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

MENDOCINO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

**California Department of Health Care
Services (DHCS)**

Review Dates:

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	6
MHP INFORMATION	6
SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS	7
INTRODUCTION.....	9
BASIS OF THE EXTERNAL QUALITY REVIEW	9
REVIEW METHODOLOGY.....	9
HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE	11
MHP CHANGES AND INITIATIVES	12
ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS	12
SIGNIFICANT CHANGES AND INITIATIVES.....	12
RESPONSE TO FY 2022-23 RECOMMENDATIONS	13
ACCESS TO CARE	16
ACCESSING SERVICES FROM THE MHP	16
NETWORK ADEQUACY.....	16
ACCESS KEY COMPONENTS	17
ACCESS PERFORMANCE MEASURES	18
IMPACT OF ACCESS FINDINGS.....	30
TIMELINESS OF CARE.....	31
TIMELINESS KEY COMPONENTS	31
TIMELINESS PERFORMANCE MEASURES.....	32
IMPACT OF TIMELINESS FINDINGS	36
QUALITY OF CARE	37
QUALITY IN THE MHP	37
QUALITY KEY COMPONENTS.....	37
QUALITY PERFORMANCE MEASURES.....	39
IMPACT OF QUALITY FINDINGS	46
PERFORMANCE IMPROVEMENT PROJECT VALIDATION.....	47
CLINICAL PIP	47
NON-CLINICAL PIP	48
INFORMATION SYSTEMS.....	50
INFORMATION SYSTEMS IN THE MHP	50
INFORMATION SYSTEMS KEY COMPONENTS	51

INFORMATION SYSTEMS PERFORMANCE MEASURES	53
IMPACT OF INFORMATION SYSTEMS FINDINGS	54
VALIDATION OF MEMBER PERCEPTIONS OF CARE.....	55
CONSUMER PERCEPTION SURVEYS.....	55
PLAN MEMBER/FAMILY FOCUS GROUPS	55
SUMMARY OF MEMBER FEEDBACK FINDINGS.....	56
CONCLUSIONS.....	57
STRENGTHS	57
OPPORTUNITIES FOR IMPROVEMENT.....	57
RECOMMENDATIONS.....	58
EXTERNAL QUALITY REVIEW BARRIERS	59
ATTACHMENTS	60
ATTACHMENT A: REVIEW AGENDA.....	61
ATTACHMENT B: REVIEW PARTICIPANTS	62
ATTACHMENT C: PIP VALIDATION TOOL SUMMARY	65
ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE	71
ATTACHMENT E: LETTER FROM MHP DIRECTOR	72

LIST OF FIGURES

Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022	21
Figure 2: MHP PR by Race/Ethnicity, CY 2020-22	22
Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22	23
Figure 4: Overall PR CY, 2020-22.....	23
Figure 5: Overall AACM, CY 2020-22	24
Figure 6: Hispanic/Latino PR, CY 2020-22.....	24
Figure 7: Hispanic/Latino AACM, CY 2020-22	25
Figure 8: Asian/Pacific Islander PR, CY 2020-22.....	25
Figure 9: Asian/Pacific Islander AACM, CY 2020-22	26
Figure 10: Foster Care PR, CY 2020-22	26
Figure 11: Foster Care AACM, CY 2020-22.....	27
Figure 12: Wait Times to First Service and First Psychiatry Service	34
Figure 13: Wait Times for Urgent Services.....	34
Figure 14: Percent of Services that Met Timeliness Standards.....	35
Figure 15: Retention of Members Served, CY 2022.....	40
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022	41
Figure 17: Diagnostic Categories by Percentage of Approved Claims, CY 2022	42
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22	43
Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22.....	44
Figure 20: Mendocino MHP Members and Approved Claims by Claim Category, CY 2022.....	46

LIST OF TABLES

Table A: Summary of Response to Recommendations.....	6
Table B: Summary of Key Components	6
Table C: Summary of PIP Submissions	7
Table D: Summary of Plan Member/Family Focus Groups	7
Table 1A: MHP Alternative Access Standards, FY 2022-23.....	17
Table 1B: MHP Out-of-Network Access, FY 2022-23.....	17
Table 2: Access Key Components	18
Table 3: Mendocino MHP Annual Members Served and Total Approved Claims, CY 2020-22	19
Table 4: Mendocino County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022.....	19
Table 5: Threshold Language of Mendocino MHP Medi-Cal Members Served in CY 2022.....	20
Table 6: Mendocino MHP Medi-Cal Expansion (ACA) PR and AACM, CY 2022	20
Table 7: Mendocino MHP PR of Members Served by Race/Ethnicity, CY 2022	21
Table 8: Services Delivered by the Mendocino MHP to Adults, CY 2022.....	28
Table 9: Services Delivered by the MHP to Mendocino MHP Youth in Foster Care, CY 2022.....	29
Table 10: Timeliness Key Components.....	31
Table 11: FY 2023-24 Mendocino MHP Assessment of Timely Access.....	33

Table 12: Quality Key Components.....	38
Table 13: Mendocino MHP Psychiatric Inpatient Utilization, CY 2020-22	42
Table 14: Mendocino MHP High-Cost Members (Greater than \$30,000), CY 2020-22.	45
Table 15: Mendocino MHP Medium- and Low-Cost Members, CY 2022	45
Table 16: Contract Provider Transmission of Information to Mendocino MHP EHR	51
Table 17: IS Infrastructure Key Components	52
Table 18: Summary of Mendocino MHP Short-Doyle/Medi-Cal Claims, CY 2022.....	53
Table 19: Summary of Mendocino MHP Denied Claims by Reason Code CY 2022.....	54
Table A1: CalEQRO Review Agenda	61
Table B1: Participants Representing the MHP and its Partners	63
Table C1: Overall Validation and Reporting of Clinical PIP Results	65
Table C2: Overall Validation and Reporting of Non-Clinical PIP Results	68

EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — December 6-7, 2023

MHP Size — Small

MHP Region — Superior

Summary of Findings

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

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	2	3	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	9	1	0
Information Systems (IS)	6	3	3	0
TOTAL	26	21	4	1

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Youth Level of Care	Clinical	12/2022	Implementation	Low
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	09/2022	Implementation	Low

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐ Adults ☐ Transition Aged Youth (TAY) ☒ Family Members ☐ Other	5
2	☒ Adults ☐ Transition Aged Youth (TAY) ☐ Family Members ☐ Other	11

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP continuously monitors data to evaluate and make data driven decisions.
- The MHP's penetration rates (PR) are higher than both the small county and statewide rates for all age categories, indicating greater service accessibility.
- The MHP leadership is actively engaged in suicide prevention activities leading to a robust prevention strategy.
- Participation in the SacValley MedShare Health Information Exchange (HIE) allows the secure sharing of myAvatar health information throughout California.
- As oversight transitions from the administrative services organization (ASO), contractors report satisfaction with the MHP's attempts to work towards building relationships.

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

- While the single service retention rate for white members was 7.91 percent, the Hispanic/Latino rate was 11.38 percent. Which suggests disparity in engagement and retention.
- Member health information is maintained in disparate Electronic Health Records (EHR) systems which limits access to this information.

- The rate of deferred diagnosis is much greater than the statewide average (18 percent vs. 6 percent). At the same time urgent service requests are defined as crisis, which may contribute to the high rate of deferred diagnoses.
- The MHP currently does not have specified peer classification in their workforce, nor does the MHP have a specified career ladder for peers.
- The demand for IT support will likely increase during the Avatar NX implementation and there may be an ongoing need for additional IT support if contract providers begin using the Avatar NX system.

Recommendations for improvement based upon this review include:

- Research possible reasons for the higher Latino/Hispanic single service percentage and design culturally appropriate ways to increase engagement and consider conducting Hispanic/Latino focus groups to gather feedback from this population.
(This recommendation was a carryover from FY 2022-23)
- To eliminate disparate EHR databases and allow 24/7 access to member health information, consider permitting all contract providers full access to the enhanced Avatar NX EHR system.
(This recommendation was a carryover from FY 2022-23)
- Consider the opportunity to redefine urgent services disparate from crisis to offer an opportunity for a more complete assessment and engagement of urgent service requests. Create a process that helps to reduce the number of deferred diagnoses.
(This recommendation was a carryover from FY 2022-23)
- Consider creating a peer classification and a peer specific career ladder.
- The MHP should consider including anticipated IT staffing requirements in their Avatar NX project plan as well as in planning the post Avatar NX IT budget.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (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 2023-24 findings of the EQR for Mendocino County MHP by BHC, conducted as a virtual review on December 6-7, 2023.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

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

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

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

The MHP continues to experience difficulties resulting from the COVID-19 pandemic, including operating without sufficient staffing and or adjusting to a slow return to in-office services. While services are increasingly being delivered in-person, telehealth is still a valuable tool for the MHP. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP has initiated steps to move away from ASO service management and moving all contracts under county oversight.
- Participation in SacValley MedShare HIE allows the MHP to share myAvatar health information electronically.
- The MHP implemented California Advancing and Innovating Medi-Cal (CalAIM) reform. Payment reform introduces challenges to providers who provide continuous services in rural locations, as they no longer are able to bill for travel time.
- The MHP initiated a dual response mobile crisis service, in which a provider responds to a need alongside law enforcement, separate from its existing crisis service.
- The MHP opened a crisis respite facility in Fort Bragg, which provides a four-bed availability.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

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

Recommendations from FY 2022-23

Recommendation 1: To eliminate disparate EHR databases and allow 24/7 access to member health information, consider permitting full contract provider access to the replacement EHR system.

☐ Addressed

☒ Partially Addressed

☐ Not Addressed

- The MHP has not developed a database that replicates the myAvatar system to be used for reporting and data analytics. There are no current plans to develop this database.
- Contract providers utilize the EXYM EHR. Disparate databases can limit systemic data analytics and reporting. The MHP will be upgrading myAvatar to myAvatar NX (Avatar NX) with implementation expected to occur in the next 12-18 months. All contract providers have been invited to transition to Avatar NX,

some but not all have agreed to begin using Avatar NX when it is implemented. This recommendation is carried over in this year's report.

Recommendation 2: Research possible reasons for the higher Latino/Hispanic single service percentage and design culturally appropriate ways to increase engagement.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP conducted survey to explore reasons for higher Latino/Hispanic single service percentage but encountered a low response rate due to stigma and or individuals not being interested in services.
- The MHP has not yet developed an engagement plan to target single service percentage for Latino/ Hispanic population.

Recommendation 3: Research possible connection between deferred diagnosis and urgent/crisis services. Consider the opportunity to redefine urgent services disparate from crisis to offer an opportunity for a more complete assessment and engagement of clients with urgent needs.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP investigated why there was a high percentage of deferred diagnosis and learned that the deferred diagnosis was assigned during a crisis episode as providers reported not having sufficient information to assign a diagnosis during crisis. Further, some of the crisis workers are rehabilitation specialists who are unable to diagnose, to which the diagnosis would then be deferred, but had not been updated in the EHR at a later time by a clinician.
- The MHP started a process that reviews the EHR on whether the diagnosis is being updated.

Recommendation 4: Research the low percentage of non-urgent appointments offered and rendered that meet the 10-day standard. Design and implement a plan to increase this percent.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP concluded that the low percentage of non-urgent appointments offered and rendered that met the 10-day standard was due to staff turnover and training issues among schedulers.
- The MHP worked with providers to improve training and staffing patterns along with continuous monitoring to meet non-urgent appointment standards.
- As result of the interventions, 94.6% of first offered non-urgent services met the standard, and 91.6% of non-urgent services were delivered meeting the timeliness standard.

Recommendation 5: Reach out to different groups of members (wellness centers, TAY, etc.) to offer information and resources on how they can be involved in

committees, volunteer work, collaboration with the National Alliance on Mental Illness (NAMI), and other ways they can have a voice in the system of care.

☒ Addressed

☐ Partially Addressed

☐ Not Addressed

- The MHP initiated a monthly meeting with NAMI and tribal partners on collaborations to increase awareness, education, and opportunities for members and tribal representatives to have their voices heard.
- During this period, the MHP lost the adult Wellness Center provider. The MHP resumed direct facilitation of the wellness centers. Wellness centers are working on building workshops into wellness center activities and NAMI is collaborating on and building capacity for Native community specific Family to Family classes.
- CalEQRO commended the MHP for their current work and provided a recommendation to further explore including collaboration with groups representing Hispanic/Latino community and those who are Spanish speakers specifically.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 27 percent of services were delivered by county-operated/staffed clinics and sites, and 73 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 95.35 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff; members may request services through the Access Line as well as a decentralized access system that is responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries may receive screening and assessment directly through the closest outpatient clinic to their residence or the clinic of their choice, including ASO locations.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 1,179 adults, 695 youth, and 109 older adults across 3 county operated sites and 19 contractor-operated sites. Among those served, 79 members received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO

¹ [CMS Data Navigator Glossary of Terms](#)

for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information in Table 1A and Table 1B.

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

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

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

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

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

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

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP expanded their connections with tribal partners and provides training that is culturally specific.
- The MHP has a robust suicide prevention effort which involves direct participation of MHP leadership in events. As part of the prevention efforts, the MHP hands out Narcan and Detera drug disposal pouches as well as providing space for community feedback.
- The MHP conducts a deep review of all MHP data monthly to evaluate system needs such as capacity and PR. All of the MHP's County management team attend this meeting.
- The MHP presents data results in meetings with ASO as well as at QIC promoting a data driven decision making process including data transparency.
- The MHP collaborates frequently with law enforcement including meetings in which the MHP director is present. The healthy collaboration between the MHP and law enforcement facilitated the creation of the dual response mobile crisis and the Heads-up program.

ACCESS PERFORMANCE MEASURES

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

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

The PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served

per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

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

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

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	44,288	2,436	5.50%	\$19,596,798	\$8,045
CY 2021	42,251	2,514	5.95%	\$17,988,321	\$7,155
CY 2020	39,837	2,406	6.04%	\$17,688,237	\$7,352

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

- While total members eligible increased 11.2 percent from CY 2020 to CY 2022, the numbers served declined. Therefore, the PR showed a decline of 8.9 percent during this time period.
- The AACM increased 12.4 percent from CY 2021 to CY 2022 (\$7,155 vs. \$8,045).

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

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	4,294	60	1.40%	1.31%	1.82%
Ages 6-17	9,792	785	8.02%	5.83%	5.65%
Ages 18-20	2,182	130	5.96%	4.72%	3.97%
Ages 21-64	23,787	1,348	5.67%	4.53%	4.03%
Ages 65+	4,234	113	2.67%	2.25%	1.86%
Total	44,288	2,436	5.50%	4.30%	3.96%

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

- The largest eligibility group by age was adults ages 21-64, followed by youth ages 6-17. Except for the age 0-5 group, the MHP's PRs are higher than both the similar sized county and statewide rates when examining age categories.

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

Threshold Language	# of Members Served	% of Members Served
Spanish	189	7.91%
Threshold language source: Open Data per BHIN 20-070		

- The MHP had one threshold language, Spanish, and 7.91 percent of those served identified Spanish as a preferred language.

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

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	14,448	676	4.68%	\$4,222,296	\$6,246
Small	218,086	8,382	3.84%	\$44,131,230	\$5,265
Statewide	4,831,118	164,980	3.41%	\$1,051,087,580	\$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This trend applies to ACA members in this county.
- The MHP's ACA PR is lower than its overall PR (4.68 percent vs. 5.50 percent). The ACA AACM is lower than that of the overall AACM (\$6,246 vs. \$8,045).
- The MHP's ACA PR exceeds the statewide rate (4.68 percent vs. 3.41 percent) and the MHP's ACA AACM is just below the statewide average (\$6,246 vs. \$6,371).

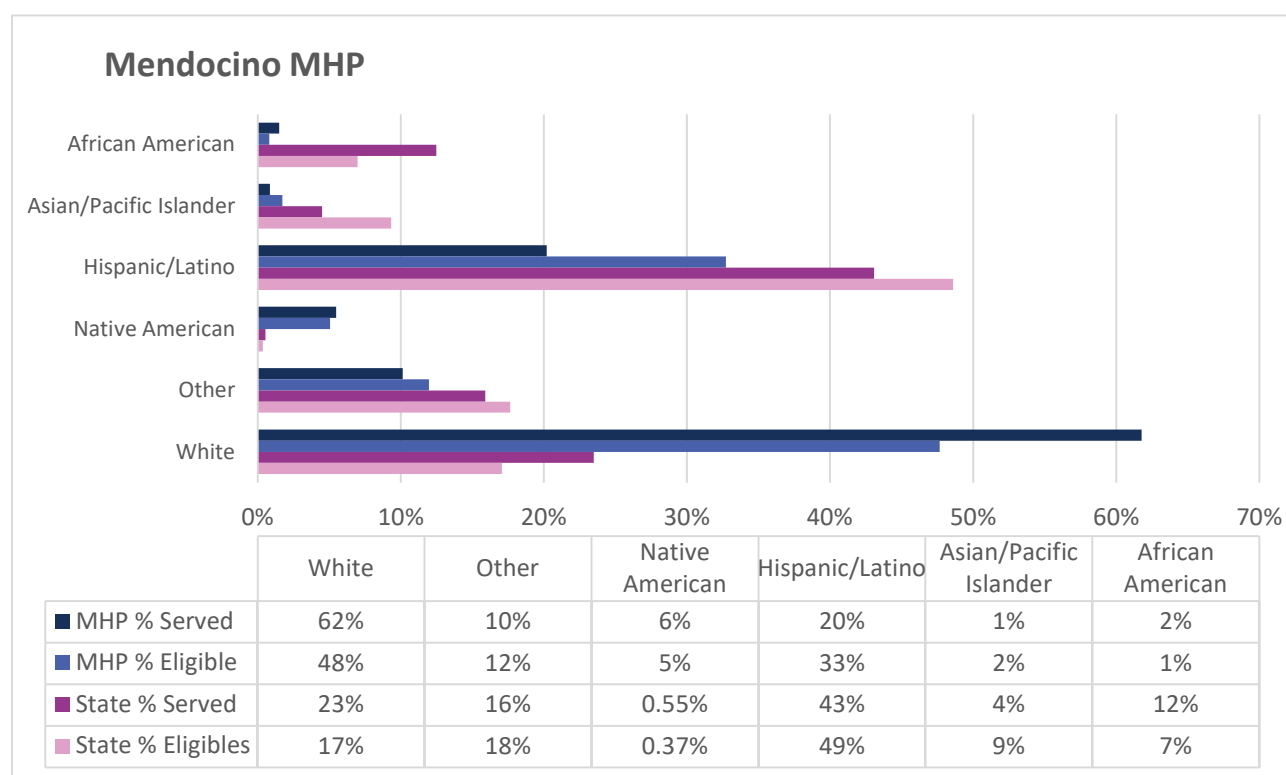
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they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

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

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	366	37	10.11%	7.08%
Asian/Pacific Islander	769	21	2.73%	1.91%
Hispanic/Latino	14,495	492	3.39%	3.51%
Native American	2,245	134	5.97%	5.94%
Other	5,304	247	4.66%	3.57%
White	21,111	1,505	7.13%	5.45%

- While PRs for African American, Asian/Pacific Islander, Other, and White groups exceed statewide rates. The Native American PR is comparable to the statewide rate, and the Hispanic/Latino PR is lower than the statewide rate (3.39 percent vs. 3.51 percent).

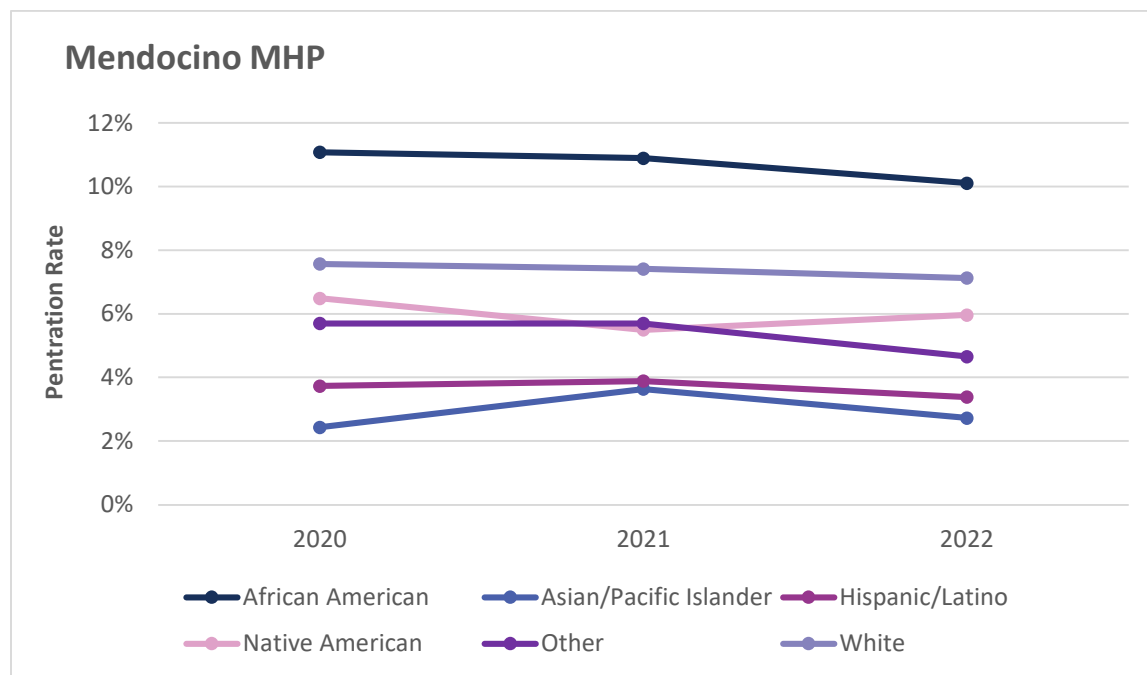
Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022



- While White was the most proportionally overrepresented racial/ethnic group in the MHP, the most proportionally underrepresented group was Hispanic/Latino.
- The MHP had a notably lower percentage of Hispanic/Latino eligibles than the state as a whole (33 percent vs. 49 percent).

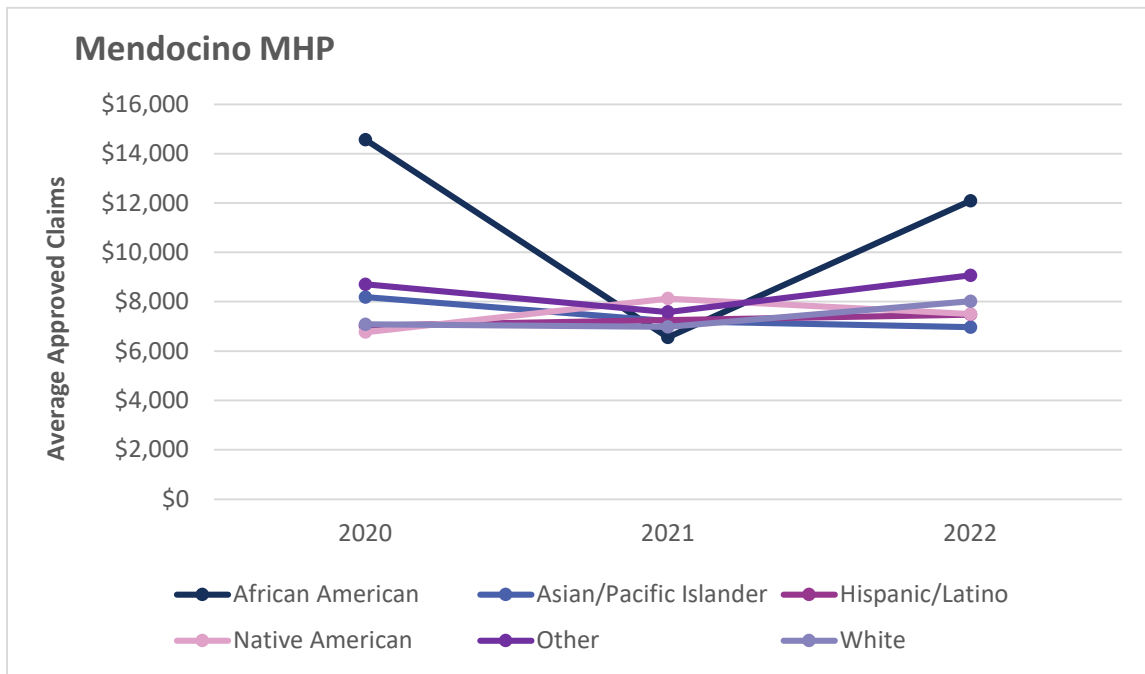
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



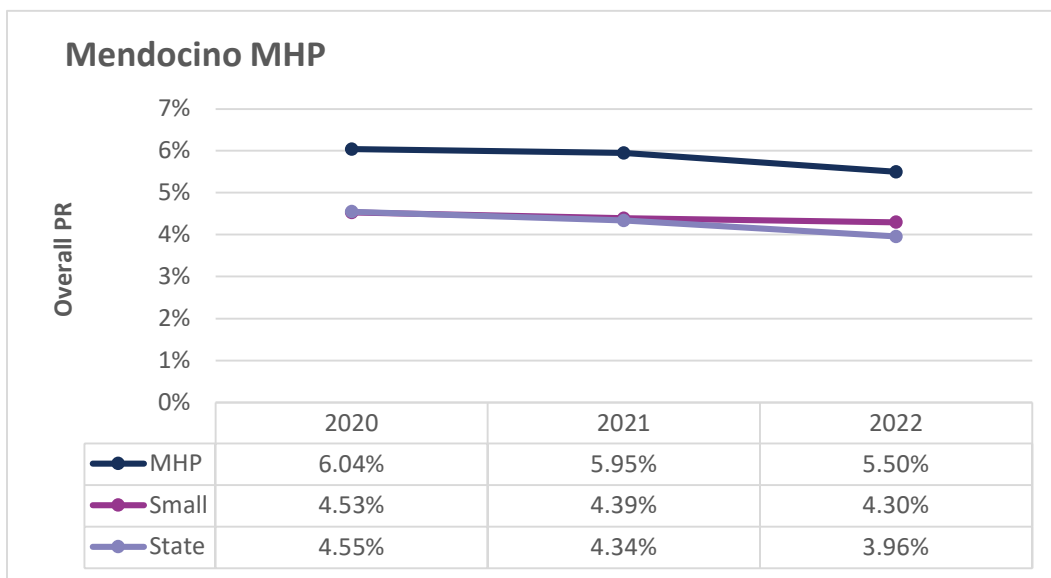
- PRs for African Americans and Whites have consistently been the highest over the past three years. It should be noted that the African American group comprised 1 percent of eligibles and 2 percent of those served and outliers in a small number of served can impact averages in a way that appears dramatic and can skew the data.
- PRs for Asian/Pacific Islanders and Hispanic/Latinos have consistently been lowest.

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



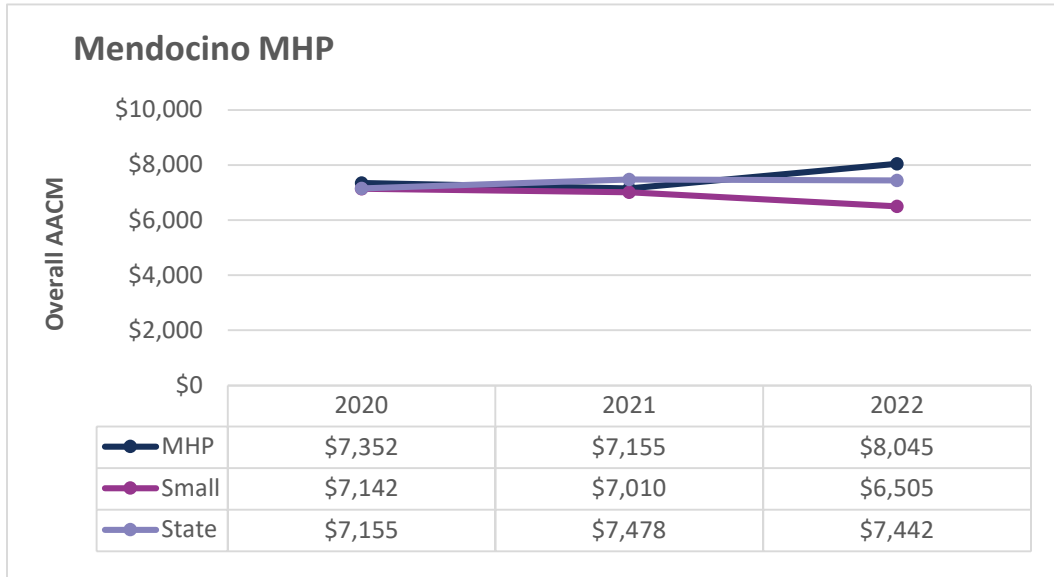
- The AACM for African American members was highest of any group in CY 2022 and displayed notable variation from CY 2020 to CY2022. It should be noted that African American members were 2 percent of all members served in CY 2022, and when a population is small, outliers can impact the average in a way that appears dramatic. Hispanic/Latino had the second highest AACM in CY 2022.

Figure 4: Overall PR CY, 2020-22



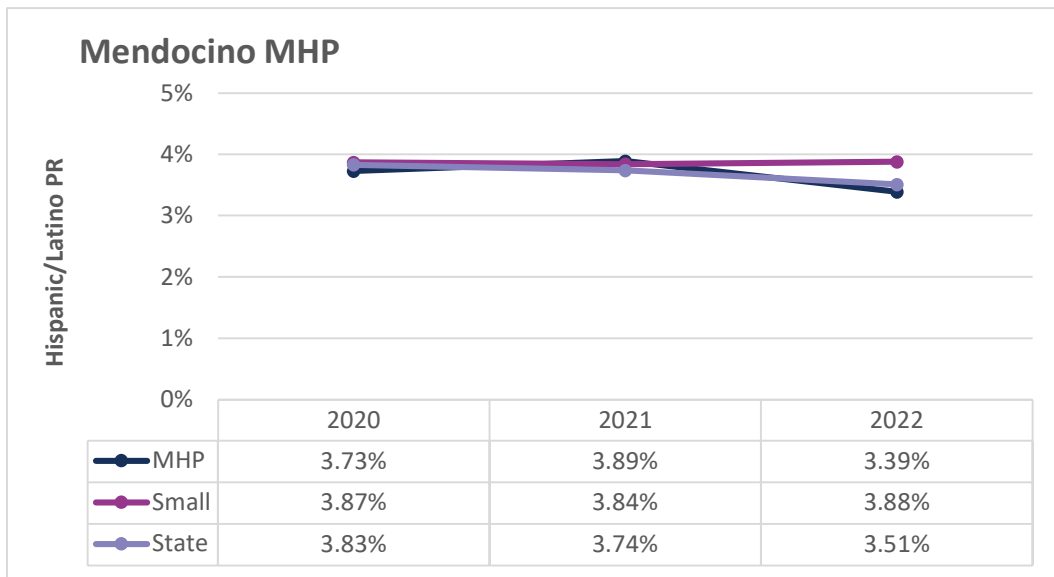
- While the MHP's PR decreased from CY 2021 to CY 2022, the MHP's CY 2022 PR was higher than that of both the small county rate (5.50 percent vs. 4.30 percent) and statewide rate (5.50 percent vs. 3.96 percent).

Figure 5: Overall AACM, CY 2020-22



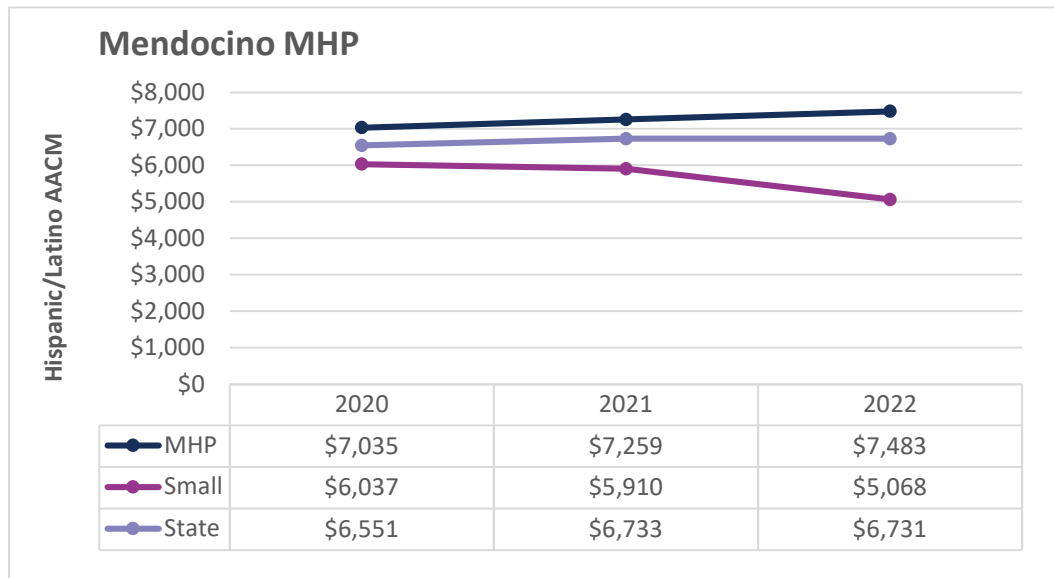
- The MHP's overall AACM increased 12.4 percent from CY 2021 to CY 2022 and was greater than the small county and statewide AACMs in CY 2022.

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



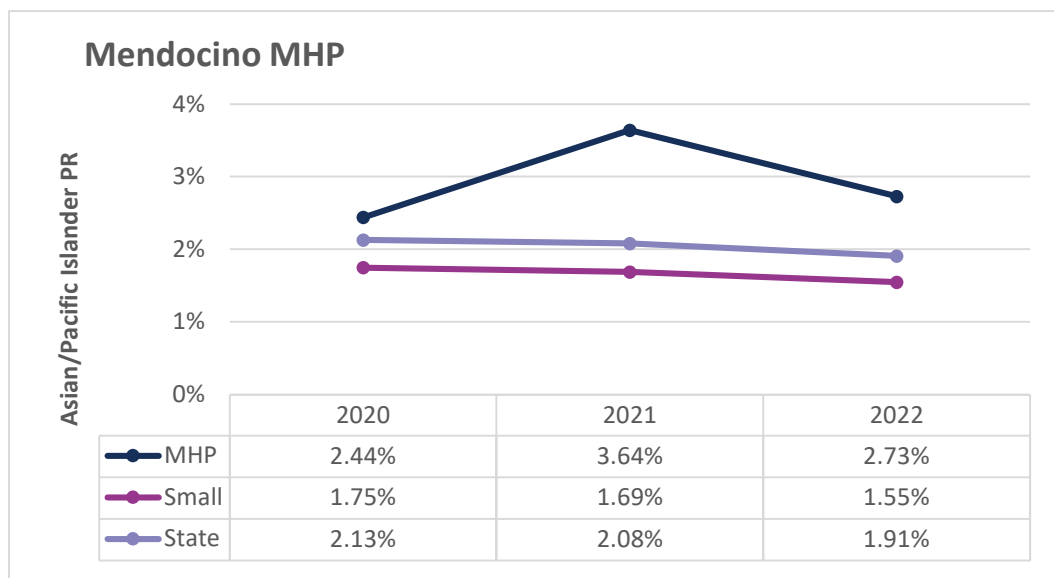
- The MHP's Hispanic/Latino PR declined 12.9 percent from CY 2021 to CY 2022 (3.89 percent vs. 3.39 percent) and is lower than that of small county and statewide rates in CY 2022.

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



- The MHP's Hispanic/Latino AACM was higher than that of the small county and statewide averages in CY 2022.

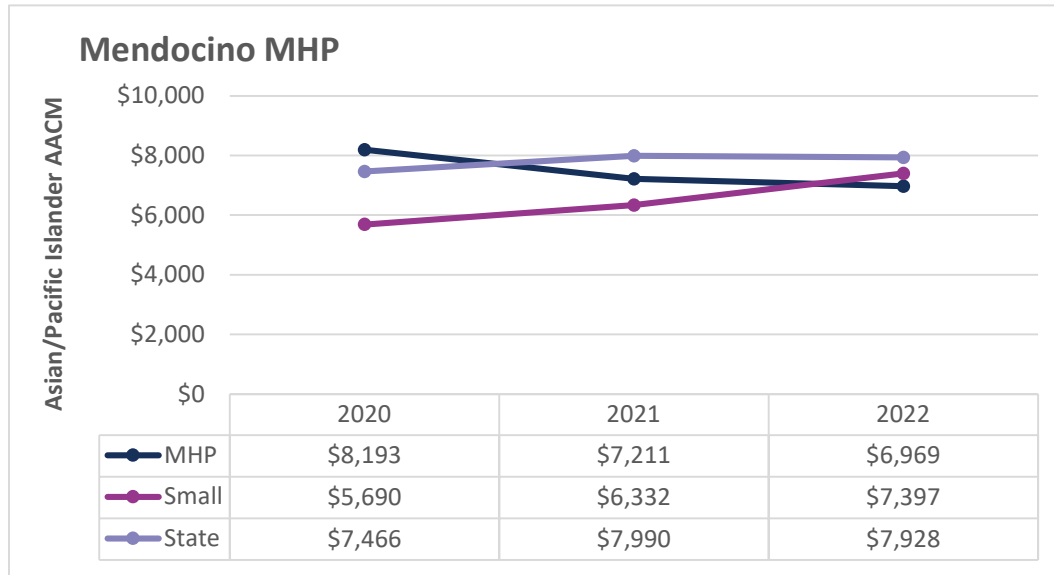
Figure 8: Asian/Pacific Islander PR, CY 2020-22



- The MHP's Asian/Pacific Islander PR exceeded the small county and statewide rates from CY 2020 to CY 2022. Asian/Pacific Islander members were 1 percent

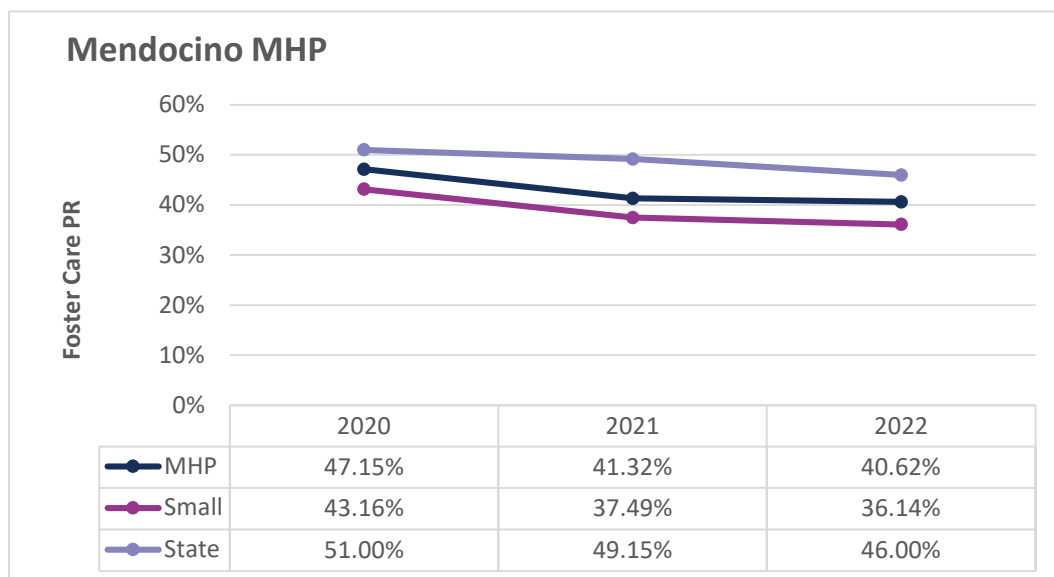
of the members served in CY 2022, and when a population is small outliers can impact rate trends in a way that appears dramatic.

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



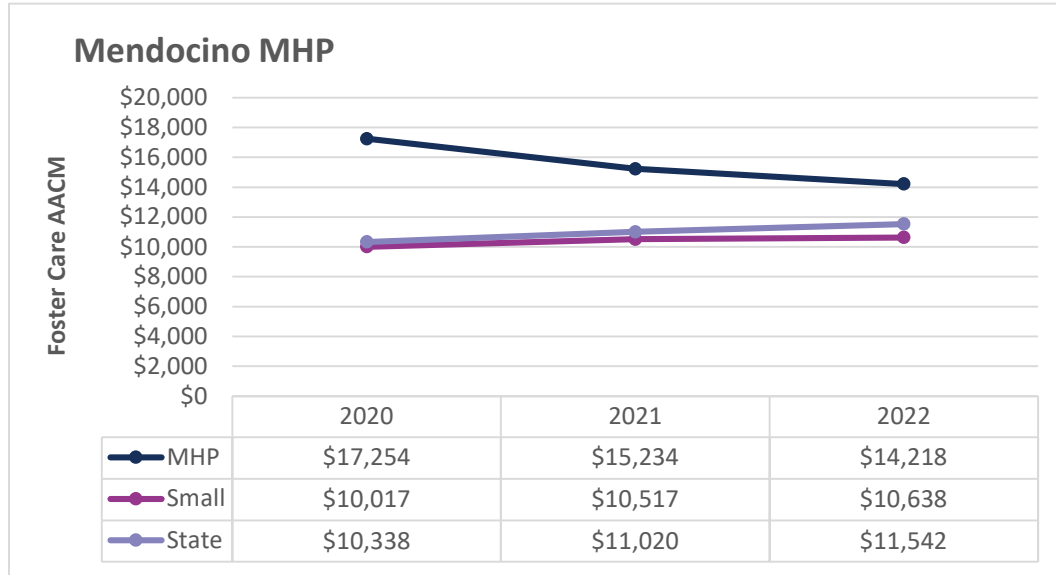
- The MHP's Asian/Pacific Islander AACM declined each year from CY 2020 to CY 2022 and was lower than small county and statewide average AACMs. It should be noted that Asian/Pacific Islander members were 1 percent of the members served in CY 2022, and when a population is small outliers can impact averages in a way that appears dramatic.

Figure 10: Foster Care PR, CY 2020-22



- The MHP's FC PR declined each year from CY 2020 to CY 2022 and was above the small county rate and lower than the statewide during this entire time period.

Figure 11: Foster Care AACM, CY 2020-22



- Statewide FC AACM has increased each year for the past three years, whereas the MHP's FC AACM has decreased for each of the past three years. However, the MHP's FC AACM remained above both small county and statewide averages during this time period.

Units of Service Delivered to Adults and Foster Youth

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

Service Category	MHP N = 1,591				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	144	9.1%	17	12	10.3%	14	8
Inpatient Admin	<11	-	6	6	0.4%	26	10
Psychiatric Health Facility	106	6.7%	1	1	1.2%	16	8
Residential	0	0.0%	0	0	0.3%	114	84
Crisis Residential	38	2.4%	43	32	1.9%	23	15
Per Minute Services							
Crisis Stabilization	21	1.3%	1,886	1,200	13.4%	1,449	1,200
Crisis Intervention	640	40.2%	416	239	12.2%	236	144
Medication Support	666	41.9%	162	110	59.7%	298	190
Mental Health Services	1,175	73.9%	1,173	541	62.7%	832	329
Targeted Case Management	1,045	65.7%	847	237	36.9%	445	135

- The MHP's combined inpatient and PHF utilization rate was higher than the combined statewide rate (15.8 percent vs. 11.5 percent).
- The MHP's crisis intervention utilization rate was greater than the statewide rate (40.2 percent vs. 12.2 percent), and the crisis stabilization rate at the MHP was notably lower than the statewide rate (1.3 percent vs. 13.4 percent), as the MHP does not operate a CSU.
- The targeted case management (TCM) utilization rate is notably higher than is seen statewide (65.7 percent vs. 36.9 percent) and units of service provided are also higher.

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

Service Category	MHP N = 132				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	16	13	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	1	1	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	<11	-	663	663	0.2%	673	435
Full Day Rehab	<11	-	30	30	0.2%	111	84
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	3.1%	1,166	1,095
Crisis Intervention	23	17.4%	330	214	8.5%	371	182
Medication Support	42	31.8%	280	245	27.6%	364	257
TBS	<11	-	2,947	1,268	3.9%	4,077	2,457
Therapeutic FC	16	12.1%	53	44	0.1%	911	495
Intensive Care Coordination	57	43.2%	1,103	528	40.8%	1,458	441
Intensive Home-Based Services	42	31.8%	2,306	1,323	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	122	92.4%	2,184	1,205	95.4%	1,846	1,053
Targeted Case Management	77	58.3%	500	230	35.8%	307	118

- The MHP's FC crisis intervention utilization rate is just over twice that of the statewide utilization rate (17.4 percent vs. 8.5 percent).
- While the count of members served is suppressed, the MHP's median and average TBS units were lower than corresponding statewide units.
- The MHP's TCM utilization rate is higher than the statewide rate (58.3 percent vs. 35.8 percent), also with more units of service.

- The MHP's intensive care coordination (ICC) utilization was comparable to the statewide pattern with 24 percent fewer units of service on average. However, the intensive home-based service (IHBS) utilization rate was 63 percent higher than the statewide rate, but average and median units were slightly higher than the statewide units.

IMPACT OF ACCESS FINDINGS

- The MHP's PRs are higher than both the similar-sized county and statewide rates for all age categories (except ages 0-5), indicating generally higher service accessibility.
- The MHP had one threshold language, Spanish, and 7.91 percent of those served identified Spanish as a preferred language and the PR for this group was lower than the statewide rate, indicating a potential need for increased outreach to this group.
- The MHP crisis utilization rate was much greater than the statewide rate (40.2 percent vs. 12.2 percent). It would be beneficial to the MHP to take a closer look at defining urgent services separately from crisis services.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The MHP's continuous data monitoring process allows for rapid response in corrective planning and provider monitoring.

- The MHP worked closely with the ASO on hiring and staff retention as the MHP continues to recover from the impact of COVID-19 pandemic. Loss of staff resulted in longer wait times for services.
- The MHP met with ASO throughout the year and provided corrective action plans to providers addressing timeliness recommendations, which overall saw an improvement to 94.6% for first offered non-urgent services and 91.6% of non-urgent services were delivered meeting the timeliness standard.

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 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	4.1 Business Days	10 Business Days*	94.6%
First Non-Urgent Service Rendered	4.1 Business Days	10 Business Days**	91.6%
First Non-Urgent Psychiatry Appointment Offered	3.1 Business Days	15 Business Days*	93.2%
First Non-Urgent Psychiatry Service Rendered	3.7 Business Days	15 Business Days**	90.6%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required ***	0.06 Hours	48 Hours*	98.4%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	0 Calendar Days	7 Calendar Days	97.3%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	0 Calendar Days	30 Calendar Days	100%
No-Show Rate – Psychiatry	6%	<10%**	n/a
No-Show Rate – Clinicians	5%	<10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards **** The MHP does not separately report urgent timeliness for services requiring prior authorization			
For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23			

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

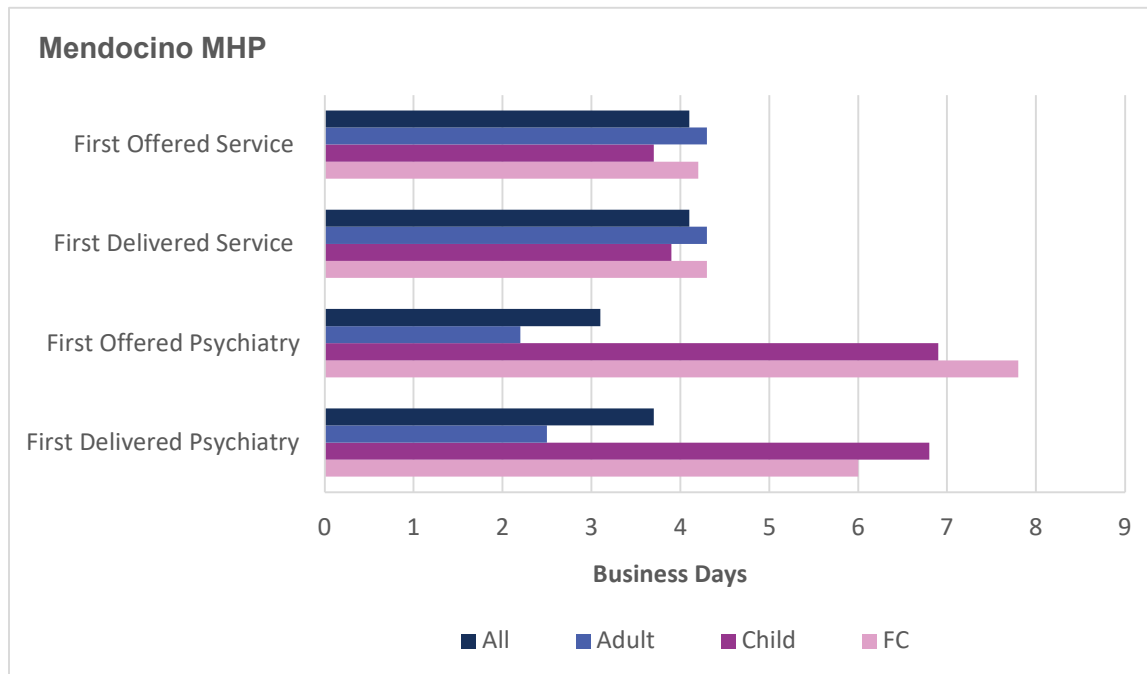


Figure 13: Wait Times for Urgent Services

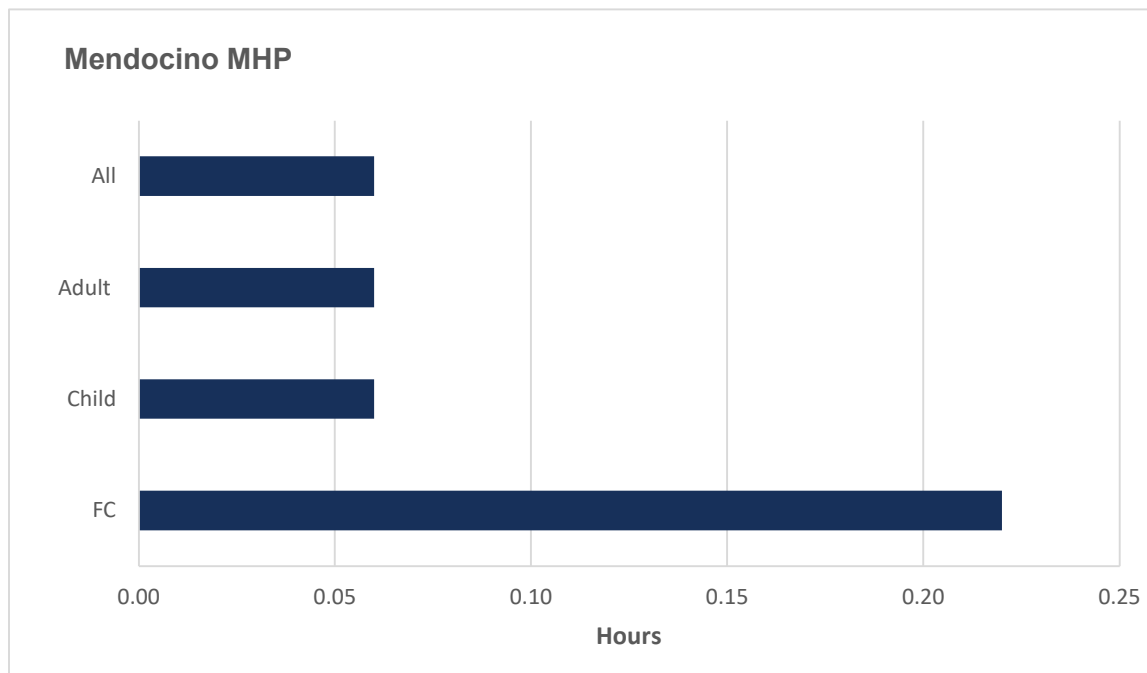
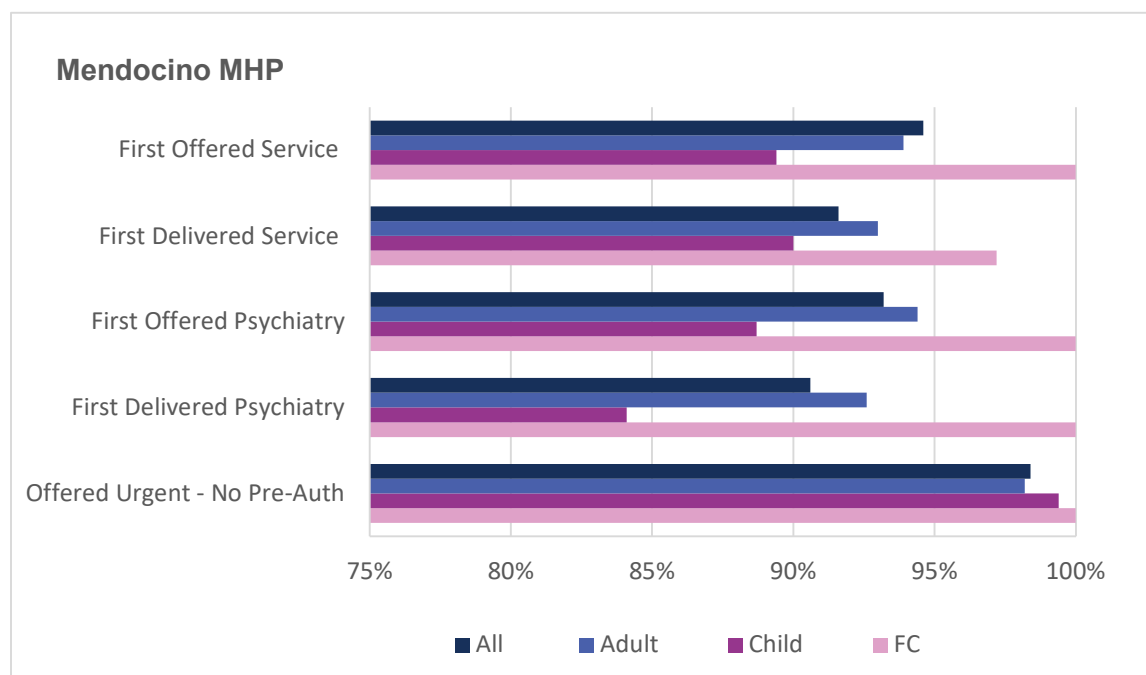


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide 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 assessments.
- The MHP defined “urgent services” for purposes of the ATA as “every request for a face-to-face or person-to-person assessment was treated as an urgent request regardless of the method of initial contact with the crisis center (phone call to crisis center; walk-in to crisis center; phone call from a hospital ER; phone call from law enforcement).” There were reportedly 2,464 urgent service requests with a reported actual wait time to services for the overall population of 0.06 hours. This does not necessarily reflect the response to those members who have a non-crisis but otherwise urgent need. The MHP does not track urgent services that require pre-authorization separately.
- The MHP defines timeliness to first delivered/rendered psychiatry services as point of first clinical determination of need. The MHP reports that it delivers the first psychiatry service within 4 days on average.
- The MHP tracks and monitors data for no-shows. The MHP reports a no-show rate of 6 percent for psychiatrists and 5 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- Although timeliness rates have improved, members report they continue to experience long wait time to be scheduled with therapist after the intake appointment.
- Faster and consistent appointments occurring for psychiatry were validated by members along with increased satisfaction with services.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

The County retains responsibility for MHP QI functions and the ASO provides QI support to contract providers. On a monthly basis, the MHP holds internal QA/QI meetings that address the full-service delivery system. Additionally, the MHP holds a quarterly public stakeholder quality committee; the quarterly stakeholder meeting occurs in a hybrid platform, allowing the public to participate remotely if desired. Quality is viewed as a continuous process and responsibility across the system of care.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of QA, NAMI, and the public, are invited. The QIC is scheduled to meet every two months. Since the previous EQR, the MHP QIC met five times. Of the 11 identified FY 2022-23 QAPI workplan goals, the MHP the majority were met or in process of being met. Staffing issues presented some barriers to some timeliness of service goals.

The MHP utilizes the following level of care (LOC) tools: Child and Adolescent Needs and Strengths assessment (CANS), Adult Needs and Strengths Assessment (ANSA), and the Pediatric Symptom Checklist-35 (PSC-35). Although ANSA is identified as a LOC for adults, there may be inconsistencies in provider utilization of the tool that limits its usefulness in analyses.

The MHP utilizes the following outcomes tools: CANS, ANSA, PSC-35.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- The MHP combines their QIC and MHSA and invites stakeholders as well as board of supervisors (BOS), newspaper and other media, and community members. The meeting is advertised through the media and is held in a hybrid format to accommodate for outlying areas in the county.
- The MHP invites and provides space for public commentary and feedback on the QAPI and MHSA plans.
- The MHP places a big emphasis on data oversight and meets frequently with ASO regarding provider performance. Data is also provided to BOS and community.
- With the transition of provider oversight from ASO to county, the MHP has been meeting frequently with providers to build relationships and provide TA. This has been positively received by the providers.
- The MHP has member-run or member-driven programs: the Arbor Youth Resource Center, Mendocino Coast Hospitality Center, and the two BHRS Wellness Centers.
- The MHP reports employing staff with lived experience; however, the MHP does not have a specified peer classification or peer ladder.

- The MHP tracks and trends the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.

QUALITY PERFORMANCE MEASURES

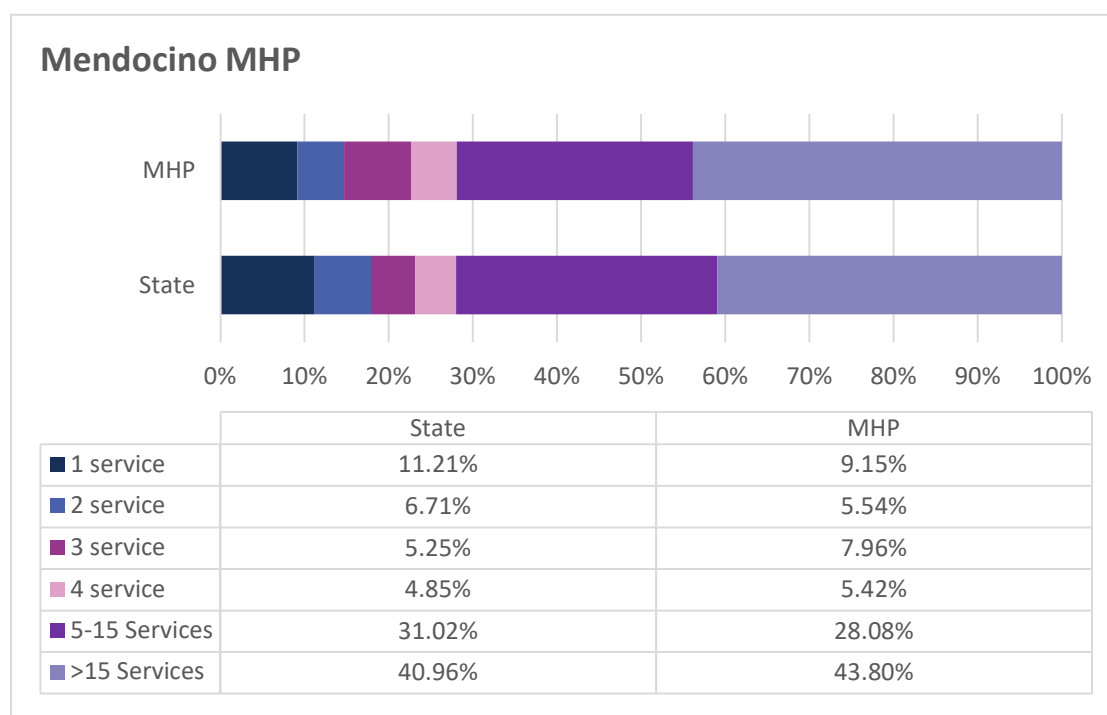
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Members Served, CY 2022

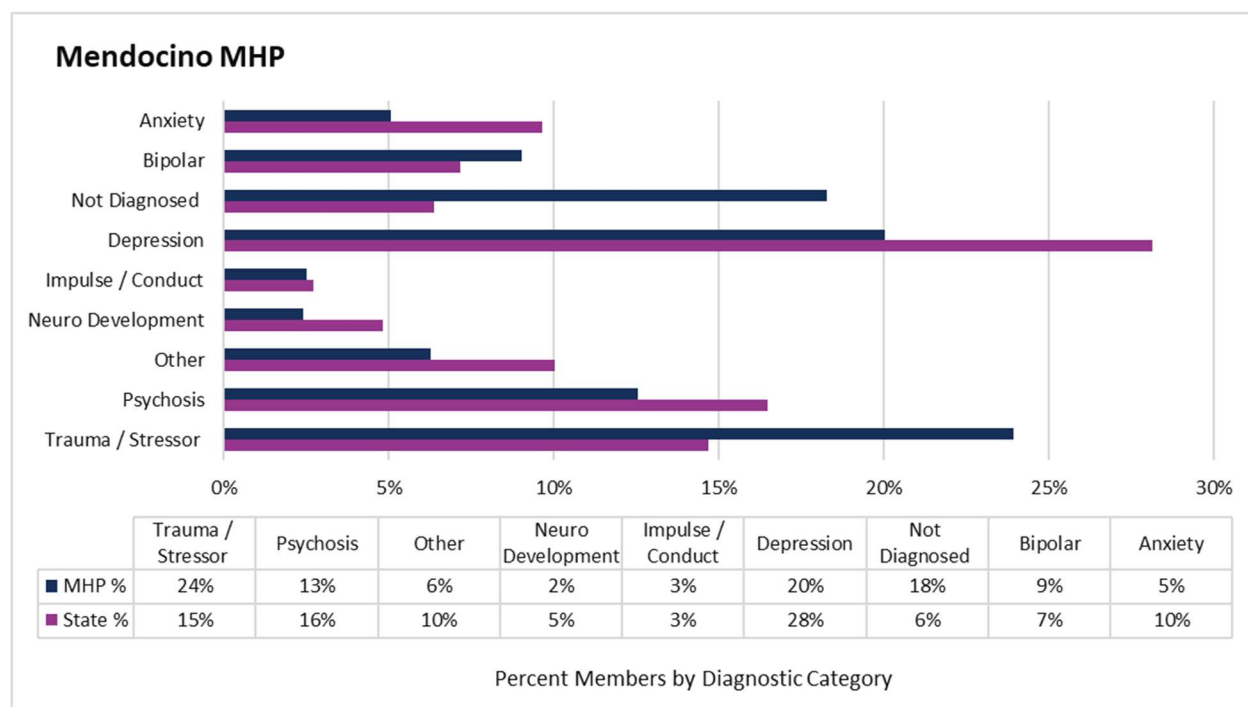


- The MHP had a lower proportion of members receiving a single service than is seen statewide (9.15 percent vs. 11.21 percent).
- While the White retention rate for one service was 7.91 percent, the Hispanic/Latino rate was notably higher, 11.38 percent (not displayed above).
- The MHP's proportion of members receiving greater than 15 services is higher than statewide (43.80 percent vs. 40.96 percent).

Diagnosis of Members Served

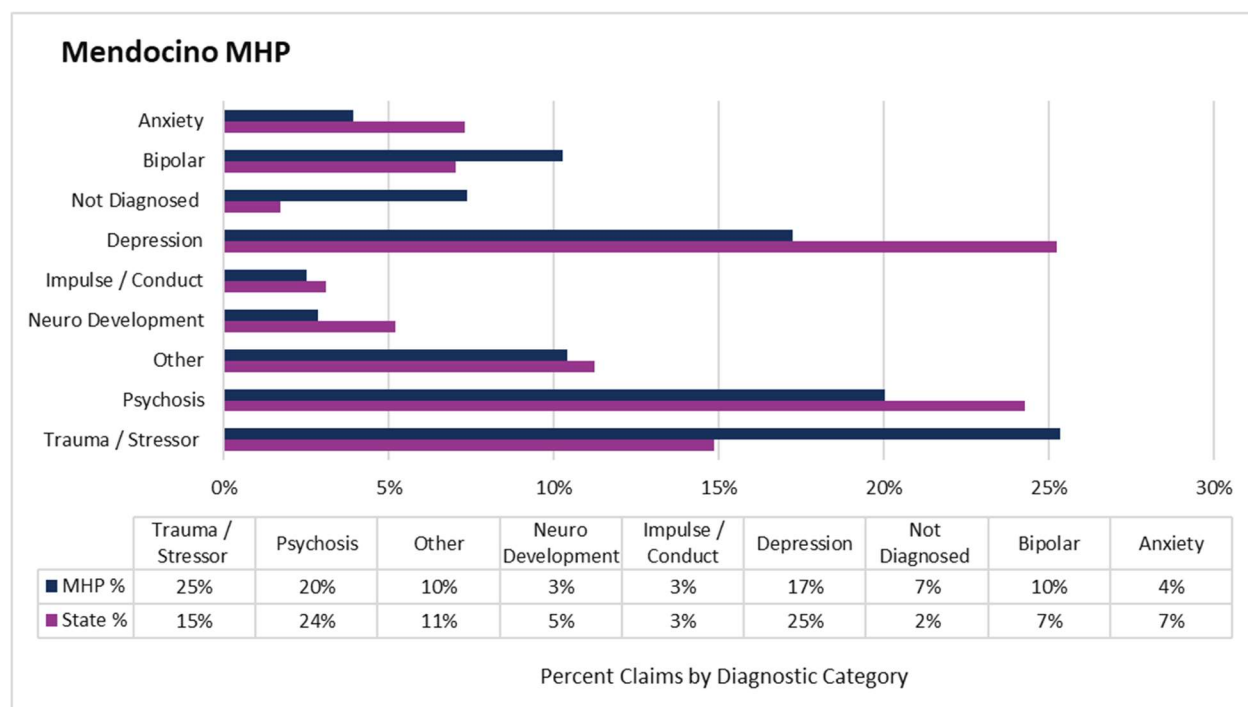
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage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

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



- 62 percent of members had one of three diagnoses: trauma/stressor (24 percent), depression (20 percent), and not diagnosed (18 percent).
- The MHP's diagnostic rates for trauma/stressor and not diagnosed are higher than statewide rates and the diagnostic rates for depression, anxiety, other and psychosis are lower than statewide rates. The MHP has reported a high rate of deferred diagnoses due to crisis intervention provided by paraprofessional staff.

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



- Taking into consideration the MHP's variation in diagnostic patterns when compared to statewide patterns, the MHP's approved claims by diagnostic category generally aligned with statewide approved claims by diagnostic category.

Psychiatric Inpatient Services

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

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

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	255	321	1.26	9.27	8.45	\$14,279	\$12,763	\$3,641,220
CY 2021	262	326	1.24	9.61	8.86	\$13,671	\$12,696	\$3,581,697
CY 2020	243	356	1.47	9.14	8.68	\$14,375	\$11,814	\$3,493,058

- The MHP's CY 2022 inpatient AACM exceeded the statewide average (\$14,279 vs. \$12,763) and MHP's LOS in days also exceeded the statewide average (9.27 days vs. 8.45 days).

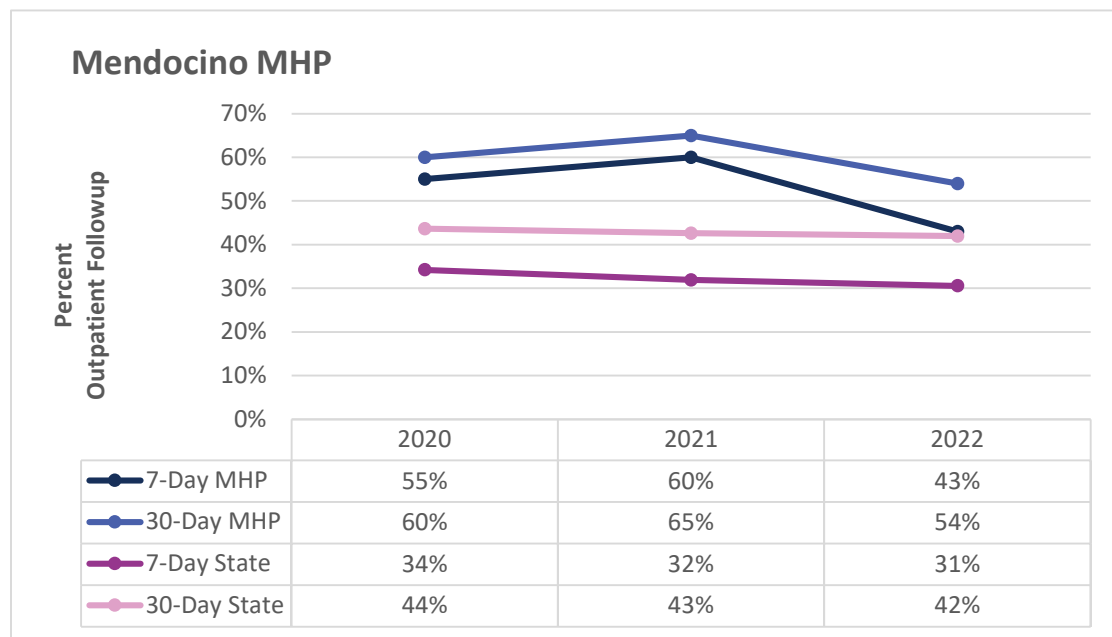
- The unique inpatient member count, total admissions, and average admissions per member were decreased slightly from CY 2021 to CY 2022, although the average and total inpatient claims increased slightly.

Follow-Up Post Hospital Discharge and Readmission Rates

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

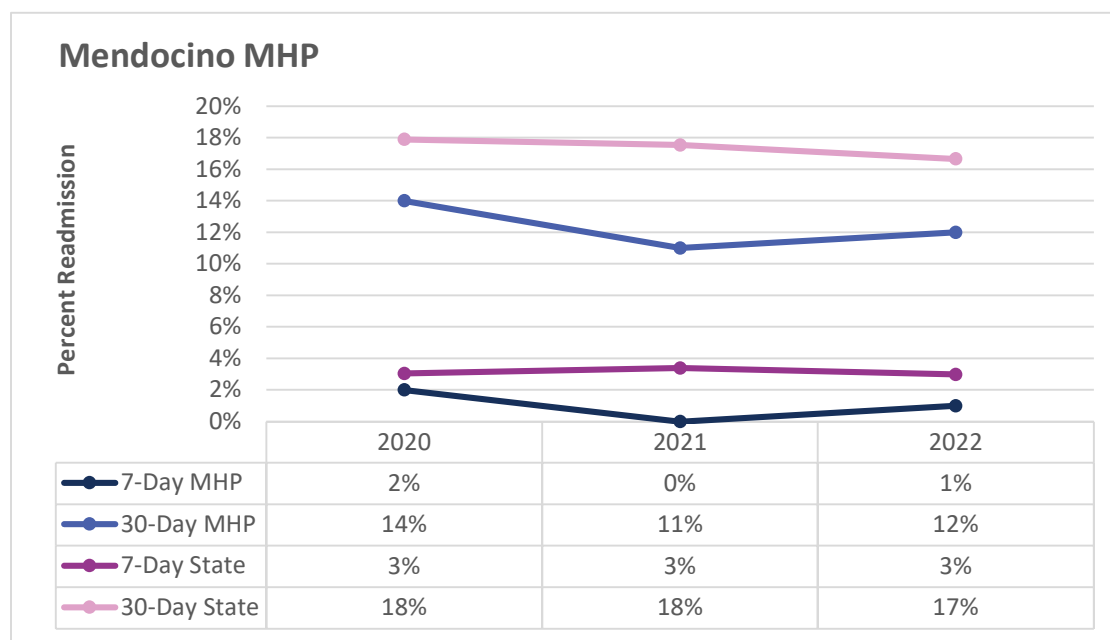
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and is reflected in the rate to which individuals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

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



- While the MHP's 7- and 30-day follow-up rates declined from CY 2021 to CY 2022, the MHP's CY 2022 7-day follow-up rate was higher than the statewide rate (43 percent vs. 31 percent) and the 30-day follow-up rate was also higher than the statewide rate (54 percent vs. 42 percent).

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



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

High-Cost Members

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

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

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

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

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	\$1,514,353,866	\$55,518	\$44,346
MHP	CY 2022	129	5.30%	37.67%	\$7,382,313	\$57,227	\$46,297
	CY 2021	104	4.14%	34.21%	\$6,154,072	\$59,174	\$46,300
	CY 2020	107	4.45%	32.59%	\$5,764,412	\$53,873	\$45,241

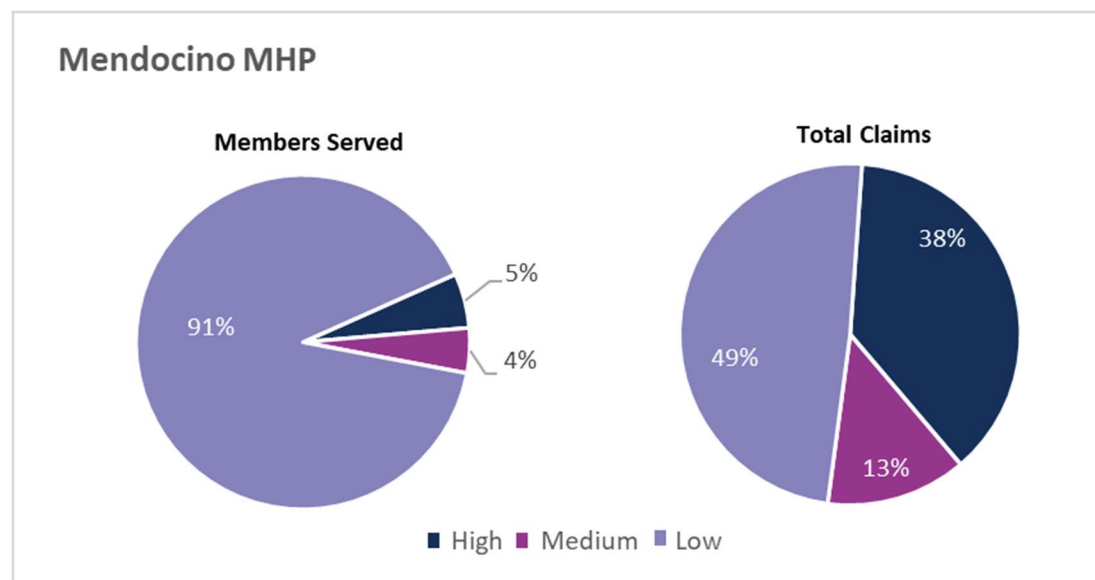
- The MHP's number of HCMs increased from CY 2021 to CY 2022 (104 vs. 129). In CY 2022 and the percentage of HCMs was above the statewide rate (5.30 percent vs. 4.54 percent).
- The MHP's CY 2022 percent of HCM approved claims dollars exceeded the statewide rate (37.67 percent vs. 33.86 percent). The MHP's HCM AACM was higher than the statewide average in CY 2022 (\$57,227 vs. \$55,518).

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

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost (\$20K to \$30K)	106	4.35%	13.33%	\$2,611,522	\$24,637	\$24,367
Low-Cost (Less than \$20K)	2,201	90.35%	49.00%	\$9,602,963	\$4,363	\$2,642

- Low-cost members comprised 90.35 percent of those served and 49.00 percent of the approved claims dollars were attributed to this population.

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



- The proportions of members in each cost category and the proportions of claims attributable to each group were generally comparable to statewide, with a higher proportion of claims associated with HCMs (38 percent vs. 34 percent) and a slightly lower proportion associated with low-cost members (49 percent vs. 54 percent) than statewide.

IMPACT OF QUALITY FINDINGS

- While the MHP had an overall lower rate for one service-only than is seen statewide (9.15 percent vs. 11.21 percent), the White rate for one service was 7.91 percent and the Hispanic/Latino rate was 11.38 percent. This presents the MHP with an opportunity to identify the reason(s) for the higher single service rate for this group.
- Providers noted less paperwork for clinical staff as a result of CalAIM; they also reported difficulties in managing transportation as travel time is no longer billed and separately reimbursed. Instead, staff are arranging transportation, which can be a very time-consuming process for them.
- Frequent collaboration with stakeholders and partners provides for a rapid turnaround in decision-making processes.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330² and 457.1240(b)³. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Youth Level of Care

Date Started: 12/2022

Aim Statement: "Improve CANS scores of youths through increasing youth and caregiver ability to accurately and consistently measure risk factors and protective factors as well as progress and challenges related to risk and protective factors. The secondary aim to improve correlation between CANS and PSC-35 scores as an accurate reflection of caregiver perception of youth treatment needs."

Target Population: All youth ages 0-24 diagnosed with severe emotional disturbance and/or severe mental illness that are Medi-Cal beneficiaries in Mendocino County will be eligible for interventions.

Status of PIP: The MHP's clinical PIP is in the implementation 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 saw incongruent reporting of the PSC-35 completed by parents/caregivers compared to the CANS level of care tool completed by clinicians. This PIP was designed to reduce the discrepancies between caregiver and clinician assessment. By bringing more opportunities to challenge biases, consistently identify symptoms and their impacts, as well as finding consistent ways to discuss strategies to mitigate and resolve symptoms.

The MHP seeks to improve consistency in youth LOC. Pre-intervention the MHP compared PSC-35 scores and CANS scores and discussed in provider discussion groups possible contributing factors. Prior to the intervention providers will be trained in any self-report scoring tools such as PHQ-9, GAD-7, PCL-5 and/or other scores to support youth and caregiver discussion of symptoms and to consistently communicate across treatment providers. As a clinical intervention the MHP plans to add time to discuss identification of symptoms and strategies during family sessions with caregiver and youth every other month. A second intervention will be the introduction of self-report or self-monitoring tools in family sessions.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence because although the methods for data collection are credible, the MHP just recently began implementing the PIP and is monitoring consistency in application of the first intervention and is yet to start the second intervention (the clinical intervention).

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

- Consider pre and post surveys to reflect consistency and effectiveness of the parent education intervention.
- Monitor consistency of training provided to clinicians regarding utilization of tools.
- Seek TA as needed during the duration of the PIP.

NON-CLINICAL PIP

General Information

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

Date Started: 09/2022

Aim Statement: “Improve FUM7 and FUM30 scores by 5 percent, moving from the third quartile to second quartile among California Counties by end of FY 2022/23 by

resuming monthly monitoring meetings of emergency department visits and tracking and addressing trends and barriers identified.”

Target Population: Members with a principal diagnosis of mental illness who have an ED visit.

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

Summary

Mendocino County as a rural county has higher than average rates of suicide and severe mental illness; the MHP frequently hears from stakeholders at public forums that they are unaware of mental health services and that the system of care is challenging to navigate and access; the MHP anticipates that increasing connections to mental health services from emergency contacts will reduce adverse health effects of severe mental illness. While Mendocino County is above the national and California benchmarks for Follow up after ED visits for mental health concerns, Mendocino County is in the third quartile among California counties and aims to improve current metrics by 5 percentage points to FUM7 58% and FUM30 68%.

The MHP resumed monitoring meetings with the ED, BHRS, and crisis team members to review data and identify when and why processes in place to support follow up are not occurring. Additional interventions will be determined based on data from resuming monitoring meetings may include discussions with Partnership HealthPlan of California (PHC) around transportation options for members; education and awareness raising with members around how to ensure members know how to access PHC transport resources; exploration of enhancing existing crisis follow-up and warm hand-off processes to ensure engagement with the follow-up service. Utilization of the enhanced care management benefit will also be considered as part of the interventions to overcome barriers to timely FUM.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence because the MHP is in the early stages of implementation of this PIP. While the first intervention is credible, the MHP is in the process of detailing the second intervention and will need to ensure reliability of the intervention delivered.

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

- The MHP was recommended to include the frequency of meetings with ED in the PIP documentation.
- Document the second intervention and how it will capture data.
- Seek TA as needed during the duration of the PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart Technologies/myAvatar, which has been in use for 20 years. MyAvatar is operated in an ASP environment. 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. The MHP plans to work collaboratively with Netsmart Technologies to upgrade the myAvatar system to myAvatar NX (Avatar NX). Avatar NX is the enhanced Netsmart product version of myAvatar.

The MHP operates a unique dual EHR system. While the MHP utilizes the myAvatar EHR, their ASO and contract providers utilize the EXYM EHR.

Approximately 1.2 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). This is a decline from 6.5 percent in the previous year. The MHP reported that the budget decline was due to being fully supported by County IT, previously the MHP had one IT staff dedicated to the MHP. The budget determination process for IS operations is under MHP control.

The MHP has 331 named users with log-on authority to the EHR, including approximately 31 county staff and 300 contractor staff. Support for the users is provided by nine full-time equivalent (FTE) IS technology positions, two county IT positions provide Avatar support, and 7 ASO/contract provider IT positions provide support for EXYM system. Currently, county IT has one vacant position, a Department Applications Specialist, which has been vacant for 1.5 years. The MHP is approved to recruit for the IT position. Thus far, the recruitment process has not resulted in the identification of a qualified candidate.

As of the FY 2023-24 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Contract providers utilize the EXYM EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

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

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

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP has not implemented a PHR in the Avatar system. The contract provider EHR, EXYM, has PHR functionality.

Interoperability Support

The MHP is a member or participant in the SacValley MedShare HIE. Healthcare professional staff also use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information its contract providers, Federally Qualified Health Centers, Community/Rural Health Centers, hospitals, primary care providers, and Indian Health Centers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP operates a unique dual EHR system. While the MHP utilizes the myAvatar EHR, their ASO/contract providers utilize the EXYM EHR. Both EHRs are operated in an ASP environment which provides the support for the implementation of software patches and promotions.
- The MHP has decided not to replace their current system. The MHP will work collaboratively with Netsmart to implement Avatar NX, an enhanced version of the MHP's current myAvatar system. A target date for this implementation is within 12 to 18 months. Two contract providers have tentatively agreed to use the Avatar NX system.
- No contract providers have access to directly enter clinical data into the MHP's EHR but use electronic data interchange to provide service data to the MHP.
- PHR functionality has not been implemented in myAvatar. The EXYM EHR includes a PHR which offers the ability to receive a medication list and a treatment summary.
- A data warehouse replicating the myAvatar system has not been developed. There is a cloud-based structured query language (SQL) data warehouse that replicates the EXYM system that is used for contract provider reporting and analytics by the ASO.
- Two-factor authentication to authorize user password change is not supported.
- The MHP offers telehealth services in Ukiah, Willits, and Fort Bragg. Contract providers offer telehealth services in more remote areas including Laytonville and Covello.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	5,718	\$1,219,338	\$12,292	1.01%	\$1,207,046
Feb	5,853	\$1,365,328	\$2,099	0.15%	\$1,363,229
Mar	6,981	\$1,646,036	\$5,548	0.34%	\$1,640,488
April	6,321	\$1,498,623	\$5,903	0.39%	\$1,492,720
May	6,126	\$1,493,576	\$27,324	1.83%	\$1,466,252
June	6,001	\$1,467,264	\$11,457	0.78%	\$1,455,807
July	5,616	\$1,368,833	\$2,057	0.15%	\$1,366,776
Aug	6,607	\$1,703,765	\$41,876	2.46%	\$1,661,889
Sept	6,174	\$1,641,801	\$2,772	0.17%	\$1,639,029
Oct	6,147	\$1,497,582	\$14,045	0.94%	\$1,483,537
Nov	6,001	\$1,416,258	\$7,083	0.50%	\$1,409,175
Dec	6,029	\$1,490,710	\$5,682	0.38%	\$1,485,028
Total	73,574	\$17,809,114	\$138,138	0.78%	\$17,670,976

- Claim volume was consistent during CY 2022.

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

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Other healthcare coverage must be billed first	123	\$53,415	38.67%
Service line is a duplicate and repeat service modifier is not present	78	\$38,362	27.77%
Medicare Part B must be billed before submission of claim	38	\$23,207	16.80%
Beneficiary is not eligible or non-covered charges	49	\$22,282	16.13%
Other	5	\$873	0.63%
Total Denied Claims	293	\$138,139	100.00%
Overall Denied Claims Rate	0.78%		
Statewide Overall Denied Claims Rate	5.92%		

- The claims denial rate for CY 2022 of 0.78 percent is notably lower than the statewide denial rate of 5.92 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The use of two EHR systems maintains member health information in disparate electronic health record databases which limits 24/7 access to health information. When the MHP implements Avatar NX, encouraging contract providers to also utilize this system would eliminate the disparate EHR databases and allow 24/7 access to member health information through a single EHR system.
- The MHP's IT budget declined from 6.5 percent to 1.2 percent in the past year due to the loss of 1 FTE IT position, and the MHP now relies fully on County IT for all IT support. The demand for IT support will likely increase during the Avatar NX implementation and there may be an ongoing need for additional IT support if contract providers begin using the Avatar NX system. The MHP should include anticipated IT staffing requirements in their Avatar NX project plan as well as in their future IT budget.
- Participation in SacValley MedShare HIE allows the MHP to share myAvatar electronic health information between northern California providers. Additionally, SacValley MedShare's membership in the California Association of Health Information Exchange will allow for the secure sharing of health information throughout California.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP conducted the CPS survey with less participants than they would like, possibly due to provision of telehealth services. The MHP reports findings to providers and analyzes possible areas needing for improvement.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested 2 90-minute focus groups with plan members and/or their family, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a culturally diverse group of parents and caregivers of youth receiving MH services who initiated and utilized services within the past 12 months. The focus group was held remotely and included five participants; no language interpreter was necessary for this focus group. All caregivers/parents participating have a family member who receives clinical services from the MHP.

The members reported general satisfaction with the MHP services. Members mentioned they appreciated the availability of transportation and how reminder calls and text messages were common. "Stepping Stone is amazing, it changed my life," one member praised.

Members reported feeling welcomed and respected by providers. Members mentioned not participating in surveys, committees, or other methods to provide feedback to the MHP.

Recommendations from focus group participants included:

- Provide more MH education to teachers to reduce police involvement in schools.
- Provide more support groups for parents and caregivers.

Consumer Family Member Focus Group Two

CalEQRO requested a culturally diverse group of adult members receiving MH services who initiated/utilized services within the past 12 months. The focus group was held remotely and included 11 participants; no language interpreter was needed for this focus group. All adult members participating receive clinical services from the MHP.

Members reported a quick turnaround time for intake, however, reported having to wait on average between four to six months for a therapist. Members reported utilizing the crisis therapist for non-crisis services while waiting to initiate services. It was reported that services with a therapist may change and be rescheduled often. Members reported transportation support was available, which was helpful to attend services. Surveys were mentioned to have been filled out, however no involvement from members in committees or other methods to provide feedback to the MHP were noted.

Members expressed their appreciation, one person stating, “I feel totally respected by case workers and staff.” Another indicated the positive impact of care, stating “I was homeless, now I am going to college, have a job and not worrying about where to eat or sleep.”

Recommendations from focus group participants included:

- Provide quicker therapy appointments.
- Increase the workforce to assist with coverage and quicker services.
- Provide more opportunities for rehabilitation services.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Members participating in the focus groups in general were very satisfied with the services they received. They felt respected and validated. Adult services were mentioned to have lengthy delays to see an assigned therapist, but members were satisfied with consistency and timeliness of psychiatric appointments. Overall members mentioned not having much knowledge on how to provide feedback to the MHP.

CONCLUSIONS

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

STRENGTHS

1. The MHP continuously monitors data to evaluate and make data-driven decisions. (Access, Timeliness, Quality)
2. The MHP's PRs are higher than both the small county and statewide rates for almost all age categories, indicating greater service accessibility. (Access)
3. The MHP leadership is actively engaged in suicide prevention activities leading to a robust prevention strategy. (Quality)
4. Participation in the SacValley MedShare HIE allows the secure sharing of myAvatar health information throughout California. (IS)
5. As oversight transitions from the ASO, contractors report satisfaction with the MHP's attempts to work towards building relationships. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. While the single service-only rate for white members was 7.91 percent, the Hispanic/Latino rate was 11.38 percent, which suggests disparity in engagement and retention. (Access, Quality)
2. Member health information is maintained in disparate EHR systems which limits access to this information. Three providers agreed to join Avatar NX, however MHP's bigger provider has not yet agreed to join. (IS)
3. The rate of deferred diagnosis continues to be much greater than the statewide average (18 percent vs. 6 percent). At the same time urgent service requests are defined as crisis, which may contribute to the high rate of deferred diagnoses. (Timeliness, Quality)
4. While the MHP mentions staff with lived experience in workforce, the MHP currently does not have specified peer classification in their workforce, nor does the MHP have a specified career ladder for peers. (Quality)
5. The demand for IT support will likely increase during the Avatar NX implementation and there may be an ongoing need for additional IT support if contract providers begin using the Avatar NX system. (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 member outcomes:

1. Research possible reasons for the higher Latino/Hispanic single service percentage and design culturally appropriate ways to increase engagement and consider conducting Hispanic/Latino focus groups to gather feedback from this population (Access, Quality)
(This recommendation was continued from FY 2022-23.)
2. To eliminate disparate EHR databases and allow 24/7 access to member health information, consider permitting all contract providers full access to the enhanced Avatar NX EHR system. (IS)
(This recommendation was continued from FY 2022-23.)
3. Consider the opportunity to redefine urgent services distinctly from crisis needs to offer an opportunity for a more complete understanding of the non-crisis but urgent service requests. Create a process that helps to reduce the number of deferred diagnoses beyond the initial engagement in services. (Timeliness, Quality)
(This recommendation was continued from FY 2022-23.)
4. Consider creating a peer classification and a peer specific career ladder to enable peer providers with certification to deliver peer support services. (Quality)
5. Consider including anticipated IT staffing requirements in the Avatar NX project plan as well as in planning the post-implementation IT budget (IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2023-24 EQR. The MHP did not identify any barriers to the EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Mendocino MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year’s recommendations
Validation and Analysis of the MHP’s Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP’s PIPs
Validation and Analysis of the MHP’s PMs
Validation and Analysis of the MHP’s Network Adequacy
Validation and Analysis of the MHP’s Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being (Katie A./CCR)
Consumer and Family Member Focus Group
Clinical Line Staff Group Interview
Contract Providers Group Interview - Management
Cultural Competence
Quality Management, Quality Improvement and Use of Data to Support Program Operations
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Nathan Lacle, MPA, PsyD(c), Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Mary Ellen Collins, 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
Anderson	Dan	Chief Operations Officer	Anchor Health Management, Inc.
Beeney	Joseph	Clinical Supervisor	RCS
Bengston	Logan	Clinical Supervisor	RCS
Bhandari	Navin	Senior Program Manager	Mendocino County BHRS
Burtis	Peter	Clinical Director	MCHC
Cuadrado	Lupita	Program Supervisor	RCS
Driggers	Melinda	BHRS AOT Coordinator	Mendocino County BHRS
Damian	Edgar	Care Manager	RSC
Harris	Carmen	Clinical Director	Anchor Health Management, Inc.
Harris	Robin	Acting Staff Service Administrator	Mendocino County BHRS
Kaye	Martin	Sr. Department Analyst	Mendocino County BHRS
Landis	Cliff	MH Clinical Manager	Mendocino County BHRS
Lemus	Tony	Department Application Specialist	Mendocino County BHRS
Livingston	Sarah	Crisis Services Director	Redwood Community Crisis Services
Logan	Alicia	Business Administrator	Anchor Health Management, Inc.
Lovato	Karen	Senior Program Manager	Mendocino County BHRS
Lower	Danielle	EHR Manager	Anchor Health Management, Inc.
Miller	Jenine	Director	Mendocino County BHRS
Miramontes	Michelle	Care Manager	RSC
Offill	Christina	Clinical Supervisor	Tapestry Family Services

Last Name	First Name	Position	County or Contracted Agency
O'Malley	Alex	Clinical Supervisor	Tapestry Family Services
Pane	Mailea	Staff Services Manager II	Mendocino County BHRS
Rathburn	Terri	Clinical Supervisor	Youth Project
Schraeder	Tim	Chief Executive Officer	Anchor Health Management, Inc.
Sells	Megan	Rehab Coordinator	Tapestry Family Services
Thomason	Tommy	Therapist	Tapestry Family Services
Twyman	Dan	BHRS Dual Response	Mendocino County BHRS
Varlow	Kate	Therapist	Tapestry Family Services
Walsh	Sarah	Contracts Data Analyst	Anchor Health Management, Inc.
Willeford	Mary Alice	Deputy Director	Mendocino County BHRS
Wilkinson	Larissa	MHRS Supervisor	Tapestry Family Services
Yovino	Mary	Program Administrator	Anchor Health Management, Inc.

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	Although the methods for data collection are credible, the MHP just recently began implementing the PIP and is monitoring consistency in application of first intervention and is yet to start the second intervention.
General PIP Information	
MHP/DMC-ODS Name: Mendocino County	
PIP Title: Youth Level of Care	
PIP Aim Statement: Improve CANS scores of youths through increasing youth and caregiver ability to accurately and consistently measure risk factors and protective factors as well as progress and challenges related to risk and protective factors. The secondary aim to improve correlation between CANS and PSC-35 scores as an accurate reflection of caregiver perception of youth treatment needs.	
Date Started: 12/2022	
Date Completed: n/a	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: Children age range 0-24	

General PIP Information						
Target population description, such as specific diagnosis (please specify): All youth ages 0-24 diagnosed with severe emotional disturbance and/or severe mental illness that are Medi-Cal Beneficiaries in Mendocino County will be eligible for interventions.						
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): Introduce member self-report/ self-monitoring tools in family sessions.						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Provide training to clinicians on self-reporting tools such as PHQ-9, GADr7, PCL-5.						
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Click or tap here to enter text.						
PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Add time to family sessions with caregiver and youth to discuss identification of symptoms and strategies			☒ 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
Introduction of self-report/self-monitoring tools with family sessions			☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PIP Validation Information						
Was the PIP validated? ☒ Yes ☐ No “Validated” means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.						
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: - The MHP could do pre and post surveys to indicate consistency and effectiveness in parent education. - Monitor consistency of training provided to clinicians regarding utilization of tools. - Seek TA as needed during the duration of the PIP.						

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The MHP is in the early stages of implementation of this PIP. While the first intervention is credible, the MHP is in the process of detailing the second intervention and will need to ensure credibility of the intervention.
General PIP Information	
MHP/DMC-ODS Name: Mendocino County	
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness	
PIP Aim Statement: Mendocino County aims to improve FUM7 and FUM30 scores by 5 percent, moving from the 3 rd quartile to 2 nd quartile among California Counties by end of FY 2022/23 by resuming monthly monitoring meetings of emergency department visits and tracking and addressing trends and barriers identified.	
Date Started: 9/15/2022	
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:	

General PIP Information						
Target population description, such as specific diagnosis (please specify): Members with a principal diagnosis of mental illness who have an ED visit.						
Improvement Strategies or Interventions (Changes in the PIP)						
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a						
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The MHP will resume meetings with the ED and crisis members to review data and identify when and why processes in place to support follow up are not occurring.						
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
resume monitoring meetings with the Emergency Department, BHRS, and Crisis members to review data and identify when and why processes in place to support follow up are not occurring			☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

- ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year
- ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

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

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

EQRO recommendations for improvement of PIP:

- The MHP was recommended to include the frequency of meetings with ED in the PIP documentation.
- Document the second intervention and how it will capture data.
- Seek TA as needed during the duration of the PIP.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, CalEQRO Approved Claims Definitions, 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 as part of this report.