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FY 2022-23
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

ALAMEDA FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — October 5-7, 2022

MHP Size — Large

MHP Region — Bay Area

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	3	2	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	3	3	0
Quality of Care	10	6	3	1
Information Systems (IS)	6	6	0	0
TOTAL	**26**	**19**	**6**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Reducing Psychiatric Emergency Services (PES) Recidivism through Pre-Discharge Visits	Clinical	06/2021	Second remeasurement	No confidence
Care Coordination with Primary Care	Non-Clinical	01/2022	First remeasurement	Low confidence

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other	8
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	5
3	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☒Other: Older Adults	15

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP began piloting beneficiary record access at some psychiatry urgent care sites which can improve care.
- The MHP has a strong quality management (QM) structure; data driven decision making is evident.
- The MHP prioritizes coordination and integration with primary care which can improve quality of care and overall health outcomes for beneficiaries.
- According to Medi-Cal data, the MHP's number of hospitalizations and the rehospitalization rate shows improvement, suggesting that post-discharge practices may be more effective.

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

- The MHP does not have a reliable process for capturing key points of entry to care in order to measure timeliness or first psychiatry services, first offered appointment, and urgent services.
- Capacity for crisis services including Psychiatric Emergency Services do not meet the high number of requests.

- The MHP does not track and trend the required HEDIS measures for foster care youth.
- Staffing and budget allocation for the implementation of Smartcare is limited.
- Stakeholders perceive and experience law enforcement interactions as a barrier to accessing services.
- The MHP website needs additional crisis service and wellness center information.
- Beneficiaries experience delays to child and youth services

Recommendations for improvement based upon this review include:

- Investigate gaps impeding systemwide measurement for first appointment offered, psychiatry services, and urgent services.
- Assess actual demand for crisis services and work toward increasing capacity.
- Resume tracking and trending HEDIS measures for youth beneficiaries.
- Increase staff and budget allocation to the SmartCare implementation to ensure that the implementation is on time and effective.
- Assess and modify the trainings provided to law enforcement based on stakeholder experience.
- Add information on crisis services and wellness centers to the website.
- Evaluate beneficiaries' experience with delays and barriers to high need youth services and implement changes needed.

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 October 2019.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs, representing compromised of 58 counties, to provide specialty mental health services (SMHS) to Medi-Cal beneficiaries 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 beneficiaries.

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, beneficiary 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 Welfare and Institutions Code). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill AB 205 (WIC Section 14197.05).

This report presents the FY 2022-23 findings of the EQR for Alameda County MHP by BHC, conducted as a virtual review on October 5-7, 2022.

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 analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, 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
- Inpatient Consolidation File (IPC).

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, 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 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 2021-22 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 beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR 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.
- Review and validation of each MHP's NA as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment 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.

- Beneficiary perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.
- 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 12, then "≤11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

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 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP is operating under the impact of the workforce crisis with loss of staff at the county-operated programs, contract providers, and other community-based partner agencies. The MHP vacancy rate is 20 percent, having reached 31 percent in the last year. CalEQRO worked with the MHP to design an alternative agenda due to the aforementioned factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP created and filled new leadership positions including a Chief Nursing Officer and a Health Equity Director.
- The MHP formed a Forensics Division for all justice-involved programs.
    - As part of a consent decree, the MHP assumed the role of hiring mental health staff for the Santa Rita Jail and connected outpatient services that has 106 new positions.
    - The MHP has launched a new intensive service team for forensics.
- Under the Office of the Medical Director, the MHP formed a Crisis Services System of Care in response to the increased need in crisis care and required cross-coordination. The MHP secured 14 million dollars of Behavioral Health Continuum Infrastructure Program (BCHIP) funding for mobile crisis, crisis stabilization and residential treatment programs. A number of programs are for youth beneficiaries.
- After evaluating the effects of expanding the designation of professionals for Lanterman-Petris-Short (LPS) holds to some contract provider organizations, the MHP permanently established the program. The MHP is also piloting 5150 authority for certain hospital Emergency Department physicians, but requiring consultation with the MHP.
- The MHP reorganized QM and created a QI Division Director position which will include overseeing California Advancing and Innovating Medi-Cal (CalAIM) implementation.

    - QM is comprised of 63 positions and has a 13 percent vacancy rate.
    - IS has a 40 percent vacancy rate. A new IS Director began August 2022.
- The MHP has continued convening a Behavioral Health Collaborative Steering Committee to collect input and guide strategies for CalAIM. The MHP has publicly posted eighteen CalAIM-related provider memorandums since January 2022.
- The MHP partnered with Streamline Healthcare Solutions, LLC to implement the SmartCare billing system, with an expected go-live date of July 1, 2023, which will ultimately provide the county with a fully integrated billing system. The implementation team is in the pre-implementation planning phase of this initiative.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 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 2021-22

Recommendation 1: Investigate the relatively low percentage of Asian/Pacific Islander (API) beneficiaries served and implement strategies to improve access to specialty mental health services for this population. (Access)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP conducted a detailed analysis of API utilization for mental health and substance use disorder services. The MHP outlined language, age, and county regional factors by penetration rates, and identified barriers and recommendations. This included a variety of mechanisms to obtain information from the API communities.
- Strategies identified include: opening an API Wellness/Community Center, expanding API-targeted services, creating community-based case management for older adults in senior/community centers, investing in a bilingual/bicultural workforce, and increasing support for integration of SMHS models in primary care. The MHP began implementing some of these strategies in FY 2021-2022, while others are in the exploratory/planning phase.
- API beneficiaries remain the most proportionally underrepresented group in the MHP, and the API PR remains the lowest of all racial/ethnic groups – not uncommon in counties with large API populations. Though data for CY 2021 may be incomplete, the PR has been trending downwards over the past three years. Additional information follows in the report.

Recommendation 2: Evaluate the MHP website for language level and "user friendly" accessibility. Amend the site to provide easily viewed information on crisis services, wellness centers, and rapid language options. (Access)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Alameda County Behavioral Health (ACBH) launched a redesigned website in October 2021 that includes website translation via Google Translate, and links to information on crisis services and mobile crisis services, as well as other updates such as information and linkage to the Mental Health Advisory Board (MHAB) web page.
- The MHP added an updated Provider Directory in May 2022 that includes new functionality and search filters, such as being able to search by geographic area or language spoken.
- It is not clear how to access crisis services from the homepage, aside from the new 988 line and the website does not contain links or information about wellness centers on the front page. Addressing this would increase user accessibility.

Recommendation 3: Investigate beneficiaries' experiences with timeliness across the system, implement strategies, and begin to address. (Access, Timeliness)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The Health Equity Division plans to conduct a listening session with beneficiaries in Fall 2022 regarding access, as part of the division workplan that includes identifying solutions for improving the beneficiary experience.
- The MHP implemented Yellowfin dashboards to track timeliness in real time. The dashboards are accessible to both county and community-based organization (CBO) providers. ACBH IS also developed new timeliness reports to track the entry of timeliness data in order to improve data collection.
- The validity and reliability of the timeliness data available to the MHP is not established. IS staff report the provider completion rate for submitting data has increased by about 25 percent and continue to work to increase the completion rate. Additional information follows in the Timeliness section of the report.
- Consumers and family members who participated in this review report delays and difficult access. The information follows in this report.

Recommendation 4: Develop a peer career implementation plan and timeline related to the MHP's level of participation in SB803 Peer Certification. The peer career ladder should include increasing levels of responsibilities and commensurate benefits and salary. (Quality)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- ACBH developed a plan and timeline for Peer Certification implementation, and the Alameda County Board of Supervisors approved a Memorandum of Understanding (MOU) with CalMHSA as the certifying body for peer specialists. As of July 2022, ACBH had submitted over 160 names to CalMHSA for scholarships for the grandparenting and certification process.
- The plan outlines ten different job classifications, ranging from Peer and Family Support Advocate to Consumer/Family Relations Manager. Compensation varies by position from a stipend to an annual salary of $116,000.
- Of note, review discussions show that peer employees were not yet aware of these developments.

Recommendation 5: Identify and expand opportunities for both County and CBO staff to provide feedback on program planning and implementation, allowing for bidirectional communication. Include County and CBO staff in the process. Consider periodic surveys measuring County and CBO staff satisfaction. (Quality)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP conducted a number of activities towards this recommendation.
    - Leadership facilitated a virtual town hall in July 2022.
    - The MHP surveyed of a broad range of stakeholders at part of strategic planning and Workforce Development, Education, and Training (WET) planning.
    - The MHP continued monthly meetings with CBO providers.
    - MHP leadership participated in monthly meetings with an association of CBOs.
- The MHP discontinued convening some meetings that were duplicative to manage resources.
- Despite a variety of venues, review discussions indicate there is a perception that stakeholder input is not used or considered in decision making.

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 beneficiaries) 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 beneficiaries 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 beneficiaries are negatively impacted.

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 20 percent of services were delivered by county-operated/staffed clinics and sites, and 80 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 84 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week operated by county staff; beneficiaries may request services through the Access Line, as well as through the following system entry points: schools, primary care, social services, community programs, and forensic based services. The MHP operates a centralized access team responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries call the Access line and complete a screening. The MHP refers qualifying applicants to a service provider who schedules an assessment. Beneficiaries are then referred to an appropriate level of care service.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults**.** In FY 2021-22, the MHP reports having provided telehealth services to 4,133 adult beneficiaries, 3,904 youth beneficiaries, and 460 older adult beneficiaries across 14 county-operated sites and 298 contractor-operated sites. Among those served, 1,903 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs

[1] CMS Data Navigator Glossary of Terms

and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Alameda County, the time and distance requirements are 15 miles and 30 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 2021-22

Alternative Access Standards	
The MHP was required to submit an AAS request due to time or distance requirements	☐ Yes ☒ No

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

Table 1B: MHP OON, FY 2021-22

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 beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries 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 beneficiaries 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 beneficiary 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 Beneficiary Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- The MHP has almost 800 County positions and remains primarily contracted for services at 87 percent.
- The MHP continues to prioritize integration and collaboration to support access. While the MHP reports challenges in implementing integration such as is evidenced in their non-clinical PIP, consumers and beneficiaries who participated in the review reported that primary care was how they first accessed mental health care or where they received treatment.
- The MHP began screening all children for Pathways ICC/IHBS eligibility. The MHP reports that this has resulted in an increase in referrals and ICC utilization, though this is not yet apparent in the CY 2021 Medi-Cal data.
- The MHP plans to reconvene the Cultural Competence Committee and revise the Cultural Competence Plan (CCP). The CCP from December 2021 is in draft form and the MHP is revising its goals and planned measurements to increase its sustainability.
- Review discussions indicate that services with language capacity such as Asian-associated languages or Spanish are insufficient in availability. It is unclear how or if the MHP monitors its use of bilingual staff. While services are offered using a language line, contract providers report that beneficiaries opt to wait for specific contract providers so that they can receive services directly in their preferred language.
- Transportation assistance is reported as inconsistent and difficult to obtain. Evaluating and improving this area was identified across stakeholder discussions. Contract providers identify their inability to purchase vehicles with contract funding as a major hardship and barrier to providing services. Staff are required to use their own vehicles which adds to staff hiring and retention challenges. Mobile services, services in the community, and services for older adults appear especially affected.
- There continues to be challenges to crisis service capacity. Crisis services taking numerous hours to arrive to not responding at all were heard throughout the review across stakeholder groups.

- Decreased capacity due to vacancy rates have resulted in larger caseloads and staff maintaining beneficiaries in short-term programs longer than designed or at levels of care not matched to beneficiary need, while waiting for a slot to open. This also includes beneficiaries being assigned to a program, but for a varied period of time not having a staff person assigned – "wait list prior to assignment." In some cases, programs refer the case back to Access for a more timely referral. The Access unit maintains real time caseload capacity, but sometimes there is no available capacity and programs may be "closed to new referrals."

- As the MHP reduces the amount of telework, depending upon the service, this may create more challenges with staff retention. At the same time, staff report understanding that high-need caseloads generally respond best to in-person services. It is unclear the extent to which telehealth is offered to those beneficiaries who prefer it due to tight schedules, lack of transportation, or preference. Psychiatry services are reported to be more likely to be provided via telehealth.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rates, and Average Approved Claims per Beneficiary Served

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

The PR is a measure of the total beneficiaries served, based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median differs significantly from the average, that information may also be noted throughout this report.

The statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, Alameda exceeded the statewide rate with a county PR of 3.93 percent. The MHP's average approved claims per beneficiary were $11,269.

The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity 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 beneficiaries served.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	452,894	17,781	3.93%	$200,373,782	$11,269
CY 2020	416,104	18,874	4.54%	$202,757,541	$10,743
CY 2019	417,484	21,372	5.12%	$204,028,702	$9,547

- While the number of total eligibles increased from CY 2020 to CY 2021, the number of beneficiaries served has been trending downwards over the past three years, as has the overall PR. AACB has been increasing over the same period.

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	37,960	662	1.74%	1.29%	1.59%
Ages 6-17	89,338	6,084	6.81%	4.65%	5.20%
Ages 18-20	21,208	1,133	5.34%	3.66%	4.02%
Ages 21-64	241,081	9,024	3.74%	3.73%	4.07%
Ages 65+	63,308	878	1.39%	1.52%	1.77%
TOTAL	**452,894**	**17,781**	**3.93%**	**3.47%**	**3.85%**

- PRs for youth and TAY exceeded that of similarly sized counties and the statewide PR. PRs for adults and older adults were lower than statewide, and for older adults the PR was lower than comparably sized counties as well. Alameda's total PR was higher than both the statewide PR and that of similarly sized counties.

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percent of Beneficiaries Served
Cantonese	245	1.38%
Mandarin	50	0.28%
Spanish	2,990	16.82%
Tagalog	37	0.21%
Vietnamese	128	0.72%
Total Threshold Languages	**3,450**	**19.41%**
Threshold language source: Open Data per BHIN 20-070		

- Nearly 20 percent of beneficiaries spoke threshold languages, with Spanish being the most prevalent.

Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	151,589	4,121	2.72%	$35,248,984	$8,554
Large	2,153,582	62,972	2.92%	$387,366,612	$6,151
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

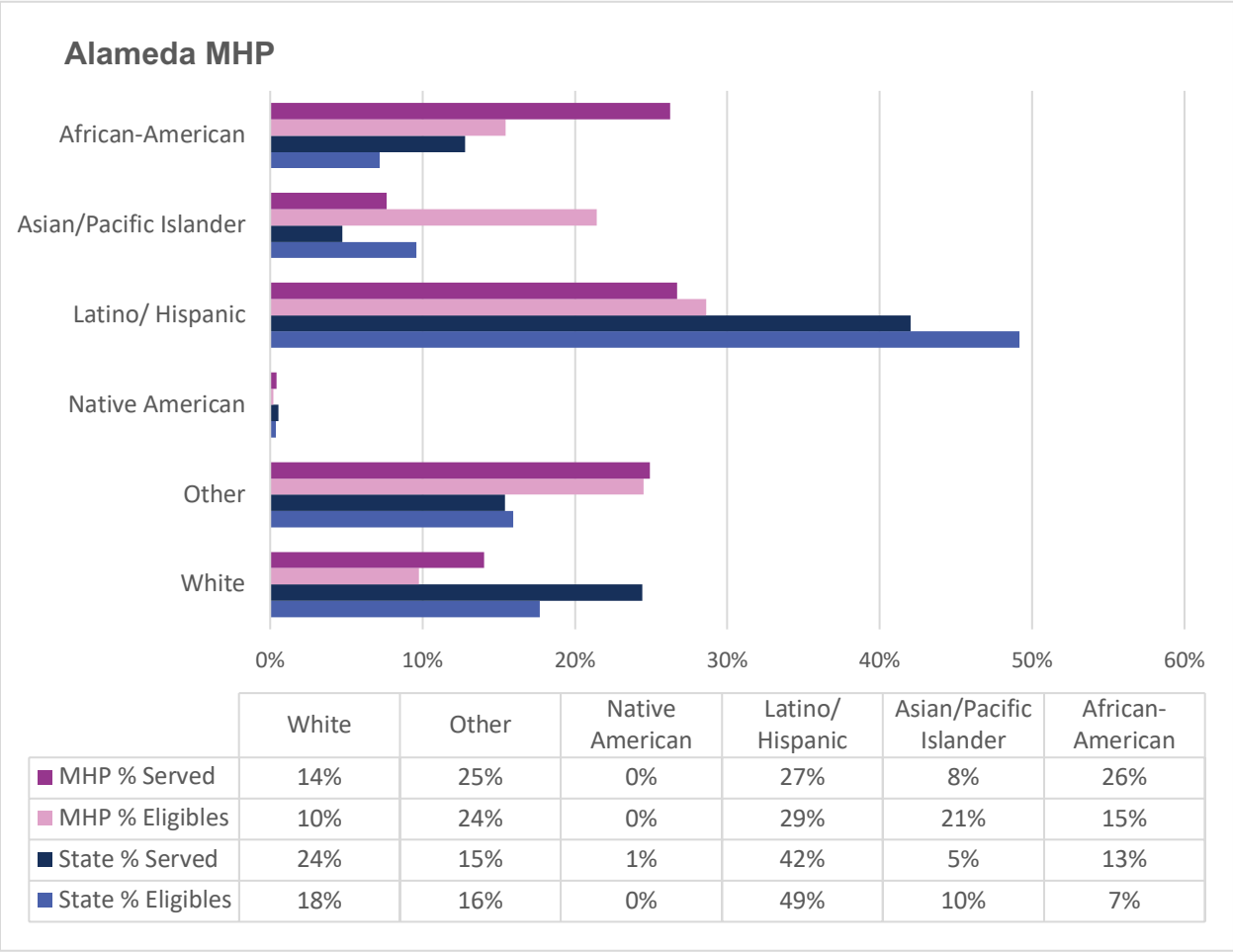
- For the subset of Medi-Cal eligibles that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries, and this pattern does hold true in the MHP. In Alameda, the PR for this population was lower than for other large counties and statewide, while AACB for this group is higher than similarly sized counties and the state as a whole.

Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	# MHP Eligibles	# MHP Served	MHP PR	Statewide PR
African-American	70,026	4,670	6.67%	6.83%
Asian/Pacific Islander	97,142	1,362	1.40%	1.90%
Hispanic/Latino	129,678	4,749	3.66%	3.29%
Native American	1,016	72	7.09%	5.58%
Other	110,895	4,431	4.00%	3.72%
White	44,140	2,497	5.66%	5.32%
Total	**452,897**	**17,781**	**3.93%**	**3.85%**

- The PRs for both African-Americans and Asian/Pacific Islanders were lower than statewide.
- The Asian/Pacific Islander PR is very low compared to other racial/ethnic groups.

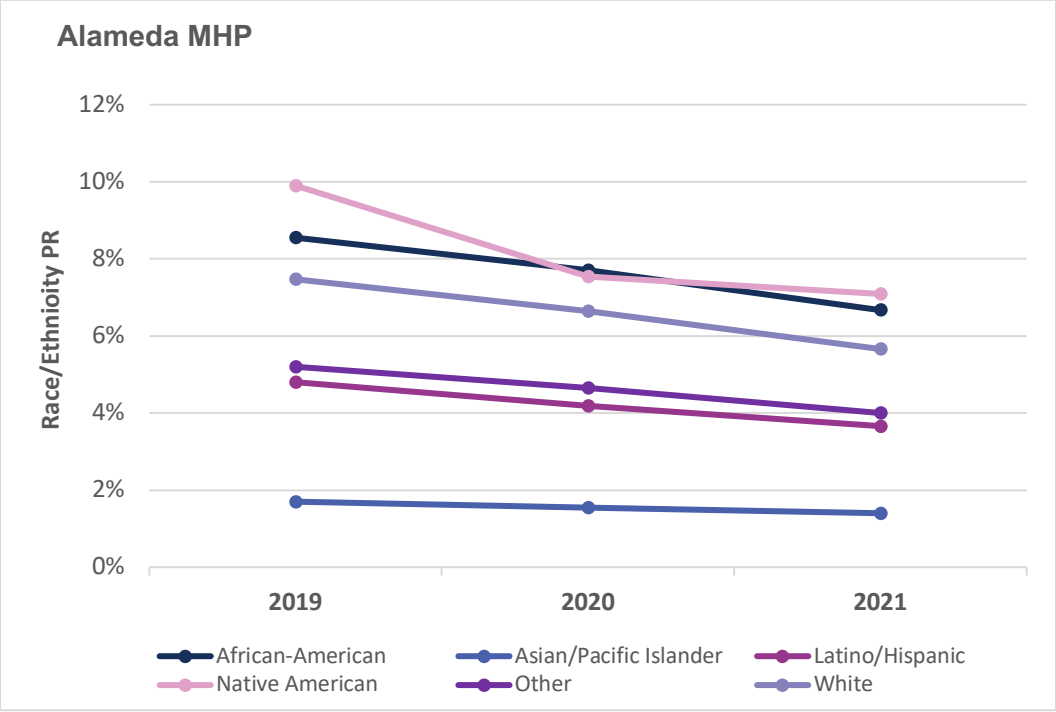
Figure 1: Race/Ethnicity for MHP Compared to State CY 2021



	White	Other	Native American	Latino/ Hispanic	Asian/Pacific Islander	African-American
MHP % Served	14%	25%	0%	27%	8%	26%
MHP % Eligibles	10%	24%	0%	29%	21%	15%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

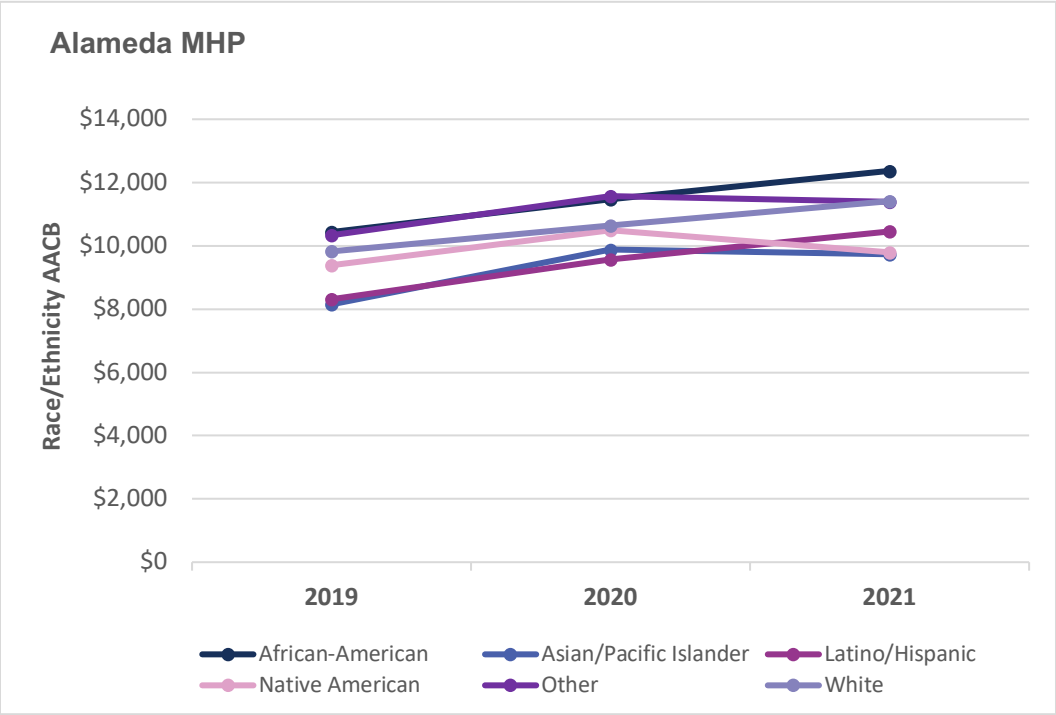
- Proportionally, the largest group served by the MHP were Latinos/Hispanics, followed by African-Americans, then Other. The most overrepresented group proportionally are African-Americans, followed by White, and the most underrepresented group are Asian/Pacific Islanders.

Figure 2: MHP PR by Race/Ethnicity CY 2019-21



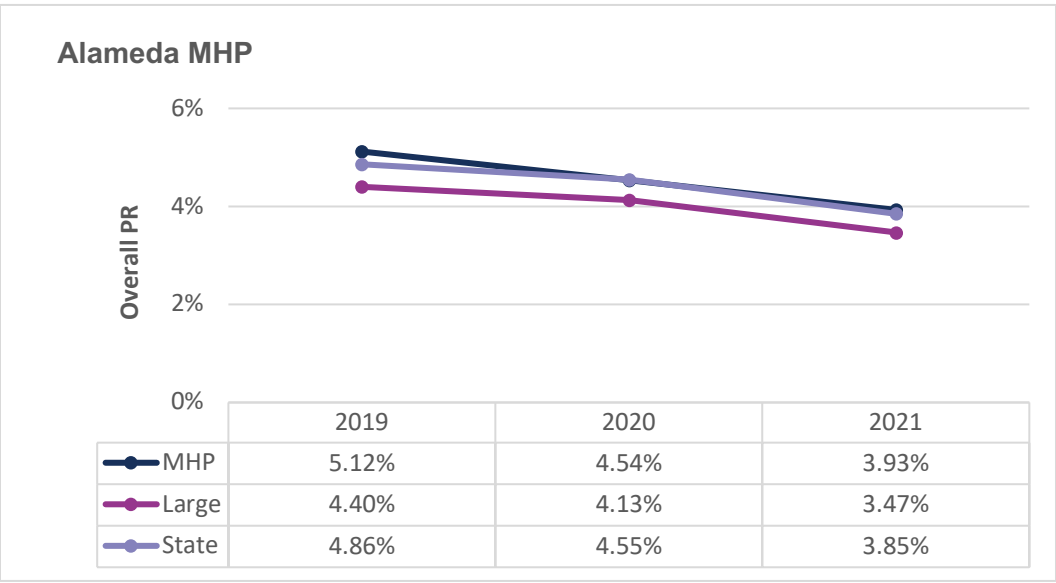
- PRs for all races/ethnicities have been trending downward, and the PR for Asian/Pacific Islanders has been consistently lower than those of other groups.

Figure 3: MHP AACB by Race/Ethnicity CY 2019-21



- AACBs have been trending up over the past three years for African-American, Hispanic/Latino, and White populations, whereas they decreased slightly from CY 2020 to CY 2021 for Asian/Pacific Islander, Native American, and Other populations.

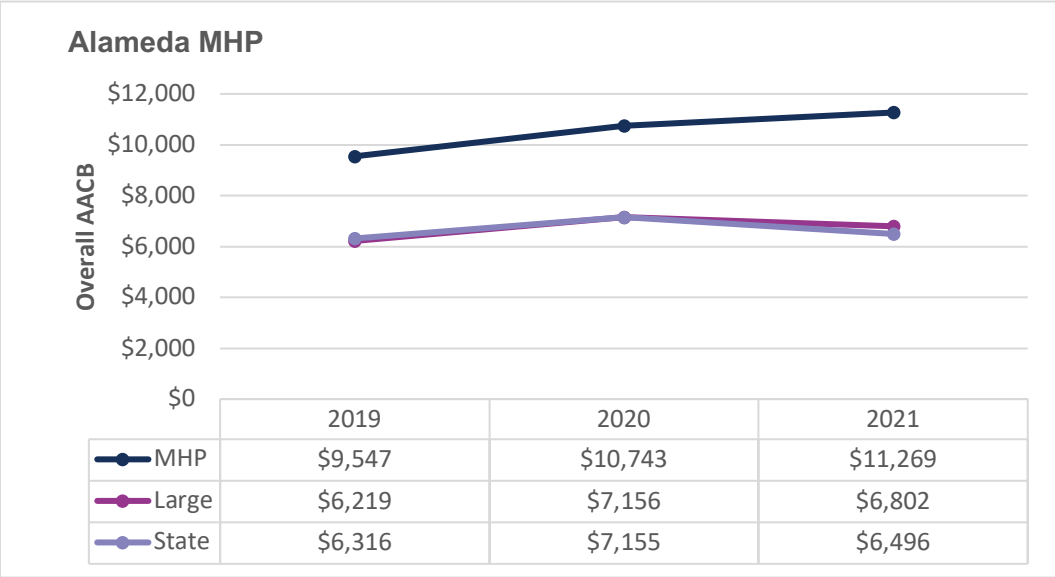
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	5.12%	4.54%	3.93%
Large	4.40%	4.13%	3.47%
State	4.86%	4.55%	3.85%

- The overall PR for Alameda has been trending downwards over a three-year period, reflecting similar trends in other large counties as well as statewide.

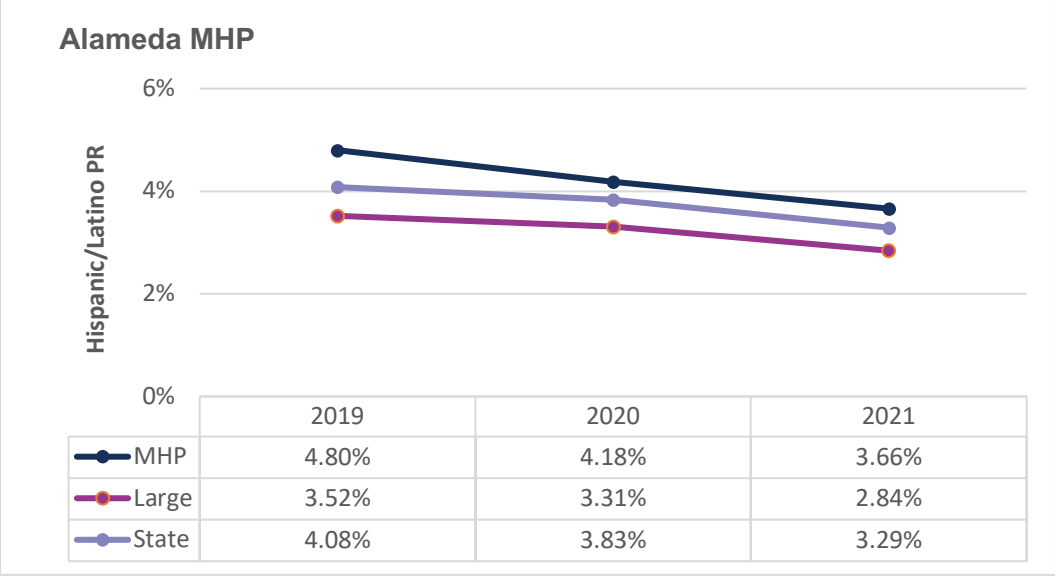
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$9,547	$10,743	$11,269
Large	$6,219	$7,156	$6,802
State	$6,316	$7,155	$6,496

- Alameda's overall AACB has been trending upwards, which is not congruent with patterns in other large counties or statewide where there were decreases in AACB from CY 2020 to CY 2021.

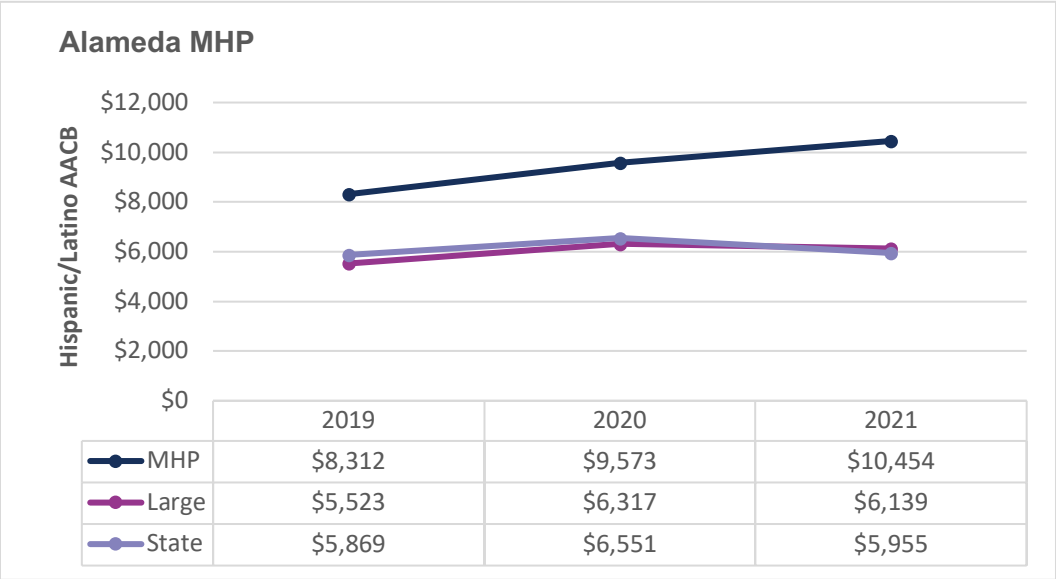
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	4.80%	4.18%	3.66%
Large	3.52%	3.31%	2.84%
State	4.08%	3.83%	3.29%

- While Alameda's PR for the Hispanic/Latino population was higher than that of other large counties and statewide, it has been trending downwards, reflective of statewide trends and those in similarly sized counties.

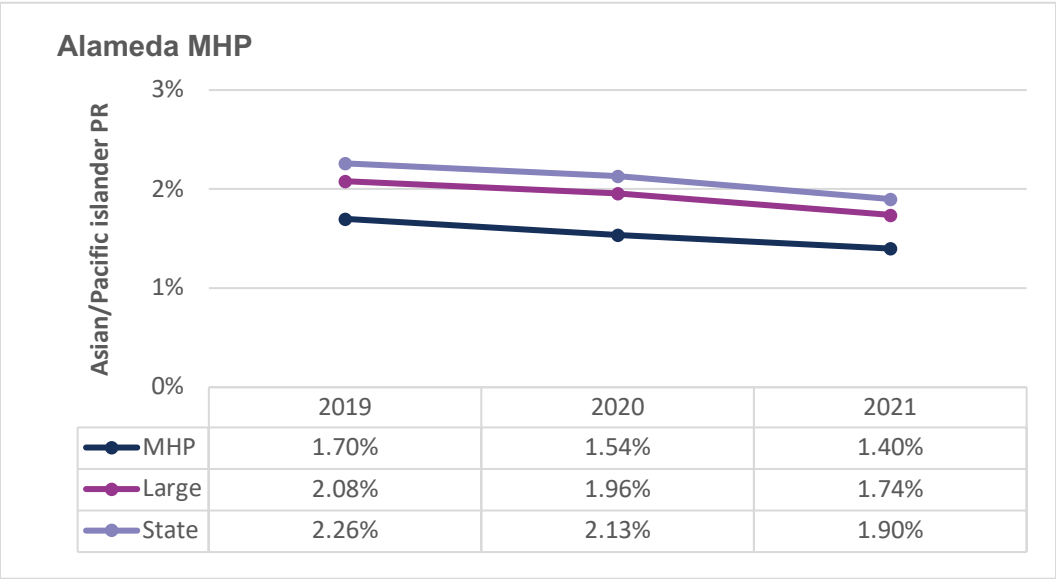
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$8,312	$9,573	$10,454
Large	$5,523	$6,317	$6,139
State	$5,869	$6,551	$5,955

- The AACB for Latino/Hispanic beneficiaries in Alameda has been consistently higher than in other large counties and the state overall, and has been steadily increasing over the last three years. This is incongruent with trends in similarly sized counties and statewide, whereby increases from CY 2019 to CY 2020 were followed by decreases in AACB for this population in CY 2021.

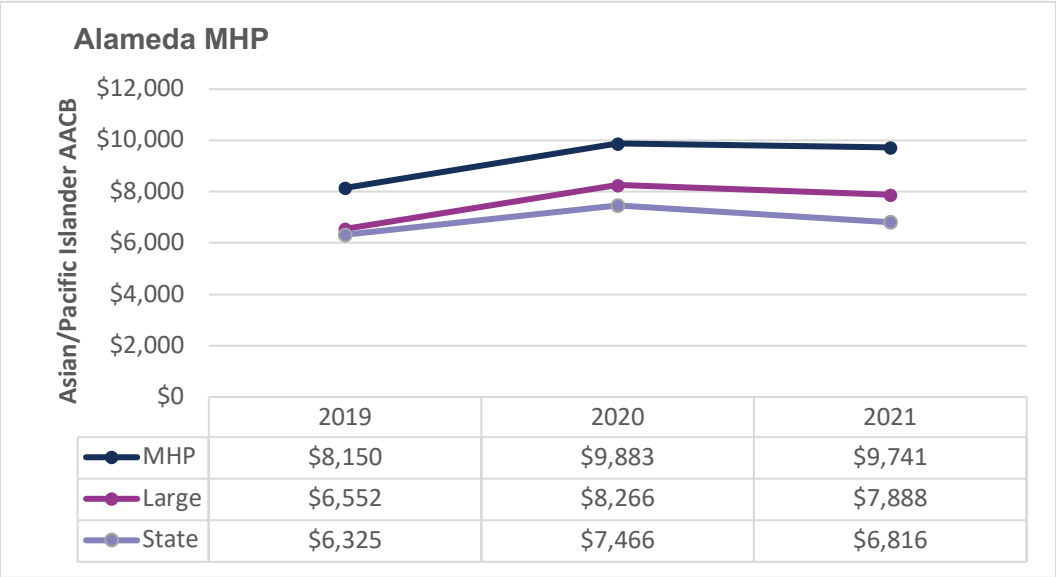
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	1.70%	1.54%	1.40%
Large	2.08%	1.96%	1.74%
State	2.26%	2.13%	1.90%

- While the MHP's PR for the Asian/Pacific Islander population has been trending downwards, this is reflective of trends both statewide and in similarly sized counties. Alameda's PR has, however, been consistently lower across this period of time despite efforts to improve.

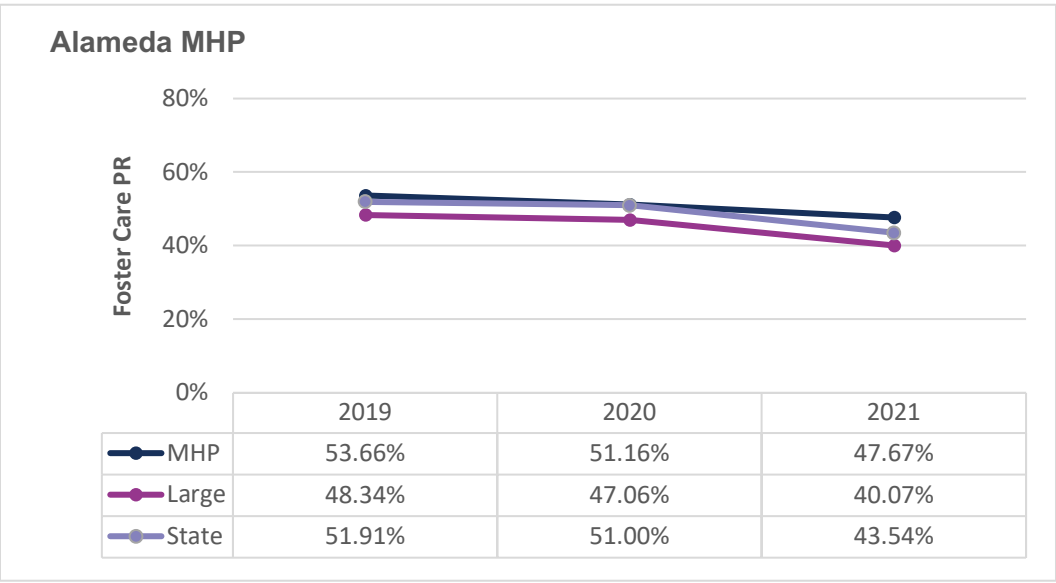
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$8,150	$9,883	$9,741
Large	$6,552	$8,266	$7,888
State	$6,325	$7,466	$6,816

- Alameda's AACB for Asians/Pacific Islanders decreased very slightly from CY 2020 to CY 2021 after experiencing an increase from CY 2019 to CY 2020, reflecting the trend statewide and in other large counties for this period. The MHP's AACB for this group has been consistently higher than similarly sized counties and the state across the same time period.

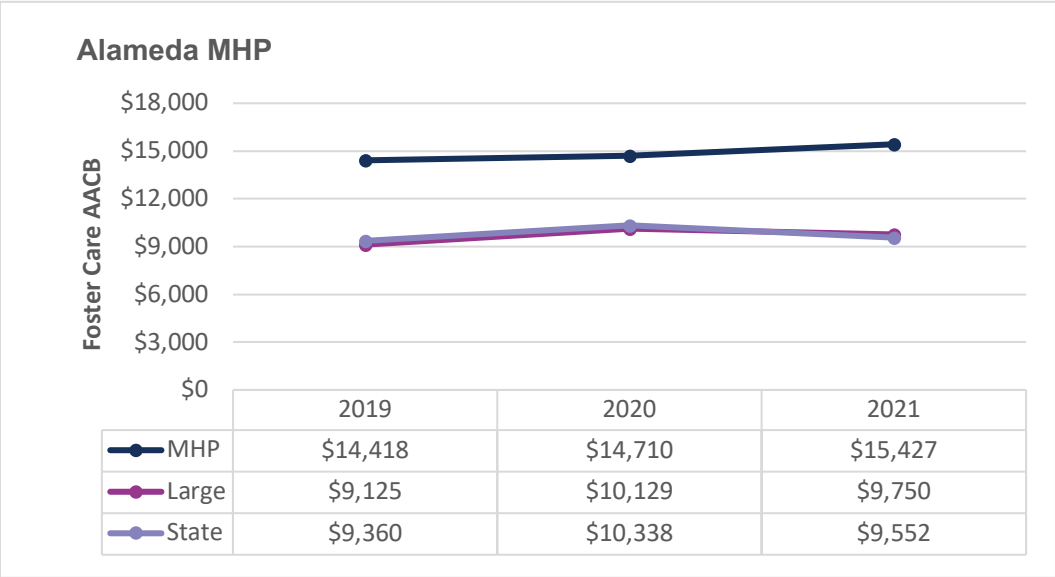
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	53.66%	51.16%	47.67%
Large	48.34%	47.06%	40.07%
State	51.91%	51.00%	43.54%

- While there was a three-year downward trend in Alameda's foster care PR, this was congruent with other large counties and statewide trends. The MHP's PR for this population is higher than either comparison group for CY 2021.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$14,418	$14,710	$15,427
Large	$9,125	$10,129	$9,750
State	$9,360	$10,338	$9,552

- In other large counties and in the state as a whole the AACB for the foster care population increased from CY 2019 to CY 2020, followed by a slight decrease in CY 2021. Alameda, however, has experienced a consistent increase in AACB across this period of time, and the AACB for this population has been consistently higher than the statewide AACB or that of similarly sized counties.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 11,036				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	1,301	11.8%	9	4	10.8%	14	8
Inpatient Admin	388	3.5%	11	6	0.4%	16	7
Psychiatric Health Facility	≤11	-	10	7	1.0%	16	8
Residential	76	0.7%	85	60	0.3%	93	73
Crisis Residential	590	5.3%	14	12	1.9%	20	14
Per Minute Services							
Crisis Stabilization	2,699	24.5%	1,981	1,200	9.7%	1,463	1,200
Crisis Intervention	989	9.0%	187	144	11.1%	240	150
Medication Support	6,154	55.8%	370	256	60.4%	255	165
Mental Health Services	6,764	61.3%	1,018	450	62.9%	763	334
Targeted Case Management	5,122	46.4%	448	120	35.7%	377	128

- The services received by the largest proportions of beneficiaries in Alameda were: Mental Health Services (61.3 percent), Medication Support (55.8 percent), Targeted Case Management (TCM) (46.4 percent), and Crisis Stabilization (24.5 percent).
- Crisis Stabilization was used at a much higher rate (24.5 percent) in the MHP compared to the statewide percentage of beneficiaries receiving that service (9.7 percent), and the average number of minutes billed was 518 minutes more than the statewide average, though the median was the same. This likely indicates there are some outlier beneficiaries who received a particularly high number of minutes for this service. Crisis Residential was provided to 5.3 percent of beneficiaries, which is also higher than statewide utilization for this service (1.9 percent), whereas Crisis Intervention provision (9.0 percent) was slightly lower as compared to the state rate (11.1 percent).
- TCM was utilized at a higher rate (46.4 percent) as compared to statewide (35.7 percent), while Medication Support was provided to a smaller proportion of beneficiaries (55.8 percent) than seen statewide (60.4 percent).

- For all Per Day services Alameda's average units provided were lower than the statewide averages, whereas for all Per Minute services (with the exception of Crisis Intervention) the MHP's average units provided were higher than statewide averages.

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

Service Category	MHP N = 889				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	27	3.0%	9	8	4.5%	13	8
Inpatient Admin	≤11	-	-	-	≤11	-	-
Psychiatric Health Facility	≤11	-	-	-	0.2%	25	9
Residential	≤11	-	-	-	≤11	-	-
Crisis Residential	≤11	-	-	-	0.1%	16	12
Full Day Intensive	≤11	-	-	-	0.2%	452	360
Full Day Rehab	≤11	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	24	2.7%	1,343	1,200	2.3%	1,354	1,200
Crisis Intervention	44	4.9%	293	182	6.7%	388	195
Medication Support	176	19.8%	335	240	28.5%	338	232
Therapeutic Behavioral Services	30	3.4%	2,502	1,742	3.8%	3,648	2,095
Therapeutic FC	≤11	-	-	-	0.1%	1,056	585
Intensive Home Based Services	199	22.4%	1,147	503	38.6%	1,193	445
Intensive Care Coordination	50	5.6%	1,491	623	19.9%	1,996	1,146
Katie-A-Like	≤11	-	-	-	0.2%	837	435
Mental Health Services	856	96.3%	2,827	1,712	95.7%	1,583	987
Targeted Case Management	313	35.2%	330	158	32.7%	308	114

- The services received by the largest proportions of foster care beneficiaries in Alameda were: Mental Health Services (96.3 percent), TCM (35.2 percent), Intensive Home Based Services (IHBS) (22.4 percent), and Medication Support (19.8 percent).

- In general, service utilization patterns were quite similar to the statewide utilization rates, with a few exceptions. The largest difference was in IHBS provision, with 22.4 percent of foster care beneficiaries receiving this service as compared to 38.6 percent statewide – equating to a 42 percent lower proportion in the MHP than statewide. Intensive Care Coordination (ICC) was also utilized at a much lower rate compared to statewide usage; 72 percent lower. The MHP also provided medication support at a lower rate than statewide, though the disparity is smaller at 31 percent lower.
- Services billed Per Day were provided at very low rates to foster care beneficiaries, which is congruent with statewide patterns of service utilization.
- About half of the service types that were billed Per Minute, which represented the bulk of services provided to foster care beneficiaries, were similar to statewide averages in terms of average minutes billed per beneficiary. The largest difference in average minutes billed was for Mental Health Services, with Alameda's average being 1,244 minutes (equivalent to almost 21 hours) higher than the statewide average. Conversely, Therapeutic Behavioral Services (TBS) had 1,146 fewer average minutes (equivalent to about 19 hours) billed in Alameda as compared to statewide. The MHP also billed for ICC on average about 505 minutes less than the statewide average number of units for that service. While 199 FC youth received IHBS, only 50 received ICC; this may represent under-utilization of Child and Family Team meetings, or those services may not be coded to be reflected in the claims data.

IMPACT OF ACCESS FINDINGS

- The proportions of eligibles compared to the proportions of beneficiaries served by the MHP were, for most groups, comparable, with the exceptions of two categories: Asians/Pacific Islanders and African-Americans. The percentage of African-American beneficiaries (26 percent) was higher than their proportion of eligibles (15 percent), indicating a comparative overrepresentation in the system of care. On the other hand, Asian/Pacific Islander populations represented 21 percent of eligibles but only 8 percent of beneficiaries served, indicating a serious underrepresentation in the system of care that has persisted over time despite Alameda's efforts. This is an area that continues to require further attention in order to provide SMHS with greater parity in the MHP.
- Adult crisis services, specifically Crisis Stabilization and Crisis Residential, were utilized at higher rates than those seen statewide, and the average Crisis Stabilization units billed were much higher than the statewide average for this service. These may be factors contributing to the MHP's AACB, which was 73 percent higher than the statewide AACB.
- For foster youth, Therapeutic Foster Care has not been implemented. Further, the comparatively lower utilization of rates for IHBS, ICC, and Medication Support in the MHP as compared to statewide, as well as the lower average units billed for TBS and ICC, may point to capacity challenges in the foster care SMHS

system of care. The MHP is engaged in the multi-agency Memorandum of Understanding that formalizes processes between the MHP and Child Welfare.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary 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	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- The Quality Improvement Work Plan (QIWP) includes goals for improving timeliness in a number of areas such as urgent services. While the MHP demonstrates routine review of data, the EQR is not able to validate the measurements provided as a sound sample or reliable to inform QM for some

access points. The number of beneficiaries in some categories reported are under 10 or under 50 beneficiaries (in psychiatry and urgent service respectively). In addition, the measurements do not appear consistent with beneficiary experience obtained in this review.

  - EQR suggests reviewing the methodology of excluding the data beyond 60 days. Examining that data may provide information on the decrease in the count of beneficiary service requests.
  - For first offered non-urgent psychiatry appointment, the MHP measures appointments only for beneficiaries who are requesting services for the first time and have not received other services. Timeliness for beneficiaries who use other outpatient service and are requesting medication services for the first time are not included. The MHP should consider including those requests or conduct separate analysis to psychiatry assessment timeliness and capacity.

- The MHP developed and began piloting beneficiary record access at some psychiatry urgent care sites.

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 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-2022. This data was reported to represent the entire system of care. The MHP timeliness methodology does not account for a “zero day” for requests that are met the same day, so it is likely that their self-reported averages, as well as their rates of meeting timeliness standards, are underestimations. At the same time, the data submitted by the county is incomplete and thus unreliable, and reflects far fewer service requests and contacts than actually occurred in the MHP. The MHP reportedly receives approximately 2,200 Access line calls per month, referring on average 504 to the MHP for services. Data collection represents only 619 new service requests in the MHP’s data submission suggesting that the timeliness data is significantly incomplete.

Claims data for timely access to post-hospital care and readmissions are discussed in the Quality of Care section. Table 11 and Figures 12 – 14 display data submitted by the MHP; an analysis follows.

Table 11: FY 2021-22 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	5.6 Days	10 Business Days*	87%
First Non-Urgent Service Rendered	5.4 Days	10 Business Days**	88%
First Non-Urgent Psychiatry Appointment Offered	14.0 Days	15 Business Days*	63%
First Non-Urgent Psychiatry Service Rendered	12.7 Days	15 Business Days**	67%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	16.2 Hours	48 Hours*	93%
Follow-Up Appointments after Psychiatric Hospitalization	5.0 Days	7 Days**	53%
No-Show Rate – Psychiatry	7%	15%**	n/a
No-Show Rate – Clinicians	9%	15%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-2022			

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

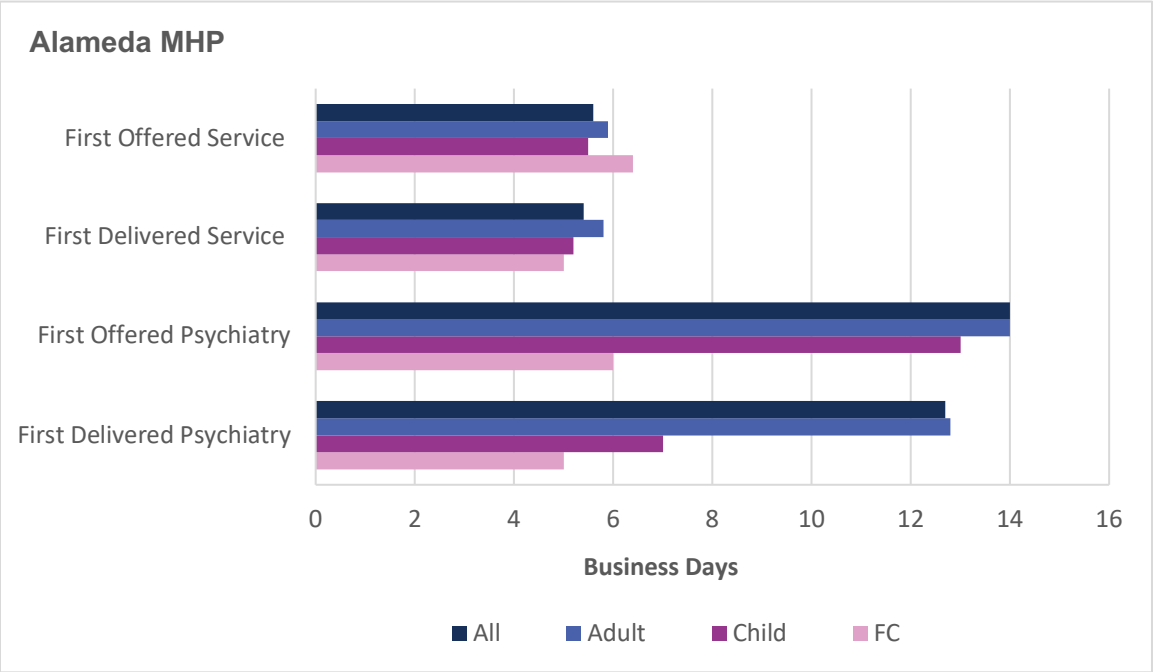


Figure 13: Wait Times for Urgent Services

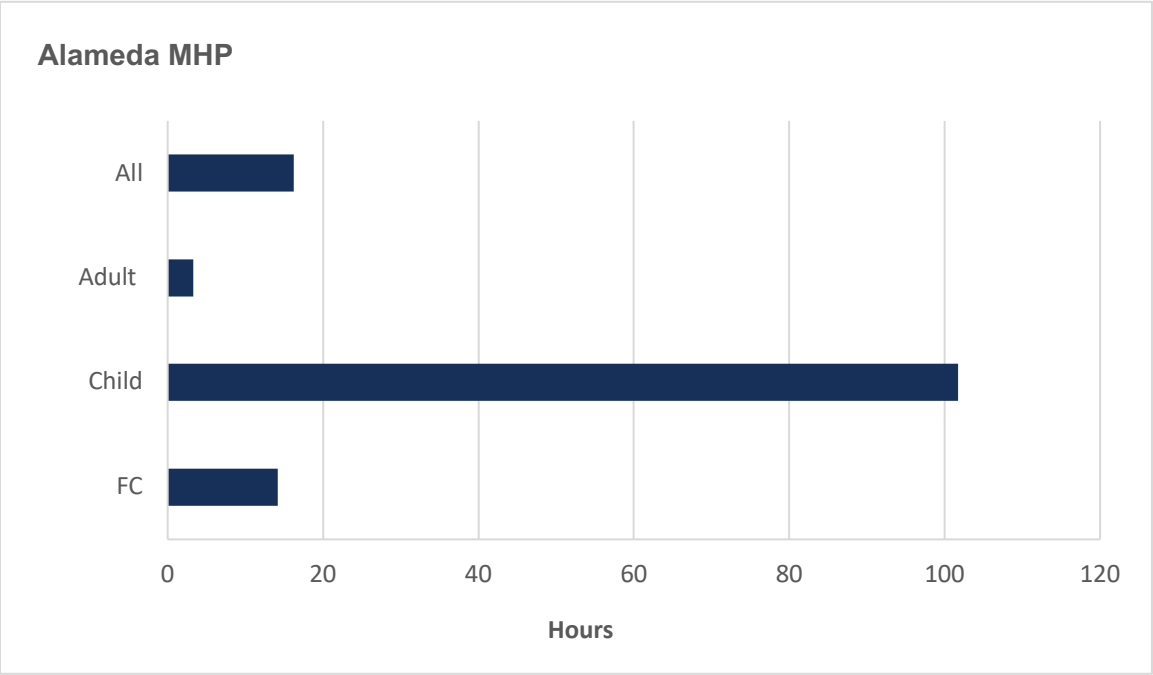
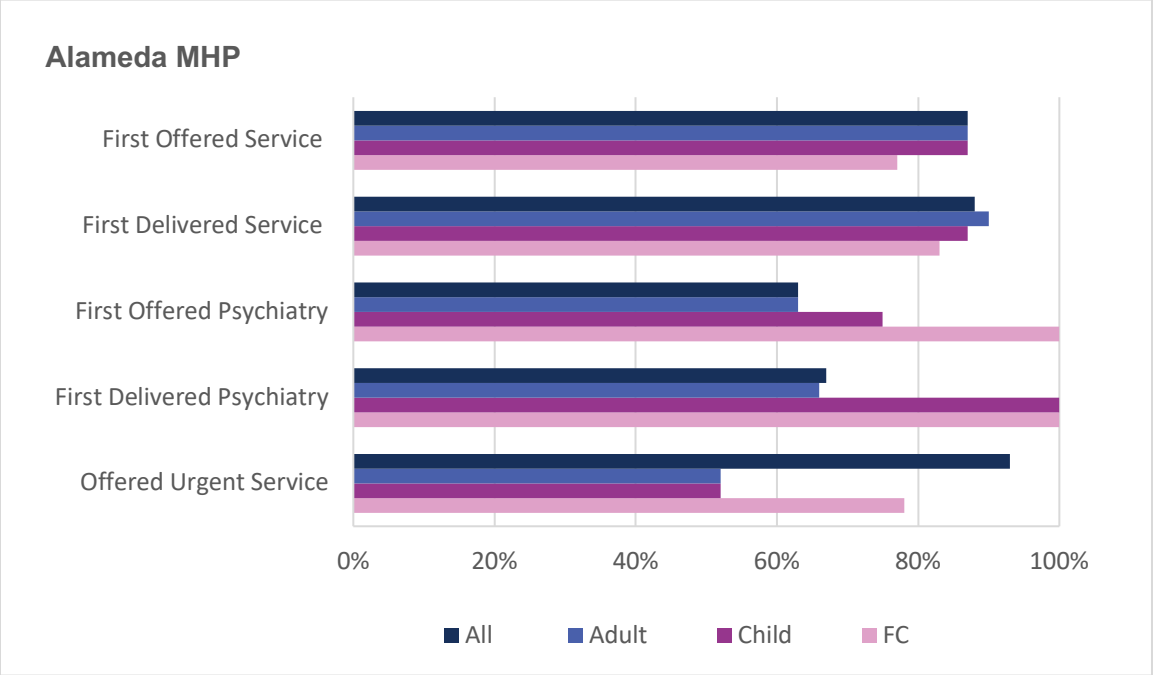


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments.

- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as being determined by screening questions to determine if the beneficiary is: 1) Pregnant or suffering a severe medical condition and at risk for complications if MH symptoms were to be unaddressed within 48-96 hours; 2) At serious increasing risk of progressing to imminent risk of suicide, homicide, grave disability, significant property destruction, loss of housing, or incarceration within 48-96 hours; 3) Indicating they are running out of antipsychotics, mood stabilizers, and/or benzodiazepines within the next seven days; or 4) Indicating they are in urgent need of mental health services for any reason. There were reportedly 381 urgent service requests with a reported actual wait time to services for the overall population of 16.2 hours.
- Though defined as 15 business days, measurement of the access points to psychiatry may be defined by the County MHP. The process as well as the definitions and tracking may differ for adults and children. The MHP has defined psychiatry access in the submission as days from first request to first psychiatry visit/service within 60 calendar days at a corresponding provider-level-modality. County staff reported that beneficiaries can generally obtain a psychiatry appointment within two weeks, though consumer experience appears to differ. For youth psychiatry in particular, contract provider staff report beneficiaries can wait for an appointment up to three months. The MHP reported a comparatively small data set for psychiatry timeliness, having received input from DHCS that after the beneficiary has begun the course of care and later requests psychiatry, that they did not track that as an initial request This appears inconsistent with other instructions and warrants clarity for the MHP.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of seven percent for psychiatrists and nine percent for non-psychiatry clinical staff; this may not be a complete data set given the unusual performance.

IMPACT OF TIMELINESS FINDINGS

- These conclusions are highly provisional given the presumed lack of reliability and validity of the MHP’s timeliness data as it is incomplete. IS staff have been working to increase provider submission of data, which is a necessity to aggregate accurate data for use in meaningful analyses.
- For adults in the system of care, psychiatric services, as well as Follow-Up Appointments after Psychiatric Hospitalization, have the lowest rates of being offered or rendered within standards for timeliness. This may be a contributing factor to the higher utilization of Crisis Stabilization and Crisis Residential services in the MHP, as beneficiaries may be more likely to experience a crisis if they are unable to access needed psychotropic medications in a timely manner

or are not being initiated quickly into follow up services upon release from a hospitalization.

- It should be noted that Alameda has improved timeliness since the prior year's self-report for both time to First Non-Urgent Psychiatry Appointment Rendered (61 percent to 67 percent) and Follow-Up Appointments after Psychiatric Hospitalization in particular (32 percent to 53 percent). The MHP had made follow-up after hospitalization a focal point and were able to make a dramatic improvement in this area.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries 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 beneficiaries. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN THE MHP

In the MHP, the responsibility for QI is under the QM Program Director, who directly oversees four FTEs: QI Analytics Manager, QI Project and Planning Manager, Utilization Management (UM) Division Director, and Quality Assurance Administrator; all of these staff collectively oversee other FTEs. There are two additional positions that are vacant: QI Performance Improvement Manager and QI Division Director.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of MHP and Substance Use Disorder staff, contract providers, and consumers and family members is scheduled to meet monthly. Since the previous EQR, the MHP QIC met seven times. Of the 30 identified FY 2021-22 QAPI workplan goals, the MHP "met" 50% of their goals and "partially met" 40% of their goals. Meeting agenda items are largely compliance focused; however significant areas of QM areas are present, although not discussed over time.

The MHP utilizes the following level of care (LOC) tools: Adult/Older Adult Outpatient Level of Care Determination Tool and Adult Behavioral Health Screening Form for Assessment and Treatment as Medically Necessary.

The MHP utilizes the following outcomes tools: Adult Needs Strengths Assessment (ANSA), Child Adolescent Needs Strengths (CANS/CANS-50), Patient Health Questionnaire (PHQ-9), and the Pediatric Symptom Check List (PSC-35).

ANSA and CANS are used for treatment planning, needs assessment, and care coordination. The MHP examines the CANS across contract providers and trends in some scores.

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 beneficiaries. These key components include an organizational culture

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The MHP's overall QM structure continues to appear strong. The MHP continues to implement a detailed QIWP with measurable goals and action steps. The MHP demonstrates data driven planning and decision making.
- Review discussions with contract providers identified a shared concern with the unprecedented high rates of suicide ideation, attempts and completions, including in beneficiaries at younger ages (starting at seven years old). The MHP is operating under the statewide suicide prevention plan from the Mental Health Services Oversights and Accountability Commission; the MHP has not yet determined if it will be creating its own plan. The MHP has an ongoing contractual relationship with the local crisis line operating 988.
- While the MHP analyzes elements of LOC tools, the MHP does not routinely track and trend transitions on an aggregate basis. The QIWP includes a goal to improve transition of clients between TAY providers and Adult providers.
    - Lack of comprehensive analysis of LOC tools limits the MHP's ability to determine whether individuals are being served at the proper level of care

to their needs, and where in the system additional services warrant expansion.

    - Review discussions emphasized difficulties with youth meeting eligibility for intensive service programs, especially if the youth has complex needs but has not yet required hospitalization. Reliance upon LOC analyses can assist in clarity for program eligibility in more upstream before inpatient needs develop.

- The Medical Director holds monthly meetings with the medical directors of contract agencies.
- The MHP does not track or trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): However, the MHP conducted a review for 18 youth in 2021
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): The MHP reviewed youth, though not specifically foster youth, as part of the system medication monitoring program.
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): The MHP reviewed youth as part of the system medication monitoring program.
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): The MHP reports no longer receiving Medi-Cal prescription claims data from the state.

QUALITY PERFORMANCE MEASURES

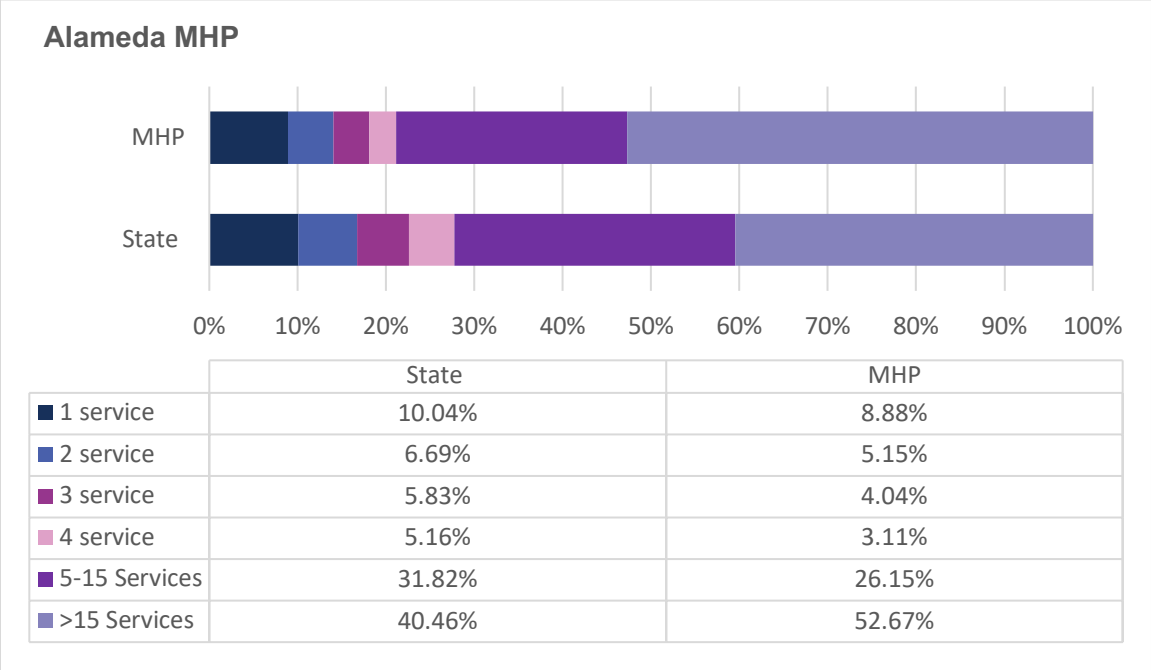
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries 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 Beneficiaries CY 2021



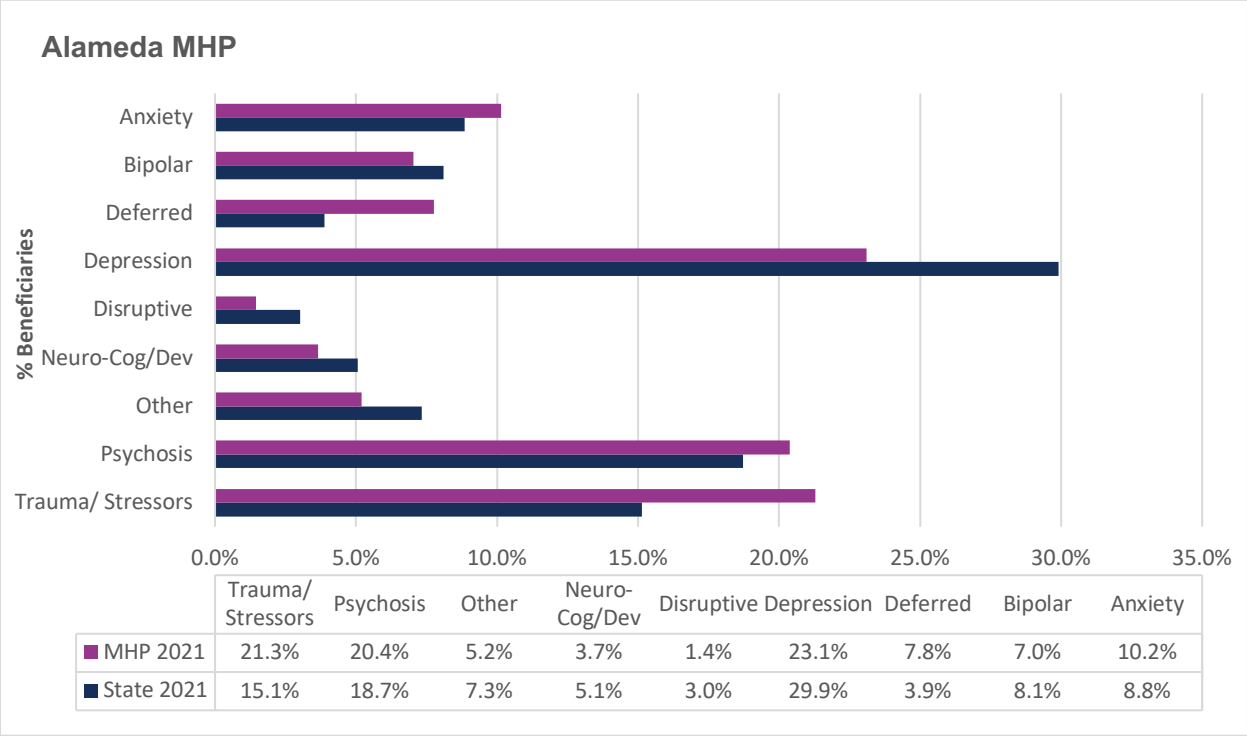
	State	MHP
1 service	10.04%	8.88%
2 service	6.69%	5.15%
3 service	5.83%	4.04%
4 service	5.16%	3.11%
5-15 Services	31.82%	26.15%
>15 Services	40.46%	52.67%

While retention between one and fifteen services was slightly lower in the MHP than statewide, the MHP retains a greater proportion of beneficiaries for more than 15 services (52.67 percent) than was seen statewide (40.46 percent).

Diagnosis of Beneficiaries 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 beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary 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.

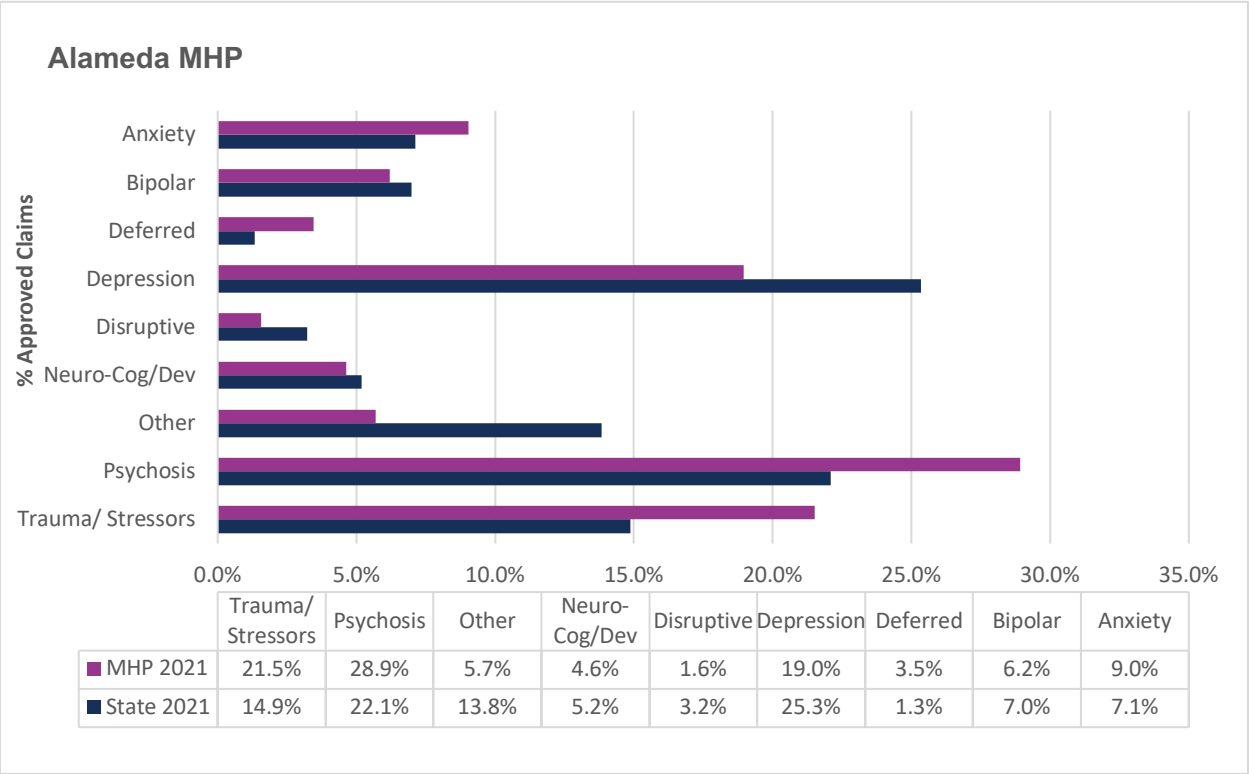
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	21.3%	20.4%	5.2%	3.7%	1.4%	23.1%	7.8%	7.0%	10.2%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

There are two diagnostic categories with differences in prevalence between the MHP and statewide data greater than five percent: Depression and Trauma/Stressors. The prevalence of Depression in the MHP was 23.1 percent as compared to 29.9 percent statewide, a 6.8 percentage point difference. Conversely, the Trauma/Stressors diagnostic category was more prevalent in the MHP (21.3 percent) than statewide (15.1 percent), a 6.2 percentage point difference, representing 41 percent more beneficiaries than statewide.

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	21.5%	28.9%	5.7%	4.6%	1.6%	19.0%	3.5%	6.2%	9.0%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

Approved claims distribution patterns across diagnostic categories were similar to the MHP's diagnostic patterns and statewide claims attributed to different diagnoses with one notable exception: 28.9 percent of claims were attributed to the Psychosis diagnostic category, as compared with 22.1 percent statewide. This is a 6.8 percentage point difference, a 31 percent greater proportion of claims than seen statewide. A population with high needs, this may be related to the MHP's relatively high usage of Crisis Stabilization and Crisis Residential services.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay (LOS).

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	1,615	3,665	7.58	8.79	$16,488	$12,052	$26,628,473
CY 2020	1,911	6,047	6.37	8.68	$14,284	$11,814	$27,297,370
CY 2019	1,991	6,674	6.46	7.63	$14,698	$10,212	$29,263,228

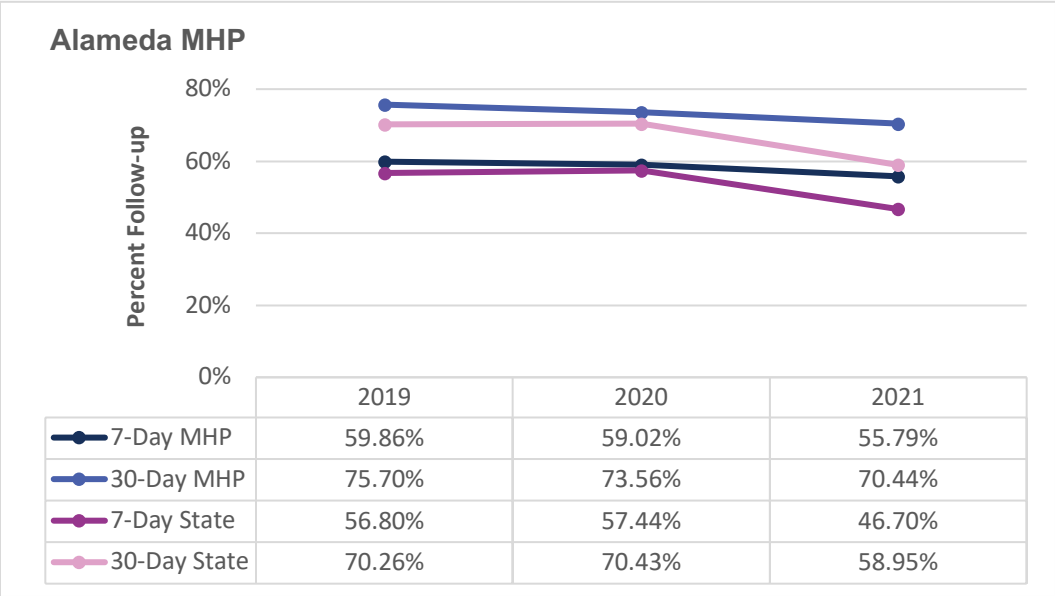
- The number of unique beneficiaries accessing psychiatric inpatient services decreased from CY 2020 to CY 2021 by 15.49 percent, and during the same time period the total number of admissions decreased by 39.39 percent. It is unclear whether the MHP is using IMD-excluded facilities that do not bill Medi-Cal or if more intensive services (measured by increases in claims) resulted in fewer hospitalizations.
- The MHP's average LOS has been trending upwards over the past three years at a rate comparable to increases statewide. However, Alameda's average LOS remains lower than that of the statewide average.
- The AACB for psychiatric inpatient services statewide increased by 20 percent from CY 2020 ($11,814) to CY 2021 ($12,052). While the MHP's AACB increased by 15 percent, it was at $16,488, it was 37 percent higher than statewide ($12,052) .

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 2021 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.

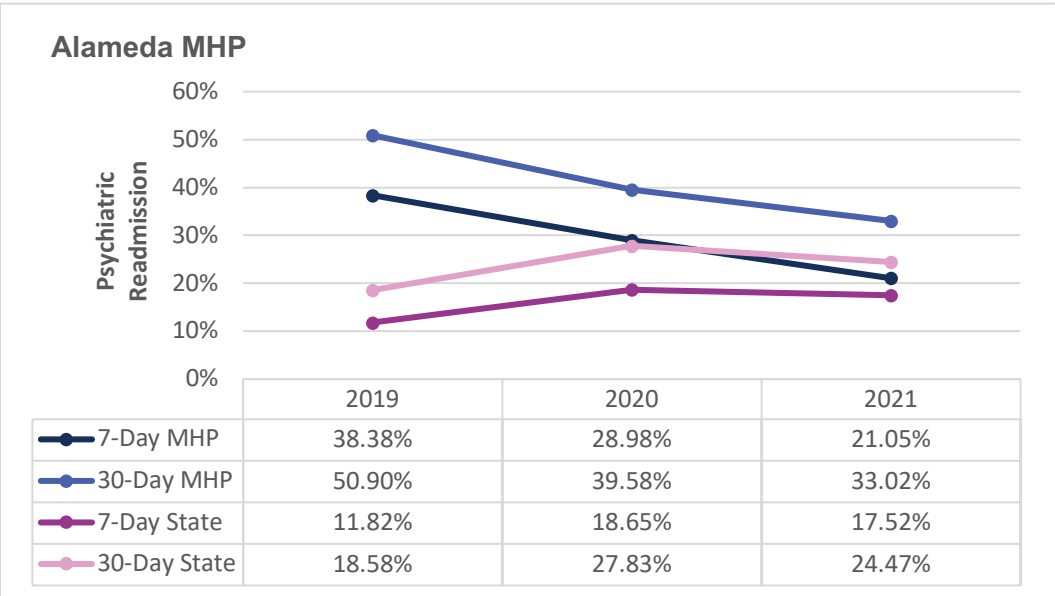
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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 2019-21



	2019	2020	2021
7-Day MHP	59.86%	59.02%	55.79%
30-Day MHP	75.70%	73.56%	70.44%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	38.38%	28.98%	21.05%
30-Day MHP	50.90%	39.58%	33.02%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- While both 7- and 30-day post psychiatric inpatient follow up have been trending downwards over the past three years in the MHP, that trend has been slower than that seen statewide, and Alameda is following up with beneficiaries after receiving psychiatric inpatient services much more frequently than seen statewide.
- Alameda's psychiatric readmission rates at both 7 and 30 days have been decreasing consistently over a three-year period. This contrasts with the statewide pattern in readmissions, whereby there was an increase from CY 2019

to CY 2020, followed by a slight decrease in CY 2021. The MHP's readmissions remain higher than the rates seen statewide, particularly at 30 days. However the MHP has made great strides from 2019 to 2021, showing a seven-day readmission rate decreasing from 38.38 percent to 21.05 percent, representing a 45 percent decrease. Over the same time frame, , the 30-day readmission rate showed a 35 percent decrease.

High-Cost Beneficiaries

Tracking the HCBs 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, HCBs may disproportionately occupy treatment slots that may prevent access to levels of care by other beneficiaries. HCB percentage of total claims, when compared with the HCB count percentage, provides a subset of the beneficiary population that warrants close utilization review, both for appropriateness of level of care and expected outcomes.

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. 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 AACB is $6,496, the median amount is just $2,928.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) and receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

Table 14: HCB (Greater than $30,000) CY 2019-21

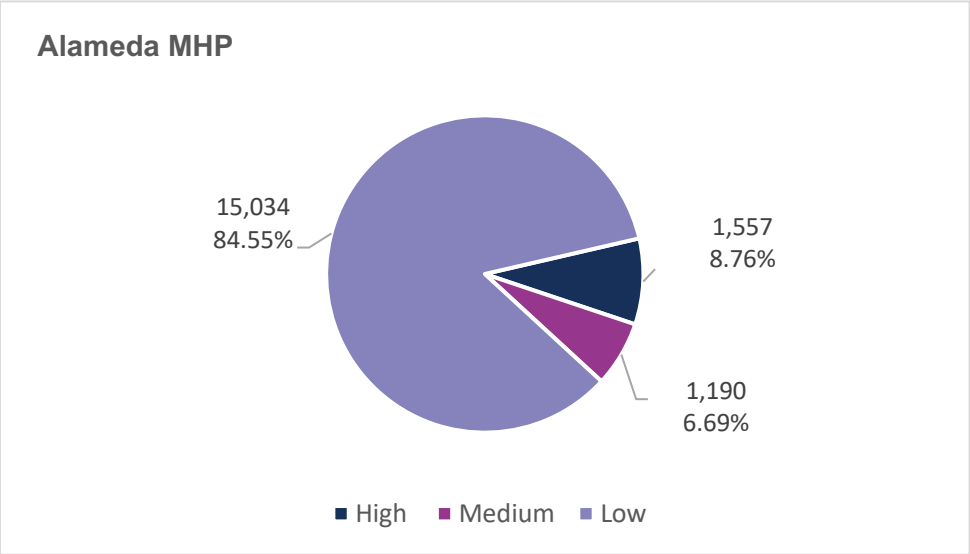
Entity	Year	HCB Count	Total Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	545,147	3.46%	$53,476	$43,231
MHP	CY 2021	1,557	17,781	8.76%	$56,195	$45,266
	CY 2020	1,554	18,874	8.23%	$54,954	$46,250
	CY 2019	1,454	21,372	6.80%	$55,267	$45,106

- The proportion of HCBs in the MHP has increased over the past three years, and for CY 2021 was much higher than the statewide proportion (8.76 percent as compared with 3.46 percent). Both median and average approved claims per HCB were slightly higher than statewide.

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

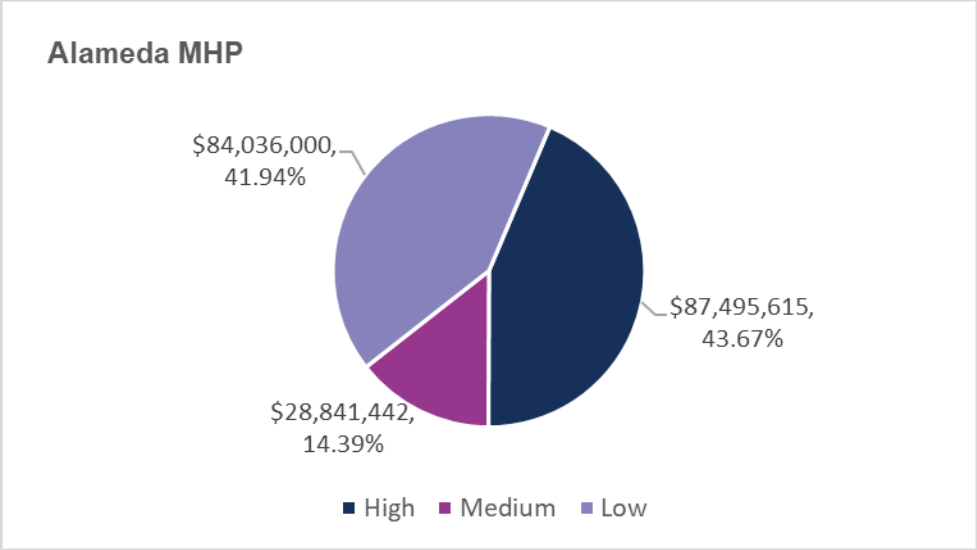
Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	1,190	6.69%	$28,841,442	14.39%	$24,237	$24,002
Low Cost (Less than $20K)	15,034	84.55%	$84,036,000	41.94%	$5,590	$3,935

Figure 20: Proportion of Beneficiary Count by Claim Amount Grouping CY 2021



- The bulk of beneficiaries in Alameda (84.55 percent) fell into the low cost (less than $20,000 in claims) category, where their claim average was $5,590.

Figure 21: Approved Claims by Cost Type CY 2021



- Claims submitted for services rendered to HCBs (8.78 percent of beneficiaries) represented 43.91 percent of total claims. This also approximated the claims for services rendered to the 84.55 percent of beneficiaries in the low cost category.
- Of the 56 MHPs, Alameda has the fourth highest proportion of beneficiaries qualifying as high cost; the other three MHPs are also Bay Area counties. Alameda's HCBs are more likely to be African-American, Other, Hispanic, or White.

IMPACT OF QUALITY FINDINGS

- The MHP's retention rate for greater than 15 services (52.67 percent) was much higher than statewide (40.46 percent). This is consistent with several services where more units were billed on average compared to statewide (e.g., Mental Health Services for children in particular).
- Alameda's claims related to diagnoses of Psychosis were disproportionately high. This may be connected to the MHP's comparatively high usage of Crisis Stabilization and Crisis Residential services.
- Over the past three years there has been a fairly dramatic decrease statewide in both 7- and 30-day follow-up after a psychiatric inpatient episode. The MHP should be acknowledged for their diligence in this area, for while Alameda has also seen a decrease in these follow-ups it has been much less dramatic, and the county had much higher rates of both follow-ups than seen statewide. While the MHP has historically exceeded the statewide rates slightly, both their 7-day and 30-day follow-up rates for CY 2021 were 19 percent higher than the statewide rates. This reflects the work of Alameda's High-Utilizer and STEPS (short-term intensive case management) Teams, the creation of a high-risk

dashboard to help identify and track beneficiaries with multiple hospitalizations or crisis services contacts, implementation of a live-feed from the hospitals to identify when beneficiaries have been admitted, and usage of push reports that notify providers when a beneficiary is hospitalized.

- The efforts described above pertaining to follow-up after hospitalization may also be responsible for the MHP's gains in closing the historical gap between Alameda's psychiatric readmission rates and those statewide. While statewide readmission has been trending up, the MHP has made great progress in bringing readmission rates down.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have two active and ongoing PIPs, 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 beneficiary satisfaction. They should have a direct beneficiary 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: Reducing Psychiatric Emergency Services Recidivism through Pre-Discharge Visits

Date Started: 06/2021

Aim Statement: "Over the next 15 months, will pre-discharge in-person contact for adults who receive psychiatric emergency services:

- Improve the percentage of clients with outpatient follow-up visits within 7 days and 30 days by 15 percent
- Reduce the percentage of clients who return to psychiatric emergency services within 7 days and 30 days by 15 percent

Target Population: Adults who received psychiatric emergency services (PES) who are not admitted to inpatient services and who do not meet the "Familiar Faces" high utilizers program criteria.

[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

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

Summary

In this second year, the MHP aimed to increase outpatient linkage and reduce readmissions after PES discharge for beneficiaries who do not meet criteria for the high utilizer program and were not hospitalized. Interventions include providing text contact to beneficiaries after discharge from PES and/or an in-person contact from a peer provider while at PES. The MHP sent a text to obtain consent to continue communication and assist linkage or communication with a beneficiaries' case managers. This was intended to improve contact, but the MHP found that calls had a low rate of contact (4.72 percent of the time) but a positive rate of engagement. The MHP found that clients who received a text contact were less likely to accept a phone call and consent to services.

In person contact at the PES did not occur as intended. While initially four FTE had been planned, only two staff remained at the time of the review. Staffing shortages and the end of grant funding for the project hampered its implementation. Staff morale surrounding the intervention waned. Ten beneficiaries had received the intervention in a 15-month period which is not within a meaningful scale for the size of the MHP. The MHP plans to continue exploring ways to provide in-person peer connection as a strategy.

The target population had been found to be a majority (63 percent) TAY, male (61.6 percent) and residing in the North County. Further targeting analysis and interventions to a TAY focus could advance performance improvement and assist sustainability.

TA and Recommendations

As submitted, this clinical PIP was found to have no confidence, because systematic delivery of the primary intervention was not conducted. The implementation plan such as operating limited hours (8:30pm – 12:00pm, Monday-Friday) and having few staff significantly were barriers and limited the viability of the PIP to provide the clinical intervention to beneficiaries.

The MHP does not intend to continue this PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Care Coordination with Primary Care

Date Started: 01/2022

Aim Statement: "This PIP will examine whether implementing care coordination strategies for adult clients in "service team" case management programs will:

- Reduce client psychiatric emergency services utilization
- Improve client engagement with physical health services
- Reduce avoidable physical emergency services utilization; and
- Improve quantifiable physical health outcomes."

Target Population: This PIP will study adult clients enrolled in seven CBO "Service Team" programs. Service Teams provide outpatient mental health, psychiatric, and care management services to individuals living with serious mental health conditions.

Service teams provide a high level of care for beneficiaries with complex needs, who have often been in a psychiatric hospital, jail, or crisis stabilization, or have used crisis services in the last two years.

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

Summary

This PIP aims to increase coordination between MHP providers and primary care which is a system goal of the MHP. The PIP also aims to improve beneficiary health outcomes. The MHP reports that this PIP will form the foundation to advance care coordination with primary care Interventions include: assessing if a beneficiary has a primary care provider (PCP) and if so, increasing collaboration, producing a monthly client primary care coordination report and the Community Health Record for the service teams to use. Performance measures include the percent of clients with a high BMI, percent of clients with a higher than normal HbA1c, percent of clients with a higher than normal blood pressure, and percent of clients who receive PES. The MHP also tracks the number of collateral services beneficiaries receive as an intervention.

The MHP completed one remeasurement but measurement for the health outcomes is not reported. The rates for percent of clients who receive case management/collateral improved, however the measurement includes a pre-intervention time period, so the results are not clear.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because the scope of the PIP appears large with the limited interventions and staffing. It is not clear that a visit or collateral service with a PCP will lead to the improved health outcomes desired. A more robust intervention may yield the desired outcomes.

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

- The performance measures should be measured using a time frame post beginning of the intervention – after January 2022. While the timeframes used

(e.g., August 2021 and after) capture a portion of the time period, measurements that include the period before the interventions limit assessing changes.

- Evaluate the scope of the PIP and consider narrowing the health outcome goals to a segment of the target population.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR systems used by the MHP are a hybrid of InSyst by Echo, which has been in use for 31 years, and Clinicians Gateway by Krassons, Inc., which has been in use for 14 years. Currently, the MHP is actively implementing a new billing system, Smartcare, which requires heavy staff involvement to fully develop with a go-live date of July 2023, and is preparing to release a Request for Proposal (RFP) in October 2023 for a new clinical EHR.

Approximately 3.46 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP purview. This funding level has decreased from the prior year's allocation of 4.21 percent.

The MHP has 3,532 named users with log-on authority to the EHR, including approximately 910 county staff and 2,622 contractor staff. Twenty-nine full-time equivalent (FTE) IS technology positions support users. These positions are shared between the MHP and the county DMC-ODS system. This represents a decrease from 32 FTEs at the time of the last EQR, and 38 FTEs in CY 2019. Currently there are two vacant FTEs. Three FTEs have turned over since the last review.

As of the FY 2022-23 EQR, all contract providers have the ability to directly enter clinical data into the EHR, however the entire clinical record is not housed in the EHR. Records that are not part of the EHR are scanned and stored in a separate electronic file management system (Laserfiche/Imaviser). Contractor staff use of a single MHP 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 beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit beneficiary 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	35%
Direct data entry into MHP IS by provider staff	☒ Daily ☒ Weekly ☒ Monthly	55%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☒ Daily ☒ Weekly ☒ Monthly	10%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP's EHR does not currently offer PHR access to beneficiaries. Alameda does plan to offer PHR access with a timeline of longer than two years (i.e., after going through the RFP and implementation processes for a new clinical EHR).

Interoperability Support

The MHP reports data exchange with local MCPs and is member of a HIE, the Social Health Information Exchange Community Health Record for Alameda County. However, the MHP uses the HIE only to collect information and does not utilize it for the exchange of information. The MHP engages in electronic exchange of information its CBOs/Contract providers and Whole Person Care (WPC).

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 beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

Table 17: IS Infrastructure Key Components

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

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

- Communication between IS and leadership is excellent, and there are standing meetings between IS and other related staffing units to ensure good collaboration across departments.
- The MHP's claims denial rate (2.13 percent) is lower than the statewide rate (2.78 percent), and the claims team has made a strong effort to cross-train staff and maintain clear desk manuals to prevent disruptions to claiming operations.
- IS has implemented and maintained a number of Yellowfin dashboards that support the MHP in tracking beneficiaries' movements through the system.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in the Table 18 including whether the claims are either adjudicated 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 2021.

For the MHP, it appears that significant claims lag begins in November 2021 and likely represents $18 to $22 million in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through CY 2021.

Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	56,737	$18,475,655	$427,022	2.31%	$18,048,633
Feb	55,012	$17,809,608	$425,093	2.39%	$17,384,515
Mar	63,841	$21,971,523	$553,876	2.52%	$21,417,647
April	55,701	$19,666,472	$488,998	2.49%	$19,177,474
May	52,310	$18,824,632	$434,385	2.31%	$18,390,247
June	48,155	$16,708,549	$305,615	1.83%	$16,402,934
July	40,066	$16,752,508	$265,175	1.58%	$16,487,333
Aug	42,306	$17,427,724	$268,521	1.54%	$17,159,203
Sept	44,714	$17,975,893	$373,032	2.08%	$17,602,861
Oct	44,338	$17,865,730	$381,582	2.14%	$17,484,148
Nov	38,227	$14,162,250	$287,871	2.03%	$13,874,379
Dec	15	$3,619	$0	0.00%	$3,619
Total	**541,422**	**$197,644,163**	**$4,211,170**	**2.13%**	**$193,432,993**

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B or Other Health Coverage must be billed before submission of claim	5,594	$2,043,915	48.54%
Beneficiary not eligible or non-covered charges	2,279	$1,063,871	25.26%
Claim/service lacks information which is needed for adjudication	2,137	$821,743	19.51%
NPI related	153	$189,887	4.51%
Service line is a duplicate and a repeat service procedure code modifier not present	195	$71,356	1.69%
Other	81	$20,401	0.48%
Total Denied Claims	10,439	$4,211,173	100.00%
Overall Denied Claims Rate	2.13%		
Statewide Overall Denied Claims Rate	2.78%		

The most common reason cited for denied claims was the need for Medicare Part B or other coverage to be billed prior to billing Medi-Cal. As noted previously, the MHP's overall rate for denied claims was 2.13 percent, which is lower than the statewide denial rate of 2.78 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Both the budget and staffing levels in IS have decreased since the last EQR, and the MHP reports having difficulty attracting staff due to competition with neighboring counties that have higher salaries. It would be prudent for Alameda to allocate additional resources to IS in preparation for the implementation of Smartcare billing and the potential move to a new clinical EHR after going through the RFP process, both of which are anticipated to occur next CY. The IS team's intentionality around these transitions is commendable.
- Implementation of Smartcare for billing is scheduled to be deployed in July 2023 and is anticipated to streamline processes for providers.
- IS has been working diligently with managers and the Behavioral Health Collaborative of Alameda County to design and implement documentation changes in response to CalAIM's goal of reducing documentation requirements.
- Staff reports of interdepartmental collaboration having "flourished" since the onset of the pandemic are encouraging, and the fiscal department reports that data provided by IS has enabled them to make extremely accurate budget projections which are vital in this large MHP.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of beneficiaries: adult, older adult, youth, and family members. MHPs administer these surveys to beneficiaries 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 completed the CPS using online and paper surveys and the MHP analysis show that the number of completed surveys is higher than in previous years. While the MHP shared detailed results of the CPS with the QIC, the MHP reports that the results did not provide any significant outcome or trend to lead to a QI action.

CONSUMER FAMILY MEMBER FOCUS GROUPS

Consumer and family member (CFM) 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 CFM involvement. CalEQRO provides gift cards to thank focus group participants.

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

Consumer Family Member Focus Group One

CalEQRO requested TAY consumers including API consumers and beneficiaries who had received crisis services in the last one year. The focus group was held virtually and included eight participants. All consumers participating receive clinical services from the MHP. Some participants are also family members and have children who receive services.

Participants had received services between three months to seven years. Five participants had begun services in the last year. Participants received services at a variety of agencies; many also participated on a TAY panel that provides mental health information and workshops on social media. Participants who started services this last year described access as difficult. Experiences include not receiving a response from an initial request or being placed on a wait list, and some are still waiting for some type of service. Some reported receiving services after waiting for over eight months until Social Services became involved.

Participants generally found services helpful once accessed. Youth valued encouraging and helpful therapists, learning about "self-efficacy", nutrition and physical health information, and "ways to think about what I can do better." Parents reported positive experience with re-unification services and parenting groups. Some participants reported high fear and dissatisfaction with experiences at John George PES with care involving "threats of restraint" to gain compliance. Experiences with rehabilitation services were generally positive. Those who used crisis services accessed a range of sources including their provider, PES, and a text line. Others valued services through Beats, Rhymes, and Life that provided therapy and hip hop where they "create ideas" that helped them. Participants valued mentors from CASA.

Most participants were not aware of the Peer Certification process or other committees outside the TAY panel.

The primary shared experience concerned interactions with law enforcement. Most beneficiaries had an experience or perception of law enforcement being the first contact when accessing help, yet they report that law enforcement "do not help" and it is not "safe." Beneficiaries expressed that stigma is not a barrier. They expressed that they want and need help but are scared to seek it out because of fear of law enforcement's disrespectful treatment of consumers and they fear for their safety. Participants believed training for law enforcement and more and effective outreach to youth are critical needs.

Recommendations from focus group participants included:

- Provide training to law enforcement including the police.
- Conduct more effective outreach to youth.
- Improve services at PES.

Consumer Family Member Focus Group Two

CalEQRO requested family members including API participants. The focus group was held virtually and included five participants; a Spanish language interpreter was used for this focus group. All family members participating have a child, youth, or adult family member who receives clinical services from the MHP.

Participants had received services between three months to five years. Participants received services at three different contract programs and some participants received services at health centers, Eastmont Center and the West Oakland Health Care Center. Two participants had family members who began services in the last one year. A parent who had another child already receiving services and obtained an appointment after two weeks after her other child's provider called Access for her. One participant waited two months for outpatient services after an adult child had been hospitalized at John George. Family members reported delays and challenges to receiving "the right services." One participant had received a referral for trauma therapy only after behavioral management services for eight months. The parent felt that they needed to prove that behavioral management services were not effective before being referred to

trauma services. Some participants waited eight months for a psychiatry referral. In the interim, Children's Hospital continued to prescribe medications while they waited.

One family member of an adult shared that maintaining treatment while her child is in Santa Rita jail requires active coordination. Her son did not receive any services while in jail and was told that he can receive services once released, but there is no process to reconnect without her coordinating that.

Participants who needed interpreters report receiving help if they asked. Some participants received rides to appointments or bus fare while others were not aware of any assistance, but therapists come to their homes. Some participants only preferred services over videoconference because of worry of "getting caught in crossfire" of gun shootings at an East Oakland site.

For experience with crisis, most participants had used crisis services and had a range. Most of the contacts involved the police and experience varied. Some met treatment teams at the police station such as Fremont. Therapists at school also call the police for crisis help. Overall family members worried about police involvement and some shared that experience varied depending on if the police have had crisis intervention training or not. Most of the participants felt satisfied with services once they received them. One child had not wanted to attend school and services helped get her to a new school and now she "gets up and goes to school." Participants feel heard and able to provide input. Some would like to receive more communication from service providers but also are happy with the communication they receive. Family members of adult beneficiaries receive little or delayed communication.

Recommendations from focus group participants included:

- Increase communication opportunities to family members on how treatment is going and planning and information of transitions to new programs.
- When removing children from parents to place in foster care, provide trauma-informed, evidence-based treatments for children and youth.
- Provide dual diagnosis centers and housing, since so many of the seriously mentally ill beneficiaries have a co-occurring substance use disorders and housing needs.

Consumer Family Member Focus Group Three

CalEQRO requested adult and older adult beneficiaries including consumers who initiated services in the preceding 12 months, used crisis services, and Asian/ Pacific Islander beneficiaries. The focus group was held virtually and included 15 participants. All consumers participating receive clinical services from the MHP; many also participate in the MHP program Pool of Consumer Champions (POCC). POCC operates committees and other ways to support consumer empowerment in the county.

Two consumers had begun services in the last one year and both reported quick access because they had started services through hospitalization. They had sought services independently and did not receive assistance to transition to outpatient service. Most participants felt services are helpful. Knowledge of and experience with crisis services in the last year was broad. Beneficiaries accessed crisis services from text chats, 988, hotlines, peer staff at 211, and acute services. While accessing at John George PES was reported to be accessible, participants shared the experience that services consisted of medications only and were not offered basic skills interventions or information leading to a relapse after discharge described as a "rotating door."

Many participants shared experiences and perceptions that training law enforcement is a priority. Beneficiaries felt the police do not want to work with MH consumers and do not know how to respond to consumers who have serious mental illness symptoms such as delusions.

Some participants had experience and knowledge with wellness centers, peer services, changing a provider, and ways to provide input to the MHP planning.

Recommendations from focus group participants included:

- Provide training to law enforcement on working with people with mental illness. Training should include an emphasis on consumers "are not criminals."
- Provide consistent transportation to appointments and meetings.
- Increase help and access for beneficiaries with additional disabilities.
- Create opportunities for beneficiaries to provide input to and discussions with MHP executive leadership.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Focus group discussions reveal that beneficiaries experience with access in the last year had delays and required multiple efforts from the beneficiaries. Consumers are generally satisfied with services once accessed and feel they are helpful. Beneficiaries and family members use an array of the crisis services the MHP provides. Assistance from acute services to outpatient services were not consistently provided to participants in these groups. A priority recommendation from beneficiaries is training and thoughtful collaboration with law enforcement. Participants perceived law enforcement as the first line of providers to mental health services and the experiences evoked fear, and were unhelpful and disrespectful.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP developed and began piloting beneficiary record access at some psychiatry walk-in urgent care sites. This can increase timeliness and quality of care for beneficiaries in acute care and provide the MHP information for expanding this practice.
2. The MHP demonstrates QM is a priority with measurable goals, routine review of data, and wide participation in QI and stakeholder meetings.
3. The MHP prioritizes coordination and integration with primary care as demonstrated by service delivery, partnerships and creating a Chief Nursing Office position. This has the potential to improve quality of care for beneficiaries.
4. The MHP's rehospitalization rate continues to improve indicating effective post-hospitalization practices.
5. Through addition of new organizational divisions and leadership, the MHP is working to better coordinate crisis services and forensic services. This has included a policy of screening for mental health needs everyone who is booked at the County jail, and strengthening the presence of mental health services at the Jail and Juvenile Hall. The MHP is endorsing a "care first, jails last" philosophy and is working to align programs accordingly.
6. The MHP obtained several grants that will enable expansion of services in key areas.

OPPORTUNITIES FOR IMPROVEMENT

1. There is a need to understand barriers and develop a method to collect reliable timeliness data for first psychiatry services and urgent services. This gap hinders QM and performance improvement in these areas. (Timeliness, Access, IS)
2. While the MHP has expanded crisis services, capacity for crisis services including mobile crisis services do not meet the high number of requests. As a large county, availability of crisis services varies across cities.
3. The MHP has established clear guidelines for medication use in child and youth services. However, the MHP does not track and trend the HEDIS measures for youth. (Quality)

4. Staffing and budget allocation for the implementation of Smartcare is limited and may impact the MHP's ability to carry out its reporting and other EHR goals. (IS)
5. Information on crisis services and wellness centers are limited or not available on the website. (Access)
6. While there is a walk-in psychiatry service for adults, there is no similar service available for youth.

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 beneficiary outcomes:

1. Investigate gaps in measurement for first appointment offered, psychiatry services, and urgent services. Develop and implement a way to compile valid and reliable timeliness data to direct QI and capacity management. Analyze beneficiaries' experiences with delays and barriers across the system. Develop interventions and measure the effectiveness of changes. (Timeliness, Access)
2. Continue to examine access to crisis services. Continue to develop strategies using data to increase meeting the demand, as well as identify other proactive service strategies that could reduce the reliance upon crisis services. (Access, Quality)
3. Resume tracking and trending HEDIS measures for youth receiving medication services, as well as other HEDIS measures for foster youth as required. (Quality)
4. Consider shifting resources to IS that can support implementation of Smartcare and other IS priorities. (Timeliness, IS)
5. Assess the current trainings provided to law enforcement and modify or expand as indicated, using stakeholder recommendations and experience as a consideration. Consider incorporating ways to invite law enforcement visits and/or ways to learn about mental health and related services. (Quality)
6. Provide clear information on the website regarding the availability of mobile crisis by region and the varied hours that those services are available. (Access)
7. Review whether youth eligible for Pathways services are being referred, or if there are any barriers to high-need youth or CWS-involved youth. (Access, Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2022-23 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT F: PM Data CY 2021 Refresh

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Alameda MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Clinical Directors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Forensics and Law Enforcement Group Interview
Community-Based Services Agencies Group Interview
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
EHR Deployment

CalEQRO Review Sessions – Alameda MHP
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rowena Nery, Lead Quality Reviewer
Sandra Sinz, Clinical Quality Strategist
Leah Hanzlicek, Information Systems Reviewer
MaryEllen Collins, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Adam	Janice	Community Relations Coordinator, Division of Health Equity	Alameda County Behavioral Health
Anderson	Kara	Departmental Personnel Officer (ACBH)	Health Care Services Agency
Aslami	Khatera	Peer Support Services Manager, Division of Health Equity	Alameda County Behavioral Health
Bailey	Annie	Youth and Family Services Division Administrator	City of Fremont Youth & Family Services
Baker	Vanessa	Older Adult Services and Schreiber Center Division Director	Alameda County Behavioral Health
Bass	John	Behavioral Health Clinician, Children's Specialized Services	Alameda County Behavioral Health
Benjamin	Danielle		Alameda County Behavioral Health
Bernhisel	Penny	Clinical Program Supervisor, Forensic, Diversion, & Re-Entry Services Director	Alameda County Behavioral Health
Biblin	Janet	Info Systems Manager, Quality Improvement	Alameda County Behavioral Health
Bolden	P'Shana	Clinical Social Worker Monument	La Clínica de La Raza
Bradley	Bill	Case Manager	Bay Area Community Services
Brown	Renikia	Intern, Adult Outpatient Services	Alameda County Behavioral Health
Buttlaire	Stuart	Inpatient Psychiatry and Continuing Care Regional Director	Northern Kaiser Permanente
Capece	Karen	Quality Management Program Director	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Carlisle	Lisa	Child & Young Adult System of Care Director	Alameda County Behavioral Health
Castillo	Michaeil	Senior Program Specialist	Alameda County Behavioral Health
Castro	Dainty	"MHAB" Liaison, Office of the ACBH Director	Alameda County Behavioral Health
Catolos	Agnes	Clinical Operations, Office of the Deputy Director	Alameda County Behavioral Health
Chambers	Dean	Critical Care Manager, Crisis System of Care	Alameda County Behavioral Health
Chand	Anuja	Program Specialist, Clinical Operations Deputy Director's Office	Alameda County Behavioral Health
Chapman, MD	Aaron	Behavioral Health Medical Director and Chief Medical Officer	Alameda County Behavioral Health
Chau	Mandy	Audit and Cost Reporting Director, Finance	Alameda County Behavioral Health
Chiang	Katy	Analyst, Information Systems	Alameda County Behavioral Health
Coffin	Scott	Chief Executive Officer	Alameda Alliance for Health
Coombs, MD	Angela	Office of the Medical Director Associate Medical Director	Alameda County Behavioral Health
Cooper Kahn	Mia	Senior Manager of Behavioral Health	Community Health Center Network
Cowell	Justin	Program Director	Bonita House, Supportive Independent Living,

Last Name	First Name	Position	County or Contracted Agency
Currie	Peter	Senior Director of Behavioral Health, Integrating Behavioral and Physical Health	Alameda Alliance
Dashiell	Margot	Founding Family Member, Alameda County Family Coalition	Alameda County Mental Health Services
Davies	Kathy	Executive Director	Mental Health Association of Alameda County
De La Torre	Nadine	Peer Employee	Felton Institute
Diedrick	Sheryl	Analyst, Information Systems	Alameda County Behavioral Health
Do, MD	Tri D.	Chief Medical Officer	Community Health Center Network
D'Valery	Rene	Oakland & Hayward Clinical Director	Family Paths Inc.
Eady	Rashad	Program Specialist, Quality Improvement	Alameda County Behavioral Health
Edwards	Charles	Interim ACCESS Director	Alameda County Behavioral Health
Eldridge	Robin	HR Liaison, Office of the ACBH Director	Alameda County Behavioral Health
Elliott	Anne	Critical Care Manager, Crisis System of Care	Alameda County Behavioral Health
Felton	Mistique	Operations Manager, Casa del Sol	La Clínica de La Raza
Firpo	Daniel Chris	Associate Clinical Social Worker	Telecare Corporation
Franklin	Paulette	Mental Health Specials II	Alameda County Behavioral Health
Freeman	Sheila	Behavioral Health Case Manager	Anthem
Gerchow	Christine	Juvenile Justice Health Services Director	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Gibbs	Laphonsa	Child & Young Adult Outpatient Services Division Director	Alameda County Behavioral Health
Gillins	LaDarien	Team Lead	Telecare Corporation
Glassie	Lori	Psychiatric Physician Assistant	Telecare Corporation
Goldberg	Seth	Behavioral Health Director	UCSF Benioff Children's Hospital Oakland
Gums	Angelica	Human Resources Liaison	Alameda County Behavioral Health
Harris	Raiyah	Transition Age Youth Services Coordinator/Supervisor	WestCoast Children's Clinic
Hayes	Steve	Program Assistant	Peers Envisioning and Engaging in Recovery Services
Hazelton	Tracy	Mental Health Services Act Division Director	Alameda County Behavioral Health
Hernandez	Diana	SmartCare Implementation Project Manager, Information Systems	Alameda County Behavioral Health
Hogan	Nellni		EBAC
Huber	Kathryn		MH Association of Alameda County
Huerta	Amelia (Amie)	Behavioral Health Clinician, Oakland Children's Services	Alameda County Behavioral Health
Hunt	Linda	Clinical Manager, Adult & Older Adult System of Care	Alameda County Behavioral Health
Iqbal	Asad		Alameda County Behavioral Health
Jackson	Summer		Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Jie	Justin	Clinical Lead	Asian Health Services
Johnson	Carla	Adult Behavioral Health Director	La Familia Counseling Services
Jones	Katherine	Adult & Older Adult Services Director	Alameda County Behavioral Health
Jones	Yvonne	Adult Forensic Behavioral Health Director	Alameda County Behavioral Health
Judkins	Andrea	Supervising Financial Services Specialist, Fiscal Services	Alameda County Behavioral Health
Karly	Wiley	Northern California Regional Administrator	Stars Behavioral Health Group
Kessler	Michael	Clinical Program Specialist, Adult & Older Adult System of Care	Alameda County Behavioral Health
Keyoumarsi	Jessica	Social Worker	La Clínica de La Raza
Kiefer	Andrea	Clinical Review Specialist, Specialty Services	Alameda County Behavioral Health
Kim	Grace	Clinical Supervisor	West Oakland Health
Kolda	Deanna	Clinical Review Specialist Supervisor, Utilization Management	Alameda County Behavioral Health
Konover	Kimberly	Clinical Manager, Forensic, Diversion, & Re-Entry Services	Alameda County Behavioral Health
Lee	Davis	Mental Health Advisory Board Chair	Alameda County Behavioral Health
Lee	SunHyung	Transition Age Youth Services Division Director	Alameda County Behavioral Health
Leon	Eugenia	Mental Health Clerk	La Clínica de La Raza

Last Name	First Name	Position	County or Contracted Agency
Lewis	Clyde	Substance Use Disorder Services Director	Alameda County Behavioral Health
Lewis	Stephanie	Acting Crisis System of Care Director	Alameda County Behavioral Health
Lilly	Siobhan	Administrative Specialist II, Office of the Deputy Director	Alameda County Behavioral Health
Linder	Sarah	Administrative Specialist II, Finance Division	Alameda County Behavioral Health
Ling	Jennifer	Clinical Review Specialist/Eating Disorder Coordinator, Specialty Services	Alameda County Behavioral Health
Lopez	Rickie Michelle	Assistant Finance Director	Alameda County Behavioral Health
Lott	Yesenia	Clinical Supervisor, Crisis System of Care	Alameda County Behavioral Health
Louie	Jill	Budget and Fiscal Services Director	Alameda County Behavioral Health
Louis	L.D.	Mental Health Advisory Board Vice-Chair	Alameda County Behavioral Health
Lozano	Ed	Applications Development Manager, Information Systems	Alameda County Behavioral Health
Lua	Juan		Alameda County Behavioral Health
Macklin	Kalil	Program Manager	Elevance Health
Madaus	Matt	Executive Director	The Behavioral Health Collaborative of Alameda County
Marquez-Cortes	Kimberly	Program Manager	Peers Envisioning and Engaging in Recovery Services

Last Name	First Name	Position	County or Contracted Agency
Mayfield	Amber	Clinical Director	Telecare
Mazid	Sanjida	Manager, Workforce Development, Education and Training	Alameda County Behavioral Health
McCarrick	Jessica	Clinical Trainee, Portia Bell Hume Behavioral Health and Training Center	The Hume Center
Mehta	Ravi	Chief Compliance & Privacy Officer	Alameda County Behavioral Health
Meinzer Valentino	Chet	Information Systems Manager, Decision Support Team	Alameda County Behavioral Health
Miao	Leslie	Director of Compliance	The Hume Center
Miller	Jennifer	San Francisco & Oakland UCSF Service Line Director	UCSF Benioff Children's Hospital Oakland
Momoh	Imo	Deputy Director/Plan Administrator	Alameda County Behavioral Health
Montgomery	Stephanie	Health Equity Division Director/Health Equity Officer	Alameda County Behavioral Health
Moore	Lisa	Billing & Benefits Support Director	Alameda County Behavioral Health
Mukai	Christine	Critical Care Manager, Youth Services	Alameda County Behavioral Health
Mullane	Jennifer	Adult & Older Adult Associate Director	Alameda County Behavioral Health
Narvaez	Cheryl	EPSDT Coordinator, Children and Young Adult System of Care	Alameda County Behavioral Health
Nichols	Paul	Management Analyst, Finance	Alameda County Behavioral Health
Obrien	Steve	Chief Medical Officer	Alameda Alliance for Health
Omoko	Alex	Employment Coordinator	Bay Area Community Services

Last Name	First Name	Position	County or Contracted Agency
Orozco	Gabriel	Management Analyst, Quality Management	Alameda County Behavioral Health
Orrante	Shaun	Lead Clinician	Bay Area Community Services
Osmond	Jessica	Older Adult Service Team Program Director	Felton Institute
Paine	Janet	Program Management Director, CA Medicaid Health Plan	Anthem
Pendleton	Laurel	Quality Improvement Project and Planning Manager, Quality Improvement	Alameda County Behavioral Health
Perales	Joseph	Casa Del Sol Manager	La Clínica de La Raza
Peterson	Camille	Analyst, Information Systems	Alameda County Behavioral Health
Phan	Jade	Manager, Information Systems	Alameda County Behavioral Health
Piedade	Chastity	Clinical Supervisor, Adult Outpatient Services Division Director	Alameda County Behavioral Health
Ponssa	Jose	Bilingual (Spanish) Early Childhood Mental Health Clinician	City of Fremont Youth & Family Services
Powell	Catherine	Early Childhood Mental Health Coordinator, Child & Young Adult System of Care	Alameda County Behavioral Health
Provost	John	Services Manager, Information Systems	Alameda County Behavioral Health
Quach	Thu	President	Asian Health Services

Last Name	First Name	Position	County or Contracted Agency
Ramcharitar	Renee	Program Coordinator	Peers Envisioning and Engaging in Recovery Services
Rassette	Kim	Administrative Specialist II, Quality Improvement	Alameda County Behavioral Health
Raynor	Charles	Pharmacy Services Director	Alameda County Behavioral Health
Razzano	Theresa	Vocational Services Division Director	Alameda County Behavioral Health
Reese	Linda	Regional Operations Director	Telecare Corporation
Rejali	Torfeh	Quality Assurance Administrator	Alameda County Behavioral Health
Reyes	Trinh	Crisis Intervention Specialist Supervisor, Crisis System of Care	Alameda County Behavioral Health
Richholt	Kinzi	Chief Nursing Officer, Office of the Medical Director	Alameda County Behavioral Health
Rodiso	Diana	MH Clinician	E BACH
Rodriguez	Laura	TEAM Program Supervisor	La Familia Counseling Services
Rosenbaum	Michael	Case Manager	Telecare Corporation
Rosso	Stephanie	Behavioral Health Clinical Operations Director	UCSF Benioff Children's Hospital Oakland
Saechao	Kao	Specialty Mental Health Director	Asian Health Services
Sampson	Sakara	Administrative Specialist II, Quality Improvement	Alameda County Behavioral Health
Sanchez-Lerma	April	Behavioral Health Clinical Supervisor, Tri-City Children and Youth Services	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Sanders	Laura	Health Care Services Agency Human Resources Deputy Director	Alameda County Behavioral Health
Sanjay	Bhatt	Medical Director, Quality Improvement	Alameda Alliance
Schrick	Juliene	Utilization Management Division Director	Alameda County Behavioral Health
Schulz	Henning	Adult Outpatient Services Division Director	Alameda County Behavioral Health
Scoggins	Radiant	Behavioral Health Associate Director	West Oakland Health
Serrano	Cecilia	Finance Director	Alameda County Behavioral Health
Smith	Freddie	Integrated Care Services Division Director	Alameda County Behavioral Health
Smith	Sandra	Clinical Manager, Eden Community Support Center	Alameda County Behavioral Health
Smith	Sarah	AdROC / TAY ROC Clinical Director	Telecare Corporation
Spensley	Catherine	Senior Services Division Director	Felton Institute
Taizan	Juan	Forensic, Diversion, & Re-Entry Services Director	Alameda County Behavioral Health
Terovic	Nermina	Behavioral Health Clinical Supervisor, Children and Young Adult System of Care	Alameda County Behavioral Health
Terry	DeAndrea	Clinical Review Specialist, Specialty Services	Alameda County Behavioral Health
Tribble	Karyn	Director	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Turbay	Camilo	Care Coordinator	Bay Area Community Services
Utecht	Dawan	Senior Vice President, Chief Development Officer	Telecare Corporation
Valentino	Chet		Alameda County Behavioral Health
Vargas	Wendi	Contracts Director	Alameda County Behavioral Health
Vazquez	Jennifer	Volunteer	La Familia Counseling Services
Wagner	James	Clinical Operations Deputy Director	Alameda County Behavioral Health
Warder	Rosa	Family Empowerment Manager	Alameda County Behavioral Health
Weissberger	Laura	Interim Executive Director	Bontia House
Whitmer	Teena	Human Resources Specialist	Health Care Services Agency
Wiley	Karly	SBHG Northern CA Regional Administrator	Stars, Starlight, and Capital Star
Wilhite	Marguerite	Behavioral Health Clinical Manager, Oakland Children's Services	Alameda County Behavioral Health
Wilkinson	Sindy	Behavioral Health Clinician II, Eden Children's Services	Alameda County Behavioral Health
Williams	Donna	Clinical Supervisor, Adult Outpatient Services Division Director	Alameda County Behavioral Health
Wong	Jenny	Management Analyst, Quality Management	Alameda County Behavioral Health
Woodland	David	Clinical Review Specialist, Quality Assurance	Alameda County Behavioral Health

Last Name	First Name	Position	County or Contracted Agency
Yates	Deb	Clinical Supervisor, Child & Young Adult System of Care	Alameda County Behavioral Health
Yee	Philip	Licensed Team Lead	Telecare Corporation
Yip	Amos	Clinical Manager	Asian Health Services
Young	Alycia	Facilities Development Manager, Finance	Alameda County Behavioral Health
Young-Hooks	Tangie	Mental Health Specialist III, Adult Outpatient Services	Alameda County Behavioral Health
Yuan	Eric	Manager, Integrated Care Services	Alameda County Behavioral Health
Zastawney	Wendy	Clinical Review Specialist Supervisor, ACCESS Program	Alameda County Behavioral Health

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	Very few beneficiaries received the in-person service intervention.
General PIP Information	
MHP/DMC-ODS Name: Alameda MHP	
PIP Title: Reducing PES Recidivism through Pre-Discharge Visits	
PIP Aim Statement: Over the next 15 months, will 1) pre-discharge in-person contact and 2) post-discharge text message follow-up for adults who receive psychiatric emergency services: • Improve the percentage of beneficiaries with outpatient follow-up visits within 7 days and 30 days by 15 percent? • Reduce the percentage of beneficiaries who return to psychiatric emergency services within 7 days and 30 days by 15 percent?	
Date Started: 06/2021	
Date Completed: n/a	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): The study population is adults who received psychiatric emergency services (PES) who are not admitted to inpatient services and who do not meet "Familiar Faces" high utilizers program criteria.
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): A) Pre Discharge In Person Contact B) Post Discharge Text Message Follow up
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): A) Pre Discharge In Person Contact B) Post Discharge Text Message Follow up
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): n/a

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
7-day outpatient follow-up of clients not already connected	6/20-5/21	168/3340 5%	6/22	1/9 11%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
30-day outpatient follow-up of clients not already connected	6/20-5/21	366/3340 11%	2022	0/10 0%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
7-day PES re-admission of clients not already connected	6/20-5/21	209/3340 6.3%	2022	5/10 50%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
# of clients who received in-person contact prior to discharge from PES	2021	57	2022	19	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
# and percent of clients who received in-person contact at PES who consent to receive help connecting to follow-up services	2021	15/57	2022	10/19 52.6%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The MHP does not plan to continue this PIP but plans to continue peer support strategies to increase engagement.

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	Additional interventions appear needed to improve the physical health outcomes identified.
General PIP Information	
MHP/DMC-ODS Name: Alameda MHP	
PIP Title: Care Coordination with Primary Care	
PIP Aim Statement: This PIP will examine whether implementing care coordination strategies for adult clients in "service team" case management programs will: - Reduce client psychiatric emergency services utilization - Improve client engagement with physical health services - Reduce avoidable physical emergency services utilization; and - Improve quantifiable physical health outcomes.	
Date Started: 01/2022	
Date Completed: n/a	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): This PIP will study adult clients enrolled in seven community based organization (CBO) "Service Team" programs. Service Teams provide outpatient mental health, psychiatric, and care management services to individuals living with serious mental health conditions. Beneficiaries in a high level of care are offered intensive services. Beneficiaries have often been in a psychiatric hospital, jail, or crisis stabilization, or have used crisis services in the last two years.
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): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1.) Adult service team staff will assess each beneficiary's engagement with a physical health provider and will work with case management and/or collateral services to increase engagement with primary care. 2.) Service team will use a monthly Client Primary Care Coordination report. 3.) Incorporation of Community Health Record into the primary care protocol.
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): 1.) Service team using a monthly Client Primary Care Coordination report. 2.) Incorporation of Community Health Record into the primary care protocol. Service team staff will access primary care and physical health information to use in treatment.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number and percent of clients who receive case management/collateral services to connect to primary care within the previous year	*3/21-2/22*	*22/1228* *1.79%*	*8/21-7/22*	*98/1184* *8.28%*	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Average number of case management/collateral services per client to connect to primary care within the previous year	*3/21-2/22*	*29/22* *1.32*	*8/21-7/22*	*233/98* *2.38*	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of clients who received psychiatric emergency services	*8/21-1/22*	*60/1228* *4.9%*	*11/21-4/22*	*55/1223* *4.5%*	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of clients who had no service within 90 days	*11/21-1/22*	*68/1228* *5.6%*	*7/21-6/22*	*622/1184* *52.5%*	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of clients with avoidable ER visits in the previous 6 months	*8/21-1/22*	*85/1228* *6.9%*	*1/22- 6/22*	*71/1184* *6.0%*	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of clients with a higher than normal BMI who reduced their body mass index (BMI) score by 10%	*No data*	*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 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
Percent of clients with a higher than normal HbA1c who reduced Hemoglobin A1c (HbA1c) score by 10%	*No data*	*n/a*			☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of clients with a higher than normal blood pressure who reduced their blood pressure measurement by 10%	*No data*	*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 part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

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

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

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

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

PIP Validation Information
EQRO recommendations for improvement of PIP: • The performance measures should be measured using a time frame post beginning of the intervention – after January 2022. While the timeframes used (e.g., August 2021 and after) capture a portion of the time period, measurements that include the period before the interventions limit assessing changes. • Evaluate the scope of the PIP and consider narrowing the health outcome goals to a segment of the target population.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, and PIP Validation Tool, are available on the CalEQRO website.

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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

ATTACHMENT F: PM DATA CY 2021 REFRESH

At the time of the MHP's review, the data set used for the PMs was incomplete for CY 2021. Across the state, most of the approved claims data November and December 2021 was not included in the original data used for this report.

CalEQRO obtained a refreshed data set for CY2021 in January 2023. The PM data with the refreshed data set follows in this Attachment.

BHC | Behavioral Health Concepts, Inc

Alameda MHP Performance Measures

REFRESHED

FY22-23

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	452,894	19,017	4.20%	$240,417,967	$12,642
CY 2020	416,104	18,874	4.54%	$202,757,541	$10,743
CY 2019	417,484	21,372	5.12%	$204,028,702	$9,547

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

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	37,960	723	1.90%	1.69%	1.96%
Ages 6-17	89,338	6,454	7.22%	5.40%	5.93%
Ages 18-20	21,208	1,196	5.64%	4.06%	4.41%

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 21-64	241,081	9,725	4.03%	4.24%	4.56%
Ages 65+	63,308	919	1.45%	1.69%	1.95%
Total	**452,894**	**19,017**	**4.20%**	**3.99%**	**4.34%**

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	3,198	16.82%
Cantonese	256	1.35%
Vietnamese	132	0.69%
Mandarin	54	0.28%
Tagalog	39	0.21%
Total Threshold Languages	**3,679**	**19.35%**
Threshold language source: Open Data per BHIN 20-070		

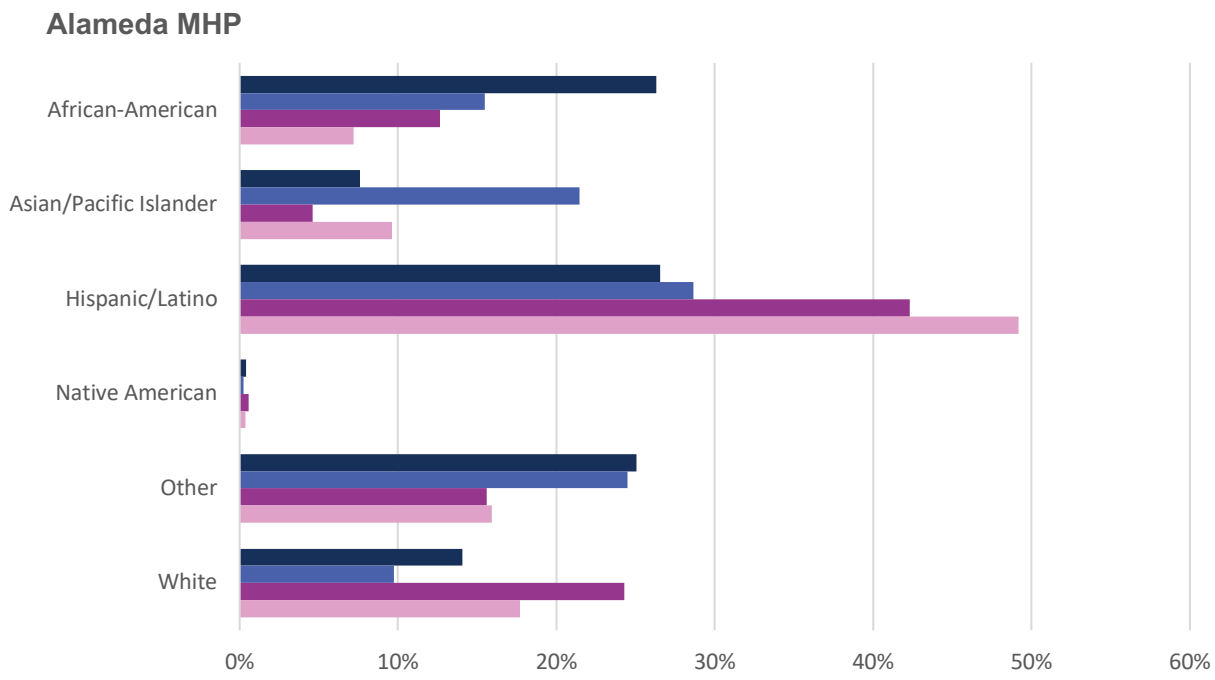
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	151,589	4,541	3.00%	$44,084,028	$9,708
Large	2,153,582	74,042	3.44%	$515,998,698	$6,969
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

Table 7: PR Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	70,026	5,005	7.15%	7.64%
Asian/Pacific Islander	97,142	1,444	1.49%	2.08%
Hispanic/Latino	129,678	5,051	3.90%	3.74%
Native American	1,016	80	7.87%	6.33%
Other	110,895	4,761	4.29%	4.25%
White	44,140	2,676	6.06%	5.96%
Total	**452,897**	**19,017**	**4.20%**	**4.34%**

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	14%	25%	0%	27%	8%	26%
MHP % Eligible	10%	24%	0%	29%	21%	15%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

Figure 2: MHP PR by Race/Ethnicity CY 2019-21

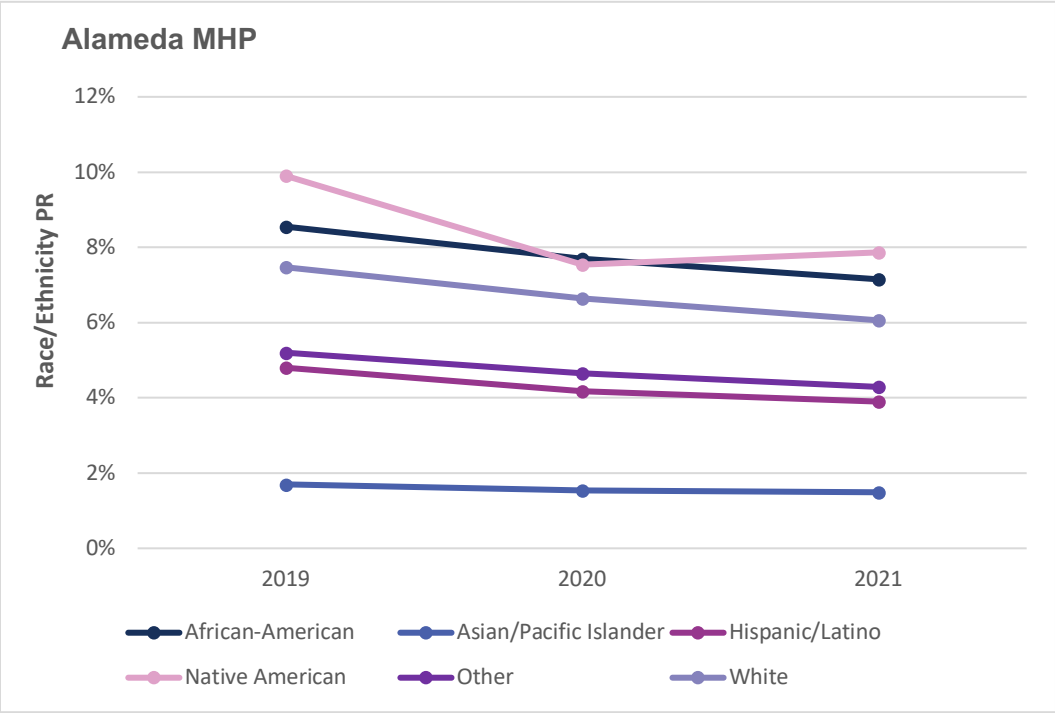


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

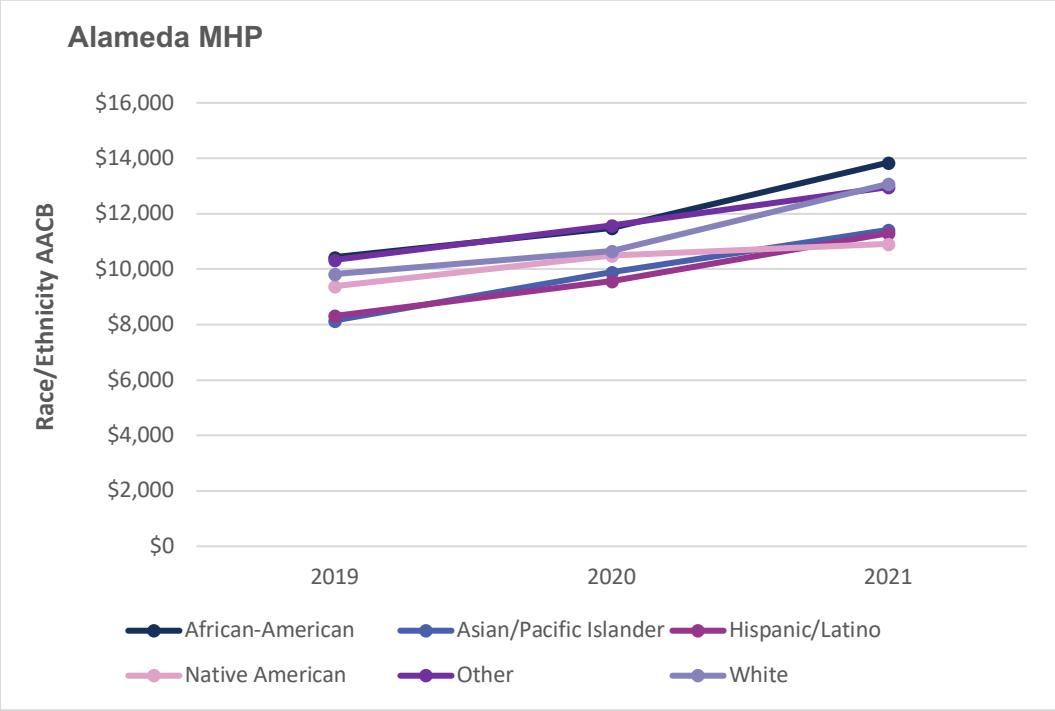
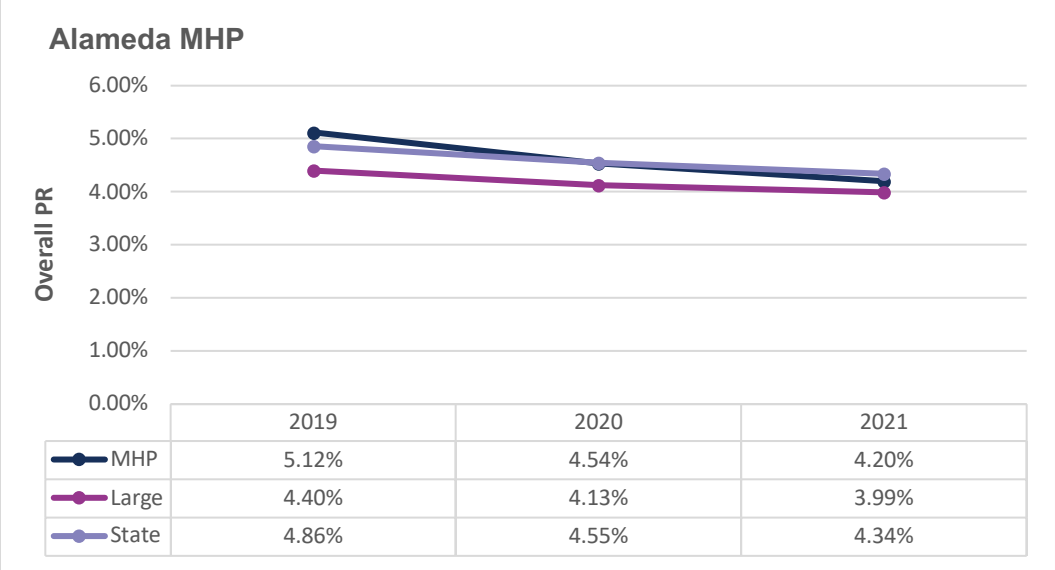
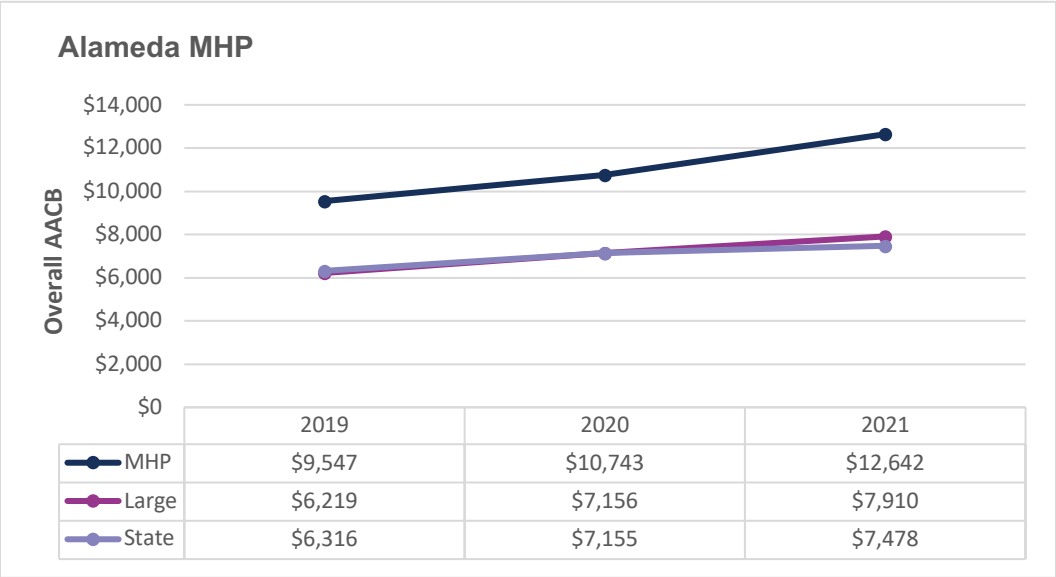


Figure 4: Overall PR CY 2019-21



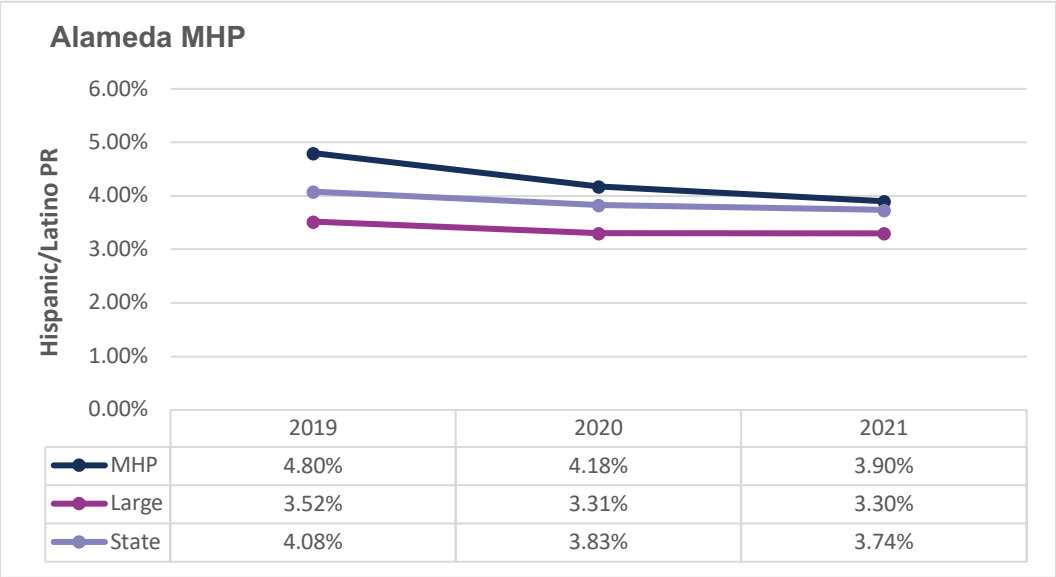
	2019	2020	2021
MHP	5.12%	4.54%	4.20%
Large	4.40%	4.13%	3.99%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



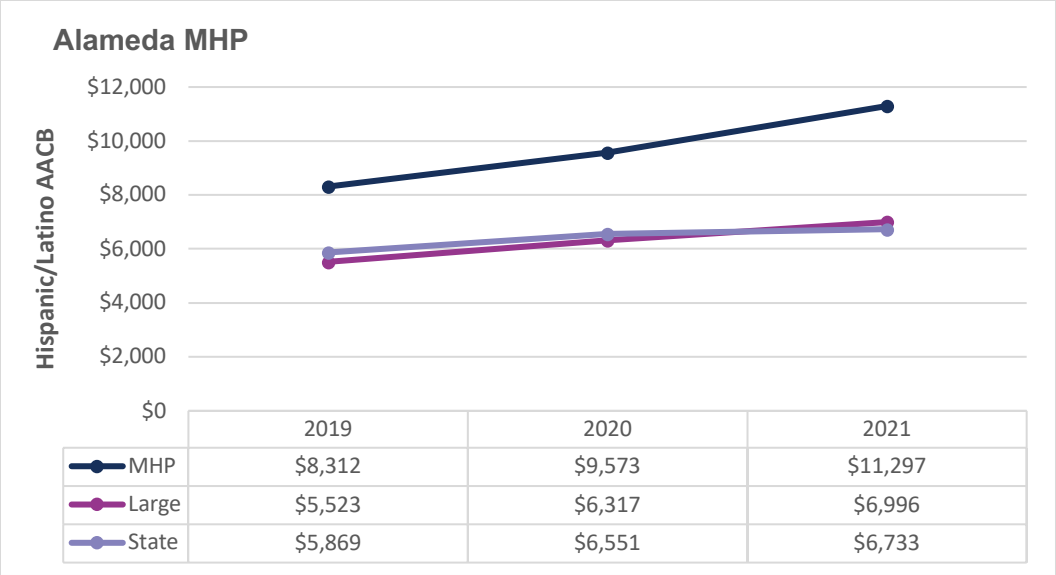
	2019	2020	2021
MHP	$9,547	$10,743	$12,642
Large	$6,219	$7,156	$7,910
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21



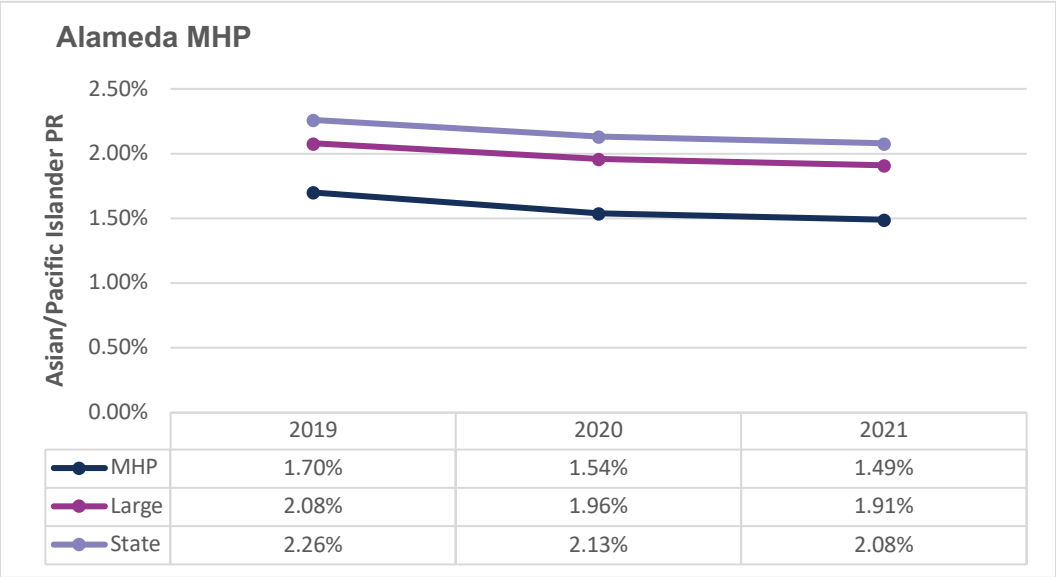
	2019	2020	2021
MHP	4.80%	4.18%	3.90%
Large	3.52%	3.31%	3.30%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21



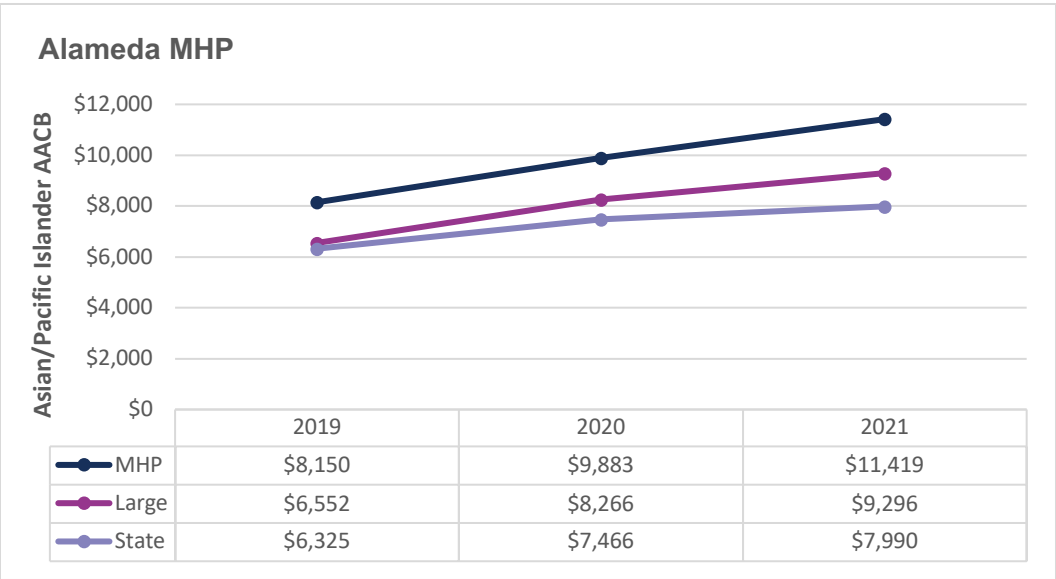
	2019	2020	2021
MHP	$8,312	$9,573	$11,297
Large	$5,523	$6,317	$6,996
State	$5,869	$6,551	$6,733

Figure 8: Asian/Pacific Islander PR CY 2019-21



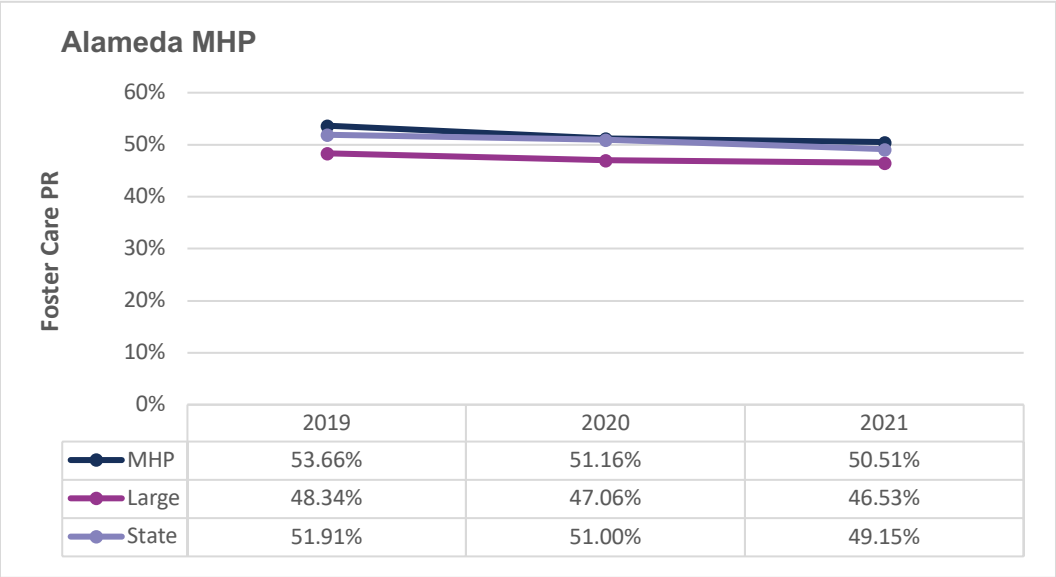
	2019	2020	2021
MHP	1.70%	1.54%	1.49%
Large	2.08%	1.96%	1.91%
State	2.26%	2.13%	2.08%

Figure 9: Asian/Pacific Islander AACB CY 2019-2021



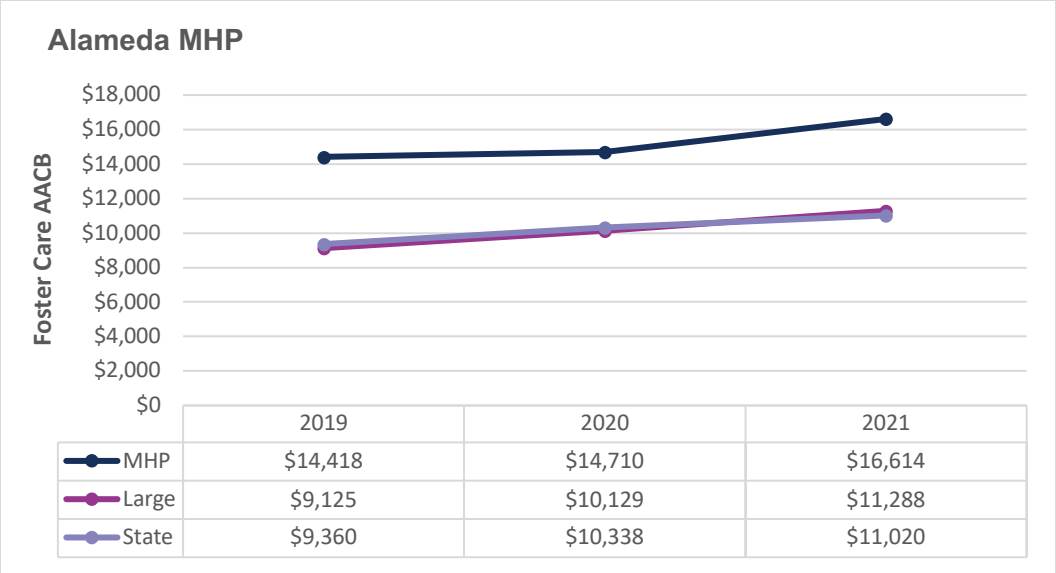
	2019	2020	2021
MHP	$8,150	$9,883	$11,419
Large	$6,552	$8,266	$9,296
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	53.66%	51.16%	50.51%
Large	48.34%	47.06%	46.53%
State	51.91%	51.00%	49.15%

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$14,418	$14,710	$16,614
Large	$9,125	$10,129	$11,288
State	$9,360	$10,338	$11,020

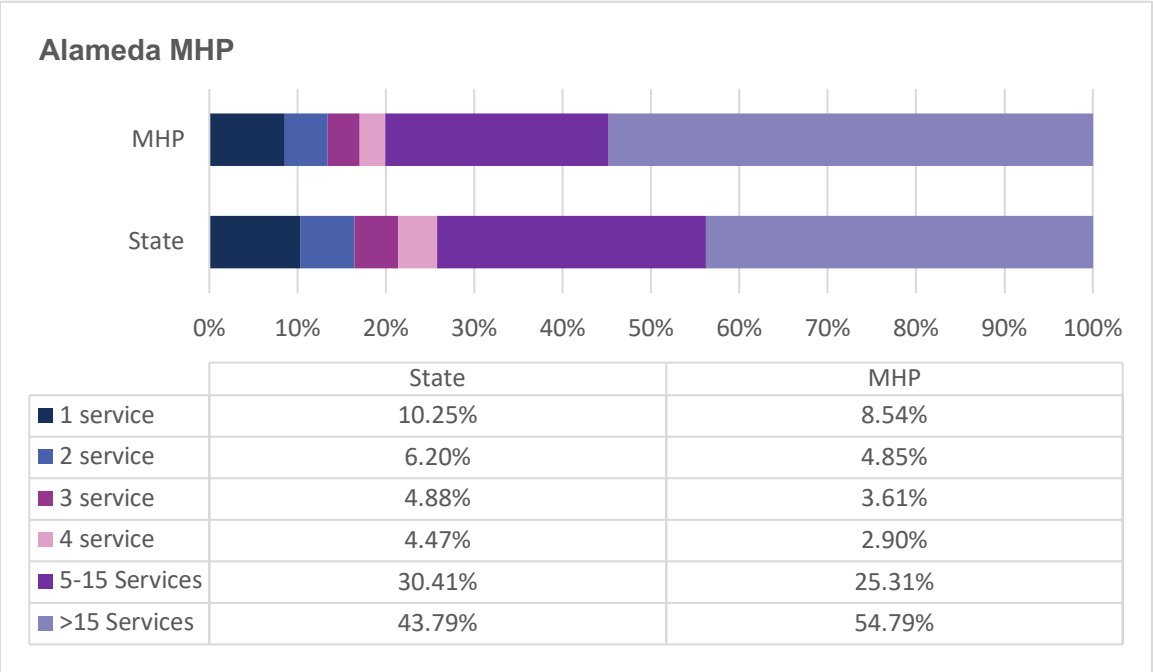
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 11,841				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	1,787	15.1%	10	5	11.6%	16	8
Inpatient Admin	567	4.8%	12	6	0.5%	23	7
Psychiatric Health Facility	<11	-	11	7	1.3%	15	7
Residential	80	0.7%	86	60	0.4%	107	79
Crisis Residential	625	5.3%	14	12	2.2%	21	14
Per Minute Services							
Crisis Stabilization	2,987	25.2%	2,044	1,200	13.0%	1,546	1,200
Crisis Intervention	1,163	9.8%	194	146	12.8%	248	150
Medication Support	6,572	55.5%	413	293	60.1%	311	204
Mental Health Services	7,442	62.8%	1,135	505	65.1%	868	353
Targeted Case Management	5,644	47.7%	491	127	36.5%	434	137

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

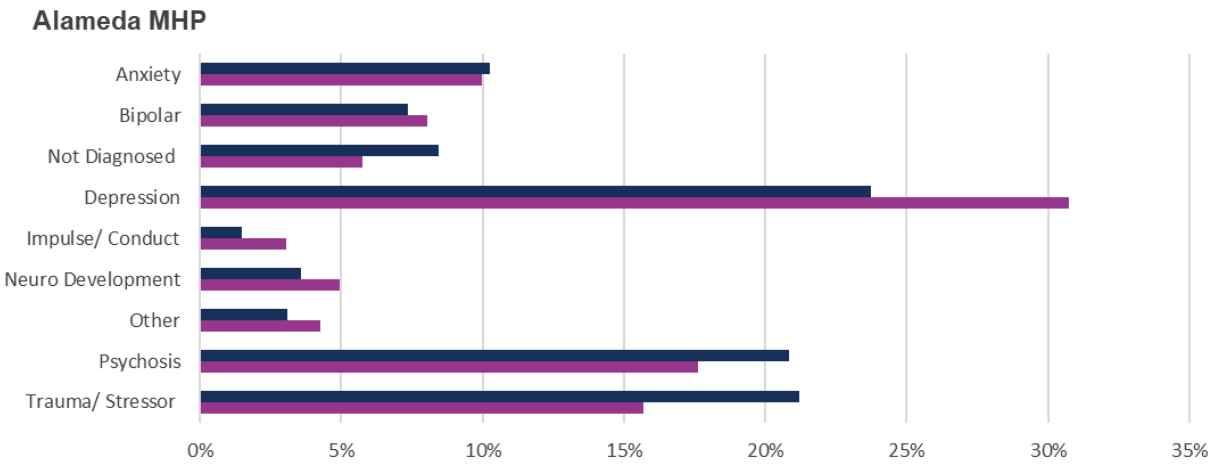
Service Category	MHP N = 918				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	43	4.7%	10	9	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	<11	-	8	6	0.2%	22	8
Residential	<11	-	274	274	0.0%	185	194
Crisis Residential	<11	-	13	12	0.1%	18	13
Full Day Intensive	<11	-	66	66	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	33	3.6%	1,615	1,200	3.1%	1,404	1,200
Crisis Intervention	59	6.4%	362	187	7.5%	406	199
Medication Support	189	20.6%	356	259	28.2%	396	273
TBS	32	3.5%	2,567	1,953	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	221	24.1%	1,132	522	40.2%	1,354	473
Intensive Home Based Services	57	6.2%	1,617	965	20.4%	2,260	1,275
Katie-A-Like	<11	-	1,058	1,058	0.2%	640	148
Mental Health Services	894	97.4%	3,108	1,896	96.3%	1,854	1,108
Targeted Case Management	352	38.3%	344	159	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	8.54%
2 service	6.20%	4.85%
3 service	4.88%	3.61%
4 service	4.47%	2.90%
5-15 Services	30.41%	25.31%
>15 Services	43.79%	54.79%

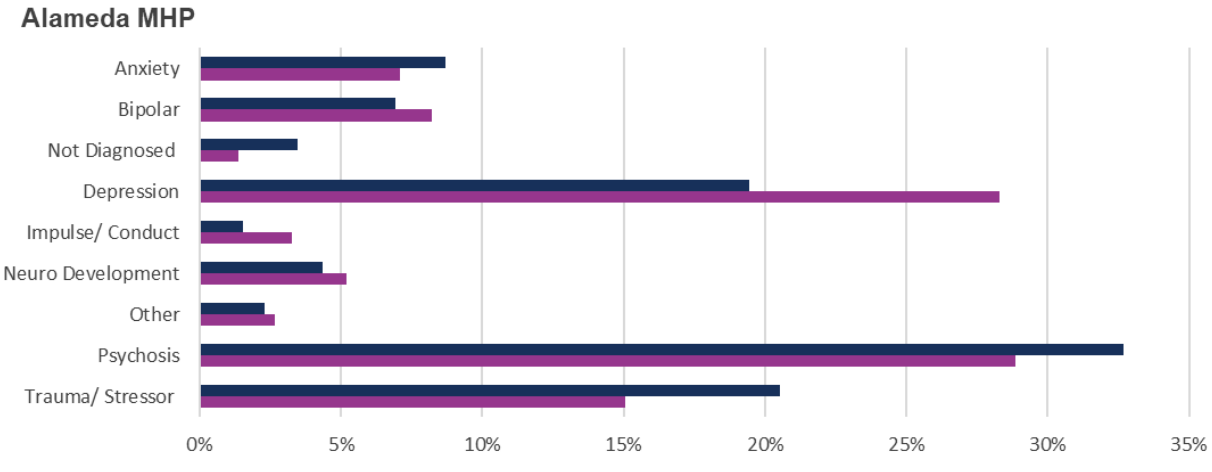
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	21%	21%	3%	4%	1%	24%	8%	7%	10%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Percent Beneficiaries

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	21%	33%	2%	4%	2%	19%	3%	7%	9%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Percent Claims

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	2,038	5,529	7.63	8.86	$19,612	$12,052	$39,969,618
CY 2020	1,911	6,047	6.37	8.68	$14,284	$11,814	$27,297,370
CY 2019	1,991	6,674	6.46	7.80	$14,698	$10,535	$29,263,228

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21

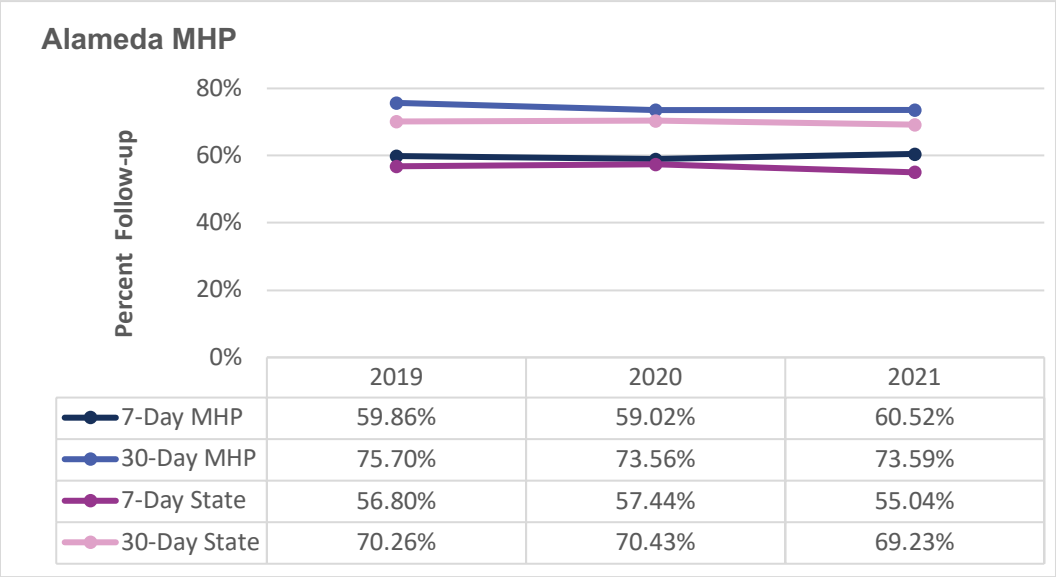


Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21

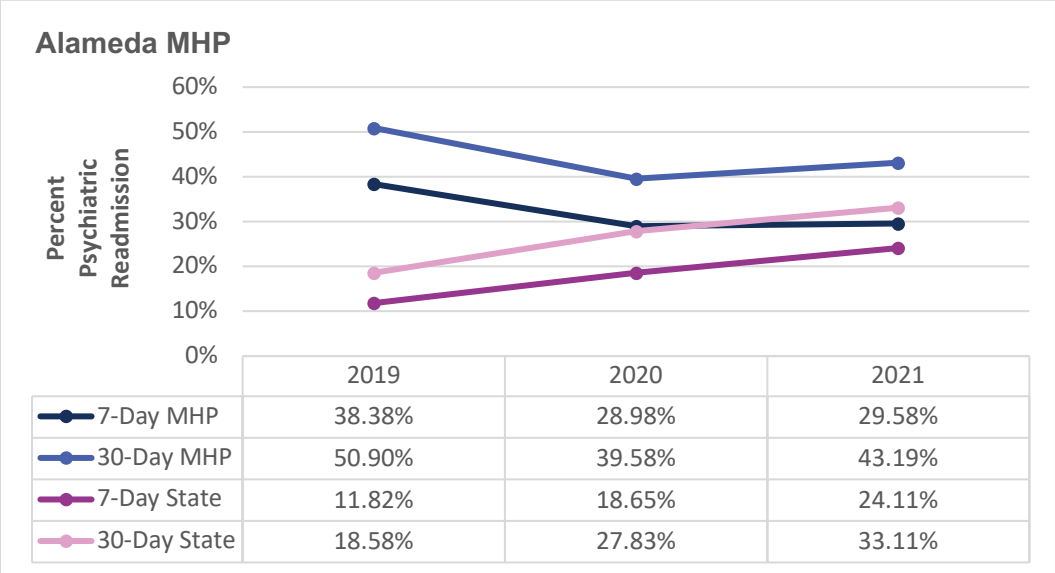


Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	1,955	10.28%	48.61%	$116,868,008	$59,779	$47,370
	CY 2020	1,554	8.23%	42.12%	$85,398,183	$54,954	$46,250
	CY 2019	1,454	6.80%	39.39%	$80,358,031	$55,267	$45,106

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approv	Total Approved Claims	Average Approved Claims	Median Approved Claims

			ed Claims		per Beneficiary	per Beneficiary
Medium Cost ($20K to $30K)	1,369	7.20%	13.91%	$33,439,144	$24,426	$24,015
Low Cost (Less than $20K)	15,693	82.52%	37.48%	$90,110,815	$5,742	$4,062

Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021

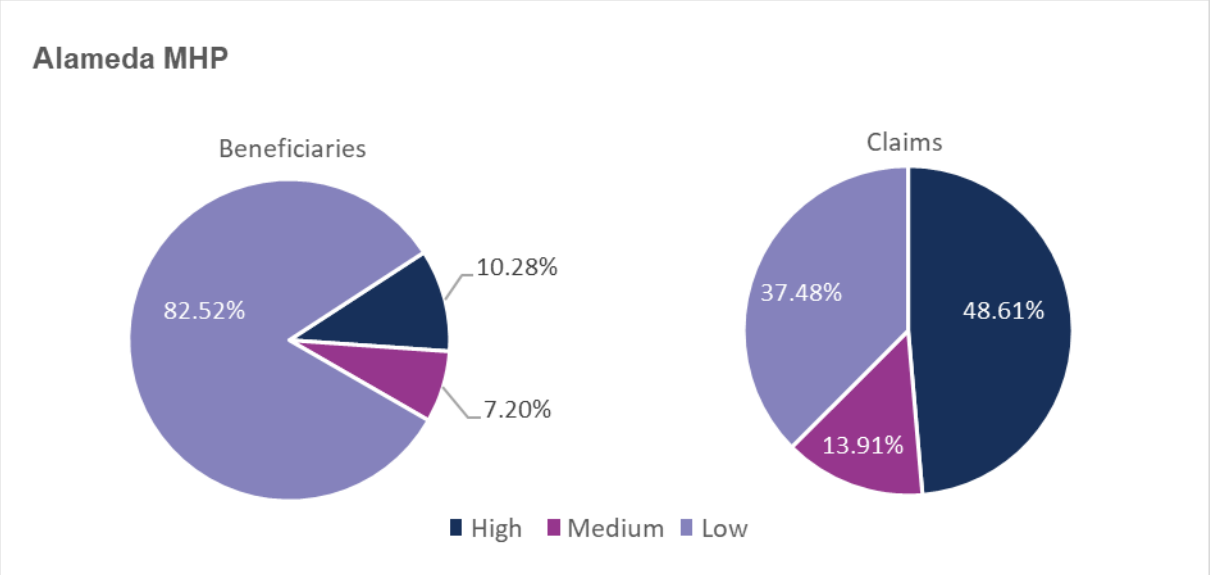


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	57,566	$19,084,435	$10,234	0.05%	$18,153,692
Feb	56,086	$18,540,765	$16,028	0.09%	$17,545,413
Mar	65,088	$22,906,208	$85,788	0.37%	$21,619,365
April	57,222	$21,299,834	$217,256	1.02%	$19,795,208
May	53,651	$20,274,581	$50,326	0.25%	$19,107,300
June	50,198	$19,921,629	$60,062	0.30%	$18,698,992
July	46,315	$19,982,516	$260,533	1.30%	$18,655,281
Aug	49,342	$20,803,766	$152,957	0.74%	$19,586,948
Sept	51,800	$21,353,293	$126,064	0.59%	$20,056,909
Oct	53,430	$22,156,306	$191,378	0.86%	$20,796,515
Nov	50,355	$21,106,098	$263,571	1.25%	$19,829,304
Dec	46,745	$20,524,560	$610,886	2.98%	$19,316,388
Total	**637,798**	**$247,953,991**	**$2,045,083**	**0.82%**	**$233,161,315**

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other healthcare coverage must be billed before submission of claim	856	$959,371	46.91%
Medicare Part B must be billed before submission of claim	924	$389,183	19.03%
Beneficiary not eligible or non-covered charges	591	$371,094	18.15%
Late claim	457	$242,830	11.87%
Service line is a duplicate and a repeat service procedure code modifier not present	169	$57,963	2.83%
Other	35	$15,812	0.77%
Deactivated NPI	28	$4,470	0.22%
Service location NPI issue	26	$4,360	0.21%
Total Denied Claims	**3,086**	**$2,045,083**	**100.00%**
Overall Denied Claims Rate	**0.82%**		
Statewide Overall Denied Claims Rate	**1.43%**		