Behavioral Health Concepts, Inc.
info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2022-23
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

MENDOCINO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

December 01, 2022

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Mendocino" may be used to identify the Mendocino County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — December 01, 2022

MHP Size — Small

MHP Region — Superior

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	5	0	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	9	1	0
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**23**	**3**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
"Social Skill Development for clients transitioning to Adulthood from TAY status"	Clinical	09/20	Other: Complete	High
"Reducing recurrent inpatient hospitalization in the community"	Non-Clinical	09/20	Other: Complete	High

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other	7

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Seven and 30-day post psychiatric inpatient follow-up rates exceed statewide averages.
- The newly opened Crisis Residential Facility gives Mendocino County another level of care (LOC) within the county.
- The MHP has a systematic clinical continuum of care to assist clinicians to develop ongoing treatment plans and adjust LOC service needs.
- Looking at resources within the tribal community, National Alliance on Mental Illness (NAMI) and the MHP worked to develop a Native Connections Partnership.
- The MHP has entered into an agreement with California Mental Health Services Authority (CalMHSA) for assistance in implementing California Advancing and Innovating Medi-Cal (CalAIM). They are considering whether Streamline's SmartCare™ Electronic Health Record (EHR) Solution for Multi-County Behavioral Health Initiative in California would be useful for Mendocino County.

The MHP was found to have notable opportunities for improvement in the following areas:

- Beneficiary health information is maintained in disparate EHR systems which limits 24/7 access to this information.
- Latino/Hispanic beneficiaries had nearly twice the rate of single services (13.64 percent) compared to White beneficiaries (7.22 percent), suggesting disparity in engagement and retention.

- The rate of deferred diagnosis is more than four times greater than the statewide average (17.1 percent vs. 3.9 percent). At the same time urgent service requests are defined as crisis, which may contribute to the high rate of deferred diagnoses.
- The MHP meets its timeliness standards for first non-urgent appointment offered and service delivered less than 70 percent of the time overall.
- Stakeholders reported limited opportunity to give their input and/or involvement in system planning and implementation.

Recommendations for improvement based upon this review include:

- To eliminate disparate EHR databases and allow 24/7 access to beneficiary heath information, consider permitting full contract provider access to the replacement EHR system.
- Research possible reasons for the higher Latino/Hispanic single service percentage and design culturally appropriate ways to increase engagement.
- Research possible connection between deferred diagnosis and urgent/crisis services. Consider the opportunity to redefine urgent services disparate from crisis to offer an opportunity for a more complete assessment and engagement of urgent service request clients.
- Research the low percent of non-urgent appointments offered and rendered that meet the 10-day standard. Design and implement a plan to increase this number.
- Reach out to different groups of beneficiaries (wellness centers, TAY, etc.) to offer information and resources on how they can be involved in committees, volunteer work, collaborate with NAMI, and other ways they can have a voice in the system of care.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services 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). The EQRO conducts an EQR that is an analysis and evaluation 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 (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs, comprised of 58 counties, to provide specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal MHP. DHCS contracts with Behavioral Health Concepts, Inc. (BHC), the CalEQRO to review and evaluate the care provided to the Medi-Cal beneficiaries.

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section14197.05).

This report presents the FY 2022-23 findings of the EQR for Mendocino County MHP by BHC, conducted as a virtual review on December 1, 2022.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age youth (TAY); and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Review and validation of each MHP's network adequacy (NA) as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Beneficiary perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 12, then "≤11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP continues to operate without sufficient staffing. While services are increasing being delivered in-person, telehealth is still a valuable tool for the MHP. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

- Mendocino Health and Human Services (HHS) dissolved as of November 2022. Behavioral Health and Recovery Services, as well as Public Health, and Social Services are now separate county departments.
- A newly constructed Crisis Residential Treatment Facility opened in 2022.
- The MHP is creating collaborative alliances with the Native American Tribal groups and NAMI to create an integrated outreach opportunities with local Native American communities.
- The MHP and their contract agencies enhanced a pay differential for bilingual Spanish speaking staff.
- The MHP has entered into an agreement with CalMHSA for assistance in implementing CalAIM.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed 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 Addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2021-22

Recommendation 1: Continue to develop and prioritize the implementation of Personal Health Records (PHRs) for beneficiaries. PHRs enhance beneficiaries' and their families' engagement and participation in treatment.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP's administrative services organization (ASO), Anchor Health Management (Anchor), implemented a personal health record in their EHR, Exym. Beneficiaries can view a medication list and treatment summary.
- The MHP is searching for a replacement EHR for myAvavtar. Due to anticipated selection of a new system, a PHR has not been implemented in myAvatar. A PHR will be included in the replacement EHR project plan.

Recommendation 2: Investigate reasons and implement strategies to recruit and retain bilingual staff. Research current outreach programs (e.g., Promotores network) for possible candidates.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP and provider agencies have continued to work on strategies to recruit and retain bilingual staff.
- The MHP and providers increased the number of bilingual staff over the last year between 8 and12 percent among various programs. In addition, the MHP and

providers now offer bilingual a 10 percent pay differential for bilingual staff, with some variation based on position.

- The MHP and providers continue to research outreach programs for possible candidates for bilingual staff positions.

Recommendation 3: Research and utilize avenues to recruit and retain clinical staff; to include interns and work study programs in collaboration with universities and colleges as appropriate.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP and provider agencies have continued to address clinical staff recruitment and retention, including the following strategies:
    - Relationships with local colleges and universities, such as Humboldt State University, Sonoma State University, and Mendocino College as a recruitment strategy for clinical staff.
    - Internship programs.
    - Job fairs, online employment services, and community events.
    - Sign-on bonuses for challenging to fill or critical positions.
- The MHP also participates in the CalMHSA Superior Region Partnership that provides support for loan repayment, scholarships, stipends, retention activities, and workforce pipeline.
- Clinicians have access to Public Service Loan Forgiveness.
- The MHP and providers investigated wages, training options, morale, and other ways to add value to employment within the field.

Recommendation 4: Research possible transportation assistance options for beneficiaries and ensure that they are aware of any benefits they might have to resolve this issue.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP researched transportation options for beneficiaries. Several options explored included bus, taxi, Uber, and Medi-Cal covered transportation.
- Several meetings occurred with Partnership Health Plan to discuss transportation options within Mendocino County and how to ensure all beneficiaries are aware of this covered service. The MHP has been informing community partners and beneficiaries of free transportation options.
- The MHP continues to provide transportation for clients through case management and offers bus tickets.

Recommendation 5: Implement regular technical assistance (TA) sessions with CalEQRO during the ongoing implementation of the PIPs.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP consulted with BHC regarding the clinical and non-clinical PIPs four times this year. and received technical assistance via videoconference, webinars, telephone, and email.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or beneficiaries) are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which beneficiaries live, equity, as well as accessibility—the ability to obtain medical care and services when needed.[1] The cornerstone of MHP services must be access, without which beneficiaries are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and PMs addressed below.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payor source, approximately 36 percent of services were delivered by county-operated/staffed clinics and sites, and 64 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 98.36 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff. Beneficiaries may request services through the Access Line as well as through a decentralized access system that is responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries may receive screening and assessment directly through the closest outpatient clinic to their residence or the clinic of their choice, including ASO locations.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and/or adults. In FY 2021-22, the MHP reports having provided telehealth services to 1,160 adult beneficiaries, 725 youth beneficiaries, and 204 older adult beneficiaries across 3 county-operated sites and 21 contractor-operated sites. Among those served, 86 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO

[1] CMS Data Navigator Glossary of Terms

for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Mendocino County, the time and distance requirements are 60 miles and 90 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 2021-22

Alternative Access Standards	
The MHP was required to submit an AAS request due to time or distance requirements	☐ Yes ☒ No

- The MHP met all time and distance standards and was not required to submit an AAS request.

Table 1B: MHP Out-of-Network Access, FY 2021-22

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No

- Because the MHP can provide necessary services to a beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries to access services via OON providers.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members. Examining service accessibility and availability, system capacity and utilization, integration, and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

Each access component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

Strengths and opportunities associated with the access components identified above include:

- The MHP has worked this past year in collaboration with the NAMI to create a native connection group.
- The MHP gives a standing invitation for NAMI to Cultural Competency Committee and Quality Improvement Committee (QIC) meetings.
- The MHP oversaw construction completed and the new Crisis Residential facility unit opened, giving Mendocino County more in-county services for beneficiaries.
- The MHP continues working with Redwood Community Services (RCS)to develop capability to create a Child Crisis Residential facility of 4-6 beds.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rates, and Average Approved Claims per Beneficiary Served

The following information provides details on Medi-Cal eligibles, and beneficiaries served by age, race/ethnicity, and threshold language.

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, the MHP's penetration rate of 5.24 percent was 36.1 percent higher than the statewide average. Mendocino's penetration rate ranks 17th of 56 MHPs.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	42,251	2,213	5.24%	$14,226,163	$6,428
CY 2020	39,837	2,406	6.04%	$17,688,237	$7,352
CY 2019	41,635	2,628	6.31%	$19,327,065	$7,354

- Mendocino's PR declined each year from CY 2019 to CY 2021. While total eligibles increased 6.1 percent from CY 2020 to CY 2021 (39,837 vs. 42,251), beneficiaries served decreased 8 percent (2,406 vs. 2,213).
- While stable from CY 2019 to CY 2020, the AACB decreased 12.6 percent from CY2020 to CY 2021 ($7,352 vs. $6,428).

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	4,404	52	1.18%	1.03%	1.59%
Ages 6-17	9,496	707	7.45%	5.00%	5.20%
Ages 18-20	2,047	129	6.30%	4.29%	4.02%
Ages 21-64	22,428	1,225	5.46%	4.15%	4.07%
Ages 65+	3,878	100	2.58%	2.09%	1.77%
Total	**42,251**	**2,213**	**5.24%**	**3.83%**	**3.85%**

- Mendocino's PRs exceeded statewide averages for all age groups with the exception of those ages 0-5.

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	171	7.81%
Threshold language source: Open Data per BHIN 20-070		

- Mendocino had one threshold language, Spanish, and served 171 beneficiaries who identified Spanish as a preferred language.

Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	13,345	557	4.17%	$2,949,500	$5,295
Small	199,673	6,647	3.33%	$36,223,622	$5,450
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The CY 2021, Mendocino's ACA PR was 26 percent greater than the statewide average (4.17 percent vs. 3.31 percent), and the AACB was just below the statewide average ($5,295 vs. $5,677).

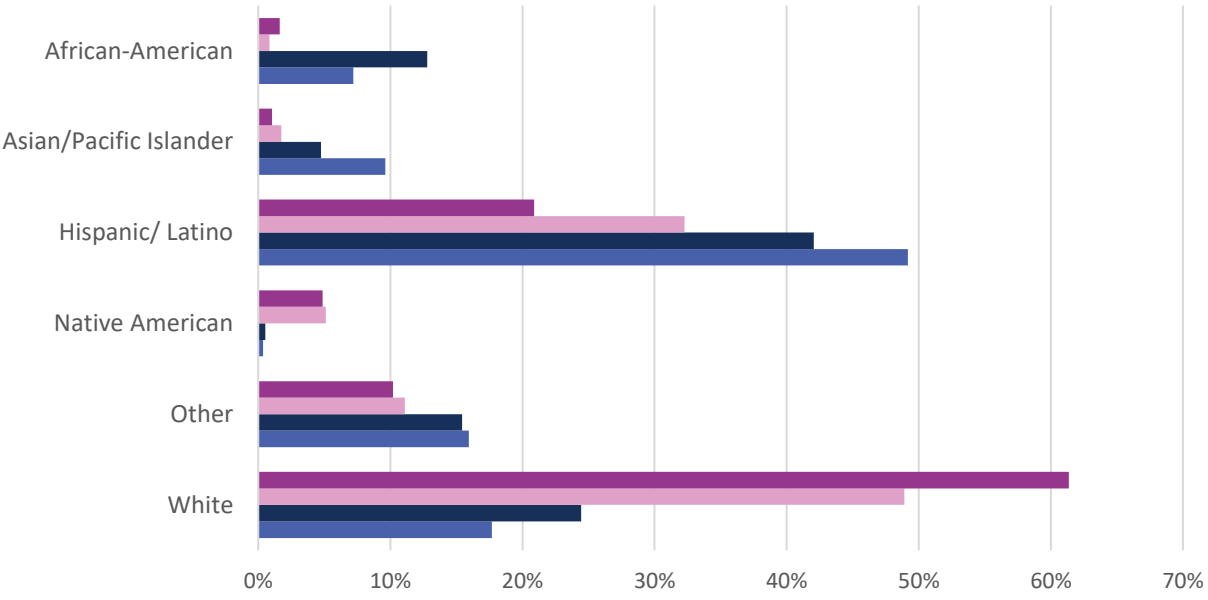
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served. Table 7 and Figures 1 – 9 compare the MHP's data with MHPs of similar size and the statewide average.

Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	# Annual Eligibles	# Beneficiaries Served	PR MHP	PR State
African-American	358	36	10.06%	6.83%
Asian/Pacific Islander	742	23	3.10%	1.90%
Hispanic/Latino	13,637	462	3.39%	3.29%
Native American	2,164	108	4.99%	5.58%
Other	4,685	226	4.82%	3.72%
White	20,667	1,358	6.57%	5.32%
Total	**42,253**	**2,213**	**5.24%**	**3.85%**

- Mendocino served 2,213 unique beneficiaries in CY 2021 with 20,667 White beneficiaries eligibles and 13,637 Hispanic/Latino beneficiaries eligibles. The MHP's White PR was 23.5 percent higher than the statewide average (6.57 percent vs. 5.32 percent) while the Hispanic/Latino PR was just above the statewide average (3.39 percent vs. 3.29 percent).

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021

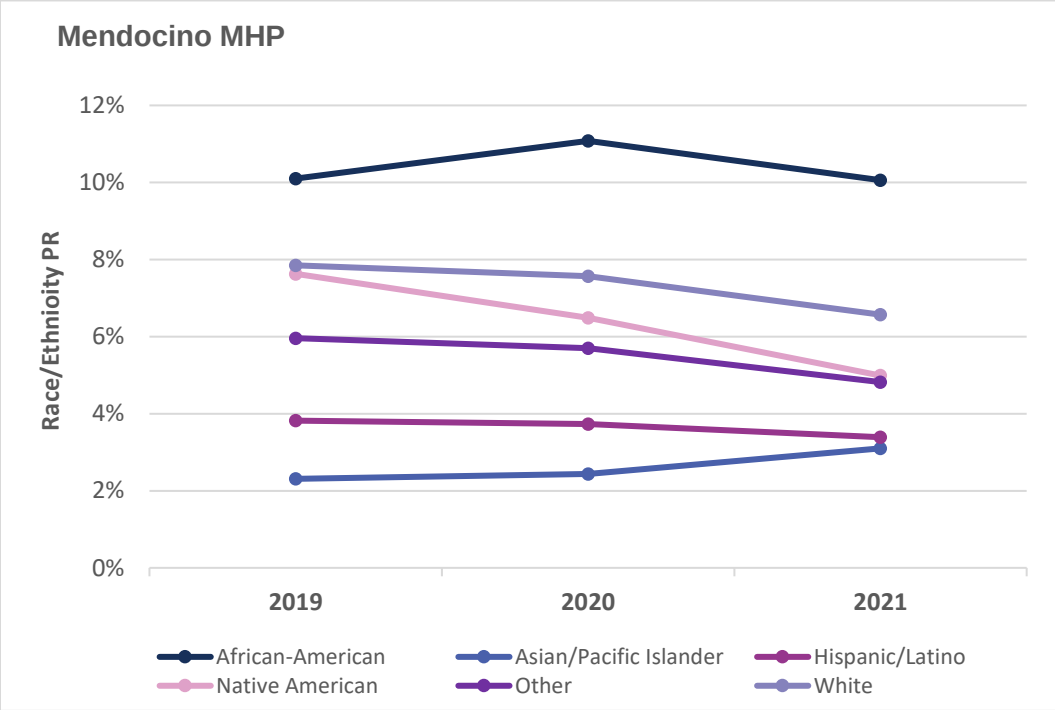


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	61%	10%	5%	21%	1%	2%
MHP % Eligibles	49%	11%	5%	32%	2%	1%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- While Mendocino's White population comprised approximately half of the eligible population (49 percent), 61 percent of those served were White. Hispanic/Latino beneficiaries comprised the next largest race/ethnicity group compromising 32 percent of the eligible population and 21 percent of those served. These two subpopulations comprised 81 percent of total eligibles and 82 percent of those served.

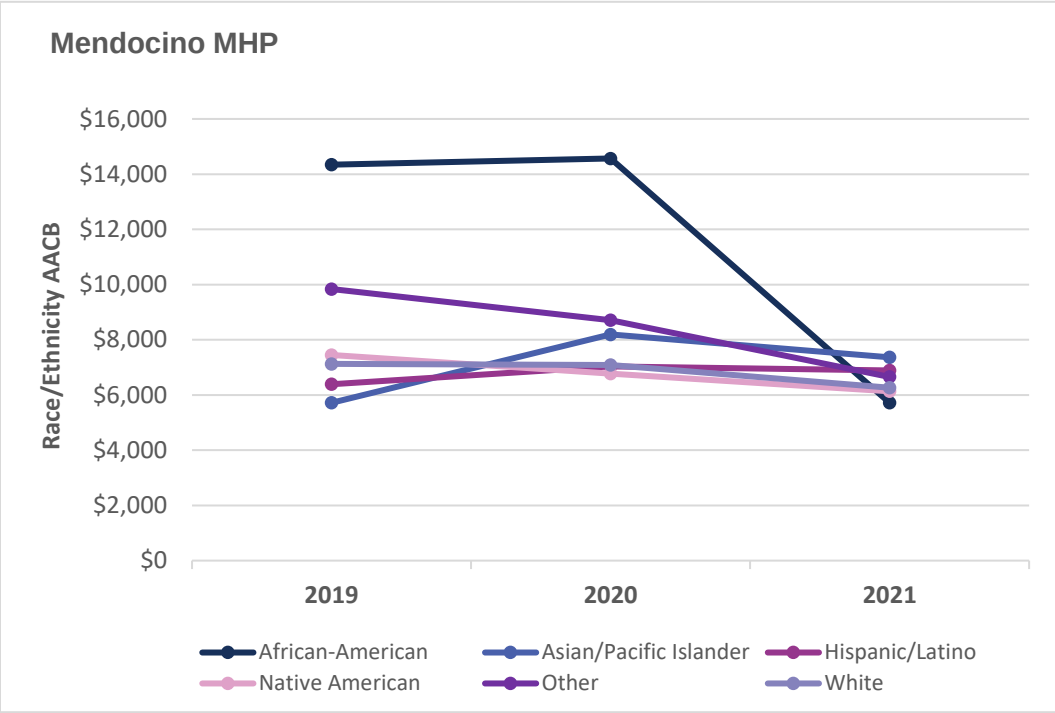
Figures 2 – 11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year trend.

Figure 2: MHP PR by Race/Ethnicity CY 2019-21



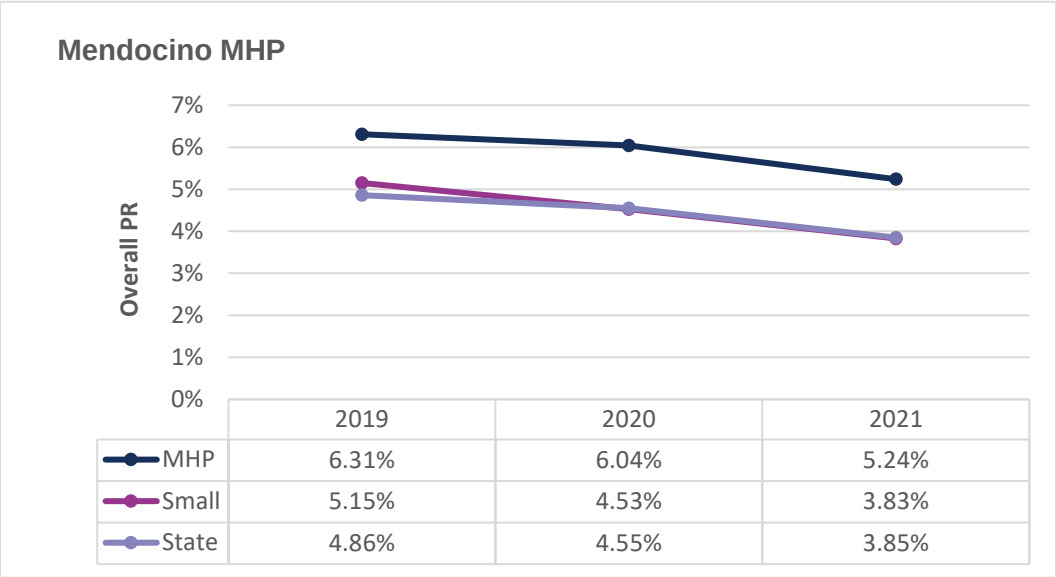
- The African American subpopulation had the highest PR from CY 2019 to CY 2021. African Americans comprised 1percent of the eligible population and 2 percent of those served. The Asian Pacific Islander and Hispanic/Latino subpopulations had the lowest PRs from CY 2019 to CY 2021.

Figure 3: MHP AACB by Race/Ethnicity CY 2019-21



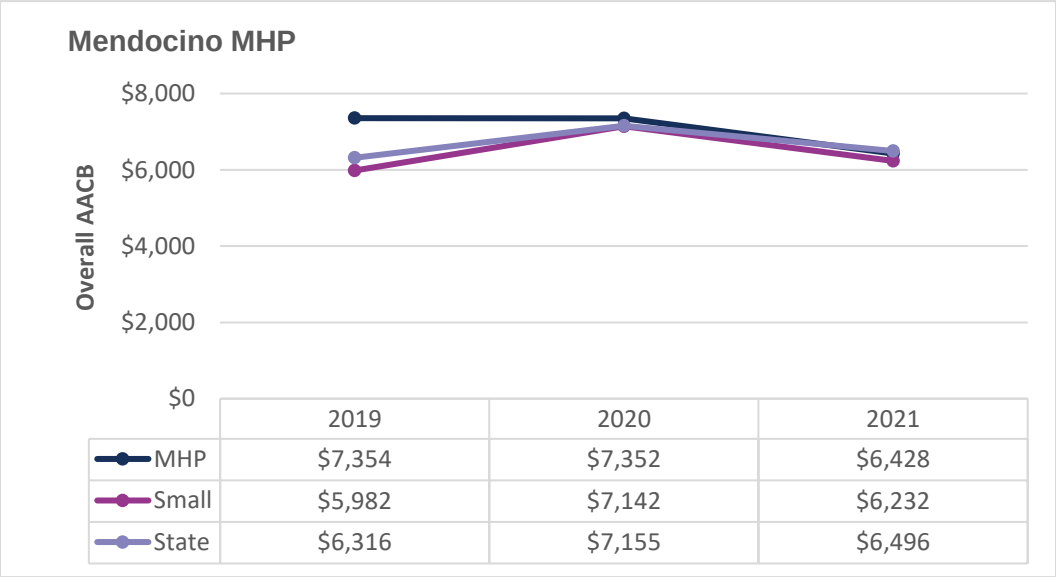
- African American AACB declined from $14,568 in CY 2020 to $5,719 in CY 2021. Thirty-six African American beneficiaries were served in CY 2021. Low beneficiary counts can significantly impact year over year data.
- In CY2021, Asian Pacific Islander ($7,367), Hispanic/Latino ($6,884) and Other ($6,653) had the highest AACBs.

Figure 4: Overall PR CY 2019-21



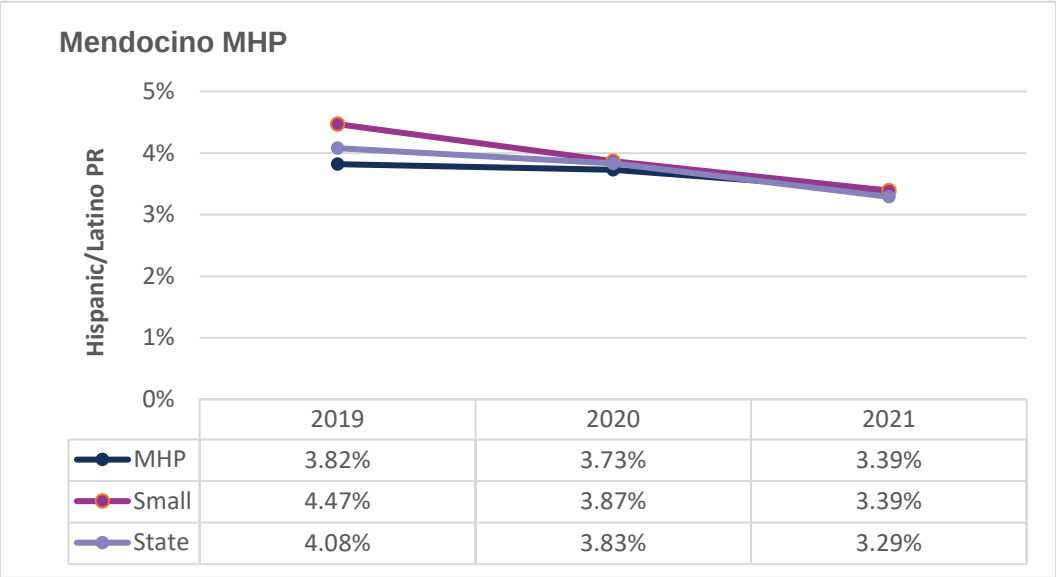
- While PRs for statewide, small county average, and Mendocino declined each year from CY 2019 to CY 2021, Mendocino's PR was notably higher than both small county and statewide averages in all three years.

Figure 5: Overall AACB CY 2019-21



- While declining from CY 2019 and CY 2020, Mendocino's AACB was comparable to small county and statewide averages in CY 2021.

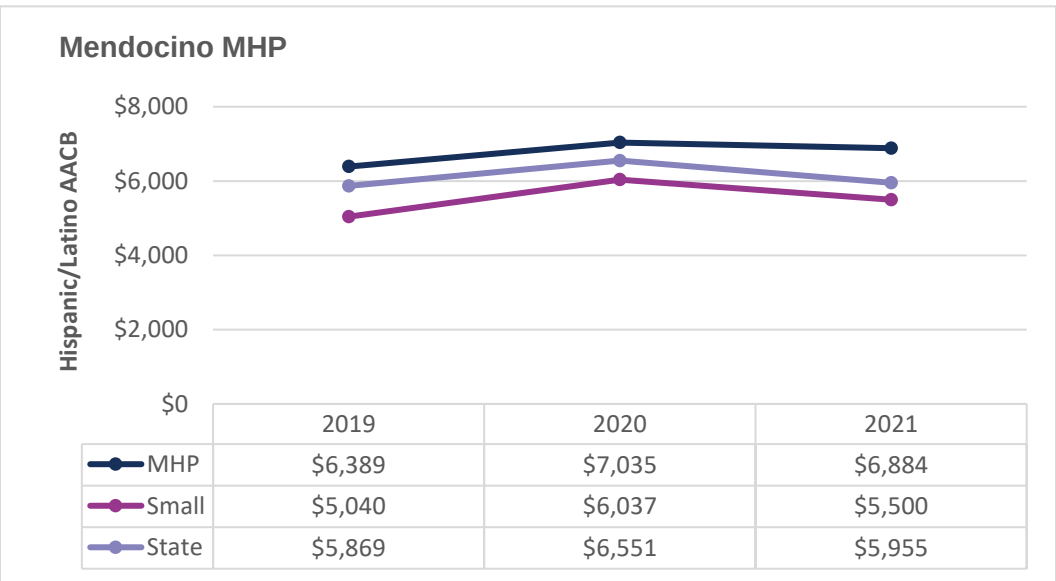
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	3.82%	3.73%	3.39%
Small	4.47%	3.87%	3.39%
State	4.08%	3.83%	3.29%

- Latino/Hispanic PRs for statewide, small county and Mendocino declined each year from CY 2019 to CY 2021, with PRs being comparable in CY 2021.

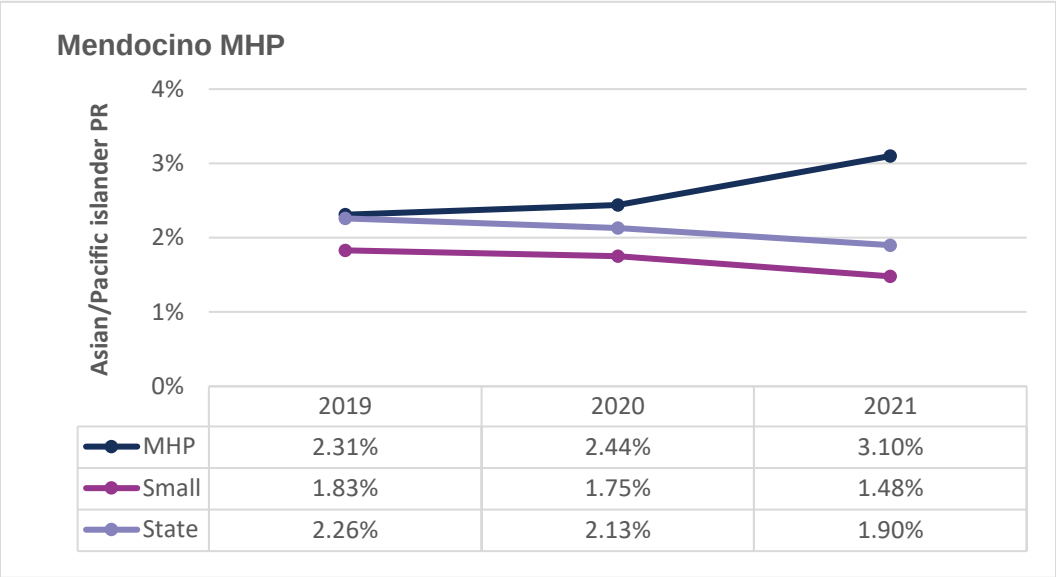
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$6,389	$7,035	$6,884
Small	$5,040	$6,037	$5,500
State	$5,869	$6,551	$5,955

- Mendocino's AACB exceeded both statewide and small county averages from CY 2019 to CY 2021.

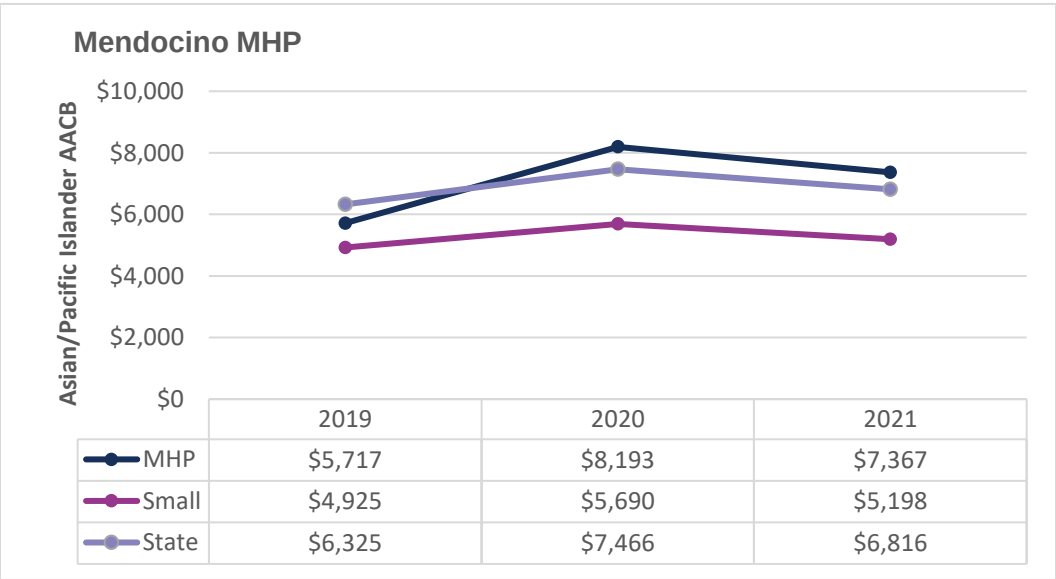
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.31%	2.44%	3.10%
Small	1.83%	1.75%	1.48%
State	2.26%	2.13%	1.90%

- Mendocino's Asian/Pacific Islander PR increased notably from CY 2020 to CY 2021. Asian/Pacific Islanders comprised 1 percent of Mendocino's eligibles and two percent of those served in CY 2021. Low beneficiary counts can cause greater fluctuations in year over year data.

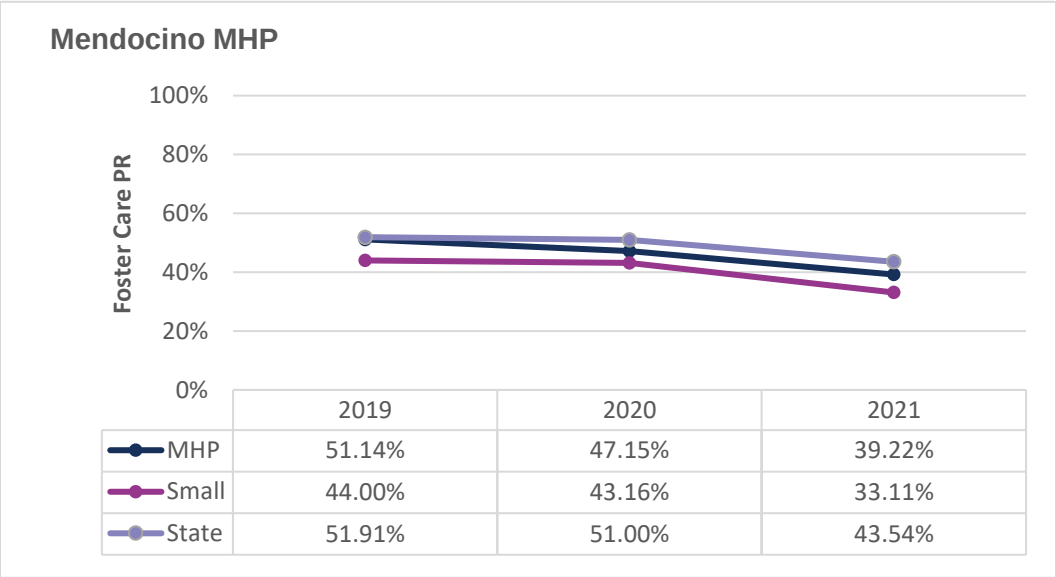
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$5,717	$8,193	$7,367
Small	$4,925	$5,690	$5,198
State	$6,325	$7,466	$6,816

- While Asian Pacific Islander AACB rates for statewide, small county and Mendocino declined from CY 2020 to CY 2021, Mendocino's AACB exceeded small county and statewide averages during this time.

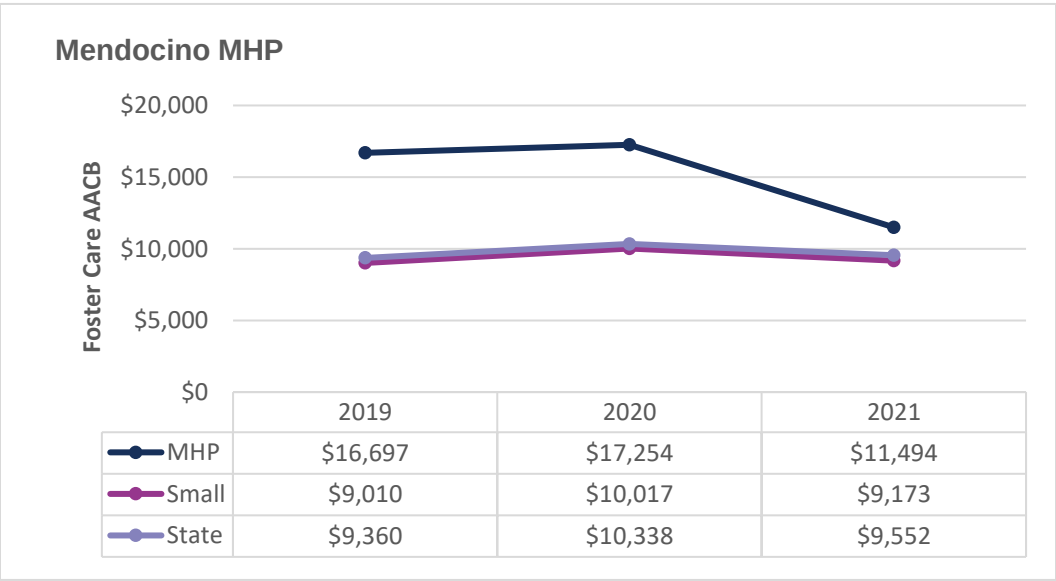
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	51.14%	47.15%	39.22%
Small	44.00%	43.16%	33.11%
State	51.91%	51.00%	43.54%

- FC PRs for small county and statewide averages and Mendocino declined each year from CY 2019 to CY 2021. Mendocino's PR exceeded the small county average in CY 2021 (39.22 percent vs. 33.11 percent) and was less than the statewide average (39.22 percent vs. 43.54 percent).

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$16,697	$17,254	$11,494
Small	$9,010	$10,017	$9,173
State	$9,360	$10,338	$9,552

- FC AACB was stable from CY 2019 to CY 2020 ($16,697 vs. $17,254) but declined significantly in CY 2021($11,494). This decrease may have been due to a reduced number of high-cost beneficiaries (HCBs). Mendocino had 334 FC eligibles in CY 2021 and served 131 beneficiaries.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 1,454				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	114	7.8%	9	7	10.8%	14	8
Inpatient Admin	≤11	-	-	-	0.4%	16	7
Psychiatric Health Facility	71	4.9%	1	0	1.0%	16	8
Residential	≤11	-	-	-	0.3%	93	73
Crisis Residential	≤11	-	-	-	1.9%	20	14
Per Minute Services							
Crisis Stabilization	15	1.0%	1,168	1,200	9.7%	1,463	1,200
Crisis Intervention	501	34.5%	382	236	11.1%	240	150
Medication Support	671	46.1%	204	143	60.4%	255	165
Mental Health Services	1,032	71.0%	1,090	432	62.9%	763	334
Targeted Case Management	864	59.4%	770	274	35.7%	377	128

- Over one third of Mendocino adult beneficiaries (34.5 percent) received crisis intervention services, three times more than seen statewide (11.1 percent). Further, the average duration of a crisis intervention service exceeded two hours more than those delivered statewide.
- The rate of Mendocino adults who received medication support services (46.1 percent) was less than that seen statewide (60.4 percent); the average and median units of service were also less in Mendocino than statewide.
- A higher percentage of adults received Mental Health Services and Targeted Case Management in Mendocino than the statewide average; the average and median units of service were also much more in Mendocino than statewide.

Table 9: Services Delivered by the MHP to Youth in Foster Care

Service Category	MHP N = 131				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	12	9.2%	12	12	4.5%	13	8
Inpatient Admin	≤11	-	-	-	n ≤11	6	4
Psychiatric Health Facility	≤11	-	-	-	0.2%	25	9
Residential	≤11	-	-	-	n ≤11	140	140
Crisis Residential	≤11	-	-	-	0.1%	16	12
Full Day Intensive	≤11	-	-	-	0.2%	452	360
Full Day Rehab	≤11	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	≤11	-	-	-	2.3%	1,354	1,200
Crisis Intervention	18	13.7%	316	213	6.7%	388	195
Medication Support	43	32.8%	251	214	28.5%	338	232
Therapeutic Behavioral Services	≤11	-	-	-	3.8%	3,648	2,095
Therapeutic FC	≤11	-	-	-	0.1%	1,056	585
Intensive Home Based Services (IHBS)	49	37.4%	708	431	38.6%	1,193	445
Intensive Care Coordination (ICC)	29	22.1%	1,485	748	19.9%	1,996	1,146
Katie-A-Like	≤11	-	-	-	0.2%	837	435
Mental Health Services	123	93.9%	1,926	898	95.7%	1,583	987
Targeted Case Management	85	64.9%	534	208	32.7%	308	114

- FC youth had notably lower median units of service compared to the statewide average for ICC (748 vs. 1,146), and notably higher median units of service for inpatient (12 vs. 8) and targeted case management (208 vs. 114). While fewer units of TCM are delivered by the MHP, the percentage of FC beneficiaries receiving TCM is nearly double the statewide rate. A comparable percentage of FC youth received IHBS compared to statewide, with the median units of service also comparable, but the average significantly lower. A significant amount of data was suppressed due to beneficiaries being ≤11.

- More FC youth received medication services, though with fewer average units delivered.
- As was seen in the adult data, a higher proportion of FC youth also received crisis intervention services (13.7 percent compared to 6.7 percent statewide).

IMPACT OF ACCESS FINDINGS

- The CY 2021 PR of 5.24 percent was 1.39 percent higher than the statewide average, 3.85 percent. PRs were higher than corresponding statewide averages for all age groups with the exception of those aged 0-5. The overall AACB was comparable to small county and statewide averages in CY 2021. This may be partially due to the fact Mendocino has moved towards a no wrong door policy in its implementation of CalAIM.
- While Mendocino's White population comprised approximately half of the eligible population (49 percent), 61 percent of those served were White. Hispanic/Latino beneficiaries made up the next largest race/ethnicity group compromising 32 percent of the eligible population and 21 percent of those served. These two subpopulations comprised 81 percent of total eligibles and 82 percent of those served.
- Mendocino had one threshold language, Spanish, and served 171 beneficiaries who identified Spanish as a preferred language. This may indicate issues with capacity of bilingual speaking clinicians, which the MHP is currently working to address.
- Mendocino's FC PR exceeded the small county average in CY 2021 (39.22 percent vs. 33.11 percent) and was less than the statewide average (39.22 percent vs. 43.54 percent). The CY2021 AACB exceeded both small county and statewide averages ($11,494 vs. $9,173 vs. $9, 552).

TIMELINESS OF CARE

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

Each Timeliness Component is comprised of individual subcomponents, which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

Strengths and opportunities associated with the timeliness components identified above include:

- The MHP meets its First Non-Urgent Request to Offered Psychiatric Appointment 91 percent of the time, with a 4-day median. This is measured by first clinical determination of need for all beneficiaries.

- While the MHP meets its 7 day standard for follow up appointments after psychiatric hospitalization discharge only 72 percent of the time, they report that 99 – 100 percent of timeliness is met by those accepting appointments.
- The psychiatric readmission rate at 30 days for the MHP is 8 percent overall, with low readmissions rates for all the population except FC. FC n is small (5) admissions, 4 discharges, 1 readmission within 30 days.
- Psychiatry no-show rates are 3 percent overall, and non-psychiatry clinical staff no-show rates are 5 percent overall. This data is for the entire delivery system.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Counties are also expected to submit the source data used to prepare these calculations. This is particularly relevant to data validation for the additional statewide focused study on timeliness that BHC is conducting.

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the period of FY 2021-22. Table 11 and Figures 12 – 14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care.

Claims data for timely access to post-hospital care and readmissions are discussed in the Quality of Care section.

Table 11: FY 2021-22 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	10 Days	10 Business Days*	67%
First Non-Urgent Service Rendered	11 Days	10**	63%
First Non-Urgent Psychiatry Appointment Offered	8 Days	15 Business Days*	91%
First Non-Urgent Psychiatry Service Rendered	7 Days	15 Days**	90%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0.22 Hours	48 Hours*	98%
Follow-Up Appointments after Psychiatric Hospitalization	0 Days	7 days**	100%
No-Show Rate – Psychiatry	3%	<10%**	n/a
No-Show Rate – Clinicians	5%	<10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

Figure 12: Wait Times to First Service and First Psychiatry Service

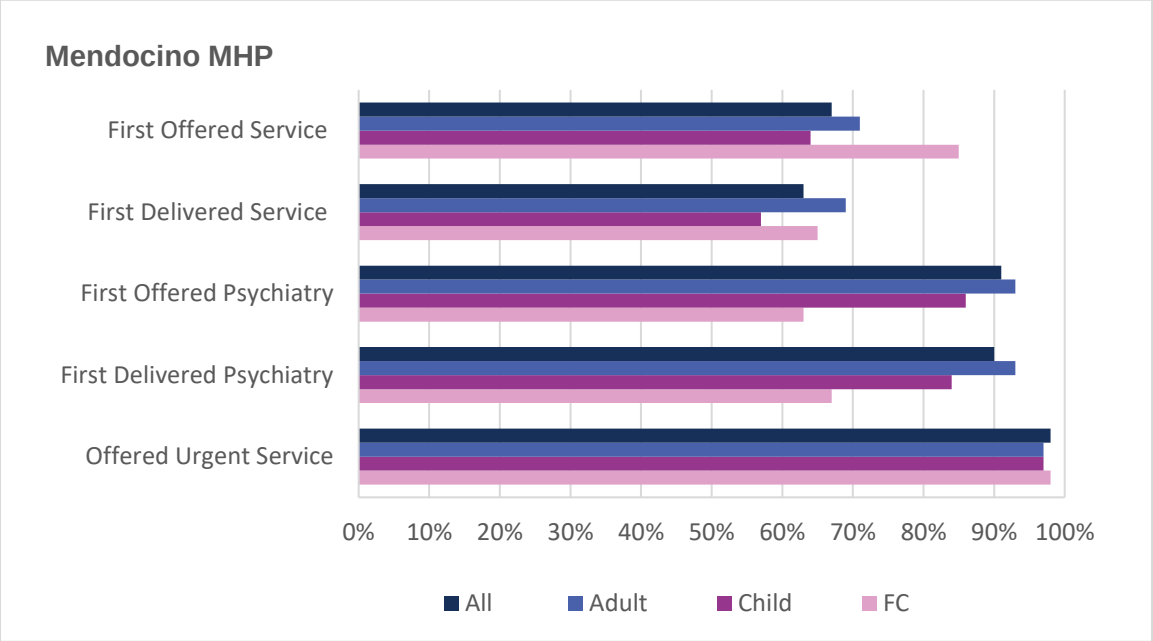


Figure 13: Wait Times for Urgent Services

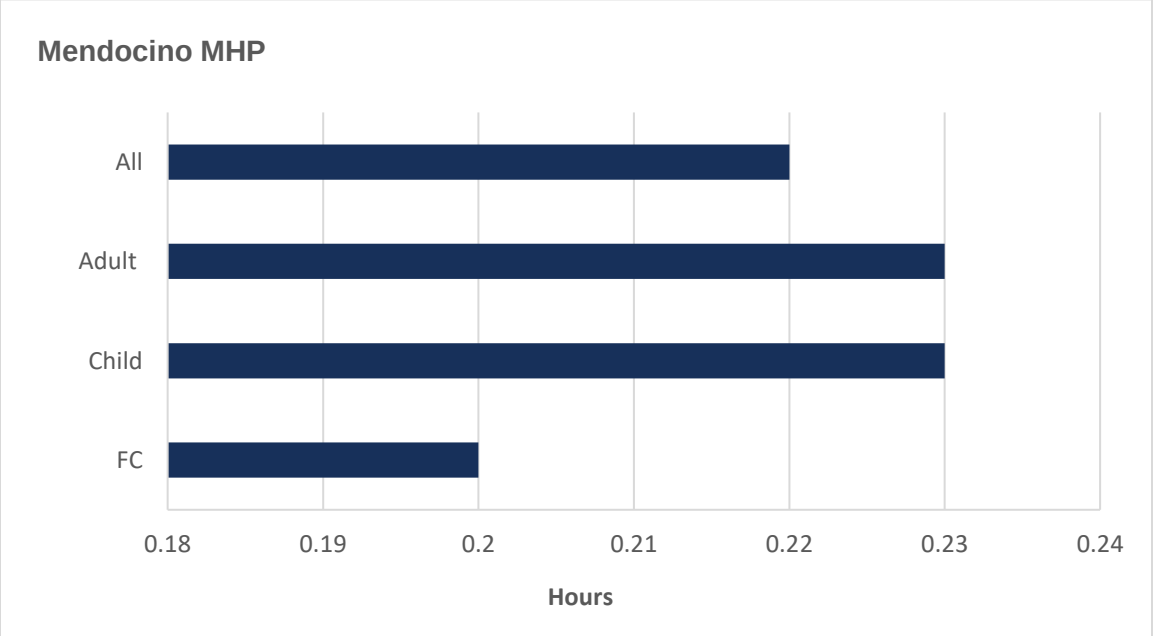
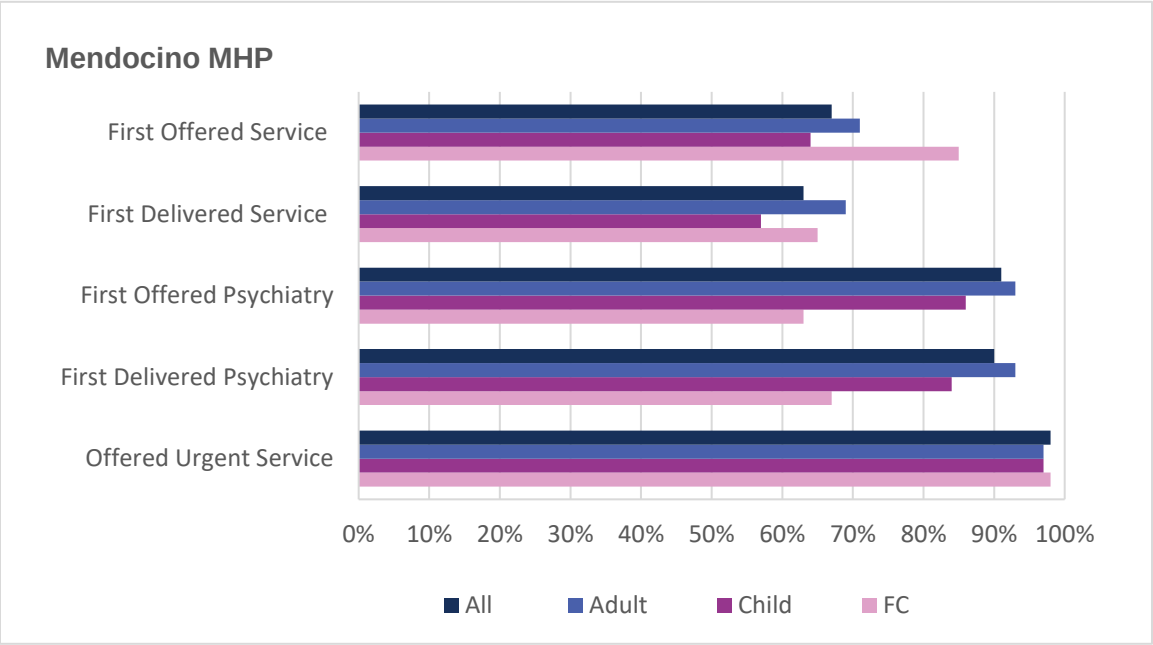


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments.
- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as Crisis Services. There were reportedly 2,364 urgent service requests with a reported wait time to services for the overall population at 0.22 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as from the point of first clinical determination of need.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 3 percent for psychiatrists and 5 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- The first offered appointment meets the 10-business day standard 67 percent of the time, and the first service is rendered 63 percent of the time within 10-business days. This likely reflects capacity challenges due to staffing shortages.

- The MHP reports that beneficiaries receive reminder telephone call and/or texts for appointments.
- While timeliness to urgent care requests is impressive, the MHP is encouraged to explore whether beneficiaries would be better served with distinct tracking and reporting of response to urgent care versus crisis needs.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, and the intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive QAPI Program for the services furnished to beneficiaries. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN THE MHP

The MHP retains responsibility for county QI functions and the ASO provides QI support to contract providers. On a monthly basis, the MHP holds internal QA/QI meetings that address the full service delivery system. Additionally, the MHP holds a quarterly public stakeholder quality committee; the quarterly stakeholder meeting occurs in a hybrid platform, allowing the public to participate remotely if desired. Quality is viewed as a continuous process and responsibility across the system of care.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of QA, NAMI, and the public, are invited. The QIC is scheduled to meet every two months. Since the previous EQR, the MHP QIC met five times. Of the 11 identified FY 2021-22 QAPI workplan goals, the MHP the majority were met or in process of being met. Staffing issues presented some barriers to some timeliness of service goals.

The MHP utilizes the following level of LOC tools: Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA). The EHR captures LOC recommendations, referrals, and admissions for beneficiaries, and reports that 100 percent of those who request treatment are screened for referrals using LOC criteria. The MHP EHR does not track the reasons for referrals that do not match LOC criteria-based recommendation for placement.

The MHP utilizes the following outcomes tools: ANSA, Generalized Anxiety Disorder-7 (GAD-7), Pediatric Symptom Checklist-35 (PSC-35), CANS/CANS-50, and Patient Health Questionnaire-9 (PHQ-9. The GAD-7 and PHQ-9 are used by clinicians to evaluate level of service needed using the scoring methodology. PSC-35 is used to assess youth through family self-report. The CANS and PSC-35 are tracked and trended through aggregate data.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

Each Quality Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

Strengths and opportunities associated with the quality components identified above include:

- Work in rolling out CalAIM is one example of the MHPs prioritizing performance improvement.
- With the opening the Crisis Residential facility, the MHP offers a full spectrum of services to beneficiaries in Mendocino, with exception of psychiatric inpatient services. The county is currently involved in the architectural design phase for a Psychiatric Hospital Facility, which will add acute services to its continuum of care.
- The MHP created a CANS/ANSA data report for the Board of Supervisors to assist them in understanding when and how beneficiaries are recovering.

- There are a robust number and varied assignments for peer employees, including the TAY Center which the stakeholders interviewed spoke highly of its usefulness to them.
- The MHP tracks and trends the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)

QUALITY PERFORMANCE MEASURES

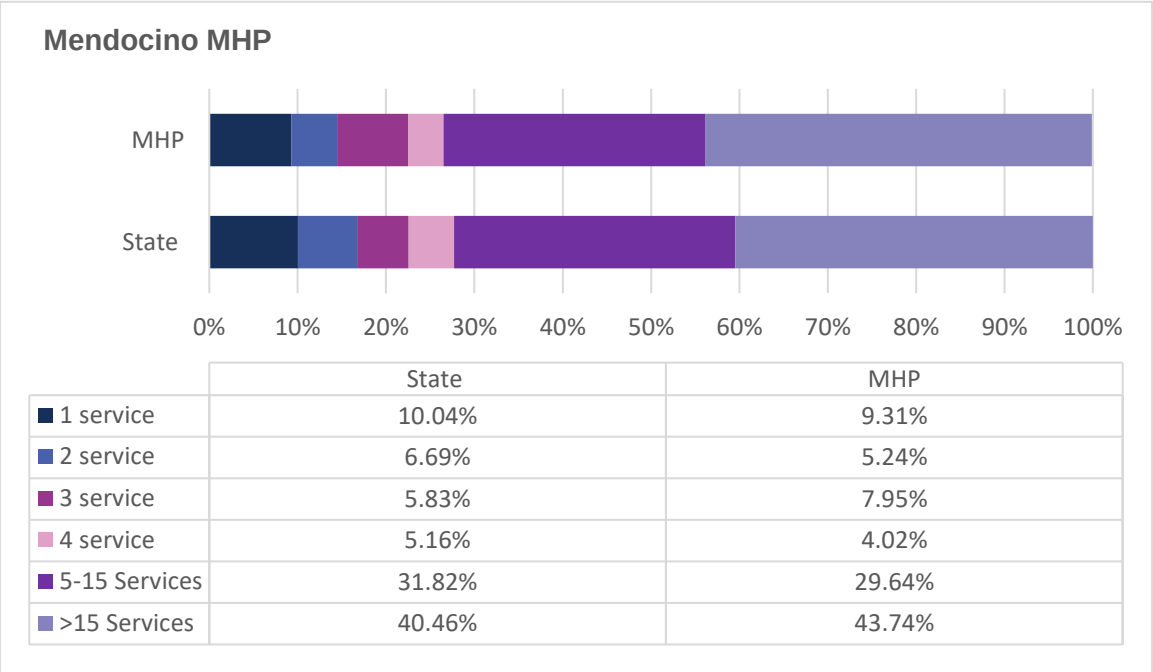
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented in the approved claims:

- Retention in Services
- Diagnosis of Beneficiaries Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Beneficiaries (HCB)

Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries served by the MHP to require 5 or more services during a 12-month period. However, this table does not account for the length of stay, as individuals enter and exit care throughout the 12-month period.

Figure 15: Retention of Beneficiaries CY 2021



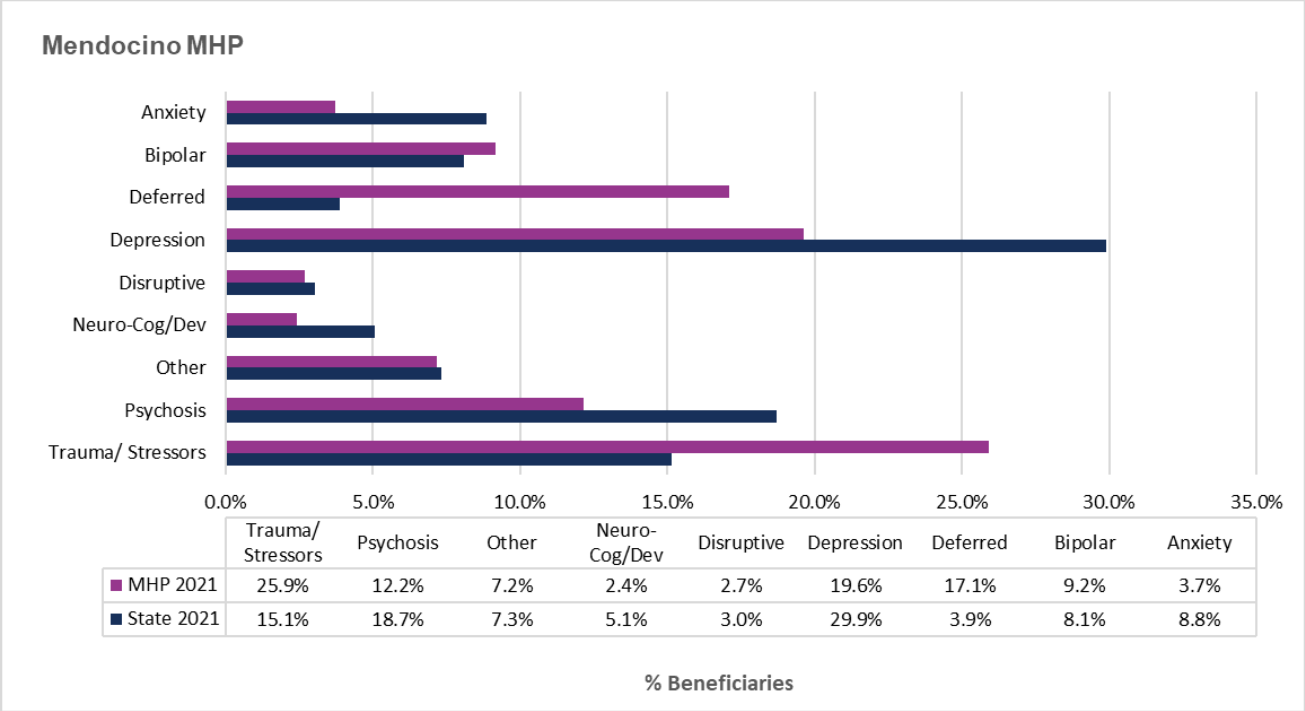
	State	MHP
1 service	10.04%	9.31%
2 service	6.69%	5.24%
3 service	5.83%	7.95%
4 service	5.16%	4.02%
5-15 Services	31.82%	29.64%
>15 Services	40.46%	43.74%

- While a single service was provided to 9.31 percent of beneficiaries, just below the 10.04 percent statewide average, 7.22 percent of White beneficiaries received a single service while 13.64 percent of Latino/Hispanic beneficiaries received a single service.
- More than 15 services were provided to 39.61 percent of Latino/Hispanic beneficiaries and 45.36 percent of White beneficiaries. FC youth had the highest percentage of greater than 15 services, 61.83 percent.

Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Specifically, Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

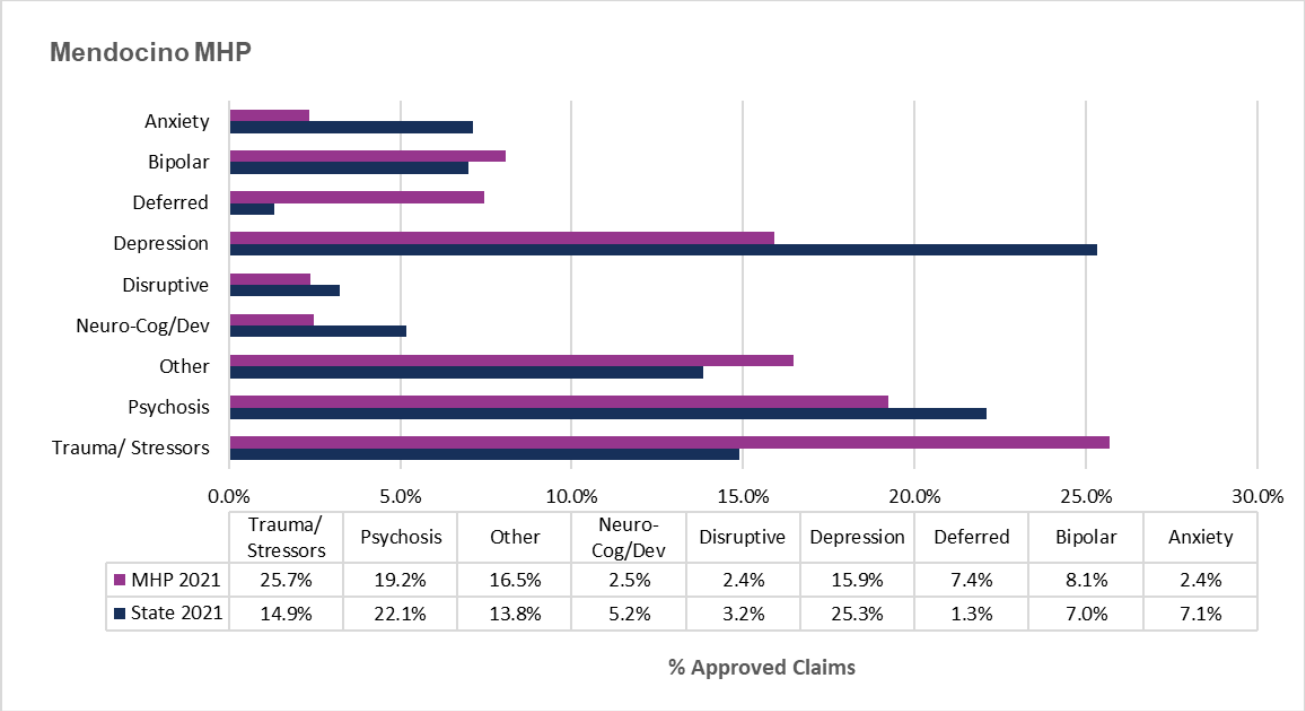
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	25.9%	12.2%	7.2%	2.4%	2.7%	19.6%	17.1%	9.2%	3.7%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- Compared to statewide averages, Mendocino had a higher percentage of beneficiaries diagnosed with trauma/stressor (25.9 vs. 15.1 percent) and deferred diagnoses (17.1 percent vs. 3.9 percent) and a lower percentage of beneficiaries diagnosed with depression (19.6 percent vs. 29.9 percent), psychosis (12.2 percent vs.18.7 percent) and neuro-cognitive/developmental disorders (2.4 percent vs. 5.1 percent).
- Approximately 63 percent of beneficiaries had one of three diagnoses: trauma/stressor (25.9 percent), depression (19.6 percent), deferred (17.1 percent).

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	25.7%	19.2%	16.5%	2.5%	2.4%	15.9%	7.4%	8.1%	2.4%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- Percentage of approved claim by diagnosis generally align with the diagnostic percentages in Figure 16. The deferred approved claim percentage is more than five times the statewide average (7.4 percent vs. 1.3 percent).

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay.

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	233	383	9.16	8.79	$12,823	$12,052	$2,987,775
CY 2020	243	569	9.14	8.68	$14,375	$11,814	$3,493,058
CY 2019	286	535	8.63	7.80	$12,197	$10,535	$3,488,376

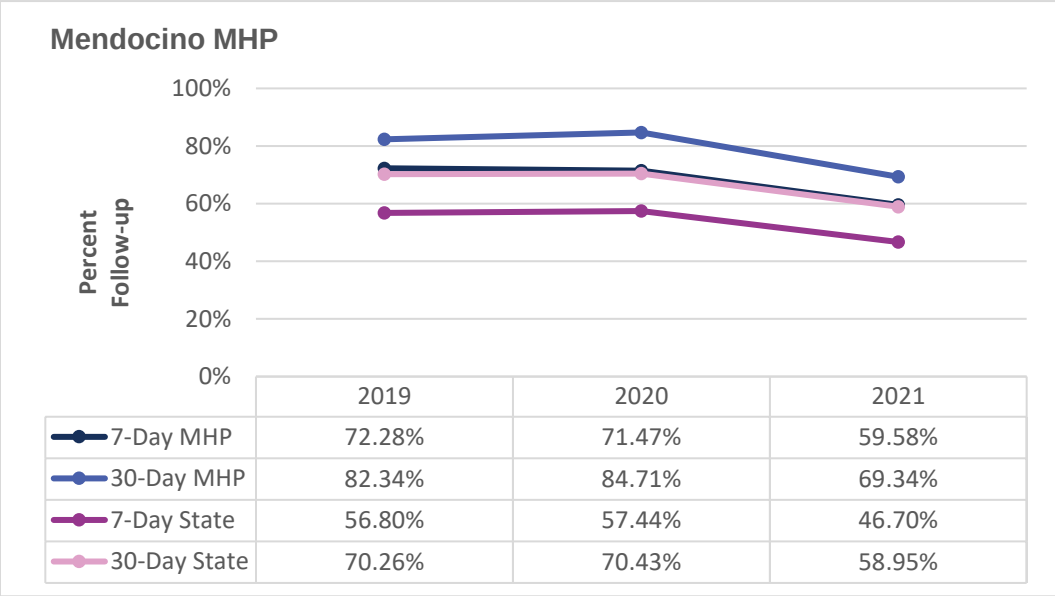
- While unique beneficiary count dropped by 10 from CY 2020 to CY 2021 (243 vs. 233), total admissions dropped by 32.7 percent (569 vs. 383). LOS was stable from CY 2020 to CY 2021 (9.14 days vs. 9.16 days) and just above the statewide average in CY 2021 (9.16 days vs. 8.79 days).

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2021 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

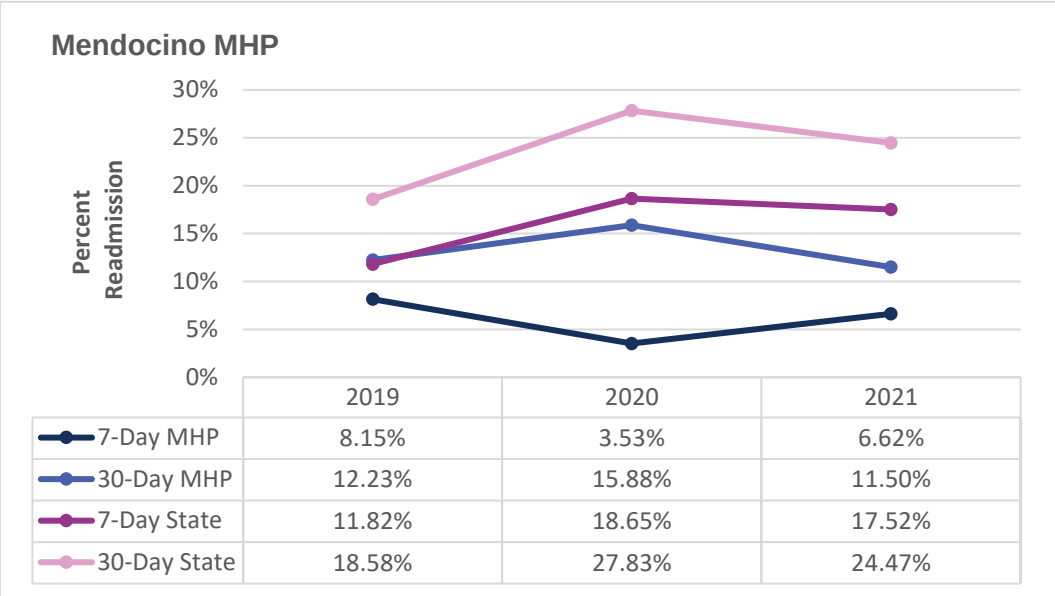
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis.

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	72.28%	71.47%	59.58%
30-Day MHP	82.34%	84.71%	69.34%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	8.15%	3.53%	6.62%
30-Day MHP	12.23%	15.88%	11.50%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The 7-day post psychiatric inpatient follow-up rate declined from CY 2020 to CY 2021 (71.47 percent vs. 59.58) but was above the statewide average in CY 2021 (59.58 percent vs. 46.70 percent).
- The 30-day post psychiatric inpatient follow-up rate declined from CY 2020 to CY 2021 (84.71 percent vs. 69.34 percent) but was above the statewide average in CY 2021 (69.34 percent vs. 58.95 percent).
- The 7-day psychiatric readmission increased from CY 2020 to CY 2021 (3.53 percent vs 6.62 percent) but was significantly lower than the CY 2021 statewide average (6.62 percent vs. 17.52 percent).
- The 30-day psychiatric readmission rate declined from CY 2020 to CY 2021 (15.88 percent vs 11.50 percent) and was less than half the CY 2021 statewide average (11.50 percent vs. 24.47 percent).

High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCBs may disproportionately occupy treatment slots that may prevent access to levels of care by other beneficiaries. HCB percentage of total claims, when compared with the HCB count percentage, provides a subset of the beneficiary population that warrants close utilization review, both for appropriateness of level of care and expected outcomes.

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $6,496, the median amount is just $2,928.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent of the statewide beneficiaries are “low cost” (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	3.46%	28.46%	$1,007,853,748	$53,476	$43,231
MHP	CY 2021	74	3.34%	29.37%	$4,178,100	$56,461	$48,459
	CY 2020	107	4.45%	32.59%	$5,764,412	$53,873	$45,241
	CY 2019	120	4.57%	33.30%	$6,435,718	$53,631	$42,108

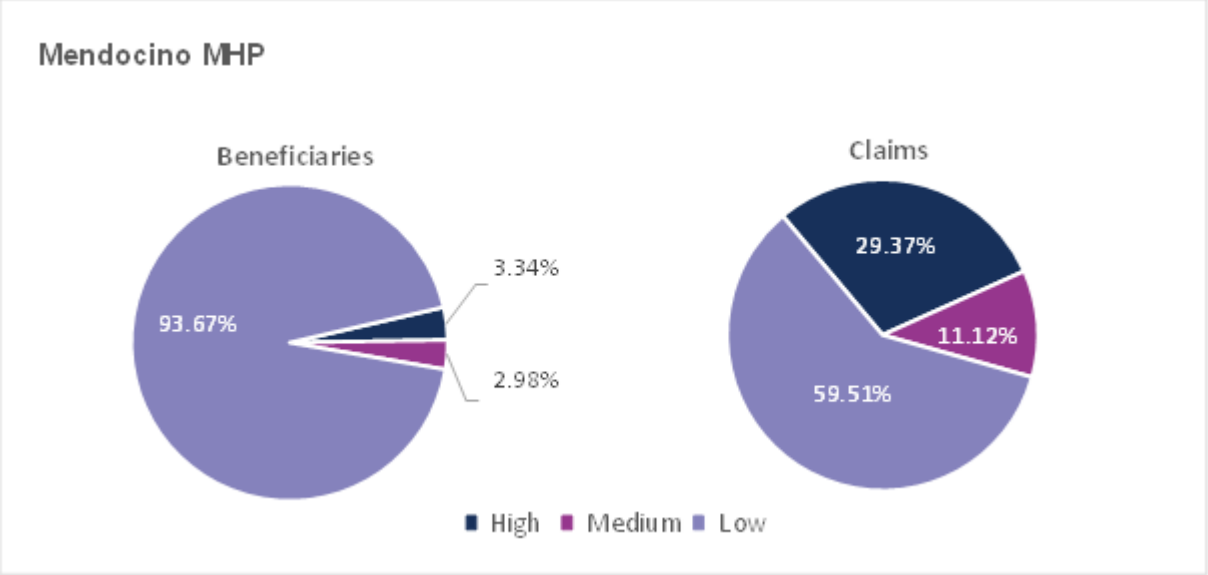
- Mendocino’s count and percent of HCBs declined each year from CY 2019 to CY 2021. In CY 2021, Mendocino’s percent of HCBs was just below the statewide average (3.34 percent vs. 3.46 percent) while the percent of claims for HCB’s was just above the statewide average (29.37 percent vs. 28.46 percent). The CY 2021 average approved claim per HCB was 5.6 percent greater than the statewide average ($56,461 vs. $53,476).

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	66	2.98%	11.12%	$1,581,505	$23,962	$23,340
Low Cost (Less than $20K)	2,073	93.67%	59.51%	$8,466,558	$4,084	$2,348

- While low-cost beneficiaries comprised 93.67 percent of those served, 59.51 percent of approved claims dollars were spent on this subpopulation.

Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021



- While HCBs were 3.34 percent of those served, 29.37 percent of approved claims dollars were spent on this subpopulation.

IMPACT OF QUALITY FINDINGS

- While a single service was provided to 9.31 percent of beneficiaries, just below the 10.04 percent statewide average, 7.22 percent of White beneficiaries received a single service compared to 13.64 percent of Latino/Hispanic beneficiaries.
- Approximately 63 percent of beneficiaries had one of three diagnoses: trauma/stressor (25.9 percent), depression (19.6 percent), deferred (17.1 percent). Deferred diagnoses are five times higher than the state average. The MHP reports this is due to crisis services; however, it remains an issue for the MHP to investigate given the disparity between the MHP and the state average.
- The 7-day post psychiatric inpatient follow-up rate declined CY 2020 to CY 2021 (71.47 percent vs.59.58) but was above the statewide average in CY 2021 (59.58 percent vs. 46.70 percent). This may be due to psychiatric hospitalization being out of county and requires significant collaboration with the inpatient facility for post discharge follow-up, especially considering some of the pandemic rules for in person visits to inpatient facilities.
- The 30-day post psychiatric inpatient follow-up rate declined from CY 2020 to CY 2021 (84.71 percent vs. 69.34 percent) but was above the statewide average in CY 2021 (69.34 percent vs. 58.95 percent). This outcome may have similar barriers as the 7-day follow-up stated above.
- Higher follow-up post discharge for psychiatric inpatient compared with statewide averages, may be a contributing factor to Mendocino's lower readmission rates.

- Mendocino's count and percent of HCBs declined each year from CY 2019 to CY 2021. In CY 2021, Mendocino's percent of HCBs was just below the statewide average (3.34 percent vs. 3.46 percent). While HCBs were 3.34 percent of those served, 29.37 percent of approved claims dollars were spent on this subpopulation.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.caleqro.com.

Validation tools for each PIP are located in Attachment C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Social Skill Development for clients transitioning to Adulthood from TAY status

Date Started: 09/2020

Date Completed: 06/2022

Aim Statement: "Will adding targeted social and independent development skills for TAY increase social and independent functioning and reduce the need for LPS conservatorship below the benchmark rate of 3.4 TAY by June 2022 and hospitalization of TAY below the average of 104 per year by June 2022?"

Target Population: TAY youth in supported housing environments in Mendocino County. All TAY youth in supported housing will be eligible for the PIP.

Status of PIP: The MHP's clinical PIP is completed.

[2] https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf

[3] https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf

Summary

Mendocino County has seen a rise in the number of LPS conservatees under aged 25 since 2019, along with TAY beneficiaries being hospitalized increasing in number. A number of these TAY had been involved in services including supported housing in the past.

This PIP was designed to increase social functioning and reduce the CANS/ANSA scoring of TAY clients in supported housing in Mendocino County by providing targeted social development. Strategies included offering targeted motivational interviewing and self-monitoring /self-management skills building to TAY in supported housing.

The interventions included Motivational Interviewing, and teaching self-monitoring/management for the TAY population in supported housing through the Raise Up Skills Group toward self-management and self-monitoring skills. Performance measured that were tracked included: the number of TAY clients on conservatorship, number of TAY clients hospitalized, final rating of involvement in vocational activities, final rating of involvement in housing activities; and results.

Improvements of decrease in hospitalization and LPS conservatorship appear to be the result of the PIP intervention, as well does the improvement of ANSA scores. The decrease in acute hospitalizations and LPS conservatorship was determined not to be statistically significant. The MHP plans to continue to offer the Raise Up group to support transition aged youth.

TA and Recommendations

As submitted, this clinical PIP was found to have high confidence, because: Credible, reliable, and valid methods for the PIP were documented.

Factors that could impact internal validity: During the interventions it was discovered that the Life Skills Inventory (LSI) responses of youth did not always reflect the behaviors observed by staff. The MHP added a measure of LSI by the providers and used the comparison as a tool for feedback with the youth. As interpretations vary by provider, this may have impacted validity with various interpretations of skills.

Factors that could impact external validity: Youth self-selected to participate in this PIP, which means those in the PIP were already inclined to reduce impacts of institutionalization to some degree. If the study were to look at all youth regardless of self-selection, the outcome of improvement may not have been as great. Another factor which may have impacted the validity of the outcome was that some participants were unable to attend groups as they were employed, and group participation conflicted with employment. In this case, youth that were more successful in overcoming the impacts of institutionalization were also excluded from the outcome.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this clinical PIP including:

- Due to the PIP being completed, no further TA was given on the PIP.
- The MHP scheduled PIP TA for January 2023 to assist in design and implementation of a new PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Reducing recurrent inpatient hospitalization in the community.

Date Started: 09/2020

Date Completed: 06/2022

Aim Statement: "Will adding targeted intensive services that include natural supports for all clients identified as at risk of re-hospitalization reduce re-hospitalization by 10 percent and all hospitalizations by 15 percent by June of 2022."

Target Population: This PIP focuses on adults MHP beneficiaries identified as high risk of rehospitalization as defined by having had two or more hospitalizations in the prior 24 month period. The PIP interventions will be offered to all adult individuals eligible via the risk criteria.

Status of PIP: The MHP's non-clinical PIP is completed.

Summary

Mendocino County has seen an increase in re-admissions and conservatorships over the past few years. Inpatient psychiatric hospitalizations increased from 248 unique beneficiaries in CY 2017 to 286 unique beneficiaries in CY2019. In addition to the increased number of individuals hospitalized, the average length of stay increased. Increased utilization of the highest levels of services has negative impacts on client care and system delivery cost.

This PIP seeks to reduce the number of clients experiencing rehospitalization by adding wraparound model support to the existing after care of those returning from inpatient care. Strategies included the Multi-Disciplinary Team (MDT) as part of the performance improvement interventions, by identifying individuals at risk and ensuring that wraparound inspired family/natural support based services are offered to individuals that meet the target population criteria. Modeled after the Wraparound youth services, the MDT interventions will seek to involve the client's family or natural supports in the intensive services and post crisis engagement. For individuals without identifiable natural supports, the intervention will work to engage a Peer supports for the individual. Performance measured that were tracked included: number of unique adult beneficiaries hospitalized per year; number of adults re-hospitalized within 30 days;

percentage of kept outpatient services appointments; percentage of kept medication management appointments; and aggregated ending ANSA scores.

This non-clinical PIP was a two year PIP, and the concept was started in September 2020. Although, the concept was built and the team was ready for intervention, it was impacted by the COVID-19 Pandemic and the intervention did not start until at the end of December 2021. To adhere the baseline data, the data collections were started in January 2022 and ended in June 2022 to compare CY 2022 data to baseline data. Therefore, only six months of data are available to compare and analyze after the intervention was started.

Results suggest that the total number unique adult hospitalization is reduced by 29.37 percent. Re-hospitalization within 30 days was reduced by 44.18 percent. Although, kept outpatient appointments are decreased by 10 percent in CY 2022 as compared to CY 2019, kept medication managements appointments are increased by 29 percent in CY 2022 as compared to CY 2019. No statistical analysis was conducted.

TA and Recommendations

As submitted, this clinical PIP was found to have high confidence, because: Credible, reliable, and valid methods for the PIP were documented.

Factors that could impact the internal validity include: Self-selection and motivation of participants could be the internal factors.

Factors that could impact the internal validity include: Assisted Outpatient Treatment Program, Crisis Residential Treatment Clean-Mendocino Non Clinical PIP 2020-2022 Draft services, Respite services, LPS conservatorship etc. could be considered external factors.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this non-clinical PIP including:

- Due to the PIP being completed, no further TA was given on the PIP.
- The MHP scheduled PIP TA for January 2023 to assist in design and implementation of a new PIP.

INFORMATION SYSTEMS

Using the Information Systems Capabilities Assessment protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for 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 to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is myAvatar from Netsmart Technologies, Inc. (Netsmart), which has been in use for 19 years. Currently, the MHP actively searching for a new system, a project plan is in place and a project team is active.

The MHP operates a unique dual EHR system. While the MHP utilizes the myAvatar EHR, they reported directly providing approximately 36 percent of services in the past year. Their ASO, Anchor Health Management (Anchor), provided approximately 64 percent of services. Anchor utilizes the EXYM EHR in an ASP environment.

Approximately 6.5 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). This is a minimal decline from 7 percent reported in the prior year. The budget determination process for IS operations is under MHP control.

The MHP has 358 named users with log-on authority to the EHR, including approximately 42 county staff and 316 contractor staff. Support for the users is provided by three full-time equivalent (FTE) MHP IS technology positions to support the use of myAvatar and three full-time equivalent ASO IT positions to support the use of EXYM. Currently, all positions are filled.

As of the FY 2022-23 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7. While a new EHR has not yet been selected by the MHP, Anchor is anticipated to have full access to the MHP's new EHR.

Contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☒ Weekly ☐ Monthly	95%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	0%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	5%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. While the MHP plans to include a PHR in their new EHR project plan, this functionality has not been implemented in myAvatar. The EXYM EHR includes a PHR, Engage, which offers the ability to receive a medication list and a treatment summary.

Interoperability Support

While the MHP is not a current participant in an HIE, they have signed a contract with SacValley MedShare and expect to be an active participant in the HIE by the end of January 2023. Anchor is not a member of an HIE. Healthcare professional staff at both organizations use secure information exchange directly with service partners through secure email.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

Each IS Key Component is comprised of individual subcomponents which are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 17: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Partially Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

Strengths and opportunities associated with the IS components identified above include:

- The MHP operates a unique dual EHR system. While the MHP utilizes the myAvatar EHR, their ASO utilizes the EXYM EHR. Both EHR's are operated in an ASP environment which provides vendor support for the implementation of software patches and promotions.
- The MHP is actively searching for a replacement for the myAvatar EHR. A project team has been assigned and is active.
- The MHP has experienced delayed CSI reporting. The January 2020 file was processed in November 2022. The MHP reported that unresolved vendor issues create complexity in resolving CSI file errors. The MHP reported plans to continue CSI submissions and plans to submit the February 2020 file in December 2022.
- PHR functionality has not been implemented in myAvatar. The EXYM EHR includes a PHR which offers the ability to receive a medication list and a treatment summary.
- While the MHP is transitioning back to in person services, telehealth services are available and remain an option based on the beneficiary need and preferences.
- The MHP has signed a contract with SacValley MedShare and expects to be an active participant in the HIE by the end of this fiscal year.
- There is a cloud-based SQL data warehouse that replicates the EXYM system that is used for reporting and analytics. A data warehouse replicating the myAvatar system is not utilized.
- Two-factor authentication to authorize user password change is not supported.
- An Ad hoc Outcome Measurement Committee was established to create alternate reporting and outcome measurements which could be provided to the community and board of supervisors to assist in the development of understanding MHP services and potential outcomes. In addition to MHP leadership and analytic staff, two board of supervisor members participated on this committee.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in the table below, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

For the MHP, it appears that significant claims lag begins in October and likely represents approximately $3,000,000 in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through September 2022 and that they did not experience a delay in claiming during CY 2021. Therefore, the chart below may reflect an incomplete claims data set for October to December 2021.

Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	6,101	$1,169,180	$4,501	0.38%	$1,164,679
Feb	6,556	$1,249,327	$5,586	0.45%	$1,243,741
Mar	7,176	$1,428,807	$1,468	0.10%	$1,427,339
April	6,735	$1,382,058	$1,289	0.09%	$1,380,769
May	6,169	$1,307,073	$1,528	0.12%	$1,305,545
June	6,342	$1,349,814	$270	0.02%	$1,349,544
July	5,840	$1,235,686	$4,217	0.34%	$1,231,469
Aug	5,692	$1,173,843	$5,468	0.47%	$1,168,375
Sept	5,068	$1,070,137	$1,998	0.19%	$1,068,139
Oct	3,226	$663,558	$1,870	0.28%	$661,688
Nov	16	$14,401	$0	0.00%	$14,401
Dec	0	$0	$0	0.00%	$0
Total	**58,921**	**$12,043,884**	**$28,195**	**0.23%**	**$12,015,689**

- The MHP reports that maintaining a long term and knowledgeable Fiscal staff contributes to their low claim denial rate.

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	57	$14,339	50.86%
Medicare Part B or Other Health Coverage must be billed before submission of claim	34	$10,142	35.97%
Service line is a duplicate and a repeat service procedure code modifier not present	12	$2,535	8.99%
Beneficiary not eligible or non-covered charges	4	$1,031	3.66%
Other	2	$148	0.52%
Claim/service lacks information which is needed for adjudication	57	$14,339	50.86%
Total Denied Claims	**109**	**$28,195**	**100.00%**
Overall Denied Claims Rate	0.23%		
Statewide Overall Denied Claims Rate	2.78%		

- Mendocino's claim denial rate of 0.23 percent for CY 2021 is significantly lower than the statewide average of 2.78 percent.
- Claims with denial codes claim/service lacks information which is needed for adjudication and Medicare Part B, or other health coverage must be billed prior to the submission of this claim are generally rebillable within State guidelines upon successful remediation of the reason for denial.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The current use of two EHR systems maintains beneficiary health information in disparate electronic health record databases which limits 24/7 access to health information. The MHP's move to a single EHR for the entire system of care would eliminate the disparate systems and allow 24/7 access to beneficiary health information through a single EHR system.
- Participation in SacValley MedShare will allow the MHP to share myAvatar electronic health information between northern California providers. Additionally, SacValley MedShare membership in the California Association of Health Information Exchange will allow for the secure sharing of health information throughout California.
- The MHP has experienced delayed CSI reporting. The January 2020 file was processed in November 2022. The MHP should continue to allocate resources as needed to support CSI file submissions.
- A stable and experienced Fiscal staff contributes to a claim denial rate that is significantly below the statewide average.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of beneficiaries: adult, older adult, youth, and family members. MHPs administer these surveys to beneficiaries receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS and provides a comprehensive analysis in the annual statewide aggregate report.

The MHP conducted the CPS survey with less participants than they would like, possibly due to remote services. They do not have results from the survey yet.

CONSUMER FAMILY MEMBER FOCUS GROUP

Consumer and family member (CFM) focus groups are an important component of the CalEQRO review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-review planning process, CalEQRO requested one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of TAY consumers who initiated services in the preceding 12 months. The focus group was held virtually and included seven participants, six who had entered services within the last year. All consumers/family members participating receive and/or have a family member who receives clinical services from the MHP.

In general, the participants reported satisfaction with the services they receive. Participants agreed that entry into services was timely without barriers, often with housing attached. Most participants had come to treatment from group homes or the FC system. The participants who entered services in the past year reported they receive regular therapy services at a reasonable, usually weekly, frequency. They do not receive reminder calls or texts for appointments. If they miss an appointment RCS is usually able to reschedule or offer a phone session. None had telehealth services via a zoom-type platform.

RCS provides case managers at the house where they live or at the TAY wellness center. The Arbor TAY Center provides bus passes to assist with transportation. The

participants are aware of urgent care and crisis response protocols and know where to go for help, if needed.

All participants were aware of staffing shortages. RCS Stepping Stones therapists meet with client who are in group homes; however, there were times in the past year when they were experiencing staffing shortages and services were not available in group homes.

None of the participants is involved in committees and all agree they are working to adapt and figure out entering adulthood. None have completed a consumer satisfaction surveys of any type. However, all agree they can discuss things with the MH system if needed.

The participants are aware of and use wellness centers, to include RCS and Arbor where there is no barrier to participation other than signing in when you arrive. All reported that the wellness centers are a significant support and important to their recovery.

Recommendations from focus group participants included:

- Send reminders of upcoming appointments for TAY.
- “Nothing else. Staff works very hard to help and does a good job.”

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The beneficiaries in the Consumer Family Member Focus Group in general were very satisfied with the services they receive. All felt services were available in a timely manner. The feedback they gave suggest there is an opportunity for the MHP to improve communication about appointments, opportunities to participate in committees, and volunteer or work opportunities due to lived experience.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. Seven and 30-day post psychiatric inpatient follow-up rates exceed statewide averages. (Timeliness)
2. The newly opened Crisis Residential Facility gives Mendocino County another LOC within the county. (Access)
3. The MHP has a systematic clinical continuum of care that includes a CANS/ANSA Scoring Guide. These Scoring Guides are documented for the purpose of allowing clinicians to develop ongoing treatment plans and adjust LOC service needs. (Quality)
4. The MHP has worked this past year in collaboration with the Mendocino NAMI to create a Native American connection group. Looking at resources within the tribal community, NAMI and the MHP worked to develop a Native Connections Partnership. (Access)
5. The MHP has entered into an agreement with CalMHSA for assistance in implementing CalAIM. They are considering whether Streamline's SmartCare™ EHR Solution for Multi-County Behavioral Health Initiative in California would be useful for Mendocino County. (Quality, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Beneficiary health information is maintained in disparate EHR systems which limits 24/7 access to this information. (Quality, IS)
2. Nearly twice as many Latino/Hispanic beneficiaries received a single service (13.64 percent) compared to White beneficiaries (7.22 percent). This suggests disparity in engagement and retention across race/ethnicity that warrants investigation. (Quality)
3. The rate of deferred diagnosis is more than four times greater than the statewide average (17.1 percent vs. 3.9 percent). At the same time urgent service requests are defined as crisis, which may contribute to the high rate of deferred diagnoses. (Quality)
4. The MHP meets its timeliness standards for first non-urgent appointment offered and service delivered less than 70 percent of the time overall and 57 percent of the time for children. (Timeliness)

5. Stakeholders reported limited opportunity to give their input and/or involvement in system planning and implementation. (Quality)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the MHP in its QI efforts and ultimately to improve beneficiary outcomes:

1. To eliminate disparate EHR databases and allow 24/7 access to beneficiary heath information, consider permitting full contract provider access to the replacement EHR system. (Quality, IS)
2. Research possible reasons for the higher Latino/Hispanic single service percentage and design culturally appropriate ways to increase engagement. (Quality)
3. Research possible connection between deferred diagnosis and urgent/crisis services. Consider the opportunity to redefine urgent services disparate from crisis to offer an opportunity for a more complete assessment and engagement of clients with urgent needs. (Quality)
4. Research the low percent of non-urgent appointments offered and rendered that meet the 10-day standard. Design and implement a plan to increase this percent. (Timeliness)
5. Reach out to different groups of beneficiaries (wellness centers, TAY, etc.) to offer information and resources on how they can be involved in committees, volunteer work, collaboration with NAMI, and other ways they can have a voice in the system of care. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a public health emergency (PHE) exists. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Mendocino MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Network Adequacy Evaluation
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
EHR Deployment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Mary Ellen Collins, Consumer Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Anderson	Dan	Chief Operations Officer	Anchor Health Management, Inc.
Beeney	Joseph	Clinical Supervisor	RCS
Bengston	Logan	Clinical Supervisor	RCS
Bhandari	Navin	Senior Program Manager	Mendocino County BHRS
Chavoya	Lilian	Program Specialist I	Mendocino County BHRS
Harris	Carmen	Clinical Director	Anchor Health Management, Inc.
Landis	Cliff	MH Clinical Manager	Mendocino County BHRS
Lemus	Tony	Department Application Specialist	Mendocino County BHRS
Livingston	Sarah	Crisis Services Director	Redwood Community Crisis Services
Logan	Alicia	Business Administrator	Anchor Health Management, Inc.
Lovato	Karen	Senior Program Manager	Mendocino County BHRS
Lower	Danielle	EHR Manager	Anchor Health Management, Inc.
Miller	Jenine	Director	Mendocino County BHRS
Offill	Christina	Clinical Supervisor	Tapestry Family Services
Pane	Mailea	Staff Services Manager II	Mendocino County BHRS
Rathburn	Terri	Clinical Supervisor	Youth Project

Last Name	First Name	Position	County or Contracted Agency
Schraeder	Camille	Chief Program Officer	Anchor Health Management, Inc.
Schraeder	Tim	Chief Executive Officer	Anchor Health Management, Inc.
Stafford	Samantha	Clinical Supervisor	Stepping Stones
Walsh	Sarah	Contracts Data Analyst	Anchor Health Management, Inc.
Willeford	Mary Alice	Deputy Director	Mendocino County BHRS
Yovino	Mary	Program Administrator	Anchor Health Management, Inc.

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	Credible, reliable, and valid methods for the PIP were documented.

General PIP Information
MHP/DMC-ODS Name: Mendocino
PIP Title: Social Skill Development for clients transitioning to Adulthood from TAY status
PIP Aim Statement: "Will adding targeted social and independent development skills for TAY increase social and independent functioning and reduce the need for LPS conservatorship below the benchmark rate of 3.4 TAY by June 2022 and hospitalization of TAY below the average of 104 per year by June 2022?"
Date Started: 09/2020
Date Completed: 06/2022
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:

General PIP Information
Target population description, such as specific diagnosis (please specify): TAY youth in supported housing environments in Mendocino County. All TAY youth in supported housing will be eligible for the PIP.
Improvement Strategies or Interventions (Changes 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): Various skill building groups to include “Raise Up Skills group” were implemented with the participants
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Providers held various skill building groups; providers assessed progress
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The MHP implemented a practice of Raise Up Skill Groups

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of TAY clients on Conservatorship being offered Raise Up Skills Group	2021	5	2022	3	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
Number of Tay hospitalized annually	2021	116 (average of over 9 per month)	2022	84 (average of 7 per month)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Increased engagement in vocational activities	2021	n/a	2022	2.37	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Increased engagement in educational activities	2021	n/a	2022	1.45	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Increased engagement in long term housing search	2021	n/a	2022	2.33	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Aggregate average ANSA Score	2021	32.068	2022	31.6	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): Completed Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Due to the PIP being completed, no further TA was given on the PIP. • The MHP scheduled PIP TA for January 2023 to assist in design and implementation of a new PIP.

Non-Clinical PIP

Table C1: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	Credible, reliable, and valid methods for the PIP were documented.
General PIP Information	
MHP/DMC-ODS Name: Mendocino	
PIP Title: Reducing recurrent inpatient hospitalization in the community.	
PIP Aim Statement: "Will adding targeted intensive services that include natural supports for all clients identified as at risk of re-hospitalization reduce re-hospitalization by 10 percent and all hospitalizations by 15 percent by June of 2022."	
Date Started: 09/2020	
Date Completed: 06/2022	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ 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): This PIP focuses on adults MHP beneficiaries identified as high risk of rehospitalization as defined by having had two or more hospitalizations in the prior 24 month period. The PIP interventions will be offered to all adult individuals eligible via the risk criteria.	

General PIP Information
Improvement Strategies or Interventions (Changes 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): Clients identified as high risk receive intensive services post discharge.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Providers will identify high risk clients.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Initiate a wraparound /natural supports inclusive intervention will be applied between a weekly and monthly basis depending on the individual needs of the client.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of unique adult beneficiaries hospitalized per year	CY 2019	286	2022	101 (total for 6 months)	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
Number of adults rehospitalized within 30 days	Average of prior 2 years	43	2022	12 (total for 6 months)	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of kept outpatient services appointments	CY 2019	90%	2022	80% (average for 6 months)	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
Percentage of kept medication management appointment	CY 2019	19%	2022	48%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): Completed

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

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

EQRO recommendations for improvement of PIP:

- Due to the PIP being completed, no further TA was given on the PIP.
- The MHP scheduled PIP TA for January 2023 to assist in design and implementation of a new PIP.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, and PIP Validation Tool, are available on the CalEQRO website.

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required to be included in this report.