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

HUMBOLDT FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

October 4, 2023

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — October 4, 2023

MHP Size — Small

MHP Region — Superior

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
6	2	4	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	5	1	0
Quality of Care	10	5	2	3
Information Systems (IS)	6	3	3	0
TOTAL	**26**	**17**	**6**	**3**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Improving family engagement and functioning for children and youth through family therapy	Clinical	09/2022	Second remeasurement	Moderate
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	09/2022	Implementation phase	Moderate

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	2*
* If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP's PRs are higher than statewide rates for all age categories other than 0-5, indicating greater access for most age groups than is seen statewide.
- The MHP's structure of operations are well suited for access and quality of care by co-locating services, proactive outreach in the schools, and strong community partnerships.
- The MHP adopted the new CalAIM Screening and Transition Tool which allowed them to reallocate staff resources and create more intake slots to promote easier access; this has shown to improve access across all demographic groups.
- Peers are well embedded in the system, present at all the primary service areas and available to the outlying clinics as needed.
- The MHP focused on crisis response improvements such as suicide prevention, follow-up after hospitalization, coordination of care between tribes, law enforcement, and EDs, and homelessness.

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

- Line staff need support to bolster their skills in the navigation and use of the SmartCare EHR.

- The MHP's FC PR was lower than small sized counties and statewide rates for the past three years.
- The MHP does not currently utilize a standardized children's or adult LOC tool. However, CANS is the identified standardized LOC tool for Children's Behavioral Health. The MHP has not used it as such in its full capacity and will seek guidance on any existing algorithms to use. The MORS for adults has been discontinued, with plans to replace it with LOCUS in June 2024.
- CANS reports are not presented with adequate granularity for clinical supervision. Upon adoption of LOCUS, reporting for clinical purposes should similarly be developed.
- The MHP is not tracking FC HEDIS measures.

Recommendations for improvement based upon this review include:

- Develop a skills gap analysis and training plan that leverages the availability of continued SmartCare EHR training.
- Collaborate with partner agencies to develop and implement strategies to better identify FC youth and improve access to MH services for them.
- Adopt standardized children's and adult LOC tools, develop a desk guide, and provide training to clinicians to determine the intensity of services needed for all members.
- Develop CANS and eventually LOCUS data reports with greater granularity to bring value to clinical supervision and programmatic oversight.
- Develop tracking and reporting mechanisms for the required FC HEDIS measures. This recommendation was continued from FY 2022-23.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2023-24 findings of the EQR for Humboldt County MHP by BHC, conducted as virtual review on October 4, 2023.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

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

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

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place when the MHP continues to experience staff shortages, affecting all areas of operations. Currently, the vacancy rate is approximately 28%.

SIGNIFICANT CHANGES AND INITIATIVES

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

- Enhanced Crisis Response: Humboldt County funded two FTE staff navigators to support members in crisis at four county hospitals. In partnership with Public Health, Humboldt County will focus on the rapid response and reporting of completed suicides and suicide attempts and will assist in funding the Children's Mobile Response Team. A community-based mobile crisis intervention will be expanded through prospective contract providers.
- Humboldt County Transition Age Youth Collaboration (HCTAYC) policy recommendations: The HCTAYC LGBTQIA+ & Two-Spirit Leadership Committee successfully finalized and launched their Youth Across Systems Policy Recommendations and held related convenings with various system partners.
- Community Information Exchange: A network of cross-sector partners (social services, community, tribal groups, government, physical and behavioral health providers) meet to coordinate care and maximize resources and supports.
- Assisted Outpatient Treatment (AOT): Through a contract with EA Family Services, AOT has been operational since July 2022, and is currently serving an average of ten members.
- Staff development: Children's Behavioral Health supported the training and certification of ten clinicians for Eye Movement Desensitization Reprocessing (EMDR) training to address the symptoms of trauma. Humboldt has applied for and is awaiting notification of bringing Child-Parent Psychotherapy to Humboldt County to serve the 0-5 population.
- Additional Peer Coaches and Parent Partners have been certified as Peer Support Specialists: Peer Coaching services have been established at Juvenile Hall and the New Horizons Program.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

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

Recommendations from FY 2022-23

Recommendation 1: Continue to collect and aggregate CANS data. Collect and aggregate PSC-35, and MORs data. Once data is aggregated, identify one or two areas the MHP can address as trends, to enhance service delivery and population improvement. Report on steps taken to implement changes in service delivery.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The Child and Adolescent Needs and Strengths (CANS) data are now collected in the aggregate and trended in a dashboard using Tableau. Based on findings, two of the highest needs identified were Adjustment to Trauma and Suicide Risk. In response, Childrens Behavioral Health (CBH) trained and certified nine clinicians in Movement Desensitization and Reprocessing (EMDR), an evidence-based practice designed to ameliorate the symptoms of trauma.
- The Pediatric Symptoms Checklist (PSC-35) reporting is currently being refined between the Childrens' team and the Quality team. However, the MHP was able to confirm that parent partner services have a positive impact on ratings.

- The Milestones of Recovery Scale (MORS) data has similarly been collected and aggregated to indicate areas of need and potential mitigation strategies. Humboldt County is in transition from MORS to the Level of Care Utilization System (LOCUS) and is expected to be implemented in this fiscal year. The MHP is currently working with CalMHSA to confirm system capabilities and licensing with SmartCare.

- While this item is rated partially addressed, it is not carried over in a recommendation for this year's review due to other priority recommendations identified and due to the plans in place to collect and aggregate both the PSC-35 and LOCUS data. A similar recommendation is proffered related to LOC tools and the development of more granular reports for clinical purposes.

Recommendation 2: Consult with other MHPs and seek TA from DHCS to understand and collect required HEDIS measures.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Initial steps have been taken to understand the HEDIS requirements by performing web site reviews and consultation with Ventura County and the Northern California Quality Improvement Coordinators committee. A clear path forward is still pending.
- This recommendation will be carried over with a slight modification.

Recommendation 3: Identify missing training for all peer staff and ensure all peer staff have completed job-specific training such as crisis intervention, case management, ethics, and learning "what is a peer/parent partner."

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP offers a rich curriculum of weekly training that is available to all peer staff. Peers also are assigned training through other sources such as Relias, QI, NAMI, and the peer staff support group. Several peer staff in the adult system were sponsored for peer certification.
- This recommendation calls out for the MHP to identify missing training and that all peers have completed job specific training as listed above.
- While this item is rated partially addressed, it is not carried over in a recommendation for this year's review due to other priority recommendations identified. The MHP is encouraged to develop a more strategic approach than offering a multitude of trainings that requires a peer to select and schedule.

Recommendation 4: Engage families in a committee to create a family-friendly environment within the youth and family clinics.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Community/stakeholders provided input to the waiting area of the -Children's Behavioral Health clinic, which is decorated to be kid friendly, with toys, comfortable, colorful chairs, and books.
- A current initiative by the Behavioral Health cultural responsiveness committee (BHCRC) is underway with three additional initiatives: 1) to extend the welcoming environments for members and staff throughout all clinics, 2) to include members, their families, and people with lived experience from the Behavioral Health Board to conduct environmental assessments, and 3) to conduct anonymous surveys about welcoming environments to staff and all members.

Recommendation 5: Provide an employee satisfaction survey to engage non-supervisory line-level staff and peer employees to express challenges and solutions within the MHP.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- An employee satisfaction survey was developed and prepared for distribution. However, in April 2023, Humboldt County Department of Health and Human Services (DHHS) conducted a similar employment engagement survey across its branches. While findings are still being aggregated, its results will be displayed for the entire department and not by separate branches.
- While this item is rated partially addressed, it is not carried over in a recommendation for this year's review due to other priority recommendations identified and the plans already in place to conduct the survey. The MHP is encouraged to follow through on this recommendation to increase both staff morale and retention and to present its findings at the next EQR.

Recommendation 6: Develop and implement a system to accurately track and report urgent service requests.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The Request to Access Services process and production log were revised to capture urgent and non-urgent service requests.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 80 percent of services were delivered by county-operated/staffed clinics and sites, and 20 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 76 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff and a contracted answering service; beneficiaries may request services through the Access Line as well as through the following system entry points: four local hospitals, crisis stabilization unit (CSU), Same Day Services (SDS) program, Mobile Response Team (MRT), Community Correction Resource Center (CCRC), Older Adults clinic, Transitional Age Youth (TAY) program, Garberville clinic, Children's BH main clinic, and the outpatient reception areas at all other county operated BH facilities. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services.

Each caller participates in an initial telephone screening, urgent calls are returned by a clinician within an hour or transferred to crisis staff immediately. Routine calls are routed for a one-to-five-day return call. In the second call, a clinician will determine the member's need and link them to appropriate services. Certain programs such as the Community Corrections Resource Center (CCRC) provide their own admissions based on the population they serve.

In addition to clinic-based MH services, the MHP provides psychiatry services via telehealth video to youth and adults and MH services via telehealth video and telephone to youth and adults. In FY 2022-23, the MHP reports having provided telehealth

[1] CMS Data Navigator Glossary of Terms

services to 1,228 adults, 268 youth, and 246 older adults across 12 county operated sites and 4 contractor-operated sites. Among those served, 18 members received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

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

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

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

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

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

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

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

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

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

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to members and family members. Examining

service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved member outcomes.

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

Table 2: Access Key Components

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

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

- The Racial Equity Plan has expanded training to include implicit bias and a four-hour foundations training that builds on the implicit bias module.
- Currently, a suicide prevention initiative is underway, and BH has provided additional training to staff who are working with members at risk for suicide.

ACCESS PERFORMANCE MEASURES

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

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

The PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the

total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, with a PR of 5.21 percent, Humboldt has better access to care than was seen statewide.

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

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	63,771	3,321	5.21%	$29,681,293	$8,937
CY 2021	60,721	3,021	4.98%	$29,891,340	$9,895
CY 2020	57,333	3,090	5.39%	$32,658,004	$10,569

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

- While PR increased from CY 2021 to CY 2022, AACM has been trending downward for the past three CYs.

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

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	5,723	92	1.61%	1.31%	1.82%
Ages 6-17	12,332	996	8.08%	5.83%	5.65%
Ages 18-20	2,689	193	7.18%	4.72%	3.97%
Ages 21-64	37,928	1,846	4.87%	4.53%	4.03%
Ages 65+	5,102	194	3.80%	2.25%	1.86%
Total	**63,771**	**3,321**	**5.21%**	**4.30%**	**3.96%**

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

- The MHP's PRs are higher than the small sized county rates for all age categories, and higher than statewide PRs for all age categories except ages 0-5.

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

Threshold Language	# Members Served	% of Members Served
No threshold languages	N/A	N/A
Threshold language source: Open Data per BHIN 20-070		

- The MHP does not have any threshold languages.

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

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	23,467	863	3.68%	$5,626,760	$6,520
Small	218,086	8,382	3.84%	$44,131,230	$5,265
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. The MHP follows the statewide trend with a higher overall PR compared to the ACA PR (5.21 percent vs. 3.68 percent)
- The MHP's ACA PR exceeds the statewide rate and is lower than the small sized county rate. The ACA AACM is greater than both the small sized county and statewide AACM.

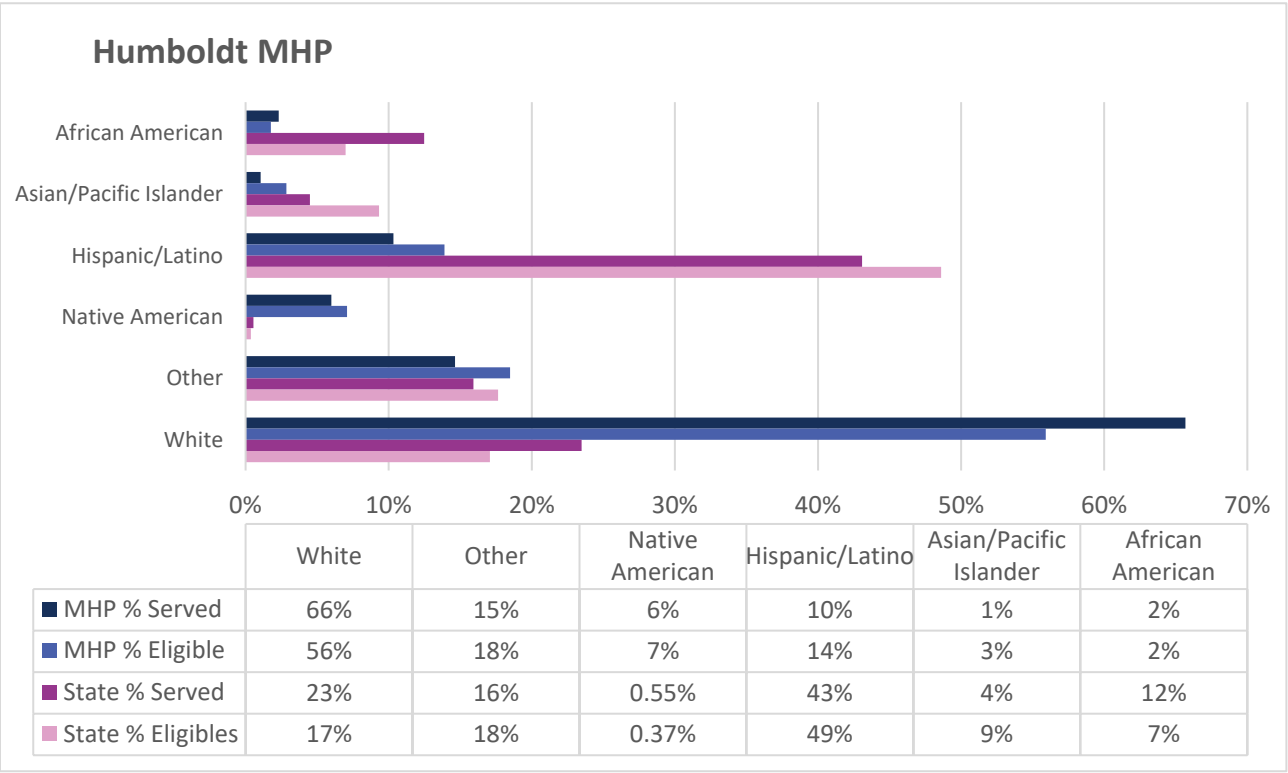
The racial/ethnic data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they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

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

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	1,128	77	6.83%	7.08%
Asian/Pacific Islander	1,819	35	1.92%	1.91%
Hispanic/Latino	8,863	343	3.87%	3.51%
Native American	4,523	199	4.40%	5.94%
Other	11,786	486	4.12%	3.57%
White	35,655	2,181	6.12%	5.45%

- PRs were lower than corresponding statewide rates for the African American, and Native American groups but exceeded statewide rates for Hispanic/Latino, Other, and White. The Asian/Pacific Islander PR was comparable to the statewide rate.

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



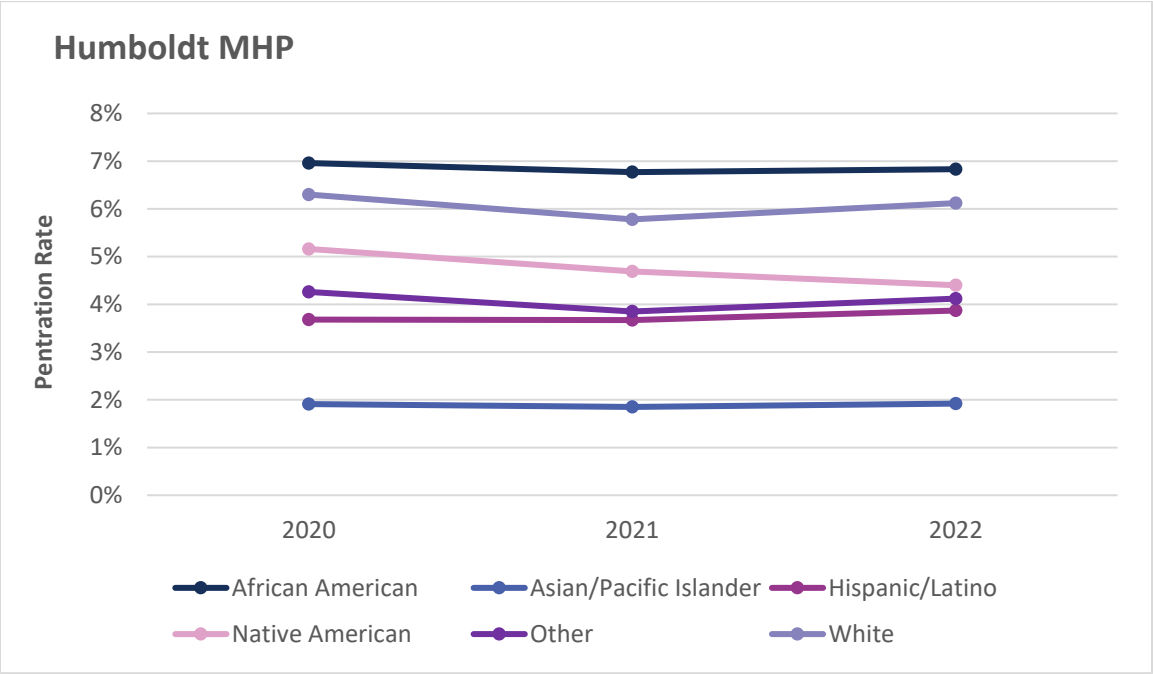
	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	66%	15%	6%	10%	1%	2%
MHP % Eligible	56%	18%	7%	14%	3%	2%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- While White was the most proportionally overrepresented racial/ethnic group in the MHP, the most proportionally underrepresented groups were Hispanic/Latino, Asian/Pacific Islander, and Other.

- The MHP had a lower proportion of Hispanic/Latino, Asian/Pacific Islander, and African American eligibles and a higher proportion of White and Native American eligibles than the state as a whole.

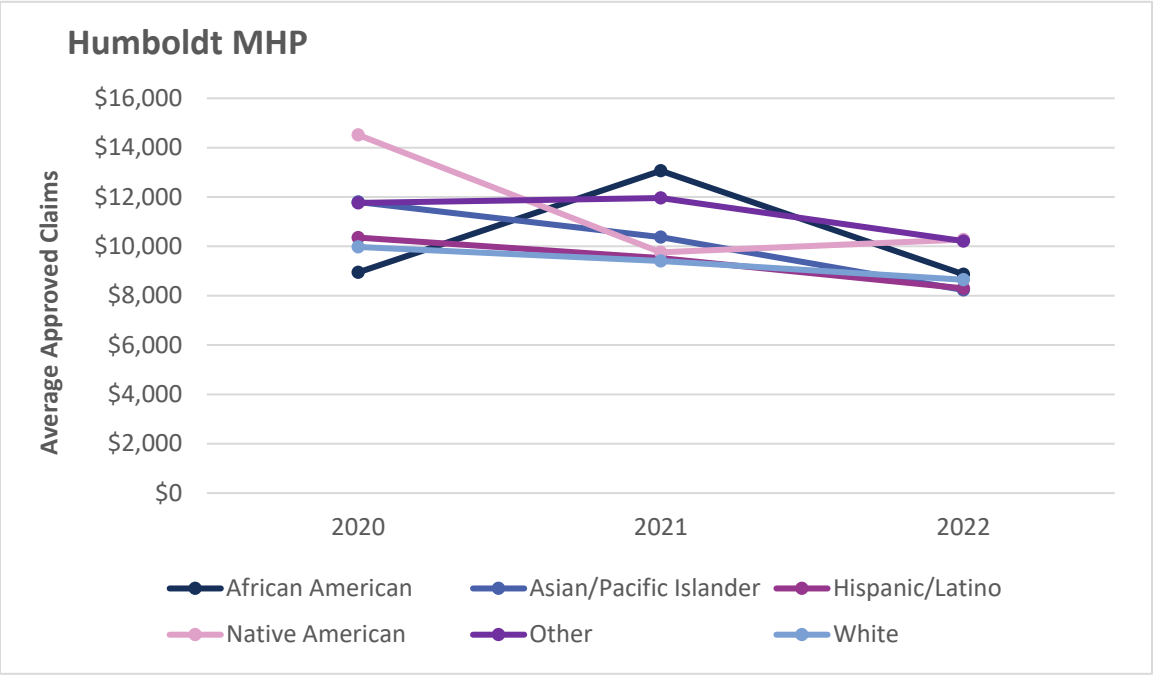
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



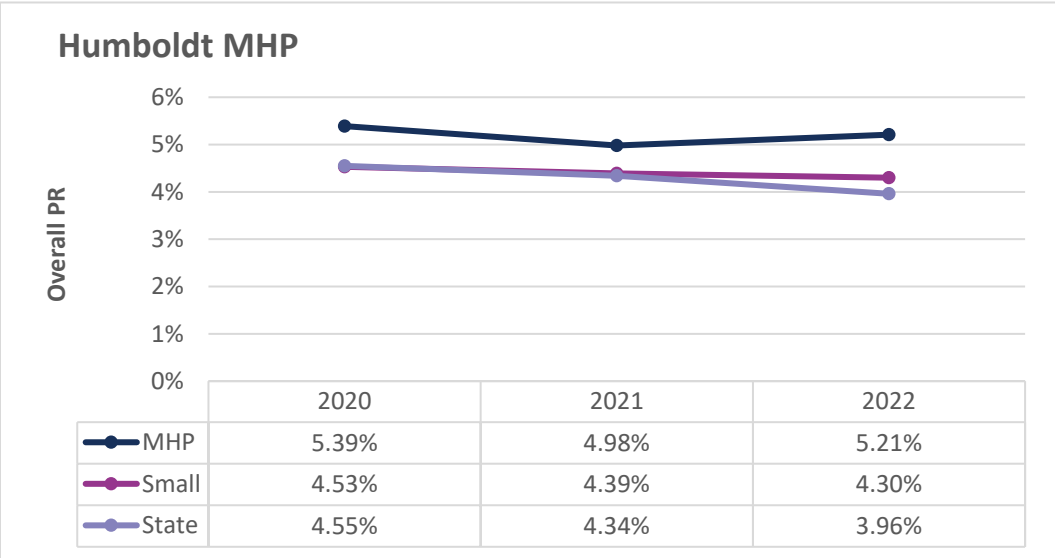
- PRs for White and African American have consistently been the highest over the past three years, whereas PRs for Asian/Pacific Islander have consistently been the lowest.

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



- AACMs for Hispanic/Latino, Asian/Pacific Islander, and White declined from CY 2021 to CY 2022.
- The AACM for Native American and African American members displayed notable variation from CY 2020 to CY2022. It should be noted that Native American members were 6 percent of all members served and African American members comprised 2 percent of all members served. When a population is small, outliers can impact averages (means) in a way that appears dramatic.

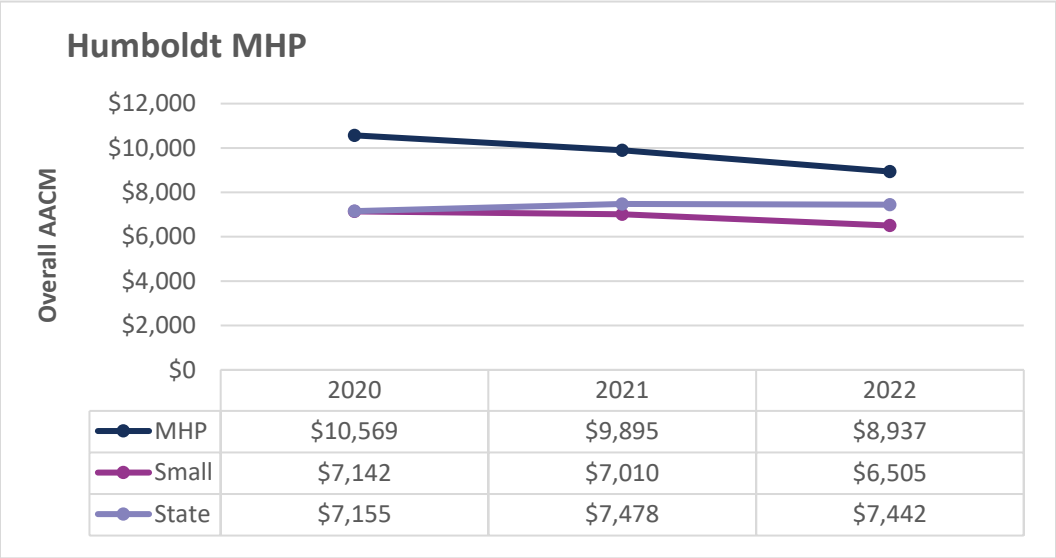
Figure 4: Overall PR CY, 2020-22



	2020	2021	2022
MHP	5.39%	4.98%	5.21%
Small	4.53%	4.39%	4.30%
State	4.55%	4.34%	3.96%

- The MHP's PR was above both small sized county and statewide rates from CY 2020 to CY 2022.

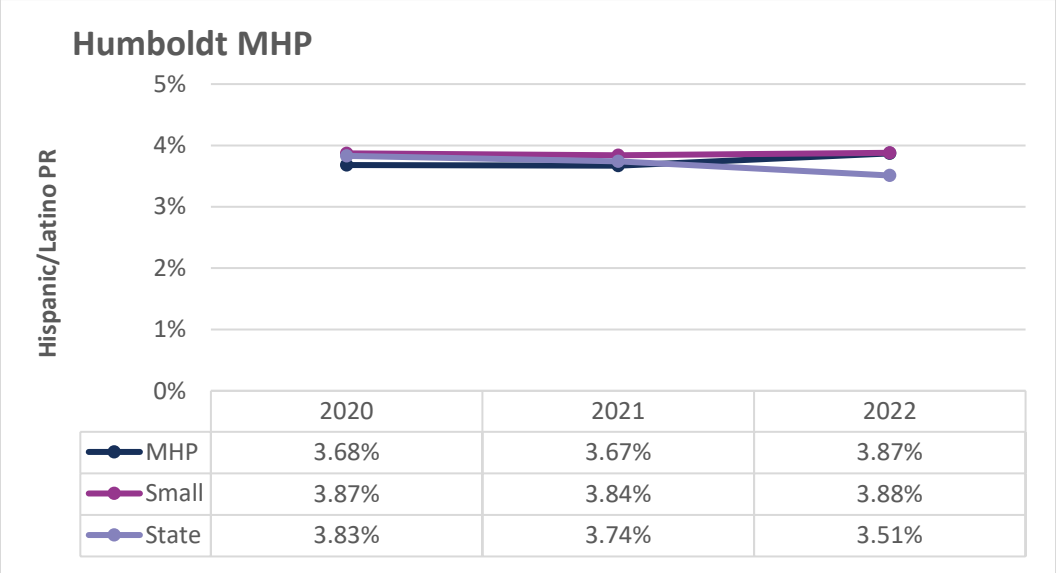
Figure 5: Overall AACM, CY 2020-22



	2020	2021	2022
MHP	$10,569	$9,895	$8,937
Small	$7,142	$7,010	$6,505
State	$7,155	$7,478	$7,442

- While the MHP's AACM declined each year from CY 2020 to CY 2022, it exceeded both small sized county and statewide AACM's during this time.

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

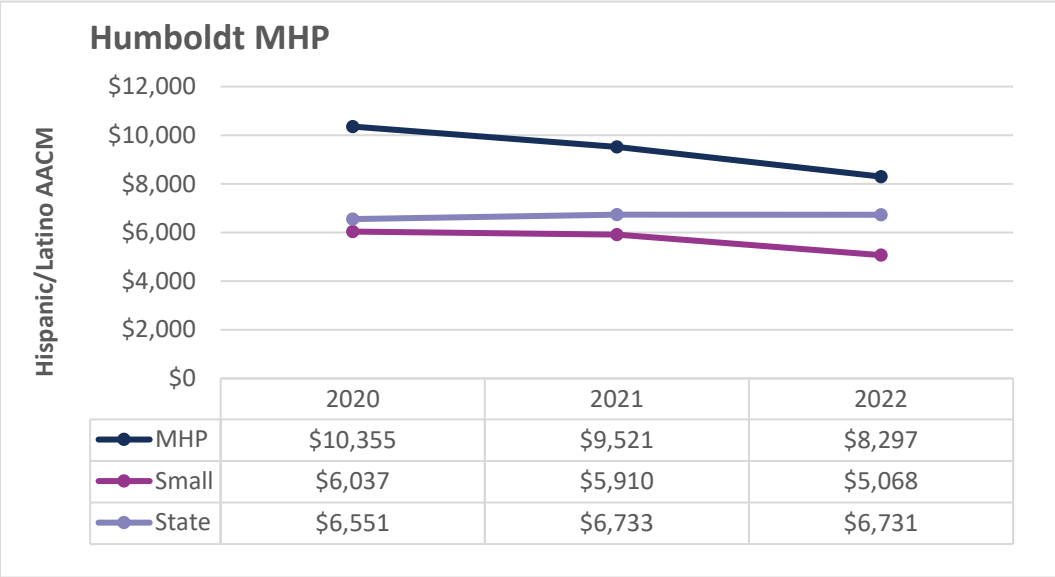


	2020	2021	2022
MHP	3.68%	3.67%	3.87%
Small	3.87%	3.84%	3.88%
State	3.83%	3.74%	3.51%

- The MHP's Hispanic/Latino PR was relatively stable from CY 2020 to CY 2022, increasing slightly (3.68 percent vs. 3.87 percent).

- In CY 2022, the MHP's Hispanic/Latino PR was comparable to the small sized county rate and exceeded the statewide rate.

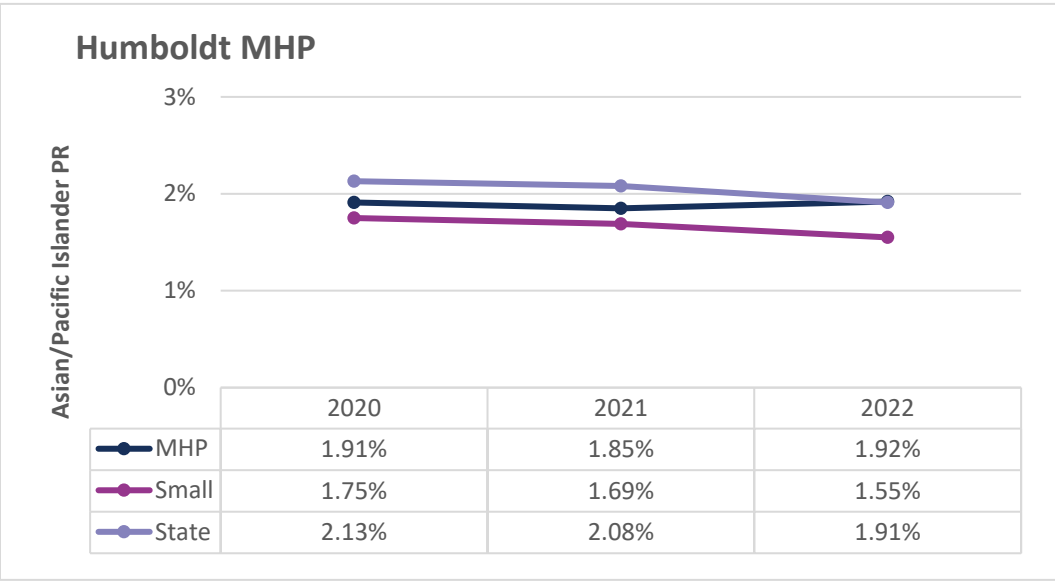
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$10,355	$9,521	$8,297
Small	$6,037	$5,910	$5,068
State	$6,551	$6,733	$6,731

- While the MHP's Hispanic/Latino AACM declined each year from CY 2020 to CY 2022, it exceeded both small sized county and statewide AACM's during this time.

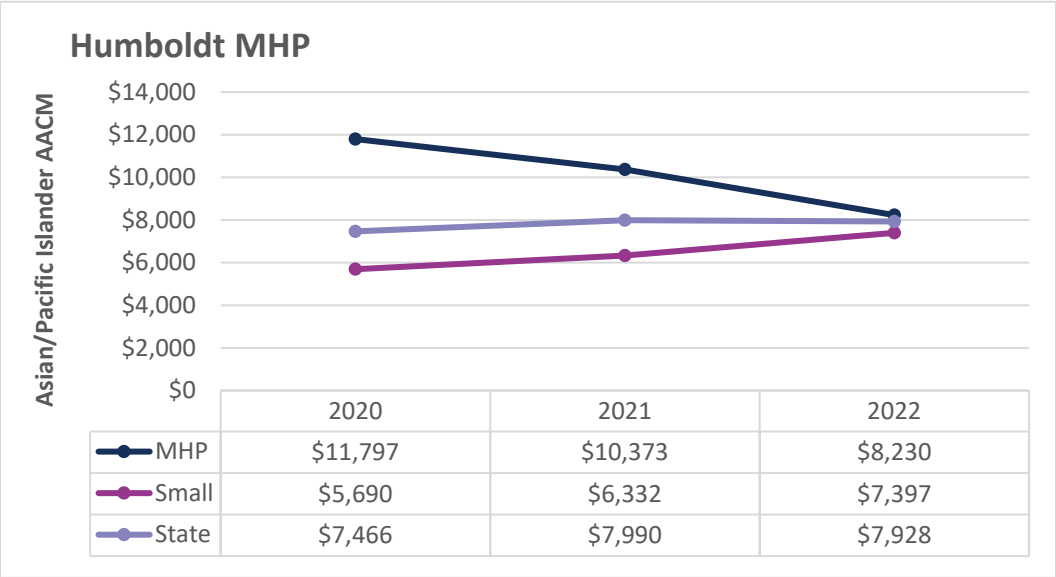
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	1.91%	1.85%	1.92%
Small	1.75%	1.69%	1.55%
State	2.13%	2.08%	1.91%

- The MHP's Asian/Pacific Islander PR was comparable to the statewide rate and above the small sized county rate in CY 2022.

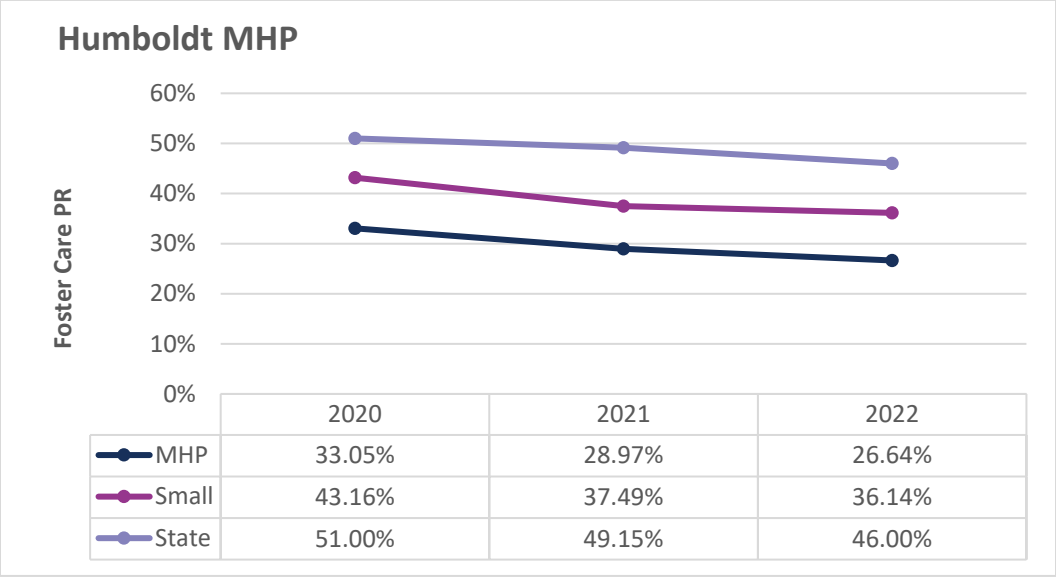
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$11,797	$10,373	$8,230
Small	$5,690	$6,332	$7,397
State	$7,466	$7,990	$7,928

- The MHP's Asian/Pacific Islander AACM declined notably from CY 2020 to CY 2022 ($11,797 vs. $8,230) but remained just above small sized county and statewide AACMs in CY 2022. Asian Pacific Islanders comprised 3 percent of the MHPs eligibles and 1 percent of those served in CY 2022 (see Figure 1).

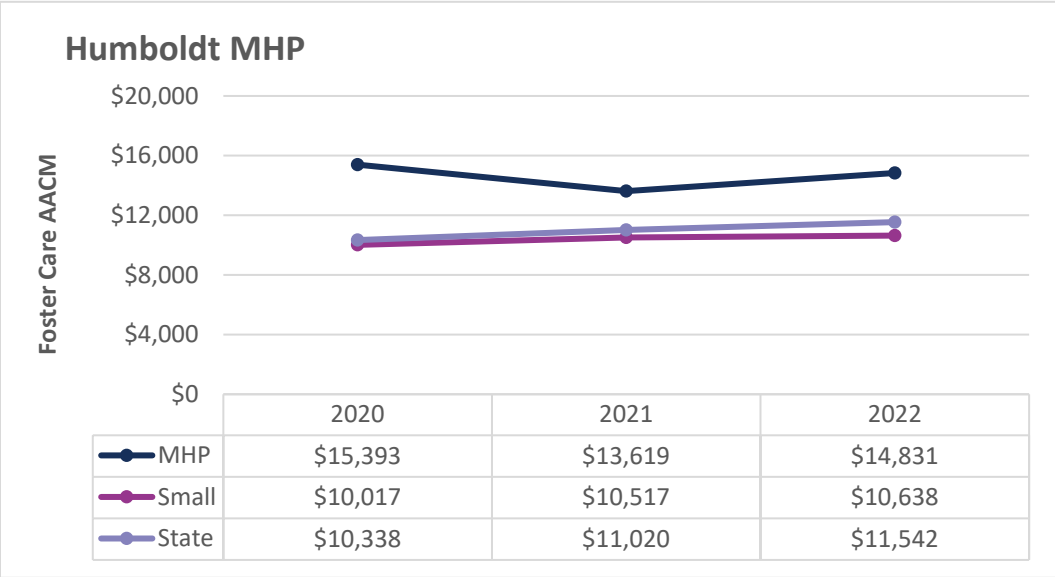
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	33.05%	28.97%	26.64%
Small	43.16%	37.49%	36.14%
State	51.00%	49.15%	46.00%

- The MHP's FC PR declined each year from CY 2020 to CY 2022. The MHP's CY 2022 FC PR was lower than both the small sized county (26.64 vs. 36.14) and statewide rates (26.64 percent vs. 46.00 percent).

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$15,393	$13,619	$14,831
Small	$10,017	$10,517	$10,638
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years.
- The MHP's FC AACM has been greater than small sized county and statewide averages from CY 2020 to CY 2022.

Units of Service Delivered to Adults and Foster Youth

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

Service Category	MHP N = 2,234				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	222	9.9%	14	8	10.3%	14	8
Inpatient Admin	27	1.2%	40	24	0.4%	26	10
Psychiatric Health Facility	47	2.1%	14	11	1.2%	16	8
Residential	<11	-	180	186	0.3%	114	84
Crisis Residential	<11	-	15	16	1.9%	23	15
Per Minute Services							
Crisis Stabilization	129	5.8%	1,133	1,200	13.4%	1,449	1,200
Crisis Intervention	669	29.9%	201	143	12.2%	236	144
Medication Support	1,160	51.9%	346	206	59.7%	298	190
Mental Health Services	1,634	73.1%	714	210	62.7%	832	329
Targeted Case Management	509	22.8%	608	266	36.9%	445	135

- The MHP's combined inpatient and psychiatric health facility utilization is just above the combined statewide rate (12 percent vs. 11.5 percent).
- While the MHP's CSU utilization rate is lower than the statewide rate (5.8 percent vs. 13.4 percent), the crisis intervention utilization rate in the MHP is more than twice the statewide rate (29.9 percent vs. 12.2 percent).
- The targeted case management (TCM) utilization rate is lower in the MHP than statewide (22.8 percent vs. 36.9 percent), though with more units of service on average.

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

Service Category	MHP N = 146				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	20	21	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	6	6	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	3.1%	1,166	1,095
Crisis Intervention	21	14.4%	293	225	8.5%	371	182
Medication Support	49	33.6%	607	514	27.6%	364	257
TBS	<11	-	4,299	2,042	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	23	15.8%	870	255	40.8%	1,458	441
Intensive Home-Based Services	12	8.2%	9,142	2,687	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	142	97.3%	1,815	824	95.4%	1,846	1,053
Targeted Case Management	39	26.7%	632	360	35.8%	307	118

- Intensive home-based services (IHBS) and intensive care coordination (ICC) utilization were notably lower than statewide rates, warranting attention to the local implementation of the Pathways to Well-Being (PWB) statewide initiative.
- Mirroring adult service utilization patterns, FC crisis intervention utilization rates are higher at the MHP than statewide and TCM rates are lower at the MHP when compared to the statewide rate.

IMPACT OF ACCESS FINDINGS

- The MHP's PRs are higher than statewide rates for all age categories other than ages 0-5, indicating greater access than is seen overall in the state.
- The MHP improved an access process which allowed for the reallocation of staff resources and created more intake slots to promote easier access; this has shown to improve access across all demographic groups.
- The MHP's FC PR was lower than small sized county and statewide rates from CY 2020 to CY 2022, indicating a potential need for increased outreach to this population. However, the FC AACM has continued to increase for the last three years and exceeds the small sized counties and statewide averages. Further, FC crisis intervention utilization rates are higher at the MHP than statewide and targeted case management rates are lower at the MHP when compared to the statewide rate. Examining the flow of FC across the system from access, LOC, and service utilization patterns may enhance strategies for serving this population to assess appropriate PWB implementation.
- The MHP has transitioned to the CalAIM Screening and Transition Tool. Further training will be warranted to ensure consistent application and ease of use with the MHP, the MCP, and referrals from other sources.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- A psychiatrist has been added to the system to improve timely access to psychiatry services.

- The Request for Access to services (RAS) report has been improved to include both urgent and non-urgent requests.
- Collecting and tracking data for FC youth continues to be a challenge.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 11-month period from July 1, of CY 2022 to May 31, 2023, for all appointment types except for psychiatry, which included data from February 15, 2023, to June 30, 2023 only. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. Data related to first non-urgent offered and rendered as well as follow-up appointments after psychiatric hospitalization represent the entire system of care. All other data represent County-operated services only.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5 Business Days	10 Business Days*	94%
First Non-Urgent Service Rendered	7 Business Days	10 Business Days**	77%
First Non-Urgent Psychiatry Appointment Offered	20 Business Days	15 Business Days*	49%
First Non-Urgent Psychiatry Service Rendered	15 Business Days	15 Business Days**	51%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required ***	18 Hours	48 Hours*	94%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	6 Days	7 Calendar Days	52%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	6 Days	30 Calendar Days	74%
No-Show Rate – Psychiatry	7%	10%**	n/a
No-Show Rate – Clinicians	2%	10%**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033

** MHP-defined timeliness standards

*** The MHP does not separately report urgent timeliness for services requiring prior authorization

For the FY 2023-24 EQR, the MHP reported its performance for the following time period:

7/1/2022 - 5/31/2023 for all services except for psychiatry which reflects data from 2/15/23 - 6/30/2023

Note: No-Show Rate-Psychiatry represents appointments that were cancelled by Psychiatrist.

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

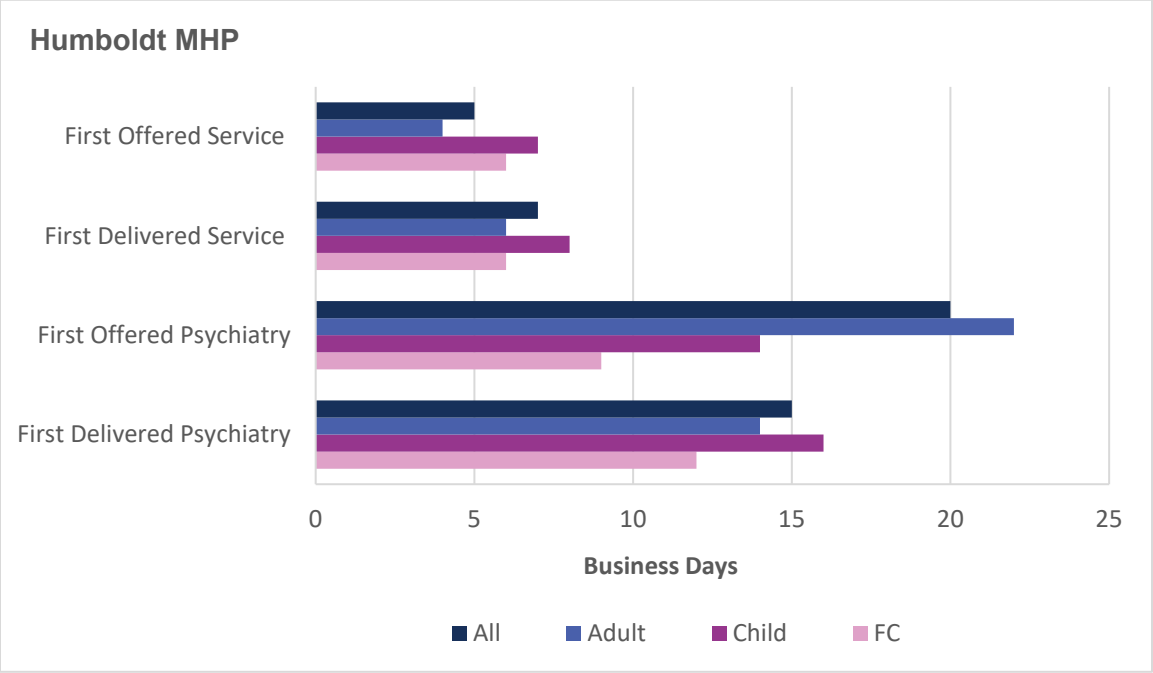


Figure 13: Wait Times for Urgent Services

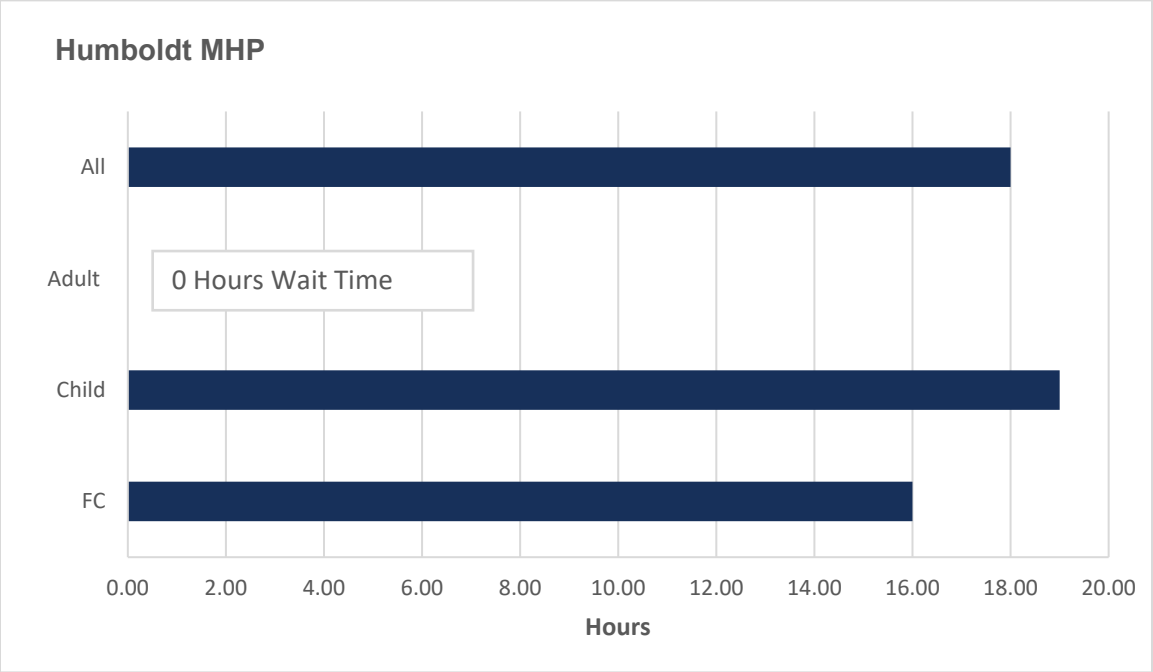
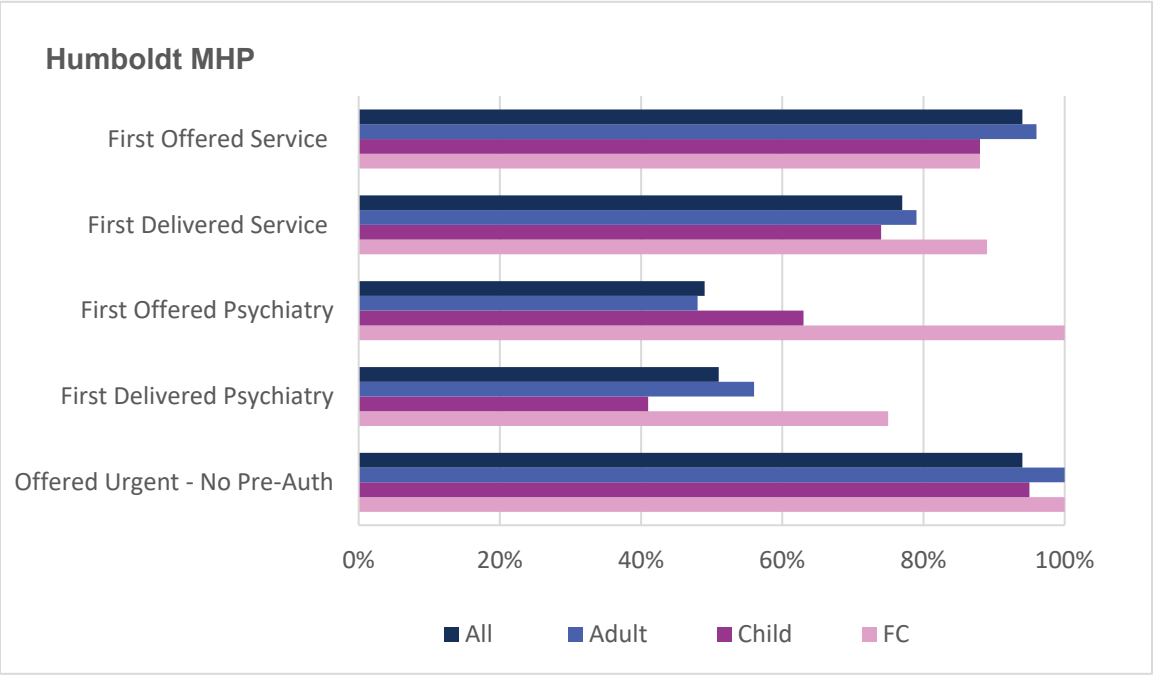


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represents a phone screening. This is of limited utilization for analysis because the screening is not actually a SMHS.
- The MHP defined “urgent services” for purposes of the ATA as determined by the assessing clinician upon first contact with the client. There were reportedly 66 urgent service requests with a reported actual wait time for services for the overall population of 18 hours average. The MHP does not offer urgent services that require separate pre-authorization.
- The MHP collected data for timeliness to first delivered/rendered psychiatry services to include only those services that were provided within 30 days for All Services. Of those, 51 percent of delivered services met the 15-day standard.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked for all services with an MHP standard for psychiatrists and non-psychiatry clinical staff of 10 percent. The MHP reports a no-show rate for psychiatrists as: adult services at 7 percent, children’s services at 5 percent, and FC at 21 percent. The MHP reports a no-show rate for non-psychiatry clinical staff as: adult services at 1 percent, children’s services at 4 percent, and foster care at 3 percent.
    - No show rates for psychiatrist also include those appointments that have been cancelled by the psychiatrist.

IMPACT OF TIMELINESS FINDINGS

- The percentages meeting the standards for first non-urgent psychiatry appointment offered and rendered were 49 percent and 51 percent respectively. However, the MHP reported psychiatry timeliness based on 4.5 months of data, February 15, 2023 - June 30, 2023, creating a threat to validity.
- The short period for capturing psychiatry timeliness was due to a change in methodology to capture the data. As of February 15, 2023, a new and more accurate process was implemented which utilized new fields in the EHR scheduling calendar to track a member's first request for psychiatry/medication support services.
- The MHP has added an additional psychiatrist which has improved timeliness.
- The MHP continues to improve no-show rates which allows for efficient use of staff time while vacancy rates are high.
- The MHP should investigate reasons for the low performance in the first delivered psychiatry appointment for youth and adults. The result(s) should assist in determining the appropriate changes to improve that finding.
- The MHP should work with partners to investigate why the FC no show rate for psychiatrists is high compared to all other groups at 21 percent, adults at 7 percent, and children's services at 5 percent. The FC no show rate for non-psychiatrist clinicians is 3 percent.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

The responsibility for QI lies within the performance management unit. The unit oversees multiple quality improvement committees (QIC) and continuous quality improvement (CQI) and remain active in advisory committees, including the Family Advisory Board (FAB), Youth Advisory Board (YAB) and Sempervirens (SV)-CQI. All Organizational Provider Meetings are held quarterly; an Org Provider representative attends the monthly OP CQI meetings. QI provides support to all outpatient, inpatient, and SUD programs. There are 12.5 allocated positions, including a newly allocated analyst. The Performance Management unit are currently 4.8 FTE short of being fully staffed due to vacancies and extended leaves of absence. This severely impacts the unit's ability to meet compliance requirements, reporting needs of the MHP.

The MHP monitors its quality processes through the quality improvement workplan (QIWP), and the annual evaluation of the QIWP. The QIWP has been enhanced by the inclusion of baseline data and measurable, time-bound targets. The QIC is comprised of county staff including executive staff, directors, administrative analysts, program managers, psychiatric nurses, clinicians, doctors, a family member, organizational provider, TAY, and one stakeholder employed by the county as a parent partner representing NAMI and families. The various committees meet monthly.

Since the previous EQR, the MHP QIC met 11 times. Of the 11 identified FY 2022-23 QIWP goals, the MHP identified 7 plan areas, 11 goals, and 33 objectives. Approximately 36 percent of goals and 48 percent of objectives were met. Areas that were partially or not met were noted if they would carry over to the following year.

For level of care (LOC) and outcomes for children, the CANS is utilized. Quarterly and yearly data trending is available. DHHS quality management services (QMS) currently issues a quarterly CANS report, which, among other elements, indicates aggregate change in scoring across time. CANS data is not presented with enough granularity so that it can be used in clinical group supervision or programmatic oversight in a meaningful way.

At this time, the MHP does not have LOC or outcome in use for the Adult System of Care. Prior to July 1, 2023, the Milestones of Recovery Scale (MORS) was utilized as the LOC and outcome measure. Due to multiple factors related to fidelity and reliability, the decision was made to discontinue MORS and implement the Level of Care Utilization System (LOCUS). Planning for implementation and training to LOCUS began after SmartCare implementation and is underway to be implemented as soon as possible. The MHP's goal is to have 90% of eligible staff trained in LOCUS by June 2024.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Not Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Not Met
3H	Utilizes Information from Member Satisfaction Surveys	Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Member and Member Employment in Key Roles throughout the System	Partially Met

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

- The MHP continues to make progress in the development of report dashboards.
- The MHP utilized a dashboard to identify homeless members who access multiple high-cost services, with the goal of linking them to housing resources. The results

have been noteworthy, as 383 members who were homeless obtained permanent supportive housing and received support from the MHP. Of the 272 who obtained housing a year or more ago, 94% remained in housing after one year and only 2% returned to homelessness. Of the 227 who obtained housing two or more years ago, only 6% returned to homelessness after two years.

- The MHP does not track or trend the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
- The MHP does not have peer managers or supervisors that sit on the executive management team.

QUALITY PERFORMANCE MEASURES

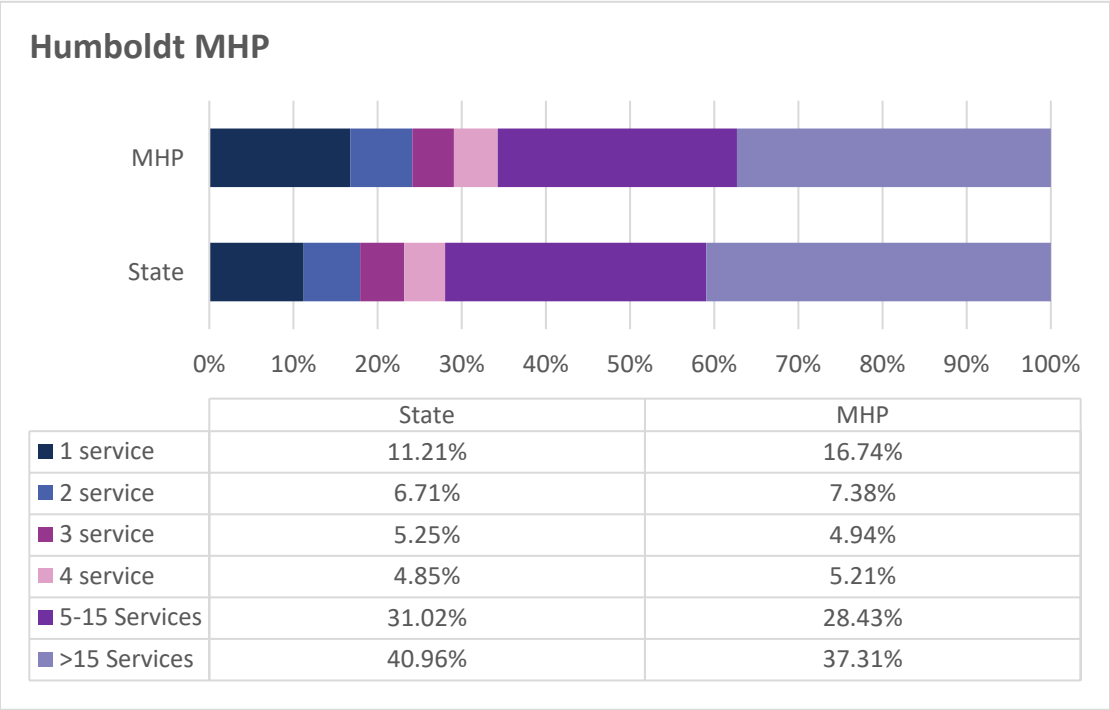
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Members Served, CY 2022



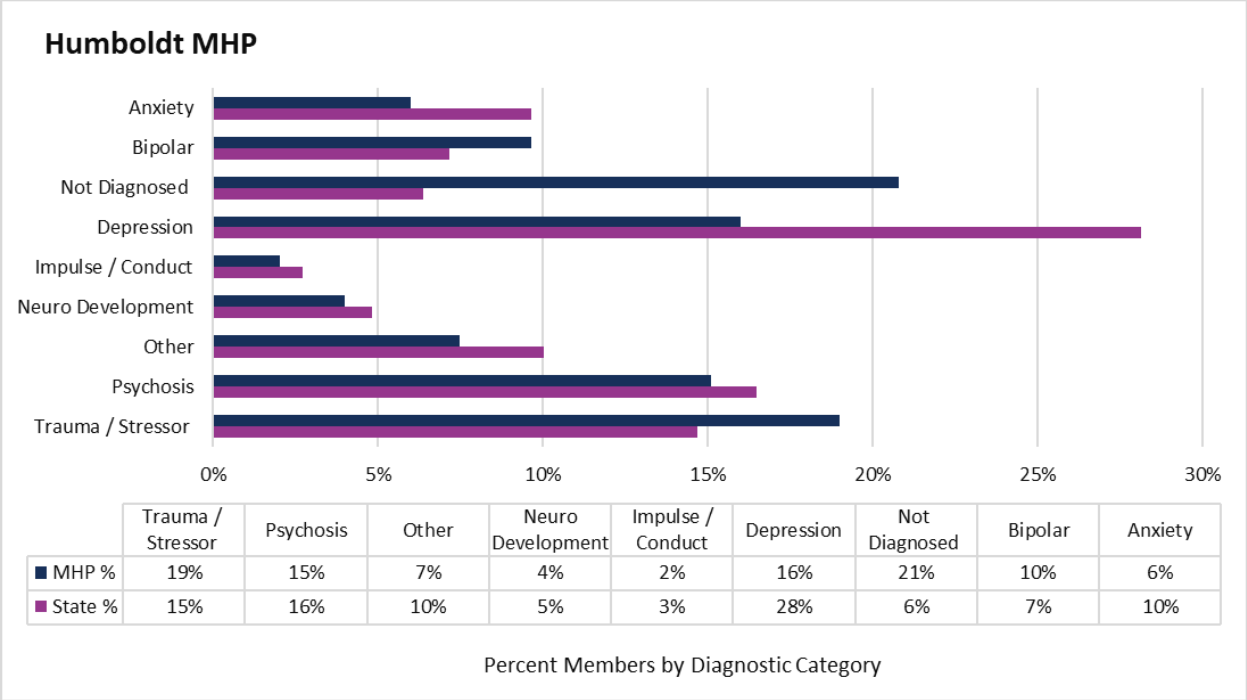
	State	MHP
1 service	11.21%	16.74%
2 service	6.71%	7.38%
3 service	5.25%	4.94%
4 service	4.85%	5.21%
5-15 Services	31.02%	28.43%
>15 Services	40.96%	37.31%

- The MHP had more members receiving only one service than is seen statewide (16.74 percent vs. 11.21 percent).
- The MHP's proportion of members receiving greater than 15 services is just below the statewide proportion (37.31 percent vs. 40.95 percent).

Diagnosis of Members Served

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

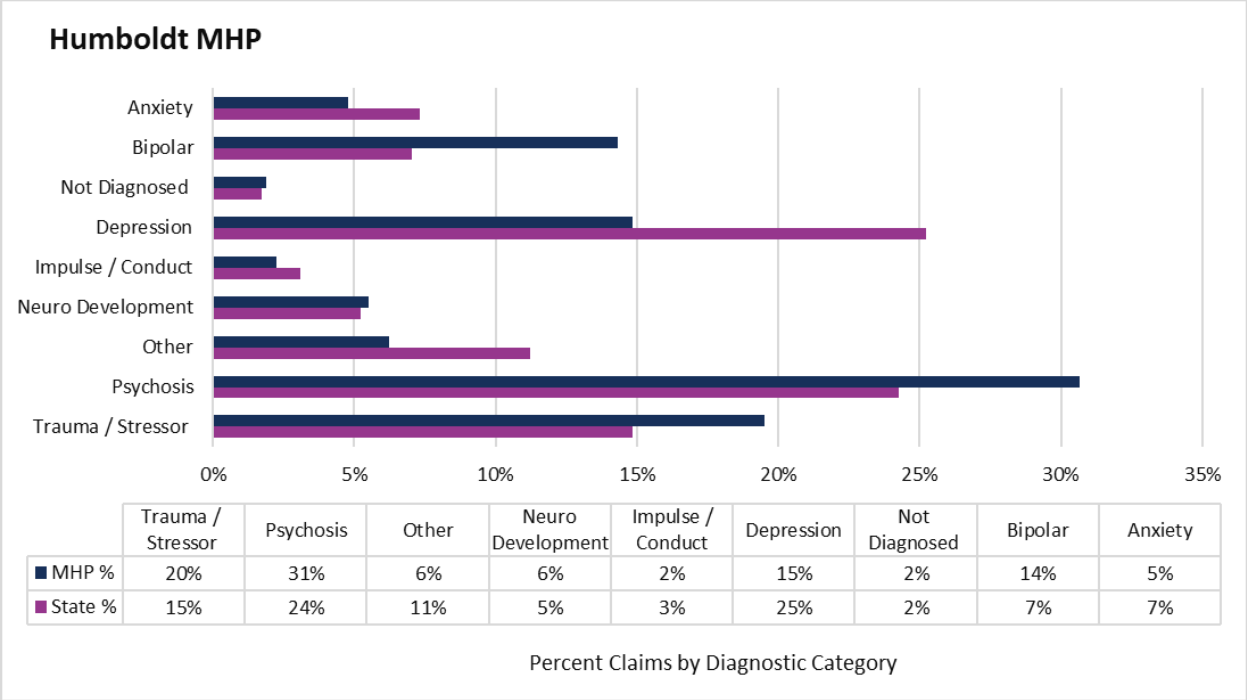
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	19%	15%	7%	4%	2%	16%	21%	10%	6%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- Fifty-six percent of members had one of three diagnoses: Not diagnosed (21 percent), trauma/stressor (19 percent), and depression (16 percent). The MHP's rate for not diagnosed was more than three times the statewide rate (21 percent vs. 6 percent). While this is not prohibited under CalAIM, the low percentage of claims (below in Figure 17) suggests that a diagnosis occurs quickly for the members who initially receive no diagnosis.
- While depression, anxiety and other disorders are diagnosed at lower rates than is seen statewide, trauma/stressor disorders are diagnosed at a higher rate.

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



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	20%	31%	6%	6%	2%	15%	2%	14%	5%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- While the MHP's approved claims percentages generally aligned with diagnostic patterns when compared to statewide data, psychosis claims were higher than their population within the MHP and compared to statewide.

Psychiatric Inpatient Services

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

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

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	290	369	1.27	13.42	8.45	$22,411	$12,763	$6,499,222
CY 2021	344	424	1.23	10.64	8.86	$15,719	$12,696	$5,407,381
CY 2020	379	479	1.26	8.67	8.68	$18,791	$11,814	$7,121,779

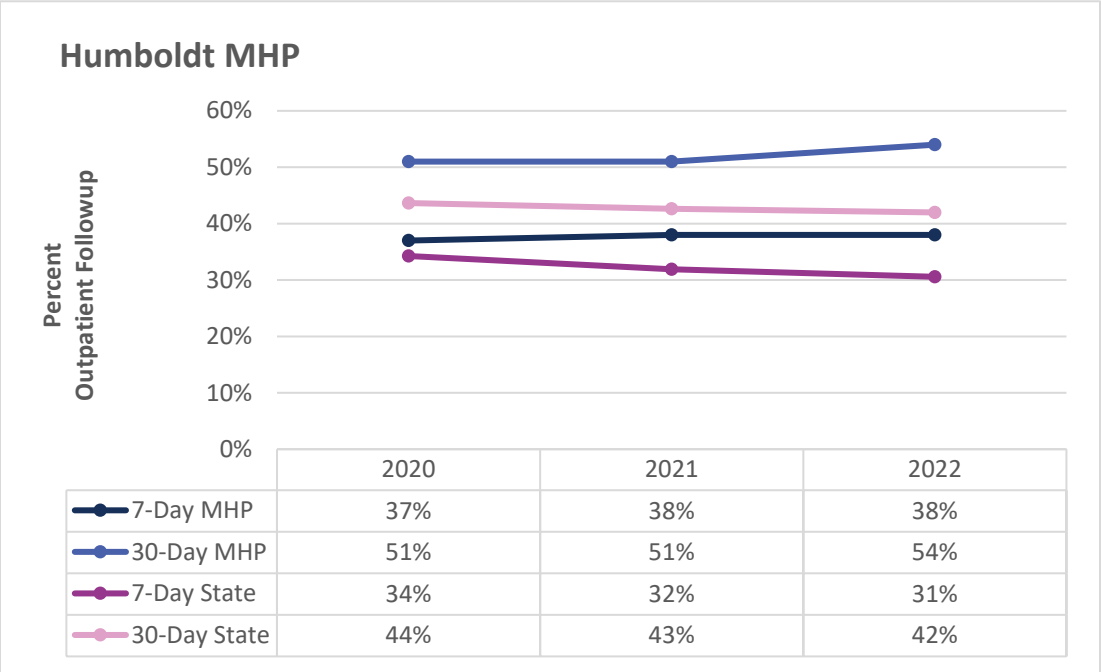
- CY 2022 showed fewer members hospitalized. However, the cost and ALOS increased significantly in CY 2022. Despite fewer hospitalizations, the MHP showed an increase in total inpatient claims.

Follow-Up Post Hospital Discharge and Readmission Rates

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

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

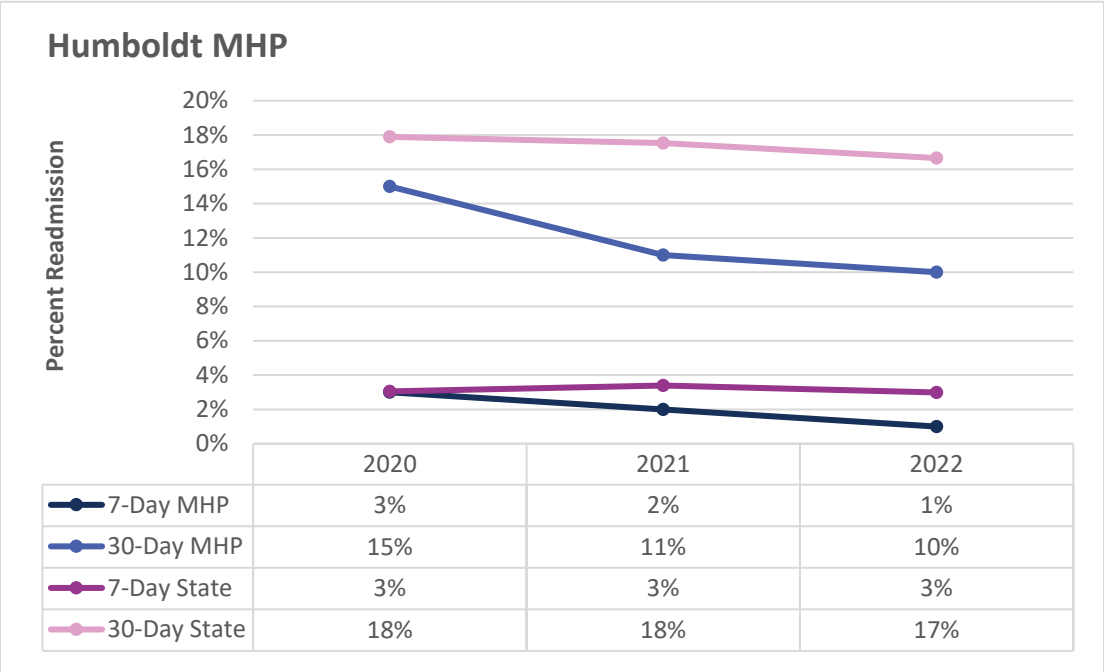
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	37%	38%	38%
30-Day MHP	51%	51%	54%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- The MHP's 7- and 30-day follow-up rates exceeded statewide rates from CY 2020 to CY 2022.

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



	2020	2021	2022
7-Day MHP	3%	2%	1%
30-Day MHP	15%	11%	10%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHPs 7-day readmission rates were lower than statewide rates in CY 2022, as well as the two prior years.
- The MHP's 30-day admission rate has been lower than the statewide rate for the past two years, CY 2021 and 2022.

High-Cost Members

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

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

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

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

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	215	6.47%	45.28%	$13,440,533	$62,514	$48,751
	CY 2021	257	8.51%	46.18%	$13,803,773	$53,711	$43,229
	CY 2020	269	8.71%	48.58%	$15,865,067	$58,978	$45,593

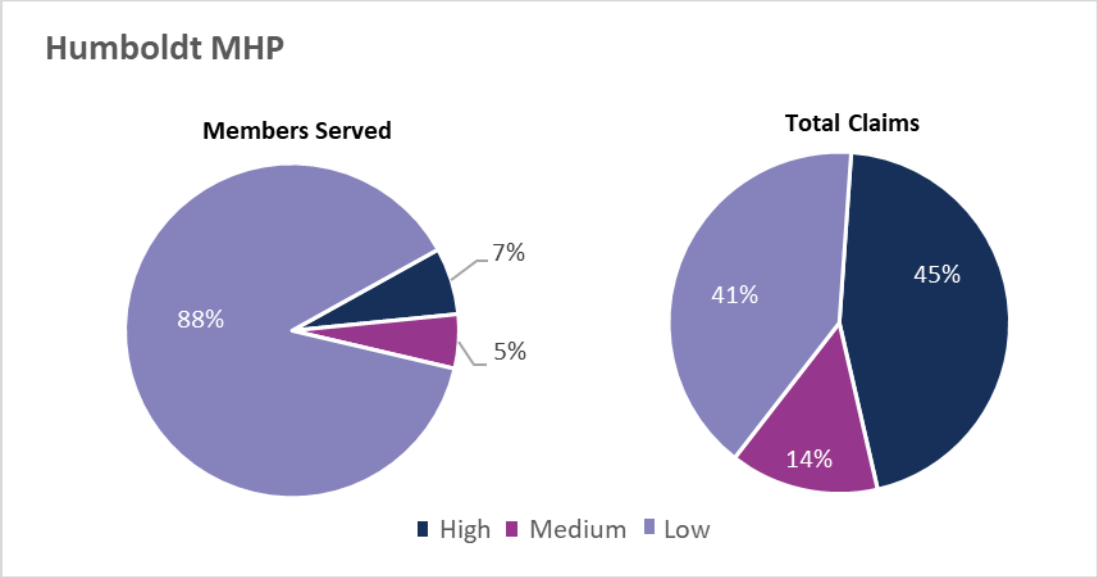
- While the MHP's HCM count, HCM percent of members served, and HCM percent of claims declined each year from CY 2020 to CY 2022, the percentage of HCMs continues to exceed the statewide rate in CY 2022 (6.47 percent vs. 4.54 percent).
- The MHP's AACM per HCM exceeded the statewide average in CY 2022 ($62,514 vs. $55,518). The increase in inpatient claims is likely a strong contributor to this measure.

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

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	174	5.24%	14.12%	$4,190,462	$24,083	$23,711
Low-Cost (Less than $20K)	2,932	88.29%	40.60%	$12,050,298	$4,110	$2,294

- Low-cost members comprised 88.29 percent of those served and 40.60 percent of the approved claims dollars were attributed to this population.

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



IMPACT OF QUALITY FINDINGS

- The QIWP has been enhanced by the inclusion of baseline data and measurable, time-bound targets.
- The increased ALOS for inpatient care, and total increase in costs despite fewer admissions, warrants evaluation by the MHP.
- The MHP's 7- and 30-day follow- up after psychiatric hospitalization is higher than the state, indicating that the MHP has employed effective strategies to ensure early contact. Further complementing this outcome is the 7- and 30-day readmission rates that are lower than the state.
- The MHP discontinued the use of MORS as of July 1, 2023, due to fidelity and utility issues. While there is a plan to replace it with LOCUS by June 2024, there currently is no formal LOC or outcome tool for adults. The MHP does not currently utilize a standardized LOC tool for children, however it does use the CANS to inform individual clinical decision-making.
- The adoption of standardized LOC tools for children and adults will permit the MHP clinicians and other providers to use shared definitions and protocols to synthesize their knowledge about a member and then assign a valid service rating, but it also has the potential to impact the ability to engage the member and/or their families in the development of their treatment plan, member outcomes, high psychosis spending, and the high rate of HCMs.
- CANS data is not presented in such a way that it can be used for clinical supervision or programmatic oversight in a meaningful way.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Improving family engagement and functioning for children and youth through family therapy.

Date Started: 09/2022

Date Completed: 08/2023

Aim Statement: "Can we increase the percentage of children who receive family therapy over a six-month timeframe by improving clinical knowledge and comfort in family engagement and family therapy through a three-part training series?"

Target Population: Children and youth receiving services from clinicians through Children's Behavioral Health and/or organizational providers and can receive family therapy based on need.

Status of PIP: The MHP's clinical PIP is in its second measurement phase, taken in 06/2023.

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

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

Summary

The goal of the clinical PIP is to improve family engagement and functioning to children and youth receiving services from the MHP by providing improved family therapy services. To accomplish this goal, a three-part training series was provided to clinicians. This series was designed to provide clinicians with the skills and techniques to increase family engagement in therapy and help improve family skills. Training was initiated in 09/2022 and concluded in11/2022. Data was reported twice in two domains, service-related and training data. The CANS outcome data was reported once, six months after the conclusion of training. Six performance measures were indicated. Initial data was tested using t-tests and ANOVA to determine study topic and performance standards. Post-study data was not tested for statistical significance as the data showed little to no improvement.

There were mixed results with this PIP. Data suggested that the completion of family therapy trainings had a positive effect in the provision of increased family therapy services, as evidenced by the percentage of clinicians providing family therapy improving from a baseline of 47 percent to 67 percent. However, it was not necessarily an indicator of improving client engagement, as evidenced by the total percentage of beneficiaries who received family therapy with a baseline of 8.3 percent showing a modest improvement to 8.8 percent. Of note was the reduced percentage of beneficiaries indicating actionable needs. Using 27 paired samples, the study indicated that there was a reduction in actionable needs from a baseline of 52 percent to 33 percent.

TA and Recommendations

As currently submitted, this clinical PIP was found to have moderate confidence because it was difficult to establish a clear relationship between the intervention and the impact to the members. Some threats to the validity of the results included but were not limited to: a short study period, staffing changes, variation of staff's prior knowledge and experience in family therapy, staff case load sizes, outside agency participation and data access issues, inconsistent number of staff who started but did not complete all three trainings, the period of performance that included holidays and school vacations, and the low number of paired member samples (27).

CalEQRO provided TA on this PIP prior to the review, and the MHP improved this PIP by incorporating several recommendations provided, including:

- Add a measurable impact to the member, identification of baselines, and the inclusion of CANS scores for actionable needs.
- The data point to correlate family therapy with reduced CANS actionable needs did yield positive results for the small population, but it would be a worthwhile effort to continue tracking this metric to see if it yields a positive trend.

Upon review, CalEQRO recommendations for improvement of this clinical PIP:

- Continue tracking results. This PIP holds promise despite the various threats to validity. Having a single CANS measurement of members for actionable needs six months after the intervention, while positive, was not sufficient to draw meaningful conclusions.
- Consider the utilization of root cause analysis tools to fully understand cause and effect and open the possibility of alternate interventions.
- Develop a clear and measurable clinical goal and its expected target performance against a baseline. Articulate this goal in all areas of the PIP development to tie the PIP together and to ensure that all participating staff are clear.
- Consider keeping measurements to two or three critical goals to ease the burden of ongoing analysis.

NON-CLINICAL PIP

General Information

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

Date Started: 09/2022

Date Completed: Planned for March 1, 2024

Aim Statement: "For Medi-Cal members with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percentage points by March 1, 2024."

Target Population: Medi-Cal members who utilize ED visits for MH conditions.

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

Summary

To meet the stated goal of this PIP, the MHP is in process to expand on existing work with the North Coast Health Improvement and Information Network (NCHIIN) and local hospitals that currently fax ED Summaries for members seen in inpatient/crisis and outpatient programs. Summary reports from NCHIIN ED can be scanned directly into the EHR then routed to attending practitioners and care teams for follow up. Similarly in process, the MHP will receive ED Summaries electronically as continuity of care documents directly into the EHR, allowing care teams direct access to information for follow up, and will improve tracking within the EHR.

In February 2023, the Providence St. Joseph's Hospital hired two navigators funded with BH grant funds. Onboarding and training were completed between February and July 2023.

Navigators engage in daily, bi-directional feedback around the status of crisis assessments, legal holds, and care coordination to higher or lower levels of care. The inter-agency, multidisciplinary team behavioral assessment response team (BART) reviewing these updates is comprised of representatives of Providence/St. Joseph's Hospital, Redwood Community Hospital, and Humboldt BH. The exchange regarding care coordination and treatment planning includes all members seen in the ED who need linkage to inpatient or outpatient services has been found to be highly effective.

Three performance measures were identified regarding the use of navigators and are listed below with their current status:

- KPI #1: Number and percent of clients who received an initial contact from the BH Mobile Response Team (MRT) before they were discharged from the ED. The MRT team saw 146 unduplicated clients at the local EDs during the period January through June 2023.
- KPI #2: Number and percent of clients who received follow-up BH services post ED discharge. Of the 146 clients, 87 (or 60%) had a non-crisis SMHS within 30 days of the initial visit at the ED.
- KPI #3: Number and percent of clients who were contacted by a navigator. Client contacts with navigators are tracked by Providence/St. Joseph's Hospital on a billing spreadsheet. Between January and June 2023, 256 clients had contact with a navigator.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence because there have been challenges with the implementation of critical aspects of this PIP, such as contractual issues, data exchange issues, and the migration from Avatar to SmartCare. However, the MHP has strong relations with community partners and is transparently working to resolve these issues. The MHP has been equally transparent with DHCS and are working diligently with them to consider how to best consider potential solutions. One course correction already implemented was the inclusion of two navigators. Partner and staff feedback has been that the addition of navigators has been highly effective.

TA was not requested by the MHP for this PIP. The MHP regularly participated in CalMHSA's office hours and 1:1 consultation around all three BHQIP PIPs.

CalEQRO recommendations for improvement of this non-clinical PIP:

- Continue to work with DHCS for the BH QIP and obtain CalEQRO TA as needed.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is the CalMHSA semi-statewide EHR, SmartCare by Streamline Healthcare, which has been in use for three months. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop all components of the EHR.

Approximately 3 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 340 named users with log-on authority to the EHR, including approximately 340 county staff and no contractor staff. Support for the users is provided by 5 full-time equivalent (FTE) IS technology positions. Currently, there is one Analyst II position vacant. This position is in recruitment.

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

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

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

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	0%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	97%
Paper documents delivered to MHP IS	☐ Daily ☒ Weekly ☐ Monthly	3%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP's target timeline for the implementation of a PHR is in more than two years.

Interoperability Support

MHP is a member of the HIE North Coast Health Improvement and Information Network (NCHIIN). While available in their previous Avatar system, the connection to this HIE has not yet been established in the new SmartCare system. Due to the requirement to reestablish and test NCHIIN connectivity, the MHP has chosen to become a member of the larger Sac Valey MedShare HIE. They expect to go-live with this HIE within the next year. Healthcare professional staff also use secure information exchange directly with service partners through secure email. The MHP engages in electronic exchange of information hospitals.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP implemented the semi-statewide EHR, SmartCare by Streamline, on July 1, 2023. Streamline will provide base product patch updates while CalMHSA will be responsible for system customization.
- Line staff reported to be continuing to learn the functionality of the new SmartCare system and do not yet feel fully knowledgeable in use of the new EHR.
- Contract providers do not have access to the SmartCare system; 20 percent of services are provided by contracted providers.
- The MHP's denied claims rate of 0.60 percent is well below the statewide rate of 5.92 percent. The denied claims rate represents claims processed with the MHP's previous Avatar system. A claim has not yet been submitted from the SmartCare system.
- The MHP does not maintain a data warehouse that replicates either the previous Avatar or current SmartCare system.
- There is an operations continuity plan for critical business functions that is maintained in readiness for use in the event of a cyber-attack, disaster, or other emergency. The MHP also has a continuity plan for internet connectivity to restore access to applications, such as SmartCare, as soon as possible. This plan is reviewed annually.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	6,693	$2,488,785	$5,204	0.21%	$2,483,581
Feb	6,062	$2,250,680	$5,279	0.23%	$2,245,401
Mar	7,676	$2,976,766	$12,605	0.42%	$2,964,161
April	6,776	$2,602,075	$20,691	0.80%	$2,581,384
May	6,903	$2,717,443	$6,581	0.24%	$2,710,862
June	6,719	$2,266,711	$26,720	1.18%	$2,239,991
July	5,800	$2,190,583	$9,484	0.43%	$2,181,099
Aug	6,756	$2,550,671	$15,785	0.62%	$2,534,886
Sept	6,577	$2,457,028	$5,299	0.22%	$2,451,729
Oct	6,227	$2,384,710	$10,225	0.43%	$2,374,485
Nov	5,688	$2,247,141	$53,595	2.39%	$2,193,546
Dec	5,510	$2,035,902	$3,710	0.18%	$2,032,192
Total	**77,387**	**$29,168,495**	**$175,178**	**0.60%**	**$28,993,317**

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

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Beneficiary is not eligible or non-covered charges	150	$81,051	46.27%
Other healthcare coverage must be billed first	54	$56,852	32.45%
Medicare Part B must be billed before submission of claim	28	$21,986	12.55%
Service line is a duplicate and repeat service modifier is not present	34	$12,816	7.32%
Late claim submission	5	$985	0.56%
Service location NPI issue	3	$878	0.50%
Other	7	$611	0.35%
Total Denied Claims	**281**	**$175,179**	**100.00%**
Overall Denied Claims Rate	**0.60%**		
Statewide Overall Denied Claims Rate	**5.92%**		

IMPACT OF INFORMATION SYSTEMS FINDINGS

- While contract providers provide 20 percent of services, no contract providers had access to the previous Avatar system in use over the past year or the newly implemented SmartCare system. Full contract provider access to SmartCare would increase the data that is available to the MHP for analysis and reporting.
- The MHP lost connection to the NCHIIN with the implementation of SmartCare. Instead of investing time and effort to rebuild the NCHIIN connection in SmartCare, the MHP has decided to join the larger Sac Valley MedShare HIE. Participation in Sac Valley MedShare is anticipated to being within the next year.
- The implementation of the CalAIM EHR and payment reform has introduced some frustration and confusion among clinicians. Addressing this early will reduce the opportunity for errors and allow clinicians and partners to realize the efficiencies that are inherent in the new system.
- The claims denial rate of 0.60 percent indicates that the MHP has an effective fiscal team and billing processes.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

Currently, the MHP administers the CPS once a year, with the most recent survey administered in May 2022. Results from the FY 2022-23 survey are currently being tabulated. In addition to meeting the four required surveys by member category, the MHP has organized the survey into four domains: Treatment, Access, Cultural Sensitivity and Outcomes. The CPS dashboard tracks and trends results for CY 2014-2022. Due to COVID, the number of returned surveys has diminished from 2019 with 346 returned surveys, to 2022 with 51 returned surveys. No older adults returned the May 2022 survey. It is noted that with the small sample sizes, represented trends may not be reliable, but they have been consistent over the years.

In the most recent adult survey, 25 of 36 items met or exceeded the indicated benchmarks. In the most recent youth and family survey, 20 of 26 items met or exceeded the indicated benchmarks.

The MHP recognizes that with the low sample sizes over the last three years, adjustments to services would not be based on valid data. Subsequently, a new strategy for soliciting responses will be addressed. To that end, paper and pencil options and kiosks in the lobby will be employed to attempt to solicit a greater number of responses.

PLAN MEMBER/FAMILY FOCUS GROUP

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

As part of the pre-review planning process, CalEQRO requested one 90-minute focus group with MHP members who initiated services in the preceding 12 months, and/or their family, containing 10 to 12 participants each. The focus group was held virtually and included two participants who received clinical services from the MHP, but no members who initiated services in the preceding 12 months. Because there were fewer

than three participants, detailed findings are not included but may inform other aspects of this report.

General comments noted that a member sits on the Behavioral Health Board, and that a choice of in-person or virtual appointments is available.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Based on the consistent pattern of responses over the years for both adults and children, the system of care seemingly does not yield the desired outcomes for members. Reinstituting focus groups and strategies to include members and/or families in the development of their treatment may provide insight for any potential improvement activities.

Members noted that the staffing shortages have impacted on their ability to receive case management and transportation services.

CONCLUSIONS

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

STRENGTHS

1. The MHP's PRs are higher than statewide rates for all age categories other than 0-5, indicating greater access for most age groups than is seen statewide. (Access)
2. The MHP's structure of operations are well suited for access and quality of care with the children's system of care co-located with Child Welfare and Older Adults co-located with Adult Protective Services. There is proactive outreach in the schools, and strong partnerships with hospitals, partners, and community organizations. (Quality, Access)
3. The addition of a psychiatrist and the restructuring of staff who administer the new Screening and Transition Tool resulted in greater capacity and improved timeliness for initial screening. (Access, Timeliness)
4. Peers are well embedded in the system, present at all the primary service areas of Eureka, Fortuna, Arcata, McKinleyville, and are available to the outlying clinics as needed. (Quality)
5. The MHP focused on crisis response improvements such as additional training in suicide prevention, a non-clinical PIP for follow-up after hospitalization, coordination of care between tribes, law enforcement, and EDs, and homelessness. (Access)

OPPORTUNITIES FOR IMPROVEMENT

1. Users of the SmartCare system indicate some uncertainty in the navigation. While implementation is in its early stages, developing a list of training needs and a training schedule to meet those needs for both staff and providers will strengthen the transition as it moves forward. (Quality, IS)
2. The MHP's FC PR was lower than small sized counties and statewide rates for the past three years. Investigating the root cause and developing an action plan will serve to ensure that children in FC receive necessary treatment and support. (Access)
3. The MHP does not currently utilize a standardized LOC tool for children or adults. However, it does use the CANS to inform clinical decision-making about LOC for youth members. MORS has been discontinued with plans to implement LOCUS

in June 2024. The MHP does not define LOC guidance to the MHP clinicians. Having a standardized tool will allow the MHP Clinicians and other providers to use shared definitions and protocols to synthesize their knowledge about a member's psychological health and functioning and then assign a service rating. Additionally, this would provide the mechanism to engage a member and/or their family in the development of their treatment plan and validate member transitions to higher or lower systems of care. (Quality)

4. While the MHP has made progress in reporting, CANS reports are not presented with adequate granularity for clinical supervision or programmatic oversight. Adult reports will be pending LOCUS implementation. (Quality)
5. The MHP is not tracking the required FC HEDIS measures. (Quality)

RECOMMENDATIONS

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

1. Develop a skills gap analysis and training plan that leverages the availability of continued SmartCare EHR training. Then, allow time for line staff, supervisors, and contract providers to take those trainings to ensure a thorough understanding and effective use of the SmartCare EHR. (Quality, IS)
2. Collaborate with partnering agencies to develop and implement strategies to better identify and track FC and improve access to MH services for them. (Quality)
3. Adopt a standardized LOC tool for children's and adult service need determination. Provide training and a desk guide to staff, providers, and partnering agencies to determine the intensity of services needed for its members. The MHP plans to implement LOCUS for adults and intends to use CANS in its capacity as LOC tool for youth. (Quality)
4. Develop CANS and eventually LOCUS data reports with greater granularity that allow for utility during clinical supervision and programmatic oversight. (Quality)
5. Develop tracking and reporting mechanisms for the required FC HEDIS measures. (Quality)

   This recommendation was continued from FY 2022-23.

EXTERNAL QUALITY REVIEW BARRIERS

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

The MHP identified no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Humboldt MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being (Katie A./CCR)
Consumer and Family Member Focus Group
Fiscal/Billing
Clinical Line Staff Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Inclusion/Peer Employees within the System of Care
Information Systems Billing and Fiscal Interview
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Elaine Crandall, Lead Quality Reviewer
Christy Hormann, Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Walter Shwe, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Beckett	Andrea	Registered Nurse	DHHS Behavioral Health QI
Bennett	Gabe	Senior Program Manager	DHHS Children's Behavioral Health
Botzler-Rodgers	Emi	Behavioral Health Director	DHHS Behavioral Health
Breazeal	Jack	Deputy Director	DHHS Behavioral Health Adult Services
Brocious	Cyanne	Director of Nursing	DHHS Behavioral Health
Bugnacki	Paul	Deputy Director	DHHS Behavioral Health
Catalan	Russ	Departmental Information Services	DHHS IS
Cone	Amy	DHHS Compliance and Quality Assurance	DHHS Quality Management Services
Culleton	Jaclyn	Program Manager	DHHS Behavioral Health
DeKruse	Jet	Senior Program Manager	DHHS Children's Behavioral Health
Duke	Jessica	Senior Program Manager	DHHS Behavioral Health Adult Services
Garfield	Betty	Peer Coach	DHHS Behavioral Health
Gonzalez-Bobadilla	Oliver	Program Manager	DHHS MHSA
Guidry	Glen	Administrative Analyst	DHHS Behavioral Health QI
Hart	Debbie	Administrative Analyst	DHHS Children's Behavioral Health
Irvin	Scott	Medical Records Manager	DHHS Behavioral Health
Maguire	Kathryn	Registered Nurse	DHHS Behavioral Health QI
Mendonca-Gupton	Susany	Accountant/Auditor	BH Fiscal Services
Munsee	Catherine	Senior Program Manager	DHHS Adult Services
Nilsen	Jeremy	Deputy Director	DHHS Children's Behavioral Health
Olivera	Alex	Administrative Analyst	DHHS Behavioral Health QI/MHSA
Olson	Chris	Accounting Systems Analyst	DHHS Claims Data Management
Reissner	Eli	Supervising Registered Nurse	DHHS Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Reyes	Stacy	Administrative Analyst	DHHS Quality Management Services
Rivera	Naoko	Fiscal Officer	DHHS Behavioral Health
Schwarz	Elvira	Program Manager	DHHS Behavioral Health QI
Smith	Zach	Deputy Director Information Services	DHHS IS
Stephan	Martin	Senior Program Manager	DHHS Children's Behavioral Health
Way	Christine	Administrative Analyst	DHHS Children's Behavioral Health

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	
General PIP Information	
MHP/DMC-ODS Name: Humboldt County	
PIP Title: Improving family engagement and functioning for children and youth through family therapy	
PIP Aim Statement: "Can we increase the percentage of children who receive family therapy over a six-month timeframe by improving clinical knowledge and comfort in family engagement and family therapy through a three-part training series?"	
Date Started: 09/13/2022	
Date Completed: 08/30/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): "Children and youth receiving services from clinicians through Children's Behavioral Health and/or organizational providers and can receive family therapy based on need."
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): To meet the goals of the PIP, the Children's Services clinicians were provided a three-part training on Family Therapy.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Click or tap here to enter text.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Percentage of total members who received family therapy (Increase)	12/2021 to 6/2022	86/1032 8.3%	12/2022 to 6/2023	97/1093	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2: Percentage of members receiving Individual Therapy and Family Therapy. (Increase)	12/2021 to 6/2022	86/300 28.6%	12/2022 to 6/2023	97/311 31.1%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3: Percentage of members receiving family therapy with four or more sessions. (Increase)	12/2021 to 6/2022	43/86 50%	12/2022 to 6/2023	32/97 33%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 4: Percentage of members receiving family therapy with one session only. (Decrease)	12/2021 to 6/2022	23/86 27%	12/2022 to 6/2023	42/97 43%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 5: Percentage of clinicians providing family therapy. (Increase)	12/2021 to 6/2022	15/32 47%	12/2022 to 6/2023	20/30 67%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 6: Percentage of beneficiaries with actionable family functioning needs. (Reduced after participating in family therapy)	12/2021 to 6/2022		12/2022 to 6/2023	27 paired samples Initial assessment: 14/27 or 52% had actionable needs Reassessment: 9/27 or 33% had actionable needs	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • The MHP is encouraged to continue tracking results. This PIP holds promise despite the various threats to validity. Having a single CANS measurement of members for actionable needs six months after the intervention was not sufficient to draw meaningful conclusions. • Consider the utilization of root cause analysis tools to fully understand cause and effect and open the possibility of alternate interventions. • Develop a clear and measurable clinical goal and its expected target performance against a baseline at the onset. Articulate this goal in all areas of the PIP development to tie the PIP together and to ensure that all participating staff and/or partners are clear. • Consider keeping measurements to two or three critical goals to ease the burden on staff.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	As submitted, this non-clinical PIP was found to have moderate confidence because of the barriers with the implementation of this PIP, such as contractual issues, data exchange issues, and the migration from Avatar to SmartCare. The MHP is leveraging the strong relations with community partners and DHCS towards potential solutions. At this time, partner and staff feedback is that the addition of navigators has been highly effective.
General PIP Information	
MHP/DMC-ODS Name: Humboldt County	
PIP Title: PIP Follow-Up After Emergency Department Visit for Mental Illness (FUM)	
PIP Aim Statement: "For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5% by June 30, 2023."	
Date Started: 09/30/22	
Date Completed: Planned for March 2024.	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): "The initial plan is to focus on beneficiaries with a qualifying event as defined in the FUM metric."
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The MHP and MCP must work together to identify ways to collaborate and provide shared data and information for client care. The Providence / St. Joseph's Hospital hired two navigators in February 2023, funded with Behavioral Health grant monies to enhance contact and provide necessary information to assist in determining follow-up supports.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
FUM 70- improve by 5 percent	2021	70th percentile	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
FUM 30- improve by 5 percent	2021	76th percentile	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

Continue to work with DHCS to assist in the BH QIP projects.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, PIP Validation Tool, and CalEQRO Approved Claims Definitions are available on the CalEQRO website.

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required as part of this report.