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FY 2023-24
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

MERCED FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

November 2-3, 2023

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EXECUTIVE SUMMARY

Highlights from the fiscal year (FY) 2023-24 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Merced" may be used to identify the Merced MHP.

MHP INFORMATION

Review Type — Virtual

Date of Review — November 2-3, 2023

MHP Size — Medium

MHP Region — Central

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	0	4	1

Table B: Summary of Key Components

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

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Post Hospitalization PIP	Clinical	July 2021	Completed	High
Follow-Up After Emergency Department Visit for Mental Illness	Non-Clinical	July 2022	First Remeasurement	Moderate

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	8
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	1*
* If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP's Quality Improvement (QI) processes are robust and have a positive impact on the quality of services.
- The Cultural Humility Health Equity Justice Committee's (CHHEJC) efforts in establishing a culturally competent system of care are noteworthy.
- The Justice Community Integration Division's (JCID) extensive efforts to link members who are on probation and parole are impressive.
- The MHP utilizes satisfaction survey feedback from surveys to improve services.
- The MHP's timeliness for post discharge outpatient follow-up and medication management have significantly improved.

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

- The MHP's first offered non-urgent appointments timeliness rate is low.
- The MHP's first offered non-urgent psychiatry appointments timeliness rate is very low and declined compared to the previous year.
- The MHP's timeliness rate for first offered urgent appointments is low and declined from the previous year.
- The MHP's strategies to address challenges with meeting standards for timeliness did not reflect an improvement in these metrics.

- The MHP's Latino/Hispanic PR continues to be much lower than the statewide average.

Recommendations for improvement based upon this review include:

- Revive the all-hands-on deck approach and implement other strategies to improve timeliness for first offered appointments.
- Explore barriers for timely psychiatry non-urgent appointments and implement strategies that target these barriers.

  (This recommendation was continued from FY 2022-23.)

- The average wait time for urgent appointments is very long. Review the reasons for these delays and implement strategies that will improve timeliness.

  (This recommendation was continued from FY 2021-22.)

- Create a workgroup within the Compliance Quality Improvement (CQI) committee to implement strategies that improve timeliness and report monthly progress to the CQI committee.
- Consider Promotoras and other effective outreach strategies to improve the Hispanic/Latino penetration rates (PRs).

  (This recommendation was continued from FY 2021-22.)

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

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

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2023-24 findings of the EQR for Merced County MHP by BHC, conducted as a virtual review on November 2-3, 2023.

REVIEW METHODOLOGY

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

CalEQRO reviews are retrospective; therefore, county documentation that is requested for this review covers the time frame since the prior review. Additionally, the Medi-Cal approved claims data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and the Inpatient Consolidation (IPC) File. PMs calculated by CalEQRO cover services for approved claims for calendar year (CY) 2022 as adjudicated by DHCS by April 2023. Several measures display a three-year trend from CY 2020 to CY 2022.

As part of the pre-review process, each MHP is provided a description of the source of the Medi-Cal approved claims data and four summary reports of this data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; transition aged youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of QI and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – summary of the validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5, and also as outlined DHCS's Comprehensive Quality Strategy. Data definitions are included as Attachment E.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report

data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding penetration rate (PR) percentages.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place after the Coronavirus Disease 2019 (COVID-19) pandemic and following significant weather events, including floods in the beginning of the calendar year. The MHP was under federal emergency alert during that time. The MHP reported that many residents including MHP staff were displaced because of the floods. The MHP had high staff turnover and vacancy rates during the past year.

CalEQRO was able to complete the review without any major challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP experienced significant staffing challenges during the past year that impacted timely access to care. The MHP is addressing the staff shortage by expanding the number of interns and developing a position to hire in a timely manner.
- The MHP has new executive leadership who have been in their positions for the past eight months. Philosophical change in the MHP has resulted in reducing the siloes and driving the system toward a more biopsychosocial model. Leadership is actively involved in collaborations with key local stakeholders to support the PIPs.
- The Behavioral Health Bridge Housing has one and a half million dollars for infrastructure to support a local Homekey 1.0 project in exchange for 20 units.
- The MHP implemented the Credible electronic health record (EHR) on April 1, 2023. Credible will be operated in an application service provider (ASP) environment with Kingsview as their provider. The MHP trained staff in billing and reports generation. The MHP is working on developing dashboards in the next year.
- JCID has implemented the community co-response team with law enforcement to assist with linkages to mental health and substance use related services. JCID has implemented other programs such as the Restart program to coordinate services with parole and probation and the Breaking Barrier program that has the MHP team co-located with probation.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations not addressed may be presented as a recommendation again for this review. However, if the MHP has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 1: Monitor any impact of increasing the telehealth capacity for psychiatry on initial psychiatry appointment timeliness at least on a monthly basis and develop or refine strategies as needed to meet the 15-day standard. (Timeliness)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP continues to have two current contracts for telehealth psychiatry services, one with Kingsview and the other with Locum Tenens. The MHP is increasing providers through the current contracts while also working on a third contract to increase telehealth services.
- The MHP could not make significant efforts to address psychiatry timeliness issues in the past nine months following the prior review and did not demonstrate an increase in telehealth capacity for psychiatry in the past year. The MHP's timeliness self-assessment completed for this review indicates that the first offered non-urgent psychiatry timeliness does not meet the DHCS standard and has declined by nine percentage points compared to the previous year.
- This recommendation has been continued in this year's EQR report in a modified manner.

Recommendation 2: Investigate the methodology of tracking urgent appointments and strategies to meet the urgent appointment timeliness standards. (Timeliness)

(This recommendation was continued from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP created a workgroup to research and update the definition of urgent appointments for SMHS that will allow for better client care and for better tracking and trending of data. The number of urgent conditions identified increased from 15 to 25 in the most recent Assessment of Timely Access (ATA).
- However, the MHP did not meet the DHCS timeliness standard for first offered urgent appointments. The MHP's timeliness rate declined by 12 percentage points compared to their rate for the previous year.
- Although the MHP has improved their tracking of urgent conditions and appointments, the strategies to meet the urgent appointment timeliness standards were not effective as indicated by a decline in performance.
- This recommendation has been continued in this year's EQR report in a modified manner.

Recommendation 3: To fully access the increased data that will be available in the Credible system and to increase in-house analytic and reporting capacity, develop a database that mirrors the Credible system. (IS)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP went live with the new EHR, Credible, on April 1, 2023. The MHP has focused major efforts towards implementation and troubleshooting.
- The MHP continues to have regular meetings with Kingsview regarding data development. Currently Kingsview and the MHP are working on developing specific data dashboards to increase standardization of data. Thus far Credible has allowed for easier report running.
- Access to Credible data is being increased in three main areas. The first area is Kingsview services, which include state reporting data scrubbers. Reports have also been created for Additional Errors, Batch Transaction Details, Episode Transactions, Forms per Episode, and Open Admissions. All reports will assist staff in EHR corrections for state reporting.
- The second area of increased data access is the MHP's Automations and Division analyst staff having access to Credible ad hoc reporting function and continued training on Structured Query language (SQL) table querying. Ad hoc reports have been created in areas such as Inactive Staff Rosters, Open Client Episodes, Restricted Clients/Staff, and Payer by Client. These reports have assisted in ensuring EHR security and data analysis/visualization.

- The third area of increased data access is the development of dashboards within the EHR. Kingsview is contracted to provide 11 dashboards for Merced. Automation Services and Division analyst staff have access to the Business Intelligence function and will create EHR dashboards. The Automation Services division will be creating an Access database that reflects the table layout in Credible in areas such as client services, episodes, demographics, treatment plans and employee information. The database will be updated weekly and will hold at least three years of data.
- While this item is rated partially addressed, it is not carried over in a recommendation for this year's review due to other priority recommendations identified and the substantive work already planned.

Recommendation 4: Continue efforts to improve access to services for Latino/Hispanic beneficiaries and monitor barriers to access through specific beneficiary surveys tailored to this need. (Access)

(This recommendation is continued from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is working on a contract and certification with La Familia which is an agency that will provide Spanish language services on the westside areas of Merced County, which has a significantly large Hispanic population.
- The MHP is also developing a workgroup of MHP leadership and staff that will partner with the CHHEJC to further investigate the low penetration rate.
- The MHP's PR is still lower than the state and counties of similar size and there were no significant changes noted over the last year as the strategies explained above have not yet been implemented.
- This recommendation has been continued in this year's EQR report in a modified manner.

Recommendation 5: Train front desk staff in creating a welcoming environment for Spanish-speaking beneficiaries. Utilize the existing available cultural competency committee expertise to develop such training for the front desk staff. (Access)

(This recommendation was continued from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is currently working to partner with Merced Community College to have staff participate in the Customer Service Academy. The plan is to have staff begin the academy in January 2024.
- An all-leadership email was sent regarding improving customer service to members, and leadership were asked to discuss with their staff at their

respective staff meetings. A customer service bulletin will be added to the next issue of the department newsletter, which is sent to all staff.

- While this item is rated partially addressed, it is not carried over in a recommendation for this year's review due to other priority recommendations identified.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 55.73 percent of services were delivered by county-operated/staffed clinics and sites, and 44.27 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 91.36 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff. Members may request services through the Access Line as well as through the 24/7 crisis services division and walk-ins at clinic sites. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. The Access team is primarily responsible for most screening and appropriate referrals for non-urgent service requests regardless of the source of referral. The MHP noted that the plan members can also walk into clinic sites and request services, but that is not common.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 1,353 adult members, 583 youth members, and 199 older adult members across 12 county-operated sites and 3 contractor-operated sites. Overall, these numbers show a great decline compared to the number of adults (2,785), youth (1,170), and older adults (408) who received telehealth services in the previous year. Among those served, 264 members received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information in Table 1A and Table 1B.

In December 2022, DHCS issued its FY 2022-23 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Merced County, the time and distance requirements are 45 miles and 75 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 2022-23

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

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

Table 1B: MHP Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☒ Yes ☐ No
OON Access for Members	
The MHP ensures OON access for members in the following manner:	☒ The MHP has existing contracts with OON providers ☐ Other:

Because the MHP can provide necessary services to a member within time and distance standards using a network provider, the MHP was not required to allow members to access services via OON providers. However, when a client needs services

that are provided out-of-county, MHP staff can assist with coordinating transportation with Alliance or link the client. Also, for Day Treatment Intensive or Day Rehabilitation these services are not provided in county and MHP staff assist with referral and linkage to services. The MHP also utilizes Intensive Care Coordination (ICC) for youth that are placed out-of-county in Short-Term Residential Therapeutic Programs (STRTP) or other treatment options.

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP has a strong cultural focus in their service delivery and thoroughly evaluates the access and service needs in the QAPI and cultural competence plan. The MHP has implemented their first Lesbian Gay Bisexual Transgender Queer (LGBTQ) group. The participants appreciate the access to additional resources offered through this support group. Their commitment to address needs for population with disabilities such as the Deaf and Hard of Hearing including afterhours demonstrates their dedication to serve these underserved populations.
- The MHP's JCID has done impressive collaborative work with law enforcement, probation, and parole and demonstrated positive outcomes for the clients in the Restart program as reported in the Transformational Equity Restart Program (TERP) report.

- The MHP has strong collaborations with several local stakeholders such as local churches, the Department of Education, public health, hospitals, schools, and universities and leverages these collaborations to improve access to care for the population served.
- The MHP's PRs for FC and Latino/Hispanic continue to be lower than the statewide average. In its cultural competency plan, the MHP identified Hispanic/Latino, Hmong, and African American as underserved communities. Additional groups included LGBTQ+ populations, college-aged transition age youth (TAY), youth and adults with developmental disabilities, deaf and hard of hearing individuals, and the homeless population.
- The MHP has one telephone number for all systems of care and the Access line. Members calling this number to contact their therapist have experienced difficulties with reaching their therapist and have not been properly directed to the appropriate program. The MHP would benefit from providing an accurate telephone directory listing to the Access line staff and the program front desk staff to direct existing members to the appropriate programs. Training Access line staff and front desk staff to ask the right questions to direct clients appropriately would be beneficial. A single number can create an easier experience for members but requires significant administrative communication regarding changes in staff assignments and locations to be successful.

ACCESS PERFORMANCE MEASURES

Members Served, Penetration Rates, and Average Approved Claims per Member Served

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

The PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, Merced demonstrates more challenges to access to care than were seen statewide.

Table 3: Merced MHP Annual Members Served and Total Approved Claims, CY 2020-22

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	156,217	5,284	3.38%	$33,495,608	$6,339
CY 2021	146,632	4,670	3.18%	$39,009,799	$8,353
CY 2020	135,916	4,422	3.25%	$33,506,647	$7,577

Note: Total annual eligibles in Tables 3 and 4 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- While total members eligible has increased 14.9 percent from CY 2020 to CY 2022, PR has increased from 3.25 percent in CY 2020 to 3.38 percent in CY 2022.
- The AACM decreased by 24.1 percent from CY 2021 to CY 2022 ($8,353 vs. $6,339).

Table 4: Merced County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	18,622	81	0.43%	1.15%	1.82%
Ages 6-17	42,991	1,585	3.69%	4.80%	5.65%
Ages 18-20	9,525	322	3.38%	3.47%	3.97%
Ages 21-64	73,915	3,090	4.18%	3.60%	4.03%
Ages 65+	11,165	206	1.85%	1.98%	1.86%
Total	**156,217**	**5,284**	**3.38%**	**3.49%**	**3.96%**

Note: Total annual eligibles in Tables 3 and 4 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The largest eligibility group by age was adults ages 21-64, followed by children and youth ages 6-17. The MHP's PRs are lower than both the similar sized county and statewide rates for those in age categories 0-5, 6-17, and 18-20.
- The MHP's PR for those aged 21-64 exceeds both the similar sized county (4.18 percent vs. 3.60 percent) and statewide rates (4.18 percent vs. 4.03 percent). The PR for those aged 65+ is lower than the medium-sized county rate (1.85 percent vs. 1.98 percent) and comparable to the statewide rate (1.85 percent vs. 1.86 percent).

Table 5: Threshold Language of Merced MHP Medi-Cal Members Served in CY 2022

Threshold Language	# Members Served	% of Members Served
Spanish	642	12.37%
Threshold language source: Open Data per BHIN 20-070		

- The MHP had one threshold language, Spanish, and 12.37 percent of those served identified Spanish as a preferred language.

Table 6: Merced MHP Medi-Cal Expansion (ACA) PR and AACM, CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	41,143	1,486	3.61%	$7,847,566	$5,281
Medium	530,704	15,912	3.00%	$110,270,160	$6,930
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. The MHP's ACA PR exceeds its overall PR (3.61 percent vs. 3.38 percent). The ACA AACM is lower than that of the overall AACM ($5,281 vs. $6,339).
- Although the AACM is lower in the MHP than statewide, the ACA PR exceeds the statewide rate.

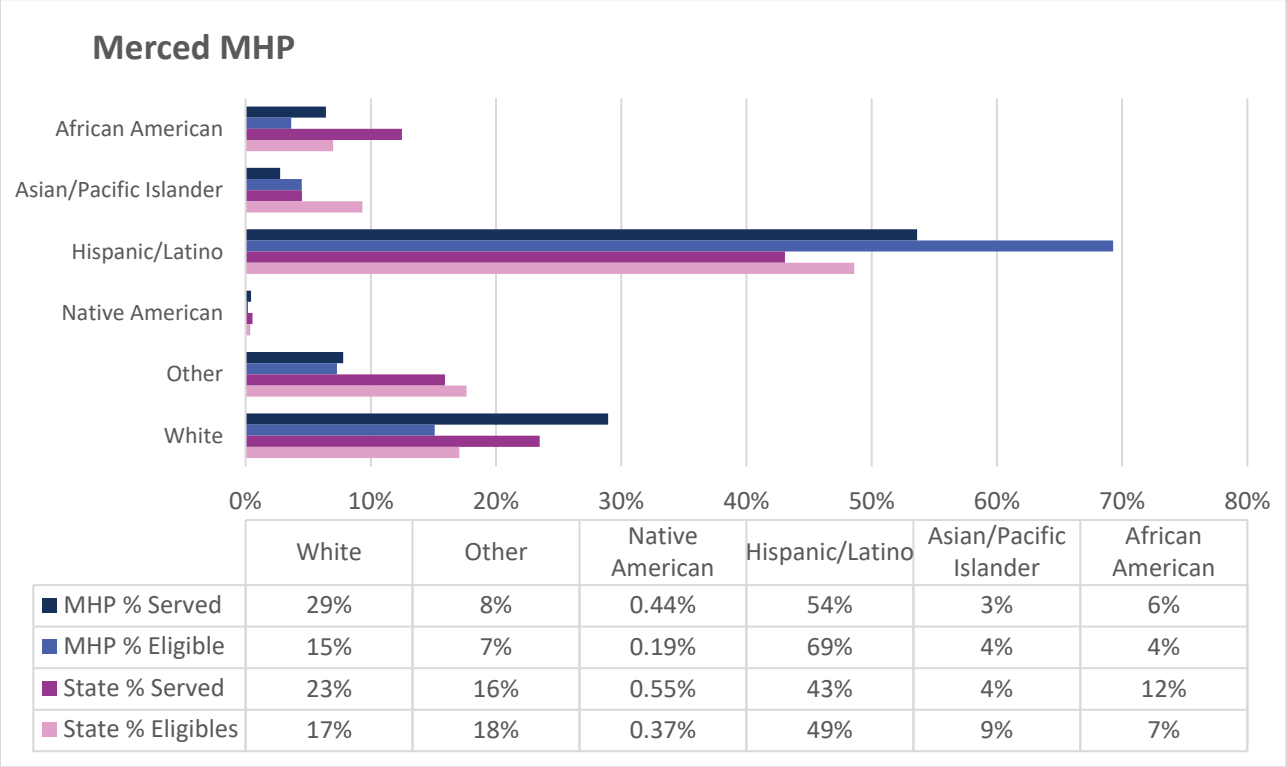
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they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

Table 7: Merced MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	5,691	339	5.96%	7.08%
Asian/Pacific Islander	7,008	146	2.08%	1.91%
Hispanic/Latino	108,239	2,834	2.62%	3.51%
Native American	295	23	7.80%	5.94%
Other	11,392	412	3.62%	3.57%
White	23,594	1,530	6.48%	5.45%

- MHP PRs were lower than the corresponding statewide PRs for African American and Hispanic/Latino groups.
- The Hispanic/Latino population makes up the largest group of eligibles by race/ethnicity in the MHP, 69 percent of total eligibles, and has the second lowest PR. Asian/Pacific Islander members had the lowest PR compared to other groups.

Figure 1: Race/Ethnicity for Merced MHP Compared to State, CY 2022



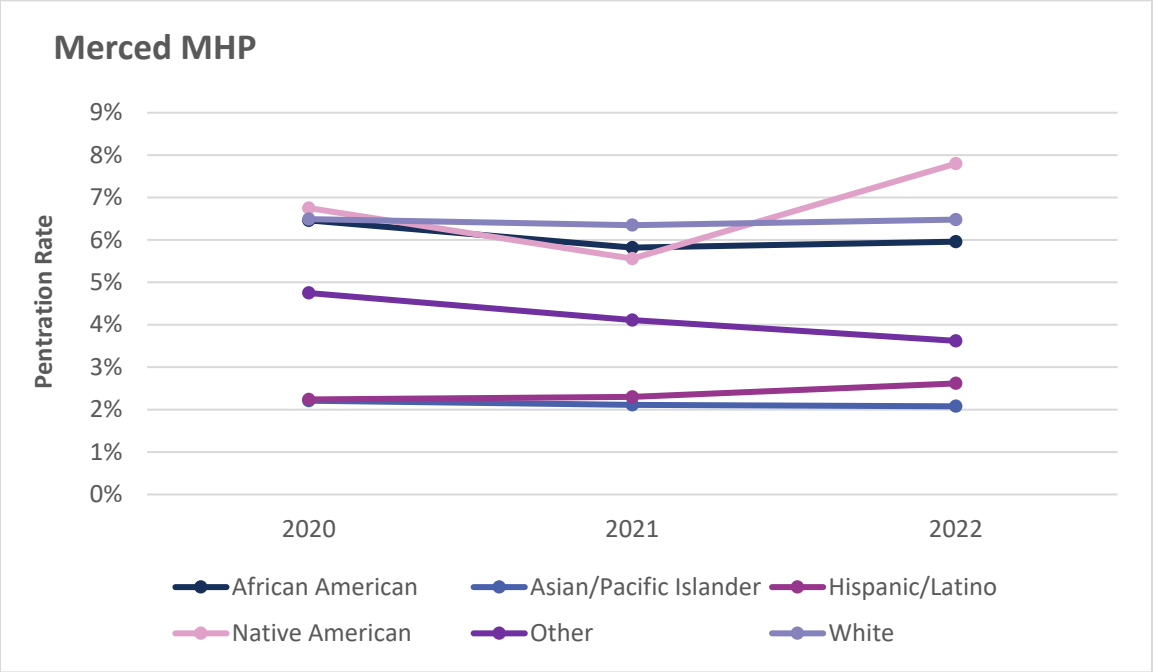
	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	29%	8%	0.44%	54%	3%	6%
MHP % Eligible	15%	7%	0.19%	69%	4%	4%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- White was the most proportionally overrepresented racial/ethnic group in the MHP and Hispanic/Latino was the most proportionally underrepresented group.

- The MHP had a notably higher percentage of Hispanic/Latino eligibles than the state (69 percent vs. 49 percent).

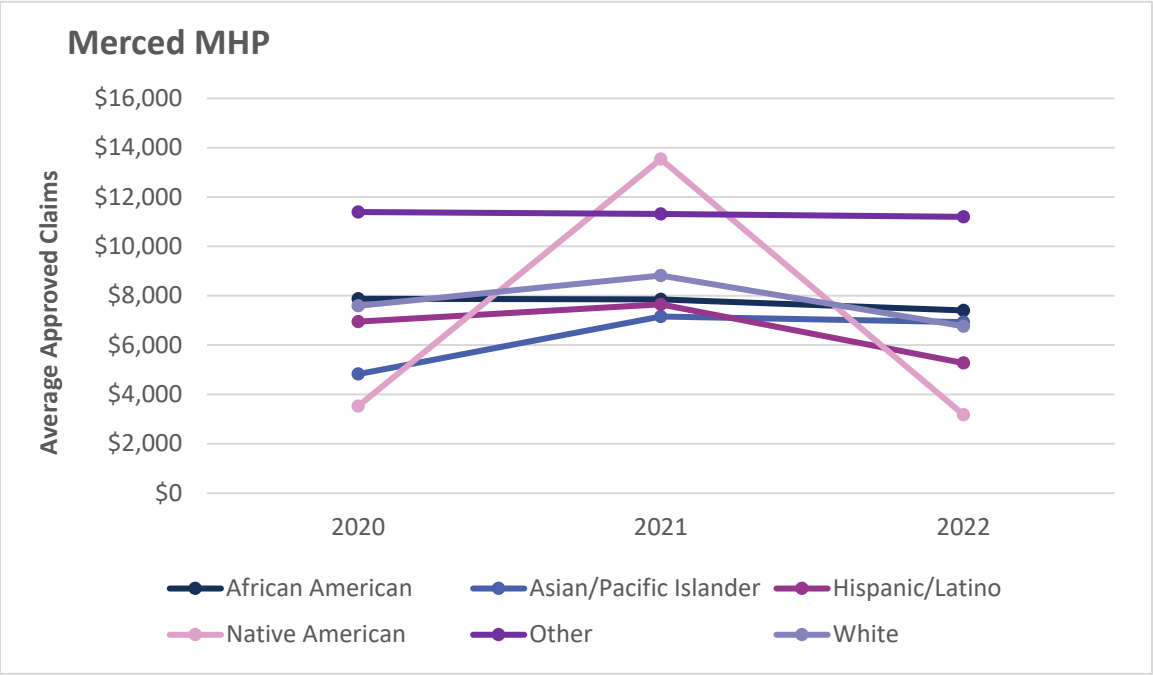
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

Figure 2: Merced MHP PR by Race/Ethnicity, CY 2020-22



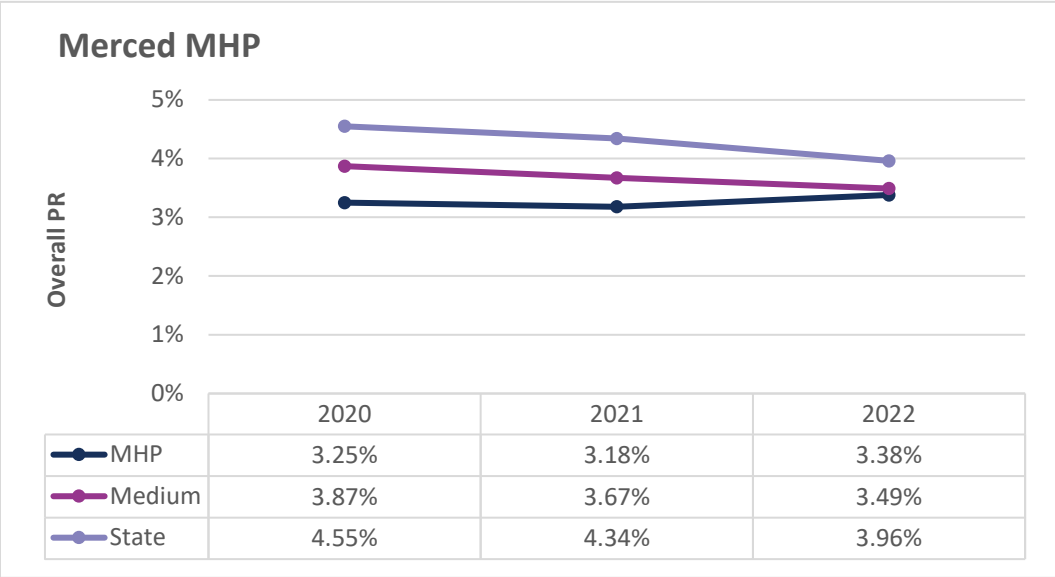
- PRs for White, Native Americans, and African Americans have consistently been the highest over the past three years, whereas PRs for Asian/Pacific Islanders and Hispanic/Latinos have consistently been lowest.

Figure 3: Merced MHP AACM by Race/Ethnicity, CY 2020-22



- The AACM for Native American members displayed notable variation from CY 2020 to CY 2022. It should be noted that Native American members were 0.44 percent of all members served, and when a population is small, outliers can impact averages (means) in a way that may appear drastic. “Other” race/ethnicity group had the highest AACM CY 2020 to CY 2022.

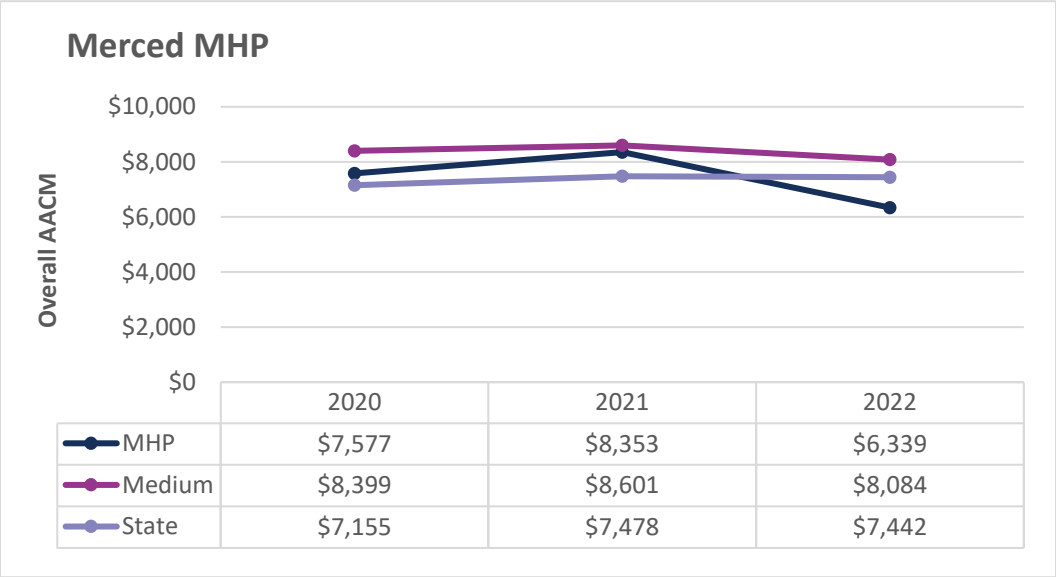
Figure 4: Merced MHP Overall PR CY, 2020-22



	2020	2021	2022
MHP	3.25%	3.18%	3.38%
Medium	3.87%	3.67%	3.49%
State	4.55%	4.34%	3.96%

- While overall PRs for the medium-sized counties, and the state declined each year from CY 2020 to CY 2022, the MHP's PR increased from CY 2021 to CY 2022. In CY 2022, the MHP's PR was lower than that of both the medium-sized county rate (3.38 percent vs. 3.49 percent) and statewide rate (3.38 percent vs. 3.96 percent).

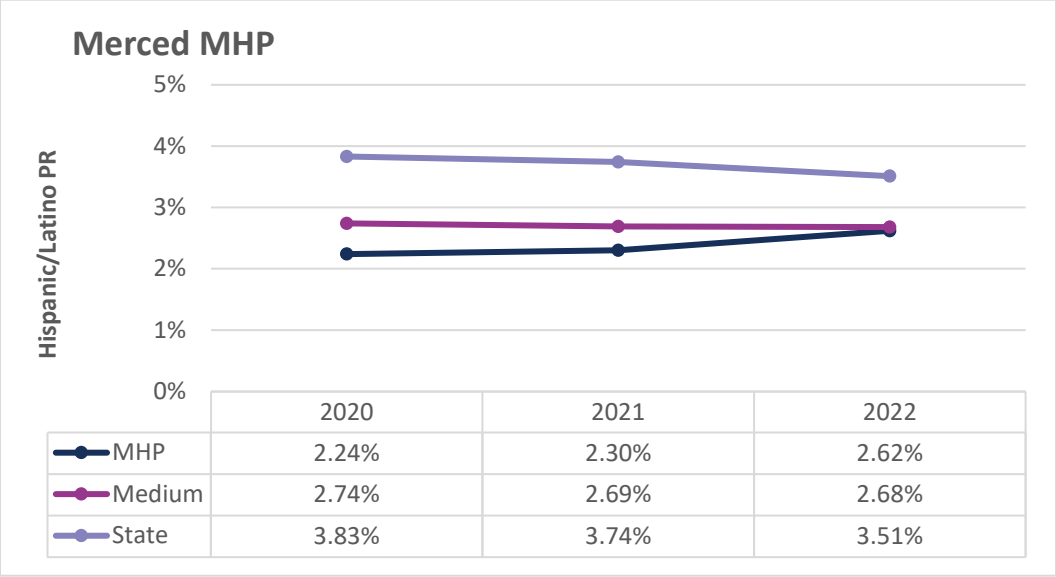
Figure 5: Merced MHP Overall AACM, CY 2020-22



	2020	2021	2022
MHP	$7,577	$8,353	$6,339
Medium	$8,399	$8,601	$8,084
State	$7,155	$7,478	$7,442

- The MHP's overall AACM declined 24.1 percent from CY 2021 to CY 2022 and was below the medium county and statewide AACMs in CY 2022.

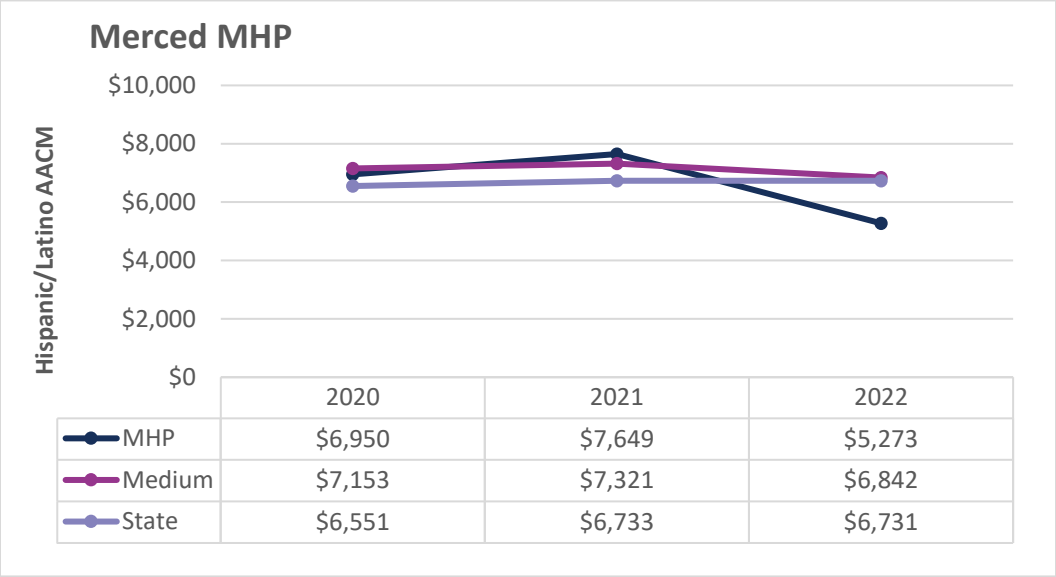
Figure 6: Merced MHP Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	2.24%	2.30%	2.62%
Medium	2.74%	2.69%	2.68%
State	3.83%	3.74%	3.51%

- While the MHP's Hispanic/Latino PR increased each year from CY 2020 to CY 2022, it remains just below the medium-sized county rate and is 25.4 percent lower than the statewide rate in CY 2022.

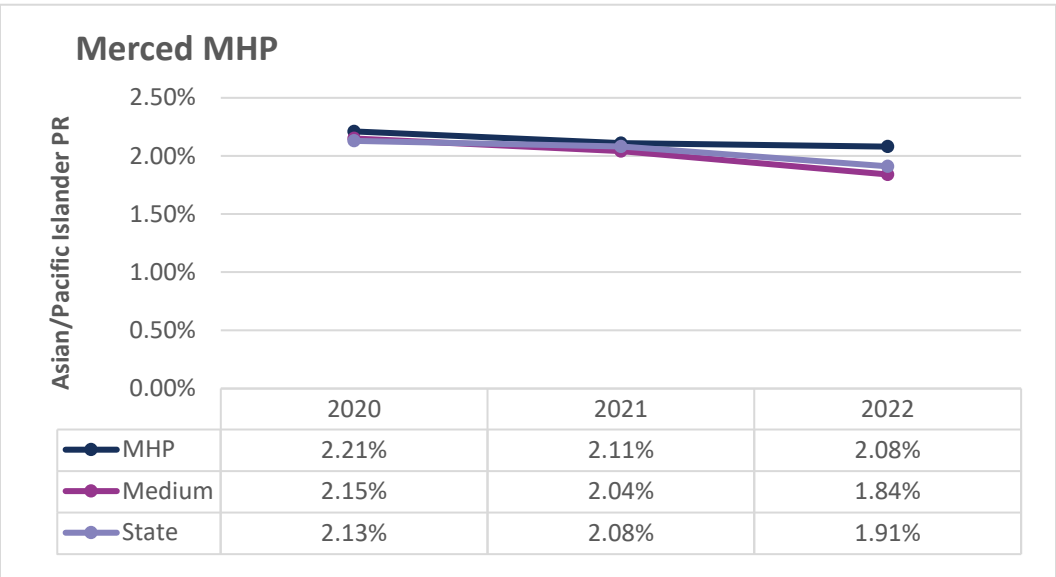
Figure 7: Merced MHP Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$6,950	$7,649	$5,273
Medium	$7,153	$7,321	$6,842
State	$6,551	$6,733	$6,731

- The MHP's Hispanic/Latino AACM deceased 31.06 percent from CY 2021 to CY 2022 and was lower than both medium county and statewide averages in CY 2022.

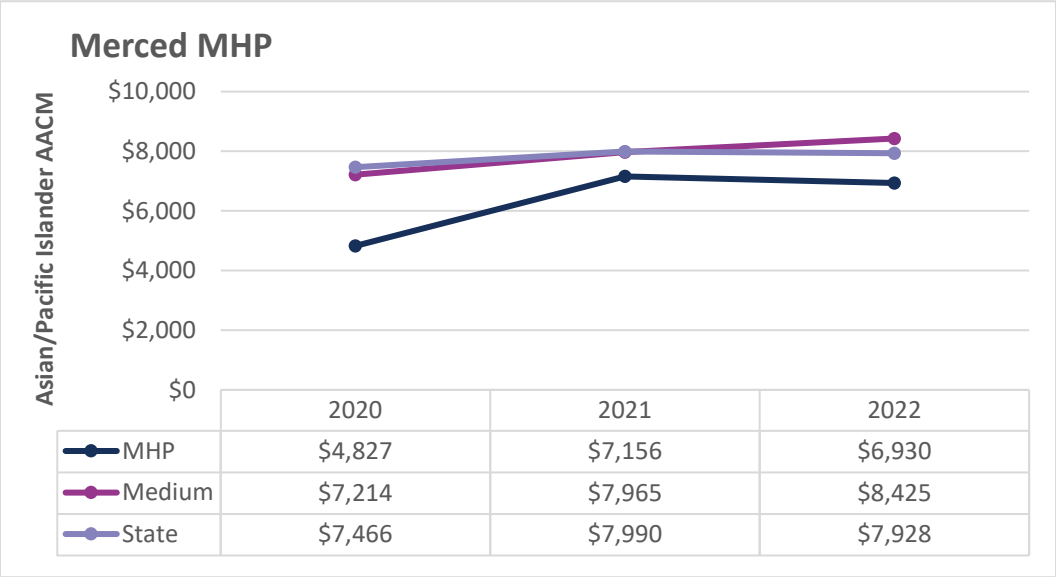
Figure 8: Merced MHP Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	2.21%	2.11%	2.08%
Medium	2.15%	2.04%	1.84%
State	2.13%	2.08%	1.91%

- While the MHP, medium county, and statewide Asian/Pacific Islander PRs declined each year from CY 2020 to CY 2022, the MHP's Asian/Pacific Islander PR exceeds both the medium county and statewide rates consistently in all three years.

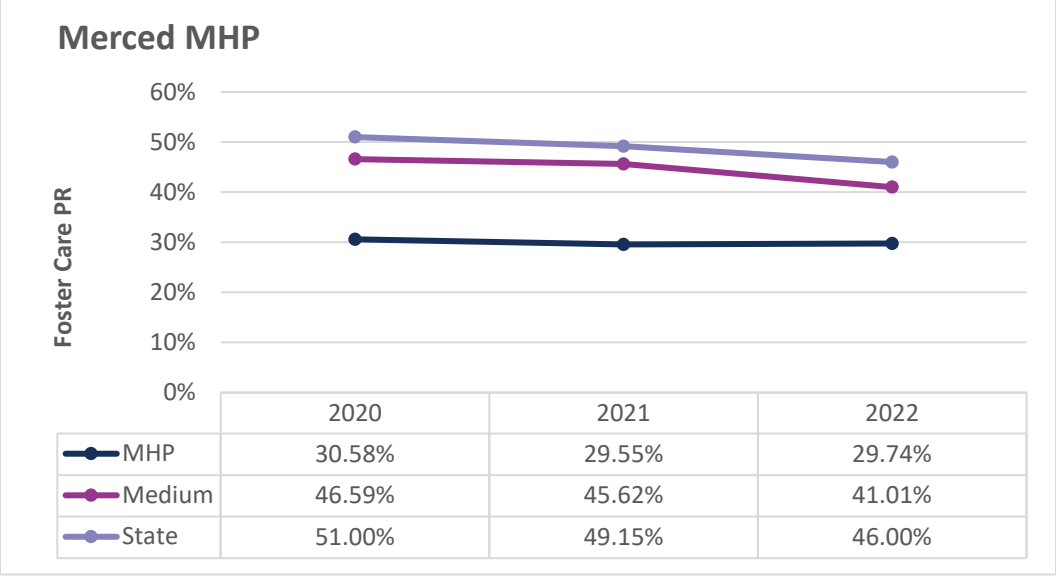
Figure 9: Merced MHP Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$4,827	$7,156	$6,930
Medium	$7,214	$7,965	$8,425
State	$7,466	$7,990	$7,928

- Although the MHP's Asian/Pacific Islander AACM increased markedly from CY 2020 to CY 2021, it has been lower than that of medium county and statewide averages for each of the last three years.

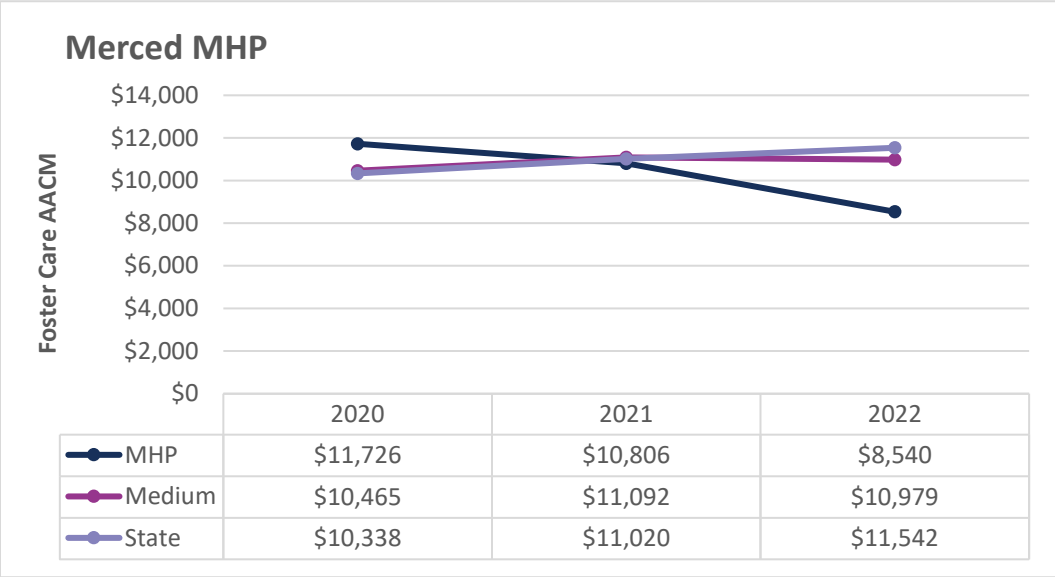
Figure 10: Merced MHP Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	30.58%	29.55%	29.74%
Medium	46.59%	45.62%	41.01%
State	51.00%	49.15%	46.00%

- The MHP's FC PR has been markedly below that of medium county and statewide rates from CY 2020 to CY 2022. In CY 2022, the MHP's PR is 27.5 percent lower than the medium county rate and 35.3 percent lower than the statewide rate.

Figure 11: Merced MHP Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$11,726	$10,806	$8,540
Medium	$10,465	$11,092	$10,979
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years, whereas the MHP's FC AACM has decreased for each of the past three years. It is less than both medium county and statewide averages in CY 2022.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Merced MHP to Adults, CY 2022

Service Category	MHP N = 3,619				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	126	3.5%	7	6	10.3%	14	8
Inpatient Admin	<11	-	28	19	0.4%	26	10
Psychiatric Health Facility	215	5.9%	14	7	1.2%	16	8
Residential	0	0.0%	0	0	0.3%	114	84
Crisis Residential	44	1.2%	35	26	1.9%	23	15
Per Minute Services							
Crisis Stabilization	53	1.5%	1,432	1,200	13.4%	1,449	1,200
Crisis Intervention	701	19.4%	233	155	12.2%	236	144
Medication Support	1,880	51.9%	218	160	59.7%	298	190
Mental Health Services	2,155	59.5%	785	270	62.7%	832	329
Targeted Case Management	1,410	39.0%	525	130	36.9%	445	135

- The MHP's combined inpatient and Psychiatric Health Facility (PHF) utilization rate was lower than the combined statewide rate (9.4 percent vs. 11.5 percent).
- Although the MHP's crisis intervention utilization rate, as well as average and median units for this service, were all greater than the statewide rate (19.4 percent vs. 12.2 percent), the crisis stabilization (CSU) rate at the MHP was 89 percent less than the statewide rate (1.5 percent vs. 13.4 percent).
- The medication support utilization rate is lower than is seen statewide (51.9 percent vs. 59.7 percent).

Table 9: Services Delivered by the MHP to Merced MHP Youth in Foster Care, CY 2022

Service Category	MHP N = 254				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	20	7.9%	12	7	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	<11	-	26	26	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	<11	-	1,174	960	3.1%	1,166	1,095
Crisis Intervention	32	12.6%	299	180	8.5%	371	182
Medication Support	73	28.7%	314	240	27.6%	364	257
TBS	<11	-	1,573	1,333	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	49	19.3%	716	244	40.8%	1,458	441
Intensive Home-Based Services	27	10.6%	1,214	805	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	239	94.1%	1,262	430	95.4%	1,846	1,053
Targeted Case Management	145	57.1%	418	135	35.8%	307	118

- The MHP's combined inpatient and PHF utilization rate was higher than the statewide rate (7.9 percent vs. 4.7 percent).
- The MHP's targeted case management (TCM) utilization rate is higher than the statewide rate (57.1 percent vs. 35.8 percent).
- The MHP's Intensive Home-Based Services (IHBS) and ICC utilization rates were lower than statewide rates and had much lower average and median units than statewide as well.

IMPACT OF ACCESS FINDINGS

- The PRs for those aged 0-5 and 6-17 were below that of statewide rates, suggesting lower service accessibility in the children's system of care.
- In CY 2022, the MHP's FC PR was 27.5 percent lower than the medium sized county rate and 35.3 percent lower than the statewide rate, suggesting lower service accessibility for FC youth than is seen statewide.
- The MHP's IHBS and ICC utilization rates for FC youth were lower than statewide rates. In addition, the MHP's combined inpatient and PHF utilization rate was higher than the statewide rate. This may indicate that lack of sufficient outpatient services could potentially result in increased utilization of inpatient services. The AACM for FC youth was 26 percent below the statewide average for this group.
- The MHP has continued outreach to the Latino/Hispanic population through media outreach including Public Service Announcements (PSAs) and radio campaigns and has been working on a contract with La Familia to serve Hispanic clients. The program is expected to open in early 2024. Impact of this program and increase in the Hispanic PR may be seen next year as the current PR continues to be lower than the statewide average.
- The MHP's telehealth services dropped for all ages compared to last year. The MHP would benefit from exploring the reasons for this decline and reviewing potential opportunities to increase telehealth services which may improve timely access to care.
- The MHP has implemented some strategies to hire staff but has been challenged with county mandates that no longer provide telework as an option. Further, neighboring counties compete for hiring with better salaries and incentives that include telework. These challenges impacted hiring and retention and resulted in a negative impact on access to care.
- Following CalAIM implementation and the No Wrong Door policy in July 2023, the MHP has experienced a tremendous increase in walk-ins to the wellness center. The MHP has a clinician at the wellness center who uses the CalAIM screening tool, and this resulted in an increase in referrals to the Managed Care Plan (MCP), Carelon.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The MHP's post outpatient follow-up rates are higher than the state and national rates and readmission rates are lower than the statewide average. The PIPs have contributed to a positive change in the follow-up rates following a decline in the previous year.

- The school-based mobile crisis team, the crisis care mobile unit at the University of (UC) Merced campus, and the Hilmar mobile youth program were implemented to provide a quick response to children and youth in crisis.
- Due to severe staffing shortages (total of 74 vacant positions, as reported during the review) and hiring challenges, the MHP has long delays for first offered non-urgent appointments, first offered non-urgent psychiatry appointments, and urgent appointments. Despite the MHP's extra help from 67 temporary staff, the timeliness in all the above areas mentioned has been severely impacted.
- Although the MHP met all the Timeliness Key Components because they track and trend metrics and identify strategies to improve timeliness, these strategies did not demonstrate significant positive impact on timeliness metrics.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of ATA, representing access to care during the 12-month period of March 1, 2022, to February 28, 2023. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. This data represents county-operated services for most metrics, and the entire system of care for follow-up services after psychiatric hospitalization.

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

Table 11: FY 2023-24 Merced MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	12 Business Days	10 Business Days*	54%
First Non-Urgent Service Rendered	18 Business Days	10 Business Days**	42%
First Non-Urgent Psychiatry Appointment Offered	36.3 Business Days	15 Business Days*	20.7%
First Non-Urgent Psychiatry Service Rendered	39.9 Business Days	15 Business Days**	18.6%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required ***	195.29 Hours	48 Hours*	28%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	12.7 Calendar Days	7 Calendar Days**	55%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	12.7 Calendar Days	30 Calendar Days	75.3%
No-Show Rate – Psychiatry	19.99%	10%**	n/a
No-Show Rate – Clinicians	15.50%	10%**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033

** MHP-defined timeliness standards

*** The MHP does not require prior authorization for urgent services.

For the FY 2023-24 EQR, the MHP reported its performance for the following time period:

March 1, 2022 - February 28, 2023.

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

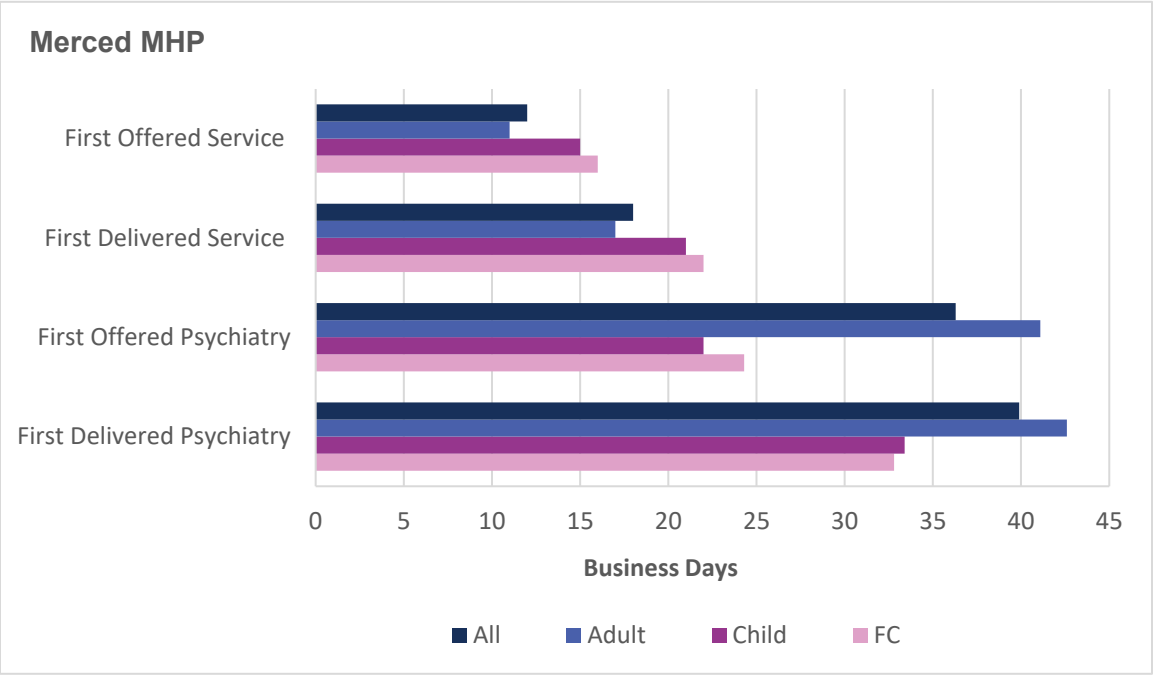


Figure 13: Merced MHP Wait Times for Urgent Services

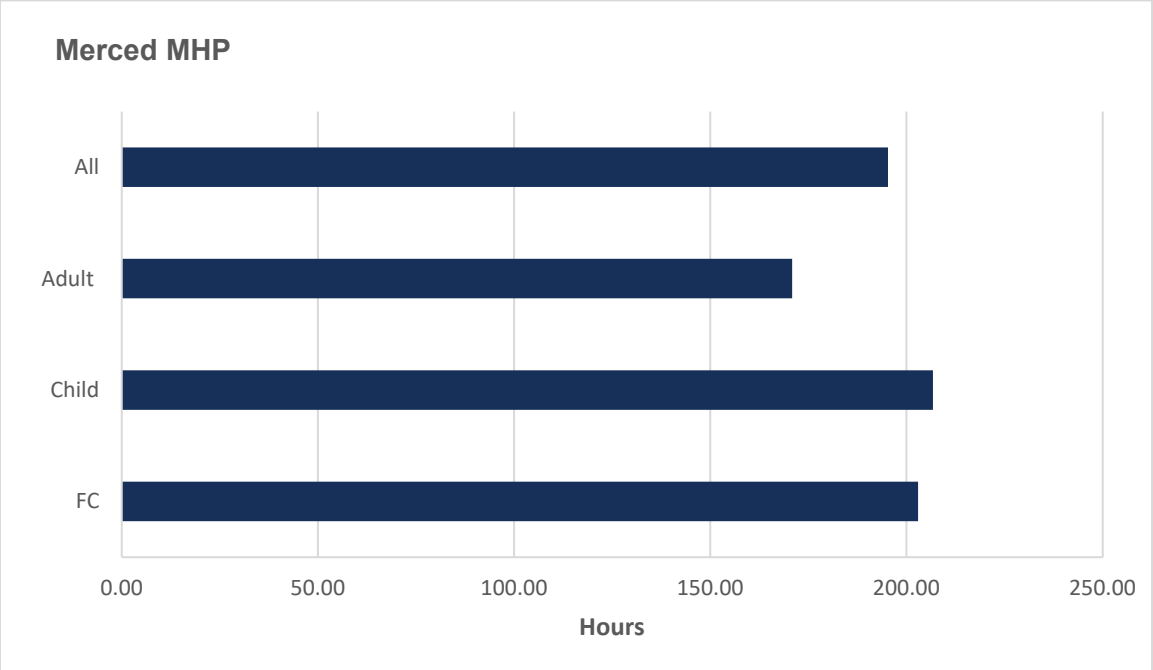
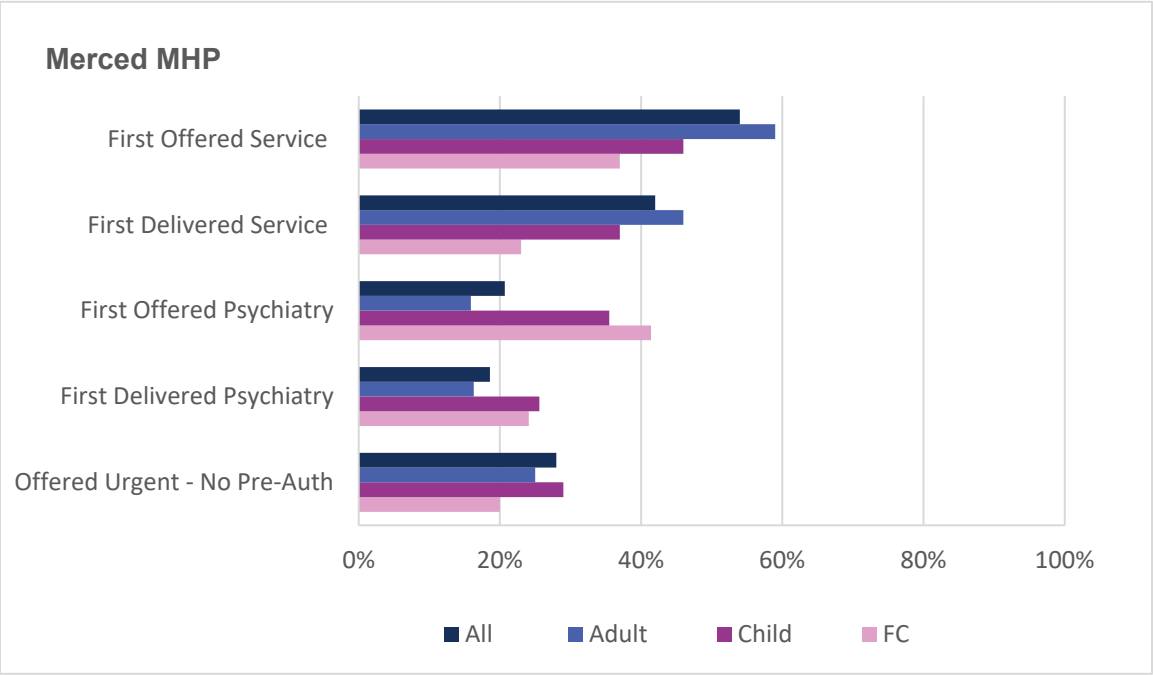


Figure 14: Merced MHP Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled and unscheduled assessments.
- The MHP defined "urgent services" for purposes of the ATA as "without timely intervention, the condition is highly likely to result in an immediate emergency due to a psychiatric condition, such as 5150 assessments for Danger to Self, Danger to Others, and/or Grave Disability not resulting in hospitalization; client recently relocated from another county and needs urgent meds/services to avoid hospitalization (i.e., less than 7 days medication supply); client released from incarceration within the last 90 days and needs urgent meds/services to avoid hospitalization and; client demonstrating increased severity of symptoms/behaviors which put them at risk for significant decline in ability to care for self." There were reportedly 25 urgent service requests with a reported overall actual wait time for services at 195.29 hours (8 days). The MHP does not require pre-authorization for urgent services.
- The MHP defines timeliness to first delivered/rendered psychiatry services as from the point of first clinical determination of need. Only 20 percent of members were offered a psychiatry appointment within 15 days, overall averaging longer than a seven week wait for the first offered psychiatry appointment.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked for both clinicians and psychiatrists. The MHP reports a no-show rate of 15.5 percent for clinicians and 20 percent for psychiatrists.

IMPACT OF TIMELINESS FINDINGS

- The MHP's clinical PIP focused on post discharge outpatient follow-up rates that resulted in significant improvement. The MHP's readmissions rates are low and indicative of timely outpatient follow-up having a potential impact in reducing readmissions.
- The MHP noted observing initial positive change with their all-hands-on deck approach and discontinuing this following the initial implementation last year to improve the first offered appointment timeliness. However, this positive change was not fully sustained as only 54 percent of the appointments met the timeliness standard of 10 business days. The timeliness rates for children were lower with timely appointments offered for only 46 percent of children. This shows a negative impact on access to care.
- The MHP's timeliness for first offered non-urgent psychiatry appointments is very low at 21 percent and shows a decline from last year (30 percent). The rate was worse for adults at 16 percent. A high no-show rate of 20 percent for psychiatry appointments provides an opportunity for the MHP to utilize any last-minute availability through higher number of offered appointments per day.
- The MHP's first offered urgent appointments show delays with only 28 percent offered timely appointments. This shows a 12-percentage point decline from the previous year. Although the MHP has increased the number of urgent conditions identified following the definition of urgent conditions and related training for the Access line, it has experienced serious challenges in meeting the timeliness standard in this area as indicated by a high average of over eight business days for first offered urgent appointments.
- While approximately 44 percent of services are provided by contract providers, contract provider timeliness data was only included in timeliness calculations for follow-up after psychiatric hospitalization and psychiatric inpatient readmission rates.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is with the Quality and Performance Management (QPM) division. In addition to QI, QPM is also responsible for quality assurance and utilization management activities. The MHP supports the activities of QPM through planned communication of its findings to different units within the agency as well as to outside stakeholders including the Behavioral Health Board (BHB).

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of the MHP leadership, beneficiaries, and family members, BHB members, community service providers, direct provider staff, wellness center consumer advisory board members, and the patients' rights advocate, is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met three times. Of the 21 identified FY 2022-23 QAPI workplan goals, the MHP met or partially met 76 percent of the goals. The serious challenges faced by MHP with hiring and staffing had a major negative impact on timeliness goals. The MHP included new goals related to the EHR implementation for this review and partially met these goals.

The MHP utilizes the following level of care (LOC) tools: Child and Adolescent Needs and Strengths (CANS), 35-item Pediatric Symptoms Checklist (PSC-35) and Adult Needs and Strengths Assessment (ANSA).

The MHP produces reports on the LOC tools at individual level in spreadsheet or dashboard format. It expects to be able to summarize the LOC tools at the system level once the new EHR becomes operational. Through QI referral process and case conferences with multidisciplinary teams, the LOC information is used to support transitions to lower or higher LOC.

The MHP utilizes the following outcomes tools: CANS, PSC-35, and ANSA. The outcome tool dashboards are reviewed in team meetings and appropriate treatment implications are discussed.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- The MHP's QPM division has robust QI processes. The QAPI plan is comprehensive and well organized, focuses on key areas of access, timeliness, and quality. The QPM tracks and trends the metrics for each goal and addresses areas for improvement through QI activities.
- The QIC is well represented by key stakeholders including BHB members, plan members, wellness center representatives, providers, the cultural competence committee members, and other advisory board members.
- The MHP has strong collaboration with contract providers and has monthly meetings that support bidirectional communication. The contract providers would benefit from timely communication on leadership changes. The MHP

communicates all system updates and invites to meetings such as QIC and cultural competence committee through email and shares meeting minutes. However, line staff did not receive operational updates related to school-based services.

- The MHP collaborates with local churches, public health and health services, managed care plans, schools, law enforcement and criminal justice departments, and housing authority to establish strong connections and improve quality of services to the clients served.
- The MHP has three wellness centers and the information about the wellness centers is posted on the website and is easily accessible. The MHP made changes to the duration and number of sessions for certain groups based on feedback from participants. There is a warm hand off for youth transitioning from the TAY wellness center to the adult wellness center.
- The MHP has a robust peer support specialist (PSS) and mental health worker (MHW) workforce. Many MHWs have lived experience. Many of the PSS staff have been promoted to MHW positions, which often leads to vacancies for PSS positions.
- The MHP continues to have serious challenges with staff hiring and retention thereby impacting access, timeliness, and quality of care. High caseloads for clinicians have limited their time spent with clients and impacted quality of care. Due to frequent staff turnover, clients experience disruption to the continuity of care and related negative impacts on quality of care.
- The MHP set a goal of 90 percent compliance related to medication monitoring. The MHP tracks and trends medication monitoring results and addresses areas for improvement. For FY 2022-23, the MHP reviewed 132 non-foster youth charts and achieved an overall compliance rate of 92.78 percent for the seven areas monitored.
- The MHP tracks and trends the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5. The MHP's Medical Director conducted medication monitoring review for 46 FC youth over three quarters of FY 2022-23 and reported an overall compliance of 94.96 percent that exceeded the goal (90 percent).
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): 100 percent compliance.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): zero percent compliance, but a very small number of youth.
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): zero percent compliance.

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): 92.31 percent compliance.

QUALITY PERFORMANCE MEASURES

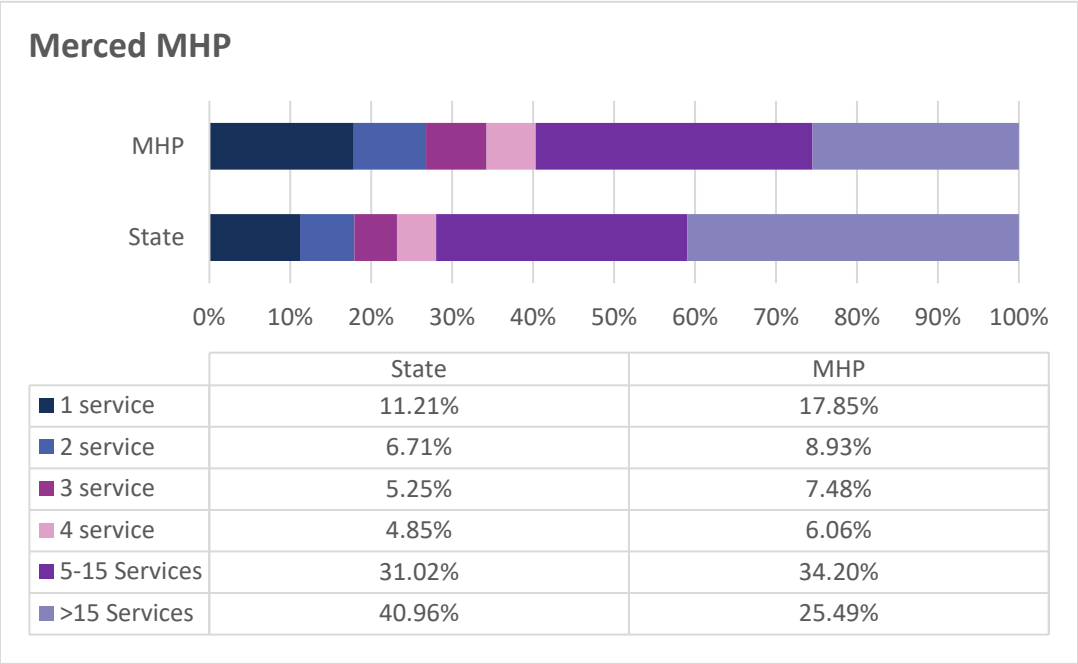
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

Retention in services is an important measure of member engagement in order to receive appropriate care and intended outcomes. One would expect most members served by the MHP to require five or more services during a 12-month period. However, this table does not account for the length of stay (LOS), as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Merced MHP Retention of Members Served, CY 2022



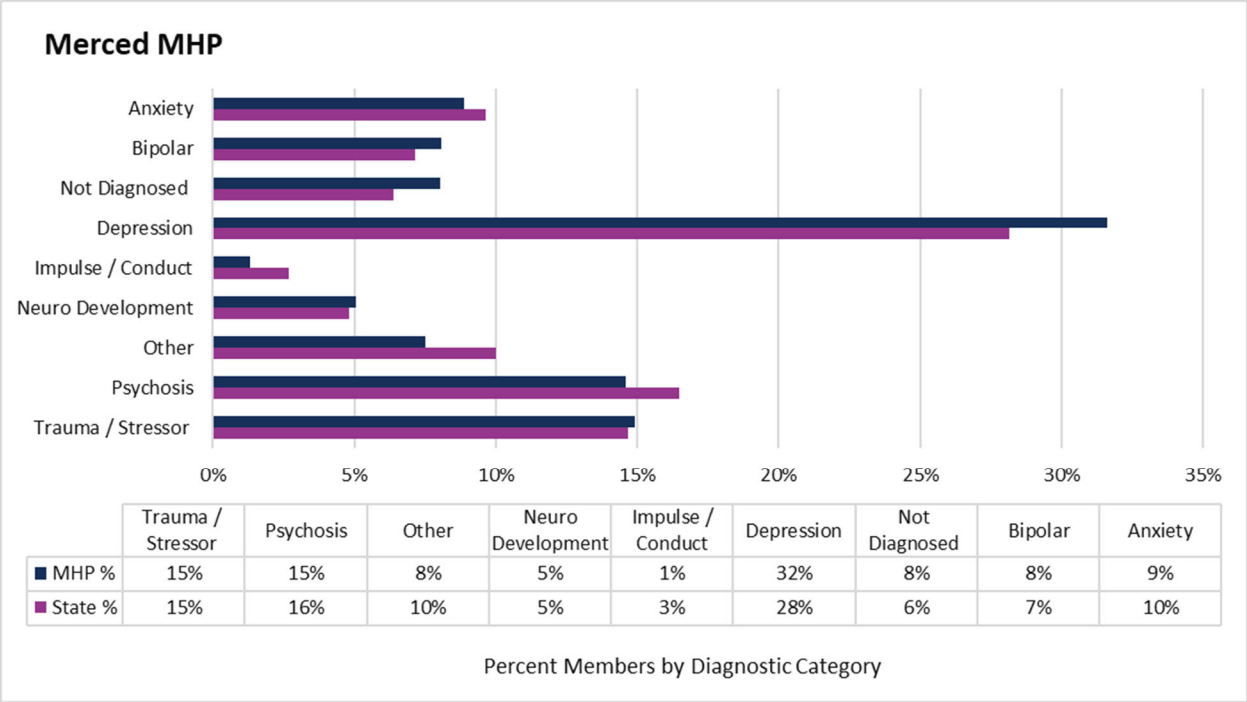
	State	MHP
1 service	11.21%	17.85%
2 service	6.71%	8.93%
3 service	5.25%	7.48%
4 service	4.85%	6.06%
5-15 Services	31.02%	34.20%
>15 Services	40.96%	25.49%

- The MHP had a greater proportion of members receiving a single service than is seen statewide (17.85 percent vs. 11.21 percent).
- The MHP's proportion of members receiving greater than 15 services is lower than statewide (25.49 percent vs. 40.96 percent). The MHP ranks 53 of 56 MHPs for this measure, where the 3 MHPs that have lower retention in this category are small MHPs.

Diagnosis of Members Served

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

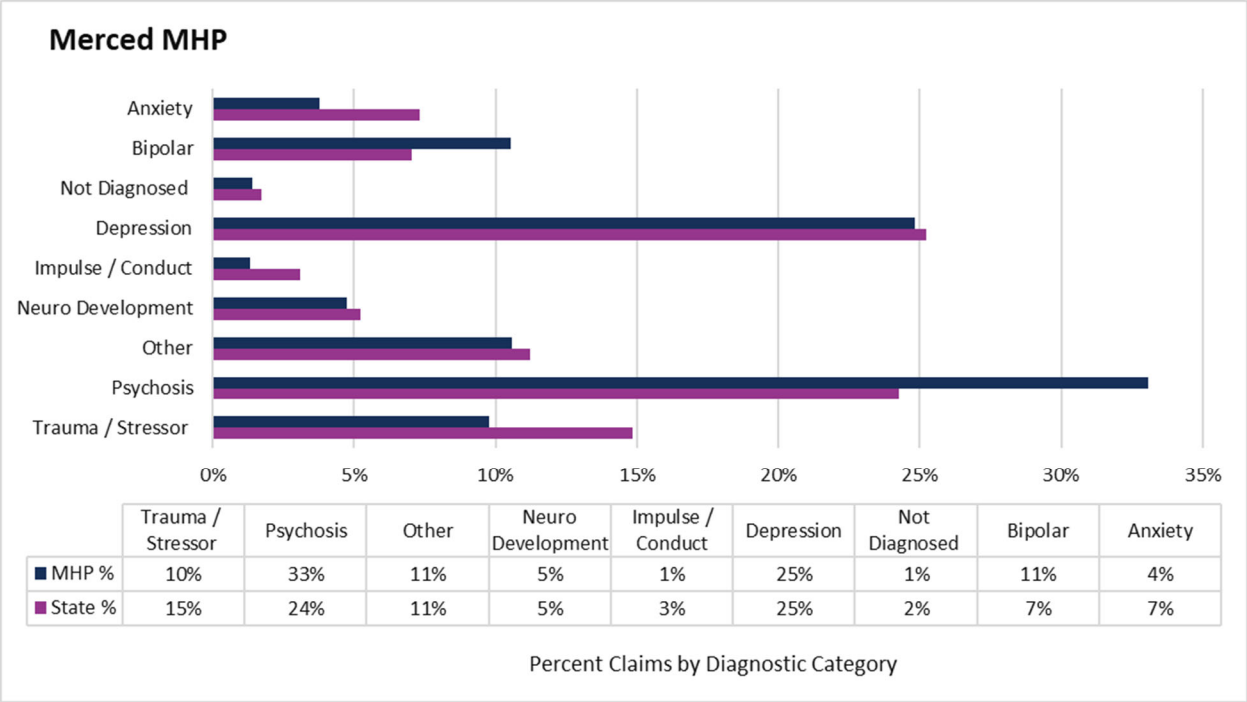
Figure 16: Merced MHP Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	15%	15%	8%	5%	1%	32%	8%	8%	9%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- 62 percent of members had one of three diagnoses: depression (32 percent), psychosis (15 percent), and trauma/stressor (15 percent).
- The MHP's diagnostic rate for depression exceeds the statewide rate by 14 percent (32 percent vs. 28 percent).

Figure 17: Merced MHP Diagnostic Categories by Percentage of Approved Claims, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	10%	33%	11%	5%	1%	25%	1%	11%	4%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- The percentage of MHP approved claims for depression diagnosis was equal to the statewide proportion of 25 percent, but the MHP diagnosed depression was at a higher rate than is seen statewide (32 percent vs. 28 percent).
- The percentage of MHP approved claims for psychosis was higher than what was observed for the state (33 percent vs. 24 percent), but the MHP diagnosed psychosis was slightly lower than what was seen statewide (15 percent vs. 16 percent). This shows a disproportionate amount of resources attributed to a smaller number of members with psychotic disorders, a service pattern which may be warranted.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS. CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

Table 13: Merced MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	506	633	1.25	9.90	8.45	$23,804	$12,763	$12,044,739
CY 2021	462	612	1.32	9.09	8.86	$20,322	$12,696	$9,388,556
CY 2020	386	489	1.27	9.28	8.68	$21,517	$11,814	$8,305,650

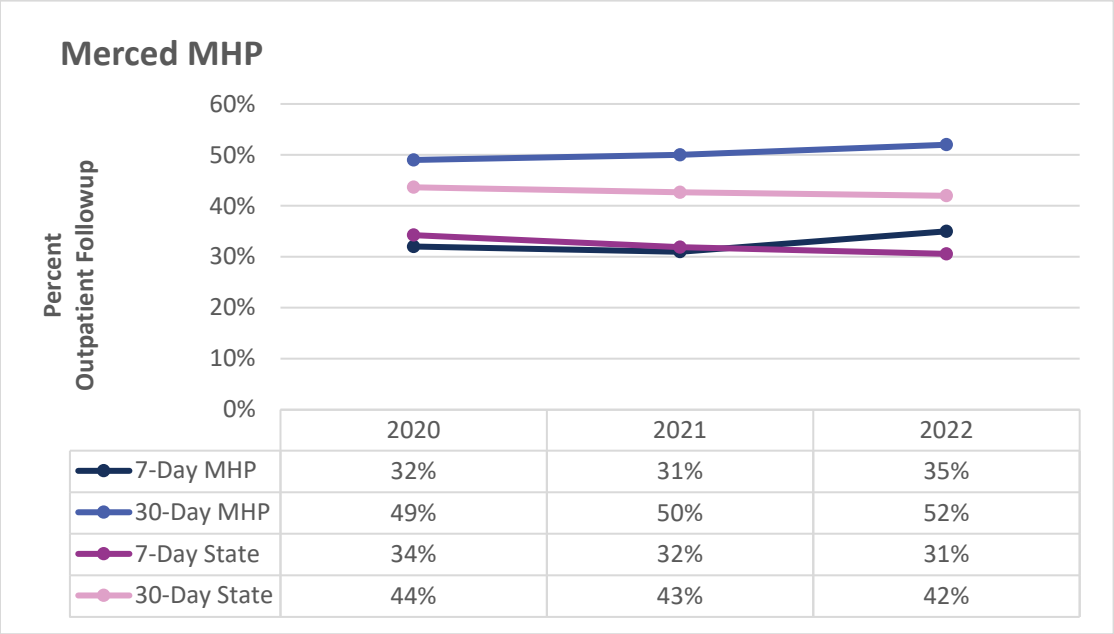
- The MHP's average LOS was higher for CY 2022 compared to CY 2021 and continues to be higher than the statewide average LOS for the past three years.
- The MHP's inpatient AACM was 46 percent higher than the state inpatient AACM. The MHP's inpatient total approved claims for CY 2022 have increased by 45 percent compared to its claims for CY 2020.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and is reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis. As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the current methodology.

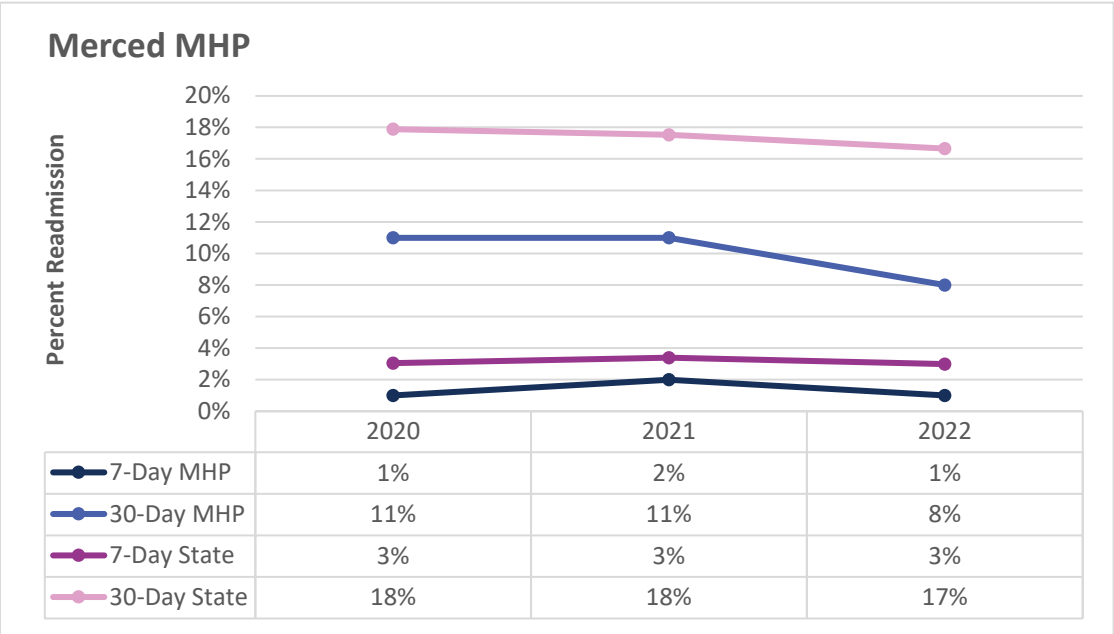
Figure 18: Merced MHP 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	32%	31%	35%
30-Day MHP	49%	50%	52%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- The MHP's 7- and 30-day follow-up rates for CY 2022 increased compared to the previous year. The 7-day follow-up rate for the MHP was four percentage points higher than what was observed for the statewide rate and the 30-day follow-up rate was ten percentage points higher than the statewide rate.

Figure 19: Merced MHP 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22



	2020	2021	2022
7-Day MHP	1%	2%	1%
30-Day MHP	11%	11%	8%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP's 7- and 30-day readmission rates have been lower than statewide rates for the past three years.

High-Cost Members

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

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

Tables 14 and 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

Table 14: Merced MHP High-Cost Members (Greater than $30,000), CY 2020-22

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	235	4.45%	47.34%	$15,856,188	$67,473	$50,695
	CY 2021	283	6.06%	49.36%	$19,255,443	$68,040	$57,047
	CY 2020	237	5.36%	46.35%	$15,529,262	$65,524	$55,304

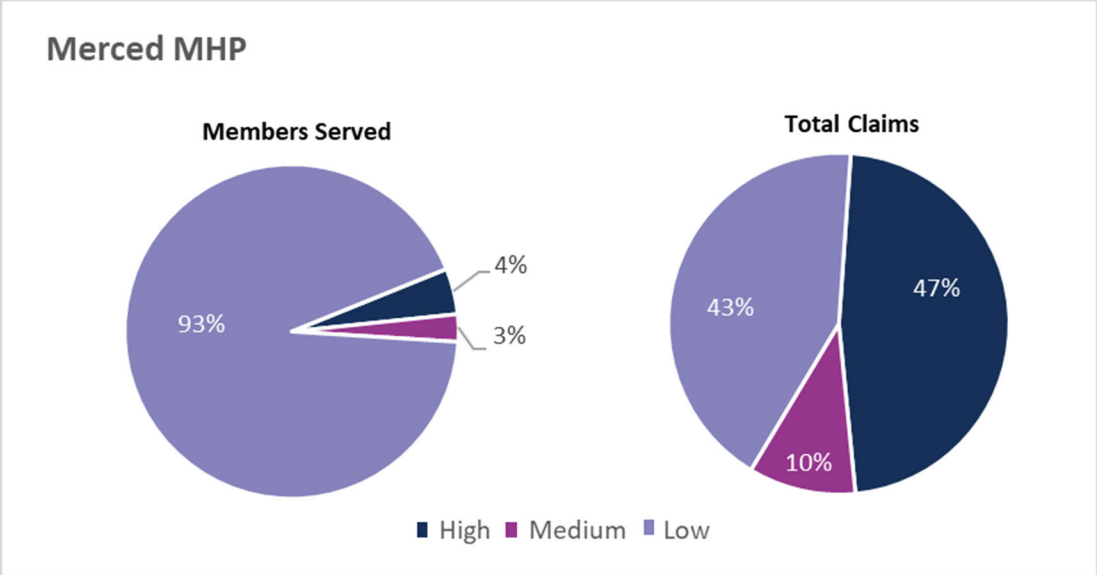
- The number of HCMs decreased from CY 2021 to CY 2022 (283 vs. 235). In CY 2022, the percentage of HCMs was just below the statewide rate (4.45 percent vs. 4.54 percent).
- The MHP's CY 2022 percent of HCM approved claims dollars exceeded the statewide rate (47.34 percent vs. 33.86 percent). The MHP's HCM AACM was higher than the statewide average in CY 2022 ($67,473 vs. $55,518).

Table 15: Merced MHP Medium- and Low-Cost Members, CY 2022

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	140	2.65%	10.18%	$3,411,121	$24,365	$24,179
Low-Cost (Less than $20K)	4,909	92.90%	42.48%	$14,228,298	$2,898	$1,479

- Low-cost members comprised 92.90 percent of those served and 42.48 percent of the approved claims dollars were attributed to this population.

Figure 20: Merced MHP Members and Approved Claims by Claim Category, CY 2022



- The proportions of members in each cost category and the proportions of claims attributable to each group were generally comparable to statewide, with a higher proportion of claims associated with HCMs (47 percent vs. 34 percent) and a lower proportion associated with low-cost members (43 percent vs. 54 percent) than statewide.

IMPACT OF QUALITY FINDINGS

- The MHP's proportion of members receiving greater than 15 services is lower than statewide (25.49 percent vs. 40.96 percent). The lower percentage of those

receiving 15 or more services is likely a contributing factor to the MHP's lower overall AACM.

- The MHP QPM division's consistent focus on access, timeliness, and quality metrics and related QI activities is a major strength of the MHP. Although the QAPI goals have not all been fully met, the routine tracking of the metrics and evaluation to review strategies and modify them gives opportunities for continuous quality improvement.
- The MHP uses several evidence-based practice models such as Cognitive Behavior Therapy (CBT), Dialectical Behavior Therapy (DBT), Wellness Recovery Action Plan (WRAP), Motivational Interviewing, and others. However, due to high caseloads, the MHP reported challenges with practicing fidelity to the model.
- Despite staffing challenges, the MHP has implemented CalAIM related projects including no wrong door policy, screening, and transition tools, and continues to monitor and address areas that need improvement.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Post Hospitalization PIP

Date Started: July 2021

Date Completed: June 2023

Aim Statement: "Merced will increase the percentage of adult members who receive follow-up care within seven days of psychiatric hospital discharge from a FY 2020-21 baseline of 36% to a national standard of 46% in FY 2022-23 and significantly increase the percentage who have 7-day medication management follow-up by FY 2022-23 by improving communications between hospitals and the outpatient system of care and establishing a twice-weekly post-hospitalization outpatient clinic."

Target Population: The study population included all adult beneficiaries aged 21 and over who were discharged from the Merced Psychiatric Health Facility (MGPC) or out-of-county hospital. Members who are open to outpatient treatment prior to hospitalization and those who are not open to services were included. The PIP

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

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

committee decided to focus exclusively on adult discharges because follow-up rates were significantly higher for children (57% vs. 27%).

Status of PIP: The MHP's clinical PIP was completed in June 2023.

Summary

The MHP completed a comprehensive review of post discharge follow-up data for two years and survey data from 25 respondents on their experiences with appointments scheduling and follow-up post discharge to identify the problem area for the PIP. The MHP implemented two interventions: improving communications between hospitals and the outpatient system of care and establishing a twice-weekly post-hospitalization outpatient clinic. The goal was to increase the percentage of adult members who receive follow-up care within seven days of psychiatric hospital discharge from a FY 2020-21 baseline of 36 percent to a national standard of 46 percent in FY 2022-23 and significantly increase the percentage who have 7-day medication management follow-up compared to the previous fiscal year.

The PIP findings demonstrate statistically significant improvement for both measures. Members already open to services were the most likely to have 7-day follow-up but showed only a small amount of improvement between the baseline and the first year of full implementation. On the contrary, members who were previously not opened to outpatient services had the lowest follow-up rate but the greatest amount of improvement between baseline and the first year of full implementation. MGPC members were more likely to receive follow-up and showed a greater rate of improvement between baseline and the first year of full implementation than out-of-county members.

For the second performance measure related to medication management, MGPC and open clients were most likely to receive medication management, and the rate of improvement between baseline and FY 2022-23 was similar for all subcategories of members and statistically significant. Overall, the PIP demonstrated sustained improvement over repeated measurements.

TA and Recommendations

As submitted, this clinical PIP was found to have high confidence because the PIP adhered to acceptable and consistent methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced statistically significant evidence of improvement. The narrative discussed the process and outcome measure data points in a detailed, thorough, and thoughtful manner to demonstrate improvement that was sustained over repeated measurements.

TA was provided outside of the review on October 16, 2023, and the MHP incorporated EQR recommendations to update their narrative and PMs for the PIP that was submitted for the review.

CalEQRO recommendations for improvement of this clinical PIP:

- The PIP concluded in June 2023 and demonstrated statistically significant improvement on both performance measures. To sustain the improvement evidenced from the implementation of the post-hospitalization clinic, the MHP would benefit from continued implementation of this clinic and increasing the number of days the clinic is open as staffing resources become available.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-Up After Emergency Department (ED) Visit for Mental Illness

Date Started: July 2022

Aim Statement: "By Quarter 4, CY 2023, Merced County BHRS aims to increase by 5 percent the percentage of MHP clients who receive follow-up services after a mental health-related Memorial Hospital ED visit[4] using low barrier then higher tech interventions, including:

1) implementing standardized referral procedures for hospital social workers and follow-up procedures for BHRS Access staff.
2) deploying an electronic closed loop referral management platform.
3) using a health information exchange to transmit Automated Data Texts (ADTs) from the ED to the BH Access team."

Target Population: All clients discharged from LBMH will be included in this study.

Status of PIP: The MHP's non-clinical PIP is in the first remeasurement phase.

Summary

The MHP noted a decline in follow-up rates after ED visits for mental health and self-harm related diagnoses between CY 2020 and CY 2021 (67% to 56% for 7-day and 75% to 67% for 30-day follow-up) and designed three interventions to improve the

[4] Goal is to increase by 5 percent over a FY 2022 (Mar 1, 2022 – Feb 28, 2023) baseline period. The baseline period involved 107 Los Baños ED visits, of which 55 (51.4%) had a follow-up within 7 days and 71 (66.4%) within 30 days. A 5% increase would mean achieving 54.0% 7-day follow-up rate and 69.7% 30-day rate.

follow-up rates by five percent. The MHP implemented the first intervention related to standardized referral procedures for hospital social workers and follow-up procedures for Access staff in August 2023. The MHP provided preliminary data for the first repeat measurement for one intervention and due to the small numbers gathered from the first month of data collection, no conclusions can be made.

The MHP has been working collaboratively with local EDs and hospitals and is making extensive efforts to implement the other two interventions with an expected timeline of December 2023. The MHP has leveraged the implementation of the EHR to implement these two high technology solutions that are promising.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence because the MHP completed a thorough review of the barriers and organized their interventions based on a low/high scale for barriers and technology. The MHP carefully considered factors that may impact the three interventions and implemented the first intervention recently with one ED and plans to expand soon to the second ED. Despite any conclusive findings from the preliminary data, the MHP's data collection methodology and structure and well thought out interventions in collaboration with key stakeholders earn a rating of "moderate" confidence for this PIP.

TA was provided outside of the review on October 16, 2023, and the MHP incorporated EQR recommendations to update their narrative and PMs for the PIP that were submitted for the review.

CalEQRO recommendations for improvement of this non-clinical PIP:

- This PIP is projected to end in March 2024. The MHP would benefit from expanding the scope of the first PIP intervention to other EDs such as Mercy as planned for November 2024.
- The MHP should continue monthly data collection for the first intervention related to referral and follow-up and consider additional targeted strategies such as Navigator and Engagement (NET) efforts at the EDs for improved engagement and successful follow-up.
- The MHP would benefit from continued collaboration with key stakeholders for successful implementation of the other two PIP interventions and tracking the performance related to those interventions. Lastly, continuing this project in some form beyond the PIP end date will improve overall timely referral and follow-up for plan members discharged from hospitals.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an ASP where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Credible from Qualifacts Systems, LLC. (Qualifacts), which has been in use for less than one year. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 3.69 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 475 named users with log-on authority to the EHR, including approximately 334 county staff and 141 contractor staff. Support for the users is provided by five full-time equivalent (FTE) IS technology positions. Currently all positions are filled.

As of the FY 2023-24 EQR, some contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to Merced MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	57%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	41%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	2%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP does not have a PHR. This functionality is expected to be implemented within the next two years.

Interoperability Support

The MHP is a member or participant in a HIE. The MHP has a signed contract with Manifest MedEX, but at the time of the review the MHP and Manifest MedEX had not had their first initial planning meeting. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with its contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP implemented the Credible system on April 1, 2023. The system is being operated in an ASP environment with Kingsview as their provider. Qualifacts will maintain and provide patches for the base system and Kingsview will support the MHP with product customization.
- The implementation of Credible is ongoing and staff reported that they are continuing to adjust and understand the full functionality of the new system.
- Some, but not all, contract providers can enter beneficiary data into the Credible EHR (e.g.: progress notes, treatment plans). Contract providers who received Credible EHR training reported the training to be sufficient and felt having the option for both live and computer-based training formats enhanced the learning process.
- Some, but not all, contract providers enter services directly into the Credible performance management system. The MHP reports that 41 percent of contract provider services are received by fax or email and 2 percent by delivery of paper documents. There were no claims submitted to the MHP by electronic batch file transfer and electronic data interchange.
- Contract provider timeliness data was not included in timeliness calculations for first offered appointment and first delivered service, first offered psychiatric appointment and first delivered psychiatric service, urgent appointment timeliness, and clinician and psychiatrist no-show rates.
- The MHP plans to join the Manifest MedEx HIE (Manifest MedEx) but at the time of the review the first planning meeting with Manifest MedEx had not yet occurred.
- The MHP's denied claims rate of 2.78 percent is lower than the statewide rate of 5.92 percent.
- Two-factor authentication to authorize user password change is not utilized.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

Table 18 appears to reflect a largely complete or very substantially complete claims data set for the time frame represented.

Table 18: Summary of Merced MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	6,967	$2,326,852	$50,322	2.16%	$2,276,530
Feb	7,001	$2,072,372	$87,027	4.20%	$1,985,345
Mar	8,116	$2,689,865	$78,593	2.92%	$2,611,272
April	7,384	$2,260,475	$54,841	2.43%	$2,205,634
May	7,697	$2,614,932	$82,426	3.15%	$2,532,506
June	7,132	$2,364,734	$123,115	5.21%	$2,241,619
July	6,793	$2,820,427	$80,523	2.85%	$2,739,904
Aug	8,780	$3,352,408	$129,454	3.86%	$3,222,954
Sept	7,768	$2,796,209	$63,609	2.27%	$2,732,600
Oct	7,280	$2,927,081	$36,681	1.25%	$2,890,400
Nov	7,026	$2,673,038	$41,763	1.56%	$2,631,275
Dec	6,977	$2,226,847	$37,578	1.69%	$2,189,269
Total	**88,921**	**$31,125,240**	**$865,932**	**2.78%**	**$30,259,308**

- The claim volume was consistent during CY 2022.

Table 19: Summary of Merced MHP Denied Claims by Reason Code CY 2022

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other healthcare coverage must be billed first	1,574	$537,128	62.03%
Medicare Part B must be billed before submission of claim	1,231	$212,359	24.52%
Beneficiary is not eligible or non-covered charges	82	$107,541	12.42%
Service line is a duplicate and repeat service modifier is not present	20	$5,463	0.63%
Late claim submission	5	$1,260	0.15%
Deactivated National Provider Identifier (NPI)	5	$1,147	0.13%
Other	15	$1,036	0.12%
Total Denied Claims	**2,932**	**$865,934**	**100.00%**
Overall Denied Claims Rate	**2.78%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The claims denial rate for CY 2022 of 2.78 percent is lower than the statewide denial rate of 5.92 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- While the Credible system will provide the benefit of new and updated functionality, the MHP reported having previously developed in-house reports and dashboards that are not available in Credible. There will be a review of currently available reports/dashboards and previously available reports/dashboards to identify desired reporting availability in the new system. The rebuilding of reporting functionality will be a time and resource consuming endeavor and a focus of the MHP over the next year.
- Some, but not all, contract providers have full access to the Credible system (EHR and performance management modules). Full contract provider access to the system increases the data that is available to the MHP for analysis and reporting.
- The MHP will vastly increase their ability for electronic exchange of healthcare data with active membership and participation in the Manifest MedEx HIE. Manifest MedEx facilitates the exchange of healthcare data for 36 million Californians via its network comprised of more than 1,800 healthcare organizations including 125 hospitals and 13 health plans including four of the state's largest health plans, Anthem Blue Cross of California, Inland Empire Health Plan, and Health Plan of San Joaquin.
- The MHP does not yet maintain a database that mirrors the Credible system for analytics and reporting; this is being considered as a post-implementation project.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP tracks and trends the consumer satisfaction survey data in the QAPI and responds to feedback provided in the open-ended section of the surveys to improve services. The findings are presented at the QIC and other internal committees and shared with staff. The MHP reviews consumer satisfaction data gathered from the WRAP and LGBTQ groups and implemented changes based on the feedback provided.

Plan Member/Family Focus Groups

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

As part of the pre-review planning process, CalEQRO requested two 90-minute focus groups with MHP members and/or their family, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested "a diverse group of adult consumers who initiated services in the preceding 12 months." The focus group was held by videoconference and included eight participants; no language interpreter was used for this focus group. All consumers participating received clinical services from the MHP within the past 12 months.

Summary of focus group findings

- Some participants described delays of up to three weeks to see a therapist and a psychiatrist. All reported receiving reminder calls for appointments.
- Participants mentioned that psychiatry appointments were offered every two or three months. Therapy appointments ranged from once every two weeks to once a month. Additional appointments were scheduled if needed.
- All shared that interpreter services were available when needed. They received bus passes for transportation, and some were transported in county cars. All

were informed about transportation options when they began services. Participants preferred appointments in person.

- Participants were aware of how to request a change of psychiatrist or therapist if they had a concern or problem. They had automatic refills available at the pharmacy for their medications and had no problems.
- Participants expressed that family members could be involved in their treatment with their consent. Family members can receive support from National Alliance for Mentally Ill (NAMI).
- All were aware of volunteer and paid opportunities and peer support specialist certification.
- All participants received information on whom to contact during a crisis. They shared that they could call the Access line and the MGPC during a crisis and mentioned that the WRAP group at the wellness center discussed resources to use during crisis.
- All expressed that they could share input with their therapists who are always willing to listen. Participants explained that they are made aware of changes and information through their therapists and case managers. They receive flyers and announcements are made at the programs and wellness centers.
- Participants received housing support through Section 8 vouchers and the Mercy rescue mission.
- A few participants completed satisfaction surveys but did not recall receiving any feedback. None of the participants recalled being invited to QIC.
- All participants said that they are happy with the services they receive and have a sense of hope and recovery.

Recommendations from focus group participants included:

- Increase peer support staff and therapists. MHP is understaffed.
- Add more activities at the wellness center – bingo, coloring contests, and tournaments.
- Extend wellness center end time from 4 pm to 5 pm.
- Revive field trips that were stopped post pandemic.

Consumer Family Member Focus Group Two

CalEQRO requested “a diverse group of family members whose children/youth were initiated services in the preceding 12 months.” The focus group was held via videoconference and included only one participant; no language interpreter was used for this focus group.

Due to the low number of participants, the information provided is included throughout the report where applicable. Though participation was low, the MHP worked diligently to recruit focus group members that included outreach to all children's programs and TAY wellness center to ensure robust participation.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Adult members who participated found services to be helpful in increasing their sense of hope and recovery. They appreciated the opportunities for wellness activities, communication and support from their treatment team, and resources such as transportation and housing.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP has robust QI processes as reflected in its comprehensive QAPI that tracks and trends key metrics and evaluates the performance. The QPM activities are supported by the MHP through planned communication of its findings to different units within the agency as well as to the external stakeholders. (Quality)

2. The CHHEJC's efforts in establishing a culturally competent system of care with a focus on cultural humility, justice, and equity is noteworthy especially with services to the Deaf and Hard of Hearing and the LGBTQ population (Access).

3. The JCID's extensive efforts to link plan members who are on probation and parole are impressive. The TERP report highlights the success of the Restart program in this area. (Access)

4. The MHP utilizes satisfaction survey feedback from surveys to improve services. The MHP increased the duration of the LGBTQ group sessions and increased the number of WRAP group sessions in response to the survey feedback from participants. The MHP also reviews open ended feedback on test calls to address areas for improvement for the Access line. (Quality)

5. The timeliness of the MHP's outpatient follow-up and medication management have significantly improved with the implementation of the clinical PIP. (Timeliness)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP's first offered non-urgent appointments timeliness rate is 54 percent with adults at 59 percent and children at 46 percent. These metrics show that a large percentage are not being offered timely first appointments and may be associated with the high percentage of members receiving only one service in CY 2022; the DHCS expectation is 80 percent meeting the 10-business day standard. (Timeliness)

2. The MHP's first offered non-urgent psychiatry appointments timeliness rate was very low at 21 percent and declined from the previous year (30 percent).

Timeliness is worse for adults at 16 percent compared to children at 36 percent indicating serious challenges for timely medication appointments. (Timeliness)

3. The MHP has struggled with timeliness on first offered urgent appointments as there is a decline from 40 percent in the previous year to 28 percent the current year. (Timeliness)

4. Although the MHP met all key components for timeliness and implemented some strategies to increase capacity and address the challenges in meeting standards for timeliness, these strategies did not reflect an improvement in timeliness metrics. (Timeliness)

5. The MHP's Latino/Hispanic PR continues to be much lower than the statewide average. The results of the MHP's efforts in addressing this issue are not evidenced in the available data at this time. (Access)

RECOMMENDATIONS

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

1. The MHP's timeliness rate for first offered non-urgent appointments is 54 percent. The "all hands-on deck" approach was discontinued by the MHP midway after initial improvement in timeliness. The MHP would benefit from reviving that approach and implementing other strategies to improve timeliness. (Timeliness)

2. The wait time for the first offered non-urgent psychiatry appointment is 36 days with only 21 percent receiving timely appointments. The MHP is working on a few strategies which have not shown any positive impact yet on the timeliness. Explore barriers to timeliness in this area and implement strategies that target these barriers including telepsychiatry. Given the long wait times, it is important to identify members with urgent needs in order to provide them with more timely care. (Timeliness)

   (This recommendation was continued from FY 2022-23.)

3. Only 28 percent of the urgent appointments met the timeliness standard of 48 hours. The average wait time is very high with an average of eight days and median of seven days. Review the reasons for these delays and implement strategies that will improve timeliness in this area. (Timeliness)

   (This recommendation was continued from FY 2021-22.)

4. Although the MHP implemented some strategies, some of which are in progress, positive impact on timeliness has not been demonstrated. There has been a decline over the past year in more than one area of timeliness. Create a

workgroup within the CQI committee to review and implement strategies that address potential barriers for meeting timeliness standards and report monthly progress to the CQI committee. (Timeliness)

5. Consider Promotoras and other effective outreach strategies to improve outreach and engagement with the Hispanic/Latino population as the PR continues to be much lower that the statewide PR. Report numbers served at the La Familia program which is scheduled to open in January 2024 and the impact on the Hispanic/Latino PRs. (Access)

   (This recommendation was continued from FY 2021-22.)

EXTERNAL QUALITY REVIEW BARRIERS

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

The caregiver focus group had only one participant as not all six caregivers who were scheduled to attend could not attend due to reasons such as their child getting sick and their inability to attend.

As part of the EQR process, the MHP Director submitted a letter identifying specific barriers to the MHP's full participation in the review. Please see Attachment E.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Merced MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Telehealth, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Clinical Line Staff Group Interview
Specialized Service Systems: Criminal Justice
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Information Systems Billing and Fiscal Interview
EHR Deployment
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Naga Kasarabada, Ph.D. Quality Reviewer
Lisa Farrell, IS Reviewer
MaryEllen Collins, Senior Consumer/Family Member Reviewer

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

All sessions were held via videoconference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Albright	Ryan	Core Program Director	Aspiranet
Angel	Adrain	Compliance Manager	BHRS
Arredondo	Diana	Administrator	Central Star
Avila	Alma	Program Manager	BHRS
Azevedo	Maria	Staff Services Analyst- Substance Use Disorders (SUD)	BHRS
Barboza	Clovia	Staff Services Analyst- Automations	BHRS
Bettencourt	Nicole	Fiscal Manager	BHRS
Bonson	Tyler	Automations Manager	BHRS
Brown	Zakia	Clinician	BHRS
Castaneda	Cresencio	SUD Counselor	BHRS
Caza-Burdick	Lidia	Division Director	BHRS
Cervantes-Puga	Gerardo	Regional Administrator	Central Star
Chang	Kit	Division Director	BHRS
Chang	Vong	Director	Turning Point
Chastain	Sarah	Peer Support Specialist	BHRS
Daffron	Joel	Chief	Probation
DeRose	Mike	Administrator	Aspiranet
Dinis	Laura	Peer Support Specialist	BHRS
Doradea	Jaime	Program Manager	BHRS
DuPont	Christina	Staff Services Analyst	BHRS
Eslinger	Lila	Program Manager	BHRS
Fernandez	Jorge	Director of Behavioral Health	Golden Vally Health Center
Green	Joni	Mental Health Director	Creative Alternatives

Last Name	First Name	Position	County or Contracted Agency
Guerrero	Corrina	Quality Assurance Specialist	Central Star
Guillen	Thalia	Clinician	BHRS
Haygood	Caitlin	Staff Services Analyst- ASOC	BHRS
Her	Shoua	Division Manager	Probation
Hernandez	Tabatha	Director of Services	Community Social Model Advocates
Hernandez	Marissa	Supervisor	Probation
Herrera	Heydi	Assistant Director of Behavioral Health	Golden Vally Health Center
Jacobs	Lisa	Assistant Executive Director	Creative Alternatives
Jones	Sharon	MHSA Program Coordinator	BHRS
Kaur	Manjit	Director of Admin Services	BHRS
Kaur	Amandeep	Clinical Director	God's Love Outreach Ministries
Key	Charlotte	Program Manager	CSMA
Lee	Nhia	Clinician	BHRS
Lockerby	Christine	Staff Services Analyst- Automations	BHRS
Loera	Dionne	Division Manager	Probation
Madriz	Rafael	Mental Health Worker	BHRS
Maloney	Conor	Assistant Director	Turning Point
Malough	Samantha	Executive Director	Aegis
Mansfield	Rosalinda	Mental Health Worker	BHRS
Marin	Valeria	Mental Health Worker	BHRS
Martinez	Christian	Program Manager	BHRS
Merrill	Joshua	Program Manager	BHRS
Nerell	Jodi	Care Team	Sutter
Orozco	Patricia	Program Manager	BHRS
Oseguera	Ana	Peer Support Specialist	BHRS

Last Name	First Name	Position	County or Contracted Agency
Patino	Raymond	SUD Counselor	BHRS
Pierce	Alexandra	Assistant Director- Admin	BHRS
Pulido	Liliana	Program Manager	BHRS
Pushia	Racheal	Peer Support Specialist	BHRS
Reed	Mattew	QPM Division Director	BHRS
Riggs	Kelsey	RN Manager	Alliance
Rodriguez	Bianca	Clinician	BHRS
Saavedra	Socorro	Administrator	Merced County Human Services Agency
Salas	Yazmin	SUD Counselor	BHRS
Servin	Leticia	Program Manager	BHRS
Sims	Julianne	Assistant Director- Clinical	BHRS
Smyth	Lanetta	Division Director	BHRS
Soza	Harvey	Mental Health Worker	BHRS
Susskind	Jennifer	Consultant	Praxis
Thao	Ye	Case Manager	Merced Lao Family
Urzua	Laura	Administrator	Central Star
Valdez	Adriana	Fiscal Manager	BHRS
Vang	Kimiko	Director	BHRS
Walter	Nicole	Peer Support Specialist	BHRS
Walters	Carolyn	Program Manager	BHRS
Xiong	May-Ci	Division Director	BHRS
Zagal	Belen	Peer Support Specialist	BHRS

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	The PIP adhered to acceptable and consistent methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced statistically significant evidence of improvement. The narrative discussed the process and outcome measure data points in a detailed, thorough, and thoughtful manner to demonstrate improvement that was sustained over repeated measurements. Therefore, a rating of High confidence is given for this PIP.
General PIP Information	
MHP/DMC-ODS Name: Merced County Behavioral Health and Recovery Services	
PIP Title: Post Hospitalization PIP	
PIP Aim Statement: Merced will increase the percentage of adult members who receive follow-up care within seven days of psychiatric hospital discharge from a FY 2020-21 baseline of 36% to a national standard of 46% in FY 2022-23 and significantly increase the percentage who have 7-day medication management follow-up by FY 2022-23 by improving communications between hospitals and the outpatient system of care and establishing a twice-weekly post-hospitalization outpatient clinic.	
Date Started: July 2021	
Date Completed: June 2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 21 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): The study population included all adult beneficiaries aged 21 and over who were discharged from MGPC or out-of-county hospital. The PIP committee decided to focus exclusively on adult discharges because follow-up rates were significantly higher for children (57% vs. 27%).
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Post-Hospitalization Clinic where clients discharged from hospitals were seen in a timely manner.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Improved communication and care coordination between MGPC and Adult System of Care (ASOC) prior to hospital discharge.
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): Click or tap here to enter text.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
1. 7-Day Post Hospitalization Follow-Up Rate (any Medi-Cal billable service)	FY 2020-21	245/672 = 36.5%	FY 2022-23	329/712 = 46.2%	☒ Yes ☐ No	☒ Yes ☐ No P-value: 0.0002 ☒ <.01 ☐ <.05 Other (specify): Significance tested using chi-sq two by two test comparing baseline and most recent measurement period.
2. 7-Day Post Hospitalization Follow-Up Rate (Medication Management services)	FY 2020-21	68/678 = 10.1%	FY 2022-23	195/712=27.4%	☒ Yes ☐ No	☒ Yes ☐ No P value: <0.00001 ☒ <.01 ☐ <.05 Other (specify): Significance tested using chi-sq two by two test comparing baseline and most recent measurement period

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☒ Other (specify): Completed Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The PIP concluded in June 2023 and demonstrated statistically significant improvement on both performance measures. To sustain the improvement evidenced from the implementation of the post-hospitalization clinic, the MHP would benefit from continued implementation of this clinic and increasing the number of days the clinic is open as staffing resources become available.

Non-Clinical PIP

Table C2: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP completed a thorough review of the barriers and organized their interventions based on a low/high scale for barriers and technology. The MHP carefully considered factors that may impact the three interventions and spent a year planning the interventions based on the study of these factors. The MHP provided preliminary data for the first repeat measurement for one intervention and due to the small numbers gathered from the first month of collection, no conclusions can be made. The MHP has provided extensive information on their efforts to implement the second and third intervention effectively and leveraged the implementation of the EHR to implement high technology solutions that are more promising. Despite any conclusive findings from the preliminary data, the MHP's data collection methodology and structured, well thought out interventions in collaboration with key stakeholders earn a rate of "Moderate" confidence for this PIP.
General PIP Information	
MHP/DMC-ODS Name: Merced County Behavioral Health and Recovery Services	
PIP Title: Follow-up after Emergency Department visit for Mental Illness	
PIP Aim Statement: By Quarter 4, CY 2023, Merced County BHRS aims to increase by five percent the percentage of MHP clients who receive follow-up services after a mental health-related Memorial hospital ED visit[5] using low barrier then higher tech interventions, including: 1) implementing standardized referral procedures for hospital social workers and follow-up procedures for BHRS Access staff. 2) deploying an electronic closed loop referral management platform. 3) using a health information exchange to transmit ADTs from the ED to the BH Access Team.	

[5] Goal is to increase by 5 percent over a FY 2022 (Mar 1, 2022 – Feb 28, 2023) baseline period. The baseline period involved 107 Los Baños ED visits, of which 55 (51.4%) had a follow-up within 7 days and 71 (66.4%) within 30 days. A 5% increase would mean achieving 54.0% 7-day follow-up rate and 69.7% 30-day rate.

General PIP Information
Date Started: July 2022
Date to be Completed: March 2024
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): The study population involves all patients discharged from one ED—LBMH.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Distribution of English/Spanish BHRS promotional flyers to clients at discharge and screening, scheduling of follow-up appointments; and reminder calls to clients.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Implementing standardized referral procedures for hospital social workers
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): Implementing standardized referral procedures and follow-up procedures for BHRS Access staff

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
1. Percentage of BHRS clients who had a 7-day follow-up after LBMH ED visit	FY 2021	335/604 = 55.5%*	September 2023	2/7 = 28.6%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): the preliminary data show no improvement. However, the numbers are low to arrive at any conclusions.
2. Percentage of BHRS clients who had a 7-day follow-up after LBMH ED visit for MI/ISH related diagnoses	FY 2021	402/604 = 66.6%	September 2023	☒ Not applicable—PIP is in planning or implementation phase, results not available	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

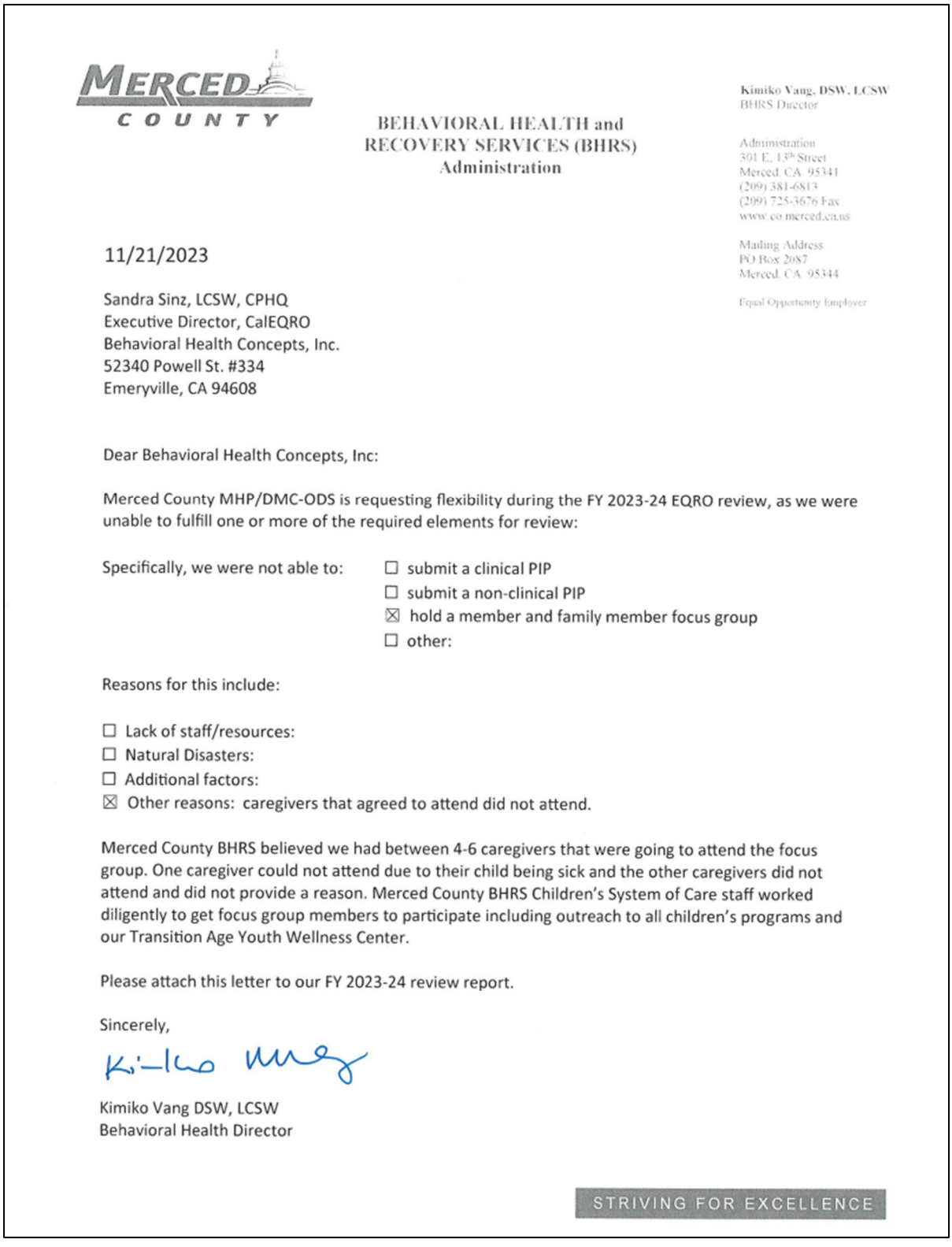
PIP Validation Information
EQRO recommendations for improvement of PIP: This PIP is projected to end in March 2024. The MHP would benefit from expanding the scope of the first PIP intervention to other EDs such as Mercy as planned for November 2024. The MHP should continue monthly data collection for the first intervention related to referral and follow-up and consider additional targeted strategies such as NET efforts at the ED's for improved engagement and successful follow-up. The MHP would benefit from continued collaboration with key stakeholders for successful implementation of the other two PIP interventions and tracking the performance related to those interventions. Lastly, continuing this project beyond the PIP end date will improve overall timely referral and follow-up for plan members discharged from hospitals.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

Please see the attached letter.



MERCED COUNTY

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Equal Opportunity Employer

11/21/2023

Sandra Sinz, LCSW, CPHQ
Executive Director, CalEQRO
Behavioral Health Concepts, Inc.
52340 Powell St. #334
Emeryville, CA 94608

Dear Behavioral Health Concepts, Inc:

Merced County MHP/DMC-ODS is requesting flexibility during the FY 2023-24 EQRO review, as we were unable to fulfill one or more of the required elements for review:

Specifically, we were not able to:
- ☐ submit a clinical PIP
- ☐ submit a non-clinical PIP
- ☒ hold a member and family member focus group
- ☐ other:

Reasons for this include:

- ☐ Lack of staff/resources:
- ☐ Natural Disasters:
- ☐ Additional factors:
- ☒ Other reasons: caregivers that agreed to attend did not attend.

Merced County BHRS believed we had between 4-6 caregivers that were going to attend the focus group. One caregiver could not attend due to their child being sick and the other caregivers did not attend and did not provide a reason. Merced County BHRS Children's System of Care staff worked diligently to get focus group members to participate including outreach to all children's programs and our Transition Age Youth Wellness Center.

Please attach this letter to our FY 2023-24 review report.

Sincerely,

Kimiko Vang DSW, LCSW
Behavioral Health Director

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