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FY 2020-21 MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

TULARE MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

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INTRODUCTION

The United States Department of Health and Human Services (HHS), 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). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO 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 Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review, or a desk review, of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also considers the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Tulare MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

MHP Information

MHP Size — Medium

MHP Region — Central

MHP Location — Visalia

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 10,491

MHP Threshold Language(s) — Spanish

CalEQRO obtained the MHP threshold language information from the DHCS Information Notice (IN) 13-09.

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

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

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed AB 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and INs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out of Network Access (ONA), Alternative Access Standard (AAS), and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS IN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS will review these forms to determine if the provider networks met required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services to youth and adults. If these standards are not met, DHCS will require the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, CalEQRO will review the AAS and ONA information as part of its annual EQR using a structured protocol.

CalEQRO reviews the NACT provider files, maps of clinics closest to the AAS zip codes, and distances to the closest providers by type and population. If there is no provider within the time or distance standard, the MHP shall develop and propose an AAS plan, and access to any alternative providers who might become Medi-Cal certified for the MHP. The MHP shall submit a plan of correction addressing the needs to meet the AAS.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO will review grievance and complaint log reports, facilitate beneficiary focus groups, review claims and other performance data, and review DHCS-approved corrective action plans.

Validation of State and MHP Beneficiary Satisfaction Surveys

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.

- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations with the MHP. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met 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 Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: Develop/present a new clinical PIP using MHP-specific evidence as the foundation for the project.

Status: Met

- The MHP developed a new clinical PIP to improve beneficiary engagement in services. The project began in July 2020.
- As evidence of a decrease in engagement, the MHP presented rates of discharge and session duration for individual therapy, case management, and rehabilitation services.

Access Recommendations

Recommendation 2: Monitor the incidence of, and response to, missed and rescheduled appointments for a given period (at least three months).

Status: Not Met

- The MHP did not monitor incidence of, and response to, missed and rescheduled appointments.
- The MHP reported that it: updated the Scheduling Calendar (SC) report to include the required data elements; mandated the use of the SC in October 2019; and trained staff on the SC.
- This recommendation will not be continued. Given COVID and the move to remote services, rescheduling appointments has been less of a concern.

Recommendation 3: If time to rescheduled appointment is protracted, implement improvement activities.

Status: Not Met

- As the MHP did not monitor missed and rescheduled appointments, the MHP cannot yet determine if improvements are needed.
- Regarding the SC, the MHP opened access to the clinical staff, in addition to support staff, so that they can also assist with scheduling and rescheduling appointments.
- This recommendation will not be continued. Given COVID and the move to remote services, rescheduling appointments has been less of a concern.

Recommendation 4: Conduct a focused, time-limited evaluation of the walk-in process that captures variables such as the number of individuals who come in for walk-in appointments; the time to services or time to leaving the clinic; who completed the assessment; and outcome of the walk-in, to gain a better understanding of the impact of this means of providing access. (This recommendation is a follow-up from FY 2018-19.)

Status: Not Met

- Due to COVID-19 and the shelter-in-place order, which prompted remote services, the MHP has not been able to monitor walk-in access.

- This recommendation will not be continued.

Timeliness Recommendations

Recommendation 5: Comply with the state timeliness metric per Information Notice (IN) 18-011 to monitor timeliness of first offered appointment.

Status: Met

- The MHP implemented the Client Services Information (CSI) Assessment Record in October 2019. It is regularly monitoring timeliness of first offered appointments.

Recommendation 6: Modify the EHR to record the date of referral to psychiatry, particularly for children's services.

Status: Partially Met

- The MHP implemented a new referral to psychiatry field in the EHR in October 2019.
- The MHP produced reports of time to psychiatry, following the first quarter of use; however, the reports were not accurate. The MHP has since modified and re-implemented the referral field.
- The revised referral field was rolled out MHP-wide in July 2020.

Quality Recommendations

Recommendation 7: Specify the number of additional staff assigned to the quality improvement (QI) unit (i.e., from the Board-approved staffing increase) and ensure sufficient resources to maintain improvement activities, such as the annual evaluation and development of the QI work plan.

Status: Met

- The MHP increased the QI unit by four positions: an analyst, an administrative specialist, a children's authorization clinician, and a problem resolution coordinator position.
- Due to COVID-19, a number of staff have been reassigned to other areas; therefore, the MHP has been unable to fully utilize the new staff in their assigned roles.

Recommendation 8: As a start to collaborative documentation, invite staff from counties that have successfully implemented collaborative documentation and that use the same EHR, to give their input on implementation and barriers. *(This recommendation is a follow-up from FY 2018-19.)*

Status: Met

- The MHP consulted with its contractor, Kings View Behavioral Health System (Kings View), which had attempted collaborative documentation, but with unsatisfactory results.
- Through the Medi-Cal Policy Committee, the MHP reached out to other counties that have attempted collaborative documentation, but did not find positive results. The MHP learned that efforts at collaborative documentation were not successful and did not locate any successful protocols.

Beneficiary Outcomes Recommendations

Recommendation 9: Convene MCPs to discuss and develop processes for transferring more beneficiaries to this lower level of service.

Status: Met

- The MHP meets quarterly with the MCPs to monitor the referral and transfer process.

Recommendation 10: Monitor the number of referrals to MCP, as per the non-clinical PIP.

Status: Met

- The MHP reported working closely with the PIP team and the MCPs to discuss and monitor the roll-out of the MCP referral form.
- The MHP began using the referral form in July 2020.
- While the form is in place, it has not had any appreciable impact on the MHP receiving feedback or being apprised of beneficiaries who were transferred successfully to MCPs.

Foster Care Recommendations

Recommendation 11: Expand the scope of monitoring of the HEDIS Foster Youth Measures to any/all psychotropic medications, as per SB 1291.

Status: Partially Met

- The MHP's Medication Monitoring Review Criteria form includes fields to record other medications that youth may be prescribed; however, the form continues to focus on antipsychotic medications.
- The MHP should ensure that its medication monitoring protocols include all requirements of SB 1291 (see page 19).

Information Systems Recommendations

Recommendation 12: Work with County information technology (IT) and local network communication providers to monitor network connectivity to determine network speed to all endpoints that support Avatar users.

Status: Met

- The county's IT staff have produced a map in the network monitoring tool that identifies failed equipment as well as issues reported by equipment that provides connectivity across the county's network.
- With the exception of some remote locations, MHP contract providers state that connectivity and speed have increased, and that connectivity is no longer a noticeable problem.
- The county's IT staff have tools that measure network speed.
- The MHP's EHR (Avatar) has brought in a separate cloud-based connection to improve both reliability and connectivity.

Recommendation 13: Establish an acceptable baseline for minimum speed and measure network speed results periodically to ensure Avatar end-user experiences are within the acceptable range.

Status: Met

- The MHP examines the overall connectivity within the county to determine if any of the connections are saturated; however, it has not seen a need to establish baselines.

- During the focus group, contract providers stated that this is no longer a problem.
- County IT staff can determine if the connection to Avatar is operable and the latency of the connection.
- County IT staff have limited visibility into the separate app service environment cloud that is currently supporting Tulare Youth Service Bureau. The MHP IT staff will investigate if connectivity and slow speeds were to be reported.

Recommendation 14: Implement corrective action at sites where baseline network speed is less than acceptable.

Status: Met

- The MHP has implemented corrective action as above.

Recommendation 15: Increase system-wide use of the EHR scheduler and run reports to ascertain staff-beneficiary engagement.

Status: Met

- The MHP developed an Appointment Calendar Details Report that shows an increase in scheduled appointments:
    - 23,569 more appointments scheduled in FY 2019-20, a 19.9 percent increase.
    - FY 2018-19: 117,933 appointments and 6,503 no-shows (5.5 percent no-show rate).
    - FY 2019-20: 141,502 appointments and 8,353 no-shows (5.9 percent no-show rate).
- The MHP mandated the use of the SC in October 2019.

Recommendation 16: Increase and provide on-going training to staff on the use of the scheduler.

Status: Met

- The MHP's QI manager informed clinics that the EHR Team was available to train staff on the SC. Two county clinics were trained in using the SC, as well as Turning Point North County One-Stop, Central County One-Stop, the Mobile Unit, and Tulare County Office of Education (TCOE).

- The SC training guide was updated in September 2019.

Recommendation 17: Integrate the Consents for Medication into the EHR.

Status: Not Met

- The EHR is not capable of producing a California-compliant Consent for Medication. The MHP states that integration of the Consents for Medication would compromise the authenticity and legality of the form, as there are limits to the length of the fields in Avatar forms, and Consents for Medications are several paragraphs long.
- A possible workaround to this limitation would allow the beneficiary to see the long text when electronically signing, but the printed copy of the form would only show the minimized version without all of the necessary details and so was found to not be practical.
- This recommendation will not be carried forward.

Recommendation 18: Collaborate with local labs to have lab reports fully integrated into the EHR.

Status: Met

- While the MHP would like to have all of its lab results in one place, several labs do not have electronic capability, precluding establishment of centralized and uniform labs results in the EHR.
- Once the Avatar NX, Order Connect upgrade is in place, the MHP will reconsider this recommendation.
- This recommendation will not be carried forward.

Recommendation 19: Increase the use of the PHR.

Status: Met

- In October 2019, the MHP mandated the use of the Patient Portal User Agreement as well as the Patient Acknowledgement and Agreement during the assessment process.
- The MHP's new protocol requires staff to document that they have informed the beneficiaries of the PHR. There have been 1,400 Patient Acknowledgment and Agreements completed; however, only 579

beneficiaries expressed interest in accessing the portal. The majority have declined interest. Furthermore, of the 98 beneficiaries who have active accounts currently, only 66 of the accounts have been activated since October 2019.

- The MHP is challenged by the lack of engagement from beneficiaries once they have been issued their personal identification number (PIN). There are a number of pending accounts in the system. This occurs when a beneficiary's information is entered into the system and a PIN is generated, but the beneficiary does not log in to complete the registration process.

Structure and Operations Recommendations

Recommendation 20: Continue to address the factors that affect staff retention and finds ways to increase retention of staff.

Status: Met

- The MHP is offering better opportunities for growth in-house and, as requested by staff, additional areas for training. Staff noted greater flexibility and accommodations for training.
- Staff also endorsed leadership efforts to increase communication and keep staff informed.

Recommendation 21: Review the roles and job descriptions of peer support specialists and ensure consistency across clinics and alignment of functions with job descriptions.

Status: Met

- Peer employees agreed that there are differences in their roles and duties based on the clinic where they are employed.
- The MHP assigned staff to work with Health & Human Services Agency (HHSA) human resources to review and revise the job descriptions for the peer support specialist classification. Draft revisions were forwarded to county Human Resources and Development for review.
- Due to the Governor's emergency orders in March 2020, the MHP awaits response from Human Resources and Development.

PERFORMANCE MEASURES

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. Senate Bill (SB) 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf

2. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to: screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.
- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).

- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (AB) 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf

5. *Katie A. v. Bonta*:
The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act (HIPAA) Suppression Disclosure

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

Table 1 provides details on beneficiaries served by race/ethnicity.

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Tulare MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	37,688	15.0%	2,435	23.2%
Latino/Hispanic	180,673	71.7%	6,499	61.9%
African-American	3,864	1.5%	232	2.2%
Asian/Pacific Islander	6,280	2.5%	170	1.6%
Native American	1,457	0.6%	72	0.7%
Other	22,019	8.7%	1,083	10.3%
Total	**251,978**	**100%**	**10,491**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

Table 2 provides details on beneficiaries served by threshold language.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

Tulare MHP		
Threshold Language	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
Spanish	2,558	24.4%
Other Languages	7,933	75.6%
Total	**10,491**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

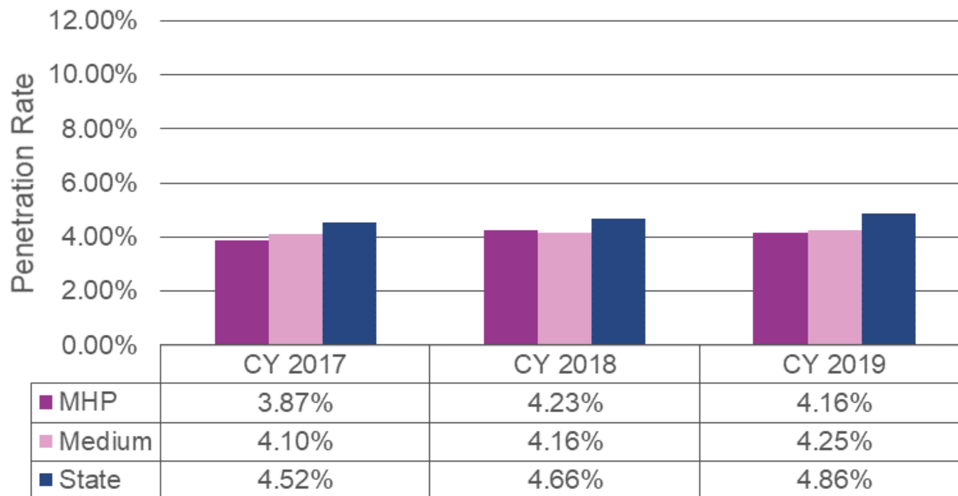
Penetration Rates and Approved Claims per Beneficiary

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment C provides further ACA-specific utilization and performance data for CY 2019. See Table C1 for the CY 2019 ACA penetration rate and ACB.

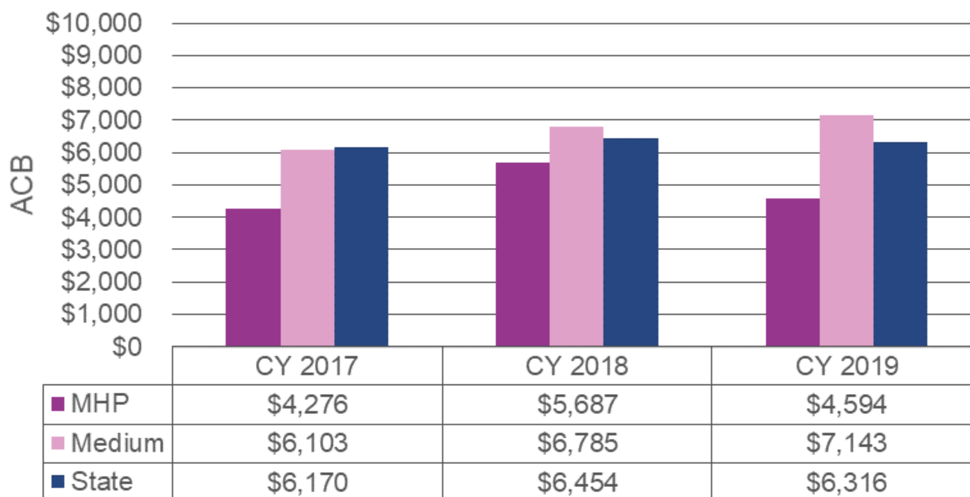
Regarding the calculation of penetration rates, the Tulare MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	3.87%	4.23%	4.16%
Medium	4.10%	4.16%	4.25%
State	4.52%	4.66%	4.86%

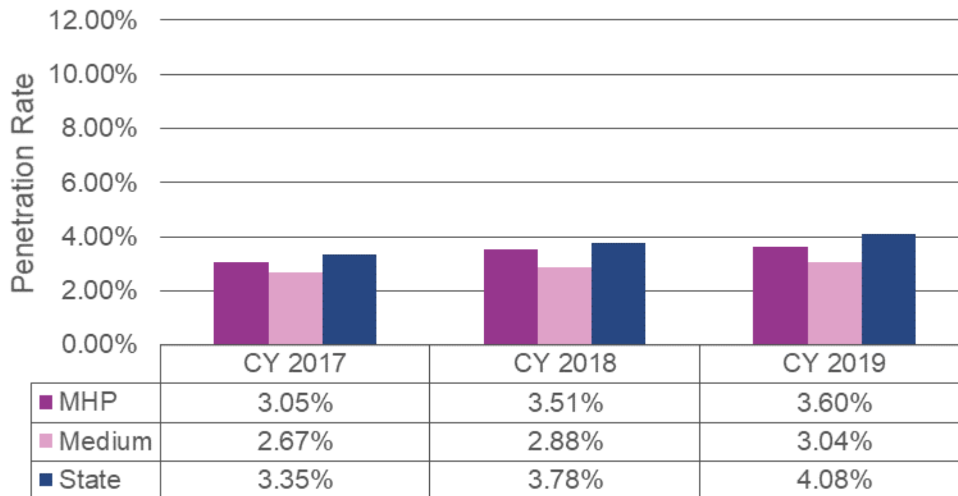
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$4,276	$5,687	$4,594
Medium	$6,103	$6,785	$7,143
State	$6,170	$6,454	$6,316

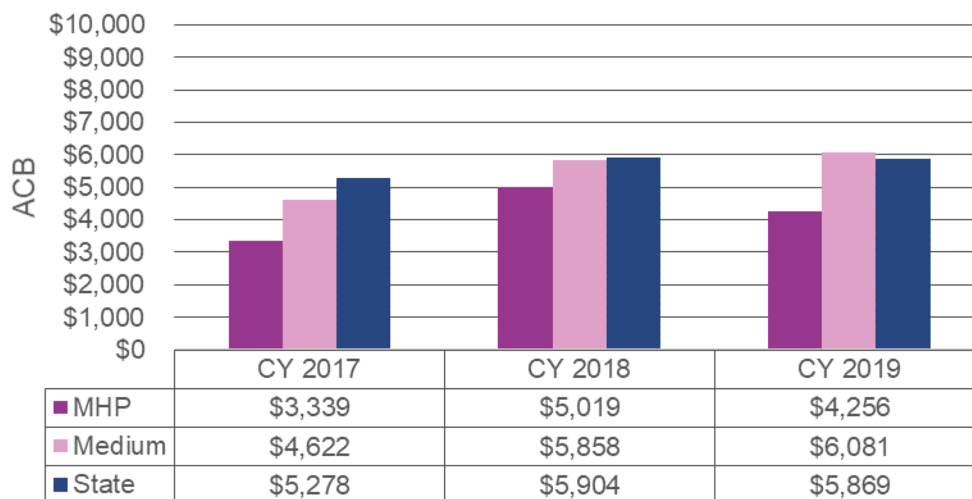
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	3.05%	3.51%	3.60%
Medium	2.67%	2.88%	3.04%
State	3.35%	3.78%	4.08%

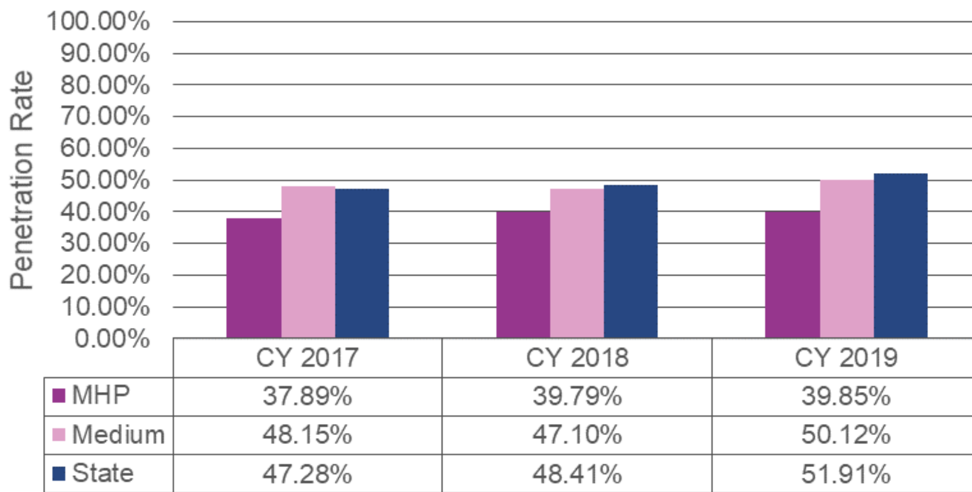
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,339	$5,019	$4,256
Medium	$4,622	$5,858	$6,081
State	$5,278	$5,904	$5,869

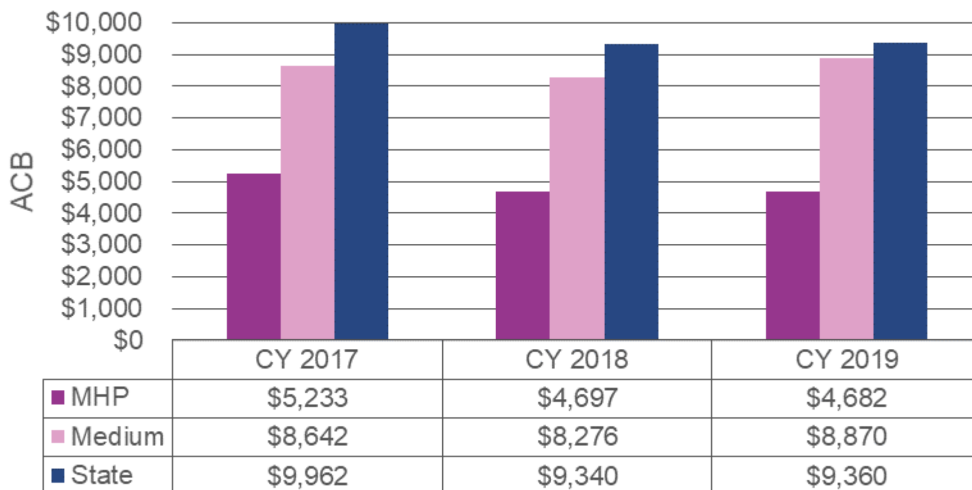
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	37.89%	39.79%	39.85%
Medium	48.15%	47.10%	50.12%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

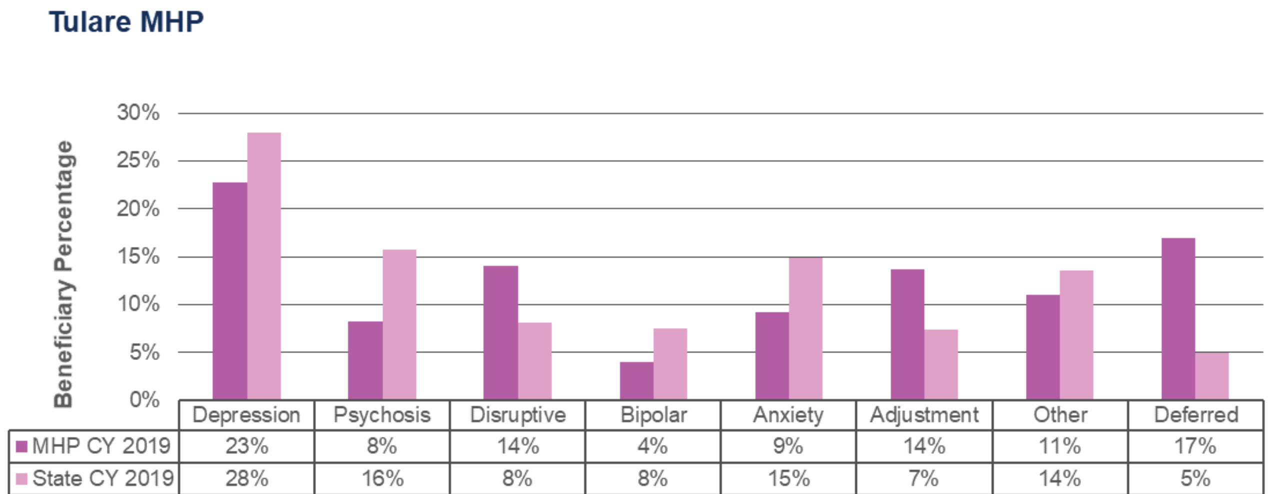


	CY 2017	CY 2018	CY 2019
MHP	$5,233	$4,697	$4,682
Medium	$8,642	$8,276	$8,870
State	$9,962	$9,340	$9,360

Diagnostic Categories

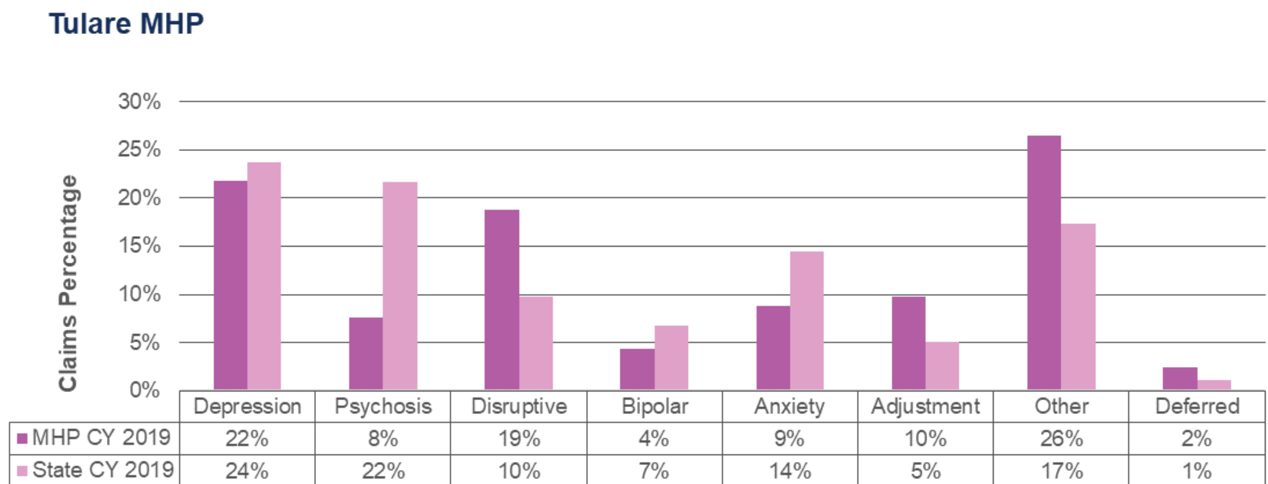
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	23%	8%	14%	4%	9%	14%	11%	17%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	22%	8%	19%	4%	9%	10%	26%	2%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

Tulare MHP								
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	158	10,491	1.51%	$55,642	$8,791,461	18.24%
	CY 2018	281	10,825	2.60%	$69,083	$19,412,376	31.53%
	CY 2017	129	10,074	1.28%	$48,865	$6,303,607	14.63%

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

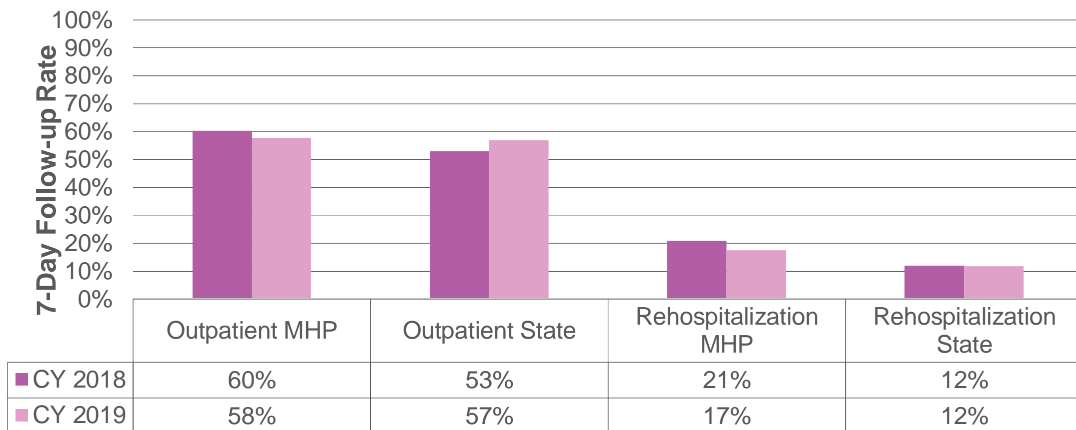
Table 4: Psychiatric Inpatient Utilization CY 2017-19

Tulare MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	813	1,453	9.52	7.80	$13,255	$10,535	$10,775,957
CY 2018	1,222	2,822	9.38	7.63	$18,614	$9,772	$22,746,331
CY 2017	690	1,211	8.44	7.36	$10,427	$9,737	$7,194,860

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

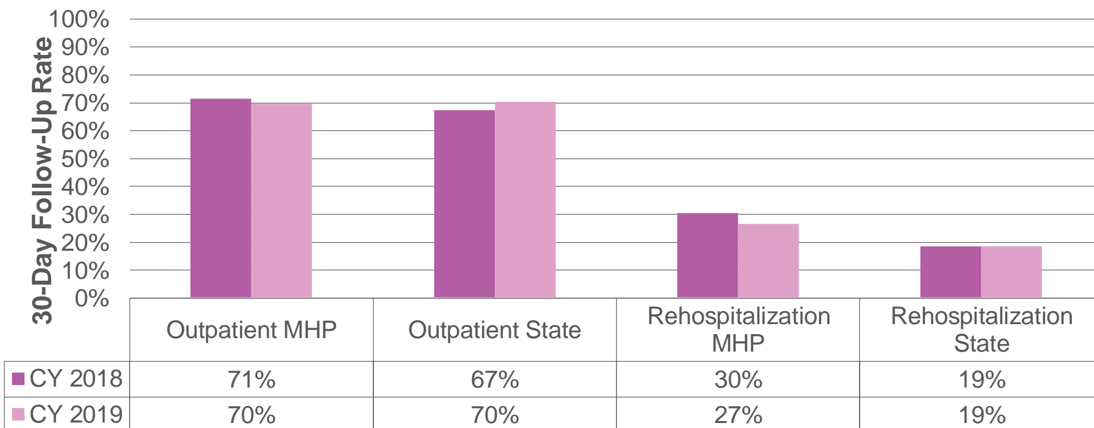
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	60%	53%	21%	12%
CY 2019	58%	57%	17%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	71%	67%	30%	19%
CY 2019	70%	70%	27%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

Tulare County MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs and validated two PIPs, as shown below.

Table 5: PIPs Submitted by Tulare County MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Increasing Therapeutic Alliance in Telehealth Services
Non-Clinical	1	Clinic Administrators

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Tulare County
PIP Title	Increasing Therapeutic Alliance in Telehealth Services
PIP Aim Statement	Will the use of Motivational Interviewing interventions with beneficiaries using telehealth services strengthen consumer engagement over a two-year period, resulting in a smaller percentage of discharges made for not returning for services and longer durations for case management, individual therapy, and rehabilitation sessions?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic)	

MHP Name	Tulare County
☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ 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): The target population is beneficiaries who receive outpatient services through telehealth, telephone, or video-based services.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested 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): The intervention is provider-focused. The intervention is for clinicians and case managers to use a new technique, Motivational Interviewing, to increase or build therapeutic alliance.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Survey of therapeutic alliance	2020	The survey has not been conducted.	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Discharge (from services) rate	2020	1,610	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Session Duration	2020	1,610	☒ n/a*		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Was the PIP validated?				☒ Yes	☐ No	

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Validation phase: ☐ 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: • Include a measure for fidelity and competency in (use of) Motivational Interviewing. The MHP has developed an intervention that requires staff to change/modify/adjust their approach with beneficiaries. However, the MHP has no measure to assess if, in fact, staff are able to apply the intervention as intended. • Use a random sample rather than including the entire MHP adult outpatient population served through telehealth/telephone/video-based. The MHP intends to expand the project to other sites and programs in the MHP, which would be over 6,500 beneficiaries. The MHP is not in a position to conduct a study of this size and obtain accurate, reliable data. Already, for the 'pilot' phase, one performance measure was not provided.						

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
• Explain how therapeutic alliance relates to change in engagement. The MHP has attributed the change in session duration and retention rate (i.e., indicators of engagement) to a decrease in therapeutic alliance. The MHP did not make clear or provide evidence of how a change in service delivery modality—telehealth—would then affect the alliance. Presumably, if the beneficiary and clinician/case managers were already working together, therapeutic alliance would have been established.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Suggestions on how to revise the written submission. • Feedback to narrow the scope of the project. • Clarification questions to elicit more information on the connection between decreased engagement and therapeutic alliance.						

*PIP is in planning and implementation phase if n/a is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Tulare County
PIP Title	Clinic Administrators
PIP Aim Statement	Will instituting a system of referral of MHP-discharged consumers of specialty mental health services to managed care plan providers of mental health services result in: • At least 65 percent of [beneficiaries] who would be expected to benefit from a referral to an MCP receiving a referral • At least a 25 percent decrease in the discharged [beneficiaries] who return to the MHP for continued treatment within six months of discharge • At least a 25 percent decrease in the discharged [beneficiaries] who experience a crisis contact within six months of discharge, and

MHP Name	Tulare County
	• At least a 25 percent decrease in discharged [beneficiaries] who experience hospitalization within six months of discharge.
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☒ 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): The target population is beneficiaries served at county-operated clinics who are discharged from MHP services for one of four reasons: treatment goals had been met; treatment goals were partially met; not/no longer meeting medical necessity; or transferred to PCP.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested 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): n/a

PIP Interventions (Changes tested in the PIP)
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): The intervention is MHP system-focused. The intervention is to change the process for coordinating beneficiary transfer to the MCP or PCP provider. The process includes use of a (new) bidirectional referral form and a new policy for this new referral process.

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Referrals to MCP/PCP	2018	918 (2.7%)	2020 ☐ n/a*	95 (65.3%)	☒ Yes ☐ No	☒ Yes ☐ No p-value: ☒ <.01 ☐ <.05 Other (specify):
Return to MHP in six months	2018	289 (11.4%)	2020 ☐ n/a*	145 (9.7%)	☒ Yes ☐ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Crisis contact within six months of discharge	2018	289 (6.6%)	2020 ☐ n/a*	145 (2.8%)	☒ Yes ☐ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Was the PIP validated? ☒ Yes ☐ No

Validation phase:

☐ 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:

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
• Use the two methods discussed by the MCP representatives (who were present at the PIP session) to confirm that beneficiaries referred to the MCP were subsequently accepted by/enrolled with the MCP. As of the review, the MHP was still not getting any confirmation back from MCP that beneficiaries were accepted, even after more referrals were being made. This has been a long-standing issue. • Monitor both the referrals to and confirmation of transfer from the MCP providers. If there continue to be issues, present details to MCPs.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Suggestions to make the target for improvement more realistic, keeping in mind that not all beneficiaries who meet study criteria will require or want ongoing services through an MCP/PCP. • Suggestions to provide justification for the goal that is ultimately selected.						

*PIP is in planning and implementation phase if n/a is checked.

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site review.

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Tulare	3.00%	4.00%	4.20%	4.00%
Medium MHP Group	n/a	3.28%	3.34%	3.01%
Statewide	n/a	3.58%	3.35%	3.34%

- This is the third year that there has been a decline in the IT budget. The MHP states that the infrastructure costs are now covered by the HHSA.
- Three percent of budget devoted to IT is on the low end of funding as noted in industry benchmarks for healthcare. An MHP EHR requires resources and staff to make effective use of its full capabilities.

The budget determination process for information system operations is:

☐ Under MHP control
☐ Allocated to or managed by another County department
☒ Combination of MHP control and another County department or Agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☒ Yes	☐ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If no BCP was selected above; the MHP uses an Application Service Provider (ASP) model to host EHR system which provides 24-hour operational support.	☒ Yes	☐ No
The BCP (if the MHP has one) is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP organization clearly identified as having responsibility for Information Security.	☐ Yes	☒ No
If no one within the MHP organizational chart has responsibility for Information Security, does either the Health Agency or County IT assume responsibility and control of Information Security?	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

- The EHR manager is not a direct report of the MHP director, instead this position reports to a Unit Manager, who reports to a Division Manager, who reports to a Deputy Director. The relegation of this fundamental aspect of data governance several layers into the organizational structure is not conducive to the full use of the EHR.
- The IS officer is not part of the MHP chain of command.

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	24.41%
Contract providers	74.13%
Network providers	1.46%

Type of Provider	Distribution
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

- The MHP has increased the use of network providers from 0.2 percent to 1.46 percent this year.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	8	3	1	3
2019-20	6	1	1	1
2018-19	5	0	1	0

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	5	0	0	0
2019-20	5	0	3	0
2018-19	6	0	2	0

- The MHP has budgeted new IT staff that will be part of the EHR team; two slots are not yet filled. There will be future costs associated once they are filled.
- The MHP was able to hire an EHR specialist before the hiring freeze was implemented. The MHP hopes to hire a supervisor and another EHR specialist once the hiring freeze is lifted.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by MHP and does not account for user's log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	55	68	123
Clinical Healthcare Professional	151	322	473
Clinical Peer Specialist	4	7	11

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Quality Improvement	7	5	12
Total	217	402	619

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Medium MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	8	7.87
Total EHR Users Supported by IT (Source: Table 17)	619	572
Ratio of IT Staff to EHR Users	1:77	1:73

- The MHP's staffing ratios are in line with other like-sized programs.

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☒ Yes	☐ No
The MHP utilizes an ASP model to support EHR operations.	☒ Yes	☐ No
The MHP also utilizes QI staff to directly support EHR operations.	☐ Yes	☒ No
The MHP also utilizes Local Super Users to support EHR operations.	☐ Yes	☒ No

- Netsmart hosts the EHR and provides 24/7 system monitoring.

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☐	☒	☐	☐
Screen workflow and navigation	☐	☒	☐	☐

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

- The MHP requires contract providers to all use the same EHR so that information flows smoothly across all agencies.
- The contract providers expressed satisfaction with their communication and working relationship with the MHP. In a focus group, they all agreed that they have a strong partner in working with their populations.

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	13
Number of county-operated telehealth sites	3
Number of contract providers' telehealth sites	10
Total number of beneficiaries served via telehealth during the last 12 months	3,763
• Adults	790
• Children/Youth	2,889
• Older Adults	84
Total Number of telehealth encounters (services) provided during the last 12 months:	24,869

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☒ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☐ To serve special populations (i.e. children/youth or older adult)
☐ To reduce travel time for healthcare professional staff
☐ To reduce travel time for beneficiaries
☐ To support NA time and distance standards
☐ To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- Prior to COVID-19, telehealth services were used for psychiatry. Since the beginning of the health emergency, the majority of most mental health services have been provided via telehealth.

- As a response to COVID-19, the MHP has added telehealth set-ups in remote locations to support services for beneficiaries who may not have connectivity or technology to otherwise participate.

- The providers state that having telehealth services across the breadth of their services has been very helpful. They hope that they may continue this practice after the medical emergency is lifted.
- Telehealth services are available with both English- and Spanish-speaking practitioners.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☐	Cambodian
☐	Cantonese	☐	Farsi	☐	Hmong
☐	Korean	☐	Mandarin	☐	Other Chinese
☐	Russian	☒	Spanish	☐	Tagalog
☐	Vietnamese				

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Turning Point of Central California	6
Tulare Youth Service Bureau	1
Tulare County Office of Education	1
Kings View Corporation	2

Current MHP Operations

- Responding to the COVID-19 pandemic, the MHP has focused on using telehealth for most of its services by providing staff with laptops for working from home.
- For the last seven years, the MHP's primary IS has been myAvatar. It is hosted and supported by Netsmart Technologies. The Avatar system provides practice management, and clinical and medical record functionality to the agency.
- The MHP has four large contract providers who have direct access to myAvatar and use it to record beneficiary encounter data.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SDMC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
MyAvatar	EHR System	Netsmart	7	Netsmart
OrderConnect	Electronic Medication Prescribing	Netsmart	8	Netsmart
ImageNow	Document Imaging System	Netsmart	4	Netsmart
myHealthPointe	Personal Health Record (PHR)	Netsmart	3	Netsmart

The MHP's Priorities for the Coming Year

- KnowBe4 security training program
- Cache 2017 testing and implemention

- NSX VXLan (Network Security Extendability Virtual Extension Local Area Network) network virtualization
- NSX Micro segmentation
- Remote Access Project
- Microsoft Exchange Project
- HIPAA Compliant Project
- Follow-Me Printing Project
- Wide Area Network (WAN) Project
- Physical Access Manager Project

Major Changes since Prior Year

- Migration to Microsoft Active Directory
- Network improvements
- Windows 10 upgrade
- Migration to TrendMicro encryption
- Electronic Prescribing of Controlled Substances
- TrendMicro Apex upgrade
- Aplication Firewall Upgrade
- Server Hardware refresh
- M*MODAL – Speech to Text Software

Other Areas for Improvement

- Although the MHP has increased the use of the scheduler, accurate use continues to lag behind expectations. The MHP's EHR indicates a no-show rate of less than 6 percent. Staff believe that the no-show rate is closer to 30 to 40 percent. Training on the correct use of the scheduler for all staff will continue until the rates are consistent with actual experience.
- In light of the COVID-19 pandemic, the MHP should develop strategies to increase the beneficiaries' use of the PHR.
- As the Information Security officer is not part of the MHP chain of command, a focus on safety and training for agency staff may be compromised. The MHP could consider having one of its management teams also share this responsibility.

Plans for Information Systems Change

- No plans to replace current system (in place more than five years).

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Netsmart/Avatar	☒	☐	☐	☐
Assessments	Netsmart/Avatar	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/ Storage	Netsmart/Avatar	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Netsmart/Avatar	☒	☐	☐	☐

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service	Netsmart/Avatar	☒	☐	☐	☐
Outcomes	Netsmart/Avatar	☒	☐	☐	☐
Prescriptions (eRx)	Netsmart/Avatar	☒	☐	☐	☐
Progress Notes	Netsmart/Avatar	☒	☐	☐	☐
Referral Management		☐	☐	☒	☐
Treatment Plans	Netsmart/Avatar	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		9	0	3	0
FY 2019-20 Summary Totals for EHR Functionality:		9	0	3	0
FY 2018-19 Summary Totals for EHR Functionality:		8	1	3	0

Progress and issues associated with implementing an EHR over the past year are summarized below:

- The MHP’s official Chart of Record remains a combination of paper and electronic forms, with vital forms remaining on paper: Release of Information, Laboratory Results, Medication Consents, and Hospital Release Documents.
- Although the EHR has the capability of integrating lab results, the MHP has chosen not to implement it.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	N/A	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	N/A	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	N/A	Not used
Direct data entry into MHP EHR system by contract provider staff	72%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	N/A	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	28%	Monthly

- The MHP partners with four contract providers to provide outpatient services locally, at clinics, schools, and field-based settings.
- The contract providers use direct entry into the MHP's EHR. The contract provider's satisfaction with the use of one EHR has increased as a direct result of improved connectivity with and stability of the EHR.

The rest of this section is applicable: ☐ Yes ☒ No

Some contract providers have EHR systems that they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Contract Provider to MHP Data Transmission

EHR Vendor	Product	Count of Providers Supported
Not Applicable		

Personal Health Record (PHR)

The beneficiaries have online access to their health records through a PHR feature provided within the EHR, a beneficiary portal, or a third-party PHR.

☒ Yes ☐ No ☐ Implementation Phase

Expected implementation timeline:

☒ Already in place
☐ Within 6 months ☐ Within the next year
☐ Within the next two years ☐ Longer than 2 years

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☒ Yes	☐ No
Initiate appointment requests to provider/team.	☒ Yes	☐ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☒ Yes	☐ No
View list of current medications through portal.	☒ Yes	☐ No
Have ability to both send/receive secure text messages with provider team.	☒ Yes	☐ No

- Although the MHP and its contract providers offer a PHR, only 98 beneficiaries are currently using it. This is less than 1 percent of the beneficiaries served.
- The MHP utilizes peer support specialists to provide one-on-one training for beneficiaries on the use of the PHR at the clinic office.
- The MHP informs and documents the availability of a PHR at admission. Expanded marketing and follow-up support from the clinical side could increase beneficiary participation.
- The MHP is exploring future expansions of the EHR with check-in and other support functions.

Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

☒	Dimension Reports application
☐	Web-based application, including the MHP EHR system, supported by vendor or ASP Staff
☐	Web-based application, supported by MHP or DMC staff
☐	Local SQL database, supported by MHP/Health/County staff
☐	Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP’s SDMC claims.

Table 29: Summary of CY 2019 Short-Doyle/Medi-Cal Claims

Tulare MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**223,366**	**$41,736,633**	**8,435**	**$1,520,261**	**3.51%**	**$40,216,372**	**$37,872,517**
JAN19	22,310	$4,498,097	3,169	$533,312	10.60%	$3,964,785	$3,301,947
FEB19	18,903	$3,477,033	233	$44,061	1.25%	$3,432,972	$3,254,037
MAR19	20,361	$3,711,339	271	$55,258	1.47%	$3,656,081	$3,461,979
APR19	21,243	$4,365,602	2,690	$474,269	9.80%	$3,891,333	$3,269,642
MAY19	19,965	$3,652,141	353	$64,417	1.73%	$3,587,724	$3,389,494
JUN19	15,872	$2,804,308	263	$47,235	1.66%	$2,757,073	$2,595,263
JUL19	15,891	$2,804,354	278	$50,713	1.78%	$2,753,641	$2,697,276
AUG19	17,556	$3,209,131	214	$48,638	1.49%	$3,160,493	$3,108,570
SEP19	18,824	$3,411,181	334	$61,235	1.76%	$3,349,946	$3,285,244
OCT19	21,408	$3,933,486	239	$51,681	1.30%	$3,881,805	$3,825,868
NOV19	16,013	$2,990,507	213	$47,711	1.57%	$2,942,796	$2,889,859
DEC19	15,020	$2,879,452	178	$41,730	1.43%	$2,837,722	$2,793,337

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

- Although the MHP had significant numbers of denied services during the months of January and April 2019, there was no significant impact on the results in the Dollars Approved column.
- The MPH's denied claims rate of 3.51 percent is consistent with the statewide average of 2.99 percent.

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

Tulare MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Service line is a duplicate and a repeat service procedure code modifier not present.	5,035	$847,802	56%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	1,664	$333,269	22%
Medicare or Other Health Coverage must be billed before submission of claim.	1,047	$207,976	14%
Beneficiary not eligible.	456	$92,101	6%
Late claim denial.	101	$17,129	1%
Total	8,435	$1,520,261	NA

The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.

- Denied claim transactions with reasons ‘Service line is a duplicate and a repeat service procedure code modifier not present’ and ‘Medicare or Other Health Coverage must be billed before submission of claim’ are generally re-billable within the State guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Tulare MHP, the time and distance requirements are 75 minutes and 45 miles for mental health services, and 75 minutes and 45 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted two consumer and family member focus groups, two stakeholder interviews, four staff and contractor interviews, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

The MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

At the time of the review, the MHP had no Plan of Correction for FY2020-21.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	3
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	24
NPI Type 1 number reported is associated with two or more providers	0

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	0
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	0

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The 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 the CFMs for their participation.

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held by Zoom.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	Zero
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group:	
Access - new beneficiaries	No new beneficiaries were part of the focus group.
Access – overall	The participants reported that the MHP provides bus passes to assist with transportation and access to clinics and

Topic	Description
	appointments. Participants agreed that the MHP provided information, forms, and services in other languages besides English, including Hmong and Spanish.
Timeliness	The participants described weekly or biweekly contact with their case managers and clinicians. Since COVID, they noted more frequent telephone contact/check-ins with them as well. Participants saw their psychiatrists anywhere from monthly to every three months. The frequency was sufficient, especially if participants had other mental health professionals to talk to or see in the interim months.
Urgent care and resource support	Participants were aware of the crisis line and have used it without issue. Participants were also aware of the warm line, though few had used it. One participant received written information, to which s/he could refer to manage symptoms during an urgent time.
Quality	The participants provided examples of how the MHP (i.e., through their case managers) assisted them with benefits such as food stamps and welfare, personal budgeting, and temporary cash/financial assistance.
Peer employment	The participants endorsed that they received services that promote employment and education. One participant was part of a supported employment program and another received assistance in applying to college.
Structure and operations	The participants were not familiar with MHP committees (e.g., cultural competence, QI) to which they could be members. They were familiar with providing feedback through the annual surveys and clinic surveys.
Recommendations from this focus group	• Offer classes/instruction on computer literacy and electronic devices. • Provide groups, particularly those at the wellness center, on Zoom.
Any best practices or innovations (optional)	None

CFM Focus Group Two

Table 33: Focus Group Two Description and Findings

Topic	Description
Focus group type	CalEQRO requested a group of Latino/Hispanic beneficiaries who reside in/near Dinuba who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group consisted of Latino men who were English-speaking. The focus group was held by Zoom.
Total number of participants	Two
Number of participants who initiated services during the previous 12 months	One
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group: As there were too few participants for a focus group, the participants' comments were included in the summary for CFM Focus Group One.	
Access - new beneficiaries	See Focus Group One
Access – overall	See Focus Group One
Timeliness	See Focus Group One
Urgent care and resource support	See Focus Group One
Quality	See Focus Group One
Peer employment	See Focus Group One
Structure and operations	See Focus Group One
Recommendations from this focus group	• None
Any best practices or innovations (optional)	• None

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 34 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 34: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	12
The MHP has used a variety of means to provide information and to communicate with beneficiaries and prospective beneficiaries over the past year, including newspaper, newsletters, radio advertisements, and community flyers. The MHP has a social media presence (e.g., Facebook and Twitter) with routine posts regarding the MHP and mental health and wellness in general. The MHP did not provide evidence of its monitoring of the posts or effectiveness of posts in facilitating access. The MHP maintains an informative website, with information in English and Spanish, the two threshold languages. It was noted that the link for the 'Mental Health Clinic Services' was not prominent; it was displayed toward the bottom of the Mental Health Branch page. The MHP's provider directory was up-to-date. The MHP provided evidence of monitoring of utilization of the language line and interpretation services and conducted test calls; however, monitoring of the Access line itself was not evident.			
1B	Capacity Management	10	8

Component		Maximum Possible	MHP Score
The MHP monitors service utilization, its penetration rate (CalEQRO data), and its staffing capacity. The MHP's overall penetration rate for CY 2019 was lower than other medium-sized MHPs and the statewide average. Latino/Hispanic beneficiaries represent the greatest proportion of beneficiaries served by the MHP; the MHP's Latino/Hispanic penetration is higher compared to other medium-sized counties (though less than the statewide average). The MHP's proportion of Latino/Hispanic staff is not comparable to the proportion of beneficiary services. For other racial/ethnic groups, staff was represented in comparable or greater numbers than the beneficiaries served. The MHP has continued with Connectedness to Community, an Innovation Project to expand community and provider understanding of the contribution of cultural values and beliefs to beneficiary health and wellness. The MHP has projects (e.g., Advancing Behavioral Health) that increase its capacity to engage beneficiaries who are otherwise difficult to reach or engage (e.g., those experiencing homelessness). In response to COVID-19, the MHP has provided staff with computers and devices to facilitate remote service-delivery. The MHP has also maintained in-person services when possible and with precautions.			
1C	Integration and Collaboration	24	23
The MHP continues to collaborate and partner with agencies and community-based organizations that enable access for beneficiaries. Partnerships with law enforcement, educational systems, and hospitals have continued. The MHP's partnership with housing agencies, including the Housing Authority and a community housing agency, were prominent this year, including the launch of the Transitional Living Center, an augmented board and care facility, and Project Room Key. COVID-19 has required more integration and collaboration with other branches of the HHSA, namely Public Health, to safely outreach and deliver services to beneficiaries. The MHP partners with two MCPs. While they collaborate on a PIP to improve transfer of beneficiaries to MCP providers, to date, the MHP does not receive feedback from the MCPs on those transfers. Bidirectional communication with the MCPs appeared difficult.			

Timeliness of Services

As shown in Table 35, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 35: Timeliness of Services Components

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td>2A</td><td>First Offered Appointment</td><td>16</td><td>13</td></tr>
<tr><td colspan="4">The MHP uses the ten-business day standard for time to first offered appointment. The MHP’s reporting includes the entire system of care. The MHP met this standard, overall 61.2 percent of the time, with a range of 1 to 265 days. The MHP met the standard 76.7 percent of the time for adults, 56.8 percent for children, and 52.9 percent for youth in FC. This metric is new to the MHP; the MHP made changes to the tracking mechanism to capture this and other CSI data over the past year. Now that the MHP has a mechanism for tracking, improvements are needed.</td></tr>
<tr><td>2B</td><td>First Offered Psychiatry Appointment</td><td>12</td><td>8</td></tr>
<tr><td colspan="4">The MHP follows a 15-business day standard for time to first offered psychiatry appointment. As the MHP is not yet able to capture time to offered appointment, the MHP reported on time to kept psychiatry appointments. The MHP met the standard 34.6 percent of the time overall, with an average of 28.9 days to the kept appointments. The MHP’s rate for adults was 46.4 percent, 25.08 percent for children, and 23.3 percent for youth in FC. The MHP attributed the low rate and protracted time, particularly for children and children in FC, to premature scheduling to psychiatry, as evidenced by some parents/caregivers subsequently canceling or delaying the appointment. The MHP developed a new referral form in October 2019 to indicate the referral to psychiatry; however, the fields required modifications, thus delaying implementation until July 2020.</td></tr>
<tr><td>2C</td><td>Timely Appointments for Urgent Conditions</td><td>18</td><td>12</td></tr>
<tr><td colspan="4">The MHP reported on time from service request to urgent appointment within 48 hours. The MHP met the standard 75.6 percent overall and averaged 130.3 hours, which is five days. The MHP attributed the long response time to beneficiary delay in follow-up; however, the measure is meant to track the MHP’s own follow-up. Focus group participants were aware of how to receive urgent services by calling Crisis or the Access Line. The MHP began reviewing and reporting on urgent appointments that require prior authorization during the third quarter of FY 2019-20. For these services, the MHP only reported time for children: 62.3 percent of urgent appointments were responded to within 96 hours.</td></tr>
<tr><td>2D</td><td>Timely Access to Follow-up Appointments after Hospitalization</td><td>10</td><td>8</td></tr>
<tr><td colspan="4">The MHP adheres to a 7-day standard for time to follow-up appointment after hospitalization. The follow-up can include a variety of appointments, including case management, rehabilitation services, and outpatient. The MHP met the standard 51.8 percent of the time overall, with a 17.8-day average to the appointment. The MHP’s rate for adults was 49.2 percent, and 73.9 percent for children. The MHP reported that</td></tr>
</table>

Component		Maximum Possible	MHP Score
no children in FC had been hospitalized. As in the previous year, the MHP has more difficulty in providing timely follow-up for adults discharged from an inpatient hospitalization. The QIC minutes note that the follow-ups do not meet the standard; however, there was no documentation of action to improve timeliness.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The MHP's rehospitalization rate was 16.0 percent overall; 16.4 percent for adults, and 13.9 percent for children. The MHP has not set a benchmark for readmission.			
2F	Tracks and Trends No-Shows	10	8
The MHP uses a standard of 20 percent for no-shows for clinicians and psychiatry. The metric captures no-shows for all appointments, including ongoing appointments. The clinician no-show rates for adults was 12.7 percent and lower than 6 percent for children and youth in FC. The psychiatry no-show rates were all lower than 6 percent, although MHP staff raised doubt about the accuracy of the rate, possibly due to inconsistent use of the Scheduler, which has been mandated. The psychiatry no-show rate is believed to be closer to 30 or 40 percent.			

Quality of Care

In Table 36, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 36: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
The MHP is informed of its county and beneficiary population by census data, most recently from 2019. The MHP was supposed to have conducted a Community Program Planning process in Spring 2020 to identify gaps and barriers in its mental health system. There was no evidence to confirm that the assessment took place. The MHP has an updated Cultural Competence Plan; however, it was unclear if the plan was prospective or retrospective, as the document mentioned what the MHP will do in			

Component		Maximum Possible	MHP Score
FY 2019-20 as well as what was done in FY 2019-20. The Cultural Competence Committee is one of a number of committees and groups from which the MHP ascertains information on its population and their needs.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	10
The MHP operates a full range of services at different levels of care. The MHP uses the LOCUS to determine level of care. Participants in the focus group endorsed being involved in their treatment. One of the Mental Health Branch's PIPs is designed to improve the transition of beneficiaries from the MHP to a MCP. Line staff raised concerns about full-service partnership (FSP) care: while FSP exists in name, the perception was that beneficiaries were not receiving any more services than in a regular outpatient program. There was little evidence of monitoring of transitions of levels of care within the MHP.			
3C	Quality Improvement Plan	10	4
The MHP did not have a current (FY2020-21) QI plan nor one in draft form. The MHP's QI plan is developed after the evaluation of the previous year's QI program and approval by QIC, both of which occur in October. The MHP representatives stated, further, that the QI plan is not due to DHCS until October. In lieu of the evaluation and plan, the MHP has a QI matrix that includes variables, performance measures, and metrics tracked throughout the year. This matrix is used as a guide to develop the evaluation and plan. QI committee meetings were held mostly monthly with corresponding minutes maintained. The meetings were moved to a virtual (Zoom) format after COVID-19.			
3D	Quality Management Structure	14	10
The MHP has a designated QM unit and designated QI manager. The QI manager and staff have a direct line of communication to MHP leadership. Various stakeholders, including MHP leadership, contract providers, community organizations, and members of the Mental Health Board, regularly attended. The MHP has expanded the QI unit by four positions, including an analyst, an administrative specialist, children's authorization clinician, and a problem resolution coordinator position. The analyst position is particularly critical for the MHP as it has had challenges over the past year in generating reliable accurate reports. Per the MHP representatives, a focus of QI over the past year has been data governance.			
3E	QM Reports Act as a Change Agent in the System	10	7
The MHP has reports that monitor aspects of access, timeliness, and quality in its system of care. Reports and monitoring of beneficiary outcomes were less evident.			

Component		Maximum Possible	MHP Score
The MHP continues to produce the Gender-Age-Language-Ethnicity (GALE) report that provides beneficiary information along several dimensions (e.g., employment, cohabitation, etc.) in addition to the demographic variables. As stated above, an ongoing priority for the MHP has been data integrity, particularly to meet state regulations and reporting requirements. The MHP developed a Matrix Group that began in July 2020, which includes program managers and QI staff who discuss data, reporting, and QI. The focus of the Matrix meetings has been on access and timeliness of service delivery, health outcomes, and fiscal sustainability.			
3F	Medication Management	12	9
The MHP tracks several HEDIS and national measures regarding diagnosis, prescribing practice, and care standards for youth and adults The MHP follows a Medication Monitoring Practice Guideline. The Guideline appeared to have last been updated 2018. The MHP has a Medication Monitoring Committee that meets monthly, with substantial attendance by program managers, contract provider staff directors and managers, and psychiatric providers. The committee is chaired by the Medical Director and is a forum to discuss practice, trends, and results of chart reviews. An average of 27 records were reviewed per month, based on the minutes of the committee meeting. Additionally, many clinics reviewed fewer than three or even no charts monthly. The MHP tracks some, but not all, of the suggested HEDIS and other national measures. Coordination with primary care providers was a normal practice for psychiatric providers, particularly when it concerned the transfer of children to MCPs or to their PCP.			

Beneficiary Progress/Outcomes

In Table 37, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 37: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	9

Component		Maximum Possible	MHP Score
The MHP's monitoring of clinical and functional outcomes has not changed from the previous year. The MHP uses the CANS-50 and the PSC-35 for children. The MHP does not have an outcome measure for adults. Clinicians used progress on treatment goals and assessment of functional outcomes as a measure of outcomes for adult beneficiaries. The MHP does not produce reports of aggregate and systemic outcomes for CANS for children nor other indicators of progress for adults.			
4B	Beneficiary Perceptions	10	7
The MHP participated in the Consumer Perception Survey (CPS), most recently in June 2020. The survey was conducted by phone and Survey Monkey, with an impressive completion of over 1,100 surveys. The MHP analyzed the CPS in November 2019; however, there was no evidence of a review of the findings. Focus group participants also endorsed receiving no feedback on the results after having taken the survey. The MHP conducts its own surveys, most recently a COVID survey on ability to access services, beneficiary experience with telehealth, and satisfaction with services during the pandemic. The MHP plans to conduct the COVID survey again to gauge service availability and efficacy during the pandemic.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
The MHP has two wellness centers, one in each of the MHP's primary service areas — in Visalia and Porterville. Both centers are peer-run and peer-driven. The centers are open access. The centers have been closed during the pandemic; however, staff have provided some outreach to members via telephone and infrequently in-person. Focus group participants appreciated the wellness center and the opportunity for learning, skill development, and social interaction.			

Structure and Operations

In Table 38, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 38: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	26

Component		Maximum Possible	MHP Score
The MHP has a variety of services and programs for children, transitional age youth (TAY), and adults, including outpatient, crisis, and residential. The MHP also provides mobile services throughout the county. The MHP does not have a crisis stabilization unit nor a psychiatric health facility and partners with the area hospitals to meet acute needs. MHP was working with a foster family agency to provide therapeutic foster care (TFC); however, the agency declined to pursue TFC. The MHP has plans to issue a request for proposal (RFP) for TFC.			
5B	Network Enhancements	18	16
The MHP uses several adjunctive services to provide SMHS to beneficiaries. These services were concentrated in Visalia. The MHP has co-located staff with Child Welfare Services and law enforcement. The MHP has wellness centers, participates in the Whole Person Care pilot, and collaborates with Indian Health Centers. The MHP has network providers that can provide services in threshold and emerging languages. Because of COVID-19, many services have been moved to remote/virtual modality. Telehealth has been expanded greatly, with telehealth stations at clinic sites for beneficiaries who do not have access to technology and the Internet. The MHP has increased its telehealth services the rural communities such as Dinuba, Earlimart, Pixley, Woodlake, and Allensworth.			
5C	Subcontracts/Contract Providers	16	16
The MHP partners with several contract providers to facilitate services. The providers each have a designated point of contact at the MHP. The contract providers endorsed good partnership and open communication with the MHP. The MHP holds routine meetings with their providers, and providers' data (e.g., timeliness) is included in the MHP's reporting. Contract providers participated regularly in a number of MHP and mental health related meetings.			
5D	Stakeholder Engagement	12	9
The MHP demonstrated stakeholder participation in system planning and program development. There were meetings for specific stakeholders, for example the peer-oriented Wellness & Recovery Committee and the Children's System Improvement Council, as well as more general meetings for all stakeholders, such as the QI Committee and the Cultural Competence Committee. Contract providers and supervisors reported involvement in system planning, committees, and projects. Line staff noted increased efforts to inform and solicit their input, although they did not themselves participate in system planning meetings. Beneficiaries from the focus group were not aware of opportunities to provide their input outside of surveys they completed. The MHP has made a concerted effort over the past year to improve communication and educate the Mental Health Board.			

Component		Maximum Possible	MHP Score
5E	Peer Employment	8	7
Peer employees, employed as peer support specialists, are represented throughout the MHP. The MHP has three classifications for peer support specialists, and the peer support specialists agreed that roles and responsibilities of the same classification differed based on one's assignment/location. A supervisory-level peer position is not available. Peer support specialists endorsed the availability of training and opportunities for skill development. Because of COVID-19, some peer support specialists were reassigned, including to help as contact tracers, which they viewed as an opportunity to improve on telephone skills. The MHP continues to support further employment opportunities for peer employees, as well as beneficiaries, through a community-based program (Community Services Employment Training) and through the county's Department of Rehabilitation.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Tulare County MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

- The Mental Health Branch restructured the intake and access team into one unit that includes crisis services, substance use disorders assessment, short-term case management, and linkages for those who do not meet medical necessity.
- Because of COVID-19, services delivery has shifted to remote/virtual, telephonic, and telehealth.
- The MHP launched its Innovation Project Advancing Behavioral Health that is meant to increase access for underserved populations.

Strengths:

- Formal convenings with stakeholders enable the MHP to identify gaps in services and develop solutions. The MHP held such a meeting, the Cross-Jurisdictional Sharing and Convening, with the Tule River Tribe and other partner agencies to discuss access for Native Americans through the Native American Indian Health Center and the MHP.

Opportunities for Improvement:

- The MHP was supposed to have conducted a Community Program Planning process in Spring 2020 to identify gaps and barriers in its mental health system. There was no evidence that this process took place.
- The MHP's proportion of Latino/Hispanic staff is not comparable to the proportion of Latino/Hispanic beneficiaries served. For other racial/ethnic

groups, staff was represented in comparable or greater numbers than the beneficiaries served.

Timeliness of Services

Changes within the Past Year:

- The MHP has modified its EHR, including the Scheduler, to capture both CSI and CalEQRO timeliness metrics.

Strengths:

- None noted

Opportunities for Improvement:

- The MHP's overall rate for time to first offered appointment in ten days (61.2 percent) was driven by protracted time to services for all children.
- The MHP attributed the long urgent service request response time to beneficiary delay in follow-up; however, the metric is supposed to track the MHP's own response time.
- As in the previous year, the MHP has more difficulty providing timely follow-up for adults discharged from an inpatient hospitalization, meeting the 7-day post hospitalization follow-up standard only 49.2 percent of the time.

Quality of Care

Changes within the Past Year:

- The Mental Health Branch opened two independent living facilities, Tulare Long-Term Housing in Tulare, and the Transitional Living Center in Visalia.

Strengths:

- The MHP practices an integrated approach to mental health care, in so doing strives to facilitate other supports and services (e.g., housing, physical health, human services) that affect beneficiary mental health. An example of this was the Community Care Coalition, which affords an opportunity to partner with the community providers to identify areas of community need.

Opportunities for Improvement:

- Several of the timeliness metrics did not meet the standards: time to first offered appointment; time to psychiatry appointment; time to follow-up post-hospitalization; and urgent appointments. The discussion at QIC meetings focused on improper documentation by staff (e.g., use of incorrect codes) rather than addressing actual delays in providing timely services.

- Per the 2018 Medication Monitoring Plan & Procedures/Practice Guidelines, 5 percent of MHP charts should be reviewed and analyzed annually. At the current rate, an average of 27 records per month, as reflected in the minutes of the committee meeting, the MHP is not meeting this standard.

Beneficiary Outcomes

Changes within the Past Year:

- None noted

Strengths:

- None noted

Opportunities for Improvement:

- Focus group participants consider the wellness center an important part of their mental health recovery and lamented the closing of the center during the pandemic. They wondered about the possibility of online/virtual (e.g., Zoom) groups.

- Based on the reports and information the MHP provided, outcomes monitoring and review is not robust.

Foster Care

Changes within the Past Year:

- The MHP is resuming the process of identifying a provider for TFC, as the prospective agency declined to pursue this type of service. The MHP has identified three youth that could benefit from TFC services.

Strengths:

- None noted

Opportunities for Improvement:

- The MHP's Medication Monitoring Review Criteria form focuses on antipsychotic medication use and does not include the other measures developed by the State Department of Social Services and HEDIS, which focus on general psychotropic medication use.

Information Systems

Changes within the Past Year:

- With the declaration of the pandemic, the MHP was able to quickly pivot to the use of telehealth for services. Prior to COVID-19, telehealth services were reserved for psychiatry.
- The MHP was able to hire an EHR specialist before the hiring freeze was implemented. It hopes to hire a supervisor and another EHR specialist once the freeze is lifted.

Strengths:

- The use of one EHR by the MHP and its contract providers allows for an efficient delivery of services to the beneficiaries and minimizes data discrepancies and inaccuracies.
- The MHP supported staff to work from home by providing them laptops.
- Responding to COVID-19, the MHP added telehealth set-ups in remote locations to support services for clients who may not have connectivity or technology to otherwise participate.
- The MHP utilizes peer support specialists to provide one-on-one training for beneficiaries on the use of the PHR at the clinic office.

Opportunities for Improvement:

- The MHP will plan for post COVID-19 increased use of telehealth as an additional medium for meeting the needs of beneficiaries.
- Build on field-based services developed during COVID-19 by providing line-staff with sufficient mobile devices such as laptops, tablets, and smartphones, and leveraging electronic signature protocol to support more efficient workflow for beneficiaries and staff.
- While the MHP's mandate to use the Scheduler has resulted in an increase in its use, the Scheduler is not used according to the protocol. The MHP staff suspect that the no-show rate is closer to 30 to 40 percent and not the (less than) 6 percent that the reports indicate.

- The MHP continues to have a mixed chart of record, in that some documents are electronic, and some are hard copy. To increase efficiency and better serve their beneficiaries, the MHP should plan for the final steps to achieve a fully electronic Chart of Record.
- The PHR continues to be an underutilized resource. Although the MHP and its contract providers offer a PHR, only 98 beneficiaries are currently using it. This is less than 1 percent of the beneficiaries served.

Structure and Operations

Changes within the Past Year:

- There are currently three vacant upper-level positions: Deputy Director MH Integrated Services, Division Manager Integrated Services, and Wellness & Recovery Manager.
- Three upper-level positions were filled this year: Budget Officer, Clinic Services Manager, and Alcohol and Other Drugs (AOD) Programs Clinic Services Manager.
- The MHP added five supervisory level positions, enabling the program managers to focus on program operations and development.

Strengths:

- The supervisory level classification enables the MHP to provide formal (clinical) supervision to staff. The MHP is improving training and staff skills, which may improve retention of staff.

Opportunities for Improvement:

- The MHP would benefit from an executive level IS staff position with direct report to the executive team. The relegation of this fundamental aspect of agency function several layers down in the organizational chart is not conducive to the fullest use of data governance. The EHR and IS reporting is not a utility; it is an important aspect of quality leadership.
- The MHP requires a stable and fully staffed upper management. Two of the three open top-level positions have been vacant since before the 2019 review: Deputy Director MH Integrated Services and Division Manager Integrated Services.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: Use a (random) sample of beneficiaries rather than the entire MHP adult outpatient population when expanding the project beyond non-county clinics.

Recommendation 2: Use the two methods discussed by the managed care plan (MCP) representatives (who were present at the non-clinical PIP session) to confirm that beneficiaries referred to the MCP were subsequently accepted by/enrolled with the MCP.

Access to Care

Recommendation 3: Provide either an update on or the outcomes of the Community Program Planning process. If the planning did not take place, indicate the MHP's plan for capturing this information.

Timeliness of Services

Recommendation 4: Modify the EHR to record the date of referral to psychiatry, particularly for children's services, and maintain consistent monitoring of this metric. (*This a follow-up recommendation from FY 2019-20.*)

Recommendation 5: Correct timeliness tracking, provide relevant staff training, and improve timeliness to services that did not meet standards: time to first offered appointment; time to psychiatry appointment; time to follow-up post-hospitalization; and urgent appointments.

Quality of Care

Recommendation 6: Document in the quality improvement committee (QIC) minutes the action(s) to improve timeliness metrics that are consistently not meeting the standard.

Recommendation 7: Increase the number of records that are reviewed in the monthly medication monitoring to ensure that the MHP's defined standard of 5 percent of all records are reviewed annually (i.e., at least 44 records with medications prescribed should be reviewed each month). This will assist the MHP to identify trends for future quality improvement activities.

Beneficiary Outcomes

Recommendation 8: Develop and routinely monitor at least one outcome indicator each for youth and adult beneficiaries.

Recommendation 9: Resume some groups from the wellness centers over Zoom.

Foster Care

Recommendation 10: Include use of psychotropic medications and use of multiple concurrent psychotropic medications in the monitoring of medication utilization for children in FC. (*This a follow-up recommendation from FY 2019-20.*)

Information Systems

Recommendation 11: Build on the remote service-delivery model developed during COVID-19 by providing and/or supporting line staff with sufficient mobile devices such as laptops, tablets, and smartphones. Incorporate/leverage electronic signature protocol to support more efficient workflow for clients and staff.

Structure and Operations

Recommendation 12: Work with County human resources to fill top-level management positions, consulting with them regarding the creation of an information systems (IS) manager position to reflect the importance of data governance.

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible, such as conducting beneficiary focus groups.
- The second beneficiary/family member focus group was not held because only two people attended.

ATTACHMENTS

Attachment A: On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms in EQRO Reports

Attachment A—On-site Review Agenda

The following sessions were held during the MHP on-site review, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

Tulare County
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Performance Improvement Projects
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Medical Prescribers Group Interview
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Ewurama Shaw-Taylor, PhD, Quality Reviewer
Lamar Brandysky, Information Systems Reviewer
Walter Shwe, Consumer/Family Member Consultant

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-site and the post-site meetings and in preparing the recommendations within this report.

Sites of MHP Review

This review was conducted through videoconferencing for the usual on-site sessions.

MHP Sites

None

Contract Provider Sites

None

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Alcantar	Jennifer	Peer Support Specialist II	(Tulare County) Health & Human Services Agency (HHSA)
Allen	Decinda	Children's Authorization Unity	HHSA
Blankenship	Chelsey	Clinical Social Worker	Turning Point, Visalia Youth Services (VYS)
Bolin	Natalie	Deputy Director, Mental Health	HHSA
Brooks	Erin	Vice Chair	Mental Health Board
Bryan	Erin	Clinical Social Worker, VAIC	HHSA
Celedo	Alexandra	Psychiatry Technician, VAIC	HHSA
Cochran	Caitlin	Clinical Social Worker, VAIC	HHSA
Cruz	Michele	MHSA Manager	HHSA
Dodd	April	Clinical Director	Tulare Youth Service Bureau
Ellis	Betsy	QI & Children Authorization Unit Manager, Managed Care	HHSA
Ennis	Casie	Clinical Administrator, VAIC	HHSA
Escobar	Selena	unknown	Anthem Blue Cross
Espinias	Denise	Children's Services	Turning Point
Evaro	Jeannette	Clinical Social Worker	Turning Point
Fragol	Prihia	unknown	Anthem Blue Cross
Franco	Corinna	Peer Support Specialist	HHSA

Last Name	First Name	Position	Agency
Freeman	Jessica	Medical Assistant, VAIC	HHSA
Garcia	Angela	Regional Clinical Services Director	Kings View Behavioral Health Systems (Kings View)
Gates	Michael	Program Director	Turning Point
Gray	Kevin	unknown	Turning Point, VYS
Guiglielmo	Monica	Supervisor, Electronic Health Records (EHR)	HHSA
Gutierrez	Ramona	Peer Support Specialist II	HHSA
Hamilton, LCSW	Joseph	Clinical Administrator, PAC/PYS	HHSA
Hernandez	Cynthia	unknown	unknown
Higginbothem	Diane	Administrative Specialist	HHSA
Hopper	Steven	PRC/UR, Managed Care	HHSA
Huizar	Irene	Case Manager II	Kings View
Hutcheson	Debbie	Administrative Specialist	HHSA
Jimenez-Mata	Karla	Clinical Social Worker, VAIC	HHSA
Lakhani	Sharmeen	QI	Tulare Youth Service Bureau
Leon	Esmeralda	Manager, Psych Services, VAIC	HHSA
Lewis	Robin	Senior Manager of Clinical Services	MHN/Health Net
Lloyd	Steven	Clinical Supervisor, TLC	unknown
Locke	Moira	Psychiatrist, VAIC	Turning Point

Last Name	First Name	Position	Agency
Lopez	Cynthia	unknown	unknown
Lopez	Elsie	Administrative Specialist	HHSA
Love	Lester	Mental Health Medical Director	HHSA
Martinez	Adrianna	Nurse, VAIC	HHSA
Martinez	Laurie	Nursing Supervisor	Turning Point, VYS
Mason	Liz	AOD Managed Care	HHSA
Massey	Darcy	Supervisor, Family Advocate	HHSA
Mikesell	Kevin	Fiscal Manager	HHSA
Montes	Deanna	Budget Officer	HHSA
Moreno	Cindy	Manager, VAIC	HHSA
Nadia May	Pugh	BH Community Liaison	Health Net
Newel	Jennifer	Clinical Director	Tulare County Office of Education
Nicotero	Bruce	Chair	Mental Health Board
Olmos	Juanita	Peer Support Specialist II, PMCH	HHSA
Oritz	Donna	Director of Mental Health	HHSA
Ortiz	Polo	Program Director	Turning Point, Sequoia Youth Services
Overholt	Colleen	Executive Director	Kings View
Paine	Janet	Program Director	Anthem Blue Cross
Pingitore	Margarita	Clinical Supervisor	Turning Point
Porter	Sherlyn	Children's Therapist, PYS	HHSA
Pugh	Nadia May	Behavioral Health Community Liaison	Health Net

Last Name	First Name	Position	Agency
Rangel	Irma	Regional Clinical Director	Turning Point
Raya	Olga	unknown	Sequoia Youth Services
Reynoso	Michelle	AOD QI Unit Manager	HHSA
Rios	Rosanne	Intake Coordinator	Turning Point, VYS
Rodriquez	Alphonso	Licensed Vocational Nurse, VAIC	HHSA
Rodriquez	Ivan	Program Director	VYS
Ross	Sharon	unknown	Turning Point
Ruddy	Andrew	Staff Service Analyst, Managed Care	HHSA
Rupp	Kristin	Clinical Social Worker, VAIC	HHSA
Sahagun	Angela	Manager, EHR	HHSA
Saldana	Darlene	Mental Health Technician, VAIC	HHSA
Stapleton	Chad	ASO III	HHSA
Tieu	Hoang	Psychiatrist, VAIC	HHSA
Trigleth	Michele	Adult Therapist, PAC	HHSA
Vafaie	Helen	Psychiatrist, VAIC	HHSA
Valencia	Carmen	Nurse, VAIC	HHSA
Valyocsik	Sander	Evaluation Consultant	unknown
Wallace	Fabiola	VAIC, Recovery	HHSA
Weldon	Cheryl	Clinical Supervisor, PAC	HHSA
Wild	Dayna	Division Manager, Managed Care	HHSA
Willet	Larry	Clinical Supervisor, VAIC	HHSA

Last Name	First Name	Position	Agency
Zavala	Tim	Executive Director	Tulare Youth Service Bureau

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table C1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Tulare MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Medium	519,441	20,353	3.92%	$121,346,017	$5,962
MHP	57,739	1,706	2.95%	$7,397,414	$4,336

Table C2 shows the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Table C2: CY 2019 Distribution of Beneficiaries by ACB Range

Tulare MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	10,143	96.68%	93.31%	$34,851,930	$3,436	$3,998	72.32%	59.06%
>$20K - $30K	190	1.81%	3.20%	$4,550,851	$23,952	$24,251	9.44%	12.29%
>$30K	158	1.51%	3.49%	$8,791,461	$55,642	$51,883	18.24%	28.65%

Attachment D—List of Commonly Used Acronyms

Table D1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CCBH	Community Care Behavioral Health
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIT	Crisis Intervention Team or Training
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSD	Community Services Division
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services

Acronym	Full Term
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay

Acronym	Full Term
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MCBHD	Medi-Cal Behavioral Health Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NA	Network Adequacy
NA (alt)	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
ONA	Out-of-Network Access
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PM (alt)	Partially Met
QI	Quality Improvement

Acronym	Full Term
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version