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

YOLO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

February 8-9, 2023

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Yolo" may be used to identify the Yolo County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type —Virtual

Date of Review — February 8-9, 2023

MHP Size — Medium

MHP Region — Central

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
7	1	5	1

Table B: Summary of Key Components

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

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Improving Screening of Co-occurring Disorders (COD) for Beneficiaries	Clinical	07/20	Other: Completed	Moderate
Follow-up After Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	10/22	Planning	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	9
2	☒Adults ☐ TAY ☒Family Members ☒Other: Latino/Hispanic	7

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP leverages case management to enable ongoing services to beneficiaries as it faces staffing challenges with clinical positions.
- Through partnerships with community agencies, the MHP facilitates access to services for Medi-Cal eligibles and beneficiaries.
- The MHP has added a governance structure for its Electronic Health Record (EHR), which puts the MHP in a better position for implementing several IS projects.
- The MHP has an established post-hospitalization process facilitated through a dedicated discharge planner.
- The MHP has systematically gone through each of its programs to develop a unique sets of parameters to measure the quantity, quality, and outcomes of the provided services.

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

- MHP staff report increased caseloads, increased administrative demands due to new regulations and initiatives, and decreased opportunity to provide system input. A concern among stakeholders was low staff morale, which may precipitate staff departures.

- The MHP's Asian/Pacific Islander (API) penetration rate (PR) for CY 2021 was below the statewide average and has remained relatively unchanged for the past three years.
- The MHP did not provide timeliness data for first offered appointment and first offered psychiatry appointment, citing challenges with data accuracy and inconsistencies in data collection.
- The MHP reports that it tracks but does not trend the key indicators for medication monitoring for youth in foster care (FC).
- The MHP intends to provide EHR access to contract providers but there are contract amendments and fiscal and operational issues that must be resolved first.

Recommendations for improvement based upon this review include:

- Investigate reasons and develop and implement strategies to increase staff engagement meaningfully in system improvement.
- Investigate reasons and develop and implement strategies to increase the API PR.
- Implement the new methodology to accurately track and report time to first offered services and incorporate routine review of the data and reports for accuracy.
- Implement solutions to produce reports that demonstrate tracking, monitoring, and analyzing of the requisite indicators for youth in FC prescribed psychotropic medications.
- Develop and implement a plan to amend existing contracts and resolve fiscal and operational issues, which would enable interested contract providers to gain full access to the EHR.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2022-23 findings of the EQR for Yolo County MHP by BHC, conducted as a virtual review on February 8-9, 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 analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

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

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS 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.
- Review and validation of each MHP's NA as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment 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.
- Beneficiary perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP continues to have a high vacancy rate and periods of staff absence due to illness (from COVID-19, Respiratory Syncytial Virus, and Mpox) and family leave. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

- In November 2022, the MHP closed one of its full-service partnership (FSP) programs, ending its contract with the contract provider.
- The MHP has had several leadership and management changes, including the appointment of a new Behavioral Health Director in August 2022. Other leadership positions are vacant, including the Behavioral Health Medical Director position that has been vacant for two years.
- The MHP continues to implement California Advancing and Innovating Medi-Cal (CalAIM) and manage the complexities inherent with system transformation. The new Quality Management Manager was appointed the CalAIM Behavioral Health Coordinator to assist with this implementation.
- The MHP has added a governance structure to its EHR system for prioritizing projects and ensuring successful IS projects and expanded the EHR training framework.
- Yolo County's Health and Human Services Agency (HHSA) has created new staff positions, filled some vacant management positions, and restructured MHP services oversight in an effort to adapt to a reduced workforce.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Addressed is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2021-22

Recommendation 1: Investigate and identify reasons for the low service PRs of the Latino/Hispanic population as well as for the API population. Implement interventions to address obstacles to service access.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially addressed this recommendation. While the MHP investigated and identified reasons for the low PRs of Latino/Hispanic and API populations and implemented interventions to increase access for Latino/Hispanic eligibles, it did not implement interventions to outreach to API communities and eligibles.
- The MHP indicates that low PRs in the Latino/Hispanic and API populations may be due to cultural understanding/perspectives and stigma around mental illness in these communities.
- The MHP credited the work and outreach of its contracted providers to gradual increase in the Latino/Hispanic PR over the past three years. In addition to promotoras, they have programs, such as the perinatal program, that links Latino/Hispanic beneficiaries to (physical) health services and then can draw them to mental health services.
- The MHP did not identify any strategies or efforts in the past year to outreach to API populations or communities.
- This recommendation will be carried over to the FY 2022-23 recommendations.

- To fully meet this recommendation, the MHP will need to deploy varied strategies to outreach to API communities. (As one stakeholder noted, Yolo County has a diverse API population including Thai, Cambodian, Chinese, and Hmong).

Recommendation 2: Provide contract providers full access to the EHR system, Avatar, and service entry modules.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially met this recommendation.
- Over the past year, the MHP has onboarded new Children, Youth and Family contract providers and has surveyed existing contract providers to determine licensing needs and staffing requirements to support additional users on the county EHR.
- The MHP is in the preliminary planning stages of providing full access to the EHR for existing contract providers.
- The MHP anticipates onboarding additional contract providers in the beginning of FY 2023-24.
- This recommendation will be carried over to the FY 2022-23 recommendations.
- To fully meet this recommendation, the MHP must amending contracts with current contract providers and complete the necessary processes (including building a budget, purchasing additional licenses, standardizing policies and procedures, and training) to provider EHR to interested contract providers.

Recommendation 3: Continue the Medicare billing workgroup and proceed with implementing a Medicare billing process for all appropriate services.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP did not address this recommendation. The MHP has not started Medicare billing; however, the MHP is working with the Medicare contractor to resolve an issue with National Provider Identification (NPI) numbers in order to recognize the MHP's clinics as valid service providers.
- This recommendation will not be continued; however, the MHP is encouraged to investigate and resolve the issues with the NPI to enable billing.

Recommendation 4: Develop and implement two active PIPs, one clinical and one non-clinical. Access TA from the EQRO for development and improvement.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation. The MHP presented two PIPs, one clinical and one non-clinical and both PIPs were validated.

- The clinical PIP has concluded and the MHP is considering new project ideas.
- The non-clinical PIP is the Behavioral Health Quality Improvement Project (BHQIP) FUM.

Recommendation 5: Continue to refine and operationalize optimal data collection approaches including the provision of ongoing staff training and the implementation of quality and reliability measures.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially addressed this recommendation. The MHP has a process to define data parameters required to monitor its programs for quality and quantity purposes.
- The MHP identified critical issues with its timeliness tracking and has developed a new mechanism to gather reliable data in the EHR. IS staff are in the process of finalizing the timeliness methodology and will begin piloting the new mechanism.
- This recommendation will be carried over to the FY 2022-23 recommendations.
- To fully meet this recommendation, the MHP should incorporate some oversights and routine monitoring of the accuracy of data and reports.

Recommendation 6: Develop and implement a mechanism to collect and access aggregated data for reporting and trending.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially addressed this recommendation. The MHP created aggregated reports specific to children's data, Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist (PSC-35); however, the MHP has yet to develop a process for regular, timely review and trending of the data.
- The MHP is working with Netsmart to implement a data analytics tool called KPI (Key Performance Indicator) Dashboards, which the MHP believes will improve analytical reporting capabilities of various performance measures.
- This recommendation will not be continued as the MHP is in the process of implementing a data analytics tool in its EHR that will enable reporting and trending.

Recommendation 7: Develop a mechanism and begin tracking or trending psychotropic medication monitoring for youth as per SB 1291 requirements.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially addressed this recommendation. The MHP developed mechanisms to collect data regarding medication utilization for youth in FC but has yet to monitor or trend the required indicators for youth in FC prescribed psychotropic medications.
- The MHP shifted some of its information technology (IT) priorities and projects to the CalAIM initiative, which then delayed implementation of the tracking mechanism. Staff reported that this monitoring may begin by/in July 2023.
- This recommendation will be carried over to the FY 2022-23 recommendations.
- To fully meet this recommendation, the MHP must begin tracking or trending the indicators using the developed mechanism or an alternate means.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 33 percent of services were delivered by county-operated/staffed clinics and sites, and 67 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 50 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: crisis walk-in at three clinics, open-access at one clinic, schools, referrals from hospitals and managed care plan providers, and court-facilitated diversion programs. The MHP operates a decentralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Clinicians conduct mental health screenings to determine the service needed, subsequently either a referral to a community provider is made or a mental health assessment appointment is scheduled within the MHP. The assessments are meant to be scheduled within one week of the screening.

In addition to clinic-based mental health services, the MHP provides psychiatry and mental health services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 2,657 adult beneficiaries, 995 youth beneficiaries, and 178 older adult beneficiaries across three county-operated sites and 12 contractor-operated sites. Among those served, 83 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

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

For Yolo County, the time and distance requirements are 45 miles and 75 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

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

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☐ Yes ☒ No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	☒ Yes ☐ No
OON Access for Beneficiaries	
The MHP ensures OON access for beneficiaries in the following manner:	☒ The MHP has existing contracts with OON providers ☐ Other: Click or tap here to enter text.

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

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members. Examining service accessibility and availability, system capacity and utilization, integration and collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

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

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Partially Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Partially 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:

- While the MHP acknowledges lower PRs across all racial/ethnic groups and disparities in access to services by race and ethnicity, per its cultural competence plan, its efforts to decrease disparities do not include specific strategies for API or African-Americans.
- The management changes within the HHSA have been met with optimism, but stakeholders expressed uncertainty and some distrust of the agencies' structure and operations, which may lead to further staff departures. Stakeholder feedback was that leadership decisions have led to siloed programs and managers overseeing multiple programs, which has affected access to and quality of services.
- Case management was described as the service that keeps the MHP running. With a reduction in the number of clinicians for therapy, case managers provide much needed support, check-ins, and connections to supportive services (e.g., housing) while beneficiaries are waiting for therapy, FSP slots, and psychiatry.
- The MHP collaborates with partner organizations to better reach and serve its beneficiaries and their family members. The MHP has partnered with the county Office of Education and the school districts to deliver school-based services through a K-12 School Partnerships Project. The MHP expanded and fully staffed

its Co-Responders program that collaborates with three local police departments, the county jail, and the Probation Department. The MHP provided TA to its contract providers on policies and procedures, coordination of care, and fiscal operations, enabling two short-term residential therapeutic programs to become licensed and begin providing intensive behavioral health services to youth placed in congregate care.

- The MHP has increased the number of peer support workers in the agency by at least 15 new positions. Peer support worker positions were added to the Adult and Aging Branch's Access Team, the Forensics team, the Wellness Center Programs, and the Co-Response unit. These positions provide additional supports and services to beneficiaries, such as transportation assistance, beneficiary engagement, and periodic check-ins and contacts. The peer support worker positions increase the opportunities for peer staff within the organization.
- After the cessation of one of the FSP program contracts, the MHP transferred all beneficiaries who met criteria for FSP services to the remaining contract provider. Some of the FSP beneficiaries were briefly served through interim services at the Access Center, while the receiving provider secured additional. Stakeholders reported that these changes destabilized services. There are waitlists for the remaining contract provider, disruptions in the continuity of care, and delays in access to care for high-needs beneficiaries.
- One of the ways the MHP monitors capacity is through the next available clinical and psychiatric assessment appointment report. The current appointment report shows appointments within the requisite timeframes, despite there being an 18 percent HHSA vacancy rate for clinical staff. The MHP reports that vacancies are mitigated by locum tenens psychiatric providers and contracted clinicians.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rates, and Average Approved Claims per Beneficiary Served

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

PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 4.34 percent, with an AACB of $7,478. Using PR as an indicator of access for the MHP, beneficiaries may be experiencing more challenges accessing mental health services in Yolo County than seen statewide.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	60,221	1,940	3.22%	$17,355,865	$8,946
CY 2020	55,914	1,824	3.26%	$18,880,459	$10,351
CY 2019	55,837	1,797	3.22%	$15,137,884	$8,424

- The MHP's PR has been consistent each year from CY 2019 to CY 2021.
- Conversely, there have been fluctuations in the AACB during this timeframe. AACB increased in CY 2020 and decreased in CY 2021.

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	6,323	115	1.82%	1.08%	1.96%
Ages 6-17	14,215	651	4.58%	4.41%	5.93%
Ages 18-20	3,146	122	3.88%	3.73%	4.41%
Ages 21-64	31,001	984	3.17%	4.11%	4.56%
Ages 65+	5,539	68	1.23%	2.26%	1.95%
Total	60,221	1,940	3.22%	3.67%	4.34%

- Although the overall MHP PR is lower than other medium-sized counties, all age groups except adults 21 and older have a higher PR than similarly sized MHPs. Adults, ages 21-64 and 65+, have lower PRs than statewide or in similarly sized counties.
- The MHP reported that with the pandemic, it was initially seeing fewer children. As children returned to in-person school, they came back with higher acuity and began receiving more services.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	192	9.90%
Threshold language source: Open Data per BHIN 20-070		

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

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	18,740	420	2.24%	$3,656,520	$8,706
Medium	613,796	20,261	3.30%	$151,430,714	$7,474
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The MHP's 2.24 percent ACA PR is lower than its overall 3.22 percent PR. Likewise the $8,706 AACB is lower than the MHP's $8,946 AACB.

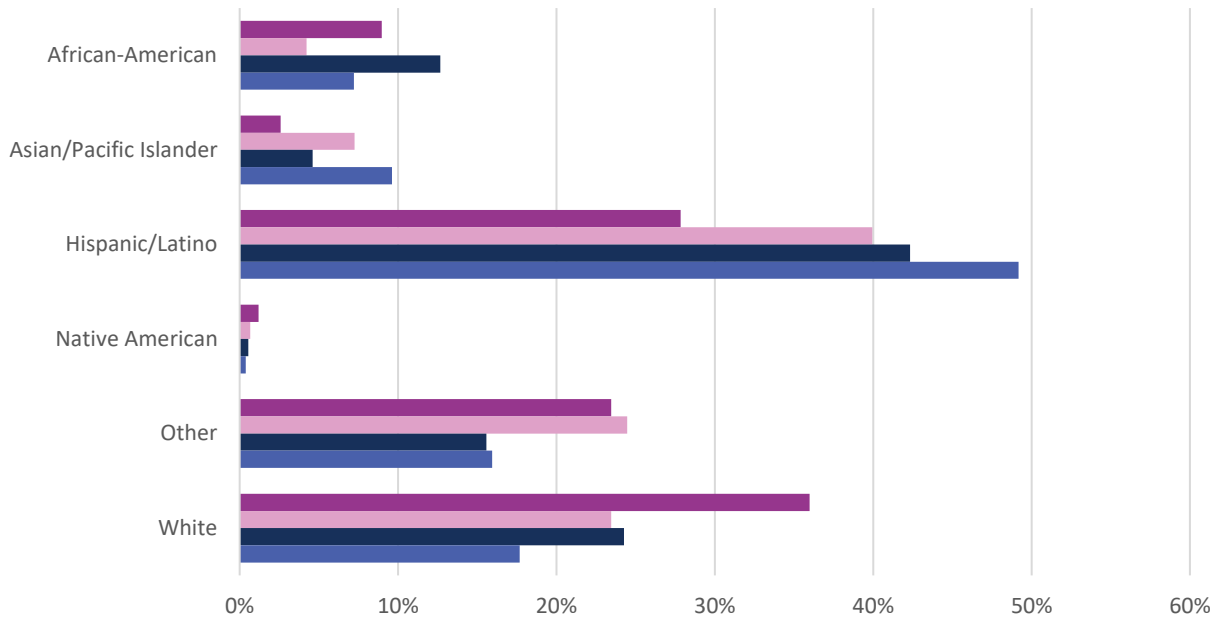
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	2,547	174	6.83%	7.64%
Asian/Pacific Islander	4,366	50	1.15%	2.08%
Hispanic/Latino	24,056	540	2.24%	3.74%
Native American	403	23	5.71%	6.33%
Other	14,730	455	3.09%	4.25%
White	14,121	698	4.94%	5.96%
Total	**60,223**	**1,940**	**3.22%**	**4.34%**

- The MHP's PRs by race/ethnicity are lower than the statewide PRs. The Hispanic/Latino PR is particularly notable, given that this population comprises the majority (39 percent) of Medi-Cal eligibles for this county.

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

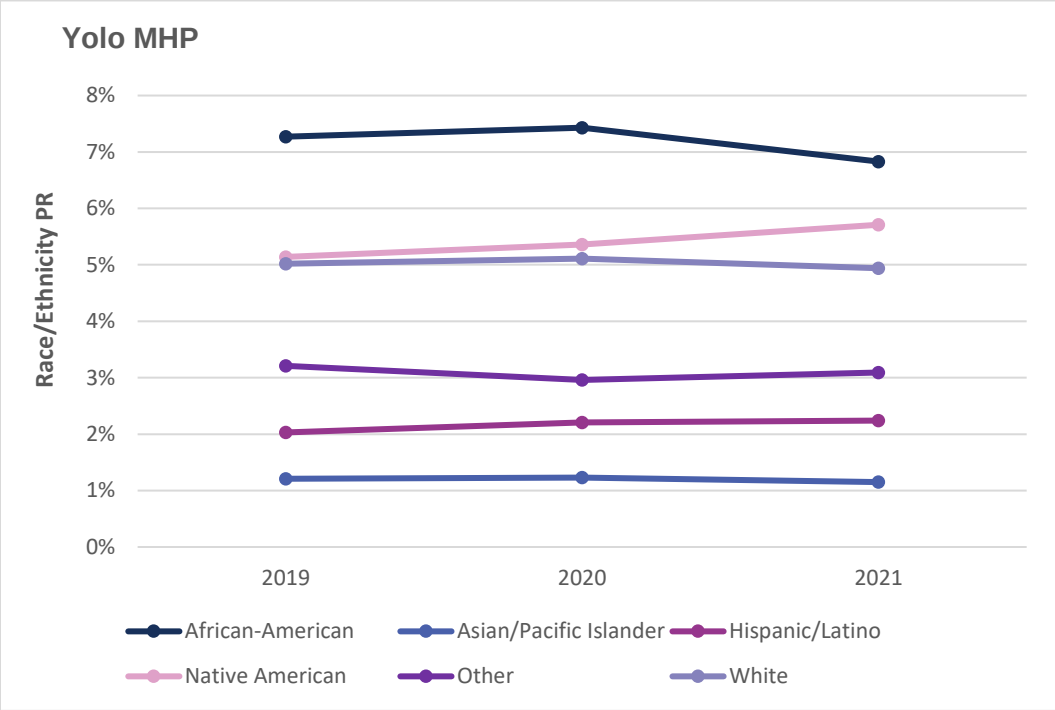


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	36%	23%	1%	28%	3%	9%
MHP % Eligible	23%	24%	1%	40%	7%	4%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- Yolo County has a higher proportion of White (23 percent) and Other (24 percent) eligibles than statewide (18 percent and 16 percent, respectively). The MHP has a lower proportion of Hispanic/Latino eligibles (40 percent) than statewide (49 percent).
- White beneficiaries represented 36 percent of the population receiving services, while they are only 23 percent of Medi-Cal eligibles in the county. Conversely, 28 percent of Hispanic/Latino beneficiaries received services, though they are 40 percent of the eligible population.

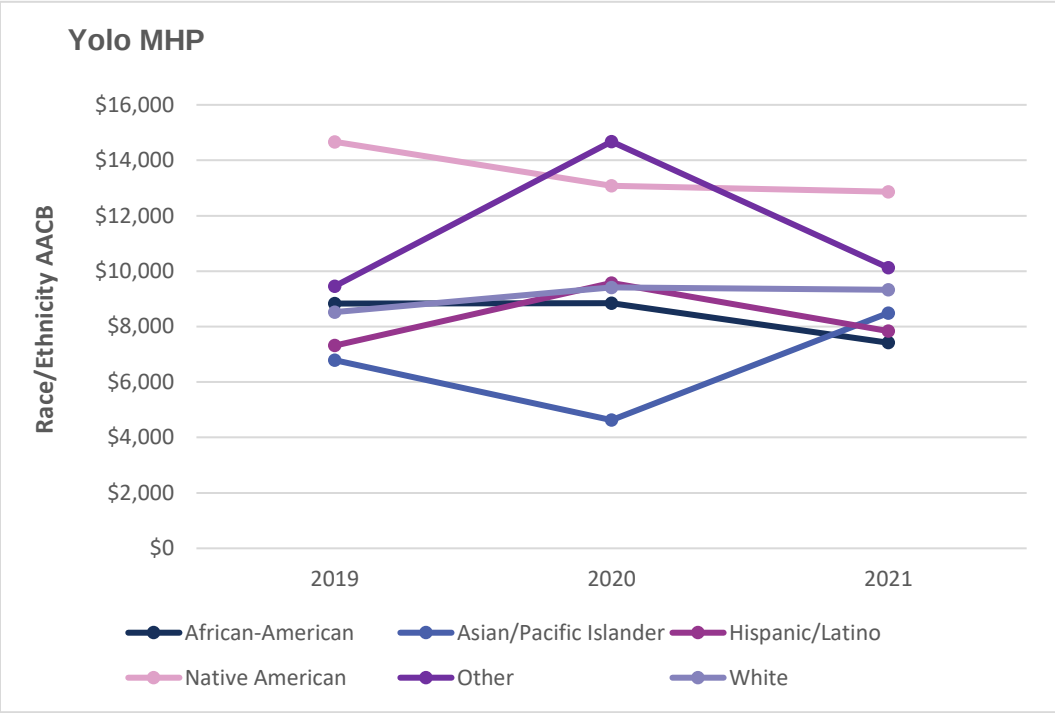
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino and API), and the high-risk FC population. For each of these measures, the MHP's data are compared to the similar county size and the statewide for a three-year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

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



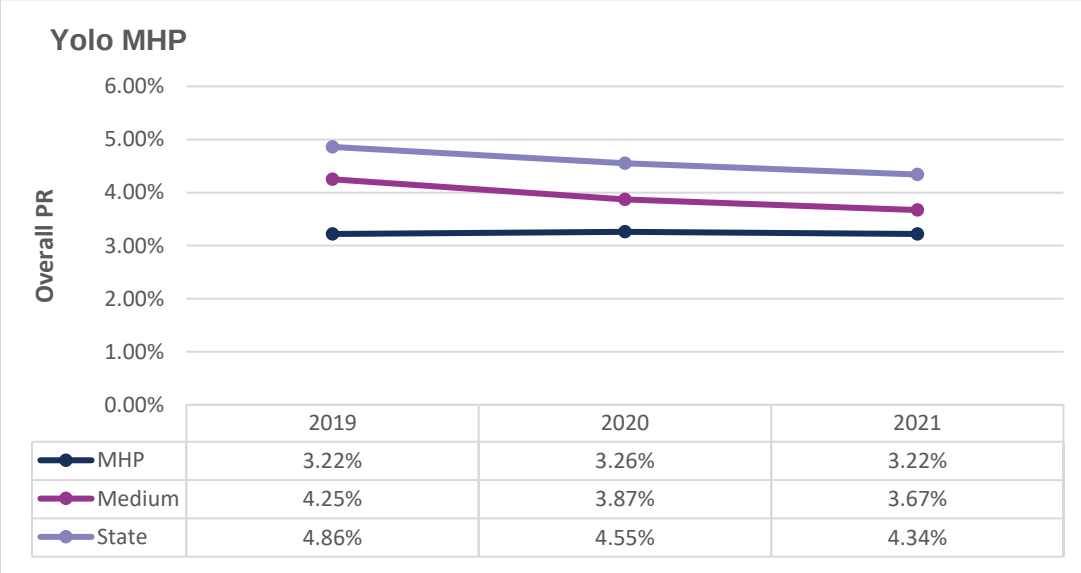
- API, Hispanic/Latino, and Other PRs have consistently been the lowest, while African-American, Native American, and White have consistently been the highest for the past three years.
- There was an increase in the Native American PR and a decrease in the African-American PR in CY 2021.

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



- The Native American and Other AACB have been the highest over the three-year period.

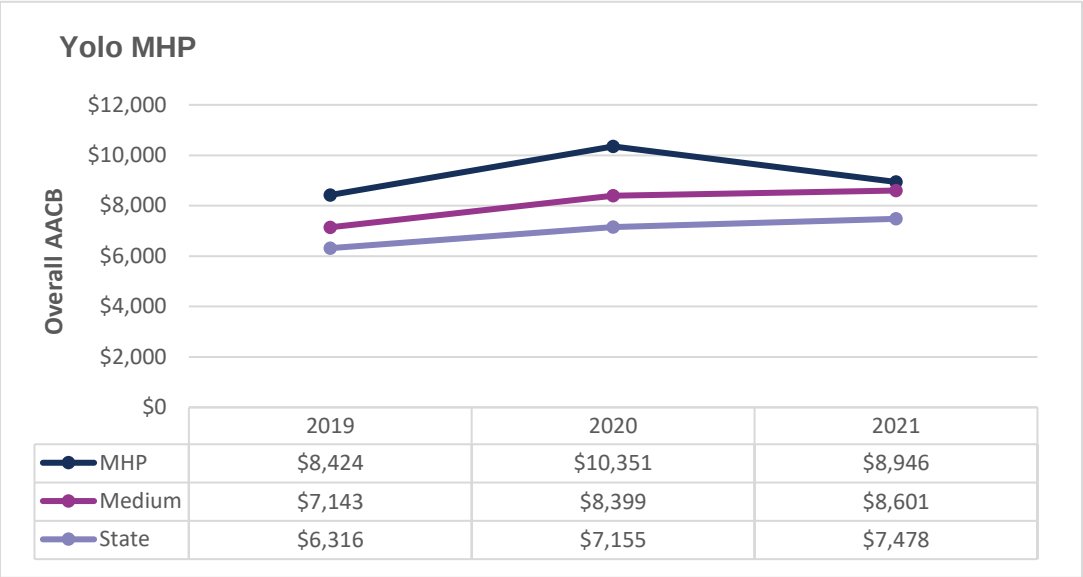
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	3.22%	3.26%	3.22%
Medium	4.25%	3.87%	3.67%
State	4.86%	4.55%	4.34%

- The MHP's PR has been below the state and other medium-sized MHP rates from CY 2019 to 2021.

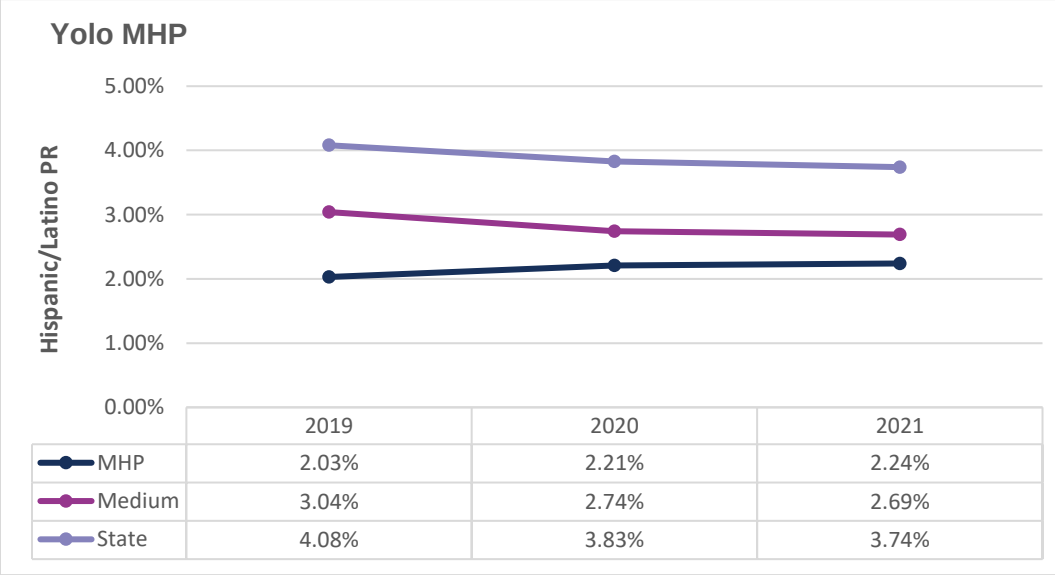
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$8,424	$10,351	$8,946
Medium	$7,143	$8,399	$8,601
State	$6,316	$7,155	$7,478

- The MHP's AACB has been higher than the statewide average and other medium sized MHPs average for the past three years. In CY 2021, the AACB dipped closer to the medium-sized MHP average.

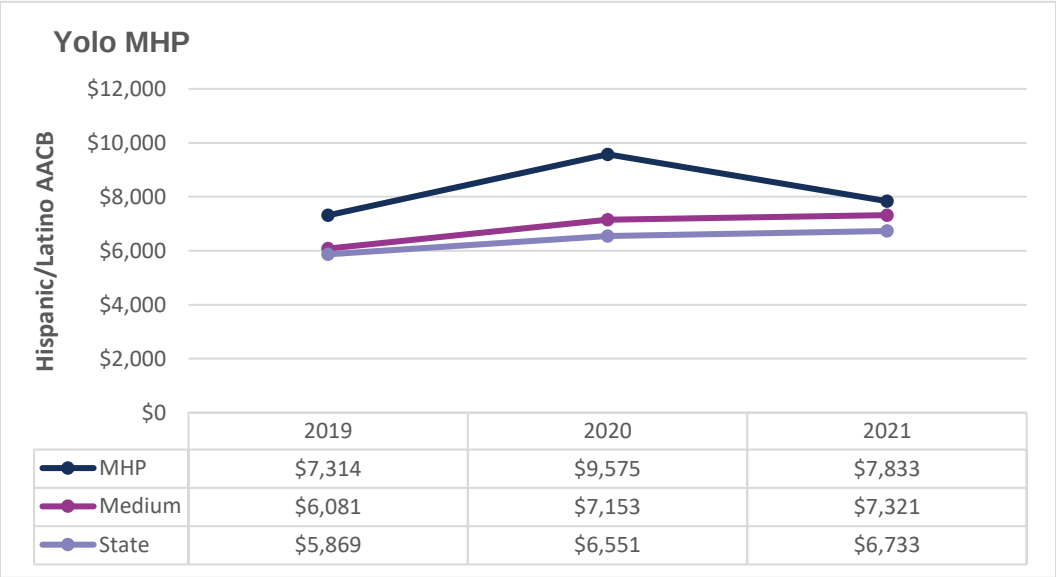
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	2.03%	2.21%	2.24%
Medium	3.04%	2.74%	2.69%
State	4.08%	3.83%	3.74%

- While the Hispanic/Latino PR has been increasing, albeit gradually, over the past three years (and the previous two), it remains consistently lower than the medium-sized county and statewide averages.

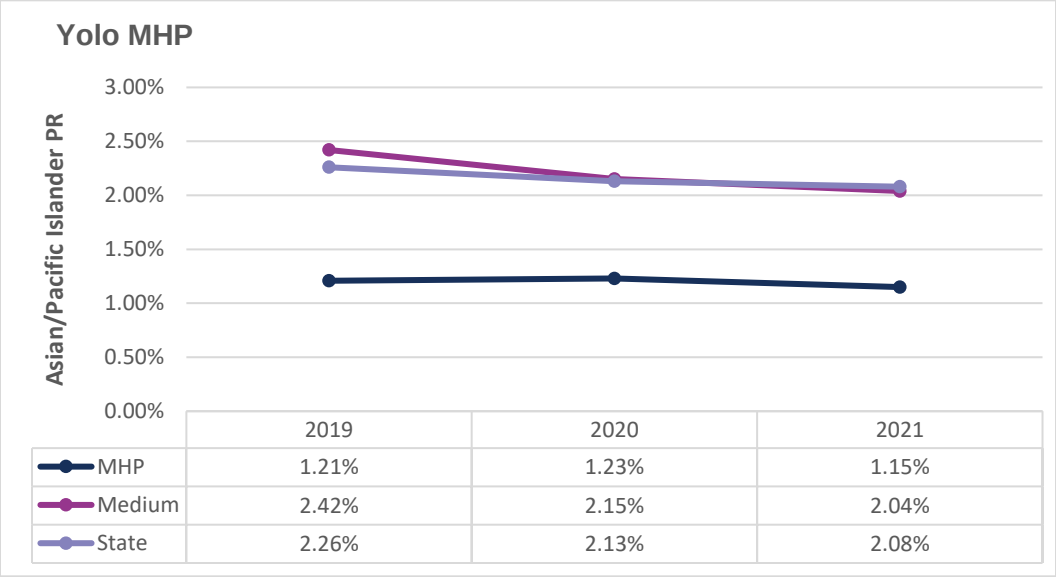
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$7,314	$9,575	$7,833
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

- Like the MHP's overall AACB, the Hispanic/Latino AACB has been higher than state and other medium-sized MHP averages.

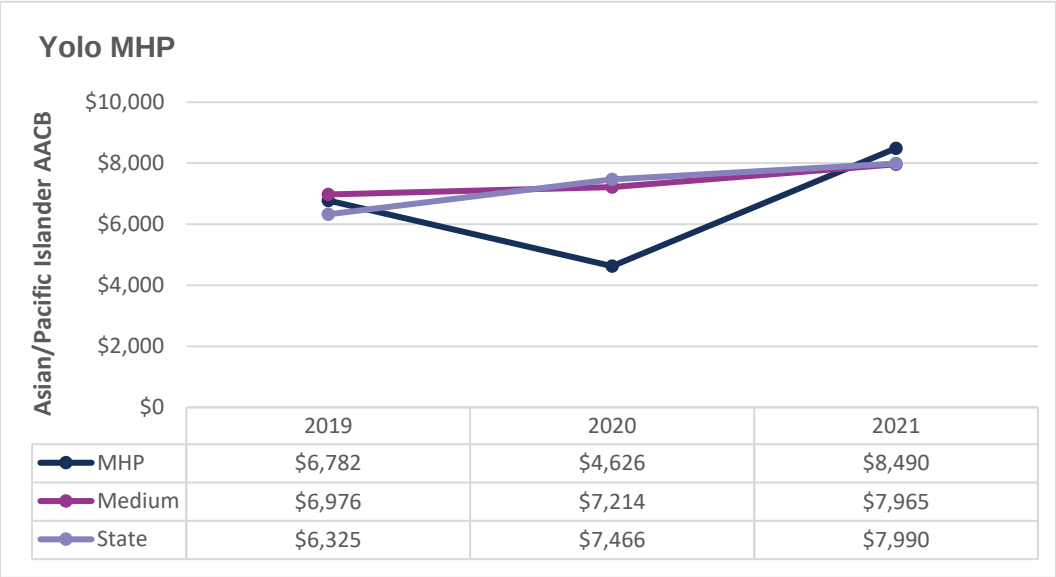
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	1.21%	1.23%	1.15%
Medium	2.42%	2.15%	2.04%
State	2.26%	2.13%	2.08%

- The API PR remains consistently lower than the statewide and medium-sized MHP rates.

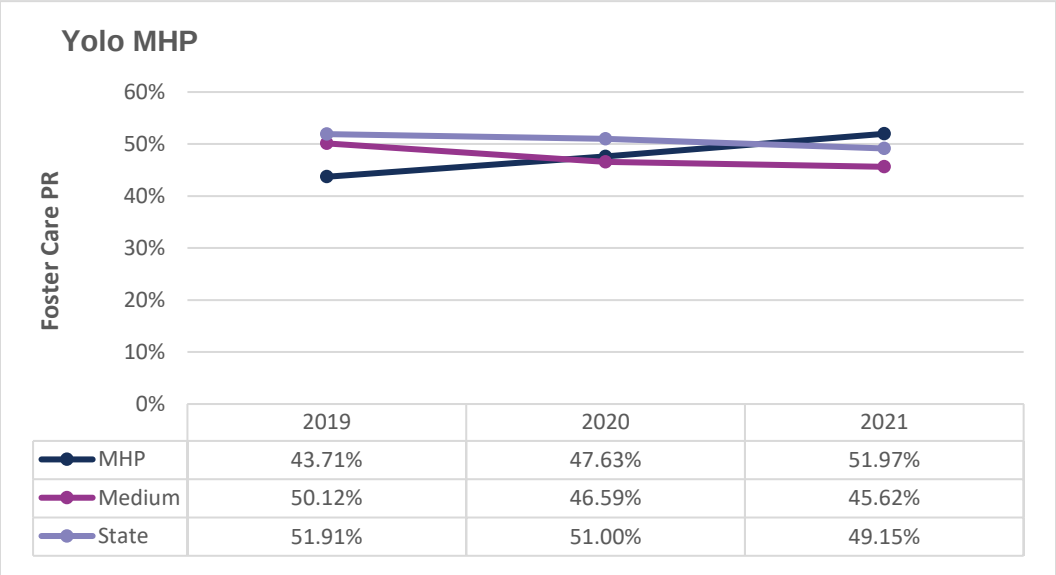
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$6,782	$4,626	$8,490
Medium	$6,976	$7,214	$7,965
State	$6,325	$7,466	$7,990

- The API AACB declined in CY 2020 and came back up in CY 2021, although relatively small numbers served can result in comparatively large fluctuations year to year.

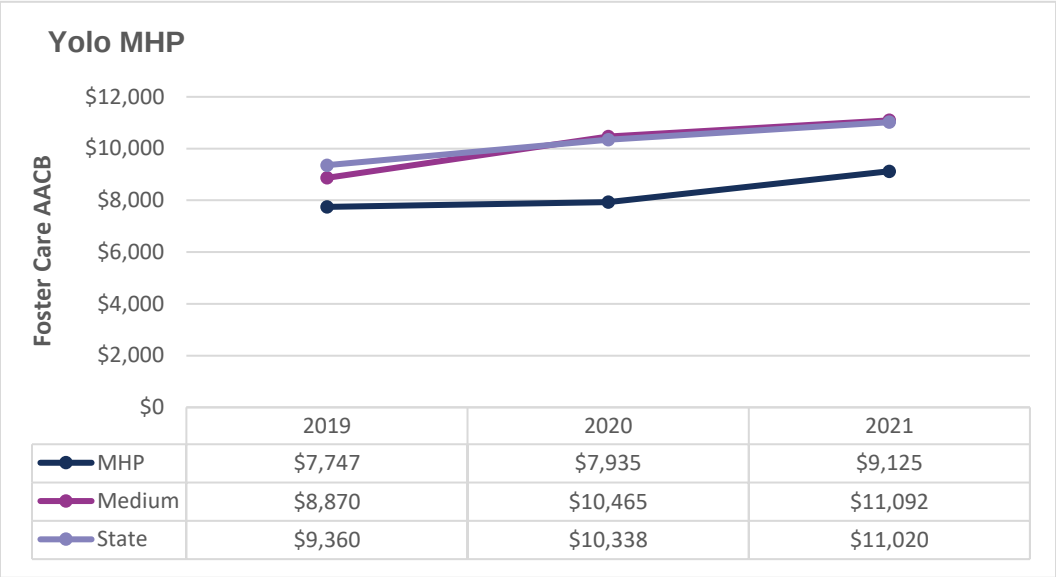
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	43.71%	47.63%	51.97%
Medium	50.12%	46.59%	45.62%
State	51.91%	51.00%	49.15%

- The MHP's FC PR has increased every year from CY 2019 to 2021. This is in contrast to the medium-sized county and statewide averages that have decreased over this same time period. In CY 2021, the MHP's FC PR was higher than both the statewide and medium-sized county rates.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$7,747	$7,935	$9,125
Medium	$8,870	$10,465	$11,092
State	$9,360	$10,338	$11,020

- While the MHP's overall AACB is higher than the state average, the FC AACB has been consistently lower than the state average.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 1,174				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	119	10.1%	11	7	11.6%	16	8
Inpatient Admin	<11	-	5	5	0.5%	23	7
Psychiatric Health Facility	105	8.9%	19	14	1.3%	15	7
Residential	20	1.7%	158	99	0.4%	107	79
Crisis Residential	65	5.5%	16	11	2.2%	21	14
Per Minute Services							
Crisis Stabilization	48	4.1%	1,279	1,200	13.0%	1,546	1,200
Crisis Intervention	125	10.6%	167	118	12.8%	248	150
Medication Support	704	60.0%	275	186	60.1%	311	204
Mental Health Services	650	55.4%	592	289	65.1%	868	353
Targeted Case Management	468	39.9%	827	286	36.5%	434	137

- The MHP provided mental health services to 55.4 percent of adult beneficiaries served compared to 65.1 percent statewide. The MHP reported that there are a large number of beneficiaries who only want medication support. Other stakeholders indicated that staff capacity issues might contribute to the number of medication-only beneficiaries.
- The MHP delivered more targeted case management with an average of 827 units compared to 434 statewide.
- A higher percentage of adult beneficiaries received psychiatric health facility, residential and crisis residential services than statewide. The residential average length of stay (LOS) (of 158 days) is substantially higher than the statewide rate (107 days).
- A lower percentage of adult beneficiaries received crisis stabilization and crisis intervention services than statewide.

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

Service Category	MHP N = 252				Statewide N = 37,489		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	15	6.0%	7	4	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.3%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	<11	-	3	3	0.1%	17	12
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	<11	-	20	18	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	1,060	1,200	3.1%	1,398	1,200
Crisis Intervention	13	5.2%	495	340	7.5%	404	198
Medication Support	56	22.2%	359	226	28.3%	394	271
Therapeutic Behavioral Services (TBS)	<11	-	2,525	1,959	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Home Based Services	130	51.6%	790	283	40.0%	1,351	472
Intensive Care Coordination	51	20.2%	1,336	519	20.3%	2,256	1,271
Katie-A-Like	<11	-	270	197	0.2%	640	148
Mental Health Services	245	97.2%	1,817	1,071	96.3%	1,848	1,103
Targeted Case Management	156	61.9%	638	154	35.0%	342	120

- As with adult beneficiaries, FC youth received more units of targeted case management than statewide. More FC youth, 61.9 percent, received this service than compared to 35.0 percent youth in FC statewide.
- A higher percentage of FC youth received intensive home based services than statewide, although the average number of units was lower than statewide.
- The MHP delivered fewer units of intensive care coordination than statewide, averaging 1,336 units compared to the 2,256 statewide average.

- The MHP indicated that there were challenges in hiring and maintaining clinical staff to provide services, especially TBS, which has resulted in decreased service delivery during this review period.

IMPACT OF ACCESS FINDINGS

- The MHP's low PR across all racial/ethnic groups should be evaluated; it may reflect systemic factors that reduce access to SMHS. The MHP should also investigate how or why it is that nearly 25 percent of its beneficiaries are identified as 'Other' compared to statewide proportion of 16 percent. If 'Other' includes beneficiaries who are, for example, Hispanic/Latino or API, it may account for some of the disparities in access.
- While the MHP has higher PRs for youth compared to similar-sized MHPs, this is offset by low adult and older adult PR, which contributes to an overall PR that is lower than the statewide and medium-sized MHPs averages.
- While the proportion of youth in FC who receive intense services are comparable to (if not greater than) the statewide proportion, the units of services are much less than what is received statewide (nearly half the amount). The workforce shortage may have contributed to a reduction in the amount of time that youth in FC receive in services.
- As the MHP reorganizes under new leadership, there is a prime opportunity to engage and involve seasoned staff on how to move forward, so as to avoid some of the challenges beneficiaries experienced following the FSP contract dissolution.
- Stakeholders noted an increase in the number of individuals requesting services who do not meet criteria for SMHS, which they attributed to CalAIM initiative. MHP leadership have (1) expressed concerns in various forums about the impact of CalAIM and (2) sought clarity from DHCS ongoingly regarding screening, eligibility, and referrals for SMHS.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Not Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Not Met
2C	Urgent Appointments	Partially 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 MHP was not able to provide the time for first offered service or first offered psychiatry appointment. While the MHP reported time to delivered services, it was not able to track this metric for youth in FC.

- The MHP has an established post-hospitalization process facilitated through a dedicated discharge planner, which may contribute to its relatively low 7-day and 30-day psychiatric inpatient readmission rates. The MHPs self-reported rates are comparable to CalEQRO's data on readmission rates.
- The MHP includes staff cancellation of appointments in its reporting of no-shows. While it is good that the MHP captures and can separately track staff cancellations, including it in this metric may conflate two of the causes of missed appointments.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of ATA, representing access to care during the 12 month period of FY 2021-22. Table 11 and Figures 12–14 below display data submitted by the MHP; an analysis follows. This data represented the entire system of care, for all but no-show data. No-show data included only county-operated appointments. As noted above, the MHP did not provide first offered non-prescribing or psychiatric appointment information. First delivered non-urgent and urgent appointments did not break out FC from other children's services.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	***	10 Business Days*	***
First Non-Urgent Service Rendered	19 Calendar Days	30 Calendar Days**	89%
First Non-Urgent Psychiatry Appointment Offered	***	15 Business Days*	***
First Non-Urgent Psychiatry Service Rendered	98 Calendar Days	30 Calendar Days**	12%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	333 Hours	48 Hours**	48%
Follow-Up Appointments after Psychiatric Hospitalization	18 Days	7 Days**	68%
No-Show Rate – Psychiatry	16%	5%**	n/a
No-Show Rate – Clinicians	1%	5%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

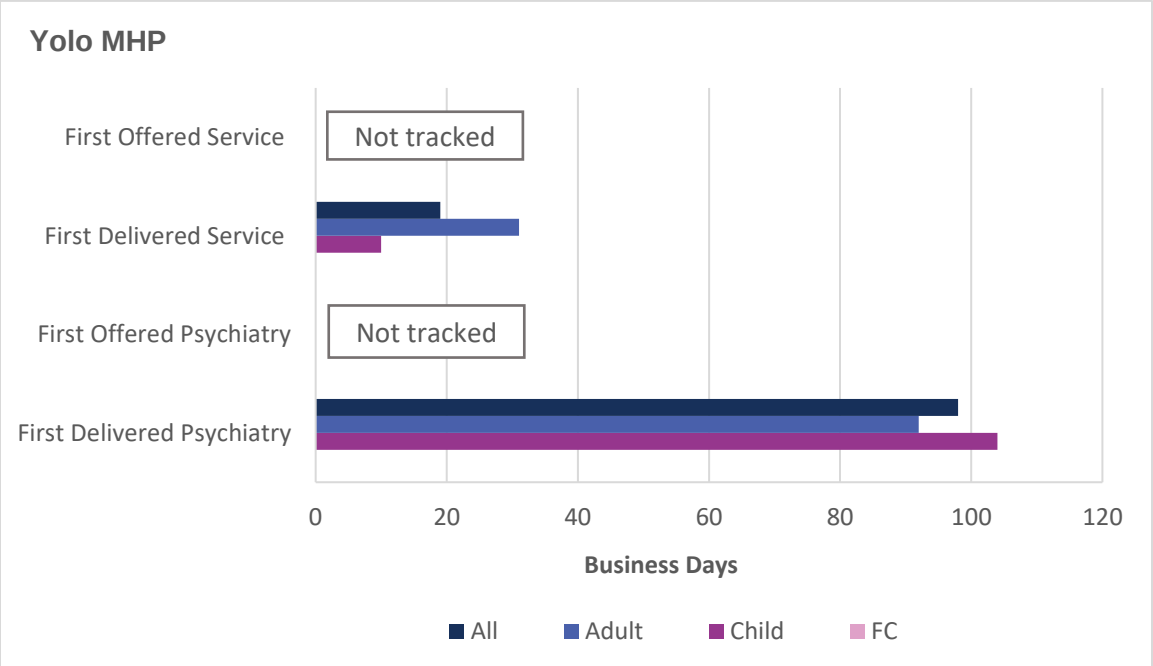


Figure 13: Wait Times for Urgent Services

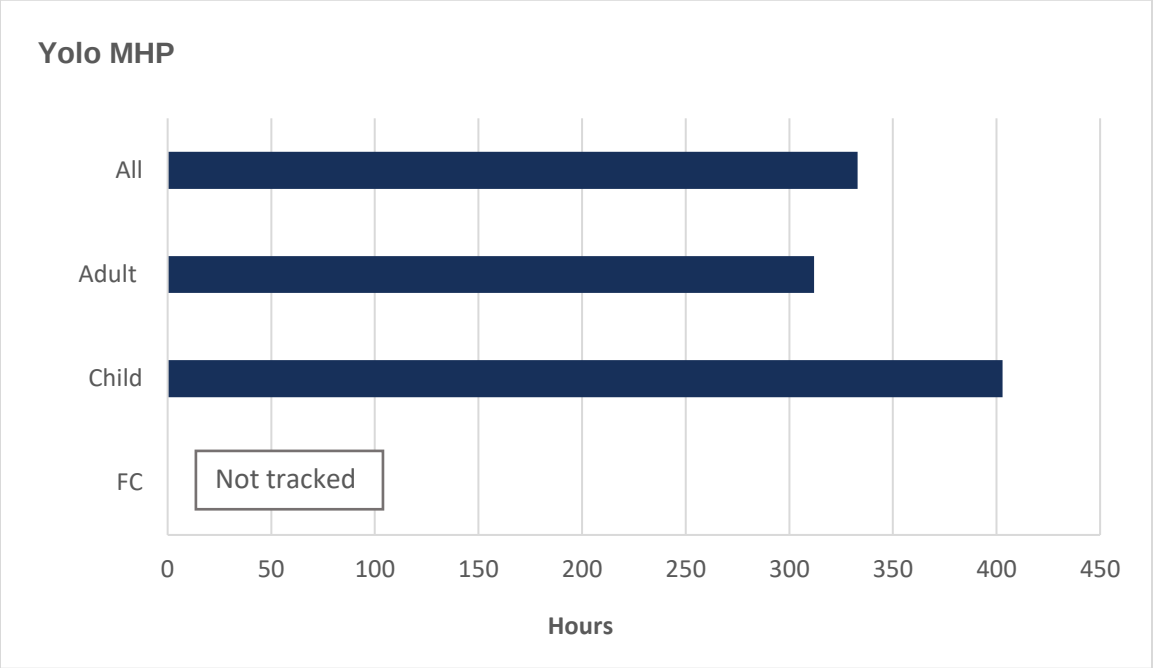
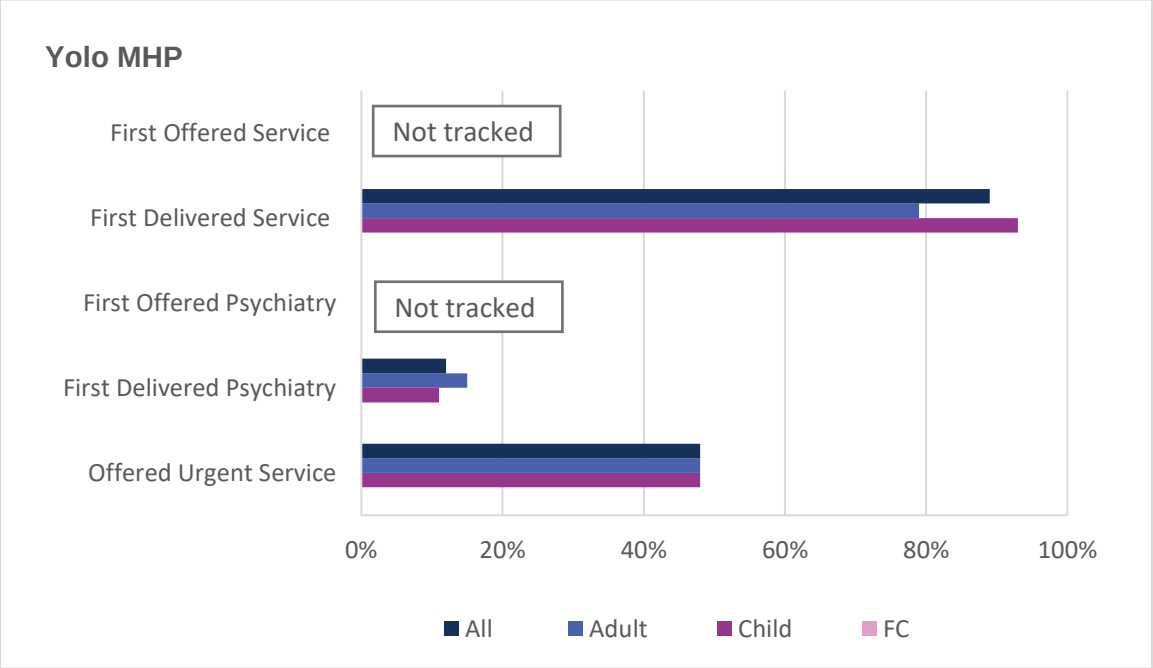


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in

Figures 12 and 13, represent the number of days to any mental health delivered service.

- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as urgent contacts captured in the MHP’s Access Log Admission Discharge Report. There were reportedly 664 urgent service requests with a reported actual wait time to services for the overall population at 333 average hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as the first psychiatric service date following triage.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 16 percent for psychiatrists and 1 percent for clinicians of county-operated appointments. With the delay for first delivered psychiatric appointments, the MHP could explore whether there are ways it could use no-show appointment times to provide initial appointments.
- The MHP is changing its methodology for collecting first offered appointments and psychiatric appointments.

IMPACT OF TIMELINESS FINDINGS

- The MHP may not have an accurate and complete picture of its capacity to provide timely initial access, given that it did not report on times to first offered service, first offered psychiatry appointment, and delivered service for youth in FC.
- Based on the time to delivered service (98-day average), the MHP is challenged in providing timely first appointments. Stakeholder feedback was that the delays also extend to ongoing appointments.
- The MHP reported 30 business days as its standard for time to delivered first services. Thirty business days is six weeks and is quite a variance from the standard to offer services within 10 business days.
- The MHP should review its processes for scheduling, coordinating appointments, and the like, as stakeholders noted some “bureaucracy” around appointments that contributed to delays.
- The psychiatry delays—in receipt of or adjustments to medications—may have other consequences, such as increased crisis or emergency department contact. It is beneficial for the MHP to increase the monitoring of utilization of acute services.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is the Quality Management (QM) Program that is led by QM Manager. The QM Manager also holds the title of CalAIM Coordinator. The responsibility for Compliance is another staff member, the Compliance Officer. The QM Manager is supported by QM clinicians and analysts who are assigned to the adult and children's system of care.

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 county behavioral health department staff, contracted providers, and other stakeholders whose roles are not indicated. The QIC is scheduled to meet quarterly and since the previous EQR, the MHP QIC met four of four times. Of the 12 identified FY 2021-22 QAPI mental health workplan goals, the MHP met or partially met the majority of the goals.

The MHP utilizes the following level of care (LOC) tools: Level of Care Utilization System (LOCUS). The LOCUS is used regularly in the adult system. The MHP aggregates the average LOCUS score at intake and annually to support transitions in care. In some programs, two clinicians will administer the LOCUS to reduce subjectivity. The MHP has successfully developed reports for the tracking and trending of LOCUS. The MHP also uses Historical, Clinical, Risk Management-20 for violence risk assessment in the Forensics program.

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

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- Because QM has been understaffed for some time, particularly in its Clinical Team, QM had to focus its limited resources on regulations, meeting state and federal demands, including planning and resolving corrective action plans item, and CalAIM implementation. Staff described several rounds of documentation review as their primary interaction with the unit.
- The MHP uses the Results Based Accountability to analyze quantity of services, quality of services, and outcomes of services. The MHP reviews the data to determine if programs are achieving intended goals and to guide decisions about program and service changes. The RBA is reviewed at least annually.
- Among stakeholders, line staff and supervisors reported being shut out of opportunities and processes to provide insight and input on services. Staff expressed that continued lack of engagement (i.e., “not have their voices heard”) could increase the likelihood of further staff departures.
- The MHP uses LOCUS throughout the adult system of care and, recently, began aggregating the LOCUS findings annually across programs.
- The MHP has a well-integrated peer employee program throughout its system of care; peer support workers were represented among county staff and contract

provider staff. The MHP has funding for 8-10 peer support workers to complete the peer certification process.

- The MHP has a wellness center at Woodland Community College that serves TAY.
- The MHP has not had a medical director for two years. Various managers have taken on some of the responsibilities of a medical director; however, these responsibilities relate more to administrative functions (e.g., scheduling and staff hires) than clinical care. There was no evidence that the MHP was monitoring routinely the HEDIS measures, best practices, or other national measures related to psychotropic medication prescribing and psychiatric care.
- The MHP reports that it tracks but does not trend the following HEDIS measures as required by WIC Section 14717.5:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

QUALITY PERFORMANCE MEASURES

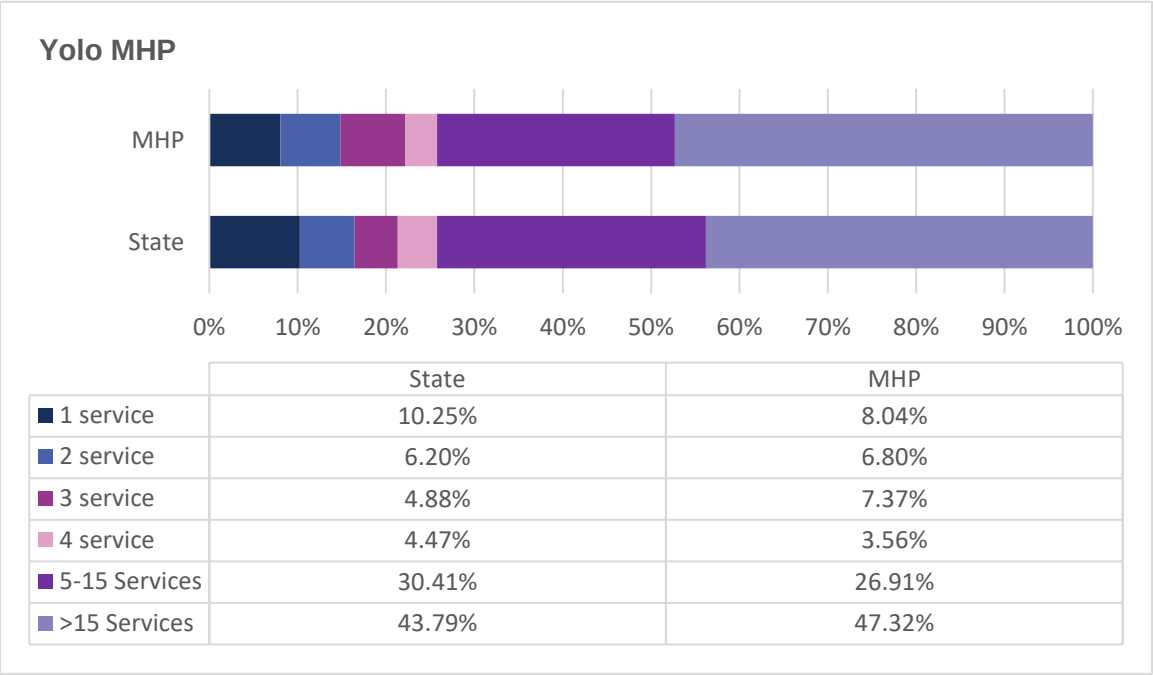
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries served by the MHP to require 5 or more services during a 12-month period. However, this table does not account for the LOS, as individuals enter and exit care throughout the 12-month period.

Figure 15: Retention of Beneficiaries CY 2021



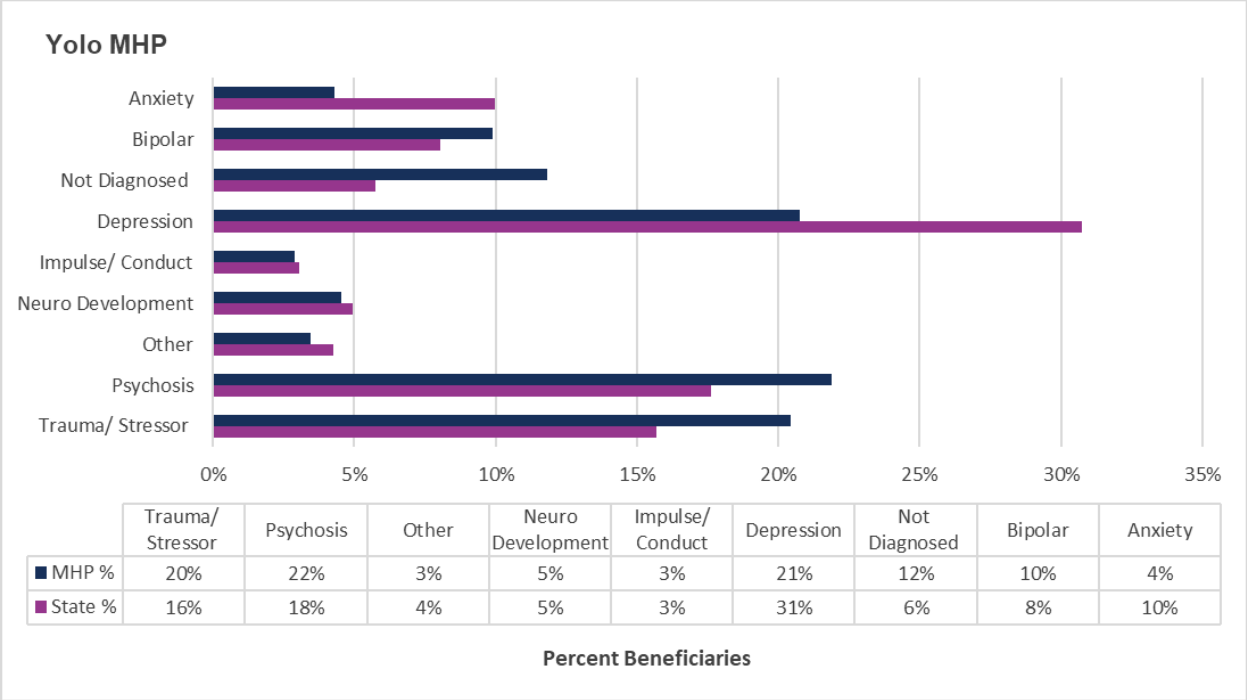
	State	MHP
1 service	10.25%	8.04%
2 service	6.20%	6.80%
3 service	4.88%	7.37%
4 service	4.47%	3.56%
5-15 Services	30.41%	26.91%
>15 Services	43.79%	47.32%

- Like the statewide data (25.80 percent), about one quarter (25.77 percent) of beneficiaries served received one to four services. The remaining three quarters received five or more services.

Diagnosis of Beneficiaries Served

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

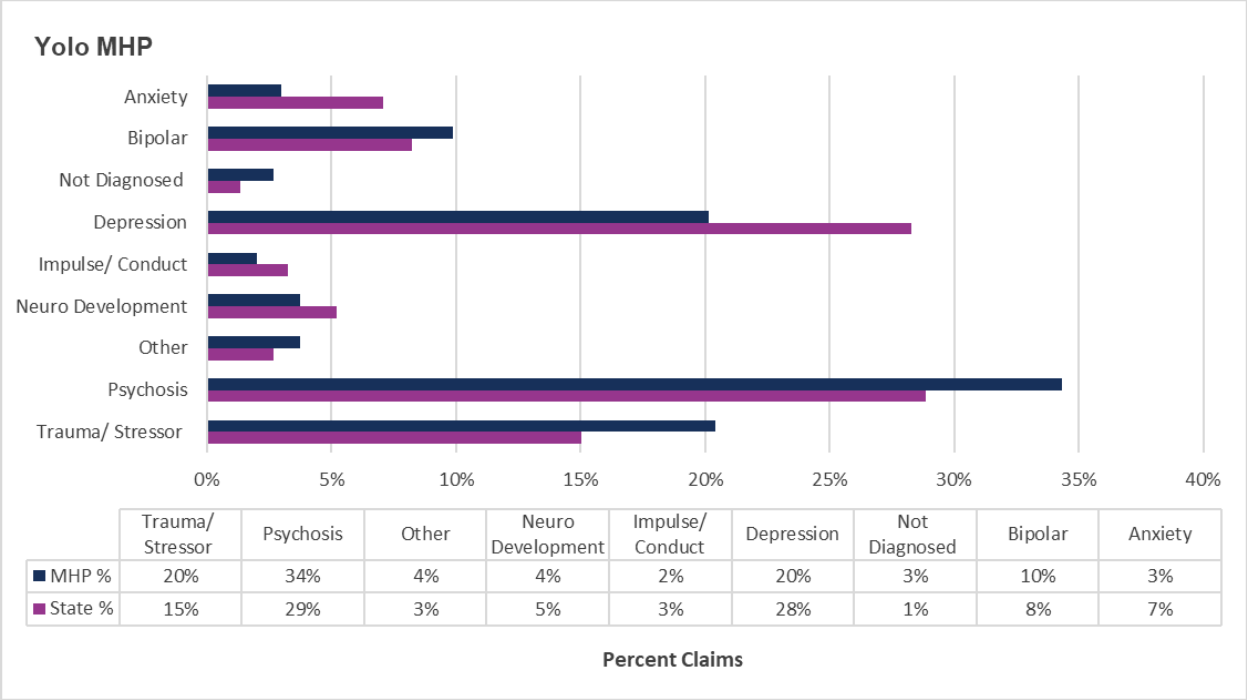
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	20%	22%	3%	5%	3%	21%	12%	10%	4%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- Over 60 percent of beneficiaries have one of three diagnoses: psychosis (22 percent), depression (21 percent), and trauma/stressor related disorders (20 percent). The MHP has a higher proportion of beneficiaries with psychosis and trauma/stressor diagnoses, and a lower proportion of depression than seen statewide.

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	20%	34%	4%	4%	2%	20%	3%	10%	3%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- Similar to the diagnostic breakdown by beneficiary, the MHP has a higher proportion of approved claims for psychosis and trauma/stressor diagnoses and a lower proportion for depression diagnoses than seen statewide.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average LOS.

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	297	532	11.61	8.86	$15,630	$12,052	$4,642,110
CY 2020	266	467	12.63	8.68	$16,940	$11,814	$4,505,917
CY 2019	263	473	10.16	7.80	$13,351	$10,535	$3,511,193

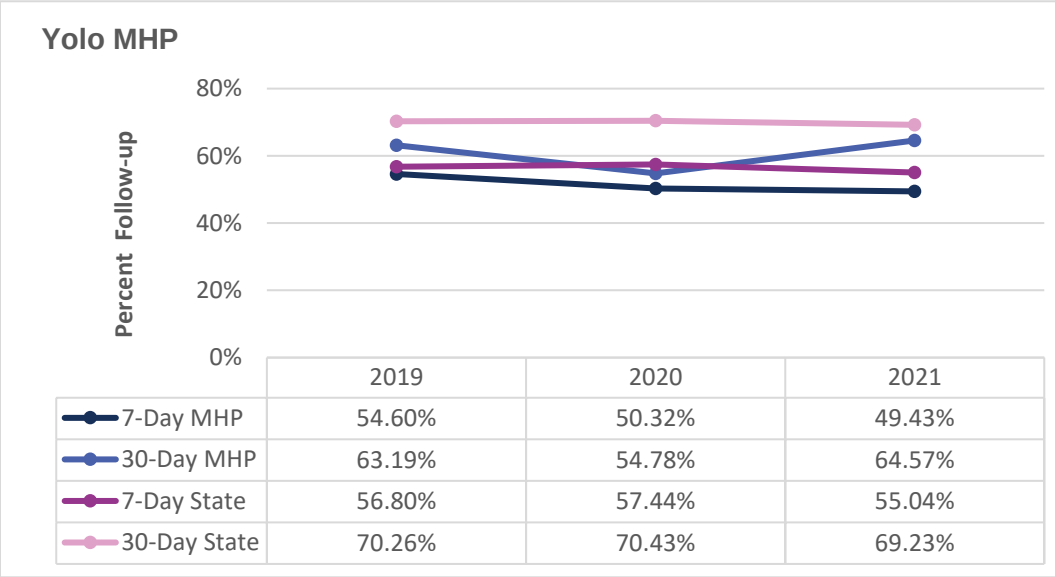
- The average LOS is consistently higher than the state average. The MHP's AACB for hospitalizations is also higher than the statewide AACB.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2021 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

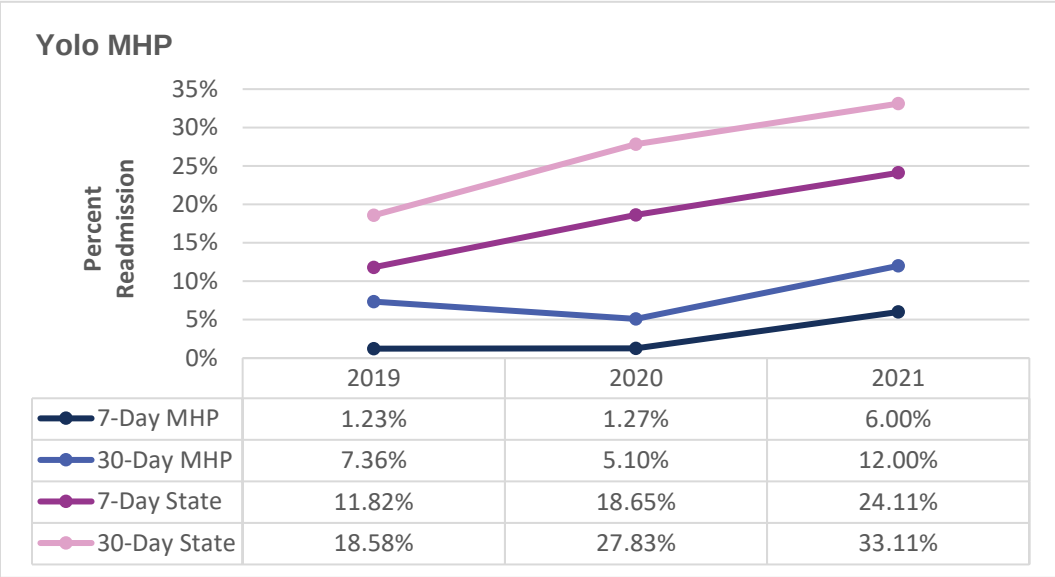
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis.

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



	2019	2020	2021
7-Day MHP	54.60%	50.32%	49.43%
30-Day MHP	63.19%	54.78%	64.57%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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



	2019	2020	2021
7-Day MHP	1.23%	1.27%	6.00%
30-Day MHP	7.36%	5.10%	12.00%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- The MHP's 7-day and 30-day post psychiatric follow-up rates have been lower than the statewide average since CY 2019. During this same timeframe, the MHP's readmission rates have been lower than the statewide. In fact, the MHP's 30-day readmission rate has been consistently lower than the statewide 7-day readmission rate.
- In August 2022, the MHP began a new program to provide case management to children in psychiatric hospitals. The program could further increase post-hospitalization follow-ups and decrease readmission for this population.
- The MHP has low psychiatric hospital readmission rates, suggesting that inpatient utilization and case management support are working for beneficiaries.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with

approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $7,478, the median amount is just $3,269.

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

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

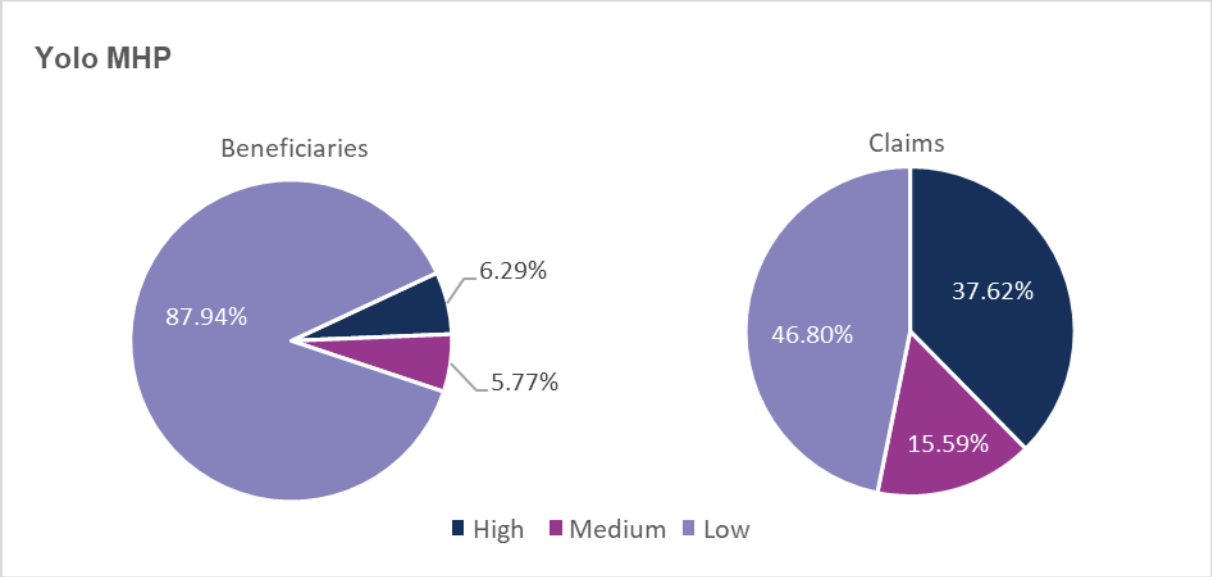
Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	122	6.29%	37.62%	$6,528,691	$53,514	$42,137
	CY 2020	144	7.89%	42.79%	$8,078,517	$56,101	$45,367
	CY 2019	117	6.51%	38.81%	$5,874,509	$50,209	$43,414

- The MHP’s HCB count, percentage of beneficiaries served, and percentage of claims increased in CY 2020 and decreased in CY 2021. The MHP’s percentage of beneficiaries in the HCB category and percentage of claims going towards those services are both higher than the statewide average. This could be related to the overall high AACB for the MHP.

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	112	5.77%	15.59%	$2,704,974	$24,152	$23,649
Low Cost (Less than $20K)	1,706	87.94%	46.80%	$8,122,200	$4,761	$3,146

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



- Over half (53.21 percent) of all approved claims were for serving the high and medium cost beneficiaries. Less than half of the claims (46.80 percent) went to serving the low-cost beneficiaries, representing 87.94 percent of beneficiaries served.

IMPACT OF QUALITY FINDINGS

- The QM unit is composed of several staff who joined the unit within the last six months and (who) are building their knowledge base. Once staff are more established in their positions, the MHP can deploy the unit to oversee and guide improvement activities, moving the focus beyond compliance to quality.
- There is a need for continued refinement in the MHP's data collection, to operationalization, and more frequent review as part of the MHP's QI processes. For example, an annual RBA review is not sufficient to determine if programs are tracking correct outcomes and if the appropriate data are being collected and for the program to make necessary changes.
- The MHP has slightly higher rates of beneficiaries with trauma/stressor disorders and psychotic disorders for which therapeutic services would be a benefit. The MHP must evaluate its ability to adequately meet beneficiary treatment needs given its reduction in clinician workforce.
- The MHP has a dedicated discharge planner and other staff who are involved in coordination of care to and from hospitals and inpatient facilities. There are opportunities for increased coordination from these staff to improve the 7-day follow-up rate, which appears to be declining.

- Some aspects of medication management monitoring and coordination of care are not happening consistently because the MHP lacks a medical director.
- Staff indicated that the LOCUS is time-consuming and that its outcomes may not align with the serves to which beneficiaries are assigned ultimately. Additional staff training would be beneficial to address clinician concerns about the time to completion and efficacy.
- The MHP should be mindful to build up its peer workforce to keep pace with the demand. Stakeholders reported that peer support workers worked more hours than they were scheduled.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.caleqro.com.

Validation tools for each PIP are located in Attachment C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Improving Screening of COD for Beneficiaries

Date Started: 07/2020

Date Completed: 12/2022

Aim Statement: Will the following identification of COD needs: increasing the Access and Crisis Line clinical capacity; staff participation in training with a focus on COD screening; implementing a substance use disorder (SUD) pre-screening tool; and implementing a [beneficiary] stakeholder/program feedback look?

Target Population: Beneficiaries who call the Access and Crisis Line requesting behavioral health services

Status of PIP: The MHP's clinical PIP is in the Other phase, completed.

[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

This submission concludes the MHP's project on increasing identification of beneficiaries with COD at initial screening. At the start of the project, the MHP reported a rate of only 5 percent for concurrent SUD at the time of mental health screening compared to 13 to 47 percent for other medium-sized MHPs. The team had a four-prong strategy to increase identification. Two strategies—increasing clinical capacity and an SUD training—took place in the first year of the project; in this second year of the project, the two other strategies were implemented—the pre-screening tools and the beneficiary survey. While the MHP has likely increased the rate of COD identification, the rate of improvement reported (81 percent) is not consistent with the data provided. The MHP struggled with the beneficiary survey, with only a 4 percent response rate (6 out of 136 callers). No conclusions could be drawn from the survey results.

Overall, the MHP has increased its identification of individuals with COD at the time of screening. The effective strategies were having clinicians (also) conduct the initial screenings and using pre-screening tools that assess both mental health and SUD needs. Currently, the MHP is considering ideas for new clinical projects.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence. The MHP had multiple, thoughtful strategies for addressing an identified problem. The team implemented the strategies, adjusted as necessary, and achieved its goals within its stated timeframe.

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

- Reanalyze data to ensure comparison of like components.
- Reconsider the need for and resources needed to effectively conduct a beneficiary survey in future projects. There may be other ways to obtain beneficiary experience without such surveys.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: FUM

Date Started: 10/2022

Aim Statement: This PIP is designed to improve [the MHP's] care coordination activities for timely 7- and 30-day follow-up and mental health service linkage for Medi-Cal

beneficiaries who are seen in an emergency department with a primary mental health diagnosis and/or self-harm.

Target Population: Beneficiaries who have an emergency department visit at local hospitals

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

Summary

The MHP has submitted one of the BHQIP projects, FUM, as its non-clinical PIP. The MHP reports 7-day and 30-day FUM rates of 36 percent and 53 percent, respectively. The MHP's goal is to increase the rates by 4 percent and 1 percent respectively, which would bring its rate to the national average by the end of the FY 2022-23. (The team plans to continue the project and further increase its rates to the statewide averages). The MHP has four strategies: join a health information exchange (HIE); conduct reviews of identified beneficiaries; assign MHP staff to engage the beneficiary; and complete a mental health screening. These strategies address the root cause—that the MHP is not routinely aware of when beneficiaries are served at an emergency department—and other factors that contribute to the low follow-up rate.

Currently, the MHP is in discussions with its managed care provider to join the HIE, which would link it to real-time hospital data. Once the HIE is established, the other strategies, which related more to coordination and provision of care, can take place.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence. The MHP has identified a beneficiary problem, a clear and attainable target for improvement, and gradual strategy for improving its 7- and 30-day FUM rates. The crux of the strategy is the HIE. The details regarding the other strategies, namely the coordination of care, were vague and not well articulated.

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

- Consider contingencies for delays in or inability to implement the HIE.
- Provide more detail and specificity regarding how MHP staff would "engage" beneficiaries; how frequently they would make contact; the medium of the contact (e.g., in person, telephone, videoconference); and the nature and purpose of the contact (e.g., to provide linkages, problem-solve transportation, connect to social supports, etc.).

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, IT, claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart myAvatar which has been in use for 18 years. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Like last year, approximately 1.9 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). While the budget is sufficient for its current user base, the MHP is determining the fiscal requirements for providing full access to the EHR to all contract providers, both in terms of software licenses and staff needed to support a large user increase. The budget determination process for IS operations is under MHP control.

The MHP has 194 named users with log-on authority to the EHR, including approximately 117 county staff and 77 contractor staff. Support for the users is provided by three FTEs IS technology positions and all positions are filled currently.

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

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
HIE between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	50%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☒ Weekly ☒ Monthly	50%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not have a PHR. It intends to implement one within the next year.

Interoperability Support

The MHP is not a member or participant in a HIE. The MHP is in preliminary phases of joining the SacValley MedShare HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: mental health contract providers and federally qualified health centers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP expanded its EHR governance in the last year. The MHP created an EHR steering committee to prioritize and drive project implementations and develop a project plan roadmap. The MHP created three user workgroups to implement projects, manage barriers, and implement the roadmap at a tactical level.
- The MHP added more structure to its EHR training program through additional training, new desk references, videos, and quick start guides to assist users. The MHP is currently in the process of developing a comprehensive training plan that will use Relias as a Learning Management System.
- The MHP has some challenges producing reliable data. It was not able to provide a complete ATA. There appears to be a lack of data integrity validation. The data team is relatively new and there are limited opportunities to learn from more experienced team members.
- The MHP hired an outside contractor to develop a Co-Responder dashboard and are implementing the Netsmart KPI Dashboards module to provide enhanced analytics.
- The MHP is in the early stages of its plan to provide its contract providers full access to the EHR. A survey was issued to providers regarding licensing needs, to determine cost and budgeting. Contract providers identified the following barriers to EHR implementation: IT staffing, fiscal staffing, software licenses, development and standardization of policies and procedures, duplicate clinical documentation, and contract amendments. The current state of data sharing will continue until contract providers have full access to enter clinical documentation.
- Currently, the MHP does not have the capability to bill Medicare; there are issues with NPI numbers. The MHP is still contracting with Netsmart to utilize the RevConnect product for submitting claims and internal training is required before billing can begin.
- The MHP received an extension for submitting the X12 274 Health Provider Directory standard to DHCS.

- The MHP is modelling historical service data to forecast reimbursement under payment reform.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	5,107	$1,234,822	$0	0.00%	$1,189,131
Feb	4,873	$1,217,275	$15,255	1.25%	$1,148,711
Mar	5,471	$1,375,801	$6,150	0.45%	$1,284,430
April	4,909	$1,243,533	$3,138	0.25%	$1,168,670
May	4,921	$1,314,031	$451	0.03%	$1,258,304
June	4,997	$1,384,031	$18,978	1.37%	$1,319,545
July	5,242	$1,430,063	$23,423	1.64%	$1,368,156
Aug	5,060	$1,427,848	$16,963	1.19%	$1,368,844
Sept	4,748	$1,236,768	$7,476	0.60%	$1,179,467
Oct	4,820	$1,262,612	$26,973	2.14%	$1,146,697
Nov	4,122	$1,129,796	$41,408	3.67%	$1,036,286
Dec	4,173	$1,082,233	$9,557	0.88%	$1,053,002
Total	58,443	$15,338,813	$169,772	1.11%	$14,521,243

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Service line is a duplicate and a repeat service procedure code modifier not present	197	$55,022	32.41%
Medicare Part B must be billed before submission of claim	135	$34,721	20.45%
Beneficiary not eligible or non-covered charges	47	$22,262	13.11%
Other	142	$18,751	11.05%
Other healthcare coverage must be billed before submission of claim	42	$15,486	9.12%
Deactivated NPI	30	$13,234	7.80%
Late claim	51	$9,880	5.82%
Service location NPI issue	1	$413	0.24%
Total Denied Claims	645	$169,769	100.00%
Overall Denied Claims Rate	**1.11%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The MHP will not be able to resolve DHCS Medicare Part B denials until direct Medicare billing is reinstated.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Enhanced EHR governance and training puts the MHP in a good position for implementing future IS capabilities.
- The MHP continues to have issues with the reliability of its data. Development of strategies to resolve these issues and augment its data analytical capabilities are warranted.
- The MHP's strategy for clinical data sharing with its contracted providers is to provide full access to the EHR but there are financial and operational challenges as well as some contract provider resistance to that plan. The MHP will need to address these challenges to achieve this goal.
- The MHP is unable to bill Medicare for dually eligible beneficiaries; therefore, Medicare billable services become wholly the financial responsibility of the county, since the MHP is unable to receive federal funds for those services.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of beneficiaries: adult, older adult, youth, and family members. MHPs administer these surveys to beneficiaries receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS and provides a comprehensive analysis in the annual statewide aggregate report.

The MHP conducted the CPS in summer of 2022 but has yet to receive the results of the survey for comparison and analysis.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested "a diverse group of adult beneficiaries and parents/caregivers of youth beneficiaries who initiated services in the preceding 12 months". The focus group was conducted in English and held via videoconference and included nine participants. All consumers and family members participating receive clinical services from the MHP.

The focus group participants had positive perceptions of MHP services over the past year. They endorsed that services have helped them to improve and address the issues that brought them into care. Participants remarked that staff seemed stretched thin. The participants were satisfied with the timeliness of appointments and reported being able to be seen earlier if an urgent need emerged. Participants had the ability to reschedule appointments if they needed to cancel. Members of the wellness center were hopeful about the MHP making wellness center services available five days a week instead of three days. Participants wanted more TAY support groups.

Recommendations from focus group participants included:

- Bring back field trips, cooking classes, and social outings to the wellness centers.
- Reduce staff caseloads.

Consumer Family Member Focus Group Two

CalEQRO requested “a group of 8-10 Latino/Hispanic beneficiaries who mostly have initiated/utilized services within the preceding 12 months”. The focus group was held via videoconference and included seven participants; a Spanish-language interpreter assisted for the focus group. All consumers and family members participating receive clinical services from the MHP.

The focus group participants described a variety of means to access services, from in-person, video-conferencing, and telephone, with a preference for in-person and telephone. The participants had access to translation and interpretation services. The participants were not familiar with the wellness center. They reported the frequency of mental health appointments as every two months. This frequency was “okay”, but more frequent appointments were preferred. If family members had a need in between appointments, they would go to crisis or the emergency department or request an appointment as soon as possible. Some of the participants were concerned about other supportive services and benefits for which their adult siblings or children qualified.

The Hispanic/Latino participants shared insight on low utilization of SMHS among Latino eligibles. First, they indicated that initially they did not know how to access mental health services. Second, they indicated that other needs (e.g., physical health) tended to be more pressing than mental health needs. In the process of having these other needs met, Latino eligibles may be more apt to address mental health concerns.

The focus group participants did not have any recommendations.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The MHP obtains beneficiary feedback from program-specific surveys and the CPS. There was more evidence of the use of findings from program surveys to affect positive change. Grievances that are reviewed at QIC meetings provide another means of identifying beneficiary concerns. From the focus groups, participants were satisfied with the services and credit MHP staff with improvements that they have seen in their health. While participants did not explicitly state the impact of the reduced number of clinicians on their services, they noted that staff were overwhelmed and long latency between appointments. Beneficiary feedback reinforces the need for both direct and indirect strategies to outreach to Hispanic/Latino eligibles. The outreach should focus on raising awareness and continuing collaborations with other service providers, as some of the MHP’s contract providers currently do.

CONCLUSIONS

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

STRENGTHS

1. Case management is a service that the MHP leverages well to enable ongoing services to beneficiaries as it faces staffing challenges among clinicians. (Access)
2. Through partnerships and collaboration with many community agencies, the MHP increases the potential for access to services for eligibles and beneficiaries. (Access)
3. The MHP has added a governance structure for use of its EHR. There is now an EHR steering committee and three user workgroups to prioritize projects and work through issues to achieve successful implementations. (IS)
4. The MHP has an established post-hospitalization process facilitated through a dedicated discharge planner, which may contribute to its relatively low rates of 7-and 30-day rehospitalizations. (Quality)
5. The MHP has a set of parameters to measure the quantity, quality, and outcomes of the services they provide. The parameters are designed to measure the unique responsibilities of each program. (Quality, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. MHP staff are contending with increased demands on their time (i.e., from filling gaps caused by reduced workforce and additional requirements from new regulations and initiatives), and few opportunities to provide input on how to manage these changes. A concern among some stakeholders was low staff morale, which may precipitate staff departures. (Access, Quality)
2. The MHP's API PR for CY 2021 was below the statewide rate and has remained largely unchanged for the past three years. (Access)
3. The MHP did not report the time to first offered appointment and first psychiatry appointment, citing challenges with data accuracy and inconsistencies in data collection. Also, there appears to be infrequent validation of the data and reports. (Timeliness)
4. The MHP reports collecting and tracking the requisite FC HEDIS measures but not trending them. As the MHP did not provide evidence (e.g., report) of its tracking, the latter could not be verified. (Quality)

5. The MHP intends to provide EHR access to contract providers but there are contract amendments and fiscal and operational issues that must be resolved first. (IS)

RECOMMENDATIONS

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

1. Investigate reasons and develop and implement strategies to increase staff engagement meaningfully in system improvement. (This will require giving staff more information; staff having a seat at the table; and staff being empowered to make decisions regarding their programs and services, among other strategies). (Quality, Access)
2. Investigate reasons and develop and implement strategies to increase API PR. (This effort may present an opportunity to engage the QM unit to assist in improving quality of services as opposed to utilization.) (Access, Quality) (This recommendation is a partial carry-over from FY 2021-22).
3. Implement the new methodology for tracking time to first offered service and first offered psychiatry service (inclusive of adults, children, and youth in FC) and incorporate routine review of the data and reports for accuracy. (Timeliness, IS) (This recommendation is a partial carry-over from FY 2021-22)
4. Implement solutions to produce reports that demonstrate tracking, monitoring, and analyzing of the requisite indicators for youth in FC prescribed psychotropic medications. (Quality) (This recommendation is a carry-over from FY 2021-22)
5. Develop and implement a plan to amend existing contracts and resolve fiscal and operational issues, which would enable interested contract providers to gain full access to the EHR. (IS) (This recommendation is a carry-over from FY 2021-22).

EXTERNAL QUALITY REVIEW BARRIERS

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

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

The focus group participants were all established beneficiaries with years, if not decades, of services through the MHP. CalEQRO was not able to obtain the experience of beneficiaries who were new to services within the past 15 months.

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, either individually or in combination with other sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Yolo MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIPs Validation and Analysis
Validation and Analysis of the MHP's Network Adequacy
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Zena Jacobi, Information Systems Reviewer
Gloria Marrin, Consumer/Family Member Reviewer
Ewurama Shaw-Taylor, PhD, CPHQ, Lead Quality 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
Ackerman	Spring	Case Manager III	Yolo HHSA
Andrews	Julie	unknown	Yolo HHSA
Barrett	Katherine	Compliance Officer, Behavioral Health	Yolo HHSA
Beville	Silvana	Supervising Clinician, Child, Youth & Family (CYF)	Yolo HHSA
Breiling, PsyD	Carol	Certified Addiction Treatment Counselor-V	Yolo HHSA
Brown	Erica	Clinician, QM	Yolo HHSA
Budhathoki	Sajana	Adult Mental Health Services Act (MHSA) Program Coordinator	Yolo HHSA
Christensen	Laura	Clinical Supervisor, Forensics Team	Yolo HHSA
Cortopassi	Dennis	Peer Support Worker	Yolo HHSA
De Wein Parino	Kerri	Case Manager, Forensics Team	Yolo HHSA
Duarte	Sylvia	Accountant III, Billing Supervisor	Yolo HHSA
Edwards	Jennifer	MHSA Program Coordinator, CYF	Yolo HHSA
England	Walter	Social Services Assistant	Yolo HHSA
Faller	Jeremy	Peer Support Worker	Yolo HHSA
Freitas	Julie	Clinical Manager, Forensics, Homeless/Alcohol and Other Drugs (AOD) Administrator	Yolo HHSA

Last Name	First Name	Position	County or Contracted Agency
Gallegati	Mario	Clinical Manager, Crisis, Access & Wellness	Yolo HHSA
Gangl	Joseph	Social Worker, Forensics Team, Restorative Partnership	Yolo HHSA
Gay	Jennifer	Supervising Clinician, QM	Yolo HHSA
Gill	Harpreet	Supervising Staff Nurse	Yolo HHSA
Graham	Dana	Behavioral Health Discharge Manager	Yolo HHSA
Green	Mila	Clinical Manager of Special Projects	Yolo HHSA
Gunn	Shirley	Peer Support Worker	Yolo HHSA
Hamdy	Kamal	Clinician, DSH	Yolo HHSA
Hendrickson	Cheri	Supervising Clinician, Access	Yolo HHSA
Inaba	Audrey	Systems Software Specialist I	Innovations & Technology Services Department (ITSD) HHSA Enterprise Applications
Jackson	Sheryl	Senior Staff Nurse, QM	Yolo HHSA
Jakowski, LCSW	Karleen	Mental Health Director/Assistant HHSA	Yolo HHSA
Johnson	Glenn	AOD HHSA Program Coordinator	Yolo HHSA
Johnson	Michael	Program Director	Hope Cooperative
Johnson	Timothy	Systems Software Spec. I	ITSD HHSA Enterprise Applications
Johnston	Robert	Program Director, ACT	Hope Cooperative

Last Name	First Name	Position	County or Contracted Agency
Joy	Michael	Clinician II, Adult & Aging	Yolo HHSA
Kildare	Tony	Branch Director, CYF	Yolo HHSA
Kuhn	Melanie	Systems Software Specialist I	ITSD HHSA Enterprise Applications
Kurzenhauser	Sara	Administrative Service Analyst, QM	Yolo HHSA QM
Littlejohn	Aisha	Administrative Service Analyst, QM	Yolo HHSA
Marin	Monique	Clinician, CYF	Yolo HHSA
Martinez	Angie	Peer Support Worker	Yolo HHSA
McGehee	Caylen	Administrative Service Analyst, QM	Yolo HHSA
Michael	Jacquenette	Program Director	Stanford Sierra Youth & Families
Millard, LMFT, LPCC	Tegwin	Associate Director, Community Mental Health	CommuniCare
Morrish	Jessica	Interim Fiscal Administrative Officer	Yolo HHSA
Mueller	Stacy	Clinician II	Yolo HHSA
Murphy	Megan	Executive Director	Victor Community Support Services
Naldoza	Chris	Peer Support Worker	Yolo HHSA
Pedersen	Lupe	Case Manager, TAY	Yolo HHSA
Peregrine	Sarah	Navigation Center Manger	CommuniCare
Ramirez	Tania	Clinician I	Yolo HHSA
Raven	Brennan	Peer Support Worker	Yolo HHSA
Roman	Tiffany	Program Manager	Stanford Sierra Youth & Families

Last Name	First Name	Position	County or Contracted Agency
Sandoval	Blanca	Office Support Specialist, QM	Yolo HHSA
Sandoval	Sophia	Senior Administrative Service Analyst, QM	Yolo HHSA
Shramenko	Anna	Wellness Center Program Coordinator	Yolo HHSA
Sidhu	Pam	Systems Software Specialist II	HHSA-Enterprise Application Team
Smith	Tessa	Cultural Competence Coordinator	Yolo HHSA
Steffensen, PsyD	Alison	Clinical Psychologist	Yolo HHSA
Strachan	Colin	Information Technology Manager	Yolo HHSA
Thao	Lisa	Hospital Discharge Coordinator	Yolo HHSA
Tormey	Tim	Clinician, QM	HHSA BH-QM
Valle	Fabian	MHSA Coordinator	Yolo HHSA
Villanueva	Melissa	Supervising Clinician, QM	Yolo HHSA
Villarreal	Rob	Supervising Clinician, Crisis	Yolo HHSA
Vittone	Tara	Case Manager II, Access Team, Adult & Aging Branch	Yolo HHSA
Wilson	Christina	Peer Support Worker	Yolo HHSA
Woods	Danyeil	Manager, QM/CalAIM Coordinator	Yolo HHSA
Yang	Rachel Maye	Clinical Director	Yolo Community Care Continuum
Yung	Mary	Clinical Manager, CYF	Yolo HHSA

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	This submission concludes the MHP's project to increase identification of beneficiaries with COD at initial screening at Access. The effective strategies were having clinicians conduct the initial screenings and using pre-screening tools that assess for both mental health and SUD needs.
General PIP Information	
MHP/DMC-ODS Name: Yolo County	
PIP Title: Improving Screening of Co-occurring Disorders (COD) for Beneficiaries	
PIP Aim Statement: Will the following measures increase the early identification of COD needs at Behavioral Health Access and Crisis Line (BH ACL) and linkage to services: increasing clinical capacity at BH ACL; staff participation in training with a focus on COD screening; implementing a substance use disorder (SUD) pre-screening tool; and implementing a [beneficiary] stakeholder/program feedback loop.	
Date Started: 07/2020	
Date Completed: 12/2022	
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:	

General PIP Information
Target population description, such as specific diagnosis (please specify): Beneficiaries who call the Access and Crisis Line requesting behavioral health 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): Conduct beneficiary survey
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Increase clinical capacity at Access 2. Provide SUD training
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Implement pre-screening tools

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
Identification of COD needs	73%	CY 2021	☐ Not applicable—PIP is in planning or implementation phase, results not available	81%	☒ 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): Completed Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Reanalyze data to ensure comparison of like components. • Reconsider the need for and resources needed to effectively conduct a beneficiary survey in future projects. There may be other ways to obtain beneficiary experience without such surveys.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP submitted the FUM for its non-clinical PIP. The MHP has four strategies that address the root cause—that the MHP is not routinely aware of when its beneficiaries are served at an emergency department. Currently, the MHP is in discussions with its managed care provider to join the HIE. Once, the HIE is established, the other strategies can take place.

General PIP Information
MHP/DMC-ODS Name: Yolo County
PIP Title: Follow-up After Emergency Department Visit for Mental Illness (FUM)
PIP Aim Statement: This PIP is designed to improve [the MHP's] care coordination activities for timely 7- and 30-day follow-up and mental health service linkage for Medi-Cal beneficiaries who are seen in an emergency department with a primary mental health diagnosis and/or self-harm
Date Started: 10/2022
Date Completed: Ongoing
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): Medi-Cal beneficiaries who are seen in an emergency department with a primary mental health diagnosis and/or self-harm

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Conduct reviews of identified beneficiaries 2. Assign MHP staff to engage beneficiary 3. Complete a mental health screening
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): Join a health information exchange (HIE)

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
7-day FUM rate 30-day FUM rates	CY 2021	36% (451) 53% (451)	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): 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: • Consider contingencies for delays in or inability to implement HIE. • Provide more detail and specificity regarding beneficiary engagement process.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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