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FY 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review

MONO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

April 25, 2023

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Onsite

Date of Review — April 25, 2023

MHP Size — Small-rural

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
6	4	2	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	1	4	1
Quality of Care	10	3	6	1
Information Systems (IS)	6	2	4	0
TOTAL	**26**	**10**	**14**	**2**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
"Vitamin D Deficiency Case Management Linkage"	Clinical	03/2023	Implementation	Moderate
"Follow-Up After Emergency Department Visit for Mental Illness (FUM)"	Non-Clinical	09/2022	Implementation	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	6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Prioritizing a flexible teleworking policy has helped with recruitment and contributed to the department becoming fully staffed, including the addition of Spanish speaking staff.
- The MHP's use of technology and collaborative relationship with IT ensures service delivery to beneficiaries and makes communication amongst staff possible when met with weather and distance challenges.
- Housing options have been a priority for the MHP for several years and a new complex is currently being constructed to include 13 dedicated mental health (MH) and No Place Like Home beds, which will provide supportive housing.
- Peers are integrated into the system of care (SOC), including two certified peers and one peer being promoted to case manager.
- The MHP has increased Medi-Cal revenues by implementing billing and productivity standards, changes in minute rate and assigning a point person to work on errors and other billing issues.

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

- Key informants fear the termination of their clinician when participating in service verification calls.
- Key informants have expressed the lack of consistency and lack of knowledge of when to attend a Wellness Center activity and when it will be open, which has deterred their use of the Wellness Center.

- There is a lack of orientation material or understanding of material provided for new beneficiaries that explains Wellness Center options, website information, and crisis phone numbers.
- The MHP is advised to identify how it will ensure timeliness data is collected while staff are trained and data is input into the new Electronic Health Records (EHR) system, to ensure the continuity of data collection and timeliness reporting.
- An inefficient workflow process allows only administrative staff to enter diagnosis into the EHR and results in one-third of beneficiaries not having a diagnosis.

Recommendations for improvement based upon this review include:

- Create a standard introduction and survey when making service verification calls to ensure beneficiaries are clear on the purpose of the call; and ensure continuity of care should a clinician leave employment.
- Provide a consistent schedule and location for ease of access to Wellness Centers activities; investigate the feasibility of expanded hours to allow for drop-in activities such as cooking, showers, laundry, and MH services.
- Provide an orientation for new beneficiaries, including those that opt for telehealth services, that fully informs the beneficiaries of the website, Wellness Centers, crisis services, and after hours phone number.
- Utilize a tracking system for all required timeliness data metrics to ensure all timeliness data is tracked and accurately reported while awaiting the installation and training on the new SmartCare EHR.
- Create a workflow that allows clinical staff to enter timely and accurate beneficiary diagnostic information into the EHR to ensure accurate clinical documentation and service claims.

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 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 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 Mono County MHP by BHC, conducted as an onsite review on April 25, 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 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 File.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age youth; 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 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 the Coronavirus Disease 2019 (COVID-19) pandemic, which is scheduled to end on May 11, 2023. The MHP faced the unusual and multiple Atmosphere weather systems which paralyzed the county with record snow fall and road closures. The county now faces the eminent repercussion of excessive flooding. The MHP is in a county where the population can rise annually, due to tourism, from a population of 7,380 residents to over one million visitors each winter. 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. 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.

- Mono vacated the implementation of the EHR system InSync and elected to implement the semi-statewide EHR, Streamline's Smartcare, with an anticipated go-live date of July 1, 2023.
- The MHP is seeing increased Medi-Cal revenues as a result of implementing billing standards and productivity, changing the minute rate, and assigning a point person to work on errors and other billing issues.
- The MHP was significantly impacted by the Atmospheric Storm systems that made roads impassable during the winter. The MHP utilized telehealth services and continues to see beneficiary desire to stay remote due to time and distance challenges within the county.
- The MHP continues outreach efforts to work with the Bridgeport Indian Community.
- The MHP has reduced their staff vacancy rate by hiring several new staff members to meet administrative, community, and clinical needs, including an experienced Wraparound Coordinator and a fully remote bilingual therapist who specializes in child therapy.

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.

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: Increase MHP capacity such that protracted time to services and waitlists, which were used as internal MHP measures of access, timeliness, and quality, decrease.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP recruited and retained several new staff on its clinical team, making the department nearly fully staffed with only one psychiatric specialist vacancy remaining.
- During the current FY, the MHP is aiming to utilize Crisis Care Mobile Unit grant funding to provide a stipend to on-call crisis team members.
- The MHP contracted with North American Mental Health Services to provide therapy via telemedicine and the department has increased capacity to serve children through the Mental Health School Services Act Grant and its collaboration with Mono County Office of Education.

Recommendation 2: In collaboration with Mono County government, resolve the soundproofing issue in the new building, which affects privacy of health care.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- In collaboration with the County Director of Public Works and County Administrative Office, the MHP addressed the sound transmission issue in the treatment rooms by installing sound proofing to dampen vibratory noise. In

addition, the MHP placed sound devices in the rooms for sound masking purposes during sessions.

Recommendation 3: Resolve discrepancies in tracking of timeliness for adults, children, and youth in FC and provide accurate timeliness report. (Accurate reporting requires regular review of data, correction of errors/data clean-up, and evaluation).

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP created a new system to track collection of offered vs. delivered telepsychiatry appointments and the collection of more complete no-show data. Some challenges to resolving all discrepancies have been poor EHR performance, staff turnover, staff maternity leave, and staff not identifying errors in the data.
- The MHP is hopeful their new chosen system, SmartCare will remedy many of the data EHR challenges they currently face with their older EHR system.
- The MHP acknowledges room for improvement as it faces the challenge of accurately tracking timeliness data. Their lack of youth and FC youth make tracking data more difficult as there is simply minimal data to track. As services expand for youth, the MHP will have to identify data perimeters to collect and accurately track and trend data across the continuum of care.
- Though partially addressed, for this recommendation to be complete, the MHP must ensure that timeliness data is collected and accurately reported. It is not the EHR that provides this ability, but instead it is the initial tracking, collection, and input of data that ensure accurate reporting within an EHR. This recommendation will carry over.

Recommendation 4: Continue to pursue viable options for a new EHR and plan for a system that will meet impending requirements of California Advancing and Innovating Medi-Cal (CalAIM), including data collection, reporting functionality, and clinical supports for the entire SOC. Additional dedicated staffing and/or external support should be included in the implementation plan.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP contracted with California Mental Health Services Authority (CalMHSA), to implement the semi-statewide EHR, Streamline's Smartcare, to meet CalAIM requirements and improve data collection, reporting functionality and clinical documentation.
- One full-time equivalent (FTE) staff member has been dedicated to EHR implementation and IS support.

Recommendation 5: Develop written policies and/or a procedural manual for Medi-Cal claims processing to facilitate training of staff in the process.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- How-to desk guides were developed to provide instructions for billing staff to perform billing tasks. Two staff are proficiently trained to complete claim processes.
- The MHP has contracted with CalMHSA to complete billing tasks after the new EHR is implemented.

Recommendation 6: Monitor and document the review of data from California Child Welfare Indicators Project and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Performance Outcomes System (POS), regarding medication utilization of youth in FC.

(This recommendation is a carry-over from FY 2018-19, FY 2019-20, & FY 2020-21.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP did not have a single FC youth receiving medication within the current review cycle or current FY.
- The MHP understands the policy regarding EPSDT and should they have a FC youth in their system they are aware of the required regulations.
- The MHP shares information with the Department of Social Services (DSS) during the Children's System of Care (CSOC) multi-disciplinary team monthly meetings for each youth that enters the CSOC.
- Due to the minimal number of FC youth that enter the CSOC, the MHP continues to be unable to address this recommendation in full due to the lack of services which require EPSDT POS monitoring and FC youth receiving medication. This recommendation will not be carried forward.

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.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by county-operated providers in the MHP. Regardless of payment source, approximately 100 percent of services were delivered by county-operated/staffed clinics and sites, and 0 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 59 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: crisis services. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The MHP completes an initial registration upon beneficiaries calling into the access line and schedules an in-person intake appointment for full assessment and linkage to services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults. In FY 2021-22, EHR and staff limitations prevented the MHP from reporting the number of adult beneficiaries, youth beneficiaries, and older adult beneficiaries that received telehealth services, but reports telehealth services are provided across two county operated sites. EHR and staff limitations also prevented the reporting of the number of beneficiaries who received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs

[1] CMS Data Navigator Glossary of Terms

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

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

Alternative Access Standards				
The MHP was required to submit an AAS request due to time or distance requirements	☒ Yes ☐ No			
AAS Details	**Psychiatry**		**MH Services**	
	Adults (ages 21+)	Youth (ages 0-20)	Adults (ages 21+)	Youth (ages 0-20)
# of zip codes outside of the time and distance standards that required AAS request	8	8	0	0
# of allowable exceptions for the appointment time standard, if known (timeliness is addressed later in this report)				
404 Miles 427 Min	404 Miles 427 min		404 Miles	
Approximate number of beneficiaries impacted by AAS or allowable exceptions	2868	1437		
The number of AAS requests approved and related zip code(s)	8 96133, 96107, 93517, 93541, 93529, 93546, 93514, 93512	8 96133, 96107, 93517, 93541, 93529, 93546, 93514, 93512		
Reasons cited for approval	From DHCS: "The basis for this approval is Telepsychiatry Services are being administered within the County."			
The number of AAS requests denied and related zip code(s)	0	0		
Reasons cited for denial	n/a	n/a		
Alternative Access Standards				
The MHP was required to submit an AAS request due to time or distance requirements	☒ Yes ☐ No			

- The MHP did not meet all time and distance standards and was 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
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☐ Yes ☒ No
Contracting status:	☒ The MHP is in the process of establishing contracts with OON providers ☐ The MHP does not have plans to establish contracts with OON providers
Contracting efforts and barriers cited by MHP:	MHP has a policy and procedure (21-006_Continuity of Care) and a tracking log for continuity of care requests. Such requests are rare in small communities and there are no current out-of-network providers interested in contracting with the MHP at this time. The MHP consistently tracks providers who are new to the community and who may be interested in establishing contracts as an out-of-network provider but has not been able to secure contracts at this time.

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- MCBH continues to implement its Racial Equity Plan, including holding regular Equity Committee meetings, dedicating 1 percent of each pay period to equity work, and meeting monthly to discuss equity topics.
- MCBH has added questions about equity work to all employment interviews to help candidates understand the values of the county department and to set expectations related to workplace culture.
- The MCBH county website information as well as printed information regarding county services are provided in Spanish. There is a Spanish speaking therapist who provides telehealth services as well as travels once a month to Mono.
- MCBH's development partner broke ground on a permanent supportive housing project that will include 13 units of housing for individuals with mental illness.
- MCBH is improving care coordination by meeting regularly with Mammoth Hospital and Emergency Department staff to coordinate care.
- Key informants reported not knowing how to access crisis after hours numbers, how to maintain in a crisis while awaiting a first clinical appointment, wellness center information, or that there was a behavioral health website.

ACCESS PERFORMANCE MEASURES

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

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median

differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, the PR is lower than that of similar size counties but higher than the statewide PR.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	3,700	182	4.92%	$402,576	$2,212
CY 2020	3,372	127	3.77%	$201,525	$1,587
CY 2019	3,441	199	5.78%	$285,574	$1,435

- Consistent with statewide patterns, the number of eligibles increased; however, unlike the statewide pattern, the number of beneficiaries served by the MHP also increased.

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	400	<11	-	1.71%	1.96%
Ages 6-17	926	41	4.43%	8.65%	5.93%
Ages 18-20	201	<11	-	7.76%	4.41%
Ages 21-64	1,976	123	6.22%	8.00%	4.56%
Ages 65+	200	<11	-	3.73%	1.95%
Total	**3,700**	**182**	**4.92%**	**7.08%**	**4.34%**

- The PR for the 21-64 age group is lower than similar size counties and higher than statewide, whereas the PR is lower than similar size counties and statewide for the 6-17 age group. Suppression rules have been applied for all other age groups.

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	34	18.68%
Threshold language source: Open Data per BHIN 20-070		

- Nearly 19 percent of beneficiaries served speak Spanish.

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	1,375	79	5.75%	$176,723	$2,237
Small-Rural	35,376	2,377	6.72%	$12,056,144	$5,072
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries. This pattern does not hold true for this county as the ACA PR and AACB is higher than the overall PR and AACB.
- ACA eligibles represent 37 percent of the overall Medi-Cal population and the PR is less than other small-rural counties but larger than statewide.

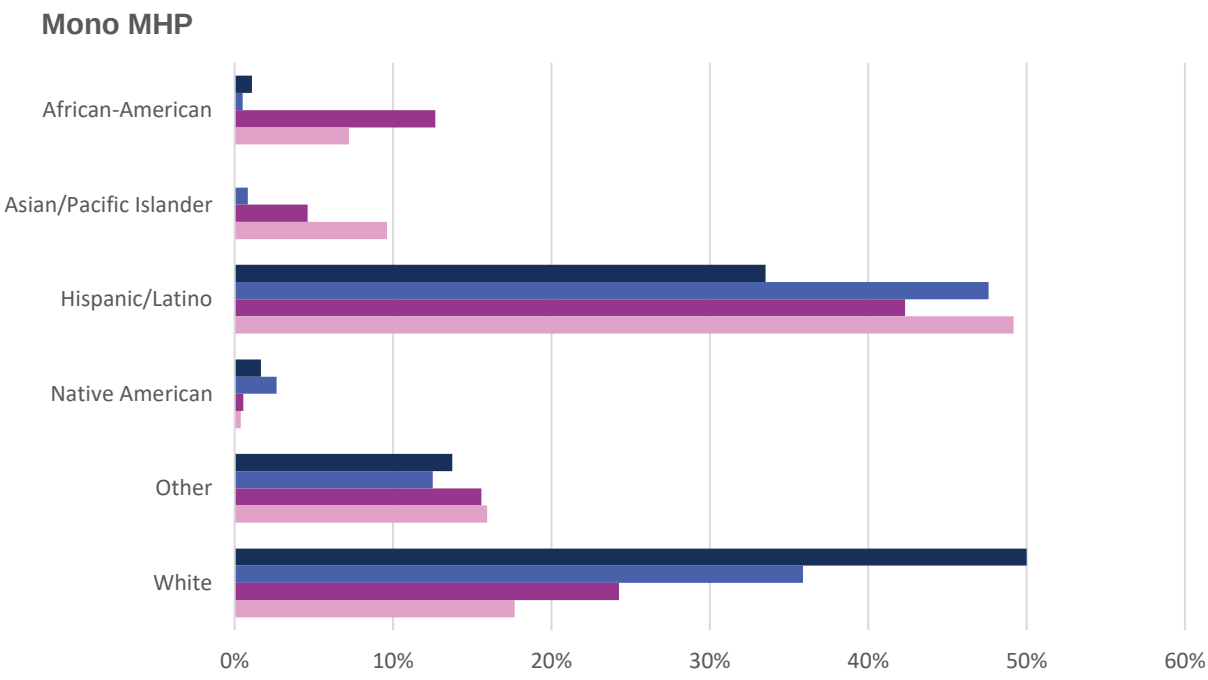
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions 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	19	<11	-	7.64%
Asian/Pacific Islander	31	0	0.00%	2.08%
Hispanic/Latino	1,763	61	3.46%	3.74%
Native American	98	<11	-	6.33%
Other	463	25	5.40%	4.25%
White	1,329	91	6.85%	5.96%
Total	**3,703**	**182**	**4.91%**	**4.34%**

- The MHP's PR is just slightly lower than the statewide rate for Hispanic/Latino beneficiaries but higher than statewide for both White and Other beneficiaries.

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

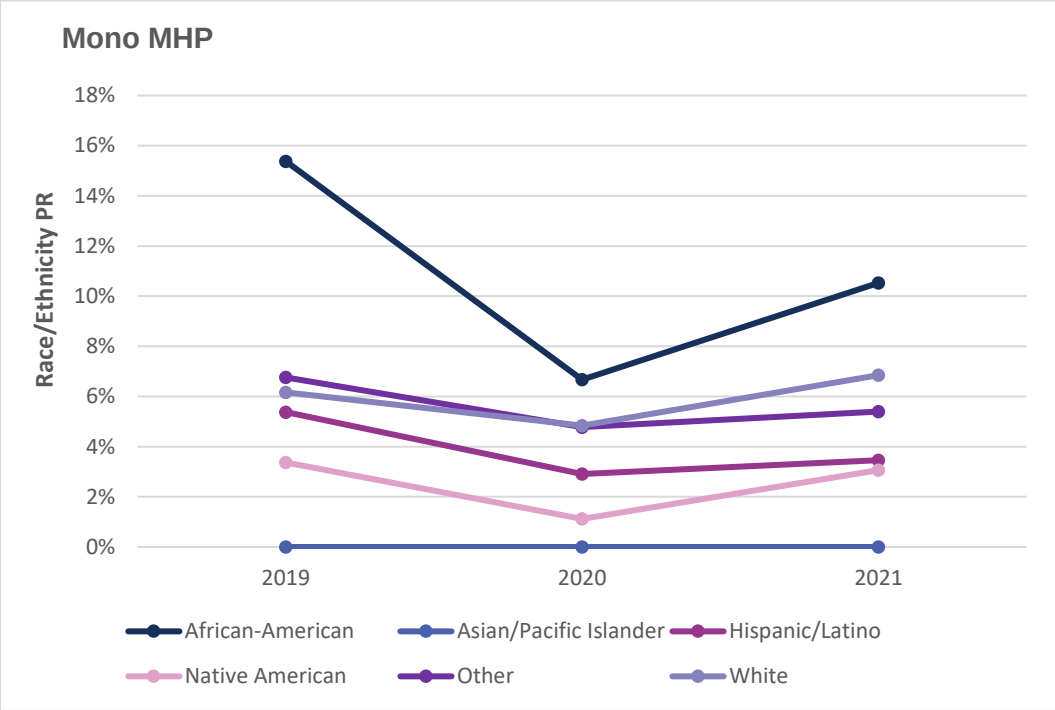


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	50%	14%	2%	34%	0%	1%
MHP % Eligible	36%	13%	3%	48%	1%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- Similar to statewide, the White group appears to be overrepresented among beneficiaries served, whereas the Hispanic/Latino group are underrepresented in the MHP.

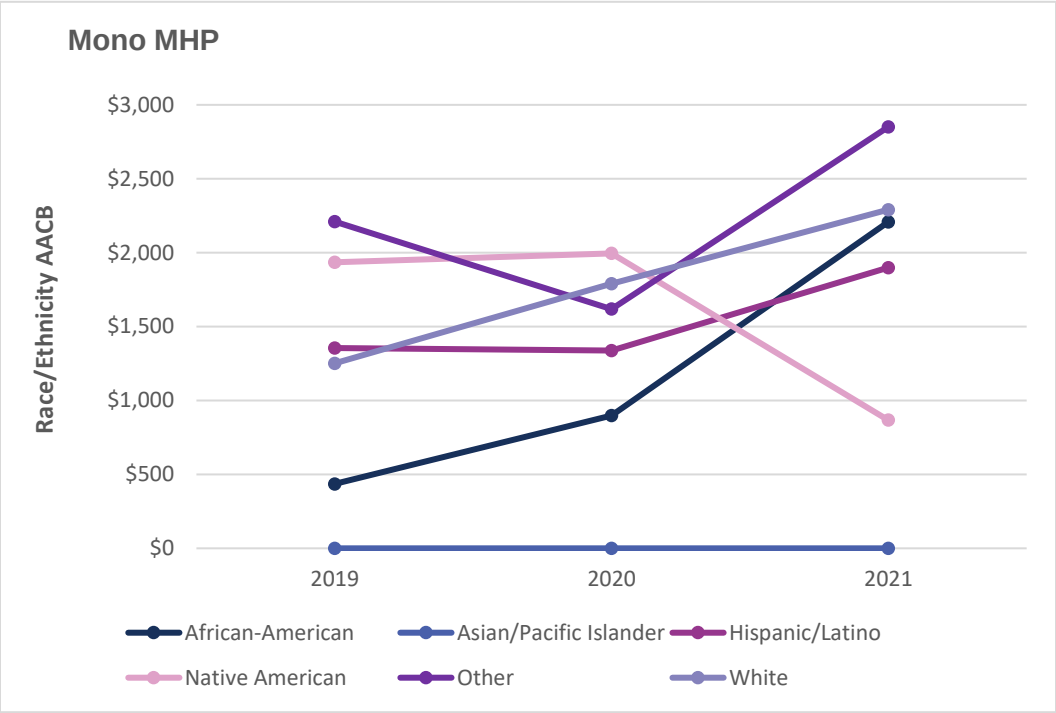
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



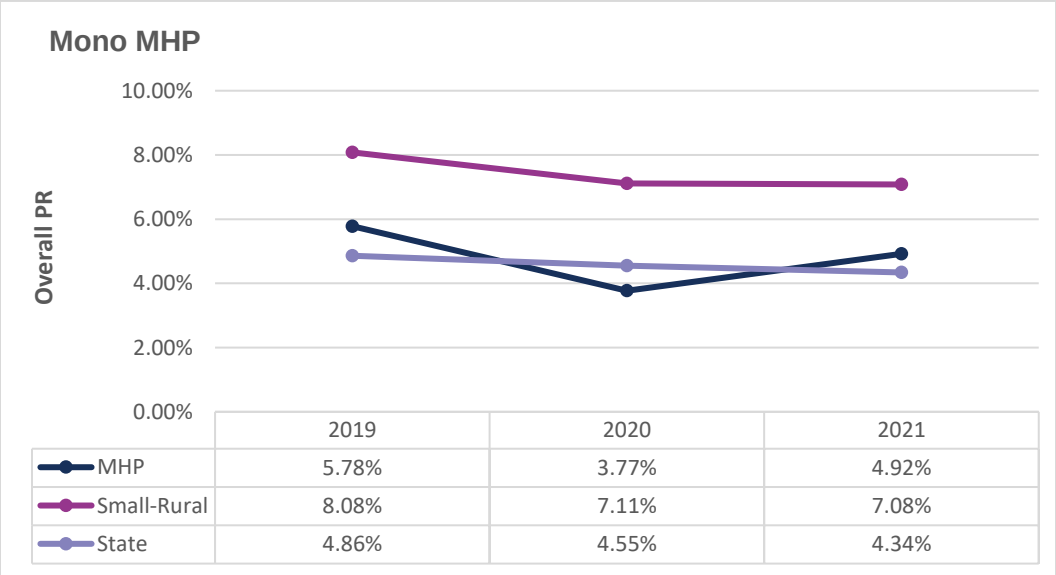
- The trend line for most race/ethnicity groups took a small downward trend between CYs 2019 and 2020, however, the downward trend for the African-American group was much greater compared to other groups because the number of beneficiaries is quite small in Mono County. In CY 2021, the trend lines turned upward for all groups except for the Asian/Pacific Islander group that has remained flat because no beneficiaries in this group have received services in the last three years.

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



- The AACB varies across race/ethnicity groups. Most groups have an increased AACB in CY 2021; however, the AACB has fallen for the Native American group and remains flat for the Asian/Pacific Islander group because no beneficiaries from this population have been served in the last three years.

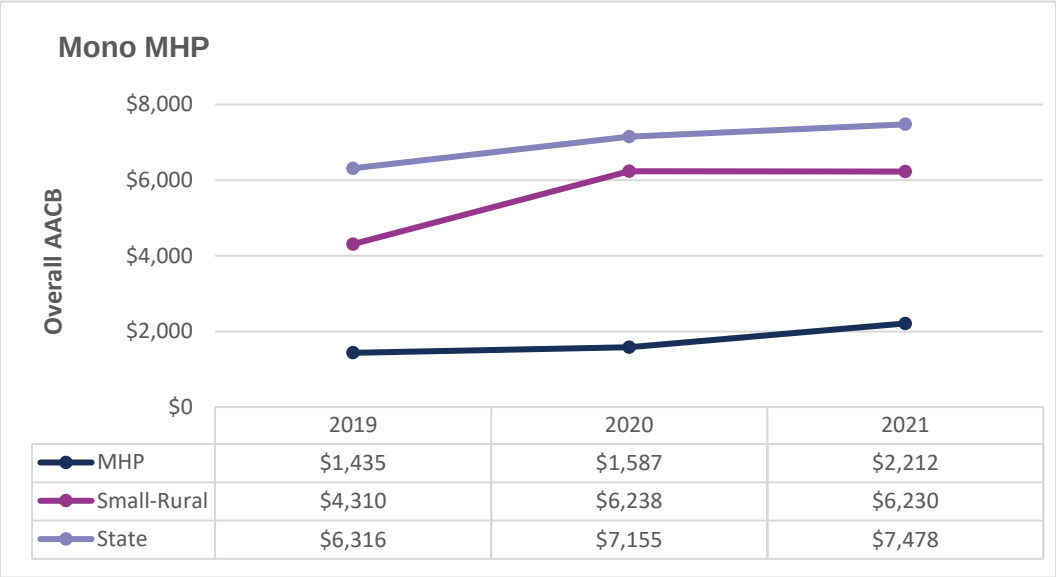
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	5.78%	3.77%	4.92%
Small-Rural	8.08%	7.11%	7.08%
State	4.86%	4.55%	4.34%

- The MHP PR fell in CY 2020 and then increased in CY 2021; whereas the small-rural counties and statewide PR has continued to slightly fall in CY 2021.

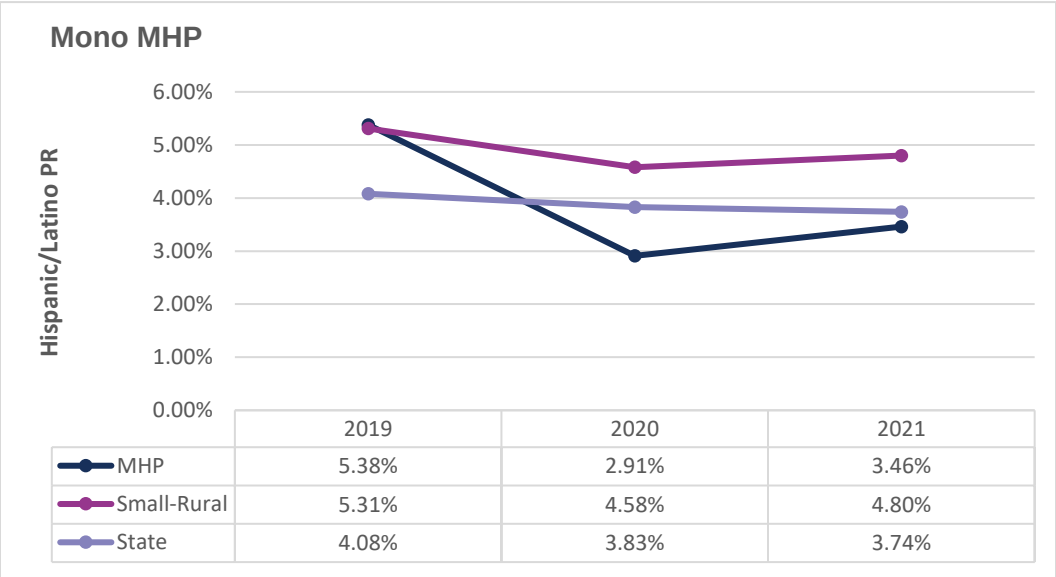
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$1,435	$1,587	$2,212
Small-Rural	$4,310	$6,238	$6,230
State	$6,316	$7,155	$7,478

- The MHP's AACB has remained noticeably lower than in other small-rural counties and statewide for the last three years.

Figure 6: Hispanic/Latino PR CY 2019-21

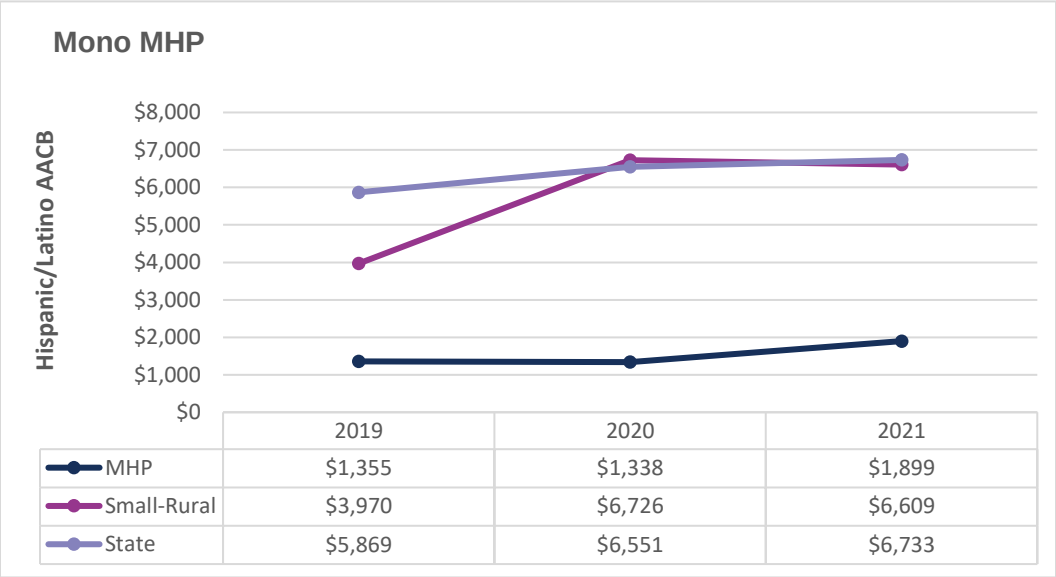


	2019	2020	2021
MHP	5.38%	2.91%	3.46%
Small-Rural	5.31%	4.58%	4.80%
State	4.08%	3.83%	3.74%

- The MHP's Latino/Hispanic PR fell in CY 2020 and was a much larger decrease compared to other small-rural counties and statewide. The PR has risen in CY

2021; however, the MHP PR remains lower than similar size counties and statewide.

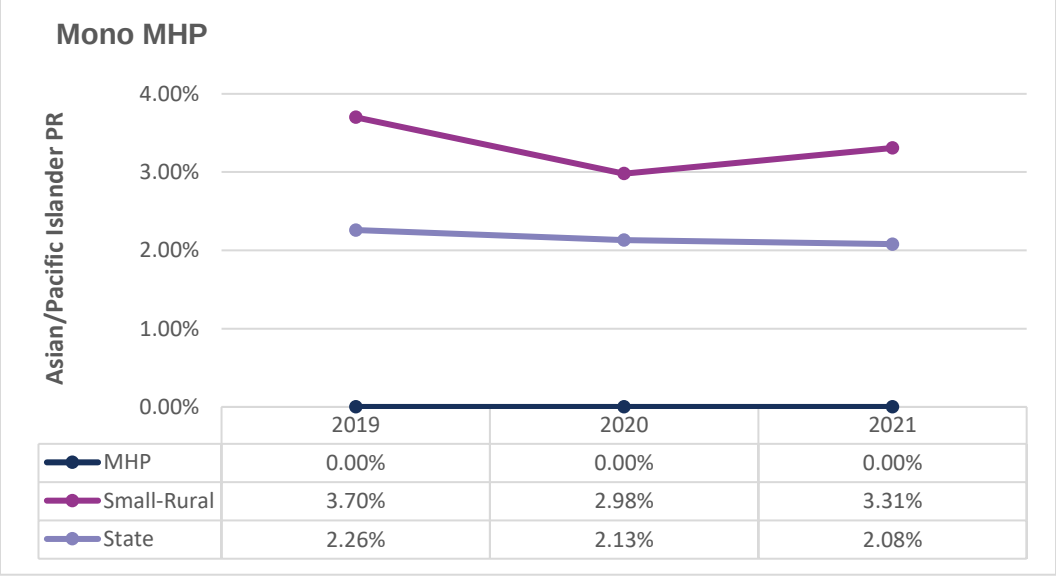
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$1,355	$1,338	$1,899
Small-Rural	$3,970	$6,726	$6,609
State	$5,869	$6,551	$6,733

- The MHP's Hispanic/Latino AACB was stable between CYs 2019 and 2020, followed by a slight increase in CY 2021. The AACB for this population has consistently been lower than in other small-rural counties and statewide.

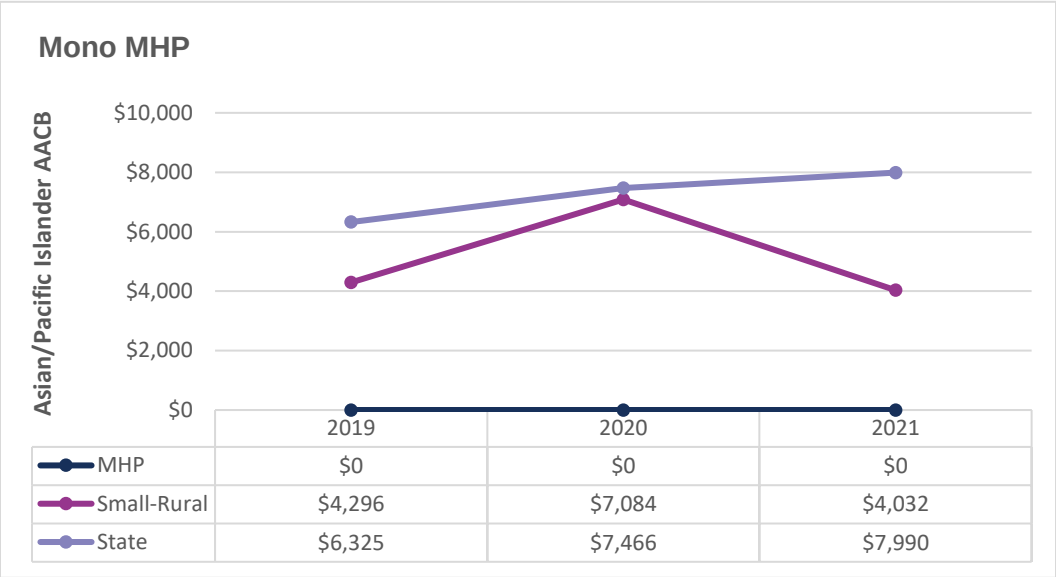
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	0.00%	0.00%	0.00%
Small-Rural	3.70%	2.98%	3.31%
State	2.26%	2.13%	2.08%

- The MHP's PR for the Asian/Pacific Islander group has remained at zero for the last three years and is lower than the small-rural and statewide PRs for this population.

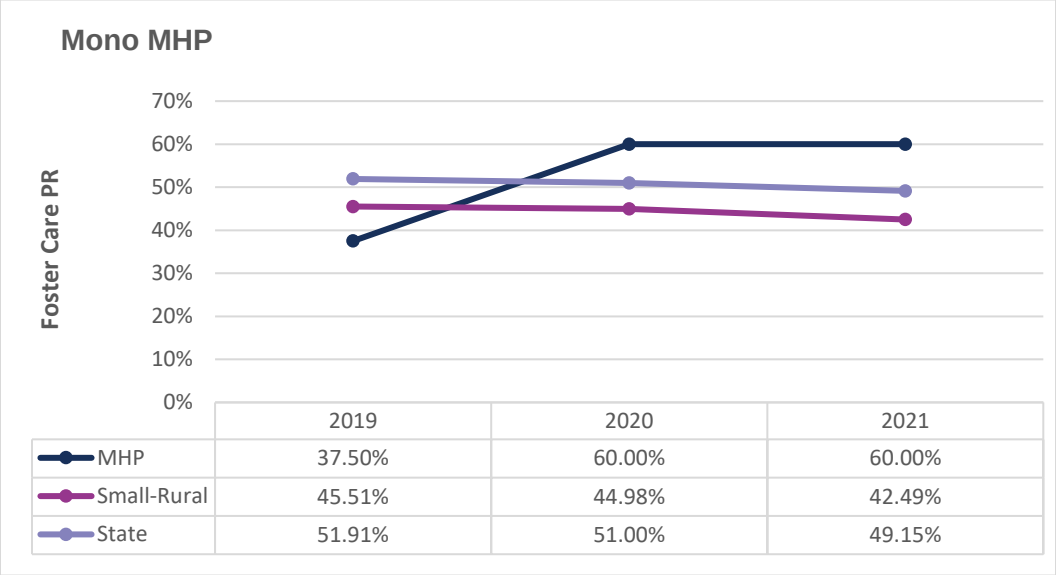
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$0	$0	$0
Small-Rural	$4,296	$7,084	$4,032
State	$6,325	$7,466	$7,990

- The AACB for the Asian/Pacific Islander group remains at $0.

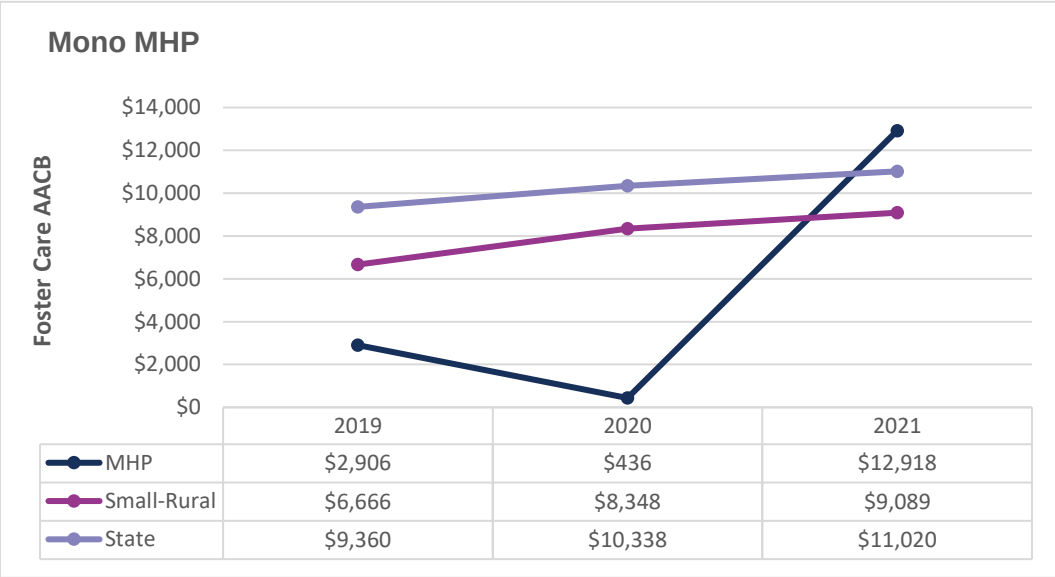
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	37.50%	60.00%	60.00%
Small-Rural	45.51%	44.98%	42.49%
State	51.91%	51.00%	49.15%

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed.
- The MHP's FC PR has remained steady at 60 percent for the last two years and is higher than small-rural counties and statewide.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$2,906	$436	$12,918
Small-Rural	$6,666	$8,348	$9,089
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased each year.
- Due to the expanded relationship with the schools the MHP saw an uptick of intensive home-based and targeted case management services to FC youth after COVID-19 and the return of youth back to the school system. The MHP's FC AACB has noticeably increased since CY 2020 and is larger than small-rural counties and statewide AACB.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 139				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	4	4	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	0	0.0%	0	0	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	0	0.0%	0	0	2.2%	21	14
Per Minute Services							
Crisis Stabilization	<11	-	2,916	2,400	13.0%	1,546	1,200
Crisis Intervention	16	11.5%	200	147	12.8%	248	150
Medication Support	<11	-	211	175	60.1%	311	204
Mental Health Services	104	74.8%	510	246	65.1%	868	353
Targeted Case Management	102	73.4%	318	195	36.5%	434	137

- The percentage of beneficiaries receiving Inpatient services is suppressed, however, the average units of service for Inpatient services is 4 days compared to 16 days statewide.
- The percentage of adult beneficiaries receiving Crisis Intervention services is slightly lower than the statewide percentage and the average units of service is also slightly lower.
- The percentage of adults receiving MH Services and Targeted Case Management services is noticeably higher compared to statewide.

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

Service Category	MHP N = < 11				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	11	11	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	3.1%	1,404	1,200
Crisis Intervention	0	0.0%	0	0	7.5%	406	199
Medication Support	0	0.0%	0	0	28.2%	396	273
Therapeutic Behavioral Services	0	0.0%	0	0	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	<11	-	5,905	2,952	40.2%	1,354	473
Intensive Home Based Services	0	0.0%	0	0	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	<11	-	1,989	995	96.3%	1,854	1,108
Targeted Case Management	<11	-	152	152	35.0%	342	120

- Although suppression rules have been applied due to the small number of FC youth receiving SMHS in Mono, it is worth noting the MHP's average units of Intensive Care Coordination is more than four times the average units statewide.

IMPACT OF ACCESS FINDINGS

- Targeted Case Management services are delivered in a larger capacity to beneficiaries throughout the county because of the remote location heavily impacted by weather and distance.
- Of note is the current collaboration with Bridgeport Indian services to offer outreach and MH services to the Native American group who would otherwise receive services through Toiyabe Indian Health Project.

- With inpatient services a minimum of five-hours away, the MHP does intensive case management on targeted MH services to stabilize beneficiaries in the community.
- Key informants reported not receiving orientation packets for those utilizing telehealth services. Further explaining they were not given crisis numbers or how to maintain in a state of crisis when awaiting clinician assignment.

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.

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	Partially met
2C	Urgent Appointments	Partially met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Partially met
2F	No-Shows/Cancellations	Not met

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

- The MHP has made significant efforts to track FC youth data and has increased their collaboration with the DSS. The MHP acknowledges that timeliness data reporting remains flawed due to the current EHR. The MHP is updating the

current system by opting into the CalMHSA SmartCare EHR, which is due to roll out on July 1, 2023.

- The Follow-Up after Psychiatric Hospitalization is related to those that enter the system within the Mammoth Lakes Hospital's inpatient unit (IPU). Those beneficiaries have case planning prior to exiting the hospital which results in 100 percent with 7- and 30- day follow up. The challenge remains for those that are sent out of county as the nearest IPU is located five hours away.
- Currently the MHP is unable to provide no-show data separated out by age or population.

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 SOC. The MHP was unable to show no-show data by age group due to EHR reporting limitations. The no-show data only included data from January 1, 2022, through September 1, 2022, when the methodology for no-show reporting was changed.

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

Table 11: FY 2022-23 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	3.3 Business Days	10 Business Days*	99%
First Non-Urgent Service Rendered	5.5 Business Days	15 Business Days**	97%
First Non-Urgent Psychiatry Appointment Offered	3.7 Business Days	15 Business Days*	100%
First Non-Urgent Psychiatry Service Rendered	7.7 Business Days	15 Business Days**	83.3%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	16.3 Hours	48 Hours**	100%
Follow-Up Appointments after Psychiatric Hospitalization	1.0 Days	7 days**	100%
No-Show Rate – Psychiatry	18%	25%**	n/a
No-Show Rate – Clinicians	15%	25%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: CY 2022			

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

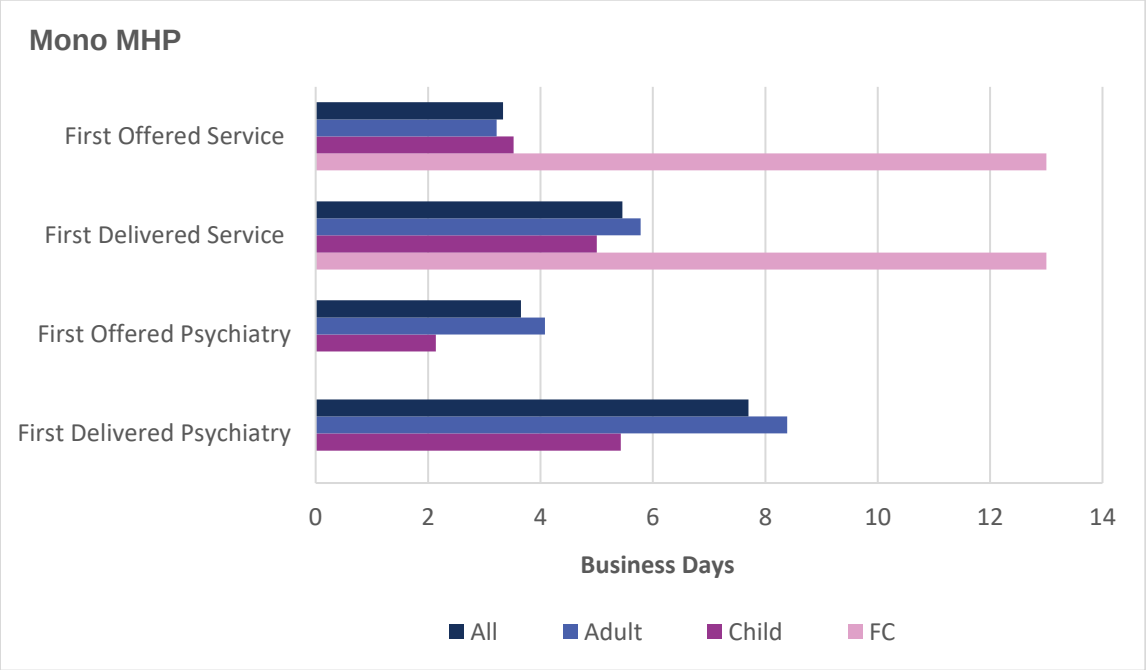


Figure 13: Wait Times for Urgent Services

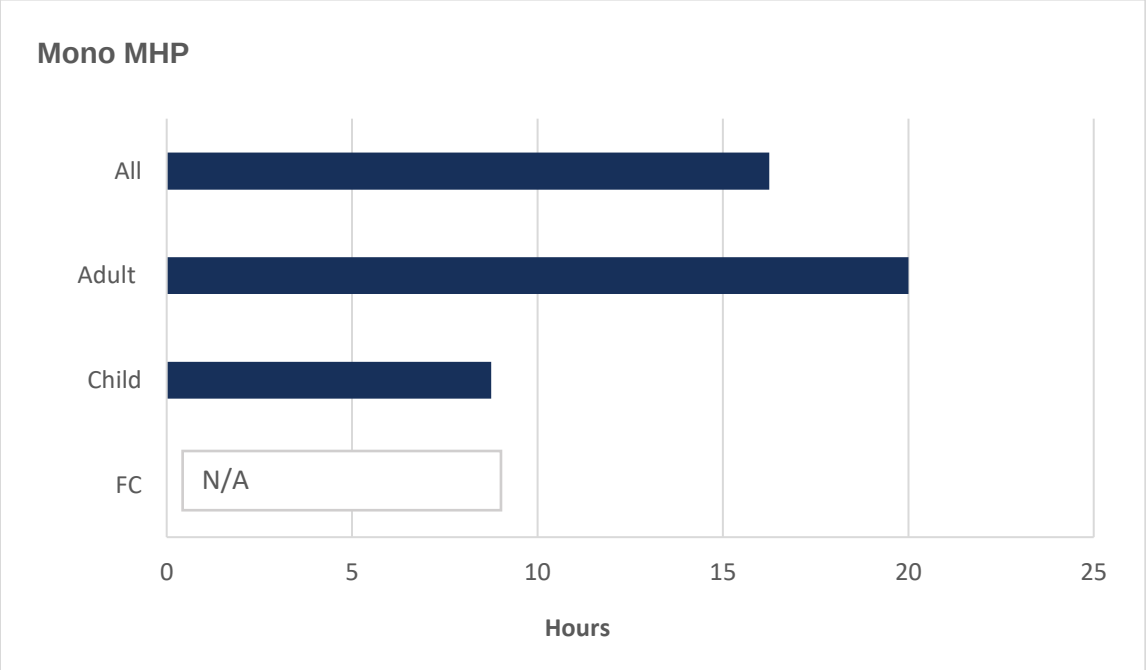
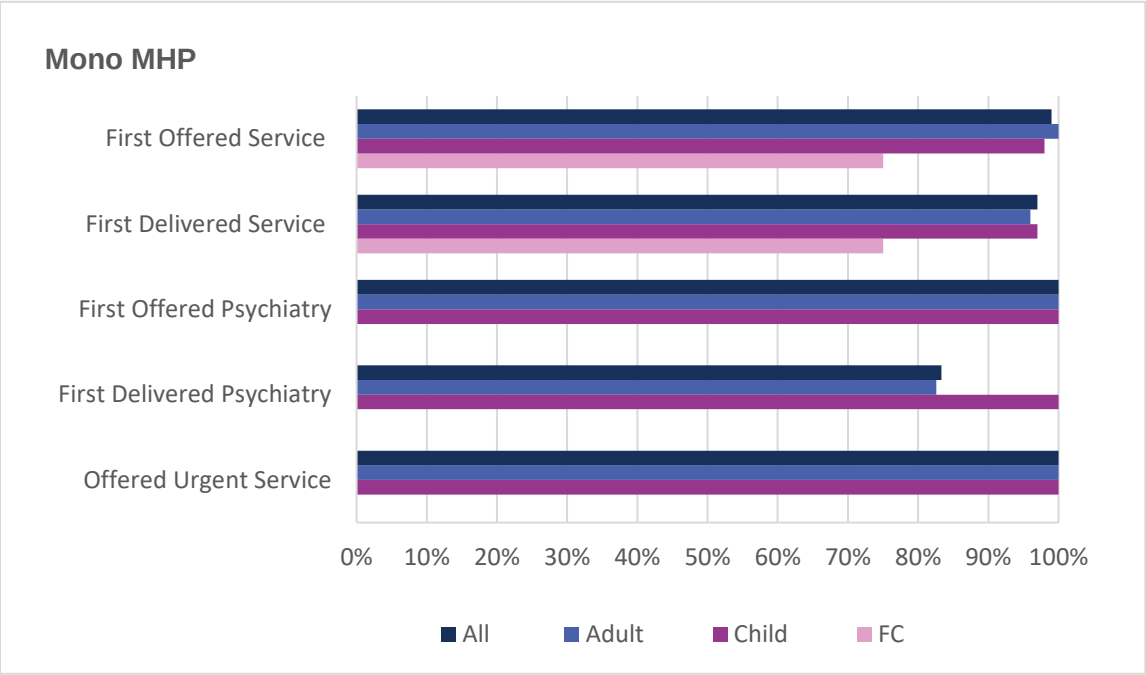


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned MH services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments and unscheduled assessments.
- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as a situation that without timely intervention is likely to result in an immediate emergency psychiatric condition. There were reportedly three urgent service requests with a reported actual wait time to services for the overall population at 16 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as from the first clinical determination of need.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 18 percent for psychiatrists and 15 percent for non-psychiatry staff. No-show data is unable to be separated due to EHR limitations.

IMPACT OF TIMELINESS FINDINGS

- The MHP provides intensive case management and MH services in the field, this has been beneficial to stabilize beneficiaries in the community and prevent hospital readmission. The MHP also has a notable 100 percent 7- and 30-day follow-up after psychiatric hospitalization.
- Tourist that encounter a mental crisis and seek services often leave shortly after receiving services which can create a skew in data when tracking timeliness for number of services delivered.
- As the MHP prepares for the new SmartCare, it is noted that data is only as valuable as what is entered. The MHP has an opportunity to evaluate all data requirements, what data collection is needed to report timeliness, create policies, and train staff on the expectations of collecting and entering data prior to the rollout of the new EHR.

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 quality assurance coordinator and two staff services analysts who facilitate data collection and reporting. The MHP does not have a QI unit. The QI program serves MCBH and includes SUD services. The quality assurance coordinator is also responsible for compliance. MCBH contracts with a consultant to provide support on policies, procedures, and compliance.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of MCBH staff primarily, including the director, clinical supervisor, accountant, and wellness center associate, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met monthly. The identified goals were met, partially met or not met. There MHP does not identify the percentage of met goals as the QAPI is a combination of MH and SUD goals. The MHP does identify a narrative explanation for each goal and items needed to address in the subsequent year. The MHP does not add impact to the beneficiaries for goals met. The goals are quantitative and do not include a qualitative evaluation.

The MHP utilizes the following level of care tool: None

The MHP utilizes the following outcomes tools: Child and Adolescent Needs and Strengths, Pediatric Symptom Checklist, Generalized Anxiety Disorder (GAD-7), Patient Health Questionnaire.

The MHP reports the clinical staff completes these tools with the consumers for the weekly or monthly monitoring of measurable goals to inform treatment and reach milestones.

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	Partially met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially met
3E	Medication Monitoring	Partially met
3F	Psychotropic Medication Monitoring for Youth	Not met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The MHP is housed in the same building as Child Welfare, Probation, and Public Health, this has led to open communication and collaboration across the SOC.
- The MHP, in efforts to support and retain staff has implemented a policy that does not allow an employee to work on their paid days off to encourage a work-life balance.
- The MHP has several peer staff throughout the department and Wellness Centers. There is not an official employment ladder, but peers can be promoted to case manager positions.
- Key informants reported not feeling welcome to attend the Behavioral Health Advisory Board (BHAB) meetings and would like to participate in QIC meetings to provide suggestions regarding systemic change and/or improvements.
- The MHP operates three Wellness Centers. Key informants relayed confusion on hours of operation, what community center was being used for activities and not being able to drop in for services. Some key informants indicated that they live in

their car and drive an additional 45 minutes to the neighboring county's Wellness Center to utilize offered meals, showers and the ability to wash laundry.

- The MHP performs standard service verification calls, however, key informants reported being fearful their information was being used to terminate staff, as several staff have left their positions.
- The county faces a transitory population that works at the winter resort. There is not adequate housing in the county and key informants expressed the MH challenges with subsistence living and living in their cars. The MHP is working with the county to address the housing issue and has secured 13 dedicated MH units within a new 400-unit complex.
- The MHP does not track and does not trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Though this measure is not met, the MHP did not identify any children or FC youth prescribed medication tracked by HEDIS and thus, did not track or trend the measures.

QUALITY PERFORMANCE MEASURES

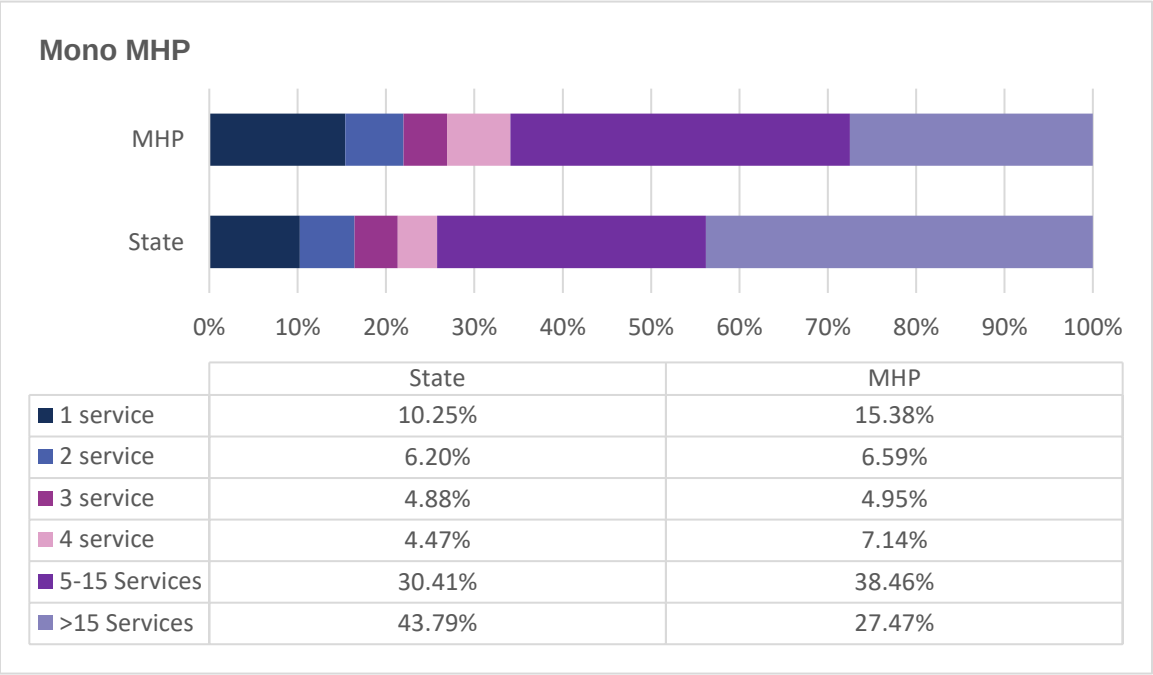
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs display the information as represented in 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 five or more services during a 12-month period. However, this table does not account for the length of stay, as individuals enter and exit care throughout the 12-month period.

Figure 15: Retention of Beneficiaries CY 2021



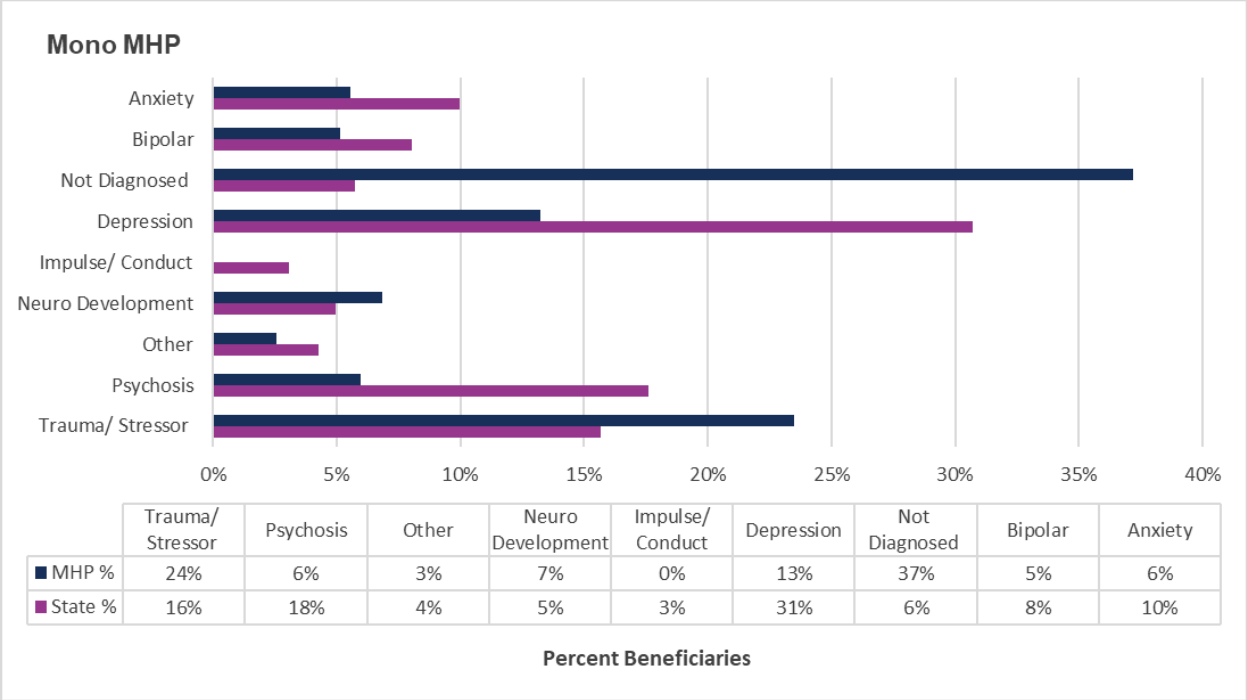
	State	MHP
1 service	10.25%	15.38%
2 service	6.20%	6.59%
3 service	4.88%	4.95%
4 service	4.47%	7.14%
5-15 Services	30.41%	38.46%
>15 Services	43.79%	27.47%

- The percentage of beneficiaries receiving one service and between 5-15 services is higher compared to the statewide percentage; however, the percentage of beneficiaries receiving over 15 services is noticeably lower compared to statewide.

Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures 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.

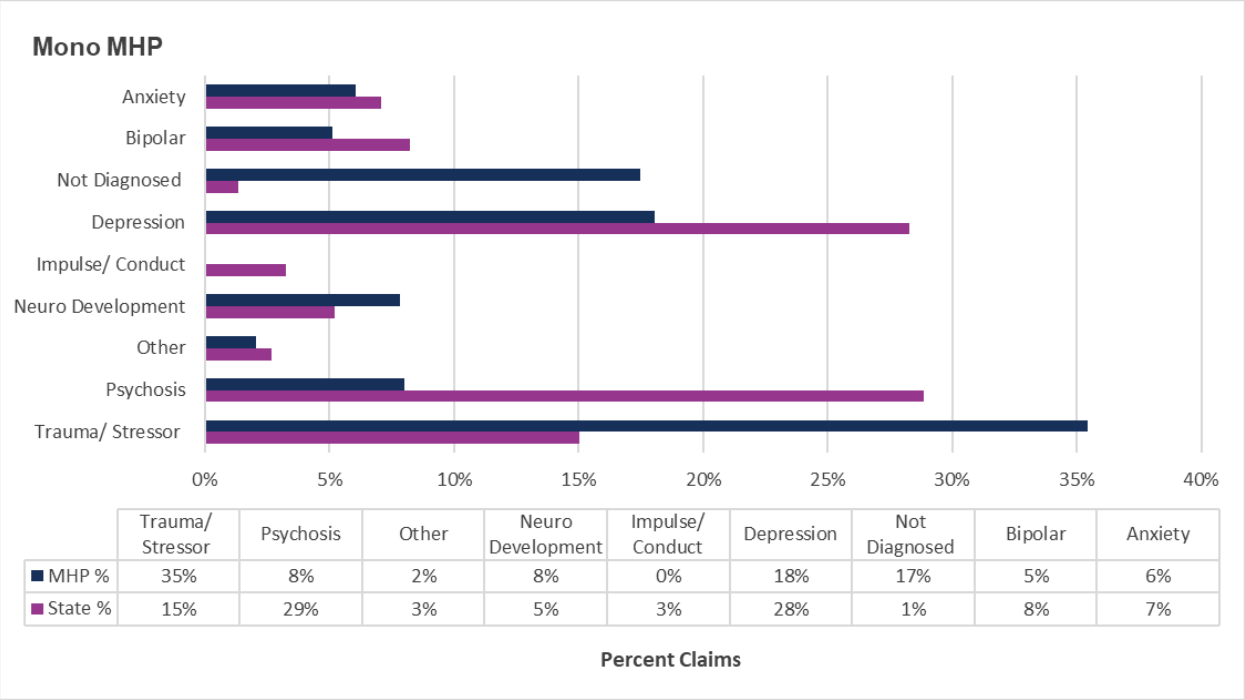
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	24%	6%	3%	7%	0%	13%	37%	5%	6%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The largest diagnostic category is Not Diagnosed, followed by Trauma/Stressors and then Depression. The large undiagnosed category is mainly attributed to a workflow issue and the entry of diagnosis into the EHR. The largest diagnostic category statewide is Depression, followed by Psychosis and then Trauma/Stressors.

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



- The distribution of approved claims is generally congruent with the diagnostic patterns displayed in Figure 16.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay (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	<11	<11	4.25	8.86	$6,072	$12,052	$24,286
CY 2020	<11	<11	7.00	8.68	$5,516	$11,814	$5,516
CY 2019	<11	<11	6.00	7.80	$5,494	$10,535	$16,483

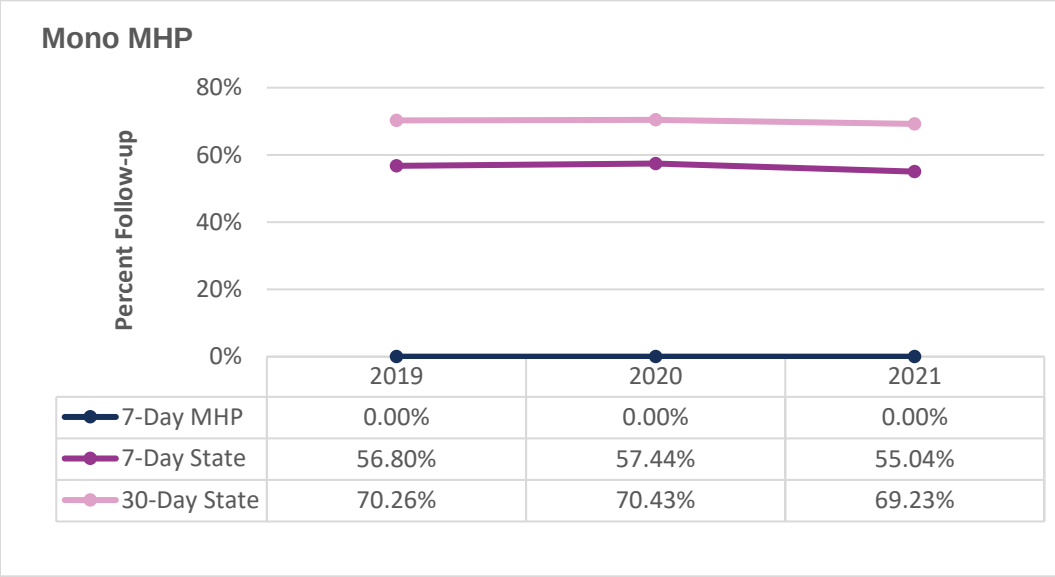
- The MHP's average LOS is about 4.5 days shorter than the statewide LOS. The AACB is equivalent to about half of the statewide AACB.

Follow-Up Post Hospital Discharge and Readmission Rates

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

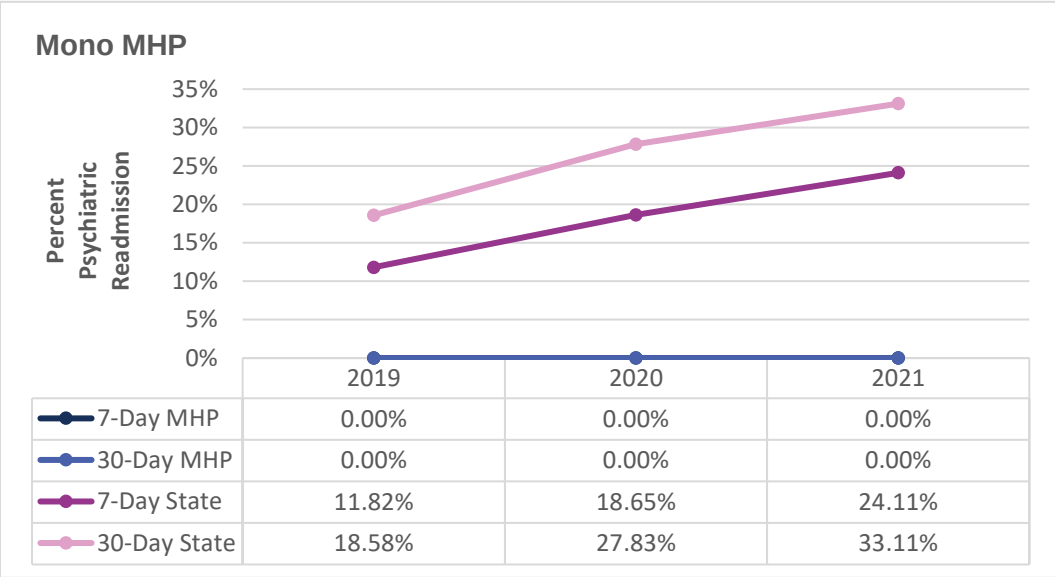
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	0.00%	0.00%	0.00%
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	0.00%	0.00%	0.00%
30-Day MHP	0.00%	0.00%	0.00%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- The MHP has no post psychiatric follow-up claims or readmissions within 7- or 30-days due to low utilization of these services. The MHP stated data was drawn from the Crisis and form, Crisis follow-up form and the EHR, which may contribute to the discrepancy between claims and reported ATA data.

High-Cost Beneficiaries

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

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

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, 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	<11	-	-	-	-	-
	CY 2020	0	0.00%	0.00%	$0	$0	$0
	CY 2019	0	0.00%	0.00%	$0	$0	$0

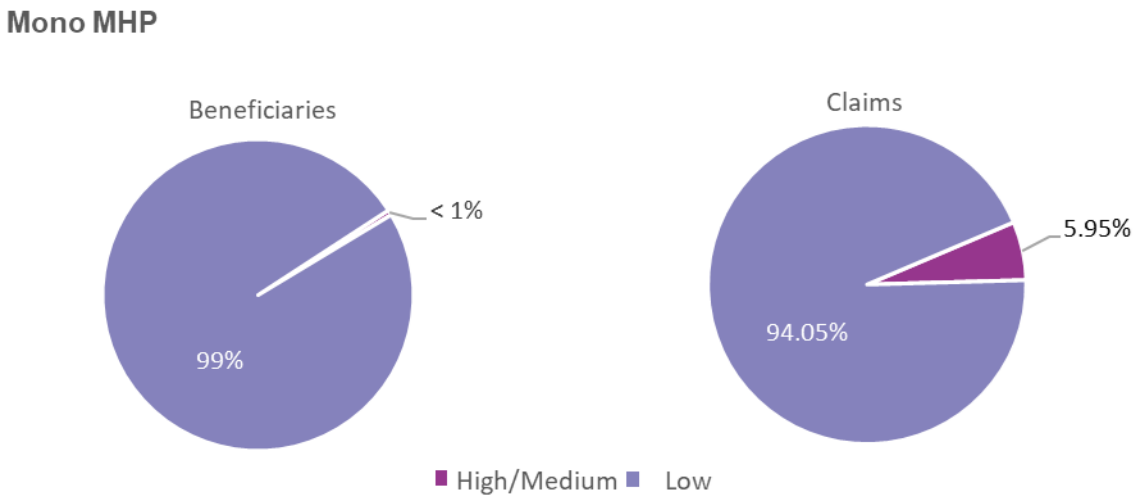
- Suppression rules have been applied for CY 2021; the state percentage is 4.50 percent.

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)	<11	-	-	-	-	-
Low Cost (Less than $20K)	181	99.45%	94.05%	$378,622	$2,092	$937

- Over 99 percent of beneficiaries fall into the low-cost category and about 50 percent of beneficiaries receive less than $937 in services. Suppression rules have been applied for the medium cost category.

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



- The majority of claims are in the low-cost category and less than 6 percent of claims are in the medium category.

IMPACT OF QUALITY FINDINGS

- The MHP reports an inefficient workflow design to enter diagnoses in the EHR is the leading cause for the large percentage of beneficiaries with No Diagnosis.
- Key informants do not utilize the Wellness Centers due to reported challenges in the times the centers are open and the varying location for activities. The large transitory population may benefit from MH services located in the Wellness Center and the opportunity to drop in as needed, perhaps avoiding a more significant crisis.
- There is unknown participation by beneficiaries in the local BHAB and QIC meetings. Understanding when the meetings take place and holding a meeting at the Wellness Center may be of value and include the voice of the beneficiaries.
- Key informants are fearful of truthfully reporting on services during the service verification calls, as there has traditionally been a high turnover in staff with a lack of warm hand off to a new case manager or clinician.

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: "Vitamin D Deficiency Case Management Linkage"

Date Started: 03/2023

Aim Statement: "As part of their treatment plans, improve client outcomes by providing clinical case management linkage to Primary Care Physician (PCP) appointments among MCBH clients who are on antipsychotic medications and have a Vitamin D deficiency (as indicated by serum laboratory results), with the goal of increasing the percent of clients who have GAD-7 score of nine or below from 0 percent to 60 percent by second follow-up at one year (a score of nine is categorized as mild anxiety.)"

Target Population: "The study population will include MCBH clients who are on antipsychotic medications, have a Vitamin D deficiency (as indicated by serum laboratory results), a GAD-7 score of ten or above, and have health-related case management linkage as part of their treatment plans."

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

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

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

Summary

The intervention in this PIP is clinical case management linkage to a PCP. In this intervention, the assigned Case Manager (CM) or Behavioral Health Services Coordinator (BHSC) will work with clients who meet the study population criteria to understand what barriers they may have around making and keeping their PCP appointments to discuss Vitamin D deficiency. Depending upon the needs of the clients and the goals in their treatment plans, the CM or BHSC may call with the client to make the appointment, follow-up with the client to check whether the appointment was kept, ensure the client will receive a reminder call or text from the PCP, provide transportation to the appointment, and/or go with the client to the appointment. This intervention is designed to help clients build their confidence and self-efficacy to access PCP appointments and their ability to follow-through and keep those appointments.

The PMs used will be the GAD-7 scores to measure whether anxiety decreases; and Vitamin D deficiency status, as Vitamin D supplementation is linked with improved anxiety symptoms (i.e., does the client still have a Vitamin D deficiency: Yes/No.)

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: there is a positive collaboration between the MHP and the PCP, with beneficiaries openly discussing MH and physical health with their case manager and PCP. As noted in the study, all participants have reported high anxiety scores on the GAD-7 and low vitamin D. The ability to increase self-efficacy and treat the whole person may indeed show promise in the proposed outcomes.

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

- The MHP worked closely with CalEQRO in the development of the PIP throughout the review period.
- Create a survey to provide participants with the ability to provide feedback on their identified improvement, the CM linkage, treatment of the whole person, and self-efficacy moving forward.
- Continue with CalEQRO TA as necessary throughout the timeline of the PIP.

NON-CLINICAL PIP

General Information

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

Date Started: 09/2022

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

Target Population: “The target population for this project will be operationalized within the parameters of the HEDIS FUM metric. MCBH will focus on beneficiaries with a qualifying event as defined in the FUM metric.”

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

Summary

The MCBH and hospital intend to partner to establish a more robust provider level intervention to improve care coordination post-discharge. This will be achieved with the specific intervention of the creation of a centralized ED referral process that allows for real-time referral coordination from the hospital ED, including functionality to generate alerts for high-risk / urgent needs and other key information. This intervention will aid in connecting the beneficiary with an appropriate agency (either the hospital BH, MCBH, or other) for after-care.

Process Measures include the completion of an interagency ED referral system between the hospital and MCBH (measured as YES or NO); the completion of the bi-monthly collaborative meetings between the hospital and MCBH, focusing on MH ED visit follow-ups (measured as YES or NO); and the percentage of ED visits for MH where the client received a follow up MH treatment service from the MHP within 7- or 30-days (FUM).

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the MHP has engaged the hospital ED in ongoing discussions around interagency referrals. There have been challenges in communication due to staffing changes at the hospital, but the MHP’s proactive approach to identifying forms and providing such forms to the hospital may elevate the hesitation from the hospital ED to engage in the sharing of beneficiary information.

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

- The MHP did not seek out TA from CalEQRO as this PIP was accepted in the first round of submission by DHCS.
- Due to staffing changes at the hospital, it is recommended the MHP engage at the director’s level to ensure ongoing communication continues.
- Provide the necessary consent form the hospital can use during their patient discharge paperwork and have a BH staff member pick up the forms daily or weekly as necessary to determine the need for FUM.

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 Echo, which has been in use for seven years. Currently, the MHP is actively implementing a new system, Streamline's Smartcare, with an anticipated go-live date of July 1, 2023, which requires heavy staff involvement to fully develop.

Approximately 4.48 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency. The IS budget allocation has increased from 2.9 percent the previous year.

The MHP has 40 named users with log-on authority to the EHR, including approximately 40 county staff and 0 contractor staff. Support for the users is provided by one FTE IS technology positions. Currently all positions are filled. There were no additional IS staff allocated since the previous EQR.

As of the FY 2022-23 EQR, contract providers are not available or used for service delivery therefore no contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table: Not applicable.

Table 16: Contract Provider Transmission of Information to MHP EHR

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

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 currently have a PHR for beneficiaries. A PHR is available with the new EHR and is included in the contract, however, the MHP was not certain if capacity existed to implement a PHR within the next year.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Not applicable.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The current EHR has limited functionality and report development by the vendor is cost prohibitive for the MHP. A new EHR, InSync, was selected and implementation began when InSync was bought by a different vendor, causing turmoil and disruption to implementation.
- The MHP has since elected to implement the semi-statewide EHR, Streamline's Smartcare, and is in the middle of implementation. A staff training plan has been developed and is scheduled to occur throughout the month of June 2023.
- The department has dedicated one FTE staff to provide IS support and oversee EHR implementation.
- Cross training occurred amongst fiscal staff to ensure staff can perform billing tasks if necessary and how-to desk guides of billing process were created.
- The MHP's claim denial rate of 2.24 percent is higher than the statewide rate of 1.43 percent.
- Security components are in place to ensure systems are secure, and security training exists ensuring staff are trained in security practices.
- The MHP has no contract providers to electronically exchange data with.

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.

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	53	$17,264	$0	0.00%	$16,013
Feb	63	$22,492	$223	0.99%	$15,859
Mar	250	$39,100	$0	0.00%	$36,697
April	264	$40,908	$1,815	4.44%	$37,224
May	236	$36,306	$0	0.00%	$35,407
June	268	$36,231	$0	0.00%	$35,370
July	205	$30,473	$493	1.62%	$29,401
Aug	266	$41,376	$2,825	6.83%	$38,284
Sept	262	$38,112	$0	0.00%	$37,970
Oct	241	$38,132	$0	0.00%	$37,470
Nov	229	$38,415	$851	2.22%	$37,025
Dec	178	$24,427	$2,834	11.60%	$21,569
Total	**2,515**	**$403,236**	**$9,041**	**2.24%**	**$378,289**

- The number of claims for the first two months of CY 2021 is lower because the MHP reports taking a conservative approach to Medi-Cal billing. Documentation training occurred in February 2021 and resulted in an increase of Medi-Cal claims the remainder of the year.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Late claim	18	$5,205	57.56%
Service line is a duplicate and a repeat service procedure code modifier not present	24	$3,179	35.15%
Medicare Part B must be billed before submission of claim	5	$659	7.29%
Total Denied Claims	**47**	**$9,043**	**100.00%**
Overall Denied Claims Rate	**2.24%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- Almost 60 percent of claim denials were due to late claims. The MHP reports the large percentage of denials occurred because EHR limitations required staff to manually void/replace services identified during the Triennial Audit and caused the untimely claim submission.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Implementing a new EHR with an anticipated go live date of July 1, 2023, is a very short period of time and a major undertaking requiring significant staff

resources to train and test to ensure fiscal and clinical operations are not negatively impacted.

- The current EHR's functionality and limited staff have made data analytics difficult and required the development of external tools to manually collect data; reporting and data analytics capability is expected to improve once the new EHR is implemented.
- The collaborative relationship between the department and IT ensures technology is in place to deliver services to/from remote areas of the county heavily impacted by weather and distance; it also makes effective collaboration and communication amongst staff possible.
- Telehealth delivery is robust across the county however current EHR limitations made telehealth service delivery untrackable, and thus unreportable.
- The MHP has contracted with CalMHSA to perform billing functions when the new EHR is implemented, which should help provide continuity of claiming processes.
- Providing documentation training for staff increased service claims and Medi-Cal revenue.
- The MHP successfully tested file production of 274 Provider Network Data Reporting and continues to submit monthly files to comply with state reporting requirements.

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 provides the required CPS forms. Due to the low number of responses the MHP does not get useful information from the report. The MHP is unable to use the information to improve their SOC and is recommended the MHP create a more useful survey they can provide to all beneficiaries when receiving services.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

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

Consumer Family Member Focus Group One

CalEQRO requested CFM FG of a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held in person and virtual and included six participants. All consumers participating receive clinical services from the MHP.

The group included those that have received services within the past year and several who have been in services for up to 15 years. Overall, the past year showed progress in clinician stability and a great deal of case manager support, which was appreciated by all. None of the participants were aware of transportation and most received in-home or telehealth services. All agreed they were not aware of crisis numbers or Wellness Center activities. Stating, the Wellness Centers were not consistently open or moved locations of activities so much they did not know where to find the local activities. A few mentioned utilizing the Wellness Center in the neighboring county as there were more services available such as drop in, meals, showers, and laundry. A few participants were among those that worked during the winter months at the resort and did not have

adequate housing instead living out of their cars. Further stating, they did not know how to regulate in a crisis or have a crisis number to call. Those that had been in services longer than a year vocalized abrupt change in services if staff leaves, with no transition for the beneficiary. All would like to be able to provide input or opinions to the SOC but felt the BHAB did not welcome them, nor did they participate in QIC meetings. All participants mentioned the friction between law enforcement and the MH community. They all felt they had a say in their treatment plans and felt services have improved their health.

Recommendations from focus group participants included:

- “Law enforcement needs CIT training.”
- “Partnership with clients, show how county includes clients.”
- “The Wellness Center needs improvement.”
- “ Provide emergency information packet or crisis management information. Even for those that opt for telehealth.”

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall, the beneficiaries were pleased with the services they received and were all very appreciative of their case managers. They unanimously agreed the Wellness Center needed to be improved and consistent in availably and services. All participants mentioned not being provided a crisis number or what to do if they were waiting for a clinical appointment and needed to manage their crisis. Some voiced concern about clinicians leaving and not being provided with a transition to a new clinician. All participants voiced the desire to participate in meetings such as the BHAB or QIC. And all voiced the adversarial relationship with the local police department and individuals with a MH condition or homelessness.

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 synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. Prioritizing a flexible teleworking policy has helped with recruitment and contributed to the department becoming fully staffed, including the addition of Spanish speaking staff. (Access, Timeliness, Quality)
2. The MHP's use of technology and collaborative relationship with IT ensures service delivery to beneficiaries and makes communication amongst staff possible when met with weather and distance challenges. (IS)
3. Housing options have been a priority for the MHP for several years and a new complex is currently being constructed to include 13 dedicated MH and No Place Like Home beds, which will provide supportive housing. (Access, Quality)
4. Peers are integrated into the SOC, including two certified peers and one peer being promoted to case manager. (Quality)
5. The MHP has increased Medi-Cal revenues by implementing billing and productivity standards, changes in minute rate and assigned a point person to work on errors and other billing issues. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP conducts service verification calls to inform quality and service compliance. Key informants report feeling fearful they are being used to check-up on clinicians as there has been a high turnover of clinicians in the past. Key informants further express the fear their clinician would leave or be terminated because of the verification calls. (Quality, IS)
2. There are three Wellness Centers across the county with services also provided in a variety of community centers. Key informants have expressed the lack of consistency and lack of knowledge of when to attend a Wellness Center activity and when the center is open, has deterred them from using the Wellness Center. Key Informants further report utilizing the Wellness Center in a neighboring county as that center provides open hours for drop-in activities, as well as providing meals, the ability to shower, and wash laundry. (Access, Quality)
3. Key informants reported a wait time of up to two months for an appointment after their initial access and during this time, being unsure of what to do in a crisis, not receiving clear information about the website, crisis phone number to call, or how to manage stress. The MHP has increased their staffing levels, which decreases

wait times, but does not address the clear need of beneficiaries to receive and understand orientation material, Wellness Center options, website information, and crisis phone numbers. (Access, Timeliness, Quality)

4. The MHP has acknowledged flaws in their data reporting and collecting system, opting to join the CalMHSA, SmartCare EHR collaborative. The MHP is advised to identify how it will ensure timeliness data is collected while staff are trained and data input begin in the new system, to continue the continuity of data collection and reporting. (Timeliness, IS)
5. An inefficient workflow process allows only administrative staff to enter diagnosis into the EHR and results in one-third of beneficiaries not having a diagnosis. (IS)

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. Create a standard introduction and survey when making service verification calls to ensure beneficiaries are clear on the purpose of the call; and ensure continuity of care should a clinician leave employment. (Quality, IS)
2. Provide a consistent schedule and location for ease of access to Wellness Centers activities; and investigate the feasibility of expanded hours to allow for drop-in activities such as cooking, showers, laundry, and MH services. (Access, Quality)
3. Provide an orientation for new beneficiaries, including those that opt for telehealth services, that fully informs the beneficiaries of the website, Wellness Centers, and crisis services and phone numbers. (Access, Timeliness, Quality)
4. Utilize a tracking system for all required timeliness data metrics to ensure all timeliness data is tracked and accurately reported while awaiting the installation and training on the new SmartCare EHR. (Timeliness, IS)

   (This recommendation is a carry-over from FY 2021-22.)
5. Create a workflow that allows clinical staff to enter timely and accurate beneficiary diagnostic information into the EHR to ensure accurate clinical documentation and service claims. (IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2022-23 EQR.

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 – Mono MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Analysis of the Plan's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Perceptions of Care
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Specialized Service Systems: <e.g., Homeless Outreach; STRTP; Crisis Residential, Crisis Stabilization; Forensics>
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Clinical Management and Supervision
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Information Systems Billing and Fiscal Interview
EHR Deployment

CalEQRO Review Sessions – Mono MHP
Telehealth
Wellness Center Site Visit
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Kiran Sahota, PhD, Lead Quality Reviewer
Rita Samartino, Information Systems Reviewer
Gloria Marrin, Consumer/Family Member Reviewer

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

MHP County Sites

Mono County Civic Center
1290 Tavern Road, Suite 276
Mammoth Lakes, CA 93546

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Addis	Dirk	Wellness Center Associate	MCBH
Baires	Luisana	Behavioral Health Services Coordinator	MCBH
Ballard	Jake	Case Manager	MCBH
Bonneau	Richard	SUD Counselor	MCBH
Burditt	Dylan	Psychiatric Specialist	MCBH
Castelan	Edgar	Wellness Center Associate	MCBH
Cruz	Jenna Lynne	Behavioral Health Services Coordinator	MCBH
Cruz	Laura	Staff Services Analyst	MCBH
Cruz	Moncerrath	Staff Services Analyst	MCBH
Curiel	Esmeralda	Behavioral Health Services Coordinator	MCBH
Duran	Iris	Fiscal Technical Specialist	MCBH
Greenberg	Amanda	Program Manager	MCBH
Hathaway	Betty	Wellness Center Associate	MCBH
Lee	Jimmy	Quality Assurance/Improvement Coordinator	MCBH
Li	Han	Psychiatric Specialist	MCBH
Lopez	Kimberly	Psychiatric Specialist	MCBH
Mejia	Stephany	Quality Assurance Coordinator SUD	MCBH

Last Name	First Name	Position	County or Contracted Agency
Montanez	Salvador	Behavioral Health Services Coordinator	MCBH
Murray	Danielle	Staff Services Analyst	MCBH
Niculescu	Adriana	Clinical Supervisor	MCBH
Plum	Lauren	Staff Services Analyst	MCBH
Ramos	Jesica	Case Manager	MCBH
Roberts	Robin	Behavioral Health Director	MCBH
Rodriguez	Tajia	Case Manager	MCBH
Stewart	Debra	SUD Supervisor	MCBH
Toledo	Maria	Staff Services Analyst	MCBH
Workman	Jessica	Staff Services Manager/Accountant	MCBH

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	There is a positive collaboration between the MHP and the PCP, with beneficiaries openly discussing mental health and physical health with their case manager and PCP. As noted in the study, all participants have reported high anxiety scores on the GAD-7 and low vitamin D. The ability to increase self-efficacy and treat the whole person may indeed show promise in the proposed outcomes.
General PIP Information	
MHP/DMC-ODS Name: Mono	
PIP Title: "Vitamin D Deficiency Case Management Linkage"	
PIP Aim Statement: : "As part of their treatment plans, improve client outcomes by providing clinical case management linkage to Primary Care Physician (PCP) appointments among MCBH clients who are on antipsychotic medications and have a Vitamin D deficiency (as indicated by serum laboratory results), with the goal of increasing the percent of clients who have GAD-7 score of 9 or below from 0 percent to 60 percent by second follow-up at one year (a score of 9 is categorized as mild anxiety.)"	
Date Started: 03/2023	
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): "The study population will include MCBH clients who are on antipsychotic medications, have a Vitamin D deficiency (as indicated by serum laboratory results), a GAD-7 score of 10 or above, and have health-related case management linkage as part of their treatment plans.)"
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): To attend PCP appointment to have blood taken to determine Vitamin D count.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): PCP and Psychiatrist will educate the participant in the benefits and importance of Vitamin D health.
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): MHP will provide case management to assist participants in self-efficacy while engaging in physical health care to improve MH.

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
PM 1. GAD-7 scores	Data drawn from Q1: 1/1/23-3/31/23	0/5 clients have a score of 9 or below	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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
PM 2. Vitamin D deficiency (Y/N)	Data drawn from: 1/1/23-3/31/23	N=5 0% of clients have NO Vitamin D deficiency	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

•The MHP worked closely with CalEQRO in the development of the PIP throughout the review period.

•Create a survey to provide participants with the ability to provide feedback on their identified improvement, with the CM linkage, treatment of the whole person, and self-efficacy moving forward.

•Continue with CalEQRO TA as necessary throughout the timeline of the PIP.

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 engaged the hospital ED in ongoing discussions around interagency referrals. There have been challenges in communication due to staffing changes at the hospital, but the MHP's proactive approach to identifying forms and providing such forms to the hospital may elevate the hesitation from the hospital ED to engage in the sharing of beneficiary information.

General PIP Information
MHP/DMC-ODS Name: Mono
PIP Title: "Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)"
PIP Aim Statement: "For Medi-Cal beneficiaries with Mammoth Hospital ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with MCBH within 7 and 30 days by 5% by June 30, 2023."
Date Started: 09/2022
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): "The target population for this project will be operationalized within the parameters of the HEDIS FUM metric. MCBH will focus on beneficiaries with a qualifying event as defined in the FUM metric."

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): Mammoth hospital will provide information on patients who are released that qualify under the HEDIS FUM measure to the MHP.
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): MHP will engage Mammoth Hospital in conversations to engage in the sharing of information on hospital patients that may need FUM.

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
The percentage of ED visits for MH where the client received a follow up MH treatment service from the MHP within 7-days (FUM).	2021	36 percent	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
The percentage of ED visits for MH where the client received a follow up MH treatment service from the MHP within 30-days (FUM).	2021	64 percent	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: •The MHP did not seek out TA from CalEQRO as this PIP was accepted in the first round of submission by DHCS. •Due to staffing changes at the hospital, it is recommended the MHP engage at the director's level to ensure on going communication continues. •Provide the necessary consent form the hospital can use during their patient discharge paperwork and have a BH staff member pick up the forms daily or weekly as necessary to determine the need for FUM.

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.