FY 2019-20

EXTERNAL QUALITY REVIEW REPORT

MEDI-CAL SPECIALTY MENTAL HEALTH

Prepared for the California Department of Health Care Services (DHCS)
By Behavioral Health Concepts, Inc. (BHC)

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Acknowledgements

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The guidance of and collaboration with the Department of Health Care Services (DHCS), Medi-Cal Behavioral Health Division have been instrumental in the successful completion of the reviews and reports this year. It is our intention that the findings from this report may be used to improve the access, timeliness, and quality of services and encourage the health and well-being of Medi-Cal beneficiaries.

BHC would also like to acknowledge the people of California who persevered through unprecedented challenges this year, facing a global pandemic, significant economic downturn, and historic social unrest. Throughout this year, Californians continued to strive not only for their own health and wellness, but for those of others as well.

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Acronyms Used in This Report

AB	Assembly Bill
ACB	Approved Claims per Beneficiary
ANSA	Adult Needs and Strengths Assessment
ASAM	American Society of Addiction Medicine
BHC	Behavioral Health Concepts, Inc.
CalAIM	California Advancing and Innovating Medi-Cal
CalEQRO	California External Quality Review Organization
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CPS	Consumer Perception Survey
CY	Calendar Year
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EHR	Electronic Health Record
EMR	Electronic Medical Record
EQR	External Quality Review
EQRO	External Quality Review Organization
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
ICC	Intensive Care Coordination

IPC	Inpatient Consolidation Claims
IS	Information System
ISCA	Information Systems Capabilities Assessment
IHBS	Intensive Home-Based Services
IT	Information Technology
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
MATA	MHP Assessment of Timely Access
MCP	Managed Care Plan
MHP	Mental Health Plan
MHSIP	Mental Health Statistics Improvement Project
MORS	Milestones of Recovery Scale
MMEF	Medi-Cal Eligibility File
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PSC	Pediatric Symptoms Checklist
QI	Quality Improvement
QIC	Quality Improvement Committee
QM	Quality Management
SB	Senate Bill
SDMC	Short-Doyle Medi-Cal
SMHS	Specialty Mental Health Services
SOR	Strengths, Opportunities, and Recommendations
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

Medi-Cal Specialty Mental Health External Quality Review Report
2019-20

Executive Summary

Executive Summary

Highlights from CalEQRO's FY 2019-20 External Quality Review of California's Medi-Cal Mental Health Plans

Introduction

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal Mental Health Plans (MHPs) to provide Medi-Cal-covered specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. In accordance with federal requirements, DHCS contracts with an external quality review organization (EQRO) to review and evaluate the care provided to the Medi-Cal beneficiaries of each of those MHPs. The review of care is conducted by Behavioral Health Concepts (BHC), also referred to as the California EQRO (CalEQRO).

This report presents the review findings of BHC for fiscal year (FY) 2019-20. Additional sources of information, including CalEQRO resources, MHP reports and summaries, presentations and materials, data analyses, and archived materials, can be found on the organization's website, www.caleqro.com.

Access

MHPs use a variety of media (visual, print, electronic, and telephonic) to communicate and distribute information about SMHS. In addition, an extensive stakeholder network contributed to dissemination of information about and referrals to MHPs. MHP-provided transportation and field-based services were characteristic of many MHPs and were opined to have a positive effect on facilitating access. MHPs with a large network of public, private, and community-based partners were successful in facilitating beneficiary access. MHP strengths that were key to facilitating access, particularly after the onset of COVID-19, included: use of telehealth; previously existing sufficient

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Key findings, supporting data and examples, as well as recommendations, are detailed in eight chapters, highlighted in this summary:

- Introduction
- Methods
- Access
- Timeliness
- Quality
- Outcomes
- Information Systems
- Conclusion and Recommendations

(staff) capacity; and an established written plan or strategy to increase beneficiary access.

Once beneficiaries connect to services, however, MHPs faced challenges in delivering services consistently—and maintaining beneficiary access. MHPs struggled with having sufficient capacity, in (1) number of mental health professionals, including psychiatric providers and licensed clinicians; (2) bilingual, primarily Spanish-speaking, mental health professionals; and (3) culturally responsive services. Some populations were under-represented, including older adults.

Despite the challenges above, the overall penetration rate has remained the same as in calendar year (CY) 2017, at 4.66 percent. MHPs are serving the same proportion of Medi-Cal beneficiaries (e.g., while the total number of beneficiaries served declined, so too did the number of Medi-Cal eligibles). Notable this year is that MHPs are serving more Hispanic/Latino beneficiaries. MHP strengths that were key to facilitating access, particularly after the onset of COVID-19, included: use of telehealth; previously existing sufficient (staff) capacity; and an established written plan or strategy to increase beneficiary access. Credit also goes to community partners that have extended MHP reach and have contributed to a strong system of access to care for beneficiaries.

Timeliness

Timeliness improved in FY 2019-20, most notably with provision of initial appointments. For most MHPs, the average time to first offered appointment was less than the state-defined standard of ten business days. While there have been improvements in time to psychiatry, the average time is still below the state standard of 15 business days. Ironically, the no-show rates for psychiatry appointments are greater, sometimes by as much as 20 percent, than those for clinician no-shows. Psychiatry is a critical piece of SMHS; that it is both difficult for MHP's to provide timely, and then misused/mismanaged, speaks to an area of need and focused attention.

Beyond the provision of timely services, there is the MHP's tracking and reporting of timeliness itself. Network adequacy requirements have generally buoyed tracking of timeliness, but there is still considerable room for improvement.

Nearly half of MHPs struggle with tracking timeliness (1) consistently; (2) across all of the providers in their networks; (3) inclusive of all demographics, particularly youth in foster care; and (4) when involving coordination with other service providers such as a hospital or psychiatric health facility. The difficulty in tracking and reporting of timeliness is particularly characteristic of small MHPs that have fewer resources (e.g., staff and electronic systems) to enable facile monitoring. MHPs with established systems for monitoring timeliness had an advantage in providing timely services.

Quality and Outcomes

Approved claims per beneficiary (ACB) increased during the past year. Absent an increase in health care pricing and costs, this suggests that MHPs are providing more services to beneficiaries and/or more intense levels of care to (better) meet beneficiary needs. Notably, the ACB of Bay Area MHPs continues to be nearly twice that of the other regions, which is more likely an artifact of differences in Short-Doyle Medi-Cal (SDMC) funding across the state rather than a difference in quality of care.

Among MHPs, there is no uniform or predominate instrument of determining level of SMHS. As in previous years, some MHPs use or have adopted a level of care tool, but the standard remains—time-tested clinical judgement. Another aspect of level of care that has also not changed is that MHPs do not consistently evaluate transitions. Less than half of MHPs evaluated movement of beneficiaries across the continuum of care and less than half of MHPs used those findings to improve transition processes.

Most MHPs provided culturally responsive services that were reflective of their beneficiary population. Because small and small-rural MHPs (and counties) have historically served a majority white population, these MHPs demonstrated less the principles of cultural competency. Cultural competence is an area of need as beneficiary populations change statewide to include beneficiaries who speak Spanish and other languages (e.g., Farsi, Hmong), who identify as non-binary, and who are long-lived, among others.

All MHPs have a quality management (QM) unit or department that is responsible for formally monitoring quality. MHPs vary in ability and sophistication of these QM units to affect change. Some QM units focused more on quality assurance (i.e., in measuring and maintaining compliance against necessary standards) than on quality improvement that is focused on beneficiaries and system and process improvements. MHPs with an improvement focus (1) were skilled in using change management processes; (2) were practiced in monitoring services according to industry standards (e.g., HEDIS and National Quality Forum measures); (3) had an inclusive quality improvement committee; and (4) evaluated improvement initiatives using a continuous quality improvement approach.

A characteristic of MHPs that spoke to the quality of SMHS was adoption of a health care approach/model that addressed social determinates of health; those MHPs focused on linkages to housing, employment, and meaningful engagement with the community.

Transitions in care also are critical for positive outcomes; 64 percent of MHPs have met required follow-up standards for outpatient follow-up post hospitalizations. Care management and hands-on approaches to assist beneficiaries have been the most successful in this regard.

Overall, MHPs do not assess beneficiary outcomes systemically. Because of the state mandate, two child outcome measures, the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist 35-item (PSC-35), are used by MHPs. However, CANS and PSC-35 are used on an individual/beneficiary level and to a lesser extent on a program level. Outcome measures for adults were uncommon or were program-specific (e.g., for full-service partnership).

Of the seven domains assessed in the Consumer Perception Surveys (CPS), beneficiaries are least satisfied with outcomes and improved functioning. As in the previous years, outcomes and improved functioning scored the lowest (at 3.7 or 3.8 out of 5.0 scale). Further commentary of the CPS was that feedback was not directly shared with the beneficiaries who completed the survey.

Rehospitalization rates are an indirect measure of outcomes. For most MHPs, rehospitalization rates were less than 14 percent. Larger MHPs had higher rehospitalization rates (at 18 percent), of which further analysis is warranted. For large MHPs, it is important to consider other benefits that beneficiaries in large urban communities may derive from being hospitalized (e.g., shelter, safety, general health care).

Most MHPs had some sort of wellness and recovery program, but how wellness and recovery fit into the MHPs continuum of care—and reflect outcomes—was unclear. The programs can be accessed at any point during care, so there is no relationship between affiliation with a wellness and recovery program and progress in care.

MHPs use few direct measures of beneficiary outcomes; outcome monitoring is decidedly an area of need for MHPs.

Challenges in many areas of quality and outcomes are exacerbated by the number of providers within MHPs who are still unable to communicate beneficiary needs electronically, coordinate their care, and use resources efficiently due to lack of critical infrastructure. Behavioral health continues to have significant unmet EHR infrastructure needs, which hinders communication across MHP provider networks and between behavioral health and health care in general.

Recommendations and Next Steps

Fifteen percent of all CalEQRO recommendations made in FY 2019-20 centered on access to care. The most common themes warranting improvement activity by MHPs included: (1) culturally responsive outreach, linkage, and engagement; (2) the availability of services in non-English languages; (3) access-related monitoring activities including the functioning of the 24-hour access line in assisting consumers and families in crisis; and (4) approaches to improving workforce challenges at the county level.

MHPs have been making steady progress in improving network adequacy, using an array of service delivery options, including telehealth, co-location of services, wellness centers, field-based services, and mobile crisis response teams. These options for additional flexibility in service delivery need to be continued and, in many cases, expanded to address both timeliness and some key quality points.

Issues that rose to the top of recommendations for timeliness included: (1) improved tracking and monitoring of first psychiatry appointment timeliness to more than a quarter of the MHPs; (2) tracking timeliness for the entire network of providers, beyond county-run services; (3) improved timeliness to psychiatry and children's services; (4) infrastructure to support timeliness tracking and monitoring; and (5) action to address delays and gaps in the continuum of care

overall as well as for special populations such as non-English speakers and elderly beneficiaries with special needs.

Quality of care is integrally linked to the completeness and capacity of the continuum of mental health services. Continued efforts to expand as well as to track delays and barriers to care are essential and these were identified in many counties with recommendations for improvement. In addition, enhanced quality is coming from participation and support of Whole Person Care projects. Finally, it is important to consider ongoing improvements in performance measures linked to better outcomes such as follow-up services after inpatient care, access to and use of medications for diagnoses linked to beneficiaries' needs, and the availability of family and peer support systems. Recommendations to continue these efforts with adequate workforce and information systems are critical and were a significant part of outcome-related recommendations.

Medi-Cal Specialty Mental Health External Quality Review Report
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Chapter 1

Introduction

Introduction

COVID-19 and the State and National Context for the 2019-20 External Quality Review Process

Structure of the 2019-20 Medi-Cal Specialty Mental Health Statewide Annual Report

1. **Introduction**
2. **Methods**
3. **Access**
4. **Timeliness**
5. **Quality**
6. **Outcomes**
7. **Structure and Operations**
8. **Conclusion and Recommendations**

The U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of state Medicaid managed care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of state Medicaid managed care services. The CMS rules (42 Code of Federal Regulations [CFR] §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) specify the requirements for evaluation of Medicaid (Medi-Cal in California) managed care programs. These rules require an onsite or desk review of each Medi-Cal Mental Health Plan (MHP).

Federal requirements regarding Medicaid managed care quality were established in statute at section 1932(c) of the Social Security Act (the Act) and are set forth in 42 C.F.R. § 438, subpart E. In October 2019, CMS issued the first revision to EQR protocols since 2012.

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year (FY) 2019-20 findings of an EQR of each MHP by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC). At the conclusion of each EQR, CalEQRO generates a comprehensive report that identifies system strengths, opportunities for improvement, and recommendations to improve the overall quality of care provided to Medi-Cal beneficiaries served by each MHP. Additional sources of information, including CalEQRO resources, MHP reports and summaries, presentations and materials, data analyses, and archived materials, can be found on the organization's website, www.calegro.com.

California Trends

Both the process and substance of this year's reviews were affected by the unfolding COVID-19 public health emergency. On March 19, 2020, California's Governor issued Executive Order N-33-20, which directed all Californians to stay home in order to protect health and well-being and to establish consistency across California to slow the spread of COVID-19. As described in more detail below, this order required a shift from onsite reviews of MHPs to desk and virtual reviews by CalEQRO. CalEQRO discontinued the onsite reviews, including the beneficiary family member focus groups, which serve as a significant component for this annual report. Twenty-five percent of MHPs were affected by the virtual review. More significantly, the crisis and shelter-in-place order shifted how MHPs delivered and monitored services. MHPs implemented or expanded telehealth services and increased contracts with contract providers. Overall, MHPs rapidly adapted to the changing environment and continued to serve beneficiaries

California Advancing and Innovating Medi-Cal (CalAIM) and Integration

DHCS formally proposed its version of the 1115 Waiver, known as California Advancing and Innovating Medi-Cal (CalAIM), in October 2019. DHCS identified three primary goals:

(1) Identify and manage member risk and need through Whole Person Care approaches and addressing social determinants of health;

(2) Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

(3) Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform.[1]

In the CalAIM proposal, DHCS outlines a plan for integrating specialty mental health and substance use disorders (SUD) into one behavioral health managed care program. The stated goal is to improve beneficiary outcomes and to reduce administrative burdens on the counties. In addition, the proposal outlines the desire to combine the EQR process and have one EQRO report for each county.

State and Local Budget Challenges

One of the consequences of the stay-at-home order due to the COVID-19 public health emergency was a profound impact on the economy. The Governor's May 2020 budget revision was dramatically different than the budget that had been presented in January 2020. The majority of the behavioral health services are funded through Medi-Cal, 2011 Realignment, and Substance Abuse and Mental Health Service Administration (SAMHSA) Block Grants. The funding is driven by economic conditions and not by the demand for services. The May revised Budget Act proposed providing $1 billion to counties for safety net services and backfilling the realignment funds. Approximately $750 million would be provided by the state and the remaining $250 million is dependent on the state receiving federal relief funds. Counties are struggling to meet their federal and state requirements with this budget shortfall as they continue to respond to the demands of an unprecedented public health emergency.

Network Adequacy (Assembly Bill 205)

CMS requires all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy pursuant to Title 42 of CFR Part 438.68. In addition, in 2018, the California State Legislature passed Assembly Bill (AB) 205 to specify how the Network Adequacy requirements must be implemented in California for MCPs and PIHPs, including the MHPs.

In California, these standards were codified through the passage of AB 205. Based on these requirements, DHCS developed the Network Adequacy Certification Tool, which the MHPs initially were mandated to submit quarterly. Effective FY 2020-21, the submissions will be due annually by April 1 of each year.

In 2020, DHCS, in consultation with CalEQRO, developed and provided guidelines for the Network Adequacy areas that CalEQRO will validate and for which they will provide technical assistance to the MHPs starting in FY 2020-21. These include Alternative Access Standards, Out-of-Network Access, and National Provider Identification (NPI) taxonomy codes.

[1] California Department of Health Care Services. California Advancing & Innovating Medi-Cal (CalAIM) Proposal. October 2019. Available from: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf

Trends in Mental Health

In spite of and in addition to these events, communities continue to be affected by mental health concerns. One in four young adults between the ages of 18 and 24 report they have considered suicide in the past month because of the pandemic, according to new Centers for Control and Prevention (CDC) data.[2]

The data also flag a surge of anxiety and substance abuse, with more than 40 percent of those surveyed saying they experienced a mental health condition connected to the COVID-19 emergency. The CDC study analyzed 5,412 survey respondents between June 24 and 30, 2020.[3]

In the second annual California Health Policy Survey, conducted in November and December 2019, Californians' identified that their top health care priority is to ensure that people with mental health problems can get treatment (52 percent say it is "extremely important"). Furthermore, the survey found that large numbers of Californians struggle to get the mental health care they need.[4]

These latest policy polls affirm that the demand for mental health services has only increased, while at the same time, financial and other resources to provide these services for those who most need them are being squeezed.

With the onset of COVID-19, telehealth has expanded exponentially. In response to the COVID-19 pandemic, federal and state regulations governing the delivery of behavioral health services via telehealth were relaxed. These temporary policy measures allowed for improved access to care for individuals enrolled in public-funded health insurance, such as Medicaid and the Children's Health Insurance Program (CHIP).

Trends Affecting Quality EQRO Environment

Either directly or indirectly, the above trends and conditions affect access, timeliness, and quality across all MHPs and throughout the state. To the extent possible, the EQR takes these trends into consideration in its methods and analyses.

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[2] Czeisler ME, Lane RI, Petrosky E et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24-30, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1050-57.

[3] Ibid.

[4] Ben-Porath E, Hachey E, Sutton J, Su J. SSRS. February 2020. Health Care Priorities and Experiences of California Residents: Findings from the California Health Policy Survey. California Health Care Foundation. Available from: https://www.chcf.org/publication/mental-health-tops-californians-health-care-priorities-in-statewide-survey/

In response to the Executive Order N-33-20, CalEQRO prohibited staff travel necessary to conduct onsite reviews in March 2020. CalEQRO quickly collaborated with MHPs to conduct desk and virtual reviews for the remainder of the FY; approved by DHCS, this also resulted in the discontinuation of consumer family focus group sessions. In total, 70 percent (39/56) of the EQRs were conducted onsite in FY 2019-20, while the remaining 30 percent (17/56) were conducted virtually.

These shifts required a balance between obtaining sufficient information to complete the EQR protocols without unduly burdening MHP systems, practitioners, and beneficiaries, each navigating the COVID-19 emergency response and resulting impact on mental health service delivery.

Some of the techniques CalEQRO implemented included:

- Developed flexible methods and contingency plans. With travel restrictions and social distancing, in-person interactions were nearly eliminated. Within the span of one week, several teams reconfigured multi-day, in-person reviews to those that used virtual focus groups and interviews and other web-based tools for data collection.
- Video conferencing with tools such as Zoom became the primary review communication tool. Zoom provides videotelephony and online chat services through a cloud-based, peer-to-peer software platform and is used for teleconferencing, telecommuting, distance education, and social relations.

Many of the newly adopted techniques are efficient and may be used in the future to save time and resources.

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Chapter 2

Methods

Methods

CalEQRO's Process for Collecting and Analyzing Data to Generate Findings and Insights About MHPs' Progress

Introduction

The Medi-Cal Specialty Mental Health EQR FY 2019-20 Annual Report aggregates and analyzes data from numerous sources derived from EQR activities throughout the FY. This section provides an overview of these methods; a companion report, Validation of Performance Measures, describes the methods for each of the sources of data in greater detail.

Data Sources and Samples

CalEQRO used data from ten unique sources in compiling this report, summarized in Table 2-1 and described in greater detail below.

Table 2-1: Summary of Annual Report Data Sources

Data Collector	Data Source	Description
DHCS	Consumer Perception Surveys	Surveys distributed to beneficiaries and family members by MHPs and returned to DHCS for tabulation
Medi-Cal approved claims data	Performance Measures	Calculations based on approved claims data
CalEQRO-developed based on CMS Protocol; MHP completed	Information Systems Capabilities Assessment	Mix of quantitative and qualitative data
Cal EQRO-developed; MHP completed	MHP Assessment of Timely Access	Primarily quantitative
CalEQRO-developed; MHP completed	Pathways to Wellness/ Katie A. Questionnaire	Mix of quantitative and qualitative data regarding children and youth in foster care or at risk of foster care placement
CalEQRO-developed based on CMS Protocol; MHP completed	Performance Improvement Projects	Primarily quantitative

Data Collector	Data Source	Description
CalEQRO	Performance and Quality Management Key Components	Quantitative scores with qualitative comments; intended to summarize all other data and experiences from the review
CalEQRO	Stakeholder Focus Groups	Qualitative focus groups conducted with beneficiaries and family members (including those serving as employees), line staff, contractors, and clinical supervisors
CalEQRO	MHP Documentation	Qualitative and quantitative reports developed by the MHP that provide evidence of quality activities throughout the review period
CalEQRO	Strengths, Opportunities, and Recommendations	Qualitative data developed as part of the MHP-level reports intended to summarize the results of the review

Consumer Perception Surveys

The Consumer Perception Surveys (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. Adult and older adult beneficiaries receive the Mental Health Statistics Improvement Project (MHSIP) survey, while the youth beneficiaries and/or their family members receive the Youth Satisfaction Survey (YSS) and the family version of the same survey (YSS-F). Both are established surveys that have been widely used across the country. Collectively, these surveys are commonly referred to as the Performance Outcomes and Quality Improvement surveys. (See Table 2-2 for a list of survey domains.) MHPs administer these surveys to beneficiaries receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS. Cleaning, preparation, and analysis are completed in SAS® (Statistical Analysis Software).

Table 2-2: CPS Domains

Mental Health Statistics Improvement Project	Youth Satisfaction Survey
General Satisfaction	General Satisfaction
Perception of Access	Perception of Access
Perception of Participation in Treatment Planning	Perception of Participation in Treatment Planning
Perception of Outcomes of Services	Perception of Outcomes of Services
Perception of Functioning	Perception of Functioning
Perception of Social Connectedness	Perception of Social Connectedness
Perception of Quality and Appropriateness	Perception of Cultural Sensitivity

Performance Measures

CalEQRO uses administrative claims data to validate the eight mandatory Performance Measures (PMs) defined by DHCS, as well as a number of additional PMs specific to the provision of services to minor and nonminor dependents per Senate Bill (SB) 1291. The eight PMs include:

- Total beneficiaries served by each county MHP
- Penetration rates in each county MHP
- Total costs per beneficiary served by each county MHP
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a calendar year (CY)
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS)
- Total psychiatric inpatient hospital episodes, costs, and average length of stay
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

The statewide Validation of Performance Measures report is the companion to this report and presents findings on these and other key PMs for California's Medi-Cal-funded SMHS delivered by the county MHPs.

Data sources for the analysis include: Short-Doyle Medi-Cal (SDMC) Claims, Inpatient Consolidation Claims (IPC), Medi-Cal Eligibility File (MMEF), and provider files. SDMC and IPC files are requested from DHCS on a bi-annual basis and cover one CY of claims for reporting. An MMEF is requested during the same time period and covers 15 months of eligibility. PMs are calculated on a CY basis.

CalEQRO requests data for the PMs from DHCS, which pulls the data, conducts quality assurance checks for accuracy, and posts the data through the Information Technology Web Services for CalEQRO to download. Data files are then securely downloaded onto CalEQRO's Health Insurance Portability and Accountability Act-compliant server. SAS® is used to process and produce all data and reports. The analysis plan follows the guidelines of the specified PMs created with DHCS.

The PMs often differentiate between "eligibles" and "beneficiaries." The term "eligible" describes a person who is entitled to receive services funded through Medi-Cal, even if they have not received SMHS. The term "beneficiary" describes a person who is Medi-Cal eligible and has received SMHS funded by SDMC.

In addition to the statewide analysis for this report, CalEQRO produces summaries and reports that are released to the MHPs prior to their onsite EQRO visits. PM data reported in this section were used onsite for the MHP reviews and reports.

Information Systems Capability Assessment

As part of the EQR protocol, MHPs are required to maintain a health information system (HIS) that collects, analyzes, integrates, and reports data for purposes including utilization, claims, grievances and appeals, disenrollment for reasons other than loss of Medicaid or CHIP eligibility, rate setting, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development. CalEQRO assesses this capacity using the Information Systems Capabilities Assessment (ISCA) tool, which CalEQRO developed based on CMS protocol in cooperation with California stakeholders and DHCS. The purpose of this assessment is to specify the desired capabilities of the MHP's information systems (IS) and to pose standard questions to assess an MHP's strengths with respect to these capabilities. For a complete list of domains covered by the ISCA, see Table 2-3.

Table 2-3: ISCA Domains

General Information
1. Business Planning and Administration
2. Primary EHR and Secondary Information Systems Used
3. Telehealth Services Use and Support
4. Beneficiary Personal Health Record
5. Public Information Sharing and Communications
Data Collection and Processing
1. Data Timeliness, Accuracy, and Completeness
2. Staff Credentialing – Network Adequacy
3. EHR Training and Ongoing User Support
4. IS and Data Analysis Staffing
5. Staff and Contract Provider Communications
6. Data Timeliness, Accuracy, and Completeness
Medi-Cal Claims Processing
Incoming Claims Processing (Network Providers)
Information Systems Security and Controls
Data Access, Usage, and Analysis

Using the ISCA protocol,[5] CalEQRO reviewed and analyzed the extent to which the MHPs meet federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the MHPs' reporting systems and methodologies for calculating PMs.

MHP Assessment of Timely Access

CalEQRO developed the MHP Assessment of Timely Access (MATA) to provide a systematic approach to assessing the MHPs' adherence to applicable timeliness standards, such as the HEDIS and AB 205. The MATA consists of six parts: timeliness to initial access, initial psychiatry encounter, urgent care, psychiatric inpatient follow-up care, rehospitalization rates, and no-show rates. In addition to the overall timeliness metrics, the MHP is asked to report on each area by adult and children's systems of care. Starting in FY 2018-19, CalEQRO asked MHPs to also report on each measure by foster care beneficiaries as part of timeliness data collection for SB 1291.

For each of these metrics, CalEQRO asks the MHPs to provide data for adults, children, and foster care beneficiaries, as well as statistics on central tendencies and the standard deviation

[5] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0*. September 1, 2012. Washington, DC: Author.

of the distributions. Further, one section of the MATA helps CalEQRO assess the MHPs' technical and analytical capabilities to capture the data elements and report on them.

Each MHP completes its MATA prior to the review. During the review, CalEQRO validates the information provided by the MHPs through focus groups with beneficiaries and family members, line staff, supervisors, contract providers, and quality improvement (QI) staff. The validation process is additionally informed by the PMs and any timeliness-related Performance Improvement Projects (PIPs). The findings are reported through the key components' analysis and ultimately through the strengths, opportunities, and recommendations that conclude this Annual Report.

CalEQRO received fully or partially completed MATAs from all 56 MHPs reviewed during FY 2019-20. Information about the completeness of each data element can be found in Table 2-4 below.

Table 2-4: MATA Data Completeness

Timeliness Tracking Capacity				
Contract Providers Included?	**Yes**	**No**		**N/A**
Initial Access to Clinical and Psychiatric Services	32	12		12
Ongoing Timeliness and Related Issues	21	14		21
Timeliness Findings	**Entire System**	**County- Operated Only**	**Contract Providers Only**	**N/A**
First Offered Appointment	33	17	0	6
First Kept Appointment	36	16	1	3
First Psychiatry Appointment	31	20	0	5
First Urgent Appointment	33	17	0	6
Follow-up After Inpatient Discharge	42	10	0	4
No-Shows	23	24	0	9
Hospital Data	**All Hospitals**	**County- Operated Only**	**Contract Hospitals Only**	**N/A**
Inpatient Discharge	43	6	3	4
Inpatient Readmission	42	5	4	5

Pathways to Wellness/Katie A. Questionnaire

As part of the annual EQR of the MHPs, DHCS requires CalEQRO to collect information on the implementation status of Pathways to Well-Being activities, also known as Katie A. As a result of the Settlement Agreement in *Katie A. v. Bonta*, the State of California agreed to take a series of actions that transformed the way California children and youth who are in foster care, or who are at imminent risk of foster care placement, receive access to mental health services. The settlement specifically changed the way a defined group of children and youth with the most intensive needs, referred to as "Katie A. subclass members," are assessed for mental health services. Pursuant to the settlement, subclass members were required to be provided an array of services, specifically Intensive Care Coordination (ICC), Intensive Home-based Services

(IHBS), and Therapeutic Foster Care (TFC) services when medically necessary, consistent with the Core Practice Model. Table 2-5 lists topics covered by the questionnaire.

Table 2-5: Topics Covered by Pathways to Wellness Questionnaire

KTA Questionnaire Topics
Shared Management/System Collaboration and Coordination
Child and Family Involvement
Mental Health Screenings, Referrals, and Assessments
Identification of Beneficiary's Provision of Services
Claiming
Documentation of Services
Core Practice Model
Outcomes/Quality Improvement
Confidentiality/Data Sharing
Therapeutic Foster Care

Performance Improvement Projects

Each MHP is required to conduct two PIPs[6] for validation during the 12 months preceding the CalEQRO review.

The CMS *Validating Performance Improvement Projects* protocol specifies that the EQRO validate two PIPs (one clinical and one non-clinical) at each MHP that have been initiated, are underway, or were completed during the reporting year; each is expected to produce beneficiary-focused outcomes.[7] Accordingly, for this Annual Report, CalEQRO examined projects that were underway at some time during the 12 months preceding the FY 2019-20 onsite reviews.

The PIP Implementation and Submission Tool (also referred to as the Road Map or PIP Development Outline) is a template provided by CalEQRO for the MHPs to use when drafting their PIP narratives.[8] CalEQRO reviews and validates any resubmitted PIPs in accordance with the requirements of CMS Protocol 3.[9] All PIPs are rated based on their completeness and

[6] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). *Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0.* September 2012. Washington, DC: Author.

[7] Ibid.

[8] To view the PIP Development Outline, visit CalEQRO's website: http://calegro.com/#!california_eqro_resources/MHP. The tool is found under Notification Materials/MHP Notification Materials__Review Preparation Materials.

[9] Ibid.

compliance with the standards found in the CMS protocols.[10] Each of the nine PIP steps includes subsections containing standards that are rated according to the PIP Validation Tool.[11]

Performance and Quality Management Key Components

A central focus of the EQR process is the validation of key performance and quality management indicators, known as key components. Collectively, these qualities comprise the key performance and quality management indicators of access, timeliness, quality, beneficiary outcomes, and structure and operations.

Each key component has three to seven corresponding subcomponents, and each subcomponent has its own set of 2 to 15 individual items. CalEQRO review teams assess key components throughout the EQR process for each MHP and determine item-level scores based on the entirety of their findings. Items are scored on a scale of 0 to 2 as Not Present (0), Partially Present (1), or Present (2). Item scores are then summed for each subcomponent.

Notable changes this year include a complete redesign of the key components, with many revised and updated. Several new components were added, including Beneficiary Progress/Outcomes and Structure and Operations. Subitems were reviewed and updated so as to be more objectively evaluated. The most noteworthy change is in the rating scheme. Prior, each item was rated as Present, Partially Present, or Not Present. As described above, each item is now assigned a rating of 2, 1, or 0 corresponding to these categories. For each key component, the subitem scores are added to create a continuous, quantitative rating scale.

Stakeholder Focus Groups

Stakeholder focus groups provide additional perspectives on MHP function and programming. During FY 2019-20, CalEQRO facilitated 172 focus groups across 41 MHP reviews. With the onset of COVID-19 and sheltering in place, stakeholder focus groups were discontinued. As a result, no stakeholder focus groups were conducted for 15 MHPs. Interpreters were used among 20 focus groups. See Table 2-6 for more information about languages used during consumer and family member (CFM) focus groups.

Table 2-6: Focus Groups Conducted During FY 2019-20 CalEQRO Reviews, by Type

Type of Group	Number of Groups
Clinical Supervisors	25
Clinical Line Staff	40
Contract Providers	16
CFM Employees	14
Beneficiaries and Family Members	77

[10] Ibid.

[11] The PIP Validation Tool is available from CalEQRO's Website, www.calegro.com.

Type of Group	Number of Groups
English	57
Spanish	17
Cantonese	2
Arabic	1

CalEQRO developed interview guides for group discussion in the areas of access to services, timeliness, quality, outcomes, and structure and operations. For focus groups involving CFMs, CFM consultants used their own lived experiences along with their training to effectively gather data reflecting beneficiaries' experiences within the MHP system. CalEQRO also collected demographic information from CFM focus group participants.

CalEQRO staff took notes during each focus group, which were later cleaned, aggregated, and analyzed for overarching themes. To protect participants' privacy, focus groups were not recorded.

MHP Documentation

In addition to the data sources described above, MHPs are asked to submit quantitative and qualitative documentation in advance of the review that provide information about their current structure, programming, capacity, and performance. These documents reflect performance management and quality improvement activities which occurred during the review period; CalEQRO validates this information during the onsite review process. Examples include QI Work Plans and Evaluations; Quality Improvement Committee minutes; Cultural Competency Plans; and data analysis reports.

The CalEQRO team assigned to each review conducts a document review and analysis prior to the onsite (or virtual) review activities taking place. During the onsite or virtual review, and as part of the validation process, CalEQRO reviewers conduct key informant interviews with MHP staff, beneficiaries, family members, line staff, contract providers, and supervisors to learn more about their experiences and perspectives.

Strengths, Opportunities, and Recommendations

The review of MHP strengths, opportunities, and recommendations (SORs) is part of federal guidelines governing EQRO. Strengths are those characteristics that enabled or enhanced an MHP's ability to provide SMHS to its beneficiary population. They also reflect industry best practices in mental health, HIS, and program operations. Opportunities are those areas where the MHP was underperforming, did not meet DHCS requirements/standards, and/or showed need for improvement in its ability to provide accessible and timely services. Recommendations are derived from the opportunities and identify the areas in which MHPs should focus improvement efforts in the upcoming year. Some recommendations also were designated as carry-over recommendations from the previous review year. A recommendation was carried over if it had not been resolved and the need to address the issue continued. The strengths, opportunities, and FY 2019-20 recommendations were drawn directly from the FY 2019-20 MHP final reports.

Data Collection

Data for this annual report are largely derived from information gathered during the annual review of each individual MHP. After completion of the 56 individual reviews, the data are aggregated to compile a statewide analysis.

Additional administrative and survey data collected by DHCS and the CalEQRO also are included in this report. DHCS collects survey data regarding CFM perspectives and provides access to claims data for analysis. CalEQRO staff log hours spent providing technical assistance to MHPs.

Data collection tools are reviewed annually. When making revisions, the CalEQRO team weighs the importance of being able to compare data by year over the need for improvements.

Analysis

Data Preparation and Preliminary Analysis

Data from MHP review forms and reports were aggregated into an online database once the source data were determined to be final. Since manual data entry of this type is prone to error, the data entry team randomly selected 10 percent of the entries for each data source to review for accuracy and completeness. The data team corrected any errors found during this process and repeated the random sampling until no errors were identified. Finally, the data team exported the aggregated data from each source into Excel files for further processing. Data not collected during MHP reviews were requested from the relevant source.

Quantitative data were cleaned and coded. The data team generated descriptive statistics for all key variables at the statewide level, by county size, and (if relevant) by region. The data team developed tables and figures to summarize these results for each data source.

Throughout this Annual Report, subgroup analyses appear by MHP size and region. CalEQRO uses five size categories based on California Department of Finance population estimates in computing its PMs: very large, large, medium, small, and small-rural. MHPs also are grouped by five regions: Bay Area, Central, Los Angeles, Southern, and Superior. To avoid focusing any subgroup analysis on a single county, Los Angeles is sometimes included in the Large and Southern categories.

Qualitative data underwent a thematic analysis. The data team prepared documents containing themes and supporting examples for each data source.

Identification of Key Findings

Quantitative and qualitative data summaries were distributed to analysts, who worked to identify the most relevant, impactful, and interesting findings within each data source. Next, analysts met in teams to review overall conclusions and the supporting evidence.

Review Barriers

Most onsite reviews were conducted without encountering significant barriers to the review process. During FY 2019-20, the most notable barrier to being able to conduct the review as planned was COVID-19. In accordance with the California Governor's Executive Order N-33-20 promulgating statewide shelter-in-place restrictions, it was not possible to conduct an onsite EQR for 30 percent (17/56) of the MHPs. Consequently, some areas of the review were limited, and others were not possible, such as conducting beneficiary focus groups.

Poor attendance for youth and family beneficiary focus groups, prior to COVID, was a leading barrier, operationalized as fewer than three participants in the focus group. Eight MHPs had low or no attendance for at least one focus group. This was especially problematic for feedback on recently initiated services, children's services, and foster care. Poor communication and attendance also affected reviewers' ability to connect with some contractors and staff.

Scheduling and communication challenges between CalEQRO and the MHP limited the ability of reviewers to connect with beneficiaries in languages other than English. For six MHPs, late and/or incomplete documentation presented challenges to carrying out the review as comprehensively as possible. Other external factors such as fires and power outages prevented some MHPs from providing or completing necessary documentation on time.

Despite these barriers and the shifts required in response to COVID-19, the CalEQRO team was able to conduct a rigorous, systematic review of the data provided by MHPs, supporting the findings presented in the following chapters.

Medi-Cal Specialty Mental Health External Quality Review Report
2019-20

Chapter 3

Access

Access

Monitoring and Improving Access at Every Point in the System of Care Continuum

Introduction

Access is the cornerstone of MHP services; if beneficiaries cannot reach the services they need, the quality of services cannot achieve its potential to improve outcomes. For an EQR, this encompasses validating PMs and monitoring the corresponding access subcomponents: (1) service access and availability; (2) capacity management; and (3) integration and collaboration. CalEQRO recognizes that access to care often varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location.

Overview of Major Access Findings

Finding 1 **California experienced a significant drop in its Medi-Cal eligible population.**

Finding 2 **MHPs continue to expand specific and often targeted service offerings; however, many still struggle with capacity, particularly for some services such as psychiatry.**

Finding 3 **MHPs score highly on collaborating with other organizations to build a strong system of care.**

Performance Measures

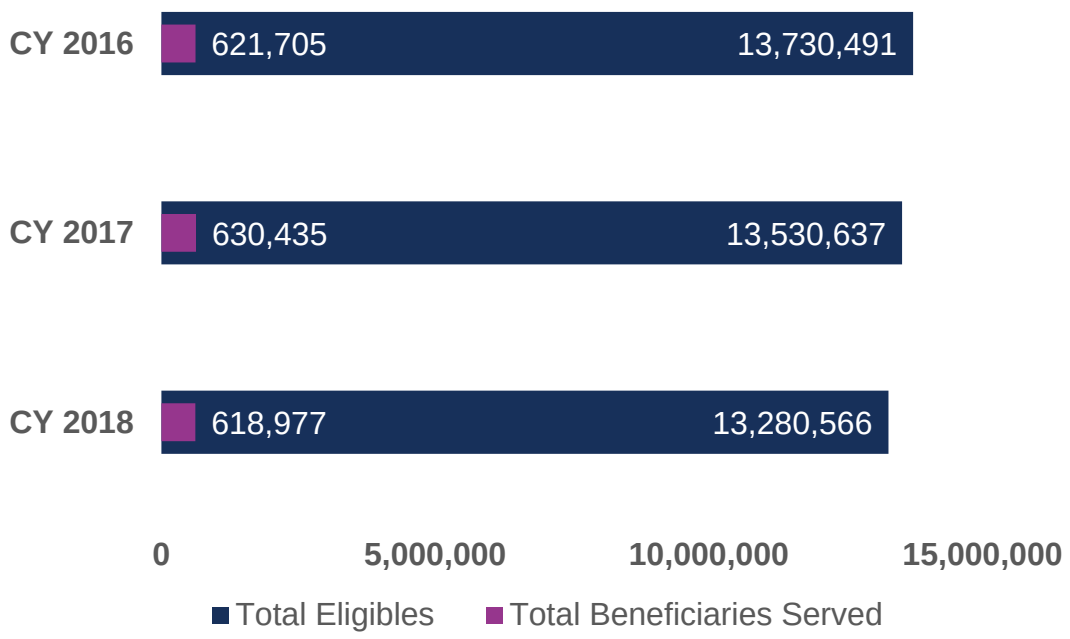
Penetration Rates

Calculated by dividing the number of beneficiaries receiving SMHS by the number of Medi-Cal eligible beneficiaries, penetration rates provide a quantifiable measure of access to services. The stratification of penetration rates across age, gender, and race/ethnicity further contribute to a more comprehensive understanding of disparities seen between demographic groups.

California experienced a drop in its Medi-Cal eligible population.

During the three-year period between CY 2016 and CY 2018, statewide, the number of Medi-Cal eligible beneficiaries declined by almost 450K, or 3.3 percent. For comparison, it is as if the entire beneficiary pool of the Superior region has disappeared in three years from the state Medi-Cal rolls (Figure 3-1).

Figure 3-1: Statewide Eligibles and Beneficiaries, CY 2016-2018



The decline in the number of eligibles is seen in four regions: Bay Area, Central, Los Angeles, and Southern. Only the smallest region, Superior, showed a modest increase (Table 3-1) in its Medi-Cal eligibles count.

Table 3-1: Region Eligibles and Beneficiaries Served, CY 2016-2018

Region / CY	Total Eligibles	Total Beneficiaries Served
Bay Area		
CY 2016	2,199,639	113,740
CY 2017	2,158,883	112,851
CY 2018	2,087,709	107,905
Central		
CY 2016	2,429,407	97,127
CY 2017	2,426,532	97,208
CY 2018	2,378,549	96,284
Los Angeles		
CY 2016	4,159,585	204,249
CY 2017	4,022,848	212,478
CY 2018	3,964,272	210,337
Southern		
CY 2016	4,531,270	179,361
CY 2017	4,510,484	180,408
CY 2018	4,437,502	177,370
Superior		
CY 2016	410,593	25,315
CY 2017	411,893	25,527
CY 2018	412,535	25,165

Table 3-2: Eligibles and Beneficiaries by Race/Ethnicity, CY 2018

Category	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate
African American	1,004,291	80,235	7.99%
Asian/Pacific Islander	1,316,629	29,595	2.25%
Hispanic/Latino	6,677,877	252,104	3.78%
Native American	53,655	3,689	6.88%
White	2,514,792	163,485	6.50%
Other	1,713,326	89,869	5.25%

Access has improved in the Los Angeles region more than the others.

The decrease in the number of beneficiaries served statewide was not uniformly distributed across the large regions. Los Angeles recorded an increase of 2.9 percent in the number of beneficiaries served at the same time that its number of Medi-Cal eligible beneficiaries was declining.

As a result, the Los Angeles region, which consists of the only very large-sized MHP, showed the most increase in penetration rate between CY 2016 and CY 2018 and continued to register a higher penetration rate than the Bay Area for the second year in a row. CY 2017 was the first time this happened since CalEQRO started reporting on this metric. Penetration rate remained mostly flat for the other regions and MHP sizes (Figures 3-2 and 3-3).

Figure 3-2: Overall Penetration Rate by Region, CY 2016-2018

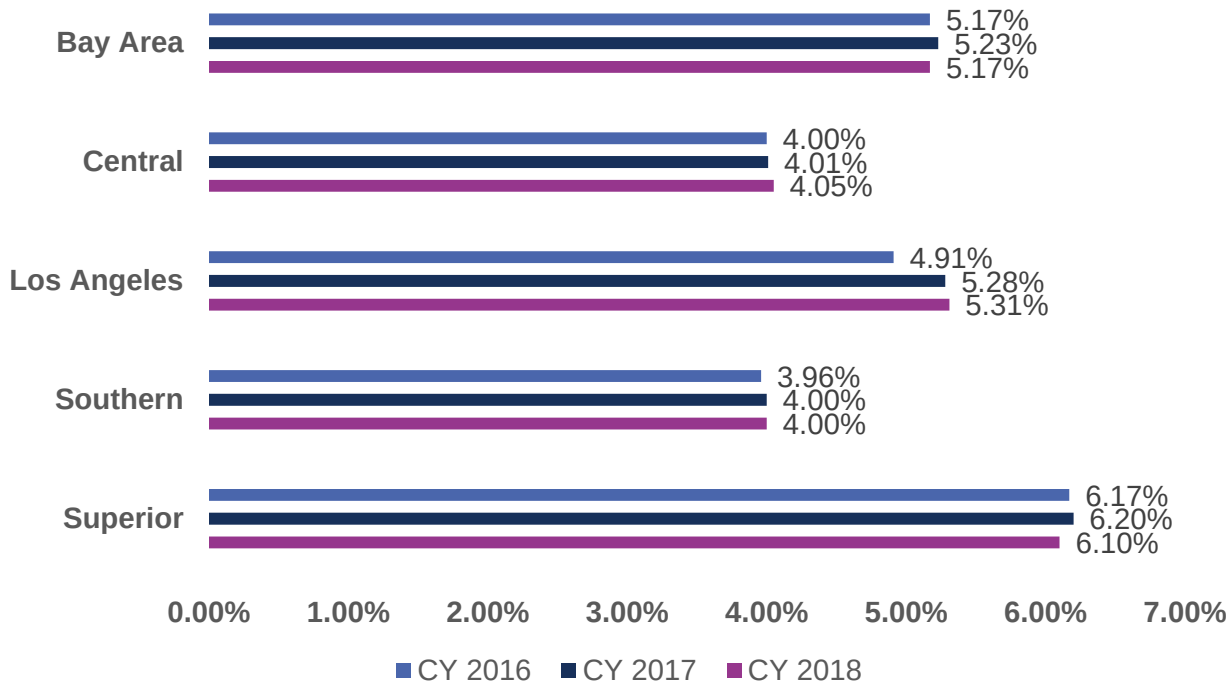
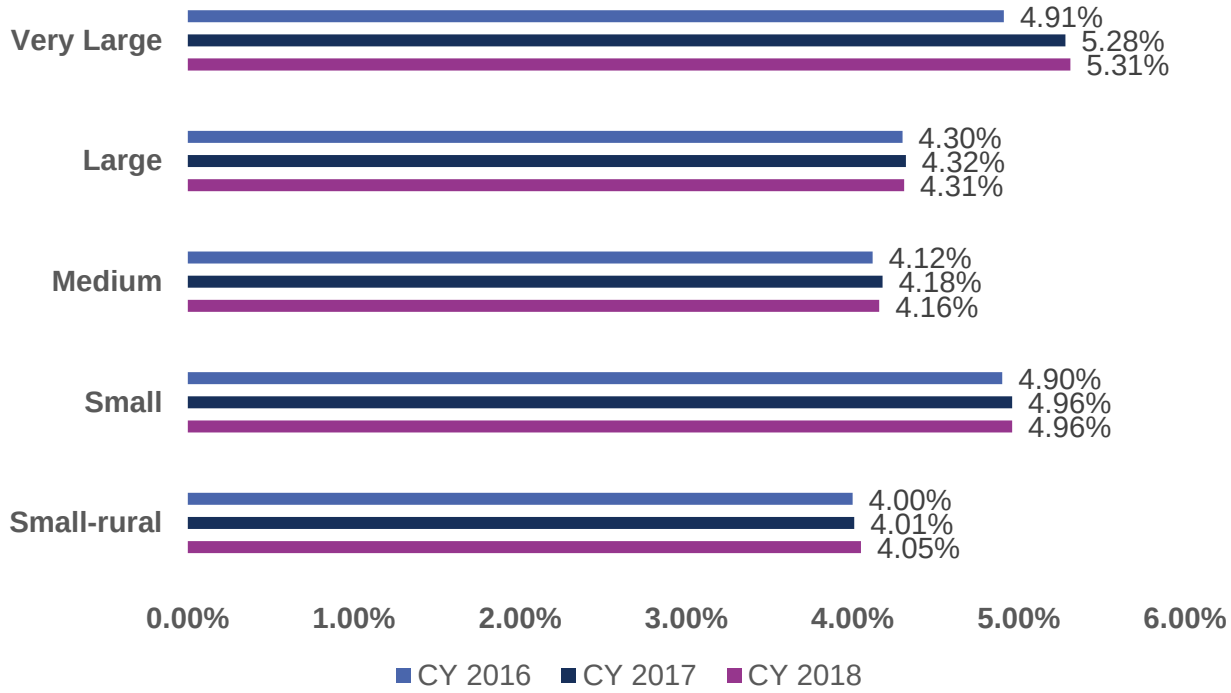


Figure 3-3: Overall Penetration Rate by Size, CY 2016-2018



Children aged 6 to 17 have greater access to SMHS than other age groups.

In CY 2018, children aged between 6 and 17 had the highest penetration rate across all MHP regions and sizes (Figures 3-4 and 3-5). However, there were large variations for all age groups by MHP region and size. Assuming a naturally low penetration rate for children between 0 and 5 and therefore setting this demographic, the older adult population had the lowest penetration rates irrespective of MHP size and region.

Figure 3-4: Penetration Rate by Region and Age, CY 2018

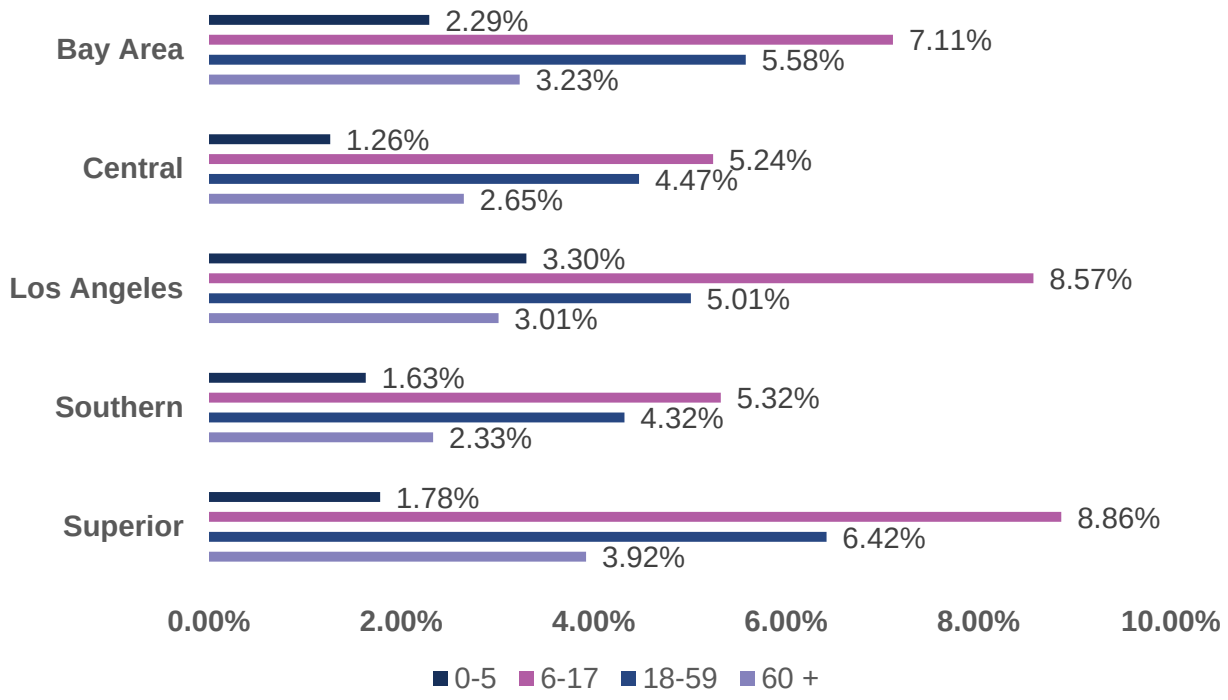
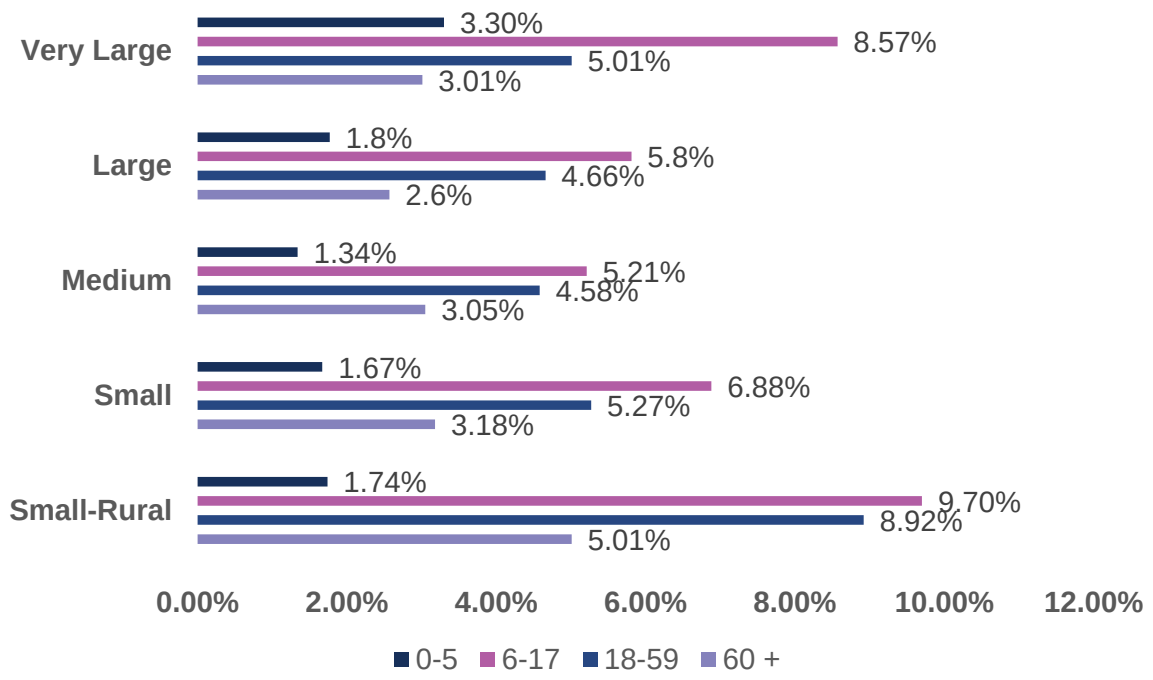


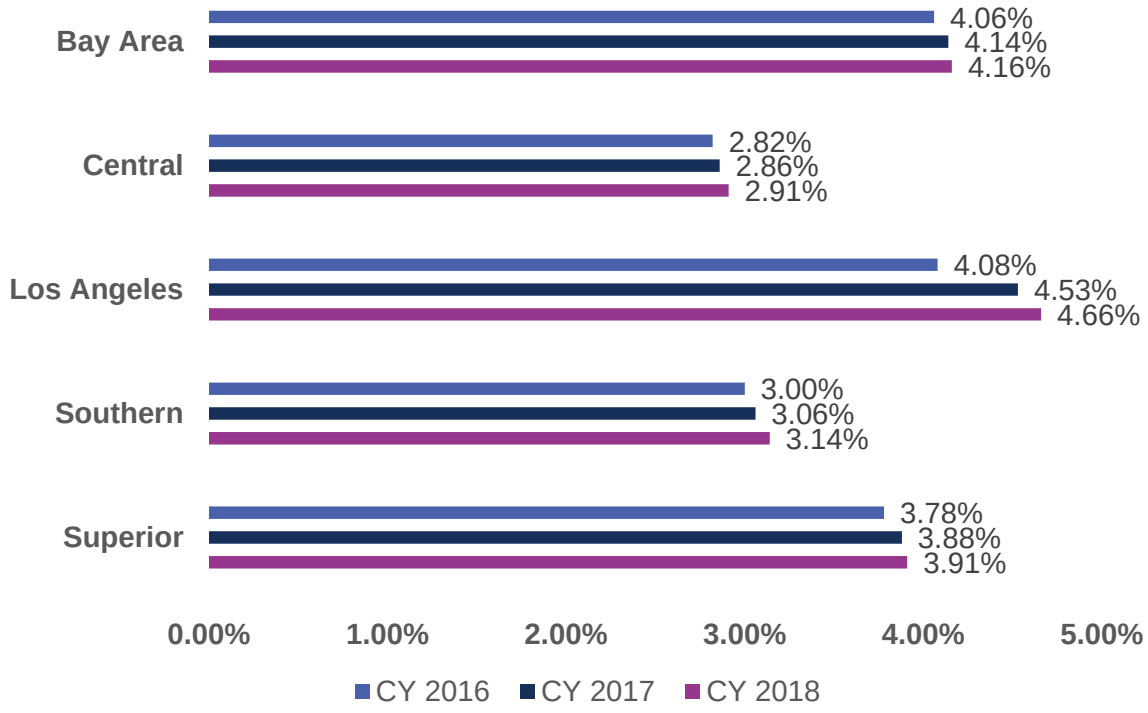
Figure 3-5: Penetration Rate by Size and Age, CY 2018



Disparities continue in Hispanic/Latino access to SMHS.

Statewide, Hispanics/Latinos constitute over half of the Medi-Cal eligible beneficiaries (calculated using Figures 3-1 and 3-6), but they constitute only 40 percent of the beneficiaries served. However, the penetration has been steadily but unevenly increasing across all MHP regions. Los Angeles has taken the lead in improving the Hispanic/Latino penetration rate, followed by the Bay Area and the Superior regions. Central and Southern regions lag behind in reaching mental health services to the Hispanic/Latino beneficiaries in comparison to the other regions (Figure 3-6).

Figure 3-6: Hispanic/Latino Penetration Rates, CY 2016-2018



Foster care penetration has plateaued.

Statewide, the number of foster care eligible and beneficiaries served remained stable over the three years between CY 2016 and CY 2018 (Figure 3-7). However, the Southern and Los Angeles regions had an increase in the FC penetration rate that compensated for the decline in the other three regions (Figure 3-8).

Figure 3-7: Foster Care Eligibles and Beneficiaries Served, CY 2016-2018

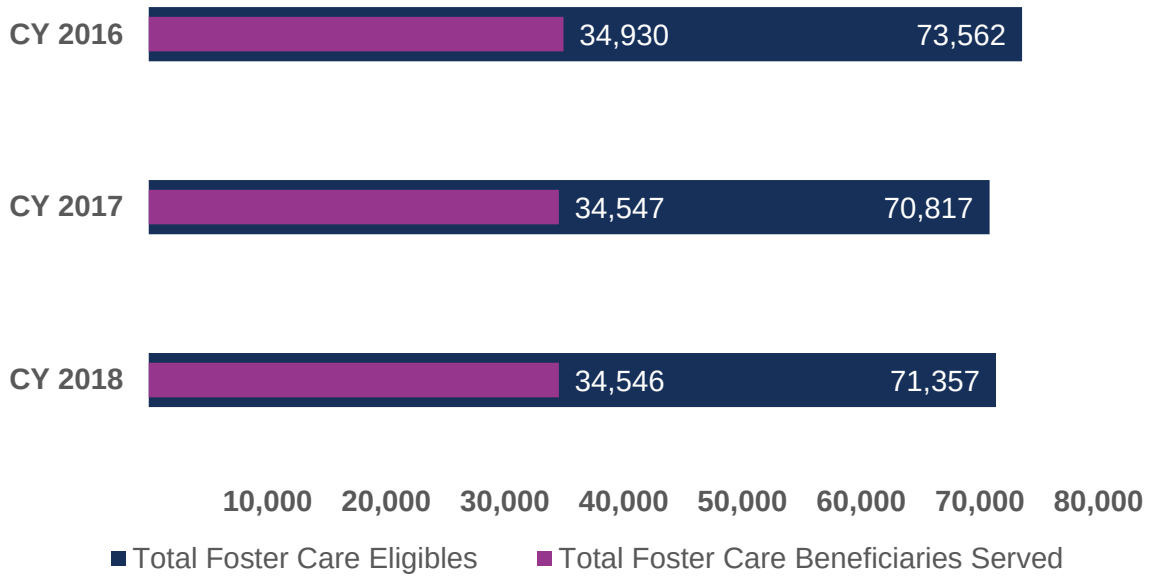
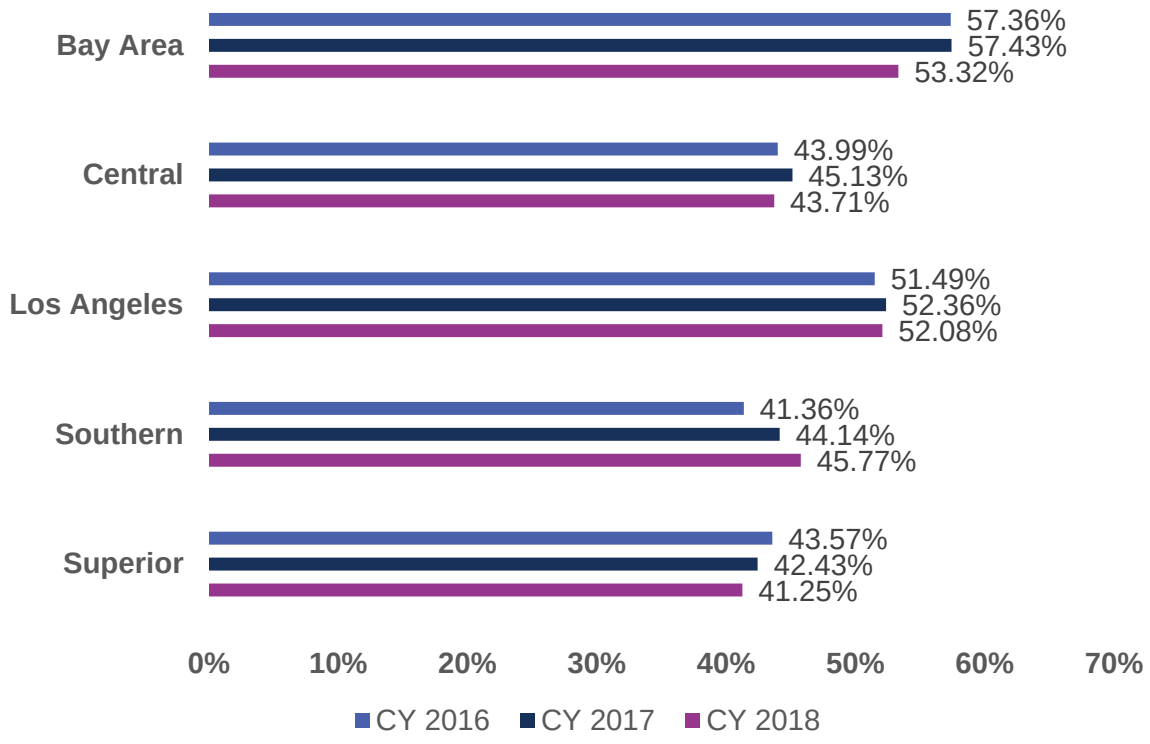


Figure 3-8: Foster Care Penetration Rates by Region, CY 2016-2018



Service Access and Availability

Service access and availability requires that the MHP have a comprehensive system for providing access information and monitoring access. This means that the MHP provides information to beneficiaries about how to access services, including transportation and language assistance/accommodations. MHPs often provide pamphlets, flyers, and other printed information on services to wellness centers, other county programs, and managed care primary health facilities. A functional and user-friendly website with an up-to-date provider directory also helps to ensure that information is available to those accessing services. Additionally, MHPs must monitor access through various venues such as walk-ins, school referrals, and phone calls. Monitoring beneficiary experience with available resources, such as 24/7 Access Lines, is also a critical component of managing access to care.

Organizing a comprehensive system to generate access-related information and monitor access are key components of an effective mental health system of care. This includes providing multiple ways for eligible people to find out about services. Overall, MHPs scored highly on service accessibility and availability, as shown in Figure 3-9 and 3-10 below.

Figure 3-9: Sum Scores for Key Component 1.A, Service Accessibility and Availability

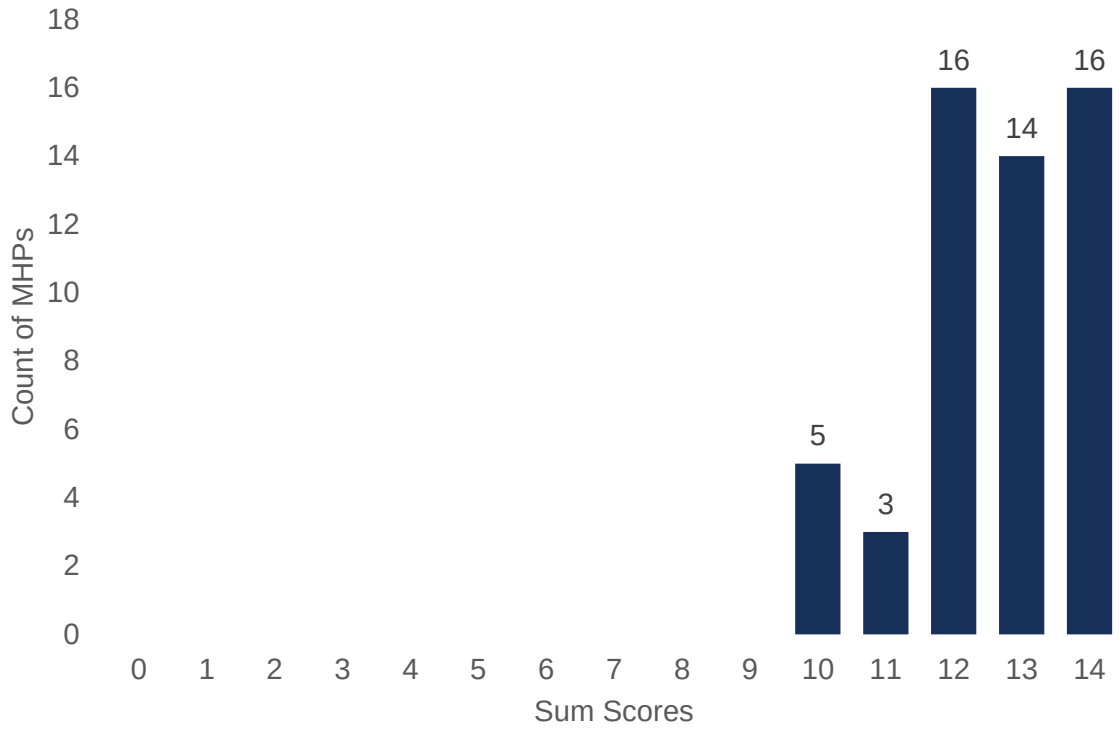
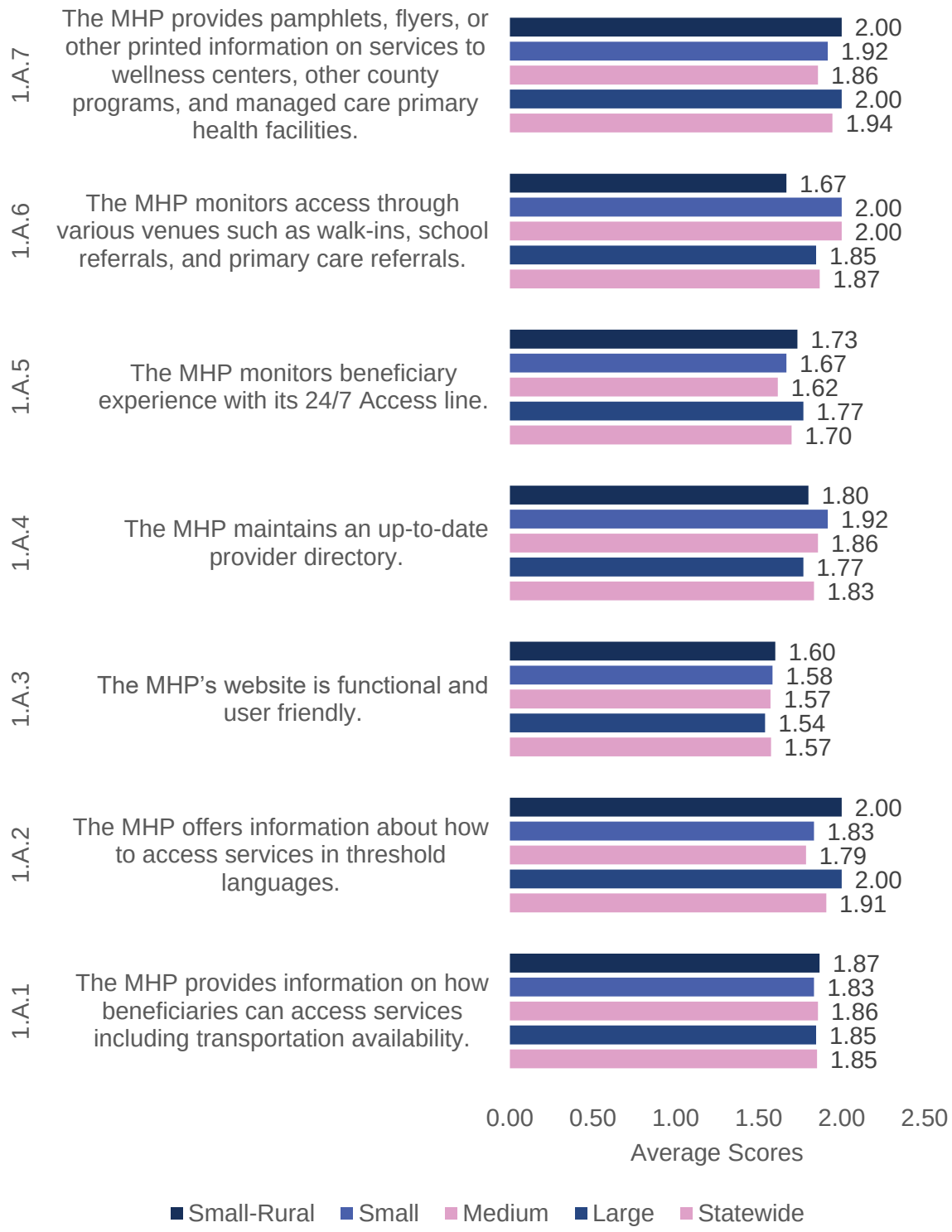


Figure 3-10: Average Item Scores for Key Component 1.A, Statewide and by MHP Size



Generally, MHPs of all sizes demonstrated the ability to provide access information through a variety of mediums.

Website functionality and user-friendliness is the lowest scoring element in this subcomponent (statewide aggregate=1.57), with large MHPs having the lowest scores (1.54). MHPs often struggle to make improvements to their websites because the sites tend to be subsidiaries of a larger agency superstructure, which limits the agency's options. Providing online information in languages other than English was noted as an opportunity for improvement for several MHPs. When such information is available, it is often difficult to locate on the website.

Monitoring beneficiary experiences via a 24-hour access line was the second weakest item in this subcomponent, with a statewide average of 1.70 (Figure 3-2). Some beneficiaries reported trouble accessing crisis services after hours because contact information was not prominently displayed in MHP information resources or the MHP did not have staff responding to its telephone line around the clock. CalEQRO noted these two as areas for improvement and either designated them as opportunities or made recommendations accordingly. Based on previous recommendations regarding MHP websites and access monitoring, MHPs are usually responsive to these recommendations.

Clinical line staff across MHPs of all sizes noted the connection between limited and/or inconsistent transportation and no-shows or beneficiaries who are late for appointments.

Available transportation also facilitates access to services. Some counties offer transportation vouchers or provide transportation directly. In these counties, bus passes and rides are provided through case managers and transportation is not a barrier. In focus groups, beneficiaries in these counties offered positive feedback about the efforts the MHPs made to facilitate access by removing transportation-related barriers. Some beneficiaries mentioned that their medications were delivered to them. Some were provided transportation to groups and to their appointments, as well as for other medical appointments. However, transportation is often not available for those who need it most or is offered inconsistently.

Transportation was raised as an opportunity for improvement in a number of MHPs, where transportation was deemed as inconsistent and difficult for beneficiaries to access. For instance, information about transportation resources is not easily accessible on many MHP websites. These transportation-related barriers directly affect beneficiary care. Clinical line staff across MHPs of all sizes noted the connection between limited and/or inconsistent transportation and no-shows or beneficiaries who are late for appointments.

Among the tools MHPs use to facilitate access were several that go beyond basic outreach. These include field outreach teams to improve engagement, separate intake units to facilitate intake assessments, and mobile crisis teams to conduct assessments in the field and coordinate care after the crisis is resolved.

Initial Access

New participants reported that they were referred for services through a variety of means including the wellness center, probation, walk-in, and self-referral, and the majority reported that they were able to get services when referred. Most beneficiaries reported satisfaction with the amount of time it took to start services. The exception to this was access to children's services. Family and youth focus group participants reported longer wait times for those new to the system. However, access to children's services was an exception—participants with children new to the system reported long wait times.

MHPs recognize the need to improve upon current access availability so that beneficiaries are entering initial and/or ongoing services quickly. This is reflected in the PIPs, where 24 percent of active and completed PIPs addressed access to care. Almost one-quarter of access-related PIPs focused on improving kept appointments or reducing no-shows, while another 19 percent focused on increasing post-hospitalization engagement or follow-up.

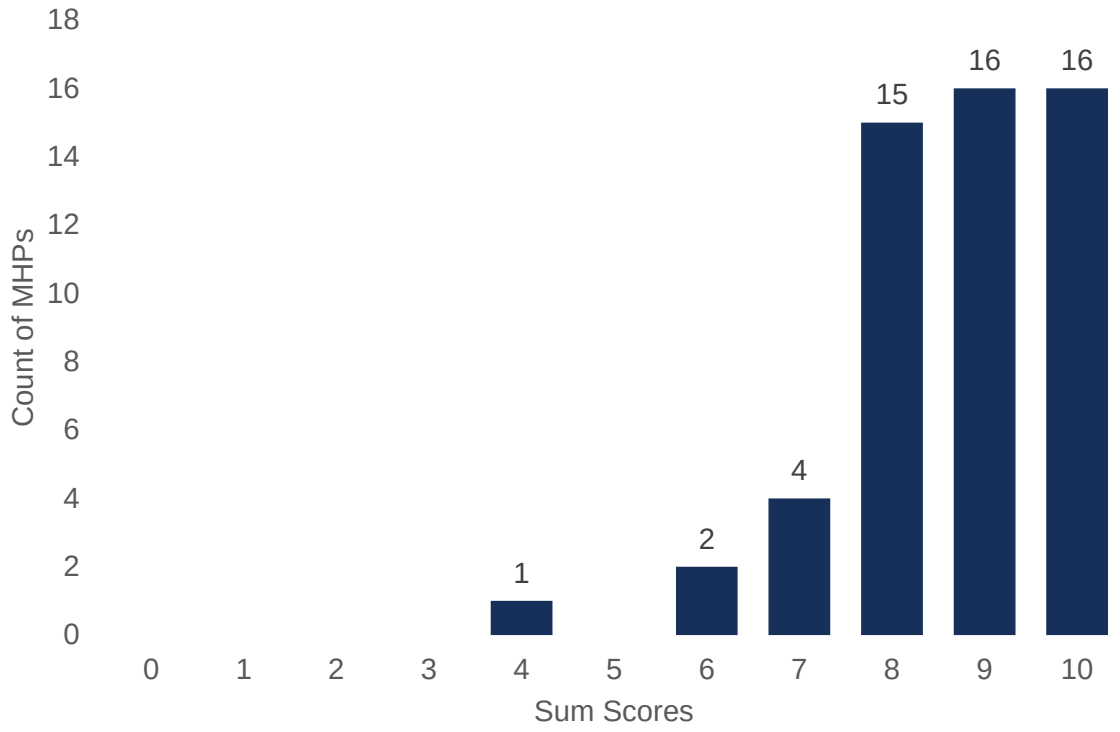
Capacity Management

In an effective system of care, the MHP manages and adapts its capacity to meet beneficiary service needs. The EQR looks at the following indicators of capacity management to evaluate that the MHP:

- Assesses the cultural, ethnic, racial, and linguistic needs of its Medi-Cal eligibles for the purpose of identifying strategies and resources to address disparities in access
- Implements strategies to address the clinical, cultural, and/or linguistic disparities in access and documents how decisions are made on resources committed to the process
- Monitors penetration rates (or other utilization reports) by beneficiary types and demographics (such as foster care, older adult, etc.)
- Monitors system demand, caseloads by provider type and service locations, and productivity
- Evaluates the implementation of strategies to address the clinical, cultural, and/or linguistic disparities in access.

Overall, MHPs reported they had expanded access by increasing service offerings, hiring more staff, and providing continued outreach to beneficiaries through various mediums, as shown in Figure 3-11.

Figure 3-11: Sum Scores for Key Component 1.B, Capacity Management



Among the different components of access, MHPs scored highest on the assessments of beneficiaries' cultural, ethnic, racial, and linguistic needs and their implementation of strategies to address the identified disparities (Figure 3-12). However, scores indicate that MHPs struggle to actually provide culturally competent and linguistically appropriate care to all beneficiaries. Beneficiaries who are able to access language assistance appear to find it very helpful; however, these services may not be available to all who need them.

Beneficiaries who are able to access language assistance appear to find it very helpful; however, these services may not be available to all who need them.

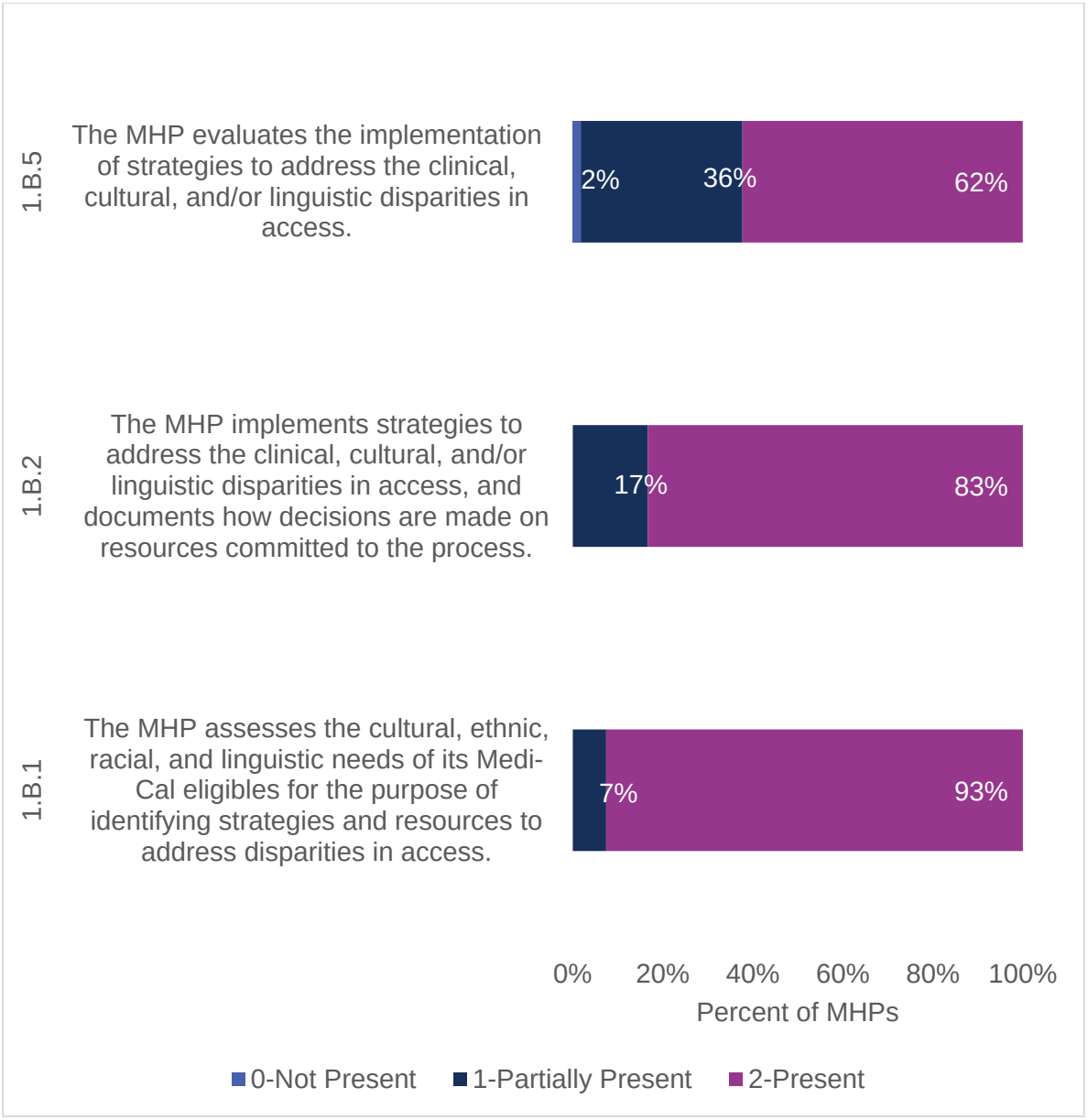
In focus groups, staff at MHPs of all sizes report a lack of capacity for translation services. Additionally, improving cultural competency was a theme across recommendations to MHPs. In focus groups, clinical line staff articulated language issues that impeded access, particularly the lack of translators for the Hispanic/Latino populations. Although beneficiaries reported that services and information were often available in their language (most commonly in the form of written materials), they also frequently recommended hiring additional bilingual staff, particularly in larger counties.

In some counties, contract providers help fill gaps in access by providing services in important threshold languages including Spanish, Tibetan, Greek, Farsi, and Mandarin. In one MHP, a contract provider even performs the initial screening for monolingual Farsi beneficiaries in their own language. Finally, several

counties received recommendations around increasing access to resources in languages other than English, particularly websites, provider lists, and access lines.

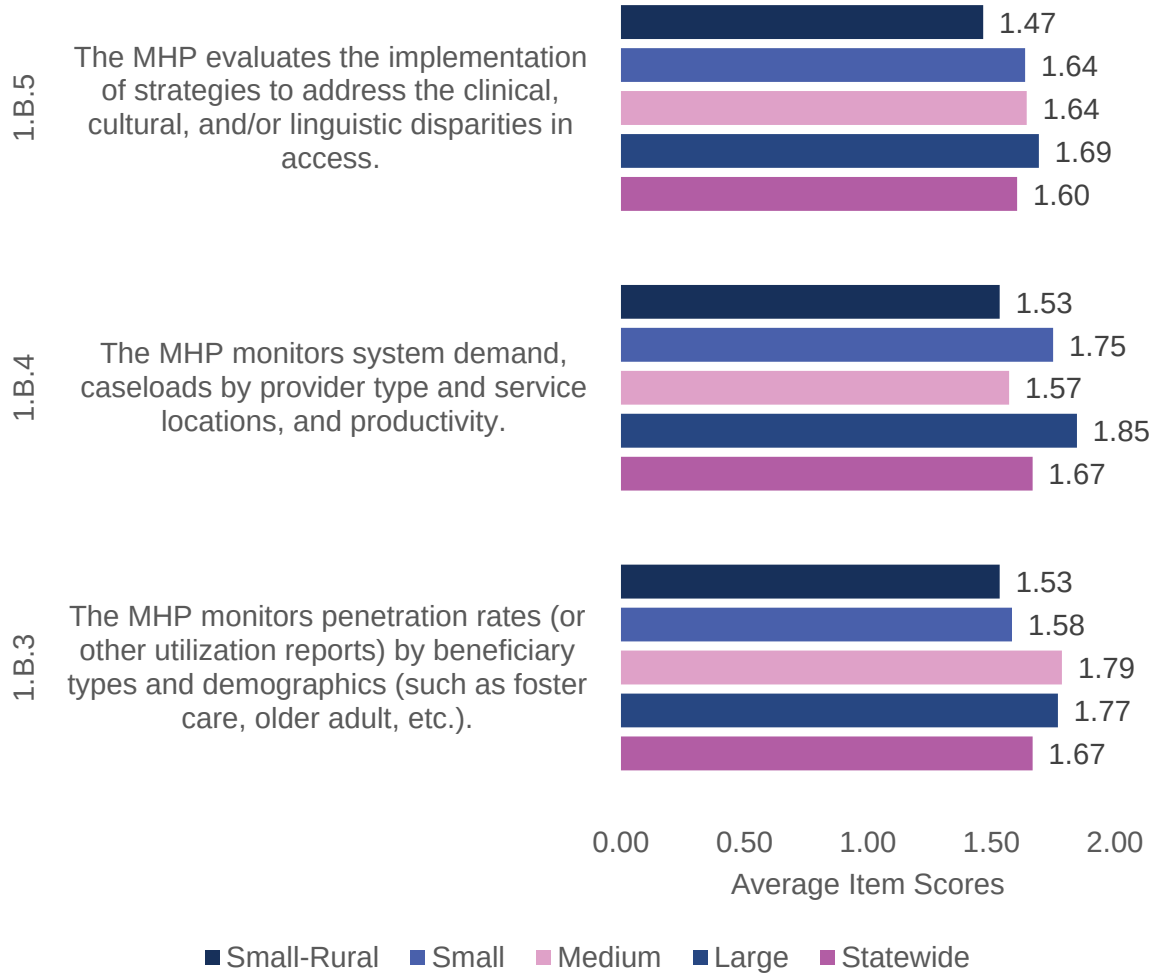
Interestingly, the area where there is room for the most improvement is in MHPs' actions to evaluate their cultural strategies (Figure 3-12). Taking this additional step may help MHPs identify and address ongoing gaps in access such as those discussed above.

Figure 3-12: Item Scores for Key Component 1.B, Selected Items



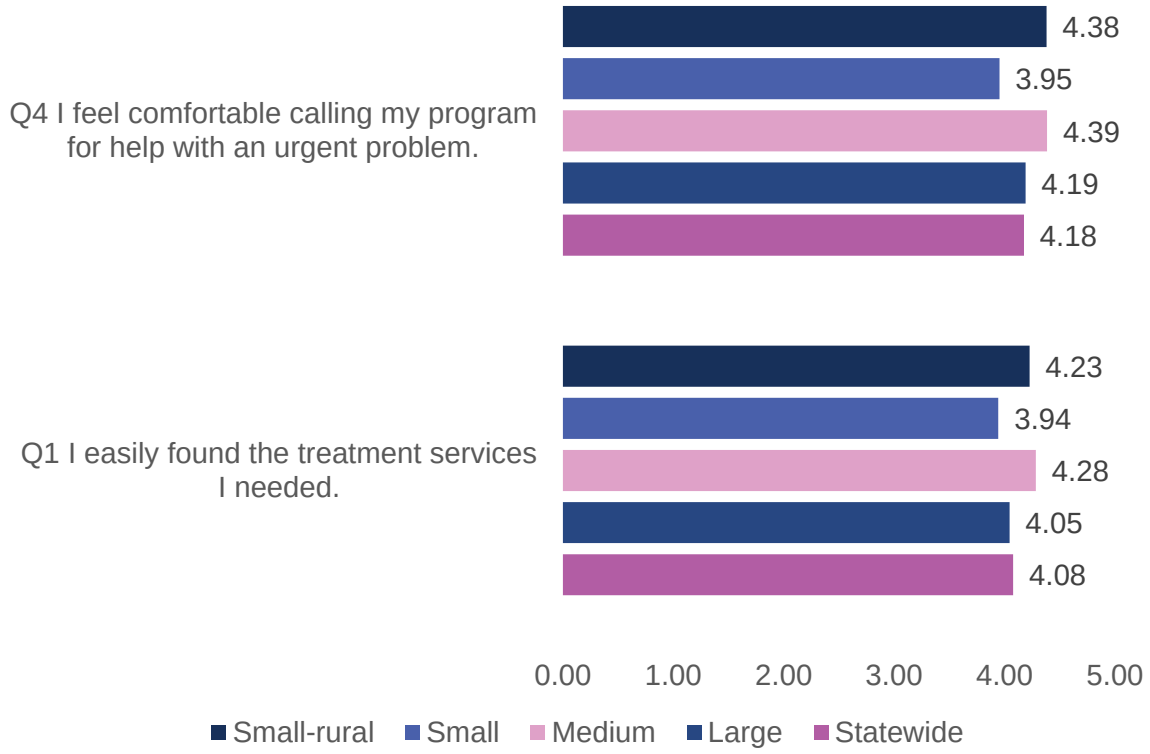
While MHPs scored moderately well with regard to monitoring and evaluating potential disparities in care, these scores attenuate somewhat as MHP size decreases, suggesting that smaller MHPs may lack the resources to monitor penetration rates and system demands and to evaluate initiatives around clinical, cultural, and linguistic disparities in access (Figure 3-13).

Figure 3-13: Average Item Scores for Key Component 1.B, Select Items, Statewide and by MHP Size



For almost all satisfaction questions in surveys completed by CFM focus group participants across all county sizes, average scores were 4 or higher (Agree or Strongly Agree), as shown in Figure 3-14. In two cases, scores were slightly lower: in small counties, beneficiaries scored ease of finding the treatment services they needed and comfort calling their program for help with an urgent problem slightly lower.

Figure 3-14: Satisfaction Scores from Surveys Administered to CFM Focus Group Participants, Selected Items

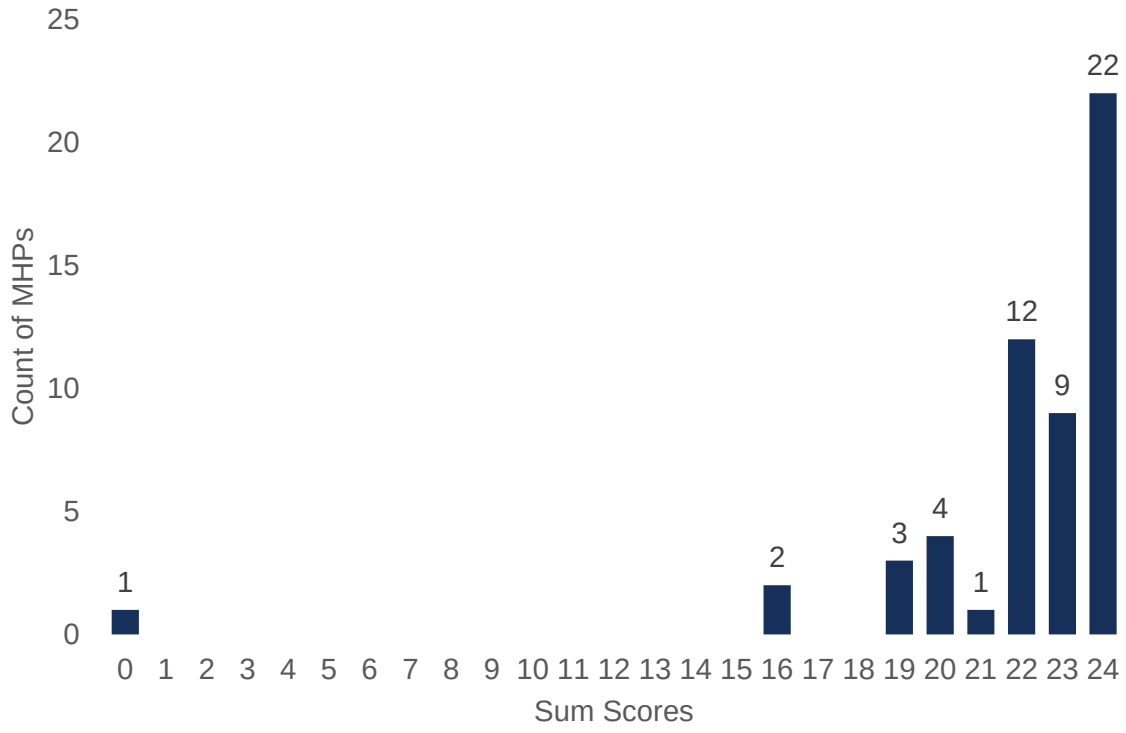


Integration and Collaboration

Effective systems of care develop integrated or collaborative programs with partnering agencies and community-based organizations. Key entities in these collaborations include: primary care providers/clinics (FQHCs, Community Health Centers, Rural Health Centers, Indian Health Clinics); hospitals and/or emergency rooms; SUD programs; child welfare/human services; educational systems (K-12, vocational, community college, higher education); law enforcement/criminal justice; public health/health department; managed care organizations; community-based organizations; faith-based organizations; housing authority/county affordable housing and other options; and departments of rehabilitation/employment support.

On balance, MHPs score highly on collaborating with other organizations to identify, outreach, and facilitate access to services, as shown in Figure 3-15. MHPs scored fairly highly overall on these aspects of collaboration, with 41 MHPs (76 percent) scoring at least 22 of the possible 24 points.

Figure 3-15: Sum Scores for Key Component 1.C, Integration and Collaboration



In general, MHPs scored very highly on key component items around integration and collaboration. There were two exceptions to this trend: faith-based organizations and departments of rehabilitation/employment support. Most notably, small-rural counties had much lower average scores on these items than the statewide average or that of larger counties. Due to their size and locations, these counties may have more limited options for local partners than other counties, depending instead on a small cadre of dedicated local professionals. Despite overall high scores in this area, the need to seek opportunities to collaborate with community stakeholders was a theme in MHP recommendations.

Summary

Statewide, the number of beneficiaries accessing services has decreased from 2016-2018 as the eligible population decreased. During the same time period, approved Medi-Cal claims data shows that disparities continue in Hispanic/Latino access to SMHS. Review findings also indicate that recruitment and retention of mental health professionals has become challenging for county programs and contract providers. Nevertheless, MHPs continue efforts to expand service offerings to underserved, vulnerable populations; 18 percent of MHPs demonstrated concrete improvements in service expansion during the FY 2019-20 EQRs. Moreover, MHPs across the state were found to collaborate well with other organizations to build a strong system of care and serve those with complex needs.

Even with these efforts, many MHPs still struggle with capacity for psychiatry services and the provision of culturally and linguistically appropriate care. Additionally, beneficiaries in many

MHPs reported not being able to access crisis services after office hours or on weekends. As critical entry points to most MHP services, Access Line activity and crisis services warrant ongoing, close evaluation and oversight.

Fifteen percent of all EQR recommendations made in FY 2019-20 centered on access to care. The most common themes warranting improvement activity by MHPs included: (1) culturally responsive outreach, linkage, and engagement; (2) the availability of services in non-English languages; (3) access-related monitoring activities including the functioning of the 24-hour access line in assisting consumers and families in crisis; and (4) approaches to improving workforce challenges in general and at the county level.

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Chapter 4

Timeliness

Timeliness

A New Assessment Tool Helps Bring Timeliness Metrics Into Sharper Focus

Introduction

Timeliness of services offered and provided to beneficiaries is a critical component of the care provided by MHPs. CalEQRO developed the MATA tool to systematically assess the MHPs' adherence to applicable timeliness standards, such as DHCS requirements and HEDIS measures. The MATA consists of six elements: timeliness to initial access, initial psychiatry encounter, urgent care, psychiatric inpatient follow-up care, rehospitalization rates, and no-show rates.

In addition to these overall timeliness metrics, MHPs are asked to report on each area by adult and children's systems of care. In FY 2018-19, CalEQRO began asking MHPs to report on each measure by foster care beneficiaries as part of timeliness data collection for SB 1291. Reporting on timeliness metrics for foster care beneficiaries varies by metric and MHP size. The

Overview of Major Timeliness Findings

Finding 1 **Tracking and reporting of timeliness indicators have improved between FY 2017-18 and FY 2019-20, and most MHPs have adopted the state-mandated timeliness standards.**

Finding 2 **Many MHPs do not have the infrastructure to track timeliness metrics consistently across all systems and providers in their network.**

Finding 3 **Wait times to children's services and initial psychiatry appointments extend beyond state-mandated standards.**

small-rural MHPs had the lowest rates of reporting separately on foster care beneficiaries regardless of the metric.

While most MHPs have adopted the state-mandated timeliness standards for metrics required by DHCS, many MHPs do not have the infrastructure in place systemwide, as contract providers may not be included in the data tracking and reporting.

Increased attention to timeliness was a theme found during this year's EQRs, reflected in both systemwide strengths and PIP activity. CalEQRO noted MHP progress in timeliness tracking as a strength in 20 percent of the FY 2019-20 reviews. Twenty-six of MHPs had a PIP on improving timeliness and timeliness tracking, and one-third of PIP-related technical assistance provided by CalEQRO focused on timeliness topics.

Statewide, timeliness to service indicators have improved between FY 2017-18 and FY 2019-20 (Figure 4-1). Across MHPs of all sizes, 84 percent of the MHPs reported on these metrics during the FY 2019-20 EQR. When the data were broken down by MHP size, some variations were evident, but all MHP size group average percentages were at or above 80 percent for all of the metrics (Figure 4-2).

Figure 4-1: Timeliness Reporting Rates—Statewide Three-Year Trend

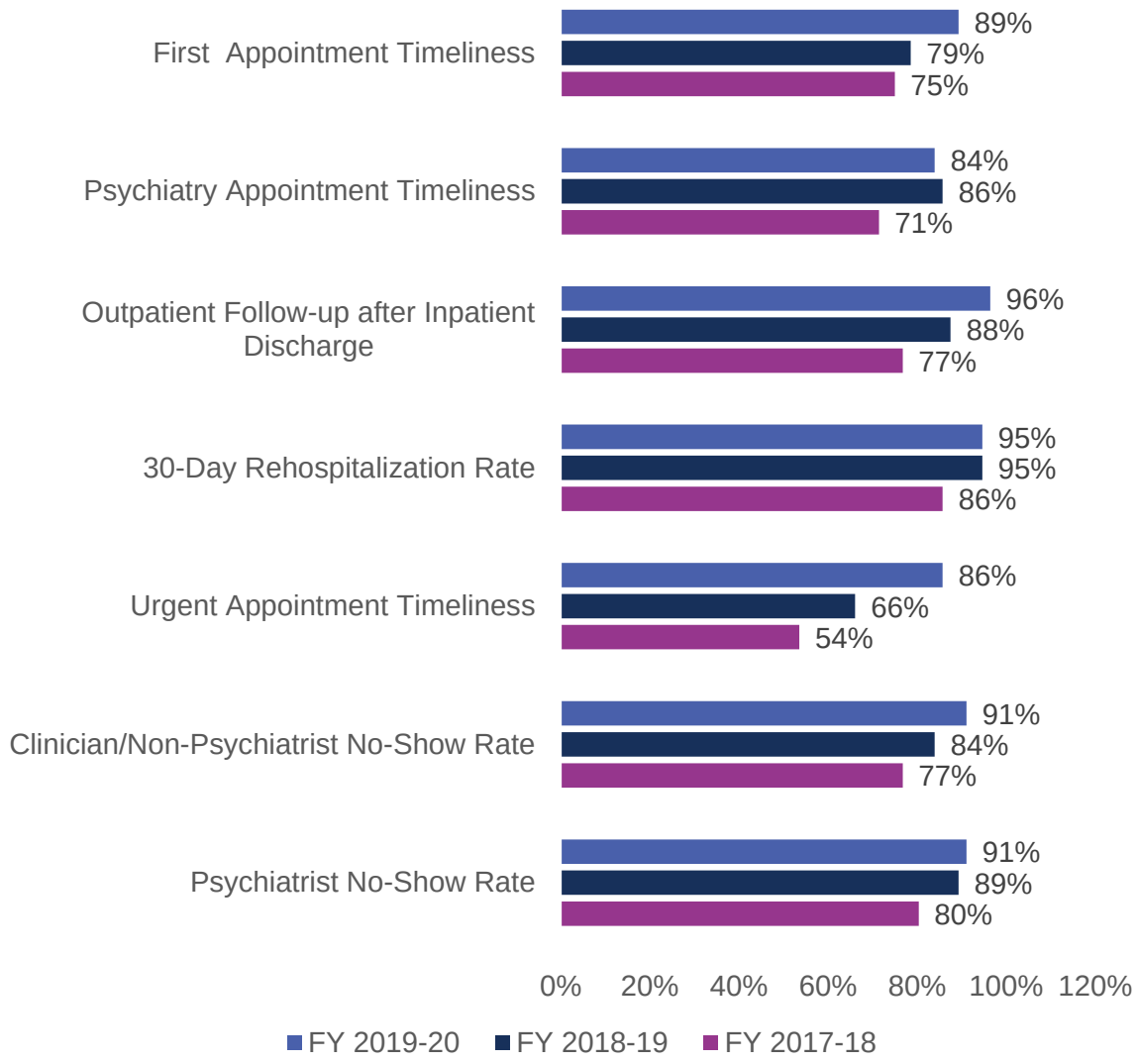
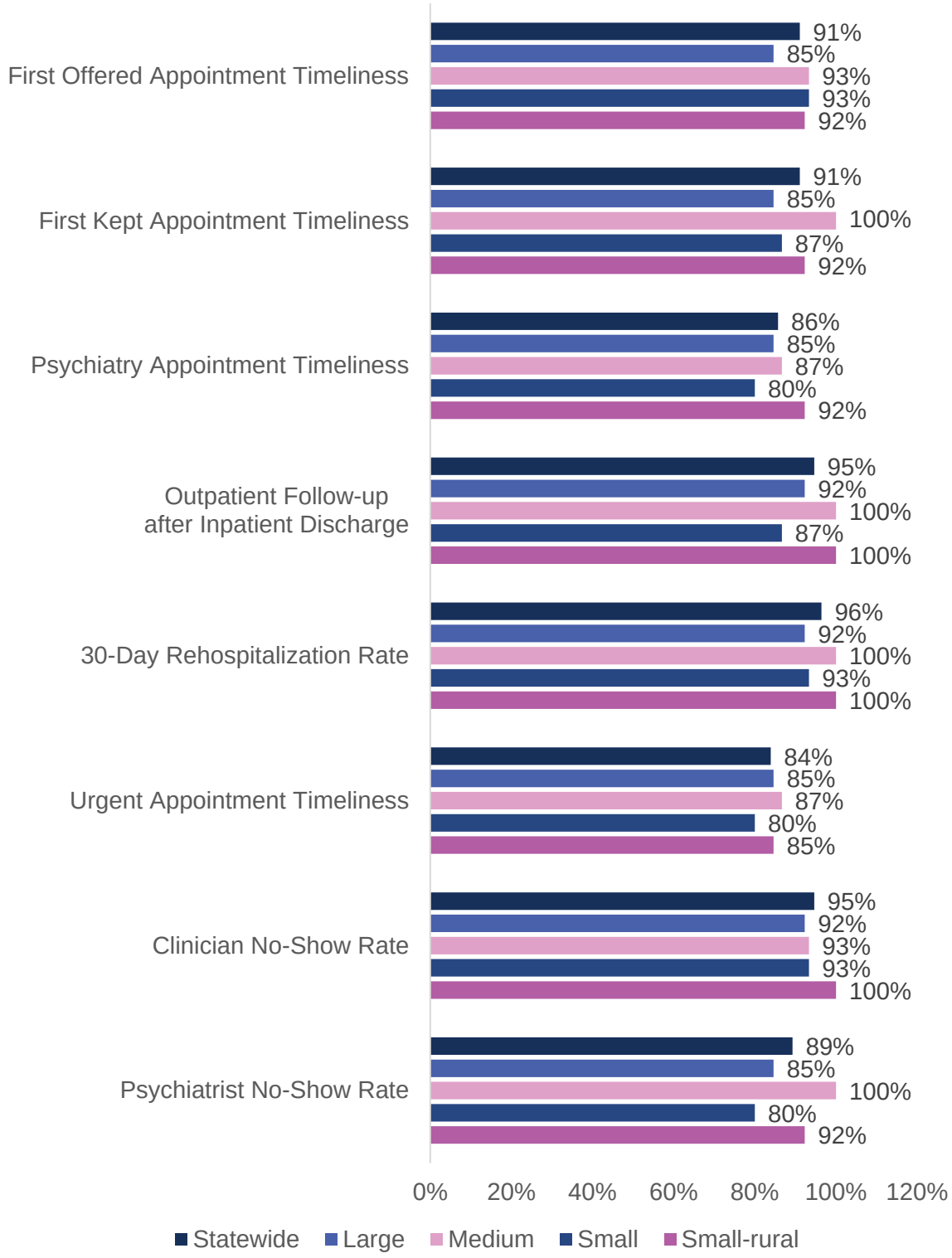


Figure 4-2: Percentage of MHPs Reporting on Timeliness Measures, Statewide and by MHP Size



Timeliness to Initial Access

One of the measures of the MHPs' ability to provide timely services to beneficiaries is the average wait time between an initial service request and the first offered appointment. While timeliness to an offered appointment reflects system capacity, timeliness to first service rendered more closely reflects the beneficiary's experience. In this measure, MHPs report on wait times to the first service delivered after service request.

While some MHPs continue to have difficulty tracking offered appointments, CalEQRO found that, among those MHPs that could track this measure, the average wait time to offered appointments was at least 30 percent lower than the state-defined standard of ten business days (Figure 4-3). In all but the large counties, average wait times were shorter than the MHP-defined standards statewide; in large MHPs, the average wait time was two days longer than the MHP-defined standard (Figure 4-4). For Pathways to Well-Being, 79 percent of the MHPs do not have a wait time for the initial intake, as shown in Figure 4-5. Large MHPs have a lower count of MHPs with a wait time to initial intake when compared with medium, small, and small-rural MHPs.

Figure 4-3: First Offered Appointment Timeliness and Standard Overall, Statewide and by MHP Size

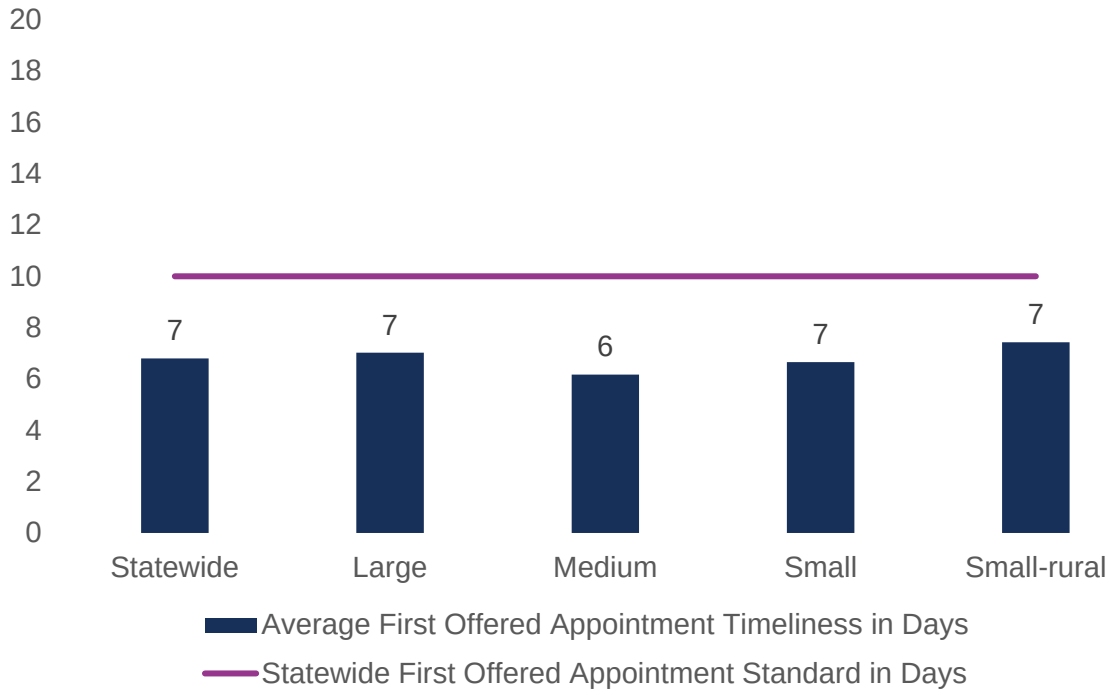
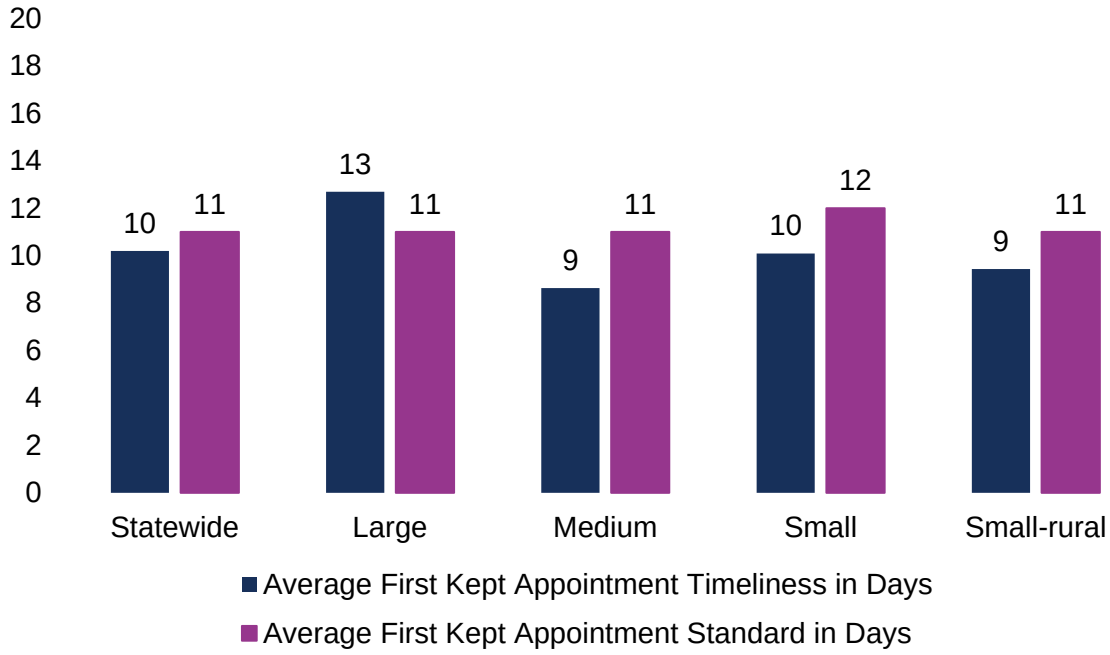


Figure 4-4: First Kept Appointment Timeliness and Standard Overall—Statewide and by MHP Size



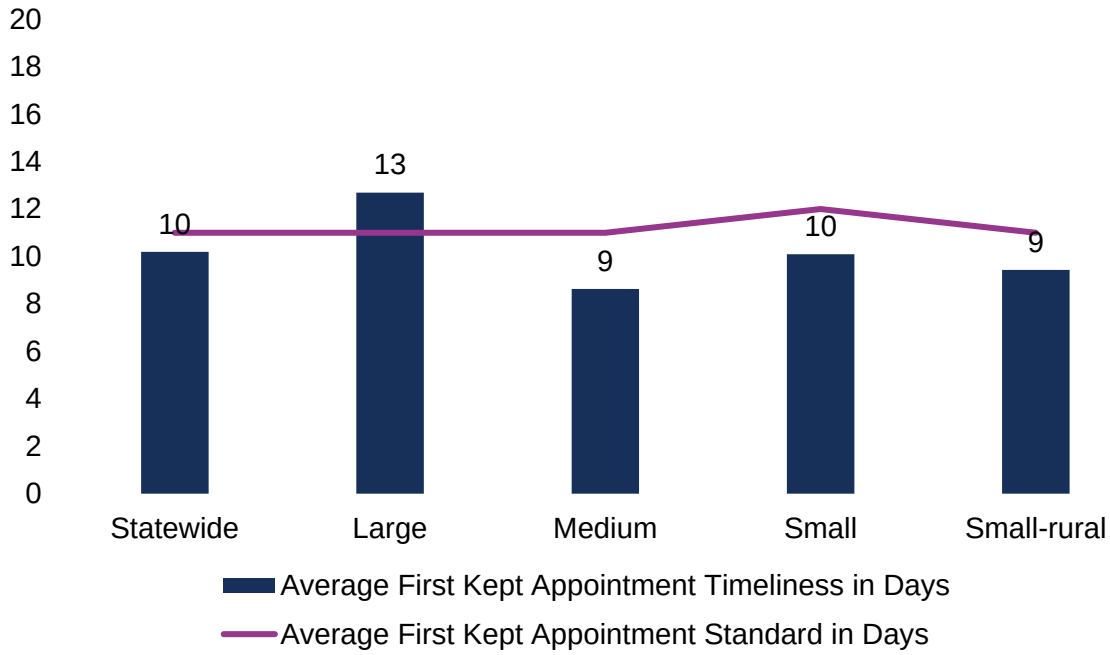
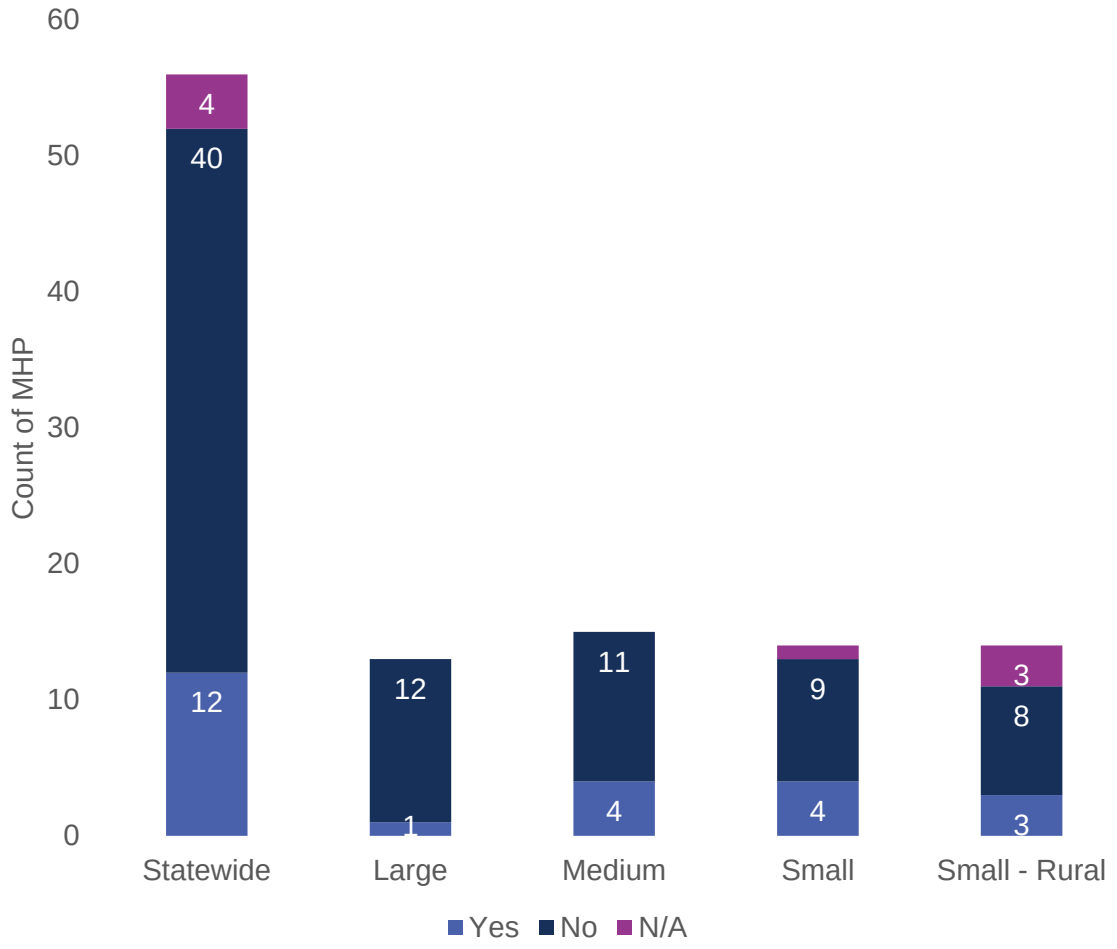


Figure 4-5: Wait Time for Initial Intake, Pathways to Well-Being



Initial Psychiatry Encounter

Delays in accessing psychiatric services can lead to lost engagement opportunities, increased emergency room encounters, and rising psychiatric inpatient hospitalizations for beneficiaries. Because of this, timeliness to initial psychiatry encounter is a critical element of the EQR process.

When looking at timeliness of first offered psychiatry appointment times statewide, MHPs of all sizes report they meet the 15-business day statewide standard at least 80 percent of the time (Figure 4-6). Average time to first psychiatric appointment is longer than the standard statewide and for all MHP sizes (Figure 4-7). CalEQRO further noted that participants in the beneficiary focus groups reported that they were able to see other providers on a timely basis and regularly, but scheduling a psychiatric appointment could be challenging. Wait times for children are longer for MHPs of all sizes when compared to the 15-day standard. Except for small MHPs, the psychiatry wait times for adults are also longer than the standard (Figure 4-8).

Figure 4-6: Percentage Meeting Statewide Standards for First Psychiatry Appointment, Statewide and by MHP Size

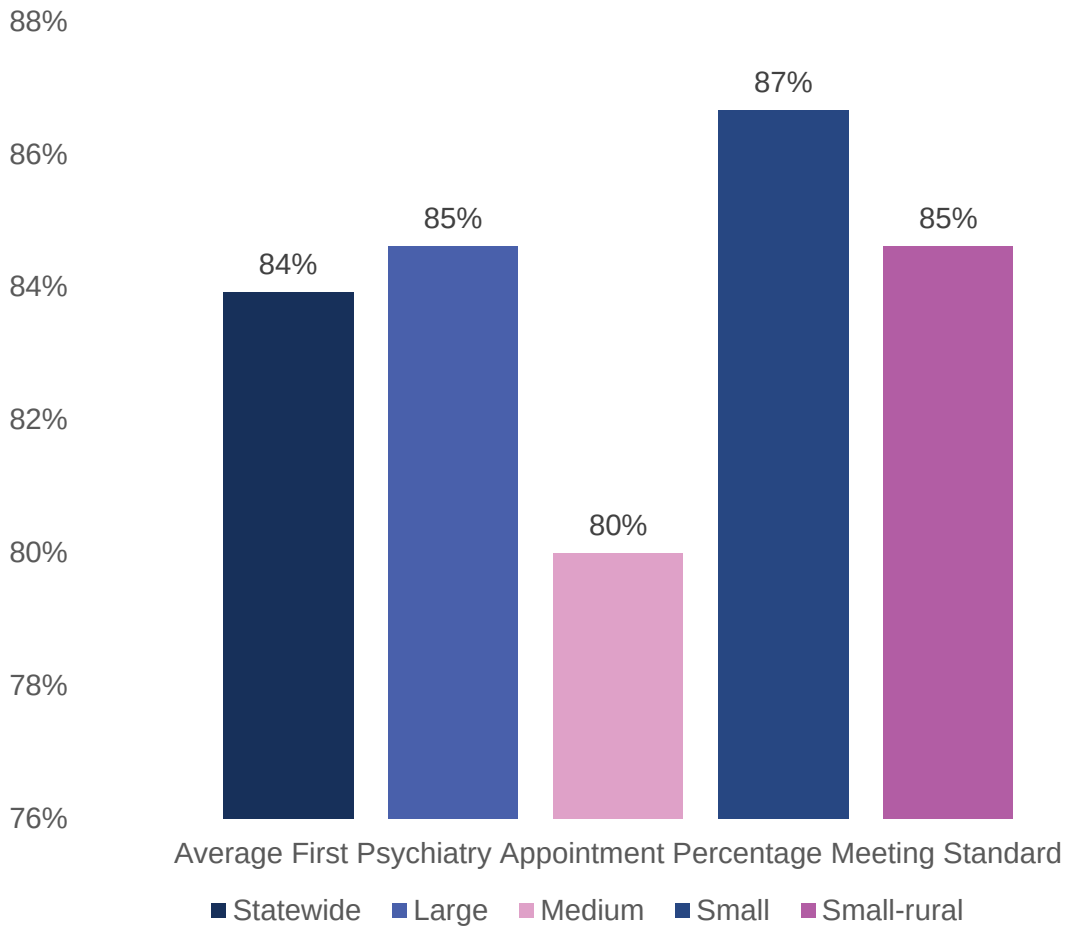


Figure 4-7: First Psychiatry Appointment Timeliness and Standard Overall, Statewide and MHP Size

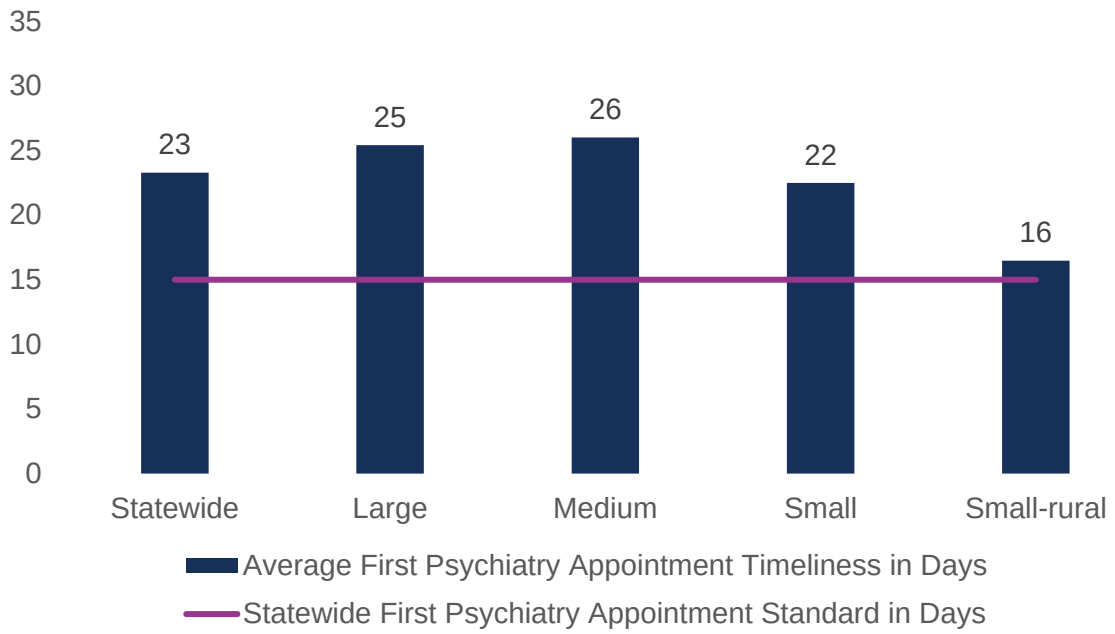
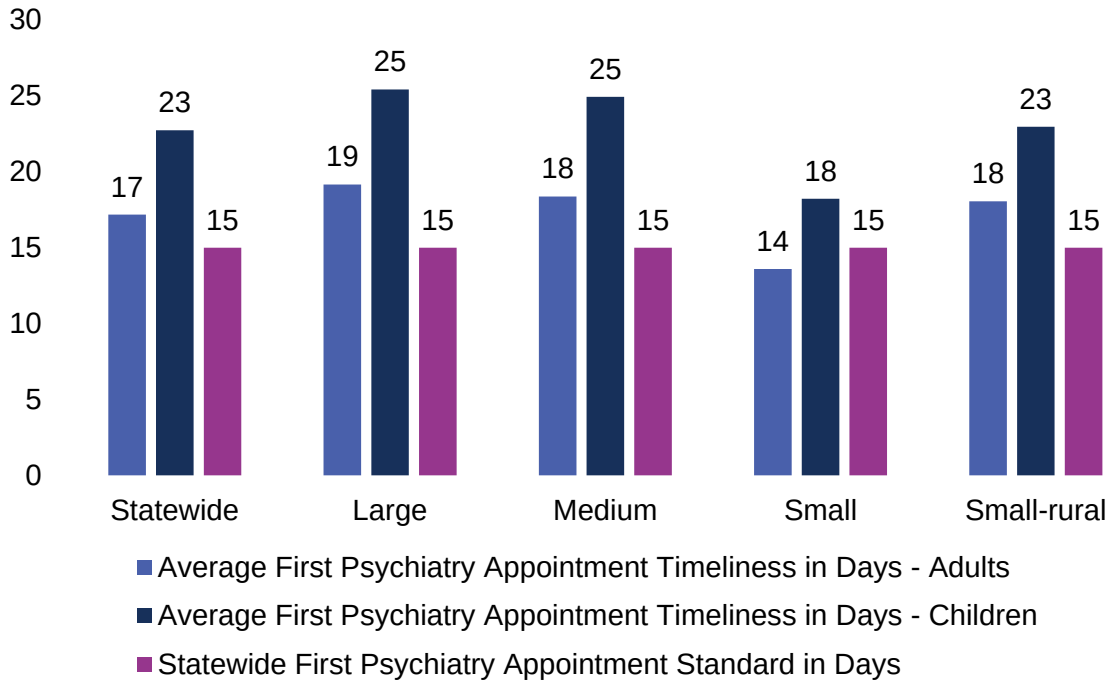


Figure 4-8: First Psychiatry Appointment Timeliness Standard—Adults and Children, Statewide and by MHP Size



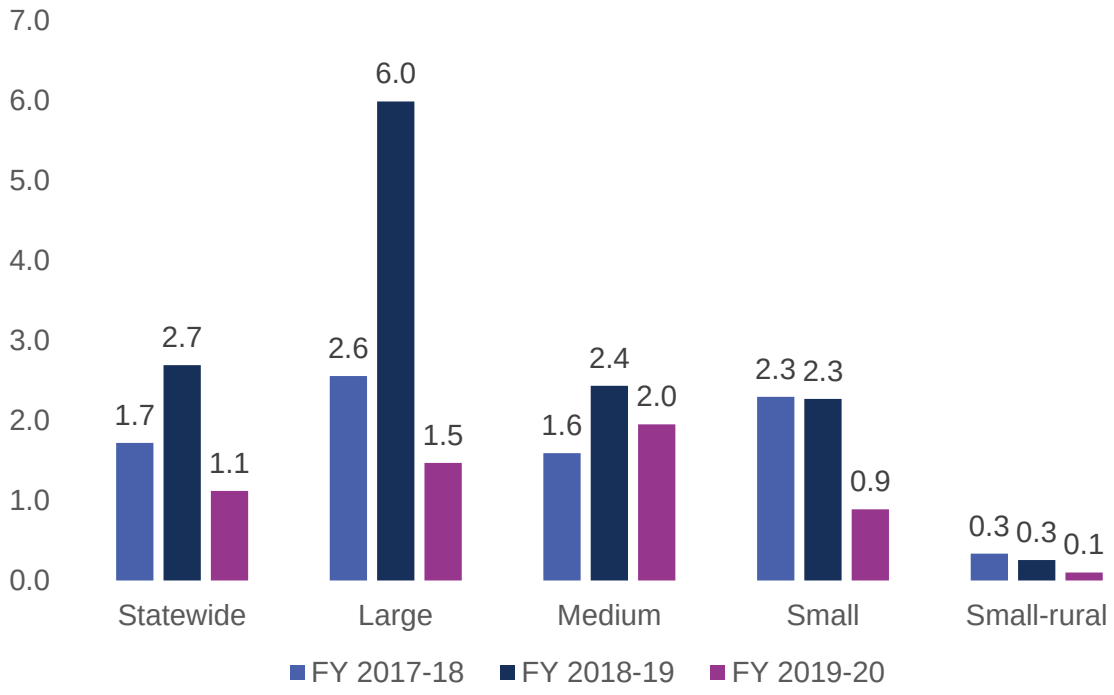
Urgent Care

CalEQRO evaluates whether the MHP has a methodology to collect data related to timeliness for urgent conditions, uses Continuum of Care Reform standards for urgent appointments, and tracks and trends the data at least quarterly.

Statewide, the 48-hour standard for an urgent appointment is being met with a 1.1-day average. While all MHP size categories meet the 48-hour standard, small and small-rural MHPs average a time to service of less than one day (Figure 4-9).

In focus groups, beneficiaries report that they can get urgent care appointments by walking into the MHP office, calling for appointments, or requesting appointments through case managers. Timeliness of appointments depends on the urgency, but all reported being seen within satisfactory times, usually within a day or two. If crises arise, participants all reported having a crisis number to call.

Figure 4-9: Urgent Appointment Timeliness, Statewide and by MHP Size, FY 2017-18 to FY 2019-20



*Rates are rounded to the tenth decimal.

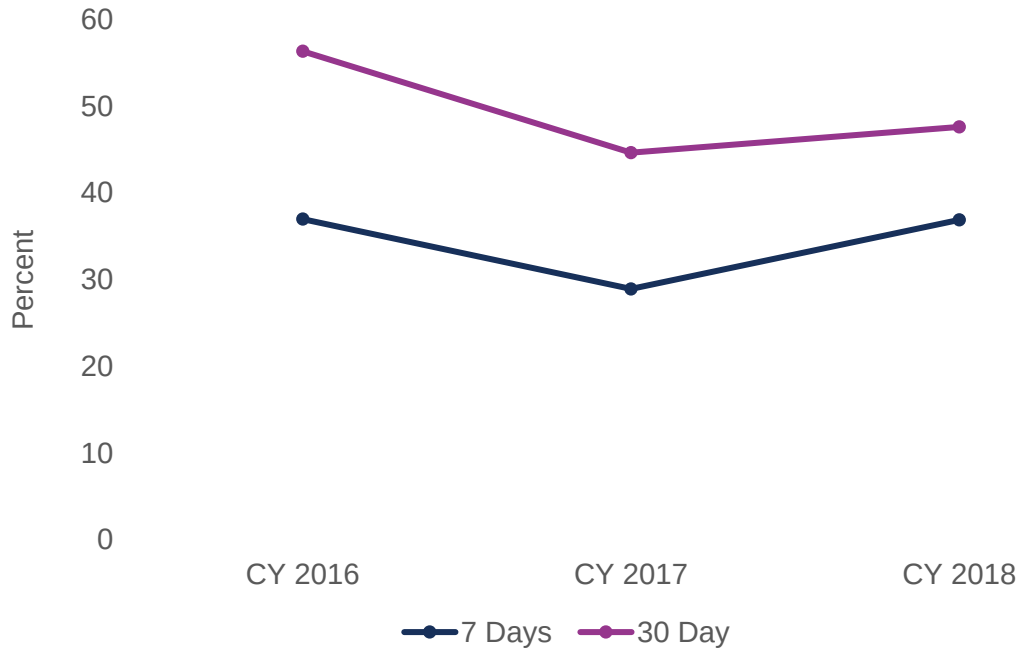
Psychiatric Inpatient Follow-up Care

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.

The 7-day outpatient follow-up rate after a psychiatric inpatient discharge (HEDIS measure) in CY 2018 returned to the CY 2016 level after a dip in CY 2017 (Figure 4-10). The 30-day follow-up rate remained lower than the CY 2016 level.

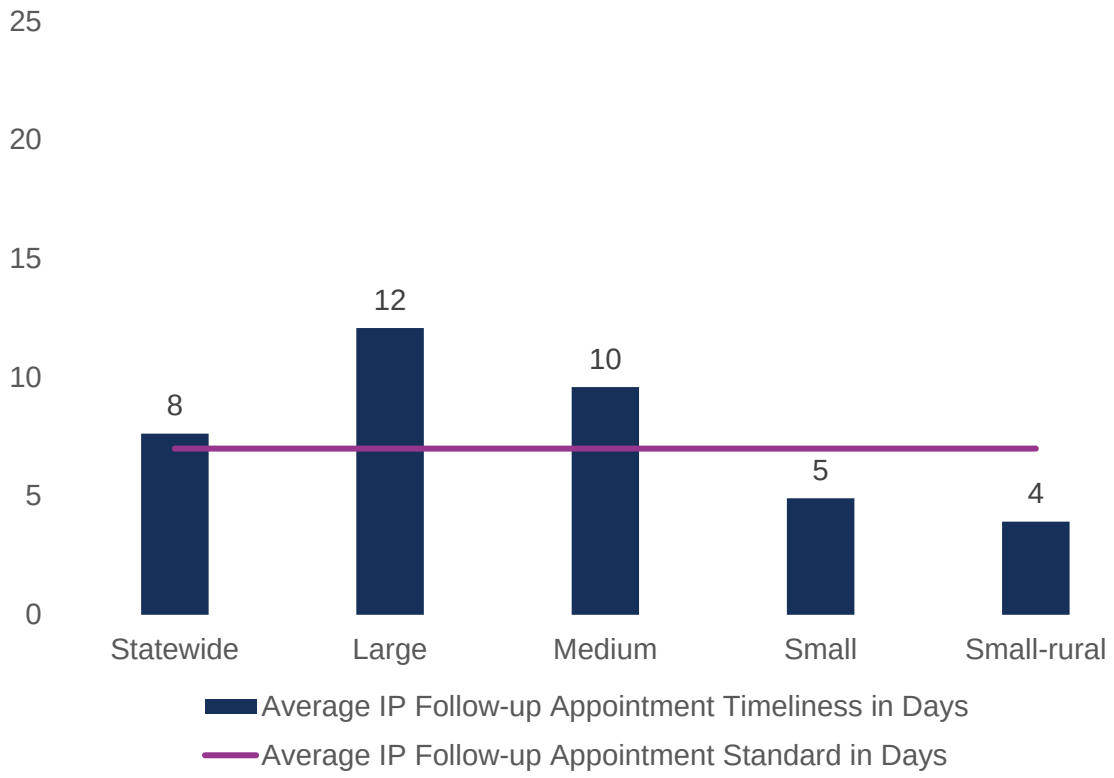
Outpatient follow-up timeliness averages for both large and medium MHPs from FY 2018-19 remain higher than seven days for large and medium-sized MHPs (Figure 4-11). This is significant since these MHPs together accounted for 97.5 percent of the statewide psychiatric inpatient admissions in FY 2019-20.

Figure 4-10: Outpatient Follow Up, CY 2016-2018



The small and small-rural MHPs, which accounted for a small percentage of psychiatric hospitalizations, provided outpatient follow-up in a timelier manner. Because the statewide average is the average of 56 MHPs and not a weighted average, the large and medium-sized averages more accurately reflect the statewide status on this metric. Outpatient follow-up rates do not meet the 7-day standard for most large and medium MHPs (Figure 4-9).

Figure 4-11: Outpatient Follow-up Timeliness and Standard After Inpatient (IP) Discharge, Statewide and by MHP Size

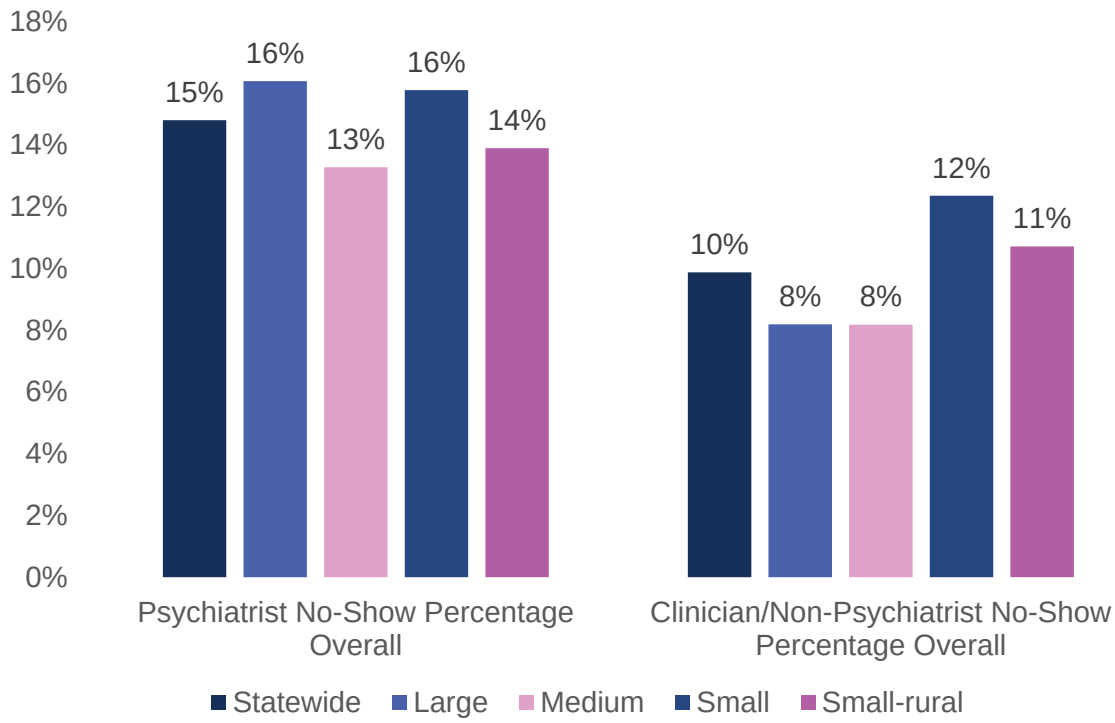


No-Show Rates

Psychiatrist no-show rates have significant beneficiary care, fiscal, and operational impacts that, in turn, affect access and timeliness. Some counties do not have clear standards to define a no-show, and therefore there may be inconsistencies with the data.

Psychiatry no-show rates are consistently and significantly higher than those for clinicians/non-psychiatrists. Although the no-show rates vary by MHP size, the psychiatrist no-show rates are consistently higher than their corresponding similarly sized MHP clinician no-show rates. The largest variation between the two rates are seen in the large and medium MHPs (Figure 4-12).

Figure 4-12: No-Show Rates for Psychiatrists and Other Clinicians, Statewide and by MHP Size



Summary

With the implementation of Network Adequacy reporting in the past two years, the MHPs' timeliness reporting rates have improved for most metrics that CalEQRO examines. At the same time, the MHPs have adopted the state-mandated timeliness standards for the metrics that they are required to report on for Network Adequacy. These include the first offered appointment, first offered psychiatry appointment, and urgent appointments. For urgent appointment, most MHPs have adopted the stricter standard of 48 hours regardless of whether the request needed prior authorization.

Despite the improvement in timeliness reporting rates, the MHPs face challenges in how they gather the information for the timeliness metrics. Because of technical challenges, the MHPs often resort to manual tracking of the data elements needed to compute the actual metrics. This particularly impacts the first offered appointment categories. The lack of widespread electronic information exchange also necessitates some manual tracking for MHPs with significant contract-provided services. This issue varies from MHP to MHP, and even within the same MHP depending on the contract providers' own IS and information exchange capabilities. Yet another dimension involves communication challenges that primarily affect the inpatient follow-up reporting rates. The MHPs and the admitting psychiatric inpatient units do not always have a set protocol for communicating discharge information, even for in-county facilities.

As more MHPs have developed the capabilities to disaggregate their reporting of timeliness metrics by age group, CalEQRO has found delays in access to services in children's services more often than on the adult services side. This is particularly visible in children's psychiatry

timeliness, often reflecting the continuing challenges in workforce shortages in child psychiatrist availability in the state and the resulting recruitment challenges. At the same time, many MHPs continue to report significant no-show rates for psychiatry appointments, sometimes as high as 20 percent. CalEQRO has pointed out in its MHP reports, whenever applicable, that this is a precious resource whose utilization should be maximized through standard and innovative practices to reduce no-shows. Consequently, many MHPs have targeted reduction of no-show rates as part of their PIPs.

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Chapter 5

Quality

Quality

Quality Improvement as a Change Agent for California's MHPs

Introduction

The quality of mental health services is comprised of structures, processes, resources, and policies, organized in service of promoting beneficiary outcomes. In the context of EQR, this encompasses validating PMs—including approved claims per beneficiary (ACB) served—and monitoring the corresponding quality subcomponents: (1) the extent to which beneficiary needs are matched to the continuum of care; (2) the MHPs' QI workplan and processes; (3) quality management (QM) organizational and communication structures; (4) the extent to which QM can act as a change agent; and (5) how the MHP manages medication services.

Overview of Major Quality Findings

Finding 1 **Sixty-nine percent of the MHPs had measurable goals in the quality improvement plans and did annual evaluations of the goals that were set.**

Finding 2 **Without a clear and uniform definition of levels of care for SMHS, MHPs continue to make treatment decisions on a case-by-case basis, relying on individual clinicians' judgment.**

Finding 3 **MHPs lack sufficient infrastructure for continuous quality improvement based on best practices, scientific evidence, and data analysis.**

Performance Measures

Approved Claims per Beneficiary

An indicator of relative quality, ACB reflects the total cost of Medi-Cal services received per unduplicated beneficiary served. As such, ACB provides a quantifiable measure of the amount and level of services beneficiaries receive once they have accessed care. The stratification of ACB across age, gender, and race/ethnicity further contribute to a more comprehensive understanding of disparities seen between demographic groups.

Bay Area ACB continues to be the highest in the state.

It is not clear that higher ACB in the Bay Area necessarily translates to better quality of care. Rather, it probably reflects the generally higher cost of doing business in the Bay Area and the lingering effects of inequities in SDMC funding across the state since its inception. Smaller and rural MHPs continue to have the lowest ACBs, often termed as under-equity counties.

After a spike in CY 2017, the Bay Area average came down to the CY 2016 level. Other MHP regional averages showed modest increases during the same three-year period (Figure 5-1a). Nonetheless, Bay Area ACB continues to be nearly twice that of the other regions. Small-rural MHP ACB remained stable between CY 2016 and CY 2018 and significantly lower than the other MHP size averages (Figure 5-1b).

Figure 5-1a: ACB by Region

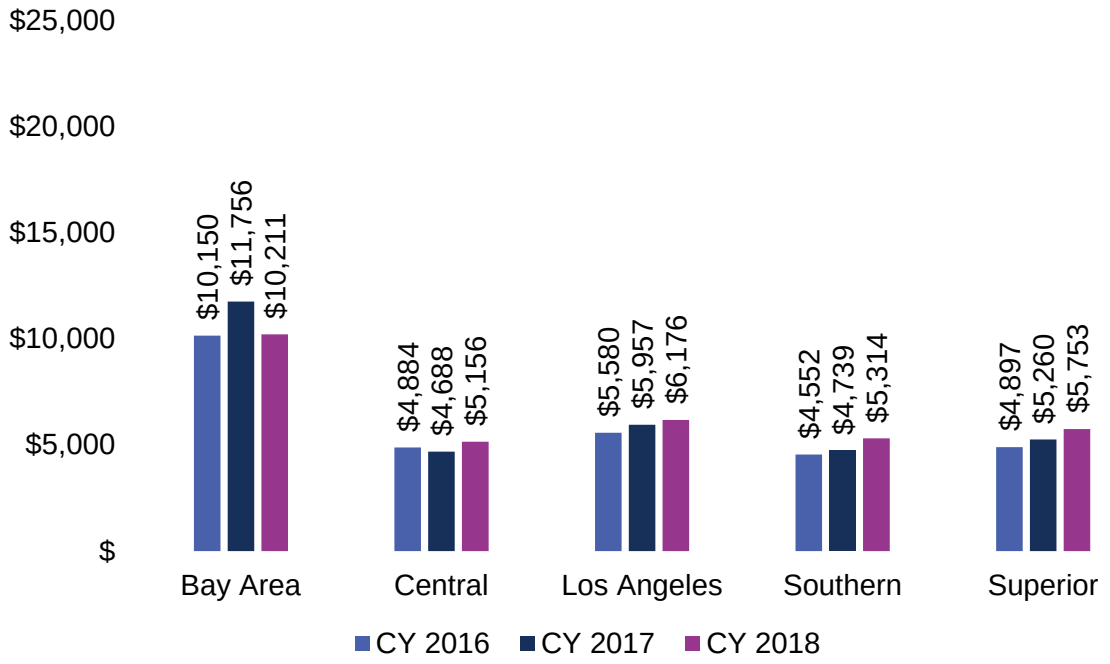
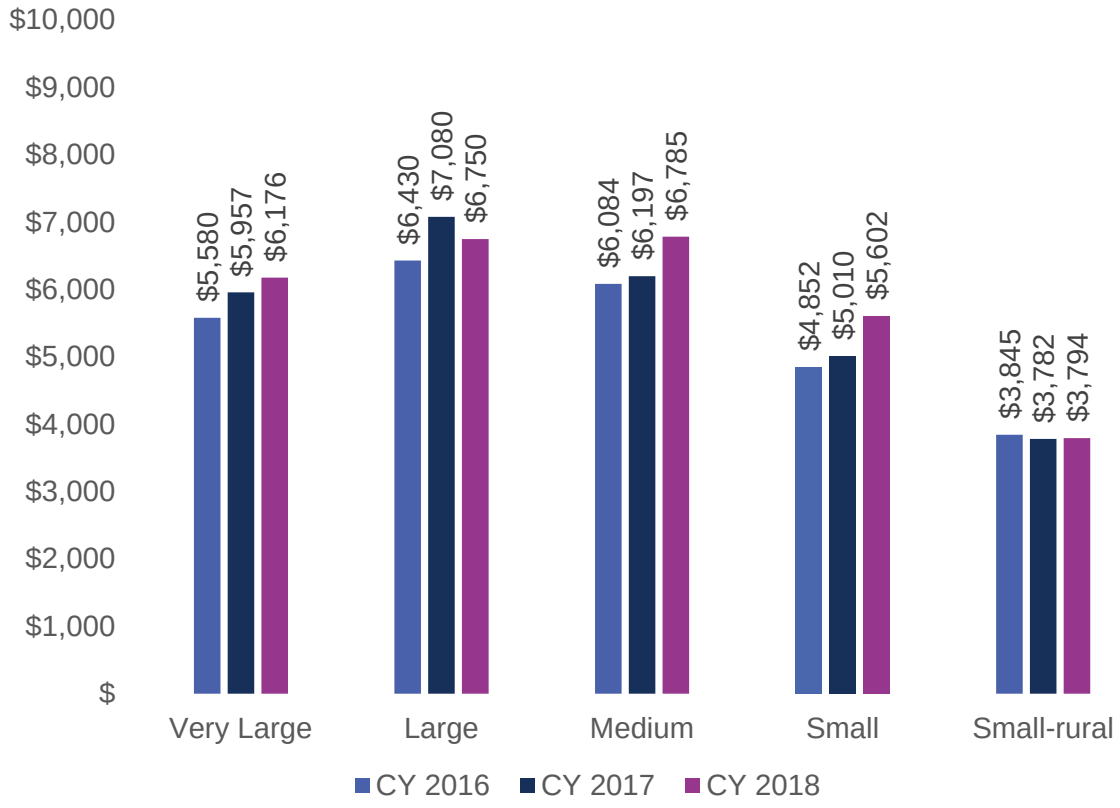


Figure 5-1b: ACB by Size



SMHS for children aged 6 to 17 is among the highest.

The ACB for the 6-17 age group is the highest, or among the highest. Like the overall ACB, it varies by MHP size and region (Figures 5-1c and 5-1d).

Figure 5-1c: ACB by Region and Age, CY 2018

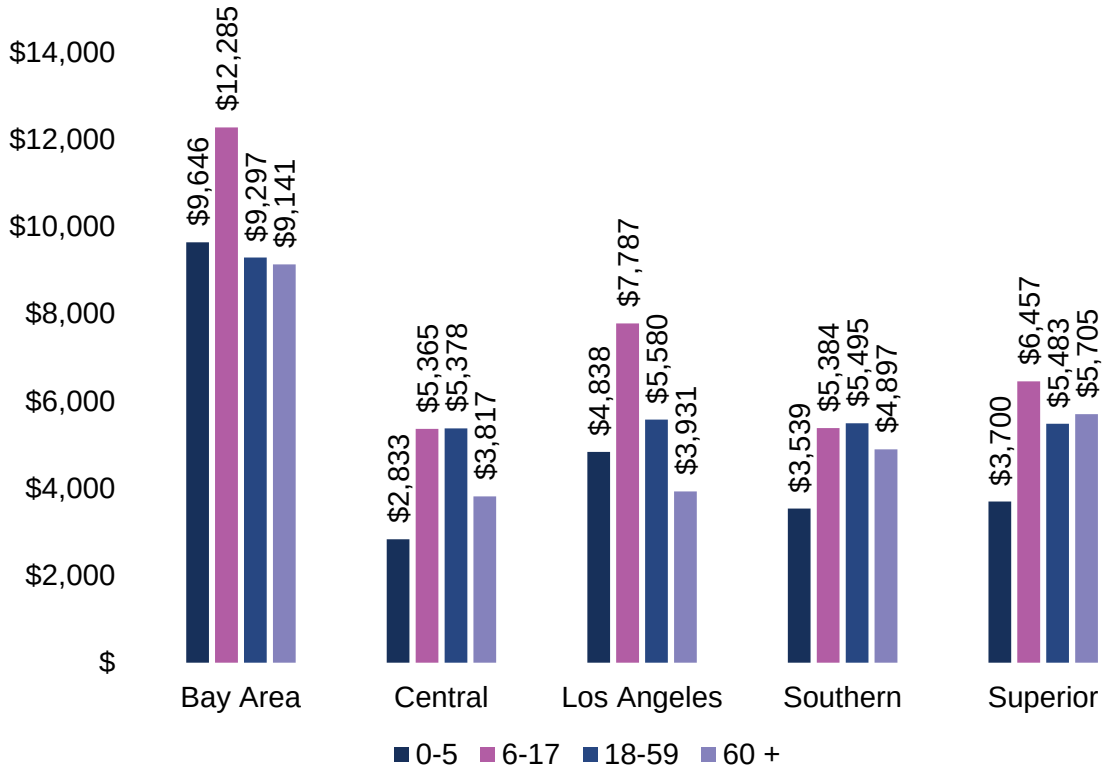
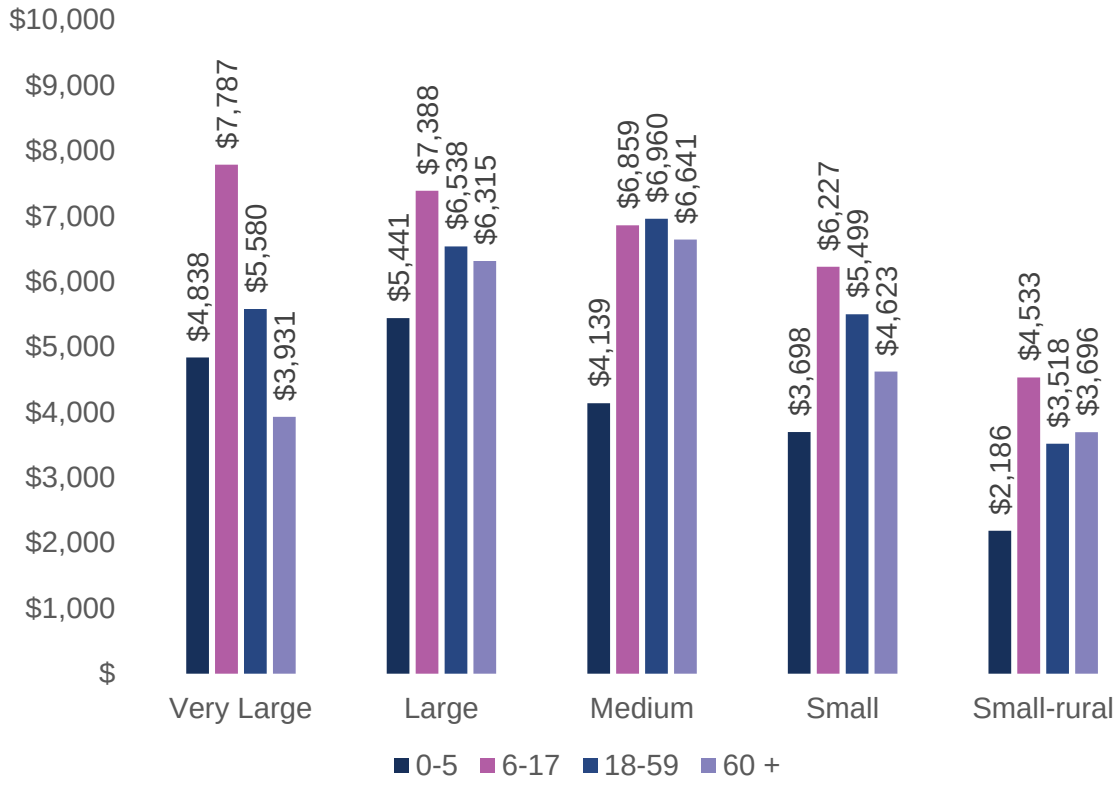


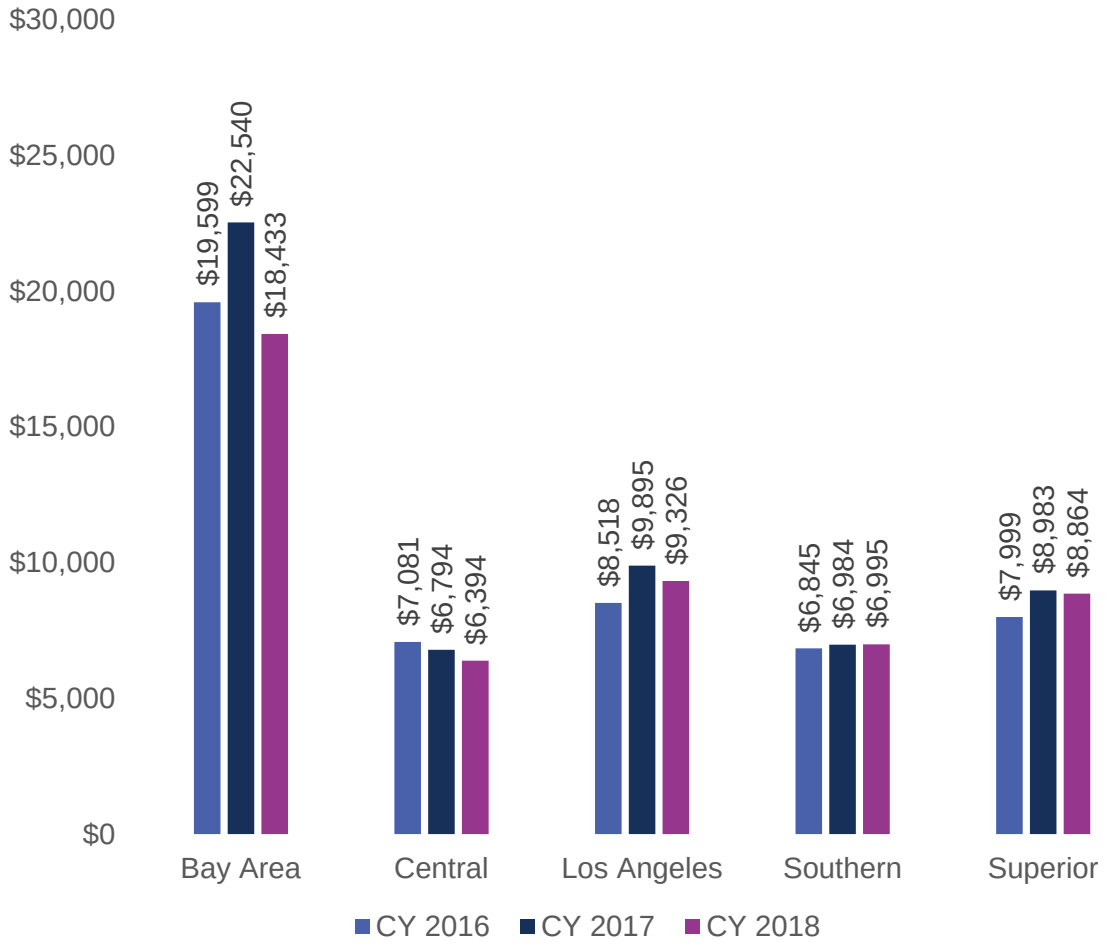
Figure 5-1d: ACB by Size and Age, CY 2018



Foster care ACB is higher than overall ACB in all regions, but the differences vary significantly.

Foster care beneficiaries had a higher ACB than the overall ACB in each of the MHP regions (Figure 5-1e). However, the magnitude of the difference varied from 25 percent to 80 percent, depending on the region.

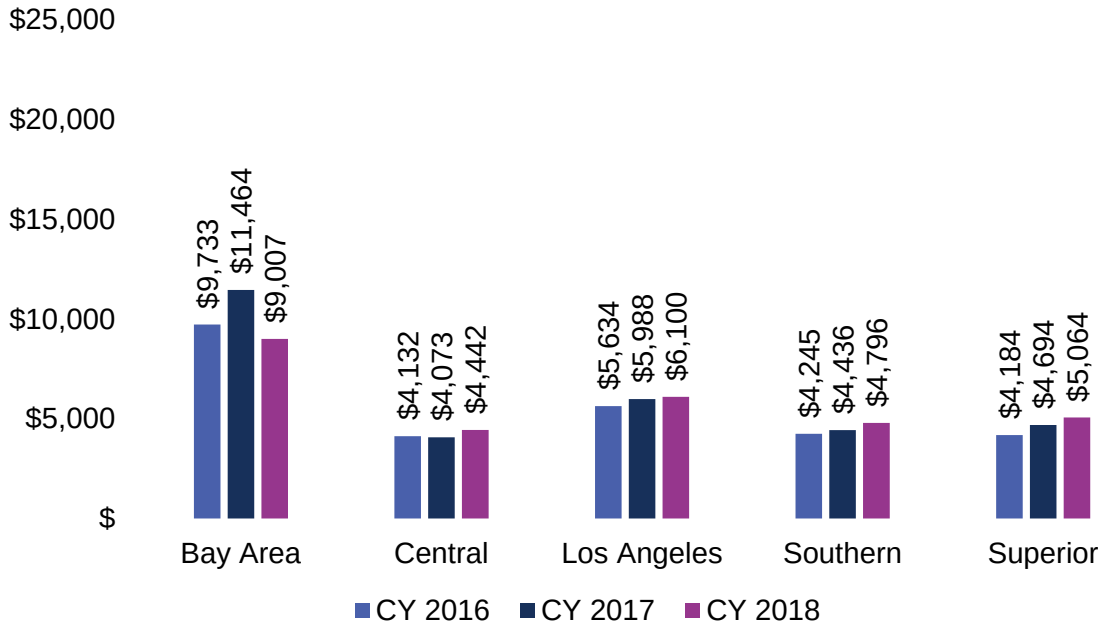
Figure 5-1e: Foster Care ACB per Beneficiary CY 2016-2018



Hispanic/Latino ACB pattern mirrors the overall ACB, but lower than the overall average.

The Hispanic/Latino ACB distribution across the MHP regions is similar to the overall ACB pattern, with each of the averages being slightly lower than the overall ACB (Figures 5-1a and 5-1f).

Figure 5-1f: Hispanic/Latino ACB per Beneficiary, CY 2018

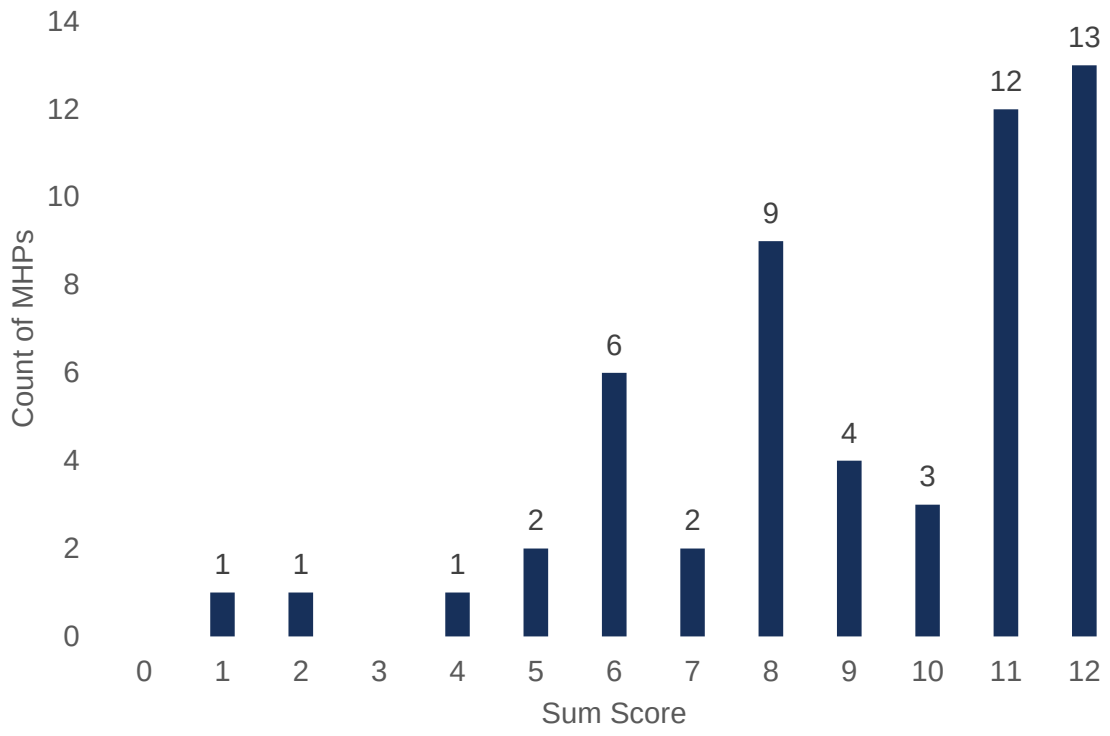


Matching Beneficiary Needs to the Continuum of Care

One of the most important indicators of quality is the extent to which an MHP operates a full range of service-level programs, both in-county and out-of-county, directly operated and contracted, to provide a comprehensive range of options for treatment from most to least restrictive.

Across the 56 MHPs, 46 scored 8 or more of the total 12 points (67 percent), as shown in Figure 5-2.

Figure 5-2: Sum Scores for Key Component 3.A Beneficiary Needs are Matched to the Continuum of Care



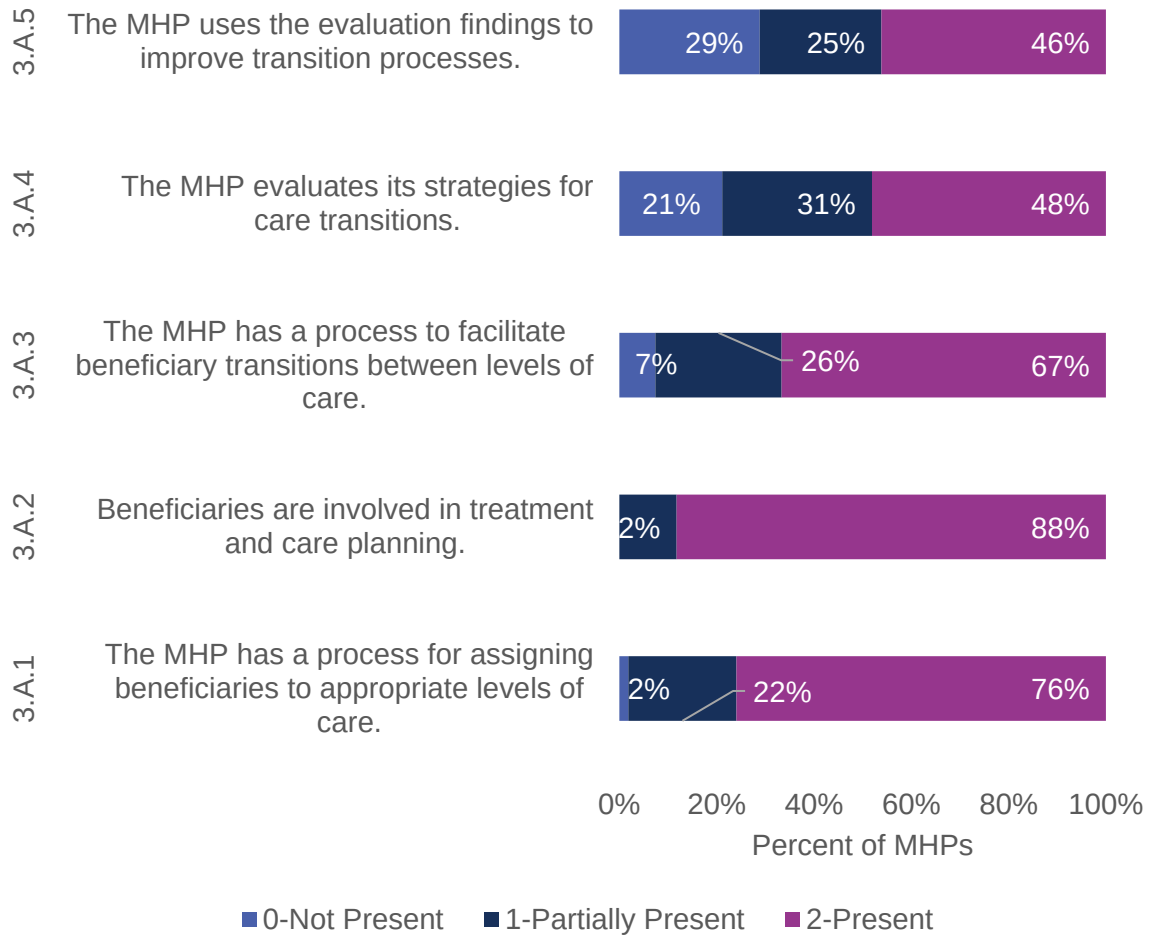
Qualities of the continuum of care stipulate that the MHP should have a process for initially assigning beneficiaries to appropriate levels of care and then transitioning them between levels of care as needed. Beneficiaries should be involved in treatment and care planning, with their cultural needs guiding treatment, and MHPs are to track and trend related data and use findings to improve transition processes.

Across all MHP sizes, assignment to appropriate levels of care and involvement of beneficiaries in their own treatment planning is high.

In the SORs analysis, 14 percent of MHPs were commended for using a social determinants of health model focusing on consumers' needs beyond clinical treatment in areas such as housing, food, employment, and meaningful engagement with the community.

Across all MHP sizes, assignment to appropriate levels of care and involvement of beneficiaries in their own treatment planning is high.

Figure 5-3: Item Scores for Key Component 3.A Beneficiary Needs are Matched to the Continuum of Care, Select Items



Almost all MHPs purport to have guidelines for assigning levels of care. This is supported by comments from clinical line staff from 20 MHPs who reported that there is a level of care tool or process in place. However, only four MHPs stated they are following it. Examples of level of care tools used by MHPs include Reaching Recovery, the World Health Organization Disability Assessment Schedule, the Level of Care and Recovery Index, and the Level of Care Utilization System.

It should be noted that there is no uniform or agreed-upon continuum of care for specialty mental health (in comparison to the American Society of Addiction Medicine [ASAM] criteria in substance use treatment). Given this, MHPs lack a clear definition of a model continuum of care, nor is there an evidence-based level of care tool to assist in transition planning. In response, clinicians report that they rely largely on clinical judgement to make transition decisions.

While there is variability in managing transitions in care, most MHPs have processes in place. Evaluating their success and making changes accordingly were follow-up steps evident in about half the MHPs. Bay Area and Southern MHPs were significantly stronger in this regard.

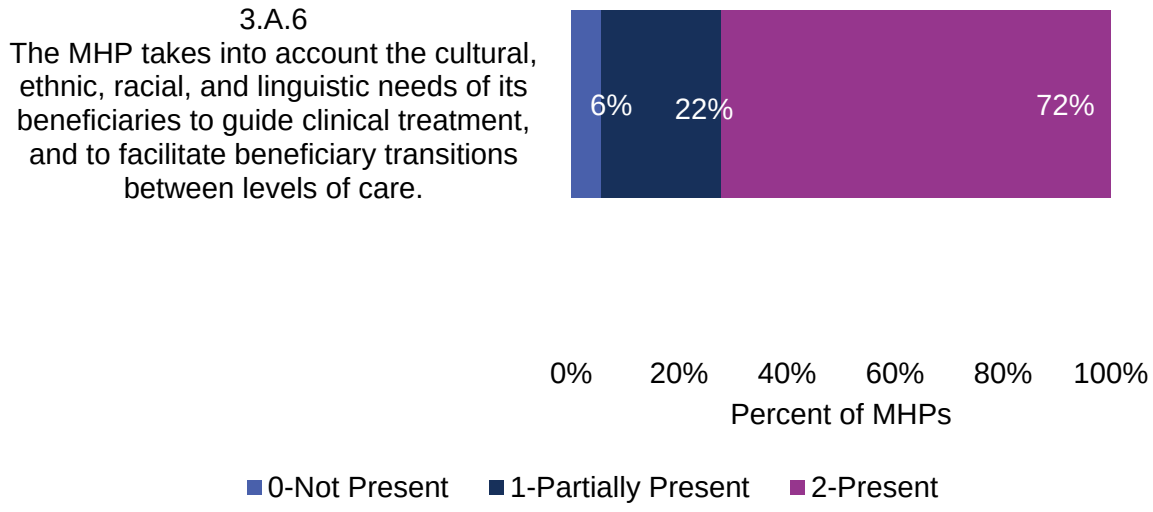
Stakeholders in multiple MHPs reported that transitions to health plans are problematic. Most small counties use a medical necessity form; however, these only evaluate whether beneficiaries qualify for services, but not necessarily the appropriate level of care.

Smooth transitions are also dependent on the level of coordination between the MHP and mild-to-moderate service providers, especially when beneficiaries are moving down from more-restrictive to less-restrictive levels. For example, one small MHP has expanded its emergency response team to better coordinate with the hospital so that people are not discharged to the street with no follow up.

Stakeholders and MHPs agreed that beneficiaries are effectively included in their treatment and care planning.

MHPs demonstrated strength in assessing and identifying strategies and resources to meet the cultural, ethnic, racial, and linguistic needs of their beneficiaries, as shown in Figure 5-4. Consideration of cultural, ethnic, racial, and linguistic needs to guide treatment and transition needs was strongly evident across 75 percent of MHPs (Figure 5-4).

Figure 5-4: MHPs Taking Into Account Cultural, Ethnic, Racial, and Linguistic Needs of Beneficiaries



Quality Improvement Workplan and Processes

Every MHP is expected to have a current QI workplan with measurable QI goals and objectives. Good QI practice includes an annual evaluation of the prior year's QI workplan. Furthermore, quality data extraction and analyses that pertain to access, timeliness, quality, and outcomes should be routinely shared with stakeholders.

Virtually all MHPs have current QI workplans in place, as shown in Figure 5-5.

However, only 63 percent of the plans include measurable QI goals and objectives, inclusive of prior year's findings and results. Small-rural MHPs were the most challenged in this regard, as shown in Figure 5-6.

Figure 5-5: Item Scores for Key Component 3.B Quality Improvement Plan, Select Items

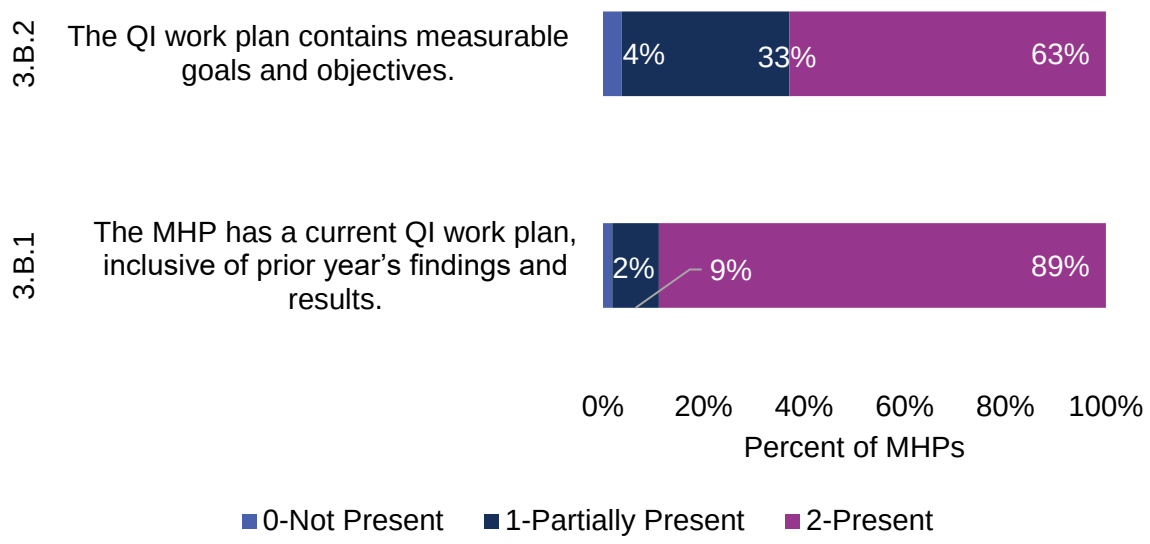
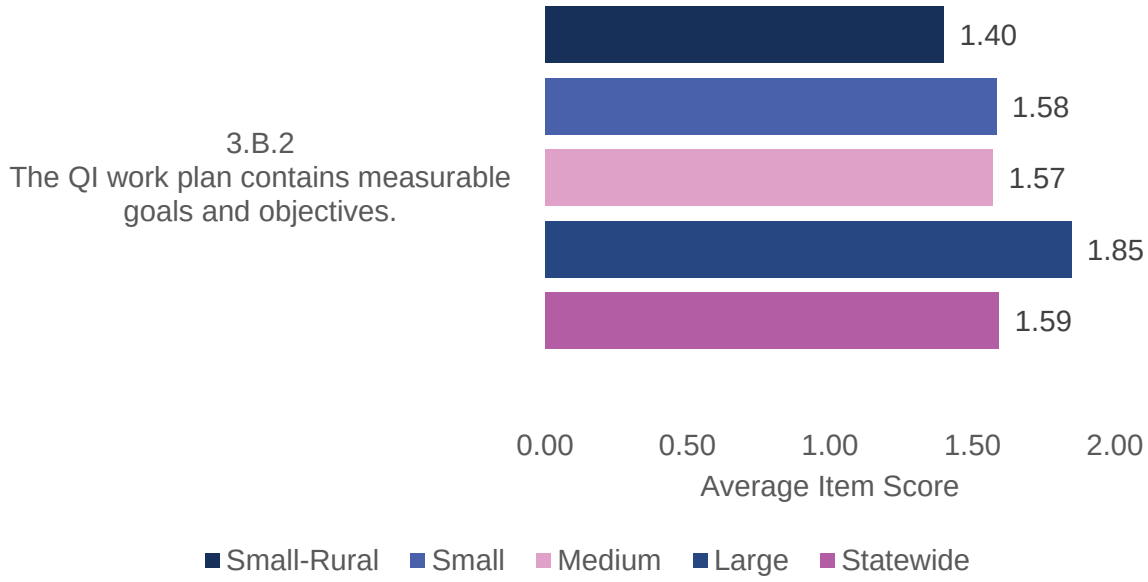


Figure 5-6: Average Item Scores for Key Component 3.B.2, Statewide and by MHP Size



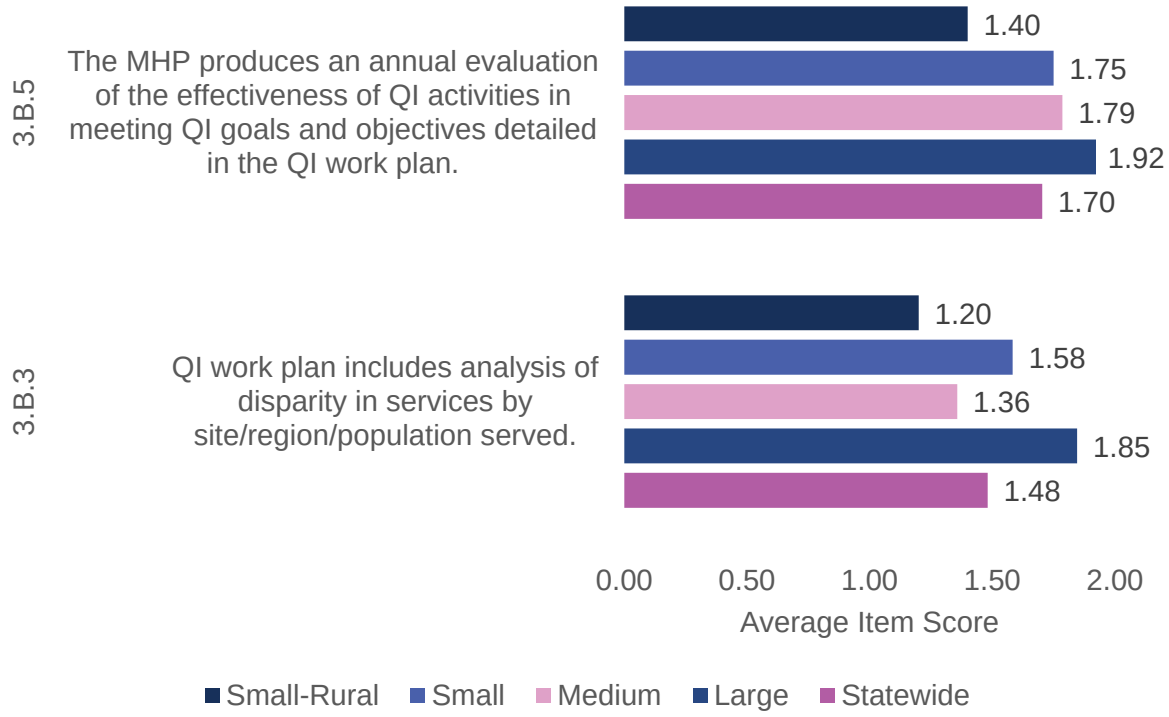
Fewer MHPs have QI committees (QICs) that are inclusive of multiple internal and external stakeholders. Consistent and routine sharing of findings and results was evident in only a few MHPs.

The notable variation among MHPs with regard to including analyses of disparities in services by key population characteristics was related to size. This element of QI workplans was the least evident overall across all sizes and statewide, as shown in Figure 5-6.

MHPs continue to be challenged to incorporate meaningful beneficiary and lived experience consumer representatives as well as line staff on the QICs. Some report that while they invite beneficiary input, it is difficult to get beneficiaries to actively participate.

MHPs' QI activities are directly affected by MHP size, with large MHPs better able to produce and evaluate measurable indicators and create a comprehensive annual evaluation of activities, as shown in Figure 5-7.

Figure 5-7: Average Item Scores for Key Component 3.B Quality Improvement Plan, Statewide and by MHP Size

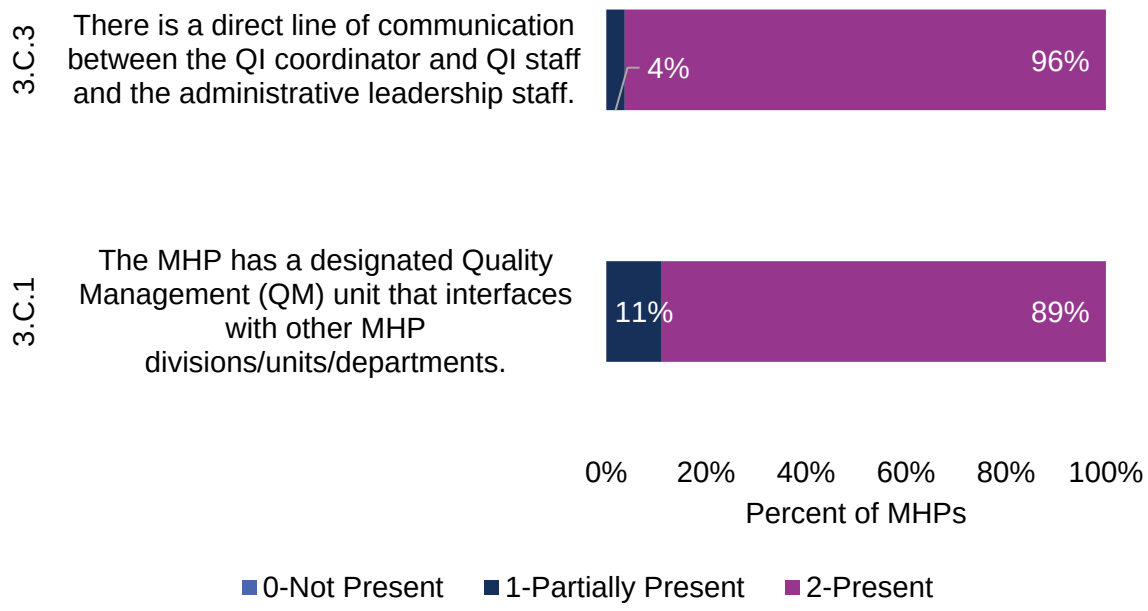


Quality Management Structure

In addition to the above quality elements, the MHP is expected to have a designated QM unit with a direct line of communication to the MHP's leadership. The MHP should also have a QIC with membership representing the entire system of care, including beneficiaries, peers, family members, and contract providers.

While there is some variation in structure, all MHPs have a designated QM unit that interfaces with other MHP divisions or departments. These QI teams have direct communication to senior leadership, as shown in Figure 5-8.

Figure 5-8: Item Scores for Key Component 3.C Quality Management Structure



Quality Management as Change Agent

In a functional MHP, QI/ QM reports are used for decision making, strategic initiatives, and performance improvement. These reports are used to monitor service access, timeliness, quality of care, and outcomes.

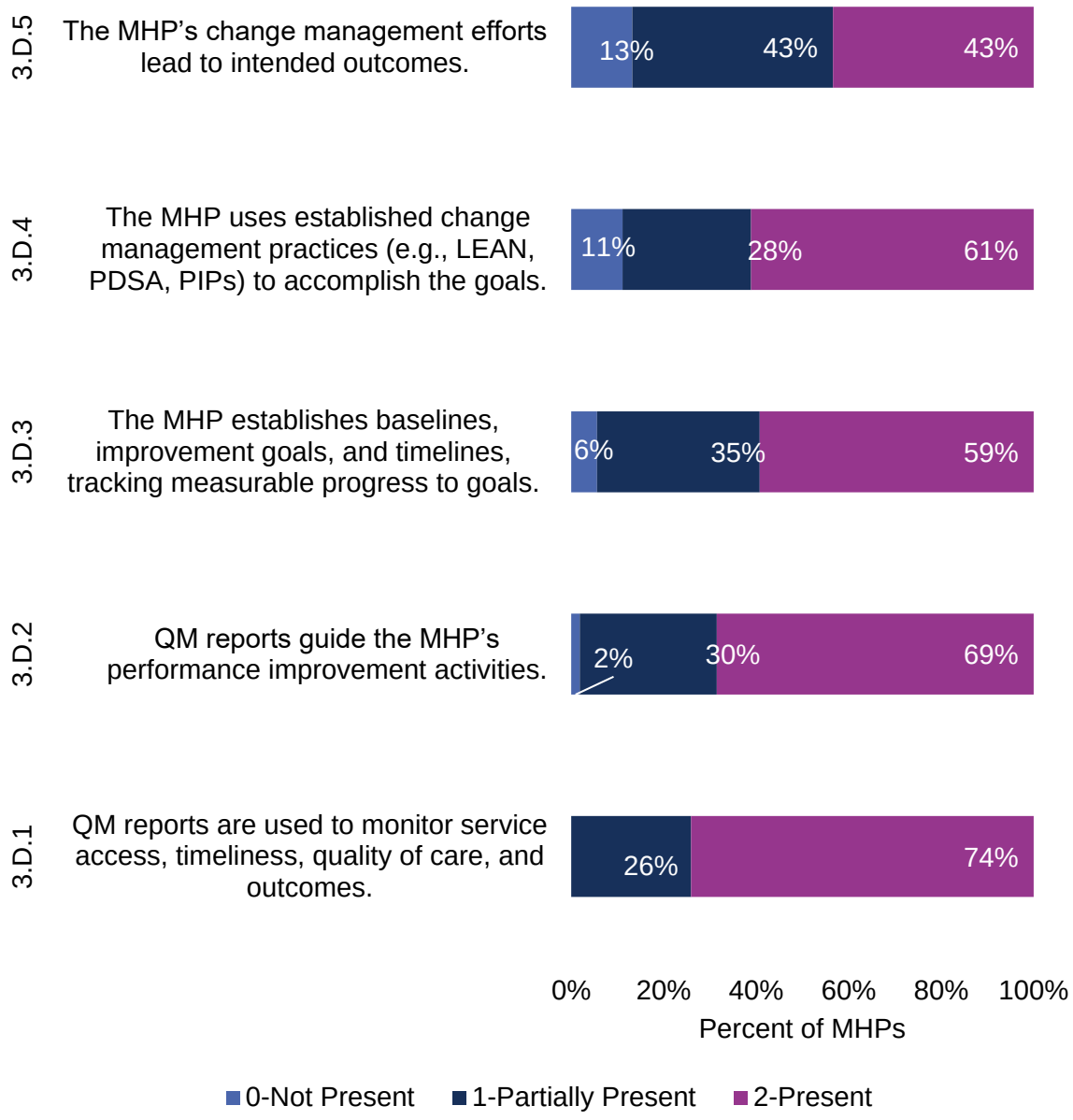
Ideally, the MHP establishes baselines, improvement goals, and timelines, tracking measurable progress to goals. The MHP then uses established change management practices (e.g., LEAN, Plan-Do-Study-Act, PIPs) to accomplish the goals. Ultimately, the MHP's change management efforts lead to intended outcomes.

All MHPs use QI/QM reports to some extent to monitor service access, timeliness, quality of care,

All MHPs use QI/QM reports to some extent to monitor service access, timeliness, quality of care, and outcomes. The vast majority of those MHPs use the reports to guide their performance improvement activities.

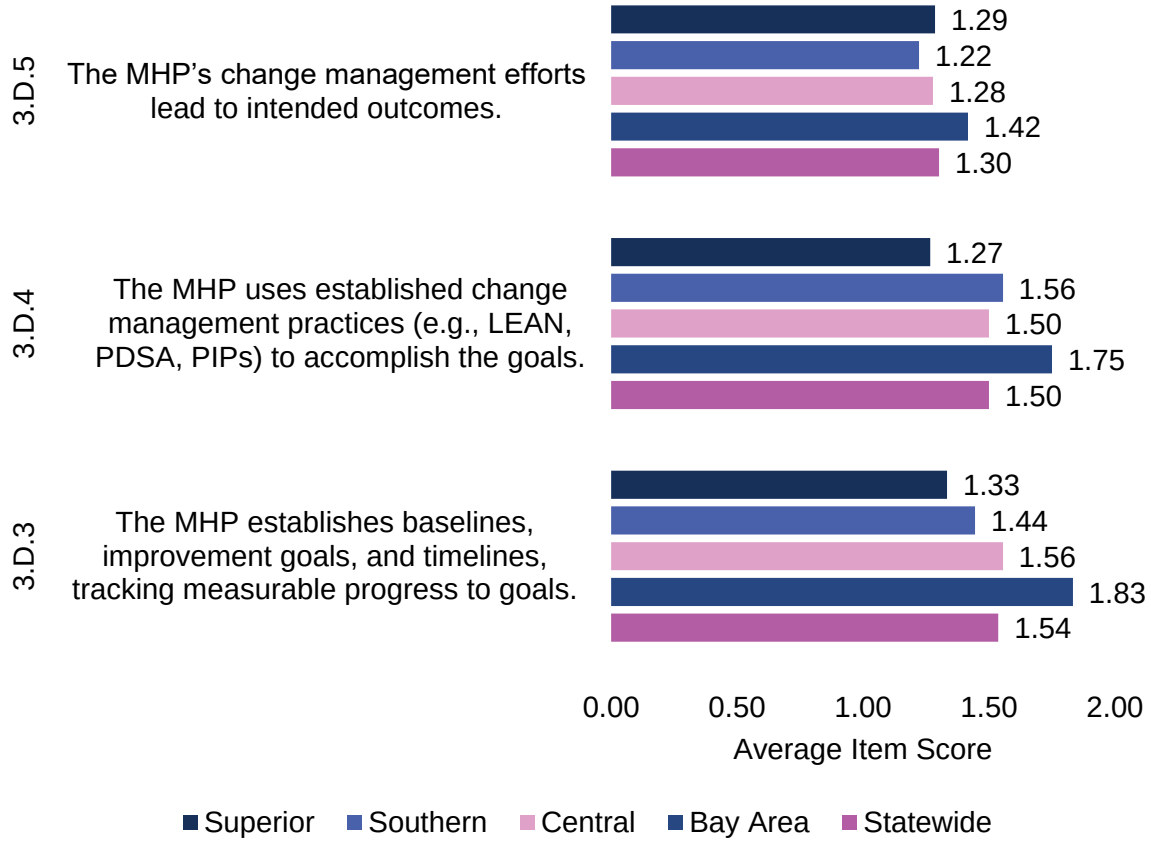
and outcomes. The vast majority of those MHPs use the reports to guide their performance improvement activities. However, there is variability across MHPs in their use of these reports for change management, as shown in Figure 5-9.

Figure 5-9: Item Scores for Key Component 3.D QM Reports Act as a Change Agent in the System



Bay Area MHPs are much more likely to have measurable goals, track performance, and use established change management practices to accomplish those goals, as shown in Figure 5-10.

Figure 5-10: Average Item Scores for Key Component 3.D Quality Improvement Plan, Statewide and by Region, Selected Items



MHPs feel the tensions between compliance and QI. While some lean in towards compliance, others have been working towards expanding their focus on QI. Over the past two years, one MHP has been shifting towards a stronger focus on data and measurable objectives. These data are being regularly reviewed by QI teams to identify service gaps and inconsistencies that inform the development of PIPs.

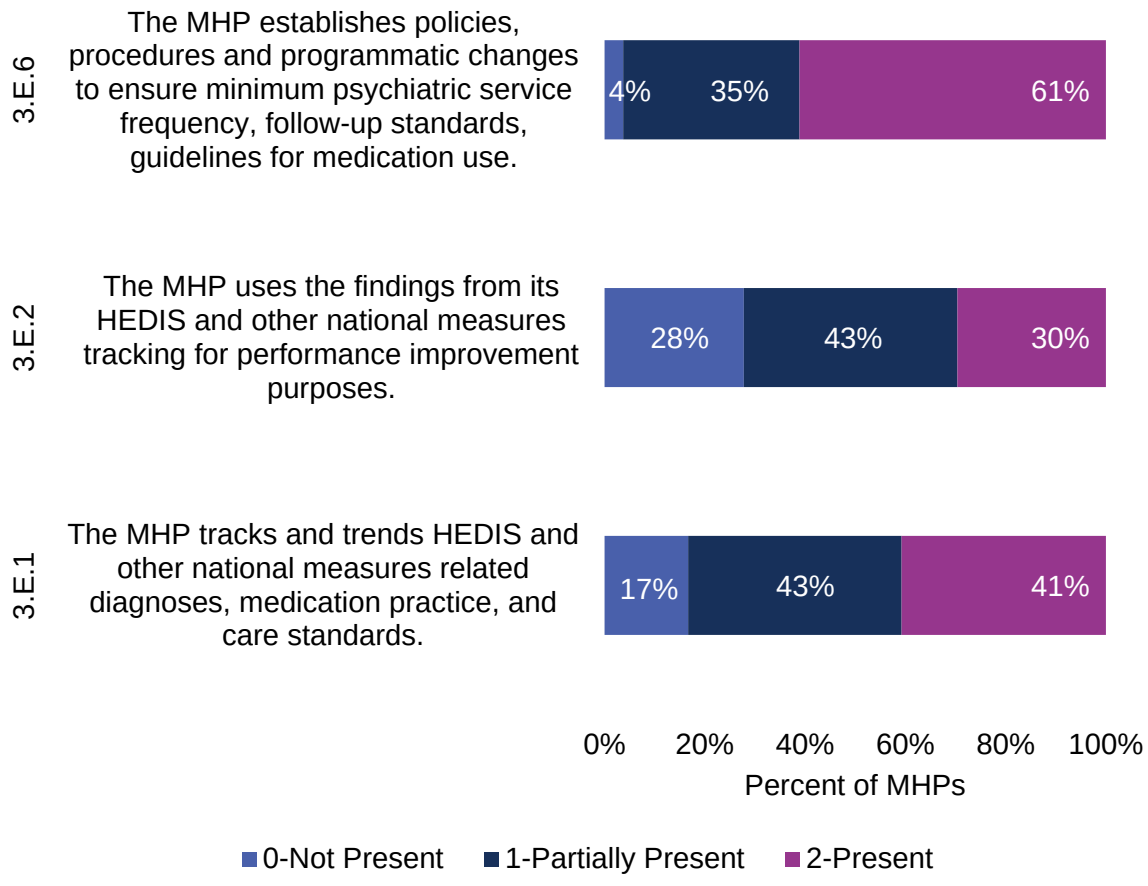
Medication Management

MHPs should be following standard practices of care regarding medication management. The MHP should have policies, procedures, and programmatic changes in place to ensure minimum psychiatric service frequency, follow-up standards, and guidelines for medication use. Additionally, MHPs should be applying HEDIS and other national measures tracking prescribing practices for the entire system of care.

Medication monitoring and associated QI activity varies greatly across MHPs.

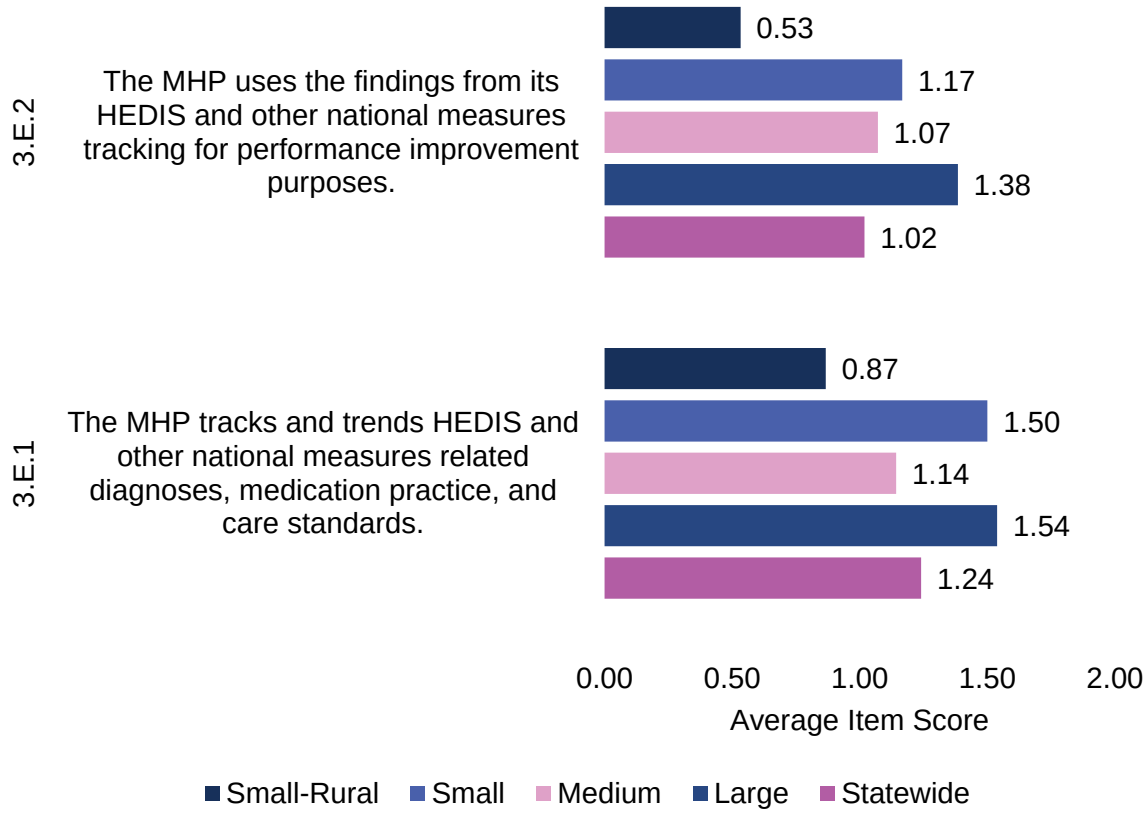
Medication monitoring and associated QI activity varies greatly across MHPs. Almost all MHPs have established policies and procedures to monitor medications generally. However, there is still considerable variability among MHPs regarding tracking and trending HEDIS-specific measures as well as the extent to which they use the findings from their monitoring in a formal QI process.

Figure 5-11: Item Scores for Key Component 3.E Medication Management



Small-rural MHPs are the least likely to have these practices in place, as shown in Figure 5-12.

Figure 5-12: Average Item Scores for Key Component 3.E Medication Management, Statewide and by MHP Size



Some MHPs have developed medication-only tracks staffed by psychiatry/prescribers with nursing support; others have this type of track augmented by peer staff or case managers with some clinician presence.

For one MHP, the prescriber peer review tool concludes with a standard of practice question asking whether the reviewer would feel comfortable taking over this patient's care if they were transferred to their caseload. This a unique way of assessing practice overall and compels the reviewer to think more critically about the treatment and practice.

Some MHPs still lack sufficient knowledge around SB 1291, as well as HEDIS measures. There is the sense that medication management is still mostly about compliance and patient safety rather than quality.

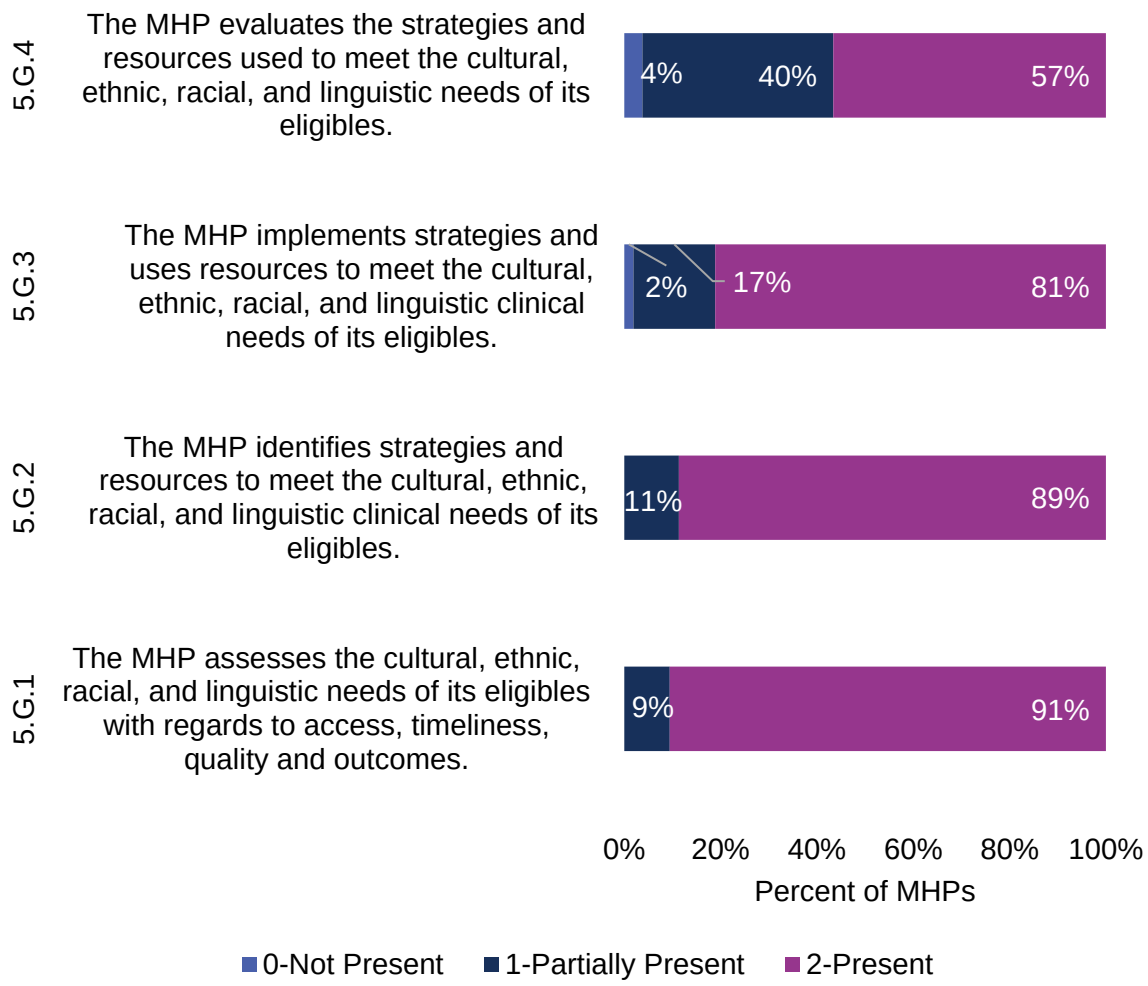
However, some noteworthy medication management practices emerged in the review. One MHP has incorporated HEDIS into its medication monitoring routine. Another MHP has a chief pharmacist who meets with the psychiatry team weekly to discuss medication and keep up with HEDIS requirements.

Cultural Competency

An MHP's quality is affected by the extent to which it incorporates cultural competency principles in the systems of care to address beneficiaries' cultural, ethnic, racial, and linguistic needs.

Most MHPs implemented strategies and used resources to meet the cultural, ethnic, racial, and linguistic needs of their eligibles (n=43), as shown in Figure 5-13. Fewer in number but still a majority are MHPs that evaluate the effectiveness of these strategies towards improving quality of care.

Figure 5-13: Item Scores for Key Component 5.G Cultural Competency

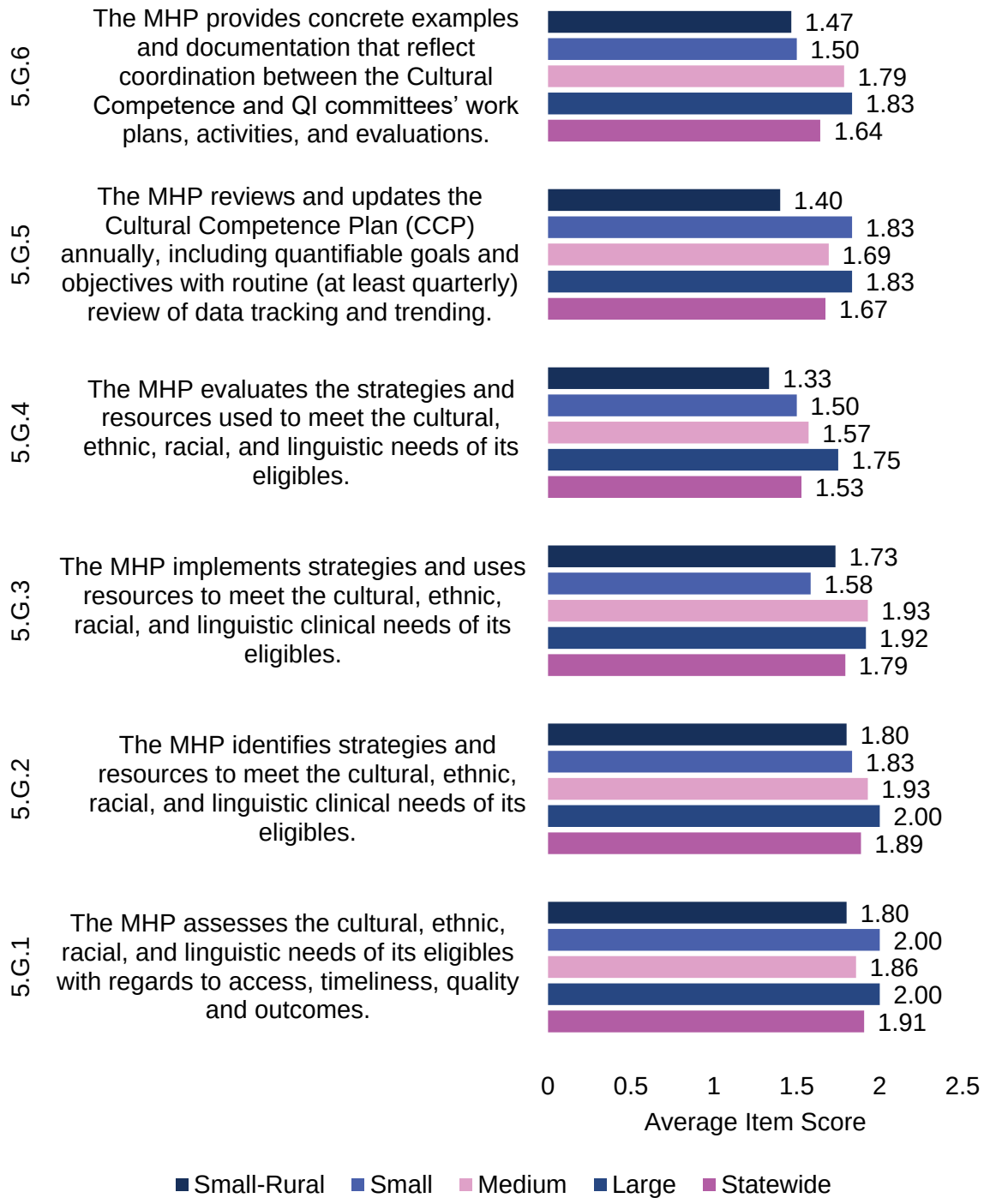


However, in focus groups, some clinical line staff report feeling that cultural competence and disparities efforts are *not* sufficient to reach and service underserved populations.

Several MHPs have made sustained efforts to identify and increase services for underserved populations including Transition-aged Youth (TAY), Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) youth, adult beneficiaries with unstable housing and employment, older adults, and Hispanic/Latino youth and families, which were noted as strengths in their review.

While MHPs generally scored strongly on all categories for cultural competency, scores attenuate slightly as MHP size decreases, as shown in Figure 5-14.

Figure 5-14: Average Item Scores for Key Component 5.G Cultural Competency, Statewide and by MHP Size



Summary

The assessment and review tools used by CalEQRO suggest general improvements in many areas linked to quality, but also challenges.

Sixty-nine percent of the MHPs had measurable goals in their QI plans and conducted annual evaluations of the goals that were set. Another important improvement was the enhancement of medication monitoring practices and policies, which were in place in 72 percent of the counties.

Importantly, there is no uniform or agreed-upon continuum of care for specialty mental health (in comparison to the ASAM criteria in substance use treatment). While this makes systemwide evaluation challenging, it also presents challenges to clinicians who report that they rely largely on clinical judgement to make transition decisions. Despite processes in place in most MHPs, there is significant variability in managing transitions in care and stakeholders across multiple MHPs reported that transitions to health plans are problematic.

Challenges in quality are exacerbated by the number of providers within MHPs who are still unable to communicate client needs electronically, coordinate their care, and use resources efficiently due to lack of critical infrastructure. Behavioral health continues to have significant unmet EHR infrastructure needs, which hinders communication across MHP county and contract provider networks and between behavioral health and health care in general.

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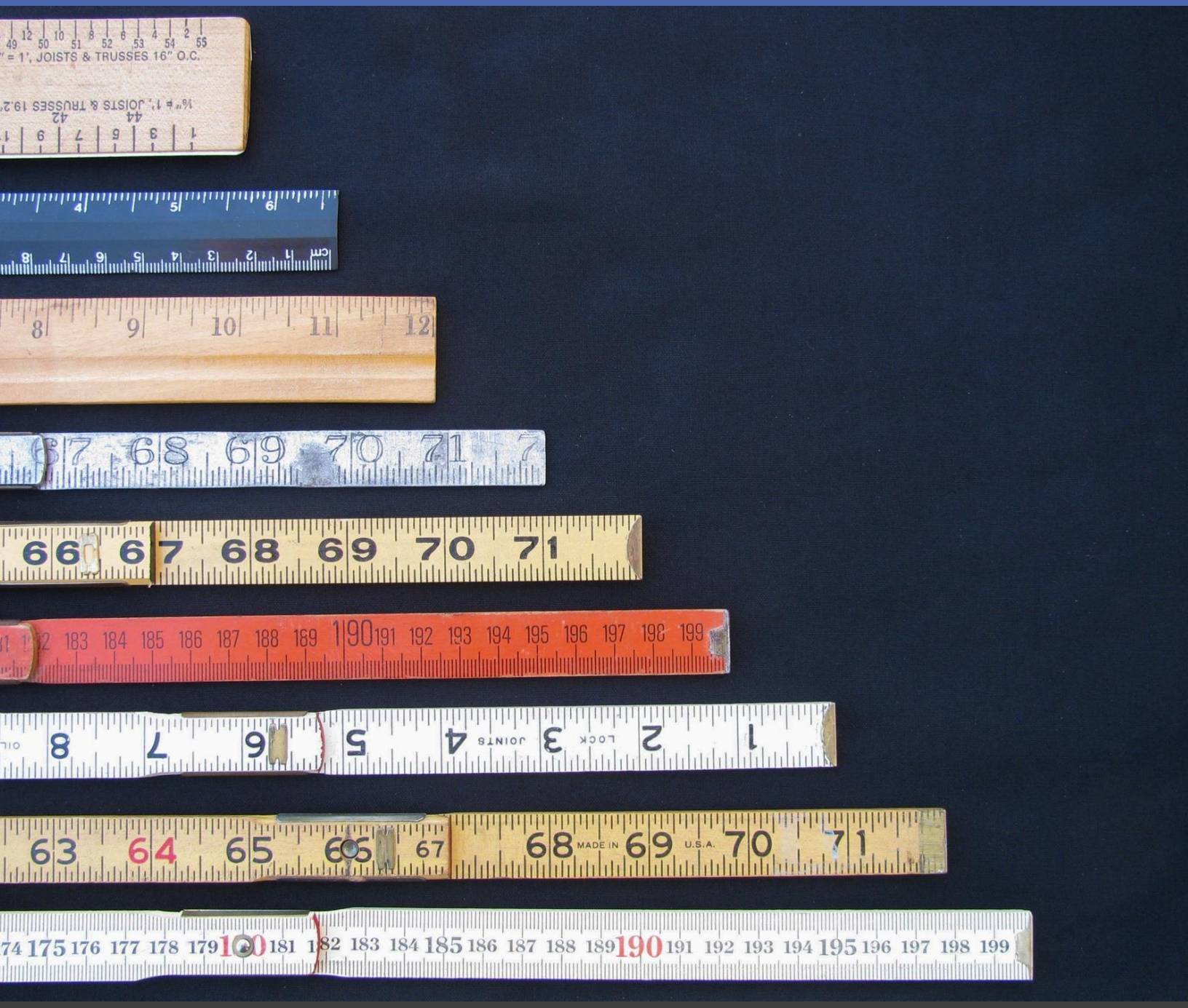


Chapter 6

Outcomes

Outcomes

How MHPs are Using Consumer Perception Surveys and Other Data to Improve Outcomes

Introduction

The EQR process identifies attributes of care that are intended to advance beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perceptions or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Overview of Major Outcome Findings

Finding 1 **The majority of MHPs have implemented the Child and Adolescent Needs and Strengths (CANS) assessment; there is not a similarly mandated outcome tool for adults.**

Finding 2 **MHPs struggle to demonstrate systemwide improvements in mental health outcomes.**

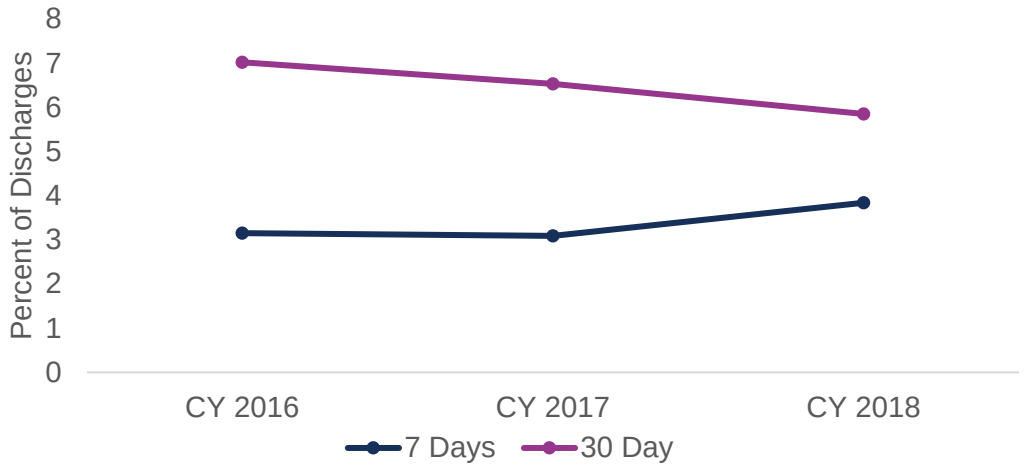
Finding 3 **Few beneficiaries reported learning results from information they have shared in surveys or suggestion boxes; when results are shared, it is often in meetings with limited or no beneficiary participation.**

Performance Measures

Readmission rates following inpatient hospital discharge (HEDIS measure)

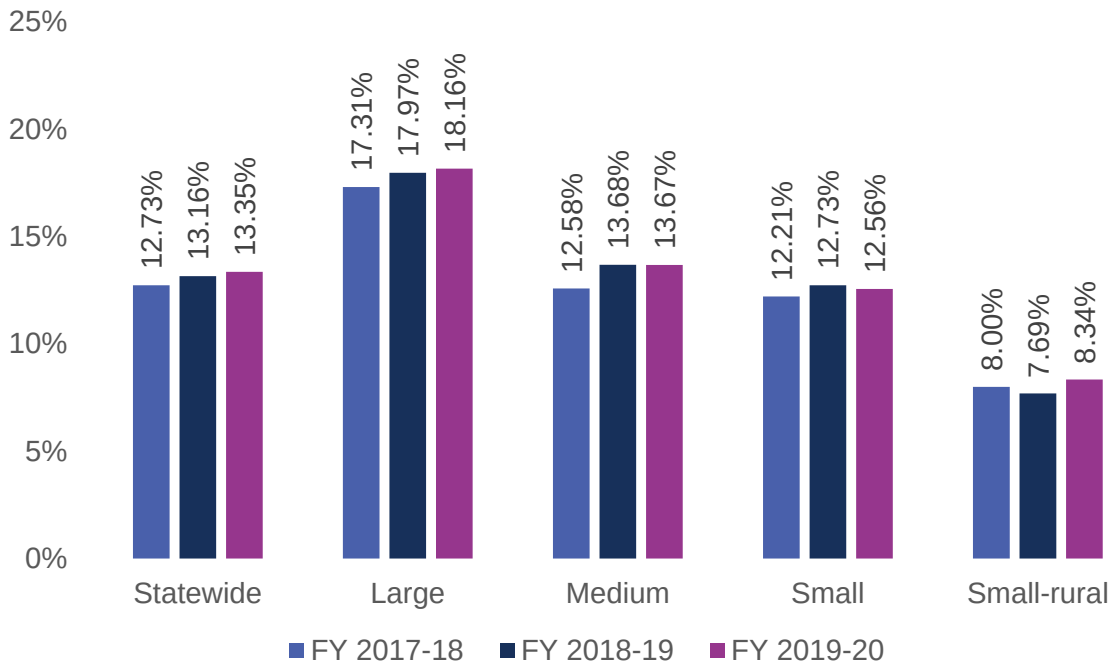
An important indicator of outcomes (as well as continuity of care and timeliness) is the 7- and 30-day rehospitalization rate. In the past year, the 30-day rate declined by more than a percentage point between CY 2016 and CY 2018, as shown in Figure 6-1. However, a proximate indicator of outcomes, the 7-day rehospitalization rate, increased slightly from 3.15 to 3.84 percent.

Figure 6-1: 7- and 30-day Rehospitalization Rates, CY 21016-18



Large MHPs have had the highest 30-day rehospitalization rates across the past three years (Figure 6-2). These higher rates appear correlated to the delay in outpatient follow up after discharge from a psychiatric inpatient unit among the large MHPs.

Figure 6-2: 30-Day Rehospitalization Rates, Statewide and by MHP Size, FY 2017-18 to FY 2019-20



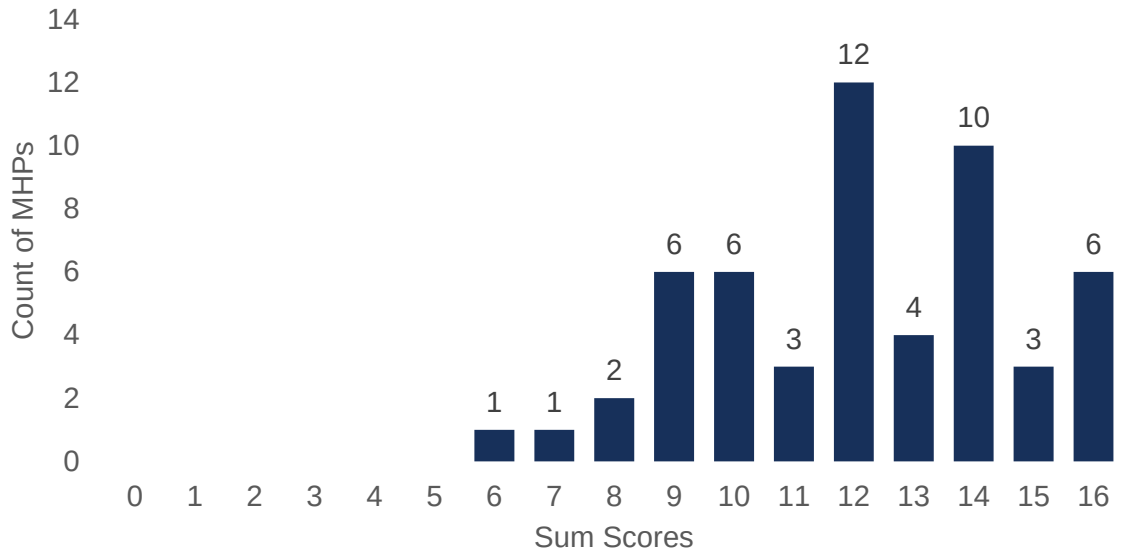
Beneficiary Progress/Outcomes

One dimension on which beneficiary progress and outcomes are assessed is the MHP's use of measures of clinical and functional outcomes and use of those results for QI. This includes:

- Adoption of a standardized tool for measuring progress of adults and of children and youth, and regular use of these assessments.
- Ability to provide evidence that outcome tools are used consistently in clinical practice.
- Evidence that results of the assessments are compiled in order to address potential gaps among subpopulations and identify groups in most need of QI.

As shown in Figure 6-3, **on balance, the majority of MHPs were successful in implementing and using outcomes tools consistently**. Fifty-seven percent (32 of 56) MHPs scored 12 or more out of a total of 16, with the scores ranging from 6 to 16.

Figure 6-3: Sum Scores for Key Component 4.A Beneficiary Progress



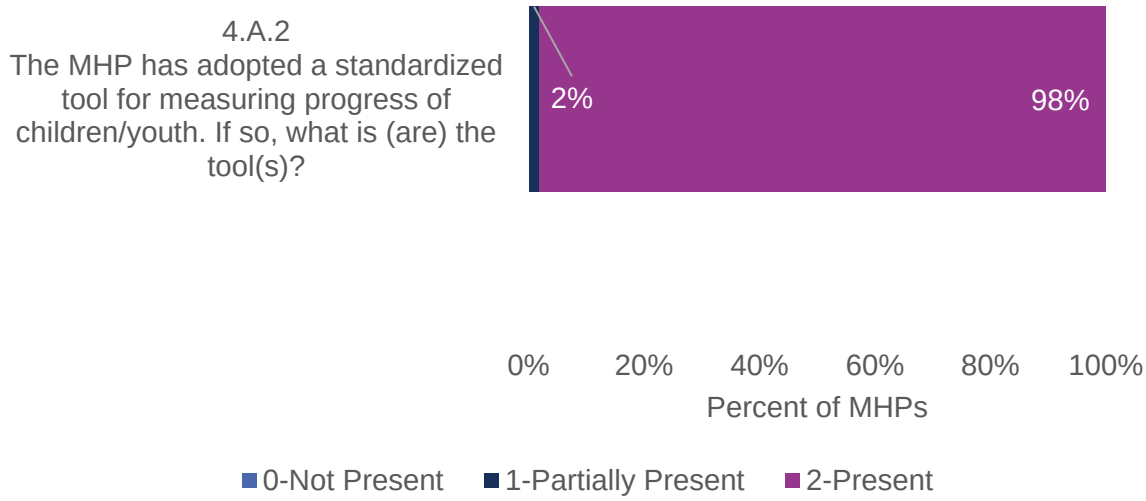
MHPs use a variety of tools to measure clinical and functional progress and/or outcomes.

During FY 2018-19, the MHPs implemented Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptoms Checklist (PSC-35), as per DHCS requirements. Progress on their implementation expanded during FY 2019-20.

The majority of MHPs (n=53) have adopted CANS as a standardized tool for measuring the progress of children and youth, as shown in Figure 6-4. The most prominent recommendation related to beneficiary progress is for the MHP to use aggregate reporting for systemwide evaluation or program improvements.

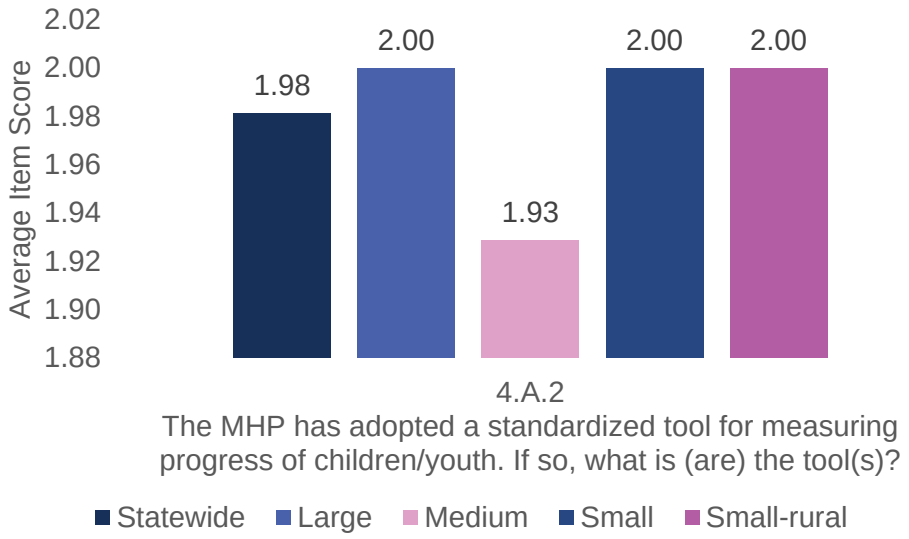
Currently, there is still no similarly mandated outcome tool for adults comparable to CANS. The most commonly used tool among contract providers of adult services is the Milestones of Recovery Scale (MORS).

Figure 6-4: Item Scores for Key Component 4.A.2



Medium and small-rural MHPs were less likely than other-sized MHPs to compile and report, as shown in Figure 6-5.

Figure 6-5: Average Item Scores for Key Component 4.A.2, Statewide and by MHP Size



While clinicians are using these tools, many do not find CANS to be particularly helpful during the treatment process. Feedback from clinicians is that completion of the CANS can be burdensome.

If tools are not being used consistently, they are less likely to be relied on by clinicians for decision making and transition planning.

Demonstrating improvements in mental health outcomes is clearly an important challenge for MHPs. Twenty-eight percent of active PIPs focused on outcomes. However, these efforts covered a wide range of topics, with no common theme related to outcomes. Additionally, few MHPs explicitly identified a clinical outcome measure in their PIPs. The PIPs implied clinical outcomes but did not have a specific outcome tool.

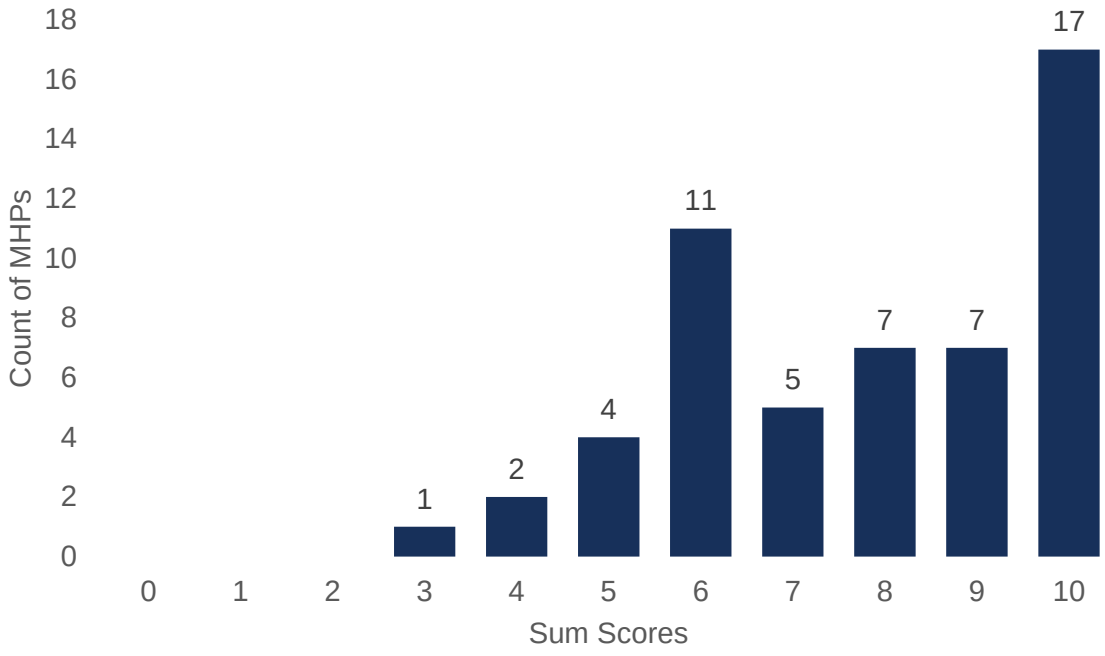
An ability to aggregate outcomes data can provide insights into the most prevalent and critical needs of beneficiaries entering the system. These insights can help inform the development of targeted training and treatment approaches. Aggregated data over time also can shed light on specific domains where beneficiaries seem to benefit from services as well as areas where services are not having as much impact. If tools are not being used consistently, they are less likely to be relied on by clinicians for decision making and transition planning.

Beneficiary Perceptions

Another way that MHPs can measure their efficacy in meeting the needs of beneficiaries is through beneficiary satisfaction surveys, most notably through the DHCS-mandated CPS. MHPs may also administer their own survey to beneficiaries. CalEQRO assesses the extent to which MHPs use CPS data to improve quality and the extent to which these results are shared with key stakeholders such as leadership, staff, contractors, and beneficiaries.

As shown in Figure 6-6, MHPs are relatively successful at conducting these surveys. However, lower scores reflect the lack of follow through on making changes to improve care based on the results.

Figure 6-6: Sum Scores for Key Component 4.B Beneficiary Perception



DHCS requires that MHPs administer the CPS to meet mandates by the federal Community Mental Health Services Block Grant through SAMHSA. The CPS contributes to national outcome measures on mental health services by assessing general satisfaction, access, quality, appropriateness, treatment planning, outcomes, functioning, and social connectedness as a result of mental health services. In addition to demographic variables, the CPS also asks questions about quality of life and involvement with the criminal justice system.

As described earlier in this report, the CPS consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes, including: the MHSIP for adult and older adult beneficiaries, the YSS for youth beneficiaries, and the YSS-F, the family version of the same survey. These remain the only instruments that are used statewide and provide comparable data across different MHPs for each age group, as well as family members of children. Findings from the CPS can be found in Appendix 4.

While the majority of MHPs administer the CPS as required, the instrument is not particularly sensitive to change and often suffers from a small sample size. Some MHPs report that they do not receive CPS data back from the state in a timely manner. As well, CPS surveys do not capture the people who dropped out of services because of long wait times or other factors, which would be an important perspective in terms of insights about quality.

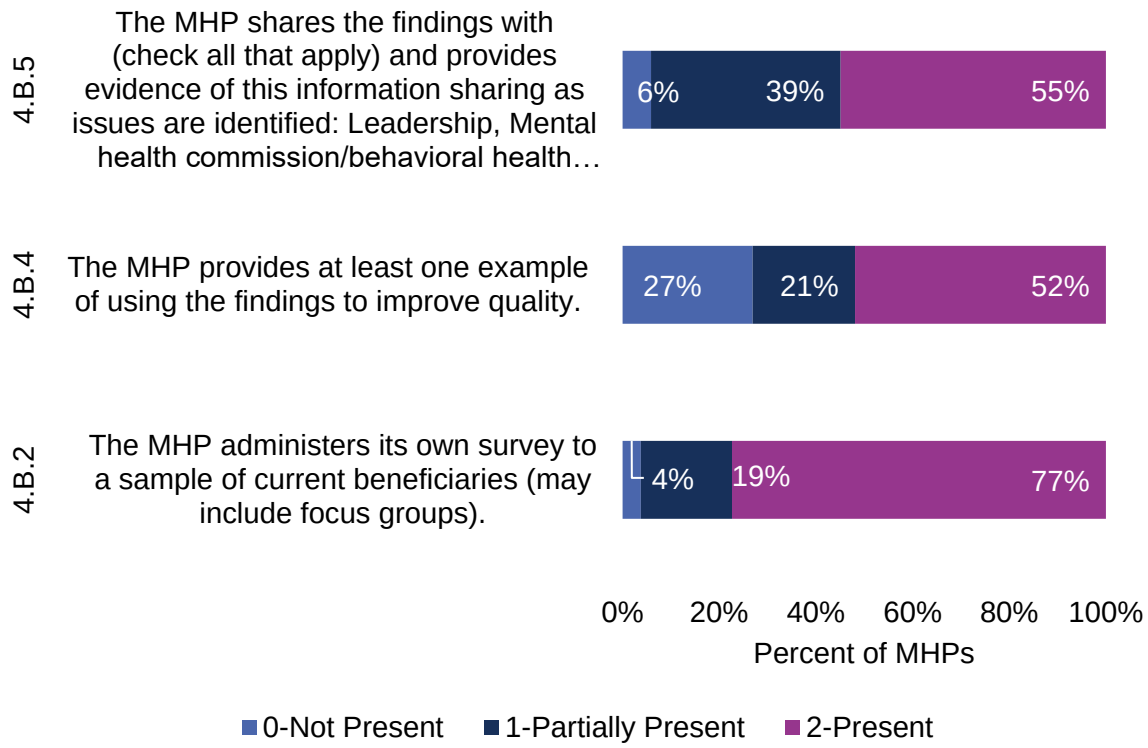
More MHPs are deploying their own surveys so they have more control over when they are administered, what types of data are collected, and how the MHP uses the results. Over three-quarters of MHPs report that they administer beneficiary surveys, questionnaires, or conduct focus groups, in addition to the CPS, as shown in Figure 6-7. However, fewer than half

of MHPs show evidence of sharing the results or are able to provide evidence of changes that have been made based on the results of the survey (Figure 6-7, Item 4.B.5).

About half of the MHP share the findings with their leadership, local mental health commissions and behavioral health boards, MHP staff, contract providers, and/or beneficiaries (Figure 6-7, Item 4.B.5,) and few MHPs were able to provide at least one example of using the findings from the CPS to improve quality (Figure 6-7, Item 4.B.4).

Few beneficiaries reported that they ever hear what happens after they share information either in surveys or suggestion boxes. When results are shared, it is often in meetings that most consumers do not attend or that only a few consumers are invited to attend.

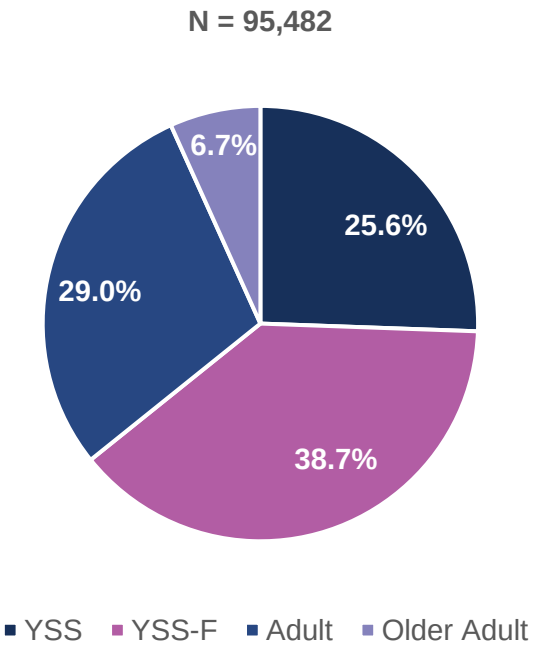
Figure 6-7: Item Scores for Key Component 4.B.2



Summary of CPS Results

In CY 2019, DHCS received 95,482 surveys for all four survey types. The highest percent of surveys received was from YSS-F at 38 percent, followed by Adults at 29 percent, YSS at 26 percent and Older Adults at 6.7 percent (Figure 6-8).

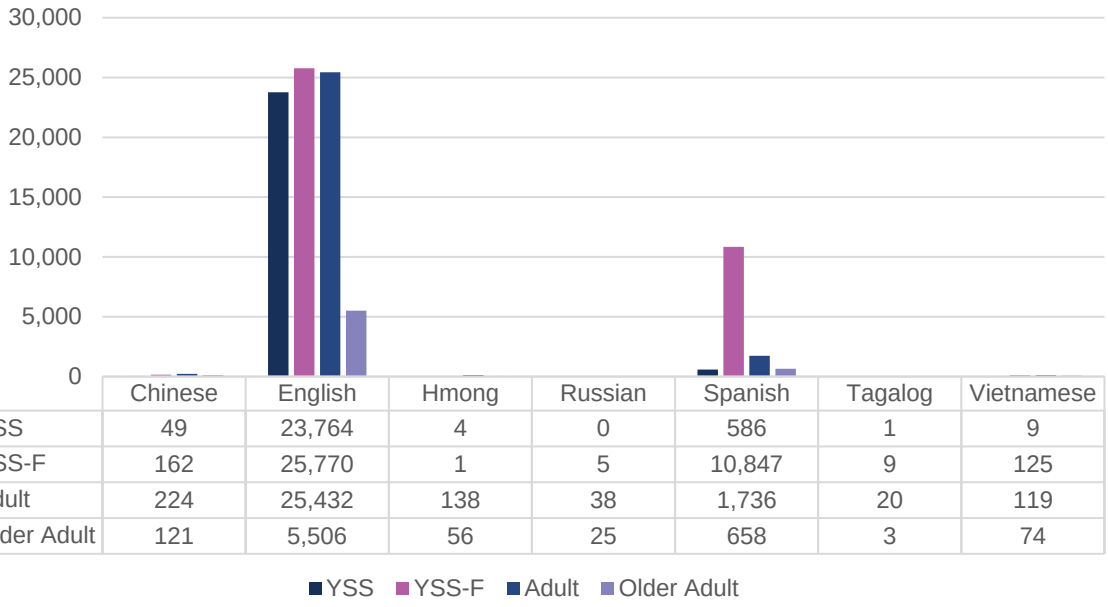
Figure 6-8: Surveys Received by Survey Type



Language of Surveys Received

Majority of the surveys for all survey types were received in English at 84.5 percent, followed by surveys in Spanish language at 14.5 percent. The remaining 2 percent of the surveys were received in other languages such as Chinese, Hmong, Russian, Tagalog, and Vietnamese (Figure 6-9).

Figure 6-9: Language of Surveys Received by Survey Type

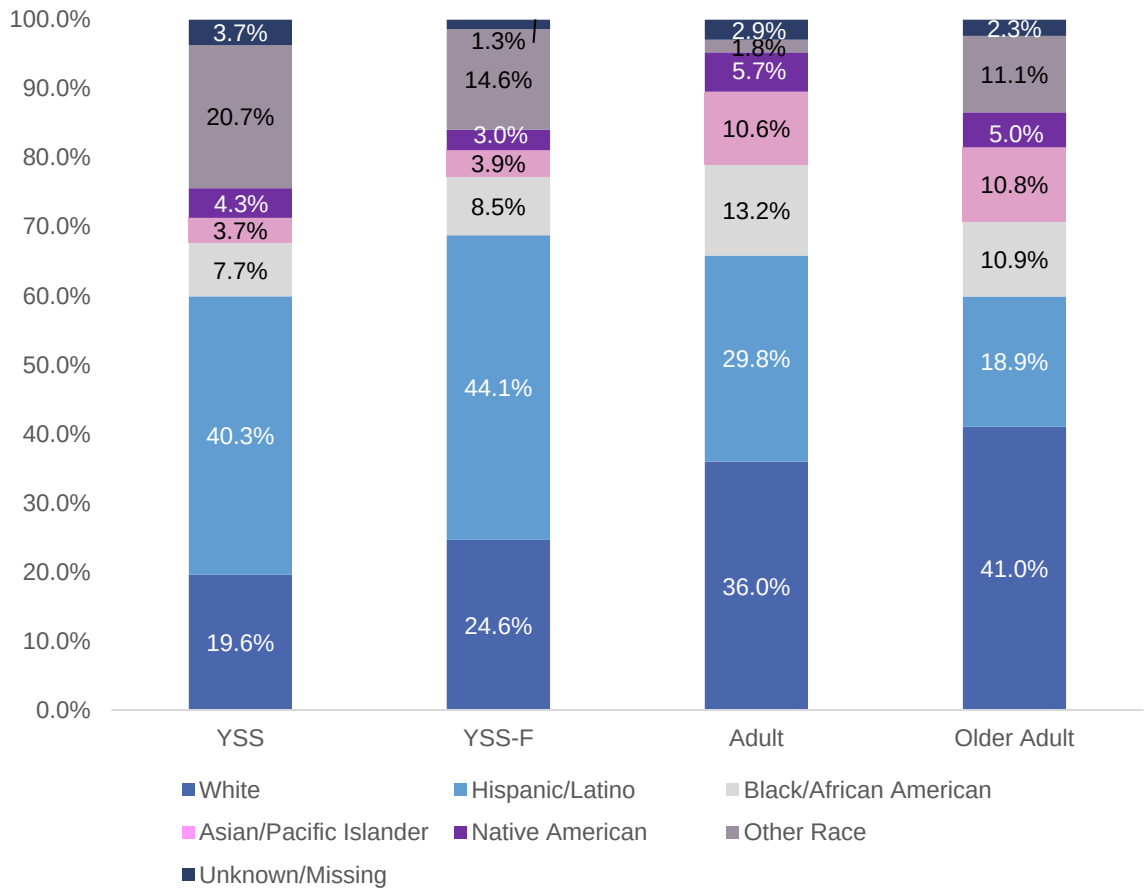


	Chinese	English	Hmong	Russian	Spanish	Tagalog	Vietnamese
YSS	49	23,764	4	0	586	1	9
YSS-F	162	25,770	1	5	10,847	9	125
Adult	224	25,432	138	38	1,736	20	119
Older Adult	121	5,506	56	25	658	3	74

Surveys Received by Race/Ethnicity

Between 40 and 44 percent of YSS and YSSF surveys were completed by Hispanics/Latinos, between 20 and 25 percent by Whites, 8 percent by Blacks, and 4 percent by Asian Pacific Islander (API) and Native American and Alaskan Native (NA/AN). In contrast, between 30 percent and 19 percent of Adult and Older Adult surveys respectively were completed by Hispanics/Latinos; between 36 and 40 percent were completed by Whites; between 13 percent and 11 percent were completed by Blacks; 11 percent were completed by API and 6 percent were completed by NA/AN (Figure 6-10).

Figure 6-10: Race/Ethnicity by Survey Type



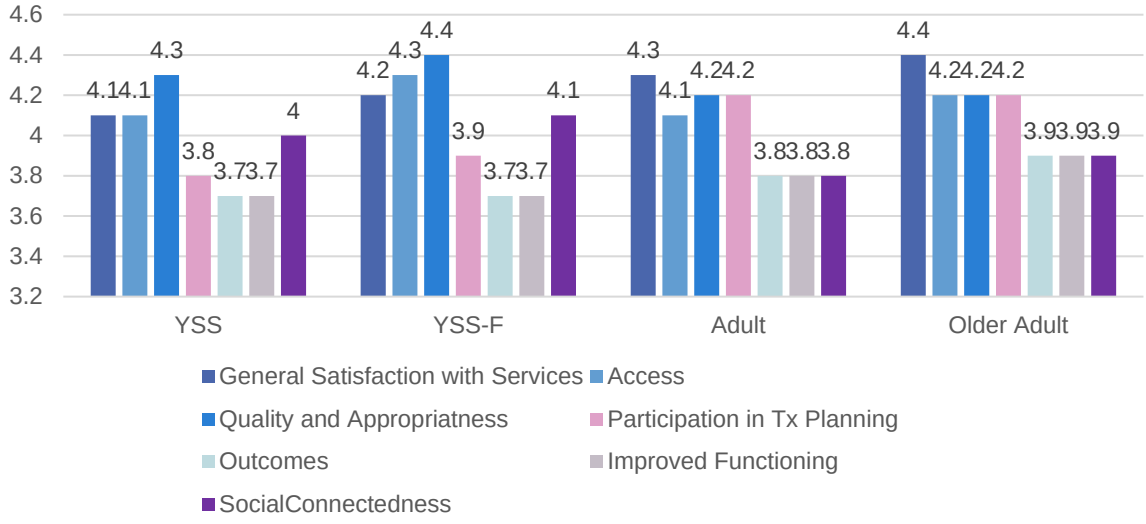
Mean Score on Perception of Satisfaction Domains by Survey Type

In general, across the four survey types, beneficiaries rated quality measures such as perception of General Satisfaction and Quality and Appropriateness higher than perception of Access and Outcomes.

Among the YSS surveys, the highest rated mean score was for perception of Quality and Appropriateness at 4.3, followed by perception of General Satisfaction and Access at 4.1. The lowest rated mean score for both YSS and YSS-F was for perception of Outcomes and Improved Functioning at 3.7.

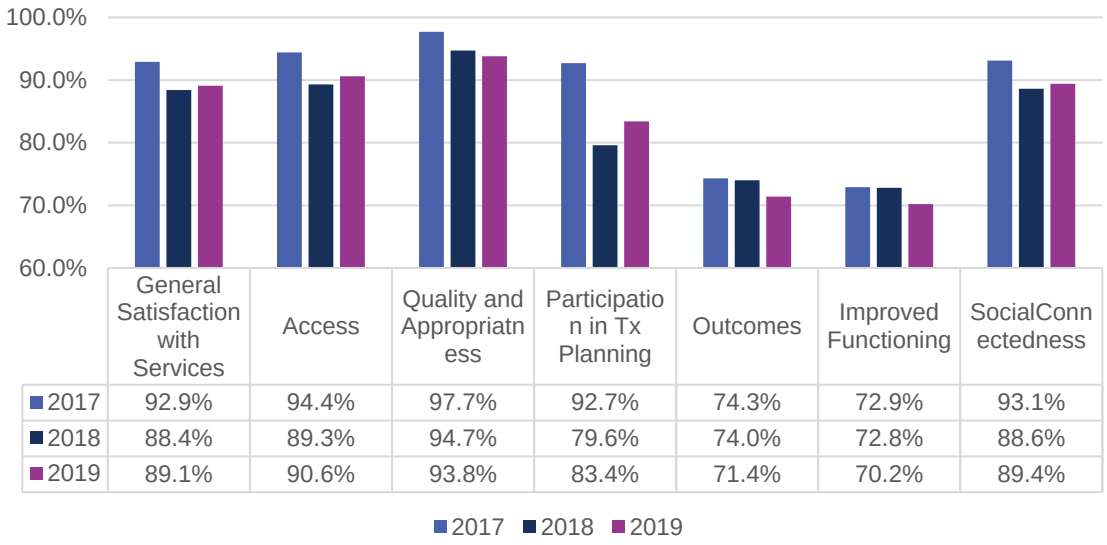
However, among Adult and Older Adult surveys, the highest rated mean score was for perception of General Satisfaction at 4.3 and 4.4 respectively followed by perception of Quality and Appropriateness and Participation in Treatment Planning at 4.2. Similar to YSS and YSS-F, the lowest rated mean scores among Adult and Older Adult surveys were for Outcome measures at 3.8 and 3.9 (see Figure 6-11).

Figure 6-11: Mean Domain Score by Survey Type



In the last three years, there was a decline in nearly all the satisfaction domains among all four survey groups. The most notable decline was among the YSS-F and YSS surveys. Among YSS-F surveys, there was a three percent or more decline in all satisfaction domains from 2017 to 2019 (as shown in Figure 6-12).

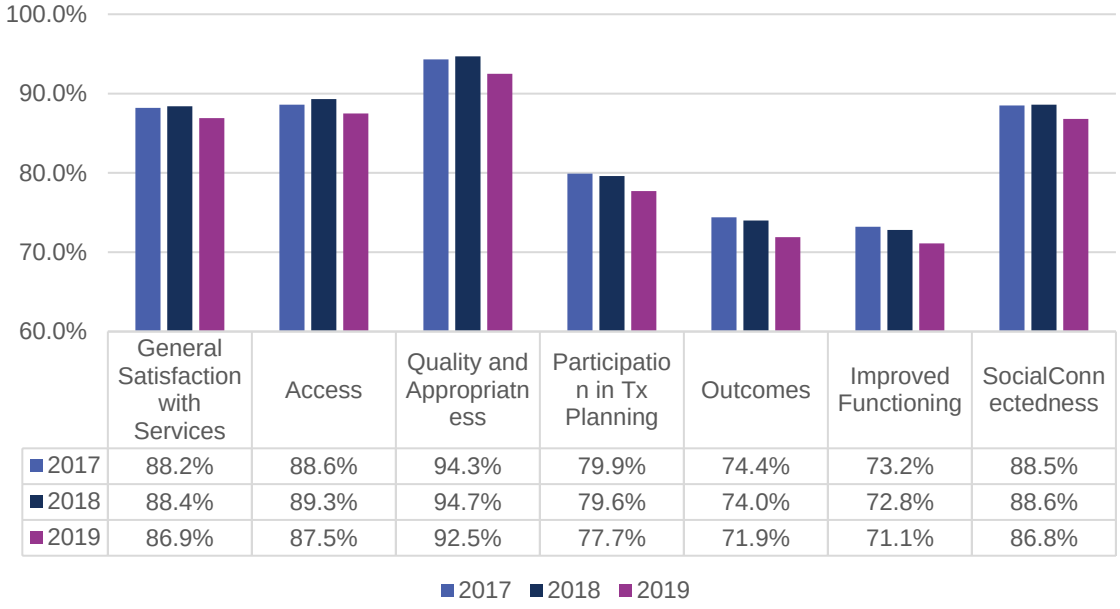
Figure 6-12: Three Year Trend in Percent Satisfied by Satisfaction Domains Families of Youth and Children (YSS-F)



	General Satisfaction with Services	Access	Quality and Appropriatness	Participation in Tx Planning	Outcomes	Improved Functioning	SocialConnectedness
2017	92.9%	94.4%	97.7%	92.7%	74.3%	72.9%	93.1%
2018	88.4%	89.3%	94.7%	79.6%	74.0%	72.8%	88.6%
2019	89.1%	90.6%	93.8%	83.4%	71.4%	70.2%	89.4%

Between 2017 and 2019, there was a four-percentage-point decline among Youth who were satisfied with Quality and Appropriateness, Participation in Treatment Planning, Outcomes, and Improved Functioning (as shown in Figure 6-13).

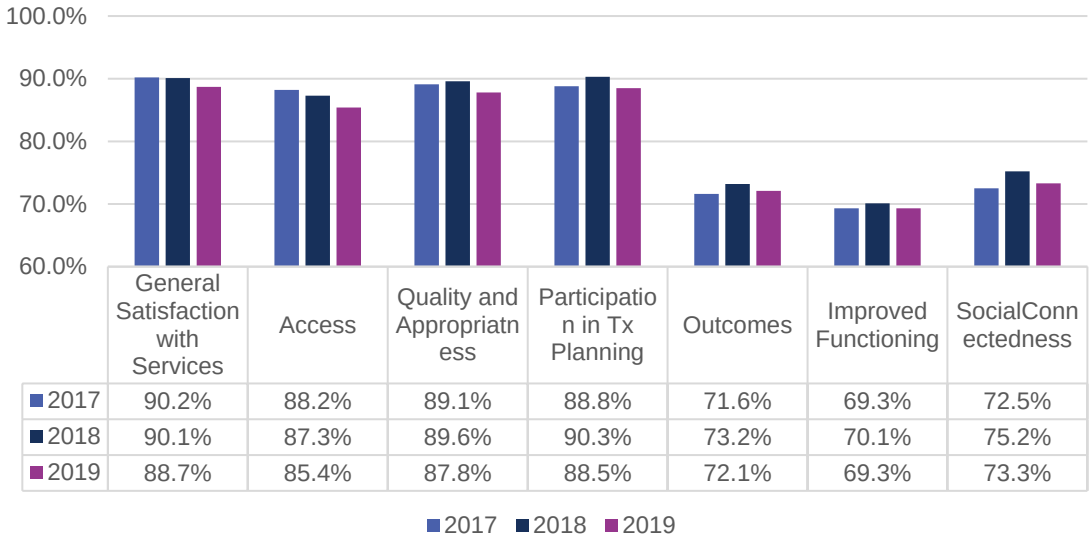
Figure 6-13: Three Year Trend in Percent Satisfied by Satisfaction Domains Youth-YSS Surveys



	General Satisfaction with Services	Access	Quality and Appropriatness	Participation in Tx Planning	Outcomes	Improved Functioning	SocialConnectedness
2017	88.2%	88.6%	94.3%	79.9%	74.4%	73.2%	88.5%
2018	88.4%	89.3%	94.7%	79.6%	74.0%	72.8%	88.6%
2019	86.9%	87.5%	92.5%	77.7%	71.9%	71.1%	86.8%

Among Adult surveys, between 2017 and 2019, there was a two-percentage-point decline in percent satisfied with Access and Quality and Appropriateness (as shown in Figure 6-14).

Figure 6-14: Three Year trend in Percent Satisfied by Satisfaction Domains Adult Surveys



	General Satisfaction with Services	Access	Quality and Appropriatn ess	Participatio n in Tx Planning	Outcomes	Improved Functioning	SocialConn ectedness
2017	90.2%	88.2%	89.1%	88.8%	71.6%	69.3%	72.5%
2018	90.1%	87.3%	89.6%	90.3%	73.2%	70.1%	75.2%
2019	88.7%	85.4%	87.8%	88.5%	72.1%	69.3%	73.3%

There was no notable change in any satisfaction domains among Older Adult surveys between 2017 and 2019.

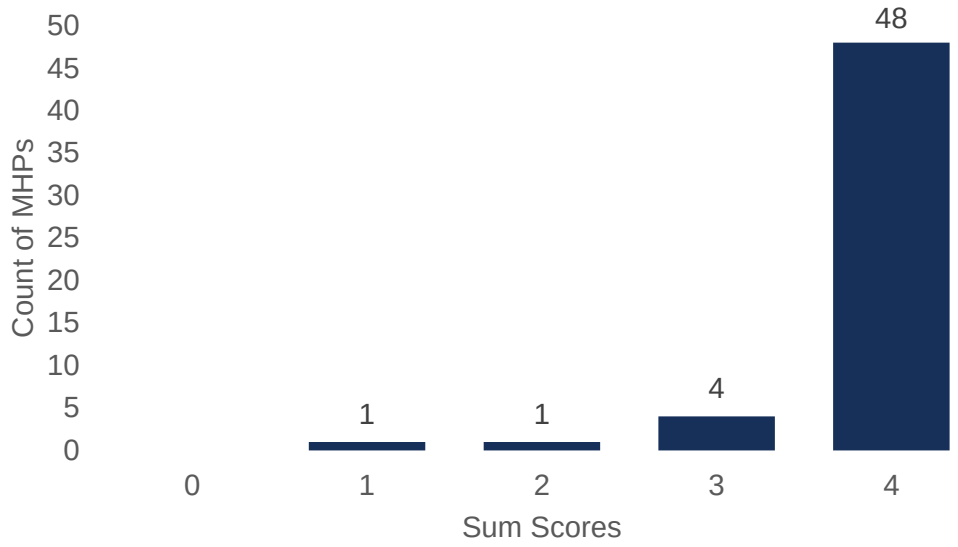
Supporting Beneficiaries through Wellness and Recovery

Another key dimension for assessing beneficiary progress is whether the MHP has peer-run/peer-driven programs that are supported or endorsed by the MHP. Beneficiaries are educated about the existence of these programs and encouraged to participate early in their treatment process.

Wellness centers are an integral part of beneficiary recovery. MHPs rely on wellness centers to provide a comprehensive array of support groups to help the beneficiaries who attend the centers reach their recovery goals. Many of the groups at these centers are run by peer employees.

Figure 6-15 shows that **almost all MHPs now have peer-run programs**.

Figure 6-15: Sum Scores for Key Component 4.C Supporting Beneficiaries through Wellness and Recovery



The number of MHPs with one or more peer-run and/or peer-driven programs continues to increase. Almost all MHPs have at least one peer-run program (Figure 6-16, Item 4.C.1). This was especially true among the large and medium-sized MHPs (Figure 6-17). Smaller MHPs were less likely to have peer-run programs (Figure 6-17). These peer-run programs tend to be open to the general population (Figure 6-16, Item 4.C.2).

Figure 6-16: Item Scores for Key Component 4.C.1 and 4.C.2

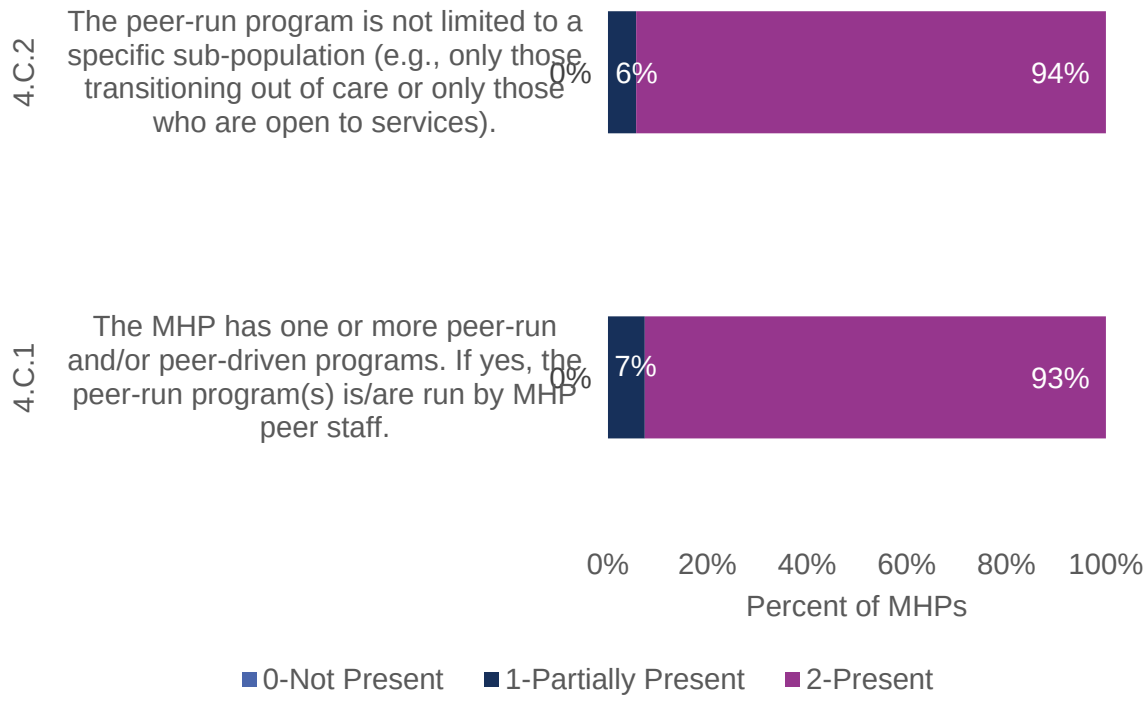
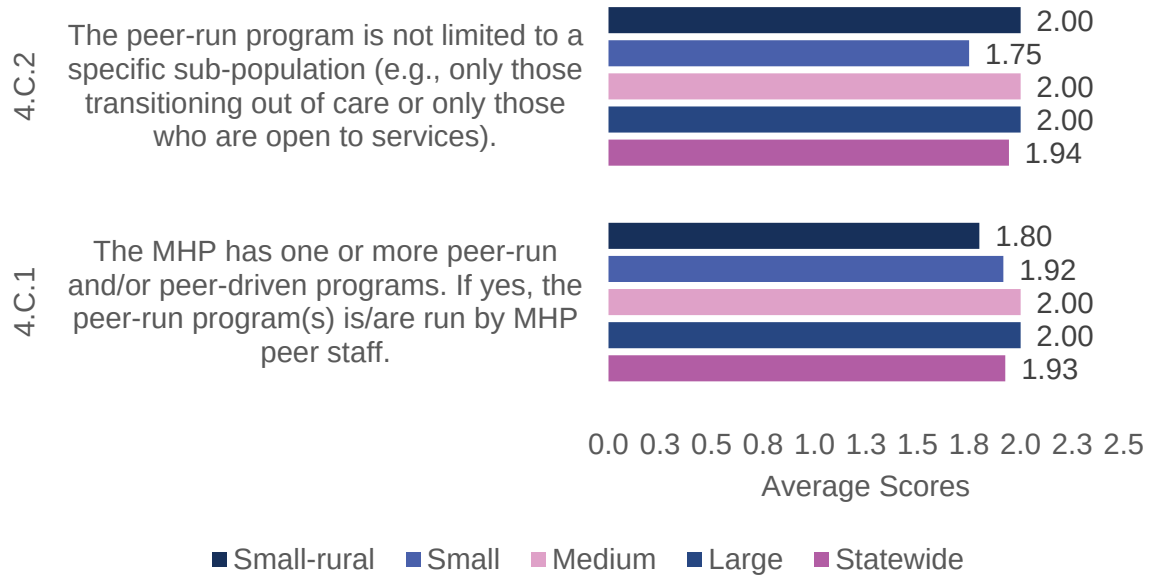


Figure 6-17: Average Item Scores for Key Component 4.C.1 and 4.C.2

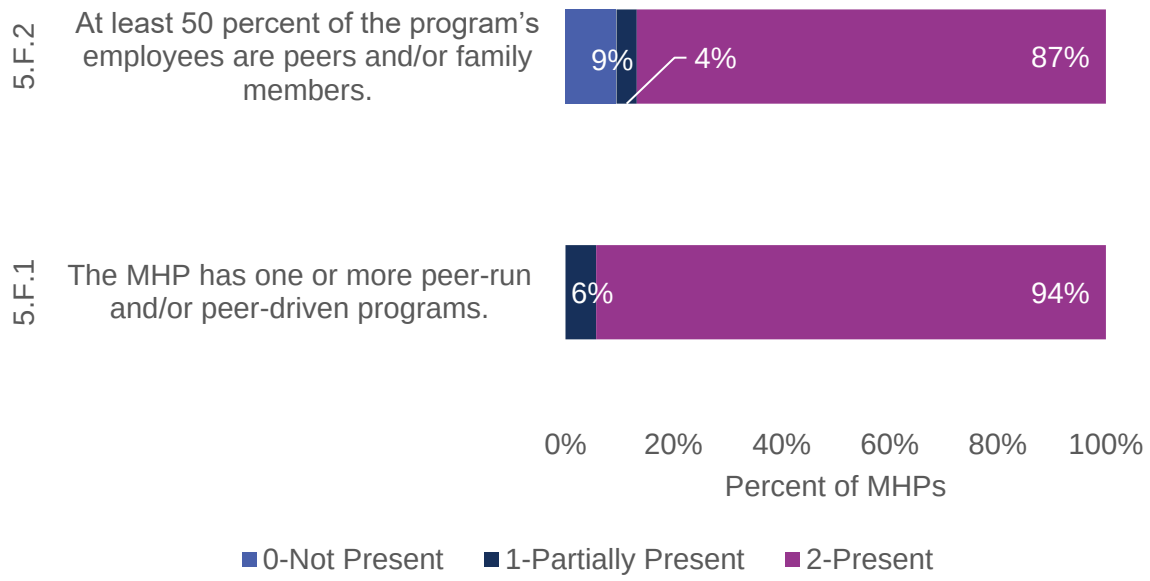


Peer Roles in Recovery

The inclusion of peers in paid positions is a definitive investment by the MHP in its infrastructure. Most MHPs demonstrate that paid positions are available specifically for peers and/or family members, who are individuals hired based upon their lived experience).

Nearly all MHPs have one or more peer-run and/or peer-driven programs (n=50) and rely on peers and family members to run these programs (Figure 6-18). In most MHPs, at least 50 percent of the peer-run program's employees are peers and/or family members (n=46), as shown in Figure 6-18.

Figure 6-18: Item Scores for Key Components 5.F.1 and 5.F.2



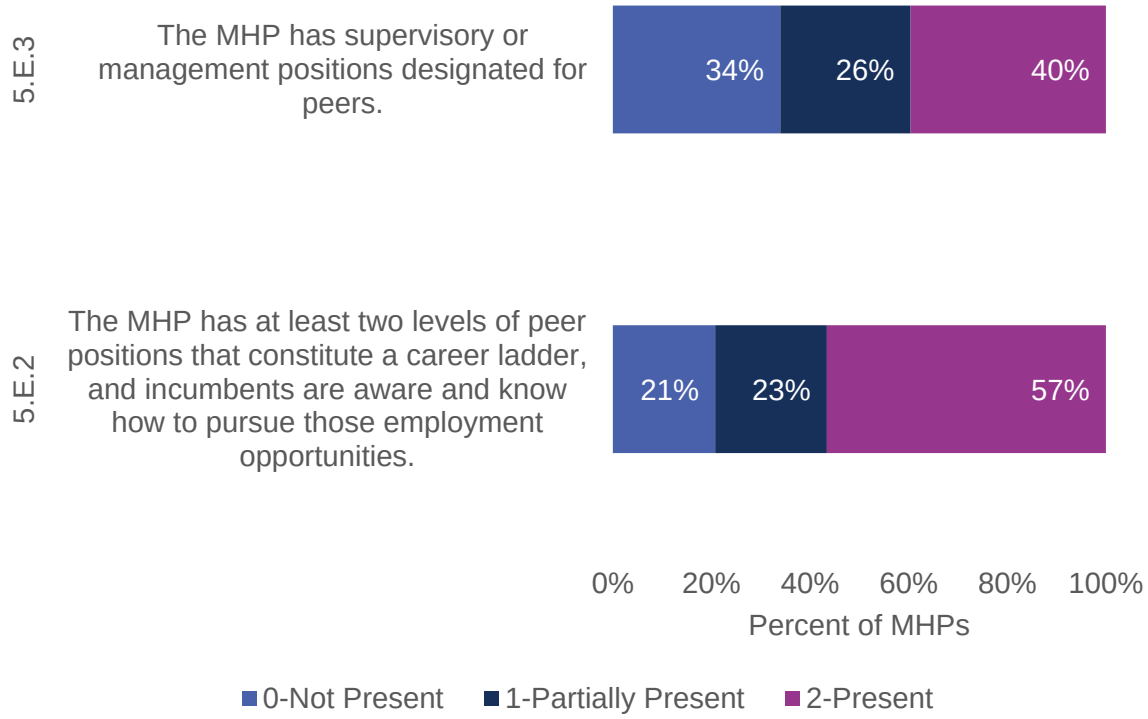
Nearly all MHPs include peer employees within the system of care, either directly operated or through contract providers. However, the level of peer employment varies across MHPs.

In focus groups, consumer employees reported receiving a variety of training at the beginning of their employment, depending on their MHP. Trainings included:

- Wellness Recovery Action Plan (WRAP)
- Workforce Integration Support and Education (WISE) University
- Abuse reporting, trauma informed care, crisis
- Peer Support Specialist training
- EHR, Relias online training, HIPPA, cultural competence

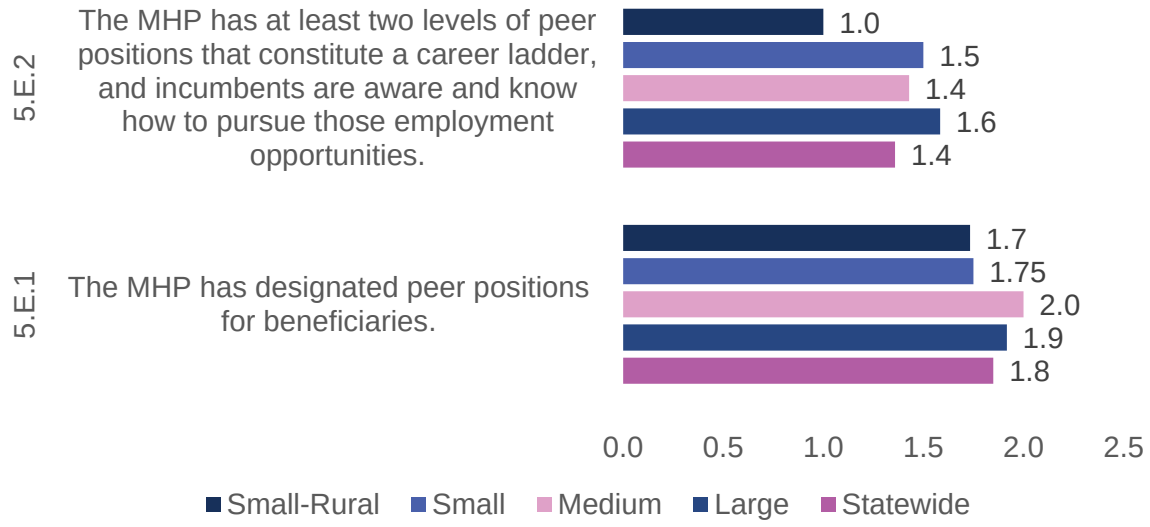
A number of MHPs have limited peer employee positions and career ladders for advancement (Figure 6-19, 5.E.2, 5.E.3.)

Figure 6-19: Item Scores for Key Component 5.E.2 and 5.E.3



Peer employment programs showed up as both strengths and opportunities for MHPs. Nearly all MHPs have designated peer positions for beneficiaries (statewide average=1.85). Many MHPs have a peer career ladder or have formed workgroups to oversee the expansion of their peer employment programs (n= 11 counties), as shown in Figure 6-20.

Figure 6-20: Average Item Scores for Key Components 5.E.1 and 5.E.2



Summary

One dimension on which beneficiary progress and outcomes are assessed is the MHP's use of clinical and functional outcomes measures to monitor individual beneficiary changes over time. Moreover, aggregated outcomes data becomes useful for informing QI activities and monitoring systemwide performance over time.

The majority of MHPs have adopted CANS as a standardized tool for measuring the progress of children and youth. Currently, there is no similarly mandated outcome tool for adults comparable to CANS. The most commonly used tool among contract providers of adult services is the MORS.

While the use of outcomes tools is increasing, many MHPs lack the necessary resources to aggregate outcomes data to provide insights into the most prevalent and critical needs of beneficiaries across the system of care. Aggregated data over time also can shed light on specific domains where beneficiaries seem to benefit from services as well as areas where services are not having as much impact.

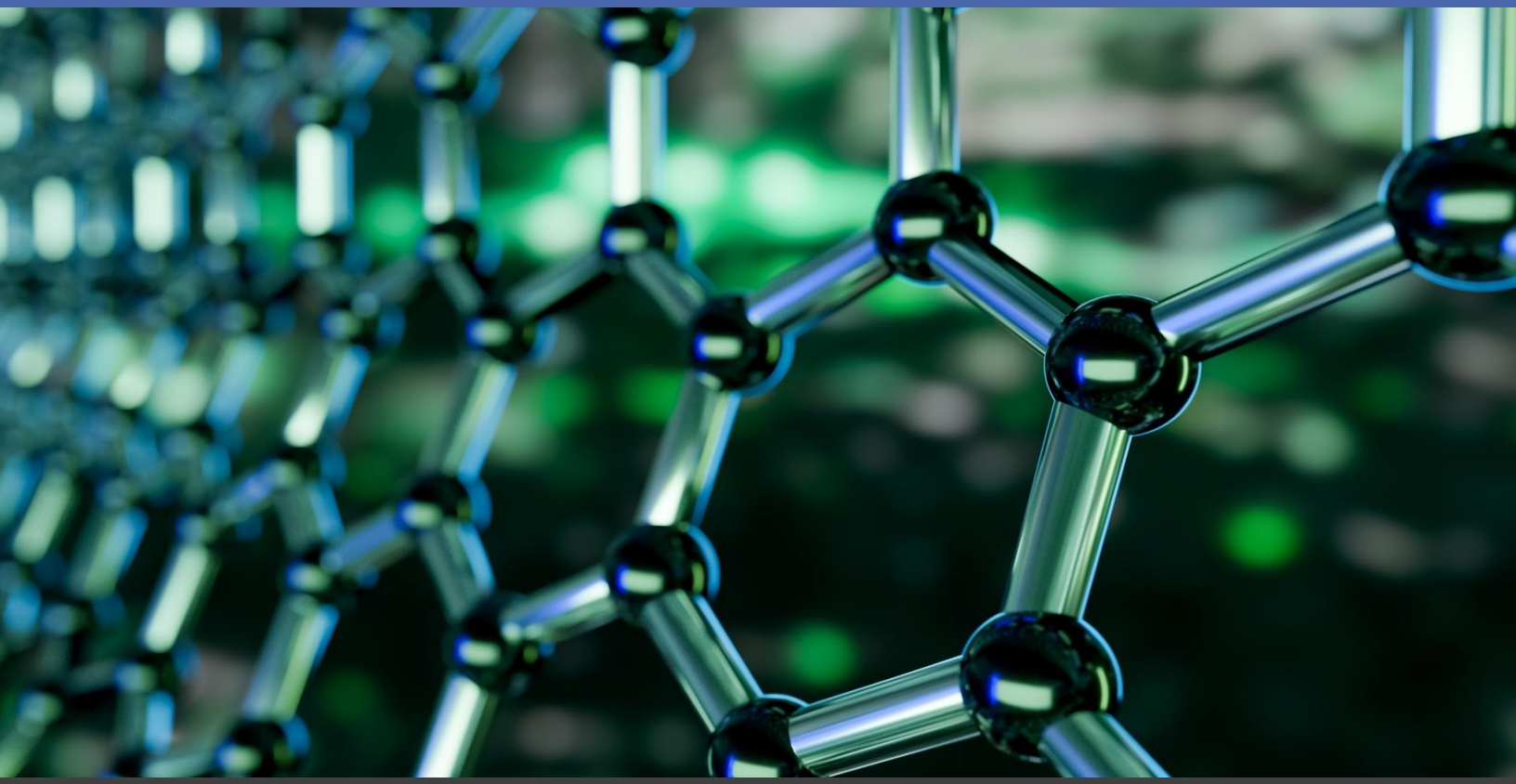
Beneficiary satisfaction surveys are another source of monitoring the MHPs' ability to meet the needs of beneficiaries. While many MHPs administer surveys to beneficiaries at least biannually, only about half share the findings with their leadership, local mental health commissions and behavioral health boards, MHP staff, contract providers, and/or beneficiaries.

In the last three years, there was a decline in nearly all the satisfaction domains among all four survey groups of the CPS. The most notable decline was among the Family and Youth surveys. Among YSS-F surveys, there was a three percent or more decline in all satisfaction domains from 2017 to 2019.

Another key dimension for assessing beneficiary progress is whether the MHP has peer-run/peer-driven programs that are supported or endorsed by the MHP. Beneficiaries are educated about the existence of these programs and encouraged to participate early in their treatment process. Almost all MHPs now have peer-run programs.

Wellness centers are an integral part of beneficiary recovery. MHPs rely on wellness centers to provide a comprehensive array of support groups to help the beneficiaries who attend the centers reach their recovery goals. Many of the groups at these centers are run by peer employees. The number of MHPs with one or more peer-run and/or peer-driven programs continues to increase.

Medi-Cal Specialty Mental Health External Quality Review Report
2019-20



Chapter 7

Information Systems

Information Systems

Strengthening the Foundation for Quality MHP Services

Introduction

The health information system (HIS) is a system that captures, stores, transmits, or otherwise manages health data or activities. These systems are used to collect, process, use, and report health information. In turn, information from an HIS can be used to drive policy and decision making, research, and ultimately improvements in health outcomes. Essentially, the HIS of MHPs is the foundational infrastructure upon which access, timeliness, quality, and outcomes depends.

Because HISs commonly access, process, or maintain large volumes of sensitive data routinely, security is a primary concern.

Overview of Major Information Systems Findings

Finding 1 **MHP IS across California continued to be dominated by a handful of EHR vendors in FY 2019-20.**

Finding 2 **The landscape of the current IS is further challenged by rapidly changing requirements at both the federal and state levels.**

Finding 3 **Healthcare data integrity and claims processes have seen significant changes in requirements that reflect greater beneficiary privacy concerns and attention to access and timeliness-related performance of the MHPs in the form of Network Adequacy.**

Figure 7-1 shows that most counties (79 percent) have implemented, or are in the process of implementing, a system that has core components that support EHR functionalities for the MHP (and, at times, Drug Medi-Cal Organized Delivery Systems [DMC-ODS] as well). EHR functionality varies by size of MHP.

Figure 7-1: Progress to Implement EHR Functionality, FY 2017-18 to FY 2019-20

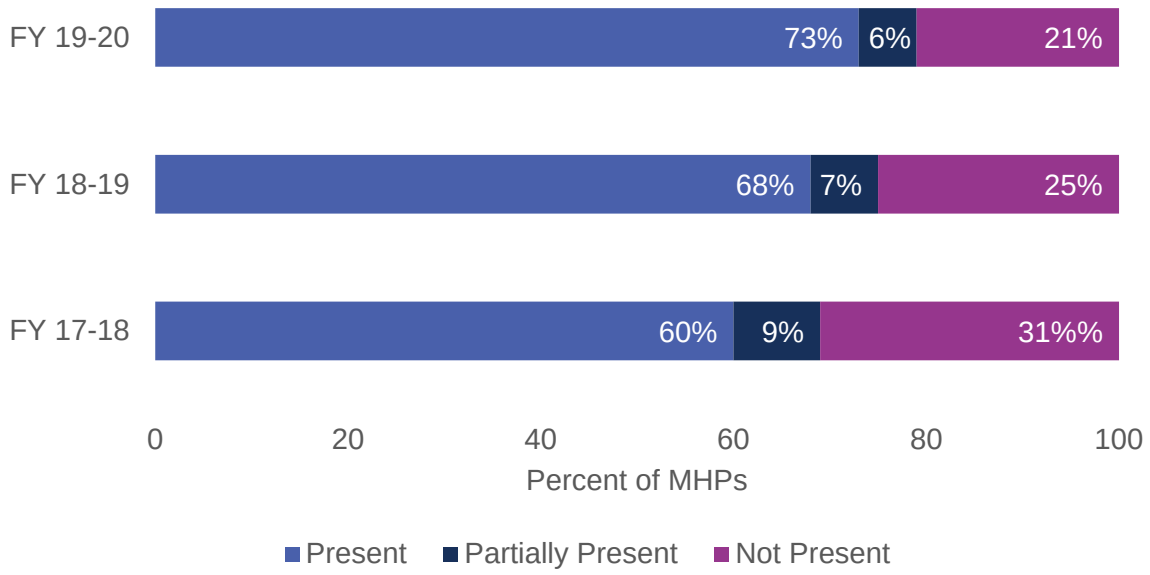
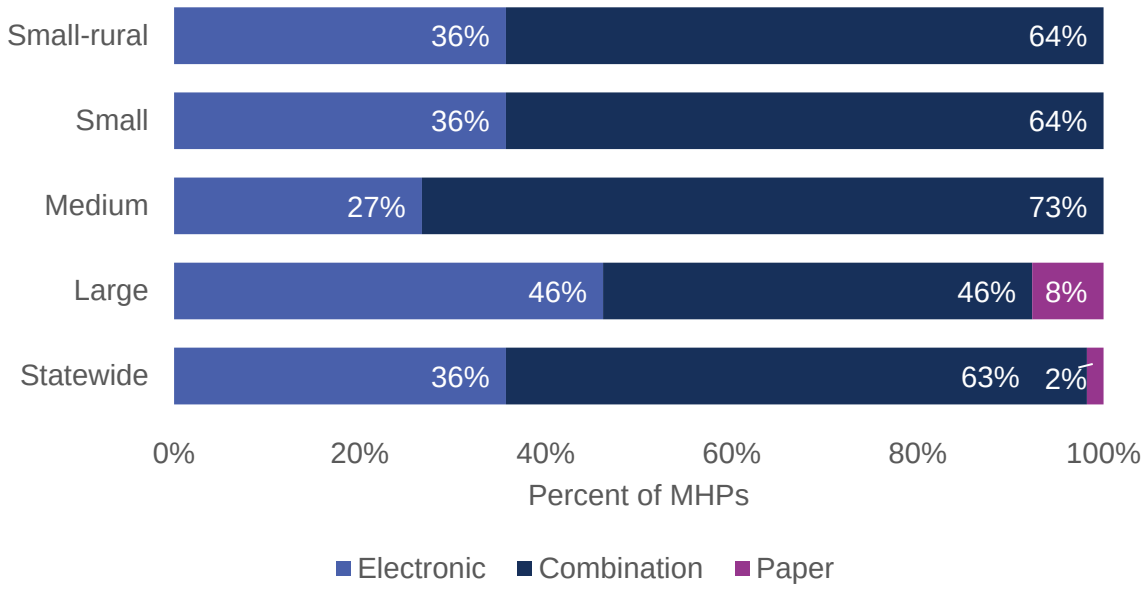


Figure 7-2 shows that almost half of the large counties reported having a patient portal by which beneficiaries may directly access their EHR records, while only a quarter of medium-sized counties have implemented that feature. Among small and small-rural counties, approximately 35 percent have this functionality, matching the statewide percentage.

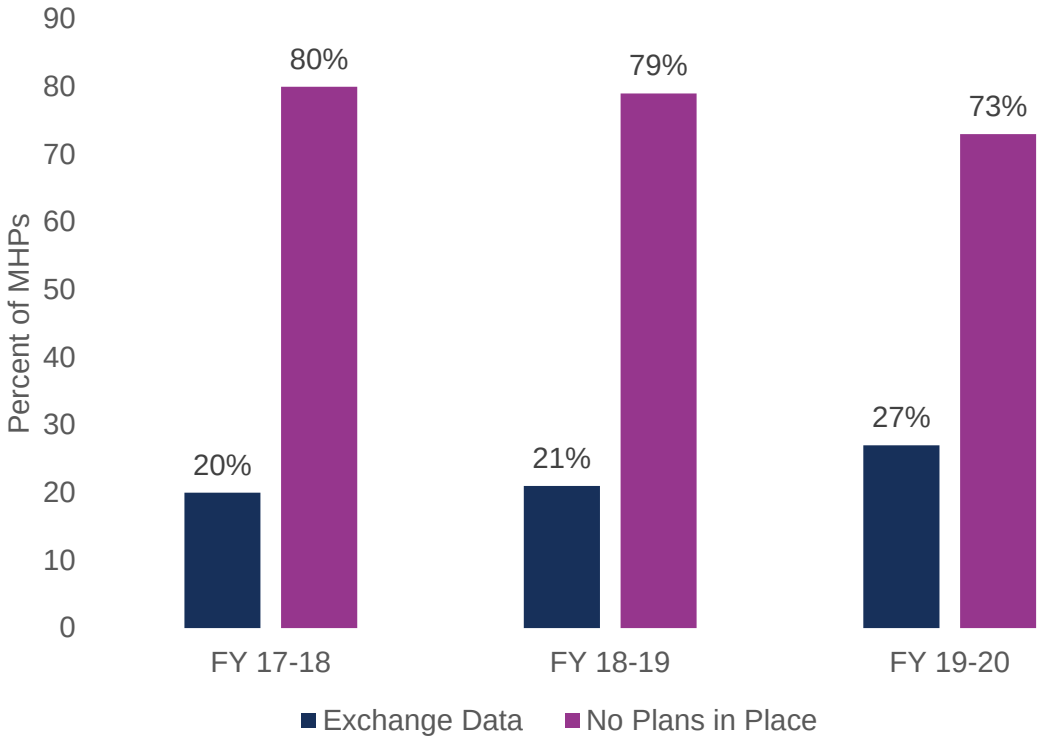
Figure 7-2: Beneficiary Health Record Format, Statewide and by MHP Size



In focus groups, contract providers noted that they tend to have their own EHRs, but these may not be compatible with the MHP's EHR.

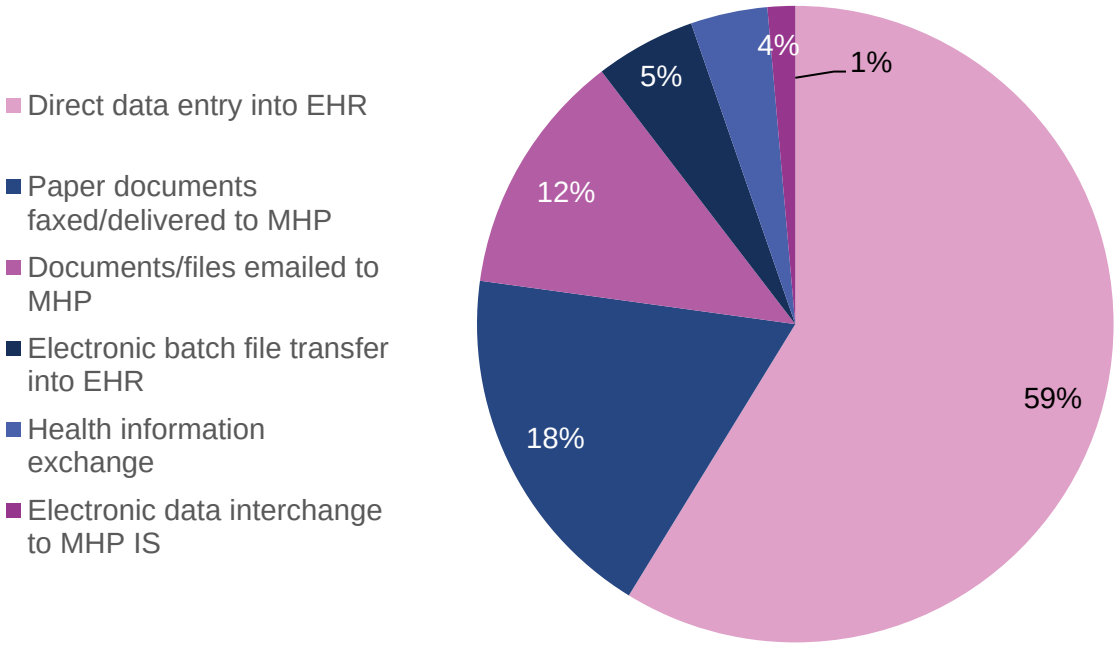
Health Information Exchanges (HIEs) offer the capability to electronically move clinical information among disparate HIS and maintain the meaning of the information being exchanged. The goal of HIEs is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, and equitable beneficiary-centered care. However, only 27 percent of MHPs participated in HIEs (Figure 7-3).

Figure 7-3: MHP Participation in HIEs, FY 2017-18 to FY 2019-20



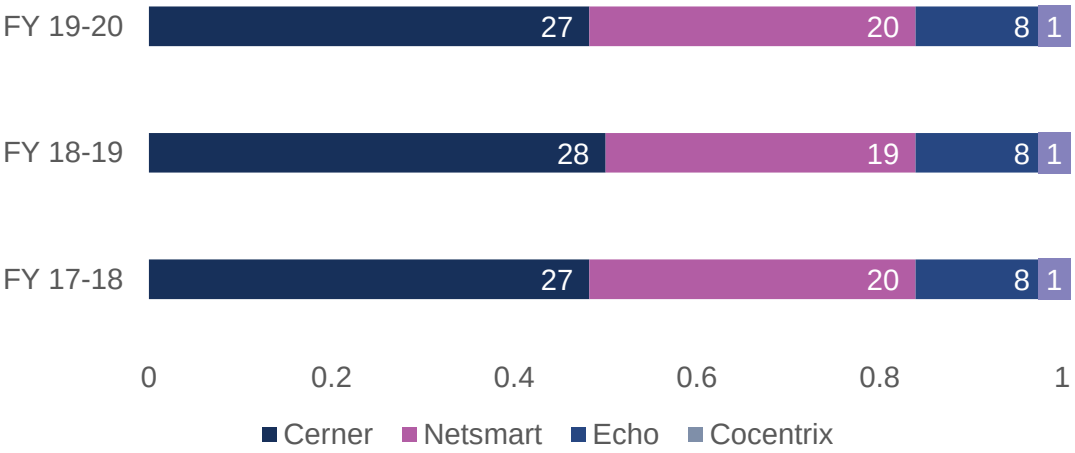
Direct data entry was the leading data exchange method used in FY 2019-20, at 58.7 percent of MHPs. Direct data entry to EHRs means that contract provider employees are entering the beneficiary data into their own EHRs, then logging into the county EHR to enter the same data there. This is inefficient, generally slows down the availability of data, is an ongoing drain on contract provider resources, and is a frequent source of data entry errors (Figure 7-4).

Figure 7-4: Method Used for Data Exchange



California counties have primarily relied on four technology vendors to support HIS in behavioral health: Cerner Corporation, Netsmart Technologies, The Echo Group, and Harris Healthcare Group (Cocentrix), as shown in Figure 7-5.

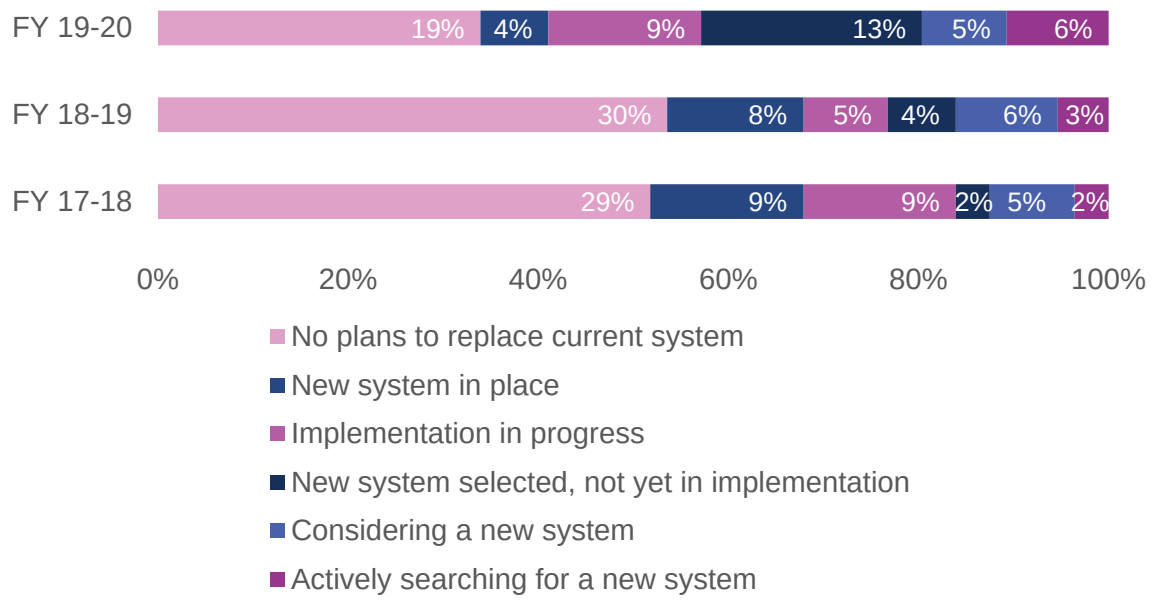
Figure 7-5: EHR Vendor Representation, FY 2017-18 to FY 2019-20



Vendors continue to modify legacy systems to conform to state and federal data collection and reporting standards.

As DHCS requirements continue to shift, an increasing number of MHPs (24) now have plans to change their systems (Figure 7-6). However, few incentives exist to develop the next generation of EHR systems to improve the providers' workflow processes and efficiencies.

Figure 7-6: EHR Replacement Status, FY 2017-18 to FY 2019-20



Summary

The MHP information systems across California continued to be dominated by only a handful of EHR vendors in FY 2019-20. Although CalEQRO has found other EHR vendors serving the organizational contract providers across the state, a lack of electronic HIE often means double data entry or reliance on mostly obsolete modes of data exchange such as fax and paper documents. This creates significant barriers to truly data-driven decision-making processes that can inform quality of care decisions and capture performance and outcome measures.

The landscape of the current information systems is further challenged by rapidly changing requirements at both the federal and state levels in the past decade. Behavioral healthcare has seen far greater evidence for and emphasis on integration of care across the silos that have traditionally divided up beneficiary care such as social services, education systems, law enforcement, justice systems, employment support, and others.

Alongside, the healthcare data integrity and claims processes have also seen significant changes in requirements that reflect greater beneficiary privacy concerns, and attention to access and timeliness related performance of the MHPs in the form of Network Adequacy.

It appears that the MHPs are becoming acutely aware of the limitations of their existing HIS as more of them have started pursuing newer systems in the past three years. Most notably, CalEQRO has found during its FY 2019-20 reviews a surge in the number of MHPs actively

searching for a new system and those having selected a new system, but not in implementation yet.

The primary barrier to selecting and implementing a new information system remains the lack of resources. Most of the MHPs implemented their current legacy systems 10 to 15 years ago using the one-time technology funding from Mental Health Service Act allocations. No such clear and uniform financial incentives exist at present, leaving the MHPs to rely on local funding sources that vary significantly from county to county. The pandemic-related financial issues are likely to negatively affect many of these efforts in the near future.

It is also imperative that DHCS takes a role in specifying factors and functionalities it would need for the newer generation of information systems to function effectively in California's unique SDMC funding environment. Clarity at the state level will help open up the IS marketplace in California. This is a recurring theme that CalEQRO has encountered during its reviews. Potential vendors are often hesitant to invest significant resources to customize their products in the absence of any uniform guidelines at the state level.

Chapter 8

Conclusion and Recommendations

Conclusion and Recommendations

The 56 MHPs had many significant changes this year that affected SMHS, both positively and negatively. Although affecting only 25 percent of the FY 2019-20 review, COVID-19 and its constraints on service capacity, staffing illness and availability, and the need for social distancing had a great impact on the service systems and will continue to do so in the year to come.

Access

Service delivery was a priority for MHPs, with a focus on facilitating access for more culturally diverse beneficiaries. There was increased attention to services for specialized populations or those with particular needs, including youth in foster care, older adults, children from birth to 5 years of age, and beneficiaries experiencing homelessness. MHPs collaborated well with other organizations, including primary health providers, to coordinate a strong system of care to serve high-risk groups in criminal justice and with co-occurring SUDs. Overall, MHPs maintained the same or comparable penetration rate in FY 2019-20 as in the previous year, despite having served fewer Medi-Cal beneficiaries.

Access to care, however, was not without challenges. Two critical challenges were staffing and providing the continuum of care. Many MHPs had workforce shortages and could not maintain sufficient numbers of skilled mental health professionals, particularly in licensed therapists and psychiatrists. MHPs attributed the difficulties in recruitment and retention to competition from private managed care plans, correctional health systems, and neighboring county MHPs. At times, though, the shortage was due to county allocations of resources and/or positions to MHPs.

Acute services, including inpatient care and crisis, both mobile and residential, were not readily available in some MHPs. Beneficiaries had difficulty accessing crisis services after-hours or on weekends. A critique of after-hours access (call) centers was that they functioned more like answering services. Nine MHPs (or 16 percent) noted beneficiaries experiencing difficulties accessing crisis services after hours or on weekends as an opportunity for improvement, although this situation likely extends across many more MHPs. After-hours services in general were not on par with those during business hours.

Several CalEQRO recommendations spoke to these challenges. MHPs were advised to evaluate and enhance service utilization, clinician capacity, and oversight of access (call) centers. Other recommendations were related to these efforts, including employing more

Spanish-speaking mental health professionals, reducing clinician caseloads, and expanding hours and regional availability of crisis services.

Paramount to facilitating access is that MHPs have sufficient financial resources. MHPs vary in budgets and funding streams. Some MHPs have the means to make these system changes to improve beneficiary access and some do not. Alas, as COVID-19 continues, there will be significant and dire consequences for MHP capacity and resources. The way forward will include—or require—some interventions from counties and the state government to enable MHPs to facilitate access for current beneficiaries and likely new beneficiaries.

Timeliness

MHPs delivered more timely services in FY 2019-20 compared to FY 2018-19. In particular, MHPs provided more timely initial appointments and post-hospitalization follow-up appointments. The expansion of telehealth, walk-in appointments, and warm handoff after hospitalization facilitated these timely services. There were, however, services that MHPs struggled to provide timely. Wait times for initial psychiatry appointments and children's services, including for youth in foster care, continue to extend beyond state-mandated standards and represent the most common opportunities for improvement in timeliness.

Improvements in timeliness were aided by enhancements in MHPs' tracking and reporting of timeliness. Many MHPs have automated and electronic monitoring systems that connect to EHRs. Thus, these MHPs are able to provide consistent and reliable measures of timeliness. There are also MHPs that provided timeliness data that included the MHP's network of contract providers. The comprehensiveness of the MHPs' reporting of timeliness was a particular focus of CalEQRO this past year.

It is disconcerting that there are still MHPs that use manual and simple monitoring mechanisms (e.g., Excel spreadsheets) to track timeliness to services. Twenty-six MHPs struggled with tracking timeliness consistently, both for county-operated and contracted services. MHPs noted gaps in IS infrastructure between contractors and county systems that precluded consistent tracking and/or easy transfer of timeliness data. There is variability in the number and diversity of contractor software systems, which also limits transfers of timeliness data.

With greater complexity in service delivery (i.e., multiple service providers and coordination to/from hospitals) and the need for coordination of timely service, rudimentary and disjointed mechanisms for tracking timeliness are untenable. CalEQRO made a number of recommendations for MHPs to use or integrate the scheduling modules in their EHRs and to direct IS/IT or analyst staff to lend support for monitoring timeliness. For several of the MHPs in question, these are not new recommendations. Likely, changes in their monitoring and provisioning of timely access may require influence or a clear stance from DHCS on EHR functionality and interoperability.

Quality of Care and Outcomes

MHPs showed improvements in many areas linked to quality and outcomes. An important positive improvement was the enhancement of medication monitoring practices and policies, which were in place in 72 percent of the counties; access to appropriate medication is one of leading interventions linked to positive mental health outcomes. Another change in MHPs' QM was the increase in goal-directed QI work plans; 69 percent of MHPs had measurable goals in their QI plans and could effectively assess the progress or achievement of the goals in the annual evaluation.

CalEQRO identified three core elements of MHPs that facilitated quality services and positive outcomes for beneficiaries: care coordination, QM infrastructure, and use of outcome tools. Care coordination enabled MHPs to link beneficiaries to appropriate services and to communicate beneficiary needs from request through to the continuum of care providers, in real time. MHPs that had an established infrastructure or framework for QM evidenced use of best practices, scientific evidence, and investments in continuous QI. These MHPs prioritized data and system oversight and used QM as a change agent. Lastly, MHPs that used measurement tools (e.g., CANS, Patient Health Questionnaire-9, and MORS) strived to use these measurements to reflect beneficiary care and provide the MHP with quantitative and qualitive pictures of having an impact on beneficiary outcomes.

Of the areas that CalEQRO evaluates, quality and outcomes are the most challenging for MHPs to demonstrate and show improvement. MHPs capture utilization data and numbers served and many MHPs can provide outcomes for particular populations or programs (e.g., FSP). However, MHPs do not have aggregate measures of the quality and outcomes of their services. Overall, MHPs are hard pressed to present the impact of services and its effect on beneficiaries systemically.

A key factor in MHPs' limited ability to demonstrate quality and outcomes of services is the MHPs' IS/IT. CalEQRO notes that some MHPs are unable to communicate and share beneficiary information electronically (e.g., through an HIE) to coordinate care. MHPs have unmet EHR and IS infrastructure needs, which hinder the MHPs' ability to show the import of services.

The landscape of mental health service delivery is changing. Services and providers are consolidating just as financial resources are limited and constrained. Plans that can demonstrate the positive impact of their services, in addition to showing utilization of services, are at an advantage. MHPs need to prioritize beneficiary outcomes, which may mean consistent use *and* evaluation of outcome measures, integration of HEDIS and NQF measures, and investment in resources to assess and report outcomes.

Recommendations

Key themes for state and local health leadership to improve quality in the MHPs are listed below and are linked to many recommendations in the county reports.

1. Improvements in Access Call Centers and acute and urgent responses to care needs additional improvements and oversight.

2. Timeliness of services can be improved with more integrated technology systems linking access points, contract providers, and—very importantly—having interoperability with other health county systems.

3. Coordination, care management, quality, and managed care improvements can be enhanced with additional investment in IS infrastructure and support staff, including analytics. This is a foundational issue for the MHPs related to their success providing managed care services, particularly in terms of interoperability with network providers and the remainder of the health care systems.

4. CPS data need to be available in a timelier period, ideally within six months of collection, to provide meaningful opportunities for interventions to improve quality by the MHPs.

5. Quality could be enhanced with a defined continuum of care for specialty mental health that offers services from acute, intensive treatments to a least restrictive support program. This will enhance opportunities for optimal treatment for individuals of all ages with serious mental health conditions.

Medi-Cal Specialty Mental Health External Quality Review Report

Appendix 1: SDMC Claim Definitions

Medi-Cal Approved Claims Code Definitions and Data Sources

Last Modified by: Rachel Phillips, Bill Ullom – July 2019 Source: Medi-Cal Aid Code Chart Master – October 18, 2017

Source: Data is derived from statewide source files.

1. Short-Doyle/Medi-Cal approved and denied claims (SD/MC) from the Department of Health Care Services (DHCS)

2. In-Patient Consolidation (IPC) approved claims from DHCS

3. Monthly MEDS Extract File (MMEF) from DHCS

4. State Provider File from DHCS

Selection Criteria:

Medi-Cal beneficiaries for whom the MHP is "County of Fiscal Responsibility" are included, even when the beneficiary was served by another MHP.

Medi-Cal beneficiaries with aid codes eligible for SD/MC program funding are included.

Process Date: The date DHCS processes files for CAEQRO. The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY2017 file with a DHCS process date of May 19, 2018 includes claims with service dates between January 1 and December 31, 2017 processed by DHCS through April 2018.

Most recent MMEF includes Medi-Cal eligibility for April (CY) or October (FY) and 15 prior months.

Service Activity: Defined by Procedure Code and Modifiers.

Service Category	Procedure Codes	Modifiers	Description
Inpatient Services	H2013, H2015	HE, HA, HC	Local Hospital, Psychiatric Health Facility
Inpatient Services	114, 124, 134, 154, 204	(modifiers not used)	In Patient Consolidation (IPC) claims/134 file
Inpatient Services	H0046, 169	HE, HA, HC	Hospital Administrative Days
Inpatient Services	90792, 99214		Professional Inpatient Visits
Crisis Stabilization	S9484	HE, TG	Emergency Room / Urgent Care
Residential Services	H0018	HE, HB, HC	Adult Crisis Residential
Residential Services	H0019	HE, HB, HC	Adult Residential
Day Treatment	H2012	HE, TG	Intensive Day Treatment and Day Rehabilitative
Case Management	T1017	HE, SC, GT, HQ	Case Management/Brokerage
Mental Health Services	H2015, H2017, H0032	HE, SC, GT, HQ	Mental Health Services
Medication Support	H2010, H0034, G8437	HE, SC, GT, HQ	Medication Support
Crisis Intervention	H2011	HE, SC, GT, HQ	Crisis Intervention
TBS	H2019	HE, SC,GT,HQ	Therapeutic Behavioral Services
ICC, IHBS	T1017, H2015	HK	Intensive Care Coordination Intensive Home-Based Services
ICC, IHBS	H2015, H2017, HOO32	HE, SC, GT, HQ	Look-alike Services Demonstration Project Indicator (DPI) = KTA

	H2010, H0034, G8437 T1017		
TFC	S5145	HE	Therapeutic Foster Care

Medi-Cal Approved Claims Code Definitions and Data Sources	
Last Modified by: Rachel Phillips, Bill Ullom - June 2018	Source: Medi-Cal Aid Code Chart Master – October 18, 2017
Data Definitions: Selected elements displayed within this report are defined below.	
Penetration rate	The number of Medi-Cal beneficiaries served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of Medi-Cal eligibles over a 12-month period.
Approved claims per beneficiary served per year	The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year.
Age Group	Age groups are determined by beneficiary's age on January 1 of the reporting calendar or fiscal year.
Eligibility Categories	Medi-Cal aid codes used to report approved claims by eligibility category.
Disabled	2H, 36, 60, 63, 64, 66, 67, 68, 6C, 6E, 6G, 6H, 6N, 6P, 6R, 6V, 6W, 6X, 6Y.
Foster Care	40, 42, 43, 46, 49, 4F, 4G, 4H, 4L, 4N, 4S, 4T, 4W, 5K.
Other Child	Beneficiary age is less than 18 AND one of the following aid codes. 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 2A, 2E, 2P, 2R, 2S, 2T, 2U, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 44, 45, 47, 4A, 4E, 4M, 5C, 5D, 54, 59, 5E, 5F, 6A, 72, 74, 7A, 7C, 7J, 7K, 7S, 7W, 82, 83, 8E, 8G, 8L, 8P, 8R, 8U, 8V, 8W, F3, G5, G7, H7, H8, H9, J1, J2, J5, J7, K1, M3, M5, M7, M9, P1, P2, P3, P4, P5, P7, P9, T1, T2, T2, T3, T4, T5.
Family Adult	Beneficiary age is greater than or equal to 18 AND one of the following aid codes. 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 2A, 2E, 2P, 2R, 2S, 2T, 2U, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 44, 45, 47, 4A, 4E, 4M, 5C, 5D, 54, 59, 5E, 5F, 6A, 72, 74, 7A, 7C, 7J, 7K, 7S, 7W, 82, 83, 8E, 8G, 8L, 8P, 8R, 8U, 8V, 8W, F3, G5, G7, H7, H8, H9, J1, J2, J5, J7, K1, M3, M5, M7, M9, P1, P2, P3, P4, P5, P7, P9,T1, T2, T2, T3, T4, T5.
Other Adult	Beneficiary age is greater than 19 AND one of the following aid codes: 0U, 0V, 1E, 1H, 1U, 1X, 1Y, 10, 13, 14, 16, 17, 3T, 3V, 48, 55, 58, 5F, 5J, 5R, 5S, 5T, 5W, 6J, 6U, 76, 7C, 80, 86, 87, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, G6, G8, J3, J4, J6, J8, M0, M4, M8
MCHIP	Expanded eligibility for certain populations of children (under age 19) as defined in federal law as targeted low-income children who would not otherwise qualify for full-scope Medi-Cal benefits AND one of the following aid codes E6, E7, H0, H1, H2, H3, H4, H5, H9, M5, M6, T0, T1, T2, T3, T4, T5, 5C, 5D, 7X, 8N, 8P, 8T, 8R, 8X.
Affordable Care Act (ACA)	ACA aid codes were effective January 1, 2014. The FFP is 100% from 2014 through 2016. In future years it will step down to 95% for 2017; 94% for 2018; 93% for 2019; 90% for 2020 and thereafter. 7U, L1, M1, M2, N0, N7, N8.

SB-75	Expanded eligibility for children under 19, who are eligible with full-scope medical benefits regardless of immigration status, as long as all other eligibility requirements are met. To be identified as "SB-75 Eligible" beneficiary status (SB-75 flag = "1") is met AND one of the following aid codes. 2H, 23, 24, 27, 3N, 34, 37, 39, 44, 47, 54, 59, 5C, 5D, 6H, 63, 64, 67, 7A, 7J, 72, 82, 83, 8P, 8R, G5, G7, J1, J2, J7, M3, M5, M7, M9, P5, P7, P9, T1, T2, T3, T4, T5. Beneficiary results are included with one of the following eligibility categories: Disabled, Other Child, Family Adult, or MCHIP that corresponds to a combination of each beneficiary's aid code and age group.
EPSDT Eligible Aid Codes	Beneficiary age is less than 21 AND identified with SB-75 status (SB-75 flag = "0") AND one of the following aid codes: 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 20, 23, 24, 26, 27, 2A, 2E, 2H, 2P, 2R, 2S, 2T, 2U, 30, 32, 33, 34, 35, 36, 37, 38, 39, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 40, 42, 43, 44, 45, 46, 47, 49, 4A, 4E, 4F, 4G, 4H, 4L, 4M, 4N, 4P, 4R, 4S, 4T, 4W, 54, 59, 5C, 5D, 5E, 5K, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6N, 6P, 6V, 6W, 6X, 6Y, 72, 7A, 7J, 7S, 7U, 7W, 8E, 8G, 8L, 8P, 8R, 8U, 8V, 8W, 8X, E6, E7, G5, G7, H0, H1, H2, H3, H4, H5, H6, H7, H8, H9, J1, J2, J7, K1, L1, M1, M3, M5, M7, M9, P1, P2, P3, P5, P7, P9, T1, T2, T3, T4, T5.
Excluded aid codes - not SDMC funded or inactive in MEDS.	0, 00, 0R, 0T, 09, 18, 28, 2G, 31, 3J, 3K, 3X, 3Y, 41, 4C, 4K, 4P, 4R, 50, 51, 53, 56, 5X, 5Y, 61, 62, 65, 68, 69, 6D, 6F, 6K, 6M, 6T, 74, 78, 7K, 7M, 7N, 7P, 7R, 7X, 81, 82, 83, 84, 85, 86, 87, 88, 89, 8A, 8F, 8H, 8Y, 9A, 9C, 9E, 9F, 9G, 9H, 9J, 9K, 9M, 9N, 9R, 9S, 9X, FX, IE, R1, RR, C5, C6, E2, E4, E5, G0, G1, G2, G9, L2, L3, L4, L5, N5, N6, N9, P0, P8.
Eligibility Status	Three-byte code – Byte one reflects beneficiary's eligibility status; Byte two Medi-Cal ID card issuance; Byte three Pre/Post eligibility status information and eligibility established for retroactive months.
	1st Digit =Medi-Cal/CMSP/Other Eligible Status **0** Eligible with no conditions (includes zero SOC) **1** Share of Cost to be met by LTC claim **2** LTC/SOC plus other conditions (i.e.1+3) **3** Other conditions-Certified SOC, Restricted Service, Minor Consent or Partial Health Care Plan **4** Medi-Cal eligible with Full Service Medi-Cal Health Care Plan Coverage **5** Unmet Share of Cost Obligation (Uncertified SOC) **6** Health and Welfare Program other than Medi-Cal/MSP eligible (SLMB, QDWI, Out –of –State Foster Care, Unborn, Healthy Families, County MI, CHDP State Only, MCE State & County, HCCI, AIM Pregnant Mother) **7** Hold **8** QMB pending Medicare part A & B confirmation **9** Ineligible **2nd Digit =Normal/Exception Eligibility** **0** Normal Eligible **1** Unconfirmed Immediate Need eligible reported more than 1 month prior

	2 Unconfirmed Immediate Need Eligible reported 1 month prior **3** Unconfirmed Immediate Need Eligible reported in current month **4** Forced eligible due to late termination **5** Partial Month Eligibility (Healthy Families, etc) **7** Exception eligible **8** Forced eligible from MEDS hold **9** Full Month Eligibility (Healthy Families, etc) **3rd Digit=Timeliness /Misc. Information** **1** Regular eligible reported timely **2** Regular eligible reported retroactively **3** 3 month retroactive eligible **4** Continuing eligible reported timely **5** Continuing eligible reported retroactively **6** Ramos/Pickle/IHSS/Other Extended eligible **7** Aid Paid Pending Ramos/Myers **8** Hold from LTC/SOC status **9** Ineligible or Regular hold
Share of Cost	Beneficiaries with monthly share of cost are obligated to meet (spent down to $0) before being considered Medi-Cal eligible and claims are approved for payment. Beneficiaries with SOC are not included in "Average Number of Eligibles per Month" count for any month until SOC is zero dollars for any month.

MEDS Race/Ethnicity Codes			
1 = White	2 = Hispanic/Latino	3 = Black	4 = Asian/Pacific Islander
5 = Alaska Native or American Indian	7 = Filipino	8 = No valid data reported	9 = Decline to state
A = Amerasian	C = Chinese	H = Cambodian	J = Japanese
K = Korean	M = Samoan	N = Asian Indian	P = Hawaiian
R = Guamanian	T = Laotian	V = Vietnamese	Z = Other

Race/Ethnicity Groups	**MEDS Code**
White	1
Hispanic/Latino	2
African American	3

Asian/Pacific Islander	4, 7, A, C, H, J, K, M, N, P, R, T, V		
Native American	5		
Other/Decline or Missing Data	8, 9, Z		
Beneficiary Primary Languages	**MEDS Code**		
0 = American Sign	1 = Spanish	2 = Cantonese	3 = Japanese
4 = Korean	5 = Tagalog	6 = Other Non-English	7 = English
8 = No Valid Data Reported	9 = No Response, Client Declined	A = Other Sign Language	B = Mandarin
C =Other Chinese Languages	D = Cambodian	E = Armenian	F = Ilocano
G = Mien	H = Hmong	I = Lao	J = Turkish
K = Hebrew	L = French	M = Polish	N = Russian
P = Portuguese	Q = Italian	R = Arabic	S = Samoan
T = Thai	U = Farsi	V = Vietnamese	
Primary Language Groups	Under development	**MEDS Code**	
English	7		
Spanish	1		
Threshold Languages – exclude Sp.	2, 4, 5, B, C, D, E, H, N, R, U, V		
Non-Threshold Languages	3, 6, F, G, I, J, K, L, M, P, Q, S, T		
Sign Languages	0, A		
Decline to State/Missing Data	8, 9		
County Codes	**MEDS Code**		
01 = Alameda	02 = Alpine	03 = Amador	04 = Butte
05 = Calaveras	06 = Colusa	07 = Contra Costa	08 = Del Norte
09 = El Dorado	10 = Fresno	11 = Glenn	12 = Humboldt
13 = Imperial	14 = Inyo	15 = Kern	16 = Kings
17 = Lake	18 = Lassen	19 = Los Angeles	20 = Madera
21 = Marin	22 = Mariposa	23 = Mendocino	24 = Merced
25 = Modoc	26 = Mono	27 = Monterey	28 = Napa
29 = Nevada	30 = Orange	31 = Placer/Sierra	32 = Plumas
33 = Riverside	34 = Sacramento	35 = San Benito	36 = San Bernardino
37 = San Diego	38 = San Francisco	39 = San Joaquin	40 = San Luis Obispo
County Codes	**MEDS Code**		
41 = San Mateo	42 = Santa Barbara	43 = Santa Clara	44 = Santa Cruz
45 = Shasta	47 = Siskiyou	48 = Solano	49 = Sonoma
50 = Stanislaus	51 = Sutter/Yuba	52 = Tehama	53 = Trinity
54 = Tulare	55 = Tuolumne	56 = Ventura	57 = Yolo

Counties by DHCS Regions	**County Code**
Bay Area	01, 07, 21, 27, 28, 35, 38, 41, 43, 44, 48, 49
Central	02, 03, 05, 09, 10, 16, 20, 22, 24, 26, 31, 34, 39, 50, 51, 54, 55, 57
Los Angeles	19
Southern	13, 15, 30, 33, 36, 37, 40, 42, 56

Superior	04, 06, 08, 11, 12, 14, 17, 18, 23, 25, 29, 32, 45, 47, 52, 53	
Counties by DHCS County Sizes	**County Code**	**Population**
Small-Rural	02, 03, 05, 06, 08, 11, 14, 18, 22, 25, 26, 32, 47, 53	<50,000
Small	09, 12, 13, 16, 17, 20, 23, 28, 29, 35, 45, 51, 52, 55	50,000 to 199,999
Medium	04, 21, 24, 27, 31, 39, 40, 41, 42, 44, 48, 49, 50, 54, 57	200,000 to 749,999
Large	01, 07, 10, 15, 30, 33, 34, 36, 37, 38, 43, 56	750,000 to 3,999,999
Very Large	19	>4,000,000
Diagnosis Groups – ICD 10	Under development **Diagnosis Codes From SD/MC Claims**	
Depressive Disorders	F39, F348, F338, F349, F341, F329, F320, F321, F322, F323, F324, F325, F3340, F339, F330, F331, F332, F333, F3341, F3342, F328	
Psychotic Disorders	F201, F202, F200, F2081, F205, F250, F251, F258, F259, F203, F209, F22, F24, F23, F28, F29	
Disruptive Disorders	F900, F902, F901, F909, F911, F912, F919, F913	
Bipolar Disorders	F3010, F309, F3011, F3012, F3013, F302, F303, F304, F310, F3189, F3110, F3111, F3112, F3113, F312, F3173, F3174, F3130, F3131, F3132, F39, F338, F348, F349, F314, F315, F3175, F3176, F3160, F3161, F3162, F3163, F3164, F3177, F3178, F319, F319, F308, F3181, F328, F348, F349	
Anxiety Disorders	F430, F419, F410, F411, F413, F418, F42, F4310, F4311, F4312, F4001	
Adjustment Disorders	F930, F4321, F4322, F4323, F4324, F4325, F4310, F4311, F4312, F4320	
DEFERRED	R69, Z0389	
OTHER	Other ICD-10 codes not listed above which were submitted thru SDMC claim transactions	

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Appendix 2: List of MHPs by Size and Region

List of MHPs

MHP County	MHP Size	MHP Region
Alameda	Large	Bay Area
Alpine	Small-rural	Central
Amador	Small-rural	Central
Butte	Medium	Superior
Calaveras	Small-rural	Central
Colusa	Small-rural	Superior
Contra Costa	Large	Bay Area
Del Norte	Small-rural	Superior
El Dorado	Small	Central
Fresno	Large	Central
Glenn	Small-rural	Superior
Humboldt	Small	Superior
Imperial	Small	Southern
Inyo	Small-rural	Central
Kern	Large	Southern
Kings	Small	Central
Lake	Small	Superior
Lassen	Small-rural	Superior
Los Angeles	Very Large	Los Angeles
Madera	Small	Central
Marin	Medium	Bay Area
Mariposa	Small-rural	Central
Mendocino	Small	Superior
Merced	Medium	Central
Modoc	Small-rural	Superior
Mono	Small-rural	Central
Monterey	Medium	Bay Area
Napa	Small	Bay Area
Nevada	Small	Superior
Orange	Large	Southern
Placer	Medium	Central
Plumas	Small-rural	Superior
Riverside	Large	Southern
Sacramento	Large	Central
San Benito	Small	Bay Area
San Bernardino	Large	Southern
San Diego	Large	Southern
San Francisco	Large	Bay Area
San Joaquin	Medium	Central
San Luis Obispo	Medium	Southern
San Mateo	Medium	Bay Area
Santa Barbara	Medium	Southern
Santa Clara	Large	Bay Area

MHP County	MHP Size	MHP Region
Santa Cruz	Medium	Bay Area
Shasta	Small	Superior
Sierra	Medium	Central
Siskiyou	Small-rural	Superior
Solano	Medium	Bay Area
Sonoma	Medium	Bay Area
Stanislaus	Medium	Central
Sutter	Small	Central
Tehama	Small	Superior
Trinity	Small-rural	Superior
Tulare	Medium	Central
Tuolumne	Medium	Central
Ventura	Large	Southern
Yolo	Medium	Central
Yuba	Small	Central

MHPs by Size

MHP County	MHP Size	MHP Region
Alpine	Small-rural	Central
Amador	Small-rural	Central
Calaveras	Small-rural	Central
Colusa	Small-rural	Superior
Del Norte	Small-rural	Superior
Glenn	Small-rural	Superior
Inyo	Small-rural	Central
Lassen	Small-rural	Superior
Mariposa	Small-rural	Central
Modoc	Small-rural	Superior
Mono	Small-rural	Central
Plumas	Small-rural	Superior
Siskiyou	Small-rural	Superior
Trinity	Small-rural	Superior
El Dorado	Small	Central
Humboldt	Small	Superior
Imperial	Small	Southern
Kings	Small	Central
Lake	Small	Superior
Madera	Small	Central
Mendocino	Small	Superior
Napa	Small	Bay Area
Nevada	Small	Superior
San Benito	Small	Bay Area
Shasta	Small	Superior
Sutter	Small	Central
Tehama	Small	Superior
Yuba	Small	Central
Butte	Medium	Superior
Marin	Medium	Bay Area
Merced	Medium	Central
Monterey	Medium	Bay Area
Placer	Medium	Central
San Joaquin	Medium	Central
San Luis Obispo	Medium	Southern
San Mateo	Medium	Bay Area
Santa Barbara	Medium	Southern
Santa Cruz	Medium	Bay Area
Sierra	Medium	Central
Solano	Medium	Bay Area
Sonoma	Medium	Bay Area
Stanislaus	Medium	Central
Tulare	Medium	Central

Tuolumne	Medium	Central
Yolo	Medium	Central
Alameda	Large	Bay Area
Contra Costa	Large	Bay Area
Fresno	Large	Central
Kern	Large	Southern
Orange	Large	Southern
Riverside	Large	Southern
Sacramento	Large	Central
San Bernardino	Large	Southern
San Diego	Large	Southern
San Francisco	Large	Bay Area
Santa Clara	Large	Bay Area
Ventura	Large	Southern
Los Angeles	Very large	Los Angeles

MHPs by Region

MHP County	MHP Size	MHP Region
Alameda	Large	Bay Area
Contra Costa	Large	Bay Area
Marin	Medium	Bay Area
Monterey	Medium	Bay Area
Napa	Small	Bay Area
San Benito	Small	Bay Area
San Francisco	Large	Bay Area
San Mateo	Medium	Bay Area
Santa Clara	Large	Bay Area
Santa Cruz	Medium	Bay Area
Solano	Medium	Bay Area
Sonoma	Medium	Bay Area
Alpine	Small-rural	Central
Amador	Small-rural	Central
Calaveras	Small-rural	Central
El Dorado	Small	Central
Fresno	Large	Central
Inyo	Small-rural	Central
Kings	Small	Central
Madera	Small	Central
Mariposa	Small-rural	Central
Merced	Medium	Central
Mono	Small-rural	Central
Placer	Medium	Central
Sacramento	Large	Central
San Joaquin	Medium	Central
Sierra	Medium	Central
Stanislaus	Medium	Central
Sutter	Small	Central
Tulare	Medium	Central
Tuolumne	Medium	Central
Yolo	Medium	Central
Yuba	Small	Central
Los Angeles	Very Large	Los Angeles
Imperial	Small	Southern
Kern	Large	Southern
Orange	Large	Southern
Riverside	Large	Southern
San Bernardino	Large	Southern
San Diego	Large	Southern
San Luis Obispo	Medium	Southern
Santa Barbara	Medium	Southern
Ventura	Large	Southern

Butte	Medium	Superior
Colusa	Small-rural	Superior
Del Norte	Small-rural	Superior
Glenn	Small-rural	Superior
Humboldt	Small	Superior
Lake	Small	Superior
Lassen	Small-rural	Superior
Mendocino	Small	Superior
Modoc	Small-rural	Superior
Nevada	Small	Superior
Plumas	Small-rural	Superior
Shasta	Small	Superior
Siskiyou	Small-rural	Superior
Tehama	Small	Superior
Trinity	Small-rural	Superior

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Appendix 3: County Population Breaks for Size

County Population Breaks for Size

County Size	Population
Small-rural	<54,999
Small	55,000 to 199,999
Medium	200,000 to 749,999
Large	750,000 to 3,999,999
Very Large	>4,000,000

California Department of Finance—Demographic Research Unit

Report E-1: Population Estimates for Cities, Counties, and the State

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Appendix 4: Summary of Beneficiary and Family Member Perspectives

Introduction

Consumer and Family Member (CFM) and stakeholder voices are an integral part of the CalEQRO review process and arguably the ultimate indicator of the success of any mental health system.

A stakeholder is an individual of any age or family member whose life is affected by serious mental illness (SMI). Stakeholder involvement in the review process elevates CalEQRO's findings and infuses first-hand knowledge in a meaningful way into the success of the local mental health system.

During FY 2019-20, 75 CFM focus groups were conducted among 41 MHPs. With the onset of COVID-19 and Sheltering in Place, CFM focus groups were suspended. As a result, no CFM focus groups were conducted for 15 MHPs. One virtual CFM focus group was conducted. (CFM FG Summary Revised v2) Interpreters were used among 18 focus groups.

Among these focus groups, 391 beneficiary and/or family members participated as shown in Table 1. (CFM FG Survey Analysis)

Table 1: CFM Focus Group Participants by Age

Age	Count	Percent
0-17	26	6.65%
18-24	38	9.72%
25-59	255	65.22%
60+	70	17.90%
Grand Total	**391**	**100%**

The majority of participants were between the ages of 25-59. The majority (62%) self-reported as female.

Table 2: CFM Focus Group Participants by Race/Ethnicity

Race/Ethnicity	Count	Percent
African American/Black	34	8.7%
Asian American/Pacific Islander	24	6.14%
Caucasian/White	128	32.74%
Hispanic/Latino	139	35.55%
Native American	12	3.07%
Other	54	13.81%
Grand Total	**391**	**100%**

Over one-third of participants self-reported as Hispanic/Latino, and almost one-third as Caucasian/White. (CFM FG Survey Analysis)

The preferred language was English (76%) followed by Spanish (16%). (CFM FG Survey Analysis)

Access

For almost all satisfaction indicators, across all county sizes, average scores were positive or very positive (score of 4 or more). (FY19-20_MH CFM FG_2020 0810-CFM3)

Beneficiaries generally were aware of mental health resources in their community and how to access them. Participants felt well-informed regarding community mental health through the MHP offices, the wellness center and through case managers.

Those with children were less satisfied with access to services for children. Participants with children new to the system reported long wait times.

Additionally, CFMs from small counties were less satisfied, particularly regarding ease of finding treatment services when needed. (FY19-20_MH CFM FG_2020 0810-CFM3)

CFMs from small counties were less satisfied than participants from other sized MHPs regarding feeling comfortable calling the program for help with an urgent problem. (FY19-20_MH CFM FG_2020 0810-CFM3)

Among new participants, the majority found entry into the system was handled efficiently. Most new CFMs were satisfied with the amount of time it took to start services. All were connected with services almost immediately. New participants were referred for services through a variety of means including the wellness center, probation, walk-in and self-referral.

When made available, transportation is acknowledged to facilitate access to services. Some counties offer transportation vouchers or go as far as providing transportation directly. Bus passes and rides may be provided through case managers. Transportation tends to be primarily offered to help get beneficiaries to groups and to their appointments.

Some beneficiaries have even been able to have their medications delivered to them.

However, transportation is not always available, or at least not consistently, for those who need it most.

Interpreter services are widely available, most commonly in written materials in threshold languages. Most CFMs seemed to know what types of translations are available depending on where they receive services, such as in print materials, language lines, or interpreters.

Timeliness

Most beneficiaries were satisfied with the amount of time it took to start services. All were connected with services almost immediately and would describe the process as positive.

Beneficiaries perceived they could get urgent care appointments by walking into the MHP office, calling for appointments, or through case managers.

However, more than 11% of beneficiaries did not feel like they could get treatment services when needed. (FY19-20_MH CFM FG_2020 0810--CFM1)

Beneficiaries are able to see providers (therapists, psychiatrists) on a regular basis. Participants received weekly, bi-weekly and monthly therapy. On balance, BFS felt that the frequency of services

was sufficient to improve functioning. However, for some this was an insufficient frequency for their therapy visits.

Some participants had longer than two weeks delay in getting an appointment for assessment.

Timeliness of appointments often depended on urgency. If a crisis arises, participants all have a crisis number to call. Beneficiaries were both aware of how to access urgent/crisis services and were able to get urgent care when they need it. They were also aware of warm lines and after-hours contact information. Some of the participants who have had to seek urgent care, reported calling their program or case manager, and some reported calling mobile response, or in some situations the police. (Contra Costa)

However, these experiences do not necessarily hold true for psychiatry. Many new participants reported lengthy wait times for psychiatry. Minimum wait times of one month were not uncommon. Observations of some participants was that there did not appear to be enough psychiatrists and clinicians.

Ongoing beneficiaries noted inconsistencies with psychiatric coverage and long waits between appointments. Even those with a regular psychiatrist agreed that psychiatry appointments were difficult to schedule and at times they must wait a month or longer for an appointment.

These delays were more pronounced among those seeking services on behalf of children and youth. Those whose children see a psychiatrist experienced significant wait times and were worried about inadequate numbers of providers.

However, psychiatry appointments can be difficult to schedule on a timely basis. Additionally, beneficiaries felt they needed more time with the psychiatrist during each visit. There was a universal sense that their psychiatry sessions are too hurried.

Some beneficiaries went outside the system to get an evaluation. It was not uncommon to hear about CFMs who sought services from private psychiatrist instead.

Quality

Overall and statewide, beneficiaries were satisfied or very satisfied with various aspects of services (upwards of 80%). (FY19-20_MH CFM FG_2020 0810--CFM1)

Participants were most positive about feeling like they can recommend their counselor(s) to friends and family if they need support and help (54.4%) (FY19-20_MH CFM FG_2020 0810--CFM1)

Beneficiaries at Medium and Small-rural counties tend to be more positive about services than in other sized counties. (FY19-20_MH CFM FG_2020 0810--CFM3)

The highest degree of agreement (4.6) was among Small-rural beneficiaries finding it helpful to work with one’s counselor(s) on solving life problems.

There were subtle, yet important differences in satisfaction between English speaking and Spanish-speaking beneficiaries. (FY19-20_MH CFM FG_2020 0810--CFM4)

Spanish speaking beneficiaries were notably more positive about the sensitivity of counselors to cultural background (race, religion, language, older adult, SOGIE, etc.). (FY19-20_MH CFM FG_2020 0810--CFM4)

They were also more positive about feeling like they can recommend counselors to friends and family if they need support and help. (FY19-20_MH CFM FG_2020 0810--CFM4)

Telehealth

Participants had mixed reactions to telehealth but admitted that it was one way to receive services if it was not possible to get a clinic appointment. Some appreciated the opportunity to have an appointment via telehealth, when they might not have been able to get an appointment at a clinic. They would prefer to have telehealth sessions at home versus in the office where they meet with a psychiatrist via a screen. Some participants found it to be impersonal.

Involvement in Care Planning

Most beneficiaries report being actively involved in their treatment and care planning. Beneficiaries report satisfaction with groups, support, and information that the wellness centers provide. These include information on education and employment.

Beneficiaries tend to have WRAP plans, or something comparable, as well as case management. Most do have a PCP that communicates with psychiatrist on a regular basis.

It was uncommon for a CFM to perceive that their input is not being sought in their care planning.

Families reported being involved in treatment and care planning but were unaware of whether their primary care doctor and psychiatrist communicated about their treatment. Services were found to be very helpful and of high quality, and participants stated that their children's mental health issues were improving.

They reported that they have made progress since beginning services. The participants felt that their programs provided supports (e.g., housing, immigration/legal assistance, and opportunities to socialize with other youth) that they may not have received at other programs.

Wellness Centers and Recovery

Wellness centers were often cited as an important source of recovery by beneficiaries. NAMI was frequently mentioned as an important community resource. Participants reported that clinicians other MHP staff, and presumably the wellness center staff, were their primary sources of information about services. The wellness centers provided additional support and "filled the gap" when participants needed care outside of regular appointments.

Sometimes beneficiaries felt that the limited days and hours of operation for the wellness and recovery center was a limitation.

National Alliance on Mental Illness (NAMI) is another regular source of support among CFMs.

Peers as Employees

In nearly all MHPs, consumers work for and/or volunteer within the MHP. Consumer employees and volunteers play important roles in MHP systems and their feedback can add valuable insights about the overall system, as well as about wellness and recovery.

Peer employees tended to be referred for employment through a personal contact, and sometimes this includes the person's case manager or therapist. Others found peer work through county websites, job boards and word-of-mouth at local wellness centers.

Consumer employees filled a variety of roles throughout the MHP. These include:

- Peer support
- Wellness center
- Transportation
- Hope/lived experience

Consumer employees received a variety of training at the beginning and throughout their employment, that may have included:

- W.R.A.P
- Workforce Integration Support and Education (WISE)
- Abuse reporting, trauma informed care, crisis
- Peer Support Specialist training
- Use of electronic health records and HIPPA
- Cultural competence

While few beneficiary employees expressed obstacles in obtaining peer positions, there were some challenges that they noted. The most common of these challenges was the lack of a career ladder for advancement. Sometimes there were informal mechanisms, but it was not transparent how to move forward. Sometimes this would require further education to advance, but peers did not have the means to do this.

It was noted that some MHPs have unofficial career ladder for those with lived experience, but formal job classifications do not specifically mention lived experience.

MHPs tend to hire and/or promote from within. For example, an MHP may provide assistance to peers to gain the necessary education or skills to qualify. For example, the peer may have started as volunteer, advanced to a paid peer support position, followed by case management, patients' rights advocacy and a supervisory role.

CFM Recommendations

Below is a summary of key recommendations made by beneficiaries and family members during focus groups.

- Expanding transportation assistance
- Hiring more bilingual staff
- Adding parent support groups
- Adding more support groups, on a variety of topics
- Expanding psychiatry availability
- Expanding access to mental health services in schools
- Adding support groups for young children below the age of ten years, particularly for anxiety and depression
- Increasing focus of schools on mental health education, particularly around stigma.
- Expanding outreach is needed for the homeless, particularly for families who are homeless.
- Providing more volunteer and/or employment opportunities for people with lived experience.
- Investing in community awareness about mental health and stigma.

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Appendix 5: Performance Improvement Projects

Introduction

A Performance Improvement Project (PIP) is "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner."[12] Each PIP is expected to produce beneficiary-focused outcomes. The CMS *Validating Performance Improvement Projects* protocol specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, or were completed during the reporting year.[13] Accordingly, for this Annual Report, CalEQRO examined projects that were underway at some time during the 12 months preceding the FY 2019-20 reviews.

During the 12 months preceding the review, each MHP is required to conduct two PIPs: one clinical and one non-clinical.

Methods

The PIP Implementation and Submission Tool (also referred to as the Road Map or PIP Development Outline) is a template provided by CalEQRO for the MHPs to use when drafting their PIP narratives.[14] Prior to the onsite review, the MHPs are to submit both PIPs to CalEQRO. The designated CalEQRO Quality Reviewer and the CalEQRO PIP Consultant review all submitted PIPs for clarity, applicability, and relevance to the MHP's population, methodology used, and appropriateness of data and data collection tools, among other features.

During the review, the CalEQRO team conducts two PIP sessions with the MHP to discuss the documentation provided. During these sessions, the team provides feedback and TA for strengthening the submitted PIPs. Following the onsite review, MHPs are allowed to resubmit their PIPs with any changes or additions discussed during the onsite review. The CalEQRO Quality Reviewer reviews and validates any resubmitted PIPs in accordance with the requirements of CMS Protocol 3.[15] All PIPs are rated based on their completeness and compliance with the standards found in the CMS protocols.[16] Each of the nine PIP steps includes subsections containing standards that are rated according to the PIP Validation Tool.[17]

The PIP rating steps are shown in Table 3-1, below:

[12] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). *Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0*, September 2012. Washington, DC: Author.

[13] Ibid.

[14] To view the PIP Development Outline, visit CalEQRO's website: http://caleqro.com/#!california_eqro_resources/MHP. The tool is found under Notification Materials/MHP Notification Materials__Review Preparation Materials.

[15] Ibid.

[16] Ibid.

[17] The PIP Validation Tool is available from CalEQRO's Website, www.caleqro.com.

Table 3-1: PIP Rating Steps

Step	PIP Section
1	Selected Study Topics
2	Study Question
3	Study Population
4	Study Indicators
5	Sampling Methods
6	Data Collection Procedures
7	Assess Improvement Strategies
8	Analysis and Interpretation of Study Results
9	Validity of Improvement

All PIP subsections receive a rating of Met, Partially Met, Not Met, Not Applicable, or Unable to Determine.

A rating of Met or Partially Met weighs positively into the overall average rating received by the PIP. Each Met item receives two points, while each Partially Met item receives one point.

The overall average rating for each PIP is calculated using the following formula:

$$\frac{(Number\ Met\ \times\ 2) + (Number\ Partially\ Met)}{Number\ of\ Applicable\ Items\ \times 2}$$

Table 3-2 shows the categories and definitions of PIP status. Only Active or Completed PIPs are rated. PIP submissions that were rated as Concept Only, Not Yet Active (and did not receive ratings for each PIP step) are not included in the tabulations in the figures and tables in this section.

A PIP is considered to have satisfied PIP requirements (i.e., met the standard) if the PIP is either Active and Ongoing or has been Completed.

Table 3-2: PIP Status—Categories and Definitions

PIP Status	Definition
Active and Ongoing	Baseline established on at least some of the indicators and at least some interventions have started. Any combination of these is acceptable.
Completed	In the past 12 months or since the prior EQR, the work on the PIP has been completed.
Concept Only, Not Yet Active	Baseline may have been established, but interventions have not started. This is NOT an active PIP.
Inactive, Developed in a Prior Year	Rated last year and not rated this year. MHP has done work on it, but it has not yet started, or it has been suspended for some reason. This is NOT an active PIP.
Submission Determined Not to be a PIP	The write-up does not contain a plan, data, and/or has no indication where data will come from. This is NOT an active PIP.

Findings

This year the number of PIPs submitted increased, as did those that were determined to be Active (Table 3-3). Of the 112 possible PIPs that could have been submitted (if all 56 MHPs submitted two PIPs as required), 104 PIPs were submitted for review, or 93 percent of the total possible. Of these, 86 percent met the PIP standard of being either Active and Ongoing or Completed.

This past year also saw a reduction in the number of PIPs submitted without documentation.

Table 3-3: PIP Submission Status

Submission Status	2019-20 Number	2019-20 Percent	2018-19 Number	2018-19 Percent
PIPs submitted	104	93%	100	89%
Active and Ongoing or Completed	86	77%	79	71%
Concept Only, Not Yet Active	12	11%	17	15%
Inactive, Developed in a Prior Year	6	5%	3	3%
Submission determined not to be a PIP	7	6%	8	7%
No documentation submitted	1	1%	5	4%
Total possible PIPs	112	100%	112	100%

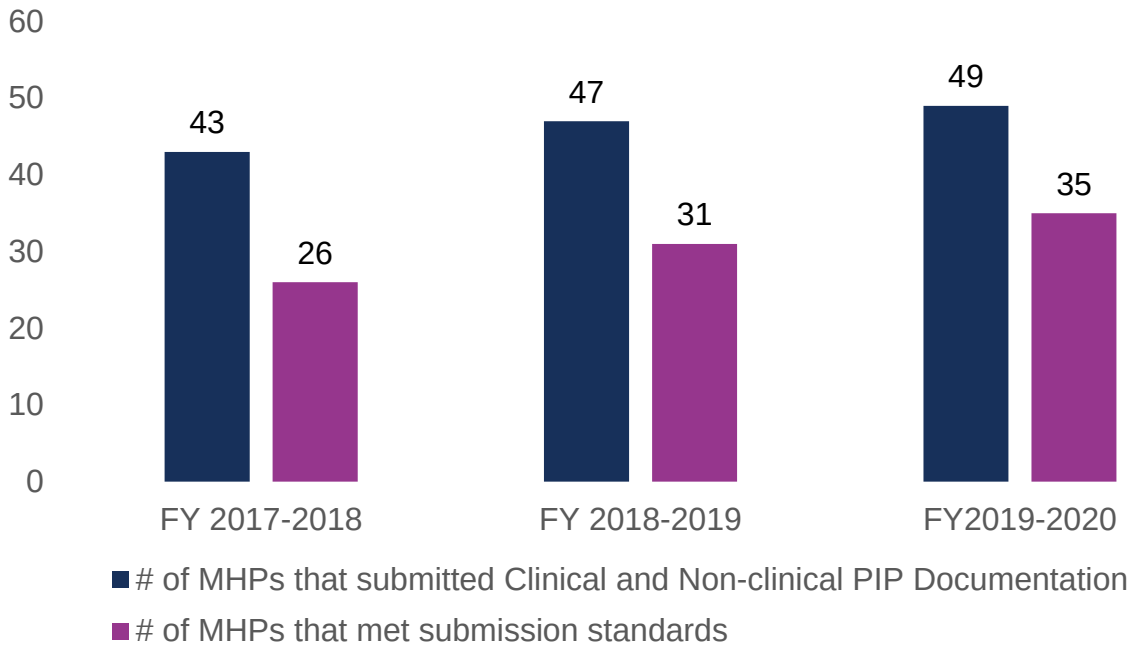
Trends in PIP Submissions

This year, there was a continued increase in the number of MHPs that submitted both clinical and non-clinical PIP documentation. For 49 of the 56 MHPs, documentation was submitted for both clinical and non-clinical PIPs (Figure 3-1). This represents improvement over previous years.

For FY 2019-20, 63 percent of MHPs (35 of 56) submitted both clinical and non-clinical PIPs that were rated as Active and Ongoing or Completed. The rates were 55 percent in FY 2018-19 and 46 percent in FY 2017-18 (Figure 3-1).

Figure 3-1: Submission of Clinical and Non-clinical PIPs, FY 2017-18 to FY 2019-20

The number of MHPs that have submitted clinical and non-clinical PIP documentation has increased over three years.



For FY 2019-20, 22 PIPs were rated as Completed (20 percent of required PIP submissions), including 11 Clinical and 11 Non-clinical PIPs. This is a decrease from the 23 PIPs (21 percent of required PIP submissions) that were rated as Completed for FY 2017-18 and an increase from the 16 PIPs (14 percent of required PIP submissions) that were rated as Completed for FY 2018-19 (Figure 3-2 and Figure 3-3).

For FY 2019- 20, the number of non-clinical PIPs that were found to be Active and Ongoing or Completed increased and was higher than any of the last three reporting years (Figure 3-3).

Figure 3-2: FY 2017-18 to FY 2019-20 Clinical PIP Submissions

The percentage of Completed Clinical PIPs almost doubled over the prior year.

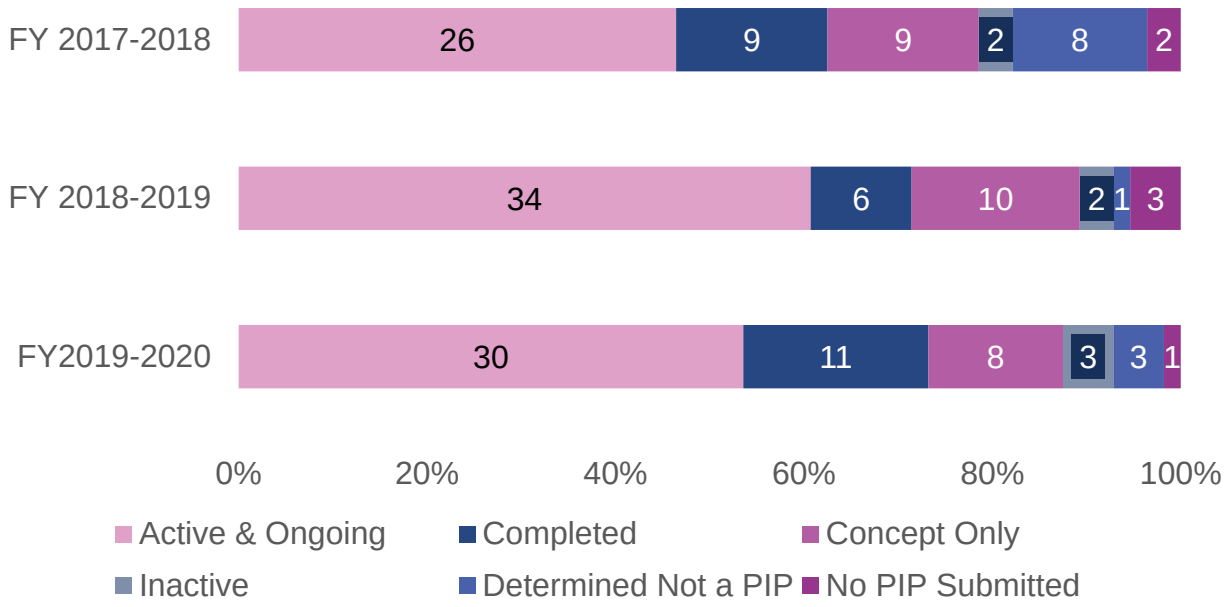
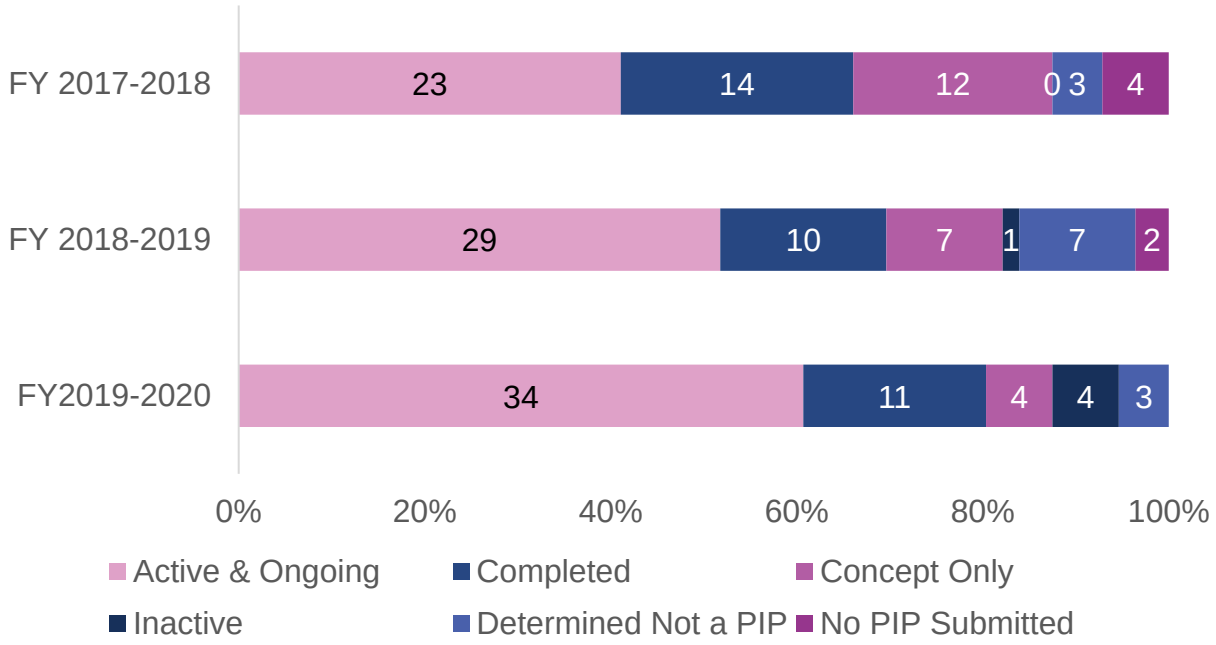


Figure 3-3: FY 2017-18 to FY 2019-20 Non-clinical PIP Submissions

The number of non-clinical PIPs that are Active and Ongoing continued to increase.



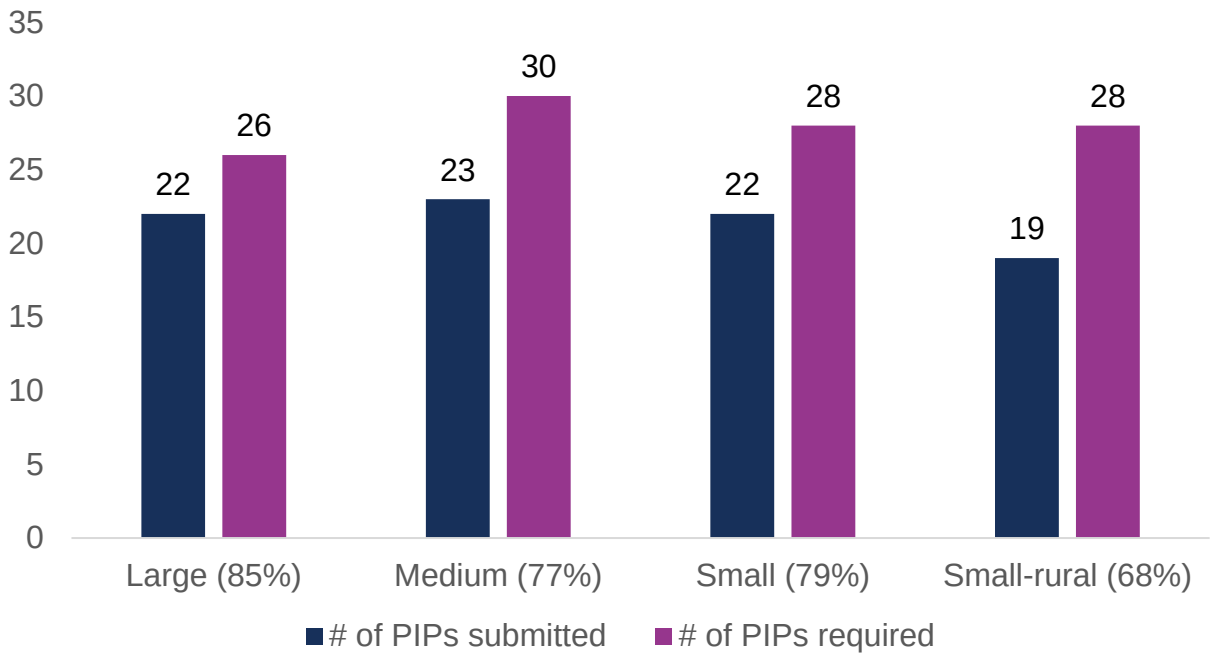
During FY 2019-20, the number of clinical PIP submissions that met the standard of Active and Ongoing or Completed ranged from a high of 85 percent (11 out of 13 Large MHPs) to a low of 64 percent (9 out of 14 Small-rural MHPs). While the overall percentage of clinical PIP submissions that met the standard of Active and Ongoing or Completed was 73 percent (Figure 3-2). During this same period, small sized MHPs had the highest rate of submissions that met the standard for non-clinical PIPs at 86 percent (12 out of 14 MHPs), while small-rural MHPs had the lowest rate of submissions that met the standard for non-clinical PIPs at 71 percent (10 out of 14 MHPs). While the overall percentage of non-clinical PIP submissions that met the standard of Active and Ongoing or completed was 80 percent (Figure 3-3).

When compared to FY 2017-18 and FY 2018-19, FY 2019-20 had more submissions that met the submission standards from all MHP categories. FY 2019-20 saw a total of 41 clinical and 45 non-clinical PIPs meeting the submission standards (Figure 3-2 and Figure 3-3).

For FY 2019-20, more medium MHPs met the submission standard of two Active and Ongoing or Completed PIPs than any other size MHP (Figure 3-4).

Figure 3-4: FY 2019-20 Total PIPs that Met Submission Standard, by MHP Size

Medium MHPs are exceeding other sized MHPs in meeting the PIP submission standards.

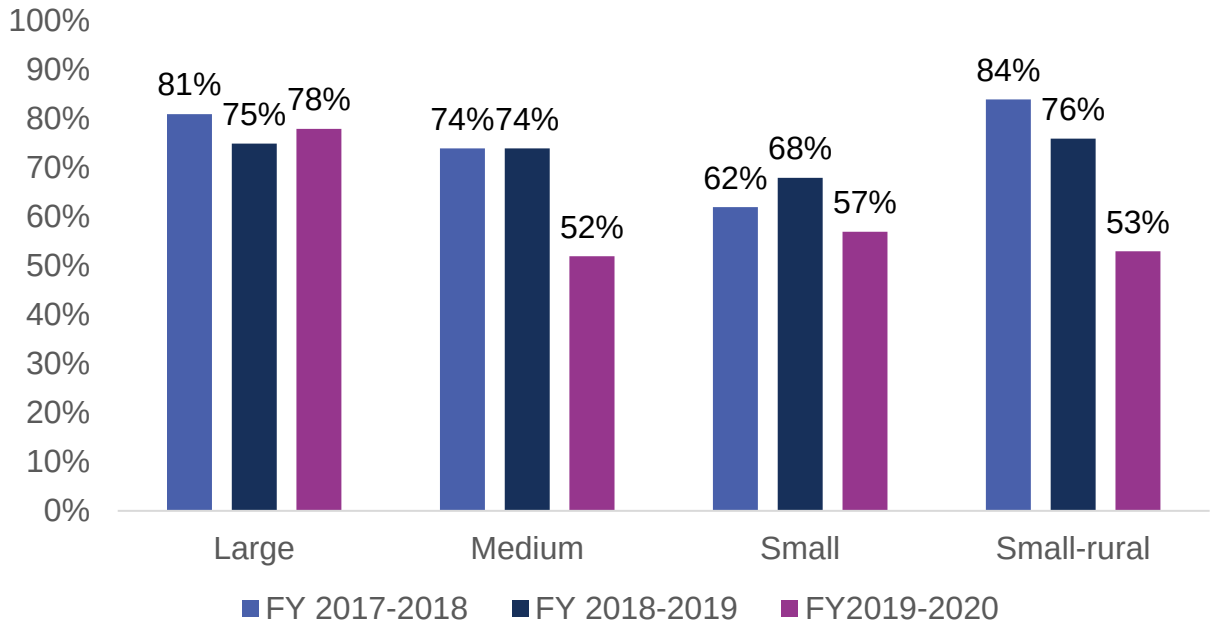


CalEQRO Ratings of Submitted PIPs

All PIPs with a status of Concept Only, Not Yet Active were rated for TA purposes only; those ratings are not factored into the overall ratings presented in this report. (Only those PIPs rated as Active and Ongoing or Completed are included in Figures 3-5 and 3-6.) Figures 3-5 and Figure 3-6 provide the average ratings by MHP size and statewide for clinical and non-clinical PIPs, respectively.

Figure 3-5: Clinical PIP Ratings, FY 2017-18 to FY 2019-20

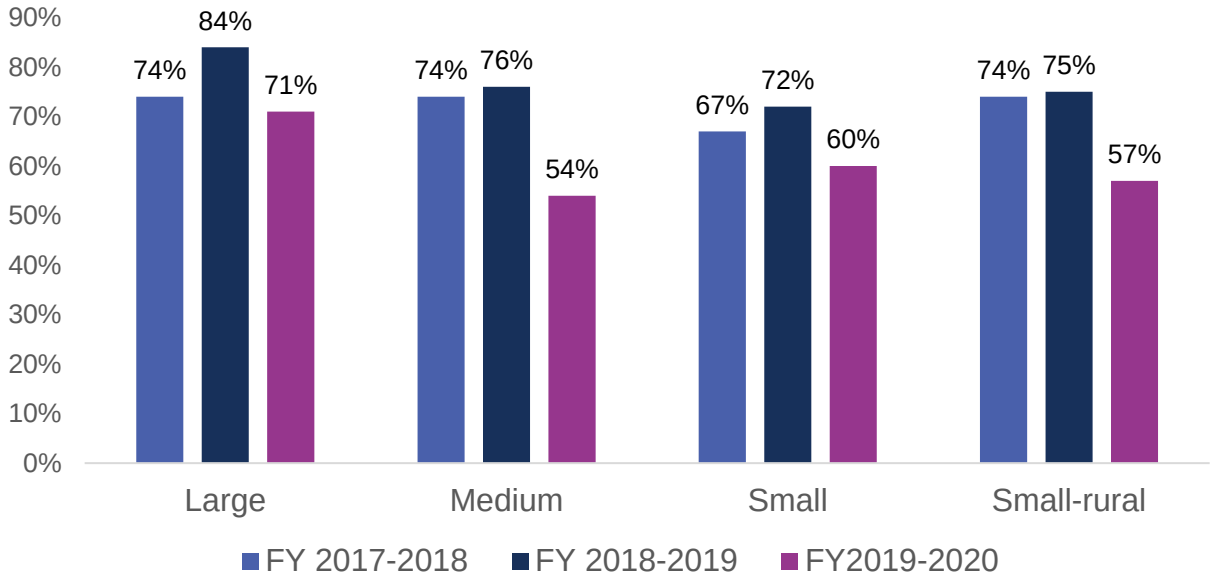
The average rating for clinical PIPs in FY 2019-20 was lower than in previous years for all MHP sizes except for Large MHPs.



All sized MHPs had lower clinical PIP ratings than the previous two years, except for large sized PIPs. The largest decrease in averaged clinical PIP ratings was seen in small-rural sized MHPs.

Figure 3-6: Non-clinical PIP Ratings, FY 2017-18 to FY 2019-20

All size MHPs showed a decrease in rating over the prior two years.



The pattern is repeated for the non-clinical PIP ratings, as all size MHPs showed a decrease in the ratings received. The most noticeable decrease was for medium MHP non-clinical PIP ratings. Although more PIPs were submitted during FY2019-20, the ratings of those PIPs were lower than in previous years.

Range of PIP Topics

The MHPs addressed a range of topics and issues in the PIPs that were submitted for review. Among the 86 PIP submissions that received a rating of Active and Ongoing or Completed, topics included access to care (24 percent); timeliness to care (26 percent); quality of care (22 percent); and outcomes of care (28 percent), as shown in Table 3-5.

CalEQRO noted that three topic areas were prominent: improving kept appointments, timeliness to appointment, and medication related treatments. However, timeliness PIPs were by far the most prominent with 17 percent of all Active and Ongoing or Completed PIPs coming from this topic.

The trend of more PIPs focusing on improvements for beneficiaries (versus MHP processes) continued. The MHPs were encouraged to continue with this trend of focusing on those direct interventions that enhance the quality of life of beneficiaries.

Table 3-5: Common PIP Topics for Active and Ongoing/Completed PIPs

PIP Topic	PIP Title	Clinical	Non-clinical
Access to Care	Improving Kept Appointments/ Reducing No-Shows		Alpine, Calaveras, Contra Costa, Kern, Monterey
	Increasing Post Hospitalization Engagement/ Follow-Up	Orange, Siskiyou	Butte, Solano
Timeliness of Care	Timeliness to Appointment	Sacramento	Del Norte, El Dorado, Glenn, Humboldt, Lake, Merced, Modoc, Mono, San Benito, San Francisco, San Joaquin, Santa Clara, Siskiyou, Yolo
Quality of Care	Co-Occurring Disorders	Los Angeles, Mendocino, Modoc	
	Medication Related Treatments	San Francisco, Santa Barbara, Tulare	Amador, Santa Cruz
Outcomes of Care	Crisis Reduction	Mariposa, Merced, Santa Cruz, Sonoma	

PIP Technical Assistance

CalEQRO offers TA onsite, via e-mail, telephone, video, and webinar to all MHPs. The intention is to help the MHPs sustain qualified PIPs, with TA ranging from helping to develop measurable study questions to a comprehensive evaluation of all PIP validation steps.

Thirty-three of the 56 MHPs took advantage of the available TA, this is a decrease from the 39 MHPs that utilized TA in FY 2018-19. Outside of the review process, in FY 2019-20 CalEQRO provided a total of 406 hours of individual TA to those 33 MHPs; this is an average of 12.3 hours per MHP. The average hours of TA provided is an increase over the 10.51 hours per MHP provided for FY 2018-2019, but is a slight decrease in the total number of 410 hours provided for FY 2018-29. Additionally, it is a significant increase over the 73 total hours of TA provided in FY 2017-18. One of the most common areas of assistance involved assisting MHPs with PIP development and providing feedback on proposed topics or study questions. The MHPs struggle to understand the concept of designing and implementing PIPs as part of the MHPs' overall QI practices, instead attempting to construct PIPs as stand-alone projects. Additionally, MHPs had difficulties collecting and using data to design PIPs targeting a specific problem in their geographical area.

Table 3-6 details the TA provided to all MHPs during the review year. In addition to onsite TA, during the FY 2019-20 review year, CalEQRO provided PIP clinic webinars and in-person presentations that focused on PIP development.

Table 3-6: Technical Assistance Provided via PIP Webinars by CalEQRO, FY 2019-20

Type of TA Provided	Title	Location	Date
PIP Webinar	PIP 101 to Implementation	Online	October 24, 2019
PIP Webinar	PIP Ideas to a Successful PIP	Online	December 18, 2019
PIP Webinar	Interactive Technical Assistance – PIP Webinar	Online	March 27, 2020
PIP Webinar	CMS Protocol 1 – Validation of Performance Improvement Projects	Online	June 30, 2020

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Appendix 6: Summary of Information Systems

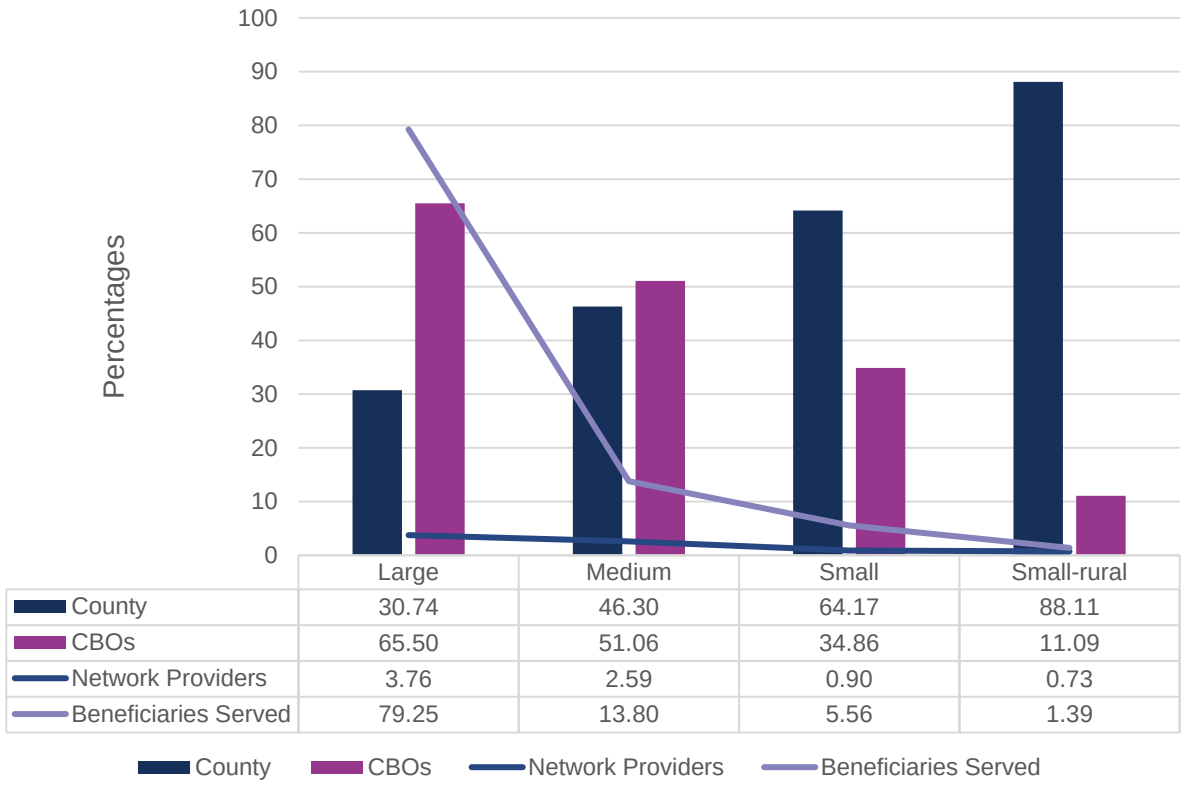
Health Information Systems (HIS) play an important role in the effectiveness and efficiency of public mental health service systems. CMS regulations require EQRO organizations to examine the role of Health Information Systems (HIS) in the mental health system. The HIS has three primary functions: (1) collection and storage of data; (2) analysis of data to support decision making; and (3) assistance with operational business processes.

CalEQRO conducts an annual assessment of each MHP's HIS derived largely from the MHP Annual Report Information Systems Capability Assessment (ISCA), a tool developed by CalEQRO. The MHP ISCA assesses the extent to which MHPs maintain the capacity to manage the needs of its beneficiaries and support the collection, management, and use of valid and reliable data.

MH Services Delivery by County Size

In FY 2019-20, 79.25 percent of beneficiaries served received specialty mental health services from Large MHPs, while CBOs provided the bulk (65.5 percent) of these services.

Figure 1: Specialty Mental Health Services Delivery



	Large	Medium	Small	Small-rural
County	30.74	46.30	64.17	88.11
CBOs	65.50	51.06	34.86	11.09
Network Providers	3.76	2.59	0.90	0.73
Beneficiaries Served	79.25	13.80	5.56	1.39

Medium-sized MHPs accounted for 13.8 percent of beneficiaries served. County-operated programs provided 46 percent of the services while CBOs provided 51 percent.

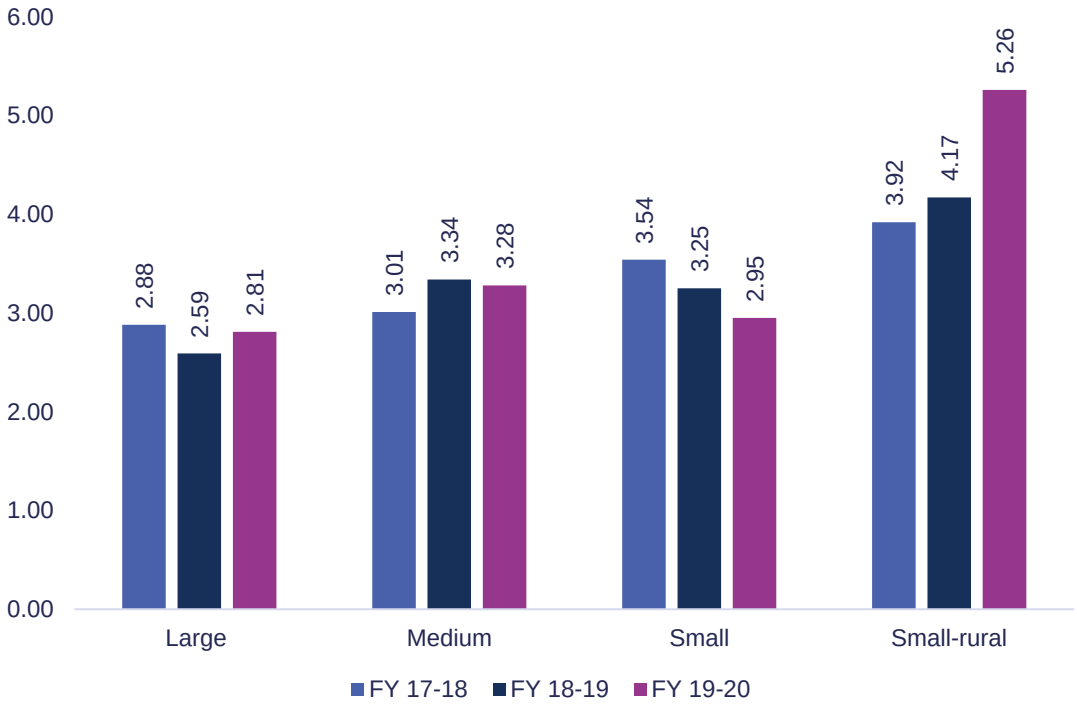
5.56 percent of beneficiaries received care from Small MHPs and 64 percent of the services were provided by county-operated programs.

Only 1.56 percent of beneficiaries received services in Small-rural MHPs. In these MHPs, 88 percent of services were provided by county-operated programs.

Network providers role in the provision of specialty mental health services was proportional to MHP sizes; ranging from 3.76 percent in large MHPs to 0.73 percent in Small-rural MHPs.

Many factors are at play in how MHPs deliver MHP services: geography, cost of living index, system of care infrastructure, workforce availability, and resources.

Figure 2: IT Budget 3-Year Trend



Budget Allocations for Information Systems

The percentage of the MHP's budget devoted to information systems is a simple indicator of the level of IT resources and capabilities available to support the administration and delivery of services. Although there are no requirement standards for the percentage of budget devoted to IT, there are literature references of 3 to 5 percent being considered the minimum necessary in health care organizations with a full-featured EHR. In FY 2019-20, the range is from the Small-rural MHPs allocating 5.26 percent of their budget to large MHPs only allocating 2.81 percent, as shown in Figure 2.

Between FY 2017-18 and FY 2019-20, large MHPs' average IT budget has stayed flat around 2.8 percent; Medium MHPs' IT budget has shown a slight increase from 3.01 to 3.28 percent; Small MHPs' IT budget has decreased from 3.54 to 2.95 percent and Small-rural MHPs have increased their average IT budget from 3.92 to 5.26 percent.

However, there is more to consider than the percentage of the MHP's budget devoted to the information system. For instance, in a county where the core system is used for more than the MHP (such as the health agency or DMC-ODS), it may not be possible to clearly identify the MHP component of the overall system cost. In reviewing the data received in FY 2019-20 ISCAs, situations like this may have affected some of the budget percentages. The results should be viewed as a rough indicator that requires more detail to be fully informative. In addition, MHPs have varying relationships with their contractors related to information system support and interfaces. Some support a unified system across the county and contract providers, while others support county functions and request data through interfaces with contractors of various kinds, and some are hybrids. All of these scenarios affect the budget and resources needed to support information systems.

Figure 3: Technology Average Staffing 3-Year Trend, FTEs

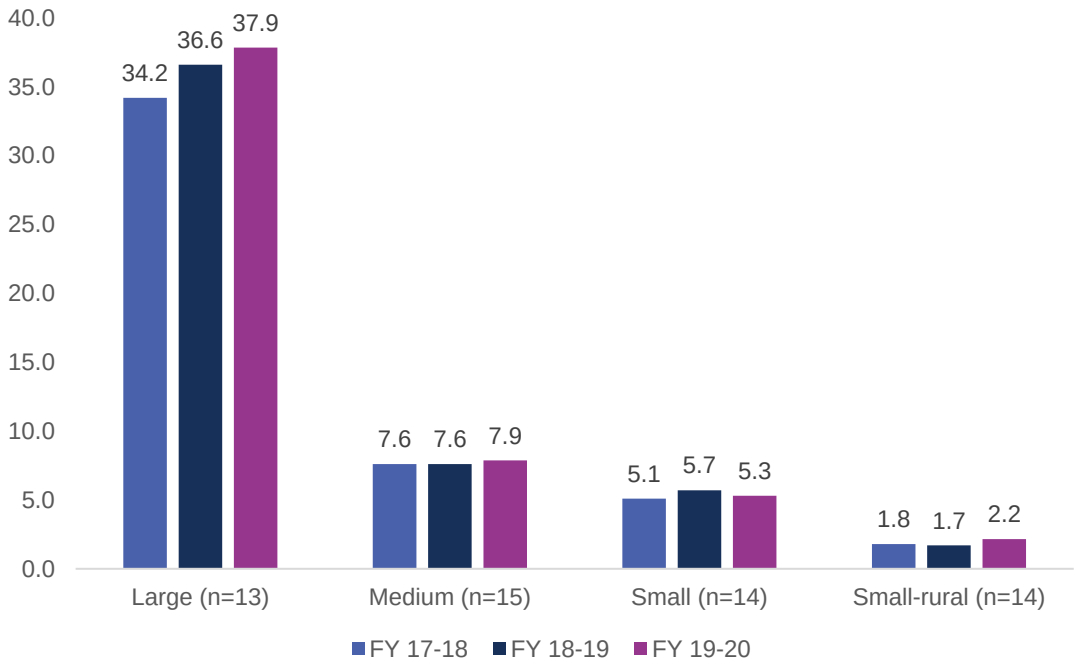
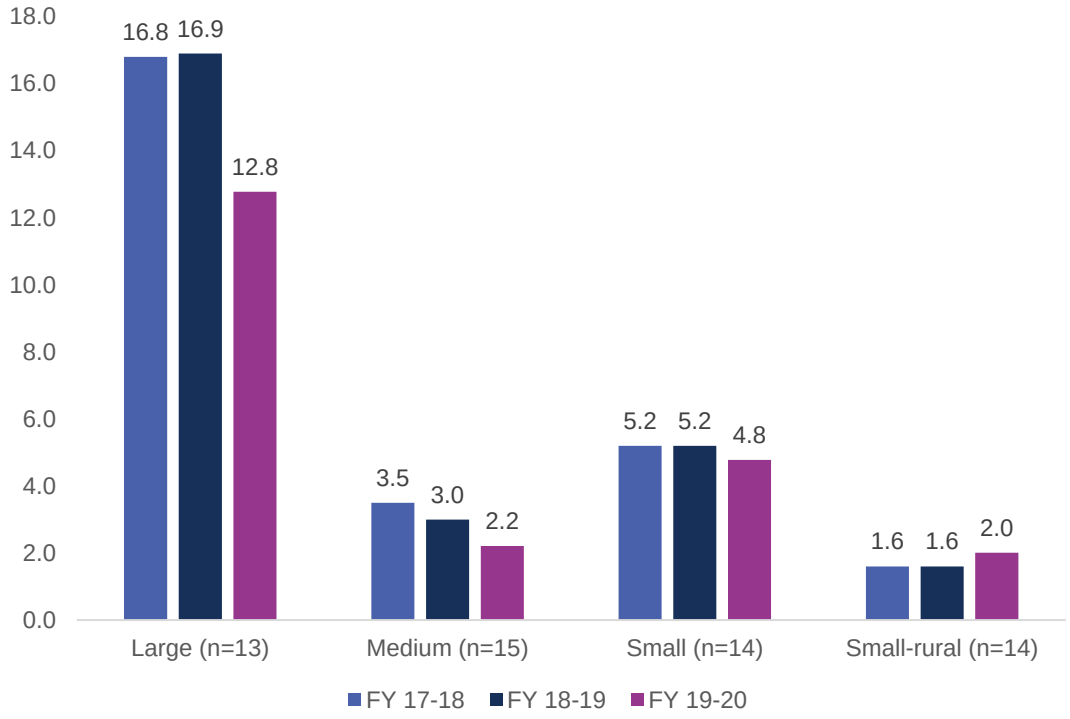


Figure 4: Data Analytics Average Staffing 3-Year Trend, FTEs



Technology & Analytics Staffing for Information Systems

Figures 3 and 4 show the FY 2017-18 to FY 2019-20 average authorized technology and analytical resources for MHPs, measured in FTEs. For technology staffing, it appears these resources are proportional to county size and large MHPs have steadily increased their technology resources from 34.2 in FY 2017-18 to 37.9 in FY 2019-20. It should be noted that all MHPs have more technology than analytics staffing. In FY 2019-20, the Medium MHPs group, on average, has only 2.2 analytics FTE, which seems very low in view of all the reporting and data analysis requirements of the state.

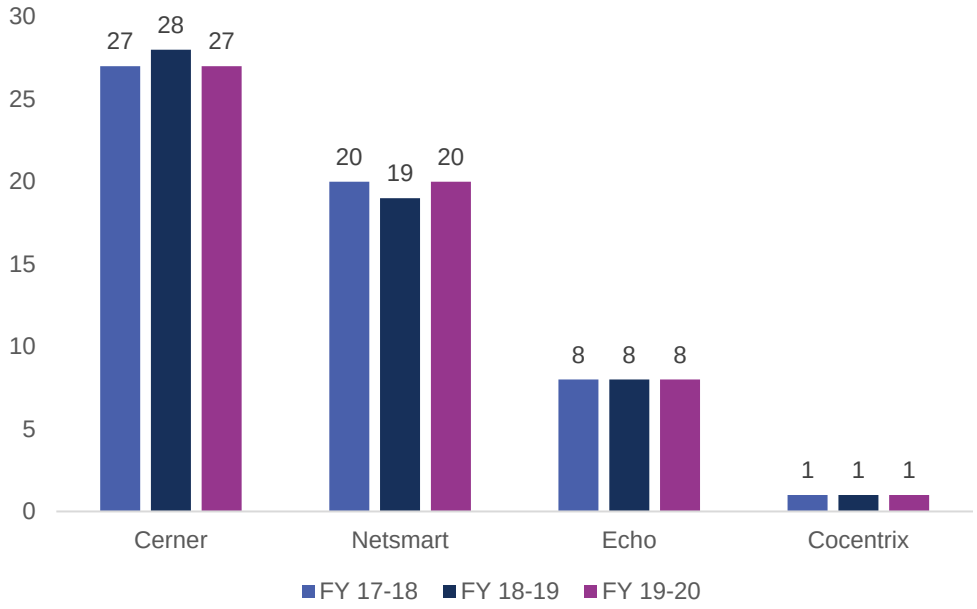
In addition to being a health record, EHRs offer data about the entire population served by the MHP. The MHP's staff can see outcomes at the population and target population levels; trends by race/ethnicity, gender or age; provider level performance; timeliness of services; and a great deal more. However, this is only the case if the MHP employs an adequate number of staff with data analysis skills to transform data into management information that could be used to inform decision-making.

Below a certain threshold of data analytics staff capacity, MHPs will not be able to realize the potential benefits of their EHRs or their practice management systems. Numbers matter, especially as state requirements become more complex. The basic skill set demands the ability to analyze data effectively and work with clinical and program staff to study issues, identify trends and problems, and design and monitor interventions to improve care. Some considerations to keep in mind:

- Some MHPs included analytics staff in reported technology FTE numbers.

- In some MHPs, technology and analytics resources are within the health agency and are not dedicated to support MHP services, with negative consequences for the program's capacity.
- Some MHPs share technology and analytics resources between mental health and SUD services, but did not report separate FTE numbers for MHP staff who have skills with some of the unique data sets (such as OSHPD).
- Some MHPs have relationships with universities, consulting organizations, or even their system vendors. These organizations provide data analytics services that the MHP cannot reliably maintain; these MHPs are getting good value from their information system investment as a result. For example, several Small-rural MHPs contract with Kings View for data analytics support.

Figure 5: County EHR Vendors



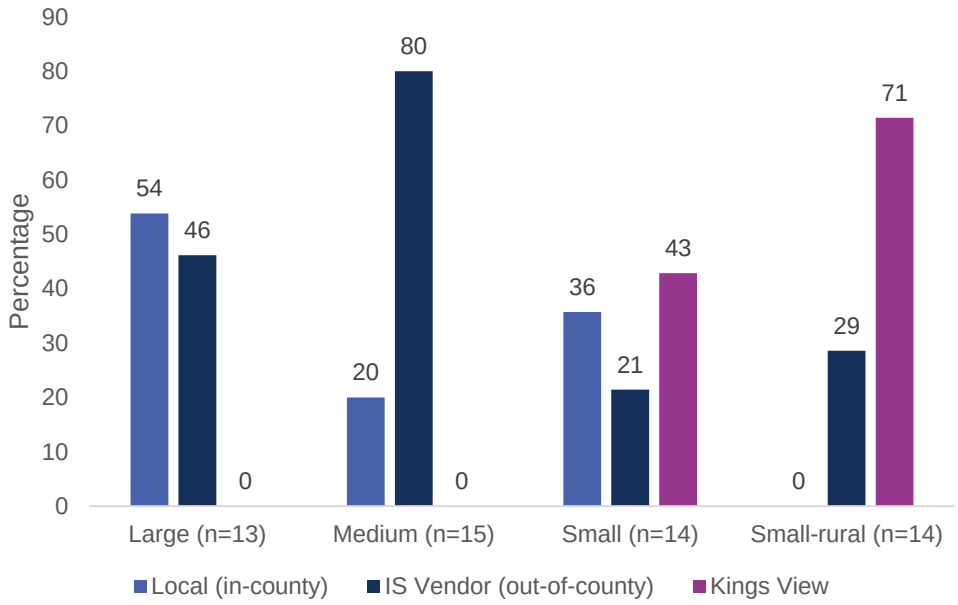
Health Information Systems by Vendor

California MHPs have primarily relied on four technology vendors to support HIS in behavioral health: Cerner Corporation, Harris Healthcare Group (Cocentrix), The Echo Group, and Netsmart Technologies, as shown in Figure 5. This narrow range of vendors is a consequence of California's unique Medicaid claims processing business rules. These vendors all have core expertise for SDMC claims processing and state-mandated reporting requirements.

While these vendors continue to modify legacy systems to conform to state and federal data collection and reporting standards, there are few incentives to develop the next generation of EHR systems to improve the providers' workflow processes and efficiencies.

Based on FY 2019-20 ISCA results, twenty MHPs use Netsmart/myAvatar; twenty-seven MHPs use Cerner Community Behavioral Health; eight MHPs use Echo InSyst/ShareCare; and one county uses Cocentrix Pro-Filer. This vendor representation has been consistent across MHPs since FY 2017-18.

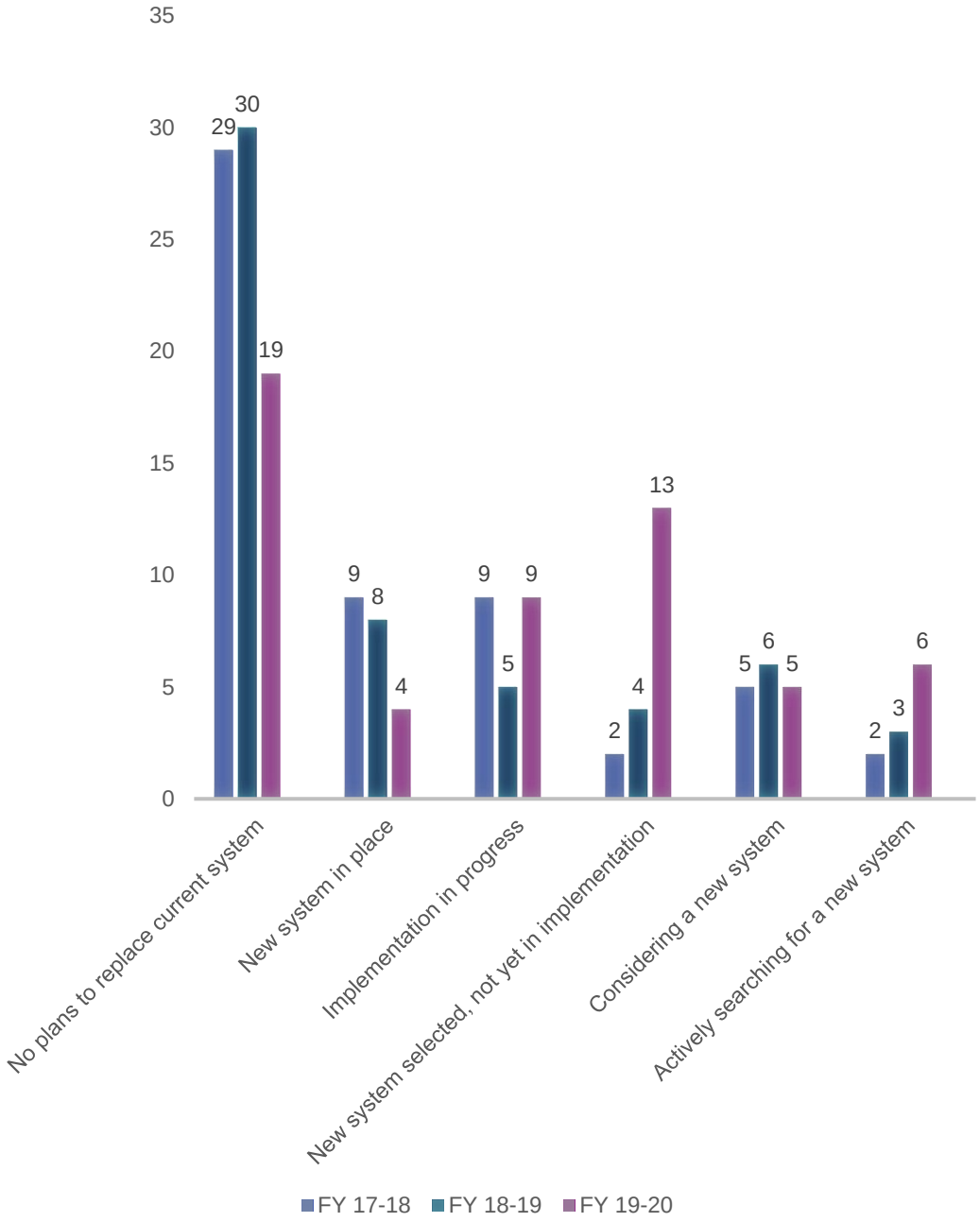
Figure 6: Hosting of County EHR Systems



Hosting County EHR Systems

Hosting systems at an Application Service Provider (ASP) is driven by the lack of local IT staff expertise to support 24/7 operational support. ASP hosting usually includes benefits such as heightened system security, business continuity assurances, and 24- hour staffing by qualified technicians. The changing IT services market also plays a role in hosting and operation decisions made by MHPs. When the challenges of hiring, training, and retaining qualified technical staff are added to the equation along with the known benefits of ASP hosting, the cost-benefit ratio generally makes for a compelling case. Only large MHPs have the majority of systems hosted in-county, as shown in Figure 6. 80 percent of medium MHPs contract with out-of-county vendors to host their EHRs. Most Small and Small-rural MHPs contract with Kings View for EHR-hosting.

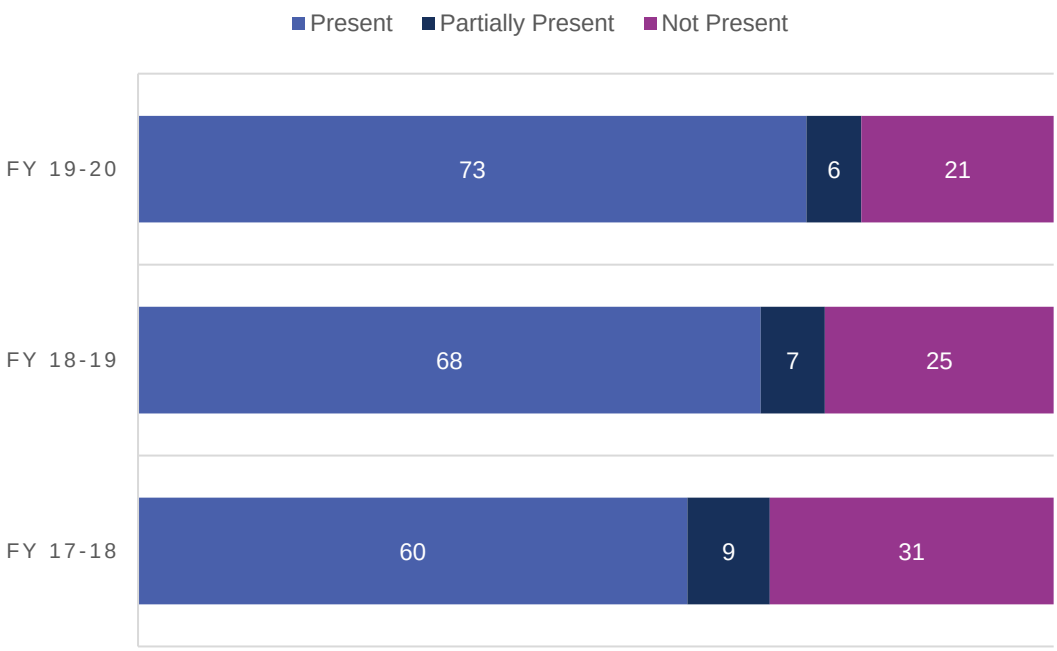
Figure 7: County EHR Replacement Status, 3-Year Trend



County EHR Replacement Status

Most MHPs have implemented or have a new system that has core components that support EHR functionalities. As state requirements continue to shift, an increasing number of MHPs now have plans to change their system (Figure 7). For the latest year, 23 of 56, less than half (41.0 percent) of MHPs have no plans to replace current systems while the majority are either implementing a new system, or in a transitional state of considering a new one.

Figure 8: Progress to Implement EHR Functionality, 3-Year Trend



Progress at Implementing EHR Functionality

Most MHPs have implemented, or are in the process of implementing, a system that has core components that support EHR functionalities for the MHP (and, at times, DMC-ODS as well), as shown in Figure 8.

An information system is a group of integrated hardware and software components designed to collect, organize, store, process, and report information. Information system functionality, from a user perspective, is the ease of use of those integrated components, often in terms of the availability of the software designed to support daily workflow. Between FY 2017-18 and FY 2019-20, MHPs have steadily added EHR functionalities in their core systems. In FY

2017-18, EHR functionalities were present, or partially present, in 69 percent of MHP core systems. In FY 2019-20, the percentage had increased to 79.

Table 1: FY 2019-20 EHR Clinical Functionalities Statewide

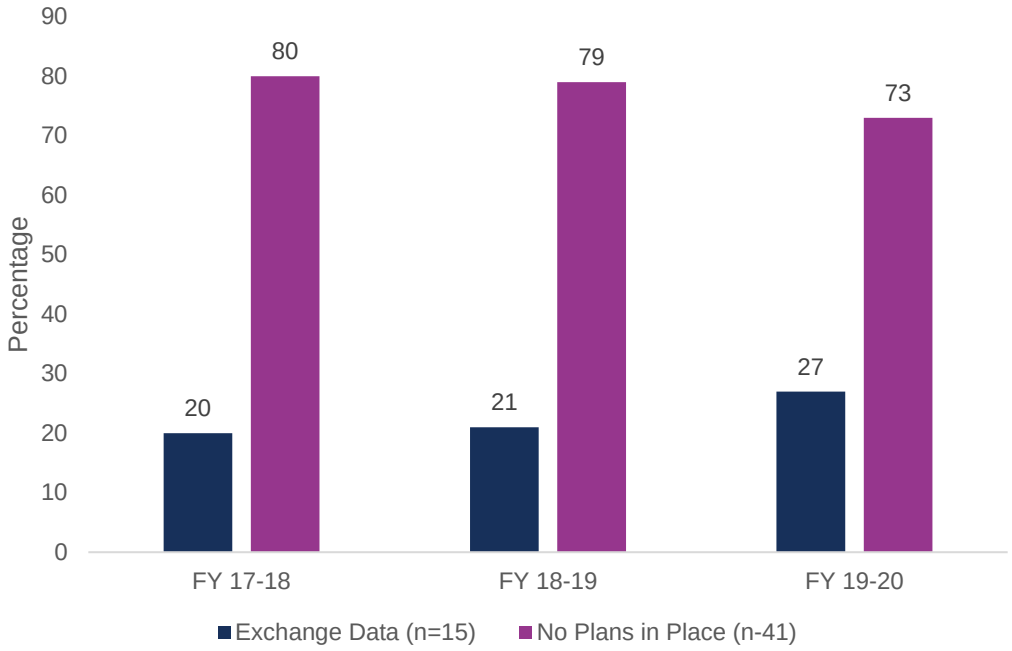
	Present	Partially Present	Not Present
Statewide	72.77	5.8	21.43
Progress Notes	96.43	0.00	3.57
Treatment Plan	94.64	0.00	5.36
Assessments	94.64	1.79	3.57
Electronic Signature	92.86	3.57	3.57
Prescriptions	92.86	3.57	3.57
Document Imaging/Storage	87.50	3.57	8.93
Outcomes	87.50	7.14	5.36
Alerts	73.21	16.07	10.71
Level of Care	60.71	5.36	33.93
Lab Results	39.29	17.86	42.86
Care Coordination	28.57	5.36	66.07
Referral Management	28.57	5.36	66.07

As Table 1 indicates, referral management, care coordination, and lab result functions are generally under-deployed in the MHP EHRs. However, progress notes, treatment plans, assessments, electronic signatures, and prescriptions are present in most systems.

Collectively, only 79 percent of EHR core functions are present or partially present in county behavioral health systems, which significantly affects how staff work.

For those contract providers with local EHRs, the ability to electronically exchange client-level clinical transactions with county EHRs is generally lacking or is limited to service transactions. Most contract providers with local EHRs also need to enter demographic, clinical, and service information directly into county behavioral health systems. Double data entry is very common.

Figure 9: Health Information Exchange Participation, 3-Year Trend



Health Information Exchange Participation

Health Information Exchange (HIE) is the mobilization of health care information electronically across organizations within a region, community or hospital system. Health Information Exchanges provide the capability to electronically move clinical information among disparate healthcare information systems and maintain the meaning of the information being exchanged. The goal of health information exchange is to facilitate access to, and retrieval of, clinical data to provide safe, more timely, efficient, effective, and equitable beneficiary centered care.

The percentage of MHPs that participated in Health Information Exchanges has increased to 27 percent in FY 2019-20 from 20 percent in FY 2017-18, as shown in Figure 9.

Table 2: Data Exchange Types

Data Exchange Type	Percent
Direct data entry into EHR	58.7
Paper documents faxed/delivered to MHP	18.4
Documents/files emailed to MHP	12.4
Electronic batch file transfer into EHR	5.1
Health information exchange (HIE)	3.9
Electronic data interchange (EDI) to MHP IS	1.4

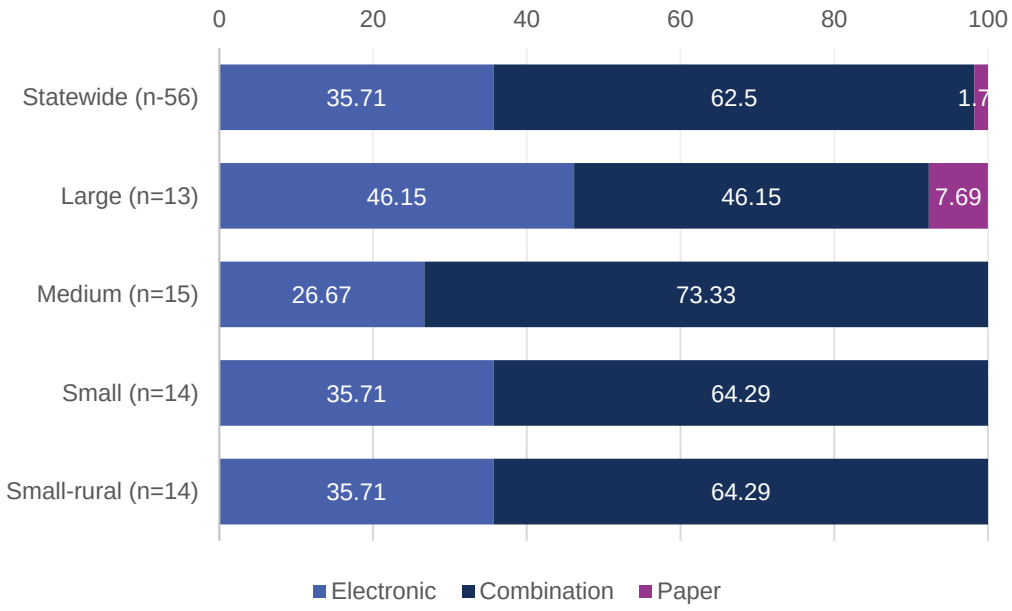
Interoperability

A significant aspect of the MHPs' use of the EHR has been the integration of services provided by contract providers into county systems. Generally, MHPs provide contract providers two or more submittal methods to exchange client information.

There is minimal use of Health Information Exchanges (HIE), which is a more efficient method of exchanging client data bilaterally. Special confidentiality requirements make this protocol difficult. Vendors continue to prioritize working with the MHPs to stay up to date with evolving state requirements.

Table 2 shows current data exchange options available to MHP contract providers from EDI transactions to sending documents attached to secured e-mails. Where "Direct data entry to EHR" is noted, it almost always means that contract provider employees are entering the client data into their own EHRs, then logging into the county EHR to enter the same data there. This is inefficient, generally slows down the availability of data, is an ongoing drain on contract provider resources, and is a frequent source of data entry errors. However, direct data entry was the leading data exchange method used in FY 2019-20 at 58.7 percent.

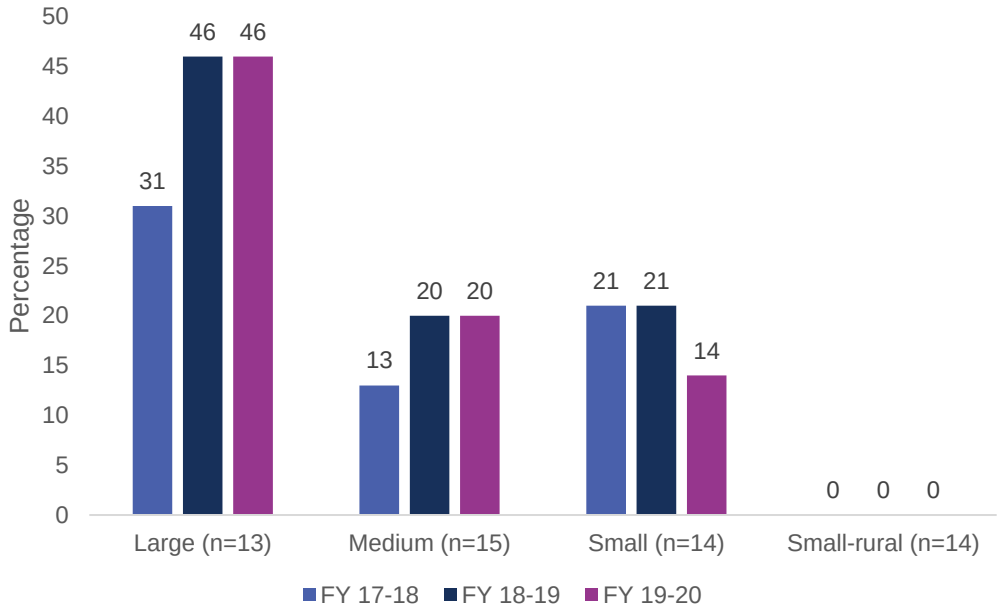
Figure 10: Beneficiary Health Records



Health Record

Health records are rated functionally as electronic, paper, or a combination of electronic and paper. An EHR environment supports better communication and coordination of care among providers, including physical health providers, and facilitates the establishment of client portals to help motivate clients to manage their own health. Almost half of the large MHPs reported having an electronic health record for beneficiaries while only a quarter of medium-sized MHPs have electronic health records, as shown in Figure 10. For small and small-rural-sized MHPs, approximately 35 percent have electronic health records which is also the statewide percentage.

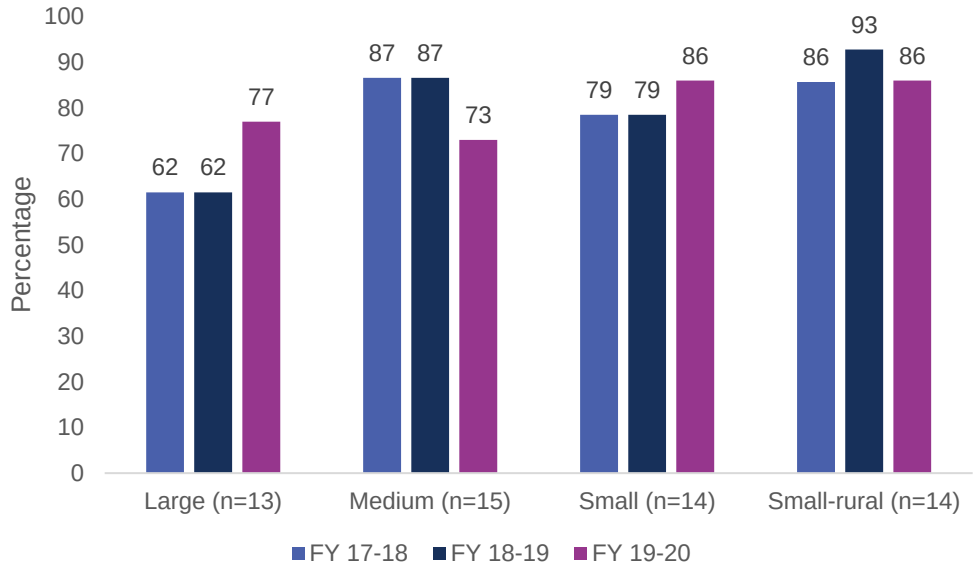
Figure 11: Online Personal Health Record Access and Availability 3-Year Trend



Internet-Accessible Personal Health Records

Internet-accessible Personal Health Records (PHRs) can improve client engagement by assisting clients in better managing their care through access to health information, such as past and future appointments and lab results. As noted in Figure 11, availability of PHR functionality has been challenging to implement in the Small-rural MHPs which do not have the resources for a successful implementation. Large and medium MHPs showed progress between FY 2017-18 and FY 2018-19 by increasing their online personal health record access from 31 percent to 46 percent, and from 13 percent to 20 percent respectively.

Figure 12: Telehealth Services Availability 3-Year Trend



Availability of Telehealth

Service delivery via telehealth benefits both the client and providers. For the client, telehealth expands access to care by overcoming the barrier of distance from established services. For providers, telehealth allows for the convenience of service delivery from their existing locations and may allow them to more efficiently serve clients. It can also help with network adequacy requirements and offers more flexibility to both clients and providers who are in remote areas of California. 77 percent of large MHPs provided telehealth services in FY 2019-20, compared to 62 percent the year prior, as shown in Figure 12. Medium-sized MHPs, however, dropped from 87 percent telehealth deployment in FY 2018-19 to 73 percent in FY 2019-20. Small MHPs also increased telehealth services from 79 percent to 86 percent.

Summary

Thirty-three MHPs reviewed in FY 2019-20 are in different stages of EHR implementation or are considering replacing/updating their information systems. These MHPs vary in size and deliver specialty mental health services through different county/contractor program combinations and have vastly dissimilar information system budgets and technology/analytics staffing.

A common but critical challenge shared by the MHPs is the interoperability between disparate electronic health record systems.

In the absence of HIEs, contract providers are often users of the MHPs' EHRs. They either enter client and service data directly into the county systems or send batch/paper files to process the data into county systems for billing and reporting. If the contract providers have their own information systems, they may have to do double entry of the same data into two systems, which is highly undesirable, inefficient, and easily prone to error.

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Appendix 7: MHP Strengths and Opportunities for Improvement

Introduction

The review of MHP strengths, opportunities, and subsequent recommendations, are part of federal guidelines governing EQRO. Strengths, Opportunities and Recommendations are organized according to the following categories: PIPs and the Key Components of Access, Timeliness, Quality, Beneficiary Progress and Outcomes, Foster Care, Information Systems, and Structure and Operations. Strengths are those characteristics that enabled or enhanced an MHP's ability to provide SMHS to its beneficiary population. They also reflect industry best practices in mental health, HIS, and program operations. Opportunities are those areas where the MHP was underperforming, did not meet DHCS requirements/standards, and/or showed potential weaknesses in its ability to provide services. Recommendations are derived from the opportunities and identify the areas where MHPs should focus improvement efforts in the upcoming year. A significant focus of the CalEQRO review is evaluating the actions taken by the MHP to address CalEQRO recommendations from the prior year, FY 2018-19. Over the course of the year after one EQR to the next, it is expected that each MHP will make concerted effort to fulfill all the recommendations.

Strengths

A total of 778 strengths was assigned to MHPs as shown in Table 1 below. The largest number of strengths was assigned to access, followed by foster care and structure and operations, as shown in Table 1. Overall, Small-rural MHPs had more strengths than medium and large-sized MHPs. Central region MHPs had more identified strengths than other regions.

Table 1: Strengths by Domain

Domain	Count	Percent
Access	159	20%
Foster Care	126	16%
Structure & Operations	119	15%
Quality	114	15%
Beneficiary Progress and Outcomes	94	12%
Timeliness	93	12%
Information Systems	73	9%
Total	**778**	100%

Figure 1: Percent of Strengths by Domain

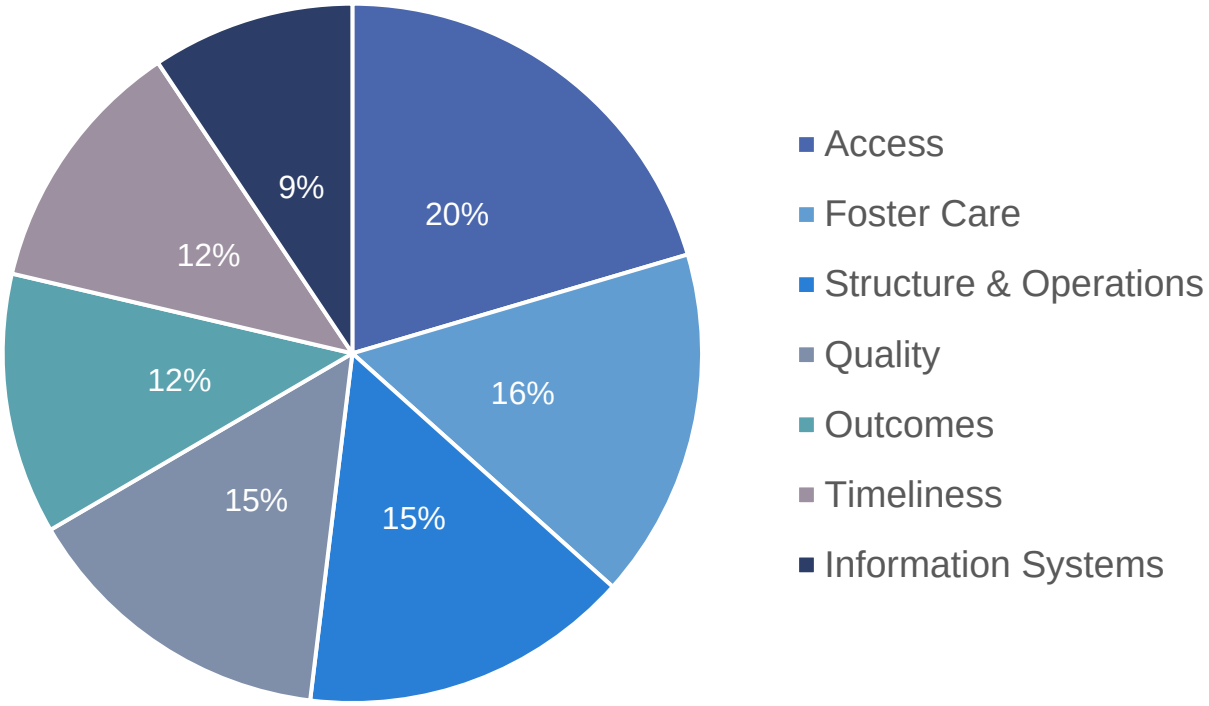

Table 2: Count and Percent of Strengths by MHP Size and Region

MHP Size	Count	Percent	MHP Region	Count	Percent
Large	181	23%	Bay Area	158	20%
Medium	203	26%	Central	307	39%
Small	189	24%	Southern	126	16%
Small-rural	205	26%	Superior	187	24%
Grand Total	**778**	**100%**	**Grand Total**	**778**	**100%**

Access to Services Strengths

A total of 30 different themes were identified for analysis of all identified strengths. The top strengths associated with access included expanded offerings of telehealth services and improvement in expanding service offerings such as hiring staff to support greater access to services, offering services to children, youth, and groups, collaborating with other community stakeholders**.**

Other strengths include active engagement in community outreach and engagement aimed at increasing reach to underserved populations such as Hispanic/Latino and Spanish speaking, Native Americans, and Sikhs as well as geographically isolated regions; expanded capacity; community engagement; written and goal-oriented plans. MHPs also have written and articulated improvement plans or studies, with clearly defined goals, and offer or facilitate transportation for consumers.

Foster Care Strengths

The top strengths for foster care include strong partnership with child welfare, juvenile justice and probation, and social services which supports access and coordination for care FC youth. Also included were policies and protocols in place for tracking the psychotropic medication, this includes quarterly meetings with partners. Recruiting Therapeutic Foster Care providers or group homes is ongoing. In some cases, timeliness data is disaggregated for foster youth.

Timeliness Strengths

A total of 10 different themes were identified for analysis of all identified strengths. The top strengths associated with timeliness was having monitoring systems in place to track timeliness metrics across the system of care. Several of these MHPs have policies for corrective action tied to compliance with timeliness standards. Other strengths included having PIPs focused on improving timeliness metrics and using telehealth to offer more timely services.

Quality Strengths

A total of 30 different themes were identified for analysis among all identified strengths. The top strengths associated with quality were policies on review and monitoring for service frequency and appropriateness of care. This requires the MHP to think critically about treatment and practice. Also mentioned were medication monitoring review plans establishing clinical practice guidelines for minimum psychiatric service frequency, follow-up standards and guidelines for medication use.

An additional strength was the utilization of a social determinates of health model of care. This focuses on beneficiaries' needs beyond clinical treatment to include areas of housing, food, employment, and meaningful engagement with the community.

Beneficiary Progress and Outcomes Strengths

The top strengths associated with consumer outcomes were the assessment of beneficiaries at regular intervals through the use a standardized tool such as the CANS, across levels of care. This is especially true for child/youth beneficiaries. Other strengths include the use of feedback and satisfaction surveys including the CPS to improve services, and utilizing wellness centers to provide a comprehensive array of groups to help beneficiaries reach their recovery goals. Many of the groups at these centers are run by peer employees.

Information Systems Strengths

The top strength related to IS was integration of outcome measures in the EHR; use of dashboards and reports on timeliness, productivity, demographics, Adult Needs and Strengths Assessment (ANSA), CANS, and caseload. Also mentioned was staff engagement with EHR and IT systems, through training, testing, and ability to access necessary information. The use of contracts for consultation services is another strength. Several MHPs had contracts with individuals or agencies to support their EHR systems, billing, data analytics, and reporting. These contracts provided subject matter expertise and/or increased the MHPs' capacity, especially when internal resources were limited.

Structure and Operations Strengths

The top strengths associated with structure and operations were strong collaborative relationships with its contract providers for services including crisis support, housing, and adult behavioral health; peer career ladders; or having formed workgroups to oversee the expansion of their peer employment programs. Related is a focus on serving homeless beneficiaries or beneficiaries with unstable housing, including youth and TAY beneficiaries. Also identified were sustained efforts to improve cultural competency for services with underserved populations including TAY and LGBTQ youth, adult beneficiaries with unstable housing and employment, older adults, and Hispanic/Latino youth and families. Regular meetings between MHP leadership, staff, and beneficiaries are cited as another strength as they offer opportunities to discuss key topics, broaden participation.

Opportunities

A total of 993 opportunities/challenges were identified for MHPs as shown in Table 3 below. The largest number of opportunities was assigned to timeliness, followed by quality and access, as shown in Figure 2. Most of the identified opportunities for improvement belonged to small-rural MHPs. In term of MHP region, most opportunities for improvement were identified in Central region MHPs.

Table 3: Opportunities by Domain

Domain	Count	Percent
Timeliness	228	23%
Quality	156	16%
Access	145	15%
Information Systems	131	13%
Structure & Operations	127	13%
Foster Care	117	12%
Outcomes	89	9%
Total	**993**	**100%**

Figure 2: Percent of Opportunities by Domain

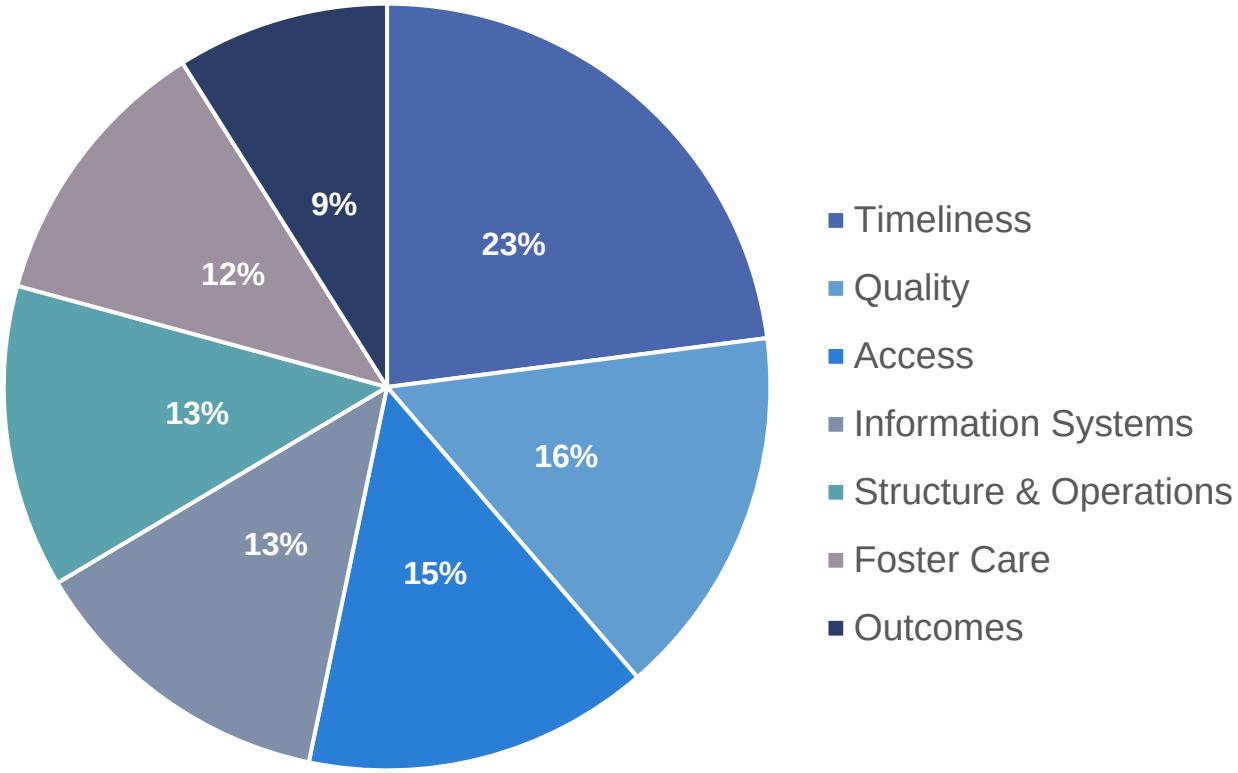

Table 4: Count and Percent of Opportunities by MHP Size and Region

MHP Size	Count	Percent	MHP Region	Count	Percent
Large	267	27%	**Bay Area**	218	22%
Medium	252	25%	**Central**	372	37%
Small	198	20%	**Southern**	182	18%
Small-rural	276	28%	**Superior**	221	22%
Total	**993**	**100%**	**Total**	993	100%

Access Opportunities

A total of 19 different themes were identified for analysis among all identified challenges. The top challenge associated with access was capacity to provide services especially for psychiatry. Transportation was also viewed as inconsistent and difficult for many beneficiaries. Furthermore, transportation resources are not easily accessible in many MHPs.

Additional challenges identified were a lack of resources in languages other than English including websites, provider lists, and access lines**.** Some beneficiaries are unaware of how or unable to access crisis services after hours since contact information is not prominently displayed in MHP resources or some MHP do not have staff responding to the telephone line around the clock.

Foster Care Opportunities

The top challenges include MHPs not reporting timeliness data for FC youth. Data are not often desegregated for psychiatric, no-show, and urgent appointments from other youth beneficiaries. Medication monitoring is inconsistent at times. Prioritizing the development of systems to monitor medication administration would ensure that the MHP is prescribing for foster youth in a manner that is consistent with currently recommended and required practice. First appointment rates are often below the statewide 10-day standard.

Timeliness Opportunities

Top challenges are not meeting DHCS 15 business day standards for adult services and not tracking key timeliness metrics or are not doing so consistently. Often clinician and psychiatrist no-show rates are not tracked. In several MHPs, there is no set standard. In addition, low rates of follow-up appointments after hospitalization meeting the 7-day standard were reported.

Quality Opportunities

A total of 17 different themes were identified for analysis of all identified challenges. The top opportunities associated with quality involved not having QM work plans that includes measurable goals and objectives or did not include results from the prior year followed by not have adequate medication monitoring practices and policies. Other challenges include not being able to aggregate outcomes data to identify gaps in clinical services or share these results throughout the system of care. Staffing for MHPs, especially for many support roles such as analytics or recovery specialists, is seen as another challenge. In some instances, transitioning beneficiaries to lower levels of care was a challenge. In many cases, MHPs reported lacking a standardized level of care assessment tool to assist in objectively transitioning beneficiaries to a different level of care.

Beneficiary Progress and Outcomes Opportunities

The top challenges associated with beneficiary outcomes involved not utilizing aggregate reporting for system-wide evaluation or program improvements and not having a standardized adult outcome tool or level of care tool across the system of care or do not provide contract provider access to a tool. Other challenges include limited peer employee positions and career ladders for advancement, improving sharing results of beneficiary surveys at the program level.

Information Systems Opportunities

The top IS-related challenges for MHPs were resource shortages and system availability for contract providers. MHPs were under-resourced in data analytical staff, IT staff, EHR support staff, telehealth operators or superusers; and laptop computers for field-based staff. Contract providers experienced long delays, poor connectivity, and connection failures in trying to use Avatar. The connectivity issues are related to Internet providers and likely limited bandwidth. Other challenges include billing/claims issues, a lack of disaster planning, limited resources for co-occurring SUD treatment, unavailability of eLabs, inadequate IT budgets for improvements and training, and no system alerts or flag for clinical staff.

Structure and Operations Opportunities

The top challenges associated with structure and operations were staffing, retention, and vacancies, all of which remain an ongoing challenge in meeting the needs of beneficiaries throughout the system of care. Also identified was the lack of a formal career ladder for peer employees for many MHPs. A lack of bi-directional communication to share information and receive feedback from MHP management was reported. Contract providers face challenges working with MHPs, including lack of feedback on submitted reports, considerable red tape and delays, and lack of IT support.

Recommendations

A total of 930 recommendations were made for MHPs as shown in Table 5 below. The largest number of recommendations were assigned to timeliness, followed by quality, and information systems, as shown in Figure 3. Most of the identified opportunities for improvement belonged to medium-sized MHPs. In term of MHP region, most opportunities for improvement were identified in Central region MHPs. Nineteen percent of recommendations were a continuation from the prior year.

Table 5: Count of Percent of Recommendation Domains

Domain	Count	Percent
Timeliness	169	18%
Quality	144	15%
Information Systems	129	14%
Access to Care	119	13%
Structure & Operations	119	13%
Foster Care	85	9%
Performance Improvement Projects	80	9%
Consumer Outcomes	79	8%
Unspecified	6	1%
Total	930	100%

Figure 3: Percent of Recommendations

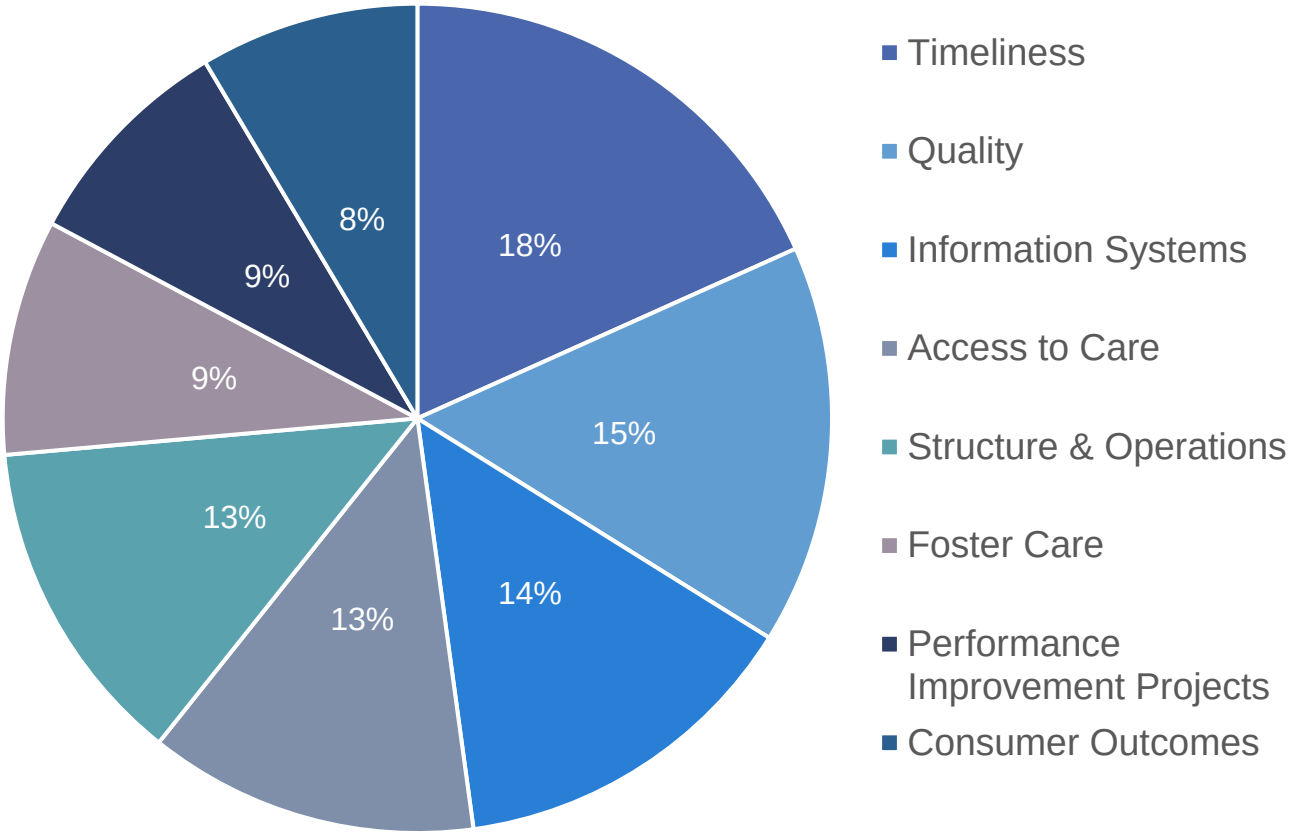

Table 6: Count and Percent of Recommendations by MHP Size and Region

MHP Size	Count	Percent	Region	Count	Percent
Large	207	22%	Bay Area	208	22%
Medium	285	31%	Central	353	38%
Small	201	22%	Southern	146	16%
Small-rural	237	25%	Superior	223	24%
Total	930	100%	Total	930	100%

Table 7: Count and Percent of Continuation of Last Year's Recommendations

Continuation of Last Year's Recommendation	Count	Percent
No	104	81%
Yes	24	19%
Unspecified	1	1%
Total	129	

Access Recommendations

The top recommendation associated with access was monitoring internal service metrics such as clinician capacity, penetration rates and utilization. Other recommendations include improve resources for non-English speakers, especially Spanish speakers, by hiring more Spanish-speaking providers, evaluating the use of language lines and ensuring non-English provider lists are up to date.

Recommendations were also made for developing or updating cultural competence work plans to include specific goals and objectives where possible. Several MHPs need to make revisions to their websites to create a format more suitable to the communication needs of beneficiaries and family members seeking information about services. Finally, MHPs should continue work on ensuring transportation is available for beneficiaries.

Foster Care Recommendations

The top foster care recommendations included improving methods for tracking and reporting children in foster care and enhancing relationships with community providers. Many of the other recommendations were related to adherence to SB 1291 and improved monitoring of those aspects of medication utilization. Also noted was the need to disaggregate timeliness data for children in foster care from data about other children and youth in care.

Timeliness Recommendations

The top recommendation associated with timeliness was improve the ability to track, monitor, and report on key timeliness metrics followed by improve the ability to respond to requests for urgent care services or improve their ability to document these services. Other recommendations were improving adherence to urgent, post-hospitalization follow-up, first psychiatric appointment, and no-show standards. Also mentioned was improving time to initial appointments, psychiatry appointments, and children's psychiatry.

Quality Recommendations

The top recommendations identified were the need to improve data reporting to assess progress to treatment goals. This was followed by developing medication monitoring systems that provides a regular, structured process for the review of all prescribers and contract providers in line with SB 1291 requirements. Other recommendations include training staff on a standardized level of care tool. Also included were the need to expand in-house data analytic capacity sufficient to provide the depth of analyses and implementation of the wide array of QI processes and prioritizing continued recruitment of peers to serve on the Quality Improvement Committee.

Beneficiary Progress and Outcomes Recommendations

The top recommendations associated with beneficiary outcomes involved the need to implement regular tracking and/or improve data tracking of patients to assess effectiveness and highlight areas of improvement. Also noted were the need to implement an assessment tool such as CANS or ANSA to better transition patients through various levels of care in treatment, and to provide career ladder for peer employees.

Information Systems Recommendations

The top IS-related recommendation for MHPs were improving the accuracy and efficiency of data reporting systems, through automation and distribution of dashboards, especially for front line staff. Other recommendations mentioned were addressing analytic and IT-focused staffing shortages to better support reporting and EHR utilization throughout the MHP and improving access and implementation of systems among CBOs and county partners. Also noted was implementation of eLab functionality, developing IS specific disaster plans, and improving claims and billing practices.

Structure and Operations Recommendations

The top recommendations for structure and operations include addressing the barriers to full staffing including recruitment, hiring, and retention. Other recommendations included were engaging internal stakeholders at all levels of the MHP and improving 24-7 crisis response services. Also noted was developing opportunities for increasing peer employment, training, and creating a career ladder for peer advancement.