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

CALAVERAS FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

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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, “Calaveras” may be used to identify the Calaveras County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — March 02, 2023

MHP Size — Small-rural

MHP Region — Central

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 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	0	3	2

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	3	3	0
Quality of Care	10	1	5	4
Information Systems (IS)	6	3	3	0
TOTAL	**26**	**11**	**12**	**4**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Clinical	09/22	Planning	Moderate
None submitted	Non-Clinical	n/a	n/a	n/a

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	2
* If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP increased access to children and youth by co-locating at all the elementary schools in the county.
- The MHP focused on and demonstrates strong performance providing follow-up care after a psychiatric hospitalization and low hospital readmissions.
- The MHP fully reopened the wellness center following reduced operations earlier in the pandemic.
- Medi-Cal claims are submitted consistently with low rates of denial.
- The MHP selected a new electronic health record (EHR), Credible, and plans to implement it in July 2023.

The MHP has opportunities to improve in the following areas:

- The MHP's IS staff capacity to support the increased demands of a new EHR and CalAIM system updates is inadequate.
- The MHP met its timeliness goal for only 46 percent of first-request appointments.
- The MHP's foster care penetration rate continued to decline; monitoring mechanisms appear to be needed.
- The MHP does not conduct medication monitoring at this time.
- Bi-directional communication with clinical line staff remains limited

Recommendations for improvement based upon this review include:

- Analyze how many IS and data analytics FTEs are needed to support the new EHR, CalAIM, state reporting requirements, and other internal reporting needs, and cross train staff.
- Examine barriers to a first appointment and improve performance.
- Evaluate access processes for foster care youth and identify barriers. Implement interventions to improve access as indicated.
- Implement a medication monitoring system.
- Implement quality improvement activities to improve bi-directional communication between MHP leadership and direct line staff.

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, comprised 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 California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section14197.05).

This report presents the FY 2022-23 findings of the EQR for Calaveras County MHP by BHC, conducted as a virtual review on March 2, 2023.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to validate and analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, 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, and Inpatient Consolidation File.

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 Early Periodic Screening, Diagnosis, and Treatment; 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.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's NA as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of beneficiaries' 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 11, then “<11” is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic which continues to significantly impact staffing due to staff quarantine periods. The MHP is also operating under the workforce crisis with a 38% clinician vacancy rate. High staff turnover has required more training compounding demands on staff capacity. The MHP experienced the winter storms in March just prior to this review; beneficiary participation in the focus group may have been limited due to this obstacle. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- In addition to the clinical staffing shortages, vacant medical record positions create ongoing challenges to beneficiary access since they staff the front desks. Lack of front-desk staff for up to 2 months impacted some sites. The MHP programs are located in six different sites. Supervisors have filled this role when necessary, including driving to different locations. Managing these shortages has been time consuming and the MHP is working with Calaveras Health and Human Services Agency to create a staff recruitment and retention plan. Competition with higher paying private agencies is a primary challenge.
- The MHP successfully obtained a Behavioral Health Continuum Infrastructure Program $22 million grant to help build a new Behavioral Health Services (BHS) site. The new site will integrate all BHS services in one structure, which will support coordination and enable consolidating access. The MHP also secured a Crisis Mobile unit planning grant.
- The MHP reopened the Peer Wellness services full-time, which had been closed at the start of the pandemic.
- The MHP is instituting California Advancing and Innovating Medi-Cal (CalAIM) requirements and created and filled a position dedicated to manage CalAIM implementation. The MHP reports that meeting with California Mental Health Services Authority (CalMHSA) project managers weekly regarding implementation has critically supported their process. While the MHP had anticipated reduced administrative requirements as a benefit of CalAIM, the MHP reports this has not yet occurred.

- The MHP is transitioning their EHR from Cerner Community Behavioral Health, to Credible, with the goal of implementing it by July 2023.

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: Implement and maintain two active and ongoing PIPs, one clinical and one non-clinical; seek technical assistance from CalEQRO as needed.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is conducting the Follow-Up After Emergency Department Visit for Mental Illness PIP with CalMHSA's assistance. The MHP does not have a non-clinical PIP and therefore this recommendation is partially addressed.
- This recommendation will not be carried over because there are other system priorities identified.

Recommendation 2: Evaluate and standardize the psychiatric intake process and implement strategies to ensure beneficiaries are offered an initial psychiatry appointment within 15 business days.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Activities toward this recommendation are limited. The MHP reports that timeliness tracking for psychiatry services has been incorporated in the new EHR dashboard plans. This recommendation is partially addressed because the MHP did not review or make changes to the appointment process.

- Review discussions showed that measuring time to an appointment for children psychiatry appointments is not complete as reported in the Assessment of Timely Access (ATA). For adults, the MHP met its 15 business day standard for 79 percent of appointments. The MHP continues to maintain dedicated medication appointments for urgent or post-hospitalization needs.
- This recommendation will not be carried over because there are other system priorities identified.

Recommendation 3: Research and secure Healthcare Effectiveness Data and Information Set (HEDIS) standards training and implement a medication monitoring system that includes HEDIS measures outlined in SB 1291.

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

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP did not conduct activities towards this recommendation. The MHP reports that given the workforce shortage and other initiatives such as CalAIM, the MHP did not select this recommendation as a priority.

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

Recommendation 4: Using the results from the staff satisfaction survey, implement quality improvement activities to improve staff morale and bi-directional communication between MHP leadership, and direct line staff.

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

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP reported that due to the workforce shortage and other mandates and initiatives, the MHP did not prioritize addressing this recommendation and conducted little activity towards it. The MHP added one bi-directional communication opportunity with a question and answer time at the end of the monthly Director's presentation.
- Review discussions indicate that increased communication and collaboration would improve organizational morale, which may help implement quality oriented priorities and lessen workforce challenges. While some staff stakeholder groups experience adequate communication, others perceive a need for more.
- This recommendation is not addressed because the MHP did not conduct quality improvement or ample activities toward this recommendation.
- This recommendation is carried over to FY 2022-23.

Recommendation 5: Evaluate existing IS and analytic staff resources and implement strategies to complete pending data projects and foster data driven service delivery decisions.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Since the last EQR, the MHP lost the sole IS staff member who also fulfilled data analytics responsibilities, but replaced that staff with a new hire. During this transition period, the MHP maintained timely submissions of State reporting requirements and incrementally increased reporting and dashboard capabilities. However, Calaveras is implementing a new EHR in July 2023 with more robust data capabilities, and more IS and a data analytics full-time equivalent (FTE) may be needed to support this transition. The MHP documented there is only one staff member handling both IS and data analytics, and the FTE is split evenly among those two areas (0.5 FTE for IS, and 0.5 FTE for data analytics). This recommendation is considered "partially addressed" because the MHP did not conduct a full evaluation of existing IS and analytic staff due to gaps in staffing, and an overall lack of resources.
- This recommendation is carried over to FY 2022-23.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 67.35 percent of services were delivered by county-operated/staffed clinics and sites, and 32.65 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 70.75 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week. Calaveras County Behavioral Health Services (CCBHS) staff respond to calls during business hours from 8:00 a.m. to 5:00 p.m., Monday through Friday, and after-hour calls are answered by a contract provider. Beneficiaries may request services through the Access Line as well as through the following system entry points: clinic walk-in and community referrals from schools, social services, law enforcement, probation, and hospitals.

The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. After a beneficiary requests services, the beneficiary is scheduled for an initial assessment with a clinician. The results are shared then reviewed at an authorization meeting for medical necessity. The MHP has a goal to begin services within ten business days.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 1,607 adult beneficiaries, 1,738 youth beneficiaries, and 502 older adult beneficiaries across 3 county-operated sites and 5

[1] CMS Data Navigator Glossary of Terms

contractor-operated sites. Among those served, 8 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

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

For Calaveras 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 Out-of-Network Access, FY 2021-22

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☒ Yes ☐ No

- Because the MHP can provide necessary services to a beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries to access services via OON providers.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members. Examining service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

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

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Partially Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- The MHP provides services at wellness centers at all the elementary schools. The MHP has a goal to replicate its presence at all high schools. In FY 2021-22, the MHP served over 400 students at the elementary schools, of which 25 percent received SMHS. The MHP completed a detailed evaluation of access in this program. Review discussions show staff perceptions of how effectively these services engage families and reduce stigma barriers. Input across groups identified MHP services only at business hours as a barrier for beneficiary access and locating at schools appear to increase access.
- The capacity for clinician services is inadequate. To improve access, the MHP had contracted a clinician to complete assessments. That clinician left in February 2023 and the MHP has arranged a fee-for-service clinician for added assessments. The MHP also began providing Integrated Dual Disorder Treatment groups again, which had been offered in the past.
- Spanish capacity is limited to one Spanish-speaking case manager and use of the language line. The MHP is seeking contract providers to improve access for Spanish-speaking beneficiaries.
- Evaluation of the effectiveness and outcomes of cultural competence strategies implemented is not evident.

- Psychiatry services continue to be provided via telemedicine. In the last year, the MHP began providing medication appointments that beneficiaries could directly link to from their own devices, rather than requiring beneficiaries to attend at the MHP clinic. Stakeholder discussions indicate that this has eased access. The MHP has found that transportation barriers are the most frequently reported obstacle.
    - After receiving board approval, the MHP recently increased the salary for a vacant full-time psychiatrist position that had gone unfilled since 2013.
- A local, primary short-term residential therapeutic program (STRTP) is struggling to establish certification for Med-Cal billing.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, the PR for Calaveras decreased over the last three years, following the statewide trend. However, the MHP's PR is more than two percentage points higher than the statewide rate (6.40 percent vs. 4.34 percent).

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	13,543	867	6.40%	$6,588,418	$7,599
CY 2020	12,404	836	6.74%	$5,822,081	$6,964
CY 2019	12,132	921	7.59%	$3,896,150	$4,230

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

- The MHP AACB has increased each year since CY 2019.

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	1,386	14	1.01%	1.71%	1.96%
Ages 6-17	2,937	241	8.21%	8.65%	5.93%
Ages 18-20	615	56	9.11%	7.76%	4.41%
Ages 21-64	7,407	521	7.03%	8.00%	4.56%
Ages 65+	1,200	35	2.92%	3.73%	1.95%
Total	**13,543**	**867**	**6.40%**	**7.08%**	**4.34%**

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

- The MHP PR for each age group is higher than the statewide PR, except for ages 0-5.
- The MHP PR is lower than similarly sized counties for each group except for 18-20 year olds.

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	853	98.39%
Language Unknown	14	1.61%
Total Threshold Languages	**867**	**100.0%**
Threshold language source: Open Data per BHIN 20-070		

- Although data in Table 5 indicates no threshold languages in Calaveras County in CY 2021, the MHP indicated that Spanish is currently a threshold language.

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	4,442	272	6.12%	$1,948,608	$7,164
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

- 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. These patterns are reflected in the MHP as well.
- The MHP has a slightly lower percentage of ACA beneficiaries served than the small-rural county average, but a considerably higher PR than the statewide rate (6.12 percent vs. 3.81 percent).

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 7 and Figures 1–9 compare the MHP's data with MHPs of similar size and the statewide average.

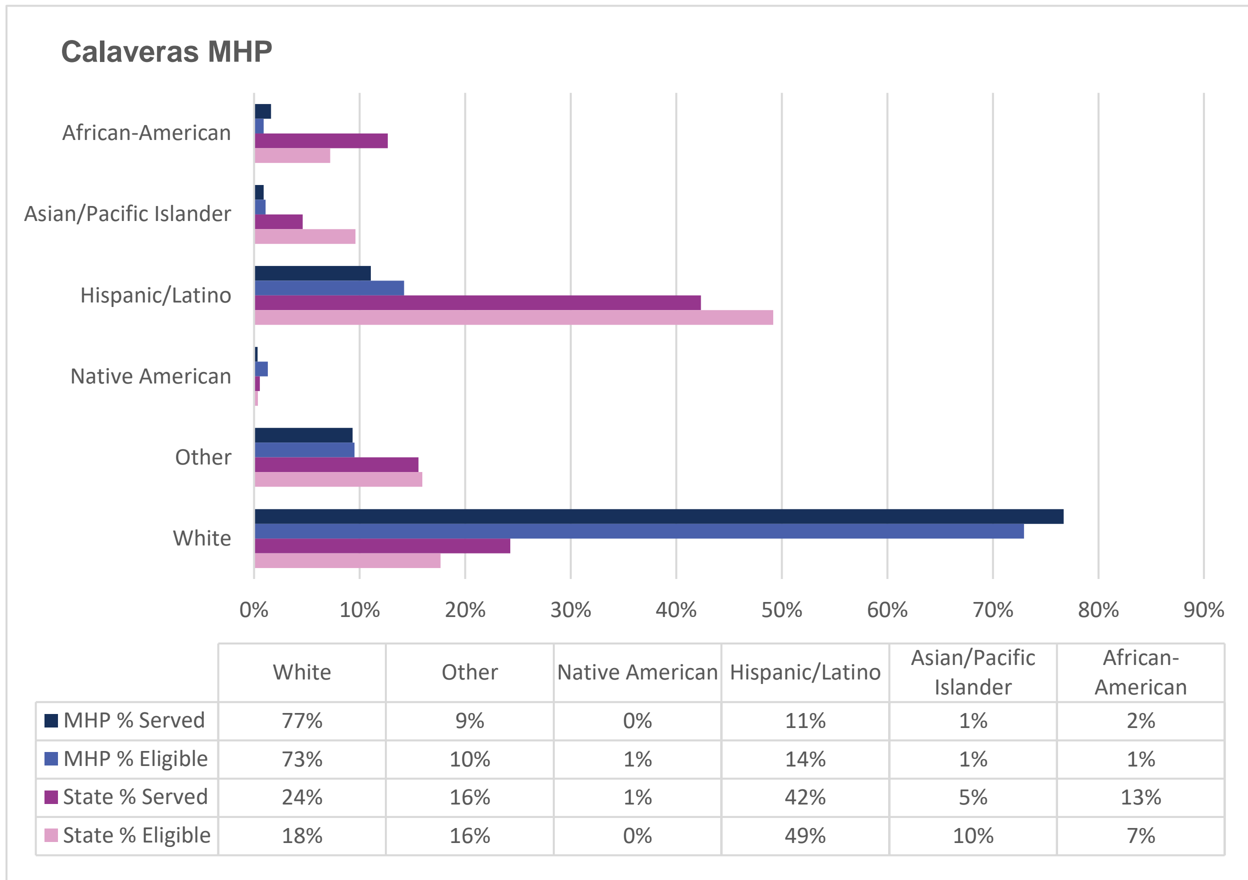
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	125	14	11.20%	7.64%
Asian/Pacific Islander	148	<11	-	2.08%
Hispanic/Latino	1,926	96	4.98%	3.74%
Native American	177	<11	-	6.33%
Other	1,289	81	6.28%	4.25%
White	9,879	665	6.73%	5.96%
Total	**13,544**	**867**	**6.40%**	**4.34%**

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

- Each of the non-suppressed race/ethnicity groups listed in Table 7 have a higher PR than the State.
- The MHP PR for Asian/Pacific Islander beneficiaries is higher than the State PR; the MHP PR for Native American beneficiaries is lower than the State PR.

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

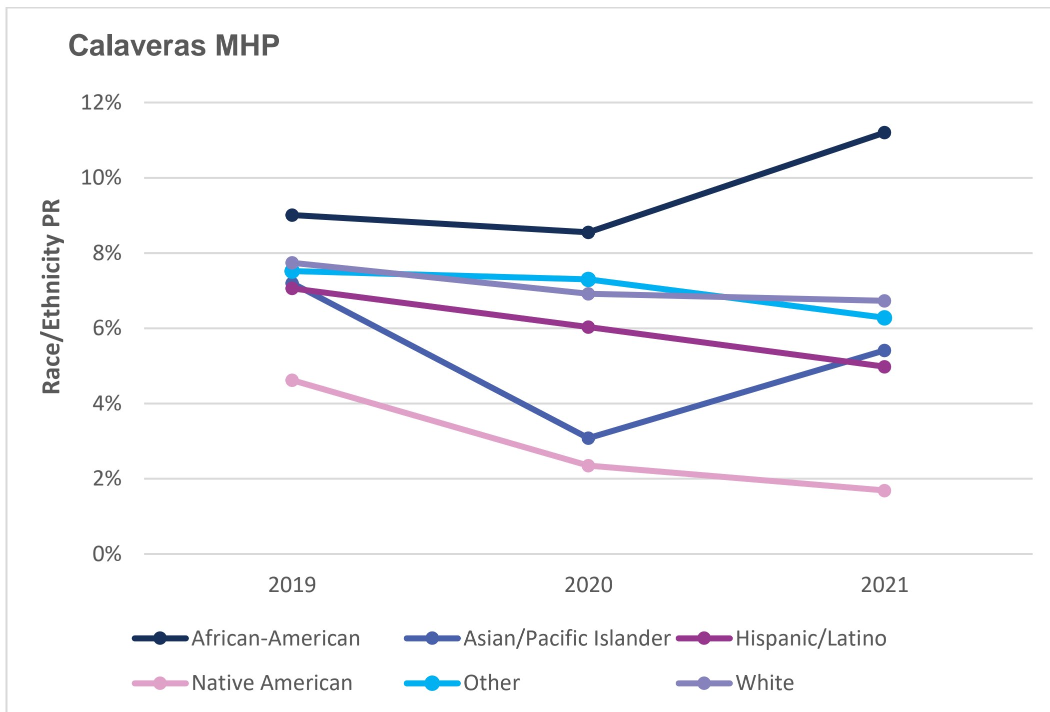


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	77%	9%	0%	11%	1%	2%
MHP % Eligible	73%	10%	1%	14%	1%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- Among the race/ethnicity groups listed in Figure 1, only Hispanic/Latino and Other race/ethnicities have an underrepresented gap between eligible and served beneficiaries. However, the gaps between eligible and served is only 3 percentage points for Hispanic/Latinos, and 1 percentage point for the Other race/ethnicity group.

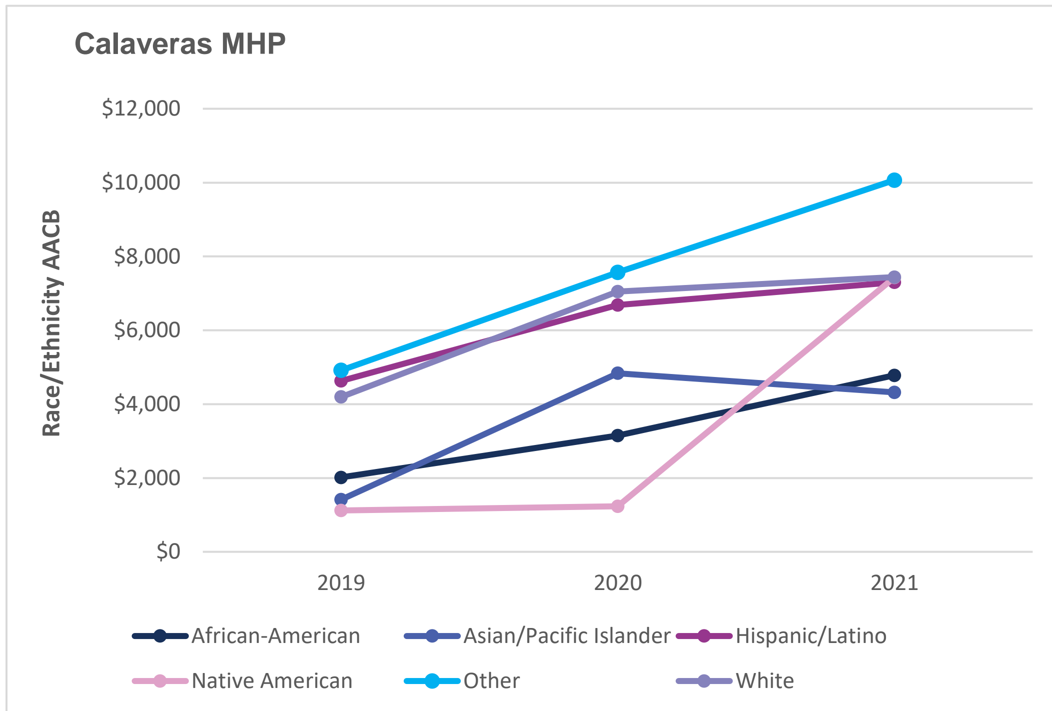
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



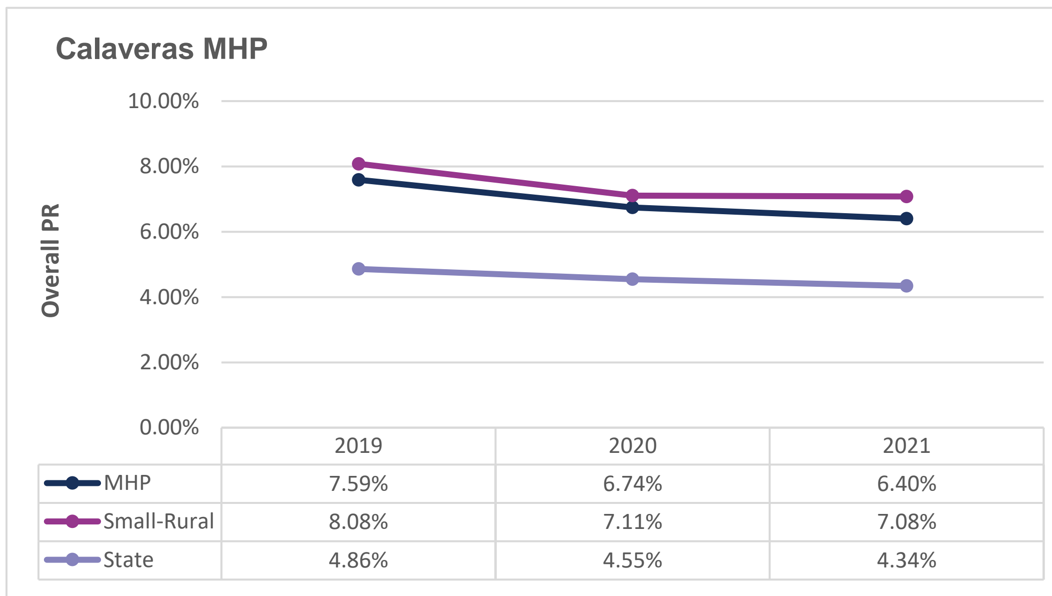
- The MHP PRs for Native American, Hispanic/Latino, White, and Other beneficiaries have declined slightly over the last two years, while PR for Asian/Pacific Islander, and African-American beneficiaries have increased. It should be noted, however, that there were a low number of African-American, Native American, and Asian/Pacific Islander beneficiaries receiving services over the last two years, so even small increases/decreases in numbers served can affect the year over year PR greatly.

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



- The AACB increased in CY 2020 for all race/ethnicity groups, and increased again in CY 2021 for all groups, except for Asian/Pacific Islander beneficiaries.

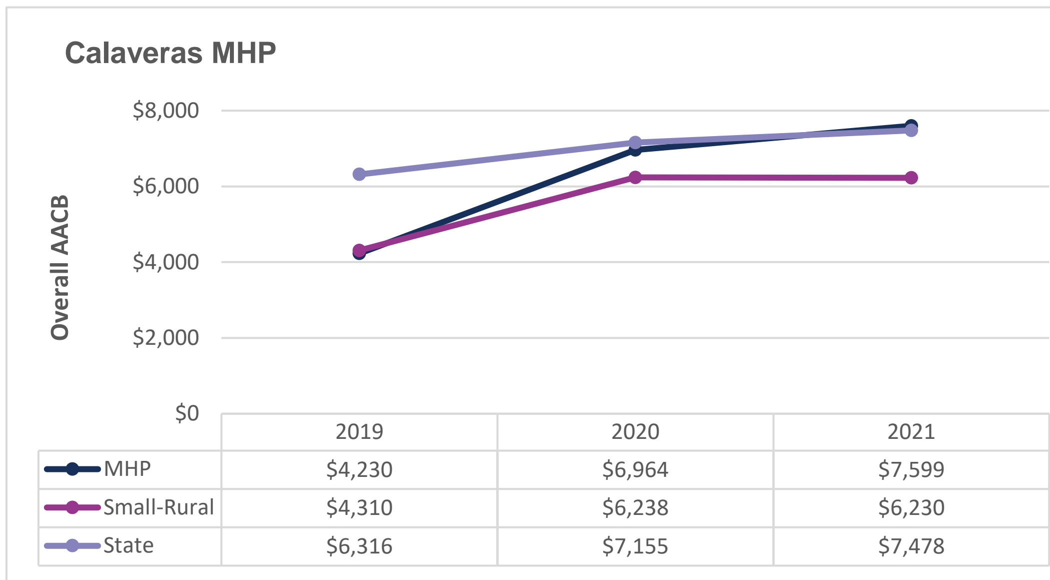
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	7.59%	6.74%	6.40%
Small-Rural	8.08%	7.11%	7.08%
State	4.86%	4.55%	4.34%

- The overall PR in Calaveras has followed statewide trends - decreasing each year since CY 2019 but remaining slightly lower than similarly sized counties and more than two percentage points higher than the State in CY 2021.

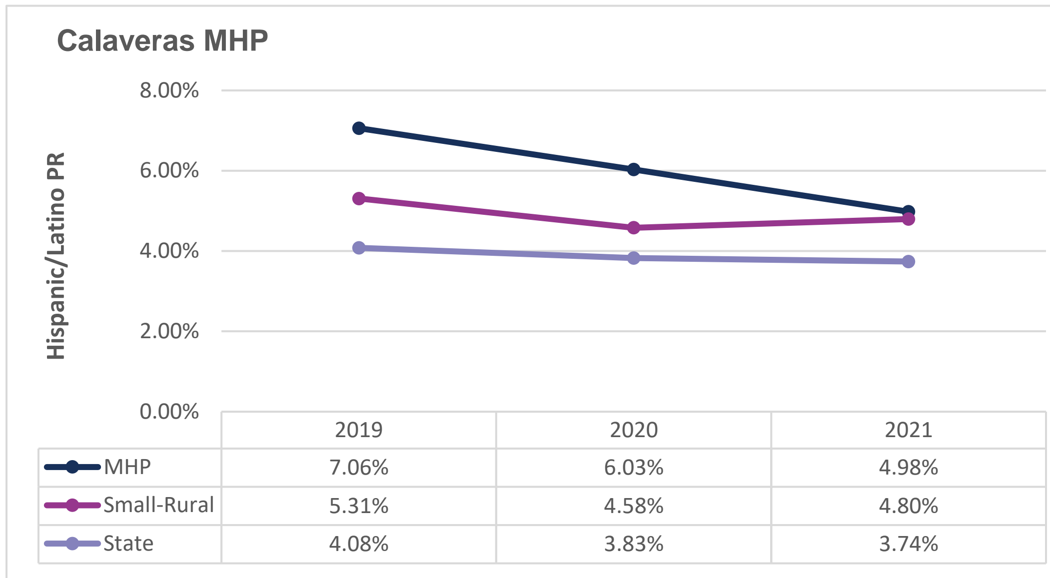
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,230	$6,964	$7,599
Small-Rural	$4,310	$6,238	$6,230
State	$6,316	$7,155	$7,478

- The overall AACB in Calaveras increased each year since CY 2019. The AACB was lower than both small-rural counties and the statewide average in CY 2019. It increased in CY 2020 to the point that it surpassed similarly sized counties, but not the State average. In CY 2021 its gap increased over small-rural counties and surpassed the State average. A correlated year-over-year increase in Psychiatric inpatient utilization since CY 2019 is likely contributing to these increases in AACB (see Table 13).

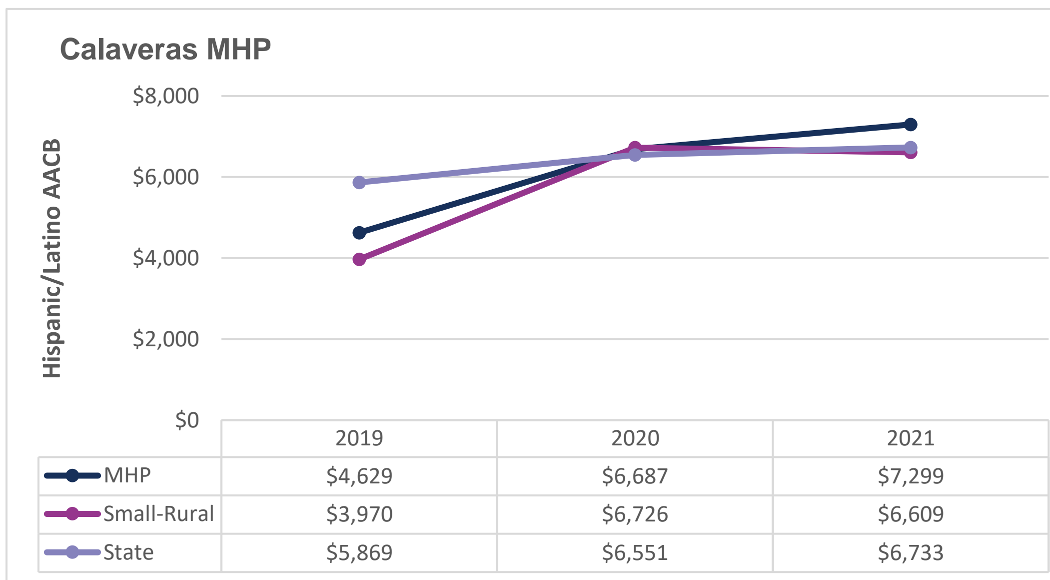
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	7.06%	6.03%	4.98%
Small-Rural	5.31%	4.58%	4.80%
State	4.08%	3.83%	3.74%

- The statewide Hispanic/Latino PR has decreased slightly each year since CY 2019, as has the PR in Calaveras. However, the MHP PR was more than one percentage point higher than the State in CY 2021, and has been consistently higher than the statewide PR for this group over the past three years.

Figure 7: Hispanic/Latino AACB CY 2019-21

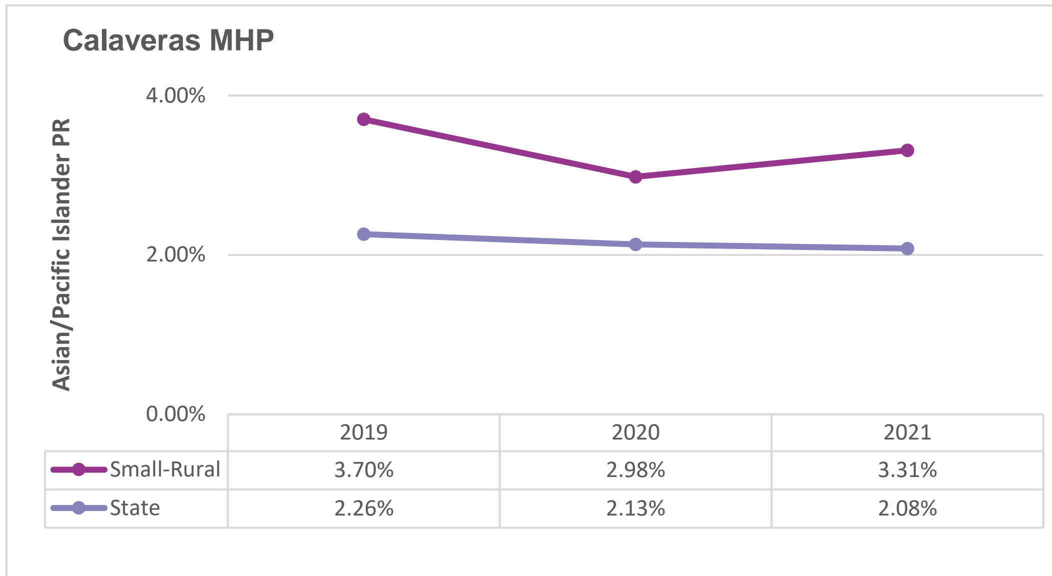


	2019	2020	2021
MHP	$4,629	$6,687	$7,299
Small-Rural	$3,970	$6,726	$6,609
State	$5,869	$6,551	$6,733

- As PR trends have been decreasing statewide since CY 2019, AACB for Hispanic/Latino beneficiaries have been increasing. Although AACB for Hispanic/Latino beneficiaries in Calaveras have also been increasing year over

year, the dollar amount surpassed that of the State in CY 2020 and the gap widened in 2021.

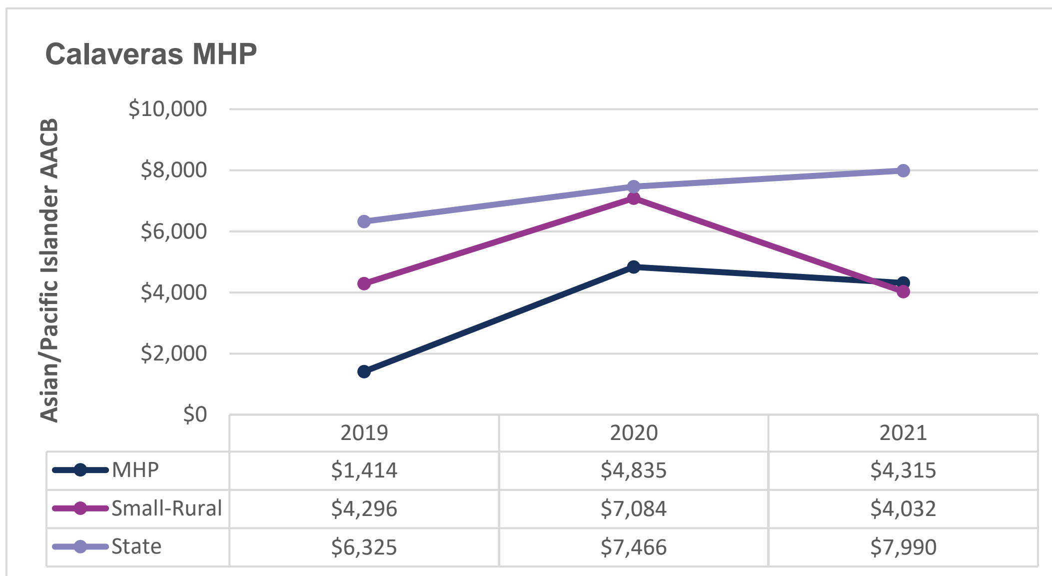
Figure 8: Asian/Pacific Islander PR CY 2019-21



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

- Asian/Pacific Islander PR data are suppressed for the MHP as the number of beneficiaries served was <11.

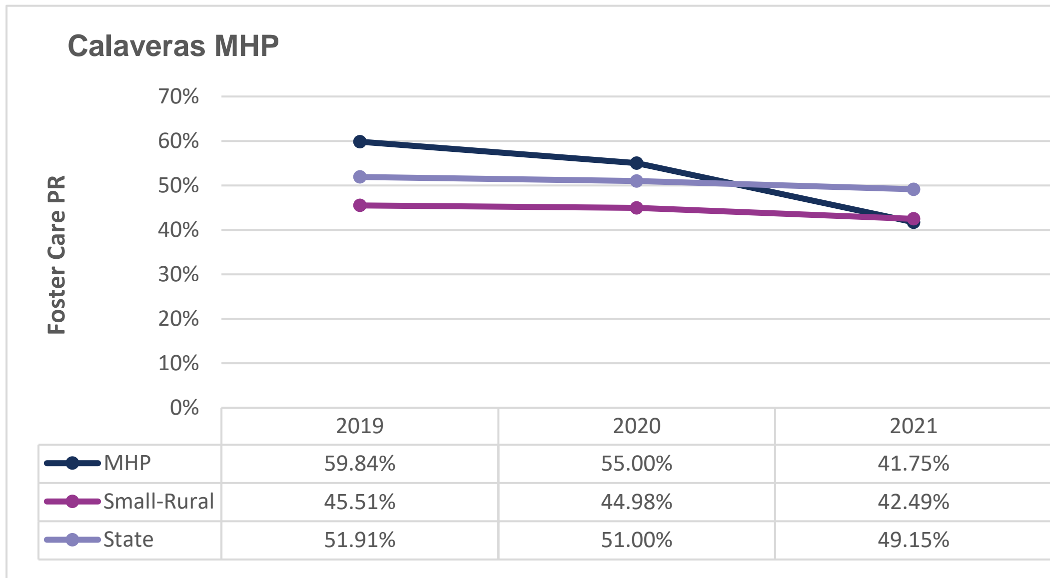
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$1,414	$4,835	$4,315
Small-Rural	$4,296	$7,084	$4,032
State	$6,325	$7,466	$7,990

- Asian Pacific Islander AACB for Calaveras increased in between CY 2019 and CY 2020, and decreased between CY 2020 and CY 2021.

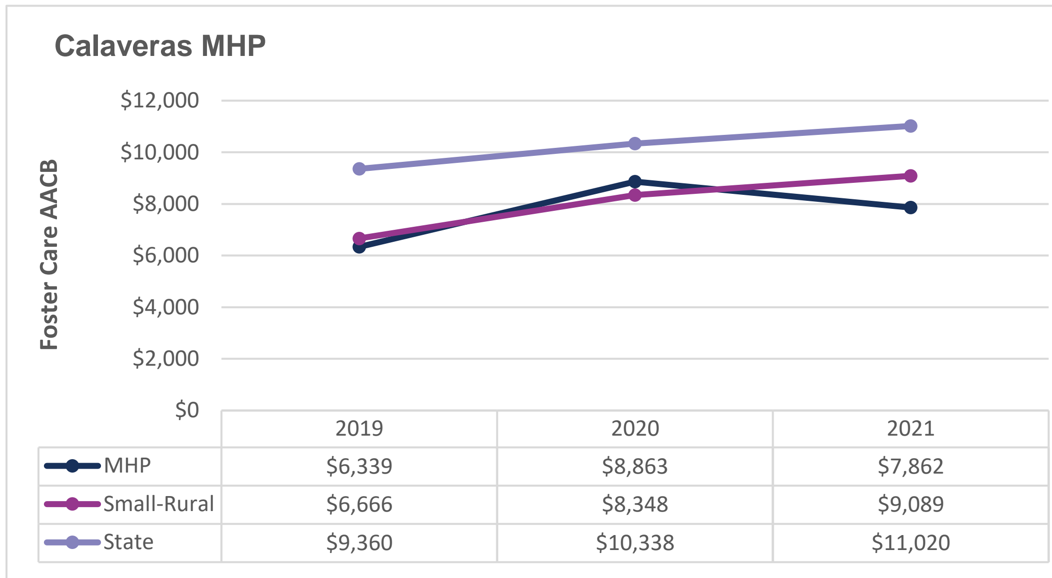
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	59.84%	55.00%	41.75%
Small-Rural	45.51%	44.98%	42.49%
State	51.91%	51.00%	49.15%

- Statewide foster care (FC) PR has remained steady at approximately 50 percent for 2019 - 2021.
- The FC PR has also remained relatively stable during the past three years in small-rural counties, however, Calaveras saw more than a four-percentage point decrease between CY 2019 and CY 2020, and a 13.25 percentage point decrease between CY 2020 and CY 2021.This is a 24 percent decline in PR. The MHP does not have processes to monitor FC access and hypothesizes that the high rate of FC beneficiaries being served out of county and retirement of Child Welfare Services clinicians may have contributed to the decreasing PR.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$6,339	$8,863	$7,862
Small-Rural	$6,666	$8,348	$9,089
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased each year.
- The MHP FC AACB decreased in CY 2021 to more than $3,000 below the State average.
- The MHP FC AACB is 13 percent lower than the small-rural FC AACB.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 612				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	39	6.4%	9	7	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	27	4.4%	32	18	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	<11	-	16	15	2.2%	21	14
Per Minute Services							
Crisis Stabilization	12	2.0%	1,135	1,200	13.0%	1,546	1,200
Crisis Intervention	228	37.3%	254	137	12.8%	248	150
Medication Support	331	54.1%	157	120	60.1%	311	204
Mental Health Services	388	63.4%	547	270	65.1%	868	353
Targeted Case Management	207	33.8%	1,541	535	36.5%	434	137

- The MHP has a notably lower percentage of adults accessing Crisis Stabilization services than the State (2 percent vs. 13 percent).
- Crisis Intervention services were accessed at a notably higher rate in Calaveras than the State (37.3 percent vs. 12.8 percent).

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

Service Category	MHP N = 41				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	7	6	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	<11	-	12	12	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	<11	-	60	60	3.1%	1,404	1,200
Crisis Intervention	<11	-	608	270	7.5%	406	199
Medication Support	18	43.9%	267	298	28.2%	396	273
TBS	<11	-	1,686	1,686	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	18	43.9%	328	143	40.2%	1,354	473
Intensive Home Based Services	<11	14.6%	2,346	2,142	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	3	95.1%	1,155	825	96.3%	1,854	1,108
Targeted Case Management	17	41.5%	583	225	35.0%	342	120

- The MHP closely aligned with statewide utilization rates for delivering services to foster youth, with the exception of Medication Support services, where Calaveras served 44.2 percent of beneficiaries compared to the statewide average of 28.3 percent.

IMPACT OF ACCESS FINDINGS

- Calaveras has seen consistently higher PRs than the State over the past three calendar years and seen an increase in overall AACB during that timeframe to

the point where they surpassed both small-rural counties and the State average in CY 2021.

- The MHP has also seen a large swing in FC PR, as they had a consistently higher rate than similarly sized counties and the State in CY 2019 and CY 2020, only to see a precipitous decrease between CY 2020 and CY 2021 (13.25 percent). Mechanisms to monitor access in FC are not in place which hinder the ability to ensure access for this group. Monitoring is more critical now, as anecdotally, the MHP reports referrals for children and youth have increased with the new CalAIM criteria.
- The MHP rate of adult Crisis Intervention were accessed at a significantly higher rate in Calaveras than the State (37.3 percent vs. 12.8 percent).
- Similarly, the MHP CY 2021 overall PR for crisis intervention (2.24 percent) is 31 percent higher than the similarly sized county PR (1.55 percent) and more than triple the State PR (0.52 percent). This higher rate of crisis utilization may indicate barriers for beneficiaries to access lower levels of care.

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	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Partially Met

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

- The MHP meets its 10-day standard to a first-offered appointment for only 46 percent of appointments. For adults, the MHP meets the standard for 38 percent of appointments. The MHP reports that clinical and medical record staff vacancies are the primary barriers to timeliness. Outside the efforts to address

workforce shortages, the MHP did not conduct performance improvement activities.

  - The MHP does not measure timeless for foster care beneficiary access for this or any other access point.

- The MHP reports metrics for timeliness for first psychiatry appointment, however, the MHP reports that data for child beneficiaries are not complete. The EQR is not able to validate the measurement for child services. For adults, the MHP meets its 15-day standard for a first-psychiatry appointment for 79 percent of appointments. The average is 18.6 days with a range of up to 236 days. ERQ review of the data shows that there are a few outliers that may account for this performance.
- No-show to psychiatry appointments is 31.4 percent for adults, exceeding the MHP's standard of 10 percent. Anecdotally, the MHP reports that COVID-related barriers prevented beneficiaries from coming to the MHP offices, and that the new ability to link directly from homes has improved engagement. Review discussions indicate that attending telepsychiatry appointments at home is not universally offered even if preferred by a beneficiary.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12 month period of FY 2021-22. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care for first offered appointment, first delivered service, first offered non-urgent psychiatry appointment, first non-urgent psychiatry service delivered, and no-show rates. The data represented county-operated services only for urgent appointments offered, follow-up services after psychiatric hospitalization, and psychiatric inpatient readmission rates.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	11.45 Business Days	10 Business Days*	46%
First Non-Urgent Service Rendered	12.83 Business Days	10 Business Days**	37%
First Non-Urgent Psychiatry Appointment Offered	16.63 Business Days	15 Business Days*	82%
First Non-Urgent Psychiatry Service Rendered	20.32 Business Days	15 Business Days**	74%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0.22 Hours	24 Hours**	100%
Follow-Up Appointments after Psychiatric Hospitalization	8.4 Days	7 Days**	59%
No-Show Rate – Psychiatry	17%	10%**	n/a
No-Show Rate – Clinicians	2.5%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-2022			

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

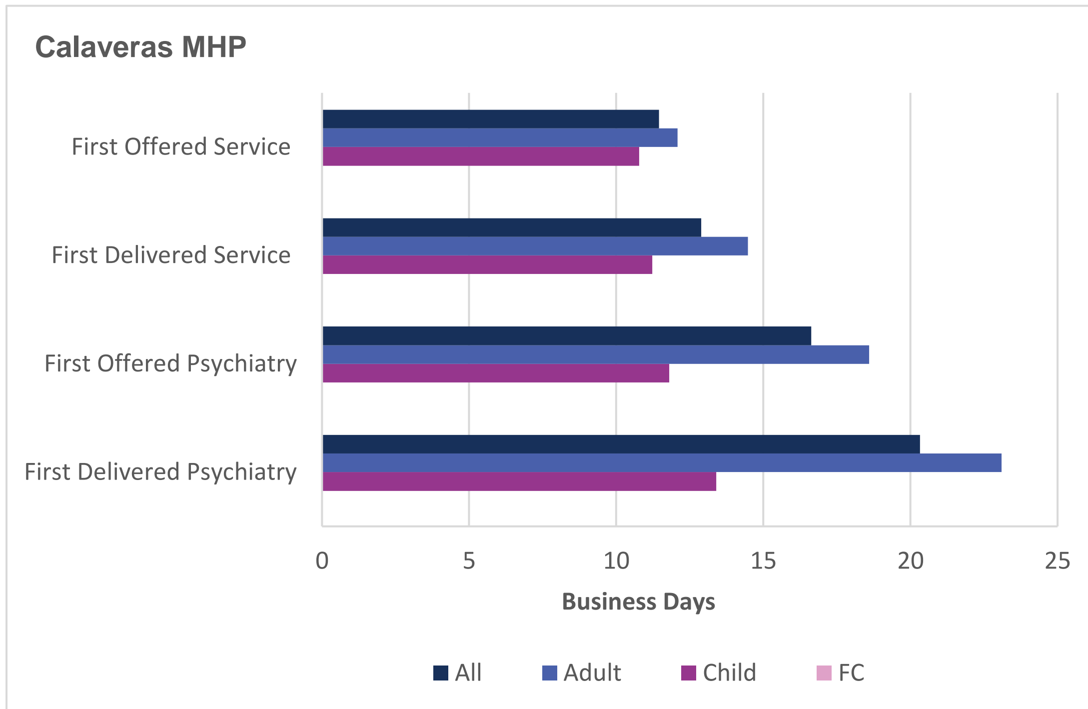


Figure 13: Wait Times for Urgent Services

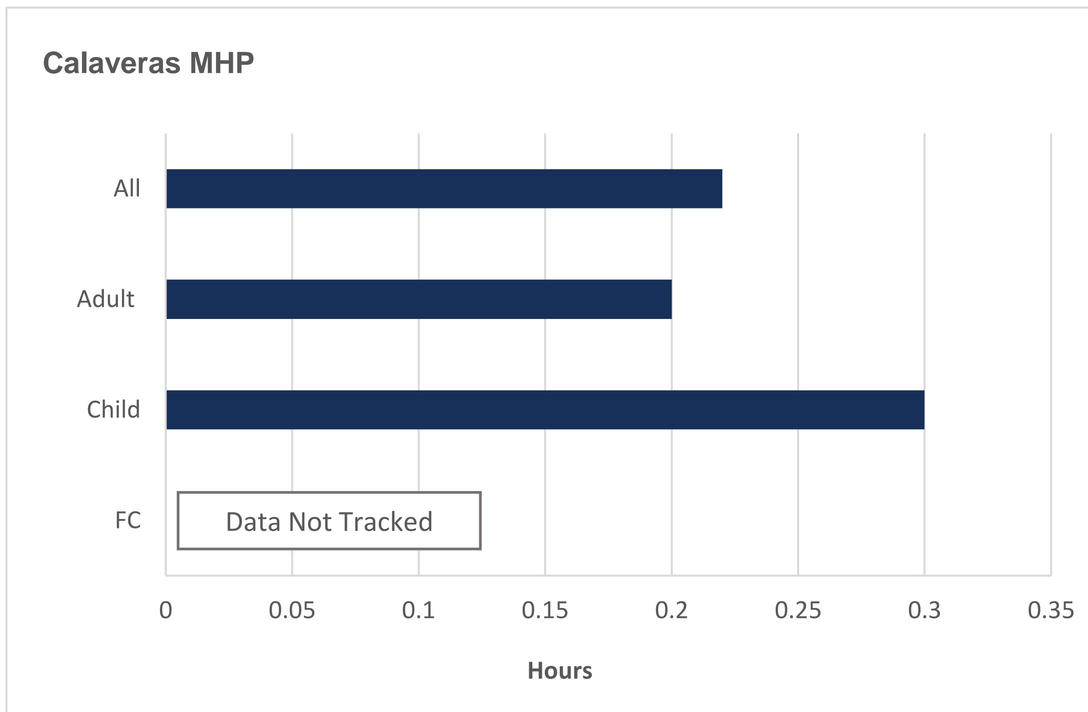
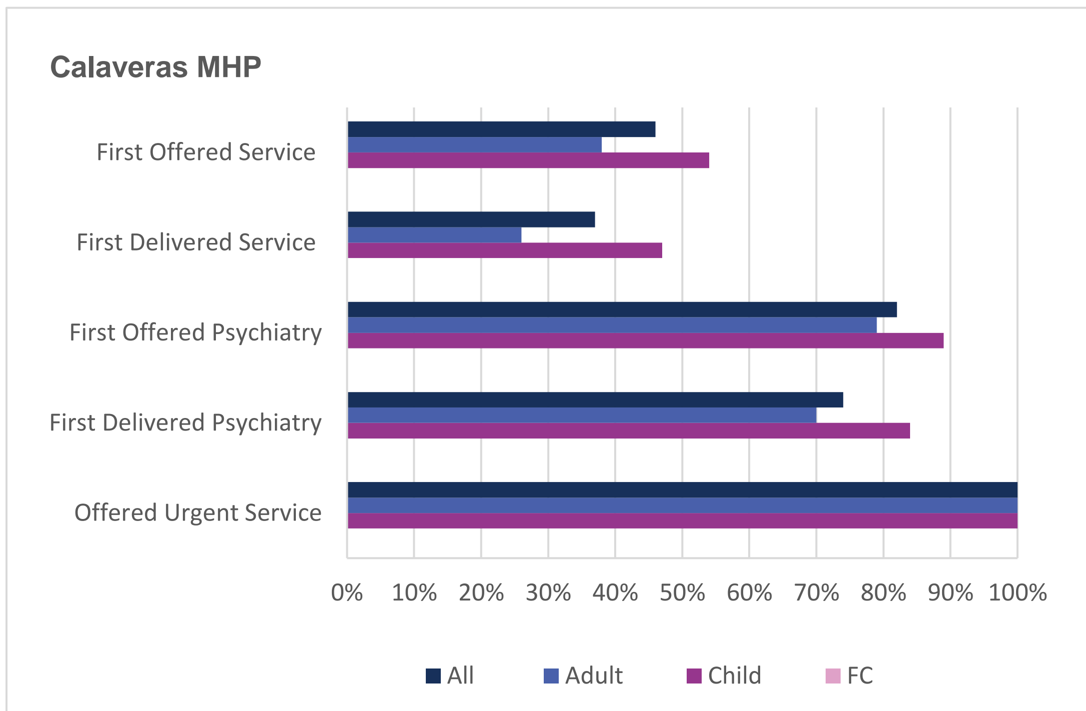


Figure 14: Percent of Services that Met Timeliness Standards



- For all metrics in Figures 12, 13, and 14, the MHP does not measure timeliness for FC beneficiaries.
- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled mental-health services, such as an intake prior to assessment.
- 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 (ED), or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as any unplanned crisis service provided within 24 hours. There were reportedly 842 urgent service requests with a reported actual wait time to services for the overall population at 0.22 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as the time from the first clinical determination of need to the first attended appointment.
- 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 17 percent for psychiatrists and 2.5 percent for clinicians.

IMPACT OF TIMELINESS FINDINGS

- The MHP's low performance in meeting its initial access standards align with the obstacles reported. Insufficient clinical staffing capacity and front-desk staff for intake processes are reflected in the initial services-timeliness metrics. With the reported increase in requests for services, and the MHP co-location at schools, demands on clinician staff will grow and mechanisms to monitor FC beneficiaries access would assist Quality Management (QM). The lack of timeliness measures for FC in conjunction with the decreasing PR highlight the MHP's gap in routinely assessing and managing this area.
- Delays to initial access to services may be associated with the higher rate of crisis-intervention utilization. This area should be evaluated.

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 lies with the Quality Improvement Committee (QIC), MHP leadership team, QI workgroups and providers.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of MHP leadership, QM, clinical staff, a consumer liaison, and Public Guardian staff, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met three times. A majority of the QAPI workplan goals were not evaluated due to the lack of QI staffing and other system priorities. For FY 2021-22, the MHP added CalAIM milestones and priorities to the QAPI.

The MHP does not utilize a systemwide level of care tool.

The MHP utilizes the following outcomes tools: Child and Adolescent Needs and Strengths, American Society of Addiction Medicine, General Anxiety Disorder 7, and the 9-Question Patient Health Questionnaire.

The MHP does not track or analyze data related to systemwide beneficiary level outcomes.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- QM staff vacancies and turnover hindered routine QM processes in the last year. The MHP reports that QI staff vacancies are currently filled, and QM processes have resumed.
- Review discussions identified increased support resources and family education related to gender identity as ways to improve the quality of services. Anectodally, the MHP has experienced an increase in psychiatric hospitalization related to gender identity issues in youth.
- The MHP did not conduct medication monitoring in the last year. The MHP has not been able to hire or contract a psychiatrist to conduct medication monitoring, despite having sought collaborations through County Behavioral Directors Association of California. The MHP reports creating a new medication monitoring dashboard reports in the IS.
- The MHP does not track or trend the following (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)

- The MHP provides a peer run wellness center which is open Monday through Thursday 9 a.m. to 2 p.m. and offers ten groups. No formal process exists to inform all beneficiaries about the center; clinicians refer beneficiaries to the center.

QUALITY PERFORMANCE MEASURES

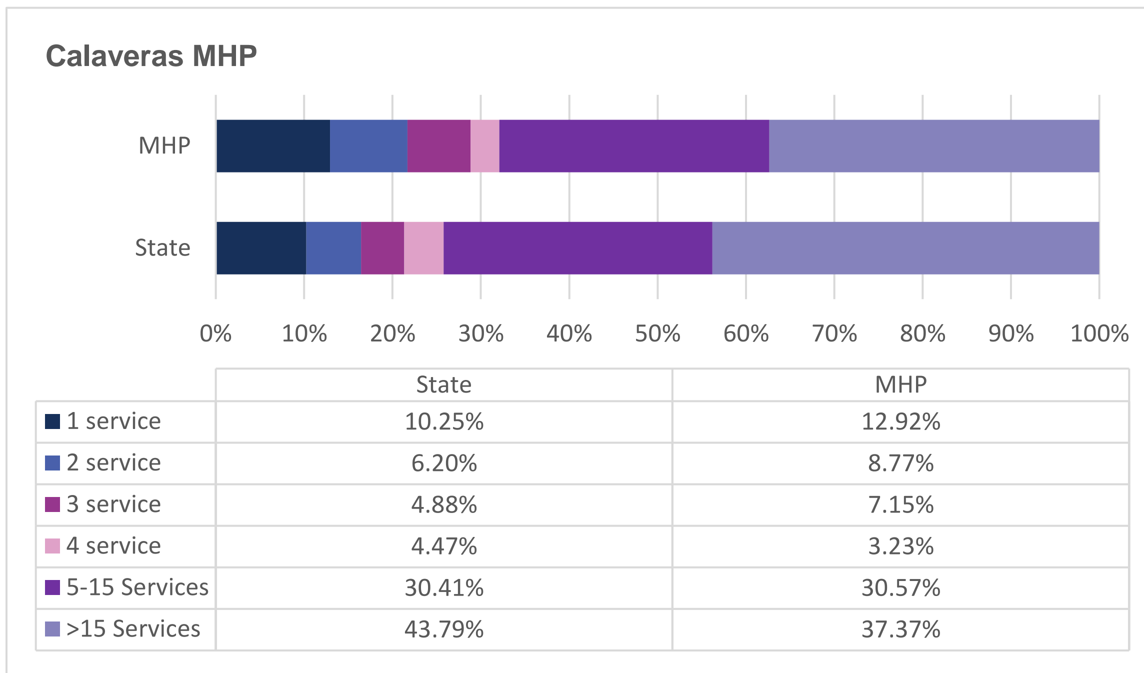
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



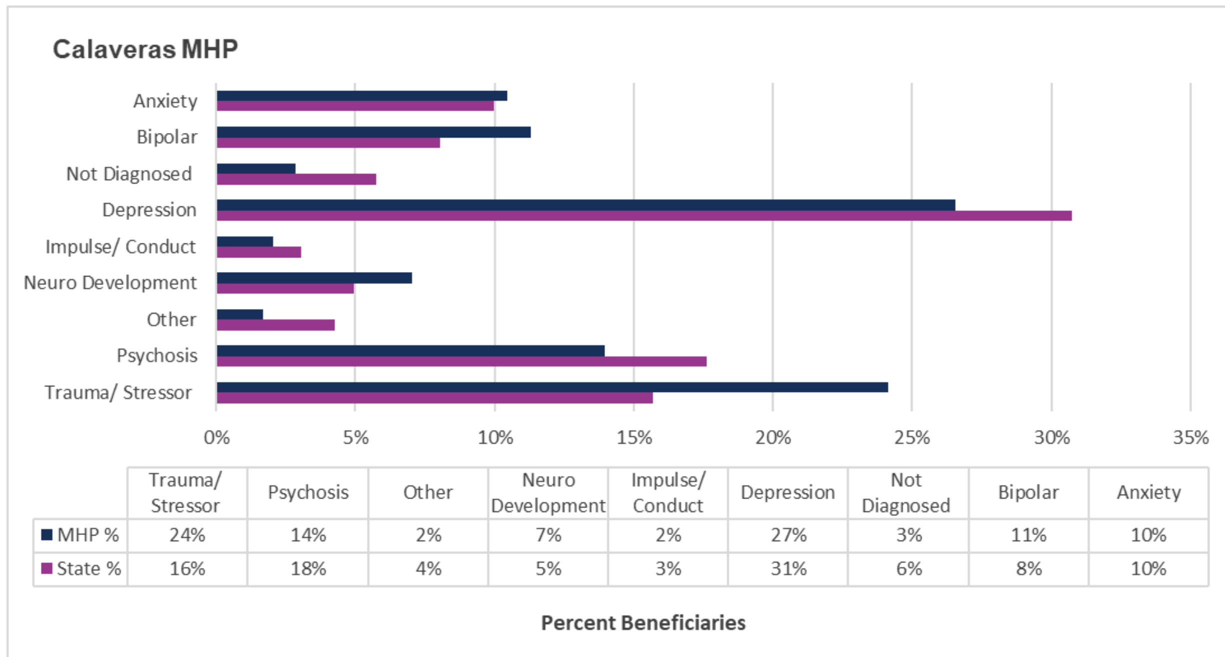
	State	MHP
1 service	10.25%	12.92%
2 service	6.20%	8.77%
3 service	4.88%	7.15%
4 service	4.47%	3.23%
5-15 Services	30.41%	30.57%
>15 Services	43.79%	37.37%

- The MHP percentage of beneficiaries who received 4 or fewer services is 24 percent higher than the State rate (32.07 percent vs 25.80 percent).
- The MHP percentage of beneficiaries who receive more than 15 services is 15 percent lower than the State rate (37.37 percent vs. 43.79 percent).

Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The following figures 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.

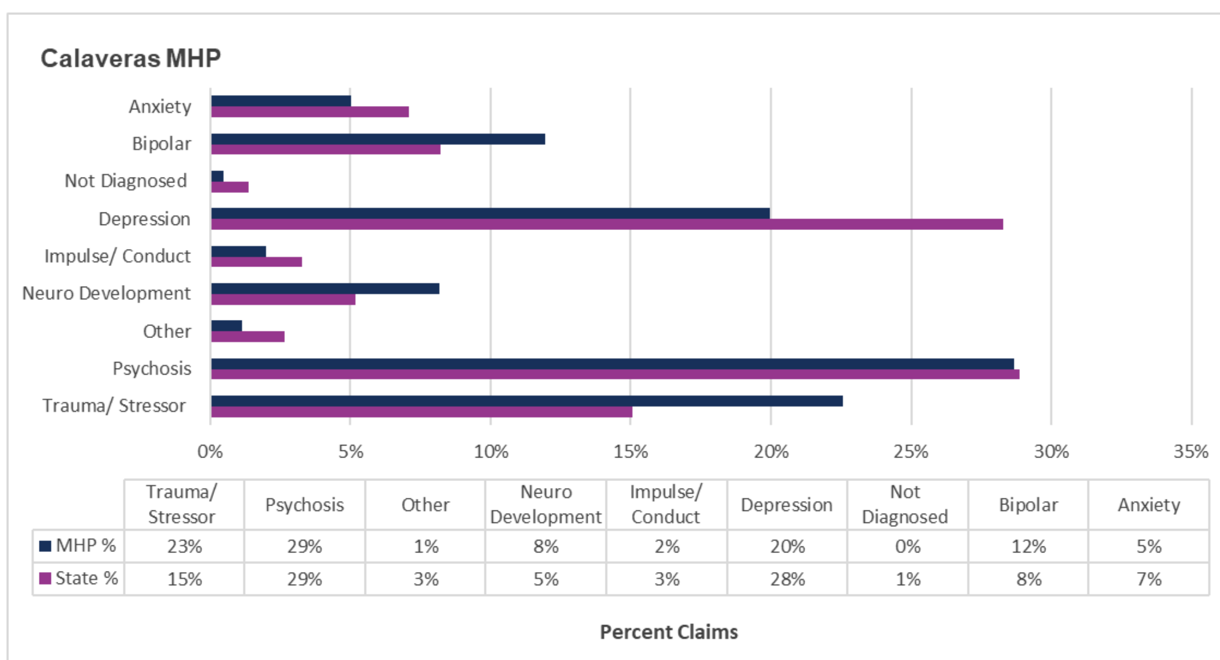
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	24%	14%	2%	7%	2%	27%	3%	11%	10%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The top three diagnostic categories in Calaveras County are depression, trauma/stressor, and psychosis.
- The MHP rate of a trauma/stressor (24 percent) diagnosis is 50 percent higher than the State rate (16 percent).
- The MHP's proportion of not diagnosed category is 50 percent lower than the State rate (6 percent).

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 %	23%	29%	1%	8%	2%	20%	0%	12%	5%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- The MHP's top three diagnostic categories by approved claims are psychosis (29 percent), trauma/stressor (23 percent), and depression (20 percent). Similar to the percentage of diagnostic categories in Figure 16, the MHP rate of approved claims for a trauma/stressor diagnosis (23 percent) is 53 percent higher than the State's rate (15 percent).
- The MHP's proportion of approved claims for depression (20 percent) is 29 percent lower than the State's proportion (28 percent).

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	88	153	14.46	8.86	$19,132	$12,052	$1,683,574
CY 2020	58	87	9.01	8.68	$12,149	$11,814	$704,639
CY 2019	46	72	7.00	7.80	$8,562	$10,535	$393,840

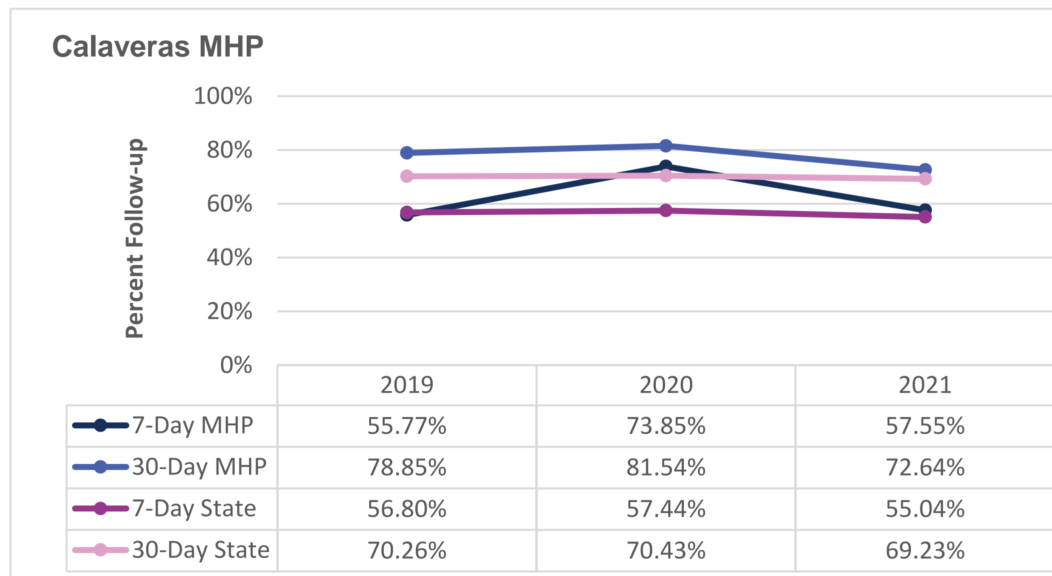
- Since CY 2019, the MHP's number of unique beneficiaries admitted to psychiatric inpatient services, total inpatient admissions, average LOS, AACB and total approved claims increased. AACB surpassed statewide rates beginning in CY 2020 and increased to more than $7,000 higher than the State in CY 2021. This is 37 percent higher than the State AACB. Further, the total approved claims for psychiatric inpatient services more than doubled in CY 2021 compared to the previous year.

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 inpatient claims data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

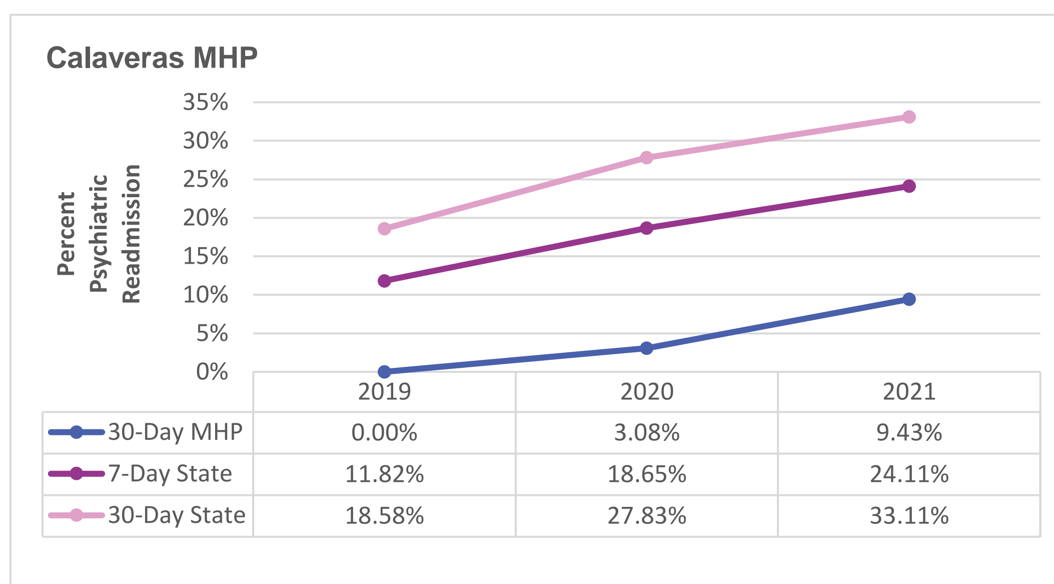
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	55.77%	73.85%	57.55%
30-Day MHP	78.85%	81.54%	72.64%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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



	2019	2020	2021
30-Day MHP	0.00%	3.08%	9.43%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- Although Calaveras has seen a significant increase in psychiatric inpatient services over the last 3 calendar years, the MHP's 7-day and 30-day follow-up rates post discharge rate have been similar or higher than the statewide rates each year since CY 2019.
- Although the number of psychiatric readmissions within 7-days are too small to report (<11), the 30-day readmission rate remained well below statewide rates each year between CY 2019 and CY 2021, Of note, however, is that the MHP's average admissions per admitted beneficiary increased in 2021.

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 $7,478, the median amount is $3,269.

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, nearly 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACB of $4,412 and median of $2,830.

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	48	5.54%	38.95%	$2,566,373	$53,466	$43,071
	CY 2020	45	5.38%	36.54%	$2,127,135	$47,270	$41,072
	CY 2019	16	1.74%	18.35%	$715,009	$44,688	$39,987

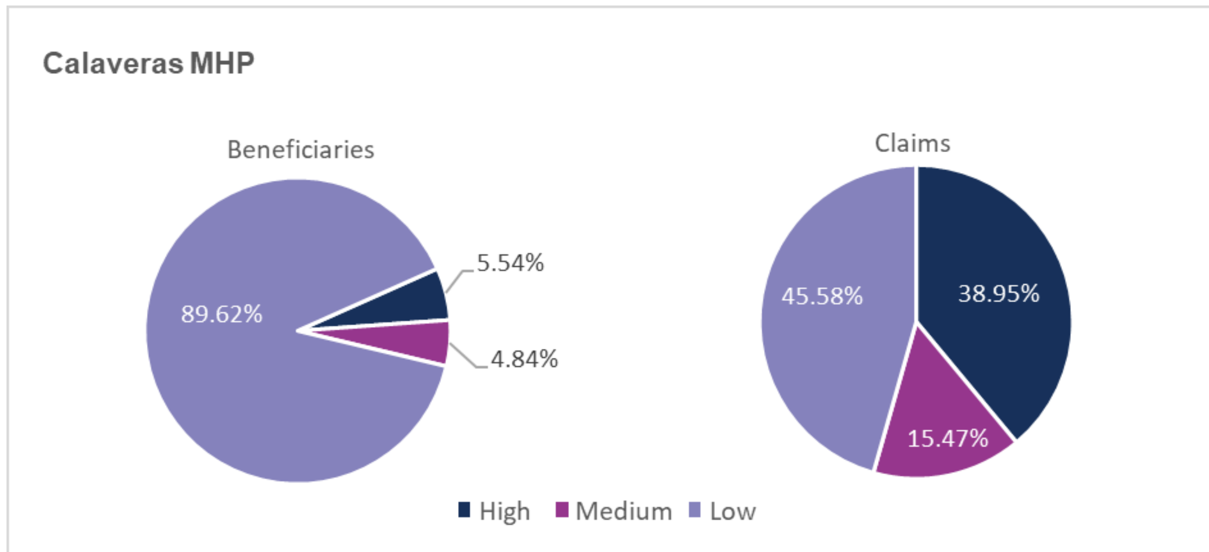
- Calaveras experienced a significant increase in the number of HCBs served in CY 2020 compared to the previous year, where 16 beneficiaries received more than $30,000 in services in CY 2019 compared to 45 in CY 2020. However, the number of HCBs stabilized in CY 2021 at 48. In CY 2021, the MHP proportion of HCBs served as a subset of total beneficiaries (5.54 percent) is 23 percent higher than the State (4.50 percent), but the AACB remained below the statewide average ($53,466 vs. $55,523).

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	42	4.84%	15.47%	$1,019,176	$24,266	$23,948
Low Cost (Less than $20K)	777	89.62%	45.58%	$3,002,868	$3,865	$1,969

- The majority of clients served in Calaveras are low-cost beneficiaries (89.62 percent) and medium-cost beneficiaries are the lowest percentage of clients served (4.84 percent).

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



IMPACT OF QUALITY FINDINGS

- Psychiatric inpatient services have increased markedly over the past three calendar years, but post inpatient follow-up services and inpatient readmissions are a notable strength, as rates for these metrics are well below statewide rates. Consistent with stakeholder reports, the dedicated appointments or “fast track” psychiatric appointments for high need beneficiaries such as post-hospitalization appear to support access and likely reduce hospital readmissions.
- The MHP has a higher proportion of beneficiaries receiving 4 or fewer services which may indicate barriers to beneficiary engagement. Because the MHP does not use or analyze beneficiary outcomes or level of care information systemwide, evaluating service effectiveness is a gap in QM.

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

Date Started: 09/2022

Aim Statement: "For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023."

Target Population: Beneficiaries age 6-64 years with an ED visit for a MH condition or intentional self-harm.

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

Summary

The MHP elected to participate in the CalAIM BHQIP and received information from DHCS that Calaveras fell in Quartile 2 compared to other MHPs for FUM7 (57 percent) and FUM30 (69 percent). This performance is above the national benchmarks. The

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

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

MHP had identified lack of follow-up for some beneficiaries as a problem in a 2019 Community Needs Assessment; broad participation including MHP staff, local consumer organizations, law enforcement, the Health and Human Service Agency, and educational agencies contributed to the process. There is one ED in the county beneficiaries use.

Root cause analysis found that insufficient data exchange, communication, and procedures to initiate or track referrals, and lack of data sharing for care coordination. Geographic and social distance, and isolation are barriers as well. Ordinarily, the MHP receives communication from the ED only if a beneficiary is placed on a 5150 hold. Interventions include implementing a collaborative care model with the ED, information sharing through a data feed, and procedures to link beneficiaries to the MHP from the ED. The MHP is partnering with the Managed Care Plan in this PIP.

Collaboration with the EDs to develop this PIP appears limited thus far and is an area to ensure as the PIP planning advances.

Primary indicators are FUM7 and FUM30; remeasurement is planned quarterly. Process measures include the percentage of beneficiaries who receive a screening in the ED, percentage of beneficiaries from the ED with a MH condition who are referred, and the and the number of ED referrals who complete an assessment for follow-up care. The MHP has entered a plan with CalMHSA for ongoing data support in this project. The MHP is currently obtaining data for beneficiaries who have received services using Finder File requests to DHCS and plans for an electronic health information exchange (HIE) after transitioning to the a new EHR.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: the PIP is in the planning phase. Collaboration and barrier analysis with the ED also appear to be needed.

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

- Establish and report baselines for the indicators with a numerator and denominator.
- Elicit input and partnership with the ED in all phases of the PIP process.

NON-CLINICAL PIP

General Information

<u>Status of PIP</u>: The MHP does not have a non-clinical PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

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

Approximately 5.3 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control.

The MHP has 71.5 named users with log-on authority to the EHR, including approximately 47.5 county staff and 24 contractor staff. Support for the users is provided by 0.5 full-time equivalent (FTE) IS technology positions. Currently all positions are filled.

As of the FY 2022-23 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit 100 percent of their beneficiary practice management and service data to the MHP IS as direct data entry, as seen 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	100%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. Calaveras beneficiaries do not have access to a PHR. However, the MHP plans to implement a PHR within the next two years through the new EHR, Credible.

Interoperability Support

The MHP is a member or participant in a HIE (Manifest Medex). However, the agreement is newly executed, and data will not be exchanged until after the new Credible EHR is fully implemented, likely toward the end of FY 2023-24.

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

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

- Investment in IT infrastructure and resources is notably strong with a sufficient budget for the acquisition of a new EHR, Credible, and a targeted implementation date of July 2023.
- The integrity of the Medi-Cal claims process is another notable strength as claims records indicate timely submittals to DHCS and the claim denial rate is below the statewide average.
- Related to the integrity of data collection and processing, the MHP does not currently have a data warehouse that replicates the EHR system to support data analytics.
- EHR functionality is another key component that was only partially met as there are a number of clinical data subcomponents that are not currently built into the EHR such as: alerts, care coordination, lab orders, level of care, outcomes, referral management, and PHR. However, many of these elements have not been modeled into the current EHR due to the limitations of the system, and most are expected to be a part of Credible.
- The security and controls key component is also considered partially met because the MHP does not review and test the Operations Continuity Plan at least annually, and formal records or logs of security training activities and user attendance are not maintained.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	1,379	$467,956	$0	0.00%	$456,226
Feb	1,458	$555,716	$4,060	0.73%	$549,447
Mar	1,631	$545,392	$0	0.00%	$529,424
April	1,604	$532,912	$0	0.00%	$522,730
May	1,525	$559,206	$1,152	0.21%	$544,706
June	1,632	$537,037	$1,552	0.29%	$521,750
July	1,673	$495,036	$5,069	1.02%	$483,634
Aug	1,531	$455,168	$1,992	0.44%	$445,798
Sept	1,421	$421,441	$9,662	2.29%	$409,570
Oct	1,434	$423,052	$4,661	1.10%	$415,523
Nov	1,369	$420,257	$5,754	1.37%	$409,452
Dec	1,395	$463,966	$4,522	0.97%	$457,884
Total	**18,052**	**$5,877,139**	**$38,424**	**0.65%**	**$5,746,144**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B must be billed before submission of claim	42	$13,039	33.93%
Service location NPI* issue	109	$12,906	33.59%
Other healthcare coverage must be billed before submission of claim	11	$4,798	12.49%
Late claim	1	$4,060	10.57%
Beneficiary not eligible or non-covered charges	10	$1,792	4.66%
Service line is a duplicate and a repeat service procedure code modifier not present	9	$1,706	4.44%
Deactivated NPI	1	$123	0.32%
Total Denied Claims	**183**	**$38,424**	**100.00%**
Overall Denied Claims Rate	**0.65%**		
Statewide Overall Denied Claims Rate	**1.43%**		
*National Provider Identifier			

- The top three denial reasons account for $30,743 and 80.01 percent of total denied claims.

- The denied claims rate is considerably lower than the statewide rate (0.65 percent vs. 1.43 percent).

IMPACT OF INFORMATION SYSTEMS FINDINGS

- One FTE is split between IS and data analytics (.5 FTE each), which is currently sufficient to meet the reporting and IS needs for the MHP. However, having only 1 FTE may be insufficient with the impending rollout of the new EHR due to the amount of training needed for both clinical and non-clinical staff, and the enhanced data analytics capabilities that come along with it. CalAIM requirements will also add to stretching IS and data analytics staff too thin which could pull them off other high-priority projects, thus creating inefficiencies in other areas. Increasing IS and data analytics FTE or cross training may be beneficial to meet the coming needs of the new EHR and CalAIM requirements.
- The MHP Medi-Cal claiming process is very consistent with a notably low denied claims rate.
- The MHP has also been proactive in granting full contractor access to the EHR. This has made submitting service and beneficiary data more efficient. The MHP has indicated that contractors will maintain full access to the new Credible EHR as well.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP completed the CPS process and reports 2022 results have not been received from the State yet. Document review shows that the MHP's most recent analysis used 2020 results.

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 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually but included only two participants. All consumers participating receive clinical services from the MHP. Due to the small number of participants attending despite MHP planning, beneficiary experience obtained could not be used to inform multiple areas of this review and also maintain anonymity.

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 increased access to children, youth and families, significantly providing services and professional training at every elementary school in the county. (Access)
2. The MHP has focused efforts on post-hospitalization services; the MHP maintains low rates of hospital readmissions compared to the state average. (Access, Timeliness, Quality)
3. The MHP fully reopened its wellness center, open four days a week. (Access, Quality)
4. Medi-Cal claims are submitted consistently with low rates of denial. (IS)
5. The MHP selected a new EHR, Credible, and has a target implementation date of July 2023. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Although the MHP has skilled IS and data analytics staff, the FTEs to support the increased demands of a new EHR and CalAIM system updates is inadequate. (IS)
2. Associated with staffing challenges, the MHP’s time to a first appointment is frequently delayed. The MHP met its timeliness goal for only 46 percent of first-request appointments. (Access)
3. The MHP’s foster care penetration rate has significantly declined, and the MHP lacks ways to monitor timeliness, access, and outcomes for foster care youth. (Access, Timeliness, Quality)
4. The MHP does not conduct medication monitoring; securing psychiatry staff is an ongoing challenge. (Quality)
5. Opportunities for collaboration and bi-directional communication with clinical staff remain limited. (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. Analyze how many IS and data analytics FTEs are needed to support the new EHR, CalAIM, State reporting requirements, and other internal reporting needs, and cross train where possible to alleviate some of the demands placed on IS staff. (IS)
2. Examine access processes to a first appointment and implement improvements to reduce barriers identified outside staffing challenges. Measure the effectiveness of changes made and modify as indicated. (Access, Timeliness)
3. Evaluate access processes for foster care youth and identify barriers. Implement interventions to improve access as indicated. Measure timeliness and penetration rates. (Access, Timeliness)
4. Implement a medication-monitoring system that includes HEDIS measures outlined in SB 1291. (Quality)

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

5. Implement quality improvement activities to improve bi-directional communication between MHP leadership, and direct line staff and to improve staff morale and staff retention. Use the results from past staff satisfaction surveys to identify focus areas. (Quality)

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

EXTERNAL QUALITY REVIEW BARRIERS

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

Despite the MHP's planning, the consumer/family member focus group was attended by only two beneficiaries.

As a result of the continued consequences of the COVID-19 pandemic, California public health emergency (PHE) was in place until February 28, 2023 and a national PHE is scheduled to end May 11, 2023. 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, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Calaveras MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
PIP Validation and Analysis
Performance Measure Validation and Analysis
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Satisfaction
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Supported Employment Interview
Information Systems Billing and Fiscal Interview
EHR Deployment

CalEQRO Review Sessions – Calaveras MHP
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rowena Nery, Lead Reviewer
Brian Deen, Information Systems Reviewer
Arden Tucker, Consumer/Family Member Consultant
Walter Shwe, Consumer/Family Member Consultant

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
Alt	Wendy	BHS Deputy Director	CCBHS
Alvarado	Kaybee	Mental Health Services Act (MHSA) Support Services Supervisor	CCBHS
Berry	Morgan	Billing Specialist	CCBHS
Bugarin	David	Technical Trainer Specialist	CCBHS
Burns	Leanne	BHS Adm. Services Manager	CCBHS
Carson	Julie	Program Analyst –MHSA Programs	CCBHS
Fulgham	Robb	Substance Use Disorder Programs & Adult Services Supervisor	CCBHS
Gonzalez	Monique	Clinical Supervisor	CCBHS
Gonzalez	Jay	Case Manager	CCBHS
Hatfield	Stephanie	Clinician	CCBHS
Jacobs	Nancy	Clinician	CCBHS
Johnson	Dianne	Quality Management Specialist	CCBHS
Lindsey	Steve	Driver	CCBHS
Lopez	Cindy	Counselor III –Youth Services	CCBHS
McCoy	Gabriel	Community Services Liaison	CCBHS
Martin	Carley	Case Manager	CCBHS
Meily	Stacey	BHS Program Manager	CCBHS
Pekarcik	Karen	Clinician	CCBHS
Pullin	Danielle	Case Manager	CCBHS

Last Name	First Name	Position	County or Contracted Agency
Radliff	Rick	Clinician	CCBHS
Skrimager	Loren	Fiscal	CCBHS
Snyder	Lisa	CalAIM Program Coordinator	CCBHS
Yount	Daryle	Clinician	CCBHS

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 MHP elected to participate in the CalAIM BHQIP FUM.
General PIP Information	
MHP/DMC-ODS Name: Calaveras MHP	
PIP Title: Follow-Up After ED Visit for Mental Illness	
PIP Aim Statement: ”For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023.”	
Date Started: 09/2022	
Date Completed: n/a	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
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): Beneficiaries age 6-64 years with an ED visit for a MH condition or intentional self-harm.	

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Creating information sharing through a data feed, and procedures to link beneficiaries from the ED and care coordination, creating a tracking system initiate and monitor referrals of the target population.
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): Creating information sharing through a data feed, and procedures to link beneficiaries from the ED and care coordination, creating a tracking system initiate and monitor referrals of the target population.

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
Percentage of ED visit for a mental health (MH) condition and receive a follow-up MH service within 7 days.	2021	57 percent of beneficiaries received mental heatlh follow-up within 7 days	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No n/a	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 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
Percentage of ED visit for a MH condition and receive a follow-up MH service within 30 days.	2021	69 percent of beneficiaries received mental heatlh follow-up within 30 days	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No n/a	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 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):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Establish and report baselines for the indicators with a numerator and denominator. • Include numerator and denominators for all the indicators. • Elicit input and partnership with the EDs in all phases of the PIP process.

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 MHP did not submit a non-clinical PIP.
General PIP Information	
MHP/DMC-ODS Name: n/a	
PIP Title:	
PIP Aim Statement:	
Date Started:	
Date Completed:	
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):	
Improvement Strategies or Interventions (Changes in the PIP)	

General PIP Information
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
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): Click or tap here to enter text.

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

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

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:

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

Calaveras Health and Human Services Agency

Wendy Alt, Mental Health Director

April 17, 2023

Samantha Fusselman, LCSW, CPHQ
Executive Director, CalEQRO
Behavioral Health Concepts, Inc.
2340 Powell St. #334
Emeryville, CA 94608

Dear Samantha,

On March 2, 2023 Calaveras County participated in our annual EQRO Review.

Calaveras County is requesting flexibility on our Consumer Focus Group which had 2 participants. The Calaveras Team had 7 clients scheduled to participate but due to connection issues in our rural community only two clients were able to participate. With the pandemic changes it is our goal next year to be able to host the Client Focus group on site to prevent any connection issues.
Also, with the implementation of CalAIM and the 3 additional PIP's required of the counties, it would be a heavy lift for a small rural county to have any more than three. Therefore we were not able to complete the second PIP under the EQRO review.

Sincerely,

Wendy Alt, Mental Health Director

Calaveras County Behavioral Health Program

Behavioral Health Services
891 Mountain Ranch Road
San Andreas, CA 95249
(209) 754-6525 Mental Health Program
(209) 754-6555 Substance Abuse Program