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

PLACER-SIERRA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 29-31, 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, "Placer-Sierra" may be used to identify the Placer-Sierra County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — August 29-31, 2023

MHP Size — Medium

MHP Region — Central

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	0	4	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	3	3	0
Quality of Care	10	7	3	0
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**18**	**8**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-up After Emergency Department visit for Mental Illness	Clinical	09/2022	Planning Phase	No Confidence
SOGI and the Beneficiary Experience in ASOC MH Clinics	Non-Clinical	10/2021	Second Remeasurement	Moderate 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	0
2	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	3

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Placer County's contracted providers report continued support throughout the implementation of SmartCare electronic health records (EHR). This includes providing contract providers full access to SmartCare, which will increase the data that is available to the MHP for reporting and analysis.
- Placer County is delivering timely mobile crisis services throughout the county.
- Placer County peer support system provides significant support for members throughout the system of care (SOC).
- Placer County's internal structure provides an environment that results in an efficient and effective coordination process between the MHP, child welfare, and probation services.
- Sierra County communicates efficiently between stakeholders, resulting in rapid response to coordination of care.

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

- The community of Auburn does not have a local wellness center.
- MHP does not aggregate and report on the data of contract providers to provide an overall perspective on the county's beneficiary timeliness and outcomes.
- The MHP lacks a universal SOC adult outcome tool.

- The MHP does not maintain a data warehouse that replicates the SmartCare system to support data analytics and reporting.
- The MHP's percentage of high-cost members (HCM) has increased each year for the past three years and exceeds the statewide rate.

Recommendations for improvement based upon this review include:

- Give due consideration to the needs of members living in Auburn to determine if a wellness center or similar is needed and initiate necessary programs for the region.
- Create reports that aggregate, track, and trend contractor data to accurately represent beneficiary timeliness and outcomes throughout the SOC.
- Research, choose, and implement a SOC outcome tool for regular adult use.
- Develop a database that replicates the SmartCare system and is updated nightly to support data analytics and reporting.
- Investigate HCM service utilization to determine if service patterns reflect the treatment needs of this population.

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 Placer-Sierra County MHP by BHC, conducted as a virtual review on August 29-31, 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) – a summary of the validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5, and also as outlined DHCS's Comprehensive Quality Strategy. Data definitions are included as Attachment E.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report

data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding penetration rate (PR) percentages.

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place after the Mosquito Fire, September 2022 to October 2022, which significantly impacted air quality for the entire region and displaced Placer County and contract provider program staff due to evacuations. Major winter storms in 2022 were followed fire, power outages, downed trees, road closures, closed highways, and hazardous conditions.

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

SIGNIFICANT CHANGES AND INITIATIVES

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

- It is important to note that Placer County also operates the MHP for Sierra County and is referred to as the Placer-Sierra MHP. Sierra County operates a behavioral health program and is working toward its own MHP contract. As a result, there are places in this report that refer only to Placer or only to Sierra, whereas references to the MHP include the existing Placer-Sierra plan.
- Placer County transitioned from the Avatar EHR and performance management system to California Mental Health Services Authority's (CalMHSA) semi-statewide EHR and performance management system, SmartCare from Streamline Healthcare Solutions (Streamline) in July 2023.
- Sierra County implemented the Credible EHR in July 2023, which will be managed by Kings View.
- Placer County is planning for a new Health and Human Services (HHS) building in Auburn to be completed at the end of 2023. Placer continues to evaluate space needs and design clinical workflows to meet the needs of both staff and members.
- Placer County prepared and implemented needed changes for California Advancing and Innovating Medi-Cal (CalAIM) and billing reform. Placer County will be changing Health Plans in January 2024, from California Health and Wellness, Anthem, and Kaiser, to Partnership Health Plan of California (PHC) and Kaiser. For their medical care, a majority of behavioral health members will be served by PHC.

- Placer County continues to work with its hospital system, law enforcement partners, and the community to improve the crisis continuum. With the development of the Lotus Behavioral Health Center for urgent care and providing the hospital with the ability to authorize 5150 holds, the MHP aims for faster placements and reducing the emergency room use for behavioral health needs.

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: To serve beneficiaries in each of the primary geographic service areas of the county, identify a location and make plans to open a wellness center in the Auburn area.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP explored a location for a wellness center in the Spring of 2023, however, the MHP was unable to open a wellness center in the Auburn area.
- Through community and stakeholder input, Placer is currently exploring the possibility of reopening the recently closed service center in Auburn as a wellness center.
- This recommendation will be provided again in this year's report.

Recommendation 2: Create reports that aggregate, track, and trend contractor data to accurately represent beneficiary timeliness and outcomes throughout the SOC.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Contract provider data was not included in the Assessment of Timely Access (ATA) document, and they represent points of entry into the system.
- Placer County transitioned to SmartCare EHR in July 2023 and began onboarding some of their contractors on the new EHR. While some of the

contractors have been onboarded, timeliness reporting is not yet available in the SmartCare system.

- Placer County is working on onboarding remaining providers with a goal to onboard all contract providers by June 2024
- This recommendation will be provided again in this year's report.

Recommendation 3: Expand interoperability functionality by allowing contract providers to use the EHR and beginning the process to exchange data through a Health Information Exchange (HIE).

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- While contract providers did not have the ability to enter clinical data while using the myAvatar EHR, three contract providers have full access to the newly implemented SmartCare EHR. Additional contract providers will be trained on the system and given full access over the next year.
- The MHP is not a member of an HIE but plans to join the SacValley Medshare HIE within the next year.
- This recommendation will not be carried forward given that there is a specific plan to address this issue in the coming year.

Recommendation 4: Explore and implement methods to bill Medicare and Other Health Care for beneficiaries with these coverages.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has entered into an agreement with CalMHSA to provide Revenue Cycle Management services to Placer County, which will include monthly batches and claims outputs for Other Health Coverage (OHC) and Medicare.
- While the MHP is Medicare certified, they are not submitting Medicare claims. They are in discussions with CalMHSA to provide this service but have not set a definitive date for when Medicare claiming will begin.
- While this item is rated partially addressed, it is not carried over in a recommendation for this year's review due to other priority recommendations identified and the current agreement with CalMHSA.

Recommendation 5: Research, choose, and implement an Adult SOC outcome tool for regular use.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP identified the statewide screening and transition of care tool as the Adult SOC outcome tool. However, this tool does not assist clinical staff with the level of care (LOC) determination within the SMHS, as the statewide screening and transition of care tool is used to distinguish the need for SMHS services.
- The MHP has not yet implemented the outcome tool for regular use.
- With the transition to the SmartCare EHR, the MHP will be able to pull outcome reports and utilize dashboards to measure data outcomes as the outcome tool is built in the system.
- This recommendation will be carried forward in this year's report.

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

For Placer, SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 66 percent of services were delivered by county-operated/staffed clinics and sites, and 34 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 63 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 contract provider staff; members may request services through the Access Line as well as through walk-in screening clinics, provider referrals, mobile crisis teams, and schools. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. The MHP operates a no wrong door access system. Beneficiaries can call the access line or walk into a clinic and receive assessment and resources linkage.

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 213 adult members, 545 youth members, and 43 older adult members across 6 county-operated sites and 50 contractor-operated sites. Among those served, 33 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

[1] CMS Data Navigator Glossary of Terms

addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

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

The time and distance requirements are 30 miles and 60 minutes for outpatient mental health and psychiatry services in Placer County and 60 miles or 90 minutes in Sierra County. 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 did meet 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	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- The MHP collaborates frequently with contractors and partners to improve access and coordination of care.
- The MHP works collaboratively with the county-operated Enhanced Care Management (ECM) to expand the populations served, including homeless and criminal justice populations.
- Members highlighted the support and ease of accessing MHP transportation services.
- The Penetration Rates (PR) for Hispanic/Latino and Asian/Pacific Islander members have been lower than medium county and statewide rates for each of the past three years, perhaps indicating challenges to accessing services for these groups.

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, with a penetration rate of 3.54 percent, Placer/Sierra demonstrates poorer access to care than was seen statewide.

Table 3: Placer/Sierra 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	76,833	2,717	3.54%	$19,701,281	$7,251
CY 2021	70,472	2,781	3.95%	$19,218,558	$6,911
CY 2020	63,376	2,456	3.88%	$13,328,021	$5,427

- While PR saw a decline from CY 2021 to CY2022, the AACM has increased in each of the past three CYs. The number of eligibles has been trending upwards over the past three CYs.

Table 4: Placer/Sierra 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	7,612	33	0.43%	1.15%	1.82%
Ages 6-17	17,883	451	2.52%	4.80%	5.65%
Ages 18-20	3,840	135	3.52%	3.47%	3.97%
Ages 21-64	40,066	1,953	4.87%	3.60%	4.03%
Ages 65+	7,434	145	1.95%	1.98%	1.86%
Total	**76,833**	**2,717**	**3.54%**	**3.49%**	**3.96%**

- The MHP's PR is lower than the statewide rate for those in age categories 0-5, 6-17 and 18-20.
- The largest eligibility group by age was adults ages 21-64, followed by youth ages 6-17. While the PR for those aged 21-64 exceeds the statewide rate, the PR for those aged 6-17 is less than half the statewide rate (2.52 percent vs. 5.65 percent).

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

Threshold Language	# Members Served	% of Members Served
Spanish	88	3.33%
Threshold language source: Open Data per BHIN 20-070		

- The MHP had one threshold language, Spanish, and 3.33 percent of those served identified Spanish as a preferred language.

Table 6: Placer/Sierra MHP Medi-Cal Expansion (ACA) PR and AACM, CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	24,192	997	4.12%	$6,368,836	$6,388
Medium	530,704	15,912	3.00%	$110,270,160	$6,930
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligibles that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. The MHP's ACA PR is higher than the overall PR (4.12 percent vs. 3.54 percent). The MHP's ACA PR is 37 percent higher than the medium county rate (4.12 percent vs. 3.00 percent) and 21 percent higher than the statewide rate 4.12 percent vs. 3.41 percent).
- The ACA AACM is lower than that of the overall AACM ($6,388 vs. $7,251).

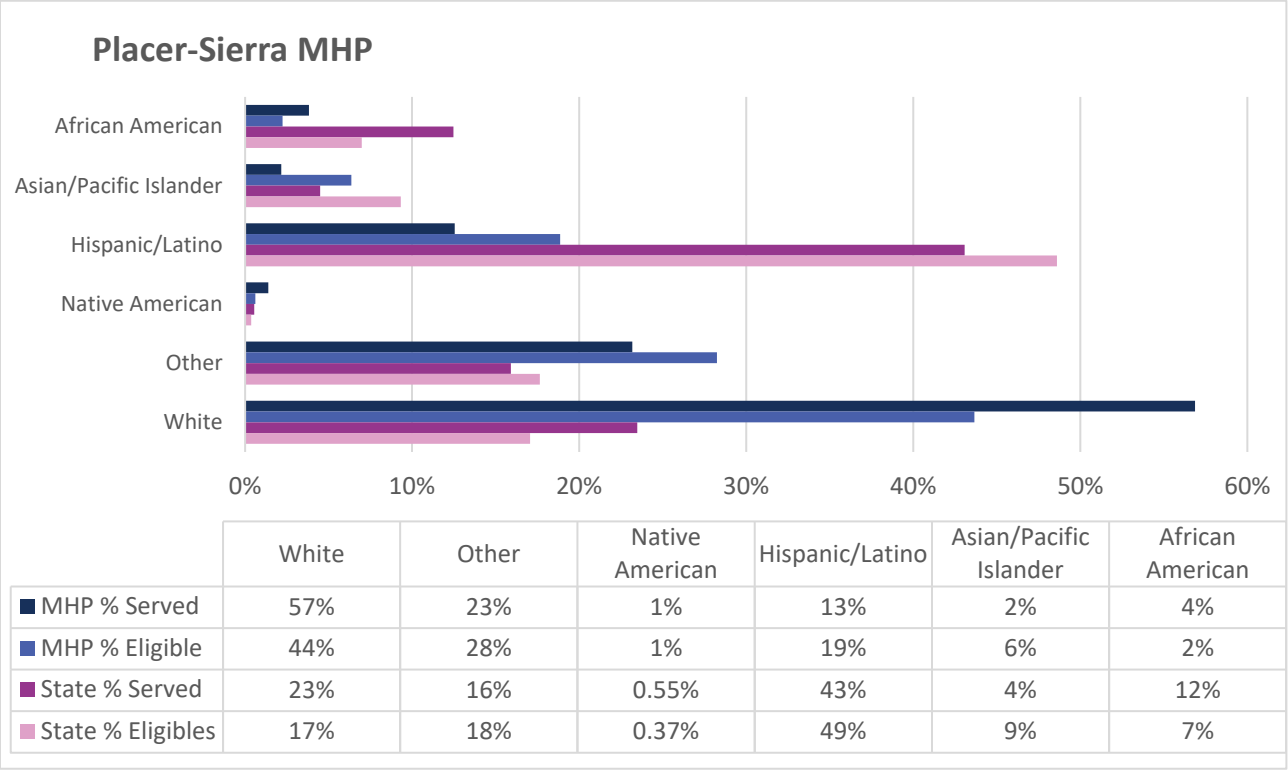
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they 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: Placer/Sierra MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	1,725	104	6.03%	7.08%
Asian/Pacific Islander	4,890	59	1.21%	1.91%
Hispanic/Latino	14,494	341	2.35%	3.51%
Native American	473	38	8.03%	5.94%
Other	21,707	630	2.90%	3.57%
White	33,546	1,545	4.61%	5.45%
Total*	**76,835**	**2,717**	**3.54%**	**3.96%**

- PRs were lower than the corresponding statewide PRs for all racial/ethnic groups except Native American.
- The Hispanic/Latino population represents the third largest group of eligibles by race/ethnicity in the MHP, 18.9 percent of total eligibles, and has the second lowest PR.
- Asian/Pacific Islander members had the lowest PR of any group.

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

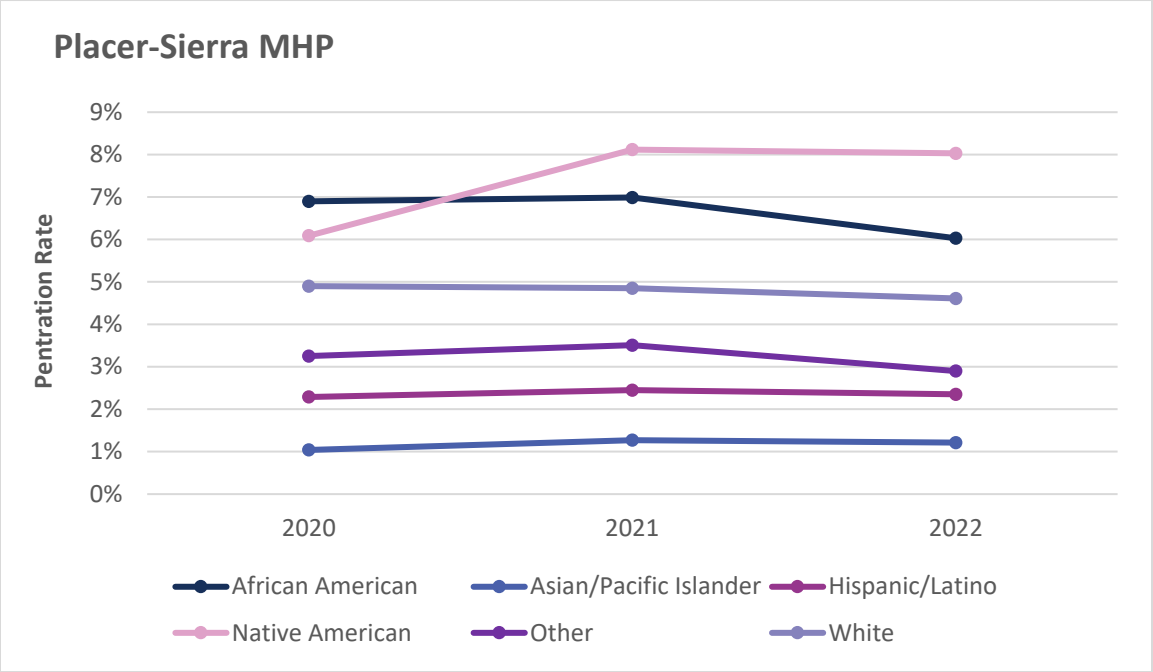


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	57%	23%	1%	13%	2%	4%
MHP % Eligible	44%	28%	1%	19%	6%	2%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- While the White category was the most proportionally overrepresented racial/ethnic group in the MHP, Hispanic/Latino, Other, and Asian/Pacific Islander were all comparatively underrepresented.
- The MHP had a higher proportion of White and Other eligibles and a lower proportion of Hispanic/Latino eligibles than the state.

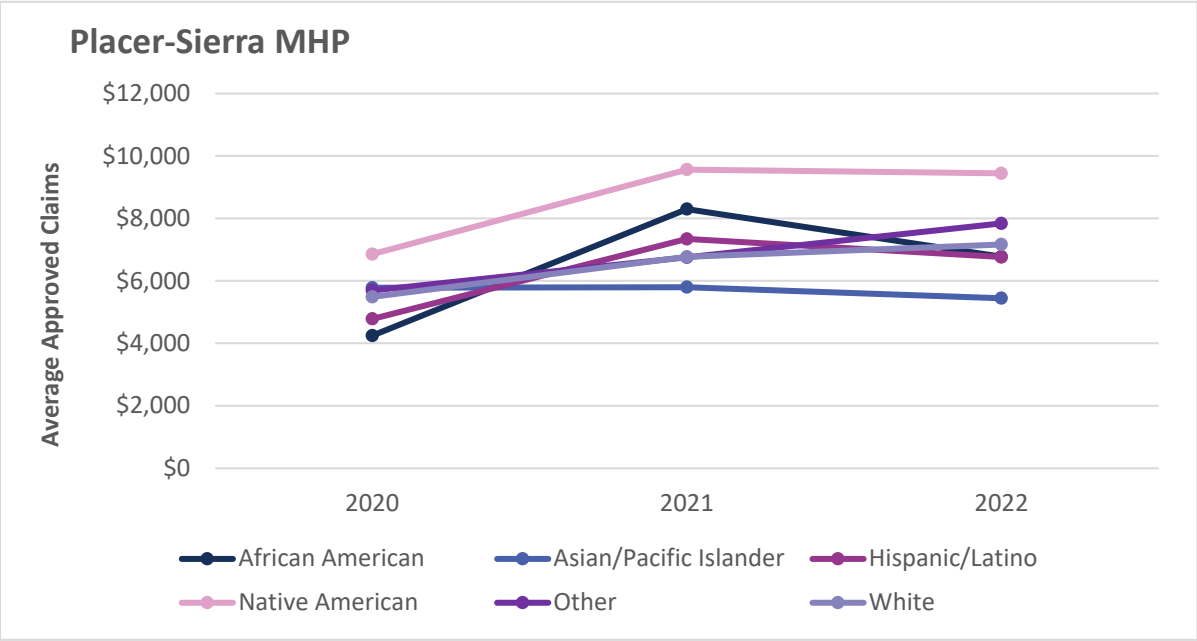
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



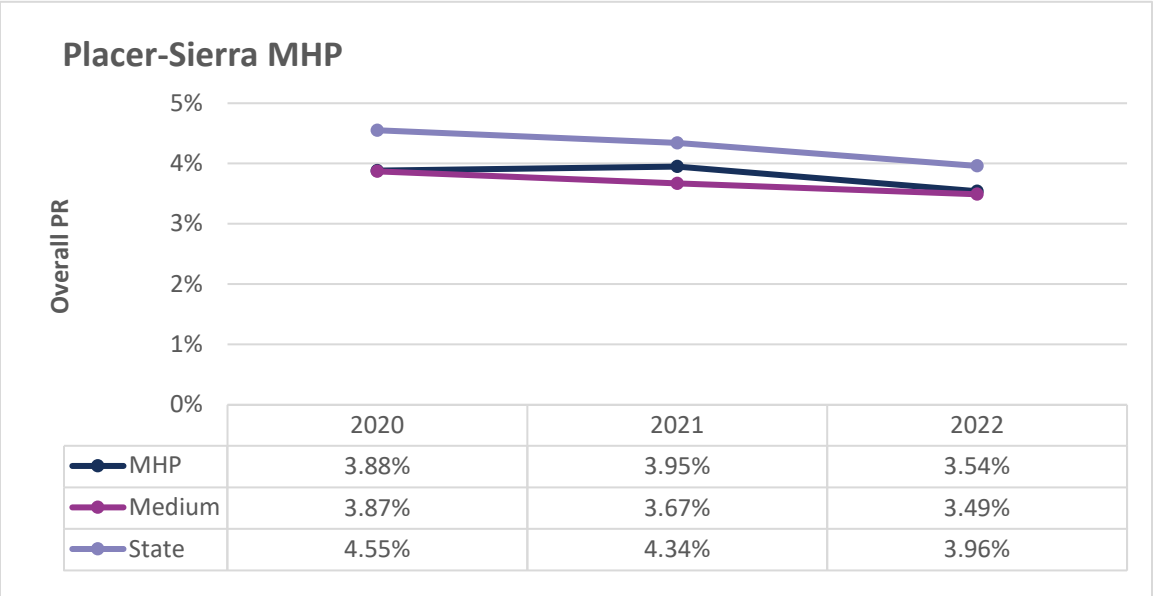
- PRs for all racial/ethnic groups have been relatively stable from CY 2020 to CY 2022. The small number of Native American eligibles and members served can create larger shifts in PR from year to year than seen in larger groups.
- PRs for Native Americans, African Americans, and Whites have consistently been the highest over the past three years, whereas PRs for Asian/Pacific Islanders and Hispanic/Latinos have consistently been the lowest.

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



- The AACM for Native American members was greater than the AACM for the MHP overall from CY 2020 to CY2022, indicating more and/or more intensive services were provided to this population. It should be noted that Native American members were only 1 percent of all members served, and when the population is small, outliers can impact averages (means).
- With the exceptions of the White and Other groups, AACMs were lower for CY 2022 than they were in CY 2021.

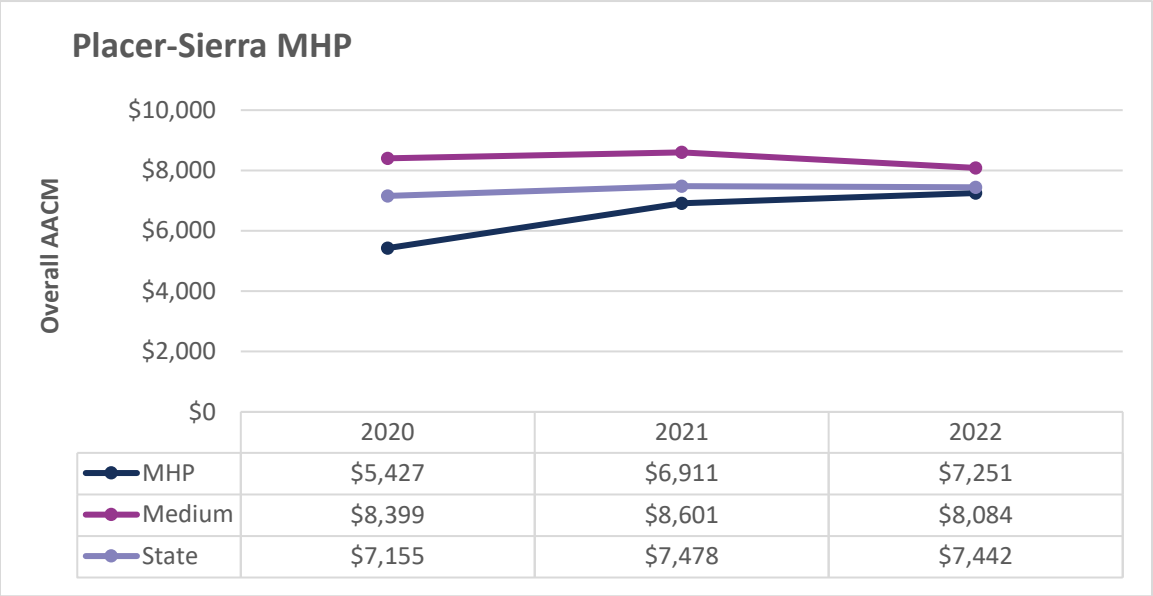
Figure 4: Overall PR, CY 2020-22



	2020	2021	2022
MHP	3.88%	3.95%	3.54%
Medium	3.87%	3.67%	3.49%
State	4.55%	4.34%	3.96%

- Overall PRs for the MHP, medium sized counties, and the state declined from CY 2021 to CY 2022. In CY 2022, the MHP's PR was just above the medium county rate (3.54 percent vs. 3.49 percent) and below the statewide rate (3.54 percent vs. 3.96 percent).

Figure 5: Overall AACM, CY 2020-22

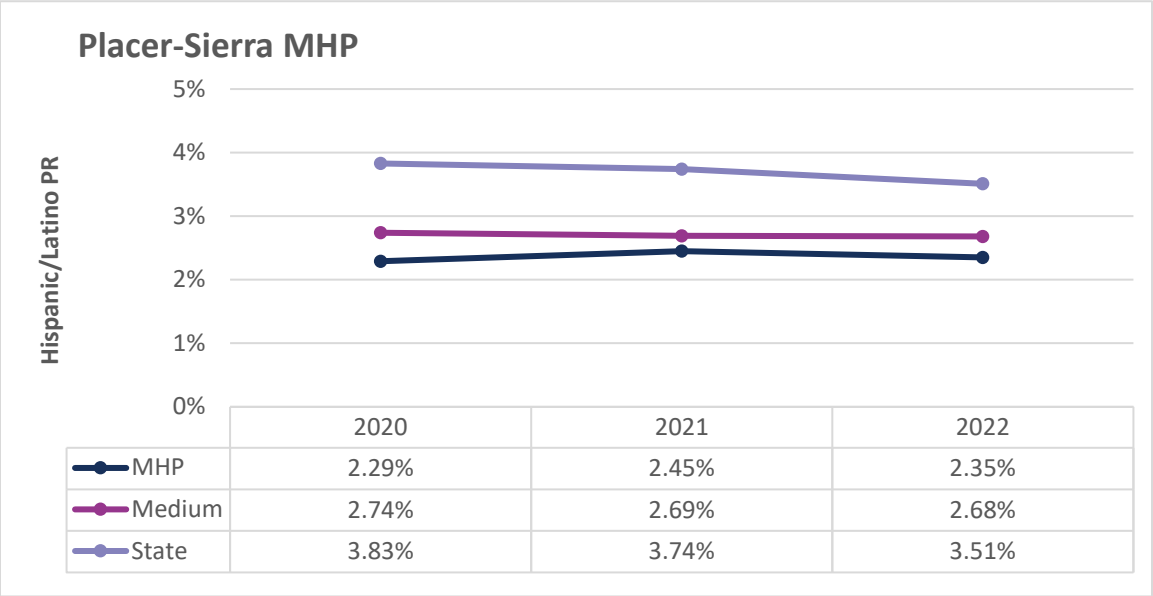


	2020	2021	2022
MHP	$5,427	$6,911	$7,251
Medium	$8,399	$8,601	$8,084
State	$7,155	$7,478	$7,442

- While the statewide AACM was relatively stable from CY 2020 to CY 2022, the MHP's AACM increased each year from CY 2020 to CY 2022 and is now just below the statewide average ($7,251 vs. $7,442).

- The increase in the number of HCM served from CY 2020 to CY 2022 (70 vs. 151) and the steady increase in HCM percent of claims from CY 2020 to CY 2022 (28.21 vs. 41.67 percent) is likely contributing to the increase in overall AACM (see Table 14, later in this report).

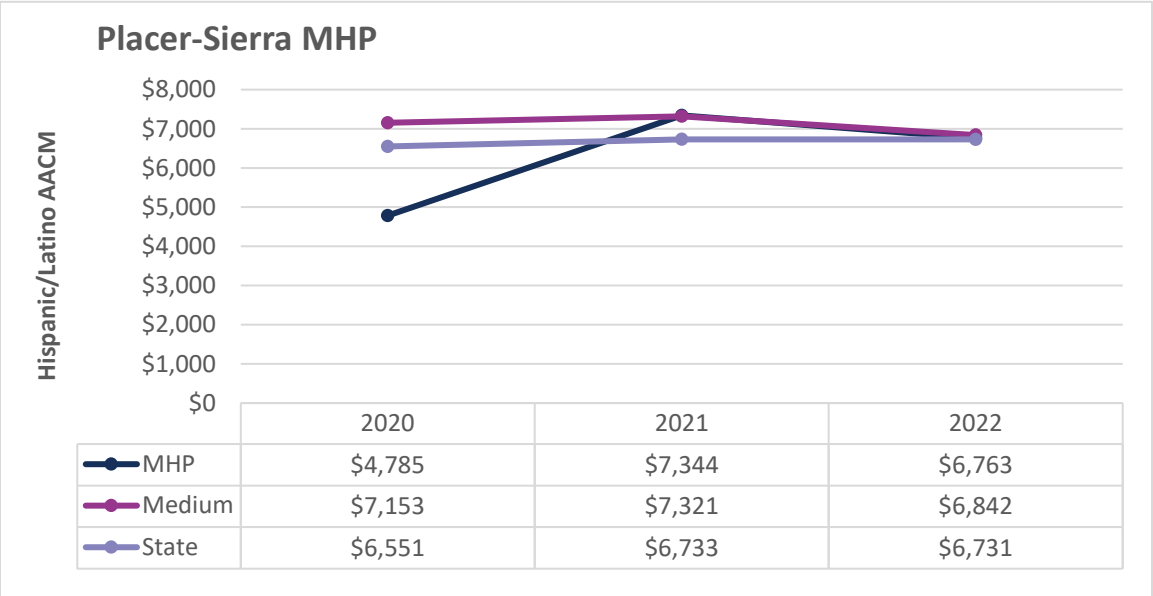
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	2.29%	2.45%	2.35%
Medium	2.74%	2.69%	2.68%
State	3.83%	3.74%	3.51%

- The MHP's Hispanic/Latino PR has been consistently lower than that of medium sized county and statewide rates from CY 2020 to CY 2022. In CY 2022, the PR for this population ranked 45th of 56 MHPs.

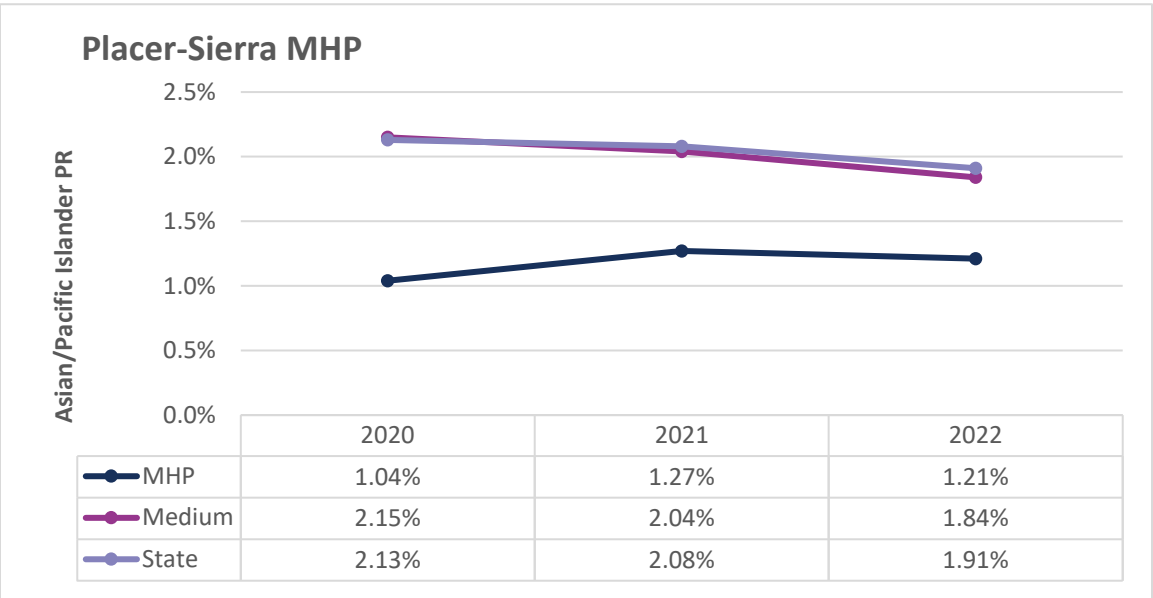
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$4,785	$7,344	$6,763
Medium	$7,153	$7,321	$6,842
State	$6,551	$6,733	$6,731

- The MHP's AACM rose 53 percent from CY 2020 to CY 2021 ($4,785 vs. $7,344) and is in CY 2022 is comparable to that of medium sized county and statewide AACMs.

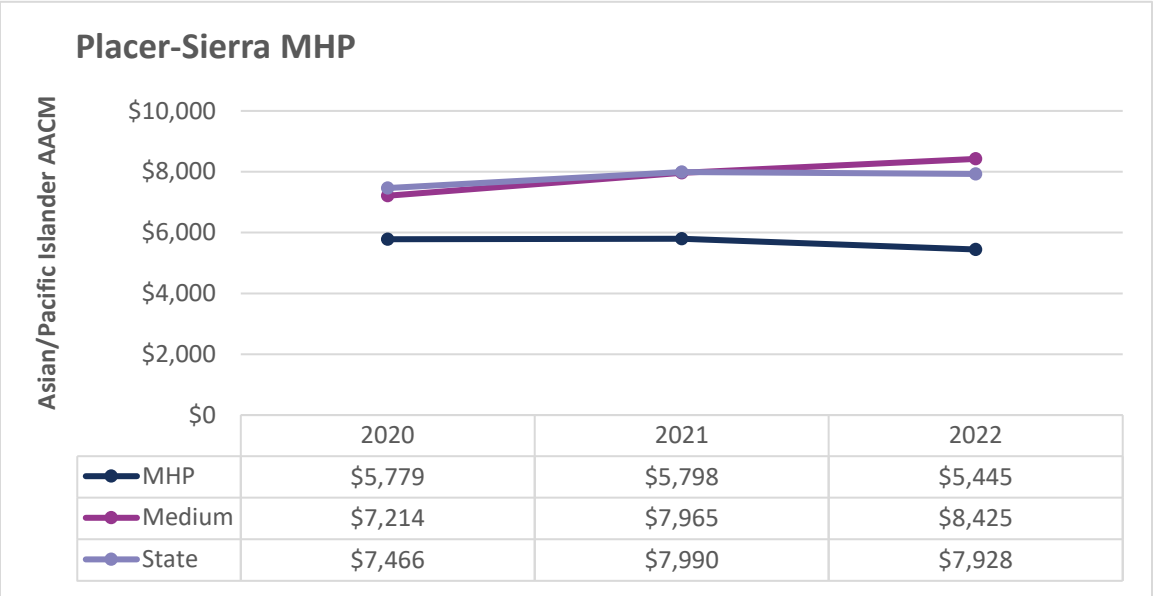
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	1.04%	1.27%	1.21%
Medium	2.15%	2.04%	1.84%
State	2.13%	2.08%	1.91%

- The MHP's Asian/Pacific Islander PR has been lower than the medium sized county and statewide rates from CY 2020 to CY 2022. In CY 2022, the PR for this population ranked 48th of 56 MHPs. Asian/Pacific Islanders represent 6 percent of the MHP's eligibles and 2 percent of those served (see Figure 1).

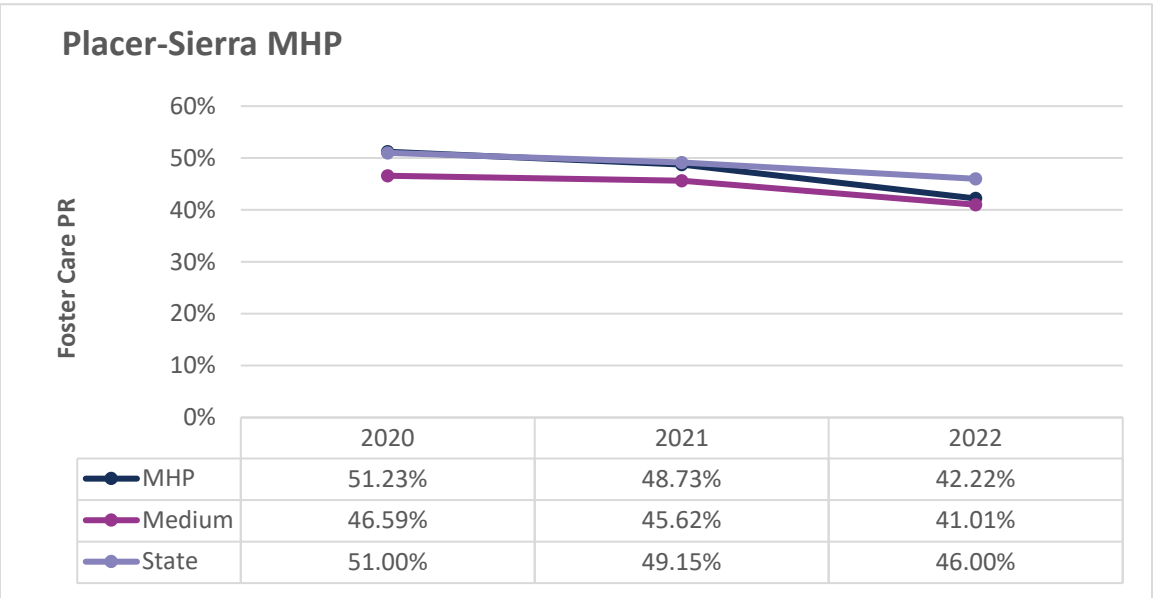
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$5,779	$5,798	$5,445
Medium	$7,214	$7,965	$8,425
State	$7,466	$7,990	$7,928

- The Asian/Pacific Islander AACM has been lower than that of medium sized county and statewide averages across each of the last three years.

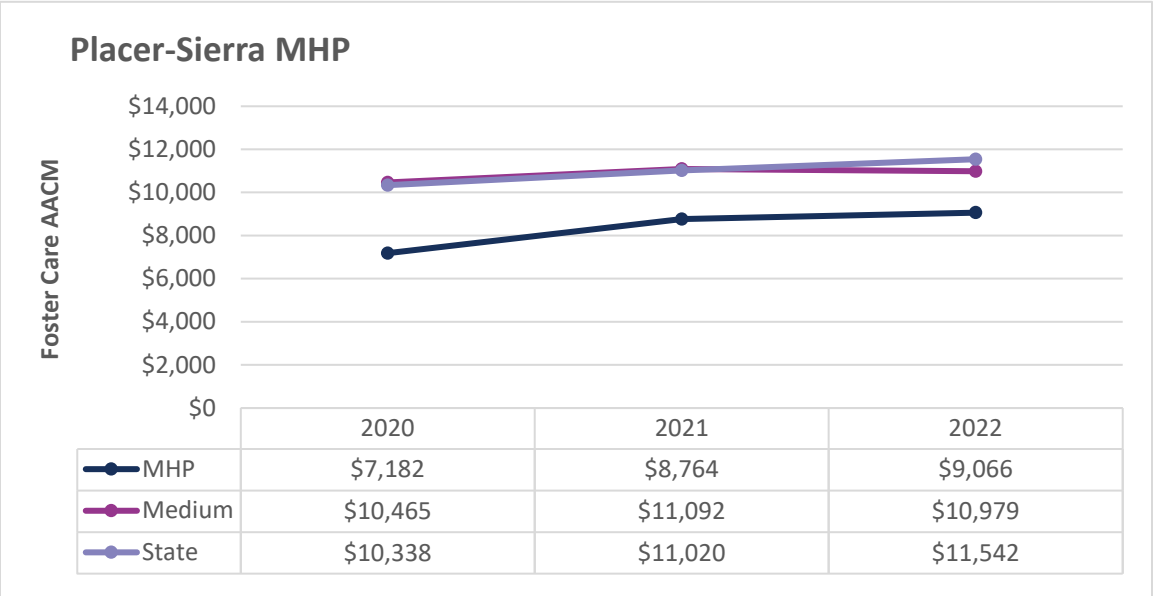
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	51.23%	48.73%	42.22%
Medium	46.59%	45.62%	41.01%
State	51.00%	49.15%	46.00%

- FC PR declined each year from CY 2020 to CY 2022 for the MHP, medium sized counties, and statewide. In CY 2022, the MHP's FC PR was just above that of medium sized counties (42.22 vs. 41.01 percent) and below the statewide rate (42.22 vs. 46 percent).

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$7,182	$8,764	$9,066
Medium	$10,465	$11,092	$10,979
State	$10,338	$11,020	$11,542

- The statewide and MHP FC AACMs have increased each year for the past three years. In CY 2022, the MHP's FC AACM remained below that of medium sized counties ($9,066 vs. $10,979) and statewide ($9,066 vs. $11,542).

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Placer/Sierra MHP to Adults, CY 2022

Service Category	MHP N = 2,233				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	28	1.3%	9	7	10.3%	14	8
Inpatient Admin	<11	-	15	15	0.4%	26	10
Psychiatric Health Facility	293	13.1%	19	11	1.2%	16	8
Residential	<11	-	85	44	0.3%	114	84
Crisis Residential	105	4.7%	19	14	1.9%	23	15
Per Minute Services							
Crisis Stabilization	67	3.0%	1,222	1,200	13.4%	1,449	1,200
Crisis Intervention	533	23.9%	225	160	12.2%	236	144
Medication Support	1,428	63.9%	454	229	59.8%	298	190
Mental Health Services	1,138	51.0%	919	259	62.7%	832	329
Targeted Case Management	1,470	65.8%	342	88	37.0%	445	135

- The MHP's combined inpatient and Psychiatric Health Facility utilization rate was 25 percent higher than the combined statewide rate (14.4 percent vs. 11.5 percent).
- While the crisis residential utilization rate at the MHP is considerably lower than the statewide rate (3.0 percent vs. 13.4 percent), crisis intervention utilization at the MHP is approaching twice that of the statewide rate (23.9 percent vs. 12.2 percent. This is associated with their strongly developed field-based crisis teams.
- The targeted case management utilization rate is higher at the MHP than statewide (65.8 percent vs. 37 percent), though at fewer units on average.

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

Service Category	MHP N = 114				Statewide N = 33,243		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	6	6	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	15	13	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	<11	-	318	318	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	15	13.2%	471	139	8.5%	371	182
Medication Support	40	35.1%	536	209	27.6%	364	257
TBS	<11	-	6,911	4,569	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Home Based Services	43	37.7%	1,266	680	40.8%	1,458	441
Intensive Care Coordination	24	21.1%	5,792	2,510	19.5%	2,440	1,334
Katie-A-Like	<11	-	191	191	0.2%	390	158
Mental Health Services	105	92.1%	6,313	1,499	95.4%	1,846	1,053
Targeted Case Management	75	65.8%	518	315	35.8%	307	118

- As seen in the adult system, for FC youth, the crisis intervention utilization rate is significantly higher than the statewide rate (13.2 percent vs. 8.5 percent) as is the MHP's targeted case management utilization rate is higher than the statewide rate (65.8 percent vs. 35.8 percent).
- Intensive Home-Based Services (IHBS) and Intensive Care Coordination (ICC) utilization were comparable to statewide, indicating the MHP has made good efforts to implement Pathways to Well-Being services for FC youth. Pathways implementation is also evidenced in providing ICC and IHBS to non-FC youth.

IMPACT OF ACCESS FINDINGS

- The Placer County management team functions as one management unit that encompasses Behavioral Health, Child Welfare, and Probation. This contributes greatly to rapid responses in coordination of care and operational decision-making process.
- As a result of implementing the CalAIM screening tool, the MHP saw an increase in access for youth with historical involvement with child welfare system and or probation.
- While PRs for those 21+ exceed statewide rates, PRs for those aged 0-5 and 6-17 are below that of medium county and statewide rates possibly indicating lower service accessibility in the Children's SOC.
- Hispanic/Latino PR and Asian/Pacific Islander PRs remained below that of medium counties and statewide rates from CY 2020 to CY 2022, indicating a potential need for increased outreach to these populations.

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 in providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to 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	Partially Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Partially Met

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

- The MHP saw an increase in timeliness for urgent services, with 100 percent of services meeting the standard. Urgent services are defined as those requiring crisis response.

- Contract provider timeliness data was not included in the data submitted to EQRO. However, the MHP reviews data for county and contract providers during Quality Improvement Committee (QIC) meetings.
- Children first offered non-urgent psychiatric appointments met the standard for 52 percent of appointments offered and 38 percent of psychiatric services delivered. The MHP indicated delays are often associated with required labs necessary for all new psychiatry services, in addition to parental consent.
- The MHP does not track first offered psychiatry appointments for adults.

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. This data represents county-operated services. First offered psychiatry is tracked for children and FC youth only, not adults.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	2.32 Business Days	10 Business Days*	95.6%
First Non-Urgent Service Rendered	2.32 Business Days	10 Business Days**	79.6%
First Non-Urgent Psychiatry Appointment Offered	10 Business Days	15 Business Days*	68.6%
First Non-Urgent Psychiatry Service Rendered	10 Business Days	15 Business Days**	65.6%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	0.39 Hours ***	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	10.9 Days	7 Calendar Days	59.5%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	10.9 Days	30 Calendar Days	65.3%
No-Show Rate – Psychiatry	16.4%	25%**	n/a
No-Show Rate – Clinicians	3.7%	25%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP does not require prior authorization for urgent services offered; all urgent services are reflected in the metric for urgent services, authorization not required.			
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

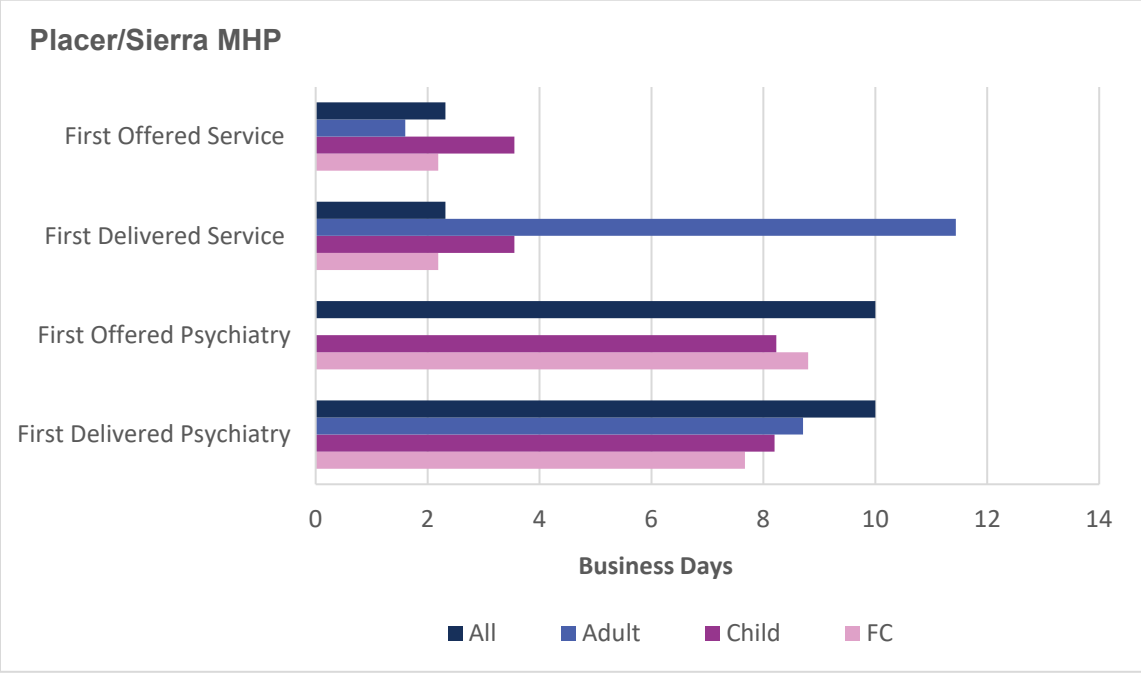


Figure 13: Wait Times for Urgent Services

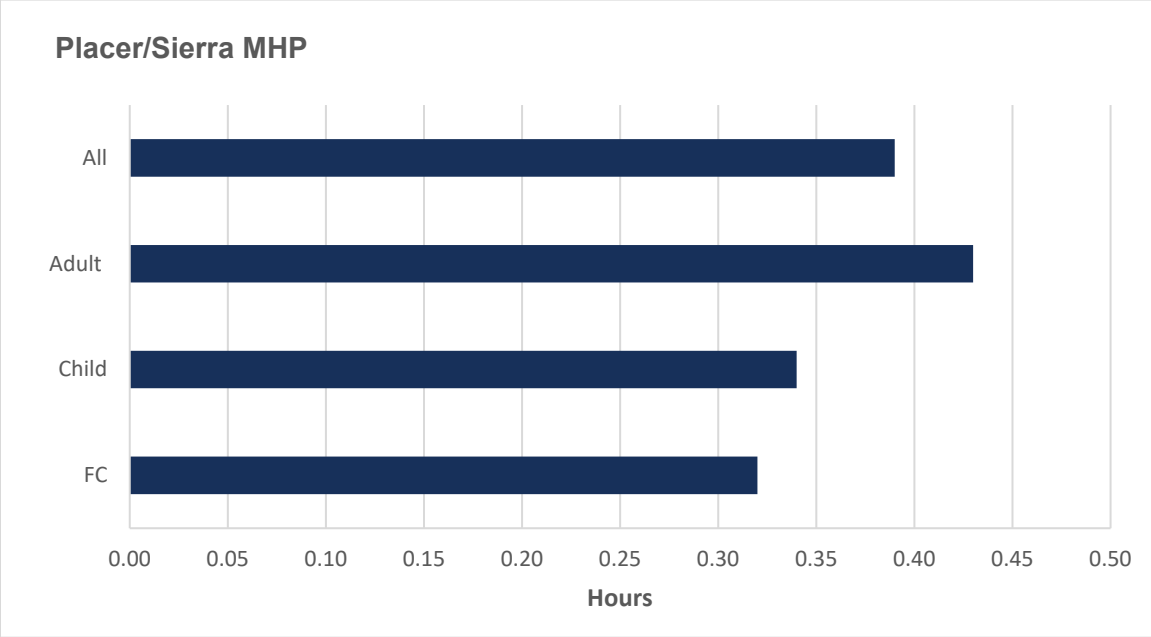
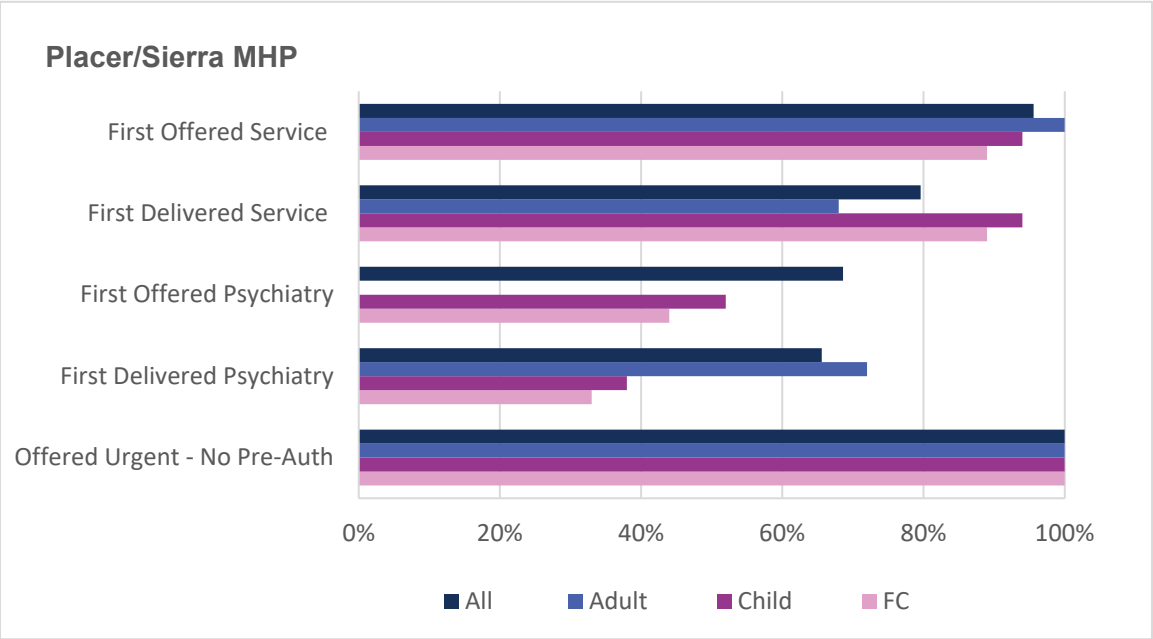


Figure 14: Percent of Services that Met Timeliness Standards



- According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments and unscheduled assessments.
- The MHP defined “urgent services” for purposes of the ATA as services provided by the Crisis Care Mobile Unit and Mobile Crisis Triage data, which is mobile crisis mitigation in the field. There were reportedly 1,158 urgent service requests with a reported actual wait time to services for the overall population of 0.39 hours.
- A 15-business day standard is expected for initial access to psychiatry, though the MHP may define when and how this is measured, and often MHP processes, definitions, and tracking may differ for adults and children. Adult psychiatry service offered is not tracked, only rendered services are tracked.
- For the MHP, no-shows are tracked only for county-operated services. The MHP reports a no-show rate of 16.4 percent for psychiatrists and 3.7 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- Considering that the MHP reported 34 percent of services are provided by and initiated at contract providers, the exclusion of their data from the timeliness metrics represents an incomplete picture of timeliness to services in the overall system.

- First non-urgent psychiatry service delivered to adults met the standard 72 percent of the time, with 38 percent of child psychiatry meeting the standard. The MHP should explore options to increase timely access to service delivered.
- The MHP does not track first offered non-urgent psychiatry appointments for adults, which presents an incomplete picture of total percentage of services that met the standard. The MHP should explore options to capture first offered non-urgent psychiatry appointment data as this may assist in tracking and evaluating trends in this area.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is within the Quality Management (QM) team which is inclusive of compliance staff. The QM team which oversees QI, QA, and compliance consists of two directors from each SOC and 15 full-time equivalent (FTE) staff from Placer, 1 FTE and one director for Sierra. Placer also provides Q/QA support to Sierra County by contract.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of the MHP QI team, the systems of care, leadership team, the HHS Department, the policy team, the Systems Management and Resource Team (SMART), Policy Board and Committees, Subcommittees and Teams, which comprise the QI Program structure. The QIC is scheduled to meet Quarterly. Since the previous EQR, the MHP QIC met two times. Of the 16 Placer and 10 Sierra-identified FY 22-23 QAPI workplan goals, the MHP continues to improve making goals and quantifiable, and include goals necessary for CalAIM requirements.

The MHP utilized the Level of Care Utilization System (LOCUS) as a LOC tool for adults for part of the year. When the use of this tool ceased no replacement was identified for use, and at the time of the review there is no LOC tool being used.

The MHP utilizes the Child and Adolescent Needs and Strengths (CANS) in the Children's SOC, but does not have any outcome measures in use for the Adult SOC.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- The MHP tracks and trends data to make informed decisions regarding needed changes within their systems of care.
- With the exception of contracted providers, stakeholders tended to view communication from MHP administration as limited, as well as few known opportunities to provide input or involvement in system planning and implementation.
- At the time of the review, the MHP had discontinued use of the LOCUS tool which had previously been used for LOC. The MHP discussed intentions of waiting for the state determined LOC tool once it is implemented by the DHCS.
- The MHP shared Consumer Perception Survey (CPS) results to stakeholders; however, the MHP has not utilized the CPS findings to address a specific identified area in findings.
- The MHP tracks and trends all of the Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.

QUALITY PERFORMANCE MEASURES

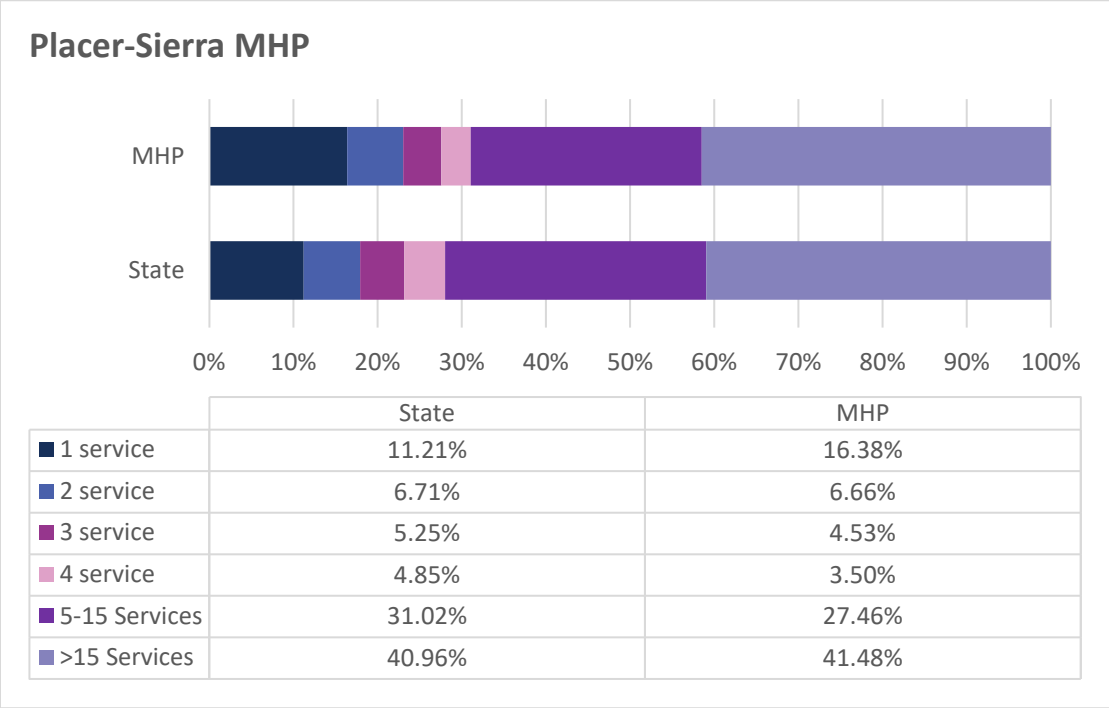
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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



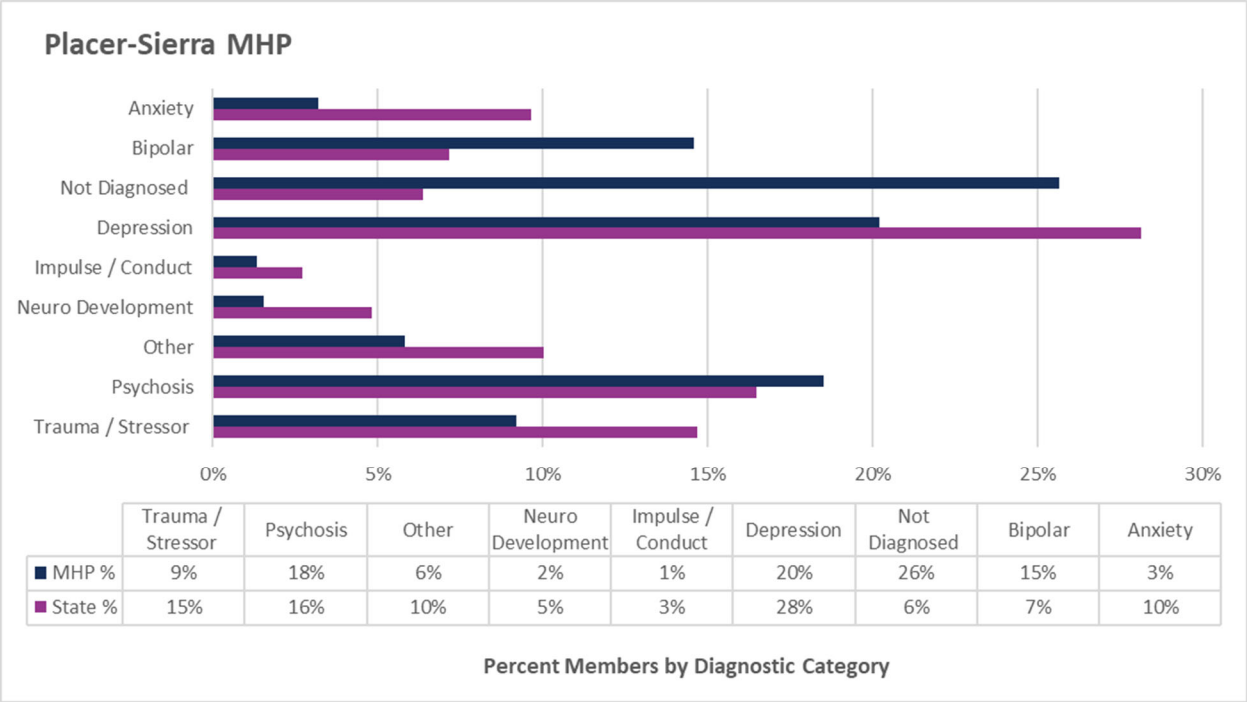
	State	MHP
1 service	11.21%	16.38%
2 service	6.71%	6.66%
3 service	5.25%	4.53%
4 service	4.85%	3.50%
5-15 Services	31.02%	27.46%
>15 Services	40.96%	41.48%

- The MHP had more members receiving one service than is seen statewide (16.38 percent vs. 11.21 percent). This may be correlated with the MHP's high crisis utilization rate associated with its field-based crisis teams. It may be important to assess the rate of engagement for those members referred to the MHP for ongoing services.
- The MHP's rate of members receiving greater than 15 services is comparable to the statewide rate (41.48 percent vs. 40.95 percent).

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

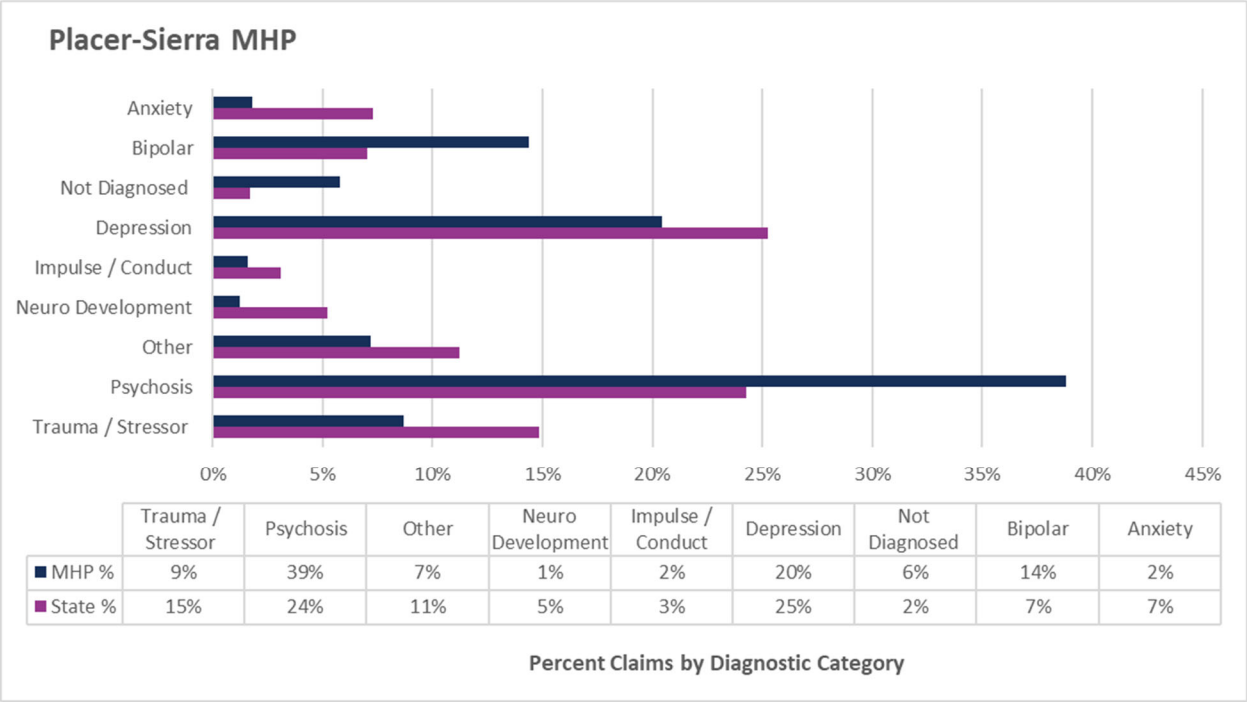


	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	9%	18%	6%	2%	1%	20%	26%	15%	3%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- Sixty-four percent of members had one of three diagnoses: Not diagnosed (26 percent), depression (20 percent), and psychosis (18 percent). The MHP's rate for not diagnosed was more than four times the statewide rate (26 percent vs. 6 percent). This might be the high percentage of members in the MHP receiving Crisis Intervention services and/or members receiving only one service.

- While trauma/stressor, anxiety, and depressive disorders are diagnosed at notably lower rates than is seen statewide, bipolar disorders are diagnosed at more than twice the statewide rate (15 percent vs. 7 percent).

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 %	9%	39%	7%	1%	2%	20%	6%	14%	2%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- The MHP's approved claims percentages generally aligned with diagnostic patterns when compared to statewide data,
- Claiming associated with Psychosis was higher than its representation in the MHP population, with 18 percent of members having received services for psychosis and 39 percent of claims spent on this diagnostic category. This may represent intentional, intensive services for this population.

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: Placer/Sierra MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	408	600	11.22	8.45	$15,980	12,763	$6,519,951
CY 2021	457	634	11.06	8.86	$12,577	$12,696	$5,747,801
CY 2020	396	504	11.87	8.68	$9,646	$11,814	$3,819,657

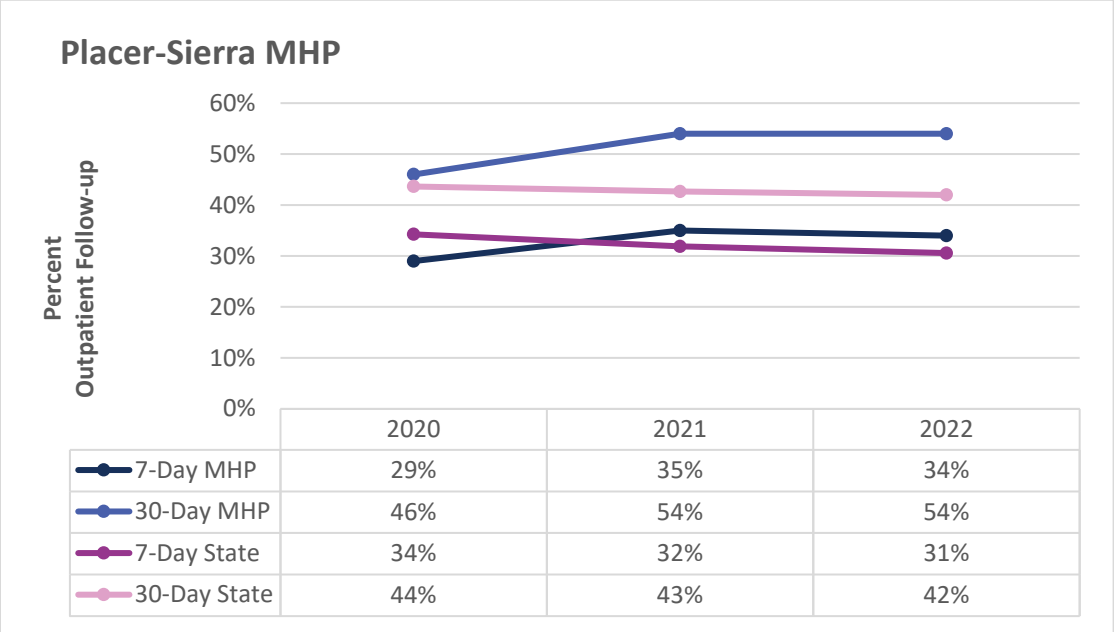
- While the number of unique inpatient members declined from CY 2021 to CY 2022 (457 vs. 408) and the number of inpatient admissions (634 vs. 600), the inpatient AACM ($12,577 vs.15,980) increased. Given that the LOS has been stable over the past three years, it appears that the AACM for inpatient services has been impacted by rate increases.

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.

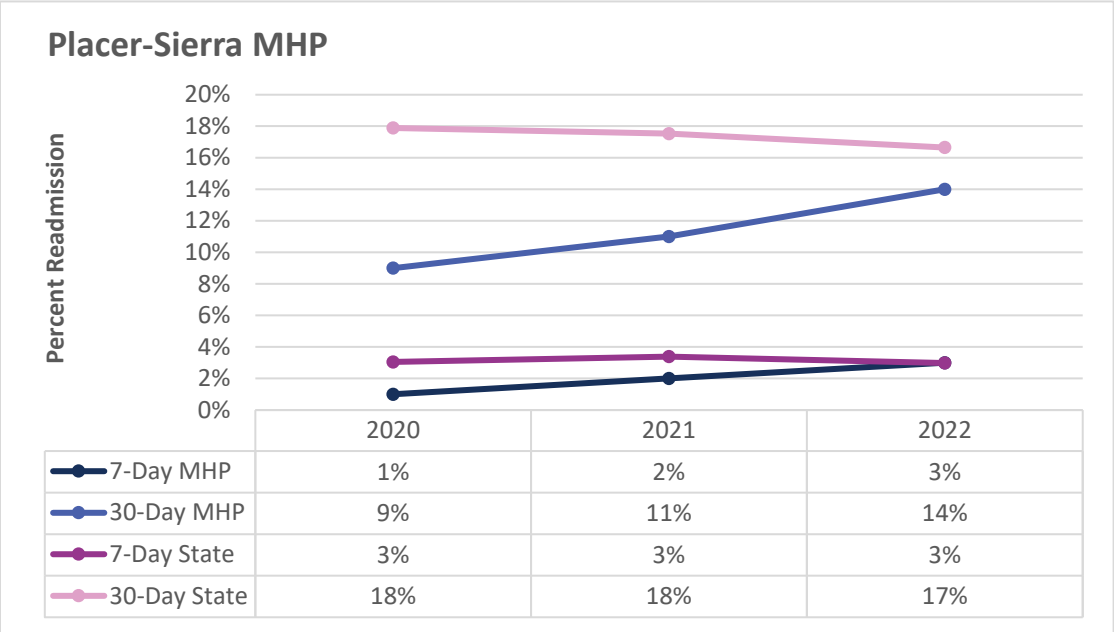
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	29%	35%	34%
30-Day MHP	46%	54%	54%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- The MHP's 7- and 30-day follow-up rates increased decreased slightly in CY 2022 but remain higher than the statewide rate.

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



	2020	2021	2022
7-Day MHP	1%	2%	3%
30-Day MHP	9%	11%	14%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP's CY 2022 7-day and 30-day readmission rates have increased slightly each year but remain lower than statewide rates.

- For FY 2022-23, the MHP reported a 7-day readmission rate of 6.6 percent and a 30-day rate of 13.5 percent.

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. HCM 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: Placer/Sierra MHP High-Cost Members (Greater than $30,000), CY 2020-22

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	151	5.56%	41.67%	$8,209,319	$54,366	$42,000
	CY 2021	144	5.18%	39.23%	$7,539,441	$52,357	$43,947
	CY 2020	70	2.85%	28.21%	$3,759,388	$53,706	$41,798

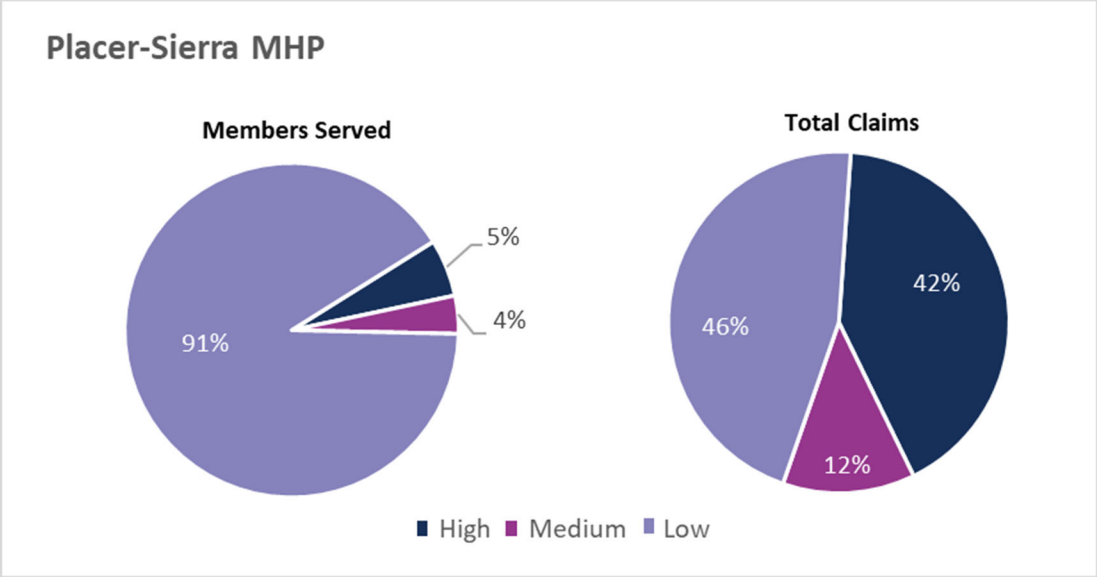
- The number of HCMs increased each year from CY 2020 to CY 2022. In CY 2022, the percent of HCMs exceeded the statewide rate (5.56 percent vs. 4.54 percent). The CY 2022 percent of HCM approved claims dollars also exceeded the statewide rate (41.67 percent vs. 33.86 percent). The AACM was just below the statewide average in CY 2022 ($54,366 vs. $55,518).

Table 15: Placer/Sierra MHP Medium- and Low-Cost Members, CY 2022

Claims Range	# of Members Served	% of Members Served	Category Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	100	3.68%	12.54%	$2,471,307	$24,713	$24,209
Low-Cost (Less than $20K)	2,466	90.76%	45.79%	$9,020,655	$3,658	$2,009

- Low-cost members comprised 90.76 percent of those served and 45.79 percent of the approved claims dollars were attributed to this population.

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



IMPACT OF QUALITY FINDINGS

- The MHP employs 41 FTE peers throughout the adult and children's systems of care. The vast network of peers provides navigation, assistance, and various services to members.
- Statewide, 11.21 percent of members received a single service compared to 16.38 percent of members receiving one service at the MHP. The MHP's rate of members receiving greater than 15 services is comparable to the statewide rate (41.48 percent vs. 40.95 percent) indicating that once services are initiated access to care is similar to that seen statewide, but early engagement may be needed to retain members past their initial service in some cases, especially if the initial service was a crisis intervention.

- While the LOS has been stable over the past three years it exceeds the statewide average by two to three days. The number of MHP unique inpatient members and the number of admissions declined from CY 2021 to CY 2022.

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: Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)

Date Started: 09/2022

Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions, will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2024.

Target Population: The MHP will focus on beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm, also referred to as MH or MH conditions.

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

[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

Placer MHP identified a number of barriers associated with their current ED processes. They are not notified about their members being served by the ED in a timely manner. Care coordination is inconsistent due to the lack of access to ED real time data. Access to real time data is not established due to concerns around communications and responsibilities between referring and receiving providers. Restraints identified in the memorandum of understanding with the Managed Care Providers (MCP) and local EDs restrict closing the referral loop for the provision of care coordination.

Placer entered into a participation agreement with CalMHSA to assist with baseline and ongoing data analysis. The DHCS summary baseline data for July 2022 was used as a launchpad for planning and initiating performance improvement efforts. Manual collection for Plan Data Feed claim files and building infrastructure, capacity and processes around data exchange are in planning and development.

The MHP submitted the BH QIP submission from September 2022, which did not represent any activity during the review period.

TA and Recommendations

As submitted, this clinical PIP was found to have no confidence because the submission did not include CY 2023 activities or data updates representing work done since the last EQR.

The MHP received TA from CalEQRO during the prior year.

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

- Continue efforts to engage stakeholders regarding the exchange of data and notification.
- For FY 2024-25 EQR update the BHQIP document to include up to date data and activities associated with this BHQIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: SOGI and the beneficiary experience in ASOC MH Clinics

Date Started: 10/2021

Aim Statement: “For adults (18+) receiving outpatient mental health services at the Adult System of Care Dewitt and Cirby clinic locations, will being asked to identify sex, gender identity, sexual orientation, preferred name, and preferred pronouns by MHP

staff appropriately equipped to ask and collect these questions increase the beneficiary experience as reported in client satisfaction surveys over a six-month period during 2022."

Target Population: All ASOC

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

Summary

The goal of this PIP is to improve the beneficiary experience by consistently asking individuals, and addressing them by, their sexual orientation gender identity (SOGI) and preferred name and pronouns in a safe and culturally responsive manner.

The intervention is to ask adult beneficiaries receiving outpatient mental health services in two ASOC clinic locations to identify their sex, gender identity, sexual orientation, preferred name, and preferred pronouns. The impact of the intervention will be monitored as reported in client satisfaction surveys.

Initial results show noticeable changes; however, the PIP is pending final its remeasurements for member satisfaction.

The MHP received TA from CalEQRO during the prior year.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence because while MHP reports noticeable changes due to PIP intervention, it cannot say if interventions directly impacted member answers in survey. Remeasurement of second intervention is still needed at 12th month mark. It is unknown how changes in the EHR may affect data collection and reporting.

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

- Include exploring possible solutions to maintain validity of the PIP due to data collection difficulties experienced by implementation of new EHR.
- Include a measure that assists in monitoring that the intervention is provided as intended.

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 the 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 Placer is the CalMHSA semi-statewide EHR, SmartCare by Streamline Healthcare, which had been in use for one month at the time of the review. MyAvatar/Netsmart Technologies was used for FY 2022-23. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

Approximately 2.6 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

Placer has 293 named users with log-on authority to the MyAvatar EHR, including approximately 249 county staff and 44 contractor staff. Support for the users is provided by 5 FTE IS technology positions, all filled.

As of the FY 2023-24 EQR, some contract providers have access to directly enter clinical data into the Placer's EHR. While no contract providers had access to enter clinical data into myAvatar, three providers already have full access to SmartCare. The number of contract providers with full access to SmartCare is expected to increase over the next year. Contractor staff have 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 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	5%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☒ Weekly ☐ Monthly	95%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP does not have a PHR. This functionality is expected to be implemented within the next year.

Interoperability Support

The MHP is not a member or participant in a HIE. Placer plans to join SacValley Medshare HIE within the next year. Healthcare professional staff use secure information exchange directly with service partners through secure email. The MHP engages in electronic exchange of information with its DMC-ODS counterpart.

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 implemented the semi-statewide EHR, SmartCare by Streamline, on July 3, 2023. Streamline will provide base product patch updates while CalMHSA will be responsible for system customization.
- While no contract providers had access to enter clinical data into myAvatar, three contract providers have full access to SmartCare. The number of contract providers with full access to SmartCare is anticipated to increase over the next year.
- The MHP's denied claims rate of 6.54 percent slightly exceeds the statewide rate of 5.92 percent.
- The MHP does not maintain a data warehouse that replicates the SmartCare system to support data analytics and reporting.
- While there is an operations continuity plan for critical business functions that is maintained in readiness for use in the event of a cyber-attack, disaster, or other emergency, it is not tested annually.
- The MHP expanded the use of telehealth services, from 168 members reported receiving telehealth services in the prior year to 801 members this year.
- While data analytics and reporting were well developed the Avatar system, this functionality is still being developed in SmartCare. This is true for all SmartCare counties due to the recent implementation of the system.

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 Placer/Sierra MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	6,306	$1,687,995	$109,213	6.47%	$1,578,782
Feb	5,681	$1,526,685	$138,962	9.10%	$1,387,723
Mar	7,054	$1,869,934	$148,364	7.93%	$1,721,570
April	6,598	$1,847,368	$123,527	6.69%	$1,723,841
May	5,933	$1,618,501	$112,674	6.96%	$1,505,827
June	6,152	$1,765,704	$115,872	6.56%	$1,649,832
July	5,534	$1,745,386	$82,006	4.70%	$1,663,380
Aug	6,378	$1,726,919	$111,427	6.45%	$1,615,492
Sept	6,104	$1,727,407	$93,319	5.40%	$1,634,088
Oct	6,132	$1,756,748	$118,568	6.75%	$1,638,180
Nov	5,464	$1,588,315	$92,799	5.84%	$1,495,516
Dec	2,108	$776,920	$37,533	4.83%	$739,387
Total	**69,444**	**$19,637,882**	**$1,284,264**	**6.54%**	**$18,353,618**

Table 19: Summary of Placer/Sierra MHP Denied Claims by Reason Code, CY 2022

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other healthcare coverage must be billed first	1,566	$426,883	33.24%
Medicare Part B must be billed before submission of claim	1,271	$336,503	26.20%
Service line is a duplicate and repeat service modifier is not present	881	$175,701	13.68%
Beneficiary is not eligible or non-covered charges	415	$140,370	10.93%
Other	529	$129,109	10.05%
Service location NPI issue	322	$66,680	5.19%
Place of service incomplete or invalid	4	$5,445	0.42%
Deactivated NPI	9	$2,323	0.18%
Late claim submission	8	$1,251	0.10%
Total Denied Claims	**5,005**	**$1,284,265**	**100.00%**
Overall Denied Claims Rate	**6.54%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The claim denial rate for CY 2022 of 6.54 percent exceeds the statewide average of 5.92 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Medicare Part B must be billed before the submission of claim was the denial code for 26.2 percent of the MHP's denied claims dollars in CY 2022. The MHP is Medicare certified but is not currently submitting Medicare claims. They are in discussions with CalMHSA to provide this service for them.
- While no Placer contract providers had access to enter clinical data into myAvatar, three contract providers have full access to SmartCare with additional providers expected to gain access to SmartCare over the next year. Full contract provider access to SmartCare will increase the data that is available to the MHP for analysis and reporting.
- While Placer is not a current member of an HIE, they are planning to join SacValley Medshare within the next year.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP conducts the CPS per DHCS requirements. The MHP reviewed results of the CPS with the SOC and stakeholders. The QAPI includes a goal to review and utilize the CPS for program quality improvement. No activities have been initiated based upon CPS results.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested two 90-minute focus groups with MHP members and/or their family, containing 10 to 12 participants each, one for the adult system and the other for the youth system.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of parents/care takers of youth who initiated services in the preceding 12 months. Unfortunately, no members showed up for this group.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included 3 participants. The participants receive clinical services from the MHP.

Recommendations from focus group participants included:

- Add more volunteer opportunities in the MHP SOC.
- Assist members with connecting to family members.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Members expressed great satisfaction with the services and support provided. Members report being grateful for counseling and psychiatric services. Compliments were given to the mental health court program and continuum of care, which included a variety of supportive services including transportation and housing. It was noted that members referred to being able to trust their providers.

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. Placer County's contracted providers report continued support throughout the implementation of SmartCare EHR. This includes providing contract providers full access to SmartCare, which will increase the data that is available to the MHP for reporting and analysis. (Timeliness, Quality, IS)
2. Placer County is delivering timely mobile crisis services throughout the county. (Access)
3. Placer County's peer support system provides significant support for members throughout the SOC. (Quality)
4. Placer County's internal structure provides an environment that results in an efficient and effective coordination process between the MHP, child welfare, and probation services. (Access, Quality,)
5. Sierra County communicates efficiently between stakeholders, resulting in rapid response to coordination of care. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Placer County was unable to open a wellness center located in the Auburn area. This leaves part of the county region without a wellness center. (Quality)
2. The MHP does not aggregate and report on the data of contract providers to provide an overall perspective on the county's beneficiary timeliness and outcomes. (Timeliness, IS)
3. The MHP lacks a universal SOC adult outcome tool. (Quality)
4. The MHP does not maintain a data warehouse that replicates the SmartCare system to support data analytics and reporting. (Quality, IS)
5. The MHP's percentage of HCM has increased each year for the past three years and exceeds the statewide rate. (Quality)

RECOMMENDATIONS

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

1. Evaluate the needs of Auburn members. Given that there is no local wellness center, if it is not feasible to do so, consider alternatives such as transportation to another center or a modified center at a feasible location. (Quality)

   (This recommendation was continued from FY 2022-23.)

2. Create reports that aggregate, track, and trend contractor access data to accurately represent beneficiary timeliness and outcomes throughout the SOC. (Timeliness, Quality, IS)

   (This recommendation was continued from FY 2022-23.)

3. Research, choose, and implement a SOC outcome tool to inform care decisions in the adult system. (Quality)

   (This recommendation was continued from FY 2022-23.)

4. Develop a local database that replicates the SmartCare system and is updated nightly to support data analytics and reporting. (Quality, IS)
5. Investigate the HCM service utilization to determine if service patterns reflect the treatment needs of this population. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

The MHP submitted a clinical PIP that did not demonstrate activity for the review period.

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 – Placer-Sierra 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, 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
Plan Member and Family Member Focus Groups
MHP Youth Services Coordination
Clinical Line Staff Group Interview
Clinical Directors Group Interview
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being Services (Katie A./CCR)
Cultural Competence
ISCA review
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Nathan Lacle, Quality Reviewer
Lisa Farrell, Information System Reviewer
Katie Faires, Consumer and Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Abrahamson	Twylla	Deputy Director of HHS, Director of CSOC/Compliance Officer	Placer County
Apgar	Daniel	Program Supervisor, ODS	Placer County
Bednar	Amanda	Client Services Counselor, MH	Placer County
Benavidez	Damien	Clinical Supervisor	Progress House
Blacksmith	Victoria	Executive Director	Granite Wellness Center
Bullis	Heather	Program Manager	Nevada County
Cadore	Aaron	Program Manager, ASOC	Placer County
Carlson	Cindy	Executive Director	Progress House
Compton	Sue	Staff Services Manager	Placer County
Cook	Jennifer	Assistant Director, CSOC	Placer County
Couture	Kelly	Program Supervisor, QM	Placer County
Davis	Heather	Program Director	Cornerstone
Develey	Melissa	Treatment Center Director	BAART
Dickman	Adrienne	Staff Services Analyst, CSOC	Placer County
Ellis	Amy	Deputy Directory of HHS, Director of ASOC	Placer County
Ezeani	Ifeanyi	Chief Executive Officer	Compassion Pathway Behavioral Health LLC
Flores-Johnson	Amy	Executive Director	Victor
Fontenot	Tanya	Assoc. VP of Programs and Community Mental Health	Wayfinder

Last Name	First Name	Position	County or Contracted Agency
Franceschini	Jamie	Contract Analyst/QM	Sierra County
Gallagher	Jamie	Program Supervisor, ASOC	Placer County
Genschmer	Scott	Program Manager, ASOC	Placer County
Giddings	Cynthia	Site Manager	Wellspace
Gold	Danielle	Program Supervisor, QM	Placer County
Graham	Russell	Accountant-Supervising, Fiscal	Placer County
Griffiths	Kevin	Information Technology Analyst, Senior	Placer County
Guilino	Nick	Chief Executive Officer	Recover Medical Group
Hanni	Lorna	Program Supervisor, ASOC	Placer County
Hanson	Kari	Clinical Director	Sprouts
Haynes	Amy	Assistant Director, ASOC	Placer County
Hill	Kathryn	Clinical Director	Sierra County
Jones	Megan	Program Supervisor, CSOC	Placer County
Kauppila	Andrea	Staff Services Analyst Sr, CSOC	Placer County
Kerschner	Jon	Executive Director	Sierra Mental Wellness Group
Leighton	Melissa	Staff Services Analyst, Fiscal	Placer County
Leonesio	Jenifer	Associate Director	WellSpace
Ludford	Jennifer	Staff Services Analyst, QM	Placer County

Last Name	First Name	Position	County or Contracted Agency
McDonald	Gary	Executive Director	Lighthouse Counseling and Family Resource Center
McLain	Courtney	Client Services Practitioner, MH	Placer County
Medina	Leslie	Program Manager, CSOC	Placer County
Medina	Jesse	Client Services Practitioner, MH	Placer County
Miller	Jessica	MH Head of Service/Supervising Social Worker	Koinonia
Mulcahy	Teresa	Information Technology Supervisor	Placer County
Ortner	Adam	Administrator	Cirby Hills Behavioral Health
Ozobiani	Issac	Clinical Director	Granite Wellness Center
Panelli	Amy	Executive Director	Aegis
Phillips	Monique	Program Manager, CSOC	Placer County
Prinz-McMillan	Sheryll	Director of Behavioral Health	Sierra County
Roth	Leslie	Program Manager, CSOC	Placer County
Rudkin	Amy	Regional Director	Victor
Salazar	Amber	Executive Director	Cornerstone
Sapno	Grace	Client Services Practitioner, MH	Placer County
Segovia	Chanel	Client Services Practitioner, MH	Placer County
Siles	Kristin	Program Supervisor, CSOC	Placer County
Smith	Geoff	Program Manager, ASOC	Placer County

Last Name	First Name	Position	County or Contracted Agency
Smith	Eric	Compliance Director	Granite Wellness Center
Smith	Jessica	Site Supervisor	WellSpace
Soto	Julia	Program Manager, QM	Placer County
Stephens	Susan	Staff Services Analyst, QM	Placer County
Turgeon	Meghan	Client Services Practitioner, MH	Placer County
Vallin	Jennifer	Regional Director	Turning Point Community Programs, Coloma Center
Warren-Morales	Allison	Client Services Practitioner, MH	Placer County
Wellenstein	Jennifer	Deputy Chief Operations Officer Executive	Turning Point Community Programs
Wright	Missy	Client Services Practitioner, MH	Placer County

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence	The validation rating for this PIP is no confidence because Placer is in the planning process, building infrastructure to access MCP data through HIE or Direct Exchange. Protocols for direct data exchange, automating components of the exchange process and oversight to minimize errors or delays are in development. The March 2023 baseline data analysis for FY 21/22 submission was not noted in this EQR submission. This PIP was not active during the review period.

General PIP Information
MHP Name: Placer-Sierra
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness
PIP Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5% by June 30, 2024.
Date Started: 09/2022
Date Completed: projected 09/2024
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:

General PIP Information
Target population description, such as specific diagnosis (please specify): The MHP will focus on beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm, also referred to as MH or MH conditions.
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): Members referred from ED to Care Coordinators receive follow-up contact 7 days and 30 days after discharge.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The Plan Care Coordinators will interface with ED SUNs to coordinate care and follow-up for members identified with an MH condition and referred from the ED
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The Plan will operationalize transfer processes, and protocols to ensure secure, reliable, and consistent data, relevant to the care of members identified with an MH condition and referred from the ED to the Plan's Care Coordinators is accessible. Scheduled data tracking, monitoring, analysis, and reporting will improve member outcomes and address gaps in services.

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
Medi-Cal beneficiaries with ED visits for MH, implemented interventions will increase the percentage of follow-up MH services with the Plan within 7 days by 5% by June 2023.	CY 2021		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Medi-Cal beneficiaries with ED visits for MH, implemented interventions will increase the percentage of follow-up MH services with the Plan within 30 days by 5% by June 2023	CY 2021		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Track the number of referrals received by the ED and MCP as it relates to the intervention of working with the ED SUNs	n/a		☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Track the percentage of successful linkage (completed a screening with a Placer Care Coordinator	n/a		☒ 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 parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: TA for the planning phase of this BHQIP, FUM, included the need for basic information for validation purposes e.g., start and end dates, clarification of clinical or non-clinical, a list of data collection personnel and their relevant qualifications. Next year's PIP/BHQIP submission for EQR validation should include documentation of the most recent data and activities/refinements. Placer provided the 09/2022 BHQIP submission for this FY 2023-24 EQR.

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	MHP reports noticeable changes due to PIP intervention, however, cannot say if interventions directly impacted member answers in survey. Remeasurement of second intervention still needed at 12th month mark. It is unknown how changes in the EHR may affect data collection and reporting.
General PIP Information	
MHP Name: Placer-Sierra	
PIP Title: SOGI and the beneficiary experience in ASOC MH Clinics	
PIP Aim Statement: "For adults (18+) receiving outpatient mental health services at the Adult System of Care Dewitt and Cirby clinic locations, will being asked to identify sex, gender identity, sexual orientation, preferred name, and preferred pronouns by MHP staff appropriately equipped to ask and collect these questions increase the beneficiary experience as reported in client satisfaction surveys over a six-month period during 2022." Note: The PIP is continued for one year until 10/2023.	
Date Started: 10/2021	
Date Completed: 10/2023	
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:	

General PIP Information
Target population description, such as specific diagnosis (please specify): Adult beneficiaries ages 18+ receiving outpatient mental health services from our Adult System of Care mental health clinic locations at our Cirby (Roseville) and Dewitt (Auburn) campuses.
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): The client will provide when asked their sex, gender identity, sexual orientation, preferred name, and proffered pronouns, and report any changes in their experience in a client satisfaction survey due to this change
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Providers ask beneficiaries to identify their sex, gender identity, sexual orientation, preferred name, and proffered pronouns, and monitor changes in beneficiary experience as report in client satisfaction surveys.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The intervention will be utilized by trained clinicians and monitored, tracked and report by the SOC.

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
# of adults accessing OPMHS at clinic locations and corresponding SOGI field data recorded in Avatar; 1b. client satisfaction surveys response rate; % indicating they were had positive experience; % indicating they were treated with respect; 1c. # of clients indicating they were asked SOGI questions by MHP staff	*5/1/22-10/31/22*	1a. F M Total Bisexual 3 2 5 Heterosexual / Straight 31 42 73 Lesbian (female) 1 1 Transgender 2 2 4 Declined 4 4 8 No Entry 590 567 1157 Total 631 617 1248 1b. 13% 85% 83% 1c. N/A	*1a. 6/30/23* *1b. 6/1/23*	*1a: approximately 18% with SOGI data entered* **Gender Identity** Female Genderqueer/Non-binary Male MTF/Transgender Female/Trans Woman No Entry Other, please specify Two-Spirit **Grand Total** **Sexual Orientation** Bisexual Gay or Lesbian No Entry Other, please specify Prefer not to answer Queer Questioning/Unsure Straight/Heterosexual **Grand Total** **Pronouns** He/him/his No Entry Other, please specify Prefer not to answer She/her/hers They/them/theirs **Grand Total** *1b: 7%* *85%* *96%* *1c. N/A*	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement t 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
Self-report on staff progress surveys during implementation period: % reporting increased ability/confidence in asking SOGI questions	10/31/21	Baseline survey was not distributed.	1a. 20 Staff indicated an average confidence rate of 8.25 out of 10 in reviewing SOGI fields/information with clients.	n/a	☐ 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 parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- Recommendation to MHP include exploring possible solutions to maintain validity of the PIP due to data collection difficulties experienced by implementation of new EHR

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 follows this page.

HEALTH AND HUMAN SERVICES
ADULT SYSTEM OF CARE
CHILDREN'S SYSTEM OF CARE
Quality Assurance,
Evaluations, and Outcomes

11/30/2023

Sandra Sinz, LCSW, CPHQ
Executive Director, CalEQRO
Behavioral Health Concepts, Inc.
52340 Powell St. #334
Emeryville, CA 94608

Dear Behavioral Health Concepts, Inc:

Placer MHP is requesting flexibility during the FY 2023-24 EQRO review, as we were unable to fulfill one or more of the required elements for review:

Specifically, we were not able to:

- ☒ submit a clinical PIP
- ☐ submit a non-clinical PIP
- ☐ hold a member and family member focus group
- ☐ other:

Reasons for this include:

- ☒ Lack of staff/resources:
- ☐ Natural Disasters:
- ☐ Additional factors:
- ☐ Other reasons:

Placer submitted a MHP Clinical PIP dated September 2022 according to the DHCS BHQIP timeline, which did not coincide with the BHC review timeline.

Please attach this letter to our FY 2023-24 review report.

Sincerely,

Amy R. Ellis, MFT
Behavioral Health Director