

BACKGROUND:

- CalAIM's 2023 standardized screening tool routes Medi-Cal members between Managed Care Plans (mild/mod) and County Mental Health Plans (specialty/SMI). It was designed to serve as administrative routing and not as a clinical assessment.
- No published county-level evaluation of the tool's post-go-live performance existed; ACCESS clinicians have raised concerns about borderline cases, self-report limitations, and routing of patients with limited insight of symptoms or language barriers.

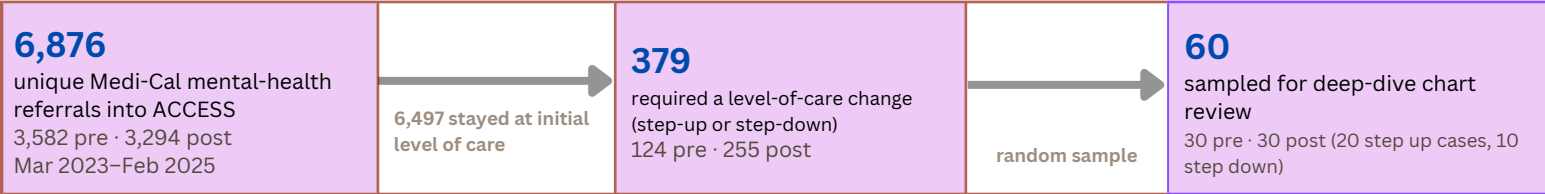
SETTING:

San Mateo County public mental health system Behavioral Health and Recovery Services(BHRS) ACCESS line implemented the CalAIM Adult Screening Tool in March 2024, replacing the county's internal screening protocol. The Transition of Care Tool has not yet been implemented.

OBJECTIVES:

- Measure triage accuracy and cross-system movement before vs. after CalAIM.
- Deep dive chart review of a random sample to characterize who gets transitioned to a different level of care and the clinical/workflow factors driving this choice.
- Identify equity signals using data the county already collects

SAMPLE — HOW WE GOT TO THE CHART REVIEW



KEY FINDINGS: WHAT CHANGED AFTER CALAIM

STEP-UP RATE		STEP-DOWN RATE		TIME TO CORRECT LEVEL OF CARE	
PRECALAIM	POSTCALAIM	PRECALAIM	POSTCALAIM	PRECALAIM	POSTCALAIM
2.8%	5.0%	9.7%	20.5%	26	107
Screened Mild/mod → later needed specialty/SMI services		Screened specialty/SMI → later mild/mod		Median days spent in the “wrong” door	

DEEP DIVE CHART REVIEW PATTERNS FOR POST CALAIM TRANSITIONED PATIENTS (N=30 cases))

- 80% (16/20) crisis-triggered step-ups came only after a 5150, ED visit, or hospitalization.
- 30% (6/20) had active psychosis yet scored ≤4(mild/mod) on the DHCS screening tool - highlighting the limitations of self-report
- 100% (10/10) of step-downs were female, none of these cases reported psychosis or hospitalization.
- CalAIM implementation: step ups involved disproportionately more Hispanic (step-ups 30% →55%) and male(25% →65%) patients.

MAIN TAKEWAYS

- Increased cross-system movement indicates more clinical transitions, which incur costs to the system
- Without a non-crisis correction pathway (like the TOC), crises serve as the correction; 80% of step-ups follow emergencies, with a median wait of 107 days before corrected
- Transition costs are asymmetric to the patient: step-ups offer relief, while step-downs result in loss of support and relationships.
- Costs fall unevenly: step-downs of female patients, step-ups of Hispanic/male patients, under-detected psychosis. The TOC tool fixes only the administrative half.

RECOMMENDATIONS:

- Every county can run this step-up/step-down analysis on existing operational data which can be an indicator of screening-tool fidelity
- Introduce a structured psychosis probe to better identify symptoms of psychosis through self-report
- Build a clinician override field at ACCESS intake to flag “scored but uncertain” cases (masked psychosis, minimizers, collateral concers) for SDA review regardless of score
- Initiate a prior-engagement flag at ACCESS intake