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

EL DORADO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

February 16, 2023

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

MHP INFORMATION

Review Type — Onsite

Date of Review — February 16, 2023

MHP Size — Small

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
6	4	2	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	0	6	0
Quality of Care	10	1	5	4
Information Systems (IS)	6	3	3	0
TOTAL	**26**	**8**	**14**	**4**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
"Ensuring Clients Are Involved in Medication Management services as evidenced by signed Medication Consent Forms."	Clinical	08/2022	Baseline	Moderate
"Follow-Up After Emergency Department Visit for Mental Illness (FUM)."	Non-Clinical	09/2022	Implementation	Moderate

Table D: Summary of Consumer/Family Focus Groups

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

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP works effectively with the physical health care system embedding staff within the Emergency Departments (ED).
- The MHP created a No-show code to accurately identify and track No-show outcomes and trends.
- The MHP has opened its onsite Wellness Center for all clients to receive in-person services.
- Due to new management staff being located in the South Lake Tahoe (SLT) site, community engagement within the clinic and staff satisfaction has increased.
- The MHP increased Foster Care (FC) penetration rates, attributed to a clear referral pathway and strong relationships between the MHP and Children's Protective Services.

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

- The MHP lacks sufficient data analytic staff and software to produce the reports needed for Quality Improvement (QI) and management decision-making.
- The MHP underutilizes its beneficiary and family stakeholders' voice to identify system change.

- Qualified employees are leaving the MHP to seek higher-paying lateral employment opportunities in surrounding counties and contracted services.
- The MHP does not adequately address beneficiary impact when formulating or reporting on goals and objectives within the Quality Improvement Workplan (QIWP)
- Inability to enter data into the Electronic Health Record (EHR) while delivering field-based services results in the line staff spending additional time entering data at a later time.

Recommendations for improvement based upon this review include:

- Add data analyst staff and data analytic software to improve data collection, report development, and analysis of outcomes.
- Engage beneficiaries and family members to discuss system-wide satisfaction, challenges, and ideas for improvements.
- Engage Human Resources (HR) to address and remedy pay disparities and lengthy wait times for onboarding.
- Expand the QIWP to include beneficiary impact goals that coincide with achieved compliance goals.
- Investigate how to improve data entry processes for field-based services that reduce the burden on the 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 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 El Dorado County MHP by BHC, conducted as an onsite review on February 16, 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 network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of 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/after the Coronavirus Disease 2019 (COVID-19) pandemic, Mosquito Wildfire, and Atmospheric River. The MHP staff was significantly impacted by both the fire and snow fall. The MHP also faced challenges in their high management turnover and fluctuating clinical vacancy rate of 30-42 percent. The MHP never reduced services and staff worked remotely during these events. 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.

- Health and Human Services Agency hired a mental health worker to assist with clinical outreach efforts after the Caldor fire and has now expanded services to be ongoing throughout the continued environmental disasters.
- Ongoing staff turnover has created new opportunities for upward mobility within the MHP. New management staff have prioritized an Equity, Diversity, and Inclusion Committee (EDIC).
- The MHP attempted to purchase a house to be a six-bed supportive housing option. These efforts were not successful once the final inspection of the house showed it would not be safe for beneficiaries. The MHP continues to look for appropriate permanent housing purchase options.
- The MHP is working with the new Managed Care Plans (MCPs) as they transition from a two MCP model to one County and one commercial MCP.
- The MHP continues to maneuver the requirements of CalAIM which have added additional workload to an already taxed workforce.

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: Clearly define and map out the business process workflow for access, including definitions of routine, urgent, and crisis requests for service.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP clearly identified timeliness definitions of Routine, Expedited and Urgent services.
- The MHP clearly identified the outline and Access process within the county.

Recommendation 2: Identify barriers and implement strategies to accurately track and report timeliness data; conduct routine timeliness data analysis, at least quarterly, and present findings to key stakeholders.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP identifies lack of appropriate staff does not allow for accurate tracking and trending of timeliness data.
- The MHP would require a data analysist position to continue to improve the tracking of timeliness data.
- A new code for No-show data was created to assist in tracking of this metric, but staff will need to receive training and oversite to ensure the use of the new code.

- The MHP hired management staff who are actively addressing strategies for accurate tracking and providing and presenting findings within their Quality Improvement Committee (QIC). For these reasons, this recommendation is not carried forward.

Recommendation 3: Resume regular QIC and Cultural Competency Committee (CCC) meetings with appropriate stakeholder participation and maintain minutes that document discussion and action items.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP held eight QIC and CCC meetings throughout the FY.
- The MHP created a new EDIC.
- The MHP invites appropriate stakeholders to the meetings, though lacks the regular participation of beneficiaries and families.

Recommendation 4: Develop an emergency response plan that includes a plan to redirect medication to an alternate pharmacy in the event of future evacuations.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has created a policy to ensure medication is accessible during an emergency.
- Due to the remoteness of the STL clinic, staff that lives closest to the identified alternate pharmacy will physically pick up all medications and hand deliver it to the clinic in need.

Recommendation 5: Ensure available staff in the SLT area who can administer medication, in-person or via telehealth.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- There is an onsite Public Health nurse that administers medication weekly. If a beneficiary is unable to make the onsite date, the nurse is available daily at the public health site located minutes from the SLT clinic.
- A new bi-lingual Psychiatrist has been hired for telehealth services.

Recommendation 6: Continue with stated plans to develop designated positions for persons with lived experience within the MHP and include a defined career ladder.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP is recommended to include the voice of the beneficiaries and families to identify a peer ladder and opportunities within the MHP.

- The MHP has submitted a letter to DHCS to add a Peer Support Specialist position to their system of care and is awaiting approval. Once approval is granted, the MHP will begin hiring peer staff. For these reasons this recommendation is not carried forward.

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 44 percent of services were delivered by county-operated/staffed clinics and sites, and 56 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 77 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 that is operated by county staff during business hours and a contracted answering service after hours; beneficiaries may request services through the Access Line as well as through the following system entry points: county clinics, community providers, and by fax. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Service requests are documented in a call intake log, screened, and referred for assessment when indicated.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth, both video and phone to youth and adults. Group therapy and support services are available by video only. In FY 2021-22, the MHP reports having provided telehealth services to adult, youth, and older adult beneficiaries across 2 county-operated sites and 13 contractor-operated sites. However, the MHP was unable to provide the count of beneficiaries who received telehealth services or who received those services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

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

[1] CMS Data Navigator Glossary of Terms

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

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

For El Dorado County, the time and distance requirements are 45 miles and 70 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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP is working with the Asian/Pacific Islander population to create and equity and competency group.
- As reported by Key Informants, alternate language lines and interpretation is available and utilized.
- The MHP offers high performing supportive housing options with coordination of care to improve access for beneficiaries.
- The MHP continues to offer telehealth as an option for beneficiary access.

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, El Dorado's PR has been lower than the statewide rate between CY 2019-21.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	41,637	1,393	3.35%	$10,548,971	$7,573
CY 2020	38,184	1,211	3.17%	$10,677,391	$8,817
CY 2019	37,339	1,311	3.51%	$10,500,494	$8,010

- Between CY 2019 and CY 2021, the MHP's eligible count increased by 11.5 percent while the number of beneficiaries served increased by 6.3 percent, resulting in a slight decrease in its PR. While the total approved claims remained virtually static, the AACB decreased by 5.5 percent during the same period.

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	3,944	55	1.39%	1.27%	1.96%
Ages 6-17	9,170	448	4.89%	5.74%	5.93%
Ages 18-20	2,076	83	4.00%	4.89%	4.41%
Ages 21-64	22,965	762	3.32%	4.73%	4.56%
Ages 65+	3,483	45	1.29%	2.45%	1.95%
Total	**41,637**	**1,393**	**3.35%**	**4.39%**	**4.34%**

- The MHP's PR for each age group is lower than the corresponding statewide PR. They are also lower than the small-sized MHPs' average PRs except for the 0-5 age group.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	34	2.44%
Threshold language source: Open Data per BHIN 20-070		

- Spanish is El Dorado County's only threshold language and the PR for the Spanish speakers is 32 percent lower than the MHP's overall PR.

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	14,334	385	2.69%	$2,336,565	$6,069
Small	199,673	7,709	3.86%	$45,313,502	$5,878
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.

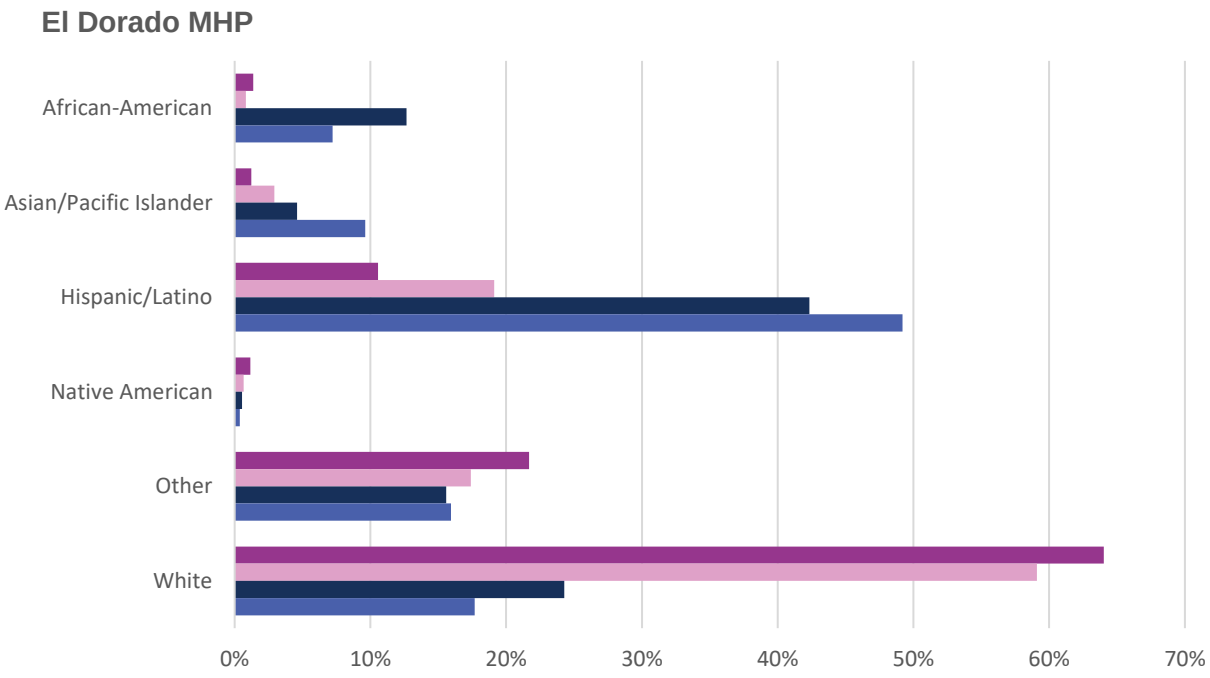
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions 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	343	19	5.54%	7.64%
Asian/Pacific Islander	1,217	17	1.40%	2.08%
Hispanic/Latino	7,961	147	1.85%	3.74%
Native American	270	16	5.93%	6.33%
Other	7,239	302	4.17%	4.25%
White	24,609	892	3.62%	5.96%
Total	**41,639**	**1,393**	**3.35%**	**4.34%**

- El Dorado MHP's PR for each race/ethnicity category is lower than the corresponding statewide PRs. However, for the Latino/Hispanic group, the difference is the largest, and the MHP's PR is roughly half of the statewide PR for that group.

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

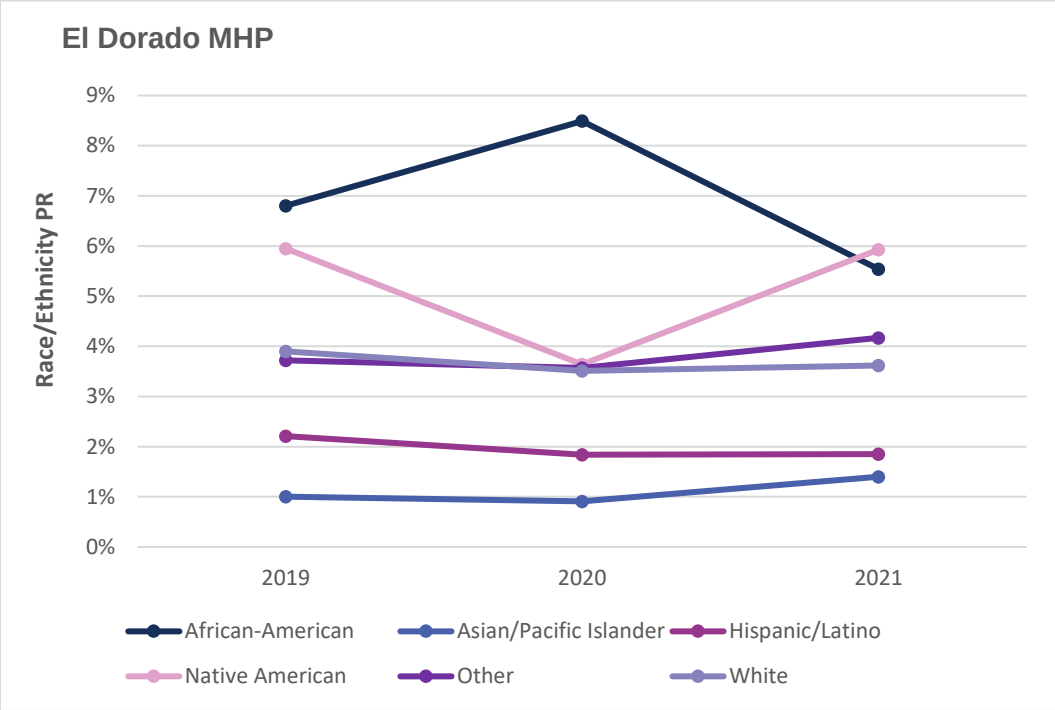


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	64%	22%	1%	11%	1%	1%
MHP % Eligible	59%	17%	1%	19%	3%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- El Dorado has a much higher percentage of White beneficiaries than that statewide, three times the percentage of eligibles and two and a half times the percentage served. On the other hand, the percentage of Latino/Hispanic beneficiaries are much lower than the state both the eligibles and the beneficiaries served.

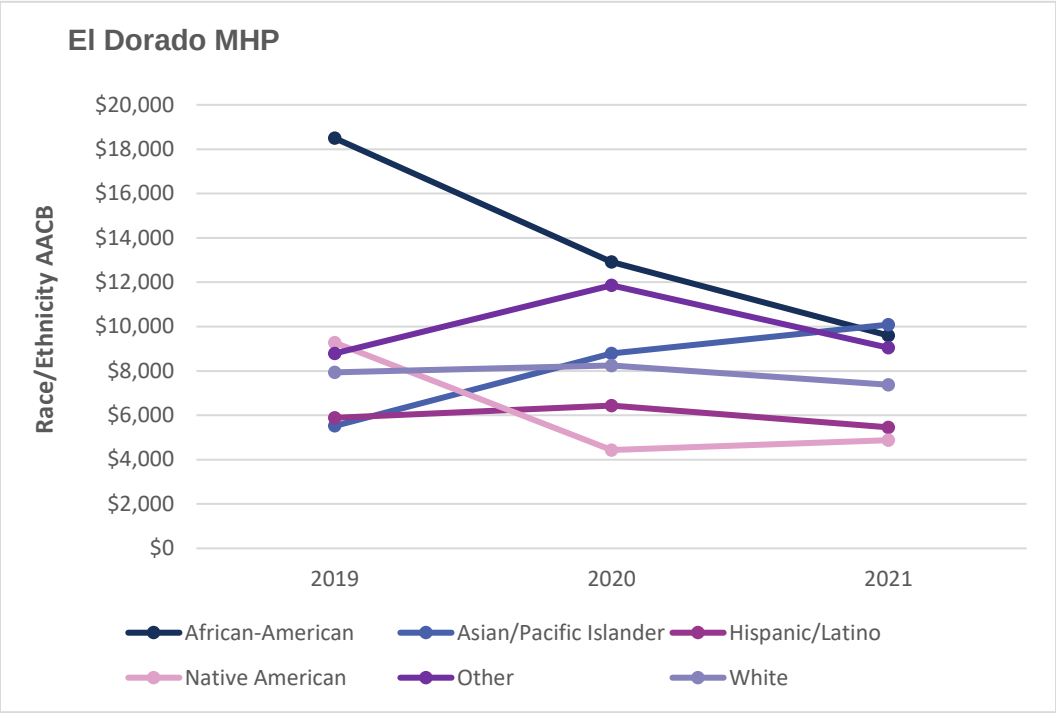
Figures 2 – 11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



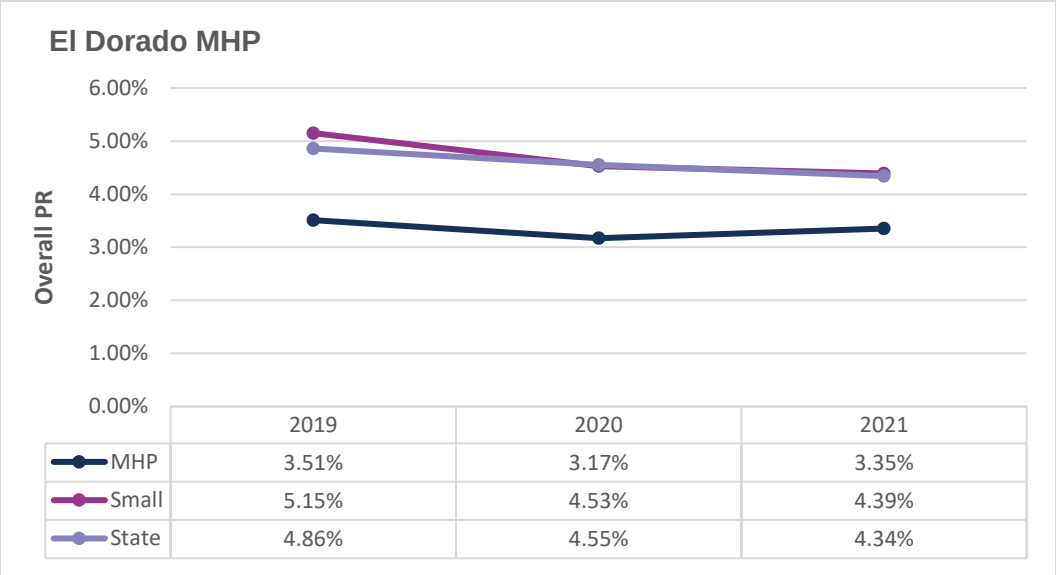
- The MHP's Asian/Pacific Islander and Latino/Hispanic PRs have been consistently much lower than the other PRs during CYs 2019-21.

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



- The African American AACB declined sharply during CYs 2019-21, but it is based on a small number of beneficiaries served and therefore can have large variations based on small changes in the actual count. The Native American and Latino/Hispanic AACBS were the lowest in CY 2021.

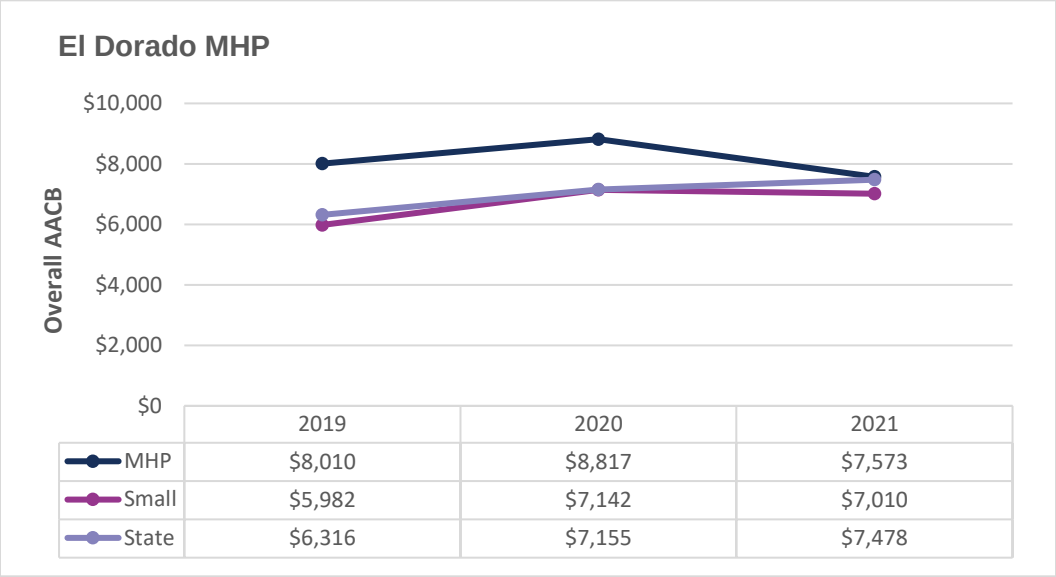
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	3.51%	3.17%	3.35%
Small	5.15%	4.53%	4.39%
State	4.86%	4.55%	4.34%

- While the PRs for the state and small MHPs are nearly the same, El Dorado's PR in CY 2021 was about 23 percent lower than both and has been consistently lower over time.

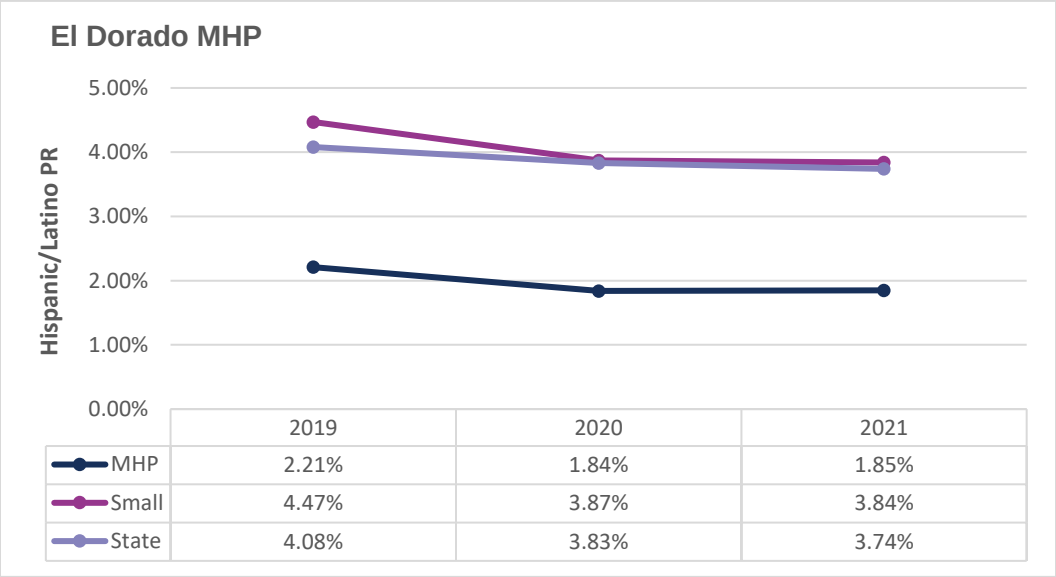
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$8,010	$8,817	$7,573
Small	$5,982	$7,142	$7,010
State	$6,316	$7,155	$7,478

- The MHP's AACB declined between CY 2019 and CY 2021 and was similar to the statewide AACB for CY 2021.

Figure 6: Hispanic/Latino PR CY 2019-21

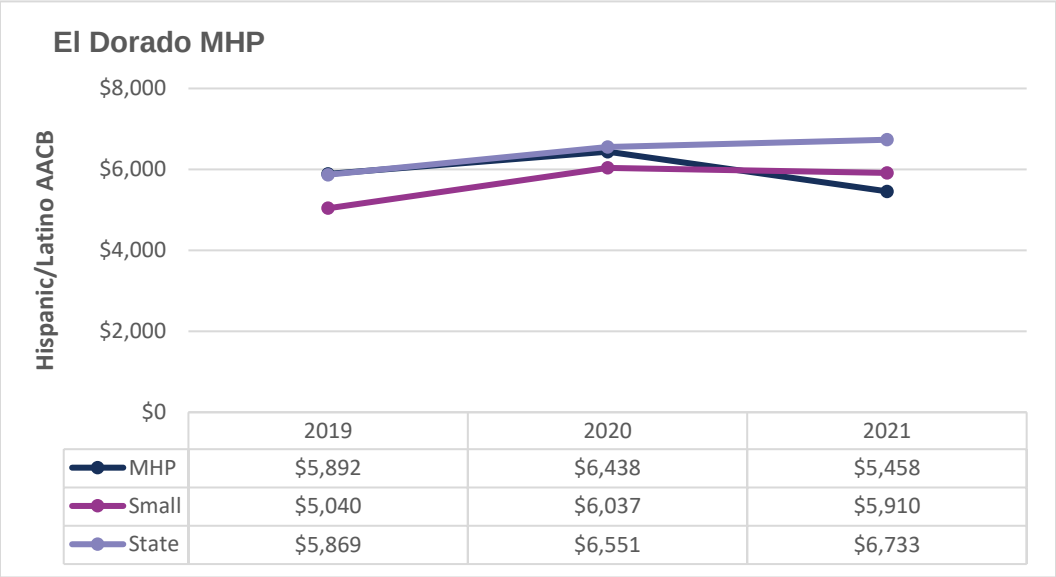


	2019	2020	2021
MHP	2.21%	1.84%	1.85%
Small	4.47%	3.87%	3.84%
State	4.08%	3.83%	3.74%

- The MHP's Latino/Hispanic PR has declined between CYs 2019 and 2021 and was less than half the statewide and small county MHP PRs in CY 2021. The PR

for this group has been consistently lower than similar sized counties and statewide over the past three years.

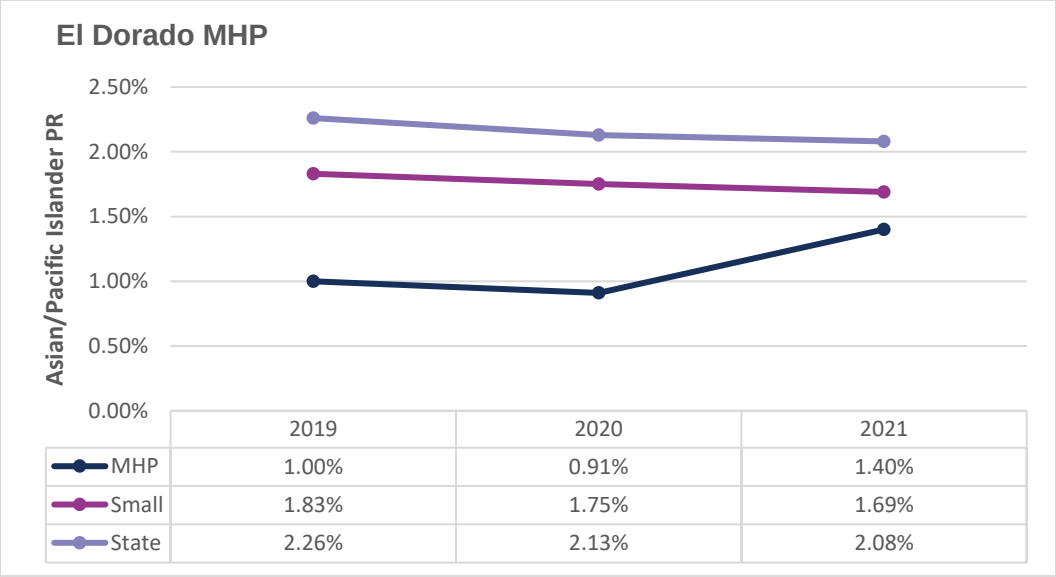
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$5,892	$6,438	$5,458
Small	$5,040	$6,037	$5,910
State	$5,869	$6,551	$6,733

- The MHP's Latino/Hispanic AACB declined from CY 2020 to CY 2021 and was lower than both statewide and small MHP averages.

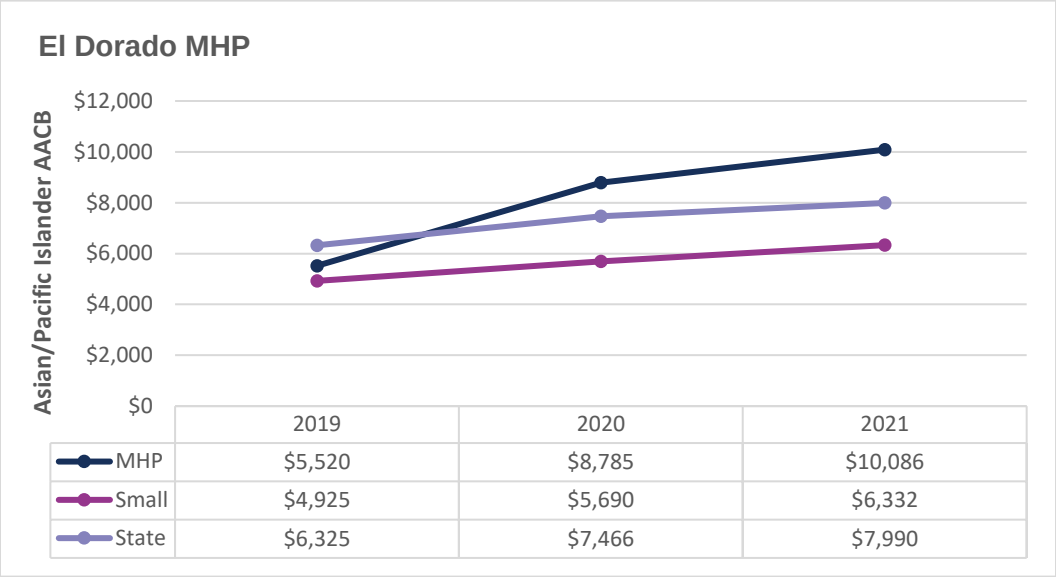
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	1.00%	0.91%	1.40%
Small	1.83%	1.75%	1.69%
State	2.26%	2.13%	2.08%

- Although the MHP's Asian/Pacific Islander PR increased from CY 2020 to CY 2021, the change is based on a small number of beneficiaries, as shown in Table 7.

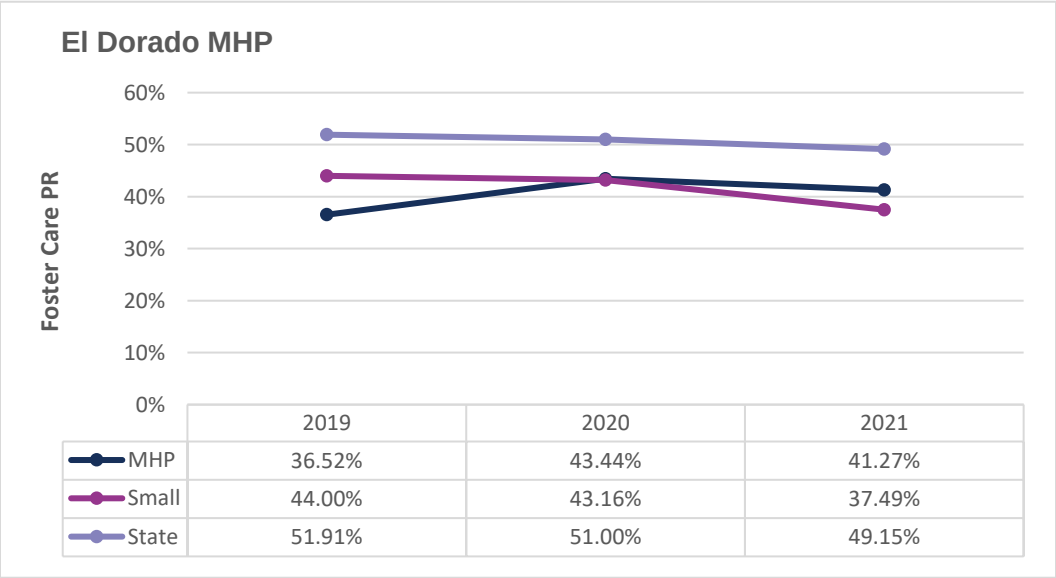
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$5,520	$8,785	$10,086
Small	$4,925	$5,690	$6,332
State	$6,325	$7,466	$7,990

- The MHP's Asian/Pacific Islander AACB nearly doubled between CYs 2019-21, but since it is based on a small number, the variation may also be attributable to a very small count of beneficiaries.

Figure 10: Foster Care PR CY 2019-21

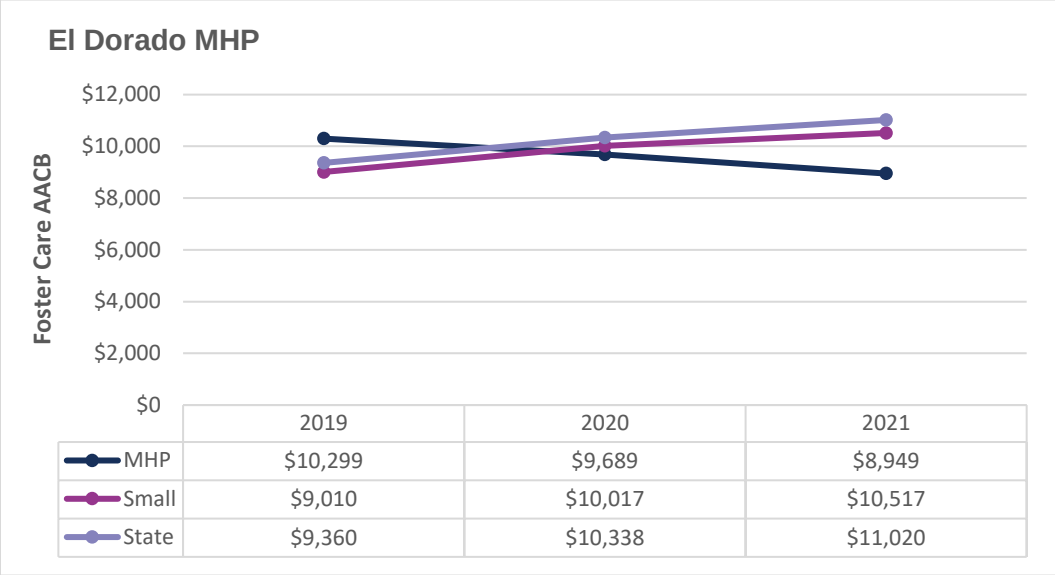


	2019	2020	2021
MHP	36.52%	43.44%	41.27%
Small	44.00%	43.16%	37.49%
State	51.91%	51.00%	49.15%

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed.

- Both the MHP's FC PR and the small MHP average FC PR have been lower than the state for all three years from CY 2019 to CY 2021.

Figure 11: Foster Care AACB CY 2019-21



- Statewide, FC AACB has increased each year between CYs 2019 and 2021.
- The MHP's FC AACB has trended in the opposite direction and become lower than the statewide AACB between CY 2019 and CY 2021.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 890				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	21	2.4%	7	5	11.6%	16	8
Inpatient Admin	<11	-	4	4	0.5%	23	7
Psychiatric Health Facility	144	16.2%	14	9	1.3%	15	7
Residential	14	1.6%	101	94	0.4%	107	79
Crisis Residential	<11	-	19	19	2.2%	21	14
Per Minute Services							
Crisis Stabilization	47	5.3%	1,178	1,200	13.0%	1,546	1,200

Crisis Intervention	389	43.7%	320	215	12.8%	248	150
Medication Support	357	40.1%	295	222	60.1%	311	204
Mental Health Services	501	56.3%	1,659	337	65.1%	868	353
Targeted Case Management	407	45.7%	335	155	36.5%	434	137

- The MHP relies more on its PHF to deliver psychiatric inpatient services than other inpatient units.
- The MHP does not have a crisis stabilization unit and relies more on crisis intervention. More than two-fifths of the beneficiaries received crisis intervention in CY 2021 as opposed to only 12.8 percent statewide.
- El Dorado provides less mental health services, but more targeted case management than the state as a whole.

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

Service Category	MHP N = 104				Statewide N = 37,489		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	12	8	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.3%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	17	12
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	<11	-	51	51	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	820	820	3.1%	1,398	1,200
Crisis Intervention	<11	-	465	137	7.5%	404	198
Medication Support	31	29.8%	366	170	28.3%	394	271
TBS	<11	-	1,785	1,785	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Home Based Services	58	55.8%	575	291	40.0%	1,351	472
Intensive Care Coordination	24	23.1%	1,697	767	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	98	94.2%	1,638	1,040	96.3%	1,848	1,103
Targeted Case Management	62	59.6%	397	175	35.0%	342	120

- The MHP provides mental health services to the FC beneficiaries on par with the state as a whole. It provides much more intensive home-based services and targeted case management to the FC beneficiaries than seen statewide.

IMPACT OF ACCESS FINDINGS

- As noted, the MHP provides many services within the county with fewer beneficiaries going out of county for services. This is seen across the age spectrum expect for youth, which do not have Crisis Residential or inpatient services located within the county.

- The MHP's crisis system has significantly more inpatient/PHF and outpatient crisis intervention than the state average, as they do not have an in-county crisis residential facility.
- Though PR are trending lower than state average, key informants report receiving services in their desired language.

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 in providing timely access to treatment services, the county must have the infrastructure to track timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Partially met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially met
2C	Urgent Appointments	Partially met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Partially met
2E	Psychiatric Readmission Rates	Partially met
2F	No-shows/Cancellations	Partially met

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

- The MHP tracks but does not trend data. The MHP identified the lack of appropriate staff to analyze data and report the results to management level staff. In addition, the EHR, over the past decade, remains close to original format

with little additional updates, which impedes the MHP's ability to accurately report required data updates.

- The MHP does not aggregate data to identify necessary improvements to the system of care or provide specific training opportunities to staff.
- The MHP created a code to have staff begin tracking No-show data accurately and is in the process of following up with staff training.

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 psychiatry appointments, the MHP reported only for county-operated services. The MHP also reported having a 3-day standard for urgent appointment which is not the standard set by DHCS. The MHP did not report on psychiatry No-show 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	4.5 Business Days	10 Business Days*	93.6%
First Non-Urgent Service Rendered	5.2 Business Days	10 Business Days**	89.0%
First Non-Urgent Psychiatry Appointment Offered	5.8 Business Days	15 Business Days*	92.1%
First Non-Urgent Psychiatry Service Rendered	6.0 Business Days	15 Business Days**	91.4%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	69.6 Hours	3 Business Days**	81.8%
Follow-Up Appointments after Psychiatric Hospitalization	9.0 Days	7 Days**	73.4%
No-show Rate – Psychiatry	***	10%**	n/a
No-show Rate – Clinicians	12.8%	15%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22.			

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

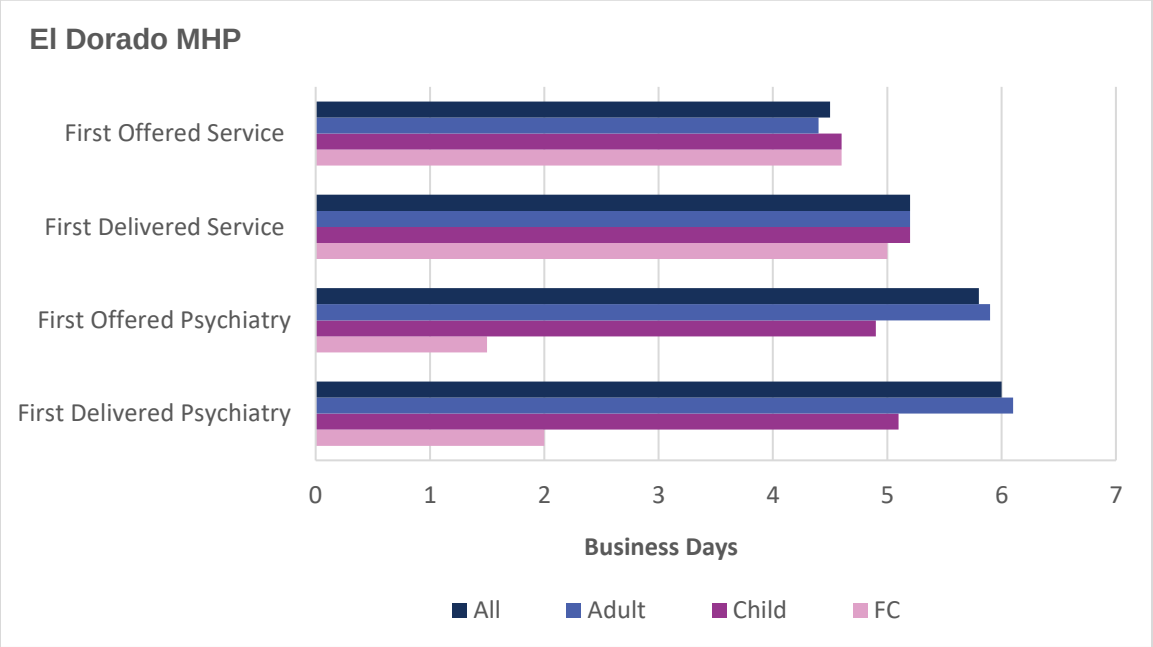


Figure 13: Wait Times for Urgent Services

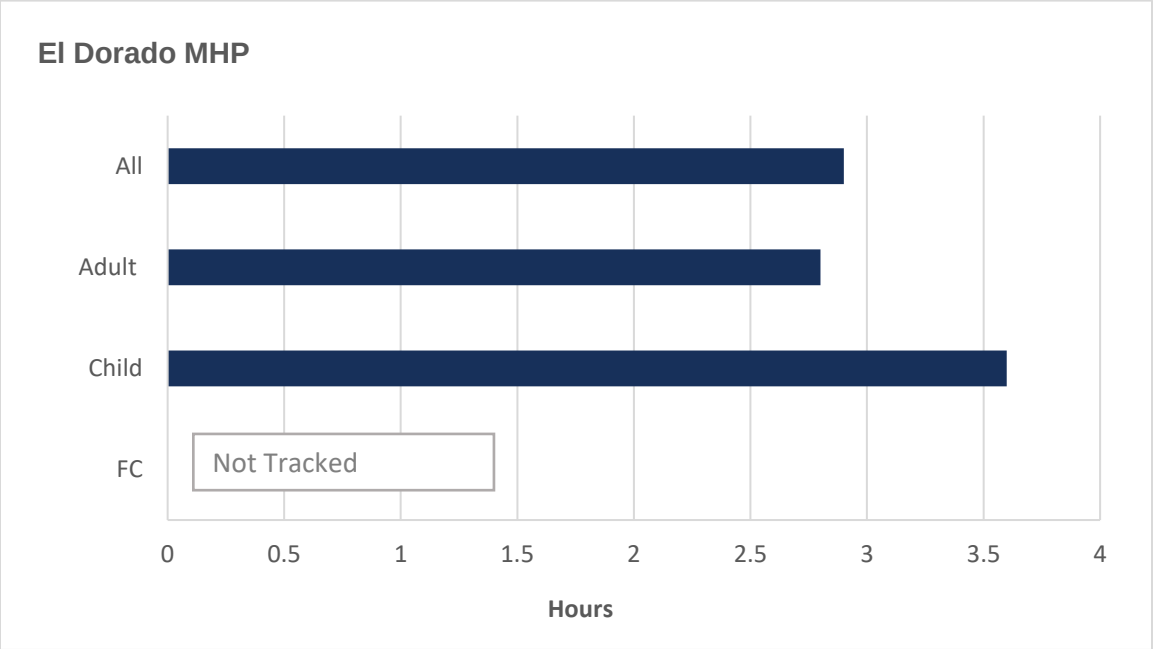
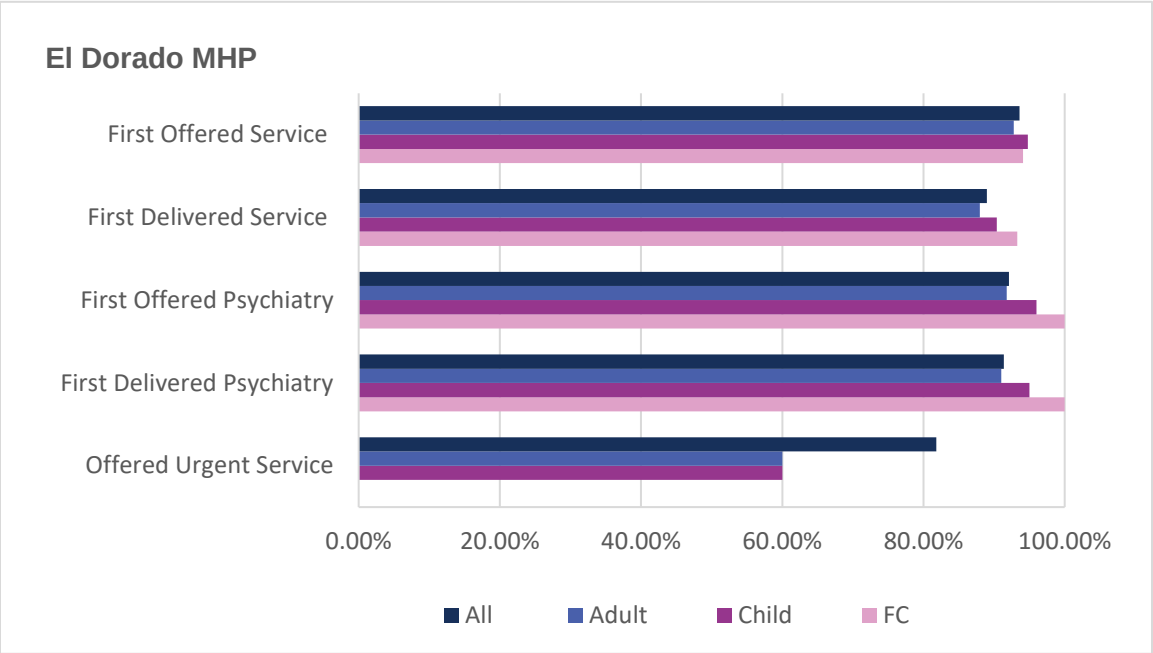


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent only beneficiaries who started an 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, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as “expedited” with scheduled services within three business days. There were reportedly 33 of urgent service requests with a reported actual wait time to services for the overall population at 69.6 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 from the first clinical determination of need.
- 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 not tracked for psychiatrists but tracked for clinicians. The MHP reports a No-show rate of 15 percent across all age groups for clinicians.
- The MHP does not track or did not report data for psychiatrist, children and FC in the categories of No-show, Timeliness to Urgent Services, and Follow-up services after Psychiatric Hospitalization.

IMPACT OF TIMELINESS FINDINGS

- The MHP openly identifies the lack of consistent data reporting. New management staff is working to identify data that is entered but may not be reflective of the clinical reality of timeliness. The lack of appropriate billing codes within the EHR and the lack of data analysts make it that much more difficult for the MHP to report accurate timeliness measures.
- With the impact of CalAIM implementation on timeliness findings and staff workload, the MHP continues to fine tune and identify gaps in reporting. The limited nature of the current EHR has also posed a significant challenge. Internal county funding constraints prevent the update of the EHR and hiring of appropriate staff.

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 falls under one manager who oversees both QI/Quality Assurance (QA) activities, quality activities are viewed as a continuous process across systems.

The MHP monitors its quality processes through the QIC, and the annual evaluation of the QIWP workplan. The QIC, comprised of county and contracted staff, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met eight times. Of the 10 identified FY 21-22 QIWP goals, the MHP did not provide an evaluation or percentage of goals met, a summary of findings or obstacles related to their plan.

The MHP utilizes the following level of care (LOC) tools: Child Welfare Mental Health Screening Tool (Child 0 Years to 5 Years), Child Welfare Mental Health Screening Tool (Child 5 Years to Adult) and Medi-Cal Screening Tool.

The MHP utilizes the following outcomes tools: Levels of Care Utilization System (LOPCUS), Adult Needs and Strengths Assessment, Child and Adolescent Level of Care Utilization System (CALOCUS), Child and Adolescent Needs and Strengths 50 and Pediatric Symptom Checklist 35.

The MHP utilize the tools within the treatment session but does not aggregate data for systemwide improvement activities. Of note, is the new requirement from CALOCUS/LOCUS that all users must now pay a licensing fee, which makes the product cost prohibitive to continue using within El Dorado County.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	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	Partially 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	Not met

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

- The MHP does provide a QIWP and utilizes the plan within conversation at their monthly QIC meetings. The MHP has also created an EDIC.
- The QIC is inclusive of staff and contract providers but does not consistently include the voice of beneficiaries or family stakeholders within those meetings.
- The MHP does not have a Peer Specialist Position or a Peer workforce. Peers can volunteer within the Wellness Center.
- The QIWP provides compliance goals but does not evaluate the impact to beneficiaries or systemwide improvements.
- Key informants reported onboarding time to be over six months which has deterred an otherwise viable workforce, and lack of equitable pay with staff leaving the MHP to work at contracted agencies or surrounding counties who pay a higher rate and are within commuting locations.
- The MHP does not track and does not trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5

- Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD).
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

QUALITY PERFORMANCE MEASURES

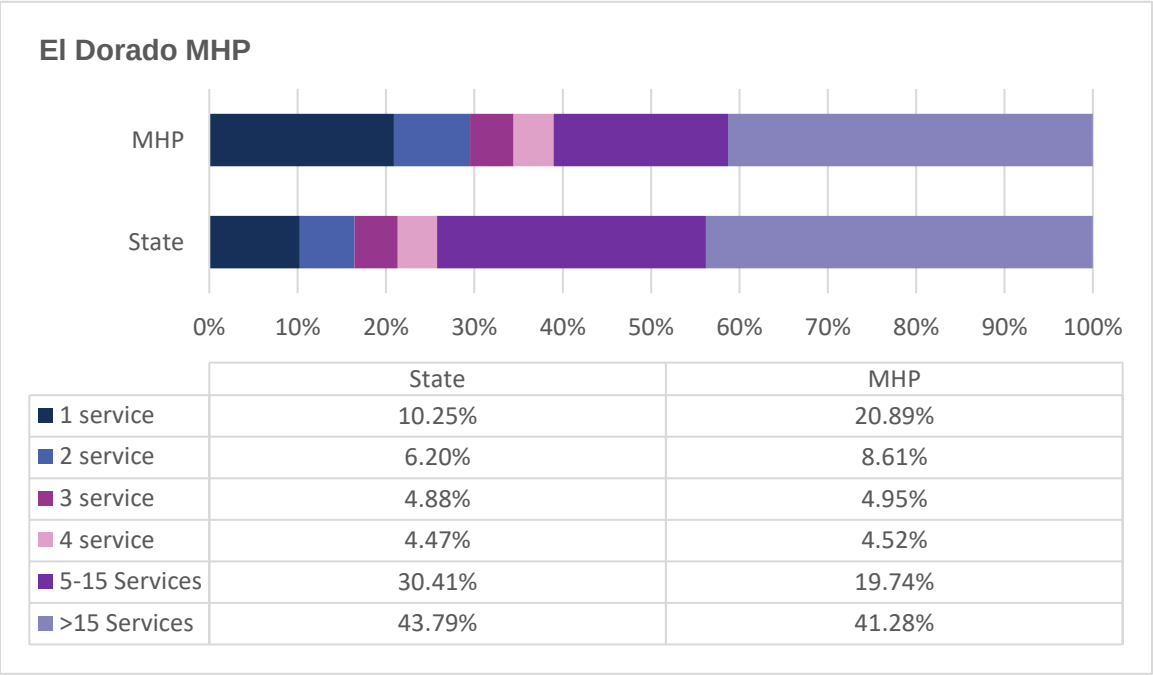
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



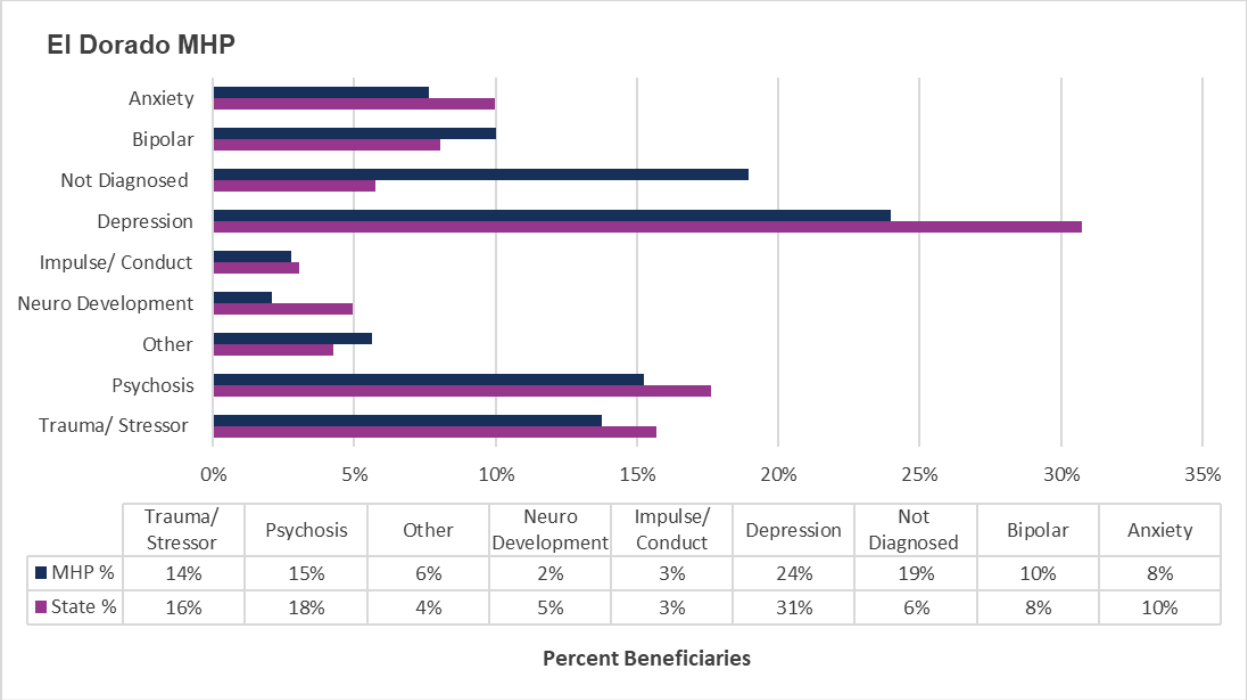
	State	MHP
1 service	10.25%	20.89%
2 service	6.20%	8.61%
3 service	4.88%	4.95%
4 service	4.47%	4.52%
5-15 Services	30.41%	19.74%
>15 Services	43.79%	41.28%

- The MHP has a high percentage of beneficiaries who received only one service in CY 2021, twice that of the state. On-site, the MHP explained that in order for them to track first service timeliness, they have to create an episode with one encounter in the EHR and that accounts for the high percentage of single service recipients.

Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

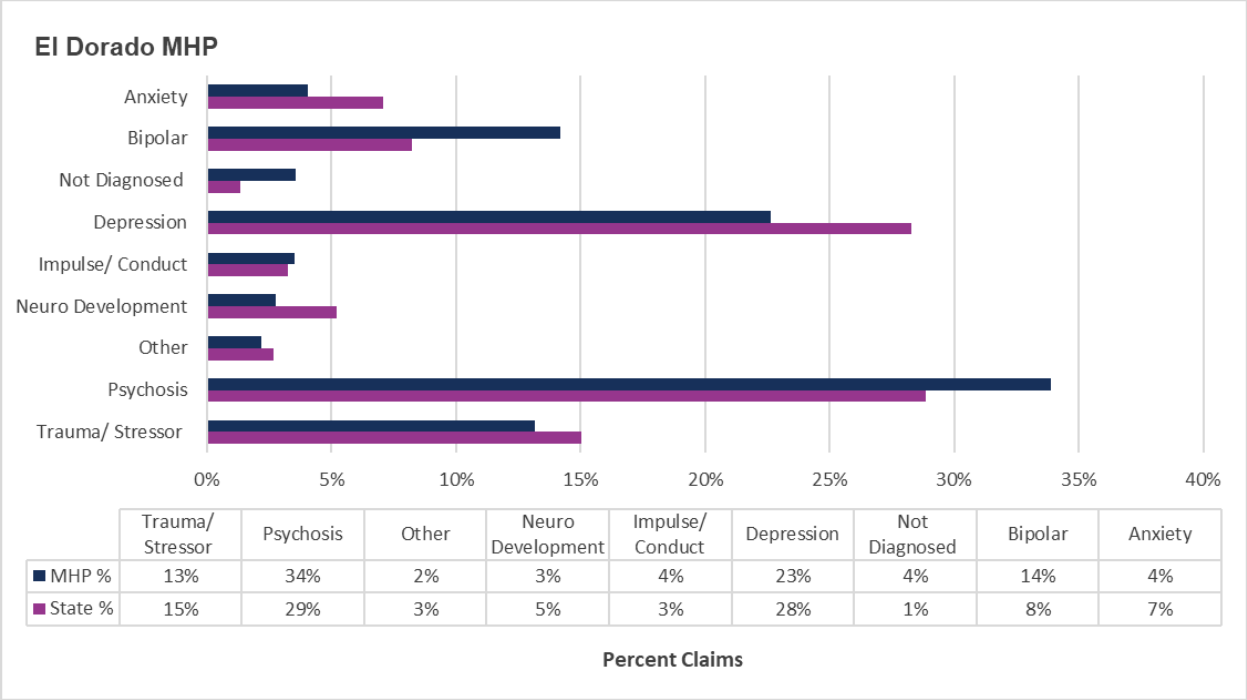
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	15%	6%	2%	3%	24%	19%	10%	8%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The MHP reported that the explanation for its high percentage of single service recipients also accounted for a high percentage of Not Diagnosed category of beneficiaries who were given a Z-code for the single encounter.
- Beneficiaries with Depression diagnoses in the MHP are 7 percentage points lower than statewide. Other than the Not Diagnosed category, the only two diagnostic categories where the MHP has slightly higher percentages than the state are Bipolar and Other disorders.

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 %	13%	34%	2%	3%	4%	23%	4%	14%	4%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- Although the MHP's percentage of Bipolar diagnoses is only slightly higher than statewide, and that of Psychosis is lower than statewide, its percentage of total approved claims for these categories are much higher than statewide.

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	214	395	9.59	8.86	$11,334	$12,052	$2,425,493
CY 2020	222	439	8.31	8.68	$9,848	$11,814	$2,186,331
CY 2019	256	431	8.96	7.80	$10,571	$10,535	$2,706,130

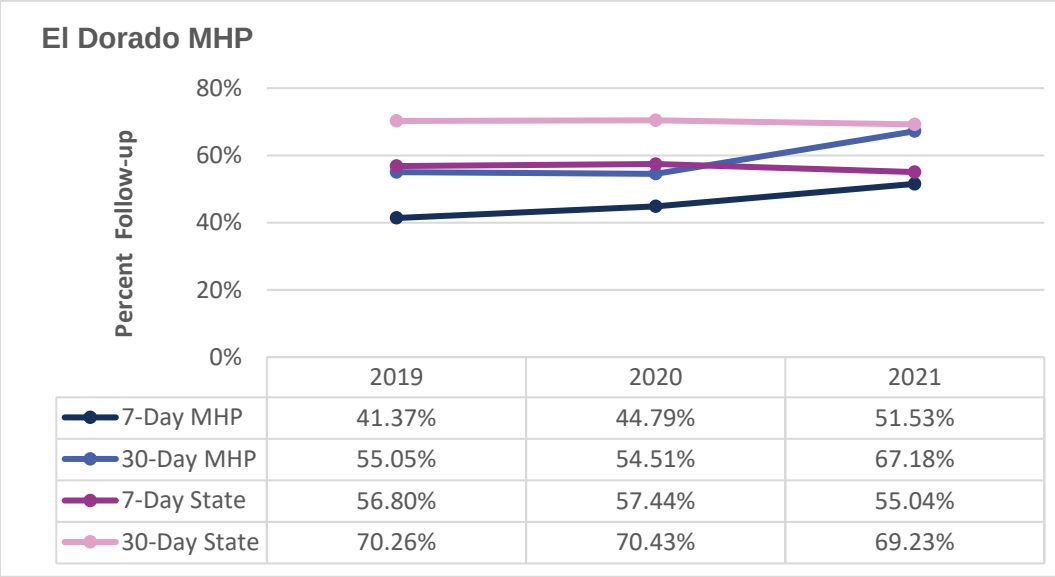
- The MHP's inpatient average LOS in CY 2021 went up by 15.4 percent from CY 2020; however, this metric is similar to the statewide averages. The MHP's inpatient AACB in CY 2021 was lower than the statewide AACB.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2021 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

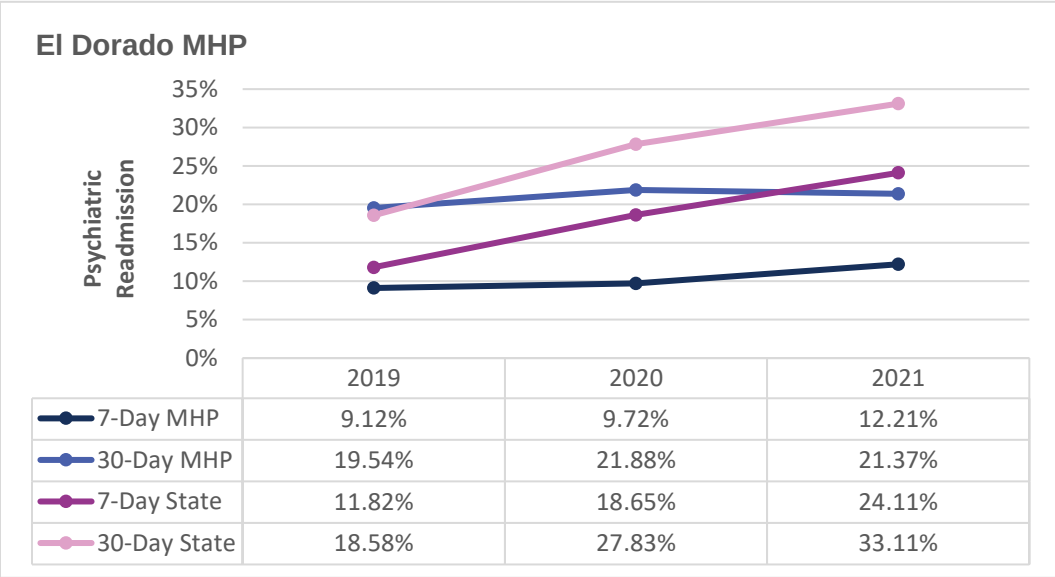
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	41.37%	44.79%	51.53%
30-Day MHP	55.05%	54.51%	67.18%
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
7-Day MHP	9.12%	9.72%	12.21%
30-Day MHP	19.54%	21.88%	21.37%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- Between CY 2019 and CY 2021, the MHP's 7- and 30-day inpatient follow-up rates have improved by 24 percent and 21 percent respectively, bringing both follow-up rates closer in line with statewide rates.
- During the same period, the 7- and 30-day inpatient readmission rates have increased, too, but by a much smaller margin. Both readmission rates for the MHP were lower than the state. The 7-day rate was half that of the state while the 30-day readmission rate was a third lower than the state.
- The MHP reported higher inpatient follow-up rates of 73.4 percent and 89.9 percent, respectively, using their own data for FY 2021-22. It also reported lower readmission rates at both 7- and 30-days post-discharge.

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 just $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

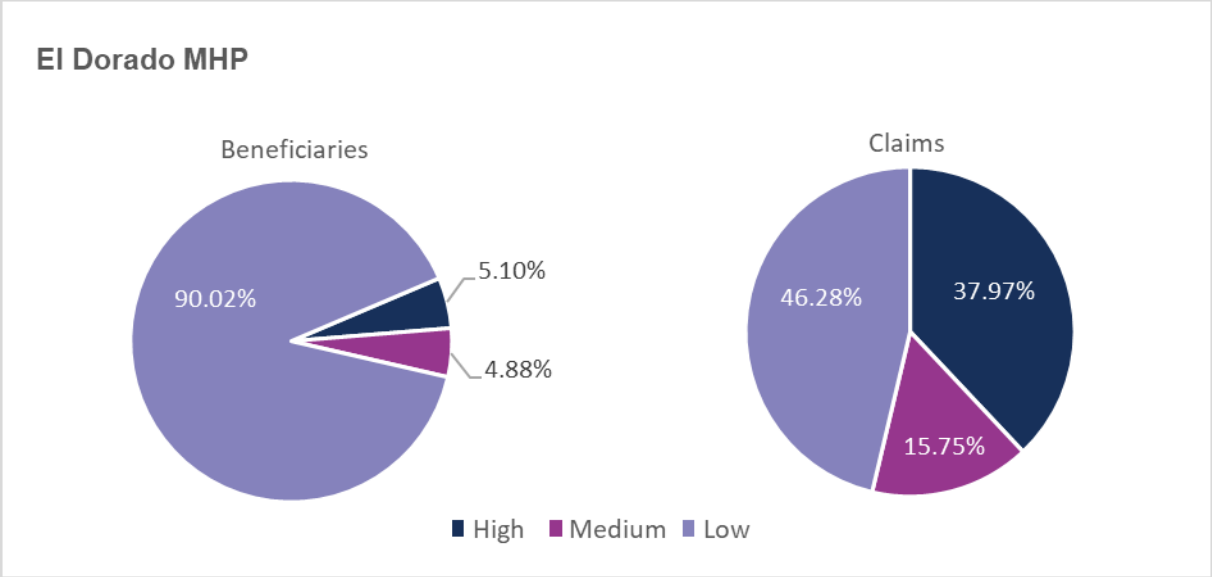
Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	71	5.10%	37.97%	$4,005,477	$56,415	$55,745
	CY 2020	85	7.02%	43.14%	$4,606,419	$54,193	$49,291
	CY 2019	77	5.87%	37.49%	$3,936,861	$51,128	$44,187

- The MHP’s count of HCBs has declined slightly from CY 2019 to CY 2021 with a corresponding drop in the percentage of HCBs served. However, the AACB per HCB increased by 10.3 percent during the same period but is similar to the state.

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)	68	4.88%	15.75%	$1,661,498	$24,434	$24,041
Low Cost (Less than $20K)	1,254	90.02%	46.28%	$4,881,995	$3,893	$2,004

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



- A relatively small group of HCBs account for a large percentage of total approved claims. In El Dorado MHP's case, HCBs constituted only 5.1 percent of the total beneficiaries served, but accounted for 37.97 percent of the total claims. When the beneficiaries with AACs between $20-30K are added to the HCBs, then less than 10 percent of the beneficiaries account for more than 88 percent of the total claims.

IMPACT OF QUALITY FINDINGS

- Key informants reported adequate service response within the MHP, this can be mirrored in the higher inpatient follow-up rates of 73.4 percent and 89.9 percent, respectively, and lower readmission rates at both 7- and 30-days post-discharge. Often smaller counties are more creative with their limited resources and are able to provide a proactive approach to crisis management.
- The lack of accurate data reported by the MHP does not go unnoticed by management. With new management in place, the MHP is striving to identify areas of improvement. This is challenging when they are working with an outdated EHR and lack of appropriate staffing such as data analysist who could review, collect, and report out on data within the MHP. The MHP is working with the Health and Human Services oversight agency to address the needs for additional staffing, the MHP is watching participating counties roll-out of the SmartCare EHR and may opt to move EHR systems in the future. The MHP is keenly aware this challenge will impact their CalAIM efforts.
- Key informants report not knowing the results of satisfaction surveys and their ability to become involved in the various committees. The MHP is losing a

valuable resource of lived experience knowledge when beneficiaries are not actively participating in conversations around systemic change.

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: "Ensuring Clients Are Involved in Medication Management services as evidenced by signed Medication Consent Forms."

Date Started: 08/2022.

Aim Statement: "The aim of this PIP is to ensure that all clients who are prescribed antipsychotic medication(s) have consistently participated in a discussion and training regarding their medications, as evidenced by a signed Medication Consent Form and being offered a copy of the informing materials for their specific medication(s). Will the psychiatrist consistently and thoroughly discussing and training clients who are prescribed antipsychotic medications, providing information about their medication(s), and obtaining a signature on the Medication Consent Form, help improve client treatment and outcomes, and ensure 100% of the forms are signed within the next six months?"

Target Population: "All clients receiving mediation services and are prescribed antipsychotic medications from EDCBH medical professionals to treat their mental

[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

health symptoms will be included in the PIP. This includes clients who are currently receiving antipsychotic medications prescribed by EDCBH medication management staff and new clients at their first medication management appointment when they are first prescribed antipsychotic medications."

Status of PIP: The MHP's clinical PIP is in the baseline year.

Summary

The goal of this PIP is for all MHP beneficiaries who are prescribed psychotropic medications will sign a Medication Consent Form annually. Signing a Medication Consent Form helps ensure that the client has been provided with sufficient information to make an informed decision about their psychiatric care.

The signing of the Medication Consent Form is validation that the process has occurred, and an agreement has been reached. This includes: a description of the indications for treatment; an explanation and purpose of the proposed treatment/procedures; the probable risks, benefits, and alternatives; and a description of the risks if the client does not consent to the proposed treatment/ procedure/ or alternatives. With the idea to improve client care and medication adherence.

A new consent form will be created, psychiatrist trained, and data will be analyzed monthly on the number of consent forms completed with specific services delivered and specific client outcomes monitored.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: with the implementation of a new form, psychiatrist training and the specific ongoing conversation with the beneficiaries about medication management and adherence, this PIP shows promise of improved clinical outcomes and functioning scores among the beneficiaries who receive medication for their symptoms.

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

- The MHP was encouraged in FY 2021-22 PIP session to engage in TA with CalEQRO. The MHP works closely with a contracted consultant to formulate and formalize this PIP and outcomes throughout the year.
- Reword the PIP AIM statement to make it clear and concise as to what the PIP is trying to accomplish.
- Record how improved functioning be measured, what tools will be used?
- Identify if the discussion with the psychiatrist impacted the improved functioning scores.
- Engage CalEQRO in ongoing TA.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: "Follow-Up After Emergency Department Visit for Mental Illness (FUM)."

Date Started: 09/2022

Aim Statement: "For Medi-Cal beneficiaries with Emergency Department (ED) visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with EDCBH within 7- and 30-day by 5% by June 30, 2023."

Target Population: "EDCBH will focus on beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm."

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

Summary

The purpose is to create and implement a formalized referral tracking mechanism that allows for real-time referral coordination from the Marshal and Barton EDs, to notify the MHP when the identified high-risk populations are admitted to the ED. This system also includes ongoing communication between the MHP, ED care coordinator staff at Marshall and Barton, and MCP staff to plan, identify, and implement the formal systems required to ensure beneficiaries are referred and connected to EDCBH and MCP services.

Currently, there is no formalized or consistent referral channel. The MHP identified a need to develop an EHR system to ensure the feedback (channel) loop is closed; a referral tracking mechanism; a real-time data sharing system to notify partner agencies when an individual needs services.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the MHP has staff co-located within the ED. Their current ability to provide care coordination and follow-up services after discharge is already build into the MHP system of care. The addition of collaboration between the MHP and MCP will enhance the current gap of communication for those currently not linked between the ED and MHP.

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

- The MHP was encouraged in FY 2021-22 PIP session to engage in TA with CalEQRO. The MHP works closely with a contracted consultant to formulate and formalize this PIP and outcomes throughout the year.
- Work with their DHCS liaison to update their Behavioral Health Quality Improvement Program-PIP (BHQIP-PIP), to align with CalAIM requirements.
- CalEQRO recommends ongoing TA to improve the understanding of the PIP as a non-clinical PIP. The PIP AIM statement is lacking variables of improvement. It is unclear if all baseline data is collected to move all aspects of the PIP to the Implementation phase.
- Correlate data with specific performance measures the MHP will focus on, in order to identify whether the interventions are successful.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart/Avatar, which has been in use for 17 years. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Approximately 4.6 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 121 named users with log-on authority to the EHR, including approximately 86 county staff and 35 contractor staff. Support for the users is provided by two full-time equivalent (FTE) IS technology positions. Currently all positions are filled. The same analysts also attend to the DMC-ODS.

As of the FY 2022-23 EQR, some 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 beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	73%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	27%
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. The MHP does not have a PHR at this time.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: MH and DMC-ODS providers.

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

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

- The MHP has a data warehouse function and uses the Dimensions Reports for its data analytical and reporting purposes.
- The MHP has most EHR functionalities in place for the county operated programs and two of the contract providers for their own episodes. For other contract providers, the MHP provides a look-up option for most functionalities.
- The MHP cited individual EHR user license fee, contract providers having their own EHRs, and potential for double data entry as primary barriers to making most functionalities fully accessible to all contract providers.
- For claims data, most contract providers can directly enter claims, while the others are able to submit electronic files through secure e-mails.
- Clinical line staff report that they are unable to enter data in the EHR when delivering field-based services, resulting in additional data entry time later.
- The MHP has insufficient staffing resources that require limited staff addressing both MH and DMC-ODS IS needs.

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.

For the MHP, it appears that significant claims lag begins in November and likely represents $550K in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through December 2021.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	3,955	$891,246	$9,363	1.05%	$862,610
Feb	4,204	$923,044	$1,393	0.15%	$897,857
Mar	4,703	$1,099,134	$5,250	0.48%	$991,678
April	3,798	$883,785	$3,105	0.35%	$840,842
May	3,902	$871,588	$14,956	1.72%	$842,023
June	3,871	$864,611	$1,007	0.12%	$846,590
July	3,688	$755,650	$2,655	0.35%	$737,533
Aug	4,422	$951,539	$3,149	0.33%	$859,745
Sept	4,000	$865,119	$2,046	0.24%	$849,365
Oct	4,095	$947,045	$3,536	0.37%	$925,709
Nov	2,798	$606,166	$8,762	1.45%	$596,400
Dec	3,120	$652,103	$3,262	0.50%	$647,430
Total	**46,556**	**$10,311,030**	**$58,484**	**0.57%**	**$9,897,782**

- The MHP showed consistent claim volumes from January to October 2021.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other healthcare coverage must be billed before submission of claim	28	$16,214	27.72%
Service line is a duplicate and a repeat service procedure code modifier not present	49	$12,358	21.13%
Medicare Part B must be billed before submission of claim	32	$10,208	17.45%
Beneficiary not eligible or non-covered charges	13	$9,407	16.09%
Late claim	9	$7,923	13.55%
Other	11	$2,373	4.06%
Total Denied Claims	**142**	**$58,483**	**100.00%**
Overall Denied Claims Rate	**0.57%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The rate of denied claims declined from CY 2020 when the MHP had a higher denial rate than the statewide denial rate. In CY 2021, the MHP's denial rate was much lower than the state.

- The MHP is not yet certified to bill for Medicare Part B, which caused 17.45 percent of the denials. Regarding the service line duplication, the MHP reported that this issue was temporary and was addressed promptly.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP has a stable EHR environment. The staff have worked diligently to maintain this EHR with all necessary updates. With all the changes going on in the statewide delivery system including CalAIM, the MHP has decided to stay with its current tried and tested EHR for the time being.
- The major challenge facing the MHP and the El Dorado Behavioral Health Services as a whole is a lack of adequate staffing to realize its full potential in IS and data analytical work. The MHP has creatively addressed this over time with distributed resources and continued to meet the reporting requirements. However, to build a true environment of continuous quality improvement and continue meeting the needs of all the changes coming down in the next two years, the MHP will need additional IS and analytical staff going forward.

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 stated receiving the CPS as a data grid without the details and data breakout necessary to identify trends related to client satisfaction.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each. The MHP requested a second group to in order to include the voice of Consumers and Family Member/Caregivers.

Consumer Family Member Focus Group One

CalEQRO requested CFM FG of a diverse group of family member/caregivers who initiated services in the preceding 12 months. The focus group was held at via Microsoft Teams at the SLT clinic, with EQR staff at the West Slope clinic and included three participants. All family/caregivers participating have a family member who receives clinical services from the MHP.

Though this FG had three participants, there was a couple and a caregiver, which represented two adult consumers. Due to the limited number of participants comments from these key informants have been added throughout the report.

Recommendations from focus group participants included:

- Bringing back sessions such as cooking classes and outings.
- Bring back support groups for family/caregivers or inform family/caregivers of upcoming groups.

Consumer Family Member Focus Group Two

CalEQRO requested CFM FG a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held at via Microsoft Teams at the SLT clinic, with EQR staff at the West Slope clinic and included eight participants. All consumers participating receive clinical services from the MHP.

Overall beneficiaries were satisfied with the services they receive. Their initial wait time for services ranged from immediate to two-weeks. Appointment reminders are received, and transportation is provided and utilized. Seven of the eight beneficiaries have telehealth available to them. In SLT a Public Health nurse provides injections and if there is a crisis, they all seemed to know how to reach the crisis line. Though they reported feeling able to offer input into the mental health system, they did not receive any feedback on surveys they have filled out. No one was aware of paid opportunities, though they knew they could volunteer at the Wellness Center.

Recommendations from focus group participants included:

- Some suggested that group scheduling could be adjusted to better accommodate beneficiary schedules. This would result in improved attendance.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Two focus groups were held, but only one could be reported on in the findings due to the limited participation of the family/caregiver group. Overall, all key informants found support and hope from their clinicians and received services in a timely manner. Now that COVID-19 is moving away from isolations, key informants request more in person activities and interactions, such as cooking classes and outings. In addition, beneficiaries would like to participate in paid opportunities for employment, and know the results of their satisfaction surveys.

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 works closely and effectively with the physical health care system to coordinate care, as evidenced in their BHQIP-PIP by embedding staff at the EDs. (Access, Quality)
2. The MHP created a No-show code to accurately identify and track No-show outcomes and trends. (Timeliness)
3. The MHP has opened its onsite Wellness Center for all clients to receive in-person services. (Access, Quality)
4. Due to new management staff being located in the SLT site, community engagement within the clinic and staff satisfaction has increased. (Access, Quality)
5. The MHP increased FC penetration rates, attributed to a clear referral pathway and strong relationships between the MHP and CPS. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP lacks sufficient data analytic staff and analytic software to produce the reports needed for QI and management decision-making. (Timeliness, Quality, IS)
2. The MHP underutilizes its beneficiary and family stakeholders' voice to identify system change. This includes the lack of relevant CPS survey use, peer employment, and participation on MHP committees. (Quality)
3. Qualified employees are both leaving the county workforce or not applying for county employment due to the length of time it takes to be onboarded through HR, especially around background checks, as well as significant disparities in pay from both contract employers and surrounding county MHPs. (Access, Timeliness, Quality, IS)
4. The MHP identifies compliance goals and expectations on their QIWP however, it is unclear if the obtained outcome impacted the beneficiary experience, treatment, and recovery, based on the outcomes presented. (Quality, IS)

5. Inability to enter data to the EHR while delivering field-based services results in the line staff spending additional time entering data at a later time. (Quality, IS)

RECOMMENDATIONS

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

1. Add data analyst staff and data analytic software focusing on producing clinical program reports for improving data collection, report development, and analysis of outcomes. (Access, Timeliness, Quality, IS)
2. Engage beneficiaries and family members to discuss system-wide satisfaction, challenges, and ideas for improvements; this discussion includes CPS, peer employment, and participation on MHP committees. Identify areas and plans for improvement. (Quality)
3. Engage HR to identify and remedy pay disparities between the MHP and surrounding county MHPs and county-specific contracted services; and identify areas to reduce the lengthy wait times to onboard potential qualified staff. (Quality, Access, Timeliness)
4. Expand on outcome goals within the QIWP by identifying impact goals that coincide with achieved compliance goals. Utilize information about the beneficiary experience, including goal-specific surveys, LOC tools, and/or client perception survey results. (Quality)
5. Investigate how to improve data entry processes for field-based services that reduces the burden on the line staff. (Quality, IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

Due to recent and significant storms, travel was not advisable between the West Slope and SLT clinics. Participants were able to access all sessions virtually if unable to attend in person. There were no other barriers to this FY 2022-23 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT 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 – El Dorado 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)
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
EHR Deployment
Telehealth
Wellness Center Site Visit
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Kiran Sahota, Quality Reviewer
Saumitra SenGupta, Information Systems Reviewer
Walter Shwe, Consumer Family Member Reviewer

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

MHP County Sites

El Dorado
768 Pleasant Valley Rd., Suite 201
Diamond Springs, CA 95619

All sessions were additionally held via video conference to create a hybrid in-person/virtual review.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Benham	Ariana	Clinician	County
Blackburn	James	Program Coordinator	County
Bogan	Danielle	Acting Program Manager	County
Callahan	Nancy	Consultant	Idea Consulting
Collinsworth	Justine	Program Manager	County
Diaz	Ramona	Fiscal Manager	County
Ebrahimi-Nuyken	Nicole	Director of BH	County
Fitzgerald	Brittiany	Program Coordinator	County
Gula	Kristin	Supervising Accountant/Auditor	County
Harris	Heather	Clinician	Summitview
Jones	Doris	Program Coordinator	County
Joyce	Xiaoting	Clinician	County
Kernes	Christianne	Deputy Director of BH	County
Kwachak-Hall	Jody	Program Coordinator	County
Langley	Kathleen	Program Coordinator	County
Larrigan	Angelina	Program Manager - MH	County
Le Pore	Matthew	Sr. Administrative Analyst	County
Migdol	Monique	Clinician	County
Numez-Rodark	Christina	Clinician	Stanford Sierra Youth and Family

Last Name	First Name	Position	County or Contracted Agency
Perez	Nicholas	IT Dept Specialist	County
Price	Robert	Medical Director	County
Refsdal	Elissa	Clinician	Summitview
Rodriguez	Lisa	Dept. Systems Analyst	County
Sauvé	Daniel	Clinician	Stanford Sierra Youth and Family
Schumacher	John	Program Coordinator	County
Silva	Monica	Clinician	County
Sutton	Aimie	Clinician	Stanford Sierra Youth and Family
Willard	Kevin	Administrative Analyst	County
Zanardi	Meredith	Sr. Administrative Analyst	County

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	With the implementation of a new form, psychiatrist training and the specific ongoing conversation with the beneficiaries about medication management and adherence, this PIP shows promise of improved clinical outcomes and functioning scores among the beneficiaries who receive medication for their symptoms.

General PIP Information
MHP/DMC-ODS Name: El Dorado
PIP Title: "Ensuring Clients Are Involved in Medication Management Services As Evidenced by Signed Medication Consent Forms."
PIP Aim Statement: "The aim of this PIP is to ensure that all clients who are prescribed antipsychotic medication(s) have consistently participated in a discussion and training regarding their medications, as evidenced by a signed Medication Consent Form and being offered a copy of the informing materials for their specific medication(s). Will the psychiatrist consistently and thoroughly discussing and training clients who are prescribed antipsychotic medications, providing information about their medication(s), and obtaining a signature on the Medication Consent Form, help improve client treatment and outcomes, and ensure 100% of the forms are signed within the next six (6) months?"
Date Started: 08/2022
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:

General PIP Information
Target population description, such as specific diagnosis (please specify): "All clients receiving mediation services and are prescribed antipsychotic medications from EDCBH medical professionals to treat their mental health symptoms will be included in the PIP. This includes clients who are currently receiving antipsychotic medications prescribed by EDCBH medication management staff and new clients at their first medication management appointment when they are first prescribed antipsychotic medications."
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): Clients will be informed by psychiatrist about their medication and sign medication consent form.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Psychiatrist will become trained in the new medication management form and discuss medication with clients. Psychiatrist will request client signature.
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): MHP will create new med management form, provide psychiatrist training, and track data and outcomes.

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
PM 1. % of new clients with signed Medication Consent Form	FY 2021-22	N = 10 Med. charts reviewed during audit 0 / 10 = 0%	☒ 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
PM 2. % of ongoing clients with signed Medication Consent Form	FY 2021-22	N = 10 Med. charts reviewed during audit 0 / 10 = 0%	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3. % of ongoing clients with signed, updated Medication Consent Form with new medications prescribed	FY 2021-22	N = 10 Med. charts reviewed during audit 0 / 10 = 0%	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 4. Perception of Services Surveys collected	N/A Survey being developed	N/A Survey being developed	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 5. # of meetings where medication consent data is discussed	FY 2021-22	6 Medication meetings 2 MH QIC meetings	☒ Not applicable—PIP is in Planning or implementation phase, results not available			
PM 6. % of clients who report improved outcomes and functioning	N/A Survey being developed	N/A Survey being developed	☒ Not applicable—PIP is in Planning or implementation phase, results not available			

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • The MHP did not seek TA from CalEQRO throughout the reported fiscal year. • Reword the PIP AIM statement to make it clear and concise as to what the PIP is trying to accomplish. • Record how improved functioning be measured, what tools will be used? • Identify if the discussion with the psychiatrist impacted the improved functioning scores. • Engage CalEQRO in ongoing TA.

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 has staff co-located within the ED. Their current ability to provide care coordination and follow-up services after discharge is already built into the MHP system of care. The addition of collaboration between the MHP and MCP will enhance the current gap of communication for those currently not linked between the ED and MHP.

General PIP Information
MHP/DMC-ODS Name: El Dorado
PIP Title: "Follow-Up After Emergency Department Visit for Mental Illness (FUM)"
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 EDCBH within 7 and 30 days by 5% 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): "EDCBH will focus on beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm."

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): ED will notify MHP when an individual comes into the ED with a MH condition.
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): MHP will provide follow-up and care coordination to all individuals entering the ED with a mental health condition.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of referrals received from the ED to EDCBH through the referral tracking system and % complete	2022	299	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number and percent of clients receiving follow-up services within 7 and 30 days of discharge from ED	2022	63 percent for 7-day 72 percent for 30-day	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number and percent of clients who received a BH screening and care coordination service before they were discharged from the ED	2022	299	☒ 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
Number of successful data exchanges with the MCP / number of successful HIE transmissions	2023		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

The MHP did not seek TA from CalEQRO throughout the reported fiscal year. The MHP works closely with a contracted consultant to formulate and formalize this PIP and outcomes.

Work with their DHCS liaison to update their Behavioral Health Quality Improvement Program-PIP (BHQIP-PIP), to align with CalAIM requirements.

CalEQRO recommends ongoing TA to improve the understanding of the PIP as a non-clinical PIP. The PIP AIM statement is lacking variables of improvement. It is unclear if all baseline data is collected to move all aspects of the PIP to the Implementation phase.

Correlate data with specific performance measures the MHP will focus on, in order to identify whether the interventions are successful.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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