Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

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

MERCED MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 6, 2021

TABLE OF CONTENTS

List of Tables 4

List of Figures 5

INTRODUCTION 6
MHP Information 6
Validation of Performance Measures 7
Performance Improvement Projects 7
MHP Health Information System Capabilities 7
Network Adequacy 7
Validation of State and MHP Beneficiary Satisfaction Surveys 8
Review of Recommendations and Assessment of MHP Strengths and Opportunities 8

PRIOR YEAR REVIEW FINDINGS, FY 2019-20 10
Status of FY 2019-20 Review of Recommendations 10
Recommendations from FY 2019-20 10

PERFORMANCE MEASURES 18
Health Information Portability and Accountability Act Suppression Disclosure 20
Total Beneficiaries Served 21
Penetration Rates and Approved Claims per Beneficiary 22
Diagnostic Categories 26
High-Cost Beneficiaries 27
Psychiatric Inpatient Utilization 27
Post-Psychiatric Inpatient Follow-Up and Rehospitalization 28

PERFORMANCE IMPROVEMENT PROJECT VALIDATION 29
Merced MHP PIPs Identified for Validation 29
Clinical PIP 29
Non-Clinical PIP 34

INFORMATION SYSTEMS REVIEW 40
Key ISCA Information Provided by the MHP 40
Summary of Technology and Data Analytical Staffing 41
Summary of User Support and EHR Training 42
Availability and Use of Telehealth Services 45
Telehealth Services Delivered by Contract Providers 47
Current MHP Operations 47
Major Changes since Prior Year 48
The MHP's Priorities for the Coming Year 49
Other Areas for Improvement 49

Plans for Information Systems Change 49
MHP EHR Status 49
Contract Provider EHR Functionality and Services 50
Personal Health Record 53
Medi-Cal Claims Processing 54

NETWORK ADEQUACY 56
Network Adequacy Certification Tool Data Submitted in April 2020 56
Findings 57
Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients 57
Provider NPI and Taxonomy Codes – Technical Assistance 57

CONSUMER AND FAMILY MEMBER FOCUS GROUPS 59

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS 60
Access to Care 60
Timeliness of Services 62
Quality of Care 64
Beneficiary Progress/Outcomes 67
Structure and Operations 69

SUMMARY OF FINDINGS 72
MHP Environment – Changes, Strengths and Opportunities 72
FY 2020-21 Recommendations 79

SITE REVIEW PROCESS BARRIERS 81

ATTACHMENTS 82
Attachment A—Review Agenda 83
Attachment B—Review Participants 84
Attachment C—Approved Claims Data 86
Attachment D—ACA Penetration Rates and ACBs 87
Attachment E—ACB Range Distributions 88
Attachment F—List of Commonly Used Acronyms 89

LIST OF TABLES

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity 21
Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language 22
Table 3: High-Cost Beneficiaries CY 2017-19 27
Table 4: Psychiatric Inpatient Utilization CY 2017-19 27
Table 5: PIPs Submitted by Merced MHP....29
Table 6: General PIP Information – Clinical PIP 29
Table 7: Improvement Strategies or Interventions – Clinical PIP 31
Table 8: Performance Measures and Results – Clinical PIP....32
Table 9: General PIP Information – Non-Clinical PIP....34
Table 10: Improvement Strategies or Interventions – Non-Clinical PIP 35
Table 11: Performance Measures and Results – Non-Clinical PIP....36
Table 12: Budget Dedicated to Supporting IT Operations....40
Table 13: Business Operations....40
Table 14: Distribution of Services by Type of Provider 41
Table 15: Technology Staff 42
Table 16: Data Analytical Staff....42
Table 17: Count of Individuals with EHR Access 43
Table 18: Ratio of IT Staff to EHR User with Log-on Authority 43
Table 19: Additional Information on EHR User Support....43
Table 20: New Users' EHR Support....44
Table 21: Ongoing Support for the EHR Users....44
Table 22: Summary of MHP Telehealth Services 45
Table 23: Contract Providers Delivering Telehealth Services 47
Table 24: Primary EHR Systems/Applications....48
Table 25: EHR Functionality 49
Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR 52
Table 27: EHR Vendors Supporting Data Transmission from Contract Provider to MHP....52
Table 28: PHR Functionalities....53
Table 29: Summary of CY 2019 SD/MC Claims 54
Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial 55
Table 31: NPI and Taxonomy Code Exceptions 57
Table 32: Access to Care Components 60
Table 33: Timeliness of Services Components....62
Table 34: Quality of Care Components....64

Table 35: Beneficiary Progress/Outcomes Components 67
Table 36: Structure and Operations Components..69
Table A1: EQRO Review Sessions...83
Table B1: Participants Representing the MHP...85
Table D1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB.......87
Table E1: CY 2019 Distribution of Beneficiaries by ACB Range..........................88
Table F1: List of Commonly Used Acronyms...89

LIST OF FIGURES

Figure 1: Overall Penetration Rates CY 2017-19..23
Figure 2: Overall ACB CY 2017-19..23
Figure 3: Latino/Hispanic Penetration Rates CY 2017-19...................................24
Figure 4: Latino/Hispanic ACB CY 2017-19...24
Figure 5: FC Penetration Rates CY 2017-19 25
Figure 6: FC ACB CY 2017-19...25
Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019 26
Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019...26
Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19......................28
Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19..................28

INTRODUCTION

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

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

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

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

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

MHP Information

MHP Size — Medium

MHP Region — Central

MHP Location — Merced

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 4,822

MHP Threshold Language(s) — Spanish, Hmong

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

Validation of Performance Measures[1]

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

Performance Improvement Projects[2]

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

MHP Health Information System Capabilities[3]

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

Network Adequacy

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

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

---

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

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

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

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

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

Validation of State and MHP Beneficiary Satisfaction Surveys

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

CalEQRO was unable to conduct 90-minute focus groups due to the COVID-19 pandemic, which typically provides the review with beneficiary and family member direct qualitative evidence.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

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

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

definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

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

Status of FY 2019-20 Review of Recommendations

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

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: Both PIPs are Active and Ongoing.

Status: Met

- The MHP is finalizing a replacement for the high frequency user clinical PIP which ended two months before this review. The replacement clinical PIP should have active interventions within the next three months.
- The initial psychiatry access non-clinical PIP accomplished significant improvement in timeliness, but merited continuation in order to achieve results that meet the 10-business day standard 75 percent of the time for all tracked groups.

Access Recommendations

Recommendation 2: Always investigate the feasibility of having dedicated staff responding to the crisis telephone line. Consider hiring additional staff, deploying current staff from different locations to meet the need, or using a contracted service for after-hours crisis calls*. (This is a follow-up recommendation from FY 2018-19.)*

Status: Met

- Staffing of the access line was increased by 1.0 FTE extra-help of mental health worker, for a total of 5.0 FTE.
- Cross-training of additional staff to access line duties was initiated to provide greater depth of coverage.
- The MHP is pursuing purchase of access line software that will support tracking of call volume and other important metrics to both monitor quality and assist in the determination of staffing needs.
- After-hours calls are managed by the crisis team, which has been trained in call response and logging of key contact information procedures, as well as provision of "point of entry" appointments.

Recommendation 3: Continue ongoing quality management (QM) efforts to improve the experience for beneficiaries when calling in to the MHP during all hours, training staff to comply with call scripts and conducting test calls to monitor performance and to inform training / staffing.

Status: Met

- Merced Behavioral Health and Recovery Services (BHRS) initiated a Test Call Committee under the aegis of QM. The committee meets monthly, reviews trends in test call findings, identifies training topics, and provides an overall analysis of access and 24/7 crisis line performance.
- The Test Call Committee developed a streamlined process for routing received calls, and cross-training for the dedicated access line staff. The committee's activities resulted in significant improvements in the documentation and logging of calls, as well as provision of information about BHRS services.
- The Test Call Committee is comprised of crisis services leadership, substance use disorder personnel, medical records, line staff and Quality and Performance Management (QPM) staff.

Timeliness Recommendations

Recommendation 4: Continue prioritizing the improvement of timeliness rates for follow-up appointments after hospital discharge, through change management processes such as the clinical PIP and implementation of interventions such as the ISN-SIT teams for adults and children.
(This recommendation is a carry-over from FY 2018-19.)

Status: Met

- BHRS implemented the strategy of establishing open urgent appointment slots for intake clinicians that are available for high-priority individuals such as post-hospital discharges. The Innovative Strategist Network Service Integration Team (ISN/SIT) clinician also offers two urgent assessment slots each week for new-to-service individuals discharged from an acute inpatient stay.
- The MHP noted that efforts to create improvement in this area are impacted by continued intake system clinician vacancies that remain difficult to fill.

Quality Recommendations

Recommendation 5: Develop a workgroup or other mechanism to gather input from a diverse group of stakeholders including beneficiaries, line staff and IT, to examine current processes and identify strategies to reduce the time that clinical staff spend on documentation. Potentially more time could be available for other aspects of delivering quality service and the effort could also have a positive impact on staff retention, especially if all staff were aware of, and invested in the process.

Status: Partially Met

- BHRS developed a forms committee, that includes feedback from the contractors' meeting, and reviews current processes and develops strategies that reduce documentation time.
- Medical staff received help from an additional office assistant who was hired to reduce administrative burden on medical staff. This addition reduced the response time for adverse benefit determination/notice of action (NOABD), including distribution and tracking.
- The MHP did not report the time saved by these actions to clinical staff availability. Quantifying and reporting results assists the MHP in determining if further efforts in a given area are required, and is an opportunity to communicate results to line staff.

Beneficiary Outcomes Recommendations

Recommendation 6: The MHP should identify barriers and implement strategies to ensure full implementation of the Adult Needs and Strengths Assessment (ANSA) outcome tool throughout the system. *(This is follow-up recommendation from FY 2018-19)*.

Status: Partially Met

- BHRS leadership continues to evaluate the various level of care tools available to determine if the ANSA is the best fit for local needs.
- ANSA challenges include staff experiencing difficulties meeting annual recertification requirements. BHRS leadership is looking at various approaches that would help with this issue, including establishing policies and protocols that ensure timely recertification.
- The ANSA implementation pilot continues primarily in the satellite clinics in Los Banos and Livingston, with limited expansion to the adult system of care Merced site.

Foster Care Recommendations

- None noted.

Information Systems Recommendations

Recommendation 7: The MHP's transition to a new EHR would be enhanced by having a dedicated Project Manager who has regular access to the management team.

Status: Met

- While the MHP has not yet selected a replacement EHR, the BHRS Automation Services Manager has been designated as the project manager for the EHR Transition Team.
- Additional members of the EHR Transition Team include two assistant directors (administrative and clinical), the contract manager, medical director, multiple clinicians, an automation services analyst, automation services assistant and the fiscal manager.

Recommendation 8: Evaluate the type and level of IT and analytic resources dedicated to MHP service needs for daily operations, improved reporting

capabilities, and the delivery of significant initiatives which will move the organization forward.
(This is a follow-up recommendation from FY 2018-19)

Status: Met

- A contract with Kings View Behavioral Health Services for general consultation, EHR training and data and analytic support has been in place since 2009. In fall 2020, this contract was expanded to include support for the continued refinement and development of Tableau dashboard reports, including reports for penetration rates, timelines to service, rehospitalization and appointment no-show data.
- Analysis of IT and analytical resource demands indicated considerable staff time is devoted to hosting the Cerner Community Behavioral Health (CCBH) EHR on county servers. Reporting inefficiencies were also identified, as data must be exported from the EHR, cleaned and analyzed in external solutions, and then populated to an external dashboard solution. These issues are a consideration for the current development of a Request for Proposal (RFP) for a replacement information system, and criteria for selection of the replacement EHR. The RFP specifications will include hosting the system on the vendor's servers and integrated reporting functionality.
- With the decision for the replacement EHR to be vendor hosted, staff time dedicated to maintaining servers will be redeployed. When the replacement EHR reporting capabilities are automated and more easily configurable, the duplication of efforts in the current reporting processes will be eliminated and allow for more in-depth analysis and reliability of reporting with the same level of staffing. The MHP determined that current Automation Services staffing levels will meet the needs of the Department while making reporting capabilities more reliable and responsive.

Recommendation 9: Ensure robust IT and analytical staffing patterns to support both the legacy system, concurrent with the new system, to enable a successful implementation.

Status: Met

- The MHP's EHR transition plan includes creation of a read-only copy of the legacy CCBH data following completion of the migration process. The CCBH legacy system will become a historical record, and not require active support.

- The MHP's transition plan includes consulting time from the vendor of the new EHR that will supplement BHRS staff time during the migration and implementation of the new EHR.
- In the early stages of the implementation plan, superusers will be identified from each unit of the department. The superusers will provide input into the system design, receive the first round of training, and be first line support for the new EHR.

Recommendation 10: Explore options for staffing enhancements sufficient to provide Help Desk support and employee training sessions simultaneously.

Status: Met

- Help desk support is bifurcated, with EHR support handled by BHRS Automation Services staff while IT and network support are handled by County IT staff.
- BHRS Automation Services conducts ongoing monitoring and analysis of EHR Help Desk requests and response times. Staff requests to unlock the EHR were trending upwards. Automation Services identified staff who had not set the security questions required for automated unlocking and provided refresher training. Following this training, calls to recover passwords became rare.
- BHRS Automation Services has enhanced coordination with the County IT Help Desk. Automation Services sought buy-in from the leadership team to advise staff to make the BHRS Help Desk their first contact, instead of contacting the County IT Help Desk. This practice allows Automation Services staff to triage reported problems and clarify information prior to sending the request to County IT support. The MHP reports the revised process has improved the relationship between County IT and BHRS staff, which has improved County IT response times.

Structure and Operations Recommendations

Recommendation 11: To ensure safety in the crisis stabilization unit (CSU), investigate the feasibility of replacing glass with unbreakable sheeting (such as Lexan) in all areas where beneficiaries in crisis have access, or implement a suitable alternative.

Status: Met

- MHP leadership confirmed with the Merced Department of Public Works that CSU external and nurses station windows are made of tempered

safety glass, which shatters into small pebbles and is fire-rated. This material lacks sharp, jagged edges and is appropriate for the CSU environment.

Recommendation 12: MHP staff and community partners responding to crises should consider a collaboration effort to manage the risks associated with beneficiaries on 5150 hold waiting too long in the ER before assessment and disposition.

Status: Met

- The BHRS Crisis Division incorporated telehealth for use in performing emergency room W&I 5150 assessments in April of 2020.
- Communication with hospitals is supported by InTouch iPad applications.
- Crisis services provides briefings of ER nursing staff each shift, which has improved communication and triaging of beneficiaries awaiting evaluation.

Recommendation 13: Investigate adding some weekend hours to the wellness centers, perhaps a weekend day or two per month, initially, and/or linking beneficiaries to other weekend community resources to further support beneficiary recovery activities.

Status: Partially Met

- The BHRS wellness centers in Merced and Los Banos closed in mid-March 2020 due to COVID-19. Peer support specialists have instead been regularly calling beneficiaries to provide support in accessing both MHP and community resources.
- The wellness center staff coordinated with the food bank to ensure food access and deliver food boxes to beneficiaries who were unable to leave home. In addition, support with housing has been integral to the peer support function.
- When the public health emergency (PHE) restrictions due to COVID-19 resolve and direct services resume as previously, the MHP plans on exploring extended hours for wellness centers, including possible weekend availability.

Recommendation 14: Explore the option of having ‘floating” staff to fill-in on teams when assigned staff are away for illness, training, or vacations. This could help minimize workload stresses and promote improved quality service.

Status: Partially Met

- BHRS created a system-wide “clinician of the day” and “office assistant rotation calendar.” These assignments assist with maintaining adequate coverage in essential areas when coverage issues arise. Staff in these roles understand how to respond when unanticipated walk-ins occur or when coverage issues arise.

Recommendation 15: Explore the development of incentives to retain licensed staff, such as meaningful bonuses after five years of employment, at the attainment of licensure, and successive bonuses at 10 years, and other milestones, for instance. *(This is a follow-up recommendation from FY 2018-19).*

Status: Partially Met

- BHRS’ response in this area focused primarily on COVID-19 related efforts. The retention efforts have included permitting staggered schedules to help staff attend to their families during the PHE. This resulted in decreased numbers of staff arriving at the same time, and reduction in risk of virus transmission. There have been related benefits for both employees and beneficiaries, including expanded service hours, from 6am to 7pm.

- BHRS permits direct service staff to telecommute up to three days each week. This option is believed to improve staff morale and decrease burnout, while also improving staff retention.

- A pilot 9/80 schedule is being offered to staff, an option that is responsive to long-stranding requests. Implementation is to be associated with increased service hours, which will be expanded to 8am to 7pm Monday through Thursday.

Recommendation 16: As part of staff retention efforts, the MHP would benefit from assuring that interns and associates on licensure track have access to individual clinical supervision as part of employment in the MHP, in addition to group supervision.

Status: Met

- Starting in March 2020, all clinical interns registered with the Board of Behavioral Sciences are provided with individual and group clinical supervision. The group supervision ratio requirements allow BHRS to add interns/associates as needed to the process.

PERFORMANCE MEASURES

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

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

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

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

---

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

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

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

Health Information Portability and Accountability Act Suppression Disclosure

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

Total Beneficiaries Served

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

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

Merced MHP				
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Beneficiaries	Percentage of Medi-Cal Beneficiaries	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
White	21,766	16.4%	1,583	32.8%
Latino/Hispanic	90,493	68.4%	2,273	47.1%
African-American	5,123	3.9%	358	7.4%
Asian/Pacific Islander	6,402	4.8%	149	3.1%
Native American	259	0.2%	20	0.4%
Other	8,350	6.3%	439	9.1%
Total	**132,391**	**100%**	**4,822**	**100%**

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

Table 2 provides details on beneficiaries served by threshold language identified in DHCS Information Notice 13-09.

For FY 2020-21 CalEQRO utilized data from the DHCS Mental Health Services Division Information Notice 13-09, which was considered current policy on threshold languages; Spanish and Hmong were recognized threshold languages at that time.

On December 14, 2020, DHCS issued BHIN 20-070 which utilizes more current Medi-Cal eligibility data to determine threshold languages.

The MHP adheres to more recent Medi-Cal eligibility data, consistent with DHCS BHIN 20-070, wherein Hmong is no longer identified as a threshold language.

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

Merced MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	543	11.3%
Hmong	116	2.4%
Other Languages	4,163	86.3%
Total	**4,822**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

Penetration Rates and Approved Claims per Beneficiary

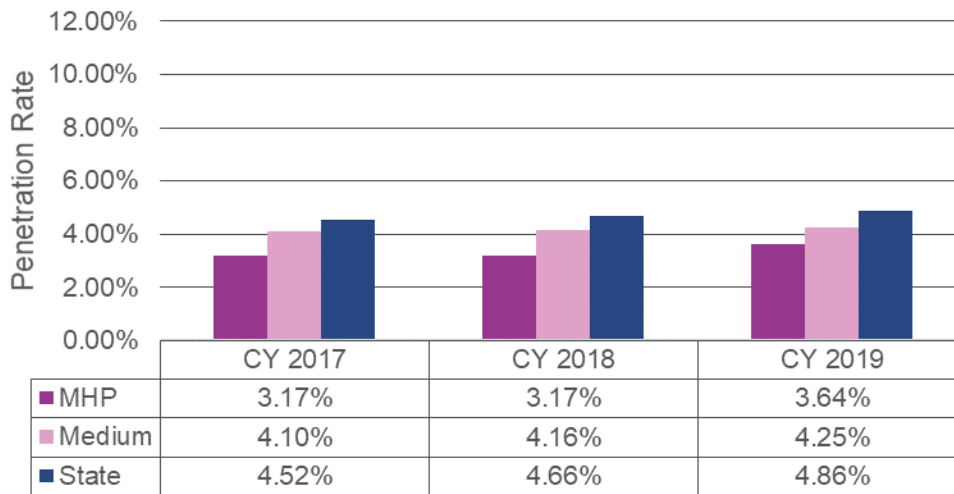
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated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

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

Regarding the calculation of penetration rates, the Merced MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19)

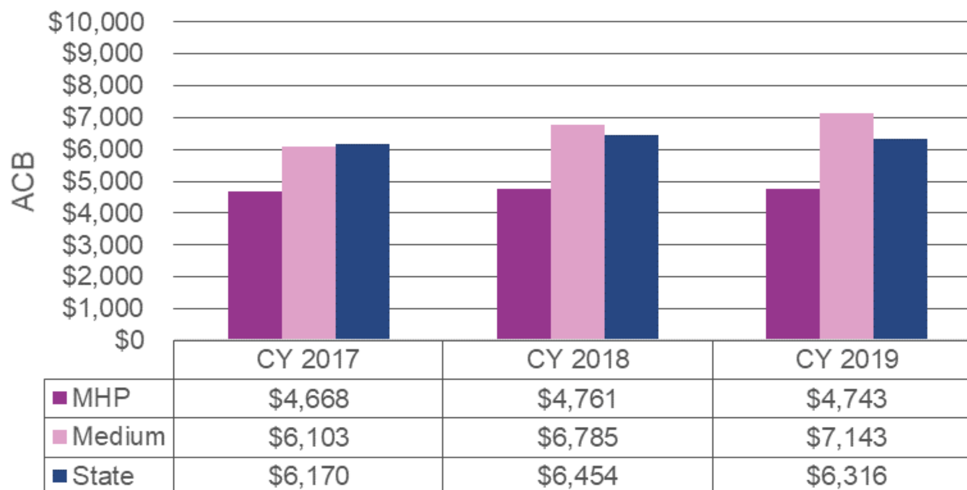
trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	3.17%	3.17%	3.64%
Medium	4.10%	4.16%	4.25%
State	4.52%	4.66%	4.86%

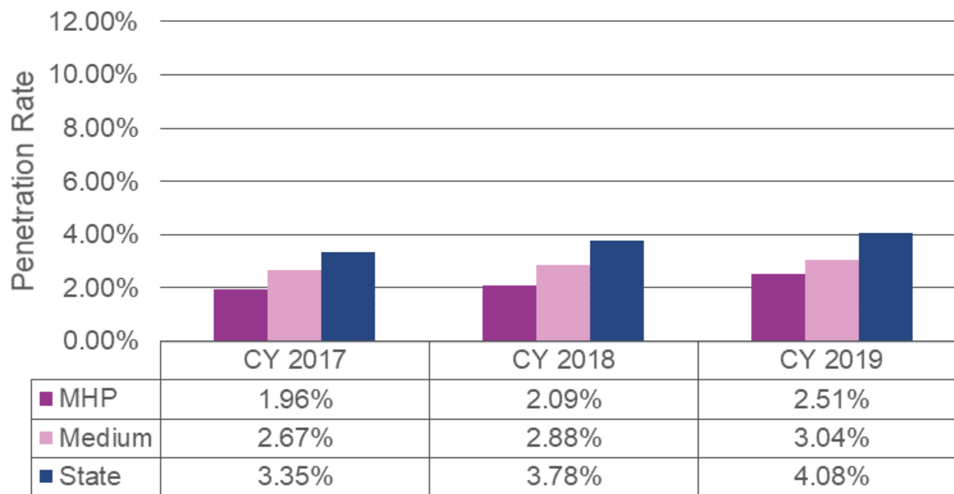
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$4,668	$4,761	$4,743
Medium	$6,103	$6,785	$7,143
State	$6,170	$6,454	$6,316

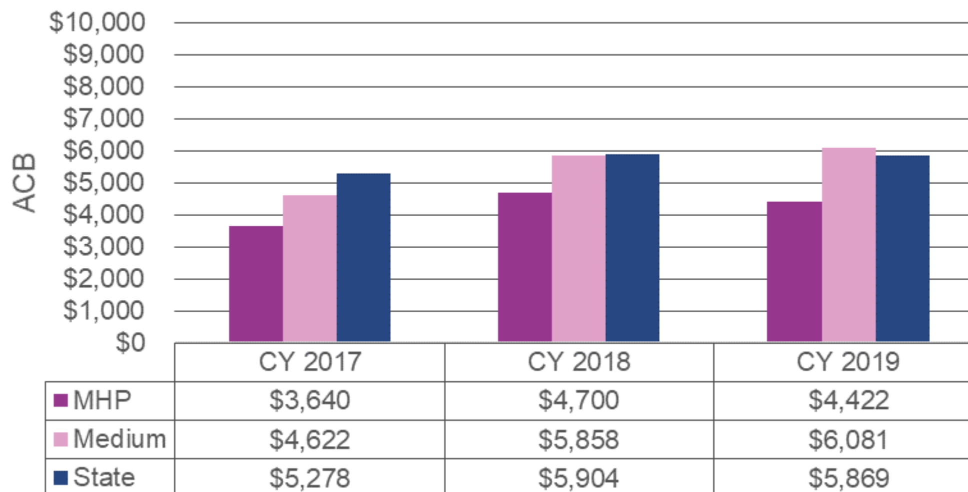
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	1.96%	2.09%	2.51%
Medium	2.67%	2.88%	3.04%
State	3.35%	3.78%	4.08%

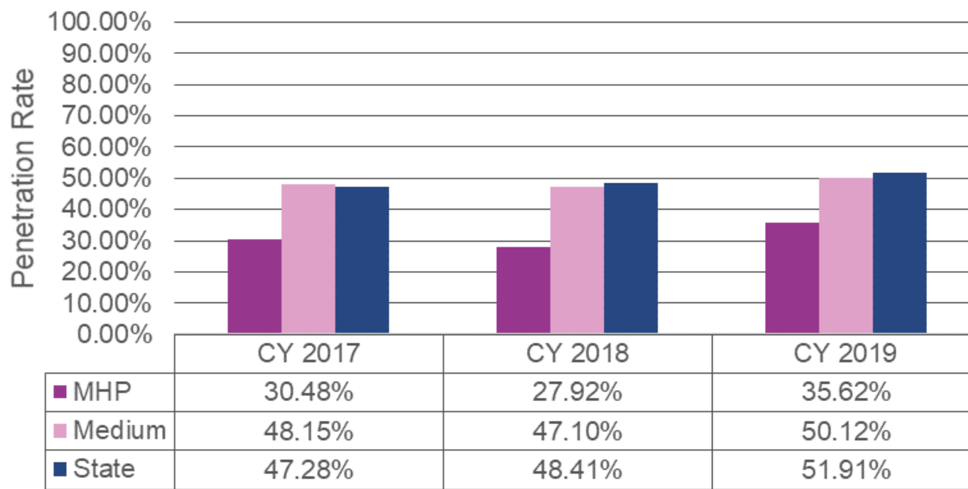
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,640	$4,700	$4,422
Medium	$4,622	$5,858	$6,081
State	$5,278	$5,904	$5,869

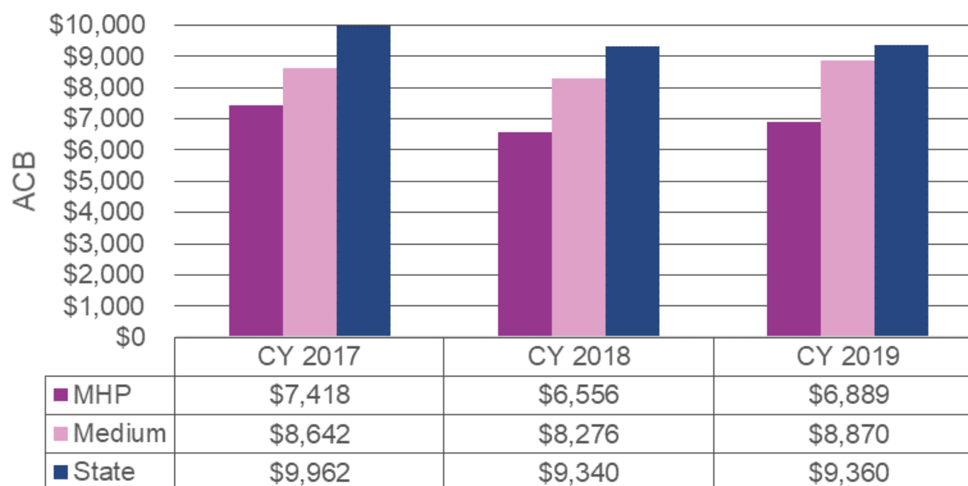
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	30.48%	27.92%	35.62%
Medium	48.15%	47.10%	50.12%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

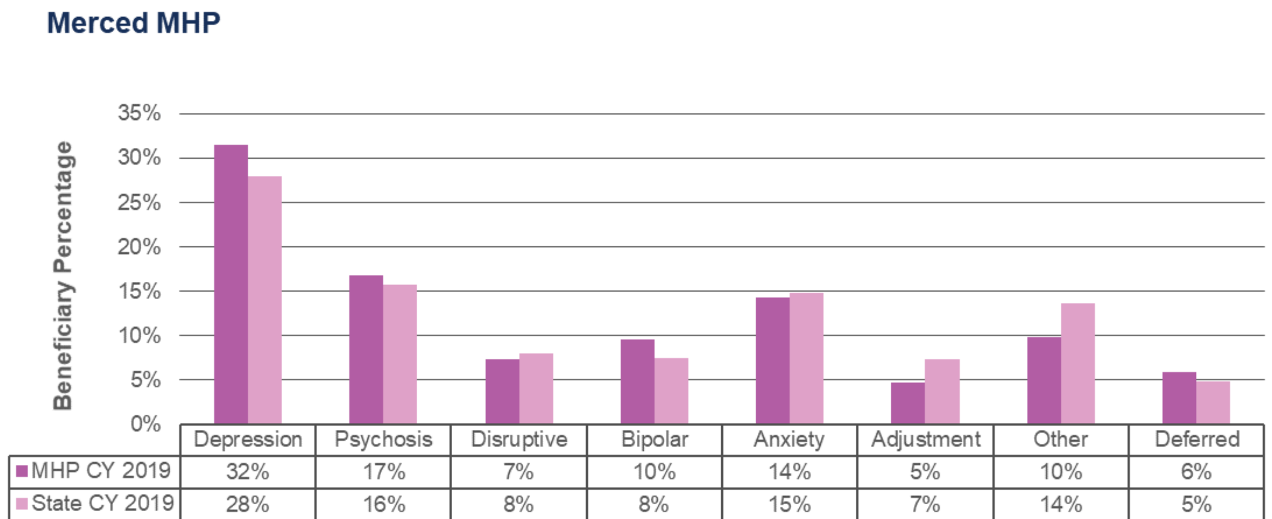


	CY 2017	CY 2018	CY 2019
MHP	$7,418	$6,556	$6,889
Medium	$8,642	$8,276	$8,870
State	$9,962	$9,340	$9,360

Diagnostic Categories

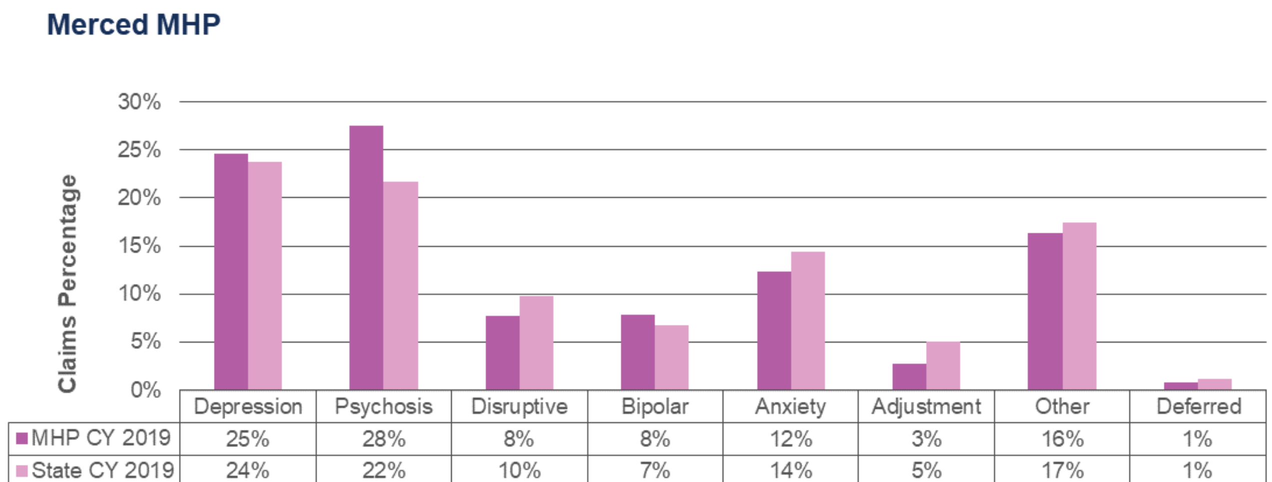
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	32%	17%	7%	10%	14%	5%	10%	6%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

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



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	25%	28%	8%	8%	12%	3%	16%	1%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

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

Table 3: High-Cost Beneficiaries CY 2017-19

Merced MHP								
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	152	4,822	3.15%	$55,145	$8,381,976	36.65%
	CY 2018	129	4,314	2.99%	$57,669	$7,439,301	36.22%
	CY 2017	136	4,459	3.05%	$54,172	$7,367,324	35.39%

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

Psychiatric Inpatient Utilization

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

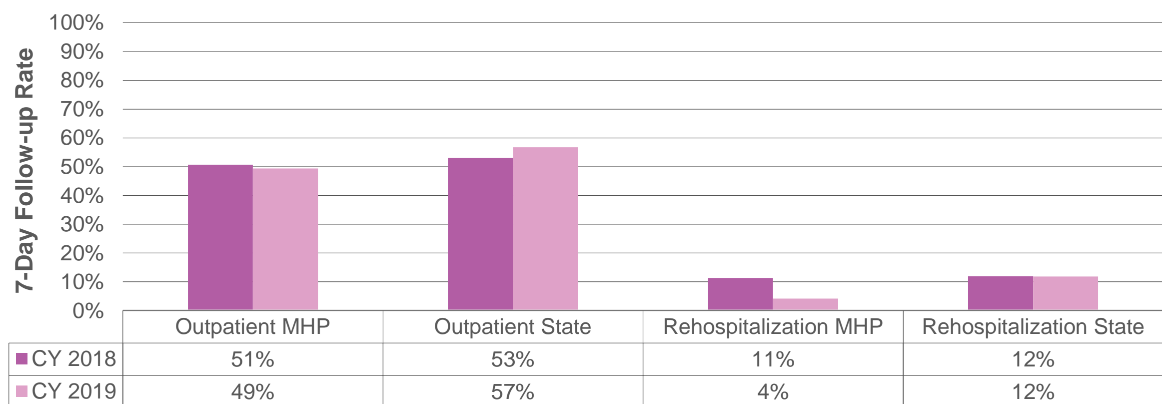
Table 4: Psychiatric Inpatient Utilization CY 2017-19

Merced MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	445	831	7.86	7.80	$16,060	$10,535	$7,146,824
CY 2018	475	1,012	7.34	7.63	$16,458	$9,772	$7,817,461
CY 2017	490	1,131	6.69	7.36	$13,304	$9,737	$6,518,925

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

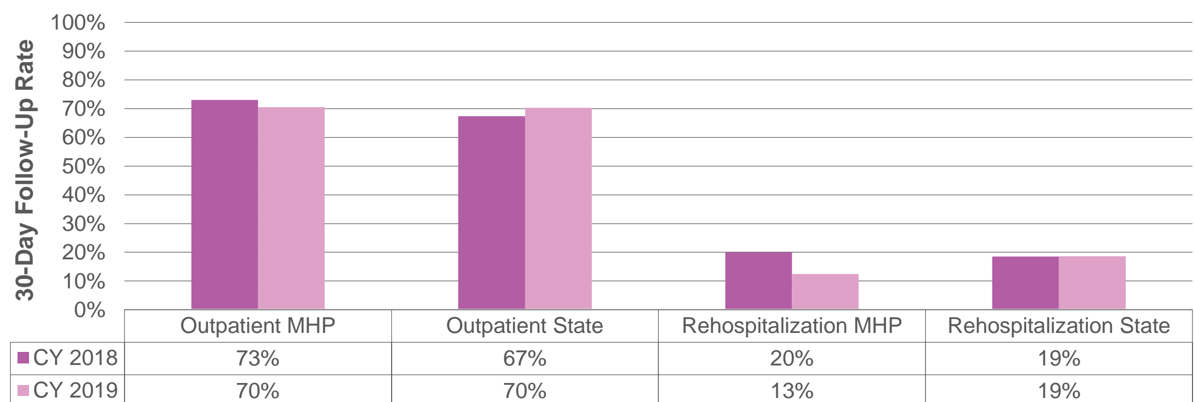
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	51%	53%	11%	12%
CY 2019	49%	57%	4%	12%

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	73%	67%	20%	19%
CY 2019	70%	70%	13%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

Merced MHP PIPs Identified for Validation

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

Table 5: PIPs Submitted by Merced MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Reducing the frequency of crisis contacts and hospitalizations for adults
Non-Clinical	1	Improving the timeliness of psychiatry referrals

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Merced
PIP Title	Reducing the frequency of crisis contacts and hospitalizations for adults
PIP Aim Statement	"The goal of this PIP is to reduce the average overall crisis/hospitalization contacts per clients within a 12-month period as stated in the performance indicator goals to below the state yearly average. This data will be tracked over a 24-month period to monitor and track data for improvement during the implementation of the interventions. The PIP will be used to improve processes and outcomes of care by evaluating clients individually with a specialized committee to identify and reduce the barriers that may have contributed to the decompensation and frequent crisis contacts leading to or resulting in psychiatric

MHP Name	Merced
	hospitalizations. It is the intent for the High Frequency User (HFU) committee to monitor on a monthly basis commence (as of January 2018) and determine if interventions applied are effective in reducing patterns of frequency crisis contacts and hospitalizations system-wide. Merced County has an estimated population of 279,977 people (*California Department of Finance (DOF) Report E-5 Population and Housing Estimates for Cities, Counties, and the State, January 1, 2011-2018 with 2010 Benchmark*). Of this population, roughly 124,739 are enrolled with Medi-Cal (*Medi-Cal Enrollments, DHCS, July 2018*). This is approximately 44.2% of the population. The MHP served 4,902 clients in FY 2017/2018, which is 3.90% of the Medi-Cal population. BHRS has defined "frequent crisis contacts and/or inpatient hospitalizations" as having three or more crisis contact and inpatient hospitalizations. BHRS client is defined as an individual who currently meets medical necessity, as defined within the California Department of Health Care Services Mental Health Services Divisions Program Oversight and Compliance, Annual review protocol for Specialty Mental Health Services and Other Funded Services (FY 2017/2018). Merced County adult Medi-Cal beneficiary, are defined as an individual residing in Merced County who has Medi-Cal benefits that falls within the age of eighteen to ninety-nine (18-99). A crisis contact is counted when an individual experiences a psychiatric emergency as a result of a mental health condition thoughts/ideation/plan for self-harm or danger to others and/or grave disability. Grave disability for adults is the inability to obtain and utilize food, clothes and shelter. Crisis services, and assessments/interventions, are provided by BHRS crisis stabilization unit, triage service (mental health professionals evaluate clients at local emergency rooms) and triage mobile crisis response (Partnership with local law enforcement, school resource officers, community members to perform a risk assessment)."
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic)	

MHP Name	Merced
☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The target population has no specific diagnostic profile, but are those who fall into the MHP's defined HFU population. Merced County has an estimated population of 279,977 people (*DOF Report E-5 Population and Housing Estimates for Cities, Counties, and the State, January 1, 2011-2018 with 2010 Benchmark*). Of this population, roughly 124,739 are enrolled with Medi-Cal (*Medi-Cal Enrollments, DHCS, July 2018*). This is approximately 44.2% of the population. The MHP served 4,902 clients in FY 2017-18, which is 3.90% of the Medi-Cal population. BHRS has defined "frequent crisis contacts and/or inpatient hospitalizations" as "having three or more crisis contact and inpatient hospitalizations." BHRS client is defined as an individual who currently meets medical necessity, as defined within the California Department of Health Care Services Mental Health Services Division's Program Oversight and Compliance, Annual review protocol for Specialty Mental Health Services and Other Funded Services (FY 2017-18). Merced County adult Medi-Cal beneficiary, are defined as an individual residing in Merced County who has Medi-Cal benefits that falls within the age of eighteen to ninety-nine (18-99).	

Table 7: Improvement Strategies or Interventions – Clinical PIP

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

PIP Interventions (Changes tested in the PIP)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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 improvement strategy is to utilize the High Frequency Committee to identify monthly priority clients who have had more than three (3) recent crisis events within the last twelve (12) months and apply specific interventions to each client as need indicates. The following interventions/referrals are applied: • Homeless Services • Case Management • Medication Services • Outpatient (if not open) • Substance Use Disorder Services • Dual Diagnosis Program • Contract Provider (AspiraNet for youths / Turning Point for adults) • Wellness Center • Crisis Rehabilitation Unit (30-day optional stay unit) Integrated Strategies Network (ISN) Program (medication management, case management, community-based referrals).

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
1. Decrease the overall % of HFU's within a 12-month timeframe	**CY16 State HCB Average**	3.33% MHP data **3.12%**	**CY18**	2.06% MHP data **3.74% State HCB Average**	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
						☐ <.05 Other (specify): n/a
					☒ No test of statistical significance	

Was the PIP validated?	☒ Yes	☐ No

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

Validation rating:
☐ High confidence[5] ☒ Moderate confidence[6] ☐ Low confidence[7]

[5] Credible, reliable, and valid methods for the PIP were documented.
[6] Credible, reliable, or valid methods were implied or able to be established for part of the PIP.
[7] Errors in logic were noted or contradictory information was presented or interpreted erroneously.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ No confidence[8]						
Justification for validation rating: This PIP was concluded October 2020, two months prior to the current MHP review. There has clearly been an improvement, with the MHP's high-cost beneficiary percentage of beneficiaries at the last measurement (Q1 FY 2020-21) a full percentage point less than the statewide average. Continued tracking of the establishing data categories of hospitalization and crisis event rates as PIP indicators would have provided more granular information as to which sectors and types of services were most effected by the HFU intervention process. At a high level, there has been improvement from the HFU committee process. As written, the HFU committee is a rather opaque process where it is not clear exactly what transpired and how referral decisions were made and implemented. "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: • n/a PIP completed.						

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Merced
PIP Title	Improving the timeliness of psychiatry referrals.
PIP Aim Statement	"The overarching goal of the PIP is to improve wait times for all clients seeking psychiatry services to less than 15

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

MHP Name	Merced
	working days over the next two (2) years to a compliance of 70% to 75%. The overall strategy of this PIP is to remove barriers both internally and externally in order to provide psychiatric referral appointments to clients within 15 working days. The population within this PIP focus includes all clients who are need of medication to help them improve their overall mental health. These include all ages of the population and is based on need and current status of their mental health.”
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☒ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): This PIP includes all beneficiaries who are need of medication to assist with improving their overall mental health. These include all ages of the population and is based on need and current status of their mental health.	

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

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Year two interventions include reminder call engagement efforts of peer support specialists.

PIP Interventions (Changes tested in the PIP)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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): • Review, evaluate and update the Initial Psychiatric Referral Form to eliminate barriers for clinical staff to directly schedule appointments for beneficiaries needing psychiatry services. • Review, evaluate and streamline the procedure for scheduling psychiatry referrals for all sites; then distribute to staff. • Training of staff in the new psychiatric referral procedure. • Implement Peer Support Specialists reminder call procedure. (FY 2020-21 new intervention).

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
1. Decrease the number of working days for psychiatric referral appointments to within 15 working days.	FY 2018-19	41 working days	2019/2020	27 working days	☒ Yes ☐ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
					☒ No test of statistical significance	
2. Increase the % of clients who were referred for psychiatric appointments within 15 working days.	FY 2018-19	8%	2019/2020	36%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
3. Decrease the number of working days for completed psychiatric referral appointments to within 15 working days.	FY 2018-19	47 working days	2019/2020	27 working days	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	

4. Increase the % of clients who completed psychiatric referral appointments within 15 working days.	FY 2018-19	11%	2019/2020	44%	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	

Was the PIP validated?	☒ Yes ☐ No

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

Validation rating:

☒ High confidence[5]
☐ Moderate confidence[6]
☐ Low confidence[7]
☐ No confidence[8]

Justification for validation rating: This PIP was associated with significant decreases in the time to first offered psychiatry appointment. The MHP reduced the working days from 41 to 27, and increased the percentage of those referred for psychiatric appointments within 15 business days from 8 to 36 percent. "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • The addition of peer support specialist is an intervention that directly impacts beneficiaries, and would be improved if it also involved testing an engagement strategy such as motivational interviewing for use with reminder calls.
The TA provided to the MHP by CalEQRO consisted of: • Discussed PIP development concepts and how to ensure that along with process interventions, other interventions directly affect the problem and/or the beneficiary.

INFORMATION SYSTEMS REVIEW

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

Key ISCA Information Provided by the MHP

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

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

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Merced	3.04%	3.52%	2.81%	2.73%
Medium MHP Group	n/a	3.28%	3.34%	3.01%
Statewide	n/a	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

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

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

Table 13: Business Operations

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

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

- Ongoing cyber resiliency information is provided to staff by security tip newsletters and other security related emails from the Merced County IT Department.

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

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	59.13%
Contract providers	32.27%
Network providers	8.60%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

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

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	7	1	0	0
2019-20	7	0	2	2
2018-19	7	2	4	1

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

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	8	0	0	0
2019-20	0	0	0	0
2018-19	7	2	4	1

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

- Technology staffing has been stable over the past year. Technology staffing includes one Assistant Director- Administration, one manager, one office assistant, one staff services assistant and five staff services analysts.
- Data staffing has increased over the past year by approximately one FTE with an increase in Kings View contracted support, effective Fall 2020. Data analytic staffing includes four Automation Services analysts, two fiscal staff and additional contracted support from Kings View that equates to approximately two FTEs.

Summary of User Support and EHR Training

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

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	115	24	139
Clinical Healthcare Professional	201	126	327
Clinical Peer Specialist	20	1	21
Quality Improvement	13	0	13
Total	349	151	500

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

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

Type of Staff	MHP FY 2020-21	Medium MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	7.0	7.87
Total EHR Users Supported by IT (Source: Table 17)	500.00	572.00
Ratio of IT Staff to EHR Users	1:71	1:73

- The MHP's IT staffing ratio is consistent with the medium county average.

Table 19: Additional Information on EHR User Support

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

- The MHP hosts the CCBH system via an onsite dedicated Cerner Structured Query Language (SQL) server that was added in the past year. There is a contract with Kings View for additional EHR and data analytic support.

Table 20: New Users' EHR Support

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

- BHRS Automation Services provides EHR support to staff.

Table 21: Ongoing Support for the EHR Users

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

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

- Mandated HIPAA trainings are monitored for both MHP and contract provider staff.

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

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

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	7
Number of county-operated telehealth sites	7
Number of contract providers' telehealth sites	3
Total number of beneficiaries served via telehealth during the last 12 months	1176
• Adults	737
• Children/Youth	391
• Older Adults	48
Total number of telehealth encounters (services) provided during the last 12 months:	4,855

- Telehealth services are available at seven MHP sites: Livingston, Los Banos, Merced Adult System of Care, Merced Children's System of Care, Medical Team (Merced), Crisis Stabilization Unit (Merced) and Marie Green Psychiatric Center (Merced).

- Telehealth services are available with English, Spanish, and Hmong speaking practitioners (not including the use of interpreters or the language line).
- There were 409 telehealth sessions conducted in Spanish or Hmong.

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

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

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

- The MHP added to telehealth group therapy, individual therapy, new client intake and assessment, case management, group education and support sessions and crisis evaluation/assessment telehealth services due to the COVID-19 pandemic.
- To support the increase in services being provided via telehealth, the MHP purchased laptops, iPads, iPhones, webcams, and seven Cisco WebEx DX80 units utilized for telehealth.

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

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

☐	Vietnamese	☐	n/a

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

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

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Aspiranet	3
Creative Alternatives	3

Current MHP Operations

- The MHP continues to utilize the CCBH system, implemented in 2009, to support EHR functionality, billing and state-mandated reporting requirements. CCBH software promotion 230.12 was installed at the time of this review.
- COVID-19 resulted in the number of services provided by individual staff increasing, but significantly reduced the total service units provided. If the current rate of billing continues through the end of the FY 2020-21, the MHP anticipates a decrease of approximately 17,000 units of service.
- BHRS had, at one point, an 85 percent pandemic-related reduction of staff in one division. This was largely due to the number of staff who were on COVID-19 related Emergency Paid Sick Leave (EPSL), Families First Coronavirus Response Act (FFCRA) and Family and Medical Leave Act (FMLA) leave. The MHP will continue to closely monitor this metric.
- Medi-Cal claiming and Client Services Information (CSI) file submission are reported as timely. The November 2020 Medi-Cal claim file was submitted in December of 2020. The October 2020 CSI file was submitted in December of 2020.

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

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Cerner Community Behavioral Health	EHR/Practice Management	Cerner	10	Automation Services/ County IT

Major Changes since Prior Year

- The Cerner Millennium EHR project was abandoned when it was identified that the core Millennium EHR would not meet the MHP's needs by the anticipated go-live date.
- Due to the cancellation of the Cerner Millennium project, the MHP began development of an RFP for a replacement information system.
- Due to COVID-19, the BHRS internet site was updated with additional resources including the Medi-Nurse Line and the Youth and Adult Warm Line. All telephone numbers were updated with additional functionality to permit users to immediately dial a phone number if clicked on. When clicked, email links now open automatically. Flyers and brochures, previously available in clinics, have been posted online in English, Hmong, and Spanish.
- A new Behavioral Health Advisory Board (BHAB) web page was added to the BHRS website. The community can use this page to obtain information on meeting dates, how to attend the meetings and view the Board member list.
- The BHRS intranet was moved to a Microsoft SharePoint platform. Updated features include improved design and navigation, announcements and calendars, newsletters and Quick Links to send emails, or to open other frequently used resources.
- A Cerner SQL server has been installed to support CCBH operations.
- All computers have background encryption.

The MHP's Priorities for the Coming Year

- The MHP plans to release an RFP for a replacement information system in February 2021.
- The MHP will select a replacement EHR system and begin implementation.
- The MHP is an active participant with the San Joaquin Health Information Exchange (SJHIE), which partners with Manifest MedEx to provide the Health Information Exchange (HIE) platform. The Assistant Director of Administration is on the SJHIE Board of Directors and the MHP has a goal of working towards HIE inter-operability with their new EHR. Interoperability is a longer-term goal, beginning after selection and full implementation of the replacement EHR system.
- The MHP upgraded all computers to Windows 10 or above.
- The MHP will complete a computer equipment inventory.
- The MHP will continue to support the organization and staff during the ongoing COVID-19 pandemic.

Other Areas for Improvement

- Supporting current CCBH EHR operations during selection, design and implementation of a new EHR in the middle of the PHE requires consistent project and staff resource monitoring.

Plans for Information Systems Change

- The MHP is searching for a new system, with a project plan in place and project team assigned and active.

MHP EHR Status

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

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	CCBH	X			

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	CCBH	X			
Care Coordination	N/A			X	
Document Imaging/Storage	CCBH	X			
Electronic Signature—MHP Beneficiary	CCBH	X			
Laboratory results (eLab)	N/A			X	
Level of Care/Level of Service	ANSA	X			
Outcomes	CANS/ PSC-35	X			
Prescriptions (eRx)	CCBH	X			
Progress Notes	CCBH	X			
Referral Management	CCBH			X	
Treatment Plans	CCBH	X			
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		8	0	4	0
FY 2019-20 Summary Totals for EHR Functionality:		8	0	4	0
FY 2018-19 Summary Totals for EHR Functionality:		8	0	4	0

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

- No EHR enhancements occurred in the past year. The ANSA continues to be piloted at the Livingston and Los Banos clinics.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

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

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

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Direct data entry into MHP EHR system by contract provider staff	57%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	41%	Daily
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	2%	Daily

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

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

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

EHR Vendor	Product	Count of Providers Supported
Geers	Geers	1
Netsmart	Evolve	1

- Geers is software developed for a community provider Creative Alternatives, which is a Short-Term Residential Treatment Program (STRTP). This system was designed for their exclusive use.

Personal Health Record

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

☐ Yes ☒ No ☐ Implementation Phase

Not Applicable

Expected implementation timeline:

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

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

Table 28: PHR Functionalities

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

Medi-Cal Claims Processing

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

☒ Yes ☐ No

If yes, product or application:

☐ Dimension Reports application

☐ Web-based application, including the MHP EHR system, supported by vendor or ASP staff

☐ Web-based application, supported by MHP or DMC staff

☐ Local SQL database, supported by MHP/Health/County staff

☒ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

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

Table 29: Summary of CY 2019 SD/MC Claims

Merced MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**71,483**	**$23,346,782**	**807**	**$812,362**	**3.36%**	**$22,534,420**	**$20,699,461**
JAN19	6,074	$1,883,733	31	$32,608	1.70%	$1,851,125	$1,691,881
FEB19	5,550	$1,615,827	43	$11,367	0.70%	$1,604,460	$1,522,705
MAR19	6,554	$1,975,031	84	$41,700	2.07%	$1,933,331	$1,840,600
APR19	6,453	$2,154,073	64	$66,021	2.97%	$2,088,052	$1,978,767
MAY19	6,706	$2,145,580	80	$60,546	2.74%	$2,085,034	$1,981,314
JUN19	5,732	$1,780,219	59	$31,074	1.72%	$1,749,145	$1,670,279
JUL19	6,280	$1,790,313	87	$33,093	1.81%	$1,757,220	$1,659,159
AUG19	5,989	$1,734,893	107	$93,797	5.13%	$1,641,096	$1,485,263
SEP19	5,639	$2,049,770	119	$69,132	3.26%	$1,980,638	$1,774,958
OCT19	6,393	$2,370,027	58	$255,179	9.72%	$2,114,848	$1,754,547
NOV19	5,241	$1,972,858	49	$97,861	4.73%	$1,874,997	$1,645,371
DEC19	4,872	$1,874,458	26	$19,984	1.05%	$1,854,474	$1,694,618

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

- Table 29 shows elevated claim denial rates for the months of August through November 2019. During this time the MHP reported experiencing higher than normal Other Health Coverage (OHC) denials. The OHC was added, OHC billed and the claim rebilled. In October 2019, Marie Green Psychiatric Center bed days denials required rebilling.

Table 30 summarizes the top five reasons for claim denial.

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

Merced MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Beneficiary not eligible or non-covered charges.	80	$403,532	50%
Beneficiary not eligible.	163	$230,326	28%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	228	$82,454	10%
Medicare or Other Health Coverage must be billed before submission of claim.	275	$73,175	9%
NPI, Type 2 credentialing data missing, incomplete, or invalid.	12	$13,688	2%
Total	807	$812,362	NA
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

- Denied claim transactions with reason International Classification of Diseases -10 (ICD-10) diagnosis code or beneficiary demographic data or rendering provider identifier missing, incomplete or invalid, Medicare or other health coverage must be billed prior to submission of claim and NPI Type 2 credentialing data is missing incomplete or invalid are generally re-billable within the State guidelines.

NETWORK ADEQUACY

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

Network Adequacy Certification Tool Data Submitted in April 2020

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

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

The travel time to the nearest provider for a required service level depends upon a county’s size and the population density of its geographic areas. For Merced, the time and distance requirements are 75 minutes and 45 miles for mental health services, and 75 minutes and 45 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

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

Review Sessions

CalEQRO conducted zero key informant interviews during the review process due to COVID-19 restrictions to identify any problems or barriers for the beneficiaries relating to access and timeliness issues. The key informants customarily included beneficiaries and family members, MHP staff, contracted providers, and other stakeholders.

Findings

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

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

Not Applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

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

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

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	2
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	54
NPI Type 1 number reported is associated with two or more providers	0

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	3
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	0

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted Zero 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups with 10 to 12 participants each, which could not be provided due to the restrictions of the COVID-19 PHE.

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

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

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

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

Access to Care

Table 32 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 32: Access to Care Components

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td>1A</td><td>Service Access and Availability</td><td>14</td><td>12</td></tr>
<tr><td colspan="4">The MHP provides information about services in a variety of ways, which includes an online provider directory, presented in Hmong, Spanish and English. The directories were updated 12/8/2020 and are current. In addition, the MHP has English, Spanish, and Hmong language flyers that provide information about access and services, including a youth warmline flyer. The website presents descriptions of the BHRS adult, court, dual diagnosis programs and more.
Information about the Medi-Nurse Line, related to COVID-19, was prominently posted in both English and Spanish. The website also integrates Google Translate, which enables translation of all sections to any needed language.
There is a Consumer Information tab which provides access to an ongoing satisfaction survey, program brochures for all service elements, a link to the provider directory, and audio handbooks.
The MHP's beneficiary handbook offers interpretation services at no cost, and explicitly describes how transportation assistance is obtained.</td></tr>
</table>

Component		Maximum Possible	MHP Score
Test calls are made monthly, usually four or more, including threshold languages. Currently, the MHP does not possess software that supports detailed analysis of access line performance, such as dropped calls, rings to pick-up, and hold-time. The MHP also utilizes a variety of media resources that include billboards and other public information postings to convey the availability of mental health resources, targeting high-trafficked and rural areas. Within the FC subset population, the MHP's penetration rate (35.62 percent) was 14.5 percent lower than other medium-sized MHPs and 16.2 percent lower than the overall statewide average.			
1B	Capacity Management	10	8
The MHP's cultural competence plan (CCP) contains data and analysis of subgroups served by culture, ethnicity, race, age and language. The CCP reflects planned strategies to address these issues. An example is the recent posting of billboards describing Merced BHRS services in high-trafficked locations with many targeting largely rural areas. Capacity management is also addressed with productivity tracking by program and staff, including expectations. The MHP also tracks trends in service delivery, including current and prior year monthly comparisons – which helps to identify increases or decreases such as those which have occurred with COVID-19.			
1C	Integration and Collaboration	24	23
Merced BHRS integrates and collaborates in numerous areas. This includes primary care settings such as Golden Valley Health Center, which has three clinics in a region that serves predominantly Latino-Hispanic beneficiaries. A clinician is out-stationed to respond to referrals, and determine the appropriate level of care. Other health integrations occur that target the lesbian, gay, bisexual, transgender, questioning (LGBTQ) and Lao communities. The BHRS criminal justice partnership meeting reflects input and collaborative work with law enforcement and justice partners. This includes Welfare & Institutions Code section 5150 (W&I 5150) trainings, and discussions to improve the delivery of behavioral health services within the jail environment. Crisis co-response teams work with Merced City Police as well and the county sheriff's deputies. Numerous partnerships with hospitals and emergency departments were documented, with recent improvements that have increased the availability of telehealth consultation and assessment, also improving response times. An ongoing meeting with the health plan focuses on referrals, process, and communication. These meetings are well-documented and provide a window into collaboration efforts.			

Timeliness of Services

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

Table 33: Timeliness of Services Components

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td>2A</td><td>First Offered Appointment</td><td>16</td><td>16</td></tr>
<tr><td colspan="4">The MHP adheres to the 10-business day first offered clinical appointment standard, with FC demonstrating the longest average (mean) days at 9.75; all other populations are less (better). Achievement of standard is greater than 80 percent for adults, which had the lowest achievement of standard for all measured subgroups.</td></tr>
<tr><td>2B</td><td>First Offered Psychiatry Appointment</td><td>12</td><td>11</td></tr>
<tr><td colspan="4">The MHP adheres to the first offered psychiatry service standard of 15 business days. All subgroups have mean access times that exceed the 15-day standard. Attainment of standard was highest for FC (74 percent), then children (66 percent), and lowest for adults (23 percent). The MHP targeted this area with a PIP. While improvement occurred during this past year, the issue was not resolved. The MHP decided to continue this PIP for another year, adding a new intervention.</td></tr>
<tr><td>2C</td><td>Timely Appointments for Urgent Conditions</td><td>18</td><td>15</td></tr>
<tr><td colspan="4">BHRS utilizes the 48-hour standard for urgent care that does not require preauthorization; no services fall into the preauthorized urgent category. The MHP was unable to report this metric during the previous review.

The average (mean) time to urgent service is best for children and youth at 37 hours, with FC at 48 hours, and adult services experiencing the longest average wait of 50 hours. Achievement of standard provides an important companion metric. FC experienced the highest achievement at 100 percent; followed by children and youth at 89 percent; and adults at 70 percent. The event totals per category were not provided.</td></tr>
<tr><td>2D</td><td>Timely Access to Follow-up Appointments after Hospitalization</td><td>10</td><td>10</td></tr>
<tr><td colspan="4">Merced BHRS adheres to the 7-day post-hospital discharge HEDIS follow-up metric. The MHP tracks both admissions and discharges by three categories – all hospitalizations, the Marie Green Psychiatric Health Facility (PHF) adult unit, and the treatment authorization requests (TARs) from other psychiatric hospitals.

The briefest average (mean) follow-up time was with the FC population at 2.57 days, adult services was second at 4.11 days, with children and youth last at 4.31 days.</td></tr>
</table>

Component		Maximum Possible	MHP Score
All subgroups represent impressively brief times to follow-up. Attainment of standard is also excellent across all categories, with the lowest at 94.19 percent for children and youth. During the previous review, the average (mean) follow-up was 33 days, with children experiencing the longest time to follow-up, at 64 days.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
Merced BHRS includes data for all hospitalizations, and by category - Marie Green adult PHF, and other hospitals that submitted treatment authorization requests (TAR). For this metric, the MHP expanded reporting to include rehospitalizations by the facility of discharge. FC (9 admissions; 3 readmissions) had the lowest number of total events, and as well the lowest readmission rate at 0.33 percent. Children and youth events were exclusively reported by TAR, with a total of 182 admissions and 28 readmissions, at 15.38 percent. Adults had the highest number of total admissions (772) which include 325 at the Marie Green adult PHF, and 447 by other psychiatric hospital TARs. The readmission percentages appear slightly skewed towards the Marie Green unit, with 18.77 percent, contrasted to the TAR hospitalizations, at 15.86 percent. There could be clinical differences or other factors between the Marie Green admissions versus those to contracted or TAR reimbursed facilities. This might benefit from additional analysis, particularly in light of the high achievement of 7-day follow-up.			
2F	Tracks and Trends No-Shows	10	9
The MHP established a 10 percent no-show standard for psychiatry and for clinicians. Psychiatry no-shows range from 0 percent for FC, to children and youth at 14.79 percent, and a high in adult services of 17.41 percent. Clinician no-shows range from FC at 9.5 percent, to adult services 13.13 percent, with a high in children and youth of 16.98 percent. The higher no-shows for psychiatry in adult services and clinician services in children and youth merits review development of interventions if a cluster of key barriers can be identified. The loss of service hours and the discontinuity of treatment can both impact outcomes. With the variety of cultures and languages within this MHP's sphere of operations, language and culture/race/ethnicity analysis might prove informative.			

Quality of Care

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

Table 34: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	10

The MHP submitted the final Cultural Competence Plan (CCP) for 2019 and the draft 2020 document. The 2019 CCP tracked numerous outreach events in the county, and reported participation by age, gender, ethnicity and other variables. Penetration rate tracking was also integrated with the CCP process.

In the draft 2020 CCP, the MHP reported 25 outreach events, and contact with more than 1000 individuals. For example, staff were involved in a Los Banos diversity fair, a Winton health fair, and a Livingston health and safety fair.

Also, in 2020, as already mentioned BHRS billboards were strategically placed across Merced County, in high traffic locations in mainly rural areas. The targeted locations included Merced, Santa Nella, Winton, Planada, Le Grand, and Dos Palos. Radio public service announcements were provided throughout FY 2019-20 in Spanish and English.

Cultural Competence Committee (CCC) minutes do reference the need to determine relevant data measures of CCP effectiveness. Numbers of individuals contacted are helpful but do not reflect outcomes. Leadership of the CCC reflects awareness for the need to tie actions to positive tracked outcomes as an important part of the process.

Relevant strategies include imbedding clinicians with health centers that serve individuals who live in remote areas. Integration with other agencies is leveraged to improve services to specific subpopulations or groups. In Livingston, BHRS integration occurs with the Livingston Community Health Center, which frequently serves LGBTQ beneficiaries. Golden Valley Health Center is another health agency with numerous colocation sites, where the focus is on the Latino/Hispanic population.

On the MHP's website, CCP access currently requires stakeholder awareness to look under the Mental Health Services Act (MHSA) tab. It would be helpful to include a link in the homepage to make it more visible to interested parties.

As previous stated, there are challenges in tracking outcomes of cultural competence efforts, and perhaps key question analysis of the consumer perception survey by ethnicity, race or culture, would provide the CCC with information that would help determine areas in need of more work.

Component		Maximum Possible	MHP Score
3B	Beneficiary Needs are Matched to the Continuum of Care	12	10
The MHP engages in numerous activities that reflect awareness of level of care and actions to match individuals to needed service levels. This includes regular meetings with the local health plan to discuss referrals between SMHS and non-specialty mental health services. The MHP established a high frequency user PIP to help provide clinical oversite and direction to individuals with recurring crisis or hospital episodes. There is also a regular crisis residential meeting with Central Stars to discuss referrals and transitions out of that level of care.			
3C	Quality Improvement Plan	10	8
In the evaluation of the previous quality improvement work plan, historic data of at least several fiscal years is available to support longitudinal analysis. A 75 percent standard is set for achievement of targets. Results are communicated within system of care and leadership meetings. While robust analysis was reflected in the presentations that accompany each Quality Improvement Committee (QIC) meeting, additional information could be obtained by review of responses through the lens of culture/race/ethnicity. The consumer perception survey (CPS) that occurs twice each year includes questions such as who determines treatment goals, and the beneficiary's experience of how their culture is received. Understanding the responses of various subgroups could help inform cultural competence activities. Analysis of free-text comments could also be informative when parsed by system of care and race/ethnicity. The minutes of most meetings are comprehensive and easily understood. The process of problem identification and descriptions of actions to be taken are clearly identified. Action items are highlighted. A more consistent approach to identifying all meeting participants by title and organization would assist tracking of attendance. In a related performance area, grievance reporting tracks timeliness of resolution, with periodic summary of distribution by category. Grievance and change of provider reasons are tracked by type. Further analysis of both grievances and provider changes might uncover training topics.			
3D	Quality Management Structure	14	12
Merced BHRS operates a quality management (QM) unit that is integrated with the larger department, and includes DMC-ODS waivered services. There is a QI coordinator and analytic staff that support the process. The quality improvement work plan (QIWP) is posted to the MHP's website, and it includes specific measurable goals, with past and recent performance included.			

Component		Maximum Possible	MHP Score
The QIWP and QIC include both DMC and MHP metrics. It is difficult to determine if there is participation of beneficiaries, family members, or contract providers from the current method of capturing attendance. The MHP's QIC utilizes slide presentations that support each monthly meeting, which are complete with comprehensive presentation of data and detailed explanations of the driving requirements. While there are areas in which greater detail and granularity of analysis would be helpful, the overall package is impressive. In addition to monthly QIC meeting minutes and slide presentations, the MHP also maintains detailed records of PIP team meetings that occur at least monthly. The information contained in the slide presentations, if possible, should be posted on the MHP's website with the QIWP. The depth of information contained in these documents would well serve to inform current and new employees, as well as interested stakeholders. Overall, documentation of quality processes is exemplary, clearly written, with specific action plans highlighted, and follow-up on topics occurring between meetings.			
3E	QM Reports Act as a Change Agent in the System	10	9
There is a strong connection between the data and the selection of PIP topics. For example, the recent time to first offered psychiatry appointment PIP tracked the MHP's history of challenges in meeting the 15-day first offered standard. Also, the recent high frequency user PIP also tracked data derived from high-cost beneficiaries by dollar and percentage of individuals in this category. In other areas, the MHP produces reports that reflect reasons for internal utilization management service denials by program. The type of information present in the QIC slide presentations furnishes both data and the regulatory context, and is ideally provided to program staff and stakeholders. In some areas, for example grievance reporting and change of clinician requests, a more granular approach could be beneficial. The grievance reporting emphasis seems to be on the timeliness of resolution, with less focus on the frequency of specific reasons and whether this could be a useful training topic for staff. Change of clinician data might also provide a useful topic for training and discussion with staff. But more detailed analysis would need to occur, while also attending to concerns for keeping both staff and beneficiaries anonymous.			
3F	Medication Management	12	7
The MHP tracking of FC prescribing was based on the general categories of diagnosis of those prescribed psychotropic medications. Review of all HEDIS measures was not included, such as metabolic monitoring, but plans were stated to improve this tracking during the current fiscal year. There is evidence that applications			

Component		Maximum Possible	MHP Score
to the court for authorization to prescribe psychotropic medications (JV-220) involves a public health nurse. The tracking of prescribing trends by this individual is not part of the MHPs documentation. It was not clear if involvement in oversight or review of the SB 1291 metrics and trends occurs or is shared with the MHP's medical director. Within the evaluation of the FY 2019-20 QIWP, the MHP notes that four prescribing measures were out-of-compliance in FY 2018-19 that came into compliance during the past year; however, 15 measures that were previously out-of-compliance have worsened. While this level of analysis does provide some basic information, identification of the specific issues involved is critical to the quality process. The MHP noted that 7 percent of beneficiaries receiving medications were reviewed, which was lower than projected for this period. The MHP reported compliance with two key indicators. The specific indicators were not identified. The MHP merits recognition for the overall approach to coverage of medication performance areas; however, value is found with the identification of the specific indicators. If there is a medical-legal concern over a certain item, that element could be shared just within committee and removed from public documents. To the extent possible, explicit identification of the metric is key to its use as a quality improvement tool.			

Beneficiary Progress/Outcomes

In Table 35, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 35: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	8
The Adult Needs and Strengths Assessment (ANSA) has received pilot implementation at satellite clinics in Los Banos and Livingston, with some limited use at the Merced adult system of care location. The MHP remains open to and is considering other options for adult outcome instruments.			

Component		Maximum Possible	MHP Score
The Child Adolescent Needs and Strengths (CANS-50) and the Pediatric Symptom Checklist – 35 (PSC-35) are implemented in all of the children's system. The CANS-50 and PSC-35 are implemented in accordance with state guidance. Redacted examples of completed instruments were provided, but the administration protocols and analysis of results were not included. Tracking aggregate scores and improvement percentages by program over time may help identify successful treatment strategies. Some MHPs perform aggregated analysis by race/culture/ethnicity to assist in creation of treatment guides for practitioners that summarize typical strengths and challenges for the various race, ethnic or cultural groups.			
4B	Beneficiary Perceptions	10	8
Merced BHRS administers the DHCS required CPS twice each year. The MHP also administers its own survey which follows the same process as the CPS, and is available on the BHRS website. The website survey just recently became available and there was no data for this review. Other programs, including wellness centers, furnish the opportunity to provide feedback directly when participating in programming. The results of these other surveys were not available for this review. Analysis of the June 2020 CPS was presented in a slide deck supporting the November 2020 QIC meeting. Reporting indicated a total of 132 surveys were collected. Analysis of survey participation occurred by age and culture/ethnicity. Additional analysis included domain areas and mean scores, within an age, culture/race/ethnicity framework. As previously mentioned, the QIC informative slide presentations are not posted to the MHP website, and would make a great addition to the QIWP. The slide presentations provide very useful and more specific detail than provided by the results in the QIWP. These presentations would be informative to any interested stakeholder. Domain averages do not offer much support to the comprehension of beneficiary feedback; however, there are specific CPS questions such as who decides treatment goals, sensitivity of staff to culture and ethnicity that would provide a culturally informed perspective of the beneficiary experience. Breaking-out responses to key questions by, age, culture/ethnicity would improve the usefulness of this information.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	8
Three wellness centers are sponsored by BHRS, with two sited in Merced, and one in Los Banos. The second Merced wellness center serves transitional age youth (TAY) is called The Community United By Empowerment (The CUBE). Due to the COVID-19 restrictions, all centers have been closed for in-person services since mid-March 2020. Wellness staff have been maintaining contact with beneficiaries through			

Component		Maximum Possible	MHP Score
telephone calls, online activities, and providing a number of services inclusive of providing food and other supplies as well as helping with housing. The BHRS wellness centers require current involvement in treatment for participation. Wellness center newsletters were uploaded to the MHP's website for Fall 2007 and August 2014. This practice was not continued. Center newsletters can provide a platform for communication with existing and potential beneficiaries. Restarting this process could serve as an opportunity to publicly showcase the activities of the wellness center and gain greater participation.			

Structure and Operations

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

Table 36: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	26
Merced BHRS provides mental health services, medication support, targeted case management and crisis intervention as core offered services. In addition, crisis stabilization and crisis residential programs are provided. The FC focused intensive care coordination (ICC) and intensive home-based services (IHBS) are delivered via contract partnerships. The MHP directly operates the Marie Green acute psychiatric health facility (PHF) adult unit. Other acute inpatient unit capacity is provided through arrangements with out-of-county resources.			
5B	Network Enhancements	18	15
As with other MHPs, the BHRS response to COVID-19 created an immediate shift to mainly telephonic with a lesser focus on video telehealth services. This expansion has incorporated the iPad telehealth support that was already approved to provide ER consultations as well as field crisis response consultations. The MHP collocates services with physical health programs throughout the county, providing onsite clinician to screen and perform interventions and identify high-risk individuals for referral to an MHP clinic. Close relationships with schools, child welfare, and law enforcement agencies assists with ensuring services are available wherever beneficiaries are identified.			

Component		Maximum Possible	MHP Score
The MHP provides three wellness centers throughout the county, however with the proviso to limit services to those open for treatment. Recently, the CUBE has lowered the age range for participation to 12 through 17, providing greater support to younger youth. The expansion of peer support specialist roles and numbers is in process and awaiting the launch of the training curriculum for full implementation.			
5C	Subcontracts/Contract Providers	16	15
For this review, the MHP provided contract provider meeting minutes, which demonstrate the interaction between these agencies and the MHP every two months. These minutes reflect two-way communication with significant time devoted to seeking contract provider feedback. The Interagency Primary Care, BHRS, Community Partner's meeting minutes reflect discussions of interactions with the local Medi-Cal health plan and Beacon, its mental health provider.			
5D	Stakeholder Engagement	12	8
The MHP provided evidence of stakeholder involvement with comprehensive mental health advisory board (MHAB) agendas and minutes. The minutes reflect a dynamic interaction between board members and MHP leadership. Website posting of MHAB minutes would improve transparency, and possibly result in greater public participation. MHAB agenda uploads ended with June 2017 and MHAB minutes were last uploaded in April 2017. Other participation venues exist such as the employee advisory council, a regular contractor's meeting, a community partner's meeting, and internally there is a clinical management team that meets and shares information. Within MHSA planning there is robust representation of community input. MHSA planning recently completed another needs assessment with stakeholder satisfaction included, which has not yet been posted. Consumer advisory committee minutes from July 2019 were provided. Due to the limitations of a desk review, beneficiaries and family members could not be interviewed for their input on this topic.			
5E	Peer Employment	8	5
The Merced BHRS plans to offer two levels of peer employment once the state certification program begins. Currently a seamless career ladder for peers is not in place. Peer support specialists serve in the role of engaging and supporting beneficiaries in many ways, including completing forms, providing transportation to resources, leading prevocational and activity groups, and translating when appropriate. There are no supervisory or management positions configured			

Component	Maximum Possible	MHP Score
exclusively for peers. The MHP advised that individuals in the peer role have applied for and been hired into other civil service classifications.		

SUMMARY OF FINDINGS

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

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Completed

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

- The MHP's central intake began telephonic assessments in April 2020, providing an alternative to the face-to-face usual process. In-person assessment remained an option for those so interested.
- Beginning in March 2020, appointment reminder calls were accompanied by a COVID-19 screen. Clinics also initiated an entry screen that included symptom and history interview, and monitoring of temperature. Isolation rooms were developed for each program location. Other measures included hand sanitizers at key points, supplies of personal protective equipment and cleaning supplies were distributed.
- The Youth Warmline was launched in June 2020. This option provided additional support to youth who found themselves isolated due to the shelter-in-place public health order, and became accessible through the MHP's website.
- Increased mental health staffing at the juvenile justice center significantly increased capacity by the addition of a fulltime clinician, a mental health worker, and part-time peer support specialist.

Strengths:

- Pre-dating the COVID-19 PHE, the MHP acquired InTouch technology and iPads to support two local ERs and field mental health evaluations. This positioned the Merced BHRS Department's rapid transition to greater telehealth usage, and expanded the use-case scenarios. Between April and the end of June 2020, 705 telehealth crisis/triage screening sessions were conducted.

- The MHP has continued to expand emergency mental health evaluation capacity, leveraging staff and telehealth facilities, and collaborations with justice partners, such as the juvenile justice facility expansion of mental health staffing.

Opportunities for Improvement:

- FC penetration rates are lower than the medium-sized MHP average and the state-wide average.
- The MHP has a higher rate of beneficiaries receiving one service in a calendar year when compared to the statewide average (21.40 percent vs. 10.62 percent).

Timeliness of Services

Changes within the Past Year:

- Changes in the psychiatry referral protocol removed a key administrative process barrier to timely access.

Strengths:

- The MHP's first offered clinical appointments fall within the mandated 10 business day standard, and have a high achievement of standard for all monitored subgroups.
- During the past year, the MHP achieved improvements in the first offered psychiatry appointment from the efforts of a PIP. While improvements occurred across all populations, the MHP chose to continue this PIP utilizing a new intervention. The intent is to ensure the 15-business day standard is met with achievement of at least 75 percent for all monitored subgroups.
- Post-hospital discharge 7-day follow-up data across all measured subgroups averages 4.2 days, with achievement of standard at or above 94 percent for all tracked subgroups.

Opportunities for Improvement:

- The MHP's high achievement of 7-day post-hospital discharge follow-up, contrasts with the Marie Green PHF 18.77 percent rehospitalization rate.
- The 17.41 psychiatry no-show rate for adults could be a contributing factor to difficulties meeting the 15-business day standard, which for this review period has a 31-day average (mean) and 23 percent achievement of standard. While this aspect is targeted by the continuing PIP for reminder calls, there could be other contributing factors.

Quality of Care

Changes within the Past Year:

- The MHP's cultural competence efforts during the past year reflected continued efforts to engage diverse populations and as well to push information about services out to the general public.
- The MHP implemented peer review with the clinical utilization review process.

Strengths:

- The MHP's QIWP was written with a clear, easily comprehensible, data-focused approach. QIC minutes consistently reflect detailed discussions of tracked metrics and clearly highlight actions that need to occur when indicated by findings.
- The MHP's reporting of change of provider requests furnishes a comprehensive approach that breaks out events by system of care and type of request, program, and category of personnel involved – medical, clinical, or case management. Katie A. related requests are another discrete category of reporting.
- The MHP's reporting of utilization review denials provides a by-program view of reasons (October 2020 QIC presentation). This approach is much more informative and useful at the program level that high-level summaries. In another table, the MHP tracks program dollars of services reviewed and dollars denied, which provides a reference point for interested stakeholders.

Opportunities for Improvement:

- High-level system summaries of grievances have limited utility for improvement. Reporting grievance information by program, with other possible breakdowns, might identify improvement areas that could be the focus of training and discussions with staff.
- QIC slide presentations summarizing the MHP's quality monitoring efforts with charts and graphs of important tracked metrics are not posted with the QMWP on the department's homepage.

Beneficiary Outcomes

Changes within the Past Year:

- The CUBE TAY wellness center lowered its eligibility age range to 12 to 17 years, opening up wider access to younger children/youth.

- The MHP added to its website a continuously available online satisfaction survey.
- In response to COVID-19 restrictions, MHP wellness centers began telephonic and online support.

Strengths:

- The MHP uses the CANS-50 and PSC-35 to monitor the progress of children and youth.
- The BHRS internet site was updated with additional resources including the Medi-Nurse Line and the Youth and Adult Warm Line due to the COVID-19 pandemic.

Opportunities for Improvement:

- The analysis of CPS results takes a high-level domain approach to average scores. Culture/race/ethnicity analysis provided remains at the global domain level and unlikely to provide actionable information.
- The CANS-50, ANSA, PSC-35 data is not aggregated and reported by program, nor tracked and trended over time.
- The ANSA remains in pilot use mode, limited to the Livingston and Los Banos clinics, with some Merced adult services usage. The MHP has not yet selected an adult outcome tool.

Foster Care

Changes within the Past Year:

- A short-term residential treatment program (STRTP) for females was developed by Rainbow Valley (RV). With the support of the children's system of care and quality management staff, RV became certified and operational in November 2020.
- In October 2020, the MHP was permitted to share the CANS-50 results with child welfare staff with the proper consents. Child welfare uses a different version of the CANS, complicating the comparison process.

Strengths:

- The MHP made process is sharing CANS information in child and family team (CFT) meetings, and working to develop a process that integrates the two different versions so that use with treatment and evaluations are supported.

Opportunities for Improvement:

- The MHP's FC penetration from the most recent CY 2019 data was 35.62 percent, which was 14.5 percentage points lower than the medium-sized MHP average and 16.2 points lower than the overall state-wide average.
- The development of Therapeutic Foster Care (TFC) continues to be a challenge, with lack of interest by local foster family agencies in developing this level of service. The restraining factors appear to be financial in nature.
- The MHP reports that SB 1291 FC HEDIS measure tracking occurs by public health nurses. High-level results were provided for this review, reflecting the number and percent authorized medications, and similar data for diagnosis distributions of those receiving medications. The specific SB 1291 HEDIS measures were not available for this review. The MHP has plans to bring some of this activity to within the MHP during the coming year.
- CANS and PSC-35 data is not aggregated, tracked and trended system-wide or by program. Merced Human Services Agency uses a different version of the CANS than that used by the MHP (CANS-50). The MHP is looking to develop an approach that supports at least same-item comparisons during the CFT process.
- The MHP has not developed a protocol for the consistent review of CANS-50 information within the TFC environment. The use of this information is quite variable and limited.

Information Systems

Changes within the Past Year:

- The Cerner Millennium EHR project was abandoned after it was identified that the core Millennium EHR would not meet the MHP's needs by the anticipated go-live date.

Strengths:

- The MHP quickly identified IT needs and priorities caused by the COVID-19 pandemic. Laptops, iPads, iPhones, webcams and Cisco Webex DX80 units utilized for telehealth were purchased and distributed to support remote services.
- There has been enhanced coordination between the BHRS Automation Services EHR Help Desk and the County IT Help Desk resulting in faster response times.

- In Fall 2020, the MHP increased the amount of data analytic support received from Kings View Behavioral Health Systems.

Opportunities for Improvement:

- Supporting the current CCBH EHR during selection, design and implementation of a new EHR system while continuing to support the organization during the pandemic requires consistent project and staff resource monitoring as well as the flexibility to adjust to evolving conditions.

Structure and Operations

Changes within the Past Year:

- The MHP reorganized crisis and other unplanned services into one division, including mobile crisis, triage, the crisis team, crisis stabilization and the Marie Green PHF.
- The MHP launched a quarterly staff newsletter called “Wings,” which helps maintain good communication within the department.
- BHRS conducts monthly agency-wide staff calls to support communication.
- Due to the effects of COVID-19, the MHP temporarily experienced an 85 percent reduction of staff within one division. This was largely related to staff absences due to on pandemic caused Emergency Paid Sick Leave (EPSL), Expanded Family and Medical Leave (EFML) and Family Medical Leave Act (FMLA) absences.
- While the number of services provided by individual staff increased, COVID-19 had a significant negative impact on the units of services. Should the current rate of billing continue through the remainder of FY 2020-21, the MHP anticipates a potential decrease of approximately 17,000 units.

Strengths:

- The MHP received funding for expansion of telehealth to support field and emergency room crisis evaluations prior to the pandemic, and was in a good position to accomplish the larger shift to telehealth for routine services.
- The MHP operates with a strong organizational structure that consistently uses data to inform structural decisions that is data-driven.

Opportunities for Improvement:

- None noted

FY 2020-21 Recommendations

PIP Status

Recommendation 1: Complete foundational work on the new clinical PIP that targets increased case management services and expansion of peer support specialist roles. This should become active by April 2021.

Recommendation 2: Continue the first offered psychiatry appointment PIP, utilizing the newly developed peer support specialist reminder call intervention that includes a focus on engagement.

Access to Care

- None noted.

Timeliness of Services

- None noted.

Quality of Care

Recommendation 3: Pair cultural competence strategies with specific core metrics that are tracked, reported, and reviewed to help measure the success of cultural competence efforts. Examples could include analysis of consumer perception survey results with a focus on specific key questions parsed by culture/race/ethnicity and preferred language. Analysis of retention rates by these parameters would be another option.

Beneficiary Outcomes

Recommendation 4: Move forward with selection and implementation of a universal adult outcome measure instrument, integrating this information with the clinical assessment and reassessment workflow. *(This is follow-up recommendation from FY 2018-19).*

Foster Care

Recommendation 5: Begin aggregating and analyzing the Child, Adolescent Needs and Strengths Survey (CANS) and Pediatric Symptom Checklist – 35 (PSC-35) data for Foster Care (FC) and the general children population.

Recommendation 6: Commence MHP concurrent tracking and reporting of FC Healthcare Effectiveness Data and Information Set (HEDIS) medication related measures, including metabolic monitoring, first line psycho-social care, and others.

Information Systems

Recommendation 7: Closely monitor project timelines and staff resources during the implementation of the new EHR to maintain routine department operations and respond to unanticipated needs that emerge from the pandemic impact.

Structure and Operations

- None noted

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site or robust video-supported external quality review of the MHP. Consequently, this review was conducted primarily as a desk-review of submitted materials, with additional video sessions to clarify remaining questions and provide PIP TA. An exit conference was provided to MHP leadership. Customary sessions including broad stakeholder participation and beneficiary focus groups were not conducted.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Data

Attachment D: ACA Penetration Rates and ACBs

Attachment E: ACB Range Distributions

Attachment F: List of Commonly Used Acronyms

Attachment A—Review Agenda

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

Table A1: EQRO Review Sessions

Merced MHP
Key Questions Session
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Robert Walton, Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Walter Shwe, Consumer-Family Member

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

MHP Review Sites and Participants

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

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Barber-Jacinto	Trechann	QPM Director	Merced BHRS
Coulter	Jacqui	Assistant Director- Clinical Services	Merced BHRS
Counter	Jacqueline	BHRS Assistant Director, Clinical	Merced BHRS
Garibaldi	Michelle	Division Director – 24/7 Psychiatric Crisis Services	Merced BHRS
Jones	Sharon	Mental Health Services Act (MHSA) Coordinator and Ethnic Services Manager	Merced BHRS
Lockerby	Christine -	Quality Assurance Specialist	Merced BHRS
Mendonca	Sharon	Assistant Director – Administrative Services	Merced BHRS
Morris	Villyginn	QPM, Office Assistant III	Merced BHRS
Reed	Matthew	Program Manager of Quality Improvement	Merced BHRS
Soofi, MD	Jin - BHRS	Medical Director	Merced BHRS
Valentine	Genevieve	Director	Merced BHRS

Attachment C—Approved Claims Data

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

Attachment D—ACA Penetration Rates and ACBs

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

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

Merced MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Medium	519,441	20,353	3.92%	$121,346,017	$5,962
MHP	30,558	1,240	4.06%	$4,069,060	$3,282

Attachment E—ACB Range Distributions

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

Table E1: CY 2019 Distribution of Beneficiaries by ACB Range

Merced MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	4,544	94.23%	93.31%	$11,431,226	$2,516	$3,998	49.98%	59.06%
>$20K - $30K	126	2.61%	3.20%	$3,058,805	$24,276	$24,251	13.37%	12.29%
>$30K	152	3.15%	3.49%	$8,381,976	$55,145	$51,883	36.65%	28.65%

Attachment F—List of Commonly Used Acronyms

Table F1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
AB	Assembly Bill
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
API	Asian/Pacific Islander
ASAM	American Society of Addiction Medicine
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organizations
CBT	Cognitive Behavioral Therapy
CCC	Cultural Competency Committee
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services
COVID-19	Corona Virus Disease-2019

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

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

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

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