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

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

FRESNO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

March 14-16, 2023

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — March 14-16, 2023

MHP Size — Large

MHP Region — Central

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	4	1	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	3	3	0
Quality of Care	10	6	4	0
Information Systems (IS)	6	6	0	0
TOTAL	**26**	**18**	**8**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Children's Full-Service Partnership (FSP) Progress Review	Clinical	01/2023	Implementation Phase	High
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	12/2022	Implementation Phase	Moderate

Table D: Summary of Consumer/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	2
3	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	7

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has a thoughtful approach to quality improvement (QI) that is outcomes-driven, with structures and data utilization that support this approach.
- The Domo software provides detailed reports and visualization of data that reinforces the use and purpose of data to drive services and outcomes.
- The MHP's marketing strategies and outreach to the community was partially credited for the increase in the number of beneficiaries served in 2021.
- The MHP provides culturally-competent services through the Living Well Center that serves Southeast Asian beneficiaries.
- The Access/Transition/Discharge (ATD) report assists the MHP in evaluating service and program utilization and transitions in services and can guide decisions about capacity.

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

- Despite the increase in Hispanic/Latino beneficiaries served, there continues to be a difference between the number of Hispanic/Latino eligibles and the number served, which may indicate a disparity in access.
- Hmong-speaking beneficiaries may wait up to four months for an appointment with the Hmong-psychiatrists. The delays raise concerns especially when there are asynchronous concerns with medications.

- Of the 18 peer positions in the Department of Behavioral Health (DBH), only two have been filled (i.e., 16 positions are currently vacant).
- Using only the day of service to track urgent conditions likely inflates the time to response.
- While DBH has no authority over Managed Care Plan (MCP) providers, delays to enrollment in mild-to-moderate programs may erode gains in beneficiary outcomes and functioning achieved through MHP services.

Recommendations for improvement based upon this review include:

- Investigate reasons for and develop and implement strategies to improve access to Hispanic/Latino beneficiaries.
- Investigate and develop and implement strategies to improve the timeliness of psychiatry services for Hmong beneficiaries served at the Living Well Center.
- Resume active recruitment to fill vacant peer employee positions and increase the number of peer employees at DBH.
- Investigate reasons and develop and implement strategies to include a timestamp (minute and hour) that an urgent service was requested.
- Continue to meet with MCP providers and develop an interim solution to serve beneficiaries who are awaiting mild-to-moderate level of care (LOC) programs.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

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

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

This report presents the FY 2022-23 findings of the EQR for Fresno County MHP by BHC, conducted as a virtual review on March 14-16, 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, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

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

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- 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.
- 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 beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during/after the Coronavirus Disease 2019 (COVID-19). The MHP continues to implement COVID-19 protocols and maintains surge readiness (e.g., the crisis and residential facilities maintain COVID-19 protocols and isolations units). Subsequent to COVID-19, the MHP has experienced workforce shortages. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP relocated operations from its long-standing Heritage location to an interim location in Air Fresno as it awaits the construction of a new building, the Olive Building.
- The MHP continues to implement California Advancing and Innovating Medi-Cal (CalAIM). It has Implemented system-wide policy changes and trainings related to CalAIM documentation reform. The Managed Care division holds bi-weekly office hours to answer questions about CalAIM.
- The MHP is in Phase 1 of the implementation of SmartCare, its new Electronic Health Record (EHR). As it does so, the MHP ensures data accessibility of the legacy system.
- The DBH adopted Domo application as its reporting and data visualization software.
- Under the direction of the DBH, the MHP is preparing to reorganize its structure to keep pace with the growth in services. As of February 2023, the executive leadership positions were filled. There is a focus on systemic and organizational wellness.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: Review bilingual (or multilingual) capacity within the DBH and among contract providers and determine if this is sufficient for the demand/need.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation. In the past year, the MHP has funded a community needs assessment to help identify language needs, barriers, and opportunities for Medi-Cal beneficiaries. The needs assessment has yet to be conducted.
- From a community forum hosted by a contract provider, over the past year, the MHP received feedback that there are challenges with the availability of services in and providers who speak Spanish, Arabic, and Indigenous Languages.
- The MHP acknowledges a shortage of its bilingual workforce and a reduction in availability of interpreter services due to a shortage of interpreters; reluctance of interpreters to render services in-person; and fluctuating and exorbitant rates of services.
- The MHP will continue to monitor the threshold languages of the county for any changes (e.g., to anticipate emerging languages); increase the number of bilingual positions; and recruit bilingual (or multilingual) clinical staff.

Recommendation 2: Resume routine review and evaluation of timeliness to services, with documentation to reflect review and subsequent action (e.g., meeting minutes).

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially addressed this recommendation. The MHP reviewed timeliness in the Access subcommittee, beginning in June 2022. The findings, implications, and subsequent action were not indicated, only that the committee "went over timeliness dashboards".
- The QI team is overseeing a Three-Month Timeliness Process review to assure compliance with timely access to care and service standards and provides quality improvement support and corrective action plan oversight when needed. Presumably with this project, timeliness will be reviewed on a monthly basis in QIC.
- This recommendation will not be continued as the MHP is reviewing timeliness more regularly and has other projects that require routine review of timeliness data for system monitoring and improvement.

Recommendation 3: Reduce rates of rehospitalization of youth in FC and provide supports to youth, perhaps through the High Intensity Outpatient Program (HIOP).

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation. The MHP reports that when youth are readmitted, service intensity increases. Youth are seen multiple times a week by the clinician. The HIOP team contacts youth multiple times within the first seven days of discharge and, for youth who are discharged subsequent to homicidal or suicidal ideation, the HIOP provides 30 days of follow-up care.
- Despite this effort, there has been no appreciable change in the self-reported 30-day rehospitalization rate for youth in FC, 22.9 percent compared to 22 percent for calendar year (CY) 2021 and CY 2022, respectively.
- As an ongoing effort to decrease youth rehospitalization, the MHP should provide support and additional services after the *initial or index* hospitalization (i.e., prior to any hospitalization) that continues to/through the 30 days post-hospitalization to prevent or reduce a subsequent hospitalization in 30 days.

Recommendation 4: Conduct two PIPs and submit them for review; seek TA from CalEQRO as needed.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation. The MHP submitted two PIPs that were both validated. The MHP will continue to work on the projects in the upcoming year.

Recommendation 5: Develop a conceptual plan regarding the information needed to facilitate Health Information Exchange (HIE).

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation. The MHP had developed a plan to facilitate an HIE. Fresno County is part of the California Mental Health Services Authority's (CalMHSA's) Semi-statewide Enterprise Health Record project to implement SmartCare.
- The MHP is working with CalMHSA's Implementation Coordinator to ensure steady progress with the HIE interface between SmartCare and Manifest Medex. SmartCare is anticipated to go-live July 2023.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 30.2 percent of services were delivered by county-operated/staffed clinics and sites, and 69.8 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 78.6 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: Urgent Care Wellness Center; Youth Wellness Center; All4Youth (for school-based services); the Crisis Stabilization Center and the psychiatric health facility; and direct access to specific programs (e.g. Perinatal Wellness Program and First Onset/TAY Program). The MHP operates a decentralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The access process includes a screening, linkage or information about possible services, and a referral to the most appropriate program.

In addition to clinic-based MH services, the MHP provides psychiatry and mental health services via telehealth video/phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 8,746 adult beneficiaries, 8,954 youth beneficiaries, and 1,296 older adult beneficiaries across 9 county-operated sites and 9 contractor-operated sites. Among those served, an unknown number of beneficiaries received telehealth services in a language other than English in the preceding 12 months as the MHP does not track this information.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

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

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

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

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

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

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

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Partially 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 Living Well Center is a culturally competent clinic that serves the southeast Asian community. The Center is well connected to the community at large and is seen as a valuable resource and service center for beneficiaries.
- The MHP has a multidisciplinary Access Committee that meets monthly to review beneficiary access to services and then identify and address any issues.
- The MHP experienced an increase in the number of beneficiaries served in CY 2021 and credits this to its public presence, including marketing of services, social media campaigns, radio advertisements, and participation in school and community events. The MHP also identified improved promotion of the health plan transportation assistance as part of this effort.
- While the MHP is serving more beneficiaries than in the prior years, the MHP is operating with a reduced workforce of both clinical and administrative staff (e.g., the DBH reported a current vacancy rate of 33 percent). Clinicians reported less frequent contacts with beneficiaries. In the Access Committee, disconnected calls and unanswered calls were noted to have increased.
- The MHP is providing more in-person services in clinic locations and in the community and is promoting the transportation benefit as well as providing transportation assistance to enable in-person services.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR in CY 2021 is 4.34 percent, with an AACB of $7,478. Using PR as an indicator of access, the MHP increased access for eligibles.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	513,780	23,566	4.59%	$126,629,602	$5,373
CY 2020	480,067	19,553	4.07%	$101,671,290	$5,200
CY 2019	475,087	19,877	4.18%	$92,353,015	$4,646

- There was a 20.5 percent increase in the number of beneficiaries served from CY 2020 to CY 2021, with no appreciable increase in AACB.

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	62,481	1,338	2.14%	1.69%	1.96%
Ages 6-17	137,387	8,765	6.38%	5.40%	5.93%
Ages 18-20	27,669	1,057	3.82%	4.06%	4.41%
Ages 21-64	248,529	11,719	4.72%	4.24%	4.56%
Ages 65+	37,716	687	1.82%	1.69%	1.95%
Total	**513,780**	**23,566**	**4.59%**	**3.99%**	**4.34%**

- PRs for all age groups were greater than the statewide averages except for beneficiaries aged 18-20 and 65 and older.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	3,355	14.24%
Hmong	317	1.35%
Total Threshold Languages	**3,672**	**15.58%**
Threshold language source: Open Data per BHIN 20-070		

- There has been no change in the threshold languages for Fresno County; the MHP provided services primarily in English, Spanish, and Hmong in CY 2021. The greatest increase was for Spanish-speaking beneficiaries at 28 percent.

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

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	134,898	5,104	3.78%	$27,352,336	$5,359
Large	2,153,582	74,042	3.44%	$515,998,698	$6,969
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligibles that qualify for Medi-Cal under the ACA, the overall PR was lower than for non-ACA beneficiaries, 3.78 percent compared to 4.59 percent. There was a negligible difference in the AACB, $5,359 compared to $5,373.

- The MHP ACA PR was comparable to the statewide rate (3.81 percent) and the AACB was 16 percent less than the statewide average ($6,383) and 23 percent less than the large MHP average($6,969).

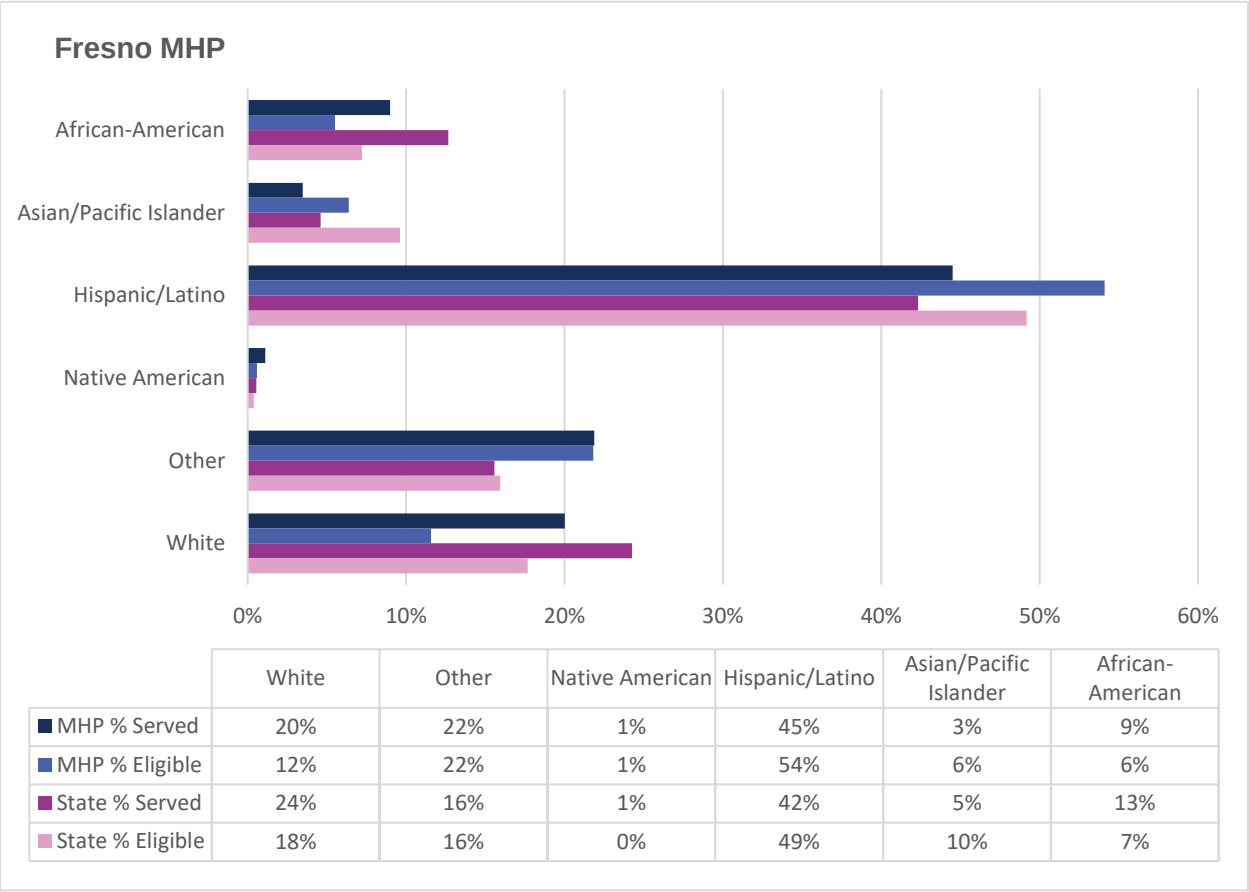
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	28,317	2,117	7.48%	7.64%
Asian/Pacific Islander	32,836	821	2.50%	2.08%
Hispanic/Latino	278,051	10,489	3.77%	3.74%
Native American	2,994	263	8.78%	6.33%
Other	112,095	5,156	4.60%	4.25%
White	59,489	4,720	7.93%	5.96%
Total	**513,782**	**23,566**	**4.59%**	**4.34%**

- Fresno served 23,566 beneficiaries in CY 2021. With the exception of the PR for African Americans (at 7.48 percent), the MHP's PRs by race/ethnicity groups were greater than corresponding statewide rates.

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

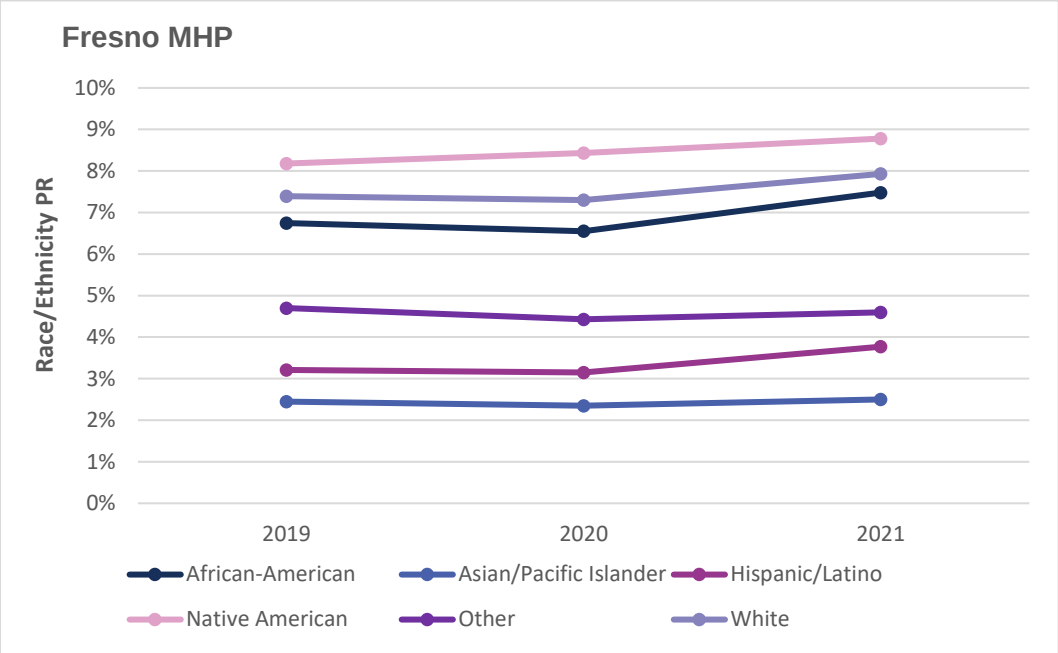


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	20%	22%	1%	45%	3%	9%
MHP % Eligible	12%	22%	1%	54%	6%	6%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- While the Hispanic/Latino population comprised 54 percent of the eligible population, only 45 percent of those served were Hispanic/Latino. Conversely, Whites comprised 12 percent of the eligible population, but represented 20 percent of those who were served in CY 2021.

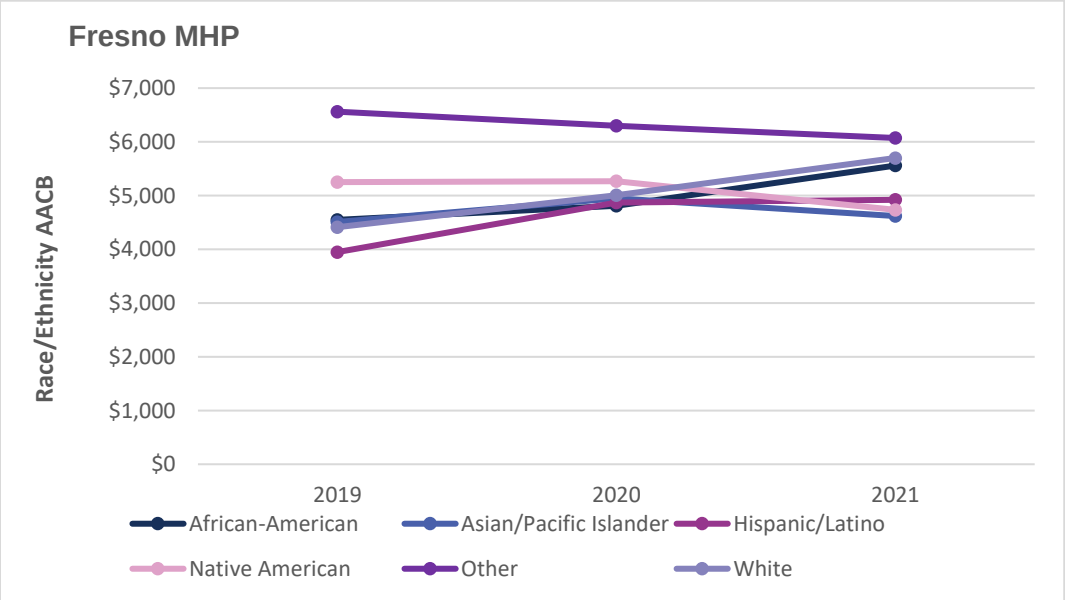
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data are compared to the similar MHP size and the statewide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

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



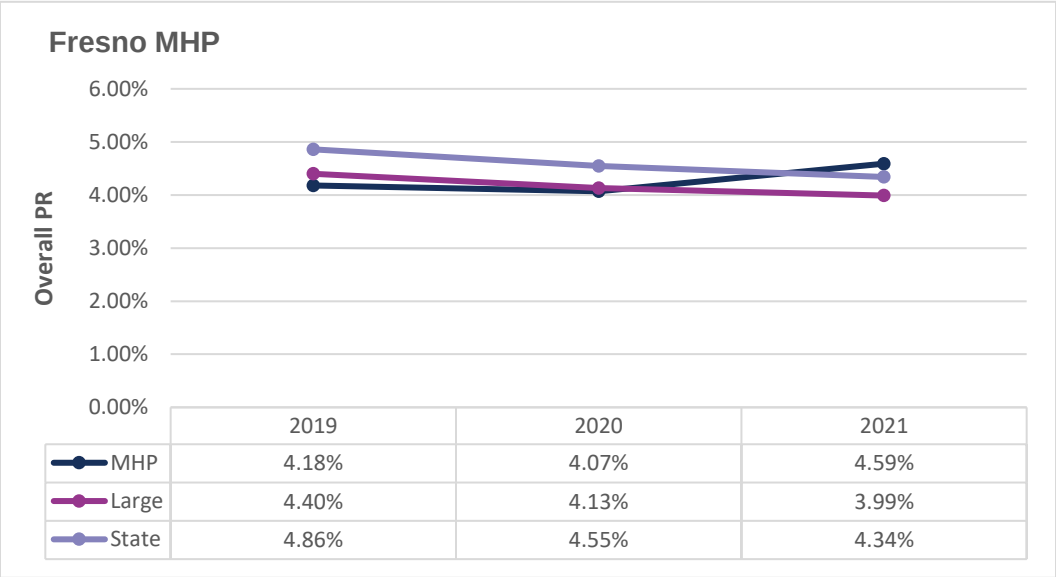
- PRs increased, from CY 2020 to CY 2021, for all race/ethnicity groups, especially for Hispanic/Latino and African-American beneficiaries, after little change from CY 2019 to CY 2020.

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



- The AACB increased for White and African American beneficiaries from CY 2020 to CY 2021 and decreased for Other and Native American beneficiaries.

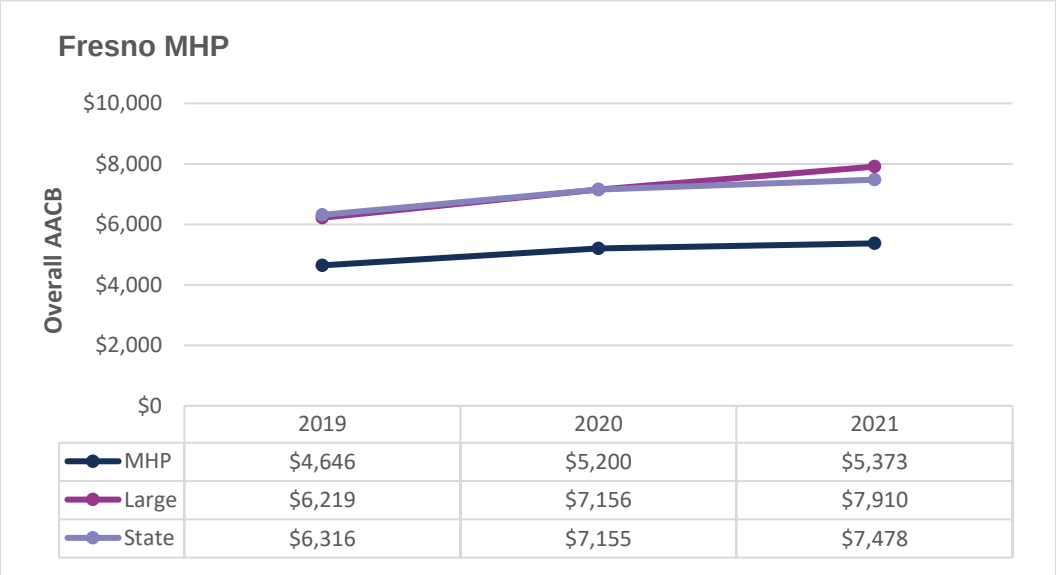
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.18%	4.07%	4.59%
Large	4.40%	4.13%	3.99%
State	4.86%	4.55%	4.34%

- The overall MHP PR increased in CY 2021 and was above the statewide rate and that of similar sized MHPs.

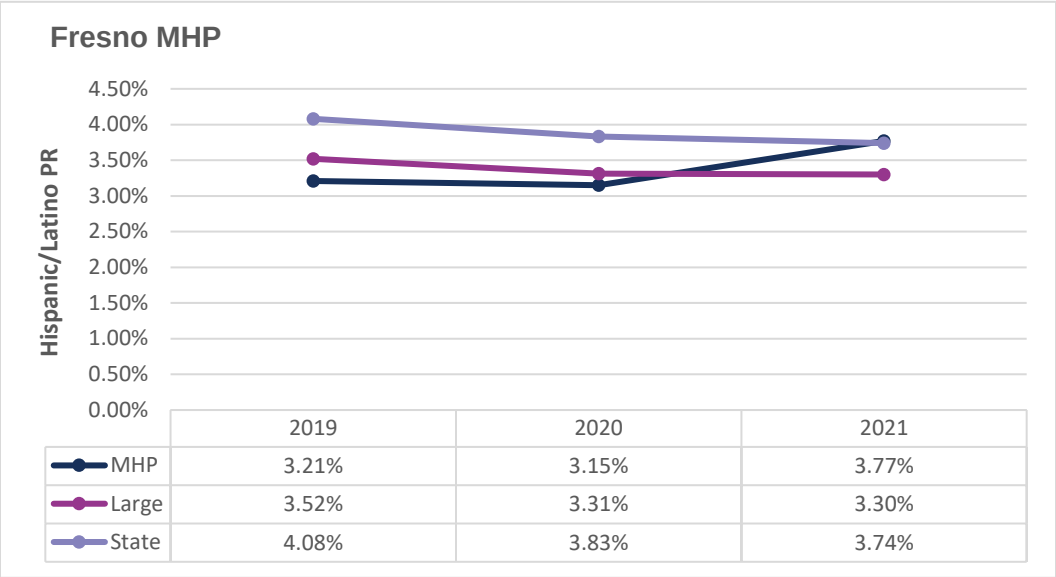
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,646	$5,200	$5,373
Large	$6,219	$7,156	$7,910
State	$6,316	$7,155	$7,478

- The AACB for the MHP was lower than both large MHPs and the statewide average for CY 2019 to CY 2021.

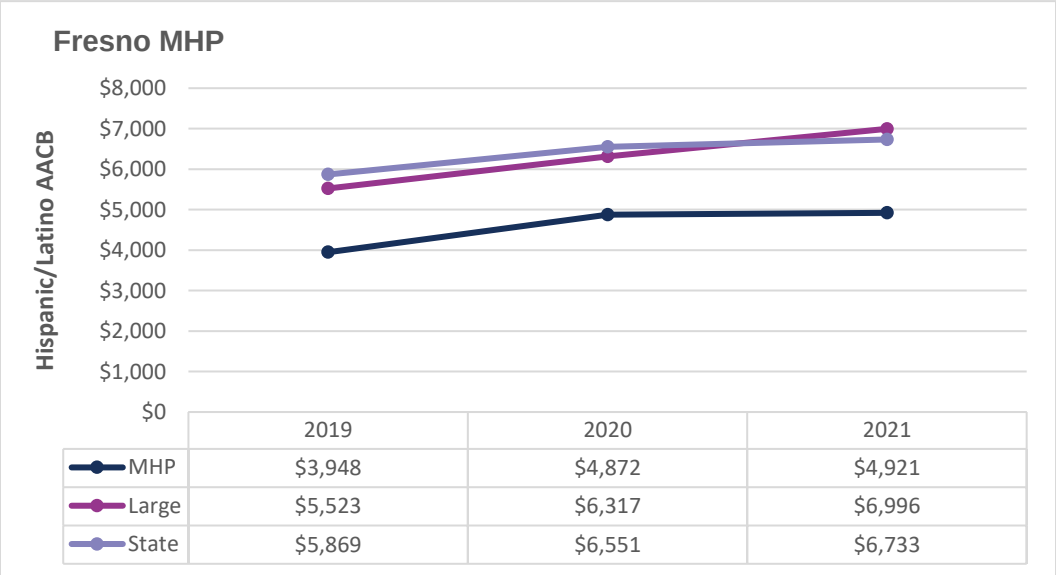
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	3.21%	3.15%	3.77%
Large	3.52%	3.31%	3.30%
State	4.08%	3.83%	3.74%

- While the Hispanic/Latino PR was less than both the large county and statewide rates in CY 2019 and CY 2020, it was comparable to the statewide rate and exceeded the large MHP rate in CY 2021.

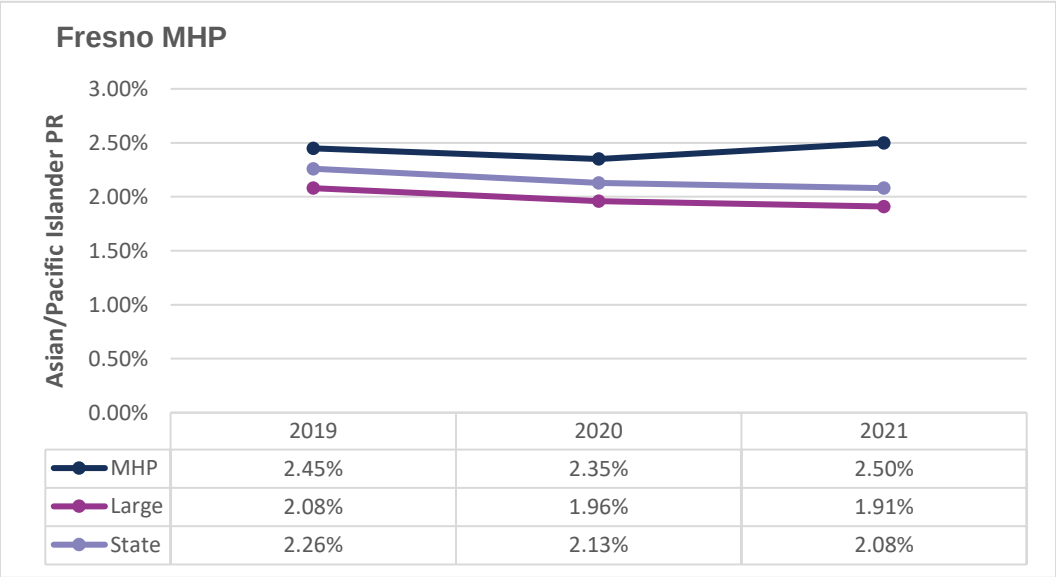
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$3,948	$4,872	$4,921
Large	$5,523	$6,317	$6,996
State	$5,869	$6,551	$6,733

- The Hispanic/Latino AACB was lower than large county and statewide averages from CY 2019 to CY 2021.

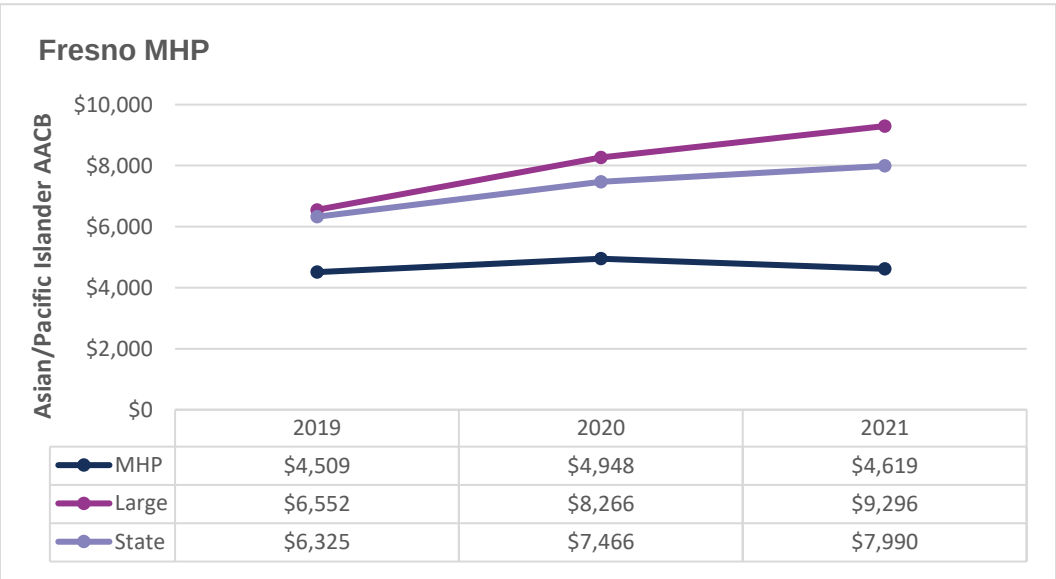
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.45%	2.35%	2.50%
Large	2.08%	1.96%	1.91%
State	2.26%	2.13%	2.08%

- The Asian/Pacific Islander PR was greater than both large MHP and statewide rates from CY 2019 to CY 2021.

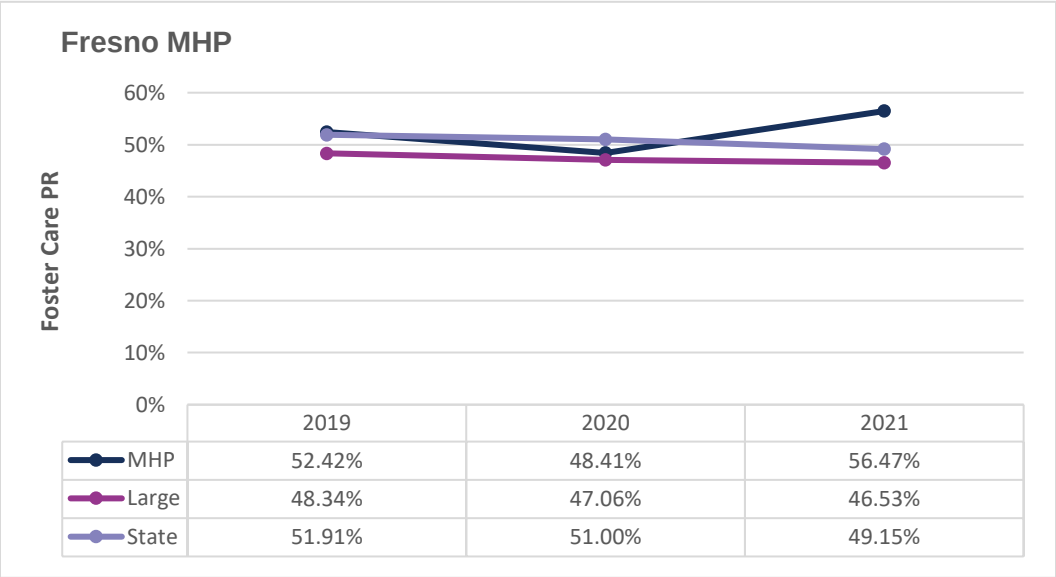
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$4,509	$4,948	$4,619
Large	$6,552	$8,266	$9,296
State	$6,325	$7,466	$7,990

- The Asian/Pacific Islander AACB was lower than large MHP and statewide averages from CY 2019 to CY 2021.

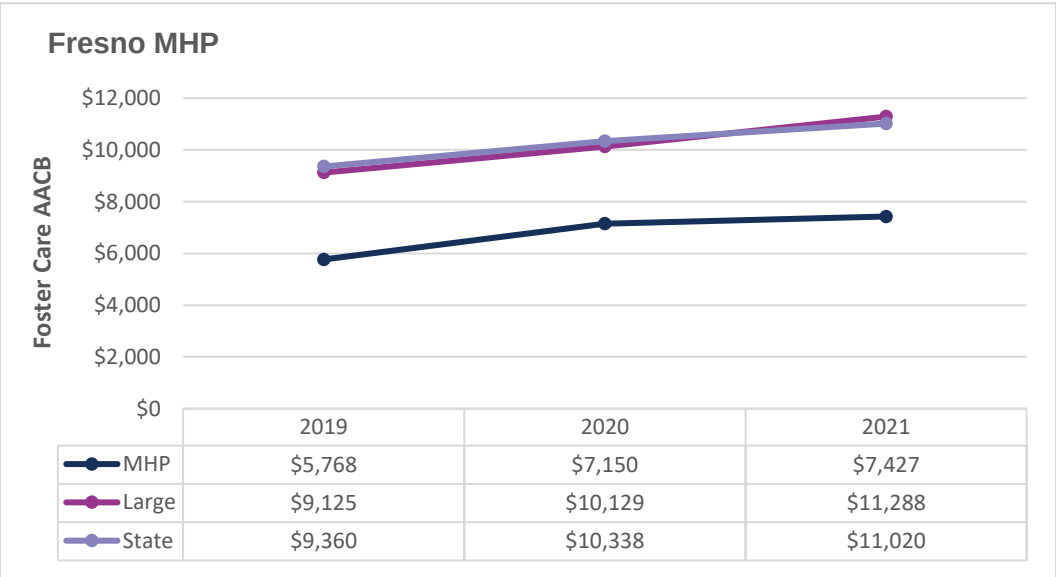
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	52.42%	48.41%	56.47%
Large	48.34%	47.06%	46.53%
State	51.91%	51.00%	49.15%

- From CY 2020 to CY 2021, the MHP's FC PR increased 16.6 percent (48.41 percent vs. 56.47 percent) and exceeded large county rates (56.47 percent vs. 46.53 percent) and statewide rates (56.47 percent vs. 49.15 percent).

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$5,768	$7,150	$7,427
Large	$9,125	$10,129	$11,288
State	$9,360	$10,338	$11,020

- FC AACB for the MHP was lower than large MHP and statewide averages from CY 2019 to CY 2021.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 13,464				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	2,053	15.2%	16	9	11.6%	16	8
Inpatient Admin	<11	-	8	8	0.5%	23	7
Psychiatric Health Facility	158	1.2%	30	18	1.3%	15	7
Residential	<11	-	8	8	0.4%	107	79
Crisis Residential	174	1.3%	22	24	2.2%	21	14
Per Minute Services							
Crisis Stabilization	1,795	13.3%	2,156	1,200	13.0%	1,546	1,200
Crisis Intervention	2,232	16.6%	165	117	12.8%	248	150
Medication Support	7,749	57.6%	241	183	60.1%	311	204
Mental Health Services	7,182	53.3%	883	420	65.1%	868	353
Targeted Case Management	4,809	35.7%	342	112	36.5%	434	137

- For crisis residential and mental health services, the MHP had a notably lower percentage of beneficiaries served compared to statewide rates.
- The MHP had a greater percentage of beneficiaries served for crisis intervention than the statewide percentage.

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

Service Category	MHP N = 1,764				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	36	2.0%	10	8	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	19	1.1%	9	7	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	<11	-	1	1	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	<11	-	24	24	0.5%	97	78
Per Minute Services							
Crisis Stabilization	74	4.2%	1,982	1,200	3.1%	1,404	1,200
Crisis Intervention	97	5.5%	233	133	7.5%	406	199
Medication Support	425	24.1%	282	225	28.2%	396	273
TBS	50	2.8%	2,835	2,411	4.0%	4,020	2,373
Therapeutic FC	<11	-	345	345	0.1%	1,030	420
Intensive Care Coordination	349	19.8%	1,454	570	40.2%	1,354	473
Intensive Home Based Services	178	10.1%	1,286	750	20.4%	2,260	1,275
Katie-A-Like	<11	-	1,065	1,065	0.2%	640	148
Mental Health Services	1,688	95.7%	1,391	727	96.3%	1,854	1,108
Targeted Case Management	1,228	69.6%	413	176	35.0%	342	120

- The MHP had a lower percentage of youth in FC who received intensive home-based services and intensive care coordination, roughly half of the statewide pattern.

IMPACT OF ACCESS FINDINGS

- While most MHPs had a decrease in PR in CY 2021, the MHP's PR increased due to an appreciable increase in the number of beneficiaries served relative to the increase in the number of eligibles. The MHP’s marketing strategies and outreach to the community appear to have been successful.
- Much of the increase in the number of beneficiaries served was from an increase (of 24 percent) in Hispanic/Latino beneficiaries. Despite this increase, there continues to be a difference between the number of Hispanic/Latino eligibles and the number served, which may indicate a disparity in access. The Hispanic/Latino access (as measured by PR) is one that the MHP should monitor closely and might consider targeted marketing strategies for this population.
- As resources are available, the MHP might also consider an evaluation and targeted strategies of access to services for young adults, aged 18-20. Compared to most of the other age groups, wherein the MHP has higher rates than similar sized MHPs and statewide, for this age group the MHP serves fewest proportion (3.82 percent) compared to similar sized MHPs (4.06 percent) and statewide (4.41 percent).
- Overall, the MHP’s AACBs were lower than that of similar size MHPs and the statewide AACB. In addition to potential differences in the rates of services, the MHP should review adult utilization of mental health services and FC youth utilization of Intensive Home Based Services and Intensive Care Coordination, all of which were notably lower in the MHP than statewide.
- Although not reflected in the performance measures presented, MHP stakeholders noted an increase in beneficiaries requesting services, including those who require housing assistance. Stakeholders attributed this increase to CalAIM and the availability of additional supports through Enhanced Care Management.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The time to services for youth and youth in FC was greater than the time for adults. The MHP's documents did not indicate efforts to improve timeliness for the first offered appointment, first delivered appointment, first psychiatry appointment, and first delivered psychiatry appointment for youth. The delay in

psychiatry for youth in FC was attributed to reduced capacity among contract providers that mostly deliver FC services.

- Several stakeholder groups raised concerns that the MHP's capacity of bilingual and multilingual providers affects timeliness of services. Purportedly, Hmong-speaking beneficiaries may wait up to four months for an appointment with the Hmong-psychiatrists, especially when there are asynchronous concerns with medications.
- Urgent appointments were reported in days, not hours. The MHP's EHR is not able to include a timestamp to document the hour (and minute) that an urgent service was requested.
- The MHP has at least two teams, the HIOP and the Hospital Access Linkage and Outreach team, that provide support to individuals transferring from acute care (e.g., inpatient facilities and psychiatric health facilities) to outpatient or residential services. These teams may contribute to the high 7-day post-hospitalization follow-up rate, at 69 percent overall.

TIMELINESS PERFORMANCE MEASURES

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

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

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

Table 11: CY 2022 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	7.9 Days	10 Business Days*	78%
First Non-Urgent Service Rendered	6 Days	10 days**	86%
First Non-Urgent Psychiatry Appointment Offered	12.9 Days	15 Business Days*	69%
First Non-Urgent Psychiatry Service Rendered	9.9 Days	15 days**	81%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	5.9 Days	48 Hours*	37%
Follow-Up Appointments after Psychiatric Hospitalization	12.5 Days	7 Days**	53%
No-Show Rate – Psychiatry	19%	20%**	n/a
No-Show Rate – Clinicians	13%	20%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: CY 2022.			

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

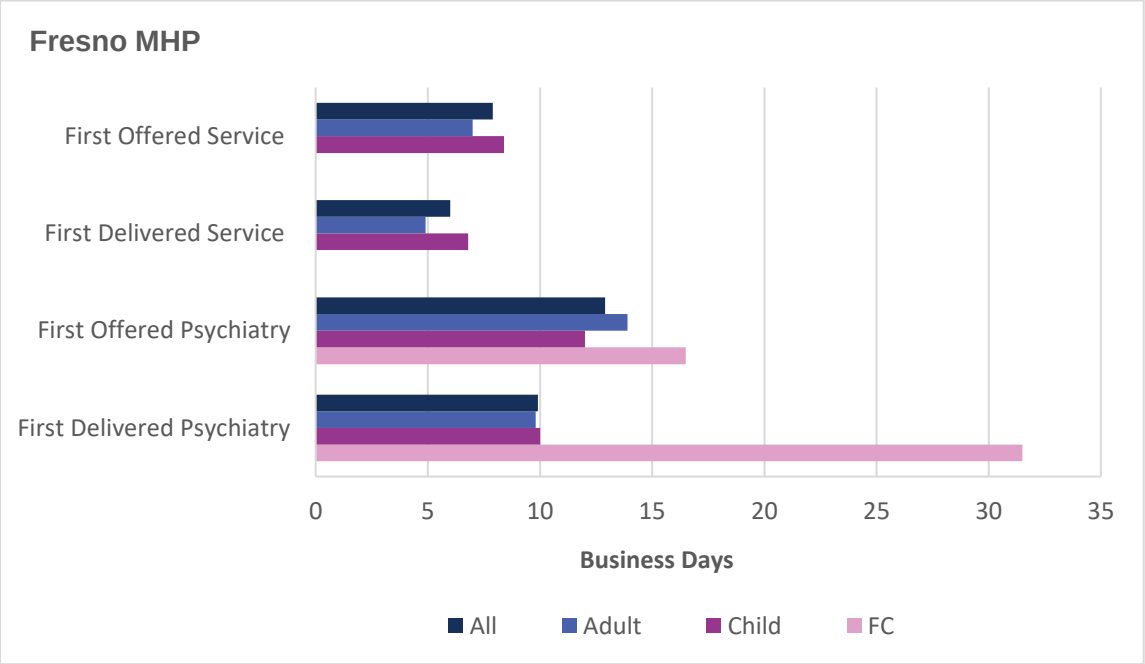


Figure 13: Wait Times for Urgent Services

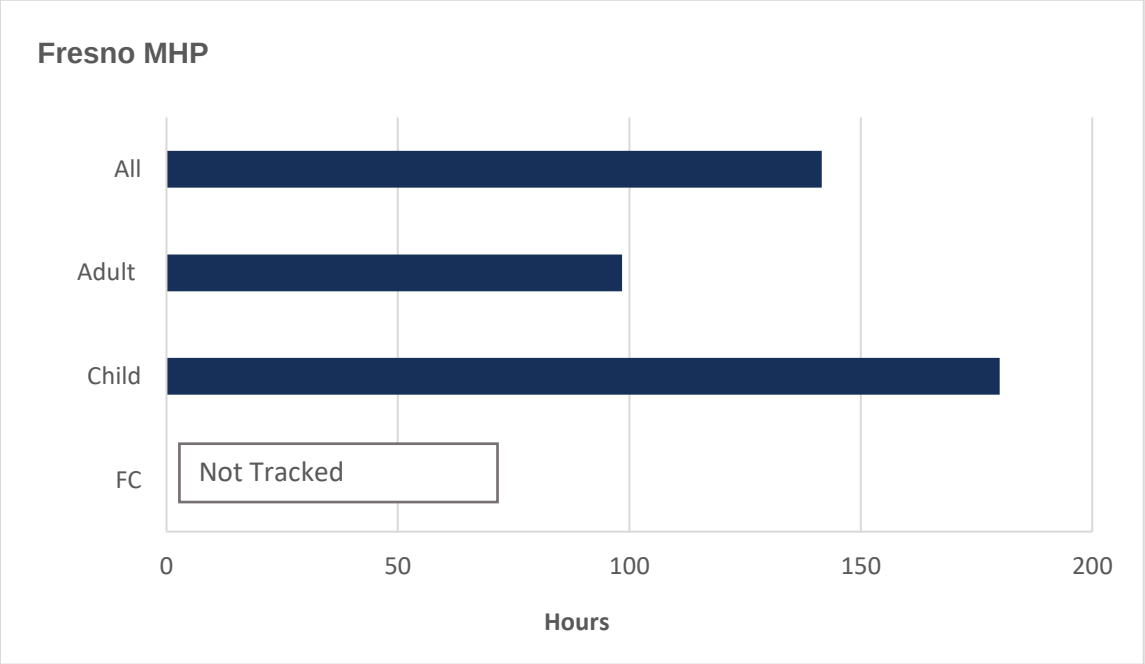
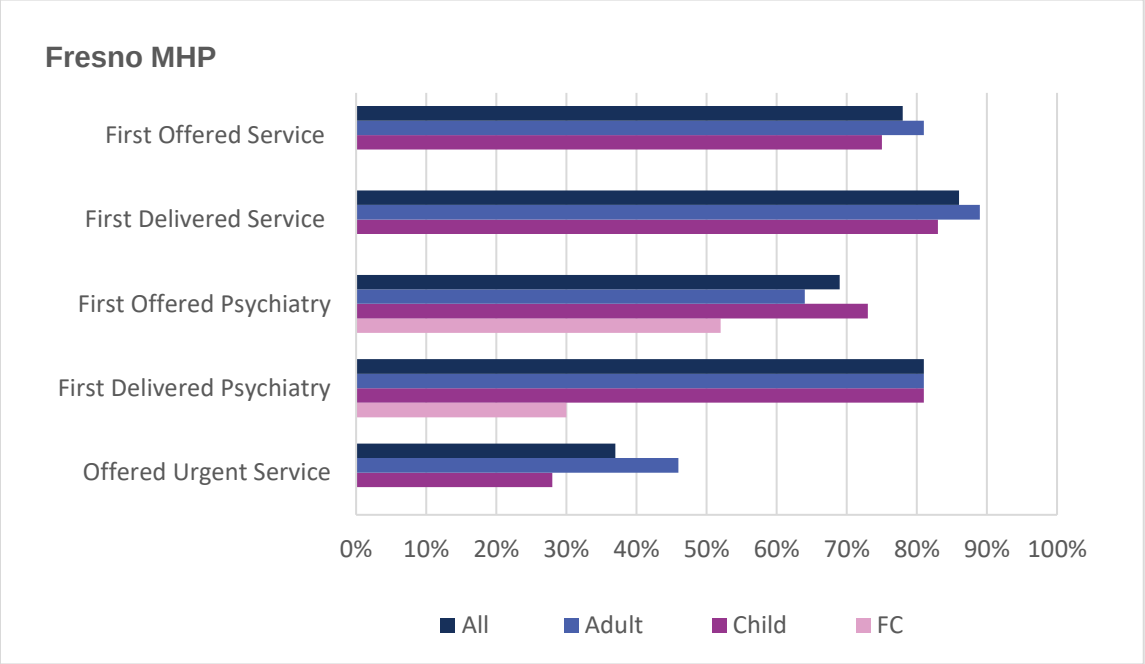


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in

Figures 12 and 13, represent both scheduled and unscheduled mental health services such as screening prior to assessment.

- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department (ED), or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as “a situation experienced by a person served that without timely intervention is highly likely to result in an immediate emergency psychiatric condition”. There were reportedly 81 urgent service requests with a reported actual wait time to services for the overall population at 5.9 days.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as from the first clinical determination of need.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked and includes DBH programs and some contract provider programs. The MHP reports a no-show rate of 19 percent overall for psychiatry appointments and 13 percent overall for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- It is to the MHP’s credit that it provides bilingual and *bicultural* services to its beneficiaries. This service delivery approach meets beneficiary needs. However, the capacity of such providers, particularly of psychiatric providers is finite, and contributes to delays in services.
- The MHP’s EHR is not able to include a timestamp to document the hour (and minute) that an urgent service was requested. The tracking for urgent conditions likely inflates the time of response and more critically, the number of individuals who are reported as having needed an urgent service in the past year is considerably lower than what most other MHPs report.
- The MHP reported that its new methodology for tracking no-shows has exposed challenges with data entry and accuracy. The MHP might consider reanalysis of its no-show to verify the rates, some of which are high (25 percent for psychiatry no-show for youth) and determine if further action should be taken to improve.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is the QI Team that is led by the QI Coordinator. The QI Team includes staff analysts, clinicians, and an epidemiologist. The MHP has adopted a continuous quality improvement approach with the QI team meeting with and supporting programs to integrate QI through use of data, key performance indicators, and regular review. Compliance is a separate unit managed through the Compliance Office.

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 has been reconfigured as a quality oversight committee and includes internal DBH staff—directors, managers, and QI—and is scheduled to meet monthly. The MHP has developed a Feedback and Improvement Committee that meets monthly (bimonthly for mental health) to solicit input from beneficiaries. Since the previous EQR, the MHP QIC met four of ten possible times. The MHP did not produce an evaluation of its QI program in the previous year.

The MHP has suspended the use of Reaching Recovery as a LOC tool.

The MHP utilizes the following outcomes tools: Child and Adolescent Needs and Strengths and the Pediatric Symptom Checklist.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- The MHP has a thoughtful approach to QI that is outcomes-driven, with structures (e.g., Access, Outcomes, and Feedback and Improvement subcommittees) and data utilization (i.e., Domo) that support this approach.
- The Feedback and Improvement Committee is a good way for the MHP to solicit beneficiary input and take action in a way that resonates with beneficiaries. However, the MHP reports that there has been low participation of beneficiaries.
- The DBH has begun an initiative ‘Organizational Wellness’ to “create a culture that fosters well-being, reduces burnout, and staff turnover.” Ultimately, the goal is to make sure employees feel safe and respected so that they are part of fulfilling the mission and striving for the Quadruple Aim. Two contract providers are represented in the Committee for Promotional Wellness, but overall representation of contract providers and an opportunity for them to be heard and make a difference was not obvious. (N.B.: Contract providers deliver 69.8 percent of the SMHS).
- The MHP is improving its ability to monitor its continuum of care through the ATD report. In addition to transitions in services, it enables evaluation of the utilization of programs.
- The MHP has a work group to develop a career ladder and trainings, with the goal of peer integration throughout the system of care. Of the 18 peer positions in DBH, only two have been filled (i.e., 16 positions are currently vacant).

- The MHP tracks and trends the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- The MHP did not track and trend the following HEDIS measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

QUALITY PERFORMANCE MEASURES

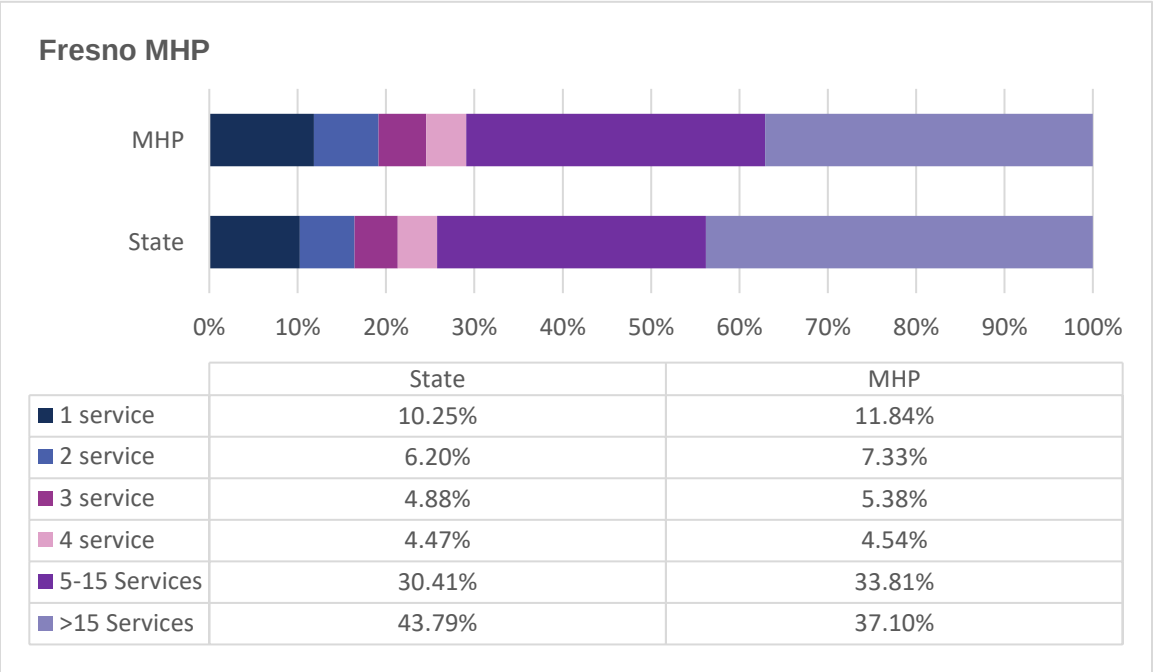
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



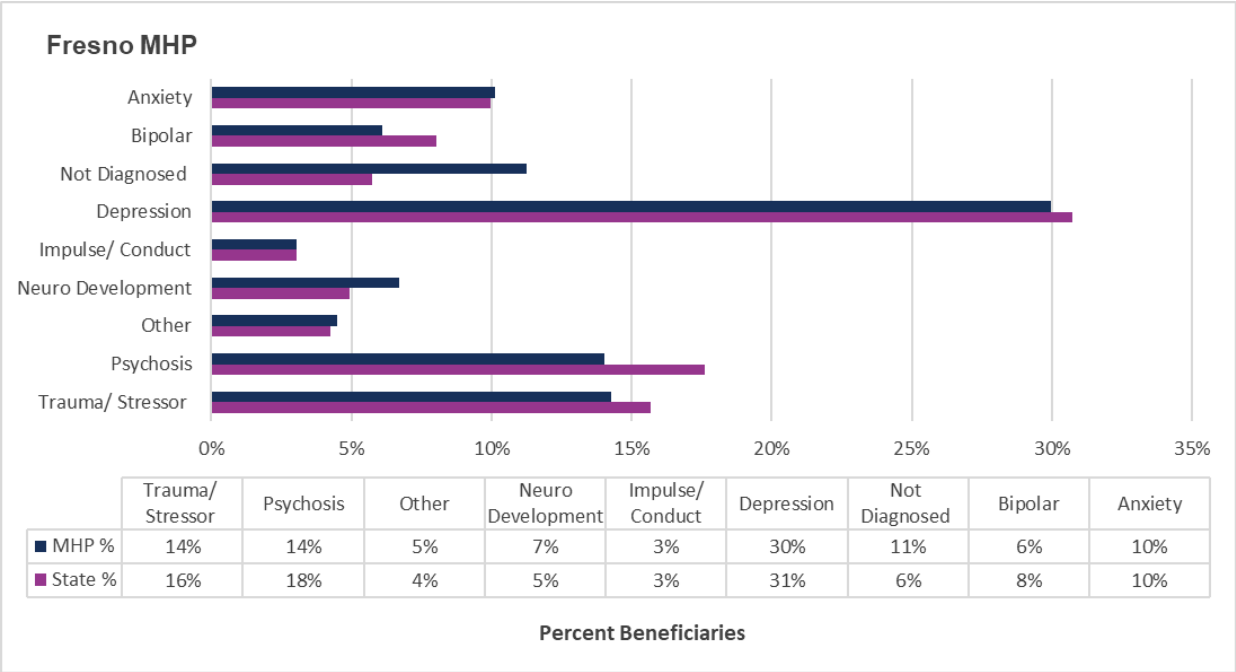
	State	MHP
1 service	10.25%	11.84%
2 service	6.20%	7.33%
3 service	4.88%	5.38%
4 service	4.47%	4.54%
5-15 Services	30.41%	33.81%
>15 Services	43.79%	37.10%

- One single service was provided to 11.84 percent of beneficiaries, 15.5 percent greater than the 10.25 percent statewide rate.
- More than 15 services were provided to 37.10 percent of beneficiaries, 15.3 percent less than the 43.79 percent statewide rate.

Diagnosis of Beneficiaries Served

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

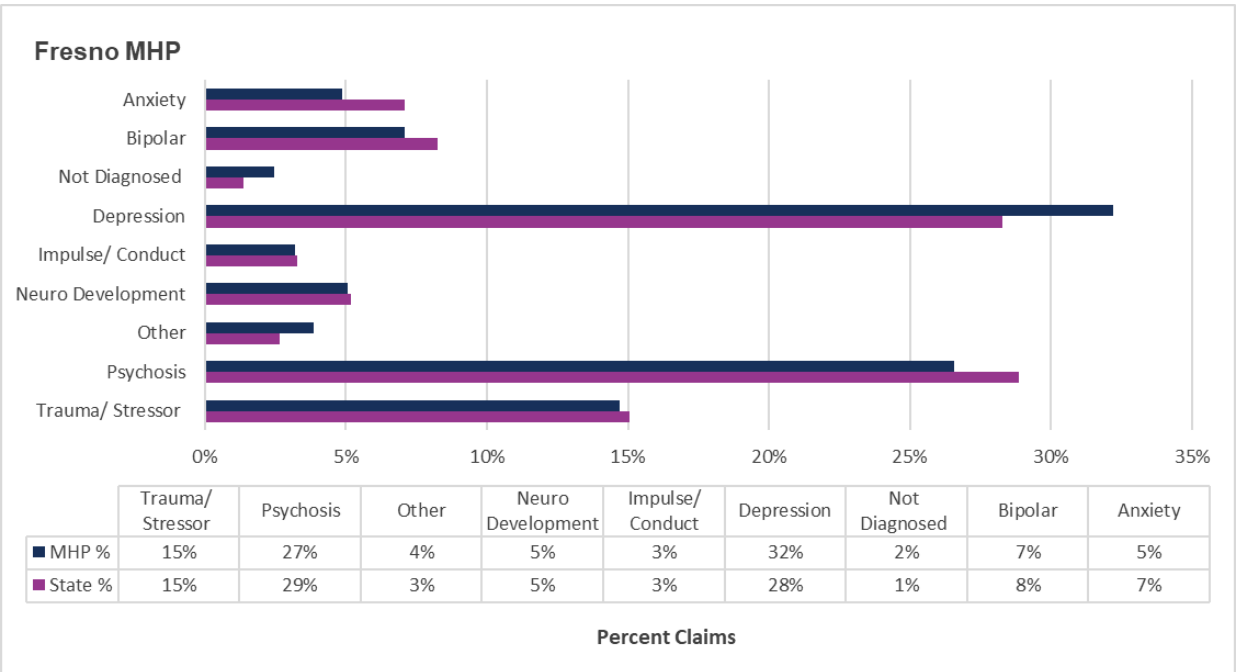
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	14%	5%	7%	3%	30%	11%	6%	10%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- Fifty-eight percent of beneficiaries had one of three diagnoses: depression (30 percent), psychosis (14 percent), and trauma/stressor related (14 percent). The MHP's diagnostic patterns were generally comparable to statewide rates.

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	15%	27%	4%	5%	3%	32%	2%	7%	5%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- While the MHP had a comparable percentage of depression diagnosis as the statewide rate (30 percent vs. 31 percent), approved claims were greater for the MHP.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	1,959	3,492	9.26	8.86	$12,129	$12,052	$23,760,325
CY 2020	1,954	4,115	8.98	8.68	$13,152	$11,814	$25,699,027
CY 2019	2,289	5,785	7.81	7.80	$12,072	$10,535	$27,631,707

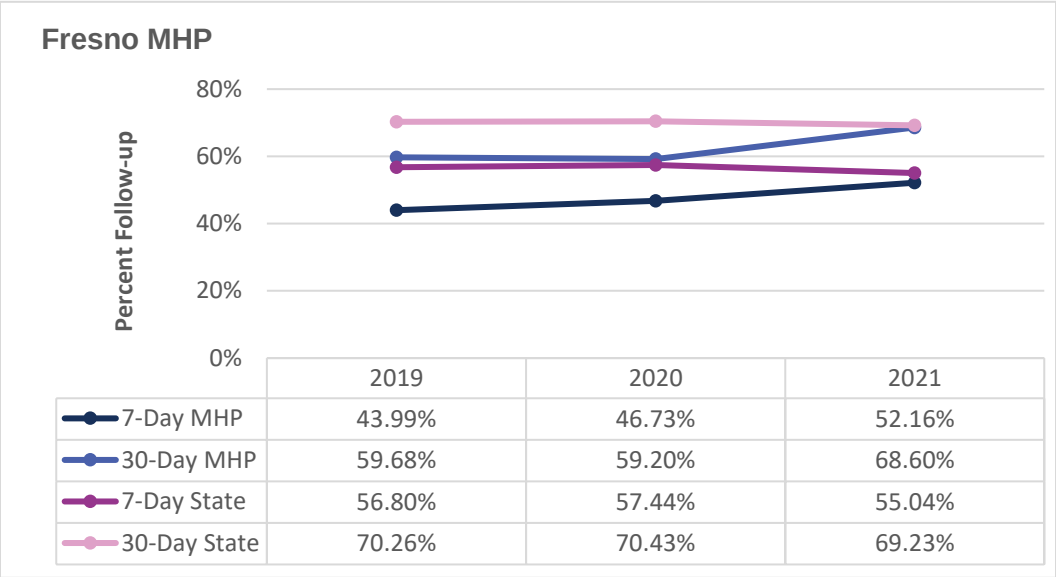
- Unique beneficiary count was stable from CY 2020 to CY 2021 (1,954 vs. 1,959) while total admissions decreased (4,115 vs. 3,492). The MHP CY 2021 average LOS is 4.5 percent greater than the statewide average (9.26 days vs. 8.86 days).
- The MHP AACB declined from CY 2020 to CY 2021 ($13,152 vs. $12,129) and was comparable to the statewide average in CY 2021 ($12,129 vs. $12,052).

Follow-Up Post Hospital Discharge and Readmission Rates

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

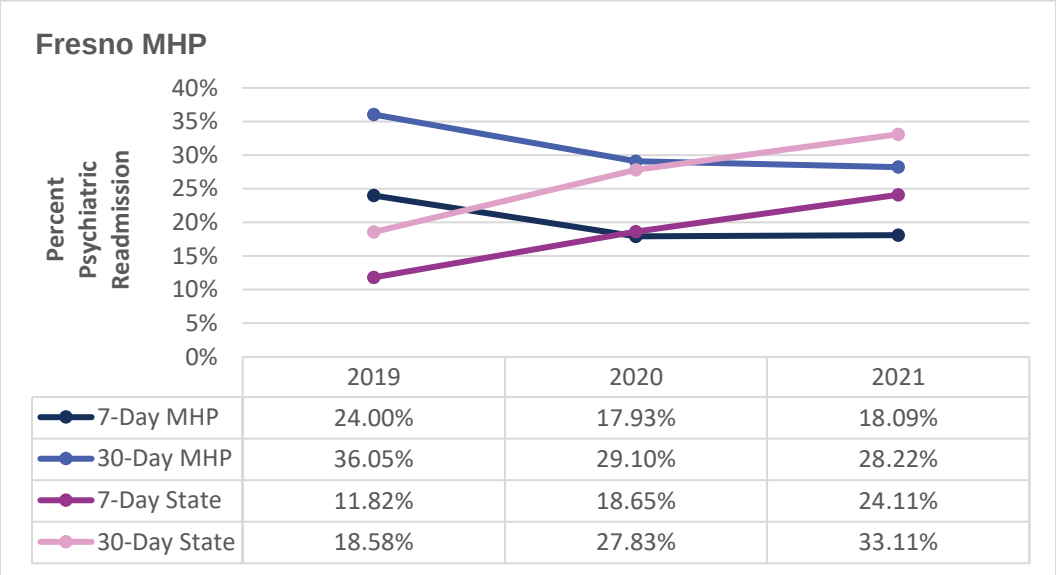
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and is reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	43.99%	46.73%	52.16%
30-Day MHP	59.68%	59.20%	68.60%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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



	2019	2020	2021
7-Day MHP	24.00%	17.93%	18.09%
30-Day MHP	36.05%	29.10%	28.22%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- The 7-day post psychiatric inpatient follow-up rate increased from CY 2020 to CY 2021 (46.73 percent vs. 52.16 percent) and was 5.20 percent less than the statewide rate in CY 2021 (52.16 percent vs. 55.04 percent).
- The 30-day post psychiatric inpatient follow-up rate increased from CY 2020 to CY 2021 (59.20 percent vs. 68.6 percent) and was comparable to the statewide rate in CY 2021 (68.60 percent vs. 69.23 percent).

- The 7-day psychiatric readmission rate increased from CY 2020 to CY 2021 (17.93 percent vs. 18.09 percent) and was 25 percent lower than the CY 2021 statewide average (18.09 percent vs. 24.11 percent).
- The 30-day psychiatric readmission rate declined from CY 2020 to CY 2021 (29.10 percent vs 28.22 percent) and was 14.8 percent less than the CY 2021 statewide rate (28.22 percent vs. 33.11 percent).

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $7,478, the median amount is just $3,269.

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 beneficiaries are "low cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACB of $4,412 and median of $2,830.

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	681	2.89%	26.48%	$33,534,655	$49,243	$41,943
	CY 2020	497	2.54%	25.21%	$25,636,341	$51,582	$44,471
	CY 2019	480	2.41%	26.60%	$24,564,346	$51,176	$42,856

- After being stable in CY 2019 and CY 2020, the HCB count increased in CY 2021 but was still less than the statewide rate. The percentage of beneficiaries served who are HCB increased 13.80 percent from CY 2020 to CY 2021. The CY 2021 percentage of HCBs served was 35.80 percent less than the statewide rate (4.50 percent vs. 2.89 percent).

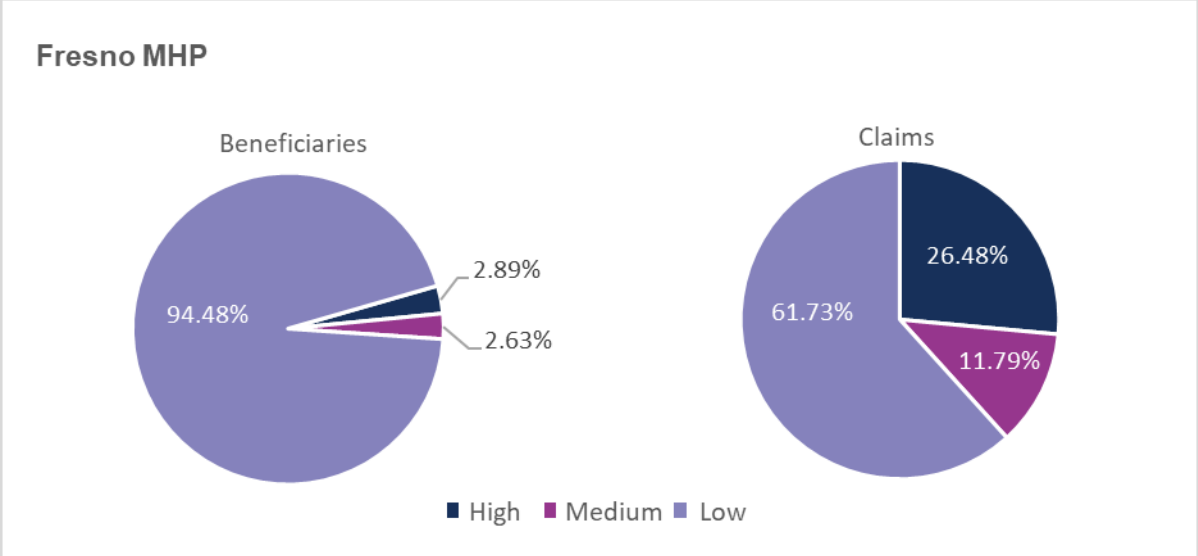
- The CY 2021 average approved claims per HCB was 11.3 percent less than the statewide average ($49,243 vs. $55,523).

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	619	2.63%	11.79%	$14,930,059	$24,120	$23,761
Low Cost (Less than $20K)	22,266	94.48%	61.73%	$78,164,889	$3,511	$2,058

- Low-cost beneficiaries comprised 94.48 percent of those served and 61.73 percent of approved claims dollars were spent on this subpopulation.

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



- While HCBs were 2.89 percent of those served, 26.48 percent of approved claims dollars were spent on this subpopulation.

IMPACT OF QUALITY FINDINGS

- The redeveloped QI program puts quality at the center of all MHP services and operations, and is fully endorsed and promoted by MHP leadership. Participation and input from contract providers and DBH staff are important to include, even as systems and structures are being developed.

- Part of the MHP's Quadruple Aim is to maximize resources while focusing on efficiency. Part of efficiency is delivering the right amount of services at the most appropriate—and least restrictive—level. The MHP has a lower proportion of HCBs and most services are delivered at low-cost.
- Overall, beneficiary use and retention in services is comparable to the statewide rate. One difference is that the MHP has a lower proportion of beneficiaries that receive 15 or more services than the state. This may be related to the aim (as above) and a focus on services that deliver outcomes.
- The MHP noted low beneficiary participation in the Feedback and Improvement Committee and is encouraging staff buy-in and promotion of the committee as a strategy to increase beneficiary participation.
- Several groups of stakeholders noted that there were long wait times for admission to mild-to-moderate programs, with some beneficiaries dropping out of services before being connected. While DBH has no authority over MCP providers, delays to enrollment in mild-to-moderate LOC programs may erode gains in beneficiary outcomes and functions achieved through MHP services.
- Statewide, the 7- and 30-day rehospitalization rates have been increasing but for the MHP, the rates have declined or have plateaued. The MHP should continue its strategies for supporting beneficiaries who have been discharged from hospitals and other acute settings to maintain, if not further decrease, these rates.
- While there are differences in the 7- and 30-day post-hospitalization follow-up rates that the MHP reported in the ATA than what is shown in the claims data, these may be accounted for by different review periods (CY 2022 vs. 2021) and different populations (all persons served vs. Medi-Cal beneficiaries only).

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Children's FSP Progress Review

Date Started: 01/2023

Aim Statement: Will implementing periodic clinical progress reviews in children's FSPs decrease average LOS by 10 percent over a one-year period in 2023?

Target Population: Children and youth ages 0-18 and some TAY already in the program who are enrolled in an FSP program.

Status of PIP: The MHP's clinical PIP is in the implementation phase.

Summary

The MHP identified waitlists and reduced access to FSP programs for youth needing a higher LOC. The MHP reported delayed entry into those programs (average of 33 days) and longer LOS for those already in the program (from 7 to 15 months). From a root

[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

cause analysis, the MHP identified two contributing factors: lack of robust understanding of the LOC system within the MHP and uncertainty/lack of knowledge about availability and capacity of FSP programs. The intervention is to conduct periodic—quarterly and semi-annual—reviews of youths' progress towards goals. The DBH also implemented an online mechanism to track program capacity; this intervention is not part of the PIP. The periodic review also informs the treatment team about youth's readiness for discharge and begins the planning and preparations for eventual discharge. The intervention was implemented in January 2023. The MHP did not have data or findings to report. The MHP has planned for monthly submission of data and quarterly analysis conducted by QI staff.

TA and Recommendations

As submitted, this clinical PIP was found to have high confidence. The MHP has a clear understanding of the issue needing improvement, supported by data, and has a straightforward, uncomplicated strategy for improvement, which it can monitor. The outcome of the project will depend on the ability of FSP programs to step-down and discharge current youth to another service provider or program. This piece of the project requires more attention.

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

- Present an average LOS that includes the relevant FSP programs, rather than program-specific LOS, which suggests program differences at the outset.
- Include a pre-existing measure of outcomes for FSP programs to confirm that youth are achieving goals and not being transitioned (out) prematurely to create space in the FSP program.
- Track the types of programs or placements that youth are discharged to after leaving the FSP program.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: FUM

Date Started: 12/2022

Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023.

Target Population: Beneficiaries with a principal diagnosis of mental illness or intentional self-harm who have an ED visit.

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

Summary

Based on a review of the data, the MHP has provided 34 percent of individuals discharged from an ED for a mental health condition received follow-up services within 7 days and 51 percent received follow-up within 30 days. The 30-day follow-up rate puts the MHP in the lowest quartile of California counties and the goal of the project is to increase the follow-up rates. The MHP identified delay in care coordination as a contributing factor to the low follow-up rate; historically, EDs were unable to determine whether or not an individual was already receiving MHP services. The improvement strategy is to create a workflow that ensures that EDs are able to obtain information to make referrals and to implement a centralized referral tracking mechanism that enables real-time referral coordination from the ED. Both strategies ensure that EDs are able to obtain in a timely manner the necessary information on beneficiaries who are already served through the MHP and then issue a referral. The workflow is coordinated through the 24/7 Access Line. After the referral, social determinants of health will be assessed and barriers to access and needs will be addressed.

The MHP implemented the referral process through the Access Line in Spring 2021. Prior to this process, a post-ED assessment averaged 2.4 times per month; after this process, the post-ED assessments have averaged 3.7 times per month. The centralized referral tracking was slated to begin in December 2022; however the start of the implementation has been delayed.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence. The MHP has a clear understanding of the issue needing improvement, supported by data, and has a strategy for improvement. One strategy has already been deployed to great effect and more current data on outcomes are needed. The second strategy requires additional components to be in place prior to implementation. The target for improvement and timeframe will need to be adjusted accordingly once the intervention is actually implemented.

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

- Provide more detail on who will address the social determinants of health and how various barriers will be addressed.
- Develop contingency plans for further delays in the implementation of the referral tracker.

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, Information Technology (IT), claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart Avatar, which has been in use for 12 years. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 2.64 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). This is an increase from 2.40 percent reported in the prior year. The budget determination process for IS operations is under MHP control.

The MHP has 1,196 named users with log-on authority to the EHR, including approximately 501 county staff, an increase from 434 reported in the prior year, and 695 contractor staff, with 693 being reported in the prior year. Support for the users is provided by 10 full-time equivalent IS technology positions. Currently, there is one vacancy, a Business Systems Analyst position which has been vacant since September 2022. Recruitment for this position is on hold until the SmartCare system has been implemented, at which time a gap analysis will be completed to better identify the skills required for this position in the new SmartCare environment.

As of the FY 2022-23 EQR, most contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
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	27%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	64%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☒ Weekly ☐ Monthly	9%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. 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. While a Manifest MedEx member, active data exchange will occur after the SmartCare implementation and connection between SmartCare and Manifest MedEx has been established by CalMHSA. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: hospitals.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The Avatar system is hosted by Netsmart Technologies, Inc.
- While some contract providers have full access to Avatar, many have chosen to utilize and maintain individual EHRs.
- The transition to the use of Domo dashboard software has been completed and previous dashboards have been replicated. New dashboards continue to be developed.
- The SmartCare system from Streamline Health Solutions is expected to be implemented in July 2023. The cloud-based system will be hosted by Streamline Health Solutions and operationally supported by CalMHSA.
- Data analytic support is embedded in QI as well as into individualized programs to provide targeted analytical needs.
- Security training is included in the employee onboarding process. Twelve security tips and warning emails were provided to staff in the past year. In the event of a specific identified risk, additional email notifications are provided to enhance staff awareness of the threat. Four faux phishing emails were utilized in the past year to assist in the identification of staff who required refresher training on cyber security.
- There is an Operations Continuity Plan for critical business functions that is maintained in readiness for use in the event of a cyber-attack, disaster, or other emergency. The plan is reviewed annually.
- The MHP maintains a data warehouse that replicates the Avatar system to support data analytics.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	40,468	$9,272,034	$20,036	0.22%	$8,946,819
Feb	41,649	$9,570,833	$24,014	0.25%	$9,261,182
Mar	46,685	$10,850,796	$24,464	0.23%	$10,571,062
April	44,427	$9,165,887	$27,959	0.31%	$8,919,635
May	42,161	$8,999,917	$24,575	0.27%	$8,802,903
June	43,467	$9,392,940	$42,661	0.45%	$9,134,357
July	40,447	$9,116,858	$124,041	1.36%	$8,889,646
Aug	40,494	$8,706,409	$104,573	1.20%	$8,508,374
Sept	40,909	$9,387,391	$117,442	1.25%	$9,185,521
Oct	41,246	$9,680,393	$124,039	1.28%	$9,452,267
Nov	37,902	$9,021,255	$84,126	0.93%	$8,854,836
Dec	37,329	$8,775,977	$102,831	1.17%	$8,599,450
Total	**497,184**	**$111,940,690**	**$820,761**	**0.73%**	**$109,126,052**

- This chart appears to reflect a largely complete or very substantially complete claims data set for the time frame claimed.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B must be billed before submission of claim	1835	$429,709	52.36%
Other healthcare coverage must be billed before submission of claim	798	$198,781	24.22%
Late claim	171	$66,460	8.10%
Service line is a duplicate and a repeat service procedure code modifier not present	246	$62,472	7.61%
Beneficiary not eligible or non-covered charges	141	$43,786	5.33%
Deactivated NPI	20	$13,799	1.68%
Service location NPI issue	18	$5,126	0.62%
Other	6	$626	0.08%
Total Denied Claims	**3,235**	**$820,759**	**100.00%**
Overall Denied Claims Rate	**0.73%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- Approximately 77 percent of claim denials were due to two reasons:
  - Medicare Part B or other health coverage must be billed prior to the submission of this claim, and
  - Other health coverage must be billed before submission of this claim.
- Claims with denial codes Medicare Part B or other health coverage must be billed prior to the submission of this claim and Other health coverage must be billed before submission of this claim are generally rebillable within State guidelines upon successful remediation of the reason for denial.
- The claim denial rate for CY 2021 of 0.73 percent is lower than the statewide average of 1.43 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The Domo application is being effectively utilized and the use of this data visualization software is a strength of the MHP.
- Data analytic support is embedded in QI as well as into individualized programs, which effectively supports the reporting and analytic needs of the organization.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP participated in the 2022 CPS survey but the findings have not been shared yet. Through the QI team, a dashboard is being developed to display outcomes over several years, to give a historical perspective of the survey finding. The dashboard will mostly show quantitative findings and less qualitative feedback. The QI team may incorporate qualitative feedback from staff who participated in a Gallup Staff Engagement Survey and from Clinical Teams.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a culturally diverse group of 8-10 Hmong adults who have initiated/utilized services within the preceding 15 months. The focus group was held via videoconference and included eight participants; a Hmong language interpreter facilitated the focus group. All consumers/family members participating receive/have a family member who receives clinical services from the MHP.

The focus group participants received services through the Living Well Center, where they have groups, individual therapy, and medication management services. Services were provided in Hmong, without the aid of interpreters, which they appreciated. The clinic and its activities were a source of social connection and destigmatizing mental illness in their community. While the frequency of therapy was sufficient, all the participants indicated that access to psychiatry (i.e., the one Hmong-speaking

psychiatrist) was insufficient, at every three to four months. Delays in access to psychiatry were made more apparent when participants have concerns with the medications and have to wait for the psychiatrist with whom they are most comfortable. Participants indicated that there were no nurses at the clinic who could otherwise assist or provide some interim solutions. Participants commented on staff turnover at this clinic and having to be reacquainted with new clinical staff over the past year. Participants have transportation assistance to and from the clinic only; the transportation service did not extend to mental health appointments or services elsewhere. The participants endorsed that the Living Well Center made a positive difference in their lives and to their wellbeing. Through the services, they had a sense of hope. In addition to the recommendations below, the participants expressed a desire for more groups and activities.

Recommendations from focus group participants included:

- Provide more transportation options (one car is insufficient).
- Increase time and availability of the psychiatric provider.
- Maintain staff and reduce the turnover.
- Increase the clinic hours.

Consumer Family Member Focus Group Two

CalEQRO requested a culturally diverse group of 8-10 parents/caregivers, especially of youth in FSP programs, who mostly have initiated/utilized services within the past 15 months. The focus group was held via videoconference and included two participants. All family members participating have a family member who receives clinical services from the MHP.

Due to the small number of participants, the feedback from this focus group is incorporated in the feedback of the other focus groups sessions and in the overall findings at the end of this section.

Consumer Family Member Focus Group Three

CalEQRO requested a group of 8-10 Latino and Hispanic adults who mostly have initiated/utilized services within the past 15 months. None of the participants identified as Latino or Hispanic. The focus group was held via videoconference and included seven participants. All consumers participating receive clinical services from the MHP.

The participants who were new to services described initial assessments within three weeks of contact, usually after hospitalization, and then another week or two for the next appointment. They indicated that subsequent appointments occurred with shorter latency and met their needs. The participants had a choice of telehealth and in-person services, either in the office or in a community setting. The frequencies of psychiatry appointments, every two months, and therapy appointments, weekly or biweekly, were

described as sufficient. Family involvement in treatment was possible and was offered to them. Participants were not aware of opportunities to participate in mental health system at large or give input, beyond their treatment. Overall, the participants were satisfied with the mental services received through the MHP. The one concern that participants raised was that sometimes calls to Access would go unanswered.

Recommendations from focus group participants included:

- Employ or recruit more peer employees as parent partners and as support staff to fill needs in operations (e.g., answering telephones).
- Provide more assistance for employment search and to access benefits and entitlements (e.g., Supplemental Nutrition Assistance Program).
- Increase access and supports during the weekend.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The MHP serves a racially and ethnically diverse beneficiary population and employs outreach and access strategies to meet their need. To its credit, the MHP can provide services to Hmong beneficiaries without the use of interpretation services. However, there are few Hmong clinical staff, particularly psychiatrists, which contributes to delays in services. Participants were reluctant to see other providers because of the rapport they had established with the current provider. This sentiment underscores the consequence of turnover of clinical staff; that it disrupts relationships and therapeutic alliance that contributes to treatment outcomes. An important component of beneficiary perception of care is the opportunity to give input, voice concerns, and be heard. Beneficiary perspective is part of the MHP's strategic plan and QI effort. As part of the Mental Health Services Act planning, the MHP has a 'reportback' forum to share information and communicate decisions. As part of QI, the MHP has a Feedback Improvement Committee that convenes monthly to solicit beneficiary input on program services. However, an area of improvement is the dissemination of findings back to beneficiaries. Although few in number, the participants did not recall being given the results of surveys in which they had participated. The MHP, as well, confirmed that it had delays in disseminating results of stakeholder surveys.

CONCLUSIONS

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

STRENGTHS

1. MHP has a thoughtful approach to QI that is outcomes-driven, with structures (e.g., Access, Outcomes, Feedback and Improvement subcommittees) and data utilization (i.e., Domo) that support this approach. (Quality)
2. The Domo software provides detailed reports and visualization of data that reinforces the use and purpose of data to drive services and outcomes. (Quality, IS)
3. The MHP's marketing strategies and outreach to the community have contributed to an increase in the number of beneficiaries served in 2021 (compared to an overall decrease in the numbers served statewide). (Access, Quality)
4. The MHP provides culturally-competent services through the Living Well Center that serves Southeast Asian beneficiaries. The Center and its approach to delivering services is of high value to beneficiaries. (Access, Quality)
5. The ATD report assists the MHP in evaluating service and program utilization and transitions in services and can guide decisions about capacity. (Access, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Despite the increase in Hispanic/Latino beneficiaries served, there continues to be a difference between the number of Hispanic/Latino eligibles and the number served, which may indicate a disparity in access. (Access)
2. Hmong-speaking beneficiaries may wait up to four months for an appointment with the Hmong-psychiatrists. The delays raise concerns especially when there are asynchronous concerns with medications. (Timeliness)
3. Of the 18 peer positions in DBH, only two have been filled (i.e., 16 are currently vacant). (Access, Quality)
4. Using only the day of service to track urgent conditions likely inflates the time to response. (Access, Timeliness, IS)
5. While DBH has no authority over MCP providers, delays to enrollment in mild-to-moderate programs may erode gains in beneficiary outcomes and functioning achieved through MHP services. (Quality)

RECOMMENDATIONS

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

1. Investigate reasons for and develop and implement strategies to improve access to Hispanic/Latino beneficiaries. (Access)
2. Investigate and develop and implement strategies to improve the timeliness of psychiatry services for Hmong beneficiaries served at the Living Well Center. (Timeliness, Quality)
3. Resume active recruitment to fill vacant peer employee positions and increase the number of peer employees at DBH. (Access, Quality)
4. Investigate reasons and develop and implement strategies to include a timestamp (minute and hour) that an urgent service was requested. (Timeliness, IS)
5. Continue to meet with MCP providers and develop an interim solution to serve beneficiaries who are awaiting mild-to-moderate LOC programs. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a California public health emergency (PHE) was in place until February 28, 2023 and a national PHE is scheduled to end May 11, 2023. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

The focus group did not include Latino/Hispanic individuals as requested.

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 – Fresno MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
PIP Validation and Analysis
Performance Measure Validation and Analysis
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Satisfaction
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Groups
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Information Systems Billing and Fiscal Interview

CalEQRO Review Sessions – Fresno MHP
Wellness Center Virtual Visit
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lisa Farrell, Information Systems Reviewer
Pamela Roach, Consumer/Family Member Reviewer
Ewurama Shaw-Taylor, PhD, CPHQ, Lead Quality Reviewer
Robert Walton, RN, 2nd Quality Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Acosta	Yessica	Clinical Supervisor, Inspiration Opportunity Transformation Team	Department of Behavioral Health (DBH)
Aguilar	Lucia	Clinical Supervisor, Adult System of Care, Housing	DBH
Akopyan	Nona	Program Director, TAY FSP	Central Star
Bahrami	Ahmad	Division Manager and Ethnic Services Manager, Public Behavioral Health	DBH
Beard	Bethany	Clinical Supervisor, TAY FSP	Central Star
Black	Marcelia	Deputy Director	DBH
Castro	Gleyra	Clinical Supervisor	DBH
Castro-Flores	Lesby	Deputy Director	DBH
Elliott	Jeffrey	QI Coordinator	DBH
Escoto	Liz	Regional Director	Turning Point of Central California
Esqueda	Chris	Clinical Director	Central Stars
Gomez, LMHC	Gabe	Clinician, QI	DBH
Gonzales	Juan	Program Supervisor	Fresno Impact
Gordon Browar	Jolie	Division Manager, Adult System of Care	DBH

Last Name	First Name	Position	County or Contracted Agency
Hafi	Muhannad (Moe)	Epidemiologist, QI	DBH
Her	Ge	Clinician, QI	DBH
Her	Song	Community Mental Health Specialist, RISE Conservatorship	unknown
Holland	LeAndra	Clinical Supervisor	Unknown
Holt	Susan	Director and Public Guardian	DBH
Horn	Dennis	Diversity Services Coordinator	DBH
Houngviengkham	Bai	Division Manager	DBH
Johnson	Mary	Compliance Staff Analyst	DBH
Luna	Laura	Program Manager, Staff Development	DBH
Martinez	Cristina	Clinical Program Manager	Pacific Clinics
McIllwain	Josh	Staff Analyst, QI	DBH
Miller	Michael	Hospital Access Linkage and Outreach	DBH
Muro	Michael	Senior Staff Analyst, Contracted Services Division	DBH
Nelson APRN	Sandra	Utilization Review Specialist, Compliance	DBH
Nguyen	Sue Ann	Program Technician, QI	DBH

Last Name	First Name	Position	County or Contracted Agency
Parra-Sanchez	Luisa	Clinical Supervisor, School-Based Program	DBH
Rangel	Joseph	Division Manager, Contracted Services	DBH
Rsmussen	Emma	Deputy Director	unknown
Rios	Silvia	Clinical Director	Exodus Recovery
Rooks	Holly	Quality Support Supervisor	All 4 Youth
Sahai-Bains	Sonia	Clinical Supervisor, Hospital Assessment Linkage Outreach	DBH
Scharffenberg	Jessica	Clinical Supervisor	All 4 Youth
Sharp-Rivas, RN	Tonya	Interim Nurse Manager, Medical Service	DBH
Solis	Jessica	Staff Analyst, QI	DBH
Stone	Alyssa	Clinical Supervisor	Shelter Plus Care
Taylor	Guadalupe (Lupe)	Senior Licensed Mental Health Clinician, Collaborative Courts	DBH
Thao	Kao	Unlicensed Mental Health Clinician, Deputy Conservator	DBH
Thomas	Elizabeth	Senior Staff Analyst, QI	DBH
Toonnachat	Kannika	Division Manager, Supporting IT & Medical Records	DBH
Tran, MD	John	Medical Director	DBH

Last Name	First Name	Position	County or Contracted Agency
VanBruggen, LCSW	Stacy	Division Manager, Adult Services	DBH
Unknown	David	Regional Director	Turning Point
unknown	Jacqui	Clinical Director, FSP	unknown
unknown	Katrina	Program Director	Turning Point
Vang	Bao	Registered Clinician	The Fresno Center - Living Well Center
Vang	Daisy	Registered Clinician	unknown
Vang	Ze	Clinical Director	The Fresno Center - Living Well Center
Vasquez	Elizabeth	Compliance Officer	DBH
Vasquez	Joyce	Clinical Supervisor, High Intensity Outpatient Program, Children's MH	DBH
Warnert, LMFT	Hannah	Clinical Program Manager	Pacific Clinics
Williams, LCSW	Cary	Clinical Supervisor, SHINE Program	Unknown
Xiong	Mee	Staff Analyst, QI	DBH
Xiong	Pa Ge	Staff Analyst, QI	DBH
Ziebell	Andrea	QI	DBH
Zulewski	Lilian	Access Team, HALO	DBH

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 MHP has a clear understanding of the issue needing improvement, supported by data, and has a straightforward, uncomplicated strategy for improvement, which it can monitor. The outcome of the project will depend on the ability of FSP programs to step-down and discharge current youth to another service provider or program. This piece of the project was not sufficiently addressed.

General PIP Information
MHP/DMC-ODS Name: Fresno County
PIP Title: Children's FSP Progress Review
PIP Aim Statement: Will implementing periodic clinical progress reviews in children's FSPs decrease average LOS by 10 percent over a one-year period in 2023?
Date Started: 01/2023
Date Completed: n/a
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:

General PIP Information
Target population description, such as specific diagnosis (please specify): Children and youth ages 0-18 and some TAY already in the program who are enrolled in an FSP program.
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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Develop clinically appropriate tools in conjunction with children's FSP providers to measure progress towards treatment goals and discharge, and administer at quarterly (ages 0-10) or semi-annually (ages 10 11-18) intervals.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

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
LOS	FY 2021-22	P-ACT: 14.9 mos. P-BB: 413 days CYS: 305 days EPU: 206 days	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ 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.
EQRO recommendations for improvement of PIP: • Present an average LOS that includes the relevant FSP programs, rather than program-specific LOS, which suggests program differences at the outset. • Include a pre-existing measure of outcomes for FSP programs to confirm that youth are achieving goals and not being transitioned (out) prematurely to create space in the FSP program. • Track the types of programs or placements that youth are discharged to after leaving the FSP program.

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 has a clear understanding of the issue needing improvement, supported by data, and has a strategy for improvement. One strategy has already been deployed to great effect but more current data of outcomes are needed. The second strategy requires additional components to be in place prior to implementation. The target for improvement and timeframe will need to be adjusted accordingly once the intervention is actually implemented.

General PIP Information
MHP/DMC-ODS Name: Fresno County
PIP Title: FUM
PIP Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023.
Date Started: 12/2022
Date Completed: n/a
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): Beneficiaries with a principal diagnosis of mental illness or intentional self-harm who have an ED visit.

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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): 1. Create a workflow between EDs and Access team 2. Implement a centralized referral tracking mechanism

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
ED Follow-up Rates 7-Day 30-Day	CY 2021	34%, 7-day 51% 30-day	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Post-ED Assessments	CY 2021	2.4 per month	CY 2022	4 per month	☒ 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.
EQRO recommendations for improvement of PIP: • Provide more detail on who will address the social determinants of health and how various barriers will be addressed. • Develop contingency plans for further delays in the implementation of the referral tracker.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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