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

## NEVADA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

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

Review Dates:

**February 13, 2023**

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# EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Nevada" may be used to identify the Nevada County MHP, unless otherwise indicated.

## MHP INFORMATION

**Review Type** — Virtual

**Date of Review** — February 13, 2023

**MHP Size** — Small

**MHP Region** — Superior

## SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 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 | 3 | 1 | 1 |

### 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 | 5 | 1 | 0 |
| Quality of Care | 10 | 5 | 5 | 0 |
| Information Systems (IS) | 6 | 4 | 2 | 0 |
| **TOTAL** | **26** | **18** | **8** | **0** |

### Table C: Summary of PIP Submissions

| Title | Type | Start Date | Phase | Confidence Validation Rating |
|---|---|---|---|---|
| No Shows for Initial Evaluation and First Service Appointment | Clinical | 12/2022 | Planning phase | Low |
| Follow-Up After Emergency Department (ED)Visit for Mental Illness (FUM) | Non-Clinical | 09/2022 | Planning phase | Moderate |

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

| Focus Group # | Focus Group Type | # of Participants |
|---|---|---|
| 1 | ☒Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other | 9 |

## SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has strong collaborative relationships with hospitals and ED.
- MHP penetration rates (PR) are higher than counties of similar size and the State average PR.
- The MHP exhibits high performance in posthospitalization follow-up to beneficiaries.

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

- The MHP has limited analytic capacity, with only one staff person leading report and data extraction for quality management.
- Consumer and family member involvement on MHP committees is not routinely present.
- The MHP does not have a level of care tool or measurement system in adult services in place.
- The MHP's foster care PR is lower than the statewide and similar size county PR.
- The MHP does not yet measure or monitor adult beneficiary outcomes systemwide.

Recommendations for improvement based upon this review include:

- Train IS and analytic staff on the new EHR environment and cross-train to provide robust, seamless support for the system.
- Re-establish consumer and beneficiary membership and ongoing participation in workgroups, committees, and/or other leadership roles.
- Select and implement a level of care tool and approach in adult services to guide and monitor services on a beneficiary and system level.
- Evaluate potential barriers to foster care (FC) access and ensure assessments and treatment, when indicated, are provided.
- Continue to implement the plans to evaluate beneficiary outcomes in adult services.

# 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 (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 Nevada County MHP by BHC, conducted as a virtual review on February 13, 2023.

## REVIEW METHODOLOGY

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

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

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

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

## HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

# MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

## ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic, large winter storms, power shutoffs and two community tragedies involving teen deaths. The latter three required staff to help beneficiaries with basic home needs and help the community with interventions. The MHP is also operating under the workforce crisis and a 30 percent vacancy rate with the shortage concentrated in clinical staff. Availability of services continues to be impacted by staff illness, especially at residential services. 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 MHP experienced high staff turnover; seven members of the clinical leadership team are new. New clinical providers also include many student trainees or recent graduates who require greater training resources.
- The MHP plans to change their managed care plan from California Health and Wellness to Partnership Health in 2024.
- The homeless services team was integrated into MHP operations from Housing Services, enabling the MHP to manage the core services for beneficiaries.
- The MHP is instituting California Advancing and Innovating Medi-Cal (CalAIM) requirements, including establishing an enhanced care management team, data sharing and payment reform. The MHP reports concern regarding the financial uncertainty related to payment reform.
- The MHP plans to open a new day resource center as part of enhanced care management.
- Active initiatives in various implementation stages include Department of State Hospitals Diversion program and Community, Assistance, Recovery and Empowerment Court.

# RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

**Addressed** is assigned when the identified issue has been resolved.

**Partially Addressed** is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

**Recommendation 1:** Develop and implement two new and ongoing PIPs. Consider performance improvement areas identified in established plans such as the QAPI or other priority areas that have been identified to concentrate quality management (QM) resources.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP developed two new PIPs which are in the planning phase.
- The nonclinical PIP aims to decrease no shows to psychiatry appointments which the MHP identified as part of their timeliness to service tracking. Additional information follows in this report.

**Recommendation 2:** Restore using a current QI Work Plan and evaluate performance at least annually for system QM.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

The MHP recently completed a draft for a new QI Work Plan. While the plan is not current with baselines to set FY2022-23 goals, resuming identifying the QM priorities and indicators allows the MHP to focus performance improvement efforts immediately.

This recommendation is fully addressed as the MHP completed all feasible steps since the last EQR.

**Recommendation 3:** Further evaluate potential barriers to FC access and build on collaboration with Child Welfare Services (CWS) to ensure assessments and treatment when indicated are provided. Develop formal processes if indicated.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP continued to collaborate closely with CWS on open cases, including monitoring access once a referral is received. However, evaluating barriers to ensuring that all FC beneficiaries receive an assessment is not apparent. The MHP's FC PR decreased from 40.37 percent in CY2020 to 36.61 percent in CY2021. The MHP PR continues to be lower than the statewide PR 49.15 percent in CY2021. This is an area that continues to warrant evaluation.
- This recommendation is not addressed because the MHP did not implement new activities toward this recommendation.

**Recommendation 4:** As planned, develop a specific plan to select and implement ways to evaluate beneficiary outcomes in Adult services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP began to expand their use of the Behavior and Symptom Identification Scale (BASIS) 24 tool and created a dashboard to report aggregate system indices and trends.
- The MHP reports long-term plans to use the Healthcare Effectiveness Data and Information Set (HEDIS) measures that would be collected in the EHR.

**Recommendation 5:** As part of the EHR replacement project, develop an approach to maximize the clinical data in the EHR and limit the amount of contract provider data entry the MHP performs.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is still in the process of developing a systematic approach to address this recommendation.
- The current go-live date for Smartcare by Streamline, the new California Mental Health Services Authority (CalMHSA) Semi-Statewide EHR, is July 1, 2023, in Nevada. The county is negotiating with providers, who do not currently enter data directly into the EHR, to join Smartcare. Nevada is currently focusing efforts on the triage/access line provider as a priority for integration.
- Since the last EQR, the percentage of clinical service data submitted by CBOs to the MHP as paper documents decreased from 41 percent to 30 percent, while documents submitted via email or fax increased from 22 percent to 30 percent, and direct data entry increased slightly from 37 percent to 40 percent. This reflects progress in decreasing MHP entry of CBO data.

- The MHP progress and plans are sufficient that this recommendation will not be carried over.

# ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or beneficiaries) are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which beneficiaries live, equity, as well as accessibility—the ability to obtain medical care and services when needed.[1] The cornerstone of MHP services must be access, without which beneficiaries are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and PMs addressed below.

## ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 25.4 percent of services were delivered by county-operated/staffed clinics and sites, and 74.6 percent were delivered by contractor-operated/staffed clinics and sites. This represents a 9.6 percentage point decrease in county-provided services from the prior year due to county staffing shortages and increases in some CBO contracts. Overall, approximately 71.4 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: MHP clinic sites in Grass Valley and Truckee. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The MHP provides assessments at the MHP operated clinic sites on a scheduled or drop-in basis.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 340 adult beneficiaries, 455 youth beneficiaries, and 82 older adult beneficiaries across three county-operated sites and five contractor-operated sites. Among those served, 59 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

## NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Nevada County, the time and distance requirements are 45 miles and 75 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.
- The MHP contracted services for youth outpatient services.

### 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 |
| **OON Details** | |
| **Contracts with OON Providers** | |
| Does the MHP have existing contracts with OON providers? | ☒ Yes ☐ No |

## 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 moved substance use service assessments from the access team to a dedicated team because the high volume of assessment requests overall exceeded capacity. To increase capacity and manage a therapist shortage, the MHP began providing group services and brief therapy.
- The MHP continues to significantly expand services and resources. Changes include: a second crisis co-responder team with law enforcement, an eating disorders task force, a staff nutritionist, and an increased teletherapy contract.

- The MHP opened 52 new supportive housing units, and additional capacity is expected since the MHP purchased two more houses. In response to insufficient housing, the MHP formed a collaborative with community organizations. The MHP reports facing Not in My Back Yard issues in their increased housing efforts.
- The MHP expanded services to beneficiaries with intellectual or developmental disabilities. The MHP provides training and supervision to registered behavioral technicians in eight school districts. The MHP aims to provide teacher support in a lower-cost model compared to providing support directly to teachers.
- The QIWP has a goal to increase the TAY penetration rate. Strategies to do this are not specified in the plan.
- As reported earlier, the MHP FC PR continues to decline; the MHP has not evaluated this area to determine if any access barriers need to be addressed.

## ACCESS PERFORMANCE MEASURES

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

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

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

The statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, Nevada demonstrates higher access to care than was seen statewide, with a total PR of 5.65 percent for the MHP. Nevada's overall PR is 30 percent higher than the statewide PR.

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

| Year | Annual Eligibles | Beneficiaries Served | Penetration Rate | Total Approved Claims | AACB |
|---|---|---|---|---|---|
| CY 2021 | 27,578 | 1,557 | 5.65% | $13,332,551 | $8,563 |
| CY 2020 | 25,368 | 1,446 | 5.70% | $12,190,798 | $8,431 |
| CY 2019 | 25,221 | 1,505 | 5.97% | $13,616,386 | $9,047 |

- The number of annual eligibles has increased each year between CYs 2019 and 2021, while the PR has decreased each year. This trend has been observed in many counties this review year. Annual eligibles represented 26.65 percent of Nevada County's total population of 103,487.
- Beneficiaries served increased by 7.7 percent from CY 2020 to CY 2021.

### 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 | 2,604 | 48 | 1.84% | 1.27% | 1.96% |
| Ages 6-17 | 5,683 | 393 | 6.92% | 5.74% | 5.93% |
| Ages 18-20 | 1,259 | 93 | 7.39% | 4.89% | 4.41% |
| Ages 21-64 | 15,705 | 928 | 5.91% | 4.73% | 4.56% |
| Ages 65+ | 2,328 | 95 | 4.08% | 2.45% | 1.95% |
| **Total** | **27,578** | **1,557** | **5.65%** | **4.39%** | **4.34%** |

- The MHP had higher PRs in all age groups, compared to counties of similar size.
- For all categories, with the exception of Ages 0-5, the MHP's PR was higher than the statewide average.

### 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 | 55 | 3.53% |
| Threshold language source: Open Data per BHIN 20-070 | | |

- Spanish is the only threshold language in the MHP, with 3.53 percent of beneficiaries being identified as Spanish-speaking.

### 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 | 10,062 | 475 | 4.72% | $2,973,975 | $6,261 |
| Small | 199,673 | 7,709 | 3.86% | $45,313,502 | $5,878 |
| Statewide | 4,385,188 | 167,026 | 3.81% | $1,066,126,958 | $6,383 |

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries. This pattern holds true in Nevada. The ACA AACB is $2,302 (equivalent to 36.76 percent) less than the MHP's overall AACB.
- The MHP's ACA PR was higher than in small counties overall and statewide.

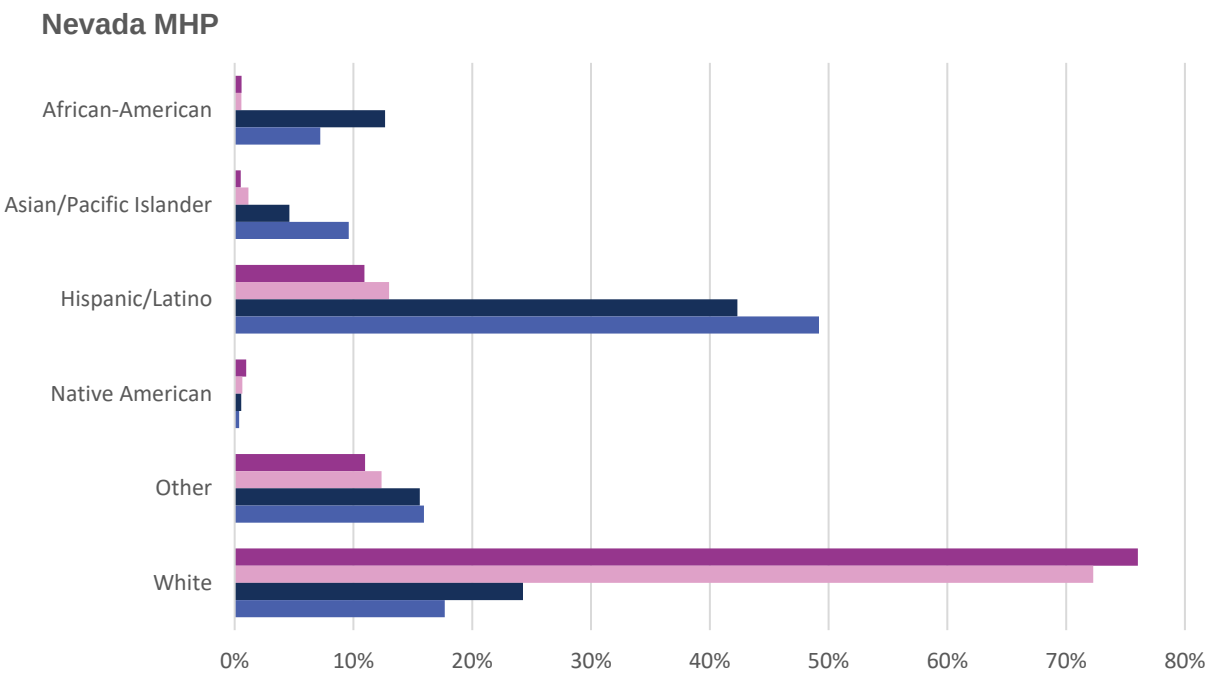
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

| Race/Ethnicity | Annual Eligibles | Beneficiaries Served | PR MHP | PR State |
|---|---|---|---|---|
| African-American | 155 | <11 | - | 7.64% |
| Asian/Pacific Islander | 320 | <11 | - | 2.08% |
| Hispanic/Latino | 3,583 | 170 | 4.74% | 3.74% |
| Native American | 177 | 15 | 8.47% | 6.33% |
| Other | 3,409 | 171 | 5.02% | 4.25% |
| White | 19,935 | 1,184 | 5.94% | 5.96% |
| **Total** | **27,579** | **1,557** | **5.65%** | **4.34%** |

- The Hispanic/Latino, Native American, and Other racial/ethnic group PRs were higher than the statewide rates.

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

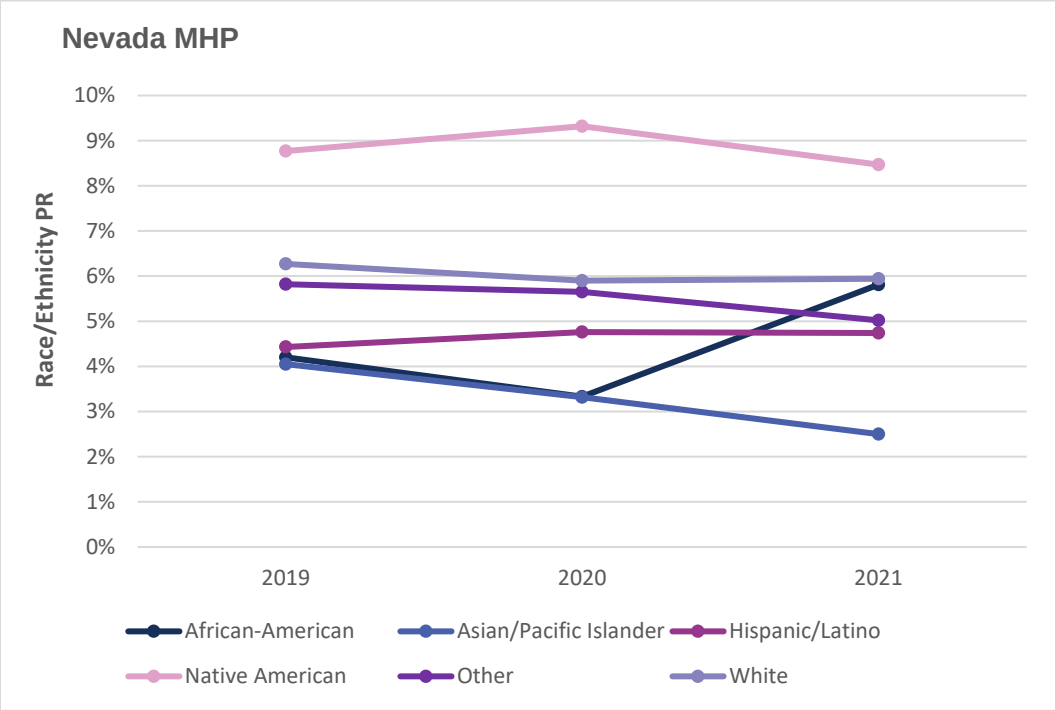



| | White | Other | Native American | Hispanic/Latino | Asian/Pacific Islander | African-American |
|---|---|---|---|---|---|---|
| MHP % Served | 76% | 11% | 1% | 11% | 1% | 1% |
| MHP % Eligible | 72% | 12% | 1% | 13% | 1% | 1% |
| State % Served | 24% | 16% | 1% | 42% | 5% | 13% |
| State % Eligible | 18% | 16% | 0% | 49% | 10% | 7% |

- Proportionally, the largest racial/ethnic group served by the MHP by far were White (representing 82 percent of the county's total population, and 72 percent of eligibles). Hispanic/Latino and the Other category each represented 11 percent of beneficiaries served.
- Beneficiaries were, in general, proportionally representative of the population of eligibles, although White beneficiaries were slightly overrepresented and Hispanic/Latino beneficiaries were slightly underrepresented.

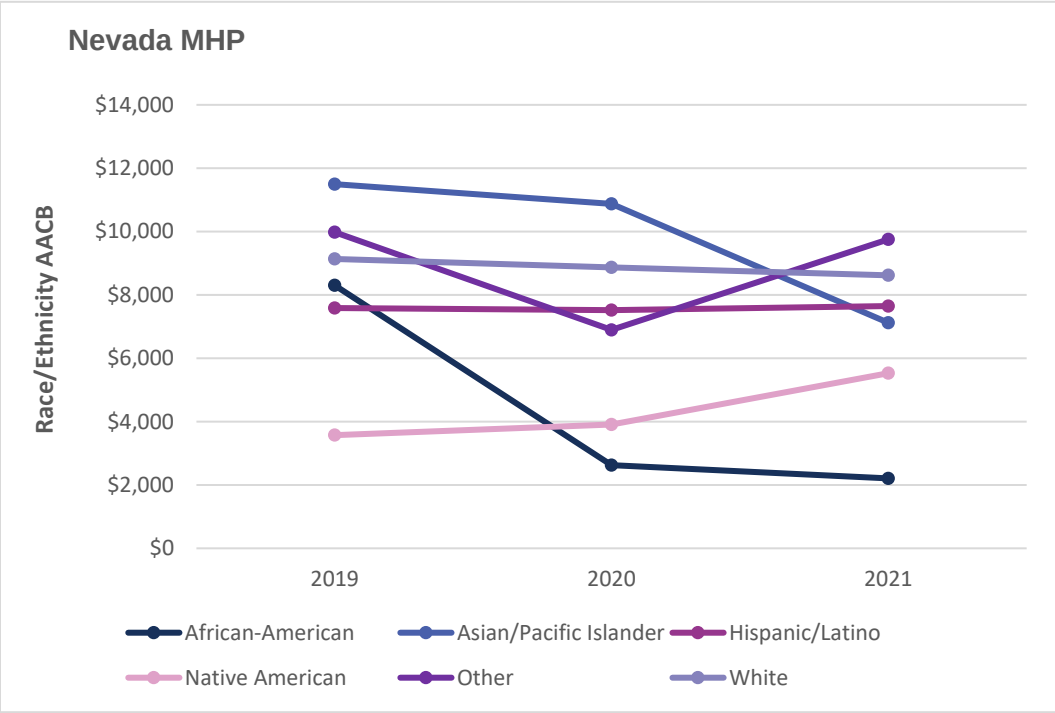
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



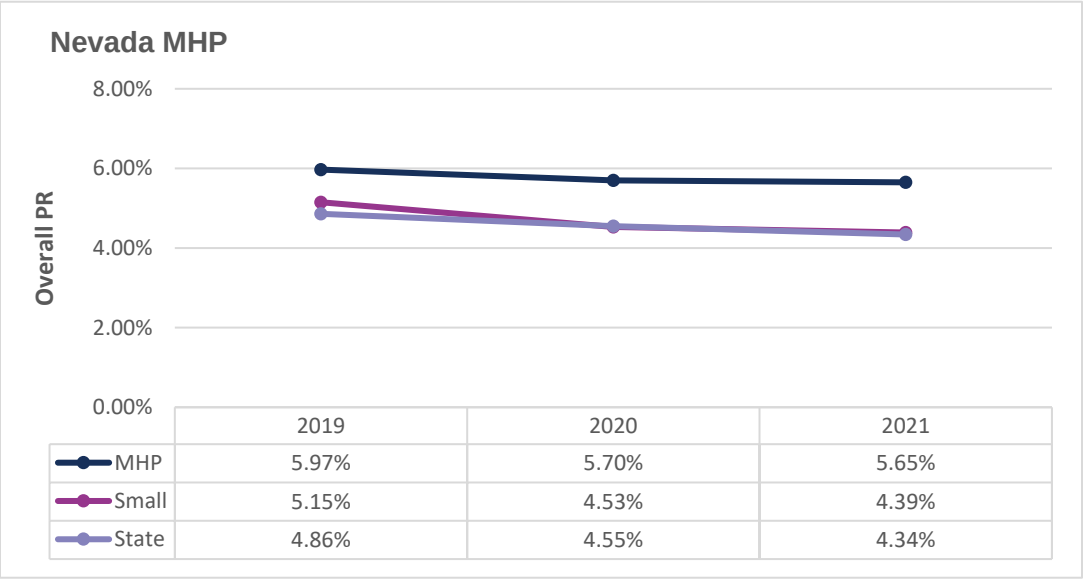

- Native American PRs have consistently been the highest in the MHP, despite being the second smallest group of eligibles in the county.
- PRs for White, Other, and Hispanic/Latino eligibles have been fairly stable over time, whereas Asian/Pacific Islander PR has been declining steadily, and African-American PR increased between CY 2020 and CY 2021.

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




- AACBs for White and Hispanic/Latino beneficiaries have been stable for the past three years, whereas the AACBs for other racial/ethnic groups have fluctuated in disparate patterns. Some of this may be due to the small numbers of beneficiaries in several of these groups, and the ability for a small number of outliers to influence group averages (means).

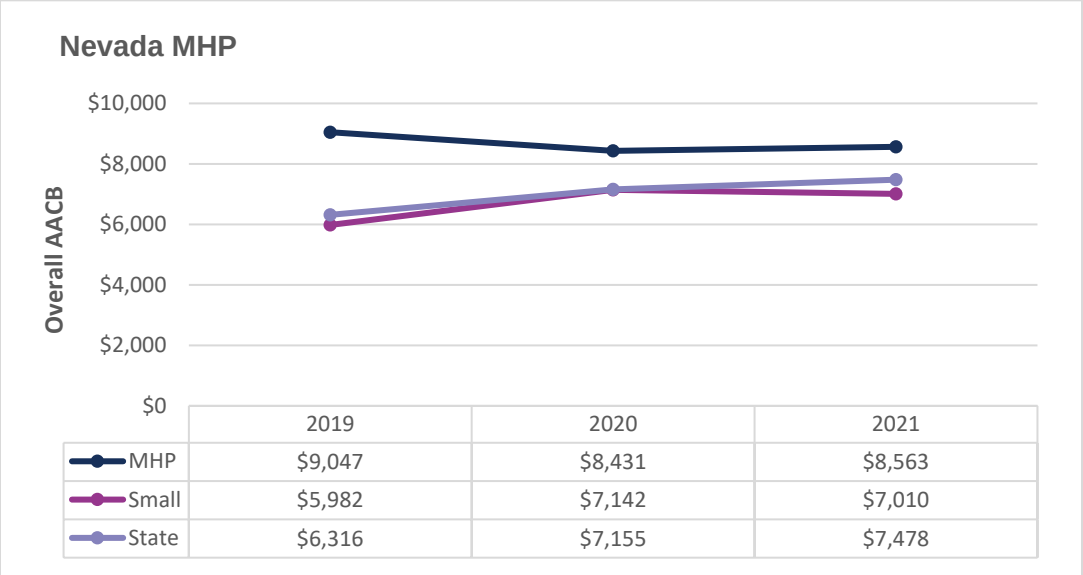
### Figure 4: Overall PR CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | 5.97% | 5.70% | 5.65% |
| Small | 5.15% | 4.53% | 4.39% |
| State | 4.86% | 4.55% | 4.34% |

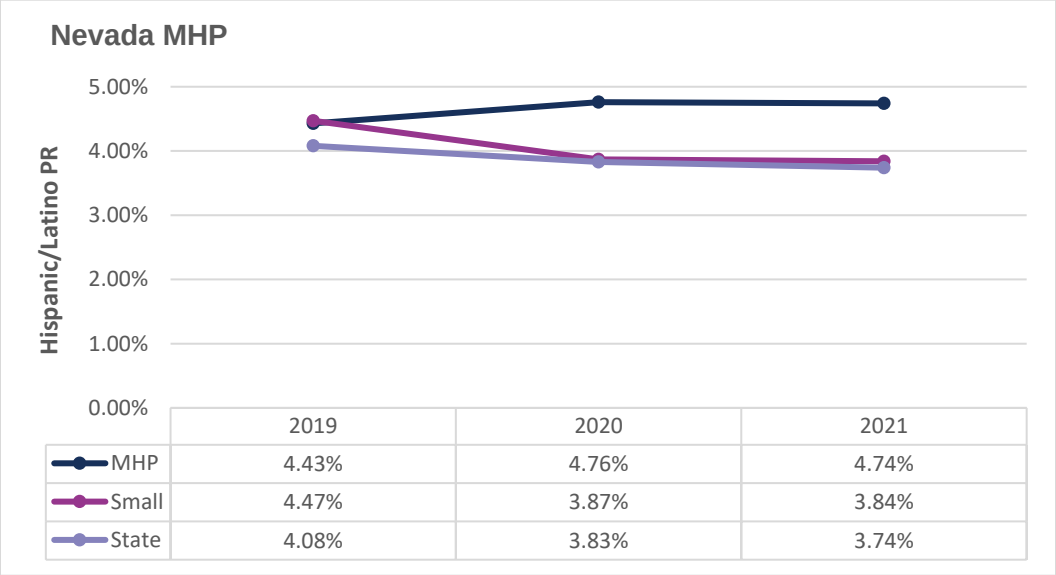
- The MHP has consistently had a higher PR than both small counties overall and statewide, despite trending downwards very slightly between CY 2019 and CY 2021.

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



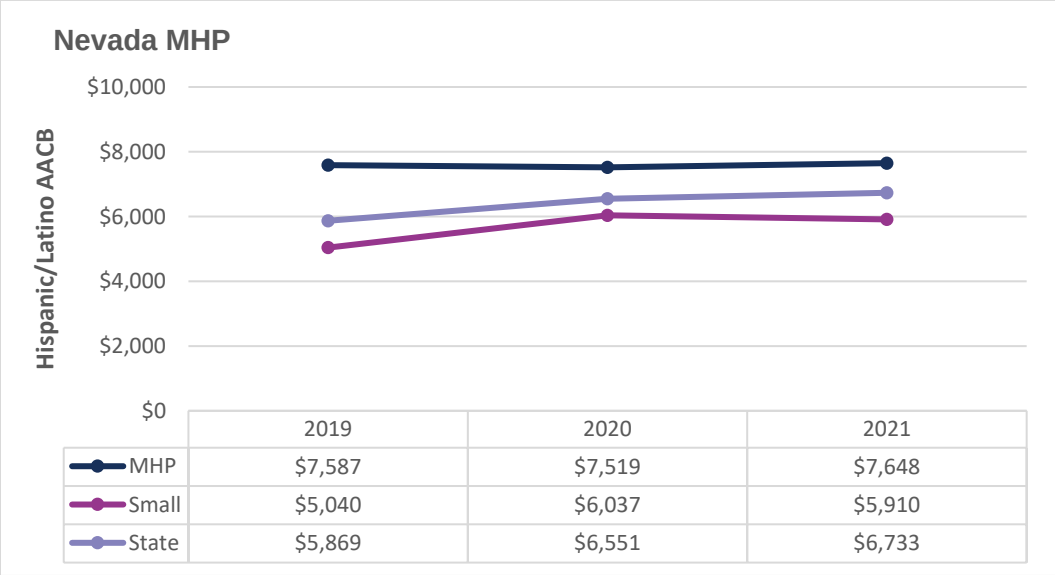

- The MHP's overall AACB has been consistently higher than other small counties and the statewide average, though the difference is smaller for CY 2021 than it was in CY 2019.

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



- Hispanic/Latino PR in the MHP has been higher than statewide averages for CYs 2019 through 2021, and was higher than the overall small county PR for this population for both CYs 2020 and 2021. The MHP Hispanic/Latino PR (4.74 percent) is 23 percent higher than the small county PR (3.84 percent) and 27 percent higher than the Statewide PR (3.74 percent) in CY 2021.

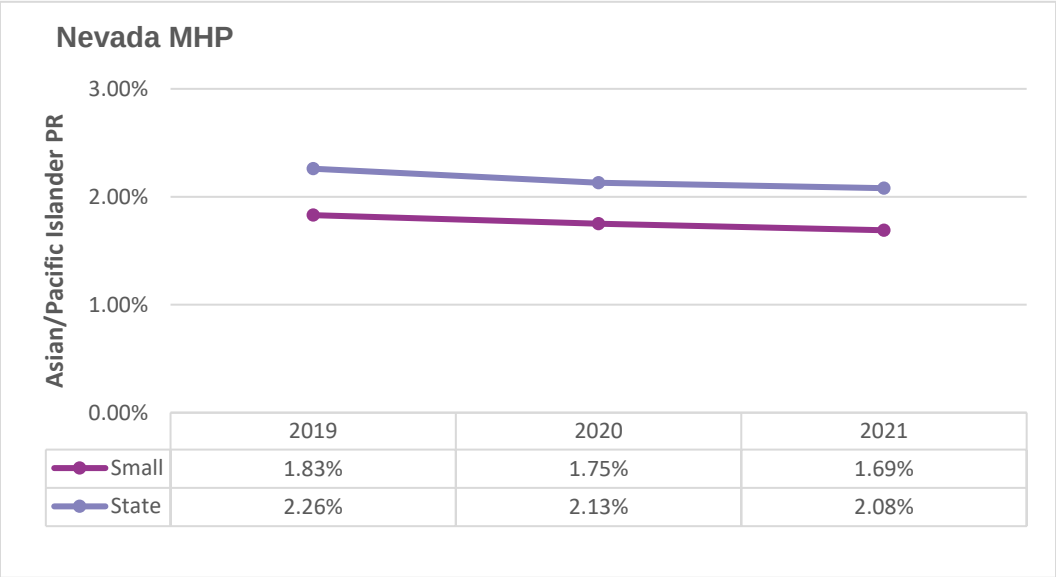
### Figure 7: Hispanic/Latino AACB CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | $7,587 | $7,519 | $7,648 |
| Small | $5,040 | $6,037 | $5,910 |
| State | $5,869 | $6,551 | $6,733 |

- The AACB for the Hispanic/Latino population was $915 (or 11.96 percent) lower than the MHP's overall AACB.
- AACB for this group has been consistently higher in the MHP, compared to the AACBs in small counties overall and statewide.

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

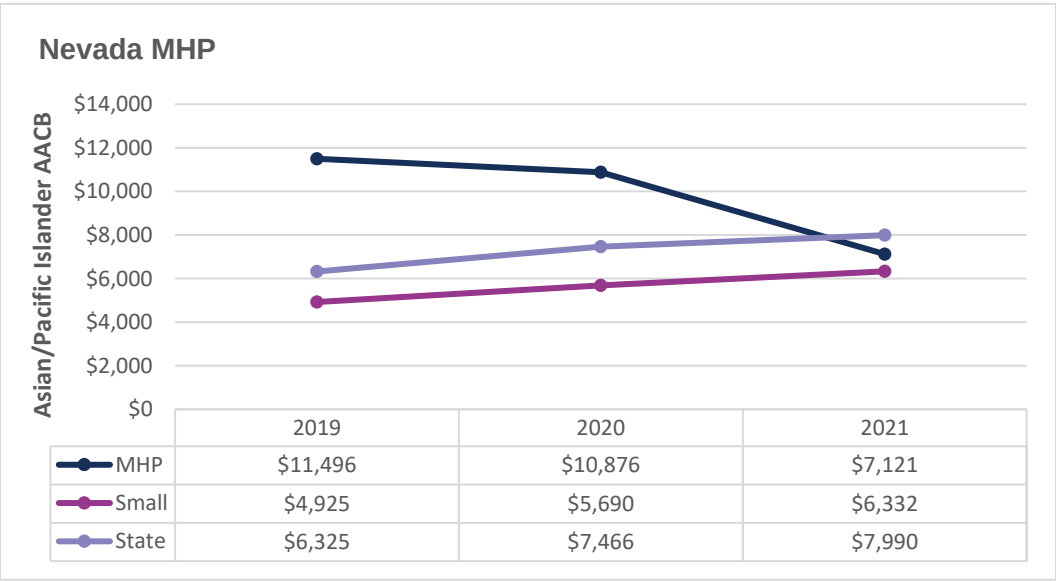



| | 2019 | 2020 | 2021 |
|---|---|---|---|
| Small | 1.83% | 1.75% | 1.69% |
| State | 2.26% | 2.13% | 2.08% |

*The MHP's data in Figure 8 is not displayed due to the small number of beneficiaries served.

- While the MHP has consistently had a higher PR for Asian/Pacific Islander eligibles than small counties overall and statewide, it has been declining over the past three years.

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

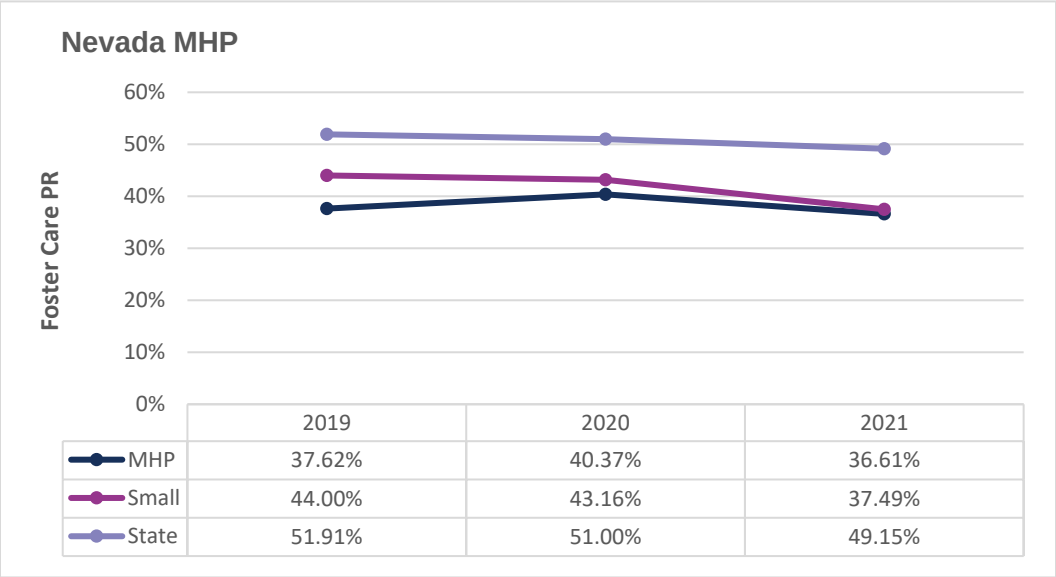



| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | $11,496 | $10,876 | $7,121 |
| Small | $4,925 | $5,690 | $6,332 |
| State | $6,325 | $7,466 | $7,990 |

- While the AACB for Asian/Pacific Islander beneficiaries was higher than small counties overall and statewide averages for CYs 2019 and 2020, in CY 2021 it decreased to a level lower than the statewide average (though it was still higher than small counties overall). However, due to the small number of Asian/Pacific

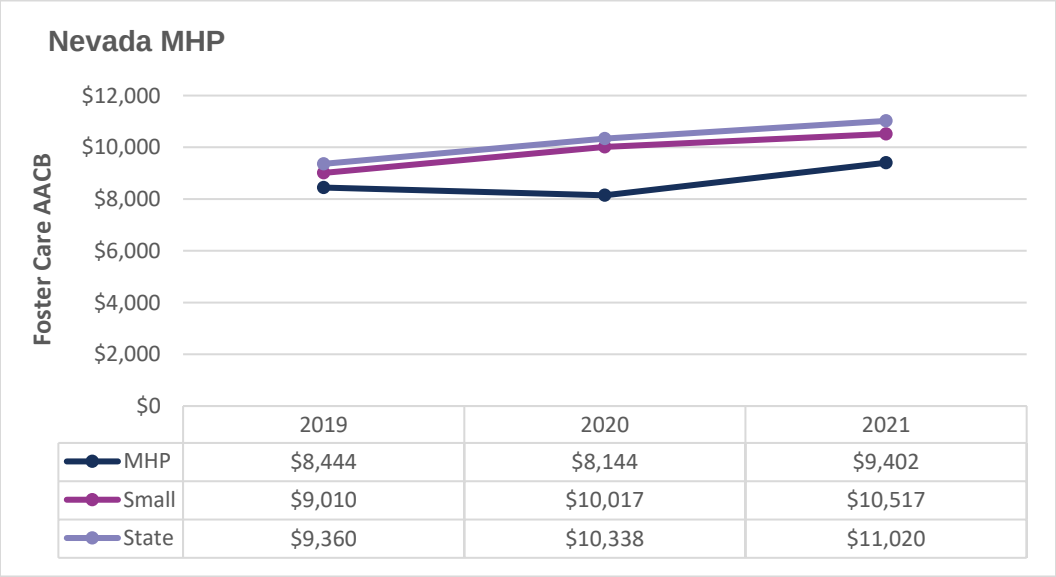
Islander beneficiaries served in the MHP, these trends may be attributable to a very small number of claims.

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




- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed, whereas the MHP's FC PR rose slightly in CY 2020 followed by a decline in CY 2021.
- The FC PR in the MHP was lower than that of small counties overall and statewide over the past three years.

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



- Statewide and small county FC AACBs have increased over the past three years, whereas FC AACB in the MHP declined slightly from CY 2019 to CY 2020, followed by an increase in CY 2021.
- The MHP's FC AACB has been consistently lower than in small counties overall and statewide over the past three years.

## Units of Service Delivered to Adults and Foster Youth

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

| Service Category | MHP N = 1,116 | | | | Statewide N = 391,900 | | |
|---|---|---|---|---|---|---|---|
| | Beneficiaries Served | % of Beneficiaries Served | Average Units | Median Units | % of Beneficiaries Served | Average Units | Median Units |
| **Per Day Services** | | | | | | | |
| Inpatient | 23 | 2.1% | 7 | 5 | 11.6% | 16 | 8 |
| Inpatient Admin | 0 | 0.0% | 0 | 0 | 0.5% | 23 | 7 |
| Psychiatric Health Facility | 115 | 10.3% | 16 | 9 | 1.3% | 15 | 7 |
| Residential | 22 | 2.0% | 123 | 125 | 0.4% | 107 | 79 |
| Crisis Residential | <11 | - | 6 | 6 | 2.2% | 21 | 14 |
| **Per Minute Services** | | | | | | | |
| Crisis Stabilization | 238 | 21.3% | 2,039 | 1,200 | 13.0% | 1,546 | 1,200 |
| Crisis Intervention | 495 | 44.4% | 184 | 120 | 12.8% | 248 | 150 |
| Medication Support | 518 | 46.4% | 694 | 482 | 60.1% | 311 | 204 |
| Mental Health Services | 629 | 56.4% | 1,529 | 456 | 65.1% | 868 | 353 |
| Targeted Case Management | 585 | 52.4% | 444 | 185 | 36.5% | 434 | 137 |

- The service categories with the highest utilization rates in the MHP were Mental Health Services (MHS) (56.4 percent) and Targeted Case Management (TCM) (52.4 percent). MHS utilization was lower than the statewide utilization and TCM was higher than the statewide average.
- The MHP had higher utilization of Crisis Intervention than seen statewide. This service was provided to 44.4 percent of beneficiaries, while statewide the percent of beneficiaries receiving Crisis Intervention was 12.8 percent. Crisis Stabilization was also utilized at a higher rate than statewide, though the statewide utilization rate for this service is low due to many counties not offering this service at all.

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

| Service Category | MHP N = 41 | | | | Statewide N = 37,489 | | |
|---|---|---|---|---|---|---|---|
| | Beneficiaries Served | % of Beneficiaries Served | Average Units | Median Units | % of Beneficiaries Served | Average Units | Median Units |
| **Per Day Services** | | | | | | | |
| Inpatient | <11 | - | 15 | 14 | 4.5% | 14 | 9 |
| Inpatient Admin | 0 | 0.0% | 0 | 0 | 0.0% | 5 | 4 |
| Psychiatric Health Facility | 0 | 0.0% | 0 | 0 | 0.3% | 22 | 8 |
| Residential | 0 | 0.0% | 0 | 0 | 0.0% | 185 | 194 |
| Crisis Residential | 0 | 0.0% | 0 | 0 | 0.1% | 17 | 12 |
| Full Day Intensive | 0 | 0.0% | 0 | 0 | 0.2% | 582 | 441 |
| Full Day Rehab | 0 | 0.0% | 0 | 0 | 0.5% | 97 | 78 |
| **Per Minute Services** | | | | | | | |
| Crisis Stabilization | <11 | - | 1,110 | 1,110 | 3.1% | 1,398 | 1,200 |
| Crisis Intervention | <11 | - | 312 | 322 | 7.5% | 404 | 198 |
| Medication Support | 13 | 31.7% | 378 | 260 | 28.3% | 394 | 271 |
| TBS | 1 | 2.4% | 147 | 147 | 4.0% | 4,019 | 2,372 |
| Therapeutic FC | 0 | 0.0% | 0 | 0 | 0.1% | 1,030 | 420 |
| Intensive Home Based Services | 22 | 53.7% | 1,087 | 565 | 40.0% | 1,351 | 472 |
| Intensive Care Coordination | <11 | - | 1,472 | 1,170 | 20.3% | 2,256 | 1,271 |
| Katie-A-Like | 0 | 0.0% | 0 | 0 | 0.2% | 640 | 148 |
| Mental Health Services | 37 | 90.2% | 1,809 | 1,453 | 96.3% | 1,848 | 1,103 |
| Targeted Case Management | 32 | 78.0% | 423 | 263 | 35.0% | 342 | 120 |

- For FC youth, the services with the highest utilization were MHS (90.2 percent), TCM (78.0 percent), and Intensive Home Based Services (IHBS) (53.7 percent). MHS was utilized at a lower rate in the MHP than statewide, whereas TCM and IHBS were utilized at higher rates.

## IMPACT OF ACCESS FINDINGS

- The MHP demonstrates high PR rates compared to the statewide and small county PR, higher PR of TCM, and comparable inpatient service PR which indicate effective capacity and access management.

- The MHP's continuing higher Hispanic/Latino PR indicate effective access and outreach systems for this group.

# 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 | Partially Met |

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

- The MHP reviews timeliness to some key access points including time to a first assessment appointment and first psychiatric appointment routinely.

- For time to a follow-up appointment after a psychiatric hospitalization, the MHP measures the time to an offered appointment. The MHP does not measure the time to a completed service. Monitoring this would provide a vital metric that determines if beneficiaries are being seen in a timely fashion, and information associated with improved beneficiary engagement and outcomes.
- The MHP met its standard to first offered and delivered psychiatry service for only 50 percent of foster-care beneficiaries' requests. The number of beneficiaries is very small which could cause metrics to shift easily.
- The MHP reports that the no-show to non-psychiatry clinical appointments in the EHR data reported in the Assessment of Timely Access form are not accurate whereas the data provided in the No Shows for Initial Evaluation and First Service Appointment clinical PIP reflects true system performance.

## TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12 month period of FY 2021-22. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care. The county employs one analyst who would typically be responsible for preparing the ATA, however this year that staff person was not available. Instead, the MHP provided Kings View with an Excel file containing internally tracked data that was not captured in the EHR to include in timeliness analyses. It is unknown how comparable this process was to previous years, and thus comparing this year's timeliness results to prior years may be unreliable.

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

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

| Timeliness Measure | Average | Standard | % That Meet Standard |
|---|---|---|---|
| First Non-Urgent Appointment Offered | 6 Business Days | 10 Business Days* | 93.20% |
| First Non-Urgent Service Rendered | 9 Business Days | 10 Business Days** | 73.43% |
| First Non-Urgent Psychiatry Appointment Offered | 16 Business Days | 15 Business Days* | 72.16% |
| First Non-Urgent Psychiatry Service Rendered | 24 Business Days | 15 Business Days** | 67.28% |
| Urgent Services Offered (including all outpatient services) – Prior Authorization not Required | 120 Hours | 48 Hours** | 0% |
| Follow-Up Appointments after Psychiatric Hospitalization | 12 Days | 7 Days** | 62.85% |
| No-Show Rate – Psychiatry | 3.82% | 8%** | n/a |
| No-Show Rate – Clinicians | 2.12% | 10%** | n/a |
| * DHCS-defined timeliness standards as per BHIN 21-023 and 22-033<br>** MHP-defined timeliness standards | | | |
| 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

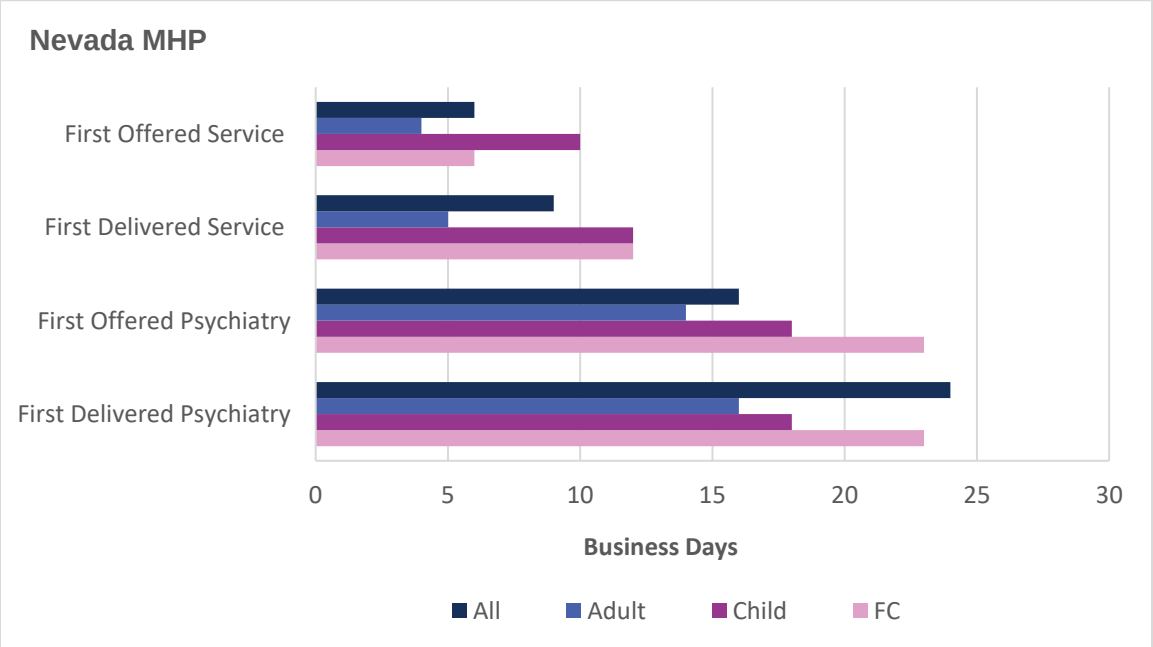


Figure 13: Wait Times for Urgent Services

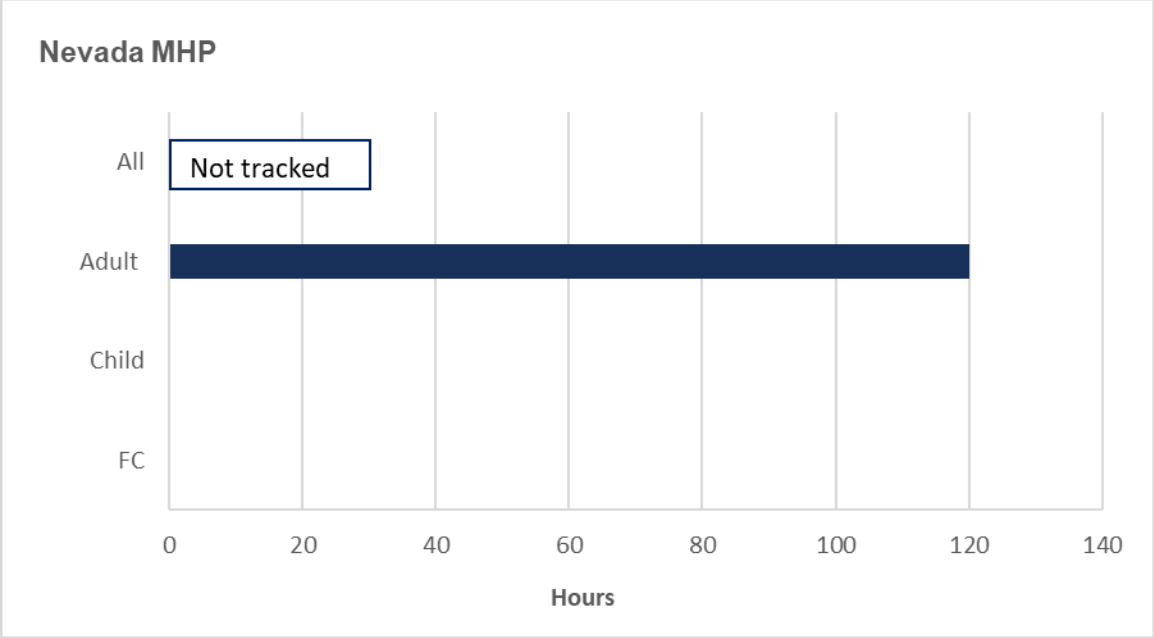
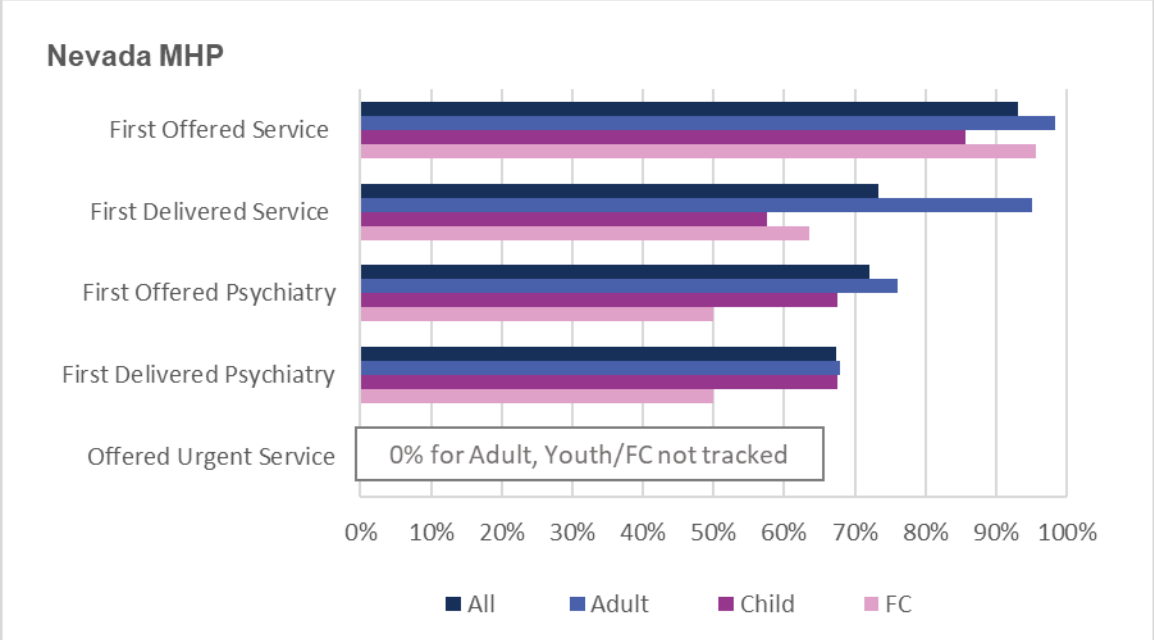



**Figure 14: Percent of Services that Met Timeliness Standards**




- 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 14, represent first rendered scheduled assessments and unscheduled assessments, and first psychiatry appointments.

- 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 ED, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as “a condition perceived by a beneficiary as serious, but not life threatening. A condition that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours. A beneficiary is assessed at contact for whether they meet ‘urgent’ standard of need, and if necessary, provided appointment or referred to Crisis Stabilization Unit for immediate walk in care.” There were reportedly only two urgent service requests with a reported actual wait time to services for the overall population at 120 hours. The MHP did not report urgent services for children or FC youth.
- 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. For the ATA, the data on the first offered services was not available or used due to key staff absence. While it is reported in the ATA, the MHP reports that it is not accurate.
- 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 low no-show rates for both psychiatry appointments and appointments with non-psychiatry clinical staff. The highest no-show rate was for adult psychiatry services, with a rate of 4.07 percent. The MHP noted that these data are inaccurate due to many no-shows entered into SharePoint not being reflected in the EHR data, as well as some potential issues with reporting of no-shows by clinical staff. This provides context for why the MHP has a PIP pertaining to no-shows when the ATA data for no-shows appear quite low.

## IMPACT OF TIMELINESS FINDINGS

- Review discussions and document review raised a number of questions regarding timeliness reported in the ATA. Overall, the timeliness to service requests data was not reliable. However, documents reviewed show that the MHP regularly used timeliness reports on time to assessments, psychiatry appointments, and post-hospital follow-up appointments with reliable information for most of the year when the primary analyst was available.

# QUALITY OF CARE

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

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

## QUALITY IN THE MHP

In the MHP, the responsibility for QI is held by the QA Manager who convenes a QI Committee for Nevada County Behavioral Health. The QA Manager reports to the MHP Director.

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 MHP executive leadership, MHP staff, SUD staff, MHP and SUD contract providers, and beneficiaries, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met six times. As last year, the MHP did not evaluate its QAPI Workplan performance this last year.

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

The MHP utilizes the following outcomes tools: Behavior and Symptom Identification Scale (BASIS-24), Child and Adolescent Needs and Strengths (CANS), Child Behavior Checklist (CBCL), Eyberg Child Behavior Inventory (ECB), Milestones of Recovery Scale (MORS), and the Pediatric Symptom Checklist (PSC-35).

The MHP uses outcome measurement reports on a clinical level individual progress towards treatment goals and to examine programs such as FSP services.

## 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 | Partially Met |
| 3D | Evidence of a Systematic Clinical Continuum of Care | Partially Met |
| 3E | Medication Monitoring | Partially Met |
| 3F | Psychotropic Medication Monitoring for Youth | Partially Met |
| 3G | Measures Clinical and/or Functional Outcomes of Beneficiaries Served | Partially Met |
| 3H | Utilizes Information from Beneficiary Satisfaction Surveys | 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 has broadened QM and QI to encompass CalAIM elements; some initiatives have dedicated workgroups, such as the Behavioral Health Quality Improvement Program (BHQIP).
- The MHP does not use a level of care tool for adult service guidance and monitoring. Aggregate analyses are not conducted.
- The MHP reports that enlisting and sustaining consumer and family member participation in MHP operations continues to be challenging. Review discussions show this is an area to strengthen.
- While the MHP demonstrates collaboration with primary care in medication management, reports to track and trend HEDIS prescribing practices were not provided.
- The MHP reports that it tracks the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5. MHP tracks general timeframes to when a medication follow-up is needed; actual service dates are not monitored.
    - 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

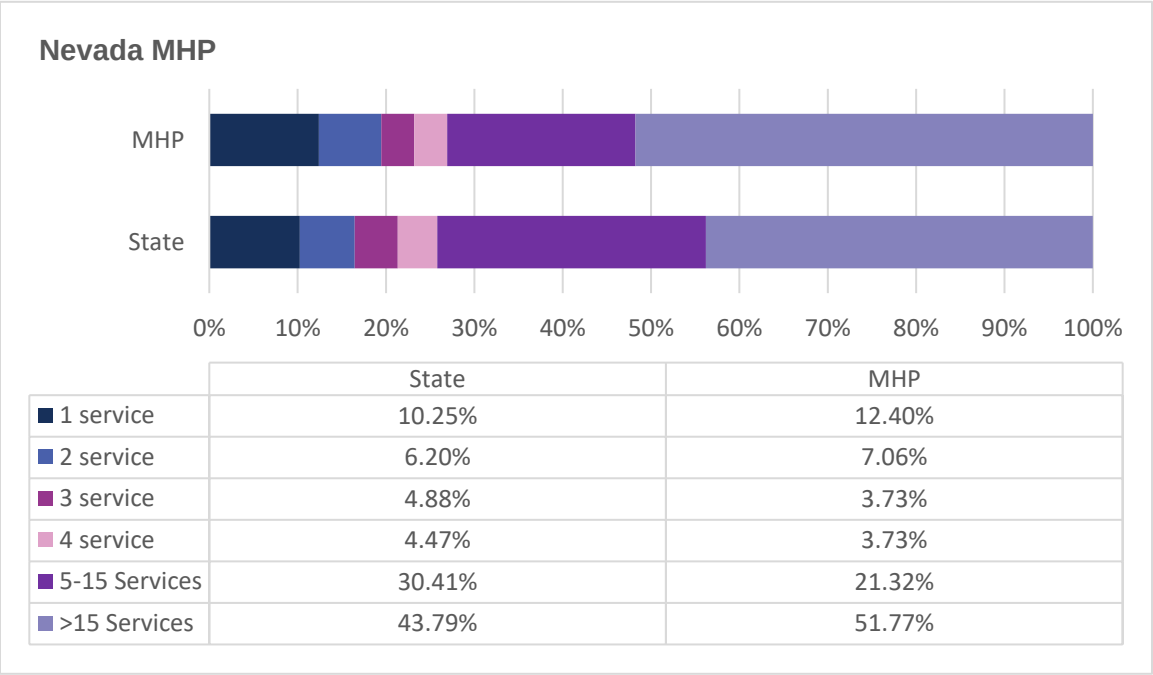
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



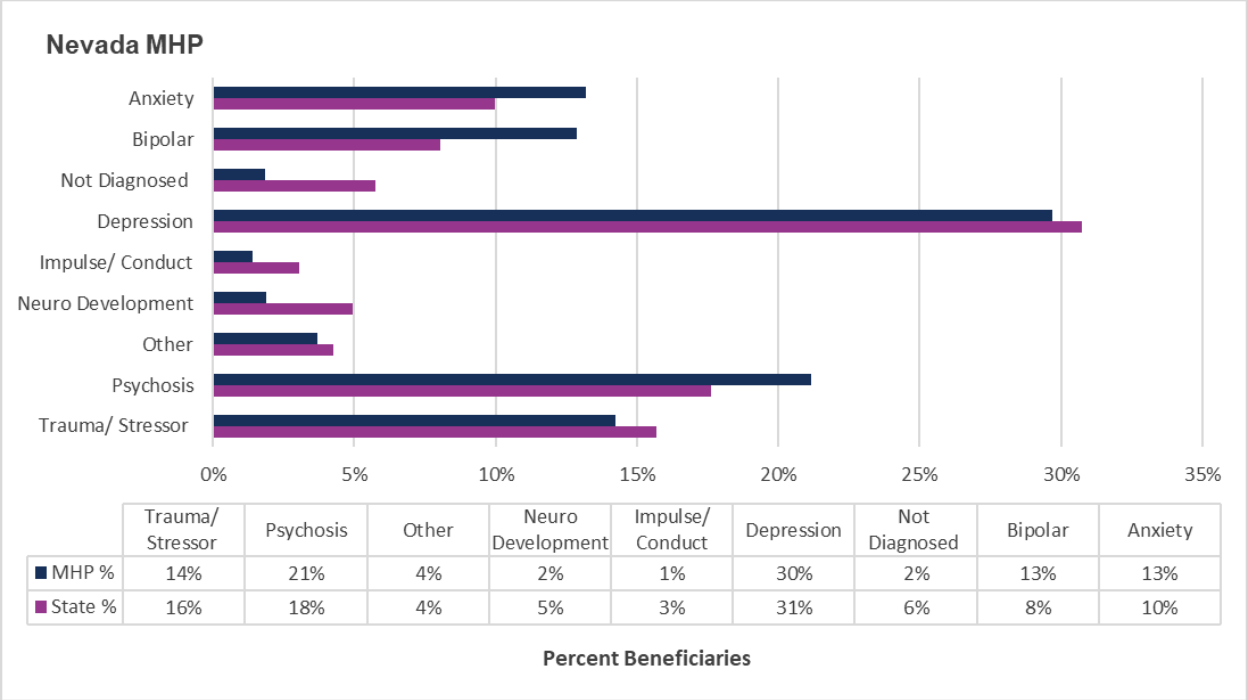

| | State | MHP |
|---|---|---|
| 1 service | 10.25% | 12.40% |
| 2 service | 6.20% | 7.06% |
| 3 service | 4.88% | 3.73% |
| 4 service | 4.47% | 3.73% |
| 5-15 Services | 30.41% | 21.32% |
| >15 Services | 43.79% | 51.77% |

- While a smaller proportion of beneficiaries in the MHP received between 5 and 15 services than statewide, 51.77 percent of the MHP's beneficiaries received more than 15 services, which was higher than statewide percent. As a result, proportions of beneficiaries receiving five or more services, indicating good retention, are comparable between the MHP and the state as a whole.

## Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The following figures represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

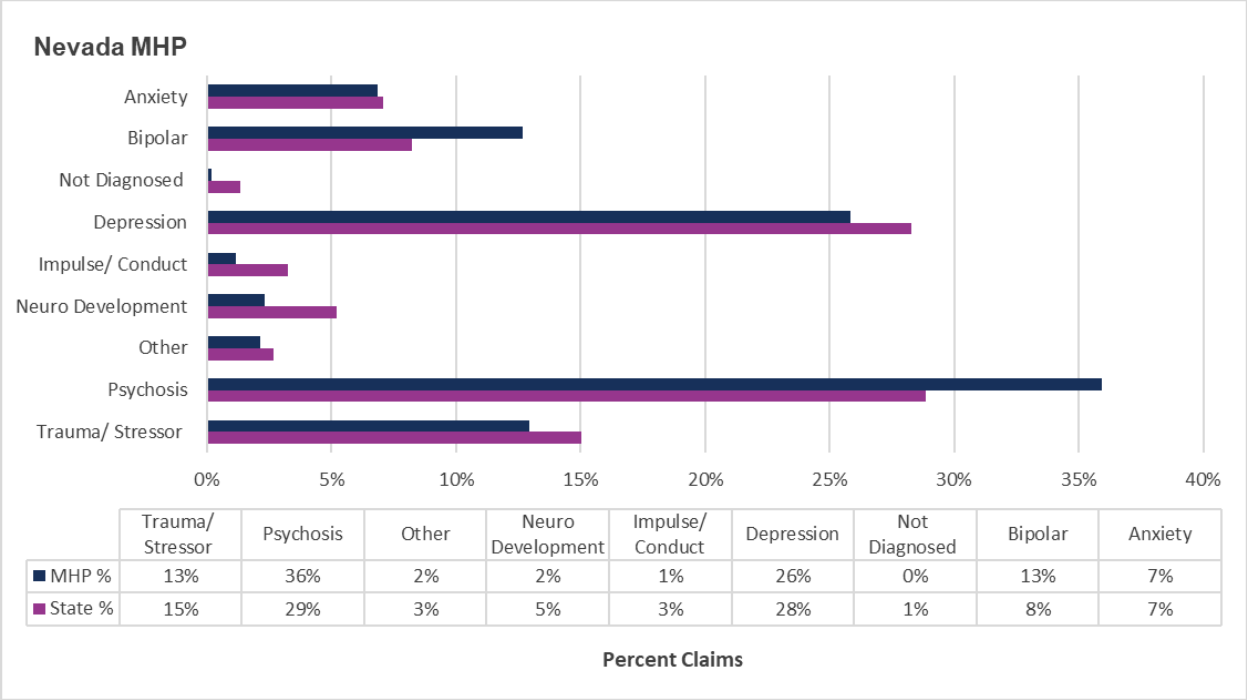
## Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021




| | Trauma/ Stressor | Psychosis | Other | Neuro Development | Impulse/ Conduct | Depression | Not Diagnosed | Bipolar | Anxiety |
|---|---|---|---|---|---|---|---|---|---|
| MHP % | 14% | 21% | 4% | 2% | 1% | 30% | 2% | 13% | 13% |
| State % | 16% | 18% | 4% | 5% | 3% | 31% | 6% | 8% | 10% |

- Depression was the most prevalent diagnosis in the MHP, followed by Psychosis.
- Overall, diagnostic patterns in the MHP are comparable to statewide patterns. The diagnosis with the biggest difference is Bipolar, which was slightly more prevalent in the MHP than statewide.

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




| | Trauma/ Stressor | Psychosis | Other | Neuro Development | Impulse/ Conduct | Depression | Not Diagnosed | Bipolar | Anxiety |
|---|---|---|---|---|---|---|---|---|---|
| MHP % | 13% | 36% | 2% | 2% | 1% | 26% | 0% | 13% | 7% |
| State % | 15% | 29% | 3% | 5% | 3% | 28% | 1% | 8% | 7% |

- Claiming patterns were generally congruent with diagnostic patterns in the MHP. The primary outlier was Psychosis, which accounted for 21 percent of diagnoses but 36 percent of claims. This could be attributable to the potentially acute nature of that diagnosis and associated need for higher LOCs.

## 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 | 187 | 334 | 11.23 | 8.86 | $13,313 | $12,052 | $2,489,602 |
| CY 2020 | 138 | 236 | 10.04 | 8.68 | $11,338 | $11,814 | $1,564,665 |
| CY 2019 | 133 | 211 | 9.09 | 7.80 | $10,730 | $10,535 | $1,427,054 |

- The unique count of beneficiaries accessing Psychiatric Inpatient services increased by 35.5 percent from CY 2020, and total admissions rose by 41.5 percent. The average admissions per beneficiary receiving these services has increased each year since CY 2019.

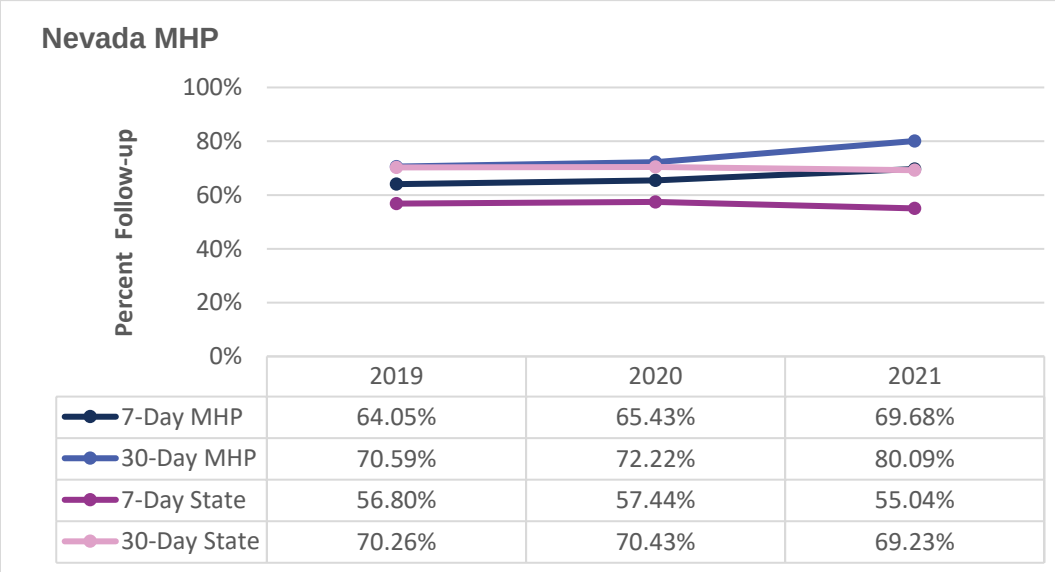
- The CY 2021 MHP PR for inpatient services (.68 percent) is 84 percent and 79 percent greater than the small county PR (.37 percent) and statewide PR (.38 percent) respectively.
- The average LOS increased by 1.19 days from CY 2020 and is 2.37 days longer than the Statewide average LOS.
- Whereas the MHP's AACB was lower than the statewide AACB in CY 2020, it was $1,261 more than the statewide AACB for CY 2021.

## 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.

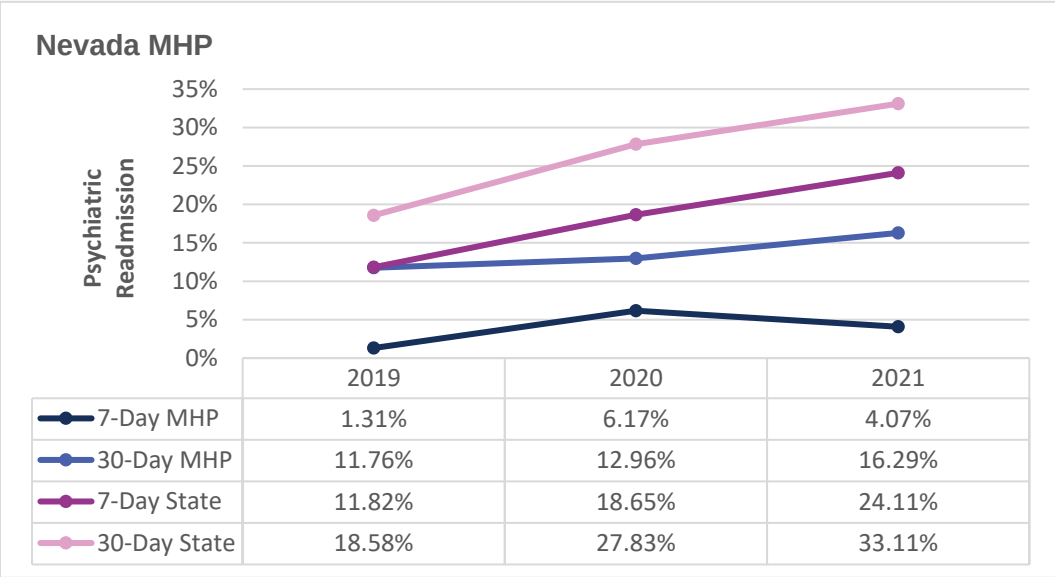
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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 | 64.05% | 65.43% | 69.68% |
| 30-Day MHP | 70.59% | 72.22% | 80.09% |
| 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 | 1.31% | 6.17% | 4.07% |
| 30-Day MHP | 11.76% | 12.96% | 16.29% |
| 7-Day State | 11.82% | 18.65% | 24.11% |
| 30-Day State | 18.58% | 27.83% | 33.11% |

- As seen in Figure 18, both the 7- and 30-day follow-up rates have increased in the MHP each year between CYs 2019 and 2021. Follow-up rates at both points in time are higher in the MHP than statewide rates. The follow-up rates calculated by the MHP for FY 2021-22, submitted as part of the ATA, were lower but comparable considering the different time period reflected in the data and the county's inclusion of all MHP clients, regardless of payor source, in their data.
- The MHPs 7-day readmission rate rose from CY 2019 to CY 2020 followed by a decline in CY 2021, whereas 30-day readmissions have increased each year. Readmission rates for both points in time have consistently been substantially lower than statewide readmission rates. The 30-day readmission rate submitted as part of the ATA was nearly 10 percent lower than that seen in the claims data, likely due to the different time period reflected in the data, the county's inclusion of all MHP clients, regardless of payor source, in their data. The MHP also noted that their data were pulled from specific sub-units and were not necessarily complete.
- The MHP routinely monitors hospital follow-up performance including within the QIC.

## 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 | 98 | 6.29% | 36.67% | $4,888,455 | $49,882 | $42,234 |
| | CY 2020 | 80 | 5.53% | 32.99% | $4,022,136 | $50,277 | $42,611 |
| | CY 2019 | 103 | 6.84% | 39.05% | $5,317,597 | $51,627 | $44,559 |

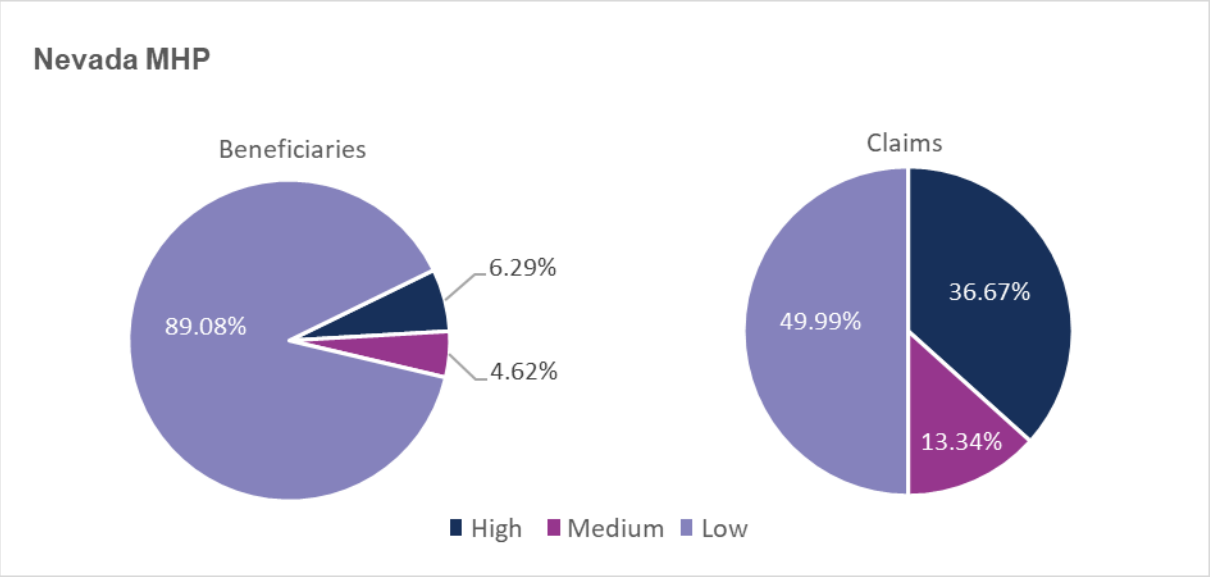
- The total count of HCBs in the MHP increased by 18 individuals in CY 2021 after experiencing a decrease from CY 2019 to CY 2020. The proportion of HCBs in the MHP was slightly higher than statewide for CY 2021, as was the percentage of claims attributed to HCBs, though both average (mean) and median AACs per HCB were lower than those seen statewide.
- HCBs represented 6.29 percent of beneficiaries in the MHP, and 36.67 percent of claims.

### 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) | 72 | 4.62% | 13.34% | $1,779,069 | $24,709 | $24,441 |
| Low Cost (Less than $20K) | 1,387 | 89.08% | 49.99% | $6,665,026 | $4,805 | $3,010 |

- Low cost beneficiaries represented 89.08 percent of all beneficiaries served by the MHP, and 49.99 percent of claims. Only 4.62 percent of beneficiaries fell into the medium cost range, and 13.34 percent of claims were attributed to medium cost beneficiaries.

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




## IMPACT OF QUALITY FINDINGS

- MHP systems to initiate and coordinate care after a hospitalization appear to be effective.
- The coordination mechanisms will be strengthened with the new BHQIP FUM PIP and the No Shows for Initial Evaluation and First Service Appointment PIP as well.
- As requests for services and acuity of needs increase, establishing level of care tools and aggregate analysis would support the MHP's capacity management and achieving positive beneficiary outcomes.

# 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: No Shows for Initial Evaluation and First Service Appointment

Date Started: 12/2022

Aim Statement: For clients with initial assessment appointments and first service appointments for SMHS, NCBH will providing automatic reminder texts and emails to reduce the percentage of no shows for initial assessments and first service appointment, as measured by Anasazi and SharePoint data, from December 2022 through November 2024, with review of preliminary data every three months?

Target Population: New adult beneficiaries who are scheduled for a first assessment or a first service appointment, and beneficiaries with a post-hospitalization appointment.

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

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

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

### Summary

Based on having reviewed no-show rates in 2019 and 2020, the MHP began and is in the early stages of planning a PIP that aims to reduce appointment no-shows. The MHP reports over 100 no-show to appointments per month which is anecdotally an underestimate because data entry is historically delayed or not completed. The MHP aims to reduce no-shows for adult beneficiaries' assessments and first delivered service; adults who are discharged from the hospital and consent to text reminders are also included.

Data, baselines, or specific improvement rate goals are not reported. While the MHP states that a range of barriers such as transportation may contribute to no-shows, the MHP did not complete a root cause analysis or examine service data. In April 2022, the MHP selected and began interventions, reminder texts and email. The technology based reminders given its established utility and acceptance in medical appointment attendance will likely improve outcomes. However, fully understanding the system problems, measuring progress and providing the necessary interventions without clear measurement and barriers will lead to limited performance improvement.

### TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: baselines are not established, processes to identify and engage the target populated need to be completed, and a root cause analysis needs to be conducted.

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

- Examine no-show data updated since reviewing the 2012 and 2020 data. Establish baselines.
- Review utilization patterns to identify root causes. Develop and select interventions based on findings.

## NON-CLINICAL PIP

### General Information

Non-Clinical PIP Submitted for Validation: Follow-Up After ED Visit for Mental Illness

Date Started: 09/2022

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

Target Population: Adult beneficiaries age 18-64 years with a qualifying event defined as an ED visit with a principal diagnosis of mental illness or intentional self-harm (MH condition).

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

### Summary

The MHP elected to participate in the CalAIM BHQIP and received information from DHCS that Nevada fell within Quartile 1 for FUM7 (72 percent) and FUM30 (78 percent.) The MHP convened several meetings with stakeholders including hospitals, contract provider crisis staff, and MHP staff. Root cause analysis found that unclear communication procedures in beneficiary transitions, insufficient systems to initiate or track referrals, and lack of data sharing for care coordination. Interventions include implementing information sharing through a data feed, and procedures to link beneficiaries from the ED and care coordination. Partners in the PIP include two local hospitals with EDs.

Indicators are FUM7 and FUM30; remeasurement is planned quarterly. Process measures include the number of clients who need a referral for MH treatment, the percentage of clients referred to the MCP, and the percentage of clients referred to the MHP. The MHP created a tracking system where beneficiaries in the target population are entered; the plan is for the crisis contract provider to enter the information for the MHP within one business day. The MHP has also entered a plan with CalMHSA for ongoing data support in this project.

### TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the PIP is in the planning phase. The MHP plans to start the tracking system in March 2023; however, the PIP plans appeared to be contingent on a key analyst's availability. Developing contingency plans and widening knowledge of the project requirements will support implementation and sustainability of the PIP.

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

- Continue to investigate the finding that beneficiaries whose primary language is Spanish are less likely to receive a follow-up within 7 and 30 days compared to beneficiaries who use English. Develop and use interventions as indicated and measure progress. Consider using rapid-cycle improvement methods before implementing interventions more broadly.
- Elicit input from consumers and family members regarding interventions and use the input to design the interventions.
- Include numerator and denominators for all measurements.

# INFORMATION SYSTEMS

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

## INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner Community Behavioral Health (CCBH), which has been in use for 11 years. Currently, the MHP is implementing a new system which requires heavy staff involvement to fully develop. Nevada has signed on to the new CalMHSA semi-statewide EHR, Smartcare by Streamline, with a planned go-live date of July 1, 2023.

Approximately 3.79 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). This represents an increase from the prior year's budget allocated of 1.5 percent, which is due to the transition to the new EHR. The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 225 named users with log-on authority to the EHR, including approximately 66 county staff and 159 contractor staff. Support for the users is provided by two full-time equivalent (FTE) IS technology positions that are shared across the MHP and the DMC-ODS. Currently all positions are filled. This staffing level is unchanged since the last EQR.

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

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

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

| Submittal Method | Frequency | Submittal Method Percentage |
|---|---|---|
| Health Information Exchange (HIE) between MHP IS | ☐ Real Time ☐ Batch | 0% |
| Electronic Data Interchange to MHP IS | ☐ Daily ☐ Weekly ☐ Monthly | 0% |
| Electronic batch file transfer to MHP IS | ☐ Daily ☐ Weekly ☐ Monthly | 0% |
| Direct data entry into MHP IS by provider staff | ☒ Daily ☐ Weekly ☐ Monthly | 40% |
| Documents/files e-mailed or faxed to MHP IS | ☐ Daily ☐ Weekly ☒ Monthly | 30% |
| Paper documents delivered to MHP IS | ☐ Daily ☐ Weekly ☒ Monthly | 30% |
| | | 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. Nevada beneficiaries do not have access to a PHR, but it is anticipated that this functionality will be available to beneficiaries within the next year, after the transition to the new EHR.

### Interoperability Support

The MHP is a member or participant in a HIE, however it has limitations in functionality with the current EHR and does not provide a bi-directional exchange of information. The MHP explored the possibility of participating in a different HIE but determined it would not be prudent at this time due to other IS priorities and projects related to CalAIM. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Mental Health CBOs/contracted providers.

## INFORMATION SYSTEMS KEY COMPONENTS

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

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

### Table 17: IS Infrastructure Key Components

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

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

- The MHP has a remarkably low claims denial rate of 0.13 percent.
- The budget for IS was increased this year to support impending implementation of a new EHR, Smartcare, as part of CalMHSA's semi-statewide EHR project.
- The MHP does not maintain a Data Warehouse to support data analytics in the MHP. Further, Nevada had some challenges pulling data for the EQR due to an analyst being unavailable, and noted their capabilities were hampered by the situation.
- The Operations Continuity Plan is not tested at least annually, and two-factor authentication has not been implemented to make password changes more secure.

## INFORMATION SYSTEMS PERFORMANCE MEASURES

### Medi-Cal Claiming

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

Table 18 appears to reflect a largely complete or very substantially complete claims data set for 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 | 5,669 | $1,109,594 | $0 | 0.00% | $1,070,450 |
| Feb | 5,264 | $1,086,562 | $0 | 0.00% | $1,053,992 |
| Mar | 6,269 | $1,245,490 | $386 | 0.03% | $1,215,467 |
| April | 5,435 | $1,078,330 | $297 | 0.03% | $1,048,705 |
| May | 5,338 | $1,111,437 | $0 | 0.00% | $1,075,318 |
| June | 5,437 | $1,100,156 | $1,150 | 0.10% | $1,055,885 |
| July | 4,810 | $1,012,866 | $0 | 0.00% | $983,163 |
| Aug | 4,844 | $1,021,085 | $764 | 0.07% | $994,996 |
| Sept | 4,923 | $1,151,297 | $99 | 0.01% | $1,120,249 |
| Oct | 4,487 | $981,582 | $1,388 | 0.14% | $963,265 |
| Nov | 4,810 | $1,062,916 | $3,830 | 0.36% | $1,041,065 |
| Dec | 4,355 | $1,009,869 | $8,914 | 0.88% | $973,890 |
| **Total** | **61,641** | **$12,971,184** | **$16,828** | **0.13%** | **$12,596,445** |

- The MHP demonstrated a consistent claims volume over time.

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

| Denial Code Description | Number Denied | Dollars Denied | Percentage of Total Denied |
|---|---|---|---|
| Other healthcare coverage must be billed before submission of claim | 13 | $7,328 | 43.54% |
| Medicare Part B must be billed before submission of claim | 42 | $4,059 | 24.12% |
| Beneficiary not eligible or non-covered charges | 5 | $2,744 | 16.30% |
| Late claim | 1 | $964 | 5.73% |
| Deactivated NPI | 2 | $795 | 4.72% |
| Other | 5 | $722 | 4.29% |
| Service line is a duplicate and a repeat service procedure code modifier not present | 1 | $218 | 1.30% |
| **Total Denied Claims** | **69** | **$16,830** | **100.00%** |
| **Overall Denied Claims Rate** | **0.13%** | | |
| **Statewide Overall Denied Claims Rate** | **1.43%** | | |

- The MHP had an impressively low denied claims rate of 0.13 percent, as compared to the statewide denied claims rate of 1.43 percent. Out of nearly $13 million in billed claims, less than $17,000 were denied.

## IMPACT OF INFORMATION SYSTEMS FINDINGS

- The implementation of the Smartcare EHR in July 2023 will bring new features, including a Data Warehouse function and beneficiary access to a PHR. It will be important for the county to devote resources to not only training staff on the use of the new EHR, but also to cross train staff so that if someone is on leave or exits their position, there can be continuity in IS support for the system overall, as well as key analytic and reporting functions.
- IS staff are juggling a number of crucial projects, including preparing to transfer data into the new EHR and mapping out how the legacy system will be handled, in addition to working to meet CalAIM requirements around documentation reform, payment reform, and data sharing.
- Additional training may be needed as the county moves away from Kings View as their Application Service Provider, since Kings View has been an integral part of the IS landscape in Nevada, providing support and expertise for a number of years.

# 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 sets CPS completion rate goals in the QIWP. The MHP reports that the QIC review of 2021 results did not yield areas that required QI.

## CONSUMER FAMILY MEMBER FOCUS GROUP

Consumer and family member (CFM) focus groups are an important component of the CalEQRO review process; feedback from those who receive services provides important information regarding quality, access, timeliness, and outcomes. Focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-review planning process, CalEQRO requested one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

### Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult or TAY consumers, and family members of child/youth beneficiaries. The focus group was held virtually and included nine participants. All consumers and family members participating receive or have a family member who receives clinical services from the MHP.

Participants had received services between eight months to several years; two participants had started services in the last one year. Family members had children who received services. New beneficiaries report the paperwork was "stressful"; some experience delays because of dual insurance. However, once done, beneficiaries received an appointment in two weeks. Beneficiaries received psychiatry appointments every four to five weeks. Some felt it was too long between appointments and some report that scheduling an appointment outside of a routine cycle was very difficult. Some received reminder texts; all participants received reminder calls. Text reminders for psychiatry appointments appeared less routine.

All participants felt services gave them a sense of hope and recovery. Half of the participants felt they would feel comfortable and know how to ask for a provider change, while the others did not feel comfortable and felt they would “quit” if in that situation.

Beneficiaries were dissatisfied with the wellness center, the Spirit Center, because they perceived it to be a homeless program rather than the peer driven activities it had offered in the past.

Recommendations from focus group participants included:

- Offer ways to provide input to the MHP management
- Provide programs with volunteer opportunities to “keep busy” or provide peer support
- Offer more opportunities to be involved in MHP planning

## SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Beneficiaries who participated in the review report satisfaction. Review discussions appear consistent with the noted opportunity for consumer and family members to participate in planning or desire to provide input to the direction of the MHP. The lack of avenues in conjunction with the decreased use of the wellness center, appear to result in decreased support and recovery-oriented resources for beneficiaries.

# 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 continues to collaborate effectively with the ED in the county. The MHP is further building on the partnership with the BHQIP FUM PIP on increasing follow-up services after emergency room visits. (Quality, Access)
2. MHP PR and average approve claims per beneficiary overall continue to be higher than similar size MHPs and statewide average rates, indicating accessible services and beneficiary engagement. (Access)
3. The MHP systems for follow-up post hospitalization appear effective, based on FUM7 and FUM30 rates. (Access, Quality)
4. The MHP continues to expand resources for MHP beneficiaries in many areas such as housing needs, and sub-population specific needs. (Access, Quality)

## OPPORTUNITIES FOR IMPROVEMENT

1. Nevada is preparing for a go-live date of July 1, 2023 of a new EHR system, Streamline, as part of the CalMHSA semi-statewide EHR project. It will be important to provide staff with the training and expertise needed to move away from Kings View as its Application Service Provider to harness the potential of the new system. The MHP has limited analytic staffing capacity with only one key staff person leading report and data extraction for quality management. This limits continuity and capacity for QI efforts. (IS)
2. Consumer and family member involvement on MHP committees is not routinely present. This limits the MHP perspective and strategic planning in quality-oriented areas. (Quality)
3. The MHP inpatient services rose significantly from CY 2020 and inpatient PR are notably higher compared to the small county and statewide PR. (Quality)
4. The MHP's FC PR is lower than the statewide and similar size county PR, and it continued to decline from CY 2020 to CY 2021. (Access, Quality)
5. The MHP does not have a way to measure and monitor outcomes for adults fully in place. (Quality)

## RECOMMENDATIONS

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

1. Train IS and analytic staff on the new EHR environment, and also cross-train, to provide robust, seamless support for the system overall, as well as continuity and enhancement of key analytic and reporting functions. Consider establishing succession plans for analytic capacity. (IS, Quality, Timeliness)
2. Examine ways to re-establish consumer and beneficiary membership and ongoing participation in workgroups, committees, and/or other leadership roles. (Quality)
3. Select and implement a level of care tool and approach in adult services to guide and monitor services on a beneficiary and system level. (Access, Quality)
4. Evaluate potential barriers to FC access and ensure assessments and treatment when indicated are provided. Establish formal processes if indicated. Monitor PR as part of the process. (Access, Quality)

   (This recommendation is a carry-over from FY 2021-22.)
5. Continue to implement the plans to evaluate beneficiary outcomes in adult services. Measure progress and adapt processes as indicated. (Quality)

   (This recommendation is a partial 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, 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.

There were no barriers to this FY 2022-23 EQR.

# 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 – Nevada 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 |
| PIP Validation and Analysis |
| Performance Measure Validation and Analysis |
| 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 Supervisors Group Interview |
| Use of Data to Support Program Operations |
| Cultural Competence / Healthcare Equity |
| Quality Management, Quality Improvement and System-wide Outcomes |
| Primary and Specialty Care Collaboration and Integration |
| Acute and Crisis Care Collaboration and Integration |
| Health Plan and MHP Collaboration Initiatives |
| Peer Inclusion/Peer Employees within the System of Care |
| Contract Provider Group Interview – Clinical Management and Supervision |
| Services Focused on High Acuity and Engagement-Challenged Beneficiaries |
| Information Systems Billing and Fiscal Interview |
| EHR Deployment |

| CalEQRO Review Sessions – Nevada MHP |
| --- |
| Telehealth |
| Closing Session – Final Questions and Next Steps |

# ATTACHMENT B: REVIEW PARTICIPANTS

## CalEQRO Reviewers

Rowena Nery, Lead Quality Reviewer
Leda Frediani, 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 |
|---|---|---|---|
| Artaz | Jenna | Supervisor | Victor Community Support Services (VCSS) |
| Bell | Phebe | Behavioral Health Director | Nevada County Behavioral Health (NCBH) |
| Bullis | Heather | 24/7 Supervisor | Auburn Counseling |
| Chavez | Bri | Adult System of Care (ASOC) Supervisor | NCBH |
| Crow | Michael | Information & General Services/Customer Management | Nevada County IT |
| Dobbins | Allison | Administrative Services Officer | NCBH |
| Farley | Sandra | Nursing Director | Sierra Mental Wellness Group |
| Federmeyer | Dawn | Admin | NCBH |
| Gruver | Ryan | Health and Human Services Agency (HHSA) Director | Nevada County |
| Hodges | Theresa | Program Director | Insight Respite |
| Lehmkul | Andrea | HHSA Administrator | NCBH |
| Long | Amanda | Supervisor Health Techs | NCBH |
| Manandik | Denise | Director | Gateway |
| Maxwell | Jamie | Quality Assurance Manager | NCBH |
| McMullan | Curtis | Children System of Care (CSOC) Supervisor | NCBH |
| Milles | Crystal | Director | Gateway |

| Last Name | First Name | Position | County or Contracted Agency |
|---|---|---|---|
| Miner-Gann | Kelly | ASOC Supervisor | NCBH |
| Morgan | Cindy | CSOC Program Manager | NCBH |
| Nerelli | Katherine | Supervisor | Stanford Sierra Youth Families (SSYF) |
| Perkins | Samantha | Program Director | Sierra Mental Wellness Group |
| Peterson | Jeff | ASOC Supervisor | NCBH |
| Phillips | Brendan | Enhanced Care Management Program Manager | NCBH |
| Rudkin | Amy | Regional Director | VCSS |
| Tomm | Jasleen | Director | VCSS |
| Vallin | Jennifer | Regional Director | Turning Point |
| Vanaman | Danielle | Director | SSYF |
| Vance | Heather | Program Director | Turning Point |
| Walden | Katherine | ASOC Supervisor | NCBH |
| Ward | Gem | Supervisor | VCSS |
| Webster | Michael | Training Supervisor/Customer Management | Kings View |
| Wellenstein | Jennifer | Deputy Chief Operations Officer | Turning Point |
| Wood | Alisa | CSOC Supervisor | NCBH |
| Yardley | Cari | ASOC Program Manager | NCBH |

# 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 | This PIP is in the planning phase. |
| **General PIP Information** | |
| **MHP/DMC-ODS Name:** Nevada MHP | |
| **PIP Title:** No Shows for Initial Evaluation and First Service Appointment | |
| **PIP Aim Statement:** For clients with initial assessment appointments and first service appointments for SMHS, NCBH will providing automatic reminder texts and emails to reduce the percentage of no shows for initial assessments and first service appointment, as measured by Anasazi and SharePoint data, from December 2022 through November 2024, with review of preliminary data every three months? | |
| **Date Started:** 12/2022 | |
| **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: | |

| General PIP Information |
|---|
| **Target population description, such as specific diagnosis (please specify):** All clients eligible for adult services with appointments for initial SMHS assessments and first service appointments who agree to receive reminder notifications of appointments; post-hospitalization clients will only be included in the study if NCBH receives a form from the hospital confirming the client's permission to receive reminder notifications. |
| **Improvement Strategies or Interventions (Changes in the PIP)** |
| **Member-focused interventions** (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>Automatic appointment reminders via text or email, depending on the individual client's preference. |
| **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>n/a |
| **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>Automatic appointment reminders via text or email, depending on the individual client's preference. |

| 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 |
|---|---|---|---|---|---|---|
| The MHP did not complete this section. | | | ☐ 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): |

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

**PIP Validation Information**

**Was the PIP validated?** ☒ Yes ☐ No

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

**Validation phase (check all that apply):**

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

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

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

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

| PIP Validation Information |
| --- |
| **EQRO recommendations for improvement of PIP:**<br>Examine no show data updated since reviewing the 2012 and 2020 data. Establish baselines.<br>Review utilization patterns to identify root causes. Develop and select interventions based on findings. |

## 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 elected to participate in the CalAIM BHQIP FUM. |
| **General PIP Information** | |
| **MHP/DMC-ODS Name:** Nevada MHP | |
| **PIP Title:** Follow-Up After ED Visit for Mental Illness | |
| **PIP Aim Statement:** "For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5% 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>Adult beneficiaries age 18-64 years with a qualifying event defined as an ED visit with a principal diagnosis of mental illness or intentional self-harm. | |

| Improvement Strategies or Interventions (Changes in the PIP) |
|---|
| **Member-focused interventions** (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>n/a |
| **Provider-focused interventions** (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):<br>Creating information sharing through a data feed, and procedures to link beneficiaries from the ED and care coordination, creating a tracking system initiate and monitor referrals of the target population. |
| **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>Creating information sharing through a data feed, and procedures to link beneficiaries from the ED and care coordination, creating a tracking system initiate and monitor referrals of the target population. |

| 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 |
|---|---|---|---|---|---|---|
| Percentage of ED visit for a mental health (MH) condition and receive a follow-up MH service within 7 days. | 2021 | 72% of beneficiaries received mental health follow-up within 7 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): |
| Percentage of ED visit for a MH condition and receive a follow-up MH service within 30 days. | 2021 | 78% received follow-up within 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): |

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

**PIP Validation Information**

**Was the PIP validated?** ☒ Yes ☐ No

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

**Validation phase (check all that apply):**

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

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

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

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

**EQRO recommendations for improvement of PIP:**

Continue to investigate the finding that beneficiaries whose primary language is Spanish are less likely to receive a follow up within 7 and 30 days compared to beneficiaries who use English. Develop and use interventions as indicated and measure progress. Consider using rapid cycle improvement methods before broader implementation of interventions.

| PIP Validation Information |
| --- |
| Elicit input from consumers and family members regarding interventions and use the input to design the interventions.<br>Include numerator and denominators for all measurements. |

# ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

## ATTACHMENT E: LETTER FROM MHP DIRECTOR

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