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FY 2021-22
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 9 and 16, 2021

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 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.

MHP INFORMATION

MHP Reviewed — Lake

Review Type — Virtual

Date of Review — December 9 and 16, 2021

MHP Size — Small

MHP Region — Superior

MHP Location — 7000-B South Center Drive, Clearlake, CA 95422

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 1,194

MHP Threshold Language(s) — English, Spanish

SUMMARY OF FINDINGS

Of the seven recommendations for improvement that resulted from the FY 2020-21 EQR, the MHP addressed or partially addressed four recommendations.

California External Quality Review Organization (CalEQRO) evaluated the MHP on the following four Key Components (KC) that impact beneficiary outcomes; among the 26 components evaluated, the MHP met or partially met the following, by domain:

- Access to Care: 100 percent (four of four components)
- Timeliness of Care: 100 percent (six of six components)
- Quality of Care: 50 percent (five of ten components)
- Information Systems (IS): 100 percent (six of six components)

The MHP submitted one of the two required Performance Improvement Projects (PIPs). The clinical PIP is focused on reducing the rate of rehospitalizations by using motivational interviewing (MI) with beneficiaries post hospital discharge. The clinical PIP is not active as baseline, nor was the first measurement data collected. The MHP submitted a non-clinical PIP from a previous year and a new PIP has not been initiated.

CalEQRO conducted one consumer family and member (CFM) focus group, comprised of a total of eight participants.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: redesign of the access team and streamlined process for new beneficiary intakes; timely access to first offered assessment appointment; response to urgent requests in less than one hour; timely follow-up post hospitalization discharge; and a robust wellness center program and involved peer support system.

The MHP was found to have notable opportunities for improvement in the following areas: staffing shortages and lack of resources are contributing to a lengthy children's triage list creating long wait times for first rendered clinical service; the MHP's submitted clinical PIP is not active and a non-clinical PIP was not submitted; the MHP lacks sufficient staff and resources to initiate and maintain ongoing quality improvement (QI) activities; staffing shortages, lack of resources, and lack of bi-directional communication is contributing to staff burnout and retention issues; and the MHP does not track and trend Healthcare Effectiveness Data Information Set (HEDIS) measures as defined in Senate Bill (SB) 1291.

FY 2021-22 CalEQRO recommendations for improvement include: implement strategies to decrease the children's triage list; implement and maintain two active PIPs; implement strategies to improve the MHP's ability to initiate and complete QI activities; implement a medication monitoring system including HEDIS measures as outlined in SB 1291.

INTRODUCTION

BACKGROUND

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 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., the California EQRO (CalEQRO), to review and evaluate the care provided to the Medi-Cal beneficiaries.

Additionally, 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 SB 1291 (Section 14717.5 of the Welfare and Institutions Code). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill (AB) 205.

This report presents the FY 2021-22 findings of the EQR for Lake County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on December 9 and 16, 2021.

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 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 are derived from three source files, unless otherwise specified. These statewide data sources include: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File (IPC). CalEQRO reviews are retrospective; therefore, data evaluated are from CY 2020 and FY 2020-21, 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–overall, FC, transitional age youth (TAY), and Affordable Care Act (ACA). CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

FINDINGS

Findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of three elements pertaining to NA: Alternative Access Standards (AAS) requests, use of out-of-network (OON) providers and rendering provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).
- Summary of MHP-specific activities related to the following four KC, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, and an examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per SB 1291 (Chapter 844).
- Review and validation of submitted Performance Improvement Projects (PIPs).
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the MHP's quality and operational processes.
- Consumer perception of the MHP's service delivery system, obtained through satisfaction surveys 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 (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) 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 percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

In this section, the status of last year's (FY 2020-21) EQR recommendations are presented, as well as changes within the MHP's environment since its last review.

ENVIRONMENTAL IMPACT

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP was adversely impacted by vacancies created by accelerated retirements and more lucrative work offers, staff illness and paid family leave, local budgetary constraints, and undependable telephone and internet services. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

MHP 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's access team expanded and is now fully staffed to include a full-time team leader and one bilingual clinician. The access team is integrated with the substance use disorder (SUD) program and is designed to streamline the access process and improve timeliness of intake appointments.
- The MHP opted into the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver with a go-live date of July 1, 2022.
- The MHP is the lead for the Lake County Continuum of Care (LCCOC) program; in April 2021, the MHP entered an emergency grant-funded contract with the Elijah House Foundation to provide shelter for individuals experiencing homelessness during the COVID-19 pandemic.
- In FY 2021-22, the MHP increased community outreach and engagement by using media outlets, health fairs, and a cargo van to distribute needed supplies to the unhoused population in Lake County.
- The MHP joined the California Mental Health Services Authority (CalMHSA) multi-county electronic health record (EHR) project that will bring counties together to co-create a semi-statewide EHR.
- The MHP joined the Mental Health Services Act (MHSA) multi-county Full Service Partnership (FSP) Innovation Project focused on creating a data-driven FSP to increase access and improve quality of delivered services.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 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 2020-21

Recommendation 1: As per Title 42, CFR, Section 438.330, DHCS requires two active performance improvement projects (PIPs); the MHP is contractually required to meet this requirement going forward.

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

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP's clinical PIP is focused on using MI with beneficiaries to reduce rehospitalizations. The PIP began as concept only in July 2019. Although the MHP planned to begin implementing the interventions in July 2021, the MHP has not collected baseline or remeasurement data. A PIP is considered active when interventions begin and at least baseline data is collected.
- The MHP's non-clinical PIP, "Timely Access to Service", began in June 2019 with a planned completion in November 2021; however, the final data remeasurements were completed in February 2021 and the MHP did not provide additional data points at the time of this review. The MHP did not submit an active non-clinical PIP, although they are brainstorming new topics.
- The MHP cited staffing shortages and lack of resources impacting its ability to maintain study timelines.

Recommendation 2: Analyze changes in intake staffing and processes, and the impact on timeliness of initial access for children; implement strategies where needed to decrease the children's triage list.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP redesigned the initial access process to identify children who would benefit from Early Intervention Services (EIS). An EIS team was created to collaborate with the access team to expeditiously triage these children who qualify for EIS.
- The average amount of time it takes from the first request for services to the first offered appointment for children's services is 6.31 business days. At the same time, key informant feedback suggests the children's triage list and a shortage in clinical therapists contributes to longer wait times for the first rendered clinical service.
- Key informant feedback reflects a very large caseload of children waiting for EIS, lack of a full EIS team, and a severe shortage of needed resources.
- Key informants maintain that children further down the triage list are utilizing the local emergency room for mental health crises as they wait for their first rendered clinical service. A large portion of beneficiaries on the triage list are not receiving interim services, i.e., case management, due to staff shortages.

Recommendation 3: Formally define requests for urgent appointments to assure complete and accurate tracking and reporting.

(*This recommendation is a carry-over from FY 2018-19 and FY 2019-20.*)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP maintains a policy and procedure to define the processes and timelines for the intake process for outpatient mental health services. The policy holds that urgent requests that do not require prior authorization should be offered an appointment within 48 hours, and 96 hours for those that do require it. The policy does not formally define urgent conditions.
- The MHP's submitted data suggests they can respond to an urgent request in under an hour; however, it would be difficult to determine the accuracy of this data as the MHP does not have a formal definition for urgent appointments.
- During this review, the MHP was encouraged to request TA from their DHCS liaison on the formal definition for urgent requests. This recommendation will not continue to the next FY.

Recommendation 4: Establish a reliable process and method of tracking incoming calls requesting a first appointment with an enhanced level of monitoring to obtain accurate and complete reporting.

(*This recommendation is a carry-over from FY 2018-19 and FY 2019-20*.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP maintains an internal policy on the tracking method for initial access calls to include a script for the access team to utilize when screening incoming calls. The access log is also a tool for staff to communicate regarding the status of requests. The MHP has implemented procedures for monitoring the effectiveness of the Access Line process through periodic test calls and access log reviews.
- Key informant interviews during this review suggest that staffing shortages/changes and lack of resources create barriers to entering information into the log on a consistent basis.
- The access log is not embedded in the current EHR. The MHP hopes to accomplish this in the near future to improve accuracy of the log, and to be more user friendly. The MHP is also researching a new EHR system; therefore, this recommendation will not move forward to the next FY.

Recommendation 5: Take steps to enhance bi-directional communication by providing line staff with information, data, and messages that enhance their knowledge on outcomes and system performance.

(*This recommendation is a carry-over from FY 2019-20.*)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP created internal dashboards for select staff to provide essential timeliness, beneficiary demographic, and caseload metrics.
- Select MHP staff are authorized to view real-time access and timeliness Kings View dashboards.
- Select key informant feedback suggests staffing shortages and an overburdened management team has created barriers for new hires to complete a robust onboarding training program; this results in new staff relying on seasoned employees for guidance on policies and procedures.
- Although the MHP offers select staff the ability to view select dashboards, staff continue to struggle with clinical oversight, clear direction on changes in policies and procedures, the scope of data tracking and trending, and a clear understanding of management structure and operations.

Recommendation 6: Develop a formal medication monitoring policy and procedure to meet SB 1291 requirements; routinely review DHCS Lake County online data to ensure requirements are met.

(*This recommendation is a carry-over from FY 2018-19 and FY 2019-20.*)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has an internal policy and procedure (effective November 2017) that outlines the requirements of medication monitoring that includes the safety and effectiveness of medication practices (including youth on psychotropic medications). The policy focuses on reducing the likelihood of adverse events and to improve quality of care and beneficiary outcomes.
- The medication monitoring committee is a sub-component of the Quality Improvement Committee (QIC) and meets on a quarterly basis with the medical director, prescribers, and clinical staff in attendance. During the meeting, committee members discuss trends in diagnosis, the use of various psychotropic medications, and the outcomes of chart reviews.
- The MHP did not submit an updated medication monitoring policy and procedure and does not have a system in place to monitor the HEDIS measures outlined in SB 1291. The MHP should improve their knowledge of HEDIS requirements outlined in SB 1291 and incorporate those practices in its medication monitoring policy.

Recommendation 7: Train new staff and provide refresher training for existing staff on the identified Level of Care (LOC) tool used by the MHP and utilization of this data.

(*This recommendation is a carry-over from FY 2018-19 and FY 2019-20*.)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- LOC assignments are reviewed on an individual basis and are defined by clinical discretion. There is no designated LOC tool for clinicians to utilize for transitions, and trainings have not occurred since the last review.
- It would benefit the MHP to research and define a formal LOC process either by choosing a LOC tool or standardized instrument, while also ensuring consistency among clinical staff by providing ongoing training This will assist the MHP to match resource intensity to beneficiary needs. Although the MHP has not chosen a LOC tool, this recommendation will not continue to the next year.

NETWORK ADEQUACY

BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All MHPs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services, for youth and adults. If these standards are not met, DHCS requires the MHP to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews separately and with MHP staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the MHP's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

FINDINGS

For Lake County, the time and distance requirements are 75 minutes and 45 miles 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)[1].

Alternative Access Standards and Out-of-Network Providers

The MHP met all time and distance standards and was not required to submit an AAS request. Further, because the MHP is able to 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.

[1] AB 205 and BHIN 21-023

Planned Improvements to Meet NA Standards

Not Applicable.

MHP Activities in Response to FY 2020-21 AAS

The MHP did not require AAS in FY 2020-21.

PROVIDER NPI AND TAXONOMY CODES

CalEQRO provides the MHP a detailed list of its rendering provider's NPI Type 1 number and associated taxonomy code and description. Individual technical assistance is provided to MHPs to resolve issues which may result in claims denials, when indicated. The data comes from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. The data are linked to the NPPES using the rendering service provider's NPI, Type 1 number. A summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO will be presented in the FY 2021-22 Annual Aggregate Statewide report.

ACCESS TO CARE

BACKGROUND

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. The cornerstone of MHP services must be access, without which beneficiaries are negatively impacted.

CalEQRO uses a number of indicators of access, including the KC and Performance Measures addressed below.

ACCESS IN LAKE COUNTY

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 75 percent of services were delivered by county-operated/staffed clinics and sites, and 25 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 74.2 percent of services provided are 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, SUD 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 meet medical necessity for SMHS, the MHP provides referrals and links the beneficiary to their Medi-Cal managed care plan for services.

The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. When a beneficiary calls the Access Line, a team member (five staff on team) processes the treatment referral, screens for SMHS medical necessity, completes the first portion of the intake assessment, informs the beneficiary of available services, and schedules a second appointment with a clinician to complete the assessment. After the full assessment is completed, the beneficiary is scheduled a third appointment with their assigned clinician, and it is at this appointment that clinical services begin.

In addition to clinic-based mental health services, the MHP provides telehealth, and in-person crisis assessments at the local emergency rooms. Although the MHP does not have a designated mobile crisis unit, crisis workers do respond to crisis events when called out by local law enforcement. Specifically, the MHP delivers psychiatry and/or mental health services via telehealth to youth and adults. In FY 2020-21, the MHP reports having served 610 adult beneficiaries, 299 youth beneficiaries, and 51 older adult beneficiaries across two county-operated sites and seven contractor-operated sites. Among those served, 25 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

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 KC rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 1: Key Components - Access

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 expansion of the access team (including a team lead) and the redesign of the intake process streamlined beneficiary access to services. An EIS team was created to collaborate with the access team to expeditiously triage children who qualify for EIS.
- The MHP follows a continuum of care treatment model that involves a range of treatment options and an integrated system of care. Furthermore, the MHP is a member of the Lake County MHSA Cultural Awareness Committee, a

cross-agency committee that works alongside the QIC workplans, activities, and evaluations to increase services to underserved populations.

- Although the MHP provides timely and efficient initial access to service, key informant feedback suggests capacity issues for the provision of first rendered clinical services after the initial assessment is completed, i.e., lack of staff to provide services.
- Children's services maintain a lengthy triage list wherein the most severe cases are moved to the front of the list. Key informant feedback suggests this process contributes to longer wait times for youth to receive the first rendered clinical service.
- The geographic nature of Lake County creates transportation difficulties for beneficiaries. Communities are dispersed around Clear Lake contributing to longer drive times to the main clinic. To address this barrier, the MHP obtained two vans for transportation and offers bus vouchers to improve beneficiary access to care.

PERFORMANCE MEASURES

In addition to the KC identified above, the following PMs further reflect access to care in the MHP:

- Total beneficiaries served, stratified by race/ethnicity and threshold language.
- Penetration rates, stratified by race/ethnicity and FC status.
- Approved claims per beneficiary (ACB) served, stratified by race/ethnicity and FC status.

Total Beneficiaries Served

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

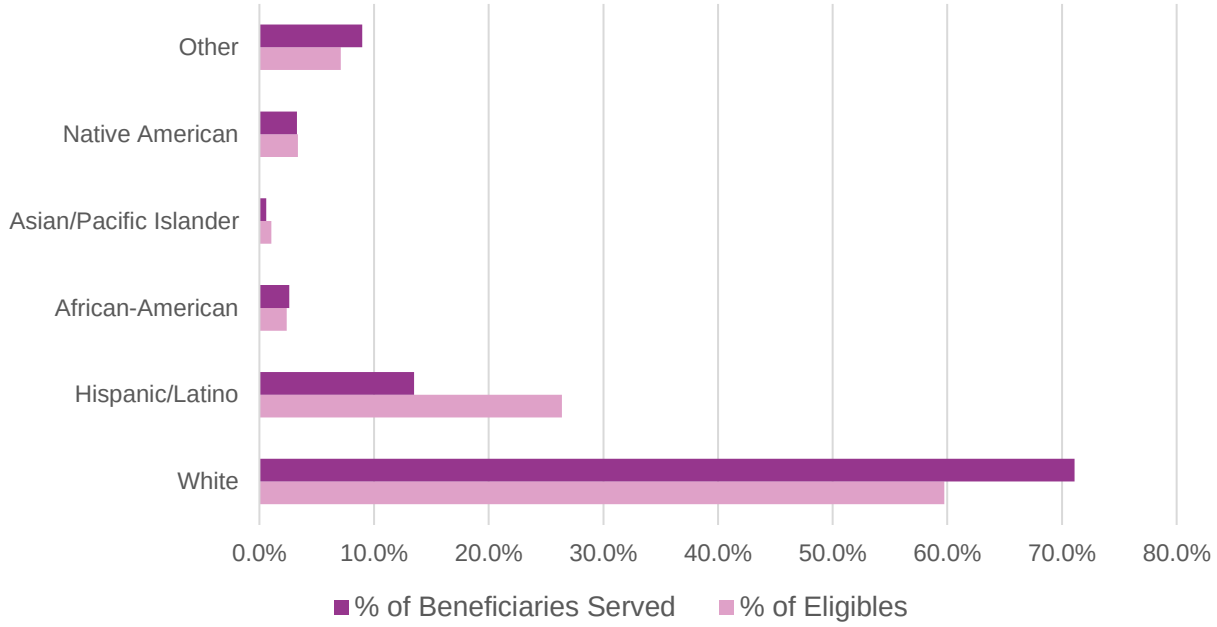
The majority of Medi-Cal eligible beneficiaries in Lake County are White (59.7 percent) as well as the largest percentage of those served (71.1 percent). This reflects fairly proportional service access in relation to the percentage eligible. The Latino/Hispanic population is the next most represented race/ethnicity group in terms of Medi-Cal eligibles and are less likely to be served. This race/ethnicity group is 26.4 percent of Medi-Cal eligibles and 13.5 percent of beneficiaries served. The visual depiction of the proportionality is in Figure 1.

Table 2: County Medi-Cal Eligible Population and Beneficiaries Served by the MHP in CY 2020, by Race/Ethnicity

Lake MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Eligibles**	**Percentage of Average Monthly Unduplicated Medi-Cal Eligibles**	**Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP**	**Annual Percentage of Medi-Cal Beneficiaries Served by the MHP**
White	19,672	59.7%	849	71.1%
Latino/Hispanic	8,694	26.4%	161	13.5%
African-American	786	2.4%	31	2.6%
Asian/Pacific Islander	340	1.0%	*	n/a
Native American	1,110	3.4%	39	3.3%
Other	2,335	7.1%	107	9.0%
Total	**32,937**	**100%**	**1,194**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Eligibles is not a direct sum of the averages above it. The averages are calculated independently.				

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups 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.

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020



The MHP's threshold language is Spanish and comprises 3.3 percent of beneficiaries served.

Table 3: Medi-Cal Beneficiaries Served by the MHP in CY 2020, by Threshold Language

Lake MHP		
Threshold Language	**Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP**	**Percentage of Medi-Cal Beneficiaries Served by the MHP**
Spanish	38	3.3%
Other Languages	1,130	96.7%
Total	**1,168**	**100%**
Threshold language source: Open Data per BHIN 20-070 Other Languages include English		

Penetration Rates and Approved Claim Dollars per Beneficiary Served

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The ACB 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.

CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. See Table D1 for the CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB.

Figures 2 through 9 highlight three-year trends for penetration rates and average approved claims for all beneficiaries served by the MHP as well as the following three populations with historically low penetration rates: FC, Latino/Hispanic, and Asian/Pacific Islander (API) beneficiaries.

The MHP's penetration rate overall has remained stable over the last three years — 3.63 percent in CY 2020. However, it is lower than other small counties and statewide.

The overall ACB reflects an increase from CY 2019 to CY 2020 for all entities. Small counties' total increased by 19.39 percent and statewide increased by 13.28 percent, while the MHP's ACB increased by 4.2 percent. In prior years, the MHP's ACB was below small counties and statewide which was true for CY 2020 as well.

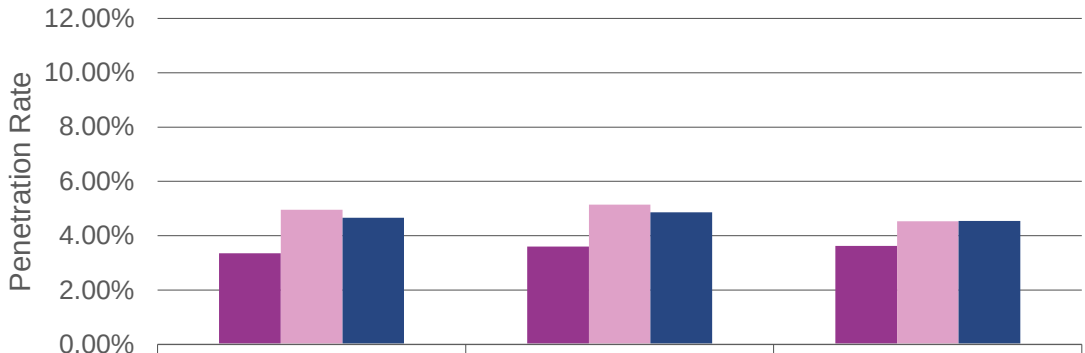
The Latino/Hispanic penetration rate in the MHP went up between CY 2019 and CY 2020, where in small counties and statewide it decreased.

The API penetration rate reflects a small percentage of beneficiaries served for the MHP, given the small number of eligible beneficiaries in this race/ethnicity group for the county.

The penetration rate for FC youth increased for the MHP, as well as for small counties and statewide; however, the MHP rate is lower than both comparison entities. The MHP has a higher ACB for FC youth compared to small counties and statewide which may be a reflection of their success with Therapeutic Foster Care and other supports for this vulnerable population.

Figure 2: Overall Penetration Rates CY 2018-20

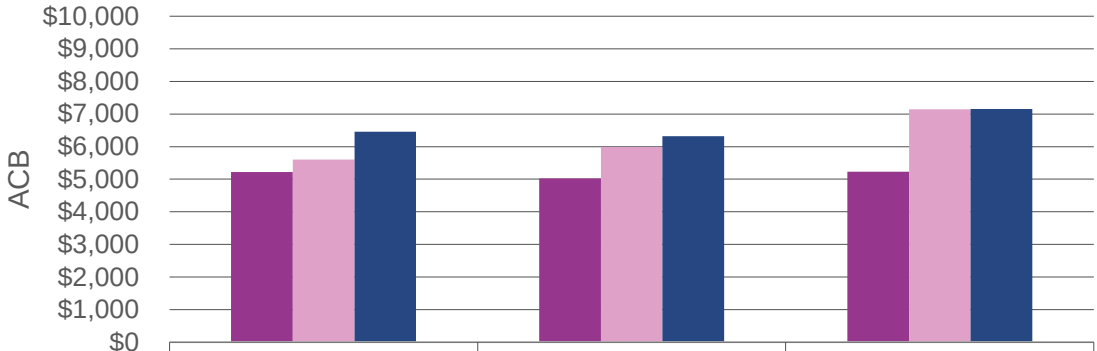
Lake MHP



	CY 2018	CY 2019	CY 2020
MHP	3.35%	3.60%	3.63%
Small	4.96%	5.15%	4.53%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20

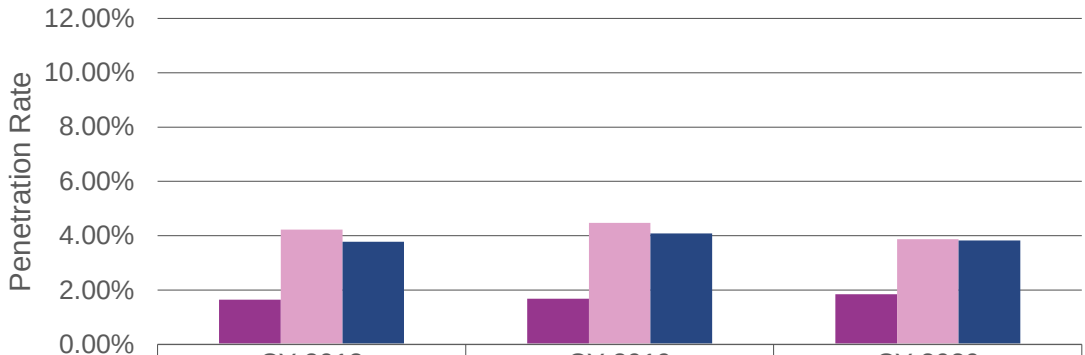
Lake MHP



	CY 2018	CY 2019	CY 2020
MHP	$5,219	$5,021	$5,234
Small	$5,602	$5,982	$7,142
State	$6,454	$6,316	$7,155

Figure 4: Latino/Hispanic Penetration Rates CY 2018-20

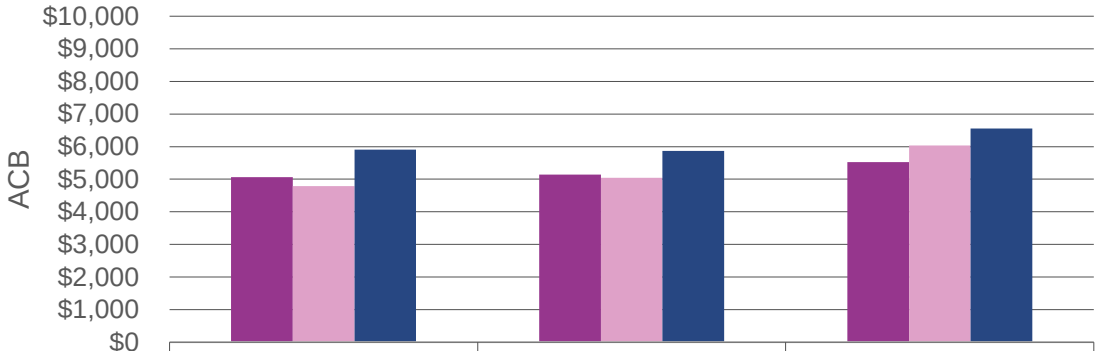
Lake MHP



	CY 2018	CY 2019	CY 2020
MHP	1.65%	1.68%	1.85%
Small	4.23%	4.47%	3.87%
State	3.78%	4.08%	3.83%

Figure 5: Latino/Hispanic ACB CY 2018-20

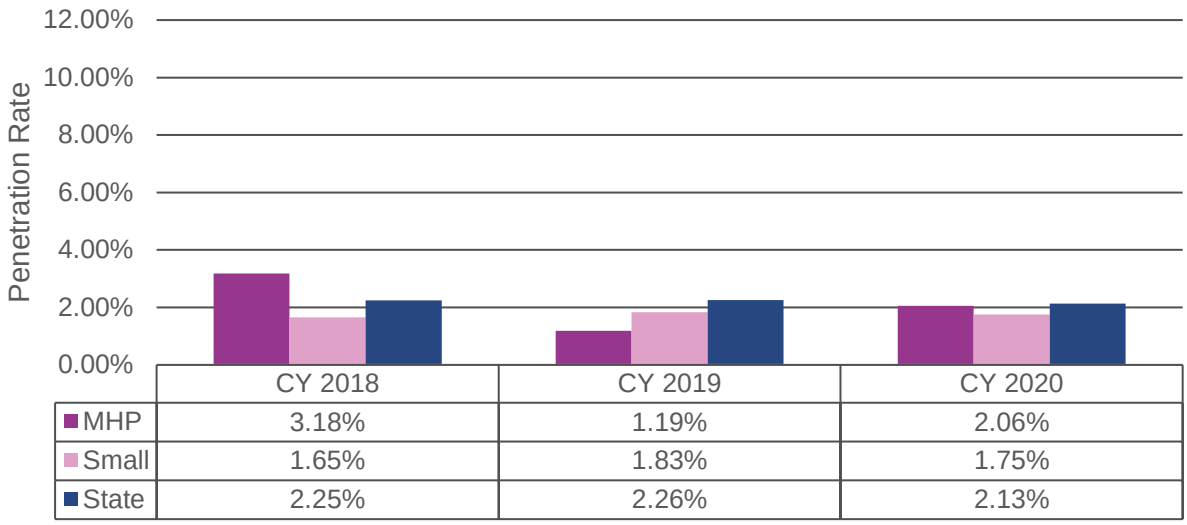
Lake MHP



	CY 2018	CY 2019	CY 2020
MHP	$5,059	$5,146	$5,526
Small	$4,788	$5,040	$6,037
State	$5,904	$5,869	$6,551

Figure 6: Asian/Pacific Islander Penetration Rates CY 2018-20

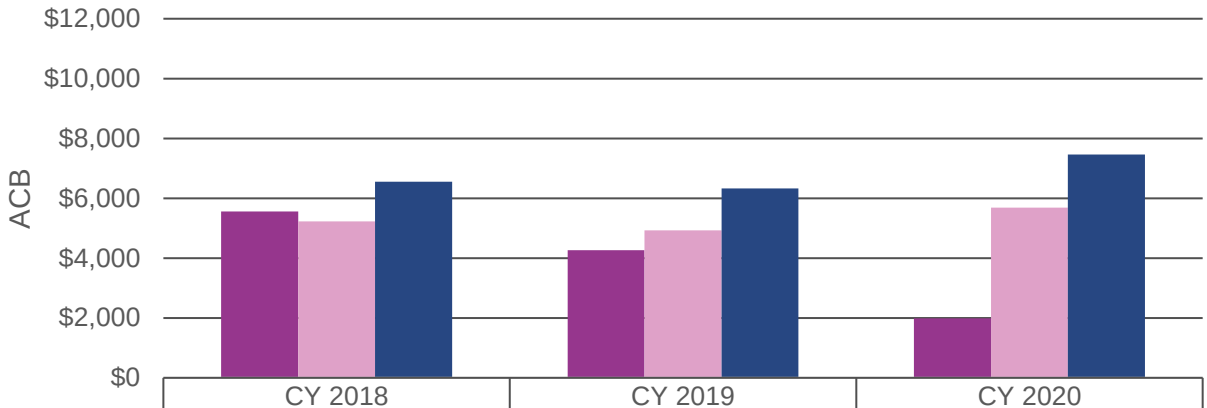
Lake MHP



	CY 2018	CY 2019	CY 2020
MHP	3.18%	1.19%	2.06%
Small	1.65%	1.83%	1.75%
State	2.25%	2.26%	2.13%

Figure 7: Asian/Pacific Islander ACB CY 2018-20

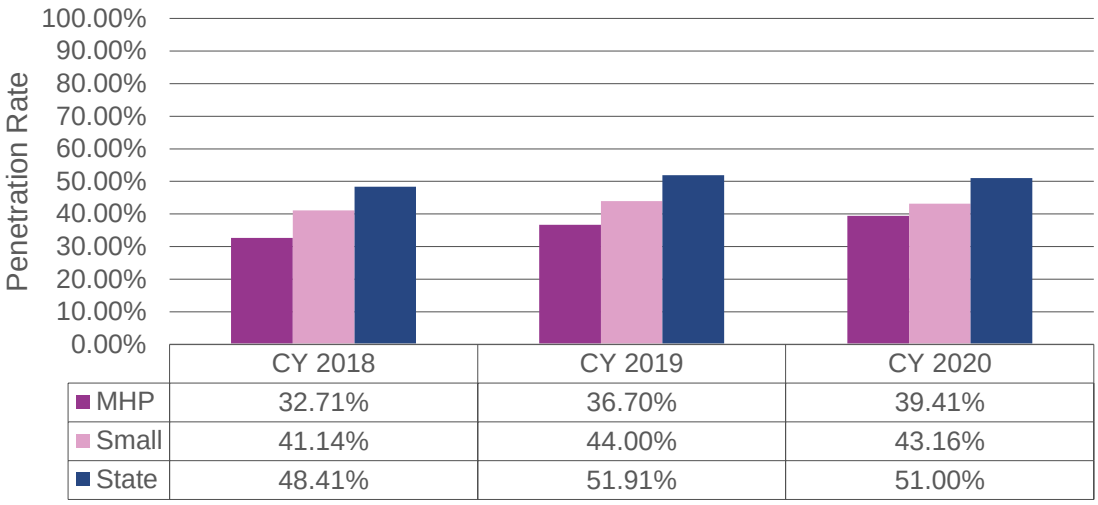
Lake MHP



	CY 2018	CY 2019	CY 2020
MHP	$5,563	$4,260	$1,982
Small	$5,228	$4,925	$5,690
State	$6,557	$6,325	$7,466

Figure 8: FC Penetration Rates CY 2018-20

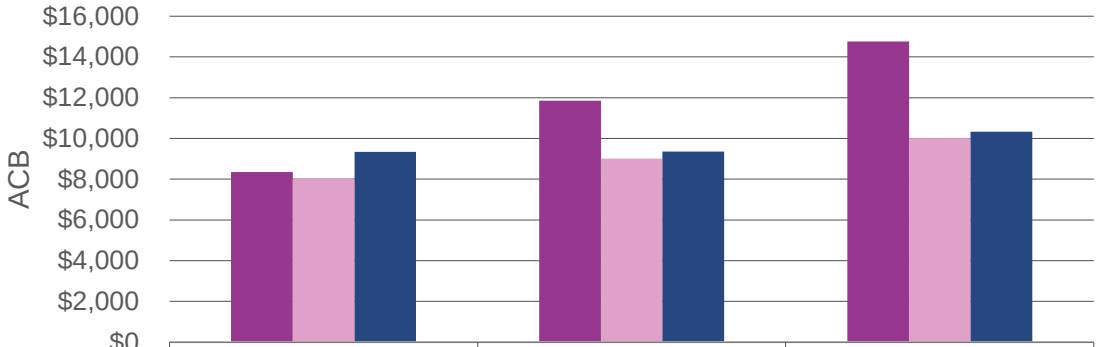
Lake MHP



	CY 2018	CY 2019	CY 2020
MHP	32.71%	36.70%	39.41%
Small	41.14%	44.00%	43.16%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20

Lake MHP



	CY 2018	CY 2019	CY 2020
MHP	$8,356	$11,862	$14,759
Small	$8,033	$9,010	$10,017
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

Penetration rates for the MHP remained stable in CY 2020 compared to CY 2019. Overall, the penetration rate is lower than small counties and statewide, and the ACB is lower as well. The exception to this trend is that the CY 2020 ACB for FC youth is $14,759 compared to $10,338 statewide. The MHP addressed these trends during the review stating FC youth penetration rates may be reflective of restricted staffing resources. At the same time, the MHP maintains a Memorandum of Understanding with Child Welfare Services and convenes weekly collaborative meetings to remove disparities in access to care.

The expansion of the access team (including a team lead) and the redesign of the intake process streamlined beneficiary's access to services. Timely access to care is a key priority in successful treatment and has significant implications for the prevention of mental health and functional outcomes and is an essential aspect to quality of care.

The MHP follows a continuum of care treatment model that involves a range of treatment options and an integrated system of care. Integrated health care services may contribute to improved access to other providers and collaboration, a broader range of supportive services, and improved beneficiary outcomes.

Although the MHP provides timely and efficient initial access to service, key informant feedback suggests capacity issues for the provision of first rendered clinical service. Factors contributing to the delay include a shortage of therapists and case managers, large caseloads, and an increase in crisis calls which take priority in the moment. Longer wait times for clinical services may impact beneficiary engagement and correlate to poorer functional outcomes.

Children's services maintain a lengthy triage list wherein the most severe cases are moved to the front of the treatment line. Feedback during the review reflects the triage list and lack of therapists are contributing to longer wait times for youth with moderate SMHS for first rendered clinical service. Longer wait times for youth may result in functional decompensation and escalation to a crisis.

TIMELINESS OF CARE

BACKGROUND

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 likely the delay will result in not following through on keeping 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 the 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. CalEQRO uses a number of indicators for tracking and trending timeliness, including the KC and Performance Measures addressed below.

TIMELINESS IN LAKE COUNTY

The MHP reported timeliness data stratified by age but not by FC status. Further, timeliness data presented to CalEQRO represented county-operated services only. Services for FC youth are provided by contracted providers, and the MHP reports the current EHR is not able to track FC timeliness measures. Contract providers are required to track timeliness metrics and maintain an access log that is shared securely with the MHP; however, the MHP stated the contract providers need additional training on this procedure. The differences in timeliness tracking and reporting creates issues reporting FC youth metrics.

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 KC ratings, and the performance for each measure is addressed in the Performance Measures section.

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

Table 4: Key Components – Timeliness

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Partially Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	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 MHP's submitted data suggests they can respond to an urgent request in under an hour; however, it would be difficult to determine the accuracy of this data as the MHP does not have a formal definition for urgent appointments.
- On average, the MHP can follow-up with beneficiaries recently discharged from an inpatient hospitalization within 4.67 days.
- The MHP tracks timeliness metrics in the access log, although the information is not always logged and may be incomplete due to work demands. The MHP's access log does not track FC timeliness metrics, and contract providers maintain their own access logs.
- The MHP can offer a first intake appointment within 5.56 business days on average, and the MHP met the 10-day standard 93 percent of time. Key informant feedback suggests the initial access process is fast, although beneficiaries experience longer wait times for the first rendered clinical appointment.
- The average time from first request to first offered psychiatry appointment is 5.56 business days. At the same time, the average wait time for first rendered psychiatry appointment is 21.03 business days for all age groups and increases to 29.38 business days for children (range of two business days to 162 business days).
- The FY 2021-22 average adult no-show rate for psychiatry is 27 percent. Key informant feedback reflects that appointment reminders and follow-up calls do not occur due to lack of staffing resources.

PERFORMANCE MEASURES

Through BHINs 20-012 and 21-023, DHCS set required timeliness metrics to which MHPs must adhere for initial offered appointments for non-urgent SMHS, non-urgent psychiatry, and urgent care. 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. Additionally, utilizing approved claims data, CalEQRO analyzes MHP performance on psychiatric inpatient readmission and follow up after inpatient discharge.

The following PMs reflect the MHP's performance on these and additional timeliness measures consistent with statewide and national quality standards, including HEDIS measures:

- First Non-Urgent Appointment Offered
- First Non-Urgent Service Rendered
- First Non-Urgent Psychiatry Appointment Offered
- First Non-Urgent Psychiatry Service Rendered
- Urgent Services Offered – Prior Authorization not Required
- Urgent Services Offered – Prior Authorization Required
- No-Shows – Psychiatry
- No-Shows – Clinicians
- Psychiatric Inpatient Hospital 7-Day and 30-Day Readmission Rates
- Post-Psychiatric Inpatient Hospital Discharge 7-Day and 30-Day SMHS Follow-Up Service Rates

MHP-Reported Data

For the FY 2021-22 EQR, the MHP reported its performance for FY 2020-21 as follows:

- Average wait time is 5.56 days from initial service request to first non-urgent psychiatry appointment offered; the MHP measures this metric from the point of initial beneficiary request.
- Average wait time is 0.94 hours from initial service request to first urgent appointment offered for services that do not require prior authorization; these appointments include outpatient mental health and psychiatry services.
- Adult services experience higher no-show rates for psychiatrists (27.1 percent) and clinicians (18.4 percent) when compared to children's services (7.2 percent for psychiatry and 8.3 percent for clinicians).

Table 5: FY 2021-22 MHP Assessment of Timely Access

FY 2021-22 MHP Assessment of Timely Access			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5.56 Days	10 Business Days*	92.99%
First Non-Urgent Service Rendered	16.98 Days	10 Business Days**	24.02%
First Non-Urgent Psychiatry Appointment Offered	5.56 Days	15 Business Days*	93.13%
First Non-Urgent Psychiatry Service Rendered	21.03 Days	10 Business Days**	45.80%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0.94 Hours	48 Hours*	100.0%
Urgent Services Offered – Prior Authorization Required	***	96 Hours*	n/a
Follow-Up Appointments after Psychiatric Hospitalization	4.67 Days	7 Business Days*	65.8%
No-Show Rate – Psychiatry	18.7%	20%**	n/a
No-Show Rate – Clinicians	15.8%	20%**	n/a
* DHCS-defined timeliness standards as per BHIN 20-012 ** MHP-defined timeliness standards *** MHP does not separately track urgent services offered based on authorization requirements; all urgent services are held to a 48-hour standard.			
For the FY 2021-22 EQR, the MHP reported its performance for the following time period: FY 2020-21			

Medi-Cal Claims Data

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 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 mental health professionals is critically important.

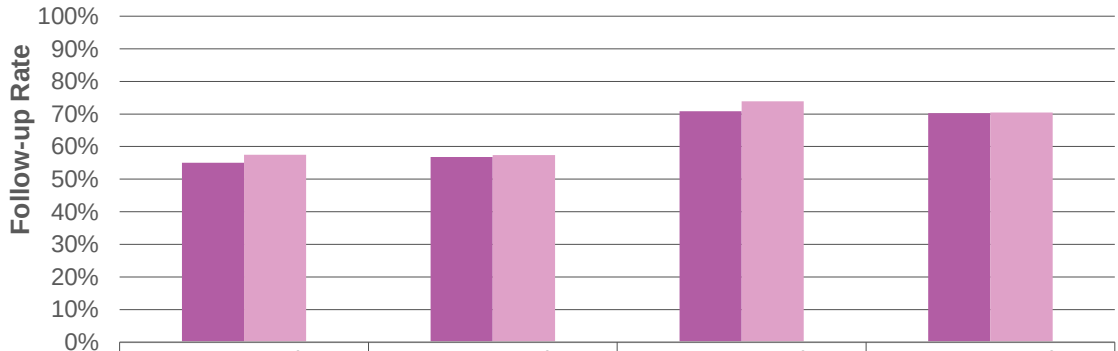
Follow-up post hospital discharge

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 MHP's 7-day post-psychiatric inpatient follow-up stayed stable between CY 2019 and CY 2020 (55 percent and 57 percent). The 30-day follow-up increased slightly from 71 percent to 74 percent.

Figure 10: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-20

Lake MHP



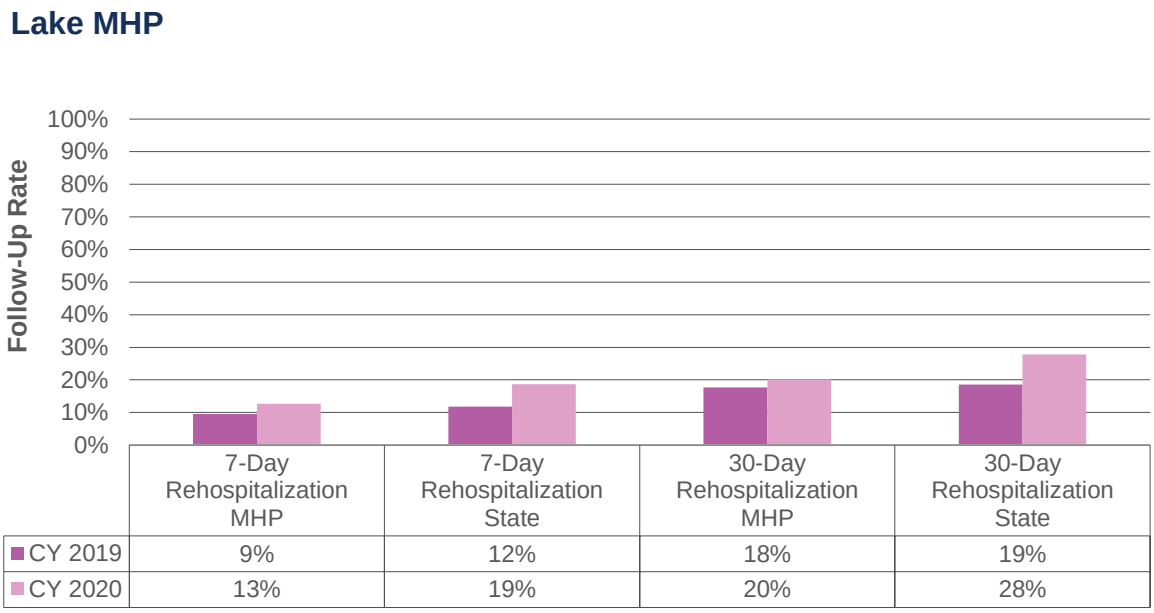
	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	55%	57%	71%	70%
CY 2020	57%	57%	74%	70%

Readmission rates

The 7 and 30-day rehospitalization rates (HEDIS measures) are important proximate indicators of beneficiary outcomes.

The 7 and 30-day rehospitalization rates for the MHP increased from CY 2019 to CY 2020. Specifically, the 7-day rehospitalization rate for CY 2020 is equal to the statewide average, and the 30-day rehospitalization rate for CY 2020 is slightly higher than the statewide average.

Figure 11: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-20



IMPACT OF FINDINGS

Follow-up post hospitalization was fairly stable for the MHP over a two-year period while rehospitalizations went up, particularly the 7-day rehospitalization rate (9 percent to 13 percent). While still lower than the statewide 7-day rehospitalization rate of 19 percent, it may be an area for the MHP to explore through QI efforts.

The MHP is taking steps to improve initial access to services such as growing the access team and streamlining the intake process. Although the MHP can respond quickly to urgent requests, key informant feedback reflects a noticeable increase in crisis events which may be exacerbated by longer wait times to first rendered service. It would benefit the MHP to explore the potential correlation between longer wait times to first rendered service to the increase in 7-day and 30-day rehospitalization rates from CY 2019 to CY 2020 trends.

Feedback also suggests the children's triage list, and a therapist shortage, are creating longer wait times for youth diagnosed with moderate SMHS. On occasion, this results in beneficiaries accessing crisis services at the local emergency room.

It would be important for the MHP to investigate the correlation between the high psychiatry adult no-show rate and long wait times for first rendered psychiatry service. Although tracking and trending no-show rates are not required by regulation, it can assist the MHP with information that potentially impacts the quality of care and beneficiary outcomes.

QUALITY OF CARE

BACKGROUND

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.
- Intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive Quality Assessment and Performance Improvement (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 LAKE COUNTY

The MHP has a designated quality management (QM) structure that guides and tracks system issues and QI initiatives. The QM staff are fully integrated with the leadership team and reports 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.

Traditionally, the MHP holds quarterly QAPI meetings with attendees from the QIC and compliance team; however, the impacts of COVID-19 and staffing shortages have created obstacles for the QIC to convene as planned. The QIC meetings provide the venue to discuss actionable items, policies procedures, and system-level changes

There are three QIC sub-committees which are the cultural competence committee, the medication monitoring committee, and the special incident sub-committee. The meeting covers topics related to compliance, QI goals, activities, and progress toward those goals. The MHP Compliance Program Committee ensures that Medi-Cal services are billed appropriately and in compliance with all state and federal regulations.

The MHP utilizes the following outcomes tools: Milestones of Recovery Scale (MORS), Pediatric Symptom Checklist, Child and Adolescent Needs and Strengths – 50 (CANS-50), Generalized Anxiety Disorder – 7, Patient Health Questionnaire, psychosis screening questionnaire, mood disorder questionnaire, and the Adverse Childhood Experience questionnaire.

The MHP utilizes the following LOC tools: LOC assignments are reviewed on an individual basis and are defined by clinical discretion. Utilization review and compliance staff monitor clinical assignments; however, there is no standardized protocol, procedure, and designated LOC tool set in place regarding beneficiary transitions**.**

The MHP has a total of five community peer support centers: the Big Oak Peer Support Center, Circle of Native Minds Cultural Center, La Voz de la Esperanza Centro Latino, the Family Support Center, and Harbor on Main. The wellness centers provide community-wide outreach and are open to the public. The MHP has fully embraced the concept of supporting wellness and recovery as demonstrated by supporting various populations such as TAY, older adults, Spanish speaking, and Native American individuals. Currently, one peer support specialist is stationed at the Big Oak wellness center, and three peers are working at the La Voz wellness center. The five wellness centers are coordinated access points for emergency housing vouchers provided by LCCOC in collaboration with the public housing authority. More peer-supported services have been offered this past FY such as wellness center access to probation check-in services, transportation enhancements, outreach and provision of essentials to unhoused individuals, increased operating hours at warming stations, and collaboration with community partners, e.g., local church.

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 KC 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 KC rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 6: Key Components – Quality

KC #	Key Components - Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Partially Met
3B	Data is Used to Inform Management and Guide Decisions	Not Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Not Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not 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 MHP is the lead for the LCCOC multi-agency program that connects housing-insecure individuals with emergency housing and provides linkage to a wide range of integrated services.
- The MHP has a robust wellness center program and employs peers throughout the system. There does not appear to be a career leader specifically for peers, although peers with historical knowledge do provide support to their colleagues.
- Key informant feedback indicates that QM and administration are receptive to QI suggestions, although the resources are not always available to ensure successful achievement of those activities. Feedback also suggests the need for more standardization and training in policies and procedures, e.g., access procedure, LOC transitions, and job roles and responsibilities.
- The MHP provides a full spectrum of services to include behavioral health promotion, prevention, treatment, and recovery. At the same time, the MHP's EHR technology does not easily allow data extraction, e.g., aggregate outcomes reporting, to guide and evaluate QI activities.
- The MHP administers the Consumer Perception Survey (CPS) as required by DHCS. The MHP did not submit documentation to support comparison of

previous CPS results to current surveys. Clinical line staff reported they were unaware of the CPS and its function, as well as the results of the surveys. The MHP had not addressed this issue at the time of the review.

- The MHP is operating from the FY 2020-21 work plan and FY 2019-20 evaluation of QI activities. The MHP does not have a current (FY 2021-22) QAPI work plan or an annual evaluation of the effectiveness of QI activities for FY 2020-21.
- The MHP does have a medication monitoring system in place to track, trend, and use medication data for performance improvement activities, although it does not include HEDIS measures outlined in SB 1291. The MHP had not addressed this issue at the time of the review.
- The MHP does not track and trend the following HEDIS measures as required by SB 1291:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD)
    - The use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC)
    - Metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)
    - The use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)

PERFORMANCE MEASURES

In addition to the KC identified above, the following PMs further reflect the Quality of Care in the MHP:

- Beneficiaries Served by Diagnostic Category
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay (LOS)
- Retention Rates
- High-Cost Beneficiaries (HCB)

Diagnosis Data

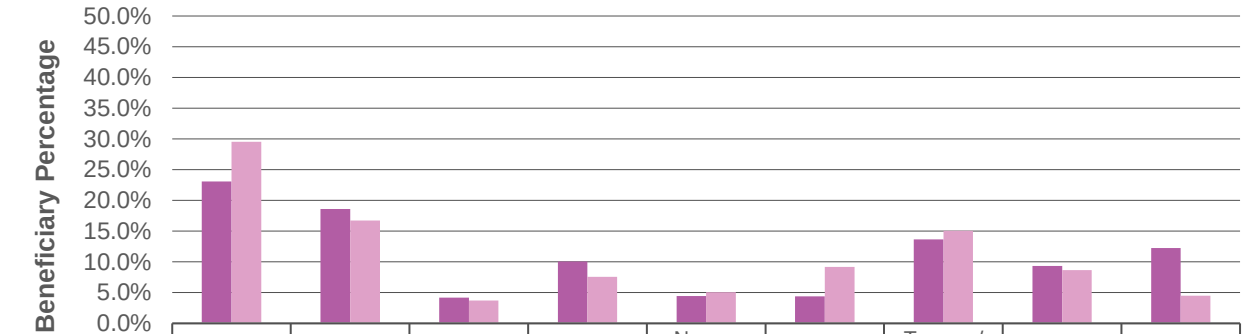
Figures 12 and 13 compare the percentage of beneficiaries served and the total approved claims by major diagnostic categories, as seen at the MHP and statewide for CY 2020.

Diagnostic patterns for the MHP differ from statewide trends for depression and deferred diagnoses. Depressive disorders are lower in the MHP compared to statewide (23.1 percent compared to 29.5 percent) while the deferred category is higher in the

MHP (12.2 percent compared to 4.5 percent). This may reflect an opportunity for additional clinical supervision for new trainees when needing supervisor approval to formulate a diagnosis.

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020

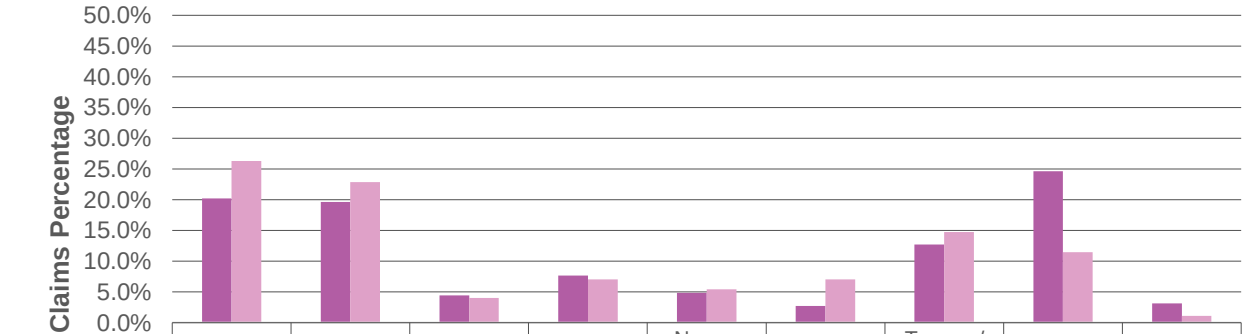
Lake MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	23.1%	18.6%	4.2%	10.1%	4.4%	4.4%	13.7%	9.3%	12.2%
State CY 2020	29.5%	16.7%	3.7%	7.5%	5.1%	9.2%	15.1%	8.6%	4.5%

Figure 13: Diagnostic Categories by Percentage of Approved Claims CY 2020

Lake MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	20.2%	19.6%	4.4%	7.7%	4.8%	2.7%	12.7%	24.7%	3.1%
State CY 2020	26.3%	22.9%	4.0%	7.1%	5.4%	7.0%	14.8%	11.5%	1.1%

Psychiatric Inpatient Services

Table 7 provides a three-year summary (CY 2018-20) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

The MHP's psychiatric inpatient utilization statistics all decreased in CY 2020, with the exception being the average LOS, which went up 6.8 percent. The MHP average LOS is slightly higher than the statewide number, as is the MHP ACB.

Table 7: Psychiatric Inpatient Utilization CY 2018-20

Lake MHP							
Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2020	119	183	12.17	8.68	$16,707	$11,814	$1,988,099
CY 2019	137	220	11.34	7.80	$14,466	$10,535	$1,981,827
CY 2018	103	135	10.91	7.63	$17,277	$9,772	$1,779,574

High-Cost Beneficiaries

Table 8 provides a three-year summary (CY 2018-20) of HCB trends for the MHP and compares the MHP's CY 2020 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Tracking the HCBs provides another indicator of quality of care. High cost of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than the rest of the beneficiaries receiving SMHS. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

The HCB count decreased slightly for the MHP and represented 2.6 percent of all beneficiaries, lower than the statewide rate of 4.07 percent. The HCB percentage of total claims was just over a third, similar to the statewide percentage.

Table 8: HCB CY 2018-20

Lake MHP							
	Year	HCB Count	Total Beneficiary County	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
MHP	CY 2020	31	1,194	2.60%	$63,703	$1,974,808	31.60%
	CY 2019	36	1,183	3.04%	$48,576	$1,748,752	29.44%
	CY 2018	43	1,142	3.77%	$49,577	$2,131,814	35.77%

See Attachment D, Table D2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Retention Data

The MHP continues to have a significantly higher percentage of beneficiaries with only one service. The MHP's percent of beneficiaries with one service at 16.25 percent is higher than the statewide average of 9.76 percent.

Table 9: Retention of Medi-Cal Beneficiaries CY 2020

	Lake			STATEWIDE			
Number of Services Approved per Beneficiary Served	**# of beneficiaries**	**%**	**Cumulative %**	**%**	**Cumulative %**	**Minimum %**	**Maximum %**
1 Service	194	16.25	16.25	9.76	9.76	5.69	21.86
2 Services	110	9.21	25.46	6.16	15.91	4.39	17.07
3 Services	90	7.54	33.00	4.78	20.69	2.44	9.17
4 Services	53	4.44	37.44	4.50	25.19	2.44	7.78
5-15 Services	341	28.56	66.00	29.47	54.67	19.96	42.46
>15 Services	406	34.00	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

Over a third (33.0 percent) of beneficiaries in the MHP have three or fewer approved services, more than the statewide cumulative percentage of 20.69 percent. There may be opportunities to identify strategies for engagement for those beneficiaries who are

more likely to drop out of services after only three or fewer services. Furthermore, the MHP would benefit from researching the possible connection between treatment disengagement and long wait times for the first rendered clinical and psychiatry services.

Inpatient admissions went down in CY 2020 compared to CY 2019 which could be an artifact of the COVID-19 crisis but is worth examining recent trends to see whether there are any access issues for beneficiaries needing hospitalization. At the same time, the MHP should investigate the barriers to a successful continuous quality improvement (CQI) approach by improving the reporting and monitoring of services.

The MHP operates a robust wellness center program with assistance from peer specialists which is reflected in the CFM focus groups. The MHP leads the LCCOC to connect individuals with emergency housing and various integrated services.

Although executive management, QI staff, and direct clinical line supervisors are receptive to QI suggestions from line staff, the needed staff and resources are not available to fully execute the ideas. Embracing a CQI approach creates efficiencies that address the needs of the beneficiary, and without sufficient time and resources, it may be difficult for leadership to undertake initiatives.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

All MHPs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's quality assessment and performance improvement 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. The submitted clinical PIP is not considered active, and the MHP did not submit an active non-clinical PIP.

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 Appendix 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: "Use of MI in Discharge Planning from Long Term Psychiatric Placement to the Community."

Date Started: The original PIP topic began in July 2019. The MHP modified the planned interventions and began a similar concept only clinical PIP in July 2021.

Aim Statement: "Will the use of a survey and MI techniques to enroll and engage consumers in mental health services reflect a noticeable reduction in the median number of days (28) beneficiaries spent in placement?"

Target Population: Beneficiaries placed in an out-of-county placement that are planning to discharge and are 18 years older and older.

[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

Validation Information: The MHP's clinical PIP is in the planning phase and is not considered active as the MHP did not provide baseline or first remeasurement data. Furthermore, the submitted clinical PIP is very similar to the concept only PIP submitted during the FY 2020-21 EQR. The only major difference in this PIP submission from the previous submission is a hospital discharge planning team will not be formed.

Summary

The MHP began the initial clinical PIP in July 2019 and was rated concept only. The goal was to reduce beneficiary rehospitalization rates and increase the LOS in community placements by using an expanded discharge planning process. The MHP planned to create a dedicated discharge team to provide mental health services to beneficiaries up to 90 days post discharge. The MHP experienced large staff turnover, difficulties implementing PIP interventions, lack of coordination with managed care team, administrative issues, and lack of data collection. The MHP ended the original concept only PIP and pivoted in December 2020 to the current study. The PIP plans to use MI with beneficiaries' post hospitalization discharge to reduce rehospitalizations and increase the LOS in the community. The planned interventions were set to begin in March 2021, although it is unclear whether the interventions began as the MHP did not present baseline or first remeasurement data.

TA and Recommendations

As submitted, this clinical PIP was found to have no confidence, because the baseline and first remeasurement data was not provided, and the PIP has been concept-only since July 2019.

The TA provided to the MHP by CalEQRO consisted of:

- Discussed barriers such as staffing shortages and lack of resources, and the development of solutions that will help the MHP implement an active PIP.

CalEQRO recommendations for improvement of this clinical PIP include:

- Limit and maintain the scope of the PIP so that staff and resources will not be overburdened. This may help the MHP to improve the ability to successfully launch the PIP.
- The MHP may benefit from discussing the pros and cons of continuing this clinical PIP as the MHP has not been successful in launching the PIP since 2019.
- Participate in frequent and on-going PIP TA from CalEQRO.

NON-CLINICAL PIP

General Information

The MHP submitted a previous year's PIP that ended in February 2021 (last data collection point); therefore, the MHP did not present an active non-clinical PIP at the time of this review.

Recommendations

CalEQRO recommendations for improvement of this non-clinical PIP include:

- Participate in frequent and on-going PIP TA from CalEQRO.
- Designate a change agent to oversee the next non-clinical PIP.
- Create a PIP team reflective of analytical, quality, and clinical staff, and develop a study timeline.
- Maintain a consistent PIP team meeting schedule to stay on the PIP timeline.

INFORMATION SYSTEMS (IS)

BACKGROUND

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

IS IN LAKE COUNTY

The primary EHR system used by the MHP is Cerner Community Behavioral Health/Anasazi, which has been in use for 13 years. Currently, the MHP is actively searching for a new system and has joined CalMHSA's multi-county effort to obtain an EHR that can be customized to meet the specific needs of county behavioral health departments.

Approximately 1.93 percent of the MHP's budget is dedicated to support the IS (County IT overhead for operations, hardware, network, software licenses, application service provider (ASP) support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control.

The MHP has 95 named users with log-on authority to the EHR, including approximately 60 county-operated staff and 35 contractor-operated staff. User support is provided by two full-time equivalent (FTE) IS technology positions. Currently, there are two unfilled FTEs within the IS department.

As of the FY 2021-22 EQR, several of the contract providers have access to directly enter clinical data into the MHP's EHR. No provider uses the EHR as their only beneficiary record. Line staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 10: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
☐	Electronic Data Interchange (EDI) 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	20%
☒	Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	50%
☒	Paper documents delivered to MHP IS	☐ Daily ☒ Weekly ☐ Monthly	30%
			100%

Beneficiary Personal Health Record

The 21st Century Cures Act (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 PHR enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not currently have a PHR. It is anticipated the new system will have PHR capability, which is an important EHR specification that CalMHSA is able to require on behalf of the counties who have joined the effort.

Interoperability Support

The MHP is not a member or participant in a Health Information Exchange (HIE). Healthcare professional staff use secure information exchange directly with service partners through secure email, fax, and United States Postal Service. The MHP engages in electronic exchange of information with mental health contract providers.

IS KEY COMPONENTS

CalEQRO identifies the following KC 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 KC is comprised of individual subcomponents which are collectively evaluated to determine an overall KC rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.

Table 11: Key Components – IS Infrastructure

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

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

- Medi-Cal claims are billed consistently and there are processes in place to void and replace denied claims.
- The MHP would benefit from formalizing a data integrity validation process, so data is complete and accurate. There are some efforts currently in place around auditing billing for telehealth and psychiatry telehealth, but expanding and formalizing efforts would be beneficial.
- The EHR does not have the following functionality: laboratory orders, LOC/level of service, outcomes, and referral management. The MHP has joined CalMHSA's efforts to secure an EHR that is customized to county behavioral health departments, which will likely include functionality in these areas.
- While the MHP has an operations continuity plan, it is not currently tested annually.
- The MHP augmented their contract with Kings View to increase the number of data analytic dashboards produced. The dashboards will include staff productivity, beneficiary outcomes, claims by payor source, and aggregate CANS-50 data.

IMPACT OF FINDINGS

The MHP is active in its collaboration with CalMSHA to identify and implement a new EHR. In the meantime, the MHP works with Kings View and County IT to support Anasazi. The MHP also works with Kings View to develop dashboards for tracking productivity and outcomes.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

BACKGROUND

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CONSUMER PERCEPTION SURVEYS

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

The MHP 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 and its results.

CONSUMER FAMILY MEMBER FOCUS GROUP

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 six to eight participants each.

Consumer Family Member Focus Group One

CalEQRO requested a culturally diverse group of six to eight adult beneficiaries who are mostly new beneficiaries that have initiated/utilized services within the past 12 months. The focus group was held via video conference and included seven participants; a Spanish interpreter was used for this focus group. All consumers participating receive clinical services from the MHP.

Generally, participants feel comfortable with the MHP and report that staff are honest and reliable. The wellness centers, case managers, and peer specialists have been a major source of comfort for the participants; beneficiaries receive food, a safe and warm environment, assistance with federal and state benefit applications and housing

resources, socialization, and use of phones. Participants appreciate the accessibility of resources and information offered at the wellness centers. Several focus group members learned of the services offered at the MHP via social media, word of mouth, peer specialists, and brochures at the wellness centers. Spanish speaking participants received help from translators during clinical and medication appointments, to include advocating on behalf of the beneficiary regarding treatment and provider recommendations.

Wait times for appointments varied depending on the type of appointment, and MHP follow-up after missed appointments was mixed, i.e., some received calls and others did not. Most participants did not have a phone and must use the phones at the wellness centers when they needed to contact their case manager. Difficulties with reliable transportation was a global theme in the group; however, some participants were able to walk from their homes to the wellness centers, and others had a 15-to-20-minute bus ride. Furthermore, roundtrip transportation was very difficult to obtain after a group meeting has ended, and participants stated they would attend more wellness center events with secured transportation.

When asked during the review, many group members were interested in participating in MHP committees and involvement in system planning; however, they were unaware of any committees at the MHP or how to become involved. One beneficiary reported they completed the initial intake assessment the previous week but did not have an assigned case manager, and a second participant reported frustration with not receiving returned phone calls from their assigned case manager.

Recommendations from focus group participants included:

- Assist beneficiaries with obtaining roundtrip transportation, especially after late group meetings.
- Ensure timely communication with assigned case workers.

IMPACT OF FINDINGS

Beneficiaries feel supported by the support offered at the MHP's wellness centers and have an overall positive experience with the MHP. Several concerns were raised about roundtrip transportation to wellness centers. Spanish translators and peer specialists are readily available, and an important part of the treatment process. Communication with case managers and follow-up calls for missed appointments was identified as an opportunity for improvement.

CONCLUSIONS

During the FY-2021-22 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 expansion of the access team (including a team lead) and the redesign of the intake process streamlined beneficiary access to services.

   (Access)

2. The MHP offers an initial intake appointment within 5.56 business days.

   (Access, Timeliness)

3. The average follow-up time post hospitalization discharge is 4.67 days.

   (Timeliness)

4. The MHP operates a robust wellness center program and beneficiaries report the centers and peer specialists are a large component of their recovery.

   (Quality)

5. The MHP joined the CalMHSA multi-county EHR project.

   (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Lack of clinical staffing and resources contributes to a children's triage list creating long wait times for the first rendered clinical service. Prolonging treatment can negatively impact beneficiary outcomes.

   (Access)

2. The MHP did not submit a clinical or non-clinical PIP.

   (Quality)

3. The MHP lacks sufficient staff and resources to initiate and complete ongoing QI activities.

   (Quality)

4. Local budgetary constraints, lack of bi-directional communication, staffing shortages and lack of resources is contributing to high caseloads, staff burnout, and high staff turnover rates.

(Quality)

5. The MHP does not track and trend HEDIS measures as required by SB 1291; without standard practices of care regarding SB 1291 requirements, it will be difficult for the MHP to analyze clinical methodologies applied to therapeutic treatment integrated with psychotropic medication use and management.

   (Quality)

RECOMMENDATIONS

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

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

   (*This recommendation is a follow-up from FY 2020-21*)

   (Access)

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)*

   (Quality)

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

   (Quality)

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 expands on recommendations from FY 2019-20 and FY 2020-21*)

   (Quality)

5. Investigate best practices and implement a medication monitoring system that includes the monitoring of HEDIS measures outlined in SB 1291.

   (*This recommendation is a follow-up from FY 2018-19, FY 2019-20, and FY 2020-21*)

   (Quality)

REVIEW BARRIERS

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

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site EQR of the MHP. Consequently, some areas of the review were limited.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: Clinical PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: REVIEW AGENDA

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

Table A1: EQRO 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 Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
QM, QI and System-Wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
CFM Focus Group(s)
Peer Employees Group Interview
Peer Inclusion/Peer Employees within the System of Care
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
IS Billing and Fiscal Interview
ISCA
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Angela Kozak-Embrey, Quality Reviewer

Melissa Martin-Mollard, IS Reviewer

Marilyn Hillerman, CFM Consultant

Katie Faires, CFM Consultant

David Czarnecki, CFM Consultant

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Abbott	Scott	Behavioral Health Program Manager (MHSA)	Lake County Behavioral Health Services (LCBHS)
Ables	David	Mental Health Peer Support Specialist	LCBHS
Andrus	Christine	Behavioral Health Fiscal Manager	LCBHS
Brown	Thomas	Native American Cultural Specialist	LCBHS
Chalmers	Robert	Staff Services Analyst (Compliance/QI)	LCBHS
Giambra	April	Substance Abuse Program Manager	LCBHS
Gray	Julia	Mental Health Case Manager	LCBHS
Grogg	Laurie	Mental Health Team Leader	LCBHS
Harding	Debra	Mental Health Case Manager	LCBHS
Hunter	Morgan	Business Software Analyst	LCBHS
Isherwood	James	Deputy Director (Clinical)	LCBHS
Jones	Elise	Deputy Director (Administration)	LCBHS
Lamkin	Michelle	Staff Services Specialist	LCBHS
Manning	Carrie	Mental Health Team Leader	LCBHS
Mayer	Vanessa	Staff Services Analyst, Senior (QI Coordinator)	LCBHS
McAtee	Danny	Staff Services Analyst (Administration)	LCBHS
Metcalf	Todd	Director	LCBHS
Neria	Zabdy	Mental Health Specialist	LCBHS
Norton	Linda	Mental Health Case Manager	LCBHS
Ontiveros	Edgar	Mental Health Cultural Specialist - Latino	LCBHS
Packs	Montinque	Staff Services Analyst (Compliance/QI)	LCBHS
Poplin	Melissa	Staff Services Analyst (Compliance/QI)	LCBHS
Powers	Lilia	Mental Health Case Manager	LCBHS
Shute	Jeffrey	Business Software Analyst	LCBHS
Singh	Hardeep	Medical Director	LCBHS
Thomas	Jayme	Mental Health Case Manager	LCBHS
Trillo	Jamilyn	Mental Health Specialist Senior	LCBHS
Wilson	Stephanie	Compliance Manager	LCBHS

ATTACHMENT C: CLINICAL 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	As submitted, this clinical PIP was found to have no confidence because the baseline and first remeasurement data were not provided, and the PIP has been a concept only since July 2019.

General PIP Information
Mental Health MHP System Name: LCBHS
PIP Title: "Use of MI in Discharge Planning from Long Term Psychiatric Placement to the Community."
PIP Aim Statement: "Will the use of a survey and MI techniques to enroll and engage consumers in mental health services reflect a noticeable reduction in the median number of days (28) beneficiaries spent in placement?"
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Beneficiaries placed in an out-of-county placement that are planning to discharge and are 18 and older.

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) The MHP will engage and outreach to adults, aged 18 and older, who are in an out-of-county psychiatric placement.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Use of MI with beneficiaries, before and after out-of-county psychiatric placement. Use of quality-of-life survey with beneficiaries, before and after out-of-county psychiatric placement.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) None

Performance measures (be specific and indicate measure steward and NQF 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
LOS in community post hospitalization discharge	None	None	☒ Not applicable—PIP is in Planning or implementation phase, results not available	None	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): not completed
MORS score	None	None	☒ Not applicable—PIP is in Planning or implementation phase, results not available	None	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): not completed

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.

This clinical PIP was found to have no confidence because the baseline and first remeasurement data were not provided, and the PIP has been a concept only since July 2019.

CalEQRO recommendations for improvement of this clinical PIP include:

- Limit and maintain the scope of the PIP so that staff and resources will not be overburdened. This may help the MHP to improve the ability to successfully launch the PIP.
- The MHP may benefit from discussing the pros and cons of continuing this clinical PIP as the MHP has not been successful in launching the PIP since 2019.
- Participate in frequent and on-going PIP TA from CalEQRO.

Non-Clinical PIP

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

The MHP did not submit a non-clinical PIP.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Lake MHP					
Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,835,638	155,154	4.05%	$934,903,862	$6,026
Small	175,792	7,277	4.14%	$43,246,554	$5,943
MHP	8,933	289	3.24%	$1,290,096	$4,464

Table D2: CY 2020 Distribution of Medi-Cal Beneficiaries by ACB Range

Lake MHP								
ACB Range	MHP Medi-Cal Beneficiaries Served	MHP Percentage of Medi-Cal Beneficiaries Served	Statewide Percentage of Medi-Cal Beneficiaries Served	MHP Total Medi-Cal Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Medi-Cal Claims	Statewide Percentage of Total Approved Medi-Cal Claims
<$20K	1,133	94.89%	92.22%	$3,552,446	$3,135	$4,399	56.84%	56.70%
$20K-$30K	30	2.51%	3.71%	$722,285	$24,076	$24,274	11.56%	12.59%
>$30K	31	2.60%	4.07%	$1,974,808	$63,703	$53,969	31.60%	30.70%

Table D3: Summary of CY 2020 Short-Doyle/Medi-Cal Claims

Lake MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**24,744**	**$5,068,053**	**442**	**$80,454**	**1.59%**	**$4,987,599**	**$4,808,630**
JAN20	2,230	$498,104	46	$10,356	2.08%	$487,748	$436,166
FEB20	2,237	$486,303	12	$3,273	0.67%	$483,030	$439,972
MAR20	2,154	$439,652	21	$3,542	0.81%	$436,110	$431,431
APR20	2,348	$432,500	68	$13,479	3.12%	$419,021	$401,624
MAY20	2,107	$383,568	60	$9,939	2.59%	$373,629	$362,065
JUN20	2,103	$402,543	48	$10,222	2.54%	$392,321	$380,721
JUL20	2,122	$420,219	53	$9,717	2.31%	$410,502	$399,158
AUG20	1,802	$384,596	4	$1,854	0.48%	$382,742	$378,884
SEP20	2,091	$405,318	6	$949	0.23%	$404,369	$402,951
OCT20	2,249	$457,155	44	$5,943	1.30%	$451,212	$443,487
NOV20	1,617	$396,041	35	$5,526	1.40%	$390,515	$384,987
DEC20	1,684	$362,052	45	$5,653	1.56%	$356,399	$347,182

Includes services provided during CY 2020 with the most recent DHCS claim processing date of July 30th, 2021. Only reports Short Doyle Medi-Cal claim transactions and does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2020 was 3.19 percent.

Table D4: Summary of CY 2020 Top Five Reasons for Medi-Cal Claim Denial

Lake MHP			
Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B or Other Health Coverage must be billed before submission of claim	239	$41,300	51%
Beneficiary not eligible or non-covered charges	131	$24,211	30%
Claim/service lacks information which is needed for adjudication	33	$6,456	8%
Beneficiary not eligible	30	$6,338	8%
Service line is a duplicate and a repeat service procedure code modifier not present	31	$7,186	6%
TOTAL	**438**	**$79,518**	**99%**