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FY 2023-24 MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

AMADOR DRAFT REPORT

MHP

DMC-ODS

Prepared for:

**California Department of Health Care
Services (DHCS)**

Review Date:

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type – Virtual

Date of Review – August 24, 2023

MHP Size – Small-Rural

MHP Region – Central

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	3	2	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	4	2	0
Quality of Care	10	5	5	0
Information Systems (IS)	6	4	2	0
TOTAL	26	17	9	0

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Peer-Led Support Group After a Crisis Event	Clinical	01/2022	Other - Completed	Moderate
Timely Access	Non-Clinical	01/2022	Implementation	Moderate

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	<input checked="" type="checkbox"/> Adults <input type="checkbox"/> Transition Aged Youth (TAY) <input type="checkbox"/> Family Members <input type="checkbox"/> Other	5

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP continues to expand their peer workforce.
- Extensive community collaboration is clear.
- The MHP takes action to address transportation needs.
- The MHP now has a certified Medi-Cal biller.
- A wide range of measures and goals directed at access, timeliness, and quality care are evident.

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

- There is no aggregate data for the child/youth outcome measures in use.
- Staff request face-to-face training on the new electronic health record (EHR).
- The MHP does not track nor trend urgent requests aggregately.
- California Department of Public Health (CDPH) publications indicate that Amador County is high for suicide and self-harm.
- The MHP relies heavily upon manual tracking and spreadsheets.

Recommendations for improvement based upon this review include:

- Create reports on aggregate child/youth outcome measures in order to understand outcomes for members and program performance.
- Regularly reassess staff need for additional training on the new EHR and in what format would be most helpful to them.

- Begin to track and trend urgent requests by age group and foster care status.
- Continue to monitor crisis utilization and appropriate linkage to outpatient services.
- Work with the new EHR vendor to create key reports necessary for management of the MHP operations.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

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

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2023-24 findings of the EQR for Amador County MHP by BHC, conducted as a virtual review on August 24, 2023.

REVIEW METHODOLOGY

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

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

CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (CY) 2022 and FY 2022-23, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – summary of the validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5, and also as outlined DHCS's Comprehensive Quality Strategy. Data definitions are included as Attachment E.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place after significant snow fall and flooding particularly in Jackson, the county seat, where homes, cars, and affordable housing were lost. The MHP notes that in February 2023, the weather resulted in a building shutdown, many cancelled or missed member appointments, and staff unable to report to work.

SIGNIFICANT CHANGES AND INITIATIVES

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

- Both peer employees are now Certified Peer Specialists. The MHP has successfully developed a job description and a supervisor position for potential career growth. Although the supervisory position is not yet budgeted, they have made substantial progress.
- In response to a rise in crisis demands, the MHP successfully trained all clinical staff on 5150 holds and is planning to expand their data collection regarding the use of crisis services. An increase in female youth crisis has been identified. The MHP shared that, according to the most recent data from CDPH, during 2012-2021, Amador County had the second highest suicide rate in the State of California and was ranked as the highest for self-harm. There is an expectation that the new EHR will offer expanded capabilities to evaluate these trends. Further, the MHP created a full time Crisis Services Counselor position, however it is currently vacant.
- The MHP implemented the California Advancing and Innovating Medi-Cal (CalAIM) Screening and Transition Tools on May 8, 2023, training their case manager staff to complete screenings, thus, freeing up clinicians for increased access to those in need of SMHS. This was also part of their nonclinical PIP's second year. Line staff shared in the review that this has been a helpful change for them, although not measured in quantitative terms.
- MHP saw the retirement of their nine-year veteran Quality Improvement/ Utilization Review (QI/UR) Coordinator II in March 2023, which was promptly filled. This resulted in PIPs being assumed by a lead who was new to these processes.

- Training and implementation were under way most of the year for a new EHR. Credible went live July 1, 2023. The MHP seems optimistic about future data expansion capabilities.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2022-23

Recommendation 1:

As planned, provide staff 5150 certification and crisis service training. Regularly assess need and provide ongoing training and mentoring to build competence and confidence. This may also support the MHP's staff retention goals. (Quality)

Addressed Partially Addressed Not Addressed

- The MHP stated that this is not only addressed but is now a regular part of their onboarding process for clinical staff.
- Line staff verification indicated general satisfaction with the training and crisis duty responsibilities.

Recommendation 2:

As started with the non-clinical PIP, analyze reasons for a higher rate of one to three services as compared to the state rate. Identify engagement barriers. Conduct QI if indicated. (Access, Quality)

Addressed Partially Addressed Not Addressed

- The non-clinical PIP is being terminated before a more robust root cause analysis is complete. Utilization data was explored resulting in the identification of female youth as fast-growing utilizers of crisis services in their system.
- MHP made significant movement in this direction with a new over/under utilizer report which is presented to the director and in QI meetings. Examples were given where prompt action was taken to support those specific members.

- The reasons for the higher rate require further evaluation and the MHP expects that the new EHR will provide that opportunity and further guide decisions about utilization and retention.
- While this item is rated partially addressed, it is not carried over in a recommendation for this year's review due to its substantial progress and other priority recommendations identified.

Recommendation 3:

Select and implement outcome measures or indicators to measure beneficiary level outcomes in adults and children services. (Outcomes)

Addressed Partially Addressed Not Addressed

- The MHP continues to utilize Milestones of Recovery Scale (MORS) for adults and the Child and Adolescent Needs and Strengths (CANS) for youth. There is evidence of increased collection, trending, and clinical use of these tools in the past year, which is validated by line staff.
- MHP states the absence of aggregate data, notably a significant barrier with the previous EHR, is expected to be overcome with the new EHR. Although the recommendation is considered addressed, the MHP is encouraged to continue and expand collection, clinical use, and aggregate evaluation of outcome measures when the tools become available.

Recommendation 4:

Continue to monitor crisis utilization. Review access patterns such as member demographics, reasons related to seeking services, prior attempts to use services to identify any interventions to improve or mitigate acute services for members. Review the high-risk factors that have been identified in the literature for youth as starting points to consider. (Access, Quality)

Addressed Partially Addressed Not Addressed

- Demographic data for crisis utilization is now shared and discussed regularly at QI meetings. There is expressed hope that the new EHR will further this exploration and expand these efforts.
- Considering elevated self-harm and suicide rates, and growing crisis utilization trends, this recommendation is being continued this year. Continue to explore patterns in crisis utilization particularly reasons related to seeking services and as it relates to youth.

Recommendation 5:

Complete incorporating the HEDIS measures outlined in SB 1291 in the medication monitoring system. Track the components, regularly assess practices, and conduct QI when needed. (Quality)
(This recommendation is a continuation from FY 2021-22.)

Addressed

Partially Addressed

Not Addressed

- MHP provided evidence for the completion of this recommendation with the caveat of the metabolic monitoring, which accidentally fell off the tracking mechanism and is being corrected. This information for foster youth is now regularly tracked in QI meetings and is part of psychiatric chart audits.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, 84.3 percent of services were delivered by county-operated/staffed clinics and sites, and 15.7 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 96.1 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county and contract provider staff; members may request services through the Access Line as well as through walk-in or phone call to the clinic and the jail. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. Members receive the CalAIM Screening Tool from trained case management staff and are assessed by clinicians. After the utilization process is complete, the member receives the first appointment to begin treatment. The CalAIM Transition Tool is used for those found to fall under nonspecialty mental health services (NSMHS) to link them with the managed care plan.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/telephone to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 196 adult members, which includes older adults, and 44 youth members across 1 county-operated site and 1 contractor-operated site. Among those served, no members received telehealth services in a language other than English in the preceding 12 months.

¹ [CMS Data Navigator Glossary of Terms](#)

NETWORK ADEQUACY

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

In December 2022, DHCS issued its FY 2022-23 NA Findings Report for all MHPs based upon its review and analysis of each MHP’s Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

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

Table 1A: Amador MHP Alternative Access Standards, FY 2022-23

Alternative Access Standards	
The MHP was required to submit an AAS request due to time or distance requirements	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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

Table 1B: Amador MHP Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP presents an extensive network of community collaboration, outreach, and partnerships. All possible partners identified by CalEQRO were established. In addition, the MHP has a peer specialist specifically assigned to member and community outreach, including attendance in a wide range of community stakeholder meetings.
- Transportation is a significant barrier for members to access services in this county. The MHP presents many ways this is addressed, including a wide variety of services available from their mobile team, including in-home assessments for those experiencing urgent need, post hospitalization follow-ups, and resource linkage from certified peers. Further, members validate that they have been offered transportation assistance.
- While the MHP does not have a threshold language other than English, the MHP assesses language access when needed, reviews Latino penetration rates regularly, and conducts outreach to Latino communities and other community populations.
- Members express appreciation for the office support team who reportedly make it easy to schedule or reschedule appointments, which is an improvement from member comments in the prior review.
- Although the 24-hour line is easily obtained on the department website, it is not clear if it may be used for accessing services or only for “crisis” services. Further, the website contains outdated information. It appears that the most updated information is on the Amador County Behavioral Health Network of Care site, which has a link but no description of what could be found there. This poses a potential barrier to members seeking services.

ACCESS PERFORMANCE MEASURES

Members Served, Penetration Rates, and Average Approved Claims per Member Served

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

The penetration rate (PR) is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with an average approved claim amount of \$7,442. Using PR as an indicator of access for the MHP, Amador demonstrates better access to care than was seen statewide.

Table 3: Amador MHP Annual Members Served and Total Approved Claims CY 2020-22

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	9,812	846	8.62%	\$3,613,145	\$4,271
CY 2021	9,063	812	8.96%	\$3,716,411	\$4,577
CY 2020	8,235	690	8.38%	\$2,877,389	\$4,170

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

- The numbers of eligibles and members served have been trending upwards over the past three CYs. Total PR, approved claims, and AACM were all slightly lower in CY 2022 than CY 2021 but higher than in CY 2020.

Table 4: Amador MHP Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	1,043	18	1.73%	1.63%	1.82%
Ages 6-17	2,114	186	8.80%	8.62%	5.65%
Ages 18-20	449	48	10.69%	6.55%	3.97%
Ages 21-64	5,200	556	10.69%	7.37%	4.03%
Ages 65+	1,009	38	3.77%	3.60%	1.86%
Total	9,812	846	8.62%	6.67%	3.96%

- The largest eligibility group by age in Amador was adults aged 21-64, followed by youth ages 6-17. These were also the groups with the largest numbers of members served.
- The PRs in all the age categories were higher than statewide with the exception of the ages 0-5. The highest PRs were for ages 21-64 and ages 18-20.
- Total PR was higher in the MHP than statewide and in similar sized counties.

Table 5: Threshold Language of Amador MHP Medi-Cal Members Served in CY 2022

Threshold Language	# Members Served	% of Members Served
No threshold language	n/a	n/a
Threshold language source: Open Data per BHIN 20-070		

- There were no threshold languages in the MHP for CY 2022.

Table 6: Amador MHP Medi-Cal Expansion (ACA) PR and AACM CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	3,069	240	7.82%	\$1,119,360	\$4,664
Small-rural	38,250	2,337	6.11%	\$11,818,209	\$5,057
Statewide	4,831,118	164,980	3.41%	\$1,051,087,580	\$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This pattern

held true in the MHP for PR, but the ACA population in Amador had a higher AACM than the overall Medi-Cal SMHS AACM.

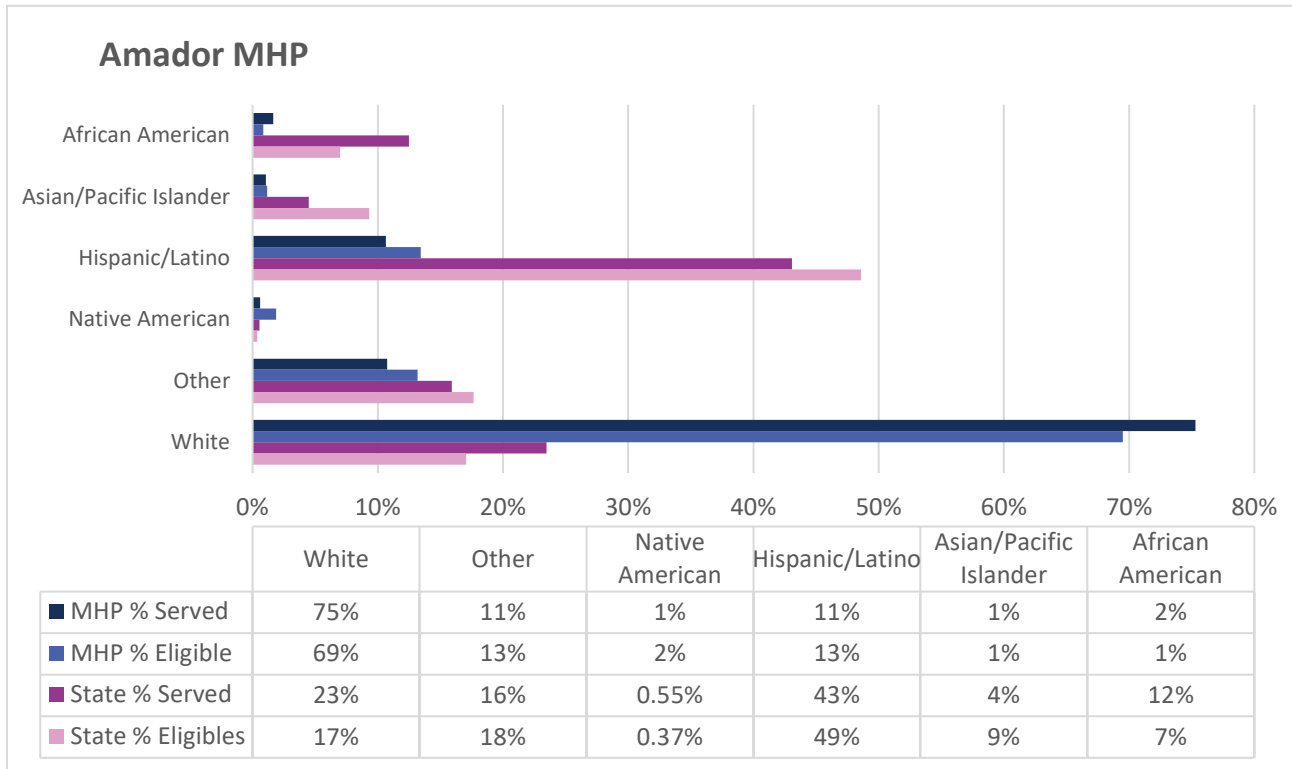
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they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

Table 7: Amador MHP PR of Members Served by Race/Ethnicity CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	84	14	16.67%	7.08%
Asian/Pacific Islander	115	<11	-	1.91%
Hispanic/Latino	1,317	90	6.83%	3.51%
Native American	185	<11	-	5.94%
Other	1,293	91	7.04%	3.57%
White	6,821	637	9.34%	5.45%
Total*	9,815	846	8.62%	3.96%

- The largest racial/ethnic group of eligibles was White, followed by Hispanic/Latino, and Other. The White group were, by far, the largest group of members served, as they are the largest eligible population.
- PRs for all racial/ethnic groups were higher in the MHP than statewide, except for Native American.

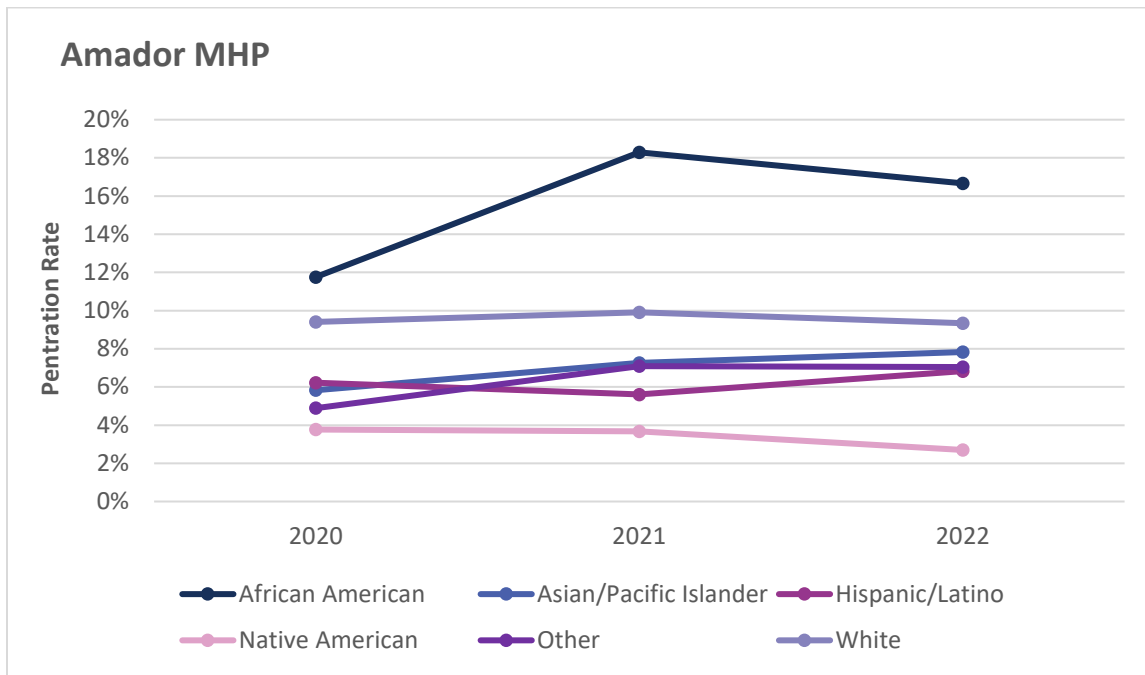
Figure 1: Race/Ethnicity for MHP Compared to State CY 2022



- The county had a much higher proportion of White eligibles, and much lower proportion of Hispanic/Latino eligibles, than the state as a whole.
- The most proportionally overrepresented racial/ethnic group in the MHP was White, and the most proportionally underrepresented groups were Other and Hispanic/Latino.

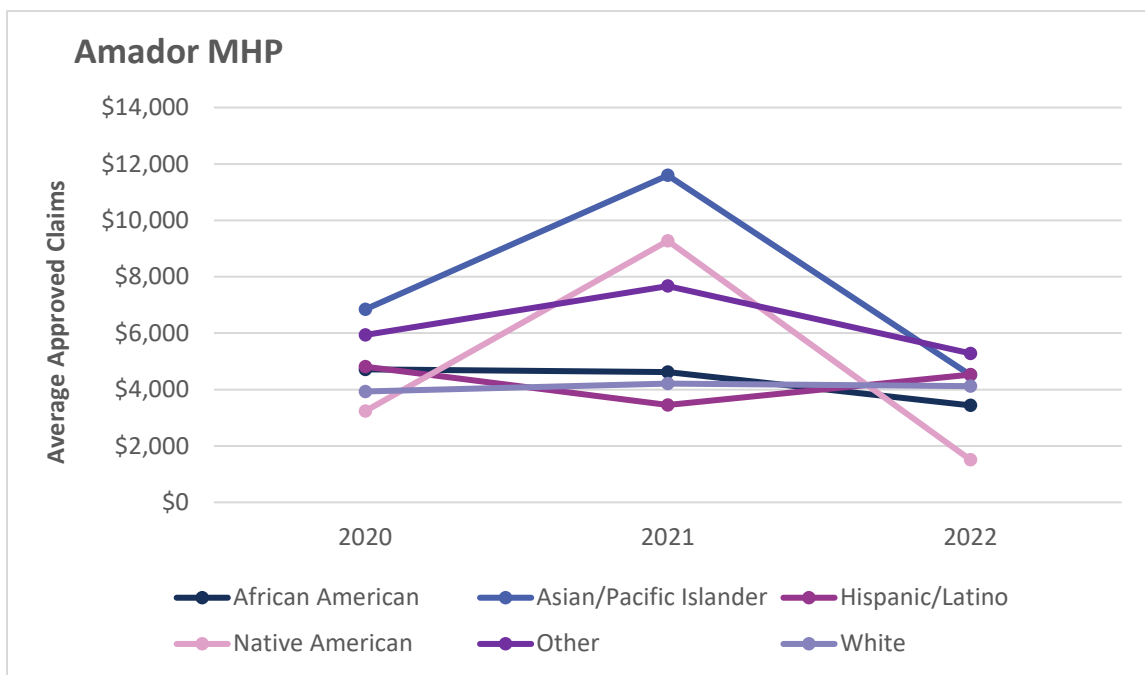
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

Figure 2: MHP PR by Race/Ethnicity CY 2020-22



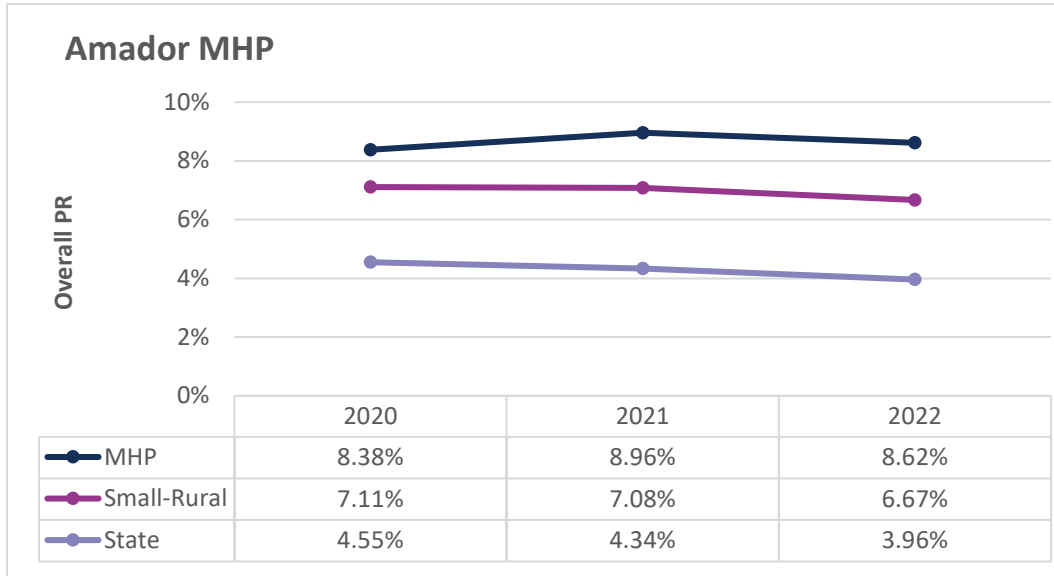
- PRs for most racial/ethnic groups have been stable over the past three years. PRs for African Americans and Whites have consistently been the highest, whereas PRs for Native Americans have consistently been lowest in the MHP.

Figure 3: MHP AACM by Race/Ethnicity CY 2020-22



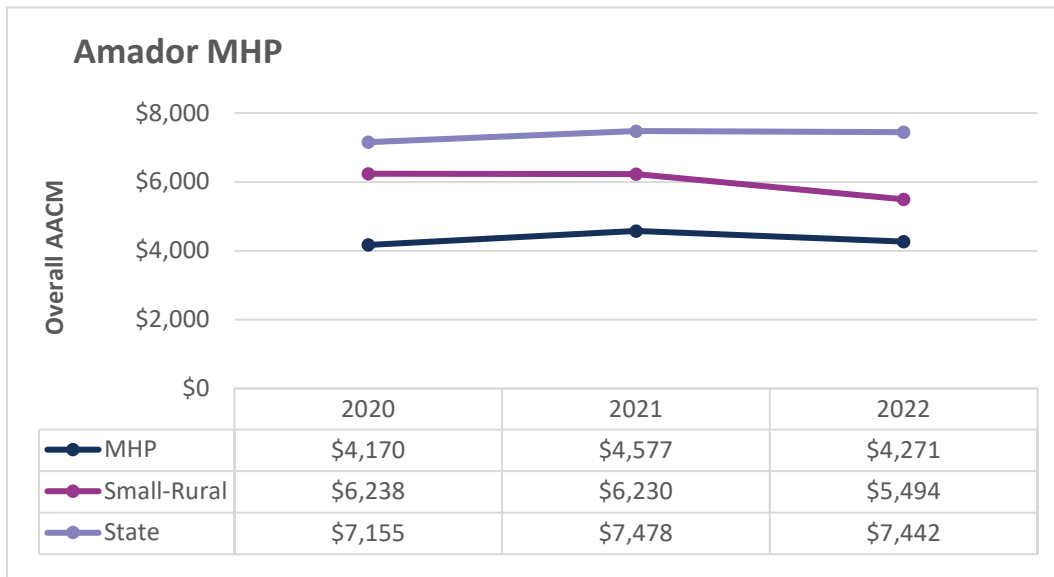
- There are more dramatic looking fluctuations in AACMs across the past three years in the Asian/Pacific Islander and Native American populations. This is likely due to a few outlier members in these groups with small numbers having higher claims and influencing the average (mean).

Figure 4: Overall PR CY 2020-22



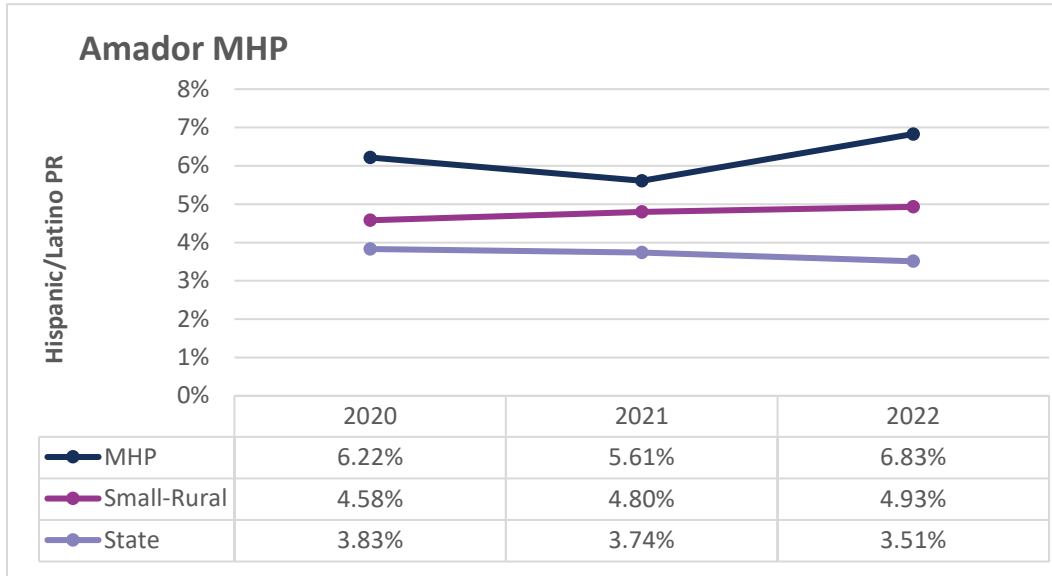
- PR trended slightly downward from CY 2021 to CY 2022 in the MHP, similar sized counties, and statewide. The MHP's PR has been consistently higher than in similarly sized counties and statewide.

Figure 5: Overall AACM CY 2020-22



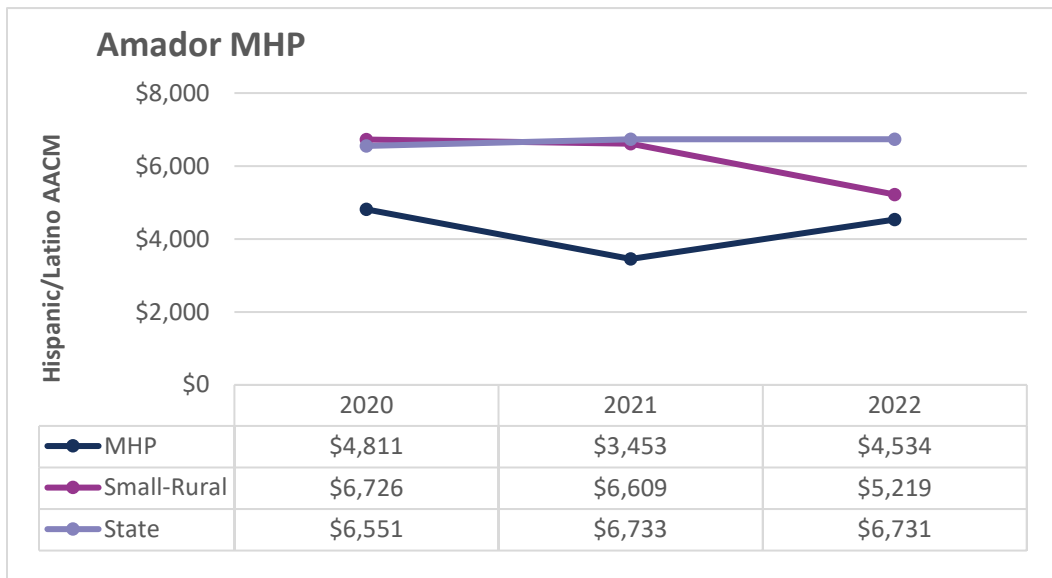
- AACM has been consistently lower in the MHP than in other small-rural counties and statewide, and the gap has been narrowing between other small-rural counties and the MHP. For CY 2022, AACM in Amador was 78 percent of similar sized county AACM, and 57 percent of the statewide AACM.

Figure 6: Hispanic/Latino PR CY 2020-22



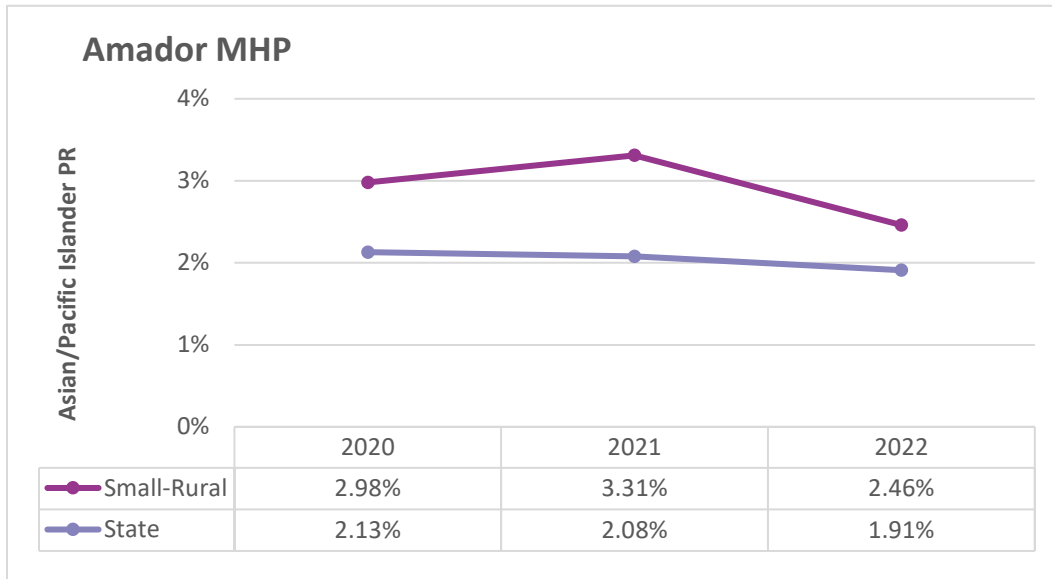
- The Hispanic/Latino PR has been consistently higher than PRs for this population in small-rural counties and statewide.

Figure 7: Hispanic/Latino AACM CY 2020-22



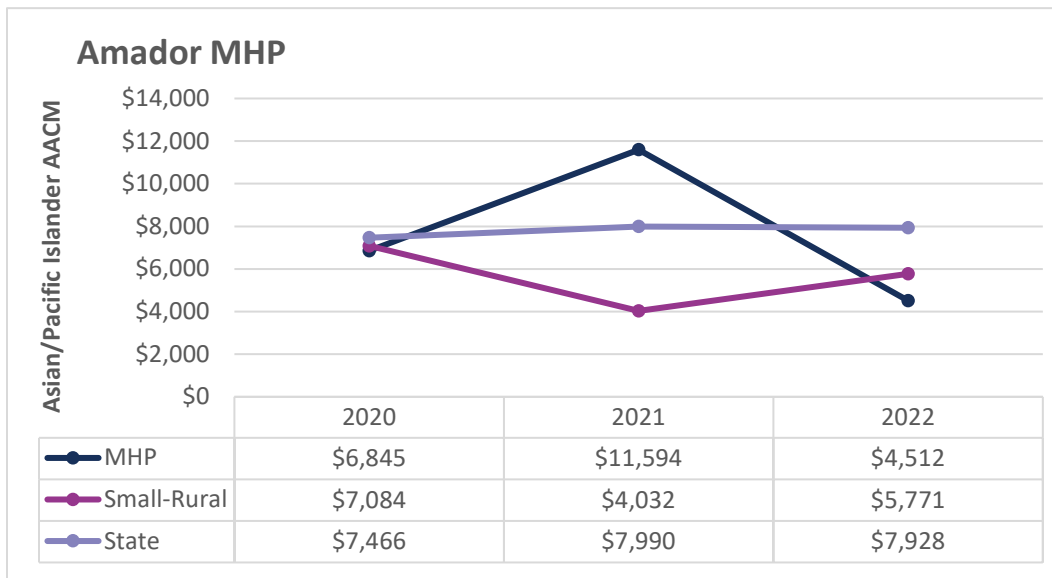
- AACM for Hispanic/Latino members in the MHP has been consistently lower than AACMs in small-rural counties and statewide for the past three years.

Figure 8: Asian/Pacific Islander PR CY 2020-22



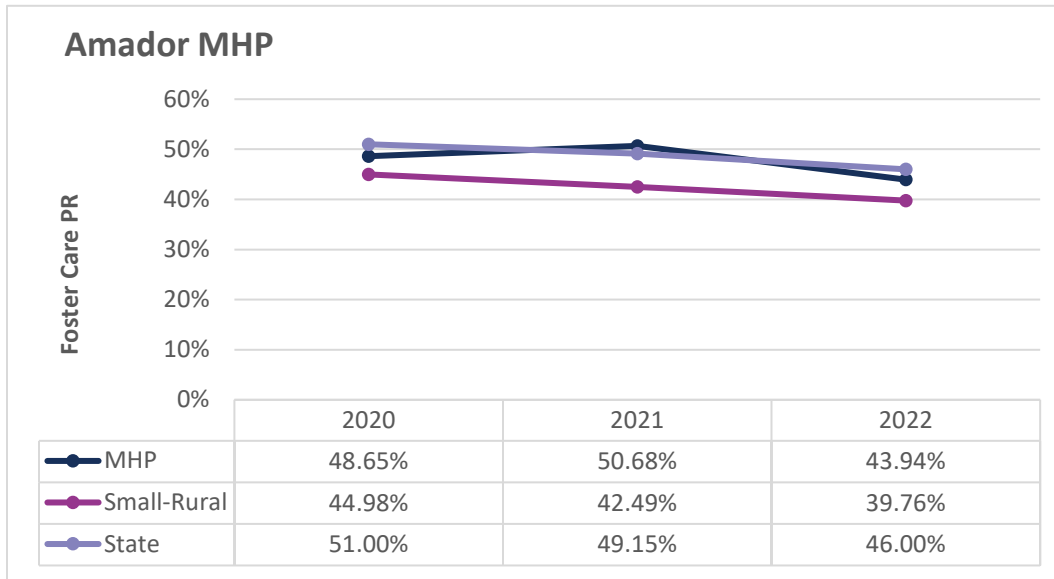
- The MHP’s Asian/Pacific Islander PRs for the past three years are suppressed due to low numbers. The MHP has been consistently higher than small-rural counties and statewide.

Figure 9: Asian/Pacific Islander AACM CY 2020-22



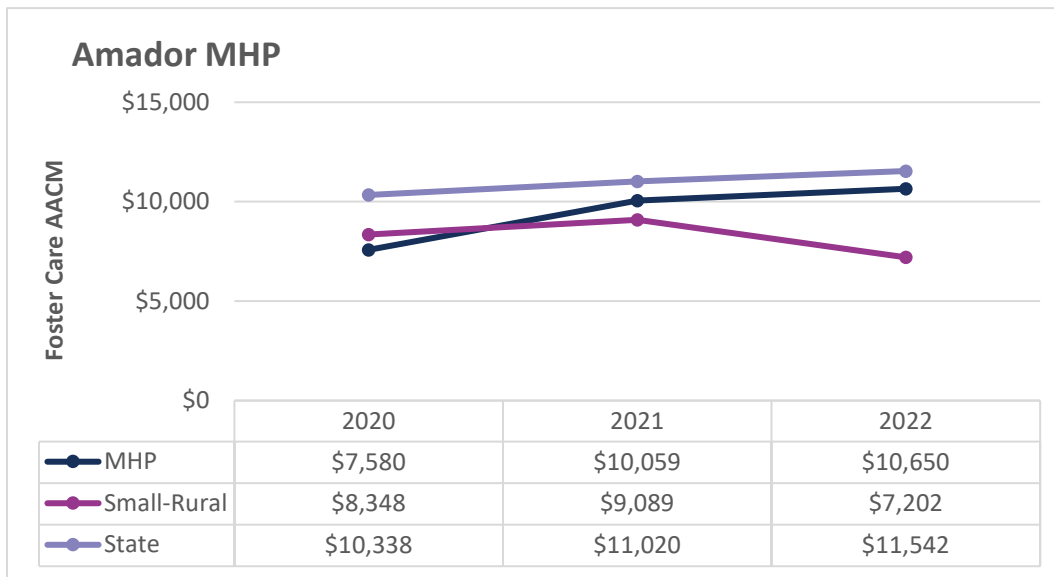
- The Asian/Pacific Islander AACM has been higher than in other small-rural counties and statewide in CY 2021, but it was lower than in other small-rural counties and statewide in CY 2022.

Figure 10: Foster Care PR CY 2020-22



- FC PR increased slightly in the MHP from CY 2020-21 but decreased in CY 2022 to below the CY 2020 PR.
- The MHP’s FC PR has been comparable to statewide, and higher than in similarly sized counties, for the past three years.

Figure 11: Foster Care AACM CY 2020-22



- Statewide FC AACM has increased each year for the past three years. The MHP’s FC AACM has been increasing as well, though it remains slightly lower than the statewide FC AACM.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by Amador MHP to Adults

Service Category	MHP N = 642				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	9	7.0	10.3%	14	8
Inpatient Admin	0	0.0%	0	0.0	0.4%	26	10
Psychiatric Health Facility	32	5.0%	19	10.0	1.2%	16	8
Residential	0	0.0%	0	0.0	0.3%	114	84
Crisis Residential	<11	-	2	2.0	1.9%	23	15
Per Minute Services							
Crisis Stabilization	<11	-	1,950	1,200	13.4%	1,449	1,200
Crisis Intervention	169	26.3%	191	120	12.2%	236	144
Medication Support	350	54.5%	152	120	59.7%	298	190
Mental Health Services	513	79.9%	431	210	62.7%	832	329
Targeted Case Management	251	39.1%	174	20	36.9%	445	135

- Inpatient, Psychiatric Health Services and Crisis Residential treatment was the only per day service with any utilization in CY 2022 and, taken together, had lower utilization than that seen statewide. For context, Amador does not have any inpatient beds or crisis residential program within the county.
- Mental Health Services, Medication Support, and Targeted Case Management (TCM) were the most used outpatient services in the MHP. While the Mental Health Services and TCM utilization rates were higher than those seen statewide, Medication Support utilization was a bit lower. Crisis Intervention also had much higher utilization rates than seen statewide.
- All outpatient services had fewer billed minutes than statewide averages, except for crisis stabilization, though the median units were the same as statewide for that service.

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

Service Category	MHP N = 29				Statewide N = 33,243		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	7	7	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	<11	-	1,560	1,560	3.1%	1,166	1,095
Crisis Intervention	<11	-	86	65	8.5%	371	182
Medication Support	<11	-	594	466	27.6%	364	257
TBS	<11	-	2,914	2,914	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Home Based Services	<11	-	417	568	40.8%	1,458	441
Intensive Care Coordination	<11	-	1,043	914	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	28	96.6%	2,174	426	95.4%	1,846	1,053
Targeted Case Management	<11	-	1,149	65	35.8%	307	118

- The only per day service provided to FC youth was inpatient, with a utilization rate that was slightly higher than statewide, albeit based on a small number of members served.
- As with statewide, the most-used service for FC youth was Mental Health Services, though the median units in the MHP were 60 percent lower than statewide.
- In general, utilization rates were comparable to statewide with a few exceptions. Crisis intervention was used at a higher rate in the MHP than statewide, whereas Intensive Case Coordination and Intensive Home-Based Services had lower

utilization rates than statewide, and significantly lower units of service per youth served.

- Except for crisis stabilization, average billed units for all other outpatient services were lower in the MHP than statewide.

IMPACT OF ACCESS FINDINGS

- New supervisory staff in Social Services had an impact on the referral process for foster youth. This break in communication related to the referrals has been corrected.
- The MHP is leveraging the CalAIM screening tool and has trained their case management staff to use it at the point of access. The goal was to ease demand on clinicians by appropriately identifying mild/moderate needs prior to assessment, and then speed up the time to the first treatment appointment. This was part of the second-year efforts on their nonclinical PIP. Line staff verified that this has been helpful and effective in improving the access process.
- Although most updated and detailed information can be found on the secondary Network of Care website, this is not clearly indicated to members on the MHP's main Website.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- Adult members expressed a high degree of satisfaction with the expediency of outpatient scheduling, psychiatric access, and crisis services.

- Significant exploration of the no-show/cancelation data is reviewed in the quarterly utilization review meeting. It is broken down by provider and other aggregate categories, and appropriate actions are taken when trends are noted. Further, members verify that they receive communication when they miss an appointment. Improvement is seen in this area when compared to the prior report.
- Although the MHP meets their same day standard of responding to urgent requests, data is not tracked and trended by age group or foster youth status.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care.

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

Table 11: FY 2023-24 Amador MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	2.32 Business Days	10 Business Days*	98.33%
First Non-Urgent Service Rendered	3.33 Business Days	10 Business Days**	93.58%
First Non-Urgent Psychiatry Appointment Offered	9.93 Business Days	15 Business Days*	86.9%
First Non-Urgent Psychiatry Service Rendered	14.08 Business Days	15 Business Days**	63.07%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	0.02 Hours ***	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	3 Days	7 Calendar Days	77.4%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	3 Days	30 Calendar Days	84.9%
No-Show Rate – Psychiatry	12.79%	15%**	n/a
No-Show Rate – Clinicians	13.46%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033			
** MHP-defined timeliness standards			
*** The MHP does not separately report urgent timeliness for services requiring prior authorization			
For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23			

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

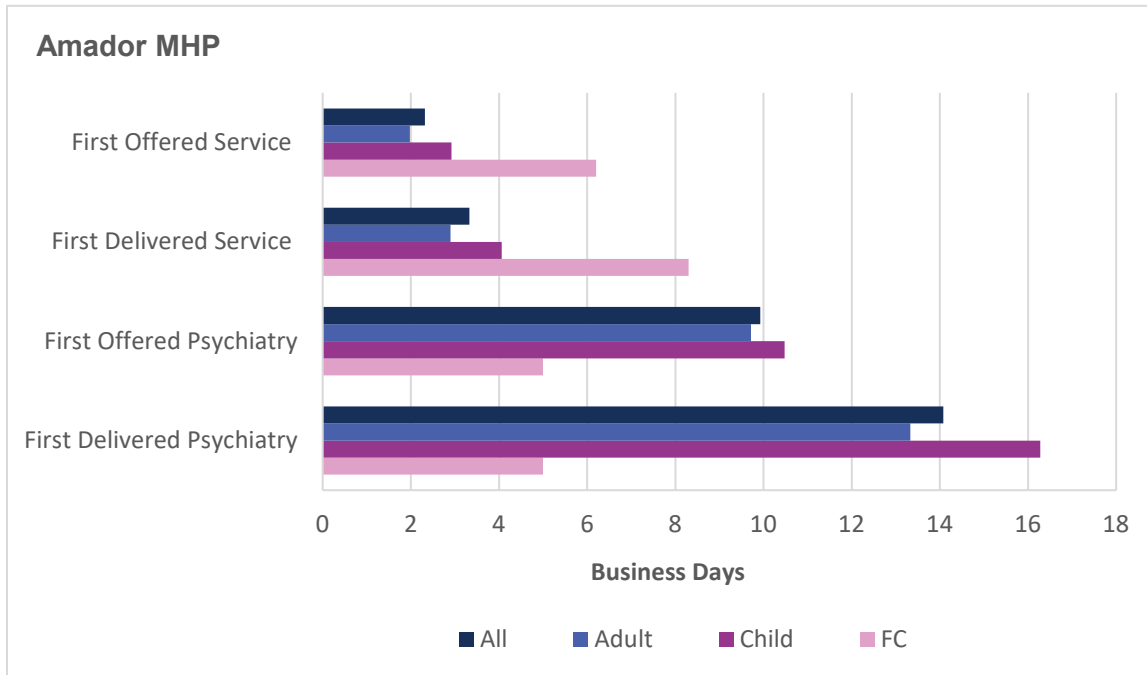


Figure 13: Wait Times for Urgent Services

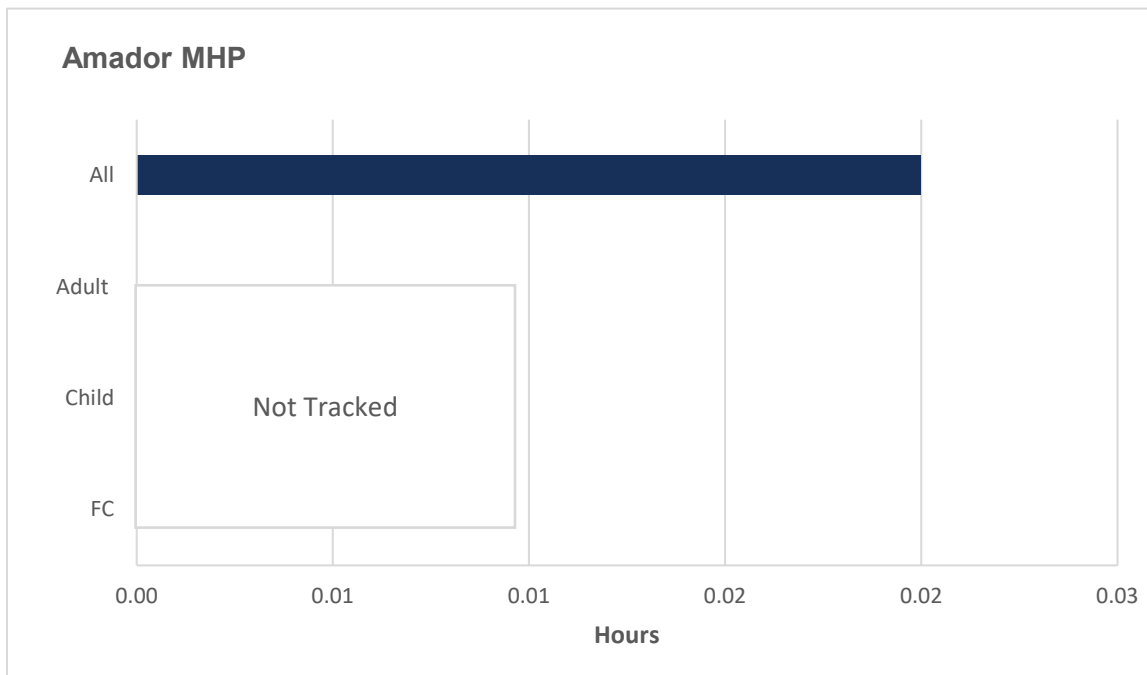
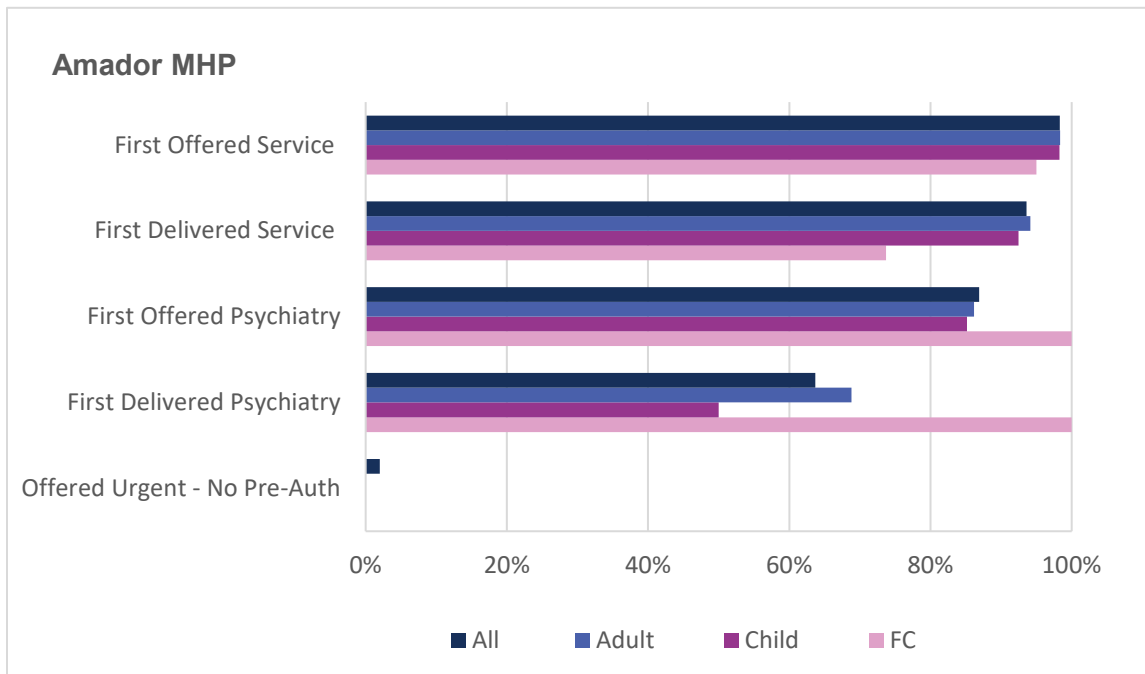


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14 represent scheduled assessments. The MHP’s submitted data shows timely initial access to care.
- The MHP defined “urgent services” for purposes of the ATA as crisis service which included after hours and 5150 evaluations. There were reportedly 810 urgent service/crisis requests with immediate response averaging 0.02 hours.
- A 15-business day standard is expected for initial access to psychiatry, though the MHP may define when and how this is measured, and often MHP processes, definitions, and tracking may differ for adults and children. The MHP defines timeliness to first delivered psychiatry service as from the point of UR team approval of clinical need and opening to the psychiatric services unit to the date of first offered appointment for all new members to psychiatry.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 12.79 percent for all services, 12.21 percent for adults, and 9.39 percent for youth.

IMPACT OF TIMELINESS FINDINGS

- Overall, the MHP shows timely initial access to care. Members state they are satisfied with timeliness and frequency of services for outpatient, crisis, and psychiatry.

- The MHP has taken substantial action to explore no-show data and apply improvement strategies.
- The MHP has met most of its timeliness standards in the past year. The lowest rates that met the standard was first non-urgent psychiatry service at 63.7 percent for overall population.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is the QI/UR Coordinator who falls under the Compliance Officer in structure, and is supported by an Administrative Assistant, Administrative Technician, and the Fiscal Officer.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of MHP leadership, QI Coordinator, clinical supervisors, and peer staff, is scheduled to meet bi-monthly. The MHP also convenes a quarterly UR/QI Leadership committee meeting. Since the previous EQR, the MHP QIC met 17 times and the UR/QI Leadership committee met 4 times. Of the 53 identified FY 2022-23 QAPI workplan goals, the MHP shows consistent monitoring and progress for most goals in their meeting minutes. It was too early in the review year to obtain their annual workplan evaluation, but they provided a comprehensive example from FY 2021-22 wherein the MHP had met a majority of its goals.

The MHP utilizes an internal level of care (LOC) tool combined with a UR approval process. Changes to a member's LOC are clinically determined then submitted for UR approval by completing the Action Form. The UR team meets several times per week to review and approve every change in LOC. Identified trends are addressed in real time.

The MHP utilizes for outcome tools the MORS for adults and the Pediatric Symptom Checklist with the CANS for youth.

The EHR used in FY 2022-23 was able to generate outcome reports for the MORS data for the clinicians' use. In the last year, efforts were made to increase the number of MORS collected and the trends were reviewed quarterly at UR meetings wherein plans to address trends were developed. Specifically, the data was used to look at members who had obtained a score of seven and may be better served by transition to NSMHS. The historical EHR was unable to generate aggregate reports on CANS data; however, the MHP plans to do so with the new EHR.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- The MHP QM processes include routine and quarterly review of data relating to QAPI goals, compliance, cultural competency, and many internal performance measures. There is evidence that the QI activities take action to improve quality of care based in data-driven decisions.
- Incorporating trends or dashboards to understand performance more easily over time is an area to develop especially given the number of metrics being monitored.
- The MHP manually enters Consumer Perception Survey (CPS) results locally to expedite their use of the information. Collection numbers are increasing post-pandemic which seems common across MHPs. Line staff validates that the results are shared, and their feedback is solicited. The MHP does not review

year-to-year results and could not provide an example of use for continuous quality improvement.

- Members indicate that they are unaware of ways to provide their input about system planning or delivery, but state general satisfaction with access, timeliness, and quality of care.
- The MHP is not yet tracking, trending, or reporting on aggregate data for youth outcome measures.
- Peer staff express a sense that their efforts appear to have a direct positive impact on member satisfaction and benefit.
- The MHP does track but does not yet provide reports of trends and analysis of the four Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5

QUALITY PERFORMANCE MEASURES

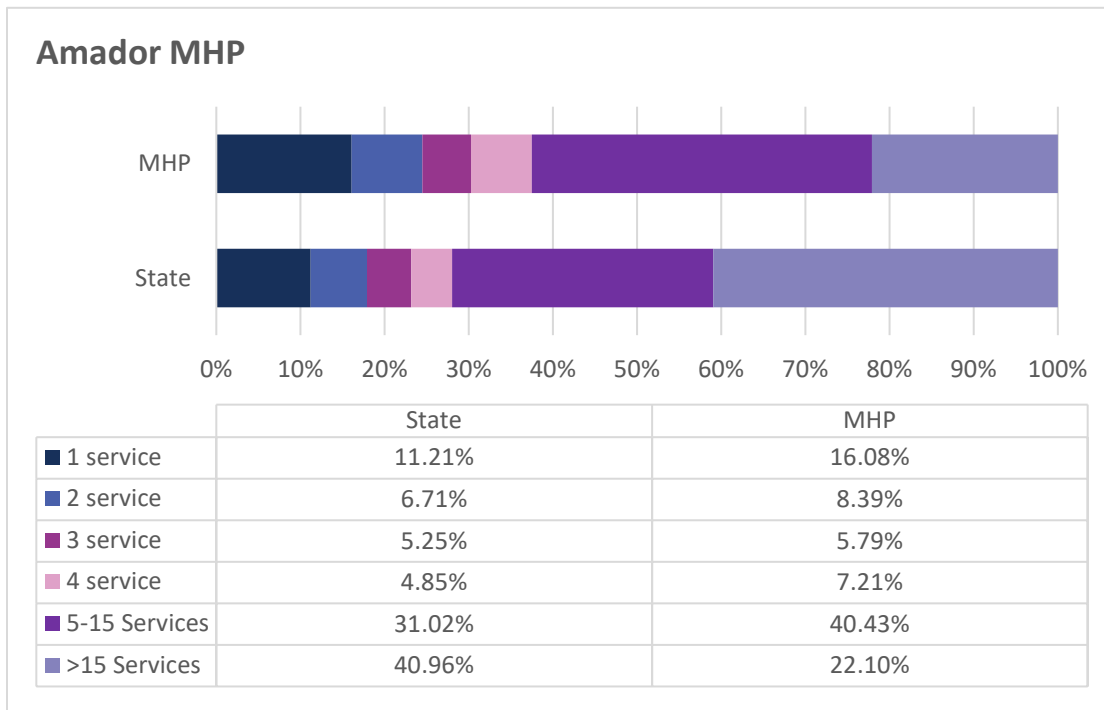
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Members Served CY 2022

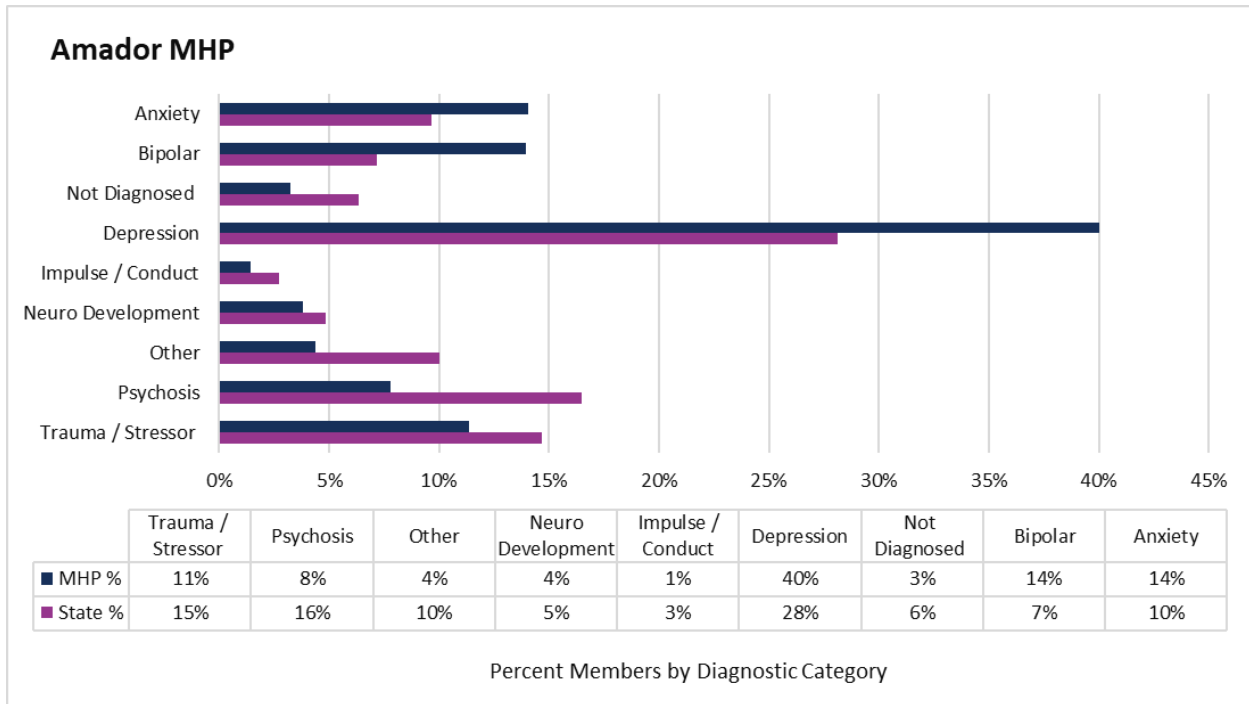


- The MHP had higher proportions of members who received 1 or 2 services than statewide and had a much lower proportion of members receiving greater than 15 services than statewide – third lowest in the state.
- A plurality of members received between 5 and 15 services, also third highest in this category among the 56 MHPs.

Diagnosis of Members Served

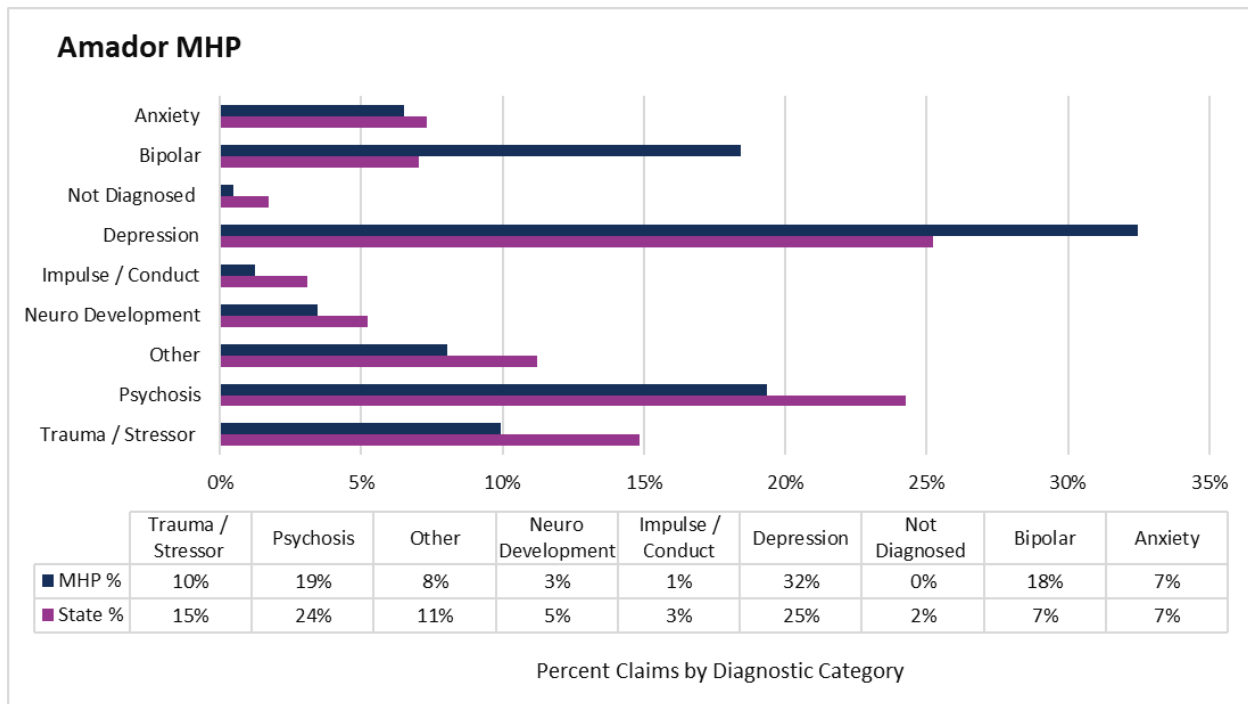
Developing a diagnosis, in combination with level of functioning, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP’s claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared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

Figure 16: Diagnostic Categories by Percentage of Members Served CY 2022



- The MHP had a higher proportion of beneficiaries diagnosed with Depression, Bipolar, and Anxiety than statewide, and lower proportions of beneficiaries in all other diagnostic categories than statewide.
- The most prevalent diagnostic category in the MHP was Depression, which represented 40 percent of members.

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2022



- Depression accounts for 40 percent diagnoses and 32 percent of claims, Trauma/Stressor-related diagnoses accounted for 11 percent of diagnoses and 9 percent of claims, Bipolar accounted for 14 percent of diagnoses and 18 percent of claims, Anxiety accounted for 14 percent of diagnoses and 7 percent of claims.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average length of stay (LOS).

Table 13: Amador MHP Psychiatric Inpatient Utilization CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	53	75	11.66	8.45	\$16,596	\$12,763	\$879,600
CY 2021	50	67	12.99	8.86	\$17,729	\$12,696	\$886,461
CY 2020	41	49	9.47	8.68	\$10,993	\$11,814	\$450,733

- The number of unique members and total admissions have increased over the past three years.

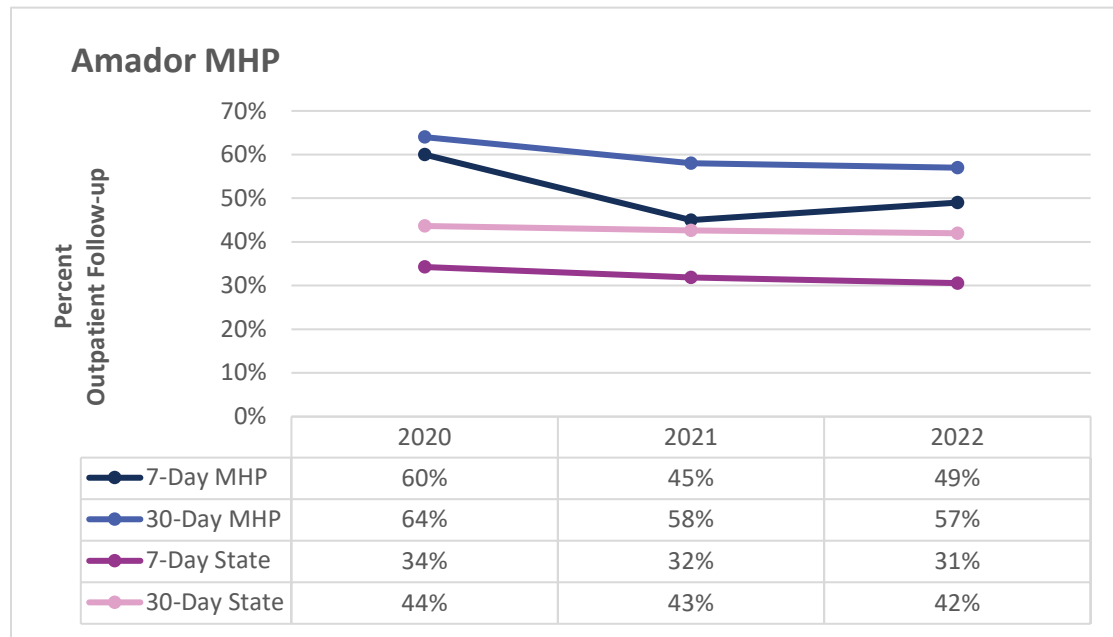
- The average LOS had increased in CY 2021 but decreased in CY 2022, both years higher than statewide. Inpatient AACM and total approved claims in the MHP followed this same pattern.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

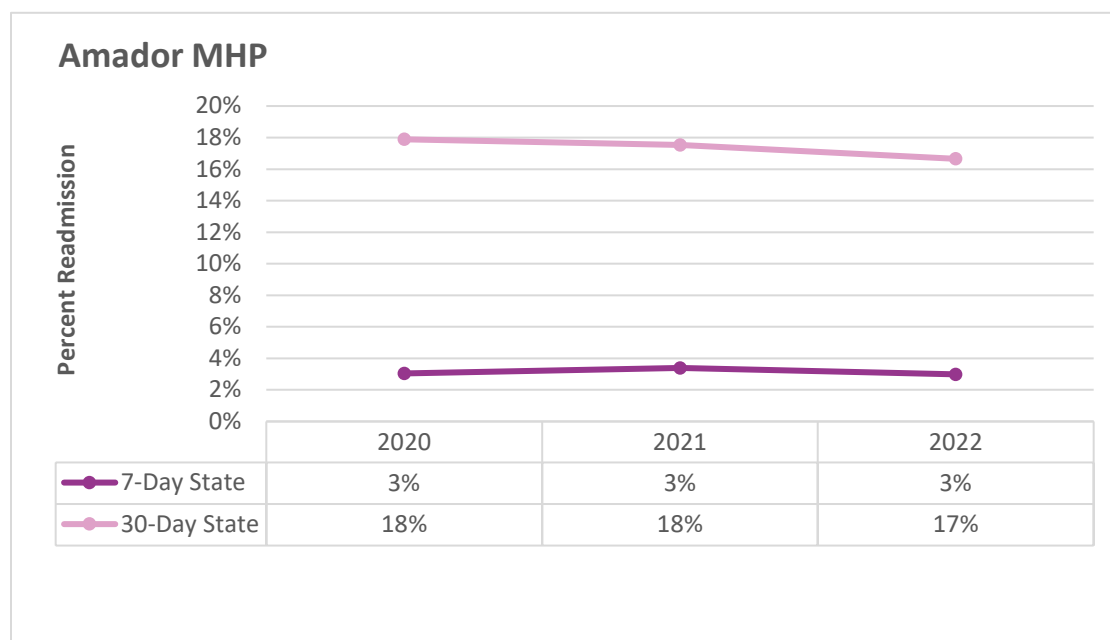
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and are reflected in the rate to which individuals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

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2020-22



- 7- and 30-day post psychiatric inpatient follow-up rates have consistently been higher in the MHP than statewide over the past three years.

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2020-22



*The MHP's data is not displayed above due to the small number of members represented.

- Both 7- and 30-day psychiatric readmission rates in the MHP have consistently been much lower than statewide readmission rates. However, in CY 2022, the MHP's 30-day readmission rate was slightly higher than the statewide rate.

High-Cost Members

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

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCBs in this table are identified as those with approved claims of more than \$30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is \$7,442, the median amount is just \$3,200.

Table 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than \$20,000 annually) and receive 54 percent of the

Medi-Cal resources, with an AACM of \$4,364 and median of \$2,761 for members in that cost category.

Table 14: Amador MHP High-Cost Members (Greater than \$30,000) CY 2020-22

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	\$1,514,353,866	\$55,518	\$44,346
MHP	CY 2022	16	1.89%	28.27%	\$1,021,337	\$63,834	\$55,616
	CY 2021	17	2.09%	22.09%	\$821,028	\$48,296	\$44,263
	CY 2020	13	1.88%	20.56%	\$591,691	\$45,515	\$37,581

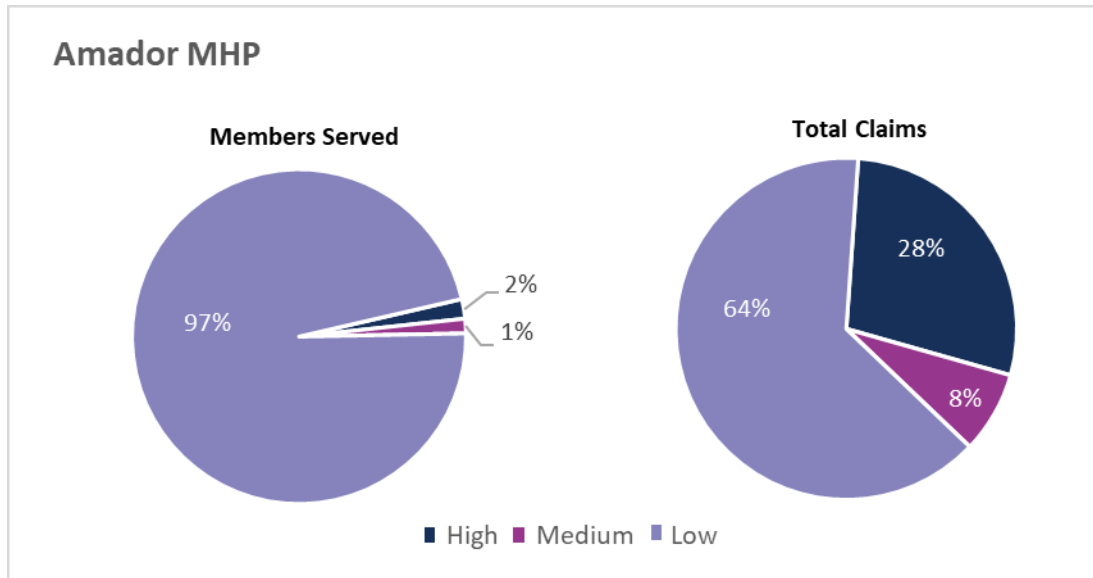
- The total counts and percentages of members served considered to be HCMs has been small for the past three years, though approved claims on behalf of HCMs have increased by 73 percent since CY 2020 and median approved claims have steadily increased as well.
- The MHP indicated that they have identified a few people who obtained Medi-Cal in Amador, then left and were hospitalized repeatedly outside of their awareness, which may impact this data.

Table 15: Amador MHP Medium- and Low-Cost Members CY 2022

Claims Range	# of Members Served	% of Members Served	Category Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost (\$20K to \$30K)	12	1.42%	7.74%	\$279,556	\$23,296	\$21,428
Low-Cost (Less than \$20K)	818	96.69%	64.00%	\$2,312,253	\$2,827	\$1,740

- 96.69 percent of members fell into the low-cost category, and the median approved claims per member in that category was \$1,740.

Figure 20: Amador MHP Members and Approved Claims by Claim Category CY 2022



- Almost all of the members served fell into the low-cost category, representing about 97 percent of all members and 64 percent of claims.
- While HCMs represented just 1.89 percent of members, 28 percent of all claims were attributable to HCMs.

IMPACT OF QUALITY FINDINGS

- In response to rising crisis demand and suicide rates, the MHP has created a new crisis services counselor position, is considering a new PIP, and is beginning to explore more deeply the associated data trends within the QI Committee. Additional data points are expected to be available with the new EHR.
- The MHP has been consistently proactive for members after hospitalization with 7- and 30-day post psychiatric inpatient follow-up rates higher than statewide over the past three years.
- There was a disruption to QI/UR processes, including PIPs, when the MHP lost their veteran QI/UR Coordinator II, but the position was promptly filled.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330² and 457.1240(b)³. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Peer-Led Support Group after a Crisis Event

Date Started: 01/2022

Date Completed: 06/2023

Aim Statement: Will providing a peer lead group to clients who have recently accessed crisis reduce inpatient utilization over the course of a fiscal year? Additionally, will access to this peer lead group increase a client's overall level of hope?

Target Population: The population in the PIP will be adult (18 years or older) Medi-Cal beneficiaries who qualify for services through the MHP and have accessed the crisis program.

Status of PIP: The MHP's clinical PIP is in the phase Other – Completed but was active during the majority of the last 12 months.

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

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

Summary

The MHP attempted to reduce psychiatric hospitalization rates among their adult population by implementing a peer support group for those who received crisis contacts. Preliminary data supported that they could improve the percentage of meeting their goal of a 7-day follow-up after hospitalization. Also, additional peer support within crisis services in general had been requested by peer staff, line staff, and members. As an outcome measure, they introduced the Hope Scale which was based on the concepts of recovery with peer support.

Although a decrease in hospitalization rate did occur between the measured fiscal years, the lack of engagement within the group makes it impossible for the MHP to link the peer group intervention to this improvement. Further, too few participants were retained in the group long enough to collect all Hope Scale measures across time. The group is now a known fixture of services and is held in hybrid format to overcome transportation barriers in the county.

The MHP sought TA in April 2023 where ideas for ensuring all those eligible for the intervention were offered the peer-led groups and a second intervention, The Hope Scale, to make the results more evident.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because the design was valid and credible. However, other indicators or controls would have made a stronger relationship between the outcomes and interventions, and thus a stronger PIP.

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

- Include an outcome indicator that reports on the total number of beneficiaries in the target group (beneficiaries who use crisis services) and the total number who receive the intervention. It may also be possible to follow a sample of unique individuals across time.
- Include a process indicator to ensure the implementation plan is occurring as intended. Provider referral to the group alone, which should also be measured, does not provide the intervention to all the eligible beneficiaries and reduces the validity and potential of the PIP design.
- Consider how the Hope Scale may be a useful outcome measure after the PIP is terminated.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Timely Access

Date Started: 1/2022

Date Completed: Planned termination for 12/2023

Aim Statement: The timeliness from assessment appointment to first offered treatment appointment will be within the 7-business day goal 80% of the time by December 2023.

Target Population: This PIP will affect all new mental health clients accessing services upon the completion of their assessment appointment.

Status of PIP: The MHP's non-clinical PIP is in the implementation phase and expected to end 12/2023.

Summary

The non-clinical PIP focuses upon timeliness of getting to the first treatment appointment after assessment and review by the UR team. They established the baseline of 15 percent meeting their 7-day goal. In the first year, they increased the frequency of UR team meetings to increase the rate of opening for scheduling in the system. Surveys were used to explore root causes and get stakeholder feedback from members and line staff.

After TA in April 2023, additional interventions were added for the second year while acknowledging the impact of staffing shortages and turnover. The CalAIM Screening Tool was implemented along with training for case management staff to open time for clinicians to get the assessments to the UR team more rapidly. Despite the additional interventions, the final outcome was an increase from baseline to 29%, still significantly short of their aim. The MHP plans to continue these efforts beyond the PIP and expects a continued gradual improvement in timeliness to the first treatment appointment.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because steps through the PIP process over the last two years have been valid, consistent, and intentional. The MHP captured root cause data, communicated with stakeholders, and based it on HEDIS measures. Methods are clearly written except for the percentage goal, but whether 50 or 80 percent, it was not met. The plan is to continue efforts beyond the PIP for the benefit of members and staff.

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

- It may be beneficial to the quality improvement process, to know the rates for both youth and adults aggregately.
- Other measurements of the second-year data may provide additional evidence for a link between the interventions and the end result. Consider the number of members who were referred to NSMHS because of using the screening tool.
- Consider whether the UR review is necessary prior to psychiatric evaluation since this service does not require pre-authorization. This step may add to delays to treatment initiation.
- With change of the EHR, include how this will impact the data collection in the final quarters of the PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California’s MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Credible by Qualifacts which has been in use for one month. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop. The go-live date for Credible, which will also be supported by Kings View, was July 1, 2023.

Approximately 8.2 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving the MHP and General Services - IT.

The MHP has 32 named users with log-on authority to the EHR, including approximately 29 county staff and 3 contractor staff. Support for the users is provided by one full-time equivalent (FTE) IS technology position.

As of the FY 2023-24 EQR, all contract providers have access to directly enter clinical data into the MHP’s EHR. Contract providers are able to execute direct entry of member practice management and service data to the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to Amador MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	<input type="checkbox"/> Real Time <input type="checkbox"/> Batch	0%
Electronic Data Interchange to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
Electronic batch file transfer to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
Direct data entry into MHP IS by provider staff	<input checked="" type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	100%
Documents/files e-mailed or faxed to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
Paper documents delivered to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP does not currently have a PHR, but it will be implementing one within the next year as part of the new EHR.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information with its contracted providers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP's Medi-Cal claim denial rate is 1.17 percent, which is below the statewide average 5.92 percent, indicating fiscal/billing staff are knowledgeable.
- The newly implemented EHR lacks some functions at this phase of the implementation, but the MHP anticipates additional functionalities will be rolled out by Kings View in the next six months.

- The security of the system could be improved. Suggested methods may be implementing two-factor authentication to authorize password changes or providing staff with regularly scheduled training in cyber-security.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

Table 18 appears to reflect a largely complete or very substantially complete claims data set for the time frame represented.

Table 18: Summary of Amador MHP Short-Doyle/Medi-Cal Claims CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	702	\$227,873	\$2,430	1.07%	\$225,443
Feb	771	\$224,374	\$2,453	1.09%	\$221,921
Mar	1,048	\$334,704	\$3,617	1.08%	\$331,087
April	871	\$262,134	\$3,803	1.45%	\$258,331
May	1,065	\$298,675	\$2,087	0.70%	\$296,588
June	1,031	\$302,608	\$5,669	1.87%	\$296,939
July	851	\$235,780	\$1,666	0.71%	\$234,114
Aug	1,056	\$308,348	\$4,933	1.60%	\$303,415
Sept	991	\$294,950	\$742	0.25%	\$294,208
Oct	831	\$258,269	\$773	0.30%	\$257,496
Nov	757	\$277,516	\$2,631	0.95%	\$274,885
Dec	814	\$324,369	\$8,439	2.60%	\$315,930
Total	10,788	\$3,349,600	\$39,243	1.17%	\$3,310,357

- The claims volume across CY 2022 was consistent, as were monthly approved claims.

Table 19: Summary of Amador MHP Denied Claims by Reason Code CY 2022

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other healthcare coverage must be billed first	51	\$14,246	36.30%
Medicare Part B must be billed before submission of claim	45	\$13,811	35.19%
Other	48	\$6,544	16.68%
Service line is a duplicate and repeat service modifier is not present	12	\$1,817	4.63%
Service location NPI issue	3	\$1,417	3.61%
Beneficiary is not eligible or non-covered charges	4	\$1,204	3.07%
Deactivated NPI	2	\$203	0.52%
Total Denied Claims	165	\$39,242	100.00%
Overall Denied Claims Rate	1.17%		
Statewide Overall Denied Claims Rate	5.92%		

- The MHP has a very low denied claims rate of 1.17 percent, as compared to the statewide rate of 5.92 percent.
- The majority of denied claims were denied due to other healthcare coverage or Medicare Part B needing to be billed first. These two denial reasons accounted for about 71 percent of denied dollars, though due to the low denial rate this represents only \$28,057.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The transition to Credible, supported by Kings View, was implemented as of July 1, 2023. In general, the rollout went smoothly, though staff indicated they would have benefitted from more live training opportunities with hands-on practice using the EHR before the go-live date.
- The new EHR will have more reporting and analytic functionality coming online to enhance the use of MORS, CANS and PCS-35 data. This will enable greater capacity in the MHP for data-informed decision making and QI efforts.
- The MHP has a certified Medi-Cal biller, and the MHP's low claims denial rate endorses the presence of fiscal staff with a strong knowledge base, providing the system with stable funds.
- The MHP does not have an IT person that is dedicated to their department, relying on county IT staff to address their needs. The MHP would likely benefit from having dedicated staff, particularly in light of the increased demands introduced by CalAIM initiatives.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP does collect CPS surveys annually as required. To be able to apply the data as soon as possible, they take the additional step of manually entering and compiling results themselves. During the review, the MHP indicated that they had not considered comparing results year-to-year and noted that they would begin looking at those results as well. The number of survey respondents dropped during the pandemic but seemed to be increasing again in the last year. The MHP utilizes other member survey efforts and puts consideration into methods to increase collection of CPSs.

PLAN MEMBER/FAMILY FOCUS GROUP

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

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

Consumer Family Member Focus Group

This group of adult consumers was held virtually and included five participants, one of whom initiated services in the preceding 12 months. All members participating receive clinical services from the MHP, and one member also had a family member receiving clinical services from the MHP.

Members of the focus group were resoundingly satisfied with many facets of their care with the MHP, including access ease and expediency. They mentioned a large packet at intake, but the front office staff were helpful, and the initial appointment was scheduled within a week. They seemed to indicate clinicians being impacted with higher caseloads, but still receive treatment at least every two weeks. They stated no problems with cultural competency, having family members involved, or getting care even before they had Medi-Cal. At least two stated this experience, as compared to other MHPs

they had utilized, was impressive to them. They were aware of transportation assistance, wellness centers, the ability to change providers if appropriate, and indicated that they believed they could get prompt and effective help if they needed urgent care.

Regarding services outside of the MHP, they noted general dissatisfaction with primary care options in the county.

Recommendations from focus group participants included:

- All members who participated stated they would recommend services with the MHP and thus had no recommendations to improve services. “Yes, I would recommend highly for behavioral health in this county... overall I’m very happy with the services I receive here... I’m overjoyed, they have helped me tremendously.”
- The intake packet was notably large, but they stated no problems with getting it completed or understanding the materials.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Member feedback indicates that at least adult members are highly satisfied with services from the MHP.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP continues to expand their peer workforce, has made significant progress on creating a peer career ladder, and empowers their peer staff in many areas to the benefit of their members. (Quality)
1. Community collaboration is seen across the MHP, both at the leadership and stakeholder levels. (Access)
2. Transportation is a significant barrier for members in this county, and the MHP takes extensive action to address this need. (Access, Quality)
3. The MHP now has a certified Medi-Cal biller with high claims approval rates. (IS)
4. At monthly QI meetings, and especially at the quarterly utilization meetings, the MHP looks at a wide range of measures and goals directed at access, timeliness, and quality care. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Aggregate data for child/youth outcome measures are not routinely tracked, trended, or reported. (Quality)
2. Staff requested access to additional in-person training opportunities for the new EHR. (IS)
3. MHP does not track or trend urgent requests by age or foster care status. (Timeliness)
4. Amador County ranks among the highest in the state for suicide and self-harm. (Access, Quality)
5. The MHP relies heavily upon manual tracking and spreadsheets for report generation. Greater efficiency may be possible if the necessary tools can be built into the new EHR. (Quality, IS)

RECOMMENDATIONS

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

1. Utilize the expanded data capabilities of the new EHR to collect aggregate child/youth outcome measures. Begin to use this data to improve or adapt services at the program or system level. (Quality)
2. Regularly reassess staff need for additional training on the new EHR and in what format would be most helpful to them. This could support improved efficiencies in documentation and provide ongoing support as additional features and updates are made by the vendor. (Quality, IS)
3. Begin to track and trend urgent requests by age group and foster care status. This may help inform exploration of crisis utilization and retention trends. (Timeliness)
4. Continue to monitor crisis utilization and appropriate linkage to ongoing outpatient care. Review access patterns such as beneficiary demographics, reasons related to seeking services, and prior attempts to use services to identify any interventions to improve or mitigate acute services for beneficiaries. Review the high-risk factors that have been identified in the literature for youth as starting points to consider. (Access, Quality)
(This recommendation was continued from FY 2022-23.)
5. Work with Kings View to create reports for system management that will eliminate the need for manual spreadsheet tracking. (Quality, IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from the MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CaIEQRO Review Agenda

CaIEQRO Review Sessions – Amador MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year’s recommendations
Validation and Analysis of the MHP’s Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP’s PIPs
Validation and Analysis of the MHP’s PMs
Validation and Analysis of the MHP’s Network Adequacy
Validation and Analysis of the MHP’s Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Primary and Specialty Care Collaboration and Integration
Clinical Line Staff Group Interview
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
EHR Deployment
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Heather Claibourn, Lead Quality Reviewer
Marcia Marsh, Information Systems Reviewer
Arden Tucker, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Abbott	Gail	Peer Personal Services Coordinator (PSC)	ACBH
Brush	Patricia	Clinician 1	ACBH
Burke	James	Peer Personal Services Coordinator (PSC)	ACBH
Cranfill	Melissa	BH Director	ACBH
Garner	Tammy	Clinician 3	ACBH
Grau	Angie	Compliance Officer	ACBH
Hess	Stephanie	MHSA Coordinator	ACBH
Hixon	Amy	SUD Program Manager	ACBH
Hoskins	Rebekah	Personal Services Coordinator (PSC)	ACBH
Kramer	Julie	Personal Services Coordinator (PSC)	ACBH
Malaspino	Erica	Administrative Technician	ACBH
Masterson	Kayla	Clinician 2	ACBH
Mitchell	Jackie	Crisis Coordinator	ACBH
Newlun	Sylvia	Clinician 3	ACBH
Noble	Jared	Clinician 1	ACBH
Perez	Monica	Clinician 1	ACBH
Razzano	Raechel	QI/UR Coordinator I	ACBH
Stojic	Nenad	Crisis Counselor II	ACBH
Vaughn	Karen	Deputy Director	ACBH

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
<input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence	<p>The design was valid and credible. However, other indicators or controls would have made a stronger relationship between the outcomes and interventions, and thus a stronger PIP.</p>
General PIP Information	
MHP/DMC-ODS Name: Amador County MHP	
PIP Title: Peer-Led Groups After a Crisis Event	
PIP Aim Statement: Will providing a peer lead group to clients who have recently accessed crisis reduce inpatient utilization over the course of a fiscal year? Additionally, will access to this peer lead group increase a client's overall level of hope?	
Date Started: 01/2022	
Date Completed: 06/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) <input type="checkbox"/> State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) <input checked="" type="checkbox"/> MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): <input type="checkbox"/> Children only (ages 0–17)* <input checked="" type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The population in the PIP will be adult (18 years or older) Medi-Cal beneficiaries who qualify for services through the MHP and have accessed the crisis program.	

General PIP Information						
Improvement Strategies or Interventions (Changes in the PIP)						
<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):</p> <p>Peer-led support groups provided in person or telehealth and welcoming invitations to participate in these supports.</p>						
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):</p> <p>Clinicians were trained to provide referrals to the peer groups. Peer staff did outreach for the intervention groups and utilized the Hope Scale for those who participated.</p>						
<p>MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):</p> <p>N/A</p>						
PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of adult hospitalizations	FY 20/21	21% 139 hospitalizations/656 clients open and seen at least 1 time.	FY 22/23	19% 117 hospitalizations/625 open clients seen at least 1 time	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify): P-value not calculated
PIP Validation Information						
<p>Was the PIP validated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>“Validated” means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.</p>						

PIP Validation Information

Validation phase (check all that apply):

- PIP submitted for approval Planning phase Implementation phase Baseline year
- First remeasurement Second remeasurement Other (specify): Other – Completed but was active during the majority of the last 12 months.

Validation rating: High confidence Moderate confidence Low confidence No confidence

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

EQRO recommendations for improvement of PIP:

- Include an outcome indicator that reports on the total number of beneficiaries in the target group (beneficiaries who use crisis services) and the total number who receive the intervention. It may also be possible to follow a sample of unique individuals across time.
- Include a process indicator to ensure the implementation plan is occurring as intended. Provider referral to the group alone does not provide the intervention to all the eligible beneficiaries and reduces the validity and potential of the PIP design.
- Consider how the Hope Scale may be a useful outcome measure after the PIP is terminated.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
<input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence	<p>Steps through the PIP process over the last two years have been valid, consistent, and intentional. The MHP captured root cause data, communicated with stakeholders, and based it on HEDIS measures. Methods are clearly written except for the goal, but whether 50 or 80 percent, it was not met. The plan is to continue efforts beyond the PIP for the benefit of members and staff.</p>
General PIP Information	
MHP/DMC-ODS Name: Amador County MHP	
PIP Title: Timely Access	
PIP Aim Statement: The timeliness from assessment appointment to first offered treatment appointment will be within the 7-business day goal 80% of the time by December 2023.	
Date Started: 1/2022	
Date Completed: 12/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) <input type="checkbox"/> State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) <input checked="" type="checkbox"/> MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): All new mental health clients accessing services, upon the completion of their assessment appointment.	

General PIP Information						
Improvement Strategies or Interventions (Changes in the PIP)						
<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):</p> <p>N/A</p>						
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):</p> <p>Increasing UR frequency of opening new members to services after assessment and increasing availability of clinicians by training case management staff in screening.</p>						
<p>MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools):</p> <p>Implementation of the CalAIM Screening Tools.</p>						
PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
<p><i>PM 1. # of days between intake and first offered treatment appointment.</i></p> <p>Goal of 50% within 7 business days.</p>	<p><i>Jan 22- May 22</i></p>	<p><i>15 % were within 7-day goal. 7/151</i></p>	<p><i>April 23- June 23</i></p>	<p><i>20 within 7 days out of 70.</i></p> <p><i>29%</i></p>	<p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Specify P-value:</p> <p><input type="checkbox"/> <.01 <input type="checkbox"/> <.05</p> <p>Other (specify): N/A</p>

PIP Validation Information

Was the PIP validated? Yes No

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

Validation phase (check all that apply):

- PIP submitted for approval Planning phase Implementation phase Baseline year
- First remeasurement Second remeasurement Other (specify):

Validation rating: High confidence Moderate confidence Low confidence No confidence

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

EQRO recommendations for improvement of PIP:

- It may be beneficial to the quality improvement process, to know the rates for both youth and adults aggregately.
- Other measurements of the second-year data may provide additional evidence for a link between the interventions and the end result. Consider the number of members who were referred to NSMHS because of using the screening tool.
- With change of the EHR, be sure to include how this will impact the data collection in the final quarters of the PIP.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, PIP Validation Tool, and CalEQRO Approved Claims Definitions are available on the [CalEQRO website](#).

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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