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

INYO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Date:

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, "Inyo" may be used to identify the Inyo County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — April 19, 2023

MHP Size — Small-Rural

MHP Region — Central

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
5	2	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	1	5	0
Quality of Care	10	0	7	3
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**8**	**15**	**3**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Title of PIP- unknown	Clinical	Not Applicable (n/a)	No PIP submitted	n/a
Follow-up after Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	09/2022	Baseline	Moderate

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:

- Case managers are highly utilized for beneficiary stabilization in the community, transportation, and field-based services.
- Video telehealth services are highly successful in engaging beneficiaries for ongoing clinical services.
- The Wellness Centers provide services to a large transitory population including food, clothing, laundry, mental health resources, and Medi-Cal benefit information.
- The MHP is utilizing technical assistance (TA) from both Qualifacts and Kings View for training and operational support while launching their new Electronic Health Record (EHR.)
- Progress House services beneficiaries aged 18-59 in a home-like environment addressing full-service partnership, crisis respite, recovery groups, and 24/7 on-call crisis services.

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

- The MHP lacks an operations continuity plan in the event of natural disasters or other emergencies.
- Due to the significant staff vacancy rate, the MHP was unable to provide the necessary documentation for validation of the clinical-PIP.

- The Wellness Center, located in Bishop, lacks a protective shelter for outdoor groups and activities; and lacks adequate signage for ease of identification.
- Timeliness to service for children/youth and foster care (FC) beneficiaries is not consistently tracked.
- Due to immigration fears many monolingual Spanish speaking community members seek mental health resources within their place of worship instead of utilizing the MHP.

Recommendations for improvement based upon this review include:

- Develop an operations continuity plan for critical business functions that is maintained in readiness for use.
- Continue to develop a clinical PIP and access CalEQRO TA to accurately provide the required clinical PIP documentation for validation. (This recommendation is a carry-over from FY 2020-21 and FY 2022-23)
- Investigate the ability to provide a covered outdoor area at the Bishop Wellness Center to accommodate participant overflow and outdoor activities; and provide adequate signage to allow for ease of identification of the center's location.
- Track children/youth and FC beneficiary timeliness and disaggregate data to identify specific timeliness challenges for these groups.
- Create outreach and access opportunities by partnering with local places of worship that specifically address the needs of the monolingual Spanish speaking community.

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 foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section14197.05).

This report presents the FY 2022-23 findings of the EQR for Inyo 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 (IPC) 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 during the Coronavirus Disease 2019 (COVID-19) pandemic, which is scheduled to end on May 11, 2023. The MHP faced the unusual Atmosphere weather system which paralyzed the county with record snow fall and road closures. The county now faces the eminent repercussion of excessive flooding. The MHP continues to report a 50 percent staff vacancy rate. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. Due to the staffing shortage the MHP was unable to complete documentation for the Clinical PIP and a county letter signed by the director is provided as 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 has faced multiple Atmospheric River weather systems depositing record amounts of snow, which caused numerous road closures, power outages and flooding, impacting beneficiaries access to in person care.
- The MHP is planning to increase the number of hours for teletherapy to 30 hours per week, including two bilingual clinicians, to assist with timeliness of scheduling appointments.
- The MHP is losing the only Ambulance transport as the company closes business in the county.
- The new admission policy has enabled MHP to improve efficiency in getting beneficiaries into services within the required timeframe and has improved no-show rate and beneficiary satisfaction.
- The county owns only 2.87 percent of public/private land creating an unusual challenge to provide housing opportunities for the large homeless and transitory population. This population frequents the Wellness Center impacting accurate data collection and performance measures.

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: Develop objective measures of beneficiary access and receipt of appropriate level of care. Implement solutions as needed to be able to provide timely, appropriate Speciality Mental Health Services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has implemented an initial screening process where referral forms are routed to the clinical administration who screens for medical necessity within 24 hours of initial call or receipt of the referral.
- The beneficiary is assigned to a clinician for a mental health assessment within 14 days unless urgent care is required, in which case, MHP will assign a clinician to meet with the beneficiary within 24 hours.

Recommendation 2: Review procedures and practices for monitoring timeliness to services and implement a process that ensures completeness, accuracy, and meaningfulness of the data.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- MHP has implemented a flow of work such that once demographic information has been recorded and Medi-Cal benefits have been verified, referrals are sent to behavioral health Clinic Administrator who contacts the beneficiary to determine medical necessity for SMHS within 24 hours.

- Timeliness to the first offered non-urgent psychiatry appointment, first non-urgent psychiatry service delivered, and timeliness to urgent appointment is not tracked for children/youth and FC youth.
- The MHP currently employes one .45 percent full-time equivalent (FTE) psychiatrist with wait times based on availability.
- To satisfy this recommendation the MHP would need to ensure completeness and meaningfulness of date, particularly around children/youth and FC youth. This recommendation will be partially carried forward.

Recommendation 3: Monitor and document the review of data from California Child Welfare Indicators Project and the Early and Periodic Screening, Diagnostic and Treatment Performance Outcome System (EPSDT), regarding medication utilization of youth in FC.

(This recommendation is a carry-over from FY 2018-19, FY 2019-20, & FY 2020-21.)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Few FC youth are serviced by the MHP on an annual basis. Many FC youth are placed in tribal homes and receive services through Toiyabe Indian Health Project Inc.
- The MHP did not have a single FC youth receiving medication within the current review cycle or current FY.
- The MHP understands the policy regarding EPSDT and should they have a FC youth in their system they are aware of the required regulations.
- The MHP is unable to address this recommendation due to the MHP not providing services to any FC youth receiving medication. This recommendation will not be carried forward.

Recommendation 4: Conduct two PIPs and submit them for review, as federally required.

(This recommendation is a carry-over from FY 2020-21.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP submitted the Behavioral Health Quality Improvement Program- PIP as the non-clinical PIP.
- The MHP has identified a clinical PIP, but due to significant staffing vacancies, the documentation was unable to be completed for validation.
- To be addressed, the MHP will need to submit a clinical PIP for validation, for this reason this recommendation will be carried forward.

Recommendation 5: Revisit the IS staffing structure, as more support will be needed during and after the rollout of a new EHR, to meet training needs and ensure system functionality.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP's IS staffing structure is not managed by the Division of Behavioral Health as IT is a county level department. MHP leadership reported that County IT is meeting their IT support needs and additional staffing is not required.
- The implementation of Credible was supported by Kings View. Kings View also provided Credible training for all staff and provides ongoing technical and reporting support. Qualifacts Systems, LLC (Qualifacts), the Credible vendor, provided additional Credible training prior to implementation. The Credible system is hosted by Qualifacts.

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 95 percent of services were delivered by county-operated/staffed clinics and sites, and 5 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 80 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. Beneficiaries may request services through the Access Line as well as through the following system entry points: two wellness centers, primary care providers, schools, emergency services, community-based organizations, child protective services, the jail, and substance use treatment programs. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The MHP has provides an orientation process whereby beneficiaries who call the Access Line or come in person are connected immediately with a care coordinator who walks the beneficiary through intake paperwork, explains the consent to treatment, and makes the first line of referrals to the appropriate program. If at this point the beneficiary is referred to an MHP therapist, then the full assessment and screening for medical necessity are conducted.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 174 adult beneficiaries, 66 youth beneficiaries, and 28 older adult beneficiaries across two county-operated sites and one contractor-operated site. Among those served, seven 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 Inyo 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:

- The MHP partners with Toiyabe Indian Heath Project to provide access as requested by tribal members.
- The MHP provides the Family Intensive Response Strengthening Team or FIRST, an intensive family-based service where children have been identified for group home or out of home placement.
- A child psychiatrist from South County is available once per month with limited capacity. The MHP may want to consider other telehealth child psychiatry options.

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, the MHP's PR of 6.84 percent was

57.6 percent greater than the statewide rate, and the average claim amount of $5,896 was 21.1 percent less than the statewide average.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	6,300	431	6.84%	$2,541,371	$5,896
CY 2020	5,835	412	7.06%	$2,302,022	$5,587
CY 2019	5,493	356	6.48%	$1,256,009	$3,528

*Total annual eligibles may differ in Tables 3, 4, and 7 due to rounding of different variables in calculating the annual number of eligibles based upon average of the monthly eligibles.

- Annual eligibles, beneficiaries served and AACB increased each year from CY 2019 to CY 2021. The PR declined from CY 2020 to CY 2021 (7.06 percent vs. 6.94 percent.)

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	720	-	-	1.71%	1.96%
Ages 6-17	1,478	134	9.07%	8.65%	5.93%
Ages 18-20	286	<11	-	7.76%	4.41%
Ages 21-64	3,157	220	6.97%	8.00%	4.56%
Ages 65+	660	43	6.52%	3.73%	1.95%
Total	**6,301**	**431**	**6.84%**	**7.08%**	**4.34%**

- PRs exceeded statewide rates for all ages except those ages 18-20. PRs exceeded similar sized county rates for those aged 0-5, 6-17, and 65 and over.

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
Spanish	25	5.80%
Threshold language source: Open Data per BHIN 20-070		

- Inyo had one threshold language other than English, Spanish. There were 25 beneficiaries served, 5.80 percent of total beneficiaries served, who identified Spanish as a preferred language.

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	1,963	89	4.53%	$365,790	$4,110
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. While the MHP's CY 2021 overall PR was 6.84 percent, the ACA PR was 4.53 percent, mirroring the statewide trend of a lower ACA penetration rate.
- The ACA PR was 18.9 percent greater than the statewide rate (4.53 percent vs. 3.81 percent) and the ACA AACB was 35.6 percent less than the statewide average ($4,110 vs. $6,383.)

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.

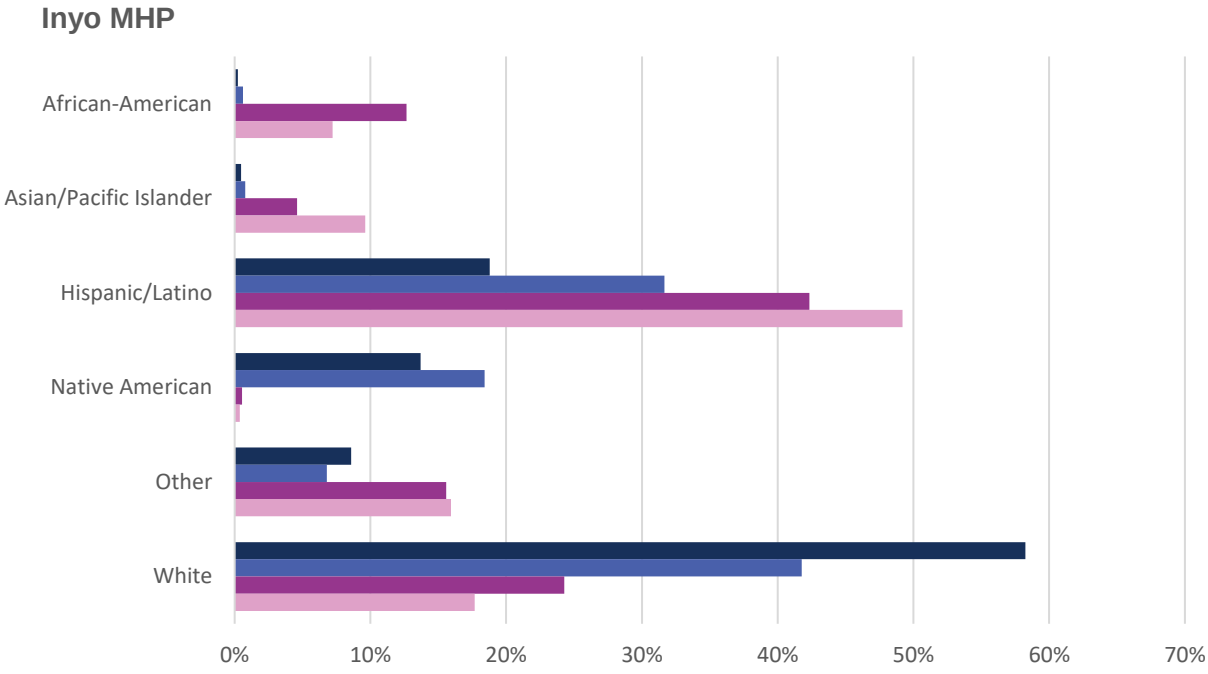
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	38	<11	-	7.64%
Asian/Pacific Islander	49	<11	-	2.08%
Hispanic/Latino	1,995	81	4.06%	3.74%
Native American	1,160	59	5.09%	6.33%
Other	428	37	8.64%	4.25%
White	2,632	251	9.54%	5.96%
Total	**6,302**	**431**	**6.84%**	**7.64%**

- Inyo served 431 unique beneficiaries in CY 2021 with 251 White beneficiaries served and 81 Hispanic/Latino beneficiaries served. The MHP's White penetration rate was 60.1 percent greater than the statewide rate (9.54 percent

vs. 5.96 percent) and the Hispanic/Latino penetration rate was 8.6 percent greater than the statewide rate (4.06 percent vs. 3.74 percent.)

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

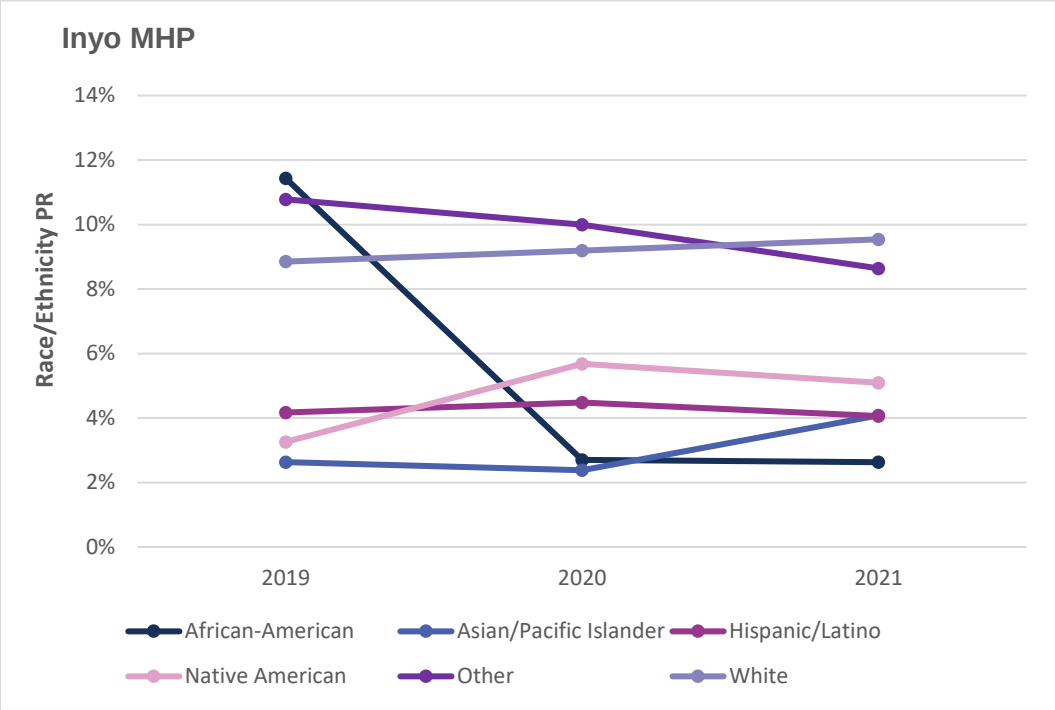


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	58%	9%	14%	19%	0%	0%
MHP % Eligible	42%	7%	18%	32%	1%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- Whites comprised 42 percent of the eligible population and 58 percent of those served. The Hispanic/Latino population comprised the next largest race/ethnicity group with 32 percent of the eligible population and 19 percent of those served.
- The most proportionally overrepresented group in the MHP was White, and the most underrepresented group in the MHP was Hispanic/Latino.

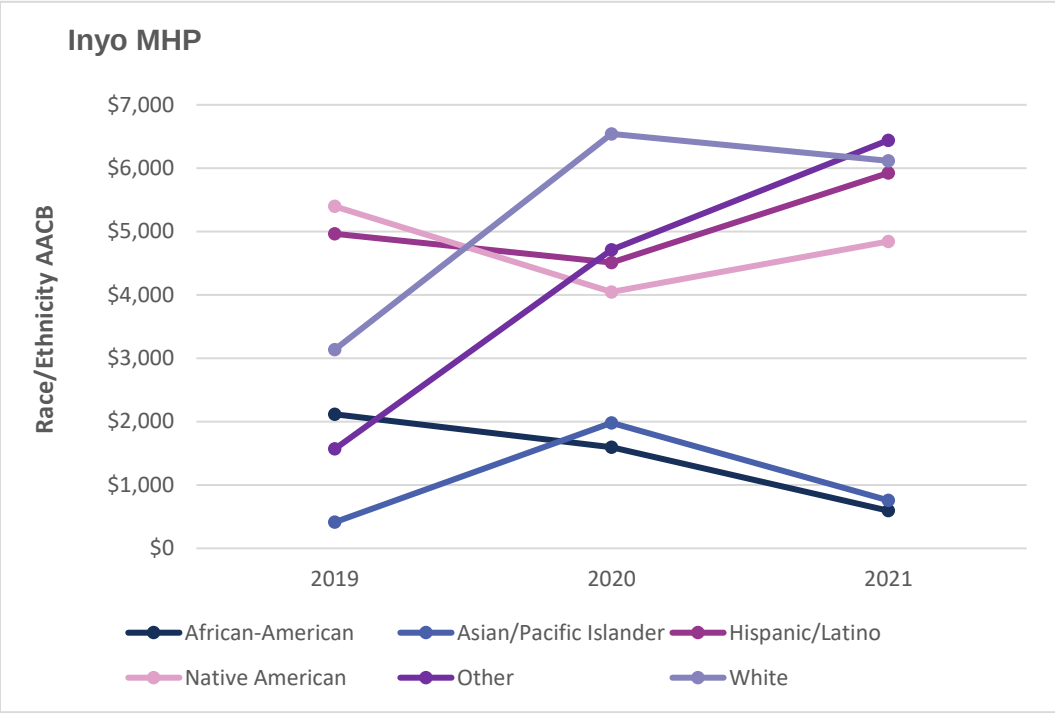
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



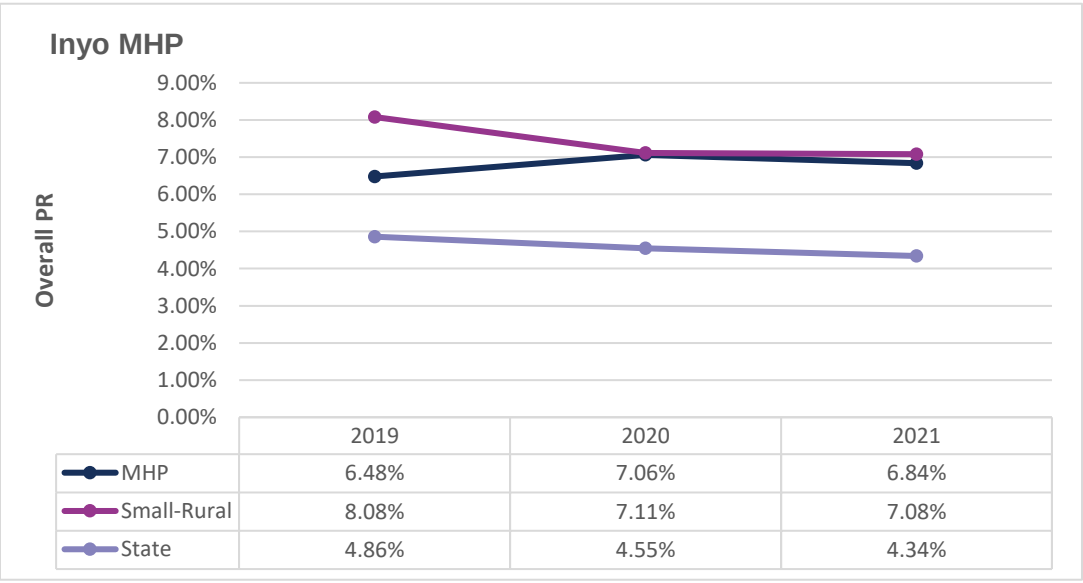
- From CY 2019 to CY 2021, Asian/Pacific Islander, Native American and Hispanic/Latino PRs were consistently lowest while White and Other had the highest PRs. It should be noted that African-American and Asian Pacific Islander race/ethnicity groups each served <11 beneficiaries, and lower beneficiary counts can cause greater year over year variations in the data.

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



- AACB for Hispanic/Latino, Other and Native American increased from CY 2020 to CY 2021 while AACB for White, Asian/Pacific Islander and African-American declined. It should be noted that the lower beneficiary counts for African-American and Asian/Pacific Islander can cause greater year over year variations in the data.

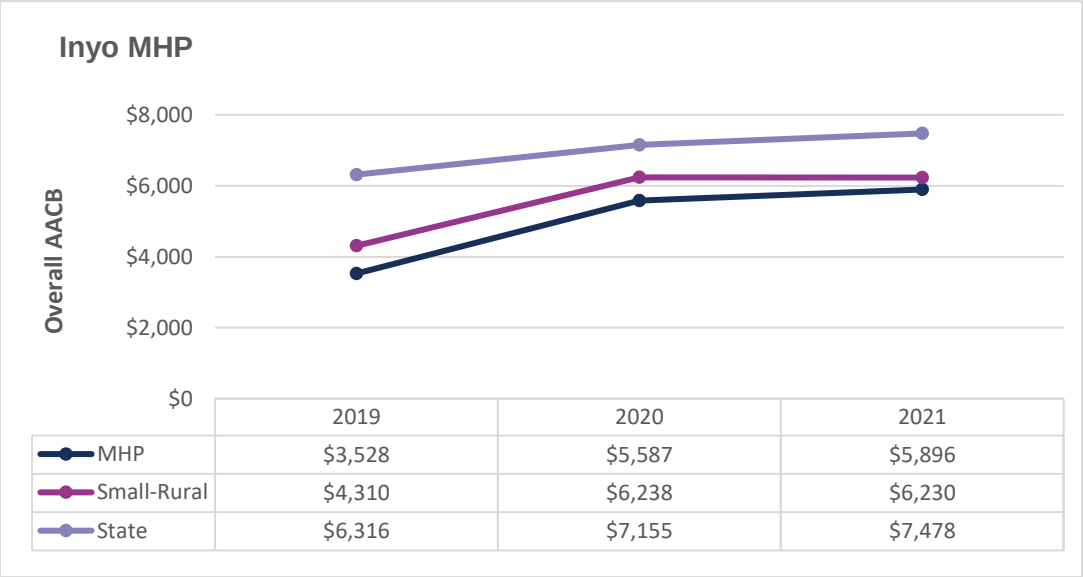
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	6.48%	7.06%	6.84%
Small-Rural	8.08%	7.11%	7.08%
State	4.86%	4.55%	4.34%

- Although overall PR declined 3.1 percent from CY 2020 to CY 2021 (7.06 percent vs. 6.84 percent) in CY 2021, it remained greater than the statewide rate (6.84 percent vs 4.34 percent) and just below the small-rural county rate (6.84 percent vs. 7.08 percent.)

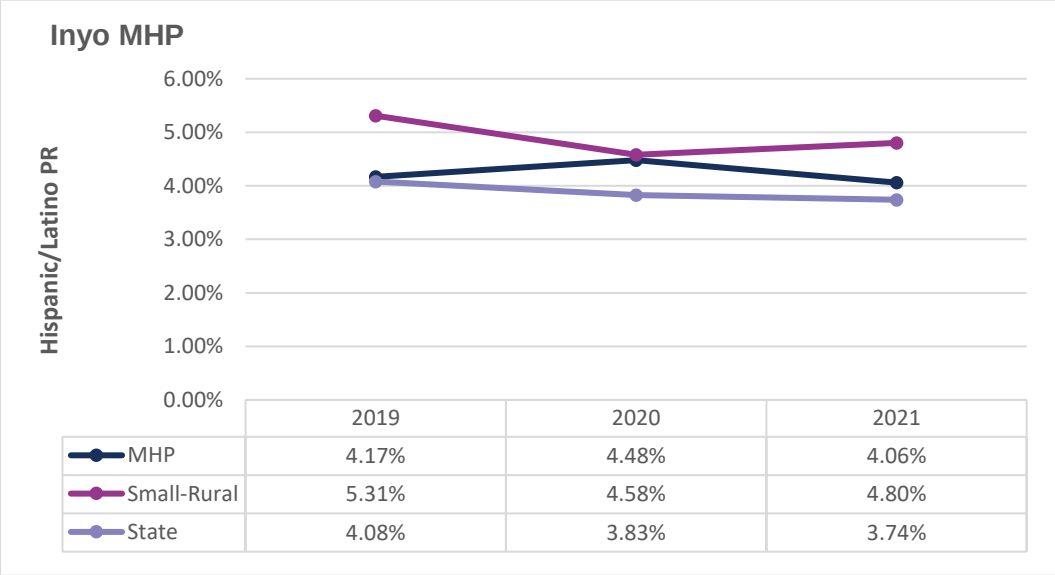
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$3,528	$5,587	$5,896
Small-Rural	$4,310	$6,238	$6,230
State	$6,316	$7,155	$7,478

- Overall AACB increased each year from CY 2019 to CY 2021 but remained below that of both the small-rural and statewide averages in CY 2021.

Figure 6: Hispanic/Latino PR CY 2019-21

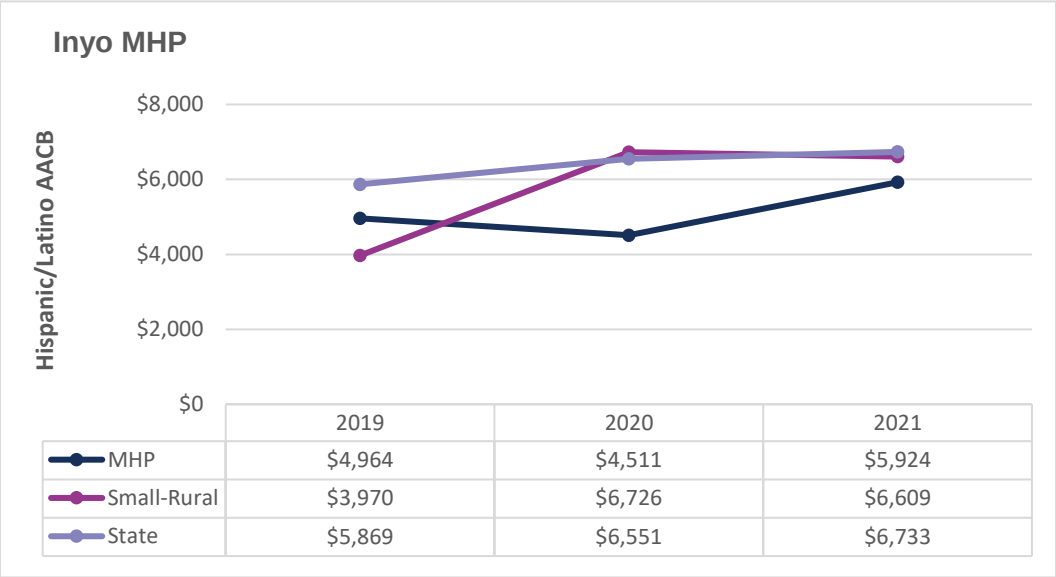


	2019	2020	2021
MHP	4.17%	4.48%	4.06%
Small-Rural	5.31%	4.58%	4.80%
State	4.08%	3.83%	3.74%

- The Latino/Hispanic PR declined 9.4 percent from CY 2020 to CY 2021 (4.48 percent vs. 4.06 percent) and in CY 2021 was greater than the statewide rate

(4.06 percent vs. 3.74 percent) and less than the small rural county rate (4.06 percent vs. 4.80 percent.)

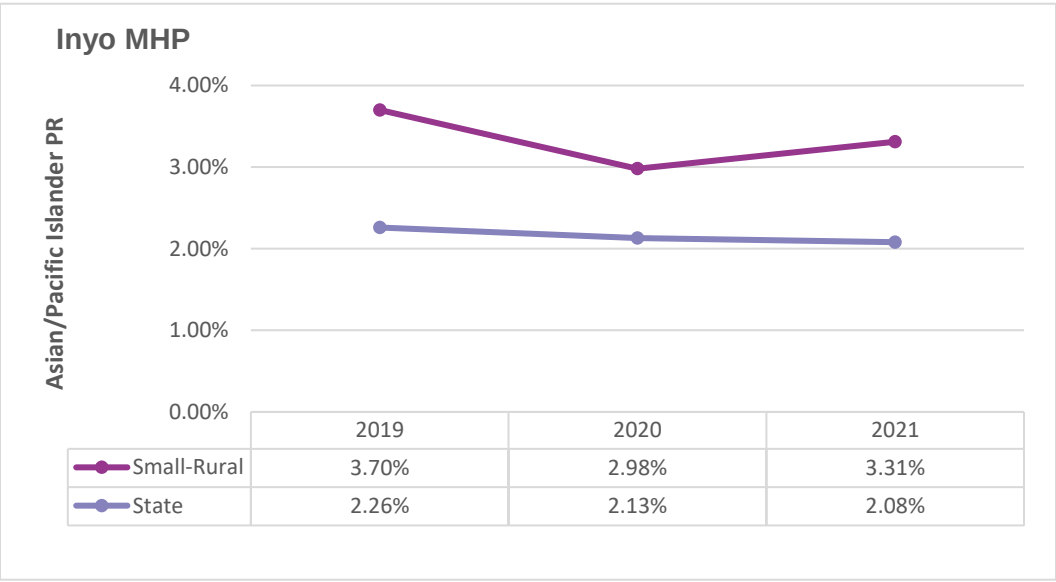
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,964	$4,511	$5,924
Small-Rural	$3,970	$6,726	$6,609
State	$5,869	$6,551	$6,733

- The Hispanic/Latino AACB increased 31.3 percent from CY 2020 to CY 2021 ($4,511 vs. $5,924) but remained below both the small-rural and statewide averages in CY 2021.

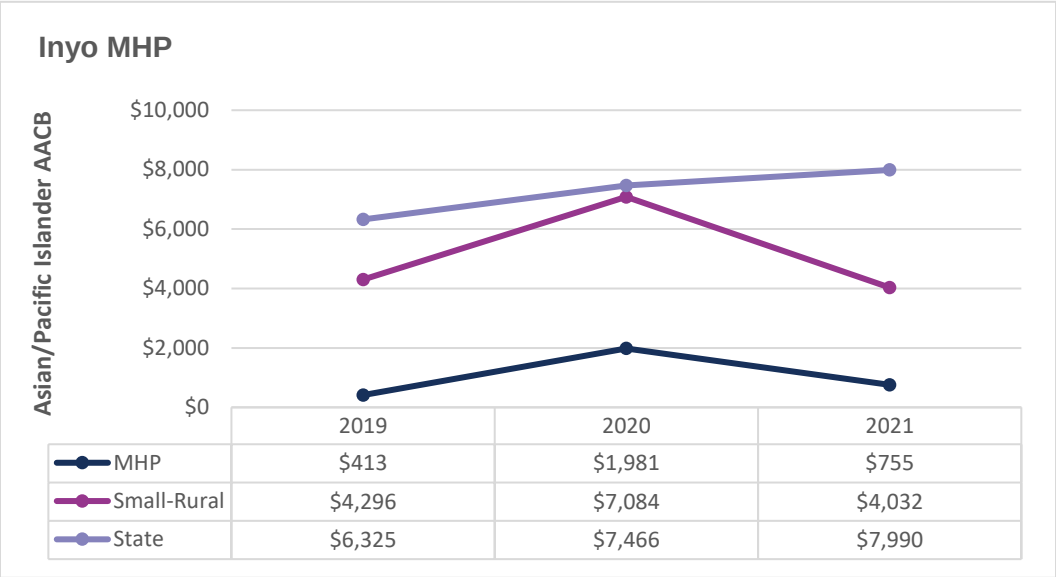
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
Small-Rural	3.70%	2.98%	3.31%
State	2.26%	2.13%	2.08%

- Due to the number of Asian/Pacific Islander beneficiaries served by the MHP being <11, PR data is not reported in this table.

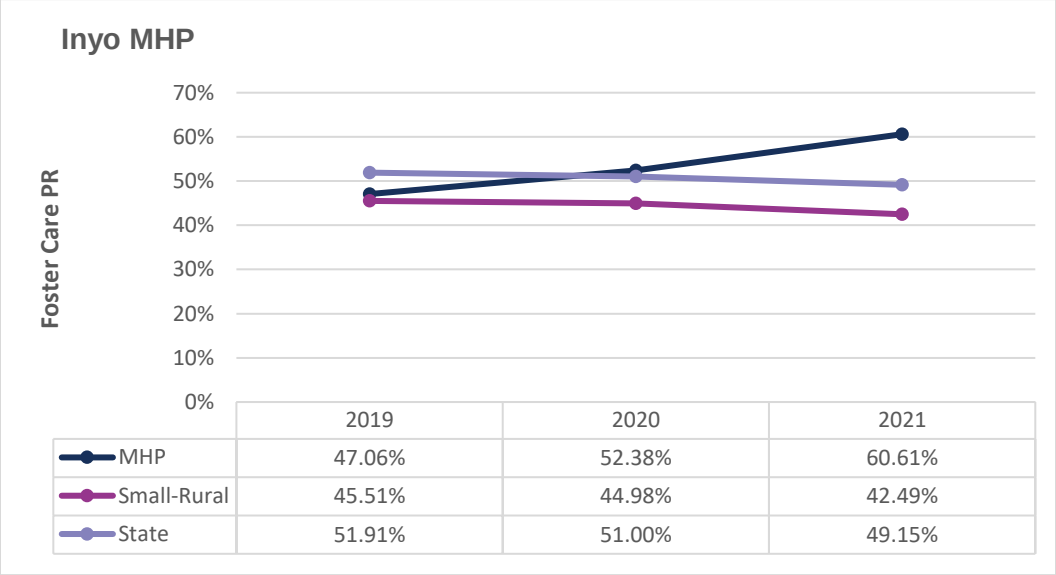
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$413	$1,981	$755
Small-Rural	$4,296	$7,084	$4,032
State	$6,325	$7,466	$7,990

- Asian/Pacific Islander AACB remained below both small-rural and statewide averages from CY 2019 to CY 2021. The number of Asian/Pacific Islander beneficiaries served in CY 2021 was <11.

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	47.06%	52.38%	60.61%
Small-Rural	45.51%	44.98%	42.49%
State	51.91%	51.00%	49.15%

- FC PR increased each year from CY 2019 to CY 2021 and in CY 2021 exceeded both the small-rural and statewide rates.

Figure 11: Foster Care AACB CY 2019-21

	2019	2020	2021
MHP	$3,850	$5,982	$7,129
Small-Rural	$6,666	$8,348	$9,089
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased each year.
- While the FC AACB increased each year from CY 2019 to CY 2021, in CY 2021 AACB remained below that of both small-rural and statewide averages.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 273				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	-	7	7	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	<11	-	7	7	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	0	0.0%	0	0	2.2%	21	14
Per Minute Services							
Crisis Stabilization	12	4.4%	1,335	1,200	13.0%	1,546	1,200
Crisis Intervention	50	18.3%	448	175	12.8%	248	150
Medication Support	150	54.9%	413	225	60.1%	311	204
Mental Health Services	160	58.6%	649	270	65.1%	868	353
Targeted Case Management	165	60.4%	255	185	36.5%	434	137

- Compared to statewide rates, Inyo had a notably lower percentage of beneficiaries receiving crisis residential and crisis stabilization services.
- A higher percentage of beneficiaries received crisis intervention and targeted case management services compared to statewide rates.

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

Service Category	MHP N = 20				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	0	0.0%	0	0	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	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	0	0.0%	0	0	3.1%	1,404	1,200
Crisis Intervention	0	0.0%	0	0	7.5%	406	199
Medication Support	<11	-	207	207	28.2%	396	273
Therapeutic Behavioral Services	0	0.0%	0	0	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	<11	-	429	176	40.2%	1,354	473
Intensive Home Based Services	<11	-	3,079	1,340	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	20	100.0%	1,054	676	96.3%	1,854	1,108
Targeted Case Management	<11	-	22	22	35.0%	342	120

- Compared to statewide rates, Inyo FC youth had a notably lower percentage of beneficiaries receiving inpatient, crisis stabilization, crisis intervention and therapeutic behavioral services compared to statewide rates.

IMPACT OF ACCESS FINDINGS

- The Hispanic/Latino population comprised 32 percent of the eligible population and 19 percent of those served. The lower percentage of Hispanic/Latinos served compared to the eligible population indicates that this population may be underserved. The MHP recognizes the need to identify additional ways to engage and outreach in a culturally sensitive way that resonates with this population.
- The MHP traditionally has a very low FC youth PR due to few FC youth being placed within the county that require mental health services from the MHP.

- The MHP has been very successful with access through their Progress House and Wellness Centers. Their new admission screening policy has enabled the MHP to improve efficiency in getting beneficiaries into service.
- Some of the links on the MHP's website are not operable; they do not direct to the stated information. The current suicide prevention number 988 is not listed on the site and access to the crisis number is not easy to quickly locate.

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	Partially Met
2C	Urgent Appointments	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Partially Met
2E	Psychiatric Readmission Rates	Partially Met
2F	No-Shows/Cancellations	Partially Met

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

- Overall timeliness standards are met except for children and FC youth. The categories are aggregated, and it is difficult to discern challenges in timeliness. One challenge is the limited number of children and FC youth receiving services from the MHP.

- The MHP has a .45 percent FTE psychiatrist which makes it challenging for beneficiaries to receive timely psychiatry services. In addition, there is limited access to a psychiatrist that serves children and FC youth.
- The MHP addresses urgent calls within one hour. Calls that are crisis related are immediately handled with all other calls being returned within 1 to 24 hours and triaged to assessment appointments within ten-days.
- The MHP has a low readmission rate for both adults and children. This is due to the significant case management, Wraparound and clinical services they provide to beneficiaries to assist in maintaining these individuals in the community.

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. The MHP did not report average time to follow-up services after psychiatric hospitalization and requested TA from the EQRO to help them identify strategies for more effectively tracking this measure.

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

Table 11: FY 2022-23 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	6.12 Business Days	10 Business Days*	83.83%
First Non-Urgent Service Rendered	18.3 Business Days	10 Business Days**	75.45%
First Non-Urgent Psychiatry Appointment Offered	6.47 Business Days	15 Business Days*	80.00%
First Non-Urgent Psychiatry Service Rendered	9.9 Business Days	15 Business Days**	73.37%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	8.26 Hours	1 Hour**	100%
Follow-Up Appointments after Psychiatric Hospitalization	***	7 Days**	58%
No-Show Rate – Psychiatry	6.5%	10%**	n/a
No-Show Rate – Clinicians	10.9%	10%**	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

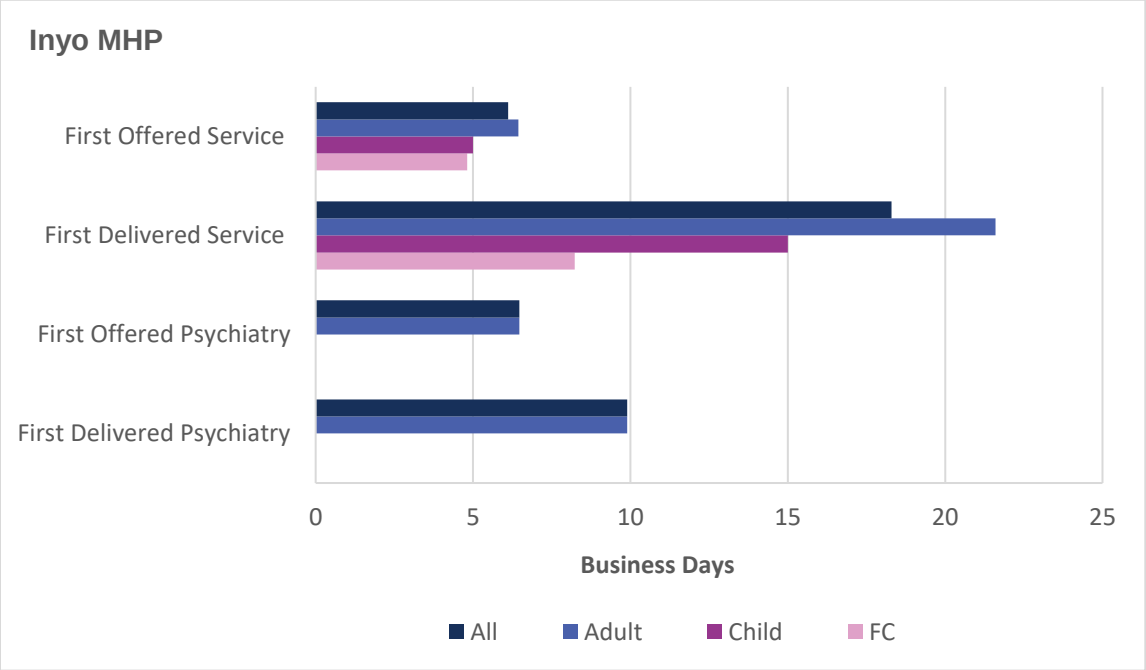


Figure 13: Wait Times for Urgent Services

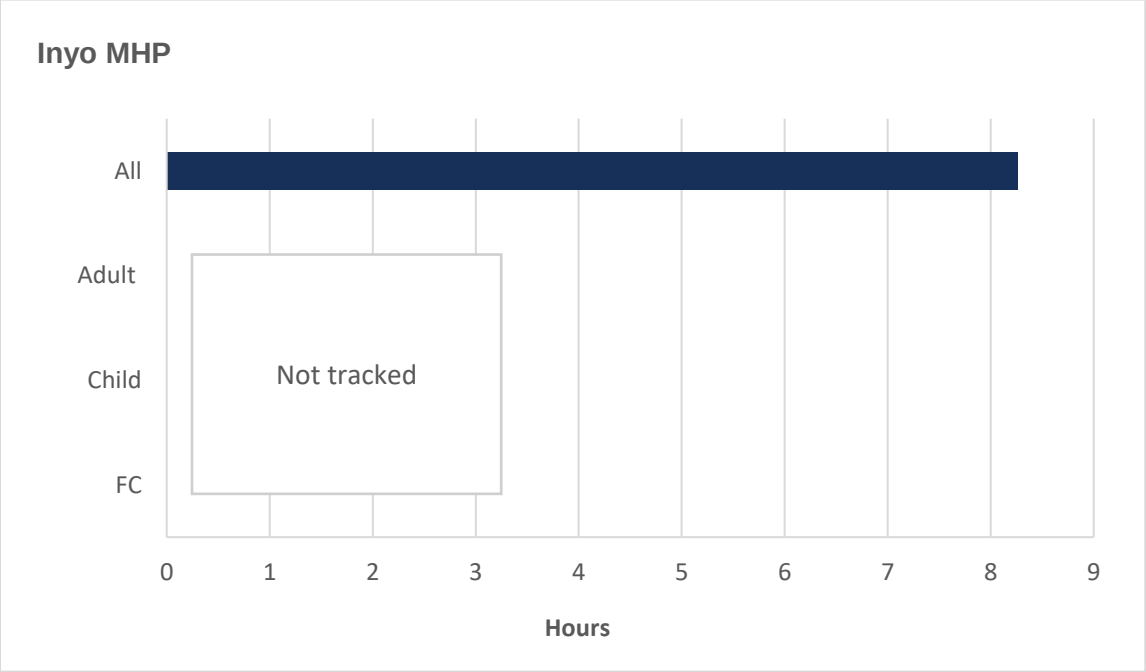
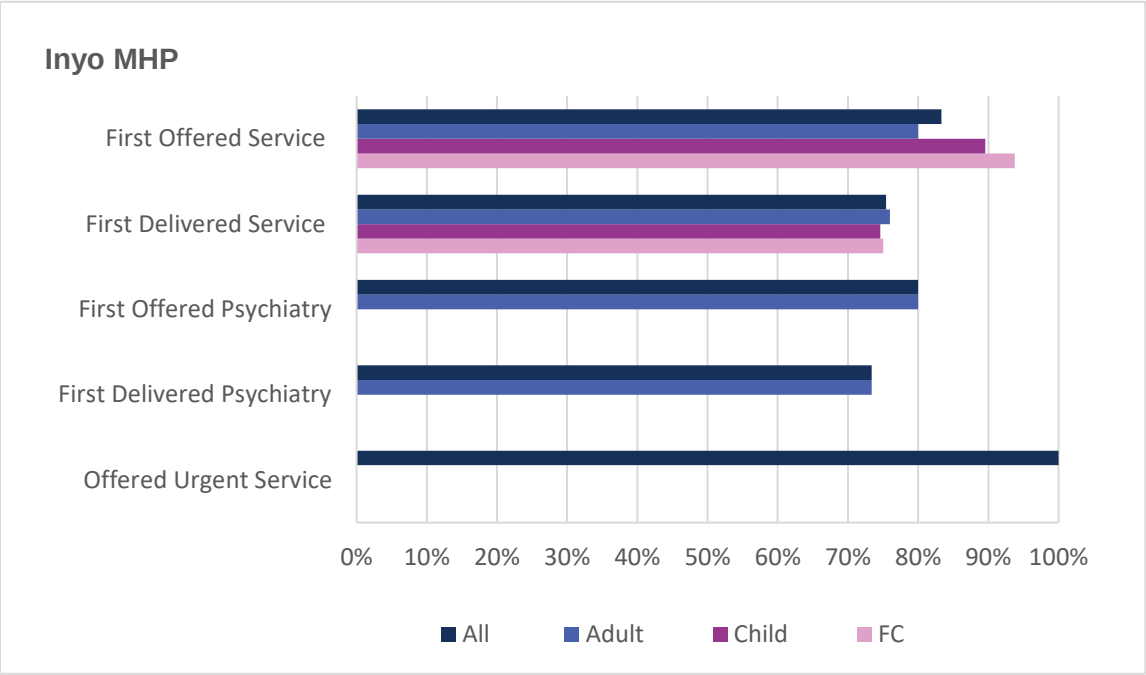


Figure 14: Percent of Services that Met Timeliness Standards



- 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 scheduled assessments, and mental health services such as case management prior to assessment.
- 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 as all calls following the guidelines of eminent or emergent need. There were reportedly 70 aggregated urgent service requests with a reported actual wait time to services for the overall population at a median of five hours with a standard of one hour.
- 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 from the point of beneficiary’s initial service request for adults. There are currently no youth receiving psychiatry services.
- 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 logged in the EHR. The MHP reports a no-show rate of 6.5 percent average for psychiatry and 10.9 average for clinicians with a 10 percent standard for both categories.

- Due to limited or no children and/or FC youth served, the MHP does not report or disaggregate data in the following categories: No show rates, non-urgent psychiatry appointment, non-urgent psychiatry service delivered, urgent appointment offered.

IMPACT OF TIMELINESS FINDINGS

- The MHP is situated in a county that has a high transitory population. Individuals may seek mental health services and quickly move to another location. For this reason, no-shows are often difficult to accurately report.
- As stated above, in addition to difficulty tracking no-show rates, follow-up after psychiatric hospitalization is also just as difficult to track. Often an individual is released, and the MHP is not notified as the nearest inpatient hospital is five hours away. And some individuals do not originate from the county and opt to move back to their county of origin.
- The MHP reported a need for training staff on how to engage the habitual no-show beneficiaries. Key informants identified the change in clinician due to absence as a deterrent to appointment attendance.
- The MHP does not disaggregate urgent service data, which makes quality improvement activities around timeliness challenging to identify area or age categories of need.
- Post-hospitalization tracking remains a challenge with local hospitals not providing the Treatment Authorization Request in a timely manner.
- Wait times for psychiatry are lengthy and key informants report that there is no other method to obtain an urgent appointment when needed.
- The MHP moved to the cloud based Credible EHR system in January 2023. The system is hosted by Qualifacts. Kings View provides additional operational and reporting support. The MHP reported they expect improvement to timeliness data reporting.

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 the Program Integrity and Quality Assurance (PIQA) Team, composed of two of four Heath and Human Services (HHS) analysts. The PIQA is responsible for compliance, staff training (as related to compliance), the QI committee (QIC), and coordinating the Behavioral Health Advisory Board.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of HHS analysts, clinical managers, the Patient's Rights Advocate, beneficiaries who identify as Native American and Hispanic, community organizations, and staff of other divisions of the HHS, is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met four times. The MHP did not provide a separate evaluation of goals but included an update within their FY 2022-23 workplan. The MHP reported continuing to work on, not met or new goals with the plan status. Many of the objectives were related to monitoring and compliance and were not measurable.

The MHP does not use a Level of Care tool.

The MHP utilizes the following outcomes tools: General Anxiety Disorder-7, Milestones of Recovery Scale, Patient Health Questionnaire-9, Child and Adolescent Needs and Strength Assessment (CANS) or CANS-50, and the Pediatric Symptom Checklist-35.

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	Partially met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially met
3E	Medication Monitoring	Partially met
3F	Psychotropic Medication Monitoring for Youth	Not met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Not met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially 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:

- The MHP provided an in-depth stakeholder interview and survey with the Director personally interviewing 15 stakeholders on mental health services.
- Key informants praise the Wellness Center for quality access to basic needs and case management services.
- There is no identification of peer and family member voice throughout the system of care. The single peer employee attends the Quality II (QII) committee, but the QIC and QII do not include the regular attendance of beneficiaries or their families.
- The MHP has a thorough QAPI that identifies compliance and quantitative outcomes. The plan lacks the impact achieving QIC goals have on the beneficiary or qualitative measures.
- The MHP does not utilize outcome tools for the children's or adult system of care. They do aggregate outcome tools such as CANS data, but do not identify trends to improve the system of care.
- 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).

- Though this measure is not met, the MHP did not identify any children or FC youth prescribed medication tracked by HEDIS and thus, did not track or trend the measures.

QUALITY PERFORMANCE MEASURES

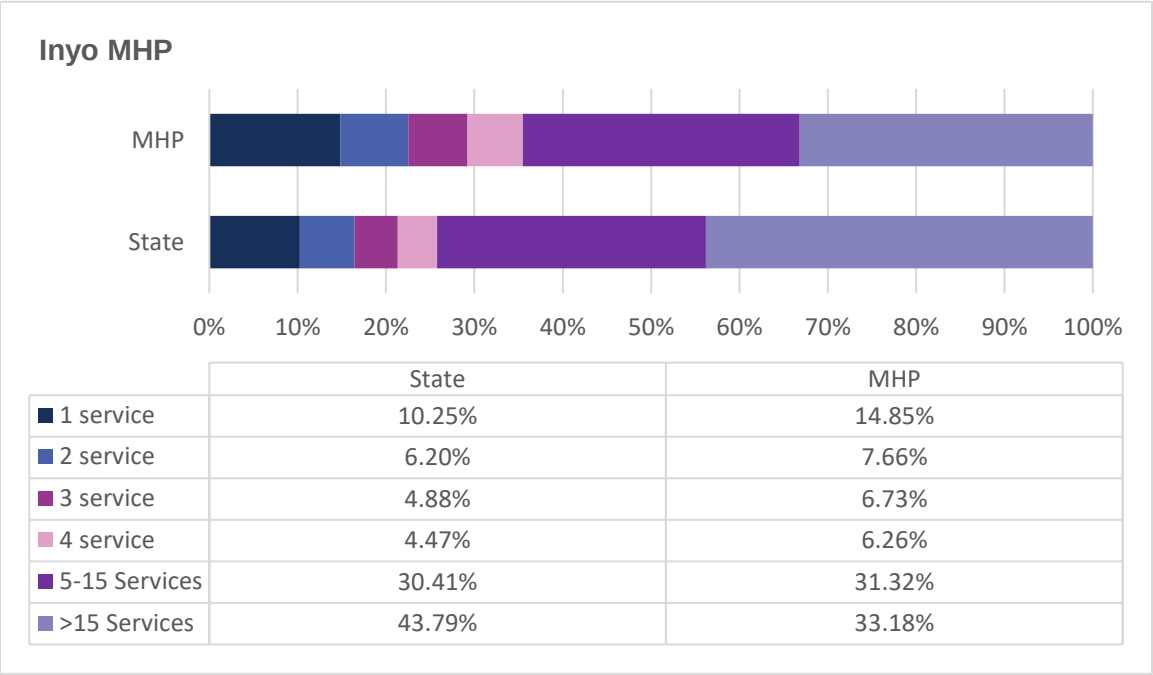
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



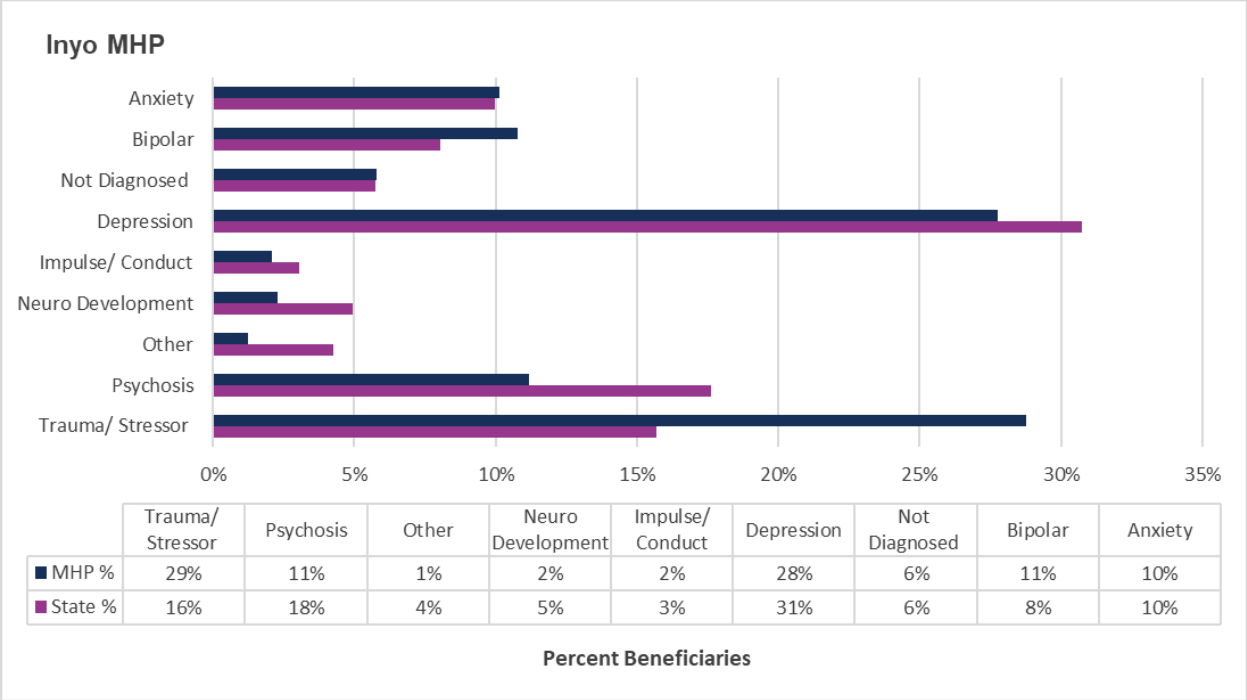
	State	MHP
1 service	10.25%	14.85%
2 service	6.20%	7.66%
3 service	4.88%	6.73%
4 service	4.47%	6.26%
5-15 Services	30.41%	31.32%
>15 Services	43.79%	33.18%

- A single service was provided to 14.85 percent of beneficiaries, 44.9 percent above the statewide rate of 10.25 percent.
- More than 15 services were provided to 33.18 percent of beneficiaries, 24.2 percent less than the statewide rate of 43.79 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.

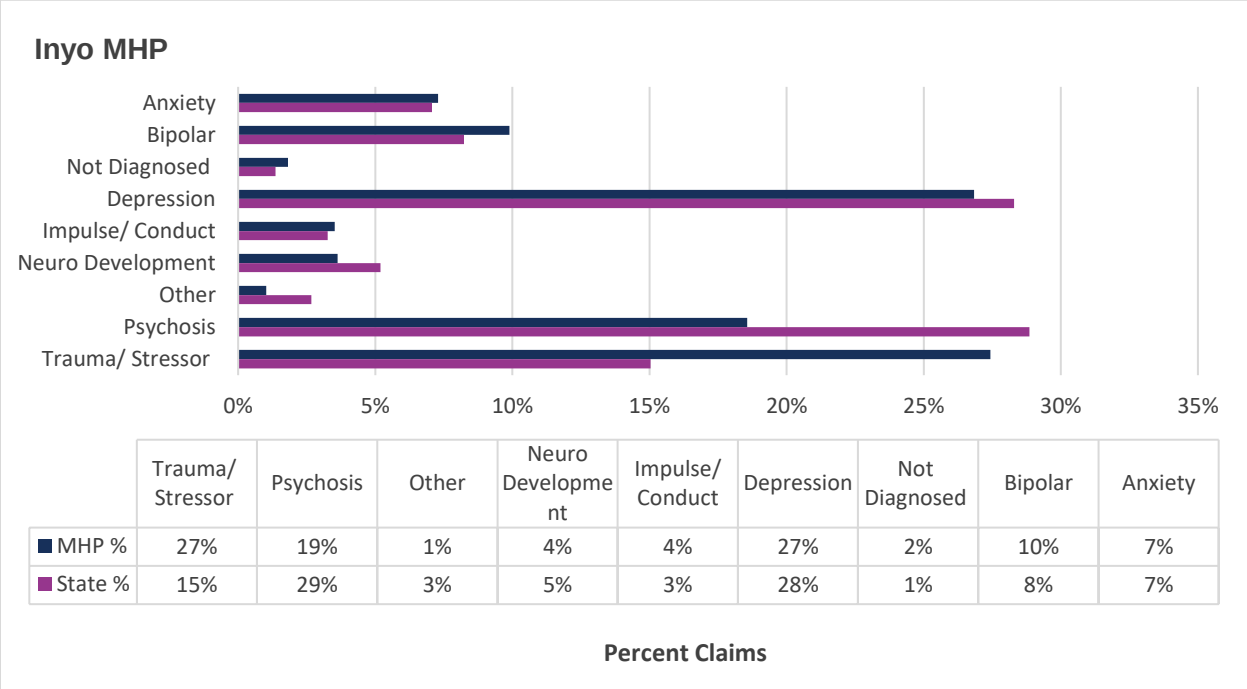
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	29%	11%	1%	2%	2%	28%	6%	11%	10%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- Fifty-seven percent of beneficiaries had one of two diagnoses: Depression (28 percent) and trauma/stressor (29 percent). Compared to statewide rates, the MHP has more trauma/stressor diagnoses (29 percent vs. 16 percent) and less psychosis diagnoses (11 percent vs. 18 percent).

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 %	27%	19%	1%	4%	4%	27%	2%	10%	7%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- The MHP's approved claims dollars are reasonably aligned with their diagnostic pattern.

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	<11	15	6.73	8.86	$5,794	$12,052	$52,143
CY 2020	15	17	8.80	8.68	$8,727	$11,814	$130,906
CY 2019	11	11	11.55	7.80	$8,112	$10,535	$89,234

- The unique number of beneficiaries served in inpatient settings in CY 2021 is suppressed due to being <11.
- LOS decreased from CY 2020 to CY 2021 (8.80 days vs. 6.73 days) and was approaching two days less than the statewide CY 2021 average (6.73 days vs. 8.86 days.)

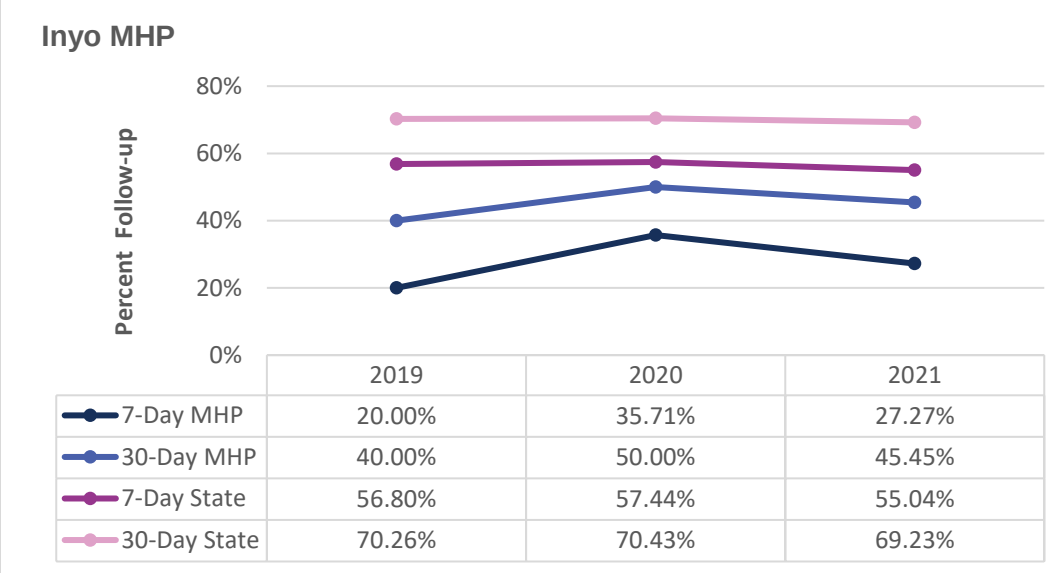
- AACB declined 33.6 percent from CY 2020 to CY 2021 ($8,727 vs. $5,794) and was 51.9 percent less than the statewide average in CY 2021 ($5,794 vs. $12,052.)

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 IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

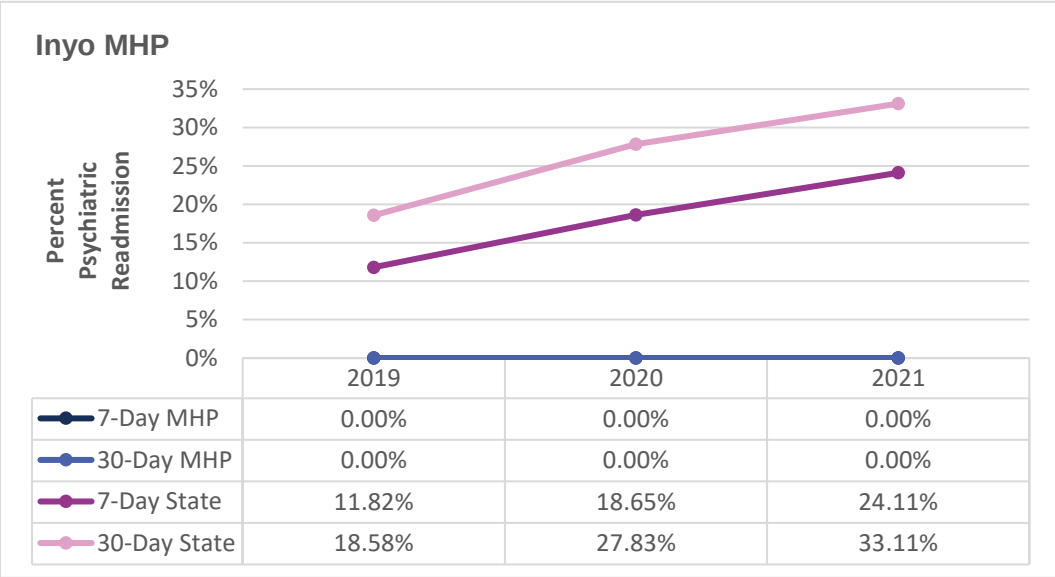
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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	20.00%	35.71%	27.27%
30-Day MHP	40.00%	50.00%	45.45%
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	0.00%	0.00%	0.00%
30-Day MHP	0.00%	0.00%	0.00%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- The 7-day post psychiatric inpatient follow-up rate declined 23.6 percent from CY 2020 to CY 2021 (35.71 percent vs. 27.27 percent) and was less than half the statewide rate in CY 2021 (27.27 percent vs. 55.04 percent).
- The 30-day post psychiatric inpatient follow-up rate declined 9.1 percent from CY 2020 to CY 2021 (50.00 percent vs. 45.45 percent) and was 34.3 percent less than the statewide rate in CY 2021 (45.45 percent vs. 69.23 percent).
- The 7-day psychiatric readmission rate has been 0.00 percent from CY 2019 to CY 2021.
- The 30-day psychiatric readmission rate has been 0.00 percent from CY 2019 to CY 2021.

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 beneficiaries, 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, Figures 20 and 21 show 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	<11	-	-		$41,385	$41,971
	CY 2020	<11	-	13.85%		$39,852	$39,930
	CY 2019	<11	-	8.23%		$34,470	$34,969

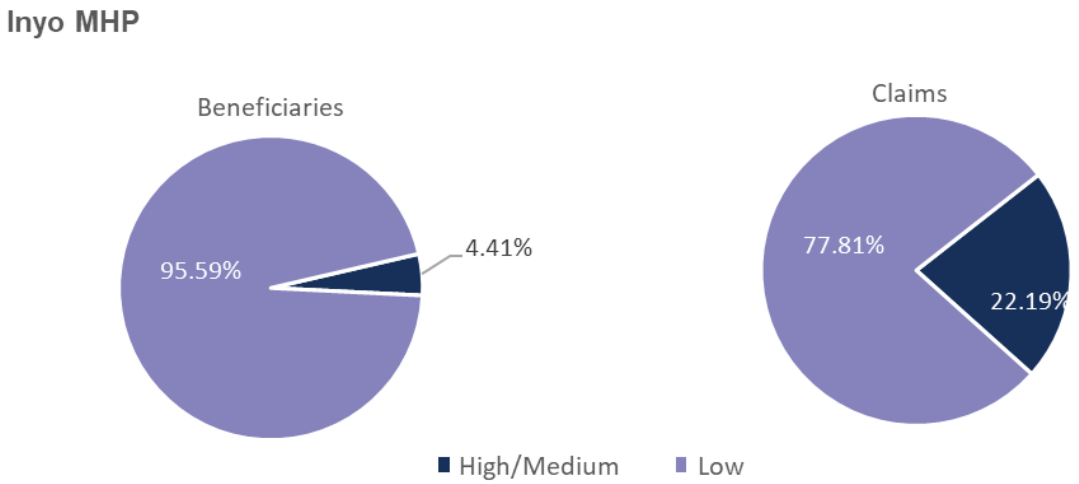
- Due to the MHP having <11 high-cost beneficiaries each year from CY 2019 to CY 2021, beneficiary counts were suppressed.
- The CY 2021 average approved claims per HCB was 25.5 percent less than the statewide average ($41,385 vs. $55,523.)

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	-	-		$24,271	$23,952
Low Cost (Less than $20K)	412	95.59%	77.81%	$1,977,540	$4,800	$2,610

- While low-cost beneficiaries comprised 95.59 percent of those served, 77.81 percent of approved claims dollars were spent on this subpopulation.

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



- High and medium cost beneficiary data are combined in this chart to allow for the suppression of high-cost beneficiary data.

IMPACT OF QUALITY FINDINGS

- More Inyo County beneficiaries receive a single service compared to the statewide average. A single service was provided to 14.85 percent of beneficiaries, 44.9 percent above the statewide rate of 10.25 percent. However, Inyo provides services for a transitory population that may receive a service and then leave the area all together. At the same time, fewer Inyo County beneficiaries receive more than 15 services compared to the statewide average. More than 15 services were provided to 33.18 percent of beneficiaries, 24.2 percent less than the statewide rate of 43.79 percent.
- While the MHP had no 7 or 30-day rehospitalizations in CY 2021, the 7-day post psychiatric inpatient follow-up rate declined 23.6 percent from CY 2020 to CY 2021 (35.71 percent vs. 27.27 percent) and the 30-day post psychiatric inpatient follow-up rate declined 9.1 percent from CY 2020 to CY 2021 (50.00 percent vs. 45.45 percent). This may indicate the MHP is struggling to engage and retain beneficiaries for services or if the beneficiaries even returned to the county and could warrant further investigation by the MHP.
- When looking at the QAPI plan, the MHP is unable to make system wide changes when there is little input from beneficiaries on the impact of the services they receive. Including beneficiaries' input on goals and participation within the QIC meetings could offer insight to services delivered.
- As reported by key informants the Bishop Wellness Center is a hub of activity for beneficiaries and prospectives, as the center grows in popularity there is little space to hold meetings, groups, and meals after often eaten standing up. It is reported that there is no noticeable identification for the center and no outside

shelter from the extreme elements within the county to hold meetings or activities outside. Though it may be unreasonable to move sites, key informants have suggested a concreate pad and overhead structure would greatly benefit services provided and received.

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

Date Completed: n/a

Aim Statement: n/a

Target Population: n/a

Status of PIP: The MHP's clinical PIP is in the no PIP submitted stage due to the significant staff vacancy, the MHP was unable to formulate a PIP and submit the required documentation.

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

TA and Recommendations

The MHP did not submit a clinical PIP, and therefore there is no clinical PIP validation rating.

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

- The MHP discussed access and timeliness standards as well as engagement and retention of beneficiaries when utilizing Auburn counseling services triage.
- The MHP is encouraged to continue TA with CalEQRO to finalize the required documentation for PIP formulation and approval to ensure an active PIP for the next review cycle.
- The director submitted the required letter as Exhibit E, identifying the lack of staffing needed to complete the clinical PIP documentation.

NON-CLINICAL PIP

General Information

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

Date Started: 09/2022

Date Completed: n/a

Aim Statement: “For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023.”

Target Population: “The target population for this project will be operationalized within the parameters of the HEDIS FUM metric. The MHP will focus on beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm, also referred to as “MH” or “MH conditions.”

Status of PIP: The MHP’s non-clinical PIP is in the baseline phase.

Summary

The MHP strives to increased multi-disciplinary team meetings between Northern Inyo Hospital ED staff and Inyo County Behavioral Health to improve crisis response, amend crisis response protocols, and track data to respond more effectively to patient needs. This includes broader recruitment practices for clinical staff, evaluate the on-call system and explore options with County Administration for alternative work schedules.

The performance measures will identify the percent of ED visits resulting in 7- and 30-day follow-up, the number of appointment reminder calls completed, the percent of beneficiaries who received care coordination and reported their needs were met and the percent of ED staff who reported satisfaction with the care coordination with the MHP. The primary outcome measure is the percentage of ED visits for MH where the beneficiary received a follow up MH treatment service from the MHP within 7 or 30 days (FUM).

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the MHP has initiated conversations with the local hospitals to improve response times and are beginning to identify areas of shared interest as it pertains to follow-up services. The MHP is working to stay in “constant contact” with the hospitals to ensure the hospitals do not feel they are left “holding the bag”, and keeping the lines of communication open and fluid as each entity maneuvers the CalAim requirements.

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

- Assist the hospitals in identifying their shared responsibility and create an MOU to assist in outlining specific expectations for the MHP and local hospitals.
- Continue to build a culture of communication and identify shared data to improve FUM.
- Continue with ongoing CalEQRO TA as challenges arise with implementing the non-clinical PIP.
- Identify base-line metrics and outcomes to address within the suggested performance measures.

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 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 Qualifacts/Credible, which has been in use for less than one year. Currently, the MHP is actively implementing this new system with the assistance of Kings View.

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

The MHP has 41 named users with log-on authority to the EHR, including approximately 39 county staff and 2 contractor staff. Support for the users is provided by 0.5 FTE IS technology positions. Currently, all positions are filled. Additional IT support is provided by Kings View and Qualifacts. Credible implementation and reporting support is provided by Kings View. The Credible system is hosted by Qualifacts.

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. The MHP does not have a PHR. This functionality is expected to be implemented within the next two years.

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 and/or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Northern Inyo Healthcare District Hospital, Rural Health Clinic –Bishop, and 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	Met
4E	Security and Controls	Partially Met
4F	Interoperability	Met

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

- The MHP migrated from Cerner Community Behavioral Health to the cloud-based Credible system in January 2023. The system is hosted by Qualifacts. Kings View provides additional operational and reporting support.
- Ninety-five percent of services are provided by county operated clinics and 5 percent by contract providers. Contract providers have full access to Credible for the entry of both service data and clinical information.
- Internal analytic support is provided by 1.5 county FTEs: 3 administrative analysts (1.25 FTEs total) and a Program Integrity and Quality Assurance Manager (0.25 FTE with this position having been vacated in March 2023). Microsoft and Tableau are utilized for internal analytics. Additional reporting and analytic support is provided by Kings View.
- Security training is included in the employee onboarding process as well as annually for existing staff. Security tip emails are provided to staff monthly. In the event of a specific identified risk, additional email notifications are provided to enhance staff awareness of the identified threat. Faux phishing emails were utilized at least once monthly in the past year to assist in the identification of staff who required refresher cyber security training.
- The MHP's CY 2021 denied claims rate of 0.63 percent is less than half the CY 2021 statewide average of 1.43 percent.
- An operations continuity plan for critical business functions has not been developed.
- The MHP does not maintain a data warehouse that replicates the Credible system to support internal data analysis.

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.

The MHP reports that claiming is current through January 2023. The MHP reported that the February and March claims will be submitted in May 2023. The MHP implemented the new Credible system in January 2023 and were reviewing and validating billing codes and Credible processes from January through March 2023.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	667	$219,685	$76	0.03%	$213,813
Feb	702	$241,053	$345	0.14%	$234,369
Mar	866	$300,697	$0	0.00%	$290,996
April	721	$270,771	$0	0.00%	$262,663
May	541	$206,639	$0	0.00%	$203,102
June	629	$231,046	$0	0.00%	$226,176
July	505	$225,733	$0	0.00%	$219,508
Aug	550	$205,578	$44	0.02%	$201,193
Sept	540	$185,470	$0	0.00%	$180,245
Oct	427	$149,555	$0	0.00%	$146,895
Nov	446	$169,418	$14,774	8.72%	$151,837
Dec	469	$180,013	$1,084	0.60%	$175,300
Total	**7,063**	**$2,585,658**	**$16,323**	**0.63%**	**$2,506,097**

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

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible or non-covered charges	3	$14,118	86.49%
Medicare Part B must be billed before submission of claim	2	$1,037	6.35%
Other healthcare coverage must be billed before submission of claim	1	$703	4.31%
Late claim	6	$465	2.85%
Total Denied Claims	**12**	**$16,323**	**100.00%**
Overall Denied Claims Rate	**0.63%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- Claims with denial codes Medicare Part B or other health coverage must be billed prior to the submission of this claim and Other health coverage must be billed before submission of this claim are generally rebillable within State guidelines upon successful remediation of the reason for denial.
- The claim denial rate for CY 2021 of 0.63 percent is much lower than the statewide rate of 1.43 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The support provided by the operation of Credible in an ASP environment, with Qualifacts hosting the system and Kings View providing additional operational support will provide operational stability to the system and is a strength for the MHP.
- The CANS and PSC-35 tools are available electronically; however, aggregate reporting for these tools was not available.
- The development of an operations continuity plan for critical business functions could help to restore order and eliminate confusion in the event of a cyber-attack, natural disaster, or other emergency.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP distributed the state provided CPS. Due to the limited responses the MHP was unable to adequately determine specific improvements. They did, however, take one suggestion as provided by the CPS to address the continuity of care when a clinician resigns or goes on leave. The MHP is working to reduce clinician burn-out and provide case manager connection to the beneficiary when a clinician leaves unexpectedly. The MHP also informed the local hospitals that individuals who ended up in the ED after hours would be assessed by clinicians, during normal work hours. This has improved clinician burn-out by offering the limited staff an opportunity to sleep at night. In addition, due to the large number of drug-induced psychosis, this has given the individuals who enter the ED after hours an opportunity to first receive appropriate medical care.

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 their family members, containing 8 to 10 participants.

Consumer Family Member Focus Group One

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

Overall, the group was satisfied with the services they received. They all agreed the wait time for services and access to the Progress house was relatively short and often upon immediate release from the hospital. They also identified they received a referral while still in the hospital which made the transition seamless. The group described

receiving text or phone call reminders and though the group did not require interpretative services they all knew of two bi-lingual staff members. All group members agreed that staff, counsellors, therapists, and Psychiatrists, all assist in connecting patients with a Primary Care Physician, Dental, and applicable specialists, arranging appointments and even providing transportation when necessary. One challenge with transportation was accessing bus passes, as many had been waiting for months for a new bus pass. The group was also very complementary of the case managers.

Recommendations from focus group participants included:

- More outdoor walks, physical activities.
- Provide another car for Wellness Center staff.
- Provide a staff appreciate day for Wellness Center staff.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall, the key informants were satisfied with their services. It was apparent that most saw their case managers and psychiatrists over clinicians. Both Wellness Centers seemed to be utilized and appreciated by the group. It was mentioned that several would like to become involved in paid or non-paid peer-related activities within the MHP. There was also the desire to have outdoor activities at the Bishop Wellness Center, but currently there is no shelter, concrete pad, or outside seating.

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. Case managers are utilized to assist in stabilizing beneficiaries in the community, for transportation needs, emergency department and jail setting as part of beneficiary discharge planning and field-based face-to-face services. (Access, Timeliness, Quality)
2. Video telehealth services are used more often than telephone only services, offering opportunities for beneficiaries and clinicians to view each other for a more engaging and collaborative relationship. (Timeliness, Quality)
3. The MHP provides services for a large transitory population that often uses the Wellness Center for mental health resources and stabilization, receiving food, showers, and a place to launder clothes, as well as Medi-Cal benefit information. (Access, Quality)
4. The MHP had a zero percent Psychiatric Inpatient Readmission Rate, due to the intensive outpatient services provided to stabilize beneficiaries in the community. (Timeliness, Quality)
5. The support provided by the operation of Credible in an ASP environment, with Qualifacts hosting the system and Kings View providing additional operational support will provide operational stability to the new EHR system. (Quality, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP has been involved in several unexpected crisis situations including the COVID-19 pandemic, the atmospheric river which created access issues due to snow fall and faces impending flooding due to the unpredicted snow melt. Currently the MHP does not have a developed operations continuity plan to pre-plan for such incidents. (Access, IS)
2. The MHP was able to address the non-clinical PIP within the required BHQIC-PIP, but due to a significant staffing shortage was unable to adequately document the clinical PIP in the PIP Development Tool for the required validation. (PIP)
3. As reported by key informants, the Bishop Wellness Center lacks easily identifiable signage for access and adequate space to hold group meetings or meals, leaving participants to stand while eating. The space does not offer the

ability to be sheltered when outdoors in inclement weather, including excessive heat or snow. (Quality)

4. Timeliness to service for children/youth and FC beneficiaries is not consistently tracked. For each of the timeliness metrics tracked, disaggregate and track children/youth and FC beneficiary timeliness to determine if there are specific timeliness challenges for these individual groups. (Timeliness)
5. Factors including COVID-19 and Immigration and Customs Enforcement created an environment of fear among the threshold monolingual Spanish speaking community. Many Spanish speaking community members seek mental health advice within their place of worship. (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 an operations continuity plan for critical business functions that is maintained in readiness for use and tested annually in the event of a cyber-attack, natural disaster, or other emergency. (Access, IS)
2. Continue to develop a clinical PIP and access CalEQRO TA to accurately provide the required clinical PIP documentation for validation. (PIP)

   (This recommendation is a carry-over from FY 2020-21 and partial carry-over from FY 2022-23)
3. Investigate the ability to provide a covered outdoor area at the Bishop Wellness Center to accommodate participant overflow and outdoor activities; and provide adequate signage to allow for ease of identification of the center's location. (Quality)
4. Track children/youth and FC beneficiary timeliness and disaggregate data to identify specific timeliness challenges for these groups; and review procedures and practices for monitoring timeliness to services and implement a process that ensures completeness, accuracy, and meaningfulness of the data for this group. (Timeliness)
5. Create outreach and access opportunities by partnering with places most frequented, of worship, or shopping that specifically address the needs of the monolingual Spanish speaking community. (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. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process. In addition, the MHP faced severe and inclement weather, snowstorms, rain, power outages, and road closures.

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

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Kiran Sahota, Lead Quality Reviewer
Lisa Farrell, Information Systems Reviewer
Katie Faires, Consumer Family Member Review

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.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Baez	Maricela	Administrative Analyst	HHS
Bengochia	Lori	Innovation & Grant Manager	HHS
Cataldo	Ralph	Administrative Analyst	HHS
De La Riva	Vivian	Case Manager – Wellness Center (WC)	HHS-Behavioral Health
DeHaven	Brandon	Peer Supporter - WC	HHS-Behavioral Health
Fregoso	Liliana	Case Manager A-Par WC	HHS-Behavioral Health
Gastelum	Perla	Clinician	HHS-Behavioral Health
Hendricks	Kurt	Administrative Analyst	HHS-Behavioral Health
Kalin	Mark	Clinician	HHS-Behavioral Health
McKinzey	Gina	MHSA Coordinator	HHS-Behavioral Health
Milos	Skye	Clinician	HHS-Behavioral Health
Morales	Araceli	Case Manager - WC	HHS-Behavioral Health
Paquette	Katharine	Rehab Specialist - WC	HHS-Behavioral Health
Pier	Kimball	Deputy Director	HHS-Behavioral Health
Pope	Chrystina	Clinical Administrator	HHS-Behavioral Health
Renda	Serena	MFT Trainee/volunteer	HHS-Behavioral Health
Ruggio	Vanessa	Wellness Center Supervisor	HHS-Behavioral Health
Taylor	Courtney	Parent Partner - FIRST	HHS-Behavioral Health
Trunnell	Lisa	Case Manager - WC	HHS-Behavioral Health
Veenker	Jody	FIRST Supervisor	HHS-Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Vincent	Lucy	Administrative Secretary	HHS-Behavioral Health

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 discussed the proposed clinical-PIP of access and timeliness standards as well as engagement and retention of beneficiaries when utilizing Auburn counseling services triage. •The MHP is encouraged to continue TA with CalEQRO to finalize the required documentation for PIP formulation and approval to ensure an active PIP for the next review cycle. •The director submitted the required letter as Exhibit E, identifying the lack of staffing needed to complete the clinical PIP documentation.

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	MHP has initiated conversations with the local hospitals to improve response times and are beginning to identify areas of shared interest as it pertains to follow-up services. The MHP is working to stay in "constant contact" with the hospitals to ensure the hospitals do not feel they are left "holding the bag", and keeping the lines of communication open and fluid as each entity maneuvers the CalAim requirements for improved beneficiary care.

General PIP Information
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: Inyo
PIP Title: "Follow-Up After Emergency Department Visit for Mental Illness (FUM)"
PIP Aim Statement: "For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7- and 30-days by five percent by June 30, 2023."
Date Started: 09/2022
Date Completed: n/a
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): "The target population for this project will be operationalized within the parameters of the HEDIS FUM metric. The MHP will focus on beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm, also referred to as "MH" or "MH conditions."

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) n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Hospitals will provide timely referral and Treatment Authorization Request (TAR) data to MHP for those that leave hospitalization for follow up by the MHP. Identify claims data and/or referral source.
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) MHP will work with local hospitals to improve communication to receive timely TARs for beneficiaries receiving MH services within the hospital setting.

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
Percent of ED visits resulting in 7- and 30-day follow-up	2021	7-day 70% 30-day 76%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of appointment reminder calls completed	2023		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percent of beneficiaries who received care coordination and reported their needs were met	2023		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of ED staff who reported satisfaction with the care coordination with the MHP	2023		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- Assist the hospitals in identifying their shared responsibility and create an MOU to assist in outlining specific expectations for the MHP and local hospitals.
- Continue to build a culture of communication and identify shared data to improve FUM.

PIP Validation Information
• Continue with ongoing CalEQRO TA as challenges arise with implementing the non-clinical PIP. • Identify base-line metrics and outcomes to address within the suggested performance measures.

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: LETTERS FROM MHP DIRECTOR

County of Inyo

HEALTH & HUMAN SERVICES DEPARTMENT

Behavioral Health- Mental Health, Progress House, Wellness Centers and Substance Use Disorders, Suite 124
1360 N. Main Street, Bishop CA 93514
TEL: (760) 873-7868 FAX: (760) 873-7800

Marilyn Mann, Director
mmann@inyocounty.us

April 12, 2023

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

Dear Samantha,

Inyo County is requesting flexibility during the FY 2022-23 EQRO review. Specifically, Inyo County cannot present both a clinical and non-clinical Performance Improvement Project (PIP) during the FY 2022-23 review due to the following:

X Lack of staff/resources
X Lack of infrastructure
X Additional factors – Need more time to gather outcomes data

Inyo County will be able to provide an outline of the clinical and non-clinical PIP. Please attach this letter to our FY 2022-23 annual report.

Sincerely,

Kimball Pier

Kimball C. Pier, Ph.D., LMFT
Deputy Director, Inyo County Behavioral Health Services
Title of Director

Strengthening Resilience & Well-Being in Our Community

County of Inyo

HEALTH & HUMAN SERVICES DEPARTMENT

Behavioral Health- Mental Health, Progress House, Wellness Centers and Substance Use Disorders, Suite 124
1360 N. Main Street, Bishop CA 93514
TEL: (760) 873-7868 FAX: (760) 873-7800

Marilyn Mann, Director
mmann@inyocounty.us

April 27, 2023

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

Dear Samantha,

As a follow-up to my letter dated April 12th, 2023, Inyo County completed the EQRO review as scheduled on April 19th. We have a clinical PIP in process, however, due to numerous staff vacancies, the template was not completed. The PIP is active and will be completed in the next review cycle.

Please contact me if you need further information.

Sincerely,

Kimball Pier

Kimball C. Pier, Ph.D., LMFT
Deputy Director, Inyo County Behavioral Health Services
Title of Director

Strengthening Resilience & Well-Being in Our Community