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

PLACER/SIERRA DRAFT REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 18-19, 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, "Placer/Sierra" may be used to identify the Placer/Sierra County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — January 18-19, 2022

Placer MHP Size — Medium

Sierra MHP Size — Small Rural

MHPs Region — Central

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	3	1	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	5	1	0
Quality of Care	10	6	4	0
Information Systems (IS)	6	2	3	1
TOTAL	**26**	**17**	**8**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Wraparound Fidelity	Clinical	02/21	Other - Completed	High
SOGI and the beneficiary experience in ASOC MH Clinics	Non-Clinical	10/21	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	1
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	2
* If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Placer County continues to strengthen their continuum of care.
- Placer County has a robust system of youth wellness centers located in schools across the county.
- Placer County has an effective process to transfer beneficiaries between the MHP and the Managed Care Plans (MCP).
- The MHP's 7-day and 30-day post psychiatric inpatient follow-up rates increased in 2021.
- Sierra County began billing Medi-Cal this past year.

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

- Following the pandemic closure of the two Placer County adult wellness centers, only the center in Roseville reopened.
- Placer County does not aggregate and report on the data of contract providers to provide an overall perspective on the county's beneficiary timeliness and outcomes.
- The MHP does not have an efficient method to share clinical data with contract providers, hospital, or primary care providers either through the EHR or an HIE.

- The MHP limits their receipt of federal and state funds by not billing Medicare and Other Health Care for beneficiaries with these coverages.
- The MHP lacks a universal system of care (SOC) adult outcome tool.

Recommendations for improvement based upon this review include:

- Identify a location and make plans to open a wellness center in the Auburn area.
- Create reports that aggregate, track, and trend contractor data to accurately represent beneficiary timeliness and outcomes throughout the SOC.
- Expand interoperability functionality by allowing contract providers to use the EHR and beginning the process to exchange data through an HIE.
- Explore and implement methods to bill Medicare and Other Health Care for beneficiaries with these coverages.
- Research, choose, and implement a SOC outcome tool for regular adult use.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs, comprised of 58 counties, to provide specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal MHP. DHCS contracts with Behavioral Health Concepts, Inc. (BHC), the CalEQRO to review and evaluate the care provided to the Medi-Cal beneficiaries.

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section14197.05).

This report presents the FY 2022-23 findings of the EQR for Placer/Sierra County MHP by BHC, conducted as a virtual review on January 18-19, 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 extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, then "<11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic, the Mosquito Fire effects, and continues experiencing staffing vacancies, especially in Sierra County. Placer County has had several leadership changes this year. 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.

- Placer County is planning for a new Health and Human Services (HHS) building in Auburn to be completed at the end of 2023. The building will house Auburn based HHS Department services including Behavioral Health. The county will need to find a new location for an Auburn wellness center as that had previously been located in the Adult System of Care Auburn HHS building.
- Placer County expanded their behavioral health continuum when they opened a Behavioral Health Urgent Care center for adults (named Lotus) in September 2022.
- Placer County expanded mobile crisis to serve all age groups with the implementation of youth mobile crisis teams.
- Sierra County began billing Medi-Cal claims to DHCS at the end of 2022.
- Placer County is implementing the California Mental Health Services Authority (CalMHSA) SmartCare Electronic Health Record (EHR) Solution for Multi-County Behavioral Health Initiative in California. They are scheduled to begin using the EHR across the MHP in July 2023.
- Sierra County is implementing the Credible EHR which will be managed by Kings View similar to how it manages the Cerner EHR today. Sierra will begin using Credible in July 2023.
- The MHP continues to prepare and implement changes for California Advancing and Innovating Medi-Cal (CalAIM).

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: Restructure medication monitoring reports to track and trend performance on chart reviews over time and use the information to identify QI opportunities. The MHP is encouraged to consult with other MHPs that successfully use similar data collection software to gather, compile, and track this data and to consider presenting data in a dashboard format.

(This recommendation is a carry-over from FY 2019-20 and FY 2020-21.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP provided documentation of medication management practices and oversight. However, no evidence was provided to confirm a dashboard format was in use. Key informants reported that this would be available in the new EHR.
- The MHP contacted two other counties to discuss medication monitoring, specifically SB 1291 requirements. The resulting information was useful for the MHP in its reformatting of data collection for these requirements. The QAPI includes a goal to track and trend medication monitoring indicators related to SB 1291.
- The Pathways to Well-Being form was submitted by both Placer and Sierra as part of the pre-EQR document submission process. Both report that Healthcare Effectiveness Data and Information Set (HEDIS) measures related SB 1291 and Welfare and Institutions Code (WIC) § 14197.05 are being monitored and

measured for FY 2022-23. Placer also notes that metabolic labs are monitored by the doctor and public health nurse per Medi-Cal and best-practice parameters.

- The MHP has a system of peer review of medication monitoring occurring in Placer County.
- This recommendation is rated as met, with the understanding that the new EHR is expected to provide dashboards to allow the MHP to identify and follow up on QI opportunities.

Recommendation 2: Identify with clinical line staff the value of providing the Level of Care Utilization System (LOCUS) for treatment planning and discharge and identify the barriers to completing the tool. Increase the percent of completed LOCUS assessments and create a report to track and trend aggregated beneficiary level outcomes to be shared with clinical line staff and supervisors.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The QAPI has a goal for an identified LOC tool to be administered to adult clients with a treatment plan within 90 days. Also, there is a goal to increase (7.5 percent to 15 percent) completion of the tool for adults within 90 days of planned discharge.
- The MHP is exploring replacing its current LOC tool with the implementation of the new EHR. The MHP is waiting to see if there will be a DHCS required tool statewide as with the Children System of Care (CSOC).
- Assuming there is a DHCS mandated tool, the MHP is waiting for the new EHR to upload the tools and CalMHSA training on any new state tool (MHP or MCP).
- The MHP expects the capability for outcomes tracking from the new EHR.
- This recommendation will not be carried forward as the MHP is working with CalMHSA to implement the SmartCare EHR, and resolve issues of this recommendation.

Recommendation 3: Collaborate with county human resources to identify discrepancies in the benefit formula and contractor pay structure to provide pay equitability and retain staff. Review the possibly of part-time or shared workload status and flexibility of telehealth work schedules.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The noted recommendations regarding pay structure and formulary are not determined by the MHP in collaboration with county human resources and are part of union negotiations. A new union contract was negotiated between the county and the Placer Public Employee's Organization (PPOE) in July of 2022 and is in place until June 2025. Employees were and are able to engage with their union representatives to address concerns in this area.

- The MHP is looking at CalAIM to help with retention by hopefully increasing rates for community business organizations (CBOs), which will assist to retain staff.
- To increase recruitment, the MHP is now able to offer compensation above the first step of a salary range.
- Telehealth provides potential options of flexible work schedules to give employees an alternative work schedule. The MHP has continued with a permanent telework policy. Most positions are hybrid, while a few are fully telework. The work continues on how to attract staff that cannot work from home (e.g., mobile programs).
- The MHP leadership is part of the larger Placer HHS leadership team, that has identified addressing workforce issues as a strategic priority into their current 3-year plan. HHS leadership is partnering with the County and pursuing strategies that simplify and adapt hiring practices, utilize creative and responsive strategies to create a more attractive work environment for staff (e.g., wellness, telework, alternative work weeks), and thoughtfully establish policies and practices geared toward attracting and retaining a diverse workforce. This work will benefit the MHP.

Recommendation 4: Create a report that aggregates, tracks, and trends contractor data to accurately represent beneficiary outcomes throughout the system of care (SOC). Continue to focus on interoperability and contractor access to the EHR.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- Sierra County does not have any contracted organizational providers/agencies. They do contract with providers who render services within Sierra County offices, as well as via telehealth.
- While Placer County requires individual reports from contract providers that are reviewed in quarterly Quality Improvement Committee (QIC) meetings, the county does not aggregate the data to provide an overall perspective on the county's beneficiary outcomes.
- The Placer new EHR will provide that functionality, however at least initially, not all contract providers will convert to the county EHR.
- To provide the overall Placer County view, they will need to develop a process where contract provider data can be consolidated with county data to provide a comprehensive view of the county's SOC.
- This recommendation would be met if the Placer ShareCare EHR is utilized to incorporate contractor data.

Recommendation 5: Update the Quality Improvement Work Plan to include goals and outcomes for new initiatives and update the plan to exclude goals that are previously

met, unless there are new outcomes identified for a previously met goal. Correct percentage rates to accurately identify proposed outcomes.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The QAPI has been reformatted to better highlight the quality aspects of the SOC.
- In addition, in response to feedback by the Drug Medi-Cal Organized Delivery System (DMC-ODS) EQRO, quality assurance/monitoring activities have been reintroduced into the workplan.
- Goals that were previously met have been updated or removed. Percentages have been updated to reflect more accurate outcomes.

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.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in Placer County. Regardless of payment source, approximately 60 percent of services were delivered by county-operated/staffed clinics and sites, and 40 percent were delivered by contractor-operated/staffed clinics and sites. This represents an increase in the proportion of county-operated services which is the result of increased county-operated Medi-Cal billing rather than a shift of services to county providers. Overall, approximately 98 percent of services provided were claimed to Medi-Cal. In Sierra County all SMHS services are delivered by county-operated providers. Sierra County began billing Medi-Cal in August 2022.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county and contracted staff; beneficiaries may request services through the Access Line as well as through the following system entry points: mobile crisis teams, walk-in screening clinics, provider referrals, schools, and family. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The MHP operates a no wrong door access system. Beneficiaries can call the access line or walk into a clinic and receive assessment and resources linkage.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth video services to 96 adult beneficiaries, 57 youth beneficiaries, and 15 older adult beneficiaries across 8 county-operated sites and 50 contractor-operated sites. Among those served, 19 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

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[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

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

For Placer/Sierra County, the time and distance requirements are 60 miles or 90 minutes for outpatient mental health and psychiatry services in Sierra County and 30 miles or 60 minutes in Placer County. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

Table 1B: MHP Out-of-Network Access, FY 2021-22

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☐ Yes ☒ No
Contracting status:	☐ The MHP is in the process of establishing contracts with OON providers ☒ The MHP does not have plans to establish contracts with OON providers
OON Access for Beneficiaries	
The MHP ensures OON access for beneficiaries in the following manner:	☐ The MHP has existing contracts with OON providers ☒ Other: When a single source contract is needed due to unavailability of resources in a specific area, the provider is contracted and brought within the network. Out of Network contracts are rare but completed when necessary to continue care for a client.

- 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 converting a Roseville hotel into permanent supportive housing that will provide behavioral health services in addition to housing.
- Placer County develops services, such as the new Lotus Center, to serve all county residents regardless of insurance.
- Placer County has expanded mobile crisis to serve all ages.
- Key informants indicated that the access process that often results in call to the intake center rather than direct walk-ins might be creating an obstacle to providing services in more remote parts of the county where there are no walk-in clinics.
- Capacity management is a top priority. Some staff returned to offices in county and CBOs. This offers more flexibility, even though supervisors are still carrying full caseloads due to staff vacancy rate.

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, with a 3.95 percent PR, continues to provide access at a lower rate than the state as a whole. The MHP's PR went up in CY 2021 while the statewide PR went down.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	70,472	2,781	3.95%	$19,218,558	$6,911
CY 2020	63,376	2,456	3.88%	$13,328,021	$5,427
CY 2019	60,543	2,488	4.11%	$13,998,971	$5,627

- The MHP's number of eligibles has gone up each year from CY 2019 to CY 2021. This trend is seen statewide.
- The PR went down to 3.88 percent in CY 2020, the first year of the pandemic and came up to 3.95 percent in CY 2021, although it has not yet reached pre-pandemic rates. The large number of vacancies seen in the MHP and nationally could be a factor in PRs being lower than pre-pandemic levels.

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	7,359	44	0.60%	1.08%	1.96%
Ages 6-17	16,586	575	3.47%	4.41%	5.93%
Ages 18-20	3,502	123	3.51%	3.73%	4.41%
Ages 21-64	36,354	1,887	5.19%	4.11%	4.56%
Ages 65+	6,673	152	2.28%	2.26%	1.95%
Total	70,472	2,781	3.95%	3.67%	4.34%

- The MHP's highest PR is with adults ages 21 to 64. The 5.19 percent adult and 2.28 percent older adult PRs are higher than seen statewide or in other medium sized counties.
- Ages 0-5, 6-17 and 18-20 all have lower PRs than statewide or similarly sized counties. This could be a result of how Placer County integrates Behavioral Health, Child Welfare, Juvenile Probation, Foster Care, and other youth services into their CSOC to seamlessly serve their beneficiaries. This organization allows additional funding streams for children's services so not all billable services are

submitted to Medi-Cal. This brings down the PRs for all children and youth age ranges.

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	94	3.38%
Threshold language source: Open Data per BHIN 20-070		

- Spanish is the only threshold language in the MHP. In CY 2021, 3.38 percent of the beneficiaries served identify Spanish as their primary language.

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

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	21,759	899	4.13%	$5,296,009	$5,891
Medium	613,796	20,261	3.30%	$151,430,714	$7,474
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligibles that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The MHP's ACA PR is higher than the statewide and medium-sized county rates.
- The MHP's 4.13 percent ACA PR is also higher than the county's 3.95 percent PR. The $5,891 ACA AACB is lower than the $6,911 county average. While the PR is higher than the county average, the ACA population receives fewer or less costly services than the non-ACA population in Placer County.

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.

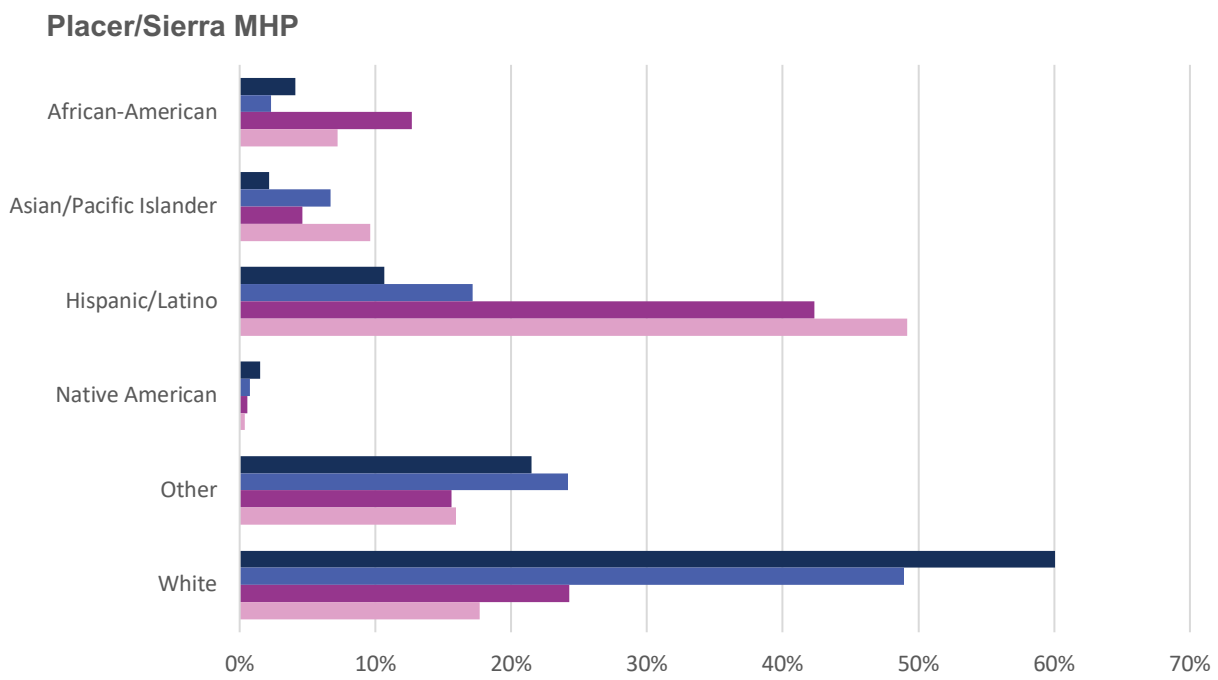
Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	1,630	114	6.99%	7.64%
Asian/Pacific Islander	4,712	60	1.27%	2.08%
Hispanic/Latino	12,081	296	2.45%	3.74%
Native American	517	42	8.12%	6.33%
Other	17,048	598	3.51%	4.25%
White	34,487	1,671	4.85%	5.96%
Total	**70,475**	**2,781**	**3.95%**	**4.34%**

** Differences in totals from Table 3 and Table 4 are due to rounding of averages across different variables.*

- The MHP's highest PR is in the Native American population. Placer works with closely with United Auburn Indian Community and Sierra Native Alliance which contributes to the high Native American PR.
- Whites and African-Americans have PRs higher than the MHP's total PR and lower than the state average.
- The Hispanic/Latino and Asian/Pacific Islander ethnicities also have PRs lower than the county and state average.

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

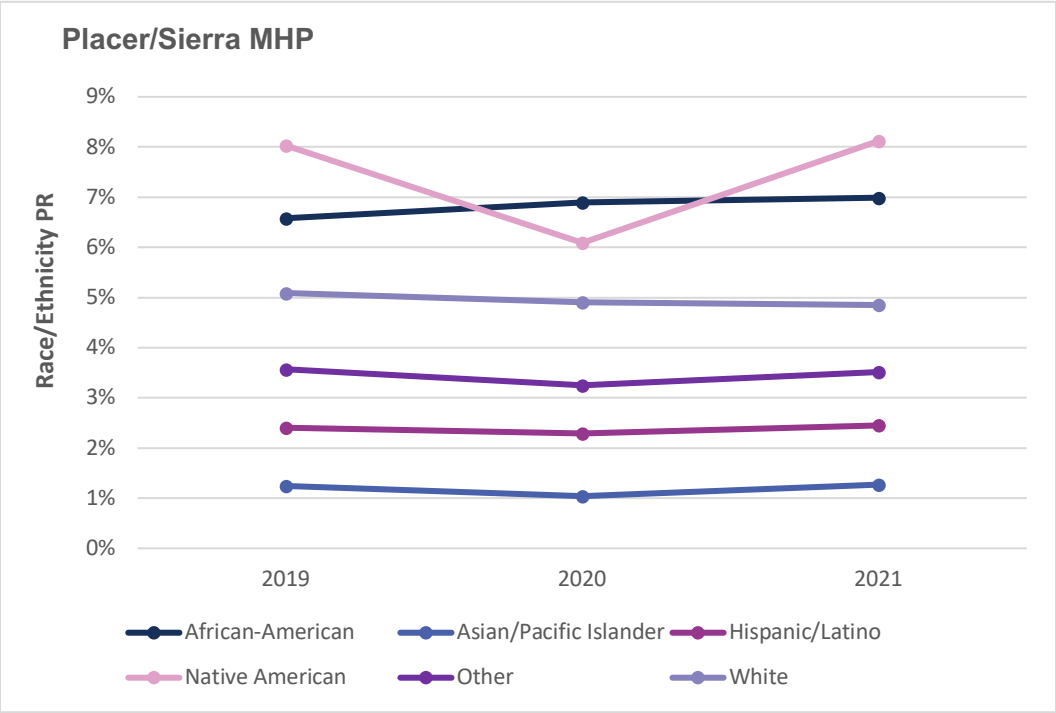


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	60%	22%	2%	11%	2%	4%
MHP % Eligible	49%	24%	1%	17%	7%	2%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- The MHP has a higher proportion of White eligibles (49 percent) than statewide (18 percent), and a lower proportion of Hispanic/Latino eligibles (17 percent) than statewide (49 percent).

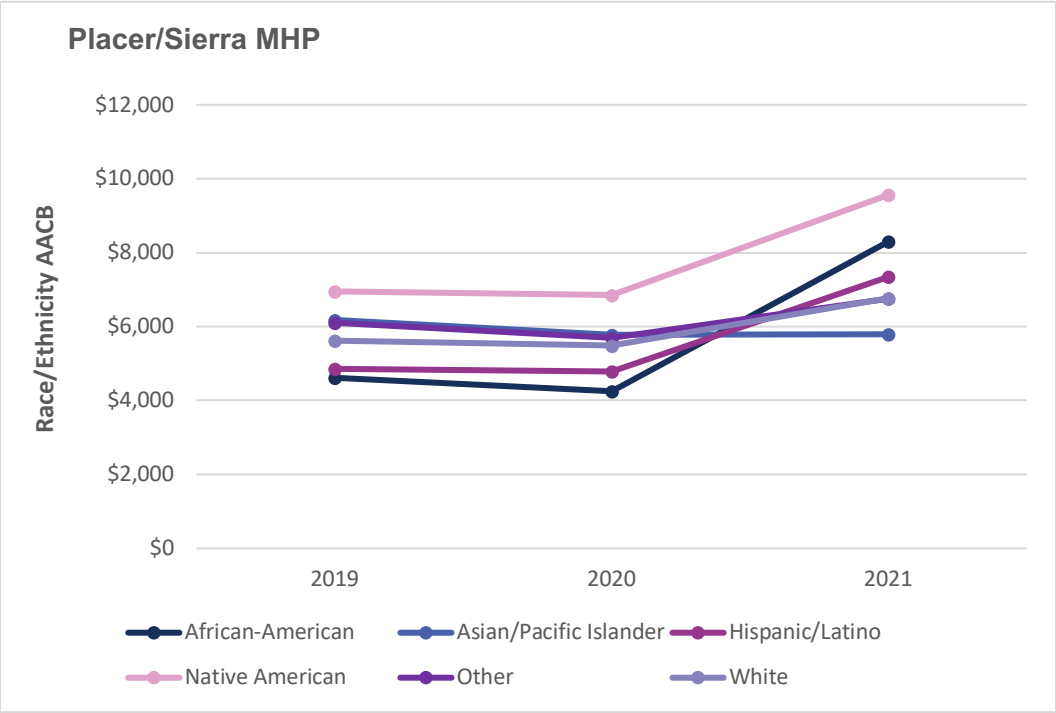
Figures 2 – 11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



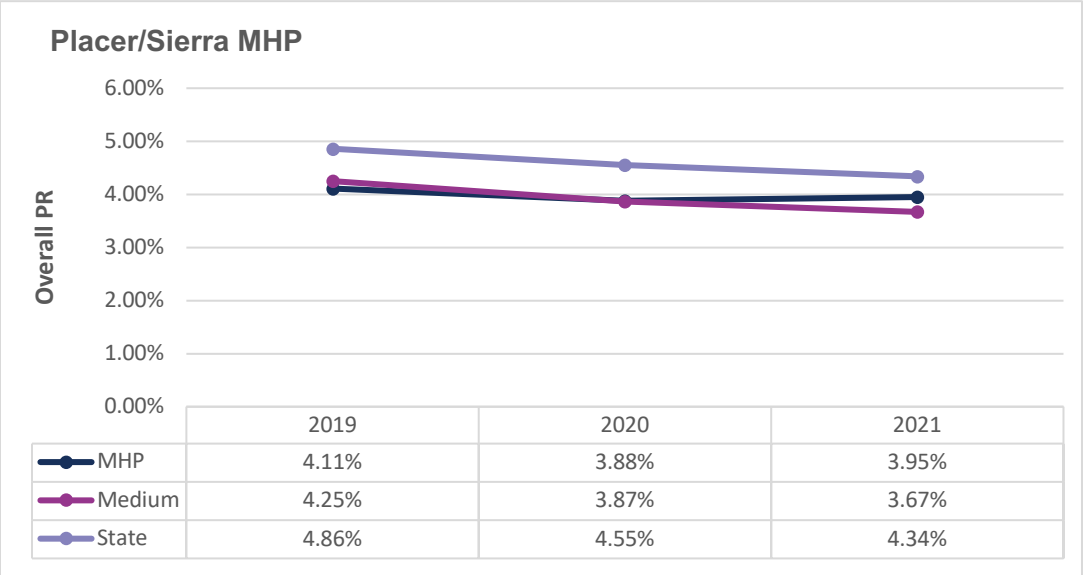
- The PRs for all ethnicities other than Native American have remained consistent between CYs 2019 to 2021. The Native American PR dipped in CY 2020, although relatively small numbers served can result in comparatively large fluctuations year to year.
- Hispanic/Latino and Asian/Pacific Islander PRs have been consistently lower than those of other groups, while African-American and White PRs have been consistently higher between CYs 2019 to 2021.

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



- Most AACBs went down slightly in CY 2020 and increased substantially in CY 2021. The Asian/Pacific Islander AACB did not increase much in CY 2021.

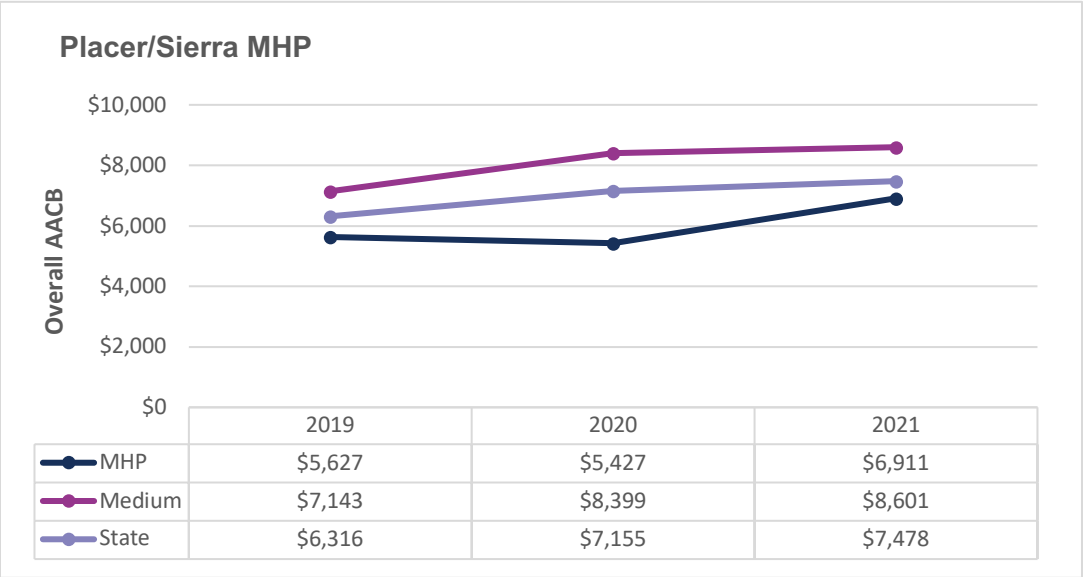
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.11%	3.88%	3.95%
Medium	4.25%	3.87%	3.67%
State	4.86%	4.55%	4.34%

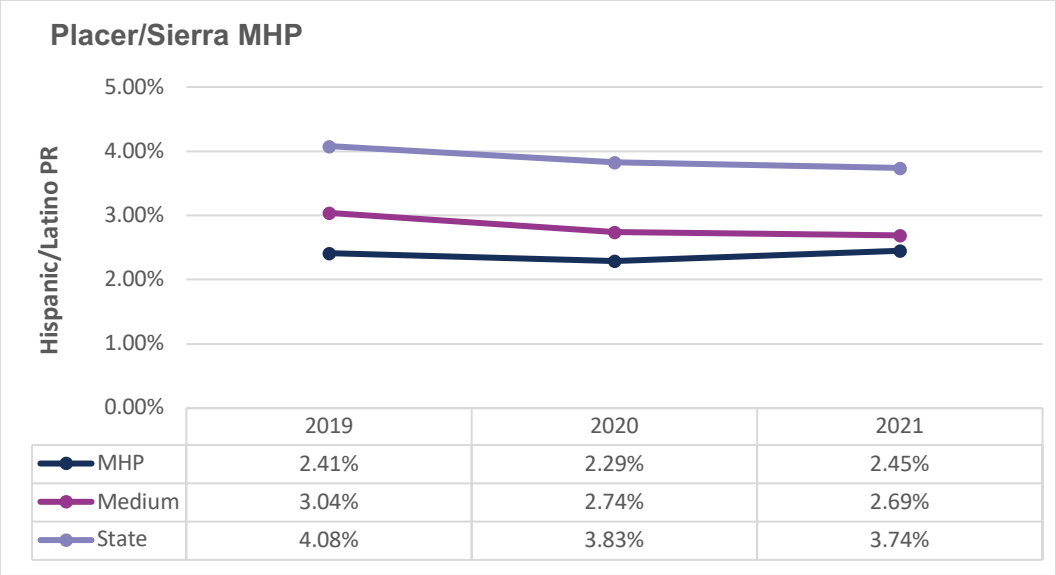
- The MHP's PR has been consistently below the state average and about the same as other medium sized counties between CY 2019 and CY 2021.

Figure 5: Overall AACB CY 2019-21



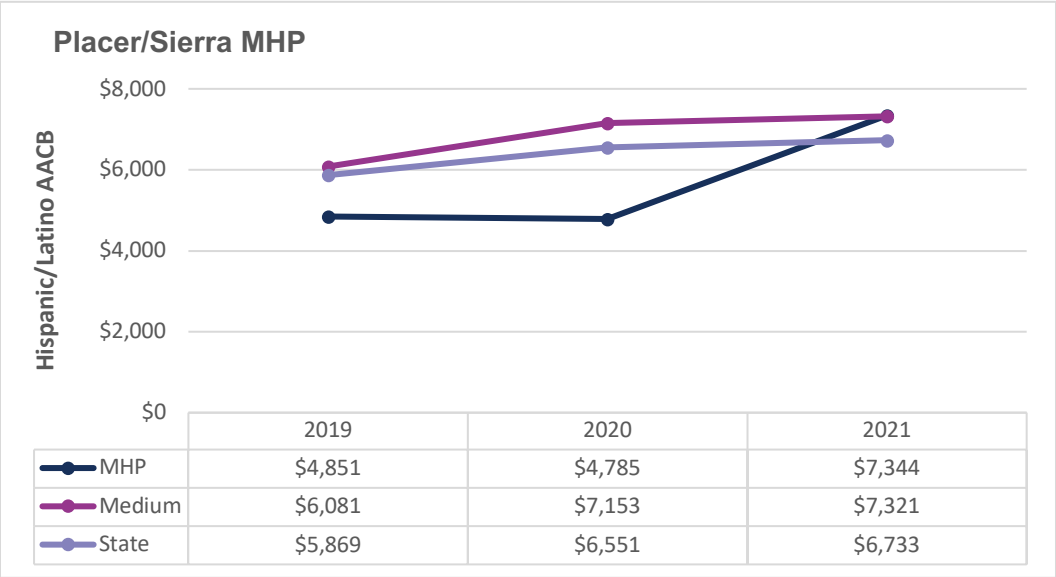
- The MHP's AACB has remained consistently lower than the state and other medium-sized counties. However, while the state and medium-county AACB increased slightly in CY 2021, the MHP's AACB increased substantially between CY 2020 and CY 2021.

Figure 6: Hispanic/Latino PR CY 2019-21



- The Hispanic/Latino PR remains consistently lower than the state average. It did go up in CY 2021, while the state and medium counties went down in CY 2021.

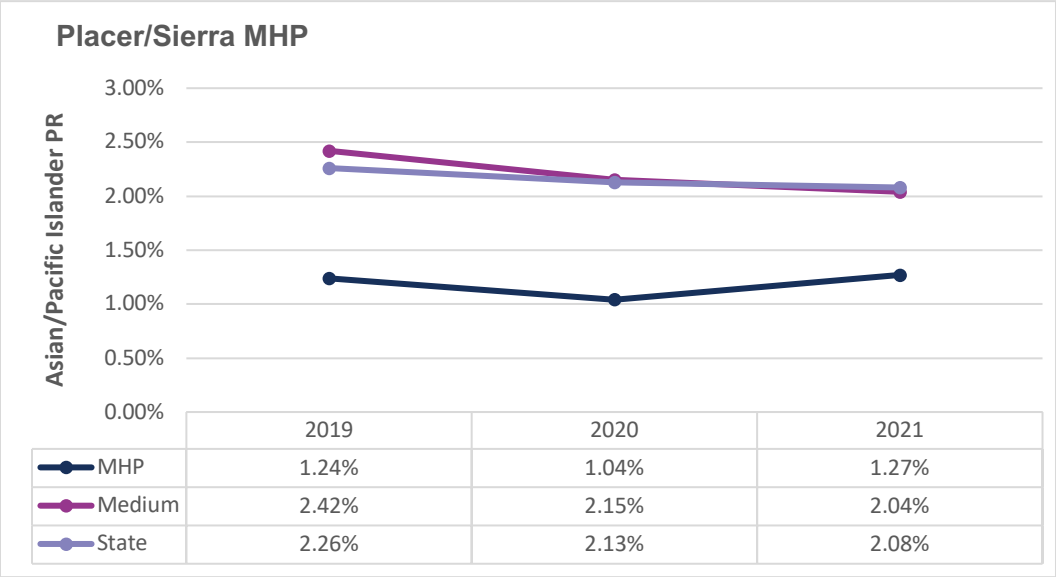
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,851	$4,785	$7,344
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

- The MHP's Hispanic/Latino AACB increased in CY 2021. In CYs 2019 and 2020 Hispanic/Latino AACB was the lowest of the three data points, and it was higher than the state and medium-sized counties in 2021.

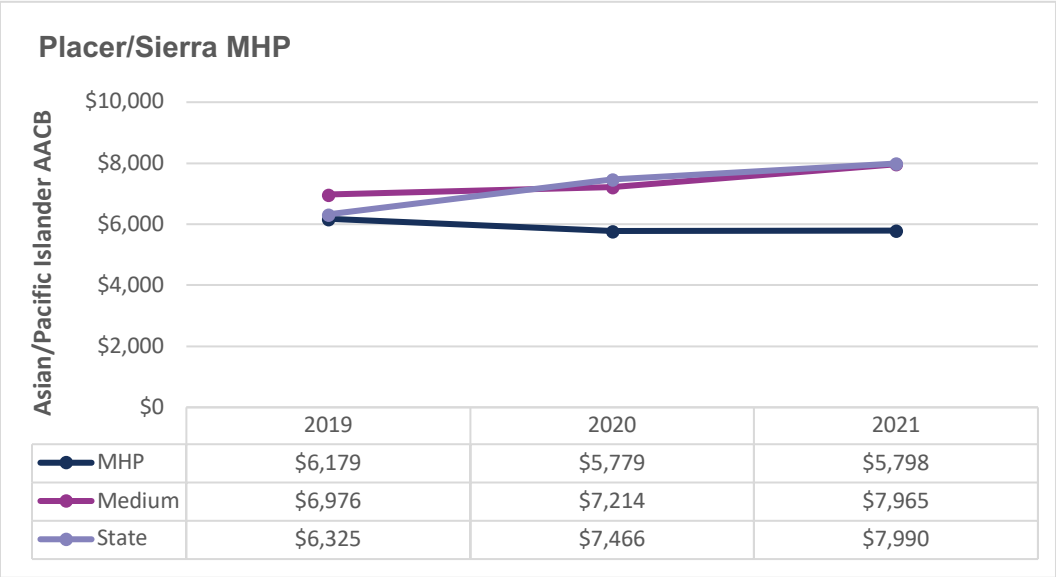
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	1.24%	1.04%	1.27%
Medium	2.42%	2.15%	2.04%
State	2.26%	2.13%	2.08%

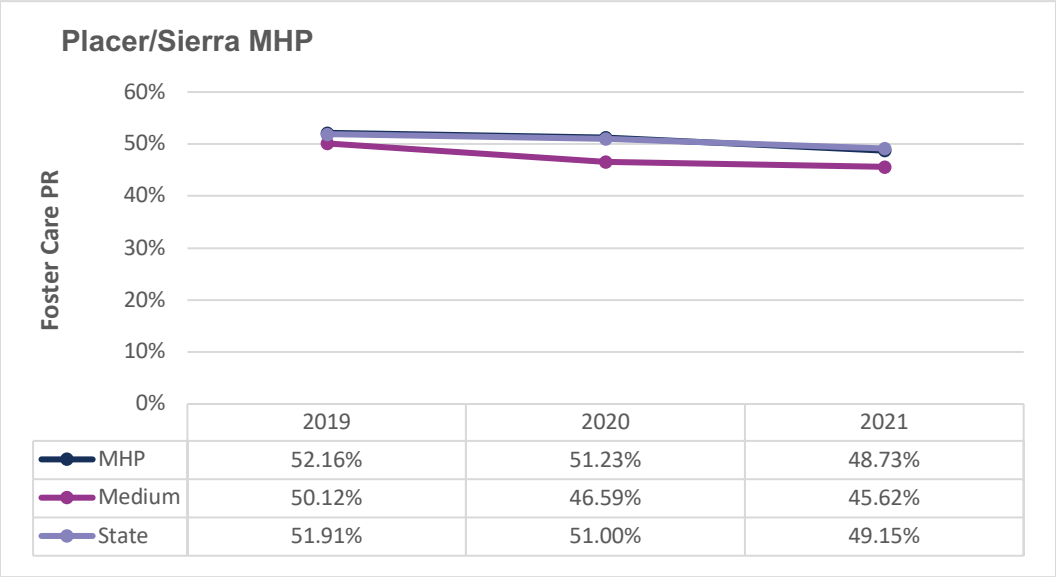
- The Asian Pacific Islander PR remains consistently lower than the state average.

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



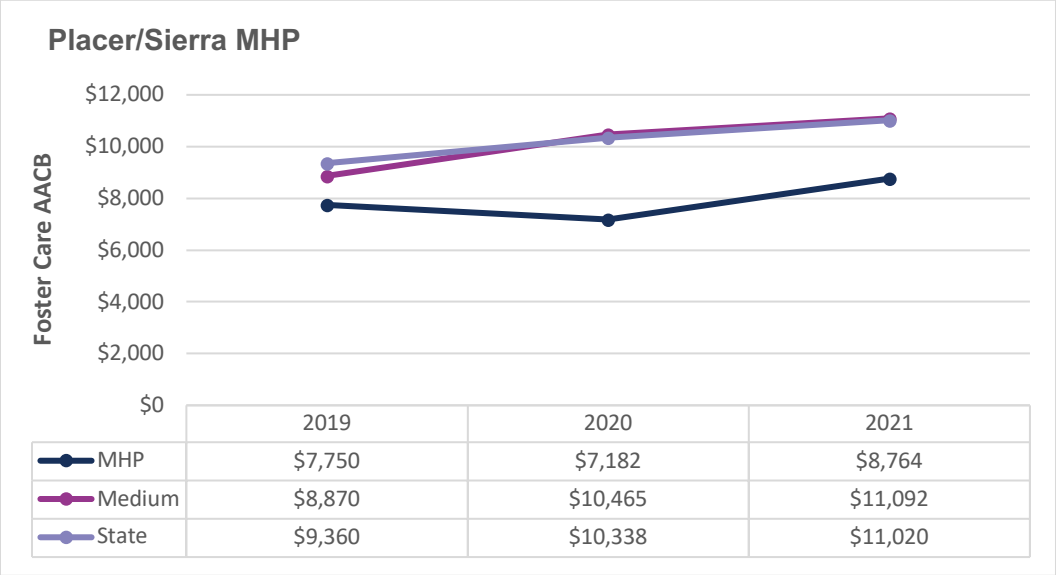
- The Asian/Pacific Islander AACB is lower than the state average. It remained fairly consistent between CY 2020 and CY 2021 while the state AACB increased between those years.

Figure 10: Foster Care PR CY 2019-21



- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed.
- The MHP's FC PR is virtually the same as the state values in all years from CY 2019 to CY 2021. It is slightly higher than other medium-sized counties.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$7,750	$7,182	$8,764
Medium	$8,870	$10,465	$11,092
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased each year.
- The MHP's FC AACB is lower than the state average. As noted earlier in the report, other funding streams are also used for children's services which contributes to the relatively low AACB for FC youth in the MHP.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 2,163				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	34	1.6%	10	6	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	292	13.5%	20	9	1.3%	15	7
Residential	<11	-	154	45	0.4%	107	79
Crisis Residential	139	6.4%	16	12	2.2%	21	14
Per Minute Services							
Crisis Stabilization	63	2.9%	1,245	1,200	13.0%	1,546	1,200
Crisis Intervention	689	31.9%	282	185	12.8%	248	150
Medication Support	1,346	62.2%	526	325	60.1%	311	204
Mental Health Services	1,198	55.4%	959	230	65.1%	868	353
Targeted Case Management	1,438	66.5%	412	104	36.5%	434	137

- Placer County has several mobile crisis teams which contribute to the 31.9 percent of adult beneficiaries served who received a Crisis Intervention service.
- Placer County has a Psychiatric Health Facility (PHF) and no Inpatient beds which contribute to the high percentage of adult beneficiaries with days in a PHF and low utilization of Inpatient services.
- Placer County provided Targeted Case Management services to two-thirds of adult beneficiaries served. Statewide 36.5 percent of beneficiaries served received Targeted Case Management services.

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

Service Category	MHP N = 134				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	-	14	10	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	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	2,960	2,100	3.1%	1,398	1,200
Crisis Intervention	21	15.7%	249	169	7.5%	404	198
Medication Support	67	50.0%	1,301	455	28.3%	394	271
TBS	<11	-	16,115	1,725	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Home Based Services	52	38.8%	1,237	434	40.0%	1,351	472
Intensive Care Coordination	32	23.9%	4,216	503	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	120	89.6%	5,148	2,204	96.3%	1,848	1,103
Targeted Case Management	86	64.2%	569	266	35.0%	342	120

- The percentages of FC youth receiving Intensive Home Based Services and Intensive Care Coordination indicate adherence to the Integrated Core Practice Model. The MHP 4,216 average Intensive Care Coordination minutes delivered is higher than the 2,256 average minutes delivered statewide. The 503 median minutes delivered in the MHP is lower than the 1,271 median minutes delivered statewide.
- As in the adult population, a relatively high percentage of FC beneficiaries served received a Crisis Intervention service in CY 2021. While a high percentage received the service, the average and median units delivered were lower than seen statewide.

- Half of FC beneficiaries served received medication support services. Statewide 28.3 percent of FC beneficiaries served received medication support.
- Average and median Mental Health Services delivered are higher in the MHP than statewide.
- Targeted Case Management is delivered to 64.2 percent of MHP FC youth compared to 35.0 percent statewide. The average and median units delivered is also higher than seen statewide.

IMPACT OF ACCESS FINDINGS

- The low Hispanic/Latino and Asian/Pacific Islander PRs suggest that there are barriers to access which warrant further evaluation. Placer County reported that they are working to reduce barriers to providing services to these communities through the Race, Equity, Access, Diversity, and Inclusion (READI) committee and other mechanisms.
- Almost one out of three adult beneficiaries served received a Crisis Intervention service in CY 2021. While the expansion of the mobile crisis teams serves an essential need, Placer County should evaluate whether other opportunities exist to provide planned services before conditions become critical.
- As half of FC beneficiaries served received a medication support service, Placer County should evaluate their first-line use of psychosocial care to ensure medications are warranted before being prescribed.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- Throughout the MHP county provided services, a high percentage of first offered and first delivered non-psychiatry services met timeliness standards. Placer County children's psychiatry offered appointments met the 15 business day

standard 74 percent of the time. All other psychiatry appointments met the timeliness standard less than 65 percent of the time.

- While contract providers delivered 40 percent of the services in Placer County, contractor data was not included in the Timeliness data submitted to the EQRO. The county and contractor data is reviewed together at QIC meetings.
- Placer County indicated that there can be delays to providing psychiatry appointments while labs are being ordered and when beneficiaries have recently moved to the county.

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, both Placer and Sierra counties reported in a submission of Assessment of Timely Access (ATA), representing access to care during the 12 month period of FY 21-22. Table 11 and Figures 12 – 14 display data submitted by the counties; an analysis follows. This data represented county-operated services. Note; Due to inaccurate data capture, Sierra County did not report data on timeliness for urgent appointment offered.

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

Table 11a: FY 2021-22 MHP Assessment of Timely Access – Placer County

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	2.9 Days	10 Business Days*	98.4%
First Non-Urgent Service Rendered	2.9 Days	10 Business Days**	98.4%
First Non-Urgent Psychiatry Appointment Offered	23 Days	15 Business Days*	56.2%
First Non-Urgent Psychiatry Service Rendered	23 Days	15 Business Days**	56.2%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0.49 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization	8.56 Days	7 Days**	64.38%
No-Show Rate – Psychiatry	7.94%	25%**	n/a
No-Show Rate – Clinicians	1.35%	25%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 21-22			

Table 11b: FY 2021-22 MHP Assessment of Timely Access – Sierra County

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	8.03 Days	10 Business Days*	77%
First Non-Urgent Service Rendered	9 Days	10 Business Days**	74%
First Non-Urgent Psychiatry Appointment Offered	14.74 Days	15 Business Days*	58%
First Non-Urgent Psychiatry Service Rendered	15.47 Days	15 Business Days**	58%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	n/a	48 Hours*	n/a
Follow-Up Appointments after Psychiatric Hospitalization	10 Days	7 Days**	50%
No-Show Rate – Psychiatry	11%	10%**	n/a
No-Show Rate – Clinicians	13%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 21-22			

Figure 12a: Wait Times to First Service and First Psychiatry Service – Placer County

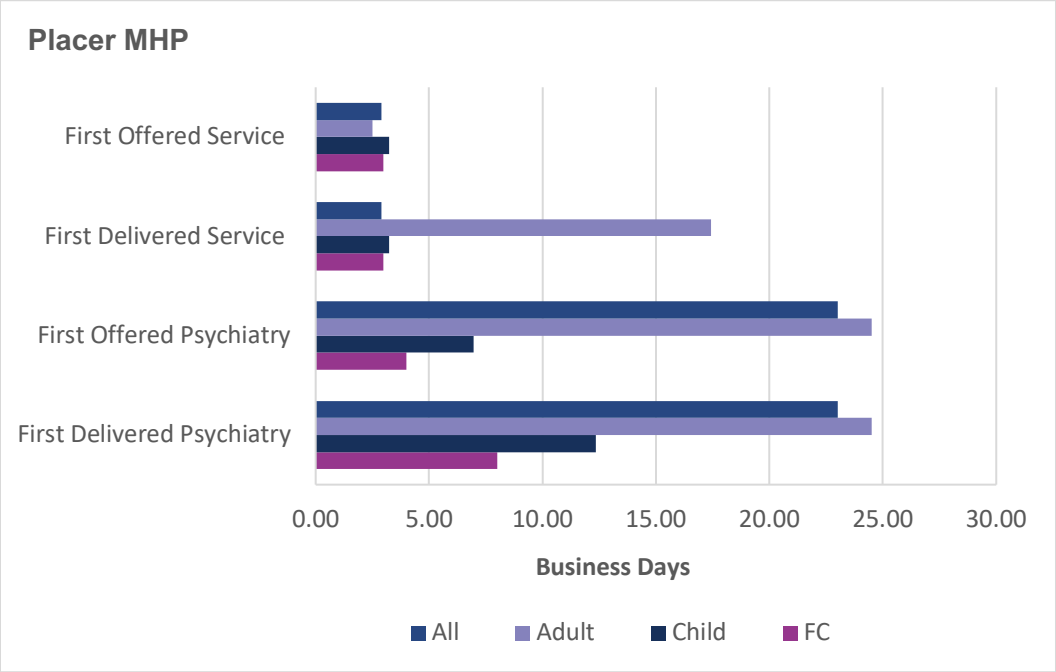


Figure 12b: Wait Times to First Service and First Psychiatry Service – Sierra County

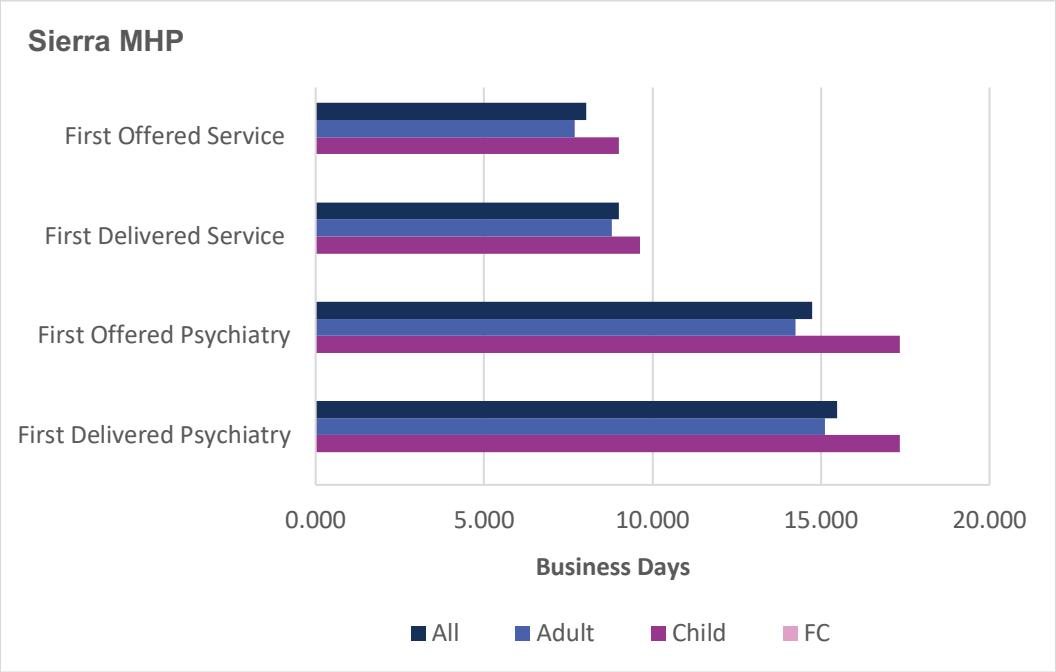


Figure 13a: Wait Times for Urgent Services – Placer County

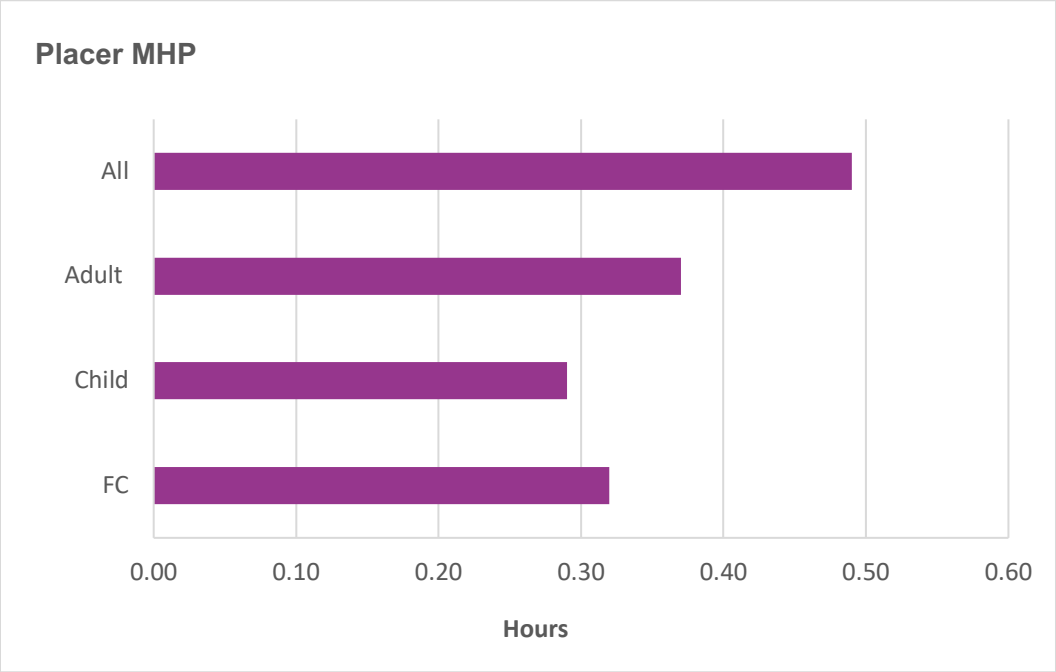


Figure 13b: Wait Times for Urgent Services – Sierra County

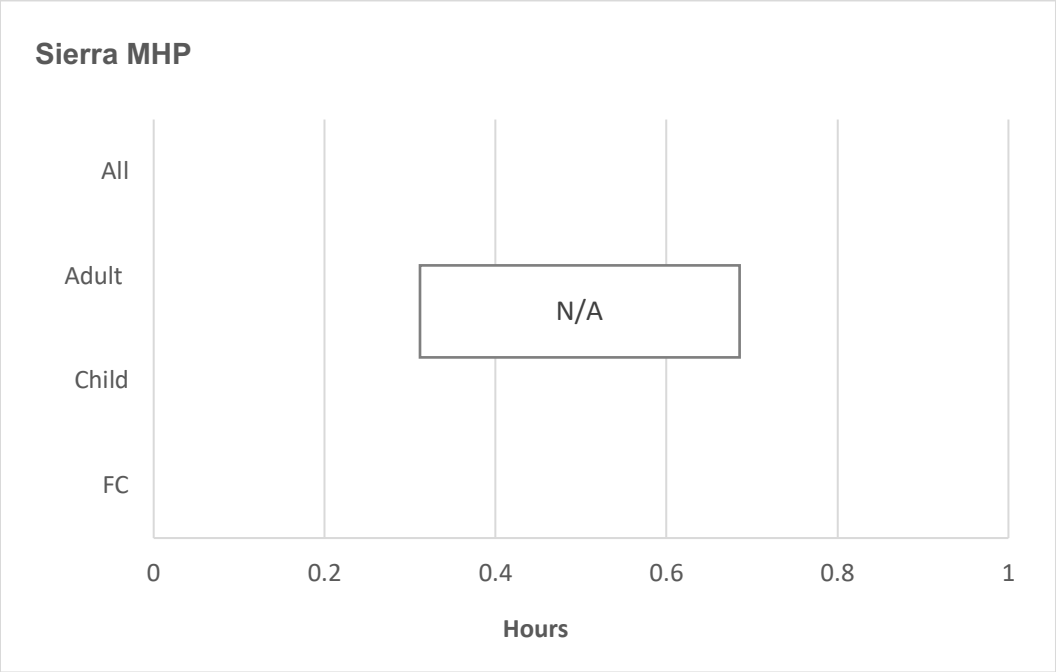


Figure 14a: Percent of Services that Met Timeliness Standards – Placer County

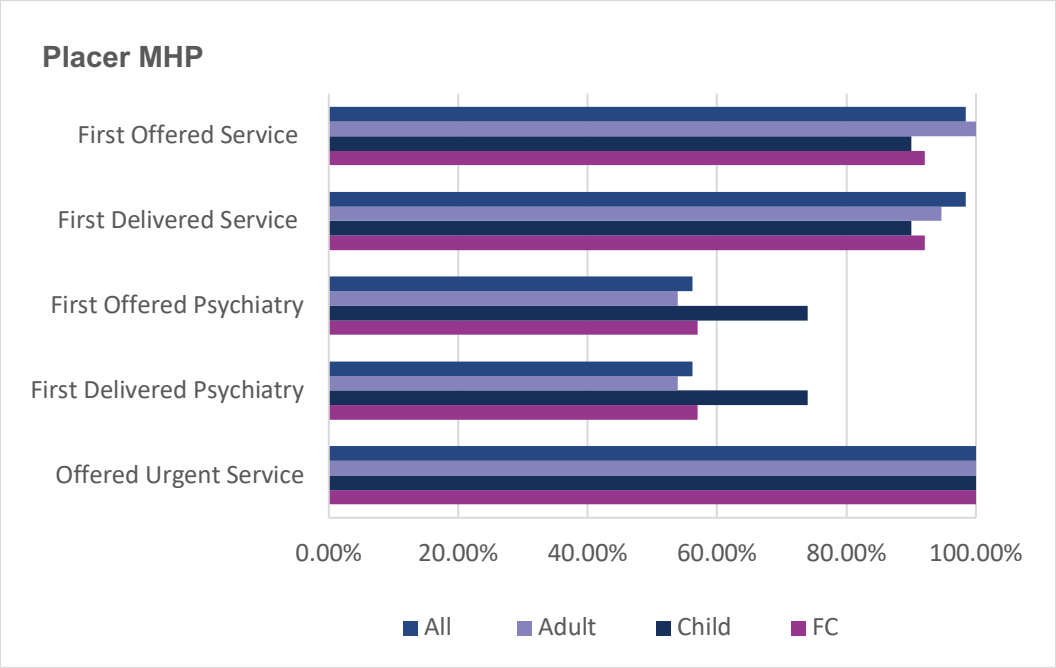
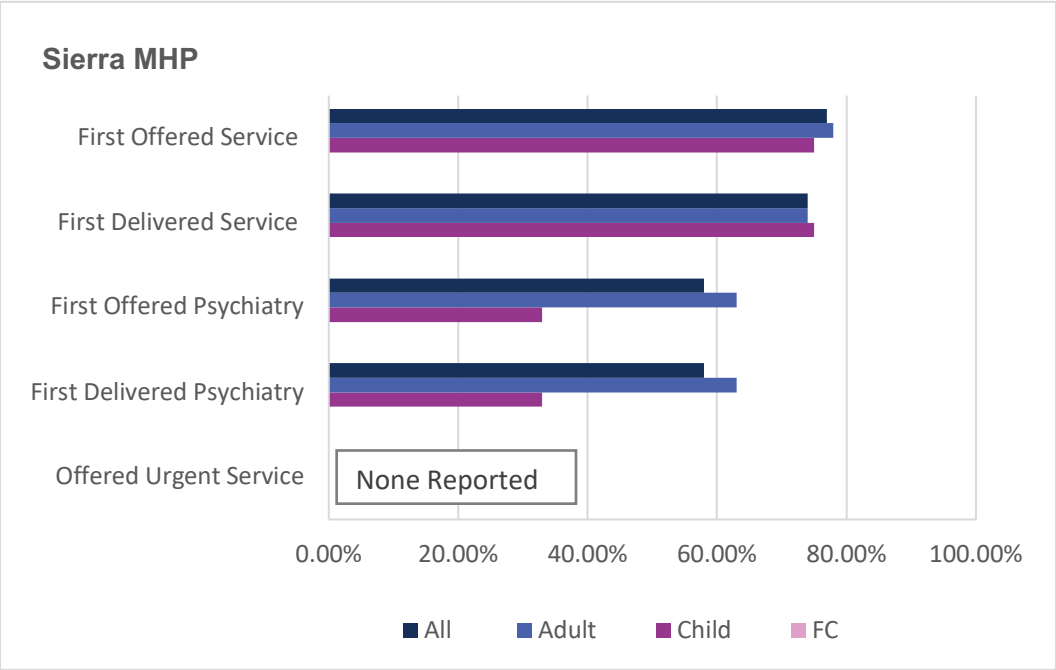


Figure 14b: Percent of Services that Met Timeliness Standards – Sierra County



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments and unscheduled assessments.
- Definitions of "urgent services" vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. Placer County defined "urgent services" for purposes of the ATA as a service provided by a crisis care mobile unit. There were reportedly 707 urgent service requests with a reported actual wait time to services for the overall population at 0.49 hours.
- Sierra County reported that there were no services meeting urgent criteria during the reporting period.
- 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 for both adults and children.
- Placer County does not track adult psychiatry appointments offered. They do track timeliness to adult psychiatry appointment delivered.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a psychiatry no-show rate of 7.94 percent in Placer

County and 11 percent in Sierra County. The non-psychiatry clinical staff no-show rate reported was 1.35 percent in Placer County and 13 percent in Sierra County.

- No-show rates are low but may be inaccurate due to the difficulty tracking that information. Providers will contact the beneficiary if they do not show up for an appointment. Placer has more confidence in the psychiatry no-show data as there is staff assigned to update the system with no-show settings.

IMPACT OF TIMELINESS FINDINGS

- While contract providers delivered 40 percent of the services in Placer County, contractor data was not included in the Timeliness data submitted to the EQRO. The county reviews the data in QIC meetings but since it is never aggregated with county data, the EQRO cannot see a comprehensive view of timeliness in the county.
- Placer County does not track first “offered” appointments for Psychiatry. The average time to first rendered psychiatry appointment is longer than DHCS standards, resulting in beneficiaries being delayed in receiving medication support for their mental health conditions. This may have a trickle-down effect to other parts of the system, such as increase in crisis or emergency department access due to the need for more immediate care which has been intensified by long outpatient wait times. It would be beneficial for the MHP to continue exploring ways to address these metrics and evaluate whether identified solutions such as adding psychiatry hours will improve timeliness and beneficiary outcomes.
- Placer County should investigate tracking timeliness to adult psychiatry appointments offered as they currently only track timeliness to adult psychiatry appointments rendered.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is within the Quality Management (QM) team which is inclusive of compliance staff. The QM team which oversees QI, QA, and compliance consists of two directors from each county and 10 full-time equivalent (FTE) staff from Placer and 1 FTE from Sierra.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC serves as the hub of the MHP QI Program and links with the systems of care, Leadership Team, the HHS Department, Policy Team, the Systems Management and Resource Team (SMART), Policy Board and Committees, Subcommittees and Teams, which comprise the QI Program structure. The QIC is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met four times. Of the 17 Placer and 10 Sierra identified FY 22-23 QAPI workplan goals, the MHP continues to improve making goals and quantifiable, and include goals necessary for CalAIM requirements. Due to staffing shortages, some goals continue to the next year.

The MHP utilizes the following level of care (LOC) tools: Pediatric Symptoms Checklist (PSC-35), Child and Adolescent Needs and Strengths (CANS), Mental Health Screening Tool (MHST), LOCUS, Beacon Diagnostic Evaluation Form. CANS data is measured and reported out on a quarterly basis at the aggregate and individual levels for the purposes of service and system efficacy determination purposes. Although PSC-35 is gathered as a LOC tool, caregiver responses can be incomplete so there is not sufficient data to aggregate. When complete PSC-35 data is available it is used at the beneficiary level. LOCUS while required is not regularly completed by clinicians.

The MHP utilizes the following outcomes tools: PSC-35, CANS, MHST, LOCUS, and Beacon.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve

outcomes for beneficiaries. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

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

Table 12: Quality Key Components

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

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

- To meet the special needs of children and youth who may be at risk, Placer County has organized an integrated team offering comprehensive services from Alternative Education, Child Welfare, Children's Mental Health, Probation, Public Health and Substance Abuse Services.
- The MHP has a robust system of youth wellness centers located in schools across the county. There is an adult wellness center located in Roseville. The Dewitt Wellness Center facility located in Auburn, was repurposed as a housing center. A new location is needed to open a second adult wellness center in the county.
- The MHP expanded the mobile crisis services by joining the Mobile Crisis Triage (MCT) team and Family Mobile Team (FMT)to create the Crisis Care Mobile Unit this past year to serve all age groups through an integrated team.
- Placer County is working with neighboring counties to develop regional youth crisis continuum services. They are building a regional youth PHF and plan to

include some swing beds in the adult PHF to provide more flexibility in treating youth or adults.

- The MHP opened the Lotus Behavioral Health Crisis Center this past year. The center was designed to serve any county resident experiencing a mental health crisis. It is on a campus that includes a PHF, Crisis Residential Center (Cornerstone), Specialty Mental Health and Substance Use Disorder services. IHSS, APS, and forensic services are also on this campus.
- Placer County has an effective process, including data sharing, to transfer beneficiaries between the MHP and MCP in the county. The MHP does not discharge a beneficiary from their caseload until there is a confirmed transition to the MCP.
- Placer County has almost 40 peer employees throughout the full continuum of care programs in both adult and children's SOC. They fill rolls including youth advocates, family advocates, peer specialists and family support specialists.
- Placer County has a Consumer Council that gives Adult System of Care (ASOC) clients the opportunity to provide feedback to their county service providers. Participants meet once a month to discuss topics that the County would like client feedback on or that the participants themselves would like addressed.
- 3C - Stakeholders interviewed did not endorse communication from MHP Administration, and/or stakeholder input and Involvement in system planning and Implementation.
- 3G – Outcome tools are not consistently used throughout the adult system of care.
- 3H – The MHP administers the required state survey each year. However, they do not have the results from the latest survey. The MHP did present evidence of using the information from the survey to improve access, timeliness, and/or quality in their programs.
- 3J – While the MHP has a robust peer staff program, there is no defined career ladder at this time.
- The MHP tracks and trends the following HEDIS measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): Metabolic labs are monitored by the doctor and public health nurse per Medi-Cal and best-practice parameters. Labs are ordered per protocol for each patient and medication regimen. If any concerning results are received, the results are discussed with the parents/caregiver

and child. A plan is developed for continued medication treatment based on risk/benefits assessment, the child's well-being, and the parents/caregiver input.

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

QUALITY PERFORMANCE MEASURES

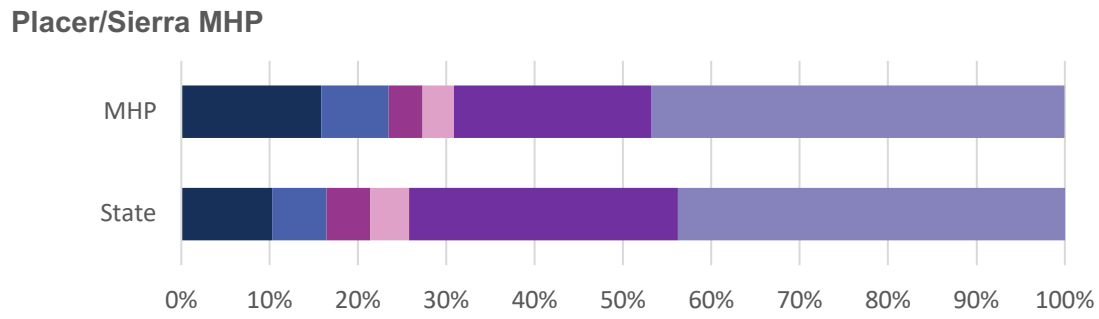
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



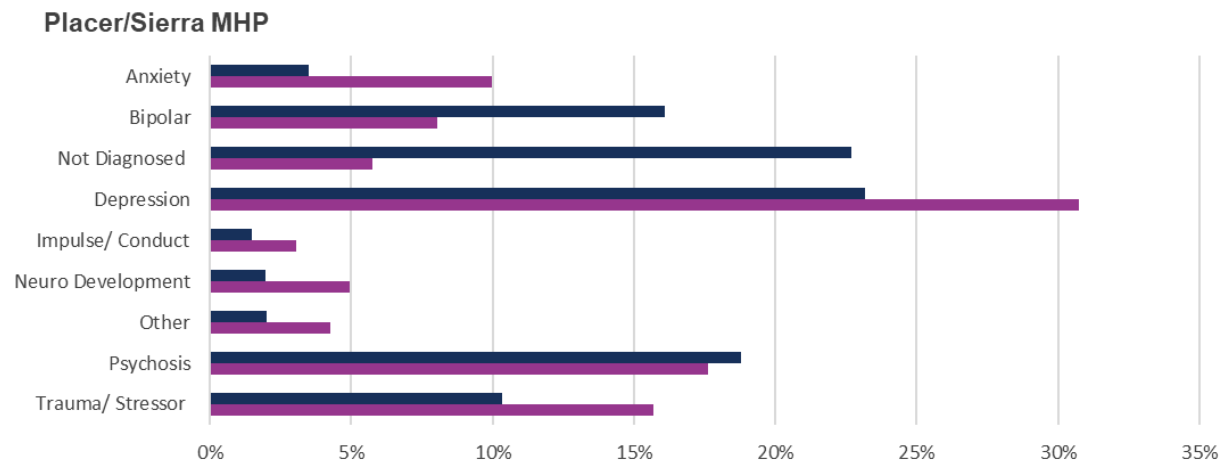
	State	MHP
1 service	10.25%	15.86%
2 service	6.20%	7.62%
3 service	4.88%	3.81%
4 service	4.47%	3.56%
5-15 Services	30.41%	22.29%
>15 Services	43.79%	46.85%

- The MHP has a higher percentage of beneficiaries receiving one to two services than the state average. In the MHP 23.48 percent received one or two services. Statewide 16.45 percent received one or two services. This could be related to the availability of mobile crisis units in Placer County.
- The MHP has a lower percentage of beneficiaries receiving 5 to 15 services than statewide. In the MHP 22.29 percent of beneficiaries received between 5 and 15 services as compared with 30.41 percent statewide.

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. Figures 16 and 17 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

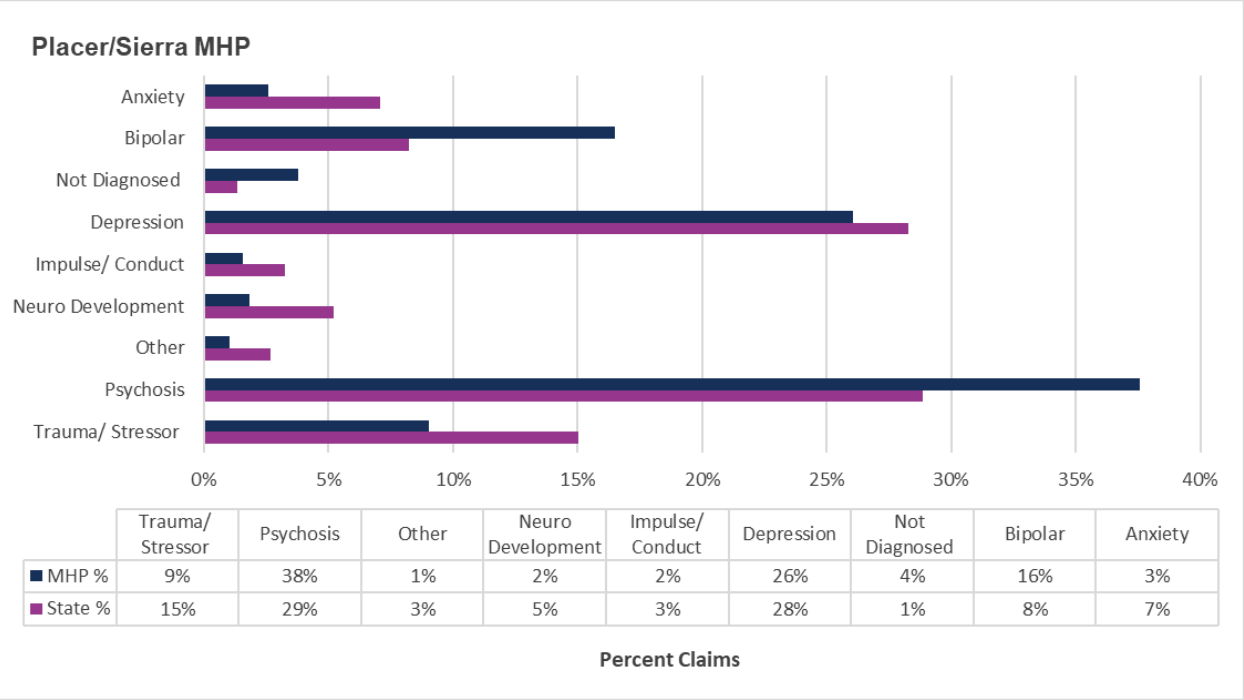


	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	10%	19%	2%	2%	2%	23%	23%	16%	3%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Percent Beneficiaries

- The MHP serves a higher proportion of beneficiaries with bipolar disorders (16 percent) than is seen statewide (8 percent).
- The proportion not diagnosed (23 percent) is well above the statewide proportion (6 percent). This could be related to the high percentage of beneficiaries in the MHP receiving Crisis Intervention services.
- The MHP serves a lower proportion of beneficiaries with depression (23 percent), trauma/stressors (10 percent) and anxiety (3 percent) compared to the state rates of 31 percent with depression, 16 percent with trauma/stressors, and 10 percent with anxiety.

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 %	9%	38%	1%	2%	2%	26%	4%	16%	3%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- Claims for psychosis (38 percent), depression (26 percent) and bipolar disorders (16 percent) represent 80 percent of the approved claims in the MHP.
- Congruent with diagnostic patterns in the MHP, the percentage of approved claims with a depression, trauma/stressor or anxiety diagnostic category is lower 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	457	951	11.06	8.86	$12,577	$12,052	$5,747,801
CY 2020	396	716	11.87	8.68	$9,646	$11,814	$3,819,657
CY 2019	403	644	10.61	7.80	$9,828	$10,535	$3,960,797

- The average LOS is consistently higher than the state average; however as seen below in Figure 19 7-day and 30-day readmission rates are lower than the state

average.

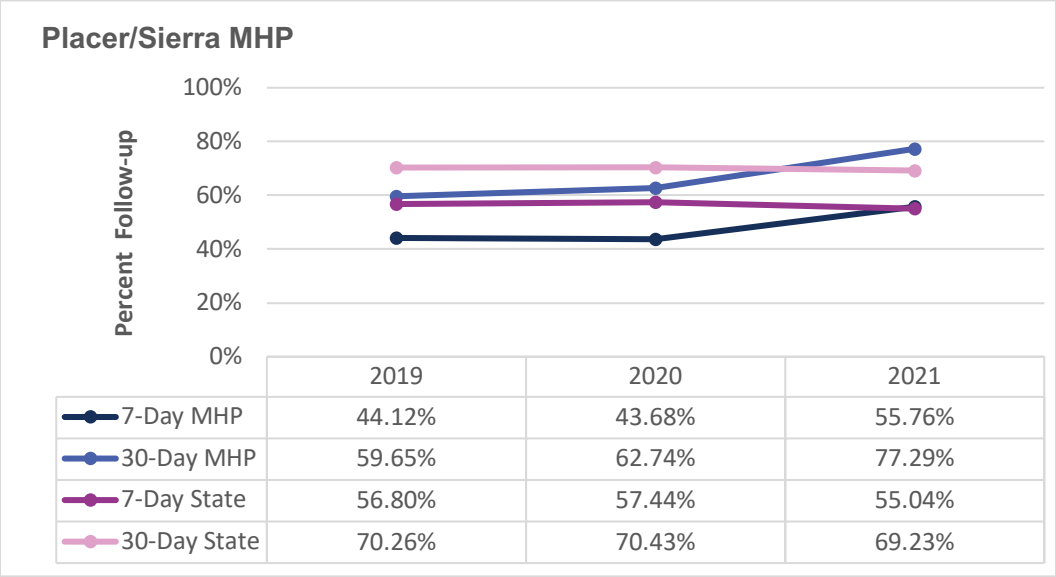
- The average number of admissions per beneficiary admitted to an inpatient bed has been going up between CY 2019 and CY 2021. This might be outside the 30-day window tracked in Figure 19.

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.

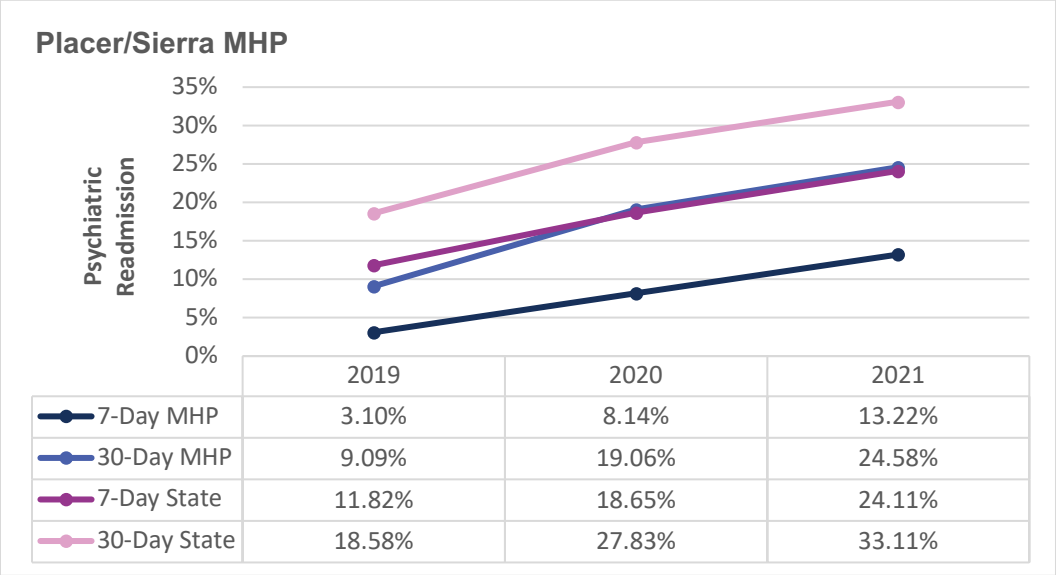
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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	44.12%	43.68%	55.76%
30-Day MHP	59.65%	62.74%	77.29%
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	3.10%	8.14%	13.22%
30-Day MHP	9.09%	19.06%	24.58%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- In CYs 2019 and 2020 the MHP's 7-day and 30-day post psychiatric inpatient follow-up rates were lower than statewide. However, both rates increased in CY 2021 resulting in rates higher than statewide.
- Placer County reported that for youth the hospitals have taken over the determination of who should be put on a 5150 involuntary hold and that has added some challenges to providing follow-up care post hospitalization.
- Although readmission rates are increasing in the MHP and statewide, the MHP's readmission rates remain lower than the state average. The MHP's 30-day readmission rate is very similar to the statewide 7-day readmission rate.

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 LOC 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	144	5.18%	39.23%	$7,539,441	$52,357	$43,947
	CY 2020	70	2.85%	28.21%	$3,759,388	$53,706	$41,798
	CY 2019	74	2.97%	25.74%	$3,602,691	$48,685	$41,292

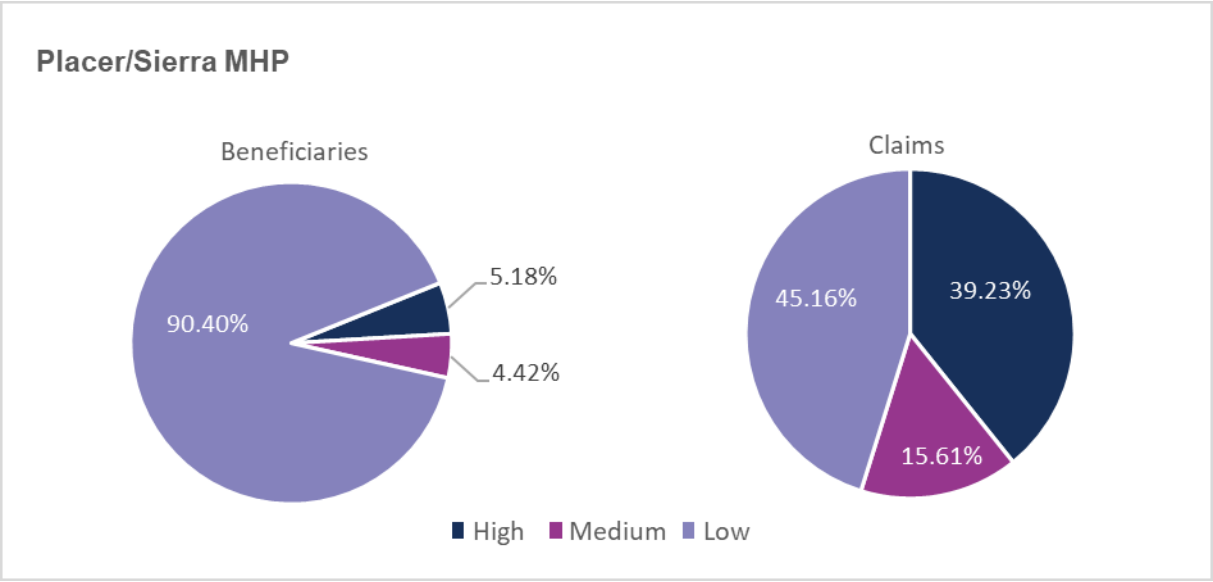
- The MHP's count of HCBs, percentage of beneficiaries in the HCB category, and percentage of claims to treat HCBs all went up between CY 2020 and CY 2021. The MHP would benefit from further analysis of the HCBs and why the numbers went up in CY 2021.

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)	123	4.42%	15.61%	$3,000,295	$24,393	$23,988
Low Cost (Less than $20K)	2,514	90.40%	45.16%	$8,678,822	$3,452	$1,757

- Over half (54.94 percent) of all approved claims are for serving the high and medium cost beneficiaries. Less than half of the claims, 45.16 percent, was for serving the low-cost beneficiaries, representing 90.40 percent of beneficiaries served.

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



- As noted above, over half of all approved claims are for serving the high and medium cost beneficiaries who represent 9.60 percent of beneficiaries served.

IMPACT OF QUALITY FINDINGS

- The MHP's improving post-hospitalization follow-up data indicates that they are paying close attention to hospitalizations and following up with beneficiaries post release. The MHP will need to continue to monitor, particularly in the children's system of care where 5150 assessments were recently transferred to hospital staff creating a possible barrier to knowing when a hospitalization occurs. However, the MHP should investigate why readmissions continued to go up even as follow-up care improved.
- Placer County integrates Behavioral Health, Child Welfare, Juvenile Probation, Foster Care, and other youth services into their Children's System of Care to more seamlessly serve their beneficiaries.

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: Wraparound Fidelity

Date Started: 02/2021

Date Completed: 01/2023

Aim Statement: "In order to improve the clinical functioning of children and youth diagnosed with an anxiety or depressive disorder, train and implement the Team Observation Measure (TOM) 2.0 and Wraparound Fidelity Index - Short Form (WFI-EZ) tools to ensure model fidelity to wraparound practices as demonstrated by increases of at least 5 percentage points in the average Integrated Practice Child and Adolescent Needs and Strengths (CANS-IP) "strengths built" and "Natural Supports" rates by January 31, 2023."

Target Population: The PIP focuses on all Placer CSOC wraparound children whose services closed in the specified timeframe, who had at least one matched-pair CANS-IP

[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

assessment within the wraparound timeframe, and who were diagnosed with an anxiety and/or depressive disorder.

Status of PIP: The MHP's clinical PIP status is other - completed.

Summary

Goal: The goal of the PIP is to improve average "strengths built" rates and "Natural Supports" rates in children diagnosed with anxiety and/or depressive disorders. The WFI-EZ and TOM 2.0 scores are designed to track the quality of wraparound meetings and their fidelity to the model in order to improve outcomes for these children, as measured by the CANS-IP matched pair assessments.

Intervention: Interventions include using the TOM 2.0 tool during wraparound child and family team (CFT) meetings and using the WFI-EZ to hone practitioners' wraparound practices to increase model fidelity. Additionally, a feedback loop provides an opportunity for practitioners and advocates to practice improved skills.

Performance measures include: Measurements include surveying practitioners, family advocates, and youth through the WrapStat system developed by the University of Washington to quantify movement toward fidelity and CANS-IP to quantify changes in strengths built, particularly for those clients diagnosed with an anxiety or depressive disorder.

Results: From FY 2020/21 to FY 2021/22: The average rate of all strengths built increased from 17 to 19 percent. The population with anxiety disorders exceeded the goal of increasing the rate of strengths built by 5 percent. The average rate of all "Natural Supports" built increased from 16 to 29 percent. The population with depressive disorders and with anxiety disorders both exceed the goal of increasing the rate of strength built by 5 percent.

TA and Recommendations

As submitted, this clinical PIP was found to have high confidence, because: The MHP presented a problem and some potential root causes. The team implemented interventions and applied it to its target population. The team analyzed data on a quarterly basis. Improvements appear to be the result of higher fidelity to the wraparound model. Future TOM 2.0 and WFI-EZ reports will provide ongoing feedback to clinicians.

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

- Discussions were held at the review PIP Session with recommendations the MHP continue ongoing feedback to clinicians to ensure continuation of positive results of the PIP.

- Engage with CalEQRO TA early and often in the development of the current year's PIP

NON-CLINICAL PIP

General Information

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

Date Started: 10/2021

Date Completed: 10/2023

Aim Statement: "For adults (18+) receiving outpatient mental health services at the Adult System of Care Dewitt and Cirby clinic locations, will being asked to identify sex, gender identity, sexual orientation, preferred name, and preferred pronouns by MHP staff appropriately equipped to ask and collect these questions increase the beneficiary experience as reported in client satisfaction surveys over a six-month period during 2022?" Note: The PIP is continued for one year until 10/2023.

Target Population: All ASOC

Status of PIP: The MHP's non-clinical PIP status is in the implementation phase, with baseline data completed.

Summary

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

Intervention: To ask adult beneficiaries receiving outpatient mental health services in two ASOC clinic locations to identify their sex, gender identity, sexual orientation, preferred name, and preferred pronouns and monitor changes in the beneficiary experience, as reported in client satisfaction surveys.

Performance measures include: Client satisfaction surveys to determine beneficiary satisfaction with their interaction with a sexual orientation and gender identity (SOGI) sensitive trained clinician.

Results: Pending results as the PIP is currently active.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: Credible, reliable methods were implied or able to be established for the PIP. Training of staff is in place, survey forms are now available, and interventions are underway.

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

- Discussions were held at the review PIP Session with recommendations the MHP continue interventions as planned.
- The MHP is encouraged to analyze data not less than quarterly.
- Engage in CalEQRO TA though the life of this PIP.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by Placer County is Netsmart myAvatar, which has been in use for 19 years. Currently, the county plans to implement the CalMHSA SmartCare by Streamline semi-statewide EHR in July 2023. Sierra County uses the Cerner Community Behavioral Health EHR, which has been in use for 8.5 years. Sierra County plans to implement the Credible Behavioral Health EHR in July 2023.

Approximately 6.8 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 282 named users with log-on authority to the EHRs, including approximately 263 county staff and 19 contractor staff. Support for the users is provided by 1.5 FTE IS technology positions. Currently all positions are filled.

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 HHS Fiscal	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to HHS Fiscal	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to HHS Fiscal	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into HHS Fiscal by provider staff	☐ Daily ☐ Weekly ☐ Monthly	0%
Documents/files e-mailed or faxed to HHS Fiscal	☐ Daily ☒ Weekly ☒ Monthly	100%
Paper documents delivered to HHS Fiscal	☐ 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. Both counties plan to implement a PHR within the next year as part of their EHR implementations.

Interoperability Support

Neither county is a member or participant in a HIE. Placer County plans to join the SacValley MedShare EHR and to exchange data through the SmartCare EHR. In both counties, healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: MH and Alcohol and Drug Contract 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	Met
4B	Integrity of Data Collection and Processing	Partially Met
4C	Integrity of Medi-Cal Claims Process	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Partially Met
4F	Interoperability	Not Met

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

- Placer County has a regular meeting with all HHS leadership that focuses on IT and authorizes and prioritizes projects that IT will work on.
- The MHP leverages multiple funding streams and in the past did not always bill all Medi-Cal billable services to Medi-Cal. Recently they began focusing on billing to Medi-Cal whenever appropriate.
- Placer County reported that the research and analysis to correct Medi-Cal billing has increased communications between Fiscal, QA, IT and programs in a collaborative procedure to increase Medi-Cal billing and decrease denied claims. They increased staff and changed the way fiscal was organized to decrease Medi-Cal claim denials and are seeing noticeable improvements in the denial rate. While the MHP's overall denial rate is higher than the state average, they brought the 21.20 percent denial rate in 2020 down to 4.68 percent in 2021.
- The MHP does not submit claims to Medicare or Other Health Care for their beneficiaries who have other insurance.
- Placer County expects data collection and interoperability to improve this current year when some contract providers will begin utilizing the county's new EHR system and the EHR is expected to provide data exchange with the local HIE. The county will also need to analyze data warehousing opportunities to maintain access to historical beneficiary data that will not be converted to the new EHR.
- Placer County does exchange data with the three MCPs in the county.
- 4E -There are minor areas for improvement for security and controls, such as requiring that passwords contain a combination of alphanumeric and special characters.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	11,048	$2,573,204	$35,039	1.36%	$1,234,931
Feb	6,298	$1,577,074	$35,115	2.23%	$1,249,498
Mar	7,613	$1,836,453	$35,205	1.92%	$1,477,408
April	7,270	$1,857,994	$76,797	4.13%	$1,478,177
May	6,788	$1,747,129	$12,469	0.71%	$1,524,504
June	7,011	$1,759,384	$11,301	0.64%	$1,551,623
July	6,379	$1,667,150	$47,187	2.83%	$1,398,933
Aug	6,896	$1,771,864	$55,679	3.14%	$1,472,766
Sept	6,567	$1,759,262	$56,895	3.23%	$1,457,616
Oct	6,337	$1,755,966	$70,349	4.01%	$1,607,642
Nov	6,014	$1,661,411	$192,697	11.60%	$1,462,228
Dec	6,135	$1,809,336	$321,797	17.79%	$1,483,403
Total	**84,356**	**$21,776,227**	**$950,530**	**4.36%**	**$17,398,729**

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	897	$442,310	46.53%
Service line is a duplicate and a repeat service procedure code modifier not present	709	$190,491	20.04%
Other	427	$96,828	10.19%
Late claim	143	$88,120	9.27%
Medicare Part B must be billed before submission of claim	321	$82,617	8.69%
Beneficiary not eligible or non-covered charges	108	$38,963	4.10%
Service location NPI issue	23	$7,196	0.76%
Deactivated NPI	6	$4,004	0.42%
Total Denied Claims	2,634	$950,529	100.00%
Overall Denied Claims Rate	**4.36%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- While denials greatly improved in 2021, the MHP's denial rate is still over three times the state average. Billing other healthcare and Medicare would greatly improve their claims denial rate.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- In order to maximize federal and state funding, the MHP should continue to focus on reducing the Medi-Cal claims denial rate.
- The MHP does not currently offer complete access to the EHR for contract providers which can result in duplication of data entry and incomplete clinical information. However, the Placer County SmartCare EHR will enhance the interoperability of the EHR with other providers.

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 conducts the CPS per DHCS requirements, although this year's survey had not been returned to the MHP. The QAPI includes a goal to review and utilize the CPS for program quality improvement.

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 two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

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

The number of participants is less than 3; therefore, feedback received during the session is incorporated into other sections of this report to ensure anonymity of the participant.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of parents/care takers of youth who initiated services in the preceding 12 months. The focus group was held virtually and included two participants. Both participants have a family member who receives clinical services from the MHP.

The number of participants is less than 3; therefore, feedback received during the session is incorporated into other sections of this report to ensure anonymity of the participant.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Due to the number of each session being less than three, findings of the sessions will be included into other sections of the report.

It is of note the effort the MHP put into soliciting participants for these two groups as follows:

- A report was run to determine who fit the specifications of the focus groups.
- A list was emailed to each case manager within ASOC and CSOC, including CBOs.
- The invitation flyer was provided to each case manager who had beneficiaries who were interested in the groups.
- Reminder were sent one week prior to the group meetings.
- Second reminder sent two days prior to the group meetings.
- Third reminder sent the evening before the group meetings.

There were at least seven confirmed participants who confirmed that they would attend.

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. Placer County continues to strengthen their continuum of care, having opened a Behavioral Health Crisis Center (a voluntary urgent care center for residents experiencing a mental Health crisis), and expanded mobile crisis services this past year. They are also working with neighboring counties to develop regional youth crisis continuum services. (Access, Quality)
2. Placer County has a robust system of youth wellness centers located in schools across the county. (Access, Quality)
3. Placer County has an effective process to transfer beneficiaries between the MHP and the MCP. (Access, Quality, IS)
4. The MHP's 7-day and 30-day post psychiatric inpatient follow-up rates increased in 2021. (Quality)
5. Sierra County began billing Medi-Cal this past year. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Following the pandemic closure of the two Placer County adult wellness centers, only the center in Roseville reopened. This leaves part of the county region without a wellness center. (Quality)
2. While Placer County requires individual reports from contract providers that are reviewed in quarterly QIC meetings, the county does not aggregate the data to provide an overall perspective on the county's beneficiary timeliness and outcomes. (Timeliness, Quality, IS)
3. The MHP does not have an efficient method to share clinical data with contract providers, hospital, or primary care providers either through the EHR or an HIE. (IS)
4. The MHP limits their receipt of federal and state funds by not billing Medicare and Other Health Care for beneficiaries with these coverages. (IS)
5. The MHP lacks an outcome tool for universal ASOC use. (Quality)

RECOMMENDATIONS

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

1. To serve beneficiaries in each of the primary geographic service areas of the county, identify a location and make plans to open a wellness center in the Auburn area. (Quality)
2. Create reports that aggregate, track, and trend contractor data to accurately represent beneficiary timeliness and outcomes throughout the SOC. (Timeliness, Quality, IS)
3. Expand interoperability functionality by allowing contract providers to use the EHR and beginning the process to exchange data through an HIE. (IS)
4. Explore and implement methods to bill Medicare and Other Health Care for beneficiaries with these coverages. (IS)
5. Research, choose, and implement an ASOC outcome tool for regular use. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT F: PM Data CY 2021 Refresh

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Placer Sierra MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
ISCA
PIP Validation and Analysis
Performance Measure Validation and Analysis
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Beneficiary Satisfaction and Other Surveys
Fiscal/Billing
Clinical Line Staff Group Interview
Specialized Service Systems: <e.g., Homeless Outreach; STRTP; Crisis Residential, Crisis Stabilization; Forensics>
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
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Information Systems Billing and Fiscal Interview
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, Lead Quality Reviewer
Zena Jacobi, Information Systems Reviewer
David Czarnecki, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Abrahamson	Twylla	Deputy Directory of HHS, Director of CSOC/Compliance Officer	Placer County
Arevalo	Sandra	Peer	Placer County/AMIH
Budge	Curtis	Program Manager, ASOC	Placer County
Bullis	Heather	Program Manager	Nevada County
Cadore	Aaron	Program Manager, ASOC	Placer County
Compton	Sue	Staff Services Manager	Placer County
Cook	Jennifer	Assistant Director, CSOC	Placer County
Couture	Kelly	Program Supervisor, QM	Placer County
Dickman	Adrienne	Staff Services Analyst, CSOC	Placer County
Dunajski	Nary	Youth Advocate	Whole Person Learning, (YES Program)
E.	Jessy	Consumer (ASOC)	Placer County
Ellis	Amy	Deputy Directory of HHS, Director of ASOC/MHP	Placer County
Evans	Lauren	Client Services Practitioner – II, ASOC	Placer County
Ezeani	Ifeanyi	Chief Executive Officer	Compassion Pathway Behavioral Health LLC
Franceschini	Jamie	Contract Analyst/QM	Sierra County
Genschmer	Scott	Program Manager, ASOC	Placer County
Griffiths	Kevin	Information Technology Analyst, Senior	Placer County
Hanni	Lorna	Program Supervisor, ASOC	Placer County

Last Name	First Name	Position	County or Contracted Agency
Haynes	Amy	Assistant Director, ASOC	Placer County
Hill	Kathryn	Clinical Director	Sierra County
Holley	Derek	Program Supervisor, QM	Placer County
Hollway (Keim)	Courtney	Client Services Practitioner – II, CSOC	Placer County
Jones	Megan	Program Supervisor, CSOC	Placer County
Kauppila	Dre	Staff Services Analyst, CSOC	Placer County
Leighton	Melissa	Staff Services Analyst, Fiscal	Placer County
Ludford	Jennifer	Staff Services Analyst, QM	Placer County
Luna-Miranda	Jessica	Youth Advocate	Whole Person Learning, (YES Program)
McDonald	Gary	Executive Director	Lighthouse Counseling and Family Resource Center
Medina	Leslie	Program Manager, CSOC	Placer County
Medlin	Denise	Administrative Services Manager	Placer County
Moore	Kristen	Client Services Practitioner – II, ASOC	Placer County
M.	Blanca	Consumer (Caregiver), CSOC	Placer County
Mulcahy	Teresa	Information Technology Supervisor	Placer County
Nordness	Andrea	Administrative Clerk - Senior	Placer County
Okolo	Safaratu	Director of Programs and Compliance	Compassion Pathway Behavioral Health LLC
O'Sullivan	Gavin	Program Supervisor, CSOC	Placer County

Last Name	First Name	Position	County or Contracted Agency
Plum	Lanette	Client Services Practitioner – II, CSOC	Placer County
Robben	Rosemary	Peer	Placer County/AMIH
Roth	Leslie	Program Manager, CSOC	Placer County
Salas	Lea	Program Director	Sierra County
Scott	Andrew	Client Services Practitioner – II, CSOC	Placer County
Shriver	Amy	Client Services Counselor – I, ASOC	Placer County
Siles	Kristin	Program Supervisor, CSOC	Placer County
Sheppard	Mary	Regional Executive Director, Capital Region	Pacific Clinics
Smith	Geoff	Program Manager, ASOC	Placer County
Soto	Julia	Program Manager, QM	Placer County
Vallin	Jennifer	Regional Director – Coloma Center	Turning Point Community Programs
V	E	Consumer (minor), CSOC	Placer County
Wellenstein	Jennifer	Deputy Chief Operations Officer Executive	Turning Point Community Programs
Wieland	Denise	Peer	Placer County/AMIH

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP presented a problem and some potential root causes. The team implemented an intervention and applied it to its target population.

General PIP Information
MHP/DMC-ODS Name: Placer/Sierra
PIP Title: Wraparound Fidelity
PIP Aim Statement: : "In order to improve the clinical functioning of children and youth diagnosed with an anxiety or depressive disorder, train and implement the Team Observation Measure (TOM) 2.0 and Wraparound Fidelity Index - Short Form (WFI-EZ) tools to ensure model fidelity to wraparound practices as demonstrated by increases of at least 5 percentage points in the average Integrated Practice Child and Adolescent Needs and Strengths (CANS-IP) "strengths built" and "Natural Supports" rates by January 31, 2023."
Date Started: 02/2021
Date Completed: 01/2023
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:

General PIP Information
Target population description, such as specific diagnosis (please specify): The PIP focuses on all Placer CSOC wraparound children whose services closed in the specified timeframe, who had at least one matched-pair CANS-IP assessment within the wraparound timeframe, and who were diagnosed with an anxiety and/or depressive disorder.
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): By providing Wraparound to fidelity, beneficiaries improve CANS scores in two or more diagnosis groups
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Wraparound practitioners and family advocates will be surveyed on the WFI-EZ to be evaluated on the TOM 2.0 to ensure Wraparound fidelity within the Child Family Team meetings.
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): Certified practitioners complete the CANS assessment on youth beneficiaries.

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
All matched pairs: Increase the rate of positive changes in the strengths domain by at least 5%	FY 20/21	n=43 pre to post intervention rate of Strengths build: 17%	FY 21/22	n=45 pre-to-post intervention rate of Strengths built: 19%	☒ 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
Children with depressive disorders: Increase the rate of positive changes in the strengths domain by at least 5%	FY 2020-21	n = 24 pre-to-post intervention rate of Strengths built: **19%**	FY 21/22	n = 30 pre-to-post intervention rate of Strengths built: **23%**	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0702
Children with anxiety disorders: Increase the rate of positive changes in the strengths domain by at least 5%	FY 2020-21	n =20 pre-to-post intervention rate of Strengths built: **18%**	FY 21.22	n =14 pre-to-post intervention rate of Strengths built: **25%**	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0702
All matched pairs: Increase the rate of positive changes in Natural Supports by at least 5%	FY 2020-21	n = 43 pre-to-post intervention rate of Natural Supports built: **16%**	FY 21/22	n = 45 pre-to-post intervention rate of Natural Supports built: **29%**	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0702
Children with depressive disorders: Increase the rate of positive changes in Natural Supports by at least 5%	FY 2020-21	pre-to-post intervention rate of Natural Supports built: **13%**	FY 21/22	n= 30 pre-to-post intervention rate of Natural Supports built: **37%**	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0702
Children with anxiety disorders: Increase the rate of positive changes in Natural Supports by at least 5%	FY 2020-21	n = 20 pre-to-post intervention rate of Natural Supports built: **10%**	FY 21/22	n = 14 pre-to-post intervention rate of Natural Supports built: **50%**	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.0702

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): Completed 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: • Discussions were held at the review PIP Session with recommendations the MHP continue ongoing feedback to clinicians to ensure continuation of positive results of the PIP. • Engage with CalEQR early and often in the development of the current year's PIP

Non-Clinical PIP

Table C1: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	Credible, reliable methods were implied or able to be established for the PIP. Training of staff is in place, survey forms are now available, and interventions are underway.

General PIP Information
MHP/DMC-ODS Name: Placer/Sierra
PIP Title: SOGI and the beneficiary experience in ASOC MH Clinics
PIP Aim Statement:
Date Started: 10/2021
Date Completed: 10/2023
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Adult beneficiaries ages 18+ receiving outpatient mental health services from our Adult System of Care mental health clinic locations at our Cirby (Roseville) and Dewitt (Auburn) campuses.
Improvement Strategies or Interventions (Changes in the PIP)

General PIP Information
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): The client will provide when asked their sex, gender identity, sexual orientation, preferred name, and proffered pronouns, and report any changes in their experience in a client satisfaction survey due to this change.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Providers ask beneficiaries to identify their sex, gender identity, sexual orientation, preferred name, and proffered pronouns, and monitor changes in beneficiary experience as report in client satisfaction surveys..
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The intervention will utilized by trained clinicians and monitored, tracked and report by the SOC.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. 1a. Number of adults accessing outpatient mental health services at clinic locations and corresponding SOGI field data recorded in Avatar; 1b. client satisfaction surveys response rate; percent indicating they had a positive experience; percent indicating they were treated with respect;. 1c. Number of clients indicating they were asked SOGI questions by MHP staff	510/1/22-10/31/22	1a. F M Total Bisexual 3 2 5 Heterosexual / Straight 31 42 73 Lesbian (female) 1 1 Transgender 2 2 4 Declined 4 4 8 No Entry 590 567 1157 Total 631 617 1248 1b. 13% 85% 83% 1c. 0%	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 2. Self-report on staff progress surveys during implementation period: % reporting increased ability/confidence in asking SOGI questions.	12/01/22-1/31/23	*1a. number TBT* *70%*	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☒ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

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:

- Discussions were held at the review PIP Session with recommendations the MHP continue interventions as planned.
- The MHP is encouraged to analyze data not less than quarterly.

PIP Validation Information
• Engage in TA though the life of this PIP.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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

ATTACHMENT F: PM DATA CY 2021 REFRESH

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

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

BHC | Behavioral Health Concepts, Inc

Placer/Sierra MHP Performance Measures

REFRESHED

FY22-23

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims, CY2019-21

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	70,472	2,781	3.95%	$19,218,558	$6,911
CY 2020	63,376	2,456	3.88%	$13,328,021	$5,427
CY 2019	60,543	2,488	4.11%	$13,998,971	$5,627

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	7,359	44	0.60%	1.08%	1.96%
Ages 6-17	16,586	575	3.47%	4.41%	5.93%
Ages 18-20	3,502	123	3.51%	3.73%	4.41%
Ages 21-64	36,354	1,887	5.19%	4.11%	4.56%
Ages 65+	6,673	152	2.28%	2.26%	1.95%
Total	70,472	2,781	3.95%	3.67%	4.34%

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	94	3.38%
Threshold language source: Open Data per BHIN 20-070		

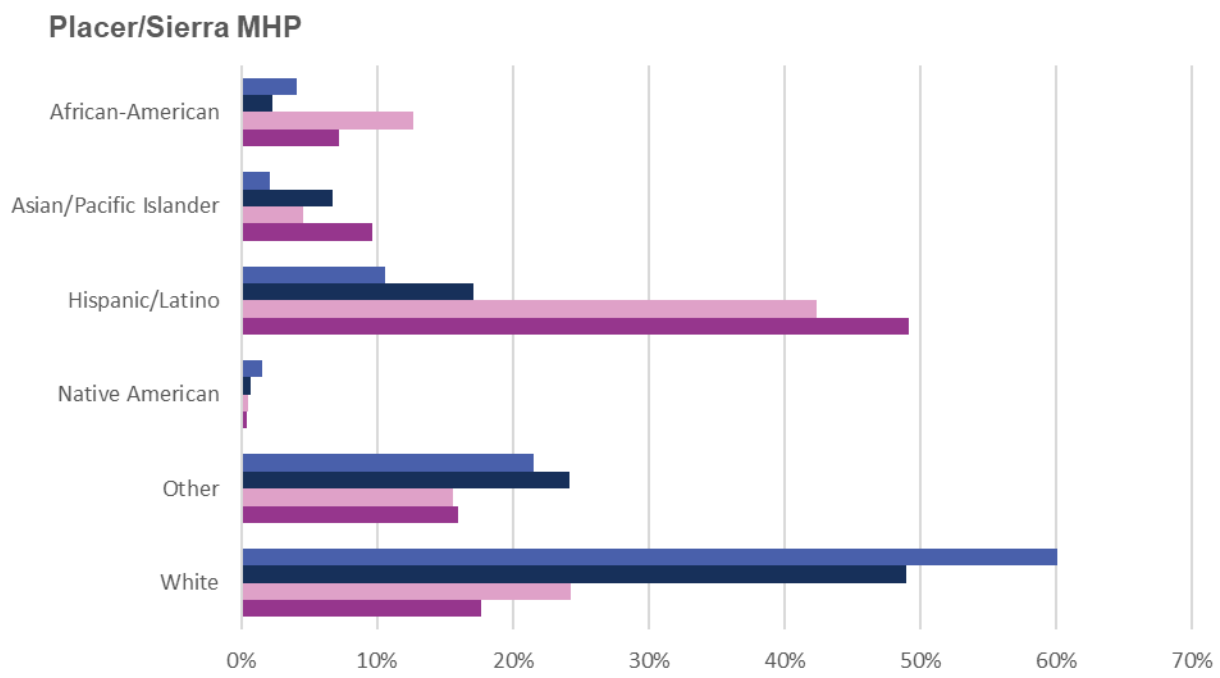
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	21,759	899	4.13%	$5,296,009	$5,891
Medium	613,796	20,261	3.30%	$151,430,714	$7,474
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	1,630	114	6.99%	7.64%
Asian/Pacific Islander	4,712	60	1.27%	2.08%
Hispanic/Latino	12,081	296	2.45%	3.74%
Native American	517	42	8.12%	6.33%
Other	17,048	598	3.51%	4.25%
White	34,487	1,671	4.85%	5.96%
Total	**70,475**	**2,781**	**3.95%**	**4.34%**

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



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	60%	22%	2%	11%	2%	4%
MHP % Eligible	49%	24%	1%	17%	7%	2%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

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

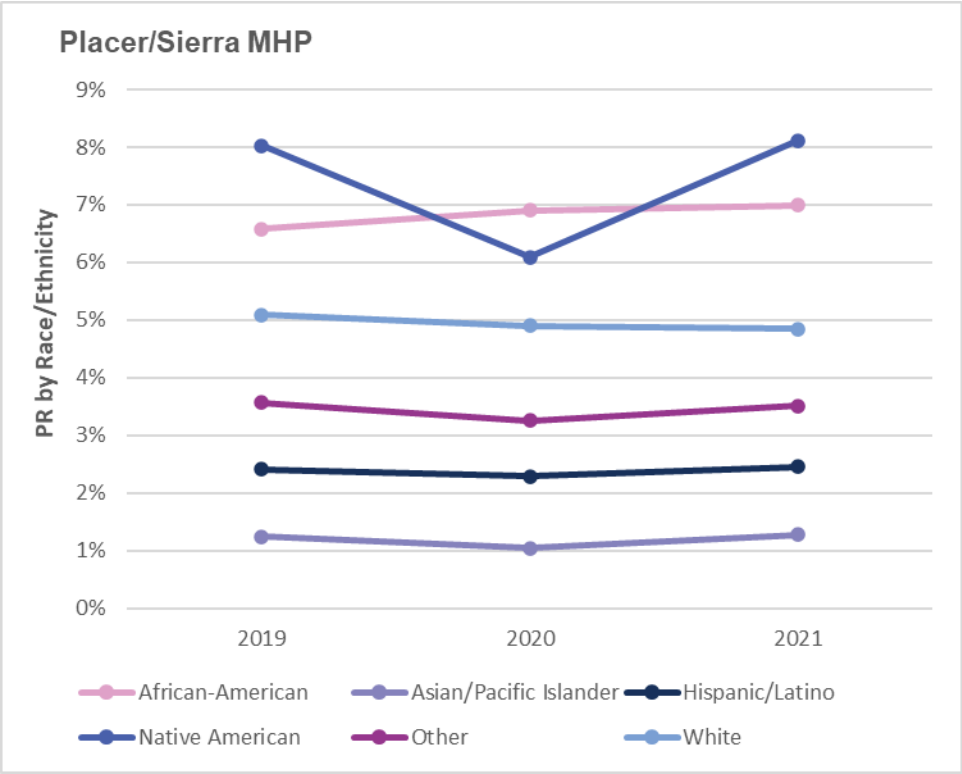


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

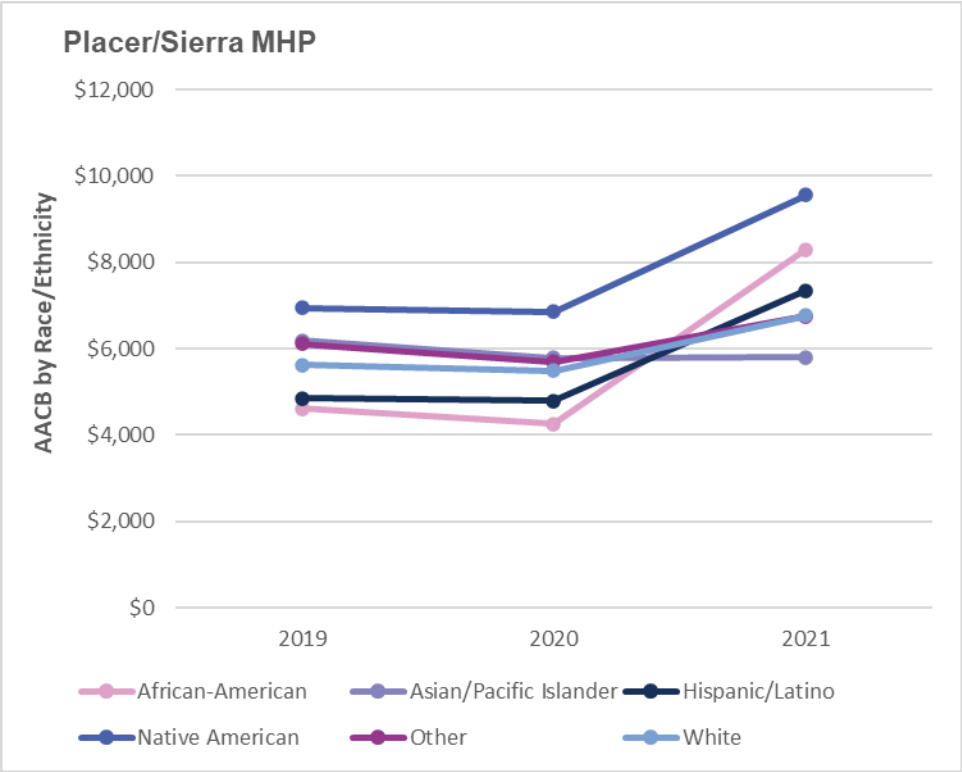
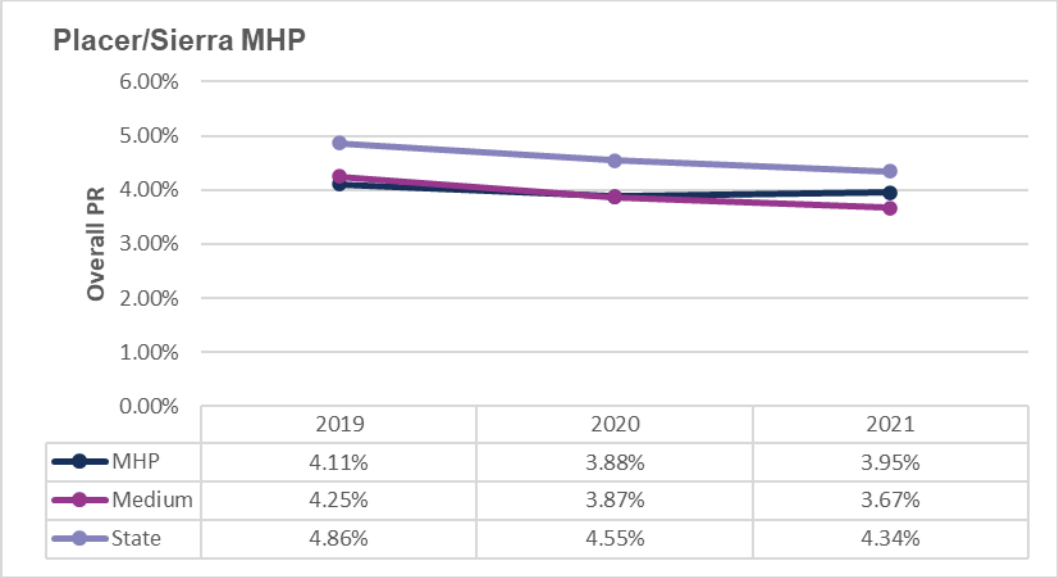
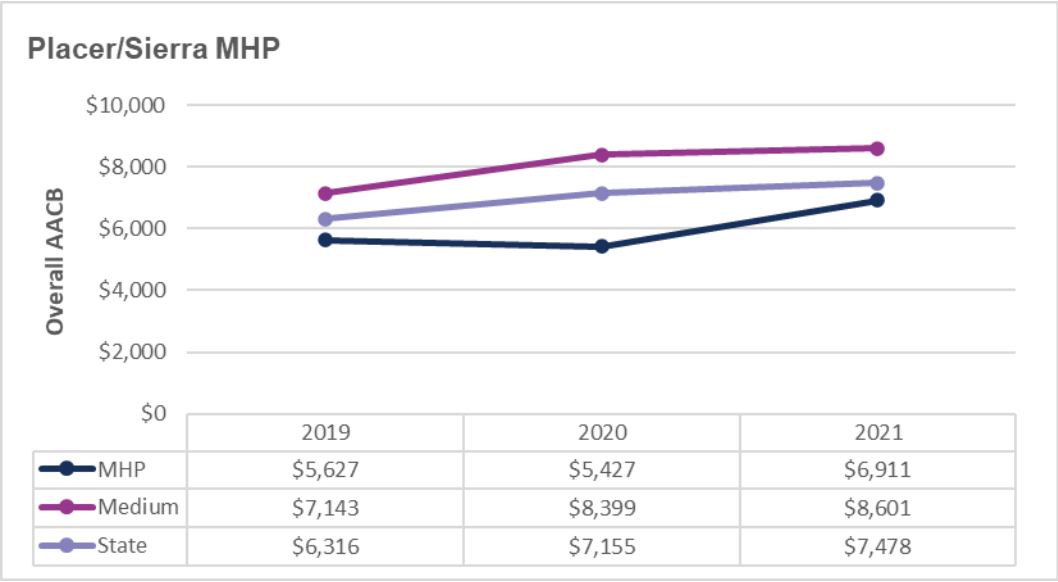


Figure 4: Overall PR CY 2019-21



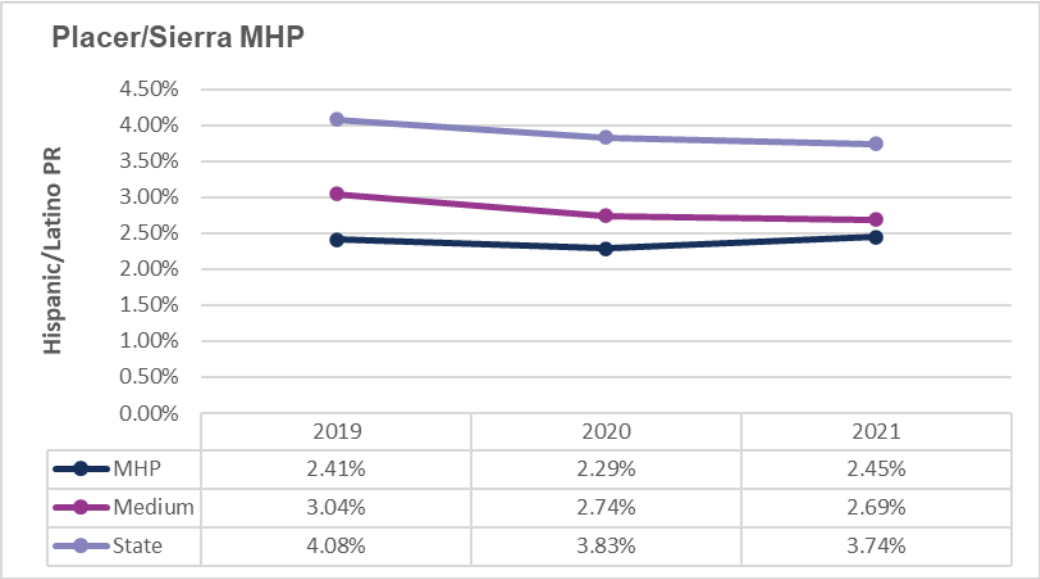
	2019	2020	2021
MHP	4.11%	3.88%	3.95%
Medium	4.25%	3.87%	3.67%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



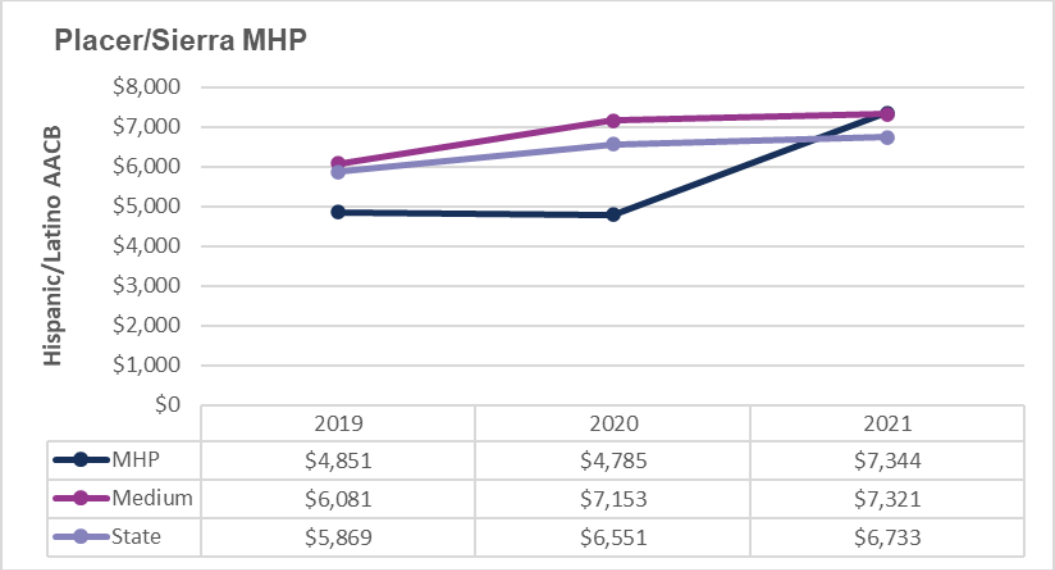
	2019	2020	2021
MHP	$5,627	$5,427	$6,911
Medium	$7,143	$8,399	$8,601
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	2.41%	2.29%	2.45%
Medium	3.04%	2.74%	2.69%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,851	$4,785	$7,344
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

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

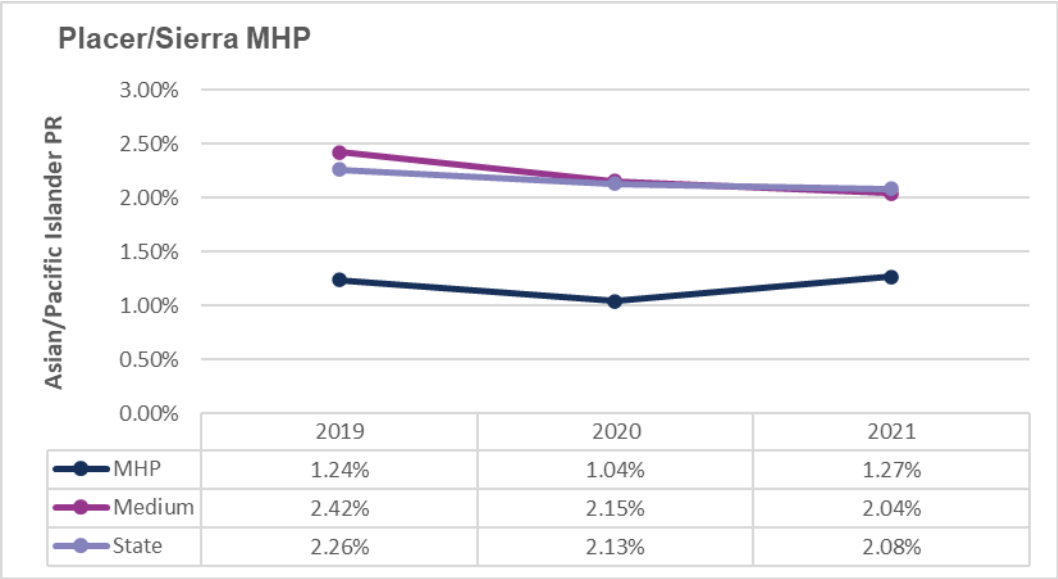


Figure 9: Asian/Pacific Islander AACB CY 2019-2021

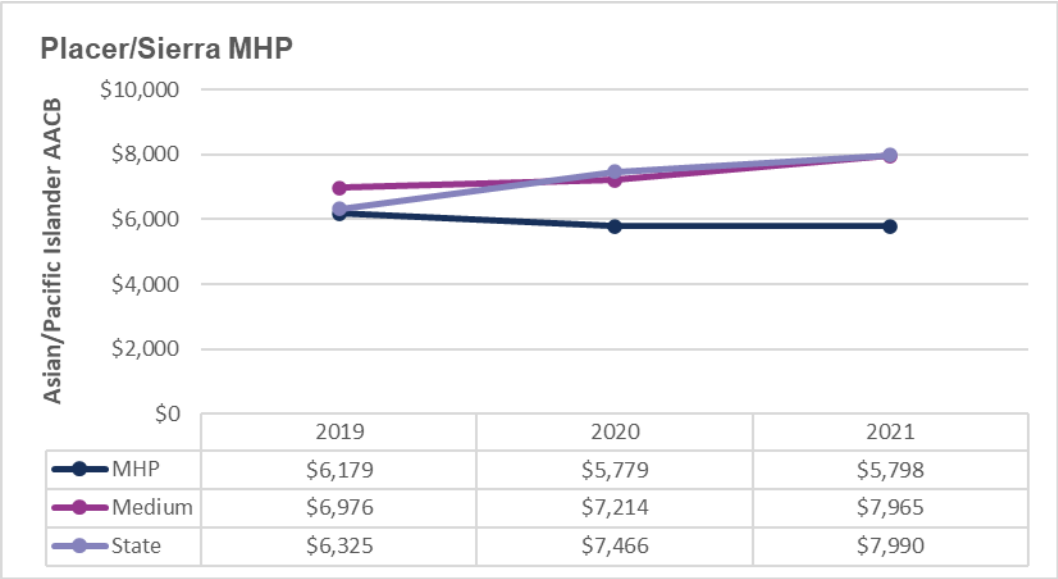
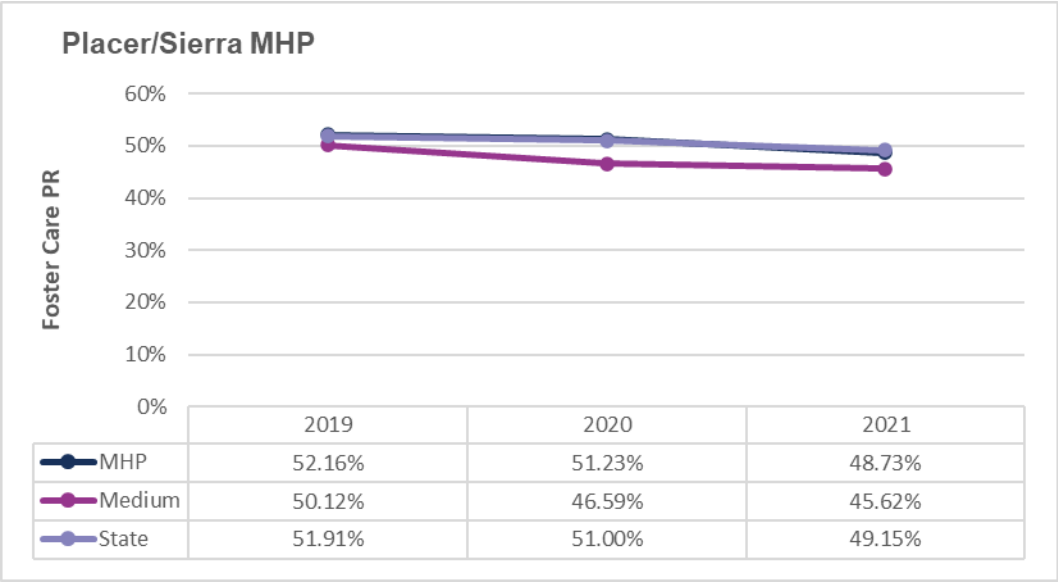
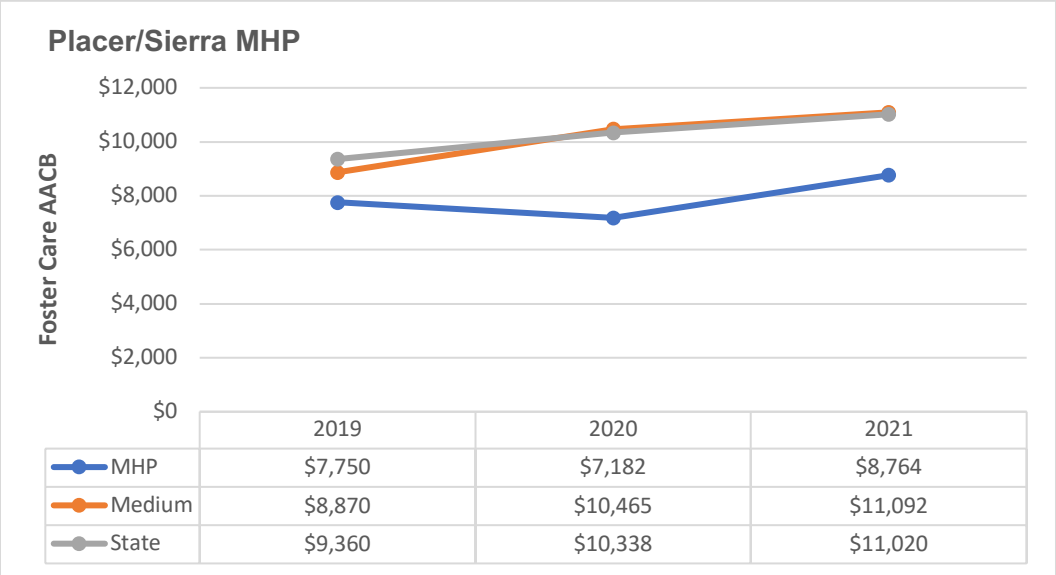


Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	52.16%	51.23%	48.73%
Medium	50.12%	46.59%	45.62%
State	51.91%	51.00%	49.15%

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$7,750	$7,182	$8,764
Medium	$8,870	$10,465	$11,092
State	$9,360	$10,338	$11,020

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 2,163				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	34	1.6%	10	6	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	292	13.5%	20	9	1.3%	15	7
Residential	<11	-	154	45	0.4%	107	79
Crisis Residential	139	6.4%	16	12	2.2%	21	14
Per Minute Services							
Crisis Stabilization	63	2.9%	1,245	1,200	13.0%	1,546	1,200
Crisis Intervention	689	31.9%	282	185	12.8%	248	150
Medication Support	1,346	62.2%	526	325	60.1%	311	204
Mental Health Services	1,198	55.4%	959	230	65.1%	868	353
Targeted Case Management	1,438	66.5%	412	104	36.5%	434	137

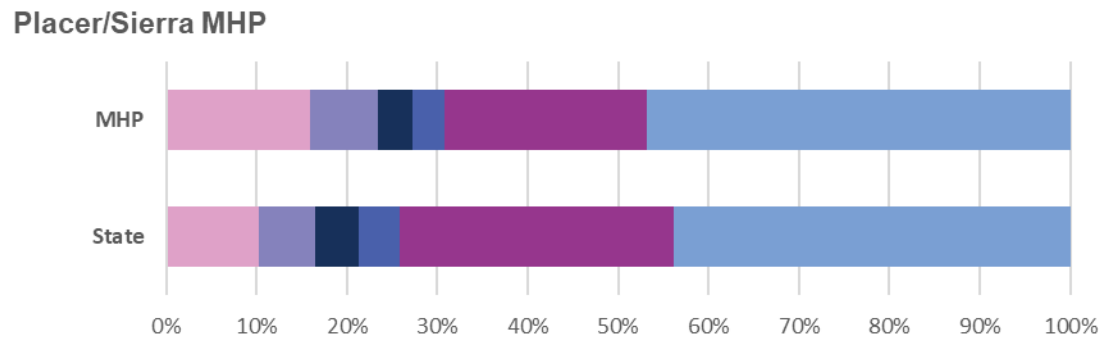
Table 9: Services Delivered by the MHP to Youth in Foster Care

Service Category	MHP N = 134				Statewide N = 37,489		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	9	6.7%	14	10	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	0	0.0%	0	0	0.5%	97	78

Table 9: Services Delivered by the MHP to Youth in Foster Care *(continued)*

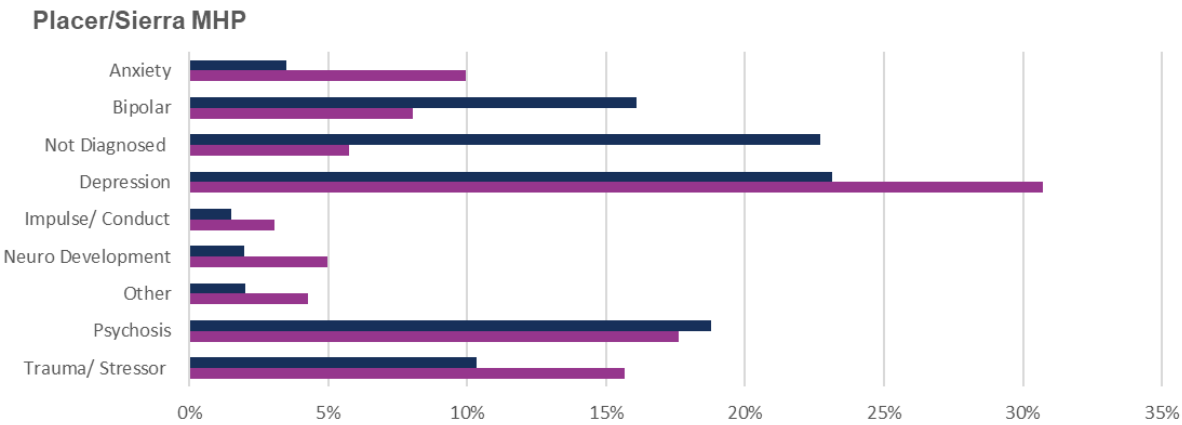
Per Minute Services							
Crisis Stabilization	<11	-	2,960	2,100	3.1%	1,398	1,200
Crisis Intervention	21	15.7%	249	169	7.5%	404	198
Medication Support	67	50.0%	1,301	455	28.3%	394	271
Therapeutic Behavioral Services	<11	-	16,115	1,725	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Home Based Services	52	38.8%	1,237	434	40.0%	1,351	472
Intensive Care Coordination	32	23.9%	4,216	503	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	120	89.6%	5,148	2,204	96.3%	1,848	1,103
Targeted Case Management	86	64.2%	569	266	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	15.86%
2 service	6.20%	7.62%
3 service	4.88%	3.81%
4 service	4.47%	3.56%
5-15 Services	30.41%	22.29%
>15 Services	43.79%	46.85%

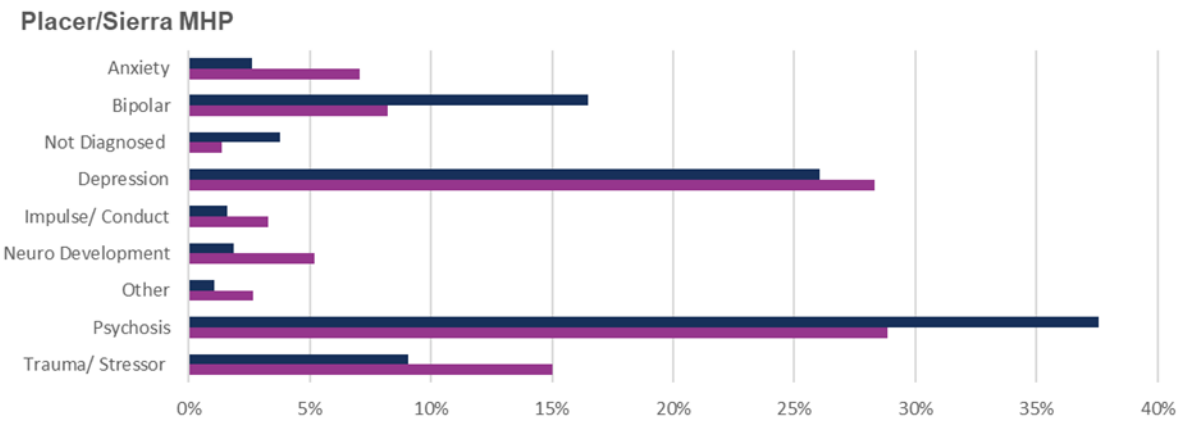
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	10%	19%	2%	2%	2%	23%	23%	16%	3%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Percent Beneficiaries

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	9%	38%	1%	2%	2%	26%	4%	16%	3%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Percent Claims

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	457	951	11.06	8.86	$12,577	$12,052	$5,747,801
CY 2020	396	716	11.87	8.68	$9,646	$11,814	$3,819,657
CY 2019	403	644	10.61	7.80	$9,828	$10,535	$3,960,797

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

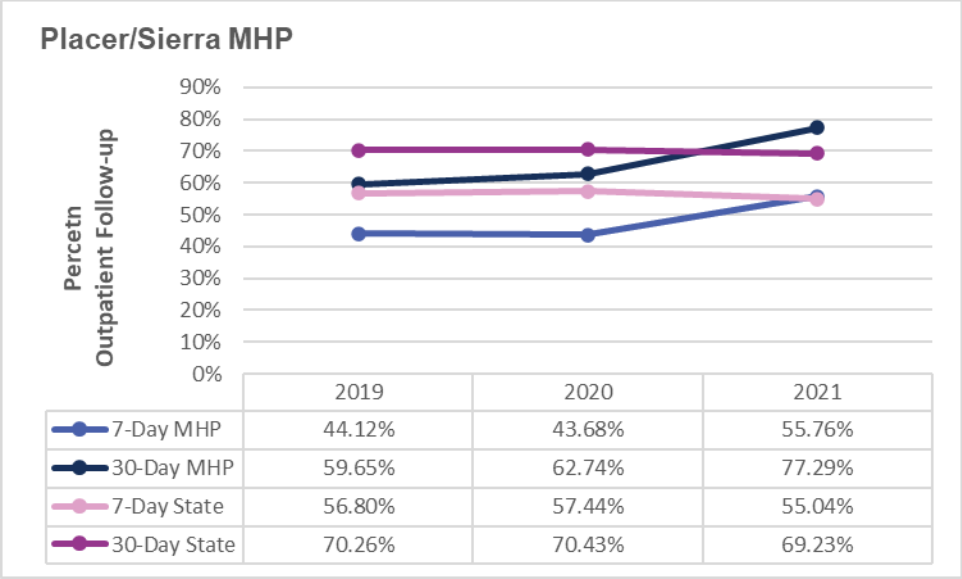


Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21

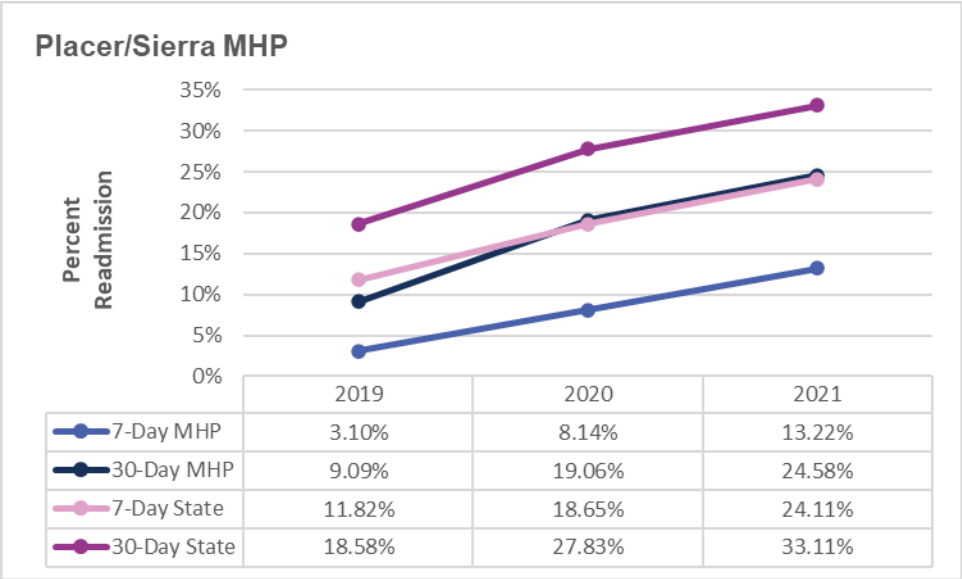


Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	144	5.18%	39.23%	$7,539,441	$52,357	$43,947
	CY 2020	70	2.85%	28.21%	$3,759,388	$53,706	$41,798
	CY 2019	74	2.97%	25.74%	$3,602,691	$48,685	$41,292

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)	123	4.42%	15.61%	$3,000,295	$24,393	$23,988
Low Cost (Less than $20K)	2,514	90.40%	45.16%	$8,678,822	$3,452	$1,757

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

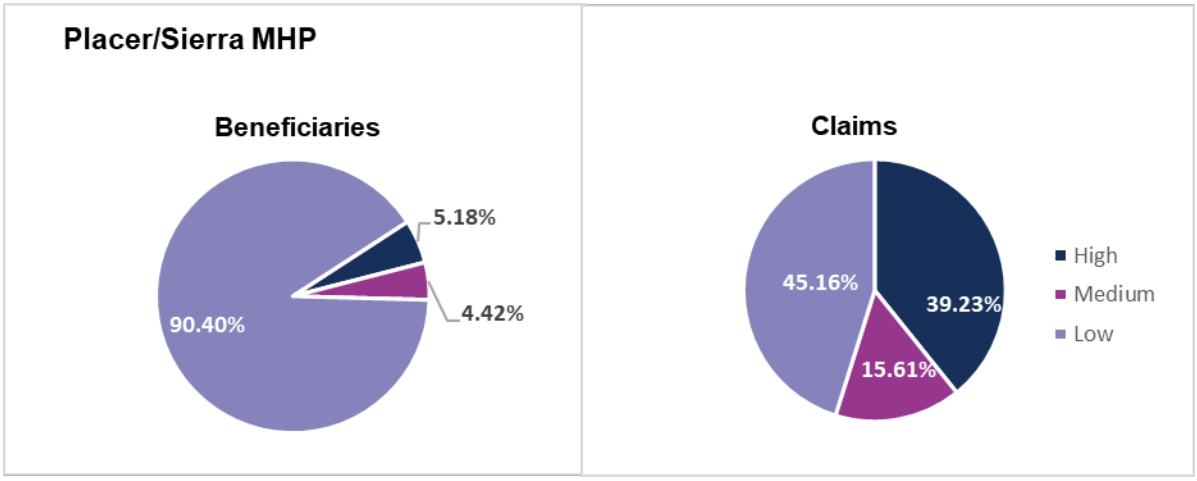


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	11,048	$2,573,204	$35,039	1.36%	$1,234,931
Feb	6,298	$1,577,074	$35,115	2.23%	$1,249,498
Mar	7,613	$1,836,453	$35,205	1.92%	$1,477,408
April	7,270	$1,857,994	$76,797	4.13%	$1,478,177
May	6,788	$1,747,129	$12,469	0.71%	$1,524,504
June	7,011	$1,759,384	$11,301	0.64%	$1,551,623
July	6,379	$1,667,150	$47,187	2.83%	$1,398,933
Aug	6,896	$1,771,864	$55,679	3.14%	$1,472,766
Sept	6,567	$1,759,262	$56,895	3.23%	$1,457,616
Oct	6,337	$1,755,966	$70,349	4.01%	$1,607,642
Nov	6,014	$1,661,411	$192,697	11.60%	$1,462,228
Dec	6,135	$1,809,336	$321,797	17.79%	$1,483,403
Total	84,356	$21,776,227	$950,530	4.36%	$17,398,729

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	897	$442,310	46.53%
Service line is a duplicate and a repeat service procedure code modifier not present	709	$190,491	20.04%
Other	427	$96,828	10.19%
Late claim	143	$88,120	9.27%
Medicare Part B must be billed before submission of claim	321	$82,617	8.69%
Beneficiary not eligible or non-covered charges	108	$38,963	4.10%
Service location NPI issue	23	$7,196	0.76%
Deactivated NPI	6	$4,004	0.42%
Total Denied Claims	**2,634**	**$950,529**	**100.00%**
Overall Denied Claims Rate	**4.36%**		
Statewide Overall Denied Claims Rate	**1.43%**		