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

MONTEREY FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

March 22-23, 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, "Monterey" may be used to identify the Monterey County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — March 22-23, 2023

MHP Size — Medium

MHP Region — Bay Area

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	1	2	2

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	3	0	3
Quality of Care	10	1	7	2
Information Systems (IS)	6	3	3	0
TOTAL	**26**	**10**	**11**	**5**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Risk Assessment Screening and Subsequent Services	Clinical	01/23	Planning Phase	Low
Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	Non-Clinical	09/22	Planning Phase	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other	4
2	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	7

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has a higher 7- and 30-day post-hospitalization follow-up rate compared to the state's average rate.
- The MHP AACB for Asian/ Pacific Islander beneficiaries is higher than similarly OCP.
- The MHP's updated website provides a user-friendly interface available in multiple languages.
- The MHP successfully provides beneficiaries with a high rate of case management.
- MHP collaboration with primary care (PC) continues to advance which can improve quality of MH care.

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

- The MHP does not measure timeliness to key access service points such as first appointment and first-psychiatry appointments.
- The MHP does not have systemwide reports on medication monitoring including reports as part of SB 1291.
- There is a need for communication, awareness, and participation regarding QM goals systemwide.

- Communication and collaboration with the county psychiatric inpatient hospital needs to be established.
- The MHP does not have an Operations Continuity Plan (OCP).
- The IS budget allocation and filled positions do not appear adequate to sustain and improve IS operations.

Recommendations for improvement based upon this review include:

- Obtain and use valid and reliable timeliness data that direct QI and capacity management for first appointment and psychiatry services.
- Implement ways including reports to examine medication monitoring systemwide, including foster care youth, as per SB 1291.
- Increase communication and collaboration organization wide to all staff and stakeholder groups including QI priorities.
- Evaluate barriers to communication and coordination with Natividad Hospital psychiatric inpatient and conduct QI.
- Develop an OCP that includes behavioral health services' disaster recovery and contingency plans.
- Evaluate the IS budget allocation and consider how to create an increase in order to sustain and improve IS operations.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2022-23 findings of the EQR for Monterey County MHP by BHC, conducted as a virtual review on March 22-23, 2023.

REVIEW METHODOLOGY

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

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation 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 network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during/ the Coronavirus Disease 2019 (COVID-19) pandemic, and a flood the week prior to the review that required staff to assist in community interventions. The MHP is also operating under the workforce crisis and a 24 percent vacancy rate with the shortage concentrated in clinical staff. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- For workforce planning, the MHP has begun to focus on becoming a training organization and is in the planning phase. Functions will include supervision academies, leadership training and an expanded psychiatric social work internship program.
- The MHP restructured the administration – expanding to four Deputy Director roles to balance the workload.
- The MHP continued system-integration work to incorporate co-occurring substance use disorders treatment capability system wide. Partners include hospitals, contract providers, and advocacy organizations.
- The MHP is instituting California Advancing and Innovation Medi-Cal (CalAIM) milestones and accessing California Mental Health Services Authority (CalMHSA) assistance. The MHP reports that data exchange remains the most challenging element.
- To advance integration with PC, the MHP hired three Wellness Navigators, peers with lived serious mental illness experience, employing one at each MHP regional clinic. Building a new PC and MH integrated health center in East Salinas also began with anticipated completion in fall 2023.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: Evaluate the IS budget allocation and consider how to create an increase in order to sustain and improve IS operations.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP did not evaluate or increase the IS budget, but rather focused on filling vacancies. The MHP filled an information specialist position that had been vacant since 2019. A management analyst position and an epidemiologist position became vacant this last year, further straining its capacity.
- This recommendation is not addressed because the issue of relatively low IS resources remains and the MHP has not advanced its assessment of the IS operations team. To address this recommendation, the MHP should evaluate its relatively low IS resources and assess the IS budget allocation for improved IS operations.
- This recommendation is carried over to FY 2023-24.

Recommendation 2: Prioritize developing, testing, and implementing a way to collect timeliness data that can confidently direct QI and capacity management for first appointment and psychiatry services.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP formed a monthly workgroup, New Client Form, with seven members including Access and other managers, to improve collection of a form the MHP uses to collect timeliness data. The workgroup met seven times and a document review of the workgroup minutes does not show progress toward solving the problem. The MHP should consider reaching out to other MHPs or other groups who effectively measure timeliness to learn how they are doing it.
- The QI Workplan FY 2021-22 Evaluation reports that only 36 percent of the new client forms expected were completed. The MHP continues to lack reliable data to monitor access and timeliness.
- This recommendation is partially addressed for beginning efforts, however, there is no clear plan to address this central component to QM, measuring time to first appointment and psychiatry services among other access points. This recommendation is carried over to FY 2023-24.

Recommendation 3: Evaluate the QM structure and communication. Include input from various levels of staff and divisions to identify consistent and clear understanding of QI priorities and goals organization wide. Share progress towards goals including data.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- In the last year, the MHP began holding quarterly all-staff meetings where the Behavioral Health Deputy Director communicates information on initiatives, changes, resources and legislation. The MHP did not increase bi-directional communication.
- Review discussions indicate no change in the continued need to disseminate quality-related priorities and involve levels of the organization in QI. This recommendation is partially addressed because the MHP did not evaluate the QM structure or communication and did not increase QI communication.
- This recommendation is carried over to FY 2023-24.

Recommendation 4: Implement medication monitoring for youth, including foster care youth, as per SB 1291, and complete the process to begin medication monitoring for adults in the EHR.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP reports working with the IT department to create an MD assessment and MD progress note form. The MHP reports that the limitations of the EHR is a primary barrier.
- The MHP does not have goals related to medication services or monitoring in the FY 2022-23 QI Work Plan. The MHP reports continuing to conduct peer review in foster-care services. Summary or compilation of medication monitoring performance were not evident.

- This recommendation is not addressed because there is not a clear plan to implement medication monitoring, including system tracking and monitoring. This recommendation is carried over to FY 2023-24.

Recommendation 5: Review the pre-claiming process and primary denial reasons in order to decrease the denial rate.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP investigated the primary reasons for high denials and determined that beneficiaries not being Medi-Cal beneficiaries was the most common reason for denials.
- This is difficult to address at the time of billing, as the service has already been rendered and a claim generated. The MHP has added a step before claims submission which requires a review of the most current Medi-Cal eligibility files and removes claims without Medi-Cal.
- This process is not completely failsafe, as the MHP reports the claims volume being high and IS is understaffed.
- CalEQRO's CY 2021 data confirms that Medi-Cal ineligibility was the biggest reason for denial, but the overall denial rate was considerably lower than the state's average rate.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 70 percent of services were delivered by county-operated/staffed clinics and sites, and 30 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 81 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: CalWORKs, schools, and other community-based sites. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The MHP operates Access sites in four regions: Coastal, North Region, South Region, and Salinas Valley. Beneficiaries complete a screen by the Access sites then receive an evaluation completed by either Access or a program. Beneficiaries are then assigned to a program for services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 2,107 adult beneficiaries, 2,176 youth beneficiaries, and 346 older adult beneficiaries across 13 county-operated sites and 39 contractor-operated sites. Among those served, 700 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

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

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

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

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

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

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

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

- 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 from the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

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

Table 2: Access Key Components

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

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

- The MHP completed updating its website to improve disseminating information to beneficiaries.
- The MHP has an extensive Cultural Competence Plan. Evaluation of the implementation and outcomes of activities is not evident. The cultural competence committee was active in the last year but paused meetings as contract provider participation decreased - likely related to staff vacancies.
- The MHP is developing an Equity and Diversity Workplan using an organizational assessment.
- The MHP created a new position beginning FY 2023-24 dedicated to outreach, and also began contracting with promotoras from community providers to conduct outreach due to high vacancies at the MHP.
- The MHP limits clinic hours to traditional 8-5 and is a barrier to working individuals and families, especially the Latino/Hispanic community. Stakeholders suggest evening and weekend hours to improve access.
- Provider discussions revealed a need and desire to conduct outreach to Hispanic/Latino, monolingual communities, but lack of time, structure and support to do so are barriers.

- The coordination between Natividad Hospital, the county hospital in Salinas, and the MHP outpatient systems for the continuity of voluntary and involuntary crisis care is reported to experience coordination and systematic communication gaps. It is not clear how the MHP monitors, tracks, trends, and perform process improvement of the crisis care continuum but the MHP is in the early stages of forming an Adult Post Hospital Team to coordinate care for beneficiaries age 25+.
- While the system allots “emergency” psychiatry appointments for beneficiaries who are discharged from a hospital or other urgent needs, accessing appointments is reported to be difficult and can result in other beneficiaries’ scheduled appointments needing to be moved and creating a month or more delay.
- Access to services is delayed. Review discussions show that time to a child assessment is four to eight weeks. Reported wait lists to services ranged from 10 to over 100 individuals at some programs. Capacity for therapy services appears to be the most challenging. Similar to input on acute services, stakeholders identified a need for referral management and coordination of care.

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, Monterey’s PR has stayed approximately the same as the state for three years.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	207,332	8,667	4.18%	$76,030,492	$8,772
CY 2020	187,630	8,462	4.51%	$76,201,960	$9,005
CY 2019	184,612	8,859	4.80%	$69,315,346	$7,824

- The MHP's PR has slowly declined between CY 2019-21. While it served less beneficiaries in the first year of the COVID-19 pandemic, CY 2020, the following year in CY 2021, the drop in PR was due to a more than 10 percent increase in the number of Med-Cal eligible beneficiaries. The total approved claims increased from CY 2019-20 but remained flat in CY 2021.

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	24,732	258	1.04%	1.08%	1.96%
Ages 6-17	55,373	2,680	4.84%	4.41%	5.93%
Ages 18-20	11,969	550	4.60%	3.73%	4.41%
Ages 21-64	102,082	4,850	4.75%	4.11%	4.56%
Ages 65+	13,178	329	2.50%	2.26%	1.95%
Total	**207,332**	**8,667**	**4.18%**	**3.67%**	**4.34%**

- Like the overall PR, the MHP's PRs for different age groups are close to the corresponding state PR. There is a significant difference for the 6-17 age group for which the state PR is 22.5 percent higher than the MHP. However, the MHP's PR in every age group was higher than the corresponding similar size counties' average PR, except for the 0-5 age group.
- The MHP's PR for 65+ is 28 percent higher than the state and 11 percent higher than the similar size county PR.

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	2,600	30.00%
Threshold language source: Open Data per BHIN 20-070		

- Spanish is the MHP's only threshold language and accounts for 30 percent of the beneficiaries served.

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	46,966	2,248	4.79%	$16,817,288	$7,481
Medium	613,796	20,261	3.30%	$151,430,714	$7,474
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.
- The MHP's ACA PR is slightly higher than its overall PR and higher than the ACA PRs statewide and for medium sized MHPs.
- The MHP's ACA AACB is 15 percent lower than its overall ACB, but higher than the state average, and similar to the medium sized MHP average.

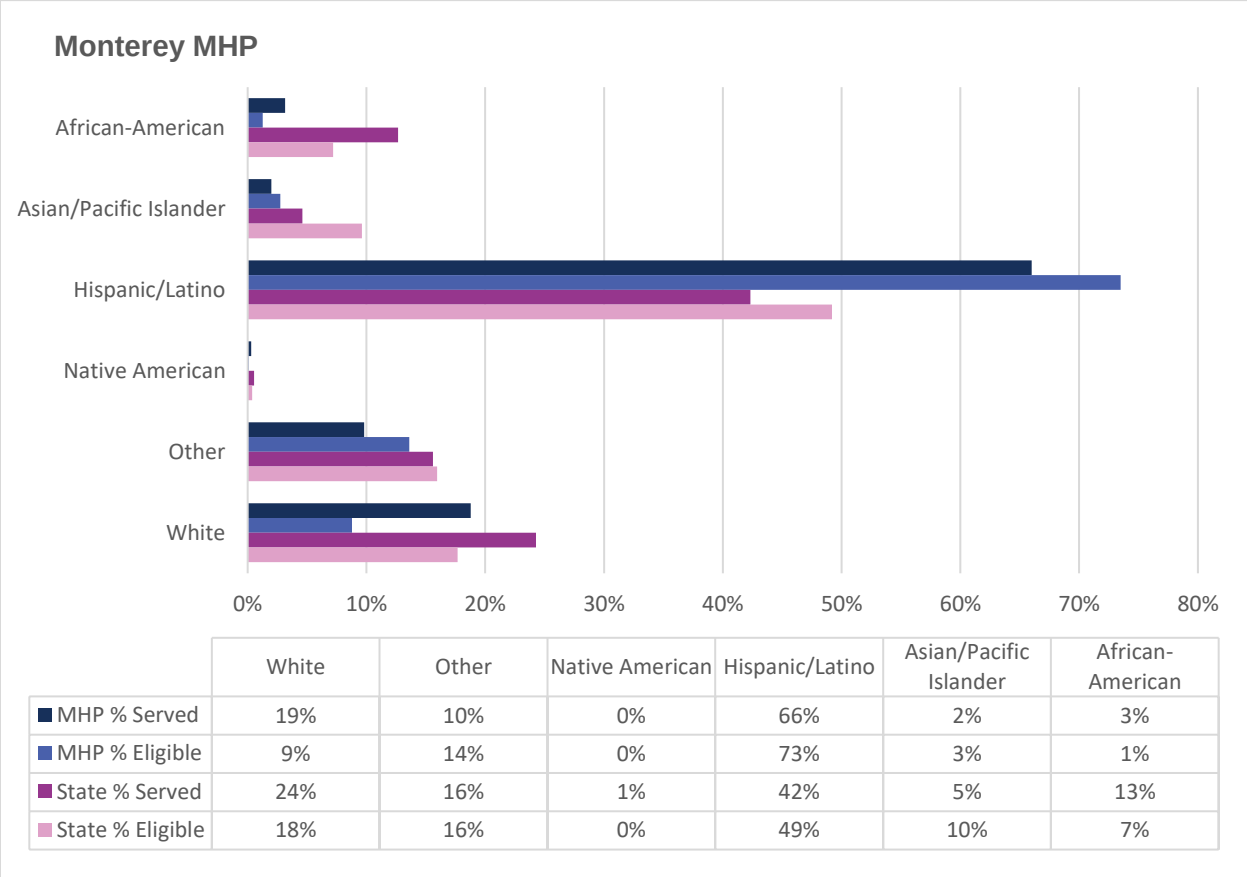
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions 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	2,640	273	10.34%	7.64%
Asian/Pacific Islander	5,673	172	3.03%	2.08%
Hispanic/Latino	152,384	5,720	3.75%	3.74%
Native American	187	25	13.37%	6.33%
Other	28,218	850	3.01%	4.25%
White	18,233	1,627	8.92%	5.96%
Total	**207,335**	**8,667**	**4.18%**	**4.34%**

- The MHP's Latino/Hispanic PR is the same as the corresponding state PR and the Other PR is lower than the state average. The other race/ethnicity PRs are much higher than the corresponding state PRs.

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



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	19%	10%	0%	66%	2%	3%
MHP % Eligible	9%	14%	0%	73%	3%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

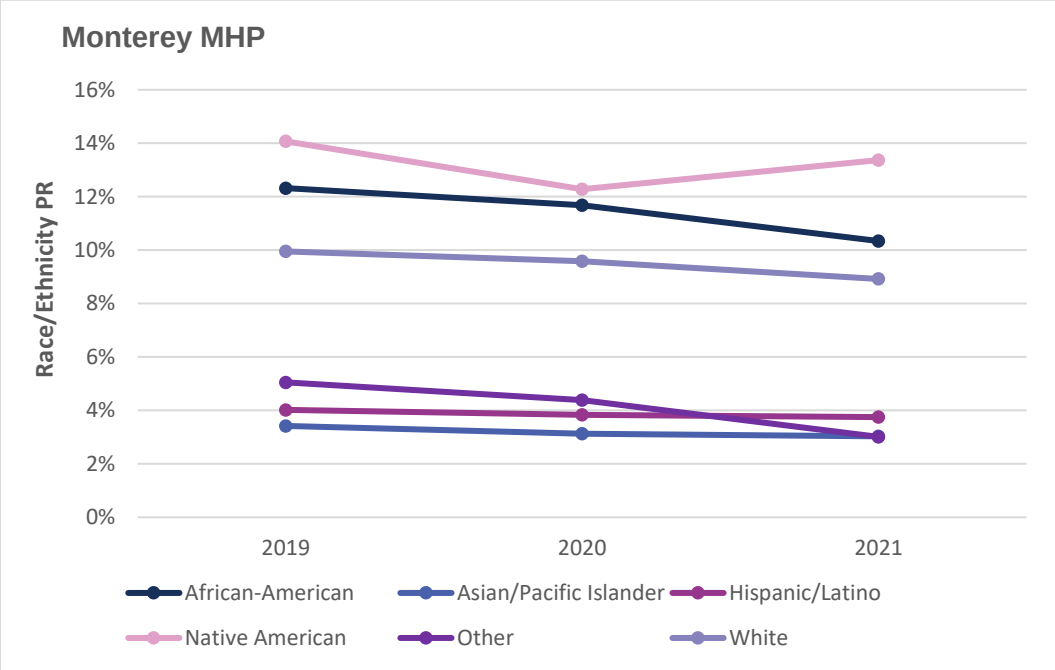
- Monterey's Medi-Cal eligible population's race/ethnicity distribution is different from the state's distribution. For instance, the percentage of White eligibles is half

that of the state, while the Latino/Hispanic eligibles are 24 percentage points higher than the state.

- The Latino/Hispanic beneficiaries served is also 24 percentage points higher than the state, while the percentage of White beneficiaries served is 5 percentage points lower than the state average.

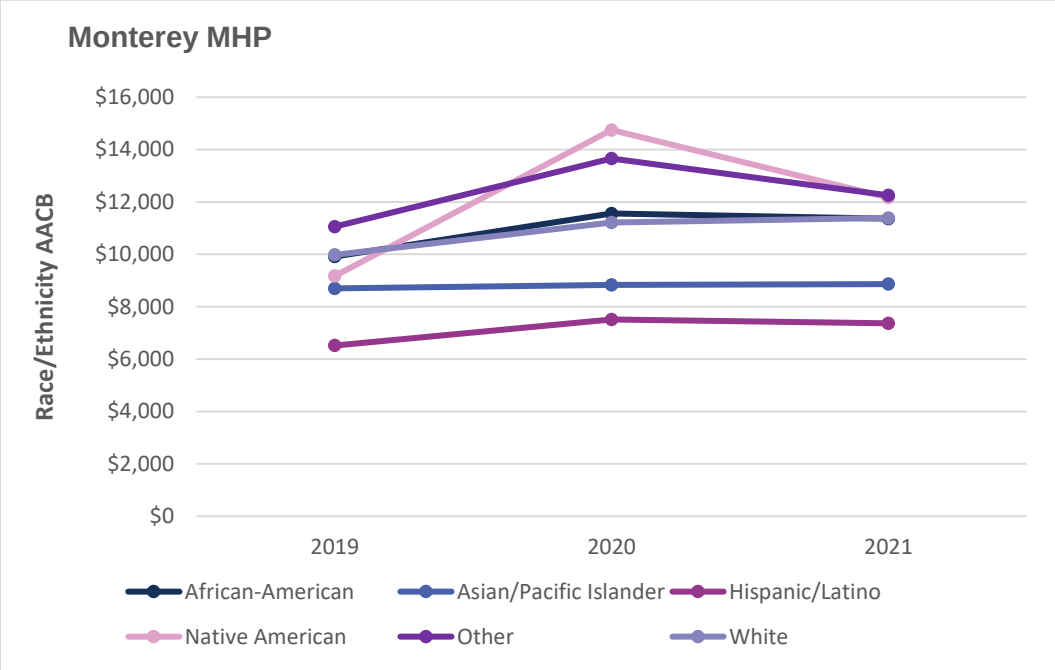
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



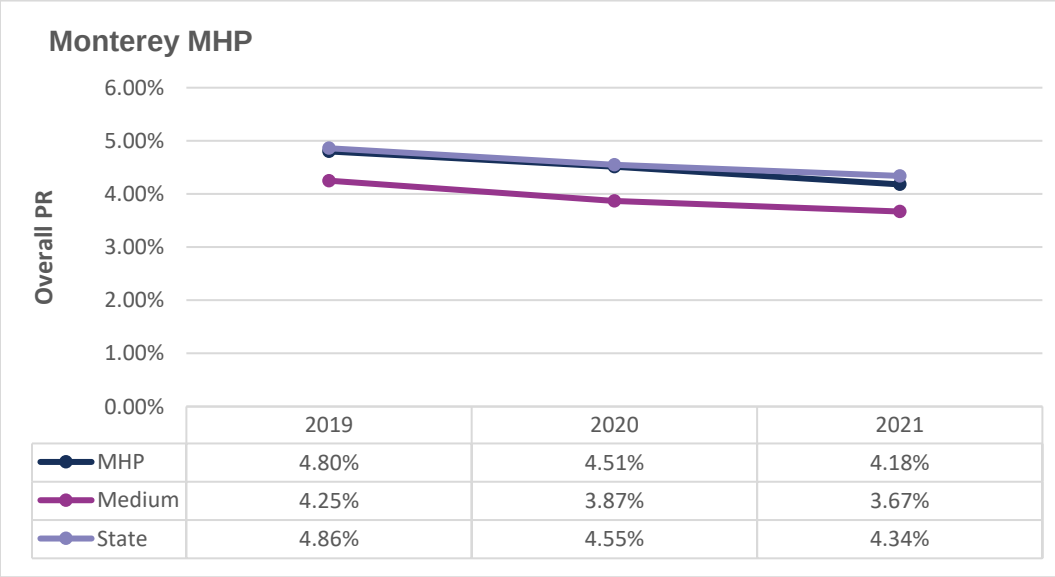
- Monterey's PR by race/ethnicity is in two distinct groups of trend lines. Those with higher penetration rates include the African-American and White beneficiaries (consistently above 8 percent). Those with similarly lower penetration rates (consistently around or below 4 percent) include the Hispanic/Latino, Asian/Pacific Islander, and Other categories.

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



- The AACB varies between different race/ethnicity groups, but there was little variation in their rankings during CY 2019-21. The Other AACB was the highest followed by White, African-American, and Asian/Pacific Islander AACB. The Hispanic/Latino AACB was the lowest. Although the Native American AACB appears the highest in CY 2020, it is based on a very low number of beneficiaries.

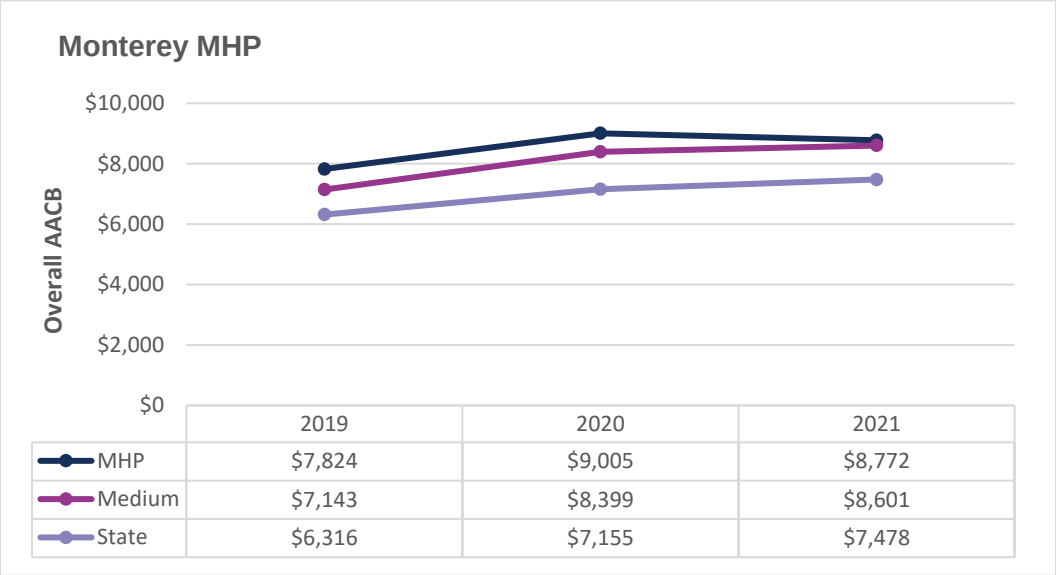
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.80%	4.51%	4.18%
Medium	4.25%	3.87%	3.67%
State	4.86%	4.55%	4.34%

- Monterey's overall PR was consistently close to the state PR during CY 2019-21 and was consistently higher than the other medium sized counties by the same margin during this period.

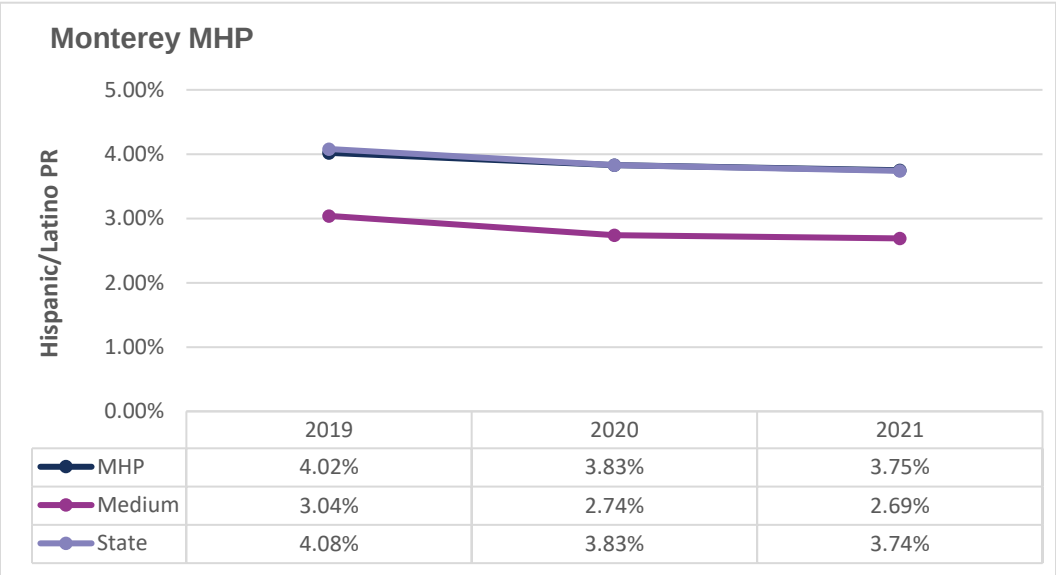
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$7,824	$9,005	$8,772
Medium	$7,143	$8,399	$8,601
State	$6,316	$7,155	$7,478

- In CY 2021, the MHP's AACB was similar to the medium sized county average and was 17.3 percent higher than the state AACB. The MHP's AACB slightly declined from CY 2020.

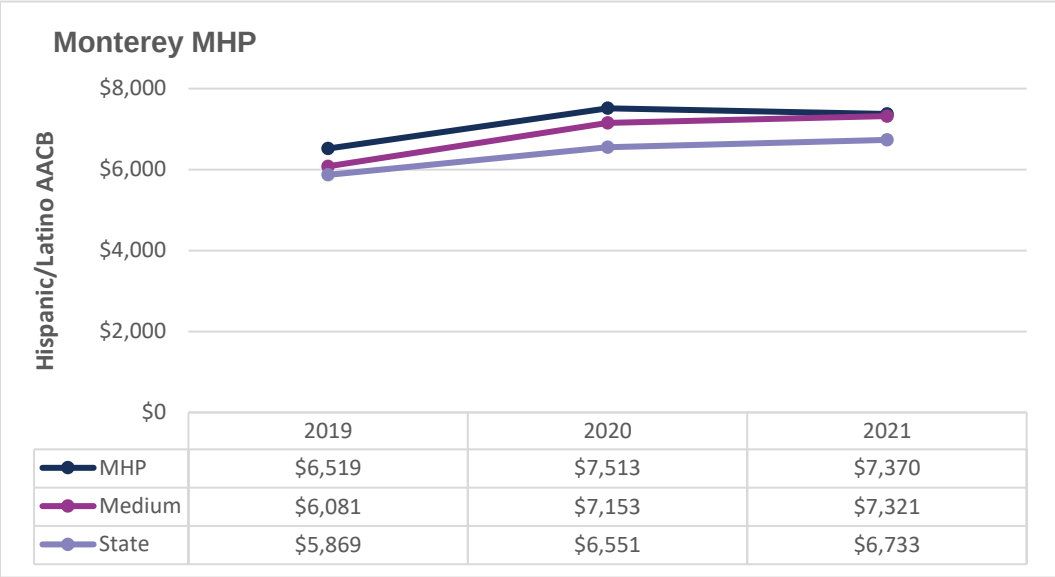
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	4.02%	3.83%	3.75%
Medium	3.04%	2.74%	2.69%
State	4.08%	3.83%	3.74%

- Like the overall PR, the MHP's Latino/Hispanic PR was the same as the state and higher than the medium MHP average each year during CY 2019-21.

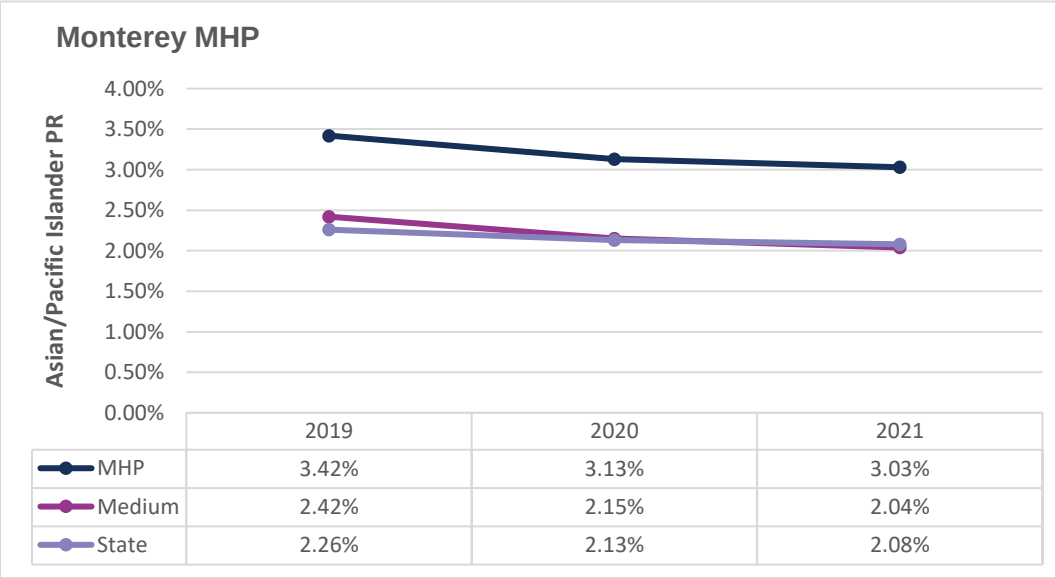
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$6,519	$7,513	$7,370
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

- The Hispanic/Latino AACB trendline is very similar to the overall AACB trend line. The MHP's Hispanic/Latino AACB in CY 2021 was nearly the same as the medium sized MHP average and higher than the state's average. Although the trend was similar, the MHP's Hispanic/Latino AACB was 16 percent lower than its overall AACB.

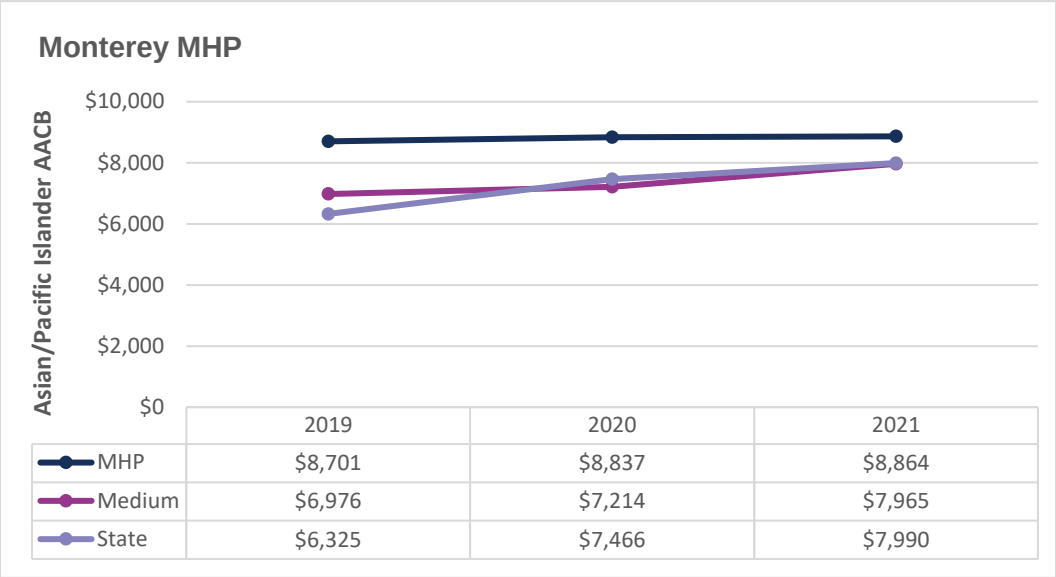
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	3.42%	3.13%	3.03%
Medium	2.42%	2.15%	2.04%
State	2.26%	2.13%	2.08%

- The MHP's Asian/Pacific Islander PR has been a third higher than both the state and medium sized county averages during CY 2019-21. However, the Asian/Pacific Islanders account for only 2 percent of the MHP's beneficiaries served (Fig.1).

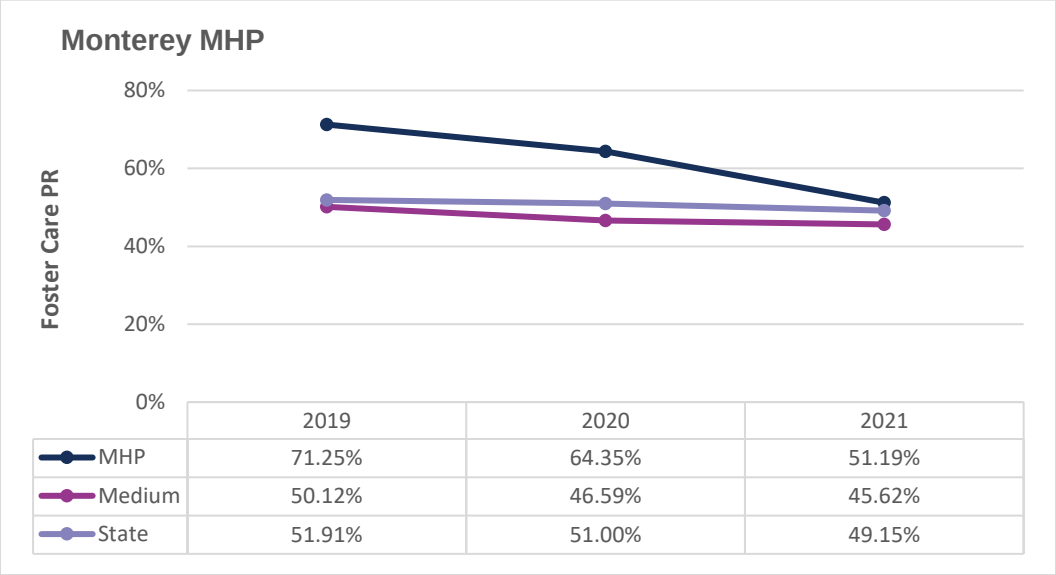
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$8,701	$8,837	$8,864
Medium	$6,976	$7,214	$7,965
State	$6,325	$7,466	$7,990

- The MHP's Asian/Pacific Islander AACB was consistently higher than the state and medium size county averages during CY 2019-21.

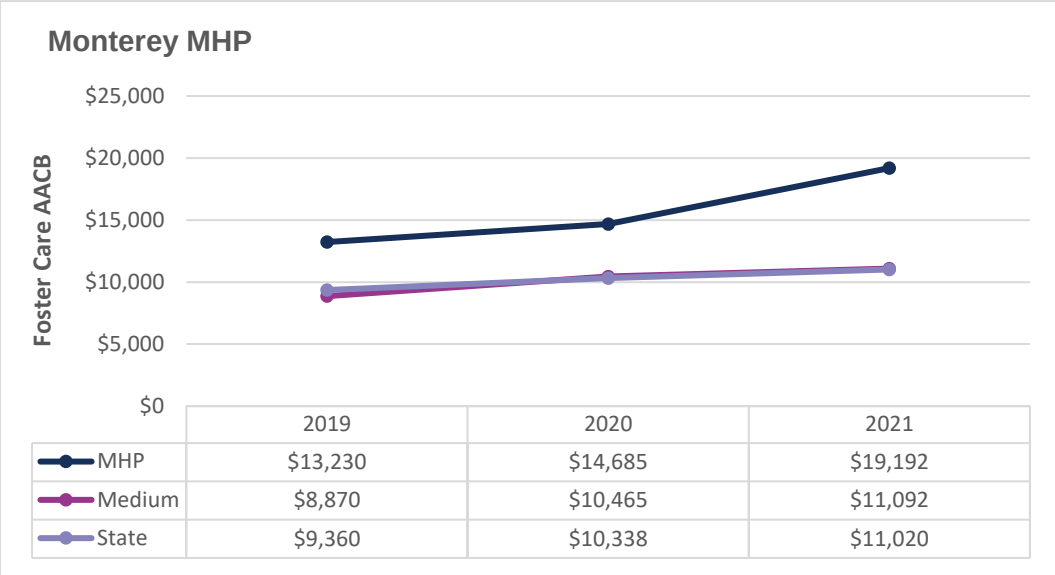
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	71.25%	64.35%	51.19%
Medium	50.12%	46.59%	45.62%
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 decreased by 20 percentage points. This is primarily due to a 44 percent reduction in the count of FC beneficiaries served between CY 2019-21.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$13,230	$14,685	$19,192
Medium	$8,870	$10,465	$11,092
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased each year.
- The MHP's FC AACB increased by 45 percent during CY 2019-21 and was 73 percent higher than the state and medium size county averages.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 5,731				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	527	9.2%	11	7	11.6%	16	8
Inpatient Admin	25	0.4%	42	4	0.5%	23	7
Psychiatric Health Facility	<11	-	4	5	1.3%	15	7
Residential	46	0.8%	97	80	0.4%	107	79
Crisis Residential	168	2.9%	39	32	2.2%	21	14
Per Minute Services							
Crisis Stabilization	76	1.3%	1,457	1,200	13.0%	1,546	1,200
Crisis Intervention	1,155	20.2%	283	185	12.8%	248	150
Medication Support	2,495	43.5%	364	250	60.1%	311	204
Mental Health Services	3,194	55.7%	933	395	65.1%	868	353
Targeted Case Management	4,495	78.4%	471	161	36.5%	434	137

- The MHP's inpatient utilization, including psychiatric health facilities, was lower than the state average. It also utilized crisis stabilization only a tenth of the time as the state average.
- The MHP's crisis intervention rate is 58 percent higher than the state rate for this service.
- While the MHP provided lower percentages of its beneficiaries with medication support and mental health services than the state, it provided targeted case management at twice the rate as the state average.
- The MHP's rate for case management is more than double the state rate for adults. Similarly, for beneficiaries overall in CY21, the MHP's case management PR is also more than double the state and is 76 percent greater than the similar size MHP rate.

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

Service Category	MHP N = 193				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	-	18	15	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	<11	-	1,050	1,050	3.1%	1,404	1,200
Crisis Intervention	21	10.9%	345	199	7.5%	406	199
Medication Support	50	25.9%	444	398	28.2%	396	273
TBS	13	6.7%	4,862	5,531	4.0%	4,020	2,373
Therapeutic FC	<11	-	2,138	2,138	0.1%	1,030	420
Intensive Care Coordination	82	42.5%	946	358	40.2%	1,354	473
Intensive Home Based Services	29	15.0%	2,949	1,253	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	183	94.8%	2,223	1,299	96.3%	1,854	1,108
Targeted Case Management	171	88.6%	806	343	35.0%	342	120

- The MHP provided slightly more Intensive Care Coordination than the state and lower Intensive Home Based Services to its FC beneficiaries. It provided more than twice the percentage of beneficiaries with Targeted Case Management than the state. In CY 2021, the MHP rate for case management (45.36 percent) is 85 percent higher than the similarly sized MHP rate (24.57 percent) and more than double the average state rate (17.18 percent).
- The MHP's rate for TBS is 68 percent higher than the state rate. In CY 2021, the MHP's TBS (3.45 percent) rate is 60 percent greater than the medium sized MHP rate (2.16 percent) and 77 percent higher than the state rate (1.95 percent).

IMPACT OF ACCESS FINDINGS

- The MHP's service system focused on case-management services may contribute to the lower rate of inpatient services beneficiaries utilized.
- While the MHP's FC PR has declined, which also reflects fewer FC beneficiaries served, FC beneficiaries served receive a high rate of case management and intensive individualized services such as TBS. This may also factor into the low rate of inpatient services.
- The crisis continuum of care is reportedly impacted by a lack of systematic access, treatment and discharge communication and coordination between the outpatient (OP) systems and Natividad Hospital. The OP continuum of care is impacted by delays accessing clinical and psychiatric care.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Not Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Not Met
2C	Urgent Appointments	Not Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- The MHP met its 7-day follow-up standard post hospital discharge for 60 percent of beneficiaries, and for 75 percent of beneficiaries within 30 days. The MHP is developing a team dedicated to post-hospital follow-up for adult beneficiaries with

a mental health or alcohol or other drug disorder diagnosis who are discharged from emergency departments.

- The data reported for initial access to care (n=482) is acknowledged to be a subset of the population that sought services from the MHP. Data sampling methods were not used. The EQR is not able to validate the metrics reported in the Assessment of Timely Access for these categories, as the number of beneficiaries contained in the data represents very few individuals.
- Data for psychiatry access and urgent care is essentially absent, with only a few clients reported for each metric. While there is a screen in the EHR to collect this information, it is rarely completed.
    - The MHP has a standard of 15 days to a first offered psychiatry service but reported data for only seven beneficiaries. Report discussions indicate delays occur for psychiatric appointments.
    - Similarly, the MHP measurements for urgent services indicate only 10 service requests for children and 29 for adults. Data associated with this access point are measured in days rather than hours, are also affected by the absence of key dates/times, and the limited results are not monitored for responsiveness to urgent needs.
- The MHP standard for non-psychiatry staff no-shows is 15 percent and the MHP rate is 9 percent. The MHP standard for psychiatry no-shows rate is 15 percent and the MHP performance is 17 percent. As part of the QIWP, the intervention appears limited to considering reinstituting reminder text software that had been in place in the past.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of CY 2022. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care. As reported earlier, the MHP has incomplete data for time to first appointment offered and rendered, first psychiatry service offered and rendered, and urgent service.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	4 Days	10 Business Days*	88%
First Non-Urgent Service Rendered	16 Days	10 Business Days**	93%
First Non-Urgent Psychiatry Appointment Offered	***	15 Business Days*	***
First Non-Urgent Psychiatry Service Rendered	***	15 Business Days**	***
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	122 Hours	48 Hours*	44%
Follow-Up Appointments after Psychiatric Hospitalization	25 Days	7 Days**	60%
No-Show Rate – Psychiatry	17%	15%**	n/a
No-Show Rate – Clinicians	9%	15%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: CY 2022			

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

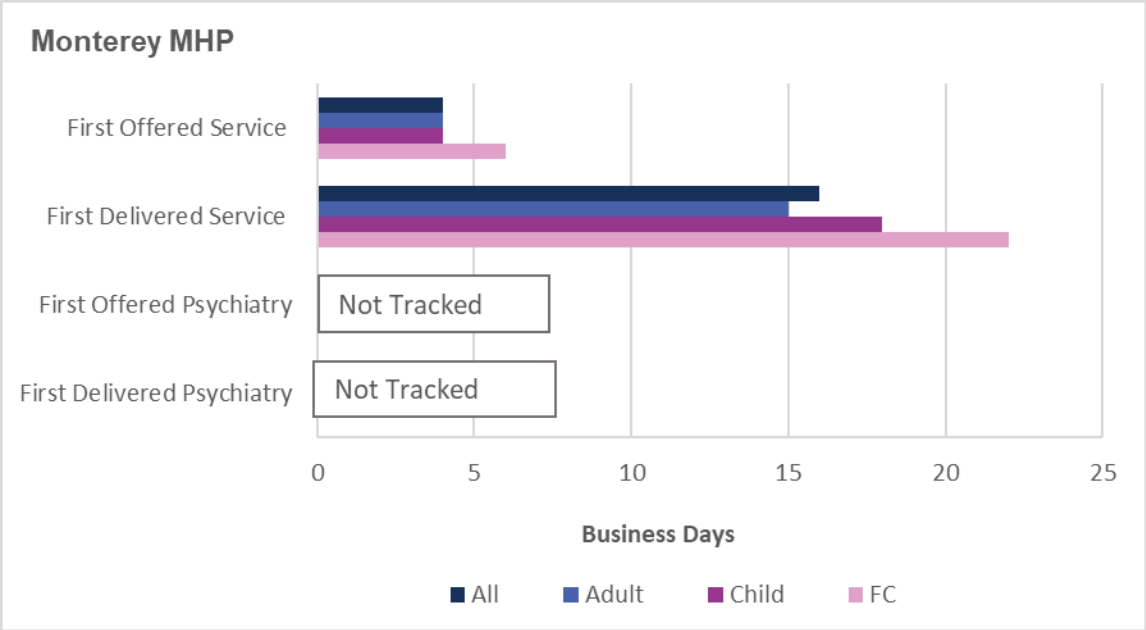


Figure 13: Wait Times for Urgent Services

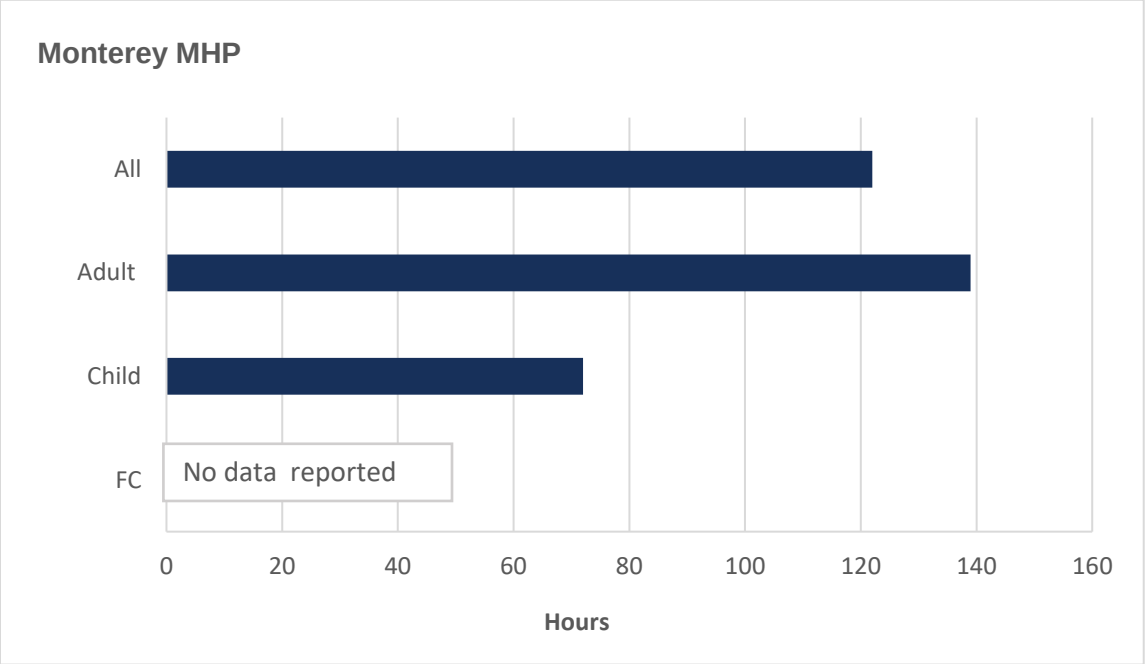
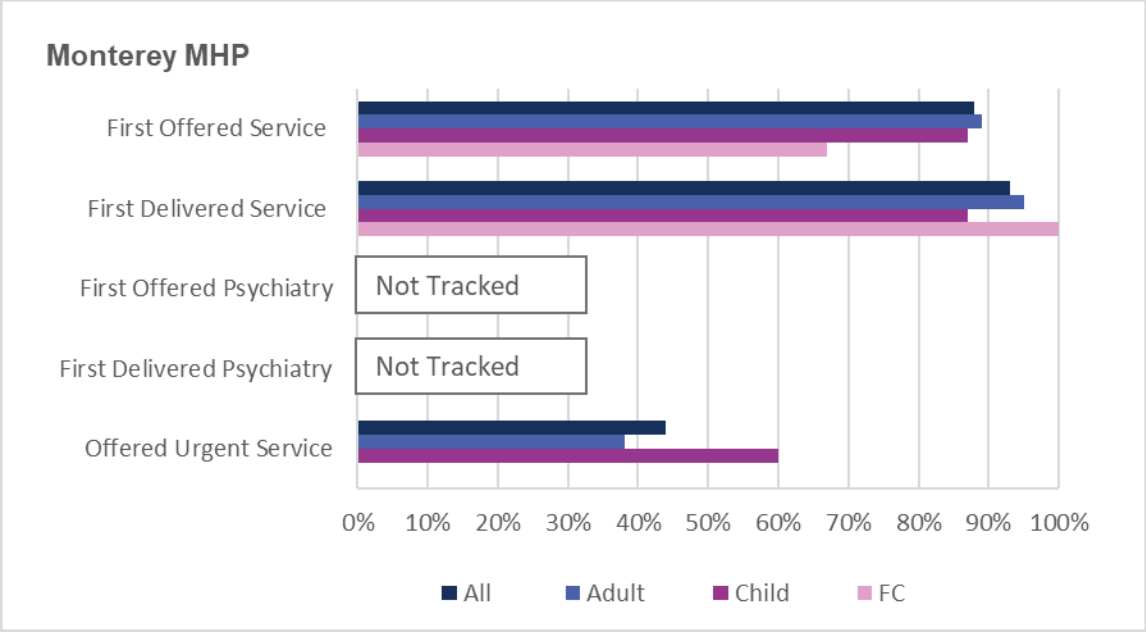


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled 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 noted as urgent by the beneficiary. There were reportedly 39 urgent service requests with a reported actual wait time to services for the overall population at 122 hours. These findings are reported to be an incomplete data set for urgent service need.
- 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 time from a beneficiary’s initial service request.

IMPACT OF TIMELINESS FINDINGS

- Because the MHP does not collect the information needed to measure timeliness for a majority of key services, access and capacity management information for decision-making is largely unavailable for QM. The measurements reported by the MHP for initial access appointments offered and rendered are not consistent with the longer wait times reported by stakeholders.
- The MHP’s increasing number of eligibles and broader CalAIM eligibility for assessments will make the importance of timeliness information more critical to obtain and use routinely.

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 held by the QI Manager who oversees QI and QA/Compliance. The QI Program encompasses SMHS, SUD, and integrated care components.

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 MHP and ODS staff and stakeholders is scheduled to meet quarterly Since the previous EQR, the MHP QIC met four times. Of the 13 identified FY 2021-22 QAPI workplan goals, the MHP assessed having met 60 percent of goals. Baselines that specify MHP performance are not consistently stated, and remeasurements are not included. Therefore, the goals are not clear. The outcomes of the QI activities conducted are also not reported.

The MHP utilizes the following level of care (LOC) tools: Reaching Recovery, Child and Adolescent Needs and Strengths (CANS). The MHP does not conduct aggregate analysis or examine improvement over time. Dashboards that had included this information in the past are not populated or used at this time.

The MHP utilizes the following outcomes tools: Reaching Recovery, CANS, and the 9-Question Patient Health Questionnaire (PHQ-9).

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	Partially 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	Not Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The MHP continues to offer peer-run wellness centers for adults and TAY in its largest population areas. However, a formal way to inform beneficiaries how to access peer-run programs is not in place.
- The MHP does not demonstrate a systematic organization-wide approach for improving overall access, timelines, and quality of care using continuous QI approaches. The MHP's QIWP and QI Work Plan Evaluation does not demonstrate established QM functioning. Reliable and routine data are not available. The MHP system is comprised of a continuum of care. Referral management and routinely tracking transitions in care on an aggregate basis are areas to develop.
- While outcome tools are used, the MHP does not aggregate, track, or trend the information on a beneficiary or system level.
- The MHP continues to have a written policy outlining a psychotropic medication monitoring plan. Mechanisms to track and trend measures related to diagnoses, medication practices, and care standards were not demonstrated.
- The MHP does not track or 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):

QUALITY PERFORMANCE MEASURES

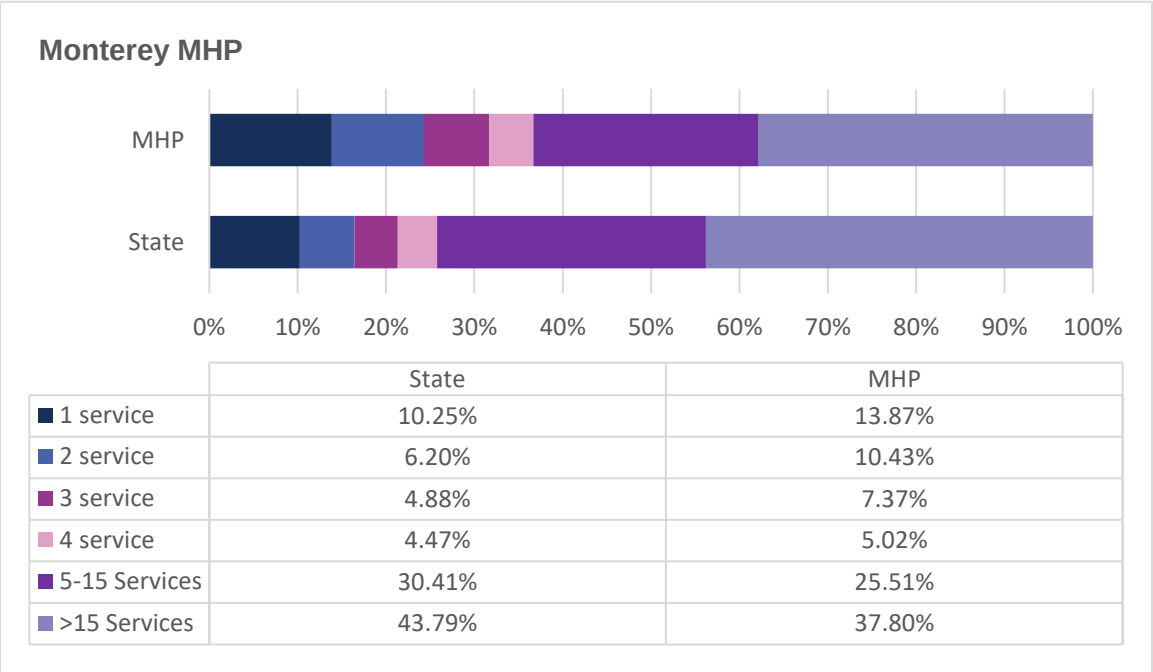
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



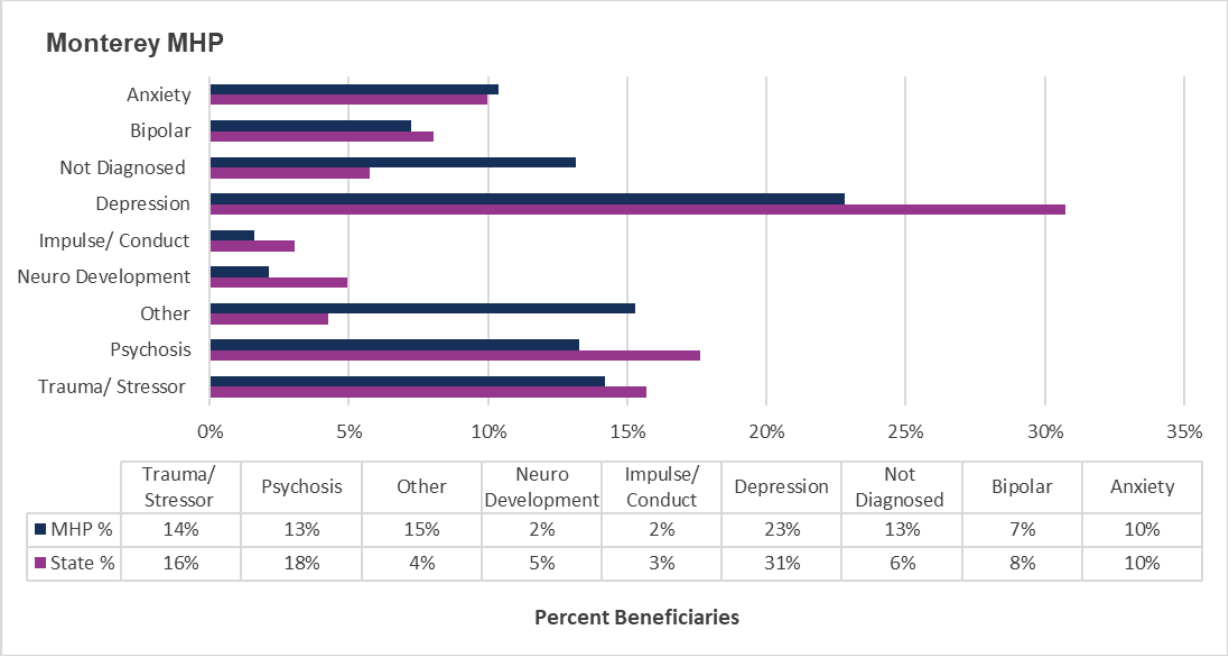
	State	MHP
1 service	10.25%	13.87%
2 service	6.20%	10.43%
3 service	4.88%	7.37%
4 service	4.47%	5.02%
5-15 Services	30.41%	25.51%
>15 Services	43.79%	37.80%

- More than a third of the MHP's beneficiaries received less than five service encounters (36.69 percent). This is more than 10 percentage points higher than the state average (25.80 percent).

Diagnosis of Beneficiaries Served

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

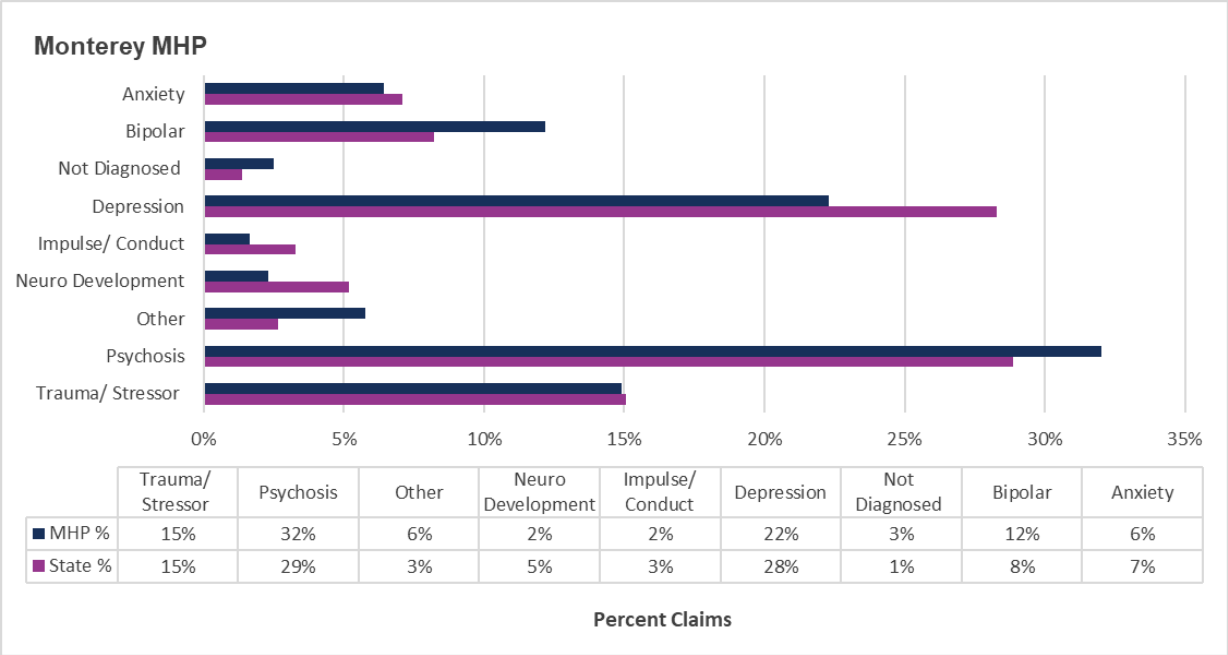
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	13%	15%	2%	2%	23%	13%	7%	10%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The MHP had high percentages of beneficiaries in the Other and Not Diagnosed category, 15 and 13 percent respectively. These were more than twice that of the state. On the other hand, the MHP's rate of Depression and Psychosis diagnoses were much lower than the corresponding state percentages.

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	15%	32%	6%	2%	2%	22%	3%	12%	6%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- Although the percentages of beneficiaries with Psychosis and Bipolar Disorders were lower than the state averages, the MHP's corresponding approved claims percentages were higher than the state.

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	585	1,105	8.56	8.86	$12,905	$12,052	$7,549,324
CY 2020	648	1,329	7.51	8.68	$11,654	$11,814	$7,551,954
CY 2019	669	1,240	6.79	7.80	$10,265	$10,535	$6,867,308

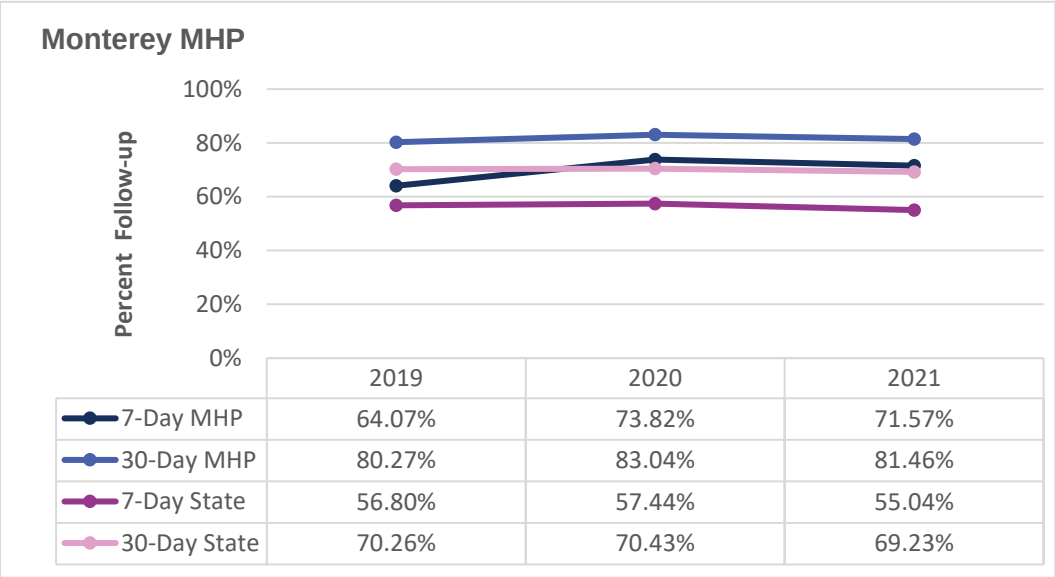
- The MHP's number of beneficiaries hospitalized and the number of inpatient admissions both declined in CY 2021. However, its average LOS went up by a day and are now closer to the state average.
- The inpatient AACB steadily increased between CY 2019-21 and at exactly the same pace and magnitude as the state.

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.

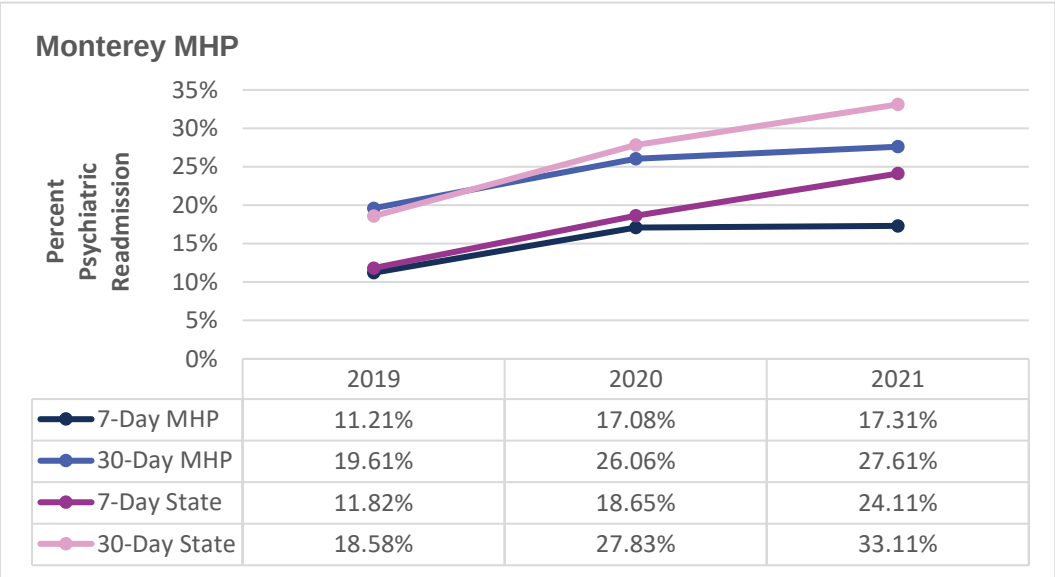
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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	64.07%	73.82%	71.57%
30-Day MHP	80.27%	83.04%	81.46%
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	11.21%	17.08%	17.31%
30-Day MHP	19.61%	26.06%	27.61%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- The MHP's 7-day and 30-day inpatient follow-up rates were consistently higher than the state averages by 10 to 15 percent between CY 2019-21.
- The MHP's 7-day and 30-day readmission rates were similar to the state's rate in CY 2019-20, but stayed the same in CY 2021 while the state's average rates went up. As a result, the MHP's CY 2021 rehospitalization rates were better than the state's.

- In its timeliness self-assessment, the MHP reported a lower number of inpatient admissions (n=859) in CY 2022 than CalEQRO's calculation based on CY 2021 approved claims data for CY 2021 (Table 13, n=1,105),
- The MHP also reported lower 7-day and 30-day follow-up rates in CY 2022 compared to CalEQRO's analysis for CY 2021 data (Fig.18) and lower readmission rates (Fig.19). These rates include all the MHP's clients which can account for the difference.

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, Figure 20 shows 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	575	6.63%	41.03%	$31,193,902	$54,250	$44,898
	CY 2020	540	6.38%	37.36%	$28,469,610	$52,721	$42,833
	CY 2019	491	5.54%	35.32%	$24,481,776	$49,861	$43,273

- The MHP's HCB beneficiary percentage increased between CY 2019-21 and was 47.3 percent higher than the state's average rate. The HCB percent of the total approved claims in CY 2021 was 22.7 percent higher than the state's average rate.

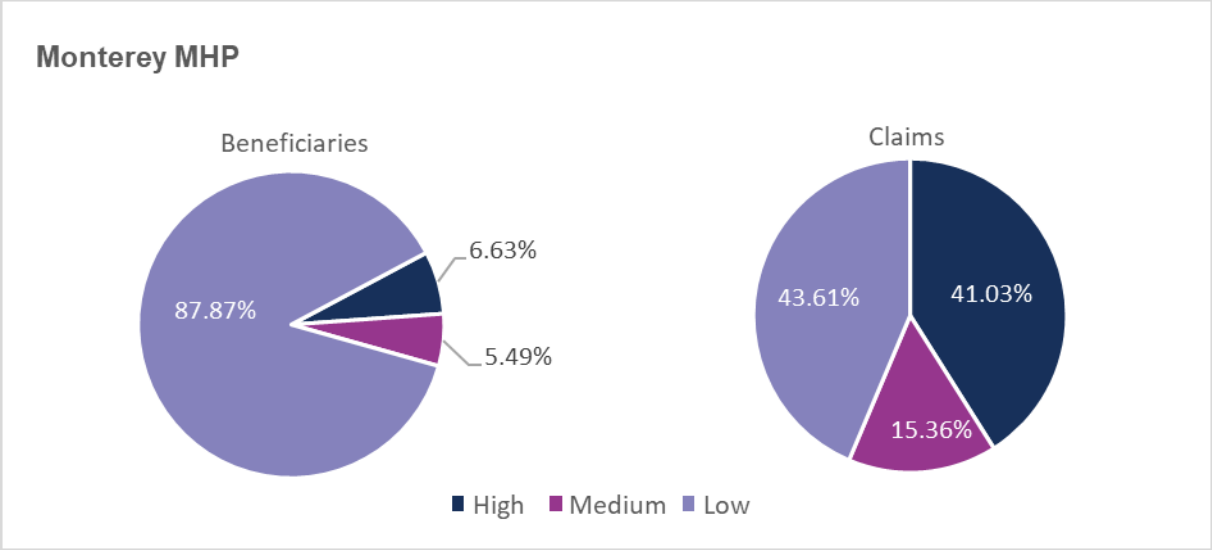
- The MHP's average and median HCB approved claims were close to the corresponding statewide average.

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)	476	5.49%	15.36%	$11,677,298	$24,532	$24,355
Low Cost (Less than $20K)	7,616	87.87%	43.61%	$33,159,291	$4,354	$2,173

- The average approved claims for beneficiaries who cost less than $20K was $4,354 and the median of the state average was $2,173.

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



- Approximately 12 percent of the beneficiaries accounted for more than 50 percent (56.39 percent) of the MHP's total approved claims.

IMPACT OF QUALITY FINDINGS

- The MHP's strong performance providing a follow-up service post hospitalization may be associated with lower readmission rates compared to the state's rates. The MHP's high rate of case management service may contribute to this beneficiary outcome as well.
- In FY 2021-22 the QIWP had a goal to decrease the number of beneficiaries readmitted to inpatient care within 30 days to 10 percent. The QIWP FY 2022-23

includes a goal for timeliness to post-hospital follow-up and no longer has an indicator on readmissions. The MHP should monitor and evaluate any unintended impact of the change in focus or metrics examined. The need to build communication and collaboration mechanisms with Natividad Hospital may also impact these outcomes.

- The MHP rate of beneficiaries who receive four or fewer services is 42 percent higher than the state rate. The MHP QI program does not have the infrastructure to examine this and thus insights into potential barriers, possible drop-out from care, and any improvements warranted are not known.

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: Risk Assessment Screening and Subsequent Services

Date Started: 01/2023

Aim Statement: "Will the use of the Columbia Suicide Severity Rating Scale (CSSRS) with Pilot Programs Adult & Children's Post-Hospital, Crisis, and Access Soledad Teams, subsequent use of Stanley Brown Safety Plan, and follow up intervention dependent on CSSRS risk outcome reduce suicide attempt rates seen in the ED by 10 percent over a 12-month period?"

Target Population: All beneficiaries who attend the following programs within the Monterey County Behavioral Health system: Access Crisis, Adult Post Hospital, Children's Post Hospital and Access Soledad.

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

[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 MHP examined Monterey County suicide death data from the Suicide Prevention Roadmap for Monterey County and identified that from 2011-2020, there was a 24 percent increase in suicide deaths while the rate of population growth was only 6 percent. In addition, the MHP noted that the Monterey California Health Interview Survey found a higher rate of reported suicidal thoughts than the State average. The MHP also found that 57 percent of all suicide attempts seen in the ED were by teens and TAY. The MHP did not examine MHP specific service data. The MHP convened stakeholder meetings with adult programs leadership which identified a lack of a standard suicide risk screen tool and safety plan. MHP chart audits and review of EHR information showed the absence of information that demonstrate suicide risk assessments and safety plans.

Interventions include implementing a standardized suicide assessment tool, the Stanley Brown Safety Plan, and follow-up care protocol to prevent and reduce suicide attempts identified in the ED. The MHP will pilot the interventions at some programs including all the adult beneficiaries at the Soledad clinic beginning April 2023.

The follow-up contact plan indicates two tiers of practice for timeliness: a minimum standard and a best practice standard. The MHP did not use established literature or other clinical guidelines for identifying the “at minimum” timeliness standards. Onsite discussion included recommending that established best practice timeframes should be used to achieve the positive outcomes intended.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: the PIP is in the planning phase and while the interventions will likely improve quality of care, the protocol for follow-up contacts and services remains unclearly defined to achieve outcomes and baseline indicators and data are not yet specified. The MHP is in the planning phase

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

- Determine and establish clear baseline measures the project will measure – the rate of suicide attempts seen at the ED. Include numerators and denominators for all indicators. Conduct remeasurements at least quarterly.
- Ensure that the point of intervention is not solely at the acute and ED point of care, given that prevention of suicide attempts is the aim.
- Provide best practice timeliness follow-up standards and measure performance to those standards.

- Include an indicator of the percentage of follow-up contacts that resulted in engagement in outpatient care. This would provide useful information on the quality of the follow-up contacts as well.
- Because the majority of beneficiaries with a suicide attempt in the ED are youth, consider targeted interventions and prioritizing this group for interventions. In addition, because there are increasing suicide and suicidality rates post-COVID overall, narrowing the target population based on level of risk or other variables may increase the sustainability of this PIP.
- Consider completing a chart sampling to examine clinical risk that was not identified to better understand the root cause and inform interventions.
- Because stigma, loneliness, and homelessness are identified as root causes, consider interventions that would address those areas.

NON-CLINICAL PIP

General Information

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

Date Started: 09/2022

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

Target Population: Beneficiaries with an ED visit and a principal diagnosis of mental illness or intentional self-harm, defined as "MH condition."

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

Summary

The MHP elected to participate in the CalAIM BHQIP and received information from DHCS that Monterey fell within Quartile 2 for FUM7 (61 percent) and FUM30 (71 percent.) The MHP met with a range of stakeholders including leadership from hospitals with EDs, MHP QI, and Crisis Service and IT management to develop this project. Root cause analysis found that inconsistent communication methods between the ED and the MHP, insufficient systems to initiate and track referrals, and lack of procedures or dedicated team for the MHP to coordinate follow-up services.

Interventions include developing a communication process and referral process from the ED, tracking ED referrals and collecting the data in Avatar, and forming a dedicated care team. The MHP began the intervention in February meeting with and posting informational fliers with ED staff promoting referrals. The MHP reports receiving a high

volume of referrals that exceed staffing capacity. The primary outcome is the percentage of beneficiaries with an ED visit for a MH condition and received a follow-up service within 7 and 30 days.

The MHP plans to establish MCP data exchange; specific plans are not outlined yet. The project is using Plan data feed from DHCS for the initial period. The MHP has also entered a plan with CalMHSA for ongoing data support in this project.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the PIP is in the planning phase. In the early stages, the MHP has already identified that the capacity to respond to the referral from the ED exceed MHP capacity.

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

- Elicit input from clinical line staff, and consumers and family members regarding interventions and use the input to design the interventions.
- Specify numerators and denominators for all measurements.
- Consider using rapid cycle testing, plan-do-study-act, or similar short term QI testing methods as processes are developed to the increase in referrals from the ED. Test the effectiveness of changes made before fully adopting in procedures.
- Measure indicators and outcomes as rates or performance, rather than counts of activities to accurately assess meeting goals.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart/Avatar, which has been in use for 13 years. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Approximately 2.89 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 percentage went up by 0.5 percent of the MHP budget from the previous year while the number of IS staff went down from 9.2 full-time equivalent (FTE) to 5 FTE.

The MHP has 682 named users with log-on authority to the EHR, including approximately 425 county staff and 257 contractor staff. Support for the users is provided by 5 FTE IS technology positions. Currently 1 FTE position remains vacant.

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

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
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	10%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	90%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP intends to implement full PHR functionality in two years. Currently the beneficiaries can send and receive secure text messages and receive appointment reminders.

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, or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Contract providers from both mental health and substance use disorder services.

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	Partially Met
4B	Integrity of Data Collection and Processing	Partially Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Met
4E	Security and Controls	Partially Met
4F	Interoperability	Met

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

- The MHP has strengthened its claims review process, which has in turn reduced its denial rates.
- The MHP's legacy EHR allows contract providers full access to the available functionalities.
- The MHP does not have an OCP in place.
- With the loss of the epidemiologist and a management analyst, the MHP's data analytical capacity has shrunk.
- At present, the MHP does not have a PHR portal for its beneficiaries.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18.

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	17,814	$6,379,372	$28,974	0.45%	$5,917,410
Feb	17,761	$6,309,698	$46,211	0.73%	$5,828,291
Mar	21,204	$7,719,550	$36,812	0.48%	$7,152,119
April	20,326	$7,301,586	$16,515	0.23%	$6,754,505
May	18,516	$6,903,471	$21,827	0.32%	$6,309,806
June	17,830	$6,611,502	$18,318	0.28%	$6,129,115
July	16,584	$6,218,619	$47,873	0.77%	$5,702,042
Aug	17,525	$6,525,775	$24,502	0.38%	$6,013,344
Sept	16,726	$6,231,650	$40,597	0.65%	$5,743,120
Oct	16,294	$6,128,782	$37,243	0.61%	$5,731,480
Nov	13,921	$5,650,657	$153,220	2.71%	$5,188,090
Dec	12,913	$5,109,046	$141,792	2.78%	$4,664,939
Total	**207,414**	**$77,089,708**	**$613,884**	**0.80%**	**$71,134,261**

- The MHP's claim volume reduced slightly starting in November 2021 according to the latest data available to CalEQRO. The denied claim amount also increased during that time. The MHP reported being current on its claims and that the denied claims have gone through the usual void and replace process.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible or non-covered charges	546	$248,101	40.42%
Medicare Part B must be billed before submission of claim	437	$162,546	26.48%
Late claim	190	$92,851	15.13%
Service line is a duplicate and a repeat service procedure code modifier not present	107	$60,810	9.91%
Other healthcare coverage must be billed before submission of claim	78	$33,775	5.50%
Service location NPI issue	46	$12,581	2.05%
Other	5	$2,348	0.38%
Place of service incomplete or invalid	4	$870	0.14%
Total Denied Claims	**1,413**	**$613,882**	**100.00%**
Overall Denied Claims Rate	**0.80%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The MHP's denial rate of 0.8 percent is much lower than the statewide average. Most of the denial reasons stemmed from the beneficiary not being eligible or non-covered charges and that Medicare Part B must be billed before submission of claim.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP lacks sufficient resources for data analytical purposes due to recent vacancies.
- Its limited IT budget and resources constrain its ability to explore possible replacement of its legacy EHR that could allow expansion of certain capabilities including PHR and data exchange.
- The MHP's lack of an OCP makes it vulnerable in the case of natural disasters or cyberattacks that may impact its IS operations.

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 completed the CPS surveys and had recently received the results and had not reviewed them yet. The use of the prior year's findings were not evident. As with other QI elements, the loss of the epidemiologist staff person is a reported barrier to QI activities.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of TAY consumers who initiated services in the preceding 12 months. The focus group was held virtually and included four participants. All consumers participating receive clinical services from the MHP.

Participants had received services between two to four years. Participants received services at four different program sites.

All participants report having received options for either in-person or video appointments for clinician or psychiatry appointments. All participants received reminders for psychiatry appointments but only some received them for other service appointments. Beneficiaries felt the reminders are helpful and needed.

None of the participants were aware of mobile crisis services.

For those who had requested an urgent service, they received an appointment the same day or within a few days. Participants were aware of the TAY Center, Avanza and the center has opened up more fully since the initial pandemic closings, participants experienced activities offered to be limited. A beneficiary needs to be referred by a clinician to attend.

All the participants felt comfortable, respected, and listened to by their therapist.

Several expressed that they “no longer feel like I want to kill myself” since receiving treatment working with their therapist and the “right” medications.

Recommendations from focus group participants included:

- Offer more family support and family therapy.
- Expand ways to communicate with therapists, such as text messaging and Google voice.
- Several would like to answer calls from their therapist. Participants recommend showing telephone numbers so they could pick it up rather than showing an “unknown” number.
- Conduct more outreach to families and use social media.
- Hire more bilingual Spanish-speaking staff.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included seven participants; Spanish language interpreters were used for this focus group. All consumers participating receive clinical services from the MHP.

Participants received services between five years to thirteen years. Participants received services at three different programs: most received services at the Salinas MHP clinic.

Some experienced unwelcoming and “disrespectful” treatment from some reception staff. There was a perception the reception staff had no training. All participants received appointment reminders. Some participants felt frustrated when they went to their medication appointments then had been informed by the MHP that their appointment had been changed. While the rescheduled appointments were about two weeks later, beneficiaries reported the hardship on transportation and planning to attend the appointments. For crisis needs, beneficiaries had a crisis number or a website resource. Some reported that when they called Natividad Hospital, no one spoke Spanish and there was no assistance to communicate emergency needs.

Some received housing assistance and transportation help by way of bus passes or from their provider. Transportation help included rides to physical care appointments.

Two participants received inpatient services in the last year. Beneficiaries reported timely and “easy” connection after discharge. Some participants reported dissatisfaction with the medication services at the hospital.

Overall, beneficiaries report satisfaction with services; experience include “my life has improved a lot with services.”

Recommendations from focus group participants included:

- Provide mobile clinics to agricultural areas. Beneficiaries report that some who need help in the agricultural areas do not know about services or are afraid to go to services because of governmental fear or distrust.
- Provide services related to human trafficking trauma.
- Enable more communication with MHP providers.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Beneficiaries who participated in the review express high satisfaction. While none of the participants-initiated services within the last year, beneficiaries who experienced an urgent need or a hospitalization reported receiving timely care.

Beneficiaries also appear to be lacking information on resources and would like more ways and improvements to communicate about appointments with their providers.

CONCLUSIONS

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

STRENGTHS

1. The MHP's post-hospitalization 7- and 30-day follow-up rate continues to be significantly higher than the state's performance. (Timeliness, Access, Quality)
2. The MHP's Asian/Pacific Islander AACB was consistently higher than the state and medium sized county averages during CY 2019-21. (Access, Quality)
3. The MHP completed updating its website which appears user friendly and easily accessible in multiple language translations. (Access)
4. The MHP provides beneficiaries with a high rate of case management services compared to similar size and state average rates. This can lead to positive outcomes for beneficiaries. (Access, Quality)
5. The MHP has continued to focus on integration with PC including collaborating on a new integrated clinic in East Salinas which will increase access to a high need region. (Access, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP continues to need reliable data for timeliness to first appointment and psychiatry services. Data driven decision-making for access management is limited by this absence. (Timeliness, Quality, IS)
2. The MHP does not conduct medication monitoring for youth as per SB 1291, and no progress has been made in this area. (Quality)
3. There is a need for consistent, organization wide, bi-directional communication related to QM. (Quality)
4. There is a need to establish communication and collaboration with the local psychiatric inpatient provider, Natividad Hospital, to ensure and improve access and quality for beneficiaries who use inpatient services. (Access, Quality)
5. The MHP lacks an OCP, which makes it vulnerable in terms of recovery following any unexpected and unforeseen event. (IS)
6. The MHP's funding level for the IS unit continues to be low for a county of its size with a budget allocation of 2.89 percent to support both MH and SUD operations. (Quality, 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. Prioritize developing a clear plan and implement the plan to obtain valid and reliable timeliness data that direct QI and capacity management for first appointment and psychiatry services. This should include testing the methods, training all staff involved in the tracking process, and routinely reviewing the validity of the data reported and its impact on care. (Timeliness, Quality, IS)

   (This recommendation is a carry-over from FY 2021-22.)

2. Implement medication monitoring for youth, including foster care youth, as per SB 1291, and implement ways including reports to examine medication monitoring systemwide. (Quality)

   (This recommendation is carried over from FY 2021-22.)

3. Continue to increase communication and collaboration organization wide to all staff and stakeholder groups including QI priorities. Consider clearly delineating compliance and procedures communications and system quality vision and goals that include baselines and remeasurements. (Quality)

   (This recommendation is carried over from FY 2021-22.)

4. As planned, evaluate barriers to communication and coordination with Natividad Hospital psychiatric inpatient. Implement processes and improvements indicated and measure the effectiveness of changes to guide the direction of managing transitions in crisis care. (Access, Quality)

5. Develop an OCP that will specifically outline behavioral health services' disaster recovery and contingency plans. (IS)

6. Evaluate the IS budget allocation and consider how to create an increase in order to sustain and improve IS operations. (IS, Quality)

   (This recommendation is carried over from FY 2021-22.)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

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 – Monterey MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
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 Satisfaction
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
Clinical Supervisors Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision

CalEQRO Review Sessions – Monterey MHP
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Information Systems Billing and Fiscal Interview
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rowena Nery, Lead Quality Reviewer
Saumitra SenGupta, Information Systems Reviewer
Diane Mintz, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Agregado-Baldo	Camille		Omni Resource Center
Arreola	Martin	Psych. Social Worker	Behavioral Health
Barajas	Janet	Manager BH QI	Behavioral Health
Betancourt	Isaias	Supervising Departmental Information	Behavioral Health
Borrell	Beth		Interim
Brunson	Teresa	Clinical Service Director	Interim
Cervantes-Gutierrez	Salvador	Management Analyst III	Behavioral Health
Chaves	Jose	Psych. Social Worker I	Behavioral Health
Chombo	Fabricio	Finance Manager II	Behavioral Health
Christian	Stephanie	Unknown	Carelon
Clayton	Lara	Behavioral Health Services Manager II	Behavioral Health
Corwin	Phillip	Wellness Navigator	Interim
Cronkite	Nick	Management Analyst III	Behavioral Health
DaSilva	Charles	Program Director	Sheriff's
Deanda	Abran	Sr. Psych. Social Worker	Behavioral Health
Degaul	Sue	Greeter	Interim
Drake	John	Assistant Bureau Chief	Behavioral Health
Eckert	Kathryn	Bureau Chief	Behavioral Health
Edgull	Dana	Behavioral Health Services Manager II	Behavioral Health
Edwards	Brie	Behavioral Health Unit Supervisor	Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Glazzard	Gregory	Probation Division Manager	Probation
Gollaher	Sharon	Director of Behavioral Health Services	Carelon
Gray	Kim	Sr. Psych. Social Worker	Behavioral Health
Henry Castaneda	Maria	Sr. Psych. Social Worker	Behavioral Health
Jarrett	Jessica	Sr. Psych. Social Worker	Behavioral Health
Jones	Leeann	Behavioral Health Unit Supervisor	Behavioral Health
Jones	Jessica	Behavioral Health Unit Supervisor	Behavioral Health
Kenyon	Julie	Director of Juvenile Probation	Probation
Kullar	Mandy	Director of Behavioral Health Services	Carelon
Lawless	Ami		Interim
Manzanero	Enrique	Psychiatric Social Worker	Behavioral Health
Marquez	Anna	Clinical Supervisor	Door to Hope
Martinez	Katie	Sr. Psych. Social Worker	Behavioral Health
McAtee	Jenifer	Unknown	Carelon
Mendoza	Nancy	Sr. Psych. Social Worker	Behavioral Health
Mendoza	CeCe	Program Director	Seneca Centers
Molton	Kelly	BEHAVIORAL HEALTH SERVICES MANAGER II	Behavioral Health
Moreno	Rosary	Management Analyst III	Behavioral Health
Morris	Raquel	Behavioral Health Services Manager II	Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Moses	Joseph	Sheriff's Captain	Sheriff's office
Norton	Julie	Behavioral Health Program Manger	Central Coast Alliance
O'Leary	Lindsey	Deputy Director BH QI	Behavioral Health
Ogas	Rosa Linda	Senior Program Officer	Community Human Services
Perez-Cordero	Liz	Behavioral Health Services Manager II	Behavioral Health
Powers	Casey	Division Director	Interim
Ramirez	Jessica	Chronic Disease Prevention Coordinator	Behavioral Health
Ramirez	Jose	Assistant Chief Probation Officer	Probation
Rhodes	Melanie	Deputy Director Access	Behavioral Health
Riley	Sharon	Clinical Supervisor	Door to Hope
Romero	Javier	Wellness Navigator	Interim Assertive Community Treatment
Sandoval	Marni	Deputy Director CSOC	Behavioral Health
Sherwood	Phil	Behavioral Health Services Manager II	Behavioral Health
Simmons	Melanie	Volunteer	Interim
Simmons	Lydia		Interim
Sims	William	Probation Division Manager	Probation
Stafford	Katerina	Clinical Supervisor	Door to Hope
Townsend	Jackie	Behavioral Health Services Manager II	Behavioral Health
Velasquez	Thi Nu Quynh	Behavioral Health Unit Supervisor	Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Wagreich	Richard	Departmental Information Systems Manager II	Monterey County Health Department
Walker	Jill	Behavioral Health Services Manager II	Behavioral Health
Wolf	Jan	Management Analyst III	Behavioral Health
Wouden	Michelle	Chief Deputy Public Defender	Public Defender
Young	Phoebe	Sr. Psych. Social Worker	Behavioral Health

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	This PIP is in the planning phase.
General PIP Information	
MHP/DMC-ODS Name: Monterey MHP	
PIP Title: Risk Assessment and Subsequent Services	
PIP Aim Statement: ”Will the use of the CSSRS with Pilot Programs Adult & Children’s Post-Hospital, Crisis, and ACCESS Soledad Teams, subsequent use of Stanley Brown Safety Plan, and follow up intervention dependent on CSSRS risk outcome reduce suicide attempt rates seen in the ED by 10 percent over a 12-month period?”	
Date Started: 01/2023	
Date Completed: n/a	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): All beneficiaries who attend the following programs within the Monterey County Behavioral Health system: Access Crisis, Adult Post Hospital, Children's Post Hospital and Access Soledad.
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): Education on suicide risk, training and use of the CSSRS, Stanley Brown Safety Plan, follow-up services
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): Use of the CSSRS at pilot sites, CSSRS in the EHR, Stanley Brown Safety Plan, follow-up MH services

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of beneficiaries with a suicide attempt at the ED • The MHP did not complete this section.			☒ 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
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

PIP Validation Information
EQRO recommendations for improvement of PIP: • Determine and establish clear baseline measures the project will measure – the rate of suicide attempts seen at the ED. Include numerators and denominators for all indicators. Conduct remeasurements at least quarterly. • Ensure that the point of intervention is not solely at the acute and ED point of care given that prevention of suicide attempts is the aim. • Provide best practice timeliness follow-up standards and measure performance to those standards. • Include an indicator of the percentage of follow-up contacts that resulted in engagement in outpatient care. This will provide useful information on the quality of the follow-up contacts as well. • Because the majority of beneficiaries with a suicide attempt in the ED are youth, consider targeted interventions and prioritizing this group for interventions. • Consider completing a chart sampling to examine clinical risk that was not identified to better understand the root cause and inform interventions. • Because stigma, loneliness, and homelessness are identified as root causes, consider interventions that would address those areas.

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 elected to participate in the CalAIM BHQIP FUM.
General PIP Information	
MHP/DMC-ODS Name: Monterey	
PIP Title: Follow-up After Emergency Department Visit for Mental Illness (FUM)	
PIP Aim Statement:	
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): Beneficiaries with an ED visit with a principal diagnosis of mental illness or intentional self-harm, defined as “MH condition.”	

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): Communication and referral process with the ED, tracking ED referrals, dedicated Post Hospital Team
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): Communication and referral process with the ED, tracking ED referrals, dedicated Post Hospital Team, establishing data exchange

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of beneficiaries with a MH condition receiving follow-up services within 7 days post ED discharge (FUM7)	2021	61%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of beneficiaries with a MH condition receiving follow-up services within 30 days post ED discharge (FUM30)	2021	71%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of successful data exchanges with the MCP			☐ 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
Number of successful data exchanges with HIE			☐ 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:

- Elicit input from clinical line staff, and consumers and family members regarding interventions and use the input to design the interventions.
- Specify numerator and denominators for all measurements.
- Consider using rapid cycle testing, plan-do-study-act, or similar short term QI testing methods as processes are developed to the increase in referrals from the ED. Test the effectiveness of changes made before fully adopting in procedures.
- Measure indicators and outcomes as rates or performance rather than counts of activities to accurately assess meeting goals.

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.