Template B (FUM)

Clinical Area of Focus: Follow-Up After Emergency Department Visit for Mental Illness

Section 1: Progress Report for Quality Improvement Project

Participating Entities may have revised or modified their quality improvement plans since the 9/30/2022 submission for BHQIP. In your responses, state your previous submission information and describe any changes the Participating Entity has made since the last submission. Address any clarifications previously sought by DHCS in responses.

1. Problem Statement: What is the problem this performance improvement plan proposes to solve? (One Sentence, Reference: Submission for 9/30/2022, Question #3)

Gaps in care coordination practices and related data exchange processes contribute to missed opportunities and delays in receiving services post-discharge from the ED for individuals with mental health (MH) conditions.

2. **Aim Statement: What is the aim/goal for this performance improvement project?** (One Sentence for each element, Reference: Submission for 9/30/2022, Question #9)

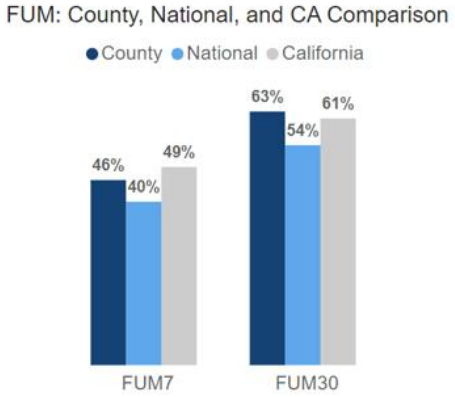
Aim Statement	For Lassen County Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of recorded follow-up mental health services with the MHP within 7 and 30 days by 5% by March 31st, 2024.
How the Aim Statement is	
Specific	*Focuses on the specific population of those discharged from the ED with MH conditions that are on Lassen County Medi-Cal.*
Measurable	*Measurability is based on percentage of those recorded by the MHP as discharged with MH condition that were provided MH follow-up services within 7 and 30 days*
Achievable	*Increasing overall percentage by 5% is achievable by increasing numbers of recorded discharges that receive timely follow-up*

Relevant	*Focus is on better identifying and providing follow-up to those discharged from ED with MH condition (FUM)*
Time-Bound	*The aim is set to be achieved by March 31st 2024.*

3. Narrative Description of Changes: Briefly describe any changes the Participating Entity has made to the Problem Statement and Aim Statement in this improvement plan. Address sources of information used to inform these changes, such as local data and stakeholder engagement. Identify challenges and lessons learned in this process

The previous Problem Statement as stated in the September 2022 submission: “Gaps in care coordination practices and related data exchange processes contribute to delays in receiving services post-discharge from the ED for individuals with mental health (MH) conditions.” The Problem Statement was revised to include “missed opportunities”.

In cases when patients were found to have a primary diagnosis of a Mental Health (MH) condition meeting the threshold of crisis, according to the most recent HEDIS Measure Analysis Report, the County was exceeding state and national timeliness standards in regards to contact and service delivery within 7 and 30 days.



Service Follow-Up	ED Visits for Mental Illness	MH Service Follow-Up	FUM %
Service Follow-Up within 7 days	59	27	46%
Service Follow-Up within 30 days	59	37	63%

In meetings with internal and external stakeholders (i.e. ED Director, MHP Director, Crisis Case Manager, Analysts, MCP BH Manager) the issue of non-crisis individuals being admitted to the ED with active MH conditions was discussed. Often,

patients in the ED with MH conditions that are not in crisis and not in immediate psychiatric need are discharged regularly by the ED without MHP notification. Beneficiaries report being given information on reaching out to the MHP for Behavioral Health (BH) services but this practice isn't always being upheld by the ED. This all results in a population of ED utilizers with MH conditions that are not being reported, tracked, or contacted by the MHP.

The change in Problem Statement to include for missed opportunities is for multiple purposes:

1. Improving delays in post-discharge follow up services,
2. Improving capture of those with MH conditions that are often high ED utilizers and would benefit from MHP contact.
3. Reducing rates in which patients with MH conditions have the responsibility to contact the MHP themselves rather than the MHP initiating contact.

A focus on capturing missed opportunities will not only help the MHP contribute to the overall 7-day and 30-day follow-up measure. The focus will help address gaps of care within the community, while also working in conjunction with the ED's goal of reducing high-utilizers of Emergency Room services.

The previous Aim Statement as stated in the September 2022 submission: "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% by June 30, 2023."

This has been revised to state that "interventions will increase the percentage of RECORDED follow-up services". The word "recorded" was added to encompass the goal of this PIP by increasing its accuracy in receiving and recording those in need of follow-up services. Beneficiaries are specified as those with Lassen County Medi-Cal to ensure capture of the population that follow-up services would apply most to. The date was extended to March 31st 2024 as the intervention was not implemented until June 28th 2023 and the MHP wishes to use all of the available time until the next submission for gathering data on implementation.

4. Selected Interventions: State the selected intervention(s) for this quality improvement project (Reference: Submission for 9/30/2022, Question #10).

Based on root cause analysis and stakeholder engagement activities, the MHP identified and selected the following intervention:

Implementation of a referral/screening tool to be used by ED staff that will assist in determining if a patient admitted for a non-crisis MH condition would qualify for MHP services. Additionally, it will assist in identifying barriers that can be addressed by case management to improve likelihood of completing follow-up services.

This has been revised from the 9/30/2022 preliminary interventions of:

1. Obtain consistent ED data from the 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. Also, to track anyone who is experiencing homelessness and ways to better track them post discharge.

2. Utilize a centralized referral tracking mechanism that allows for real-time referral coordination from the ED, including functionality to generate alerts for high-risk / urgent needs and other key information (e.g., homelessness).

5. Narrative Description of Changes: Briefly describe any revisions to selected interventions since the last submission for BHQIP. Address the reasons leading to any changes, as well as the data or evidence considered leading to these changes

Originally, interventions focused on seamless data exchange with the MCP and with the ED via HIE. While the MHP is in the process of entering into an HIE, the timeframe to go live has exceeded the timeframe of applying an intervention to meet the BHQIP requirements.

While the MHP participated in a data sharing agreement with the MCP, the MCP was unable to provide timely data as requested. As communication from the MCP was not reliably consistent, stakeholders agreed to focus energy on building a better functional relationship with the ED while still utilizing the MCP for supplemental data and providing the MCP data on identified individuals discharged that might indicate an error in their system.

In meeting with the ED, an agreement was made to try and begin exchanging daily patient rosters for the MHP to cross reference over EHR for prior beneficiaries and to reach out to those with reported MH conditions and report back to the

ED on successes and challenges. However, after review, the ED legal would not allow sharing of full patient data outside of an HIE with releases of information (ROI).

In order to facilitate data exchange and still identify patients in need of care coordination and MH follow-up, an agreement was made between internal and external stakeholders to develop a referral/screening tool that would fulfill the following criteria:

1. Allow ED staff to know when a patient would be eligible for services through the MHP
2. Identify Social Determinates of Health (SDOH) barriers that could impede on completing follow up services if not addressed.
3. Allow for secure data exchange without sharing of unnecessary Personal Health Information (PHI)

This screening, when attached with an ROI, would function as a referral to BH services. Upon receipt of a referral, the BH Analyst cross references EHR and Crisis/Hospital Discharge tracking sheet for prior beneficiaries, recorded barriers, and for multiple hospital discharges to better inform contacting-staff. The MHP will then promptly attempt contact for the purpose of getting the referred individual scheduled into follow-up services within 7 days. Upon contact, necessary staff will be informed of barriers to discuss with the beneficiary to assist in addressing difficulties that may arise in completing follow-up service.

In reframing the focus onto capturing missed opportunities, the proposed new intervention was established following an updated Five Whys Root Cause Analysis (RCA):

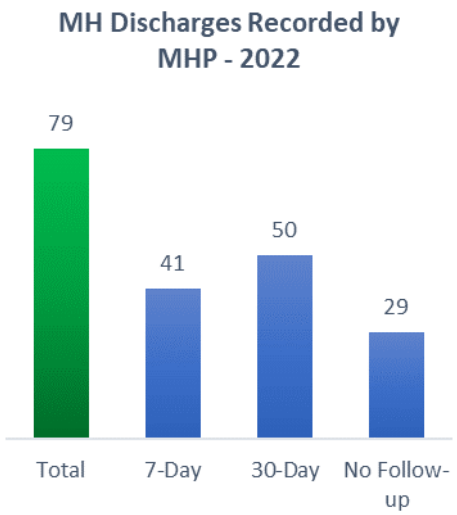
Problem Statement: There are missed opportunities and delays in receiving services post-discharge from the ED for individuals with mental health (MH) conditions.

Why?	MHP is primarily only aware of ED admissions for MH conditions when the patient is in crisis. All other patients with MH discharges are responsible for initiating contact with MHP.
Why?	ED patients who were discharged for non-crisis MH conditions are not being communicated to the MHP and barriers to initiating contact and completing follow up services for this population are not being considered.

Why?	Current referral process for the ED is not standardized. Referrals are not common, with little detail on reason for admission, SDOH barriers, and Medi-Cal status - often those referred from hospital are not eligible for services with the MHP and are only referred by PCP
Why?	Not all referring ED staff are aware of requirements for eligibility for MHP services as well as conditions when or when not to refer a patient that was not experiencing MH crisis.
Why?	Communication has been established between ED and MH in regards to Crisis but no practices have been solidified between ED and MHP in regards to referring others who were admitted for MH Conditions and identifying barriers that could impede on completing follow-up services with the MHP.
Root Cause:	Lack of established communication and defined referral process between ED and MHP for patients with non-crisis MH conditions

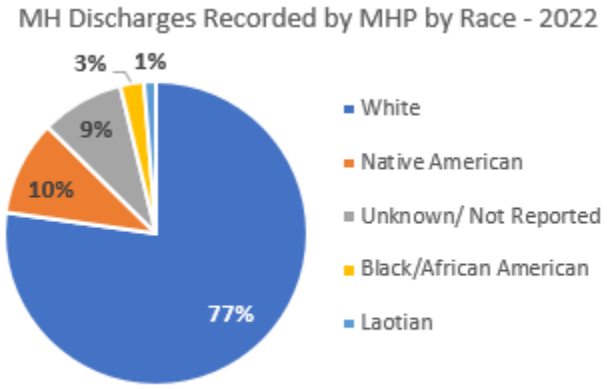
6. Equity Analysis: Participating Entities are required to complete an Equity Analysis as part of their quality improvement plans for BHQIP Goal 3. Describe how the intervention(s) identified in Question 4 consider and address disparities faced by Lassen County Medi-Cal beneficiaries who have a mental illness in the Participating Entity's service area.

In review of FY 2022-23 data on ED discharges for MH as collected from the MHP Crisis/Hospitalization tracking sheet, 79 discharged individuals were identified as having Lassen County Medi-Cal, 41 completed follow-up by 7 days, 50 by 30 days, and 29 did not complete at all.



The profile of the average discharged individual reported to the MHP is that of a white (61/79; 77%), non-Hispanic (65/79; 82%), female (39/79; 49%) who lives within the town of the MHP (56/79; 71%) and referred self (32/79; 41%) to only MH services (68/79; 86%). Each of these demographics are leading qualities of those most likely to complete follow-up services within 7 days post-discharge. Individuals who meet all of these combined characteristics completed timely follow-up services 91% (11/12) of the time.

Of discharged Lassen County Medi-Cal patients that are recorded by the MHP there is a clear disparity between rates of non-white versus white individuals. Laotian, Asian, Native Hawaiian and Other Pacific Islander races comprised of only 1.3% (1/79) and Black/African American individuals comprised of only 2.5% (2/79). This is in contrast with the 2020 census data for Lassen County[1] where the populations comprise 2.7% and 7.6% respectively. This applies particularly to Hispanic or Latino individuals who make up 20.3% of the county but 0% of the recorded crises.



While this population makes up the largest minority of the County, the penetration rate for MH services is not representative (11.17% as stated in the FY22-23 Cultural Competency Plan). 100% of recorded discharged individuals speak English as their primary language. The greatest racial disparity in the opposite direction is that of Native Americans who make up only 4.4% of the County but are over represented in those discharged for MH conditions (8/79; 10%). This is considered within the MHP Cultural Competency Plan as Native Americans are identified as the population with the largest ethnic penetration rate (from EHR data, 6% of all MHP beneficiaries are Native American) and this heightened penetration rate is reflected in the crisis/hospitalization data. In the first step of the process, there is a wide disparity among racial lines of who are even admitted/discharged from the ED with an MH condition and are reported to the MHP.

In terms of completing timely follow-up services post discharge, while females were most likely to be reported discharged, males (33/79; 42%) are slightly more likely to complete timely follow up services (24/33; 73% - females 26/39; 67%) with females being more likely to not complete services (13/39; 33% - Males 9/33; 27%). The greatest racial disparity in terms of completing services has been identified as Native Americans, of whom 63% (5/8) do not complete any timely follow up services.

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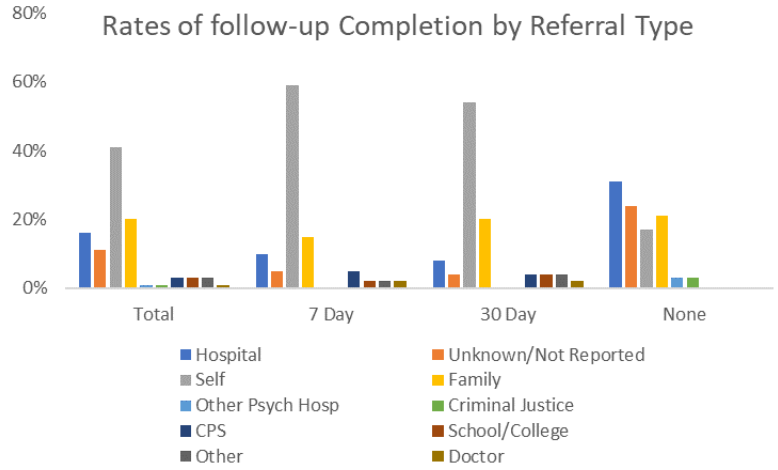
[1] U.S. Census Bureau (2022). *Lassen County Population Estimates, July 1, 2022, (V2022).* Retrieved from U.S. Census Bureau QuickFacts: Lassen County, California

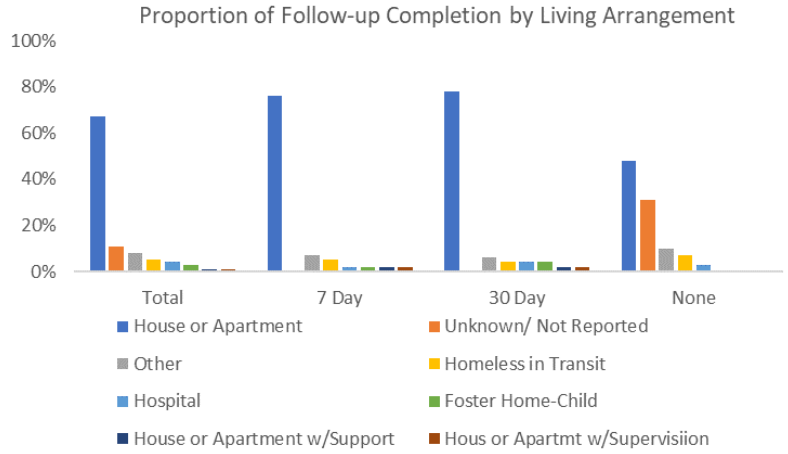
Race		7 Day	% 7 day	30 Day	% 30 day	None	% None
White	**61**	37	**61%**	45	**74%**	16	**26%**
AI/AN	**8**	2	**25%**	3	**38%**	5	**63%**
Unknown/ Not Reported	**7**	0	**0%**	0	**0%**	7	**100%**
Black/African American	**2**	2	**100%**	2	**100%**	0	**0%**
Laotian	**1**	0	**0%**	0	**0%**	0	**0%**

Individuals most likely to complete follow-up services referred themselves voluntarily to the MHP. 41% (32/79) of total recorded discharges were of those who then voluntarily referred themselves to services. 84% (27/32) of that population went on to receive timely follow up. This is in contrast to those referred by the hospital, who historically do not necessarily volunteer to be referred. Those referred by the hospital comprise 16% (13/79) of total recorded discharges while 69% (9/13) of that population did not complete follow up services. This PIP tackles this disparity by working to increase referrals from the hospital where the patient consents and volunteers to be referred.

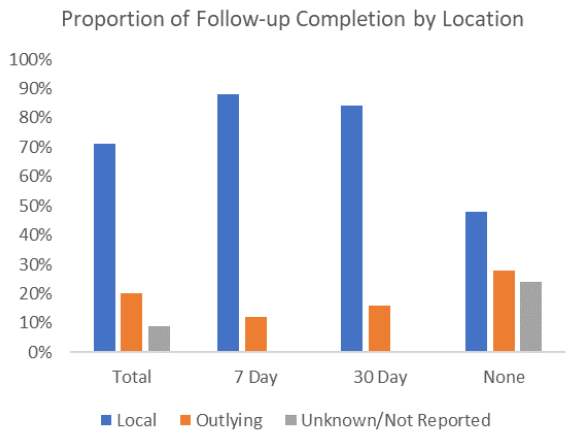


Housing and location contribute greatly to an individual's likelihood of completing follow up services. Those living in a house or apartment make up 67% (53/79) of those recorded discharged with 74% (39/53) completing timely follow-up.

This is in contrast to those recorded as homeless who make up a minute percentage of those recorded - 5% (4/79) – but make up 7% (2/29) of those that did not complete services. Of the small population of recorded homeless, 50% (2/4) completed timely follow-up, and 50% (2/4) did not.



In the same vain, a similar result can be found for those living in outlying communities. As Lassen County is a large rural county, outlying individuals are defined as individuals who report their residence as outside of the town where the MHP is located. While this comprises 20% (16/79) of those reported discharged, the likelihood of completion of follow-up is similar to that of homeless individuals, with 50% (8/16) completing timely follow-up and 50% (8/16) not completing follow up.



This equity analysis has identified four primary disparities to be taken into consideration within the implementation of this PIP: Native American population, Hispanic or Latino population, Homeless, and Outlying individuals. In addressing these disparities, this PIP will focus on collecting and monitoring demographic and housing data within the referral tracking and ensuring that contacting-staff/providers are notified upon receipt of referrals when an individual with the given disparities is identified so as to provide a higher degree of attention to addressing service enrollment and follow-up. Additionally, KPIs will also be stratified by racial and housing demographics to better monitor these populations. Lassen County does not have a Threshold Language but Spanish versions of all LCBH paperwork are made available with a Spanish version of the referral/screening to be developed. Importantly, beneficiary input will focus on achieving feedback in regards to this implementation from those in the reported disparities.

In conducting this PIP, all actions are taken with consideration of the MHP Cultural Competency Plan (CCP). As stated in the CCP LCBH recognizes the need to be culturally responsive to Hispanics, Native Americans, and other minority groups in our county. LCBH will reach out to a variety of individuals with different points of view, and will emphasize on reaching out to the community for the services that LCBH is planning to provide. Community input is invaluable in preventing oversight of key components as well as developing and understanding any missing components needed for future outreach efforts. In addition to outreach efforts already being conducted by the MHP, obtaining diverse beneficiary feedback and input that is representative of the disparities identified will be instrumental toward the success of this PIP.

7. Implementation Steps Completed: Describe steps completed as of 9/29/2023 to implement the interventions identified, including time periods or dates of action (Reference: Submission for 9/30/2022, Question #12).

Following agreement with the ED on instituting a referral/screening tool on May 30th 2023, the tool was developed in June of 2023, with it receiving approval by the Quality Improvement Committee (QIC) on June 19th 2023. The ED conducted training and began implementing the tool on June 23rd 2023. The first referral received was July 7th 2023, with 4 subsequent referrals with attached ROIs received in July and August with no errors in submission. Upon receipt, the MHP front office has begun to make timely contact to schedule those referred for services. While referrals have not been frequent, we are receiving referrals for those properly screened by the ED and have been making contact with those discharged with MH conditions who we would have otherwise not been made aware of. Receiving referrals and making contact to schedule services are two successfully completed steps to increasing follow up services for this population.

MHP Analyst has created a tracking sheet for input of referral information, including date and time of referral and first contact, name, contact information, and selections on SDOH barriers and program need, insurance information, and whether an ROI was attached. An important factor added is that of demographics as related to the equity analysis. This includes race, housing situation, and zip code to measure impact of intervention on identified disparities. MHP Front Office staff indicate on the form the date and time of contact and whether contact was made or why it wasn't able to be made and is recorded by the Analyst in the tracking sheet. Analyst confirms daily the referrals that were received within the previous 24 hours and biweekly will cross reference referral list with EHR to confirm and record first service, date, and completion status. Following successful registration, when an individual is brought up to the MHP's weekly Access meeting, the Analyst will share barriers indicated by the individual in the screening to help determine proper case manager / therapist assignment for follow-up.

8.Challenges Faced: For all implementation steps identified in the 9/30/2022 submission that did not occur as anticipated, address reasons why.

In the original implementation of this Performance Improvement Project, the potential interventions selected focused on achieving consistent, seamless, and real-time data exchange between the MHP and the ED and MCP. This intention was not actualized for a number of reasons.

Originally the MHP sought coordination with the MCP. What the MCP was able to provide, however, was not consistent individualized data but macro-level data and analysis in relation to the FUM measure as well as data on utilization and demographics. The MCP was unable to furnish lists of discharged individuals that the MHP could contact for follow-up services. In instances where the MCP could provide names, contact was not able to be made as releases of information were required to initiate. Communication and data exchange have been ongoing between the MHP and MCP but data exchange that would facilitate the MHP's interventions was not achieved. Additionally, timely response from the MCP was not reliably met. Data exchange with the MCP was determined best practice for receiving informing materials and notifying the MCP of referrals for them to internally account for errors into why a person wasn't forwarded to the MHP. However, data elements exchanged between with MHP and MCP did not meet the direct needs for the MHPs goals within this PIP.

In regards to achieving seamless and consistent data exchange with the ED, the MHP encountered a number of challenges. During the development of the first iteration of this PIP, interventions were chosen in mind of the MHP entering into a Health Information Exchange (HIE). Being integrated with an HIE could allow for connection with the ED so information on discharges could be accessible in real-time and the MHP could cross reference to determine shared beneficiaries that could be contacted and followed up with. However, as the MHP entered into a new EHR in July of 2023, integration into the HIE was delayed by 3 months to allow for a review and revision period within the EHR. The MHP still hopes to begin the process of going live with an HIE by October, but for the purpose of achieving an implemented intervention by the 2023 BHQIP deadline, data exchange via HIE was not able to be considered.

In efforts to implement data exchange between with the ED and MHP outside of a centralized data exchange, meetings with the ED Director resulted in developing a plan for the MHP to begin receiving patient roster information. The ED had agreed to begin sending bi-weekly scans of "stickers in the book" where patients who were admitted for MH conditions would be identified and forwarded to the MHP. This intervention plan would not have allowed for contact with non-beneficiaries but would have allowed the MHP to cross reference the EHR for current beneficiaries whom the MHP would

have been unaware of their ED discharges; this way contact could be made to schedule follow up services with this population.

Following internal discussions by the ED, a follow up meeting was scheduled May 30th 2023 with the ED Director, ED Case Manager, ED IT Security, ED Analyst, ED legal team, and MHP Analyst. In that meeting the ED legal team shared that they would disallow data exchange of any patient rosters with the MHP. Due to HIPAA concerns, the ED was not comfortable sharing Personal Health Information (PHI) outside of an established HIE with all precautions already established. Being that this tactic was infeasible, discussion turned to how to exchange data given the patient's expressed consent. It was then that the proposed intervention began to take focus on a referral tool with an included ROI. In discussing the ED's process for referral, it was clear that the ED was not aware of MHP eligibility standards and had not known who and when they could refer to the MHP for follow-up services. While the MHP has worked with the ED in the past to address this training, due to new staff, the information has not been passed along. In order to combat a lack of information on MHP eligibility among ED staff, the referral form developed by the MHP was made to encompass screening for eligibility so that anyone conducting the screening at the ED would be able to pass along the eligibility requirements without chance of information being lost during staff changes. Additionally, the use of a referral/screening tool allows for capture of Social Determinates of Health (SDOH) barriers that could impede on an individual completing follow-up services. This allows the MHP to track for barriers such as homelessness, transportation, or food insecurity, and enables barriers to be discussed immediately upon contact.

Upon implementation of the referral/screening tool, the initial referrals received from the ED were lacking completed ROIs or had errors in the scanning process. Discussion then ensued with the ED Case Worker to ensure that the completed tool was sent over. At that time the Case Worker was not recording/filing sent referrals and was shredding immediately after referring. This resulted in 2 referrals not being able to be contacted. Following this instance, the case worker has begun saving and securely filing the sent referrals and will call the MHP to notify when a referral is being sent to ensure that it was received and that all necessary information was included.

9.Key Performance Indicators (KPI): Report out regarding the performance of the selected interventions using the performance indicators selected by the Participating Entity in the 9/30/2022 submission.

Due to revision of the original preliminary interventions, the Key Performance Indicators have been modified to relate to the data that the MHP will have available. The revised primary KPIs for this PIP are the total percentage of:

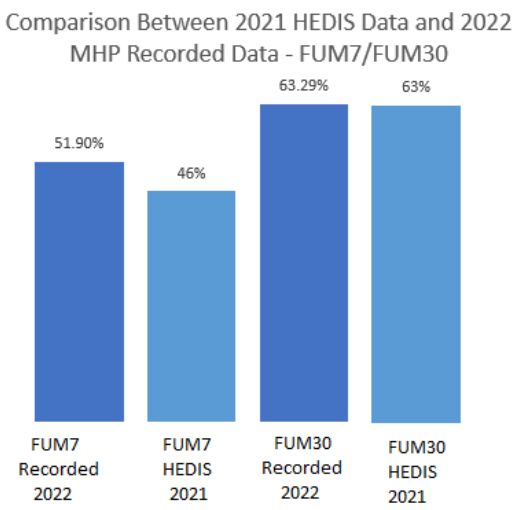
$$\text{Numerator: } \frac{\text{The number of recorded Lassen County Medi-Cal beneficiaries discharged with MH-condition who received a follow up MH treatment service from the MHP within 7 days}}{\text{Denominator: The total number of Lassen County Medi-Cal beneficiaries discharged with MH-condition recorded by the MHP}}$$

AND

$$\text{Numerator: } \frac{\text{The number of recorded Lassen County Medi-Cal beneficiaries discharged with MH-condition who received a follow up MH treatment service from the MHP within 30 days}}{\text{Denominator: The total number of Lassen County Medi-Cal beneficiaries discharged with MH-condition recorded by the MHP}}$$

Additionally, an essential data element will be the number of referrals received from the ED per month and percent complete so as to monitor trends and address when less-than-expected-results are achieved.

For the primary KPIs, a preliminary analysis was conducted from discharge data as recorded on the Crisis/Hospitalization Tracking Sheet for FY 2022. The MHP found that there were 79 incidents of discharge recorded for individuals with Lassen County Medi-Cal. Of those 79, 41 had received a follow-up service within 7-days (51.90%), and 50 had received a follow-up service within 30 days (63.29%). This finding tracks well with the 2021 HEDIS measure for FUM where the MHP scored 46% and 63% respectively.



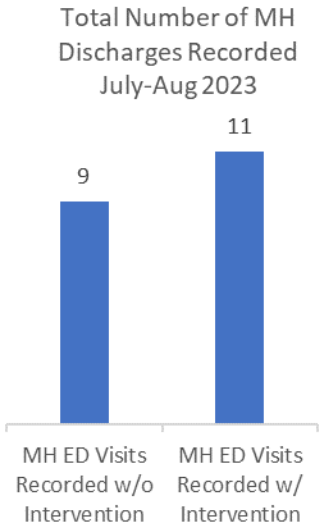
2022

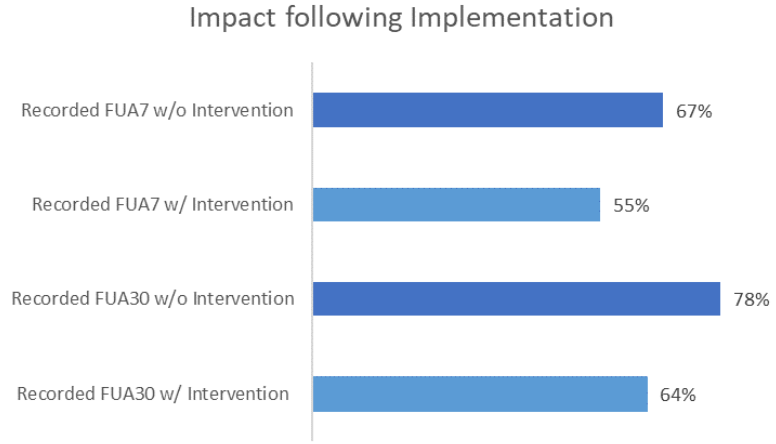
Service Follow-Up	Recorded ED Visits for Mental Illness	MH Service Follow-up	Recorded FUM %
Service Follow-Up within 7 Days	79	41	51.90%
Service Follow-Up within 30 Days	79	50	63.29%

Since beginning this intervention, the MHP has received 5 referrals from the ED using the referral/screening tool. 2 of the 5 had to be immediately discarded as ROIs were improperly scanned, and before correcting the issue with the ED Case Worker, the referrals had been being shredded after transmission instead of securely filed. Of the 3 remaining referrals, one was non-Medi-Cal due to ED error and could not be provided MH services by the MHP. Two eligible referrals remained.

Of FY 2023, for the months of July and August, when not including those referred by the referral/screening tool, there were 9 discharges (i.e. crises at the ED that were reported to and recorded by the MHP) of individuals with Lassen County Medi-Cal. 6 of the 9 received a follow-up service within 7-days (67%), and 7 of the 9 received service within 30 days (78%).

Including the two eligible referrals into the Crisis/Hospitalization tracking that would have otherwise not been identified, there are 11 MH discharges recorded by the MHP, with 6 of the 11 receiving follow-up services within 7 days (55%), and 7 of the 11 receiving service within 30 days (64%).





2023 - Excluding Intervention

Service Follow-Up	Recorded ED Visits for Mental Illness	MH Service Follow-up	Recorded FUM %
Service Follow-Up within 7 Days	9	6	67%
Service Follow-Up within 30 Days	9	7	78%

2023 - Including Intervention

Service Follow-Up	Recorded ED Visits for Mental Illness	MH Service Follow-up	Recorded FUM %
Service Follow-Up within 7 Days	11	6	55%
Service Follow-Up within 30 Days	11	7	64%

In regards to stratified KPI's, it was found that of the total 11 recorded discharges since 7/1/2023, the majority recorded were Male (7/11; 64%), knowingly housed (5/11; 45%), reported Not Hispanic (8/11; 73%), white (7/11; 64%) and living in the town of the MHP (9/11; 82%). Hispanic/Latino individuals comprised of 9% of recorded discharges (1/11), an increase from previous tracking but still below the percentage of capture as expected of a population that makes up 20% of the county. Native Americans also comprised 9% (1/11), a slight decrease in capture compared to previous year's tracking. Due to small sample size the finding for racial disparity cannot be assumed.

Similarly for housing disparities, 9% of the recorded discharges were homeless (1/11), an increase in proportion compared to prior tracked year. 82% lived within the town of the MHP (9/11), with 18% unknown (2/18). Due to small sample sizes valid analysis on these disparities cannot be generalized.

While the two additional individuals did not contribute to improvement in the overall KPIs, their presence being reported in the KPIs signifies improvement in capturing a more accurate representation of the population of those discharged from the ED for MH-conditions. As the intervention continues and the MHP is able to leverage data on SDOH barriers and continue to receive additional referrals from voluntary individuals, the hope is that the additional referrals will contribute to an increasing KPI to meet the Aim statement of this PIP.

While the frequency of referrals received is not high, the MHP believes it is still significant enough to have positive impacts toward the goal of this PIP. In a Medicaid Analytic Extract on characteristics of ED visits with mental disorder diagnoses[2], the rates of MH-related ED admissions over a four-year span that were not for suicidal ideation or suicide attempts/self-harm was found to be 16.4%. This 16.4% would include all MH-related admissions that are not crisis, since any admission that involves suicidal ideation or suicide attempts/self-harm would be a crisis (and reported to the MHP and subsequently tracked). While of the 16.4% there would undoubtedly be non-suicide/self-harm-related crises included (that the MHP would be informed of), this data would indicate that out of all crises recorded by the MHP, there could be an estimated maximum of an additional 16.4% of non-crisis MH ED admissions. Given a maximum of an additional 16.4%, from the MHP historical crisis tracking we can calculate a yearly and monthly average of the estimated maximum number of incidences of MH ED admissions that are non-crisis and therefore the MHP would not have been notified of to record and would have been missed opportunities for contact.

In total, from five years of MHP crisis data (2018-2022), 822 crises were reported from the ED, equaling an average of 164.4 ED crises recorded per year. If a maximum of 16.4% of total MH discharges were not recorded, there is a potential for up to 31.31 MH discharges per year that were not reported to the MHP. Per month, this figure could mean up to 2.6 discharges per month that were not reported to the MHP.

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[2] Olfson M, Gao YN, Xie M, Wiesel Cullen S, Marcus SC. Suicide risk among adults with mental health emergency department visits with and without suicidal symptoms. J Clin Psychiatry. 2021;82(6):20m13833. doi: 10.4088/JCP.20m13833. - DOI - PMC - PubMed

While the study period for the Medicaid Analytic Extract took place prior to 2018, and the data source is nationally aggregated, this finding is still a good indicator of the frequency to which we would receive these additional referrals from the ED for MH-related discharges. Being that five referral/screening tools were received from the ED within 2 months, the rate to which the MHP is now being notified of additional discharges is in line with the estimated maximum monthly average as determined from the Medicaid Analytic Extract.

When comparing with FY 2022 MHP Crisis/Hospitalization data, if a maximum of an additional 31 discharges were provided timely 7 and 30-day follow-up that year, this would increase the KPI measure for 7-day follow-up by 26% and 30-day by 16%. While achieving this level of success is unlikely it is an indicator for how increased capture of missed discharges can significantly impact the overall follow-up rates and help the MHP in achieving the objective of the Aim Statement.

10. Lessons Learned: Provide a brief reflective summary of the improvement plan implementation process. In this response, identify **at least 2 lessons learned** for the next phase of improvement plan implementation.

The biggest lesson was that seamless, real-time data exchange and coordination was not going to happen in the snap of a finger by instituting an HIE, and that the viewpoint that that would be the case allowed for complacency in deriving initial goals out of this PIP. The lack of the HIE, while not allowing for rapid development of data exchange capabilities, did allow for the development of a more common-sense approach to coordinating with the ED and allowed the MHP to better focus on internal methods of improving tracking capabilities and coordination with the ED.

While better coordination with the MCP is necessary moving forward, in working with the MCP it has been an important lesson to learn the flows and timeframes of communication as well as the scope of what information they are able to provide. The MCP fills an important role of providing top-down data and analysis, but has not been as useful in obtaining bottom-up data needed for making timely contact with those potentially missed in our usual processes.

As per discussions with the MCP, the MHP is notified for “crisis” when an individual is presenting at the ED and receives a primary diagnosis of a mental health condition. For individuals missed, many who are presenting with an MH condition but

are not given a primary diagnosis as such, often do not meet the threshold of the MHP being notified. This is particularly salient in cases where a medical condition is identified during the ED visit that takes immediate precedence over the MH condition. These circumstances do not add into our FUM HEDIS measure but highlight a gap in service linkage to be addressed between the ED and MHP.

Section 2: Next Steps for Improvement Plan

The following section focuses on further implementation of the Participating Entity's improvement plan. This section is analogous to the Act portion of a PDSA cycle, leading to the Plan portion of the next PDSA cycle.

11. Implementation Steps, Planning for the Future: Describe at least **3 concrete steps** that the Participating Entity will carry forth in the following 6 months to implement the interventions specified in Question 4 and to assess performance on the key performance indicators specified in Question 12. Provide time frames or dates for each step identified.

Of three concrete steps that will be taken going forward, two will be directly related to assessment while the third may encompass restrategizing.

Firstly, it will be imperative to maintain regular communication with the ED. This will involve weekly status calls with the ED case worker to confirm flow of referrals, as well as accuracy of shared spreadsheet where referral information will be tracked. Additionally, minimum quarterly meetings will be conducted between the MHP and ED Director, ED Caseworker, and other ED stakeholders. Discussion will center on the following:

- Impact on ED workflow from use of the tool
- Efficacy of our coordination in regards to helping the ED by identifying and integrating high ED-utilizers with MH conditions into MH services and increasing MHP follow-up services.
- Any challenges to be addressed, changes desired to the tool or means of coordination, and de-identified successes.

Quarterly communication with the MCP will be necessary in this as well to continue to receive macro reports in regards to the FUM metric, MH-related admissions/discharges, and aggregated demographic data to inform further development of the referral/screening tool and facilitation of an equity-driven approach.

Secondly, minimum quarterly internal stakeholder review will be conducted among the MHP QIC to report on KPIs and discuss findings, successes, and challenges. Upon review, if the decision is made to make any edits to the intervention, the QIC will be responsible for approval of changes. The QIC is also always seeking beneficiary involvement, and will be continuing to seek beneficiary input on the implementation, progress, and effect of this PIP during QIC meetings as well as quarterly consumer surveys.

Lastly, the MHP will be entering an HIE in October. Upon necessary training and acclimation, within the following months meetings will be conducted internally with QIC and HIE vender to discuss and develop capacity for further data exchange with the ED as well as the MCP. The MHP predicts that once connection between HIE and ED is feasible that discussion will be needed to restrategize the data collection and exchange aspect of this PIP. Internal planning will be followed by follow-up planning and meetings with the ED to determine the best course of action.

12. Key Performance Indicators (KPI), Future: Identify **at least 2 key performance indicators** that will be used to assess the implementation and success of **each intervention** (process or outcome, Science of Improvement: Establishing Measures) identified in Question 4 above during the upcoming reporting period. For each indicator, indicate target performance. These KPIs may (but do not have to) differ from those identified in Question 9 based on the Participating Entity's implementation plan.

The most critical KPIs that will be used to assess implementation and success of the interventions will be that of the rates of those captured that received follow-up services after discharge by 7 days and by 30 days. This will be analyzed internally from data collected on the Crisis and Hospitalization spreadsheet in regards to ED visits as well as the ED Referral/Screening Tool Tracking Sheet. Both worksheets contain information on when the client was referred, when first contact by MHP was made as well as subsequent contact attempts, and when first follow up appointment was completed. The rate of those who received follow-up services within 7 and 30 days will be calculated quarterly and used as the benchmark to measure and compare growth for this PIP. When the MCP is able to provide updated FUM HEDIS metrics, discharge by diagnosis, and demographic reports, the MHP will utilize this data to compare with the tracked internal measure to ascertain the larger scale impact of the interventions.

An additionally critical data element that will be showcased is the specific number of referrals received from the ED. It is easy to predict that there will be ebbs and flows in the number of referrals received by the ED month-over-month, just as there would be ebbs and flows in actual MH admissions. This measure, however, will be key in determining the ongoing

continuance of the process by the ED as repeated months of lower or 0 referrals would indicate a need to discuss implementation, investigate cause, and address potential training. This measure will also be critical in showcasing the rate of those referred by the ED that enter into services with the MHP. It is this measure that is the direct consequence of the element within the Problem Statement regarding “missed opportunities”. Positive growth would reflect effectiveness of intervention in regards to capturing discharges with MH conditions that would have never received MHP contact.

These measures will be calculated and shared at a minimum quarterly with stakeholders, QIC, MHP staff, MCP, and ED. Quarterly analysis will build off of findings from previous quarters to show trends and patterns within the implementation.

KPI Targets for March 31st 2024: Capturing at least 2 additional missed MH discharges through use of intervention every month from July 2023 to March 2024 – goal of 18 captured in total. Outside of the intervention, the MHP anticipates to have a similar rate of MH discharges recorded as previous years. Average monthly rate over prior 5 years has been 13.67. Over the next 7 months we can estimate recording 95 MH discharges, not from the intervention, in addition to the 9 already recorded for July and August, totaling 104 expected recorded discharges by March 31st 2024 outside of the intervention.

Aim is that the total rate of recorded FUM7 and FUM30 by March 2023 will be 5% higher after including additional captures of MH Discharge that receive timely follow-up.

KPI: Not including Invention (FUM7 and FUM30 rates from previous year) – 7-day/30-day = 52% / 63%

The number of recorded Lassen County Medi-Cal beneficiaries discharged with SUD-condition who received a follow up SUD treatment service from the MHP within 7 days	54	/	The number of recorded Lassen County Medi-Cal beneficiaries discharged with SUD-condition who received a follow up SUD treatment service from the MHP within 30 days	66	/
The total number of Lassen County Medi-Cal beneficiaries discharged with SUD-condition recorded by the MHP	104		The total number of Lassen County Medi-Cal beneficiaries discharged with SUD-condition recorded by the MHP	104	

KPI: Including Invention – 7-day/30-day = 57% / 69%

$$\frac{\text{The number of recorded Lassen County Medi-Cal beneficiaries discharged with SUD-condition who received a follow up SUD treatment service from the MHP within 7 days}}{\text{The total number of Lassen County Medi-Cal beneficiaries discharged with SUD-condition recorded by the MHP}} = \frac{70}{122}$$

$$\frac{\text{The number of recorded Lassen County Medi-Cal beneficiaries discharged with SUD-condition who received a follow up SUD treatment service from the MHP within 30 days}}{\text{The total number of Lassen County Medi-Cal beneficiaries discharged with SUD-condition recorded by the MHP}} = \frac{84}{122}$$

Section 3: Beneficiary Identification, Data Exchange, and Stakeholder Engagement

Managed Care Plans and Behavioral Health Plans are jointly responsible for improving follow-up after emergency department presentation for mental illness for the entire Medi-Cal covered population. The following section focuses on collaborations and data exchange efforts between Participating Entities and other stakeholders to facilitate implementation of Selected Interventions and evaluation.

13. Collaborations with Managed Care Plans: What collaborations has the Participating Entity engaged in with Managed Care Plan partners to identify Medi-Cal beneficiaries who present to the emergency department for mental illness? DHCS **requires** that Behavioral Health Plans engage in good faith efforts collaborate with Managed Medi-Cal Plans.

- **Part A, Description of Collaboration**: Describe **existing and future** collaborations with Managed Care Plan partners in this clinical area of focus.

  Discussions with MCP have been conducted in the lead up to this PIP with MCP helping to inform process and capture of supplemental data. The MCP has been a continuing resource of information on how MH discharges are captured and tracked to ensure that the MHP is capturing the right data from the ED. The MCP is collaborating with the MHP by providing regular reports on numbers of MH discharges recorded per quarter as well as demographics. In a standard Admissions-by-Diagnosis report received by the MCP, numbers of MH discharges recorded from the ED can indicate an issue where someone was given a primary MH diagnosis by an ED doctor and was discharged before financial responsibility was transferred to the MHP. This can often indicate a discharge without contact to the MHP. In cases where this is found, the MCP and MHP can work together to identify and verify if these individuals received services from the MHP.

- **Part B, Description of Data Exchange:** Identify and describe data exchange efforts between the Participating Entities and other stakeholders to identify beneficiaries eligible for treatment after presenting to the emergency department for mental illness. In this response, identify the Entity’s ability to access data to drive change towards

its Aim Statement. **While no specific type of data exchange is required, Entities are required describe whether and how they are exchanging data in the following ways:** (1) Receiving data from Managed Care Plan partners and (2) Sending data to Managed Care Plan partners.

The MHP initially was trying to increase data exchange with the MCP to help identify MH discharges. The MHP however encountered a number of challenges with this goal. Firstly, timely exchange with the MCP was not reliable. While the MCP was able to provide valuable information when requested, response times would not be frequent enough to ensure that if data was received on an individual that needed follow-up services post-discharge, that the MHP would be made aware in time to contact within a consistently timely manner.

The largest roadblock in the initial goal of utilizing MCP data as the intervention for this PIP was that even if the MCP was able to provide data on individuals discharged for MH conditions, the MHP had no ability to use said data to make contact with these missed opportunities to get into timely follow up services without consent. The data provided by the MCP could assist in identifying current clients admitted but would not impact capturing those that needed to be in services but were never contacted.

As joint cooperation between the MHP and ED was restricted to only circumstances when individuals were in crisis, coordination for individual data on identifying MH discharges was recommended by the MCP to be sought directly from the ED to improve this cooperation.

The data that is received from the MCP for the purpose of this PIP includes any updated FUM metrics, Service Utilization, LOS Trends, Diagnoses, Demographics, and Admissions by Primary Diagnosis reports for the local ED. In instances where the MCP identifies that someone was discharged with a primary MH diagnosis and responsibility wasn't transferred to the MHP, patient information is securely exchanged on the MCP sFTP for MHP to cross reference with EHR and Crisis Tracking sheet to indicate to MCP if the patient was met during crisis and confirm whether or not the crisis service was billed under the MHP.

14. Collaborations with Health Care Delivery Partners: What collaborations has the Participating Entity engaged in with Health Care Delivery Partners (e.g. hospitals or clinics) to identify Medi-Cal beneficiaries who present to the

emergency department for mental illness? DHCS **does not require but strongly encourages** collaborative relationships of Participating Entities with health delivery partners.

- **Part A, Description of Collaboration:** Describe **existing** or **future** collaborations with Health Delivery Partners in this clinical area of focus.

  Collaboration with the local ED was necessary in being able to identify areas of needed improvement and address gaps in communication and care coordination. Collaboration began with discussion of the need to better ensure that those admitted with an MH condition but not in crisis were being properly referred to the MHP, thus began the joint development of the screening/referral tool. Regular meetings began to address the lack of communication between the MHP and ED. These meetings have involved clarifying roles, admission and discharge processes, MHP eligibility and scope, and challenges associated with admissions of those with MH conditions and where the MHP can help. These meetings will be ongoing with quarterly meetings set to continue discussion as well as to report on progress and challenges within this PIP.

  The ED is collaborating by identifying and screening patients with MH conditions and referring them in a timely manner to the MHP. Every time following submission of the tool, the ED calls the MHP to confirm receipt. The MHP is responsible for ensuring that the ED is well aware of the referral/screening tool and providing explanation/training when needed. The ED case worker and MHP Analyst work together to resolve any issues in the receipt of the tools as well as identify areas in the referral itself that might not be completed (e.g. SDOH barriers, insurance, ROI) and discuss reasons or ways to address inconsistencies.

  The MHP and ED will work together in the evaluation of the intervention's impact and effectiveness on an ongoing basis, with the ED being a key stakeholder in discussion of PIP strategy and any potential changes needed or updates to make the process better for all involved.

- **Part B, Description of Data Exchange**: Identify and describe data exchange efforts between the Participating Entities and other stakeholders to identify beneficiaries eligible for treatment after presenting to the emergency department for mental illness. In this response, identify the Entity's ability to access data to drive change towards

its Aim Statement. **While no specific type of data exchange is required, Entities are specifically required to describe whether and how they are exchanging data in the following ways:** (1) Receiving data from Health Delivery Partners and (2) Sending data to Health Delivery Partners.

Data is initially collected by the ED in the form of physical referral/screening tools. Upon completion by a patient with a physician or nurse, the form is given to the ED case worker or designee (when case worker is unavailable). The MHP is then notified and the referral is sent to the MHP. Currently, referrals are being received by secure fax, with the goal moving to digital exchange as the MHP is onboarded into an HIE.

The MHP keeps a secure central tracking sheet that is shared with the ED case worker at the monthly meeting to go over and confirm all referrals received. Information shared is deidentified but includes dates and answers to screening questions to confirm referrals. This tracking sheet is encrypted and shared via a HIPAA/HITECH compliant Dropbox. Once the encrypted tracking sheet is received by the ED case worker, the case worker will cross reference the individuals listed with their filed records of referral/screening tools sent and will report back to the MHP any discrepancies, after which the tracking sheet will be deleted from the Dropbox and an updated sheet uploaded the next month.

15. Data Exchange Strategy: Identify and describe data exchange efforts between the Participating Entities and other stakeholders to identify beneficiaries eligible for treatment after presenting to the emergency department for mental illness and to assess performance via Key Performance Indicators and drive change towards its Aim Statement. (Reference: Submission for9/30/2022, Question #17).

The MHP aim is to achieve routine data exchange with the ED, with the goal of enhancing care coordination. This will be accomplished through the following technology-related steps:

- 1st step: Meetings - Identify and assess what information is collected by BH case workers during crisis responses at ED, what information is collected by ED Case workers, how that data is stored and what precautions are necessary for exchange, as well as making improvements where necessary to capture data.

- 2nd Step: Direct Exchange – Transmission and receipt of securely faxed referral/screening tools with confirmation of successful exchange conducted over the phone between BH Analyst and ED Case worker.
- 3rd Step: Data Matching – Referral/Screening tools from ED will be received and processed by BH Analyst, recorded and cross-referencing with Crisis Spreadsheet and EHR for reporting gaps in service/referrals and notifying assigned BH provider of beneficiary discharge when appropriate. The BH Analyst will continuously track referrals, cross referencing EHR for BH registrations, first contact attempt, and first completed service.
- 4th step: Shared Spreadsheets – Deidentified tracking data of those referred and barriers (e.g. homeless, living in outlaying areas) discharged from ED is compiled, reported, and securely shared routinely with ED to ensure accuracy, closed loop referrals, and successes or challenges in the coordination of care.
- 5th step: Central Repository - Institution of HIE will improve data exchange capabilities and timeliness of data access. Once facilitated with the MHP, discussions with ED and HIE vender will work to establish how data on MH patients is recorded and stored by the ED electronically, what access is available to the MHP, how data is securely shared through the HIE, and how further data exchange can be leveraged for the benefit of both the ED and MHP.

The data exchanged, i.e. referral/screening tools, are able to be leveraged by the MHP to record additional numbers of ED discharges that would have otherwise gone unreported. This data element, in addition to already collected numbers on discharges reported to the MHP through crisis, forms the denominator of our KPI. Follow-up tracking on services completed and time spans following discharge will be used to calculate the number within that cohort that received and completed a service within 7 days and within 30 days, forming the numerator of the KPI. The calculated KPI over time will determine the progress toward meeting the Aim of increasing our 7- and 30-day follow-up rate by 5% in total by March 31st 2024.

Data Element	Source of Data	Method of Exchange	Function of Data
Identifying information on patients discharged with MH-condition	Referral/ screening tool	Currently secure fax, moving to HIE	For MHP to cross-reference with EHR and either make initial contact or inform current provider of areas to address
Received referrals	Referral tracking spreadsheet	Secure dropbox	For routine review by ED Case Worker to ensure that all referrals sent were received
Identifying information on patients discharged with MH-condition	Referral Tracking spreadsheet	Partnership sFTP	To be shared with MCP for purpose of informing MCP of any potential errors where someone might have been discharged with a primary MH diagnosis but not forwarded to the County

HEDIS Measures and Discharge by Diagnosis report	MCP	Partnership sFTP/secure email	To be routinely requested by the MHP and provided by the MCP for use as supplemental data to indicate rate of success in capturing additional SUD Discharges

16. Data Exchange, Narrative: Briefly describe the Participating Entity's experience since the last BHQIP submission regarding data exchange. Identify any challenges faced and lessons learned specific to implementation of the improvement plan

As discussed in the Narrative Description of Changes in regards to the intervention, the MHP learned a hard lesson following the 9/30/2022 PIP submission that the degree of seamless and encompassing data exchange that was planned for this PIP would not be able to be realized without being a part of an HIE and without having had plenty of time to become proficient and capable with the new system. In meetings with the MCP, data exchange was facilitated but measures that were sought were not able to be provided in the level of detail and timeliness that the preliminary interventions would have required. In meeting with the ED, the same level of seamless data exchange was not allowed by their legal team without being in an HIE.

The MCP's role in data exchange has progressed from being the primary focus of the intervention to being a valuable resource on aggregate analysis as well as point of contact to securely share information via sFTP on those the MHP found that were referred by the ED so as to inform of potential errors and to investigate the reason for why an individual wasn't referred to the MHP.

In working with internal stakeholders (MHP director, QIC, Analysts, Nurses, Case Managers, Therapists, Case Manager Supervisor, Beneficiary Surveys) and external stakeholders (MCP BH Manager, MCP Program Manager, ED Director, ED Case Worker, ED Analyst, ED IT security), the plan for data exchange was agreed to be most fruitful with the ED and in lieu of an HIE had to be "manually" exchanged. The process of exchanging data via referrals and shared spreadsheets leaves room for human error that would not be present in an HIE. Being that the referrals are voluntary, by its nature not

all additional unknown MH discharges will be captured by the MHP. For the purpose of the Aim however, additional voluntary referrals could have a higher likelihood of participating in follow-up services than if they were not actively seeking a referral.

Incidences such as what happened when first rolling out the referral/screening tool prove the drawback of this method. The first 2 referrals sent by the ED were not able to be processed due to technical problems in scanning and a lack of filing needed by the ED so as to resubmit. This issue was thankfully resolved going forward. This was achieved through discussion with the ED Case Worker who now securely files all referral/screening tools once sent to the MHP, follows-up with the MHP Analyst immediately upon transmission, and participates in a monthly meeting to review the referral tracking sheet provided by the MHP. These extra steps are needed for confirmation but are clunky when compared to what data exchange could be feasible with an HIE.

In all, aside from the initial setbacks and extra steps and precautions needed to facilitate this method of data exchange, exchange between the MHP has been overall successful and will only continue with additional coordination and discussions among stakeholders within the MHP, ED, and MCP.

17. Care Navigation:

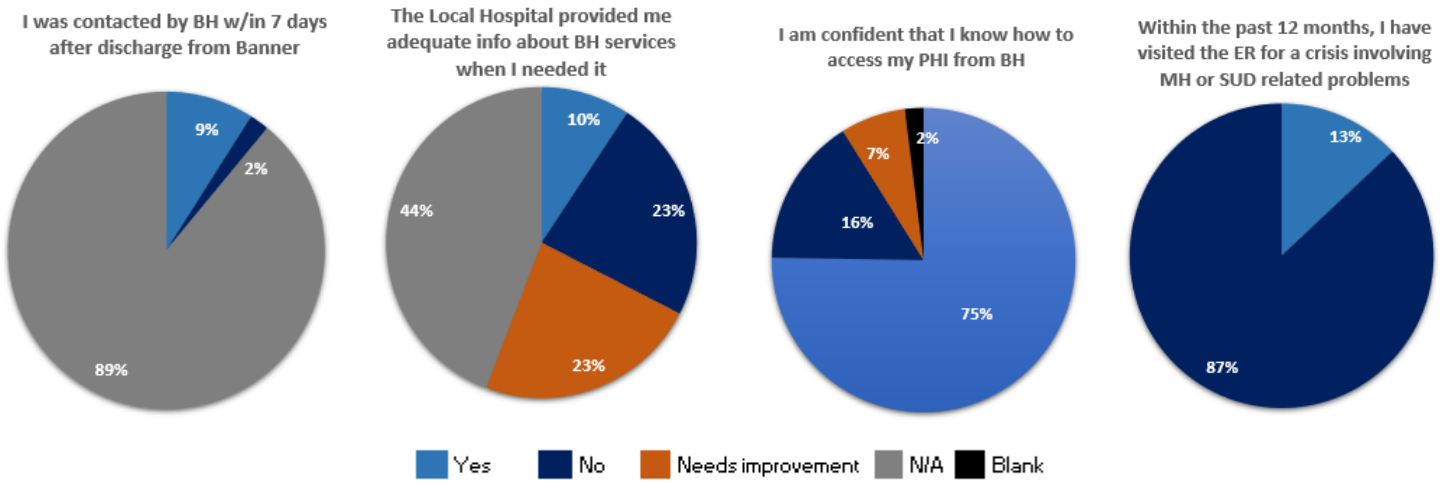
- **Part A:** Is the Entity collaborating with CA Bridge or another stakeholder that receives funding from CABridge? (Yes/No) No
- **Part B:** Describe any engagement of the Participating Entity with the CA Bridge Program or other efforts to improve care navigation for people who have a mental illness.

  The three Participating Entities for this implementation are the MHP, the ED, and the MCP. The ED, upon judgement and screening, utilize the intervention for the ED Case Worker to navigate patients in need of further MH care to the MHP. The MHP will then be responsible for further assessment of needs and medical necessity where it will be determined whether an individual is best served in an Outpatient County setting or if transition to lower or higher-level care is appropriate. In those cases, the MHP works with the MCP to guide the individual to an appropriate facility and works with the individual and referred entity to help navigate them to the proper level of care with a warm handoff. The MHP is not currently collaborating with the California Bridge Project.

18. Beneficiary Engagement: Address when and how beneficiaries will be engaged in the period prior to the next reporting period in 9/29/2023. Specifically address how beneficiaries will be engaged

Beneficiary feedback is essential on understanding the impact and success of this intervention. For the week of May 15th 2023, the MHP issued a consumer perception survey with additional questions related to ED Discharge. Of the respondents, 80% who had reported to have been discharged for an MH or SUD-related condition received contact prior to 7 days from the MHP while 20% reported that they did not. 64% received adequate information from the ED about MHP services but 36% reported that the ED did not provide adequate information or needs improvement. These measures helped dictate the need and direction of this PIP. Going forward, the MHP is always seeking beneficiary involvement in the QIC and PIP review, with providers routinely asking beneficiaries if they are interested and offering participation. In lieu of active participation in QA/QI, beneficiary input on the PIP process and progress will continue to be sought through routine surveys.

PIP Survey Findings: n=45



Template A (FUA)

Clinical Area of Focus: Follow-Up After Emergency Department Visit for Alcohol Use Disorder or Other Substance Use Disorder

Section 1: Progress Report for Quality Improvement Project

Participating Entities may have revised or modified their quality improvement plans since the 9/30/2022 submission for BHQIP. In your responses, state your previous submission information and describe any changes the Participating Entity has made since the last submission. Address any clarifications previously sought by DHCS in responses.

1. Problem Statement: What is the problem this performance improvement plan proposes to solve? (One Sentence, Reference: Submission for 9/30/2022, Question #3)

Gaps in care coordination practices and related data exchange processes contribute to missed opportunities and delays in receiving services post-discharge from the ED for individuals with Substance Use Disorder (SUD) conditions.

2. Aim Statement: What is the aim/goal for this performance improvement project? (One Sentence for each element, Reference: Submission for 9/30/2022, Question #9)

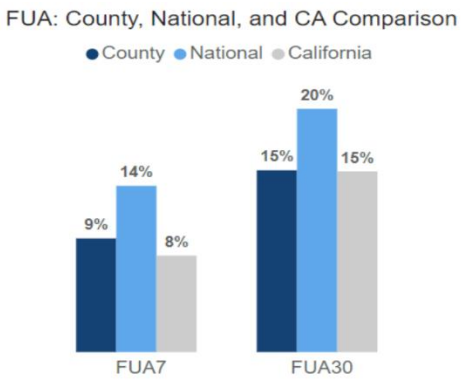
Aim Statement	For Lassen County Medi-Cal beneficiaries with ED visits for SUD conditions, implemented interventions will increase the percentage of SUD-related ED discharges recorded by the MHP by 50% and will increase the percentage of recorded follow-up SUD services with the Plan within 7 and 30 days by 10% by March 31st, 2024.”
How the Aim Statement is	
Specific	*Focuses on the specific population of those discharged from the ED with SUD conditions that are on Lassen County Medi-Cal.*
Measurable	*Measurability is based on percentage of SUD discharges recorded by the MHP that were provided follow-up services within 7 and 30 days, and the percent of total additional discharges recorded by intervention in relation to the percent of those recorded outside of intervention.*
Achievable	*Given the rate of recorded SUD discharges outside of intervention, a 50% increase can be achieved with a minimum of one additional individual captured every other month; increasing*

	the pool of recorded beneficiaries and helping to identify barriers/notify providers will help increase overall follow up rates to meet national averages.
Relevant	*Focus is on better identifying and providing follow-up to those discharged from ED with SUD condition (FUA)*
Time-Bound	*The aim is set to be achieved by March 21st 2024.*

3. Narrative Description of Changes: Briefly describe any changes the Participating Entity has made to the Problem Statement and Aim Statement in this improvement plan. Address sources of information used to inform these changes, such as local data and stakeholder engagement. Identify challenges and lessons learned in this process

The previous Problem Statement as stated in the September 2022 submission: “Gaps in care coordination practices and related data exchange processes contribute to delays in receiving services post-discharge from the ED for individuals with substance use disorder (SUD) conditions.” The Problem Statement was revised to include “missed opportunities”.

In cases of Behavioral-Health-related discharges, the MHP has historically not been notified of Substance Use Disorder (SUD)/Alcohol or Other Drug Abuse (AOD) related discharges. What has been captured has been primarily mental health (MH) crises where substance use was a factor and was documented within crisis notes. From the 2021 HEDIS Measure Analysis Report for Lassen County, the MHP’s rates of follow up for this population is significantly lower than the national average and this can be reflected in the lack of data and tracking internally of those who were discharged for SUD/AOD.



Service Follow-Up	ED Visits for AOD	SU Service Follow-Up	FUA%
Service Follow-Up within 7 days	53	5	9%
Service Follow-Up within 30 days	53	8	15%

While certainly mechanisms needed to be put in place within the MHP's crisis tracking to ensure that SUD was captured clearly outside of crisis notes, the most blaring issue was that of a very small number of SUD-related discharges that the MHP has been notified of and documented. Given that the number of events recorded by the MHP for 2022 were only 5% of the total reported in the 2021 HEDIS measure, it is clear that there is a large gap between how many people are discharged for SUD in the County and how many people the MHP is being notified of by the ED.
In meetings with internal and external stakeholders (i.e. ED Director, MHP Director, Crisis Case Manager, Analysts, MCP BH Manager) the issue of non-crisis individuals being admitted to the ED with active SUD conditions was discussed. Often, patients in the ED with SUD conditions that are not in MH crisis and not in immediate psychiatric need are discharged by the ED without MHP notification. Beneficiaries report being given information on reaching out to the MHP for Behavioral Health (BH) services but this practice isn't always being upheld by the ED. This all results in a population of ED utilizers with SUD conditions that are not being reported, tracked, or contacted by the MHP.

The revised Problem Statement points to the following objectives:

4. Improving delays in post-discharge follow up services.
5. Improving capture of those with SUD conditions that would have gone unreported and would benefit from MHP contact.
6. Reducing rates in which patients with SUD conditions have the responsibility to contact the MHP themselves rather than the MHP initiating contact.

A focus on capturing missed opportunities will not only help the MHP contribute to the overall 7-day and 30-day follow-up measure. The focus will help address gaps of care within the community, while also working in conjunction with the ED's goal of reducing high-utilizers of Emergency Room services.

The previous Aim Statement as stated in the September 2022 submission: "For Medi-Cal beneficiaries with ED visits for SUD, implemented interventions will increase the percentage of follow-up SUD services with the Plan within 7 and 30 days by 5% by June 30, 2023."

Given that very few events of SUD-related discharges were reported to the MHP in 2022, if trends were to continue, the number of additional beneficiaries needing to be captured and providing timely follow up to exceed this 5% goal would not be significant enough to demonstrate true success of the intervention. In creation of an aim that better reflects the impact of this PIP, this 5% goal was increased to 10%. Along with screening for SDOH barriers to be shared with providers, the MHP intends to achieve the Aim through increasing the known population to which these follow-up services can be provided. This will be done by increasing capabilities for identifying and contacting those discharged from the ED.

Additionally, the element of quantity of SUD discharges RECORDED has been included in the revised Aim Statement. As the MHP has historically rarely been informed of SUD discharges, the goal of this intervention is to make significant progress in identifying and capturing more SUD discharges. The primary goal of this intervention will be to increase the amount of SUD discharges that the MHP is notified of and are recorded. The MHP has agreed on a goal of increasing total SUD discharges recorded by 50%. The timeline has been extended to account for addition collection time until next submission. The timeline was extended to March 31st 2024.

4. Selected Interventions: State the selected intervention(s) for this quality improvement project

Based on root cause analysis and stakeholder engagement activities, the MHP identified and selected the following intervention:

> Implementation of a referral/screening tool to be used by ED staff and other community partners that will assist in determining if a patient admitted for a non-crisis SUD condition would qualify for MHP services. Additionally, it will assist in identifying barriers that can be addressed by case management to improve likelihood of completing follow-up services.

This has been revised from the 9/30/2022 preliminary interventions of:

1. Obtain consistent ED data from the 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. Also, to track anyone who is experiencing homelessness and ways to better track them post discharge.

2. Utilize a centralized referral tracking mechanism that allows for real-time referral coordination from the ED, including functionality to generate alerts for high-risk / urgent needs and other key information (e.g., homelessness).

5. Narrative Description of Changes: Briefly describe any revisions to selected interventions since the last submission for BHQIP. Address the reasons leading to any changes, as well as the data or evidence considered leading to these changes.

Originally, interventions focused on seamless data exchange with the MCP and with the ED via HIE. While the MHP is in the process of entering into an HIE, the timeframe to go live has exceeded the timeframe of applying an intervention to meet the BHQIP requirements.

While the MHP participated in a data sharing agreement with the MCP, the MCP was unable to provide timely data as requested. As communication from the MCP was not reliably consistent, stakeholders agreed to focus energy on building a better functional relationship with the ED, and community partners that work with the ED, while still utilizing the MCP for supplemental data and providing the MCP data on identified individuals discharged that might indicate an error in their system.

In meeting with the ED, an agreement was made to try and begin exchanging daily patient rosters for the MHP to cross reference over EHR for prior beneficiaries and to reach out to those with reported SUD conditions and report back to the ED on successes and challenges. However, after review, the ED legal team would not allow sharing of full patient data outside of an HIE with releases of information (ROI). This was particularly salient for patients with disclosed SUD, whom the ED required that consent be given from the patient for such protected information.

In order to facilitate data exchange and still identify patients in need of care coordination and SUD follow-up, an agreement was made between internal and external stakeholders to develop a referral/screening tool that would fulfill the following criteria:

4. Allow ED staff to know when a patient would be eligible for services through the MHP
5. Identify Social Determinates of Health (SDOH) barriers that could impede on completing follow up services if not addressed.
6. Allow for secure data exchange without sharing of unnecessary Personal Health Information (PHI)

This screening, when attached with an ROI, would function as a referral to BH services. Upon receipt of a referral, the BH Analyst cross references EHR and Crisis/Hospital Discharge tracking sheet for prior beneficiaries, recorded barriers, and for multiple hospital discharges to better inform contacting-staff. The MHP will then promptly attempt contact for the purpose of getting the referred individual scheduled into follow-up services within 7 days. Upon contact, necessary staff will be informed of barriers to discuss with the beneficiary to assist in addressing difficulties that may arise in completing follow-up service.

Along with the screening/referral for the ED, this intervention is also being applied to a local community partner, Judy's House. Judy's House is a peer-run drop-in center contracted by the MHP that are often the first ones called by the ED for providing transport for those discharged with an SUD condition. The referral/screening tool will also be used by Judy's House staff to assist in capturing consent and contact information to assist in capturing any individuals potentially missed by the ED.

In reframing the focus onto capturing missed opportunities to increase overall timely follow-up, the proposed new intervention was established following an updated Five Whys Root Cause Analysis (RCA):

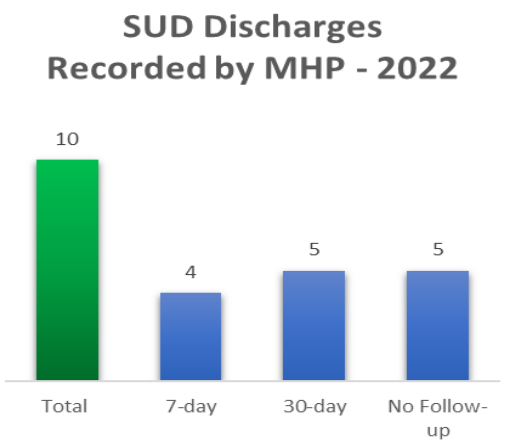
<u>Problem Statement:</u> There are missed opportunities and delays in receiving services post-discharge from the ED for individuals with substance use disorder (SUD) conditions.

Why?	MHP is primarily only aware of ED admissions for SUD conditions when the patient is reported in MH crisis. All other patients with SUD discharges are responsible for initiating contact with MHP.

Why?	ED patients who were discharged for non-crisis SUD conditions are not being communicated to the MHP and barriers to initiating contact and completing follow up services for this population are not being considered.
Why?	Current referral process for the ED is not standardized. Referrals are not common, with little detail on reason for admission, SDOH barriers, and Medi-Cal status - often those referred from hospital are not eligible for services with the MHP and are only referred by PCP if at all.
Why?	Not all referring ED staff are aware of requirements for eligibility for MHP services as well as conditions when or when not to refer a patient that was experiencing an SUD-related condition.
Why?	Communication has been established between ED and MHP in regards to Crisis but no practices have been solidified between ED and MHP in regards to referring others who were admitted for SUD Conditions and identifying barriers that could impede on completing follow-up services with the MHP.
Root Cause:	Lack of adequate tracking, established communication, and defined referral process between ED and MHP for patients with SUD conditions that are not in crisis.

6. Equity Analysis: Participating Entities are required to complete an Equity Analysis as part of their quality improvement plans for BHQIP Goal 3. Describe how the intervention(s) identified in Question 4 consider and address disparities faced by Medi-Cal beneficiaries who have alcohol use disorder or substance use disorders in the Participating Entity's service area.

In review of FY 2022-23 data on ED discharges for SUD as collected from the MHP Crisis/Hospitalization tracking sheet, only 10 discharged individuals were identified as having Lassen County Medi-Cal, 4 completed follow-up services by 7 days (40%), 5 by 30 days (50%), and 5 did not complete at all (50%)



The profile of the average discharged individual reported to the MHP is that of a White (7/10; 70%), non-Hispanic (7/10; 70%), Male (6/10; 60%) who lives within the town of the MHP (7/10; 70%), lives in a house or apartment (7/10; 70%) and referred self to services (4/10; 40%). Each of these demographics are leading qualities of those reported that are most likely to complete follow-up services within 7 days post-discharge.

Of discharged Lassen County Medi-Cal patients that are recorded by the MHP there is a clear racial disparity between rates of non-white versus white individuals. Confirmed non-white individuals only represent 20% of the recorded data, with 1 (10%) being unknown. This is in contrast with the estimated 2022 census data for Lassen County[1] where the non-White population comprises approximately 40% of the County. Note that due to small sample size, these findings may not represent a true disparity in service follow-up.

In order to understand a more accurate representation of disparities, the MHP was provided a HEDIS Performance Measure Report in January of 2023 by CalMHSA using unsuppressed 2021-2022 data requested from DHCS. In the report analyzing rates of Lassen Medi-Cal eligible beneficiaries by race/ethnicity it was found that American Indian/Alaskan Native (AI/AN) beneficiaries are over represented in ED events for substance use compared to the Lassen County Medi-Cal eligible population.

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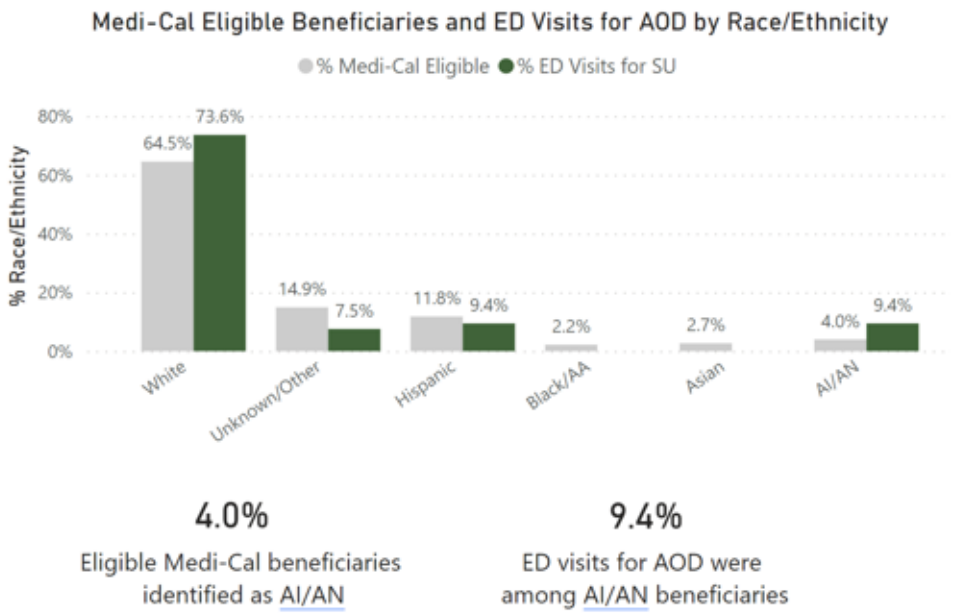
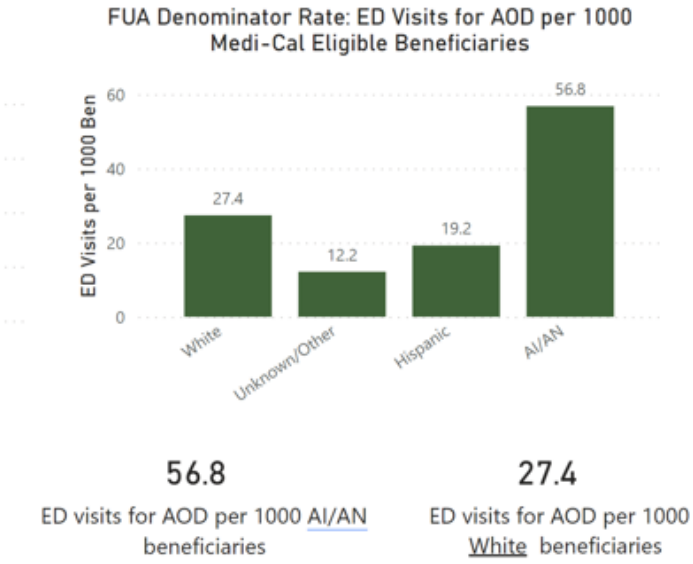
[1] U.S. Census Bureau (2022). *Lassen County Population Estimates, July 1, 2022, (V2022)*. Retrieved from U.S. Census Bureau QuickFacts: Lassen County, California



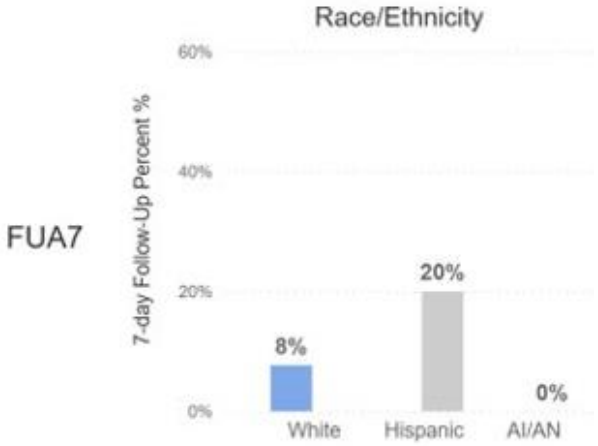
While the data collected from internal Crisis/Hospital tracking is a small sample, this finding is in line with what was recorded where 10% of SUD discharges recorded were for AI/AN beneficiaries and 70% for white beneficiaries.

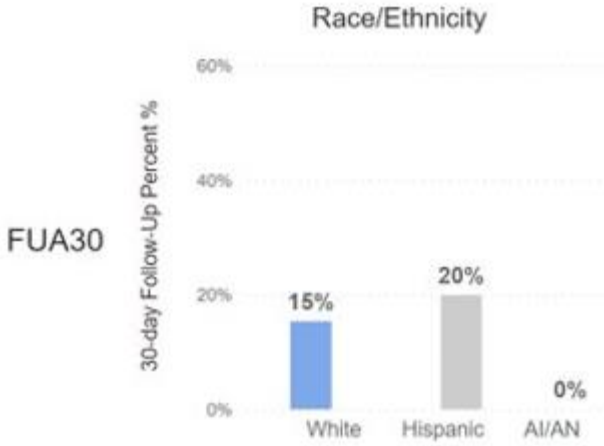
Per 1000, it was found that AI/AN beneficiaries were more than twice as likely than White beneficiaries to visit the ED for substance use.

Race/Ethnicity	MC Elig Ben	% MC Elig Ben	ED Visits	% ED Visits	Rate: ED Visits per 1000 Ben
White	1424	64.5%	39	73.6%	27.4
Unknown/Other	329	14.9%	4	7.5%	12.2
Hispanic	260	11.8%	5	9.4%	19.2
AI/AN	88	4.0%	5	9.4%	56.8
Asian	59	2.7%			
Black/AA	48	2.2%			



This heightened propensity stands out in regards to CalMHSA-provided data on follow-up services where the population with the greatest likelihood of ED visits for SUD is also the population that is least likely to complete follow-up services.



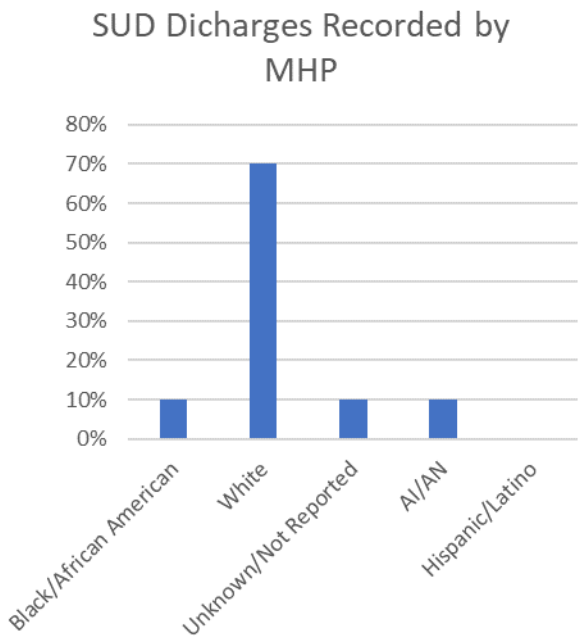


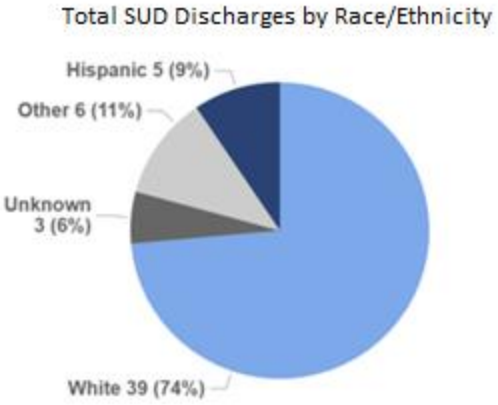
0% of the ED events for substance use among AI/AN beneficiaries have substance use service follow-up, compared to 15% for White Beneficiaries. This indicates a large racial disparity that needs to be addressed in the implementation of this PIP

This disparity is considered within the MHP Cultural Competency Plan as AI/AN beneficiaries are identified as the population with the largest ethnic penetration rate (from EHR data, 6% of all MHP beneficiaries are AI/AN while only making up 4% of the Medi-Cal Eligible population in the County). This heightened penetration rate is reflected in the crisis/hospitalization data and for the data provided on Lassen Medi-Cal Eligible Beneficiaries and ED Visits for AOD by Race/Ethnicity.

The greatest racial disparity in terms of completing services has also been identified as AI/AN population, of whom 63% (5/8) did not complete any timely follow up services.

Another significant racial disparity can be identified in regards to the limited number of SUD discharges the MHP has been notified of to record. For example, out of total Lassen Medi-Cal Eligible beneficiaries, Hispanic/Latino individuals made up 9.4% of total ED visits for substance use. Of those events, 20% received follow-up services by 7 days, more than twice as high as the percentage of White beneficiaries. This is in large contrast to what can be seen in the SUD discharges recorded by the MHP. According to 2022 Crisis/Hospitalization tracking, there were 0 reported individuals identified as Hispanic/Latino. Even with the small sample size, rates of White and AI/AN beneficiaries reported to the MHP is largely representative of the total rates of Lassen Medi-Cal Eligible Beneficiaries with ED visits for substance use by race/ethnicity (Crisis/Hospitalization Data: 70% White, 10% AI/AN; Data on Lassen Medi-Cal Eligibles: 73.6% White, 9.4% AI/AN). This absence of recorded MHP data on Hispanic/Latino SUD discharges points to a significant disparity in those that the MHP is notified of.



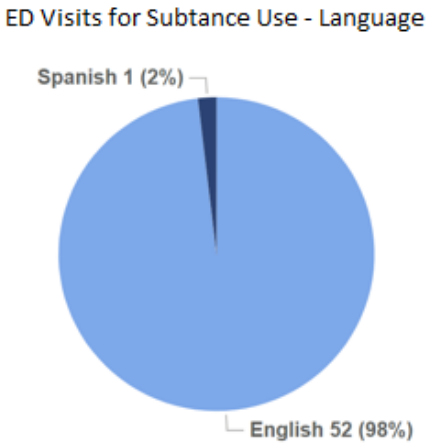


Race/Ethnicity	ED Visits	% ED Visits
White	39	73.6%
AI/AN	5	9.4%
Hispanic	5	9.4%
Unknown	3	5.7%
Other	1	1.9%
Total	**53**	**100.0%**

This equity analysis has identified two primary disparities to be taken into consideration within the implementation of this PIP: AI/AN population for overrepresentation in discharges but underrepresentation in follow-up services, and Hispanic/Latino population for underrepresentation in notification to the MHP. In addressing these disparities, this PIP will focus on collecting and monitoring demographic data within the referral tracking and ensuring that contacting-staff/providers are notified upon receipt of referrals when an individual with the given disparities is identified so as to provide a higher degree of attention to addressing service enrollment and follow-up. KPIs will also be stratified by racial demographics to better monitor these populations. Lassen County does not have a Threshold Language but Spanish versions of all LCBH paperwork are made available with a Spanish version of the referral/screening tool to be developed. Importantly, diverse beneficiary input will focus on achieving feedback in regards to this implementation from those in the reported disparity populations.

Lassen MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
No Threshold Languages	*	n/a
Total	**868**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

LCBH Cultural Competency Plan - EQRO 2019



Language	ED Visits	% ED Visits
English	52	98.1%
Spanish	1	1.9%
Total	**53**	**100.0%**

The MHP has identified these disparities in penetration rates previously among Hispanic/Latino and AI/AN beneficiaries and takes addressing these disparities in service delivery seriously. As mentioned in the LCBH Cultural Competency Plan, “LCBH Training Plan identified a number of components designed to address these issues, such as the use of the CA

Multi-Cultural Scale to assess our system of services; trainings to increase the effective use of interpreters in service delivery; creation of a clinical consultation resource for providers working with Hispanic/Native American consumers; addressing cultural issues when providing services to consumers suffering from co-occurring disorders and trauma." The MHP intends to carry this mentality through the PIP to acknowledge and address cultural issues throughout not just service delivery but through service initiation.

In conducting this PIP, all actions are taken with consideration of the MHP Cultural Competency Plan (CCP). As stated in the CCP, LCBH recognizes the need to be culturally responsive to Hispanic/Latino, AI/AN, and other minority groups in our county. LCBH will reach out to a variety of individuals with different points of view, and will emphasize on reaching out to the community for the services that LCBH is planning to provide. Community input is invaluable in preventing oversight of key components as well as developing and understanding any missing components needed for future outreach efforts. In addition to outreach efforts already being conducted by the MHP, obtaining diverse beneficiary feedback and input that is representative of the disparities identified will be instrumental toward the success of this PIP.

7. Implementation Steps Completed: Describe steps completed as of 9/29/2023 to implement the interventions identified, including time periods or dates of action

Following agreement with the ED on instituting a referral/screening tool on May 30th 2023, the tool was developed in June of 2023, with it receiving approval by the Quality Improvement Committee (QIC) on June 19th 2023. The ED conducted training and began implementing the tool on June 23rd 2023. The first referral received was July 7th 2023, with 3 subsequent referrals received in July and August. Upon receipt, the MHP front office has begun to make timely contact to schedule those referred for services. While referrals have not been frequent, we are receiving referrals for those properly screened by the ED and have been making contact with those discharged with SUD conditions whom we would have otherwise not been made aware of. Receiving referrals and making contact to schedule services are two successfully completed steps to increasing follow up services for this population.

The intervention has begun to be applied with Judy's House with Judy's House beginning use of the referral/screening on August 24th, 2023. Judy's house has reported providing three transports since that time but out of those three have yet to have someone consenting to SUD treatment. The intervention is still ongoing with the hope that over time, referrals from

Judy's house will contribute to the overall referrals provided by the ED and provide a larger picture of those would-have-been missed opportunities.

MHP Analyst has created a tracking sheet for input of referral information, including date and time of referral and first contact, name, contact information, and selections on SDOH barriers and program need, insurance information, and whether an ROI was attached. An important factor included is that of demographics (as related to the equity analysis) to ensure measure of the intervention's impact on identified disparities. MHP Front Office staff indicate on the form the date and time of contact and whether contact was made or why it wasn't able to be made. It is then recorded by the Analyst on the tracking sheet. Analyst confirms daily the referrals that were received within the previous 24 hours and biweekly will cross reference referral list with EHR to confirm and record first service, date, and completion status. Following successful registration, when an individual is brought up to the MHP's weekly Access meeting, the Analyst will share barriers indicated by the individual in the screening to help determine proper case manager / SUD counselor assignment for follow-up.

8. Challenges Faced: For all implementation steps identified in the 9/30/2022 submission that did not occur as anticipated, address reasons why.

In the original implementation of this Performance Improvement Project, the potential interventions selected focused on achieving consistent, seamless, and real-time data exchange between the MHP and the ED and MCP. This intention was not actualized for a number of reasons.

Originally the MHP sought coordination with the MCP. What the MCP was able to provide, however, was not consistent individualized data but macro-level data and analysis in relation to the FUA measure as well as data on utilization and demographics. The MCP was unable to furnish lists of discharged individuals that the MHP could contact for follow-up services. In instances where the MCP could provide names, contact was not able to be made as releases of information were required to initiate. Communication and data exchange have been ongoing between the MHP and MCP but data exchange that would facilitate the MHP's interventions was not achieved. Additionally, timely response from the MCP was not reliably met. Data exchange with the MCP was determined best practice for receiving informing materials and notifying the MCP of referrals for them to internally account for errors into why a person wasn't forwarded to the MHP. However, data elements exchanged between with MHP and MCP did not meet the direct needs for the MHPs goals within this PIP.

In regards to achieving seamless and consistent data exchange with the ED, the MHP encountered a number of challenges. During the development of the first iteration of this PIP, interventions were chosen in mind of the MHP

entering into a Health Information Exchange (HIE). Being integrated with an HIE could allow for connection with the ED so information on discharges could be accessible in real-time and the MHP could cross reference to determine shared beneficiaries that could be contacted and followed up with. However, as the MHP entered into a new EHR in July of 2023, integration into the HIE was delayed by 3 months to allow for a review and revision period within the EHR. The MHP still hopes to begin the process of going live with an HIE by October, but for the purpose of achieving an implemented intervention by the 2023 BHQIP deadline, data exchange via HIE was not able to be considered.

In efforts to implement data exchange between with the ED and MHP outside of a centralized data exchange, meetings with the ED Director resulted in developing a plan for the MHP to begin receiving patient roster information. The ED had agreed to begin sending bi-weekly scans of “stickers in the book” where patients who were admitted for SUD conditions would be identified and forwarded to the MHP. This intervention plan would not have allowed for contact with non-beneficiaries but would have allowed the MHP to cross reference the EHR for current beneficiaries whom the MHP would have been unaware of their ED discharges; this way contact could be made to schedule follow up services with this population.

Following internal discussions by the ED, a follow up meeting was scheduled May 30th 2023 with the ED Director, ED Case Manager, ED IT Security, ED Analyst, ED legal team, and MHP Analyst. In that meeting the ED legal team shared that they would disallow data exchange of any patient rosters with the MHP. Due to HIPAA and 42 CFR concerns, the ED was not comfortable sharing Personal Health Information (PHI) outside of an HIE with all precautions already established. Being that this tactic was infeasible, discussion turned to how to exchange data given the patient’s expressed consent. It was then that the proposed intervention began to take focus on a referral tool with an included ROI. In discussing the ED’s process for referral, it was clear that the ED was not aware of MHP eligibility standards and had not known who and when they could refer to the MHP for follow-up services. While the MHP has worked with the ED in the past to address this training, due to new staff, the information has not been passed along. In order to combat a lack of information on MHP eligibility among ED staff, the referral form developed by the MHP was made to encompass screening for eligibility so that anyone conducting the screening at the ED would be able to pass along the eligibility requirements without chance of information being lost during staff changes. Additionally, the use of a referral/screening tool allowed for capture of Social Determinates of Health (SDOH) barriers that could impede on an individual completing follow-up services. This allows the MHP to track for barriers such as homelessness, transportation, or food insecurity, and enables barriers to be discussed immediately upon contact.

Upon implementation of the referral/screening tool, the initial referrals received from the ED were lacking completed ROIs or had errors in the scanning process. Discussion then ensued with the ED Case Worker to ensure that the completed tool was sent over. At that time the Case Worker was not recording/filing sent referrals and was shredding immediately after referring. This resulted in 2 referrals not being able to be contacted. Following this instance, the case worker has begun saving and securely filing the sent referrals and will call the MHP to notify when a referral is being sent to ensure that it was received and that all necessary information was included.

9. Key Performance Indicators (KPI): Report out regarding the performance of the selected interventions using the performance indicators selected by the Participating Entity in the 9/30/2022 submission. In this response, Participating Entities must specify

- At least one KPI for each Selected Intervention
- The Participating Entity's actual measured performance on the KPI(s) at the time of reporting
- An assessment of how this performance compares to the Participating Entity's expectations

Due to revision of the original preliminary interventions, the Key Performance Indicators have been modified to relate to the data that the MHP will have available. The revised primary KPIs for this PIP are the total percentage of recorded follow-up services provided at 7 days and at 30 days, and the ratio of total SUD discharges recorded from the intervention to total SUD discharges recorded outside of the intervention.

KPI 1:

$$\frac{\text{Total \# of MHP-Eligible Referral/Screening Tools for SUD successfully completed}}{\text{\# of Lassen County Medi-Cal SUD discharges recorded from Crisis tracking that were not referred using referral/screening tool}}$$

KPI 2:

Numerator: The number of recorded Lassen County Medi-Cal beneficiaries discharged with SUD-condition who received a follow up SUD treatment service from the MHP within 7 days

Denominator: The total number of Lassen County Medi-Cal beneficiaries discharged with SUD-condition recorded by the MHP

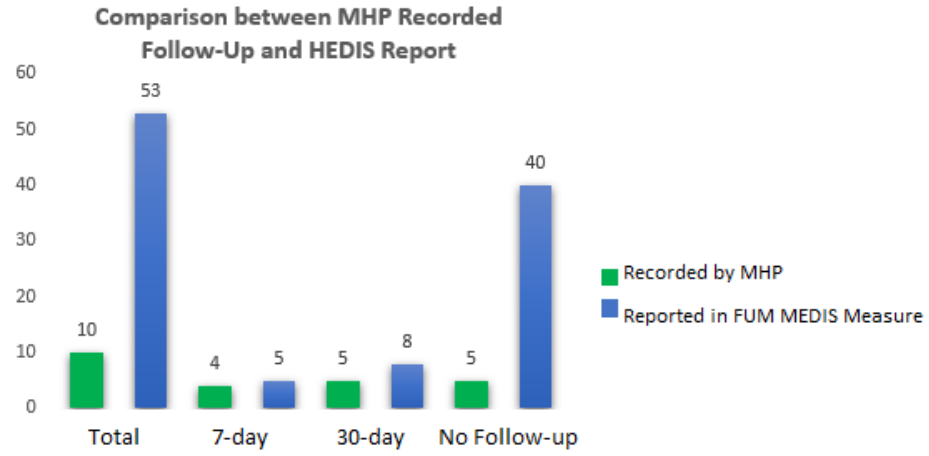
AND

Numerator: The number of recorded Lassen County Medi-Cal beneficiaries discharged with SUD-condition who received a follow up SUD treatment service from the MHP within 30 days

Denominator: The total number of Lassen County Medi-Cal beneficiaries discharged with SUD-condition recorded by the MHP

Additionally, an essential data element will be the number of referrals received from the ED per month and percent complete so as to monitor trends and address when less-than-expected-results are achieved.

For the primary KPIs, a preliminary analysis was conducted from discharge data as recorded on the Crisis/Hospitalization Tracking Sheet for FY 2022. The MHP found that there were only 10 incidents of discharge with an SUD-related condition for individuals with Lassen County Medi-Cal that the MHP was notified of. Of those 10, 4 had received a follow-up service within 7-days (40%), and 5 had received a follow-up service within 30 days (50%). This finding is starkly in contract to the 2021 HEDIS Measure Analysis Report where 53 ED visits were identified with 9% following up within 7 days and 15% in 30 days. The large factor in this discrepancy is that, if given the same trend in 2022, at least 43 incidents of SUD-related discharge would have gone unreported to the MHP.

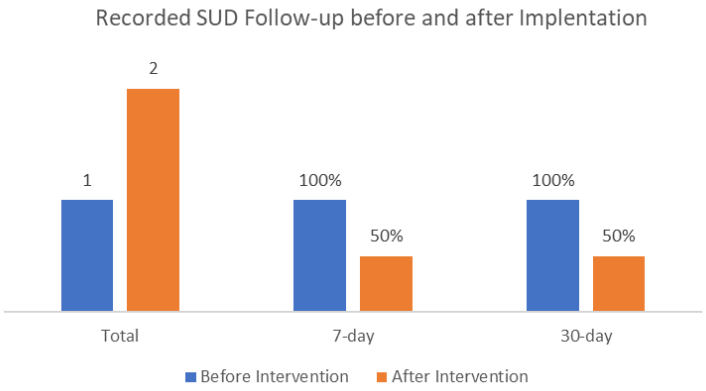


Service Follow-Up	ED Vists for Substance Use	Service Follow-Up	FUA%
Service Follow-up within 7 days	10	4	40%
Service Follow-up within 30 days	10	5	50%

Since beginning this intervention, the MHP has received 4 SUD-related referrals from the ED using the referral/screening tool. 2 of the 4 had to be immediately discarded as ROI's/other critical information were improperly scanned, and before correcting the issue with the ED Case Worker, the referrals had been being shredded after transmission instead of securely filed. Of the 2 remaining referrals, one was non-Medi-Cal due to ED error with the other seeking SUD follow-up.

Of FY 2023 for the months of July and August, when not including those referred by the referral/screening tool, there was only 1 recorded SUD-related discharge for individuals with Lassen County Medi-Cal. For that one event, the individual did receive follow up service within 7 days and within 30 days (100%)

When including the additional eligible referral into the SUD Crisis/Hospitalization tracking that would have otherwise not been identified, there are 2 SUD discharges recorded by the MHP for FY 2023, with 1 of 2 receiving follow-up services within 7 days (50%), and 1 of the 2 receiving service within 30 days (50%).



While the additional individual did not contribute to improvement in the overall follow up KPIs, their presence being reported in the KPIs signifies improvement in capturing a more accurate representation of the population of those discharged from the ED for SUD-conditions. As the intervention continues and the MHP is able to leverage data on SDOH barriers and continue to receive additional referrals from voluntary individuals, the hope is that the additional referrals will contribute to balancing out the follow-up KPI to meet the Aim statement of this PIP. For KPI 1, the MHP captured 1 additional SUD discharge from the referral/screening tool, while 1 was captured outside of the tool. For this preliminary analysis, the intervention increased the percentage of SUD-related ED discharges recorded by the MHP by 100%, exceeding the Aim. This metric will be observed going forward with the goal of 50% being actualized for final analysis by March 31st, 2024 when FY data is complete.

While the frequency of referrals received is not high, the MHP believes it is still significant enough to have positive impacts toward the goal of this PIP. In the 2021 HEDIS Measure Analysis Report, the report identified 53 Medi-Cal Beneficiaries in Lassen County that had been discharged with SUD. According to MHP data pulled from the 2021 Crisis/Hospitalization tracking, 14 Lassen County Medi-Cal beneficiaries were reported as in crisis at the ED with an SUD-related condition. This would indicate that for 2021, 39 individuals were discharged with SUD and were not reported to the MHP and provided follow-up services. This would be a rate of around 3.25 individuals per month. While only receiving one confirmed referral from the ED in August and September is below the total capture, the use of a voluntary referral must be taken into consideration.

Due to only one additional individual being identified, the MHP is unable to stratify for this current submission as both identified SUD discharges were for White, non-Hispanic Males.

In a 2021 SAMHSA National Survey of Drug Use and Health, it was reported that 94% of people aged 12 and older with SUD did not receive treatment and most did not think treatment was necessary[3]. If just 10% of those discharged with SUD were interested in services, we could expect to have received only up to 0.33 voluntary referrals a month if this tool was in place in 2021. In capturing 1 individual who is voluntarily seeking SUD service post-discharge within 2 months, the rate of capture is on track given the rates of missed captures, data on voluntary treatment seeking, and given the parameters of the intervention. The goal is still to achieve a higher rate of capture with assistance and support of the ED and Judy's house.

10. Lessons Learned: Provide a brief reflective summary of the improvement plan implementation process. In this response, identify **at least 2 lessons learned** for the next phase of improvement plan implementation.

The biggest lesson was that seamless, real-time data exchange and coordination was not going to happen in the snap of a finger by instituting an HIE, and that the viewpoint that that would be the case allowed for complacency in deriving initial goals out of this PIP. The lack of the HIE, while not allowing for rapid development of data exchange capabilities, did allow for the development of a more common-sense approach to coordinating with the ED/community partnrs and allowed the MHP to better focus on internal methods of improving tracking capabilities and coordination with the ED.

While better coordination with the MCP is necessary moving forward, in working with the MCP it has been an important lesson to learn the flows and timeframes of communication as well as the scope of what information they are able to provide. The MCP fills an important role of providing top-down data and analysis, but has not been as useful in obtaining bottom-up data needed for making timely contact with those potentially missed in our usual processes.

As the gap in reporting between the ED and MHP has been so wide, it is noticeable that with such a low number of recorded discharges available to the MHP for 2022, the original Aim of increasing follow up services by 5% would not be a substantial improvement and could be achieved by successfully capturing and providing timely follow up to only a handful of additional individuals. In order for the MHP to properly assess for improvement, a revised Aim statement was needed that focused largely on increasing the rate of capture and recording of those discharged with SUD while increasing follow-up rates.

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3. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality. (2023, January 4). 2021 National Survey of Drug Use and Health (NSDUH) releases. SAMHSA.gov. https://www.samhsa.gov/data/release/2021-national-survey-drug-use-and-health-nsduh-releases#annual-national-report

Section 2: Next Steps for Improvement Plan

The following section focuses on further implementation of the Participating Entity's improvement plan. This section is analogous to the Act portion of a PDSA cycle, leading to the Plan portion of the next PDSA cycle.

11. Implementation Steps, Planning for the Future: Describe at least **3 concrete steps** that the Participating Entity will carry forth in the following 6 months to implement the interventions specified in Question 4 and to assess performance on the key performance indicators specified in Question 12. Provide time frames or dates for each step identified.

Of three concrete steps that will be taken going forward, two will be directly related to assessment while the third may encompass restrategizing.

Firstly, it will be imperative to maintain regular communication with the ED. This will involve weekly status calls with the ED case worker to confirm flow of referrals, as well as accuracy of shared spreadsheet where referral information will be tracked. Additionally, minimum quarterly meetings will be conducted between the MHP and ED Director, ED Caseworker, and other ED stakeholders. Discussion will center on the following:

- Impact on ED workflow from use of the tool
- Efficacy of our coordination in regards to helping the ED by identifying and integrating high ED-utilizers with SUD conditions into SUD services and increasing MHP follow-up services.
- Any challenges to be addressed, changes desired to the tool or means of coordination, and de-identified successes.

The same degree of communication will need to be observed with Judy's House. This will involve weekly calls to ensure numbers of referrals received as well as quarterly discussions on efficacy, challenges, and needed changes.

Quarterly communication with the MCP will be necessary in this as well to continue to receive macro reports in regards to the FUA metric, SUD-related admissions/discharges, and aggregated demographic data to inform further development of the referral/screening tool and facilitation of an equity-driven approach.

Secondly, minimum quarterly internal stakeholder review will be conducted among the MHP QIC to report on KPIs and discuss findings, successes, and challenges. Upon review, if the decision is made to make any edits to the intervention, the QIC will be responsible for approval of changes. The QIC is also always seeking beneficiary involvement, and will be

continuing to seek beneficiary input on the implementation, progress, and effect of this PIP during QIC meetings as well as quarterly consumer surveys.

Lastly, the MHP will be entering an HIE in October. Upon necessary training and acclimation, within the following months meetings will be conducted internally with QIC and HIE vender to discuss and develop capacity for further data exchange with the ED as well as the MCP. The MHP predicts that once connection between HIE and ED is feasible that discussion will be needed to restrategize the data collection and exchange aspect of this PIP. Internal planning will be followed by follow-up planning and meetings with the ED to determine the best course of action.

12. Key Performance Indicators (KPI), Future: Identify **at least 2 key performance indicators** that will be used to assess the implementation and success of **each intervention** (process or outcome, Science of Improvement: Establishing Measures) identified in Question 4 above during the upcoming reporting period. For each indicator, indicate target performance. These KPIs may (but do not have to) differ from those identified in Question 9 based on the Participating Entity's implementation plan.

The critical KPIs that will be used to assess implementation and success of the interventions will be that of percentage increase of total SUD discharges identified that can be attributed to the intervention and the rates of those captured that received follow-up services after discharge by 7 days and by 30 days. This will be analyzed internally from data collected on the Crisis/Hospitalization spreadsheet in regards to ED visits as well as the Referral/Screening Tool Tracking Sheet. Both worksheets contain information on when the client was referred, when first contact by MHP was made as well as subsequent contact attempts, and when first follow up appointment was completed. The rate of those who received follow-up services within 7 and 30 days will be calculated quarterly and used as the benchmark to measure and compare growth for this PIP. The percentage of increase will be calculated quarterly as well from comparing numbers of those identified on the Referral Tracking Sheet, and those recorded with SUD discharges on the Crisis/Hospitalization tracking sheet to evaluate effectiveness in reaching the Aim of this PIP. When the MCP is able to provide updated FUA HEDIS metrics, discharge by diagnosis, and demographic reports, the MHP will utilize this data to compare with the tracked internal measure to ascertain the larger scale impact of the interventions.

An additionally critical data element that will be showcased is the specific number of referrals received from the ED. It is easy to predict that there will be ebbs and flows in the number of referrals received by the ED month-over-month, just as there would be ebbs and flows in actual SUD admissions. This measure, however, will be key in determining the ongoing continuance of the process by the ED as repeated months of lower or 0 referrals would indicate a need to discuss

implementation, investigate cause, and address potential training. This measure will also be critical in showcasing the rate of those referred by the ED that enter into services with the MHP. It is this measure that is the direct consequence of the element within the Problem Statement regarding “missed opportunities”. Positive growth would reflect effectiveness of intervention in regards to capturing discharges with SUD conditions that would have never received MHP contact.

These measures will be calculated and shared at a minimum quarterly with stakeholders, QIC, MHP staff, MCP, and ED. Quarterly analysis will build off of findings from previous quarters to show trends and patterns within the implementation.

KPI Targets for March 31st 2024: Capturing at least 1 additional missed SUD discharge through use of intervention every other month.

KPI1: 50%

Total # of MHP-Eligible Referral/Screening Tools for SUD successfully completed	4
# of Lassen County Medi-Cal SUD discharges recorded from Crisis tracking that were not referred using referral/screening tool	8

KPI2: 50% 7-day, 60% 30-day

The number of recorded Lassen County Medi-Cal beneficiaries discharged with SUD-condition who received a follow up SUD treatment service from the MHP within 7 days	4	The number of recorded Lassen County Medi-Cal beneficiaries discharged with SUD-condition who received a follow up SUD treatment service from the MHP within 30 days	5
The total number of Lassen County Medi-Cal beneficiaries discharged with SUD-condition recorded by the MHP	8	The total number of Lassen County Medi-Cal beneficiaries discharged with SUD-condition recorded by the MHP	8

Section 3: Beneficiary Identification, Data Exchange, and Stakeholder Engagement

Managed Care Plans and Behavioral Health Plans are jointly responsible for improving follow-up after emergency department presentation for alcohol use disorder or other substance use disorder for the entire Medi-Cal covered population. The following section focuses on collaborations and data exchange efforts between Participating Entities and other stakeholders to facilitate implementation of Selected Interventions and evaluation.

13. Collaborations with Managed Care Plans: What collaborations has the Participating Entity engaged in with Managed Care Plan partners to identify Medi-Cal beneficiaries who present to the emergency department for alcohol use disorder or other substance use disorder? DHCS **requires** that Behavioral Health Plans engage in good faith efforts collaborate with Managed Medi-Cal Plans.

- **Part A, Description of Collaboration:** Describe **existing and future** collaborations with Managed Care Plan partners in this clinical area of focus.

  Discussions with MCP have been conducted in the lead up to this PIP with MCP helping to inform process and capture of supplemental data. The MCP has been a continuing resource of information on how SUD discharges are captured and tracked to ensure that the MHP is capturing the right data from the ED. The MCP is collaborating with the MHP by providing regular reports on numbers of SUD discharges recorded per quarter as well as demographics. In a standard Admissions-by-Diagnosis report received by the MCP, numbers of SUD discharges recorded from the ED can indicate an issue where someone was given a primary SUD diagnosis by an ED doctor and was discharged before financial responsibility was transferred to the MHP. This can often indicate a discharge without contact to the MHP. In cases where this is found, the MCP and MHP can work together to identify and verify if these individuals received services from the MHP.

- **Part B, Description of Data Exchange:** Identify and describe data exchange efforts between the Participating Entities and other stakeholders to identify beneficiaries eligible for treatment after presenting to an emergency department for alcohol use disorder or other substance use disorder. In this response, identify the Entity's ability to access data to drive change towards its Aim Statement. **While no specific type of data exchange is required, Entities are required describe whether and how they are exchanging data in the following ways:** (1) Receiving data from Managed Care Plan partners and (2) Sending data to Managed Care Plan partners.

The MHP initially was trying to increase data exchange with the MCP to help identify SUD discharges. The MHP however encountered a number of challenges with this goal. Firstly, timely exchange with the MCP was not reliable. While the MCP was able to provide valuable information when requested, response times would not be frequent enough to ensure that if data was received on an individual that needed follow-up services post-discharge, that the MHP would be made aware in time to contact within a consistently timely manner.

The largest roadblock in the initial goal of utilizing MCP data as the intervention for this PIP was that even if the MCP was able to provide data on individuals discharged for SUD conditions, the MHP had no ability to use said data to make contact with these missed opportunities to get into timely follow up services without consent. The data provided by the MCP could assist in identifying current clients admitted but would not impact capturing those that needed to be in services but were never contacted.

As joint cooperation between the MHP and ED was restricted to only circumstances when individuals were in crisis, coordination for individual data on identifying SUD discharges was recommended by the MCP to be sought directly from the ED to improve this cooperation.

The data that is received from the MCP for the purpose of this PIP includes any updated FUA metrics, Service Utilization, LOS Trends, Diagnoses, Demographics, and Admissions by Primary Diagnosis reports for the local ED. In instances where the MCP identifies that someone was discharged from the ED with a secondary SUD-related diagnosis and a primary MH diagnosis and responsibility wasn't transferred to the MHP, patient information is securely exchanged on the MCP sFTP for MHP to cross reference with EHR and Crisis Tracking sheet to indicate to MCP if the patient was met during crisis and confirm whether or not the crisis service was billed under the MHP.

14. Collaborations with Health Care Delivery Partners: What collaborations has the Participating Entity engaged in with Health Care Delivery Partners (e.g. hospitals or clinics) to identify Medi-Cal beneficiaries who present to the emergency department for alcohol use disorder or other substance use disorder? DHCS **does not require but strongly encourages** collaborative relationships of Participating Entities with health delivery partners.

- **Part A, Description of Collaboration:** Describe **existing or future** collaborations with Health Delivery Partners in this clinical area of focus.

Collaboration with the local ED was necessary in being able to identify areas of needed improvement and address gaps in communication and care coordination. Collaboration began with discussion of the need to better ensure that those admitted with a non-MH-crisis SUD-related condition were being properly referred to the MHP, thus began the joint development of the screening/referral tool. Regular meetings began to address the lack of communication between the MHP and ED. These meetings have involved clarifying roles, admission and discharge processes, MHP eligibility and scope, and challenges associated with admissions of those with SUD conditions and where the MHP can help. These meetings will be ongoing with quarterly meetings set to continue discussion as well as to report on progress and challenges within this PIP.

Upon learning of the extent to which Judy's House services the mentioned population, the MHP began collaboration with Judy's House to begin using the tool as well.

The ED and Judy's House are participating in collaboration by identifying and screening discharging/discharged patients with SUD conditions and referring them in a timely manner to the MHP. Every time following completion of the tool, the ED or responding Judy's House staff calls the MHP to inform and arrange for receipt. The MHP is responsible for ensuring that the ED and Judy's House are well aware of the referral/screening tool and providing explanation/training when needed. The ED case worker/responding Judy's House staff and the MHP Analyst work together to resolve any issues in the receipt of the tools as well as identify areas in the referral itself that might not be completed (e.g. SDOH barriers, insurance, ROI) and discuss reasons or ways to address inconsistencies.

The MHP, ED, and Judy's House will work together in the evaluation of the intervention's impact and effectiveness on an ongoing basis, with the ED being a key stakeholder in discussion of PIP strategy and any potential changes needed or updates to make the process better for all involved.

- **Part B, Description of Data Exchange:** Identify and describe data exchange efforts between the Participating Entities and other stakeholders to identify beneficiaries eligible for treatment after presenting to an emergency department for alcohol use disorder or other substance use disorder. In this response, identify the Entity's ability to access data to drive change towards its Aim Statement. **While no specific type of data exchange is required, Entities are specifically required to describe whether and how they are exchanging data in the following ways:** (1) Receiving data from Health Delivery Partners and (2) Sending data to Health Delivery Partners.

Data is initially collected by the ED in the form of physical referral/screening tools. Upon completion by a patient with a physician or nurse, the form is given to the ED case worker or designee (when case worker is unavailable). The MHP is then notified and the referral is sent to the MHP. Currently, referrals are being received by secure fax, with the goal moving to digital exchange as the MHP is onboarded into an HIE.

The MHP keeps a secure central tracking sheet with deidentified data shared with the ED case worker at the monthly meeting to go over and confirm all numbers and dates that referrals were received. This tracking sheet is shared via a HIPAA/HITECH compliant Dropbox. Once the tracking sheet is received by the ED case worker, the case worker will cross reference the dates and times listed with their filed records of referral/screening tools sent and will report back to the MHP any discrepancies.

In regards to Judy's House, data is also collected by use of the referral/screening tool. Upon pick-up following ED discharge, the responding staff will work with the individual to complete the tool and will then notify the MHP by phone of completion once the individual is dropped off. If drop off was during normal MHP office hours, the responding Judy's House staff will hand deliver the completed tool to the MHP for referral tracking. If after-hours, Judy's house will securely store the referral for transport, securely fax the referral to the MHP, and will call the next morning to confirm receipt. The MHP and Judy's house will have monthly meetings to go over all numbers and dates that referrals were completed for the prior month to identify and address any discrepancies.

15. Data Exchange Strategy: Identify and describe data exchange efforts between the Participating Entities and other stakeholders to identify beneficiaries eligible for treatment after presenting to an emergency department for alcohol use disorder or other substance use disorder and to assess performance via Key Performance Indicators and drive change towards its Aim Statement.

The MHP aim is to achieve routine data exchange with the ED, with the goal of enhancing care coordination. This will be accomplished through the following technology-related steps:

- 1st step: Meetings - Identify and assess what information is collected by BH case workers during crisis responses at ED, what information is collected by ED Case workers, how that data is stored and what precautions are necessary for exchange, as well as making improvements where necessary to capture data.
- 2nd Step: Direct Exchange – Transmission and receipt of securely faxed referral/screening tools with confirmation of

successful exchange conducted over the phone between BH Analyst and ED Case worker.

- 3rd Step: Data Matching – Referral/Screening tools from ED will be received and processed by BH Analyst, recorded and cross-referencing with Crisis Spreadsheet and EHR for reporting gaps in service/referrals and notifying assigned BH provider of beneficiary discharge when appropriate. The BH Analyst will continuously track referrals, cross referencing EHR for BH registrations, first contact attempt, and first completed service.
- 4th step: Shared Spreadsheets – Deidentified tracking data of those referred and barriers (e.g. homeless, living in outlaying areas) discharged from ED is compiled, reported, and securely shared routinely with ED to ensure accuracy, closed loop referrals, and successes or challenges in the coordination of care.
- 5th step: Central Repository - Institution of HIE will improve data exchange capabilities and timeliness of data access. Once facilitated with the MHP, discussions with ED and HIE vender will work to establish how data on SUD patients is recorded and stored by the ED electronically, what access is available to the MHP, how data is securely shared through the HIE, and how further data exchange can be leveraged for the benefit of both the ED and MHP.

The data exchanged, i.e. referral/screening tools, are able to be leveraged by the MHP to record additional numbers of ED discharges that would have otherwise gone unreported. This data in addition to already collected numbers on discharges reported to the MHP through crisis, forms the denominator of KPI 2. Follow-up tracking on services completed and time spans following discharge will be used to calculate the number within that cohort that received and completed a service within 7 days and within 30 days, forming the numerator of the KPI. The calculated 7-day and 30-day KPIs over time will determine the progress toward meeting the Aim of increasing 7- and 30-day follow-up rates by 10% in total by 2024. Additionally, data on referral/screening tools received will be leveraged to calculate total increase of recorded SUD discharges as a result of the intervention. This data will form the numerator of KPI 1, with numbers on discharges reported to the MHP through crisis and not through the screening/referral tool forming the denominator. This calculated KPI over time will determine the progress toward meeting the Aim of increasing total SUD discharges captured by 50% in total by 2024.

Data Element	**Source of Data**	**Method of Exchange**	**Function of Data**
Identifying information on patients discharged with SUD-condition	Referral/ screening tool, attached ROI	ED - Currently secure fax, moving to HIE Judy's House – Secure Fax or hand delivery	For MHP to cross-reference with EHR and either make initial contact or inform current provider of areas to address

Received referrals	Referral tracking spreadsheet	ED - Secure dropbox Judy's House – In person meetings/Zoom	For routine review by ED Case Worker/Judy's House Staff to ensure that all referrals sent were received
Referrals- Identifying Information, e.g. name, date of discharge	Referral Tracking spreadsheet	Partnership sFTP	To be shared with MCP for purpose of investigating any potential errors where someone might have been discharged with an SUD condition and had a primary MH diagnosis but was not forwarded to the County.
HEDIS Measures and Discharge by Diagnosis report	MCP	Partnership sFTP/secure email	To be routinely requested by the MHP and provided by the MCP for use as supplemental data to indicate rate of success in capturing additional SUD Discharges

16. Data Exchange, Narrative: Briefly describe the Participating Entity's experience since the last BHQIP submission regarding data exchange. Identify any challenges faced and lessons learned specific to the implementation of the improvement plan

As discussed in the Narrative Description of Changes in regards to the intervention, the MHP learned a hard lesson following the 9/30/2022 PIP submission that the degree of seamless and encompassing data exchange that was planned for this PIP would not be able to be realized without being a part of an HIE and without having had plenty of time to become proficient and capable with the new system. In meetings with the MCP, data exchange was facilitated but measures that were sought were not able to be provided in the level of detail and timeliness that the preliminary interventions would have required. In meeting with the ED, the same level of seamless data exchange was not allowed by their legal team without being in an HIE.

The MCP's role in data exchange has progressed from being the primary focus of the intervention to being a valuable resource on aggregate analysis. The MCP additionally is used as point of contact to securely share information via sFTP on those the MHP found that were referred by the ED. This is to inform of potential errors and provide information for the MCP to investigate reasons for why an individual wasn't referred to the MHP.

In working with internal stakeholders (MHP director, QIC, Analysts, Nurses, Case Managers, SUD Counselors, Case Manager Supervisor, Beneficiary Surveys) and external stakeholders (MCP BH Manager, MCP Program Manager, ED Director, ED Case Worker, ED Analyst, ED IT security), the plan for data exchange was agreed to be most fruitful with the ED and in lieu of an HIE had to be "manually" exchanged. The process of exchanging data via referrals and shared

spreadsheets leaves room for human error that would not be present in an HIE. Being that the referrals are voluntary, by its nature not all additional unknown SUD discharges will be captured by the MHP. For the purpose of the Aim however, additional voluntary referrals could have a higher likelihood of participating in follow-up services than if they were not actively seeking a referral.

Incidences such as what happened when first rolling out the referral/screening tool prove the drawback of this method. The first referrals sent by the ED were not able to be processed due to technical problems in scanning and a lack of filing needed by the ED so as to resubmit. This issue was thankfully resolved going forward. This was achieved through discussion with the ED Case Worker who now securely files all referral/screening tools once sent to the MHP, follows-up with the MHP Analyst immediately upon transmission, and participates in a monthly meeting to review the referral tracking sheet provided by the MHP. These extra steps are needed for confirmation but are clunky when compared to what data exchange could be feasible with an HIE.

For data exchange with Judy's House, Judy's house does not have any prior data infrastructure that would be conducive to seamless data exchange. Therefore, a similar tact was taken with data having to be exchanged manually. In meeting with Judy's House, lessons from referral exchange with the ED were applied to ensure that Judy's House had a way to securely store referrals and had the capacity to maintain a similar level of verification activities with the MHP as the MHP does with the ED.

In all, aside from the initial setbacks and extra steps and precautions needed to facilitate this method of data exchange, exchange has been overall successful and will only continue with additional coordination and discussions among stakeholders within the MHP, ED, Judy's House, and MCP.

17. Care Navigation:

- **Part A:** Is the Entity collaborating with CA Bridge or another stakeholder that receives funding from CA Bridge? (Yes/No) No
- **Part B:** Describe any engagement of the Participating Entity with the CA Bridge Program or other efforts to improve care navigation for people who have a substance use disorder.

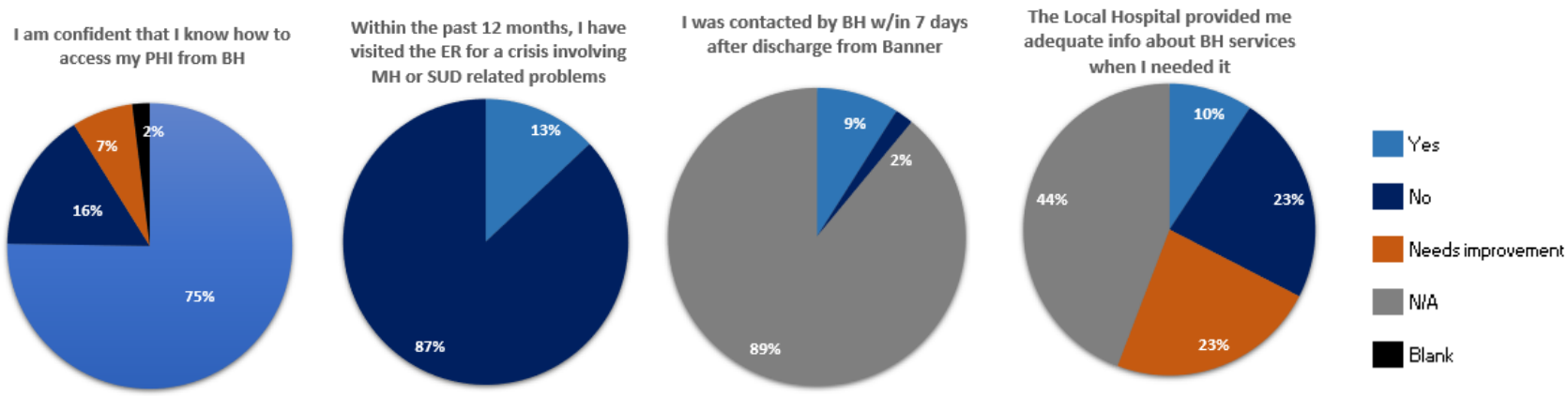
  The four Participating Entities for this implementation are the MHP, the ED, Judy's House and the MCP. The ED/Judy's House, upon judgement and screening, utilize the intervention for the ED Case Worker/responding staff

to navigate individuals in need of further SUD care to the MHP. The MHP will then be responsible for further assessment of needs and medical necessity where it will be determined whether an individual is best served in an Outpatient County setting or if transition to lower or higher-level care is appropriate. In those cases, the MHP works with the MCP to guide the individual to an appropriate facility and works with the individual and referred entity to help navigate them to the proper level of care with a warm handoff. The MHP is not currently collaborating with the California Bridge Project.

18. Beneficiary Engagement: Address when and how beneficiaries will be engaged in the period prior to the next reporting period in 9/29/2023. Specifically address how beneficiaries will be engaged

Beneficiary feedback is essential on understanding the impact and success of this intervention. For the week of May 15th 2023, the MHP issued a consumer perception survey with additional questions related to ED Discharge. Of the respondents, 80% who had reported to have been discharged for an MH or SUD-related condition received contact prior to 7 days from the MHP while 20% reported that they did not. 64% received adequate information from the ED about MHP services but 36% reported that the ED did not provide adequate information or needs improvement. These measures helped dictate the need and direction of this PIP. Going forward, the MHP is always seeking beneficiary involvement in the QIC and PIP review, with providers routinely asking beneficiaries if they are interested and offering participation. In lieu of active participation in QA/QI, beneficiary input on the PIP process and progress will continue to be sought through routine surveys.

PIP Survey Findings: n=45



Template C (POD)

Clinical Area of Focus: Pharmacotherapy for Opioid Use Disorder

Section 1: Progress Report for Quality Improvement Project

Participating Entities may have revised or modified their quality improvement plans since the 9/30/2022 submission for BHQIP. In your responses, state your previous submission information and describe any changes the Participating Entity has made since the last submission. Address any clarifications previously sought by DHCS in responses.

1. Problem Statement: What is the problem this performance improvement plan proposes to solve?

Gaps in care coordination practices and related data exchange processes contribute to delays and missed opportunities in receiving continuous MAT services for recorded individuals with Pharmacotherapy for Opioid Use Disorder (POD).

2. Aim Statement: What is the aim/goal for this performance improvement project?

Aim Statement	For recorded Lassen County Medi-Cal beneficiaries diagnosed with OUD and initiating MOUD from the MHP's provider network, implemented interventions will increase the percentage of continuous MOUD events (90+ continuous days) recorded by the MHP by 100% by March 31st, 2024.
How the Aim Statement is	
Specific	*Focuses on the specific population of Lassen County Medi-Cal beneficiaries as recorded by the MHP with an OUD diagnosis that are initiating MOUD*
Measurable	*Measurability is based on the percentage of the number of beneficiaries that achieve continuous MOUD events (90+ continuous days) out of the total number of MOUD initiations recorded by the MHP*

Achievable	*As the MHP has not historically collected data on MOUD initiations or events, interventions to enable just one event of continuous MOUD participation to be tracked and recorded by the MHP would increase percentage of recorded continuous MOUD events by 100%*
Relevant	*As Lassen County Medi-Cal clients with OUD diagnoses are not accessing MAT treatment, interventions to increase recorded continuous MOUD events address both initiation, participation, and tracking.*
Time-Bound	*The aim is set to be achieved by March 31st 2024.*

3. Narrative Description of Changes: Briefly describe any changes the Participating Entity has made to the Problem Statement and Aim Statement in this improvement plan. Address sources of information used to inform these changes, such as local data and stakeholder engagement. Identify challenges and lessons learned in this process (250 words or less).

The previous Problem Statement as stated in the September 2022 submission: *Gaps in care coordination practices and related data exchange processes contribute to delay and lack of support for individuals receiving MAT services with Pharmacotherapy for Opioid Use Disorder (POD).*

In internal stakeholder discussions (MHP Analysts, Director, SUD Counselors, Nurses), the problem statement was revised to include "missed opportunities". As the MHP has not been tracking MAT initiations and participation, the purpose of this PIP is to increase MHP awareness on missed opportunities for capturing and assisting a population that has gone historically unaddressed. The Problem Statement was revised to specify a focus on capturing "continuous" MAT services to reflect the Aim Statement of this PIP. Lastly, the Problem Statement was revised to specify the population of focus as individuals who are "recorded" by the MHP, i.e. MHP beneficiaries. This is to ensure direct and accurate data capture on OUD individuals that the MHP has permission to access.

The previous Aim Statement as stated in the September 2022 submission: *"For Medi-Cal beneficiaries initiating MOUD from the MHP's provider network, implemented interventions will increase the percentage of continuous MOUD events by 5% by June 30, 2023."*

The Aim Statement was revised to specify the population as Lassen County Medi-Cal Beneficiaries, whom the MHP serves. This was decided upon discussion with the Quality Improvement Committee (QIC) to ensure that the population studied is the population that the MHP is best able track and to provide services to.

Additionally, the goal of increasing continuous MOUD events by 5% was revised. The MHP has historically done no tracking of when a beneficiary is referred to MAT. The MHP does not provide MAT services and does not have any contracted MAT providers. Beneficiaries in the County have 2 options for a currently accessing MAT: Northeastern Rural Health Clinic, and Brightheart Health. Both providers provide outpatient Mental Health (MH) services via telehealth. When individuals have been referred to MAT in the past, they will discontinue services with the MHP to receive all their needed MH services through one telehealth avenue. This means that not only has the MHP not been recording when a beneficiary is referred to MAT, but once they are referred, they fall off from the MHP system and no efforts have been made to follow-up on participation once the beneficiary's MHP chart has been closed.

With this being the background of this PIP, the MHP has no data to refer to when making an AIM to increase recorded Continuous MOUD events by 5%. With zero continuous MOUD events recorded at the onset of the intervention, any increase in events would increase the amount recorded by at least 100%.

The MHP's goal is that through interventions to better initiate, capture, and track MAT referrals, as well as to leverage identified barriers for working to address during participation, the MHP will be able to begin recording successfully completed continuous MOUD events. For this reason, the Aim Statement was revised toward increasing recorded continuous MOUD events by 100%.

The threshold for continuous MOUD events was agreed to be reduced from the HEDIS POD measure of 180+ continuous days to 90+ continuous days to enable the MHP to monitor continuous participation without having to run up against the deadline for next submission.

Timeline for this PIP was extended to March 31st 2024 to ensure data is captured up to the deadline for next submission.

4. Selected Interventions: State the selected intervention(s) for this quality improvement project

In working with internal stakeholders (MHP director, QIC, Analysts, Nurses, Case Managers, SUD Counselors, Case Manager Supervisor) and external stakeholders (MCP BH Manager, MCP Program Manager, Northeastern, Indian Health, and Brightheart MAT providers), the MHP has identified two interventions:

1. Use of a MAT referral for SUD counselors that identifies addressable Social Determinates of Health (SDOH) barriers that could impede on MAT participation and includes an ROI for MHP follow-up with the MAT provider.
2. Data sharing with MAT provider for MHP to be provided status updates on MAT referrals sent and participation updates on successes and challenges of those referred.

This has been revised from the 9/30/2022 preliminary interventions of:

Screening:

- *Screen for Social Determinates of Health (SDOH) and provide care coordination to address barriers to engagement*
- *Assess for co-occurring MH, SUD and medical needs at intake and providing care coordination when these needs cannot be addressed internally*

Data Exchange:

- *Implement a process to routinely monitor pharmacy data for unfilled MOUD prescriptions to identify discontinuation instances and trends to target care coordination efforts*

Tracking:

- *Implement an engagement tracking system to closely monitor clients for the first 90 days of treatment. The tracker may flag / create alerts for risk, such as being homeless; being under 30; being new to treatment; having a co-occurring diagnosis; being LGBTQ+. Assign staff (e.g., counselor, peer) to monitor and provide follow-up care coordination as needed*

5. Narrative Description of Changes: *Briefly describe any revisions to selected interventions since the last submission for BHQIP. Address the reasons leading to any changes, as well as the data or evidence considered leading to these changes*

The interventions were revised from the preliminary submission to more accurately and concisely define the MHP's intentions.

For screening, internal stakeholders agreed to integrate screening into the referral for MAT services. This screening would be conducted by the SUD counselor with the beneficiary so as barriers are identified, the SUD counselor will have the opportunity to offer discussion, linkage, and care coordination to address barriers at the onset of MAT initiation. Areas such as co-occurring status and medical needs can be evaluated from data collected within the EHR and don't need to be explicitly stated within the screening during MAT referral. It is for these reasons that the original intervention of Screening for Social Determinates of Health (SDOH) and providing care coordination to address barriers to engagement*, and* Assessing for co-occurring MH, SUD and medical needs at intake and providing care coordination when these needs cannot be addressed internally *was specified to be: "Development of a MAT referral for SUD counselors that identifies addressable Social Determinates of Health (SDOH) barriers that could impede on MAT participation". In addition, the verbiage for having an added ROI attached to the referral was included to facilitate the second intervention of enabling data exchange of protected information between the MHP and MAT provider.*

For data exchange, the preliminary intervention of monitoring pharmacy data was entirely thrown out as the MHP does not have the capability to do so at this current time. In creation of the preliminary interventions, the MHP intended to be involved in a Health Information Exchange (HIE) that would enable a higher degree of cross-provider data exchange and access. Due to the MHP having to change EHR's in July, and having to undergo three months of review and revision within the new EHR system, HIE onboarding was delayed until the EHR review period is concluded. The MHP is currently still in the process of being onboarded with SacValley Medshare HIE, with the hope to be Live by October. With the timeline for onboarding, and given the time it would take to successfully be trained and competent, the use of HIE-obtained data as an intervention for this PIP was infeasible.

Additionally, the MHP sought this data through the MCP on multiple occasions and was not able to furnish the information that was requested. While the MHP participated in a data sharing agreement with the MCP, the MCP has been unable to provide timely data as requested and has only been providing top-down data and analysis on the POD measure and demographics. As communication with the MCP has been unreliable and not received in a timely manner, for the purposes of this PIP, the most accurate and timely data on beneficiary MAT participation would have to come directly from the referred MAT provider. It is for this reason that the intervention on data exchange is focused on creating the connections and capacity for sharing data on referred MAT participants with the MAT provider and not through Pharmacy data accessed by either HIE or MCP.

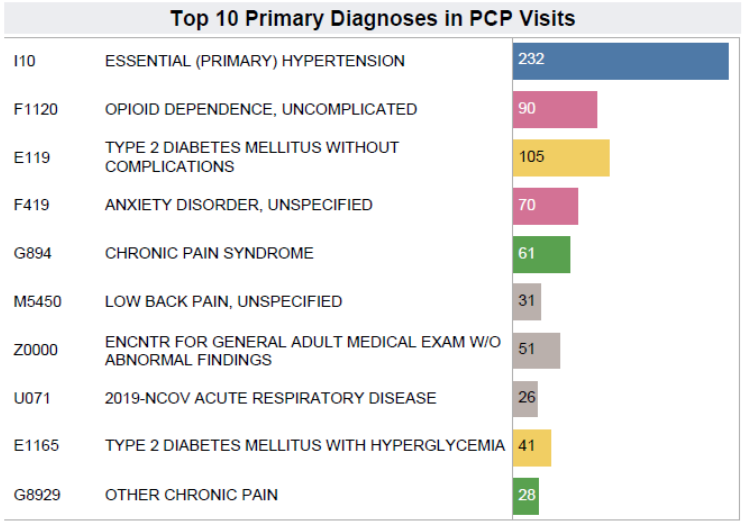
The original preliminary intervention that focused on tracking has been discarded. This is because increasing tracking capability and alerting to barriers is a requirement of the other interventions and by itself does not constitute an intervention. Assigning staff based on the tracking is not a required intervention as any beneficiary being referred to MAT by the MHP would already be assigned an SUD

counselor that would be their point-of-contact in resolving barriers and providing linkage and care coordination. It is for these reasons that stakeholders agreed to limit the interventions to the processes around referring/screening and exchanging data with MAT providers.

6. Equity Analysis: Participating Entities are required to complete an Equity Analysis as part of their quality improvement plans for BHQIP Goal 3. Describe how the intervention(s) identified in Question 4 consider and address disparities faced by Medi-Cal beneficiaries who have opioid use disorder or substance use disorders in the Participating Entity's service area.

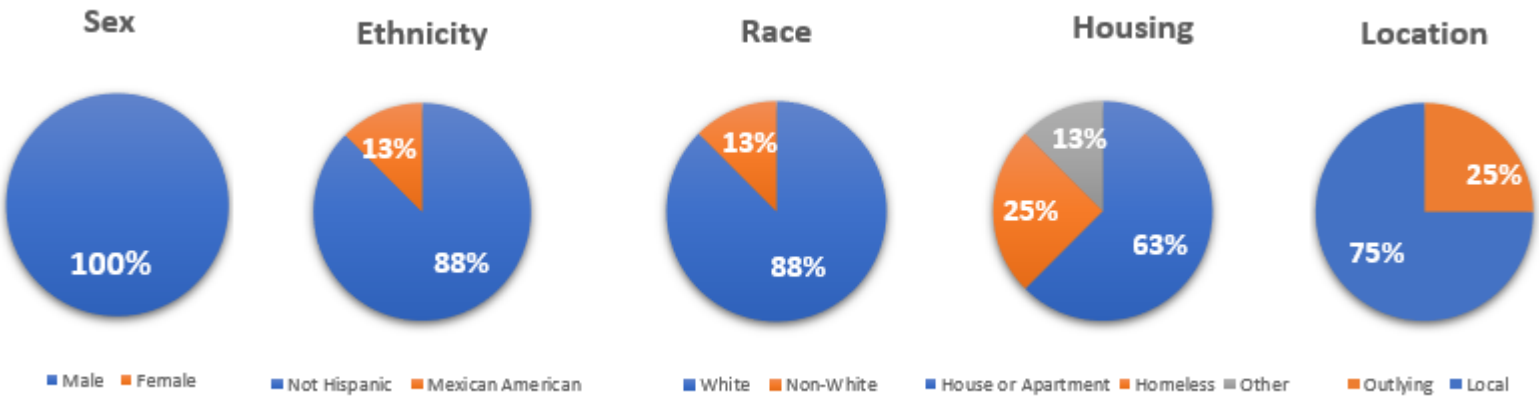
In beginning this PIP, the MHP has no recorded data on beneficiaries that are offered, initiated, and participating in MAT. Internal data used as a starting ground for this equity analysis is that of beneficiaries with an OUD diagnosis.

The population of OUD MHP beneficiaries is exceedingly low. From 7/1/2022 onward, only 8 individuals entered service with the MHP and were given an OUD diagnosis. This alone indicates a large gap in the total number of OUD individuals in the county verse OUD individuals served by the MHP. In a 2022 report provided by the MCP on Top 10 Primary Diagnoses in PCP Visits, the MCP indicated 90 Partnership members with Opioid Dependence diagnosis visiting a PCP in 2022. From the onset, this indicates a large discrepancy between what the MHP records and what is really seen within the county.



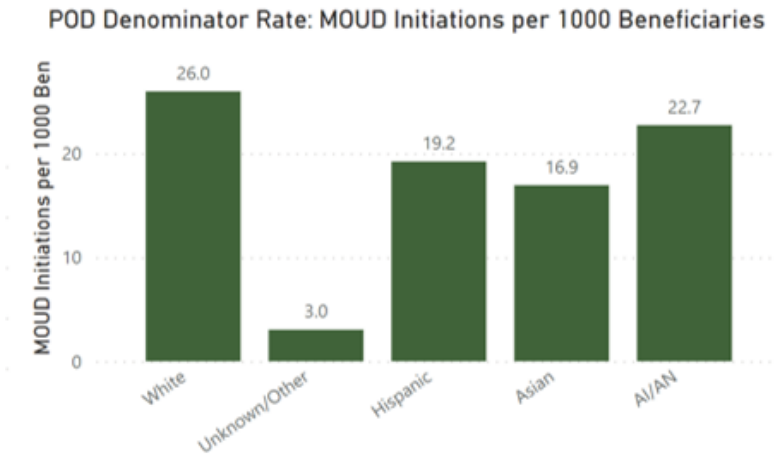
Of the MHP beneficiaries identified with OUD, the majority were male (100%; 8/8), non-Hispanic (88%; 7/8), White (88%; 7/8), living in house or apartment (63%; 5/8), and living within the town of the MHP (75%; 6/8).

Demographics of MHP Beneficiaries with OUD – 7/1/2022-9/1/2023

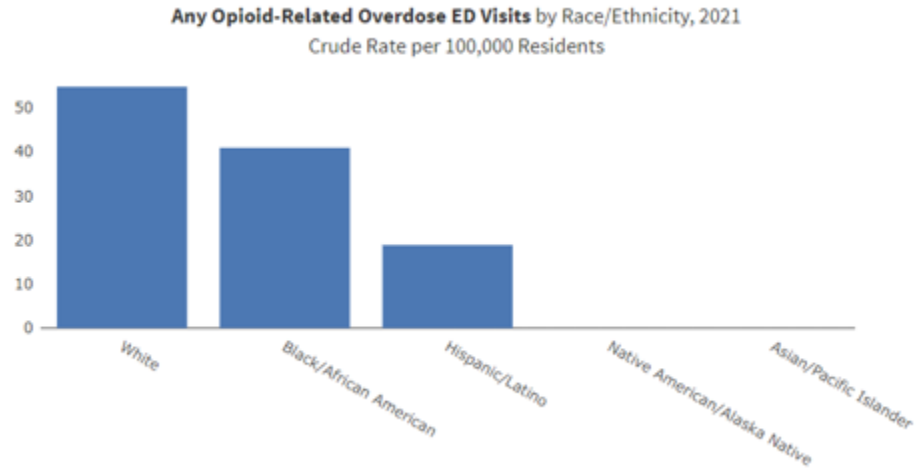


Compared to the total MHP population we can see a large lack in diversity among those diagnosed with OUD. This is exemplified by 100% of recorded OUD diagnosed beneficiaries being male while of current EHR data, only 47% of the total MHP beneficiary population are male. While the proportion of non-Hispanic beneficiaries is the same among the OUD population as it is with the total current MHP population (486/551; 88%), Mexican American/Chicano individuals are overrepresented in those diagnosed with OUD. For the total MHP population, Mexican American/Chicano accounts for only 5% of current active beneficiaries, but 13% of those diagnosed with OUD. The absence of any other ethnicity with an OUD diagnoses also highlights a gap, where an additional 7% of total MHP beneficiaries are not Hispanic or Mexican American. This is apparent with race as well, where for OUD individuals, only white or non-white-other races were identified. This points to a large disparity in data captured by the MHP given the rates of MOUD initiations among non-white races recorded for the State and the County as a whole.

In statewide data obtained from the California Overdose Surveillance Dashboard[1], racial minorities make up a significant percentage of MOUD initiations. Asian and American Indian/Alaskan Native (AI/AN) individuals make up a similar percentage of MOUD initiations as Hispanic individuals, but neither race is present in MHP OUD diagnoses.



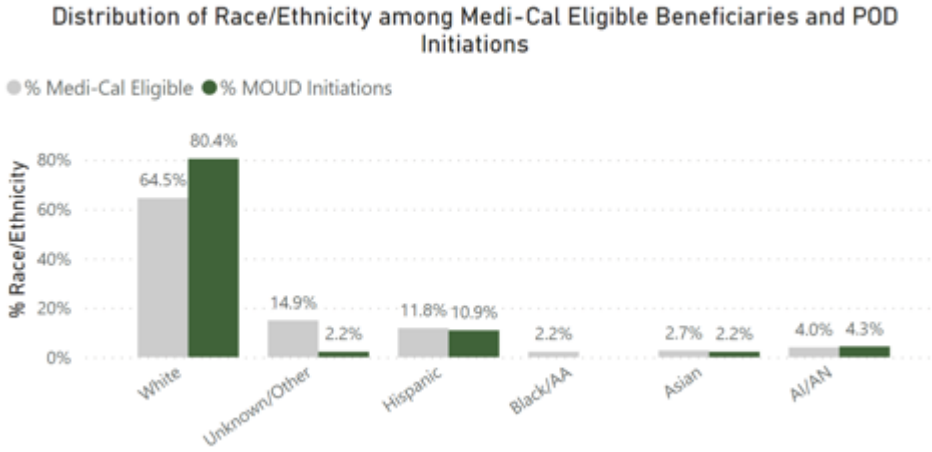
In the above graph it is shown that the largest population MOUD initiations outside of White individuals is AI/AN, but AI/AN beneficiaries are not represented in MHP OUD diagnoses. Additionally, for data on opioid-related overdose ED visits from the same dashboard, Black/African American individuals make up a large percentage of opioid overdoses within the state, while they are completely absent from all MHP OUD data as well as County Medi-Cal data on MOUD initiations.



In all sources, white beneficiaries are more likely to have MOUD initiations than other races and are over represented in County-wide MOUD initiations. In County Medi-Cal claims data provided by DHSA and analyzed by CalMHSA, out of total

percentage of Medi-Cal Eligible Beneficiaries, White beneficiaries make up 80.4% of MOUD initiations while making up only 64.5% of Medi-Cal Eligible Beneficiaries. Hispanic, Asian, and AI/AN beneficiaries who initiated MAT were largely representative of their percentages of Medi-Cal Eligible Beneficiaries. Outside of the disparity of White individuals being overrepresented, Black/African Americans were the only minority group significantly underrepresented in County Medi-Cal data. While Black/African American beneficiaries comprised 2.2% of Medi-Cal Eligible Beneficiaries, they represented 0% of MOUD initiations. The Black/African American population in Lassen County is small (7.6% according to 2022 Census estimates[2]), but is still larger than the entire AI/AN (4.4%) and Asian (2.7%) populations combined. The lack of representation in MHP OUD and County MOUD data points to a clear disparity. In addition, a smaller disparity can be seen from County Medi-Cal data as a slight overrepresentation of AI/AN beneficiaries initiating MAT.

Race/Ethnicity	MC Elig Ben	% MC Elig Ben	MOUD Initiations	% MOUD Initiations	MOUD Initiations per 1000 Ben
White	1424	64.5%	37	80.4%	26.0
Unknown/Other	329	14.9%	1	2.2%	3.0
Hispanic	260	11.8%	5	10.9%	19.2
Black/AA	48	2.2%			
Asian	59	2.7%	1	2.2%	16.9
AI/AN	88	4.0%	2	4.3%	22.7



[1] U.S. Census Bureau (2022). *Lassen County Population Estimates, July 1, 2022, (V2022).* Retrieved from U.S. Census Bureau QuickFacts: Lassen County, California

While data collected on the MHP OUD population cannot be used to prove disparity due to small sample size, the over representation of homelessness in the data is worth taking into consideration. Of OUD diagnosed MHP beneficiaries, homeless individuals comprised 25%. This is a large overrepresentation given that homelessness makes up 8% (42/551) of the total MHP population. In a longitudinal study that followed 28,033 adults for 15 years it was found that opioid overdose has been one of the major causes of death among people experiencing homelessness. Individuals experiencing homelessness in the study were nine times more likely to die from an overdose than those who were stably housed. Compared to 61% nationally, 81% of overdose deaths were caused by opioids among those experiencing homelessness[3].

From these findings, opioid use and overdose disproportionately impacts homeless individuals. While homelessness is not stipulated in the Medi-Cal Claims analysis, it is clear that the SDOH barrier of being unsheltered can form an impediment to successfully participating in treatment and recovery.

There was no identified barrier with Language in the County in regards to MOUD for 2022. For all initiated MAT beneficiaries, 0% had a primary language other than English. As well, of the MHP OUD beneficiaries, 100% had English as their primary language. Lassen County does not have a Threshold Language but in referencing the MHP Cultural Competency Plan, the MHP makes available all forms and means of communication to be translated into the required language. The MHP maintains Spanish versions of all forms and works with bilingual staff, AT&T Language Line, and TDD or California Relay Service to ensure that all beneficiaries are able to receive information and communication in their spoken language. Importantly, the MHP puts great focus on obtaining diverse beneficiary input in Quality Improvement meetings to ensure that everyone has equal access to BH services regardless of primary language.

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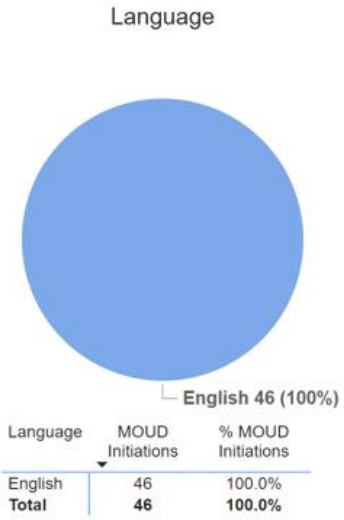
[3] Baggett TP, Hwang SW, O'Connell JJ, et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA Intern Med. Feb 11 2013;173(3):189-195.



Language	MOUD Initiations	% MOUD Initiations
English	46	100.0%
Total	**46**	**100.0%**

Lassen County Medi-Cal Claims Analysis – CalMHSA 2022

Lassen MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
No Threshold Languages	*	n/a
Total	**868**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

LCBH Cultural Competency Plan - EQRO 2019

This Equity Analysis has identified four primary disparities that will be taken into consideration with the implementation of this PIP:

- Black/African American Population is significantly underrepresented in MHP OUD and County MOUD initiation data.

- AI/AN population is underrepresented in MHP OUD data but slightly overrepresented in County MOUD initiation data.
- Hispanic/Latino population is underrepresented in MHP OUD data.
- Homelessness is overrepresented in MHP OUD data and in studied rates of overdose deaths.

In addressing these disparities, this PIP will focus on collecting and monitoring demographic data within the OUD diagnosis and MAT referral/initiation/participation tracking. The MHP will ensure that SUD-Counselors/MAT providers are notified when an individual with the given disparities is identified so as to provide a higher degree of attention to addressing MAT initiation and continuous participation. KPIs will also be stratified by racial demographics to better monitor these populations. In the MHP's objective to involve beneficiaries in the PIP review process and obtain diverse beneficiary input, the MHP will focus on achieving feedback in regards to this implementation from those in the reported disparity populations.

In conducting this PIP, all actions are taken with consideration of the MHP Cultural Competency Plan (CCP). As stated in the CCP, LCBH recognizes the need to be culturally responsive to Hispanic/Latino, AI/AN, and other minority groups in our county. LCBH will reach out to a variety of individuals with different points of view, and will emphasize on reaching out to the community for the services that LCBH is planning to provide. Community input is invaluable in preventing oversight of key components as well as developing and understanding any missing components needed for future outreach efforts. In addition to outreach efforts already being conducted by the MHP, obtaining diverse beneficiary feedback and input that is representative of the disparities identified will be instrumental toward the success of this PIP.

7. Implementation Steps Completed: Describe steps completed as of 9/29/2023 to implement the interventions identified, including time periods or dates of action

Following agreement among internal stakeholders (QIC, SUD Counselors, MHP Analysts, Director) and external stakeholders (MAT providers for Northeastern, Indian Health, Brightheart), the MHP began creation of a referral to be used by SUD counselors when referring a beneficiary to MAT. The referral contains identifying prompts for contact, such as name and phone number and screens for current barriers such as homelessness, issues with transportation, living in

outlying communities, food/housing instability, problems with employment, phone service, and co-occurring mental conditions. Attached to the referral is an ROI to be filled out to allow the MHP to receive updates on treatment.

Upon creation of the referral, training was conducted with SUD counselors to ensure that referrals were completed correctly every time a beneficiary is referred to MAT and that physical referrals were to be immediately passed to the MHP Analyst for recording and tracking.

In establishing communication with a MAT provider, the MHP was able to identify the provider for Brightheart Health that oversees the MHP county. In building communication, an agreement was reached where if a beneficiary is referred to Brightheart, with the beneficiary's consent (ROI) the MHP will be able to request weekly reports on referral statuses, i.e. whether a referred individual accepts the referral with Brightheart, declines, or does not respond. Then biweekly, the MHP will receive a report on participation of all referred that will include notes on successes and challenges of the participants, whether they have missed any appointments, and whether or not they are accessing other outpatient services with Brightheart. This will enable the MHP be able to consistently track initiation and participation and provide updates to SUD counselors on beneficiary status and needs, clarifying if they are not receiving outside outpatient services and are still eligible for intervening MHP outpatient services.

The MHP and Brightheart MAT Provider have agreed on a method of data exchange through a shared HIPAA/HITECH compliant Dropbox. When a beneficiary is recommended and agrees to a referral to Brightheart for MAT, the SUD counselor will work with them through the screening and referral and will call Brightheart with the beneficiary. They complete the steps for enrollment together and the SUD counselor scans the referral with ROI to a secure email provided by Brightheart. Brightheart will then schedule a follow-up appointment with the beneficiary and assign them to the appropriate provider for their area. After a referral is sent, the SUD counselors provide the referral to the MHP Analyst for them to make contact with the Brightheart MAT provider. Via Dropbox, the MHP Analyst shares a list of completed referrals with the Brightheart contact for them to cross reference. At the end of each week, the Brightheart provider will upload a document into the Dropbox stating the referral status for each of the received referrals sent by the MHP Analyst. Then every other week, the provider will upload a spreadsheet of all beneficiaries that have been referred by the MHP, detailing their status in participation and notes on successes and challenges. Upon receipt of identified challenges or missed appointments, the Analyst will inform the assigned SUD Counselor for them to make contact with the beneficiary to try and address issues with participation.

All SUD counselors have been trained on this process as of August 2023 and have begun issuing referrals and forwarding to the MHP Analyst as of September 2023. The MHP Analyst has forwarded what was received to the Brightheart Provider and the Brightheart Provider has begun sending status updates for the Analyst to track.

8. Challenges Faced: For all implementation steps identified in the 9/30/2022 submission that did not occur as anticipated, address reasons why. (125 words or less)

There were a number of challenges associated with the implementation of the agreed upon interventions. At the onset of this PIP there were three entities providing MAT services within the County: Northeastern Rural Health Clinic, Brightheart health, and Lassen Indian Health Center. All three entities are not contract providers with the MHP and coordination for the purposes of MAT has never been established. The MHP first sought coordination with Indian Health to establish a means for data exchange. In meeting with the MAT provider for Indian Health it was revealed that due to the ending of a grant, MAT services would no longer be available at Indian Health as of August of 2023. The MAT participants under Indian Health were then transferred to Northeastern Rural Health clinic without passing through MHP services. Due to the protected nature of Substance Use-related diagnoses, individual information could not be shared without participant's consent so the MHP was unable to get any information on individuals changing providers out of Indian Health.

With Indian Health MAT services ending, the MHP sought coordination with Northeastern. In meeting with the MAT provider for Northeastern, the provider was open to using an MHP-issued referral to refer her patients to the MHP, however, she acknowledged that any of her clients that are in need, already access outpatient Behavioral Health (BH) services from Northeastern. Therefore, the participants would not qualify for services with the MHP anyway. When discussing coordination in tracking individuals that were referred to Northeastern for MAT by the MHP, the MAT provider was less responsive. In following contact attempts, emails and phone calls to the MAT provider either went unresponsive or were followed up with weeks later. For the purposes of this PIP, the level of data exchange needed to achieve the aim of the interventions requires timely and consistent response between the MHP and MAT provider. This is to ensure that when challenges or absences are identified, that the MHP has the opportunity to promptly respond to the beneficiary to address issues in continuance.

As delays in communication contributed to a roadblock in implementing the intervention, upon recommendation by the SUD counselors, the MHP reached out to contact Brightheart Health. Brightheart Health is an entirely telehealth provider and was initially not on the MHP's radar until recommended by the SUD counselors. Upon contact, the MHP was able to navigate to the provider who manages MAT services for the County. Connections were able to be built with Brightheart to

fulfill implementation of the interventions with timely data exchange schedules and responsive communication. While coordination is still desired between the MHP and Northeastern, implementation has initiated with Brightheart, with a caveat open for further coordination with Northeastern as the interventions are implemented.

In meetings with the ED, it was found that the ED will be beginning its own MAT program but currently do not have a MAT provider. While the interventions are being implemented with Brightheart Health, the MHP hopes to be able to incorporate the ED and Northeastern within the goal for MAT coordination.

9. Key Performance Indicators (KPI): Report out regarding the performance of the selected interventions using the performance indicators selected by the Participating Entity in the 9/30/2022 submission. In this response, Participating Entities must specify

- At least one KPI for each Selected Intervention
- The Participating Entity's actual measured performance on the KPI(s) at the time of reporting
- An assessment of how this performance compares to the Participating Entity's expectations

The KPIs selected have been revised from the performance metrics listed in the September 2022 submission. As interventions have been revised, KPIs have been updated by stakeholders to more accurately reflect the new interventions.

For the first intervention, the use of a MAT referral that identifies barriers and provides release of information, the Key Performance Indicator for success would be the amount to which it is used and the rate that it is successfully completed and sent to Brightheart with barriers identified and ROIs signed.

The KPIs for the first intervention are as follows:

<u>KPI1:</u>

Numerator: Number of completed MAT referrals that were successfully sent to Brightheart by the MHP

Denominator: Total number of MAT referrals sent to MHP Analyst by MHP SUD counselors

KPI2:

Total number of referrals completed and referred to Brightheart by the MHP and change from prior month

For the second intervention, successful data exchange between the MHP and MAT provider(s) to leverage data on participation and address challenges/barriers to achieve the Aim, the Key performance Indicator for success would be rate to which beneficiaries are contacted following disclosure of a challenge in MAT participation and the rate of MHP beneficiaries initiated into MAT from the intervention that maintain continuous participation for 90+ days.

The KPIs for the second intervention are as follows:

KPI3:

$$\frac{\text{Numerator: Number Continuous MOUD events (90+) recorded by MHP}}{\text{Denominator: Number of recorded MHP Beneficiaries initiated into MAT}}$$

KPI4:

$$\frac{\text{Numerator: Number of successful SUD counselor contacts following disclosure of challenges}}{\text{Denominator: Number of challenges reported by MAT provider to the MHP}}$$

KPI1 will be determined by the tracking of the Referral Status Report sent weekly by Brightheart and the MAT Referral Tracking sheet recorded from physical referrals sent to the MHP Analyst by the SUD Counselors. The Referral Status Report will show how many referrals were successfully received while the Referral Tracking Sheet will show how many were reported as sent. These

metrics are expected to equal each other with monitoring of this KPI for the purpose of finding discrepancies and identifying areas in which the referral process might have failed.

KPI2 is the numerator of KPI1 recorded from the Weekly Brightheart Referral Status Report. This is an important measure to monitor to ensure that there is positive month-to-month growth and to identify times in which referrals are not being successfully completed in order to address reasons why.

KPI3 will be calculated from tracked data from Brightheart's bi-weekly Referral Participation Report and is a primary indicator not only on the success of the referred MAT population in treatment but will point to success in the MHP's use of identifying challenges/barriers and providing contact to work to address said challenges to continuing participation.

KPI4 will be determined by tracking of Brightheart's Referral Participation report. In the Referral Participation Tracking, the MHP Analyst will not only record information that was provided by Brightheart, but will identify participants where challenges to participation was disclosed, notify SUD Counselors for contact, and will note in the tracking the day that successful contact was achieved. This measure will be important in verifying that contact was being initiated due to reported challenges.

The findings for this current reporting period have been limited but do show progress in beginning to meet the goal of this PIP. The intervention began in August of 2023. EHR reports at the time indicated only 6 active MHP beneficiaries with a diagnosed OUD. Upon SUD Counselor consultation, 4 of the 6 were not currently using and were not in need of MAT. The 2 remaining beneficiaries, however, were recommended for MAT referral. Of the 2, only one individual agreed to referral.

The referral was completed in September 2023 and the SUD counselor assisted the beneficiary in getting registered and scheduled with Brightheart. The completed referral was received by the MHP Analyst and forwarded to the Brightheart provider by Dropbox. The following Thursday, the first Referral Status Report was received by the MHP from Brightheart. The status showed that the beneficiary had rescheduled their appointment with Brightheart and had yet to be initiated into MAT services. Upon disclosure, the SUD counselor was notified to follow-up to ensure that appointment is kept and clarify what factors led to rescheduling. The beneficiary rescheduled due to a conflict in they're schedule and intended to go through with MAT. The following Thursday report from Brightheart indicated that the beneficiary was successfully initiated into MAT services.

From this one successful capture we are able to calculate the following KPI's –

KPI1: 100%

$$\frac{\text{Number of completed MAT referrals that were successfully sent to Brightheart by the MHP}}{\text{Total number of MAT referrals sent to MHP Analyst by MHP SUD counselors}} = \frac{1}{1}$$

KPI2: +1

Total number of referrals completed and referred to Brightheart by the MHP and change over prior month = +1

KPI3: 0%

$$\frac{\text{Number Continuous MOUD events (90+) recorded by MHP}}{\text{Number of recorded MHP Beneficiaries initiated into MAT}} = \frac{0}{1}$$

KPI4: 100%

$$\frac{\text{Number of successful SUD counselor contacts following disclosure of challenges}}{\text{Number of challenges reported by MAT provider to the MHP}} = \frac{1}{1}$$

Due to only one recorded participant, KPI's are not yet able to be compared by stratified demographics. However, individual initiated was not in a population identified as a disparity in the Equity Analysis. The individual was a white, non-Hispanic, non-homeless, male

Findings in these KPIs indicate positive growth toward the MHP reaching its goals for this PIP. In beginning to track initiations, the amount of recorded MAT initiations among MHP beneficiaries has increased by 100%. There was positive growth from the prior month of +1 participant. The disclosure of referral status/challenges has successfully allowed for information to be passed to the SUD counselor to initiate contact and address reasons that would impede on continuation. The new participant was able to contribute to the denominator of KPI3, but as they have not been receiving MAT services long enough to reach the goal of continuous participation, they do not add into the numerator. The hope is that with monitoring and support, this participant will stay in MAT for 90+ days and will contribute to the MHP's Aim of achieving an increase in the percentage of continuous MOUD events recorded by the MHP by 100% by March 31st, 2024.

10. Lessons Learned: Provide a brief reflective summary of the improvement plan implementation process. In this response, identify **at least 2 lessons learned** for the next phase of improvement plan implementation.

The first lesson learned in administering the mentioned KPIs was how the MHP wants to define challenges worthy of Counselor contact. In the Referral Participation Report sent by Brightheart, challenges are indicated as "challenges" within a column of the report. However, in instances where a referral was successfully received and reported by Brightheart, but no movement has been made in regards to initiation, discussion among stakeholders led to agreement that time delay in scheduling/initiation constitutes as a challenge, as well as any other detraction within the Referral Status Report indicating that the beneficiary has not fully accepted MAT treatment. All instances such as this should be reported to SUD counselors for them to attempt follow-up contact.

The next lesson learned was in regard to the limited scope of this new tracking given that so few of the MHP beneficiary population are diagnosed with OUD. With so few people within the MHP's awareness being eligible for MAT, so much of the weight of the success of this PIP is driven by the participation of only a select few individuals. It is for this reason that identifying challenges and maintaining counselor contact are even more crucial. In order to increase this population, SUD counselors have been trained to ask about MAT the moment an OUD diagnosis is revealed and continue to regularly offer referrals. Additionally, SUD workers who conduct outreach have been instructed to pay particular attention to trying to reach members in the community with opioid struggles and to be actively promoting referral to MAT services in the hope of capturing and initiating MAT for a wider population.

The MHP will continue outreach efforts to try and bring in increased numbers of OUD beneficiaries and will seek further collaboration with community partners such as Judy's House - a local BH drop-in center, Crossroads - non-profit providing

transitional housing, homeless assistance, and food services, LassenWorks –county welfare administration, and any other entities that work with the community to conduct outreach and spread the word for SUD counseling and MAT services.

Section 2: Next Steps for Improvement Plan

The following section focuses on further implementation of the Participating Entity's improvement plan. This section is analogous to the Act portion of a PDSA cycle, leading to the Plan portion of the next PDSA cycle.

11. Implementation Steps, Planning for the Future: Describe at least **3 concrete steps** that the Participating Entity will carry forth in the following 6 months to implement the interventions specified in Question 4 and to assess performance on the key performance indicators specified in Question 12. Provide time frames or dates for each step identified.

Of three concrete steps that will be taken going forward, two will be directly related to assessment while the third may encompass restrategizing.

Firstly, it will be imperative to maintain regular communication with the SUD Counselors, Brightheart Health, and the MCP. This will involve weekly and quarterly status updates with the SUD counselors during SUD Access meetings to confirm flow of referrals and explore and address findings among the MAT-participating and OUD population. Communication between MHP and Brightheart will be ongoing weekly to ensure accuracy as data is shared. Minimum quarterly meetings will be conducted between the MHP and Brightheart. Discussion will center on the following:

- Patterns in successes and challenges among MAT participants referred by MHP.
- Impact of MHP contact for MAT participants when challenges are reported.
- Any challenges/obstacles to be addressed, changes desired to the referral or means of coordination, and shared successes.

Quarterly communication with the MCP will be necessary in this as well to continue to receive macro reports in regards to the POD metric, incidences of MAT within the county as reported to Partnership and aggregated demographic data to inform further development of the referral and methods for coordination for the facilitation of an equity-driven approach.

Secondly, minimum quarterly internal stakeholder review will be conducted among the MHP QIC, with SUD Counselors included, to report on KPIs and discuss findings, successes, and challenges. Upon review, if the decision is made to make any edits to the intervention, the QIC will be responsible for approval of changes. The QIC is also always seeking beneficiary involvement, and will be continuing to seek diverse beneficiary input on the implementation, progress, and effect of this PIP during QIC meetings as well as quarterly consumer surveys.

Lastly, the MHP will be entering an HIE in October. Upon necessary training and acclimation, within the following months meetings will be conducted internally with QIC and HIE vender to discuss and develop capacity for further data exchange with MAT Providers as well as the MCP. The MHP predicts that once connection between HIE is feasible that discussion will be needed to potentially restrategize the data collection and exchange aspect of this PIP. Internal planning will be followed by follow-up planning and meetings with QIC, MAT providers, and HIE vender to determine the best course of action. Additionally, continuous outreach will be maintained to Northeastern in trying to coordinate the same way as the MHP is coordinating with Brightheart. Regular meetings and discussions will be held in efforts to facilitate that goal or make accommodation as needed to increase overall coordination with MAT providers within the County. The MHP will be monitoring progress on the ED obtaining a MAT provider. Once obtained, the MHP intends on involving the ED as well in MAT coordination.

12. Key Performance Indicators (KPI), Future: Identify **at least 2 key performance indicators** that will be used to assess the implementation and success of **each intervention** (process or outcome, Science of Improvement: Establishing Measures) identified in Question 4 above during the upcoming reporting period. For each indicator, indicate target performance. These KPIs may (but do not have to) differ from those identified in Question 9 based on the Participating Entity's implementation plan. (250 words or less)

The KPIs used to assess implementation and success of both interventions are the 4 KPIs as mentioned in question 9.

The overall goal is for the MHP to achieve at least 1 successfully completed MAT referral and at least 1 additional MAT initiation every other month. Given that in two months of implementation one beneficiary was initiated, this goal has remained successful but will be considered the benchmark for frequency desired for initiations going forward.

This translates to the first two KPIs where the goal for KPI2 would be 1 completed referral every 2 months from August 2023 to March 2024, i.e. a minimum of 4 completed referrals by March 31st 2024. For KPI1, the expectation is that all referrals completed will be successfully processed by Brightheart resulting in 4/4 or 100% for KPI1 for March 31st 2024.

For KPI3, the MHP's targeted outcome is that at least 1 participant is able to maintain continuous MAT treatment for 90+ days. The result of this KPI being achieved would be the achievement of the Aim statement of increasing recorded continuous MAT participation by 100% by March 31st 2023.

For KPI4, the MHP does not have a target on numbers of challenges expected to be reported per individual. This is particularly true given that target population is so small. However, the MHP's target for this KPI is to achieve 100%, where every instance of a reported challenge in the Referral Participation Report will result in a contact attempt by an assigned SUD counselor.

These measures will be calculated and shared at a minimum quarterly with stakeholders, QIC, MHP staff, MCP, and Brightheart. Quarterly analysis will build off of findings from previous quarters to show trends and patterns within the implementation.

Section 3: Beneficiary Identification, Data Exchange, and Stakeholder Engagement

Managed Care Plans and Behavioral Health Plans are jointly responsible for improving longitudinal receipt of pharmacotherapy for opioid use disorder for the entire Medi-Cal covered population. The following section focuses on collaborations and data exchange efforts between Participating Entities and other stakeholders to facilitate the implementation of Selected Interventions and evaluation.

13. Collaborations with Managed Care Plans: What collaborations has the Participating Entity engaged in with Managed Care Plan partners to identify Medi-Cal beneficiaries who may benefit from longitudinal receipt of pharmacotherapy for opioid use disorder? DHCS requires that Behavioral Health Plans engage in good faith efforts collaborate with Managed Medi-Cal Plans.

- **Part A, Description of Collaboration (125 words):** Describe **existing and future** collaborations with Managed Care Plan partners in this clinical area of focus.

  Discussions with MCP have been conducted in the lead up to this PIP with MCP helping to inform process and capture of supplemental data. The MCP has been a continuing resource of information on the MAT population within the county that the MHP has not been aware of. The MCP is collaborating with the MHP by providing regular reports on numbers of Lassen County Medi-Cal beneficiaries are receiving MAT as well as demographics such as sex, age, language, and race. The data provided by the

MCP was essential in understanding the population in conducting an Equity Analysis. When the MHP had no prior local data to learn from, the MCP has been able to step up to provide.
For the direct intervention of this PIP, the MHP has been adamant about involvement with the MCP. However, as the MCP was not reliably able to provide data upon request, would go often unresponsive when requested, or would respond in an untimely manner, leveraging data exchange between the MHP and MCP as a means for the intervention was not a successful endeavor.
For the MHP, collaboration with the MCP is for the purpose of staying informed about the total Lassen County Medi-Cal MAT-participant population to guide implementation. For the MCP, collaboration with the MHP is for the purpose of receiving updates on initiations to remain abreast of POD progress and for confirmation that there are no errors in what they are reporting.

MHP plans to meet quarterly with the MCP to discuss successes or challenges with data exchange, any additional data that can be provided from both parties, and areas needed for improvement.

- **Part B, Description of Data Exchange (125 words):** Identify and describe data exchange efforts between the Participating Entities and other stakeholders to identify beneficiaries eligible for treatment from longitudinal receipt of pharmacotherapy for opioid use disorder. In this response, identify the Entity's ability to access data to drive change towards its Aim Statement. **While no specific type of data exchange is required, Entities are required describe whether and how they are exchanging data in the following ways:** (1) Receiving data from Managed Care Plan partners and (2) Sending data to Managed Care Plan partners

  In trying to still facilitate a mutually beneficial data exchange that wasn't make-it-or-break-it for the interventions, the MCP agrees to send supplemental data as it is released and quarterly upon request. This data is the top-down information on the entire Lassen County Medi-Cal population that the MHP can use to inform progress in capturing as many MAT-participating beneficiaries as possible. This data is received by either the Partnership sFTP or through secure email. The MHP is working with the MCP by uploading monthly lists of active MAT participants that the MHP has captured to the Partnership sFTP. This data is for the purpose of keeping the MCP aware of PIP progress while also providing identification for the MCP to confirm or not, the status of each member as actually receiving MAT. When the MCP would provide this confirmation, it can help to inform the MHP of any discrepancies between what is reported by Brightheart and what is actually being billed through the MCP. In the event of discrepancies, the MHP and MCP will coordinate to identify and address the problem.
  The MHP is hopeful that once onboarding begins with the HIE, that there would be open opportunities for expanded data exchange between the MHP and MCP for the purpose of this PIP.

14. **Collaborations with Health Care Delivery Partners:** What collaborations has the Participating Entity engaged in with Health Care Delivery Partners (e.g. hospitals or clinics) to identify Medi-Cal beneficiaries who may benefit from longitudinal receipt of pharmacotherapy for opioid use disorder? DHCS **does not require but strongly encourages** collaborative relationships of Participating Entities with health delivery partners.

- **Part A, Description of Collaboration (125 words):** Describe **existing or future** collaborations with Health Delivery Partners in this clinical area of focus.
  The primary focus of collaboration for this PIP currently is between the MHP and Brightheart Health, with the hope of including Northeastern and the ED as this PIP progresses. Brightheart is collaborating by working with the MHP to be the primary provider of MOUD treatment that MHP beneficiaries are referred to. Upon identification of a beneficiary wanting MAT, the MHP refers the beneficiary to Brightheart and works together with Brightheart and the individual to complete registration. Following completed referral and linkage, the MHP and Brightheart remain in routine communication. The MHP provides lists of referrals and Brightheart provides status updates. When Brightheart identifies a challenge experienced by a referred participant, the MHP is informed so as to address the challenge and increase likelihood of continued participation. Additionally, Brightheart will utilize the MHP as a fail-safe for when a referred participant is late or absent from any appointments so as to have multiple entities trying to make contact. In the event that the MAT provider would see greater benefit from the participant attending in-person outpatient BH services than through the telehealth services Brightheart provides, a referral to the MHP has been provided for the participant to restart in-person out-patient care.
  Along with weekly contact in the form of data exchange, the MHP plans to conduct quarterly review meetings with the Brightheart provider to discuss successes and challenges in data exchange as well as success and challenges of the participants and where improvements can be made for the sake of increasing initiations, continuous participation, and participation in general for the benefit of this population and for meeting the goals of this PIP.

- **Part B, Description of Data Exchange (125 words):** Identify and describe data exchange efforts between the Participating Entities and other stakeholders to identify beneficiaries eligible for treatment with pharmacotherapy for opioid use disorder. In this response, identify the Entity's ability to access data to drive change towards its Aim Statement. **While no specific type of data exchange is required, Entities are specifically required to describe whether and how they are exchanging data in the following ways:** (1) Receiving data from Health Delivery Partners and (2) Sending data to Health Delivery Partners.

When an MHP beneficiary is diagnosed with OUD by an SUD Counselor, they are offered whether they would like to participate in MAT. If a client consents they are asked to fill out the referral form with attached ROI. The Counselor with call Brightheart and work with the beneficiary and Brightheart to complete registration and scheduling of the first appointment. The Referral form is then sent to the MHP Analyst for recording. The MHP will then scan the referral and ROI to upload into the shared Dropbox between the MHP and Brightheart. Upon upload the MHP Analyst will contact the Brightheart provider to inform them of the referral. The Analyst will do this for every instance of referral. Every Thursday, the Brightheart provider will upload a sheet into the Dropbox containing referral statuses of all referrals that were sent, organized by most recent week. These statuses will indicate to the MHP any one that has denied the referral, went unresponsive, or confirmed appointment. This information can then be used by the MHP to make contact and address as to why a referral wasn't successful. Then bi-weekly, every other Thursday, the Brightheart provider will upload a spreadsheet to the Dropbox identifying everyone referred by the MHP and what their status is for participation. This will indicate those that are participating continuously, how many days of continuous participation, who has missed appointments, and who has dropped out. Additionally, notes will be included by the provider to indicate successes or challenges identified or expressed by the participants, and whether or not they are receiving outpatient services with Brightheart. The MHP Analyst cross references the provided list with the EHR to identify who is active with the MHP and can be confirmed as a beneficiary that can still be provided billable services. The MHP can then leverage this data to inform SUD counselors of need to make contact and what areas need to be and can be addressed for each participant.

The MHP is continuing efforts to include Northeastern Rural Health Clinic into this process to increase the scope of awareness of MAT participants within the County as well as monitoring progress on the ED's MAT program to hopefully do the same.

15. Data Exchange Strategy: Identify and describe data exchange efforts between the Participating Entities and other stakeholders to identify beneficiaries eligible for treatment with longitudinal receipt of pharmacotherapy for opioid use disorder and to assess performance via Key Performance Indicators and drive change towards its Aim Statement. (250 words or less, Reference: Submission for 9/30/2022, Question #17).

The MHP identified the following steps needed in order to measure and improve performance on this Aim and plan to access (collect / exchange) the data moving forward:

Receiving Data –

1. Creation of tracking lists, standardized and intuitive. Completed by BH Analyst with input and approval from stakeholders

2. MHP will receive weekly data from Brightheart and develop process for cleaning and recording data into tracking sheets. Data received, recorded, and analyzed from Brightheart will form the indicator for the success of achieving the Aim.

3. MHP will receive quarterly informing data from the MCP for BH Analyst to reference tracking data and report to stakeholders for feedback and adjustment

4. Institution of HIE in October 2023 and meetings with MCP will open up MHP to potential for further direct data exchange, hopefully improving timeliness and scope of MCP data access, potentially necessitating restrategizing on data exchange infrastructure, capacity, and processes. This applies as well to the ED for when they have an operational MAT Program.

Sending Data –

1. MHP Analyst compile weekly list from EHR of OUD beneficiaries. If newly registered, information is relayed to SUD counsellors to recommend MAT Referral

1. MHP Analyst compiles lists of daily MAT referrals provided by the SUD Counselors. The data is securely sent to the Brightheart Provider via Dropbox on the day of receipt.

2. Upon receiving data from MAT Providers, MHP will standardize procedures for analyzing and reporting on MAT participants, generating lists of MAT participants who would benefit from care coordination with the SUD Counselors, Caseworkers, Therapists, or other community agencies. Lists generated by the MHP Analyst will be sent to the participants' assigned SUD counselors for best delegation to address identified needs.

3. Monthly, the MHP will upload a spreadsheet of all active MAT Participants and new initiations over the last month to the MCP Partnership sFTP. The MCP will use this data for their own purposes of identifying internal errors but will inform MHP of areas in which assistance or clarification is needed.

4. Institution of HIE in October 2023 and meetings with MCP will open up MHP to potential for expanded direct data exchange, particularly with the MCP and ED, potentially necessitating restrategizing on data exchange infrastructure, capacity, and processes. This applies to the ED for when they have an operational MAT Program.

Data Element	**Source of Data**	**Method of Exchange**	**Function of Data**
Identifying information of MHP Beneficiaries with OUD	MHP EHR	MHP Analyst to SUD Counselors – EHR notification, secure email, or hand delivery	To inform or remind SUD counselors of new OUD beneficiaries so as to recommend MAT referral
Identifying Information on beneficiaries referred to MAT	MHP MAT Referral	SUD Counselors – Secure email or Hand Delivery	For recording and tracking of beneficiaries referred and for relaying to Brightheart for tracking of participation
Beneficiary Referral Status	Weekly Referral Status Spreadsheet	Brightheart- uploaded and retrieved from secure shared Dropbox	For recording and tracking of initiations and for relaying to SUD counselors to address reasons for not initiating MAT

Beneficiary Participation Status	Bi-Weekly Participation Status Spreadsheet	Brightheart- uploaded and retrieved from secure shared Dropbox	For recording, tracking and identifying continuous participation to meet the Aim Statement and for relaying challenges and lack of progress to SUD counselors to reach out and address.
Total County Medi-Cal MAT population – Demographics, numbers, participation	Quarterly MCP reports	MCP – Partnership sFTP or secure email	For analysis of success in MHP capturing greater rates of MAT participants, and for BH Analyst to reference tracking data and report to stakeholders for feedback and adjustment. Informs equity analysis and can identify additional disparities to be addressed

16. Data Exchange, Narrative: Briefly describe the Participating Entity's experience since the last BHQIP submission regarding data exchange. Identify any challenges faced and lessons learned specific to the implementation of the improvement plan (125 words or less).

In trying to facilitate data exchange during the formulation of this PIP, the MHP ran into multiple challenges. This ranged from the initial intended entity for collaboration closing its MAT Program, to roadblocks in achieving consistent communication and collaboration with the other local MAT Provider Northeastern, roadblocks in achieving positive collaboration with the MCP in a reliable, consistent, or timely manner, and complete restrategizing for what was possible given current MHP data infrastructure after plans for HIE integration were not able come to fruition by the time of needed implementation. It's important to mention again

that the MHP had to change EHRs in July 2023 leading to a period of training, adjustment, and relearning methods of data access, cleaning, compilation, and reporting.

Since implementing the interventions, data exchange has been successful, though has been slow of pace. The MHP has a low number of beneficiaries with an OUD diagnosis to begin with. An EHR report in September 2023 only identified 6 individuals with OUD, and only two of the individuals were still active users in need of MAT. With only one accepting MAT services, the amount of data exchange conducted so far is not enough to conclude full success in the process. However, for the one individual that was referred, all data exchange elements were completed with success. The Analyst was able to properly identify those needing referrals; the SUD counselors were able to offer the referrals and walk the accepting beneficiary through the process of registration with Brightheart. Information on the referral was successfully sent by the MHP to Brightheart via Dropbox; Brightheart was later able to provide the referral status report indicating that the beneficiary had not yet initiated MAT services; this information was then able to be relayed to the SUD counselors to attempt contact; the information was uploaded to Partnership sFTP – no response from MCP yet. While the MCP did not respond to upload of beneficiary status, that is to be expected unless there is an error that the MCP wishes to gain assistance or clarification from the MHP.

While the example is only for one event of referral, the process of the Data Exchange Strategy was followed and completed successfully.

17. MOUD Treatment Access: Identify engagement of the Participating Entity with the initiatives of the MAT Expansion Project or other efforts to improve care access to pharmacotherapy for opioid use disorder. (250 words or less)

- **Part A:** Is the Entity collaborating with entities funded by the MAT Expansion Project? (Yes/No)
  No
- **Part B**: Describe any engagement of the Participating Entity with MAT Expansion Project-funded projects or other efforts to improve access to medications for addiction treatment (MAT), also known as medications for opioid use disorder (MOUD). (125 words or less)
  The MHP is not currently engaged with the MAT Expansion Project or related MAT Expansion Project-funded projects. The MHP is however working to improve access to MAT in its referral to telehealth providers that can be accessible to everyone in disparate parts of the county. During the referral process, the MHP's focus on SDOH barriers is intended to identify barriers that individuals would have to accessing MAT so that Counselors are informed of areas needing to be addressed.

With the goal of including coordination with other MAT providers aside from Brightheart, the MHP intends to be able to offer referrals to individuals for all MAT providers within the county so that the beneficiary is able to have agency in choosing the appropriate provider for them and are able to start MAT at the earliest available opportunity.

18. Beneficiary Engagement: Address when and how beneficiaries will be engaged in the period prior to the next reporting period in 9/29/2023. Specifically, address how beneficiaries will be engaged

Beneficiary feedback is essential on understanding the impact and success of this intervention. For the week of May 15th 2023, the MHP issued a consumer perception survey with additional questions related to BHQIP PIPS. The surveys were issued to all active MHP beneficiaries. Of the respondents, 0 indicated any MAT involvement. This can be a reflection of simply the supreme minority of beneficiaries with OUD that are seeking MAT. The MHP will continue to ask MAT-related questions in surveys delivered to the entire MHP population. However, as tracking and identification increases of the MHP's MAT population, surveys for beneficiary input will be geared particularly to those participating in MAT and impacted by the intervention. This will allow the MHP to derive direct feedback from those who are the focus of the interventions.

Going forward, the MHP is always seeking beneficiary involvement in the QIC and PIP review, with providers routinely asking beneficiaries if they are interested and offering participation. In lieu of active participation in QA/QI, beneficiary input on the PIP process and progress will continue to be sought through routine surveys.