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

ALPINE FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 8, 2022

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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, "Alpine" may be used to identify the Alpine County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — September 8, 2022

MHP Size — Small-rural

MHP Region — Central

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 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	2	2	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	1	4	1
Quality of Care	10	0	3	7
Information Systems (IS)	6	4	1	1
TOTAL	**26**	**9**	**8**	**9**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
"Beneficiary Enrollment Issues"	Clinical	n/a	planning	no
"Native American Support Group"	Non-Clinical	n/a	planning	no

Table D: Summary of Consumer/Family Member (CFM) Focus Groups

Focus Group #	Focus Group Type	# of Participants
0	No focus groups held. See Validation of Beneficiary Perceptions of Care section for details.	

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP did not have denied claims in CY 2021.
- The MHP is within the 75 percentile or higher with timeliness ratings.
- The MHP continues to seek tribal employees to staff one of their Wellness Centers.
- Given the significant loss of staff, the remaining employees at the MHP are both active and dedicated to Cal Aim expectations and beneficiary services.
- The MHP provides a monthly Newsletter that is informative to MHP sponsored activities throughout the county.

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

- Due to significant staff turnover, current Administration staff lacks the knowledge of resources such as inclusion in the small county network through the California Behavioral Health Directors Association (CBHDA).
- The MHP struggles to find applicants to fill clinical positions. Utilizing telehealth for clinical services could offer expanded clinical opportunities.
- The MHP lacks case managers or peer staff to support the beneficiaries, wellness center, and current staff activities.
- The shortage of staff prevented the MHP from adequately preparing for CalEQRO activities.
- The MHP does not fully utilize the contracts they have to assist with data collection and reporting, quality improvement activities, formulation of PIPs and timeliness reporting.
- There is a perceived lack of bi-directional communication with remaining staff, which may impact the MHPs ability to retain current staff.

Recommendations for improvement based upon this review include:

- Engage the Board of Supervisors (BOS)/County Administrative staff to provide support for the MHP to leverage existing IT, neighboring county, and CBHDA resources.
- Investigate expanded Telehealth to support clinical services.
- Actively recruit a peer staff member to assist with case management, front desk assistance, staff the Wellness Center, and provide outreach to beneficiaries.
- Comply with all CalEQRO protocols, by uploading two active PIPs, data tracking and trending, holding a minimum of one CFM focus group and the upload of all documents in a timely manner.
- Engage in contract understanding to acquire assistance and expertise with Quality, Access, Timeliness, Information Systems (IS) and PIPs documentation and requirements.
- Engage in bi-directional conversations with staff to open dialogue to increase job satisfaction and retention.

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 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 205 (WIC 14197.05 o).

This report presents the FY 2022-23 findings of the EQR for Alpine County MHP by BHC, conducted as a virtual review on September 8, 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 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) – also listed in Attachment E PMs. 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 network adequacy (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/after the Coronavirus Disease 2019 (COVID-19) pandemic, the Tamarack and Caldor fires, and record snow levels which impeded the ability to conduct business within the county. The MHP has been deeply impacted by the lack of staffing. After the fires the county population decreased, housing assistance does not exist, there are no hospitals, and no grocery stores. Currently the MHP has 11 of their 17 allocated positions vacant. Staff that remains are then placed into unfamiliar positions, with little if any transfer of knowledge. The MHP remains focused on requirements of California Advancing and Innovating Medi-Cal (Cal AIM) but is unable to perform other regulatory requirements. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review however there were several challenges. The MHP did not have staff with the knowledge to complete required review documents, the MHP did not hold a Consumer Family Member Focus group for the second year, and did not perform PIP requirements for a third year. (See Attachment E)

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 is experiencing a 65 percent vacancy rate. There is an interim Director and an interim Clinical Director with the remaining leadership positions vacant. The Quality Management (QM) positions are all vacant, and one employee is covering some QM functions as necessary.
- Conversion to a new EHR system, Credible, is currently in process with a scheduled go live data of January 1, 2023.
- The MHP implemented a comprehensive, community based strategic plan for suicide prevention.
- The MHP continues outreach and engagement efforts with the tribal community.
- The MHP is investigating options to expand services to the isolated community of Bear Valley.

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: Every effort should be made to recruit new employees including hiring a recruitment consultant if internal efforts are unsuccessful. Continue efforts to expand the workforce through increased use of media for recruitment and streamlined flexibility in the hiring processes. Consider utilizing a hiring consultant.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP continued to employment advertisement to expand the application pool.
- The MHP hired a staff member who did not complete the probationary period.
- There is a decline in population and lack of applicants interested in moving to the remote county location.

Recommendation 2: Update the county behavioral health website so that the crisis telephone number and instructions for access to urgent services are more prominent.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP website has been updated to display the crisis phone number and information on accessing urgent services are on the opening page and are displayed in red font.
- CalEQRO suggested adding a banner with the local crisis number or 988 to the website.

Recommendation 3: Consult with other small rural counties to identify methods to increase engagement of beneficiaries; develop strategies and begin implementation.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP stated the interim director is involved with CBHDA. The MHP did not know if the small county committee was active and CalEQRO encouraged the MHP to seek out CBHDA resources and assistance.
- The MHP contracts with El Dorado County for in-patient services, and Sierra County for clinical supervision.

Recommendation 4: Implement and maintain two active and ongoing performance improvement projects (PIPs) as required per Title 42, CFR, §438.330.

(This recommendation is a carry-over from FY 2020-21.)

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP reported the reduction in staff capacity prevented the ability to move the current PIPs forward during the review period.
- The MHP was encouraged to create PIPs that could be achieved with the existing staff and obtainable goals for improvement.
- This recommendation is carried over to an expanded recommendation.

Recommendation 5: Work with a consultant to complete the Rural Utilities Service (RUS) grant application to improve network connectivity to further support services in remote and frontier communities.

(This recommendation is a carry-over from FY 2020-21.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The need for network connectivity does not fall solely on the MHP. As a countywide issue of concern, the BOS is currently looking at ways to enhance services by installing a tower to offer expanded countywide services. The MHP must defer this activity to the BOS for continued solutions.

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 county operated providers in the MHP, except for services delivered by Kingsview (KV) contract psychiatrists. Regardless of payment source, approximately 100 percent of services were delivered by county operated/staffed clinics and sites. Overall, approximately 58.44 percent of services provided are claimed to Medi-Cal.

The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The MHP has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week that is operated by county staff. Beneficiaries may request services through the Access Line as well as through the following system entry points: calling Access, walk ins or by referral. Referrals are provided through Barton Hospital (5150s), Carson Counseling Center (substance use disorder [SUD] services and medication assisted treatment), Child Protective Services and the combined elementary and junior high school. Law enforcement will bring 5150 individuals to the MH office during the day and to Barton Hospital after hours. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services.

In addition to clinic-based MH services, the MHP provides psychiatry services via telehealth video to youth and/or adults. In FY 2021-22, the MHP reports having provided telehealth services to ≤11 for all categories adult, youth, and older adult beneficiaries across county operated site. Among those served, no beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

An adequate network of providers is necessary in order for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC 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 below.

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

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

Table 1A: MHP Alternative Access Standards, FY 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 out-of-network (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 set up a separate room within the clinic to provide private telehealth services. The MHP is encouraged to investigate additional clinical services through telehealth.
- The MHP hired a Native American staff member specifically to work within the tribal Wellness Center and provide outreach services to tribal beneficiaries.
- The MHP provides transportation through County operated Dial-a-Ride.

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 Penetration Rate (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 served (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 (AAC) amount of $6,496. Using PR as an indicator of access for the MHP, the PR for CY 2021 is 8.70 percent, and an AAC of $3,183 both reflective of a third year with a downward trend.

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	322	28	8.70%	$89,129	$3,183
CY 2020	295	41	13.90%	$133,910	$3,266
CY 2019	316	47	14.87%	$217,814	$4,634

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	39	≤11	-	1.45%	1.59%
Ages 6-17	58	≤11	-	7.65%	5.20%
Ages 18-20	14	≤11	-	7.07%	4.02%
Ages 21-64	177	14	7.91%	7.15%	4.07%
Ages 65+	36	≤11	-	3.18%	1.77%
TOTAL	**322**	**28**	**8.70%**	**6.29%**	**3.85%**

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
No Threshold	28	100.00%
Threshold language source: Open Data per BHIN 20-070		

Although the overall number of beneficiaries in Alpine County increased, the number of beneficiaries served decreased by approximately 32 percent from the PY.

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	103	≤11	-	$34,642	-
Small-Rural	35,376	2,077	5.87%	$9,182,717	$4,421
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

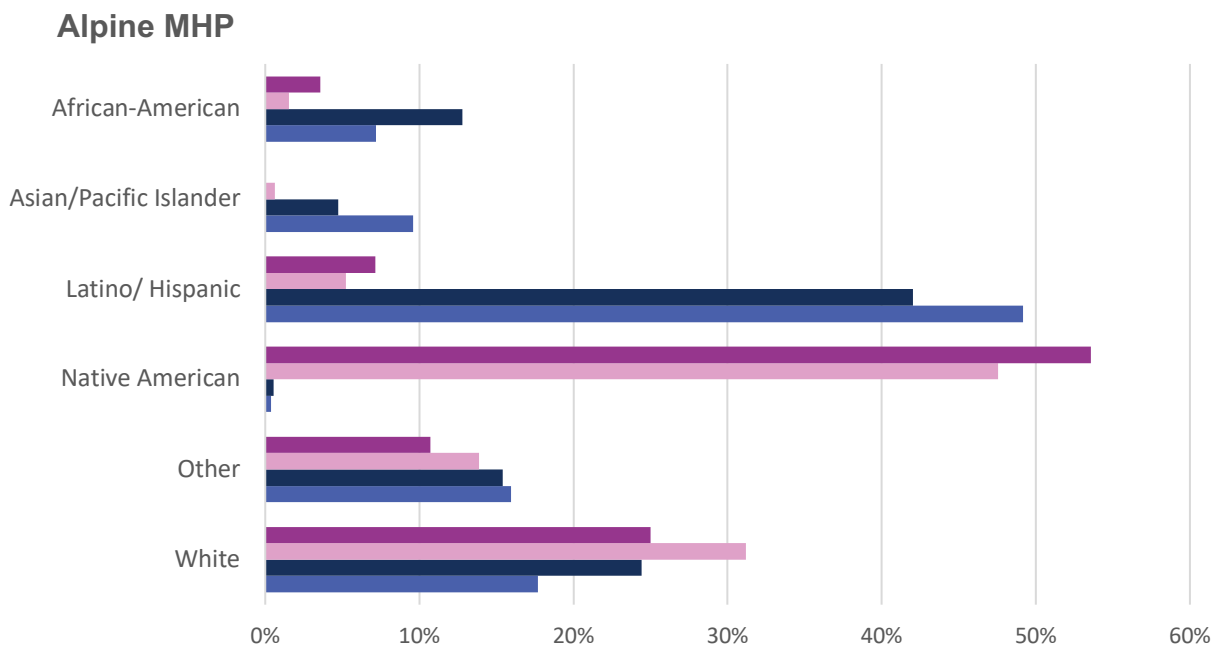
For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries. The MHP's PR for ACA beneficiaries is lower than non-ACA, however the AACB is higher for ACA.

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

Race/Ethnicity	# MHP Served	# MHP Eligibles	PR MHP	PR State
African-American	≤ 11	-	-	6.83%
Asian/Pacific Islander	≤ 11	-	-	1.90%
Latino/Hispanic	≤ 11	-	-	3.29%
Native American	15	154	9.74%	5.58%
Other	≤ 11	-	-	3.72%
White	≤ 11	-	-	5.32%
Total	**28**	**324**	**8.64%**	**3.85%**

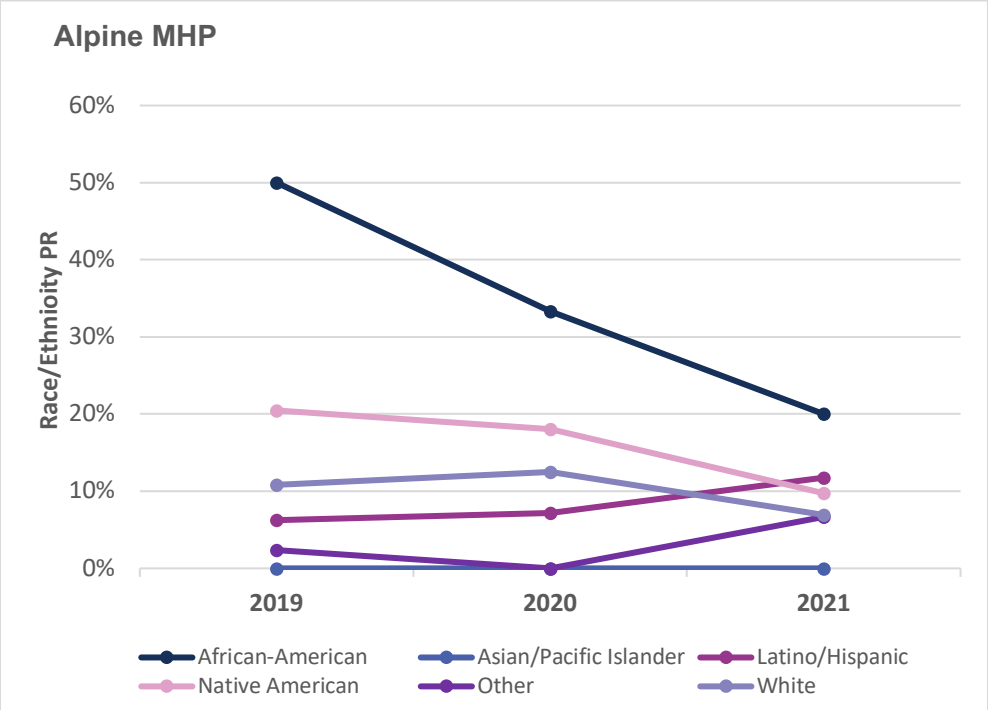
The MHP PRs are higher than the State numbers which may be due to the beneficiary population size in the MHP. A single beneficiary can impact the PR substantially.

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



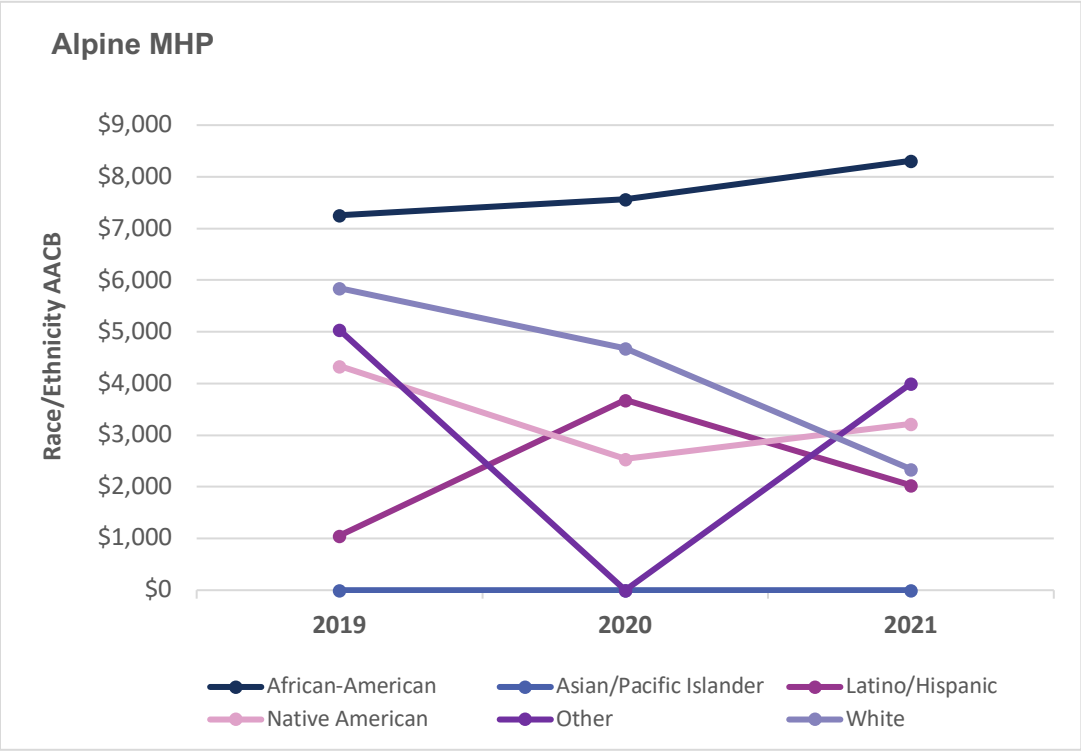
	White	Other	Native American	Latino/ Hispanic	Asian/Pacific Islander	African-American
MHP % Served	25%	11%	54%	7%	0%	4%
MHP % Eligibles	31%	14%	48%	5%	1%	2%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

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



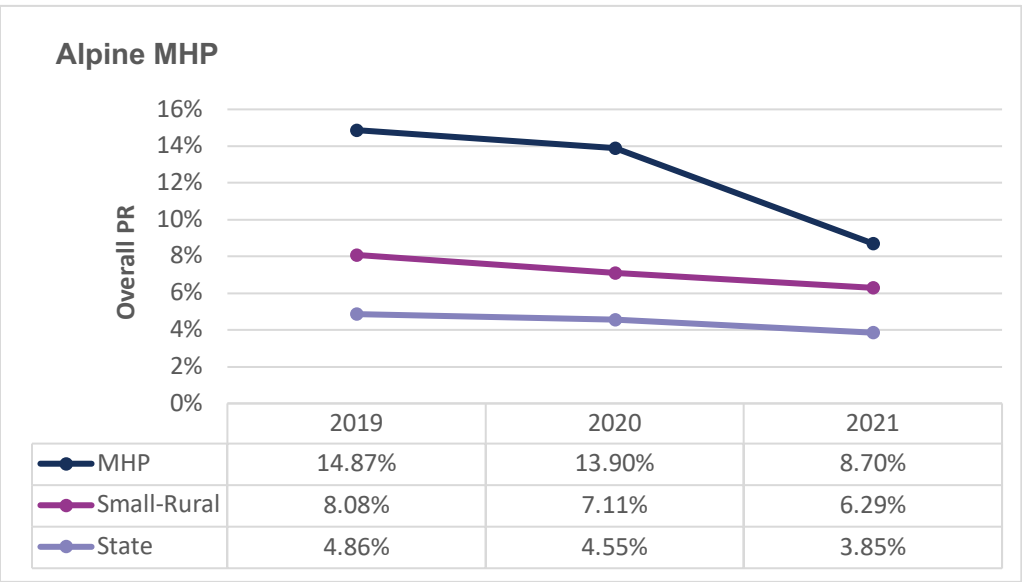
The MHP's PRs for White and Native American are above the State totals; there has been a substantial decline in African American PR in the last three years, and there have been slight decreases in Native American and White PR and increases in the Latino/Hispanic and Other populations.

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



In CY 2021 there is a significant variance in AACB from approximately $2,000 for the Latino/Hispanic community to over $8,000 for the African/American community in 2021.

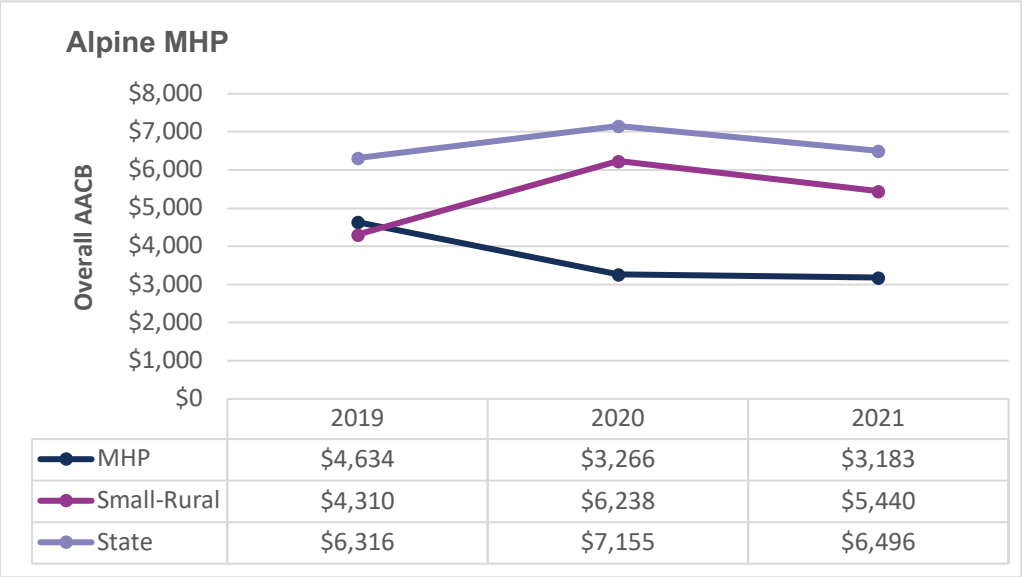
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	14.87%	13.90%	8.70%
Small-Rural	8.08%	7.11%	6.29%
State	4.86%	4.55%	3.85%

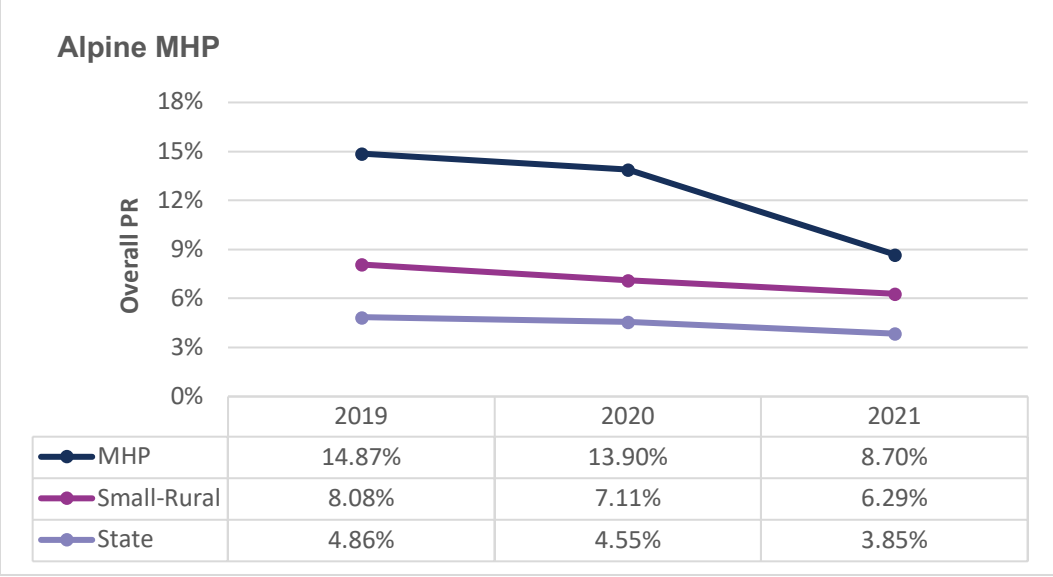
The MHP's PRs have been higher than the Small-Rural and State rates for the three years reflected in the graph. PRs for all sectors are reflecting a downward trend.

Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,634	$3,266	$3,183
Small-Rural	$4,310	$6,238	$5,440
State	$6,316	$7,155	$6,496

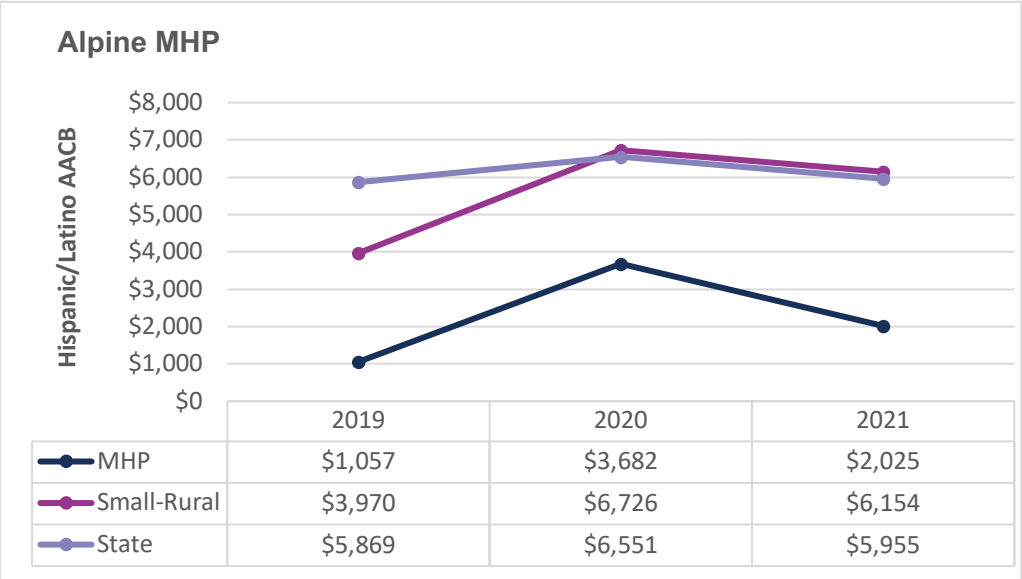
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	14.87%	13.90%	8.70%
Small-Rural	8.08%	7.11%	6.29%
State	4.86%	4.55%	3.85%

The MHP's PR for the Hispanic/Latino community reflect an increase in the three-year period and is higher than both Small-Rural and State rates. (MHP percentages were rounded to protect the privacy of relatively small numbers:)

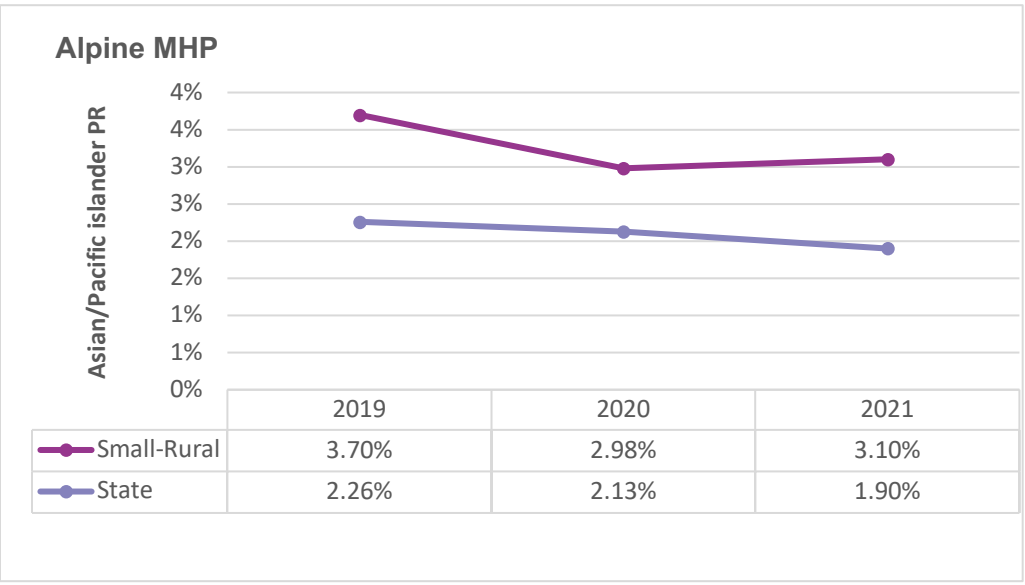
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$1,057	$3,682	$2,025
Small-Rural	$3,970	$6,726	$6,154
State	$5,869	$6,551	$5,955

The Hispanic/Latino AACB for the MHP is significantly lower than the other sectors.

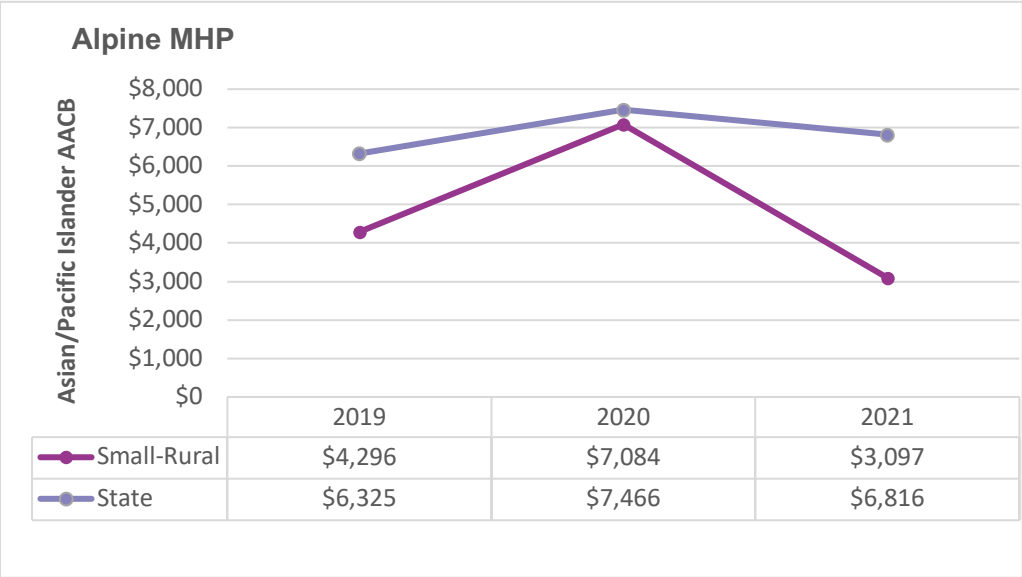
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
Small-Rural	3.70%	2.98%	3.10%
State	2.26%	2.13%	1.90%

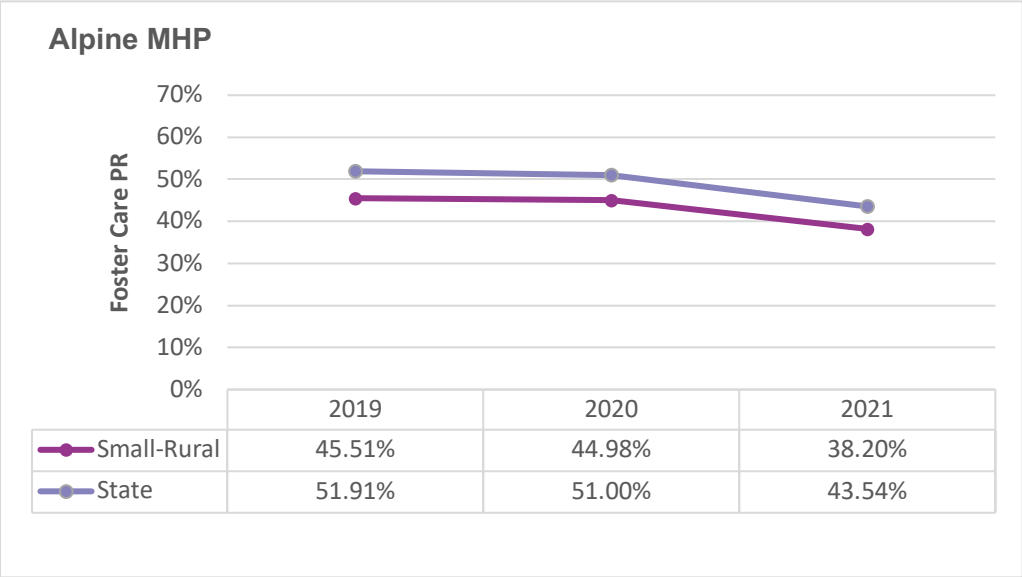
MHP data for API beneficiaries was fewer than 12 and so the line representing MHP data is removed for HIPAA privacy protection.

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



	2019	2020	2021
Small-Rural	$4,296	$7,084	$3,097
State	$6,325	$7,466	$6,816

Figure 10: Foster Care PR CY 2019-21

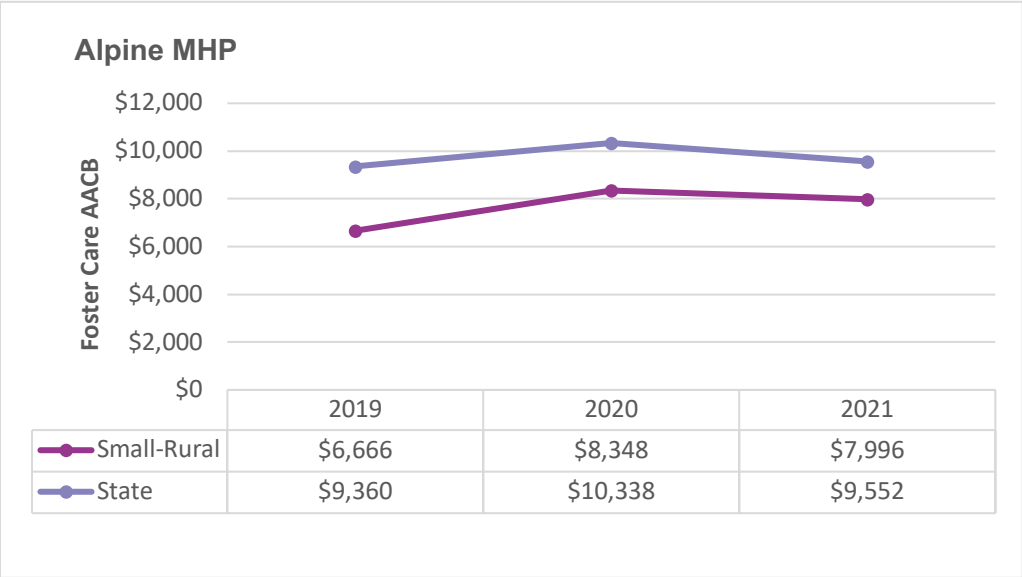


	2019	2020	2021
Small-Rural	45.51%	44.98%	38.20%
State	51.91%	51.00%	43.54%

MHP data for FC beneficiaries was fewer than 12 and so the line representing MHP data is removed for HIPAA privacy protection.

It is noted that FC youth in the sovereign Native American Community and served by the MHP do not appear in the Medi-Cal claims.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
Small-Rural	$6,666	$8,348	$7,996
State	$9,360	$10,338	$9,552

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 20				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	≤11	-	-	-	10.8%	14	8
Inpatient Admin	≤11	-	-	-	0.4%	16	7
Psychiatric Health Facility	≤11	-	-	-	1.0%	16	8
Residential	≤11	-	-	-	0.3%	93	73
Crisis Residential	≤11	-	-	-	1.9%	20	14
Per Minute Services							
Crisis Stabilization	≤11	-	-	-	9.7%	1,463	1,200
Crisis Intervention	≤11	-	-	-	11.1%	240	150
Medication Support	≤11	-	-	-	60.4%	255	165
Mental Health Services	15	75.0%	416	245	62.9%	763	334
Targeted Case Management	≤11	-	-	-	35.7%	377	128

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

Service Category	MHP N = 0				Statewide N=33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	≤11	-	-	-	4.5%	13	8
Inpatient Admin	≤11	-	-	-	0.0%	6	4
Psychiatric Health Facility	≤11	-	-	-	≤11	6	4
Residential	≤11	-	-	-	0.2%	25	9
Crisis Residential	≤11	-	-	-	≤11	140	140
Full Day Intensive	≤11	-	-	-	0.2%	452	360
Full Day Rehab	≤11	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	≤11	-	-	-	2.3%	1,354	1,200
Crisis Intervention	≤11	-	-	-	6.7%	388	195
Medication Support	≤11	-	-	-	28.5%	338	232
TBS	≤11	-	-	-	3.8%	3,648	2,095
Therapeutic FC	≤11	-	-	-	0.1%	1,056	585
IHBS	≤11	-	-	-	38.6%	1,193	445
ICC	≤11	-	-	-	19.9%	1,996	1,146
Katie-A-Like	≤11	-	-	-	0.2%	837	435
Mental Health Services	≤11	-	-	-	95.7%	1,583	987
Case Management	≤11	-	-	-	32.7%	308	114

IMPACT OF ACCESS FINDINGS

- The MHP has had a decline in beneficiary population due to the impact of the recent fires. Beneficiaries lost their homes and there are no housing options with the county forcing beneficiaries to move to other locations. This has significantly impacted the penetration rate within the MHP.
- The MHP continues to engage the tribal community and operates the Wellness Center on tribal land to increase access to services for this priority population.

- There is no MCP within the county and the MHP works to consider how to achieve CalAIM data interoperability with neighboring MCPs that share beneficiaries.

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	Met
2d	Follow-Up Appointments After Psychiatric Hospitalization	Partially Met
2e	Psychiatric Readmission Rates	Not Met
2f	No-Shows/Cancellations	Partially Met

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

- The MHP sets and meets minimum standards 75 percent or higher for timeliness in First Non-Urgent Services, First Delivered Service, First Non-Urgent Psychiatry, and Urgent Offered Appointment.

- FC youth are typically under the Indian Child Welfare Act and not reported by Medi-Cal. The MHP did not serve any FC youth as reported to Medi-Cal.
- The MHP tracks but does not trend any performance metric for youth or adult.
- The MHP is encouraged to engage contracted services such as IDEA Consulting to assist in trending data and identifying performance improvement activities.

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 21-22. This data represented county-operated services. As noted above, the MHP does not report FC services, does not trend data, or initiate performance improvement activities.

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 below 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	4.8 Days	10 Business Days*	98.4%
First Non-Urgent Service Rendered	9.6 Days	10 Business Days	76%
First Non-Urgent Psychiatry Appointment Offered	8.8 Days	15 Business Days*	100%
First Non-Urgent Psychiatry Service Rendered	15.8 Days	15 Business Days	66.7%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	1 Hour	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization	4.5 Days	7 Days**	100%
No-Show Rate – Psychiatry	7%	10%**	n/a
No-Show Rate – Clinicians	0%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 22-033 ** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: 07/01/21 to 06/30/22 on MHP ATA.			

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

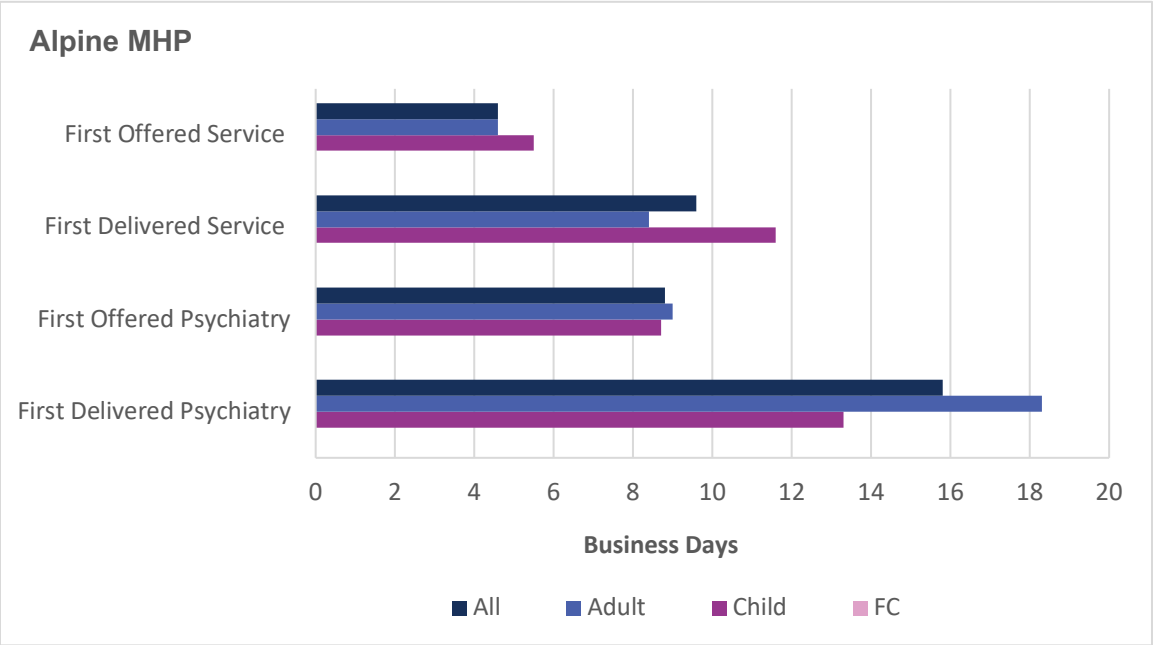


Figure 13: Wait Times for Urgent Services

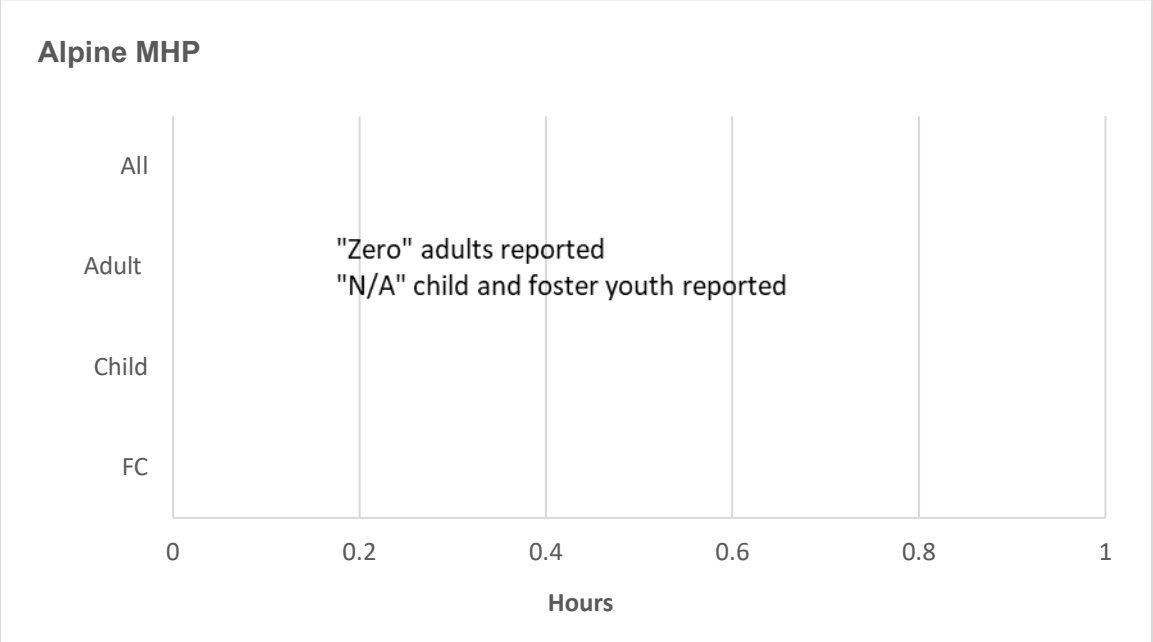
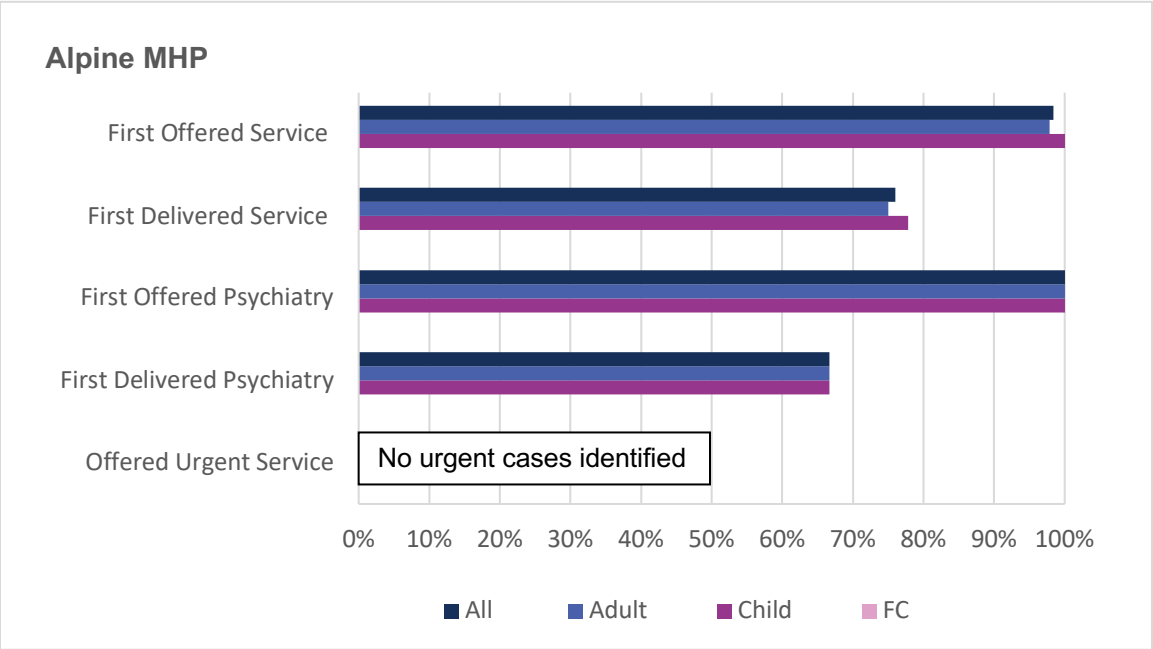


Figure 14: Percent of Services that Met Timeliness Standards



- 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, only clients who were offered a service are counted towards the percent that met the standard.
- 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 crisis calls answered immediately. There were reportedly ≤ 11 of urgent service requests with a reported actual wait time to services for the overall population at ≤ one-hour.
- Timely access 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 first clinical determination of need. No additional information was provided.
- 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 zero percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

The MHP is limited to two clinicians, which have a caseload total of approximately 28 beneficiaries. This has allowed the MHP to be timely in urgent requests, reduce no-show rates, provide outreach to the beneficiaries, and have the availability for scheduled or walk-in appointments. The MHP does provide services to foster youth, but the youth do not receive reported Medi-Cal benefits. The MHP offers services to all in the county regardless of payer source.

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 does not differ from QA/Compliance.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the Quality Improvement workplan (QIWP), and the annual evaluation of the QIWP.

The QIC, comprised of the Director, Clinical Coordinator, Behavioral Health Services Coordinator, Alcohol and Drug Program Specialist, designated clinical staff, designated administrative staff, and community members, including beneficiaries and family members, as well as Mental Health Services Act (MHSA) and SUD funded agencies. The QIC is scheduled to meet quarterly; however, staffing vacancies, especially those among leadership and the QI department, hamper the MHP's ability to host continuous QI activities. Since the previous EQR, the QIC was unable to meet.

The MHP utilizes the following level of care (LOC) tool: Though the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) can be used as LOC tools, the MHP does not utilize the tools for the purpose of evaluation of appropriate LOC. Clinicians conduct a psycho-social document with the beneficiary and make a determination of LOC based on their clinical knowledge and experience.

The MHP utilizes the following outcomes tools: ANSA, General Anxiety Disorder-7 , Pediatric System Checklist-35, CANS, CANS-50, Patient Health Questionnaire-9, Post Traumatic Stress Disorder Checklist-5.

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
O3a	Quality Assessment And Performance Improvement Are Organizational Priorities	Partially Met
3b	Data Is Used To Inform Management And Guide Decisions	Not Met
3c	Communication From Mhp Administration, And Stakeholder Input And Involvement In System Planning And Implementation	Not Met
3d	Evidence Of A Systematic Clinical Continuum Of Care	Partially Met
3e	Medication Monitoring	Not Met
3f	Psychotropic Medication Monitoring For Youth	Not Met
3g	Measures Clinical And/Or Functional Outcomes Of Beneficiaries Served	Not Met
3h	Utilizes Information From Beneficiary Satisfaction Surveys	Not Met
3i	Consumer-Run And/Or Consumer-Driven Programs Exist To Enhance Wellness And Recovery	Not Met
3j	Consumer And Family Member Employment In Key Roles Throughout The System	Partially Met

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

- The MHP has expanded relationships with schools, Probation, tribal leadership, neighboring state and county hospitals and clinics.
- The county in general has a larger population of older adults and is seen as a retirement county. The MHP has identified late onset of depression and has increased its outreach and engagement activities to the older adult population.
- Due to the 65 percent vacancy rate the MHP is lacking the expertise and historical knowledge of quality improvement strategies.
- The MHP has underutilized contracts with IDEA Consulting, Kingsview and Gary Ernst. The MHP is recommended to engage with their contractors to gain the support needed to complete basic quality improvement activities, such as completing an updated QIWP.
- The MHP reported not having the capacity to hold QIC during the review period.
- The MHP does not have designated peer positions which could offer assistance in front desk activities, outreach, case management and input to the QIC.

- The MHP does not track and does not 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)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)

QUALITY PERFORMANCE MEASURES

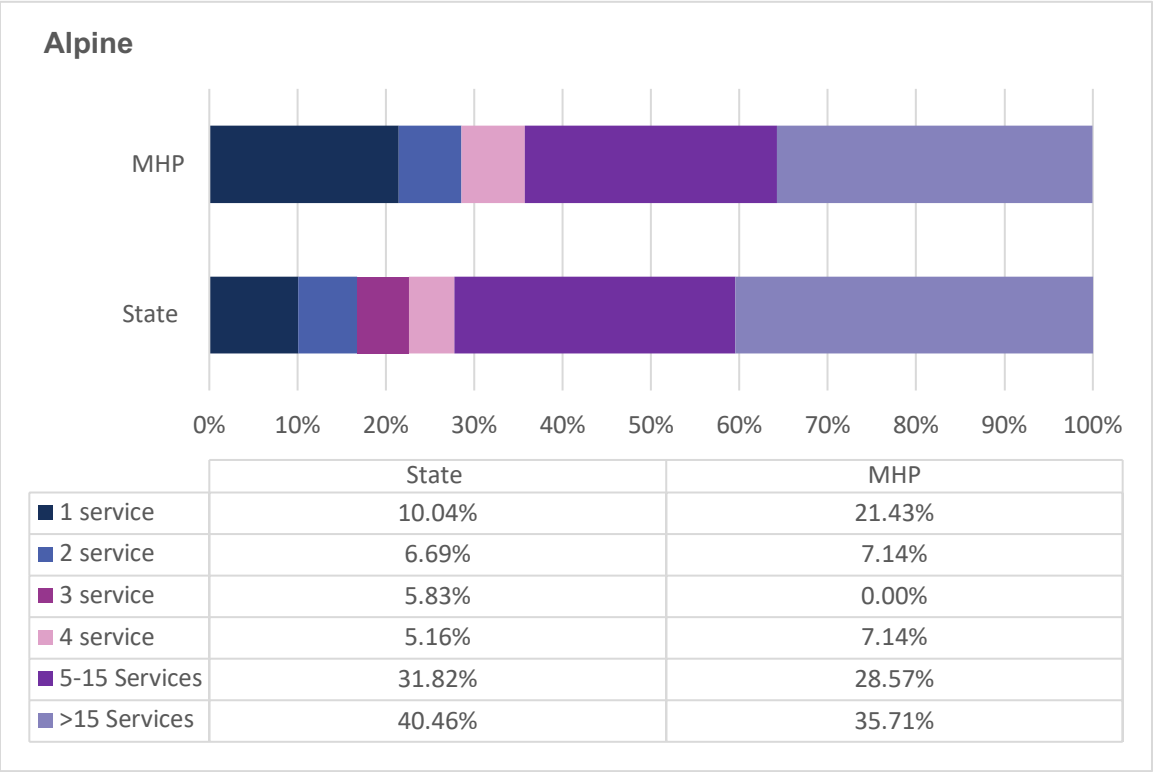
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



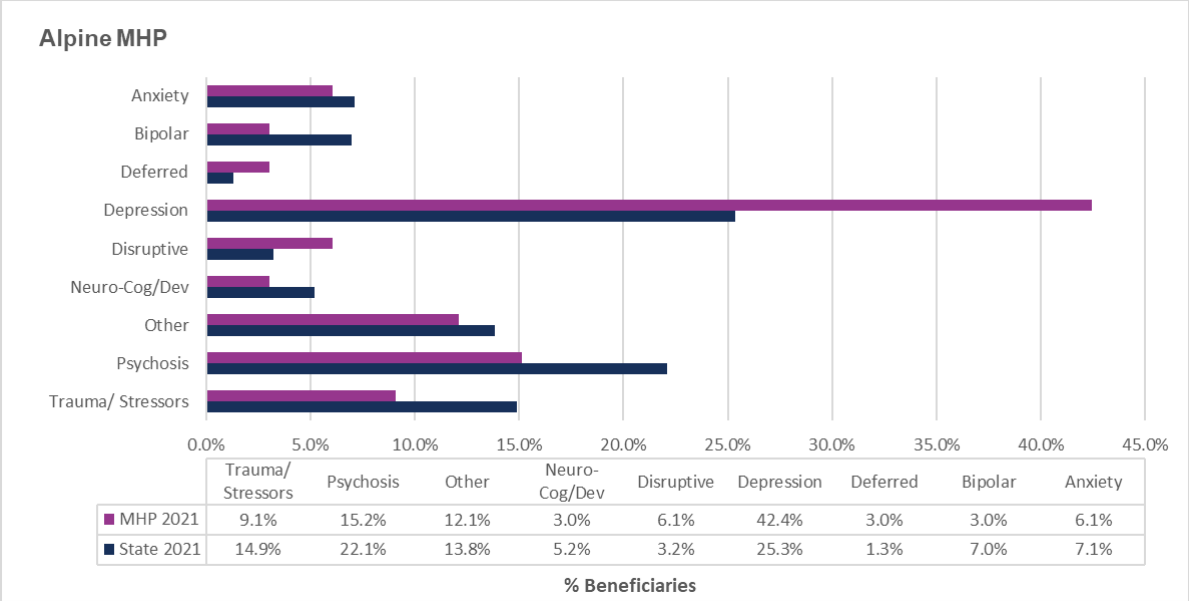
	State	MHP
1 service	10.04%	21.43%
2 service	6.69%	7.14%
3 service	5.83%	0.00%
4 service	5.16%	7.14%
5-15 Services	31.82%	28.57%
>15 Services	40.46%	35.71%

The MHP has a significant percentage of beneficiaries with only one service.

Diagnosis of Beneficiaries Served

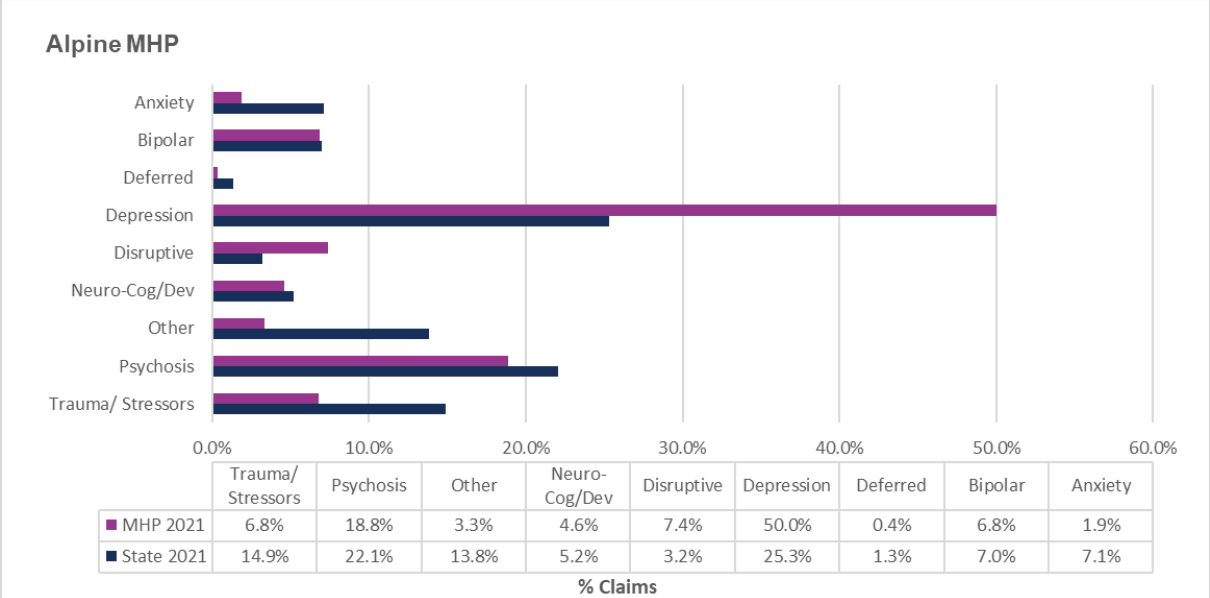
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. 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	9.1%	15.2%	12.1%	3.0%	6.1%	42.4%	3.0%	3.0%	6.1%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

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	6.8%	18.8%	3.3%	4.6%	7.4%	50.0%	0.4%	6.8%	1.9%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- The diagnosis of depression is the most significant for the MHP in both the general and approved claims.

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.

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	*	*	3.00	8.79	$2,505	$12,052	$2,505
CY 2020	-	-	0.00	8.68	$0	$11,814	$0
CY 2019	*	*	12.00	7.63	$10,020	$10,212	$10,020

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

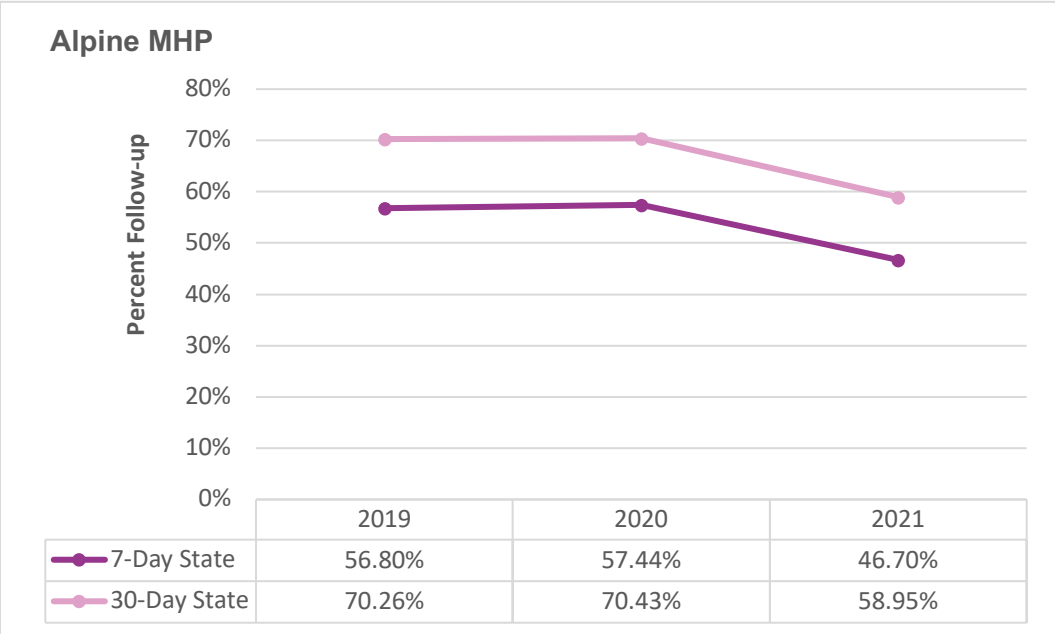
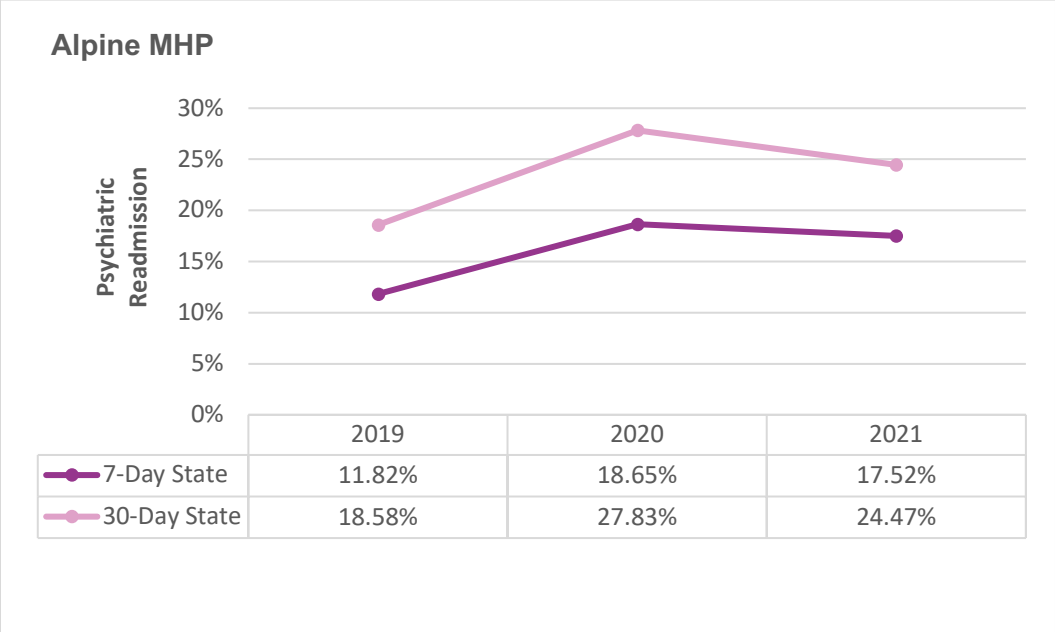


Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



- The MHP data is not displayed due to very small numbers, less than 12 individuals.
- Follow up in CY 2019 is at 100 percent for both 7 and 30 days.

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) 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	-	28	0.00%	$0	$0
	CY 2020	-	41	0.00%	$0	$0
	CY 2019	-	47	0.00%	$0	$0

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)	-	-	-	-	-	-
Low Cost (Less than $20K)	28	100.00%	$89,129	100.00%	$3,183	$2,484

- The MHP has only low-cost beneficiaries in CY 2021.

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

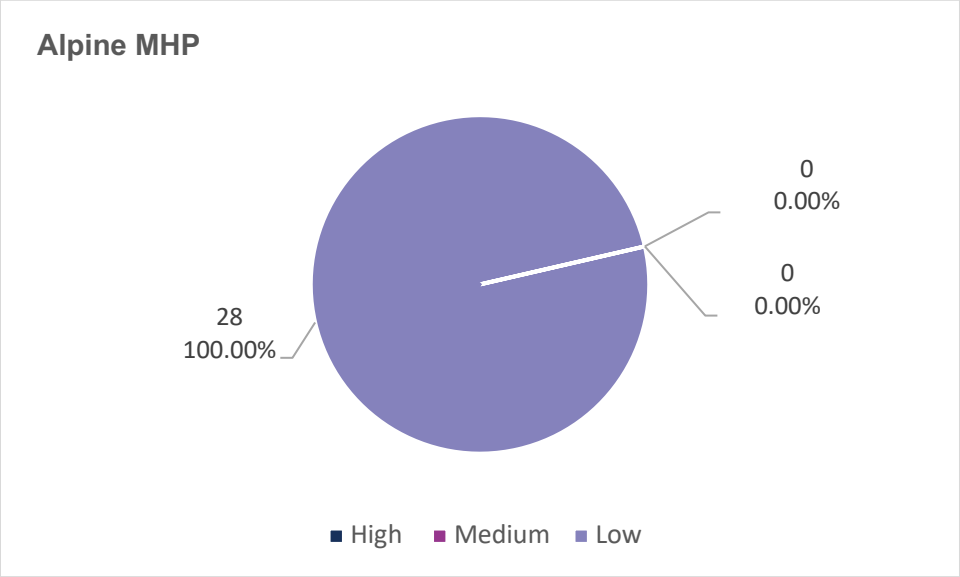
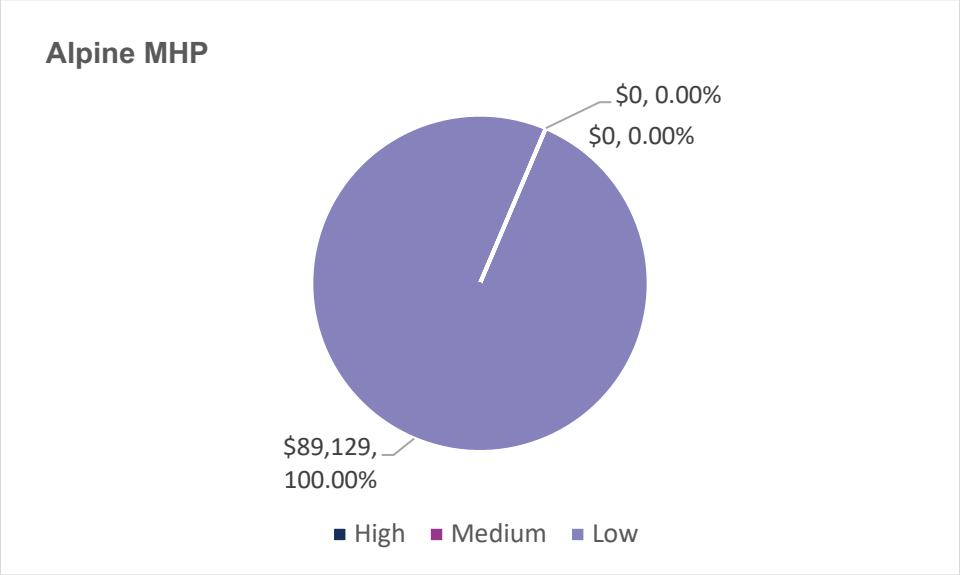


Figure 21: Approved Claims by Cost Type CY 2021



IMPACT OF QUALITY FINDINGS

- The MHP has endured the isolation of COVID-19, which may impact small rural counties significantly as compared to larger metropolitan counties. The added catastrophic fires and loss of homes could add to the high rates of depression found within the MHP beneficiaries.

- The lack of staff has impacted the ability for the MHP to follow through with basic quality performance standards. The engagement of contracted services such as IDEA Consulting, Kingsview and Gary Ernst, may enhance the ability for the MHP county to accomplish basic quality goals.

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: "Beneficiary Enrollment Issues"

Date Started: n/a

Date Completed: n/a

Aim Statement: "Will a monthly Mental Health focused Newsletter and Outreach Calls by clinical staff monthly improve the re-engagement rate for clients over a 12-month period as measured by the services enrollment rate?"

Target Population: "All Alpine County BHS enrolled clients"

[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 planning stage.

Summary

The submitted PIP is a duplicate submission from FY 2021-22 EQR. Due to the lack of capacity the MHP reported being unable to move forward with the PIP. No action has been taken to complete the PIP document.

TA and Recommendations

As submitted, this clinical PIP was found to have no confidence, because: The MHP has not added additional information to complete the PIP documentation since the original submittal.

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

- The PIP as written would need to identify PMs, a timeline to completion and clinical outcome goals to qualify as a clinical PIP.
- The MHP is encouraged to focus on a PIP that is utilizing improvement needs with current staff and without adding an additional workload burden.
- The MHP is encouraged to set up regular TA with both contracted consultants and CalEQRO staff to identify an achievable PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: "Native American Support Group"

Date Started: n/a

Date Completed: n/a

Aim Statement: "Would members of the Hung-A-Lel-Ti community enroll and continue to receive specialty mental health services if services were trauma-informed, culturally responsive, and utilized traditional values, beliefs, and expressions of cultural beliefs with ongoing engagement and input from Hung-A-Lel-Ti community members?"

Target Population: "All members of the Hung-A-Lel-Ti Community as well as other individuals who are Native Americans living in Alpine County."

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

Summary

The submitted PIP is a duplicate submission from FY 2021-22 EQR. Due to the lack of capacity the MHP reported being unable to move forward with the PIP. No action has been taken to complete the PIP.

TA and Recommendations

As submitted, this non-clinical PIP was found to have no confidence, because: The MHP has not added additional information to complete the PIP documentation since the original submittal.

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

- When the MHP has the capacity to implement the non-clinical PIP shows promise and could possibly garner positive results
- During the PIP session several ideas were discussed with the MHP to identify a PIP would be simple to initiate. The MHP identified the possibility of outreach opportunities in the remote town of Bear Valley.
- The MHP is encouraged to set up regular TA with both contracted consultants and CalEQRO staff to identify an achievable PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner Community Behavioral Health (CCBH) which has been in use for 11 years. Currently, the MHP is actively implementing a new system through Kings View, which requires some staff involvement to fully develop.

Approximately 1.68 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is allocated to the MHP but managed by another county department.

The MHP has 6 named users with log-on authority to the EHR, including approximately 4 county staff and 2 contractor staff. Support for the users is provided by 0.15 full-time equivalent (FTE) IS technology positions. Currently all positions are filled. This is a change from the 1.0 FTE reported last year, which represented assistance from the county IT department. For reporting this year, the MHP calculated the dollars paid to Kings View and other consultants who support the EHR to arrive at the FTE for IT assistance.

As of the FY 2022-23 EQR, Crisis Services of Alameda County, who provide crisis line services, has access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for 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	0%
Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	0%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		n/a*

* There are no contract providers who provide in county direct service.

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 does not have a PHR at this time.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Public Health and Health and Human Services.

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	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Not Met
4F	Interoperability	Met

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

- The MHP had zero Medi-Cal denials for CY 2021.
- Integrity of Medi-Cal Claims Process is rated as partially met due to claims volume inconsistency in the latter months of the year. This may be due to continued loss of staff at the MHP.
- Security and Controls is rated as not met as the MHP is unable to meet several of the elements of the Key Components at this time. There is no Systems Security Officer due to their 65 percent vacancy rate. In addition, the MHP was unable to produce a Continuity of Operations plan. There is no evidence of an estimated timeline to restore the EHR to operational status or the provision of regularly scheduled cyber-security information and/or training to staff.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in the table below, 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.

This chart appears to reflect a largely complete or very substantially complete claims data set for the time frame claimed.

The MHP reported that the November 2021 claim was submitted on 12/15/2021 and adjudicated on 02/09/2022 in the amount of $5,332.01; and the December 2021 claim was submitted on 01/20/2022 and adjudicated on 02/25/2022 in the amount of $3,706.04.

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

Month	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	$15,793	$0	0.00%	$15,793
Feb	$9,349	$0	0.00%	$9,349
Mar	$8,753	$0	0.00%	$8,753
April	$14,538	$0	0.00%	$14,538
May	$10,365	$0	0.00%	$10,365
June	$8,162	$0	0.00%	$8,162
July	$4,488	$0	0.00%	$4,488
Aug	$5,193	$0	0.00%	$5,193
Sept	$7,655	$0	0.00%	$7,655
Oct	$4,832	$0	0.00%	$4,832
Nov	$0	$0	0.00%	$0
Dec	$0	$0	0.00%	$0
Total	**$89,128**	**$0**	**0.00%**	**$89,128**

The MHP provided information and the timely submission and adjudication of the November and December 2021 claims.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Overall Denied Claims Rate	0%		
Statewide Overall Denied Claims Rate	2.78%		

- The MHP continues to maintain a zero Medi-Cal denial rate in CY 2021.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP is in the process of implementing Credible, a new EHR system, through Kings View. This requires the participation of MHP staff in making system set up decisions and will require training for all staff on system processes.
- The MHP is working with California Mental Health Services Authority (CalMHSA) on the implementation of CalAIM and are current on implementation deadlines.

- Even with the significant loss of staff, the MHP maintained a zero Medi-Cal denial rate in CY 2021.
- Although the MHP's Medi-Cal statistics show timely claiming, there is a downward trend in the amount of the claim moving forward through CY 21.
- Due to the significant vacancies at the MHP, they lack sufficient staff to provide data analysis and provide data reports readily available to management.

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 did provide beneficiaries the opportunities to fill out the CPS. The MHP reported not receiving results to assess the outcome of the CPS.

CONSUMER FAMILY MEMBER FOCUS GROUP

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 one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members, containing 6 to 8 participants.

The MHP reported the lack of capacity and limited beneficiary base as reasons why it was unable to complete the focus group requirement. (See ATTACHMENT E)

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

CalEQRO offer the ability to telephone interview beneficiaries after the review date to gather information to include in the review document. The MHP was unable to secure a beneficiary interview.

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 has maintained a zero medi-cal claim denial rate throughout CY 2021. (Quality, IS)
2. The MHP is a small- rural county, with limited beneficiaries. These low numbers have allowed the MHP to achieve timeliness metrics of at least 75 percent. (Timeliness)
3. The MHP continues to recruit tribal staff for outreach and to staff the Wellness Center on tribal land. (Quality)
4. The MHP has a 65 percent vacancy rate, yet remaining staff remain active and dedicated to both the roll out of Cal Aim, and services to active beneficiaries. (Quality)
5. The MHSA staff member at the MHP provides a monthly Newsletter that is very informative and inclusive of activities throughout the county and tribal land. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The current Administration staff may not be aware of existing resources within the CBHDA, including the Small County meetings, some meetings require an official appointment to attend. Additional guidance and resources may be provided through relationships with adjacent small counties. (Quality, Access, Timeliness, IS)
2. The MHP is in a critical staffing decline. After COVID-19 and several substantial fires, the county population decreased, and individuals are not seeking employment inside the county. The MHP utilizes telehealth for psychiatry. Additional telehealth clinical services could offer relief to the limited staff available and options to increase the beneficiary penetration rate. (Access, Timeliness, Quality)

3. Remaining staff have taken on all activities including, administration, front-desk, case management, clinical, outreach, phone calls, and data input. The lack of case managers impacts the staff's ability to continue the expanding expectations. (Quality)

4. The critical limit of staffing prevented to MHP from conducting regulatory requirements for reporting during the past fiscal report period. Utilizing the expertise of current contracts could assist in meeting those requirements. (Access, Timeliness, Quality, IS)

5. There is a lack of historical training and information among the remaining staff within the MHP. The current contracts are underutilized due to a lack of information on what services they can offer the MHP to enhance and comply with all requirements.
(Access, Timeliness, Quality, IS)

6. The perceived lack of bi-directional communication may leave the current staff insecure as to training and data collection expectations, job security, and leadership permanency.
(Quality)

RECOMMENDATIONS

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

1. The Interim Director/Director in an effort to support the MHP, to engage the Board of Supervisors and/or County Administrative staff in conversations to provide support for the Behavioral Health department, leverage existing County IT resources, appoint a representative to CBHDA, and solicit adjacent small counties' recommendations.
(Quality, Access, Timeliness, IS)

2. Investigate the use of expanded Telehealth to provide additional clinicians, reducing the challenge of hiring onsite staff.
(Access, Timeliness, Quality)

3. Actively recruit and hire a peer staff member to offer case management services, engage beneficiaries in outreach efforts, participate in QIC activities, and staff the onsite Wellness Center.
(Quality)

4. Comply with all EQR protocols set forth by DHCS. This includes two active PIPs, data collection, data tracking, and trending, organizing a minimum of one CFM Focus group, holding a minimum of quarterly QIC meetings, and the upload of all required documents in a timely manner.
   (Access, Timeliness, Quality, IS)

5. Engage in conversations with current contract consultants, IDEA consulting, Kingsview, and Gary Ernst, to utilize their expertise in accomplishing the goals of training, data collection, and reporting requirements, including impacts of services on beneficiaries.
   (Access, Timeliness, Quality, IS)

6. Enhance bi-directional communication with current staff to include, transparency of decisions being made within the department, plans for hiring a permanent director, provide the necessary training for absorbed tasks, and include in open dialogue to increase retention and job satisfaction.
   (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a public health emergency (PHE) exists. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

As part of the EQR process, the MHP Director submitted a letter identifying specific barriers to the MHP's full participation in the review. Please see Attachment E.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Alpine 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
Peer Inclusion/Peer Employees within the System of Care
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
Electronic Health Record Deployment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Kiran Sahota, Quality Reviewer
Leda Frediani, Information Systems Reviewer
Walter Shwe, Consumer Family Member

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
Dee	Misty	AOD Specialist	Alpine County BHS
Ingram-Flores	Anastasia	Clinician	Alpine County BHS
Kuhns	Richard	Interim BHS Director	Alpine County BHS
McAlpin	Teri	Fiscal & Technical Specialist	Alpine County BHS
Pitts	Crystal	Clinician	Alpine County BHS

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence	The PIP remains in the planning phase and could not gain momentum throughout the year due to continued unplanned staff vacancies.
General PIP Information	
MHP/DMC-ODS Name: Alpine	
PIP Title: Beneficiary Enrollment Issues	
PIP Aim Statement: "Beneficiary Enrollment Issues"	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): All Alpine County BHS enrolled beneficiaries.	

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): As beneficiaries are enrolled in services, a program of a monthly follow-up call by clinical staff one week after the Newsletter is received by the Alpine County community will become procedure. This call will address 1) receipt of the monthly MH Newsletter, 2) a brief discussion of something in the MH Newsletter that appealed to the beneficiary, and 3) a pointed question, "What is your self care plan tonight considering this portion of the MH Newsletter that appealed to you."
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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
n/a			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

•The PIP as written would need to identify PMs, a timeline to completion and clinical outcome goals to qualify as a clinical PIP.

•The MHP is encouraged to focus on a PIP that is utilizing improvement needs with current staff and without adding an additional workload burden.

•The MHP is encouraged to set up regular TA with both contracted consultants and CalEQRO staff to identify an achievable PIP.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence	The PIP remains in the planning phase and could not gain momentum throughout the year due to continued unplanned staff vacancies.
General PIP Information	
MHP/DMC-ODS Name: Alpine	
PIP Title: "Native American Support Group"	
PIP Aim Statement: "Would members of the Hung A Lel Ti community enroll and continue to receive specialty mental health services if services were trauma informed, culturally responsive, and utilized traditional values, beliefs, and expressions of cultural beliefs with ongoing engagement and input from Hung A Lel Ti community members?"	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): "All members of the Hung A Lel Ti community as well as other individuals who are Native Americans living in Alpine County. All Latinx, and other residents of Alpine County are also welcomed to attend the program."	

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): "Groups will include activities culturally relevant to the Hung A Lel Ti community using evidence based, trauma informed treatment. Paperwork activities will be modified to create a culturally responsive environment to help engage the Native American community and invite optimum feedback and outcome assessment data collection. Staff will receive trauma informed training to help them better understand and serve the Hung A Lel Ti community."
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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
Number of Native American beneficiaries who received mental health services	FY 2019-20	29	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percent of Native American beneficiaries who received 5 or more mental health services	FY 2019-20	17 / 29 = 58.6%	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of Latinx beneficiaries who received mental health services	FY 2019-20	10	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percent of Latinx beneficiaries who received 5 or more mental health services	FY 2019-20	4 / 10 = 40%	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

•When the MHP has the capacity to implement, the non-clinical PIP show promise and could possibly garner positive results.

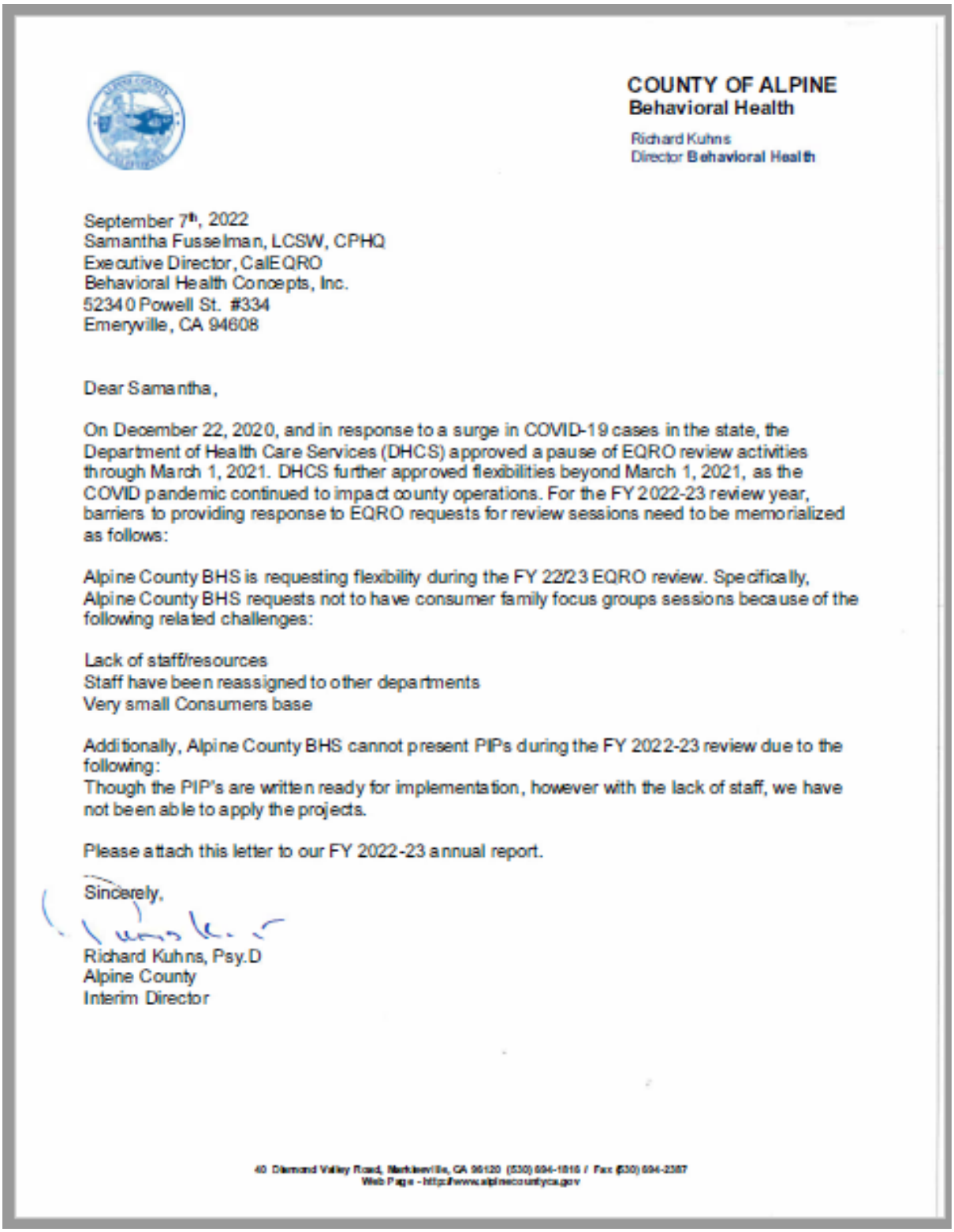
•During the PIP session several ideas were discussed with the MHP to identify a PIP would be simple to initiate. The MHP identified the possibly of outreach opportunities in the remote town of Bear Valley.

•The MHP is encouraged to set up regular TA with both contracted consultants and CalEQRO staff to identify an achievable PIP.

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



COUNTY OF ALPINE
Behavioral Health

Richard Kuhns
Director Behavioral Health

September 7th, 2022
Samantha Fusselman, LCSW, CPHQ
Executive Director, CalEQRO
Behavioral Health Concepts, Inc.
52340 Powell St. #334
Emeryville, CA 94608

Dear Samantha,

On December 22, 2020, and in response to a surge in COVID-19 cases in the state, the Department of Health Care Services (DHCS) approved a pause of EQRO review activities through March 1, 2021. DHCS further approved flexibilities beyond March 1, 2021, as the COVID pandemic continued to impact county operations. For the FY 2022-23 review year, barriers to providing response to EQRO requests for review sessions need to be memorialized as follows:

Alpine County BHS is requesting flexibility during the FY 22/23 EQRO review. Specifically, Alpine County BHS requests not to have consumer family focus groups sessions because of the following related challenges:

Lack of staff/resources
Staff have been reassigned to other departments
Very small Consumers base

Additionally, Alpine County BHS cannot present PIPs during the FY 2022-23 review due to the following:
Though the PIP's are written ready for implementation, however with the lack of staff, we have not been able to apply the projects.

Please attach this letter to our FY 2022-23 annual report.

Sincerely,

Richard Kuhns, Psy.D
Alpine County
Interim Director

40 Diamond Valley Road, Markleeville, CA 96120 (530) 694-1818 / Fax (530) 694-2387
Web Page - http://www.alpinecountyca.gov

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

Alpine 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	322	29	9.01%	$99,886	$3,444
CY 2020	295	41	13.90%	$133,910	$3,266
CY 2019	316	47	14.87%	$217,814	$4,634

*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	39	0	0.00%	1.71%	1.96%
Ages 6-17	58	<11	-	8.65%	5.93%
Ages 18-20	14	<11	-	7.76%	4.41%
Ages 21-64	177	15	8.47%	8.00%	4.56%
Ages 65+	36	<11	-	3.73%	1.95%
Total	**322**	**29**	**9.01%**	**7.08%**	**4.34%**

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
No threshold language	N/A	N/A
Threshold language source: Open Data per BHIN 20-070		

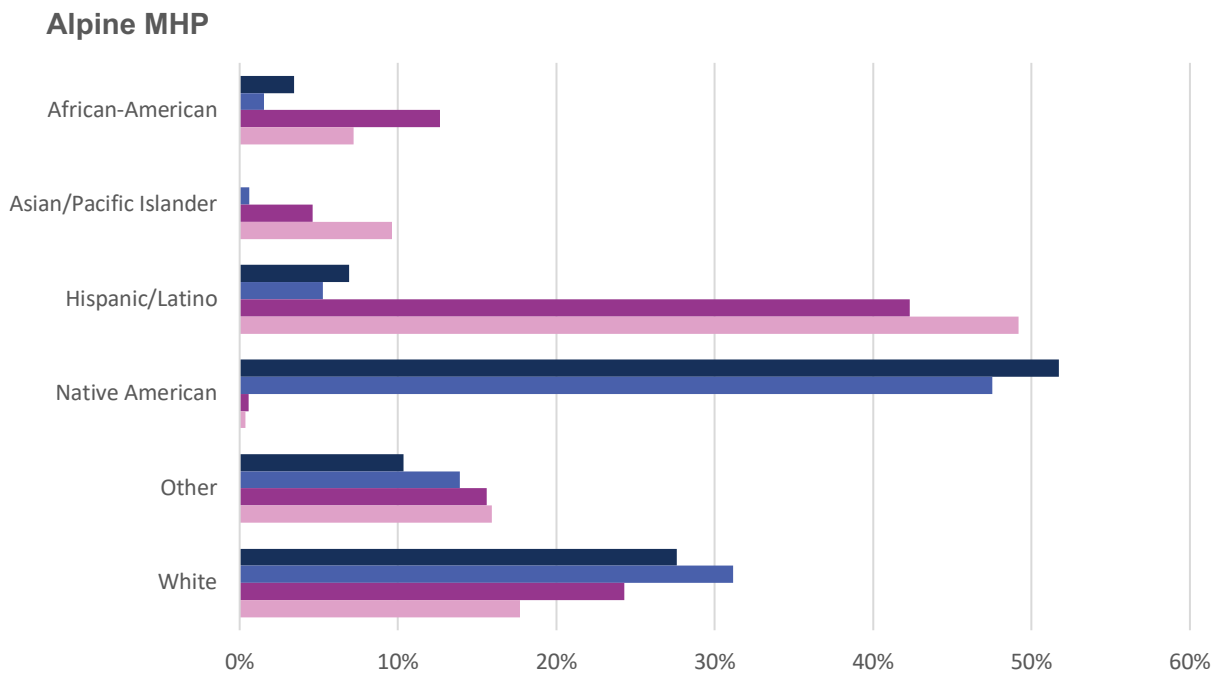
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	103	<11	-	$42,021	$4,669
Small-Rural	35,376	2,377	6.72%	$12,056,144	$5,072
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	<11	<11	-	7.64%
Asian/Pacific Islander	<11	0	0.00%	2.08%
Hispanic/Latino	17	<11	-	3.74%
Native American	154	15	9.74%	6.33%
Other	45	<11	-	4.25%
White	101	<11	-	5.96%
Total	**324**	**29**	**8.95%**	**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	28%	10%	52%	7%	0%	3%
MHP % Eligible	31%	14%	48%	5%	1%	2%
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

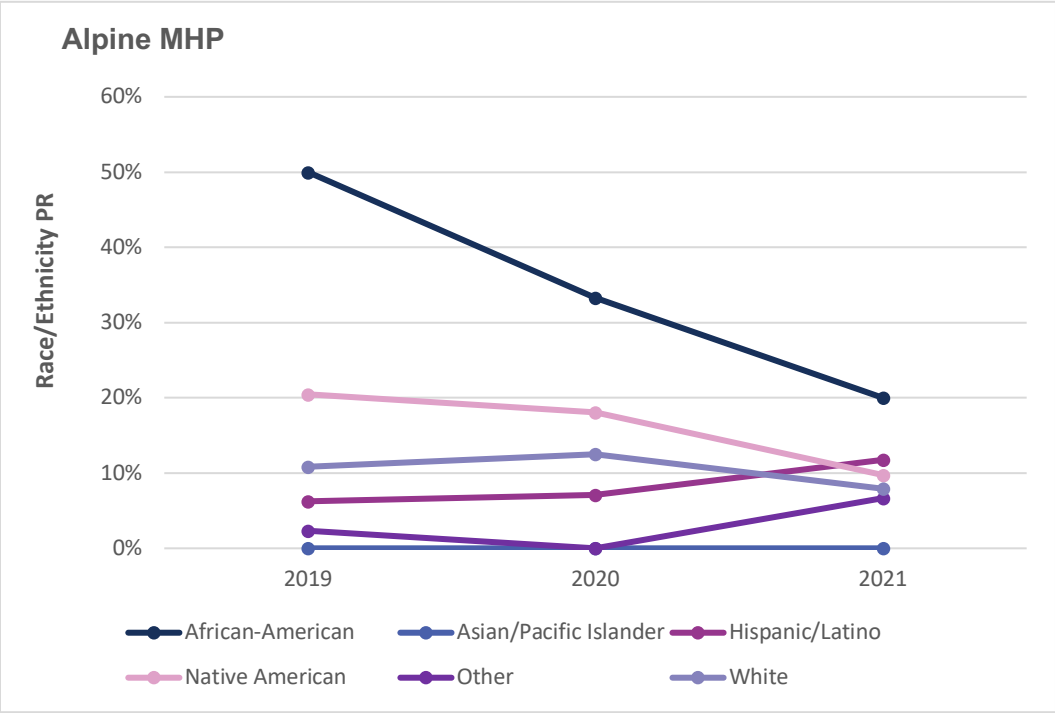


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

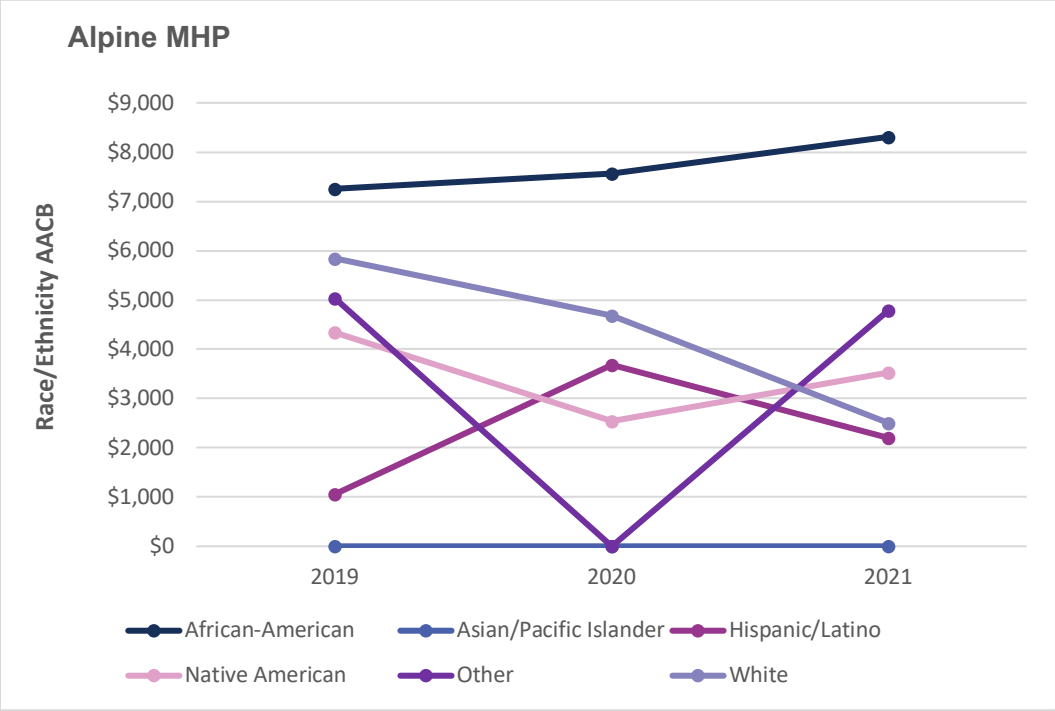
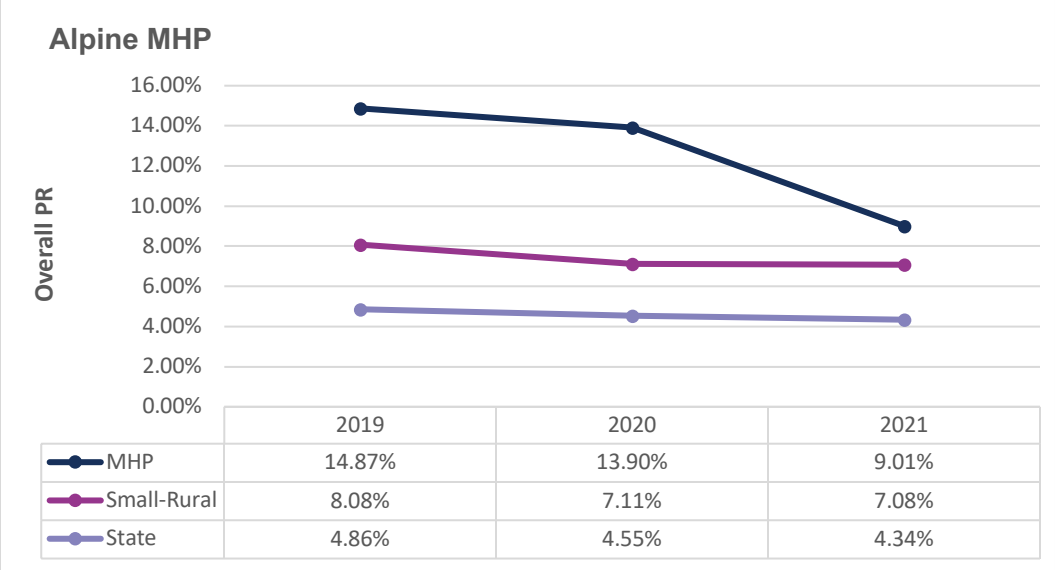
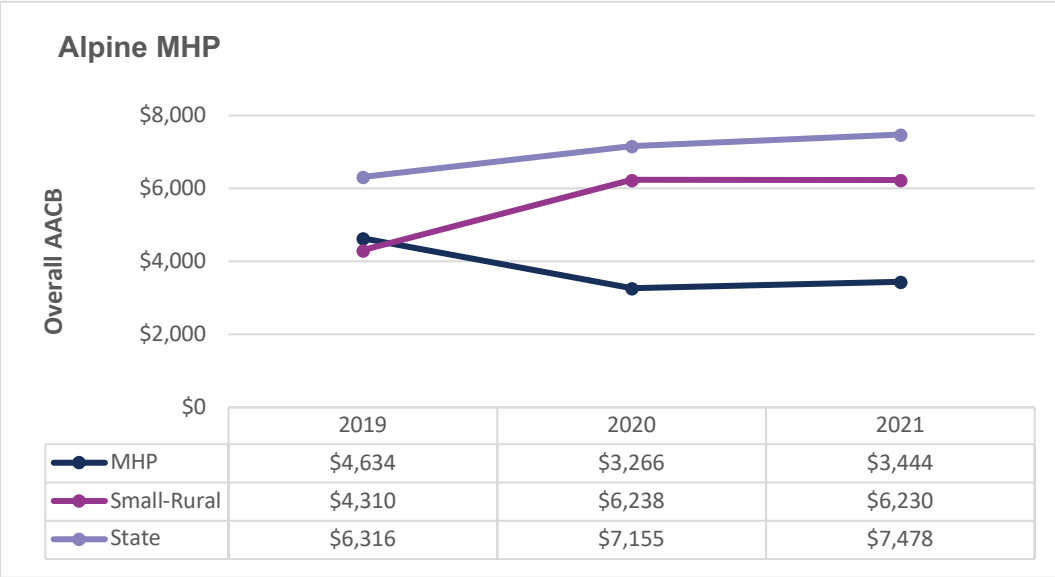


Figure 4: Overall PR CY 2019-21



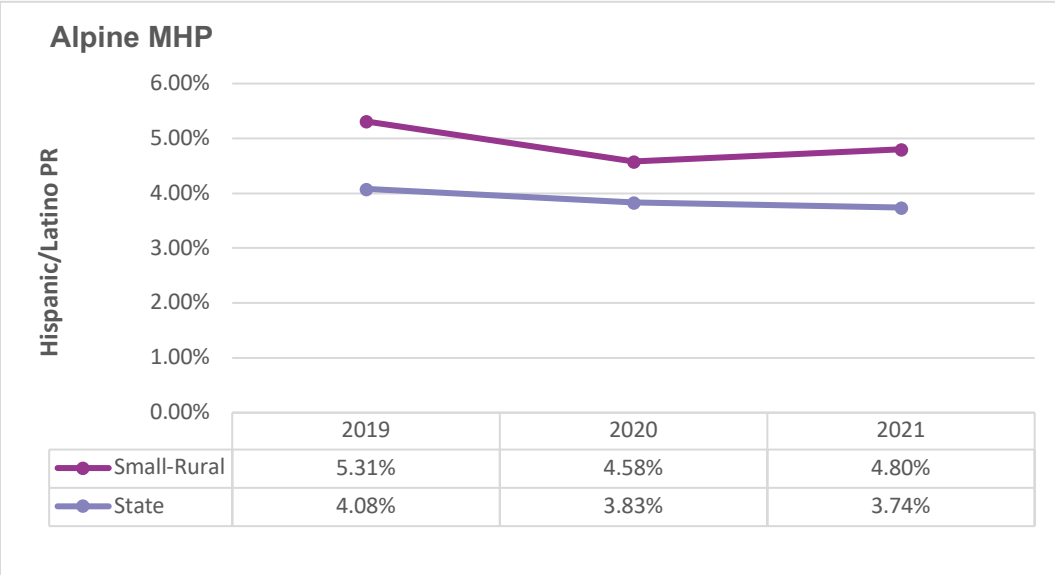
	2019	2020	2021
MHP	14.87%	13.90%	9.01%
Small-Rural	8.08%	7.11%	7.08%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,634	$3,266	$3,444
Small-Rural	$4,310	$6,238	$6,230
State	$6,316	$7,155	$7,478

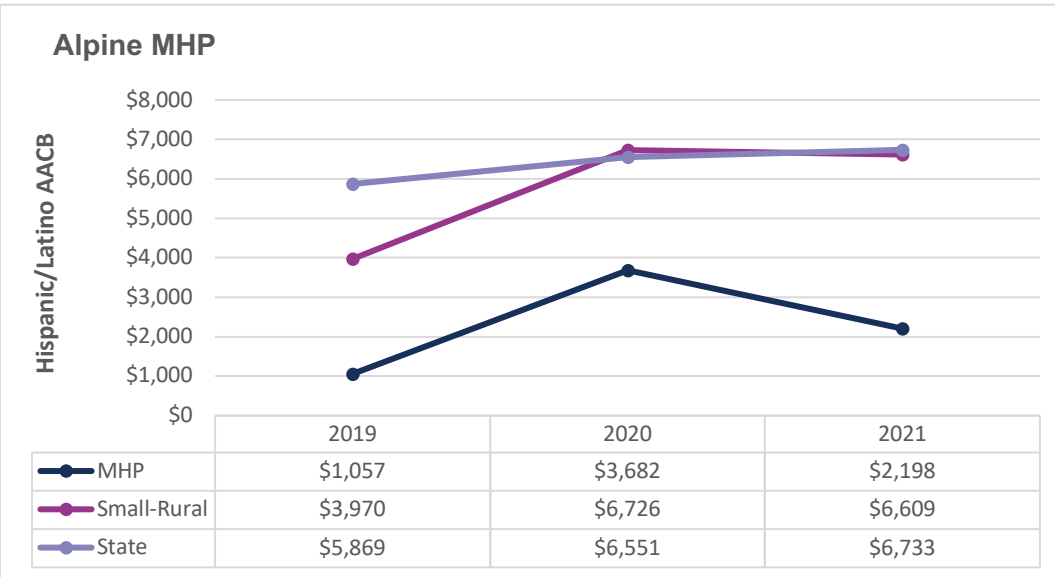
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
Small-Rural	5.31%	4.58%	4.80%
State	4.08%	3.83%	3.74%

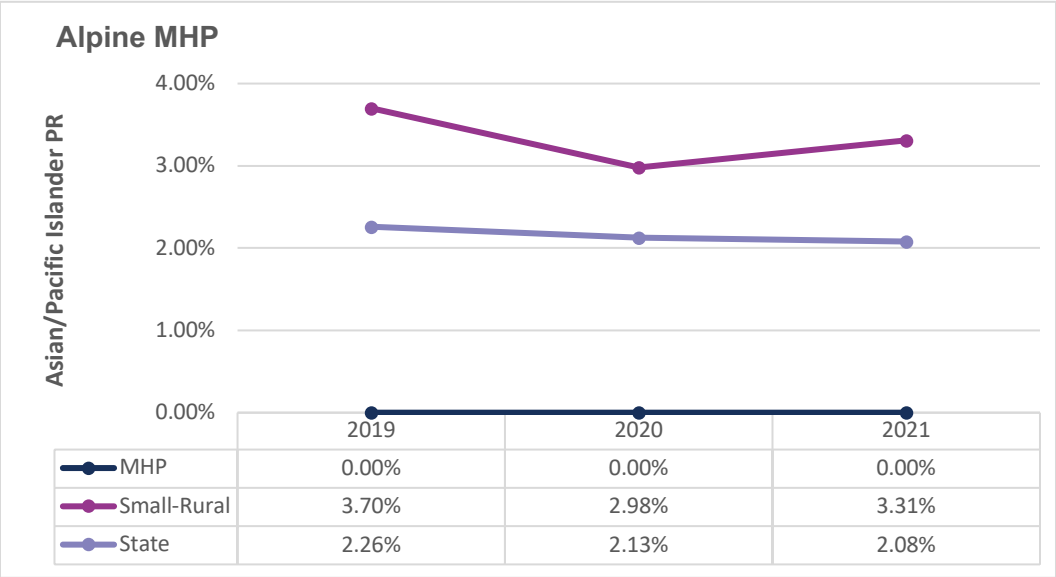
*The MHP's data is not displayed above due to the small numbers of beneficiaries represented.

Figure 7: Hispanic/Latino AACB CY 2019-21



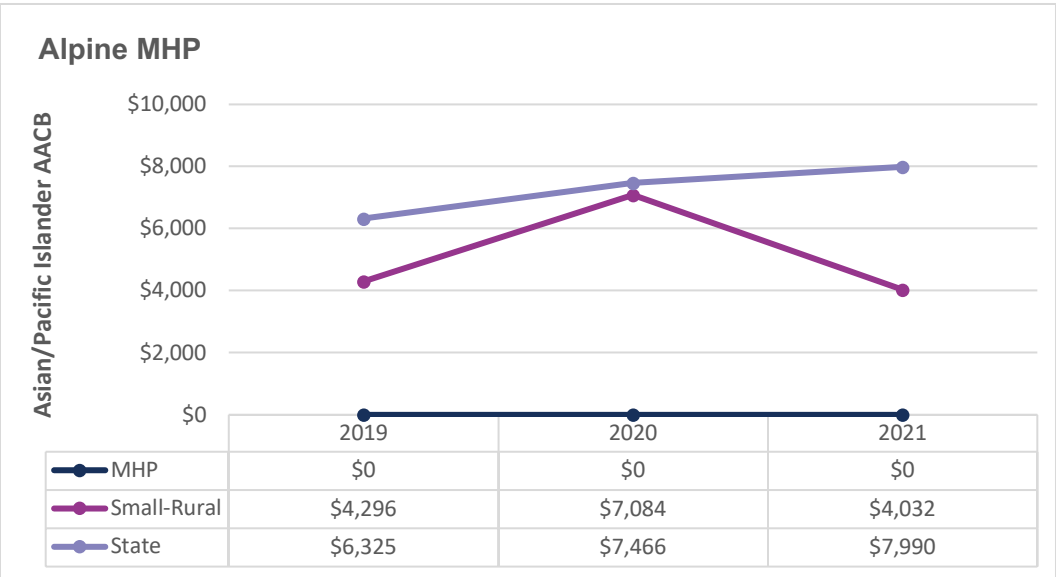
	2019	2020	2021
MHP	$1,057	$3,682	$2,198
Small-Rural	$3,970	$6,726	$6,609
State	$5,869	$6,551	$6,733

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



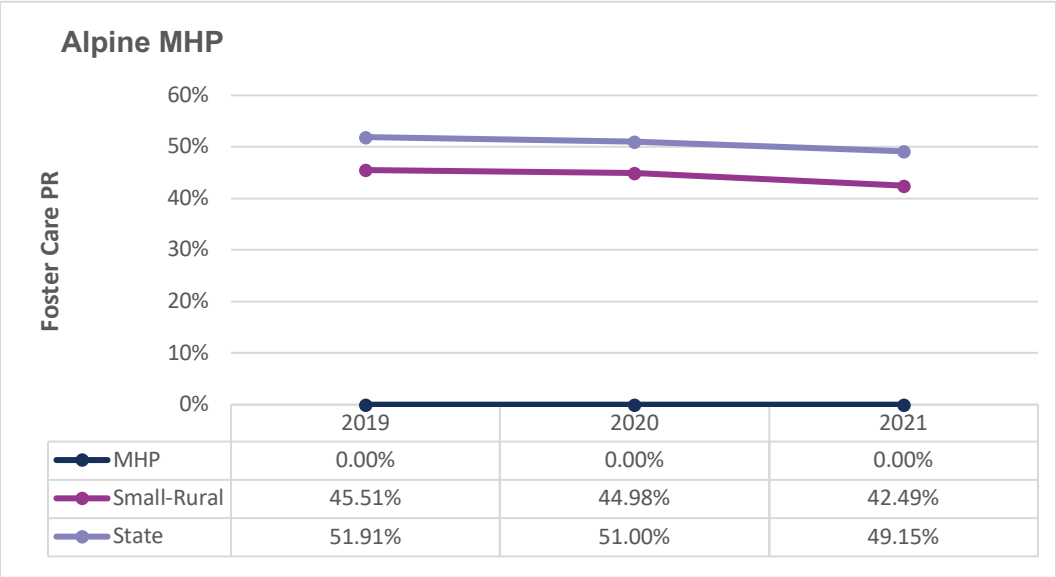
	2019	2020	2021
MHP	0.00%	0.00%	0.00%
Small-Rural	3.70%	2.98%	3.31%
State	2.26%	2.13%	2.08%

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



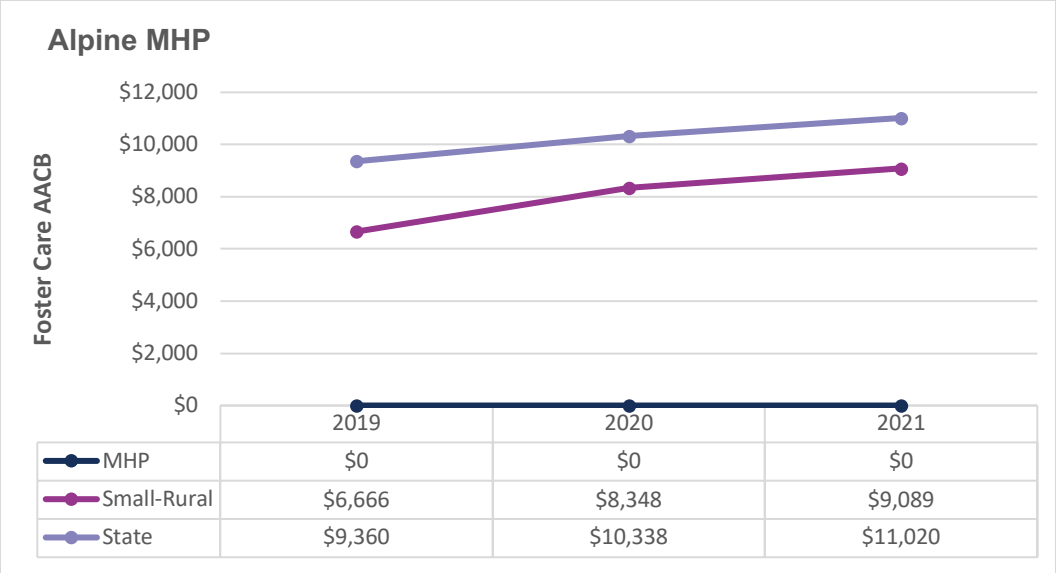
	2019	2020	2021
MHP	$0	$0	$0
Small-Rural	$4,296	$7,084	$4,032
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	0.00%	0.00%	0.00%
Small-Rural	45.51%	44.98%	42.49%
State	51.91%	51.00%	49.15%

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$0	$0	$0
Small-Rural	$6,666	$8,348	$9,089
State	$9,360	$10,338	$11,020

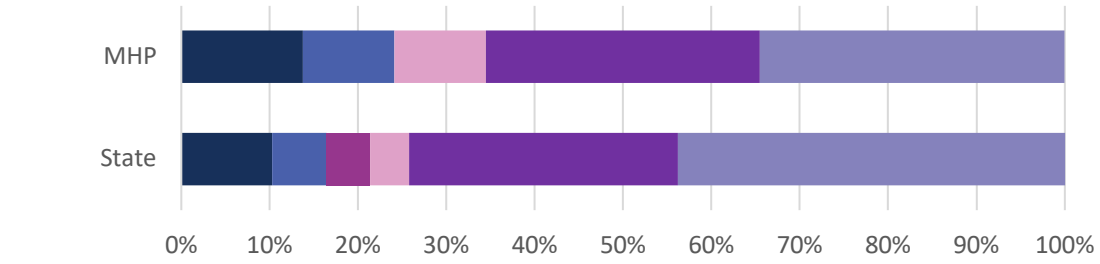
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 21				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	0	0.0%	0	0	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	0	0.0%	0	0	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	0	0.0%	0	0	2.2%	21	14
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	13.0%	1,546	1,200
Crisis Intervention	<11	-	236	236	12.8%	248	150
Medication Support	<11	-	278	248	60.1%	311	204
Mental Health Services	16	76.2%	447	283	65.1%	868	353
Targeted Case Management	<11	-	230	184	36.5%	434	137

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

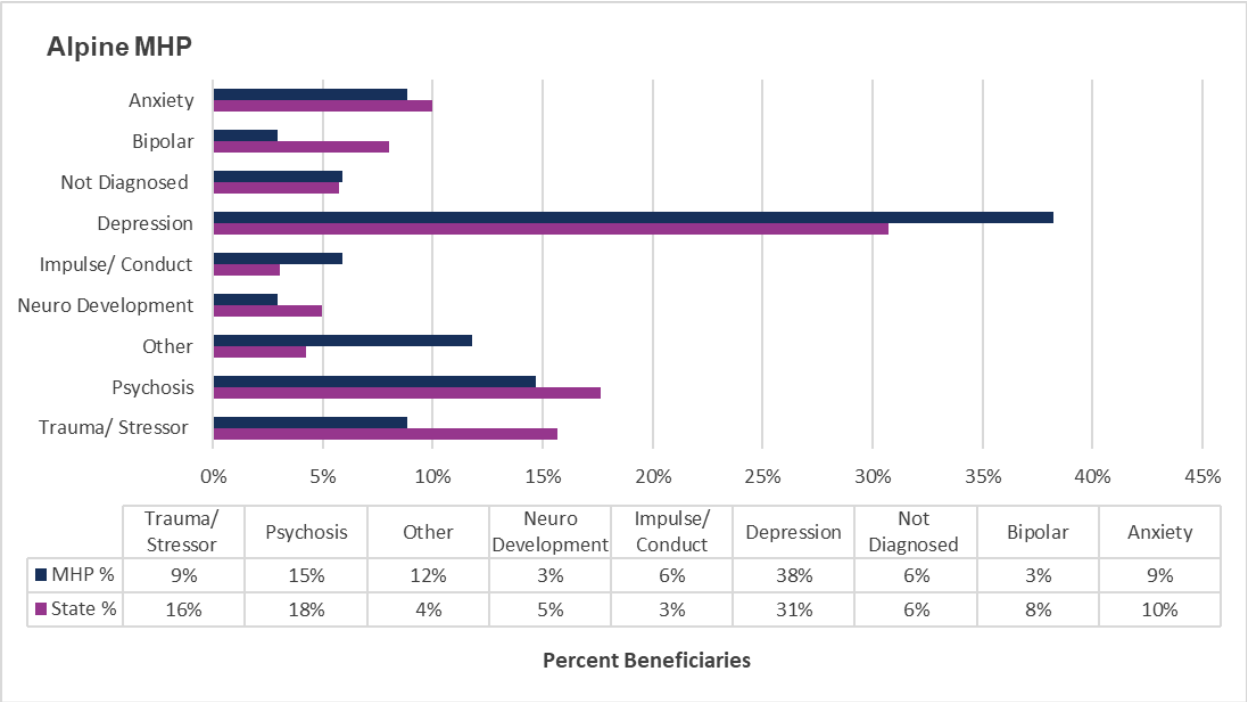
Service Category	MHP N = 0				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	0	0.0%	0	0	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	3.1%	1,404	1,200
Crisis Intervention	0	0.0%	0	0	7.5%	406	199
Medication Support	0	0.0%	0	0	28.2%	396	273
TBS	0	0.0%	0	0	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	0	0.0%	0	0	40.2%	1,354	473
Intensive Home Based Services	0	0.0%	0	0	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	0	0.0%	0	0	96.3%	1,854	1,108
Targeted Case Management	0	0.0%	0	0	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



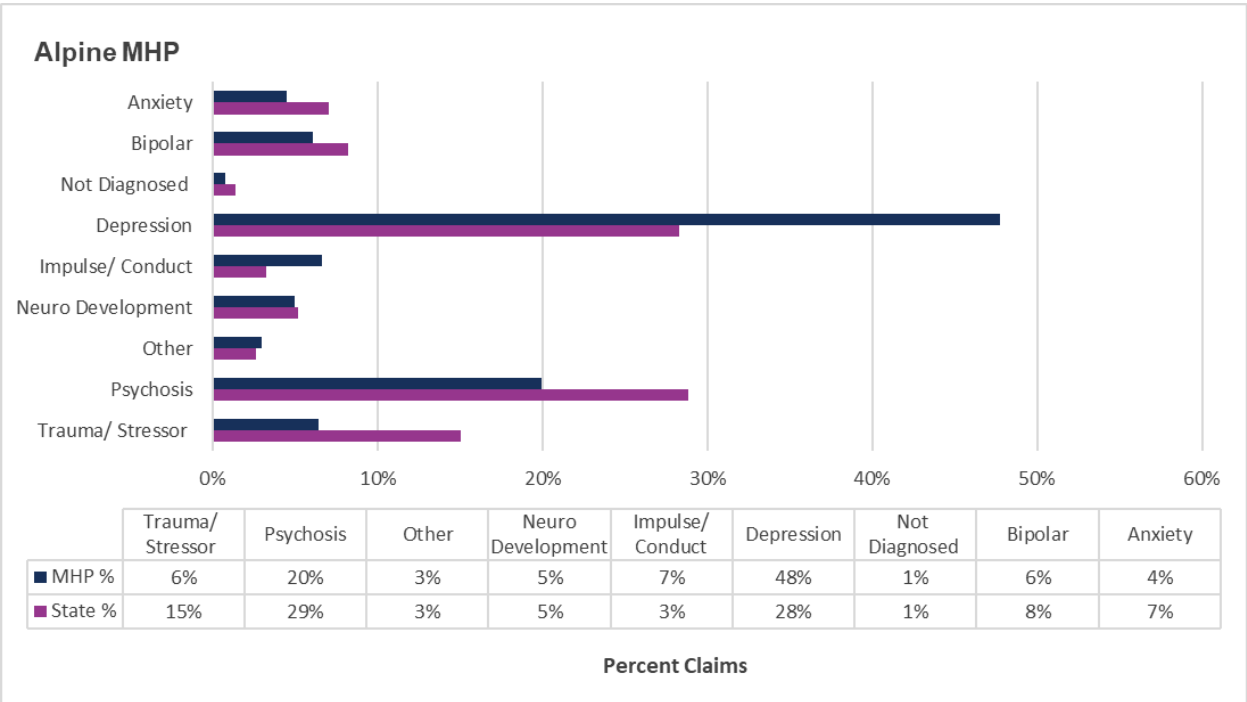
	State	MHP
1 service	10.25%	13.79%
2 service	6.20%	10.34%
3 service	4.88%	0.00%
4 service	4.47%	10.34%
5-15 Services	30.41%	31.03%
>15 Services	43.79%	34.48%

Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	9%	15%	12%	3%	6%	38%	6%	3%	9%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

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 %	6%	20%	3%	5%	7%	48%	1%	6%	4%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

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	<11	<11	3.00	8.86	$2,505	$12,052	-
CY 2020	0	0	0.00	8.68	$0	$11,814	$0
CY 2019	<11	<11	12.00	7.80	$10,020	$10,535	-

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

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

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

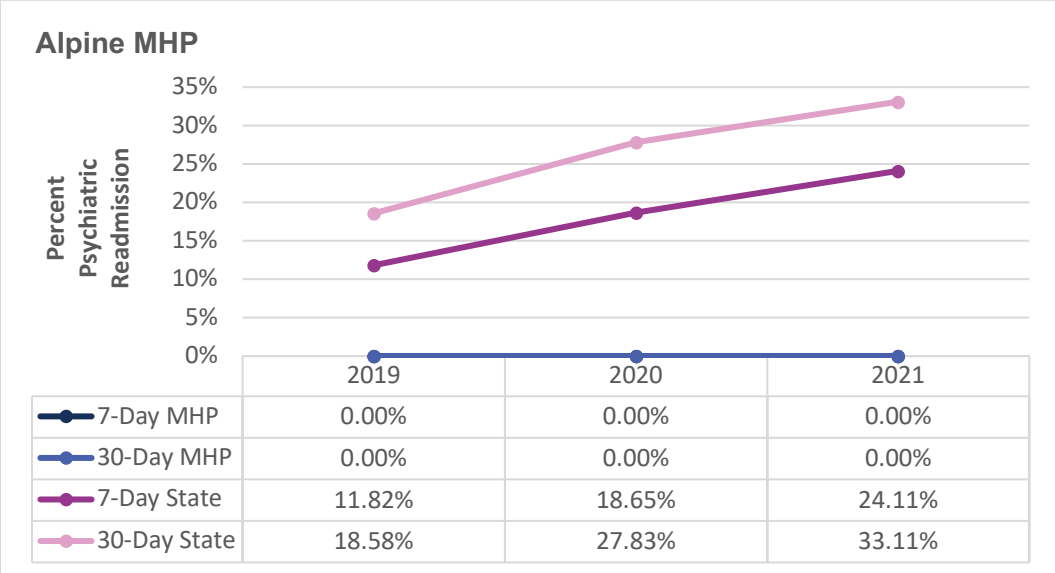


Table 14: HCB (Greater than $30,000) CY 2019-21

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	0	0.00%	0.00%	$0	$0	$0
	CY 2020	0	0.00%	0.00%	$0	$0	$0
	CY 2019	0	0.00%	0.00%	$0	$0	$0

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

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

			ed Claims	ed Claims	per Beneficiary	per Beneficiary
Medium Cost ($20K to $30K)	0	0.00%	0.00%	$0	$0	$0
Low Cost (Less than $20K)	29	100.00%	100.00%	$99,886	$3,444	$2,231

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

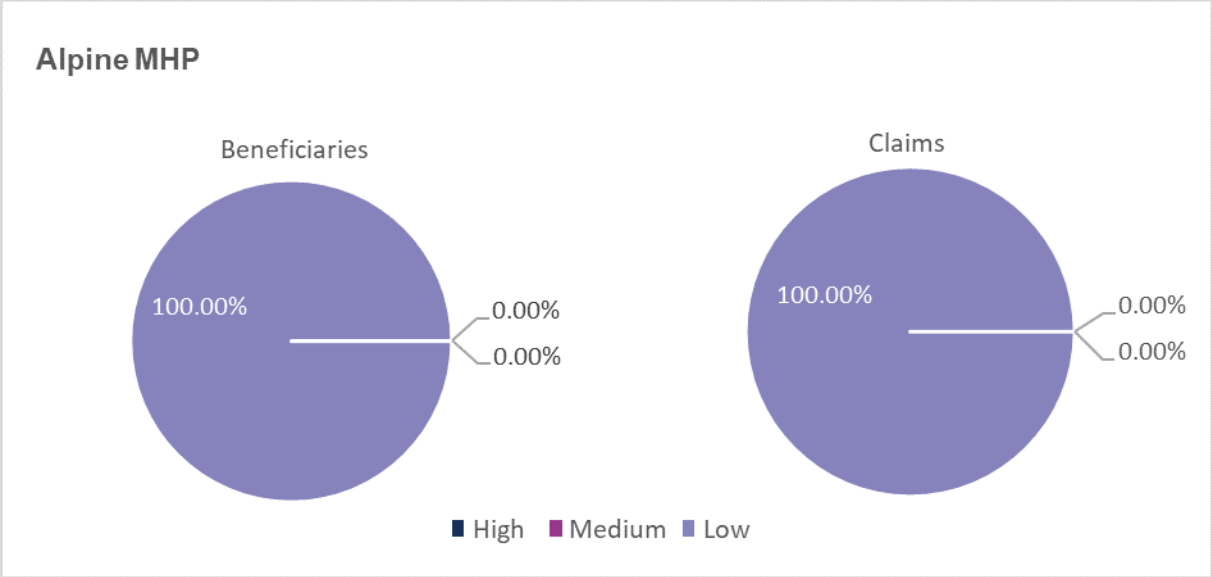


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	40	$16,650	$0	0.00%	$15,793
Feb	31	$9,349	$0	0.00%	$9,349
Mar	31	$8,753	$0	0.00%	$8,753
April	50	$14,538	$0	0.00%	$14,538
May	35	$10,365	$0	0.00%	$10,365
June	24	$8,162	$0	0.00%	$8,162
July	20	$4,488	$0	0.00%	$4,488
Aug	14	$5,193	$0	0.00%	$5,193
Sept	29	$7,655	$0	0.00%	$7,655
Oct	17	$4,832	$0	0.00%	$4,832
Nov	20	$6,387	$0	0.00%	$6,387
Dec	13	$4,370	$0	0.00%	$4,370
Total	**324**	**$100,742**	**$0**	**0.00%**	**$99,885**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
None	0	0	0
Total Denied Claims	**0**	**$0**	**0.00%**
Overall Denied Claims Rate	**0.00%**		
Statewide Overall Denied Claims Rate	**1.43%**		