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FY 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review

PLUMAS FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

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

MHP INFORMATION

Review Type — Virtual

Date of Review — March 15, 2023

MHP Size — Small-Rural

MHP Region — Superior

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
4	1	1	2

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	3	3	0
Quality of Care	10	1	5	4
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**12**	**10**	**4**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
None Submitted	Clinical	N/A	N/A	N/A
Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	Non-Clinical	N/A	Planning Phase	Low

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
* If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has a strong access system that ensures timely initial appointments and contributes to a penetration rate (PR) greater than the state or Small-Rural MHP average.
- Last year, the MHP utilized a No Place Like Home supportive housing funding to establish a 32-unit housing unit that will open once its plumbing issues are resolved. The MHP collaborates closely with the county housing agency for housing needs of its beneficiaries.
- The MHP has a good partnership with the Drug Court with regular attendance by a clinician and a case manager.
- The MHP also has a strong partnership with jail-based health system and provides mental health services including medication support in the jail.
- The MHP has started producing useful data dashboards that are easily accessible to supervisors and line staff.

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

- The MHP was only able to submit the FY 2021-22 QI plan. The staffing shortage and implementing CalAIM requirements have consumed the only QI staff's time during the past year. There has not been any QIC meetings since April 2022.

- The MHP acknowledged making minimal progress in developing a medication monitoring tool and reporting on state and national quality measures related to diagnoses, medication practices, and care standards.
- The MHP does not track any of the FC Healthcare Effectiveness Data and Information Set (HEDIS) measures mandated by California Senate Bill (SB) 1291.
- The MHP continues to lack a Clinical PIP and has not yet begun interventions for non-clinical PIP on tracking the HEDIS Follow-Up After ED Visit for FUM measure.

Recommendations for improvement based upon this review include:

- Annually update the QI Plan to address the MHP's current needs. Ensure the evaluation of each QI Plan metric at least annually and reactivate the QIC through regular meetings.
- Develop and implement a medication monitoring tool, utilizing contracts with subject matter experts as appropriate. Track, trend and report out at least quarterly complying with HEDIS and other national and/or state quality measures related to diagnoses, medication practices, and care standards. (This recommendation is a carry-over from FY 2021-22.)
- Track and trend the FC HEDIS measures as mandated by SB 1291. Utilize TA from CalEQRO and DHCS as needed. (Quality)
- Identify subject, design, develop and implement two active PIPs utilizing CalEQRO TA on a regular basis throughout the year. (This recommendation is a carry-over from FY 2021-22.)

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 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 Plumas County MHP by BHC, conducted as a virtual review on March 15, 2023.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to validate and analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, then "<11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding 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 after the Coronavirus Disease 2019 (COVID-19) pandemic, 2022 Dixie fire, and the flooding events of Winter 2022-23. The MHP experienced significant losses as the behavioral health center in Greenville burned down, and the MHP also experienced acute staffing shortages. 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.

- The previous MHP director resigned in May 2022. Since then, the MHP has been operating with an interim director. The county has not been able to hire a permanent director as of the FY 2022-23 EQR.
- Other staffing challenges include:
    - Lack of an in-person therapist. The MHP states that it has had no applicant for an open therapist position in the past 18 months. The MHP has hired two new telehealth providers to maintain its services.
    - Many of the case managers and line staff are new to behavioral health and require more than usual guidance and supervision.
    - At the time of the review, the MHP had a 34 percent vacancy rate, including the director position. The Dixie fire and the winter floods have ravaged the county and housing has become a challenge, reducing the pool of out-of-county applicants.
- The MHP is establishing a new wellness center in Quincy, the county seat.
- It is also working on reopening behavioral health services in Greenville that were destroyed in the Dixie fire.
- The MHP is trying to maintain transitional housing at the same level as pre-Dixie fire. One of its contractors has decided to end its transitional housing contract with the county. The MHP is in the process of recruiting a new contractor.

- The MHP is in the process of changing from its legacy EHR system to a new system. The application service provider (ASP), Kings View is managing the transition.

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: Track, trend and report out at least quarterly FC timeliness data for the entire system of care.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP included FC-specific questions on its access form to ensure that all FC beneficiaries are identified at the time of service requests and referrals.
- This recommendation was fully addressed as the MHP reported on FC timeliness data for the entire system of care.

Recommendation 2: Develop and implement standards for psychiatrist and clinicians other than psychiatrist no-shows. Track, trend and report out at least quarterly for the entire system of care.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The recommendation was partially addressed as the MHP has provided documentation training to clinicians to improve the accuracy of no-show reporting. However, the MHP has not yet developed no-show standards.
- Barriers to fully address this recommendation include QI and clinical staffing shortages.

- This recommendation will not be carried over in this year's EQR report as the MHP continues to work on this issue without any significant adverse impact to beneficiary access to MHP services.

Recommendation 3: Develop and implement a medication monitoring tool, utilizing contract as appropriate. Track, trend and report out at least quarterly complying with HEDIS and other national and/or state quality measures related to diagnoses, medication practices, and care standards.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- This recommendation was not addressed as the MHP acknowledged making minimal progress in implementing a medication monitoring tool or reporting on HEDIS and other quality measures.
- The MHP reported that the barriers included a decrease in staffing and an increase in state compliance activities.
- This recommendation will be carried over in this year's EQR report. In order to fully address this recommendation, the MHP will have to develop a medication monitoring tool and start reporting on HEDIS and other quality measures.

Recommendation 4: Identify subject, design, develop and implement two active PIPs utilizing CalEQRO TA on a regular basis throughout the year.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- This recommendation was not addressed because the MHP was unable to develop and submit a clinical PIP. The MHP cited staffing shortage and a lack of any identified topics for a clinical PIP as the main barriers to addressing this recommendation; a letter from the MHP Director attesting to additional barriers is included at the end of this report.
- The MHP is in the planning phase of its non-clinical PIP on HEDIS FUM measure as part of its California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Quality Improvement Plan (BHQIP) requirements. At the time of the review, the MHP had not yet begun to implement interventions.
- CalEQRO will continue with this recommendation in this EQR report. In order to fully address this recommendation, the MHP will need to be actively working on two PIPs, ideally based on topics identified through the QI plan evaluation process.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 84 percent of services were delivered by county-operated/staffed clinics and sites, and 16 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 100 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: MHP main clinic and any of the satellite wellness centers. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Access Line callers are given an intake appointment while the walk-in individuals are given an intake the same day on a first-come, first-served basis.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults**.** In FY 2021-22, the MHP reports having provided telehealth services to 168 adult beneficiaries, 89 youth beneficiaries, and 23 older adult beneficiaries across 4 county-operated sites and no contractor-operated sites. Among those served, no beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

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

[1] CMS Data Navigator Glossary of Terms

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

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

Alternative Access Standards				
The MHP was required to submit an AAS request due to time or distance requirements	☒ Yes ☐ No			
AAS Details	**Psychiatry**		**MH Services**	
	Adults (ages 21+)	Youth (ages 0-20)	Adults (ages 21+)	Youth (ages 0-20)
# of zip codes outside of the time and distance standards that required AAS request	*	*	N/A	N/A
# of allowable exceptions for the appointment time standard, if known (timeliness is addressed later in this report)	*	*	N/A	N/A
Distance and driving time between nearest network provider and zip code of the beneficiary furthest from that provider for AAS requests	*	*	N/A	N/A
Approximate number of beneficiaries impacted by AAS or allowable exceptions	*	*	N/A	N/A
The number of AAS requests approved and related zip code(s)	*	*	N/A	N/A
Reasons cited for approval	*	*	N/A	N/A
The number of AAS requests denied and related zip code(s)	*	*	N/A	N/A
Reasons cited for denial	*	*	N/A	N/A

*The MHP was unable to provide any details.

- The MHP did not meet all time and distance standards and was required to submit an AAS request.
- The MHP did not implement improvement activities, due to the following barriers:
    - Search for locum tenens psychiatrist did not yield any local providers; therefore, the MHP was unable to address the reason for AAS requirement – lack of in-person psychiatry.

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
OON Access for Beneficiaries	
The MHP ensures OON access for beneficiaries in the following manner:	☒ The MHP has existing contracts with OON providers ☐ Other: Click or tap here to enter text.

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:

- Despite various setbacks due to the COVID-19 pandemic, significant staffing shortage, and natural disasters like the Dixie fire and massive winter floods, the MHP has managed to keep its access process easy and timely.
- The MHP ensures a community needs assessment through its Mental Health Services Act planning process. Establishing Tai Chi groups in the past year is an example of the MHP's addressing community needs.
- The MHP cited strong collaborations with various partners such as the school district, local homeless housing organization, drug court, and jail health as examples that enhance access to mental health services.

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, it appears that access is easier in Plumas as compared to the state as a whole.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	6,884	531	7.71%	$4,681,663	$8,817
CY 2020	6,580	497	7.55%	$4,865,173	$9,789
CY 2019	6,507	592	9.10%	$3,744,558	$6,325

- During the COVID-19 pandemic, initially the MHP's PR went down by 17 percent in CY 2020. In CY 2021, both the number of beneficiaries served, and the PR

started increasing again. During the same period, the MHP's total approved claims and the AACB both increased due to pandemic-related temporary rate increases.

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	680	<11	-	1.71%	1.96%
Ages 6-17	1,436	167	11.63%	8.65%	5.93%
Ages 18-20	295	27	9.15%	7.76%	4.41%
Ages 21-64	3,782	309	8.17%	8.00%	4.56%
Ages 65+	693	-	-	3.73%	1.95%
Total	**6,884**	**531**	**7.71%**	**7.08%**	**4.34%**

- In CY 2021, the MHP's PR was 77.6 percent higher than statewide and 8.9 percent higher than the Small-Rural county averages. Its PR was higher for each of the non-suppressed age groups as well.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
No threshold	516	100%
Threshold language source: Open Data per BHIN 20-070		

- The MHP did not have any threshold language other than English.

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	2,220	172	7.75%	$1,131,932	$6,581
Small-Rural	35,376	2,377	6.72%	$12,056,144	$5,072
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal 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 beneficiaries accounted for a third of the overall Medi-Cal eligibles, and the ACA PR was similar to the overall PR in CY 2020 and twice that of the statewide ACA PR.

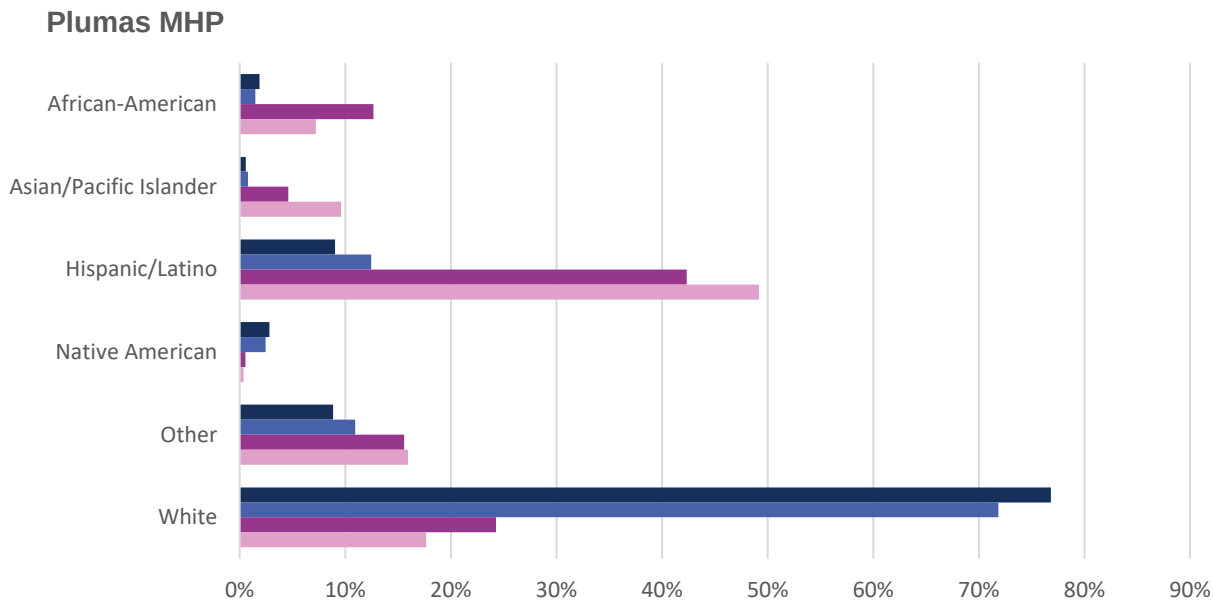
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions 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	103	<11	-	7.64%
Asian/Pacific Islander	54	<11	-	2.08%
Hispanic/Latino	858	48	5.59%	3.74%
Native American	170	15	8.82%	6.33%
Other	753	47	6.24%	4.25%
White	4,948	408	8.25%	5.96%
Total	**6,886**	**531**	**7.71%**	**4.34%**

- Plumas County's Medi-Cal eligible population is predominantly White, accounting for 72 percent of the total. Of the rest, the Latino/Hispanic and Other beneficiaries account for 23.4 percent together. While the Latino/Hispanic PR is 32 percent lower than the White PR, it is almost 50 percent higher than the corresponding statewide PR.

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

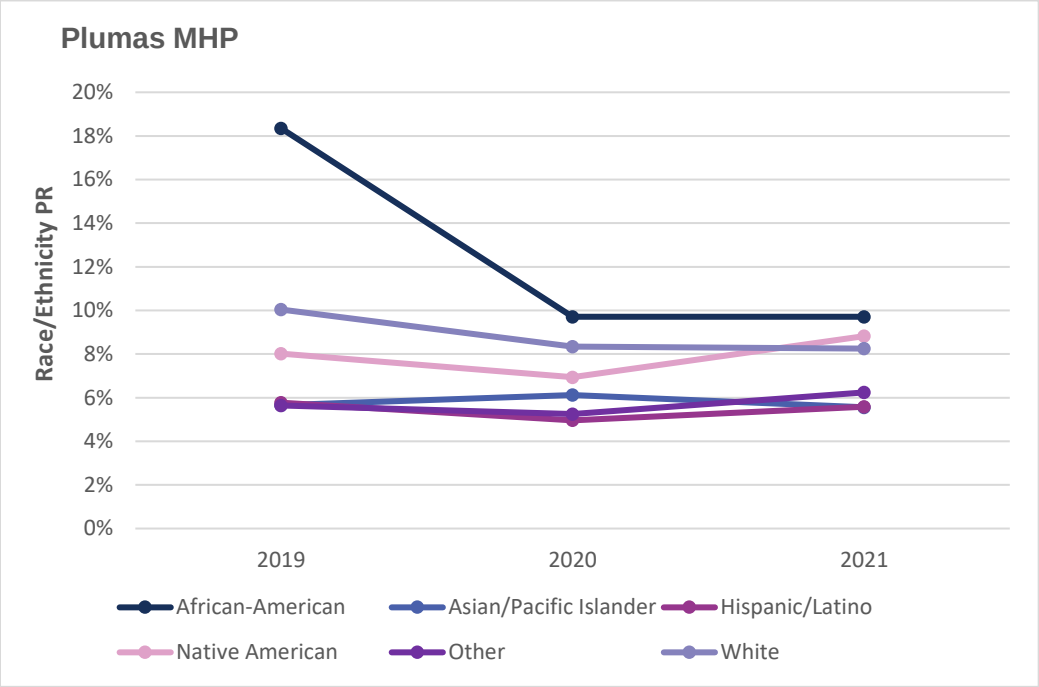


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	77%	9%	3%	9%	1%	2%
MHP % Eligible	72%	11%	2%	12%	1%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- The percentages of White Medi-Cal eligible and the beneficiaries served are both three times the corresponding statewide percentages. The Latino/Hispanic percentages are less than a quarter of the corresponding statewide percentages.

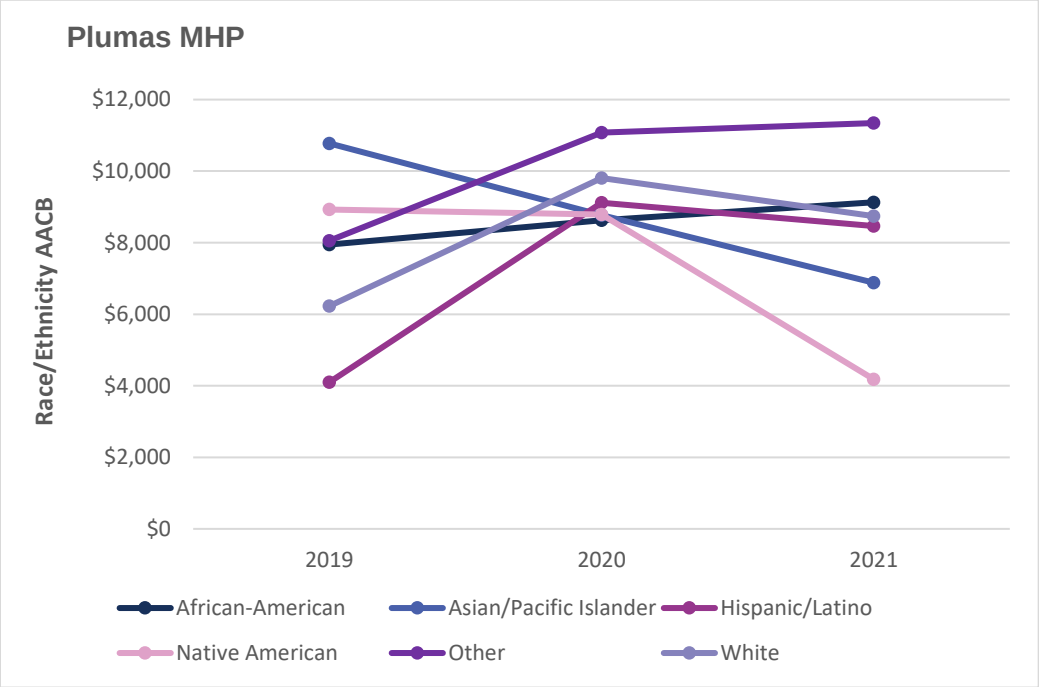
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



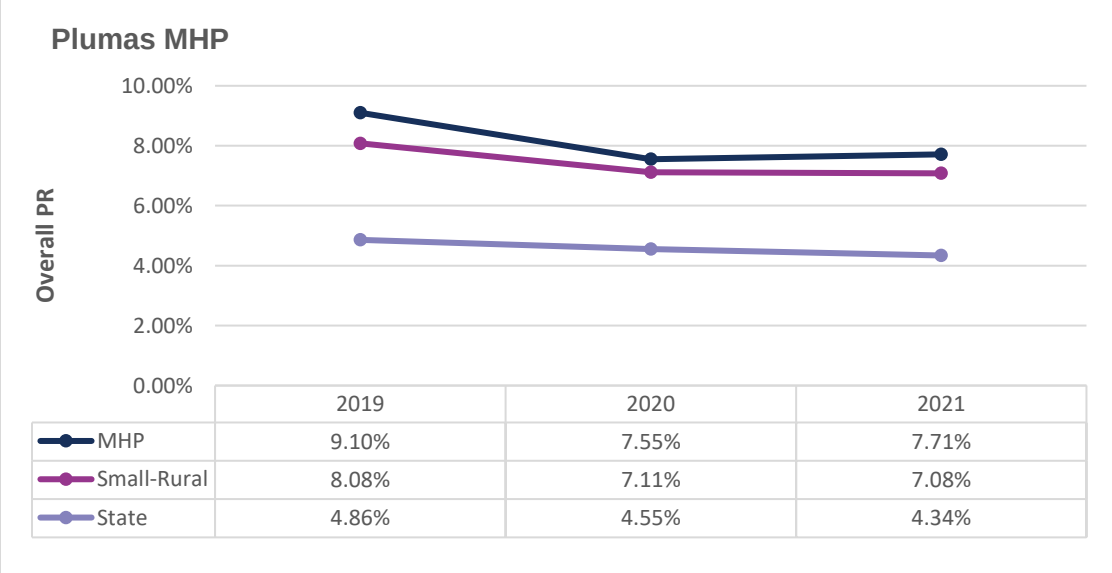
- The African American PR declined by 8 percentage points between CYs 2019-20. However, it is based on a small actual count which makes this an unstable indicator. The Latino/Hispanic, Other, and Asian/Pacific Islander PRs were the lowest all three years between CYs 2019-21.

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



- Although the overall AACB went up by more than 50 percent between CY 2019-20 and then declined in CY 2021, the rate of change was not uniform across different race/ethnicity groups. The Other group showed the highest increase while the African-American AACB increased the least. All other groups showed declining AACB between CYs 2020-21.

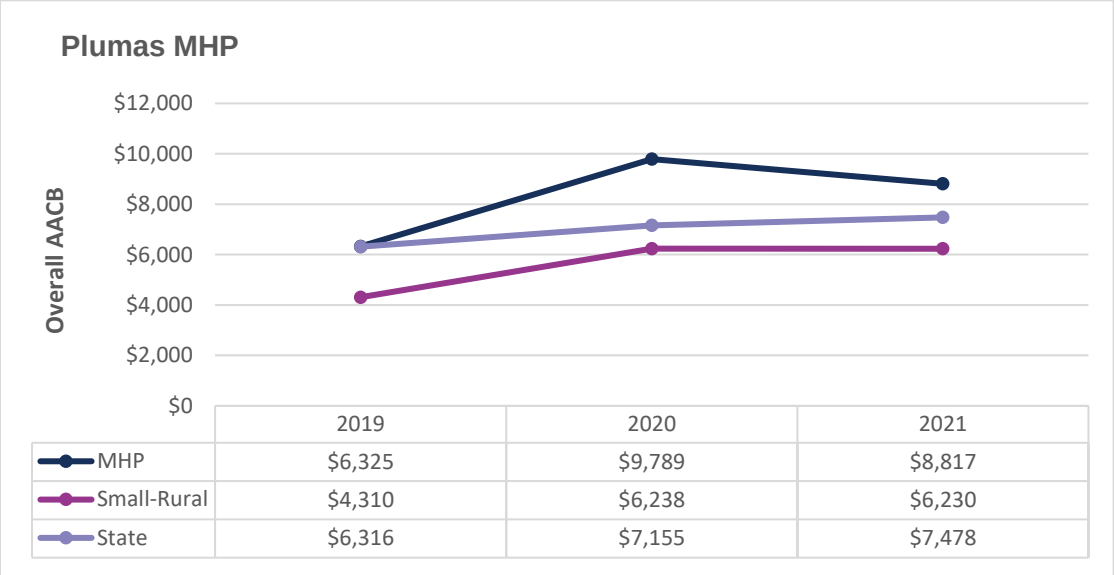
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	9.10%	7.55%	7.71%
Small-Rural	8.08%	7.11%	7.08%
State	4.86%	4.55%	4.34%

- The MHP's overall PR declined between CY 2019-21, but it remained consistently much higher than the statewide PR. It has also been higher than the Small-Rural average PR, but more modestly.

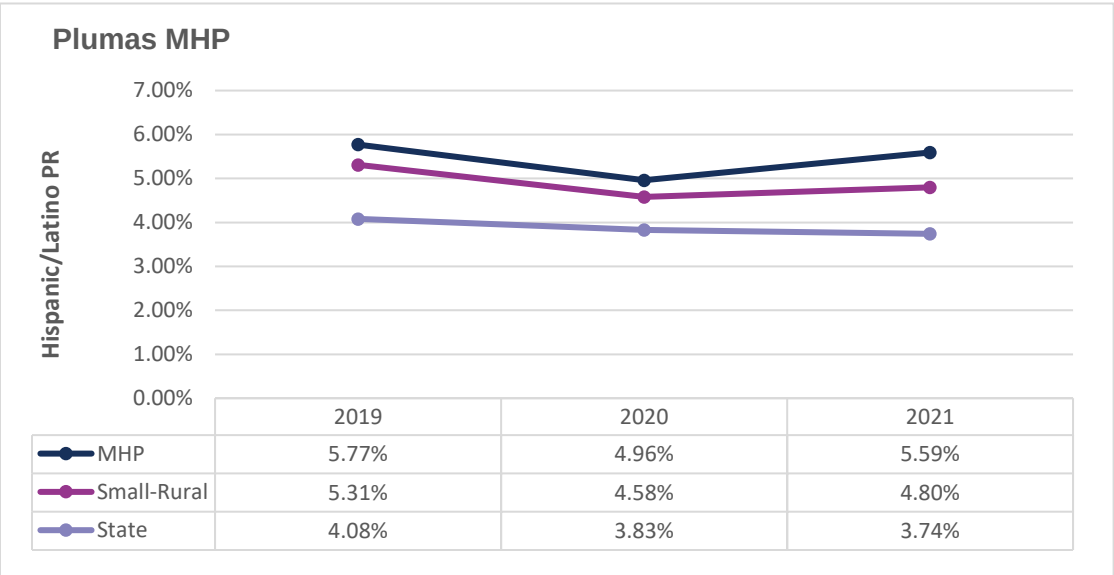
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$6,325	$9,789	$8,817
Small-Rural	$4,310	$6,238	$6,230
State	$6,316	$7,155	$7,478

- The MHP's AACB was similar to statewide in CY 2019, but then went up at a faster pace than the state and remained 18 percent higher in CY 2021 despite a decline from CY 2020. It was also 42 percent higher than the Small-Rural average AACB in CY 2021.

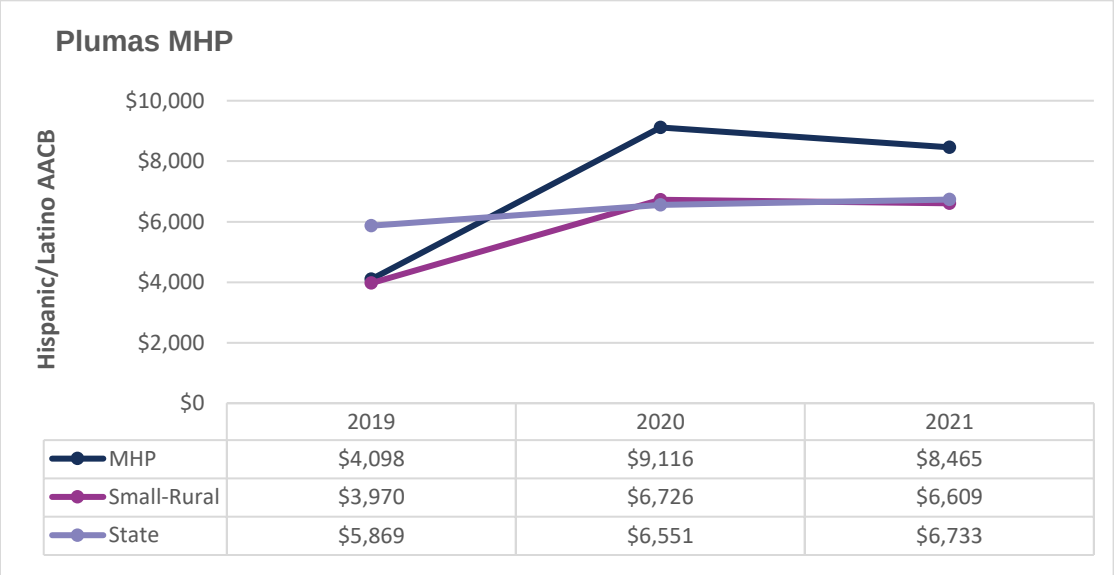
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	5.77%	4.96%	5.59%
Small-Rural	5.31%	4.58%	4.80%
State	4.08%	3.83%	3.74%

- The MHP's Latino/Hispanic PR went down in CY 2020 and then rebounded in CY 2021 to nearly the same level. It has been consistently higher than corresponding statewide PR being nearly 50 percent higher in CY 2021.

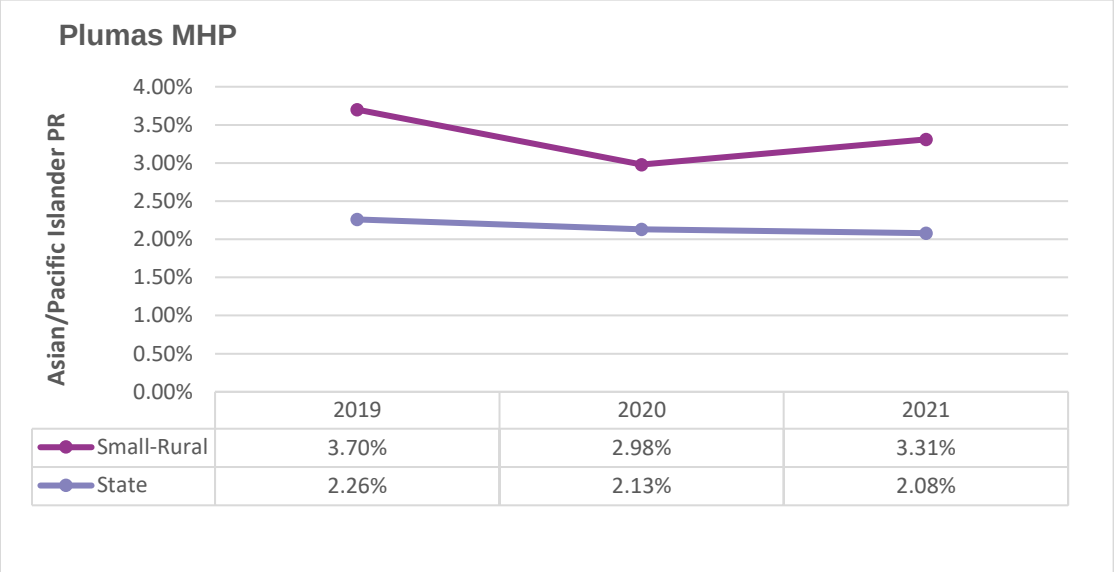
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,098	$9,116	$8,465
Small-Rural	$3,970	$6,726	$6,609
State	$5,869	$6,551	$6,733

- The MHP's Latino/Hispanic AACB was lower than the state in CY 2019, but increased to more than double in CY 2020 while the corresponding statewide AACB remained relatively flat. It was a third higher than the state in CY 2021.

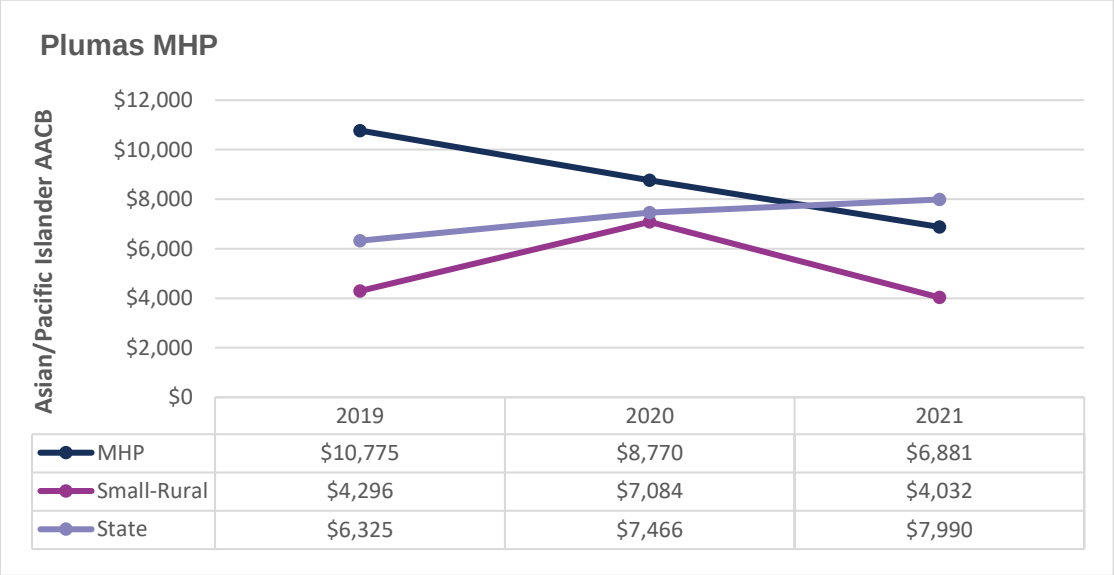
Figure 8: Asian/Pacific Islander PR CY 2019-21



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

- The MHP's Asian/Pacific PR was suppressed due to HIPAA suppression rules.

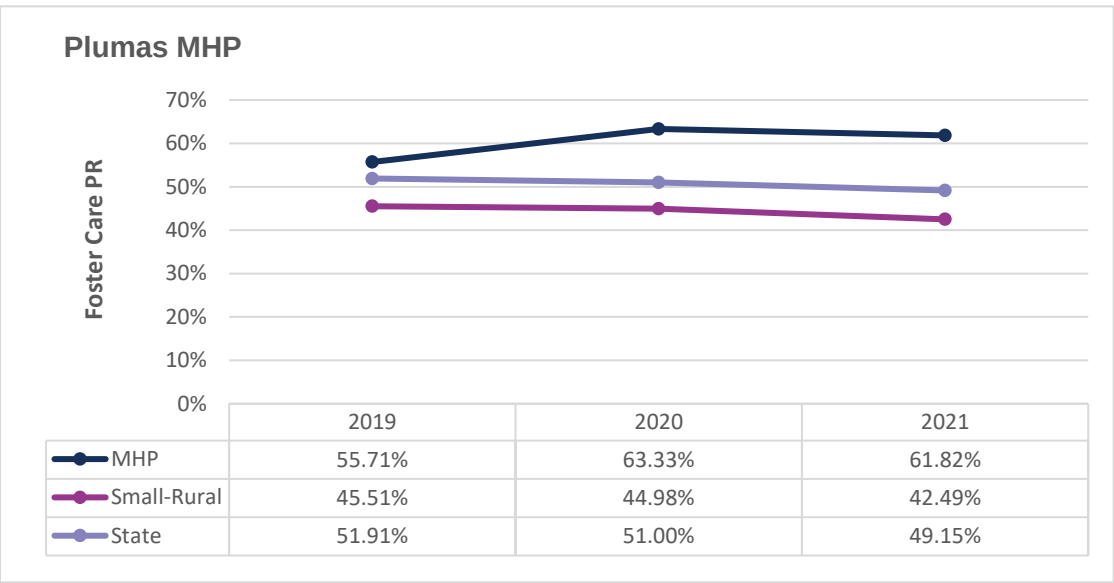
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$10,775	$8,770	$6,881
Small-Rural	$4,296	$7,084	$4,032
State	$6,325	$7,466	$7,990

- The MHP's Asian/Pacific Islander AACB declined sharply between CY 2019-21; however, it is based on very low count and therefore not a stable indicator.

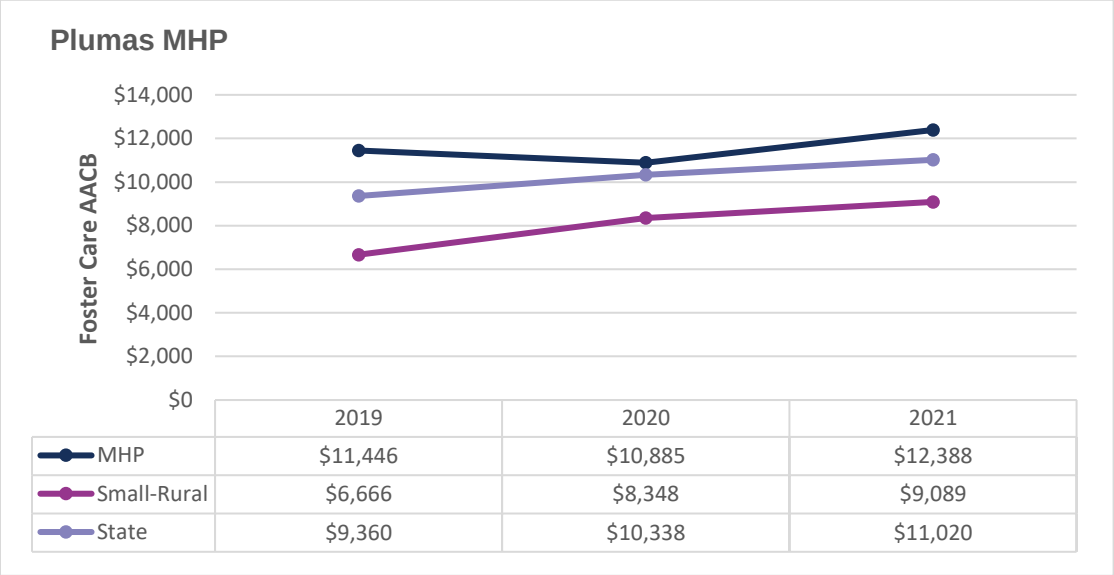
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	55.71%	63.33%	61.82%
Small-Rural	45.51%	44.98%	42.49%
State	51.91%	51.00%	49.15%

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed. The MHP's FC PR went up between CYs 2019-21, and in CY 2021, it was more than 12 percentage points higher than the statewide and almost 20 percentage points higher than the Small-Rural average.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$11,446	$10,885	$12,388
Small-Rural	$6,666	$8,348	$9,089
State	$9,360	$10,338	$11,020

- Statewide FC AACB increased each year between CYs 2019-21. The MHP's FC AACB was higher than both statewide and Small-Rural averages during the same year.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 355				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	19	5.4%	7	5	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	<11	-	1	1	1.3%	15	7
Residential	<11	-	29	29	0.4%	107	79
Crisis Residential	<11	-	9	9	2.2%	21	14
Per Minute Services							
Crisis Stabilization	<11	-	800	840	13.0%	1,546	1,200
Crisis Intervention	63	17.7%	143	91	12.8%	248	150
Medication Support	112	31.5%	274	132	60.1%	311	204
Mental Health Services	291	82.0%	1,227	374	65.1%	868	353
Targeted Case Management	216	60.8%	260	64	36.5%	434	137

- In CY 2021, the MHP provided much less medication support than the statewide average but much more mental health services and targeted case management.
- The MHP was able to keep its inpatient utilization much lower than the state and provided a higher percentage of beneficiaries with crisis intervention services.

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

Service Category	MHP N = 34				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	-	15	13	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	-	1,200	1,200	3.1%	1,398	1,200
Crisis Intervention	<11	-	122	90	7.5%	404	198
Medication Support	14	41.2%	352	156	28.3%	394	271
TBS	0	0.0%	0	0	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination (ICC)	<11	-	780	329	40.0%	1,351	472
Intensive Home Based Services (IHBS)	<11	-	1,028	779	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	30	88.2%	2,184	1,365	96.3%	1,848	1,103
Targeted Case Management	19	55.9%	133	75	35.0%	342	120

- Although the MHP's adult medication support utilization was lower than the state, it provided more medication support to the FC beneficiaries than was seen statewide. It also provided more targeted case management to the FC beneficiaries.

IMPACT OF ACCESS FINDINGS

- The MHP has solid access processes for mental health services that is evidenced in the higher than statewide and similar-sized MHP PR averages. This

is reflected also when the PR is examined by beneficiaries' age group or race/ethnicity.

- Close partnerships and outreach to specific populations such as jail health, drug court, school students, and homeless individuals have contributed to better access to mental health services.
- The network for mild-to-moderate is limited in the county, so the MHP needs to coordinate with the Managed Care Plans (MCPs) for any transitions.

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	Met
2C	Urgent Appointments	Partially Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Partially Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Partially Met

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

- Despite its staffing shortages, the MHP was able to provide timely access to initial appointments, both psychiatric and other mental health services.

- The MHP appears to have used a narrow definition of urgent appointment requests and may have treated many of the urgent appointments as crisis intervention. This may have provided quick intervention but could have resulted in an undercount of the actual urgent appointments.
- The MHP appears to have underreported the count of psychiatric hospitalization in measuring the follow-up to hospitalization metric. It does not match CalEQRO's own count for CY 2021 nor the MHP's own rehospitalization numbers.
- MHP continues to not define any standard for its no-show metrics. Further, it has struggled to capture the true number of psychiatric no-shows.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12–14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care. The MHP's urgent appointment and psychiatry no-show data appeared incomplete.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	1.8 Business Days	10 Business Days*	99%
First Non-Urgent Service Rendered	0.6 Business Days	10 Business Days**	99%
First Non-Urgent Psychiatry Appointment Offered	1.7 Business Days	15 Business Days*	100%
First Non-Urgent Psychiatry Service Rendered	5 Business Days	15 Business Days**	***%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0.5 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization	8 Days	7 Days**	71%
No-Show Rate – Psychiatry	1.2%	***%	n/a
No-Show Rate – Clinicians	20.5%	***%	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

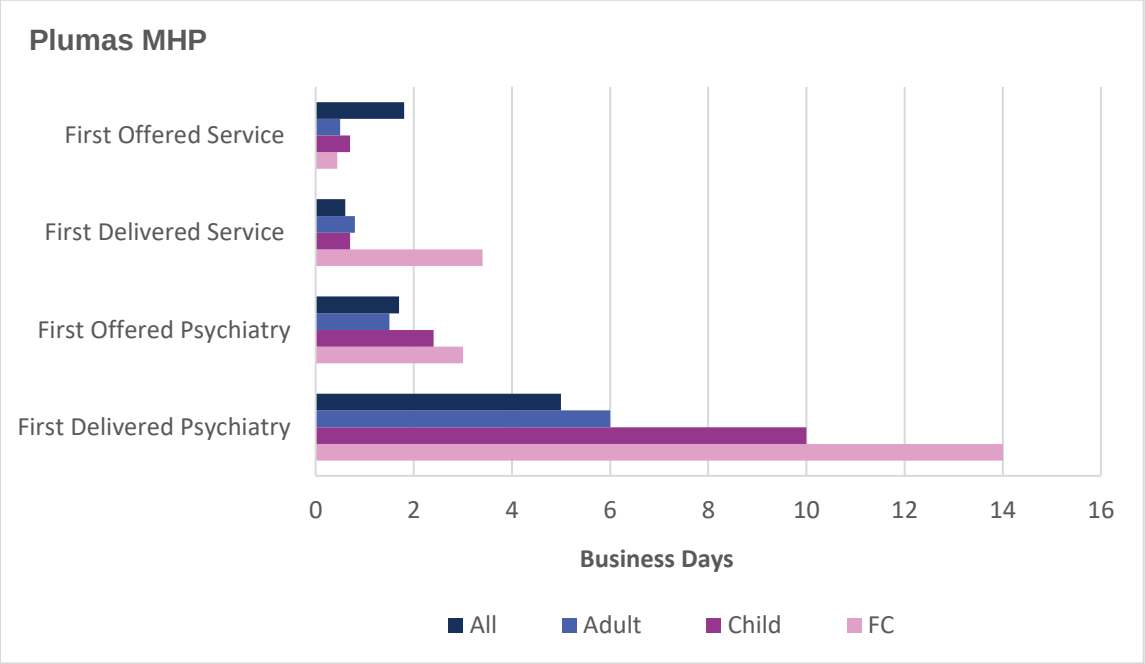


Figure 13: Wait Times for Urgent Services

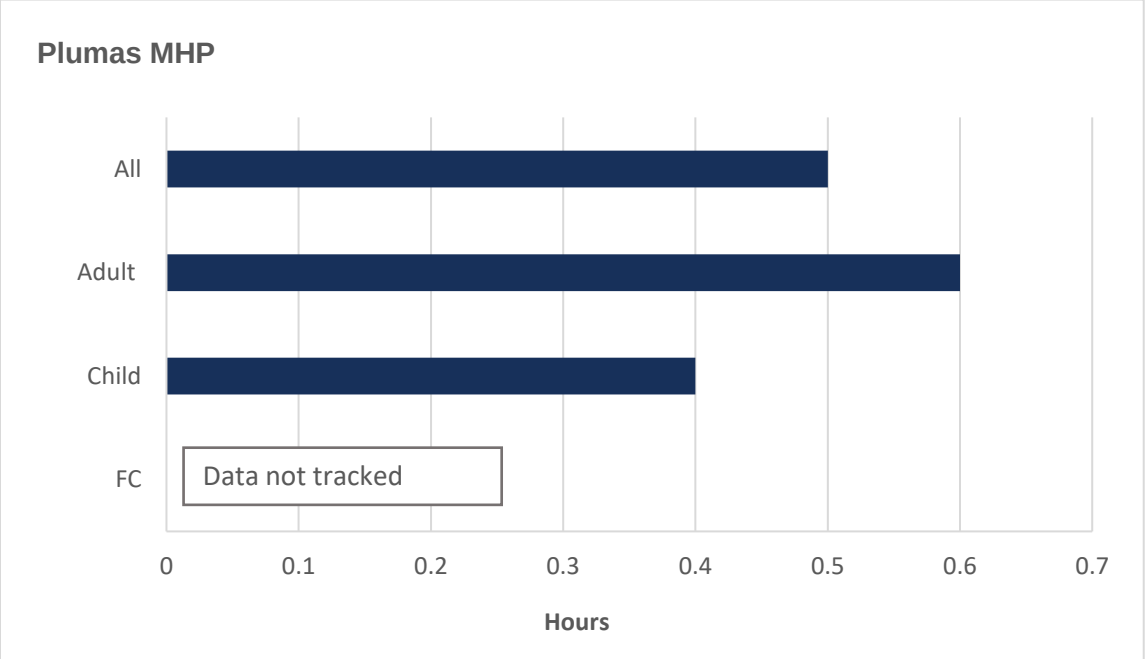
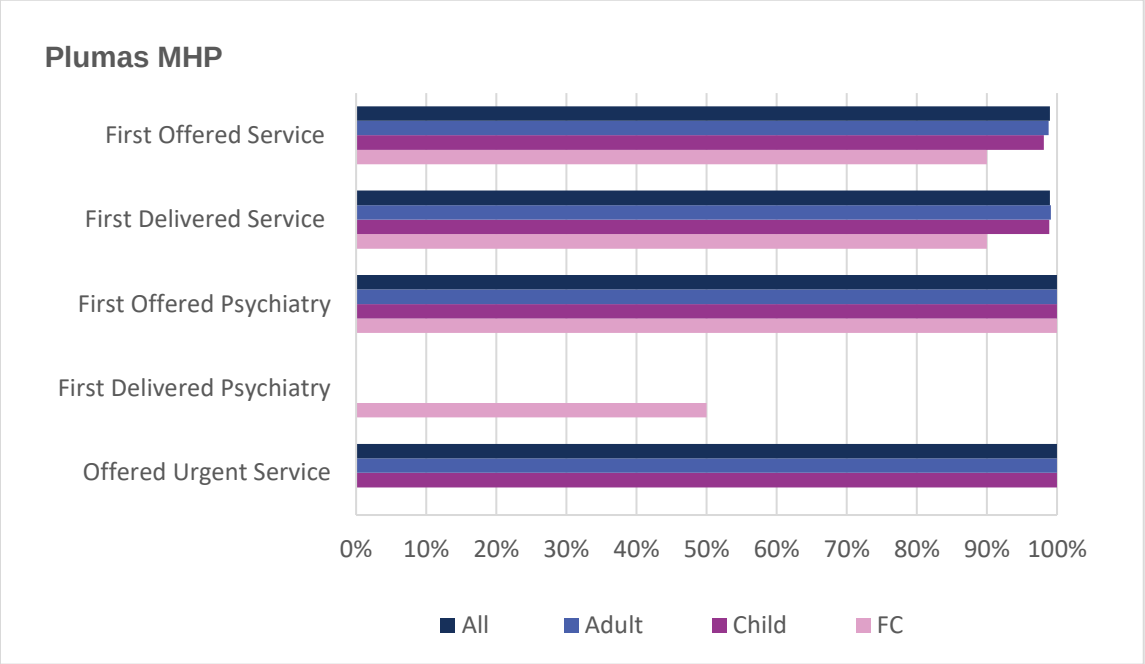


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments and mental health services.
- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP did not define “urgent services” for purposes of the ATA. There were reportedly <11 of urgent service requests with a reported actual wait time to services for the overall population at 0.5 hours. When compared to the crisis intervention counts in Table 8, it appears likely that many urgent requests may have been treated as an outpatient crisis intervention cases.
- 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 beneficiaries’ first request for a psychiatric appointment.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked, but during the review, the MHP reported that the psychiatry no-show data may represent an incomplete set. The MHP reports a no-show rate of 1.2 and 20.5 percents, respectively, for psychiatry and non-psychiatry mental health appointments.

IMPACT OF TIMELINESS FINDINGS

- The MHP's initial psychiatric and non-psychiatric appointments have been very timely. Both the administration and the line staff have been diligent in ensuring quick access to mental health services.
- The available timeliness data preceded the Dixie fire and the floods, so it was not possible to accurately assess the impact on timeliness of services. However, anecdotal evidence from the staff and administration showed special efforts to mitigate any impacts.
- The line staff noted delays in follow-up care appointments after the initial assessment and service due to staffing shortages.
- The MHP needs to continue its methodologies for tracking urgent appointment, inpatient follow-up, and no-show metrics.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is under the Quality Assurance and Compliance Manager.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC has been inactive for a year and has not met since April 2022. Since the previous EQR, the MHP QIC met zero times. Of the 16 identified FY 2021-22 QAPI workplan goals, the MHP was unable to provide evaluation findings at the end of the FY.

The MHP utilizes the following level of care (LOC) tool: Child and Adolescent Needs and Strengths. Although the MHP stated that this is used for LOC determination and treatment planning, no overall summaries were available.

The MHP utilizes the following outcomes tools: Patient Health Questionnaire-9, Generalized Anxiety Disorder-7, Pediatric Symptoms Checklist-35, and Columbia Suicide Severity Rating Scale. No overall summaries were available.

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

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

- The MHP has regular and adequate communications both internally and with outside partners, agencies, and other health care providers.
- Since the departure of the previous MHP director, the QI function has suffered due to lack of staffing. This has been compounded by the QI manager and other key staff being stretched to the limit managing all the changes required by CalAIM in the past year.
- Recently the MHP added a data analyst to its QI unit; however, this has left a vacancy on the IS side.
- The MHP has several mental health clinics that it terms as wellness centers, but these are not peer-run or peer-driven. It employs individuals with lived experience for front-desk operations and changed the peer support specialist job title to reflect the actual job functions. It is planning to train peers to become certified peer support specialists.
- The MHP does not track or trend the following HEDIS measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): N/A
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): N/A

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): N/A
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP): N/A

QUALITY PERFORMANCE MEASURES

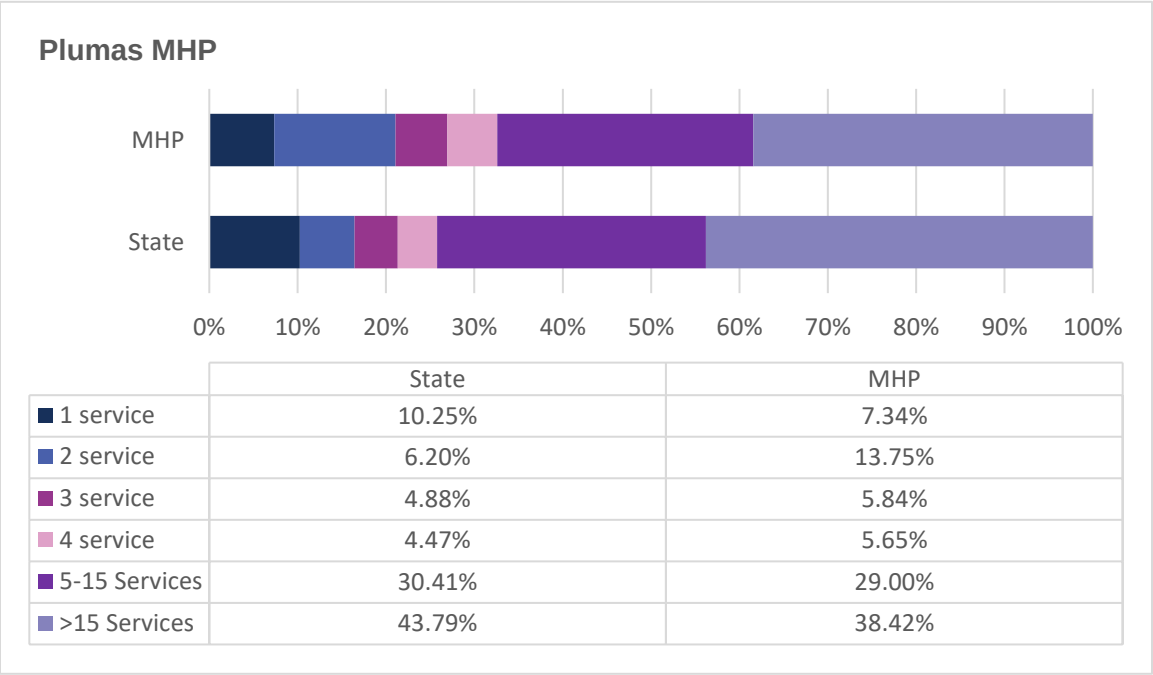
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



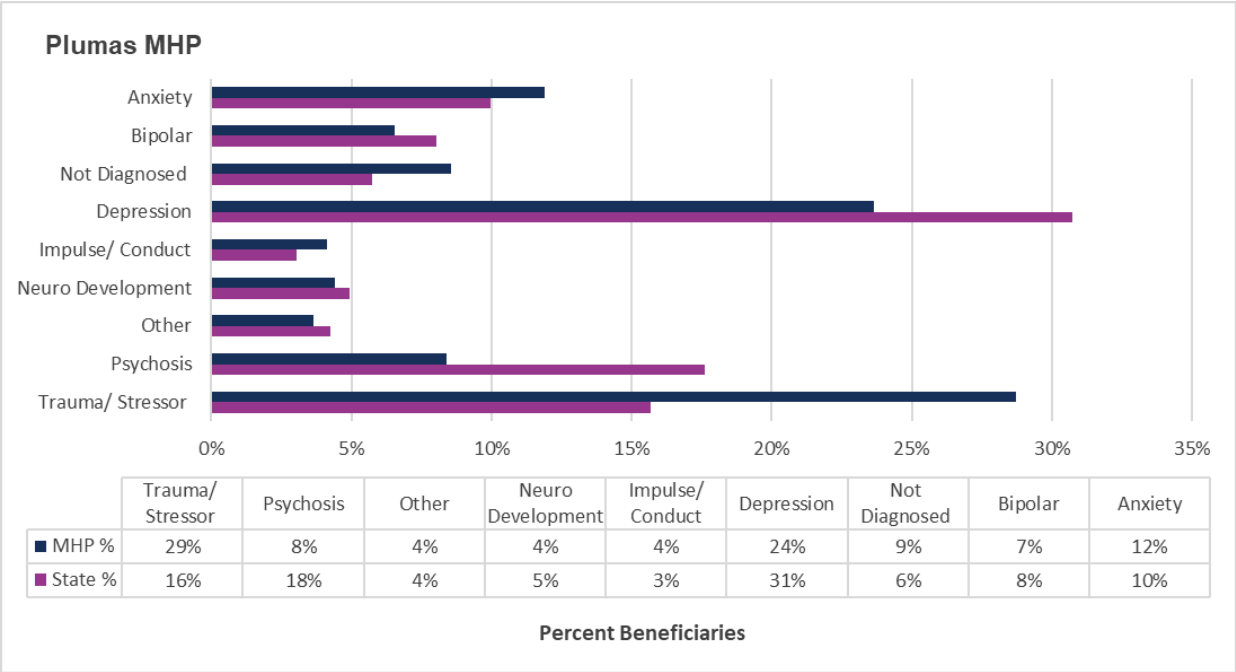
	State	MHP
1 service	10.25%	7.34%
2 service	6.20%	13.75%
3 service	4.88%	5.84%
4 service	4.47%	5.65%
5-15 Services	30.41%	29.00%
>15 Services	43.79%	38.42%

- The MHP had a higher percentage of beneficiaries receiving 4 or less services than the state in CY 2021. A lower percentage of beneficiaries received more than 15 services than the statewide average the same year.

Diagnosis of Beneficiaries Served

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

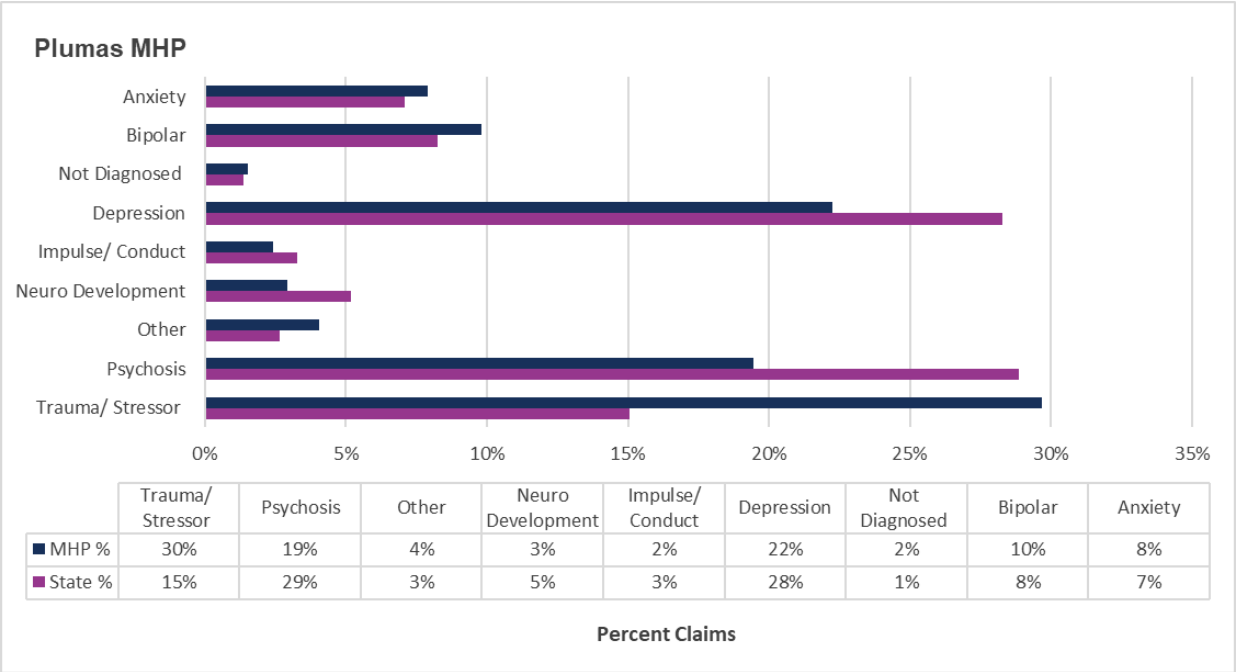
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	29%	8%	4%	4%	4%	24%	9%	7%	12%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The MHP served much smaller proportions of individuals with psychosis and depression than the state as a whole. On the other hand, it served a much higher percentages of beneficiaries with trauma/stressor disorders. The MHP reported higher incidence of the latter during the COVID-19 pandemic as well as the natural disasters.

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 %	30%	19%	4%	3%	2%	22%	2%	10%	8%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- The MHP's diagnostic categories by percentage of approved claims closely mirrored its actual beneficiary percentages, and was similarly different from the state.

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	25	27	8.96	8.86	$10,142	$12,052	$253,551
CY 2020	24	44	9.47	8.68	$10,309	$11,814	$247,405
CY 2019	31	38	10.21	7.80	$10,559	$10,535	$327,319

- Although the MHP's overall AACB went up by nearly a third since CY 2019, the inpatient AACB actually declined slightly during the same period and was lower than the state in CY 2021 by 15.8 percent.

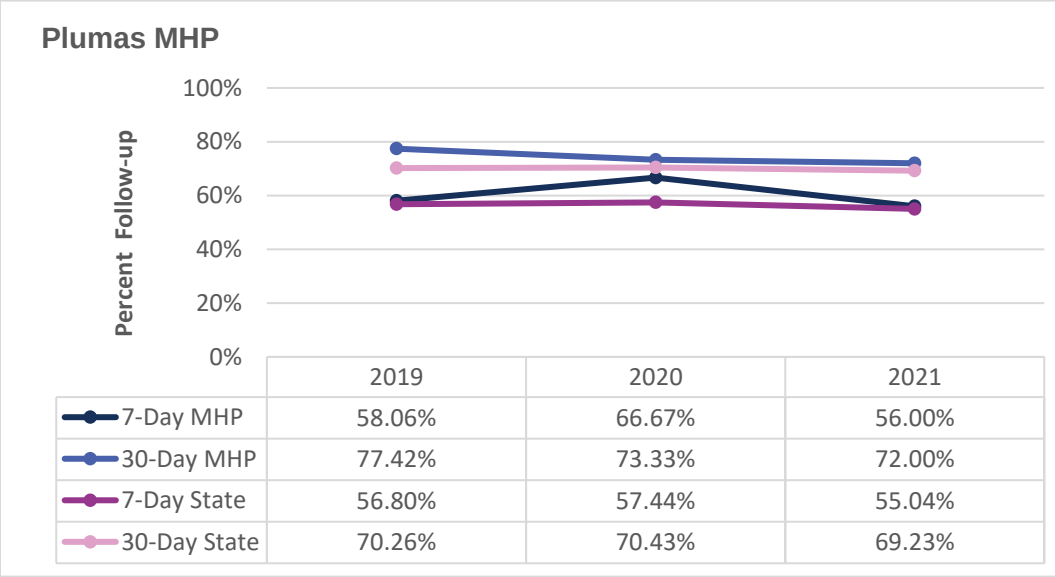
- The MHP's inpatient beneficiary count, the number of inpatient admissions, the LOS, and the total approved claims, all declined between CY 2019-21 reflecting fewer readmissions.

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.

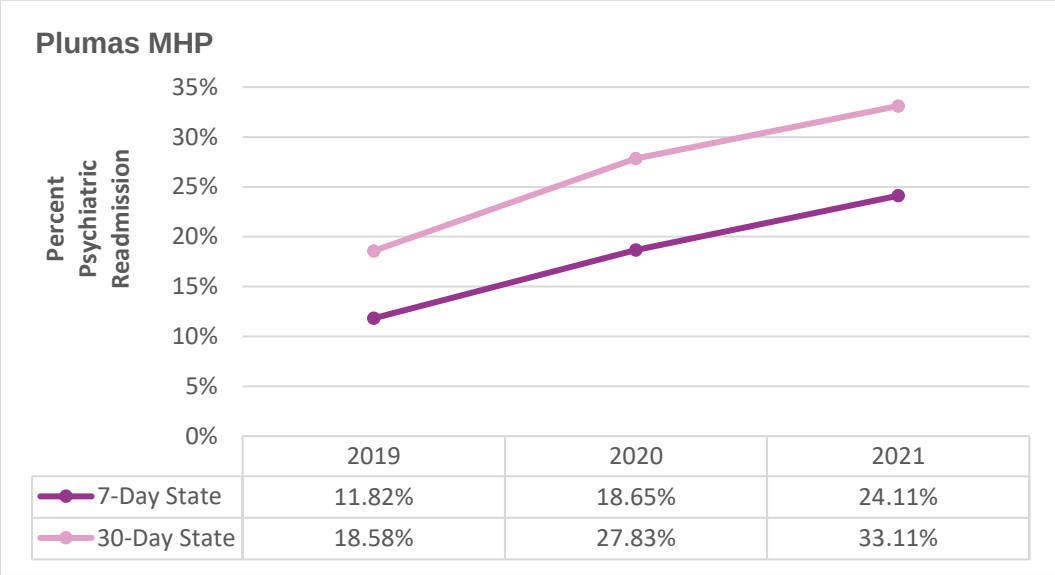
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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	58.06%	66.67%	56.00%
30-Day MHP	77.42%	73.33%	72.00%
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 State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- The MHP's 7- and 30-day readmission rates remained mostly the same and similar to the statewide corresponding rates.
- The MHP had very few readmissions within 30 days, and this trend was suppressed for HIPAA reasons.

High-Cost Beneficiaries

Tracking the HCBs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCBs may disproportionately occupy treatment slots that may prevent access to levels of care by other beneficiaries. HCB percentage of total claims, when compared with the HCB count percentage, provides a subset of the beneficiary population that warrants close utilization review, both for appropriateness of level of care and expected outcomes.

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $7,478, the median amount is just $3,269.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, nearly 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACB of $4,412 and median of $2,830.

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	33	6.21%	36.31%	$1,699,742	$51,507	$40,306
	CY 2020	40	8.05%	45.54%	$2,215,456	$55,386	$44,283
	CY 2019	23	3.89%	30.54%	$1,143,480	$49,717	$41,871

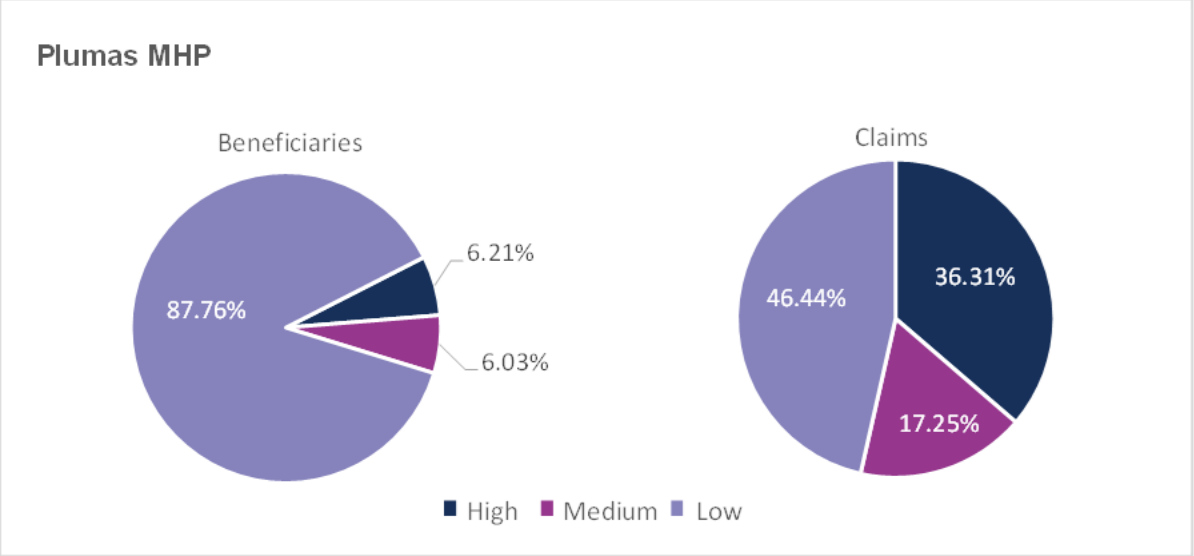
- The MHP's growth in HCB counts and percentages are similar to its increase in the overall AACB. However, its mean and median approved claims per HCB were lower than the state.

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	32	6.03%	17.25%	$807,686	$25,240	$25,793
Low Cost (Less than $20K)	466	87.76%	46.44%	$2,174,234	$4,666	$2,714

- Like most MHPs, the beneficiaries in the low-cost category account for most served by the MHP.

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



- High- and medium-cost beneficiaries together accounted for more than half of the total approved claims despite totaling only 12.24 percent of the total beneficiary count.

IMPACT OF QUALITY FINDINGS

- The MHP's QI functions have been seriously compromised since the last EQR. Inability to update the QI plan metrics and failure to evaluate the previous year's goals mean that many priority indicators are not being tracked regularly and data-driven decision making is not taking place.
- This is further compounded by the fact that the interim director is having to fulfill a clinical supervisor role due to staffing shortages while carrying out the MHP director responsibilities.
- Despite many staffing and other challenges related to natural disasters, the MHP has been able to enhance staff training, outreach to schools, and skills training for its Full-Service Partnership (FSP) beneficiaries.
- While the CalAIM implementation has proved to be a heavy lift for the MHP with its more than a third vacancy rate, the MHP noted a few benefits such as the staff preferring the problem lists over treatment plans.

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: None submitted

Date Started: N/A

Date Completed: N/A

Aim Statement: N/A

Target Population: N/A

Status of PIP: No clinical PIP submitted.

Summary

N/A

[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

TA and Recommendations

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

- The MHP needs to update its QI plan, evaluate the indicators, and discuss its findings in the QIC meetings in order to identify areas that may need a PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-Up After ED Visit for Mental Illness (FUM)

Date Started: N/A

Aim Statement: Based on the following statistics: Plumas County residents who utilize ED for mental health related services are experiencing a delay in accessing outpatient services. In 2021, only 31 percent of ED visits for mental health symptoms were followed by connection to MHP Services within 7 days and 60 percent within 30 days, which are well below State and National benchmarks, 49 percent and 40 percent within 7 days; and 61 percent and 54 percent within 30 days; for Medi-Cal beneficiaries with ED visits for mental health conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023.

Target Population: The target population for this project will be operationalized within the parameters of the HEDIS FUM metric. The MHP will focus on beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm.

Status of PIP: The MHP's non-clinical PIP is in the Planning Phase.

Summary

The MHP conducted a "Five Whys" analysis and found that its 7-day FUM rate is much lower than the state and national benchmarks. It engaged a number of internal and external stakeholders including the local hospital and the managed care plan (MCP) in examining the reasons and appropriate remedial interventions that are likely to resolve the underlying cause that "the MHP and Quincy Hospital have not established a referral system or protocol for how, when, and for whom to send mental health referrals when it is not a 5150/crisis evaluation."

The MHP plans to implement advanced care coordination, collaborative care, critical time intervention, and behavioral intervention along with better data exchange with the local ED and the MCP to improve the 7-day FUM rate. The primary outcome measure

for this PIP is the percentage of ED visits for MH where the client received a follow up MH treatment service from the MHP within 7 or 30 days.

TA and Recommendations

As submitted, CalEQRO rated this PIP as low confidence since no intervention has started yet.

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

- The MHP was encouraged to seek regular TA from CalEQRO once the PIP is approved, especially regarding operationalizing the primary outcomes into measurable variables.
- The initial focus of this PIP may better be focused on 7-day follow-up since the 30-day follow-up rates were closer to the state and national benchmarks.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an ASP where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner Anasazi, which has been in use for 11 years. Currently, the MHP is actively implementing a new system, Credible, which requires heavy staff involvement to fully develop. The projected go-live date for the new EHR is July 2023.

Approximately 10 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control. The IS budget percentage is twice that reported last year, and accounts for the implementation of a new EHR.

The MHP has 51 named users with log-on authority to the EHR, including approximately 38 county staff and 13 contractor staff. Support for the users is provided by 2.5 full-time equivalent (FTE) IS technology positions. Currently 1 position is vacant since an IS analyst took an analyst position under QI.

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

Contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	95%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	5%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP currently does not have the PHR function but expects one to be installed as part of the new EHR within next year.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Contract providers. The MHP reported a memorandum of understanding on data exchange was recently established for data exchange with the MCP.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP has an established ASP, King View, which ensures strong support and maintenance of the EHR. It has also taken charge of the new EHR implementation that should be completed by the end of this FY.
- The MHP has adequate structure in place to ensure the integrity of Medi-Cal claims process resulting in low denial rates.
- The MHP has all the necessary IS security and controls in place including a disaster recovery plan by the ASP.
- Although the MHP provides regular IS-related trainings to its staff, it does not maintain an attendance log.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18.

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	927	$374,383	$0	0.00%	$372,561
Feb	886	$383,823	$0	0.00%	$377,824
Mar	1,284	$549,042	$8,825	1.61%	$532,523
April	1,101	$492,258	$0	0.00%	$484,317
May	1,081	$445,045	$1,201	0.27%	$442,274
June	1,126	$456,385	$0	0.00%	$449,944
July	903	$344,889	$0	0.00%	$334,131
Aug	797	$324,246	$1,087	0.34%	$317,837
Sept	925	$313,396	$0	0.00%	$309,938
Oct	873	$272,091	$562	0.21%	$271,272
Nov	853	$301,268	$0	0.00%	$297,859
Dec	724	$240,012	$0	0.00%	$240,012
Total	**11,480**	**$4,496,838**	**$11,675**	**0.26%**	**$4,430,492**

- The claims volume appeared consistent from month to month in CY 2021.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Late claim	19	$9,402	80.52%
Medicare Part B must be billed before submission of claim	3	$1,188	10.17%
Beneficiary not eligible or non-covered charges	2	$1,087	9.31%
Total Denied Claims	**24**	**$11,677**	**100.00%**
Overall Denied Claims Rate	**0.26%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The MHP had a low denial rate, less than a fifth that of the statewide rate. Of the denials, four-fifths were due to late claims.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Despite the MHP's challenges in the areas of quality improvement, it has invested in the IS, and the results show in having a stable EHR environment.
- While there will be a learning curve for the staff with the implementation of the new EHR, it will bring several new capabilities that the current system lacks.

These include a PHR module, off-line data entry for staff providing services off-site and without internet connection, e-script, and further data reporting.

- In the past year, new data dashboards were created that are available to the staff and supervisors. These will transition to the new EHR once it is implemented.

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 had low CPS response rates during the COVID-19 pandemic and natural disasters.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

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

Consumer Family Member Focus Group One

CalEQRO requested diverse group of adult consumers and family members of youth who initiated services in the preceding 12 months. The focus group was held via videoconference and included one participant; No language interpreter was used for this focus group. All consumers/family members participating receive/have a family member who receives clinical services from the MHP.

No focus group summary is provided due to low participation rate.

Recommendations from focus group participants included:

- N/A

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

N/A

CONCLUSIONS

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

STRENGTHS

1. The MHP has a strong access system that ensures timely initial appointments and contributes to a penetration rate (PR) greater than the state or Small-Rural MHP average. (Access, Timeliness)
2. Last year, the MHP utilized a No Place Like Home supportive housing funding to establish a 32-unit housing unit that will open once its plumbing issues are resolved. The MHP collaborates closely with the county housing agency for housing needs of its beneficiaries. (Access)
3. The MHP has a good partnership with the Drug Court with regular attendance by a clinician and a case manager. (Access)
4. The MHP also has a strong partnership with jail-based health system and provides mental health services including medication support in the jail. (Access)
5. The MHP has started producing useful data dashboards that are easily accessible to supervisors and line staff. (Quality, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP was only able to submit the FY 2021-22 QI plan. The staffing shortage and implementing CalAIM requirements have consumed the only QI staff during the past year. There has not been any QIC meetings since April 2022. (Quality)
2. The MHP acknowledged making minimal progress in developing a medication monitoring tool and reporting on state and national quality measures related to diagnoses, medication practices, and care standards. (Quality)
3. The MHP does not track any of the FC HEDIS measures mandated by SB 1291. (Quality)
4. The MHP continues to lack two active PIPs. It is awaiting DHCS' approval for a non-clinical PIP proposal on tracking the HEDIS FUM measure. (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. Annually update the QI Plan to address the MHP's current needs. Ensure the evaluation of each QI Plan metric at least annually and reactivate the QIC through regular meetings.
2. Develop and implement a medication monitoring tool, utilizing contracts with subject matter experts as appropriate. Track, trend and report out at least quarterly complying with HEDIS and other national and/or state quality measures related to diagnoses, medication practices, and care standards. (This recommendation is a carry-over from FY 2021-22.)
3. Track and trend the FC HEDIS measures as mandated by SB 1291. Utilize TA from CalEQRO and DHCS as needed. (Quality)
4. Identify subject, design, develop and implement two active PIPs utilizing CalEQRO TA on a regular basis throughout the year. (This recommendation is a carry-over from FY 2021-22.)

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, a California public health emergency (PHE) was in place until February 28, 2023 and a national PHE is scheduled to end May 11, 2023. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

CalEQRO was unable to summarize beneficiary focus group findings due to low attendance.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Plumas MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
PIP Validation and Analysis
Performance Measure Validation and Analysis
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Satisfaction
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Information Systems Billing and Fiscal Interview
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Saumitra SenGupta, PhD, Lead Quality and IS Reviewer
Christin Zamora, CFM Reviewer
Samantha Fusselman, LCSW, CPHQ, Executive Director
Leah Hanzlicek, MSW, PhD, IS Reviewer Supervisor

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

MHP County Sites

All sessions were held via video conference.

MHP Contract Provider Sites

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
Hardee	Kyle	Administrative Services Officer	Plumas County Behavioral Health (PCBH)
Kristy	Pierson	MHSA Coordinator	PCBH
McGill	Jessica	Quality Assurance and Compliance Manager	PCBH
Nielson	Anne	Care Coordinator	PCBH
Sanderson	Gary	Case Manager	PCBH
Schopplein	Samuel	Systems Analyst	PCBH
Schwartz	Kathleen	Unit Supervisor	PCBH
Sousa	Sharon	Interim Director	PCBH
Ward	Matt	Case Manager	PCBH

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 did not submit a Clinical PIP

General PIP Information
MHP/DMC-ODS Name:
PIP Title:
PIP Aim Statement:
Date Started:
Date Completed:
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify):
Improvement Strategies or Interventions (Changes in the PIP)

General PIP Information
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Click or tap here to enter text.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Click or tap here to enter text.

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

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

PIP Validation Information

Was the PIP validated? ☐ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant parts 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:

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The MHP submitted a copy of its proposed non-clinical PIP on HEDIS FUM measure. It was awaiting DHCS' approval at the time of the review. Based on this submission, CalEQRO determined this PIP to be in the planning phase.
General PIP Information	
MHP/DMC-ODS Name: Plumas MHP	
PIP Title: Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	
PIP Aim Statement: Based on the following statistics: Plumas County residents who utilize ED for mental health related services are experiencing a delay in accessing outpatient services. In 2021, only 31 percent of ED visits for mental health symptoms were followed by connection to MHP Services within 7 days and 60 percent within 30 days, which are well below State and National benchmarks, 49 percent and 40 percent within 7 days; and 61 percent and 54 percent within 30 days; for Medi-Cal beneficiaries with ED visits for mental health conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023.	
Date Started: N/A	
Date Completed: N/A	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☒ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): Medi-Cal beneficiaries in Plumas County who present at the ED with mental health symptoms.
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): Critical Time Intervention, Behavioral Intervention
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Advanced Care Coordination
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): Collaborative Care, Better Data Exchange with ED and MCP.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of ED visits for MH where the client received a follow up MH treatment service from the MHP within 7 days.	2021	Sample size not reported. 31%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of ED visits for MH where the client received a follow up MH treatment service from the MHP within 30 days.	2021	Sample size not reported. 60%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

PIP Validation Information
EQRO recommendations for improvement of PIP: Define the PIP variables better. Seek TA from CalEQRO as needed.

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

PLUMAS COUNTY BEHAVIORAL HEALTH SERVICES
270 County Hospital Road, #109 Quincy, CA 95971
Phone: (530) 283-6307 FAX: (530) 283-6045
Sharon Sousa, LMFT, Interim Director

April 19th, 2023

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

Dear Samantha,
Plumas MHP is requesting flexibility during the FY 2022-23 EQRO review. Specifically, Plumas MHP was not able to present both a clinical and non-clinical Performance Improvement Project (PIP) during the FY 2022-23 review due to the following:

- ☒ Lack of staff/resources
- ☒ Lack of infrastructure
- ☒ Natural Disasters
- ☐ Additional factors (Please specify):

Plumas MHP was able to provide an outline of the non-clinical PIP proposal submitted to DHCS for approval.

In addition, we understand that the consumer/family member focus group was attended by less than three individuals and therefore a summary will not be included in the EQRO report. Plumas staff worked hard to secure better attendance, but various barriers related to recent natural disasters likely contributed to the lack of attendance.

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

Sincerely,

Sharon R. Sousa, LMFT

Sharon Sousa
LMFT, Interim Director
Plumas County Behavioral Health