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FY 2022-23
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

DEL NORTE FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

April 19, 2023

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 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, "Del Norte" may be used to identify the Del Norte County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — April 19, 2023

MHP Size — Small-rural

MHP Region — Superior

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
6	3	2	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	4	1	1
Quality of Care	10	3	4	3
Information Systems (IS)	6	3	3	0
TOTAL	**26**	**13**	**9**	**3**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
No PIP Submitted	Clinical	n/a	Other: No PIP Submitted	n/a
To Identify Barriers for Client Non-attendance to Therapy Appointments at Remi Vista and Address with Intervention	Non-Clinical	08/22	Other: Completed	High

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has adapted to the challenges of recruiting and retaining licensed clinicians through the development of unlicensed staff operating in many different types of positions.
- The MHP well funds the IS budget, including data analytic staff, to position itself well to make the transition to the Credible electronic health record (EHR).
- The MHP has strong relationships with the local Native American tribes, which are included in planning efforts for all initiatives.
- The MHP leverages relationships with local law enforcement, hospital emergency departments for its crisis response, which often may entail long stays while acute inpatient resources are secured for its beneficiaries.
- The MHP's Crisis Care Mobile Unit (CCMU) planning is a significant step towards improving crisis response within Del Norte County.

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

- The MHP is currently unable to track urgent care needs.
- The MHP's provision of medication management to Foster Care (FC) youth is nearly double the statewide rate.

- The MHP's Quality Assessment and Performance Improvement (QAPI) work plan is very limited in scope and use of quantifiable metrics that include trend data.
- The MHP has experienced challenges in the identification and support of PIPs.
- The MHP currently lacks any adult system licensed clinical staff available for treatment and consultation throughout the work week.

Recommendations for improvement based upon this review include:

- Develop a system to identify, track, and trend urgent service needs.
- Review the provision of medication management for FC youth, and determine if intensive psychosocial services have been or are being provided.
- Develop a QAPI Work Plan that includes the performance metrics the MHP is expected to track, and contains quantifiable goals that include performance data over time.
- Seek early and frequent PIP technical assistance (TA), and if additional assistance is required, consider seeking outside contractor assistance.
- Until licensed clinical staff are hired into the adult system, consider retaining an experienced telehealth clinician who would be available throughout the work week for complex case consultation.

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 October 2019.

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 beneficiaries 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 beneficiaries.

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

This report presents the FY 2022-23 findings of the EQR for Del Norte County MHP by BHC, conducted as a virtual review on April 19, 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, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized 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 2021-22 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 beneficiary 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) – 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.
- Validation and analysis of each MHP's NA as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, then "<11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

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 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place following the Coronavirus Disease 2019 (COVID-19) pandemic and episodic isolation due to Last Chance Grade landslides. The MHP has experienced loss of staff due to regional competition and challenges attracting outside candidates to the area. As well, the local internet bandwidth creates challenges for beneficiaries who may wish to access telehealth services from home. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges. Due to staffing losses, the MHP was unable to address a number of recommendations and also was not able to develop and operate two PIPs. See the list of challenges described in the county letter (Attachment E).

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 is transitioning EHRs from Cerner Community Behavioral Health (CCBH) to Credible, with an implementation goal of July 2023.
- The MHP experienced landslide and weather-related episodic isolation due to road closures of the Last Chance Grade, impacting staff who commute, transportation of beneficiaries to acute facilities, and transit of resources for the area.
- Both the MHP and its children's services contractor Remi Vista experienced high turnover in staff during the last year, resulting in a decrease in filled clinical positions.
- The MHP received a CCMU planning grant, which involved local collaboration for input to the action plan.
- The health department created a Monthly Highlights email for each branch, as part of communication efforts with stakeholders.
- The MHP became part of a Joint Jurisdiction Wellness Court with the Yurok Tribe, partnering in the planning process.
- The MHP developed a homeless ad hoc committee, to improve and coordinate services to this population.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: Incorporate performance measures associated with behavioral healthcare standards in the Quality Assessment and Performance Improvement (QAPI) Work Plan and the Cultural Competence Plan (CCP). Define indicators and review performance quarterly. Use the information to identify and address barriers.

(This recommendation is a carry-over from FY 2019-20 & FY 2020-21)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is waiting for DHCS to release the revised CCP template before embarking on an update. The MHP anticipates the review format will include substantial performance measures.
- The MHP cites staff turnover and challenges with recruitment efforts, including the loss of a Staff Services Analyst who also served as the QI Coordinator. This position was finally filled two months ago. Thus, efforts to make significant headway in this area were paused as the new hire became familiar with job duties.
- The MHP's QAPI evaluation of the FY 2021-22 period included one quantifiable element among the three improvement areas, which focused on overall achievement of timeliness submissions, and resulted in a 62 percent achievement of standards.
- This recommendation will be continued in order to provide the MHP with more time to make progress on both CCP updates and QAPI plan development.

Recommendation 2: Measure and monitor hospital readmissions. Examine the FY 2020 rehospitalization treatment patterns. Identify and conduct performance improvement to resolve any barriers identified.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has been reviewing 5150 rehospitalization rates with upper management but has been unable to compare this data to previous FY rates due to a delay in the creation of a spreadsheet that contains historical hospitalization data.
- The FY 2022-23 readmission rate thus far is 9.89 percent, which indicates improvement.
- In that the MHP appears to be making progress and is actively tracking readmission rates, this recommendation will not be continued.

Recommendation 3: Review access to psychiatry services data monthly and conduct performance improvement assertively. Measure the effectiveness of interventions. Continue to consider to further increase telepsychiatry contract services to provide timely access.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP faced turnover in telepsychiatry staffing since the last EQR and struggled to fill those openings throughout the year. An in-person provider was hired early in CY 2022 but resigned within a few months of employment. An additional tele psychiatrist was hired in January 2023, which has improved timeliness to medication support services.
- The MHP's child psychiatrist met with primary care physicians to discuss bidirectional referrals. The focus was on supporting the referral of MHP stabilized children from child psychiatry to primary care for maintenance services.
- A request for proposal has also been developed to seek proposals for both in-person and telepsychiatry which will be posted in the next fiscal year. Furthermore, psychiatric timeliness data is tracked through a Psychiatric Access Service Request form in the EHR; reports are run based on this data and reviewed for timeliness to services.

Recommendation 4: Implement a way to examine and ensure appropriate levels of care in the adult and child system using a level of care (LOC) instrument or selected indicators.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP is using the state transition of care tool for identification and transfer of individuals back to primary care who are receiving medication support services and no longer require SMHS.

- The MHP currently does not have the bandwidth, among the CalAIM changes and impending shift to a new EHR, to support implementation of clinical LOC tools in adult and children's systems of care.
- The MHP is not prepared to convert current outcome instrument scores into LOC bands.
- The MHP will continue to use it clinical assessment process and data from outcome instruments to provide decision support to service levels furnished to its beneficiaries.
- This recommendation will not be continued at this time due to the need to focus limited resources on the adoption of a new EHR and implement CalAIM changes.

Recommendation 5: Institute consumer and family member employment, involvement, and leadership throughout the system that incorporate recovery principles, to include involving beneficiaries or family members in developing PIPs and/or other initiatives.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP added two beneficiaries to the local Behavioral Health Advisory board for participation in oversight and planning activities. The CCMU planning included a collaborative workgroup that resulted with the identification of a need to establish a local National Alliance on Mental Illness (NAMI) group. Interested parties took part in the required training and will soon be starting a local chapter.
- The MHP continues its efforts to engage lived experience individuals in MHP planning and oversight activities. This area remains challenging.

Recommendation 6: Develop and conduct two PIPs. Consider designing PIPs that are associated with the MHP's QI such as the increasing crisis services. Obtain TA or other support throughout the stages of the PIP.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Turnover in key personnel critical to creation and operation of PIPs occurred, as well as other operational priorities such as CalAIM were barriers to PIP development.
- The MHP was able to support a single PIP for this review period, targeting no-shows for children's services.
- This recommendation is considered partially addressed, and will be continued for this review period, with the focus on having two active PIPs. Should the MHP determine it lacks bandwidth in this area, it may wish to consider use of a consultant to help provide guidance.

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 beneficiaries) are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which beneficiaries live, equity, as well as accessibility—the ability to obtain medical care and services when needed.[1] The cornerstone of MHP services must be access, without which beneficiaries are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and 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 73.39 percent of services were delivered by county-operated/staffed clinics and sites, and 23.61 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 89 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff during business hours, while after-hours and holiday/weekend calls are managed by a contracted service called Night Watch located in Alameda County. Beneficiaries may request services through the Access Line as well as through the following system entry points: direct presentation to the MHP's programs. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. An intake appointment is scheduled with the age-appropriate treatment team, which results in completion of a clinical assessment.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 234 adult beneficiaries, 72 youth beneficiaries, and 48 older adult beneficiaries across two county-operated sites and two contractor-operated sites. Among those served, 23 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries 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 contained in Table 1A and Table 1B.

In November 2021, DHCS issued its FY 2021-22 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 Del Norte County, the time and distance requirements are 60 miles and 90 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 2021-22

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

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

Table 1B: MHP Out-of-Network Access, FY 2021-22

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

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

ACCESS KEY COMPONENTS

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

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

Table 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 Beneficiary Needs	Partially 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:

- 1A – The MHP makes strong efforts to identify strategies to address cultural, ethnic, racial, and linguistic needs of its beneficiaries. An example of this is the consistent representation and participation of the local Native American community at cultural competence meetings and other community events the MHP sponsors. With the homeless population, the MHP participates in Mission Possible, a homeless outreach service, and there are ambassadors identified within the homeless population who help guide others towards services.
- 1B – The MHP has made numerous efforts to improve capacity, including employing a part-time telehealth clinician to perform assessments. This is in response to the challenges with hiring and retaining full-time clinicians. At the time of this review, all full-time licensed clinician positions were vacant. There are challenges with compensation and the relative isolation of the MHP's location that create barriers to recruitment. At this time, this item is considered partially met because of the critical need within adult services for the acquisition of onsite licensed clinical staff, and in the interim, availability of a licensed clinician via telehealth throughout the work week for treatment and consultation purposes. The MHP was recently able to add a prescribing practitioner to it telehealth program through Kings View.
- 1C – The MHP is engaged in numerous collaborative activities within the local community. These include emergency department (ED) liaisons for crisis response; law enforcement; and managed care plan bidirectional referrals. To improve work with the local ED, the MHP installed a computer connected to the MHP's EHR, improving the information available to crisis response staff, and improving documentation of services.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rates, and Average Approved Claims per Beneficiary Served

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

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

The Statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, Del Norte County has seen a decrease in rates each year since CY 2019, which follows statewide trends. However, the MHP has maintained a rate higher than the State over the last three calendar years, and in CY 2021, PR in Del Norte was 2.83 percentage points higher than the State at 7.17 percent.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	12,626	905	7.17%	$4,009,624	$4,431
CY 2020	11,993	946	7.89%	$4,455,618	$4,710
CY 2019	11,857	1,099	9.27%	$4,579,442	$4,167

- While the number of eligibles have increased in Del Norte each year since 2019, the MHP has seen a decrease in the number of beneficiaries served and total approved claims in each calendar year. These trends have been seen statewide since the beginning of the COVID-19 pandemic.

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	1,255	24	1.91%	1.71%	1.96%
Ages 6-17	2,933	341	11.63%	8.65%	5.93%
Ages 18-20	569	54	9.49%	7.76%	4.41%
Ages 21-64	6,768	458	6.77%	8.00%	4.56%
Ages 65+	1,103	28	2.54%	3.73%	1.95%
Total	**12,626**	**905**	**7.17%**	**7.08%**	**4.34%**

- PR for each age group is higher than the statewide PR, except for ages 0-5. PR is higher than for similar sized counties for each group except for 21-64 year-olds, and ages 65+.

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
No Threshold	n/a	n/a
Threshold language source: Open Data per BHIN 20-070		

Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	3,502	206	5.88%	$436,926	$2,121
Small-Rural	35,376	2,377	6.72%	$12,056,144	$5,072
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries. These patterns are reflected in the MHP as well.
- At 5.88 percent, ACA PR is 0.84 percentage points lower in Del Norte than similar sized counties (6.72 percent), but 2.07 percentage points higher than the statewide PR (3.81 percent).

The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had

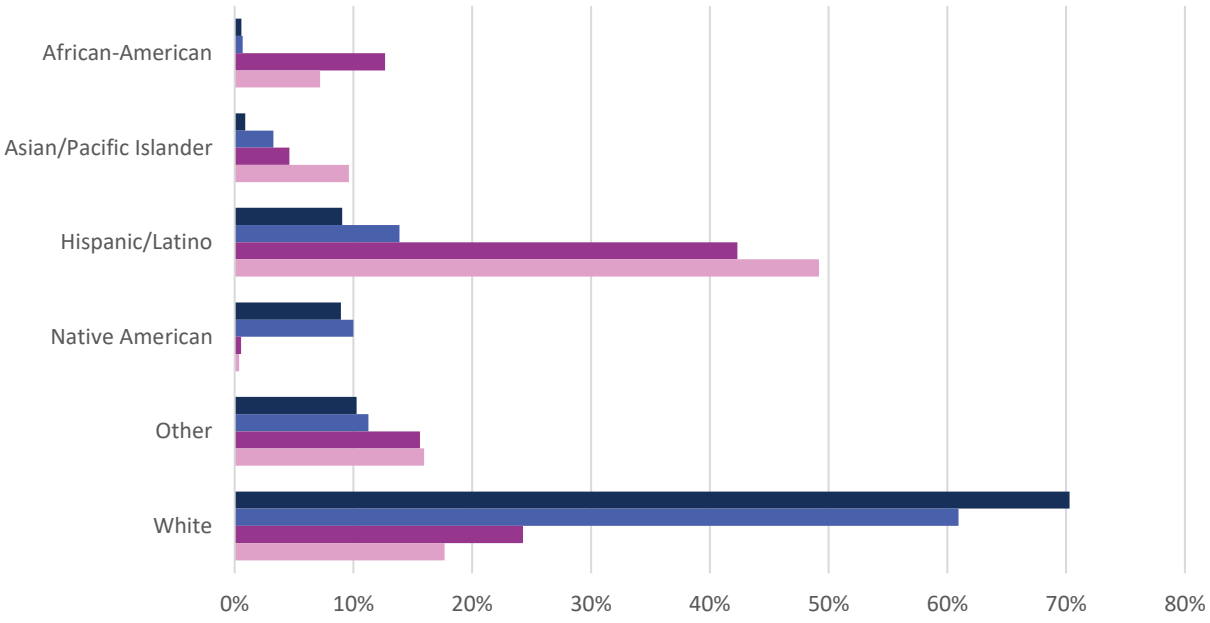
similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served. Table 7 and Figures 1 – 9 compare the MHP's data with MHPs of similar size and the statewide average.

Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	86	<11	-	7.64%
Asian/Pacific Islander	412	<11	-	2.08%
Hispanic/Latino	1,751	82	4.68%	3.74%
Native American	1,261	81	6.42%	6.33%
Other	1,422	93	6.54%	4.25%
White	7,697	636	8.26%	5.96%
Total	**12,629**	**905**	**7.17%**	**4.34%**

- Each of the non-suppressed race/ethnicity groups listed in Table 7 have a higher PR than statewide.

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021

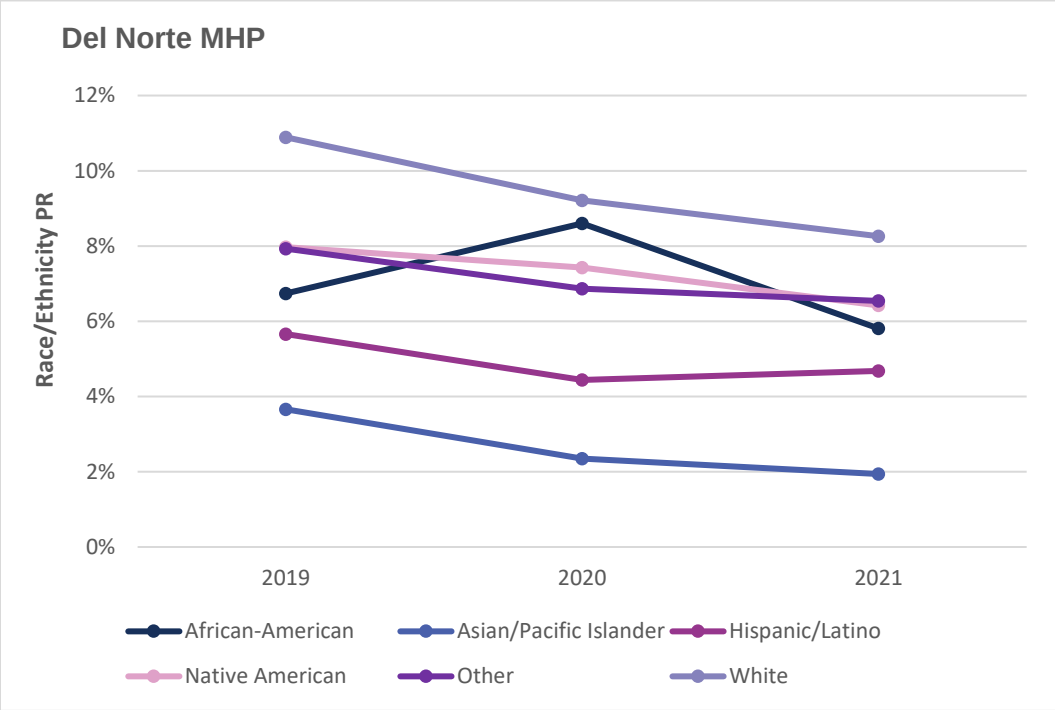


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	70%	10%	9%	9%	1%	1%
MHP % Eligible	61%	11%	10%	14%	3%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- Among the race/ethnicity groups listed in Figure 1, the Hispanic/Latino group has the largest incongruence between Medi-Cal eligibles and beneficiaries served (14 percent vs. 9 percent).
- White beneficiaries account for the largest overrepresentation of those served as this group accounts for 70 percent of all services, but only 61 percent of Medi-Cal eligibles in the County.

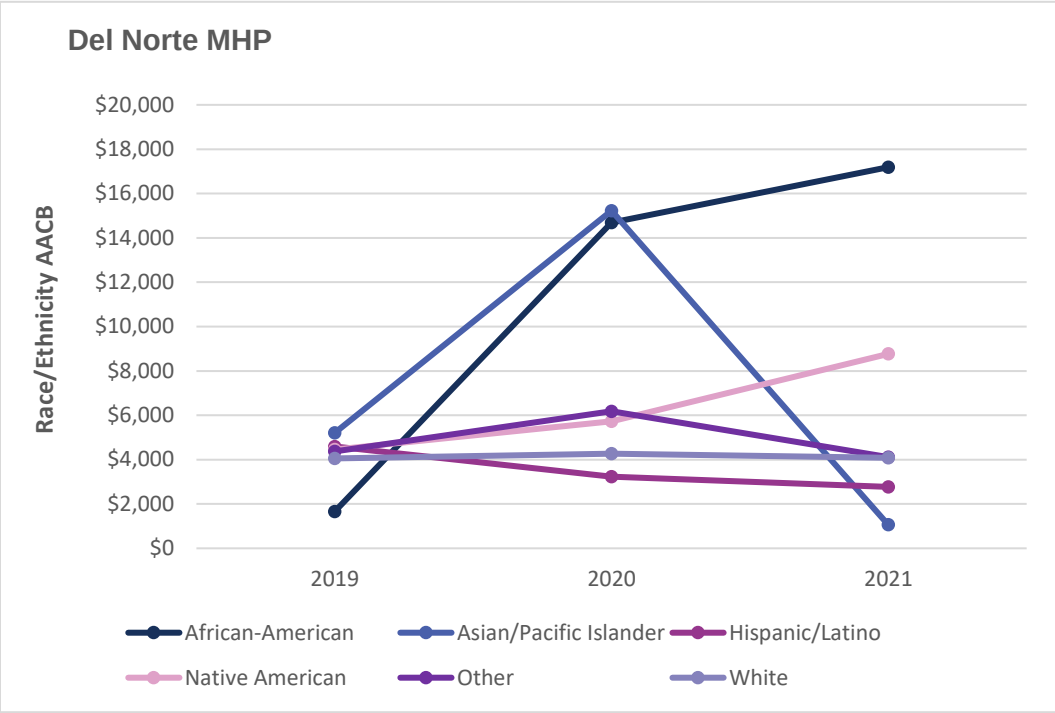
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

Figure 2: MHP PR by Race/Ethnicity CY 2019-21



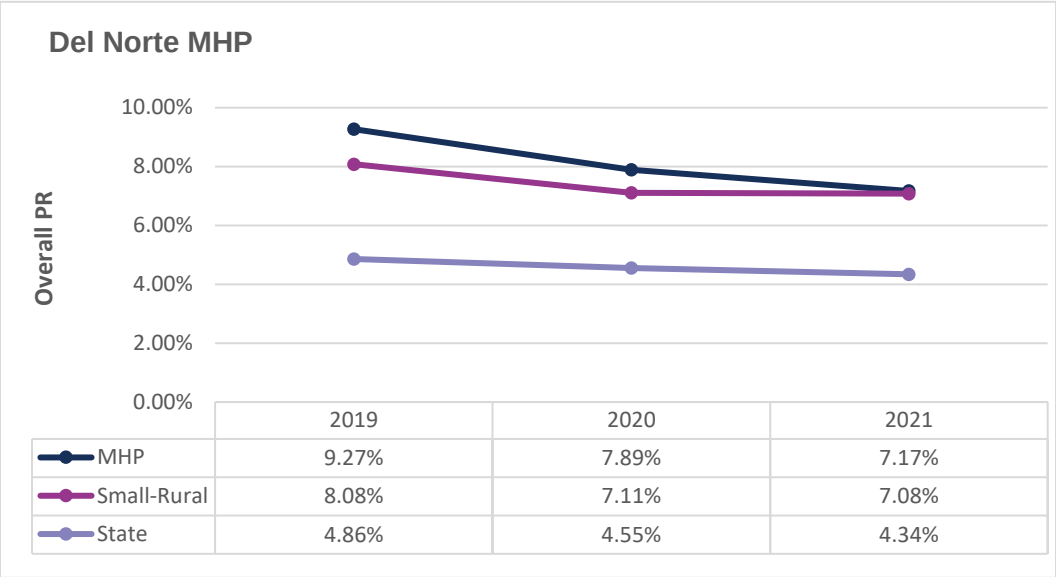
- PR for the majority of race/ethnicity groups seen in Figure 2 have followed a similar downward trend since CY 2019. The PR trend for African-Americans has seen more variance than other groups, however, there were a low number of clients served in this group, so small increases or decreases to the number of clients served will create more significant looking swings in the trendlines.

Figure 3: MHP AACB by Race/Ethnicity CY 2019-21



- The AACB increased in CY 2021 for Native American and African-American beneficiaries, while decreasing sharply for Asian/Pacific Islander beneficiaries. However, it should be noted the total number of clients served for these three groups were very small, so any changes in the number of clients seen from one year to the next are more likely to show a more dramatic change in AACB. White and Hispanic/Latino beneficiaries had a more stable AACB between the last two fiscal years as those are the predominant race/ethnicity groups served in Del Norte.

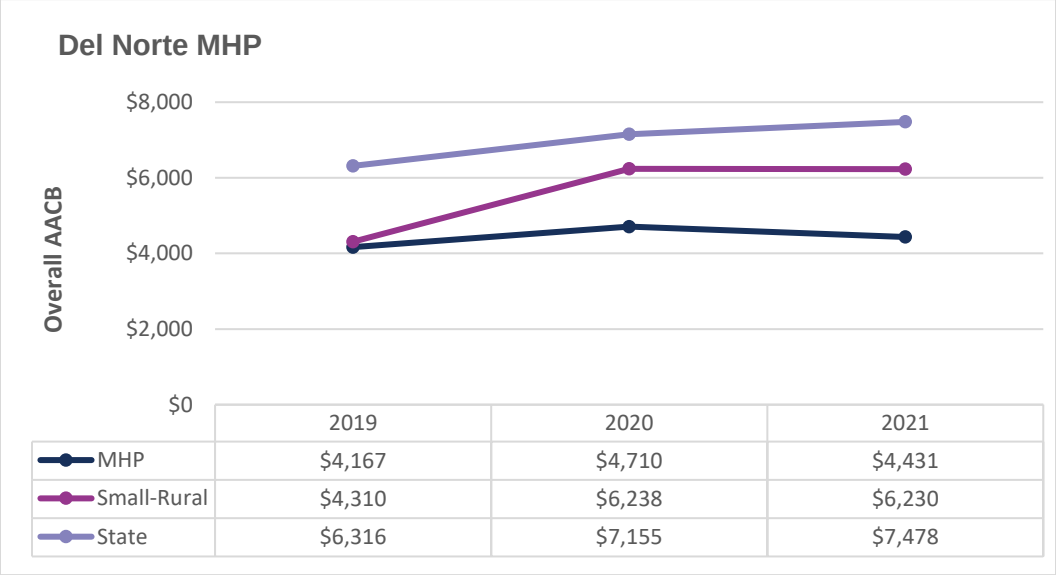
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	9.27%	7.89%	7.17%
Small-Rural	8.08%	7.11%	7.08%
State	4.86%	4.55%	4.34%

- The overall PR in Del Norte has followed statewide trends by decreasing each year since CY 2019, but remained slightly higher than similar sized counties and more than two percentage points higher than the state overall in CY 2021.

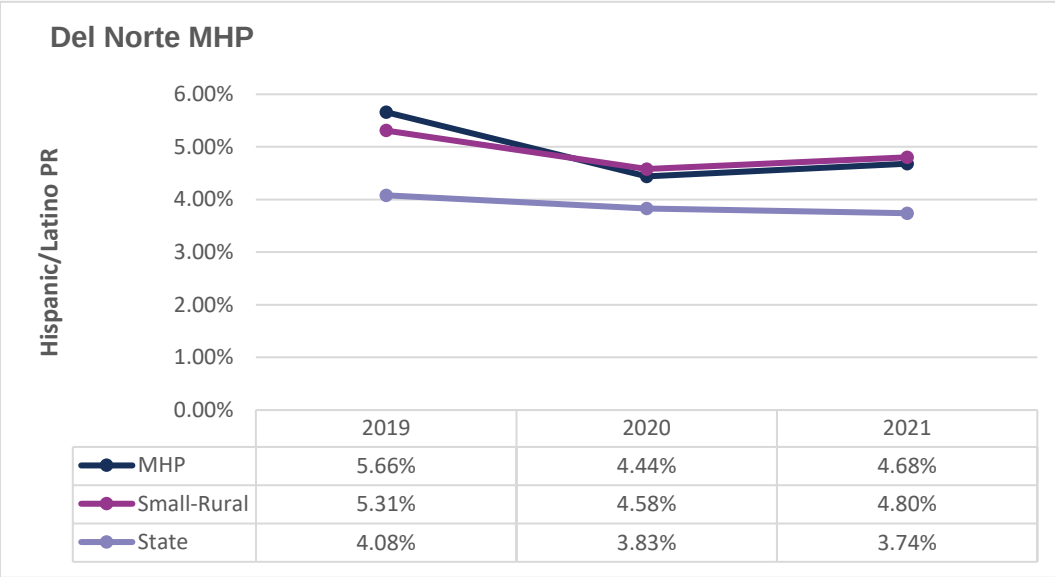
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,167	$4,710	$4,431
Small-Rural	$4,310	$6,238	$6,230
State	$6,316	$7,155	$7,478

- AACB in Del Norte has remained relatively stable over the past three calendar years and decreased slightly in CY 2021 from the previous year.

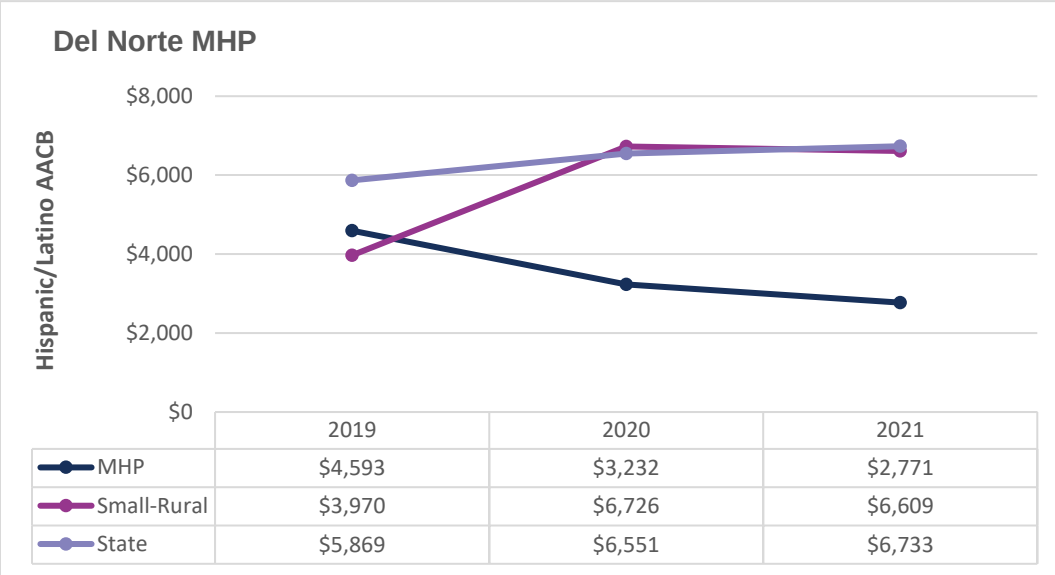
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	5.66%	4.44%	4.68%
Small-Rural	5.31%	4.58%	4.80%
State	4.08%	3.83%	3.74%

- Hispanic/Latino PR in Del Norte has followed the trend of similar sized counties by increasing slightly in CY 2021 from the previous year, while also remaining higher than the state by nearly one percentage point.

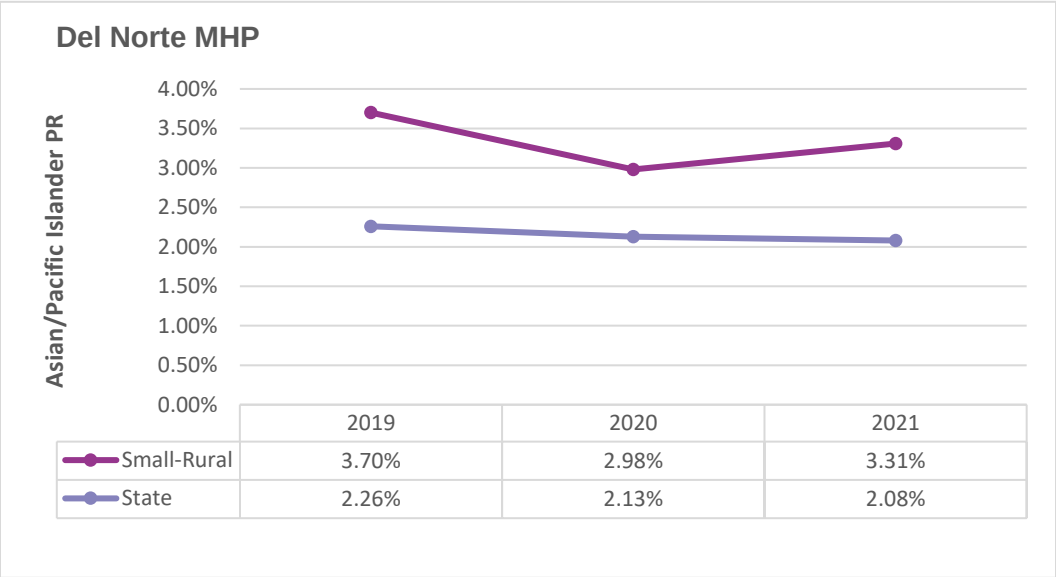
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,593	$3,232	$2,771
Small-Rural	$3,970	$6,726	$6,609
State	$5,869	$6,551	$6,733

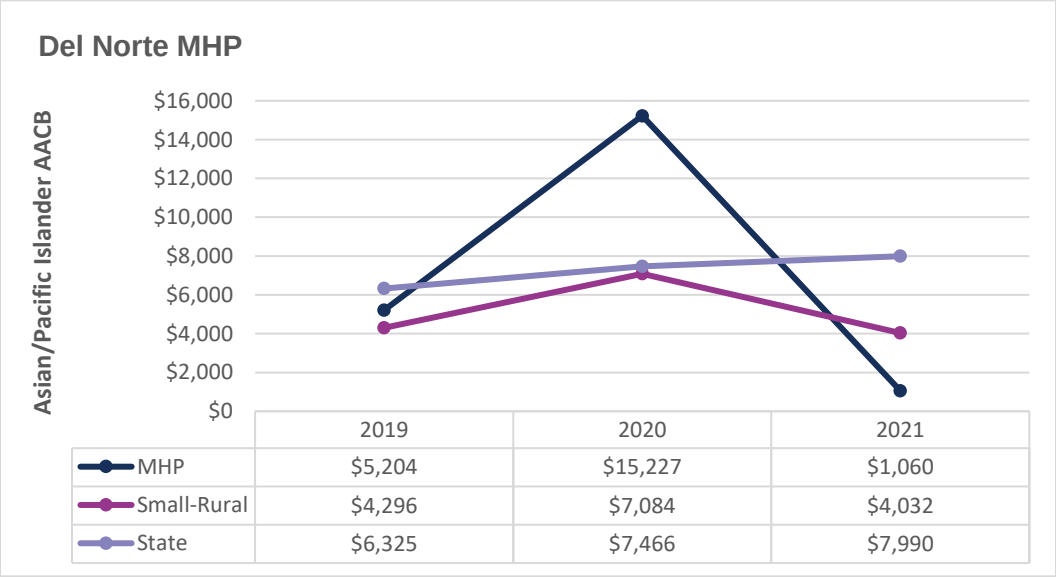
- While Hispanic/Latino AACB for the State and similar sized counties have increased each year since 2019, Del Norte has seen a decrease each year since CY 2019. For CY 2021, the AACB for this population decreased to $2,771, which is $1,822 less than the AACB in CY 2019, and also less than half the AACB for small-rural counties.

Figure 8: Asian/Pacific Islander PR CY 2019-21



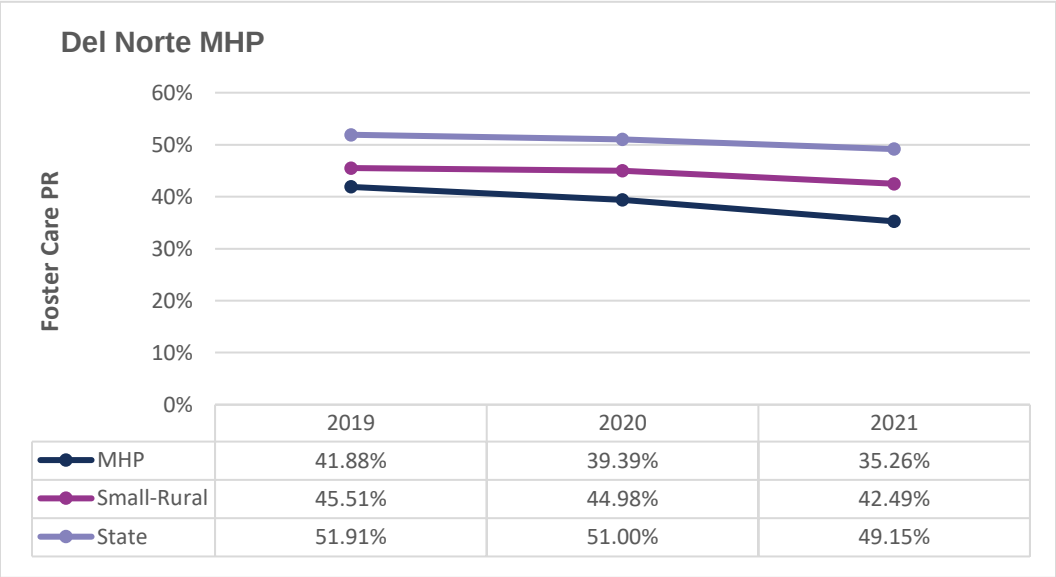
- Asian/Pacific Islander PR data is suppressed for Del Norte County as the number of beneficiaries served was <11.

Figure 9: Asian/Pacific Islander AACB CY 2019-21



- There have been notable swings in AACB for Asian/Pacific Islander beneficiaries between CY 2019 and CY 2021 due to the small numbers of clients receiving services in this race/ethnicity group.

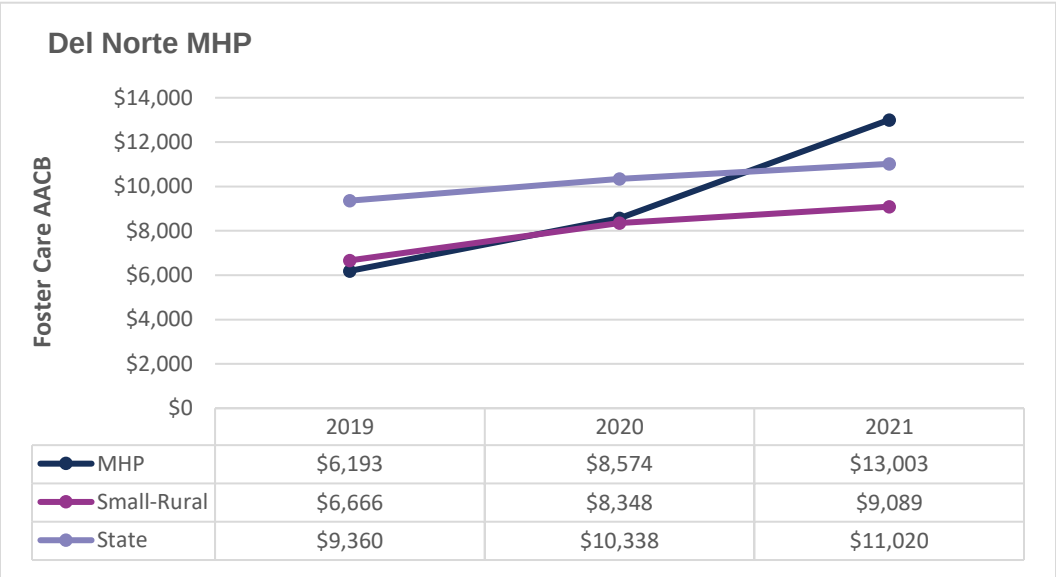
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	41.88%	39.39%	35.26%
Small-Rural	45.51%	44.98%	42.49%
State	51.91%	51.00%	49.15%

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed.
- FC PR has also remained relatively stable during the past three years in small-rural counties; however, Del Norte saw more than a more than 2 percentage point decrease between CY 2019 and CY 2020, and more a more than 4 percentage point decrease between CY 2020 and CY 2021.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$6,193	$8,574	$13,003
Small-Rural	$6,666	$8,348	$9,089
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased each year.

- As FC PR has decreased each year since CY 2019 and remained below both small-rural counties and the state as a whole, FC AACB has increased each year and has surpassed both similar sized counties and statewide AACBs.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 540				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	13	5	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	28	5.2%	22	14	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	<11	-	1	1	2.2%	21	14
Per Minute Services							
Crisis Stabilization	<11	-	900	720	13.0%	1,546	1,200
Crisis Intervention	162	30.0%	284	140	12.8%	248	150
Medication Support	233	43.1%	193	180	60.1%	311	204
Mental Health Services	334	61.9%	534	210	65.1%	868	353
Targeted Case Management	354	65.6%	397	147	36.5%	434	137

- The MHP has a notably higher percentage of adults accessing crisis intervention services than statewide (30.0 percent vs. 12.8 percent), likely due to a lack of local crisis stabilization and inpatient hospitalization resources.
- Medication Support for adults lags behind the statewide utilization rate (43.1 percent vs. 60.1 percent) due to difficulty sustaining consistent, adequate psychiatrist coverage.
- Del Norte has a considerably higher percentage of clients receiving targeted case management services than statewide (65.6 percent vs. 36.5 percent), likely due to difficulties recruiting and retaining clinicians.

Table 9: Services Delivered by the MHP to Youth in Foster Care

Service Category	MHP N = 55				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	12	12	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	<11	-	25	10	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	7,140	7,140	3.1%	1,404	1,200
Crisis Intervention	18	32.7%	487	282	7.5%	406	199
Medication Support	28	50.9%	393	240	28.2%	396	273
TBS	<11	-	2,032	2,517	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	<11	-	1,232	1,361	40.2%	1,354	473
Intensive Home Based Services	<11	-	2,863	277	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	49	89.1%	1,887	764	96.3%	1,854	1,108
Targeted Case Management	31	56.4%	425	205	35.0%	342	120

- Similar to adult service utilization in Table 8, FC youth are receiving a high number of crisis intervention services due to a lack of local crisis stabilization, crisis residential and inpatient hospitals in the vicinity of the County.
- Where adult beneficiaries lack medication support services, FC youth are receiving a high number of medication support compared to statewide (50.9 percent vs. 28.2 percent), as the MHP has had greater success filling youth psychiatry positions than it has for adults. This could also be related to challenges in retention of licensed clinicians, as medications tend to be utilized more frequently when access to licensed clinical staff is difficult.

- Like adults, FC youth are also seeing a high percentage of beneficiaries receiving targeted case management compared to statewide (56.4 percent vs. 35.0 percent). This type of service shift may occur when the availability of licensed clinical staff is not adequate to meet the demand.

IMPACT OF ACCESS FINDINGS

- PRs in Del Norte have remained higher than the State and similar sized counties over the past three calendar years, while AACB has remained relatively stable. This could be an indication that clients are getting initial screenings, but not as many follow-up services due to staffing difficulties.
- Crisis intervention services have been accessed by both adult and FC youth at considerably higher rates than the State, likely due to a lack of crisis alternatives such as crisis stabilization, crisis residential, and challenges in accessing acute psychiatric inpatient hospitals near Del Norte County.
- Medication support services have been utilized by adults at a much lower rate than the State, while these same services are utilized by FC youth at a much higher rate than the State. Difficulty in retaining adult psychiatrists is likely the reason for the low adult utilization, and the MHP has made recent advances in procuring more telepsychiatry while actively recruiting for these positions as well.
- The MHP's high utilization of medication support with FC youth seems to be contrary to statewide trends, and sufficient licensed clinical staff could be a related challenge which should be explored as a possible capacity issue driving higher utilization of medications.
- The MHP identifies its use of the CalAIM screening and transition tools with the local MCP for children and adults.

TIMELINESS OF CARE

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more 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 beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the 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	Not Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Partially Met
2F	No-Shows/Cancellations	Met

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

- 2A – The MHP successfully tracks and trends time from first non-urgent requests to first offered appointments for all age groups including FC youth, and has developed dashboards utilizing data captured in the EHR to review this data on a monthly basis.

- 2C – The Urgent Appointment element is considered not met because the MHP does not have a mechanism in place to track urgent requests. Del Norte is working with its application service provider (ASP), Kings View, to develop a tool which will track urgent appointments, but with the current plan to implement a new EHR by July 2023, this initiative may be put on hold until the Credible EHR goes live.
- 2E – Psychiatric Readmission Rates is considered partially met because the MHP has not fully begun the process of evaluating longitudinal readmission data, nor implemented specific performance improvement strategies for this area. However, the MHP reported that, to date, in FY 2022-23 the current readmission rate stands at 9.89 percent, which is an improvement.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care; however, no urgent appointment data was provided because the MHP cannot currently track this metric.

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

Table 11: FY 2021-22 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	10 Business Days	10 Business Days*	62%
First Non-Urgent Service Rendered	11 Business Days	10 Business Days**	56%
First Non-Urgent Psychiatry Appointment Offered	33 Business Days	15 Business Days*	21%
First Non-Urgent Psychiatry Service Rendered	33 Business Days	15 Business Days**	19%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	***	n/a	***
Follow-Up Appointments after Psychiatric Hospitalization	7 Days	7 Days**	47%
No-Show Rate – Psychiatry	11%	15%**	n/a
No-Show Rate – Clinicians	7%	15%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

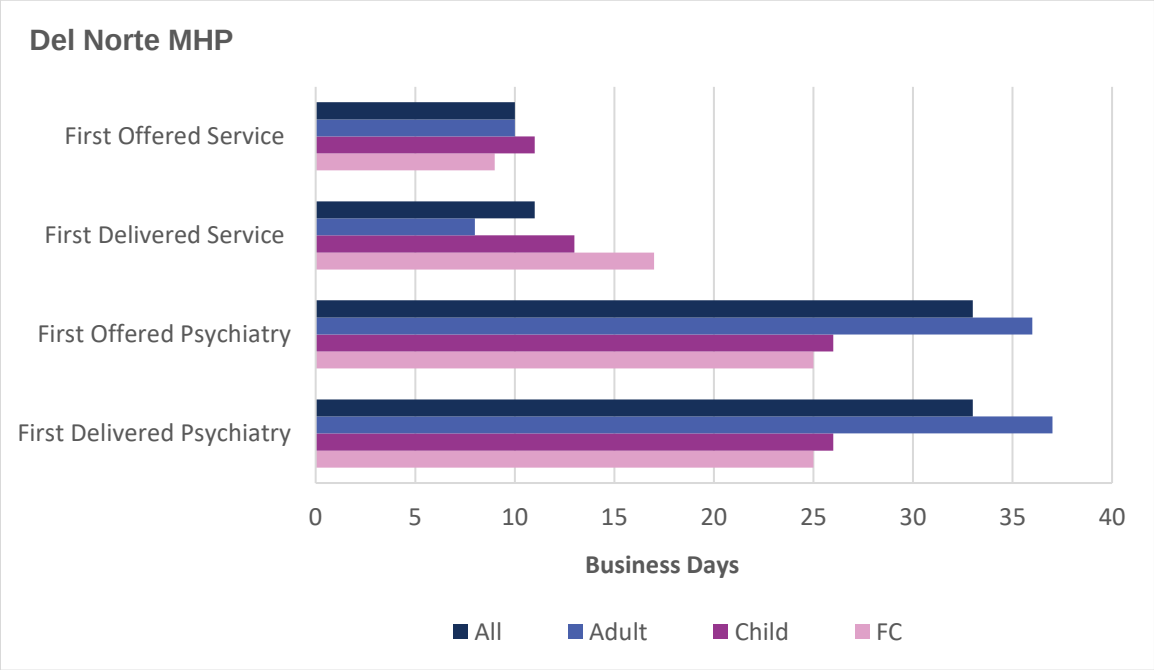


Figure 13: Wait Times for Urgent Services

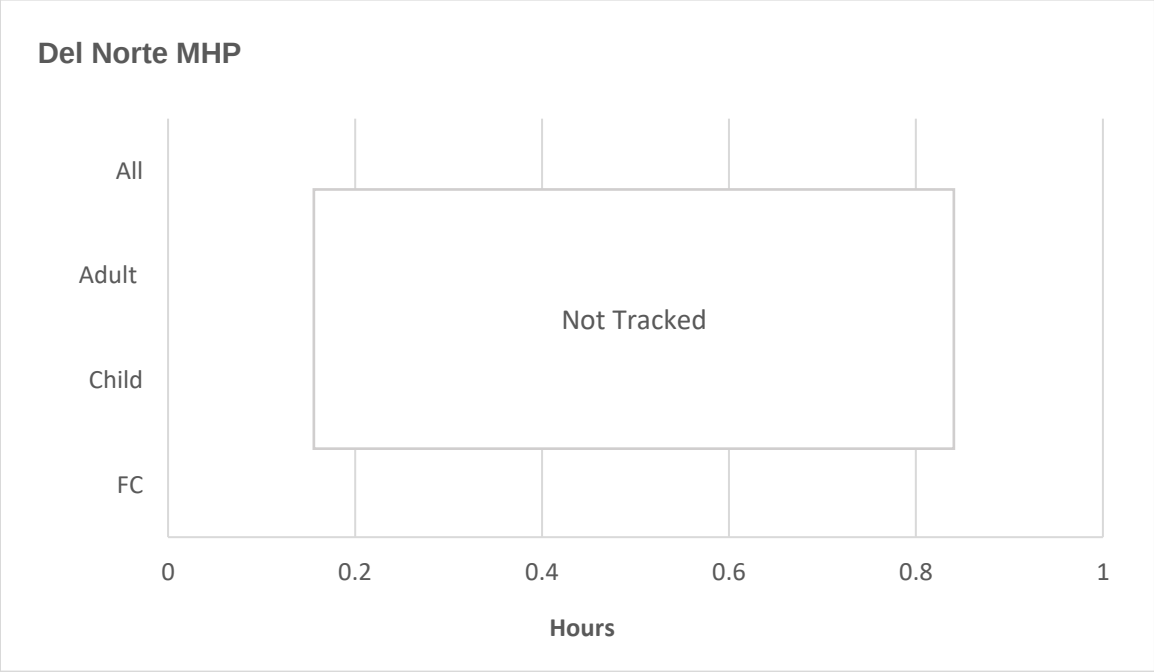
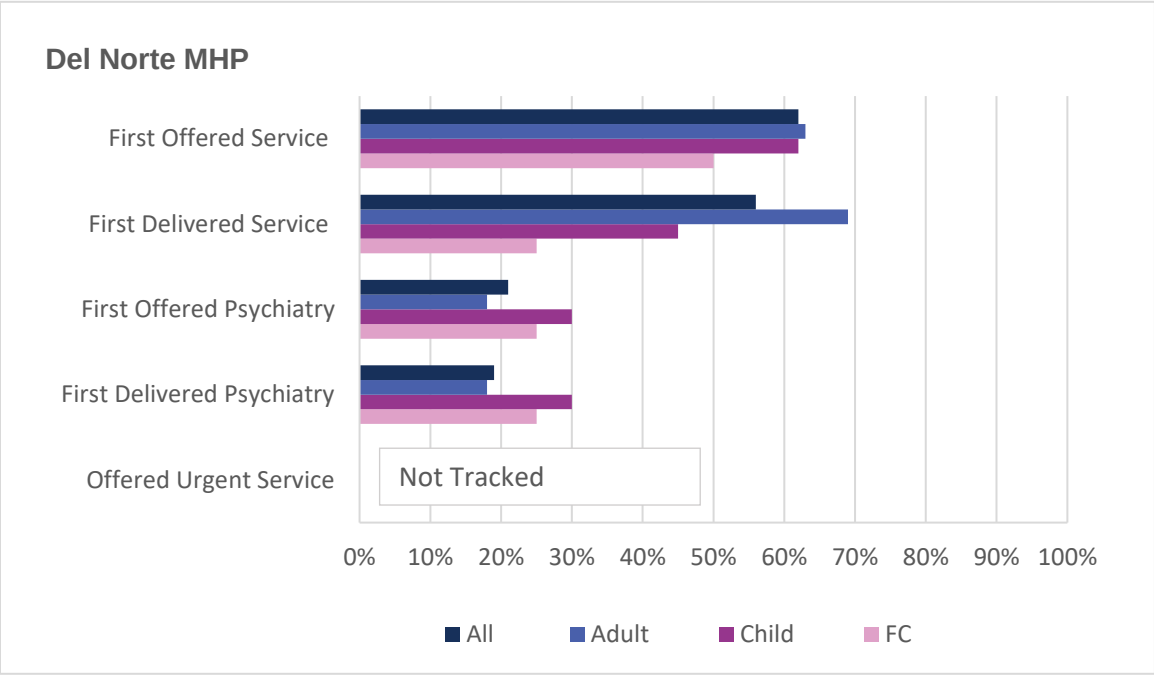


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned 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 13, represent screenings, scheduled assessments, and unscheduled assessments.
- Definitions of "urgent services" vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined "urgent services" for purposes of the ATA a situation experienced by a beneficiary that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition. The MHP's response timeframe for "urgent" conditions requires beneficiaries be seen within 48 hours of request or 96 hours if prior authorization is needed. In crisis situations staff response time is to respond within 30 minutes of request. Del Norte did not report on this metric as they currently do not have a tracking mechanism for urgent appointments. The MHP anticipates tracking mechanism will be established once the new EHR is implemented in July 2023.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as the time from the beneficiary's initial service request to the first attended psychiatric appointment.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are

tracked. The MHP reports a no-show rate of 11 percent for psychiatry and 7 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- The MHP's first offered and rendered non-urgent psychiatry service averages 33 days, which is more than double the standard. When examined by population it becomes clear that the adult system is most heavily impacted. The additional hire of an adult psychiatrist through Kings View will hopefully see this statistic improve over the course of FY 2022-23. Delays in psychiatry access may result in increased crisis and acute care needs and adverse outcomes.
- The current inability to track urgent service needs presents a gap in the MHP's understanding of system response needs and performance. Hopefully, with the installation of the new EHR this gap will be remedied.
- While the MHP acknowledges the use of DHCS issued screening tools and bidirectional referrals, there were no change trends noted in services delivered during this review.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, 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 beneficiaries. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN THE MHP

In the MHP, the responsibility for QI is integrated with QA/Compliance, and includes involvement of fiscal staff with some projects. There are two staff analysts involved with supporting the QI Coordinator, and operates as a continuous process across the systems.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of representatives from Behavioral Health Branch's provider staff, (licensed, pre-licensed, and non-licensed), the Behavioral Health Director, the Assistant Director, the Clinical Services Manager, the Program Manager, Fiscal Manager, Branch Analysts, Branch Supervisors, and the Patient's Rights Advocate. The Behavioral Health Branch makes every effort to include consumer participation. QIC is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met four times. Of the three identified FY 2021-22 QAPI workplan goals, the MHP two were partially met, one was met.

The MHP does not utilize a level of care (LOC) tool.

The MHP utilizes the following outcomes tools: The Milestones of Recovery Scale (MORS), The Child and Adolescent Needs and Strengths (CANS), and The Pediatric Symptom Checklist (PSC-35).

The MHP does not utilize specific LOC tools for children or adults, and has not created LOC bands for using outcome measures in this role.

QUALITY KEY COMPONENTS

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

Each Quality Component is comprised of individual subcomponents 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 Beneficiaries Served	Partially Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Not Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Not Met

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

- 3A – The Quality Improvement Work Plan evaluation for FY 2021-22 presented three areas of focus, with one involving quantifiable data as a key element. Because of the limited Work Plan content and lack of trend data this element is considered partially met.
- 3B – Data is used to inform management and guide decisions as evidenced by the MHPs use of dashboards for timeliness measures, productivity, and CANS data. These reports strongly support a data-driven approach.
- 3C – The MHP makes efforts to communicate and include beneficiaries and family members in planning activities such as for the CCMU development, and other activities. It has been unsuccessful in obtaining consistent beneficiary input and participation in some of the other forums that are available.
- 3D – Continuum of care speaks to a comprehensive system of care, and is considered partially met. Beneficiaries often experience long emergency department waits while acute resources are sought. Efforts for multiple small MHPs to partner in the development of shared resources could be fruitful and reduce the frequency of long waits for crisis care. The MHP also does not have the bandwidth currently to seek out and implement a clinical level of care tool.

- 3G – The MHP utilizes the MORS, CANS, and PSC-35 to monitor progress/outcomes of beneficiaries. Aggregate reports are periodically generated for the children's instruments; however, there is no indication this occurs in the adult system with the MORS. This item is therefore considered partially met.
- 3H – Beneficiary satisfaction survey, currently in the form of the annual Consumer Perception Survey (CPS) is considered not met. There was no information from the most recent survey provided for this review; there is no indication of comparison of current with prior results occurring; there was no indication results were provided to beneficiaries, staff and contract agencies.
- 3I – Consumer run/driven programs – This element is considered partially met. The MHP's Adult Service Center provides various activities and services, but is not run by consumers or lived experience staff. Beneficiaries must be referred by a therapist. The consumer council can make suggestions about activities. Coastal Connections is a MHSA funded youth and transitional aged youth program that is supported by non-peer staff as well as peer mentors.
- 3J – Consumer and family member employment in key roles throughout the system is considered not met. Consumer/family members are not represented on the executive team, nor have a direct report process through a designated consumer voice. There are no consumer/family member supervisory positions, and there is not a specific career ladder for lived experience individuals within that category of staff.
- The MHP does not track or trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD):
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC):
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM):
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP):

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:

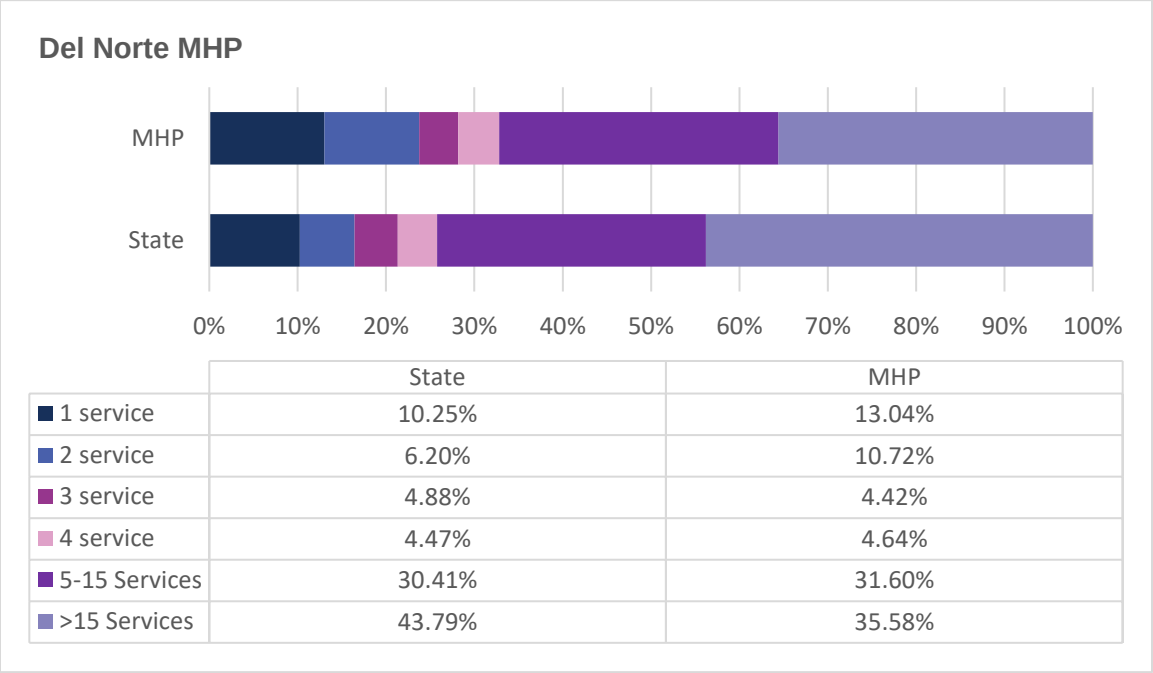
- Retention in Services
- Diagnosis of Beneficiaries Served

- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Beneficiaries (HCB)

Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries served by the MHP to require 5 or more services during a 12-month period. However, this table does not account for the length of stay, as individuals enter and exit care throughout the 12-month period.

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	13.04%
2 service	6.20%	10.72%
3 service	4.88%	4.42%
4 service	4.47%	4.64%
5-15 Services	30.41%	31.60%
>15 Services	43.79%	35.58%

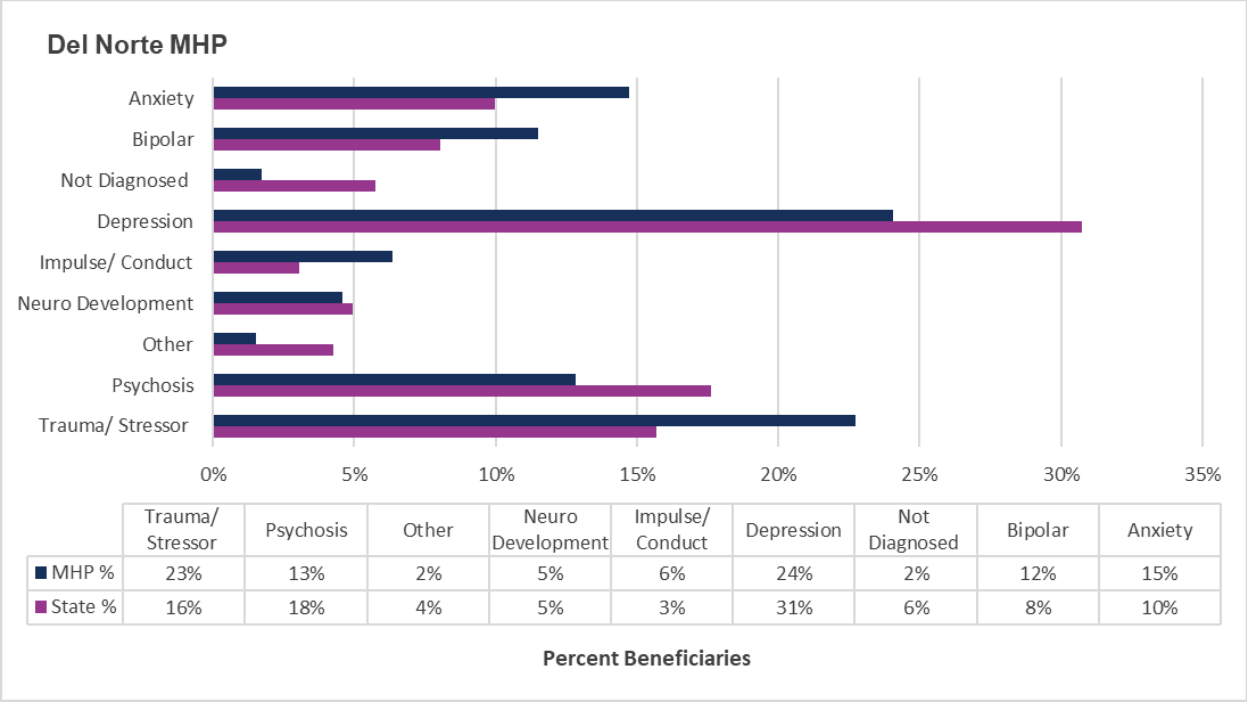
- Retention is higher in Del Norte than statewide for four services or less (32.82 percent vs. 25.80 percent), while the state as a whole has higher rates for five or more services (74.20 percent vs. 67.18 percent).

Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The following figures represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary 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.

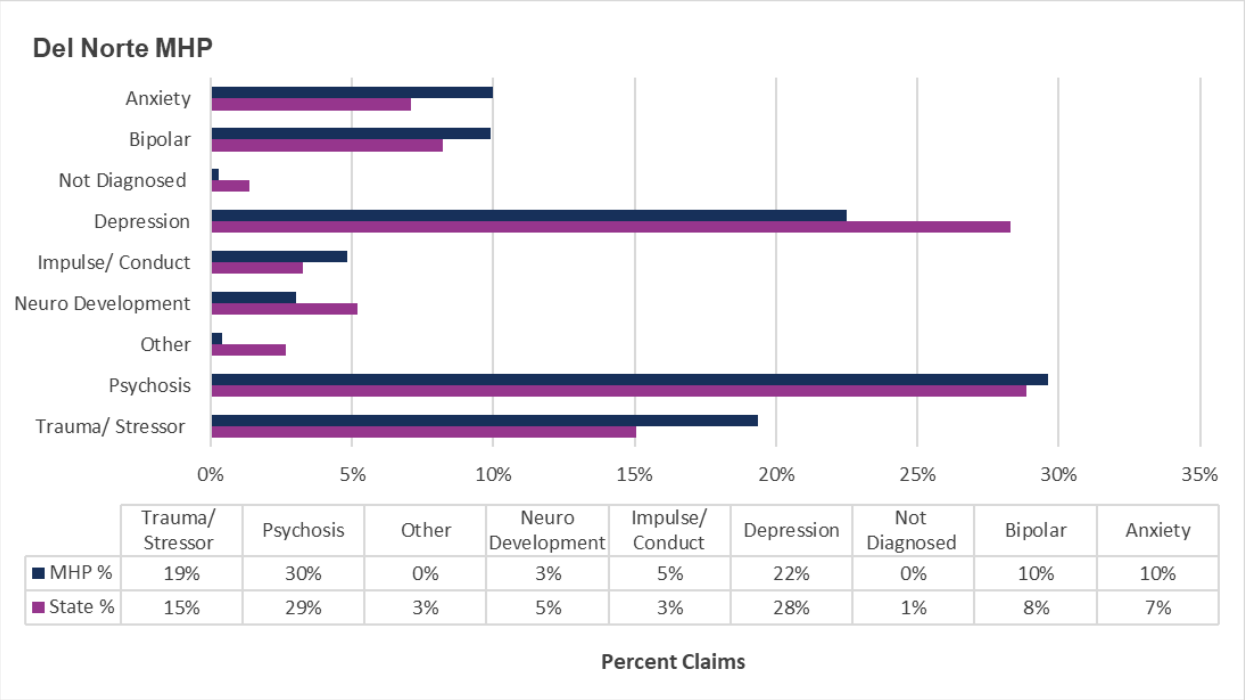
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	23%	13%	2%	5%	6%	24%	2%	12%	15%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The top three diagnostic categories in Del Norte County are Depression, Trauma/Stressor, and Anxiety. The largest gap between the MHP and statewide diagnostic rates are for the Trauma/Stressor diagnostic category, where the MHP's rate is 7 percentage points higher than statewide. The MHP's diagnostic rate of Depression was 7 percentage points lower than statewide.

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	19%	30%	0%	3%	5%	22%	0%	10%	10%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- The top three diagnostic categories by approved claims are Psychosis, Depression, and Trauma/Stressor. Psychosis is the fourth most prevalent diagnosis in Del Norte, however, having this diagnosis as the leader in approved claims points to the higher level of acuity for this category.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay (LOS).

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	57	100	14.46	8.86	$17,578	$12,052	$1,001,929
CY 2020	59	173	14.27	8.68	$23,034	$11,814	$1,359,031
CY 2019	60	86	14.60	7.80	$16,767	$10,535	$1,006,018

- Since CY 2019, Del Norte has seen a decrease in unique Medi-Cal beneficiaries utilizing psychiatric inpatient care. However, total inpatient admissions doubled from CY 2019 to CY 2020. Total admissions dropped from 173 in CY 2020 to 100

in CY 2021, but it is clear there are many clients utilizing psychiatric inpatient hospitalization multiple times within the calendar year.

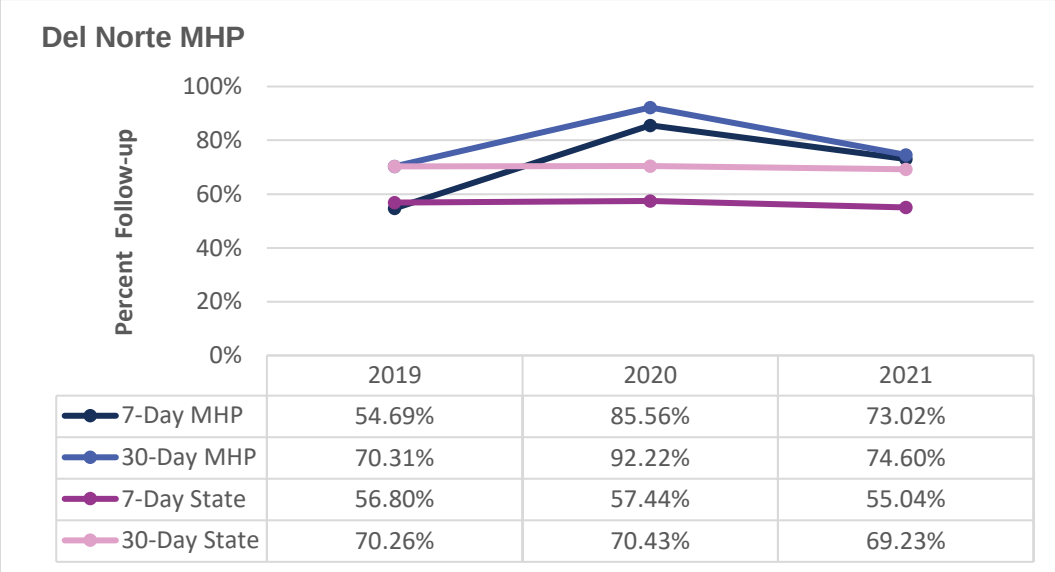
- In CY 2021, the average LOS in Del Norte was more than five days longer than the statewide LOS.
- The MHPs AACB was considerably higher than the state in CY 2021 ($17,578 vs. $12,052). The higher AACB is attributable to the longer LOS.

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 2021 SDMC and Inpatient Consolidation 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.

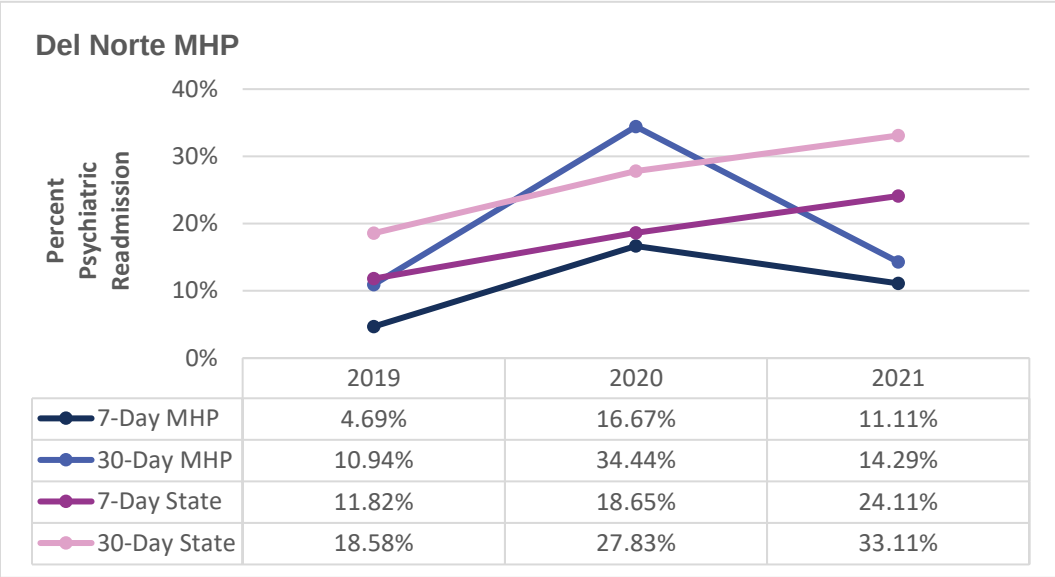
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	54.69%	85.56%	73.02%
30-Day MHP	70.31%	92.22%	74.60%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	4.69%	16.67%	11.11%
30-Day MHP	10.94%	34.44%	14.29%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- 7-day and 30-day inpatient follow-up decreased in CY 2021 compared to the prior year, but both remained above the statewide rates.
- 7-day and 30-day psychiatric readmission rates increased greatly in CY 2020 from the previous year and even surpassed statewide rates, then decreased in CY 2021 to below statewide rates.
- It would seem that the MHP is frequently involved in the transportation of beneficiaries back from acute care hospitals, thus presenting engagement opportunities for follow-up/discharge planning.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs 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 AACB is $7,478, the median amount is just $3,269.

Tables 14 and 15, Figure 20 shows how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, nearly 92 percent of the statewide beneficiaries are “low cost” (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACB of $4,412 and median of $2,830.

Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	26	2.87%	34.98%	$1,402,398	$53,938	$42,724
	CY 2020	24	2.54%	33.93%	$1,511,799	$62,992	$51,222
	CY 2019	20	1.82%	25.22%	$1,155,092	$57,755	$53,360

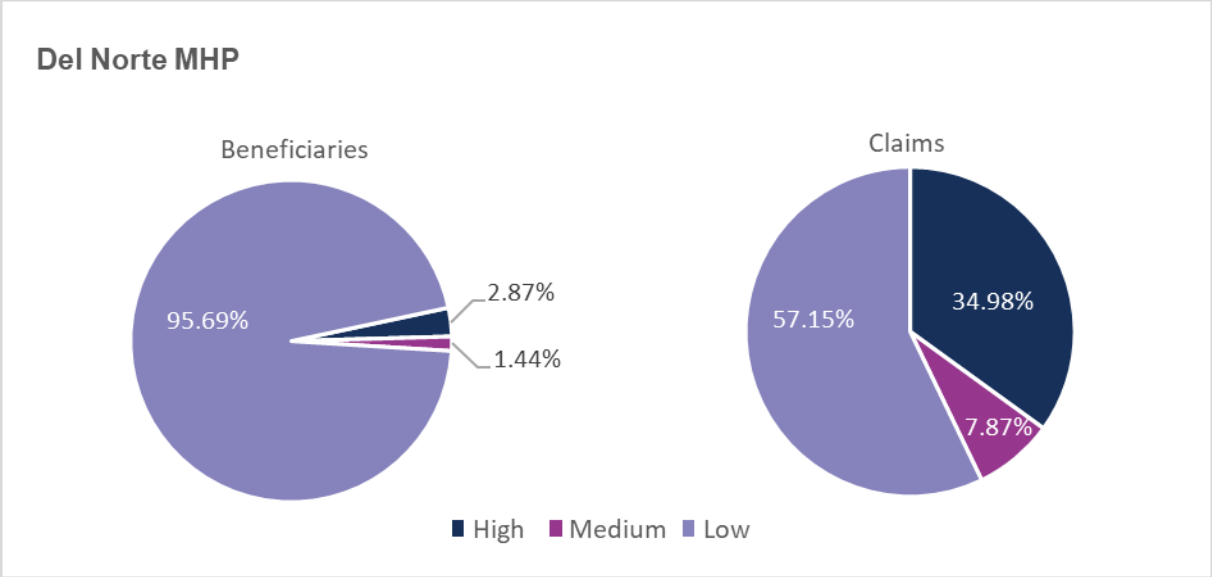
- The number of HCBs in Del Norte has increased slightly each year between CY 2019 and CY 2021.
- The percentage of beneficiaries served that are considered HCBs remains below the statewide proportion (2.87 percent vs. 4.50 percent), however, HCBs do account for roughly 1.5 percent more of the MHP’s total claims than statewide (34.98 percent vs. 33.45 percent).

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	13	1.44%	7.87%	$315,596	$24,277	$24,675
Low Cost (Less than $20K)	866	95.69%	57.15%	$2,291,630	$2,646	$1,771

- The vast majority of beneficiaries seen in Del Norte are low-cost beneficiaries (95.69 percent), and that group accounts for 57.15 percent of total approved claims.

Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021



IMPACT OF QUALITY FINDINGS

- Psychiatric inpatient utilization has increased since CY 2019 with the average LOS more than five days longer than statewide rates. The MHP indicated during the review that clients likely have longer LOS than the State because hospitals are not located nearby, and they use their influence and knowledge of beneficiary history to ensure clients are fully ready to step down to a lower LOC before discharge.
- Psychiatric readmission rates have taken significant swings since CY 2019 with a large increase in readmissions in CY 2020, and a large decrease in CY 2021. Del Norte now has a readmission rate below the State for both 7-day and 30-day psychiatric readmissions. It is possible the reduction in psychiatric readmissions is due to the longer LOS in the initial hospitalizations as discussed in the bullet above.
- The local lack of crisis diversion resources such as crisis stabilization and crisis residential as well as acute psychiatric inpatient and psychiatric health facility programs creates a gap cited by beneficiaries and staff. Exploration of a regional project that includes multiple MHPs could offer a benefit to enhance the system of care available.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have two active and ongoing PIPs, 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 beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or MHP system level.

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

Validation tools for each PIP are located in 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: n/a

Date Started: n/a

Aim Statement: n/a

Target Population: n/a

Status of PIP: No clinical PIP was submitted due to lack of staffing during the period in which a clinical PIP would have been developed and operated. No specific TA was provided because the MHP was not prepared to engage in PIP topic discussions due to new staffing who were not ready to have this discussion.

Summary

n/a

[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

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: To Identify Barriers for Client Non-attendance to Therapy Appointments at Remi Vista and Address with Intervention

Date Started: 08/2022

Date Completed: 03/2023

Aim Statement: The aim/goal of this PIP, which runs from August 2022 through March 2023, is to determine the cause of client no shows to therapy appointments through using a questionnaire given to Remi Vista clients. 29 Remi Vista clients answered the questionnaire and 16 of those answered questionnaires indicated that the reason for no-show was that they forgot their appointment. The intervention applied here is for Remi Vista staff to call clients the day before their appointment and remind them of their appointment. Monthly reports will be conducted to be able to gather data on the rate of no shows and see if the intervention makes a difference.

Target Population: Remi Vista clients who had low attendance rates for therapy sessions were affected by the problem. Remi Vista provides therapy for children and teens.

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

Summary

In order to address high no-show rates for the Del Norte MHP's children's contract provider, Remi Vista, a non-clinical PIP was developed to understand the most frequent reasons no-shows were occurring and apply an appropriate intervention. The beneficiaries surveyed (29) indicated that forgetting appointments was the most frequent cause (16) for missing appointments. A reminder call strategy was developed and implemented, which has resulted in a significant decrease in no-shows, from a baseline of 14.45 percent to the most recent of 12.98 percent.

TA and Recommendations

As submitted, this non-clinical PIP was found to have high confidence, because: while the MHP has not performed a statistical analysis of significance, the intervention directly addresses the most frequent cited cause of no-shows and has produced improvement. Given more time, the impact will likely be greater. To that end, the MHP intends to continue tracking results for at one more period outside of the PIP framework.

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

- As this PIP is considered completed, no further specific TA is indicated.
- The MHP is encouraged to seek EQR TA early and often in the development of a new non-clinical PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is CCBH, which has been in use for 16 years. Currently, the MHP is actively implementing a new system, Credible, which requires heavy staff involvement to fully develop.

Approximately 3.34 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 50 named users with log-on authority to the EHR, including approximately 35 county staff and 15 contractor staff. Support for the users is provided by ten full-time equivalent (FTE) IS technology positions. Currently all positions are filled.

As of the FY 2022-23 EQR, all-contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to 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	100%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. Del Norte does not currently have a PHR in their EHR, however, they plan on implementing a PHR within two years as part of their new Credible EHR system.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: MH CBOs/Contract Providers.

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

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

Table 17: IS Infrastructure Key Components

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

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

- 4A – There is a sufficient budget for the acquisition and maintenance of an EHR. The MHP is moving away from CCBH and implementing Credible with a goal to go-live in July 2023.
- 4C – Del Norte has a very low denied claims rate along with consistent and timely claim submittals to DHCS.
- 4F – The MHP does not maintain a data warehouse that replicates the EHR system, which would be worth exploring once the new EHR is implemented. A data warehouse would improve reporting capabilities and data analysis.
- 4D – The current EHR does not track prescriptions, lab orders, outcomes, referral management, or PHR. All of these should be considered with the new EHR to ensure the MHP has fully electronic client charts.
- 4E – The MHP does not test and review the Operations Continuity Plan at least annually, maintain a standard or estimated timeline to restore the EHR in the event it is disrupted, and does not support two-factor authentication to authorize user password change.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either adjudicated 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 2021.

This chart appears to reflect a largely complete or very substantially complete claims data set for the time frame claimed.

Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	1,433	$311,477	$156	0.05%	$307,089
Feb	1,411	$303,837	$0	0.00%	$299,033
Mar	1,571	$293,709	$0	0.00%	$287,294
April	1,765	$301,387	$0	0.00%	$283,169
May	1,578	$352,739	$0	0.00%	$342,671
June	1,783	$372,242	$666	0.18%	$364,473
July	1,581	$350,013	$711	0.20%	$338,043
Aug	1,582	$304,925	$3,295	1.08%	$293,053
Sept	1,629	$287,601	$7,059	2.45%	$276,406
Oct	1,646	$337,273	$2,860	0.85%	$329,909
Nov	1,392	$277,319	$4,227	1.52%	$270,836
Dec	1,315	$311,355	$827	0.27%	$305,932
Total	**18,686**	**$3,803,877**	**$19,801**	**0.52%**	**$3,697,908**

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other healthcare coverage must be billed before submission of claim	73	$7,465	37.70%
Medicare Part B must be billed before submission of claim	18	$6,203	31.33%
Service line is a duplicate and a repeat service procedure code modifier not present	2	$3,007	15.19%
Beneficiary not eligible or non-covered charges	3	$2,970	15.00%
Late claim	1	$156	0.79%
Total Denied Claims	**97**	**$19,801**	**100.00%**
Overall Denied Claims Rate	**0.52%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The top two denial reasons account for $13,668 and 69.03 percent of total denied claims.
- The denied claims rate of 0.52 percent is very low compared to the statewide rate of 1.43 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Del Norte has a robust budget allocation dedicated to IS of 3.34 percent.
- With ten FTEs dedicated to IS, four FTEs dedicated to data analytics, and the support of the ASP Kings View, the MHP is in a solid position to transition to Credible in July 2023.
- Clinical and administrative staff have been undertaking trainings for the new EHR, and executive staff feel confident that the transition will be smooth.
- It would benefit the MHP to implement prescription, lab order, outcomes, referral management, ROI, and PHR functionality in the new EHR.
- Del Norte has given full access of their EHR to their contractor, Remi Vista, which has optimized data entry of claims data and state reporting requirements such as CANS, PSC, 274 standard submissions of provider network data, and Client Services Information.
- The MHP commented on the difficulty they have had implementing some of the CalAIM changes due to functionality limitations with the CCBH EHR. Implementing an HIE has essentially been impossible with CCBH, but the MHP expects to implement an HIE with the help of Kings View once Credible is up and running.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP presented no consumer perception survey data during this review. Discussion of how this is usually shared indicates that it may be shared with staff but there is no formal mechanism to ensure that beneficiaries have access to the results.

CONSUMER FAMILY MEMBER FOCUS GROUP

Consumer and family member (CFM) 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 CFM 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 consumers (MHP beneficiaries) and/or family members, containing 6 to 8 participants each.

Consumer Family Member Focus Group One

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

All participants were Lanterman-Petris-Short Act conservatees, who experienced rapid initial access to services following court or institutional referral. All participants reported receiving reminders about pending appointments, at times from the public guardian's office and at others by email or calls or visits from workers. The service center where they receive treatment also issues appointment reminders.

Transportation to services occurs via a van, which take them to appointments, shopping, and activities. All appreciate and enjoy the van.

Inclusion of the family in treatment was identified as relevant by several participants. The issue of requiring paperwork document approval of this involvement can delay it occurring.

Communication about physical healthcare was cited by a number of participants. Some have pre-existing conditions that encouragement is given about exercise and eating healthy. Other participants mentioned yoga, basketball, and other activities to improve physical health. However, most are unaware if their psychiatrist and physical health practitioner communicate.

In speaking about the fit between beneficiary and mental health provider, most felt that staff were reasonable to work with. There were some concerns about the limited numbers of staff that could create difficulties for the beneficiary if there was a conflict.

Telehealth is the exclusive modality for receiving psychiatric services. Even if in-person is preferred, it is not available. Most are comfortable with telehealth.

The frequency of service includes daily groups, weekend activities, and basketball twice weekly. ICAN (Independence Counseling Advocacy Network) facilitated group therapy occurs weekly, with psychiatry once monthly. Stress management classes are provided once weekly.

To respond to urgent, unanticipated needs, the reported first option is hospitalization, and participants report the ER does not have mental health capabilities. The 988 number reportedly does not offer much in the way of options when in crisis. The general consensus was that the options were too limited when having a crisis. However, it was said the conserved individuals received better services than non-conserved.

Consumer feedback surveys had not been taken by the majority of participants. They also mentioned that the service center does not solicit opinions or input on activities. Other topics around input and information included the finding that information from the MHP is experienced as slow and minimal. Posting boards are infrequently updated and often devoid of information about activities. There are gardening and volunteer work activities starting soon, an area in which there has been response to beneficiary feedback.

Opportunities for involvement seemed very limited, and none were aware of what they might take part in. However, all have a sense of hope, looking forward.

Recommendations from focus group participants included:

- Develop local alternatives to hospitalization, such as crisis stabilization or similar “chill house” setting versus hospitalization, where one is sent away.
- Improve the information published about Del Norte services and all of the aspects of treatment, including information about opportunities to volunteer.
- Funding for in-county acute county psychiatric beds or a psychiatric health facility.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The feedback of beneficiaries focused on the need for crisis alternatives to hospitalization and out-of-county transport to acute care facilities. This would seem to include crisis stabilization, crisis residential and some regional improved access to acute care.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. While lacking a core of experienced, licensed clinicians the MHP has adapted service delivery to creatively utilize unlicensed staff to provide services that seem to be well-received by beneficiaries. (Access, Quality)
2. The MHP has a strong IS budget with enough IS and data analytics support to successfully implement the Credible EHR, and leverage the improved data reporting capabilities to aid executive leadership in decision making and performance improvement initiatives. (Access, Timeliness, Quality, IS)
3. Del Norte does an excellent job working with the local Native American community and involving them in cultural competency meetings and other community events. -(Access, Quality,)
4. The MHP is closely involved with the local emergency department and law enforcement in the coordination and delivery of crisis services, which may involve substantial stays in the emergency department when acute psychiatric inpatient resources are needed. (Access, Timeliness, Quality)
5. With the CCMU planning, the MHP is making progress to developing a service that will likely improve access to interventions that may reduce the need for out-of-area hospitalizations, and improve the treatment experience of beneficiaries. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP currently lacks the ability to track and trend urgent care needs. (Access, Timeliness, Quality, IS)
2. While the absolute number of MHP FC youth provided medication support are low (28), the MHP has a concerning level of these youth (50.9 percent) receiving medication services vs statewide (28.1 percent) with average units of service for the MHP (393) nearly identical to the statewide number (396). It is not clear if this reliance on medications is due to limited clinician capacity or unique clinical factors of its beneficiaries. (Access, Quality)
3. The MHP's QAPI Work Plan, contains limited target areas (three in the QAPI) and only one of which presents quantifiable tracked indicators. The CCP also lacks quantifiable tracked measures. (Quality, IS)

4. The MHP has faced challenges with identification of a support a clinical PIP. (Quality, IS)
5. The MHP currently lacks any on-site licensed clinician available to provide clinical consultation and guidance to paraprofessional staff. (Access, Quality)

RECOMMENDATIONS

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

1. Develop and implement an urgent care service definition, and create a tracking mechanism in the new EHR for this metric that can be utilized for timeliness data analysis. (Access, Timeliness, Quality, IS)
2. Investigate the level of outpatient clinical services provided to those FC beneficiaries who are receiving medication support, to ensure that psychosocial therapeutic interventions have been applied at a high level, including the intensive services such as IHBS, before psychotropics are utilized. Consider increasing non-medication interventions if it is determined this approach has not been utilized. (Access, Quality)
3. Develop a comprehensive set of QAPI and CCP goals, which incorporate metrics routinely tracked by the MHP utilizing a quantifiable strategy that tracks and presents results over time. The potential elements may include timeliness, grievances, consumer perception surveys, aggregated outcome data, access test call results which include afterhours provider performance, and others. Results should receive at least quarterly review in QIC. (Timeliness, Quality, IS)

   (This recommendation is a revised carry-over from FY 2019-20, FY 2020-21, FY2021-22.)
4. The MHP would be advised to see early and frequent PIP TA in selecting and developing a focus for both clinical and non-clinical PIP topics, then following up with data review. Should insufficient internal bandwidth or technical knowledge exist, consideration of external consultant support would be advised. (Quality,)

   (This recommendation is a carry-over from FY 2021-22.)
5. The MHP should consider, in the absence of onsite adult licensed clinical staff, retention of an experienced telehealth clinician who would be available throughout the work week to provide clinical guidance for complex presentations. It would also be advisable for the MHP to develop a protocol that specifies when such consultation is required. (Access, Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, California public health emergency (PHE) was in place until February 28, 2023 and a national PHE is scheduled to end May 11, 2023. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.}

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 – Del Norte 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 Beneficiaries' Perception of Care
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Information Systems Billing and Fiscal Interview
Telehealth
Evaluation of Compliance
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rob Walton, Quality Reviewer
Brian Deen, Information Systems Reviewer
Mary Ellen Collings, Consumer-Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Austin	Patty	Supervising Behavioral Health Specialist	Department of Health and Human Services – Behavioral Health Branch (DHHS-BHB)
Azevedo	Devin	Behavioral Health Specialist	DHHS-BHB
Bohannon	Becky	Office Manager	Remi Vista
Brown	Ranell	Director	DHHS-BHB
Bruschi	Deborah	Administrative Analyst	DHHS-BHB
Campbell	Jacobson	Interim Assistant Director	DHHS-BHB
Cha	Shirley	Fiscal Manager	DHHS-BHB
Coats	Mariah	Behavioral Health Specialist	DHHS-BHB
Crowell	Karena	Supervising Behavioral Health Specialist	DHHS-BHB
Cusumano	Michelle	Ethnic Services Manager	DHHS-BHB
Fowles	Corrie	Staff Services Analyst	DHHS-BHB
Gomez	Dulce	Clinical Supervisor	Remi Vista
Hodies	Julie	Supervising Behavioral Health Specialist	DHHS-BHB
Hogan	Shiann	Program Manager	DHHS-BHB
Horner	John	Recovery Specialist	DHHS-BHB
Reagen	Samantha	Staff Services Manager	DHHS-BHB
Schaad	Christy	Administrative Analyst	DHHS-BHB
Stephens	Michelle	Administrative Analyst	DHHS-BHB

Last Name	First Name	Position	County or Contracted Agency
Wilkinson	Jennifer	Staff Services Analyst	DHHS-BHB
Workman	Naome	Behavioral Health Program Coordinator	DHHS-BHB

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

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): No PIP submitted 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 reported that due to staffing turnover it was unable to identify and operate a clinical PIP. • The MHP is encouraged to seek EQR TA for assistance in identification and operation of a clinical PIP. • The MHP director submitted the required letter as Exhibit E identifying lack of staffing prevented development and completion of a clinical PIP for this review period.

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 no-show rates reflected continual improvement, that for the second remeasurement period January 2023, was 11.86 percent when the baseline was 14.45 percent. One might anticipate further improvement over time. The goal of 10 percent no-shows was not met. The MHP plans to continue tracking outside of the PIP framework for one more period, April through May of 2023.
General PIP Information	
MHP/DMC-ODS Name: Del Norte MHP	
PIP Title: To Identify Barriers for Client Non-attendance to Therapy Appointments at Remi Vista and Address with Intervention	
PIP Aim Statement: The aim/goal of this PIP, which runs from August 2022 through March 2023, is to determine the cause of client no shows to therapy appointments through using a questionnaire given to Remi Vista clients. 29 Remi Vista clients answered the questionnaire and 16 of those answered questionnaires indicated that the reason for no-show was that they forgot their appointment. The intervention applied here is for Remi Vista staff to call clients the day before their appointment and remind them of their appointment. Monthly reports will be conducted to be able to gather data on the rate of no shows and see if the intervention makes a difference.	
Date Started: 08/2022	
Date Completed: 03/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): Those beneficiaries who no-show to Remi Vista appointments.
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): Appointment reminder calls.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Remi Vista to provide reminder calls to beneficiaries the day before the scheduled appointment.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

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
No-Show rates Goals: 10 percent reduction	8/2022 – 9/2022	14.45% (no baseline size stated)	12/2022-1/2023	12.98%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

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): PIP completion 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 formal PIP has been completed, thus no further TA is indicated. • The MHP is encouraged to seek EQR TA early and often in the development of a replacement PIP.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

COUNTY OF DEL NORTE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health Branch

455 K Street
Crescent City, California 95531
Toll Free 1(888) 446-4408

Phone
(707) 464-7224

Fax
(707) 465-4272

Ranell Brown, Director

May 23, 2023

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

Dear Samantha Fusselman,

The County of Del Norte Department of Health and Human Services Behavioral Health Branch (DHHS-BHB) is requesting flexibility during the FY 2022-23 EQRO review scheduled for April 19, 2023.

Specifically, DHHS-BHB was unable to create and operate a Clinical Performance Improvement Project (PIP) during the FY 2022-23 review due to the following:

X Lack of staff/resources
X Staff have been reassigned to other departments
_ Lack of infrastructure
_ Additional factors _____

DHHS-BHB was able to provide the single Non-Clinical PIP. Please attach this letter to our FY 2022-23 annual report.

Sincerely,

Ranell Brown, MSML, IPMA-SCP
Director
Department of Health and Human Services
County of Del Norte