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

LASSEN FINAL REPORT

MHP

DMC-ODS

Prepared for:

**California Department of Health Care
Services (DHCS)**

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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, “Lassen” may be used to identify the Lassen County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — May 11, 2023

MHP Size — Small-rural

MHP Region — Superior

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	0	5	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	2	2	0
Timeliness of Care	6	3	3	0
Quality of Care	10	2	8	0
Information Systems (IS)	6	4	1	1
TOTAL	26	11	14	1

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Integration of Clinical Contact between Registration and Assessment to Improve Assessment Retention Rate	Clinical	02/2020	Second remeasurement	Moderate
Implementation of New Substance Use Disorder (SUD) Screening Tool	Non-Clinical	02/2020	Second remeasurement	Low

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	<input checked="" type="checkbox"/> Adults <input type="checkbox"/> Transition Aged Youth (TAY) <input type="checkbox"/> Family Members <input type="checkbox"/> Other	4

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

1. Lassen’s PR (7.87 percent) was higher than statewide (4.34 percent) and similar sized counties (7.08 percent).
2. The MHP deployed GrandCare portable units allowing beneficiaries to receive services via telehealth throughout the PHE and beyond.
3. The MHP tracks timeliness measures and meets most standards consistently.
4. Lassen uses therapeutic drug testing — mouth swab to determine the best medication for each consumer.
5. The MHP has two analysts on staff now, and one is a new position that was added to support implementation of CalAIM initiatives.

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

1. Lassen hand-tabulates some data and is not yet trending results for identifying QI initiatives.
2. The MHP has limited peer support staff and as a result, wellness centers in the outlying areas had to close.
3. Lassen hand tracks FC youth results and uses a spreadsheet to track follow-ups.
4. Consumers in crisis are directed to go to the local six-bed ED. The MHP is not tracking and trending services received in the ED and consumers transitioning out of crisis.
5. Transportation services continue to pose challenges and currently there are barriers to utilizing the MCP transportation benefit.

Recommendations for improvement based upon this review include:

1. Routinely pull automated reports for monitoring, tracking, and trending of data and implement QI initiatives to address areas of concern, including for FC youth.
2. Improve the number, retention, and career opportunities of peer support staff and ensure that the wellness centers can remain open.
3. Monitor, track, and trend data for consumers receiving crisis services in the ED and initiate QI activities to address areas of concern.
4. Improve transportation services for consumers and resolve challenges with the transportation vendor.
5. Contact CalEQRO for technical assistance prior to the next annual review to discuss plans for the clinical and non-clinical PIPs.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

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

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

This report presents the FY 2022-23 findings of the EQR for Lassen County MHP by BHC, conducted as a virtual review on May 11, 2023.

REVIEW METHODOLOGY

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

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

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 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 network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of 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 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 at the end of the public health emergency for the Coronavirus Disease 2019 (COVID-19) pandemic. Lassen reported that in 2022 it was coming out of the effects of the Dixie and Beckwourth Fires. The MHP also lost key staff including the Behavioral Health Nurse/QI Member who passed away, Compliance Officer for Health and Social Services (no replacement yet), and two therapists — one retiring after 15 years with the MHP. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

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.

- Replaced the prior Electronic Health Record (EHR) on November 1, 2022, with Kingsview Cerner and no billing was completed from February 1, 2022, through October 31, 2022. Lassen has hired two analysts who hand-entered all the claims through Cerner.
- Established a Memorandum of Understanding for data sharing with the MCP and added a contract with SacValley MedShare for Health Information Exchange (HIE) to start July 1, 2023.
- Experienced difficulties with the most recent MCP transportation provider whose contract was terminated April 2023. The MHP is providing transportation services and attempting to resolve the challenges with the MCP transportation vendor system.
- Closed the Big Valley and Fort Sage Wellness Centers temporarily due to lack of peer support staff. Westwood Wellness Center was operational with limited staff.
- Approved for Enhanced Case Management services through the managed care system.
- Request for Proposal (RFP) for Therapeutic FC and received no response (second time).

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: Identify a geographic and demographic plan for outreach and engagement activities, especially for underserved populations. Conduct data tracking and evaluation of outreach activities and initiate QI activities when warranted to address where there has been lack of services.

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

Addressed

Partially Addressed

Not Addressed

- Lassen partially met this recommendation. The MHP's PR was higher than statewide and in similar sized counties. Lassen should track the availability and delivery of services in satellite areas for underserved populations and conduct additional outreach, if needed.
- Lassen's barriers included staffing changes (i.e., death, resignation, retirement, new hires) and difficulty keeping peer support staff, especially for the wellness centers.
- This recommendation will not carry over to next year's EQR. Based on the PR, it appears that Lassen is providing ample services to its entire eligible population; however, further tracking and trending of data for the underserved areas would confirm this.

Recommendation 2: Prioritize consistency, accuracy, completeness, and orderliness of data entry processes and content to produce well-founded timeliness reports; this will assist the MHP with making data-driven improvements.

(This recommendation is a carry-over from FY 2017-18, FY 2018-19, FY 2019-20, and FY 2020-21.)

Addressed Partially Addressed Not Addressed

- Lassen partially met this recommendation. The MHP reported its two analysts on staff now are consistently tracking monthly timeliness reports; however, they are not yet trending the data. Additionally, Lassen still hand-tabulates some results.
- Lassen’s barriers included a new EHR system in February 2022 that did not meet the organization’s needs, a subsequent EHR system implemented in November 2022, and another new EHR system planned to start in July 2023. The MHP had not billed any services from February 2022 to October 2022 and Lassen’s analysts needed considerable time to complete the billing.
- This recommendation will not carry over to next year’s EQR because Lassen is transitioning to a new EHR and HIE in 2023. The MHP will have the ability and plans to pull reports from the system for tracking and trending.

Recommendation 3: Engage in meaningful dialogue and consensus building to ensure all key players, both internal DHCS/CWDA staff and external stakeholders, have an opportunity to provide feedback and perspectives to inform a uniform and agreed upon approach to address the unique and complex mental health care needs of FC youth in Lassen County.

(This recommendation is a carry-over from FY 2017-18, FY 2018 19, FY 2019-20, and FY 2020-21.)

Addressed Partially Addressed Not Addressed

- Lassen partially met this recommendation. The MHP participates in monthly interagency meetings regarding the welfare of children in Lassen County, including FC youth. Lassen’s Assessment of Timely Access reported FC data this year whereas it did not in the prior year. However, the MHP’s FC PR has been consistently lower (22.02 percent) than statewide (49.15 percent) and similar sized counties (42.49 percent) from 2019 to 2021.
- The MHP reported an informal process for beneficiaries to provide feedback/input.
- Lassen’s barriers included receiving no responses for a Therapeutic FC RFP.
- This recommendation will not carry over to next year’s review in its entirety. CalEQRO will include a new recommendation pertaining to FC youth.

Recommendation 4: Investigate barriers to providing adults, children, and FC youth with a comprehensive range of treatment options from most to least restrictive; implement creative QI activities to address capacity challenges contributing to the situation.

Addressed

Partially Addressed

Not Addressed

- Lassen partially met this recommendation. The MHP has investigated barriers; however, there are still opportunities for a comprehensive range of treatment options. The MHP's crisis flow includes sending beneficiaries to the local hospital which has limited capacity and services for behavioral health treatment.
- For FC youth, the MHP reported it is working to accurately track and provide services and there are multiple avenues in which FC youth can obtain services. Therefore, participation in services at Lassen is lower than the overall population would indicate.
- Lassen reported its most significant barrier pertains to the homeless population and those living in distant/underserved areas. With reliable transportation being an issue, the MHP is working to ensure that all qualifying individuals have access to services.
- This recommendation will not carry over to next year's review in its entirety. CalEQRO will include a new recommendation pertaining to Lassen's crisis services.

Recommendation 5: Establish standardized expectations for all clinicians, as well as up-to-date policies and procedures, for regular administration and evaluation of all level of care (LOC) outcome tools to measure, monitor, and guide clinical treatment of all beneficiaries.

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

Addressed

Partially Addressed

Not Addressed

- Lassen partially met this recommendation. The MHP reported it uses the Adult Needs and Strengths Assessment (ANSA) tool, Children and Adolescent Needs and Strengths (CANS) assessment, and Pediatric Symptoms Checklist (PSC-35). However, the tools appeared to be used for outcomes and not LOC.
- The MHP reported in 2023 it will be utilizing the Daily Living Activities-20 (DLA-20) standardized outcome tool to begin tracking outcome metrics.
- Lassen reported tracking of the tools has been consistent in 2023 and going forward, it will conduct quarterly aggregate analysis and reports. The MHP should include how it utilizes the tools to transition individuals' LOC.

- This recommendation will not carry over to next year’s review. The MHP is using standardized outcomes tools, has begun tracking outcome metrics, and plans to conduct aggregate analysis and reports.

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 county-operated providers in the MHP. Regardless of payment source, approximately 100 percent of services were delivered by county-operated/staffed clinics and sites. Overall, approximately 85 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week that is operated by county staff during business hours. The Crisis Support Services of Alameda County contracts with the MHP to operate the NightWatch crisis line during non-business hours. During non-business hours, county staff are on call and respond immediately to beneficiaries in crisis that are referred by the NightWatch crisis workers. Beneficiaries may request services through the access line as well as through the following system entry points: clinic walk-in; Partnership Health Plan of California (PHPC); Beacon Health Options (BHO); local law enforcement and probation; Lassen Community College (LCC); the court system; Lassen County Office of Education (LCOE); community agencies and CFS; Banner Lassen Medical Center (BLMC); and caregivers.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 315 adult beneficiaries, 83 youth beneficiaries, and 46 older adult beneficiaries at one county-operated site. Among those served, zero

¹ [CMS Data Navigator Glossary of Terms](#)

beneficiaries received telehealth services in a language other than English in the preceding 12 months.

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 Lassen 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

- The MHP can provide necessary services to a beneficiary within time and distance standards.

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	Partially 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:

- Lassen has a cultural competence plan, focuses on the LGBTQ community, and outreaches the homeless. Lassen continues to provide GrandCare units for telehealth to ensure that beneficiaries can still receive services if they are unable to go in person. The MHP collaborates with stakeholders and participates in interagency meetings regarding the welfare of children and youth in the county.
- For 1A, Lassen does not have a cultural competency committee or coordinator. The MHP did not provide evaluation and outcomes of strategies to address the cultural needs of its beneficiaries.
- For 1B, Lassen has a limited mobile crisis response and beneficiaries in crisis are directed to go to the local six-bed Emergency Department (ED). Beneficiaries may need to travel for hours for inpatient psychiatric services. The MHP does not formally monitor, track, and trend its crisis service delivery system. Lassen should provide data and evaluation of strategies to meet beneficiary crisis needs.

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, Lassen demonstrates better access to care than was seen statewide.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	8,843	696	7.87%	\$1,323,481	\$1,902
CY 2020	8,095	699	8.63%	\$1,385,510	\$1,982
CY 2019	7,839	868	11.07%	\$2,237,849	\$2,578

*Total Annual eligibles may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The number of eligibles has been trending upwards over the past three CYs. Beneficiaries served, total approved claims, and AACB were slightly lower in CY 2021 than CY 2020, after larger decreases from CY 2019 to CY 2020. Total PR has been trending downwards over the past three years.

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	1,044	17	1.63%	1.71%	1.96%
Ages 6-17	1,919	127	6.62%	8.65%	5.93%
Ages 18-20	401	36	8.98%	7.76%	4.41%
Ages 21-64	4,708	480	10.20%	8.00%	4.56%
Ages 65+	772	36	4.66%	3.73%	1.95%
Total	8,843	696	7.87%	7.08%	4.34%

*Total Annual eligibles may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The largest eligibility group by age in Lassen was adults aged 21-64, followed by youth ages 6-17. These were also the groups with the largest numbers of beneficiaries served.

- The PRs in all of the age categories other than 0-5 were higher than statewide. The highest PR was for the 21-64 age group, followed by TAY (ages 18-20). Total PR was higher in the MHP than statewide and in similar sized counties.

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

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

- There were no threshold languages in the MHP for CY 2021.

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	2,354	208	8.84%	\$316,784	\$1,523
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. In Lassen, this pattern held true for AACB but the PR for the ACA eligibility group was higher than the total PR.
- PR for ACA eligibles in the MHP was higher than in similarly sized counties and statewide, whereas AACB was much lower than in similarly sized counties and statewide.

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.

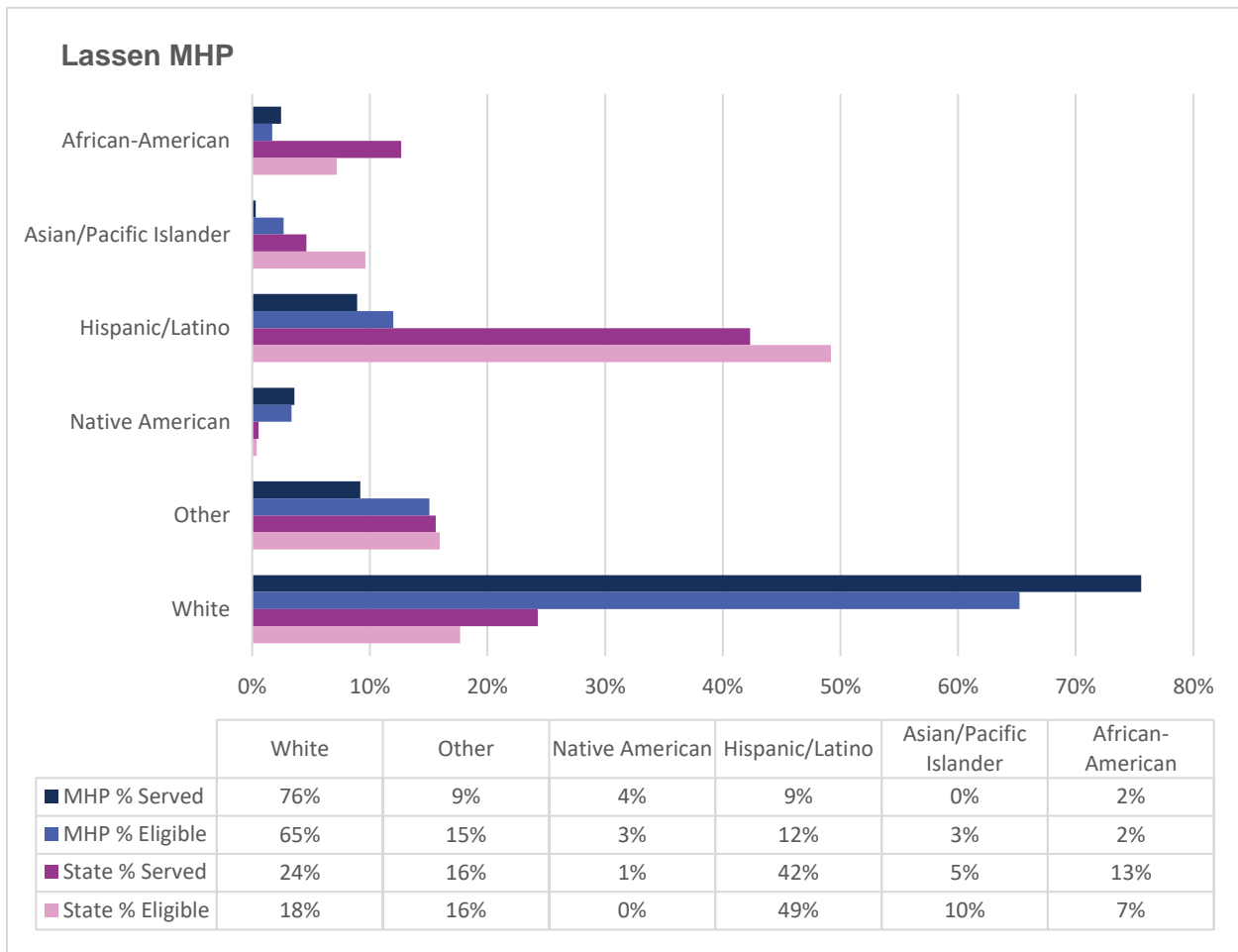
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	151	-	-	7.64%
Asian/Pacific Islander	237	<11	-	2.08%
Hispanic/Latino	1,060	62	5.85%	3.74%
Native American	296	25	8.45%	6.33%
Other	1,333	64	4.80%	4.25%
White	5,768	526	9.12%	5.96%
Total	8,845	696	7.87%	4.34%

*Total Annual eligibles may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The largest racial/ethnic group of eligibles was White, followed by Other and Hispanic/Latino. Whites were, by far, the largest group of beneficiaries served.
- PRs were higher than the statewide PRs for all racial/ethnic groups whose data were not suppressed due to low ns.

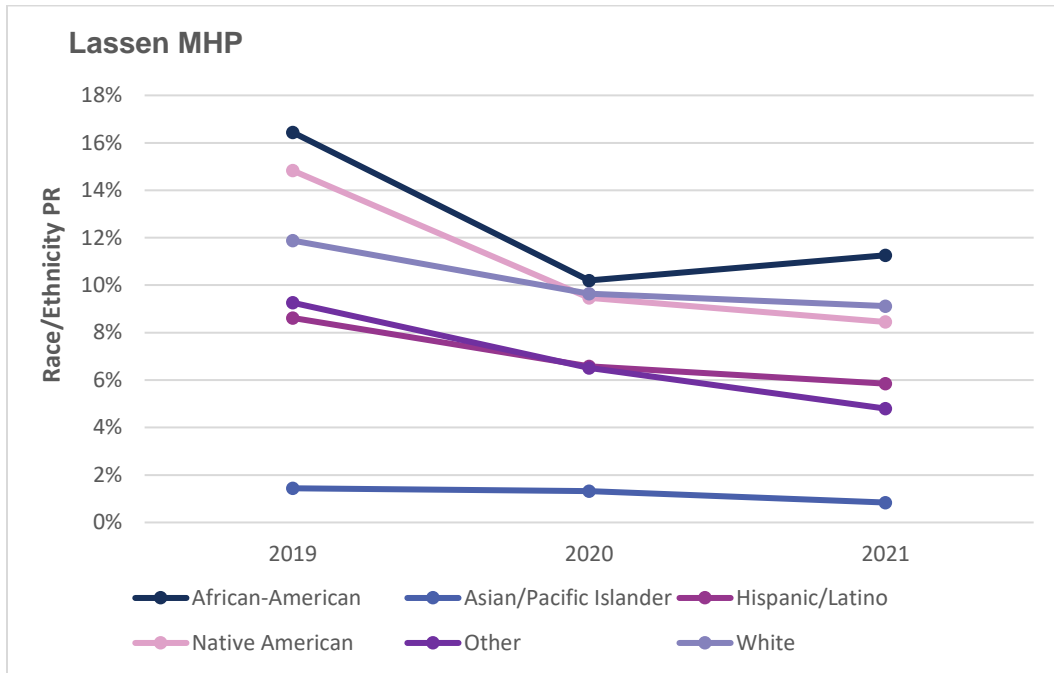
Figure 1: Race/Ethnicity for MHP Compared to State CY 2021



- The county had a much higher proportion of White eligibles, and much lower proportion of Hispanic/Latino eligibles, than the state as a whole.
- The most proportionally overrepresented racial/ethnic group in the MHP was White, and the most proportionally underrepresented group was Other, followed by Hispanic/Latino.

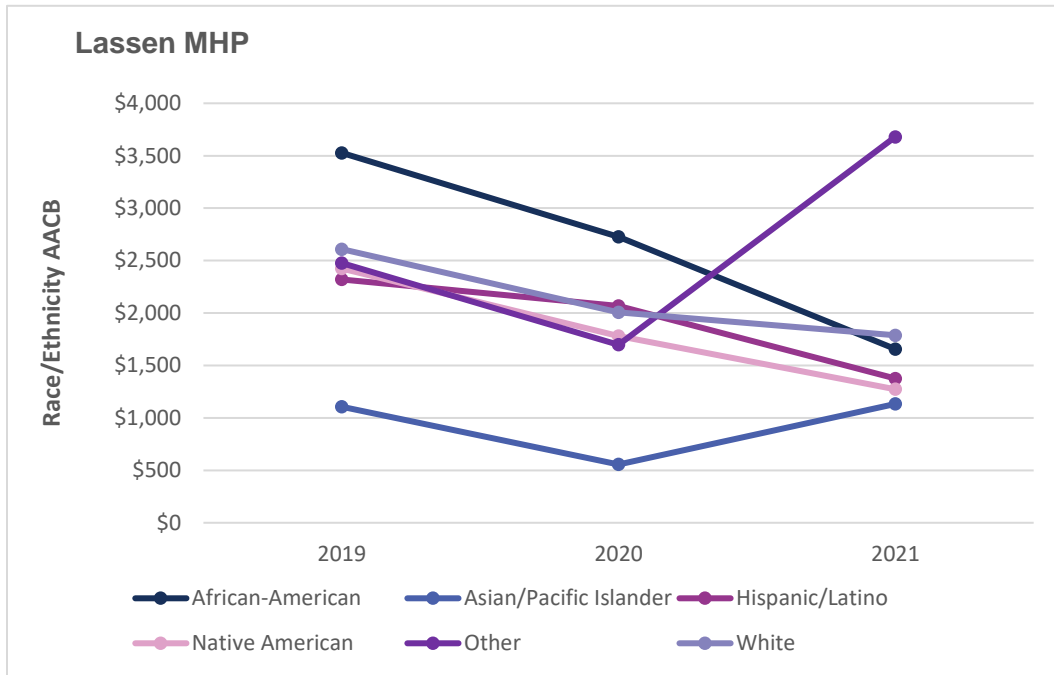
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



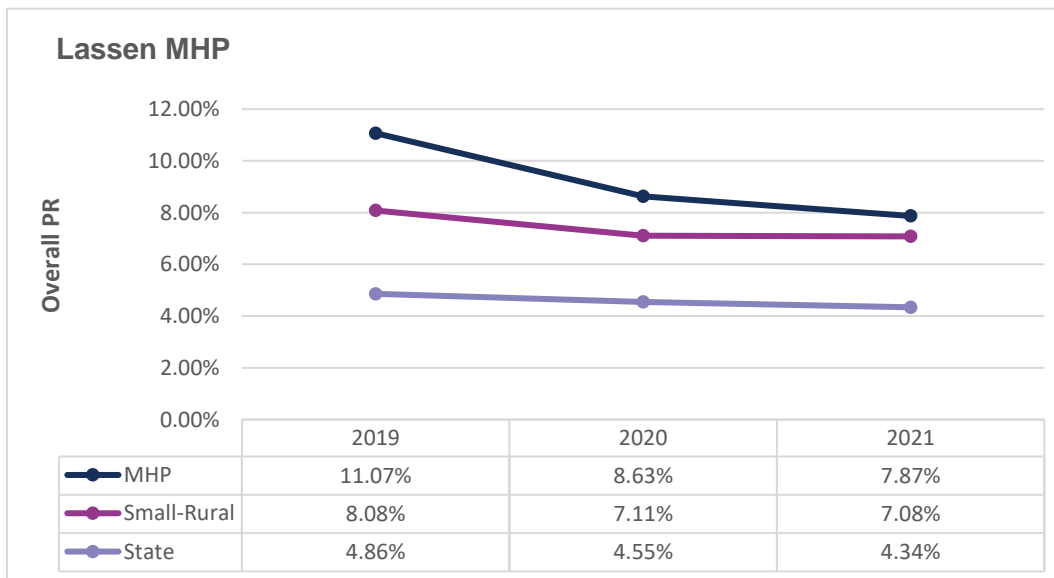
- PRs for most racial/ethnic groups have been trending downwards over the past three years. PRs for Native Americans, African Americans, and Whites have consistently been the highest, whereas PRs for Asians/Pacific Islanders have consistently been lowest in the county.

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



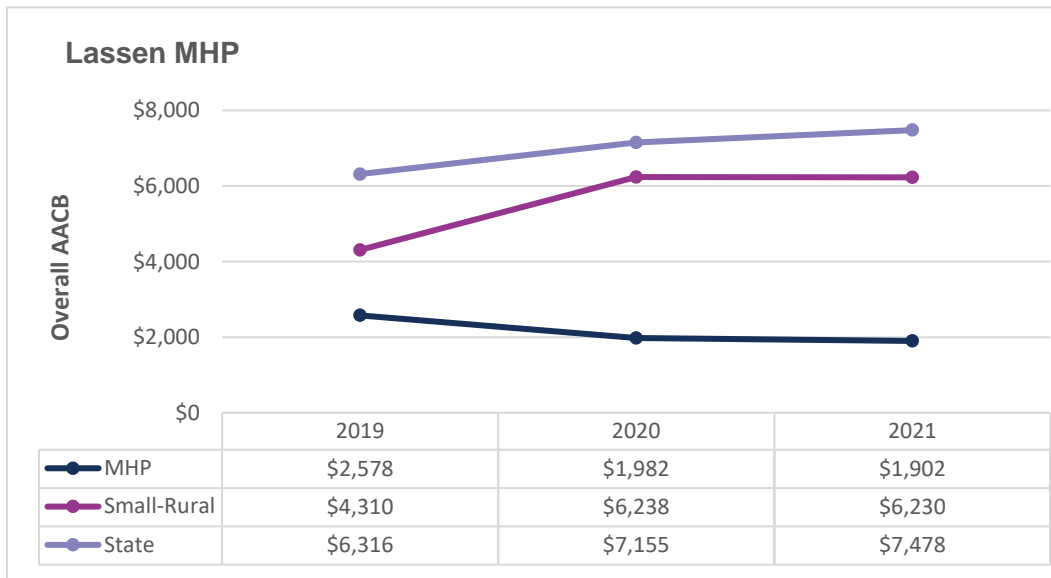
- AACBs across racial/ethnic groups were generally lower for CY 2021 than they were in CY 2019, with the exception of the Other category and Asian/Pacific Islander population. Some groups' shifts could be due to a small number of outliers, however, because the n for several groups were quite small (Asian/Pacific Islander, African-Americans, Native Americans).

Figure 4: Overall PR CY 2019-21



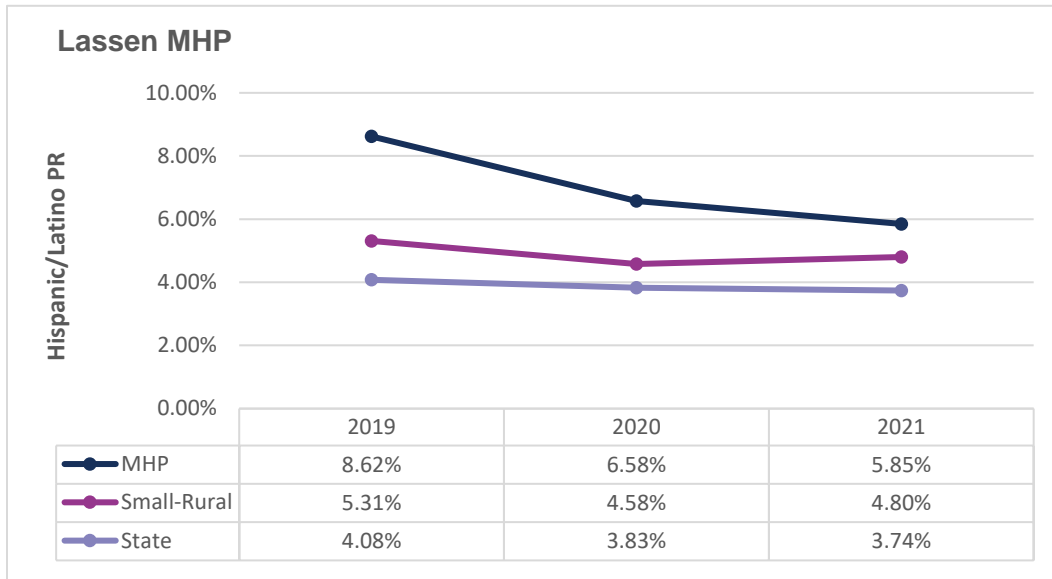
- Over the past 3 years PR has been trending downward in the MHP, similar sized counties, and statewide. The MHP's PR has been consistently higher than in similarly sized counties and statewide, though the gap has been narrowing.

Figure 5: Overall AACB CY 2019-21



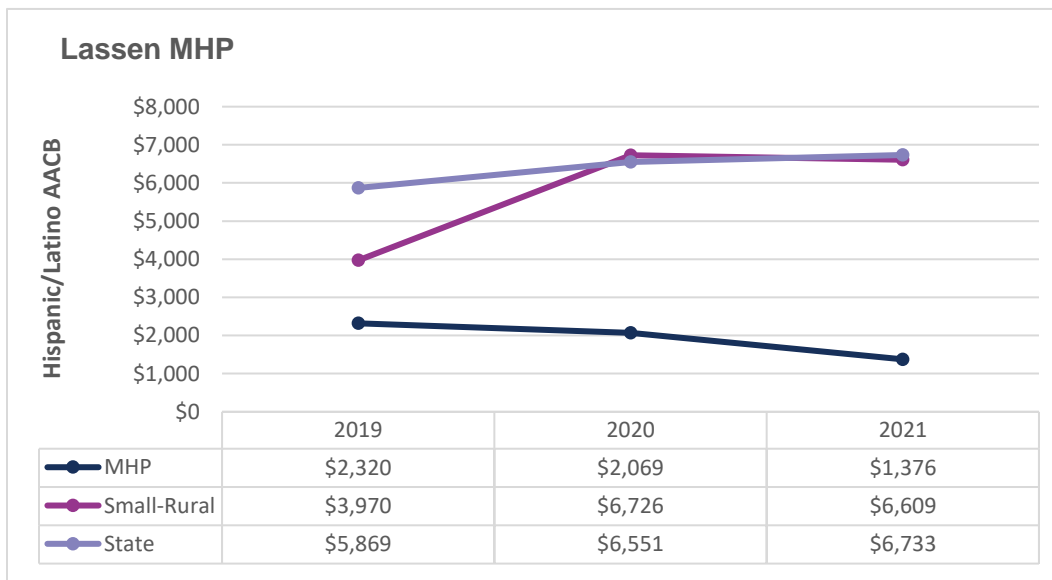
- AACB trended downwards over the past three years in the MHP, whereas it has trended upwards in similar sized counties and statewide.
- AACB has been consistently lower in the MHP than in other similar sized counties and statewide, and the gap has been widening. For CY 2021, AACB in Lassen was less than one-third that of similar sized county AACB, and about one-quarter of the statewide AACB.

Figure 6: Hispanic/Latino PR CY 2019-21



- Hispanic/Latino PR has been decreasing since CY 2019, though the MHP has consistently had higher PRs than similar sized counties and the state as a whole for this population. The gaps between the MHP and similar sized counties and statewide PRs have been narrowing over time.

Figure 7: Hispanic/Latino AACB CY 2019-21



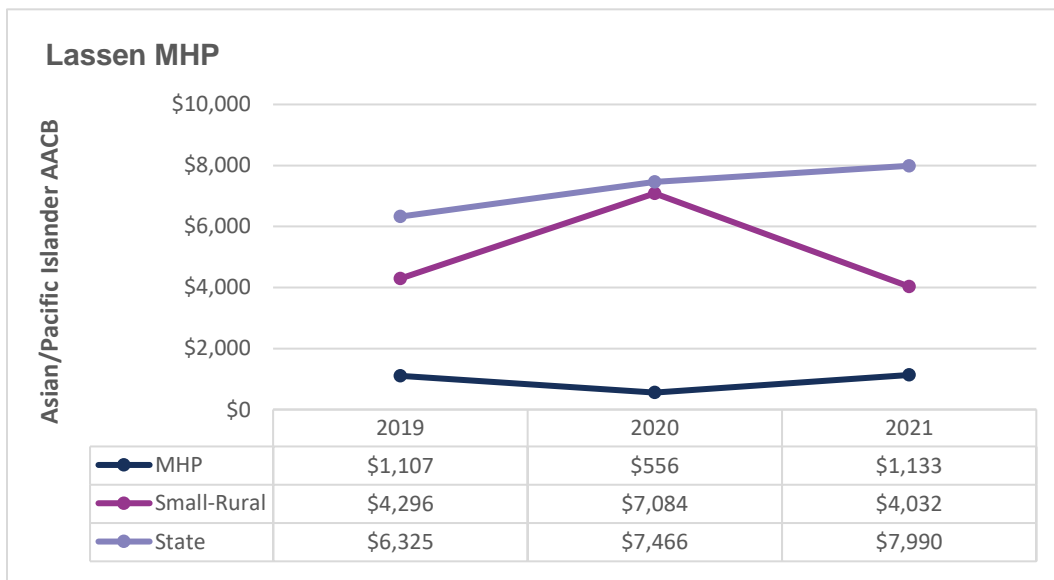
- AACB for Hispanic/Latino beneficiaries has been decreasing over time in the MHP and has been consistently lower than AACBs in similar sized counties and statewide over the past three years as well.

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



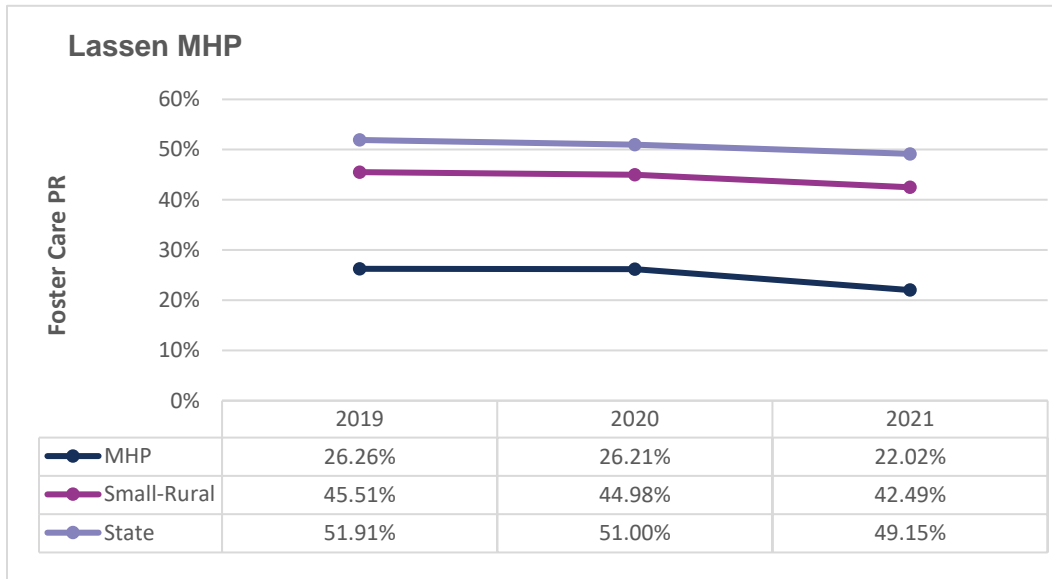
- The MHP’s Asian/Pacific Islander PRs for the past three years are suppressed due to low ns.

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



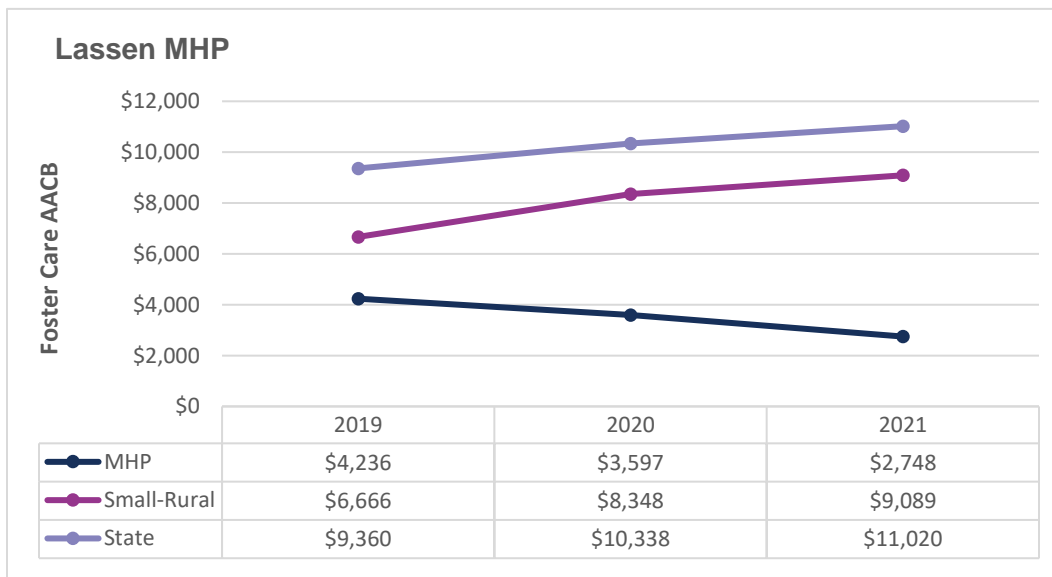
- The Asian/Pacific Islander AACB has been consistently lower than in other small-rural counties and statewide.

Figure 10: Foster Care PR CY 2019-21



- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed. Foster care PR was quite stable in the MHP from CY 2019 to CY 2020 but decreased slightly in CY 2021.
- The MHP’s FC PR has been consistently much lower than statewide and in similarly sized counties.

Figure 11: Foster Care AACB CY 2019-21



- Statewide FC AACB has increased each year for the past three years, whereas the MHP’s FC AACB has been decreasing consistently.

- The FC AACB in the MHP has been consistently much lower than in similar sized counties and statewide. FC AACB was about 25 percent that of the statewide AACB for CY 2021.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 552				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	-	8	8	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	0	0.0%	0	0	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	<11	-	1,044	1,200	13.0%	1,546	1,200
Crisis Intervention	111	20.1%	116	70	12.8%	248	150
Medication Support	301	54.5%	161	135	60.1%	311	204
Mental Health Services	423	76.6%	301	131	65.1%	868	353
Targeted Case Management	366	66.3%	128	70	36.5%	434	137

- Inpatient treatment was the only per day service with any utilization in CY 2021 and had much lower utilization than that seen statewide. The inpatient data does not include stays in the local medical hospital ED, which can last for days with a discharge back to the community.
- Mental Health Services, Targeted Case Management (TCM), and Medication Support were the most used per minute services in the MHP. While the Mental Health Services and TCM utilization rates were higher than those seen statewide, Medication Support utilization was a bit lower. Crisis Intervention also had higher utilization rates than seen statewide.
- All per minute services had fewer billed minutes than statewide averages.

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

Service Category	MHP N = 24				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	4	4	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.3%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	17	12
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%	1,398	1,200
Crisis Intervention	<11	-	251	240	7.5%	404	198
Medication Support	<11	-	288	272	28.3%	394	271
TBS	0	0.0%	0	0	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Home Based Services	<11	-	91	41	40.0%	1,351	472
Intensive Care Coordination	<11	-	1,397	1,397	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	20	83.3%	526	314	96.3%	1,848	1,103
Targeted Case Management	13	54.2%	149	90	35.0%	342	120

- As with statewide, the far and away most-used service for FC youth was Mental Health Services. The second most-used service in the MHP by FC youth was TCM.
- The only per day service with FC utilization was Inpatient, which was utilized at a comparable rate to statewide, though the exact rate had to be suppressed.
- The MHP had lower utilization rates than those seen statewide for all service categories other than TCM, and lower average billed units in all service categories than statewide.

IMPACT OF ACCESS FINDINGS

- Due to lack of a field-based crisis response system, consumers go to the ED which can overwhelm the six-bed unit. ED staff are not trained in behavioral health crisis and billing and treatment flow data are not received and monitored by the MHP for QI.
- Access to inpatient services is a challenge in both the adult and youth systems of care, and all inpatient providers are currently out of county.
- The MHP has been unable to secure a provider for Therapeutic Foster Care despite putting out a request for proposals.
- The MHP did not report any significant impacts of CalAIM initiatives.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	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:

- Lassen improved the tracking of its timeliness and FC youth data for this review. For 2A through 2C, the MHP reported meeting the standards consistently. The MHP has an access team that meets weekly with a second check-in on Friday. Lassen hired a Physician's Assistant to address capacity issues and modified the

children's psychiatry schedule. Prior, the psychiatrist was only available on Fridays which led to delayed appointments.

- For 2D, the MHP follows-up within 7-days after discharge from inpatient psychiatric care 64 percent of the time. Lassen reported manually entered and incomplete data. Lassen did not evaluate its performance through data analysis or initiate improvement activities to address process, system, or capacity issues.
- For 2E, Lassen acknowledged hand-tabulated and incomplete data. The MHP is unable to identify FC in the EHR; therefore, hand-tabulates results from case manager meeting minutes.
- For 2F, although results meet the standard of 30 percent, the average no-show rate for non-psychiatry clinical staff is 21 percent (27 percent for children and 24 percent for FC youth). Lassen hand-tabulates FC youth data from Pathways to Wellbeing forms and acknowledged it may be incomplete. The MHP provides reminder calls to beneficiaries; however, it has not initiated other system-level performance improvement activities to decrease no shows.

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 CY 2022. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented county-operated services. The MHP noted that its timeliness data for urgent services and follow-up services after hospitalization were tracked in a spreadsheet outside the EHR and that some data for these measures were missing.

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	4.07 Business Days	10 Business Days*	93.3%
First Non-Urgent Service Rendered	5.61 Business Days	10 Business Days**	87.1%
First Non-Urgent Psychiatry Appointment Offered	6.14 Business Days	15 Business Days*	96.0%
First Non-Urgent Psychiatry Service Rendered	7.26 Business Days	15 Business Days**	94.7%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0.14 Hours	1 Hour**	91.2%
Follow-Up Appointments after Psychiatric Hospitalization	3.28 Days	7 Days**	64.4%
No-Show Rate – Psychiatry	3%	30%**	n/a
No-Show Rate – Clinicians	21%	30%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033			
** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: CY 2022			

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

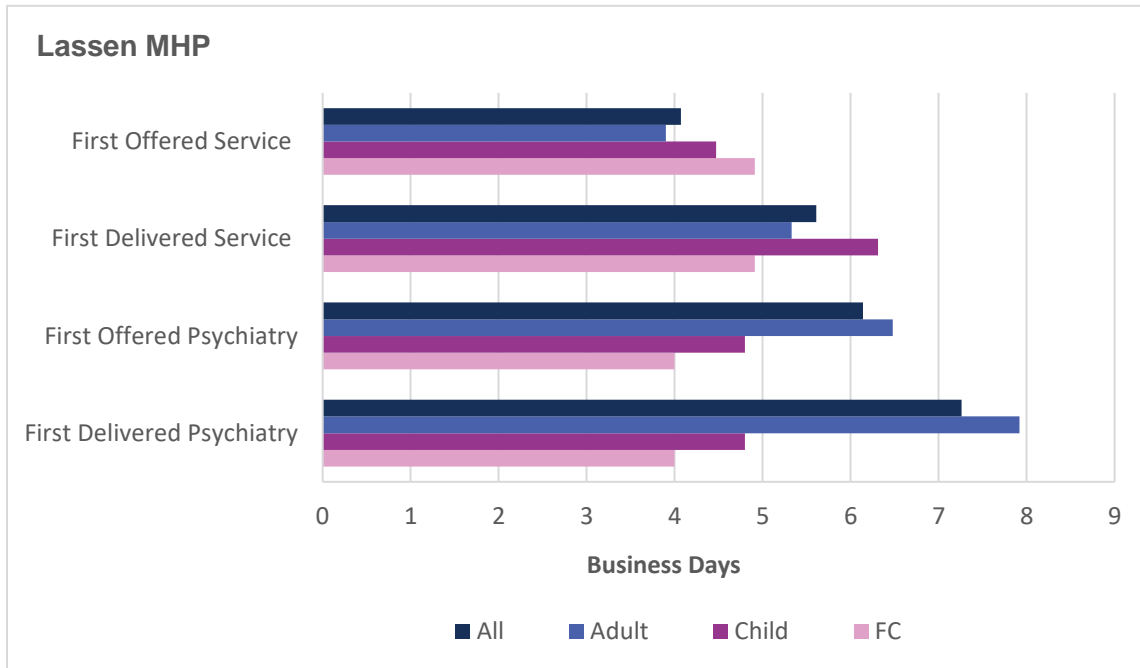


Figure 13: Wait Times for Urgent Services

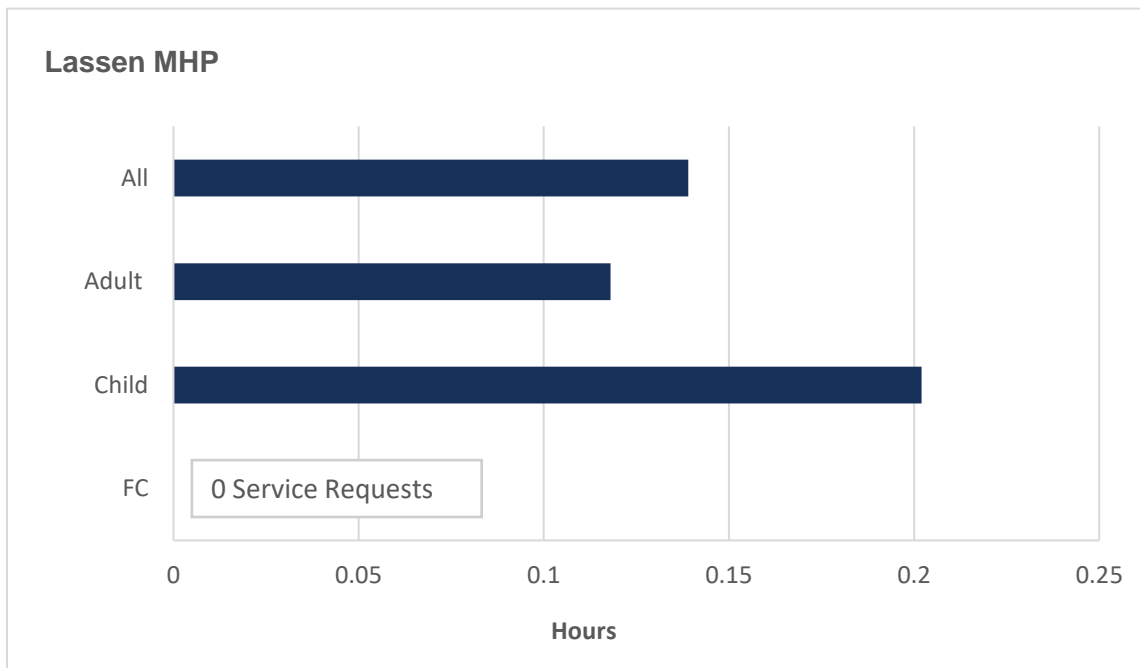
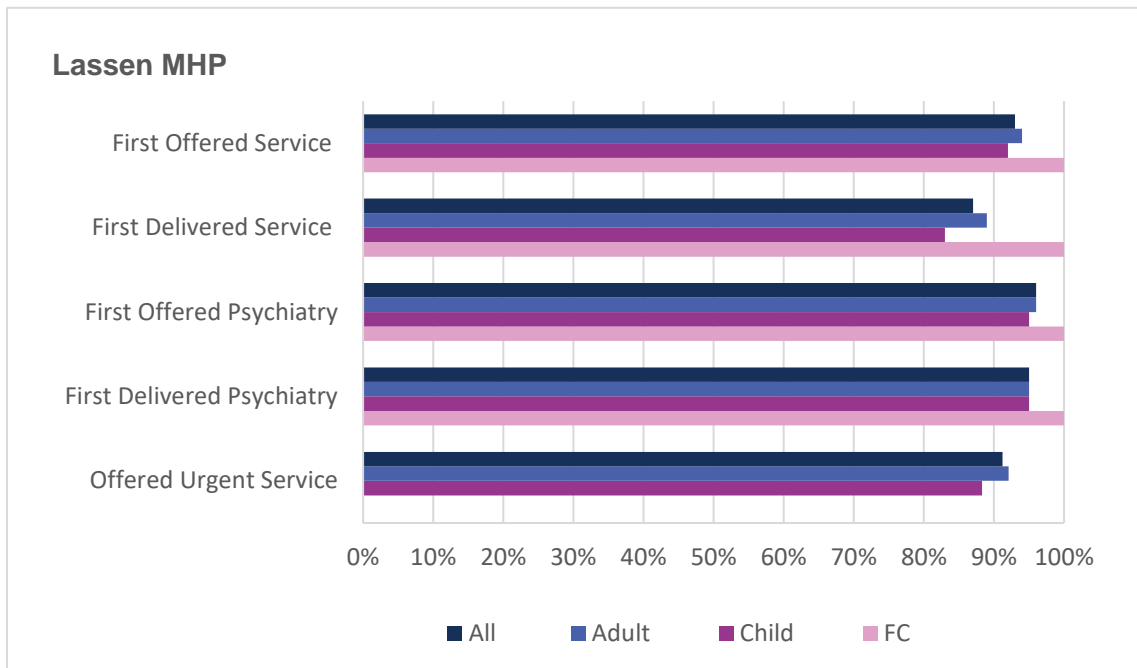


Figure 14: Percent of Services that Met Timeliness Standards



- 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 assessments conducted by a therapist.
- 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 crisis situations, where “crisis” is “when an individual calls in/presents in a condition where they could be a harm to themselves or to others.” There were reportedly 238 urgent service requests with a reported actual wait time to services for the overall population of 0.14 hours.
- 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 calculates timeliness for psychiatry appointments offered at the time of a beneficiary’s initial contact or service request.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked in the EHR, with the exception of no-shows for FC youth whose no-shows are hand tabulated. The MHP reports a no-show rate of 21 percent for non-psychiatry clinical staff (27 percent for children and 24 percent for FC youth). The MHP provides reminder calls to beneficiaries; however, it has not initiated

other system-level activities to decrease no shows. Lassen reported a lower average no-show rate (three percent) for psychiatrist appointments.

IMPACT OF TIMELINESS FINDINGS

- Behavioral health services consumers receive in the ED are not billed under the MHP; therefore, there is no QI monitoring, tracking, and trending of consumers receiving crisis services in the ED and transitioning back to the community.
- The MHP appears to have some challenges in providing timely follow-up services to beneficiaries after they discharge from inpatient psychiatric care, meeting their 7-day standard only about 64 percent of the time. While some beneficiaries may not be returning to the county after discharge, the MHP may want to reexamine its processes to ensure recently discharged beneficiaries are not slipping through the cracks.
- The MHP no-show rates for clinical staff of 21 percent (27 percent for children and 24 percent for FC youth) impacts the continuity of services.

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, assign responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN THE MHP

The MHP has two committees, the Quality Improvement Committee (QIC) and the Compliance Program Committee (CPC), that are responsible for the key functions of the QI program. The QIC meets monthly, and is responsible for collecting, reviewing, and analyzing data; implementing and providing oversight of QI activities, e.g., PIPs, QAPI workplan; and maintains a continuous quality improvement (CQI) philosophy.

The QIC is comprised of the MHP director, behavioral health data analyst, clinical supervisors, nurse, SUD counselor, case worker, and prevention manager. The QIC presents findings to the MHP's director, staff, providers and community partners, the behavioral health board members, and other key stakeholders to improve system performance.

There is not a carved-out QI/QA department, nor is there a dedicated QI coordinator position. Most QI/QA activities are overseen by the MHP's director and the behavioral health analyst with the support of QIC and CPC participants. In a small-rural county the MHP staff fill multiple roles within the MHP.

For this review, the MHP submitted minutes for 12 QI meetings from November 21, 2022, through May 1, 2023, and reported it did not keep minutes specific for the QI Work Plan, but the work plan was discussed over the course of the QI meetings.

The MHP utilizes the following outcomes tools: American Society of Addiction Medicine Assessment (ASAM), ANSA, CANS, PSC-35, and DLA-20.

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	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	Partially Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	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	Partially Met

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

- Lassen has a current QI Work Plan and QIC, administers the Consumer Perception Survey (CPS), and adopted standardized outcome tools.
- For 3B and 3C, while Lassen improved tracking of data, the MHP should move away from using hand-tabulated results and trend data to identify and test QI initiatives using Plan-Do-Study-Act (PDSA) and adopt a systematic approach for receiving stakeholder input.
- For 3D, Lassen should monitor, track, and trend data on the MHP’s crisis and inpatient psychiatric care delivery system and use LOC tools to measure, monitor, and guide clinical treatment and transitions of beneficiary care.
- For 3E and 3F, Lassen should improve medication monitoring care coordination activities.
- For 3H, the MHP should compare prior CPS findings to current results and initiate QI initiatives that include stakeholders, staff, and beneficiaries.
- For 3I and 3J, Lassen should establish a formal process for beneficiaries to provide feedback and input on system planning and improve the number, retention, and career opportunities of peer support staff.

- The MHP tracks but does not trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
 - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
 - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
 - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)

QUALITY PERFORMANCE MEASURES

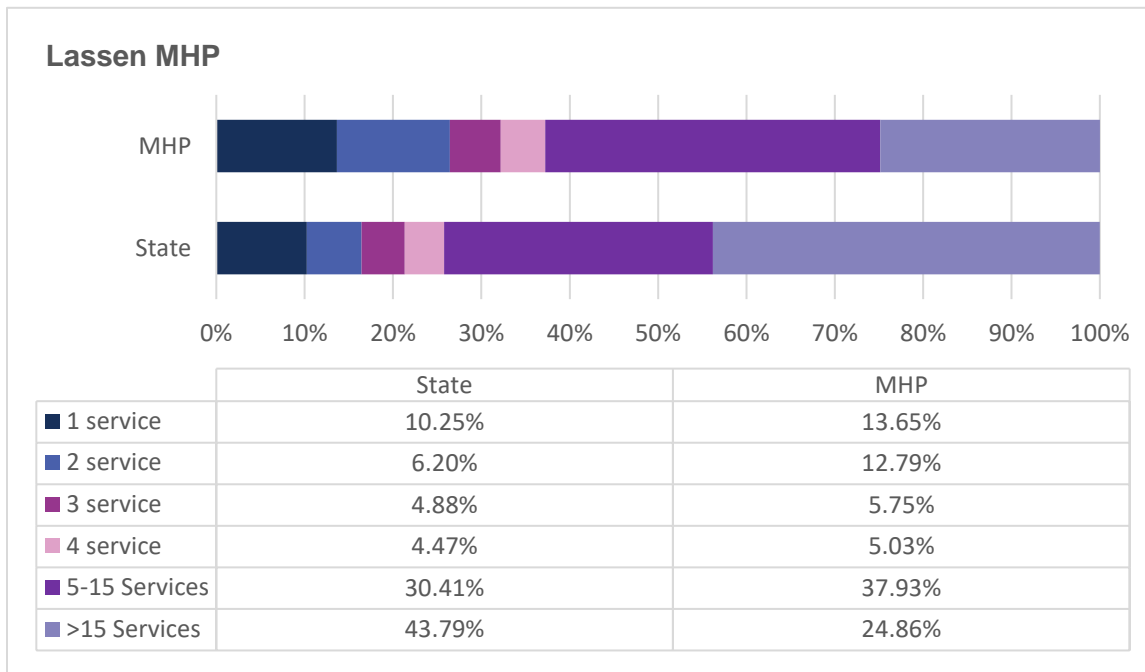
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021

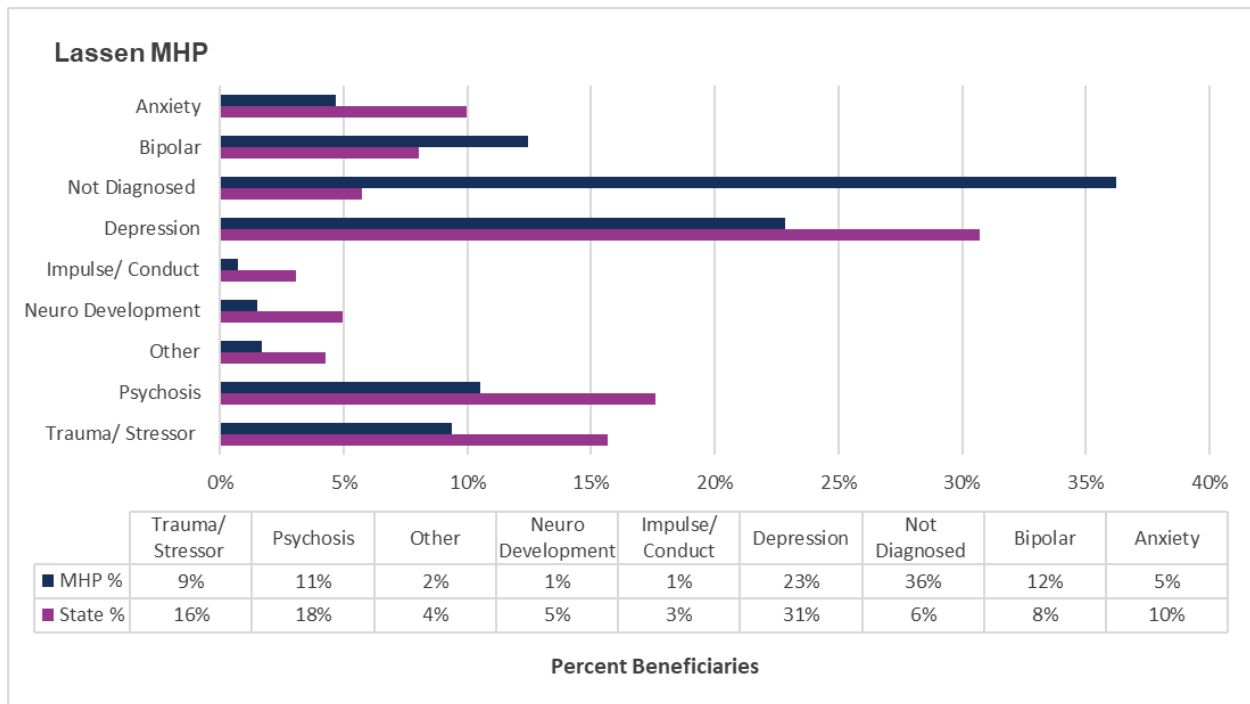


- The MHP had a slightly higher proportion of beneficiaries who received just 1 or 2 services than statewide, but also had a higher proportion of beneficiaries receiving 5-15 services than statewide.
- Overall, the MHP had a much smaller proportion of beneficiaries who received 5 or more services (about 63 percent) than statewide (about 74 percent) due to retaining a smaller proportion of beneficiaries for greater than 15 services.

Diagnosis of Beneficiaries Served

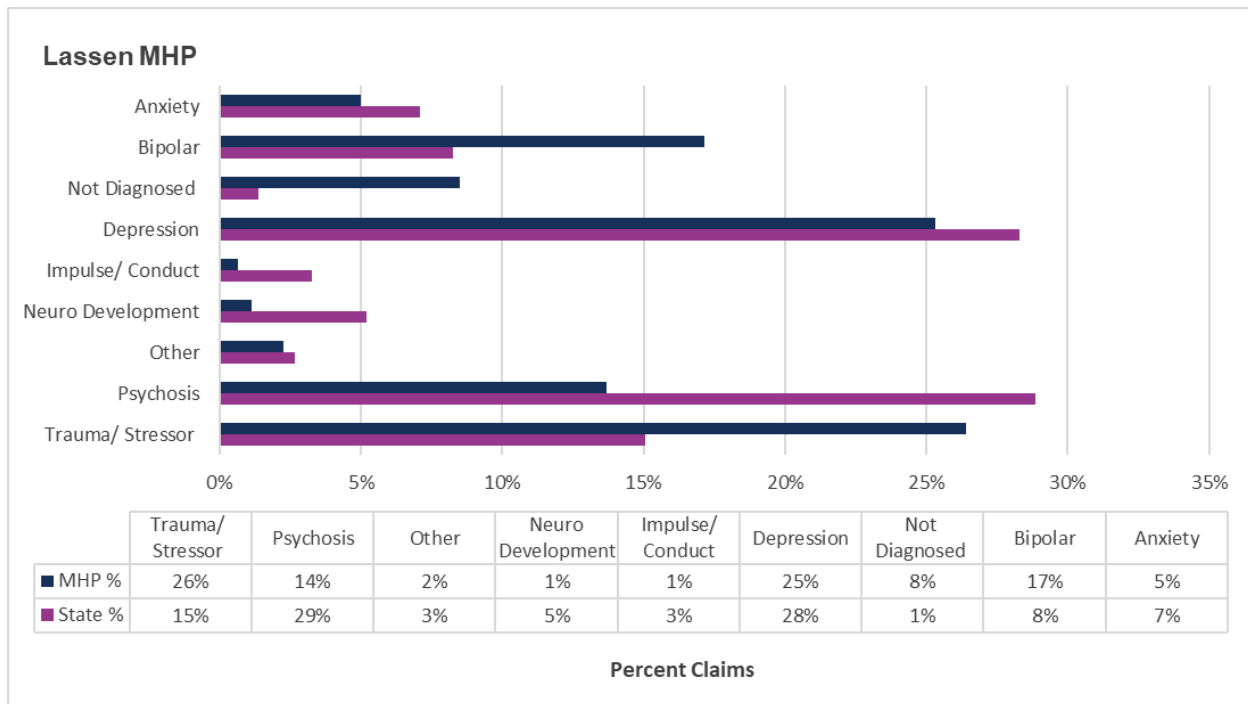
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The following figures represent the primary diagnosis as submitted with the MHP’s claims for treatment. 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



- Not Diagnosed was, by far, the most common diagnostic category in the MHP. This is because in Lassen case managers provide an initial “registration” service and do not diagnose beneficiaries, so all beneficiaries who are not retained beyond the initial service would remain undiagnosed. Depression was the most common diagnostic category for those beneficiaries who were diagnosed.
- The MHP had a higher proportion of beneficiaries diagnosed with Bipolar than statewide, and lower proportions of beneficiaries in all other diagnostic categories than statewide (likely due to more than one-third having no diagnosis).

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



- Despite 36 percent of beneficiaries having no diagnosis, the Not Diagnosed category was responsible for only 8 percent of claims.
- Trauma/Stressor-related diagnoses accounted for 9 percent of diagnoses and 26 percent of claims, and Bipolar accounted for 12 percent of diagnoses and 17 percent of claims.

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	<11	7.25	8.86	-	\$12,052	\$56,428
CY 2020	14	19	5.31	8.68	\$7,414	\$11,814	\$103,792
CY 2019	23	30	8.35	7.80	\$8,042	\$10,535	\$184,973

- The number of unique beneficiaries and total admissions has continuously declined over the past three years.

- The average LOS decreased in CY 2020 but increased (though still below the CY 2019 LOS) in CY 2021; it was slightly lower than statewide for CY 2021.
- The MHP’s AACB for inpatient services has consistently decreased over the past three years and has consistently been lower than the statewide AACB. As of CY 2021 it is equivalent to a little more than half of the statewide AACB. Total approved claims have been decreasing precipitously over the past three years and are now less than one-third of the total approved claims in CY 2019.
- It is unlikely the data in Table 13 are reflective of all inpatient services provided by the MHP as Lassen primarily uses Restpadd Inc. for inpatient services, which are IMD-excluded facilities. The MHP reports having 58 unique beneficiaries who received inpatient services in CY 2022.

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

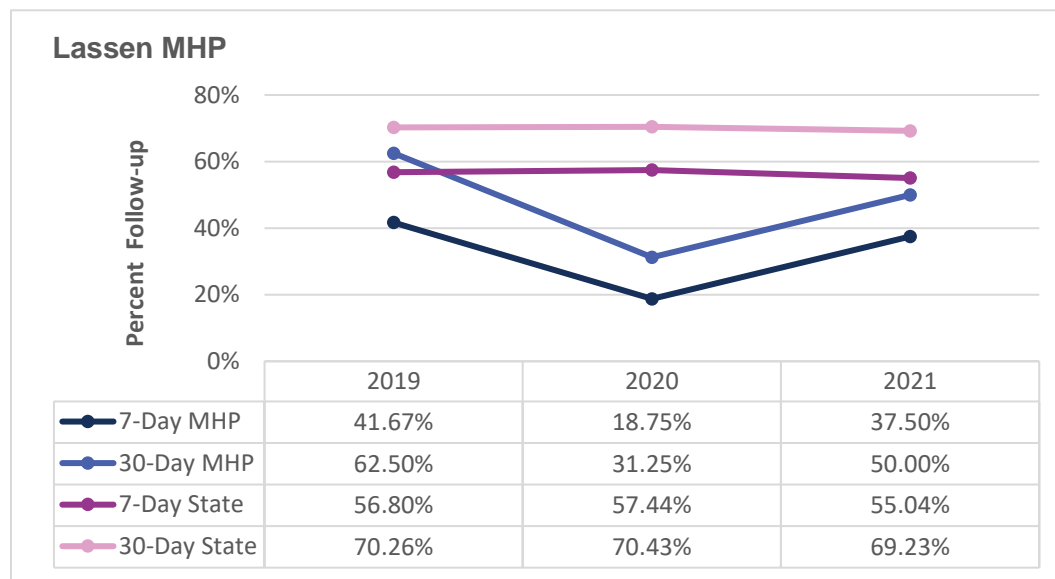
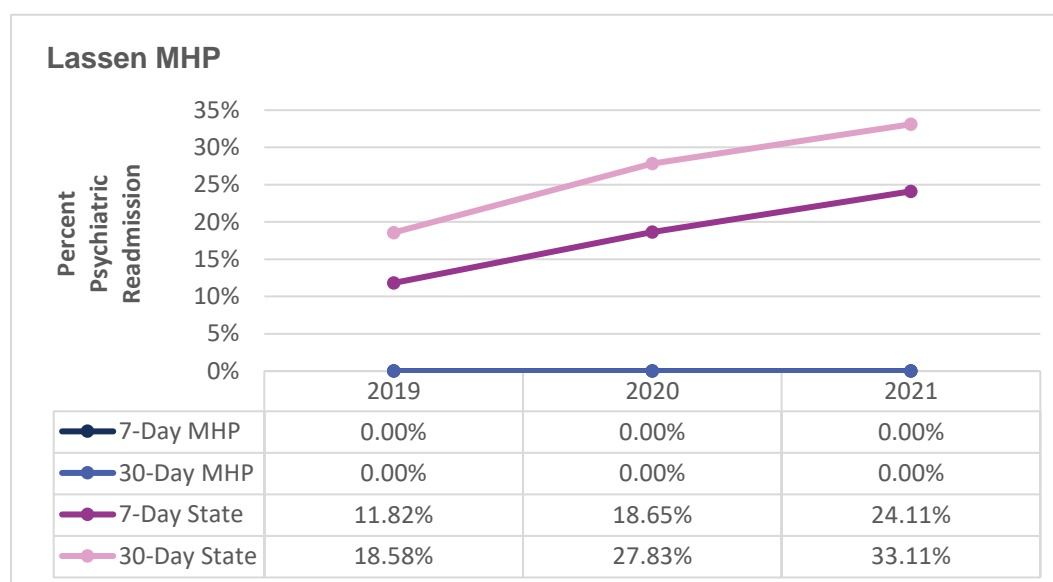


Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



- 7- and 30-day post psychiatric follow-up rates have consistently been much lower in the MHP than statewide over the past three years. Both rates are lower in CY 2021 than they were in CY 2019. The MHP reported 64.4 percent of beneficiaries received follow-up services within 7 days, and 71.1 percent received follow-up services within 30 days, for CY 2022. The MHP also noted that all inpatient services are provided outside of Lassen County, and some beneficiaries do not return to Lassen after discharge.
- Claims data have reflected no readmissions within 7 or 30 days for the past three years. MHP data reflect 2.2 percent of beneficiaries were readmitted within 7 days, and 4.4 percent were readmitted within 30 days, for CY 2022.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with

approved claims of more than \$30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is \$7,478, the median amount is just \$3,269.

Tables 14 and 15, and Figure 20 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, nearly 92 percent of the statewide 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	-	-	-	-	-
	CY 2020	<11	-	-	-	-	-
	CY 2019	<11	-	-	-	-	-

- The total counts and percentages of beneficiaries served falling into the HCB category have been extremely small for the past three years.

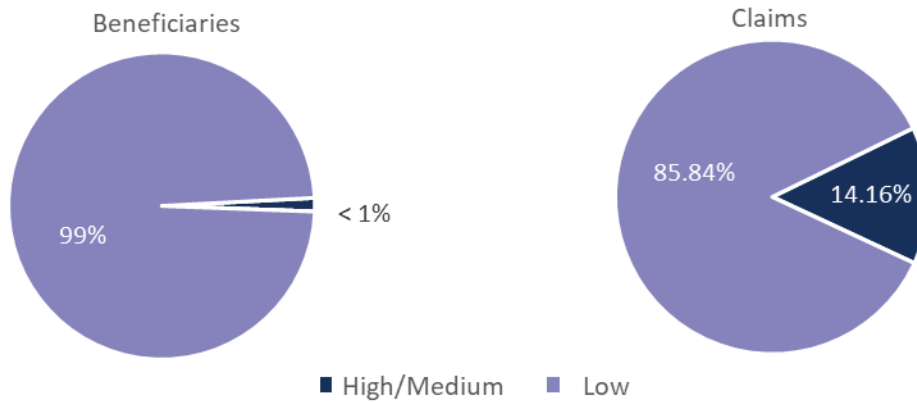
Table 15: Medium- and Low-Cost Beneficiaries CY 2021

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)	<11	-	-	-	-	-
Low Cost (Less than \$20K)	693	99.57%	85.84%	\$1,136,112	\$1,639	\$1,048

- Over 99 percent of beneficiaries fell into the low-cost category, and the median approved claims per beneficiary in that category was \$1,048.

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

Lassen MHP



- Almost all of the beneficiaries served fell into the low-cost category, representing about 86 percent of all claims.

IMPACT OF QUALITY FINDINGS

- Because of hand tabulation and multiple EHR changes recently, the MHP cannot have full confidence in data for monitoring, tracking, trending, and QI initiatives.
- Lack of peer staff led to wellness center closures in outlying areas, thereby reducing support services for consumers in those areas.
- The local six-bed ED is the crisis and involuntary location of initial service often resulting in multi-day waits for inpatient beds or a discharge back to the community. Daily medical ED treatment bed availability is impacted by beds taken by MH patients. QI functions are impacted in that the ED delivery system is external to the MHP EHR and billing system.

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 §§ 438.330² 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: Integration of Clinical Contact between Registration and Assessment to Improve Assessment Retention Rate

Date Started: 02/2020

Date Completed: 03/2023

Aim Statement: Over the next 2 years, Medi-Cal clients ages 18 and up will receive contact by caseworkers following their registration to improve assessment retention rates from 72.14 percent to 85 percent.

Target Population: Beneficiaries ages 18 and older who complete registration with Lassen County Behavioral Health

Status of PIP: The MHP's clinical PIP is in the second remeasurement phase.

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

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

Summary

The PIP had two performance measures:

- Assessments completed of the total number of registrations completed on an annual basis.
- Assessments completed of the registrations who were offered an assessment appointment by the case manager.

The MHP reported second remeasurement results and demonstrated improvement in both measures. The first performance measure had a baseline rate of 72.1 percent from 2020 and the second remeasurement from 2023 was 81.0 percent, which was a statistically significant increase. The second performance measure's baseline rate from 2020 was 79.5 percent and the second remeasurement from 2023 was 85.1 percent, a non-statistically significant increase.

Lassen selected one consumer-focused intervention for the PIP as documented below. The PIP's original intervention was to contact all consumers who had an appointment for the assessment; however, the MHP modified the intervention as the PIP progressed. The MHP did not have any provider or system-level interventions for this PIP.

- Case manager contacts consumers who missed their originally scheduled assessment appointment. The case manager uses motivational interviewing to perform a missed assessment check-in to determine how the consumer is feeling at that time and whether they are still interested in receiving services with Lassen.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence. The PIP demonstrated improvement in both performance measures; however, the MHP did not involve beneficiaries in the development of the PIP and designed an intervention that focused on motivational interviewing when there was not a clear link to a consumer barrier to support this intervention. The PIP did not include any system level changes. Lassen intended to contact all consumers with an assessment appointment; however, altered the intervention to only contact consumers who had missed the appointment.

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

- Provide data and root cause analysis on why appointments are missed. Involve beneficiaries in determining the problem, barriers, and interventions.
- Include prevention steps such as text or telephone reminders or reduction in process steps to expedite the assessment.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Implementation of New SUD Screening Tool

Date Started: 02/2020

Date Completed: 04/2023

Aim Statement: Would the implementation of a scored basic SUD screening tool at Mental Health assessment result in an increased number of co-occurring diagnoses as appropriate from 23.5 percent to 33.1 percent in a 24-month period.

Target Population: Beneficiaries ages 21 years and older receiving an initial Mental Health assessment or an annual Mental Health reassessment.

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

Summary

The PIP had two performance measures:

- Clients with co-occurring diagnoses.
- Referrals to SUD Program.

The MHP reported second remeasurement results did not demonstrate improvement. The first performance measure had a baseline rate of 23.5 percent from 2021 and the second remeasurement from 2022 was 19.0 percent. The second performance measure's baseline rate from 2021 was 26.8 percent and the second remeasurement from 2022 was 25.4 percent.

Lassen selected one intervention for the PIP.

- Basic SUD screening tool used at assessment.

The MHP reported that the SUD screening tool was not used with every assessment and not every therapist was consistently conducting screenings. With the implementation of the Drug Abuse Screening Test (DAST-10), Lassen no longer uses the SUD screening tool.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence. The MHP did not involve beneficiaries in identifying problems, barriers, or interventions and the PIP did not demonstrate improvement in the performance measures. Lassen reported due to staffing shortages, data on the assessments offered and accepted was inconsistent and the MHP analyzed results annually instead of quarterly. Lassen identified concerns with

therapists consistently using the SUD screening tool. The tool was discontinued in August 2022; therefore, the MHP will not measure the long-term impact of the SUD screening tool.

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

- Involve beneficiaries in determining the problem, barriers, and interventions. A focus group could identify how consumers would like to receive co-occurring services.
- Address lessons learned (e.g., inconsistent process) using PDSA.

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 Kings View/Cerner, which has been in use for one year. Currently, the MHP is actively preparing for implementation of a new system, Credible, which requires heavy staff involvement to fully develop. The go-live date for Credible, which will also be supported by Kings View, is July 1, 2023.

Approximately 1.5 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 allocated to the MHP but managed by another county department. The IS allocation is smaller than the previous year's allocation of 3 percent. The MHP notes this likely reflects budget constraints resulting from not executing any billing for much of CY 2022, and predicts the next allocation will be larger due to implementation of the new EHR.

The MHP has 30 named users with log-on authority to the EHR, all of whom are county staff. Support for the users is provided by four full-time equivalent (FTE) IS technology positions. Currently all positions are filled.

All services are provided by County staff only. As of the FY 2022-23 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR nor do 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	<input type="checkbox"/> Real Time <input type="checkbox"/> Batch	0%
Electronic Data Interchange to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
Electronic batch file transfer to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
Direct data entry into MHP IS by provider staff	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
Documents/files e-mailed or faxed to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
Paper documents delivered to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
		0%

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 currently have a PHR, but it will be implementing one within the next year as part of the new EHR.

Interoperability Support

The MHP is not currently a member or participant in a HIE, however it is currently working with SacValley MedShare to implement their HIE on July 1, 2023, to coincide with the roll out of the new EHR. As of the time of the EQR, healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: DHCS, Kings View, and Partnership HealthPlan of California (PHC).

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

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

- The MHP deftly deployed GrandCare devices (initially purchased as part of an underutilized Mental Health Services Act [MHSA] Innovation project) during the COVID-19 pandemic public health emergency (PHE), allowing beneficiaries to receive services via telehealth throughout the PHE and beyond.
- The MHP is now supported by two analysts, one of whom is in a new position that was added to support implementation of CalAIM initiatives. The analysts were also essential to getting the MHP’s billing up to date after no claims were submitted between February 1 and October 31 of CY 2022 due to EHR/vendor issues.
- Joining SacValley MedShare HIE in July 2023 will facilitate information sharing with managed care, PHC, and local hospitals.
- The current EHR lacks some functions, but the new EHR is anticipated to include additional functionality, including Outcomes and Referral Management.
- The MHP could improve security by supporting two-factor authentication to authorize password changes and providing regularly scheduled cyber-security training to staff.

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.

Table 18 appears to reflect a largely complete or very substantially complete claims data set for CY 2021.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	638	\$129,716	\$0	0.00%	\$97,039
Feb	722	\$102,578	\$0	0.00%	\$58,781
Mar	808	\$117,192	\$0	0.00%	\$115,929
April	772	\$116,234	\$0	0.00%	\$115,617
May	772	\$108,876	\$0	0.00%	\$107,574
June	811	\$125,095	\$0	0.00%	\$123,439
July	725	\$125,828	\$0	0.00%	\$120,075
Aug	643	\$104,022	\$0	0.00%	\$101,512
Sept	824	\$125,711	\$0	0.00%	\$121,107
Oct	780	\$118,202	\$1,712	1.45%	\$116,490
Nov	818	\$120,939	\$2,465	2.04%	\$118,246
Dec	491	\$72,982	\$1,153	1.58%	\$71,829
Total	8,804	\$1,367,375	\$5,330	0.39%	\$1,267,638

- The MHP has an extremely low denied claims rate of 0.39 percent, as compared to the statewide rate of 1.43 percent.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B must be billed before submission of claim	18	\$2,619	49.15%
Beneficiary not eligible or non-covered charges	9	\$1,390	26.08%
Service line is a duplicate and a repeat service procedure code modifier not present	7	\$793	14.88%
Other healthcare coverage must be billed before submission of claim	1	\$527	9.89%
Total Denied Claims	35	\$5,329	100.00%
Overall Denied Claims Rate	0.39%		
Statewide Overall Denied Claims Rate	1.43%		

- The majority of denied claims were denied for the claim being late (about 49 percent), followed by the beneficiary not being eligible or non-covered charges (about 26 percent). Together, those two reasons accounted for about 75 percent of denied dollars.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP has weathered multiple transitions in EHRs over a short period of time (implementation of FIE in February 2022, implementation of Cerner in November 2022, and now preparing for implementation of Credible in July 2023) as well as having no claims paid for eight months in CY 2022, with little to no impact on service provision to beneficiaries. The resilience of staff despite these challenges is laudable.
- The transition to Credible, supported by Kings View, will facilitate implementation of payment reform, which the current EHR cannot accommodate.
- The addition of a second analyst position to support CalAIM initiatives has also boosted the MHP's ability to develop its data collection and analytic capabilities, which will facilitate quality improvement efforts in Lassen moving forward. The MHP has also hired a consultant who has been helping them with analyses that will assist them in identifying at-risk populations and support the MHP in applying for grants to improve outreach and services to those populations.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP administers the CPS; however, reported it is difficult to get beneficiaries to complete the survey. Lassen provides paper surveys to consumers when they come to the clinic but indicated they believe consumers would rather provide feedback verbally. Consumer focus group attendees remember taking surveys in the past but do not recall seeing the results. The MHP does not currently use the results to initiate QI activities. In 2022, Lassen had 32 completed surveys — two Family, six Youth, 22 Adult, and two Older Adult. The MHP does not currently use other surveys and would like to do a Lassen-specific consumer survey.

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 a 90-minute focus group with six to eight consumers (MHP beneficiaries) and/or their family members.

Consumer Family Member Focus Group

CalEQRO requested a culturally diverse group of six to eight adult consumers who mostly have initiated/utilized services within the past 15 months. The focus group of four participants was held virtually, with consumers attending the MHP clinic location. All participating consumers speak English; therefore, no translator was needed. All consumers in the focus group receive clinical services from the MHP.

Consumers agreed MHP services were initiated timely and receive a reminder call prior to appointments. The consumers mostly transport themselves or caseworkers may transport them. One consumer used MHP-provided transportation recently. She did not receive a reminder call and the driver arrived early. The consumers have had family involved in their treatment or believe it is possible. None had been invited to participate in committees or to help make decisions about services. Two consumers reported

completing a satisfaction survey in the past; however, they did not see the results. Consumers feel they can share feedback with their caseworker. Consumers were not aware of peer support staff opportunities.

Consumers reported overall satisfaction with their caseworker, therapist, and psychiatrist and the case manager or therapist will see them more frequently if needed. Psychiatric appointments are by telehealth and all therapy sessions are in person. None of the consumers were aware of the wellness centers but had heard of Judy's House. One consumer stated it was very helpful to get help right away and the staff are great.

Recommendations from focus group participants included:

- Psychiatric providers should communicate with therapists to get details of how the consumer has been doing prior to a medication appointment.
- Compassionate ED staff/designated rooms for a consumer in crisis.
- More alternatives to hospitalization.
- Provide more information to consumers regarding peer opportunities, community resources, wellness centers, and meetings.
- Regarding the behavioral health treatment system overall: More follow-through and treatment plan changes after hospitalization because the same treatment prior to hospitalization may not be helpful.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall, adult consumers spoke positively about their Lassen providers. They do not wait long for services and are able to reschedule in a reasonable timeframe when an appointment is missed. Areas where improvement may be needed is an invitation to provide feedback/input in MHP system planning and committee involvement, more compassionate crisis care, and providing more information on resources and opportunities that are available.

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. Lassen's PR (7.87 percent) was higher than statewide (4.34 percent) and similar sized counties (7.08 percent). (Access)
2. The MHP deployed GrandCare portable units during the COVID-19 PHE allowing beneficiaries to receive services via telehealth throughout the PHE and beyond. (Access)
3. The MHP tracks timeliness measures and meets most standards consistently. (Timeliness)
4. Lassen uses therapeutic drug testing — mouth swab to determine the best medication for the consumer. (Access and Quality)
5. The MHP has two analysts on staff now, and one is a new position that was added to support implementation of CalAIM initiatives. (IS, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Lassen hand-tabulates some data and is not yet trending results for identifying QI initiatives. (Timeliness)
2. The MHP has limited peer support staff and as a result, wellness centers in the outlying areas had to close. (Access, Quality)
3. Lassen hand tracks FC youth results and uses a spreadsheet to track follow-ups. (Timeliness)
4. Consumers in crisis are directed to go to the local six-bed ED. The MHP is not tracking and trending services received in the ED and consumers transitioning out of crisis. (Access, Quality)
5. Transportation services continue to pose challenges and currently there are barriers to utilizing the MCP transportation benefit. (Access)

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. Routinely pull automated reports for monitoring, tracking, and trending of data and implement QI initiatives to address areas of concern, including for FC youth. (Timeliness, Quality)
2. Improve the number, retention, and career opportunities of peer support staff and ensure that the wellness centers can remain open. (Access, Quality)
3. Monitor, track, and trend data for consumers receiving crisis services in the ED and initiate QI activities to address areas of concern. (Access, Quality)
4. Improve transportation services for consumers and resolve challenges with the transportation vendor. (Access)
5. Contact CalEQRO for technical assistance prior to the next annual review to discuss plans for the clinical and non-clinical PIPs. (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, a California PHE was in place until 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.

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 – Lassen 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: Adult Beneficiaries
Fiscal/Billing
Clinical Line Staff Group Interview
Information Systems Billing and Fiscal Interview
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
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Bill Walker, Quality Reviewer Supervisor

Christy Hormann, Quality Reviewer

Leah Hanzlicek, Information Systems Reviewer Supervisor

Sharon Mendonca, Information Systems Reviewer

MaryEllen Collins, Consumer/Family Member Reviewer

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	County or Contracted Agency
Armstrong	Tiffany	BH Director	LCBH
Bustamante	Sarah	Administrative Assistant	LCBH
Griffith	Lori	Analyst	LCBH
Bradley	Joshua	Analyst	LCBH
Ross	Jennifer	Fiscal	LCBH
Housel	Jason	IT	LCBH
Oliver	ShiAnn	IT	LCBH
Nordstrom	Scott	Supervising Therapist	LCBH

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
<input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence	In 2021, the MHP changed the intervention. Consumers who missed an assessment were contacted by case managers. Prior, the MHP contacted all consumers with an assessment appointment.
General PIP Information	
MHP/DMC-ODS Name: Lassen County Behavioral Health	
PIP Title: Integration of Clinical Contact between Registration and Assessment to improve Assessment Retention Rate	
PIP Aim Statement: Over the next 2 years, Medi-Cal clients ages 18 and up will receive contact by caseworkers following their registration to improve assessment retention rates from 72.14 percent to 85 percent.	
Date Started: 02/2020	
Date Completed: 03/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) <input type="checkbox"/> State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) <input checked="" type="checkbox"/> MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> 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): Medi-Cal adult beneficiaries ages 18 and older who complete registration with Lassen County Behavioral Health	

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):

Case manager contacts consumers who missed their originally scheduled assessment appointment. The case manager uses motivational interviewing to perform a missed assessment check-in to determine how the consumer is feeling at that time and whether they are still interested in receiving services with Lassen.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):

None

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):

None

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
Assessments completed of the total number of registrations completed on an annual basis	2020	72.1%	2022	81.0%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input checked="" type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
Assessments completed of the registrations who were offered an assessment appointment by the case manager	2020	79.5%	2022	85.1%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.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:

- Provide data and root cause analysis on why appointments are missed. Involve beneficiaries in determining the barriers and interventions.
- Include prevention steps such as text or telephone reminders or reduction in process steps to expedite the assessment.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
<input type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input checked="" type="checkbox"/> Low confidence <input type="checkbox"/> No confidence	<p>The MHP reported that the SUD screening tool was not used consistently. With implementation of the DAST-10, Lassen discontinued using the SUD screening tool.</p>
General PIP Information	
MHP/DMC-ODS Name: Lassen County Behavioral Health	
PIP Title: Implementation of New SUD Screening Tool	
PIP Aim Statement: Would the implementation of a scored basic SUD screening tool at Mental Health assessment result in an increased number of co-occurring diagnoses as appropriate from 23.5 percent to 33.1 percent in a 24-month period.	
Date Started: 02/2020	
Date Completed: 04/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) <input type="checkbox"/> State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) <input checked="" type="checkbox"/> MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> 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): Beneficiaries ages 21 years and older receiving an initial Mental Health assessment or an annual Mental Health reassessment.	

Improvement Strategies or Interventions (Changes in the PIP)						
<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):</p> <p>None</p>						
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):</p> <p>Basic SUD screening tool used at assessment</p>						
<p>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):</p> <p>None</p>						
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
Clients with co-occurring diagnoses	2021	23.5%	2022	19.0%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
Referrals to SUD Program	2021	26.8%	2022	25.4%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
PIP Validation Information						
<p>Was the PIP validated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>“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</p>						

PIP Validation Information

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:

- Involve beneficiaries in determining barriers and interventions. A focus group may identify how consumers would like co-occurring services.
- Address lessons learned (e.g., therapists not consistently using a tool) using PDSA.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required to be included in this report.