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

SHASTA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — October 25-26, 2022

MHP Size — Small

MHP Region — Superior

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

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

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	5	5	0
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**19**	**7**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Applied Behavior Analysis (ABA): Improving Functioning of Youth Experiencing Anxiety	Clinical	08/2021	First Remeasurement	Moderate
Decreasing No-Show Rates for Adult Services Outpatient Psychiatric Provider Appointments	Non-Clinical	01/2022	Implementation	Moderate

Table D: Summary of Consumer/Family Focus Groups

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

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP implemented several changes in the children's system of care to improve overall access and services.
- The MHP implemented a new PIP to reduce psychiatric medication appointment no-shows by improving transportation.
- The MHP realigned the adult and children's branches under one leadership and has committed to include leadership in the quality improvement processes.
- The MHP QI plan and quality improvement committee (QIC) actively address the California Advancing and Innovating Medi-Cal (CalAIM) initiatives and evidence a developed data driven quality approach to implementing standards of care.
- The MHP has chosen, contracted, and is meeting regularly with Netsmart to implement a new electronic health record (EHR), myAvatar, by July-August 2023.

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

- Families of youth served in crisis systems presented they, on several occasions, had poor experiences in emergency departments (EDs), inpatient (IP) settings or the transition to the outpatient (OP) service system. Concerns included not feeling that the decisions or facilities kept their youth safe.
- The MHP continues to experience delays providing the first non-urgent psychiatry appointment for adults, children, and foster youth.

- It was unclear whether the single service Penetration Rate (PR) of 20.07 percent, 50 percent greater than the state average, represented a quality care gap.
- With the launch of a new EHR, it would greatly improve care coordination if the community-based organizations (CBOs) were included in the new EHR
- Clinical line staff, clinical supervisors, and CBO and contractors, universally endorsed morale, bidirectional communication, and leadership clinical policy decision making, as areas needing improvement.

Recommendations for improvement based upon this review include investigate the reasons, develop strategies, and implement solutions to:

- Improve the monitoring and reporting of safe care in EDs, IP settings, and the transition to the OP service.
- Improve timeliness in providing the first non-urgent psychiatry appointment for adults and children, including foster youth.
- Improve the single service PR.
- Allow contract provider access to the myAvatar EHR, including the ability to input and maintain clinical data such as progress notes and medication lists.
- Improve morale, bidirectional communication and concerns related to bi-directional communication in leadership clinical policy decision making.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2022-23 findings of the EQR for Shasta County MHP by BHC, conducted as a virtual review on October 25-26, 2022.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

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

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 12, then "≤11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding PR percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the third year of the Coronavirus Disease 2019 (COVID-19) pandemic. The impact of COVID-19 was continuous throughout the FY, up to and including the time of the review in October 2022. COVID-19 presented challenges of continuing to deliver services to people with severe and persistent mental illness. COVID-19 staffing shortages and leaves impacted the MHP the entire rating period.

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.

- Leadership changes occurred, including Health and Human Services Agency (HHSA) Director, Branch Director Adult, Deputy Branch Director Children's, and Managers in Children's and Adult services.
- Children's services experienced multiple changes, including but not limited to: FC; wraparound services; Dialectal Behavioral Therapy; crisis systems; juvenile justice; and partner agency collaboration.
- The MHP has identified a new EHR system, Netsmart.
- The MHP is implementing several recruitment and retention actions, including but not limited to implementing a traineeship program in Children's Services, collaboration with California Mental Health Services Act (CalMHSA) developing onboarding bonuses, and 'thanks for staying' monetary recognition.
- The MHP has prioritized the implementation of the statewide DHCS CalAIM initiatives and 274 standard network reporting.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: Prioritize systemwide timely access tracking, trending, and reporting. Explore root causes for existing methodological and performance challenges and implement alternative strategies to monitor timeliness that incorporate all service entry points. To promote consistent processes across branches, document specific methodology to track and trend first non-urgent request to first offered appointment and first offered psychiatric appointment, urgent appointments, and no-shows.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP contracted with Netsmart to utilize their product as a replacement behavioral health EHR system in place of Cerner - Anasazi. Data gathering and reporting mechanisms within Netsmart are anticipated to resolve many reporting obstacles.
- A multidisciplinary data workgroup, meeting monthly, addresses variables such as first offered psychiatric appointments, urgent appointments, and no-shows. As a result, the current non-clinical PIP addresses adult psychiatric appointment no-shows.
- With current organizational restructuring, the leadership at the director and deputy director levels has assumed oversight over both Adult and Children's Mental Health Services, including utilizing data to make management decisions.

- The MHP has reported in the QIC the accurate reporting and submission of Client Services Information data, including first non-urgent request to first offered appointment. The MHP anticipates the most recent submission of the Timely Access Data Tool as part of Network Adequacy Certification to exceed the 80 percent mark for the 10-business day regulation (between first non-urgent request to first offered appointment). For FY 2020-21, the data exceeds the 90 percent mark.

Recommendation 2: Continue the evaluation and selection process for a replacement EHR, ensuring the implementation team includes representation from subject matter experts in all coordinating divisions to provide feedback on functionality to support clinical, reporting, beneficiary care and record access, interoperability, claiming, scheduling, quality assurance.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- As of July 1, 2022, the MHP contracted with Netsmart to utilize their product as a replacement behavioral health EHR system in place of Cerner - Anasazi. The projected go live date for the EHR system is September 2023.
- The implementation team included members from Technology; Quality Management; Clinical; Fiscal; Outcomes, Planning and Evaluations (reporting unit); and various other units.
- Additionally, as part of CalAIM discussions, new interoperability and billing/claiming requirements are being addressed with Netsmart.

Recommendation 3: Identify the service delivery system process workflow, from beneficiary entry to discharge. Formalize processes across the adult services and children's services branches. Consider leveraging existing electronic learning management systems to aid in staff training.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The Adult and Children's Services have an independent but similar workflow around opening and discharging a client's chart, based on the framework of Title-9 regulations. Both branches utilize the Beacon screening tool to identify mild/moderate and moderate/severe functioning. This tool allows the Access Teams to provide linkage to the most appropriate level of mental health treatment.
- Client discharge is performed collaboratively with the consumers and their caregivers whenever possible. In situations where consumers become disconnected from treatment, clinical staff utilize protocols to attempt to contact by phone or in person to discuss plans for ongoing treatment prior closure.
- The MHP is actively implementing CalAIM initiatives and leveraging products developed by CalMHSA such as policies and procedures, documentation manuals, and training modules offered on their learning management system.

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

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has conducted staff surveys: Thanks for Staying Survey (July 2021) and an employee wellness survey to all HHSA employees (July 2022).
- Based on the surveys, reports were compiled and are currently being discussed by leadership for areas of opportunities. The Children's staff follow-up survey was strongly negative toward the new Children's leadership. The leadership team worked to ensure that the comments made were addressed and is taking steps to communicate more effectively with the branch.
- The rating is partially met due to the clinical line staff, clinical supervisors, and CBO and contractors' validation sessions, universally endorsed morale as an area for continued opportunity for improvement while identifying some improvement. This recommendation was not carried over to FY 2022-23 recommendations.

Recommendation 5: Improve bi-directional communication between MHP leadership, direct line staff, and community agencies servicing FC youth to address the requirements related to SB1291, promote integrated core practices, and achieve positive beneficiary outcomes.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP leadership openly communicates with direct line staff through email, phone calls, and in-person attendance at Adult and Children's Services departmental meetings.
- Children's Branch has quarterly meetings with each contracted provider regarding program operations, success, challenges, and budget. The MHP Utilization Management and Quality Assurance team is a member of these quarterly meetings.
- Contracted providers are included in the bimonthly QIC meetings.
- The MHP Healthcare Effectiveness Data and Information Set (HEDIS) measures requirements of SB1291 are monitored utilizing SafeMeasures Medi-Cal reports and the Berkley California Child Welfare Indicators Project data reports on a monthly and quarterly basis to track psychotropic meds data.
- The rating is partially met due to the clinical line staff, clinical supervisors, and CBO and contractors' validation sessions, universally endorsed communication

as an area for continued opportunity for improvement while identifying some improvement.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 65.6 percent of services were delivered by county-operated/staffed clinics and sites, and 34.4 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 77.2 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff during business hours and a contractor after business hours; beneficiaries may request services through the Access Line as well as through the following system entry points: clinic walk-in; primary care referrals; Shasta County Children's Services Branch (CSB) Access Services; school referrals; probation referrals; interagency and community provider referrals; and Medi-Cal managed health care plan. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services.

In addition to clinic-based MH services, the MHP provides psychiatry and, to a lesser extent, MH services, via video telehealth to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 527 adult beneficiaries, 617 youth beneficiaries, and 134 older adult beneficiaries across two county-operated sites and four contractor-operated sites. Among those served, no beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs

[1] CMS Data Navigator Glossary of Terms

and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

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

For Shasta County, the time and distance requirements are 60 miles and 90 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

Table 1B: MHP OON, FY 2021-22

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP has realigned the adult and children's service branches under one management structure providing more direct access and treatment oversight.
- Children's services have seen extensive service development. In line with the new CalAIM children's SMHS admission criteria, the MHP has incorporated Adverse Childhood Experiences (ACES) scores to monitor trauma risk.
- The cultural competency plan is outdated and would benefit from a more specific focus on the impact of culture on service delivery and disparities.
- The MHP does not proactively utilize the MCP transportation benefit for their consumers.
- Families of youth reported crisis experiences in hospital EDs, psychiatric inpatient, and post inpatient follow-up to be chaotic and un-necessarily traumatic.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, the MHP's PR of 3.69 percent was 4.2

percent lower than the statewide average, and their average claim amount of $8,329 was 28.2 percent greater than the statewide average.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	68,886	2,541	3.69%	$21,164,614	$8,329
CY 2020	63,996	2,696	4.21%	$22,308,407	$8,275
CY 2019	62,974	3,099	4.92%	$18,756,636	$6,052

- Total eligibles increased from CY 2019-CY 2021. Beneficiaries served, and PR declined each year from CY 2019-CY 2021. The average approved claim amount per beneficiary was stable from CY 2020-CY 2021.

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

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	7,562	93	1.23%	1.03%	1.59%
Ages 6-17	15,567	933	5.99%	5.00%	5.20%
Ages 18-20	3,105	128	4.12%	4.29%	4.02%
Ages 21-64	36,485	1,288	3.53%	4.15%	4.07%
Ages 65+	6,167	99	1.61%	2.09%	1.77%
TOTAL	**68,886**	**2,541**	**3.69%**	**3.83%**	**3.85%**

- While the MHP's PRs exceeded statewide averages for those aged 6-17 and 18-20, PR for those aged 21-64 and 65+ were lower than corresponding statewide averages.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percent of Beneficiaries Served
No Threshold	2,449	100.00%
Threshold language source: Open Data per BHIN 20-070		

- The MHP served 2,449 Medi-Cal beneficiaries in CY 2021 and had no threshold language other than English.

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

Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	18,736	473	2.52%	$3,758,363	$7,946
Small	199,673	6,647	3.33%	$36,223,622	$5,450
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The ACA PR is 32 percent lower than the overall PR (2.52 percent vs. 3.69 percent), and the AACB for this group is 5 percent less than the overall AACB ($8,329 vs. $7,946).
- The ACA PR is 24 percent lower than the statewide average (2.52 percent vs. 3.31 percent), and the AACB is 40 percent greater than the statewide average ($7.946 vs. $5,677).

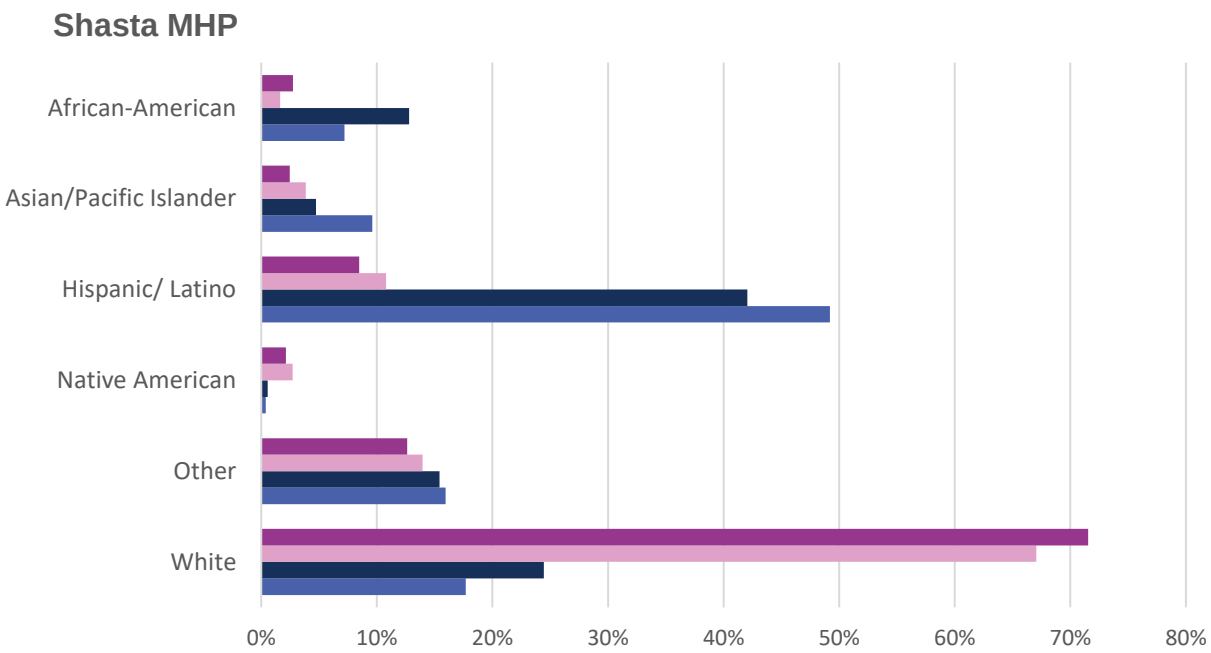
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	# MHP Served	# MHP Eligibles	MHP PR	Statewide PR
African-American	70	1,120	6.25%	6.83%
Asian/Pacific Islander	63	2,649	2.38%	1.90%
Hispanic/Latino	215	7,447	2.89%	3.29%
Native American	54	1,861	2.90%	5.58%
Other	321	9,616	3.34%	3.72%
White	1,818	46,193	3.94%	5.32%
Total	**2,541**	**68,886**	**3.69%**	**3.85%**

- The MHP served 2,541 unique beneficiaries in CY 2021. Their eligible population was largely comprised of white beneficiaries with this group comprising 67 percent of the eligible population and 72 percent of those served. Other beneficiaries comprised the next largest race/ethnicity group compromising 14 percent of the eligible population and 13 percent of those served.
- African American had the highest PR from CY 2019-CY 2021, and served 70 beneficiaries in CY 2021, 3 percent of those served.

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

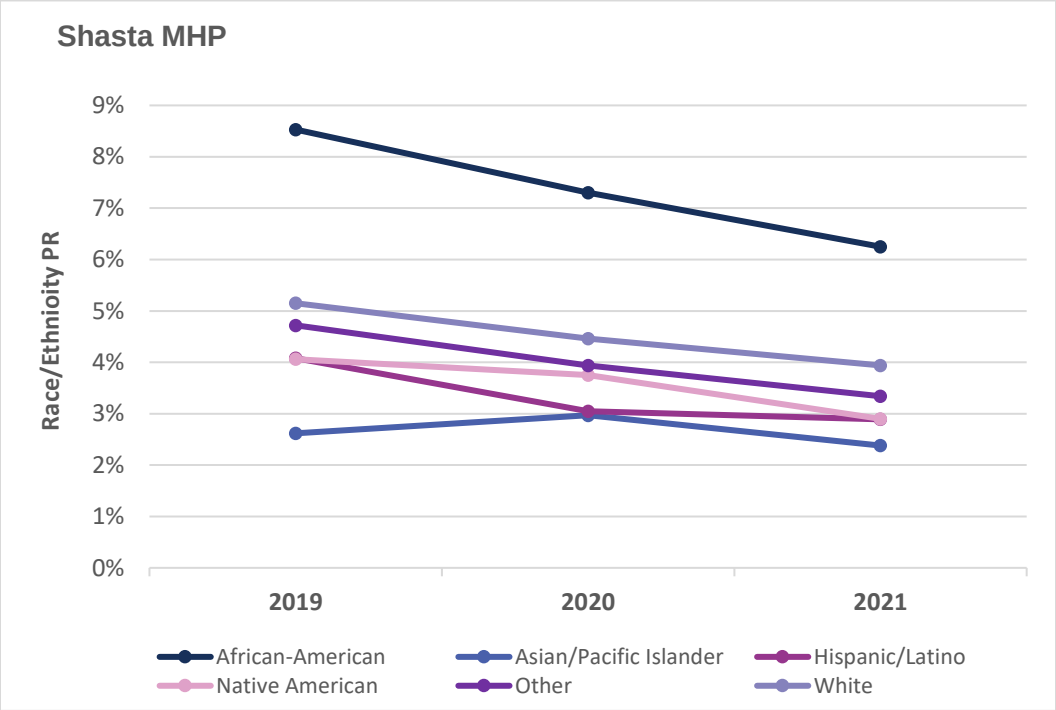


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	72%	13%	2%	8%	2%	3%
MHP % Eligibles	67%	14%	3%	11%	4%	2%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- Billing rates impacted by the COVID-19 pandemic likely contributed to the CY 2019 to CY 2020 AACB increases for overall and all subpopulation data in Figures 2-11.

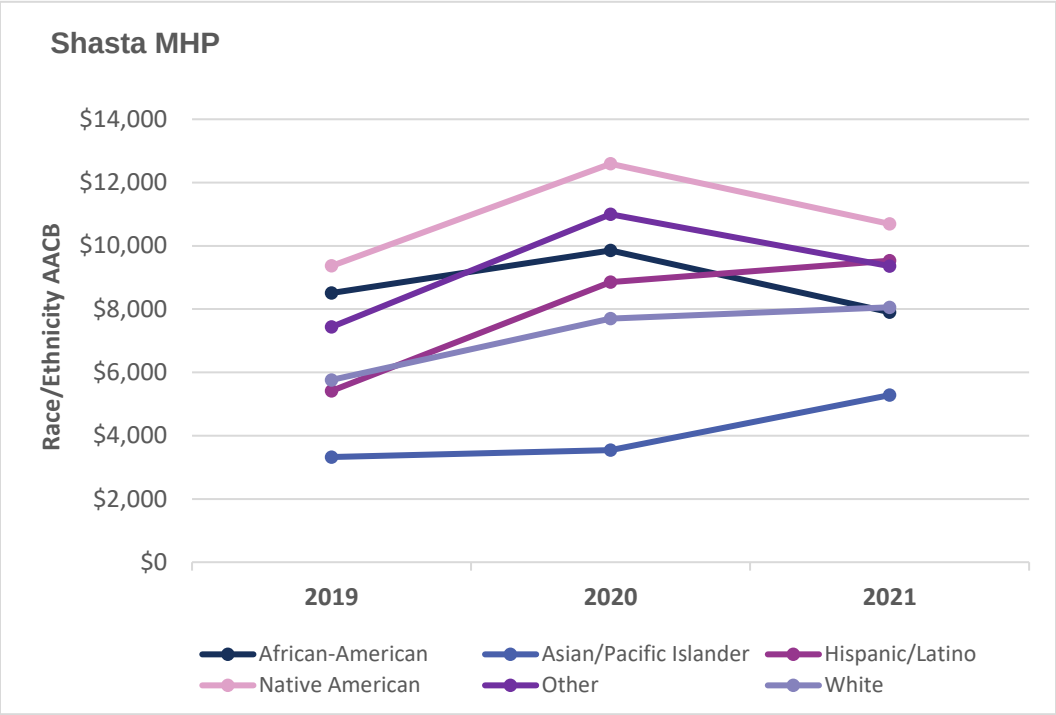
Figures 2 – 11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



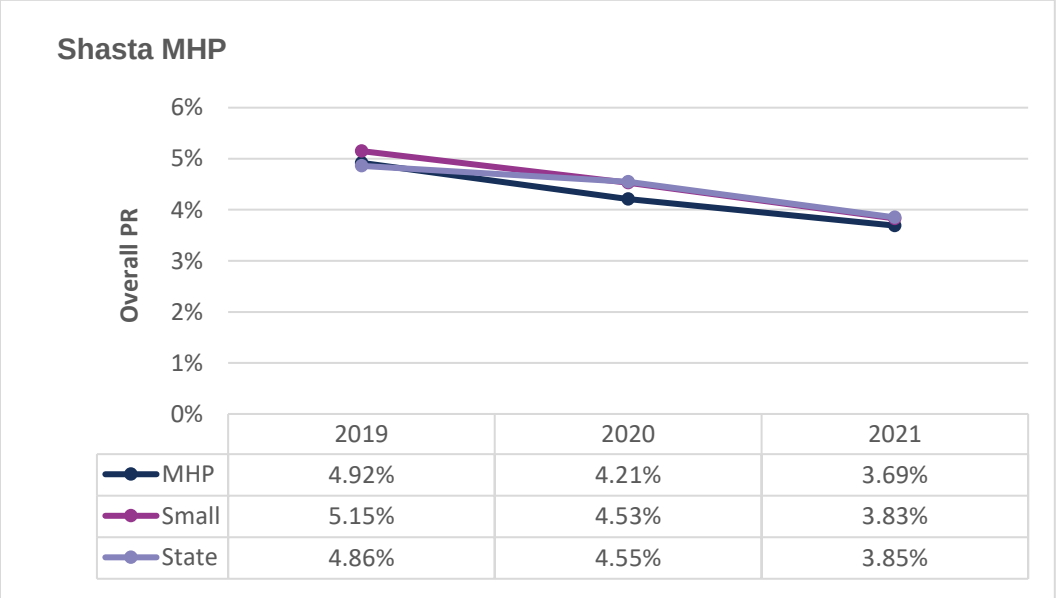
- Except for Hispanic/Latino, which was stable from CY 2020 to CY 2021, PRs for all other groups declined from CY 2020 to CY 2021. African American had the highest PR from CY 2019-CY 2021, serving 70 beneficiaries in CY 2021.

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



- AACB increased for all populations from CY 2019 to CY 2020. Native American had the highest AACB from CY 2019 to CY 2021 while Asian Pacific Islander had the lowest AACB during this period.

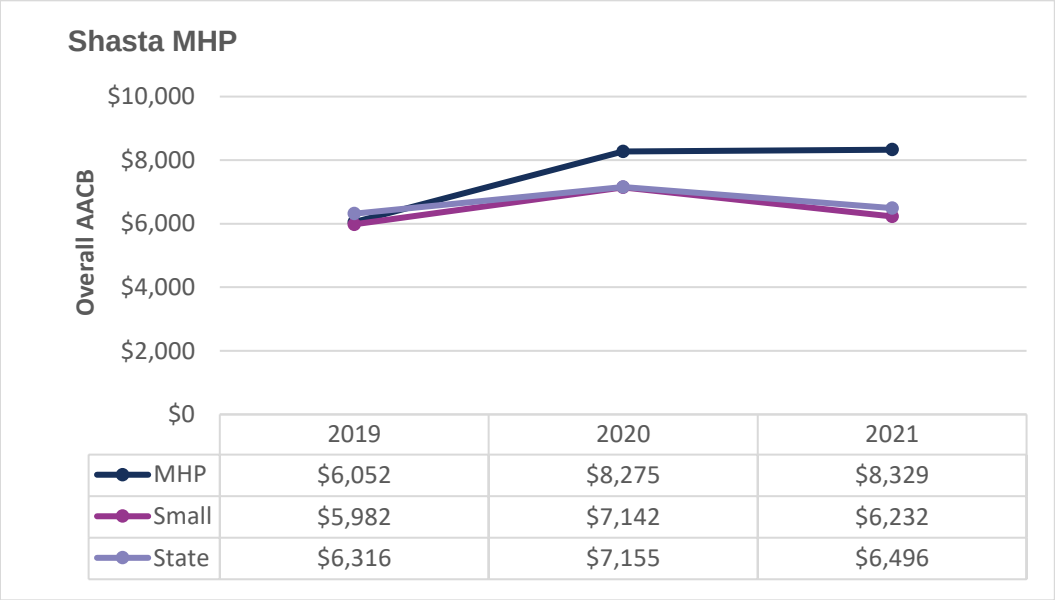
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.92%	4.21%	3.69%
Small	5.15%	4.53%	3.83%
State	4.86%	4.55%	3.85%

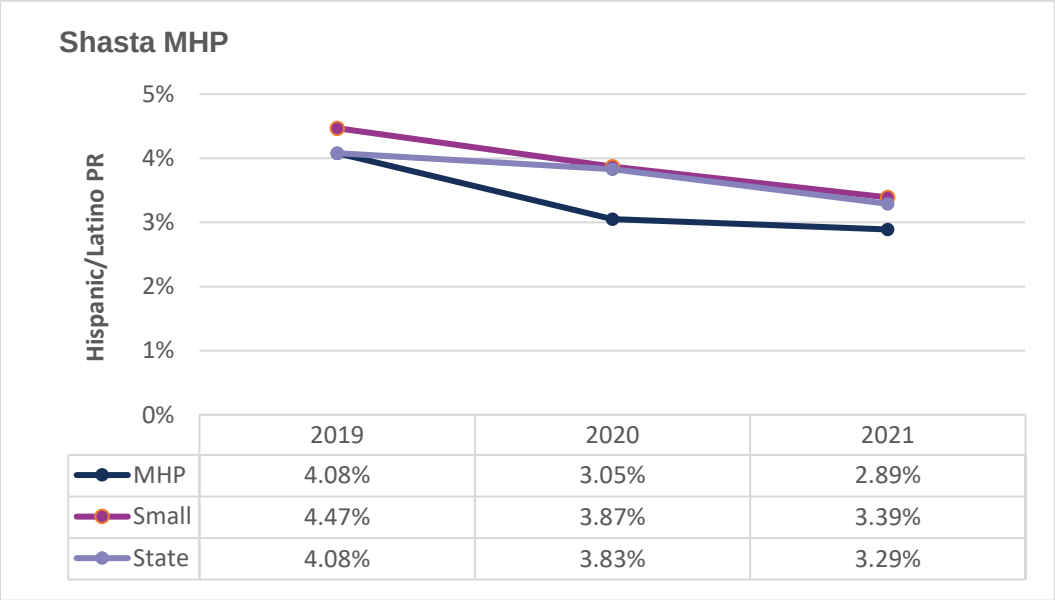
- While PRs for statewide and comparative county averages, and the MHP declined each year from CY 2019-CY 2021, Shasta's PR was just below the statewide average in CY 2021 (3.69 percent vs. 3.85 percent).

Figure 5: Overall AACB CY 2019-21



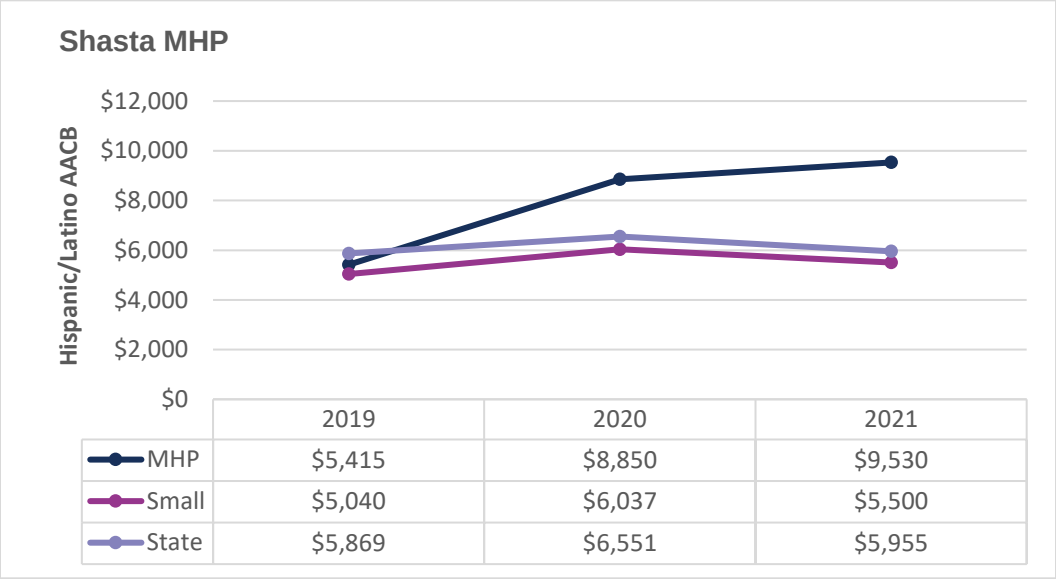
- The MHP's AACB was significantly greater than statewide and comparative county averages in CY 2020 and CY 2021. In CY 2021, Shasta's AACB was 28 percent greater than the statewide average ($8,329 vs. $6,496).

Figure 6: Hispanic/Latino PR CY 2019-21



- Latino/Hispanic PRs for statewide and comparative county averages, and the MHP, declined each year from CY 2019-CY 2021. In CY 2021, Shasta's Latino/Hispanic PR ranking was 33rd of 56 MHPs.

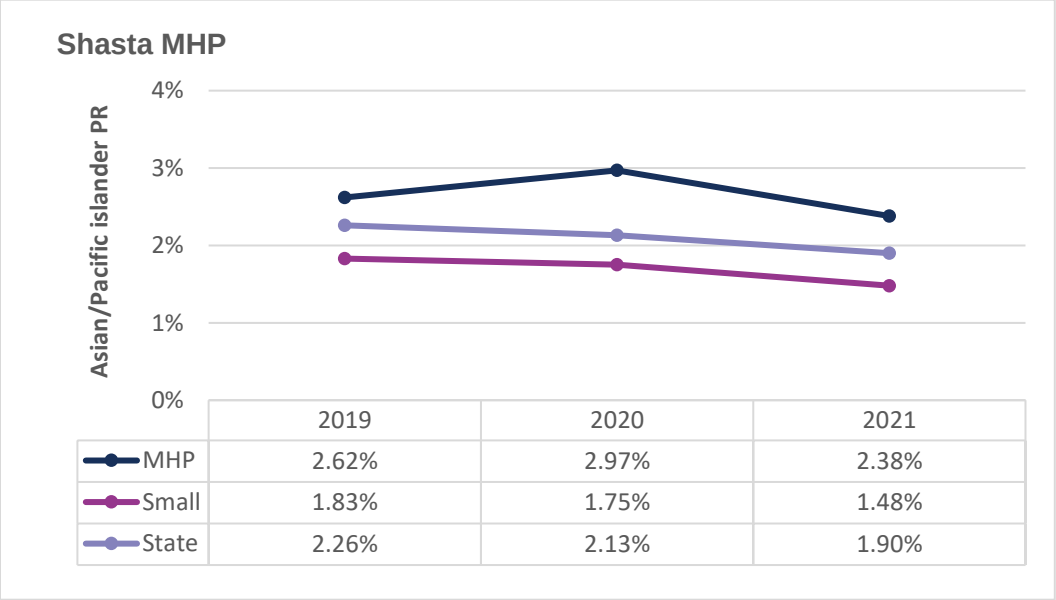
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$5,415	$8,850	$9,530
Small	$5,040	$6,037	$5,500
State	$5,869	$6,551	$5,955

- The MHP's Latino/Hispanic AACB was significantly greater than that of the statewide and comparative county averages in CY 2020 and CY 2021 and 60 percent greater than the statewide average ($9,530 vs. $5,955) in CY 2021.

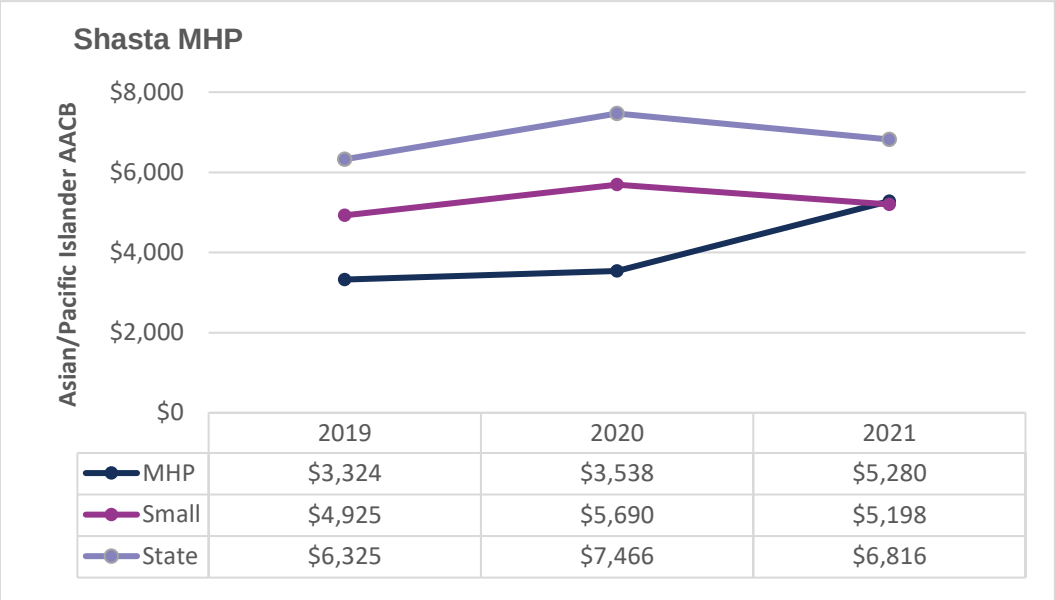
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.62%	2.97%	2.38%
Small	1.83%	1.75%	1.48%
State	2.26%	2.13%	1.90%

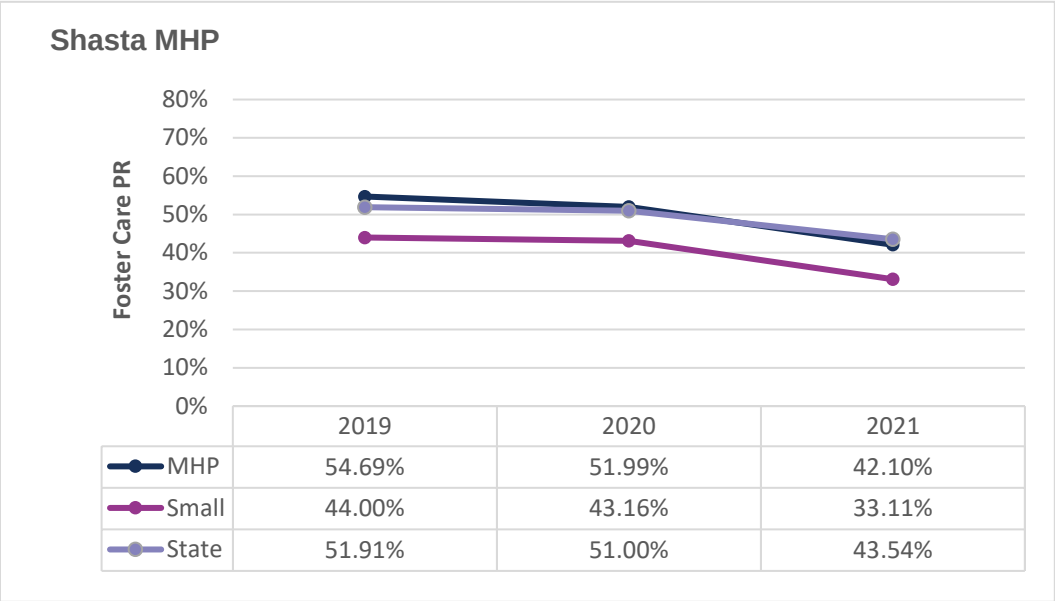
- Asian/Pacific Islander PRs for statewide and comparative county averages, and the MHP, declined from CY 2020 to CY 2021, with the MHP having the highest PRs from CY 2019-CY 2021. In CY 2021, the MHP's Asian/Pacific Islander PR ranking was 19th of 56 MHPs.

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



- Asian/Pacific Islander AACB was less than that of the statewide and comparative county averages in CY 2019 and CY 2020 but increased to be comparable to the comparative county average in CY 2021 but remains 23 percent less than the statewide average ($5,280 vs. $6,816).

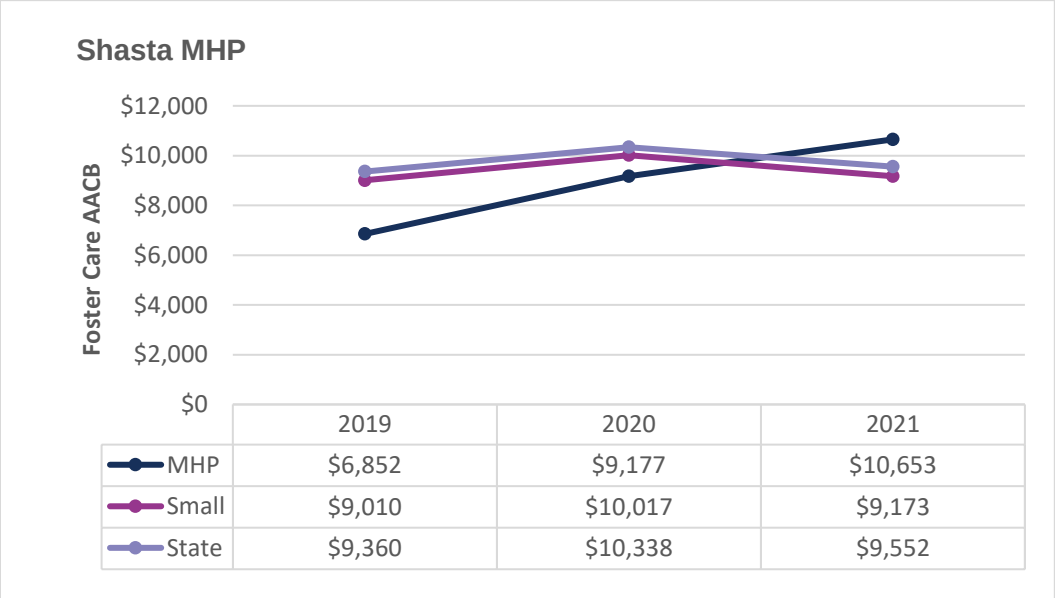
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	54.69%	51.99%	42.10%
Small	44.00%	43.16%	33.11%
State	51.91%	51.00%	43.54%

- FC PRs for statewide and comparative county averages and Shasta declined from CY 2019-CY 2021 and is comparable to the statewide average in CY 2021. In CY 2021, the MHP's FC PR ranking was 25th of 56 MHPs.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$6,852	$9,177	$10,653
Small	$9,010	$10,017	$9,173
State	$9,360	$10,338	$9,552

- FC AACB increased each year from CY 2019 and CY 2021 and in CY 2021 exceeded the statewide average by 12 percent ($10,653 vs. $9,552).

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 1,516				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	135	8.9%	16	8	10.8%	14	8
Inpatient Admin	≤11	-	-	-	0.4%	16	7
Psychiatric Health Facility	116	7.7%	10	8	1.0%	16	8
Residential	≤11	-	-	-	0.3%	93	73
Crisis Residential	94	6.2%	24	21	1.9%	20	14
Per Minute Services							
Crisis Stabilization	31	2.0%	1,341	1,200	9.7%	1,463	1,200
Crisis Intervention	522	34.4%	176	130	11.1%	240	150
Medication Support	639	42.2%	350	193	60.4%	255	165
Mental Health Services	847	55.9%	434	186	62.9%	763	334
Targeted Case Management	644	42.5%	416	131	35.7%	377	128

- The percentage of adult beneficiaries who received crisis residential services exceeded the statewide rate by more than three-fold, and the median length of stay was 21 days compared to 14 days statewide.
- 30 percent fewer adults receive medication services, though those who receive this service received more units of service than is seen statewide.
- The MHP provides relatively less mental health service and more targeted case management services than statewide.
- Perhaps in relation to lower rates of medication support and mental health services, crisis intervention is provided to three times as many adults as is seen statewide.

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

Service Category	MHP N = 237				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	≤11	-	-	-	4.5%	13	8
Inpatient Admin	≤11	-	-	-	n ≤11	6	4
Psychiatric Health Facility	≤11	-	-	-	0.2%	25	9
Residential	≤11	-	-	-	n ≤11	140	140
Crisis Residential	≤11	-	-	-	0.1%	16	12
Full Day Intensive	≤11	-	-	-	0.2%	452	360
Full Day Rehab	≤11	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	≤11	-	-	-	2.3%	1,354	1,200
Crisis Intervention	19	8.0%	227	157	6.7%	388	195
Medication Support	53	22.4%	353	293	28.5%	338	232
Therapeutic Behavioral Services	≤11	-	-	-	3.8%	3,648	2,095
Therapeutic FC	≤11	-	-	-	0.1%	1,056	585
Intensive Home Based Services	139	58.6%	619	231	38.6%	1,193	445
Intensive Care Coordination	56	23.6%	740	374	19.9%	1,996	1,146
Katie-A-Like	≤11	-	-	-	0.2%	837	435
Mental Health Services	229	96.6%	1,162	736	95.7%	1,583	987
Targeted Case Management	127	53.6%	174	88	32.7%	308	114

- The MHP's FC youth had lower median units of service compared statewide averages for the following service types: crisis intervention, intensive home-based services, Intensive care coordination, mental health services and targeted case management. A significant amount of data was suppressed due to beneficiaries being ≤11.
- The MHP delivered both ICC and IHBS to relatively more youth than statewide, though at fewer units per beneficiary served. The MHP also provides FC youth TCM at a higher rate, but like many other service categories, at significantly

fewer units per beneficiary served.

IMPACT OF ACCESS FINDINGS

- The MHP's children's branch attention to ACES scores, the new DHCS access SMHS criteria, and the MHP's leadership changes, are all focused to improve children's access while incorporating the new CalAIM changes.
- The MHP's PR of 3.69 percent was 4.2 percent lower than the statewide average, and their average claim amount of $8,329 was 28.2 percent greater than the statewide average.
- The MHP served 2,541 unique beneficiaries in CY 2021. Their eligible population was largely comprised of white beneficiaries with this group comprising 67 percent of the eligible population and 72 percent of those served. Other beneficiaries comprised the next largest race/ethnicity group compromising 14 percent of the eligible population and 13 percent of those served.
- The Latino/Hispanic PR declined each year from CY 2019 to CY 21, mirroring statewide and comparative county trends.
- The FC PR declined from CY 2019-CY 2021 mirroring statewide and comparable county trends and is comparable to the statewide average in CY 2021.
- FC AACB increased each year from CY 2019 and CY 2021 and in CY 2021 exceeded the statewide average.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The MHP introduced a new non-clinical PIP, "Decreasing No-Show Rates for Adult Services Outpatient Psychiatric Provider Appointments".

- The MHP outperforms state average on 7-day and 30-day rehospitalization rates on both the county developed Assessment of Timely Access (ATA) and the Performance Measures data.
- EHR data compromises some data analytics integrity, especially first offered and rendered non-urgent psychiatric appointment tracking. The MHP expects the new EHR will improve data analytics.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of ATA, representing access to care during the 12-month period of CY 2021 of FY 2021-22. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	4.3 Days	10 Business Days*	92.1%
First Non-Urgent Service Rendered	4.0 Days	10 Days	92.5%
First Non-Urgent Psychiatry Appointment Offered	19.3 Days	15 Business Days*	56.6%
First Non-Urgent Psychiatry Service Rendered	19.9 Days	15 Days	55.4%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	7.0 Hours	48 Hours*	99.9%
Follow-Up Appointments after Psychiatric Hospitalization	7.3 Days	7 Days	89.8%
No-Show Rate – Psychiatry	9.8%	None	n/a
No-Show Rate – Clinicians	17.6%	None	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22.			

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

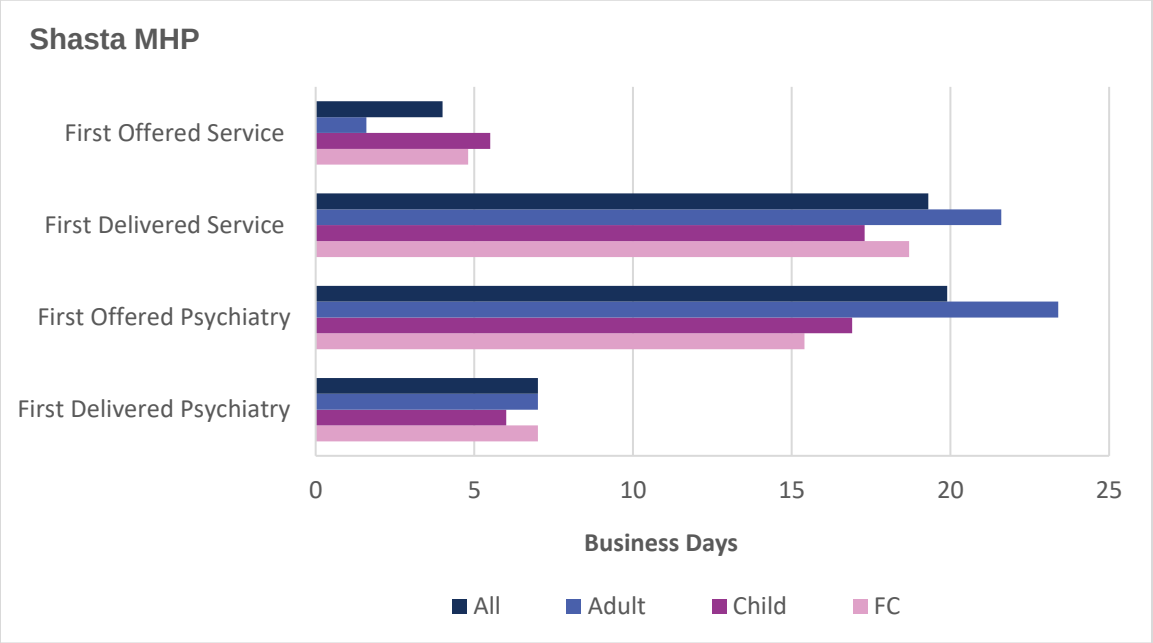


Figure 13: Wait Times for Urgent Services

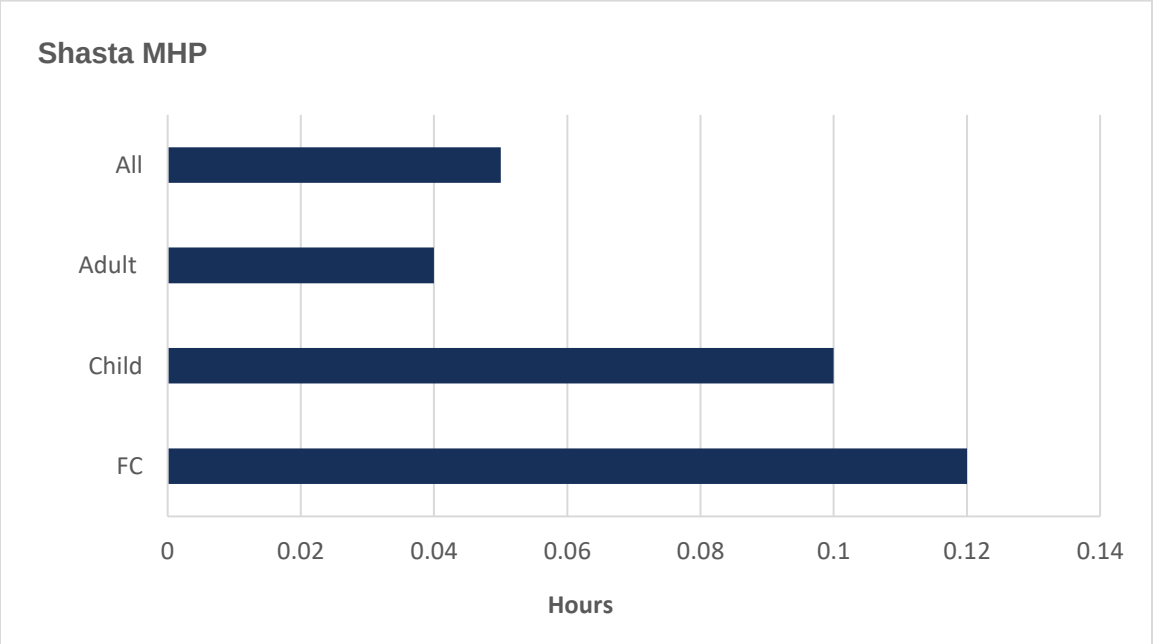
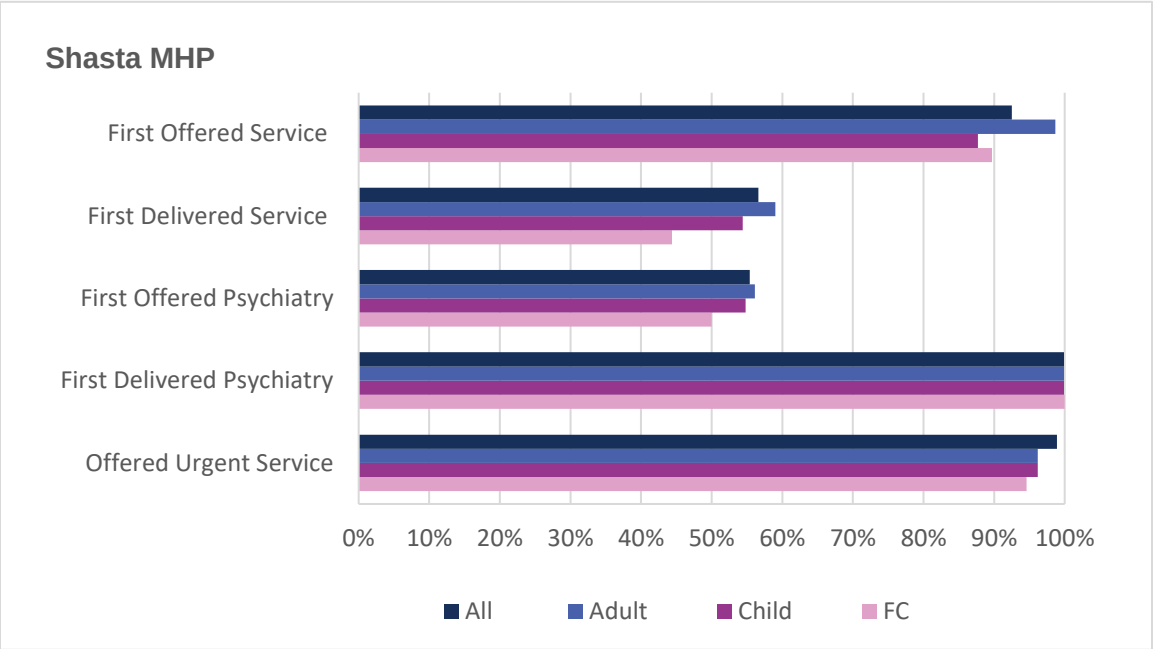


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments.
- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit.
- The MHP defined “urgent services” for purposes of the ATA as beneficiaries seen through the local EDs as the current EHR does not track hours from request for a service and service delivery. Average, Median, and Range of hours are calculated using ED data collected in a separate database. There were reportedly 4,344 urgent service requests with a reported actual wait time to services for the overall population at seven hours.
- Timely access to psychiatry may be defined by the County MHP. The process as well as the definitions and tracking may differ for adults and children. The MHP has defined psychiatry access in the submission as the MHP current EHR does not have adequate method for tracking initial requests for psychiatric services separate from the initial request for general services.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked.

IMPACT OF TIMELINESS FINDINGS

- The MHP implemented a PIP to reduce psychiatric outpatient no-shows.
- The MHP current EHR limitations has made it difficult to track and trend some timeliness measures, impacting data integrity for psychiatric appointments and urgent care monitoring. The new EHR is expected to improve data analytics and address new reporting requirements under CalAIM.
- The MHP is actively working to implement the new CalAIM initiatives.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

The responsibility for quality management of the MHP is provided by the Quality Management and Administrative Hearings (QMAH) section of the HHSA. The QMAH is overseen by a HHSA Program Manager who reports directly to the HHSA Deputy Branch Director. The QMAH is divided into three sections: Utilization Management and Quality Assurance (8.5 FTEs, 1.0 vacancy), Compliance and Quality Improvement (7.5 FTEs, 1.5 vacancies), and Administrative Hearings (7 FTEs, 0 vacancies).

The MHP monitors its quality processes through the QIC, QIC subcommittees; the QI workplan; and the annual evaluation of the QI workplan. The QIC, is comprised of department, clinical, and fiscal leadership; quality staff; CBOs; compliance officer; and Patients' Rights. The QIC is scheduled to meet monthly. Since the previous EQR, the MHP QIC met seven times. At the time of the writing of this report, the annual QI workplan evaluation was partially completed. The QI workplan consists of ten goals with twenty-seven distinct objectives. The QI workplan evaluation documented each objective as goal, objective, and evaluation. The evaluation section consisted of data reports and analysis. There was not a clearly identified status (met, partially met, or not met) or a clearly identified section to address recommendations for the next QI workplan.

The MHP does not site LOC tools in the ISCA but does cite outcomes tools. The California Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist (PSC-35) youth. The outcomes from the CANS and PSC-35 are shared with Children's management/directors during the quarterly QIC Meetings. The MHP utilizes the following adult outcomes tool: Milestones of Recovery Scale (MORS II). This tool is used to determine level of care and movement on the continuum of care.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for beneficiaries. These key components include an organizational culture

that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Partially Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The QI team and data tracking evidence a significance emphasis on standards of care and developed data.
- Subcomponents 3C, 3H are partially met due to a lack of adult beneficiary or parent/caregiver involvement in QIC, PIP or other bi-directional communication processes. Consistent concerns of inconsistent bi-directional communication were raised in sessions, despite obvious efforts to improve communication.
- Subcomponent 3D is partially met due to the transition between systems would benefit from a more systematically tracked and trended approach. .
- Subcomponents 3E and 3F monitors medication for adults and youth. The measures would benefit from a systematic and bi-directional coordination and communication with primary care.
- Telehealth services are primarily limited to psychiatric services. Beneficiaries are not offered a choice for utilizing telehealth.

- As identified in recommendation four and the MHP response, despite efforts by the MHP, morale, bidirectional communication, and leadership decision making were illuminated in the line, supervisor, and CBO sessions as areas needing improvement.
- The MHP does track, but does not trend, the following HEDIS measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)

QUALITY PERFORMANCE MEASURES

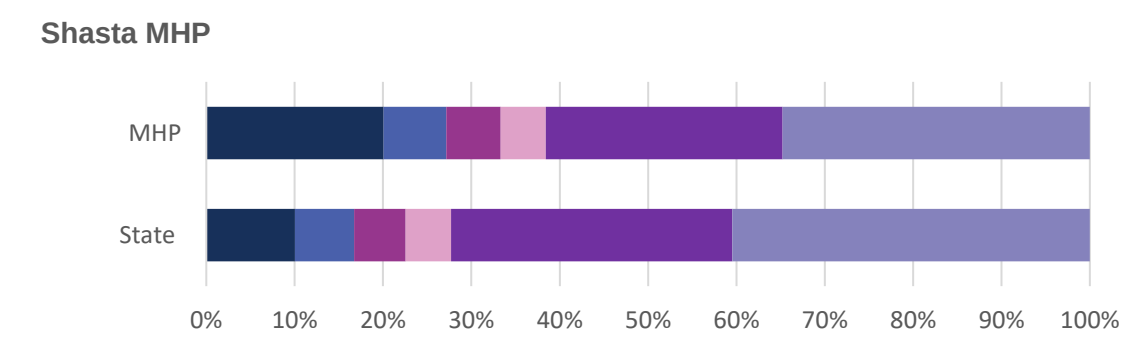
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



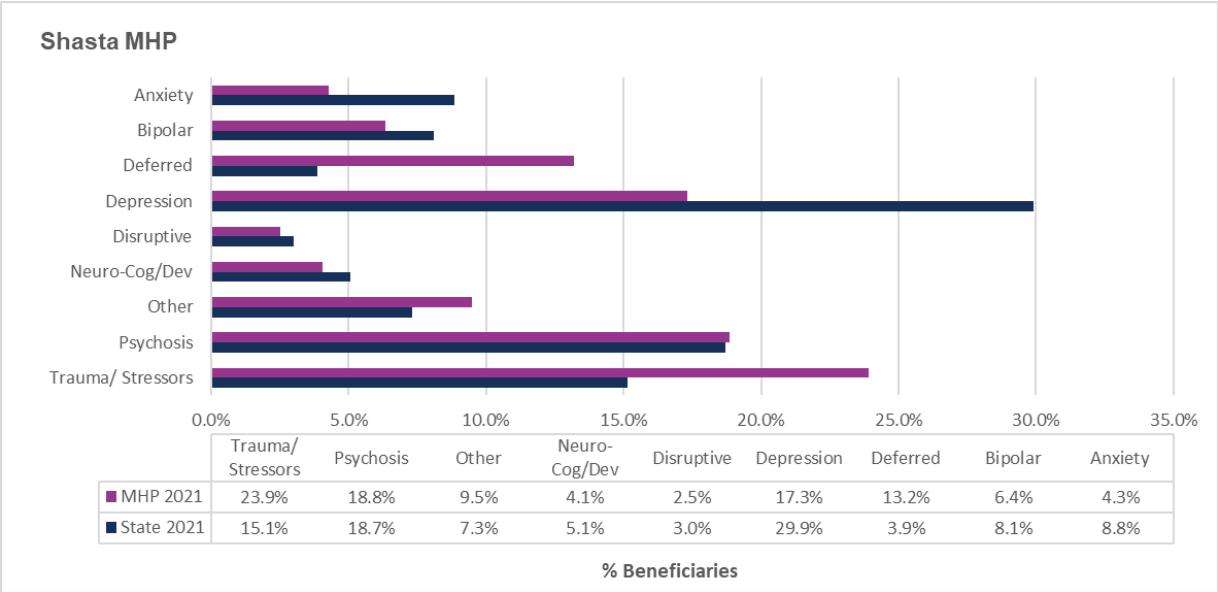
	State	MHP
1 service	10.04%	20.07%
2 service	6.69%	7.08%
3 service	5.83%	6.18%
4 service	5.16%	5.08%
5-15 Services	31.82%	26.80%
>15 Services	40.46%	34.79%

- A single service was provided to 20.07 percent of beneficiaries, twice the statewide average of 10.04 percent.
- More than 15 services were provided to 34.70 percent of beneficiaries, 14 percent lower than the 40.46 percent statewide average.
- More than 15 services were provided to 39.07 percent of Latino/Hispanic beneficiaries and 34.43 percent of White beneficiaries. FC youth had the highest percentage of greater than 15 services, 52.74 percent.

Diagnosis of Beneficiaries Served

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

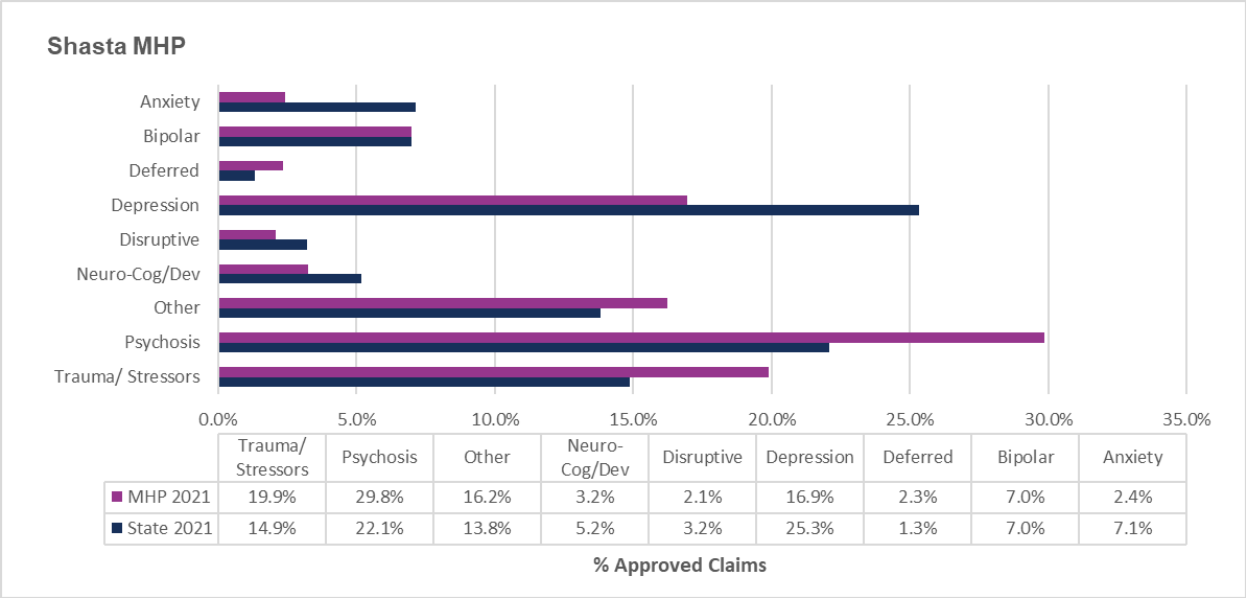
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	23.9%	18.8%	9.5%	4.1%	2.5%	17.3%	13.2%	6.4%	4.3%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- Approximately 60 percent of beneficiaries had one of three diagnoses: trauma/stressor related (23.9 percent), psychosis (18.8 percent), and depression (17.3 percent). Shasta had a significantly higher percentage of trauma/stressor related diagnoses compared to the statewide average (23.9 percent vs. 15.1 percent) and a lower percentage of depression diagnoses (17.3 percent vs. 29.9 percent).

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



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	19.9%	29.8%	16.2%	3.2%	2.1%	16.9%	2.3%	7.0%	2.4%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- While serving the same percentage of beneficiaries (18.8 percent vs. 18.7 percent), The MHP is spending greater for beneficiaries diagnosed with

psychosis compared to the statewide average (29.8 percent vs. 22.1 percent). The spending patterns in other diagnosis categories reasonably aligned with corresponding statewide averages.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	332	541	11.49	8.79	$13,116	$12,052	$4,354,539
CY 2020	374	703	9.70	8.68	$12,520	$11,814	$4,682,623
CY 2019	455	888	8.60	7.63	$10,717	$10,212	$4,876,077

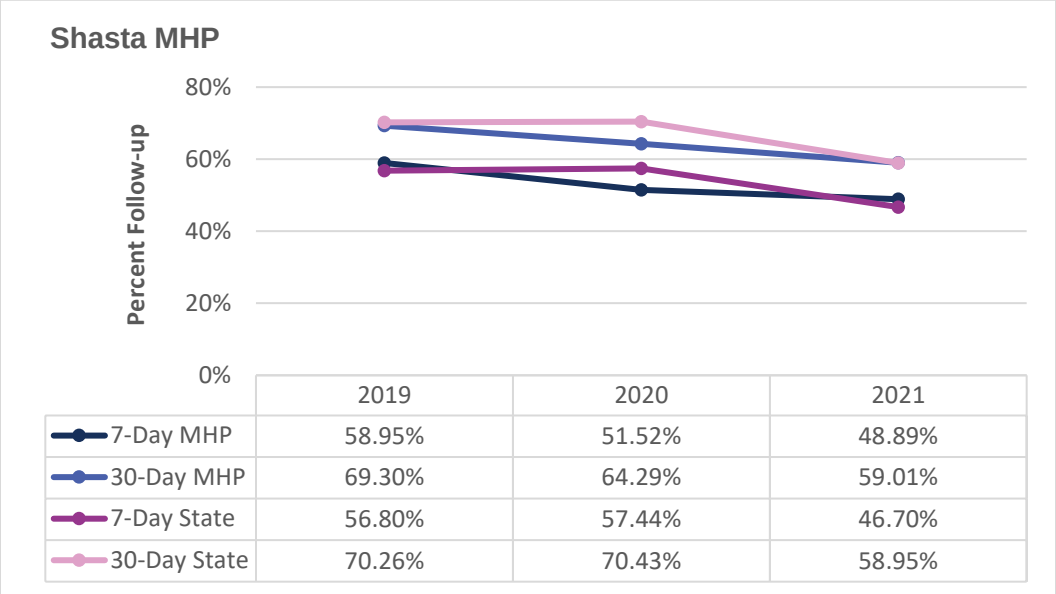
- While unique beneficiary count and total admissions declined each year from CY 2019-CY 2021, LOS increased and continued to be greater than the statewide average in CY 2021 (11.49 days vs. 8.79 days).

Follow-Up Post Hospital Discharge and Readmission Rates

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

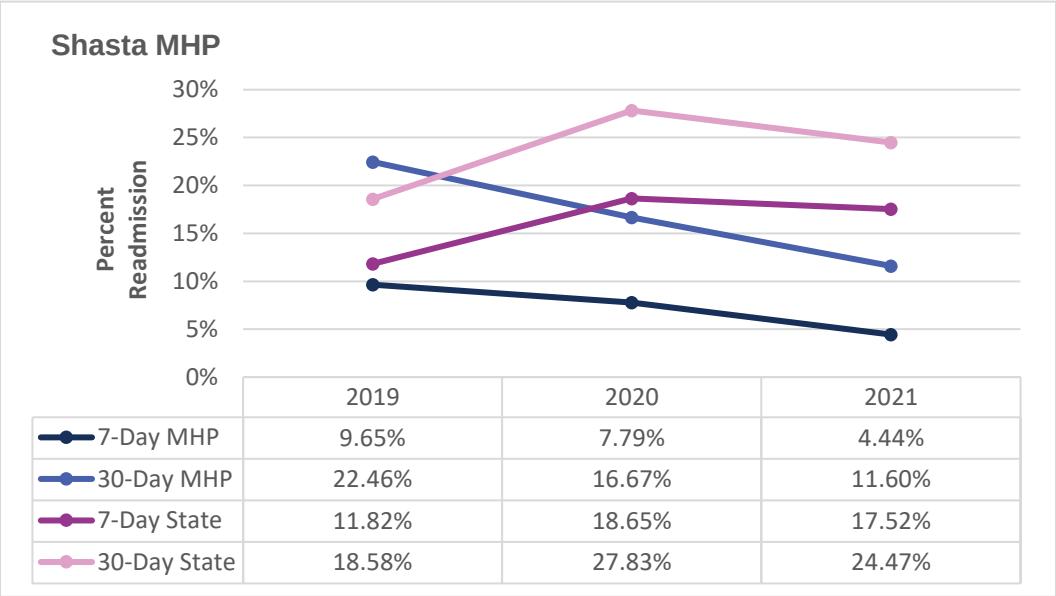
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	58.95%	51.52%	48.89%
30-Day MHP	69.30%	64.29%	59.01%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

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



	2019	2020	2021
7-Day MHP	9.65%	7.79%	4.44%
30-Day MHP	22.46%	16.67%	11.60%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The 7-day post psychiatric inpatient follow-up rate declined each year from CY 2019-CY 2021 (58.95 percent vs.51.52 percent vs. 48.89 percent) and was just above the statewide average in CY 2021 (48.89 percent vs. 46.70 percent).
- The 30-day post psychiatric inpatient follow-up rate declined each year from CY 2019-CY 2021 (69.30 percent vs.64.29 percent vs. 59.01 percent) and was comparable to the statewide average in CY 2021 (59.01 percent vs. 58.95 percent).

- The 7-day psychiatric readmission rate declined each year from CY 2019-CY 2021 (9.65 percent vs. 7.79 percent vs 4.44 percent) and was 75 percent lower than the CY 2021 statewide average (4.44 percent vs. 17.52 percent).
- The 30-day psychiatric readmission rate declined each year from CY 2019-CY 2021 (22.46 percent vs. 16.67 percent vs 11.60 percent) and was 53 percent lower than the CY 2021 statewide average (11.60 percent vs. 24.47 percent).
- Unique beneficiary count and total admissions declined each year from CY 2019-CY 2021. LOS continued to be greater than the statewide average in CY 2021 (11.49 days vs. 8.79 days).

High-Cost Beneficiaries

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

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

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

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

Entity	Year	HCB Count	Total Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	545,147	3.46%	$53,476	$43,231
MHP	CY 2021	163	2,541	6.41%	$56,865	$48,877
	CY 2020	160	2,696	5.93%	$58,916	$52,158
	CY 2019	118	3,099	3.81%	$50,580	$40,034

- The number of high-cost beneficiaries was stable from CY 2020 to CY 2021 2021 (160 vs. 163), the percent of high-cost beneficiaries increased (5.93 percent vs. 6.41 percent) due to a decline in total beneficiaries served (2,696 vs. 2,541).
- The percent of high-cost beneficiaries in CY 2021 was 85 percent greater than the statewide average (6.41 percent vs. 3.46 percent) and the average approved claim amount per high-cost beneficiaries was 6 percent higher than the statewide average ($56,865 vs. $53,476).

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	106	4.17%	$2,601,443	12.29%	$24,542	$24,589
Low Cost (Less than $20K)	2,272	89.41%	$9,294,128	43.91%	$4,091	$2,350

- While low-cost beneficiaries comprised 89.41 percent of those served, 43.91 percent of approved claims dollars were spent on this subpopulation.

Figure 20: Proportion of Beneficiary Count by Claim Amount Grouping CY 2021

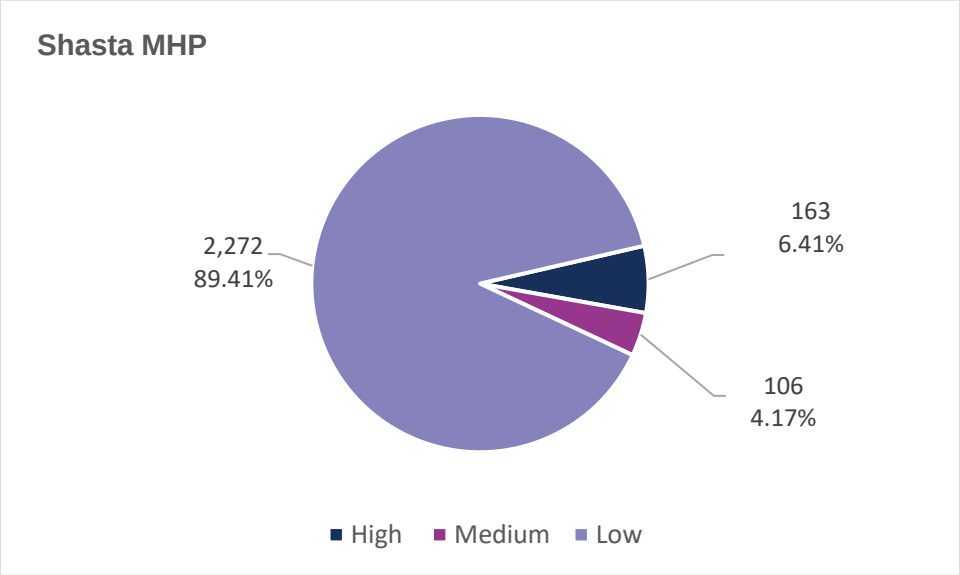
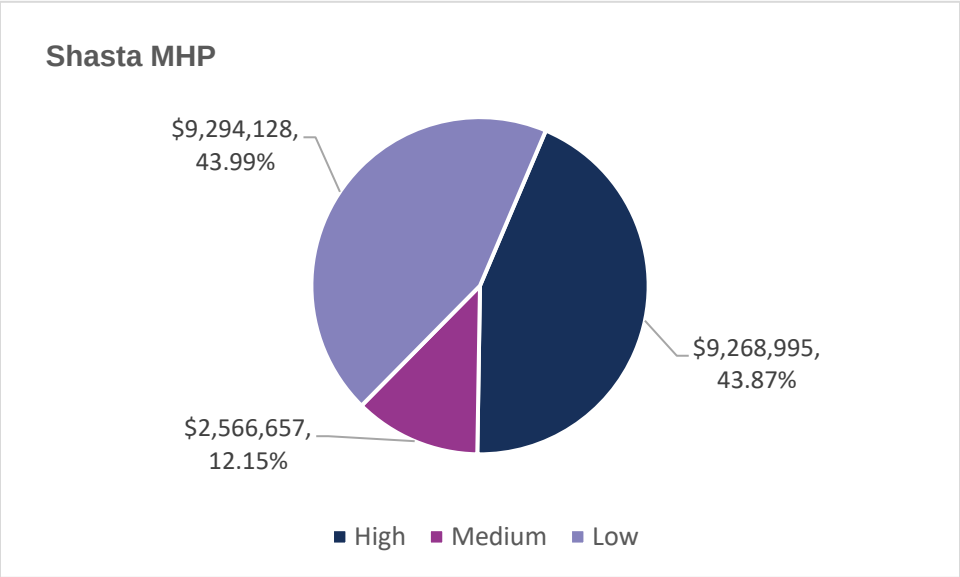


Figure 21: Approved Claims by Claim Amount Grouping



- While high-cost beneficiaries were 6.41 percent of those served, 43.87 percent of approved claims dollars were spent on this subpopulation.

IMPACT OF QUALITY FINDINGS

- It was unclear whether the single service PR of 20.07 percent, 50 percent greater than the state average, represented a quality care gap. Further analysis by the MHP is recommended.
- The MHP has proactively focused on the new CalAIM children's SMHS trauma exposed criteria for youth services. The diagnosis of trauma, 23.9 percent, is 38 percent greater than the state average and seems to be matched by a decline in the diagnosis of depression, which at 15.1 percent is 49 percent lower than the state average. It appears that the MHP may be refining depression to the root cause of trauma, when appropriate.
- The MHP has developed a specialty for monitoring and serving the transition from acute to routine care as positively evidenced by the MHP outperforming the state averages in 7-day and 30-day follow-up as well as lower re-hospitalization rates at 7 and 30 days.
- Morale, bi-directional communication, and concerns related to some leadership clinical policy decision making continue.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: ABA: Improving Functioning of Youth Experiencing Anxiety

Date Started: 08/2021

Aim Statement: Will the application of ABA by caregivers to children and youth ages 3 to 13 diagnosed with SMI, improve the youth's functioning, as evidenced by decreasing the occurrence of anxiety as an actionable item on the CANS from 36% to 25% or less by the end of this two-year study. (NOTE: Age range was changed from 3 to 21 to 3 to 13 after a TA call with BHC in June 2022.)

Target Population: The population consists of children between the ages of 3 and 13 years of age who receive their mental health treatment in the Outpatient clinic or are involved in the Shasta County FC system.

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

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

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

Summary

The clinical PIP is focused on reducing anxiety levels in children between 3 and 21 years old who are receiving services in the CSB outpatient clinic or Shasta County HHSA FC system. The team chose ABA as the evidenced based clinical intervention to assist youth and their caregivers with reducing anxiety symptoms and improving emotion regulation skills. The goal of the PIP is to reduce anxiety as a treatment goal on the CANS-50 outcome tool from 36 percent to 25 percent at the end of two years.

Results are pending as the MHP did not provide the first remeasurement phase data or analysis, PIP Development Tool Worksheet 8 and 9.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: see PIP TA provided.

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

- Update the PIP Development Tool to include the data, analysis, and recommendations from the first remeasurement.
- Consider the impact of active traumas and ACES scores as a confounding variable.
- Assure that the PIP focus on assisting parents and caregivers in learning and applying ABA is maintained with fidelity and documented in all Development Tool Worksheets.
- Include parents and caregivers directly in future PIP processes.
- Table 5.1 measures the evidence of the intervention, not the goal, and should be redeveloped accordingly.
- Worksheet 6.4 does not address parents, only the youth. If the intervention is to train parents and caregivers 6.4 should be changed.
- Worksheet 7.2, please define “Documented count of ABA services”.
- Complete Worksheets eight and nine.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Decreasing No-Show Rates for Adult Services Outpatient Psychiatric Provider Appointments

Date Started: 01/2022

Aim Statement: The aim of this PIP is to decrease the no-show rate by five percent to adult beneficiaries in the subunit 5151 Adult Service population through systematically educating beneficiaries about the importance of attending psychiatric appointments as well as transportation options and assistance available to them. The time period of the study is from October 2021 through July 2023.

Target Population: Adult beneficiaries (age 20.6 and older) in the subunit 5151 BRES-Adult Service population.

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

Summary

Direct care staff reported that adult beneficiaries often cited transportation as a barrier to attending appointments. This is supported by a literature review conducted by the National Institute of Health in 2013, which states that "Barriers include costs (e.g., affordability of transport), physical factors (e.g., requiring a wheelchair-accessible vehicle or mobility assistance getting from their room to the vehicle), availability (e.g., car ownership or living near transit stops), and reliability (e.g., timeliness of pick-ups and drop-offs)." The study concludes that "lack or inaccessibility of transportation may be associated with less health care utilization, lack of regular medical care, and missed medical appointments, particularly for those from lower economic backgrounds

Interventions will include education and problem-solving transportation options proactively and at the time of need and utilization of reminder systems. Performance measures will be monitored through a no0show report and chart audits. Data has not yet been published.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the initial TA session revealed that there was a need to document the transportation options and how the MHP would assist the beneficiary in addition to educating the beneficiary.

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

- The MHP should include beneficiaries directly in the problem development; barrier and root cause analysis; goals; and intervention(s) development.
- The intervention should be rewritten to provide the MHP assistance beyond educating the beneficiary in more detail.
- The MHP should consider include working with the MCP and that plan's requirement to provide transportation and assist the beneficiary's success in its utilization.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner/Community Behavioral Health system (CCBH), which has been in use for 11 years. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to design and develop the system.

Approximately 1.4 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving HHSA Tech and County IT.

The MHP has 205 named users with log-on authority to the EHR, including approximately 205 county staff and zero contractor staff. Support for the users is provided by 25 full-time equivalent (FTE) IS technology positions. Currently 19 County IT staff and six HHSA IT staff have access to the Cerner server. The MHP receives additional support from Cerner Corporation which hosts the CCBH system.

As of the FY 2022-23 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	45%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	55%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not have a PHR. This functionality will be discussed with Netsmart Technologies during the myAvatar EHR design and implementation process.

Interoperability Support

The MHP is a member of SacValley MedShare HIE. Progress notes, medication lists, appointments and current and past diagnosis data is uploaded to SacValley MedShare. Healthcare professional staff can also use secure information exchange directly with service partners through secure email.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- Netsmart Technologies' myAvatar was selected as the replacement EHR system; a contract was signed July 1, 2022; IT, clinical, QI and fiscal staff have been meeting with Netsmart approximately eight hours per week; and the Go Live date for myAvatar is September 2023.
- While 34.4 percent of services are provided by contract providers, no contract providers have full access to CCBH.
- Shasta is able to share electronic health information between providers in a 21-county area of Northern California via SacValley MedShare. SacValley MedShare is a member of the California Association of Health Information Exchanges which allows the secure sharing of health information throughout California.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

For the MHP, it appears that significant claims lag begins in October and likely represents $6,000,000 in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through August 2022. Therefore, table 18 may reflect an incomplete claims data set for the time period reported.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	4,935	$2,059,141	$22,349	1.09%	$2,036,792
Feb	5,550	$2,236,151	$43,246	1.93%	$2,192,905
Mar	6,264	$2,730,328	$50,957	1.87%	$2,679,371
April	5,521	$2,474,162	$28,206	1.14%	$2,445,956
May	4,752	$2,130,904	$35,849	1.68%	$2,095,055
June	4,626	$2,012,917	$44,339	2.20%	$1,968,578
July	3,424	$1,901,684	$55,706	2.93%	$1,845,978
Aug	2,966	$1,664,303	$58,847	3.54%	$1,605,456
Sept	2,758	$1,393,295	$10,332	0.74%	$1,382,963
Oct	276	$81,719	$9,698	11.87%	$72,021
Nov	82	$32,428	$3,808	11.74%	$28,620
Dec	0	$0	$0	0.00%	$0
Total	**41,154**	**$18,717,032**	**$363,337**	**1.94%**	**$18,353,695**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	275	$257,778	70.95%
Medicare Part B or Other Health Coverage must be billed before submission of claim	251	$69,971	19.26%
Beneficiary not eligible or non-covered charges	31	$20,962	5.77%
Service line is a duplicate and a repeat service procedure code modifier not present	39	$9,238	2.54%
NPI related	20	$5,388	1.48%
Total Denied Claims	**616**	**$363,337**	**100.00%**
Overall Denied Claims Rate	**0.32%**		
Statewide Overall Denied Claims Rate	2.78%		

- The MHP's claim denial rate for CY 2021 of 0.32 percent is significantly lower than the statewide average of 2.78 percent.
- Claims with denial codes claim/service lacks information which is needed for adjudication, Medicare Part B or other health coverage must be billed prior to the submission of this claim and National Provider Identifier (NPI) related are generally rebillable within State guidelines upon successful remediation of the reason for denial.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- A robust Outcome, Planning and Evaluations team effectively supports the analytic needs of the organization.
- While participation in SacValley MedShare allows the MHP to share electronic health information between northern California providers, SacValley MedShare's membership in the California Association of Health Information Exchange allows for the secure sharing of health information throughout California.
- Shasta has selected Netsmart's myAvatar as a replacement system for the CCBH system. A new EHR will provide the benefit for designing improved functionality as well as CalAIM compliant billing functionality.
- Without contractor provider access to CCBH, beneficiary health information is maintained in disparate electronic health records which limits 24/7 access to beneficiary health information.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP shares results from the CPS in the QIC and various staff meetings.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers. The focus group was held at via tele-video and included seven participants, all English speaking. All consumers participating receive clinical services from the MHP.

Access to initial services ranged from immediately to six to eight weeks. Family can be involved if needed. Discussions regarding coordination with physical health providers was presented as not consistent for all beneficiaries, but no concerns were raised. Options for transportation were not universally known, but not transportation problems were identified. Services were represented as timely. Most services were face to face. Telehealth is utilized for doctor visits but no other services. Consumers generally knew where and how to access crisis services. The consumers were favorable of the peer staff and the wellness center. Consumers did not recall consumer surveys or other organized efforts to involve them in MHP processes. Overall, the adult consumers were very appreciative and positive about the staff and services they receive.

Recommendations from focus group participants included: none.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of parents/caregivers of youth receiving MHP services. The focus group was held at via tele-video and included seven participants, all English speaking.

Access to initial services ranged from immediately to six to eight weeks. Family members are directly involved as needed. Discussions regarding coordination with physical health providers was presented as not consistent for all beneficiaries, but no concerns were raised. Options for transportation were not universally known, but not transportation problems were identified. Services were represented as timely. Most services were provided face-to-face. Telehealth is utilized for doctor visits, but not other services. Consumers did not recall consumer surveys or other organized efforts to involve them in MHP processes. Overall, the adult consumers were very appreciative and positive about the staff and services they receive.

Consumers generally knew where and how to access crisis services. Crisis experiences in EDs and IP care varied but several participants presented that they had a poor experience in at least one aspect of the ED, IP, or transition to OP continuum.

Caregivers felt they were informed about their services and were listened to if they had a concern but were not involved in any formal communications or MHP processes.

Recommendations from focus group participants included:

- The MHP to provide a local crisis / talk line other than national hotlines.
- The MHP to provide more evening hours.
- The MHP to provide more evening crisis response for youth that does not include going to the ED.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall adults and parents/caregivers were pleased with their psychiatric, clinical and case management services. All levels of providers were spoken of favorably. Access was generally within days. Crisis systems, especially for youth, was represented as chaotic and was the only area of negative feedback.

CONCLUSIONS

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

STRENGTHS

1. The MHP has implemented several changes in the children's system of care to improve overall access and services. (Access)
2. A new PIP to reduce psychiatric medication appointment no-shows by improving transportation opportunities has been implemented. (Timeliness)
3. The MHP has realigned the adult and children's branches under one leadership and has committed to include leadership in the QI processes. (Quality)
4. The MHP QI plan and QIC actively address the CalAIM initiatives and evidence a developed data driven quality approach to implementing standards of care. (Quality)
5. The MHP has chosen, contracted, and is meeting regularly with Netsmart to go-live with a new EHR, myAvatar, by July-August 2023. (Information Systems)

OPPORTUNITIES FOR IMPROVEMENT

1. Families of youth presented that, on several occasions, they had poor experiences in emergency departments (EDs), inpatient (IP) settings or the transition to the outpatient (OP) services. Concerns included not feeling that the decisions or facilities kept their youth safe. (Access)
2. The MHP continues to experience delays providing the first non-urgent psychiatry appointment for adults, children, and FC youth. (Timeliness)
3. It was unclear whether the single service PR of 20.07 percent, 50 percent greater than the state average, represented a quality care gap. (Quality)
4. With the launch of a new EHR, it would greatly improve care coordination if the CBOs and contract providers were included in the new EHR development. (IS)
5. Clinical line staff, clinical supervisors, and CBO and contractors, universally endorsed morale, bidirectional communication, and leadership clinical policy decision making, as areas needing improvement. (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. Investigate the reasons, develop strategies, and implement solutions to improve the monitoring and reporting of safe care in EDs, IP settings, and the transition to the OP service. (Access)
2. Investigate the reasons, develop strategies, and implement solutions to improve timeliness in providing the first non-urgent psychiatry appointment for adults, children, and FC youth. (Timeliness)
3. Investigate the reasons, develop strategies, and implement solutions to improve the single service PR of 20.07 percent. (Quality)
4. Investigate the reasons, develop strategies, and implement solutions to allow full contract provider access to the myAvatar electronic health record, including the ability to input and maintain clinical data such as progress notes and medication lists. (Information Systems)
5. Investigate the reasons, develop strategies, and implement solutions to improve morale, bidirectional communication and concerns related to bi-directional communication in leadership clinical policy decision making. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Shasta MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Clinical Management and Supervision
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
EHR Deployment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Bill Walker, QR
Lisa Farrell, ISR
Valerie Garcia, CFMR

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.

MHP County Sites

All sessions were held via video conference

MHP Contract Provider Sites

All sessions were held via video conference

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Adams	Crystal	Program Manager	Children's
Anderson	Shannon	Program Manager	Children's
Bastaros	Andrew	Program Manager	Business Support Services
Bergen	John	Peer Support Specialist	Adult
Betts	Graceann	Peer Support Specialist	Adult
Betts	Karen	Clinical Division Chief	Adult
Black	Kristina	Senior Staff Services Analyst	Adult/Children's
Boss	Trisha	Audit, Accountability & Compliance Manager	Agency Director's Office
Buck	Amparo	Program Manager	Adult
Burch	Laura	Director	HHSA
Carnate	Darlyn	Clinician	Children's
Carlon	Julie	Program Manager	Adults
Caro	Julee	Social Worker	Children's
Carothers	Mary (Molly)	Staff Services Analyst	Business Support Services
Carpenter	Joseph	Agency Staff Services Analyst	Agency Director's Office
Cassidy	Katie	Program Manager	Adult
Chao	Cela	Supervising Accountant	Business Support Services
Chao-lee	Mey	Clinical Program Coordinator	Adult
Cogger	Bailey	Senior Staff Services Analyst	Children's
Constant	Alexis	Clinician	Adult

Last Name	First Name	Position	County or Contracted Agency
Conti	Michael	Deputy Director	Business Support Services
Costa	Shellie	Program Manager	Business Support Services
Crumby	Carlene	Senior Staff Services Analyst	Business Support Services
Dorney	Megan	Director	Business Support Services
Englin	Jehoisabiah (Josie)	Peer Support Specialist	Adult
Evanzia	Dominic	Senior Staff Services Analyst	Agency Director's Office
Field	Melissa	Program Manager	Agency Director's Office
Fischer	Nicole	Patients Right's Advocate	Adult
Green	Dwayne	Deputy Director	Adult
Greenhood	William	Peer Support Specialist	Children's
Grey	Ellawyn	Assistant Social Worker	Adult
Heberlein	Clemencia	Supervising Accountant	Business Support Services
Hillman	Margaret	Clinician	Adult
Hosler	Louellen	Social Service Aide	Children's
Hughes	Stacey	Clinician	Children's
Killgore	Kevin	Senior Social Worker	Adult
Lane	Cindy	Deputy Director	Children's
Larson	Justina	Clinical Program Coordinator	Business Support Services
Limon	Kimberly	Staff Services Analyst	Business Support Services

Last Name	First Name	Position	County or Contracted Agency
Marvin	Peter	Clinical Program Coordinator	Adult
McAuliffe	Natalie	Community Development Coordinator	Adult
McKinney	Kimberly	Clinical Program Coordinator	Adult
Moon	Wendy	Clinical Program Coordinator	Children's
Moua	Leah	Clinical Division Chief	Children's
Nelson	John	Clinician	Business Support Services
Nowain	Benjamin	Agency Staff Services Analyst	Business Support Services
Ohler	Marcus	Clinician	Children's
Ottinger	Pamela	Program Manager	Children's
Peluso	Christopher	Social Worker	Adult
Restivo	Genell	Clinical Division Chief	Adult
Rhymes-Danielson	Shawna	Clinical Program Coordinator	Children's
Riddle	Rachelle	Staff Services Analyst	Business Support Services
Riley	Ashley	Office Assistant	Business Support Services
Rodriguez	Miguel	Director	Adult/Children's
Shanahan	Tara	Program Manager	Children's
Shuffleton	Leah	Clinical Program Coordinator	Business Support Services
Stapp	Laura	Deputy Director	Adult/Children’s

Last Name	First Name	Position	County or Contracted Agency
Stewart	Christina	Clinical Program Coordinator	Children's
Taylor	Stacy	Senior Staff Analyst	Business Support Services
Tucker	Wesley	Program Manager	Business Support Services
Walker	Daniel	Epidemiology & Evaluations Supervisor	Agency Director's Office
Ward	Deidra	Clinician	Adult
Ward	Jill	Patients Right's Advocate	Adult
West	James	Clinical Program Coordinator	Business Support Services
Zumalt	Monteca	Clinical Division Chief	Children's
Diamantine	Amy	Regional Director of Program Development	Northern Valley Catholic Social Services (NVCSS)
Fontenot	Tanya	Director of Community Mental Health and Post Adoption Services	Wayfinder
Foster	Troy	Quality Assurance Officer	Remi Vista
Green	Kaitlyn	Clinical Supervisor	Wayfinder
Grovet	Jennifer	Clinical Supervisor and TBS Clinical Coordinator	NVCSS-Victor
Jackson	Addie	Administrative Specialist	Kingsview
McCullough-Stubbs	Katie	Executive Director	victor
Stine	Anthony	Clinician	Kingsview
Stout	Lisa	Clinical Program Manager	NVCSS

Last Name	First Name	Position	County or Contracted Agency
Montgomery	Mark	Regional Director	Kingsview

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	See" EQRO Recommendations for improving the PIP".

General PIP Information
MHP/DMC-ODS Name: Shasta County MHP
PIP Title: ABA: Improving Functioning of Youth Experiencing Anxiety
PIP Aim Statement: "Will the application of ABA by caregivers to children and youth ages 3 to 21 diagnosed with serious mental illness (SMI), improve the youth's functioning, as evidenced by decreasing the occurrence of anxiety as a treatment goal on the CANS-50 from 36 percent to 10 percent or less by the end of this two-year study?"
Date Started: 08/2021
Date Completed: Planned completion 08/2023
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
PIP Aim Statement: "Will the application of ABA by caregivers to children and youth ages 3 to 21 diagnosed with serious mental illness (SMI), improve the youth's functioning, as evidenced by decreasing the occurrence of anxiety as a treatment goal on the CANS-50 from 36 percent

General PIP Information
to 25 percent or less by the end of this two-year study?”
Date Started: 08/2021
Target population description, such as specific diagnosis (please specify): The population consists of children between the ages of 3 and 13 years of age who receive their mental health treatment in the Outpatient clinic or are involved in the Shasta County FC system.
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): ABA by caregivers to children and youth ages 3 to 13
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
CANS-50 scores with anxiety as treatment goal	FY2019-20	36%	☐ Not applicable—PIP is in planning or implementation phase, results not available	Data due 08/2022 not yet available	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PSC-35 scores with anxiety reported by caregivers	FY2019-20	34.1%	☐ Not applicable—PIP is in planning or implementation phase, results not available	Data due 08/2022 not yet available	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of ABA sessions (EHR Documentation)	N/A	Zero	☐ Not applicable—PIP is in planning or implementation phase, results not available	Data due 08/2022 not yet available	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- Update the PIP Development Tool to include the data, analysis, and recommendations from the first remeasurement.
- Consider the impact of active traumas and ACES scores as a confounding variable.
- Assure that the PIP focus on assisting parents and caregivers in learning and applying ABA is maintained with fidelity and documented in all Development Tool Worksheets.

PIP Validation Information
• Include parents and caregivers directly in future PIP processes. • Table 5.1 measures the evidence of the intervention, not the goal, and should be redeveloped accordingly. • Worksheet 6.4 does not address parents, only the youth. If the intervention is to train parents and caregivers 6.4 should be changed. • Worksheet 7.2, please define “Documented count of ABA services”. • Complete Worksheets 8 and 9.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The initial TA session revealed that there was a need to document the transportation options and how the MHP would assist the beneficiary in addition to educating the beneficiary.

General PIP Information
MHP/DMC-ODS Name: Shasta County MHP
PIP Title: Decreasing No-Show Rates for Adult Services Outpatient Psychiatric Provider Appointments
PIP Aim Statement: The aim of this PIP is to decrease the no-show rate by 5% to adult beneficiaries in the subunit 5151 BRES-Adult Service population through systematically educating beneficiaries about the importance of attending psychiatric appointments as well as transportation options and assistance available to them. The time period of the study is from October 2021 through July 2023.
Date Started: 01/2022
Date Completed: NA
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: Adult beneficiaries (age 20.6 and older) in the subunit 5151 BRES-Adult Service population.

General PIP Information
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Systematically educating beneficiaries about the importance of attending psychiatric appointments as well as transportation options and assistance available to them.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):
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):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Reduce number of unkept psychiatric appointments by 5% (from 14% average to 13.3% or lower)	**FY21-22 Q4**	No provided	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • The MHP should include beneficiaries directly in the problem development; barrier and root cause analysis; goals; and intervention(s) development. • The intervention should be rewritten to provide the MHP assistance beyond educating the beneficiary in more detail. • The MHP should consider include working with the MCP and that plan's requirement to provide transportation and assist the beneficiary's success in its utilization.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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