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

MARIPOSA DRAFT REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 6, 2023

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2023-24 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, "Mariposa" may be used to identify the Mariposa County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — September 6, 2023

MHP Size — Small-rural

MHP Region — Central

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
6	2	3	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	6	0	0
Quality of Care	10	2	6	2
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**15**	**9**	**2**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Psychiatry no-shows	Clinical	07/2022	Other – completed	Low confidence
Phone services	Non-Clinical	12/2022	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	4

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Peer Specialist (I/II/III) is a newly created civil service classification that enables the MHP to hire certified peers and expects to add two full-time equivalent (FTE) staff in this job class.
- The MHP's paperless EHR, inclusive of scanned historical records, ensures information is centrally located and readily available for staff to effectively provide treatment to members.
- The MHP is approaching its launch of the LOCUS tool which will be useful for managing service capacity and assuring that members are served at the most suitable level of care (LOC).
- As the county is the new provider health and MH services in the jail, the MHP can more readily bring members into care upon their re-entry to the community.

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

- The MHP's implementation of the CalAIM screening tool does not lend itself to the less labor-intensive and consistent screening intended.
- The high percentage of members only receiving one to two services may represent issues with member engagement after an intake or crisis intervention.
- The low number of referrals to psychiatry suggests this service type may be under-utilized, particularly for adults. The referral process may be cumbersome for staff and add delays for members waiting for care.
- The MHP provides an unsual amount of targeted case management (TCM) to adults; this may in fact represent an unusual service pattern or could be a data integrity issue.

- The MHP lacks mechanisms to solicit feedback and input from functional area stakeholders and subject matter experts regarding clinical processes and electronic health record (EHR) development.
- The MHP may not have a sufficient number of staff to adequately manage the Medi-Cal claiming process.

Recommendations for improvement based upon this review include:

- Consult with DHCS regarding parameters and expected fidelity to the CalAIM screening tool. Determine the extent to which members are not screened prior to their assessment.
- Examine service patterns for members who receive only one to two services to determine whether more attention should be given to clinical engagement or if other issues are apparent.
- Examine a reasonable sample of charts to determine whether psychiatry is being offered at clinically appropriate stages of care. This analysis should include participation from psychiatric providers, as well as someone with lived-experience if possible, to help inform the process.
- Examine service patterns for adults receiving TCM, particularly those members who are outliers receiving well above the average. This may reflect an unintended service pattern or miscoding of services delivered.
- Provide a mechanism for staff to contribute as subject matter experts when new initiatives are being discussed and planned. This should include the development and testing of workflows to provide feedback regarding new EHR functionality and implementation.

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 Mariposa County MHP by BHC, conducted as a virtual review on September 6, 2023.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's 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

The MHP engaged in significant post-disaster response after the Oak Fire which burned from July to August 2022.

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 county began as the provider of BH services in the jail in July 2023. This enables individuals to enter into the MHP system quickly after release from jail.
- The county is considering adding tiny homes to extend shelter capacity, which generally houses about 20 individuals. There is a homeless encampment near the shelter, both of which are not far from the MHP office. Outreach services and mobile crisis response is provided to the shelter and encampment.
- A site has been selected in the North County for a clinic site.
- No Place Like Home funding delivered 11 units (of 21 new units) for MH clients; all are provided an MHP case manager.
- The QA unit, which is responsible for QA of the integrated agency, was expanded from only one staff to three staff and a supervisor. None are dedicated entirely to the MHP QA functions. There is no operational link from an organizational standpoint between QA and the BH division (within the MHP operates).
- The organizational chart shows 5.8 FTE outpatient MH clinician positions vacant – three of five clinician positions in the adult system and 2.8 of 5 positions in the children's program. In addition to two filled positions in the outpatient programs for youth and adults, the adult SOC includes two MH assistants and one MH aide; children's services include three MH assistants.
- A new BH director, a long time Mariposa employee, was appointed in June 2023.

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: Increase average units of service provided to members, which may require more staff than the MHP currently has.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- This issue was an artifact of late claims submission due to problems with claiming in 2021. This was resolved between reviews. CalEQRO's refreshed CY 2021 data substantiates this.

Recommendation 2: Expand the outreach initiatives to older adults, provide evidence-based strategies for this population, and monitor the efficacy of those strategies. The MHP should consider a Plan-Do-Study-Act cycle that allows efficient testing and evaluation of ideas.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP conducted stakeholder and community planning meetings where concerns regarding the older adult population were expressed. The previously implemented "friendly visitor" program was well-liked by the community and is slated to be implemented again with a volunteer workforce, managed by a staff program coordinator.

- It will be important to determine whether the older adults are receiving services they need, and upon referral to the MHP, the rate at which older adults successfully link to services. The volunteer workforce should be trained on screening for MH needs and referral procedures.
- While not implemented yet, this will not be carried over as an ongoing recommendation as the MHP is engaged in activities to address this issue.

Recommendation 3: Provide additional training opportunities for analytic and quality improvement staff to expand their expertise in the usage and interpretation of data for program evaluation and improvement.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- All Quality Assurance (QA) staff have been enrolled in Lean Six Sigma (LSS) and will be trained at either green belt or black belt levels.

Recommendation 4: Engage staff in generating solutions and give them some autonomy in implementing strategies to meet the current demands in care. The behavioral health department leadership can begin by disseminating to staff minutes from management meetings (which were previously shared).

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Staff appear to be disengaged from the leadership and disconnected from systemwide issues. There does not appear to have been any substantive activities to engage staff in identifying, testing, and implementing solutions. While managers are expected to disseminate information to line staff, this is not conducted consistently.
- Staff engagement appears to be a significant need for the MHP and this recommendation will be carried forward with modified language.

Recommendation 5: Research and develop a plan for integrating peer employees into the system of care. Present this plan to requisite stakeholders for consideration.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has created a civil service Peer Support Specialist (I/II/III) classification. No employees have been hired into this classification yet.
- A peer mental health aide oversees activities at the wellness center. It does not appear however that the wellness center or other recovery-oriented services are embedded throughout the service continuum.

- This recommendation will not be continued in this report due to other issues warranting recommendation.

Recommendation 6: Update InSync to capture FC status, integrate relevant medication monitoring areas for youth prescribed psychotropic medications, and track urgent services by hours.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The Electronic Health Record (EHR), InSync, was updated to include a referral tracker that allows the MHP to capture urgent services in hours.
- The MHP has taken steps toward integrating the LOCUS in the EHR and is pending implementation.
- Medication monitoring and FC status is not embedded in the EHR.
- This is not carried over in this year's report due to other priority recommendations.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 68 percent of services were delivered by county-operated/staffed clinics and sites, and 32 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 82 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 staff; members may request services through the access line as well as drop-in at the clinic site. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services.

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 78 adults, 41 youth, and 18 older adults across 3 county-operated sites and three contractor-operated sites. Among those served, 3 members received telehealth services in a language other than English in the preceding 12 months.

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

[1] CMS Data Navigator Glossary of Terms

informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

In May 2023, 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 Mariposa County, the time and distance requirements are 60 miles and 90 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 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: 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	Partially 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 QIC reviews open caseload by zip code, PRs, demographics, service modality. The MHP does monitor the numbers of assessments and discharges to anticipate the impact on service delivery. Implementation of the LOCUS will provide a useful tool for managing capacity. There is reportedly a sufficient provider base in the managed care plan (MCP) network, which should enable transfer of cases that upon assessment do not require SMHS.
- A number of completed suicides occurred on a local bridge. The MHP recently put signs at that location that provide numbers for crisis support.
- Implementation of the new CalAIM Screening Tool has been challenging, as the MHP observed that members who previously would have been enrolled in care at the MHP screen to the MCP level on the tool. As a result, they have supervisors conducting the screening call, often a call-back after the initial access line interaction, but before the scheduled assessment appointment. When the follow-up screening has not occurred, a member may show for an assessment appointment to be screened and referred out.
- Staff and member feedback indicated that the emphasis on in-person appointments makes it difficult for some members to keep their appointments when a telehealth service would have been preferred.
- Staffing has been a challenge with few applicants interested in providing services in-person when the community-based organizations are providing primarily telehealth and offer more flexible hours.

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 an average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, Mariposa demonstrates better access to care than seen in similar size counties and statewide.

Table 3: 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	6,208	550	8.86%	$4,905,757	$8,920
CY 2021	5,808	507	8.73%	$4,021,646	$7,932
CY 2020	5,268	473	8.98%	$4,839,241	$10,231

*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.

- Consistent with statewide patterns, the number of eligibles increased; however, unlike the statewide pattern, the number of members served by the MHP also increased.

Table 4: County 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	589	<11	-	1.63%	1.82%
Ages 6-17	1,172	124	10.58%	8.62%	5.65%
Ages 18-20	265	24	9.06%	6.55%	3.97%
Ages 21-64	3,523	348	9.88%	7.37%	4.03%
Ages 65+	661	44	6.66%	3.60%	1.86%
Total	**6,210**	**550**	**8.86%**	**6.67%**	**3.96%**

- The total PR, as well as the PRs in every age group except 0-5, exceed both the county size group and statewide rates. The 0-5 PR was in line with the statewide PR, whereas other age groups' PRs were two to three times higher than statewide numbers.
- The MHP's claims were behind when CY 2021 data was initially analyzed by CalEQRO. Last year's review suggested decreased access by older adults. This was not as significant when CalEQRO refreshed the CY 2021 data, showing a 5.42 percent PR for the 65+ population. In CY 2022 13 more members were served in this population, and while the PR is higher than CY 2021, and well above the statewide rate, this group has a lower PR compared to other age groups served by the MHP.

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

Threshold Language	# Members Served	% of Members Served
No Threshold Language	N/A	N/A
Threshold language source: Open Data per BHIN 20-070		

- The MHP does not have a threshold language.

Table 6: 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	2,243	192	8.56%	$1,777,152	$9,256
Small-Rural	38,250	2,337	6.11%	$11,818,209	$5,057
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. The ACA PR was just almost as high as overall PR in the county, and the AACM is higher than the overall AACM.
- The PR for ACA eligibles was higher than other small-rural counties and statewide, as was the AACM.

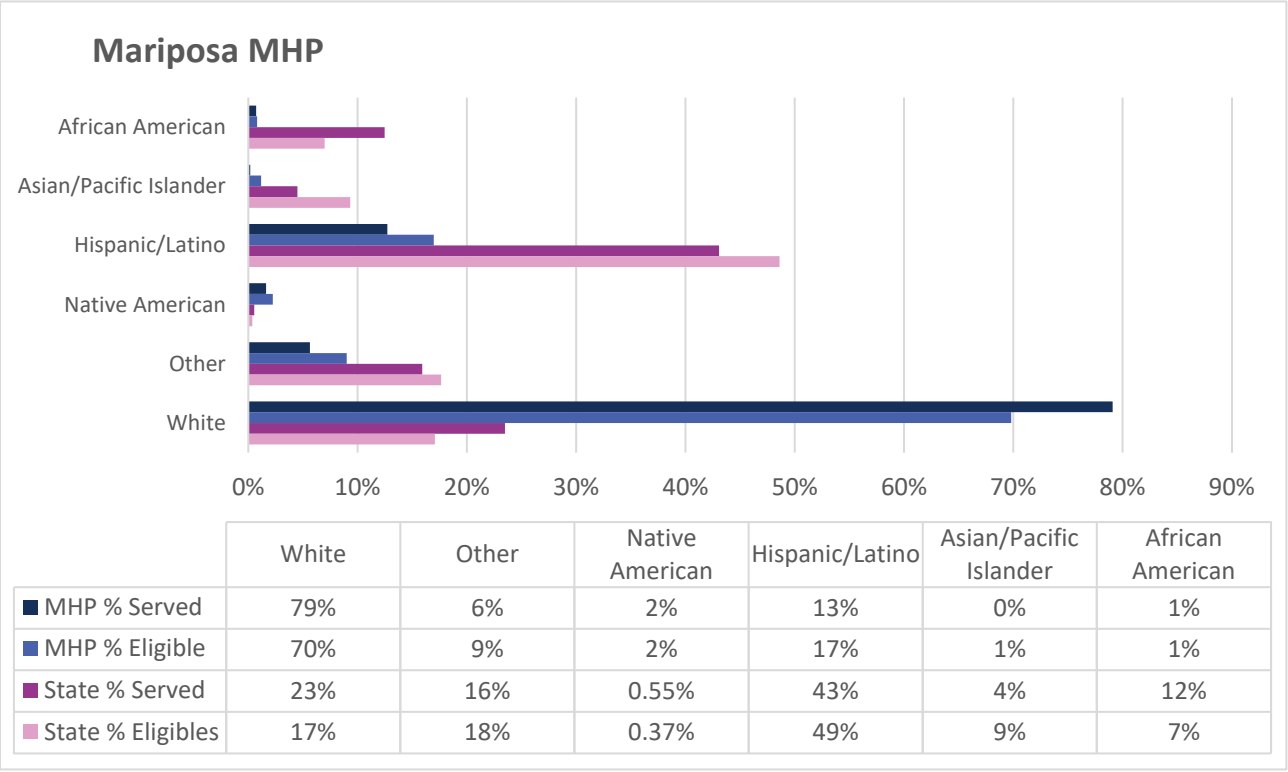
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they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

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

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	50	<11	-	7.08%
Asian/Pacific Islander	73	<11	-	1.91%
Hispanic/Latino	1,054	70	6.64%	3.51%
Native American	139	<11	-	5.94%
Other	559	31	5.55%	3.57%
White	4,334	435	10.04%	5.45%
Total*	**6,209**	**550**	**8.86%**	**3.96%**

- The PRs for all race/ethnic groups other than Asian/Pacific Islander were higher than statewide.

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



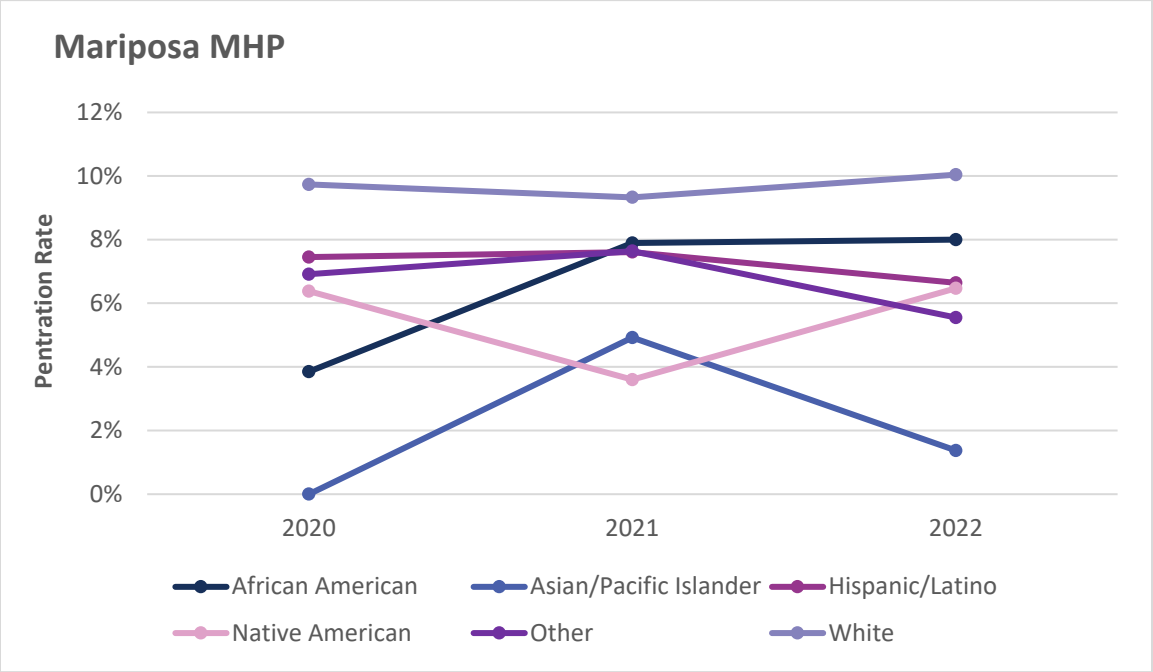
	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	79%	6%	2%	13%	0%	1%
MHP % Eligible	70%	9%	2%	17%	1%	1%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- The proportions of members served by race/ethnicity were comparable to the eligibles for most groups. The over-representation of White members was larger than in the previous year.

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),

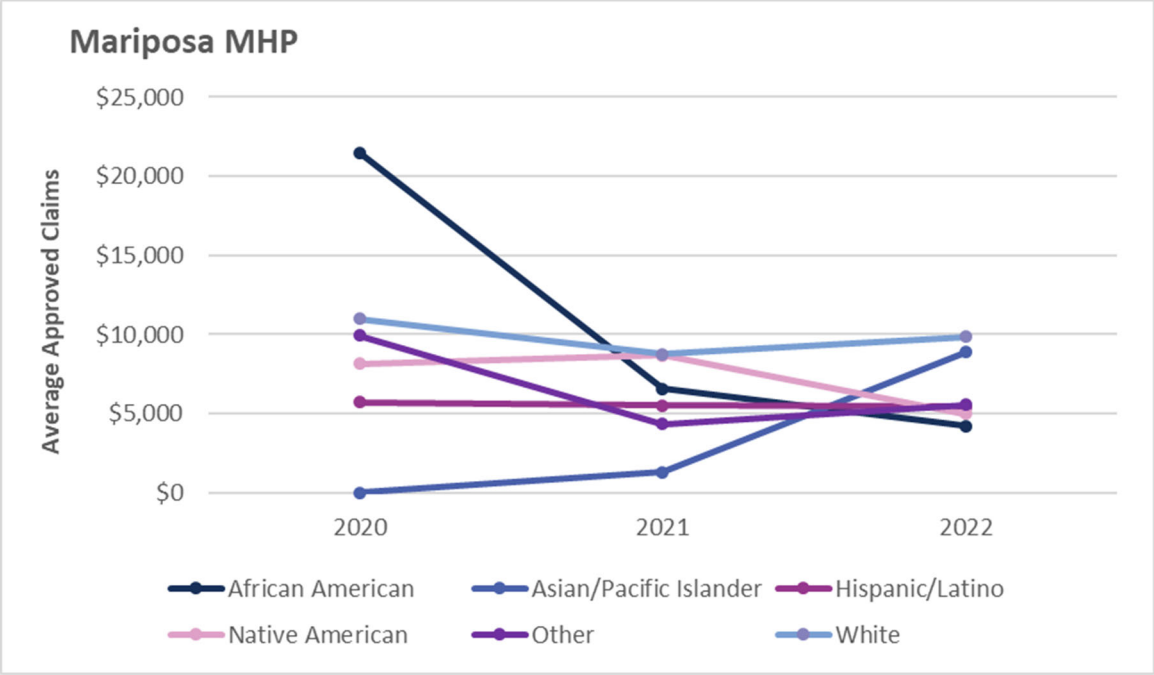
and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year trend.

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



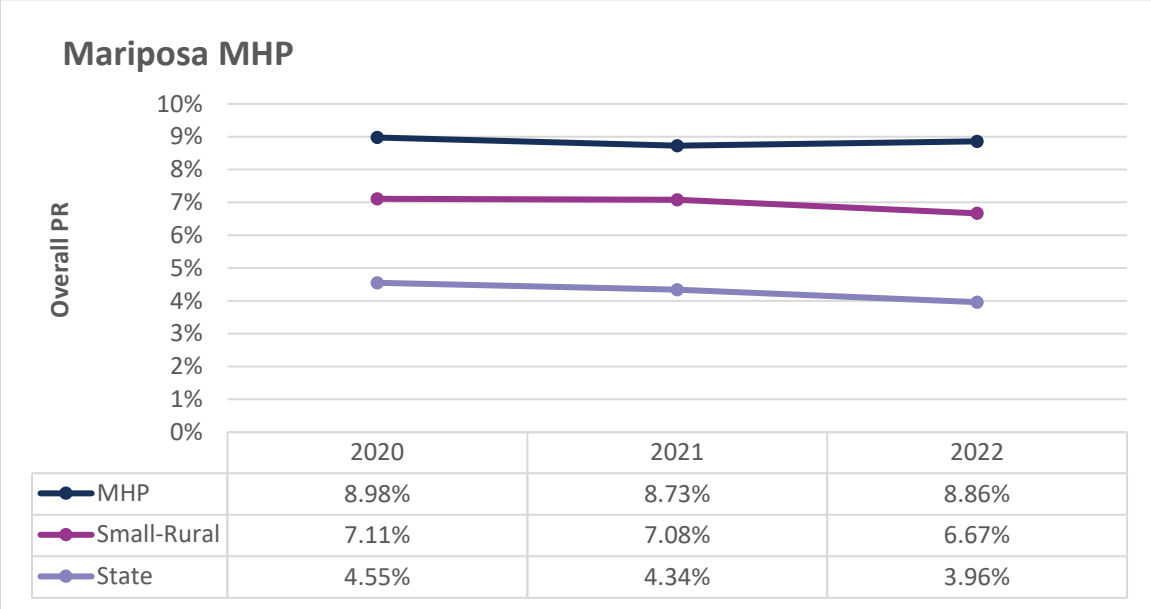
- The White group has the largest PR consistently over the last three years.
- Due to the small numbers of eligibles in several racial/ethnic groups, any change in the numbers of members served from year to year can make the trendlines for PR appear dramatic. A change of only a few members can appear to be a significant change.

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



- The AACM for the White and Hispanic/Latino group remained steady the past three years, unlike the other race/ethnic groups that have turned downward.

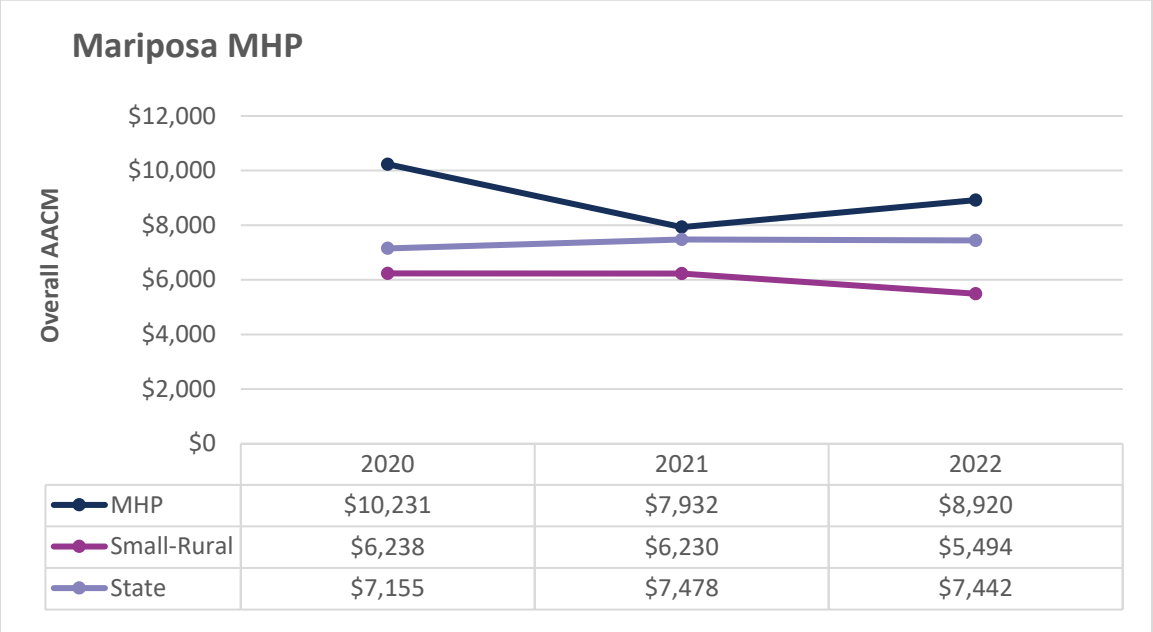
Figure 4: Overall PR CY 2020-22



	2020	2021	2022
MHP	8.98%	8.73%	8.86%
Small-Rural	7.11%	7.08%	6.67%
State	4.55%	4.34%	3.96%

- The PR in the MHP increased in the last year, whereas it has been trending downwards in small-rural counties and statewide over the past three years.

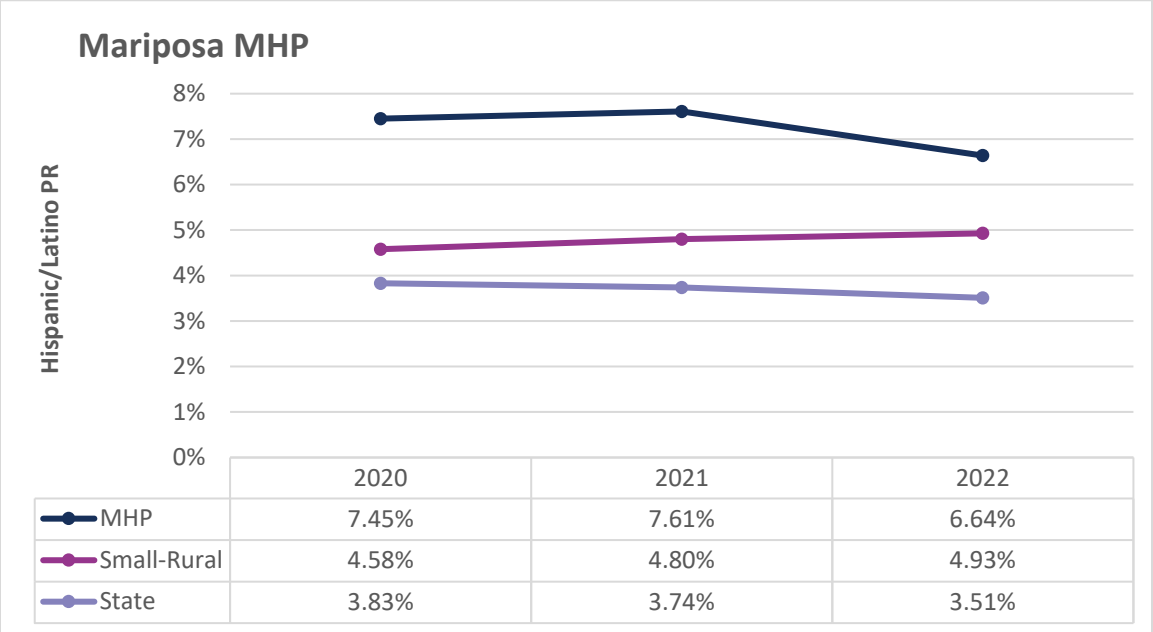
Figure 5: Overall AACM CY 2020-22



	2020	2021	2022
MHP	$10,231	$7,932	$8,920
Small-Rural	$6,238	$6,230	$5,494
State	$7,155	$7,478	$7,442

- The AACM decreased from CY 2020 to CY 2021, followed by an increase in CY 2022. AACM in the MHP has consistently exceeded the AACM in other small-rural counties and statewide across the past three years.

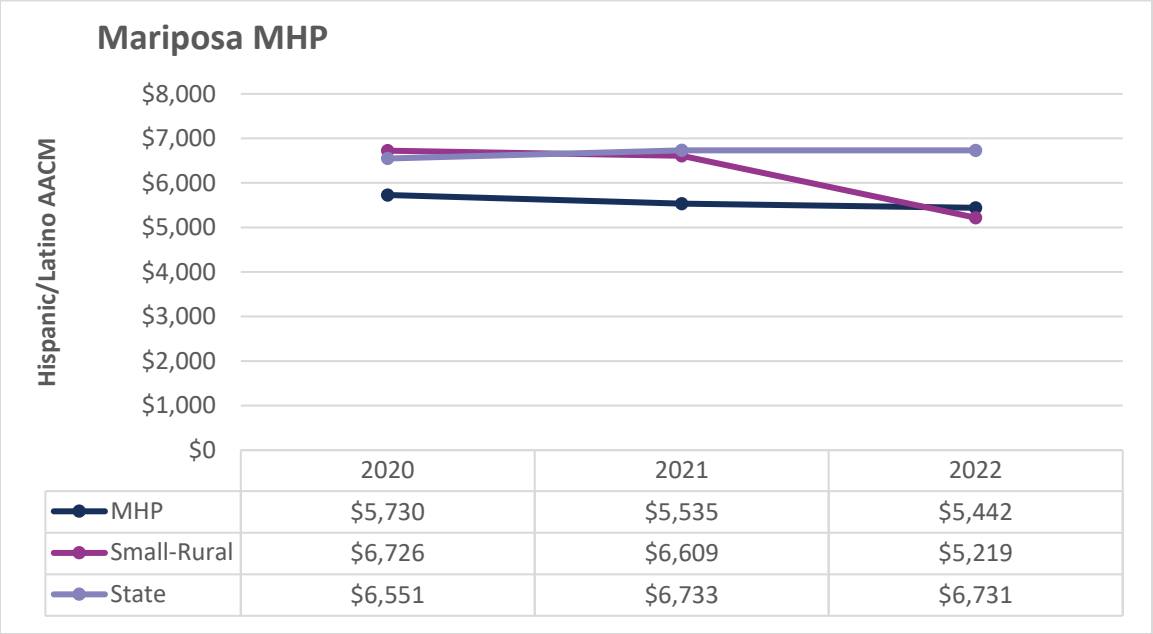
Figure 6: Hispanic/Latino PR CY 2020-22



	2020	2021	2022
MHP	7.45%	7.61%	6.64%
Small-Rural	4.58%	4.80%	4.93%
State	3.83%	3.74%	3.51%

- PRs for Hispanic/Latino eligibles increased slightly between CY 2020 and CY 2021, but decreased in CY 2022. The MHP's PR has been consistently higher than other small-rural counties and statewide.

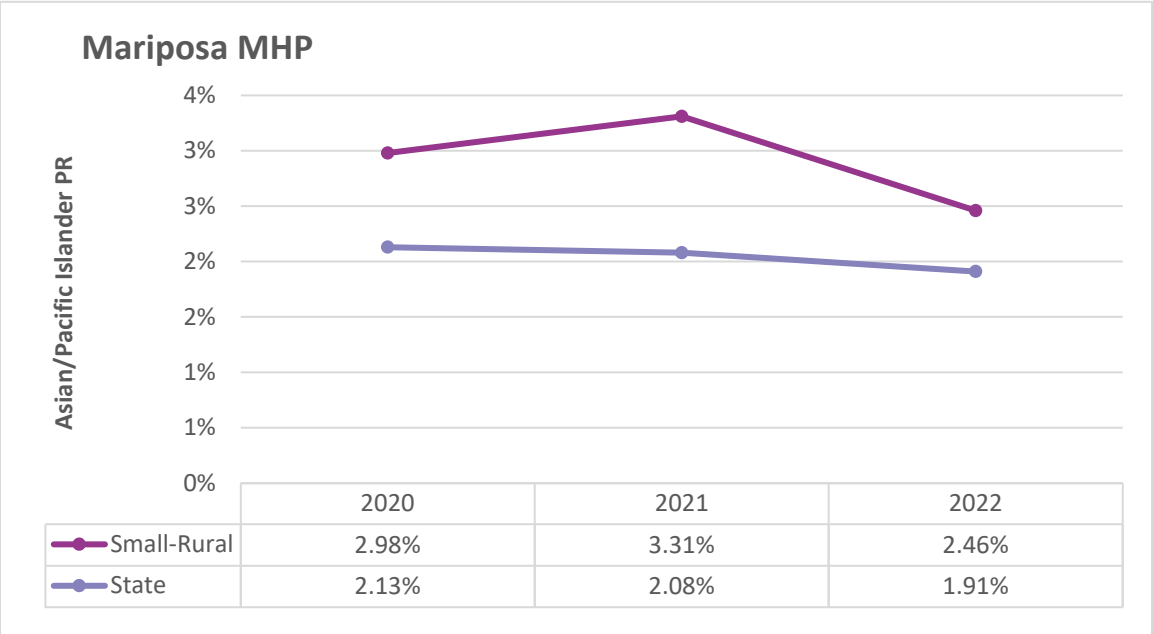
Figure 7: Hispanic/Latino AACM CY 2020-22



	2020	2021	2022
MHP	$5,730	$5,535	$5,442
Small-Rural	$6,726	$6,609	$5,219
State	$6,551	$6,733	$6,731

- The AACM for Hispanic/Latino members has decreased slightly each year since CY 2020. The MHP's AACM was comparable to small-rural counties for CY 2022, but has been consistently lower than the statewide AACM for this population.

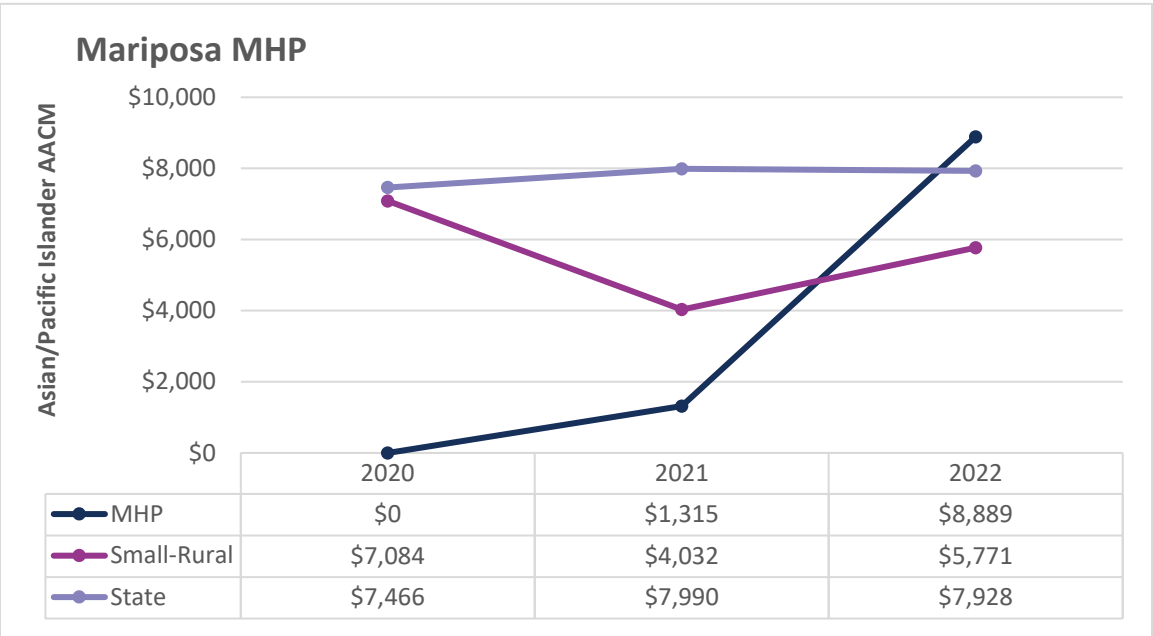
Figure 8: Asian/Pacific Islander PR CY 2020-22



	2020	2021	2022
Small-Rural	2.98%	3.31%	2.46%
State	2.13%	2.08%	1.91%

- The CY 2022 PR was lower than the previous year for Asians/Pacific Islanders in Mariposa and remains lower than small-rural counties and statewide. The downward trend is similar to the trend seen in small-rural counties as a group and statewide. The number of Asian/Pacific Islander members served in each the last three years was less than 11.

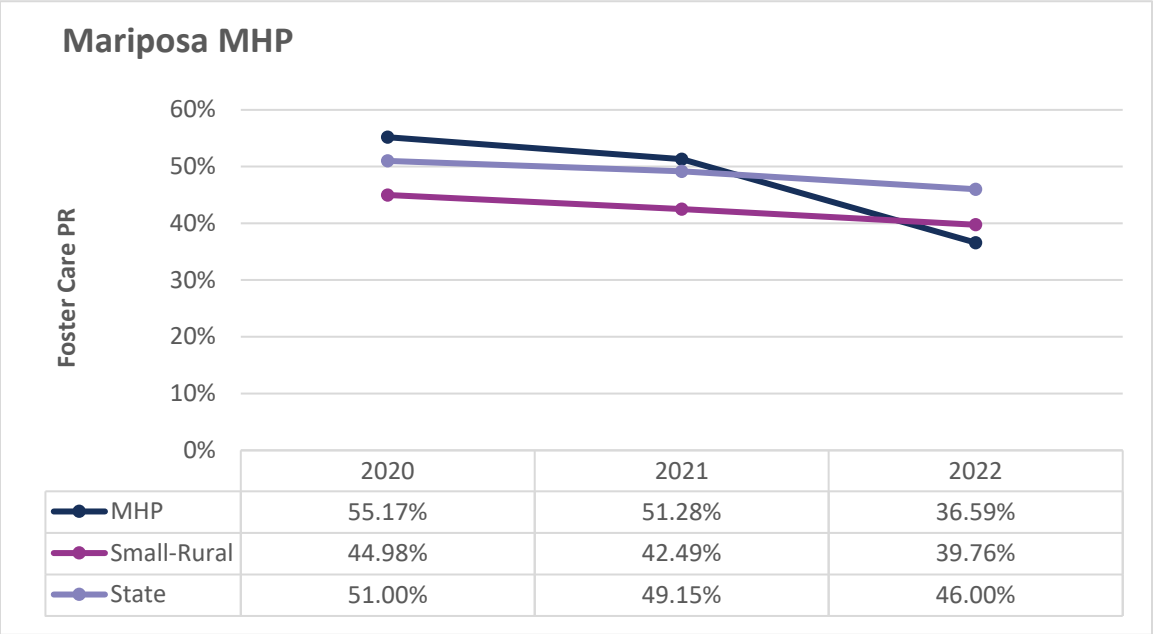
Figure 9: Asian/Pacific Islander AACM CY 2020-22



	2020	2021	2022
MHP	$0	$1,315	$8,889
Small-Rural	$7,084	$4,032	$5,771
State	$7,466	$7,990	$7,928

- The AACM for the Asian/Pacific Islander has risen over the past the three years with a sharp increase in CY 2022, exceeding both small-rural county and statewide AACM. Small numbers served can result in large changes in the data from year to year.

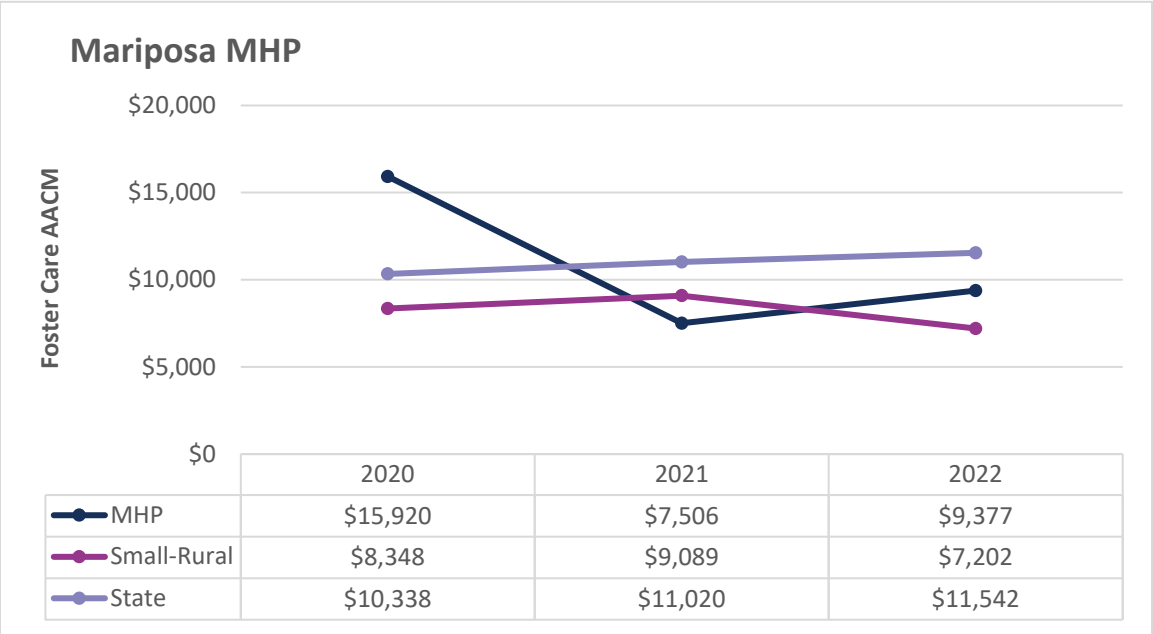
Figure 10: Foster Care PR CY 2020-22



	2020	2021	2022
MHP	55.17%	51.28%	36.59%
Small-Rural	44.98%	42.49%	39.76%
State	51.00%	49.15%	46.00%

- The MHP's FC PR was higher than both the small-rural county and statewide rates in CY 2020 and CY 2021; however, in CY 2022 the MHP's FC PR decreased by almost 15 percentage points, making it lower than the small-rural and statewide PRs. With only 41 eligibles, the impact of a few members served or not served can have a large impact on the percentage (6 more FC youth would have maintained the prior year's FC PR).

Figure 11: Foster Care AACM CY 2020-22



	2020	2021	2022
MHP	$15,920	$7,506	$9,377
Small-Rural	$8,348	$9,089	$7,202
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years, whereas in the MHP it decreased dramatically in CY 2021 followed by a slight increase in CY 2022.
- The MHP's FC AACM for CY 2022 is higher than the small-rural counties AACM but lower than the statewide AACM.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 417				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	51	12.2%	8	3	10.3%	14	8
Inpatient Admin	0	0.0%	0	0	0.4%	26	10
Psychiatric Health Facility	<11	-	9	4	1.2%	16	8
Residential	0	0.0%	0	0	0.3%	114	84
Crisis Residential	<11	-	29	29	1.9%	23	15
Per Minute Services							
Crisis Stabilization	<11	-	1,920	930	13.4%	1,449	1,200
Crisis Intervention	75	18.0%	339	165	12.2%	236	144
Medication Support	150	36.0%	354	315	59.7%	298	190
Mental Health Services	344	82.5%	811	480	62.7%	832	329
Targeted Case Management	81	19.4%	1,152	555	36.9%	445	135

- Mariposa had a higher percentage of adults receiving inpatient services than statewide, though with shorter stays.
- Mental health services had a higher utilization rate than statewide, whereas medication support services and TCM had lower utilization rates than statewide. For adults who received TCM, they received significantly more units than statewide (1,152 vs. 445 minutes), a difference of nearly 12 hours of TCM.

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

Service Category	MHP N = 15				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	-	11	11	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	3.1%	1,166	1,095
Crisis Intervention	<11	-	173	173	8.5%	371	182
Medication Support	<11	-	225	225	27.6%	364	257
TBS	<11	-	1,258	1,258	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Home-Based Services	<11	-	210	210	40.8%	1,458	441
Intensive Care Coordination	<11	-	338	338	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	15	100.0%	722	525	95.4%	1,846	1,053
Targeted Case Management	<11	-	305	90	35.8%	307	118

- Due to the small number of FC youth receiving SMHS, there was low utilization of most service categories. The most utilized service category was mental health services, followed by intensive care coordination (ICC), TCM, and IHBS. Though small in numbers served, both ICC and IHBS were provided with significantly fewer units of service compared to statewide.
- The MHP had lower average units of service than statewide for all outpatient SMHS utilized – while delivered to all FC youth who were served, the number of units was 61 percent below statewide.

IMPACT OF ACCESS FINDINGS

- High PRs suggest strong initial access to care, but coupled with high approved claims for the ACA population suggests that the MHP may be allocating service capacity to members who are less functionally impaired than members with “disabled” aid codes. This may mean that some members could be served at the MCP LOC to enable more intensive services for SMHS members who have greater needs.
- To broadly implement Pathways, the MHP developed a checklist that is applied to youth in care. The provision of ICC and IHBS to youth outside of FC represents some success in that regard. All clinicians are trained in doing the ICC child and family team meetings. However, the few units of service in both ICC and IHBS suggest either lack of sufficient service capacity or impaired engagement in these services.
- The MHP shows significantly more units of TCM (over 2.5 times) than statewide; this warrants investigation by the MHP. This might be mis-coding by staff or a quite unusual amount of TCM being provided. This pattern of service is not shown in the FC population, where in fact TCM is aligned with statewide numbers and ICC is delivered at the MHP with much fewer units of service.

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 has systems in place to monitor timely access to care. Metrics are reviewed in the QIC and by the management team.

TIMELINESS PERFORMANCE MEASURES

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

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

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5.8 Business Days	10 Business Days*	98.7%
First Non-Urgent Service Rendered	10.7 Business Days	10 Business Days**	62%
First Non-Urgent Psychiatry Appointment Offered	8.8 Business Days	15 Business Days*	100%
First Non-Urgent Psychiatry Service Rendered	11 Business Days	15 Business Days**	87.5%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	10.5 Hours ***	48 Hours*	90%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	9.13 Days	7 Calendar Days	61.5%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	9.13 Days	30 Calendar Days	64%
No-Show Rate – Psychiatry	22.9%	10%**	n/a
No-Show Rate – Clinicians	10%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP does not track separately any urgent services that must be provided within 96 hours due to pre-authorization.			
For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23			

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

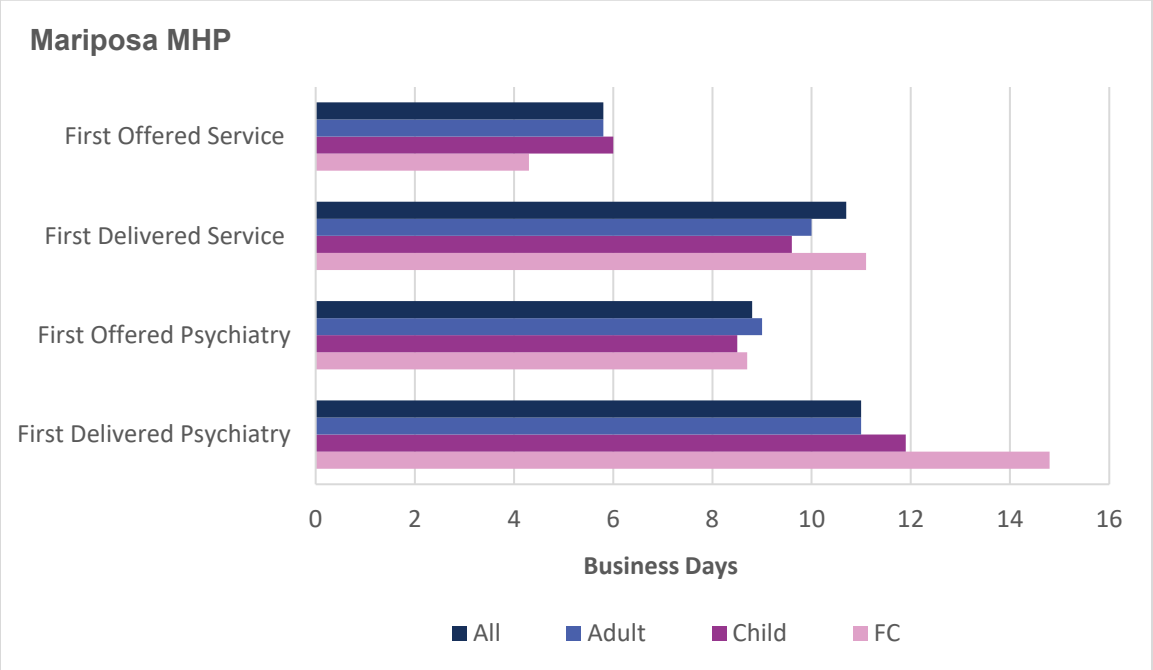


Figure 13: Wait Times for Urgent Services

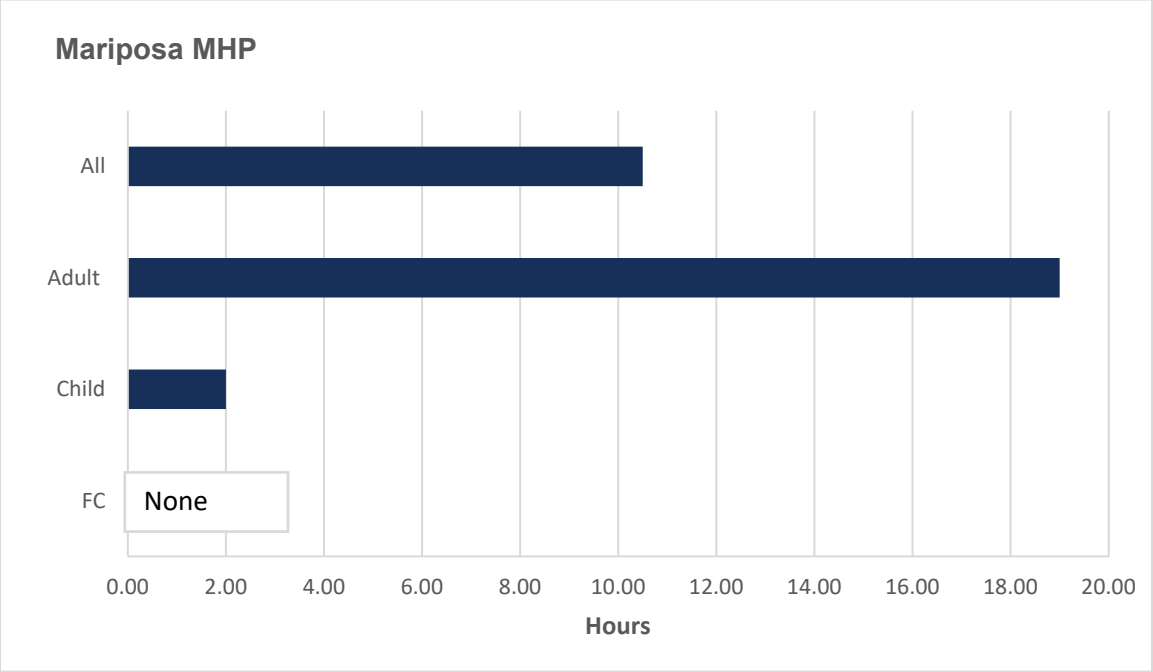
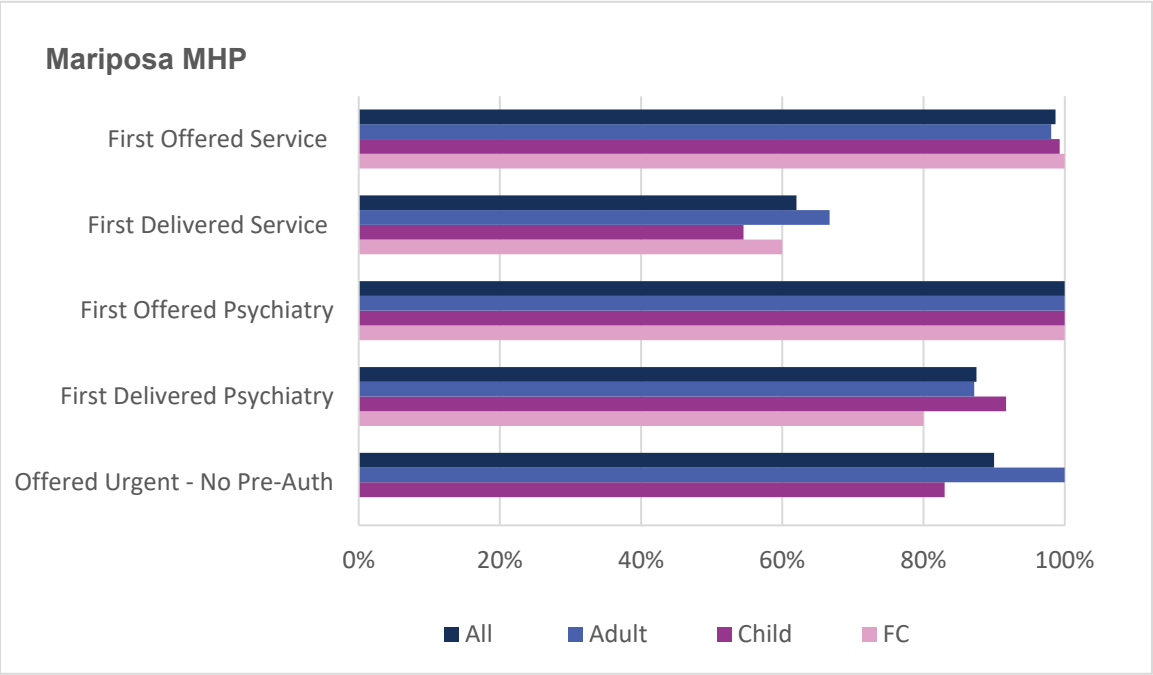


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments.
- The MHP defined "urgent services" for purposes of the ATA as "a non-life-threatening situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress, considering harm to self, or others, disoriented, or delusional, has a compromised ability to function, or is otherwise agitated, and unable to be calmed, without intervention a serious decompensation or risk of life is expected." Upon review, the MHP indicated that urgent contacts also included inpatient discharges, minor consent cases, and member requests.
    - There were only 10 urgent service requests reported with an actual wait time for services at 10.5 hours.
    - The MHP does not track urgent services that require pre-authorization separately. The MHP reports that TBS is the only service offered requiring prior authorization. These services are contracted out, and the MHP reports that any urgent request is processed within 96 hours.
- The average wait time to psychiatry was reported at 8.8 days overall. The number of members referred to psychiatry appears somewhat low – 15 percent of adults who sought services in FY 2022-23.
- The MHP tracks no-shows, reporting a rate of 22.9 percent for all psychiatry services, and 10 percent for all clinical services.

IMPACT OF TIMELINESS FINDINGS

- While the MHP-submitted data indicates timely access to the initial intake assessment, it was apparent in review discussions that members experienced a wait after the assessment for their ongoing care. The wait time until engagement with an ongoing provider is not tracked.
- The MHP added functionality through a “referral tracker” in the EHR to identify urgent cases at the time of the call to access. However, because the screening may occur after the access call, it is unclear if urgent needs are identified at that time as well. Additionally, clinicians can identify cases at the time of assessment as having urgent needs, but this is not reflected in the EHR. The number of urgent service requests at ten members is likely an under-representation of true clinical need.
- Referral to psychiatry, while timely from the point of referral, is reportedly rarely provided at the time of the intake assessment. This may add unnecessary wait and continued symptoms for members who could be referred to psychiatry earlier in the process. It is noted that the organizational chart shows that psychiatry does not report through the MHP director; the only full-time staff psychiatrist (extra help) reports directly to the Health Services division director, and the psychiatric nurse practitioner reports through the Public Health division.
- There may be opportunities within the existing capacity to improve timely access to care. All members served by the MHP are assigned a clinician. Even if they do not want therapy they are encouraged to be seen in-person at least monthly. This practice likely diverts service capacity from individuals with higher needs who could benefit from more frequent services.

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 sits with the QA unit that includes one supervisor and three analysts. There are no clinical staff directly working on QA/QI functions. Regulatory compliance is embedded within that unit as well.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of MHP staff and one community member. It is unclear if contractor staff or any other stakeholders are involved as the membership includes names but not titles or affiliations. The QIC is scheduled to meet every two months and was held accordingly with the exception of one meeting that was cancelled due to significant post-disaster work occurring. The QIC reviews a standardized set of metrics throughout the year.

Data associated with the goals being monitored in the QIC are reviewed routinely, as evidenced by MHP minutes and presentations at the QIC.

The MHP does not yet utilize a LOC tool but has modeled Level of Care Utilization System (LOCUS) into the EHR and expects to launch its use within two months of the review. Training materials are being produced and LOCUS will be used during the adult assessment.

The MHP utilizes the following outcomes tools: Patient Health Questionnaire (PHQ-9), General Anxiety Disorder (GAD-7), Child and Adolescent Needs and Strengths (CANS-50),and Pediatric System Checklist (PSC-35). In the EHR, CANS results are displayed in a dashboard that shows changes over time at the member level.

QUALITY KEY COMPONENTS

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

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Not Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Partially Met
3H	Utilizes Information from Member Satisfaction Surveys	Partially Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Partially 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 is implementing the CLAS standards. They discuss a standard at each “All Staff” meeting, held twice monthly. This is an opportunity to review case examples that apply to the topic discussed.
- The QIC reviews several metrics in a uniform manner and compares results to prior quarters. There is one community member engaged in the QIC; it is unclear if this member has lived-experience with SMHS. It does not appear that any clinical line staff participate in the QIC. This would be beneficial to provide a current “boots on the ground” lens to discussions.
- Through the QIC, the MHP is monitoring provision of service types. Their review of data indicated an increase in the percentage of open cases receiving individual therapy and TCM.
- Youth caseloads at 35 members, if all are actively being seen, is somewhat high for a children’s caseload. Use of a LOC tool would provide insight for determining whether youth are receiving services at the frequency of care warranted.

- Clinical staff productivity was reviewed in the QIC and shown to be well below the MHP's set standard. This may represent unutilized service capacity.
- The MHP created a Peer Support Specialist (I/II/III) civil service classification for peer employees who become trained and certified, with promotional positions built into the classification. This position is differentiated from the historical Mental Health Aide position as staff which does not provide Medi-Cal billable services. They expect to add two FTE in this category.
- QIC minutes show reports on overall averages for outcome data from the PHQ-9, GAD-7, and CANS. Rather than displaying this as an average, CalEQRO suggested displaying as a frequency of scores in order to better identify high need versus lower need and changes over time. Opportunities to identify populations potentially eligible for lower levels of care, including service by the managed care plan, could be evidenced by low scores. Reportedly the CANS data must be displayed this way due to the copyright.
- The MHP does not have any medication monitoring in place and therefore does not track the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5. Establishing a contract with a vendor to do this would be beneficial.
- The MHP indicates that only about 20 percent of their members served in outpatient care are served by MHP psychiatry. Analysis of claims data shows 31 percent of members served received medication support services. Regardless of the data source, this is a low percentage of the SMHS population and may be reflective of a barrier to psychiatry access. Some members may be seeing their primary care physicians for medication, and this is not reflected in SMHS approved claims; if so, this may require additional efforts to coordinate service delivery.

QUALITY PERFORMANCE MEASURES

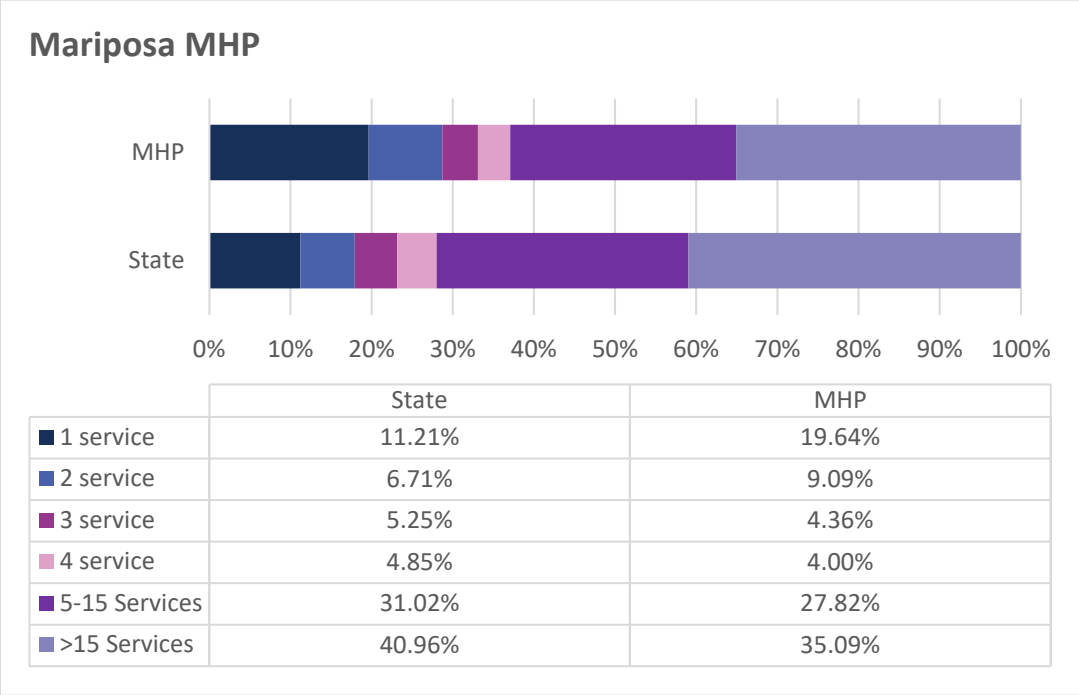
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Members Served CY 2022



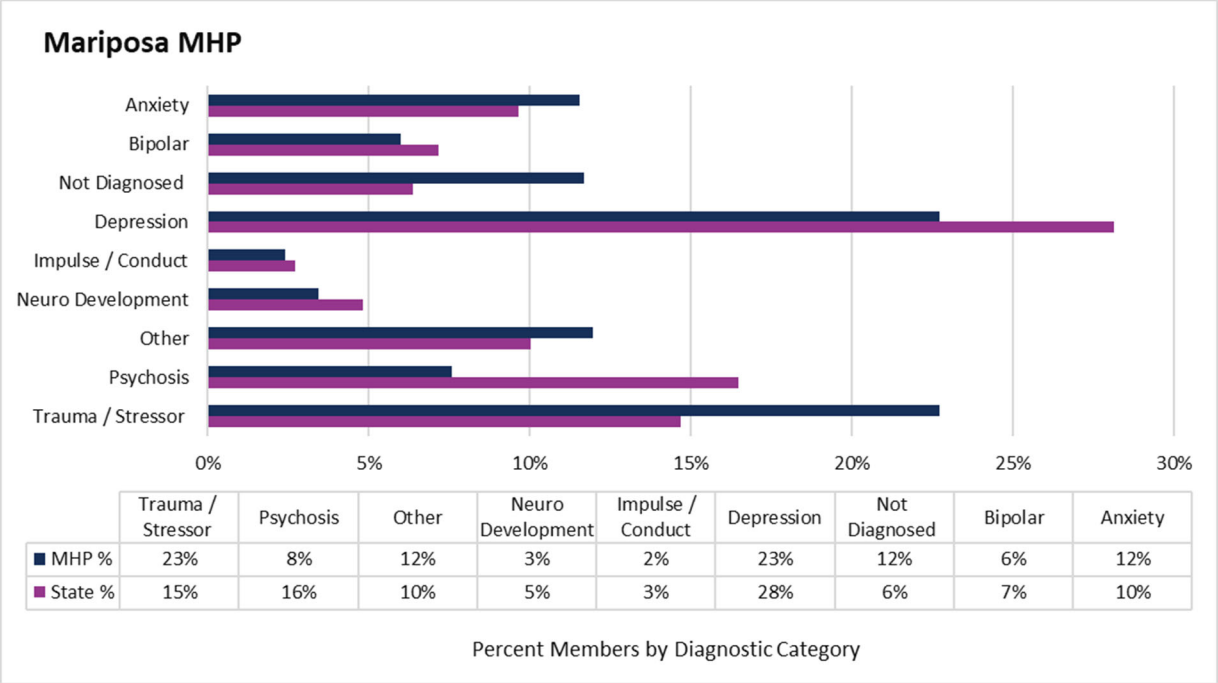
	State	MHP
1 service	11.21%	19.64%
2 service	6.71%	9.09%
3 service	5.25%	4.36%
4 service	4.85%	4.00%
5-15 Services	31.02%	27.82%
>15 Services	40.96%	35.09%

- Almost 29 percent of all members served received only 1 or 2 services.
- The MHP acknowledges challenges in retaining members from the assessment to ongoing care, as well as crisis intervention that does not result in outpatient engagement. This warrants focused attention by the MHP.

Diagnosis of Members Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP 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.

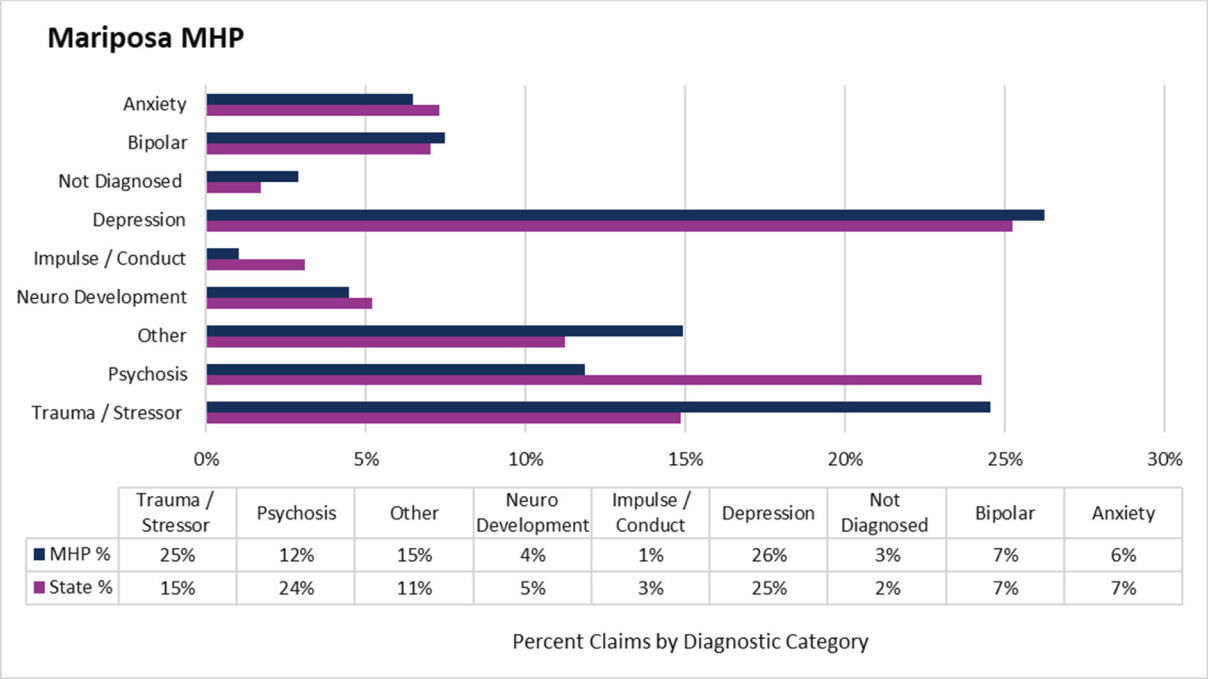
Figure 16: Diagnostic Categories by Percentage of Members Served CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	23%	8%	12%	3%	2%	23%	12%	6%	12%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- The MHP's largest diagnostic categories were depression and trauma/stressor. The proportion of members with a trauma/stressor diagnosis was higher than statewide, a pattern often seen in MHPs with recent natural disasters. The MHP has a lower proportion of members with a psychosis or depression diagnosis than seen statewide.

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 %	25%	12%	15%	4%	1%	26%	3%	7%	6%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- The MHP had a larger percentage of approved claims with a trauma/stressor and "other" diagnosis compared to statewide and a lower percentage of approved claims with a psychosis diagnosis. Despite comparatively fewer members with depression diagnoses, the MHP shows more claims than statewide. The distribution of approved claims is congruent with the diagnostic patterns displayed in Figure 16.

Psychiatric Inpatient Services

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

Table 13: Mariposa 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	66	146	2.21	4.36	8.45	$8,931	$12,763	$589,418
CY 2021	20	23	1.15	6.89	8.86	$9,278	$12,696	$185,551
CY 2020	17	18	1.06	8.17	8.68	$9,021	$11,814	$153,364

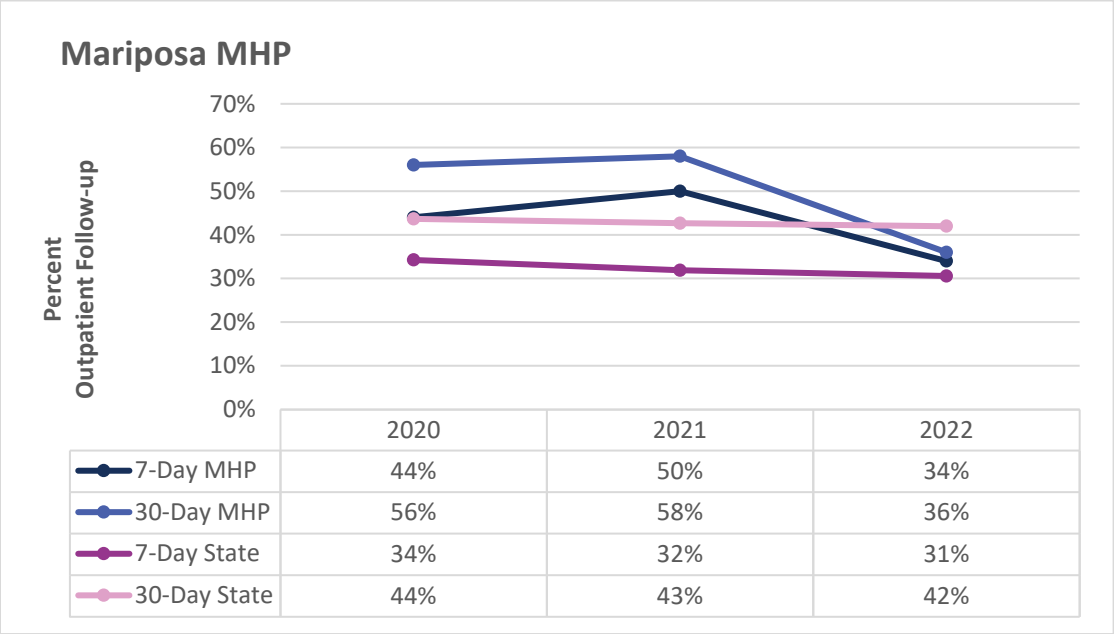
- In CY 2022 the MHP showed a prominent spike in the number of members hospitalized and number of inpatient admissions, with a shorter ALOS. This was more than triple CY 2021 in total dollars for Medi-Cal inpatient services.

Follow-Up Post Hospital Discharge and Readmission Rates

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

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

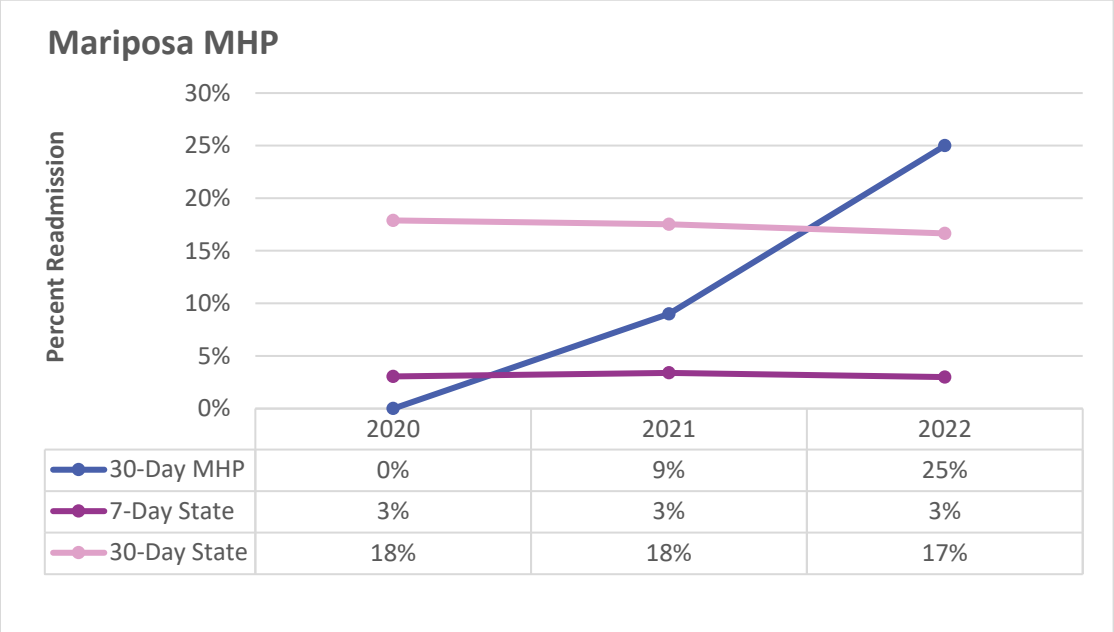
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2020-22



	2020	2021	2022
7-Day MHP	44%	50%	34%
30-Day MHP	56%	58%	36%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- The MHP 7-day follow-up rate increased between CY 2020 and CY 2021 and turned downward in CY 2022 and consistently remained less than the statewide rate.
- The MHP's 30-day follow-up rate has consistently increased over the last three years, unlike the statewide rate which has decreased.

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



	2020	2021	2022
30-Day MHP	0%	9%	25%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP's 7-day readmission rate had a very low rate of 7-day readmissions – the MHP data is suppressed due to the small number of members represented.
- The MHP's 30-day readmission rate (25 percent) exceeded the statewide (17 percent), though it had been below the statewide rate in the prior two years.

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 clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCMs may disproportionately occupy treatment slots that may prevent access to levels of care by other members. HCB percentage of total claims, when compared with the HCM count percentage, provides a subset of the member population that warrants close utilization review, both for appropriateness of level of care and expected outcomes.

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

Tables 14 and 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: High-Cost Members (Greater than $30,000) CY 2020-22

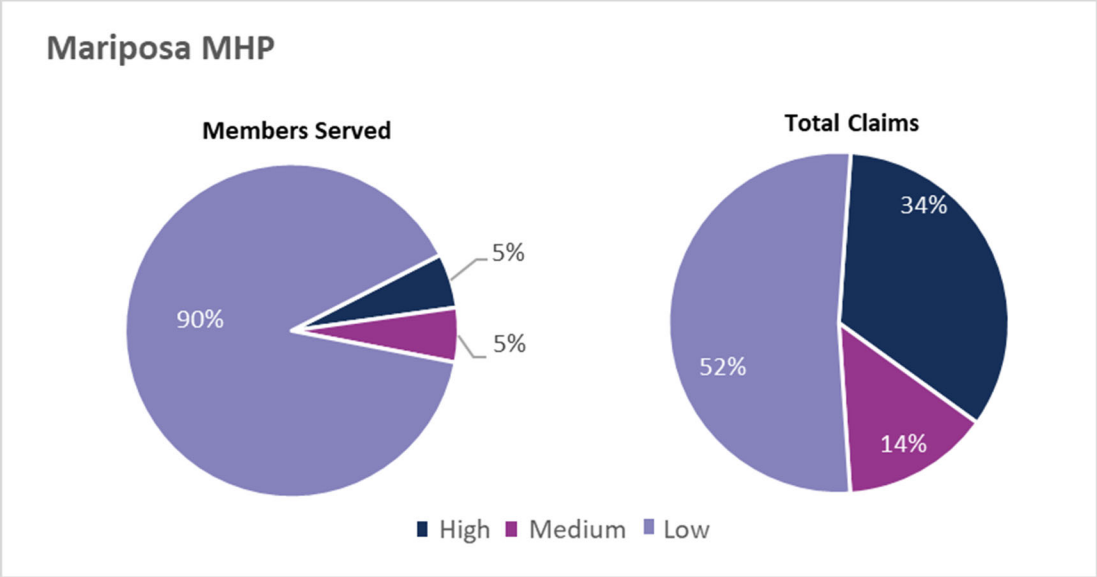
Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	29	5.27%	33.83%	$1,659,819	$57,235	$41,727
	CY 2021	25	4.93%	29.89%	$1,202,230	$48,089	$43,173
	CY 2020	30	6.34%	32.54%	$1,574,613	$52,487	$43,209

- The MHP had a higher proportion of HCMs compared to statewide, and the average approved claim per HCM was also higher than statewide.

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

Claims Range	# of Members Served	% of Members Served	Category Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	29	5.27%	13.99%	$686,147	$23,660	$23,254
Low-Cost (Less than $20K)	492	89.45%	52.18%	$2,559,790	$5,203	$3,374

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



- Claims for services provided to high- and medium-cost members represented 10 percent of the members but almost half (48 percent) of the total claims in the MHP for CY 2022.
- As occurs statewide, almost 90 percent of members were considered low-cost, with claims of less than $20,000.

IMPACT OF QUALITY FINDINGS

- The diagnostic claiming patterns, coupled with a high overall PR and an equally high ACA PR, suggest that the MHP may be serving members who do not necessarily require the SMHS LOC. Implementation and monitoring of the results from the LOCUS should illuminate this issue further, and assist the MHP in identifying whether changes should be occurring at points in care such as screening, intake, and step-down transfer of care.

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: Psychiatry Appointment No Shows

Date Started: 07/2022

Date Completed: 06/2023

Aim Statement: In the form of a study question: "Will providing case management to link clients to transportation resources in our community help clients attend their psychiatric appointments and decrease the no-shows from 36% to 12%?"

Target Population: Adult psychiatry

Status of PIP: The MHP's clinical PIP has concluded and was in the planning phase during the previous 12 months.

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

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

Summary

The MHP identified that psychiatry appointments were showing a 36 percent no-show rate, though this varied by quarter and by provider. The MHP initiated barrier analysis by surveying members to identify reasons for no-show visits; they learned that transporation issues and lack of knowledge about transportation resources. Therefore, they identified providing case management services to link individuals to transportation services as the intervention, to be offered to members at the time of their first psychiatry appointment.

The MHP decided to implement the intervention to members at the time of their initial psychiatry appointment; therefore, the PIP went on to not include members from ongoing caseloads for the intervention. Only four adults were referred for the PIP intervention, which is an apparent subset of the individuals who initiated psychiatry. Additionally, of the four referred, two declined the intervention because they had transportation, one could not be reached, and the other received the intervention (transporation assistance was scheduled). Ultimately, this translates to only one person receiving the intended intervention.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence because the intervention was delivered to a very small number of affected members. Any change in no-show rate, if produced, could not be attributed to the intervention.

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

- Monitor the intervention upon implementation so that it is clear early on whether individuals are accepting and receiving the intended intervention(s), and that there is a sufficient number for the study population. This allows for flexibility to change course if the intervention is not working or not being accepted by the target population.
- Identify the population for whom the aim statement applies and ensure that this population is identified to receive the intervention. If numbers are large, a reasonable sample can be used.
- Continue to seek TA from CalEQRO when a new PIP topic is selected. The MHP was provided additional TA on this PIP after the review; they intend to start a new PIP.

NON-CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Phone services

Date Started: 12/2022

Date Completed: undetermined

Aim Statement: Will implementing virtual meeting rooms embedded in the Electronic Health Records (Insync) reduce the number of phone services from XXX down to XX?

Target Population: All MHP population

Status of PIP: The MHP's clinical PIP has been concluded. It was in the planning phase (pre-implementation) during the prior 12 months.

Summary

The MHP had reviewed in the QIC that a higher percentage of members were receiving phone services rather than in-person or telehealth. They had received some grievances from members on this issue. The county implemented a policy that members must receive three in-person/telehealth services prior to a phone service. The MHP hypothesized that embedding the Zoom platform into the EHR would result in more telehealth services.

During the process of getting the telehealth function set up in the EHR and subsequent accounts activated, more data was reviewed and the MHP observed that the proportion of phone services had decreased from the prior review of the data. It appears that the shift in service delivery occurred without the intended intervention. It may be attributed to other administrative interventions/guidance. As a result, the MHP decided to discontinue this PIP.

TA and Recommendations

The MHP was provided additional TA on this PIP after the review; they intend to start a new PIP.

As submitted, this clinical PIP was found to have no confidence because the intervention was not delivered and results were not obtained.

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

- When conducting a PIP, identify baselines at the launch of the project and obtain post-intervention outcomes more frequently.
- Identify goals and include them in the aim statement. The baseline data should be clearly identified at the outset of the project.
- Continue to seek TA from CalEQRO when a new PIP topic is selected. The MHP was provided additional TA on this PIP after the review; they intend to start a new PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Qualifacts' InSync Healthcare Solutions, which has been in use for three years. Currently, the MHP has no plans to replace the current system, which is functioning in a satisfactory manner, and has implemented all components of the EHR.

Approximately 5.3 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 IS budget has increased from 4.6 percent the previous year.

The MHP has 83 named users with log-on authority to the EHR, including approximately 57 county staff and 26 contractor staff. Support for the users is provided by one-half of a full-time equivalent (FTE) IS technology position. Currently all positions are filled. A countywide restructuring reduced IS technology positions from one FTE to one-half FTE.

As of the FY 2023-24 EQR, all 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 MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	98%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	2%
		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. A patient portal is available for members to access their medical records. Members can use the portal to view upcoming appointments, schedule or request new appointments, receive appointment reminders, view active prescriptions, and send/receive secure text messages.

Interoperability Support

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

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	Partially Met
4C	Integrity of Medi-Cal Claims Process	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Met

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

- The MHP secured grant funds to upgrade equipment for both the county and community partners. The funds were also used to integrate Zoom into the EHR in order to streamline access to telehealth sessions for members.
- The last successful Client Services Information (CSI) report submission was in CY 2021. EHR functionality has prevented successful CSI report submissions, and the MHP is working closely with its vendor to resolve the issue in order to meet state reporting requirements.
- The Medi-Cal claim denial rate of 9.16 percent exceeds the statewide denial rate.
- Security components are in place to ensure systems are secure, and security training exists ensuring staff are trained in security best practices.
- Although not fully implemented at the time of the review, the MHP purchased and developed a community information exchange (CIE) product to allow information exchange with members and community partners. The project is 75 percent complete.

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 Short-Doyle/Medi-Cal Claims CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	806	$405,144	$53,014	13.09%	$352,130
Feb	753	$420,930	$53,929	12.81%	$367,001
Mar	1,040	$575,444	$46,708	8.12%	$528,736
April	817	$419,185	$38,719	9.24%	$380,466
May	862	$502,294	$48,597	9.68%	$453,697
June	819	$452,647	$49,511	10.94%	$403,136
July	699	$357,634	$50,436	14.10%	$307,198
Aug	908	$460,947	$49,873	10.82%	$411,074
Sept	663	$340,214	$10,880	3.20%	$329,334
Oct	460	$254,338	$5,503	2.16%	$248,835
Nov	639	$362,852	$27,384	7.55%	$335,468
Dec	599	$325,324	$12,192	3.75%	$313,132
Total	**9,065**	**$4,876,953**	**$446,746**	**9.16%**	**$4,430,207**

- The MHP's number of claims per month appears to fluctuate throughout the year.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B must be billed before submission of claim	299	$165,306	37.00%
Service line is a duplicate and repeat service modifier is not present	230	$126,360	28.28%
Beneficiary is not eligible or non-covered charges	139	$92,831	20.78%
Other healthcare coverage must be billed first	34	$51,152	11.45%
Other	18	$11,098	2.48%
Total Denied Claims	**720**	**$446,747**	**100.00%**
Overall Denied Claims Rate	**9.16%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The largest claim denial reason is for not billing Medicare Part B before billing Medi-Cal. Medicare claim denials had to manually be attached to Medi-Cal claims before submitting, which was a labor-intensive process. The MHP and Revenue Cycle Management (RCM), the MHP's vendor, worked together to correct the issue and were confident the issue had been resolved.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Contracting with RCM assists the MHP with its billing processes. The MHP QA staff, fiscal staff, and RCM staff meet weekly to review billing processes, claim denials, and resolve billing issues.
- The MHP's EHR is entirely paperless, and the older historical paper charts have been scanned into EHR, eliminating the need to retain paper charts, and ensuring the availability of all clinical information that can inform care.
- The MHP had completed Phase 3 of 274 provider network data reporting and was expected to move into production shortly after the review.
- QA staff are primarily responsible for EHR development, functionality, and implementation decisions. Feedback about functionality and workflows is not provided by clinical staff and therefore it may not be as efficient or useful as possible.
- Decreased dedicated IS staff could delay development and reporting efforts and prevent MHP from meeting state requirements.

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 demonstrated evidence of reviewing the CPS survey data in QIC meetings. There were no apparent improvement activities initiated as a result of the surveys. Outcomes and functioning domains rated less than 4.0 for both the youth and adult surveys. Additionally, adults rated social connectedness slightly below 4.0. General satisfaction for adults averaged 4.38 and youth 4.18. Youth indicated lower agreement with the item on participation in treatment planning (4.08 for youth, 4.29 for adults). Responses were highest in the culture domain at 4.37. Documentation did not display the number of surveys collected, so it is difficult to determine if the results could be generalized.

PLAN MEMBER/FAMILY FOCUS GROUP

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

As part of the pre-review planning process, CalEQRO requested one 90-minute focus group with adult MHP members, containing 10 to 12 participants each, to include members who initiated care in the past year. The group was conducted via Zoom, with three participants onsite at the MHP in a conference room and one participant at home. An interpreter was not necessary for this focus group. All received services from the MHP.

Only one of the participants had entered services within the last year and this occurred swiftly, about one week and then assigned to a therapist. Others recalled their prior experience taking one to two months for an assessment, and then another couple of months to be assigned to a therapist. Most a psychiatrist monthly and a therapist every other week or monthly. One member indicated having a case manager but not a therapist and felt that therapy would be helpful. They felt that they could share anything with their provider, but were not aware of any mechanisms for providing input into

system planning; they felt that they could offer good suggestions. They also indicated a desire to “give back.”

One participant indicated that they didn’t qualify for transportation assistance and takes the bus, which reportedly does not adhere to its published schedule, sometimes coming early. Participants either didn’t have a primary care physician or didn’t think that the MHP coordinated care with their primary care physician.

All felt that they could ask for a new provider if they felt it necessary, including one member who recalled being specifically informed of this option. They were aware of how to contact the MHP in a crisis and some had received mobile crisis intervention. Crisis residential which was viewed as helpful, especially the peer counseling provided there.

There was a general preference for in-person services but a desire to be seen over telehealth when transportation is not feasible. Some noted that therapy appointments have been only 30 minutes and would prefer it longer. Psychiatry reportedly was provided via phone during the pandemic but now requires in-person attendance. If SUD is an issue, linkage to treatment is available, and “they kind of insist on it.” All felt that staff give them hope and that services have made them stronger.

Members reported that they have been on waiting lists for housing, “have been bumped down on the list,” and that “you have to be in MH treatment to stay in certain housing.” They felt that a lot of housing resources are available out of the county but they cannot get there for assistance.

Recommendations from focus group participants included:

- Provide more MH housing.
- Provide longer therapy appointments.
- Provide telehealth more flexibly, especially when transportation interferes in attendance and the person is interested in telehealth.

SUMMARY OF MEMBER FEEDBACK FINDINGS

The member focus group was small but shared a lot of information about their experiences in care. The perception that a person in MH housing must be in treatment warrants some investigation by the MHP, as this is generally not an acceptable practice, if occurring. Based upon member input, exposure to harm reduction training could benefit MHP clinical staff.

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. Peer Specialist (I/II/III) is a newly created civil service classification that enables the MHP to hire certified peers along with built in opportunity for promotion within that classification. The MHP expects to add two FTE in this job class. (Quality)
2. The MHP's paperless EHR, inclusive of scanned historical records, ensures information is centrally located and readily available for staff to effectively provide treatment to members. (IS, Quality)
3. The MHP is approaching launch of the LOCUS which will be useful for managing service capacity and assuring that members are served at the most suitable LOC. (Access, Quality)
4. As the county is the new provider health and MH services in the jail, the MHP can more readily bring members into care upon their re-entry to the community. (Access)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP's implementation of the CalAIM screening tool does not lend itself to the less labor-intensive and consistent screening that was intended. It is unclear how many members receive a full screening prior to their assessment appointment. This can result in missed identification of urgent care needs and opportunities to the MCP system in a more timely manner when indicated. (Access)
2. The MHP shows a high percentage of members only receiving one to two services. This may represent issues with member engagement after an intake or crisis intervention. (Access)
3. The low number of referrals to psychiatry suggests this service type may be under-utilized, particularly for adults. The referral process may be cumbersome for staff and add delays for members waiting for care. (Access, Quality)
4. The MHP provides an unusual amount of TCM to adults; this may in fact represent an unusual service pattern or could be a data integrity issue. (Quality)
5. The MHP lacks mechanisms to solicit feedback and input from functional area stakeholders regarding clinical processes and EHR development. (Quality, IS)

6. The MHP may not have a sufficient number of staff to adequately manage the Medi-Cal claiming process. (IS)

RECOMMENDATIONS

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

1. Consult with DHCS regarding parameters and expected fidelity to the CalAIM Screening Tool. Track the number of members who did not get screened prior to their assessment, as well as the number that are subsequently referred outside of the MHP. (Access, Quality)
2. Examine service patterns for members who receive only one to two services to determine whether more attention should be given to clinical engagement or if other issues are apparent. (Access, Quality)
3. Examine a reasonable sample of charts to determine whether psychiatry is being offered at clinically appropriate stages of care. Earlier identification and referral may result in improved outcomes. This analysis should include participation from psychiatric providers, as well as someone with lived-experience if possible, to help inform the process. (Access, Quality)
4. Examine service patterns for adults receiving TCM, particularly those members who are outliers receiving well above the average. This may reflect an unintended service pattern or miscoding of services delivered. (Access, Quality)
5. Provide a mechanism for staff to contribute as subject matter experts when new initiatives are being discussed and planned. This should include the development and testing of workflows to provide feedback regarding new EHR functionality and implementation. This could help improve workforce morale and retention. (Quality, IS)

   (This is similar to a Recommendation from FY 2022-23.)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from 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 – Mariposa MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Sandra Sinz, LCSW, Executive Director, Quality Reviewer
Rita Samartino, IS Reviewer
Walter Shwe, Consumer/Family Member Reviewer

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

All sessions were conducted via videoconference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Amborn	Saxon	Clinician	Mariposa County
Baker	Shelia	Deputy Director of Behavioral Health & Recovery Services	Mariposa County
Ballinger	Rebecca	Registered Psychiatric Nurse	Mariposa County
Bone	Nicole	Office Technician Supervisor	Mariposa County
Cotter	Katie	Clinician	Mariposa County
Davidson	Todd	Social Worker Supervisor II	Mariposa County
Feuerstein	Jinger	Staff Services Analyst II	Mariposa County
Glenn	Laura	Administrative Analyst II	Mariposa County
Howes-Medley	Brandi	Clinician	Mariposa County
Jaskowiak	Wendy	Clinician	Mariposa County
Jenkins	Kyle	Social Worker Supervisor II	Mariposa County
Olvera	Gustavo	Clinician	Mariposa County
Radonic	Claudia	Mental Health Assistant III	Mariposa County
Ridenhour	Randy	Senior Administrative Analyst	Mariposa County
Rodriguez	Jillian	Social Worker Supervisor II	Mariposa County
Rubalcava	Rene	Mental Health Assistant III/ MFT Trainee	Mariposa County
Rumfelt	Lynn	Senior Administrative Analyst	Mariposa County
Sturm	Britany	Staff Services Analyst II	Mariposa 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	

General PIP Information
MHP/DMC-ODS Name: Mariposa
PIP Title: Psychiatry No shows
PIP Aim Statement: In the form of a study question: Will providing case management to link clients to transportation resources in our community help clients attend their psychiatric appointments and decrease the no-shows from 36% to 12%?
Date Started: 07/2022
Date Completed: 06/2023
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Adults in psychiatry services – intervention to be applied to those with a first psychiatry appointment

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): Case management to link to transportation services when needed.						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): None						
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): None						
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**
No-show rate	36% (quarter)		☐ Not applicable—PIP is in planning or implementation phase, results not available	50% 1 client received intervention	☐ 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: As outlined in the narrative 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	No interventions were applied and no results were obtained from this PIP.
General PIP Information	
MHP/DMC-ODS Name: Mariposa	
PIP Title: Phone Services	
PIP Aim Statement: Will implementing virtual meeting rooms embedded in the Electronic Health Records (Insync) reduce the number of phone services from XXX down to XX? (numbers not stated)	
Date Started: 12/2022	
Date Completed: undetermined	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): All MHP clients served.	

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): None
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Focused on staff to prioritize delivering in-person and/or telehealth versus phone services
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): None

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

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: As detailed in report narrative.

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.