FY 2023-24
Medi-Cal Specialty Behavioral Health External Quality Review

LAKE FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Date:

December 11-12, 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, "Lake" may be used to identify the Lake County Behavioral Health Services (LCBHS).

MHP INFORMATION

Review Type — Virtual

Date of Review — December 11-12, 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	3	3	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	5	3	2
Information Systems (IS)	6	3	2	1
TOTAL	**26**	**18**	**5**	**3**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
PIP was not submitted	Clinical	N/A	N/A	N/A
Follow-up after Emergency Department (ED) visit for mental illness	Non-Clinical	7/2022	Planning	Low

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	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 four peer-run centers provide an array of services and immense support to diverse populations. Peer employees are very appreciative of the changes made by the new director to enhance peer support.

- The MHP's timeliness for first offered non-urgent appointments, urgent appointments, and post-discharge outpatient follow-up meets DHCS standards.

- The MHP's strategies such as paid clinical supervision and adding contracts for psychiatry have proven successful in improving timely access to care.

- The MHP reported positive changes from the implementation of California Advancing and Innovating Medi-Cal (CalAIM) projects related to payment reform.

- The MHP has strong collaboration with key stakeholders in their outreach efforts to reach diverse populations including the homeless, Native American, and Latino.

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

- The MHP did not implement a clinical PIP for this year's review.

- The MHP's quality assessment and performance improvement (QAPI) plan is not current and includes the evaluation for FY 2020-21 goals. The QAPI does not include clinical and functional outcomes related goals.

- Lack of clear data definitions for timeliness metrics and errors in computing these metrics may impact review of accurate data and related qualitive improvement (QI) activities.

- There are problems with access to informational materials and forms in Spanish both for staff and plan members that may have a negative impact on timely access to care for the monolingual members and MHP's low Hispanic penetration rate (PR).

- Key informants expressed problems with upward communication beyond the supervisor that has created hurdles in addressing their concerns and may impact timely access to care and quality of services to the plan members.

Recommendations for improvement based upon this review include:

- Implement a clinical PIP for the next review.

- Submit an updated QAPI work plan evaluation for the past three fiscal years and a QAPI work plan for FY 2024-25 which includes goals related to clinical and functional outcomes data from outcome tools.

  (This recommendation is continued from FY 2022-23)

- Create a workgroup that includes executive leadership, QI team, information systems (IS) staff, and program staff to ensure clear data definitions for the tracking of all data metrics in the new electronic health record (EHR). Report on the progress of the workgroup's efforts.

- Ensure all information materials and forms are available in Spanish to line staff and plan members including website information and improve outreach to Latino population. Report if there is an increase in the numbers served for FY 2023-24.

- Establish bi-directional communication with line staff and address concerns related to high caseloads and staff turnover through an organized and consistent communication channel.

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 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 Lake County MHP by BHC, conducted as a virtual review on December 11-12, 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 (TAY); 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. Data definitions are included as Attachment E.

- 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 QAPI program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

There were no significant issues other than staffing challenges which affected the MHP operations over the prior year.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP had significant changes in the leadership team including the director and deputy director of administration. The new director has a vision for an important initiative, the "Living Room." The Living Room would serve as a safe place for people in crisis to stay up to 23 hours where they will be deescalated and receive support. The site for the Living Room has been identified and the proposed date for the implementation of the Living Room is March 2024.

- As a pilot county, the MHP converted to the California Mental Health Services Authority (CalMHSA) SmartCare by Streamline EHR as part of the semi-statewide EHR initiative on March 1, 2023. Internally, they began using the CalAIM mandated current procedural terminology (CPT) codes when they went live, although the codes were not used in DHCS billing until July 2023.

- The MHP is focused on employee engagement and has implemented monthly staff-only newsletters with staff stories, resumed monthly all staff meetings with a focus on gratitude, implemented student loan repayment and stipend programs, and offered paid clinical supervision through a vendor, Motivo Health.

- The MHP has been working diligently towards implementing mobile crisis benefit on January 1, 2024.

- The MHP has their first in-person prescriber for the first time since the pandemic.

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: Explore reasons why 82.39 percent of non-urgent requests for service resulted in an offered appointment within 10 days, yet only 1.05 percent resulted in a delivered service during that time frame while the rate of adults who receive crisis intervention is more than twice the state average. Create and implement a process to correct this timeliness to services issue and decrease the need for crisis intervention.

☒ Addressed   ☐ Partially Addressed   ☐ Not Addressed

- The MHP conducted data analysis and reviewed metrics related to first offered non-urgent appointments and noted the barriers associated with timely access to care that included availability of assessment appointments, no-shows, and communication barriers with members.

- The MHP developed incentives to hire new staff by offering paid clinical supervision through a vendor, Motivo Health, and offered a hybrid model for work that includes telework as an option. These strategies resulted in hiring new staff in the last year and improving timeliness for both offered and delivered appointments.

- The Assessment of Timely Access (ATA) FY 2022-23 data submitted by the MHP indicated 83.5 percent met the standard for 10 business-day first offered non-urgent appointments and 79.9 percent met the standard for first delivered non-urgent appointments. There were errors in the calculations for the percentage of first offered; the correct number was 81 percent. Based on this data, the timeliness for first offered and first delivered appointments met the 80 percent timeliness standard.

Recommendation 2: Research issues, create, and implement a plan to ensure that members are aware of all transportation resources available to them when they begin services.

☒ Addressed   ☐ Partially Addressed   ☐ Not Addressed

- The MHP implemented two training sessions in March and July 2023 in partnership with the managed care plan (MCP). These training sessions were conducted to ensure that all staff are aware of transportation resources and can in turn share these with plan members.

- The MHP improved the transportation referral infrastructure in the EHR based on stakeholder feedback and provided guidelines on how to refer a plan member to the MCP for transportation.

Recommendation 3: As the new SmartCare EHR is implemented, ensure that all timeliness data can be tracked and reported for the entire system of care.

☐ Addressed   ☒ Partially Addressed   ☐ Not Addressed

- The MHP did provide timeliness data for county provided services including data since the MHP began using SmartCare. Contract provider services were not included in any of the data. The MHP reported that they receive and review timeliness data from their contract providers but were unable to incorporate the data with county operated information.

- To receive the "Addressed" rating, the MHP needed to report all timeliness data for both county-operated and contracted providers.

- While this rating is partially addressed, it is not carried over as a standalone recommendation for this year's review. The need is embedded in a broader recommendation regarding data tracking.

Recommendation 4: Create a system, memorialized in the Quality Work Plan, to measure clinical and/or functional outcomes of members served, and utilize information from the Beneficiary Satisfaction Survey to create dialog for possible areas of quality improvement.

☐ Addressed   ☒ Partially Addressed   ☐ Not Addressed

- The MHP utilizes information from member satisfaction surveys such as the cultural humility survey administered annually to members to improve areas that need to be addressed. The MHP utilizes information from the test call surveys to conduct training twice a year for the Access line staff to address areas for improvement.

- The MHP's QAPI did not include outcomes data related to Child and Adolescent Needs and Strengths (CANS) and 35-item Pediatric Symptoms Checklist (PSC-35) and did not develop goals for any other clinical and functional outcomes for plan members.

- This recommendation will be carried over in a modified manner for this year's review.

Recommendation 5: Develop and implement a SmartCare EHR training plan that will include some level of MHP-focused training that meets the MHP's needs.

☒ Addressed   ☐ Partially Addressed   ☐ Not Addressed

- The MHP developed a comprehensive training plan for staff and subcontractors that included focused training specific to departmental training initiatives for the EHR, CalAIM, and general policies and procedures. The vendor-provided EHR training was released only two days prior to the go-live. The county set up all-day Zoom sessions to get staff started in the new system and now has specific team meetings to address unique needs.

- The MHP reported limited success with billing from the new EHR and is still determining the cause of the problems. Some issues might be dependent on the vendor to resolve, but if there are billing issues related to how service and clinical data is entered, the MHP will need to address the issues through additional end-user training.

Recommendation 6: Develop and implement a plan to provide user access to historical member data that is not converted to the new SmartCare EHR.

☐ Addressed   ☒ Partially Addressed   ☐ Not Addressed

- Upon request from members and providers, the department has granted access to the legacy system to designated staff.

- The legacy system is on an aging server that could become non-functional soon. In the future, the MHP intends to convert data from the legacy system to a CalMHSA-hosted data warehouse. A concrete plan to convert the legacy data to the CalMHSA data warehouse was needed to rate this recommendation as "Addressed."

- This recommendation is not being continued because it is heavily dependent on the vendor providing a solution and there are other priority recommendations for the MHP to work on.

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 87 percent of services were delivered by county-operated clinics and sites, and 13 percent were delivered by contractor-operated clinics and sites. This shows an increase in services delivered by the county compared to last year at 67 percent and a decrease in services provided by the contract providers at 33 percent. The MHP explained that their success with hiring new county staff resulted in an increase in services delivered by the county programs. Overall, approximately 70.5 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 Monday through Friday 8 a.m. to 5 p.m. After-hours requests are answered by a contract provider. The Access Line responds to both routine and crisis calls and meets member language needs. Beneficiaries may request services through the Access Line as well as through the following system entry points: crisis services, clinic walk-ins, law enforcement, substance use disorder and mental health community agencies, probation/parole, child welfare services, homeless shelters, and hospitals. The MHP follows a continuum of care treatment model, i.e., no wrong door, and coordinates care with partnering agencies to access services the MHP does not provide. If the member does not qualify for services, the MHP provides referrals and links the member to their Medi-Cal MCP. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, necessary services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 1,132 adults 491 youth, and 186 older adults two county-operated sites and two contractor-operated sites. There is a slight increase in the use of

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[1] CMS Data Navigator Glossary of Terms

telehealth services by all age groups compared to the prior year. Among those served, 410 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 Lake County, the time and distance requirements are 45 miles and 75 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

- Per the NA form submitted for the EQRO review, the MHP met all time and distance standards and was not required to submit an AAS request.

- However, per the Lake County MHP FY 2022-23 DHCS NA findings report, Lake was out-of-compliance in the following areas for time or distance standards:
  - Time and distance standards for adult psychiatry and child psychiatry.
  - Language capacity

- The MHP was required to complete a corrective action plan (CAP) by March 15, 2023, detailing actions the MHP will immediately implement to ensure compliance with the requirements. The MHP engaged in the following improvement activities to improve access to services for members:
  - The MHP now has an in-person prescriber.
  - The MHP implemented strategies to hire clinical staff and bilingual staff.
    - The MHP non-psychiatry clinical staffing is at 71 percent and psychiatry staffing is at 40 percent per documentation submitted for this review.

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

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

- Per the NA form submitted for this review, the MHP indicated that they were not required to provide OON access due to time and distance standards. However, the MHP has existing OON contracts with psychiatrists and therapists to ensure timely access for psychiatry and non-psychiatry clinical services to the plan members.

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 degrees to which an MHP informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved member outcomes.

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

Table 2: Access Key Components

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

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

- The MHP provides access to wellness activities at the four peer-run centers and these centers serve as the point of entry to access both crisis and routine services as appropriate. The MHP's significant outreach to the Hispanic, Native American, and TAY populations through these peer-run centers is impressive.

- The MHP added two contract provider sites and hired new staff for the county-operated sites that increased the numbers served compared to the past year. The MHP uses telehealth services at the member's discretion and has shown a slight increase in telehealth services for all age groups compared to the previous year. This continued use of telehealth increases access for members and provides flexibility to both members and staff.

- The MHP has a strong focus on reducing homelessness and is the lead administrator for the Lake County Continuum of Care (LCCOC) program, a consortium focused on reducing homelessness in the county.

- The MHP has improved access to transportation over the past year through their collaborative work with the MCP and staff training for successful coordination of transportation.

- Key informants expressed lack of availability information brochures and forms in Spanish which may impact access to care for Spanish speaking members. Although the MHP has Spanish documents on its website, it would be hard for a Spanish speaker to find these documents. Similarly, the La Voz de la Esperanza wellness center website, which focuses on the Hispanic/Latino population is not fully available in Spanish.

- The MHP's outreach for the Hispanic populations could benefit from additional effective outreach strategies such as Promotoras to improve access for this population.

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 3.90 percent PR, members may be experiencing similar challenges accessing mental health services in Lake compared to what is seen statewide.

Table 3: Lake 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	36,848	1,437	3.90%	$8,344,214	$5,807
CY 2021	35,095	1,332	3.80%	$7,959,875	$5,976
CY 2020	32,934	1,194	3.63%	$6,249,539	$5,234

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.

- There was a 12 percent increase in the number of eligible members between CY 2020 and CY 2022. The number of members served increased each year between CY 2020 and CY 2022. Despite the increase in members eligible each CY between 2020 and 2022, the greater increase in number of members served resulted in an increased PR for the MHP over the past two years.

- The AACM increased in CY 2021 and decreased in CY 2022. In CY 2022, the MHP's AACM was 78 percent of what was seen for the statewide average.

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

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	3,579	27	0.75%	1.31%	1.82%
Ages 6-17	7,978	429	5.38%	5.83%	5.65%
Ages 18-20	1,627	82	5.04%	4.72%	3.97%
Ages 21-64	19,813	809	4.08%	4.53%	4.03%
Ages 65+	3,851	90	2.34%	2.25%	1.86%
Total	**36,848**	**1,437**	**3.90%**	**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.

- PRs for all age groups other than 18-20 and 65+ are generally lower than seen in other small counties and statewide.

- The MHP's early intervention services program which detects and treats youth at risk of developing psychosis could be a factor in ages 18-20 having a higher PR than the state and other small counties despite the overall lower MHP PR rate.

- The MHP's contract with the Konocti senior center to improve outreach efforts for seniors may potentially contribute to higher PR for older adults compared to the statewide and small county rates.

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

Threshold Language	# of Members Served	% of Members Served
Spanish	41	2.88%
Threshold language source: Open Data per BHIN 20-070		

- The MHP reported that they have recently hired a Spanish speaking cultural outreach specialist to expand services to the Hispanic/Latino population in the county.

Table 6: Lake 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	10,684	358	3.35%	$1,467,800	$4,100
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, Lake's overall PR and AACM tend to be lower than what is seen for non-ACA members.

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

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

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	837	45	5.38%	7.08%
Asian/Pacific Islander	399	<11	-	1.91%
Hispanic/Latino	10,539	204	1.94%	3.51%
Native American	1,240	-	-	5.94%
Other	2,635	111	4.21%	3.57%
White	21,200	1,026	4.84%	5.45%
Total*	**36,850**	**1,437**	**3.90%**	**3.96%**

Note: Total annual eligibles in Tables 3, 4 and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals

- The Hispanic/Latino population is the second largest Medi-Cal ethnicity in Lake and the PR at 1.94 percent is about half the county average, and well below the statewide average, for that population.

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

	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	71%	8%	-	14%	-	3%
MHP % Eligible	58%	7%	3.36%	29%	1%	2%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%
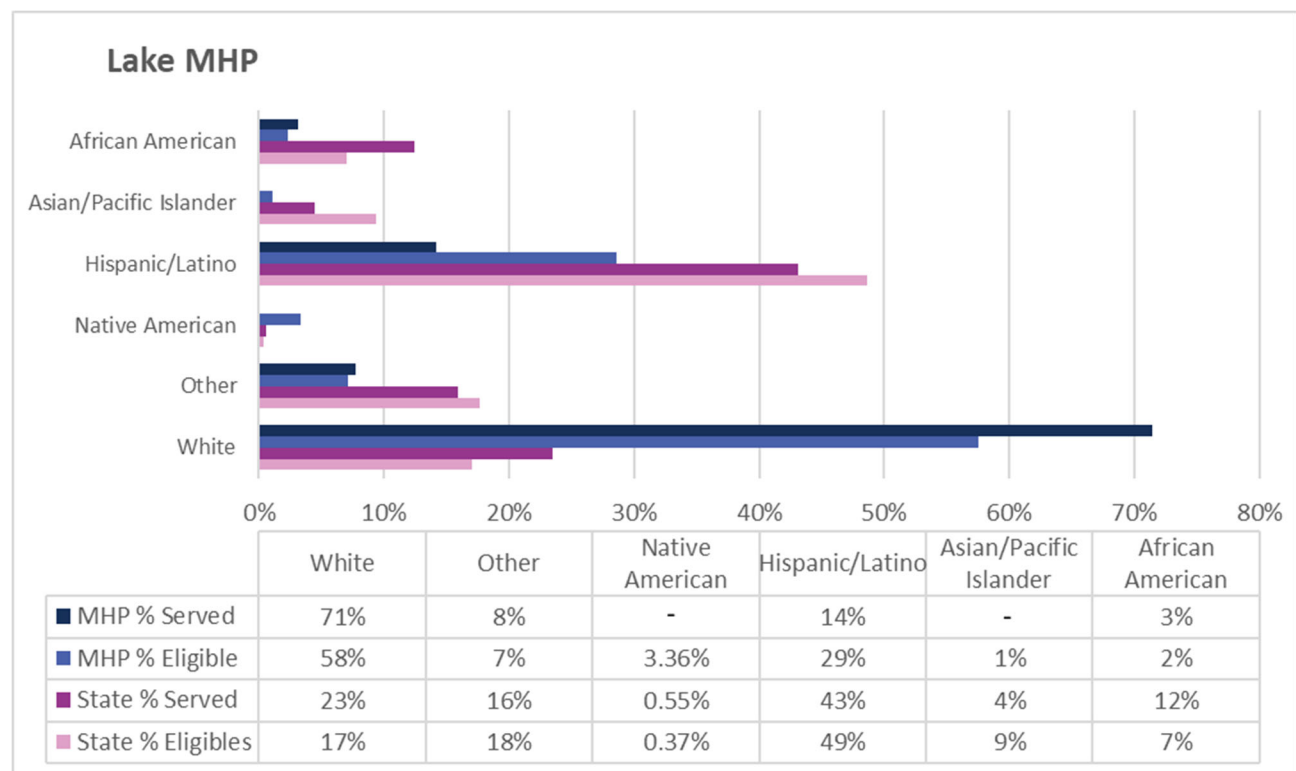
- The largest category of members eligible and members served is White. They are about three times the state average of members eligible and served. They

are proportionally overrepresented as they make up 58 percent of the Medi-Cal eligibles and are 71 percent of the members served.

- Hispanic/Latinos make up the next most populous category of members eligible and served. They are underrepresented as they are 29 percent of the eligible members but only 14 percent of the members served.

- Together, White and Hispanic/Latino comprise 85 percent of the members served and 87 percent of the members eligible.

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

Figure 2: MHP PR by Race/Ethnicity, CY 2020-22
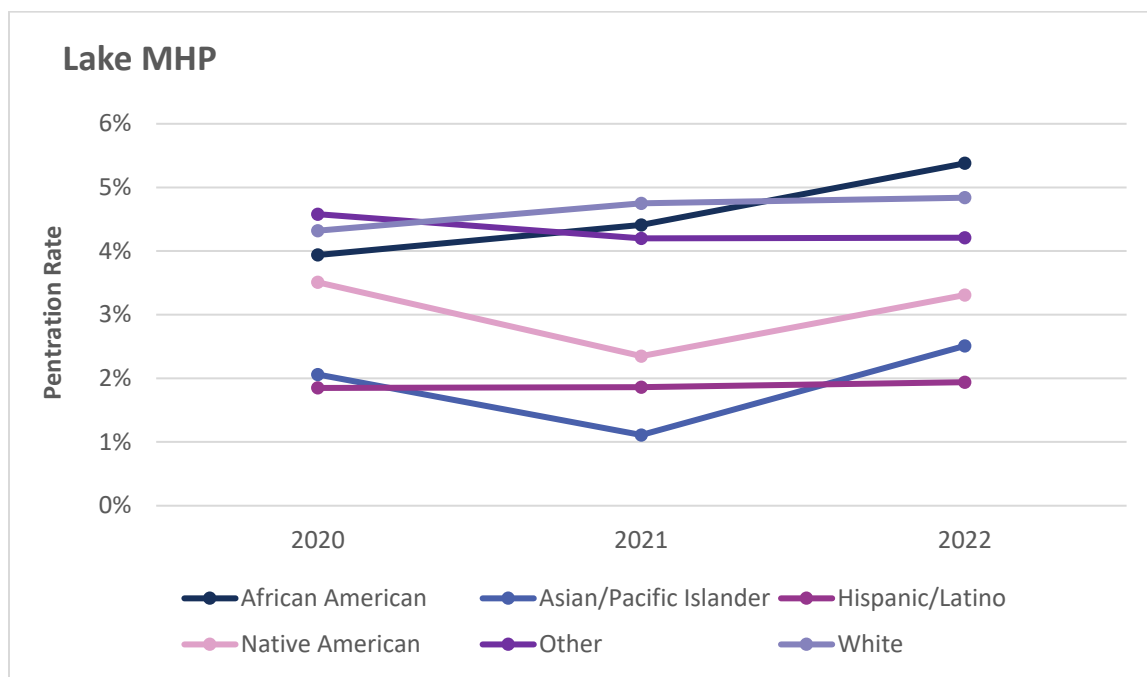
- African American, White, and Other ethnicities have maintained the highest PRs between CY 2020 and CY 2022.

- Native Americans have been in the middle among all groups on their PR, indicative of positive relations between the MHP and Native American organizations in the county.

- Hispanic/Latino and Asian/Pacific Islander have had lower PRs compared to all other groups in the three-year period between CY 2020 and CY 2022.

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

Lake MHP
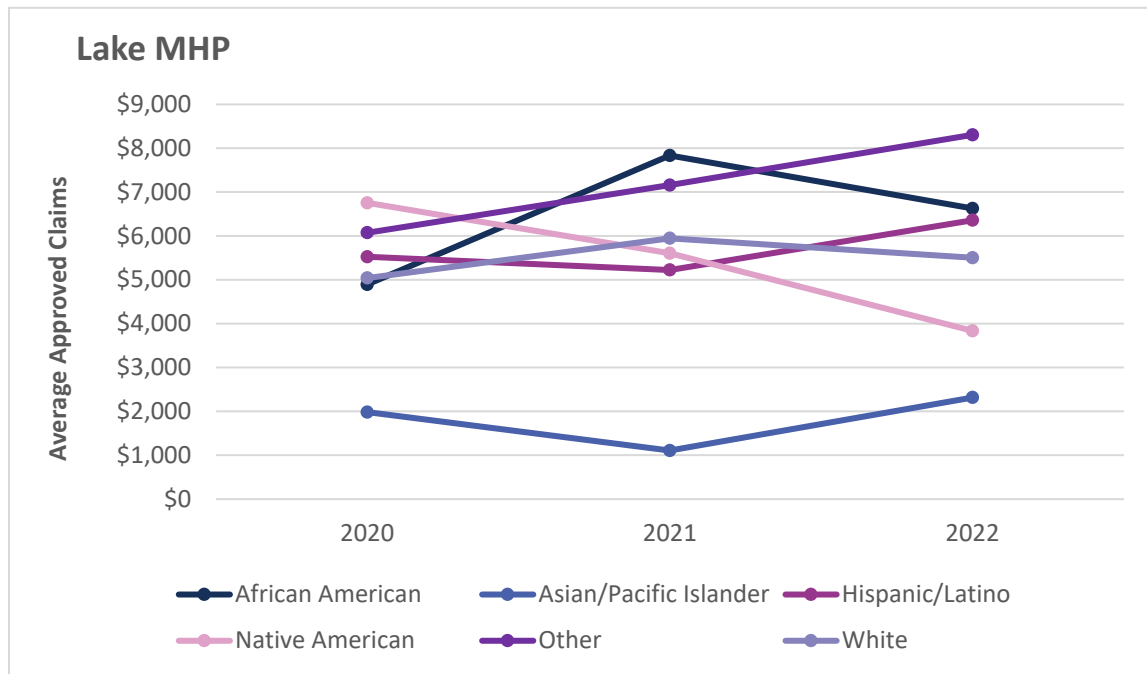
- There are not any consistent trends in the AACM by race/ethnicity between CY 2020 and CY 2022 other than the Asian/Pacific Islander population (which is fewer than 11 members) having much lower AACMs than other racial/ethnic groups for each of these years.

- There was more variation in the AACMs across groups in CY 2022 than in the previous two years.

Figure 4: Overall PR, CY 2020-22

Lake MHP

	2020	2021	2022
MHP	3.63%	3.80%	3.90%
Small	4.53%	4.39%	4.30%
State	4.55%	4.34%	3.96%
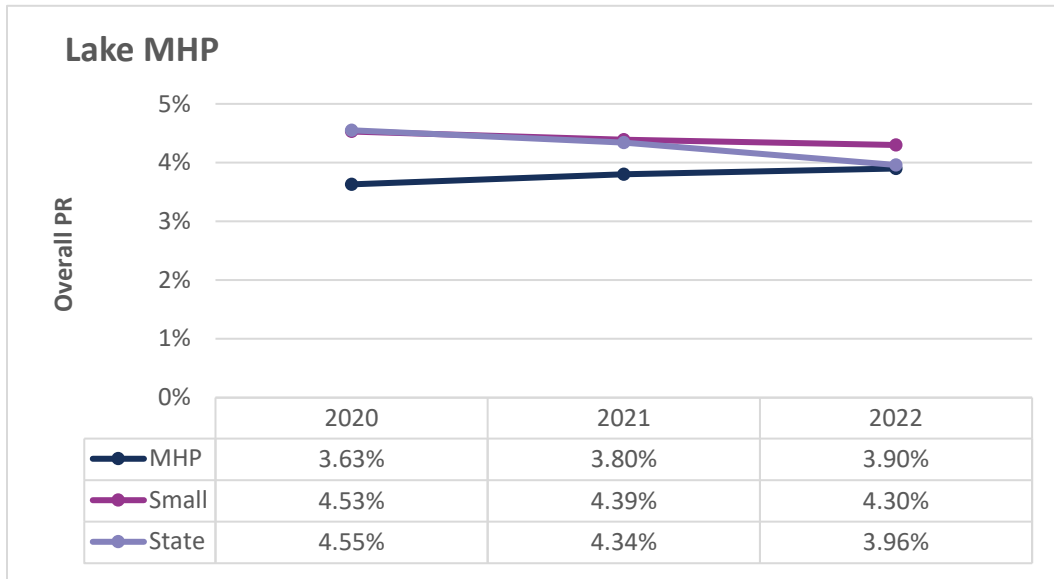
- While the MHP's PR is consistently lower than other small counties and the state, the MHP's PR has increased while the state and other small counties rates declined over the past three years. The MHP's CY 2022 PR is very close to the statewide rate.

Figure 5: Overall AACM, CY 2020-22

Lake MHP

	2020	2021	2022
MHP	$5,234	$5,976	$5,807
Small	$7,142	$7,010	$6,505
State	$7,155	$7,478	$7,442
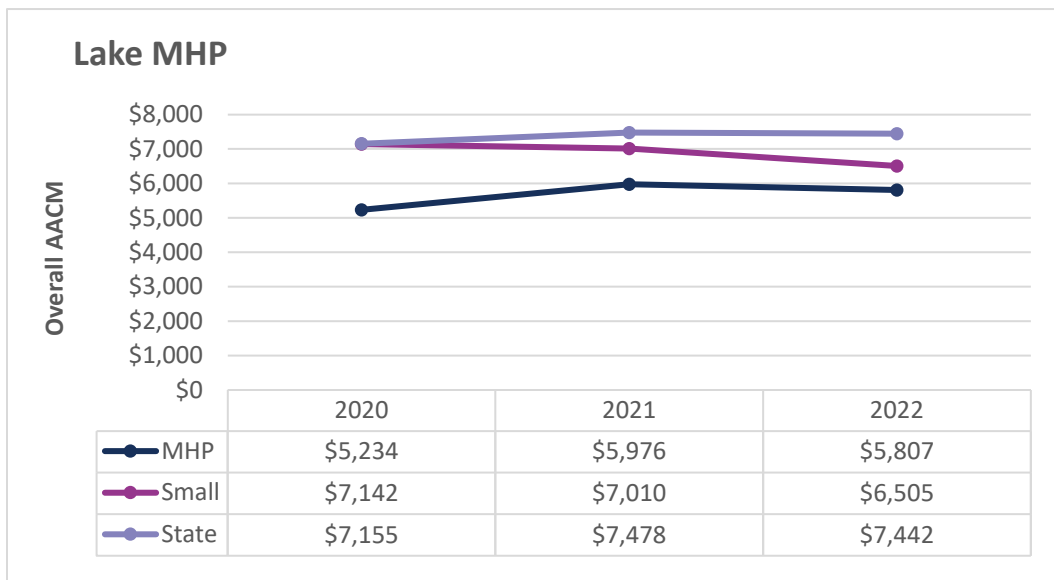
- The MHP's AACM has been consistently lower than small county and statewide averages.

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

Lake MHP

	2020	2021	2022
MHP	1.85%	1.86%	1.94%
Small	3.87%	3.84%	3.88%
State	3.83%	3.74%	3.51%
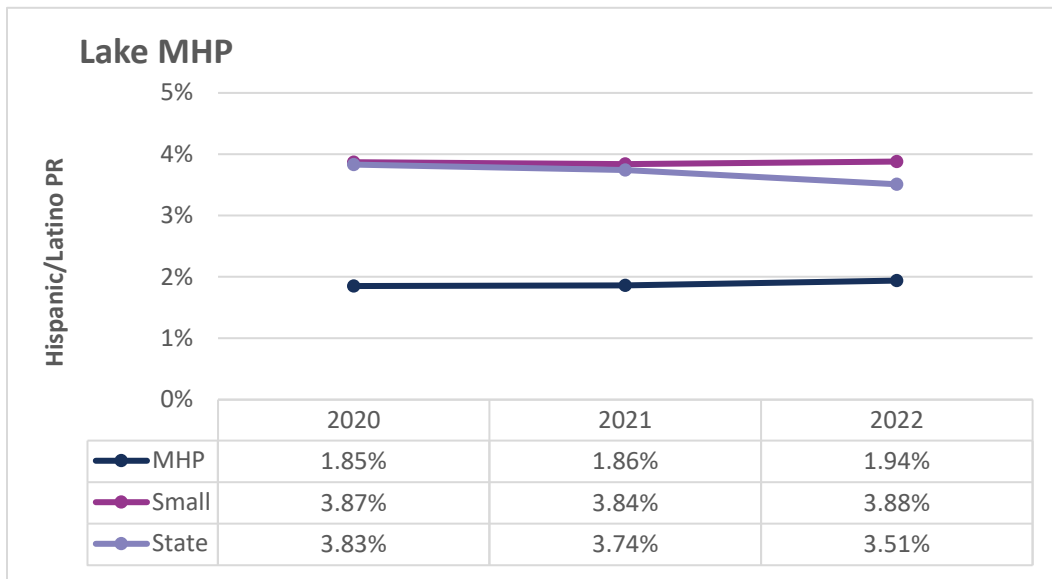
- The Hispanic/Latino PR remains consistently lower than the state average. It tends to be about half of what is seen for the state rate.

- The Hispanic PR for Lake increased each year since CY 2020 with a higher increase seen between CY 2021 and CY 2022.

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

Lake MHP

	2020	2021	2022
MHP	$5,526	$5,225	$6,358
Small	$6,037	$5,910	$5,068
State	$6,551	$6,733	$6,731
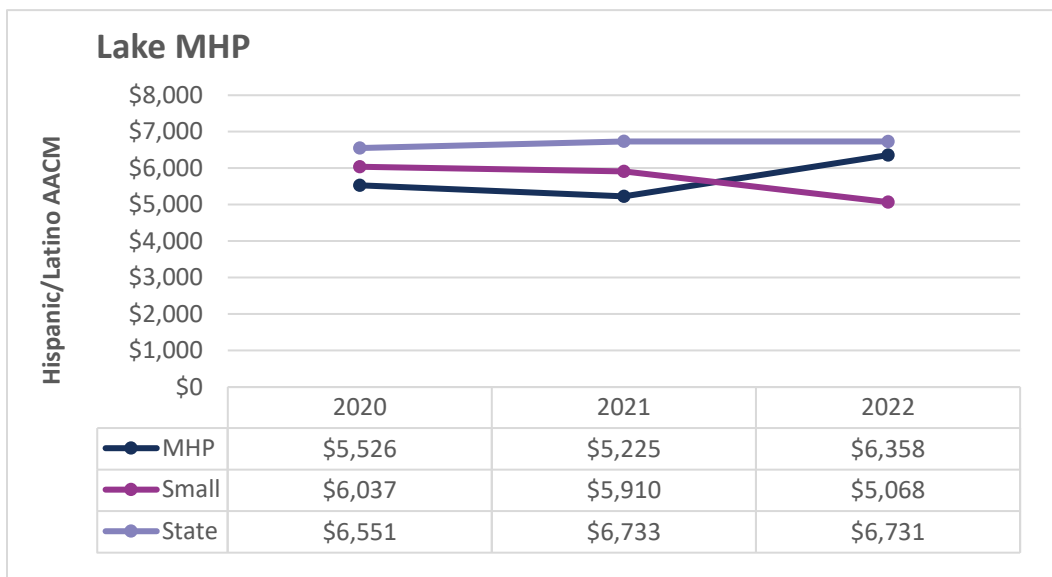
- The Hispanic/Latino AACM was lower than the statewide average in CY 2020 and CY 2021. It increased in CY 2022, almost reaching the statewide average. This is contrary to the small county trend that showed a decrease each year in the past three years.

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

Lake MHP

	2020	2021	2022
MHP	2.06%	1.11%	-
Small	1.75%	1.69%	1.55%
State	2.13%	2.08%	1.91%
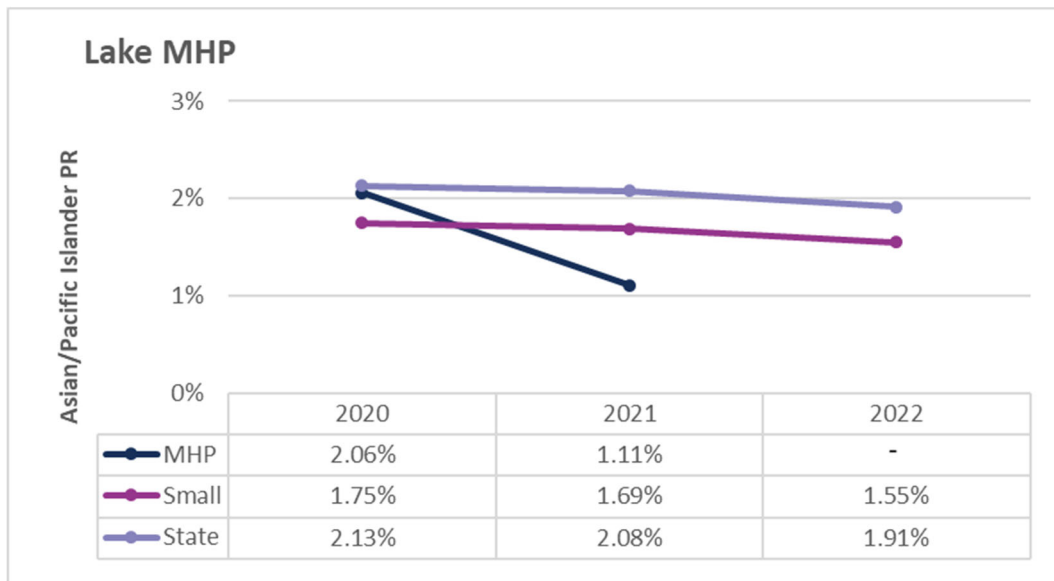
- The MHP's Asian/Pacific Islander PR declined by almost 50 percent in CY 2021. However, due to the low numbers served, the fluctuations may appear significant. There has been a smaller decline over the past three years for the small counties and statewide.

- The CY 2022 Asian/Pacific Islander PR is not provided since fewer than 11 members were served.

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

Lake MHP

	2020	2021	2022
MHP	$1,982	$1,108	$2,318
Small	$5,690	$6,332	$7,397
State	$7,466	$7,990	$7,928
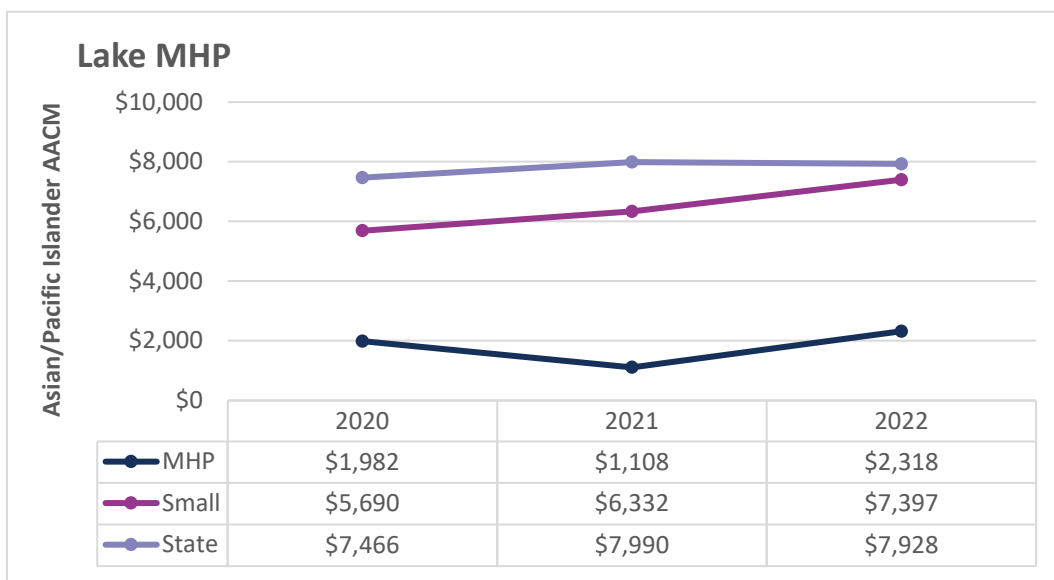
- The Asian/Pacific Islander AACM is noticeably lower than the state and other small county data and the number of members served is very low. This can result in significant fluctuations when calculating averages from year to year.

Figure 10: Foster Care PR, CY 2020-22

Lake MHP

	2020	2021	2022
MHP	39.41%	44.30%	39.86%
Small	43.16%	37.49%	36.14%
State	51.00%	49.15%	46.00%
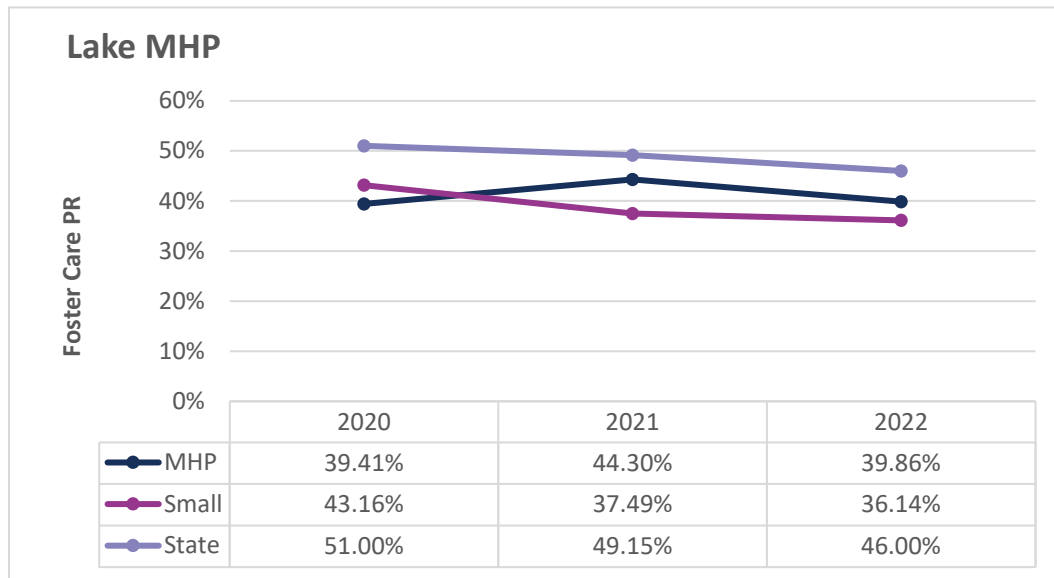
- The MHP's FC PR went up in CY 2021 and came back down to the CY 2020 level in CY 2022. It was lower than the state rate each of the three years and higher than the small county rate in CY 2021 and CY 2022.

Figure 11: Foster Care AACM, CY 2020-22

Lake MHP

	2020	2021	2022
MHP	$14,759	$15,429	$17,892
Small	$10,017	$10,517	$10,638
State	$10,338	$11,020	$11,542
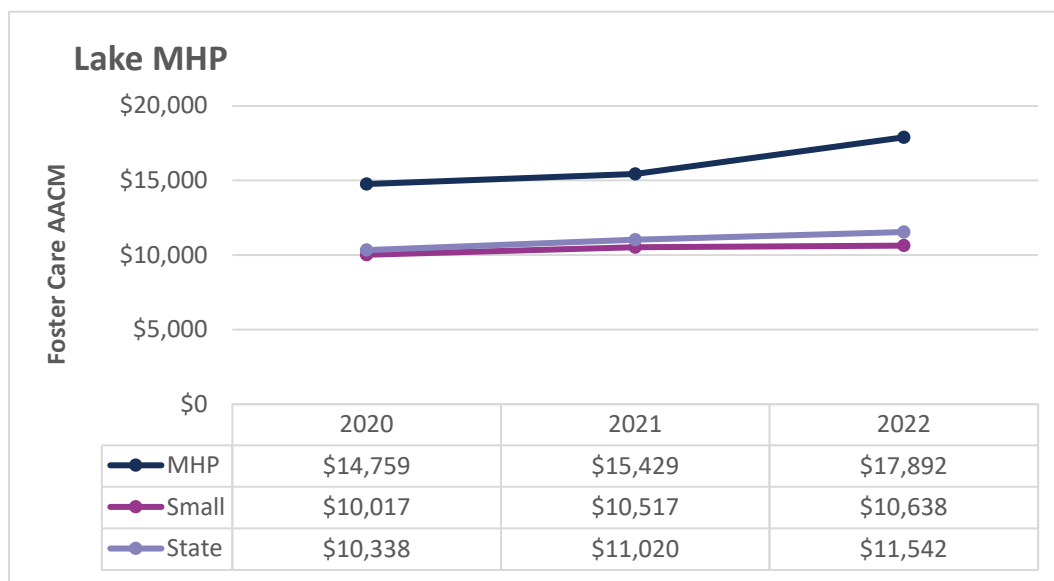
- Statewide FC AACM has increased each year for the past three years. The MHP's FC AACM was about 40 percent higher than the state in CY 2020 and CY 2021 and increased to 55 percent higher than the state in CY 2022.

- The MHP has a relatively high FC inpatient utilization. Shown later in Table 9, the MHP provides medication support to a higher percentage of FC members, and more units of intensive home-based services, mental health services, and targeted case management (TCM) than statewide. All of these services contribute to the higher AACM.

Units of Service Delivered to Adults and Foster Youth

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

Service Category	MHP N = 982				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	113	11.5%	10	7	10.3%	14	8
Inpatient Admin	<11	-	5	5	0.4%	26	10
Psychiatric Health Facility	16	1.6%	27	22	1.2%	16	8
Residential	0	0.0%	0	0	0.3%	114	84
Crisis Residential	<11	-	19	19	1.9%	23	15
Per Minute Services							
Crisis Stabilization	11	1.1%	1,004	1,200	13.4%	1,449	1,200
Crisis Intervention	296	30.1%	294	209	12.2%	236	144
Medication Support	400	40.7%	239	145	59.7%	298	190
Mental Health Services	679	69.1%	421	225	62.7%	832	329
Targeted Case Management	379	38.6%	522	139	36.9%	445	135

- Both inpatient and psychiatric health facility (PHF) utilization are higher than the state rates. The average days in a PHF is more than 50 percent higher than the state average. The MHP expects that the Living Room scheduled to open in early CY 2024 will lower the need for out of county PHF services.

- Thirty percent of adult members received crisis intervention services in Lake, almost two and a half times the 12.2 percent statewide average. Members served also received more units of crisis intervention than seen statewide.

- While medication support utilization is approximately two-thirds of the state rate, the number of members served increased from 328 in CY 2021 to 400 in CY 2022. The MHP has expanded their contract with North American Mental Health Services to provide additional psychiatry services.

- A higher percentage of MHP members served receive mental health services, though they receive about half the average number of units, compared to the statewide average.

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

Service Category	MHP N = 57				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	-	11	12	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	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	<11	-	960	960	3.1%	1,166	1,095
Crisis Intervention	<11	-	566	492	8.5%	371	182
Medication Support	20	35.1%	311	222	27.6%	364	257
TBS	<11	-	7,678	4,950	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	23	40.4%	1,421	427	40.8%	1,458	441
Intensive Home-Based Services	<11	-	19,813	10,353	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	55	96.5%	2,671	1,085	95.4%	1,846	1,053
Targeted Case Management	30	52.6%	366	186	35.8%	307	118

- In Lake, 35.1 percent of FC members receive medication support compared to 27.6 percent statewide.

- The MHP's intensive care coordination (ICC) utilization is very similar to the statewide data. However, the percentage served IHBS is well below the statewide rate, but with significantly more units of service provided.

- The MHP provides more units of TCM to a higher percentage of members than statewide. They also provide an average of about 45 percent more units of mental health services than seen statewide.

IMPACT OF ACCESS FINDINGS

- Hispanic/Latinos make up the second largest Medi-Cal ethnicity in Lake, yet their PR is less than half of the county average. Although there is a slight increase in the Hispanic PR for the MHP over the past two years, the MHP's Hispanic PR continues to be lower than the rates for the state and small-sized counties suggesting potential barriers to access for this population. The MHP is encouraged to analyze the disparity and design and implement strategies to ensure that the needs of the Hispanic/Latino community are met, including ensuring that resources are available in Spanish.

- The MHP's FC PR is lower than the state FC PR. In contrast, the MHP's FC AACM is well above the state average. This could be a result of providing more services and more expensive services to FC youth served by the MHP. The MHP should research and analyze whether the additional services are resulting in positive outcomes.

- The MHP's notable efforts to expand mobile crisis services in January 2024 will improve access to crisis services.

TIMELINESS OF CARE

The amount of time it takes for members to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likelihood individuals will not keep the appointment. Timeliness tracking is critical at various points in the system including requests for initial, routine, and urgent services. To be successful 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	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- The MHP's timeliness for first delivered non-urgent appointments has improved compared to the previous year and met the standard for ten business days.

- The MHP expanded their contract for psychiatric services including an on-site prescriber. This is the first on-site prescriber providing services in the MHP since the COVID-19 pandemic.

- The MHP's timeliness with outpatient follow-up is potentially contributing to the low readmission rates. The rates were consistent with EQRO data for Medi-Cal hospitalizations.

- The MHP reported timeliness data for only county-operated services and did not include the contractor-operated services. Monitoring the overall timely access to care by including the contract provider data would be beneficial for the MHP as this provides a clear picture of the entire system's performance.

- The MHP reported zero for the numbers served related to FC timeliness metrics for FY 2022-23 for first offered psychiatry, urgent conditions, psychiatric hospitalizations, and readmissions. The CY 2022 FC Access PM data indicates 20 FC members received medication support and the percentage who received medication support of those served was higher than the state (35.7 percent vs. 28.5 percent) indicative of psychiatry service utilization by FCs. The inpatient services were below 11 suggesting low inpatient utilization for the FCs. This disparity in the numbers reported by the MHP indicates an opportunity for accurate reporting of FC metrics.

- The average no-show rates for psychiatry are slightly higher than the non-psychiatry clinician rates. The average no-show rates for adults are higher than the rates for children for both psychiatry and non-psychiatry clinicians and almost twice as high for adults than children for the non-psychiatry clinician appointments. The MHP would benefit from exploring the reasons for the higher no-show rates for psychiatry and for adults as the no-shows prevent an efficient use of clinician time.

- Timeliness Key Components refer to the actual tracking and monitoring of results of the above metrics. Where results are poor, improvement activities are warranted and should be noted if any activities are planned or in place.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access (ATA) 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 ATA, representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent county-operated services.

The first offered and first delivered non-urgent psychiatry appointment data had some internal discrepancies. The total count of offered appointments that met the standard did not match the age group data. Also, the MHP did not explain why the count of adult delivered services that met the standard was higher than the count of adult offered services that met the standard.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	6.25 Business Days	10 Business Days*	83.52%
First Non-Urgent Service Rendered	7.18 Business Days	10 Business Days**	79.86%
First Non-Urgent Psychiatry Appointment Offered	6.98 Business Days	15 Business Days*	88.46%
First Non-Urgent Psychiatry Service Rendered	7.59 Business Days	10 Business Days**	80.76%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	1.02 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	4.53 Calendar Days	7 Calendar Days	69%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	4.53 Calendar Days	30 Calendar Days	75%
No-Show Rate – Psychiatry	19.38%	<20%**	n/a
No-Show Rate – Clinicians	17.19%	<20%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033			
** MHP-defined timeliness standards			
For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23			

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

Lake MHP

First Offered Service

First Delivered Service

First Offered Psychiatry

First Delivered Psychiatry

Business Days

■ All ■ Adult ■ Child ■ FC

Figure 13: Wait Times for Urgent Services

Lake MHP

All

Adult

Child

FC   MHP did not report any numbers for this category
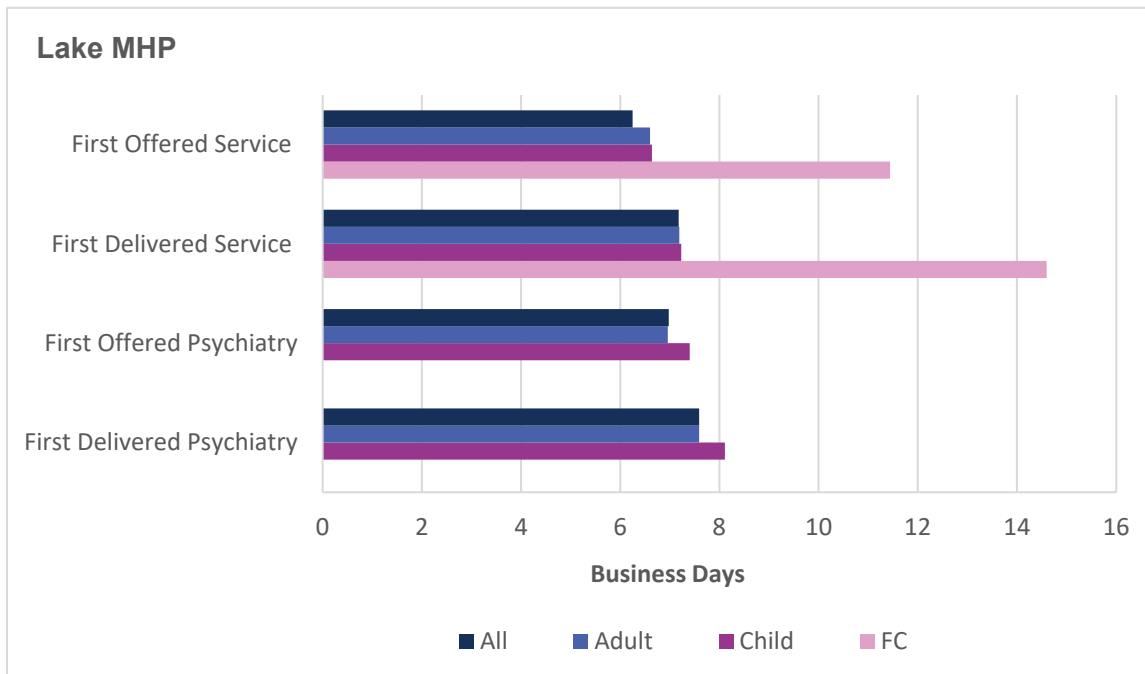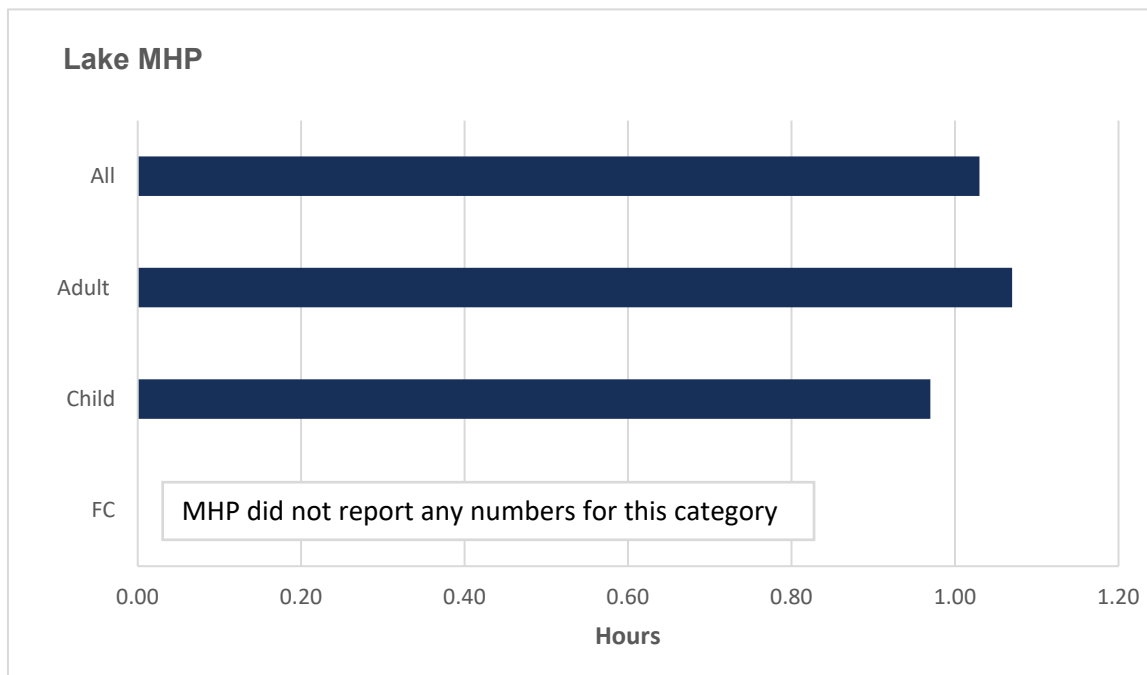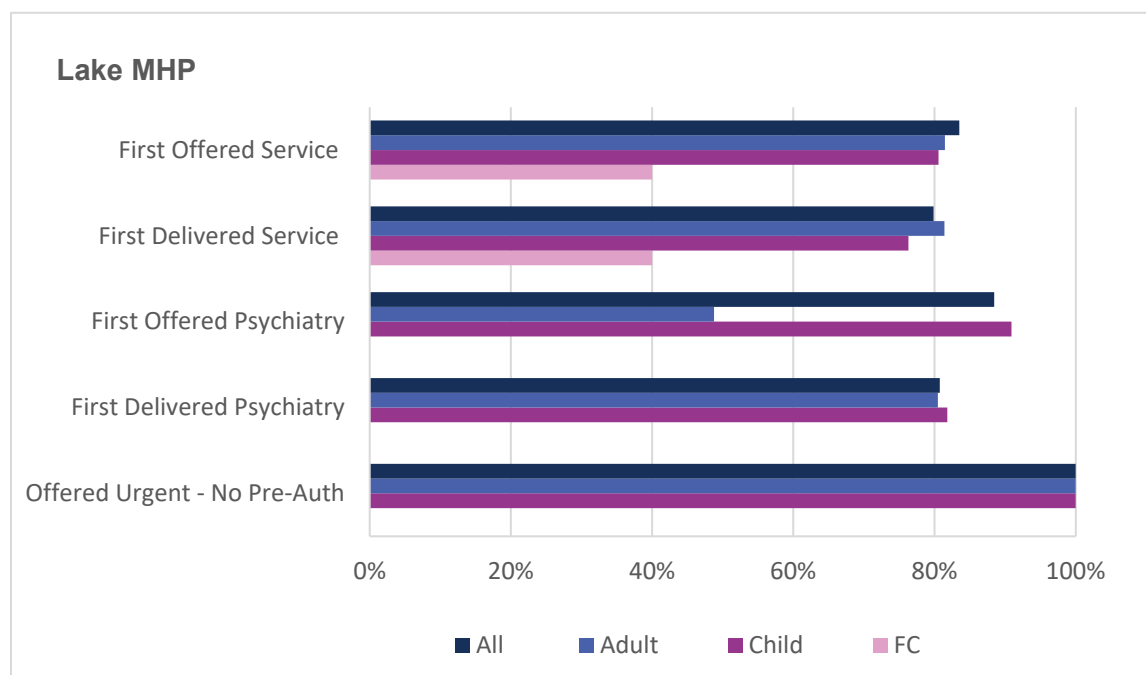
Hours

Figure 14: Percent of Services that Met Timeliness Standards

- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments tracked by the Access log.

- The MHP ATA reported timeliness for first offered non-urgent appointments was 83.52 percent. There were basic arithmetic errors in the ATA and the EQRO calculated first offered non-urgent appointments that met the 10-day standard was 81.03 percent.

- The MHP defined "urgent services" for purposes of the ATA as crisis services provided by the MHP in response to the requests from the emergency room logged into their crisis tracker. The MHP uses the crisis tracker to track the response time of the mobile crisis team for a crisis response request from the ED. There were reportedly 742 urgent service requests with a reported actual wait time of 1.03 hours for services for the overall population. The MHP does not require pre-authorization for urgent services.

- The MHP defines timeliness to first delivered/rendered psychiatry services from the member's initial request for service. The ATA reported that 88.46 percent of the first offered non-urgent psychiatry appointments met the 15-day standard. There were basic arithmetic errors in the ATA and the EQRO calculated first offered non-urgent psychiatry appointments that met the 15-day standard was 57.69 percent.

- The MHP reports a no-show rate of 19.38 percent for psychiatrists and 17.19 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- There were inconsistencies in the ATA data and methodology that warrant follow-up. Totals did not match up to the age group numbers provided. In general, procedures should be put in place to have a second level of review before data is shared. The MHP would benefit from capturing accurate data definitions for reporting timeliness metrics in the new EHR by involving all key stakeholders.

- Contract provider data was not provided. The MHP should develop methods to include the contractor data to understand and potentially improve the timeliness of services delivered by contract providers.

- The MHP reported crisis services as urgent conditions and was interested in revising the definition of urgent conditions to capture all urgent appointments that align with the 48-hour time frame instead of the one-hour time frame for crisis. The MHP would benefit from defining urgent conditions and training staff to capture the urgent condition timeliness metrics accurately.

- With high caseloads, the MHP could investigate ways to limit no-show appointments to maximize the use of clinician time.

- The MHP would benefit from accurate tracking of timely access to care for FC members to ensure appropriate QI activities are implemented to address areas for improvement.

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

In the MHP, the responsibility for QI is within quality management (QM). The MHP has a QM structure that guides and tracks system issues and QI initiatives. The QM staff are fully integrated with the leadership team and report directly to the MHP Director. QM staff are embedded in the compliance department, and the MHP QI Coordinator facilitates the implementation of the QAPI work plan activities. The compliance committee is separate from the quality improvement committee (QIC) to ensure separation of compliance from QI, and each program has its own committee with separate committee chairs, goals, and tasks. The CQI is an internal committee and the QIC includes external stakeholders.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC is comprised of the QI Coordinator, management/supervisory staff, clinical staff, case management staff, clerical and support staff; clients, family members, and other stakeholders. It is scheduled to meet quarterly, and the MHP reported that post-pandemic consumer participation in QIC has been sparse. Of the nine identified FY 2020-21 QAPI workplan goals, the MHP identified five goals that were met. The MHP was two years behind with evaluating QAPI goals and developing current QAPI goals for the review. The MHP is yet to evaluate goals for FY 2021-22 and FY 2022-23 and has not developed QAPI goals for FY 2023-24. During the review, the MHP explained that staffing challenges impacted the timeliness of tracking QAPI goals. The MHP hired a clinical staff who will be part of the QM team to assist with the QAPI goals and other QI activities.

The MHP does not currently utilize a standardized level of care (LOC) tool. However, the MHP reviews LOC transitions and continuum of care through their case consultations and relies heavily on this process to determine transition to lower or higher LOC. The MHP utilizes the following outcomes tools: PSC-35 and CANS for children and prodromal questionnaire–brief version adult screening, and abbreviated clinical structured interview for psychosis syndrome for screening adults with attenuated psychotic syndrome. The MHP does not aggregate outcomes data and uses the information only at an individual level.

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	Partially 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	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	Partially 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	Met

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

- The MHP has an enthusiastic new leadership team that is trying new methods to improve employee engagement that may address concerns expressed by key informants on limited communication.

- The MHP's QAPI work plan goals and QAPI evaluation are not current and are two years behind. The MHP would greatly benefit from evaluating goals in a timely manner to ensure QI strategies can be adjusted timely when there is no positive impact.

- The MHP has strong collaboration and communication with local community agencies and stakeholders. However, line staff noted challenges with communication upward beyond the immediate supervisor, resulting in concerns

not being addressed. Key informants expressed that the all-staff meetings are not the appropriate forum to address concerns.

- The MHP does not use LOC tools to evaluate systematic clinical continuum of care. The MHP relies on case consultations among multi-disciplinary teams for transitions related to LOC and on executive leadership involvement to address concerns with high-risk cases. The MHP does not aggregate outcomes data and include this in the QAPI goals, nor does it have dashboards.

- The MHP has medication monitoring protocols and a QAPI goal related to the number of charts included for the medication review which has been set at ten percent. The MHP submitted medication monitoring for three quarters with 20 charts reviewed for each quarter. The MHP compliance rates for lab work dropped from 40 percent in February to 10 percent both for May and August reviews. The only area for which the compliance rates were consistent at 100 percent for all three reviews was for DSM-V codes. The compliance rates for all other review parameters decreased for the May and August reviews compared to the February review. This indicates an opportunity for timely performance improvement activities to improve compliance rates in all areas.

- The MHP does not track the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5. The medication monitoring review documentation submitted by the MHP did not have FC related HEDIS measures listed below.

- The MHP uses data from the cultural humility and test calls surveys to implement QI activities in response to the feedback.

- The MHP's four peer-run centers offer immense support and offer a wide range of resources and services to the served and unserved, making a huge impact on the quality of care in this area.

- The MHP has a career ladder with three levels – client support assistant, peer support specialist (PSS), and PSS Senior. The MHP has hired a consumer who has worked through several levels in the system including middle manager positions as the Deputy Director over clinical services.

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:
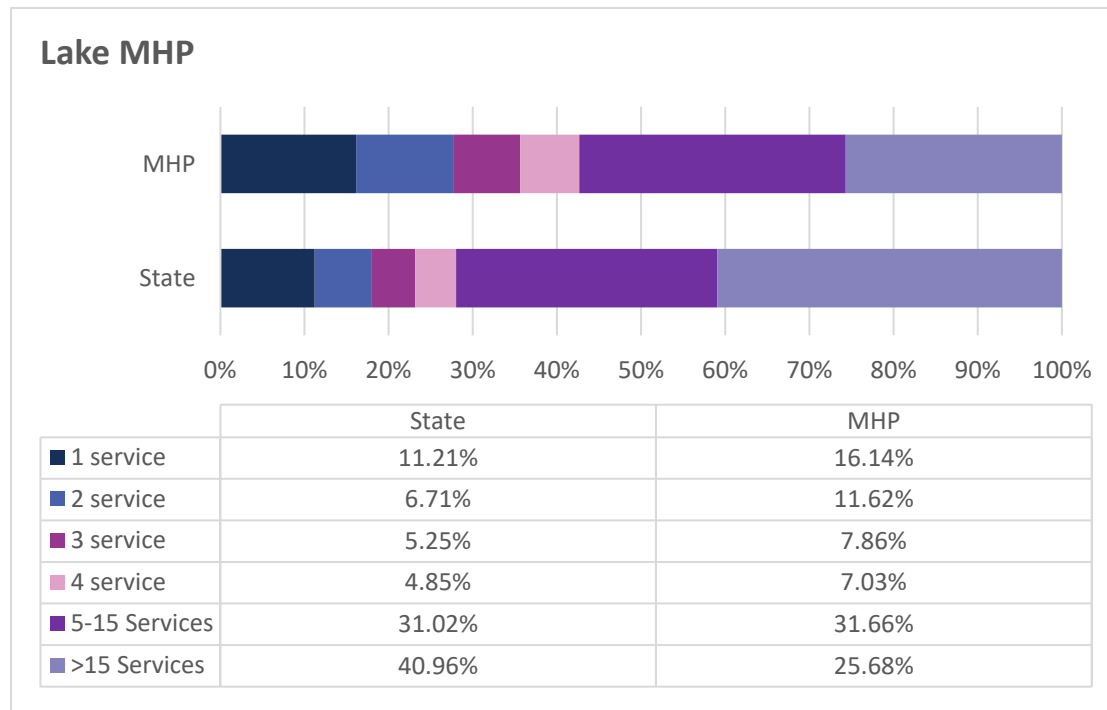
- Retention in Services
- Diagnosis of Members Served
- Psychiatric Inpatient Services

- 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

Lake MHP

	State	MHP
1 service	11.21%	16.14%
2 service	6.71%	11.62%
3 service	5.25%	7.86%
4 service	4.85%	7.03%
5-15 Services	31.02%	31.66%
>15 Services	40.96%	25.68%

- In Lake 42.65 percent of members received one to four services, compared to 28.02 percent statewide. The relatively high number of members receiving a low number of services might be a result of low engagement when members may come in for crisis intervention.

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 %	16%	15%	7%	6%	3%	21%	14%	13%	5%
■ State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

Percent Members by Diagnostic Category
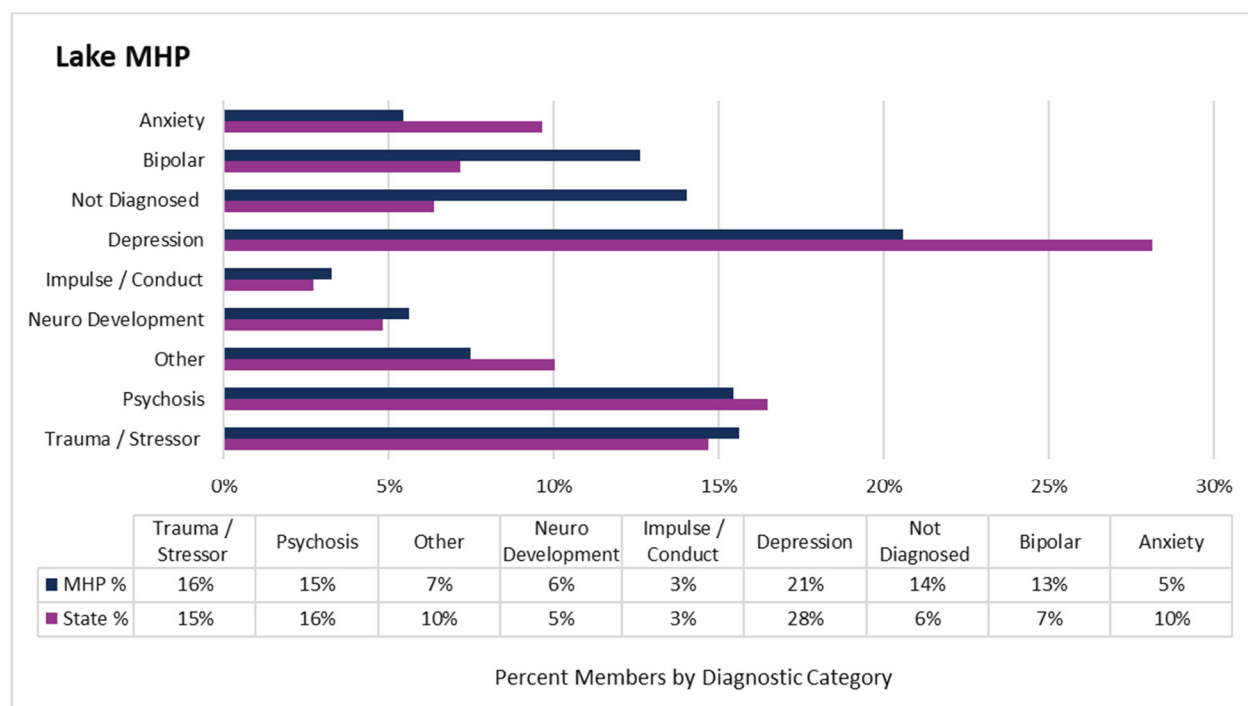
- The MHP serves a lower proportion of members with depression (21 percent) and anxiety (5 percent) compared to the state at 28 percent for depression and 10 percent for anxiety.

- The MHP serves a higher proportion of members with bipolar disorder (13 percent) than is seen statewide (7 percent).

- The proportion of not diagnosed members (14 percent) is well above the statewide average (6 percent), possibly related to the high percentage of members who receive crisis intervention services.

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

Lake MHP

	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
■ MHP %	18%	21%	20%	6%	5%	13%	4%	10%	3%
■ State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

Percent Claims by Diagnostic Category
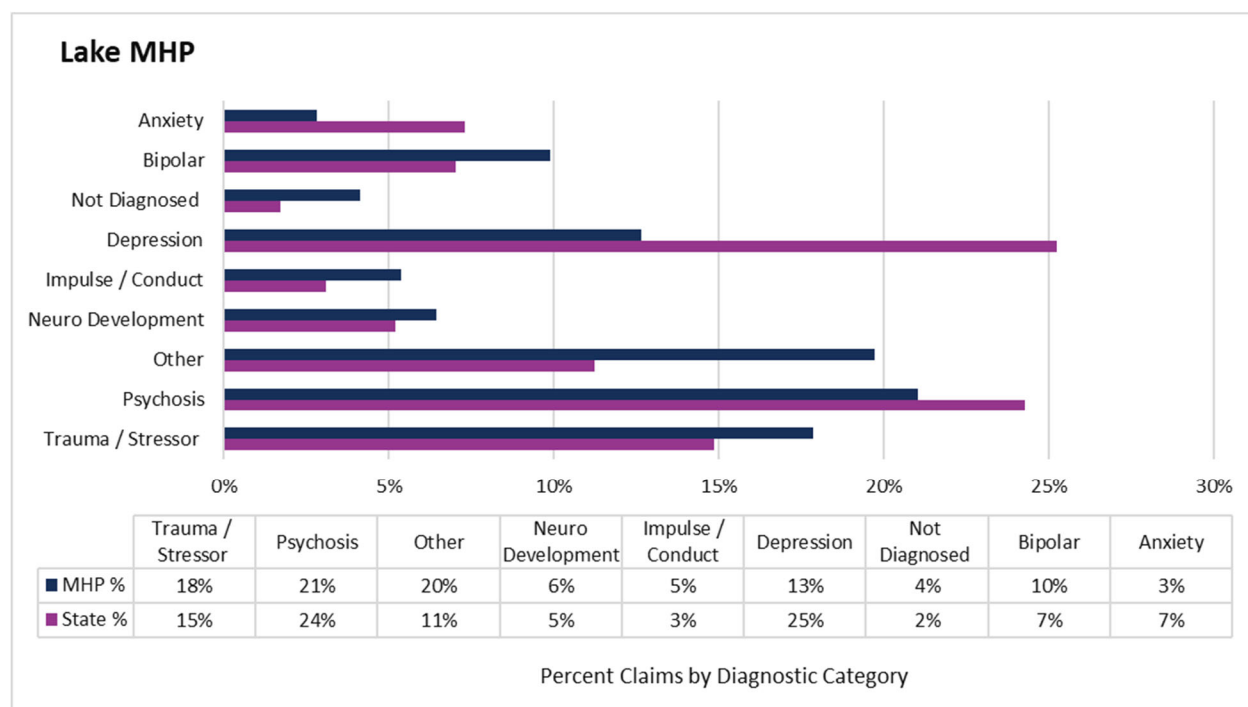
- The relatively low percentage of approved claims for members with depression and anxiety diagnoses is more pronounced than seen in Figure 16. Both are about half of the state average.

- Although only 7 percent of members had a diagnosis in the Other category, 20 percent of approved claims were in this category.

- The proportion of those with no diagnosis and claims for this category for the MHP are about twice as that seen for the state.

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: Lake MHP Psychiatric Inpatient Utilization, CY 2020-22

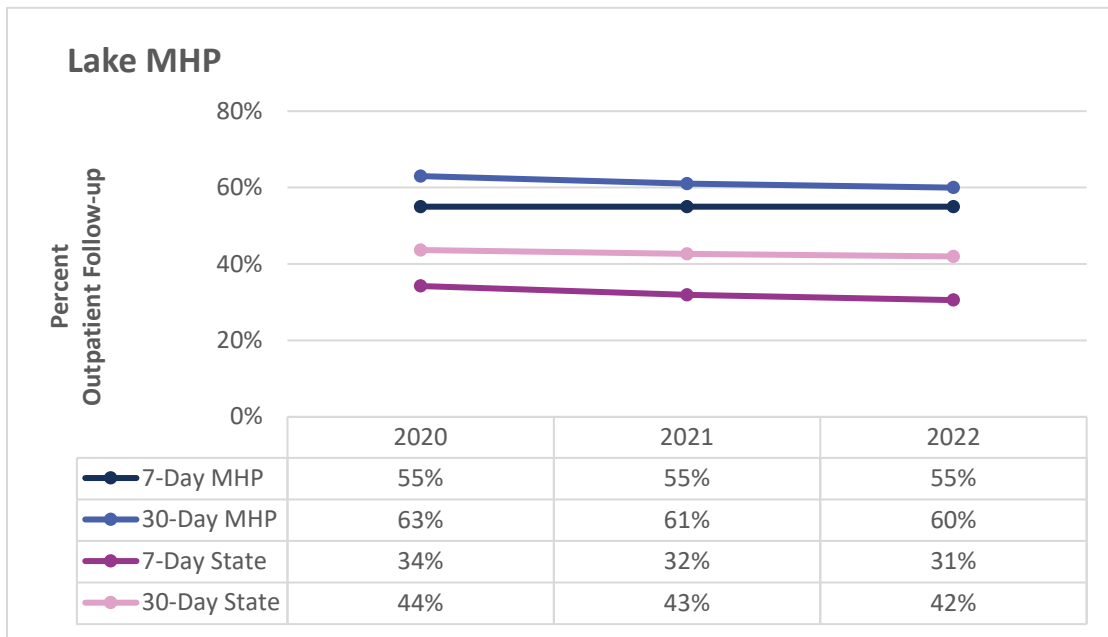| Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	131	136	1.04	12.33	8.45	$15,914	$12,763	$2,084,681
CY 2021	147	179	1.22	12.49	8.86	$16,858	$12,696	$2,478,112
CY 2020	119	138	1.16	12.17	8.68	$16,707	$11,814	$1,988,099

- The MHP's unique Medi-Cal members hospitalized, total Medi-Cal admissions, average admissions per member, and average LOS increased in CY 2021 and declined in CY 2022.

- The MHP's average LOS tends to be almost 50 percent higher than statewide average, contributing to the higher average inpatient AACM than the statewide average. With 1.04 admissions per member, and as seen below in Figure 19, readmission rates are lower than the statewide rates.

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

Lake MHP

	2020	2021	2022
7-Day MHP	55%	55%	55%
30-Day MHP	63%	61%	60%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- The MHP continues to have an impressive and steady record of post psychiatric inpatient follow-up, despite the hospitalizations all occurring outside of the county. For all three CYs displayed, Lake's follow-up rate at seven days is higher than both the state's 7-day and 30-day rate suggesting immediate post-discharge outpatient follow-up is a MHP priority.

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

Lake MHP

	2020	2021	2022
7-Day MHP	1%	3%	1%
30-Day MHP	4%	11%	6%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%
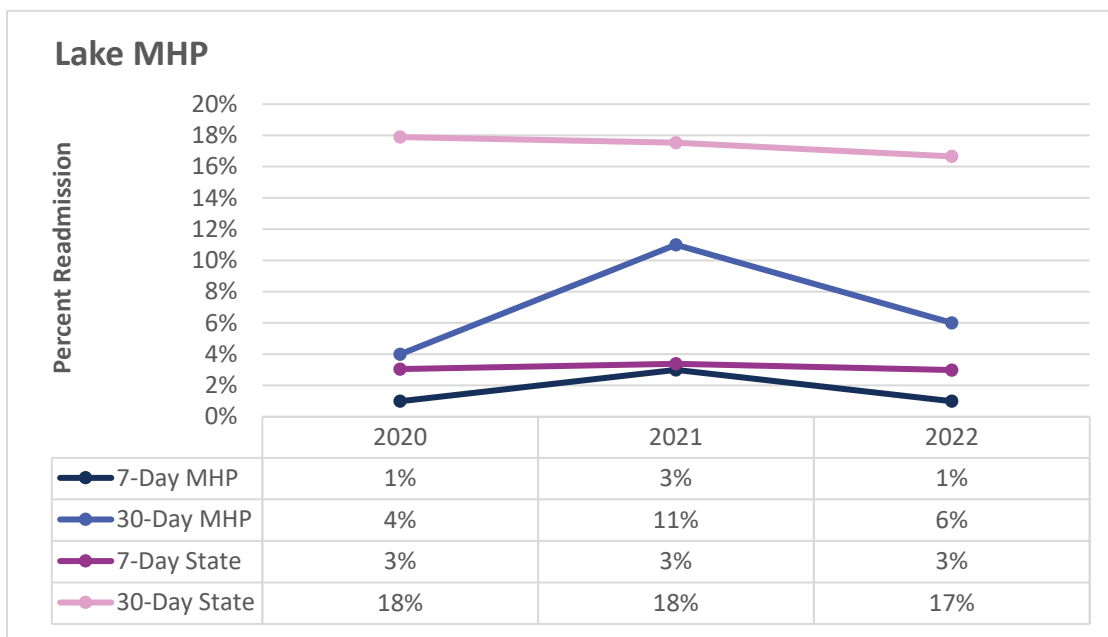
- The MHP's readmission rates are also lower than the state rate at both 7 and 30 days. The ATA reported similar readmission rates and somewhat higher post psychiatric discharge follow-up rates.

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 members, 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 LOC 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: Lake 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	47	3.27%	34.91%	$2,912,694	$61,972	$45,755
	CY 2021	52	3.90%	38.04%	$3,027,871	$58,228	$42,087
	CY 2020	31	2.60%	31.60%	$1,974,808	$63,703	$41,936

- The MHP's HCM count, percentage of members served, and total approved claims declined in CY 2022.

- Although the MHP's proportion of members considered to be HCMs is lower than the statewide proportion, the percentage of approved claims attributed to HCMs is somewhat higher than statewide. The AACM is higher than the statewide average, despite the overall AACM being 78 percent of the statewide average.

Table 15: Lake 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)	45	3.13%	13.07%	$1,090,189	$24,226	$23,483
Low-Cost (Less than $20K)	1,345	93.60%	52.03%	$4,341,330	$3,228	$1,566

Figure 20: Lake MHP Members and Approved Claims by Claim Category, CY 2022
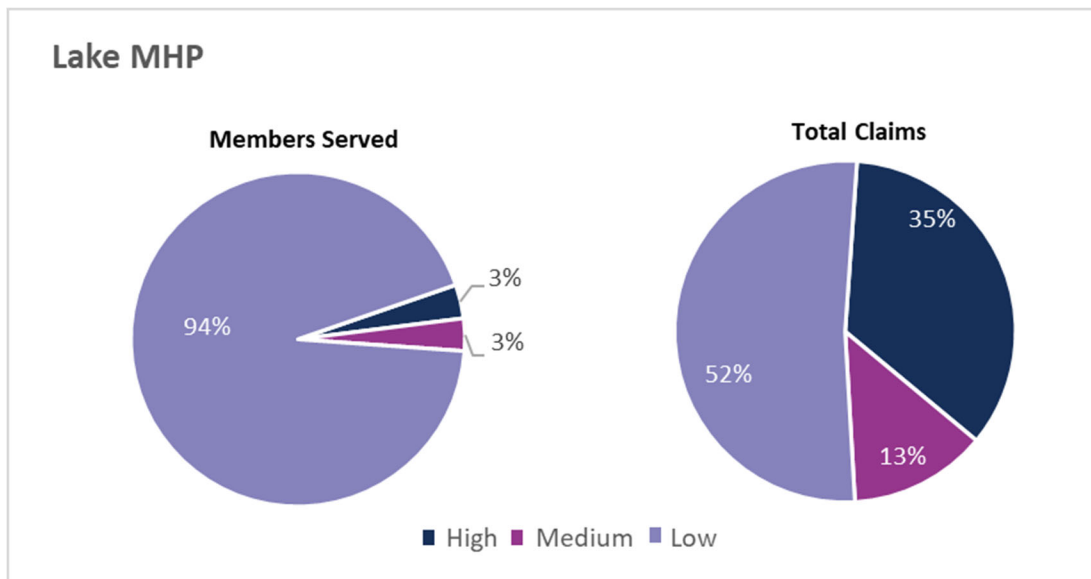
- The MHP has more members in the low-cost category than statewide. Although the MHP's percent of low-cost members served (94 percent) is higher than the statewide rate (92 percent), the percent of low-cost member approved claims is lower for the MHP (52 percent) compared to the state at 54 percent.

IMPACT OF QUALITY FINDINGS

- In the area of member retention, the MHP is about 5 percentage points higher than the statewide average with individuals that receive one and two services, and 15 percentage points lower than the statewide average for those who receive more than 15 services. This may suggest easier initial access and potential barriers to retention that may be worth further exploration.

- Though now allowable under CalAIM, the proportion of deferred diagnoses (14 percent) is over double the statewide average (6 percent). At the same time, 16.1

percent of MHP beneficiaries received one service, compared to 11.2 percent statewide, and 30.1 percent of adult beneficiaries received crisis intervention compared to the statewide rate of 12.2 percent. The high number of deferred diagnoses may be attributed to the high number of members receiving one service, which may be crisis intervention and a deferred diagnosis.

- The high percentage of approved claims with a diagnosis in the Other category should be analyzed to ensure that members are getting the treatment needed.

- The MHP's 7-day and 30-day post-discharge outpatient follow-up rates are much higher than the state rates and have potentially contributed to the lower readmission rates compared to the state, especially the 30-day readmission rate (6 percent vs. 17 percent).

- While the MHP is trying new methods to improve employee engagement, key informants indicate that additional work is needed. The MHP should consider additional approaches to ensure they are getting feedback from all staff levels.

- The MHP generally uses clinical judgment rather than data for treating members and analyzing system performance. As CalAIM reinforces the need for a data-driven quality of care, the MHP should consider using the data they generate to inform their system of care.

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: The MHP did not submit a clinical PIP that was mental health related for this review. The MHP submitted a pharmacotherapy for opioid use disorder (POD) PIP which was a substance use disorder related PIP.

Date Started: N/A

Date Completed: N/A

Aim Statement: N/A

Target Population: None

Status of PIP: The MHP's clinical PIP was not implemented due to lack of staff resources.

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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

N/A

TA and Recommendations

CalEQRO recommendations include:

- Implement the clinical PIP originally planned to be implemented in FY 2022-23.

- Designate a lead to oversee the implementation.

- Create a PIP team reflective of quality, clinical and analyst staff, and develop a timeline for the various phases of the PIP.

- Seek TA from EQR to ensure acceptable methodology for the implementation of the PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-up after ED visit for mental illness

Date Started: 07/01/2022

Proposed Date for Completion: 06/30/2024

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 five percent by June 30, 2024.

Target Population: All plan members discharged from ED for a mental health related visit who need outpatient follow-up.

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

Summary

The MHP conducted a root cause analysis of barriers for timely outpatient follow-up following discharge from EDs after meeting with key stakeholders in December 2022. Barriers identified from the analysis included member, provider, and system barriers such as inadequate engagement and care coordination efforts that address the complex needs of plan members; care fragmentation and communication gaps between EDs, the MHP, and provider network including "cold hand-offs;" insufficient processes to track ED referrals and ensure referral loops are closed; and lack of infrastructure to routinely access, exchange, and analyze data from MCPs on ED utilization to ensure focused care coordination strategies.

The MHP plans to implement a formalized referral process from the ED that includes consent for text messaging effective 02/01/2024 and secondly, initiate automated text reminders for outpatient follow-up appointments starting 03/01/2024. Due to staffing shortages on the QI team, the department was unable to implement a referral system until early 2024. The MHP collaborates with the local ED who receives funding from CA Bridge.

The measures for the PIP include number of referrals received through the referral tracking system and percent of the referrals that are complete, the number and percent of members who received an initial contact from the MHP within seven days of discharge, and the percent of members who received a follow-up mental health treatment service within 7 and 30 days.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence because the PIP lacked detail, comprehensive review of data for current and past year's follow-up rates, and a thorough narrative of the PIP design that clearly explains the interventions, training for staff involved in the PIP, and the data collection methodologies. There was no supporting documentation that demonstrates MHP efforts for designing this PIP with a clearly defined plan for implementing the interventions and well-designed data collection tools. There was no detail provided on the recent communications with the EDs nor a clear plan on training staff who will be sending reminder texts, the format of those texts, and the referral logs used for tracking ED referrals. Overall, due to lack of acceptable methodology, data collection details, and evidential documentation to support a sound PIP design, this PIP is rated "low" confidence.

CalEQRO recommendations for improvement of this non-clinical PIP:

- The MHP did not submit the PIP documents prior to the review and was not prepared to discuss the PIP during the review session. The MHP submitted the PIP post-review; therefore, TA could not be offered during the review session specific to this topic. During the review, the MHP was encouraged to schedule TA calls with EQR team.

- The MHP would benefit from assigning a lead for this PIP and having a PIP committee comprised of key QI, clinical, and analyst staff to ensure timely progress through all phases of PIP implementation.

- The MHP would benefit from identifying all data elements needed to report data for the measures identified and training all staff involved in tracking and reporting data on the data collection and tracking tools.

- Supporting documentation that demonstrates the MHP's efforts for the implementation of this PIP through various phases will be critical for providing a clear roadmap of the PIP design and implementation.

INFORMATION SYSTEMS

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the MHP's 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 Streamline's SmartCare product, which was implemented in March 2023. Currently, the MHP is actively implementing the new system which requires heavy staff involvement to fully develop.

Approximately 2 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control. The budget increased from 1.41 percent last year to support the new system.

The MHP has 117 named users with log-on authority to the EHR, including approximately 86 county staff and 31 contractor staff. Support for the users is provided by two full-time equivalents (FTEs) IS technology positions. One of the two IT positions is currently vacant. This is a challenge for the MHP while they are implementing a new EHR. The MHP had several candidates in upcoming interviews which could bring them back to full staffing.

As of the FY 2023-24 EQR, some contract providers have access to directly enter service 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 Lake 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	75%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	25%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP does not have a PHR but intends to implement one within the next year.

Interoperability Support

The MHP is a member or participant in a HIE. They have established admit, discharge, and transfer connectivity with the SacValley MedShare HIE. Despite the effort that went into establishing the connection, they have decided to discontinue that HIE in favor of the CalMHSA SmartCare HIE, which is expected to be better integrated with the EHR. Healthcare professional staff use secure information exchange directly with service partners through secure email. The MHP does not engage in electronic exchange of information at this time but intends to establish electronic exchange of information with its MCP in CY 2024.

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	Not Met
4C	Integrity of Medi-Cal Claims Process	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

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

- The MHP improved their implementation of security and controls with the new SmartCare EHR. They also strive towards independence by doing their own Medi-Cal billing and writing their own reports.

- Integrity of Medi-Cal claims process is partially met because there has been very little Medi-Cal billing for any services delivered after March 2023. They are heavily dependent on their vendor to resolve the billing issues. In contrast, their billing records for CY 2022 showed consistent billing and a 0.79 percent denial rate compared to the 5.92 percent state average.

- Interoperability is also rated as partially met. They are not using the HIE which they went through the effort to implement. Also, contract providers do not enter clinical data such as progress notes and problem lists into the EHR, although they can look up this information if it was entered by county staff.

- Integrity of data collection and processing Key Component was not met. There were internal inconsistencies in the ATA data provided suggesting a lack of data integrity verification. Although heavily dependent on their vendor, they are behind in state reporting and unable to submit the health provider directory in the 274 electronic data interchange format. They do not have a data warehouse to support data analytics.

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 Lake MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	1,976	$687,669	$2,072	0.30%	$685,597
Feb	1,838	$604,960	$4,263	0.70%	$600,697
Mar	2,343	$719,697	$12,557	1.74%	$707,140
April	1,947	$569,513	$2,326	0.41%	$567,187
May	1,889	$546,256	$6,433	1.18%	$539,823
June	1,811	$554,139	$3,096	0.56%	$551,043
July	1,739	$535,148	$12,815	2.39%	$522,333
Aug	2,008	$583,515	$533	0.09%	$582,982
Sept	1,925	$525,834	$3,021	0.57%	$522,813
Oct	1,962	$560,034	$759	0.14%	$559,275
Nov	1,842	$512,042	$1,745	0.34%	$510,297
Dec	1,407	$410,883	$4,237	1.03%	$406,646
Total	**22,687**	**$6,809,690**	**$53,857**	**0.79%**	**$6,755,833**

- While this table reflects pre-payment reform rates, the MHP expects that the CalAIM rates will be beneficial to the county once they begin to successfully bill for services provided since they implemented the SmartCare EHR.

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

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Other healthcare coverage must be billed first	61	$19,458	36.13%
Medicare Part B must be billed before submission of claim	50	$18,207	33.81%
Beneficiary is not eligible or non-covered charges	14	$6,043	11.22%
Late claim submission	7	$4,610	8.56%
Deactivated NPI	16	$4,260	7.91%
Service location NPI issue	1	$878	1.63%
Service line is a duplicate and repeat service modifier is not present	3	$402	0.75%
Total Denied Claims	**152**	**$53,858**	**100.00%**
Overall Denied Claims Rate	**0.79%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- Over two-thirds of the MHP's very low claims denial rate is related to billing other healthcare coverage or Medicare prior to billing Medi-Cal.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- To maintain adequate cash flow and prevent any impact to delivering services, the MHP must resolve the SmartCare billing issues. The MHP has been using CPT codes since they converted to SmartCare in March 2023, but they have not been able to successfully claim to Medi-Cal. Once billing is successful, the MHP expects to benefit from the new payment reform rates.

- The MHP must develop processes to ensure the reliability of reports and data that they produce. This is particularly important as the MHP moves increasingly towards being a data-driven organization.

- Contract providers only enter service information into the EHR. They do not enter clinical data such as assessments, progress notes, and problem lists. This limits the clinical data that is shared between care teams when a member switches between county and contracted provider services. Increased interoperability, through an HIE, other electronic exchange mechanisms, or increased usage of the EHR by contract providers would improve the exchange of clinical information between care teams.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP administers the CPS surveys and uses data related to the overall satisfaction and cultural responsiveness areas for their QAPI goals. The MHP does not have current CPS survey findings posted on the website and displays the Spring 2019 data. The MHP relies on the state contracted entities to provide CPS data and is pending results from CY 2022 surveys.

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 Spanish speaking plan members, containing 10 to 12 participants.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held via video conference and included only two participants. A Spanish interpreter was used for this focus group. One member who participated and one parent who participated had a child who received clinical services from the MHP. Due to the low number of participants, the information provided is included throughout the report where applicable. Though participation was low, the MHP took the following steps to ensure robust participation.

Seven members were scheduled for focus group on the original date for the review, December 5, 2023, and it had to be rescheduled because the county internet was down. The focus group was rescheduled to December 11, 2023, and some of the members scheduled for the original date could not attend the group due to transportation and childcare issues. However, they did not inform the peer leader who recruited the members that they are not able to attend the focus group. The two members whom the MHP could reach participated.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Due to the low number of participants, the information provided is included throughout the report where applicable.

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 has four peer-run centers run by passionate and dedicated peers who provide a wide range of services and immense support to diverse populations. The peer employees receive excellent supervisory support and are very appreciative of the changes made by the new director to enhance peer support. (Quality)

2. The MHP provides timely access to care for first offered non-urgent appointments, and post-discharge outpatient follow-up appointments and has low inpatient readmission rates. (Timeliness)

3. The MHP has been successful in hiring new clinicians and contracting with psychiatrists to improve timely access to care and implemented new strategies such as paid clinical supervision through a vendor. (Timeliness, Access)

4. The MHP reported positive changes from the implementation of CalAIM projects related to payment reform that were favorable and conducive to fee-for-service contracts. (Access)

5. The MHP has strong collaboration with contract providers, local communities, governmental organizations, and stakeholders and collaborates in their outreach efforts with these entities to reach diverse populations including the homeless, Native American, and Latino. The MHP is the lead administrator for the Lake LCCOC program, a consortium focused on reducing homelessness in the county. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP submitted two PIPs in the planning phase for last year's review and did not implement both PIPs as planned. The MHP changed the interventions designed for the clinical PIP from last year and submitted this as a non-clinical PIP for this review. The MHP did not submit a clinical PIP for this year's review. (Quality)

2. The MHP's QAPI plan is not current and includes the evaluation for goals for FY 2020-21. This delay impacts timely and appropriate quality improvement activities for areas that warrant improvement and timeliness with work plan goals

for the current fiscal year. The QAPI plan does not track or trend outcomes data. (Quality)

3. Lack of clear data definitions in some areas and errors in computing timeliness reports may be addressed by involving all key stakeholders in developing accurate data definitions for all data metrics for the new reports and dashboards in the new EHR. (Quality, IS)

4. The MHP has a lower Hispanic PR than the state and counties of similar size. The website does not have a translation feature for monolinguals to view the information in Spanish and the information for La Voz de la Esperanza, the Latino wellness center is not in Spanish. There are problems with access to informational materials and forms in Spanish both for staff and plan members. (Access)

5. Key informants expressed problems with upward communication beyond the supervisor that have created hurdles in addressing their concerns, which may have a negative impact on timely access to care and quality of services to the plan members. (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. As per Title 42, CFR, Section 438.330, DHCS requires two active performance improvement projects (PIPs); the MHP is contractually required to meet this requirement going forward. The MHP did not implement a clinical PIP for this review. Submit a clinical PIP for the next review. Implement the non-clinical PIP and report results of the interventions for this PIP for the next review. (Quality)

2. The MHP would benefit from timely evaluation of the QAPI goals to implement timely QI activities. For the next review, submit an updated QAPI Work Plan evaluation that trends metrics for the past three fiscal years. Include QAPI goals related to outcomes data from CANS, PSC-35, and adult outcome tools in the FY 2024-25 work plan. (Quality)

3. Create a workgroup that includes executive leadership, QI team, IS staff, and program staff to ensure accurate data definitions and tracking of all data metrics in the new EHR. Report on the progress of the workgroup's efforts and timeliness metric dashboards for the next review. (Quality, IS)

4. Ensure all information materials and forms are available in Spanish to line staff and plan members. Add a translation feature for the website that allows review in Spanish for monolingual members and ensure the information on the website for the Latino peer center, La Voz de la Esperanza is in Spanish. In addition to the efforts to address these two areas, improve outreach to Latino population and report if there is an increase in the numbers served for FY 2023-24. (Access)

5. Establish bi-directional communication with line staff and address concerns related to high caseloads and staff turnover through organized and consistent communication channels; for example, through a staff advisory group that represents clinical and non-clinical staff and meets with the director to voice the concerns that are not being addressed. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

- The MHP was not able to submit all pre-review documents including PIP documents, significant initiatives and changes, and responses to recommendations in a timely manner and some documents were incomplete including the ISCA and the ATA.

- The MHP did not implement the two PIPs that were in the planning phase for last year's review due to staffing shortages. The clinical PIP was changed to a non-clinical PIP with new and different interventions and submitted post-review. The MHP did not submit a clinical PIP for this review.

- The county's internet was down on the original date, December 5, 2023, for this review and had to be rescheduled to December 11, 2023.

- The virtual review session with the peer employees could not be conducted on December 11, 2023, as no participants attended this session; the MHP was not able to coordinate with the participants to join this session timely after being informed that there were no attendees. The review session was rescheduled to December 12, 2013, which was well attended by many participants.

- For the member focus group session, there were only two participants; one participant was a caregiver when the session was intended to be for consumers.

As part of the EQR process, the MHP Director submitted a letter identifying specific barriers to the MHP's full participation in the review. Please see Attachment E.

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

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Naga Kasarabada, Ph.D., Quality Reviewer
Zena Jacobi, IS Reviewer
Janet Fricke, Consumer and 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
Abbott	Scott	Program Manager Mental Health Services Act	Lake County Behavioral Health
Ali-Adeeb	Lan	Business Software Analyst	Lake County Behavioral Health
Andrus	Christine	Deputy Director Administration	Lake County Behavioral Health
Boyce	Kendra	Behavioral Health Clinical Specialist Supervisor	Lake County Behavioral Health
Calderon	Laura	MH Case Manager	Lake County Behavioral Health
Castillo	Gerardo	Crisis Supervisor	Lake County Behavioral Health
Chalmers	Robert	Staff Services Analyst Senior	Lake County Behavioral Health
Fagalde	Gerry	Staff Services Specialist Human Resources	Lake County Behavioral Health
Farrell	Melissa	Behavioral Health Clinical Specialist	Lake County Behavioral Health
Furia	Rebecca	Behavioral Health Clinical Specialist	Lake County Behavioral Health
Giambra	April	Deputy Director Clinical	Lake County Behavioral Health
Grogg	Laurie	Behavioral Health Clinical Specialist Supervisor	Lake County Behavioral Health
Hutchins	Gina	Behavioral Health Clinician Supervisor	Lake County Behavioral Health
Jones	Elise	Director	Lake County Behavioral Health
Kopf	Melissa	Staff Services Analyst Senior	Lake County Behavioral Health
Lamkin	Michelle	Staff Services Specialist	Lake County Behavioral Health
Laub	Donald	MH Case Manager	Lake County Behavioral Health
Lewis	Jenna	MH Case Manager	Lake County Behavioral Health
Madero	Amber	Program Manager Fiscal	Lake County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Manning	Carrie	Behavioral Health Clinical Specialist Supervisor	Lake County Behavioral Health
Mayer	Vanessa	Program Manager Compliance	Lake County Behavioral Health
Miller	Kayla	MH Case Manager	Lake County Behavioral Health
Messner	Patricia	Behavioral Health Clinical Specialist Supervisor	Lake County Behavioral Health
Moss	Michael	Prevention Specialist	Lake County Behavioral Health
Nell	Rachel	Behavioral Health Clinical Specialist Supervisor	Lake County Behavioral Health
Ogawa	Ken	Staff Services Analyst II	Lake County Behavioral Health
Packs	Monti	Staff Services Analyst Senior	Lake County Behavioral Health
Pearson	Brian	MH Case Manager	Lake County Behavioral Health
Pimenta	Carolina	Behavioral Health Clinical Specialist Supervisor	Lake County Behavioral Health
Poplin	Melissa	Staff Services Analyst II	Lake County Behavioral Health
Rodrigues	Crystal	Behavioral Health Clinical Specialist Supervisor	Lake County Behavioral Health
Shepherd	Raevan	Behavioral Health Clinical Specialist	Lake County Behavioral Health
Smith	Matthew	Business Software Analyst	Lake County Behavioral Health
Trillo	Jamilyn	Behavioral Health Clinician Senior	Lake County Behavioral Health
Trongo	Summer	Program Manager MH/Mobile Crisis	Lake County Behavioral Health
Westphal	Amber	Program Manager Substance Use Disorders	Lake County 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	No PIP was submitted.
General PIP Information	
MHP/DMC-ODS Name:	
PIP Title:	
PIP Aim Statement:	
Date Started:	
Date Completed:	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify):	
Improvement Strategies or Interventions (Changes in the PIP)	

General PIP Information

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):

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
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information

Was the PIP validated? ☐ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The PIP lacked detail, comprehensive review of data on current or past year's follow-up rates, and a thorough narrative of the PIP design that clearly explains the interventions, training for staff involved in the PIP, and the data collection methodologies. There was no supporting documentation that demonstrates MHP's efforts for designing this PIP with a clearly defined plan for implementing the interventions and well-designed data collection tools. There was no detail provided on the recent communications with the EDs nor a clear plan on training staff who will be sending reminder texts, the format of those texts, and the referral logs used for tracking ED referrals. Overall, due to lack of acceptable methodology and data collection details and evidential documentation to support a sound PIP design, this PIP is rated "Low" confidence.
General PIP Information	

MHP/DMC-ODS Name: LCBHS

PIP Title: Follow-up after ED visit for mental illness

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 five percent by June 30, 2024.

Date Started: 07/01/2022

Proposed Date for Completion: 06/30/2024

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

General PIP Information
*If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): All plan members discharged from the ED for a mental health visit.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Text reminders to members for follow-up appointments and treatment.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Referrals sent by EDs to the MHP and by the MHP to MCP when LOC is more appropriate for the MCP.
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): Referral log to track referrals and text reminders sent by MHP on follow-up appointments.

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

PIP Validation Information

Was the PIP validated?   ☒ Yes   ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- The MHP would benefit from assigning a lead for this PIP and having a PIP committee comprised of key QI, clinical, and analyst staff to ensure timely progress through all phases of PIP implementation.

- The MHP would benefit from identifying all data elements needed to report data for the measures identified and training all staff involved in tracking and reporting data on the data collection and tracking tools.

- Supporting documentation that demonstrates the MHP's efforts for the implementation of this PIP through various phases will be critical for providing a clear roadmap of the PIP design and implementation to EQR.

- The MHP would benefit from TA offered by the EQR team.

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 is attached.

Lake County Behavioral Health Services
Elise Jones, Director
PO BOX 1024, LUCERNE, CALIFORNIA 95458-1024
P 707-274-9101 F 707-274-9192

LCBHS

01/02/2024

Sandra Sinz, LCSW, CPHQ
Executive Director, CalEQRO
Behavioral Health Concepts,
Inc. 52340 Powell St. #334
Emeryville, CA 94608

Dear Behavioral Health Concepts, Inc:

Lake County MHP/DMC-ODS is requesting flexibility during the FY 2023-24 EQRO review, as we were unable to fulfill one or more of the required elements for review:

Specifically, we were not able to:
   ☒ submit a clinical PIP
   ☐ submit a non-clinical PIP
   ☒ hold a member and family member focus group
   ☐ other:

Reasons for this include:

   ☒ Lack of staff/resources:
   ☐ Natural Disasters:
   ☐ Additional factors:
   ☒ Other reasons:

1. <u>Submit a clinical PIP</u> – Lack of staff/resources. LCBHS submitted a clinical PIP for evaluation during the EQR but were advised it did not meet the criteria for a MH PIP.

2. <u>Member Focus Group</u> - 7 members were scheduled to attend the original session on 12/5/23. These members were asked to reschedule for 12/11/23 due to the internet/power outage, and stated they would try. None of the members were able to arrange their schedule to accommodate the changed date but failed to inform our Peer leader. We were able to reach 3 of the members to inquire about not showing up, the other 4 members we left messages to

call us. One member had transportation issues and the other two had childcare issues. All three did not inform us of their difficulties before the scheduled session.

Please attach this letter to our FY 2023-24 review report.

Sincerely,

Elise Jones (Jan 2, 2024 11:36 PST)

Elise Jones
Lake County Behavioral Health Director