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

BUTTE FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 6
MHP INFORMATION 6
SUMMARY OF FINDINGS 6
SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS 7
INTRODUCTION 9
BASIS OF THE EXTERNAL QUALITY REVIEW 9
REVIEW METHODOLOGY 9
HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE 11
MHP CHANGES AND INITIATIVES 12
ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS 12
SIGNIFICANT CHANGES AND INITIATIVES 12
RESPONSE TO FY 2022-23 RECOMMENDATIONS 13
ACCESS TO CARE 17
ACCESSING SERVICES FROM THE MHP 17
NETWORK ADEQUACY 18
ACCESS KEY COMPONENTS 18
ACCESS PERFORMANCE MEASURES 19
IMPACT OF ACCESS FINDINGS 31
TIMELINESS OF CARE 32
TIMELINESS KEY COMPONENTS 32
TIMELINESS PERFORMANCE MEASURES 33
IMPACT OF TIMELINESS FINDINGS 36
QUALITY OF CARE 38
QUALITY IN THE MHP 38
QUALITY KEY COMPONENTS 38
QUALITY PERFORMANCE MEASURES 39
IMPACT OF QUALITY FINDINGS 46
PERFORMANCE IMPROVEMENT PROJECT VALIDATION 47
CLINICAL PIP 47
NON-CLINICAL PIP 49
INFORMATION SYSTEMS 51
INFORMATION SYSTEMS IN THE MHP 51

INFORMATION SYSTEMS KEY COMPONENTS 52
INFORMATION SYSTEMS PERFORMANCE MEASURES 53
IMPACT OF INFORMATION SYSTEMS FINDINGS 55
VALIDATION OF MEMBER PERCEPTIONS OF CARE 56
CONSUMER PERCEPTION SURVEYS 56
PLAN MEMBER/FAMILY FOCUS GROUPS 56
SUMMARY OF MEMBER FEEDBACK FINDINGS 57
CONCLUSIONS 58
STRENGTHS 58
OPPORTUNITIES FOR IMPROVEMENT 58
RECOMMENDATIONS 59
EXTERNAL QUALITY REVIEW BARRIERS 60
ATTACHMENTS 61
ATTACHMENT A: REVIEW AGENDA 62
ATTACHMENT B: REVIEW PARTICIPANTS 63
ATTACHMENT C: PIP VALIDATION TOOL SUMMARY 67
ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE 73
ATTACHMENT E: LETTER FROM MHP DIRECTOR 74

LIST OF FIGURES

Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022 22
Figure 2: MHP PR by Race/Ethnicity, CY 2020-22 23
Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22 24
Figure 4: Overall PR CY, 2020-22 24
Figure 5: Overall AACM, CY 2020-22 25
Figure 6: Hispanic/Latino PR, CY 2020-22 25
Figure 7: Hispanic/Latino AACM, CY 2020-22 26
Figure 8: Asian/Pacific Islander PR, CY 2020-22 26
Figure 9: Asian/Pacific Islander AACM, CY 2020-22 27
Figure 10: Foster Care PR, CY 2020-22 27
Figure 11: Foster Care AACM, CY 2020-22 28
Figure 12: Wait Times to First Service and First Psychiatry Service 35
Figure 13: Wait Times for Urgent Services 35
Figure 14: Percent of Services that Met Timeliness Standards 36
Figure 15: Retention of Members Served, CY 2022 40
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022 41
Figure 17: Diagnostic Categories by Percentage of Approved Claims, CY 2022 42
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22 43
Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22 44
Figure 20: Members Served and Approved Claims by Claim Category, CY 2022 46

LIST OF TABLES

Table A: Summary of Response to Recommendations 6
Table B: Summary of Key Components 6
Table C: Summary of PIP Submissions 7
Table D: Summary of Plan Member/Family Focus Groups 7
Table 1A: Butte MHP Alternative Access Standards, FY 2022-23 18
Table 1B: Butte MHP Out-of-Network Access, FY 2022-23 18
Table 2: Access Key Components 19
Table 3: Butte MHP Annual Members Served and Total Approved Claims, CY 2020-22 20
Table 4: Butte MHP Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022 20
Table 5: Threshold Language of Butte MHP Medi-Cal Members Served in CY 2022 21
Table 6: Butte MHP Medi-Cal Expansion (ACA) PR and AACM, CY 2022 21
Table 7: Butte MHP PR Members Served by Race/Ethnicity, CY 2022 22
Table 8: Services Delivered by the Butte MHP to Adults, CY 2022 29
Table 9: Services Delivered by the Butte MHP to Youth in Foster Care, CY 2022 30
Table 10: Timeliness Key Components 32
Table 11: FY 2023-24 Butte MHP Assessment of Timely Access 34
Table 12: Quality Key Components 39
Table 13: Butte MHP Psychiatric Inpatient Utilization, CY 2020-22 43
Table 14: Butte MHP High-Cost Members (Greater than $30,000), CY 2020-22 45

Table 15: Butte MHP Medium- and Low-Cost Members, CY 2022 45
Table 16: Contract Provider Transmission of Information to Butte MHP EHR..... 52
Table 17: IS Infrastructure Key Components 53
Table 18: Summary of Butte MHP SDMC Approved and Denied Claims, CY 2022..... 54
Table 19: Summary of Butte MHP Denied Claims by Reason Code, CY 2022 54
Table A1: CalEQRO Review Agenda 62
Table B1: Participants Representing the MHP and its Partners 64
Table C1: Overall Validation and Reporting of Clinical PIP Results 67
Table C2: Overall Validation and Reporting of Non-Clinical PIP Results 70

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, "Butte" may be used to identify the Butte County MHP.

MHP INFORMATION

Review Type — Virtual

Date of Review — September 6-7, 2023

MHP Size — Medium

MHP Region — Superior

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	2	3	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	9	1	0
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**24**	**2**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Youth Level of Care Intervention Standards	Clinical	09/2023	Planning	No confidence
Youth Level of Care Dashboard	Non-Clinical	09/2023	Planning	No confidence

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	5
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	3

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP is dedicated to meeting the state's California Advancing and Innovating Medi-Cal (CalAIM) requirements and has already submitted a small number of claims for reimbursement utilizing the payment reform rates.
- The MHP has increased training in leadership and strives for a more supportive and effective leadership team. They have been able to promote internal staff into leadership positions.
- The MHP has reallocated staff resources and redesigned their intake process to expedite accessibility.
- The MHP has 19 peers support specialists employed by the county.
- The MHP utilizes an outcome tool for both adults and youth. Initiatives to utilize the Child and Adolescent Needs Assessment (CANS) data for reporting will put this information to use for guiding clinical and program decisions.

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

- The MHP has increased efforts to recruit personnel, although staff turnover and retention continue to impact the department. Newly hired staff indicate a lack of comprehensive training coupled with high caseloads.
- The MHP redesigned the intake process to allow for more assessments; however, this has led to the staff reporting unusually high caseloads.
- Timeliness data does not include contract provider access points.

- Even though efforts have been made to improve collaboration and morale, contracted providers report being left out and not seen as partners.
- Despite having many peer employees, the MHP does not have a peer supervisory position, nor direct relationships between peer employees and the leadership team.

Recommendations for improvement based upon this review include:

- Continue efforts to reduce the vacancy rate by considering more flexible schedule options, more comprehensive training and onboarding, and other strategies that may improve employee engagement and, therefore, staff retention.

  (This is a similar recommendation from FY 2022-23, now with the focus on staff retention.)
- Evaluate workloads and the system capacity that is available based upon existing clinical staff systemwide. Consider whether caseloads are at numbers that can allow for appropriate clinical management.
- Continue efforts to improve comprehensiveness and accuracy of contract provider timeliness data through the use of the improved data capture. This should result in the MHP's ability to include contract provider timeliness information for the next EQR. Contractor use of the EHR would enable this to be feasible.

  (This recommendation is a carry-over from FY 2022-23.)
- Increase communication with contracted providers and county-operated line staff. CalAIM has implemented many changes in services rendered, how to code, and how to bill. Contracted providers and staff are feeling left out of decisions being made, and not feeling there is a supportive partnership.
- Restart efforts to consider the development of a peer supervisory role. The MHP has many peer positions in all geographical areas. However, there is no potential for upward mobility, supervisory roles, or the ability to expand in their positions. Peers benefit from supervision and guidance from a supervisor with peer support expertise.

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 Butte County MHP by BHC, conducted as a virtual review on September 6-7, 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 (TAY); 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.
- 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

There was an emergency relocation of the Oroville adult services clinic to a new location, due to water intrusion, mold, and building deterioration. This temporarily impacted the efficiency of the adult services provided in Oroville.

The MHP continues to experience staff shortages for both county and contracted providers.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The leadership team was able to fill some of their vacant positions, including its Medical Director.
- The MHP reduced the staff vacancy rate from a peak of 29 percent to 19 percent. The vacancy rate was 21.4 percent at the time of the previous EQR. The department is still impacted by vacancies and difficulty with overall retention.
- The Resilience Empowerment Support Team (REST) was created to do intensive outreach with people with mental illness who are living in camps and on the streets of Chico.
- A new site was purchased on Cohasset Rd for relocation of Chico Community Counseling Center and Chico Stepping Stones.
- Community Development Block Grant (CDBG funds) were allocated for the renovation and/or purchase of additional buildings in Oroville and Gridley for relocation of adult and youth services and modernization of infrastructure.
- Comprehensive documentation training and systems reform were developed to accommodate documentation and payment reform changes associated with CalAIM.
- The MHP received initial psychiatric residency accreditation allowing Butte to increase the number of available psychiatrists through psychiatry residents.
- The class and compensation study were finalized, and departments were able to increase their site differential pay.

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: Continue efforts to reduce the vacancy rate through approaches such as salary equity evaluations and work schedule options that improve the ability to recruit and retain needed categories of clinical staff when facing competition from nearby medium and large MHPs.

(This recommendation was continued from FY 2021-22.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP completed a classification and compensation study and was successful in negotiating additional differentials for several county programs, including REST, full service partnership (FSP), crisis, and psychiatric health facility (PHF) staff.
- Butte increased strategic recruiting and has streamlined the hiring and recruitment process in partnership with program leadership and Human Resources.
- Prior vacancies at the Program Manager and Supervisor levels have been filled to support program stability.
- Butte MHP recruited a Medical Director and became a certified training site for new psychiatrists.
- The staff vacancy rate has been reduced from 29 percent at its peak, to 21 percent at the last review, and now 19 percent at the time of this review.

- While the MHP has made improvements in reducing its vacancy rates, this issue continues to negatively impact on the department. Both line staff and management report that the vacancy rate consistently fluctuates due to difficulty in recruiting, coupled with the inability to retain newly hired employees. Barriers that have impacted recruitment have been the lack of qualified applicants in the behavioral health sector.
- Implementing an employee engagement committee could help stabilize the vacancies and improve overall retention.
- Despite the Addressed rating, crediting the significant work that occurred over the year, this recommendation will be continued because there is still room for improvement with a 19 percent vacancy rate.

Recommendation 2: The MHP is encouraged to continue its efforts to improve communication and engagement with staff and realize the benefits of the leadership, management and supervisor training that started in August 2022. The MHP may wish to continue the staff engagement survey to help assess the effectiveness of its efforts.

(This recommendation was continued from FY 2021-22.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Butte has streamlined meetings and agendas to assist the teams with being more intentional with time and improving communication.
- Butte has increased training and professional development opportunities for leadership staff. Increased training will need to continue as it seems more collaboration and professional development could be beneficial.
- Butte has piloted a Leadership Communications training course that will be expanded to include all staff and new hires.
- While the MHP has made efforts to improve in this area, communication and staff engagement continue to be a problem, as a wide variety of informants endorse this viewpoint. Butte MHP continues to complete the employee engagement survey annually in a continued effort to improve employee engagement and improve morale. The MHP way wish to increase the frequency of the staff engagement surveys to every six months. High staff turnover can exacerbate problems with communication and engagement.

Recommendation 3: The MHP to continue its efforts to improve comprehensiveness and accuracy of contract provider timeliness data through the use of the improved data

capture solutions being tested as of this current review. This should result in the MHP's ability to include contract provider timeliness information for the next EQR.

(This recommendation was continued from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Contract providers can now access the MHP's EHR, which could enable them to enter service data for access points, but it is not yet being used for this purpose. Staff turnover at both county and contract programs impacted their implementation of systemwide timeliness data monitoring.
- The MHP is currently in discussions about potentially launching a request for proposals (RFP) to acquire an EHR that all providers could either utilize or easily import their data into.
- This recommendation will be carried over in this year's recommendations.

Recommendation 4: The MHP would benefit in surveying members at the point of service with the intent of identifying the most effective mechanisms for providing them with information about services, including results of the state and local satisfaction surveys. This may include integrating this material with intake packets.

(This recommendation was continued from FY 2021-22.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Butte installed televisions which play videos with informational materials at some but not all clinic sites.
- The MHP integrated informational materials into intake packets, but this reportedly is not being done consistently across all intake points. Some were not aware this was being done.
- Many members learn about the wellness center by word of mouth and/or by the sharing of the activities calendar.
- Prior to their assessment, case managers meet with members for an orientation as their first visit; members receive information about services at this time. During orientation the members are also able to provide their feedback on the most effective ways to provide them with information. (Sometimes but not always members will see a clinician for their assessment on the same day.)
- A robust and specific, consistent communication mechanism to communicate service information to members is needed.
- While this component has been rated as partially addressed, it is not carried over in a recommendation for this year's review due to other priority recommendations identified.

Recommendation 5: Explore and implement options for electronic batch file upload with additional contract providers that have EHRs.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP's recently implemented CalAIM changes have added some complexity related to add-on codes and the ability of contracted providers being able to submit services via data entry. The MHP is working with their EHR vendor to resolve the problem. Currently, while the resolution is pending, add-on information is being manually added to the records that are electronically uploaded.
- Butte is currently conducting research to issue a Request for Proposals (RFP) for an EHR that could be utilized by both the county and contracted providers.
- The contracted providers utilize various EHR systems which creates a unique barrier to each provider when they are required to submit data. When new data requirements are made each contracted provider must identify how their EHR can produce the required information.
- While the MHP has made efforts to implement options for electronic batch file upload by the contracted providers, new CalAIM requirements have created barriers in achieving this goal. Data is being added manually to augment the electronically uploaded data. Butte County is currently working with their EHR vendor on rectifying the issue.

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 and contractor operated providers in the MHP. Regardless of payment source, approximately 53 percent of services were delivered by county-operated/staffed clinics and sites, and 47 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 85 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 contractor staff; members may request services through the Access Line or walk-in to a clinic. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. Screenings and assessments are conducted at the age-appropriate regional clinic. Regardless of whether requests are made by walk-in or telephone call, all events are recorded in the access log. The MHP has put in place a process to refer to managed care plans those individuals who do not meet criteria for MHP services via a bidirectional referral process overseen by quality management (QM), with the MHP providing care and case management during the transition, as required by CalAIM.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 2,941 adults, 685 youth, and 556 older adults across 15 county-operated sites and 7 contractor-operated sites. Among those served, 161 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 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 Butte County, the time and distance requirements are 45 miles and 75 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: Butte 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	☐ Yes ☒ No

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

Table 1B: Butte 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	☐ Yes ☒ 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 has a strong partnership with an American Sign Language (ASL) provider and has staff who are ASL certified.
- MHP has robust processes to help assess the needs of member needs. This includes a cultural competency team, a cultural competency coordinator, and an equity diversion inclusion committee.
- The community outreach team solicits input for areas such as cultural, ethnic, racial, and linguistic needs of the community to help improve overall service delivery.
- The MHP offers services in all geographical areas of the county and most services can be provided in the field; this occurs even in the further-away rural areas.

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 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 a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, Butte demonstrates better access to services than was seen statewide.

Table 3: Butte 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	86,105	5,421	6.30%	$40,691,616	$7,506
CY 2021	82,084	5,542	6.75%	$41,762,787	$7,536
CY 2020	78,225	5,845	7.47%	$41,711,950	$7,136

Note: 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 total number of eligibles has increased each of the past three years, while the number of members served and PR have decreased each year during this period.

Table 4: Butte 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	8,186	210	2.57%	1.15%	1.82%
Ages 6-17	17,791	1,850	10.40%	4.80%	5.65%
Ages 18-20	4,197	306	7.29%	3.47%	3.97%
Ages 21-64	48,231	2,823	5.85%	3.60%	4.03%
Ages 65+	7,702	232	3.01%	1.98%	1.86%
Total	**86,105**	**5,421**	**6.30%**	**3.49%**	**3.96%**

Note: 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.

- PRs for all age groups are higher than PRs in other counties of similar size and statewide. Youth ages 6-17 had the highest PR in the MHP.
- Total PR in the MHP was also higher than in similar sized counties and statewide.

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

Threshold Language	# Members Served	% of Members Served
Spanish	194	3.58%
Threshold language source: Open Data per BHIN 20-070		

- Spanish is the only threshold language, with 3.58 percent of members reporting Spanish as their primary language.

Table 6: Butte 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	27,609	1,310	4.74%	$6,367,910	$4,861
Medium	530,704	15,912	3.00%	$110,270,160	$6,930
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- Butte has a higher PR than medium-sized counties and statewide for the ACA population. However, the AACM for this group is lower than in other medium-sized counties and statewide, meaning fewer and/or less intensive services were provided to ACA-eligible members in Butte on average.

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.

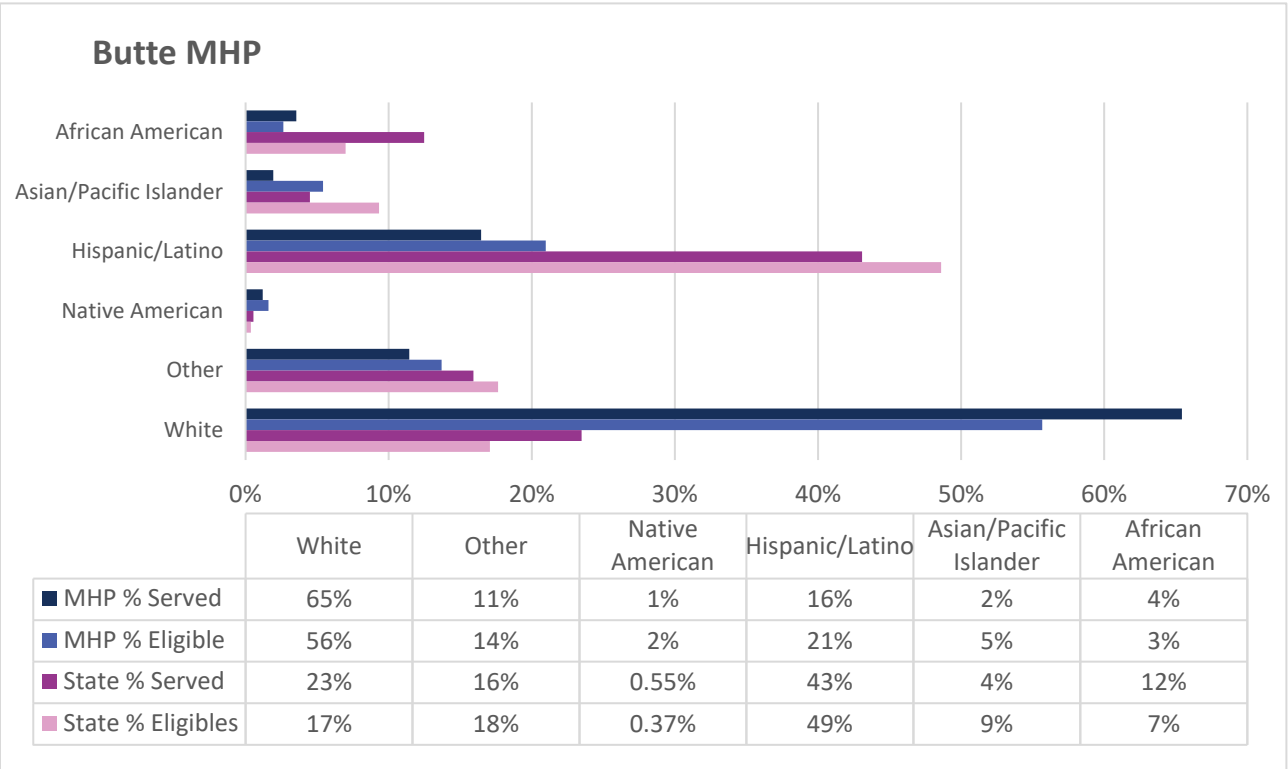
Table 7: Butte MHP PR Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	2,273	192	8.45%	7.08%
Asian/Pacific Islander	4,663	105	2.25%	1.91%
Hispanic/Latino	18,065	892	4.94%	3.51%
Native American	1,375	65	4.73%	5.94%
Other	11,794	620	5.26%	3.57%
White	47,937	3,547	7.40%	5.45%
Total	**86,107**	**5,421**	**6.30%**	**3.96%**

Note: 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.

- Butte has higher PRs for all racial/ethnic groups than statewide with the exception of the Native American PR which was lower.
- Asian/Pacific Islander members had the lowest PR of any group served by the MHP, though slightly higher than the statewide PR.

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

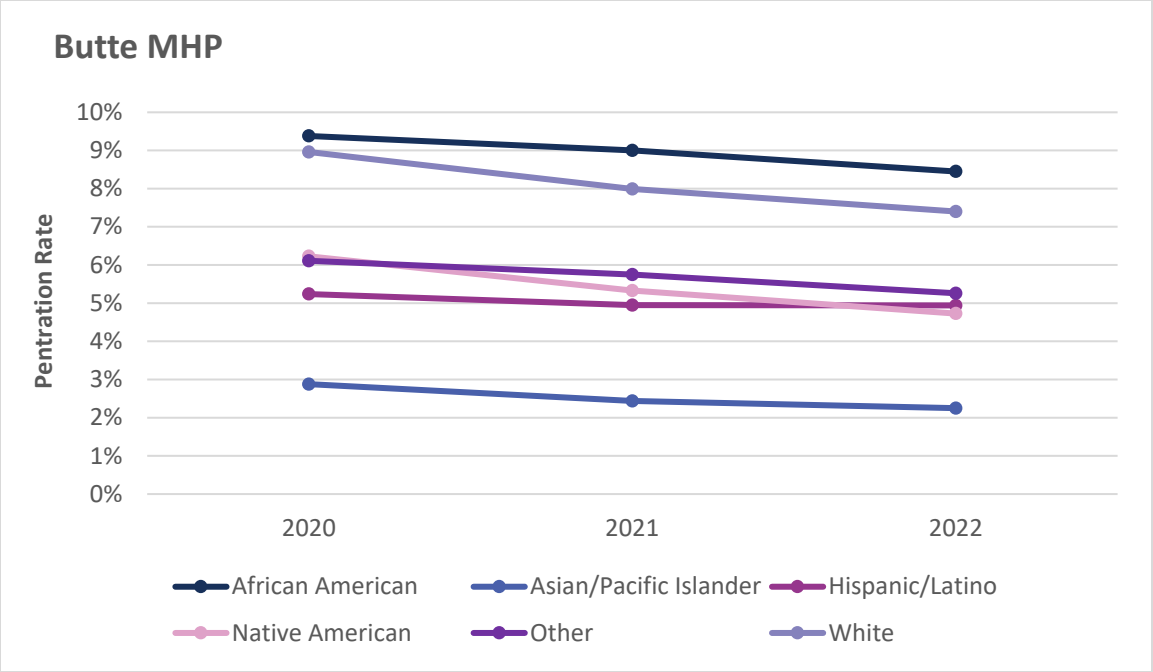


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	65%	11%	1%	16%	2%	4%
MHP % Eligible	56%	14%	2%	21%	5%	3%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- Butte has a much higher proportion of White eligibles than the state as a whole, and this group is overrepresented among MHP members. The Hispanic/Latino population is proportionally smaller than statewide, and this group is underrepresented in the MHP.

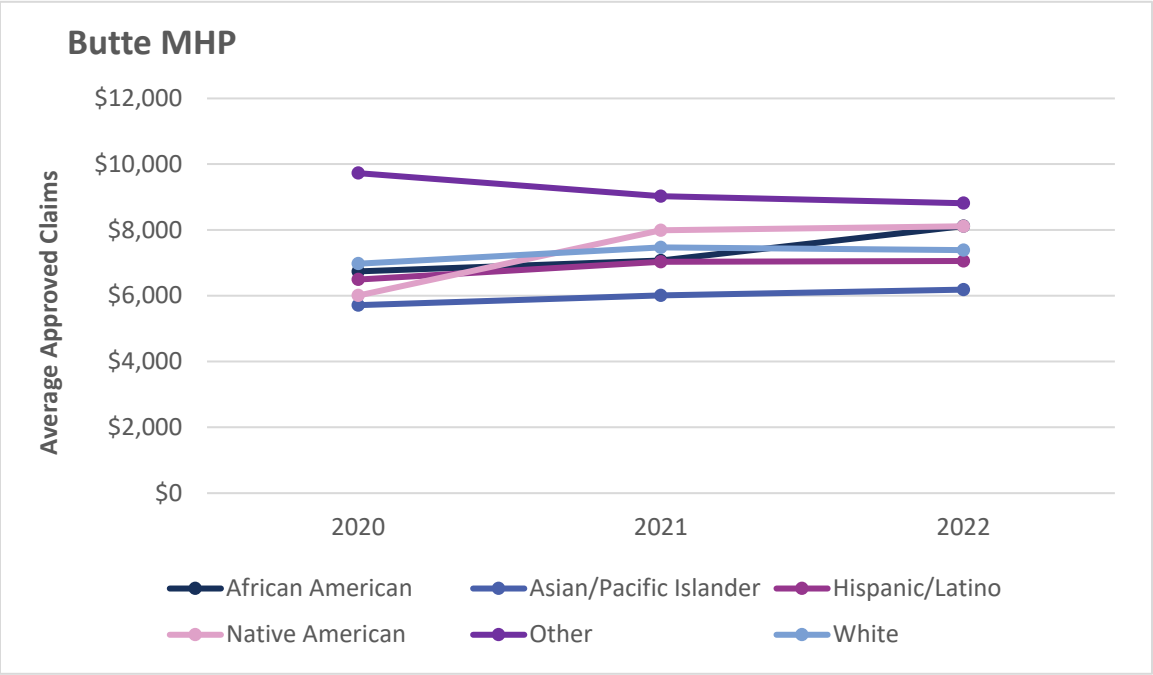
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



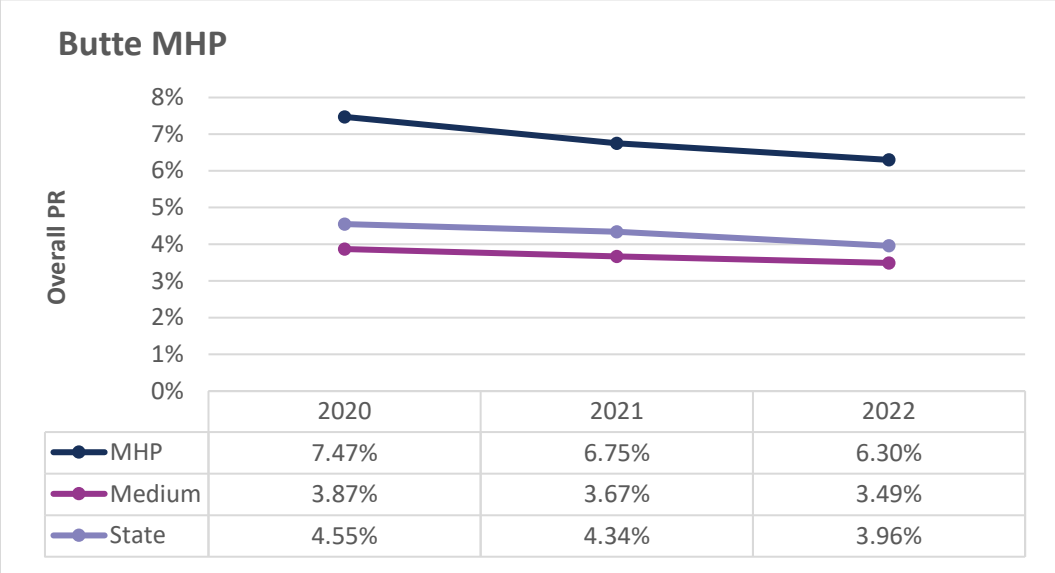
- White and African American PRs were consistently highest over the past three years, and the Asian/Pacific Islander PR has consistently been the lowest in the MHP.

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



- The Other racial/ethnic group has consistently had the highest AACMs over the past three years, whereas Asians/Pacific Islanders have consistently had the lowest.

Figure 4: Overall PR CY, 2020-22



	2020	2021	2022
MHP	7.47%	6.75%	6.30%
Medium	3.87%	3.67%	3.49%
State	4.55%	4.34%	3.96%

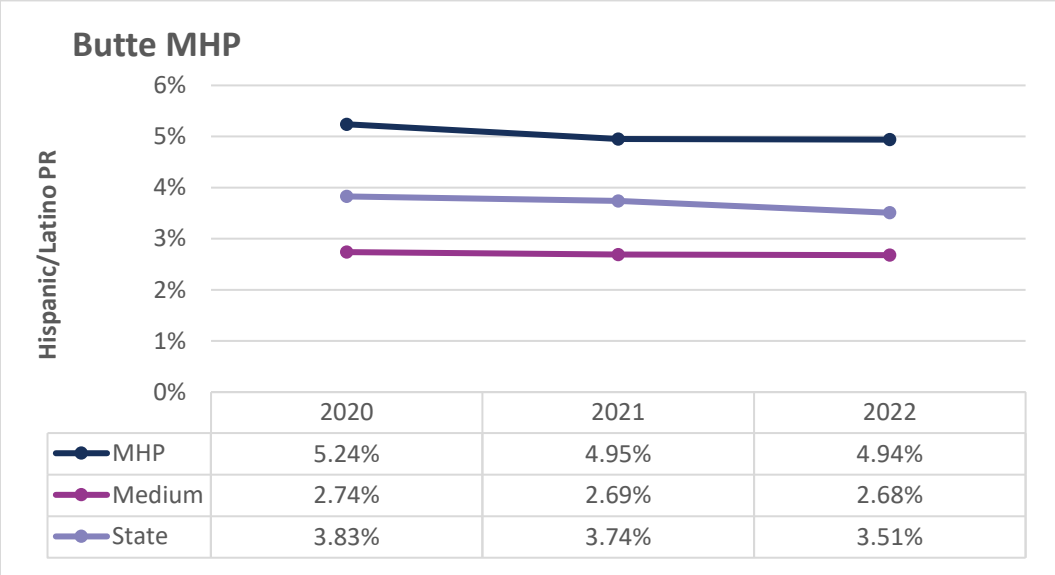
- Overall PR in the MHP has decreased each year over the past three years;; however, Butte's PRs have also been consistently higher than medium-sized counties and statewide.

Figure 5: Overall AACM, CY 2020-22

	2020	2021	2022
MHP	$7,136	$7,536	$7,506
Medium	$8,399	$8,601	$8,084
State	$7,155	$7,478	$7,442

- The overall AACM in the MHP is consistent with prior years and has been nearly identical to the statewide AACMs over the past three years.

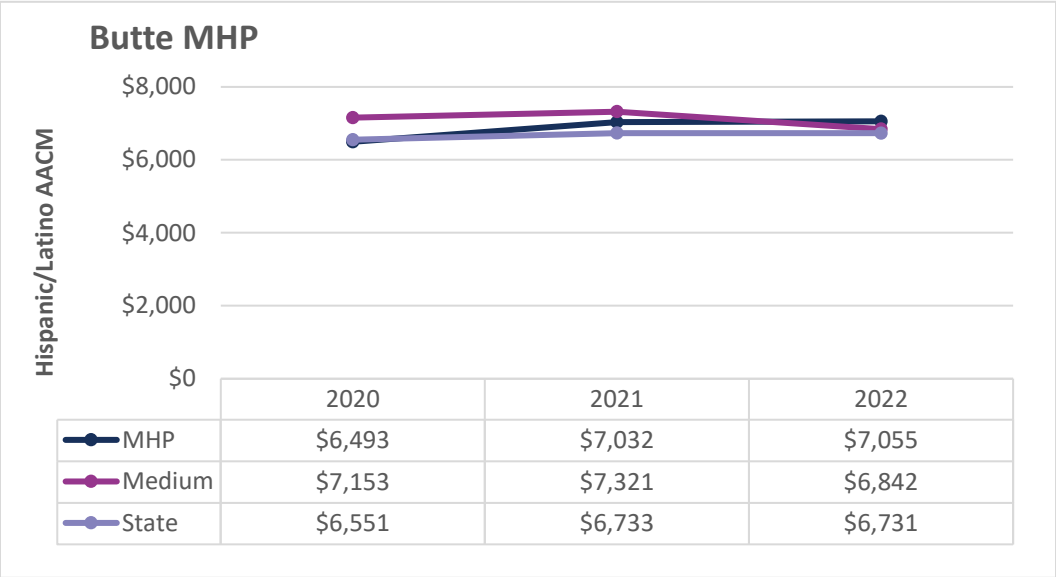
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	5.24%	4.95%	4.94%
Medium	2.74%	2.69%	2.68%
State	3.83%	3.74%	3.51%

- Butte's Hispanic/Latino PR for CY 2022 was almost exactly the same as the previous year's PR, and it has been consistently higher than PRs in medium-sized counties and statewide.

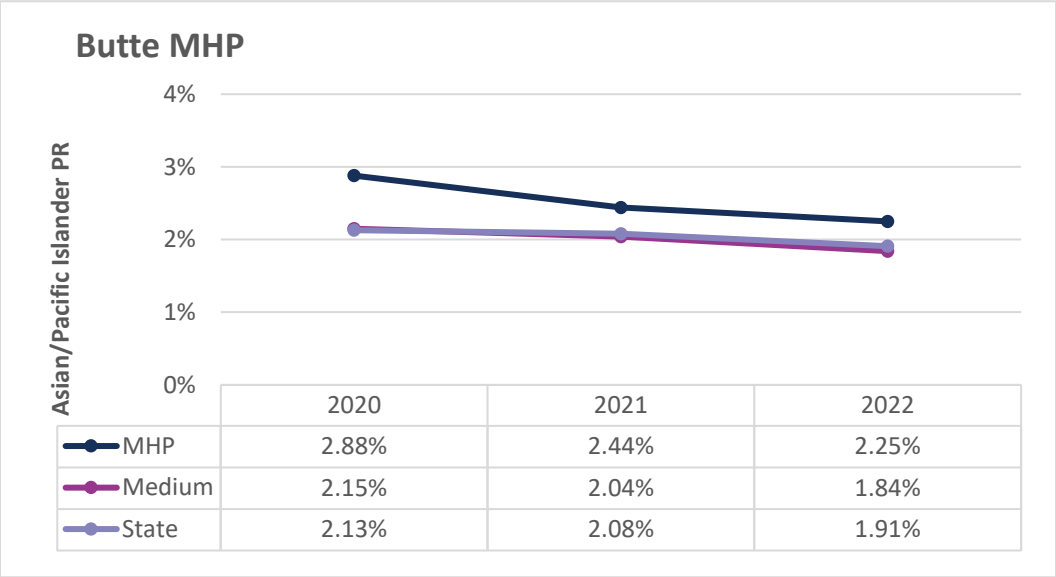
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$6,493	$7,032	$7,055
Medium	$7,153	$7,321	$6,842
State	$6,551	$6,733	$6,731

- The AACMs over the past three years for the Hispanic/Latino population are comparable to those in medium-sized counties and statewide and have been relatively stable.

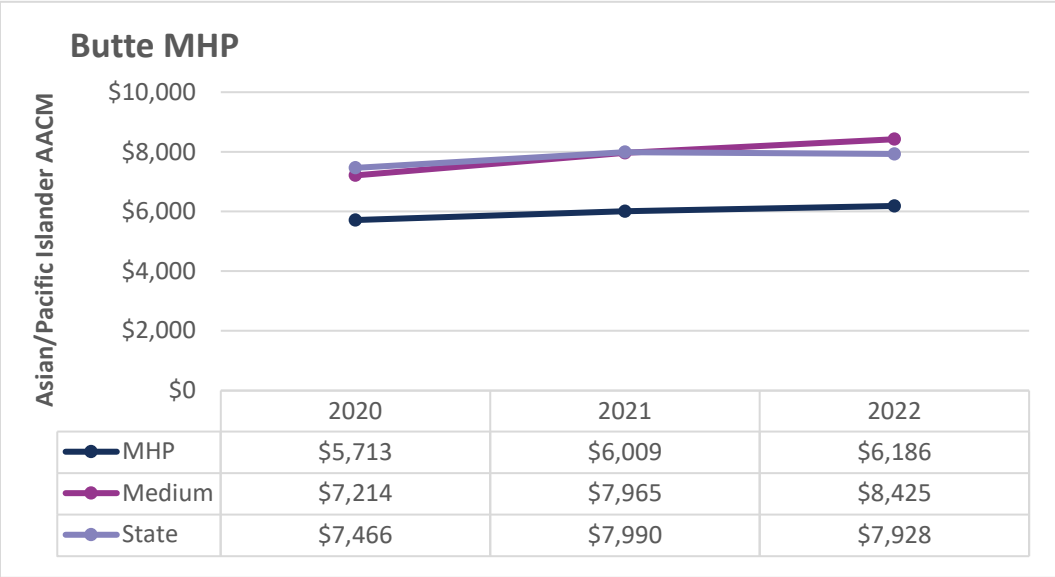
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	2.88%	2.44%	2.25%
Medium	2.15%	2.04%	1.84%
State	2.13%	2.08%	1.91%

- Asian/Pacific Islander PRs have decreased over the past three years but have been consistently higher than PRs in medium-sized counties and statewide.

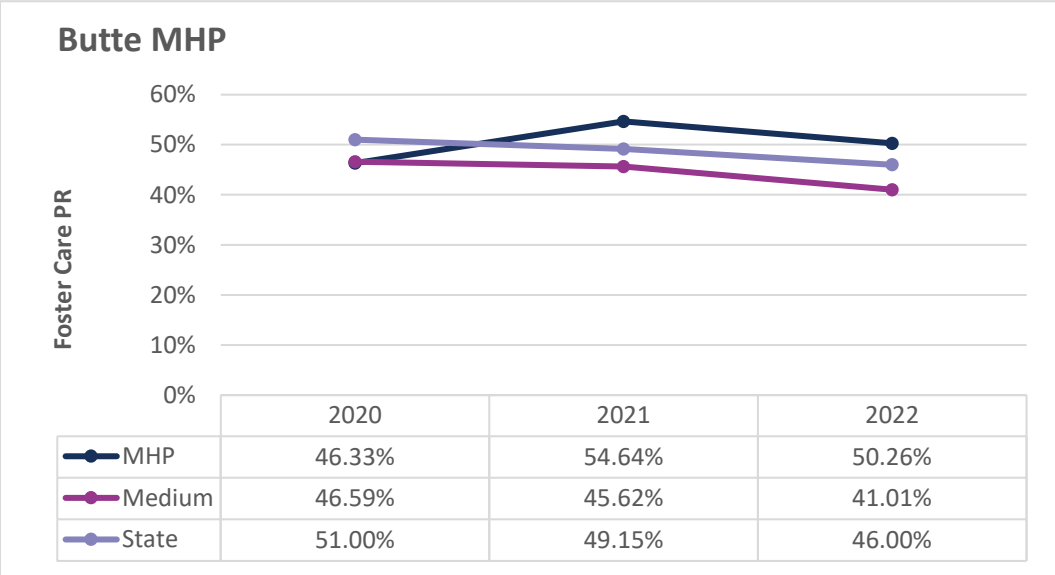
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$5,713	$6,009	$6,186
Medium	$7,214	$7,965	$8,425
State	$7,466	$7,990	$7,928

- AACMs for the Asian/Pacific Islander population have been consistently lower than AACMs for this group in medium-sized counties and statewide over the past three years.

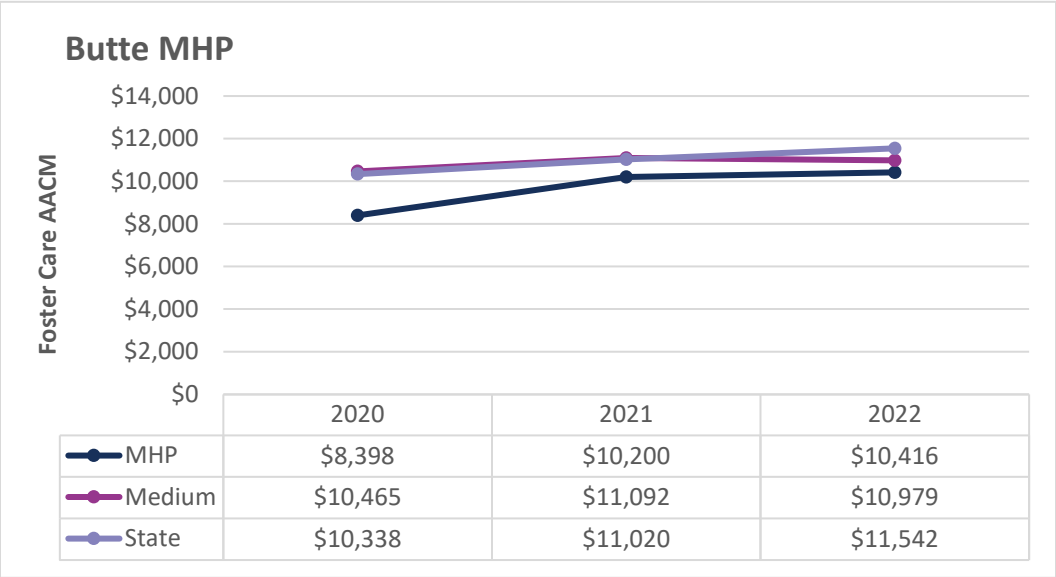
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	46.33%	54.64%	50.26%
Medium	46.59%	45.62%	41.01%
State	51.00%	49.15%	46.00%

- The PR for the FC population has been higher than in medium-sized counties and the state as a whole for the past two years.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$8,398	$10,200	$10,416
Medium	$10,465	$11,092	$10,979
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years. This pattern is also seen in Butte, and though the increase in AACM in the MHP has been larger than that seen statewide ($2,018 increase in Butte vs $1,204 statewide), Butte's FC AACM has consistently been lower than in medium-sized counties and statewide.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Butte MHP to Adults, CY 2022

Service Category	MHP N = 3,361				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	25	0.7%	9	6	10.3%	14	8
Inpatient Admin	0	0.0%	0	0	0.4%	26	10
Psychiatric Health Facility	232	6.9%	10	4	1.2%	16	8
Residential	<11	-	239	254	0.3%	114	84
Crisis Residential	22	0.7%	28	23	1.9%	23	15
Per Minute Services							
Crisis Stabilization	38	1.1%	1,142	1,200	13.4%	1,449	1,200
Crisis Intervention	853	25.4%	278	170	12.2%	236	144
Medication Support	1,901	56.6%	560	381	59.7%	298	190
Mental Health Services	2,569	76.4%	791	310	62.7%	832	329
Targeted Case Management	1,340	39.9%	360	106	36.9%	445	135

- Total inpatient utilization in the MHP (inpatient and psychiatric health facility [PHF]) was lower than statewide, with fewer days claimed on average for both services as well.
- Similar to statewide patterns, mental health services and medication support showed the highest utilization in the MHP, and mental health services utilization rate was higher in Butte than statewide. The average units for medication support are higher in Butte than the statewide average.
- Crisis intervention services were used at a much higher rate than statewide (25.4 percent in the MHP vs. 12.2 percent statewide). This could be due to the lack of a crisis stabilization unit as well as the MHP's field-based crisis response.

Table 9: Services Delivered by the Butte MHP to Youth in Foster Care, CY 2022

Service Category	MHP N = 295				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	12	8	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	18	18	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	<11	-	996	996	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	<11	-	1,056	1,200	3.1%	1,166	1,095
Crisis Intervention	25	8.5%	300	175	8.5%	371	182
Medication Support	91	30.8%	558	340	27.6%	364	257
TBS	11	3.7%	4,278	3,531	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	158	53.6%	508	185	40.8%	1,458	441
Intensive Home-Based Services	53	18.0%	4,387	1,488	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	280	94.9%	1,519	963	95.4%	1,846	1,053
Targeted Case Management	121	41.0%	419	103	35.8%	307	118

- FC youth in the MHP had low utilization rates for all per day services.
- As is statewide, the most utilized per minute services was mental health services.
- Intensive Care Coordination (ICC) had higher utilization than statewide, though the average and median minutes billed were much lower than statewide. Targeted Case Management (TCM) utilization was also higher than statewide, with comparable average units provided.

IMPACT OF ACCESS FINDINGS

- The MHP has a rapid response crisis unit, which can also serve as an access point for members. This coupled with their redesign of the access process to shorten member access time has strengthened PR for nearly all populations served.
- Intensive Home-Based Services (IHBS) is comparable to the statewide average and the ICC services provided were higher than the statewide average. This indicates that the MHP has made good efforts to implement Pathways of Well-Being services to Foster Care (FC) youth. Their delivery of these services to non-FC show fidelity to the expanded Pathways population.
- The MHP believes that implementation of CalAIM has caused an increase in referrals to the MHP for services. The influx of referrals has increased the need for additional staffing, at least for an assessment.
- Butte has higher PRs for all racial/ethnic groups than statewide, with the exception of the Native American PR, indicating a potential need for increased outreach to that population.

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	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- The MHP saw an improvement in timeliness for non-urgent requests first offered appointments with 73.73 percent of the services meeting the standard.

- The contract provider timeliness data was not included in the data submitted to EQRO. However, the MHP reviews data for contract providers during their Quality Improvement Committee (QIC) meetings. The MHP is currently working with their EHR vendor and contract providers to be able to aggregate the data more efficiently.

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 2022-2023. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent county-operated services only. Claims data for timely access to post-hospital care and readmissions are discussed in the Quality of Care section.

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	8.60 Business Days	10 Business Days*	73.73%
First Non-Urgent Service Rendered	15.23 Business Days	10 Business Days**	57.60%
First Non-Urgent Psychiatry Appointment Offered	13.47 Business Days	15 Business Days*	72.63%
First Non-Urgent Psychiatry Service Rendered	17.75 Business Days	15 Business Days**	57.92%
Urgent Services Offered (including all outpatient services) – Regardless of prior authorization requirement	32.38 Hours	48 Hours*	83.61%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	4.04 Days	7 Calendar Days	76.94%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	4.04 Days	30 Calendar Days	80.43%
No-Show Rate – Psychiatry	19.32%	15%**	n/a
No-Show Rate – Clinicians	8.19%	15%**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033

** MHP-defined timeliness standards

For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-2023

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

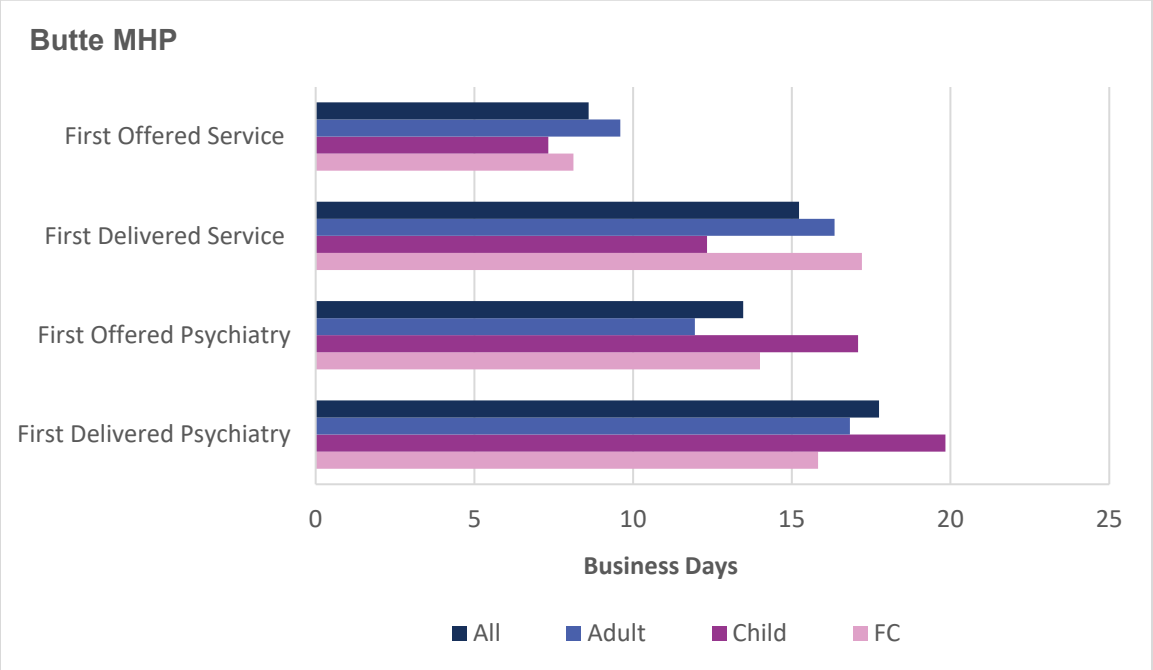


Figure 13: Wait Times for Urgent Services

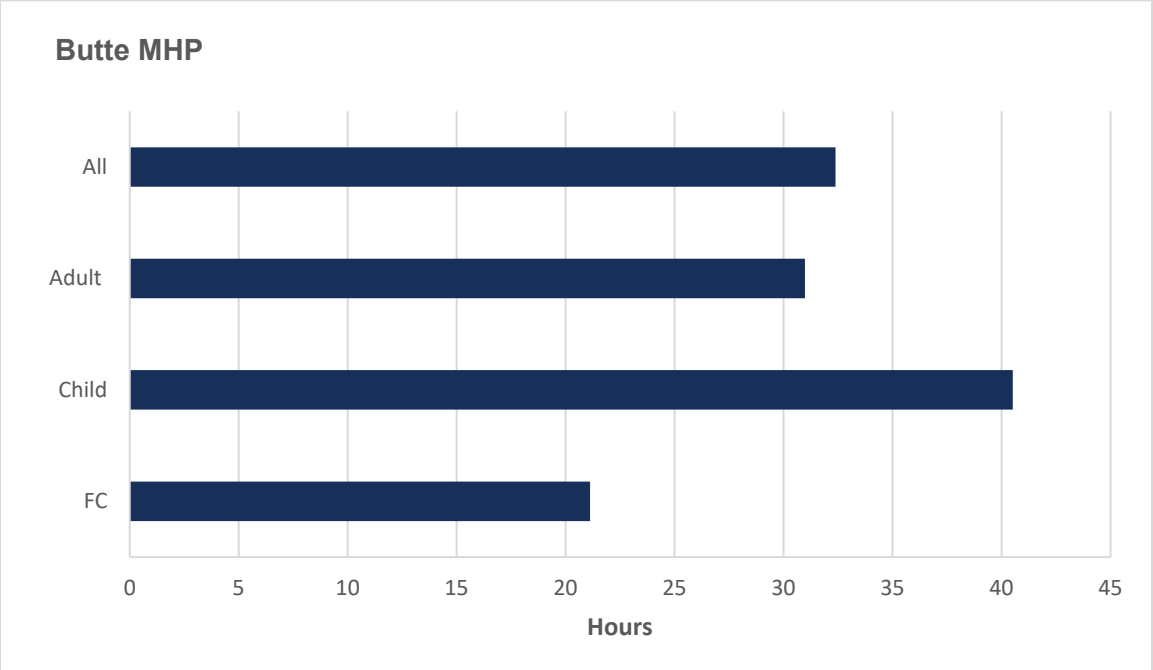
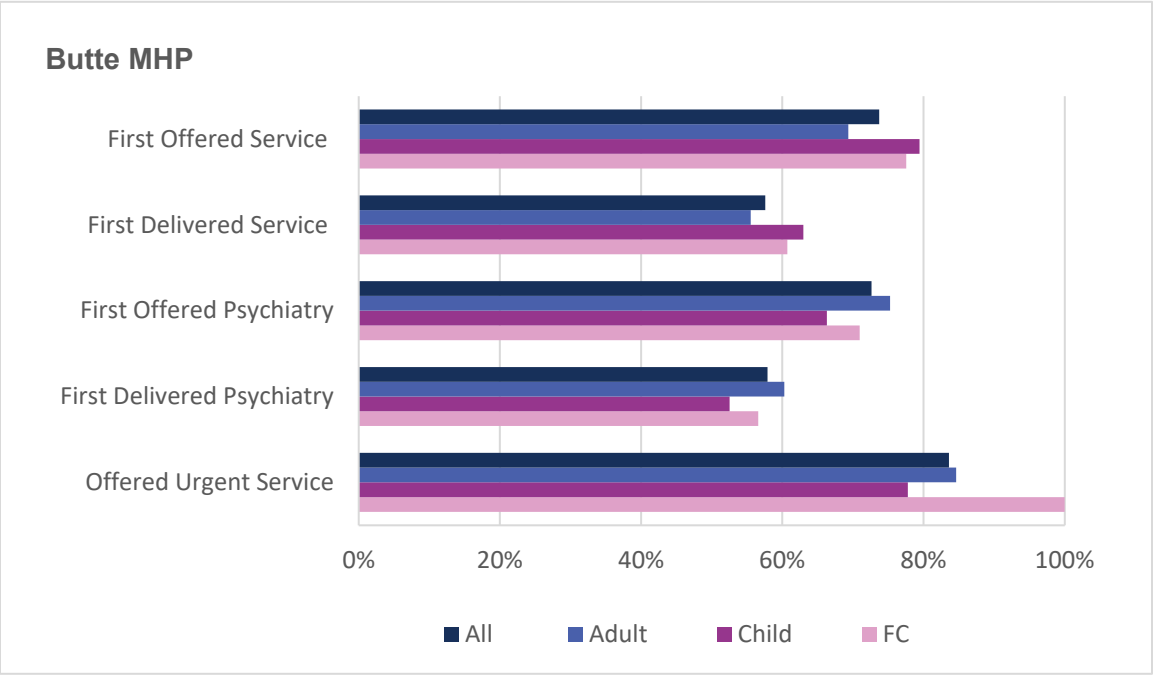


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide 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 and unscheduled assessments.
- The MHP defined “urgent services” for purposes of the ATA as a mental health or substance use disorder service that must be provided within 48 hours of the client’s request in order to prevent a crisis, imminent risk/hospitalization or significant decompensation in functioning. There were reportedly 61 urgent service requests with a reported actual wait time to services averaging 32.38 hours.
- For the MHP, no-shows are tracked only for county-operated services. The MHP reports a no-show rate of 10.32 percent for psychiatrists and 8.19 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- Butte County is reaching out to adults who have been hospitalized and has been successful in connecting them to outpatient services post hospitalization.
- Considering that the MHP reported that 47 percent of services are provided by contracted providers, the exclusion of their data from timelines metrics represents an incomplete picture of timeliness services in the overall system.
- The MHP did not meet the first non-urgent services rendered with an average of an initial offered appointment in 8.6 business days. However, the first delivered

service averages nearly 7 business days longer. The MHP should explore options to increase timely access to this component of service delivered.

- The MHP believes that the implementation of CalAIM has caused an increase in referrals to the MHP for services. The influx of referrals has increased the need for additional staffing and impacted caseload sizes. Trend data should be reviewed for capacity management purposes.

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 under the direction of the assistant Director, who oversees the systems performance program manager and the QI coordinator. The MHP distinguishes and separates Quality Assurance (QA) from QI; However, at this particular time there are two vacant QA coordinator positions.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of the MHP Director, compliance, quality management, leadership, program managers, program supervisors, and contracted providers, is scheduled to meet monthly. Since the previous EQR, the QIC met six times. Of the fourteen identified FY 2021-22 QAPI workplan goals, the MHP met three, partially met four, did not meet five, and two were not rated due to revisions in criteria.

The MHP utilizes the following level of care (LOC) tools: The Milestones of Recovery Scale (MORS) is utilized as an LOC tool for adults. The MORS is utilized upon admission and administered continuously every six months thereafter.

The MHP utilizes the Child and Adolescent Needs and Strengths (CANS) in the children's system of care (SOC). The MHP has currently established a PIP that will utilize CANS scores to better align members with the appropriate LOC. A dashboard report has been created to not only track CANS scores, but to also assist in transitioning members down to lower levels of care as they improve.

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	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Met
3H	Utilizes Information from Member Satisfaction Surveys	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 has created a comprehensive data dashboard that allows it to track trends to make informed decisions within their system of care.
- The MHP has a robust QIC with consistent attendance by leadership and stakeholders that represent the entire MHP. The data discussed at the QIC is used to guide decisions.
- The MHP utilizes the MORS to track the treatment for adult members.
- The MHP has an opportunity to work toward creating a peer supervisory role, which would allow peers to have the ability to expand in their positions.
- The MHP tracks and trends all of the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.

QUALITY PERFORMANCE MEASURES

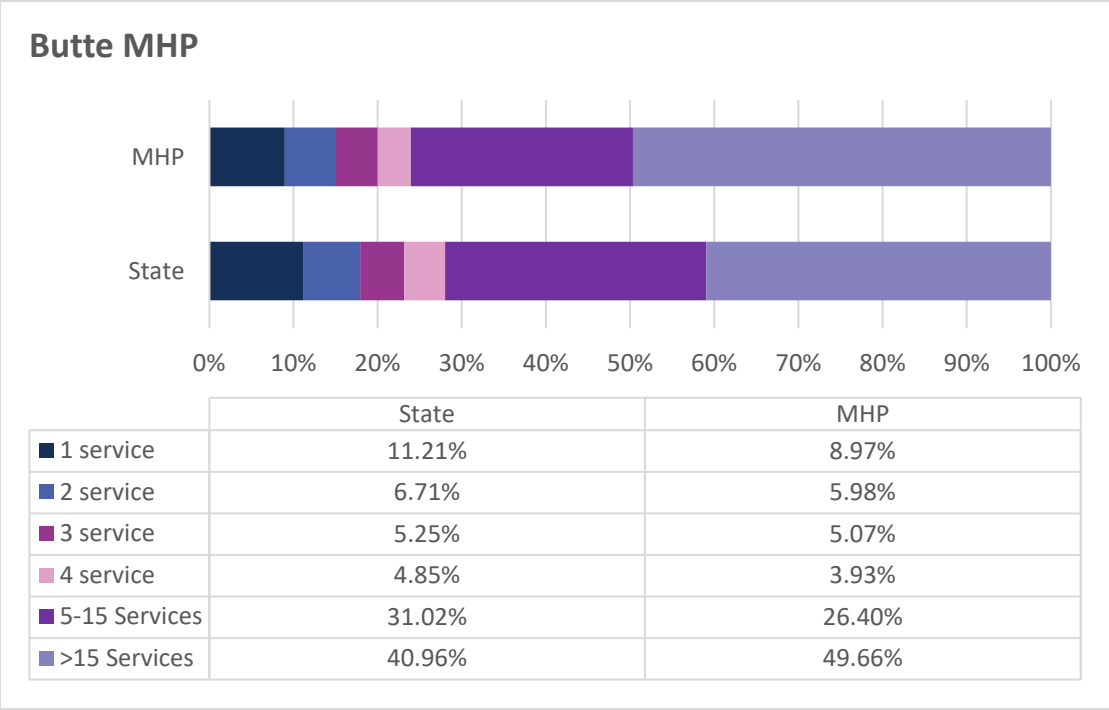
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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 (LOS), as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Retention of Members Served, CY 2022



	State	MHP
1 service	11.21%	8.97%
2 service	6.71%	5.98%
3 service	5.25%	5.07%
4 service	4.85%	3.93%
5-15 Services	31.02%	26.40%
>15 Services	40.96%	49.66%

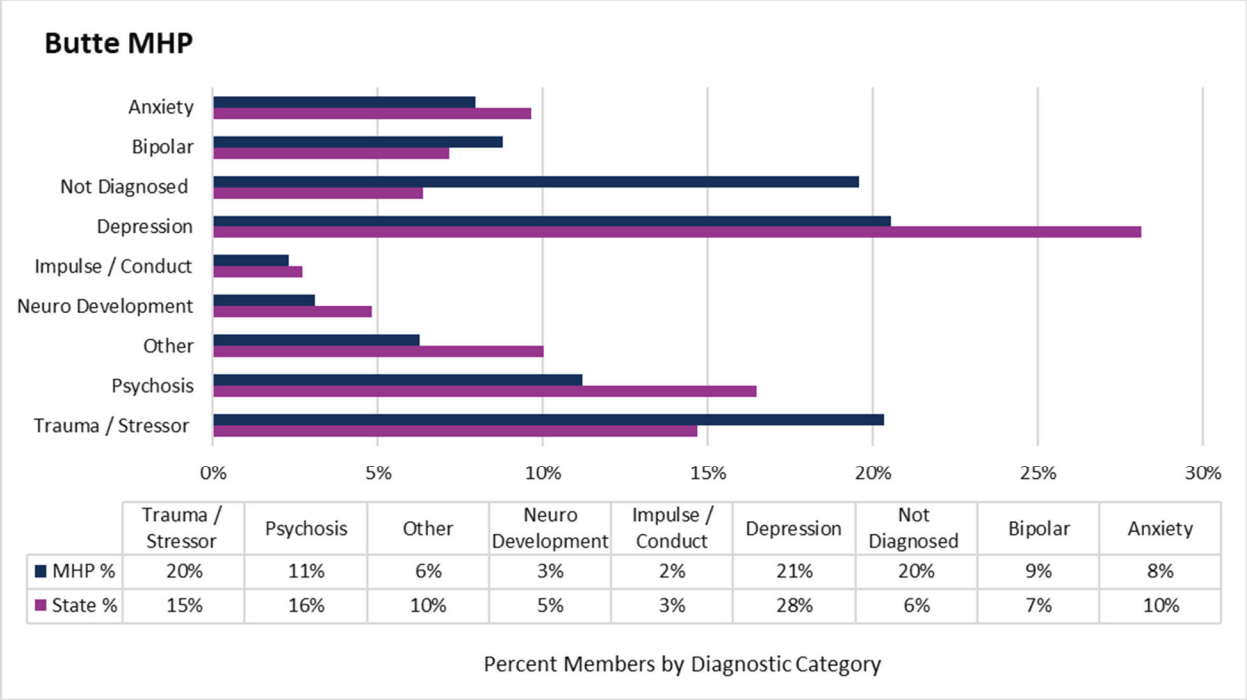
- The MHP had higher retention of members in services than statewide, retaining a plurality of its members for greater than 15 services. More than 76 percent of members received five or more services, compared to almost 72 percent statewide.
- The MHP's rate of members receiving greater than 15 is greater to the statewide rate (49.66 percent vs. 40.96 percent).

- The MHP shows a slightly lower rate of members who receive only one service.

Diagnosis of Members Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, 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

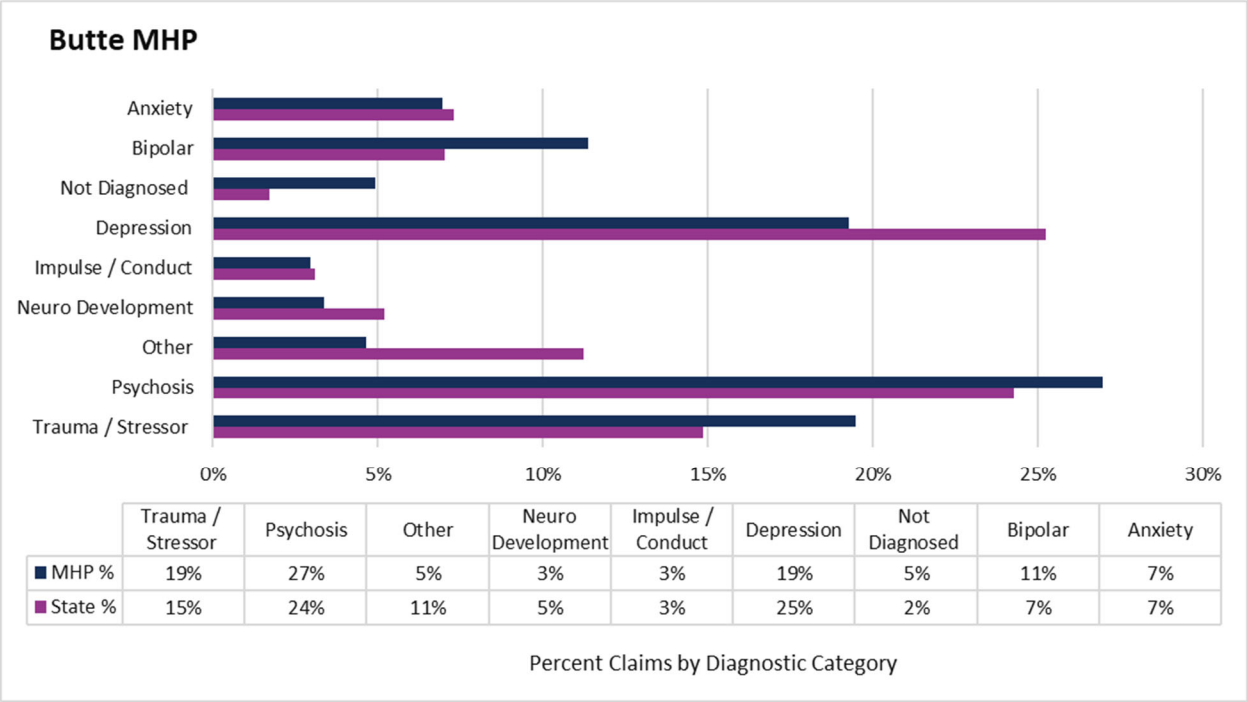


	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	20%	11%	6%	3%	2%	21%	20%	9%	8%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- Butte has higher rates of trauma/stressor diagnoses (its recent history of destructive fires), as well as a greater proportion of members who were not diagnosed, compared to statewide diagnostic patterns. However, the MHP has lower proportions of members diagnosed with depression, psychosis, and "other" diagnoses (that do not fit into any of the other categories) than seen statewide.
- While anxiety, depression, and psychosis disorders are diagnosed notably lower than in seen statewide, bipolar (9 percent vs. 7 percent) and trauma (20 percent vs 15 percent) are higher than the state average.

- Overall conclusions about the diagnostic profile across the MHP is limited by the large percentage with no diagnosis.

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



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	19%	27%	5%	3%	3%	19%	5%	11%	7%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- Claims by diagnostic categories were generally congruent with diagnostic patterns seen in Figure 16, with the only exception being psychosis. While 11 percent of members were diagnosed with psychosis, that diagnosis represented 27 percent of claims in the MHP.

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). CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

Table 13: Butte MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	307	382	1.24	9.03	8.45	$15,615	$12,763	$4,793,735
CY 2021	403	501	1.24	9.38	8.86	$12,874	$12,696	$5,188,064
CY 2020	348	468	1.34	12.11	8.68	$16,265	$11,814	$5,660,321

- Butte showed a decrease in its inpatient admissions in CY 2022, lower than both of the prior two years. They show a slightly longer ALOS than statewide.

Follow-Up Post Hospital Discharge and Readmission Rates

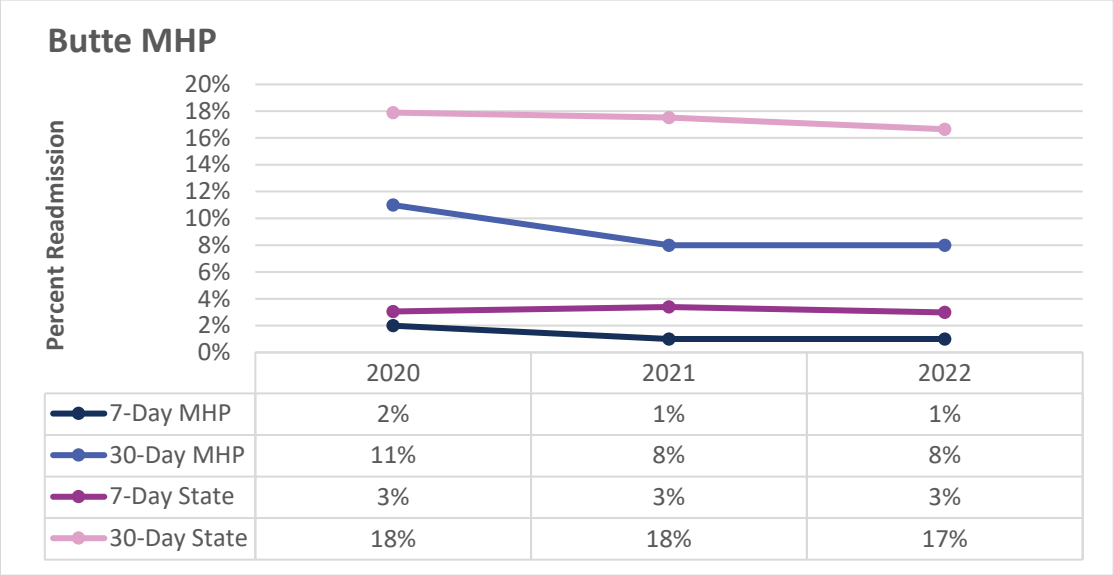
The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; 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. As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the current methodology.

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

- Butte continues to exceed the statewide rates for both 7-day and 30-day follow-up services post hospitalization.

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



	2020	2021	2022
7-Day MHP	2%	1%	1%
30-Day MHP	11%	8%	8%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP has low rates of 7- and 30-day readmissions after receiving psychiatric inpatient services. Butte's 7-day readmission rate has been lower than the statewide rate for the past three years.
- The MHP reported a 5 percent 7-day rate and a 16.94 percent 30-day readmission rate for FY 2022-23.

High-Cost Members

Tracking the 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 members, 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 LOC 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.

Tables 14-15 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: Butte 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	245	4.52%	31.60%	$12,856,689	$52,476	$42,222
	CY 2021	277	5.00%	33.84%	$14,132,603	$51,020	$41,645
	CY 2020	248	4.24%	32.99%	$13,762,823	$55,495	$44,003

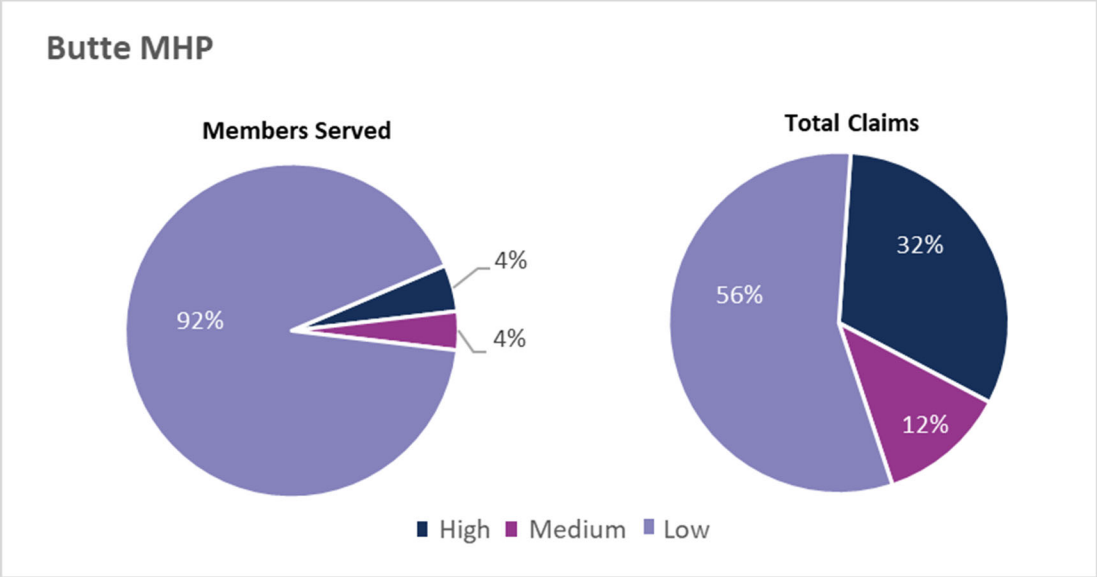
- The proportion of HCMs in the MHP is comparable to statewide and decreased slightly in CY 2022 from the previous year. The average approved claims per HCM is lower in the MHP compared to statewide.

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

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	203	3.74%	12.20%	$4,965,973	$24,463	$24,285
Low-Cost (Less than $20K)	4,973	91.74%	56.20%	$22,868,954	$4,599	$3,181

- Most of the MHP’s members are considered low-cost (less than $20,000 in claims). Only 12.20 percent of the MHP’s services were considered medium-cost (claims totaling $20,000 - $30,000).

Figure 20: Members Served and Approved Claims by Claim Category, CY 2022



- While 92 percent of members served were considered low-cost, they only accounted for 56 percent of claims. Just 4 percent of members were considered HCMs, and that group accounted for 32 percent of the county's overall approved claims.

IMPACT OF QUALITY FINDINGS

- The MHP maintains a higher post-discharge follow-up and lower psychiatric readmission rate compared to statewide.
- The MHP employs 19 peers throughout the adult and children's system of care. The vast network of peers provides navigation, assistance, groups, and various other services to members. Given the large number of peer employees, efforts to create a peer supervisor position should be revisited as this topic was not a priority during the COVID-19 pandemic.
- The MHP has been impacted by a large number of youth needing services, though specific numbers and the percentage change were not available. This is reportedly due to CalAIM, which qualifies all youth with trauma for SMHS.
- The MHP is working hard to meet the state's CalAIM requirements and has already submitted a small number of claims for reimbursement utilizing the payment reform rates.

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 §§ 438.330[2] 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: Youth Level of Care Intervention Standards

Date Started: 09/2023

Aim Statement: Proposed as a study question, "For youth aged 5-21, will establishment of standardized intervention practices based on CANS scores result in a decrease CANS score and/or decrease in length of stay over the next year?" Additionally, the aim refers to focusing on those youth with elevated CANS scores.

Target Population: youth aged 5-21 years old in programs across the SOC.

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

Summary

The stated goal of this PIP is to develop and utilize a LOC tool based upon a weighted algorithm of CANS scores that can take the strengths and needs into account.

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

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

Initial analysis of the problem showed that youth in outpatient programs had similar CANS scores to youth in high acuity FSP programs. However, the MHP also noted that their analysis included strengths in the averaging of total scores. For example, using CANS, a need rated 2 indicates "action needed," and a strength rated 2 indicates "identified strength" – both are a "2" and have very different meaning in a total of the CANS ratings.

The PIP does not yet define its PMs and goals for improvement. Strategies involved are described as "meetings with providers, gathering internal and external data, and enhancing training for staff services." The development of the actual algorithm is proposed as a separate non-clinical PIP. The intervention itself is the development of a LOC algorithm (in the non-clinical PIP) and implementation of that algorithm (in this clinical PIP). Clinical interventions stated are to "engage in therapeutically appropriate interventions by establishment of guidelines for best clinical intervention and triage strategies for youth entering our system of care." The guidelines themselves are pending development. A pilot design is referenced but not detailed as to how it is different from the ongoing intervention and analysis, and the time parameters for this intended pilot.

TA and Recommendations

The MHP received TA prior to the review and submitted an updated PIP document after the review which serves as a basis for this report. As submitted, this clinical PIP was found to have no confidence because the study design is not yet sufficiently detailed and therefore the methods cannot be determined to be valid, credible, or reliable. The submission has not yet included PMs, baseline data, targeted goals for improvement, and detailed interventions.

CalEQRO recommendations for improvement of this clinical PIP:

- As suggested by the MHP, it is difficult to evaluate the initial program-specific aggregated data that serves as the problem analysis with the total scores as presented. Consider domain-specific analysis that distinguishes strengths from needs or otherwise accounts for them, as may be suggested by the MHP's intention to do a "weighted analysis."
- Define measures and outline methodology for pilot study. This may produce the baseline data upon which future results can be compared. Specify what an "elevated CANS score" is defined as, for this sets the study population and goals for improvement. The initial data set can be used to establish the baseline and goals.
- Include a measure of CANS scores at admission by program type so that it is clear upon initial engagement that a client is served at the appropriate LOC.
- Because the design seeks to only include youth with two or more CANS administrations (for pre/post study design), it can miss the improvement opportunity that is independent of the course of treatment. This is an important

distinction between a research study design and improvement project study design. Research design that is testing impact would include only those youth with pre/post CANS scores, but improvement design seeks to evaluate the impact on the intended population, which would be youth in outpatient programs or youth in those programs with the elevated scores.

- Include local CANS subject matter experts, such as experienced clinical line staff or program supervisors, who can provide context for CANS scores, and speak to hands-on implementation of the LOC guidelines.
- LOS analysis should be provided contextually as shorter LOS may be associated with premature drop-out rather than achieving outcomes.
- Consult with other counties that have developed and implemented algorithms using CANS data to glean lessons from their development, implementation, and utilization that can inform Butte's process.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Youth Level of Care Dashboard Report

Date Started: 09/2023

Aim Statement: Presented as a study question, "For youth aged 5-21 receiving services in internal and external behavioral health services, will established LOC standards improve triage efforts, ensuring that clients receive appropriate LOC and services, as measured by alignment with CANS and Level of Care, over the next year?"

Target Population: youth aged 5-21 years old in programs across the SOC.

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

Summary

The non-clinical PIP is based upon the problem analysis identified in the clinical PIP submitted and a very similar study aim. The MHP seeks to create a dashboard report that enables program leadership to evaluate adherence to guidelines in real time. This would also enable clinical staff to see CANS scores in real time. Pre-intervention activities include developing the reports, developing the LOC criteria, and training staff. The pre-intervention activities have not been completed.

TA and Recommendations

The MHP received TA prior to the review and submitted an updated PIP document after the review which serves as a basis for this report. As submitted, this non-clinical PIP was found to have low to no confidence as the study design is not sufficiently detailed in

order to evaluate whether the study design and methods are credible, reliable, and valid.

CalEQRO recommendations for improvement of this non-clinical PIP:

- The non-clinical PIP appears to be intended to develop the intervention that will be utilized in the clinical PIP. Because it is the same topic of focus for the same youth, it is a single project. Develop a more comprehensive data analysis plan that establishes baseline data that are the identified measures to be targeted for improvement by the outlined interventions.
- As presented, the two PIPs submitted together likely form a single, non-clinical PIP, where the recommendations provided for the clinical PIP above apply to the overall topic as presented.
- Seek consultation on study design from CalEQRO.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart/My Avatar, which has been in use for 14 years. Currently, the MHP is considering a new system but has no formal project plan in place and no project team assigned to accomplish it.

Approximately 3 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control.

The MHP has 568 named users with log-on authority to the EHR, including approximately 488 county staff and 80 contractor staff. Support for the users is provided by 14 full-time equivalent (FTE) IS technology positions. Currently all positions are filled.

As of the FY 2023-24 EQR, some contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

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

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☒ Batch	2%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	8%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	35%
Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☒ Monthly	53%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	2%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ 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 offers a PHR to members who receive services directly from county-run programs. Via the PHR members can view future appointments, receive appointment reminders, and view their active medication prescriptions. The extent to which contract programs who have their own EHRs support PHR functionality is unknown. There have only been three members who accessed their PHR in the last year.

Interoperability Support

The MHP is a member or participant in a HIE, however Sac Valley Medshare, whom they have contracted with, is currently implementing another county's system prior to working with Butte, so the MHP is not able to use it to exchange information yet. The MHP engages in electronic exchange of information with contract providers and SUD Contract 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	Met
4E	Security and Controls	Met
4F	Interoperability	Partially Met

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

- The MHP has increased staff to meet the needs of the IS department.
- The MHP has an extremely low denied claims rate.
- The MHP has contracted with Sac Valley Medshare HIE for future interoperability; however, Sac Valley Medshare is currently working with another county prior to Butte County.

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 Butte MHP SDMC Approved and Denied Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	12,566	$2,906,894	$13,662	0.47%	$2,893,232
Feb	13,246	$3,499,393	$11,113	0.32%	$3,488,280
Mar	15,049	$4,032,398	$9,809	0.24%	$4,022,589
April	13,240	$3,663,500	$8,744	0.24%	$3,654,756
May	13,639	$3,589,712	$11,194	0.31%	$3,578,518
June	13,012	$3,465,940	$8,521	0.25%	$3,457,419
July	11,709	$2,988,935	$45,525	1.52%	$2,943,410
Aug	14,302	$3,551,646	$50,874	1.43%	$3,500,772
Sept	13,861	$3,415,947	$39,048	1.14%	$3,376,899
Oct	13,079	$3,259,183	$10,001	0.31%	$3,249,182
Nov	11,594	$2,813,281	$9,852	0.35%	$2,803,429
Dec	11,202	$2,739,826	$3,825	0.14%	$2,736,001
Total	**156,499**	**$39,926,655**	**$222,168**	**0.56%**	**$39,704,487**

- Butte has a low denied claims rate. However, there were a few high dollar amounts seen in July and August 2022. This is due to the need for other forms of insurance and Medicare needing to be billed prior to SDMC.

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

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Member is not eligible or non-covered charges	137	$69,831	31.43%
Service line is a duplicate and repeat service modifier is not present	124	$66,811	30.07%
Medicare Part B must be billed before submission of claim	144	$41,597	18.72%
Other healthcare coverage must be billed first	113	$35,871	16.15%
Late claim submission	6	$3,039	1.37%
Place of service incomplete or invalid	2	$1,530	0.69%
Other	7	$1,371	0.62%
Deactivated NPI	3	$1,249	0.56%
Service location NPI issue	2	$867	0.39%
Total Denied Claims	**538**	**$222,166**	**100.00%**
Overall Denied Claims Rate	**0.56%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The denied claims rate is low for Butte, under 1 percent. The top reasons claims were denied were the member not being eligible or the charges not being covered (31.43 percent of denied dollars), and the service line being a duplicate without a repeat service modifier present (30.07 percent of denied dollars).

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP has contracted with Sac Valley Medshare HIE. This will allow them to move towards CalAIM requirements to share information in the future, though the HIE has not yet been set up and is not yet being used to exchange information.
- The MHP has increased IS staff by one technician and one analyst since the last EQR to meet the needs of the department and CalAIM requirements. The MHP is working hard to meet the state's CalAIM requirements and has already submitted a small number of claims for reimbursement utilizing the payment reform rates.
- Butte has a number of contract providers submitting services to the MHP by allowing direct entry into the EHR and electronic batch file transfers.
- Butte County successfully reviews their claims prior to submission. This is seen in the low rate of denied claims.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) 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 conducts the CPS per DHCS requirements. The MHP reviews the results of the CPS with the system of Care and stakeholders once the results are received. The QIC utilizes CPS data for quality improvement.

PLAN MEMBER/FAMILY FOCUS GROUPS

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 90-minute focus groups with plan members and/or their family, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included 5 participants. All participants receive clinical services from the MHP.

Recommendations from focus group participants included:

- "Do a better job spreading information."
- Offer more flexible hours.
- "They should increase their outreach with social media, maybe use YouTube."
- Group members reported a need for more affordable housing.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of parents/caregivers of consumers who initiated services in the preceding 12 months. The focus group was held virtually and included

three participants. The group participants were parents or caregivers of members who were receiving clinical services from the MHP.

Recommendations from focus group participants included:

- “Implement more family-based services.”
- “They need to work on having consistent staff and not so much turnover.”
- The MHP could do a better job or market all of the services that are offered.
- Services helped their family but they did notice a lot of staff turnover which at times impacted rapport.

SUMMARY OF MEMBER FEEDBACK FINDINGS

The group members indicated that they were very satisfied with the services they were receiving. They also indicated appreciating being able to receive services through various modalities such as in-person and telehealth. The group members complimented the staff and indicated that they go above and beyond to provide the best service possible. Group members indicated they have noticed staff turnover, but reported that the services were helpful.

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 is dedicated to meeting the state's CalAIM requirements and has already submitted a small number of claims for reimbursement utilizing the payment reform rates. (Quality, IS)

2. The MHP has increased training in leadership, and strives for a more supportive, and effective leadership team. They have been able to promote internal staff with subject matter experience from within the department. (Quality)

3. The MHP redesigned the intake process, reallocated staff resources, and created more intake slots to promote faster, easier access. This has improved the process across all demographic areas. (Timeliness)

4. The MHP has 19 peers employed by the county. (Quality)

5. The MHP utilizes an outcome tool for both adults and youth. Initiatives to utilize the CANS data for reporting will put this information to use for guiding clinical and program decisions. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP has increased efforts to recruit personnel, but currently maintains a 19 percent vacancy rate. This is complicated by additional staff turnover; retention challenges continue to impact the net gain of staff. Additionally, new staff indicate a lack of comprehensive training coupled with high caseloads. (Quality)

2. The MHP redesigned the intake process to allow for more assessments; however, the increased number of new members entering the system has reportedly led to the staff having unusually high caseloads. Some report caseloads as high as 150 to 200 members. (Access)

3. Contract provider access data is not included in the review of timeliness for access to services. This results in an incomplete assessment of how quickly members can access services through the MHP. (Timeliness)

4. Even though efforts have been made to improve collaboration and morale, contracted providers indicate that they are not as involved as they would like and are not seen as partners. (Quality)

5. Despite having many peer employees, the MHP does not have a peer supervisory position, nor direct relationships between peer employees and the leadership team.

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. As the MHP reduces its vacancy rate, still at 19 percent, work toward improved retention by initiating some specific activities designed to improve employee engagement. This should include developing processes to provide training during the onboarding process, and perhaps a staff mentor to assist new staff in learning the work and becoming more engaged with the system. Consider flexible staff scheduling but with attention toward on-site work as a component to meet member needs. (Quality, Access)

   (This recommendation is partially carried over from FY 2022-23.)

2. Evaluate workloads and system capacity that is available based upon existing clinical staff systemwide. Consider whether caseloads are at numbers that can allow for appropriate clinical management. Create a workload audit process which includes a caseload assignment metric to ensure staff workloads are reasonable and can enable quality service delivery. (Access)

3. Continue efforts to improve comprehensiveness and accuracy of systemwide timeliness monitoring by including contract provider timeliness data. This would be most readily achieved by engaging the contracted providers in using a county-wide EHR. (Timeliness)

   (This recommendation is a carry-over from FY 2021-22)

4. Increase communication with contracted providers and line staff. CalAIM has implemented many changes in services rendered, how to code, and how to bill. Contracted providers and staff are feeling left out of decisions being made and desire a stronger partnership. Identify opportunities in-person and through writing to maintain a consistent flow of information. (Quality)

5. Revisit prior efforts to create a peer supervisory role and explore the feasibility of implementation. The MHP has many peer positions in all geographical areas that could benefit from oversight or guidance from a peer supervisor, and such a position could provide valuable insight to the leadership team. (Quality)

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 identified by the MHP or CalEQRO in conducting 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 MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Butte 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 Well-Being (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Clinical Line Staff Group Interview
Program Managers Group Interview
Contract Provider Group Interview – Clinical Management and Supervision
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Cristobal Hernandez, Quality Reviewer
Sharon Mendonca, Information Systems Reviewer
Pamela Roach, Consumer and 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.

This review was held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Barstow	Jessye	Administrator	Counseling Solutions
Brianna	Ocampo	QM Analyst	Butte County
Brock	Autumn	FSP Clinician	Butte County
Brown	Lauren	Interim QM Clinician	Butte County
Brown	Spencer	IT Supervisor	Butte County
Casale	Sam	Mental Health Services Act, Research and Evaluation, Sr. Program Manager, Public Information Officer	Butte County
Cheema	Sukhveer	QM Clinician	Butte County
Chia	Thao	Clinical Supervisor	Butte County
Clifton	Kristie	Crisis Supervisor	Butte County
Davis	Essence	Assistant Director	Butte County
Feingold	Sarah	Director	Youth for Change
Frohock	Sarah	Interim, Performance Management, Clinical Services	Butte County
Gilligan	Jessica	Program Manager, Clinical Services	Butte County
Gonzalez	Rick	Adult Outpatient Clinician	Butte County
Gothan	Mathew	Support Services, Medical Records Program Manager	Butte County
Hope	Kilby	Crisis Services Clinical Supervisor	Butte County
Jones	Crystal	Clinician	Butte County
Kennelly	Scott	Director	Butte County
Kirk	Zeller	Crisis Supervisor	Butte County
Lor	Cindy	Crisis Counselor	Butte County

Last Name	First Name	Position	County or Contracted Agency
Lyon	Jennifer	Regional Director	Victor Community Support Services
Lyons	Aaron	Program Manager, Clinical Services	Butte County
Mausolff	Chris	Clinical Supervisor	Butte County
Meyer	Helena	Crisis Supervisor	Butte County
Nagra	Manpreet	QM, SPRE Analyst	Butte County
Naron	Bianca	Compliance Officer	Butte County
Perez	Michelle	QM Clinician	Butte County
Phillippe	Katy	Assistant Director	Northern Valley Catholic Social Services
Pilgram	Andy	IT Manager	Butte County
Read	Jacob	Sr. Program Manager, Clinical Services	Butte County
Reimers	Nicole	Extra Help QM Program Manager	Butte County
Rice	Bow	QM, Program Manager	Butte County
Rindlisbacher	Suzanne	Program Manager, Clinical Services	Butte County
Robinson	Melody	Assistant Director	Butte County
Stofa	Jenn	Assistant Director	Butte County
Taylor	Laurie	Supervising Clinician	Valley Oak Services
Tena	Brenda	QM Analyst	Butte County
Thao	Valerie	Clinician	Butte County
Thao	Mai	Clinician	Butte County
Thomas	Anna	QM Clinician	Butte County
Tomm	Jasleen	Executive Director	Victor Community Support Services

Last Name	First Name	Position	County or Contracted Agency
Waddell	Reidun	Sr. Program Manager, Clinical Services	Butte County
Williams	Belinda	Clinician	Butte County
Wong	Donovan	Medical Director	Butte County
Wood	Jessica	Program Manager, Clinical Services	Butte County
Zaveson	Christine	Nursing Supervisor	Butte County

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence	The validation rating for this PIP is no confidence as the study did not provide enough documentation to determine whether credible, reliable valid methods were employed or will be employed.
General PIP Information	
MHP/DMC-ODS Name: Butte County Behavioral Health	
PIP Title: Youth Level of Care Intervention Standards	
Aim statement: "For youth 5-21, will establishment of standardized intervention practices based on CANS scores result in a decrease in CANS score and/or decrease in LOS over the next year?" posed as a study question.	
Date Started: 09/2023	
Date Completed: N/A	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: age 5-21	
Target population description, such as specific diagnosis (please specify): Members between the ages of 5-21.	
Improvement Strategies or Interventions (Changes in the PIP)	

General PIP Information
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Clinical interventions have not been identified.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The clinical guideline that serves as the intervention is pending development and implementation. The MHP intends to refer members to the appropriate LOC based on their baseline CANS scores and seek improved outcomes based upon utilization of the new practice guideline.
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): The MHP will improve the youth introduction into services via new triage standards, refining LOC referrals, and establishing best practices for clinical interventions for members with high CANS scores.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
CANS score improvement (not quantified yet)			☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
LOS decrease (not quantified yet)			☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

Detailed in the body of the report.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence	The validation rating for this PIP is no confidence as the study did not provide enough documentation to determine whether credible, reliable valid methods were employed or will be employed.
General PIP Information	
MHP/DMC-ODS Name: Butte	
PIP Title: Youth Level of Care Dashboard Report	
PIP Aim Statement: "For youth aged 5-21 receiving services in internal and external behavioral health services, will establish Level of Care standards improve triage efforts, ensuring that clients receive appropriate LOC and services, as measured by alignment with CANS and Level of Care, over the next year."	
Date Started: 09/2023	
Date Completed: N/A	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: 5-21	
Target population description, such as specific diagnosis (please specify): Youth in the SOC age 5-21 receiving services from the MHP and contracted providers.	

General PIP Information
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Interventions are non-clinical and provider-focused
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The members' CANS scores will be displayed in a dashboard. Initial CANS scores are intended to align their needs with the appropriate LOC. The dashboard will have updated CANS scores and will also be utilized to step down members to lower LOC when applicable.
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): This intervention will be develop a new algorithm to serve as a practice guideline for youth.

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
Measures are not detailed			☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP: Detailed in the report

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 as part of this report.