Behavioral Health Concepts, Inc.
info@bhceqro.com
www.caleqro.com
855-385-3776

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

LAKE FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

December 14, 2022

TABLE OF CONTENTS

EXECUTIVE SUMMARY 5
MHP INFORMATION 5
SUMMARY OF FINDINGS 5
SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS 6
INTRODUCTION 8
BASIS OF THE EXTERNAL QUALITY REVIEW 8
REVIEW METHODOLOGY 8
HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE 10
MHP CHANGES AND INITIATIVES 11
ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS 11
SIGNIFICANT CHANGES AND INITIATIVES 11
RESPONSE TO FY 2021-22 RECOMMENDATIONS 12
ACCESS TO CARE 15
ACCESSING SERVICES FROM THE MHP 15
NETWORK ADEQUACY 16
ACCESS KEY COMPONENTS 17
ACCESS PERFORMANCE MEASURES 18
IMPACT OF ACCESS FINDINGS 30
TIMELINESS OF CARE 31
TIMELINESS KEY COMPONENTS 31
TIMELINESS PERFORMANCE MEASURES 32
IMPACT OF TIMELINESS FINDINGS 35
QUALITY OF CARE 36
QUALITY IN THE MHP 36
QUALITY KEY COMPONENTS 36
QUALITY PERFORMANCE MEASURES 38
IMPACT OF QUALITY FINDINGS 45
PERFORMANCE IMPROVEMENT PROJECT VALIDATION 46
CLINICAL PIP 46
NON-CLINICAL PIP 48
INFORMATION SYSTEMS 50

INFORMATION SYSTEMS IN THE MHP 50
INFORMATION SYSTEMS KEY COMPONENTS 51
INFORMATION SYSTEMS PERFORMANCE MEASURES 52
IMPACT OF INFORMATION SYSTEMS FINDINGS 54
SVALIDATION OF BENEFICIARY PERCEPTIONS OF CARE 55
CONSUMER PERCEPTION SURVEYS 55
CONSUMER FAMILY MEMBER FOCUS GROUP 55
SUMMARY OF BENEFICIARY FEEDBACK FINDINGS 56
CONCLUSIONS 57
STRENGTHS 57
OPPORTUNITIES FOR IMPROVEMENT 57
RECOMMENDATIONS 58
EXTERNAL QUALITY REVIEW BARRIERS 59
ATTACHMENTS 60
ATTACHMENT A: REVIEW AGENDA 61
ATTACHMENT B: REVIEW PARTICIPANTS 62
ATTACHMENT C: PIP VALIDATION TOOL SUMMARY 65
ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE 72
ATTACHMENT E: LETTER FROM MHP DIRECTOR 73

LIST OF FIGURES

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021 21
Figure 2: MHP PR by Race/Ethnicity CY 2019-21 22
Figure 3: MHP AACB by Race/Ethnicity CY 2019-21 23
Figure 4: Overall PR CY 2019-21 23
Figure 5: Overall AACB CY 2019-21 24
Figure 6: Hispanic/Latino PR CY 2019-21 24
Figure 7: Hispanic/Latino AACB CY 2019-21 25
Figure 8: Asian/Pacific Islander PR CY 2019-21 25
Figure 9: Asian/Pacific Islander AACB CY 2019-21 26
Figure 10: Foster Care PR CY 2019-21 26
Figure 11: Foster Care AACB CY 2019-21 27
Figure 12: Wait Times to First Service and First Psychiatry Service 33
Figure 13: Wait Times for Urgent Services 34
Figure 14: Percent of Services that Met Timeliness Standards 34
Figure 15: Retention of Beneficiaries CY 2021 39

Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021 40
Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021 41
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21 42
Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21 43
Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021 45

LIST OF TABLES

Table A: Summary of Response to Recommendations 5
Table B: Summary of Key Components 5
Table C: Summary of PIP Submissions 6
Table D: Summary of Consumer/Family Focus Groups 6
Table 1A: MHP Alternative Access Standards, FY 2021-22 16
Table 1B: MHP Out-of-Network Access, FY 2021-22 16
Table 2: Access Key Components 17
Table 3: MHP Annual Beneficiaries Served and Total Approved Claim 18
Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021 19
Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021 19
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021 20
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021 20
Table 9: Services Delivered by the MHP to Youth in Foster Care 29
Table 10: Timeliness Key Components 31
Table 11: FY 2021-22 MHP Assessment of Timely Access 33
Table 12: Quality Key Components 37
Table 13: Psychiatric Inpatient Utilization CY 2019-21 41
Table 14: HCB (Greater than $30,000) CY 2019-21 44
Table 15: Medium- and Low-Cost Beneficiaries CY 2021 44
Table 16: Contract Provider Transmission of Information to MHP EHR 51
Table 17: IS Infrastructure Key Components 52
Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims 53
Table 19: Summary of Denied Claims by Reason Code CY 2021 53
Table A1: CalEQRO Review Agenda 61
Table B1: Participants Representing the MHP and its Partners 63
Table C1: Overall Validation and Reporting of Clinical PIP Results 65
Table C2: Overall Validation and Reporting of Non-Clinical PIP Results 69

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

MHP INFORMATION

Review Type — Virtual

Date of Review — December 14, 2022

MHP Size — Small

MHP Region — Superior

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	3	2	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	1	5	0
Quality of Care	10	8	0	2
Information Systems (IS)	6	3	3	0
TOTAL	**26**	**16**	**8**	**2**

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
Increasing Attendance Rates for Psychiatry Services	Non-Clinical	07/2022	Implementation	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other	5
* If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP provides significant outreach to Native American and Lesbian, Gay, Bisexual, Transgender, Queer, or Questioning (LGBTQ) communities through culturally appropriate outreach activities and collaboration with community groups.
- The MHP recently acquired a Street Outreach Van which offers telehealth services providing access to both mental health and substance use issues.
- The county responds to urgent service needs in a very timely manner, significantly faster than the 48-hour DHCS standard.
- Despite leadership turnover and staffing issues, the MHP has conducted two PIPs, one of which is a Behavioral Health Quality Improvement Program (BHQIP) PIP.
- The MHP is proactively implementing peer certification for peer staff.

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

- While 82.39 percent of non-urgent requests for service resulted in an offered appointment within 10 days, only 1.05 percent resulted in a delivered service during that time frame. Further, the rate of adults who receive crisis intervention services (27.0 percent) is more than twice the statewide average (11.1 percent).

- Key informants report that information on available transportation resources is not routinely given to beneficiaries.
- The MHP tracks data for only county-operated services, which fails to provide the MHP with a full understanding of access to care.
- The MHP neither measures clinical and/or functional outcomes of beneficiaries served, nor shows any ways they utilize information from the Beneficiary Satisfaction Survey.
- The MHP did not have a plan for providing training for implementation of the new Electronic Health Record (EHR).
- The MHP has an aging EHR and not all historical beneficiary data will be converted to the new SmartCare™ system.

Recommendations for improvement based upon this review include:

- Explore reasons why 82.39 percent of non-urgent requests for service resulted in an offered appointment within 10 days, yet only 1.05 percent resulted in a delivered service during that time frame, while the rate of adults who receive crisis intervention is more than twice the state average. Create and implement a process to correct this timeliness to services issue and decrease the need for crisis intervention.
- Research issues, create, and implement a plan to ensure that beneficiaries are aware of all transportation resources available to them at the time of engagement in services.
- As the new SmartCare EHR is implemented, ensure that all timeliness data can be tracked and reported for the entire system of care in order to have an accurate picture of timeliness functions.
- Create a system, memorialized in the Quality Work Plan, to measure clinical and/or functional outcomes of beneficiaries served. This should include analysis of results from the Beneficiary Satisfaction Survey to create dialog for possible areas for quality improvement.
- Develop and implement a SmartCare EHR training plan that will include some level of MHP-focused training that meets the MHP's needs.
- Develop and implement a plan to provide user access to historical beneficiary data that is not converted to the new SmartCare EHR.

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 Lake County MHP by BHC, conducted as a virtual review on December 14, 2022.

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 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.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS 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.
- Review and validation of each MHP's network adequacy (NA) as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment 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.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP continues to operate without sufficient staffing. While services are increasingly being delivered in-person, telehealth is still a valuable tool for the MHP. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

- The MHP has experienced significant management changes this past year. The Clinical Deputy Director, several Behavioral Health Program Managers, and a Supervising Clinical Specialist have been promoted into their roles since May 2022. There have also been 30 new hires throughout the Behavioral Health department in calendar year 2022.
- The MHP plans to implement the California Mental Health Services Authority (CalMHSA) SmartCare EHR Solution for Multi-County Behavioral Health Initiative in California. They are one of the pilot counties, scheduled to begin using the EHR across the MHP in February 2023.
- The MHP is proactively implementing peer certification. They currently have peer employees working at the five peer support centers in the county.
- The MHP is the lead administrator for the Lake County Continuum of Care (LCCOC) program, a consortium focused on reducing homelessness in the county. They are responsible for all requests for proposal and contracting towards building 40 new housing units.

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: Evaluate obstacles and implement strategies to decrease the children's triage list and wait time to first rendered clinical service.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- In FY 2022-23 Lake County Behavioral Health Services (LCBHS) initiated a contract with Redwood Community Services (RCS) for an expansion of children's SMHS from $900,000 to $1.5 million dollars to reduce the triage list of those waiting to be screened and help bolster the supports needed for an expected expansion of Medi-Cal eligible population of children.
- The county's ATA reports that 90 percent of county-operated first-offered appointments for children's services met the DHCS ten business day standard; however, none of the first rendered services were delivered within ten business days. Service access data through RCS was not included in the ATA report submitted.
- The MHP needs to continue to work to deliver first rendered services within ten business days, per standard, to increase this recommendation to addressed.

Recommendation 2: Implement and maintain two active and ongoing PIPs, one clinical and one non-clinical.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Although the MHP has proactively engaged in ongoing support from BHC in the form of TA for PIPs, the MHP had struggled for multiple years with developing and implementing PIPs. Showing improvement, they were successful in implementing non-clinical PIPs in the last two years.
- The MHP, utilizing assistance from CalMHSA, is implementing a BHQIP PIP as a clinical PIP. The PIP is entitled "Follow-Up After Emergency Department Visit for Mental Illness (FUM)." This PIP is in the planning phase and this recommendation will be considered addressed since the MHP will be applying interventions this year.

Recommendation 3: Evaluate existing QI staff resources and implement strategies to initiate and complete ongoing QI projects.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Changes made to improve the QI programs included:
  - Promoted a new QI Coordinator/SR Analyst.
  - Assigned Quality Improvement Committee (QIC) meeting responsibility to an individual to ensure consistency and reliability of meetings.
  - Carved out the Compliance Committee from QIC, affording each program its own committee with separate committee chairs, goals, and tasks.
- The MHP also plans to utilize the new semi-statewide EHR to generate reports and analyze data in new and essential ways to evaluate QI.

Recommendation 4: Investigate concerns regarding staff morale, health and wellness, job security and satisfaction, connectedness, confidence and contribution, inspiration, and transformation. Seek and incorporate staff input, explore underlying causes, and implement strategies to promote staff retention. Broadly share results and plans to address findings.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP focused on multiple efforts to improve staff morale. Amidst a nationwide staffing shortage and a workforce with new perspectives on job expectations and satisfaction, the MHP:

- Implemented a Stipend/Loan Repayment/Scholarship program for hard-to-fill county positions.
- Filled 30 vacancies in the last year.
- Conducted more frequent all-staff and leadership meetings.
- Negotiated a three-year contract which includes annual raises.
- Provided more flexible remote work schedules.

- Key informants report that there remains a lot of stress working in the MHP's clinical environment, mostly relating to staff turnover, caseloads, and productivity standards.
- As the MHP is continuing in this effort and moving towards addressing these issues, this recommendation will not be carried forward this year.

Recommendation 5: Investigate best practices and implement a medication monitoring system that includes the monitoring of Healthcare Effectiveness Data and Information Set (HEDIS) measures outlined in SB 1291.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has a team in place to coordinate psychiatric medication management services.
- In partnership with Kingsview, the MHP purchased a medication monitoring dashboard which allows them to track and monitor medication services for SB 1291.
- The MHP strengthened the Medication Monitoring Committee in FY 2020/21 and 2021/22 by assigning a Chair and adding the attendance of the Medical Director and medication providers.
- In FY 2022/23 the MHP plans to incorporate the recently published Medication Monitoring Dashboard) into the monitoring meeting materials to analyze and improve medication services for patients.

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 67 percent of services were delivered by county-operated/staffed clinics and sites, and 33 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 72 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff Monday through Friday 8 a.m. to 5 p.m. After hours requests are answered by a contract provider. The Access Line responds to both routine and crisis calls and meets beneficiary language needs. Beneficiaries may request services through the Access Line as well as through the following system entry points: crisis services, clinic walk-ins, law enforcement, Substance Use Disorder and Mental Health community agencies, probation/parole, Federally Qualified Health Centers, Child Welfare Services, homeless shelters, and hospitals. The MHP follows a continuum of care treatment model, i.e., no wrong door, and coordinates care with partnering agencies to access services the MHP does not provide. If the beneficiary does not qualify for services, the MHP provides referrals and links the beneficiary to their Medi-Cal managed care plan. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, necessary services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 1,003 adult beneficiaries, 411 youth beneficiaries, and 122 older adult beneficiaries across 2 county-operated sites and 49

[1] CMS Data Navigator Glossary of Terms

contractor-operated sites. The MHP did not provide the number of beneficiaries who received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

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

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

For Lake County, the time and distance requirements are 45 miles and 75 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

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	
OON Access for Beneficiaries		
The MHP ensures OON access for beneficiaries in the following manner:	☒ The MHP has existing contracts with OON providers. ☐ Other: Click or tap here to enter text.	

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP has a strong emphasis on reducing homelessness which serves to improve access to care. It serves as the administrator in the LCCOC and provides a wide range of social services to the unhoused through their network of five peer support centers.
- The MHP provides significant outreach to Native Americans through the Circle of Native Minds Peer Support Center and to LGBTQ communities through dedicated outreach staff and LGBTQ trainings at a Peer Center.
- The MHP has been increasing capacity by expanding contracted services. The RCS contract increased 67 percent from $900,000 to $1,500 million. Psychiatry contracts have also increased this past year.
- The MHP reports having a new outreach van which offers telehealth services for both mental health and substance use treatment.
- Stakeholders report that they do not receive information on transportation resources available to them.

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 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, with a 3.20 percent PR, continues to provide access at a lower rate than the state as a whole. The MHP's PR went down in CY 2021 similar to the statewide trend. This may be partly ascribed to a CY 2021 claims lag in the data that CalEQRO received.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	35,095	1,124	3.20%	$6,028,633	$5,364
CY 2020	32,934	1,194	3.63%	$6,249,539	$5,234
CY 2019	32,856	1,183	3.60%	$5,939,531	$5,021

- The MHP has experienced a 6.6 percent increase in Medi-Cal eligibles and a 6.1 percent decrease in beneficiaries served which resulted in a decreased PR. Staff turnover could attribute to the decrease in PR from 2020 to 2021.
- Despite the decline in PR, the AACB has increased every year between 2019 and 2021.

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

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	3,588	25	0.70%	1.03%	1.59%
Ages 6-17	7,598	335	4.41%	5.00%	5.20%
Ages 18-20	1,541	82	5.32%	4.29%	4.02%
Ages 21-64	18,872	626	3.32%	4.15%	4.07%
Ages 65+	3,498	56	1.60%	2.09%	1.77%
TOTAL	**35,095**	**1,124**	**3.20%**	**3.83%**	**3.85%**

- The MHP has a higher penetration rate for youth compared to adults and older adults, as is the pattern statewide. However, the MHP's adult PR is 18 percent below the statewide average.
- All of the MHP's PR by age are lower than other small counties with the exception of the 18-20 year-olds. The county's Early Intervention Services Team, which provides services to Transitional Age Youth who are exhibiting signs and symptoms of early psychosis, might account for the higher engagement of the 18-20 year-olds.
- Though lower than the state and small MHPs, the county's recent contract expansion with RCS could be a factor in its higher youth PR. Stronger engagement may be associated with the implementation of group therapy in their youth programs.

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	Percent of Beneficiaries Served
Spanish	35	3.14%
Threshold language source: Open Data per BHIN 20-070		

- One of the Spanish speaking clinicians resigned this past year, making it more difficult to provide services in Spanish.
- Key informants indicated the language line is used but is difficult to navigate.
- Other employees reported that they provide translation services in clinical sessions when a Spanish speaking clinician is not available.

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

Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	9,970	245	2.46%	$1,384,219	$5,650
Small	199,673	6,647	3.33%	$36,223,622	$5,450
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligibles that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- In Lake County, the ACA PR is lower than the county 3.20 PR, though the ACA AACB is higher than the $5,364 county average, suggesting that this population may receive slightly more services or more costly services than the non-ACA population.

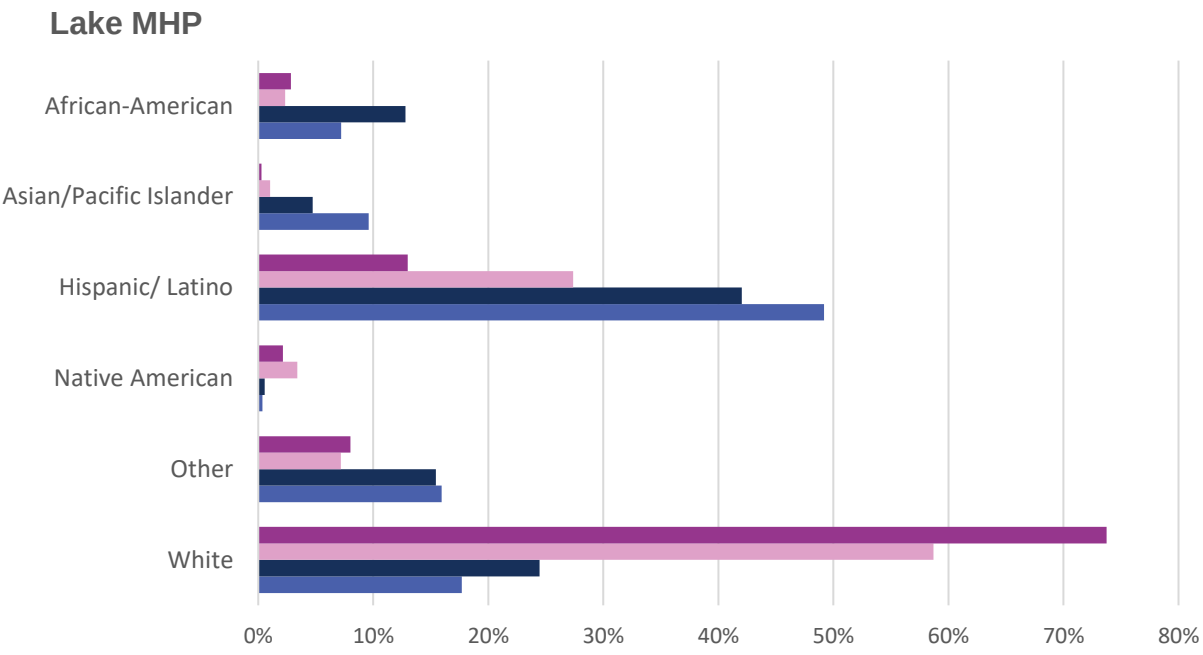
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions 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	# MHP Eligibles	# MHP Served	MHP PR	Statewide PR
African-American	816	32	3.92%	6.83%
Asian/Pacific Islander	361	<11	-	1.90%
Hispanic/Latino	9,608	146	1.52%	3.29%
Native American	1,189	-	-	5.58%
Other	2,521	90	3.57%	3.72%
White	20,603	829	4.02%	5.32%
Total	**35,098**	**1,124**	**3.20%**	**3.85%**

- The Hispanic/Latino population is the second largest Medi-Cal ethnicity in Lake County and the PR at 1.52 percent is less than half the county average as well as the statewide average for that population.

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

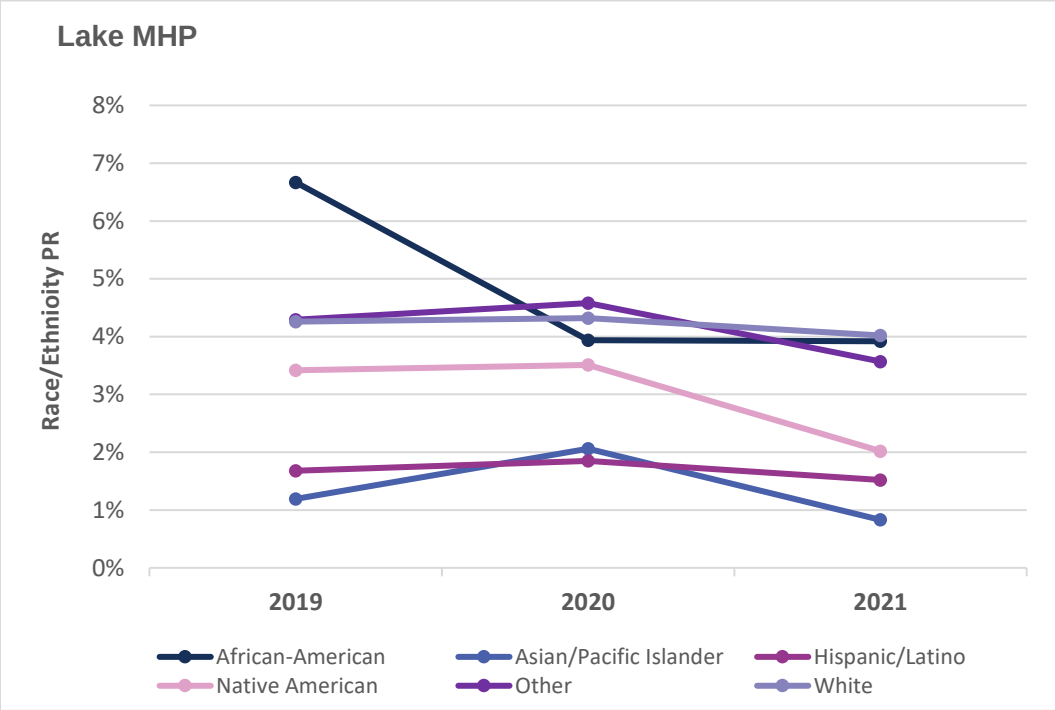


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	74%	8%	2%	13%	0%	3%
MHP % Eligibles	59%	7%	3%	27%	1%	2%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- Lake County has a higher White and lower Hispanic/Latino population than the state as a whole.

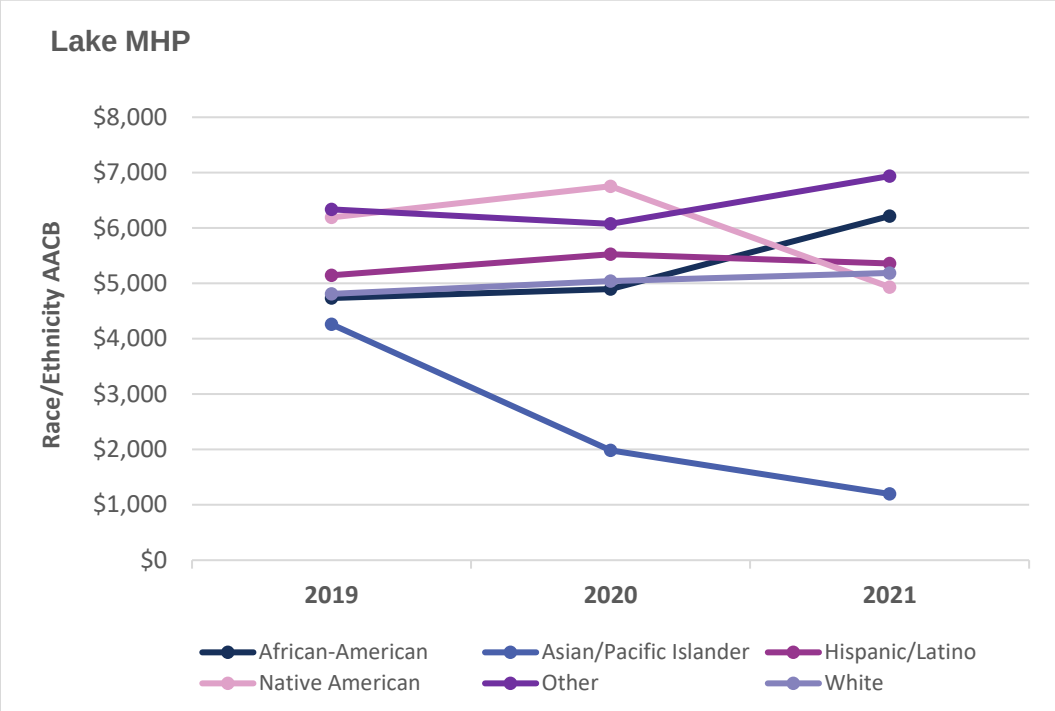
Figures 2-11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



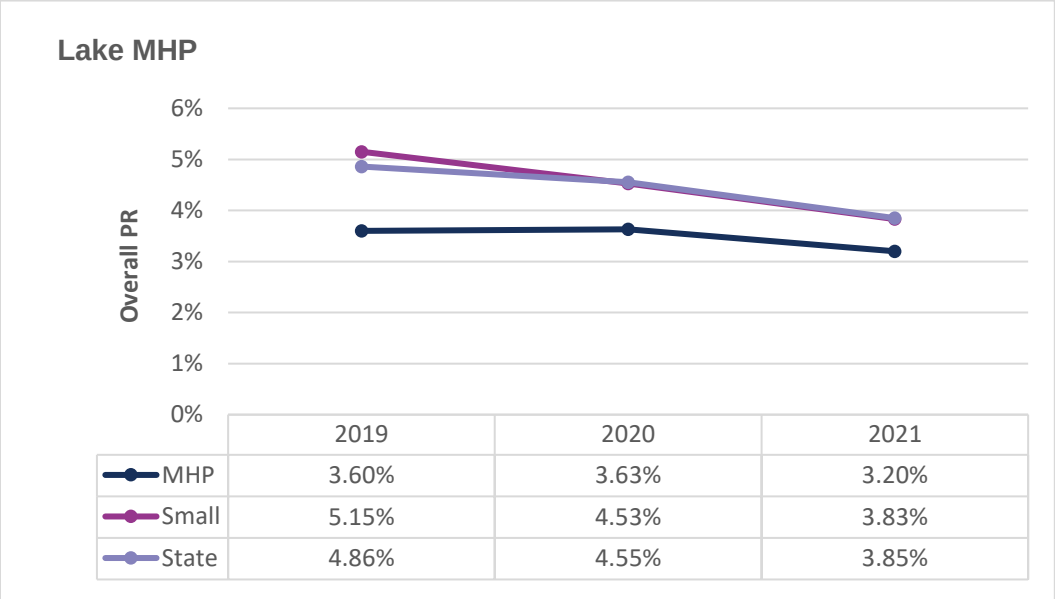
- The PR for the largest Medi-Cal populations in the county, White and Hispanic/Latino, have remained fairly constant between CY 2019 to 2021.
- As a small county, relatively small numbers served can result in comparatively large fluctuations year to year.

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



- Beneficiaries categorized as "Other" had the highest AACB.

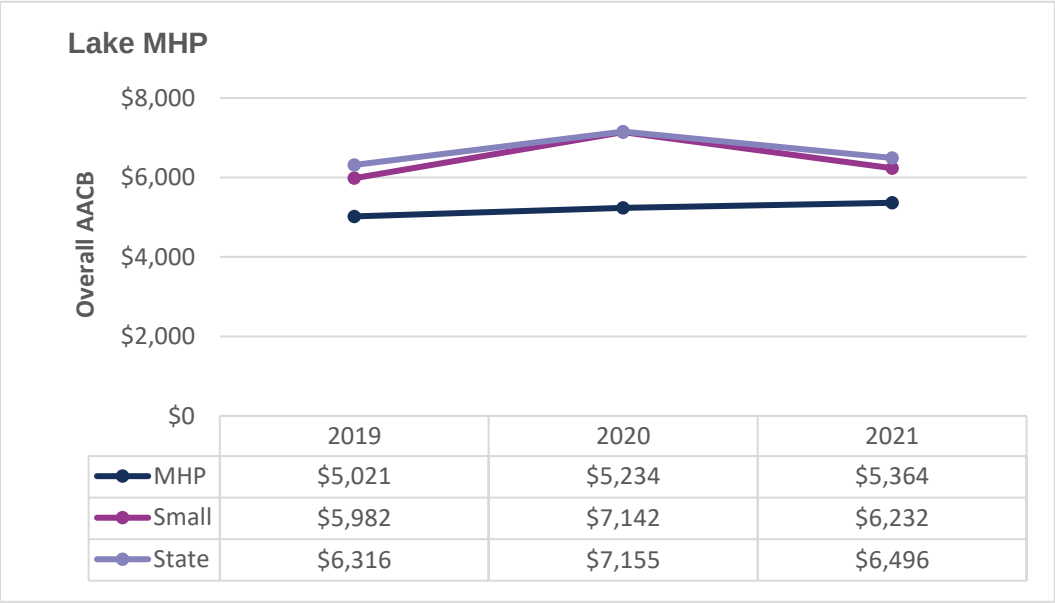
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	3.60%	3.63%	3.20%
Small	5.15%	4.53%	3.83%
State	4.86%	4.55%	3.85%

- The MHP's PR has remained consistently lower than the state and other small counties.

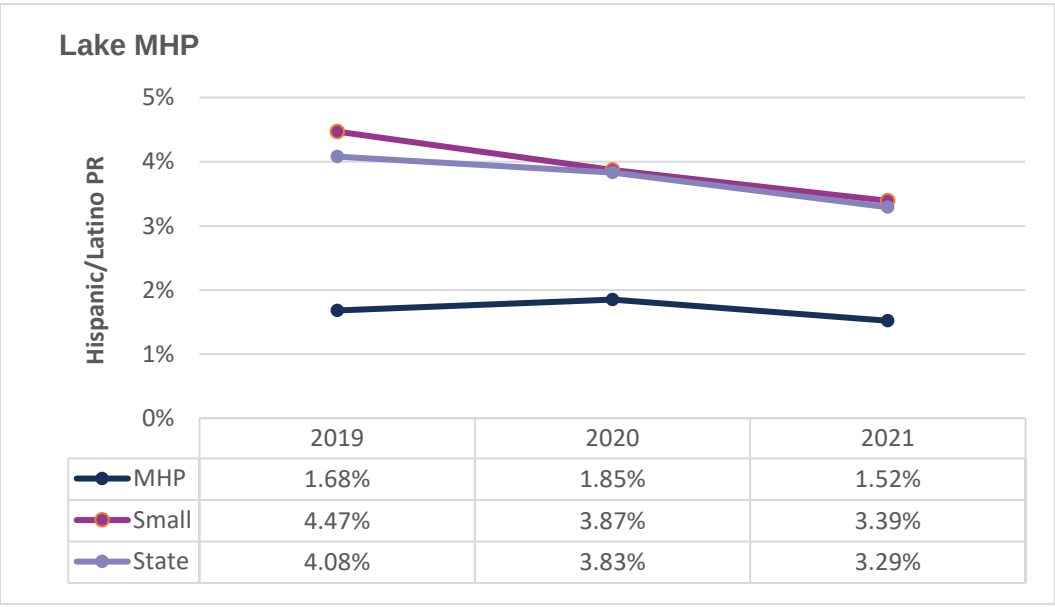
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$5,021	$5,234	$5,364
Small	$5,982	$7,142	$6,232
State	$6,316	$7,155	$6,496

- The MHP's AACB has remained consistently lower than the state and other small counties. However, while the state and small county AACB went down in 2021, the MHP's AACB increased between 2020 and 2021.

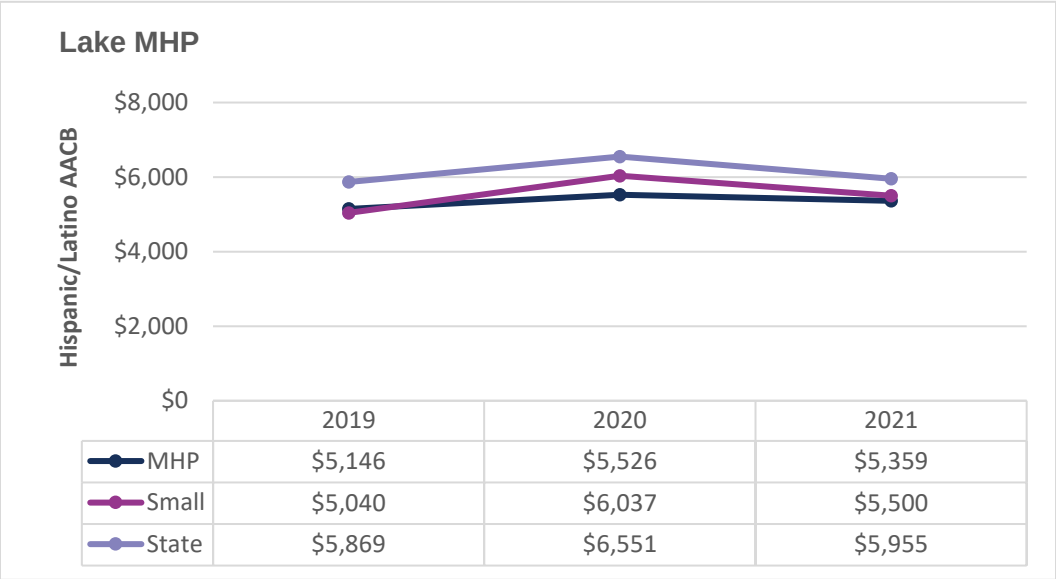
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	1.68%	1.85%	1.52%
Small	4.47%	3.87%	3.39%
State	4.08%	3.83%	3.29%

- The Hispanic/Latino PR remains consistently lower than the state average.

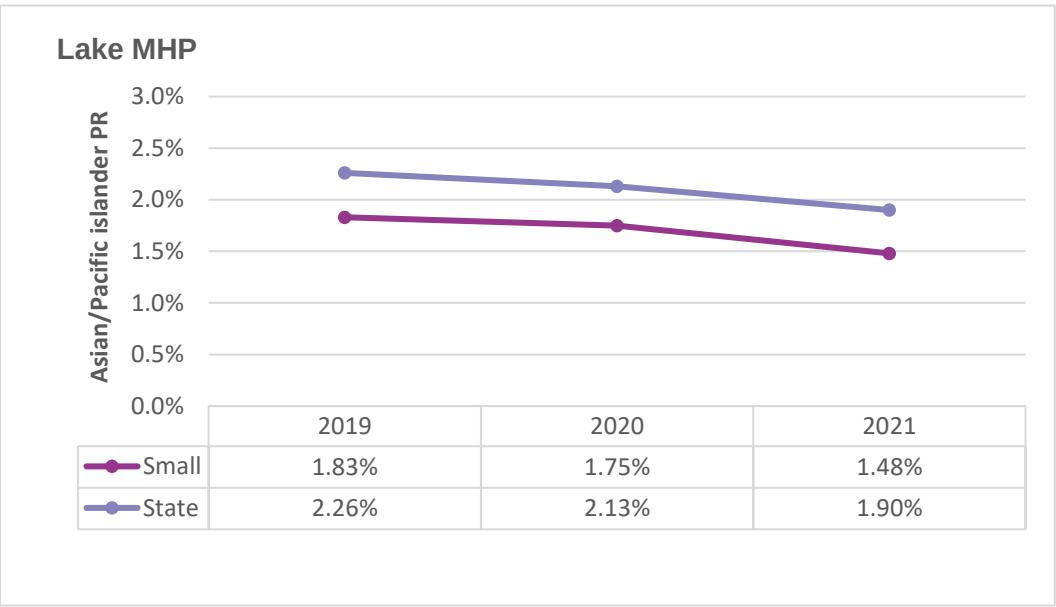
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$5,146	$5,526	$5,359
Small	$5,040	$6,037	$5,500
State	$5,869	$6,551	$5,955

- The Hispanic/Latino AACB is consistently close to other small counties.

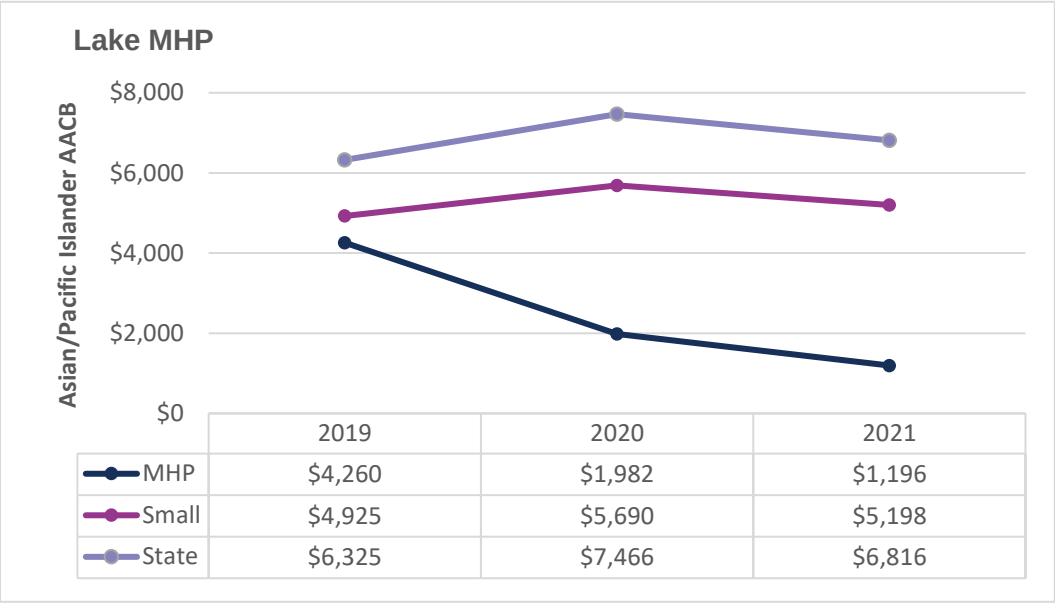
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
Small	1.83%	1.75%	1.48%
State	2.26%	2.13%	1.90%

- The Asian/Pacific Islander PR is below small MHPs and the state for the three comparison years. However, the MHP's data is not displayed as the number served is less than 11 beneficiaries.

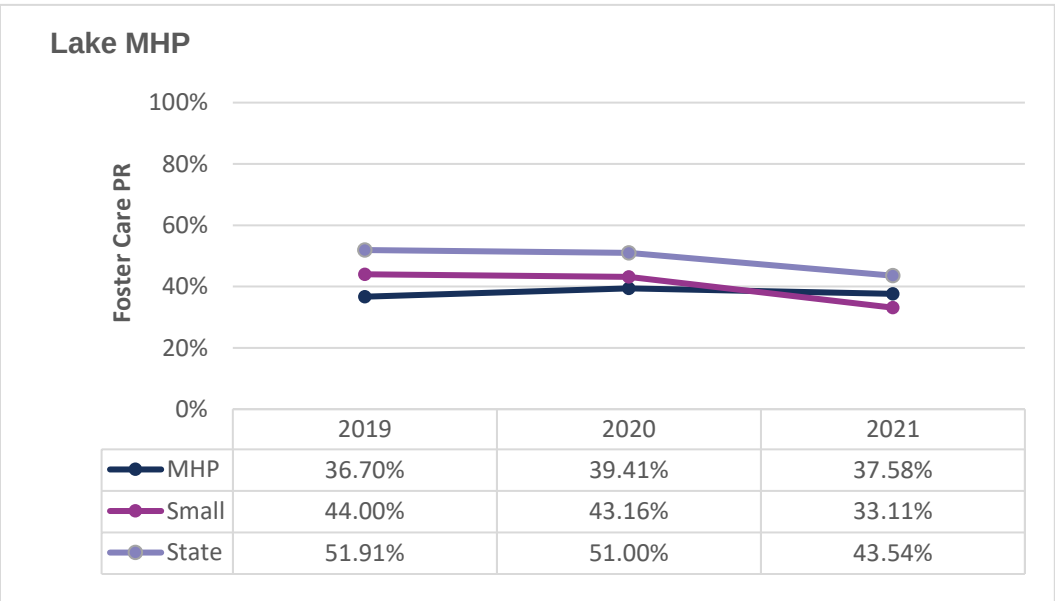
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$4,260	$1,982	$1,196
Small	$4,925	$5,690	$5,198
State	$6,325	$7,466	$6,816

- The Asian/Pacific Islander AACB is noticeably lower than the state or other small county data, but the number of beneficiaries served is very low. This can result in significant fluctuations when calculating averages from year to year.

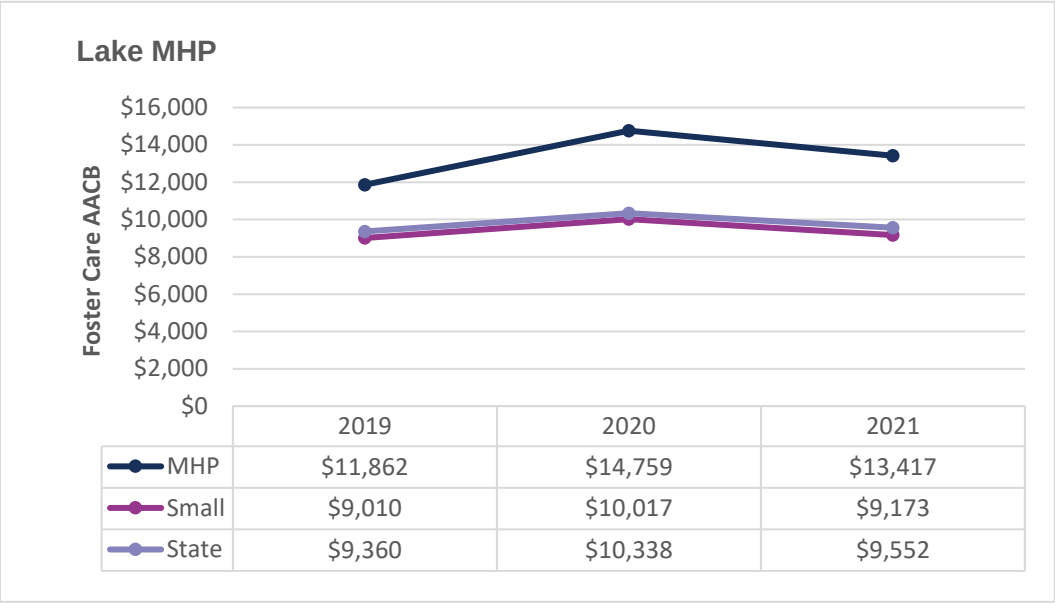
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	36.70%	39.41%	37.58%
Small	44.00%	43.16%	33.11%
State	51.91%	51.00%	43.54%

- While other small county FC PRs went down significantly between 2020 and 2021, the MHP's FC PR only dipped a small amount in those years. Lake County's FC PR was higher than other small counties in 2021.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$11,862	$14,759	$13,417
Small	$9,010	$10,017	$9,173
State	$9,360	$10,338	$9,552

- The MHP's FC AACB has been consistently higher than the state and small county average between 2019 and 2021. Shown later in Table 9, the MHP provides more units of mental health services to FC youth than statewide.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 764				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	85	11.1%	12	8	10.8%	14	8
Inpatient Admin	0	0.0%	0	0	0.4%	16	7
Psychiatric Health Facility	22	2.9%	23	15	1.0%	16	8
Residential	0	0.0%	0	0	0.3%	93	73
Crisis Residential	<11	-	-	-	1.9%	20	14
Per Minute Services							
Crisis Stabilization	15	2.0%	1,656	1,200	9.7%	1,463	1,200
Crisis Intervention	206	27.0%	250	193	11.1%	240	150
Medication Support	280	36.6%	238	132	60.4%	255	165
Mental Health Services	460	60.2%	377	198	62.9%	763	334
Targeted Case Management	302	39.5%	630	141	35.7%	377	128

- The county has a low percentage of adult beneficiaries receiving medication support (36.6 percent) compared to the statewide average (60.4 percent). This is particularly noteworthy given the high rate of unplanned services and that some beneficiaries reportedly only receive medication services.
- Over one in four (27 percent) adult beneficiaries received crisis intervention services in Lake County, more than twice the statewide average (11.1 percent).

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

Service Category	MHP N = 56				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	-	-	4.5%	13	8
Inpatient Admin	0	0.0%	0	0	≤11	6	4
Psychiatric Health Facility	<11	-	-	-	0.2%	25	9
Residential	0	0.0%	0	0	≤11	140	140
Crisis Residential	<11	-	-	-	0.1%	16	12
Full Day Intensive	0	0.0%	0	0	0.2%	452	360
Full Day Rehab	0	0.0%	0	0	0.4%	451	540
Per Minute Services							
Crisis Stabilization	<11	-	-	-	2.3%	1,354	1,200
Crisis Intervention	<11	-	-	-	6.7%	388	195
Medication Support	20	35.7%	302	252	28.5%	338	232
Therapeutic Behavioral Services	0	0.0%	0	0	3.8%	3,648	2,095
Therapeutic FC	<11	-	-	-	0.1%	1,056	585
Intensive Home Based Services	24	42.9%	713	235	38.6%	1,193	445
Intensive Care Coordination	<11	-	-	-	19.9%	1,996	1,146
Katie-A-Like	0	0.0%	0	0	0.2%	837	435
Mental Health Services	53	94.6%	1,843	1,099	95.7%	1,583	987
Targeted Case Management	22	39.3%	437	162	32.7%	308	114

- In Lake County, 35.7 percent of FC beneficiaries receive medication support compared to 28.5 percent statewide.
- The MHP provides IHBS at a rate slightly higher than the state, but at fewer units of service per FC youth served.
- The MHP provides more units of MHS and TCM than the statewide average.

IMPACT OF ACCESS FINDINGS

- The rate of adult beneficiaries who received a crisis intervention service (27 percent) is roughly two and a half times greater than the statewide average (11.1 percent), which is over one in four adults receiving this unplanned service. While some of these services are delivered through a joint community response with law enforcement to people experiencing a mental health crisis in the community, other factors may be involved. Investigation of the high utilization of crisis intervention services relative to planned outpatient services is warranted, as is the implementation of solutions to address the findings.
- Hispanic/Latinos make up the second largest Medi-Cal ethnicity in Lake County, yet their PR is less than half of the county average. The MHP is encouraged to analyze the disparity and design and implement strategies to ensure that the needs of the Hispanic/Latino community are met.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Partially Met
2E	Psychiatric Readmission Rates	Partially Met
2F	No-Shows/Cancellations	Partially Met

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

- The county responds to urgent service needs in a very timely manner; significantly faster than the 48-hour DHCS standard.

- The county reported relatively high percentages of first offered non-psychiatric and psychiatric appointments meeting the DHCS 10-day and 15-day standards. They then reported very low, 0 to 1.05, percentages of first delivered services.
- Key informants indicated that it took longer to get into psychiatry then the first offered data indicated. They reported that it could take a month for children to get an appointment and longer than that for adults. Some beneficiaries reported that they will go to their primary care physician rather than waiting for a psychiatrist.
- The MHP defines “urgent” as “crisis” in request for services.
- The MHP reported timeliness data for only county-operated services and did not include the contractor-operated services which would provide an entire service delivery picture.
- The MHP did not provide data for FC services for urgent appointments or follow-up after psychiatric hospitalization separate from children’s services in general.
- The MHP reports a 7-day readmission rate at 28.21 percent and 30-days at 48.72 percent. The PM data for this metric is presented later in this report.
- The MHP has a 20 percent standard for no-shows for both psychiatrist and non-psychiatry clinical staff. No-shows are reported at 16.49 percent for psychiatrist services and 9.84 percent for non-psychiatry clinical staff.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of the ATA, representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12-14 display data submitted by the MHP; an analysis follows. This data largely represented county-operated services. Timeliness to follow-up services after psychiatric hospitalization was reported for the entire delivery system.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	7.06 Days	10 Business Days*	82.39%
First Non-Urgent Service Rendered	44.19 Days	10 Business Days**	1.05%
First Non-Urgent Psychiatry Appointment Offered	6.99 Days	15 Business Days*	82.12%
First Non-Urgent Psychiatry Service Rendered	52.65 Days	10 Business Days**	0.00%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	1.23 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization	***	7 Days**	55%
No-Show Rate – Psychiatry	16.49%	< 20%**	n/a
No-Show Rate – Clinicians	9.84%	< 20%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

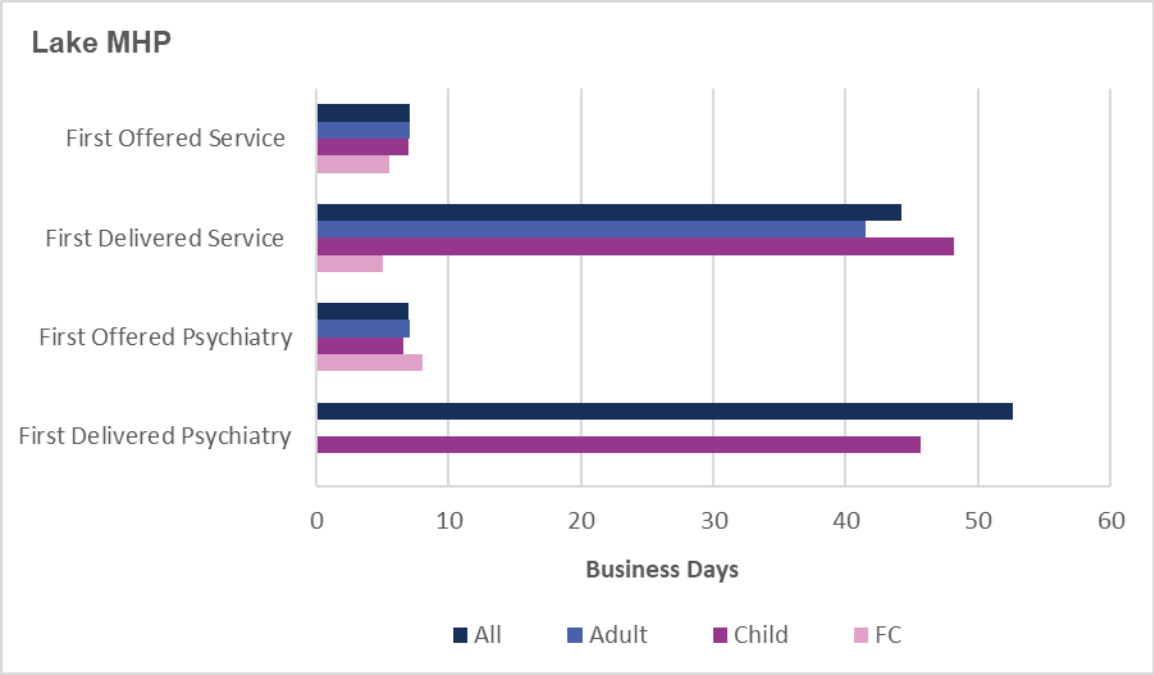


Figure 13: Wait Times for Urgent Services

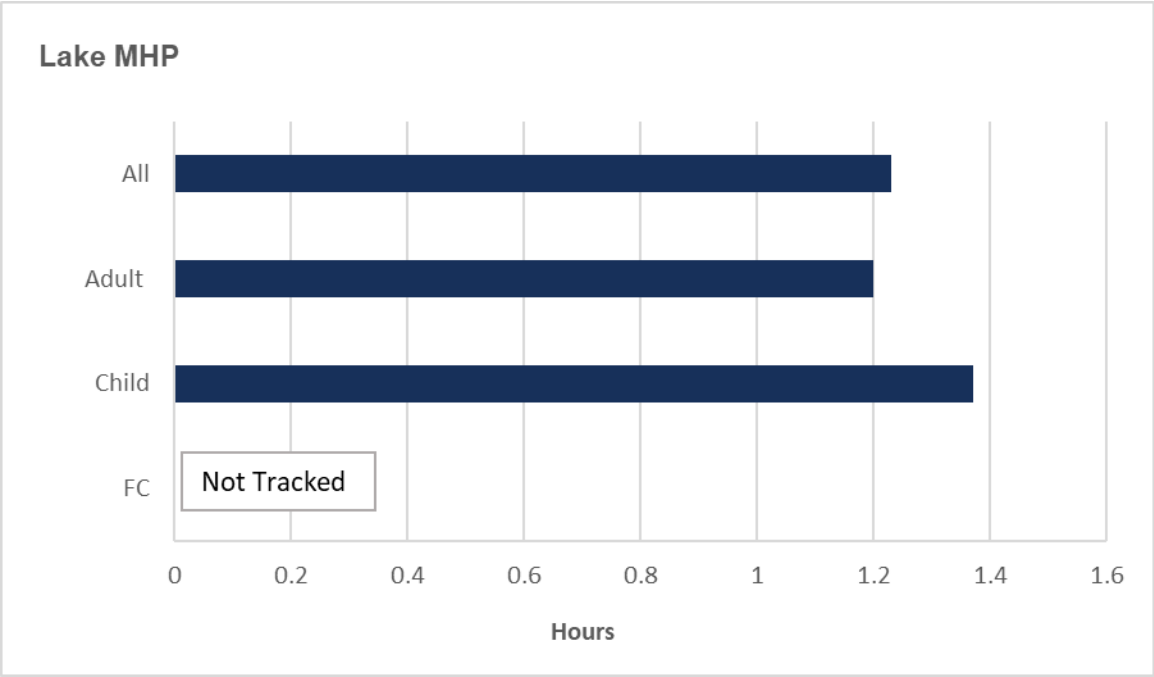
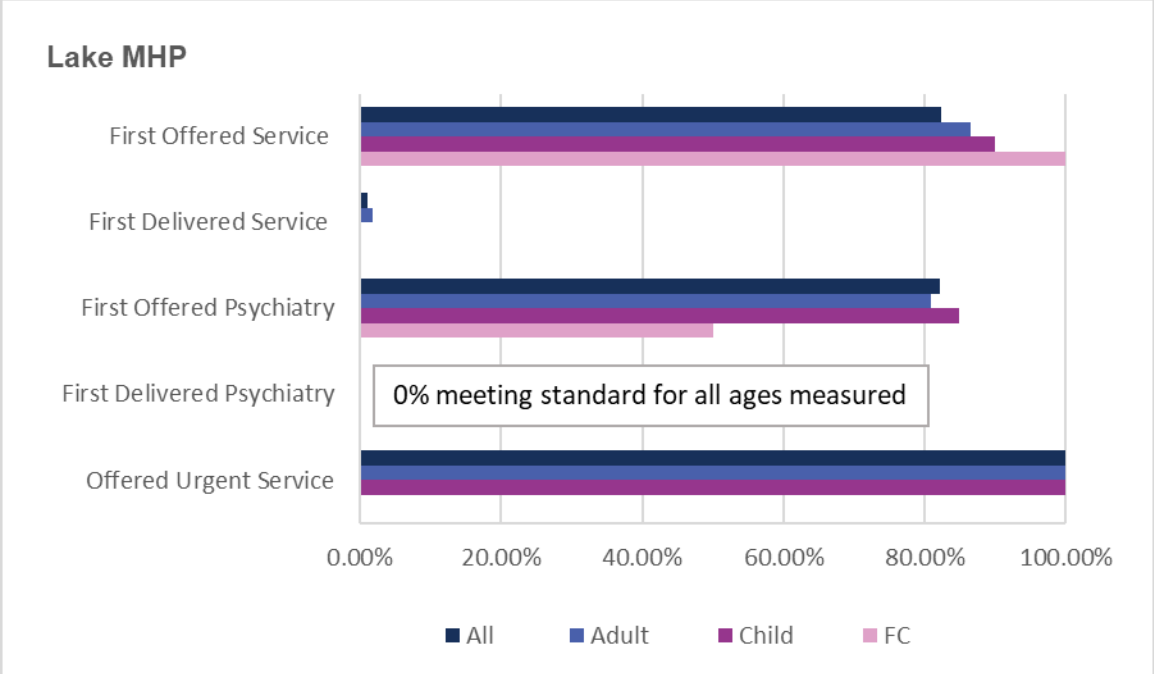


Figure 14: Percent of Services that Met Timeliness Standards



- While 82.39 percent of non-urgent requests for service resulted in an appointment offered within 10 days, only 1.05 percent received a service within that time frame; the average wait to first rendered service was 44.19 days, the median wait time was 39.00 days, and the range was 7 to 144 days.

- 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.
- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” as urgent care requests logged into their crisis tracker. There were reportedly 660 urgent service requests with a reported actual wait time to services for the overall population at 1.23 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as from the beneficiary’s first request for service for both adults and children.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 16.49 percent for psychiatrists and 9.84 percent for non-psychiatric clinical staff.

IMPACT OF TIMELINESS FINDINGS

- The extreme difference in wait times between first offered and first rendered non-urgent service warrants investigation. The MHP investigate the reasons for this difference and identify and implement strategies to ensure that beneficiaries receive services when needed.
- About one-third of services are rendered by contract providers and their service access data is not included in analysis provided. The MHP should develop methods to include the contractor data to understand and potentially improve the timeliness of services delivered by contract providers.

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 within QM. The MHP has a quality management (QM) structure that guides and tracks system issues and QI initiatives. The QM staff are fully integrated with the leadership team and report directly to the MHP Director. QM staff are embedded in the compliance department, and the MHP QI Coordinator facilitates the implementation of the QAPI work plan activities. The Compliance Committee is separate from QIC in order to ensure separation of Compliance from QI, and each program has its own committee with separate committee chairs, goals, and tasks.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of the QI Coordinator; management/supervisory staff; clinical staff; case management staff; clerical and support staff; clients; family members; and other stakeholders, and is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met four times. Of the ten identified FY 2020-21 QAPI workplan goals, the majority achieved improvement or reached successful completion. At the time of the EQR, the MHP had not completed the FY 2022-23 QAPI workplan.

The MHP utilizes the following level of care (LOC) tools: Pediatric Symptoms Checklist (PSC-35), Child and Adolescent Needs and Strengths (CANS), Patient Health Questionnaire-9 (PHQ-9), and General Anxiety Disorder-7 (GAD-7). The MHP does not aggregate LOC data for improvement over time.

The MHP utilizes the following outcomes tools: PSC-35, CANS, PHQ-9, GAD-7.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- The county is an active participant in multi-county initiatives which serve to extend the quality oversight activities that can be difficult for a small county to execute on their own. For example, they are one of eight counties in the California Multi-County Full Service Partnership (FSP) Innovation Project which aims to identify and implement changes to improve FSP programs within the county and across the state. They also participate in multiple CalMHSA projects including the Semi-Statewide EHR implementation and development of the Stipend/Loan Repayment/Scholarship program.
- The MHP has a robust network of five wellness centers called Peer Support Centers. The centers provide a wide range of services, especially for the unhoused population.
- The MHP recently acquired a Street Outreach Van which has had a five-fold expansion of the number of beneficiaries they engage with on a weekly basis. They have also increased staffing at the peer centers and the operating hours are going to seven days a week with longer hours. Peer workers report that they are satisfied with their opportunities for advancement.
- The county collaborated with a vendor to create some new demographic and HEDIS measure dashboards.

- The MHP follows a continuum of care treatment model that involves a range of treatment options and an integrated system of care.
- The MHP tracks and trends the following HEDIS measures as required by WIC Section 14717:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)

QUALITY PERFORMANCE MEASURES

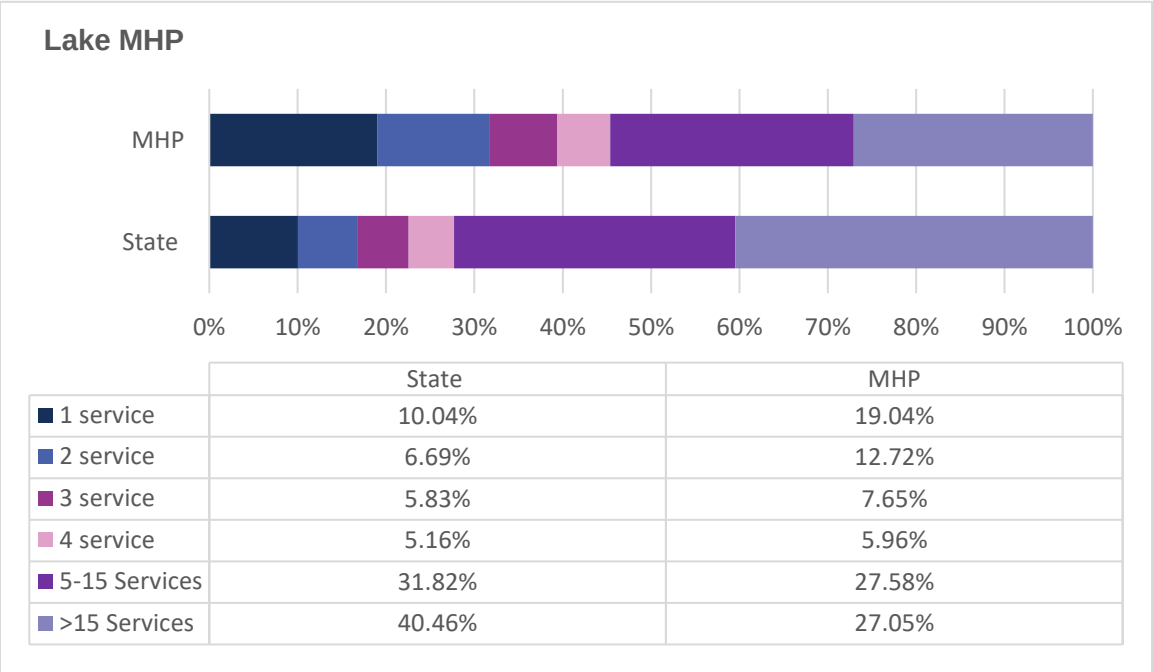
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



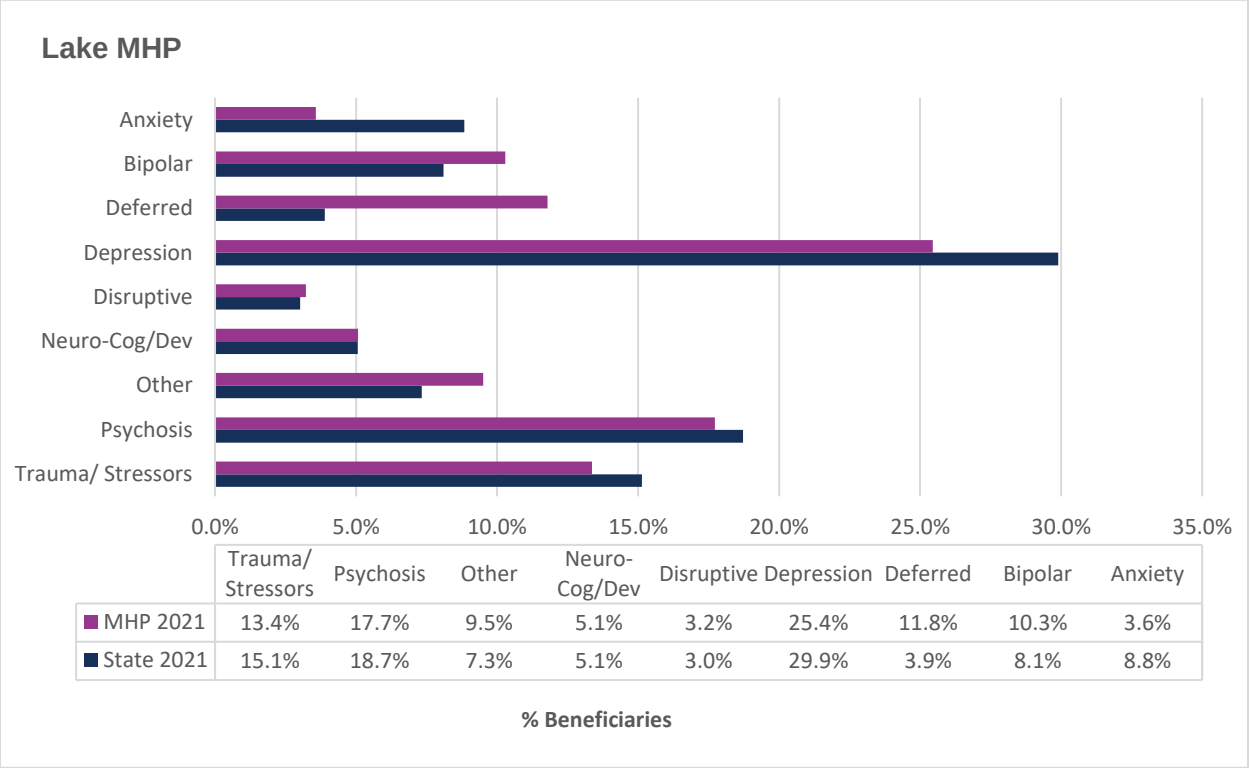
	State	MHP
1 service	10.04%	19.04%
2 service	6.69%	12.72%
3 service	5.83%	7.65%
4 service	5.16%	5.96%
5-15 Services	31.82%	27.58%
>15 Services	40.46%	27.05%

- In Lake County 45.37 percent of beneficiaries received one to four services, compared to statewide at 27.72 percent. The relatively high number of beneficiaries receiving a low number of services could be related to a high number of medication-only clients, beneficiaries receiving only crisis intervention services, transferring clients to a Managed Care Plan lower level of care, issues ensuring that billable services are billed, capacity issues, or other factors.

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.

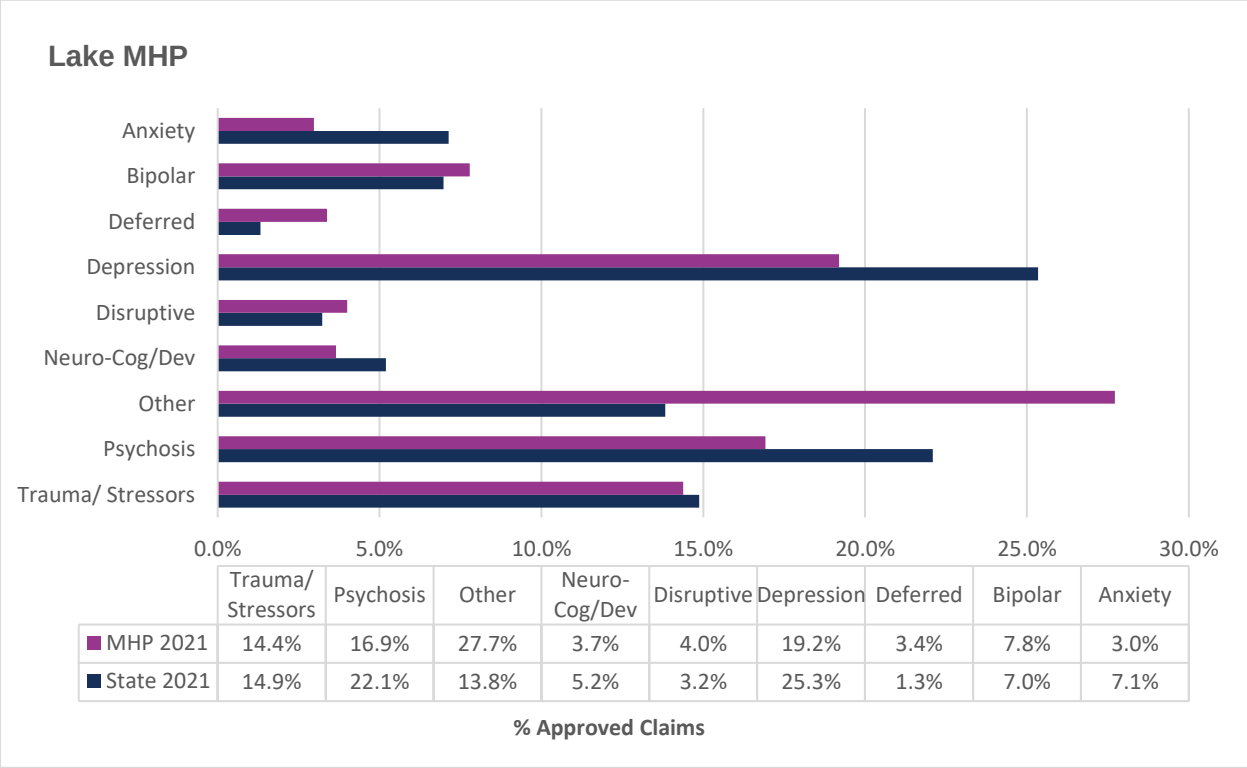
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	13.4%	17.7%	9.5%	5.1%	3.2%	25.4%	11.8%	10.3%	3.6%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- The MHP serves a higher proportion of beneficiaries with bipolar disorders (10.3 percent) than is seen statewide (8.1 percent).
- The proportion of deferred diagnoses (11.8 percent) is well above the statewide average (3.9 percent).
- The MHP serves a lower proportion of beneficiaries with depression (25.4 percent) and anxiety (3.6 percent) compared to the state averages of 29.9 percent with depression and 8.8 percent with anxiety.

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



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	14.4%	16.9%	27.7%	3.7%	4.0%	19.2%	3.4%	7.8%	3.0%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- The MHP's approved claims for Other diagnostic categories is more than twice the state average.
- Like the percentage of beneficiaries, the percentage of approved claims with a depression or anxiety diagnostic category is lower than the state average.

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	132	233	11.79	8.79	$16,266	$12,052	$2,147,049
CY 2020	119	183	12.17	8.68	$16,707	$11,814	$1,988,099
CY 2019	137	220	11.34	7.8	$14,466	$10,535	$1,981,827

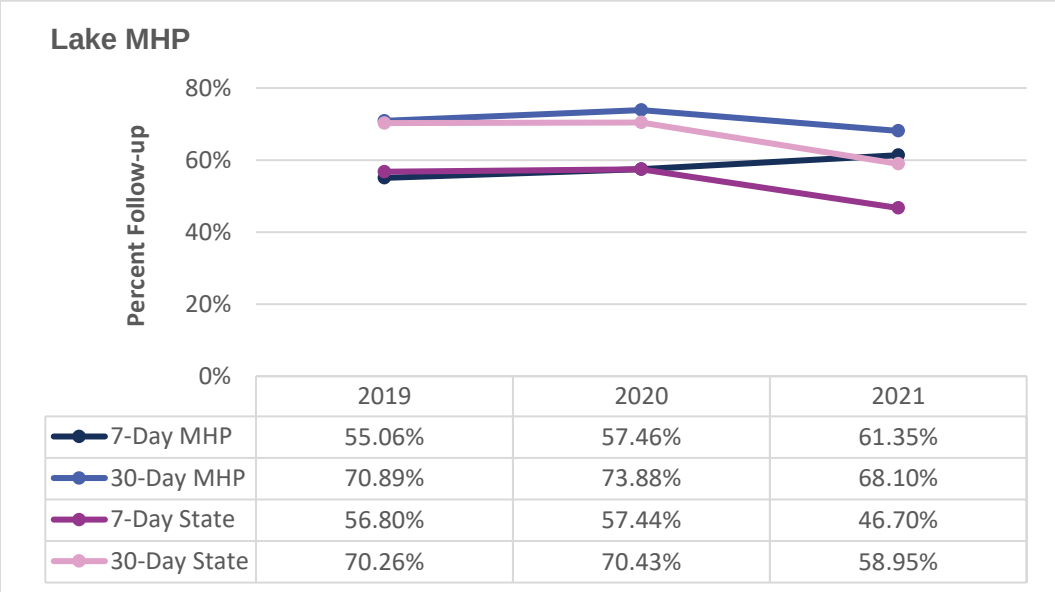
- Both the beneficiary count and the total number of inpatient admissions went down from CY 2019 to CY 2020 and up from CY 2020 to CY 2021. The average LOS is consistently higher than the state average; however as seen below in Figure 19 readmission rates are lower than the state average.

Follow-Up Post Hospital Discharge and Readmission Rates

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

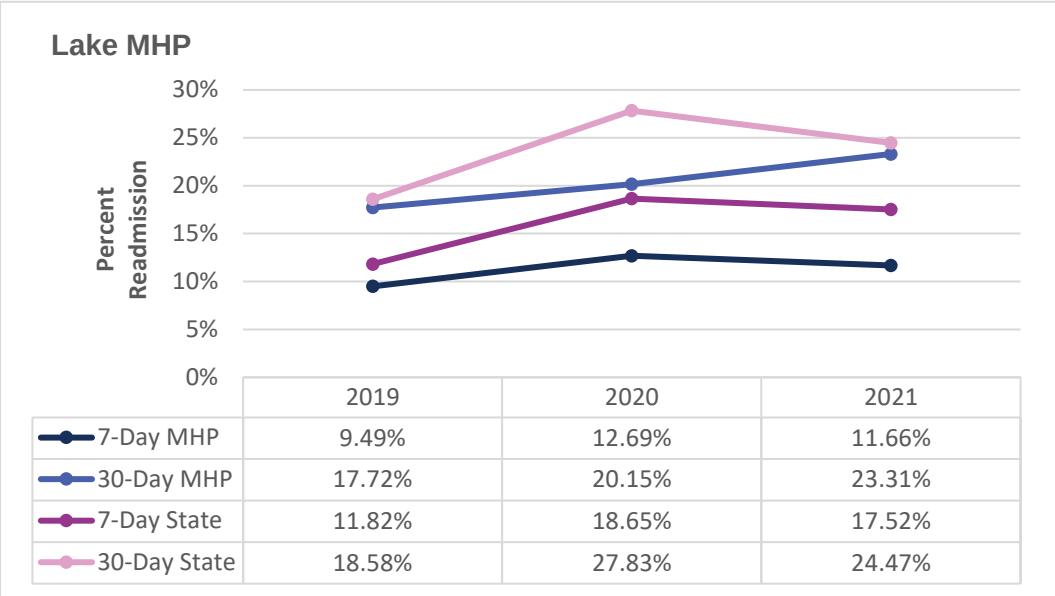
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	55.06%	57.46%	61.35%
30-Day MHP	70.89%	73.88%	68.10%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

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



	2019	2020	2021
7-Day MHP	9.49%	12.69%	11.66%
30-Day MHP	17.72%	20.15%	23.31%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The county's post psychiatric inpatient hospitalization follow-up is higher than state, with 7-day 61.35 percent vs 46.70 percent, and 30-day 68.10 percent vs 58.95 percent.
- The 7-day and 30-day rehospitalization rates are lower than the states, with 7 day (11.66 percent vs 17.52 percent), and 30-day (23.31 percent vs 24.47 percent).

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $6,496, the median amount is just $2,928.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent

of the statewide beneficiaries are “low cost” (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

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	18,847	3.46%	28.46%	$1,007,853,748	$53,476	$43,231
MHP	CY 2021	32	2.85%	33.33%	$2,009,327	$62,791	$49,608
	CY 2020	31	2.60%	31.60%	$1,974,808	$63,703	$41,936
	CY 2019	36	3.04%	29.44%	$1,748,752	$48,576	$43,870

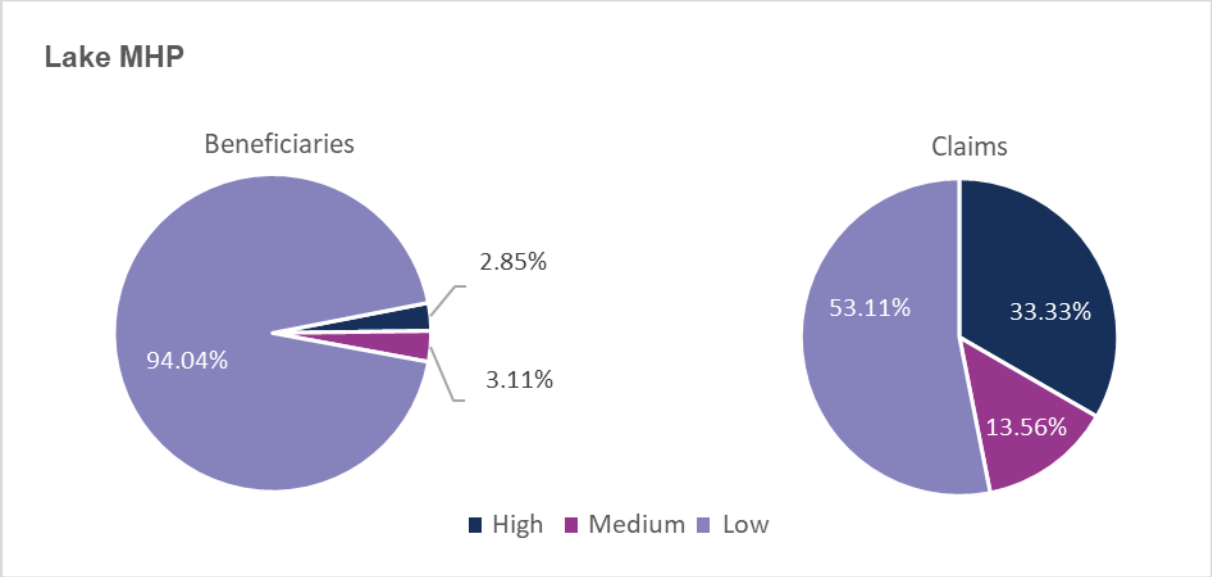
- While the MHP's percentage of HCB beneficiaries is lower than the state average, the percentage of approved claims serving HCBs is higher than the state average. In CY 2021, one-third of approved claims were for services provided to the 32 HCB beneficiaries.

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	35	3.11%	13.56%	$817,307	$23,352	$22,537
Low Cost (Less than $20K)	1,057	94.04%	53.11%	$3,201,999	$3,029	$1,201

- Almost half of all approved claims are for serving the high and medium cost beneficiaries. A little over half of the claims, 53.11 percent, was for serving the low-cost beneficiaries, representing 94 percent of beneficiaries served.

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



- As noted above, almost half of all approved claims are for serving the high and medium cost beneficiaries who represent 5.96 percent of beneficiaries served.

IMPACT OF QUALITY FINDINGS

- Almost half (45.37 percent) of beneficiaries receive four or fewer services suggesting that beneficiaries might prematurely disengage from services or are not engaged after crisis services are provided. The MHP can investigate this pattern and identify strategies to retain beneficiaries who are most likely to drop out of services early.
- The proportion of deferred diagnoses (11.8 percent) is well above the statewide average (3.9 percent). At the same time, 19.04 percent of MHP beneficiaries received one service, compared to 10.04 percent statewide, and 27 percent of adult beneficiaries receive crisis intervention. It is possible the high number of deferred diagnoses is partially explained by the high number of beneficiaries receiving one service, which may be crisis intervention and a deferred diagnosis.
- Key informants indicate post hospitalization appointments for psychiatry and assessments are a priority for the MHP. The county's post psychiatric inpatient hospitalization follow-up data support their observations. The county's readmission rates also suggest that the MHP is providing quality services following an inpatient discharge.

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 (ED) Visit for Mental Illness (FUM)

Date Started: 09/2022

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

Target Population: The target population for this project will be operationalized within the parameters of the HEDIS FUM metric. The MHP will focus on beneficiaries with a qualifying event as defined in the FUM metric.

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

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

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

Summary

The MHP presented their CalAIM BHQIP PIP to serve as the EQR clinical PIP. The problem statement was presented as: Lake County's Follow-Up After Emergency Department Visit for Mental Illness (FUM) is lower than the state average and contributes to a higher incidence of suicide in Lake County than other California Counties. Potential root causes include: (a) challenges engaging clients in timely follow-up MH treatment after ED visits and, (b) insufficient tracking/exchanging related data to make person-centered, data-informed decisions.

Lake County residents presenting to the ED for mental health needs are not always tracked appropriately, and the MHP hypothesizes that:

- ED staff may not always be knowledgeable about referral/tracking processes.
- ED staff are disconnected from MHP staff, detached from utilization data.
- ED staff may not always prioritize this population, may divide between "medical" clients and "mental health" clients, though these are community clients.
- ED staff is unaware of resources, and MHP capacity challenges.

Additional factors of root causes include:

- Ambiguity around communication preferences and expectations / responsibilities between referring / receiving providers (e.g., when / how should EDs be notifying the or the Plan's network providers, of discharges, and for which beneficiaries?).
- Insufficient systems and processes to initiate and track referrals as well as ensure referral loops are closed.
- Lack of access to accurate and consistent real-time ED data to assist with care coordination, as well as historical ED utilization data to review patterns and identify specific high-risk populations, such as frequent utilizers of ED services or individual disengaged from services.
- Gaps in client supports (e.g., identifying / resolving barriers to attending follow-up appointments; providing prompt scheduling and reminders; addressing a person's unique motivation, needs, and preferences for treatment). The result is that beneficiaries are missed by the MHP for follow up care.

The MHP identified interventions to include implementing a collaborative care model:

- Screening in the ED.
- Brief Intervention (e.g., Motivational Interviewing).
- Care coordination with the ED.
- Linkage to existing and new care based on presenting needs.
- Care coordination post-discharge (e.g., call or text appointment reminders, referrals).

These interventions were chosen to include and consider client-level, provider-level, and systems/infrastructure-level barrier and facilitators to transitions between ED and follow-up treatment.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: credible, reliable, or valid methods were implied or able to be established for part of the PIP.

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

- Because the PIP is still in the planning phase, the MHP needs to move forward with implementation in a timely manner.
- Interventions need to be operationalized, implemented, and tracked.
- Data needs to be collected and analyzed not less than quarterly.
- Engage in TA with CalEQRO on a consistent, at least quarterly, basis throughout the life of the PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Increasing Attendance Rates for Psychiatry Services

Date Started: 07/2022

Aim Statement: “The no-show rate for adult psychiatry appointments will decrease from 27 percent to 20 percent or less (the MHP standard) through the implementation of an automated text message reminder system by 06/2023. Our hope is to expand this project to other demographic populations in a multi-year phased in approach if deemed successful after year 1.”

Target Population: All adult (18+) psychiatry patients

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

Summary

The goal of the PIP is to address stakeholder and staff member concerns regarding the rate of no-shows to psychiatry appointments. The PIP is designed to reduce the

no-show rate for adult psychiatry appointments by increasing the attendance rate to psychiatry appointments. The improvement strategy includes implementing a software platform to remind clients of upcoming appointments. The intervention involves implementing an automated text message appointment reminder system. All clients age 18+ will receive a text message appointment reminder for 100 percent of psychiatry appointments. The intervention will include Spanish language capability in order to make the intervention culturally informed for the beneficiaries who read Spanish not English.

Short Message/Messaging Service (SMS) consent will be offered to clients at the front desk by QA staff, case managers will offer it at check-in, and the case manager will also offer this at check-in prior to the client's service with the psychiatrist. Consent forms will be forwarded to OA staff for entry.

All QA staff receive training on using the automated SMS system. QI staff will compare text/call logs weekly/monthly to services reports to confirm that the reminder went out for all adult psychiatry appointments.

The PIP is in the implementation phase as the intervention has begun; however, baseline data has not been collected and reported or measured.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: credible, reliable, or valid methods were implied or able to be established for part of the PIP, and intervention began 07/2022, although there is no data reported and assessed at this time.

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

- A baseline from FY2020-21 is needed.
- Continue the intervention and collect and analyze data not less than quarterly.
- Engage in TA with CalEQRO on an early and frequent basis this year.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is the Cerner Anasazi system which has been in use for 13 years. Currently, the MHP plans to implement the CalMHSA Streamline SmartCare semi-statewide EHR in its pilot implementation in February 2023.

Approximately 1.41 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 budget is down from 1.93 percent last year. The MHP determined that they could eliminate, with no negative impact, an IT position that had been vacant for a long time.

The MHP has 77 named county staff users with log-on authority to the EHR. The number of contractor staff with log-ons to the EHR was not provided. Support for the users is provided by 2 FTE IS technology positions. Currently all positions are filled. To address increasing reporting requirements, they added 2.5 data analytical full-time equivalents (FTEs) for a total of 6.5 data analyst FTEs.

As of the FY 2022-23 EQR, all contract providers, excluding network providers, have access to directly enter clinical data into the MHP's EHR.

Most contract providers enter beneficiary practice management and service data directly into the EHR. Network and inpatient providers email service data to the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☐ Daily ☒ Weekly ☐ Monthly	75%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	25%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not have a PHR but intends to implement one associated with the new EHR within the next two years.

Interoperability Support

The MHP is not a member or participant in an HIE. They are exploring participation in the SacValley MedShare HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information with the MH and Substance Use Disorder contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP has managed their IT operations with a small staff of two FTEs. To address increasing reporting requirements, they added two and one-half data analyst FTEs in the past year.
- The MHP could improve their data collection and processing capabilities through improved data integrity validations. They believe the SmartCare Electronic Health Record (EHR) Solution for Multi-County Behavioral Health Initiative in California choice should provide better data integrity than their current system.
- The MHP has indicated that they could improve their processes to ensure that all Medi-Cal billable services are billed. What is billed is submitted timely and with a low denial rate.
- SmartCare is expected to improve password security processes such as requiring password resets on a regular basis and requiring passwords to contain a combination of alphanumeric and special characters.
- The MHP is looking to expand their interoperability functionality by expanding the functions contract providers can utilize in the SmartCare EHR and joining an HIE to aid in providing MH services following behavioral health emergency room encounters.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in the table below, 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.

For the MHP, it appears that significant claims lag begins in October and likely represents $1,400,000 in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through June 2022.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	1,795	$370,795	$1,062	0.29%	$369,733
Feb	2,099	$494,124	$11,777	2.38%	$482,347
Mar	2,431	$605,420	$41,099	6.79%	$564,321
April	2,128	$524,366	$15,997	3.05%	$508,369
May	2,037	$482,347	$5,349	1.11%	$476,998
June	2,251	$502,091	$3,181	0.63%	$498,910
July	1,554	$527,529	$10,186	1.93%	$517,343
Aug	1,600	$458,172	$4,661	1.02%	$453,511
Sept	1,696	$509,235	$5,592	1.10%	$503,643
Oct	165	$55,640	$965	1.73%	$54,675
Nov	25	$11,797	$0	0.00%	$11,797
Dec	0	$0	$0	0.00%	$0
Total	**17,781**	**$4,541,516**	**$99,869**	**2.20%**	**$4,441,647**

- The October and November claims appear to be incomplete and there should be claim data reported for December.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	278	$65,681	65.77%
Beneficiary not eligible or non-covered charges	44	$20,694	20.72%
NPI related	29	$5,947	5.95%
Medicare Part B or Other Health Coverage must be billed before submission of claim	9	$4,023	4.03%
Other	11	$2,965	2.97%
Service line is a duplicate and a repeat service procedure code modifier not present	2	$560	0.56%
Total Denied Claims	**373**	**$99,870**	**100.00%**
Overall Denied Claims Rate	**2.20%**		
Statewide Overall Denied Claims Rate	**2.78%**		

- The MHP's claim denial rate is lower than the state average.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- As a small county with a small IT staff, meeting increasing data analytical requirements is a challenge, which will benefit greatly from the now 6.5 FTE data analysts. The MHP is proactively participating in several multi-county initiatives which effectively extend their IT and data capabilities by bringing in developed solutions. The most significant project is the SmartCare EHR implementation which is expected to greatly expand tracking, aggregation and analytical capabilities relating to timeliness, level of care, and outcomes. The MHP is expecting the EHR and working with CalMHSA to be a critical component of developing interoperability with an HIE. The EHR is also expected to incorporate best practices related to cyber security procedures. Next year's EQR should provide perspective on whether these goals are being met.
- At the time of the review, there were some gaps in the EHR project plan. CalMHSA is expected to provide online training and the system itself includes how-to help, however the MHP thought in-person training would be more effective. Developing an effective training strategy will be critical to a successful implementation. Another gap was how to provide access to beneficiary data that is not being converted to SmartCare. The data is now part of an aging EHR and although the MHP will retain access to the server it is unknown how long that can continue. The MHP will need to develop and implement a plan to retain access to any data that is not being converted to SmartCare.
- To support the county's financial health, the MHP could investigate strategies to ensure that all Medi-Cal billable services are claimed to Medi-Cal.

SVALIDATION 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 conducts the CPS per DHCS requirements, although documentation was not submitted during this review to reflect that survey results are used for QI purposes. Line staff report they are unaware of the CPS results.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of TAY consumers who initiated services in the preceding 12 months. The focus group was held virtually and included five participants; with one participant who had entered services within the past year. All consumers participating receive clinical services from the MHP.

In general, the participants reported satisfaction with the services they receive. Participants agreed that entry into services was timely without barriers, although one participant reported having to wait a few months for services. The participants reported they receive regular therapy services at a reasonable, usually weekly, frequency. However, there is a wait for psychiatry, and some receive medication from their primary care physician to avoid the wait. They do not routinely receive reminder calls or texts for appointments. If they miss an appointment, they are normally able to reschedule. Some participants have telehealth services via a zoom-type platform, while some receive

in-person services. RCS offers only virtual appointments at this time. All were aware of interpreter options for those who request it. Stakeholders report that the only transportation available was for Native American clients.

The participants are aware of urgent care and crisis response protocols and know where to go for help, if needed. All agreed they are working to adapt and figure out entering adulthood.

All participants were aware of staffing shortages. All participants like the TAY center because the staff are welcoming, food is provided, and they feel there are good services there. Participants were not aware that their medical provider and mental health provider communicated regarding their treatment. Some participants lack a medical provider.

None of the participants were aware of committees that could contribute to decision making regarding services. None have completed a consumer satisfaction surveys of any type. However, all agree they can discuss things with the MH system if needed.

Recommendations from focus group participants included:

- Speed up the process to begin services.
- Offer transportation or use of a tablet for telehealth services. Some beneficiaries don't have adequate telecommunications or equipment to do telehealth services.
- Some of the therapists allow clients to bring their children to their services and felt that therapists should be required to allow for this.
- "More compassionate services in the ER."

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The TAY group of participants agreed that the TAY Center is a positive and an important part of their recovery. It was noted that the TAY center was welcoming, and that some other services would do well to emulate that. Transportation for in-person services and telecommunication capability for virtual services are viewed as needing to be enhanced.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP provides significant outreach to Native American and LGBTQ communities through culturally appropriate outreach activities and collaboration with community groups. (Access)
2. The MHP recently acquired a Street Outreach Van which offers telehealth services providing access to both mental health and substance use issues. This has resulted in a five-fold expansion of the number of beneficiaries they engage with in outreach on a weekly basis. (Access)
3. The county responds to urgent service needs in a very timely manner; significantly faster than the 48-hour DHCS standard, with an average of 1.14 hours and a percent of offered urgent appointments meeting the standard 100 percent of the time. (Timeliness)
4. Despite leadership turnover and staffing issues, the MHP has produced two PIPs this year. (Quality)
5. The MHP is proactively implementing peer certification for peer staff. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. While 82.39 percent of non-urgent requests for service resulted in an offered appointment within 10 days, only 1.05 percent resulted in a delivered service during that time frame. Further, the rate of adults who receive crisis intervention services (27.0 percent) is more than twice the statewide average (11.1 percent). (Access, Timeliness)
2. Key informants agreed that information on transportation resources available is not routinely given to beneficiaries. (Access)
3. The MHP reported only county-operated services regarding timely access to care; this fails to give a systemwide report of services. (Timeliness)
4. The MHP neither measures clinical and/or functional outcomes of beneficiaries served, nor shows any ways they utilize information from the Beneficiary Satisfaction Survey. (Quality)
5. Implementing a new EHR is a major project for any healthcare organization and a positive beginning with well-trained staff is key to staff acceptance and a

successful project. At the time of the review the MHP did not have a plan for providing training other than the online training that CalMHSA will provide. (IS)

6. The MHP has an aging EHR and not all beneficiary data will be converted to the new SmartCare system. They will need to determine how to retain access to historical consumer data after they convert to the new EHR. (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. Explore reasons why 82.39 percent of non-urgent requests for service resulted in an offered appointment within 10 days, yet only 1.05 percent resulted in a delivered service during that time frame while the rate of adults who receive crisis intervention is more than twice the state average. Create and implement a process to correct this timeliness to services issue and decrease the need for crisis intervention. (Access, Timeliness)
2. Research issues, create, and implement a plan to ensure that beneficiaries are aware of all transportation resources available to them when they begin services. (Access)
3. As the new SmartCare EHR is implemented, ensure that all timeliness data can be tracked and reported for the entire system of care. (Timeliness)
4. Create a system, memorialized in the Quality Work Plan, to measure clinical and/or functional outcomes of beneficiaries served, and utilize information from the Beneficiary Satisfaction Survey to create dialog for possible areas of quality improvement. (Quality)
5. Develop and implement a SmartCare EHR training plan that will include some level of MHP-focused training that meets the MHP's needs. (IS)
6. Develop and implement a plan to provide user access to historical beneficiary data that is not converted to the new SmartCare EHR. (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 public health emergency (PHE) exists. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Lake MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs Validation and Analysis
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Medical Prescribers Group Interview
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
EHR Deployment
Telehealth
Jail Mental Health Services Site Visit
Site Visit to Innovative Clinical Programs: Innovative program/clinic that serve special populations or offer special/new outpatient services.
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Zena Jacobi, Information Systems Reviewer
Walter Shwe, Consumer Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Metcalf	Todd	Director	Lake County Behavioral Health Service (LCBHS)
Jones	Elise	Deputy Director	LCBHS
Giambra	April	Deputy Director	LCBHS
Abbott	Scott	Program Manager, MHSA	LCBHS
Andrus	Christine	Program Manager, Fiscal	LCBHS
Mayer	Vanessa	Program Manager, Compliance	LCBHS
Westphal	Amber	Program Manager, SUDS	LCBHS
Neria	Zabdy	Program Manager, Clinical	LCBHS
Lamkin	Michelle	Staff Services Specialist	LCBHS
Fagalde	Gerry	Staff Services Analyst, BH Department	LCBHS
Madero	Amber	Staff Services Analyst, Senior, Fiscal	LCBHS
Kopf	Melissa	Staff Services Analyst, Senior, MHSA	LCBHS
Chalmers	Robert	Staff Services Analyst, Senior, Compliance	LCBHS
Austinson	Holly	SUDS Program Coordinator, SUDS Treatment	LCBHS
Pimenta	Carolina	Supervising BH Clinician, Senior, MH	LCBHS
Grogg	Laurie	Supervising BH Clinician, Access Team, MH	LCBHS

Last Name	First Name	Position	County or Contracted Agency
Trongo	Summer	Supervising BH Clinical Specialist, MH	LCBHS
Manning	Carrie	Supervising BH Clinical Specialist, MHSA	LCBHS
Rodrigues	Crystal	Supervising BH Clinician, MH	LCBHS
Bevan	Elizabeth	Supervising BH Clinician, Senior, MH	LCBHS
Trillo	Jamilyn	BH Clinician, Senior, MH	LCBHS
Smith	Matthew	Business Software Analyst	LCBHS
Goodrich-Patten	Justin	Business Software Analyst	LCBHS
Boyce	Kendra	Prevention Specialist, MHSA/MH	LCBHS
Yang	Anne	Prevention Specialist, SUDS	LCBHS
Ables	David	Peer Support Specialist, Big Oak	LCBHS
Ontiveros	Edgar	Peer Support Specialist, La Vos	LCBHS
Lewis	Kate	Staff Services Analyst II, Compliance, MH	LCBHS
Button	Janet	Accountant II, Fiscal, MC	LCBHS

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	Credible, reliable, or valid methods were implied or able to be established for part of the PIP.
General PIP Information	
MHP/DMC-ODS Name: Lake	
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness (FUM)	
PIP Aim Statement: "For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023".	
Date Started: 09/2022	
Date Completed: to be decided	
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: see below	

General PIP Information
Target population description, such as specific diagnosis (please specify): The target population for this project will be operationalized within the parameters of the HEDIS FUM metric. The MHP will focus on beneficiaries with a qualifying event as defined in the FUM metric.
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): For beneficiaries identified as needing the MHP level of care, the MHP will provide coordination services to ensure follow up with the MHP.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Develop a referral tracking mechanism, a screening will be completed with the beneficiary while in the ED to determine the level of need (i.e., Primary Care Physician, MCP, or MHP). For those beneficiaries identified as needing the MHP level of care, the MHP will provide care coordination services
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): Change in communication system between the MCP and MHP around information of beneficiaries seen in ED

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
Screening in Ed	2022	n/a	☐ 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):

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
Brief intervention (e.g., motivational interviewing)	2022	n/a	☒ 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):
Care coordination with ED (e.g., case review)	2022	n/a	☒ 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):
Linkage to existing and new care based on presenting needs	2022	n/a	☒ 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):
Care coordination post-discharge (e.g., call or text appointment reminders, referrals, review of progress with client and treatment team)	2022	n/a	☒ 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):

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.

PIP Validation Information
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: • The PIP is still in the planning phase. The MHP needs to move forward with implementation in a timely manner. • Interventions need to be operationalized, implemented, and tracked. • Data needs to be collected and analyzed not less than quarterly. • Engage in TA with CalEQRO on a consistent, at least quarterly, basis throughout the life of the PIP.

Non-Clinical PIP

Table C1: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	Credible, reliable, or valid methods were implied or able to be established for part of the PIP, and intervention began 07/2022, although there is no data has been reported and assessed at this time.

General PIP Information
MHP/DMC-ODS Name: Lake
PIP Title: Increasing Attendance Rates for Psychiatry Services
PIP Aim Statement: "The no-show rate for adult psychiatry appointments will decrease from 27 percent to 20 percent of less (the MHP standard) through the implementation of an automated text message reminder system by 06/2023. Our hope is to expand this project to other demographic populations in a multi-year phased approach if deemed successful after year 1."
Date Started: 07/2022
Date Completed: 07/2023
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): All adult (18+) psychiatry patients.

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): Client will receive text message reminder.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Provider will send text message reminder.
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): The improvement strategy includes implementing a software platform to remind clients of upcoming appointments. SMS consent will be offered to clients at the front desk by QA staff, case managers will offer it at check-in, and case manager will also offer this at check-in prior to client meeting with the psychiatrist. Consent forms will be forwarded to OA staff for entry. All QA staff receive training on using the automated system. QI staff will compare text/call logs weekly/monthly to services reports to confirm that the reminder went out for all adult psychiatry appointments.

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
PM 1. Rate of attendance at appointments	Not determined	Not determined	☒ Not applicable—PIP is in planning or implementation phase, results not available	2022 implemented n/a no data given	☐ 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: • A baseline from FY 2019-20 and FY2020-21 is needed. • Continue the intervention and collect and analyze data not less than quarterly. • Engage in TA with CalEQRO on an early and frequent basis this year.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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