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FY 2023-24
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

PLUMAS FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

April 23,2024

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EXECUTIVE SUMMARY

Highlights from the fiscal year (FY) 2023-24 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.

MHP INFORMATION

Review Type — Virtual

Date of Review — April 23,2024

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 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
4	1	3	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	5	1	0
Quality of Care	10	4	2	4
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**18**	**4**	**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	02/2023	Implementation	Low Confidence

Table D: Summary of Plan Member/Family Focus Groups

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

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP prioritizes timely access to its services and ensures at least weekly follow-up for new members.
- The MHP has developed a comprehensive Level of Care (LOC) tool that the clinical staff have started using for assigning appropriate combination of services and transitioning to other levels of care as needed.
- The MHP has developed strong partnerships with a number of other agencies to improve access and quality of care.
- The MHP has maintained a less than one percent Medi-Cal claim denial rate throughout CY 2022.
- The MHP pays attention to the locally relevant cultural factors such as poverty, rural living, isolated communities in addition to demographic-based ones.

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

- The MHP has not yet been able to fully develop its medication monitoring protocol including the relevant national and state measures related to diagnosis, medication practices and care standards.

- The MHP has not been able to complete its tracking of FC HEDIS measures.
- The MHP lacked a clinical PIP for this year's EQR.
- The MHP lacks any designated peer positions for individuals with lived experience. It cited fiscal constraints in creating and maintaining such positions.
- Due to the new EHR implementation, the MHP's tracking of urgent appointment timeliness appears incomplete.

Recommendations for improvement based upon this review include:

- Complete developing a medication monitoring tool that conforms to national and state standards.

  (This recommendation is a carry-over since FY 2021-22.)
- Establish tracking mechanisms for FC Healthcare Effectiveness Data and Information Set (HEDIS) measures.

  (This recommendation is a carry-over since FY 2021-22.)
- Implement a clinical PIP and continue the implementation of the non-clinical PIP on FUM.

  (This recommendation is a carry-over since FY 2021-22.)
- Further explore the possibilities of establishing peer positions, including navigator and volunteer ones, even if certification is not possible at this time.
- Ensure that the timeliness data for urgent appointments is fully captured and reported.

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 February 2023.

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 members 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 members.

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, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2023-24 findings of the EQR for Plumas County MHP by BHC, conducted as a virtual review on April 23,2024.

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, members, 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.

CalEQRO reviews are retrospective; therefore, county documentation that is requested for this review covers the time frame since the prior review. Additionally, the Medi-Cal approved claims data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and the Inpatient Consolidation (IPC) File. PMs calculated by CalEQRO cover services for approved claims for calendar year (CY) 2022 as adjudicated by DHCS by April 2023. Several measures display a three-year trend from CY 2020 to CY 2022.

As part of the pre-review process, each MHP is provided a description of the source of the Medi-Cal approved claims data and four summary reports of this data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT); FC; transition aged 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 2022-23 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 member 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) – summary of the 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, and also as outlined DHCS's Comprehensive Quality Strategy.
- 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 members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- 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, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding penetration rate (PR) percentages.

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 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

The MHP had a significant challenge with one of the main roads, Highway 70, being closed most of the year. As a result, the MHP had reduced access to care for members and it was also difficult for staff to get to work. This resulted in one psychiatrist leaving due to the long commute. The geographic area has also experienced a diminishing affordable housing stock for both members and employees. This has made it an even greater challenge to hire and retain staff.

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 Plumas County Behavioral Health (PCBH) now has a permanent director who transitioned from her acting role in August 2023.
- A new electronic health record (EHR) system, Credible, was implemented on July 1, 2023, with the support of the MHP's application service provider (ASP), Kings View.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 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 not addressed may be presented as a recommendation again for this review. However, if the MHP has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 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.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP updated its QI Plan for FY 2023-24 and evaluated its performance. From the current FY, the MHP is preparing to move to a CY-based plan that will encompass the Drug Medi-Cal measures and efforts.

Recommendation 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.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has been able to contract with a psychiatrist to address this recommendation. This psychiatrist has started working on medication monitoring protocol and independent practice review protocols.
- This recommendation will be carried over this year.

Recommendation 3: Track and trend the FC Healthcare Effectiveness Data and Information Set (HEDIS) measures as mandated by SB 1291. Utilize TA from CalEQRO and DHCS as needed.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- A nurse has been assigned to work with the new contracted psychiatrist to start working on this recommendation.
- The MHP purchased and implemented dash boards with the support of Kings View. With the support of Kings View, the MHP continues to formulate processes and reports in order to monitor SB 1291 youth.
- This recommendation will be carried over this year.

Recommendation 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.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP did not submit a clinical PIP. It is currently working on identifying a clinical PIP topic.
- The MHP submitted a non-clinical PIP that is in the implementation phase.
- This recommendation will be carried over this year.

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 members) 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 members 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 members 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 83 percent of services were delivered by county-operated/staffed clinics and sites, and 17 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 88 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff during business hours. For after hours, weekends, and holidays, the MHP contracts with an answering service. However, the MHP maintains 5150 evaluation capacity 24/7. Members may request services through the Access Line as well as through walk-in at the main clinic in Quincy and the wellness centers. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. For regular services, case managers use the State screening tool to see if the caller is eligible for SMHS. If not, they are referred to Partnership Health Plan (PHP), the new managed care plan (MCP) in the county. If eligible for SMHS, then the utilization review committee assigns the member to therapists. The therapist does the assessment and continues the therapy.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 172 adults, 70 youth, and 18 older adults across four county operated sites and one contractor-operated site. Among those served, no members received telehealth services in a language other than English.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

In December 2022, DHCS issued its FY 2022-23 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 MH 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 2022-23

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

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

Table 1B: MHP Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No

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

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to members 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 member 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 Member Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- The MHP prioritizes access to its services despite a continuing shortage of clinical staff. Members new to mental health services are routinely scheduled for once-a-week appointments with their therapists until it is determined that they can transition to less frequent services. For targeted case management (TCM), the members are assigned a case manager from the beginning.
- The MHP has strong partnerships with various agencies that also touch the lives of the Plan members. In addition to the services with Drug Medi-Cal being integrated, the MHP specifically evidenced strong partnerships with the schools, Child Welfare Services, criminal justice, faith-based entities, housing, and the MCP.
- To address its clinical staff shortage, the MHP contracts with Chico State University to attract practicum students. In addition, the MHP director has asked for a wage study and is revising the job descriptions in order to bring the county closer to other similar counties in California.
- Challenges in access to services arise if there are requests for specific type of providers, e.g., female or in-person therapy. The overall capacity is managed despite the staff shortage, partly through telehealth.

ACCESS PERFORMANCE MEASURES

MEMBERS SERVED, PENETRATION RATES, AND AVERAGE APPROVED CLAIMS PER MEMBER SERVED

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

The PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served

(receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar-size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, it appears that access to services is easier in Plumas as compared to the state as a whole.

Table 3: Plumas MHP Annual Members Served and Total Approved Claims, CY 2020-22

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	6,988	527	7.54%	$3,122,369	$5,925
CY 2021	6,884	531	7.71%	$4,681,663	$8,817
CY 2020	6,580	497	7.55%	$4,865,173	$9,789

Note: Total annual eligibles in Tables 3 and 4 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The number of eligibles increased from the prior year, while the number of members served decreased slightly from the previous year.
- This resulted in the MHP's overall PR decreasing from the previous year (7.71 percent to 7.54 percent), as did total approved claims and AACM.

Table 4: Plumas County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	639	11	1.72%	1.63%	1.82%
Ages 6-17	1,439	200	13.90%	8.62%	5.65%
Ages 18-20	306	22	7.19%	6.55%	3.97%
Ages 21-64	3,822	269	7.04%	7.37%	4.03%
Ages 65+	783	25	3.19%	3.60%	1.86%
Total	**6,988**	**527**	**7.54%**	**6.67%**	**3.96%**

Note: Total annual eligibles in Tables 3 and 4 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The MHP's overall PR was higher than similar-sized counties and nearly double the statewide PR. It ranked fourth among the 56 MHPs in PR in CY 2022.
- The MHP's PR is higher than statewide in all age groups over 5, with the largest gap seen in ages 6-17 where the MHP's PR is more than twice the statewide PR. With the exception of this age group, the MHP's PR resembles the other similar-sized counties' average PR.

Table 5: Threshold Language of Plumas MHP Medi-Cal Members Served in CY 2022

Threshold Language	# of Members Served	% of Members Served
No threshold language	N/A	N/A
Threshold language source: Open Data per BHIN 20-070		

- There were no threshold languages in the MHP for CY 2022.

Table 6: Plumas MHP Medi-Cal Expansion (ACA) PR and AACM, CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	2,303	144	6.25%	$696,816	$4,839
Small-Rural	38,250	2,337	6.11%	$11,818,209	$5,057
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This was consistent with that seen in the MHP.
- The ACA eligibles increased from the prior year; however, the number of members served and the PR decreased. A decrease in the AACM was also seen in CY 2022.
- Though lower than its overall AACM, Plumas PR for the ACA eligible populations was higher than that of other small-rural counties and statewide averages.

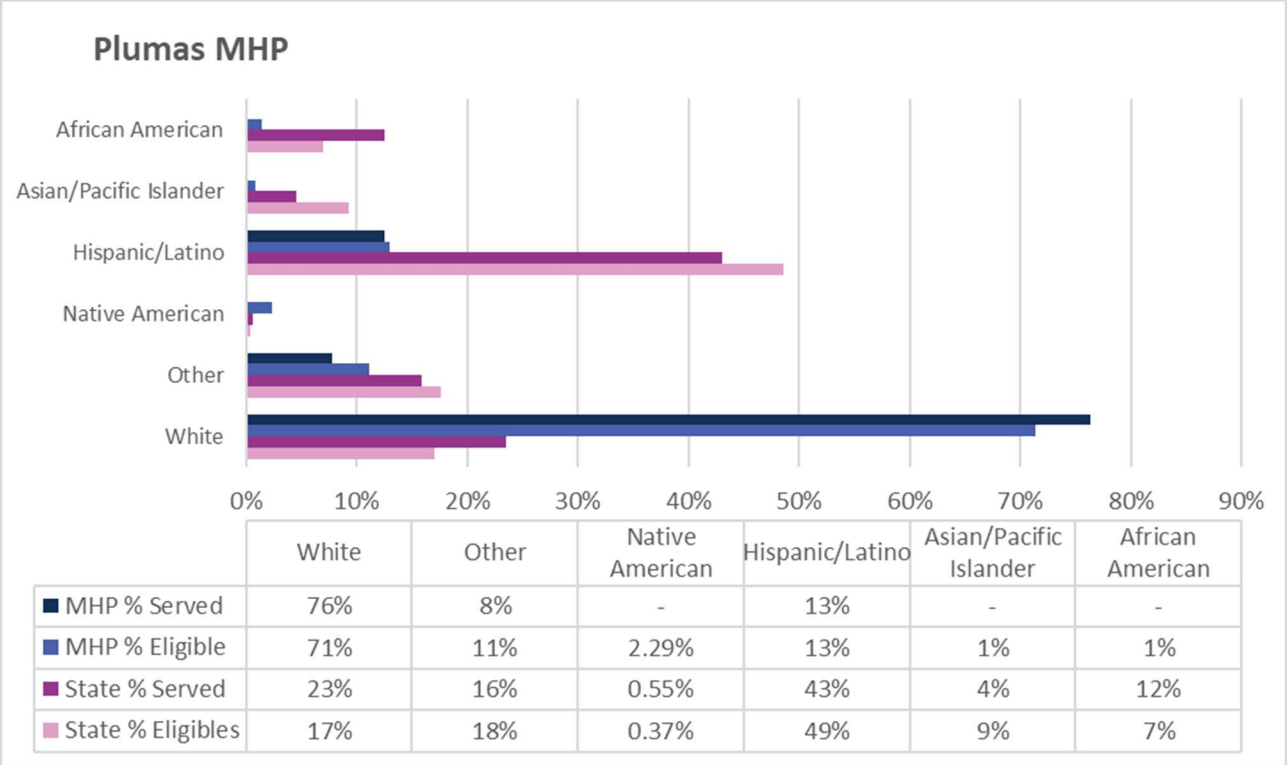
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total members served. Table 7 and Figures 1-9 compare the MHP's data with MHPs of similar size and the statewide average.

Table 7: Plumas MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	97	<11	-	7.08%
Asian/Pacific Islander	60	<11	-	1.91%
Hispanic/Latino	909	66	7.26%	3.51%
Native American	160	<11	-	5.94%
Other	779	41	5.26%	3.57%
White	4,986	402	8.06%	5.45%

- Plumas County's Medi-Cal eligible population is predominantly White, accounting for 71 percent of the total eligibles, and 76 percent of those served. Hispanic/Latino and Other members account for 24 percent of the eligibles combined.
- While the Hispanic/Latino PR is 10 percent lower than the White PR, it is almost 52 percent higher than the corresponding statewide PR.
- All other races/ethnicities saw a decrease in PR, with the largest decrease being seen for the Native American. However, because a significant number of Native Americans receive services through the Indian Health Service, the MHP serves a low number of individuals and slight variations in numbers served can make big changes in the Native American PR. This number is not displayed due to the small numbers served, as is the case for African American and Asian/Pacific Islander members served.

Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022

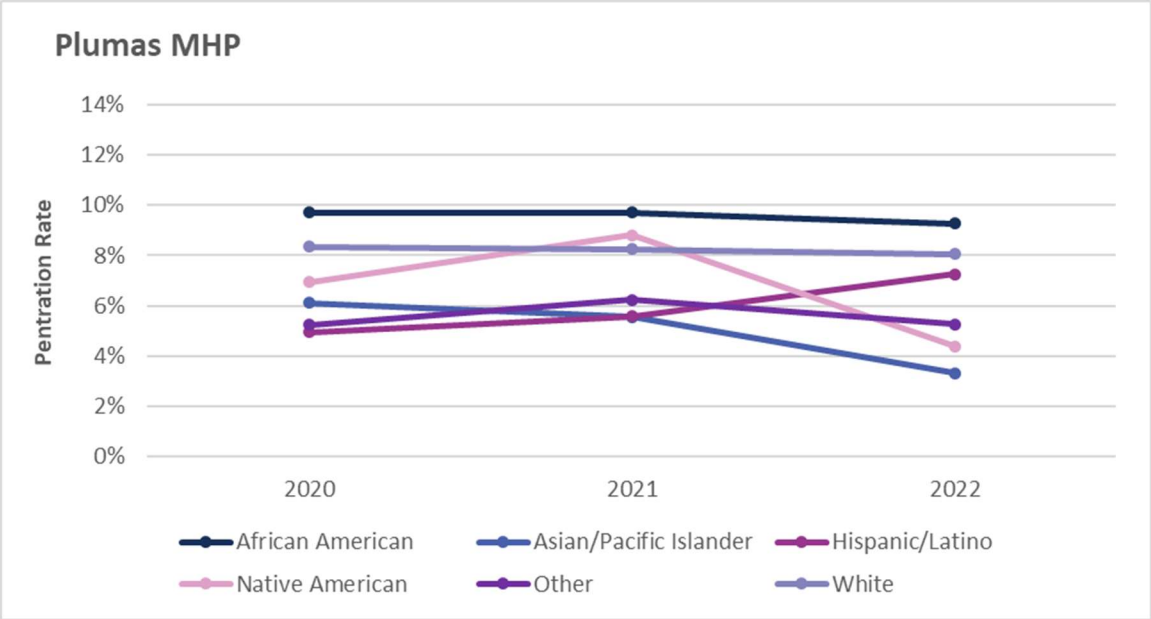


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	76%	8%	-	13%	-	-
MHP % Eligible	71%	11%	2.29%	13%	1%	1%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- The percentages of White Medi-Cal eligibles and members served are both three times the corresponding statewide percentages. The Hispanic/Latino percentages are less than a quarter of the corresponding statewide percentages.
- White members are slightly proportionally overrepresented in the MHP.

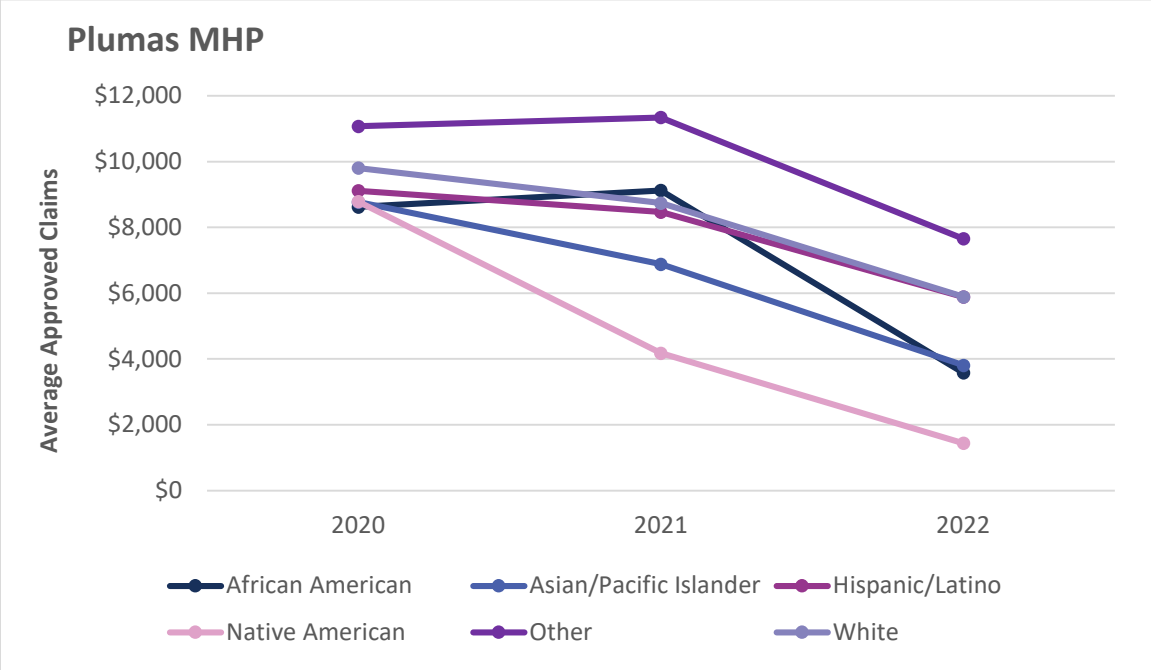
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

Figure 2: MHP PR by Race/Ethnicity, CY 2020-22



- The Hispanic/Latino PR had a notable increase this past CY, going from 5.59 percent to 7.26 percent between CY 2020-22.

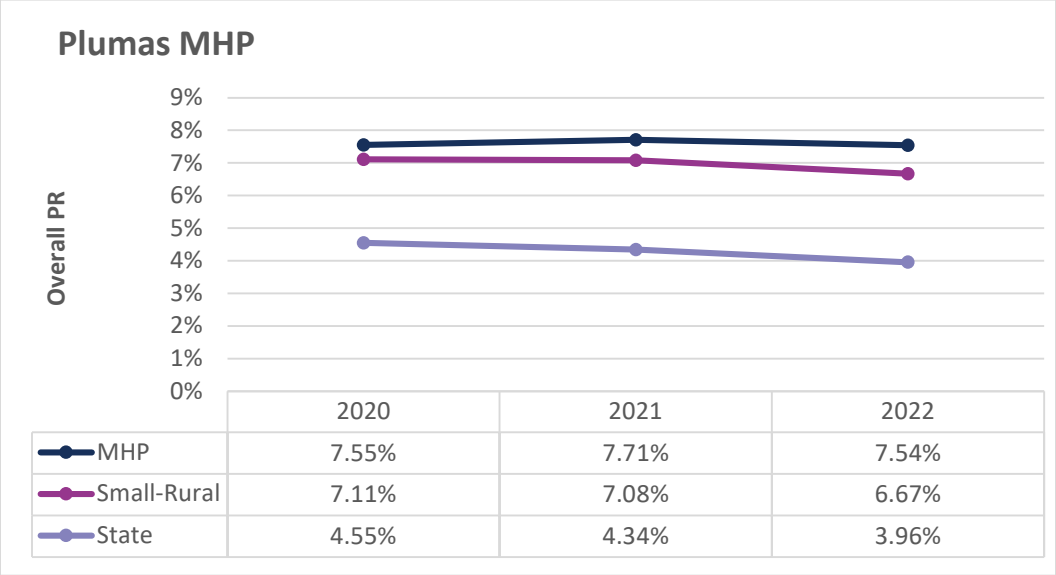
Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22



- The AACM has decreased from CY 2021 to CY 2022 across all racial/ethnic categories.

- The Other racial/ethnic group has consistently had the highest AACMs over the past three CYs, whereas the Native American group remained one of lowest.

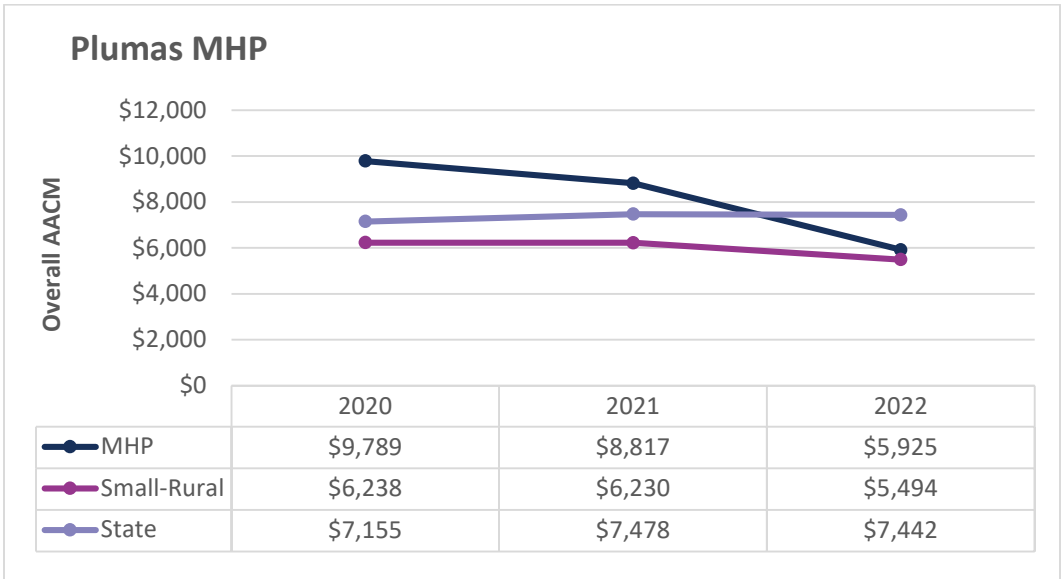
Figure 4: Overall PR CY, 2020-22



	2020	2021	2022
MHP	7.55%	7.71%	7.54%
Small-Rural	7.11%	7.08%	6.67%
State	4.55%	4.34%	3.96%

- The overall PR decreased very slightly in CY 2022 from the prior year; however, the MHP has consistently maintained a higher PR than other small-rural MHPs and statewide for the last three CYs.

Figure 5: Overall AACM, CY 2020-22

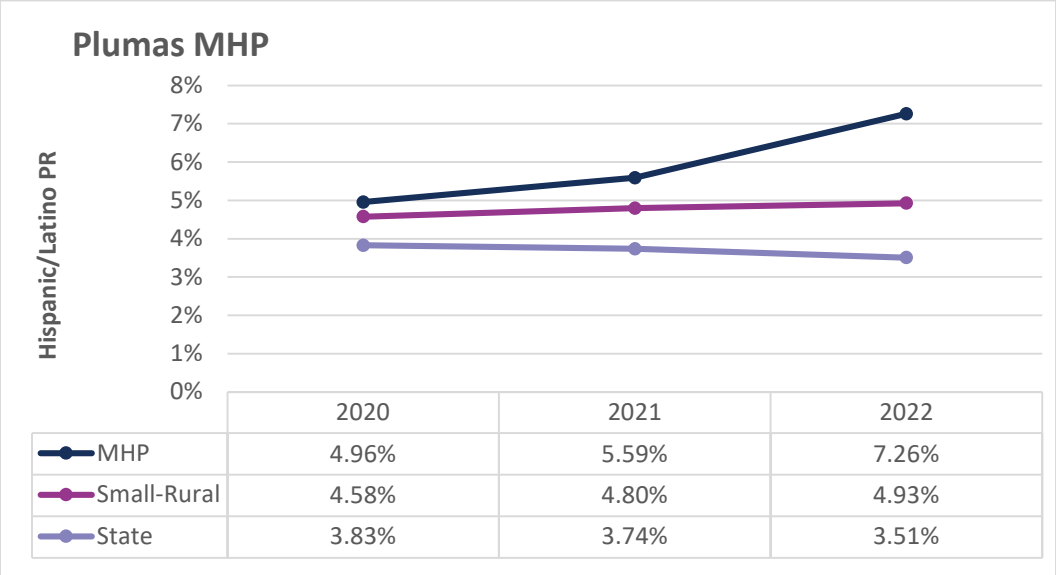


	2020	2021	2022
MHP	$9,789	$8,817	$5,925
Small-Rural	$6,238	$6,230	$5,494
State	$7,155	$7,478	$7,442

- The overall AACM decreased from CY 2020 to CY 2022.

- AACM in the MHP has consistently exceeded the AACM in other small-rural counties and statewide until CY 2022 when it was only slightly higher than other small-rural counties and was lower than statewide.

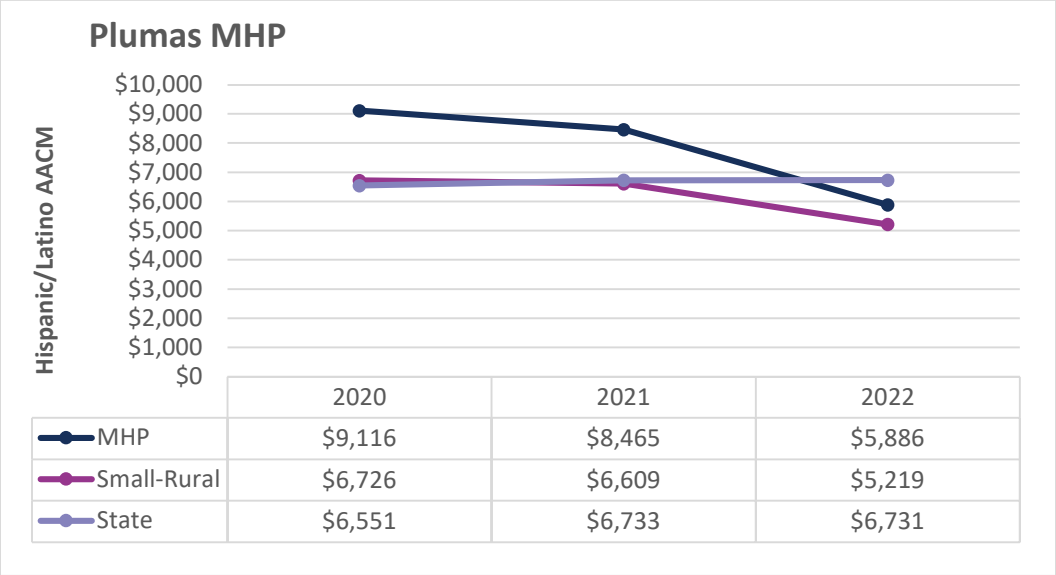
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	4.96%	5.59%	7.26%
Small-Rural	4.58%	4.80%	4.93%
State	3.83%	3.74%	3.51%

- The MHP's Hispanic/Latino PR increased in CY 2022. The MHP's Hispanic/Latino PR has been consistently higher than other small-rural counties and statewide.

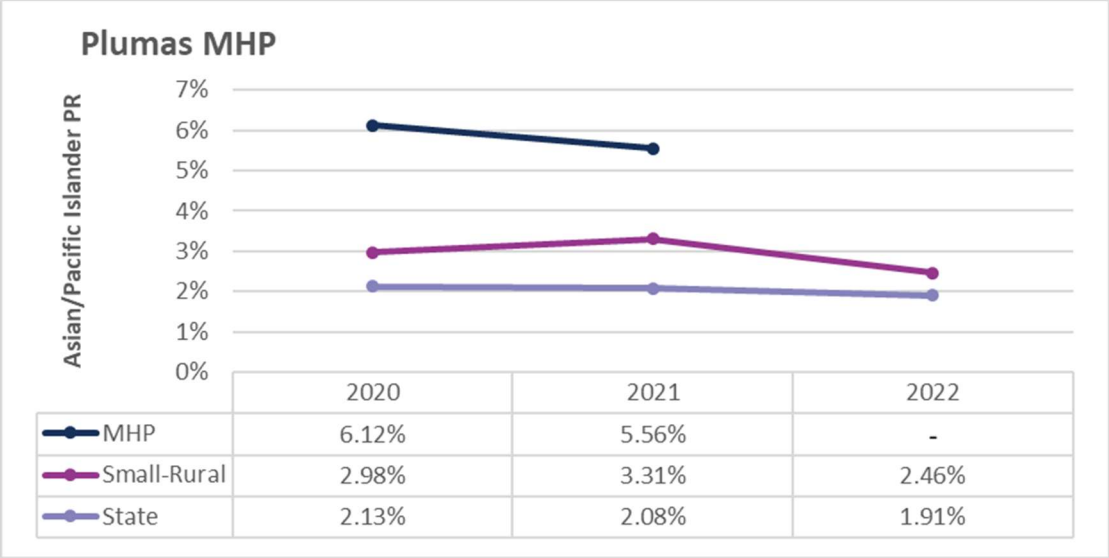
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$9,116	$8,465	$5,886
Small-Rural	$6,726	$6,609	$5,219
State	$6,551	$6,733	$6,731

- The MHP's Hispanic/Latino AACM decreased approximately 35 percent between CY 2020-22. However, the AACM is consistently higher than small-rural counties.

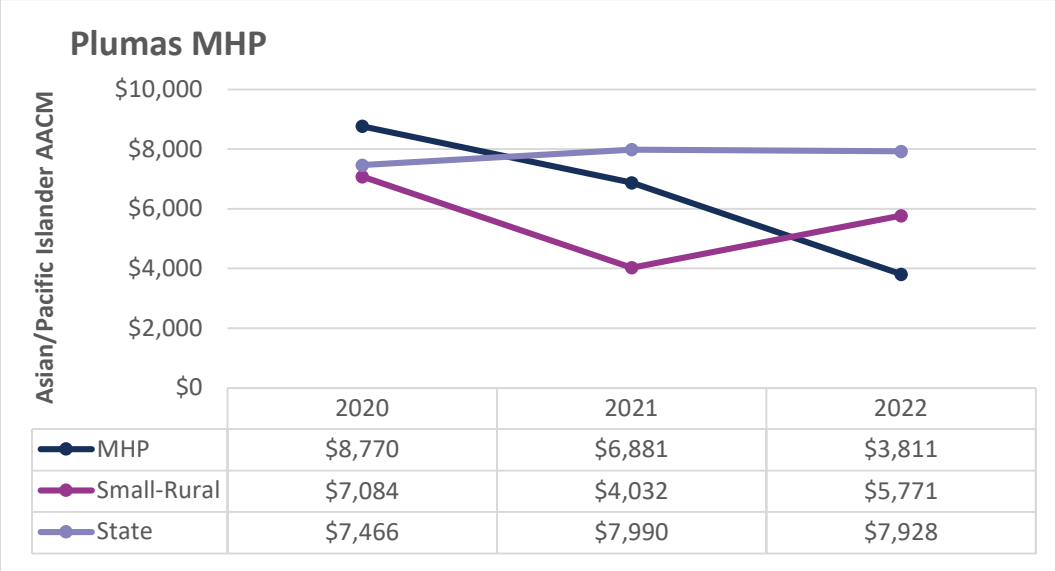
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	6.12%	5.56%	-
Small-Rural	2.98%	3.31%	2.46%
State	2.13%	2.08%	1.91%

- The MHP's Asian/Pacific Islander PR was suppressed due to the low numbers of those served in CY 2022.

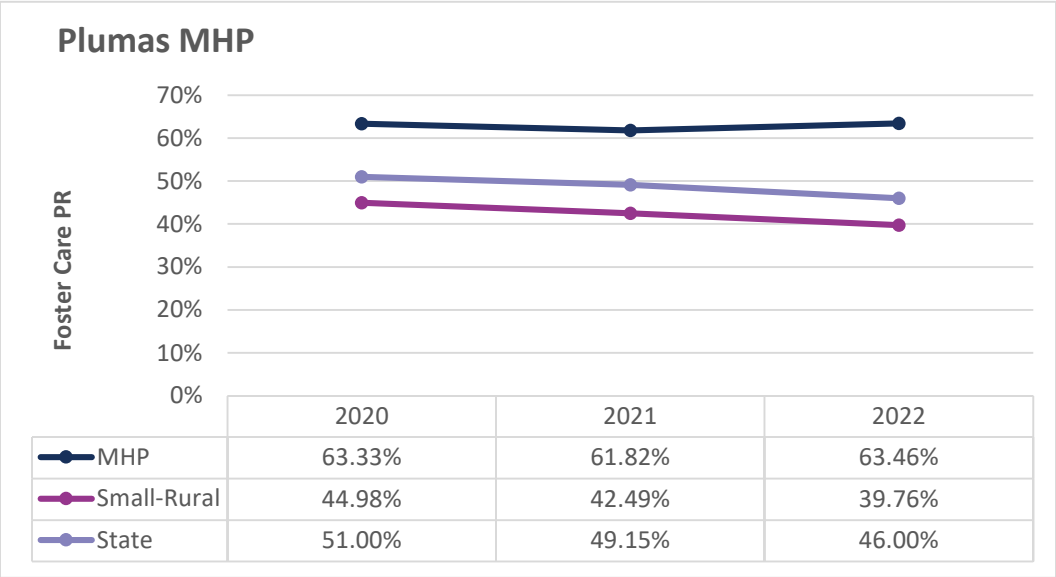
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$8,770	$6,881	$3,811
Small-Rural	$7,084	$4,032	$5,771
State	$7,466	$7,990	$7,928

- The MHP's Asian/Pacific Islander AACM declined sharply between CY 2019-22; however, it was based on exceptionally low count and therefore the average could be reflective of the impact of outliers.

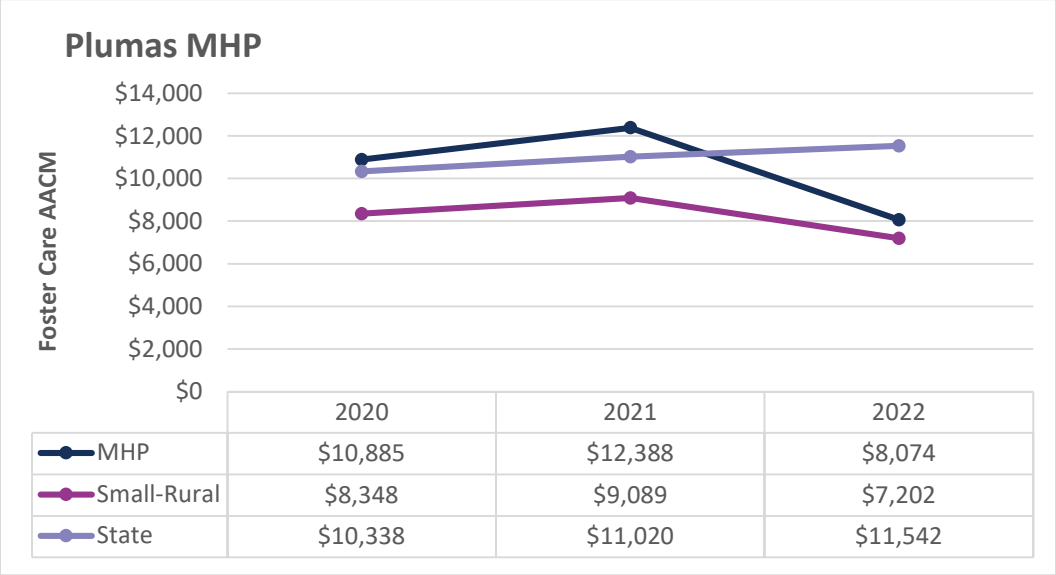
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	63.33%	61.82%	63.46%
Small-Rural	44.98%	42.49%	39.76%
State	51.00%	49.15%	46.00%

- Statewide FC PR has remained steady at greater than 60 percent for the three CYs displayed. The MHP's FC PR went up between CYs 2020-22 and was higher than the small-rural PR and that seen statewide.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$10,885	$12,388	$8,074
Small-Rural	$8,348	$9,089	$7,202
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years.
- Plumas FC AACM sharply decreased in 2022 from 2021. The MHP's FC AACM was higher however than other small-rural counties.

UNITS OF SERVICE DELIVERED TO ADULTS AND FOSTER YOUTH

Table 8: Services Delivered by the Plumas MHP to Adults, CY 2022

Service Category	MHP N = 316				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	6	6	10.3%	14	8
Inpatient Admin	0	0.0%	0	0	0.4%	26	10
Psychiatric Health Facility	<11	-	25	17	1.2%	16	8
Residential	0	0.0%	0	0	0.3%	114	84
Crisis Residential	0	0.0%	0	0	1.9%	23	15
Per Minute Services							
Crisis Stabilization	<11	-	1,650	1,650	13.4%	1,449	1,200
Crisis Intervention	25	7.9%	101	47	12.2%	236	144
Medication Support	89	28.2%	271	143	59.7%	298	190
Mental Health Services	246	77.8%	1,104	376	62.7%	832	329
Targeted Case Management	199	63.0%	166	64	36.9%	445	135

- Significantly fewer adults were hospitalized compared to statewide.
- The MHP provided much less medication support, less than half, than statewide but exceeded statewide utilization rates in mental health services (MHS) and TCM.

Table 9: Services Delivered by the MHP to Plumas MHP Youth in Foster Care, CY 2022

Service Category	MHP N = 33				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	0	0.0%	0	0	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	0	0.0%	0	0	3.1%	1,166	1,095
Crisis Intervention	<11	-	50	50	8.5%	371	182
Medication Support	<11	-	405	333	27.6%	364	257
TBS	0	0.0%	0	0	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	<11	-	1,103	740	40.8%	1,458	441
Intensive Home-Based Services	<11	-	809	809	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	32	97.0%	1,268	554	95.4%	1,846	1,053
Targeted Case Management	<11	-	278	49	35.8%	307	118

- The MHP provided more MHS to the percentage of FC members served than statewide.
- Fewer FC youth received intensive care coordination (ICC) and intensive home-based services (IHBS) than statewide. Those served also received fewer units of service.

IMPACT OF ACCESS FINDINGS

- The MHP prioritizes access to care for its members. This was evident throughout the review and the access related PMs.
- The MHP has developed particularly solid partnerships with various other agencies and organizations that touch the service delivery system for its members. This contributes to better access and coordination of care.
- FC members account for a small percentage of services provided by the MHP. Although the MHP maintains very collaborative processes with the County Human Services, it reported that like the MHP, the Human Services have also struggled with staff shortages post-pandemic and natural disasters from prior years.
- Low utilization of ICC and IHBS suggest that the implementation of Pathways to Well-Being should be examined.

TIMELINESS OF CARE

The amount of time it takes for members 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 members. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved member 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	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- The MHP offers very timely first appointment as well as follow-up appointments to members new to its services. In FY 2022-23, it reported an average of three

days for the first offered appointment, which met the 10-day standard 96 percent of the time.

- The MHP also reported more children than adults for the first offered appointment metric. They stated that this trend has emerged since they implemented the state-mandated initial screening tool. More adults appear to be screened out now than children.
- The MHP reported an average of three days for the first offered psychiatry appointments and met the 15-day standard 100 percent of the time.
- The MHP's urgent appointment data appears to be incomplete. One possible reason cited was the implementation of the new EHR during which the urgent appointments may not have been fully identified and tracked in the system.
- The MHP does not have a no-show rate standard, but at this time a standard does not seem necessary because of the MHP's quick rescheduling practices in place for missed appointments and low no-show rates. The MHP also has a robust appointment reminder process in place.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access (ATA) 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 2023-24 EQR, the MHP reported in its submission of the ATA, representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care. It appears the MHP reported averages and ranges in calendar days, rather than business days, though they acknowledge the timeliness standards are identified in business day units.

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

Table 11: FY 2023-24 Plumas MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	3 Calendar Days	10 Business Days*	95.7%
First Non-Urgent Service Rendered	6 Calendar Days	10 Business Days**	84%
First Non-Urgent Psychiatry Appointment Offered	3 Calendar Days	15 Business Days*	100%
First Non-Urgent Psychiatry Service Rendered	8 Calendar Days	15 Business Days**	95%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	11 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	5 Calendar Days	7 Calendar Days	87.5%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	5 Calendar Days	30 Calendar Days	100%
No-Show Rate – Psychiatry	5%	***	n/a
No-Show Rate – Clinicians	7%	***	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033

** MHP-defined timeliness standards

*** The MHP does not have a standard for no-show rates.

For the FY 2023-24 EQR, the MHP reported its performance for the following time period:

FY 2022-23

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

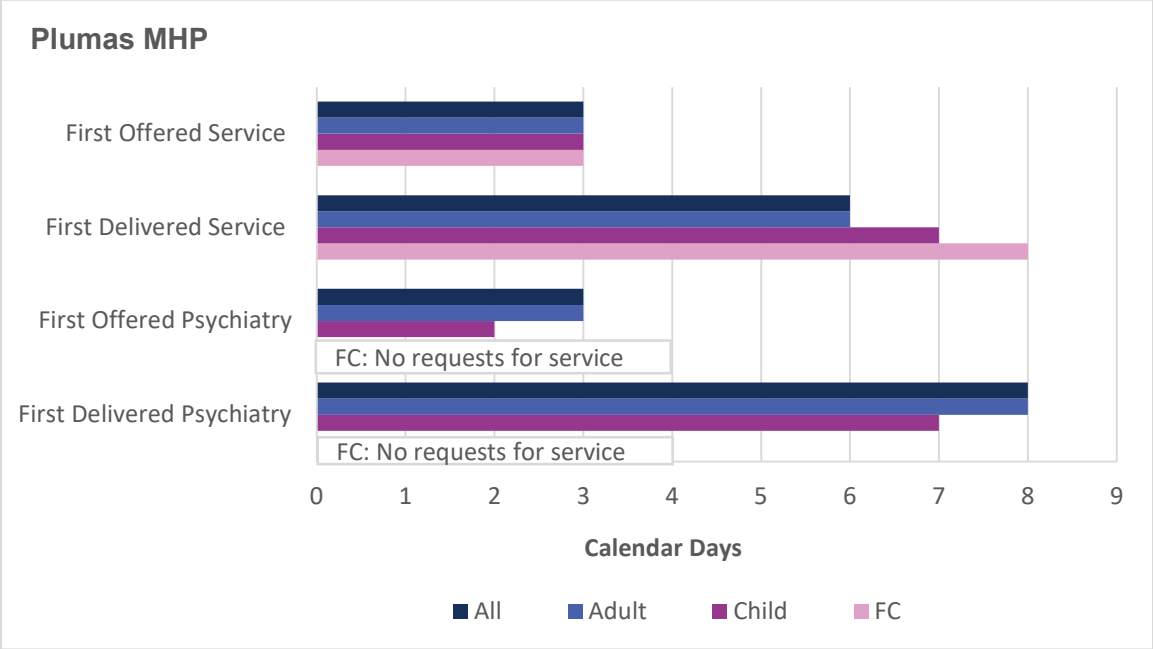


Figure 13: Wait Times for Urgent Services

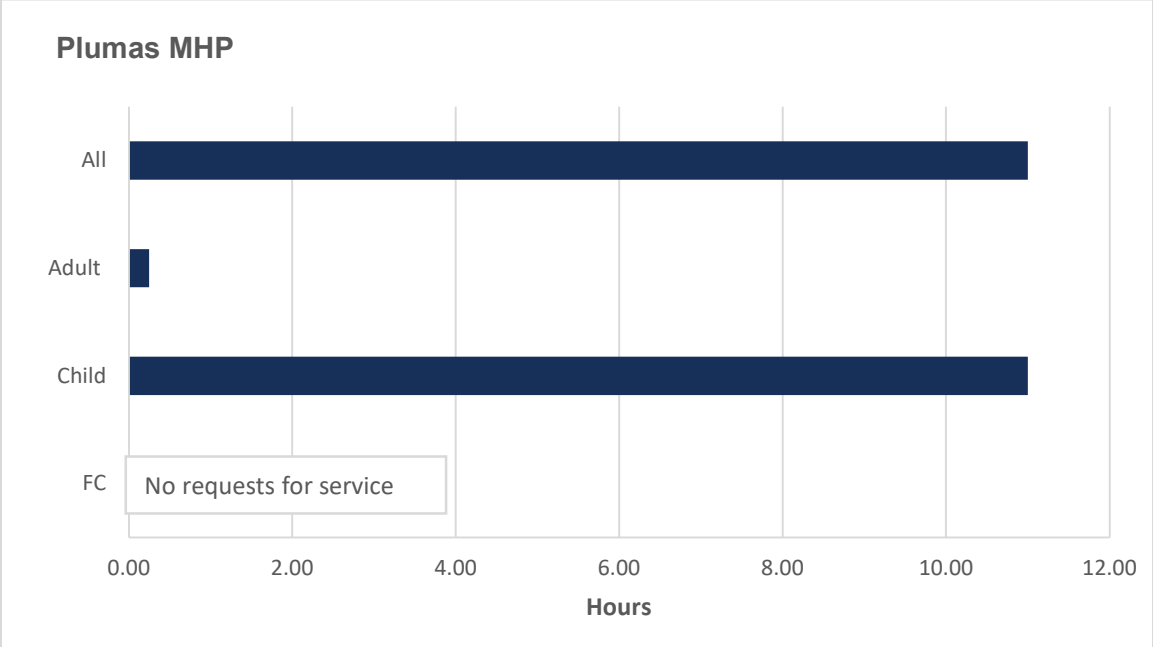
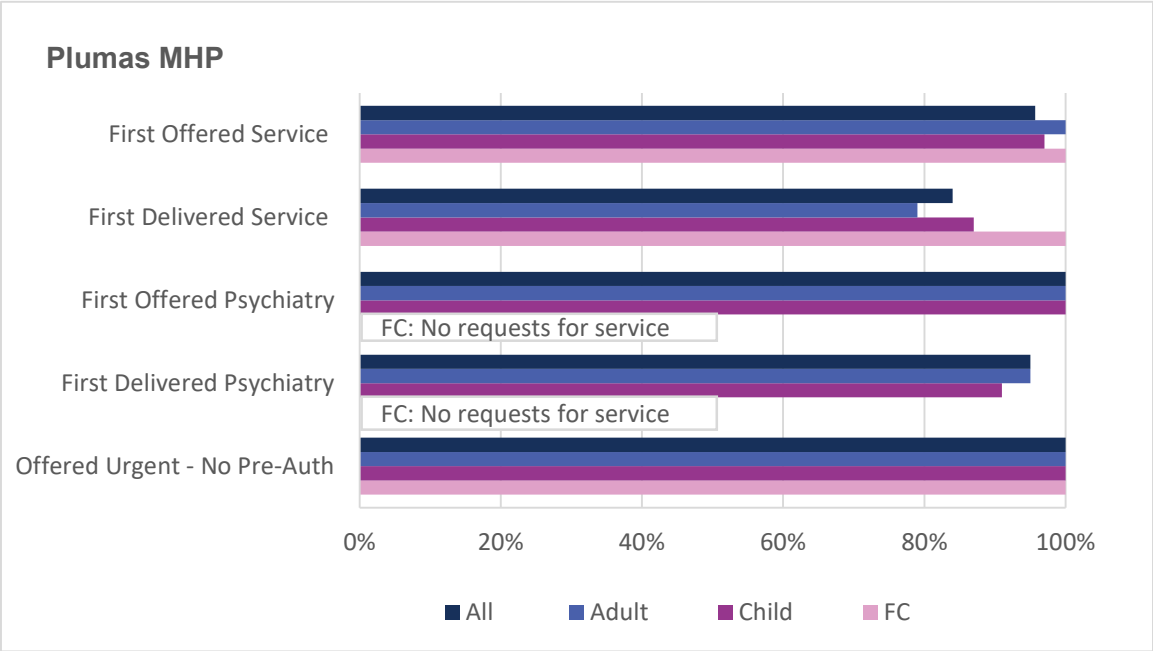


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide 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 and unscheduled/walk-in assessments.
- The MHP defined “urgent services” for purposes of the ATA as that provided to individuals at risk of decompensating into an emergency requiring psychiatric evaluation. There were reportedly seven urgent service requests with a reported actual wait time until services for the overall population of 11 hours. The MHP does not require pre-authorization for any conditions that are deemed urgent.
- The MHP defines timeliness to first delivered/rendered psychiatry services as the time it takes from date of the member’s first request for psychiatrist appointment or clinician’s determination of such needs to the first offered or first delivered prescriber appointment date.
- The MHP does track and monitor data for no-shows for both clinician and psychiatrist appointments. It reported a no-show rate of 5 percent for psychiatry appointments and 7 percent for other clinicians.
- For the metrics measured in days, the MHP tracks them by calendar days, not business days.

IMPACT OF TIMELINESS FINDINGS

- For almost all initial requests, the MHP offers and schedules the first appointment for a full assessment following screening for SMHS qualifications in a very timely manner. This is true for both clinician and psychiatrist appointments.
- The MHP prioritizes follow-up services for inpatient-discharged members and, in most cases, provides it within five days.
- The MHP appears to have more children accounting for initial appointments than adults. This needs further examination to identify possible causes and whether actions are warranted to improve adult access.
- The MHP appears to have underreported the data on urgent appointments. Although this is likely due to technical challenges arising from the new EHR implementation, it should be examined for any other potential causes such as not identifying clinically urgent issues.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the members 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 members. 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 with its Quality Improvement and Compliance Program (QICP). The Quality Assurance and Compliance Manager (QACM) oversees the QICP for the entire behavioral health, including Drug Medi-Cal.

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 is scheduled to meet quarterly and the MHP QIC met three times since the last EQR. It is comprised of PCBH employees, Behavioral Health Board members, contract providers, and the Patient Rights Advocate. Of the 16 identified FY 2023-24 QAPI workplan goals comprising of 51 indicators, the MHP reported meeting 68.6 percent of the indicators, with most of the rest being either incomplete or on hold at the time of this review, and 4 percent being not met. The reasons cited for the ones incomplete or on hold include EHR implementation, CalAIM related changes, and other system or environmental challenges.

The MHP utilizes the following level of care (LOC) tools: The MHP uses CANS in the children's system of care. For the adults, MHP has developed a detailed LOC guide based on presenting symptoms, severity, clinical assessment, and other factors to determine the best placement and movement between LOC.

The MHP utilizes the following outcomes tools: The MHP uses CANS, PHQ-9, and GAD-7 for tracking member progress and outcomes.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Not Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Partially Met
3H	Utilizes Information from Member Satisfaction Surveys	Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Not Met
3J	Member and Member Employment in Key Roles throughout the System	Not Met

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

- During the previous year's EQR, the MHP lacked a current QAPI. The MHP has since developed a comprehensive, current QAPI. It continually monitors the QAPI indicators and the evaluation it presented for this year's EQR contains the summary of progress on each indicator to date for the current year QAPI. Accordingly, there is no evaluation of a prior year QAPI.
- The MHP's ASP, Kings View, produces many of the data reports needed for QI purposes.
- The MHP uses various means to communicate with and elicit feedback from various stakeholders. In addition to posters and flyers at clinic and wellness center locations, an easy-to-navigate website, and stakeholders can provide input through the Behavioral Health Commission meetings and the Mental Health Services Act planning meetings.
- The MHP has developed a new LOC tool that is now used by the clinicians in the adult system of care. This tool is embedded in the new EHR. At the time of this EQR, the MHP had not yet progressed to summarizing aggregate reports based on this tool.

- In the past year, the MHP has contracted with a psychiatrist and a psychiatric nurse to work on developing a medication monitoring tool as well as the mechanism for tracking the relevant HEDIS measures.
- The wellness centers are run by the MHP staff and the centers also act as community centers open to the public. The Chester location also provides some produce and canned food. These centers have also provided pivotal services during natural disasters. The MHP offers some groups at the Quincy Wellness Center and Seeking Safety training at the Chester location. None of these centers have any peer employees with lived experience.
- The MHP does not track or trend the SB 1291 HEDIS measures as required by WIC Section 14717.5 at this time.

QUALITY PERFORMANCE MEASURES

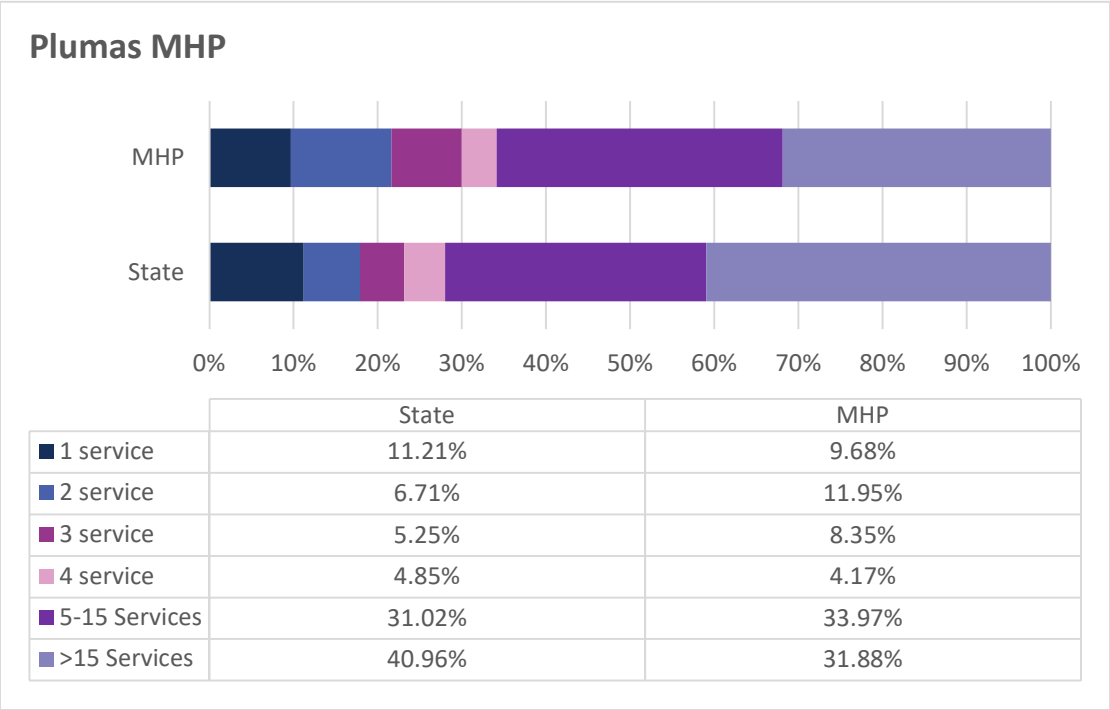
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

RETENTION IN SERVICES

Retention in services is an important measure of member engagement in order to receive appropriate care and intended outcomes. One would expect most members served by the MHP to require five or more services during a 12-month period. However, this table does not account for the length of stay (LOS), as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Retention of Members Served, CY 2022



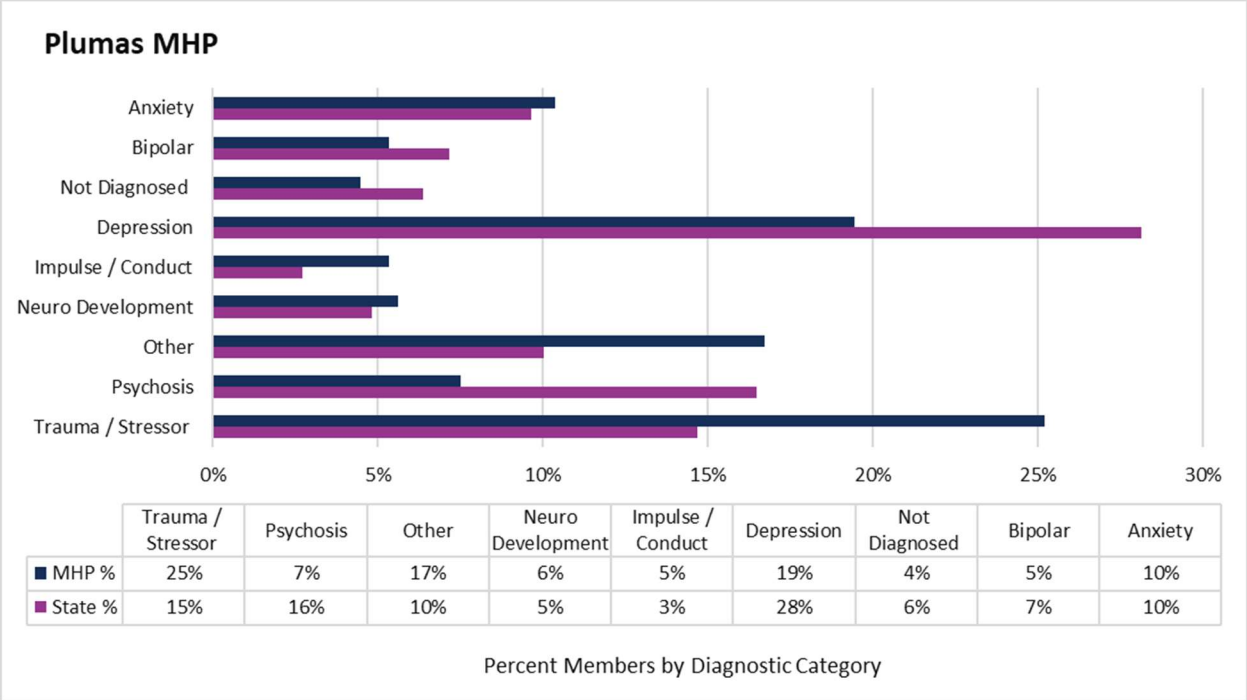
	State	MHP
1 service	11.21%	9.68%
2 service	6.71%	11.95%
3 service	5.25%	8.35%
4 service	4.85%	4.17%
5-15 Services	31.02%	33.97%
>15 Services	40.96%	31.88%

- The MHP retained 66 percent of members for five or more approved services for CY 2022. This was slightly lower than the statewide retention rate of 72 percent for 5 or more services.
- The MHP had a higher percentage of members receiving four or less services than in CY 2021, in CY 2021 it was at 32.58 percent. In CY 2022 it was at 34.15 percent. It was also higher than that seen statewide for CY 2022 which was 28.02 percent.

DIAGNOSIS OF MEMBERS SERVED

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared to statewide. This is not an unduplicated count as a member 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.

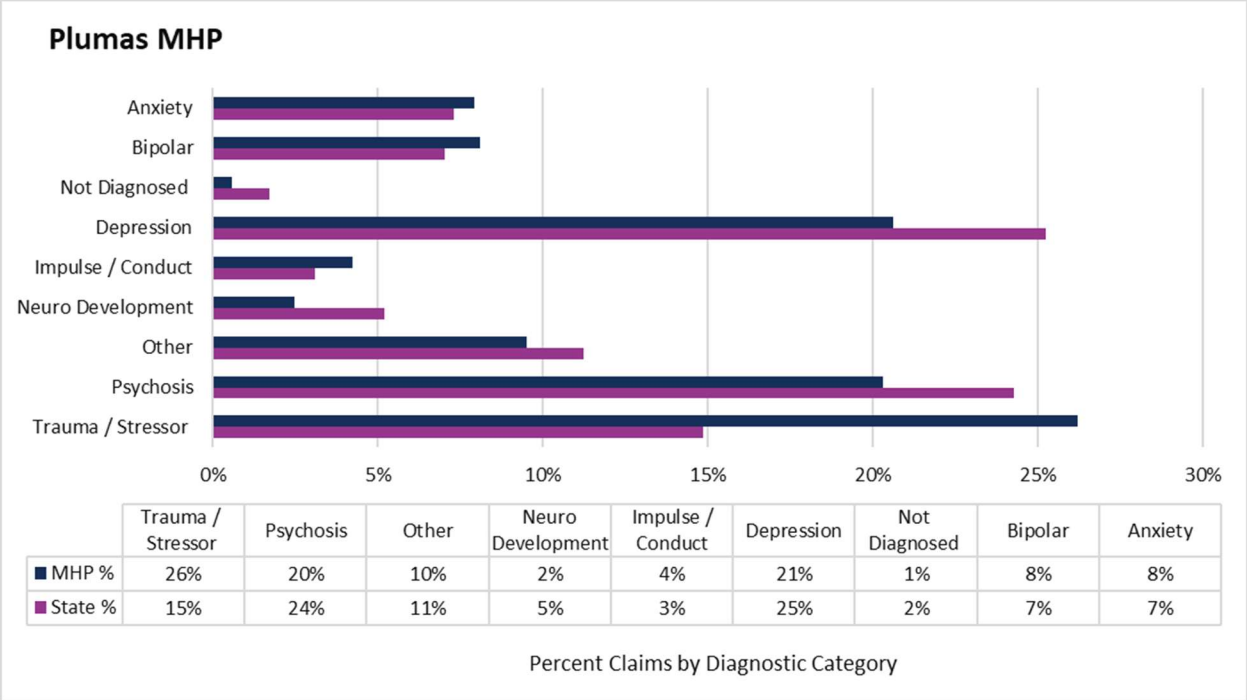
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	25%	7%	17%	6%	5%	19%	4%	5%	10%
State %	15%	16%	10%	5%	3%	28%	6%	7%	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 percentage of members with trauma/stressor disorders and diagnoses in the Other category.

Figure 17: Diagnostic Categories by Percentage of Approved Claims, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	26%	20%	10%	2%	4%	21%	1%	8%	8%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

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

PSYCHIATRIC INPATIENT SERVICES

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS. CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

Table 13: Plumas MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	18	20	1.11	15.67	8.45	$18,827	$12,763	$338,888
CY 2021	25	25	1.00	8.96	8.86	$10,142	$12,696	$253,551
CY 2020	24	29	1.21	9.47	8.68	$10,309	$11,814	$247,405

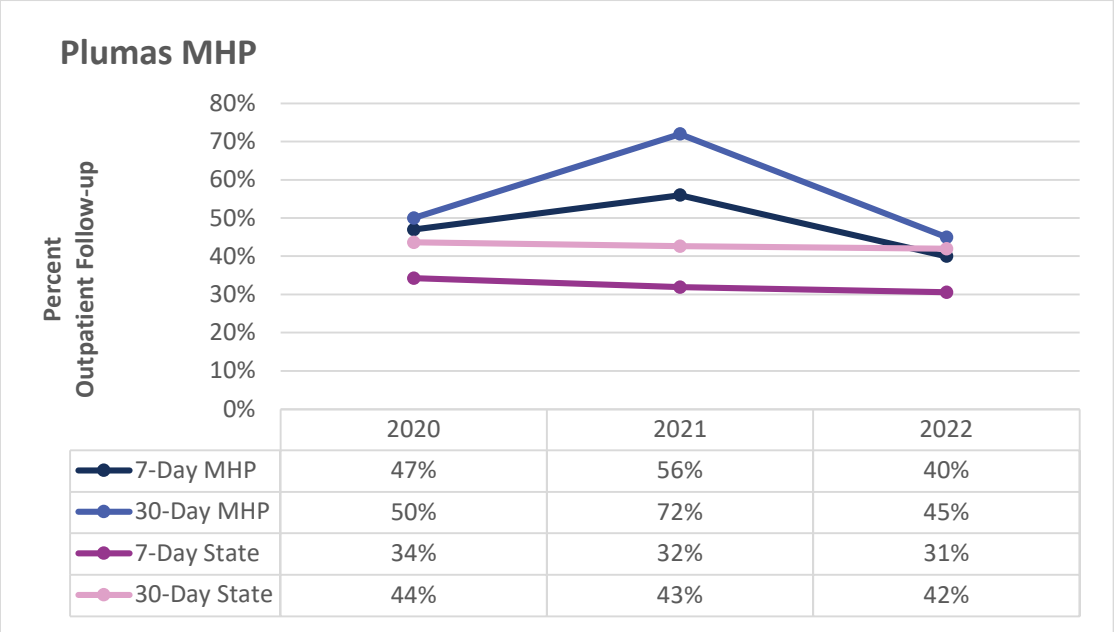
- The MHP's inpatient member count, the number of inpatient admissions, declined between CYs 2020-22 reflecting fewer readmissions.

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 2022 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 member outcomes and is 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. As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the current methodology.

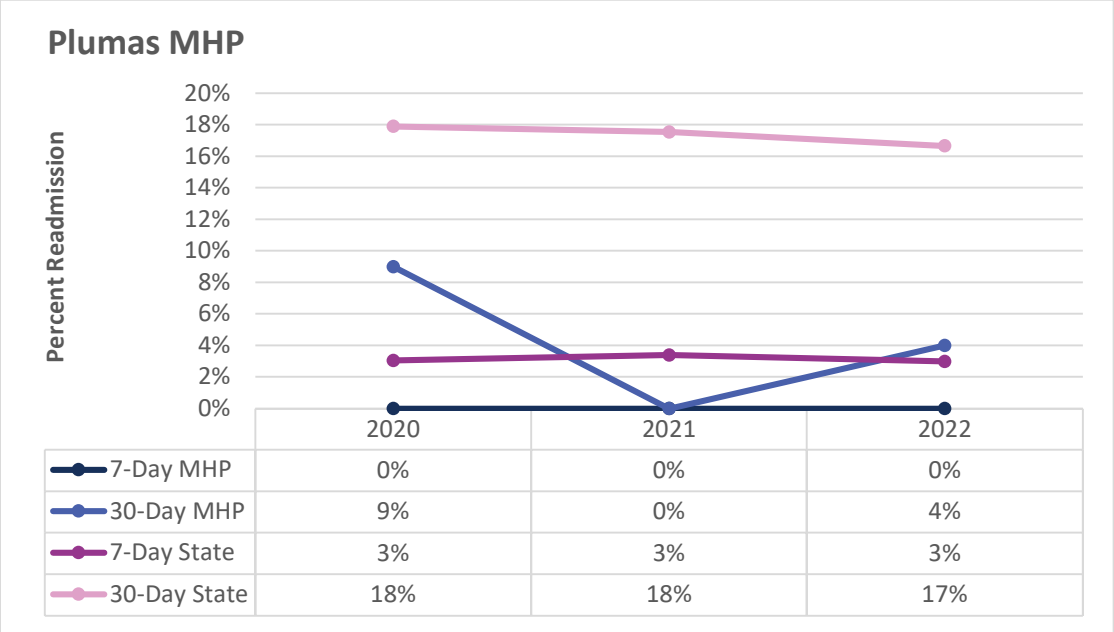
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	47%	56%	40%
30-Day MHP	50%	72%	45%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- The MHP's 7- and 30-day post psychiatric inpatient follow-up rates decreased in CY 2022 and remain lower than those seen statewide.

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22



	2020	2021	2022
7-Day MHP	0%	0%	0%
30-Day MHP	9%	0%	4%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP's 7- and 30-day readmission rates remain very low and are much lower than those seen statewide.

HIGH-COST MEMBERS

Tracking the HCMs 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, HCMs may disproportionately occupy treatment slots that may prevent access to levels of care by other members. HCM percentage of total claims, when compared with the HCM count percentage, provides a subset of the member population that warrants close utilization review, both for appropriateness of level of care and expected outcomes.

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs 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 AACM is $7,442, the median amount is just $3,200.

Tables 14 and 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

Table 14: Plumas MHP High-Cost Members (Greater than $30,000), CY 2020-22

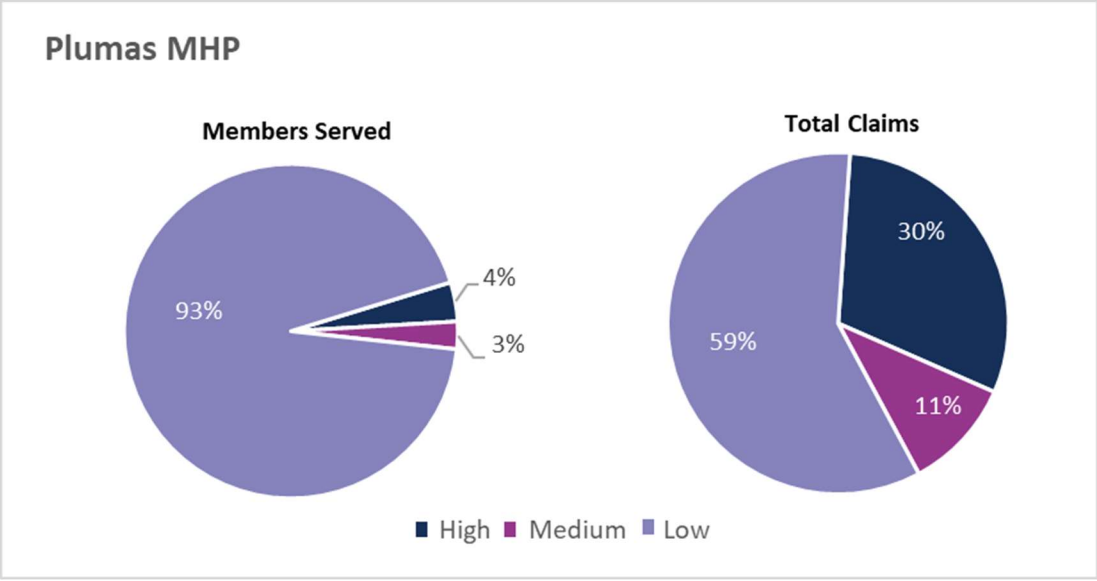
Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	20	3.80%	30.48%	$951,590	$47,579	$44,209
	CY 2021	33	6.21%	36.31%	$1,699,742	$51,507	$40,306
	CY 2020	40	8.05%	45.54%	$2,215,456	$55,386	$44,283

- The MHP's reduction in HCM counts and percentages are similar to its decrease in the overall AACM. However, its mean and median approved claims per HCM increased and were comparable to that seen statewide.

Table 15: Plumas MHP Medium- and Low-Cost Members, CY 2022

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	14	2.66%	10.56%	$329,775	$23,555	$24,029
Low-Cost (Less than $20K)	493	93.55%	58.96%	$1,841,004	$3,734	$2,291

Figure 20: MHP Members and Approved Claims by Claim Category, CY 2022



- High- and medium-cost members together accounted for 41 percent of the total approved claims despite totaling only 7 percent of the total member count.

IMPACT OF QUALITY FINDINGS

- This year's EQR found that PCBH is in a transitional period of progressing toward a quality-driven system. It is not fully there yet, but the following positive developments are major factors in CalEQRO's assessment of this status:
    - The MHP is in a more stable staffing situation in terms of its leadership and QI. It now has a permanent director and the QACM manager has been able to devote more time to QI with additional analyst positions.
    - The newly contracted psychiatrist and nurse will help the MHP to standardize its medication monitoring protocol and also to start tracking the HEDIS measures.
    - The newly implemented LOC tool will guide the members receiving the most appropriate array of services. As it gets used, the MHP will be able to track the findings and make adjustments more systematically.
- The MHP should formulate a path forward to incorporate individuals with lived experience of receiving mental health services in designated positions in its workforce. This can include developing truly peer-driven wellness centers, peer navigators, and other positions. The MHP has determined that peer certification is not fiscally viable at this time, but consideration of adding non-certified peer staff would be beneficial.

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, 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 member satisfaction. They should have a direct member 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

No clinical PIP was submitted.

SUMMARY

The MHP reported that it is working on identifying an appropriate clinical PIP topic.

TA AND RECOMMENDATIONS

The MHP was encouraged to seek TA from the EQRO as it identifies a clinical PIP topic.

[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

NON-CLINICAL PIP

GENERAL INFORMATION

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

Date Started: 02/2023

Date Completed: N/A

Aim Statement: "For Plumas County Medi-Cal beneficiaries that visit the ED for non-emergent mental health related reasons or who endorse MH symptoms during medical screening, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 18 percent within 7 days and by 1 percent for 30 days or more by March 1st 2024 to better align Plumas County with the State benchmarks, that are respectively 49 percent within 7 days and 61 percent within 30 days."

Target Population: Medi-Cal beneficiaries with ED visits for mental health related reasons.

Status of PIP: Implementation phase

SUMMARY

PCBH found that those who present at the local ED with mental health issues as the primary diagnoses are less likely to get connected to the MHP services within 7- and 30-days than the comparable state and national rates. This is particularly true for 7-day FUM.

The MHP has worked with the ED to plan its interventions of training and development of a simplified referral form. Since starting the implementation of this PIP in September 2023, the MHP has received very few referrals (N<11). Based on member interviews, the MHP has determined that most members presenting at the ED are not willing to receive services from the MHP.

TA AND RECOMMENDATIONS

As submitted, this non-clinical PIP was found to have low confidence because the ED and the MHP were unable to connect many members from the ED to MHP services. However, it should be noted that the small number who were referred to the MHP were connected to the MHP services within 48 hours.

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

- Recognizing the barriers to increase referrals to MHP services from the ED, both sides need to work on reducing stigma and develop ways including case manager or navigator outreach so that the first visit can be arranged in a more confidential setting of members' choices, rather than having to walk into a clinic or wellness center.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an ASP where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Qualifacts' Credible, which has been in use for one year. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop.

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 and is consistent with that of the prior review period.

The MHP has 38 named users with log-on authority to the EHR, including approximately 31 county staff and 7 contractor staff. Support for the users is provided by 3.5 full-time equivalent (FTE) IS technology positions. Currently all positions are filled, including one vacant position since the prior review.

As of the FY 2023-24 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 members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to Plumas 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%

MEMBER PERSONAL HEALTH RECORD

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' 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, and/or electronic consult. The following outside entities have access to the EHR or engage in electronic exchange of information with the EHR: MH contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive member 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, Kings 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.
- Once the MHP has the full implementation of the new EHR a data warehouse will be created in order to support HIE.

INFORMATION SYSTEMS PERFORMANCE MEASURES

MEDI-CAL CLAIMING

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

For the MHP, it appears that claims lag in November and December. However, the MHP states that the number of claims is higher than that represented in Table 18. This could be due to the EQRO data pull occurring before the end of the claims adjudication period towards the end of the FY 2022-23.

The MHP reports that their claiming is current through June 2023. The claims from July through December 2023 are scheduled to be billed by the end of May. The delay is due to the implementation of payment reform under CalAIM and the new EHR.

Table 18: Summary of Plumas MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	895	$315,249	$0	0.00%	$315,249
Feb	732	$267,152	$0	0.00%	$267,152
Mar	1,026	$359,566	$0	0.00%	$359,566
April	860	$301,840	$0	0.00%	$301,840
May	909	$299,431	$969	0.32%	$298,462
June	729	$240,294	$1,732	0.72%	$238,562
July	599	$209,771	$1,229	0.59%	$208,542
Aug	749	$269,582	$569	0.21%	$269,013
Sept	771	$294,516	$278	0.09%	$294,238
Oct	726	$242,086	$372	0.15%	$241,714
Nov	115	$39,973	$0	0.00%	$39,973
Dec	594	$178,264	$0	0.00%	$178,264
Total	**8,705**	**$3,017,724**	**$5,149**	**0.17%**	**$3,012,575**

- The claims volume appeared consistent from month to month in CY 2022 with the exception of some lag in November and December submissions.

Table 19: Summary of Plumas MHP Denied Claims by Reason Code CY 2022

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Medicare Part B must be billed before submission of claim	13	$3,239	62.92%
Other healthcare coverage must be billed first	6	$1,909	37.08%
Total Denied Claims	**19**	**$5,148**	**100.00%**
Overall Denied Claims Rate	**0.17%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The MHP had an extremely low denial rate.
- Medicare certification was held up at the time of this EQR due to an NPI error that was in the process of rectification.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- While there was a learning curve for the staff with the implementation of the new EHR, it continues to bring several new capabilities that the past system lacked. New EHR features include off-line data entry for staff providing services off-site and without internet connection, e-script, and additional data tracking. In the

future the EHR will include a PHR module as well as the capability to support an HIE.

- In the past year, additional data dashboards were created and are available to the staff and supervisors. Some of these dashboards include the initial contact to first date of service offered, the number of members who accepted assessment appointments, as well as what the referral source was to initial contact.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting members' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of members: adult, older adult, youth, and family members. MHPs administer these surveys to members 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 analyzed the CPS items and produced a summary report that is used for the QAPI monitoring purposes.

PLAN MEMBER/FAMILY FOCUS GROUP

Plan member and family member (PMF) 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 PMF 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 MHP members and their family, containing 10 to 12 participants each.

PLAN MEMBER/FAMILY FOCUS GROUP SUMMARY

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months and family members of children and youth who receive services from the MHP. The focus group was held by video conference and included two participants. All consumers and family members participating receive or have a family member who receives clinical services from the MHP.

Due to the low number of participants, CalEQRO is unable to provide details from the focus group in order to maintain confidentiality of the participants. The focus group feedback has been incorporated in other sections of the report as appropriate.

SUMMARY OF MEMBER FEEDBACK FINDINGS

None are offered in this review.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member 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 prioritizes timely access to its services and ensures at least weekly follow-up for new members to the system. (Access, Timeliness)

2. The MHP has developed a comprehensive LOC tool that the clinical staff have started using for assigning appropriate combination of services and transitioning to other LOC as needed. (Quality)

3. The MHP has developed strong partnerships with a number of other agencies to improve access and quality of care. (Access, Quality)

4. The MHP has maintained a less than one percent Medi-Cal claim denial rate throughout CY 2022. (IS, Quality)

5. The MHP pays attention to the locally relevant cultural factors such as poverty, rural living, isolated communities in addition to demographic-based ones. (Access, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP has not yet been able to fully develop its medication monitoring protocol according to the relevant national and state measures related to diagnosis, medication practices, and care standards. (Quality)

2. The MHP has not been able to complete its tracking of FC HEDIS measures. (Quality)

3. The MHP lacked a clinical PIP for this year's EQR. (Quality)

4. The MHP lacks any designated peer positions for individuals with lived experience. It cited fiscal constraints in creating and maintaining such positions. (Quality)

5. Due to the new EHR implementation, the MHP's tracking of urgent appointment timeliness appears incomplete. (Timeliness)

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 member outcomes:

1. Complete developing a medication monitoring tool that conforms to national and state standards. (Quality)

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

2. Establish tracking mechanisms for FC HEDIS measures. (Quality)

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

3. Implement a clinical PIP and continue the implementation of the non-clinical PIP on FUM. (Quality)

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

4. Further explore the possibilities of establishing peer positions, including navigator and volunteer ones, even if certification is not possible at this time. (Access, Quality)

5. Ensure that the timeliness data for urgent appointments is fully captured and reported. (Timeliness)

EXTERNAL QUALITY REVIEW BARRIERS

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

- No Clinical PIP was submitted: Due to BHQIP and other related project responsibilities the limited QI staff were unable to work on a clinical PIP.
- No CFM focus group was conducted: Although the MHP lined up an adequate number of members for the focus group, only two showed up. CalEQRO conducted the focus group with the two members present, but was unable to provide any summary or recommendations from that focus group due to the small number.

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Plumas MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being
Plan Member/Family 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
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CALEQRO REVIEWERS

Saumitra SenGupta, PhD, Quality Reviewer
Sharon Mendonca, Information Systems Reviewer
Gloria Marrin, Consumer Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Bakkie	Caylan	QA Clinician	Contracted
Beck	Lisa	Fiscal Officer	PCBH
Connell	Paige	Practicum Student	PCBH
Dehart	Ashley	Kings View ISCA support	Kings View
Dost	Anthony	Kings View ISCA support	Kings View
Fletcher	Eliza	Unit Supervisor - Nursing	PCBH
Hardee	Kyle	Administrative Services Officer	PCBH
Hemphill	Jay	IT Help Desk	PCBH
Hood	Keegan	BH Therapist	PCBH
Issacson	Allison	BH Therapist	Contracted
LaMattina	Juanita	BH Therapist	PCBH
McGill	Jessica	QA/QI Manager	PCBH
Nemati	Sadiq	Kings View ISCA support	Kings View
Pierson	Kristy	MHSA Coordinator	PCBH
Pound	Avery	Information Systems Analyst	PCBH
Sale	Tessa	QA clinician	Contracted
Sanderson	Gary	AOD Administrator	PCBH
Schwartz	Katherine	Unit Supervisor	PCBH
Shannon	Che	Management Analyst	PCBH
Sousa	Sharon	Director	PCBH
Ward	Matt	BH Therapist	PCBH
Webster	Michael	Kings View ISCA support	Kings View

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: Plumas	
PIP Title: N/A	
PIP Aim Statement: N/A	
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):
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): 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
N/A			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): The MHP did not submit a PIP 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: Develop a clinical PIP and seek TA from the EQRO as needed.

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	This non-clinical PIP was found to have low confidence because the ED and the MHP were unable to connect many members from the ED to MHP services.
General PIP Information	
MHP/DMC-ODS Name: Plumas	
PIP Title: Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)	
PIP Aim Statement: For Plumas County Medi-Cal beneficiaries that visit the ED for non-emergent mental health related reasons or who endorse MH symptoms during medical screening, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 18 percent within 7 days and by 1 percent for 30 days or more by March 1st 2024 to better align Plumas County with the State benchmarks, that are respectively 49percent within 7 days: 61 percent within 30 days.	
Date Started: 02/2023	
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 with ED visits for mental health related reasons.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): N/A
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): ED Staff training
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): Implementation of a new referral form

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
Increase the percentage of those presenting at the local ED for mental health reasons connecting to the MHP services	2021	<11	☒ 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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: Work on reducing stigma and develop ways including case manager or navigator outreach so the first visit can be arranged in a more confidential setting of members' choices rather than having to walk into a clinic or wellness center.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

April 26th, 2024

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

Dear Behavioral Health Concepts, Inc:

Plumas County Behavioral Health MHP is requesting flexibility during the FY 2023-24 EQRO review, as we were unable to fulfill one or more of the required elements for review:

Specifically, we were not able to:
- ☒ submit a clinical PIP
- ☐ submit a non-clinical PIP
- ☒ hold a member and family member focus group
- ☐ other:

Reasons for this include:

☒ Lack of staff/resources: During this audit period limited QA/PIP staff available focused on BHQIP process and related projects and were not able to formulate a clinical PIP.
☒ Other reasons: For the consumer focus group adequate consumers accepted the invitation, however, experienced technical difficulties and/or last minute personal emergencies preventing them from attending. We were only able to provide two consumers to attend the consumer focus group.

Please attach this letter to our FY 2023-24 review report.

Sincerely,

Sharon R. Sousa, LMFT

Sharon Sousa, LMFT,
Plumas County Behavioral Health Director.