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

ALAMEDA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

October 24-26, 2023

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

MHP INFORMATION

Review Type — Virtual

Date of Review — October 24-26, 2023

MHP Size — Large

MHP Region — Bay Area

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
7	7	0	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	9	1	0
Information Systems (IS)	6	6	0	0
TOTAL	**26**	**24**	**2**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-Up After Emergency Department Visit for Mental Illness Behavioral Health Quality Improvement Program (BHQIP)	Clinical	09/2022	Implementation	Low
Adult Access to Psychiatric Care	Non-Clinical	05/2023	Implementation	Low

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	7
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members (Spanish) ☐Other	6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Peer employment and voluntary peer services are showcased throughout the system of care (SOC), including an increase in numbers of certified peer specialists.
- Providers were complimentary to the supportive nature of the MHP while transitioning to California Advancing and Innovating Medi-Cal (CalAIM) objectives.
- The MHP has a strong validation protocol when validating data and new or additional data metrics.
- The MHP increased both the number of IS full-time equivalent (FTE) and the IS budget allocation since the last EQR.
- Utilizing new intern billing codes, the MHP was able to improve staff retention and recruitment with the ability to hire new and retain current interns.

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

- Though the MHP uses ALCOHub and SharePoint, key informants reported lack of knowledge of a centralized location for documents, policy and procedures, new priorities, and new-hire orientation information.

- Internal and external key informants reported they would appreciate an easy-to-access directory where they can find information for referral purposes.
- The website does not offer quick access to crisis care numbers or 988, and may be difficult to connect if members seeking information are using an outdated digital system.
- Clinicians Gateway is an older system, and it may benefit the MHP to consider using a new Electronic Health Record (EHR) for all of their documentation needs.
- The MHP utilizes peers throughout the SOC; however, key informants have identified that there was no increase in pay for obtaining certification and use peer billing codes have not been implemented.

Recommendations for improvement based upon this review include:

- Provide training on how to access the shared intranet, and where to locate resources, policies and procedures, new-hire orientation information, and intra-department communications.
- Redesign the website to highlight the Provider Directory to easily find contact information for all providers in the MHP, to help providers expedite referrals to appropriate levels of care (LOC) for the members.
- Provide ease of access to crisis numbers, 988, and after-hours services, in plain sight, on the landing page of the MHP's Website.
- Assign a project team to assess using SmartCare or another solution to replace the Clinicians Gateway.
- Investigate Certified Peer Support Specialist pay equity and the ability to utilize billing codes to enhance an additional revenue stream.

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 Alameda County MHP by BHC, conducted as a virtual review on October 24-26, 2023.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to validate and analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, 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 in DHCS's Comprehensive Quality Strategy. Data definitions are included as Attachment D.
- Validation and analysis of each MHP's NA as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report

data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of 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 continues to be impacted by staffing vacancy rates.

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 MHP implemented a new billing system, SmartCare by Streamline, in August 2023.
- The MHP is working on a departmental Strategic Plan.
- The MHP is engaged in a Community Services Planning and Forensic Services System redesign.

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: Investigate gaps in measurement for first appointment offered, psychiatry services, and urgent services. Develop and implement a way to compile valid and reliable timeliness data to direct QI and capacity management. Analyze members' experiences with delays and barriers across the system. Develop interventions and measure the effectiveness of changes.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Alameda utilized a multi-pronged approach in addressing this recommendation. First, the MHP allocated 1.5 FTE to analyze timeliness processes to identify discrepancies and to develop a more effective and wide-ranging data capture protocol. Next, Alameda analyzed member experiences with delays and barriers by conducting listening sessions through the Health Equity division. These sessions gave members the opportunity to give feedback on their experience in entering the system. Finally, the MHP was able to implement strategies to address language barriers to services and expand telehealth, among other interventions.

Recommendation 2: Continue to examine access to crisis services. Continue to develop strategies using data to increase meeting the demand, as well as identify other proactive service strategies that could reduce the reliance upon crisis services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP created the new Crisis Services System of Care, elevating it from a division, which has allowed for the intentional and improved review of departmental coordination and system resources.
- Substantial progress has been made in expanding community services, providing de-escalation training, family crisis management training, and in-school crisis response plans.
- The MHP expanded county emergency departments and contract providers authorized to write 5150/5585 holds, to now include Alta Bates Summit Medical Center, Eden Medical Center, Stanford Valley Care Medical Care, Roots Community Health Center, Asian Health Services, Seneca, La Clinica, and Pathways to Wellness. The pilot expansion has become permanent.

Recommendation 3: Resume tracking and trending Healthcare Effectiveness Data and Information Set (HEDIS) measures for youth receiving medication services, as well as other HEDIS measures for foster youth as required.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP is tracking and trending HEDIS measures for youth receiving medication services, as well as other HEDIS measures for foster youth through development and utilization of YellowFin software. YellowFin reports allow for filtering to track/monitor/trend HEDIS measures for foster youth.
- Quality staff collaborated with the Director of Pharmacy Services and Senior Clinical Pharmacist to validate data sources and methods.

Recommendation 4: Consider shifting resources to IS that can support implementation of SmartCare and other IS priorities.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Although the MHP has experienced staffing and hiring challenges similar to other counties in the state, they have been creative in providing added support for the implementation of SmartCare. The County has worked with SmartCare to increase technical support during the implementation, while IS staff have been reassigned to billing system projects to reduce the load for other staff. The MHP also increased the percentage of the budget that is allocated to IS from 3.46 percent in FY 2022-23 to 4.99 percent in FY 2023-24, increasing IS FTEs from 29 to 40 over the same timeframe.

Recommendation 5: Assess the current trainings provided to law enforcement and modify or expand, as indicated, using stakeholder recommendations and experience as

a consideration. Consider incorporating ways to invite law enforcement visits and/or ways to learn about mental health and related services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The crisis SOC engaged in regular consultation and referral sessions with various law enforcement agencies, providing guidance for the implementation of mobile crisis teams in their respective cities. The MHP extended invitations to law enforcement and other first responders to the quarterly 988 collaborative meetings.
- The MHP conducts presentations regularly for law enforcement and other first responders, such as fire departments and paramedics/emergency medical technicians.
- The MHP convenes monthly with law enforcement, probation department, and other community-based organizations as part of the Multidisciplinary Forensics Team, an initiative launched in conjunction with Bay Area Rapid Transit's (BART) police department to link services to individuals who frequently interact with BART law enforcement.

Recommendation 6: Provide clear information on the website regarding the availability of mobile crisis by region and the varied hours that those services are available.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP updated their website to feature detailed information on the Crisis SOC services, incorporating a comprehensive map that visually breaks down the availability of mobile crisis services by region, offering a straightforward way for individuals to locate the nearest services.
- The website addressed mobile crisis but does not address in-the-moment crisis and immediate access to 988. This recommendation is addressed, but a new recommendation will be created to include the crisis number on the landing page of the website.

Recommendation 7: Review whether youth eligible for Pathways services are being referred, or if there are any barriers to high-need youth or Children's Welfare Services involved youth.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The Pathways to Wellness (i.e. psychiatry clinic) contract now includes children/youth, in addition to adults.
- Alternative Family Services is now contracted to provide children/youth psychiatry services. This added to the Alameda County network capacity to serve children/youth.
- There were no specific barriers for referral identified.

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 20.73 percent of services were delivered by county-operated/staffed clinics and sites, and 79.27 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 77.23 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week operated by county staff; beneficiaries may request services through the Access Line, as well as through schools, primary care, social services, community programs, and forensic based services. The MHP operates a centralized access team responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries call the Access line and complete a screening. The MHP refers qualifying applicants to a service provider who schedules an assessment.

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 4,027 adults, 3,080 youth, and 479 older adults across 14 county-operated sites and 236 contractor-operated sites. Among those served, 1,604 members received telehealth services in a language other than English.

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

[1] CMS Data Navigator Glossary of Terms

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 Alameda County, the time and distance requirements are 15 miles and 30 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 Health Equity division provided listening sessions in both English and Spanish to determine access challenges within the community.
- The MHP is working with the Latinx community targeting members and their families.
- The MHP utilizes hiring practices that allow for hiring psychiatrists outside of the county to address capacity issues.
- Upon admission to jail, inmates are assessed for mental health services and needs.

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, Alameda demonstrates nearly identical access to care as seen statewide, with a PR of 3.93 percent.

Table 3: Alameda 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	482,052	18,949	3.93%	$253,363,129	$13,371
CY 2021	452,894	19,017	4.20%	$240,417,967	$12,642
CY 2020	416,104	18,874	4.54%	$202,757,541	$10,743

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 total number of Medi-Cal eligibles in Alameda has increased 15.85 percent since CY 2020, while members served has increased only 0.40 percent.
- Total approved claims have increased 24.96 percent since CY 2020.
- AACM has also increased since CY 2020 (24.46 percent).

Table 4: Alameda 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	38,001	661	1.74%	1.50%	1.82%
Ages 6-17	92,331	6,386	6.92%	5.01%	5.65%
Ages 18-20	22,726	1,182	5.20%	3.66%	3.97%
Ages 21-64	261,056	9,747	3.73%	3.73%	4.03%
Ages 65+	67,939	973	1.43%	1.64%	1.86%
Total	**482,052**	**18,949**	**3.93%**	**3.60%**	**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.

- Members aged 65+ are the only age group with a PR smaller than for similar sized counties (1.43 percent vs. 1.64 percent). The MHP is planning to create a plan to increase the older adult PR. In FY 2023-24, the MHP started a new older adult-focused certificate program for all providers currently serving or who may serve this population in the future, to be offered annually.
- PRs for ages 6-17 and 18-20 are higher in Alameda than statewide, while all other age categories are below statewide PR.
- Total PR in the MHP is higher than in similar sized counties and very slightly lower than statewide.

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

Threshold Language	# Members Served	% of Members Served
Spanish	3,194	16.86%
Cantonese	239	1.26%
Vietnamese	134	0.71%
Mandarin	59	0.31%
Arabic	46	0.24%
Tagalog	36	0.19%
Members Served in Threshold Languages	**3,708**	**19.58%**
Threshold language source: Open Data per BHIN 20-070		

- Alameda has six threshold languages, and 19.58 percent of all members served do not use English as their primary language.
- The most prevalent threshold language is Spanish.

Table 6: Alameda 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	166,483	4,724	2.84%	$50,820,792	$10,758
Large	2,532,274	76,457	3.02%	$535,657,742	$7,006
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 holds true in Alameda, as ACA members have a PR of 2.84 percent compared to 3.93 percent for the overall PR, and an AACM that is more than $2,000 less than the overall AACM ($13,371 vs. $10,758).
- The MHP's ACA PR is lower than large county and statewide PRs but the AACM is higher.

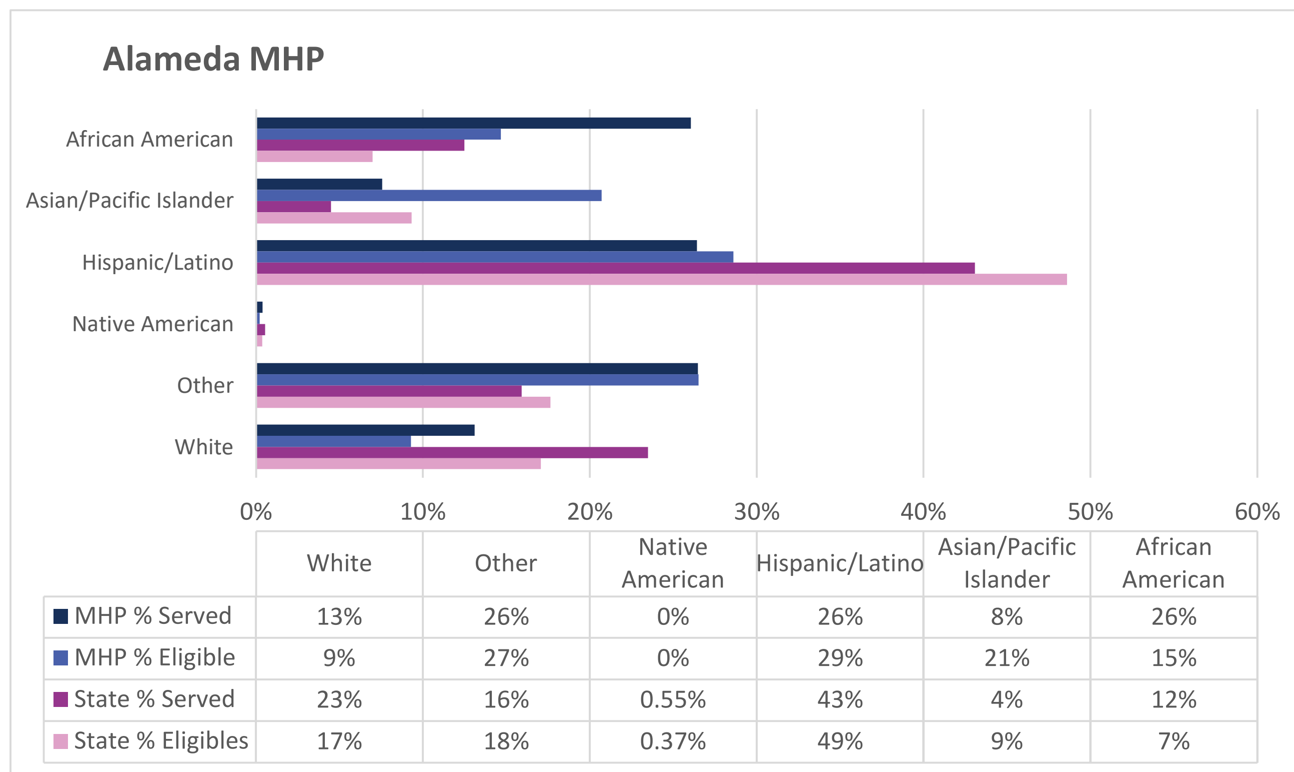
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they 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: Alameda MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	70,740	4,937	6.98%	7.08%
Asian/Pacific Islander	99,830	1,433	1.44%	1.91%
Hispanic/Latino	137,869	5,005	3.63%	3.51%
Native American	1,066	74	6.94%	5.94%
Other	127,820	5,017	3.93%	3.57%
White	44,728	2,483	5.55%	5.45%

- African American and Asian/Pacific Islander members are the only racial/ethnic groups with PRs lower than statewide PRs.

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



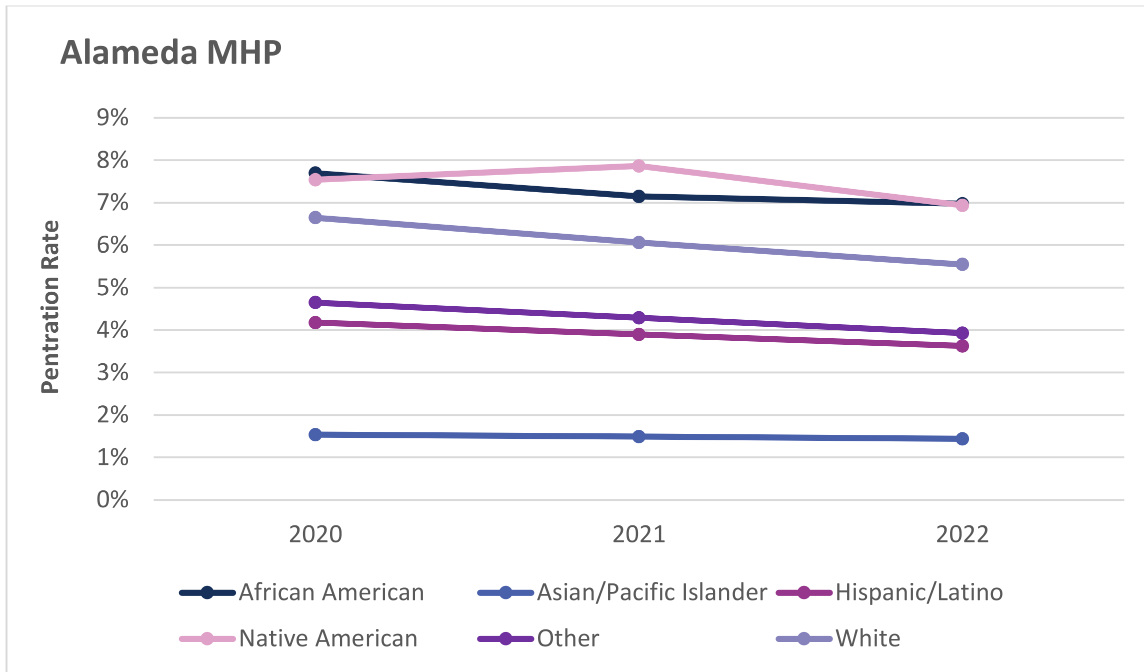
	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	13%	26%	0%	26%	8%	26%
MHP % Eligible	9%	27%	0%	29%	21%	15%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- The Asian/Pacific Islander group has the largest incongruence between Medi-Cal eligibles and members served (21 percent vs. 8 percent), indicating this group is proportionally underrepresented in the MHP.

- African American members account for the largest proportional overrepresentation of those served, as this group accounts for 26 percent of all members served, but only 15 percent of Medi-Cal eligibles in the county.

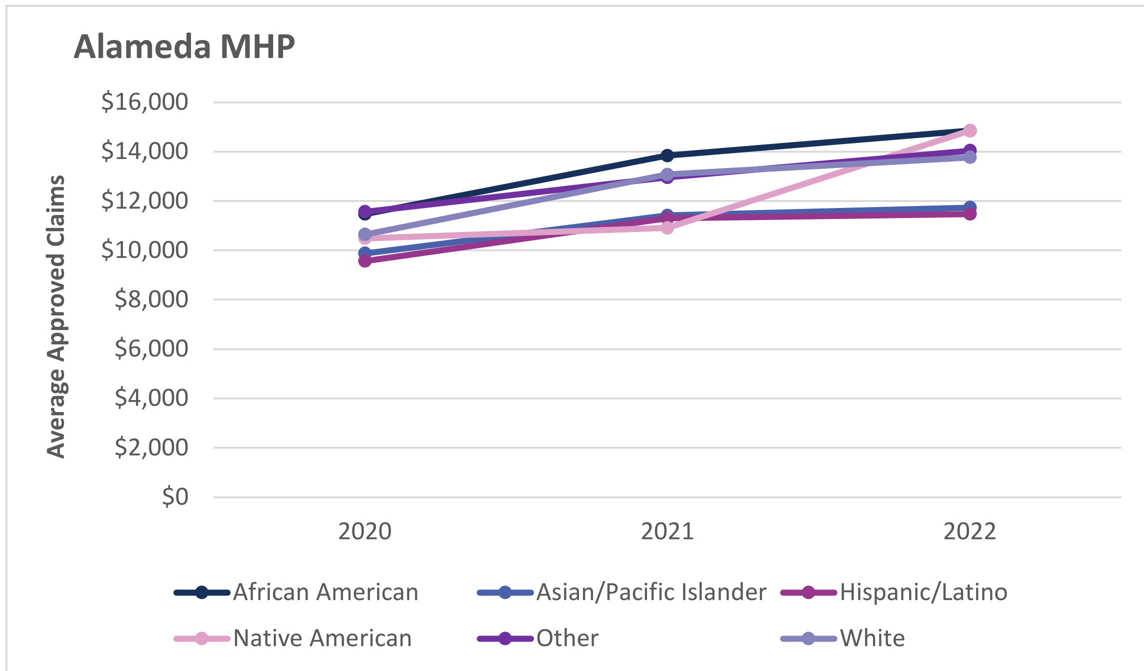
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



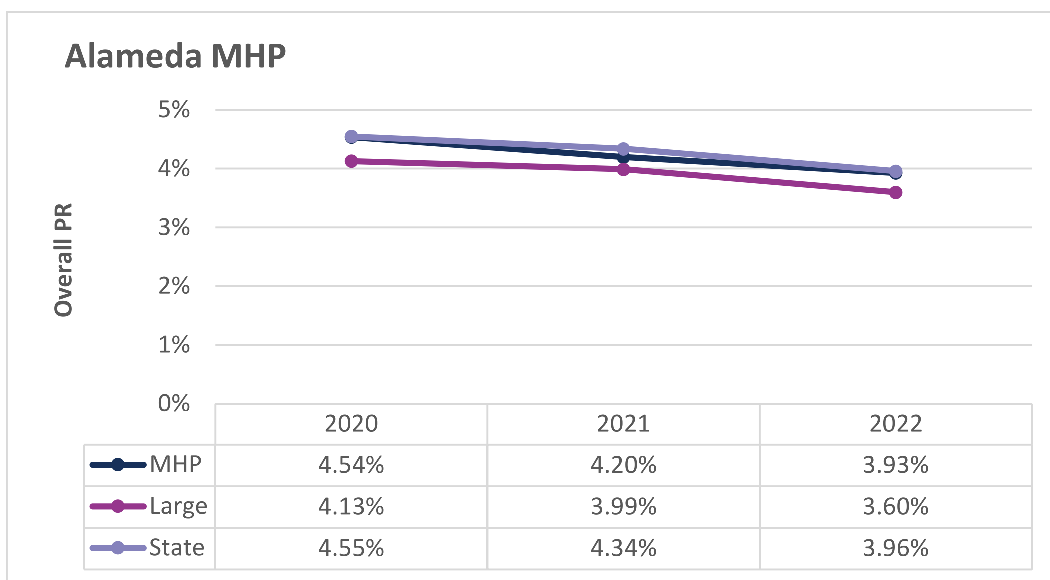
- Following statewide trends resulting from the increased number of Medi-Cal eligibles, there has been a decrease in PR for each racial/ethnic group in Alameda since CY 2020.
- The PRs for African American, Native American, and to a lesser extent, White, have been consistently highest, while the PR for Asians/Pacific Islander has consistently been the lowest in the MHP.

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



- AACM has increased each year since CY 2020 for all racial/ethnic groups in Alameda.
- AACM increased 36.12 percent for Native Americans between CY 2021 and CY 2022 ($10,912 vs. $14,853).

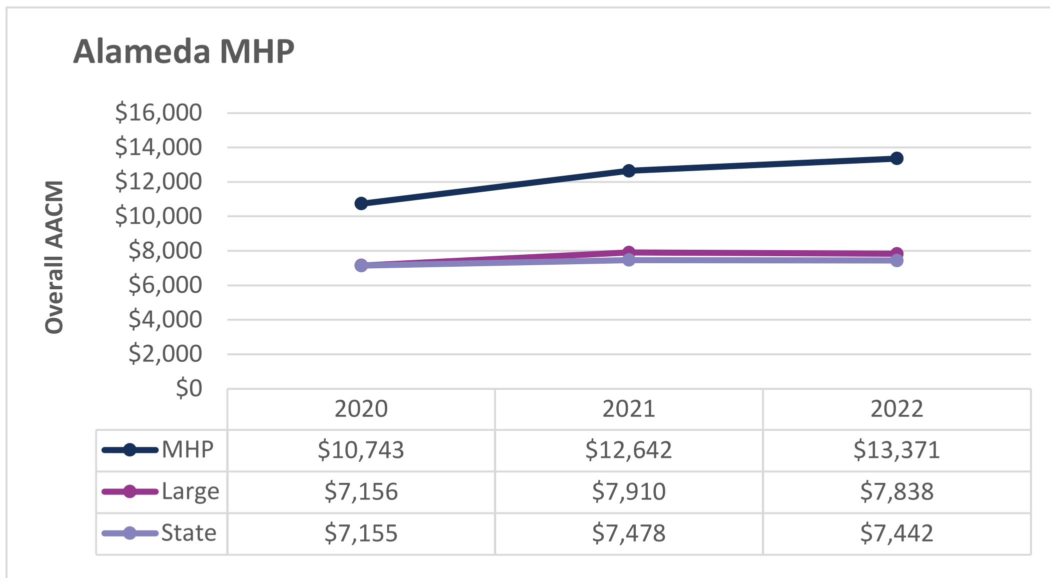
Figure 4: Overall PR CY, 2020-22



	2020	2021	2022
MHP	4.54%	4.20%	3.93%
Large	4.13%	3.99%	3.60%
State	4.55%	4.34%	3.96%

- Overall PR has decreased in similar sized counties and statewide each year since CY 2020. PR in Alameda has followed a similar trend and has consistently been higher than in large counties as a group.

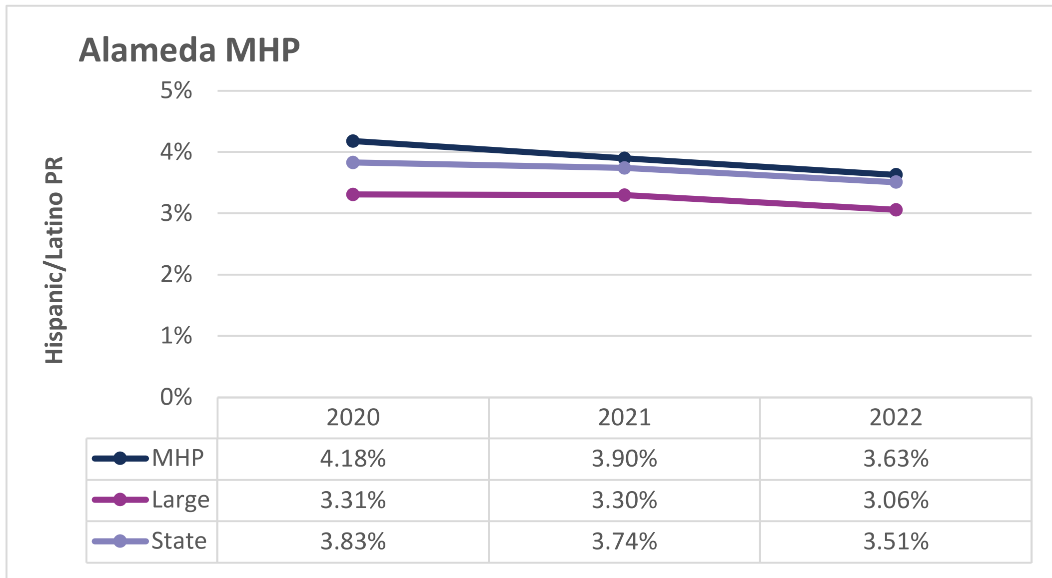
Figure 5: Overall AACM, CY 2020-22



	2020	2021	2022
MHP	$10,743	$12,642	$13,371
Large	$7,156	$7,910	$7,838
State	$7,155	$7,478	$7,442

- Overall AACM increased in similar sized counties and statewide in CY 2021 compared to the previous year, then decreased slightly in CY 2022, while AACM in Alameda has increased each year since CY 2020.
- For CY 2022, AACM is 70.59 percent higher in Alameda than in similar sized counties, and 79.67 percent higher than the statewide AACM. The MHP's AACM has been consistently higher across all of the past three years, with the gap widening each year.

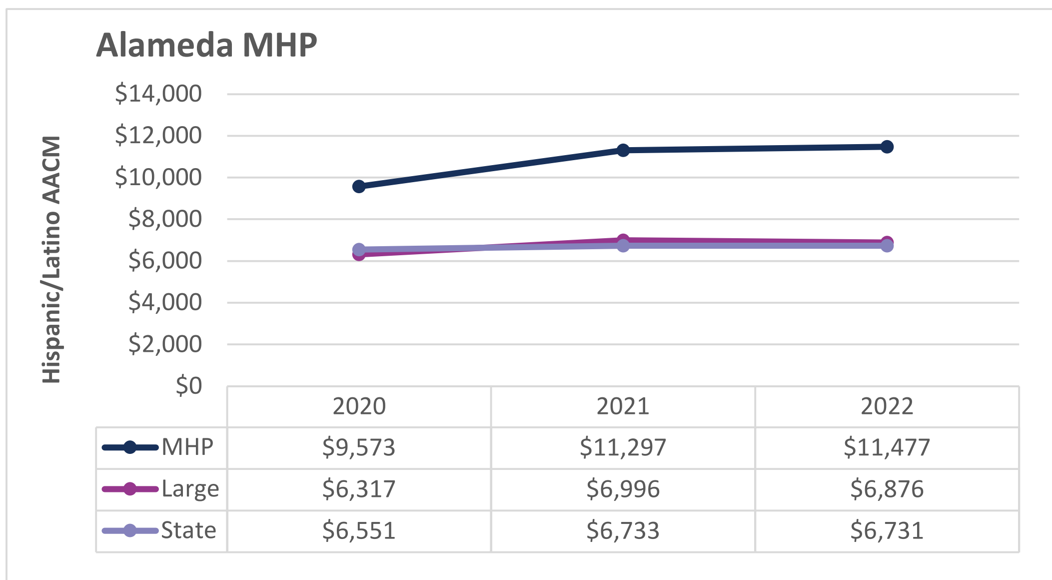
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	4.18%	3.90%	3.63%
Large	3.31%	3.30%	3.06%
State	3.83%	3.74%	3.51%

- In alignment with statewide trends due to the increase in Medi-Cal eligibles, Hispanic/Latino PR in Alameda has decreased each year since CY 2020. However, PR for this group remains higher in the MHP than similar sized counties and statewide.

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

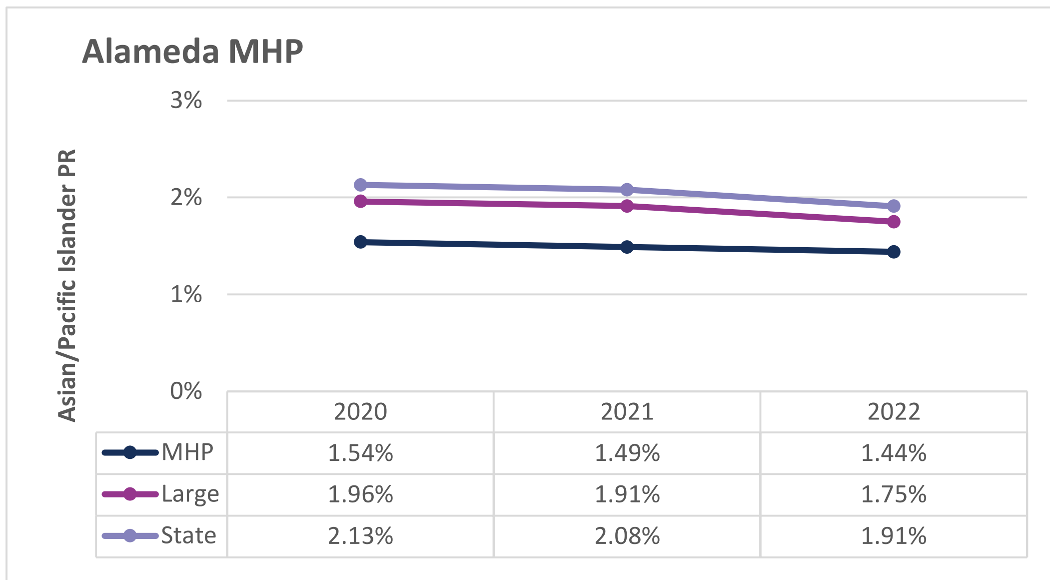


	2020	2021	2022
MHP	$9,573	$11,297	$11,477
Large	$6,317	$6,996	$6,876
State	$6,551	$6,733	$6,731

- Hispanic/Latino AACM is 70.51 percent higher in Alameda than statewide in CY 2022.

- The MHP has seen an increase in AACM each year since CY 2020, although the increase in CY 2022 was slight, whereas there was an 18 percent increase between CY 2020 and CY 2021.

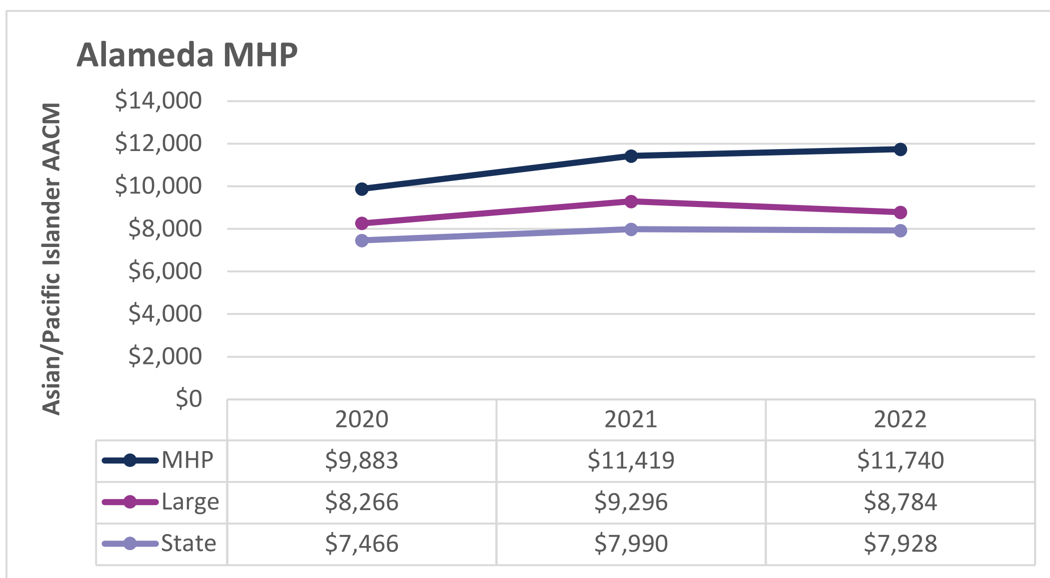
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	1.54%	1.49%	1.44%
Large	1.96%	1.91%	1.75%
State	2.13%	2.08%	1.91%

- Asian/Pacific Islander PR in Alameda has decreased each year since CY 2020, following the statewide trend.
- PR for this group has been lower than both similar sized county and statewide PRs each year since CY 2020.

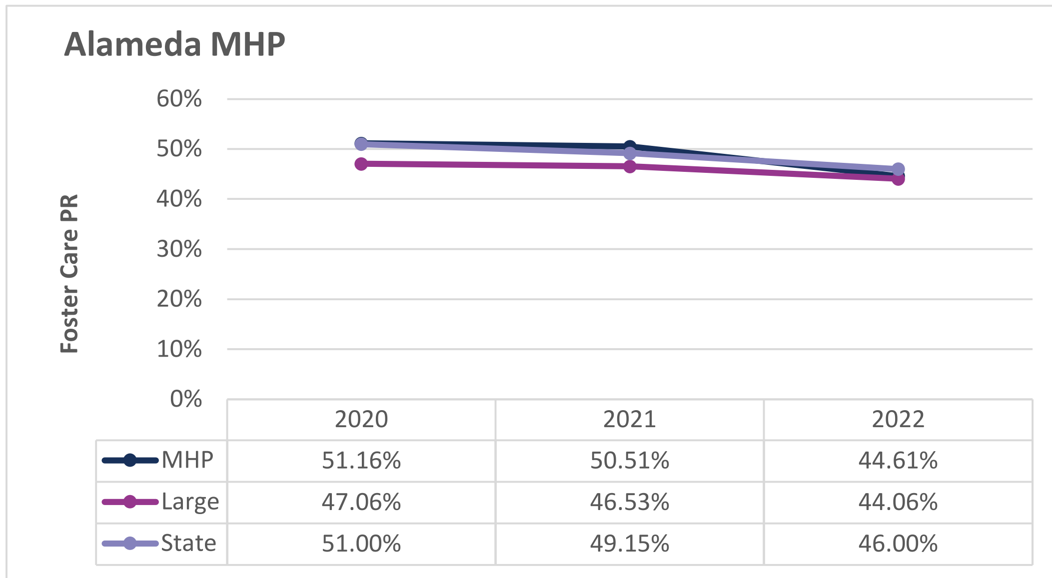
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$9,883	$11,419	$11,740
Large	$8,266	$9,296	$8,784
State	$7,466	$7,990	$7,928

- Asian/Pacific Islander AACM in the MHP increased in CY 2022, while it decreased in similar sized counties and statewide.
- AACM for this group has been consistently higher than in large counties and statewide over the past three years.

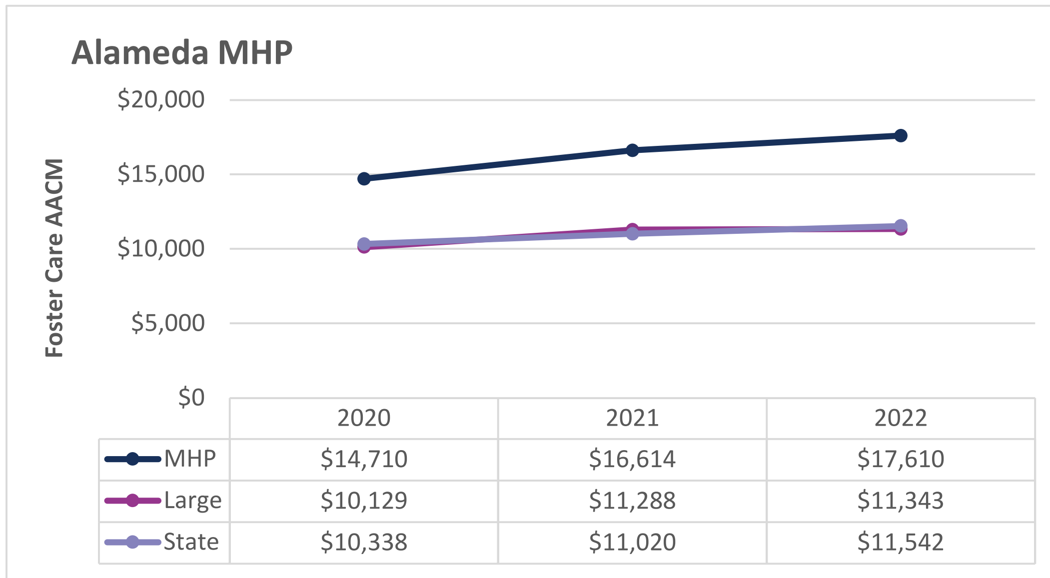
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	51.16%	50.51%	44.61%
Large	47.06%	46.53%	44.06%
State	51.00%	49.15%	46.00%

- FC PR has been on the decline statewide since CY 2020, and Alameda has followed this trend.
- Although FC PR in the MHP is slightly higher than the large county rate, in CY 2022 it dipped below the statewide rate for the first time in the past three years.

Figure 11: Foster Care AACM, CY 2020-22



- Statewide FC AACM has increased each year for the past three years and was 11.65 percent higher in CY 2022 compared to CY 2020.
- FC AACM in Alameda has increased 19.71 percent since CY 2020 and is now more than $6,000 higher than similar sized counties and statewide.

Units of Service Delivered to Adults and Foster Youth

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

	MHP N = 11,904				Statewide N = 381,970		
Service Category	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	1,398	11.7%	10	5	10.3%	14	8
Inpatient Admin	355	3.0%	14	7	0.4%	26	10
Psychiatric Health Facility	11	0.1%	16	12	1.2%	16	8
Residential	46	0.4%	100	73	0.3%	114	84
Crisis Residential	527	4.4%	15	13	1.9%	23	15
Per Minute Services							
Crisis Stabilization	2,906	24.4%	2,192	1,200	13.4%	1,449	1,200
Crisis Intervention	1,077	9.0%	186	145	12.2%	236	144

Medication Support	6,470	54.4%	386	270	59.7%	298	190
Mental Health Services	7,992	67.1%	1,051	454	62.7%	832	329
Targeted Case Management	5,316	44.7%	596	155	36.9%	445	135

- Similar to statewide utilization patterns, the MHP's most-used services are mental health services, medication support, and targeted case management (TCM).
- Crisis residential services are utilized more than 2 percentage points higher than statewide; however, the average units in the MHP are only 15 days compared to 23 days statewide.
- Crisis stabilization is utilized more often than statewide (24.4 percent vs. 13.4 percent), and average units for this modality are more than 700 minutes higher than the statewide average. It should be noted that most counties do not have a crisis stabilization unit which may contribute to the lower overall average units for the state compared to the MHP.
- TCM utilization is 7.8 percentage points higher than statewide.

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

	MHP N = 758				Statewide N = 33,234		
Service Category	**Members Served**	**% of Members Served**	**Average Units**	**Median Units**	**% of Members Served**	**Average Units**	**Median Units**
Per Day Services							
Inpatient	34	4.5%	10	7	4.5%	12	8
Inpatient Admin	<11	-	6	6	0.0%	5	3
Psychiatric Health Facility	<11	-	4	4	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	<11	-	32	32	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	<11	-	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	19	2.5%	1,304	1,200	3.1%	1,166	1,095
Crisis Intervention	48	6.3%	319	148	8.5%	371	182
Medication Support	151	19.9%	308	262	27.6%	364	257

Therapeutic Behavioral Services (TBS)	21	2.8%	3,385	2,503	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	197	26.0%	906	441	40.8%	1,458	441
Intensive Home-Based Services	52	6.9%	1,843	819	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	737	97.2%	3,027	1,781	95.4%	1,846	1,053
Targeted Case Management	268	35.4%	350	172	35.8%	307	118

- FC per day services were minimally used in Alameda, with the rate of inpatient use similar to statewide.
- Medication support services were utilized 7.7 percentage points lower than statewide.
- Intensive care coordination (ICC) and intensive home-based services (IHBS) were utilized less frequently than statewide with lower units of services delivered.

IMPACT OF ACCESS FINDINGS

- Overall PR is almost in line with statewide rates (3.93 percent vs. 3.96 percent) which indicates consistent and reliable access to care for members.
- Twenty-one percent of eligibles in Alameda are Asian/Pacific Islander, but only 8 percent of members served are from this group. The PR for Asian/Pacific Islanders has declined each year since CY 2020 and has remained below statewide PR each year, indicating a potential opportunity for outreach to this underserved population.
- Outreach efforts to the African American community have been effective as this group accounts for 15 percent of Medi-Cal eligibles, but 26 percent of all members served.
- Pathways ICC and IHBS services for FC members are utilized considerably less than statewide. The MHP mentioned that these services were impacted by staff turnover and difficulty finding families who would accept Pathways referrals. This warrants further examination.

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

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

- The Access Team and data analytics work closely together, with 30 percent of members going through Access.

- The MHP expanded access to medication support through an additional contracted provider that serves members in person.
- The MHP added a Care Coordinator so missed appointments could be rescheduled.
- Though the department does track and trend data, lack of compliance or understanding from new staff or staffing turnover impacts data collection and created data gaps.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (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 excluding several specific modalities/service delivery sites (Crisis Stabilization, hospital, and jail/Juvenile Justice).

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	6.8 Business Days	10 Business Days*	80%
First Non-Urgent Service Rendered	9.2 Business Days	10 Business Days**	68%
First Non-Urgent Psychiatry Appointment Offered	14 Business Days	15 Business Days*	53%
First Non-Urgent Psychiatry Service Rendered	17.9 Business Days	15 Business Days**	37%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	24.2 Hours	48 Hours*	91%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	4.4 Calendar Days	7 Calendar Days	45%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	4.4 Calendar Days	30 Calendar Days	56%
No-Show Rate – Psychiatry	7%	15%**	n/a
No-Show Rate – Clinicians	9%	15%**	n/a

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

** MHP-defined timeliness standards

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

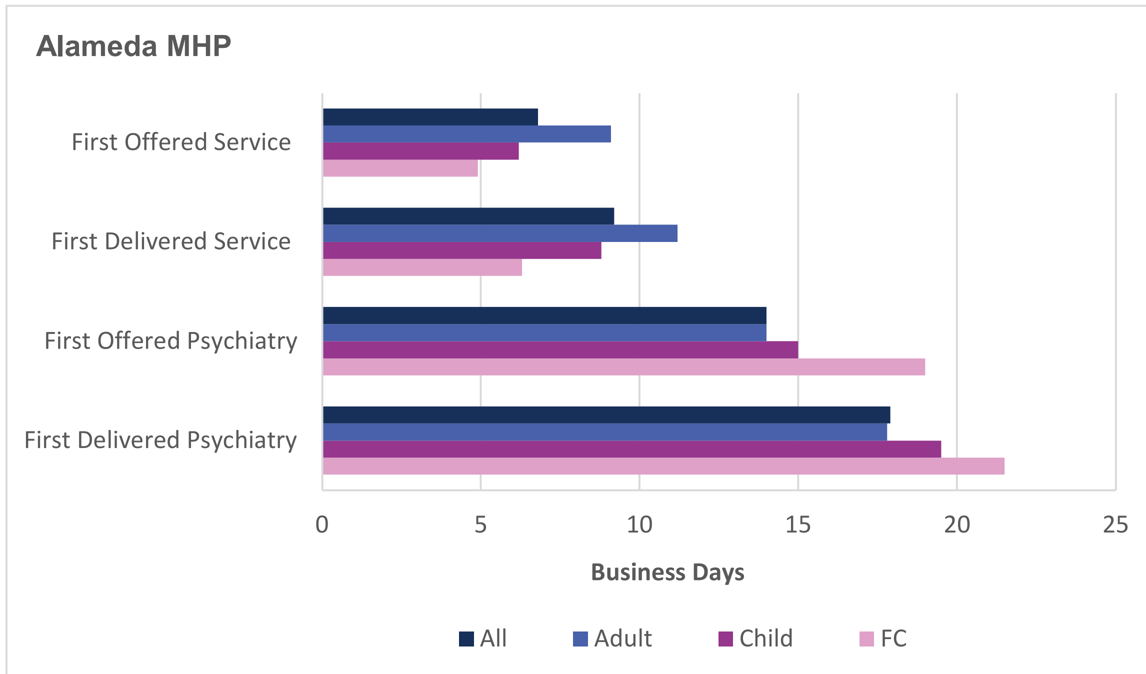


Figure 13: Wait Times for Urgent Services

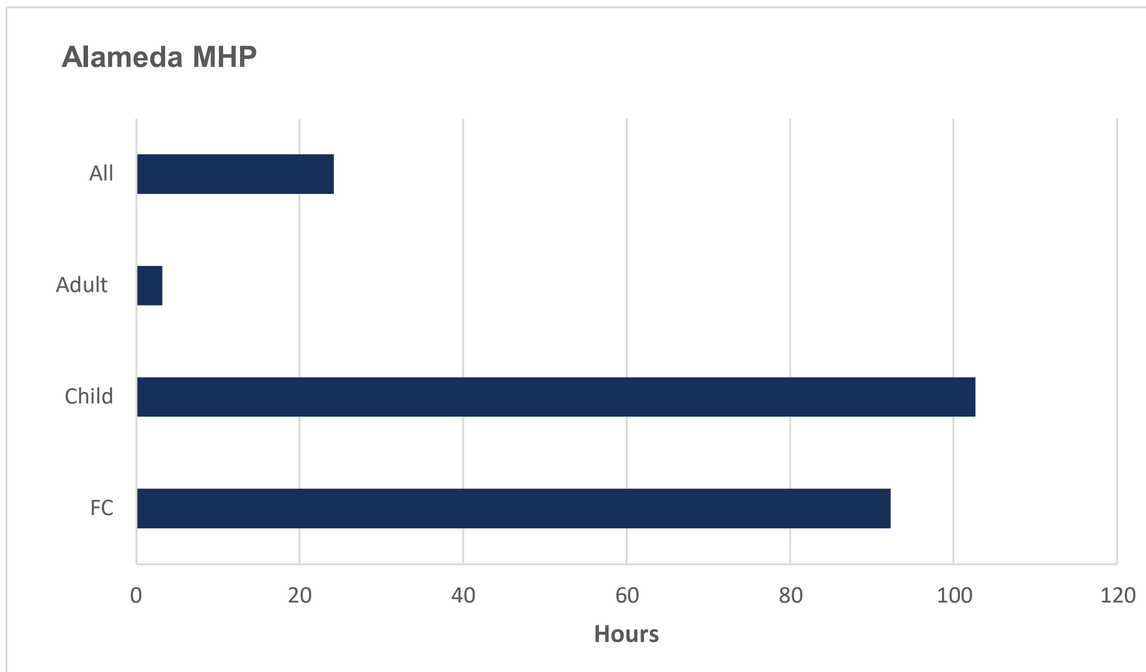
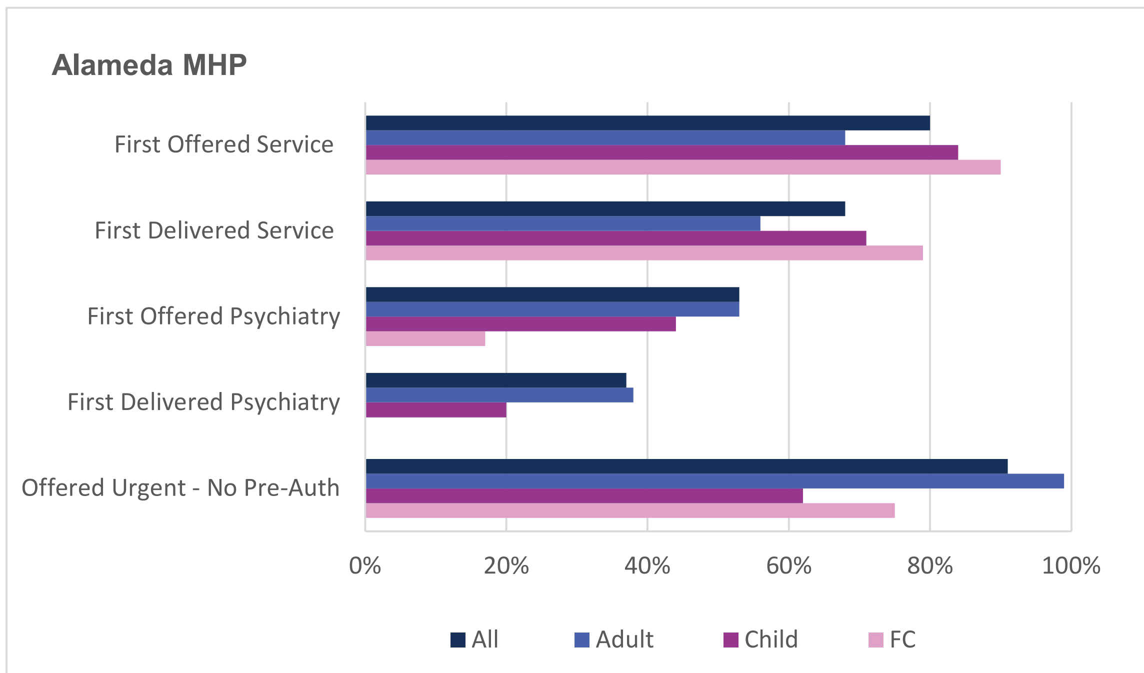


Figure 14: Percent of Services that Met Timeliness Standards



- 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 assessments.
- There were reportedly 972 urgent service requests with a reported actual wait time to services for the overall population of 24.2 hours. The MHP does not offer urgent services that require pre-authorization. The MHP defined "urgent services" for purposes of the ATA as the following:
    - Is the client pregnant or suffering a severe medical condition and at risk for complications if mental health symptoms are not addressed within the next 48-96 hours (i.e. two to four days)?
    - Does the client appear to be at serious increasing risk of progressing to imminent risk of suicide, homicide, grave disability, significant property destruction, loss of housing, risk of incarceration in the next 48-96 hours (i.e. two to four days)?
    - Is the client indicating they are running out of antipsychotics, mood stabilizers, and/or benzodiazepines within the next seven days?
    - Does the client indicate that they are in urgent need of mental health service, for any reason?
- A 15-business day standard is expected for initial access to psychiatry, though the MHP may define when and how this is measured, and often MHP processes, definitions, and tracking may differ for adults and children. The MHP defines

timeliness to first delivered/rendered psychiatry services as the time between initial psychiatry service request and the first psychiatry visit/service. The first psychiatry service is offered on average in 14 business days.

- The MHP reports a no-show rate of 7 percent for psychiatrists and 9 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

Though there are still gaps in data collection and reporting, the MHP made significant strides within FY 2022-23 to improve data metrics.

Use of the screening tool decreased the number of members that entered through Access, which assisted in providing the appropriate level of care for those seeking behavioral health treatment.

No-show rate tracking within the contracted providers remains an area the MHP could focus some attention on, with a lens towards creating a tracking system with a simplified methodology.

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 under the Quality Management (QM) Program Director, who directly oversees four FTEs: QI Analytics Manager, QI Project and Planning Manager, Utilization Management Division Director, and Quality Assurance Administrator; all of these staff collectively oversee other FTEs.

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 comprised of MHP and Substance Use Disorder staff, contract providers, and members and family members. It is scheduled to meet monthly. Of the 18 identified FY 2022-23 QAPI workplan goals, the MHP "met" 22 percent of their goals and "partially met" 55 percent of their goals and continue to work on the goals "not met."

The MHP utilizes the following LOC tool: Adult/Older Adult Outpatient Level of Care Determination Tool, this is an internally created tool.

The MHP utilizes the following outcomes tools: Pediatric Symptom Checklist (PSC-35), Child and Adolescent Needs and Strengths (CANS/CANS-50), Patient Health Questionnaire (PHQ-9), Assertive Community Treatment (ACT) fidelity tools.

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	Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	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	Met
3J	Member and Member Employment in Key Roles throughout the System	Met

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

- The QIC workplan interfaces with all divisions within the MHP, including the DMC-ODS, by integrating the monthly workgroups.
- The quality department utilized QIC dashboards to track and trend data.
- The MHP values the voice of the members with bi-directional communication. This approach is multi-pronged with regular provider meetings, targeted town halls, and peers/family member committees that all feed into the system.
- Peer staff reported being required to obtain peer certification without a salary increase or compensation for the newly acquired certificate, and also reported an inability to use peer billing codes.
- The MHP does track and trend the HEDIS measures as required by WIC Section 14717.5

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:

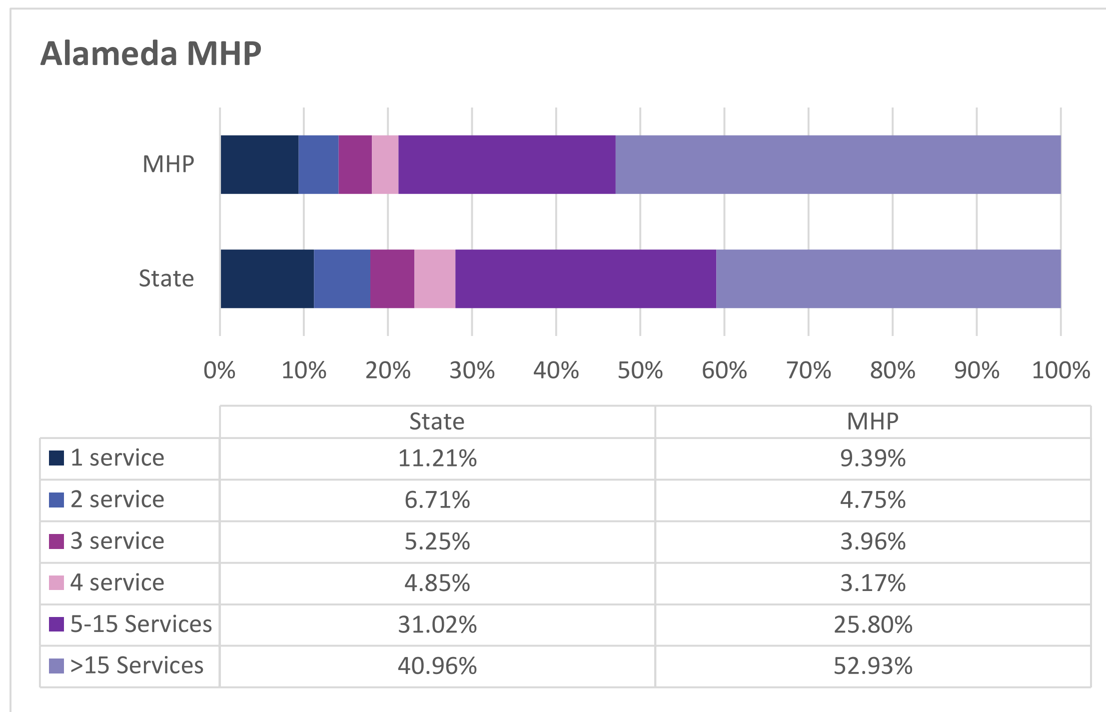
- Retention in Services

- 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%	9.39%
2 service	6.71%	4.75%
3 service	5.25%	3.96%
4 service	4.85%	3.17%
5-15 Services	31.02%	25.80%
>15 Services	40.96%	52.93%

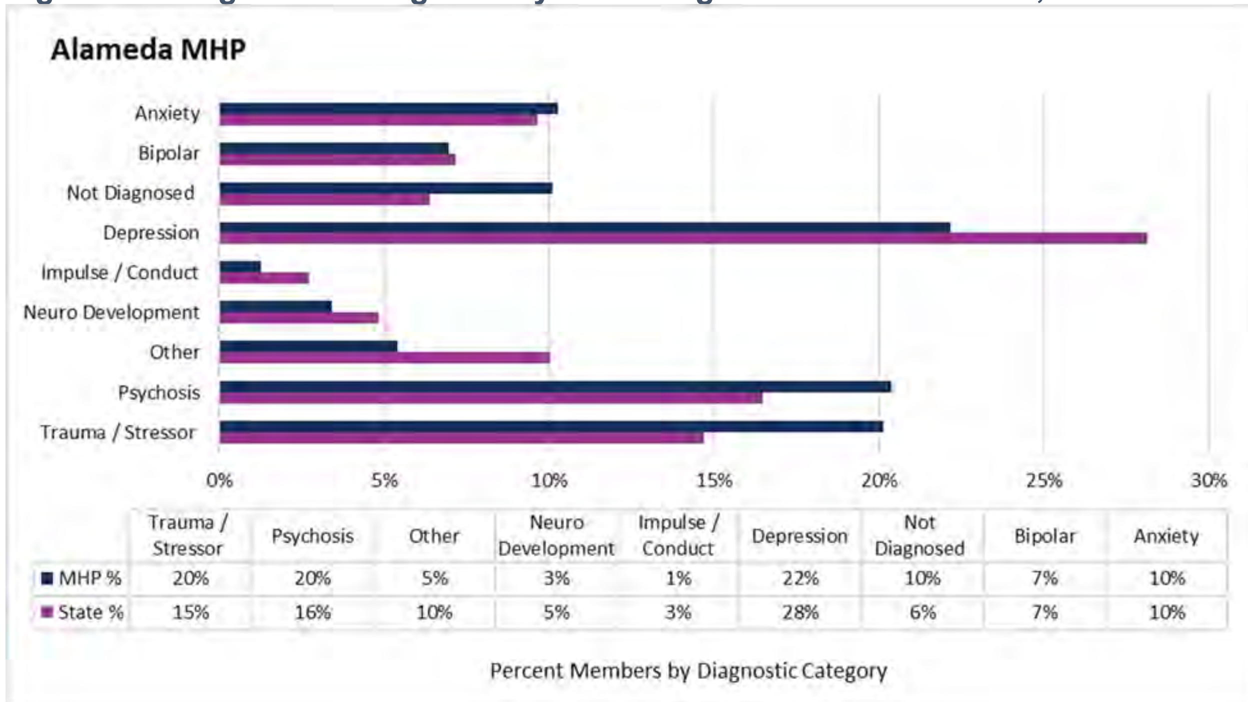
- The MHP has been able to retain members over longer periods of time with 78.73 percent of members receiving five or more services, above the statewide retention rate for five or more services at 71.98 percent.

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.

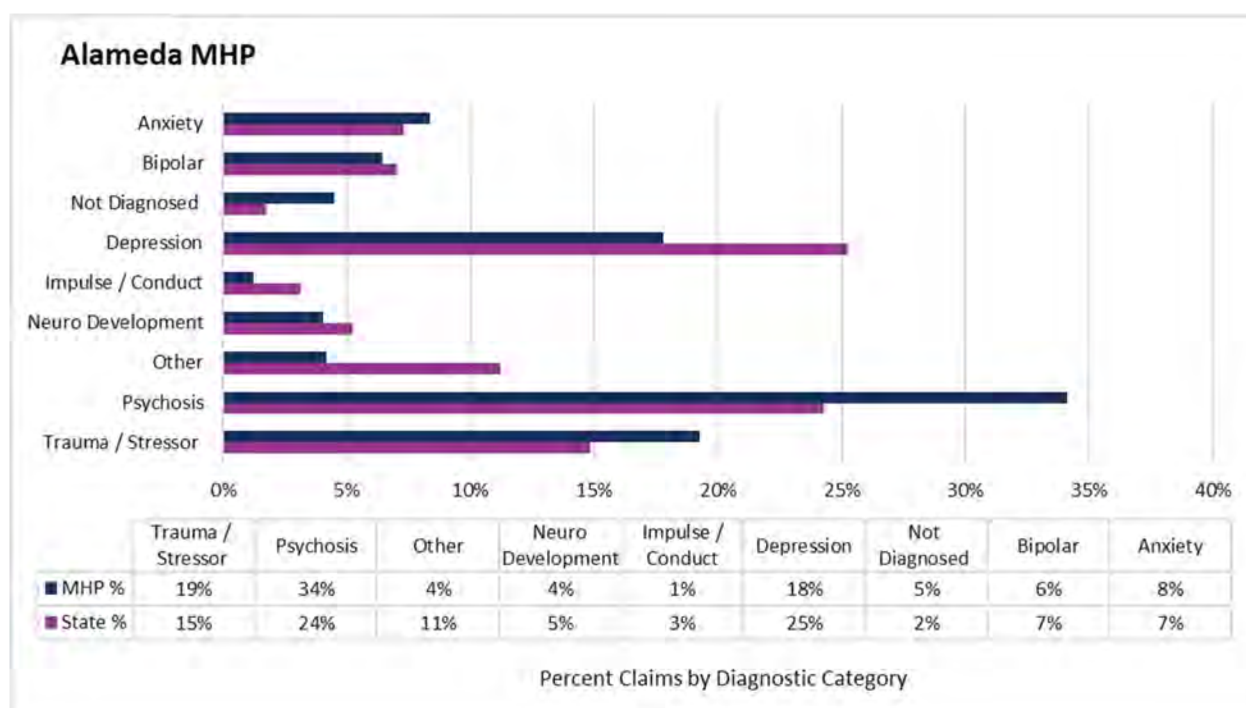
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	20%	20%	5%	3%	1%	22%	10%	7%	10%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- The top three diagnostic categories in Alameda are depression, psychosis, and trauma/stressor. Trauma/stressor and psychosis are more prevalent in the MHP than statewide, while depression is less prevalent.

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



- Psychosis is the leading diagnostic category by percentage of approved claims at 34 percent, while trauma/stressor is the second highest at 19 percent.

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: Alameda 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	1,715	2,499	1.46	7.25	8.45	$22,668	$12,763	$38,876,040
CY 2021	2,038	3,146	1.54	7.63	8.86	$19,612	$12,696	$39,969,618
CY 2020	1,911	3,161	1.65	6.37	8.68	$14,284	$11,814	$27,297,370

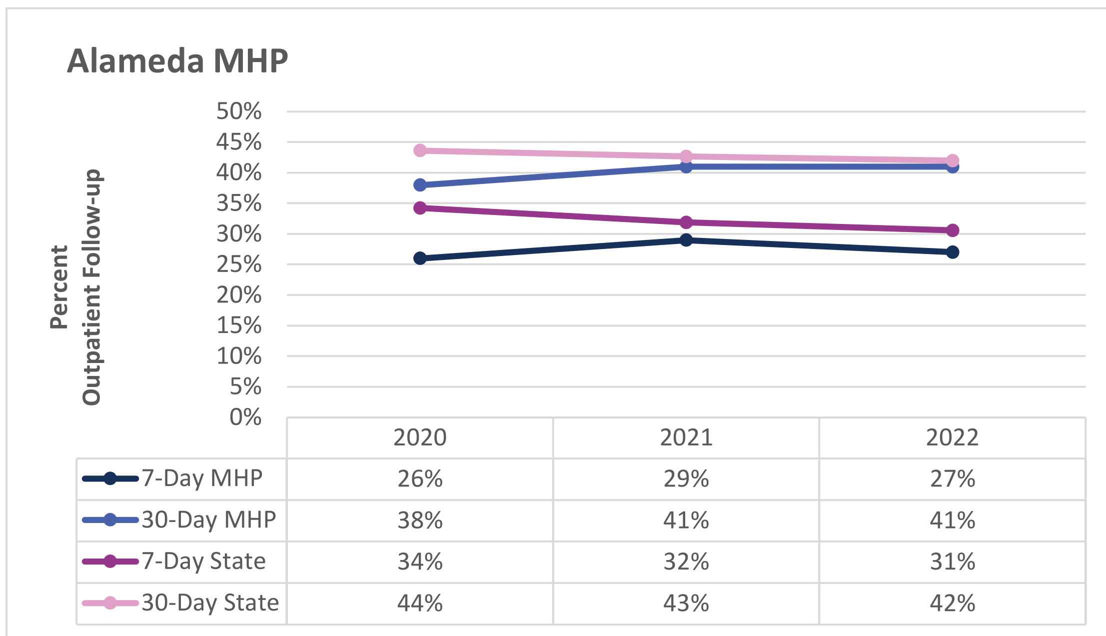
- The MHP showed reduced inpatient utilization in CY 2022, with fewer members, admissions, and a shorter average LOS.

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.

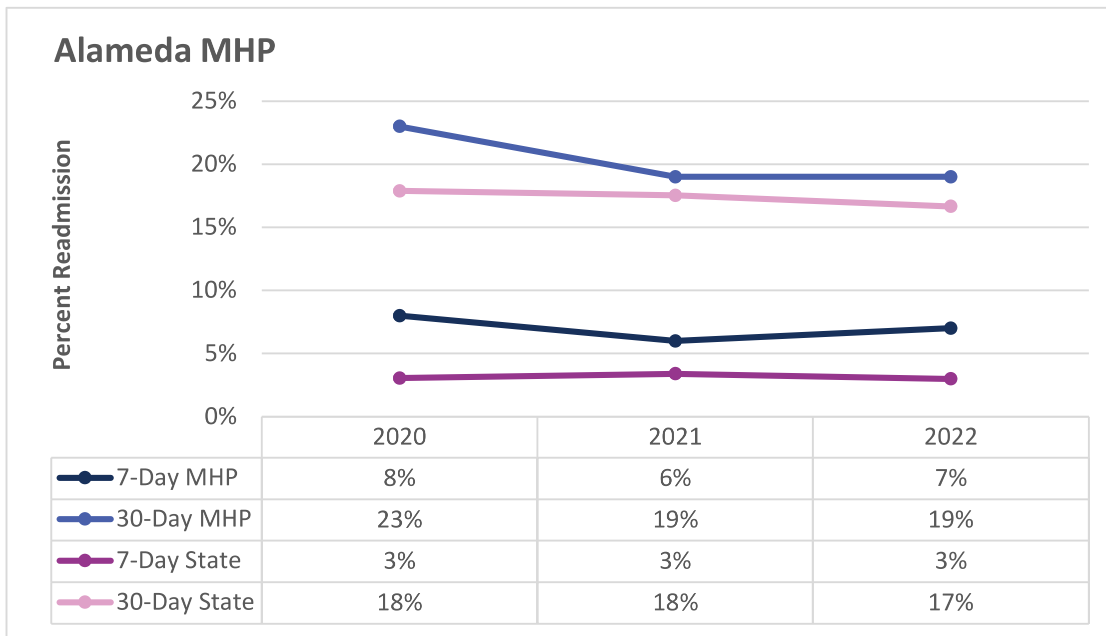
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	26%	29%	27%
30-Day MHP	38%	41%	41%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- Alameda's follow-up rates have been slightly below statewide numbers.

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



	2020	2021	2022
7-Day MHP	8%	6%	7%
30-Day MHP	23%	19%	19%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP's 7-day readmission rate is more than double statewide (7 percent versus 3 percent). The 30-day readmission rate for the MHP (19 percent) is higher than statewide (17 percent).
- The MHP's rates have been higher than statewide in the three years displayed for both 7-day and 30-day metrics. The MHP suspects that increases in the unhoused population contributes to their readmission rates.

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: Alameda 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	2,096	11.06%	51.54%	$130,587,766	$62,303	$47,609
	CY 2021	1,955	10.28%	48.61%	$116,868,008	$59,779	$47,370
	CY 2020	1,554	8.23%	42.12%	$85,398,183	$54,954	$46,250

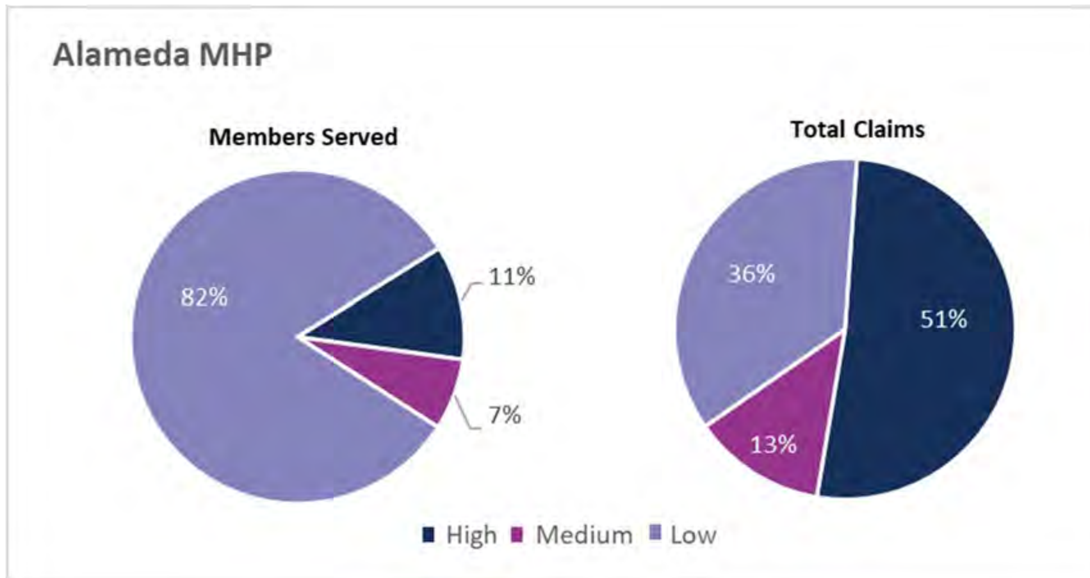
- The proportion of members considered HCMs has increased in Alameda over the past three years and was more than 6 percentage points higher than statewide in CY 2022.
- Claims attributed to HCMs account for more than half of all claims in the MHP for CY 2022.
- Average approved claims per HCM have increased 13.37 percent since CY 2020.

Table 15: Alameda 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)	1,314	6.93%	12.66%	$32,074,181	$24,410	$24,097
Low-Cost (Less than $20K)	15,539	82.00%	35.80%	$90,701,181	$5,837	$4,300

- Low-cost members make up most of the members in Alameda (82 percent), and account for 35.80 percent of all approved claims. Medium-cost members account for 12.66 percent of all approved claims and 7 percent of the members.

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



IMPACT OF QUALITY FINDINGS

- Retention in services is a strength in Alameda as 78.73 percent of members had five or more services in CY 2022.
- At 34 percent, psychosis leads all diagnoses in percentage of approved claims. This may correlate with the high percentage of approved claims for HCMs which accounts for 11.06 percent of all members served, but 51 percent of approved claims.
- 7- and 30-day psychiatric readmission rates are higher than statewide which may also contribute to the high percentage of approved claims for HCMs.
- Peer support specialist certification and Medi-Cal claiming could offer an additional revenue stream and provide peer employees with justification for a compensation review.
- With 79 percent of services contracted out, key informants have identified the need for a robust referral process to ensure members are receiving appropriate LOC and services. They also identified a lack of understanding of where to find internal information about job requirements and responsibilities. Training on what is available for staff could be beneficial in timely access to services for members and retention efforts with staff.
- Further study is recommended of the HCM population so that the MHP can start developing a plan to address the increase.

PERFORMANCE IMPROVEMENT PROJECT 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

Clinical PIP Submitted for Validation: Follow-Up After Emergency Department Visit for Mental Illness (FUM) Behavioral Health Quality Improvement Program (BHQIP)

Date Started: 09/2022

Aim Statement: "Increase timely information sharing from primary care Emergency Departments (ED) to improve pilot mental health Service Team 1) awareness of their Medi-Cal beneficiary clients' ED discharges; 2) capacity to provide follow-up services, and 3) rate of timely client follow-up. Implemented interventions aim to increase the percentage of specialty mental health follow-up activities within 30 days of ED visits for MH conditions by 5 percent by March 31, 2024."

Target Population: Members with ED visit for mental health conditions.

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

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

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

Summary

A root cause analysis indicated lack of access to real-time data and inconsistent communication from the numerous area hospitals as factors contributing to gaps in member identification, outreach, and care coordination capacity. Subsequent stakeholder engagement, conducted with the Adult and Older Adult System of Care and the County Specialty Mental Health Clinics, between January and June 2023, highlighted the need for timely and current client data from EDs as important for the clinics' ability to reach members immediately following ED discharge.

Interventions began in mid-2023 and were revised to accurately reflect the source and uses of ED discharge data used to program alerts that are facilitating improved clinical follow-up activities. In addition, the MHP decided to pilot interventions with service teams at the county-operated clinics only. This decision allows processes to be tested and refined with a smaller set of providers, to minimize disruptions to contracted community-based organizations serving members. Alameda is focusing on data exchange to improve care coordination. The intervention includes developing a dashboard and sharing discharge data with county-operated clinics for improved follow-up activities with members who visited the emergency department. The intervention began in mid-2023.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because the project so far only has baseline data.

CalEQRO recommendations for improvement of this clinical PIP:

- Clearly and completely define all aspects of the methodology for the PIP including the aim, target population, and data collection process.
- Consider measuring follow-ups for all eligible members. The baseline numbers are extremely low, and it may be difficult to generalize results to the entire eligible population.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Adult Access to Psychiatric Care

Date Started: 05/2023

Aim Statement: "Beginning May 2023, the MHP will pilot transferring up to five calls a week for adults who are referred by Access to Pathways to Wellness Medication Support services. By eliminating the need for a member to make a second call, the MHP hopes to increase the rate of connection by 15 percent."

Target Population: Adults of all ages calling the access line and request medication support services.

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

Summary

Previously, after receiving a referral, members were responsible for directly contacting Pathways to Wellness to secure their initial appointment. This initial step, following their initial contact with Access, can serve as a barrier to receiving care. The MHP initiated a PIP to improve the percentage of adult members who call the access line, need medication services, and receive those services in a timely manner. Alameda identified that members were given a phone number to call and that they may not follow-through with that due to other issues. The MHP decided to initiate a warm hand off process from the access line to the Pathways to Wellness medication support service. Alameda selects five members to pilot the intervention each week. The MHP will measure whether members who receive the warm hand off attend a medication appointment within one month of the referral.

The intervention has a "warm handoff" immediately occurring from Access and Pathways to Wellness by transferring the call while the member is still on the line to immediately receive an appointment time.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence because are no post-intervention results yet.

CalEQRO recommendations for improvement of this non-clinical PIP:

- Enhance the PIP's aim statement to include the baseline and a planned end date.
- Ensure that the performance measures' baseline and remeasurement results are comparable data.
- Investigate and implement efforts so that members speaking a language other than English can be included in the intervention.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR systems used by the MHP are SmartCare by Streamline, which was implemented in August 2023, and Clinicians Gateway by Krassons, Inc., which has been in use for 15 years. Currently, the MHP is actively implementing a new system which requires heavy staff involvement to fully develop. The MHP mentioned that Clinicians Gateway is an older system that will need to be replaced within the next two years and they are actively looking into other vendors, including SmartCare.

Approximately 4.99 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control. The IS budget is roughly 1.5 percentage points higher than it was at the time of last year's EQR (3.46 percent).

The MHP has 3,683 named users with log-on authority to the EHR, including approximately 917 county staff and 2,766 contractor staff. Support for the users is provided by 40 FTE IS technology positions. Currently there are 14 unfilled positions. The number of allocated FTEs has increased since last year's EQR when the MHP had 29 FTEs dedicated to IS. 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 Alameda 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	35%
Direct data entry into MHP IS by provider staff	☒ Daily ☒ Weekly ☒ Monthly	55%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	10%
		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 does not currently have a PHR but plans to implement one within the next year.

Interoperability Support

The MHP is a member or participant in a HIE. The MHP engages in electronic exchange of information with its contract providers and MCPs.

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	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:

- A notable strength for the MHP is the process in which data integrity validations occur. Data requests come into the QI and Data Analytics department through a tracking system where the project is assigned. Once the project is completed, another member of the data analytics team validates the data by re-running the data to ensure accuracy. Code is also vetted through a tracking system. This process ensures complete accuracy in reports before they are released to the end user.
- Alameda is a member of a HIE, Social Health Information Exchange (SHIE), where data is shared with local jails and emergency departments.
- Alameda's denied claims rate is nearly 3 percentage points lower than the statewide rate.

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.

Table 18 appears to reflect a mostly complete or very substantially complete claims data set for the time frame represented.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	50,213	$20,728,139	$756,629	3.65%	$19,971,510
Feb	51,795	$21,029,689	$812,064	3.86%	$20,217,625
Mar	61,622	$24,466,206	$826,680	3.38%	$23,639,526
April	50,277	$20,527,138	$641,279	3.12%	$19,885,859
May	51,311	$20,784,916	$671,985	3.23%	$20,112,931
June	45,286	$18,728,700	$474,571	2.53%	$18,254,129
July	39,959	$17,322,826	$396,873	2.29%	$16,925,953
Aug	47,064	$20,211,903	$613,756	3.04%	$19,598,147
Sept	50,086	$20,653,775	$528,445	2.56%	$20,125,330
Oct	50,669	$21,052,751	$551,524	2.62%	$20,501,227
Nov	48,107	$20,408,279	$598,777	2.93%	$19,809,502
Dec	42,396	$18,164,822	$514,916	2.83%	$17,649,906
Total	**588,785**	**$244,079,144**	**$7,387,499**	**3.03%**	**$236,691,645**

- Claims volume is relatively stable from month to month, with a very low denied claims rate.

Table 19: Summary of Alameda 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	8,583	$3,384,490	45.81%
Other healthcare coverage must be billed first	3,242	$2,038,759	27.60%
Beneficiary is not eligible or non-covered charges	2,498	$1,507,174	20.40%
Deactivated National Provider Identifier (NPI)	760	$297,792	4.03%
Late claim submission	81	$51,982	0.70%
Service line is a duplicate and repeat service modifier is not present	127	$50,754	0.69%
Other	116	$41,630	0.56%
Service location NPI issue	42	$14,919	0.20%
Total Denied Claims	**15,449**	**$7,387,500**	**100.00%**
Overall Denied Claims Rate	**3.03%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- Alameda has an overall denied claims rate well below the statewide rate (3.03 percent vs. 5.92 percent).
- The leading reason for denial in the MHP is Medicare Part B must be billed before submission of claim (45.81 percent of denials).

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP replaced its legacy billing system InSyst by Echo with SmartCare by Streamline by SmartCare in August 2023. Although Clinicians Gateway will be replaced sometime in the next year or two, Alameda continues to use this EHR for most clinical documentation. Besides billing, SmartCare will also be used for timeliness data submissions as well as State-mandated forms by the end of 2025.
- The budget for IS, as well as the number of IS FTEs, increased since last year, placing the MHP in a position of strength to meet the demands of the SmartCare implementation, along with the future EHR which will replace Clinicians Gateway.

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 reviews the mandatory CPS as provided to the County, but supplements these efforts with consumer feedback, townhall meetings, and QIC member/family member feedback. Through community listening sessions the MHP purchased a building to become a hub for the African American/Black community to investigate utilizing culturally relevant services.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

Consumer Family Member Focus Group One Summary

CalEQRO requested a peer employee group with a diverse group of adult members. The focus group was held virtually and included seven participants.

There are supervisory roles available for peers. The jobs provided to peers are both exciting and challenging. There are many resources available, but it is very challenging to navigate where clinics are and what are valid addresses and referral information. Housing continues to be a main issue for members.

Recommendations from focus group participants included:

- "More providers who look like me."
- "Replicate expanded peer support in the jails and court system."
- "Provide additional funding for transportation and travel to member locations."
- "Need more peer support for older adults."

Consumer Family Member Focus Group Two Summary

CalEQRO requested PMF focus group of Spanish speaking family members who initiated services in the preceding 12 months. The focus group was held virtually and included six participants; a Spanish language interpreter was used for this focus group. All family members participating have a family member who receives clinical services from the MHP.

There were many challenges in gaining access for children. Often phone calls were not returned, or paperwork was lost. The family members reported not knowing if staff would be present upon their arrival to the wellness center. They also noted having had poor interactions with crisis services. The family members would like the clinical staff to listen to parents as they may know when something is wrong with their loved one.

Recommendations from focus group participants included:

- "More sub-acute facilities."
- "Appointments scheduled before discharge, a better transition of services."
- "Work with the entire family."
- "Don't wait for more 'hits' on a chart to determine level of service."

SUMMARY OF MEMBER FEEDBACK FINDINGS

- Overall, peer employees enjoy working as peer support specialists and find support from supervisor and job satisfaction. They expressed the desire to expand services throughout the continuum.

- Family members express feelings of frustration at not being "heard," and knowing information that could assist their loved one in clinical services. They also expressed challenges accessing services and working with crisis staff.

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 is managing contracted providers for 79 percent of their services. Providers were complementary to the supportive nature of the MHP while transitioning to CalAIM objectives.

2. Peer employment and voluntary peer services are showcased throughout the SOC, including an increase in peer certification.

3. The MHP has a strong validation protocol when validating data and new or additional data metrics.

4. The MHP increased both the number of IS FTEs and the IS budget allocation since the last EQR. These increases, along with a strong quality data team, put Alameda in a position of strength to meet the current and future demands of EHR implementation, while also enabling them to meet increased reporting needs.

5. Utilizing new intern billing codes, the MHP was able to improve staff retention and recruitment with the ability to hire new and retain current interns.

OPPORTUNITIES FOR IMPROVEMENT

1. Though the MHP uses ALCOHub and SharePoint, key informants reported lack of knowledge of a centralized location for documents, policy and procedures, new priorities, and new-hire orientation information.
2. Internal and external key informants reported they would appreciate an updated website to highlight the Provider Directory, and include contact information, points of contact, location, and referral requirements. They believe this would help them to feel less siloed and would optimize their ability to refer members to more appropriate settings when applicable.
3. On the MHP's Website, it is difficult to identify crisis care numbers and 988. Additionally, it may be difficult to connect if the user is on an outdated computer system.

4. Although the MHP has implemented SmartCare by Streamline to handle billing, Clinicians Gateway is an older system, and it may benefit the MHP to consider using SmartCare for all of their documentation needs.
5. The MHP utilizes peers throughout the SOC, and many peers have become certified under SB 803. Key informants reported receiving no increase in pay upon becoming certified; additionally, they are not using the peer specialist Medi-Cal billing codes.

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. Provide all employees with training on how to access the shared intranet, and where to locate resources, policies and procedures, new hire orientation information, and intra-departmental communications.

2. Redesign the MHP Website to highlight the Provider Directory where contractors can easily find contact information for other providers in the MHP to help providers, especially crisis providers and those who work in the jails, expedite referrals to appropriate levels of care for the members.

3. Redesign the MHP Website to highlight crisis numbers such as 988 or after-hour services on the landing page.

4. Assign a project team to assess using SmartCare or another solution to replace the Clinicians Gateway.

5. Investigate Certified Peer Support Specialist pay equity and the ability to utilize billing codes for reimbursement.

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers identified by CalEQRO or the MHP.

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 – Alameda 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 Member Focus Groups
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Clinical Management and Supervision
Information Systems Billing and Fiscal Interview
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Cristobal Hernandez, PsyD, Quality Reviewer
Kiran Sahota, MA, Quality Reviewer
Brian Deen, Information Systems Reviewer
David Czarnecki, Member/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
Adam	Janice	Community Relations Coordinator, Division of Health Equity	Alameda County Behavioral Health
Anderson	Kara	Departmental Personnel Officer (ACBH)	Health Care Services Agency
Aslami	Khatera	Peer Support Services Manager, Division of Health Equity	Alameda County Behavioral Health
Arenius	Greg	Data Warehouse Engineer	Alameda County Behavioral Health
Bailey	Annie	Youth and Family Services Division Administrator	City of Fremont Youth & Family Services
Baker	Vanessa	Deputy Director, Plan Administration	Alameda County Behavioral Health
Bass	John	Behavioral Health Clinician, Children's Specialized Services	Alameda County Behavioral Health
Bergson	Melissa	Program Manager	Telecare
Bernhisel	Penny	Clinical Program Supervisor, Forensic, Diversion, & Re-Entry Services Director	Alameda County Behavioral Health
Biblin	Janet	Info Systems Manager, Quality Improvement	Alameda County Behavioral Health
Bhatt, MD	Sanjay	Senior Medical Director	Alameda Alliance for Health
Bolden	P'Shana	Clinical Social Worker Monument	La Clínica de La Raza
Bradley	Bill	Case Manager	Bay Area Community Services
Brown	Renikia	Intern, Adult Outpatient Services	Alameda County Behavioral Health
Buttlaire	Stuart	Inpatient Psychiatry and Continuing Care Regional Director	Northern Kaiser Permanente

Last Name	First Name	Position	County Or Contracted Agency
Capece	Karen	Quality Management Program Director	Alameda County Behavioral Health
Carlisle	Lisa	Child & Young Adult System of Care Director	Alameda County Behavioral Health
Castro	Dainty	"MHAB" Liaison, Office of the ACBH Director	Alameda County Behavioral Health
Catolos	Agnes	Clinical Operations, Office of the Deputy Director	Alameda County Behavioral Health
Chambers	Dean	Critical Care Manager, Crisis System of Care	Alameda County Behavioral Health
Chand	Anuja	Program Specialist, Clinical Operations Deputy Director’s Office	Alameda County Behavioral Health
Chapman, MD	Aaron	Behavioral Health Medical Director and Chief Medical Officer	Alameda County Behavioral Health
Chau	Mandy	Audit and Cost Reporting Director, Finance	Alameda County Behavioral Health
Chiang	Katy	Analyst, Information Systems	Alameda County Behavioral Health
Clark	Lynsey	Clinical Supervisor	West Oakland Health Center
Coffin	Scott	Chief Executive Officer	Alameda Alliance for Health
Coombs, MD	Angela	Office of the Medical Director Associate Medical Director	Alameda County Behavioral Health
Cooper Kahn	Mia	Senior Manager of Behavioral Health	Community Health Center Network
Currie	Peter	Senior Director of Behavioral Health, Integrating Behavioral and Physical Health	Alameda Alliance
Dashiell	Margot	Founding Family Member, Alameda County Family Coalition	Alameda County Mental Health Services
Davies	Kathy	Executive Director	Mental Health Association of Alameda County

Last Name	First Name	Position	County Or Contracted Agency
De La Torre	Nadine	Peer Employee	Felton Institute
Deleon	Ebonye	Recovery Specialist II	Telecare
Diedrick	Sheryl	System Analyst	Alameda County Behavioral Health
Dhillon	Narges	Executive Director	Crisis Support Services of Alameda County
Do, MD	Tri D.	Chief Medical Officer	Community Health Center Network
DValery	Rene	Oakland & Hayward Clinical Director	Family Paths Inc.
Eady	Rashad	Program Specialist, Quality Improvement	Alameda County Behavioral Health
Edwards	Charles	Interim ACCESS Director	Alameda County Behavioral Health
Eldridge	Robin	HR Liaison, Office of the ACBH Director	Alameda County Behavioral Health
Elliott	Anne	Critical Care Manager, Crisis System of Care	Alameda County Behavioral Health
Farrow	Robert	Training Officer	Alameda County Behavioral Health
Felton	Mistique	Operations Manager, Casa del Sol	La Clínica de La Raza
Firpo	Daniel Chris	Associate Clinical Social Worker	Telecare Corporation
Freeman	Sheila	Behavioral Health Case Manager	Anthem
Gerchow	Christine	Juvenile Justice Health Services Director	Alameda County Behavioral Health
Gibbs	Laphonsa	Child & Young Adult Outpatient Services Division Director	Alameda County Behavioral Health

Last Name	First Name	Position	County Or Contracted Agency
Glassie	Lori	Psychiatric Physician Assistant	Telecare Corporation
Golub	Adm	QI Management Analyst	Alameda County Behavioral Health
Goldberg	Seth	Behavioral Health Director	UCSF Benioff Children's Hospital Oakland
Goodman	Necole	Associate Data Analyst	Alameda County Behavioral Health
Grayson	Kellen	Clinical Supervisor	Pathways to Wellness
Gums	Angelica	Human Resources Liaison	Alameda County Behavioral Health
Hall, PhD	Lorenza	Senior Management Analyst	Alameda County Behavioral Health
Harrington	Ellen	Program Manager	Felton Institute
Harris	Bradley	Peer Employee	Telecare
Harris	Raiyah	Transition Age Youth Services Coordinator/Supervisor	WestCoast Children's Clinic
Hayes	Steve	Program Assistant	Peers Envisioning and Engaging in Recovery Services
Hazelton	Tracy	Mental Health Services Act Division Director	Alameda County Behavioral Health
Henry	Krishna	Quality Management, Administrative Assistant	Alameda County Behavioral Health
Hernandez	Diana	SmartCare Implementation Project Manager, Information Systems	Alameda County Behavioral Health
Huerta	Amelia (Amie)	Behavioral Health Clinician, Oakland Children's Services	Alameda County Behavioral Health
Hunt	Linda	Clinical Manager, Adult & Older Adult System of Care	Alameda County Behavioral Health

Last Name	First Name	Position	County Or Contracted Agency
Jackson	Summer	Project Manager	Alameda County Behavioral Health
Johnson	Carla	Adult Behavioral Health Director	La Familia Counseling Services
Jones	Katherine	Adult & Older Adult Services Director	Alameda County Behavioral Health
Jones	Yvonne	Adult Forensic Behavioral Health Director	Alameda County Behavioral Health
Judkins	Andrea	Supervising Financial Services Specialist, Fiscal Services	Alameda County Behavioral Health
Kessler	Michael	Clinical Program Specialist, Adult & Older Adult System of Care	Alameda County Behavioral Health
Keyoumarsi	Jessica	Social Worker	La Clínica de La Raza
Kiefer	Andrea	Clinical Review Specialist , Specialty Services	Alameda County Behavioral Health
Kim	Grace	Clinical Supervisor	West Oakland Health
Kolda	Deanna	Clinical Review Specialist Supervisor, Utilization Management	Alameda County Behavioral Health
Kong	Jennifer	Clinical Supervisor	Telecare
Konover	Kimberly	Clinical Manager, Forensic, Diversion, & Re-Entry Services	Alameda County Behavioral Health
Lee	Davis	Mental Health Advisory Board Chair	Alameda County Behavioral Health
Lee	Rashawnda	Program Specialist	Alameda County Behavioral Health
Lee	SunHyung	Transition Age Youth Services Division Director	Alameda County Behavioral Health
Leon	Eugenia	Mental Health Clerk	La Clínica de La Raza

Last Name	First Name	Position	County Or Contracted Agency
Lesova	Svetlana	Assistant Director - Forensic, Diversion, and Re-entry System of Care	Alameda County Behavioral Health
Lewis	Clyde	Substance Use Disorder Services Director	Alameda County Behavioral Health
Lewis	Michelle	Interim Clinical Supervisor	Alameda County Behavioral Health
Lewis	Stephanie	Acting Crisis System of Care Director	Alameda County Behavioral Health
Lilly	Siobhan	Administrative Specialist II, Office of the Deputy Director	Alameda County Behavioral Health
Ling	Jennifer	Clinical Review Specialist/Eating Disorder Coordinator, Specialty Services	Alameda County Behavioral Health
Lopez	Rickie Michelle	Assistant Finance Director	Alameda County Behavioral Health
Lott	Yesenia	Clinical Supervisor, Crisis System of Care	Alameda County Behavioral Health
Louie	Jill	Budget and Fiscal Services Director	Alameda County Behavioral Health
Lozano	Ed	Applications Development Manager, Information Systems	Alameda County Behavioral Health
Macklin	Kalil	Program Manager	Elevance Health
MacMillan	Tom	Information Systems Deputy Director	Alameda County Behavioral Health
Madaus	Matt	Executive Director	The Behavioral Health Collaborative of Alameda County
Manor	Michelle	QI Project & Planning Manager/Supervising Program Specialist	Alameda County Behavioral Health
Marquez-Cortes	Kimberly	Program Manager	Peers Envisioning and Engaging in Recovery Services

Last Name	First Name	Position	County Or Contracted Agency
Mazid	Sanjida	Manager, Workforce Development, Education and Training	Alameda County Behavioral Health
McCarrick	Jessica	Clinical Trainee, Portia Bell Hume Behavioral Health and Training Center	The Hume Center
Mehta	Ravi	Chief Compliance & Privacy Officer	Alameda County Behavioral Health
Meinzer Valentino	Chet	Information Systems Manager, Decision Support Team	Alameda County Behavioral Health
Miao	Leslie	Director of Compliance	The Hume Center
Miller	Jennifer	San Francisco & Oakland UCSF Service Line Director	UCSF Benioff Children's Hospital Oakland
Momoh	Imo	Deputy Director/Plan Administrator	Alameda County Behavioral Health
Montgomery	Stephanie	Health Equity Division Director/Health Equity Officer	Alameda County Behavioral Health
Moore	Lisa	Billing & Benefits Support Director	Alameda County Behavioral Health
Mukai	Christine	Critical Care Manager, Youth Services	Alameda County Behavioral Health
Mullane	Jennifer	Adult & Older Adult Associate Director	Alameda County Behavioral Health
Narvaez	Cheryl	EPSDT Coordinator, Children and Young Adult System of Care	Alameda County Behavioral Health
Nichols	Paul	Management Analyst, Finance	Alameda County Behavioral Health
Obrien	Steve	Chief Medical Officer	Alameda Alliance for Health
Olvera	Patricia	Marriage and Family Therapist	Multilingual Counseling
Omoko	Alex	Employment Coordinator	Bay Area Community Services

Last Name	First Name	Position	County Or Contracted Agency
Orozco	Gabriel	Management Analyst, Quality Management	Alameda County Behavioral Health
Orozco	Tiffany	Clinical Supervisor	Alameda County Behavioral Health
Orrante	Shaun	Lead Clinician	Bay Area Community Services
Osmond	Jessica	Older Adult Service Team Program Director	Felton Institute
Paine	Janet	Program Management Director, CA Medicaid Health Plan	Anthem
Perales	Joseph	Casa Del Sol Manager	La Clínica de La Raza
Peterson	Camille	Analyst, Information Systems	Alameda County Behavioral Health
Phan	Jade	Manager, Information Systems	Alameda County Behavioral Health
Phipps	Brion	Clinical Review Specialist Supervisor	Alameda County Behavioral Health
Piedade	Chastity	Clinical Supervisor, Adult Outpatient Services Division Director	Alameda County Behavioral Health
Ponssa	Jose	Bilingual (Spanish) Early Childhood Mental Health Clinician	City of Fremont Youth & Family Services
Powell	Catherine	Early Childhood Mental Health Coordinator, Child & Young Adult System of Care	Alameda County Behavioral Health
Provost	John	Services Manager, Information Systems	Alameda County Behavioral Health
Purciel-Hill	Marnie	QI Performance Improvement Manager	Alameda County Behavioral Health
Quach	Thu	President	Asian Health Services
Ramcharitar	Renee	Program Coordinator	Peers Envisioning and Engaging in Recovery Services

Last Name	First Name	Position	County Or Contracted Agency
Raynor	Charles	Pharmacy Services Director	Alameda County Behavioral Health
Razzano	Theresa	Vocational Services Division Director	Alameda County Behavioral Health
Reese	Linda	Regional Operations Director	Telecare Corporation
Rejali	Torfeh	Quality Assurance Administrator	Alameda County Behavioral Health
Reyes	Trinh	Crisis Intervention Specialist Supervisor, Crisis System of Care	Alameda County Behavioral Health
Richholt	Kinzi	Chief Nursing Officer, Office of the Medical Director	Alameda County Behavioral Health
Rodriguez	Laura	TEAM Program Supervisor	La Familia Counseling Services
Rosenbaum	Michael	Case Manager	Telecare Corporation
Rosso	Stephanie	Behavioral Health Clinical Operations Director	UCSF Benioff Children's Hospital Oakland
Rowe	Kathryn	Data Quality Coordinator	Alameda County Behavioral Health
Saechao	Kao	Specialty Mental Health Director	Asian Health Services
Sakhai	Roya	Program Manager	Multilingual Counseling
Sampson	Sakara	Administrative Specialist II, Quality Improvement	Alameda County Behavioral Health
Sanchez-Lerma	April	Behavioral Health Clinical Supervisor, Tri-City Children and Youth Services	Alameda County Behavioral Health
Sanders	Laura	Health Care Services Agency Human Resources Deputy Director	Alameda County Behavioral Health
Sanjay	Bhatt	Medical Director, Quality Improvement	Alameda Alliance

Last Name	First Name	Position	County Or Contracted Agency
Schrick	Juliene	Utilization Management Division Director	Alameda County Behavioral Health
Schulz	Henning	Adult Outpatient Services Division Director	Alameda County Behavioral Health
Scoggins	Radiant	Behavioral Health Associate Director	West Oakland Health
Serrano	Cecilia	Finance Director	Alameda County Behavioral Health
Shah	Mona	Health Equity Policy and Systems Manager/ Interim Office of Ethnic Services Administrator	Alameda County Behavioral Health
Shallcross	Lori	Clinical Review Specialist, Utilization Management	Alameda County Behavioral Health
Smith	Freddie	Integrated Care Services Division Director	Alameda County Behavioral Health
Smith	Sandra	Clinical Manager, Eden Community Support Center	Alameda County Behavioral Health
Smith	Sarah	AdROC / TAY ROC Clinical Director	Telecare Corporation
Spensley	Catherine	Senior Services Division Director	Felton Institute
Sunga	Doris	Data Infrastructures Engineer	Alameda County Behavioral Health
Taizan	Juan	Forensic, Diversion, & Re-Entry Services Director	Alameda County Behavioral Health
Terovic	Nermina	Administration Program Specialist	Alameda County Behavioral Health
Terry	DeAndrea	Clinical Review Specialist, Specialty Services	Alameda County Behavioral Health
Tribble, PhD	Karyn	Director	Alameda County Behavioral Health
Turbay	Camilo	Care Coordinator	Bay Area Community Services

Last Name	First Name	Position	County Or Contracted Agency
Utecht	Dawan	Senior Vice President, Chief Development Officer	Telecare Corporation
Vargas	Wendi	Contracts Director	Alameda County Behavioral Health
Vazquez	Jennifer	Volunteer	La Familia Counseling Services
Wagner	James	Clinical Operations Deputy Director	Alameda County Behavioral Health
Warder	Rosa	Family Empowerment Manager	Alameda County Behavioral Health
Weissberger	Laura	Interim Executive Director	Bonita House
Whitmer	Teena	Human Resources Specialist	Health Care Services Agency
Wiley	Karly	SBHG Northern CA Regional Administrator	Stars, Starlight, and Capital Star
Wilhite	Marguerite	Behavioral Health Clinical Manager, Oakland Children's Services	Alameda County Behavioral Health
Wilkinson	Sindy	Behavioral Health Clinician II, Eden Children's Services	Alameda County Behavioral Health
Williams	Donna	Clinical Supervisor, Adult Outpatient Services Division Director	Alameda County Behavioral Health
Wong	Jenny	Management Analyst, Quality Management	Alameda County Behavioral Health
Woodland	David	Clinical Review Specialist, Quality Assurance	Alameda County Behavioral Health
Yates	Deb	Clinical Supervisor, Child & Young Adult System of Care	Alameda County Behavioral Health
Yee	Philip	Licensed Team Lead	Telecare Corporation
Yip	Amos	Clinical Manager	Asian Health Services

Last Name	First Name	Position	County Or Contracted Agency
Young	Alycia	Facilities Development Manager, Finance	Alameda County Behavioral Health
Young-Hooks	Tangie	Mental Health Specialist III, Adult Outpatient Services	Alameda County Behavioral Health
Yuan	Betsy	Senior Clinical Pharmacist	Alameda County Behavioral Health
Yuan	Eric	Manager, Integrated Care Services	Alameda County Behavioral Health
Yun	Jennifer	Clinical Supervisor	Alameda County Behavioral Health
Zastawney	Wendy	Clinical Review Specialist Supervisor, ACCESS Program	Alameda County Behavioral Health

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 submitted the FUM BHQIP for its clinical PIP. Alameda is focusing on data exchange to improve care coordination. The intervention includes developing a dashboard and sharing discharge data with county operated clinics for improved follow-up activities with members who visited the emergency department. The intervention began in mid-2023. The MHP provided baseline data.
General PIP Information	
MHP/DMC-ODS Name: Alameda	
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness (FUM) Behavioral Health Quality Improvement Program (BHQIP)	
PIP Aim Statement: "Increase timely information sharing from primary care ED to improve pilot mental health Service Team 1) awareness of their Medi-Cal beneficiary clients' ED discharges; 2) capacity to provide follow-up services, and 3) rate of timely client follow-up. Implemented interventions aim to increase the percentage of specialty mental health follow-up activities within 30 days of ED visits for MH conditions by 5 percent by March 31, 2024."	
Date Started: 09/2022	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

Target population description, such as specific diagnosis (please specify): Members with ED visits for mental health conditions.

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):

Call to the client or a visit in person at the hospital to connect the individual with a clinical outpatient appointment.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):

n/a

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):

Data exchange collaboration with local hospitals and county-operated clinics on emergency department discharges.

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
Percent of pilot clinics reporting they are receiving the ED discharge alerts	July-Sept 2023	4/4=100%	☐ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number and percent of pilot Service Team-connected clients who received a follow-up service within 7 days of ED discharge	May-June 2023	6/9=66.7%	☐ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number and percent of pilot Service Team-connected clients who received a follow-up service within 30 days of ED discharge	May-June 2023	8/9=88.9%	☐ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- Clearly and completely define all aspects of the methodology for the PIP including the aim, target population, and data collection process.
- Consider measuring follow-ups for all eligible members. The baseline numbers are extremely low, and it may be difficult to generalize results to the entire eligible population.
- The MHP should identify if there are more than four clinics for the PIP and provide the names of the clinics.
- Performance measure 1, "Percent of pilot clinics reporting they are receiving the ED Discharge alerts" appears to be an intervention tracking measure and not a performance measure.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	The MHP initiated a PIP to improve the percentage of adult members who call the access line, need medication services, and receive those services in a timely manner. Alameda identified that members were given a phone number to call and that they may not follow-through with that due to other issues. The MHP decided to initiate a warm hand off process from the access line to the Pathways to Wellness medication support service. Alameda selects five members to pilot the intervention each week. The MHP will measure whether members who receive the warm hand off attend a medication appointment within one month of the referral.

General PIP Information
MHP/DMC-ODS Name: Alameda
PIP Title: Adult Access to Psychiatric Care
PIP Aim Statement: “Beginning May 2023, the MHP will pilot transferring up to five calls a week for adults who are referred by ACCESS to Pathways to Wellness Medication Support services. By eliminating the need for a member to make a second call, the MHP hopes to increase the rate of connection by 15 percent.”
Date Started: 05/2023
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Adults of all ages calling the access line and request medication support services.

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): Warm hand off for adult members from access line to medication support services.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
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): n/a

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Rate of being seen within 30 days of referral for intervention pop	5/2022 – 4/2023	127/685 18.5%	5/22/2023-6/30/2023	12/18 66.7%	☐ Yes ☐ No Results do not appear comparable	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 2. Rate of being seen within 30 days of referral for non-intervention pop	5/2022 – 4/2023	127/685 18.5%	5/22/2023-6/30/2023	38/61 62.3%	☐ Yes ☐ No Results do not appear comparab le	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3. Number of referrals per week with Warm Handoff	5/22/2023 – 6/30/2023	18 referrals made in the 6-week period				

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Enhance the PIP's aim statement to include the baseline and an end date. • Performance measure 3, "Number of referrals per week with Warm Handoff" appeared to be an intervention tracking measure, and not a performance measure. • Ensure that the performance measure's baseline and remeasurement results are comparable data. • Investigate and implement efforts so that members speaking a language other than English can be included in the intervention.

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

A letter from the MHP Director was not required as part of this report.