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

## MODOC FINAL REPORT

☒ **MHP**

☐ **DMC-ODS**

Prepared for:

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

Review Date:

May 9, 2023

# TABLE OF CONTENTS

# LIST OF FIGURES



# LIST OF TABLES

# 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, "Modoc" or MHP may be used to identify the Modoc County MHP, unless otherwise indicated.

## MHP INFORMATION

**Review Type** — Virtual

**Date of Review** — May 9, 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 | 4 | 1 | 0 |

### Table B: Summary of Key Components

| Summary of Key Components | Number of Items Rated | # Met | # Partial | # Not Met |
|---|---|---|---|---|
| Access to Care | 4 | 4 | 0 | 0 |
| Timeliness of Care | 6 | 6 | 0 | 0 |
| Quality of Care | 10 | 9 | 1 | 0 |
| Information Systems (IS) | 6 | 4 | 2 | 0 |
| **TOTAL** | **26** | **23** | **3** | **0** |

### Table C: Summary of PIP Submissions

| Title | Type | Start Date | Phase | Confidence Validation Rating |
|---|---|---|---|---|
| Not submitted | Clinical | n/a | n/a | n/a |
| Follow-Up After Emergency Department Visit for Mental Illness (FUM) | Non-Clinical | 09/2022 | Implementation | High |

### Table D: Summary of Consumer/Family Focus Groups

| Focus Group # | Focus Group Type | # of Participants |
|---|---|---|
| 1 | ☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other | 7 |
| 2 | ☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other | 4 |

## SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP conducts a weekly triage assessment day followed by a weekly staffing to provide assessments and initiation of clinical services within 1-2 weeks.
- The MHP has implemented a strategic crisis plan resulting in IP utilization and recidivism lower than state averages.
- There is overall improvement in the Assessment of Timely Access (ATA) measure indicating improved timeliness year-over-year.
- The MHP has developed extensive dashboards to provide consumers, staff, and management with information to monitor, track, trend, and perform process improvement.
- The MHP uses data to guide their decision making. They look at penetration rates to identify populations that are underserved and share outcomes data with beneficiaries when appropriate.

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

- Foster Care (FC) penetration rates declined in calendar year (CY) 2021 with only 13 FC receiving services in only four of sixteen Service Categories.
- The psychiatry no-show rate of 18.1 percent is the outlier to the Timeliness metrics that otherwise exceed the metric standards.

- Although the MHP provides initial psychiatry appointments within the 15-day DHCS standard, they do not track the first offered psychiatry appointment. This limits analytical capabilities related to instances where the standard is not met.
- The MHP has joined but not begun to utilize the services of the SacValley MedShare Health Information Exchange (HIE) which should improve coordination of care when beneficiaries receive services outside of the MHP.
- The MHP would benefit from utilizing California Innovating and Improving Medi-Cal (CalAIM) initiatives, or other significant areas of change, to identify two PIPs, and engage in technical assistance (TA) as needed to develop and implement.

Recommendations for improvement based upon this review include:

- Review FC service delivery system and develop and implement strategies to increase the FC penetration rate (PR) and continuum of services delivered.
- Develop and implement strategies to decrease the psychiatry no-show rate of 18.1 percent.
- Develop and implement strategies to track the first offered psychiatry appointment.
- Implement the services of the SacValley MedShare HIE which should improve coordination of care when beneficiaries receive services outside of the MHP.
- Utilize CalAIM initiatives, or other significant areas of change, to identify two PIPs, and engage in TA as needed to develop and implement.
- (This recommendation is a carry-over from FY 2021-22.)

# 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 Section14197.05).

This report presents the FY 2022-23 findings of the EQR for Modoc County MHP by BHC, conducted as a virtual review on May 09, 2023.

## REVIEW METHODOLOGY

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

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

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's 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 after the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP did not experience any new fires, floods, or other natural disasters, however, the ongoing post-COVID difficulties with recruitment and retention of staff continues to impact the Modoc MHP. At the time of the review, the Modoc MHP branch had 18 of 23 positions filled, for a 22 percent vacancy. Vacant positions included a clinical supervisor; clinician; case manager; nursing; and support. 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.

- The total population of Modoc County has been declining since CY 2011, while the number of Medi-Cal eligibles has been increasing, contributing to challenges meeting the needs of all Medi-Cal beneficiaries with reduced clinical staffing. The MHP is actively addressing recruitment and retention of staff. Efforts include ongoing recruitment, tele-work, and assisting existing staff to further their education.
- Behavioral Health Quality Improvement Program (BHQIP) and CalAIM milestones are a significant priority. The MHP is advancing documentation reform, initiating payment reform, and developing data sharing. The MHP is engaged in a contract with SacValley MedShare for a HIE and began building the exchange system within their electronic health record (EHR).
- The MHP had seven individuals with lived-experience attend the Painted Brain training for the peer certification program. One person has become certified.
- To better facilitate data informed care, several data dashboards have been developed and implemented.
- The MHP continues to expand the Positive Behavioral Interventions Services (PBIS) and other School Wide Interventions and Trainings: which is a school climate change intervention grounded in the behavioral and prevention sciences.
- Promatora Program: The recent establishment of promatora and behavioral health navigator positions in the Newell area are specifically meant to increase

timely access and linkage to mental health services for the underserved population in that area.

- The MHP is implementing an 18-month learning collaborative, Cultivating Outcomes Through Equity In Behavioral Telehealth in partnership with the California Institute for Behavioral Health Solutions (CIBHS). The goal of this project is to help specialty behavioral health improve meaningful outcomes for people from communities with historic behavioral health inequities.
- The MHP is implementing the Qualifacts Credible Electronic Health Record (EHR). They are scheduled to begin using the EHR in July 2023.

# 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:** Engage in frequent TA, implement PIP recommendations contained in the EQR report, and ensure the MHP has two viable PIPs.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- This recommendation is partially met as the MHP submitted only one PIP. The PIP was well developed, but the MHP did not engage in TA. The MHP shifted its focus related to PIPs to comply with the State BHQIP PIP requirements.
- Barriers to fully addressing this recommendation included that the MHP's was impacted by the need to comply with multiple concurrent audits and an EHR transition from Anasazi to Credible that is planned in July 2023. The MHP indicated that they will increase TA use related to PIPs once those audits and EHR transition activities are completed.
- To fully address this recommendation the MHP would need to have two active PIPs and TA as needed. This recommendation will be carried over to promote the development of two active PIPs with TA, as indicated.

**Recommendation 2:** Standardize the Client Services Information (CSI) timeliness tracking procedure to accurately capture urgent (requiring prompt attention), versus crisis (requiring immediate attention) metrics. This includes a method to track the time from first request (screening, triaging) to first offered appointment (provision of mental health services by a qualified provider) which is similar to other counties' best practices

and federal requirements. Provide training to staff to ensure accuracy and consistency with the new policy and procedure.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation. In the summer of CY 2022 the MHP updated forms and procedures to distinguish between urgent and crisis metrics.

**Recommendation 3:** Using the newly developed Kings View dashboards, create a standardized QI strategy that provides feedback to staff, contract providers, leaders, board members, and beneficiaries about the MHP's progress toward transformation and the outcomes of the care received.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation. The MHP has worked with their vendor since early CY 2022 to develop new dashboards including assignments; caseloads; demographics by appointment type; medication tracking, outcomes; and CSI timeliness. The dashboards can select and aggregate by a wide range of factors such as ethnicity, age, zip code, language preference, gender, and more. Some of the dashboards, such as individual outcomes, are shared with line staff and beneficiaries.

**Recommendation 4:** Standardized level of care (LOC) and beneficiary outcome tools to measure and guide clinical treatment; train staff and monitor programs for fidelity to evaluate transitions in care performance data and implement QI activities when warranted.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP collects and tracks Pediatric Symptoms Checklist (PSC-35); Child and Adolescent Needs and Strengths (CANS); Milestone of Recovery Scale (MORS); Patient Health Questionnaire (PHQ-9); and Generalized Anxiety Disorder Scale (GAD-7) assessment data to monitor client outcomes over time. Additionally, the MHP built and implemented new state screeners and medical necessity forms for beneficiaries youth and adults as part of implementing CalAIM. New state medical necessity forms are used with every assessment and reassessment. Modoc conducts weekly clinical supervision and weekly Utilization Review team meetings to support staff and monitor programs.

**Recommendation 5:** To ensure national culturally and linguistically appropriate services standards are met, track and trend demographic information for outreach and engagement activities in each geographic region of the county; ensure activities are offered in English and Spanish simultaneously; and provide intake paperwork, outreach

and engagement informational notices, and community flyers, etc. that are produced in preferred languages (English and Spanish) to reduce access language barriers.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation by tracking demographics on individuals served via the Kings View dashboards. To ensure outreach and engagement activities reach every geographic region of the county and are accessible to all Modoc County residents, the county works with Promatoras and has implemented outreach and engagement activities in schools across the county. All forms, intake information, and brochures are available in English and Spanish. The MHP community planning process is conducted in both English and Spanish.

# 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 in the MHP by county-operated providers and a tele-psychiatry contract. Overall, approximately 74 percent of services provided were claimed to Medi-Cal. This is down from 93 percent last year. The MHP is seeing more non-Medi-Cal clients, particularly in the schools and older adults. The schools are paying the county for services delivered to non-Medi-Cal youth and the county is billing Medicare for more older adult services.

The MHP has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week that is operated by the MHP during business hours and by Crisis Support Services of Alameda County for after-hours calls. Beneficiaries may request services through the access line as well as through the following system entry points: self-referral telephone call, clinic walk-in, Modoc County Department of Social Services, local law enforcement, probation, schools, caregivers, and other community providers. The MHP has designated one day per week, known as “triage Tuesday,” when assigned clinicians complete between two and four assessments. Walk-in beneficiaries also receive a same day assessment on Tuesdays. For those who cannot attend a Tuesday appointment, a future appointment will be scheduled. After the assessment is complete, the QI Staff Training Committee reviews the case during the weekly meeting to determine medical necessity and to assign a clinician. After the clinician is assigned, the beneficiary is scheduled for their first clinical appointment. For those that do not qualify for SMHS, they are referred to the MCO, or a community provider. For children and youth receiving mental health services at the local schools, the embedded mental health clinician can provide assessments in-person or at the main clinic.

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

[1] CMS Data Navigator Glossary of Terms

having provided telehealth services to 183 adult beneficiaries, 42 youth beneficiaries, and 44 older adult beneficiaries in one county-operated site. Among those served, zero 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 Modoc County, the time and distance requirements are 60 miles and 90 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

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

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

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

## ACCESS KEY COMPONENTS

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

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

### Table 2: Access Key Components

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

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

- The MHP has an active promatoras program to extend services to the Hispanic/Latino community in the underserved Newall area. They are also partnering with CIBHS in the learning collaborative Cultivating Outcomes through Equity in Behavioral Telehealth targeted to the migrant farm worker population.
- The MHP has many cooperative arrangements with partner agencies such as the schools, jail, and emergency department (ED). They have embedded a clinician in the local schools and developed a payment mechanism with the Department of Education so they can see students regardless of payer. They also have a nurse working in the jail to provide an array of pre-release services. Furthermore they are looking into the feasibility of using Mental Health Services Act (MHSA) funds to create a psych room in the ED to reduce the impact of behavioral health clients on the ED.
- Beneficiaries, especially full-service partnership beneficiaries, have a number of options to assist with transportation needs. The MHP has ten vehicles that are used for beneficiary transport and 20 staff members who can provide transportation. The contracted Wellness Center and a tribal resource center also provide transportation.

- The MHP could put more resources into maintaining their website. Some links do not work, the translation feature was not working, and while the Provider Directory is in both English and Spanish the website label does not indicate that Spanish is available in the document.

## ACCESS PERFORMANCE MEASURES

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, with a 10.99 percent PR, continues to demonstrate considerably better access to care than the state.

**Table 3: MHP Annual Beneficiaries Served and Total Approved Claim**

| Year | Annual Eligibles | Beneficiaries Served | Penetration Rate | Total Approved Claims | AACB |
|---|---|---|---|---|---|
| CY 2021 | 3,659 | 402 | 10.99% | $1,901,277 | $4,730 |
| CY 2020 | 3,474 | 392 | 11.28% | $2,137,843 | $5,454 |
| CY 2019 | 3,343 | 457 | 13.67% | $1,919,399 | $4,200 |

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

- While the PR has decreased each year from CY 2019 to CY 2021, it is consistently higher than the state rate. The number of annual eligibles has increased 9 percent in that timeframe while the overall county population has gone down, creating additional challenges to providing care.
- There have been fluctuations in the AACB, which is substantially lower than the statewide average.

### 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 | 378 | <11 | 0.53% | 1.71% | 1.96% |
| Ages 6-17 | 810 | 123 | 15.19% | 8.65% | 5.93% |
| Ages 18-20 | 165 | 14 | 8.48% | 7.76% | 4.41% |
| Ages 21-64 | 1,917 | 244 | 12.73% | 8.00% | 4.56% |
| Ages 65+ | 391 | 19 | 4.86% | 3.73% | 1.95% |
| **Total** | **3,659** | **402** | **10.99%** | **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 MHP PR is higher than other small-rural counties and the statewide rate for all age groups other than ages 0-5.
- While the PR is high relative to other counties, based on PRs, the MHP is increasing outreach to the TAY and older adult populations. They are providing outreach at the Public Health 'Health Hub which has a focus on adolescents and are present at activities such as bingo that attract an older adult population.

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

| Threshold Language | Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP | Percentage of Medi-Cal Beneficiaries Served by the MHP |
|---|---|---|
| Spanish | <11 | - |
| **Total Threshold Languages** | **<11** | **-** |
| Threshold language source: Open Data per BHIN 20-070 | | |

- Spanish is a threshold language for the MHP, however the number of clients served who identified Spanish as their primary language was small and had to be suppressed per Health Insurance Portability and Accountability Act (HIPAA) rules.
- As Hispanic/Latino is one of the larger ethnicities in the county, it is concerning that less than 11 beneficiaries served identify Spanish as their primary language. The MHP has three Spanish speaking staff and are looking into barriers for providing services to Spanish speaking beneficiaries.

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

| Entity | Annual ACA Eligibles | Total ACA Beneficiaries Served | Penetration Rate | Total Approved Claims | AACB |
|---|---|---|---|---|---|
| MHP | 1,009 | 97 | 9.61% | $358,027 | $3,691 |
| 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 eligibles that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The MHP's 9.61 percent ACA PR is lower than its overall 10.99 percent PR. Likewise the $3,691 AACB is lower than the MHP's $4,730 AACB.

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.

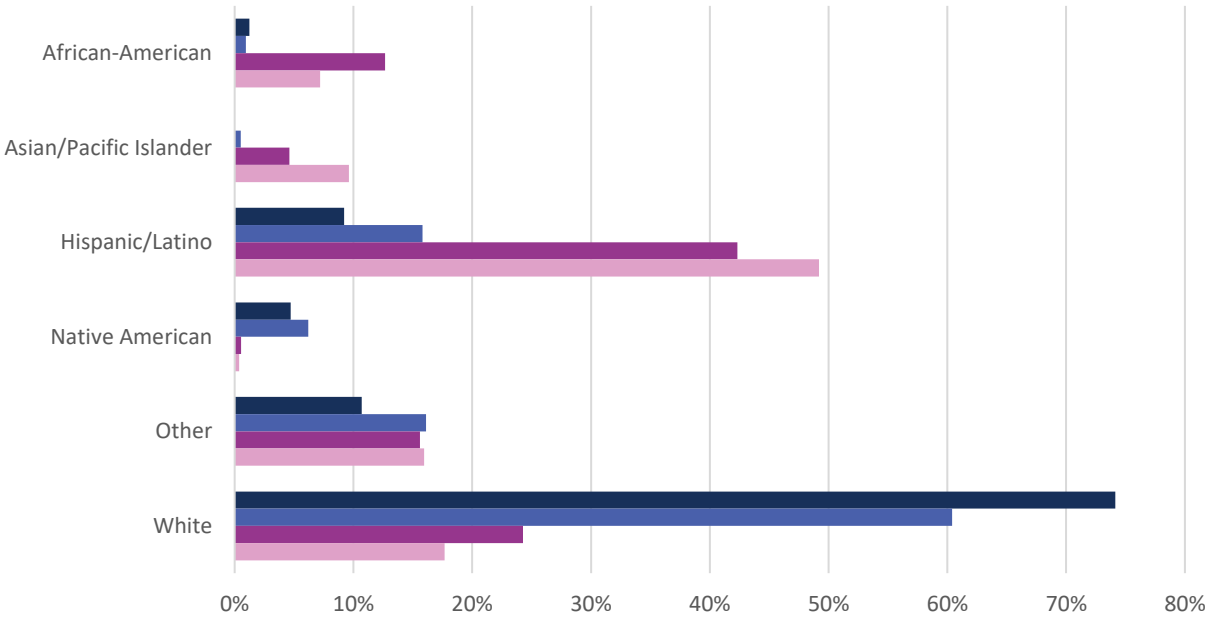
### Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

| Race/Ethnicity | Annual Eligibles | Beneficiaries Served | PR MHP | PR State |
|---|---|---|---|---|
| African-American | 34 | <11 | - | 7.64% |
| Asian/Pacific Islander | 19 | 0 | 0.00% | 2.08% |
| Hispanic/Latino | 579 | 37 | 6.39% | 3.74% |
| Native American | 227 | <11 | - | 6.33% |
| Other | 590 | 43 | 7.29% | 4.25% |
| White | 2,211 | 298 | 13.48% | 5.96% |
| **Total** | **3,660** | **402** | **10.98%** | **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 PR is higher than the state rate for every race/ethnicity where there is sufficient data to report.
- Within the county, the only PR that is higher than the 10.98 percent overall PR is for white beneficiaries. Services to white beneficiaries contribute greatly to the overall high PR in Modoc County.

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

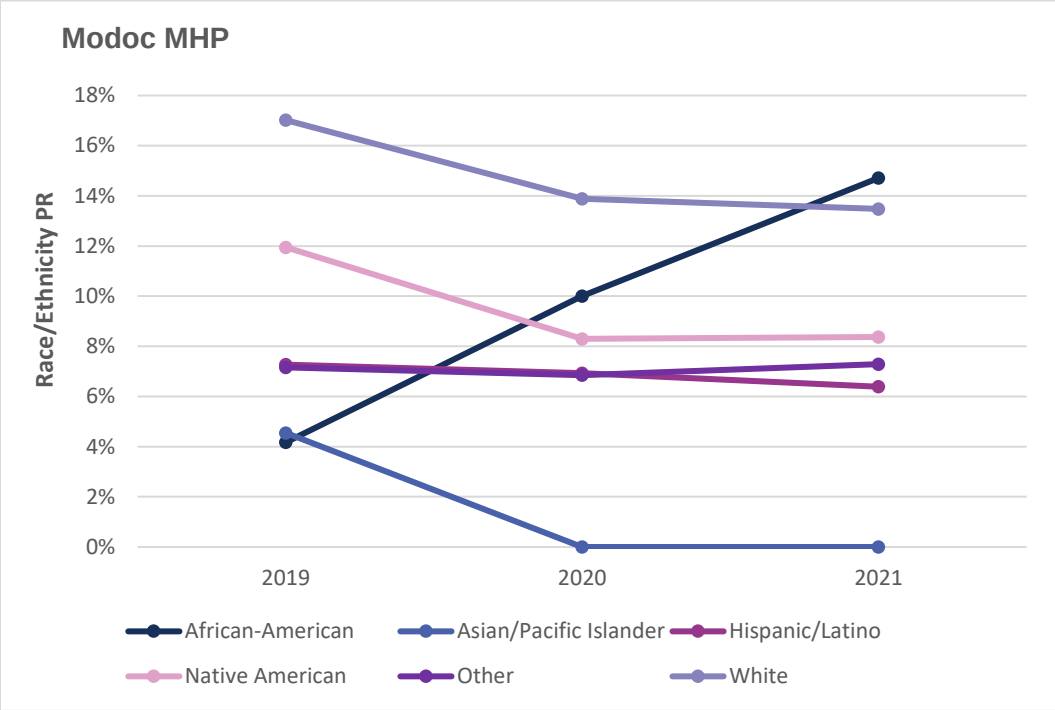



| | White | Other | Native American | Hispanic/Latino | Asian/Pacific Islander | African-American |
|---|---|---|---|---|---|---|
| MHP % Served | 74% | 11% | 5% | 9% | 0% | 1% |
| MHP % Eligible | 60% | 16% | 6% | 16% | 1% | 1% |
| State % Served | 24% | 16% | 1% | 42% | 5% | 13% |
| State % Eligible | 18% | 16% | 0% | 49% | 10% | 7% |

- Almost three out of four beneficiaries served are white, while whites make up 60 percent of the eligible population. Hispanic/Latino and other ethnicities each make up 16 percent of the eligible population, and represent 9 and 11 percent, respectively, of the beneficiaries served.
- The MHP has a higher percentage of Native Americans than seen statewide. They are working on strategies to best engage the tribal communities, such as working directly with tribal leadership, and collaboration with Resources for Indian Student Education, a local tribal resource center.

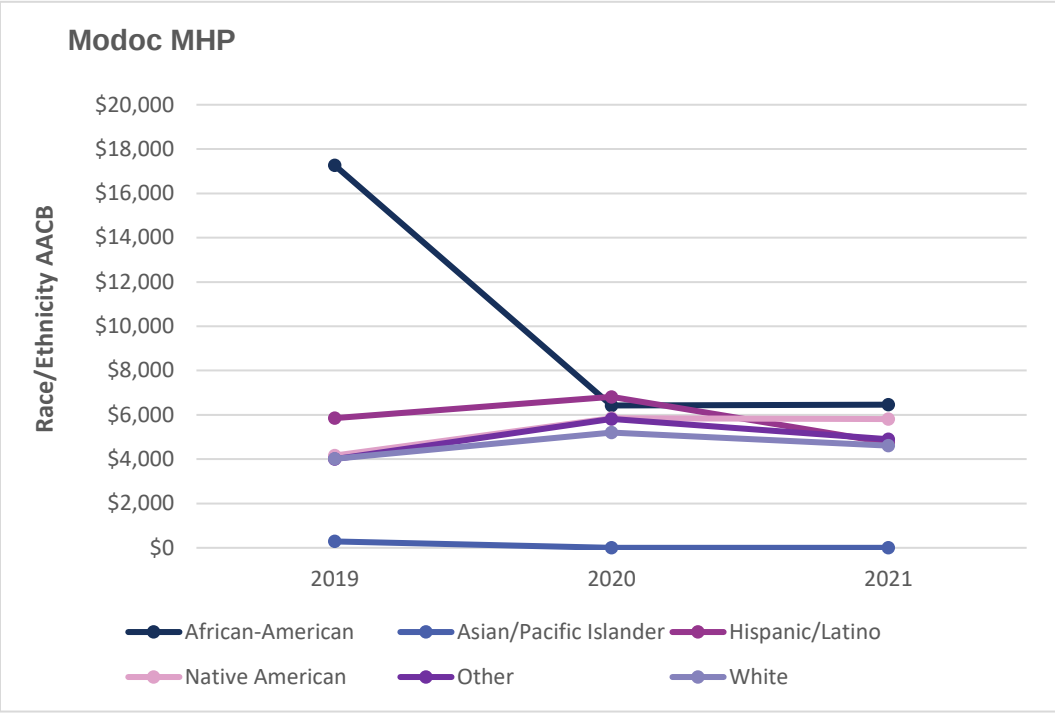
Figures 2 – 11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



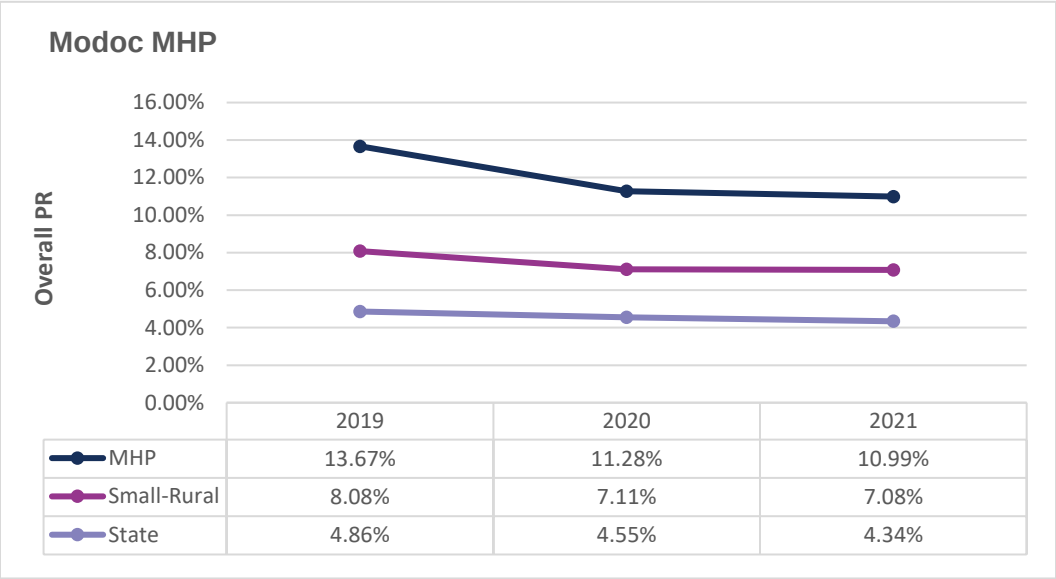

- With the exception of African-Americans and Asian/Pacific Islanders, both of whom are only 1 percent of Medi-Cal eligibles in the county, the relative PR by ethnicity has been fairly stable between CY 2019 and CY 2021. Whites have the highest PR, followed by Native Americans, Other and then Hispanic/Latinos.

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




- The African-American AACB was an outlier in CY 2019 and the Asian/Pacific Islander AACB was an outlier in all three CYs displayed. All other ethnicities have been clustered around $4,000 - $6,000 in CYs 2019 to 2021, with white beneficiaries having the lowest AACB each year. While white beneficiaries have the highest PR, they have the lowest AACB indicating they receive fewer or less expensive services.

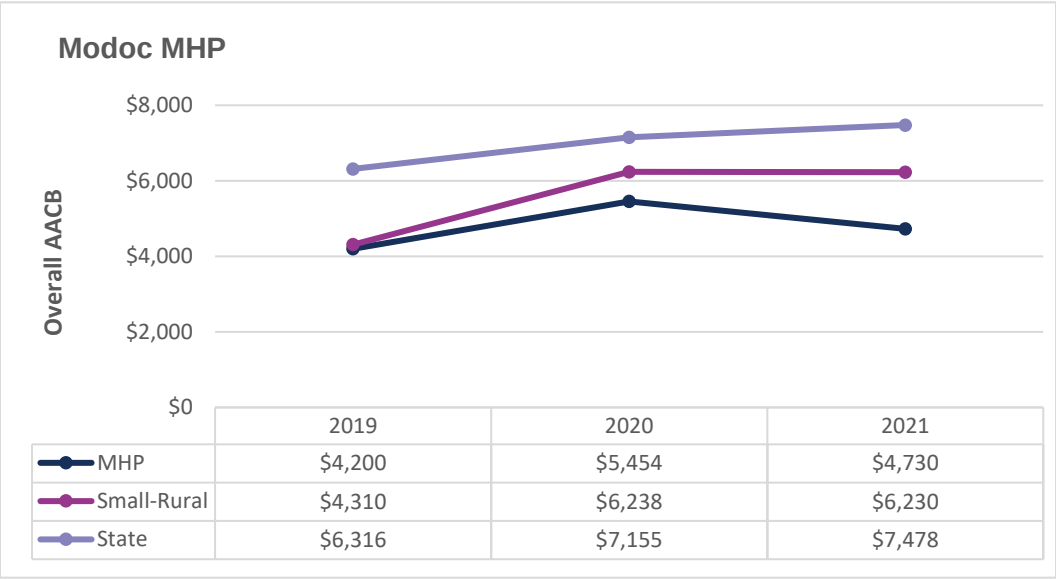
### Figure 4: Overall PR CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | 13.67% | 11.28% | 10.99% |
| Small-Rural | 8.08% | 7.11% | 7.08% |
| State | 4.86% | 4.55% | 4.34% |

- The MHP's PR has been consistently well above the state and small-rural county PRs between CY 2019 and CY 2021.

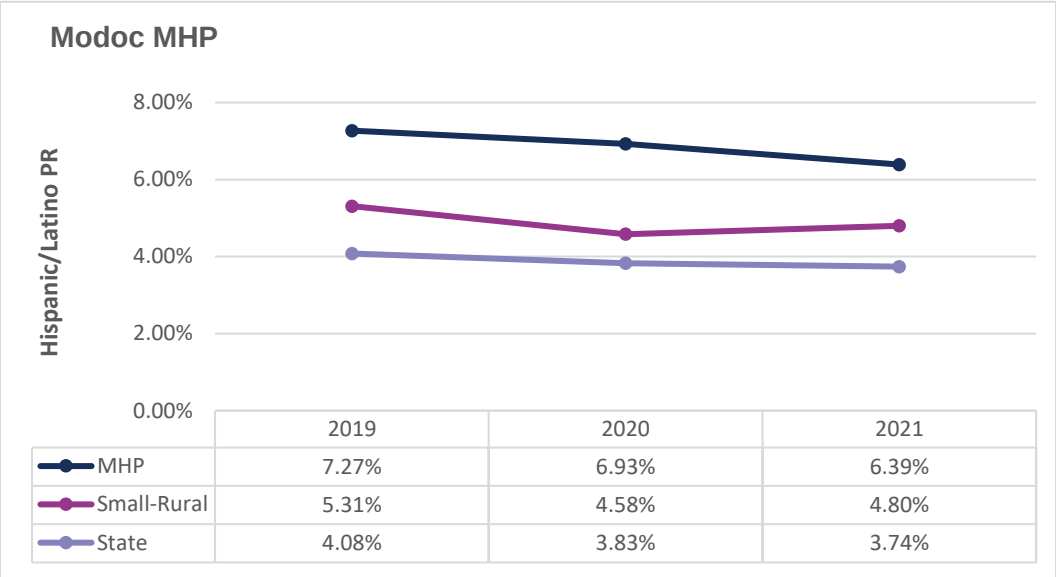
### Figure 5: Overall AACB CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | $4,200 | $5,454 | $4,730 |
| Small-Rural | $4,310 | $6,238 | $6,230 |
| State | $6,316 | $7,155 | $7,478 |

- The MHP's AACB has been consistently below the state and small-rural county averages between CY 2019 and CY 2021. While the state and small-rural county averages remained relatively stable between CY 2020 and CY 2021, the AACB went down in Modoc County. The MHP indicated that there was more concern in the county about COVID in CY 2021 than CY 2020 resulting in beneficiaries coming in for fewer services and bringing the average down.

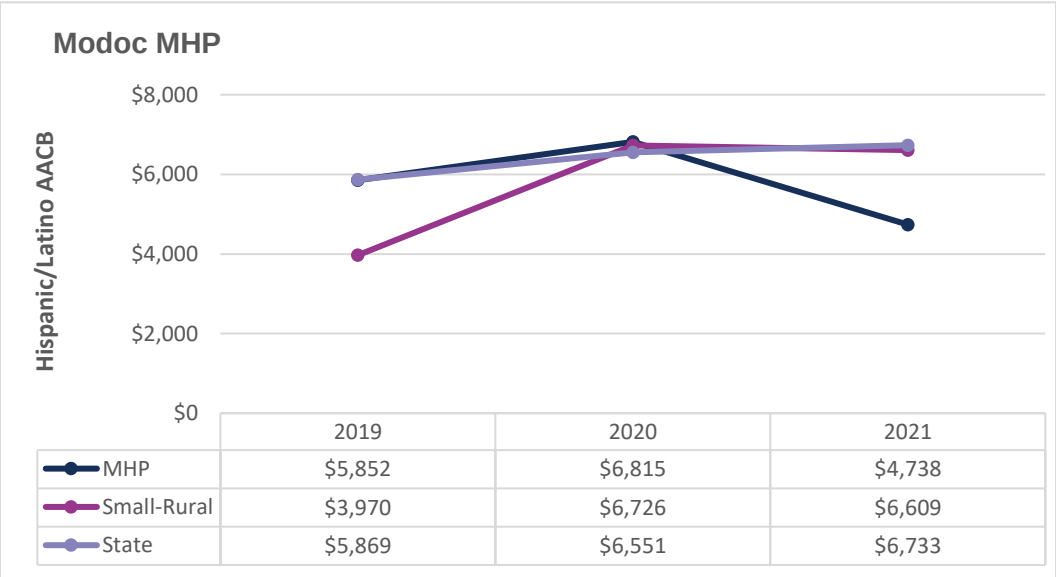
### Figure 6: Hispanic/Latino PR CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | 7.27% | 6.93% | 6.39% |
| Small-Rural | 5.31% | 4.58% | 4.80% |
| State | 4.08% | 3.83% | 3.74% |

- Like the overall PR, the Hispanic/Latino PR is well above the small-rural county and statewide rates every year between CY 2019 and CY 2021.

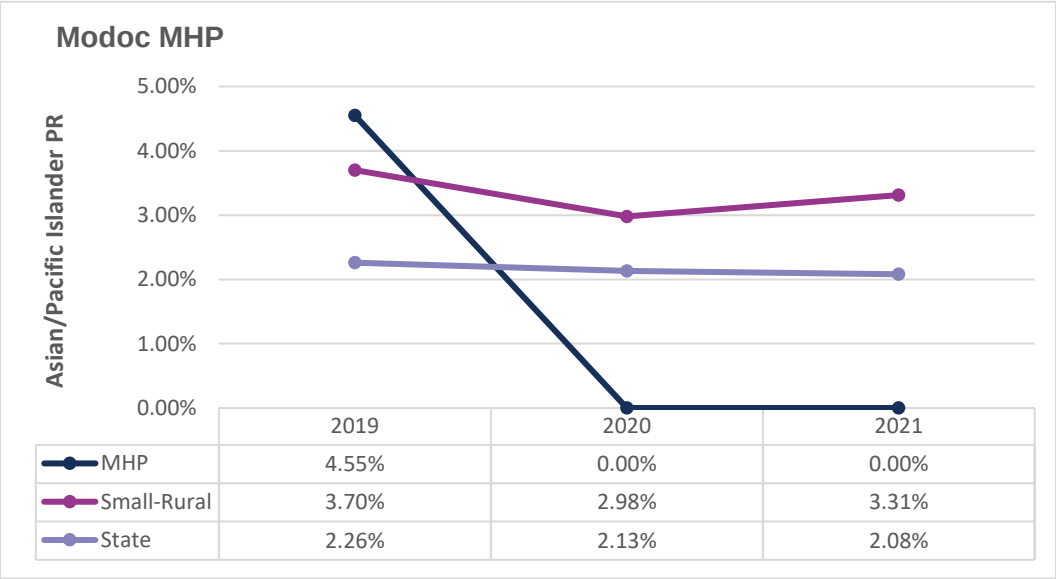
### Figure 7: Hispanic/Latino AACB CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | $5,852 | $6,815 | $4,738 |
| Small-Rural | $3,970 | $6,726 | $6,609 |
| State | $5,869 | $6,551 | $6,733 |

- The MHP, small-rural county, and state Hispanic/Latino AACBs were similar in CY 2020. The MHP's Hispanic/Latino AACB then fell 30 percent in CY 2021, which is a larger decrease than the MHP's overall AACB decrease in CY 2021.
- The MHP's Hispanic/Latino AACB was considerably higher than the overall MHP AACB in CYs 2019 and 2020. After falling 30 percent in CY 2021, it was about the same as the overall AACB.

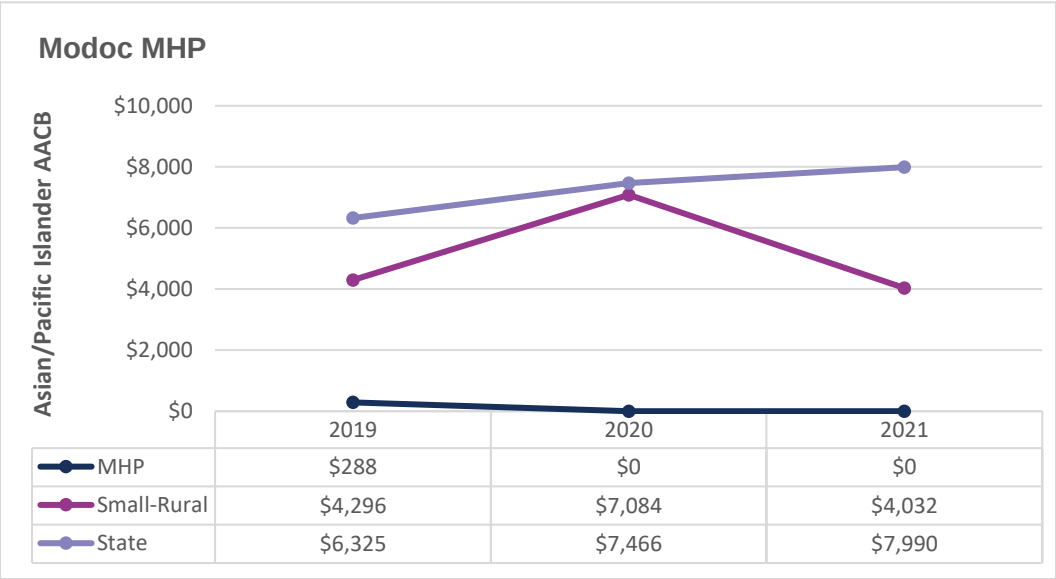
### Figure 8: Asian/Pacific Islander PR CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | 4.55% | 0.00% | 0.00% |
| Small-Rural | 3.70% | 2.98% | 3.31% |
| State | 2.26% | 2.13% | 2.08% |

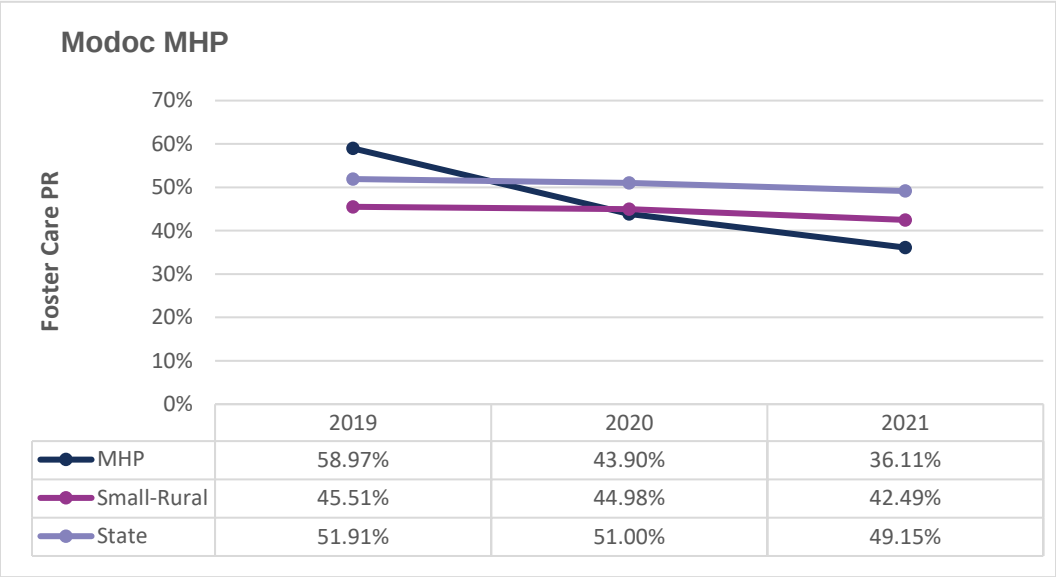
- Asian/Pacific Islanders represent 1 percent of the eligibles in the MHP and there were no Asian/Pacific Islanders served in CYs 2020 or 2021.

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




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | $288 | $0 | $0 |
| Small-Rural | $4,296 | $7,084 | $4,032 |
| State | $6,325 | $7,466 | $7,990 |

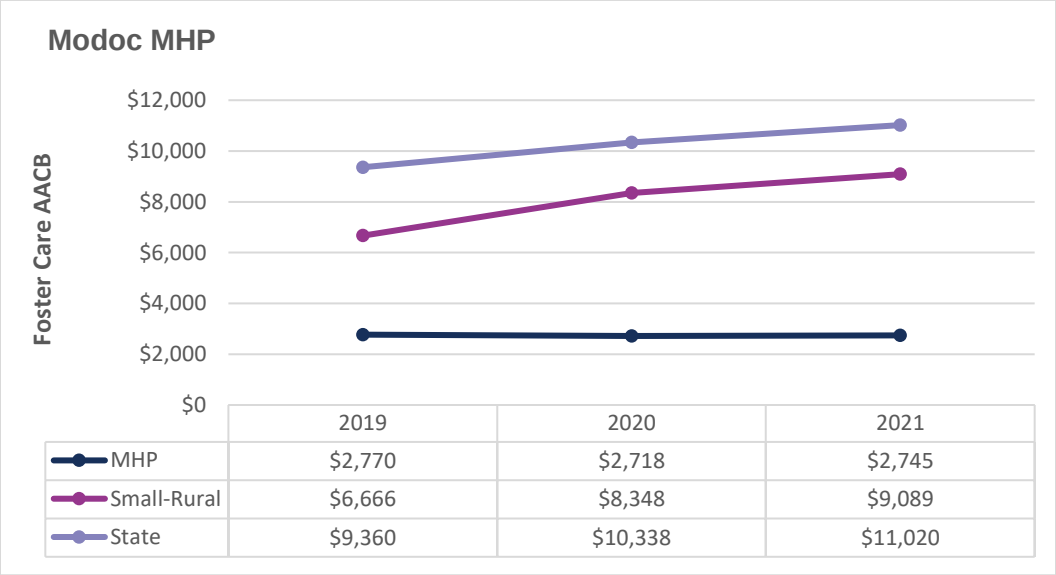
### Figure 10: Foster Care PR CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | 58.97% | 43.90% | 36.11% |
| Small-Rural | 45.51% | 44.98% | 42.49% |
| State | 51.91% | 51.00% | 49.15% |

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed. The MHP's FC PR has gone down every year between CY 2019 and CY 2021. The MHP is working with their Intensive Outpatient Teams to ensure that all FC youth are being brought in for services.

### Figure 11: Foster Care AACB CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | $2,770 | $2,718 | $2,745 |
| Small-Rural | $6,666 | $8,348 | $9,089 |
| State | $9,360 | $10,338 | $11,020 |

- Statewide FC AACB has increased each year, while the MHP FC AACB has remained steady each year between CY 2019 and CY 2021. This may be an indication that some FC homes are not bringing FC youth in for regular services.

## Units of Service Delivered to Adults and Foster Youth

### Table 8: Services Delivered by the MHP to Adults

| Service Category | MHP N = 277 | | | | 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 | - | 5 | 5 | 11.6% | 16 | 8 |
| Inpatient Admin | 0 | 0.0% | 0 | 0 | 0.5% | 23 | 7 |
| Psychiatric Health Facility | <11 | - | 3 | 3 | 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 | 0 | 0.0% | 0 | 0 | 13.0% | 1,546 | 1,200 |
| Crisis Intervention | 60 | 21.7% | 366 | 110 | 12.8% | 248 | 150 |
| Medication Support | 192 | 69.3% | 703 | 370 | 60.1% | 311 | 204 |
| Mental Health Services | 247 | 89.2% | 436 | 310 | 65.1% | 868 | 353 |
| Targeted Case Management | 83 | 30.0% | 245 | 100 | 36.5% | 434 | 137 |

- Higher percentages of MHP adult beneficiaries received crisis intervention, medication support, and mental health services than statewide. MHP beneficiaries also received more units of crisis intervention, and many more units of medication support, than statewide. MHP beneficiaries received about half the number of units of mental health services compared to the statewide average.
- Fewer MHP adult beneficiaries received fewer targeted case management units than compared to the statewide data.

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

| Service Category | MHP N = 13 | | | | Statewide N = 37,203 | | |
|---|---|---|---|---|---|---|---|
| | Beneficiaries Served | % of Beneficiaries Served | Average Units | Median Units | % of Beneficiaries Served | Average Units | Median Units |
| **Per Day Services** | | | | | | | |
| Inpatient | 0 | 0.0% | 0 | 0 | 4.5% | 14 | 9 |
| Inpatient Admin | 0 | 0.0% | 0 | 0 | 0.0% | 5 | 4 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Psychiatric Health Facility | 0 | 0.0% | 0 | 0 | 0.2% | 22 | 8 |
| Residential | 0 | 0.0% | 0 | 0 | 0.0% | 185 | 194 |
| Crisis Residential | 0 | 0.0% | 0 | 0 | 0.1% | 18 | 13 |
| Full Day Intensive | 0 | 0.0% | 0 | 0 | 0.2% | 582 | 441 |
| Full Day Rehab | 0 | 0.0% | 0 | 0 | 0.5% | 97 | 78 |
| **Per Minute Services** | | | | | | | |
| Crisis Stabilization | 0 | 0.0% | 0 | 0 | 3.1% | 1,404 | 1,200 |
| Crisis Intervention | <11 | - | 55 | 42 | 7.5% | 406 | 199 |
| Medication Support | <11 | - | 79 | 65 | 28.2% | 396 | 273 |
| TBS | 0 | 0.0% | 0 | 0 | 4.0% | 4,020 | 2,373 |
| Therapeutic FC | 0 | 0.0% | 0 | 0 | 0.1% | 1,030 | 420 |
| Intensive Care Coordination | <11 | - | 146 | 125 | 40.2% | 1,354 | 473 |
| Intensive Home Based Services | 0 | 0.0% | 0 | 0 | 20.4% | 2,260 | 1,275 |
| Katie-A-Like | 0 | 0.0% | 0 | 0 | 0.2% | 640 | 148 |
| Mental Health Services | 13 | 100.0% | 597 | 278 | 96.3% | 1,854 | 1,108 |
| Targeted Case Management | <11 | - | 565 | 565 | 35.0% | 342 | 120 |

- With only 13 FC beneficiaries served, the only category with sufficient data to report is that all FC beneficiaries served received mental health services. They received about one third of the number of units provided to FC youth statewide.

## IMPACT OF ACCESS FINDINGS

- The MHP strategic access system's weekly "triage Tuesday"; weekly staffing and case assignment; Clinician of the Day (COD) to address urgent and crisis situations; positive consumer feedback on ease access; and high penetration rate indicates that access is a system of care priority and strength of service.
- As there were less than 11 beneficiaries served who identify Spanish as their primary language, there may be barriers to accessing services for non-English speaking beneficiaries. While not necessarily directly related, the MHP's website could be enhanced to support Spanish speakers.
- Continued work with Child Welfare Services and Child Family Teams may be needed to ensure that FC youth receive all needed services.

# 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 | Met |
| 2E | Psychiatric Readmission Rates | Met |
| 2F | No-Shows/Cancellations | Met |

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

- The MHP has a very good record of offering and delivering first appointments within 10 business days, 95.7 percent of the time. In addition, though a weekly triage and assignment process, 50-60 percent of individuals will begin active

service within an additional 10 business days, with a prioritization based on acuity.

- The MHP provides transportation to beneficiaries who are discharged from inpatient facilities, all of which are out of county. This facilitates positive measures for follow-up appointments after psychiatric hospitalization and low psychiatric readmission rates.
- The MHP uses a COD to address urgent and crisis situations. The COD also provides support for beneficiaries that need daily check-ins.
- The MHP only tracks the first non-urgent psychiatry service rendered. They do not track the first non-urgent psychiatry service offered. The MHP reported that there were no FC first requests for non-urgent psychiatry services and indicated they would need to review whether that was accurate.
- The MHP reported an 18.1 percent no-show rate for psychiatrists which is well above their 10 percent standard.

## 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.

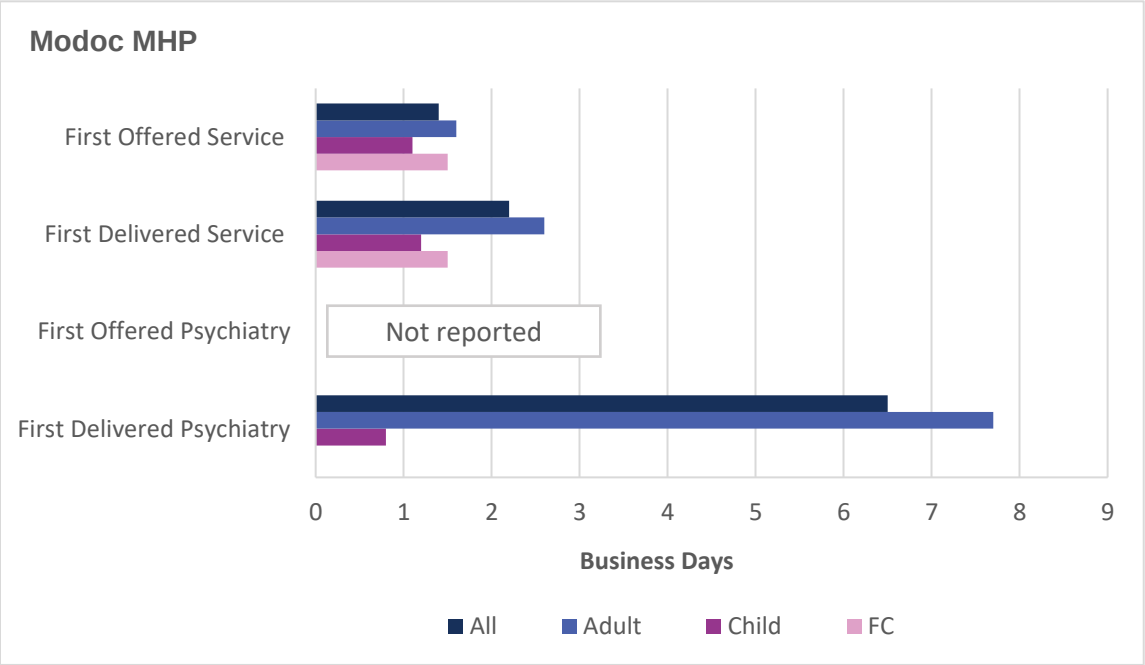
For the FY 2022-23 EQR, the MHP reported in its submission of the ATA, representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12 – 14 below display data submitted by the MHP; an analysis follows. This data represented the entire system of care. The MHP does not track first offered psychiatry appointment. They track the first rendered psychiatry appointment.

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

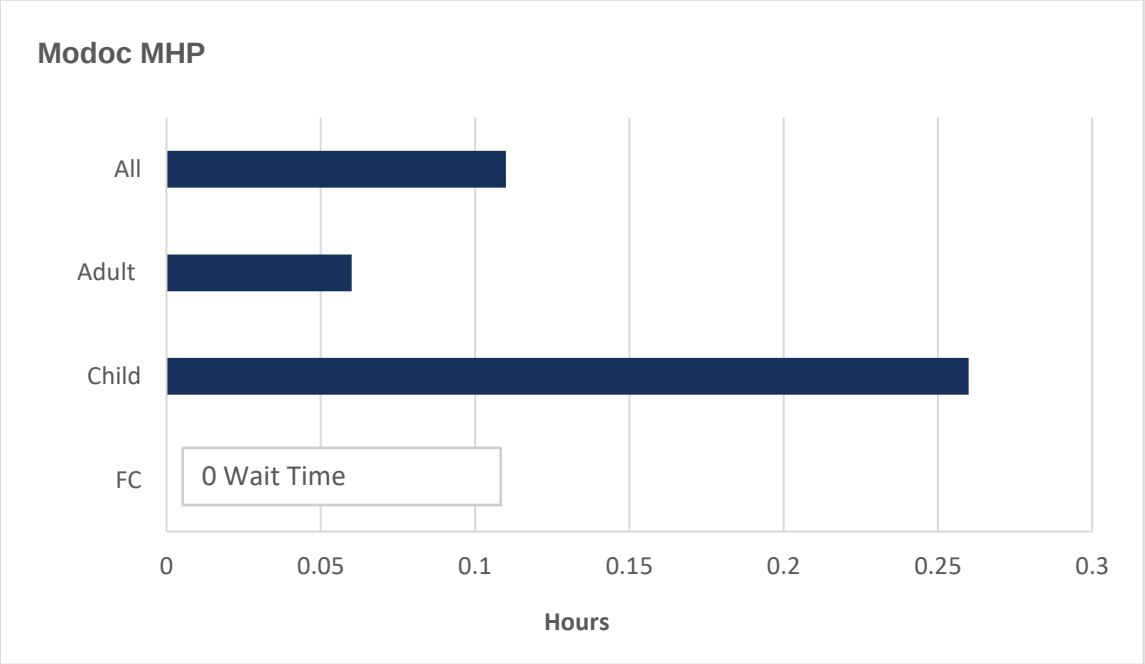
## Table 11: FY 2022-23 MHP Assessment of Timely Access

| Timeliness Measure | Average | Standard | % That Meet Standard |
|---|---|---|---|
| First Non-Urgent Appointment Offered | 1.4 Business Days | 10 Business Days* | 100.0% |
| First Non-Urgent Service Rendered | 2.2 Business Days | 10 Business Days** | 95.7% |
| First Non-Urgent Psychiatry Appointment Offered | *** | 15 Business Days** | *** |
| First Non-Urgent Psychiatry Service Rendered | 6.5 Business Days | 15 Business Days** | 90.7% |
| Urgent Services Offered (including all outpatient services) – Prior Authorization not Required | 0.11 Hours | 1 Hour** | 98.7% |
| Follow-Up Appointments after Psychiatric Hospitalization | 1.4 Days | 7 Days** | 100.0% |
| No-Show Rate – Psychiatry | 18.1% | 10%** | n/a |
| No-Show Rate – Clinicians | 5.0% | 10%** | n/a |
| * DHCS-defined timeliness standards as per BHIN 21-023 and 22-033<br>** MHP-defined timeliness standards<br>*** The MHP did not report data for this measure | | | |
| For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22 | | | |

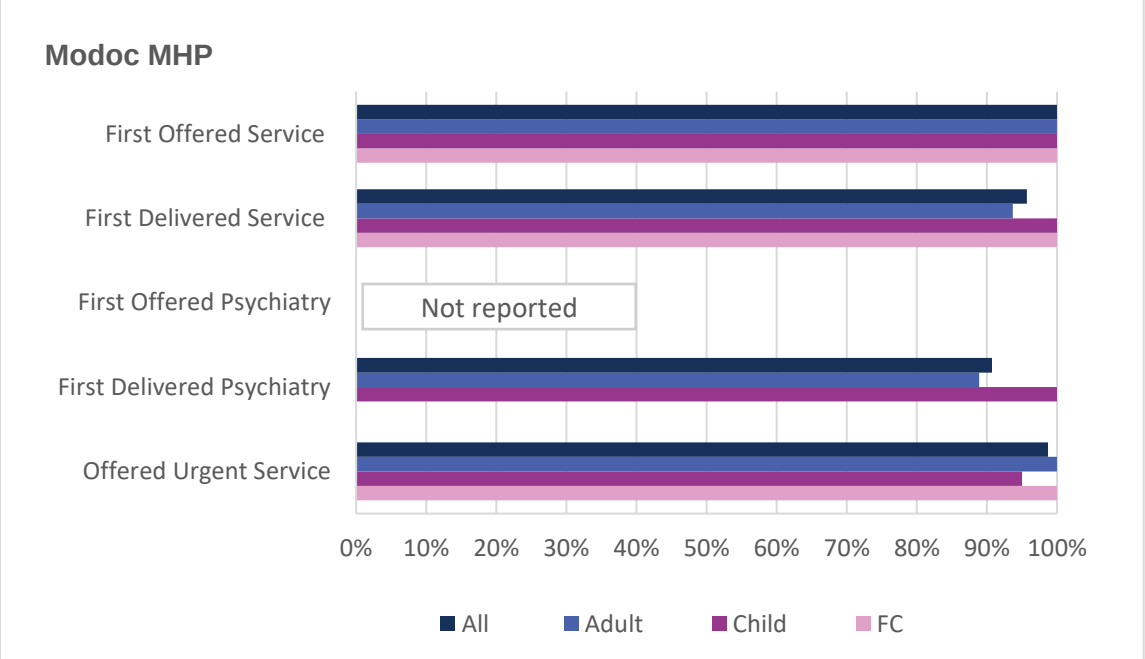
## Figure 12: Wait Times to First Service and First Psychiatry Service



## Figure 13: Wait Times for Urgent Services




## Figure 14: Percent of Services that Met Timeliness Standards




- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary.

According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent rendered assessments.

- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as crisis calls. The MHP began distinguishing between crisis and urgent calls in the summer of 2022 and will be able to report on urgent services rather than crisis services in the next EQR. There were reportedly 79 urgent/crisis service requests with a reported actual wait time to services for the overall population at 0.11 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 defines psychiatry access as the first clinical determination of need for both adults and children.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 18.1 percent for psychiatrists and 5.0 percent for non-psychiatry clinical staff.

## IMPACT OF TIMELINESS FINDINGS

- While the MHP’s first non-urgent psychiatry service rendered data indicates that the services are regularly offered within 15 business days, the MHP should begin tracking first non-urgent psychiatry service offered as well. This will allow the MHP to understand whether outlier data is something the MHP can control or related to beneficiary availability. The MHP should also review their FC non-urgent psychiatry data to ensure that it is being accurately collected.
- The MHP provides transportation to beneficiaries who are discharged from inpatient facilities, all of which are out of county. This facilitates positive measures for follow-up appointments after psychiatric hospitalization and low psychiatric readmission rates.
- Except for the psychiatry no-show rate, 18.1 percent, the MHP meets or exceeds each timeliness metric. The impact of the psychiatric no-show rate is not clear but warrants further MHP review.

# QUALITY OF CARE

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

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

## QUALITY IN THE MHP

Four committees comprise the MHP's CQI program: a) the quality management/compliance committee (QMC); b) QI staff training committee; c) CQI committee; and, d) Modoc County Behavioral Health Advisory Board (BHAB). These forums are responsible for the key functions of the MHP's CQI program.

The QMC is responsible for addressing programs policy and procedural changes and compliance adherence. The QI staff training committee provides an opportunity for program staff to review information from the QMC and items from the annual QAPI work plan. The CQI committee conducts key activities of the CQI program; The BHAB meets at least ten times annually.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of the MCPH Director; Behavioral Health Branch Director and Program Manager; Medical Director; QI Coordinator; designated clinical and case management staff; Mental Health Services Act (MHSA) Coordinator; designated administrative staff; Patient's Rights Advocate; and community members (including beneficiaries and family members). The QIC is scheduled to meet monthly. Since the previous EQR, the MHP QIC met 10 times. The MHP met four of the five identified FY 2022-23 QAPI workplan goals.

The MHP utilizes the following tools for LOC tools and Outcomes: PSC-35; CANS; MORS; PHQ-9; and GAD-7. The MHP uses the tools for changes over time with beneficiaries and in clinical meetings. The MHP has the ability to aggregate results but expects to begin using aggregated data in a systematic fashion after they convert to the new EHR.

## 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 | Met |
| 3C | Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation | Met |
| 3D | Evidence of a Systematic Clinical Continuum of Care | Met |
| 3E | Medication Monitoring | Met |
| 3F | Psychotropic Medication Monitoring for Youth | 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 | Met |
| 3J | Consumer and Family Member Employment in Key Roles throughout the System | Met |

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

- The MHP demonstrated regular usage of data to guide their decision making. They look at penetration data to identify populations that need additional outreach and engagement. They worked with their vendor to develop a number of new dashboards which they will use more extensively after they convert to the new EHR. Outcomes data is shared with beneficiaries as well as in clinical meetings.
- A weekly all staff meeting promotes communication throughout the MHP, where in addition to general beneficiary updates a nurse presents all medication changes to the clinical staff.
- The MHP has a peer ladder in their job classification, has seven peers on staff (which is a significant number for a small-rural county), and is incorporating peers into all new programs. In addition, 30 – 40 percent of their staff have lived experience, regardless of whether they were hired into a peer designated role.
- The MHP does track and trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.

- Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD):
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC):
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM):
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP):

## QUALITY PERFORMANCE MEASURES

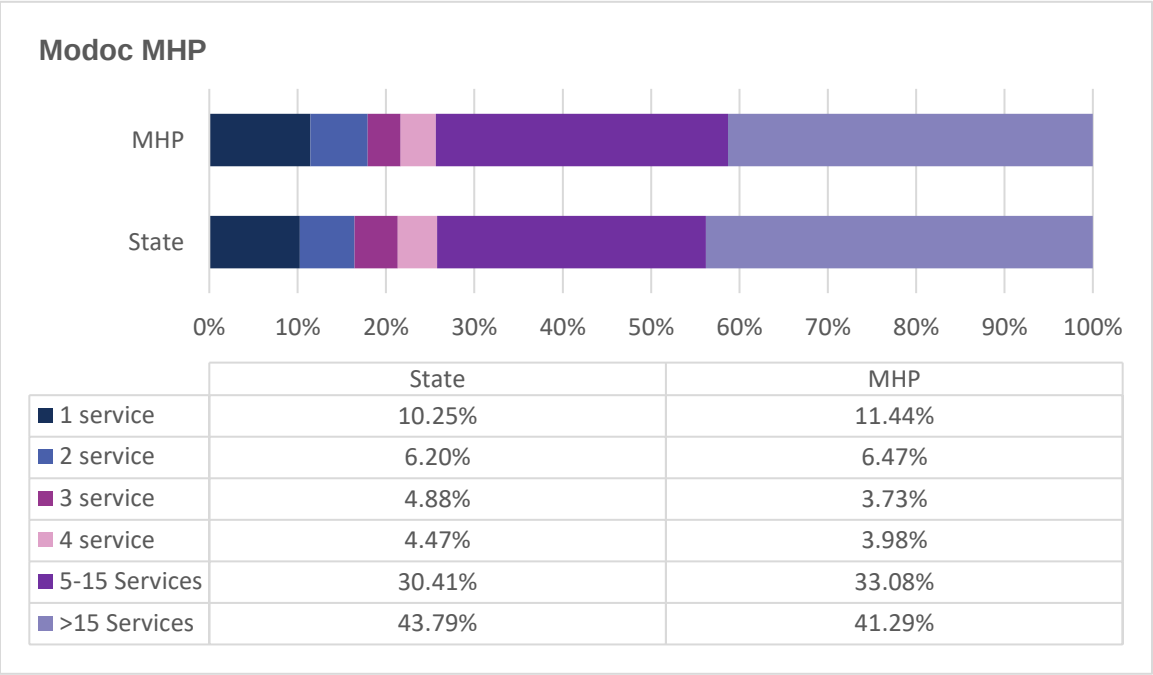
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

### Retention in Services

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

### Figure 15: Retention of Beneficiaries CY 2021



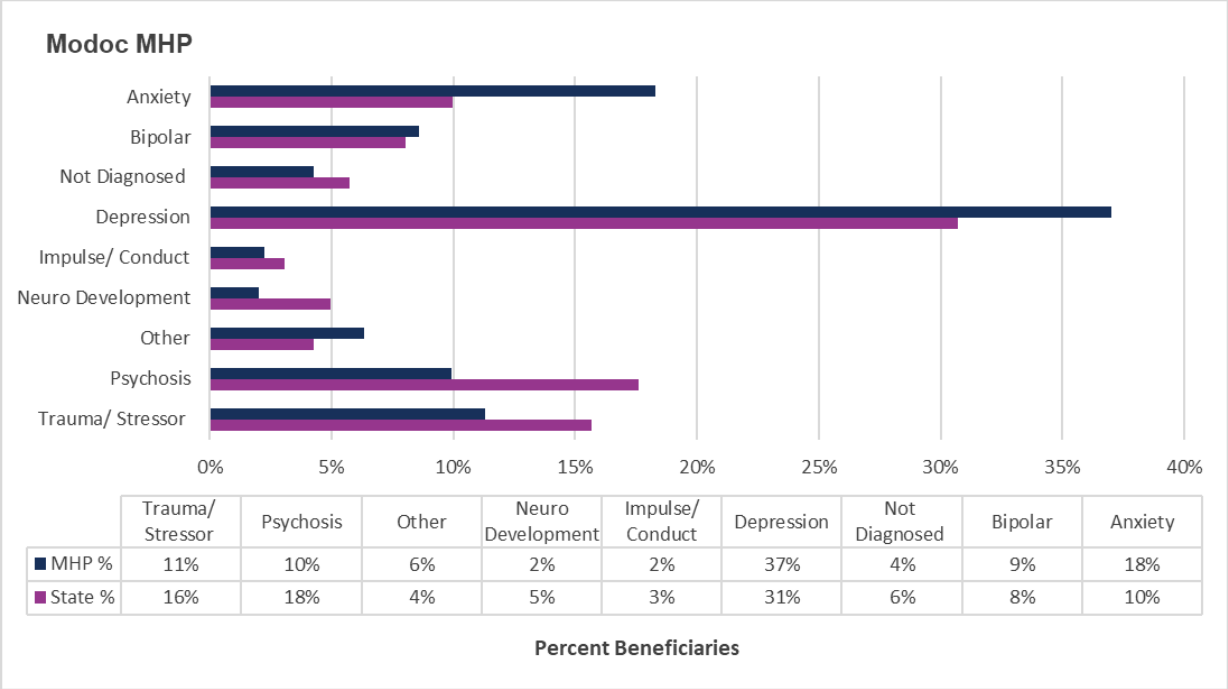

| | State | MHP |
|---|---|---|
| 1 service | 10.25% | 11.44% |
| 2 service | 6.20% | 6.47% |
| 3 service | 4.88% | 3.73% |
| 4 service | 4.47% | 3.98% |
| 5-15 Services | 30.41% | 33.08% |
| >15 Services | 43.79% | 41.29% |

- The MHP's retention of beneficiaries is similar to statewide. About 25 percent beneficiaries received 1-4 services, about 30 percent received 5-15 services, and the remaining 40 percent received more 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 figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

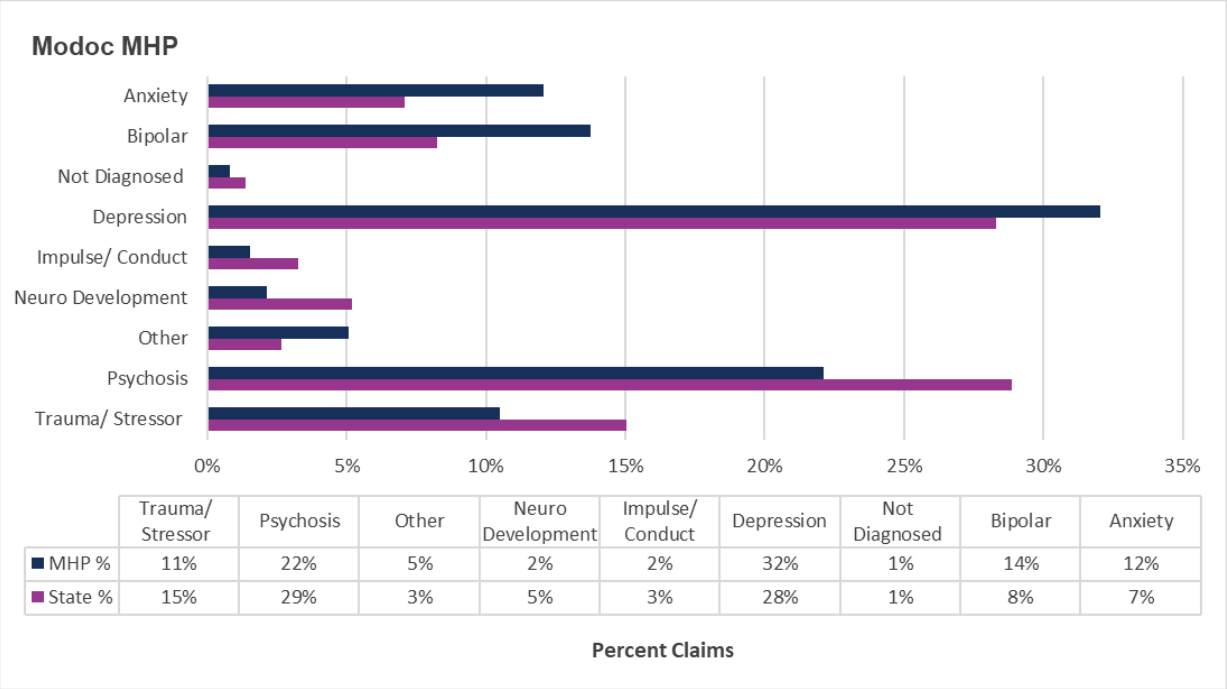
## Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021




| | Trauma/ Stressor | Psychosis | Other | Neuro Development | Impulse/ Conduct | Depression | Not Diagnosed | Bipolar | Anxiety |
|---|---|---|---|---|---|---|---|---|---|
| MHP % | 11% | 10% | 6% | 2% | 2% | 37% | 4% | 9% | 18% |
| State % | 16% | 18% | 4% | 5% | 3% | 31% | 6% | 8% | 10% |

- The most common diagnostic categories in the MHP are depression and anxiety, which together account for 55 percent of beneficiaries. Trauma/stressor, psychosis, and bipolar represent 30 percent of diagnoses. The MHP has a higher proportion of beneficiaries with depression and anxiety, and lower proportion of psychosis and trauma/stressor diagnoses, than seen statewide.

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




| | Trauma/ Stressor | Psychosis | Other | Neuro Development | Impulse/ Conduct | Depression | Not Diagnosed | Bipolar | Anxiety |
|---|---|---|---|---|---|---|---|---|---|
| MHP % | 11% | 22% | 5% | 2% | 2% | 32% | 1% | 14% | 12% |
| State % | 15% | 29% | 3% | 5% | 3% | 28% | 1% | 8% | 7% |

- Similar to the breakdown of diagnostic categories, 32 percent of claims were attributed to the depression diagnostic category. Psychosis accounted for 22 percent of claims, while only 10 percent of beneficiaries had a psychosis diagnosis. Claims for psychosis were still lower than the 29 percent statewide average. Bipolar and anxiety diagnoses represented a higher proportion of claims than seen statewide.

## 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 | 4.00 | 8.86 | $5,601 | $12,052 | $39,205 |
| CY 2020 | 14 | 24 | 6.90 | 8.68 | $9,627 | $11,814 | $134,783 |
| CY 2019 | 18 | 24 | 7.62 | 7.80 | $7,687 | $10,535 | $138,372 |

- While the number of Medi-Cal beneficiaries has been going up in the county, the number of hospitalized beneficiaries has been going down from CY 2019 to CY

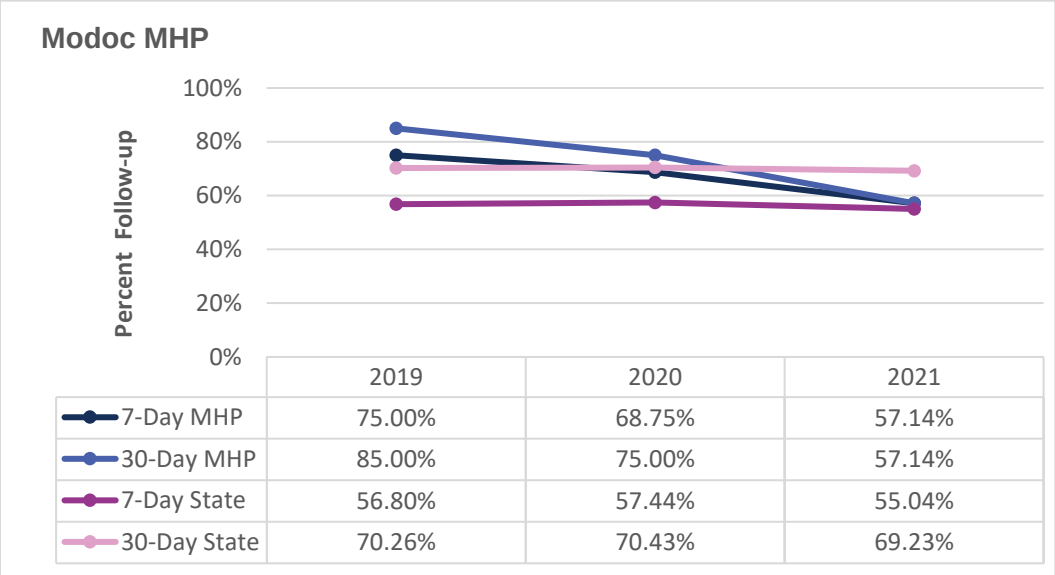
2021. The low numbers of hospitalization and shorter average LOS are likely factors in keeping the county's overall AACB down.

## Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2021 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

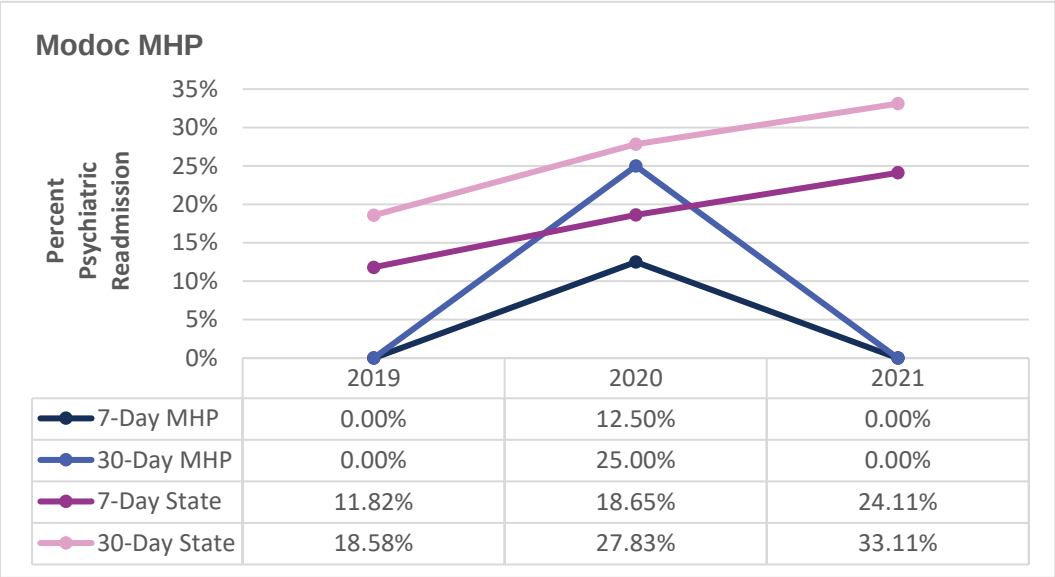
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| 7-Day MHP | 75.00% | 68.75% | 57.14% |
| 30-Day MHP | 85.00% | 75.00% | 57.14% |
| 7-Day State | 56.80% | 57.44% | 55.04% |
| 30-Day State | 70.26% | 70.43% | 69.23% |

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




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| 7-Day MHP | 0.00% | 12.50% | 0.00% |
| 30-Day MHP | 0.00% | 25.00% | 0.00% |
| 7-Day State | 11.82% | 18.65% | 24.11% |
| 30-Day State | 18.58% | 27.83% | 33.11% |

- While there has been some decline in the MHP's post psychiatric inpatient follow-up rates between CY 2019 and CY 2021, the MHP generally has a higher rate of follow-up in each of those years at both 7 and 30 days.
- The MHP had no 7- or 30-day readmissions in CY 2019 or CY 2021. While there were some readmissions in CY 2020, it is based on a very small number of MHP hospitalizations that year.

## 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, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, nearly 92

percent of the statewide beneficiaries are “low cost” (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACB of $4,412 and median of $2,830.

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

| Entity | Year | HCB Count | % of Beneficiaries Served | % of Claims | HCB Approved Claims | Average Approved Claims per HCB | Median Approved Claims per HCB |
|---|---|---|---|---|---|---|---|
| **Statewide** | CY 2021 | 27,729 | 4.50% | 33.45% | $1,539,601,175 | $55,523 | $44,255 |
| **MHP** | CY 2021 | <11 | - | - | - | - | - |
| | CY 2020 | <11 | - | 11.52% | $246,188 | $41,031 | $39,479 |
| | CY 2019 | <11 | - | 8.79% | $168,678 | $42,170 | $38,254 |

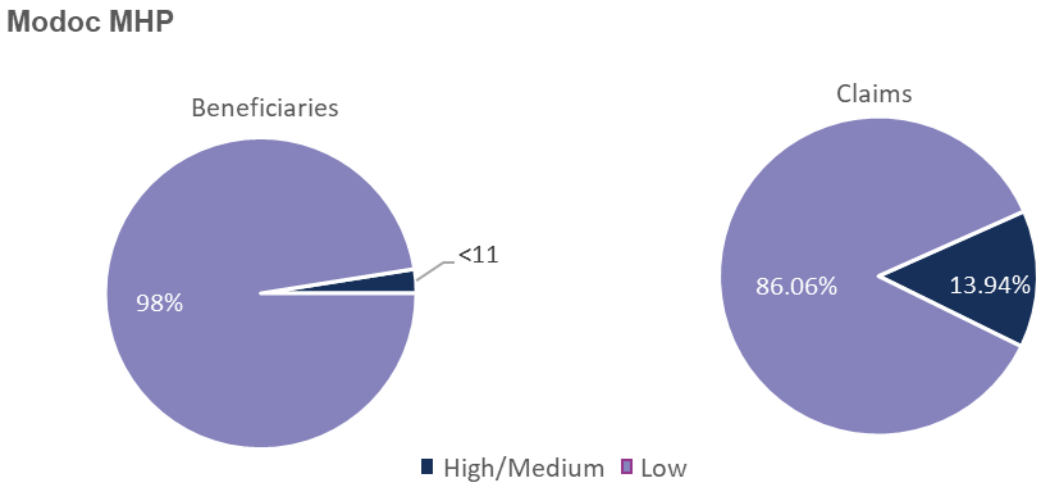
- There are less than 11 HCBs in the county, so the percentage of beneficiaries served is suppressed.

### 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) | 392 | 97.51% | 86.06% | $1,636,226 | $4,174 | $2,829 |

- Low-cost beneficiary claims represent a much higher proportion of claims in the MHP than statewide. Statewide 54 percent of claims are for low-cost beneficiaries. In Modoc County they account for 86 percent of claims.

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




- Almost all beneficiaries (approximately 98 percent) and 86 percent of approved claims are for low-cost beneficiaries.

## IMPACT OF QUALITY FINDINGS

- The MHP's CY 2019 to CY 2021 psychiatric inpatient data shows declining numbers of inpatient admissions, LOSs and no 7- or 30-day readmissions in CY 2021, suggesting an effective program for treating hospitalized beneficiaries.
- The MHP's use of peers for peer support; as ED crisis sitters; to transport out of county psychiatric IP discharges back to Modoc county; and promoting people with lived experience into other MHP positions; cumulatively enrich the consumer experience and reduce the need for more intensive services.

# PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

## CLINICAL PIP

### General Information

Clinical PIP Submitted for Validation: A Clinical PIP was not submitted.

Date Started: n/a

Aim Statement: n/a

Target Population: n/a

Status of PIP: No clinical PIP was submitted due to lack of staffing during the period in which a clinical PIP would have been developed and operated.

**Summary:** n/a

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

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

# NON-CLINICAL PIP

## General Information

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

Date Started: 09/2022

Aim Statement: For Medi-Cal beneficiaries with ER visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with Modoc County Behavioral Health (MCBH) within 7 and 30 days by 3 percent by June 30, 2023.

Target Population: The target population for this project is operationalized within the parameters of the HEDIS FUM metric. A qualifying event is an individual with an ER visit and a principal diagnosis of mental illness or intentional self-harm.

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

## Summary

There is no consistent 24/7 process to immediately notify MHP staff when a person with a mental health condition is admitted to the ER. As a result, individuals may not receive a follow-up appointment. The development of an integrated EHR and HIE systems, system standards for screening mental health conditions, and strategies for referring individuals to needed services will create the opportunity to ensure individuals are referred and linked to needed services. Based on root cause analysis and stakeholder engagement activities, MCBH identified the following preliminary intervention(s):

- Develop data sharing channels with the Modoc Medical Center ER and MCP.
- Obtain regular and consistent data from the ER and MCP.
- Link persons discharged from the ER to services based on presenting needs.
- Create and implement a formalized referral tracking mechanism that allows for real-time referral coordination from the Modoc Medical Center ER.
- Assign a care coordinator to monitor and follow-up on referrals that include regular meeting with the ER staff and hospital medical social workers.
- Utilize support services (e.g., care coordination, outreach, advocacy, and empowerment) to support transitions following an ER visit, inpatient admission, and Support Awareness, Follow-up, and Engagement interventions.

### TA and Recommendations

As submitted, this non-clinical PIP was found to have high confidence, because: the PIP includes well developed strategies to improve data sharing, monitoring and clinical follow-through.

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

- TA included a review of how to report the DHCS BHQIP FUM in the EQRO format.

# 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 Cerner Community Behavioral Health, which has been in use for 11 years. Currently, the MHP plans to implement the Qualifacts Credible EHR in July 2023.

Approximately 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 under MHP control.

The MHP has 32 named users with log-on authority to the EHR, including approximately 28 county staff and 4 contractor staff. Support for the users is provided by one full-time equivalent (FTE) IS technology position. Currently the position is filled.

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

Contracted tele-psychiatry providers enter beneficiary practice management and service data directly into the MHP EHR.

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

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

### Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP plans to implement the Credible PHR within the next year.

### Interoperability Support

The MHP is contracted with the SacValley MedShare HIE. They have not begun any data exchange with the HIE.

## INFORMATION SYSTEMS KEY COMPONENTS

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

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

### Table 17: IS Infrastructure Key Components

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

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

- The MHP devotes time and effort into developing dashboards and incorporating them into their operations.
- Modoc County had an outside organization perform a HIPAA Risk Assessment. They were scored A's in most areas and received one A- and one B+. The MHP provided their Corrective Action Plan for items that needed to be addressed.
- The MHP's denied claim rate was only 0.02 percent.
- The MHP has joined an HIE but not begun any implementation activities.
- The MHP received a Partially Met in Data Collection and Processing because they do not have a data warehouse. However, as a small, rural county they were able to demonstrate data analytic capabilities without a data warehouse.
- The MHP received a Partially Met in EHR Functionality based on the number of EHR components they use. Since changing EHR's results in a fair amount of disruption there is not a recommendation to increase the number of modules they utilize. As they adjust to the new EHR the MHP is encouraged to utilize additional EHR components such as using electronic lab orders and results and collection of LOC data.
- The MHP's training plan for transition to the Credible EHR was not very well defined at the time of the EQRO review. To ensure a successful implementation the MHP should make sure their super users have adequate training to support others, work out the details of when general staff will be trained, and ensure they have adequate vendor support for a smooth transition.

## INFORMATION SYSTEMS PERFORMANCE MEASURES

### Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

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

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

| Month | # Claim Lines | Billed Amount | Denied Claims | % Denied Claims | Approved Claims |
|---|---|---|---|---|---|
| Jan | 626 | $158,204 | $0 | 0.00% | $156,411 |
| Feb | 608 | $149,807 | $0 | 0.00% | $148,061 |
| Mar | 812 | $204,236 | $0 | 0.00% | $201,620 |
| April | 647 | $158,751 | $147 | 0.09% | $156,616 |
| May | 569 | $139,283 | $0 | 0.00% | $137,413 |
| June | 636 | $152,341 | $147 | 0.10% | $147,492 |
| July | 585 | $154,533 | $0 | 0.00% | $150,329 |
| Aug | 665 | $175,281 | $0 | 0.00% | $172,462 |
| Sept | 659 | $152,325 | $0 | 0.00% | $149,871 |
| Oct | 561 | $148,762 | $0 | 0.00% | $146,270 |
| Nov | 624 | $160,072 | $0 | 0.00% | $156,383 |
| Dec | 658 | $158,541 | $0 | 0.00% | $155,505 |
| **Total** | **7,650** | **$1,912,136** | **$294** | **0.02%** | **$1,878,433** |

### 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 | 2 | $294 | 100.00% |
| **Total Denied Claims** | **2** | **$294** | **100.00%** |
| **Overall Denied Claims Rate** | **0.02%** | | |
| **Statewide Overall Denied Claims Rate** | **1.43%** | | |

- The MHP has a very low denied claims rate.

## IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP demonstrated a good balance between a personal approach to providing care and a data-focused approach to identifying gaps and analyzing outcomes. With the transition to the Credible EHR they should explore using the new dashboards in a systematic manner and utilizing additional EHR features such as lab orders/results and entering level of care information in their EHR. To

ensure a successful transition to the Credible EHR the MHP should define a more explicit training plan for super users and general staff.

- While the MHP has a signed agreement with the SacValley MedShare HIE they have not begun data sharing with the HIE or utilizing any of the HIE services for coordinating care between providers.

# VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

## CONSUMER PERCEPTION SURVEYS

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

The MHP completed the most recent CPS but there were only ten completed surveys, nine adult and one child survey. Not every survey was fully completed. The MHP is implementing a strategy to assist beneficiaries to complete surveys for the next CPS.

## CONSUMER FAMILY MEMBER FOCUS GROUPS

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 two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

### Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held via videoconference and included seven participants; a language interpreter was not used for this focus group. All consumers participating receive clinical services from the MHP.

Access was reported to be within days to a few weeks and was seen as a positive experience. Ongoing appointments are timely, and consumers receive appointment reminders. Transportation can be provided but not all participants understood the transportation options. Most services are face-to-face except for psychiatry, which is always through telehealth. Several consumers praised the Sunrise of Hope peer-run program for the classes and social programs. Four of the seven participants recalled filling out the CPS but none recalled ever seeing any of the results. The consumers were aware of peer work opportunities as transporters and sitters. Overall, staff were represented as positive, helpful, and professional.

Recommendations from focus group participants included:

- Pay the staff more money and give them more resources to help us.
- Please build the sunshade for the Sunshine of Hope patio.
- More housing is needed.

### Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of parent/caretakers of youth consumers who initiated services in the preceding 12 months. The focus group was held via teleconference and included four participants; a language interpreter was not used for this focus group. All parent/caretakers participating have a family member who receives clinical services from the MHP.

Participants reported that access was initiated through the Tuesday access day process, and they moved from assessment to initiating services within one to two weeks. All services, except psychiatry, are received face-to-face. Appointment reminders are helpful and staff are responsive. Family can be included in the services delivery as needed and appropriate.

Recommendations from focus group participants included:

- A concern was raised that, being a small town, people see you going into the facility.
- Wish there was a larger pool of professionals, especially more male counselors.

## SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall, the MHP is experienced as an easy to access delivery system inclusive of one-on-one services, psychiatry, and peer support. The overarching theme is one of satisfaction. Generally, participants were either unaware or did not participate in MHP committees.

# 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. The MHP conducts a weekly triage assessment day followed by a weekly staffing to provide assessments and initiation of clinical services within 1-2 weeks. (Access)
2. The MHP has implemented a strategic crisis plan inclusive of ED direct MHP response; providing ED sitters; and providing transporters from IP facilities back to the community; resulting in IP utilization and recidivism lower than state averages. (Access, Quality)
3. There is overall improvement in ATA measure indicating improved timeliness year-over-year. (Timeliness)
4. The MHP has developed extensive dashboards to provide consumers, staff, and management with information to monitor, track, trend, and perform process improvement. (Quality)
5. The MHP uses data to guide their decision making. They look at penetration rates to identify populations that are underserved and share outcomes data with beneficiaries when appropriate. (Access, Quality, IS)

## OPPORTUNITIES FOR IMPROVEMENT

1. FC penetration rates declined from 59 to 36 percent in two years and only 13 FC received services in CY 2021. The 17 FC Service Categories reported in Table 9 documented that FC beneficiaries received zero services in 12 categories, suppressed (<11) in four categories, and only Mental Health Services, 13, as a reportable number for inclusion in the report. (Access, Quality)
2. The psychiatry no-show rate of 18.1 percent is the outlier to the Timeliness metrics that otherwise exceed their metric standards. (Timeliness)
3. Although the MHP provides initial psychiatry appointments within the 15-day DHCS standard, they do not track the first offered psychiatry appointment. This limits analytical capabilities related to instances where the standard is not met. (Timeliness, Quality)
4. The MHP has joined but not begun to utilize the services of the SacValley MedShare HIE which should improve coordination of care when beneficiaries receive services outside of the MHP. (IS, Quality)

5. The MHP would benefit from utilizing CalAIM initiatives, or other significant areas of change, to identify two PIPs, and engage in TA as needed to develop and implement. (PIPs)

## 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. Review FC service delivery system and develop and implement strategies to increase FC PR and continuum of services delivered. (Access, Quality)
2. Develop and implement strategies to decrease the psychiatry no-show rate of 18.1 percent. (Timeliness)
3. Develop and implement strategies to track the first offered psychiatry appointment. (Timeliness, Quality)
4. Implement the services of the SacValley MedShare HIE which should improve coordination of care when beneficiaries receive services outside of the MHP. (IS, Quality)
5. Utilize CalAIM initiatives, or other significant areas of change, to identify two PIPs, and engage in TA as needed to develop and implement. (PIPs)

   (This recommendation is a carry-over from FY 2021-22.)

# 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 public health emergency (PHE) was in place until February 28, 2023 and a national PHE is scheduled to end May 11, 2023. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

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

# ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

## ATTACHMENT A: REVIEW AGENDA

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

### Table A1: CalEQRO Review Agenda

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

# ATTACHMENT B: REVIEW PARTICIPANTS

## CalEQRO Reviewers

Bill Walker, Lead Quality Reviewer
Christy Hormann, Second Quality Reviewer
Zena Jacobi, Information Systems Reviewer
David Czarnecki, Consumer Family Member Reviewer

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

**All sessions were held via video conference.**

### Table B1: Participants Representing the MHP and its Partners

| Last Name | First Name | Position | County or Contracted Agency |
|---|---|---|---|
| | | | |
| Boland | Lorna | Foster Care Nurse | Modoc County Public Health (MCPH) |
| Brazil-Hams | Jamie | Clinician | MCBH |
| Bush | Myriah | Case Manager | MCBH |
| Holmes | Charles | Information Systems | MCBH |
| Mandel | Cecelia | Administrative Specialist | MCBH |
| Menkes | Cheyenne | Clinician I | MCBH |
| Moore | Adelaiola | Administrative Specialist | MCBH |
| Muller | Paul | Clinician II | MCBH |
| Petty | Lorie | Nurse II | MCBH |
| Reed | Lisa | Financial Manager | MCBH |
| Thompson | Krestr | Case Manager | MCBH |
| Traverso | Michael | BH Branch Director | MCBH |
| Turner | Delores | Clinical Supervisor | MCBH |
| Williams | Julie | Clinician II | MCBH |
| Works | Sarah | Administrative Clerk II | MCBH |

# ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

## Clinical PIP

### Table C1: Overall Validation and Reporting of Clinical PIP Results

| PIP Validation Rating (check one box) | Comments |
|---|---|
| ☐ High confidence<br>☐ Moderate confidence<br>☐ Low confidence<br>☐ No confidence | The MHP did not submit a clinical PIP. |

**EQRO recommendations for improvement of PIP:**

- The MHP reported that due to staffing limitations and BHQIP and CalAIM priorities it was unable to identify and operate a clinical PIP.
- The MHP is encouraged to seek EQR TA for assistance in identification and operation of a clinical PIP.
- The MHP director submitted the required letter as Exhibit E identifying lack of staffing prevented development and completion of a clinical PIP for this review period.

## Non-Clinical PIP

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

| PIP Validation Rating (check one box) | Comments |
|---|---|
| ☒ High confidence<br>☐ Moderate confidence<br>☐ Low confidence<br>☐ No confidence | The MHP is implementing the BHQIP FUM utilizing a HIE with the single hospital to establish 24/7 exchange of information and a dedicated outpatient follow-up. |
| **General PIP Information** | |
| **MHP/DMC-ODS Name:** Modoc County Behavioral Health | |
| **PIP Title:** Follow-Up After Emergency Department Visit for Mental Illness (FUM) | |
| **PIP Aim Statement:** For Medi-Cal beneficiaries with ER visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with MCBH within 7 and 30 days by 3 percent by June 30, 2023. | |
| **Date Started:** 09/2022 | |
| **Date Completed:** n/a | |
| **Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply)**<br>☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic)<br>☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases)<br>☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic) | |
| **Target age group (check one):**<br>☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children<br>*If PIP uses different age threshold for children, specify age range here: | |
| **Target population description, such as specific diagnosis (please specify):**<br>The target population for this project is operationalized within the parameters of the HEDIS FUM metric. A qualifying event is an individual with an ER visit and a principal diagnosis of mental illness or intentional self-harm. | |
| **Improvement Strategies or Interventions (Changes in the PIP)** | |

| General PIP Information |
|---|
| **Member-focused interventions** (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>None |
| **Provider-focused interventions** (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>Hospital will enter data into the HIE and coordinate discharge with the MHP. |
| **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):<br>MHP will utilize HIE data and coordinate discharges with the hospital. |

| 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 |
|---|---|---|---|---|---|---|
| For Medi-Cal beneficiaries with ER visits for MH conditions, increase the percentage of follow-up mental health services with MCBH within 7 and 30 days by 3 percent. | 2021 | Sample Size, 16<br><br>63% 7-days<br>75% 30-days | ☐ Not applicable—PIP is in planning or implementation phase, results not available | n/a | ☐ Yes<br>☐ No | ☐ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |

| PIP Validation Information |
|---|
| **Was the PIP validated?** ☒ Yes ☐ No<br>"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. |

| PIP Validation Information |
|---|
| **Validation phase (check all that apply):**<br>☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year<br>☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):<br>Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence<br>"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:** TA included a review of how to report the DHCS BHQIP FUM in the EQRO format. |

## 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

**MODOC COUNTY**
**Health Services Department, Behavioral Health Branch**

441 North Main Street
Alturas, CA 96101
(530)233-6312 / Fax (530)233-6339

**Stacy Sphar, DNP**
*Director of Health Services*
**Edward P. Richert, MD**
*Public Health Officer/Medical Director*
**Michael Traverso, LMFT**
*Branch Director*

May 30, 2023

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

Dear Samantha,

Modoc County is requesting flexibility during the May 2023 EQRO review. Specifically, Modoc County cannot present both a clinical and non-clinical Performance Improvement Project (PIP) during the FY 2022-23 review due to the following:

- Staff have been reassigned to other departments and duties to cover the staffing shortages throughout the agency
- Additional factors: Modoc County has three active PIPs and is in the process of implementing all the CalAIM initiatives through the BHQIP

Modoc County will be able to provide a single non-clinical PIP. Please attach this letter to our FY 2022-23 annual report.

Sincerely,

Stacy Sphar
Modoc County
Director of Health Services