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FY 2021-22
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

MENDOCINO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

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December 8, 2021

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 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.

MHP INFORMATION

MHP Reviewed — Mendocino

Review Type — Virtual

Date of Review — December 8, 2021

MHP Size — Small

MHP Region — Superior

MHP Location — Ukiah

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 2,406

MHP Threshold Language(s) — English, Spanish

SUMMARY OF FINDINGS

Of the five recommendations for improvement that resulted from the FY 2020-21 EQR, the MHP addressed or partially addressed all five recommendations.

CalEQRO evaluated the MHP on the following four Key Components that impact beneficiary outcomes; among the 26 components evaluated, the MHP met or partially met the following, by domain:

- Access to Care: 100 percent (four of four components)
- Timeliness of Care: 100 percent (six of six components)
- Quality of Care: 100 percent (ten of ten components)
- Information Systems (IS): 100 percent (six of six components)

The MHP submitted both required Performance Improvement Projects (PIPs). The clinical PIP, “Social Skill Development for clients transitioning to Adulthood from Transition Age Youth (TAY) status”, is in the implementation phase with a low confidence validation rating. The non-clinical PIP, “Reducing recurrent inpatient hospitalization in the community”, was found to be active (implementation phase) with a low confidence validation rating.

CalEQRO conducted one consumer family member focus group, comprised of a total of five participants.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: the MHP implemented the first Mobile Crisis Team in co-response with the Mendocino County Sheriff's Office the MHP provides telehealth services in a language other than English. Due to restrictions of the COVID-19 public health emergency, the MHP implemented Zoom meetings of the Cultural Diversity Committee to address cultural competence; the MHP meets the standard for first offered and first rendered psychiatry 99 and 98 percent of the time, respectively; the MHP has a systematic clinical continuum of care that includes a Child and Adolescent Needs and Strengths (CANS)/Adult Needs and Strengths Assessments (ANSA) Scoring Guide; and the Information Technology (IT) budget was reported to be 7.00 percent, an increase from 1.57 percent in FY 2020-21.

The MHP was found to have notable opportunities for improvement in the following areas: The MHP does not have a Personal Health Record (PHR) at this time. There is an insufficient number of Spanish-speaking bilingual staff in proportion to the number of beneficiaries who prefer Spanish. The MHP reports difficulty recruiting licensed clinical staff. Stakeholders report transportation when receiving services in person is often difficult to provide for themselves. Both PIPs encountered barriers in implementation specific to issues of the COVID-19 pandemic restrictions.

FY 2021-22 CalEQRO recommendations for improvement include; Continue to develop and prioritize the implementation of PHRs for beneficiaries. Investigate reasons and implement strategies to recruit and retain bilingual staff. Research possible avenues to increase clinical staff; to include interns and work study programs as appropriate. Research transportation options for beneficiaries and ensure that they are aware of any benefits they might have to resolve this issue. Implement regular technical assistance (TA) sessions with CalEQRO during the ongoing implementation of the PIPs.

INTRODUCTION

BACKGROUND

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

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

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

This report presents the fiscal year (FY) 2021-22 findings of the EQR for Mendocino County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on December 8, 2021.

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 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 analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior

year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files, unless otherwise specified. These statewide data sources include: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File (IPC). CalEQRO reviews are retrospective; therefore, data evaluated are from CY 2020 and FY 2020-21, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data–overall, FC, transitional age youth, and Affordable Care Act (ACA). CalEQRO also provides individualized TA related to claims data analysis upon request.

FINDINGS

Findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of three elements pertaining to NA: Alternative Access Standards (AAS) requests, use of out-of-network (OON) providers and rendering provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).
- Summary of MHP-specific activities related to the following four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, and an examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per SB 1291 (Chapter 844).
- Review and validation of submitted Performance Improvement Projects (PIPs).
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the MHP's quality and operational processes.
- Consumer perception of the MHP's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data; its corresponding penetration rate percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

In this section, the status of last year's (FY 2020-21) EQR recommendations are presented, as well as changes within the MHP's environment since its last review.

ENVIRONMENTAL IMPACT

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic that took place across the state. From April to September 2021, Mendocino County was affected by the Turnout, Tomki, Broiler, Bell, and Hopkins fires. The MHP experienced loss of staff, was required to adjust service delivery processes, and needed to rapidly pivot to increased telehealth services and telework for staff. The MHP noted difficulty in recruiting licensed staff, partially due to ongoing statewide shortage of candidates. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

MHP 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 Health and Human Services Agency (HHSA) Director retired September 2020. At that time changes included retiring the HHSA model. Mendocino Mental Health became a standalone program.
- Implementation of the first Mobile Crisis Team with Mendocino County Sheriff's Office and significant expansion of Mobile Crisis Response Services.
- Completion of the building of a crisis residential treatment operation facility in past 14 months, with plans for the grand opening in February 2022.
- Innovation Plan Healthy Living Community approved by state Mental Health Services Oversight and Accountability Commission (MHSOAC) and now entering the request for proposal process.
- Mendocino County tax measure for mental health treatment in 2017, the oversight committee approved funding for a coast respite center. The MHP plans an opening in Fort Bragg the first quarter of 2022.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2020-21

Recommendation 1: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Mendocino County MHP produces two PIPs each year with one being clinical and one being non-clinical. Both were submitted and validated by EQRO for FY 2021-22.
- The PIPs this year are a clinical PIP that focuses on social skills development for clients transitioning to adulthood from TAY status, and a non-clinical PIP that focuses on reducing recurrent inpatient hospitalization. EQRO provided TA for both PIPs.
- Both PIPs encountered barriers in implementation specific to issues of the COVID-19 pandemic restrictions. The MHP plans to continue the PIPs with adjustments made to address the restrictions that affect them.
- The MHP reports that it begins the PIP planning process as soon as the prior PIP is complete.

Recommendation 2: The MHP is encouraged to make frequent use of technical assistance (TA) from the EQRO in the development of both new PIPs.

(This recommendation is a carry-over from FY 2019-20.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Over the past few years Mendocino County MHP has consulted with and made frequent use of the EQRO TA regarding PIPs. The MHP sought out TA for PIPs during the EQR in November 2020 and immediately following the review.
- The MHP attended the June 30, 2021, BHC PIP webinar, and met with the current lead reviewer in June of 2021.
- The MHP commits to ongoing TA with EQRO for the current and upcoming year.

Recommendation 3: Ensure that the MHP's website provides prominent information about accessing Redwood Quality Management Company's (RQMC's) website for detail about available services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Mendocino County MHP has an individual assigned to review and update the Behavioral Health website on a regular basis. The individual works with the unit managers to ensure that the material is current and makes any needed updates, changes, or additions.
- The MHP responds to stakeholder feedback regarding the website to ensure it remains user friendly and includes ease of access to all available services.
- The website has links to all provider and wellness centers, including RQMC. However, the County website is the main webpage for the community on details about available services (e.g., during the COVID-19 Pandemic, the website was updated with "How to Access Services During COVID-19" which allows beneficiaries to see all the programs, contact information, services provided, and accessibility options).
- The MHP will need to update the website as to how to locate services once COVID-19 is not an issue.

Recommendation 4: Explore and address beneficiaries' concerns about insufficient information when medications are changed.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Mendocino County MHP discussed with the RQMC concerns of the beneficiaries related to insufficient information provided when a provider is considering a medication change.
- The insufficient information around medication changes was discussed during Quality Assurance (QA) meetings.

- RQMC worked with their providers to make sure that more information is provided to individuals when there is a proposed medication change.
- The MHP tracked medication consent signatures in FY 2019-20. In FY 2020-21 the MHP set a goal of 85 percent compliance of having medication consent signatures and observed over 87.5 percent of medication consent forms in compliance. This indicates that beneficiaries are informed of and consent with medication changes.
- The MHP is in the process of developing a survey to collect beneficiary feedback about medication information and satisfaction.

Recommendation 5: Create and implement policies and procedures for monitoring, tracking, and reporting on EQRO-mandated SB 1291 elements and Healthcare Effectiveness Data Information Set (HEDIS) medication administration practices. Ensure that results are incorporated into a Quality Improvement (QI) process.

(This recommendation is a carry-over from FY 2019-20.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has been monitoring medication administration and tracking trends in FY 2020-21 and FY 2021-22 to date.
- Through the process of an ad-hoc Utilization Management (UM) workgroup, the MHP and contractors researched the SB1291 elements and discovered that they monitor and track the HEDIS measures required of (1) follow-up care for children prescribed attention deficit hyperactivity disorder medication, (2) use of multiple concurrent antipsychotics in children and adolescents, (3) use of first-line psychosocial care for children and adolescents on antipsychotics, and (4) metabolic monitoring for children and adolescents on antipsychotics. This information was provided to EQRO in the MHP's Pathways to Wellness Questionnaire response.
- However, the MHP struggles to develop a reporting mechanism that tracks FC youth independently of youth in general due to the shifting legal status of the beneficiary moving in or out of the Child Welfare system. In the final workgroup of FY 2020-21 the medication clinic pointed out that Child Welfare involved youth have unique Medi-Cal aid code identifiers. Utilizing that indicator moving forward, QA intends to report this out bi-annually in UM meeting reports.
- The MHP has drafted an updated policy to include reporting on these measures and is working with direct service providers to improve the reporting capacity of this data.

NETWORK ADEQUACY

BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All MHPs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services, for youth and adults. If these standards are not met, DHCS requires the MHP to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews separately and with MHP staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the MHP's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

FINDINGS

For Mendocino County, the time and distance requirements are 60 miles and 90 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over)[1].

Alternative Access Standards and Out-of-Network Providers

The MHP met all time and distance standards and was not required to submit an AAS request. Further, because the MHP is able to provide necessary services to a beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries to access services via OON providers.

Planned Improvements to Meet NA Standards

Not Applicable.

MHP Activities in Response to FY 2020-21 AAS

The MHP did not require AAS in FY 2020-21.

PROVIDER NPI AND TAXONOMY CODES

CalEQRO provides the MHP a detailed list of its rendering provider's NPI Type 1 number and associated taxonomy code and description. Individual technical assistance is provided to MHPs to resolve issues which may result in claims denials, when indicated. The data comes from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. The data are linked to the NPPES using the rendering service provider's NPI, Type 1 number. A summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO will be presented in the FY 2021-22 Annual Aggregate Statewide report.

[1] AB 205 and BHIN 21-023

ACCESS TO CARE

BACKGROUND

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

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

ACCESS IN MENDOCINO COUNTY

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 34 percent of services were delivered by county-operated/staffed clinics and sites, and 66 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 61 percent of services provided are claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff during business hours and by Tri-Cities Answering Services Call Center after hours and as back up staff; beneficiaries may request services through the Access Line as well as through the following system entry points: any specialty mental health service provider and Mental Health Services Act (MHSA) Wellness Center including but not limited to RQMC, Manzanita Services, Redwood Community Services, Mendocino County AIDS/Viral Hepatitis Network (MCAVHN), Mendocino County Youth Project, Tapestry Family Services, and/or Mendocino County Behavioral Health and Recovery Services. The MHP operates a decentralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Service provider access points that are able to complete an assessment, do so and triage the client into services. Service providers that are at capacity or do not have clinical staff to complete the assessment triage the assessment for medically necessary services through RQMC, who determines the best fit service provider with capacity to serve the client.

In addition to clinic-based mental health services, the MHP provides telehealth and mobile mental health services. Specifically, the MHP delivers psychiatry and/or mental health services via telehealth to youth and/or adults. In FY 2020-21, the MHP reports having served 1,197 adult beneficiaries, 716 youth beneficiaries, and 86 older adult beneficiaries across 3 county-operated sites and 21 contractor-operated sites. Among

those served, 91 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

ACCESS KEY COMPONENTS

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

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

Table 1: Key Components - Access

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

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

- The MHP provides telehealth services in a language other than English.
- Due to restrictions of the COVID-19 public health emergency, the MHP implemented Zoom meetings of the Cultural Diversity Committee to address cultural competence and hear feedback from community members, beneficiaries of health services, and other interested stakeholders on their cultural diversity needs and goals.
- The MHP implemented the first Mobile Crisis Team with the Mendocino County Sheriff's Office. Recent partnerships around mobile crisis teams and co-response are evidence of the supportive collaboration.

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect access to care in the MHP:

- Total beneficiaries served, stratified by race/ethnicity and threshold language.
- Penetration rates, stratified by race/ethnicity and FC status.
- Approved claims per beneficiary (ACB) served, stratified by race/ethnicity and FC status.

Total Beneficiaries Served

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

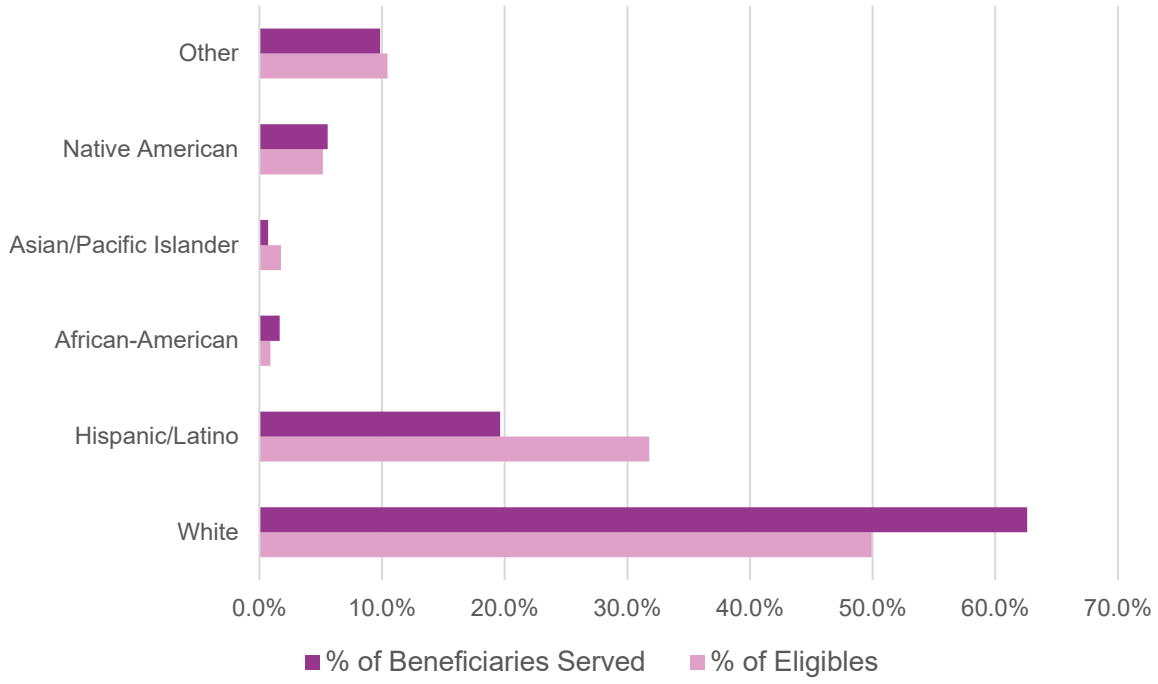
Table 2: County Medi-Cal Eligible Population and Beneficiaries Served in CY 2020, by Race/Ethnicity

Mendocino MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	19,887	49.9%	1,506	62.6%
Latino/Hispanic	12,665	31.8%	472	19.6%
African-American	361	0.9%	40	1.7%
Asian/Pacific Islander	698	1.8%	17	0.7%
Native American	2,066	5.2%	134	5.6%
Other	4,161	10.4%	237	9.9%
Total	**39,838**	**100%**	**2,406**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries

served. Latino/Hispanic beneficiaries comprised the next largest race/ethnicity group being 31.8 percent of the eligible population and 19.6 percent of those served. The disproportion between percent of Latino/Hispanic eligibles and percent of beneficiaries (31.8 percent vs. 19.6 percent) indicates that the Latino/Hispanic population may be underserved.

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020



Mendocino has one threshold language other than English, Spanish, and served 153 unique beneficiaries who identified Spanish as a preferred language.

Table 3: Beneficiaries Served in CY 2020, by Threshold Language

Mendocino MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	153	6.5%
Other Languages	2,203	93.5%
Total	**2,356**	**100%**
Threshold language source: Open Data per IN 20-070 Other Languages include English		

Penetration Rates and Approved Claim Dollars per Beneficiary Served

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The ACB served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. Table D1 is “CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB.”

Figures 2 through 9 highlight three-year trends for penetration rates and average approved claims for all beneficiaries served by the MHP as well as the following three populations with historically low penetration rates: FC, Latino/Hispanic, and Asian/Pacific Islander (API) beneficiaries.

Mendocino’s overall penetration rate (Figure 2) declined from CY 2019 to CY 2020 (6.31 percent vs. 6.04 percent). However, it remains more than 1 percentage point greater than both the small county (6.04 percent vs. 4.53 percent) and statewide average (3.43 percent vs. 4.55 percent).

The overall approved claims dollars per beneficiary (Figure 3) was stable from CY 2019 to CY 2020 ($7,354 vs. 7,352) and slightly above both the small county average ($7,352 vs. $7,142) and the statewide average ($7,352 vs. $7,155).

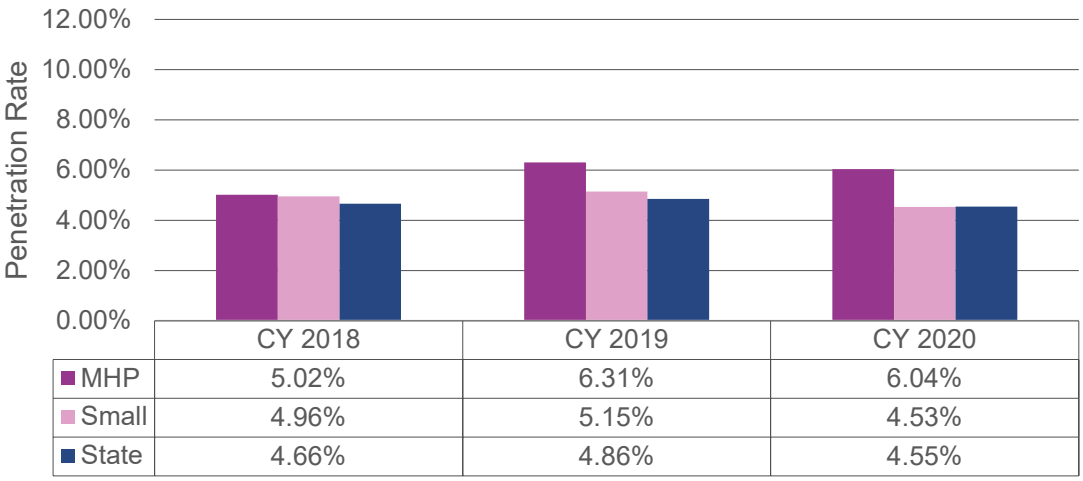
There was no significant change in the Latino/Hispanic penetration rate (Figure 4) from CY 2019 to CY 2020 (3.82 percent vs. 3.73 percent) and it is comparable to both the

small county (3.73 percent vs. 3.87 percent) and statewide average (3.73 percent vs. 3.83 percent).

The FC penetration rate (Figure 8) declined from CY 2019 to CY 2020 (51.14 percent vs. 47.15 percent) and is greater than the small county average (47.15 percent vs. 43.16 percent) but less than the statewide average (45.86 percent vs. 51.00 percent).

FC approved claims dollars per beneficiary (Figure 9) increased each year from CY 2018 to CY2020 ($15,830 vs. $16,697 vs. $17,254) and in CY 2020 is significantly greater than both the small county ($17,254 vs. $10,017) and statewide averages ($17,254 vs. $10,338).

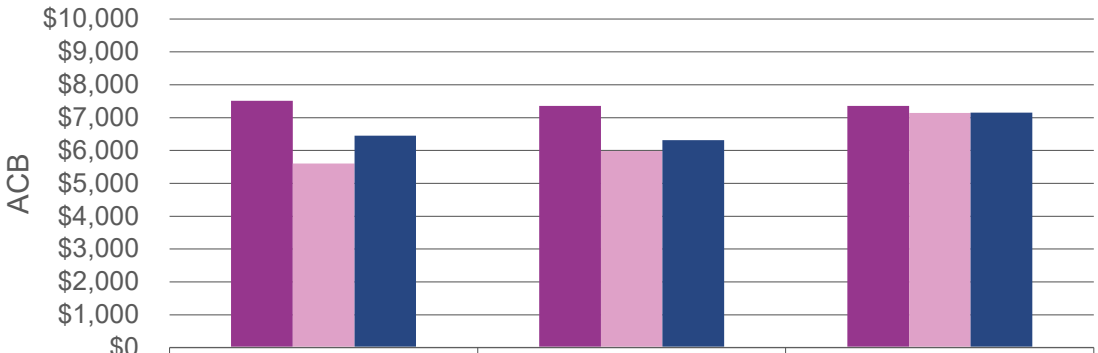
Figure 2: Overall Penetration Rates CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	5.02%	6.31%	6.04%
Small	4.96%	5.15%	4.53%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20

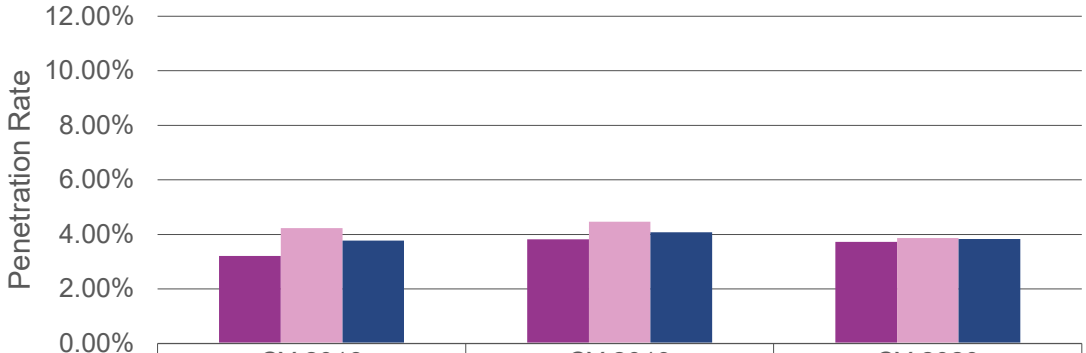
Mendocino MHP



	CY 2018	CY 2019	CY 2020
MHP	$7,511	$7,354	$7,352
Small	$5,602	$5,982	$7,142
State	$6,454	$6,316	$7,155

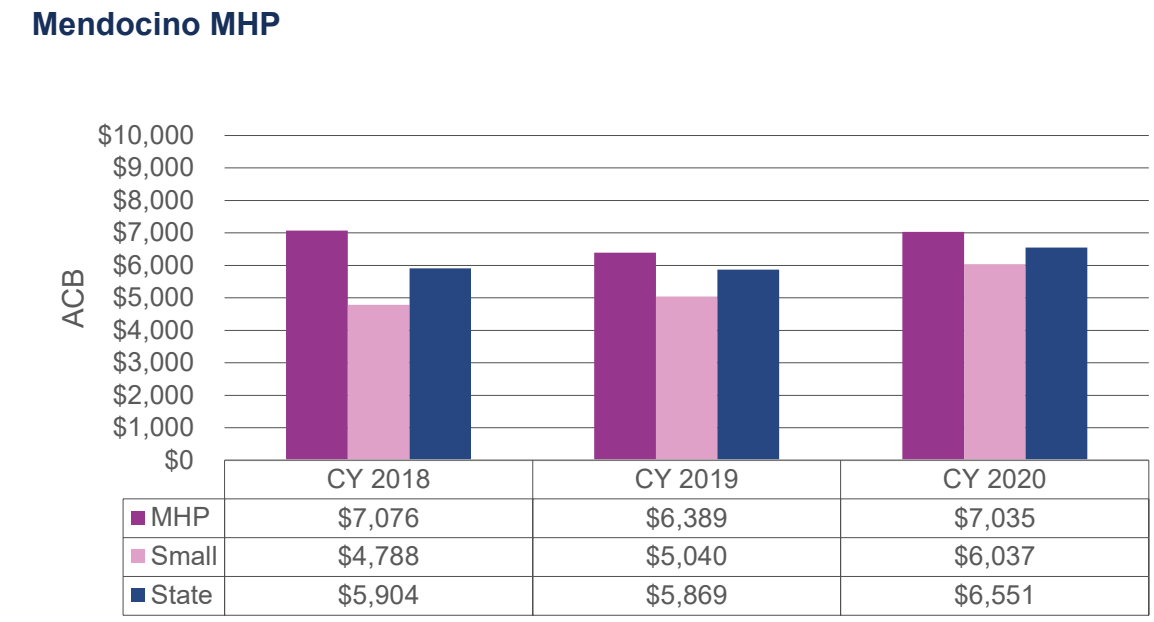
Figure 4: Latino/Hispanic Penetration Rates CY 2018-20

Mendocino MHP



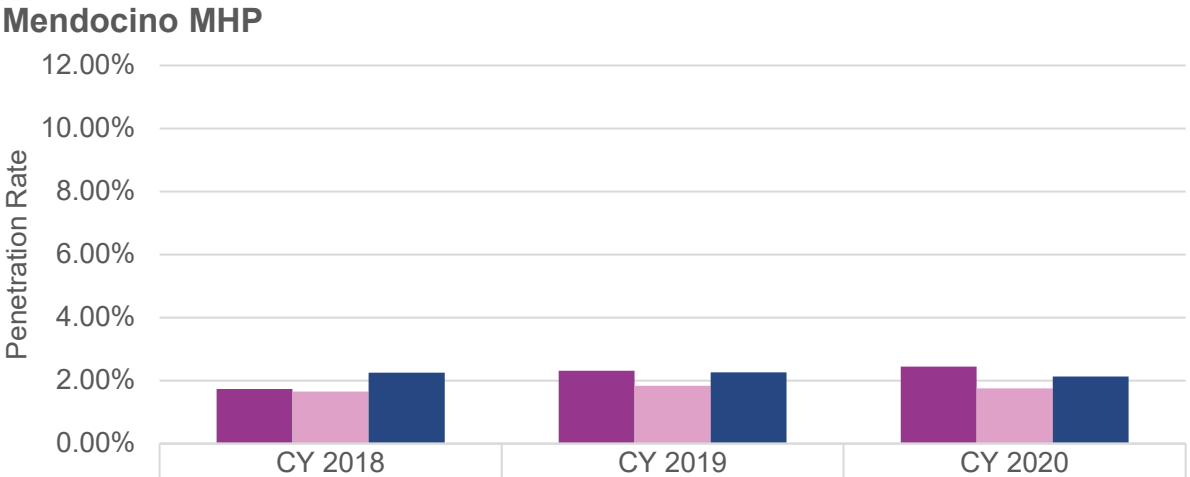
	CY 2018	CY 2019	CY 2020
MHP	3.21%	3.82%	3.73%
Small	4.23%	4.47%	3.87%
State	3.78%	4.08%	3.83%

Figure 5: Latino/Hispanic ACB CY 2018-20



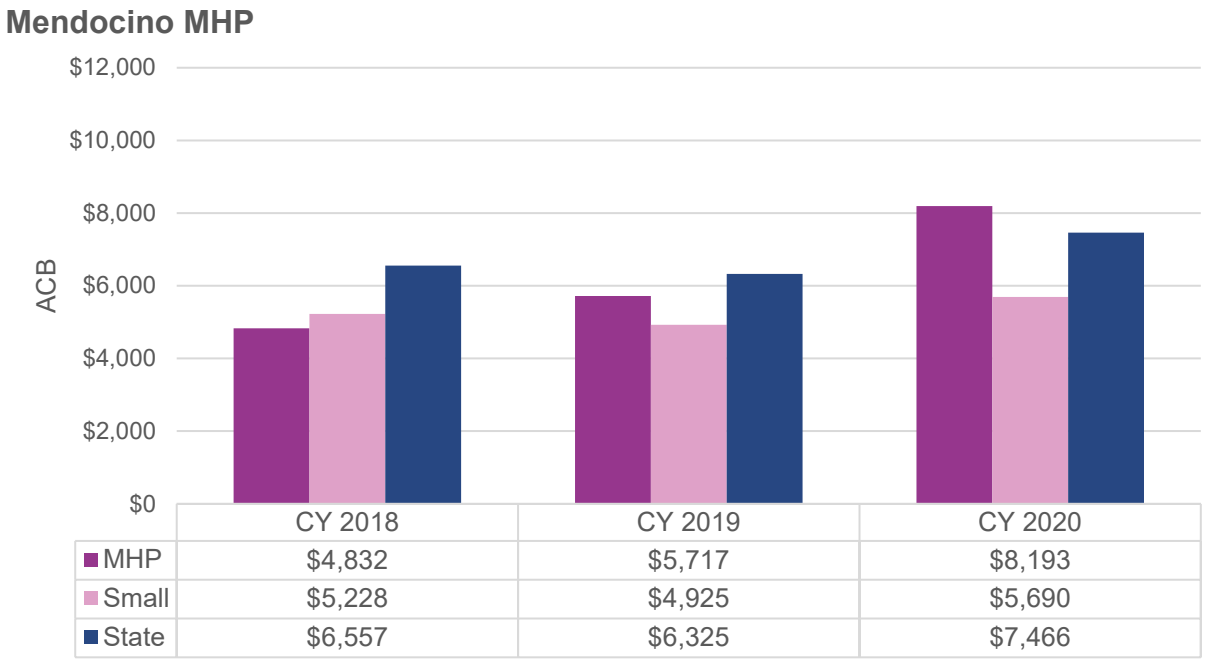
	CY 2018	CY 2019	CY 2020
MHP	$7,076	$6,389	$7,035
Small	$4,788	$5,040	$6,037
State	$5,904	$5,869	$6,551

Figure 6: Asian/Pacific Islander Penetration Rates CY 2018-20



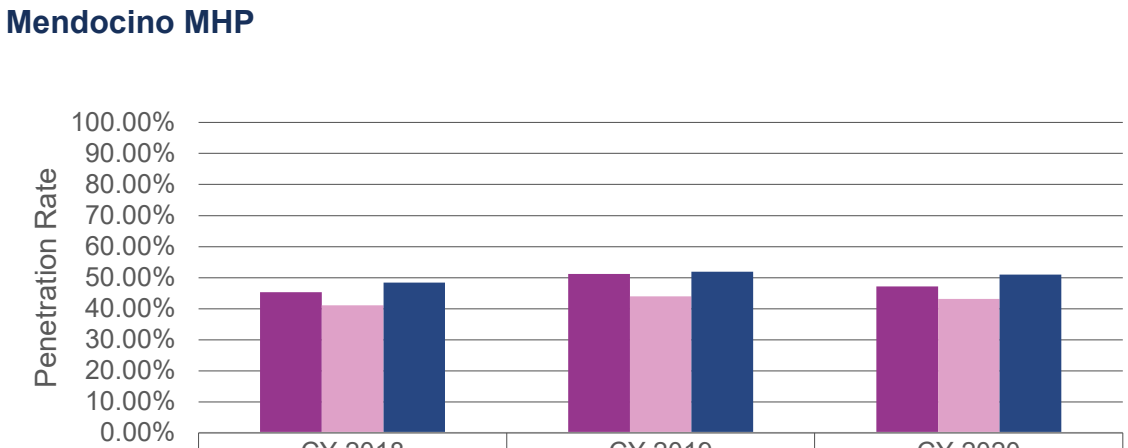
	CY 2018	CY 2019	CY 2020
MHP	1.73%	2.31%	2.44%
Small	1.65%	1.83%	1.75%
State	2.25%	2.26%	2.13%

Figure 7: Asian/Pacific Islander ACB CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	$4,832	$5,717	$8,193
Small	$5,228	$4,925	$5,690
State	$6,557	$6,325	$7,466

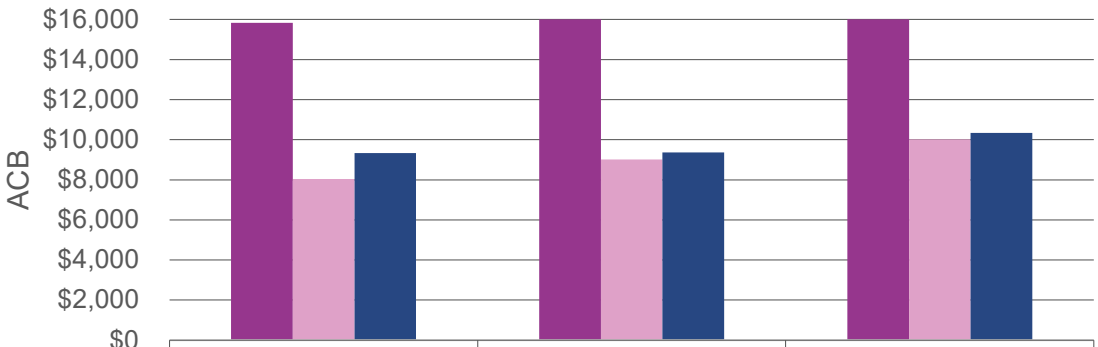
Figure 8: FC Penetration Rates CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	45.28%	51.14%	47.15%
Small	41.14%	44.00%	43.16%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20

Mendocino MHP



	CY 2018	CY 2019	CY 2020
MHP	$15,830	$16,697	$17,254
Small	$8,033	$9,010	$10,017
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

White beneficiaries comprised the MHP's largest race/ethnicity group being 49.9 percent of the eligible population and 62.6 percent of those served. The disproportion between percent of White eligibles and percent of beneficiaries (49.9 percent vs. 62.6 percent) indicates that the White population may be overserved.

Latino/Hispanic beneficiaries comprised the MHP's second largest race/ethnicity group being 31.8 percent of the eligible population and 19.6 percent of those served. The disproportion between percent of Latino/Hispanic eligibles and percent of beneficiaries (31.8 percent vs. 19.6 percent) indicates that the Latino/Hispanic population may be underserved. The MHP strives to addresses this concern by contracting with culturally specific community -based organizations through MHSA to address this concern. The MHP actively recruits for bilingual Medi-Cal service providers.

FC approved claims dollars per beneficiary increased each year from CY 2018 to CY2020 and in CY 2020 is significantly greater than both the small county ($17,254 vs. $10,017) and statewide averages ($17,254 vs. $10,338). This may indicate that the FC penetration rates are improving over time.

Native American beneficiaries account for 5.2 percent of race/ethnicity group of the MediCal eligible population with 5.6 percent served. This indicates that the outreach and

collaboration the MHP has engaged in with the Native American tribal communities is increasing their engagement in services.

TIMELINESS OF CARE

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likely the delay will result in not following through on keeping the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful with providing timely access to treatment services, the county must have the infrastructure to track the 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. CalEQRO uses a number of indicators for tracking and trending timeliness, including the Key Components and Performance Measures addressed below.

TIMELINESS IN MENDOCINO COUNTY

The MHP reported timeliness data stratified by age and FC status. Further, timeliness data presented to CalEQRO represented the complete SMHS delivery system.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the Performance Measures 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 4: Key Components – Timeliness

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 meets the 15 days standard for first offered non-urgent psychiatry service 99 percent of the time. The standard for rendered psychiatry service is met 98 percent of the time, with 5 days average, 2 days median, and a range of 29 days. Psychiatry no-shows are 2 percent, with the standard being 10 percent.

PERFORMANCE MEASURES

Through BHINs 20-012 and 21-023, DHCS set required timeliness metrics to which MHPs must adhere for initial offered appointments for non-urgent SMHS, non-urgent psychiatry, and urgent care. 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. Additionally, utilizing approved claims data, CalEQRO analyzes MHP performance on psychiatric inpatient readmission and follow up after inpatient discharge.

The following PMs reflect the MHP's performance on these and additional timeliness measures consistent with statewide and national quality standards, including Healthcare Effectiveness Data and Information Set (HEDIS) measures:

- First Non-Urgent Appointment Offered
- First Non-Urgent Service Rendered
- First Non-Urgent Psychiatry Appointment Offered
- First Non-Urgent Psychiatry Service Rendered
- Urgent Services Offered – Prior Authorization not Required
- Urgent Services Offered – Prior Authorization Required

- No-Shows – Psychiatry
- No-Shows – Clinicians
- Psychiatric Inpatient Hospital 7-Day and 30-Day Readmission Rates
- Post-Psychiatric Inpatient Hospital Discharge 7-Day and 30-Day SMHS Follow-Up Service Rates

MHP-Reported Data

For the FY 2021-22 EQR, the MHP reported its performance for FY 2020-2021 as follows:

- Average wait time of five days from initial service request to first non-urgent appointment offered.
- Average wait time of four days from initial service request to first non-urgent psychiatry appointment offered; the MHP measures this metric from the point of initial beneficiary request.
- Average wait time of .18 hours from initial service request to first urgent appointment offered for services that do not require prior authorization; the MHP does not have urgent services that require prior authorization. These appointments include outpatient mental health and psychiatry services.

Table 5: FY 2021-22 MHP Assessment of Timely Access

FY 2021-22 MHP Assessment of Timely Access			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5 Days	10-Business Days*	93%
First Non-Urgent Service Rendered	6 Days	10 Days**	87%
First Non-Urgent Psychiatry Appointment Offered	4 Days	15-Business Days*	99%
First Non-Urgent Psychiatry Service Rendered	5 Days	15 Days**	98%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	.18 Hours	48 Hours*	99%
Urgent Services Offered – Prior Authorization Required	**** Hours	96 Hours*	****%
Follow-Up Appointments after Psychiatric Hospitalization	0 Days	7 Days**	99%
No-Show Rate – Psychiatry	2%	10%**	n/a
No-Show Rate – Clinicians	5%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 20-012 ** MHP-defined timeliness standards ***MHP did not report data for this measure **** MHP does not separately track urgent services offered based on authorization requirements; all urgent services are held to a 48-hour standard.			

Medi-Cal Claims Data

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 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 mental health professionals is critically important.

Follow-up post hospital discharge

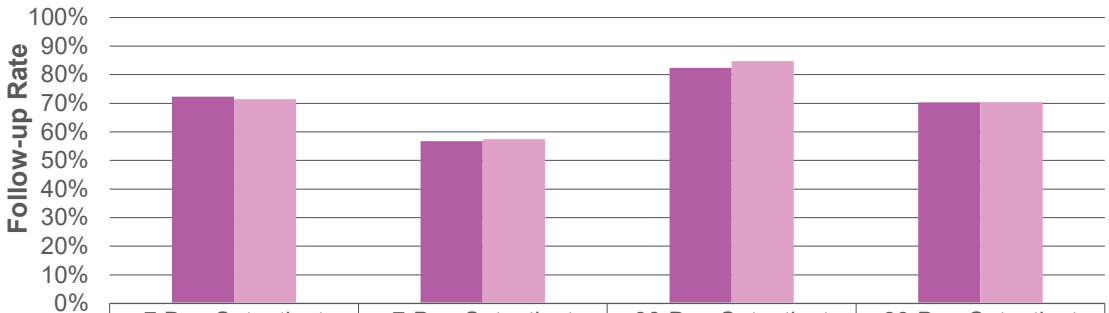
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care.

The 7-day post psychiatric inpatient follow-up rate remained stable from CY 2019 to CY 2020 (72 percent vs. 71 percent) and is higher than the CY 2020 statewide average (71 percent vs. 57 percent).

The 30-day follow-up increased three percent from CY 2019 to CY 2020 (82 percent vs. 85 percent) and is greater than the statewide average in CY 2020 (85 percent vs. 70 percent).

Figure 10: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-20

Mendocino MHP



	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	72%	57%	82%	70%
CY 2020	71%	57%	85%	70%

Readmission rates

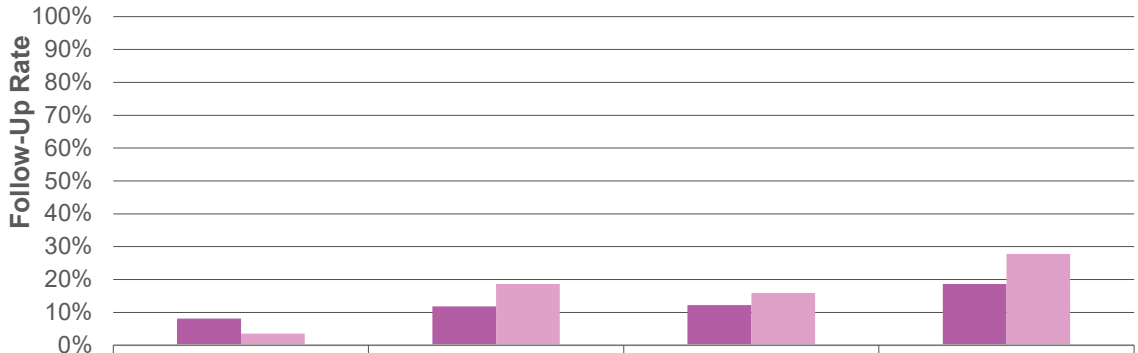
The 7- and 30-day rehospitalization rates (HEDIS measures) are important proximate indicators of outcomes.

The 7-day psychiatric readmission rate decreased from CY 2019 to CY 2020 (8 percent vs. 4 percent) and is significantly lower than the statewide average in CY2020 (4 percent vs. 19 percent).

The 30-day psychiatric readmission rate increased four percent from CY 2019 to CY 2020 (12 percent vs. 16 percent) but remains lower the statewide average (16 percent vs. 28 percent).

Figure 11: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-20

Mendocino MHP



	7-Day Rehospitalization MHP	7-Day Rehospitalization State	30-Day Rehospitalization MHP	30-Day Rehospitalization State
CY 2019	8%	12%	12%	19%
CY 2020	4%	19%	16%	28%

IMPACT OF FINDINGS

Compared to corresponding statewide averages, the MHP's higher 7- and 30-day post psychiatric inpatient follow-up rates could indicate successful beneficiary service engagement which may be contributing to the MHP's lower rehospitalization rates when compared to statewide averages.

QUALITY OF CARE

BACKGROUND

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through:

- Its structure and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based knowledge.
- Intervention for performance improvement.

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

QUALITY IN MENDOCINO COUNTY

In the MHP, the responsibility for QI is part of Quality Management. Quality Management committees and workgroups include the Cultural Diversity Committee, Behavioral Health Leadership Team, Administrative Service Organization (ASO) Care Coordination, Behavioral Health Executive Team, and the Compliance Committee. These entities inform and provide feedback to the Quality Improvement Committee (QIC).

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of:

- Mendocino County Behavioral Health and Recovery Services (MCBHRS) Director,
- MCBHRS Deputy Director,
- MCBHRS Compliance Officer,
- QAPI Manager/Supervisor,
- MCBHRS Manager/Supervisor,
- Ethnic Services Representative,
- MCBHRS Fiscal Representative,
- ASO staff,
- RQMC Compliance Officer,
- Clinical staff,
- Beneficiaries,

- Family members,
- Patient Rights Advocate, and
- Community service providers
    - Ad Hoc Member: Medical Director.

The QIC is scheduled to meet bi-monthly when Public Health Orders allow and will resume in-person meetings, when allowed, at different locations throughout the county allowing the public and beneficiaries to attend, ask questions, report on their experience receiving Specialty Mental Health Services and Substance Use Disorders Treatment, and provide recommendations for improvement. In order to entice stakeholder involvement by attending meetings, the QIC and MHSA meetings have been combined. During the COVID-19 Pandemic, meetings have been held via virtual meeting software which resulted in increased attendance. The MHP plans to continue to offer virtual access to meetings when in-person meetings can resume.

Since the previous EQR, the MHP QIC met six times. Of the seven identified FY 2020-21 QAPI workplan goals, the MHP met or partially met all goals and their objectives, with the exception of the following:

Goal 1: Ensure MCBHRS Service Delivery Capacity, Objective B: Monitor service capacity: Reaching 60 percent productivity in the clinical staff. Not met: (it decreased from 58.8 percent in FY 2019-20 to 52 percent for FY 2020-21). The MHP believes that reduction in productivity is related to the COVID-19 Pandemic. The MHP increased non billable services to increase access for beneficiaries during this time.

Goal 2: Ensure Accessibility to MCBHRS Services, Objective I: 95 percent of all access line calls will provide beneficiaries with the information they need regarding how to access specialty mental health services, information on urgent conditions, and information on beneficiary problem resolution and fair hearing processes. 100 percent of all calls will be logged. Not met for logging: 26 percent of the calls were not logged.

Goal 3: Monitor Client Satisfaction and Protections, Objectives A, B, C, D: Not met: DHCS halted Consumer Surveys for fall 2020 by DHCS due to the social distancing effects of the Covid-19 Pandemic, and the Spring 2021 Survey results are not yet available. The MHP attempted to meet these goals by conducting the CPS survey but were unable to monitor the results as the results were completely inaccessible due to the new DHCS CPS processes. Additionally, the MHP did conduct the Client Satisfaction Questionnaire (CSQ4) Survey for internal Consumer satisfaction feedback.

The MHP utilizes the following Level of Care (LOC) tools: ANSA and CANS. LOC tools are used to screen 100 percent of MHP beneficiaries who request treatment.

The MHP utilizes the following outcomes tools: ANSA, CANS, General Anxiety Disorder-7(GAD-7), Pediatric Symptom Checklist (PSC-35), Patient Health Questionnaire-9 (PHQ-9).

The MHP developed and instituted a CANS/ANSA Scoring Guide. These Scoring Guides are used by clinicians to determine recommended level of service. The CANS/ANSA are integrated into the EHR, and the score is calculated and stored which allows for clinicians to be able to see the information on a regular basis to develop treatment plans.

Clinicians use the GAD-7 and PHQ-9 to evaluate level of service needed using the scoring methodology. There is a weekly meeting between the MHP, their ASO and providers to go over all client information and referrals. There are separate meetings for the Adult System of Care and the Child and Youth System of Care.

QUALITY KEY COMPONENTS

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

Each Quality Component is comprised of individual subcomponents 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 6: Key Components – Quality

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 Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The MHP has a systematic clinical continuum of care that includes a CANS/ANSA Scoring Guide. Clinicians use these Scoring Guides to determine recommended level of service and are documented for the purpose of allowing clinicians to develop ongoing treatment plans and adjust level of service needs.
- The MHP does track and trend the following HEDIS measures as required by SB 1291:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD)
    - The use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC)
    - Metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)
    - The use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP:

- Beneficiaries Served by Diagnostic Category
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay (LOS)
- Retention Rates
- High-Cost Beneficiaries (HCB)

Diagnosis Data

Figures 12 and 13 compare the percentage of beneficiaries served and the total approved claims by major diagnostic categories, as seen at the MHP and statewide for CY 2020.

- Approximately 59 percent of clients have one of three diagnoses: trauma/stressor related disorders (26.6 percent), depression (19.2 percent), and deferred (13.5 percent).
- The MHP has a higher rate of trauma/stressor related disorders (26.6 percent vs. 15.1 percent) and deferred diagnosis (13.5 percent vs. 4.5 percent) and a lower rate of depressive disorders (19.2 percent vs. 29.5 percent) when compared to statewide averages.
- Approved claims dollars are reasonably aligned with the distribution of services by diagnosis.

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020

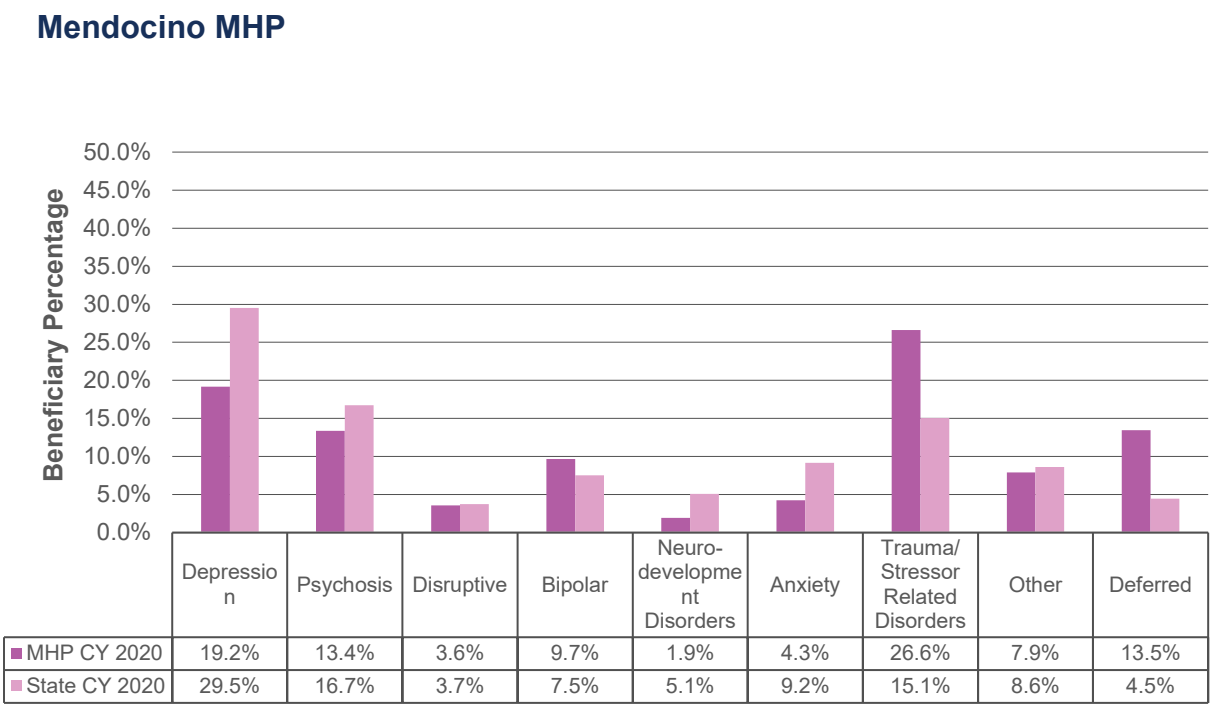
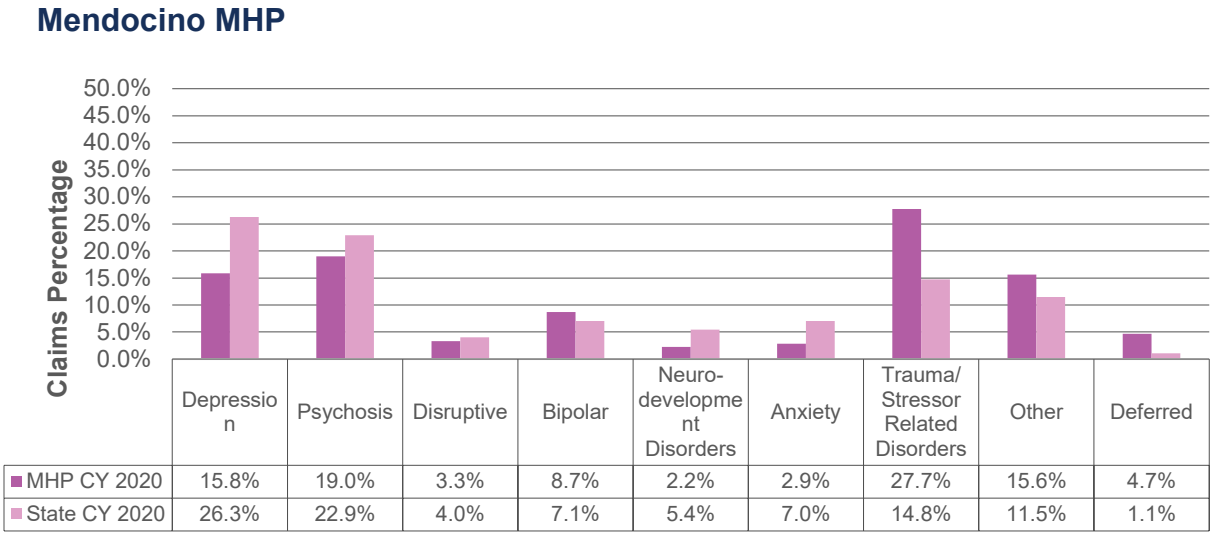


Figure 13: Diagnostic Categories by Percentage of Approved Claims CY 2020



Psychiatric Inpatient Services

Table 7 provides a three-year summary (CY 2018-20) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

From CY 2019 to CY 2020, the number of unique beneficiaries hospitalized declined (286 vs. 243) while the total inpatient admissions (535 vs.569) increased. The CY 2020 average length of stay is just above the statewide average (9.14 days vs. 8.68 days).

Table 7: Psychiatric Inpatient Utilization CY 2018-20

Mendocino MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2020	243	569	9,14	8.68	$14,375	$11,814	$3,493,058
CY 2019	286	535	8.63	7.80	$12,197	$10,535	$3,488,376
CY 2018	264	489	8.53	7.63	$17,214	$9,772	$4,544,538

High-Cost Beneficiaries

Table 8 provides a three-year summary (CY 2018-20) of HCB trends for the MHP and compares the MHP's CY 2020 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Tracking the HCBs provides another indicator of quality of care. High cost of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than the rest of the beneficiaries receiving SMHS. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

The MHPs number of high-cost beneficiaries declined from CY 2019 to CY 2020 (120 vs. 107) with the percentage of high-cost beneficiaries remaining stable (4.57 percent vs. 4.45 percent). The MHP's CY 2020 average approved claim per HCB is comparable to the statewide average ($53,873 vs. $53,969).

Table 8: HCB CY 2018-20

Mendocino MHP							
	Year	HCB Count	Total Beneficiary County	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
MHP	CY 2020	107	2,406	4.45%	$53,873	$5,764,412	32.59%
	CY 2019	120	2,628	4.57%	$53,631	$6,435,718	33.30%
	CY 2018	116	2,184	5.31%	$59,320	$6,881,095	41.94%

See Attachment D, Table D2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Retention Data

The MHP's retention data indicates no significant variation when compared to statewide averages.

Table 9: Retention of Beneficiaries

	Mendocino MHP			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 Service	225	9.35	9.35	9.76	9.76	5.69	21.86
2 Services	131	5.44	14.80	6.16	15.91	4.39	17.07
3 Services	174	7.23	22.03	4.78	20.69	2.44	9.17
4 Services	101	4.20	26.23	4.50	25.19	2.44	7.78
5-15 Services	634	26.35	52.58	29.47	54.67	19.96	42.46
>15 Services	1,141	47.42	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

- Approximately 59 percent of clients have one of three diagnoses: trauma/stressor related disorders (26.6 percent), depression (19.2 percent), and deferred (13.5 percent). Possible explanations include the stressors of the COVID-19 pandemic that took place across the state from March 2020 and ongoing, as well as simultaneously from April to September 2021, Mendocino County was affected by the Turnout, Tomki, Broiler, Bell, and Hopkins fires.

- The MHP has a higher rate of trauma/stressor related disorders (26.6 percent vs. 15.1 percent) and deferred diagnosis (13.5 percent vs. 4.5 percent) and a lower rate of depressive disorders (19.2 percent vs. 29.5 percent) when compared to statewide averages. The MHP may want to investigate training staff in trauma informed evidence-based practices (EBPs) to ensure that trauma is correctly diagnosed and treated.

- The MHP has a lower rate of psychosis claims than state average (19 percent vs. 22.9 percent), and a lower rate of diagnoses than state average (13.4 percent vs. 16.7 percent). This might imply that psychosis is being underdiagnosed.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

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

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

Validation tools for each PIP are located in Appendix 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: "Social Skills Development for clients transitioning to Adulthood from TAY status"

Date Started: September 2020

Aim Statement: "Will adding targeted social and independent development skills for TAY increase social and independent functioning and reduce the need for Lanterman-Petris-Short Act (LPS) conservatorship of TAY below the benchmark rate of 3.4 and hospitalization of TAY below the average of 104 per year by June 2022?"

Target Population: TAY youth in Mendocino County supported living environments.

Validation Information:

[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

The MHP's clinical PIP is in the implementation phase and considered active and ongoing.

Summary

Mendocino County has seen a rise in the number of under age 25 (TAY population) LPS conservatees and rehospitalization of those beneficiaries since 2019. Several of these TAY had been involved in services including supported housing services in the past. This PIP seeks to increase social functioning and reduce the CANS/ANSA scoring of TAY clients in supported housing in Mendocino County by providing targeted social skills development. Strategies will include offering targeted motivational interviewing and self-monitoring /self-management skills building to TAY in supported housing.

The PIP was planned as a two-year PIP from concept to completion. The MHP began PIP development in September of 2020; however, the start date for PIP was delayed due to impacts of the COVID-19 pandemic and the need to make alterations to the original concept, as it was initially intended for in-person therapeutic groups to be part of the interventions offered. Telehealth service options were available to youth as were individual outreach; however, the socialization and peer influenced skills building was something that the PIP authors felt were more effective in group settings. Therefore, the PIP is currently still in the implementation phase.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence because not enough documentation is yet available to determine whether credible, reliable, and valid methods were implemented throughout the time of the interventions and analysis of the PIP.

The TA provided to the MHP by CalEQRO consisted of:

- Discussion of how to move forward with the interventions during current pandemic restrictions.
- Consideration of how to include beneficiaries in the PIP team as it progresses.

CalEQRO recommendations for improvement of this clinical PIP include:

- Continue implementing the interventions of the PIP.
- Include beneficiaries in PIP team as appropriate.
- Engage in PIP TA with CalEQRO early and often in the development and implementation of the PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: “Reducing recurrent inpatient hospitalization in the community”

Date Started: September 2020

Aim Statement: “Will adding targeted intensive services that include natural supports for all clients identified as at risk of rehospitalization reduce rehospitalization by 10 percent and all hospitalizations by 15 percent by June of 2022.”

Target Population: All adult MHP beneficiaries at risk of rehospitalization as defined by having been hospitalized at least once in a 24-month period.

Validation Information:

The MHP’s non-clinical PIP is in the implementation phase and considered active and ongoing.

Summary

Mendocino County has seen an increase in re-admissions and conservatorships over the past few years, inpatient psychiatric hospitalizations have increased from 248 unique beneficiaries in CY 2017 to 286 unique beneficiaries in CY 2019. In addition to the increased number of individuals hospitalized, the average length of stay increased. Increased utilization of the highest levels of services has negative impacts on client care as well as on system delivery cost. This PIP seeks to reduce the number of clients experiencing rehospitalization by adding a wraparound model support to the existing after care of those returning from inpatient care.

Individuals that have been hospitalized one or more times in the past 24 months will be referred for intensive services that include natural supports. The variables that are tracked related to the interventions include the number of service contacts individuals keep (as opposed to cancel/no-show/decline). The outcomes that are monitored related to the number of intervention contacts include follow up with outpatient appointments, follow up with medication management appointments, rehospitalization within 30 days, and annual unique beneficiary hospitalization count.

This was planned as a two-year PIP from concept to completion. Development began September 2020; however, the start date for PIP development was delayed due to impacts of the COVID-19 pandemic and the need to make alterations to the original concept as it was initially intended for socialization and peer groups to be part of the targeted wraparound activities offered.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence because not enough documentation is yet available to determine whether credible, reliable, and valid methods were implemented throughout the time of the interventions and analysis of the PIP.

The TA provided to the MHP by CalEQRO consisted of:

- Discussion of how to move forward with the interventions during current pandemic restrictions.
- Consider how to include beneficiaries in the PIP team as it progresses.

CalEQRO recommendations for improvement of this non-clinical PIP include:

- Continue implementing the interventions of the PIP.
- Include beneficiaries is PIP team as appropriate.
- Define specific ways in which socialization and groups are going to be used to promote stability.
- The MHP has received and scheduled to continue to receive TA from EQRO as this PIP progresses.

INFORMATION SYSTEMS (IS)

BACKGROUND

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

IS IN MENDOCINO COUNTY

California MHP EHRs fall into two main categories - those that are managed by county application MHP IT and those being 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 myAvatar from Netsmart Technologies (Netsmart) which has been in use for 18 years. Currently, the MHP is considering a new system, but no formal project plan in place and no project team has been assigned. RQMC has no plans to replace the EXYM system.

Approximately seven percent of the MHP budget is dedicated to support the IS (County IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget increased from 1.57 percent in FY 2000-21 to 7.0 percent in FY 2021-22. The MHP attributes the budget increase to COVID-19 related hardware purchases and an operational change from self-hosting to an ASP hosting of myAvatar. The budget determination process for IS operations is under MHP control.

The MHP operates a unique dual EHR system. While the MHP utilizes the myAvatar EHR, they reported directly providing approximately 2 percent of claimed services in the past year. Their ASO, RQMC, provided approximately 98 percent of claimed services. RQMC utilizes the EXYM EHR. RQMC sends claim files electronically to the MHP and the MHP processes the monthly claim using Netsmart Avatar.

The MHP has 43 myAvatar named users and one RQMC user with log on authority to the myAvatar EHR. RQMC has 311 named EXYM users and 6 MHP users with log on authority to the EXYM EHR. Support for myAvatar and EXYM EHR users is provided by eight full-time equivalent (FTE) IS technology positions across the two organizations. Currently, all MHP IS and RQMC IS technology positions are filled. Both EHRs are operated in an ASP environment with the EHR vendors providing additional support.

Line staff have direct 24/7 access to the EHR, EXYM which is where the clinical records, assessments, client plans and other client data is stored. The MHP EHR AVATAR is used for billing, and not to store clinical data is stored. The MHP does not believe that there are potential errors with the existing EHR system.

Table 10: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
☒	Electronic Data Interchange (EDI) to MHP IS	☐ Daily ☒ Weekly ☐ Monthly	95%
☐	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	5%
			100%

Beneficiary Personal Health Record

The 21st Century Cures Act (Cures Act) of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a PHR enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not have a PHR but plans to implement this functionality within two years.

Interoperability Support

The MHP is not a member or participant in a Health Information Exchange (HIE). Healthcare professional staff use secure information exchange directly with service partners through encrypted email and electronic file transfer. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Alcohol and Drug Services, RQMC, two FQHCs, Mendocino Coast Clinics and Mendocino Community Health clinic, and one rural health clinic, Ukiah Valley Rural Health Center.

IS KEY COMPONENTS

CalEQRO identifies the following key components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive

beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

Table 11: Key Components – IS Infrastructure

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

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

- **Investment in IT Infrastructure and Resources is a Priority**
  - The IT budget was reported to be 7.00 percent, an increase from 1.57 percent in FY 2020-21.
  - While the MHP does not maintain a data warehouse for myAvatar data; however, to support data analytics, RQMC maintains a data warehouse for EXYM data.
  - There are 3 MHP and 21 contract provider telehealth sites, with sites in the rural areas including Laytonville, Covelo, Gualala and Point Arena.
- **Integrity of Medi-Cal Claims Process**
  - Service date, time and verification of progress note, and treatment plan are verified at time-of-service entry into the myAvatar.
- **Integrity of Data Collection and Processing**
  - The MHP's claim denial rate of 0.82 percent is significantly lower than the statewide average of 3.19 percent.

- **EHR Functionality**

- The MHP's myAvatar is a fully functional EHR with the exception of eLab and ERX functionality which is not utilized due to RQMC providing psychiatry services.
- RQMC reported their EHR to be fully functional including care coordination and referral management capacity which is not available in myAvatar.
- The CANS, PSC-35, ANSA, GAD-7 and PHQ-9 were reported to be available in electronic format.

- **Security and Controls**
  - The MHP and RQMC use email security tips to maintain and enhance staff security knowledge. The MHP has established an email address for staff to send concerns regarding suspicious emails.
- **Interoperability**
  - Both the MHP and RQMC utilize secure email is used to exchange information with external service providers.
  - RQMC has the capability for electronic data exchange with the MHP which allows them to provide service data to the MHP for processing and claim creation.
  - The MHP is not a member of a health information exchange.

IMPACT OF FINDINGS

- The MHP operates a unique dual EHR system. The MHP utilizes the myAvatar EHR for approximately 2 percent of services while the MHP's ASO, RQMC, uses the EXYM EHR for approximately 98 percent of services. RQMC sends claim files electronically to the MHP and the MHP processes the monthly claim using Netsmart Avatar.

- The IT budget was reported to be 7.00 percent, an increase from 1.57 percent in FY 2020-21. IT infrastructure and resources are MHP priorities.

- The MHP's claim denial rate of 0.82 percent is significantly lower than the statewide average of 3.19 percent. This speaks to integrity of data collection and processing.

- While the MHP does not maintain a data warehouse for myAvatar data. To support data analytics, RQMC maintains a data warehouse for EXYM data.

- There are 3 MHP and 21 contract provider telehealth sites, with sites in the rural areas including Laytonville, Covelo, Gualala and Point Arena. The MHP has facilitated multiple sites and regions to make telehealth available to beneficiaries.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

BACKGROUND

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CONSUMER PERCEPTION SURVEYS

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

The MHP does not yet have the results of the spring 2021 CPS. DHCS paused the fall of 2020 CPS due to COVID-19 restrictions. Mendocino County Beneficiary Satisfaction Surveys were paused during the past year due to social distancing effects of the COVID-19 Pandemic making implementing this survey difficult. The MHP relies on these surveys to evaluate programs and inform programmatic changes.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

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

Consumer Family Member Focus Group One

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

There were no participants who had begun treatment in the last 12 months. All participants agreed that the initial entry into services was timely, and that the MHP aided them in accessing services. The time between appointments is approximately

once a month for psychiatrists, and weekly for clinical therapy and other meetings, or as needed. It can be longer between sessions at times due to shortage of clinicians in different programs. There was general agreement among participants that they knew what to do if they missed an appointment, although not all had the crisis telephone number, and that they do receive text messages or reminder calls prior to some appointments. The participants are able to access on-line services; yet, report the on-line groups are more difficult because not everyone can attend. The participants are aware of a warmline, peer staff, and case managers as resources in crisis. The participants were aware of the exchange of information between their physical health and mental health providers, and the mental health providers being interested in their overall health. All participants felt the staff were supportive and addressed their cultural and linguistic needs. However, one participant voiced that the peer staff understood where the staff without lived experience might not. Several participants have participated in volunteer opportunities, to include some with churches and food banks. The participants noted that many programs were restricted in what they can offer due to COVID-19, and that transportation is still an issue for some beneficiaries.

Recommendations from focus group participants included:

- Consistency in treatment and being able to depend on service with same provider and a timely frequency.
- More stable staff to fill vacancies as they arise.
- A van available to the MHP to provide beneficiaries transportation when necessary.
- Peer employment opportunities to enhance wellness and recovery.

IMPACT OF FINDINGS

Overall, the participants were positive about the last year of treatment. They reported that they are receiving adequate services that are generally timely. They have information on how to reschedule appointments when necessary and know how to access crisis services. All those interviewed agreed that their service providers are supportive, engaged in facilitating their recovery, and that their cultural and linguistic needs are respected and addressed. The need for virtual service delivery due to the COVID-19 Public Health Emergency has resulted in beneficiaries being able to continue services without lapse. Peer staff are valued by the participants interviewed for their lived experience. The participants endorse these staff as instrumental in their progress in wellness and recovery.

CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP implemented the first Mobile Crisis Team with the Mendocino County Sheriff's Office. Recent partnerships around mobile crisis teams and co-response are evidence of supportive collaboration.(Access)
2. Due to restrictions of the COVID-19 public health emergency, the MHP implemented Zoom meetings of the Cultural Diversity Committee to address cultural competence and hear feedback from community members, beneficiaries of health services, and other interested stakeholders on their cultural diversity needs and goals. (Access, Quality)
3. The MHP meets the 15 days standard for first offered non-urgent psychiatry service 99 percent of the time. The standard for rendered psychiatry service is met 98 percent of the time, with 5 days average, 2 days median, and a range of 29 days. Psychiatry no-shows are 2 percent, with the standard being 10 percent. (Timeliness)
4. 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.(Quality, Timeliness)
5. The MHP has a systematic clinical continuum of care that includes a CANS/ANSA Scoring Guide. These Scoring Guides are used by clinicians to determine recommended level of service and are documented for the purpose of allowing clinicians to develop ongoing treatment plans and adjust level of service needs. (Quality)
6. Investment in IT infrastructure and resources are MHP priorities. The IT budget was reported to be 7.00 percent, an increase from 1.57 percent in

   FY 2020-21.(Information Systems)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP does not have a PHR currently. This has been in a planning stage for several years. (Information Systems)

2. There is an insufficient number of Spanish speaking bilingual staff in proportion to the number of beneficiaries who have this as a preferred language. (Access, Quality)
3. The MHP reports difficulty in recruiting and retaining licensed clinical staff. (Access)
4. Stakeholders report that transportation when receiving services in person is often a barrier to access. (Access)
5. Both PIPs encountered barriers in implementation specific to issues of the COVID-19 pandemic restrictions. (Quality)

RECOMMENDATIONS

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

1. Continue to develop and prioritize the implementation of PHRs for beneficiaries. PHRs enhance beneficiaries' and their families' engagement and participation in treatment. (IS, Quality)
2. Investigate reasons and implement strategies to recruit and retain bilingual staff. Research current outreach programs (e.g., Promotores network) for possible candidates. (Access/Quality)
3. Research and utilize avenues to recruit and retain clinical staff; to include interns and work study programs in collaboration with universities and colleges as appropriate. (Access/Quality)
4. Research possible transportation assistance options for beneficiaries and ensure that they are aware of any benefits they might have to resolve this issue. (Access)
5. Implement regular technical assistance (TA) sessions with CalEQRO during the ongoing implementation of the PIPs. (Quality)

SITE REVIEW BARRIERS

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

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: CALEQRO REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

Mendocino
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Clinical Line Staff Group Interview
Consumer and Family Member Focus Group(s)
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Deborah Strong, 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-site and the post-site meetings and in preparing the recommendations within this report.

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Anderson	Dan	COO	Redwood Quality Management Company
Bhandari	Navin	Sr. Program Manager	Mendocino County BHRS
Harris	Carmen	Clinical Director	Redwood Quality Management Company
Kaye	Marty	Department Analyst II	Mendocino County BHRS
Kazarian	Katrina	Clinical Line Staff rep	Mendocino Coast Hospitality Center
Landis	Cliff	Mental Health Clinician II	Mendocino County BHRS
Lemus	Tony	Department Application Specialist	Mendocino County BHRS
Limosnero	Glen	Clinical Line Staff rep	Redwood Community Services
Logan	Alicia	Business Administrator	Redwood Quality Management Company
Lovato	Karen	Sr. Program Manager	Mendocino County BHRS
Miller	Jenine	Behavioral Health and Recovery Services Director	Mendocino County BHRS
Morgan	Heather	Clinical Line Staff rep	Tapestry Family Services
Petrykowski	Jake	Clinical Line Staff rep	Mendocino County AIDS/Viral Hepatitis Network
Schraeder	Camille	CFO	Redwood Quality Management Company
Schraeder	Tim	CEO	Redwood Quality Management Company
Simmons	Annette	Clinical Line Staff rep	Redwood Community Services Crisis Center

Last Name	First Name	Position	Agency
Thompson	Dustin	Sr. Program Specialist	Mendocino County BHRS
Turchin	Andrea	Administrative Manager II	Mendocino County BHRS
Walsh	Sarah	Data Analyst	Redwood Quality Management Company
Yovino	Mary	Program Administrator	Redwood Quality Management Company

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	
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Mendocino MHP	
PIP Title: Social Skill Development for clients transitioning to Adulthood from TAY status	
PIP Aim Statement: **a. "Will adding targeted social and independent development skills for TAY increase social and independent functioning and reduce the need for LPS conservatorship below the benchmark rate of 3.4 TAY by June 2022 and hospitalization of TAY below the average of 104 per year by June 2022?"**	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

Target population description, such as specific diagnosis (please specify):

. The population is TAY youth in Mendocino County based supported living environments.

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)

Motivational interviewing and teaching self-monitoring/management for the TAY population in supported housing.

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)

n/a

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of TAY clients on Conservatorship	FY 2020-21	5	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of TAY clients hospitalized	FY 2020-21	116	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Final rating of involvement in vocational activities	No information		☒ Not applicable—PIP is in Planning		☐ Yes	☐ Yes ☒ No Specify P-value:

Performance measures (be specific and indicate measure steward and NQF 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
			or implementation phase, results not available		☒ No	☐ <.01 ☐ <.05 Other (specify):
Final rating of involvement in educational activities	No information		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Final rating of involvement in housing activities	No information		☒ 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: Continue implementing the interventions of the PIP. The validation rating of low confidence is due to the fact that not enough documentation is yet available to determine whether credible, reliable, and valid methods were implemented throughout the time of the interventions and analysis of the PIP. The MHP has received and scheduled to continue to receive TA from EQRO as this PIP progresses.

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	
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name:	
PIP Title: Reducing recurrent inpatient hospitalization in the community	
PIP Aim Statement: "Will adding targeted intensive services that include natural supports for all clients identified as at risk of rehospitalization reduce rehospitalization by 10 percent and all hospitalizations by 15 percent by June of 2022."	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one):	

☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children

*If PIP uses different age threshold for children, specify age range here:

Target population description, such as specific diagnosis (please specify):

All adult MHP beneficiaries identified as high risk of rehospitalization as defined by having had two or more hospitalizations in the prior 24-month period.

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)
Increased social contact through wraparound services.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
Increased provider contact through wraparound services

MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)
Number of Wraparound post hospital interventions.

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of unique adult beneficiaries hospitalized per year	FY 2020-21	286	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of adults re-hospitalized within 30 days	FY 2020-21	58	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of kept outpatient services appointments			☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Aggregate ANSA score			☒ 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: Continue implementing the interventions of the PIP. The validation rating of low confidence is due to the fact that not enough documentation is yet available to determine whether credible, reliable, and valid methods were implemented throughout the time of the interventions and analysis of the PIP.
The MHP has received and scheduled to continue to receive TA from EQRO as this PIP progresses.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Mendocino MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,835,638	155,154	4.05%	$934,903,862	$6,026
Small	175,792	7,277	4.14%	$43,246,554	$5,943
MHP	12,098	632	5.22%	$3,993,208	$6,318

Table D2: CY 2020 Distribution of Beneficiaries by ACB Range

Mendocino MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
<$20K	2,204	91.60%	92.22%	$9,607,484	$4,359	$4,399	54.32%	56.70%
>$20K-$30K	95	3.95%	3.71%	$2,316,341	$24,383	$24,274	13.10%	12.59%
>$30K	107	4.45%	4.07%	$5,764,412	$53,873	$53,969	32.59%	30.70%

Table D3: Summary of CY 2020 Short-Doyle/Medi-Cal Claims

Mendocino MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
TOTAL	78,431	$15,514,398	403	$127,335	0.82%	$15,387,063	$15,128,076
JAN20	7,373	$1,476,826	20	$11,984	0.81%	$1,464,842	$1,422,520
FEB20	6,559	$1,363,289	31	$8,398	0.62%	$1,354,891	$1,307,159
MAR20	7,416	$1,462,135	57	$13,607	0.93%	$1,448,528	$1,406,699
APR20	7,481	$1,414,670	9	$2,230	0.16%	$1,412,440	$1,386,659
MAY20	6,164	$1,215,584	9	$2,363	0.19%	$1,213,221	$1,208,770
JUN20	6,212	$1,227,208	16	$4,171	0.34%	$1,223,037	$1,216,479
JUL20	6,403	$1,338,094	13	$4,984	0.37%	$1,333,110	$1,327,770
AUG20	5,987	$1,180,245	11	$3,762	0.32%	$1,176,483	$1,172,181
SEP20	6,192	$1,211,621	31	$7,870	0.65%	$1,203,751	$1,195,083
OCT20	6,934	$1,419,282	83	$29,587	2.08%	$1,389,695	$1,358,783
NOV20	5,819	$1,103,092	77	$23,118	2.10%	$1,079,974	$1,055,429
DEC20	5,891	$1,102,353	46	$15,261	1.38%	$1,087,092	$1,070,546
Includes services provided during CY 2020 with the most recent DHCS claim processing date of July 30th, 2021. Only reports Short-Doyle Medi-Cal claim transactions and does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2020 was 3.19 percent.							

Table D4: Summary of CY 2020 Top Five Reasons for Claim Denial

Mendocino MHP			
Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B or Other Health Coverage must be billed before submission of claim	179	$45,779	36%
Beneficiary not eligible or non-covered charges	69	$37,348	29%
Claim/service lacks information which is needed for adjudication	81	$27,434	22%
Beneficiary not eligible	33	$8,241	6%
Service line is a duplicate and a repeat service procedure code modifier not present	31	$7,186	6%
TOTAL	**393**	**$135,988**	**99%**