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FY 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review

SISKIYOU FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

May 17, 2023

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — May 17, 2023

MHP Size — Small-rural

MHP Region — Superior

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

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

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	1	5	0
Quality of Care	10	4	5	1
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**14**	**11**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
"Moral Recognition Therapy (MRT) Diversion Group"	Clinical	04/2022	Implementation	Moderate
"Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)"	Non-Clinical	09/2022	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	6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP provided excellent preparation and efforts towards the CalEQRO FY 2022-23 review with detailed reporting, completed PIPs and documented performance on the required FY 2021-22 Recommendations.
- In addition to Project Basecamp, a new housing option, "Siskiyou Crossroads" will offer a supportive housing option with 50 supportive units and 24 "No Place Like Home (NPLH)" beds.
- The MHP works diligently to manage beneficiary crisis within the community with initiatives to offer an array of field-based services which mitigate the need for inpatient care.
- The MHP is a data driven department which consistently reviews data to identify needed improvements and mirrors the additional requirements and changes that impact the behavioral health system.
- Working with the counties of Kern, Nevada and San Benito the MHP participates in a four-county collaboration to improve quality services and create a learning community for shared knowledge.

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

- The MHP has opted to join the California Mental Health Services Authority (CalMHSA), SmartCare Electronic Health Record (EHR) collaborative, which includes a limited set of standardized data metrics and may not fully meet unique data thresholds.

- Key informants have suggested expanding Wellness Centers hours and activities to reduce no-show rates, as well as offer activities such as showers, laundry, and clinical services.
- The MHP has identified areas within their Quality Assurance and Performance Improvement (QAPI) plan that do not correlate with current services, expectations and/or are not consistent with the Key Performance Indicators (KPIs) they would like to address.
- There is a lack of consistency and equitability in allowing staff a hybrid working environment; and access to data entry when providing field-based services, leading to employee dissatisfaction and increased staffing turnover.
- The MHP has reported the Consumer Perception Survey (CPS) does not offer usable data and the small sample size does not offer aggregated information for improvement.

Recommendations for improvement based upon this review include:

- Determine specialized reports to customize for specific data needs that are not included within the standard SmartCare EHR data templates.
- Investigate the feasibility of expanded hours in the Wellness Centers to allow for drop-in activities such as cooking, showers, laundry, and clinical services, to increase beneficiary access and reduce no-show rates.
- Improve the QAPI plan by reviewing each goal and objective, including the voice of stakeholders, and create an updated plan that allows for accurate identification of desired KPIs, and evaluation of each goal.
- Create a policy and implement an equitable field-based “in the moment” data entry process for field-based services; and investigate the feasibility of a hybrid work environment to increase staff satisfaction and retention.
- Identify or create and implement a beneficiary and family/caregiver satisfaction survey or focus group, to address the accessibility and satisfaction of offered and rendered services.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2022-23 findings of the EQR for Siskiyou County MHP by BHC, conducted as a virtual review on May 17, 2023.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

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

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, then “<11” is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages 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 after the Coronavirus Disease 2019 (COVID-19) pandemic, the Mill fire which burned 100 homes to the ground, an ongoing severe drought, followed by the atmospheric river which dumped unprecedented snow, leaving staff and clients unable to travel for services and now threatening the county with extreme flood conditions. The county remains 57th out of 58 counties on the state overall wellbeing and health ranking of California Counties. The MHP continues to see an impact of the reduction of clinical staff, either leaving employment or opting to work in surrounding counties. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP continues to struggle hiring and retaining staff. The MHP has increased their efforts to hire telehealth providers by adding two new contracts. The MHP offers loan assumption and retention bonuses.
- In collaboration with the city of Yreka, the MHP was responsible for staffing five separate warming centers during the extensive inclement weather and low temperatures in the county, putting additional strain on staff.
- The MHP is implementing a new EHR that will change its current application service provider (ASP) to a CalMHSA run system with increased ability for MHP set up and system administration.
- The MHP reclassified two supervisors Adult and Children's System of Care (ASOC and CSOC) to System Administrators and added a Fiscal Deputy Director.
- In response to new legislation, the MHP has contracted with Cal Hearing Officers LLP to provide hearings in the ED when the initial 72-hour hold will expire prior to placement or stabilization. A Patients' rights advocate will coordinate hearings.

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: Identify gaps in services to the Spanish speaking community. Investigate the feasibility of Spanish speaking telehealth options when an adequate bi-lingual workforce is unattainable.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP hired two Spanish speaking telehealth clinicians.
- The MHP hired one additional Spanish speaking in-person clinician.
- The MHP now has one Spanish speaking Access Coordinator, two in-person Spanish speaking clinicians and two telehealth clinicians, as well as translation and interpretation contracts.

Recommendation 2: Provide a private space and necessary technology to allow for telehealth to beneficiaries who prefer telehealth over in person and/or telephonic outpatient services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- For therapy services, the MHP added two telehealth offices to the north county clinic and two to the south county clinic. Additionally, the medication department was updated to include telehealth suits in every office. Nursing is now conducted from a centralized location and the MHP added two Psychiatric Aides to support telehealth appointments.

Recommendation 3: Identify and implement transportation options to meet the needs of beneficiaries; this may include contracting directly with a transport provider.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP hired extra help drivers to fulfill transportation needs.
- Partnership Health Care (PHC) notified the MHP of the change from the previous transportation vendor to a new one. The expectation is the new vendor will reduce the negative impact that was experienced with the previous vendor.
- The MHP has contracted with Mt Shasta Ambulance and Rouge Valley Medical Transport for transportation of individuals for 5150 applications with additional medical/physical health needs.

Recommendation 4: Expand outcome goals within the Quality Improvement Workplan (QIWP), (language used interchangeably with the QAPI) to include the impact on beneficiaries when compliance percentage goals are measured.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation by adding beneficiary impact to each of its identified goals.
- The QIWP/QAPI is available on the MHP's website.
- The MHP self-identified the desire to relook at the QAPI and identify more aligned goals and KPIs.

Recommendation 5: Identify the cause(s) for claim denials labeled as "beneficiary not eligible or non-covered charges" and "beneficiary not eligible" and develop a protocol to reduce the percentage of claims denied in these categories.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP determined these denied claims to be associated with Medi-Cal beneficiaries whose eligibility aid codes do not qualify them for mental health services. The MHP has put in place a policy for stricter monitoring of the eligibility aid codes from the time a beneficiary is enrolled in MHP services.
- Although in the latest claims data available to CalEQRO this denial reason continued to be the top reason, CalEQRO considers this recommendation addressed because of the steps taken by the MHP and due its very low denial rate.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 97.86 percent of services were delivered by county-operated/staffed clinics and sites, and 2.14 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 88.2 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 and contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: self-referrals, phone, fax, in-person, schools, and the Child Welfare System (CWS). The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. An individual is screened for Level of Care (LOC), then offered an assessment, the assessment then places the individual into the proper LOC within the continuum of care. If the individual does not meet threshold the individual is referred to Beacon for lower LOC services

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 610 adult beneficiaries, 147 youth beneficiaries, and 56 older adult beneficiaries across two county-operated sites and one contractor-operated sites. Among those served, <11 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

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

For Siskiyou 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	
AAS Details	**Psychiatry**	**MH Services**

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

Table 1B: MHP Out-of-Network Access, FY 2021-22

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

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

ACCESS KEY COMPONENTS

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

the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

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

Table 2: Access Key Components

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

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

- Key informants are aware of translation and interpretations services offered to beneficiaries.
- As a Super Agency, the MHP activity collaborates with the CWS and Probation for improved access and services to both youth and adults.
- The MHP reported providing intern positions in partnership with three universities to assist with capacity needs.
- The MHP collaborates with other entities to construct affordable supportive housing units throughout Siskiyou County.
- In addition to Project Basecamp a low barrier with 32 beds, a new housing option, “Siskiyou Crossroads” will offer a supportive housing option with 50 supportive units and 24 NPLH beds. The supportive housing nature of this project will increase ease of access to services for potential members.
- Of note is the reported lack of collaboration between substance use disorder (SUD) staff and mental health staff.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, Siskiyou's access appears to have improved in CY 2021 compared to CY 2020.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	19,839	1,296	6.53%	$7,104,574	$5,482
CY 2020	18,554	1,130	6.09%	$5,860,695	$5,186
CY 2019	18,535	1,117	6.03%	$5,538,529	$4,958

*Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- In CY 2021, Siskiyou experienced a 6.9 percent increase in the number of Medi-Cal eligibles. At the same time, the MHP increased its number of beneficiaries served by 14.7 percent, resulting in a 7.2 percent increase in the PR.
- In CY 2021, the MHP's total approved claims increased by 21.2 percent primarily due to the increase in the number of beneficiaries served. Its AACB increased by a more modest 5.7 percent.

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	1,920	39	2.03%	1.71%	1.96%
Ages 6-17	4,277	255	5.96%	8.65%	5.93%
Ages 18-20	836	55	6.58%	7.76%	4.41%
Ages 21-64	10,832	864	7.98%	8.00%	4.56%
Ages 65+	1,975	83	4.20%	3.73%	1.95%
Total	**19,839**	**1,296**	**6.53%**	**7.08%**	**4.34%**

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

- Siskiyou's overall PR is 0.55 percentage point lower than the small-rural MHP average PR, but 2.19 percentage points higher than the average statewide PR.
- Its lower than small-rural MHP average PR is mostly accounted for by its PR for the 6-17 age group which has the largest difference of all age groups when compared to the small-rural MHP average PR.
- The largest number of beneficiaries served were adults in the age group of 21-64 years. For this age group, Siskiyou's PR in CY 2021 was similar to the small-rural MHP average and 75 percent higher than the statewide average PR.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Total Threshold Languages	None	**-**
Threshold language source: Open Data per BHIN 20-070		

- Siskiyou has not had a threshold language since the first data collection in 2018.

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

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	5,921	373	6.30%	$1,537,879	$4,123
Small-Rural	35,376	2,377	6.72%	$12,056,144	$5,072
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- In CY 2021, Siskiyou's ACA PR was comparable to its overall PR; however, the ACA AACB was lower than the overall AACB by 24.8 percent. It was also lower than the small-rural MHP and the statewide average AACBs by $949 and $2,260 respectively.

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

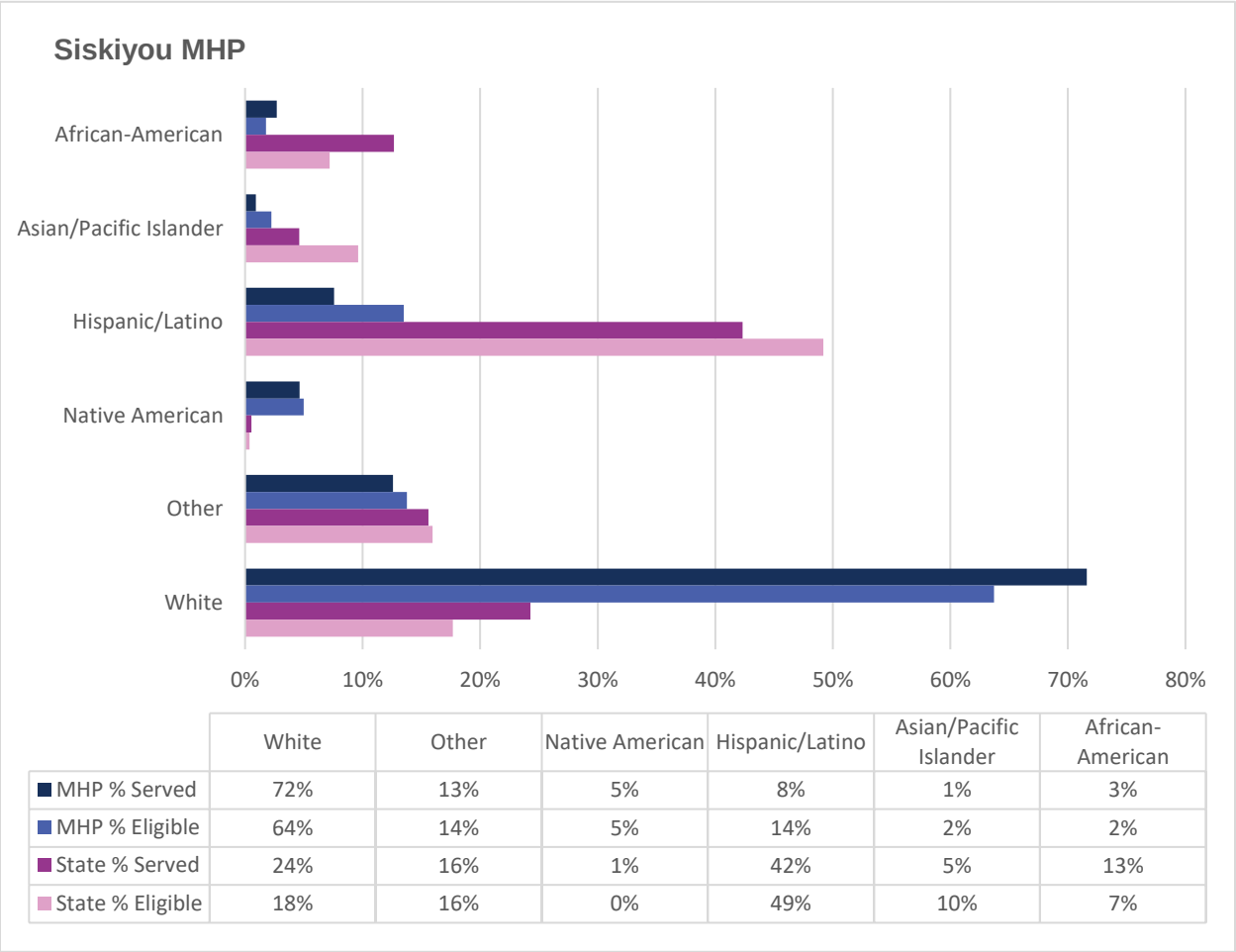
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	354	35	9.89%	7.64%
Asian/Pacific Islander	443	12	2.71%	2.08%
Hispanic/Latino	2,679	98	3.66%	3.74%
Native American	990	60	6.06%	6.33%
Other	2,734	163	5.96%	4.25%
White	12,642	928	7.34%	5.96%
Total	**19,842**	**1,296**	**6.53%**	**4.34%**

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

- Siskiyou's PR for most race/ethnicity groups were higher than the corresponding statewide averages in CY 2021. This includes Whites, who are the largest race/ethnicity group in Siskiyou and whose PR was 23.2 percent higher than the state.
- Latino/Hispanic and Native Americans were the groups for which the PRs were slightly lower than the corresponding statewide average PRs.

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

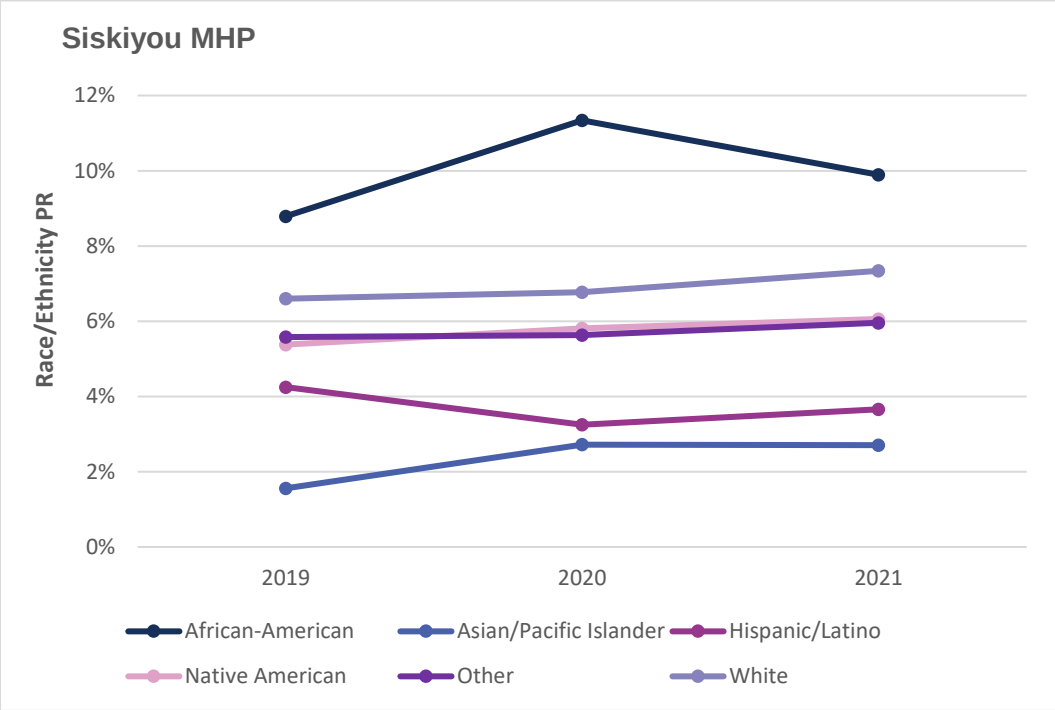


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	72%	13%	5%	8%	1%	3%
MHP % Eligible	64%	14%	5%	14%	2%	2%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- Latino/Hispanics constitute the second largest beneficiary group along with Other by race/ethnicity and had the largest disparity in terms of the eligible and beneficiaries served percentages. The Other group did not show such disparities and Whites, the largest group, was served at a greater proportion than their eligible percentage.

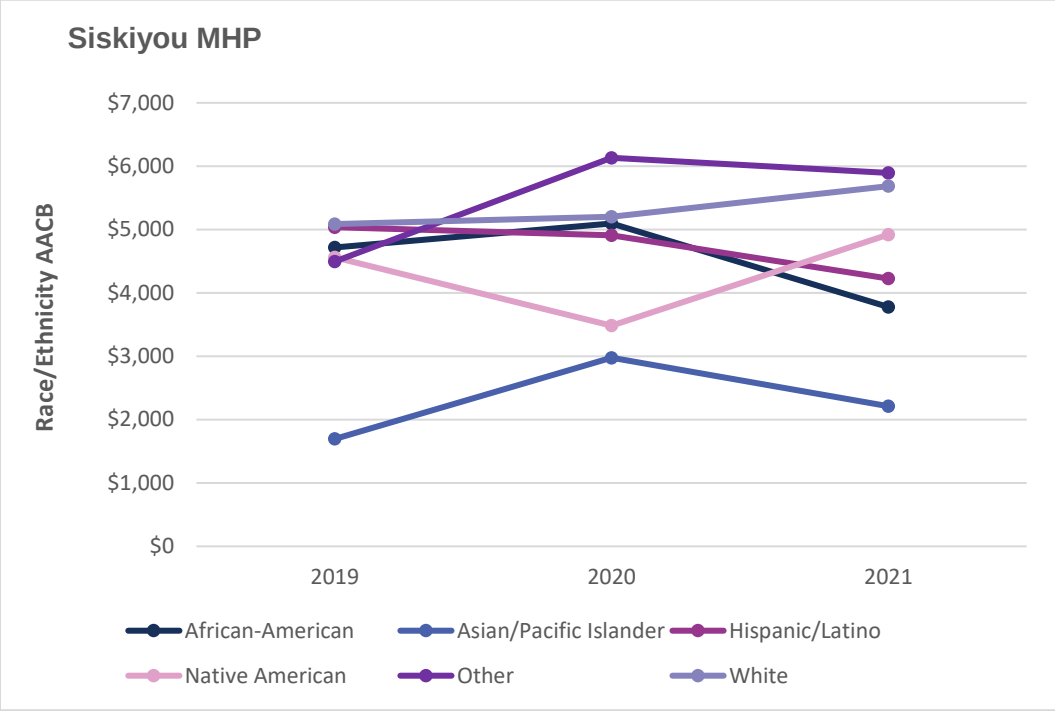
Figures 2 –11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



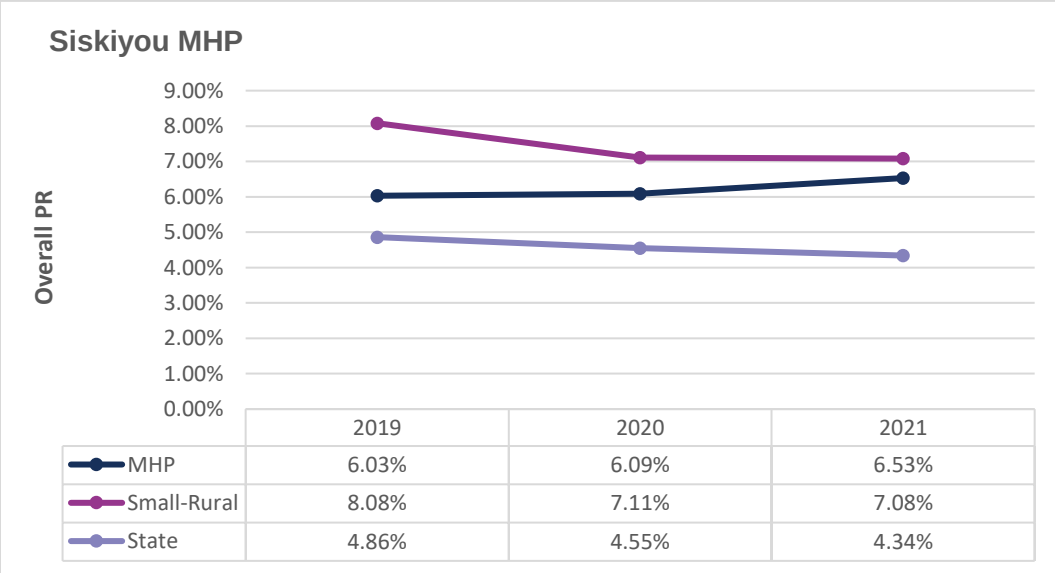
- Asian/Pacific Islanders constitute a low percentage of MHP's eligibles and had the lowest PR of all race/ethnicity groups. During the review, the MHP noted that this has traditionally been a hard-to-reach population with various cultural and linguistic barriers. They were also likely to receive less services than their counterparts from other groups.
- Latino/Hispanic PR declined since CY 2019 and was the second lowest after the Asian/Pacific Islanders.
- African Americans had the highest PR, but it was based on a relatively small number of beneficiaries. Among the significant groups, Whites consistently had the highest PR for three years between CY 2019 and CY 2021.

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



- Asian/Pacific Islanders (API) had the lowest AACB as well among all race/ethnicity groups, thus validating the MHP's statement on this group receiving lower number of services.
- White and Other race/ethnicity groups had the highest AACB in CY 2021 while the Latino/Hispanic AACB went down in CY 2021.

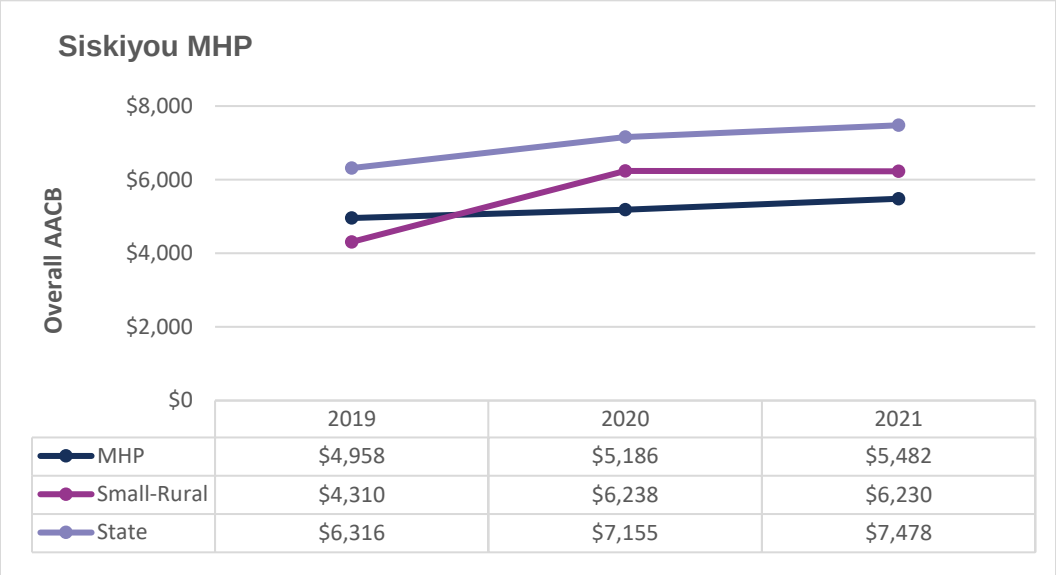
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	6.03%	6.09%	6.53%
Small-Rural	8.08%	7.11%	7.08%
State	4.86%	4.55%	4.34%

- The MHP's PR, while lower than the small-rural MHP average, steadily increased between CYs 2019 and 2021 while both the small-rural and statewide average PRs decreased.

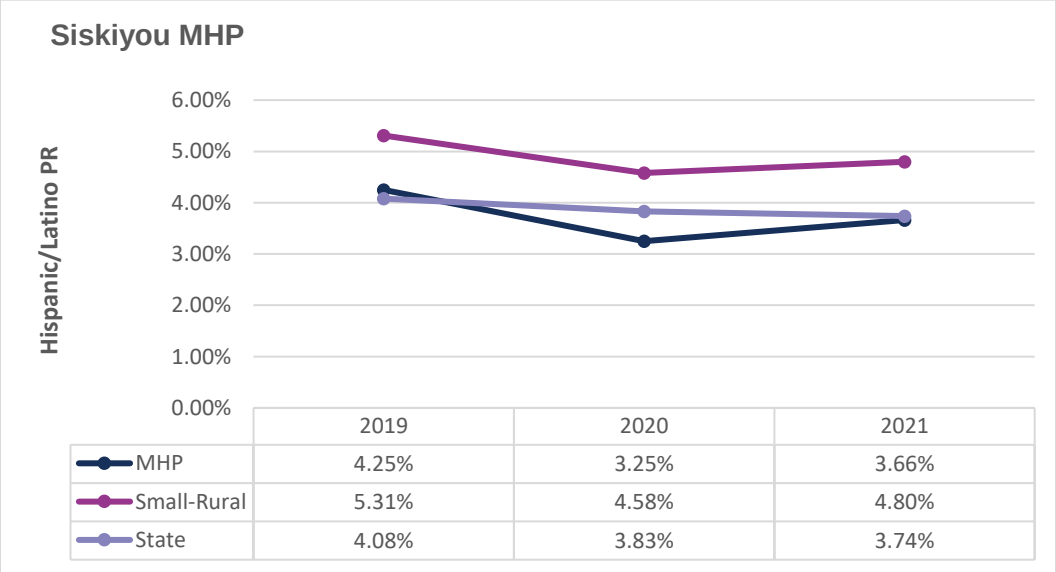
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,958	$5,186	$5,482
Small-Rural	$4,310	$6,238	$6,230
State	$6,316	$7,155	$7,478

- Compared to the small-rural MHPs' and statewide overall AACBs, Siskiyou's AACB increased more modestly between CY 2019 and CY 2021. It was lower than both of those in CY 2021.

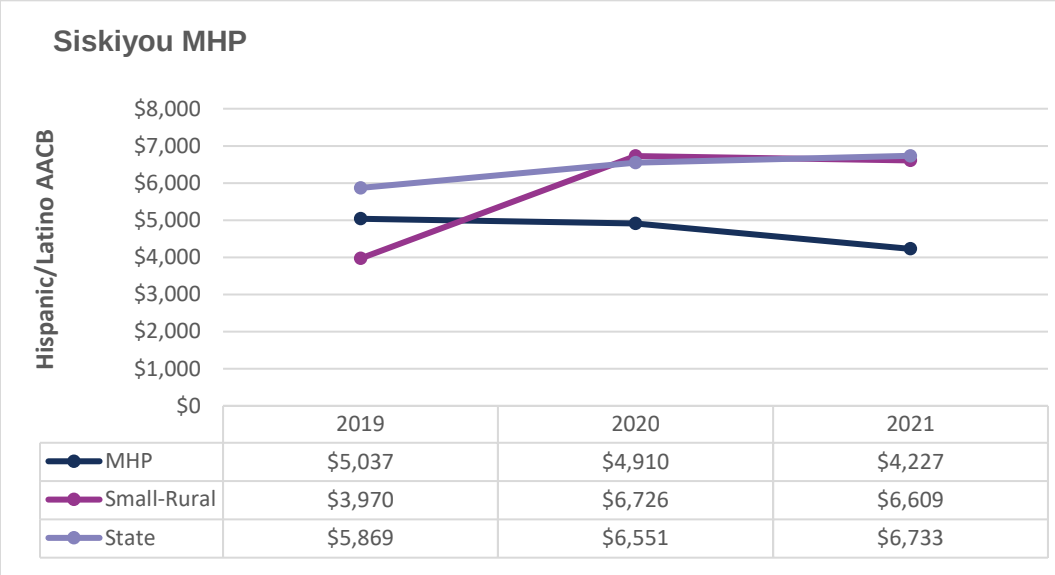
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	4.25%	3.25%	3.66%
Small-Rural	5.31%	4.58%	4.80%
State	4.08%	3.83%	3.74%

- Siskiyou's Latino/Hispanic PR declined by 23.5 percent between CY 2019 and CY 2020, then recovered slightly in CY 2021, but was well below the small-rural average PR and lower than the state.

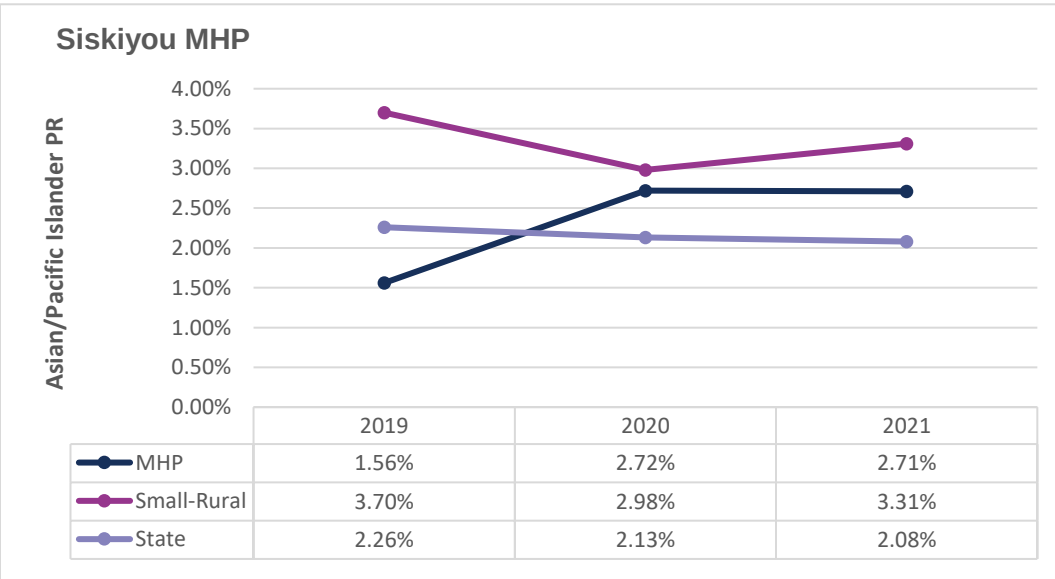
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$5,037	$4,910	$4,227
Small-Rural	$3,970	$6,726	$6,609
State	$5,869	$6,551	$6,733

- The MHP's Latino/Hispanic AACB declined by 16.1 percent between CYs 2019 and 2021. This contrasted with the MHP's overall AACB which showed a modest increase during the same period. In CY 2021, the MHP's Latino/Hispanic AACB was less than two-thirds of the corresponding small-rural MHP and statewide averages.

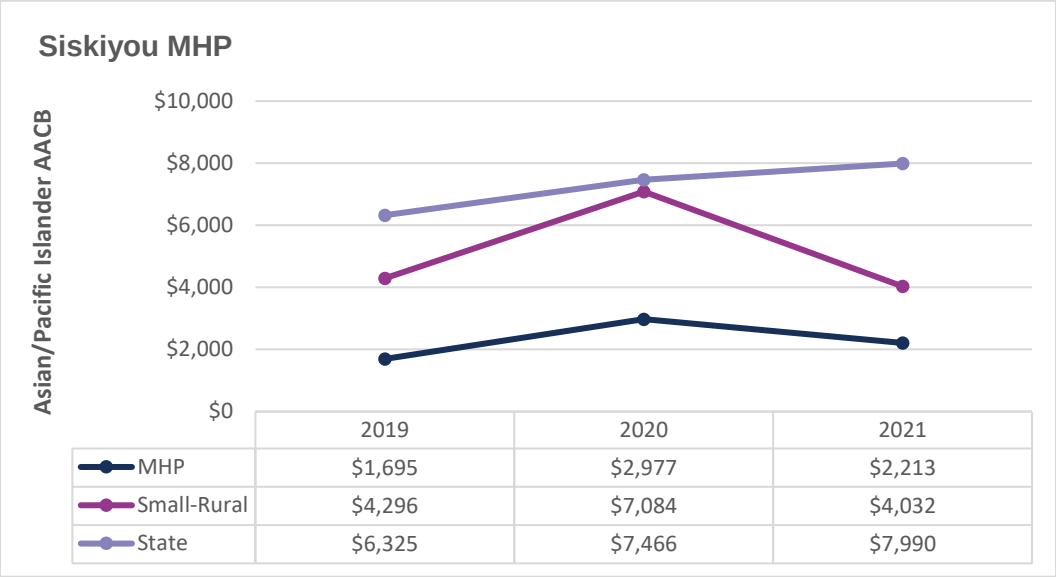
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	1.56%	2.72%	2.71%
Small-Rural	3.70%	2.98%	3.31%
State	2.26%	2.13%	2.08%

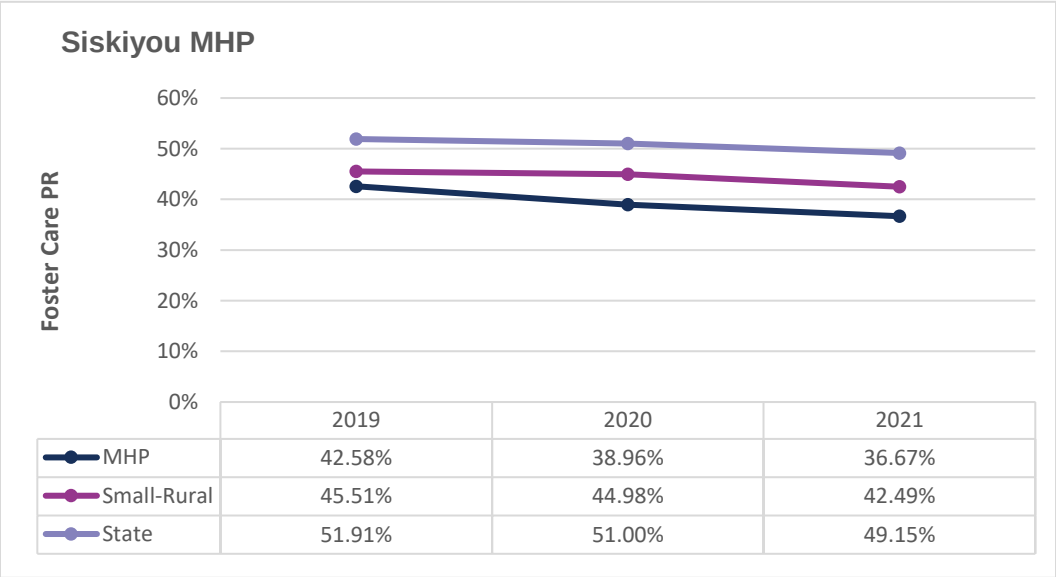
- The MHP's Asian/Pacific Islander PR improved since CY 2019 and was higher than the state in CYs 2020 and 2021. It was however lower than the corresponding small-rural MHP PR.
- The largest of the Asian/Pacific Islander population is the Hmong community. The MHP has made progress in engaging the community, though it remains challenging due to fears of governmental agencies and lack of immigration status.

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



- While statewide, the Asian/Pacific Islander AACB is increasing, for small-rural MHPs, including Siskiyou, after an increase in CY 2020, it decreased once again. For Siskiyou especially the AACB for Asian/Pacific Islanders is even lower and as mentioned, the lowest of all race/ethnicity groups in the county.

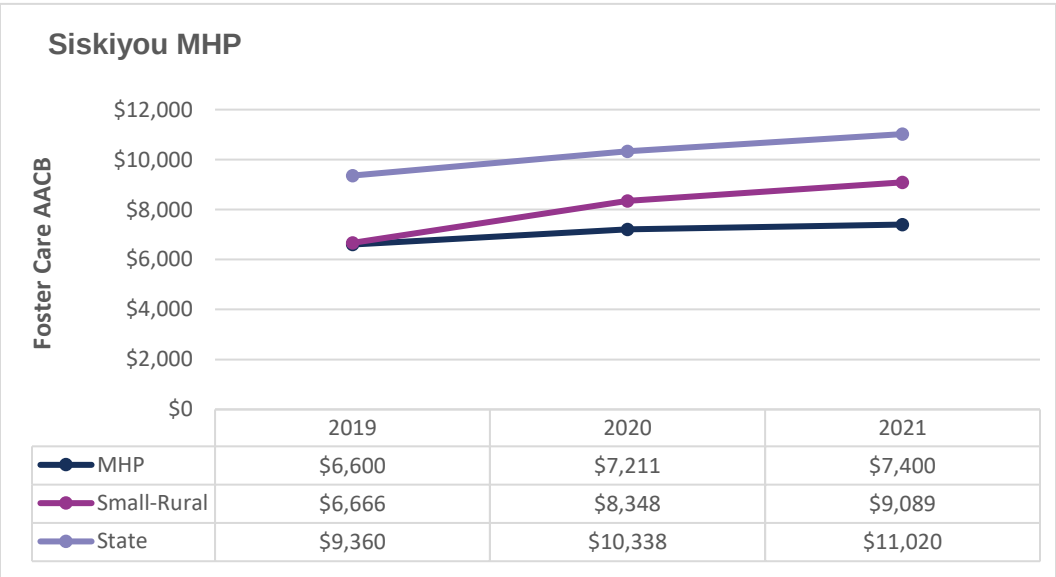
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	42.58%	38.96%	36.67%
Small-Rural	45.51%	44.98%	42.49%
State	51.91%	51.00%	49.15%

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed.
- Siskiyou's FC PR declined between CYs 2019 and CY 2021, and it was consistently lower by 13 percentage points than the state in CYs 2020 and 2021. It was also lower than the small-rural MHP average FC PR.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$6,600	$7,211	$7,400
Small-Rural	$6,666	$8,348	$9,089
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased each year.

- Like its overall AACB, the MHP's FC AACB increased very modestly from CY 2019 to CY 2021. Its CY 2021 FC PR was 35 percent higher than its overall PR, but lower than the corresponding state and small-rural MHP averages by big margins.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 1,002				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	25	2.5%	8	5	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	24	2.4%	8	7	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	<11	-	12	12	2.2%	21	14
Per Minute Services							
Crisis Stabilization	13	1.3%	1,685	1,140	13.0%	1,546	1,200
Crisis Intervention	196	19.6%	267	170	12.8%	248	150
Medication Support	600	59.9%	225	190	60.1%	311	204
Mental Health Services	680	67.9%	753	393	65.1%	868	353
Targeted Case Management	333	33.2%	520	193	36.5%	434	137

- The MHP's adult hospitalization rate in CY 2021 was less than half that of the state, and its average inpatient units was half that of the state. The MHP does not have a Crisis Stabilization Unit or psychiatric emergency services and crisis stabilization was a fraction of the statewide rate, as most of these services happen out of the county. Instead, the MHP relied on crisis intervention more than statewide.
- The MHP's percentages of adult beneficiaries receiving lower intensity services including medication support, mental health services, and targeted case management were comparable to the corresponding statewide percentages.

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

Service Category	MHP N = 54				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	0	0.0%	0	0	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.3%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	17	12
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	3.1%	1,398	1,200
Crisis Intervention	<11	-	289	210	7.5%	404	198
Medication Support	17	31.5%	221	157	28.3%	394	271
TBS	<11	-	800	243	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Home-Based Services (IHBS)	25	46.3%	327	302	40.0%	1,351	472
Intensive Care Coordination (ICC)	13	24.1%	249	66	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	54	100.0%	1,343	667	96.3%	1,848	1,103
Targeted Case Management (TCM)	24	44.4%	194	133	35.0%	342	120

- Although Siskiyou has a lower FC PR than the state, those who receive services receive ICC, IHBS, and TCM at higher rates than statewide. Siskiyou's FC beneficiaries did not have any inpatient episodes.
- The average units per beneficiary is much lower than the corresponding statewide rates, which likely accounts, in part, for Siskiyou's lower than statewide FC AACB.

IMPACT OF ACCESS FINDINGS

- The MHP is still challenged with engaging by the Spanish and Hmong communities. Both communities identify fear of government and cultural stigma as reasons to not participate in services. The MHP has attempted to reach the community by hiring both Spanish and Hmong clinicians.
- The MHP is servicing the API population but not retaining in services, this population often seeks medication only services. Enlisting API stakeholder input could assist the MHP in identifying ways to engage this population.
- The CWS has a reported 53 percent decrease in staffing which may impact the sharing of timely FC information. Continue to ensure open communication with CWS to ensure the FC population is served.
- The MHP is encouraged to identify the reported lack of collaboration between SUD and behavioral health staff, which may affect the beneficiary experience.

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 in 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 adjust their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The MHP has a high percentage rate across the age span for the first offered appointment.

- The MHP has self-identified challenges within the current EHR, opting to join the CalMHSA SmartCare EHR collaboration, with the expectation that timeliness data will be collected and reported more accurately in the future.
- The MHP, like other counties, is challenged to identify an appropriate LOC tool for adults. Whereas the Child and Adolescent Needs and Strengths (CANS) is a required tool for youth, there is no such tool for adults. The Level of Care Utilization System used to be a tool of choice, but recently is no longer a free tool and the licensing fee has become cost prohibitive for counties.
- Timeliness standards and performance improvement activities would be appropriate to add to an updated QAPI document.
- The MHP continues to have a high rate of no-shows for both psychiatry and clinical services. Key informants would like more in-person contact, not simply attending a session in a clinic and receiving services via telehealth. Key informants suggested opening the Wellness Centers to in-person clinical activities to reduce no-show rates.
- Staffing levels remain a challenge for both the MHP and their provider Remi Vista.

TIMELINESS PERFORMANCE MEASURES

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

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

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	6 Business Days	10 Business Days*	93%
First Non-Urgent Service Rendered	10 Business Days	10 Business Days**	62%
First Non-Urgent Psychiatry Appointment Offered	9 Business Days	15 Business Days*	95%
First Non-Urgent Psychiatry Service Rendered	12 Business Days	15 Business Days**	79%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	8.8 Hours	48 Hours*	92%
Follow-Up Appointments after Psychiatric Hospitalization	6 Days	7 Business days**	53%
No-Show Rate – Psychiatry	15%	10%**	n/a
No-Show Rate – Clinicians	16%	10%**	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

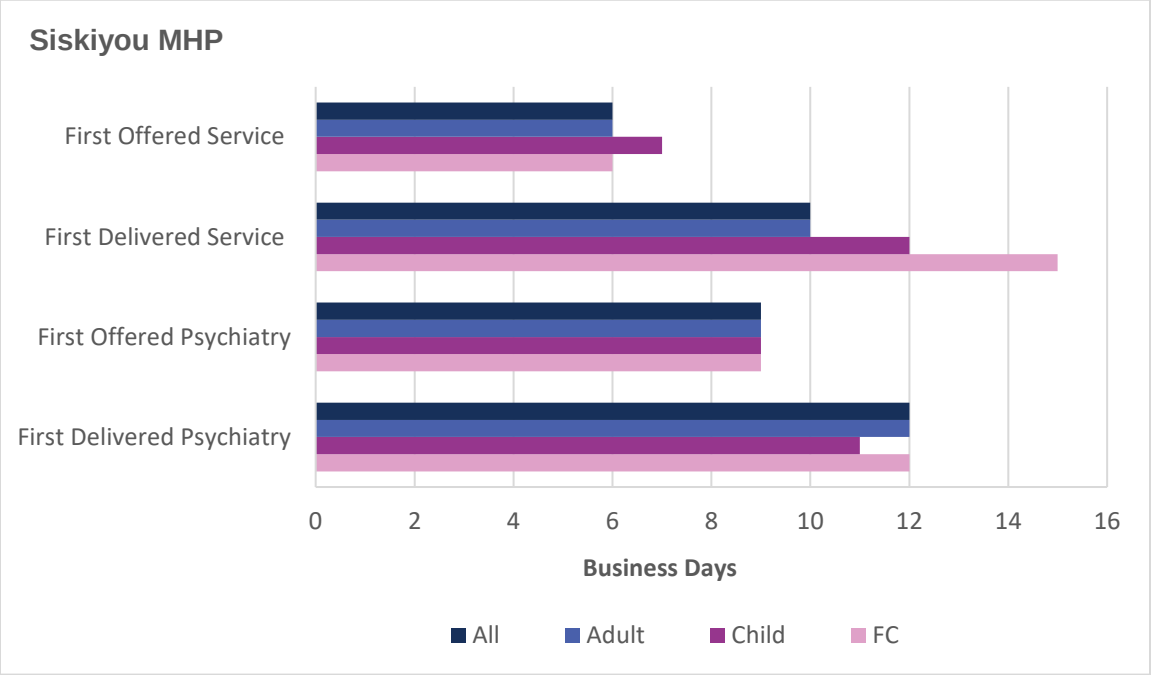


Figure 13: Wait Times for Urgent Services

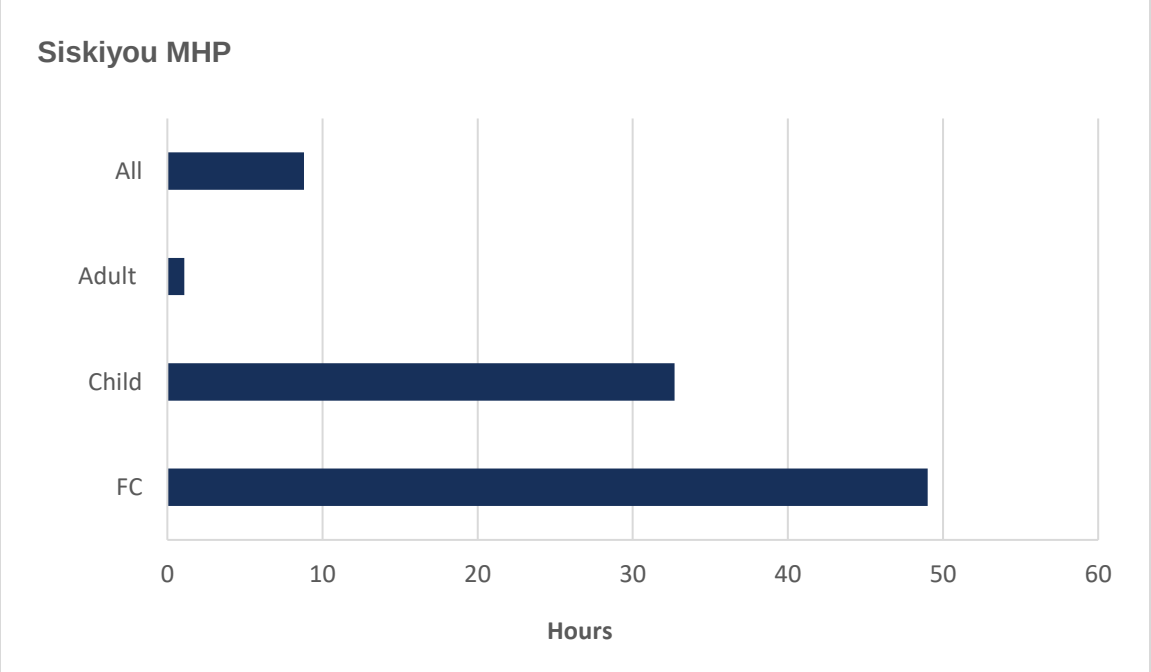
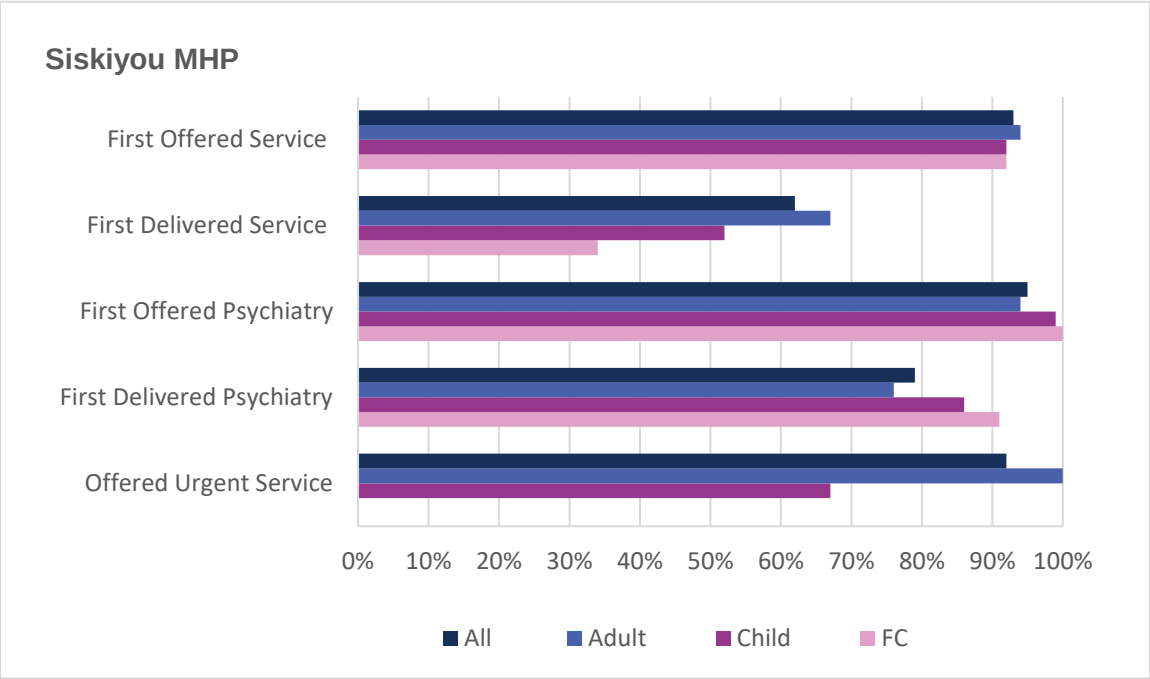


Figure 14: Percent of Services that Met Timeliness Standards



- 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 all requests for services and the first assessment or mental health service appointment. Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an ED, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as any service request in which the client cannot wait until the first available appointment. The determination is made by the clinical supervisor. There were reportedly 37 urgent service requests with a reported actual wait time to services for the overall population at 8.8 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as beneficiary’s initial service request.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports an average no-show rate of 15 percent for psychiatrists and 16 percent for clinicians, with a MHP standard of 10 percent.

IMPACT OF TIMELINESS FINDINGS

- The current EHR does not provide accurate collection or aggregation of data. The MHP has opted to join the CalMHSA SmartCare EHR which is expected to provide standard templates for data reporting. However, these limited templates do not offer the depth of reporting and analysis the MHP currently utilizes. The MHP will want to investigate additional add-on templates to meet unique data thresholds.
- Key informants have reported high no-show rates even with reminders both sent and received. The Wellness Centers may be an option to provide clinical services to meet the beneficiaries “where they are at,” as many do not want to enter the “Super Agency” which includes other governmental offices.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is different from overall QA/Compliance, QI is one team that consists of one FTE with the addition of a partial FTE from a Project Coordinator. The QA manager (QAM) oversees all QI activities.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of the QAM, consumers, stakeholders, Behavioral Health Specialists, crisis workers, Licensed Professionals of the Healing Arts, the Patient's Rights Advocate, fiscal staff, management, and representatives from the organizational provider network is scheduled to meet monthly. Since the previous EQR, the MHP QIC met nine times. Of the 20 identified FY 21-22 QAPI workplan goals, the MHP provided a summary of findings, or obstacles related to their plan. In addition, the MHP has identified that many of the goals and KPIs do not fully reflect the current objectives and goals for the department and would like to spend time rewriting their plan, to represent the current environment more accurately within the department, as it relates to the community and CalAIM.

The MHP reports utilizing the following LOC tools: Level of Service Assessment, and CANS. The data is not currently aggregated to identify improvement over time. The MHP is attempting to identify an Adult LOC tool to implement.

The MHP utilizes the following outcomes tools: No specific outcomes tool, but annual review of the level of service assessment findings.

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	Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Not met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Partially met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Partially met

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

- The MHP added beneficiary impact to each goal of the QAPI. The MHP could take the impact information one step further by bringing the goals to the QIC for review.
- The QIC is attended by two Peer employees. A bi-annual meeting at the Wellness Center may bring more beneficiary attendance.
- The MHP has a robust doctor's group which addresses medication management.
- The MHP has identified the need to reassess all goals and KPIs within the QAPI to ensure the goal aligns with the current state of the department.
- The MHP is advised to rename the QIWP to the QAPI to align with mandated language.
- The MHP provides the CPS, though it is reported the CPS does not offer usable information for the department, and key informants do not recall filling out a CPS.
- Key informants have reported the lack of services within the Wellness Center. There are limited clinical services, and no ability to cook, shower or wash a load of laundry. Key informants have suggested a reduction in appointment no-shows by allowing services at the Wellness Centers.

- Key informants have described discrepancies in remote work and accessing laptops for in-the-field data entry. The inability to remote work when the department is hiring telehealth clinicians and the requirement for most staff to return to the office when inputting field-based data has impacted staff satisfaction and retention.
- The MHP does track and does trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): There were 18 children between the ages of 6 and 12 who were diagnosed with ADHD and 15 were prescribed ADHD medication in the fiscal year. 100% of the children that were prescribed an ADHD medication attended a follow-up visit with a prescriber within 30 days of their first ADHD prescription.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): Of the 76 children/youth reviewed, 62 were prescribed at least one antipsychotic medication, and 47 had at least 90 days of antipsychotic use. Only ≤11 clients were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the year.
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): Of the 47 clients that had at least 90 days of antipsychotic use, 39 (83%) had received both a glucose and cholesterol test during the year. The Medication Department works closely with the Children's Services of Care Department to ensure that metabolic monitoring protocols are followed.
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): Twenty-six children and adolescents between the ages of 1 and 17 did not have a Food and Drug Administration indication for an antipsychotic. Of these clients, 21 (81%) received psychosocial support before or after starting antipsychotic medication. The average number of psychosocial services before being prescribed an antipsychotic was 7 visits, with a range of 0-16 visits.

QUALITY PERFORMANCE MEASURES

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

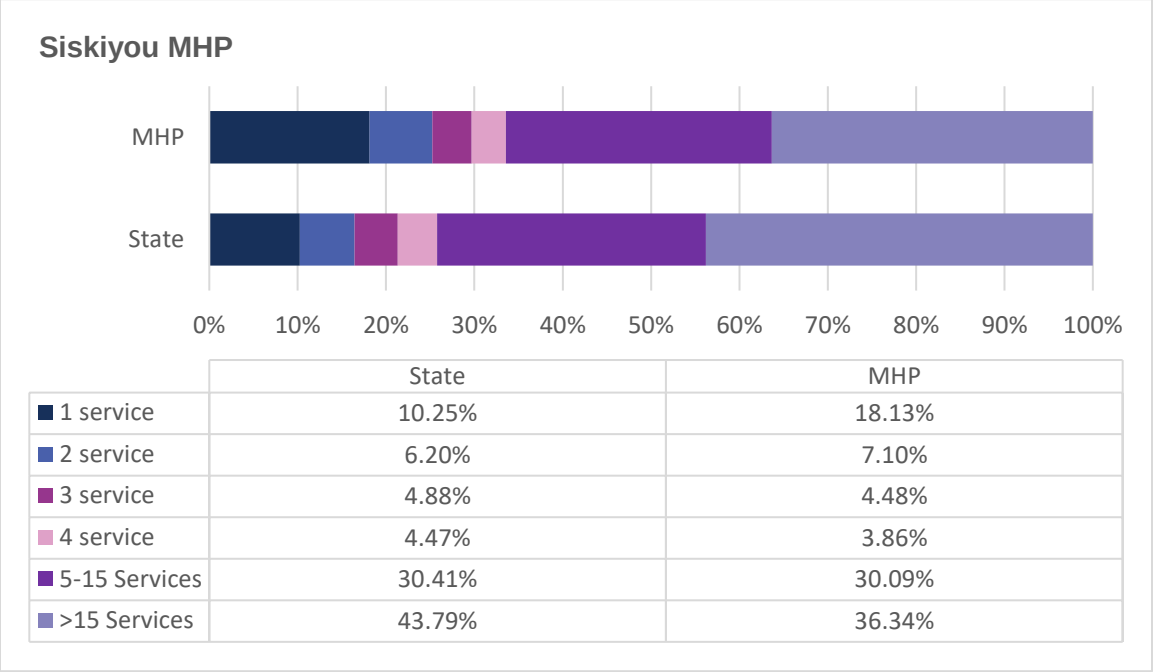
- Retention in Services
- Diagnosis of Beneficiaries Served
- Psychiatric Inpatient Services

- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Beneficiaries (HCB)

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	18.13%
2 service	6.20%	7.10%
3 service	4.88%	4.48%
4 service	4.47%	3.86%
5-15 Services	30.41%	30.09%
>15 Services	43.79%	36.34%

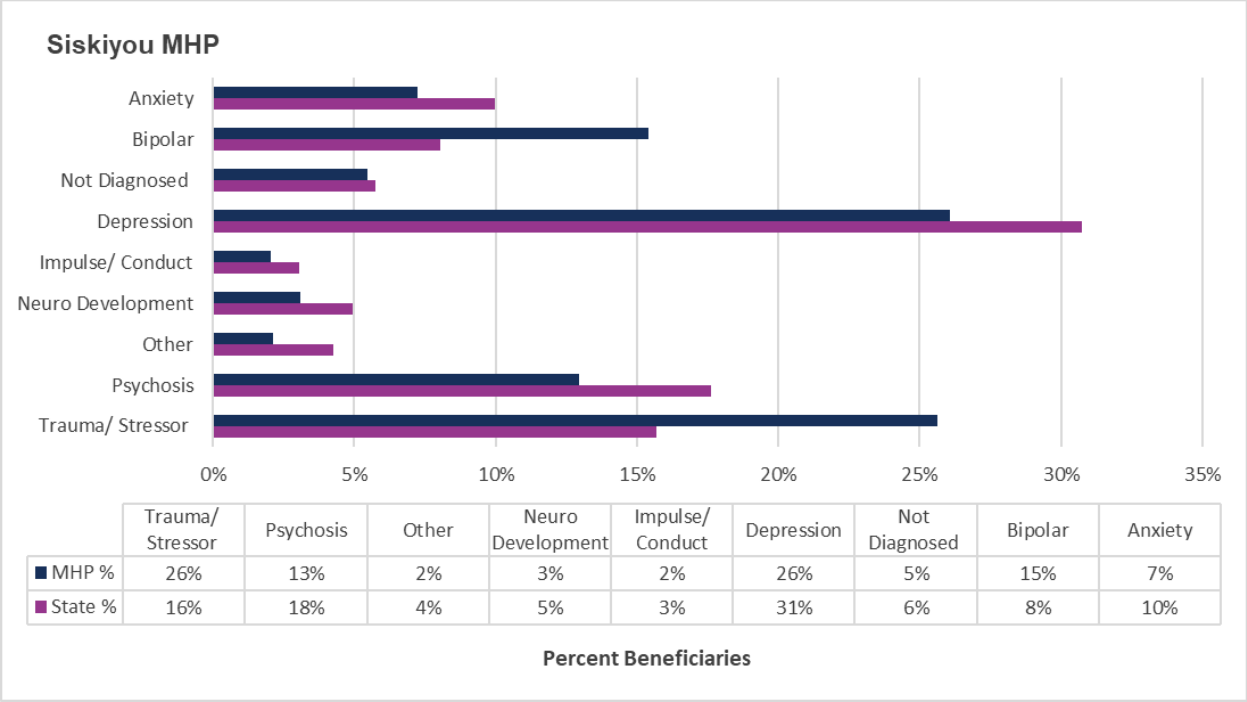
- In CY 2021, Siskiyou had a high percentage of beneficiaries who received only 1 service encounter, 80 percent higher than the corresponding statewide rate. At the other end, it had 7.45 percentage points lower number of beneficiaries than the statewide average who received more than 15 service encounters. The rest of the categories had comparable percentages with the state.

Diagnosis of Beneficiaries Served

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

crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

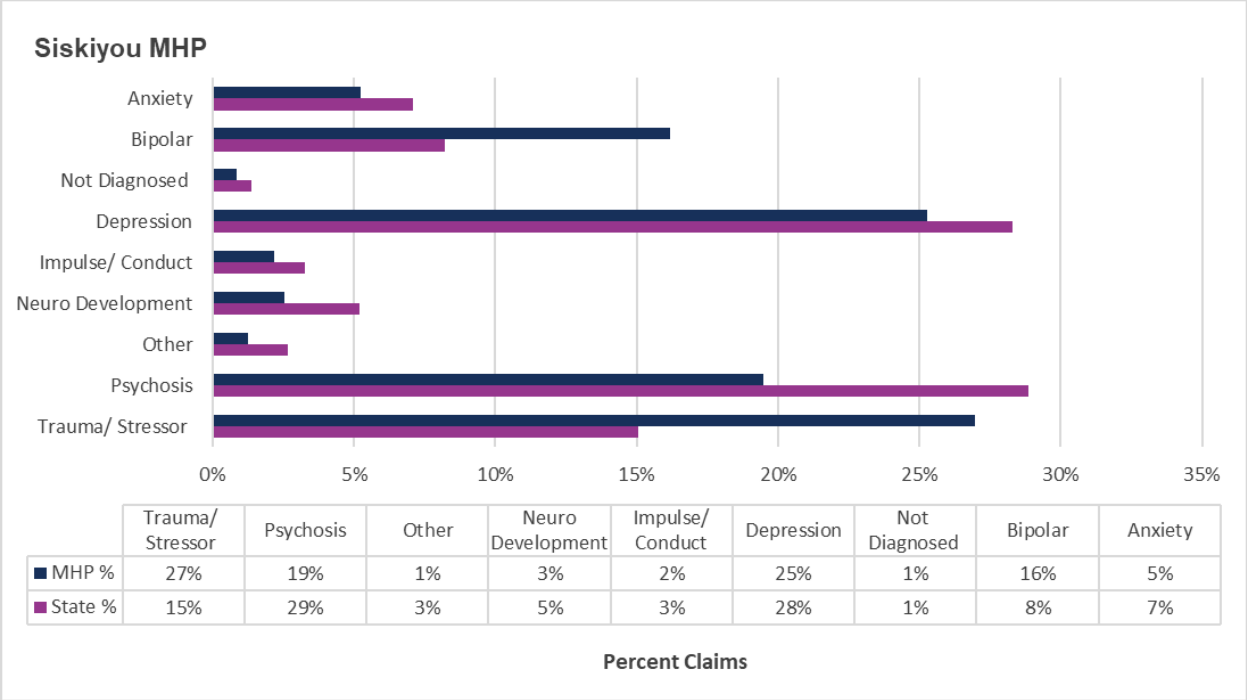
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	26%	13%	2%	3%	2%	26%	5%	15%	7%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- Siskiyou had markedly higher percentages of beneficiaries who were diagnosed with either bipolar or trauma/stressor-related disorders than the statewide corresponding averages.
- It had lower percentages of beneficiaries with anxiety, depression, and psychosis disorders than the state.

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	27%	19%	1%	3%	2%	25%	1%	16%	5%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- The MHP's AACB distribution by diagnostic categories closely resembles its percentages of beneficiaries by diagnostic categories.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	61	94	8.12	8.86	$10,385	$12,052	$633,460
CY 2020	46	58	9.29	8.68	$9,867	$11,814	$453,893
CY 2019	60	73	9.24	7.80	$9,344	$10,535	$560,612

- Siskiyou had very consistent psychiatric hospitalization counts in CYs 2019 and 2021. In between, in CY 2020, its unique count of beneficiaries utilizing psychiatric inpatient services went down by one-quarter, most likely due to initial COVID-related restrictions on facilities. The MHP's total inpatient admission went up much higher in CY 2021 which indicated higher rates of readmissions beyond

30-days as the MHP's 7- and 30-day readmission rates were very low as discussed under Figure 19.

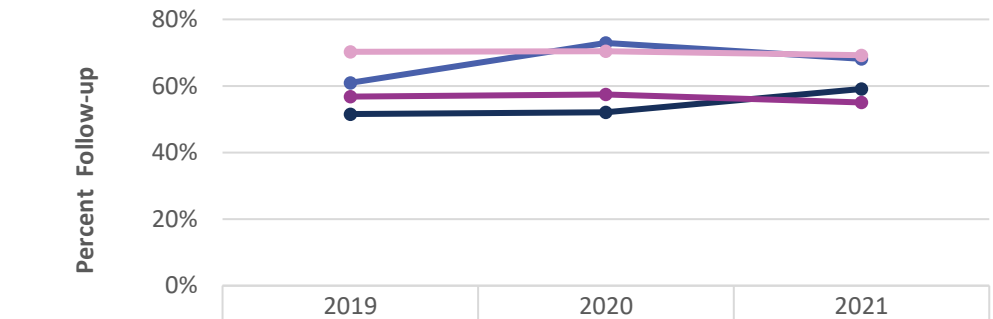
- The MHP's average inpatient LOS was similar to statewide LOS in CY 2021.
- Siskiyou's inpatient AACB was consistently lower than the statewide average for all three years.

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 is 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	51.56%	52.08%	59.09%
30-Day MHP	60.94%	72.92%	68.18%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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

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

*The MHP's readmission data is not displayed above due to the small number of beneficiaries reflected in the data.

- The MHP was able to improve both its 7- and 30-day inpatient follow-up rates from CY 2019 to CY 2021. As a result, its 7-day follow-up rate went from below the corresponding statewide average to higher than the state. The MHP's 30-day follow-up rate became comparable to the statewide average.
- The MHP's own data showed more hospitalizations as it included all beneficiaries regardless of the payor source.
- Siskiyou had very few inpatient readmissions within 7- or 30-days in all three years from CY 2019 to CY 2021. Though the data is suppressed due to the low number recorded.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $7,478, the median amount is just $3,269.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, nearly 92 percent of the statewide beneficiaries are “low cost” (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACB of $4,412 and median of $2,830.

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	25	1.93%	16.05%	$1,140,340	$45,614	$39,152
	CY 2020	18	1.59%	12.56%	$736,090	$40,894	$38,847
	CY 2019	16	1.43%	14.19%	$785,730	$49,108	$39,772

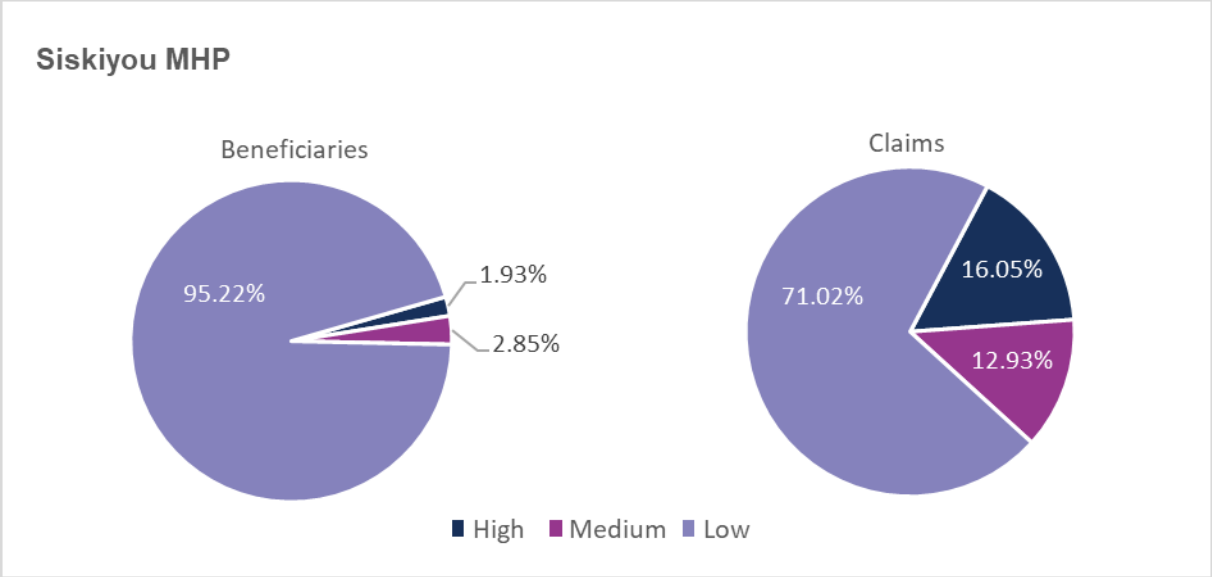
- Although the number of HCBs increased between CYs 2019 and 2021, the MHP had a much lower percentage of HCBs compared to the state. The HCB percentage of total approved claims was also correspondingly lower than the state as was the average approved claims per HCB.

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	37	2.85%	12.93%	$918,417	$24,822	$25,119
Low Cost (Less than $20K)	1,234	95.22%	71.02%	$5,045,817	$4,089	$2,468

- Most of the Siskiyou beneficiaries belonged to the less than $20K category.

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



- In CY 2021, only 4.78 percent of the beneficiaries accounted for 28.98 percent of the total approved claims.

IMPACT OF QUALITY FINDINGS

- The MHP created an updated QAPI plan that included beneficiary impact. The MHP self-identified the need for an updated QAPI and would like to spend time reviewing all goals and KPIs to include those that impact the department and accurately reflect goals including changes with CalAIM implementation.
- The lack of a LOC tool for adults does not assist the clinician or client in identifying appropriate movement within the SOC. The MHP is currently working with the counties of Kern, San Benito and Nevada to improve Quality in a learning community collaborative to assist in identify a LOC tool and other quality metrics.
- The MHP has a staff retention challenge which may be mitigated by having an open conversation with department heads and staff on a hybrid work schedule. Hiring telehealth staff does not create an equitable working environment when department staff are unable to telework. In addition, the disparity in accessing a laptop for consistent documentation in-the-field with the expectation that staff must return to the office to input notes is a contributing factor to staffing dissatisfaction. The MHP in a post-COVID environment may want to investigate current working styles to address staff satisfaction and retention.
- Key informants have identified the Wellness Centers as an opportunity for access and a way to reduce no-show rates, by offering clinical services as well as the ability to cook meals, shower, and wash laundry for those that are unhoused.

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 MHP'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: "MRT Diversion Group"

Date Started: 04/2022

Aim Statement: "The MHP will address the unique needs of the individuals in the Diversion program by offering MRT to improve functioning and engagement in mental health services."

Target Population: "The target population includes adults that have a mental health diagnosis, an SUD diagnosis, and are justice-involved. The target group includes individuals that have been granted mental health diversion through the Siskiyou County Superior Court or are in a pending status. The primary diagnoses that are expected to be in the target population include Schizophrenia, Schizoaffective, PTSD, and bipolar disorder."

Status of PIP: The MHP's clinical PIP is in the implementation year.

[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

Moral Recognition Therapy is an evidence-based intervention used to reduce substance use and recidivism, as well as improve psychiatric symptoms and functioning. Currently the MHP diversion program does not have a specific evidence-based intervention. All beneficiaries meeting the target population will be referred to MRT group, unless clinically inadvisable. Certified MRT MHP staff will facilitate the intended group intervention.

Performance measures include increased mental health treatment participation and improved mental health outcomes as measured by attendance in MRT groups, number of beneficiaries referred to group, graduation rate, and MRT Group survey tool. Results are pending as the PIP is currently active.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: The MHP, as recommended in the last review, added a survey for the beneficiaries to express their satisfaction with the curriculum after each class. The MHP will be identifying the impact on clinical services by adding a qualitative survey, reviewing key events and/or an exit interview, to show the correlation between the intervention and clinical improvement.

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

- Include outcome measures that identify improved mental health functioning as a result of MRT attendance and/or graduation.
- Include qualitative data not just quantitative results.
- CalEQRO recommends ongoing TA as clinical impact is identified.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: “Follow-Up After ED Visit for Mental Illness (FUM)”

Date Started: 09/2022

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

Target Population: “All beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm.”

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

Summary

The MHP will obtain consistent ED data from the Managed Care Plan (MCP.) For data on historical utilization, implement processes to routinely review the data to identify utilization patterns and high-risk populations (e.g., individuals not engaged in services or who frequently use ED services) to inform follow-up care coordination needs.

Although the MHP will continue to pursue consistent and effective data share with the MCP, it is likely the implementation of this intervention will be delayed, potentially until The MHP implements its new EHR, July 1, 2023. Due to this delay a new primary intervention has been developed to utilize Psychiatric Emergency Team (PET) workers stationed at the ED to collect and link patient population seen in the ED for crisis to a follow-up urgent SMHS (within 96 hours).

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: Significant legal issues out of the control of the MHP prevent a fluid relationship of shared data. Despite this barrier the MHP enlists the use of its PET team to acquire information on those exiting the ED. In addition, with the onboarding of the new EHR, the local PHC will participate in a new HIE between the MHP and MCP. This will not solve the engagement challenges with all area hospitals, but it will increase the information shared with the MHP.

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

- Legal challenges out of the control of the MHP create a tepid relationship with the ED. The county is recommended to continue engaging the PET team to obtain information on those individuals leaving the ED.
- Continue building relationships and partnerships with the MCPs.
- Identify data to be collected from the HIE prior to implementation and create shared agreements for continued collaboration.
- The MHP will need to address the date as listed in their Aim Statement to extend the timeline for this PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an ASP where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner Anasazi, which has been in use for nine years and supported by Kingsview ASP. Currently, the MHP is actively implementing a new system, Streamline SmartCare which requires heavy staff involvement to fully develop.

Approximately four percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control. The MHP reported no change in the percentage of budget dedicated to support the IS.

The MHP has 83 named users with log-on authority to the EHR, including approximately 68 county staff and 15 contractor staff. Support for the users is provided by 2.5 full-time equivalent (FTE) IS technology positions. Currently all positions are filled and no changes in IS staffing have taken place in the past year.

As of FY 2022-23 EQR, The MHP's sole organizational contract provider does not have access to directly enter clinical data into the MHP's EHR. However, the MHP's own contracted individual providers have direct access to the EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	0%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	100%
		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 currently does not have the PHR functionality but expects to institute it with the implementation of the new EHR in the coming year.

Interoperability Support

The MHP is a member or participant in a HIE. However, until the new EHR is fully implemented, the MHP will not be able to fully participate with the HIE as the older EHR is not compatible with the HIE that the MHP is a member of.

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	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:

- The MHP is moving to a new EHR and has prioritized its staffing and processes for a successful transition. It has adopted a superuser model for staff training in the new EHR and at the time of the review was ready to begin the superuser training.
- The fiscal and IT staff manage the MHP's claims processing and submission well with low denial rates.
- The MHP has joined the Sacramento Valley HIE. The new EHR will enable it to communicate with the HIE once it is implemented.
- The MHP's only organizational contract provider's EHR does not communicate with the MHP's EHR, and therefore their data is submitted as paper documents and the MHP staff enter it in the EHR.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021. Table 18 appears to reflect a largely complete or very substantially complete claims data set for the time frame claimed.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	1,838	$474,360	$0	0.00%	$471,042
Feb	1,792	$461,442	$0	0.00%	$457,017
Mar	2,325	$625,690	$0	0.00%	$616,535
April	2,152	$559,138	$0	0.00%	$547,901
May	1,986	$534,873	$0	0.00%	$528,396
June	2,169	$564,846	$0	0.00%	$552,758
July	1,960	$558,236	$107	0.02%	$546,397
Aug	2,009	$643,651	$2,447	0.38%	$629,050
Sept	2,155	$652,853	$1,815	0.28%	$643,034
Oct	2,013	$619,265	$164	0.03%	$611,633
Nov	1,871	$586,307	$0	0.00%	$579,089
Dec	1,764	$561,478	$1,197	0.21%	$553,558
Total	**24,034**	**$6,842,139**	**$5,730**	**0.08%**	**$6,736,410**

- The MHP's monthly claim volume appears to have been stable in CY 2021 with low denial rates. All the denied claims took place in the second half of the year.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible or non-covered charges	14	$4,338	75.71%
Medicare Part B must be billed before submission of claim	4	$1,197	20.89%
Service line is a duplicate and a repeat service procedure code modifier not present	1	$195	3.40%
Total Denied Claims	**19**	**$5,730**	**100.00%**
Overall Denied Claims Rate	**0.08%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The MHP has a very low denial rate and 75.71 percent of it was attributable to "beneficiary not eligible or non-covered charges" which was the subject of a FY 2021-22 CalEQRO recommendation.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Siskiyou is transitioning not only to a new EHR, but also to a different arrangement for managing and maintaining the EHR. This will require continuous monitoring of staffing and other resource needs for at least the next two years as well as ensuring that all the expected functionalities are adequately put in place.
- Although the denied claims rate for the MHP is very low, it would be important to monitor it closely when there are distinct patterns such as most denied claims happening in a short period of time.
- Although the MHP has mobile devices available for staff operating in-the-field, it needs to examine its current mobile device check out policies and procedures to create an equitable workflow for entering data into the EHR when providing field-based services.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey 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 provides the CPS survey as directed each year. Unfortunately, the number of returned surveys is so low the MHP does not receive useful information or data. Often the "n" is withheld leaving no information for the MHP to review.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

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

Consumer Family Member Focus Group One

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

Overall, the key informants were very complimentary of services, reporting receiving services within a month, with regular appointments typically two weeks apart, and rescheduling appointments was easy over the phone. None of the participants could remember filling out a CPS, nor were any invited to participate in a committee or QIC meeting. All participants have visited the Wellness Centers and suggested several areas where the Wellness Centers could impact beneficiary wellbeing. The participants reported the high staff turnover and high vacancy rate impacted the consistency of their services, though they were complimentary of all case managers.

Recommendations from focus group participants included:

- “Provide the ability to cook a meal, shower, or wash laundry at the Wellness Center.”
- “Provide therapy at the Wellness Center.”
- “Need more case managers because of turnover.”
- If possible, the key informants would like to have more in-person psychiatry. They do not prefer to come in person to the clinic, yet the psychiatrist is via tele-health.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Key informants though overall are satisfied with services, did report the high turnover rate in clinicians and case managers have impacted their services. The ability to go to a Wellness Center for therapy and to cook or shower may reduce no-show rates as well as increase access to those individuals that would normally not walk into the MHP. The key formats reported no knowledge of the CPS and are unsure of how to get their opinions heard regarding services and program improvements.

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 provided excellent preparation and efforts towards the CalEQRO FY 2022-23 review, with detailed reporting, completed PIPs and documented performance on the required FY 2021-22 Recommendations. (Access, Timeliness, Quality, IS)
2. In addition to Project Basecamp, a new housing option, "Siskiyou Crossroads" will offer a supportive housing option with 50 supportive units and 24 NPLH beds. (Access, Quality)
3. The MHP works diligently to manage beneficiary crisis within the community with initiatives to offer an array of field-based services which mitigate the need for inpatient care. (Access, Timeliness, Quality)
4. The MHP is a data driven department which consistently reviews data to identify needed improvements and mirrors the additional requirements and changes that impact the behavioral health system. (Access, Timeliness, Quality, IS)
5. Working with the counties of Kern, Nevada, and San Benito the MHP participates in a four-county collaboration to improve quality services and create a learning community for shared knowledge. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP has acknowledged flaws in their data tracking, reporting, and collecting system, opting to join the CalMHSA, SmartCare EHR collaborative. The new EHR will have a limited number of standard reporting metrics which may not fully exam specific data parameters the MHP will need to meet unique threshold expectations. (Timeliness, IS)
2. The MHP has a consistent level of no-show appointments; key informants suggest offering mental health services on a walk-in basis within the Wellness Centers offering an alternative for beneficiaries. In addition, key informants suggest an expanded Wellness Center that offers showers, the ability to cook a meal and limited laundry services would encourage current and potential beneficiaries to seek and remain in services and expand the current LOS within the continuum of care. (Access, Timeliness, Quality)

3. The MHP has identified areas within their QAPI that do not correlate with current services, expectations and/or are not consistent with the KPI's they would like to address. Readdressing each goal and prescribed outcome will offer the MHP a clear direction with obtainable goals, objectives, and outcomes. (Quality)
4. The MHP does not have a standard policy for all staff to operate within a hybrid work environment, and the ability to enter data when delivering field-based services. The inability to enter data to the EHR while delivering field-based services results in the line staff spending additional time entering data at a later time; and the inability to work in a hybrid telework environment when the MHP is hiring telehealth employees has increased employee dissatisfaction and increased staffing turnover. (Quality, IS)
5. The MHP has reported the CPS does not offer usable data and the small sample size does not offer aggregated information for improvement. Without the beneficiary voice the MHP cannot accurately determine if service delivery is achieving the desired outcome and impact for the family and beneficiary experience. (Access, Timeliness, 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. Utilize a tracking system for all required timeliness data metrics to ensure all timeliness data is tracked and accurate for ease of transition into the new SmartCare EHR; and determine specialized reports needed to customize specific data needs that are not included within the standard SmartCare data templates. (Timeliness, IS)
2. Provide a link to the Wellness Center on the landing page of the Behavioral Health website; and investigate the feasibility of expanded hours to allow for drop-in activities such as cooking, showers, laundry, and clinical services, to increase beneficiary access and reduce no-show rates. (Access, Timeliness, Quality)
3. Improve the QAPI plan by reviewing each goal and objective and create an updated plan that allows for accurate identification and outcomes of desired KPIs, and evaluation of each goal; include stakeholder and beneficiary input when creating the updated plan. (Quality)
4. Create a policy and implement an equitable field-based "in the moment" data entry process for field-based services that reduces the burden on the line staff; and investigate the feasibility of an equitable hybrid work environment, involving all levels of line staff in the discussion. (Quality, IS)
5. Identify or create and implement a beneficiary and family/caregiver satisfaction survey or focus group, to address the accessibility and satisfaction of services

that will provide accurate information to address areas of success or needed improvement within the department. (Access, Timeliness, 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 California public health emergency (PHE) was in place until February 28, 2023, and a national PHE is scheduled to end May 11, 2023. The review was held six days post PHE, 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, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

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

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Kiran Sahota, Quality Reviewer
Saumitra SenGupta, Information Systems Reviewer
Rick Jackson, Information Systems Reviewer (observer)
Walter Shwe, Consumer Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Ames	Tara	Project Coordinator	Siskiyou County Behavioral Health Department (SCBHD)
Bedford	Vicki	So County Supervisor	SCBHD
Bray	Ashley	QA Manager	SCBHD
Bryan	Maddelyn	Staff Services Analyst III	SCBHD
Bullock	Rose	Dept. Director Administrative Services	SCBHD
Cheula	Wendy	Patient's Rights Advocate/Health Assistant	SCBHD
Clymer	Shannon	ASOC System Administrator	SCBHD
Collard	Sarah	Health and Human Services Agency Director	SCBHD
Drake	Kyler	ISS IV	SCBHD
Gannon	Christine	CSOC System Administrator	SCBHD
Halsebo	Mark	Supervisor	SCBHD
Height	Sasha	Supervisor	Six Stones Wellness Center
Hunt	Debbie	Regional Supervisor	Remi Vista
Lima	Tracie	Clinical Director BH Division	SCBHD
Mathie	Amanda	Behavioral Health Specialist II	SCBHD
Nair	Sapna	Clinician III	SCBHD
Pickens	Kariel	Behavioral Health Specialist I	SCBHD
Saldana	Paloma	Clinician II	SCBHD
Sapna	Nair	Behavioral Health Specialist I	SCBHD

Last Name	First Name	Position	County or Contracted Agency
Schlieter	Samantha	Behavioral Health Specialist II	SCBHD
Sippel	Develyn	Administrative Services Manager	SCBHD
Swain	Jaclyn	Behavioral Health Specialist II (EH)	SCBHD
Von Tungeln	Aimee	Deputy Director of BH	SCBHD
Zufelt	Angie	Social Worker Supervisor	Child Welfare Services

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP, as recommended in the last review, added a survey for the beneficiaries to express their satisfaction with the curriculum after each class. The MHP will be identifying the impact on clinical services by adding a qualitative survey, review key events or an exit interview, to show the correlation between the intervention and clinical improvement.
General PIP Information	
MHP/DMC-ODS Name: Siskiyou	
PIP Title: "MRT Diversion Group"	
PIP Aim Statement: "The MHP will address the unique needs of the individuals in the Diversion program by offering Moral Recognition Therapy (MRT) to improve functioning and engagement in mental health services."	
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): "The target population includes adults that have a mental health diagnosis, an SUD diagnosis, and are justice-involved. The target group includes individuals that have been granted mental health diversion through the Siskiyou County Superior Court or are in a pending status. The primary diagnoses that are expected to be in the target population include Schizophrenia, Schizoaffective, PTSD, and bipolar disorder."	

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): Beneficiaries will attend MRT classes achieving the status of graduate.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools: All individuals meeting the target population will be referred to the MRT group, unless clinically inadvisable.

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
Increase mental health treatment participation and improve mental health outcomes. 1. Number of beneficiaries referred to MRT.	2022-23		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
2. Number of beneficiaries that attend at least 6 MRT groups.	2022-23		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
3. Unduplicated number of beneficiaries served.	2022-23		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
4. Unduplicated number of beneficiaries referred.	2022-23		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- Include outcome measures that identify improved mental health functioning as a result of MRT attendance and/or graduation.
- Include qualitative data not just quantitative results.
- CalEQRO recommends ongoing TA as clinical impact is identified.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	Significant legal issues out of the control of the MHP prevent a fluid relationship of shared data. Despite this barrier the MHP enlists the use of its PET team to acquire information on those exiting the ED. In addition, with the onboarding of the new EHR, the local PHC will participate in a new HIE between the MHP and MCP. This will not solve the engagement challenges with all area hospitals, but it will increase the information shared with the MHP.
General PIP Information	
MHP/DMC-ODS: Siskiyou	
PIP Title: "Follow-Up After ED Visit for Mental Illness (FUM)"	
PIP Aim Statement: "For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percentage points by June 30, 2023."	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐Children only (ages 0–17)* ☐Adults only (age 18 and over) ☒Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): "all beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm."	

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Obtain consistent ED data from the MCP.
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): Utilize PET workers stationed at the ED to collect and link parget population seen in the ED for crisis to a follow-up urgent SMHS (within 96 hours).

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage receiving 7-day follow up.	2021	62 percent	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage receiving 30-day follow-up.	2021	68 percent	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number and percent of clients who received an initial contact from the MHP before they were discharged from the ED.	2023		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number and % of clients experiencing social determinants of health needs (e.g., homelessness) that impact engagement in treatment at the time of their ED visit who received a referral to address those needs	2023		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Legal challenges out of the control of the MHP create a tepid relationship with the ED. The county is recommended to continue engaging the PET team to obtain information on those individuals leaving the ED. • Continue building relationships and partnerships with the MCPs. • Identify data to be collected from the HIE prior to implementation and create shared agreements for continued collaboration. • The MHP will need to address the date as listed in their Aim Statement to extend the timeline for this PIP.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required for this report.