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

TRINITY FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

May 16, 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, "Trinity" may be used to identify the Trinity County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — May 16, 2023

MHP Size — Small-rural

MHP Region — Superior

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

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

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	1	3	0
Timeliness of Care	6	5	1	0
Quality of Care	10	1	7	2
Information Systems (IS)	6	3	2	1
TOTAL	**26**	**10**	**13**	**3**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	Clinical	09/2022	Planning	Moderate
No PIP submitted	Non-Clinical	n/a	n/a	n/a

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	5

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP hired several key staff, including a Mental Health Services Act (MHSA) coordinator and case managers.
- The MHP clinical line staff collaborate with the emergency department (ED) staff.
- The MHP meets its timeliness to first offered and first delivered service for a high percentage of beneficiaries.
- The MHP continues to collaborate with schools and has invested in programs for youth.
- The MHP has a productive relationship with its application service provider (ASP).

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

- The MHP meets its timeliness standard to first non-urgent psychiatry appointments for only 21 percent of appointments.
- The wellness center has low attendance and community knowledge of the resource appears limited.
- The Quality Improvement Workplan (QIWP) lacks clear baselines and measures in order to monitor and improve performance.
- Clinical staff who are not a member of the beneficiary's assigned treatment team are not fully aware of how to gain access to the beneficiary's record in the EHR to complete clinical documentation.

- The MHP needs to be knowledgeable and skilled in implementation of the Operations Continuity Plans (OCP).

Recommendations for improvement based upon this review include:

- Examine barriers to improve timely initial access to psychiatry appointments.
- Evaluate barriers to the wellness center attendance and implement ways to promote the center and wellness concepts.
- Incorporate baselines and measurements in the QIWP and evaluate progress quarterly and in an annual QIWP Evaluation.
- Assure that all clinical staff who may provided crisis services are aware of how to document in the EHR despite being not part of the identified treatment team.
- Review OCPs from the County IT Department and Kings View and become knowledgeable and skilled in the OCP implementation.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill SB 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section14197.05).

This report presents the FY 2022-23 findings of the EQR for Trinity County MHP by BHC, conducted as a virtual review on May 15-16, 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 is included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's NA as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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 that contributed to a health workforce shortage crisis. The county was also impacted by significant winter snow and rainstorms that reduced clinic access due to road closures and power outages. Additionally, a community shooting occurred in November 2022 during business hours at the Weaverville clinic.

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.

- Staff vacancies and turnover continue to be significantly challenging. The MHP presented the following summary of recent and future hiring plan.
    - The MHP hired three case managers, all of the front office staff positions, and an MHSA coordinator.
    - The MHP has 5.2 vacant, budgeted positions which include hiring for an analyst, a Substance Use Disorder (SUD) clinician, and an accountant.
    - The MHP contracts with individual clinicians to provide assessments. This function has been unstable with multiple turnovers in the past year, which created barriers to timely access to care.
- The MHP acquired a mobile unit and located the base of operations outside the local hospital's ED. Operations had not yet been initiated at the time of the review.
- In response to the shooting at the Weaverville Clinic, the MHP hired a full-time security guard. The MHP also completed remodeling the lobby to improve both security and Americans with Disabilities Act accessibility. Review discussions indicate positive staff morale and a sense of support from the organization in its response.
- The MHP reports the Sheriff's office is understaffed and there is a perceived lack of mental health understanding by the deputies. With a new jail opening in the County, the MHP plans to provide beneficiary services 90 days prior to release and consultations to jail staff consultations as requested.

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: Measure timeliness to psychiatry services routinely and conduct performance improvement as indicated. Measure the effectiveness of the changes made frequently. Consider expanding psychiatry staffing in addition to the existing goals of decreasing no-shows to psychiatry services.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Performance in timeliness to care decreased from CY 2021 to CY 2022, with only 24 percent of beneficiaries offered a non-urgent psychiatry appointment within 15 days. Twenty-one percent of the beneficiaries received their psychiatry service within 15 days.
- The MHP increased its standard expectation of a 20 percent no-show rate to 25 percent. However, the MHP no-show rate for psychiatry is reported at 15.4 percent overall, slightly improved from the prior year.
- The MHP's long-time nurse who attended telepsychiatry appointments and helped scheduling retired in the last year. The MHP does not plan to refill this position and has moved the scheduling assistance to case managers. This has resulted in lack of consistent psychiatric care.
- The MHP staffs 12 hours per week in psychiatry and has no plans to expand due to budget limitations. Anecdotally the wait time until a medication evaluation was reported to be four to six weeks. Similarly, the annual average wait time was reported at 23 business days.

- This recommendation is partially addressed because while the MHP continued to measure timeliness, there has not been any demonstrated improvement. This recommendation will be carried over to FY 2023-24.

Recommendation 2: Take immediate steps to ensure accurate tracking of all initial non-urgent service requests and conduct performance improvement activities as indicated to meeting standards for timely services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP produced dashboards that include time to non-urgent requests to first offered and first delivered services.
- The MHP met its 10-day standard for 99 percent of first appointments offered.
- The MHP also met its 10-day standard for first appointment delivered at a high rate of 98 percent. Of note, however, of 230 appointments offered, only 64 percent were delivered (148 appointments).

Recommendation 3: Implement a way to examine and ensure appropriate levels of care in the adult and child system using a tool or selected indicators. Among other areas, use this information to review high-cost beneficiaries.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP continues to use the CANS and ANSA but did not implement ways to use them for level of care monitoring. The MHP reports that the clinical team determines the appropriate level of care beneficiaries need.
- The MHP reports having started to review high-cost beneficiaries, but examination is paused due to other priorities such as CalAIM and implementing a new EHR.
- This recommendation is not addressed but will not be carried over to FY 2022-23 because other system priorities have been identified.

Recommendation 4: Continue to expand consumer and family member involvement and leadership throughout the system. Involve beneficiaries or family members in developing PIPs.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP did not expand consumer involvement and unfortunately lost a participating consumer member of the Quality Improvement Committee (QIC).
- This recommendation is not addressed but will not be carried over to FY 2022-23 due to other priority recommendations.

Recommendation 5: Examine services patterns using claims data or other sources to monitor access such as engagement, and quality. Include areas such as FC beneficiaries and beneficiaries with high service utilization. Use the information for performance improvement as indicated.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP did not analyze service patterns for FC or beneficiaries with high service utilization in the last year. The MHP reports that limited analytic staff is a barrier and hopes to hire an analyst.
- While this is not addressed, this recommendation will not be carried over to FY 2022-23 due to other priority recommendations.

Recommendation 6: Conduct two active PIPs as part of the MHP's QI operations. Prioritize developing projects that have feasible and sustainable interventions in the current workforce climate.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is conducting a clinical PIP as part of the BHQIP but does not have a non-clinical PIP. The MHP reports ongoing efforts to hire a consultant for this area but has not yet succeeded in hiring one.
- Though partially addressed, this recommendation will not be carried over to FY 2022-23 due to other priority recommendations. However, the MHP must maintain two PIPs for review by EQRO, and technical assistance is available throughout the year.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 73 percent of services were delivered by county-operated/staffed clinics and sites, and 27 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 88 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 8am to 5pm and by contract provider staff after hours. Beneficiaries may request services through the Access Line as well as at the MHP clinic in Weaverville. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video or phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 109 adult beneficiaries, 70 youth beneficiaries, and 13 older adult beneficiaries across 2 county-operated sites and 1 contractor-operated sites. Among those served, no beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

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

[1] CMS Data Navigator Glossary of Terms

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 NA Certification Tool and supporting documentation, per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN). These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

For Trinity County, the time and distance requirements are 60 miles and 90 minutes for outpatient children's mental health and adult psychiatry services.

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	
AAS Details	**Psychiatry**		**MH Services**	
	Adults (ages 21+)	Youth (ages 0-20)	Adults (ages 21+)	Youth (ages 0-20)
# of zip codes outside of the time and distance standards that required AAS request	2	n/a	n/a	2
# of allowable exceptions for the appointment time standard, if known (timeliness is addressed later in this report)	0	n/a	n/a	0
Distance and driving time between nearest network provider and zip code of the beneficiary furthest from that provider for AAS requests	64/104	n/a	n/a	64/104
Approximate number of beneficiaries impacted by AAS or allowable exceptions	65	n/a	n/a	22
The number of AAS requests approved and related zip code(s)	2	n/a	n/a	2
Reasons cited for approval	Telehealth implementation at school			
The number of AAS requests denied and related zip code(s)	0	n/a	n/a	0
Reasons cited for denial	n/a	n/a	n/a	n/a

- The MHP did not meet all time and distance standards and was required to submit an AAS request.
- The MHP engaged in the following improvement activities to improve access to services for beneficiaries living within AAS areas: continued a telehealth unit at Southern Trinity High School and a mobile crisis unit that will visit the outlying areas of Trinity County.

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
Contracting status:	☒ The MHP is in the process of establishing contracts with OON providers ☐ The MHP does not have plans to establish contracts with OON providers
Contracting efforts and barriers cited by MHP:	TCBHS is in the process of implementing a mobile telehealth unit in addition to the already established mobile crisis unit. In addition to the mobile telehealth unit, TCBHS offers transportation in the event that a beneficiary requests it.

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP continues to partner with schools and demonstrates significant investment in youth psychoeducation and prevention, such as Friday Night Live.
- Collaboration with primary care and the ED is not established.
- The MHP has paused the cultural competence committee and other associated measurements and goals due to limited staffing. The MHP reports that other CalAIM and the EHR implementation are the system priorities.
- The MHP identifies the primary cultural of poverty as critical to address. The Milestones Wellness Center is a primary strategy for meeting beneficiaries' needs. However, review discussions indicate that very few beneficiaries attend the Wellness Center; the far distance from the town center and transportation are problematic to consumers.
- Clinician staff shortage is identified as most significant of the workforce shortage. The MHP currently staffs 2.6 licensed providers and has two vacancies. Anecdotally, the wait for an assessment was one month at the time of the review.
- Crisis clinician access to medical records has been problematic and impacts the ability to provide and document appropriate crisis intervention.
- The MHP reports that staff choose the modality of providing service either in-person or telehealth "as long as the services meet the needs of clients." Anecdotally, the MHP reports that consumer choice is often provided, but there does not appear to be a mechanism to evaluate whether in fact consumer choice drives this decision.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, the PR of 5.23 percent is higher than the statewide PR and the AACB of $10,811 is higher than the statewide AACB. The MHP PR and AACB indicate that beneficiaries are able to access treatment.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	5,550	290	5.23%	$3,135,075	$10,811
CY 2020	4,981	305	6.12%	$3,320,200	$10,886
CY 2019	4,708	340	7.22%	$2,178,941	$6,409

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

- Trinity MHP annual eligibles increased 11 percent in CY 2021.
- The MHP served 15 fewer beneficiaries (5 percent) in CY 2021 than CY 2020.
- The penetration rate (PR) decreased almost a full percentage point from CY 2020 to CY 2021.
- Increasing its rates, the AACB increased significantly between CY 2019 and CY 2020. The AACB in CY 2022 decreased only slightly from 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	526	<11	-	1.71%	1.96%
Ages 6-17	1,077	81	7.52%	8.65%	5.93%
Ages 18-20	223	14	6.28%	7.76%	4.41%
Ages 21-64	3,174	174	5.48%	8.00%	4.56%
Ages 65+	553	-	-	3.73%	1.95%
Total	5,550	290	5.23%	7.08%	4.34%

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

- Based on compliance with HIPAA guidelines, two of the age groups (Ages 0-5 and Ages 65+) had too few beneficiaries served to display.
- For the three age groups measured in Table 4 above, the MHP PR falls between the statewide and similar size counties PR. The same is true for the overall PR.
- The MHP overall PR is 26 percent lower than similar size counties PR (7.08 percent) but 20 percent greater than the statewide PR (4.34 percent) 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
No Threshold Language	n/a	n/a
Threshold language source: Open Data per BHIN 20-070		

- The MHP does not have a threshold language.

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

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	1,861	80	4.30%	$726,160	$9,077
Small-Rural	35,376	2,377	6.72%	$12,056,144	$5,072
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries. While the MHP's PR for ACA Eligibles is lower compared to other small rural counties, their PR is higher than the statewide rate.
- The MHP's AACB for ACA Eligibles ($9,077) is 42 percent higher than the statewide AACB ($6,383) and 79 percent higher than the AACB for small rural counties ($5,072).

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.

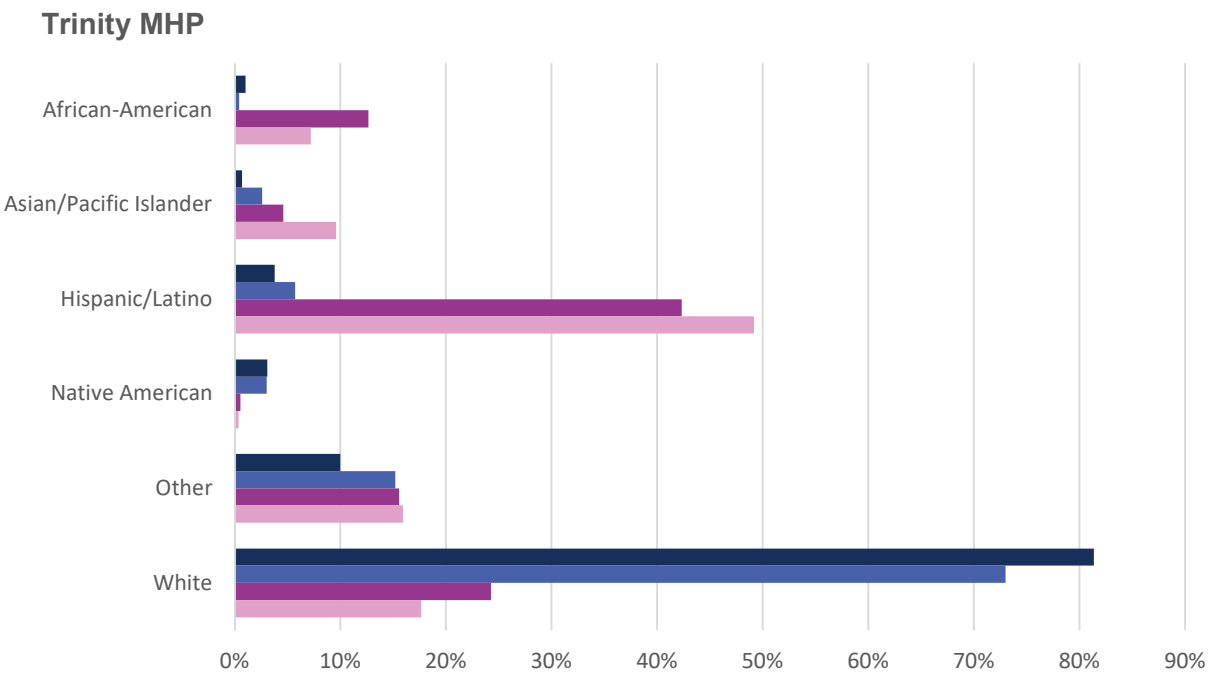
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African Americans	23	<11	-	7.64%
Asian/Pacific Islander	145	<11	-	2.08%
Hispanic/Latino	318	11	3.46%	3.74%
Native American	169	<11	-	6.33%
Other	844	29	3.44%	4.25%
White	4,053	236	5.82%	5.96%
Total	**5,552**	**290**	**5.22%**	**4.34%**

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

- Overall, the MHP's PR is higher than the statewide rate.
- Three race/ethnicity groups – African Americans, Asian/Pacific Islander and Native American – had fewer than 11 beneficiaries served.
- The Hispanic/Latino PR is slightly lower than the statewide rate.
- The Other PR is 19 percent lower than the statewide rate.
- The White PR is slightly under the statewide rate.

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

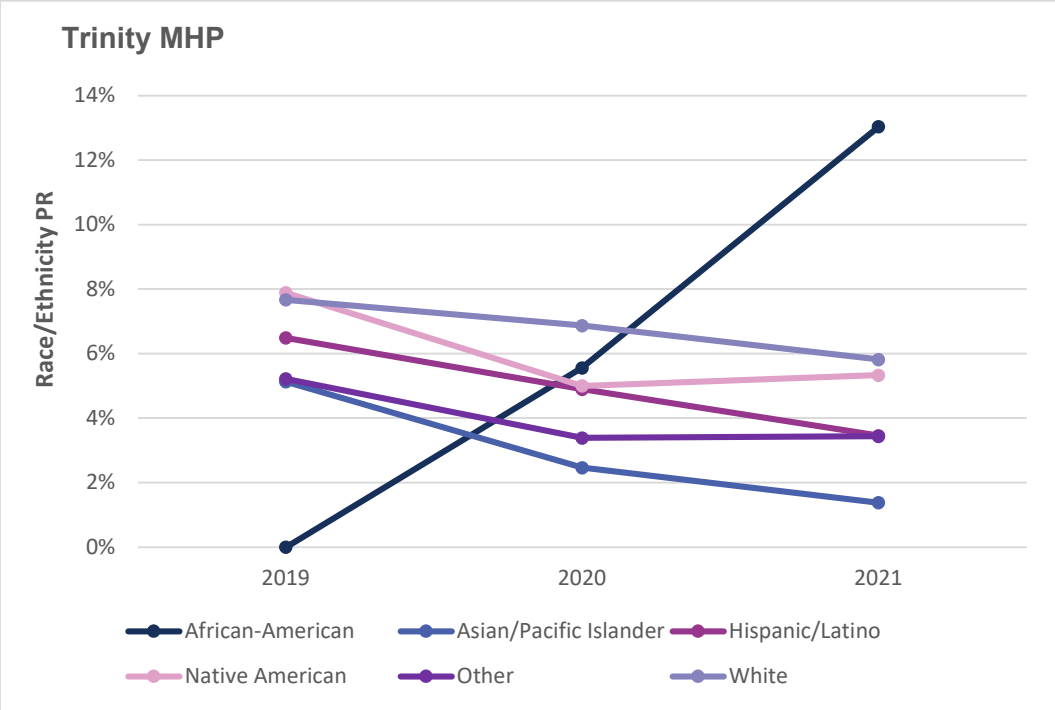


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	81%	10%	3%	4%	1%	1%
MHP % Eligible	73%	15%	3%	6%	3%	0%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- While 73 percent of MHP eligibles are white, 81 percent of beneficiaries served are white. The higher percentage of white beneficiaries served indicates they are over-represented.
- For Native Americans and African Americans the beneficiaries served are comparable to their presence in the eligible population.
- The remaining categories Hispanic/Latino, Asian/Pacific Islanders and Other eligibles are the most comparatively underserved race/ethnicities.

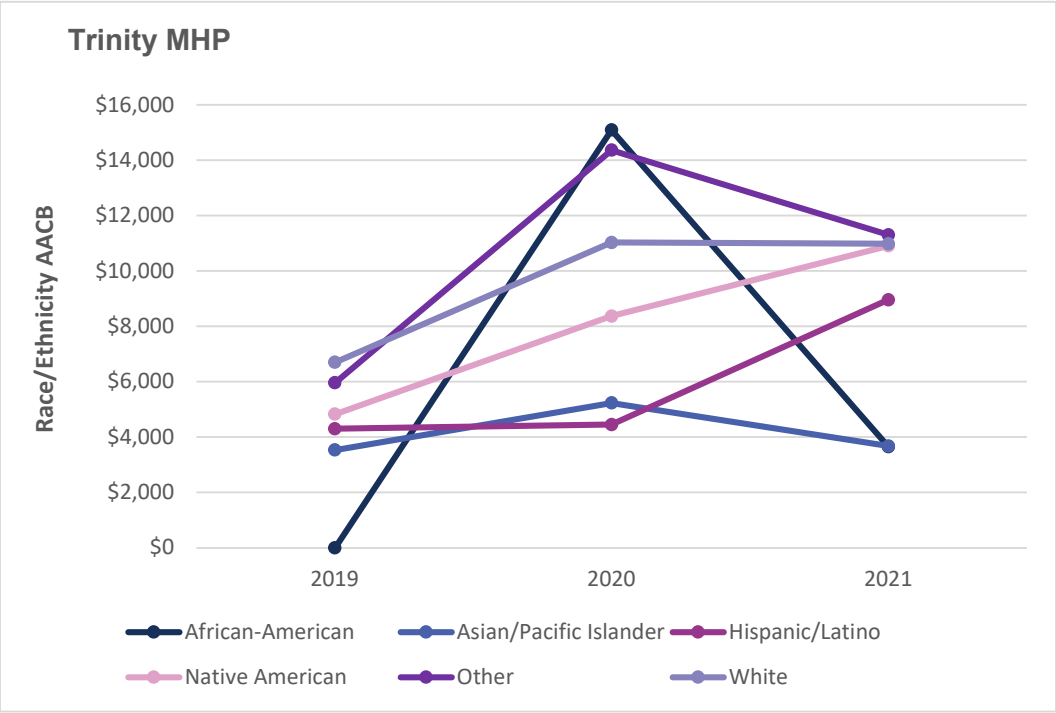
Figures 2-11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



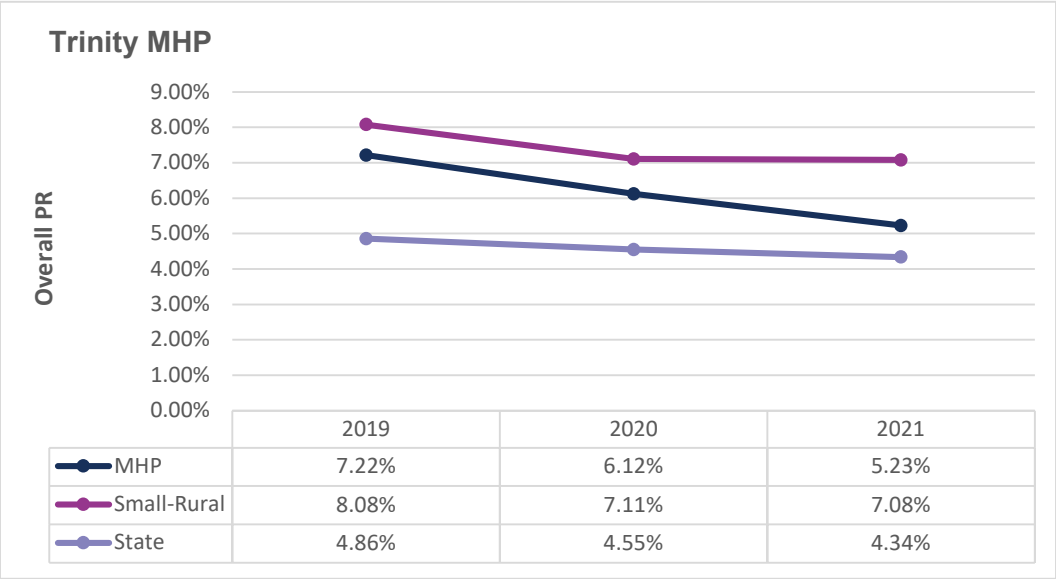
- Small numbers result in large variations in percentages when displayed. For all populations except for White, changes by one or two individuals will result in large percentage changes.

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



- The large increase in AACB from CY 2019 to CY 2020 was due to the increase in the reimbursement rate implemented during the first pandemic year. The MHP reportedly decreased their rates the following year, though this is not apparent in the overall averages in the CY 2021 claims. A decrease is shown in the lower AACB in CY 2021 for Asian Pacific Islanders, African Americans, Whites and Others.
- The trend for Whites, Hispanic/Latinos and Native Americans over the three-year trend follow a similar pattern increasing for each group over the three years.
- The trend for African Americans shows the most variability due to its small numbers.
- Asian Pacific Islanders show an increase of almost 48 percent in AACB from CY 2019 to CY 2020. The AACB then decreased from CY 2020 to CY 2021 by 30 percent. Again this variation is impacted by small numbers.
- The changes in AACB for Other show large variations over the three years trended in Figure 3. The AACB more than doubled from CY 2019 to CY 2020 ($5,966 to $14,364).

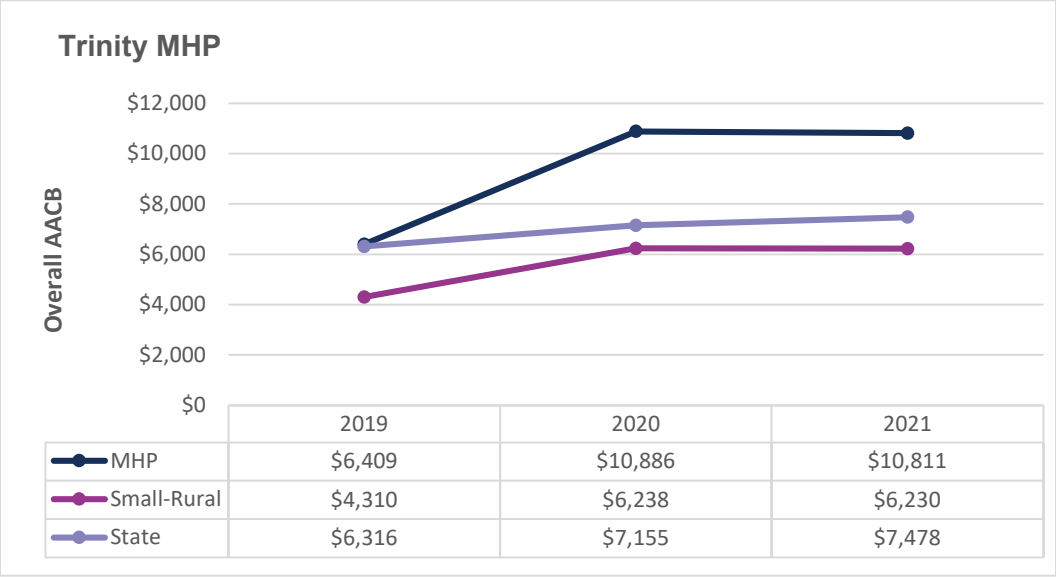
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	7.22%	6.12%	5.23%
Small-Rural	8.08%	7.11%	7.08%
State	4.86%	4.55%	4.34%

- While the statewide overall PR decreased by 11 percent, the overall PR for the MHP decreased 28 percent over the three years displayed.
- Small-rural Counties overall PR decreased by 12 percent over the same period.

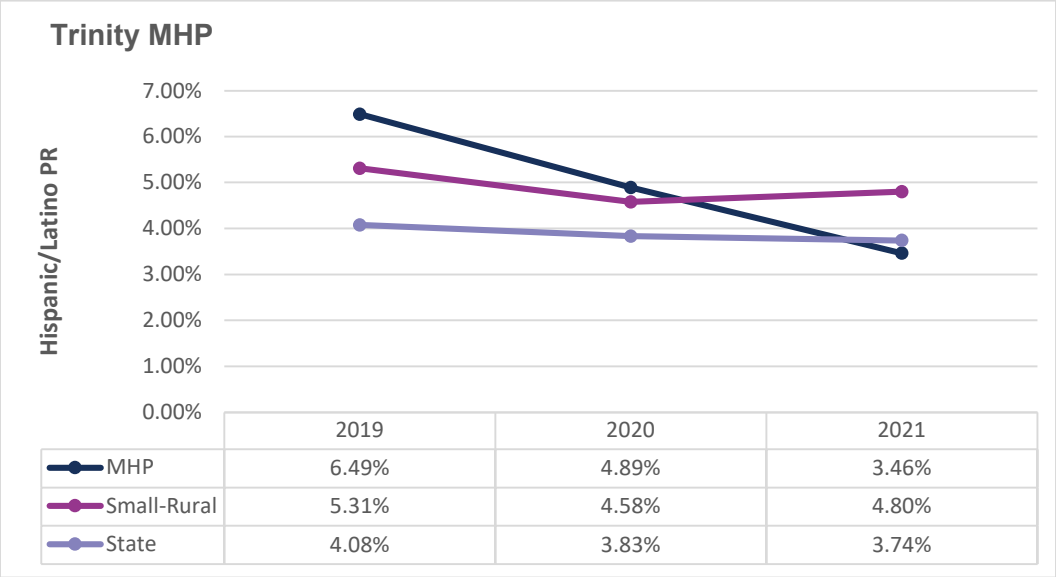
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$6,409	$10,886	$10,811
Small-Rural	$4,310	$6,238	$6,230
State	$6,316	$7,155	$7,478

- The MHP overall AACB for the period CY 2019 to CY 2020 increased 70 percent. The overall AACB for the period CY 2020 to CY 2021 decreased slightly by $75.
- The MHP AACB exceeded other small rural counties and statewide in CY 2020 and CY 2021.

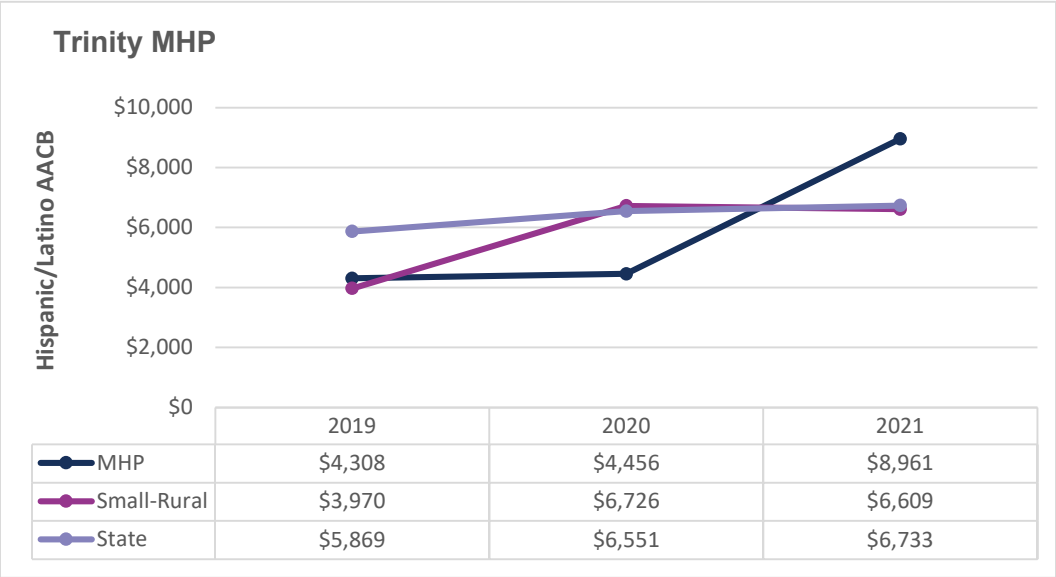
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	6.49%	4.89%	3.46%
Small-Rural	5.31%	4.58%	4.80%
State	4.08%	3.83%	3.74%

- While the MHP PR for Hispanic/Latinos started out higher than other small rural counties and statewide average in CY 2019, the MHP PR dropped steadily in CY 2020 and CY 2021. The MHP PR for Hispanic/Latinos in CY 2021 (3.46 percent) decreased by 47 from CY 2021.
- In CY 2021 for Hispanic/Latino beneficiaries who are also youth, the MHP Hispanic/Latino PR (1.69 percent) is 70 lower than the small-rural PR (5.66 percent).

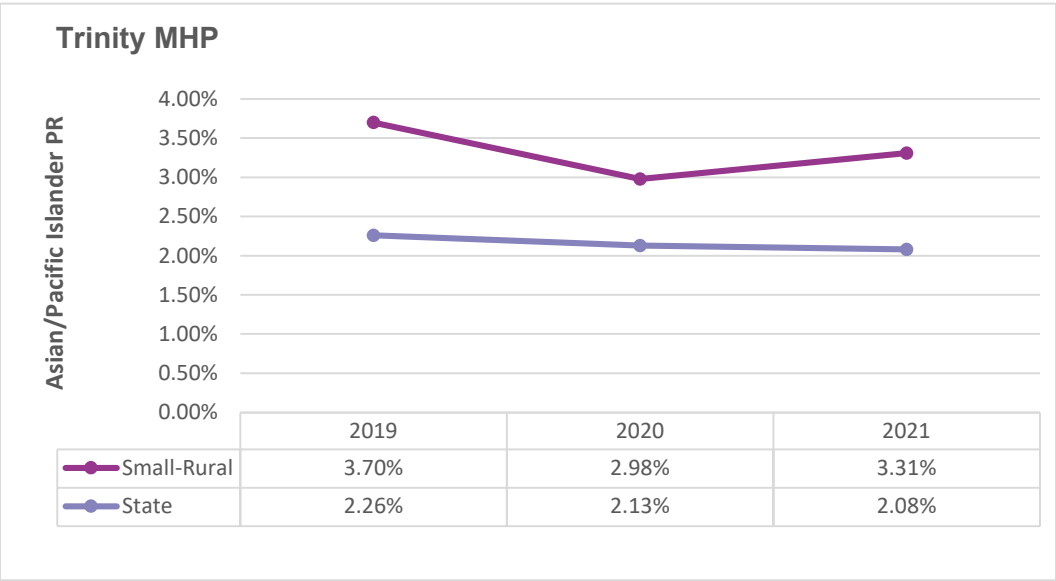
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,308	$4,456	$8,961
Small-Rural	$3,970	$6,726	$6,609
State	$5,869	$6,551	$6,733

- The AACB for the Hispanic/Latino beneficiaries more than doubled over the period in Figure 7. While the MHP's claiming rates increased in CY 2020, the MHP lowered their claiming rates in FY 2021-22, which is reflected in the CY 2021 data. Therefore, the increase is likely due to an increase in the number of services or higher acuity services (or both). This is further elaborated in discussion of Table 8 later in this report.

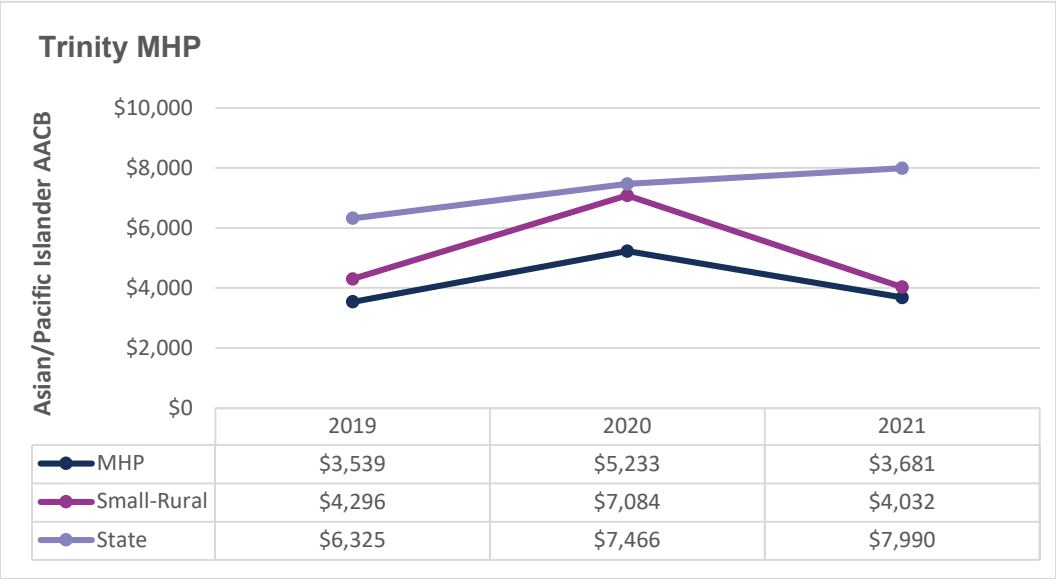
Figure 8: Asian/Pacific Islander PR CY 2019-21



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

- The Asian/Pacific Islander PR for is too low to present in Figure 8.

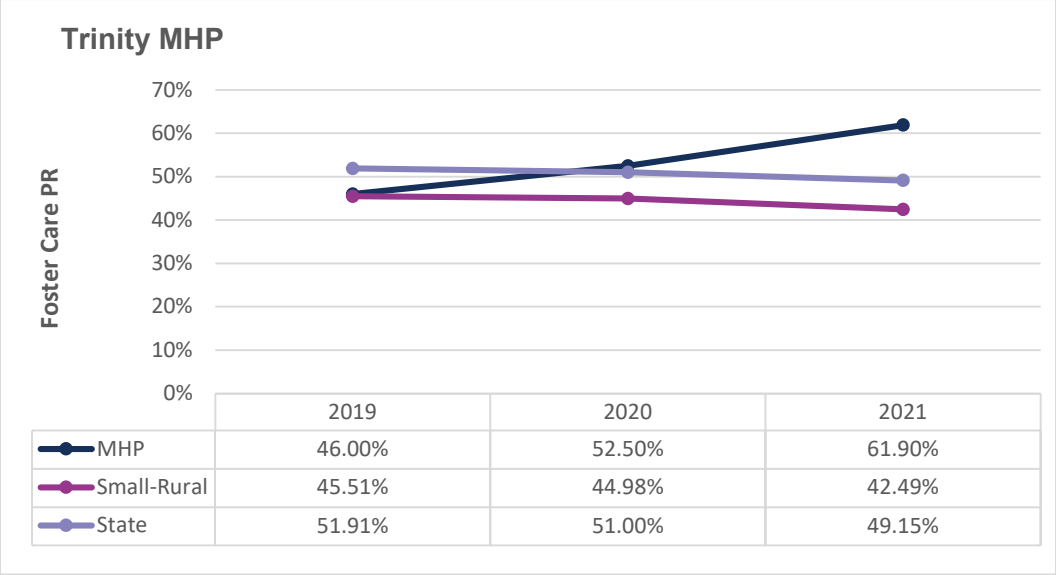
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$3,539	$5,233	$3,681
Small-Rural	$4,296	$7,084	$4,032
State	$6,325	$7,466	$7,990

- The Asian/Pacific Islander AACB increased 47 percent from CY 2019 to CY 2020 and then decreased 30 percent from CY 2020 to CY 2021.
- The changes to the MHP's AACB for Asian/Pacific Islander beneficiaries follow the MHP's changes to claiming rates discussed earlier.

Figure 10: Foster Care PR CY 2019-21

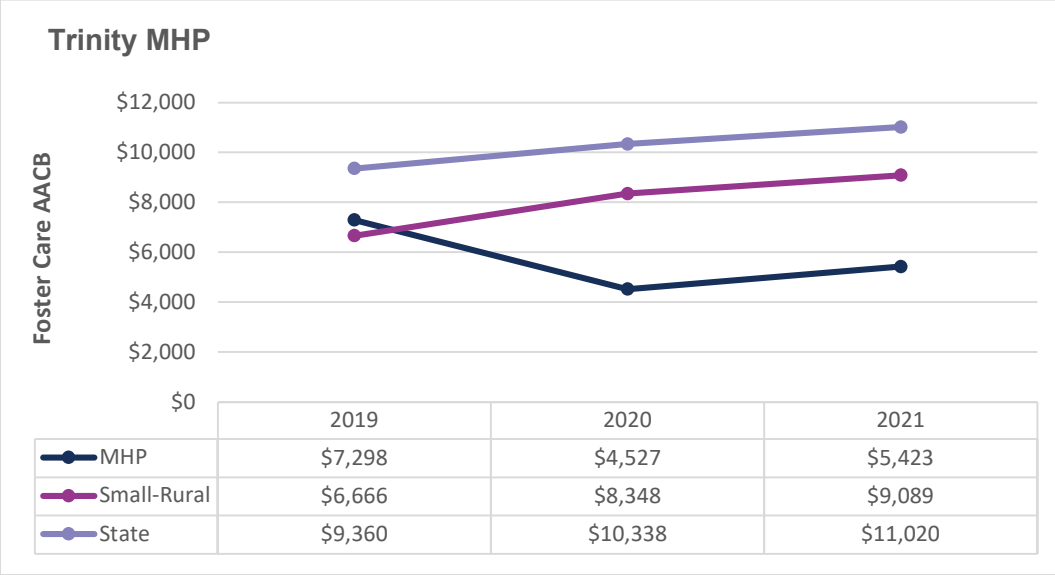


	2019	2020	2021
MHP	46.00%	52.50%	61.90%
Small-Rural	45.51%	44.98%	42.49%
State	51.91%	51.00%	49.15%

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed.

- The MHP's FC PR increased 35 percent over the three years in Figure 10, standing 26 percent higher than statewide.

Figure 11: Foster Care AACB CY 2019-21



- Statewide FC AACB has increased each year. Over the three-year period in Figure 11, the MHP's FC AACB decreased 26 percent.
- The MHP FC AACB is 40 percent lower than other small rural counties and 51 percent lower than the statewide AACB.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 201				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	10	10	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	<11	-	5	7	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	0	0.0%	0	0	2.2%	21	14
Per Minute Services							
Crisis Stabilization	<11	-	1,140	1,200	13.0%	1,546	1,200

Crisis Intervention	40	19.9%	247	119	12.8%	248	150
Medication Support	137	68.2%	433	300	60.1%	311	204
Mental Health Services	150	74.6%	1,082	593	65.1%	868	353
Targeted Case Management	29	14.4%	295	168	36.5%	434	137

- Of the services provided to the MHP's adult beneficiaries, 74.6 percent of adult beneficiaries received mental health services. The average units provided are 25 percent higher than the statewide average.
- 68.2 percent of the MHP's adult beneficiaries received medication support services and the average units provided are 39 percent higher than the statewide average.
- 19.9 percent of the MHP's beneficiaries received crisis intervention services. The statewide percent of beneficiaries served for crisis intervention is seven percentage points lower (12.8 percent).
- The MHP's Targeted Case Management rate is 61 percent lower than the state rate.
- The MHP's beneficiaries had low utilization of per day services. Fewer than eleven beneficiaries received inpatient care with average units at 37.5 percent lower than the statewide average.

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

Service Category	MHP N = 26				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	4	4	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	<11	-	7	7	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	3.1%	1,404	1,200
Crisis Intervention	<11	-	605	605	7.5%	406	199
Medication Support	<11	-	364	294	28.2%	396	273
Therapeutic Behavioral Services	0	0.0%	0	0	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	<11	-	259	104	40.2%	1,354	473
Intensive Home Based Services	<11	-	359	359	20.4%	2,260	1,275
Katie-A-Like	<11	-	149	149	0.2%	640	148
Mental Health Services	25	96.2%	888	588	96.3%	1,854	1,108
Targeted Case Management	<11	-	111	111	35.0%	342	120

- Fewer than 11 MHP FC youth received Inpatient services or services in a Psychiatric Health Facility (PHF).
- Almost all foster youth served by the MHP received Mental Health Services (96.2 percent), comparable to the statewide pattern.
- The average units provided the MHP's FC youth for Mental Health Services are lower than the statewide average and median units. The MHP's average units are 47.8 percent of the statewide average units and the median units for the MHP's FC youth are 53.0 percent of the statewide median units.

- The MHP provided Targeted Case Management to fewer than 11 FC youth, The percentage of FC youth receiving this service was not displayed to comply with HIPAA regulations.
- While fewer than 11 MHP FC youth received Crisis Intervention services, both the average units and median units exceeded the statewide average and median units.

IMPACT OF ACCESS FINDINGS

- The MHP's higher crisis intervention utilization rate for adults compared to the state may be associated with the lower rate of case management services provided. Examining service patterns to identify service barriers or gaps that could be improved and mitigate acute service use.
- The significantly lower PR for Hispanic/Latino EPSDT beneficiaries in particular warrants identifying barriers and increasing understanding for the MHP's declining Hispanic/Latino PR.

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:

- For time to first appointment offered, the MHP met its standards for 98.6 percent of the appointments.

- The MHP met its 48 hour standard for an urgent request for 62 percent of requests. The MHP considers all calls to the crisis line as “urgent” requests, and the staff phone call in response is the urgent service delivered. Given the MHP’s definition of urgent service delivery, this performance warrants attention.
- The MHP has a 25 percent standard for non-psychiatry staff no-shows; the MHP overall non-psychiatry staff no-show rate was 29.4 percent. The MHP did not conduct performance improvement in this area.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of CY 2022. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. This data represented the entire system of care.

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

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

Timeliness Measure	Average	Standard	% That Met Standard
First Non-Urgent Appointment Offered	7.08 Business Days	10 Business Days*	98.6%
First Non-Urgent Service Rendered	4.7 Business Days	10 Business Days**	97.9%
First Non-Urgent Psychiatry Appointment Offered	22.92 Business Days	15 Business Days*	24%
First Non-Urgent Psychiatry Service Rendered	23.8 Business Days	15 Business Days**	21%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	25.73 Hours	48 Hours*	62.1%
Follow-Up Appointments after Psychiatric Hospitalization	6.76 Days	7 Business Days**	62.5%
No-Show Rate – Psychiatry	15.2%	25%**	n/a
No-Show Rate – Clinicians	29.4%	25%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: CY 2022			

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

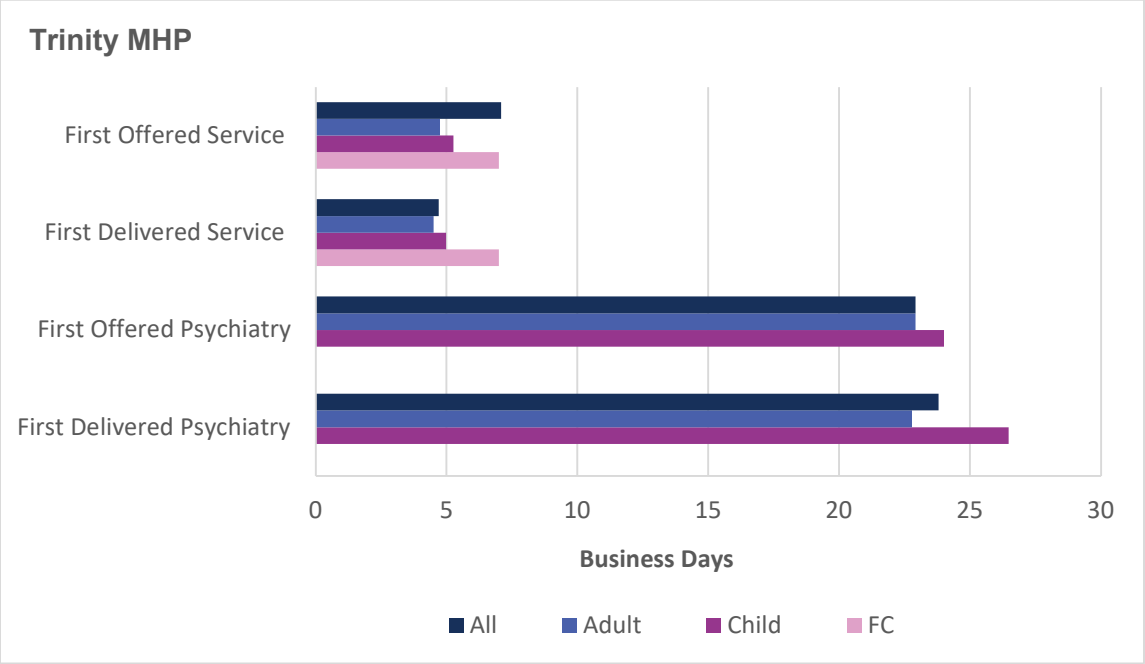


Figure 13: Wait Times for Urgent Services

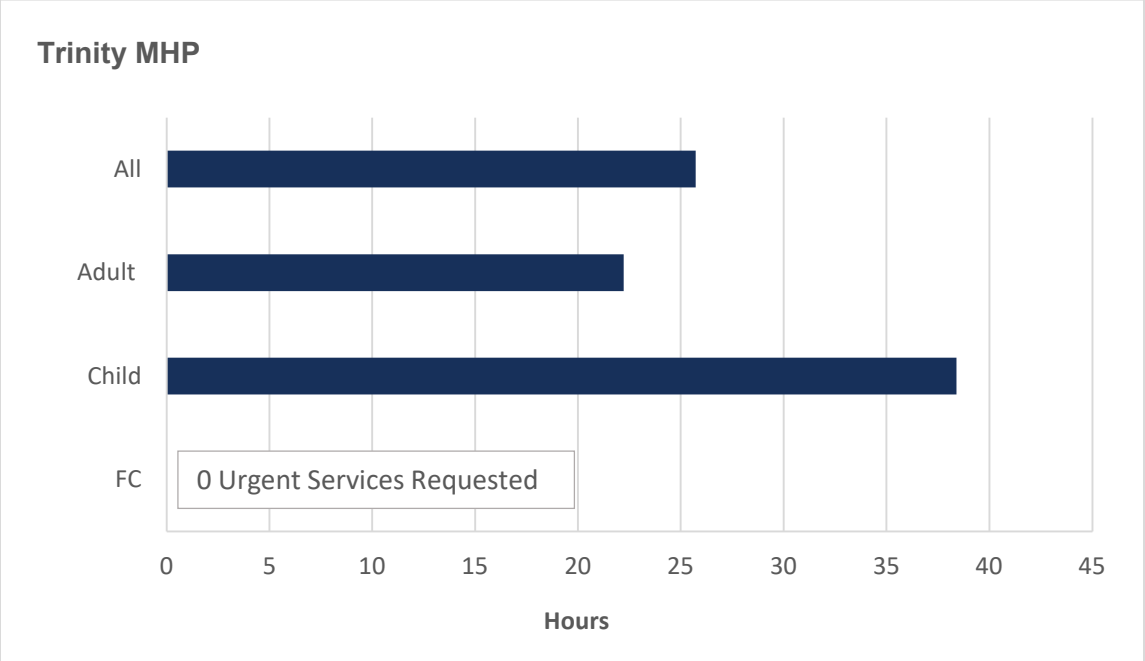
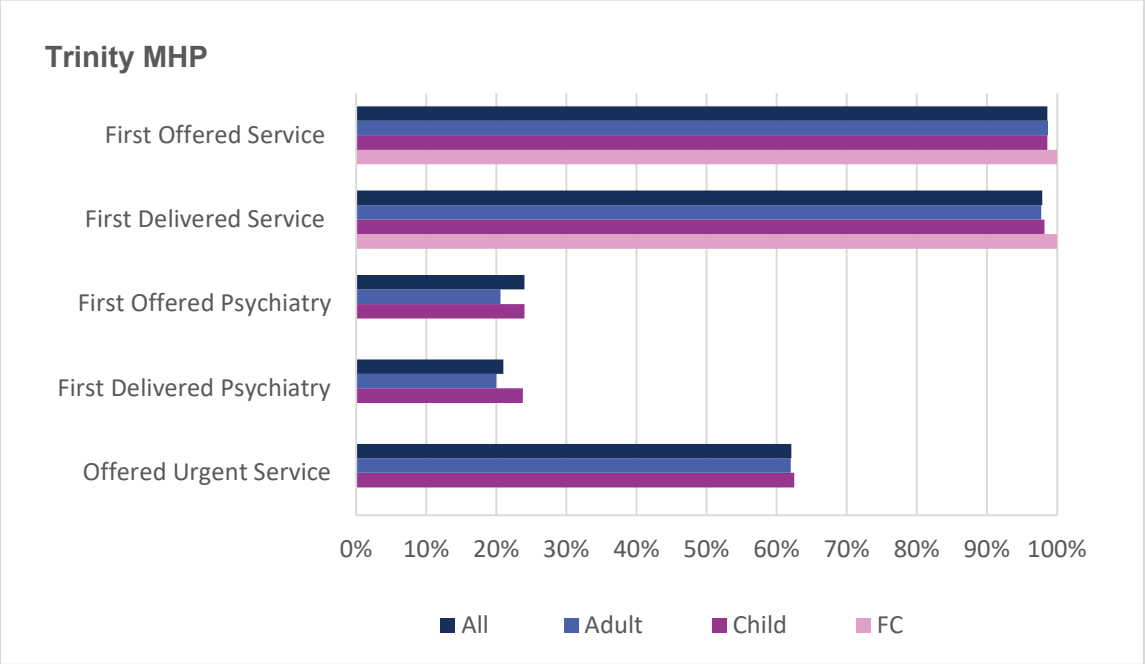


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13 represent scheduled assessments.
- The MHP defined “urgent services” as phone calls identified as urgent. There were reportedly 37 such requests with a reported actual wait time to services for the overall population at 25.73 hours.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 15.2 percent for psychiatrists and 29.4 percent for non-psychiatry staff.
- The non-psychiatry no-show rate for children is significantly higher at 33.2 percent. The MHP did not conduct QI in this area.

IMPACT OF TIMELINESS FINDINGS

- The MHP’s high rate of no-shows to psychiatry appointments may be related to the MHP’s wait times for psychiatry. Evaluating processes, barriers and potential improvements could improve this area.
- The MHP’s high rate of non-psychiatry appointment no-shows, especially in child services, impacts capacity. Analyzing this area for barriers and potential improvements could increase engagement and assist capacity management.

- The MHP's broad definition of urgent services limits its ability to monitor responsiveness to actual urgent needs throughout the course of care. Delineating crisis service from an urgent request that requires a quicker service than routine timeliness standards could help the MHP manage the levels of care more closely.

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 under the QIC team under the Deputy Director Quality Assurance. The MHP monitors its quality processes through the QIC, and the QAPI workplan. The QIC, comprised of MHP clinical and administrative staff is scheduled to meet bimonthly. Since the previous EQR, the MHP QIC met three times. The MHP did not evaluate its workplan goals from the previous year. The instituting of continuous quality improvement is not in place. The MHP reports that it does not understand directing efforts to areas that are believed to be done consistently well. However, systems to monitor that are not established.

The MHP QIC meetings report anomalies or areas where the MHP is not meeting standards. The MHP aims to focus meetings on examining and addressing problems. The MHP does not maintain meeting minutes. Reference and communication sources continue to be unavailable and tracking committee work is not possible.

The MHP utilizes uses no level of care (LOC) tools.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths Assessment (ANSA), Pediatric Symptom Checklist, and Child and Adolescent Needs and Strengths (CANS). The MHP reviews the aggregate reports of the CANS and ANSA to monitor beneficiary progress; the MHP does not use the information for system or program management because they believe the information is subjective and not consistent for evaluation purposes.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Partially Met
3B	Data is Used to Inform Management and Guide Decisions	Partially Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Not Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Partially Met

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

- In the last year, the MHP hired six peer employees. Two peers have completed peer certification and the others are all in the process of completing the program. The MHP does not yet have consumer/family members on the executive team or in supervisory positions. A defined consumer/family member career ladder is also not evident.
- The MHP maintains its medication monitoring policy from 2017 and has a revision from 2022. However, summary or compilation of medication monitoring performance are not evident.
- The MHP does not track or trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures, as required by WIC Section 14717.5
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).

    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- The QIWP included a goal to increase consumer perceptions survey participation by eight percent. Strategies to achieve this and measure progress were not apparent. The MHP reports that the results are not usually useful for QI because results are generally very positive. Comparing results to prior years and use of the results were not evident.
- The MHP offers Milestones, a wellness center, and Respite home which are both peer-run. Milestones is open three days a week and offers limited activities at this time. Utilization has reportedly declined since the center moved out of the downtown in 2019.

QUALITY PERFORMANCE MEASURES

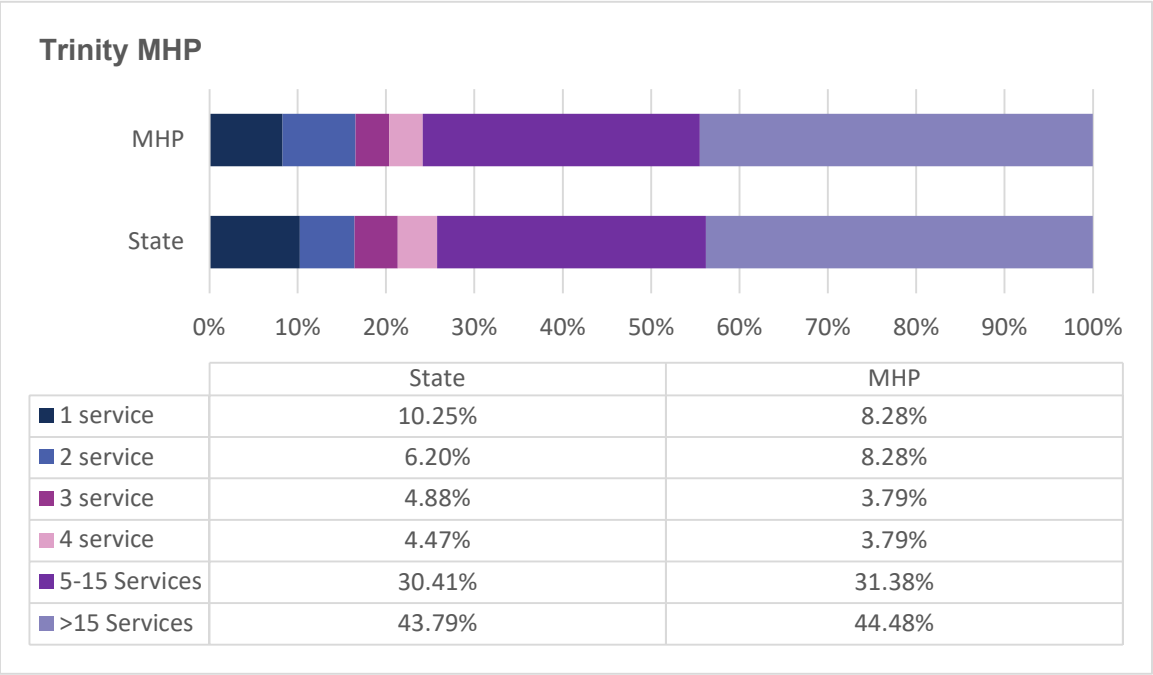
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



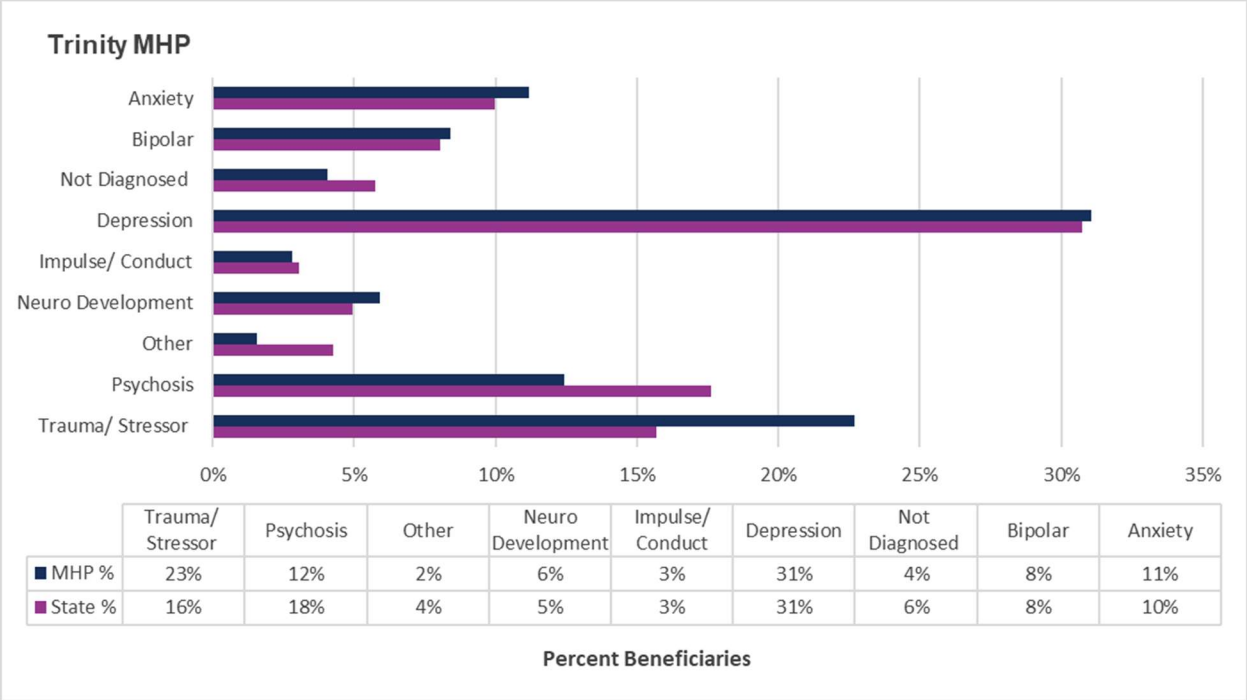
	State	MHP
1 service	10.25%	8.28%
2 service	6.20%	8.28%
3 service	4.88%	3.79%
4 service	4.47%	3.79%
5-15 Services	30.41%	31.38%
>15 Services	43.79%	44.48%

- The MHP's retention patterns are similar to statewide, with a slightly lower rate of one-service only but a slightly higher rate of two services only.

Diagnosis of Beneficiaries Served

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

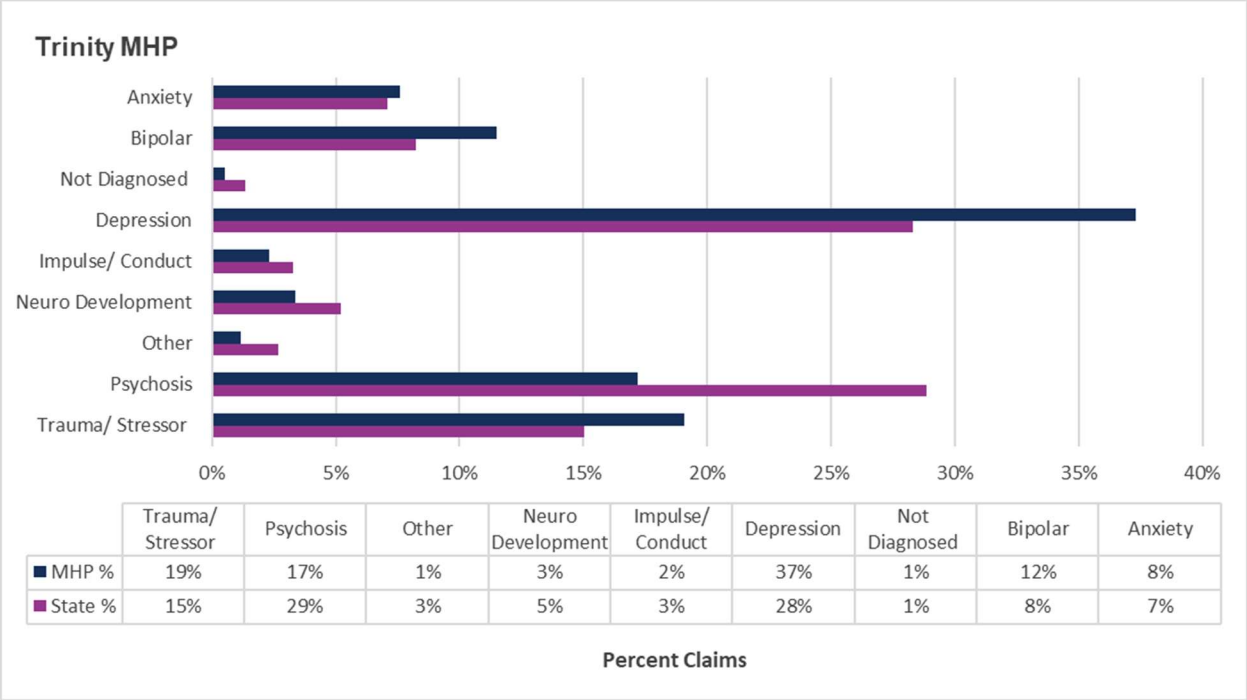
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	23%	12%	2%	6%	3%	31%	4%	8%	11%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The MHP's diagnostic category percentages were similar to statewide percentages in anxiety, bipolar disorder, depression, and neurodevelopment.
- For the diagnostic category Other, the MHP's percentage was half that of the statewide percentage.
- The MHP's percentage for the diagnostic category Psychosis was one-third less than the statewide percentage.
- The MHP's percentage for the diagnostic category Trauma/Stressor was 43.75 percent higher than the statewide percentage. The MHP reports that the community and beneficiaries have been highly impacted by the wildfires in the county over the last several years. This need aligns with the pattern depicted.

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	19%	17%	1%	3%	2%	37%	1%	12%	8%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- Over one-third of the MHP's resources are devoted to treatment of depression.
- Trauma/stressor claims are expected to exceed statewide numbers given their high prevalence in the MHP.
- The MHP's percentage of approved claims for diagnostic categories Impulse/Conduct, Neuro Development, Other are less than the statewide average.
- Similar to the prevalence in the population, approved claims for psychosis are lower than the statewide percentages.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	<11	11	6.50	8.86	-	$12,052	$63,686
CY 2020	<11	<11	7.40	8.68	-	$11,814	$24,980

CY 2019	<11	<11	4.75	7.80	-	$10,535	$13,770

- Few of the MHP's beneficiaries are represented in Medi-Cal hospitalizations, though CY 2021 represented an increase in inpatient utilization.
- The MHP average LOS in CY 2021 was 2.36 days lower than the statewide average LOS.

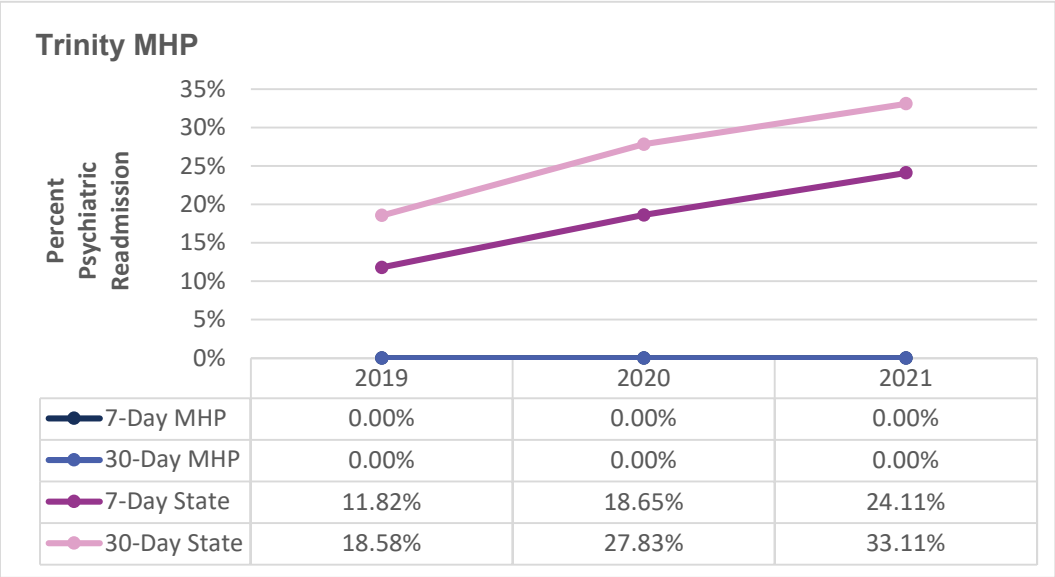
Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post-hospital discharge, as reflected in the CY 2019-21 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

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

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

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



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

- In Figure 18, the MHP's follow-up data is not displayed due to the small number of beneficiaries represented.
- While statewide readmission rates increased for both 7 and 30 days categories, the MHP did not have readmissions within 7 or 30 days.

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 statewide overall AACB is $7,478, the median amount is just $3,269.

Additionally, Table 15 and Figure 20 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, nearly 92 percent of the

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

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	23	7.93%	31.17%	$977,127	$42,484	$40,309
	CY 2020	20	6.56%	28.23%	$937,154	$46,858	$38,008
	CY 2019	<11	-	10.53%	$229,465	-	$36,360

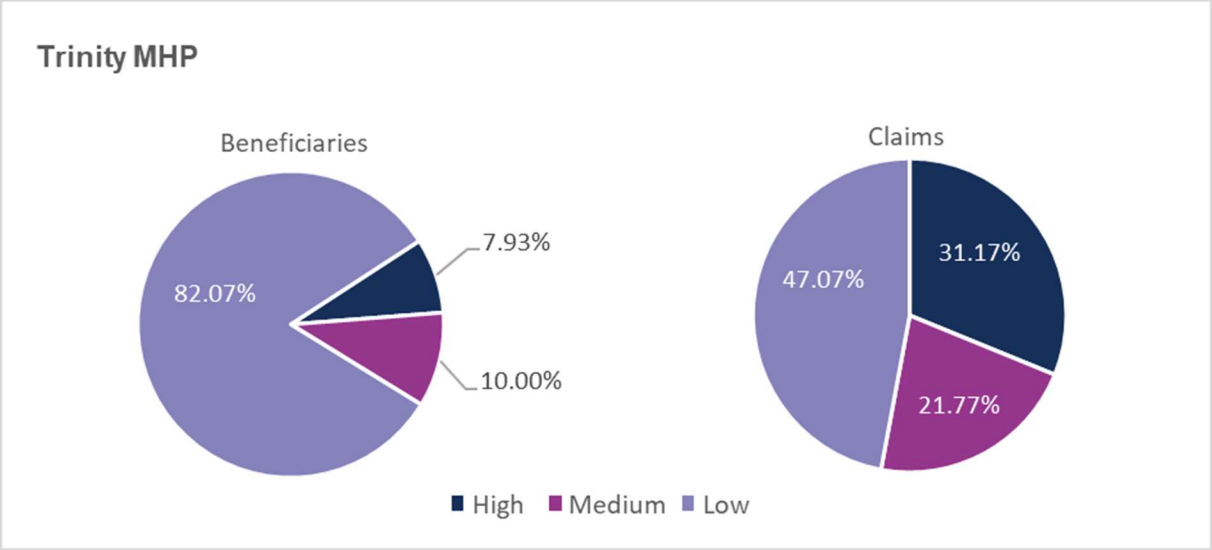
- The number of HCBs increased over the three-year period CY 2019 to CY 2021 from <11 to 23.
- The MHP’s percentage of HCBs increased in CY 2020 and CY 2021 in percentage of beneficiaries served as well as percentage of claims.
- The MHP’s percentage of HCBs served was greater than the statewide percentage in CY 2021.
- The MHP’s HCB percentage of total claims was lower than the statewide.
- The MHP’s average and median approved claims per HCB were lower than the statewide average and median approved claims.

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	AACB by Category	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	29	10.00%	21.77%	$682,352	$23,529	$22,745
Low Cost (Less than $20K)	238	82.07%	47.07%	$1,475,596	$6,200	$4,445

- The majority of the MHP’s beneficiaries (82.07 percent) fall into the low-cost category, representing 47.07 percent of total approved claims.

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



IMPACT OF QUALITY FINDINGS

- The MHP shows a lower rate of inpatient services and readmissions. This may be related to the provision of crisis intervention services and/or the MHP's peer-run respite home, in addition to the follow-up processes. This area is a strength of the MHP and will advance with the MHP's FUM PIP.
- While the MHP increased dashboards to monitor areas, the overall QM structure using baselines, monitoring of indicators and remeasurement for decision making is largely absent. At minimum, evaluating the QIWP would help advance goals and QM organization wide.
- The gradual increase in HCBs over the three-year period warrants analysis for appropriateness of service delivery, especially since the MHP does not have a process for assessing level of care needs.

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: Follow-up After Emergency Department Visit for Mental Illness (FUM)

Date Started: 09/2022

Aim Statement: "For Medi-Cal beneficiaries with ED visits for FUM, implemented interventions will increase the percentage of follow-up FUM services with the MHP for 30 days by 5 percent by December 31, 2023."

Target Population: Beneficiaries with an ED visit with a primary mental health diagnosis.

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

Summary

The MHP elected to participate in the CalAIM BHQIP and received information from DHCS that in 2021 Trinity FUM7 (50 percent) and FUM30 (65 percent) were above state and national benchmarks. In 2022, the MHP FUM7 declined to zero percent

[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

FUM30 to 30 percent. The MHP met with program managers, QI staff, and the Managed Care Plan (MCP) to develop the project. A crucial hindrance to the development is the local/ED hospital staff that reportedly do not collaborate in care for beneficiaries with a MH diagnosis.

Root cause analysis found that the lack of data from the ED and MCP when a beneficiary visits the ED, and an absence of communication between the ED and the MHP for referrals and coordination. The MHP also found that 35 percent of the beneficiaries visited an ED outside of Trinity County, thus making tracking a follow-up difficult. Additionally, 22 percent who utilized an ED no longer lived in Trinity County.

Interventions include developing a relationship with the local ED, developing a relationship with the MCP to gain information about all ED visits for FUM, and tracking ED referrals to schedule and ensure follow-up appointments. The MHP has contracted to establish a Health Information Exchange (HIE) with SacValley Med Share.

The primary outcome is the percentage of beneficiaries with an ED visit for a MH condition and receive a follow-up service within 30 days and number of beneficiaries who receive a follow-up service. EQR recommends including FUM within 7 days in the aim statements and performance indicators.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because the PIP is in the planning phase.

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

- Incorporate FUM7 into the aim statement and performance monitoring.
- Include numerator and denominators for all indicators.
- Specify the target goal further. Clarify if it is a 5 percentage point increase or a 5 percentage rate increase. Ensure the goal is a meaningfully improved outcome.
- Specify the target population. Include whether beneficiaries under 18 will be included.
- As planned, elicit input from beneficiaries and family members. Use input to plan strategies and conduct continuous QI.

NON-CLINICAL PIP

General Information

Status of PIP: The MHP did not submit a non-clinical PIP.

INFORMATION SYSTEMS

Using the Information Systems Capabilities Assessment protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for HIS, as identified in 42 CFR §438.242. This evaluation included a review of the MHP's 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 ASP where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Credible from Qualifacts which has been in use for three months. Currently, the MHP has a new system in place that was installed within the past five years where the MHP must dedicate staff and resources to implement all components of the EHR.

Approximately 8 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control. The percent of the MHP budget dedicated to support IS increased 1.71 percentage points from the previous year.

The MHP has 37 named users with log-on authority to the EHR, including approximately 27 county staff and 10 contractor staff. Support for the users is provided by two MHP staff analysts and by their ASP, Kings View. Currently all positions are filled. The number of MHP analysts increased by one since last year. The MHP acquired another analyst to handle the increase in requirements from CalAIM.

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

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

Table 16: Contract Provider Transmission of Information to MHP EHR

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

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not have a PHR and has no plans currently to implement one.

Interoperability Support

The MHP is a member or participant in the SacValley MedShare HIE. The MHP engages in electronic exchange of information with the following: MH Community Based Organizations (CBO)/Contract Providers, Federally Qualified Health Centers (FQHC), Alcohol and Drug CBO/Contract Providers, Community/Rural Health Center, Hospitals, Primary Care Providers and the Indian Health Center in the county.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Partially Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Partially Met
4E	Security and Controls	Not Met
4F	Interoperability	Met

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

- The MHP has a good level of investment in technology to support their staff and beneficiaries. The percentage of budget for IS increased over the last year because of their move to a new EHR, Credible, in January 2023. The new EHR is expected to comply with CalAIM requirements.
- MHP reports are generated from the production database and not from a data warehouse. Staff report that running reports has no impact on EHR response time. Therefore, the MHP staff feel that they do not need a data warehouse.
- The MHP works closely with their ASP Kings View on Medi-Cal claiming. The data integrity checks as well as the error correction reports alert staff to claiming issues before an 837 is submitted. The effectiveness of their collaboration is seen in the overall denied claims rate of 0.16 percent.
- The MHP's EHR lacks the following functionality: care coordination, laboratory orders and results, referral management, level of care/level of service, referral management, and a personal health record.
- The MHP lacks an Operations Continuity Plan (OCP). While the MHP executive team knows that their ASP Kings View has one and believes that the County IT Department has one, they haven't confirmed that such plans exist and if they do exist, what the details of the plans are and whether they are sufficient.
- The MHP joined SacValley Med Share HIE. Their EHR provider Qualifacts is working with the HIE to enable data exchange by July 2023.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	485	$327,713	$0	0.00%	$319,972
Feb	486	$337,207	$0	0.00%	$331,710
Mar	582	$381,733	$0	0.00%	$370,700
April	577	$396,487	$0	0.00%	$384,621
May	530	$360,727	$0	0.00%	$351,157
June	554	$365,284	$0	0.00%	$351,408
July	465	$201,448	$0	0.00%	$196,077
Aug	438	$164,696	$0	0.00%	$154,317
Sept	460	$180,707	$0	0.00%	$168,944
Oct	478	$174,276	$300	0.17%	$167,654
Nov	397	$159,092	$4,621	2.90%	$149,847
Dec	373	$150,856	$85	0.06%	$147,017
Total	**5,825**	**$3,200,226**	**$5,006**	**0.16%**	**$3,093,424**

- The change seen in the MHP's billed amount starting in July, and continuing through the end of the calendar year, reflects the change in billing rates at the beginning of FY 2021-22. The MHP decided to lower billing rates in that fiscal year to avoid possible issues with cost settlement at the end of that period.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other	5	$790	15.78%
Other healthcare coverage must be billed before submission of claim	4	$4,216	84.22%
Total Denied Claims	**9**	**$5,006**	**100.00%**
Overall Denied Claims Rate	**0.16%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The Kings View ASP works with the MHP to provide data integrity checking and produce error checking reports for claims. Trinity MHP staff review the errors and take appropriate action on services based on their established procedures. Their work has resulted in a very low rate of denied claims.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP's experience with the new EHR implementation in January 2023 was rocky. Administrative staff are more satisfied with Credible than clinical staff. Clinical staff say that Credible is not as user-friendly as they had expected.
- Staff reported that documentation of crisis services is more difficult if the clinician providing services is not a part of the beneficiary's treatment team as defined in Credible. The EHR has a business rule that prevents staff not part of a beneficiary's care team from documenting services for that person. The clinician must then initiate, and follow up as needed, contact with super users or other staff to get the EHR permission to document the services they provided.
- Telehealth has become a standard offering for a number of services Trinity MHP provides. The MHP made telehealth rooms available in several locations within the County for beneficiaries who may not be able to participate in telehealth from home. The size of the county as well as sometime extreme weather conditions make the availability of telehealth an important service for beneficiaries.
- The Executive Team is very involved in the administration of the EHR. All changes to Credible, including regular updates and upgrades, have to be authorized by a member of the Executive Team before being applied. For EHR changes based on directions from DHCS, the MHP reviews BHINs and then discusses them with Kings View to jointly determine what changes, if any, are required.
- Kings View created dashboards for the MHP that the MHP did not find very useful. Kings View is switching from the software Tableau to Yellowfin, which will give them the ability to provide more real-time data. The MHP expects revised dashboards will have more utility. In addition, Kings View provides standard reports and claims data in a shared folder. The MHP finds this data very useful.
- The MHP plans to submit visit details (e.g., date of service, provider, duration of service, procedure code), diagnoses, and medications to the HIE. They expect to receive information about active beneficiaries and eligible beneficiaries who receive mental health services outside of their system will be reported to them. They have not yet set up internal policies and procedures to display and respond to incoming data.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP completed the CPS surveys in November 2022. The MHP did not conduct any analysis of these findings.

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

Consumer Family Member Focus Group One

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

Participants had received services between a few weeks to thirty years. Three participants began services in the last year and received an assessment two to four weeks after their request. Beneficiaries felt assessments were timely. Some participants were waiting post-assessment to be assigned a provider to start outpatient services.

Participants received group treatment including SUD, an arts group, and a men's group. Beneficiaries received reminder calls and transportation assistance such as gas vouchers or rides and had options to attend appointments in-person or by telehealth.

Most did not report physical health discussion as part of their care. For crisis needs, all participants reported they would call crisis service or 911, and some would call their provider. Those who received crisis services including hospitalization felt care was helpful and had communication and coordination from the MHP while in the hospital.

Most knew of the wellness center, however understanding the purpose and offerings were not known across the group.

Recommendations from focus group participants included:

- Resume providing biofeedback groups.
- Increase communication and awareness of available services. Some learned of resources and groups by hearing from others, rather than receiving information from the MHP.
- Improve group facilitation skills to enable all participants to contribute.
- Increase the number of groups offered. Some felt attending only one group a week was not enough.
- Increase the gas voucher amount; one ten-dollar voucher covers one trip a week and participants felt more assistance would help.
- Provide housing assistance including shelters.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

- Beneficiaries generally had high satisfaction with the access experience or services and had a sense of recovery.
- The MHP does not have a reliable source of beneficiary and family member satisfaction information for QM purposes. This gap, in addition to the absence of consumer and family members participating in planning or other areas, is a barrier for QI evaluation, planning, and system improvement.

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. Trinity MHP has established a strong and productive relationship with their ASP, Kings View. (IS)
2. The MHP hired several staff in the last year including an MHSA coordinator, case managers, and front desk staff. (Quality)
3. Despite the absence of a formalized agency partnership with the ED, MHP line staff make efforts to coordinate care with hospital line staff. (Quality)
4. The MHP meets its 10-business day standard to first offered and first delivered service for a high percentage of beneficiaries, indicating effective initial access to care. (Timeliness)
5. The MHP has a presence and partnerships with schools. The MHP demonstrates strong investment in youth psychoeducation and prevention such as Friday Night Live. (Access, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP meets its timeliness standard to first psychiatry appointments for only 21 percent of appointments. This is additionally complicated by a fairly high rate of no-shows to psychiatry appointments. (Timeliness)
2. Community knowledge about the wellness center appears limited and the wellness center is attended by very few beneficiaries. (Access)
3. The QIWP lacks clear baselines and measures. Organization-wide knowledge of QI priorities, goals, and progress are not established and documented. (Quality)
4. Clinical staff who are not a member of the beneficiary's assigned treatment team are not fully aware of how to gain access to the beneficiary's record in the Credible EHR to complete clinical documentation. (Quality, IS)
5. The MHP does not know whether the County IT Department has an OCP but believes that their ASP, Kings View, has one. They do not know the content of existing OCPs that impact them, nor do they know if the plans are workable and sufficient. (IS)

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. Examine barriers to timely initial access to psychiatry appointments, including no-shows to psychiatry appointments. Design and implement improvement strategies with input from line staff and beneficiaries. Measure the effectiveness of changes implemented. (Timeliness, Access)

   (This recommendation is a carry-over from FY 2021-22.)
2. Incorporate baselines and measurements in the QIWP and evaluate progress for priority goals. Modify performance improvement strategies as indicated and share this information across the MHP. (Quality)
3. Complete an evaluation of reasons why the wellness center is not highly utilized. Incorporate input from providers, peer staff, line staff, beneficiaries, and family members to identify and implement strategies for improvement. Consider having a community event or other way to promote the wellness center. (Quality)
4. Provide training to clinical staff so that they are aware of mechanisms to access the clinical record for purposes of crisis intervention for those beneficiaries who are not part of their identified caseload in the Credible EHR. (Quality, IS)
5. Request the OCPs from the County IT Department and Kings View. Review the plans and determine if they are sufficient and suitable for MHP staff and beneficiaries. Create a plan that incorporates existing plans and includes what and how services will be provided in the event of an emergency. Share information with staff and ensure that a subset of staff practice the plan annually. (IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

The MHP did not submit a non-clinical PIP. As part of the EQR process, the MHP Director submitted a letter identifying specific barriers to the MHP's full participation in the review.

Please refer to Attachment E.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

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

CalEQRO Review Sessions – Trinity MHP
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rowena Nery, Lead Quality Reviewer
Lorrie Sheets, Information Systems Reviewer
Mary Ellen Collins, 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

Last Name	First Name	Position	County or Contracted Agency
Cardilino	Torri	Deputy Director Quality Assurance	Trinity County Behavioral Health
Cudziol	James	Clinician II	Trinity County Behavioral Health
Forbes	Tiffany	Staff Analyst	Trinity County Behavioral Health
Hall	Leah	Case Manager	Trinity County Behavioral Health
Hanley	Shawna	Triage Manager	Trinity County Behavioral Health
Klein	Debbie	Deputy Director of Clinical Services	Trinity County Behavioral Health
Lagorio	Kathryn	Clinician I	Trinity County Behavioral Health
Marshall-Winks	Brian	Deputy Director Business Services	Trinity County Behavioral Health
Peterson	Adriane	Case Manager I	Trinity County Behavioral Health
Prunty	Katie	Compliance Officer	Trinity County Behavioral Health
Russak	Benjamin	Case Manager I	Trinity County Behavioral Health
Smith	Connie	Behavioral Health Director	Trinity County Behavioral Health

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 ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP elected to participate in the CalAIM BHQIP FUM.
General PIP Information	
MHP/DMC-ODS Name: Trinity MHP	
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness	
PIP Aim Statement: "For Medi-Cal beneficiaries with ED visits for FUM, implemented interventions will increase the percentage of follow-up FUM services with the MHP for 30 days by 5 percent by December 31, 2023."	
Date Started: 09/2022	
Date Completed: n/a	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): Beneficiaries with an ED visit with a primary mental health diagnosis.	

General PIP Information
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Tracking ED referrals to schedule and ensure follow up appointments.
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): Developing a relationship with the local ED and MCP, tracking ED referrals to schedule and ensure follow-up appointments, and establishing an HIE.

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 beneficiaries who attended follow up appointment within 7 days	CY 2021	50%	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
Percentage of beneficiaries who attended follow up appointment within 30 days	CY 2021	65%	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a

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

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

Incorporate FUM 7 in the aim statement and performance monitoring.

Include numerator and denominators for all indicators.

Specify the target goal further. Clarify if it is 5 percentage points increase or a 5 percentage rate increase. Ensure the goal is a meaningful

PIP Validation Information
improved outcome. Specify the target population. Include whether beneficiaries under 18 will be included. As planned, elicit input from beneficiaries and family members. Use input to plan strategies and conduct continuous QI.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP did not submit a non-clinical PIP.
General PIP Information	
MHP/DMC-ODS Name:	
PIP Title:	
PIP Aim Statement:	
Date Started:	
Date Completed:	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify):	
Improvement Strategies or Interventions (Changes in the PIP)	

General PIP Information
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
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): Click or tap here to enter text.

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 ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information

Was the PIP validated? ☐ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

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

TRINITY COUNTY

Behavioral Health Services

MENTAL HEALTH · SUBSTANCE USE DISORDERS · PREVENTION

June 23, 2023

Samantha Fusselman, LCSW, CPHQ
Executive Director, CalEQRO
Behavioral Health Concepts, Inc.
2340 Powell St. #334
Emeryville, CA 94608

Dear Samantha,

On December 22, 2020 and in response to a surge in COVID-19 cases in the state, the Department of Health Care Services (DHCS) approved a pause on EQRO review activities through March 1, 2021. DHCS further approved flexibilities beyond March 1, 2021, as the COVID pandemic continued to impact county operations.

Accordingly, Trinity County is requesting flexibility during the May 2023 EQRO review.

Specifically, Trinity County is requesting flexibility to not have 2 mental health PIPs in place because of one or more of the following related challenges:

- ☒ Lack of staff/resources
- ☐ Staff have been reassigned to other departments
- ☒ Lack of infrastructure
- ☐ Consumers did not have access to a phone or video
- ☐ Additional factors:_____

Please attach this letter to our FY2022-2023 annual report.

Digitally signed by: Connie Smith
DN: CN = Connie Smith email = tcardilino@trinitycounty-ca.gov C = AD O = TCBHS OU = TCBHS Date: 2023.06.27 14:17:19 -07'00'

Connie Smith
Trinity Behavioral Health Director