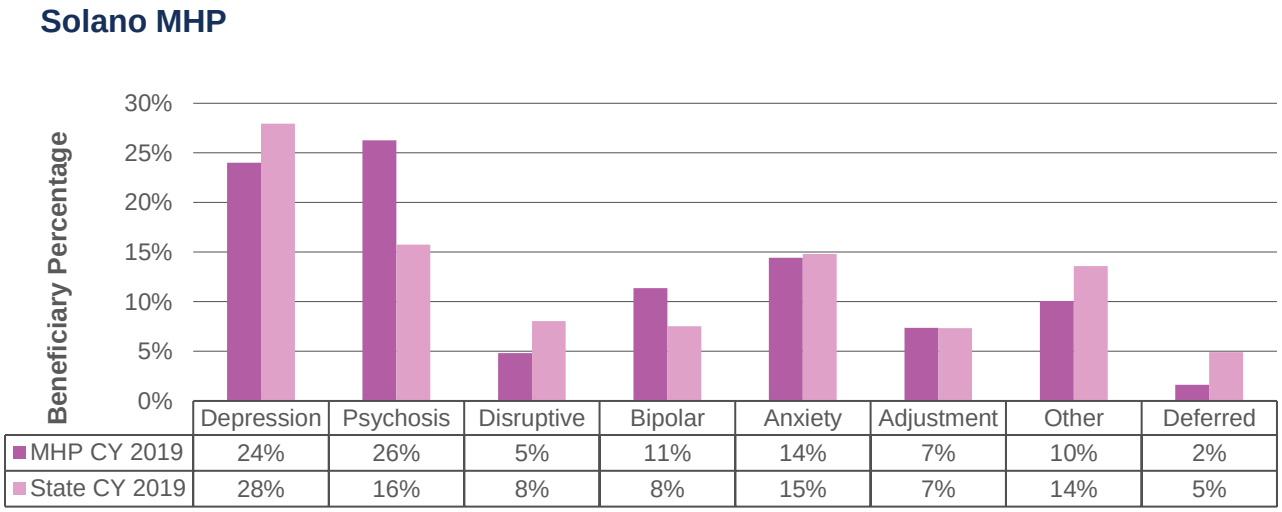


	CY 2017	CY 2018	CY 2019
MHP	$12,786	$12,022	$12,613
Medium	$8,642	$8,276	$8,870
State	$9,962	$9,340	$9,360

Diagnostic Categories

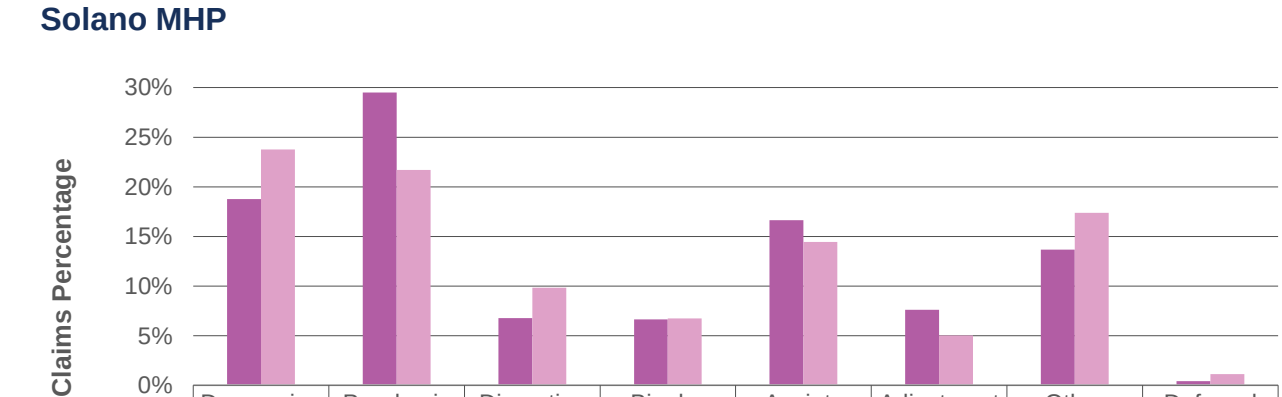
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	24%	26%	5%	11%	14%	7%	10%	2%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

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



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	19%	30%	7%	7%	17%	8%	14%	0%
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

Solano 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	189	4,821	3.92%	$49,786	$9,409,623	28.82%
	CY 2018	162	4,693	3.45%	$53,273	$8,630,231	30.00%
	CY 2017	181	4,938	3.67%	$47,816	$8,654,658	29.74%

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

Psychiatric Inpatient Utilization

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

Table 4: Psychiatric Inpatient Utilization CY 2017-19

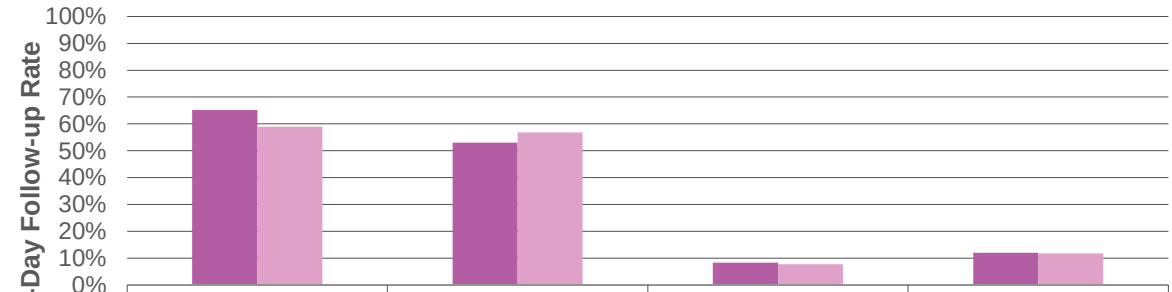
Solano MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	398	717	9.25	7.80	$11,855	$10,535	$4,718,263
CY 2018	361	743	8.31	7.63	$13,227	$9,772	$4,774,952
CY 2017	352	658	8.53	7.36	$11,033	$9,737	$3,883,540

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

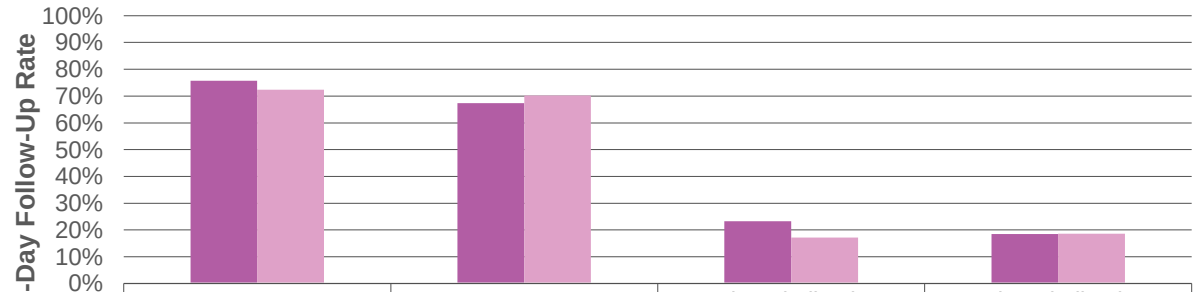
Solano MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	65%	53%	8%	12%
CY 2019	59%	57%	8%	12%

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

Solano MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	76%	67%	23%	19%
CY 2019	72%	70%	17%	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.

Solano MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. SCBH submitted two PIPs both of which CalEQRO reviewed and validated. as shown below.

Table 5: PIPs Submitted by Solano MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Beneficiary Engagement with Mental Health Treatment after Discharge from a Psychiatric Hospital or Crisis Stabilization Unit (for those not open to outpatient services at the time of the crisis or inpatient event, separately tracking assessment and first treatment event)
Non-Clinical	1	Benefits of Increased Telehealth Services

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Solano
PIP Title	Beneficiary Engagement with Mental Health Treatment after Discharge from a Psychiatric Hospital or Crisis Stabilization Unit (for those not open to outpatient services at the time of the crisis or inpatient event, separately tracking assessment and first treatment event)
PIP Aim Statement	Will specific interventions delivered by the adult outpatient and the Hospital Liaison/CARE (HL/CARE) programs improve Solano's retention of previously unserved beneficiaries who were referred while being discharged from

MHP Name	Solano
	an acute psychiatric hospital or the CSU, as evidenced by improved show rates to Intake Assessment and first treatment appointment?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): Adults receiving an inpatient or CSU service who were not open to outpatient services prior to the crisis event.	

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): Reminder call, reminder letter, direct follow-up if the preceding are ineffective.
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

PIP Interventions (Changes tested in the PIP)
operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Development or a Hospital Liaison/CARE team (HL/CARE) to provide follow-up after adult outpatient staff provide reminder call and reminder letter, HL/CARE will initiate follow-up contact. (It is unclear in the write-up if the adult outpatient clinics are providing the initial contact or this is within the purview of HL/CARE, or if HL/CARE only provides the direct follow-up/outreach.)

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
Percent of those who showed for assessment	Prior to 11/2020	N = 35 52.68%	11/2020 to 4/2021	Those who received reminder calls, letter, outreach from HL/CARE team and attended Ax. 48.57%	☐ Yes ☒ No 7.8% Decrease	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): ☒ No test of statistical significance
Percent of those who showed for first treatment appointment	Prior to 11/2020	47.77%	11/2020 to 4/2021 (presumably; not specified. No N listed.)	Those who received reminder calls, letter, outreach	☐ Yes ☒ No 28.22% Decrease	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05

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
				from HL/CARE team and attended Tx. 34.29%		Other (specify): ☒ No test of statistical significance

Was the PIP validated?	☒ Yes ☐ No
Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☐ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☐ Planning phase	
☒ Other, inactive (Not a PIP)	Inactive, Developed in a Prior Year
Validation rating:	
☐ High confidence[5] ☐ Moderate confidence[6]	

[5] Credible, reliable, and valid methods for the PIP were documented.
[6] Credible, reliable, or valid methods were implied or able to be established for part of the 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

☐ Low confidence[7]

☒ No confidence[8]

Justification for validation rating:

This non-clinical activity is intended to improve the engagement with assessment and treatment of individuals who receive a crisis stabilization or inpatient service and are not at the time open to outpatient services.

The PIP references baseline data from March 2019 to March 2020, and initially presents those who request mental health services are more likely to follow-up with outpatient care than those who received involuntary CSU or inpatient care. This element is not revisited when it comes to presentation of results from follow-up calls, letters or direct contact. Therefore, while there is baseline data on the differences between voluntary and involuntary individuals, post-intervention data is not separately analyzed. Furthermore, the focus of this PIP is upon CSU and inpatient discharges, most frequently not involving those self-requesting services.

As to the nature of the clinical intervention, there not a description of the reminder calls, letters or direct contact afterwards of the clinical approach or strategy utilized. Reminder calls and letters are more technical strategies that can be applied by support staff and other non-clinical actors. Direct follow-up may, in fact, have a clinical component or strategy, if such is developed and described. But there were no details of any particular engagement strategy described in the PIP. The PIP appears to make the assumption that the HL/CARE team would provide a clinical intervention without specifics. However, without testing a given approach (i.e., motivational interviewing) analysis of results, and perhaps changes to the strategy cannot be tracked or implemented.

It is also important to note that in the development of the problem description it appears that reminder calls and letters are also applied by outpatient clinic staff to this population. This makes it difficult to determine whether the interventions of the

[7] Errors in logic were noted or contradictory information was presented or interpreted erroneously.

[8] The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

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

HL/CARE team are unique or merely duplicative of those already in use with this population by outpatient staff.

The MHP does discuss possible barriers to assessment and treatment that may include transportation, homelessness, or psychosocial stressors. These are not enumerated or tracked subsequently, which could help to identify and quantify the exact resources required for engagement success. For example, is transportation assistance a key element that would resolve the assessment and treatment service barriers? Or would providing free cell phones to beneficiaries help in receiving reminders and improve engagement rates?

The MHP struggles with the sampling concept and asserts the small number of individuals discharged from inpatient or crisis services and not currently open to outpatient care constitutes sampling. This is not the case. The PIP population is narrowly defined as those not open to an outpatient services who are discharged from inpatient or CSU care. While this is a limited size population, there is no sampling occurring.

As to specific interventions being tested, something as basic as the development of a crisis or inpatient discharge protocol that might ensure that aftercare plans are secured safely secured with the discharged beneficiary could prove useful and effective. Identification of a contact person and phone number for follow-up could be another approach. These are unique, distinct interventions that could be tested. The reminder calls, letters, and additional follow-up do not provide specific detailed intervention guidance that would support replicability.

This PIP interventions began in November 2020. Nothing in the intervention strategy appears to meet the criteria for a consistent, structured clinical intervention. The change in the metrics of assessment and treatment services are presented as an “11/2020” baseline, with subsequent post-intervention data also cited (unclear as to the timeframe identified) which show actual decreased performance for both assessment and treatment. Further data analysis is promised.

There are numerous aspects of this PIP that pose an analytic challenge. In the intervention write-up, as mentioned, it appears that adult outpatient staff engage in the reminder calls and issuance of a reminder letter to the crisis/inpatient beneficiaries who were not open to outpatient services at the time of the crisis episode. Yet, the intervention also states that HL/CARE staff will also contact beneficiaries at discharge

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
and send reminder letters if assessment follow-through does not occur. If both outpatient and HL/CARE are doing the same interventions, it is unclear how to distinguish the HL/CARE results from those of outpatient. Furthermore, none of the interventions are described in a manner that would support replicability. As of the current review, this effort does not conform to the requirements of a PIP. The MHP would be advised to address the identified issues, particularly in the development of a reminder call, letter, and direct contact protocol. These interventions should not be applied by both HL/CARES and outpatient staff. Early contact with CalEQRO FY 2021-22 lead quality reviewer is recommended to address the challenges of this PIP. "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: • Revision and clarification of numerous issues is required before this can be considered an active PIP.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • TA provided in the form of PIP feedback and suggest early and continuous TA. • The MHP may wish to pursue an alternate PIP topic.						

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Solano
PIP Title	Benefits of Increased Telehealth Services
PIP Aim Statement	Will expanding telehealth to adult outpatient beneficiaries allow us to provide better access to services, measured by reduced no-shows and an increase in services provided?

MHP Name	Solano
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): All adults 18 years and older served at the Fairfield, Vacaville, and Vallejo clinics, who meet medical necessity for receiving specialty mental health services (SMHS).	

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): Provision of telehealth.
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

PIP Interventions (Changes tested in the PIP)
operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Training staff to Doxy.me, and issuance of an administrative memo authorizing and directing telehealth services in March of 2020.

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
Total adult services	July to December 2019	8770	July to December 2020 ☐ n/a	9562	☒ Yes ☐ No 9% 792 count	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Telehealth services	July to December 2019	1432	July to December 2020 ☐ n/a	2248	☒ Yes ☐ No 57% 816 count	☐ Yes ☐ No p-value: ☐ <.01

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
						☐ <.05 Other (specify):
					☒ No test of statistical significance	
Telephone Services	July to December 2019	145	July to December 2020 ☐ n/a	2509	☒ Yes ☐ No 1630% 2364 count	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
No-shows	July to December 2019	3791	July to December 2020 ☐ n/a	3664	☒ Yes ☐ No 8.63% decrease 327 count	☐ Yes ☐ No p-value: ☐ <.01

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
					decrease	☐ <.05 Other (specify):
					☒ No test of statistical significance	
					☐ No test of statistical significance	

Was the PIP validated?	☒ Yes ☐ No

Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☐ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☐ Planning phase	
☒ Other, inactive (Not a PIP)	Inactive, Developed in a Prior Year

Validation rating:
☐ High confidence[5] ☐ Moderate confidence[6]

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
☐ Low confidence[7] ☒ No confidence[8] Justification for validation rating: This activity presents numerous difficulties in meeting the requirements of a PIP. First, the shift to telehealth and telephonic services which MHPs did statewide to reduce transmission of the COVID-19 virus is proposed to constitute a PIP. There was nothing new, unusual, or novel to be found in the training of staff in telehealth services and the issuance of a policy memo directing staff to provide services via electronic means instead of face-to-face. Difficulties arise in viewing these actions as unique interventions when most every county in the state, encouraged by CMS and DHCS, was making this shift. Furthermore, there was no unique strategy employed that would make this shift more successful, such as capturing the hardware, internet access, and preferences of all served beneficiaries in format that stored and provided to practitioners when delivering services. A mechanism for recording and communicating these preferences to clinical staff could have been such an intervention, along with strong messages to deliver services by video link as much as was possible, if in accord with the beneficiaries' preferences and capabilities. Decreased no-shows and increased numbers of services became common among those MHPs transition from in-person services during the pandemic response – but this was not known in March of 2020 when the MHP identifies the start of this PIP and a telehealth shift occurred. In an update, the MHP specified that beneficiary and staff surveys were employed to capture data on the type of telehealth preferred – video vs. telephone – and preferences for a specific type of telehealth platform, and problems with these platforms. Sustaining this improvement is mentioned in the Worksheet 1 brief description of this PIP. As written, this PIP presents telehealth improvement data as if it was available at the time of the writing of this PIP, March of 2020. In addition, no actions that would improve the utilization of telehealth and/or sustain practice shifts are mentioned as PIP interventions. Perhaps acknowledging staff who have a high percentage of services delivered via the preferred approach of clients – video, telephone, in person – would have been useful to encourage adhering to beneficiary wishes. But this would also require an effort to capture, record, and share with staff each beneficiaries' preferences.						

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
There was no indication this occurred. And there are no indications of any special efforts to encourage staff to shift to or maintain telehealth services outside of the initial doxy.me training and telehealth memo. Finally, as identified by the BHC CalEQRO PIP consultant, there is a partial overlap in populations with the clinical PIP, in the area of crisis/inpatient discharges who are not open to the MHP before the admission. Both PIPs seek to reduce no-shows. To the extent these populations overlap determining which intervention is impacting no-shows would be challenging. Starting in March 2020, this PIP appears to utilize a retrospective evaluation of data from the telehealth shift occurring from March 2020, and there are no unique interventions described that support or encourage staff continued use of the telehealth modality. As configured, this activity does not constitute a PIP. "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: • Develop a new PIP topic and conclude activities in this current area.						
The TA provided to the MHP by CalEQRO consisted of: • By way of background, the MHP did not reach out early in the identification or writing of this PIP to see CalEQRO feedback. • During the PIP session, MHP staff were encouraged to review alternate potential PIP topics and strategies early and often with the incoming reviewer.						

INFORMATION SYSTEMS REVIEW

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

Key ISCA Information Provided by the MHP

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

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

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Solano	3.00%	3.00%	3.00%	3.00%
Medium MHP Group	n/a	3.28%	3.34%	3.01%
Statewide	n/a	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

☐ Under MHP control
☐ Allocated to or managed by another county department
☒ Combination of MHP control and another county department or agency

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

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☐ Yes	☒ No

Business Operations	Status	
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☐ Yes	☒ No
If the BCP status is “No,” the MHP uses an Application Service Provider (ASP) model to host the EHR system, which provides 24-hour operational support.	☒ Yes	☐ No
If the BCP status is “Yes,” it is tested at least annually.	☐ Yes	☒ No
There is at least one person within the MHP clearly identified as having responsibility for information security.	☐ Yes	☒ No
If no one within the MHP is identified as having responsibility for information security, the parent agency or county IT assume responsibility and control of information security.	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

- The MHP is available on social media @solanocountybh on Facebook, Instagram and Twitter.

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	60%
Contract providers	39%
Network providers	1%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

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

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	2.5	.5	1	1
2019-20	3	0	0	0
2018-19	3	0	0	0

- The Solano County IT Department is restructuring staff and responsibilities. While additional positions have been approved by the County Board of Supervisors, it has yet to be made clear how much total staff time will be allocated to Avatar Support vs multiple other systems being supported within the larger department and its multiple divisions.

- The MHP is currently recruiting for 1.5 FTE due to 1.0 FTE retirement and .5 FTE staff for data warehouse support.

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	1	1	0	0
2019-20	0.50	0	0	0
2018-19	1	0.50	0	0

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

- Solano Behavioral Health was able to obtain a Data Analyst from the Department's Public Health division. This Data analyst position is the first where the role is dedicated solely to data Analysis with Solano MHP.

Summary of User Support and EHR Training

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

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	64	34	98
Clinical Healthcare Professional	137	57	194
Clinical Peer Specialist	3	0	3
Quality Improvement	21	4	25
Total	225	95	320

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

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

Type of Staff	MHP FY 2020-21	Medium MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	2.50	7.87
Total EHR Users Supported by IT (Source: Table 17)	320.00	572.00
Ratio of IT Staff to EHR Users	1:128	1:73

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	26
Number of county-operated telehealth sites	13
Number of contract providers' telehealth sites	13
Total number of beneficiaries served via telehealth during the last 12 months	2982
• Adults	1853
• Children/Youth	947
• Older Adults	182
Total number of telehealth encounters (services) provided during the last 12 months:	25,616

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

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

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

- The MHP conducts most meetings via Zoom, or similar application during COVID-19 pandemic.
- For those working remotely the infrastructure was enhanced with Windows Desktop. This process required an extra log on, and it took longer to save documents, but provided a more secure environment.
- The DoIT chose the free version of Doxy.me as the platform to deliver telehealth services during the COVID-19 pandemic.

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

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

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

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

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

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Bay Area Community Support	1
Psynergy	2
Seneca	1

Current MHP Operations

- The MHP continues to use Avatar, hosted by Netsmart Technologies, as its EHR. The Avatar system provides Practice Management, Clinical Workstation, and Managed Services.
- The MHP uses an Application Service Provider (ASP) to maintain and support the EHR.

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

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Avatar	CWS, Practice Management,	Netsmart	7	Netsmart

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
	Managed Services			
Order Connect	Prescriptions, Labs	Netsmart	7	Netsmart
Perceptive	Document Imaging	Hyland	2	Netsmart
Assessment Engine	Assessment	Netsmart	2	Netsmart
Reaching Recovery Portal	Assessment	Netsmart	1	Netsmart

Major Changes since Prior Year

- Implemented the new Client Service Plan.
- Deployed document imaging/scanning.
- Implemented Universal Assessment.
- Effective September 2020, the Recovery Needs level of care element of Reaching Recovery was integrated into the clinical assessment process in the EHR.
- Deployed Psychiatric Referral form for children.
- Moved from 270/271 Eligibility Checking in Avatar to an alternative process developed by Solano Fiscal department.

The MHP's Priorities for the Coming Year

- Support state data reporting development: 274 Expansion, CalAIM and any requirements that are mandated in FY 2021-22.
- Support state data reporting maintenance: Client Services Information (CSI) Assessment, CSI legacy, NACT, Child and Adolescent Needs and Strengths (CANS) /Pediatric Symptom Checklist-35 (PSC-35).
- Complete the full implementation of the Reaching Recovery toolset.
- Make improvements to telehealth services process, including exploring acquisition of the most reliable, user friendly platform possible.

- Move forward with interoperability and patient blocking.

Other Areas for Improvement

- Ensure that all beneficiaries in the adult system of care receive a baseline score in RR-RNL.
- Establish a policy and procedure to capture retroactive Medi-Cal eligibility.
- Update the MHP's public facing website to include information on the Wellness and Recovery Centers.
- Update the MHP website to make information that beneficiaries and the public may be seeking more readily available including links to the provider directory and transportation services information.

Plans for Information Systems Change

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

MHP EHR Status

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

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts		☒	☐	☐	☐
Assessments		☒	☐	☐	☐
Care Coordination		☐	☐	☐	☐
Document Imaging/Storage		☒	☐	☐	☐
Electronic Signature—MHP Beneficiary		☒	☐	☐	☐
Laboratory results (eLab)		☒	☐	☐	☐
Level of Care/Level of Service		☒	☐	☐	☐

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Outcomes		☒	☐	☐	☐
Prescriptions (eRx)		☒	☐	☐	☐
Progress Notes		☒	☐	☐	☐
Referral Management		☐	☐	☒	☐
Treatment Plans		☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		11	0	1	0
FY 2019-20 Summary Totals for EHR Functionality:		8	0	4	0
FY 2018-19 Summary Totals for EHR Functionality:		7	0	5	0

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

- Alerts were deployed since the last EQR.
- The initial module of the Reaching Recovery tool has been incorporated into clinical assessments. Staff are utilizing the tool for all clinical assessments and transition determinations.

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	95%	Monthly
Direct data entry into MHP EHR system by contract provider staff	5%	Weekly
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	0%	Not used

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

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

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

EHR Vendor	Product	Count of Providers Supported
My Harmony	Harmony EHR	1
Cerner	Anasazi	1

EHR Vendor	Product	Count of Providers Supported
Exym LLC	Exym	1
Credible	Credible	1
ContinuumCloud	Welligent	1
	Online Assistant	1
Azzly	eChart	1

Personal Health Record

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

☐ Yes ☒ No ☐ Implementation Phase

Expected implementation timeline:

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

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

Table 28: PHR Functionalities

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

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

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

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

Table 29: Summary of CY 2019 SD/MC Claims

Solano MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**106,166**	**$35,169,479**	**5,071**	**$1,418,697**	**3.88%**	**$33,750,782**	**$30,447,327**
JAN19	9,415	$3,149,999	354	$100,338	3.09%	$3,049,661	$2,742,389
FEB19	8,777	$3,085,465	330	$200,078	6.09%	$2,885,387	$2,543,201
MAR19	9,497	$3,287,067	259	$141,473	4.13%	$3,145,594	$2,850,709
APR19	9,850	$3,258,769	242	$110,236	3.27%	$3,148,533	$2,849,995
MAY19	9,997	$3,090,325	186	$52,398	1.67%	$3,037,927	$2,785,405
JUN19	7,780	$2,615,031	150	$57,524	2.15%	$2,557,507	$2,353,073
JUL19	8,942	$2,864,039	910	$144,294	4.80%	$2,719,745	$2,456,804
AUG19	9,354	$3,035,965	1,121	$208,371	6.42%	$2,827,594	$2,463,963
SEP19	9,149	$2,979,917	973	$206,855	6.49%	$2,773,062	$2,439,135
OCT19	9,132	$3,006,213	327	$94,855	3.06%	$2,911,358	$2,645,938
NOV19	7,465	$2,478,932	133	$41,773	1.66%	$2,437,159	$2,243,137
DEC19	6,808	$2,317,759	86	$60,503	2.54%	$2,257,256	$2,073,579
The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments from Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.							
Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2019 was **2.99 percent.**							

During CY 2019 the MHP experienced claims submission delays which resulted in a significant number of claim transactions not being included in the below analysis for CY 2019 results.

Table 30 summarizes the top five reasons for claim denial.

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

Solano MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Beneficiary not eligible or non-covered charges.	2,992	$711,691	50%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	455	$165,407	12%
Medicare or Other Health Coverage must be billed before submission of claim.	396	$149,966	11%
Beneficiary not eligible.	305	$148,766	10%
Service line is a duplicate and a repeat service procedure code modifier not present.	568	$144,802	10%
Total	5,071	$1,418,697	n/a
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

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

NETWORK ADEQUACY

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

Network Adequacy Certification Tool Data Submitted in April 2020

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

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS request 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 Solano the time and distance requirements are 60 minutes and 30 miles for mental health services, and 60 minutes and 30 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

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

Review Sessions

CalEQRO was unable to conduct key informant interviews with beneficiaries or caregivers of children and youth during this review due to reassignments and staffing issues related to the COVId-19 pandemic.

Findings

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

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

Not applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

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

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

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	4
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	5
NPI Type 1 number reported is associated with two or more providers	0

Description of NPI Exceptions	Number of Exceptions
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	0

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO was unable to conduct consumer focus groups for this review. The impact of COVID-19 on staffing levels and assignments was a barrier to these sessions.

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 32 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 32: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	9
For this review, which was mainly performed as a limited virtual review without beneficiary focus groups, the MHP's website was explored for useability and ease of access to information about services. Direct validation with beneficiaries could not occur. The homepage prominently lists the Access Line, with a phone number and support for both Spanish and English. The review team could not identify a global translation function for all languages. Instead, most important elements contain individual Spanish and English language translations, with some also containing Tagalog. The TRUEcare map provides a degree of information about type of services, in English, Spanish and Tagalog. One of the QI action plans targets improved communication of resources mapped in web-based and printed formats. Transportation information is addressed at the end of the telephone directory, and refers readers to Solano Transportation Authority link, which was not active when initially tested. Non-medical transportation is available through the Partnership Health Plan; however, requests must be submitted five days in advance. There is no textual information that describes alternatives for obtaining transportation assistance, other than references to external providers. While the review team understands that much			

Component		Maximum Possible	MHP Score
of the website design follows a universal countywide format, there are areas that could be improved for usability. The provider directory was last revised in April 2021 in both English and Spanish. It is located under the QI tab, a location required by DHCS. There is also a link to the English and Spanish directories under the Access To Services tab. The Network of Care site also possesses a translation feature, but contains slightly less comprehensive information compared to the TRUEcare map. The website's "Who we are" section provides a high-level description of supportive services and the Behavioral Health Wellness and Recovery Unit (WRU), which broadly outlines peer support specialists, family supports, and wellness and recovery action plan (WRAP) groups. Specific information about the wellness and recovery centers was not be found on the SCBH website. Interested parties must know to search for Caminar in Solano County. Integrating wellness center information, including a prominent link to Caminar on the MHP's website, would be helpful to those who are seeking supportive services. The review team confirmed that multiple flyers and brochures were available on the website. Efforts to review the website with adult beneficiaries and caregivers of children and youth may furnish more feedback as to important and useful improvements that would create greater usability.			
1B	Capacity Management	10	9
The MHP assesses the cultural, ethnic, racial, and linguistic needs of its eligibles, and describes specific strategies to improve access for each subgroup. The Diversity and Equity Plan contains this type of analysis with interventions that include training and funding of specific programs that reach target populations. Incorporation of the Culturally and Linguistically Appropriate Standards (CLAS) are included, and specific elements referenced for each component. Actions include faith-based services, and an emphasis on the Filipino population the Hispanic/Latinx, LGBTQ, and much more. Specific action plans are detailed and comprehensive. Penetration rates are also tracked by these key groups, with data through the FY 2019-20 period. The TRUEcare map is evidence of one strategy to improve access for those who prefer a non-English language, specifically those who speak Tagalog or Spanish.			
1C	Integration and Collaboration	24	18
Integration and collaboration occur with the Solano County Office of Education, which includes the "Faith and Education Collaborative." This aspect works with local churches that recruit volunteers for school-based wellness centers. There is also the African-America Faith-Based Initiative Mental Health Friendly Communities project.			

Component	Maximum Possible	MHP Score
Caminar's Jobs Plus program offers services that support and assist employment pursuits of beneficiaries. There is evidence of efforts to improve primary care communication, including coordination and involvement when termination of mental health services is being planned. Emergency department partners meet monthly or bimonthly to discuss challenges and beneficiary transfers.		

Timeliness of Services

As shown in Table 33, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 33: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	13
The MHP follows the ten-business day standard for first offered outpatient services and tracks electronic as well as other requests, evaluated quarterly. Adults experiences a very brief wait time (2.51 day mean), FC is slightly more (8.84-day average), with children's slightly exceeding standard (10.2-day average). Except for children's services (73.01 percent), all other populations exceed the 75 percent standard achievement expectation. Beneficiary focus groups could not be conducted for this review; however, staff sessions confirmed efforts to achieve quick access to care. While these participants could not recall being provided with periodic reports on their timeliness, there was sense of urgency and quick access was identified.			
2B	First Offered Psychiatry Appointment	12	4
The MHP utilizes the 15-business day standard. It is unable to report out data on this element due to lacking a mechanism to identify the decision point or referral to psychiatric services. However, a modification to the "referral for psych services" form will, upon implementation, enable capture of offered and accepted date fields for child psychiatry. The MHP states that psychiatry is standard of care for adults but did not set forth a time for starting to report this metric.			
2C	Timely Appointments for Urgent Conditions	18	5
The MHP states that it lacks a mechanism for reporting of time from urgent service request to actual encounter in hours and did not report this information in days. Beneficiaries presenting to the crisis unit are all assessed. While listing the 48- and			

Component		Maximum Possible	MHP Score
96-hour standards, there was no indication of which services apply to each metric. The MHP references crisis unit presenters are all assessed; non-routine assessment needs are met within 3 days and provided no data on those events.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	9
The MHP's psychiatric inpatient unit discharge follow-up standard is 7-days for clinical follow-up and 30-days for psychiatry. The reported data indicated means of 16.05 days for adults and 17.46 days for children. The standard is met 19.19 percent for adults and 38.36 percent for children. No FC data was reported. Follow-ups occurring more than 60 days after discharge are considered outliers and excluded from calculations. A PIP was established that focused on improving follow-up of individuals who are not open to MHP outpatient services at the time of admission.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The MHP rehospitalization rates of 17.49 percent for adults could be better, but the 9.02 percent for children and youth is relatively low. MHP improvement activities focused on engaging inpatient and crisis discharges who were not open to outpatient services at the time of admission may improve (decrease) readmission rates.			
2F	Tracks and Trends No-Shows	10	7
Across all measured populations, the MHP has a 20 percent no-show standard for psychiatry and 10 percent standard for non-psychiatry clinicians. Adult service results for non-psychiatry were 8.74 percent, and 3.47 percent for children and youth. Psychiatry no-shows have a high in adult services of 14.53 percent and children's' services have approximately half of that, 7.28 percent. Reported data includes only the MHP's directly operated programs, and not contract entities.			

Quality of Care

In Table 34, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 34: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	11
The MHP efforts in cultural competence are inclusive of diversity and equity, and focused on implantation of the CLAS standards. There are significant efforts to promote and ensure both contract agencies and county employees at all levels receive regular, ongoing training in these areas. The goals of 2020 included community empowerment, policy and systems change, and improving access to language assistance. Accomplishments included greater involvement of stakeholders in regular input that increased the frequency that issues were discussed, and participants informed of strategies and progress. The MHP's activities identified communication strategies to ensure underserved groups received relevant information regarding access and treatment. Also, the MHP partners with relevant community entities to implement actions plans developed by those who are intended to be impacted. The focus in this this area was upon the Latino-Hispanic, Filipino and LGBTQ, but is expanding to further focus on African Americans and Native Americans. The MHP's plan was updated for 2021.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	11
The MHP meticulously tracks and reports utilization of all levels of care, with a strong emphasis on the highest levels. This includes tracking and trending Welfare and Institution (W&I) conservatorships, temporary conservatorships and W&I 5270s (30-day involuntary treatment stays. They also track monthly total hospitalizations and average length of stay. Tracking by month the average numbers treated at the county facility vs. those in other facilities provides information about the need and frequency of using additional resources. The monthly TIC Leadership Collaborative is intended to assist in bridging barriers to appropriate movement of beneficiaries between levels of care that often involve both			

Component		Maximum Possible	MHP Score
county and contract programs. The process has reportedly worked so well that it has expanded to include homeless outreach and mobile crisis services. Implementation of the Reaching Recovery suite of instruments is another step towards improvements in the matching of services to the needs of beneficiaries, which is clearly a goal of this MHP. Extensive maps of services for both children's and adult systems of care exist that provide extensive detail as to the service levels available to beneficiaries. The transitions in care meeting are used to evaluate the needs of individuals being considered for step up or down in level of care.			
3C	Quality Improvement Plan	10	9
The MHP's current QAPI work plan contains baseline data for most metrics under review. Cultural competence does not exist alone in the Disparities and Equity Plan but has tracked QI metrics related to trainings. Specifically tracked are the data of Latinx posters distributed and QR code reads that take an individual to the MHP website. This is also true for Filipinex and links to the Solano Pride Center. Measurable goals are described in the plan. For many metrics, the MHP evaluates disparities by clinic site or population. The QAPI quarterly meeting slide decks provide information regarding progress. The MHP's is to wait until the end of the year to update the QAPI work plan itself. The slide decks contain more detailed information than typically is entered into the work plan, and if circulated to internal and external stakeholders routinely can be useful. However, common practice is to use a QAPI document as a living document with progress information routinely entered during the course of a fiscal year. Many of the activities and tracking efforts were paused during the pandemic, and have not generated new data; however, the format is comprehensive and should be useful to tracking key areas.			
3D	Quality Management Structure	14	11
The QAPI plan details the position types and FTEs that are engaged in supporting quality activities. The plan breaks out the activities into the categories of quality assurance, quality management, and quality improvement. Each category lists the component activities. There is clear and direct communication between the MHP director and the QI coordinator. Active and concurrent data extraction and analysis is evident in the slide decks created to support quarterly QAPI meetings. The MHP's approach to the recording of meetings does not indicate the role of each participant, and it therefore challenging to identify if there are line staff, contract providers, beneficiaries, or family member involved in the process. It is clear that the MHP has made efforts in this past year to increase the diversity or participation in these meetings. However, the posting or distribution of the slide deck information is unclear. None of the line staff participants could recall receiving this			

Component		Maximum Possible	MHP Score
information. The local decision to wait until the end of the fiscal year to enter quarterly information into the QAPI document may be a missed opportunity to communicate with staff and other key stakeholders the status of important performance measures.			
3E	QM Reports Act as a Change Agent in the System	10	7
The MHP has developed Reaching Recovery RNL tracking reports, to help ensure the completion of baseline and continued administration over time. Both most recent and due treatment plan reports also provide information to staff and supervisors. The MHP has liaisons between QI and clinical programs. Currently the MHP lacks a report for retroactive eligibility and rebilling of claims. While the MHP has developed a mechanism for tracking the first offered psychiatry appointment, as of this review it was unable to produce timeliness data for this important service for either adult of children and youth. Also, the ability to report out urgent service request to actual service does not currently exist. For the FC cohort, there was no post-hospital follow-up timeliness data, 30-day inpatient readmission data, nor no-show data. Comprehensive reporting in these areas could provide better information on system capacity. These issues aside, the MHP does produce extensive reporting which, as already mentioned, appears in the quarterly QI slide decks. In other reports, county suicide deaths by ethnicity are shows, which can help the MHP target prevention efforts. Direct sharing of this type of information with stakeholders could prove beneficial to services and MHP operations.			
3F	Medication Management	12	2
For this review, the MHP provided a report of children and youth prescribed psychotropics during FY 2021, height, weight, BMI, BP, pulse, and lab date. This type of reporting supports identification of unhealthy metrics and development of medical action plans. No policies and procedures, or prescribing guidelines were furnished for this review. Coordination between psychiatry and primary care was identified as infrequently occurring during sessions in this review. There was no evidence of overall medication monitoring results or protocols provided in the submissions for this review. The JV-220 process is required for FC psychotropic medications, which mandates review and oversight. No aggregate summary for that activity was provided.			

Beneficiary Progress/Outcomes

In Table 35, 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 35: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	11
The MHP uses the CANS and PSC-35 routinely with all children and youth. Both are administered at intake, every six months thereafter, and at exit from treatment. With adult beneficiaries, the Reaching Recovery, Recovery Needs Level is used at intake, and every 12 months, or if there is a significant change, and at exit from treatment. This clinician completed instrument identifies the level of services required by each individual. The MHP has created a matching list of services and programs that align with the RNL scores. As of this review, the MHP is working to ensure that each beneficiary has a baseline RNL completed. The next step be adding the Recovery Marker Inventory (RMI), which is an objective rating of eight factors associated with current recovery status: employment, housing, education, symptom management, etc. The MHP does not have the capacity to aggregate and regularly report out on instruments for children and youth. The adult Reaching Recovery instrument implementation has yet to reach a phase which would suggest benefit from program or aggregate analysis. Thought has been given to development of a contract for aggregation and analysis in the future.			
4B	Beneficiary Perceptions	10	5
The MHP utilizes the DHCS CPS for tracking the feedback of beneficiaries. The MHP has a mechanism for sharing the results with leadership, the Behavioral Health Board, contract providers and beneficiaries.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	9
As previously mentioned, wellness center information is not routinely provided to all individuals engaged in treatment. Individually, the decision is made by clinical staff based on the perceived needs of each beneficiary.			

Component	Maximum Possible	MHP Score
Peers and line staff who provided information during this review possessed differing understandings of wellness center participation requirements. Current or recent enrollment in treatment is preferred, related to limited capacity. Contract changes have resulted in Caminar becoming the sole provider of wellness centers, located in Vallejo, Fairfield, and Vacaville, the latter being a part-time program. A link to Caminar on the MHP's webpage could be a useful way of providing information to the community, caregivers and potential or current beneficiaries. Line staff understand wellness program referrals typically come from peer support specialists. The specialist/advocates often are engaged in monitoring waiting rooms and interacting with beneficiaries. During the course of those interactions, they may provide information about other resources and the wellness center programs.		

Structure and Operations

In Table 36, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 36: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	24
The MHP provides the majority of MHP contracted service types in the DHCS MHP contract, with the exception of day treatment intensive. It does offer day rehabilitation services to children and youth at the Sierra School outside Vacaville. Local therapeutic foster care (TFC) remains a challenge, and despite continued efforts this level remains locally unavailable. The MHP created the Crisis Aftercare and Recovery Engagement (CARE) team within the Hospital Liaison (HL) unit, intended to support unconnected individuals who are discharged from inpatient or crisis services. CARE provides bridge services for the period of up to 60 days, until connected to outpatient care. A streamlined process for referral and entry into the Rosewood Crisis Residential Treatment (CRT) program was developed, eliminating or reducing the logistical barriers that had impeded admission of needy individuals. The impact is to lower the wait time to within one to three days of identification.			

Component		Maximum Possible	MHP Score
5B	Network Enhancements	18	14
Solano increased the use of telephonic and video telehealth services, using the free version of Doxy.me. Review participants experienced the free version of Doxy.me to manifest technical issues, for which there is no support with a free version. The feature-set is also limited in the free version. These issues may result in using telephone only when the beneficiary would prefer a video link. Ongoing efforts to deliver services in the method preferred by the beneficiary are occurring. The intent is to continue telehealth post-pandemic as it aligns with preferences and capabilities of beneficiaries, anticipating those fewer no-shows and increased productivity and satisfaction will occur. The MHP's clinics are collocated with county health service providers, but ongoing coordination and true ongoing collaboration continue to be an ideal to be fully realized. Wellness centers have been consolidated under the Caminar umbrella. Mobile crisis teams are in the process of phase-in, with hours and location of operations still being tested. The Hospital Liaison CARE team is an aspect of care continuity intended to improve linkage of non-open individuals with a crisis or inpatient event to outpatient assessment and follow-up treatment.			
5C	Subcontracts/Contract Providers	16	10
The MHP engages a number of contract entities to assist with delivery of services. This is particularly prominent with the children's system of care. Caminar operates the wellness centers distributed among the largest cities in the county. This provider also operates a FSP and older adult (OA) program. Crestwood operates a CSU and psychiatric health facility (PHF) for the MHP. Mobile crisis response is contracted to Uplift Family Services. The MHP stated there are plans to initiate regular contract provider meetings in the near future. No surveys or feedback results were shared during this review. Due to the abbreviated review process dictated by the impact of COVID-19 on staffing, a contract provider session was not conducted.			
5D	Stakeholder Engagement	12	7
The Wellness and Recovery Unit is developing a strategy for the inclusion of beneficiary and family member voice and has started a recruitment process and training for advocates to serve on system of care committees and workgroups. The goal is to engage youth, families and adult peers in standing committees, and reimburse for travel and participation with gift cards. Current examples include the			

Component		Maximum Possible	MHP Score
following: Peer Support Network, Diversity and Equity Committee, and Wellness and Recovery Event Planning.			
5E	Peer Employment	8	4
Within the MHP there is a single category devoted to peers, but opportunities exist to apply for the mental health specialist category – which is a higher level and does not require lived experience. This is not, however, an automatic process. Input during the review indicated a desire for the specialist category to be aligned with the social worker pay and steps. Within the Solano MHP the debate continues as whether effort should be put in the creation of dedicated lived experience positions or providing peers with the training and experience necessary to qualify for open recruitment of existing categories. Currently, efforts seem to be shifting towards the latter. Caminar is contracted to provide the Jobs Plus program, which operates in partnership with the department of rehabilitation. Contract agencies also employ peers, but the levels, types, and distribution of positions was not available for this review.			

SUMMARY OF FINDINGS

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

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Submission determined not to be a PIP (not rated)

Non-clinical PIP Status: Submission determined not to be a PIP (not rated)

Access to Care

Changes within the Past Year:

- Increased use of telehealth – both telephone and video-supported.
- More efforts to bridge linguistic gaps in access to care.

Strengths:

- The TRUECare Roadmap, posted to SCBH website, is available in English, Spanish, and Tagalog, and provides an interactive informing experience to the MHP and community resources.
- The MHP has considered the improvements to productivity and reductions in no-shows related to telehealth to initiate efforts to sustain those non-in-person services where they meet the needs of beneficiaries.

Opportunities for Improvement:

- The MHP's website lacks easy access to information about transportation availability and options.
- Additional links on the MHP's homepage to Caminar and the wellness and recovery programs could provide improved support to beneficiaries and caregivers as well as low threshold access opportunities.

Timeliness of Services

Changes within the Past Year:

- The Referral for Psych Services form creates a mechanism for tracking timeliness of psychiatry services with fields for offered and accepted dates.

Strengths:

- First offered appointment presents a very brief time and high achievement of standard for most populations.

Opportunities for Improvement:

- Line staff do not routinely receive their timeliness performance.
- Capture and reporting of first offered psychiatry appointments remains in process and yet to produce data.
- Post-hospital follow-up reflects data that exceeds the 7-day standard by 128 percent for adults and more for children and youth.

Quality of Care

Changes within the Past Year:

- Increased focus on clinical quality of care, including improved reporting of outcomes, investment in outcome tools and Avatar enhancements.

Strengths:

- Evidence of a strong focus on interventions that improve awareness of mental health services and increase access to care for the diverse populations served by the MHP. This includes LBGTQ, Latino-Hispanic, Filipino, African Americans, and Native Americans.
- The MHP mapped its services to levels of care that include both county and contract provider programs and developed a TIC meeting that serves to review level-of-care changes of individuals who are going to both higher and lower levels of care.
- The adoption of RR toolset should provide robust information that will assist in guiding level of care conversations and decisions.

Opportunities for Improvement:

- Ensure all adult beneficiaries received a baseline RR-RNL score.
- Evaluate results of the RNL to inform the adoption of the next RR toolset element implemented for the MHP’s beneficiaries.

Beneficiary Outcomes

Changes within the Past Year:

- Implementation of the RNL instrument, which improves aligning beneficiary needs with programs and services.

Strengths:

- The MHP is clearly moving to improve the integration of outcome instruments with evaluating treatment results and to inform changes of intensity of services.

Opportunities for Improvement:

- The MHP does not possess the technology for aggregating CANS and PSC-35 data to provide analysis of program results.

Foster Care

Changes within the Past Year:

- Since the previous EQR review, SCBH expanded Intensive Care Coordination (ICC) service eligibility to include all youth who are open to two or more of: MH, Child Welfare Services (CWS), probation, regional center, substance use disorders, and special education.

- Seneca Center, which provides SCBH wraparound services, was contracted to be the Family Urgent Response System (FURS) mobile response provider. Seneca already serves a number of nearby counties as the FURS provider. As of March 2021, Seneca was able to receive calls from the FURS state hotline.

- SCBH assisted Solano CWS by providing training to three in-county short-term residential treatment (STRTP) programs, assisting them to become Medi-Cal certified. They are now able to provide specialty mental health services and are contracted with the MHP.

Strengths:

- The most recent penetration rate for FC youth (CY 2019) of 52.46 percent is higher than both the average medium-sized county (50.12 percent) and the statewide average (51.91 percent).

- SCBH conducts medication monitoring consistent with the requirements set forth in SB 1291 and incorporates the resultant information in the Clinical Quality Review Committee discussions, every other month. An Avatar report tracks prescriptions for youth, and relevant parameters of height, weight, BMI, pulse, and blood pressure. Dates of ordered lab work is also included. These reports flag polypharmacy, and metabolic

monitoring. The MHP's reports its CY 2019 FC prescribing is below that of the medium sized MHP as well as overall statewide average.

- The MHP created a FC code, accessible on beneficiary registration information, which supports the separate tracking of these individuals in reporting of timeliness and other metrics.
- The MHP created a dedicated sub-code for ICC that is used only for Child and Family Team (CFT) meetings. This supports distinguishing routine ICC services from the 90-day CFT requirement. This ensures that required CFT frequency is maintained.
- In January 2020, SCBH streamlined the process for sending presumptive transfer records to other MHPs, with those in active SBCH treatment having their records sent to the receiving county. Two SCBH staff ensure HIPAA and other confidentiality protocols are followed. Contact information from the current treatment agency is also provided.

Opportunities for Improvement:

- The MHP and CWS continue to lack a global data/information sharing agreement. A universal release of information that supports information sharing is not available.
- Despite multiple efforts to reach out to foster family agencies with the aim of developing therapeutic foster families, results have not been forthcoming. The risks of failing to meet rate requirements, in addition to the complexity and risks of denials once services are delivered, reportedly create barriers to establishing these services.

Information Systems

Changes within the Past Year:

- Implemented the new client service plan.
- Deployed document imaging/scanning.
- Implemented Universal Assessment.
- Effective September 2020, the RNL of the RR instrument suite was integrated into the clinical assessment process in the EHR.
- Deployed the Psychiatric Referral form for children.
- Moved from 270/271 eligibility checking in Avatar to an alternative process developed by the Solano Fiscal department.

Strengths:

- None noted.

Opportunities for Improvement:

- Retroactive Medi-Cal eligibility lacks a process for identification and claiming related services.
- The MHP's public-facing website lacks information about the wellness and recovery centers.
- Key website content areas are not prominently displayed – such as the provider directory and information related to transportation services.

Structure and Operations

Changes within the Past Year:

- The MHP implemented a HL/CARE Team, providing 60 days of bridge services to help newly served beneficiaries transition back into the community and engage with treatment after a crisis or inpatient hospital stay.

Strengths:

- Overall, organizational changes have prioritized removal of barriers and creation of speedy access to care processes that should enhance the treatment experience of beneficiaries.
- A streamlined CRT referral and admission process will reduce the barriers and wait-time for speedy engagement in this critical service.

Opportunities for Improvement:

- The free version of Doxy.me, used by many staff for video supported telehealth, lacks support and technical features of the paid version.
- Staff are anxious that coming changes to the work schedule may result in the loss of options to work from home and have other alternative schedules.
- Recurring meetings with contract agencies as a group, outside of those focused on pandemic response, have not been occurring. This type of meeting could serve as an avenue to hear from this important stakeholder group and communicate information that is relevant to their operations.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: SCBH to review data, speak with stakeholders, and identify a clinical PIP topic, followed by early and frequent consultation with the incoming CalEQRO lead reviewer. DHCS contractually requires two active PIPs per Title 42, CFR, Section 438.330.

Recommendation 2: SCBH to review data, speak with stakeholders and identify a clinical PIP topic, followed by early and frequent consultation with the incoming CalEQRO lead reviewer. DHCS contractually requires two active PIPs per Title 42, CFR, Section 438.330.

Access to Care

Recommendation 3: Update the MHP's public facing website to include information on the wellness and recovery centers, and information about transportation assistance.

Timeliness of Services

Recommendation 4: Begin regular reporting and analysis of psychiatry first offered timeliness and urgent services time from request to appointment.

Quality of Care

Recommendation 5: Complete training of staff and implementation of the key Reaching Recovery measures.

Beneficiary Outcomes

- None noted.

Foster Care

Recommendation 6: Continue work with child welfare on the development and support of therapeutic foster care providers.

Information Systems

Recommendation 7: Establish a policy and procedure process to regularly capture and claim for retroactive Medi-Cal eligibility.

Structure and Operations

- None noted.

SITE REVIEW PROCESS BARRIERS

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

During the FY 2020-21 review, and 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 Solano MHP. Therefore, a modified virtual/desk review agenda was conducted. The MHP submitted the requisite letter to DHCS detailing the specific circumstances, which is included in the final report submission.

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May 5, 2021

Samantha Fusselman, LCSW, CPHQ
Executive Director, CalEQRO
Behavioral Health Concepts, Inc.
5901 Christie Ave., Ste. 502
Emeryville, CA 94608

Dear Samantha:

On December 22, 2020 and in response to a surge in COVID-19 cases in the state, the Department of Health Care Services (DHCS) approved a pause on EQRO review activities through March 1, 2021. DHCS further approved flexibilities beyond March 1, 2021 as the COVID pandemic continued to impact county operations.

Solano County greatly appreciates the consideration of the reduced audit demand in light of the many pressures facing MHPs and the clients we serve in unprecedented times.

Accordingly, Solano County requested flexibility during the May 2021 EQRO MHP review, specifically a desk review and to eliminate the consumer family focus group sessions because of the following related challenges:

- Lack of staff/resources to support consumer/family Zoom sessions in their homes
- Some staff have been reassigned to other Public Health to do Contact Tracing
- Many Consumers do not have personal access to a stable and private phone or video
- Reduced staffing with many staff on FMLA either related to COVID or for other reasons has posed challenges requiring prioritizing direct service care among other staff
- An inability to have enough predictive insight into future demands and system crises that could interfere in proper review planning

Please attach this letter to our FY2020-2021 annual report.

Sincerely,

Sandra Sinz, LCSW
Behavioral Health Director
Solano County

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Data

Attachment D: ACA Penetration Rates and ACBs

Attachment E: ACB Range Distributions

Attachment F: List of Commonly Used Acronyms

Attachment A—Review Agenda

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

Table A1: EQRO Review Sessions

Solano MHP
Performance Improvement Projects
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Peer Employees/Parent Partner Group Interview
Information Systems Capabilities Assessment (ISCA)
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Rob Walton, Quality Reviewer
Leda Frediani, Information Systems Reviewer
Pamela Roach, Consumer-Family Member

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

MHP Review Sites and Participants

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

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Akoni	Cheryl	Clinician (Vallejo Adult)	Solano County Behavioral Health
Bird-Marinucci	Meredith	Clinical Supervisor (Fairfield Adult)	Solano County Behavioral Health
Bolden	Sandra	Peer Support Specialist	Solano County Behavioral Health
Coleman	Denise	Peer Support Specialist	Solano County Behavioral Health
Cordero	Kattera	Clinician (FSP Youth)	Solano County Behavioral Health
Cruz	Ashley	Clinical Supervisor (Inst Care Svcs)	Solano County Behavioral Health
Davis	Amanda	Clinical Supervisor (Vacaville Adult)	Solano County Behavioral Health
De La Cruz-Salas	Leticia	Behavioral Health Administrator	Solano County Behavioral Health
Esters	Cheryl	Compliance Manager	Solano County Behavioral Health
Ezenwa	Yvonne	Planning Analyst	Solano County Behavioral Health
Fahey	Sherry	Clinical Supervisor (Vallejo Youth)	Solano County Behavioral Health
Ford	Freddy	Clinician (Forensics Triage)	Solano County Behavioral Health
Fulford	Joseph	Sr. Staff Analyst	HSS Administration
George	Rob	Sr. Manager (QI)	Solano County Behavioral Health
Halpin	Danielle	Clinical Supervisor (Foster Care)	Solano County Behavioral Health
Hammons	Leti	Clinician (Access/Central Assess Team)	Solano County Behavioral Health
Harris-Bray	Kerra	Peer/Partner Volunteer	Solano County Behavioral Health
Kautz	Jodi	Peer/Partner Volunteer	Solano County Behavioral Health

Last Name	First Name	Position	Agency
Liberato	Esmeralda	Peer Support Specialist	Solano County Behavioral Health
Lippincott	Greg	Clinician (Vacaville Youth)	Solano County Behavioral Health
Lofton	Theresa	MH Specialist (Foster Care)	Solano County Behavioral Health
Lucchesi	Michael	Clinician (Inst Care Svcs)	Solano County Behavioral Health
Ma	Devin	Clinician (QI)	Solano County Behavioral Health
Morales	Carlos	Clinician (Fairfield Adult)	Solano County Behavioral Health
Neal	Kristin	Policy & Financial Manager	Solano County Behavioral Health
Ortiz	Jose	Info Tech Analyst III	Department of Technology
San Nicolas Tagliaboschi	Laura	Principal Info Tech Analyst	Department of Technology
Schraer	Hilda	MH Specialist (Vacaville Adult)	Solano County Behavioral Health
Sexton	Luke	Office Assistant II (Access/Cent Assess Team)	Solano County Behavioral Health
Seymour	Colby	Clinician (Vallejo Youth)	Solano County Behavioral Health
Shahbazian,	Mary	MH specialist Vallejo adult	Solano County Behavioral Health
Sinz	Sandra	Chief Director Behavioral Health	Solano County Behavioral Health
Spars	Jonathan	Clinical Supervisor (Hospital Liaison)	Solano County Behavioral Health
Stimmann	Christina	Manager (Hospital Liaison and Inst Care Svcs)	Solano County Behavioral Health
Tolentino	Diana	Clinical Supervisor (Access/Central Assess Team)	Solano County Behavioral Health
Uribe	Layla	MH Clinician (Hospital Liaison CARE Team)	Solano County Behavioral Health

Last Name	First Name	Position	Agency
Whall	Mary Kate	Clinical Supervisor (QI)	Solano County Behavioral Health
Wilson	Eleanor	Info Tech Analyst III	Department of Technology
Woodhall	Cathy	Office Coordinator (QI)	Solano County Behavioral Health

Attachment C—Approved Claims Data

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

Attachment D—ACA Penetration Rates and ACBs

Table D1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

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

Solano MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Medium	519,441	20,353	3.92%	$121,346,017	$5,962
MHP	32,212	1,176	3.65%	$6,335,048	$5,387

Attachment E—ACB Range Distributions

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

Table E1: CY 2019 Distribution of Beneficiaries by ACB Range

Solano 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	4,441	92.12%	93.31%	$18,631,121	$4,195	$3,998	57.07%	59.06%
>$20K - $30K	191	3.96%	3.20%	$4,604,896	$24,109	$24,251	14.11%	12.29%
>$30K	189	3.92%	3.49%	$9,409,623	$49,786	$51,883	28.82%	28.65%

Attachment F—List of Commonly Used Acronyms

Table F1: List of Commonly Used Acronyms

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

Acronym	Full Term
COVID-19	Corona Virus Disease-2019
CPM	Core Practice Model
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CURES	Controlled Substances Utilization Review and Evaluation System
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FTE	Full Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

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

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

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