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

YOLO 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).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Yolo MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC). In response to the pandemic, this year’s EQR was conducted primarily by document review, with limited virtual interaction with the MHP leadership and quality staff.

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 — Woodland

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 1,797

MHP Threshold Language(s) — Spanish, Russian

CalEQRO obtained the MHP threshold language information from the DHCS Behavioral Health Information Notice (BHIN) 20-070.

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 Assembly Bill (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 BHINs 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

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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.

(AAS), and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

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 BHIN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS reviews these forms to determine if the provider networks meet required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services for youth and adults. If these standards are not met, DHCS requires 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.

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 reviews access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

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. 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: The non-clinical PIP is active and ongoing; however, the MHP did not present a clinical PIP for review. As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. The MHP is encouraged to contact BHC for technical assistance (TA) on an ongoing basis to develop an active clinical PIP before the next review.

Status: Partially Met

- The MHP submitted one new clinical PIP. The last FY's non-clinical PIP was projected to be completed in June 2020; however, the MHP did not submit the final data nor evidence that the PIP was active until that date.
- The MHP did not submit a new non-clinical PIP.

Access Recommendations

Recommendation 2: Improve communication about transportation resources and explore how resources could be enhanced to improve access.

Status: Met

- The changes in service delivery as a result of the pandemic have reduced the need for transportation during the last year.
- The Health and Human Services Agency (HHSA) has implemented a new process for requesting and tracking county vehicles for Behavioral Health (BH) staff use, which has improved access to those vehicles.
- The MHP communicated about the new system in agency newsletters and all-staff meetings. Ongoing communication will be important as beneficiaries increasingly access services in person.

Recommendation 3: Follow up on unmet goals in the Quality Improvement (QI) Work Plan to increase the amount of test calls in English and Spanish. Consider addressing wait times and dropped calls in the plan.

Status: Met

- The Quality Management (QM) team exceeded the test call goal, having conducted 18 test calls since March 2020 (an average of nine per quarter); 11 were in English (61 percent), five were in Spanish, and two were in another non-English language (39 percent).
- Subsequent feedback to the 24/7 BH Access Line vendor has contributed to improvements in test call outcomes related to ensuring language accessibility. No dropped calls were noted during these test calls. On average, test calls were answered by Access Line staff within three rings. When the number of seconds was reported, the average wait time was under seven seconds (range = one second to 12 seconds).

Timeliness Recommendations

Recommendation 4: Begin to track and report first offered psychiatry appointments in accordance with the standard as outlined in IN 18-011 of 15 business days. *(This is a carry-over recommendation from FY 2018-19.)*

Status: Partially Met

- The MHP reported that the Scheduling Calendar in the EHR contains a data field to track first offered psychiatry appointment for the adult system of care (SOC), though not for children and foster youth. They also reported using the EHR-based Access Log as their initial data point for

service requests. The CSI-Assessment (CSI-A) form is the source of the data for the Children's System of Care

- The MHP reported concerns about data reliability but did not specify the source(s) of their concerns.

Recommendation 5: Ensure that planned improvements in EHR functionality will include expanding data gathering and process improvements across the continuum.

Status: Partially Met

- The MHP updated timeliness reports to include Client Services Information - Assessment (CSI-A) data and an updated new client definition. The MHP intends to use the CSI-A for tracking timeliness data for adults and youth.
- The MHP developed a plan to improve functionality in the EHR by utilizing a widget system to track and send reminders to staff (including network providers) when a CSI-A form is needed but is missing or incomplete.
- The MHP reported barriers to implementation of planned improvements related to form functionality issues within Avatar, which Netsmart is working to address, and inadequate staffing resources dedicated to the EHR.

Quality Recommendations

Recommendation 6: MHP leadership should engage internal stakeholders regarding concerns about uneven resources such as QM support between Child, Youth, and Family (CYF) and Adult and Aging (AA) branches. There is an opportunity to communicate more effectively regarding the positive impact of organizational decisions on beneficiary outcomes and working conditions in the long term.

Status: Met

- The MHP reported that under new leadership for the CYF QI team, QI activity is increasingly shared across branches, including joint monthly BH staff meetings and QI staff attendance at youth provider meetings. A larger system perspective is consistently promoted by the new manager, who has direct access to the AA QI unit.

Recommendation 7: Prioritize the implementation of an outcomes tool for adults that can provide reliable and valid data for program improvement.

Status: Met

- The MHP adopted and trained staff in the use of the Level of Care Utilization System (LOCUS), which is completed for all new beneficiaries entering the system and whenever a level of care (LOC) change has been recommended. As of January 2020, all completed assessments are reviewed in the weekly Utilization Management (UM) Committee.
- Staff have also been trained in the use of the Adult Needs and Strengths Assessment (ANSA). The MHP reported their plan to institute at least annual use of this tool once staff and beneficiaries return to the office.
- The MHP also uses the Results-Based Accountability (RBA) framework to track outcomes across multiple programs.

Beneficiary Outcomes Recommendations

- **None noted.**

Foster Care Recommendations

Recommendation 8: Continue to explore options to establish Therapeutic Foster Care (TFC) within Yolo County, seek guidance from DHCS regarding challenges in implementing the expectations, and document the steps taken to achieve the goal.

Status: Met

- The MHP had preliminary conversations with local foster family agencies (FFAs) about partnering to provide both Intensive Service Foster Care (ISFC) and TFC in the local community.
- The MHP reported that while they do not have a formal implementation plan for TFC at this time, it is an important task that has been identified for the new leadership staff recently added to the CYF Branch. The MHP reported that a formal plan is forthcoming.
- The MHP has continued discussions with other counties regarding the challenges related to establishing TFC.

Information Systems Recommendations

Recommendation 9: To improve accuracy and efficiency, the MHP should develop an automated system for inputting contract providers' claims data.

Status: Partially Met

- The MHP reported that transitioning Avatar to a hosted environment in the last year was a necessary first step to move forward with providing direct Avatar access to providers.

- The ISCA included evidence that there has been a large increase in direct provider data entry into Avatar; however electronic claiming is still pending.

Recommendation 10: Assign a dedicated Mental Health Services Act (MHSA) analyst to manage data, track fiscal trends, and produce reports.

Status: Met

- The MHP reported that there are two dedicated MHSA analysts: one in Fiscal and one in the MHSA Program.
- The fiscal analyst developed a new three-year database that contains MHSA budget and full-time equivalent (FTE) information; it is updated quarterly and used to develop and monitor the budget.
- The MHSA program analyst has managed and collected demographic data for compliance reporting and served as the liaison for gathering internal data that informs planning and reporting requirements.

Recommendation 11: Analyze the greater efficiencies to be gained if all contracted providers were required to use the same EHR.

Status: Met

- The MHP reported completing an analysis and continuing discussions with stakeholders on EHR interoperability.
- The MHP's focus is on moving forward with implementing provider access to the Yolo EHR; however, they reported a lack of funding to invest in the infrastructure and insufficient staffing resources necessary to support these efforts.

Recommendation 12: Implement an on-line asset management system and then run reports to develop a time-driven computer replacement schedule.

Status: Met

- The MHP is moving forward with Quest's "KACE" asset management system. Implementation was delayed from last year due to Corona Virus Disease-2019 (COVID-19) and is now planned for March 2021. This system will allow real-time tracking of computers within their SOC.
- The MHP is currently completing a final deployment of laptops from prior year purchases and has computer replacement funds budgeted in the current FY budget. Additional purchases will be included in the next FY budget.

Structure and Operations Recommendations

Recommendation 13: Address the critical issue of understaffing on the IT and data analysis team to assist the executive team with technical and functional assistance needed for data governance.

Status: Partially Met

- The MHP lost an Information System (IS) Coordinator position due to the COVID-19 budget impact; however, the position was refilled in November 2020.
- A dedicated report writer position was lost due to retirement with no plans to replace the position. Between FY 2019-20 and 2020-21, there was a net loss of .65 IT FTEs.
- The MHP reported a full team (three FTEs) of analysts in QM who support data submission and performance outcome data. Two of the three analysts started within the last six months and are still learning the system.

Recommendation 14: Establish and document in one of the MHP's change management processes/forums how the vital functions of the Cultural Competence (CC) Coordinator/Ethnic Services Manager position will be sustained while the position is vacant.

Status: Partially Met

- The Ethnic Services Manager position was filled in March 2020, and the person was immediately deployed to assist with the pandemic response.
- The CC Committee did not meet in 2020; however, the MHP's initiatives and partnerships were maintained by MHSA staff.
- Documentation of the above-requested sustainability plan was not provided; the MHP reported having been more focused on getting things done than on documentation during this difficult year.
- The MHP submitted a draft 2020 Cultural Competence Plan update shortly after this year's review and prior to the final DHCS report submission deadline.

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]

- 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, 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.

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

1. 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: https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx
3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
   - 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
4. 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.

- 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).
  - 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 Suppression Disclosure

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11, and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries . Further suppression was applied, as needed, 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

Yolo 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	14,410	25.8%	723	40.2%
Latino/Hispanic	23,908	42.8%	486	27.0%
African-American	2,545	4.6%	185	10.3%
Asian/Pacific Islander	4,287	7.7%	52	2.9%
Native American	428	0.8%	22	1.2%
Other	10,263	18.4%	329	18.3%
Total	**55,837**	**100%**	**1,797**	**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.				

During CY 2019, the MHP experienced claims submission delays that resulted in a significant number of claim transactions not being included in the analysis below for CY 2019 results.

Table 2 provides details on beneficiaries served by threshold language identified in DHCS BHIN 20-070.

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

Yolo MHP		
Threshold Language	Unduplicated Annual Count of Beneficiaries Served by the MHP	Percentage of Beneficiaries Served by the MHP
Spanish	161	9.0%
Russian	16	0.9%
Other Languages	1,620	90.2%
Total	**1,797**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

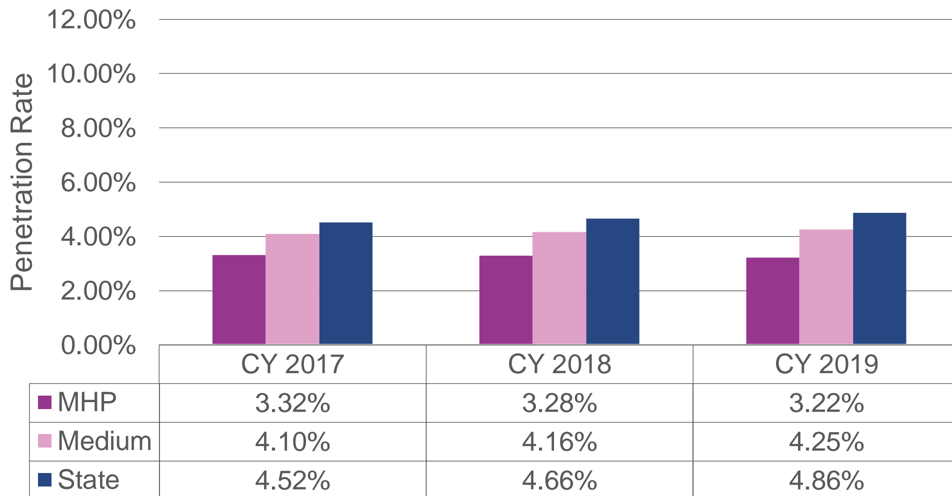
Penetration Rates and Approved Claims per Beneficiary

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.

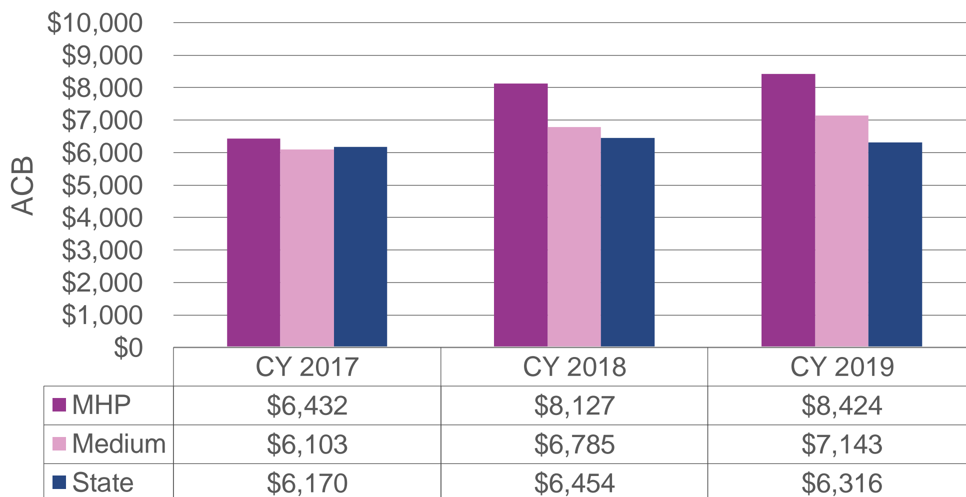
Regarding the calculation of penetration rates, the Yolo MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	3.32%	3.28%	3.22%
Medium	4.10%	4.16%	4.25%
State	4.52%	4.66%	4.86%

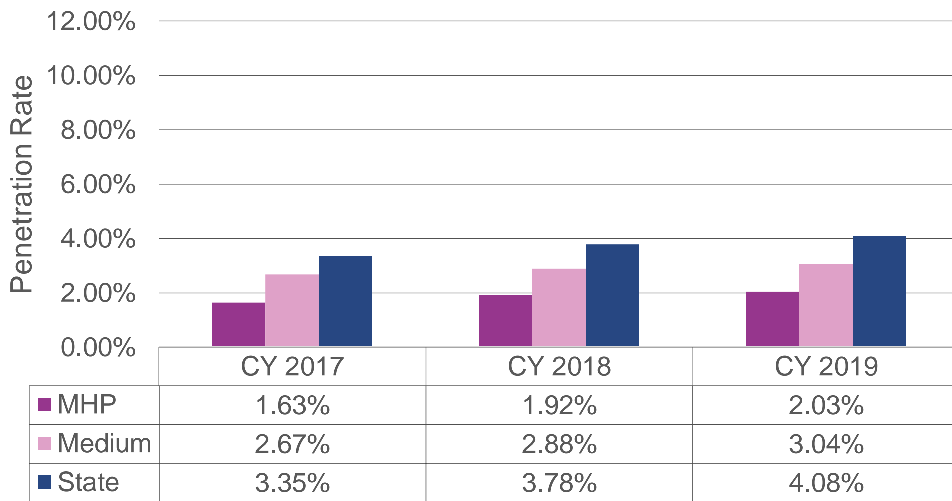
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$6,432	$8,127	$8,424
Medium	$6,103	$6,785	$7,143
State	$6,170	$6,454	$6,316

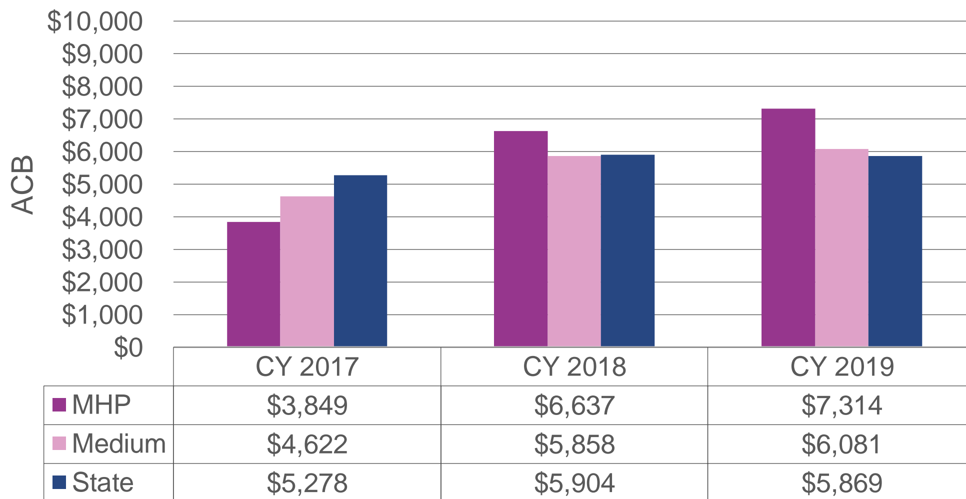
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	1.63%	1.92%	2.03%
Medium	2.67%	2.88%	3.04%
State	3.35%	3.78%	4.08%

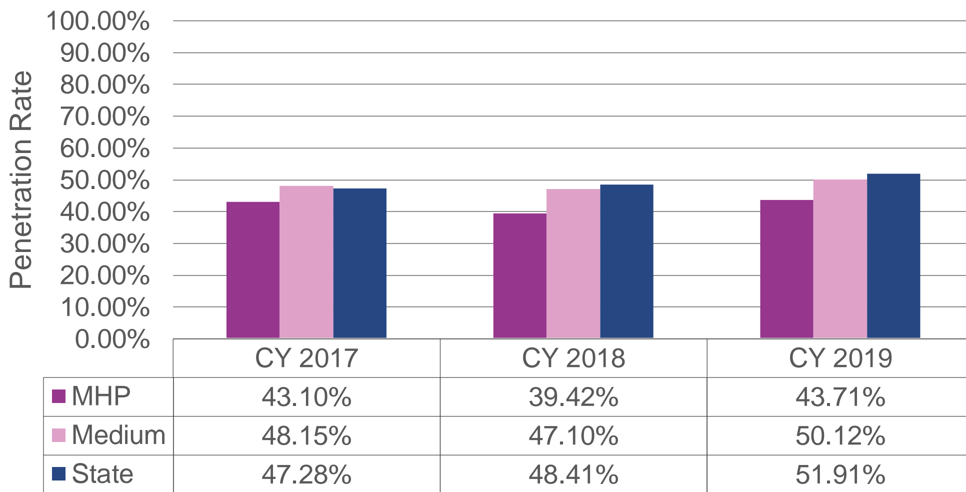
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,849	$6,637	$7,314
Medium	$4,622	$5,858	$6,081
State	$5,278	$5,904	$5,869

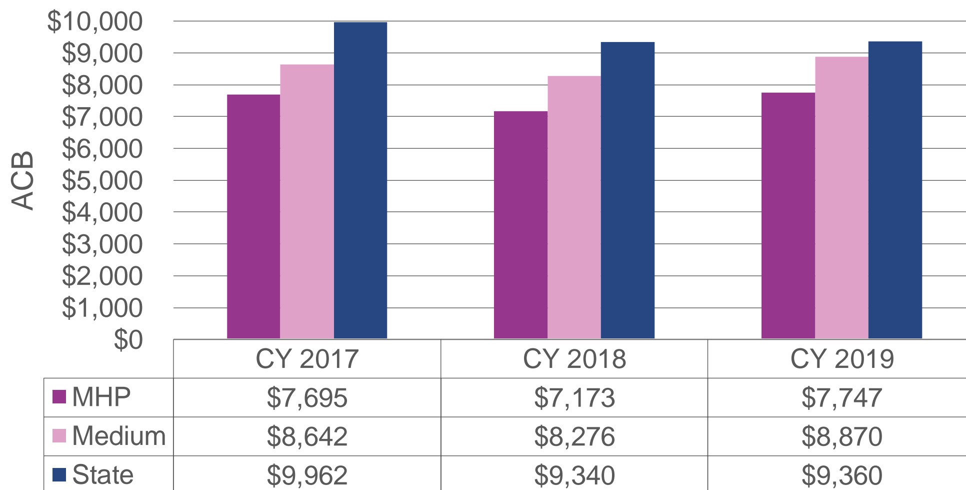
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	43.10%	39.42%	43.71%
Medium	48.15%	47.10%	50.12%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

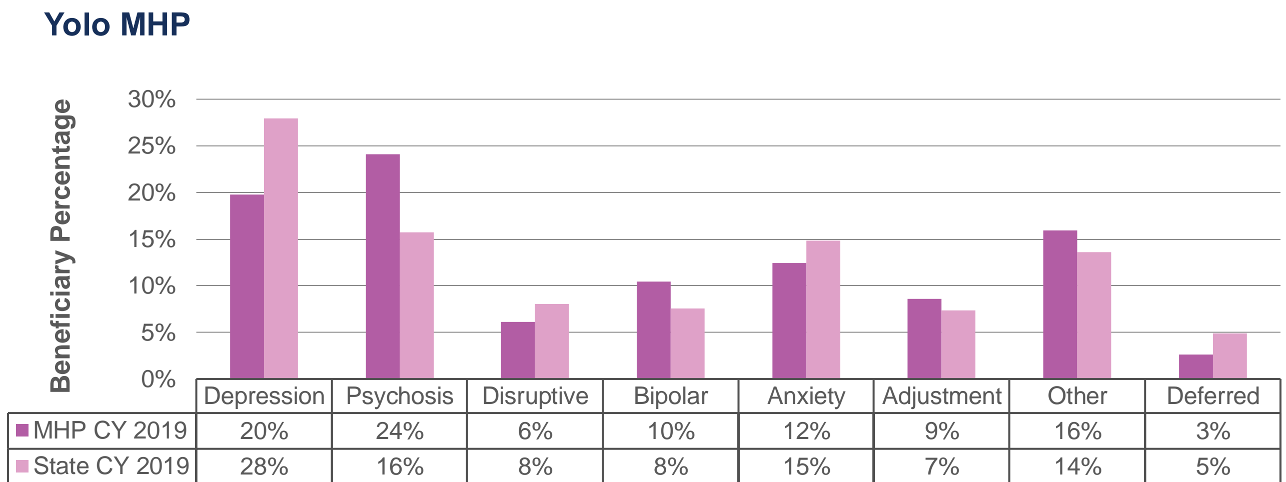


	CY 2017	CY 2018	CY 2019
MHP	$7,695	$7,173	$7,747
Medium	$8,642	$8,276	$8,870
State	$9,962	$9,340	$9,360

Diagnostic Categories

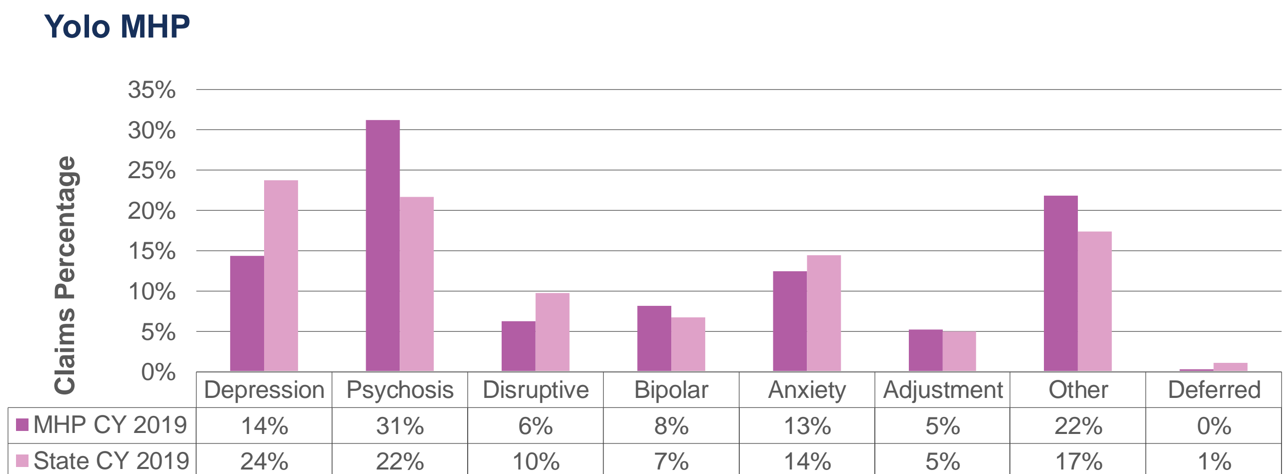
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	20%	24%	6%	10%	12%	9%	16%	3%
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	14%	31%	6%	8%	13%	5%	22%	0%
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

Yolo 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	117	1,797	6.51%	$50,209	$5,874,509	38.81%
	CY 2018	99	1,920	5.16%	$69,035	$6,834,471	43.80%
	CY 2017	86	1,985	4.33%	$48,524	$4,173,047	32.68%

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.

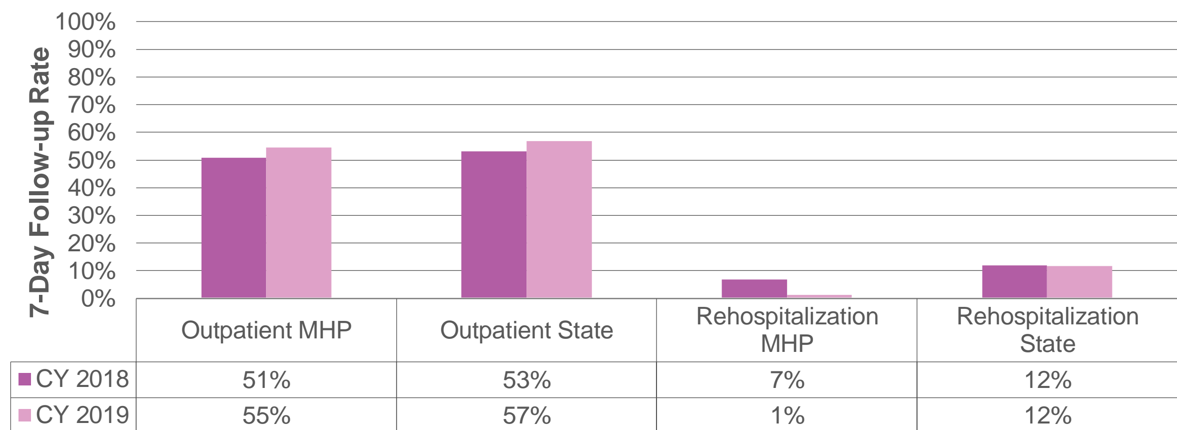
Table 4: Psychiatric Inpatient Utilization CY 2017-19

Yolo 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	263	473	10.16	7.80	$13,351	$10,535	$3,511,193
CY 2018	395	757	9.43	7.63	$18,599	$9,772	$7,346,728
CY 2017	335	727	9.89	7.36	$13,803	$9,737	$4,623,912

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

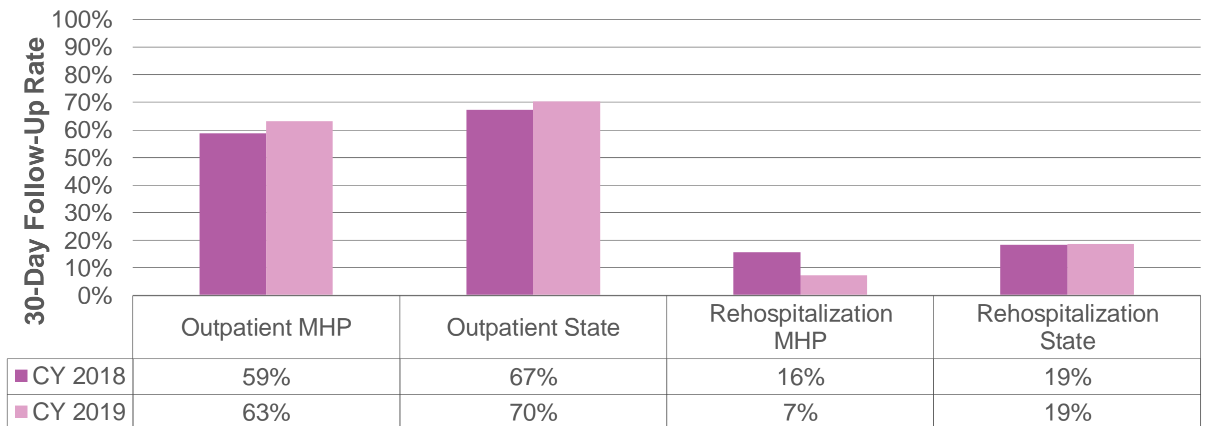
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	51%	53%	7%	12%
CY 2019	55%	57%	1%	12%

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



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	59%	67%	16%	19%
CY 2019	63%	70%	7%	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.

Yolo MHP PIPs Identified for Validation

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

Title 42, CFR, §438.330 requires two PIPs; the MHP is urged to meet this requirement going forward.

Table 5: PIPs Submitted by Yolo MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Improving Screening and Assessment of Co-occurring Disorders (COD) for Beneficiaries

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	YOLO MHP
PIP Title	Improving Screening and Assessment of Co-occurring Disorders (COD) for Beneficiaries
PIP Aim Statement	"1. Will increasing 24/7 BH Access Line clinical capacity (by staffing with only clinicians) increase identification of COD needs by 30% by 7/1/2021? 2. Will updating business processes around entering diagnoses in Avatar increase data entry of COD as indicated by a 30% increase in diagnostic information entered into Avatar by 7/1/2021?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply)	

MHP Name	YOLO MHP
☐ 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 MHP described the population in the following way: "The initial focus of the PIP will be on Yolo County beneficiaries who request services through a Yolo County Access Point (as evidenced by an Access Log service request entered into Avatar)." The age range was not specified, implying that all ages would be included, nor was a time frame or any other limiting characteristics. Specifics about the study population, including the timeframe of the study, keep data collection and analysis clean and focused.	

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): 1. Change composition of Access Point staff from case managers to clinicians. 2. Improve business process related to entering data into Avatar.

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): 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
Percentage of co-occurring diagnoses recorded in Avatar Diagnosis Form	FY 2020/21	Not specified	☒ n/a[5]		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Percentage of Access screenings entered into Avatar following an Access contact and the percentage that	FY 2020/21	Not specified	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05

[5] PIP is in planning and implementation phase if n/a is checked for all performance measures.

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
have a COD need identified						Other (specify):
					☒ No test of statistical significance	
Percentage of client “agree/strongly agree” responses in ongoing Access Point performance survey	FY 2020/21	Not specified	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	

Was the PIP validated?	☒ Yes	☐ No

Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☒ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in XX months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active

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
☐ Planning phase						
☐ Other, inactive			Inactive, Developed in a Prior Year			
Validation rating:						
☐ High confidence[6] ☒ Moderate confidence[7] ☐ Low confidence[8] ☐ No confidence[9] Justification for validation rating: If the MHP gains clarity about the baseline, the staffing change to clinicians should make a difference. In addition, they discuss training needs of those staff and a plan to implement, which will also boost reliability of diagnoses. "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: • Provide more specific responses to the questions in the tool rather than generalities. • Eliminate most of the general research information and concentrate on MHP-specific data and investigation of root causes. • Provide more detail regarding the population definition. • Specify the study period and when each intervention began. • Focus on near-term plan (interventions) and remove repeated references to Plan Do Study Act cycles.						

[6] Credible, reliable, and valid methods for the PIP were documented.
[7] Credible, reliable, or valid methods were implied or able to be established for part of the PIP.
[8] Errors in logic were noted or contradictory information was presented or interpreted erroneously.
[9] The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

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

- The change to clinical staffing is the key intervention. The other activities are back-office action items that reflect a need for greater compliance with established procedures and ensuring that the clinicians have the required skills. These would be considered preparation for implementing the intervention and ensuring the availability of reliable data.
- Clarify the baseline to which post-intervention measures will be compared.
- Prioritize an outcome (PM) that addresses improvement in beneficiary functioning or health status to further substantiate the clinical nature of this PIP.
- Track and record performance on each measure at least quarterly. The change in staffing was effective in July 2020; there should have been some data by the time this was submitted.

The technical assistance (TA) provided to the MHP by CalEQRO consisted of:

- Due to the pressures of the COVID-19 response on the MHP, no formal PIP session was scheduled for this review. The MHP is welcome to reach out to schedule TA at their convenience.

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Yolo MHP
PIP Title	n/a
PIP Aim Statement	n/a
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) n/a ☐ 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):	

MHP Name	Yolo MHP
n/a ☐ 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): n/a	

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
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 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
n/a	n/a	n/a	☐ n/a	n/a	☐ Yes ☐ No	☐ 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
						p-value: ☐ <.01 ☐ <.05 Other (specify):
						☐ No test of statistical significance
						☐ No test of statistical significance
						☐ No test of statistical significance

Was the PIP validated? n/a	☐ Yes ☐ No

Validation phase: n/a	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☐ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in XX months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☐ Planning phase	
☐ Other, inactive	Inactive, Developed in a Prior Year

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 rating: n/a						
☐ High confidence[6] ☐ Moderate confidence[7] ☐ Low confidence[8] ☐ No confidence[9] Justification for validation rating: n/a "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: • n/a						
The TA provided to the MHP by CalEQRO consisted of: • n/a						

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 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
Yolo	1.9%	2.50%	2.00%	2.00%
Medium MHP Group	n/a	3.28%	3.34%	3.01%
Statewide	n/a	3.58%	3.35%	3.34%

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 the BCP status is "No," the MHP uses an Application Service Provider (ASP) model to host the EHR system, which provides 24-hour operational support.	☐ Yes	☐ No
If the BCP status is "Yes," it is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP clearly identified as having responsibility for information security.	☒ Yes	☐ No
If no one within the MHP is identified as having responsibility for information security, the parent 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

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	54.6%
Contract providers	45.2%
Network providers	.2%
Total	**100%***

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

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	1.85	0.25	0.65	0.25
2019-20	2.50	0	0	0.25
2018-19	2.50	0	0	1

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	1.73	0.69	0	0
2019-20	1	0	0	0
2018-19	1	0	0	0

The following should be noted with regard to the above information:

- The number of technology FTEs has decreased by 26 percent over the last FY.

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 the MHP and does not account for users' 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	29	43	72
Clinical Healthcare Professional	59	51	110
Clinical Peer Specialist	0	0	0
Quality Improvement	10	0	10
Total	98	94	192

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)	1.85	7.87
Total EHR Users Supported by IT (Source: Table 17)	192.00	572.00
Ratio of IT Staff to EHR Users	1:104	1:73

- The Yolo IT staff ratio is lower compared to other medium-size MHPs.
- Netsmart hosts Avatar and provides EHR operations support.

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

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	☒	☐	☐	☐

- Yolo purchased a one-year subscription to Netsmart Enterprise Training System; however, due to COVID-19, Netsmart did not offer any trainings.

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

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	15
Number of county-operated telehealth sites	3
Number of contract providers' telehealth sites	12
Total number of beneficiaries served via telehealth during the last 12 months	3186
• Adults	1978
• Children/Youth	1046
• Older Adults	156
Total number of telehealth encounters (services) provided during the last 12 months:	1089

- Yolo is unable to break out the counts of telehealth only due to system limitations; therefore, the numbers reported above include all delivered services.
- The number of reported telehealth encounters over the last 12 months includes only those services for which the provider was able to enter progress notes directly into the EHR. There were additional encounters not entered directly into the EHR and not counted due to system limitations.

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.

- n/a

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	☐	n/a		

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
MHP provided no information.	n/a

Current MHP Operations

- Avatar software supporting EHR operations is the 2020 version.

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 (SD/MC) 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
Avatar CalPM	Practice Management	Netsmart	17	Netsmart
Avatar CWS	Clinical Workstation	Netsmart	14	Netsmart
OrderConnect	Electronic Prescribing & Lab Results	Netsmart	10	Netsmart

Major Changes since Prior Year

- The MHP migrated Avatar to a Netsmart hosted environment in April 2020.
- Due to COVID-19, the MHP expanded remote delivery of services where available.

The MHP's Priorities for the Coming Year

- Implement Quest's "KACE" IT ticketing system to track incidents and requests for Avatar and related applications. This is a county-wide initiative.
- Implement CareConnect Inbox and CareQuality for Avatar. CareQuality will enable increased sharing of beneficiary information between the MHP and contract providers.
- Implement Netsmart's online learning center.
- Provide EHR access to new Full-Service Partnership contract providers.
- Implement electronic claiming.

Other Areas for Improvement

- Contract providers' inability to directly enter data into Avatar impacts reporting capabilities related to telehealth services and language capacity, as well as system-wide timeliness reporting.
- Implementation of care coordination and referral management modules in Avatar would benefit service delivery effectiveness and efficiency.
- The MHP is not currently billing Medicare Part B-eligible services, contributing to the primary reason for Medi-Cal claims denials.
- The MHP remains challenged to address further development and implementation of EHR improvements and data reporting capacity due to insufficient IT and data analytic staffing.

Plans for Information Systems Change

- The MHP has no plans to replace the current system.

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	☒	☐	☐	☐
Assessments	Netsmart	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/Storage	Netsmart	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Netsmart	☒	☐	☐	☐
Laboratory results (eLab)	Order Connect	☒	☐	☐	☐
Level of Care/Level of Service	Netsmart	☒	☐	☐	☐
Outcomes	Netsmart	☐	☒	☐	☐
Prescriptions (eRx)	Order Connect	☒	☐	☐	☐
Progress Notes	Netsmart	☒	☐	☐	☐
Referral Management		☐	☐	☒	☐
Treatment Plans	Netsmart	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		9	1	2	0
FY 2019-20 Summary Totals for EHR Functionality:		9	1	2	0
FY 2018-19 Summary Totals for EHR Functionality:		9	0	3	0

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

- Over the last three years there has been minimal change to the metrics in Table 25.

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	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Direct data entry into MHP EHR system by contract provider staff	4%	Weekly
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	45%	Daily
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	51%	Daily

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 Data Transmission from Contract Provider to MHP

EHR Vendor	Product	Count of Providers Supported
NextGen Healthcare	NextGen	1
eClinicalWorks	eClinicalWorks	1
Netsmart	TIER	2

Personal Health Record

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

☐ Yes ☒ No ☐ Implementation Phase

n/a

Expected implementation timeline:

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

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

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

- The MHP does not currently have a mechanism to bill Medicare.

Table 29 summarizes the MHP's SD/MC claims.

Table 29: Summary of CY 2019 SD/MC Claims

Yolo MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**58,033**	**$14,877,838**	**1,390**	**$388,420**	**2.54%**	**$14,489,418**	**$12,706,615**
JAN19	4,342	$1,161,961	146	$33,584	2.81%	$1,128,377	$914,797
FEB19	4,005	$1,063,402	135	$30,759	2.81%	$1,032,643	$826,473
MAR19	4,501	$1,212,688	78	$20,111	1.63%	$1,192,577	$957,508
APR19	5,326	$1,351,523	113	$28,043	2.03%	$1,323,480	$1,083,037
MAY19	5,205	$1,358,776	132	$32,263	2.32%	$1,326,513	$1,089,513
JUN19	4,761	$1,232,399	105	$25,864	2.06%	$1,206,535	$970,486
JUL19	5,656	$1,417,347	111	$29,320	2.03%	$1,388,027	$1,325,468
AUG19	5,766	$1,416,370	121	$37,765	2.60%	$1,378,605	$1,306,235
SEP19	5,343	$1,268,228	77	$16,912	1.32%	$1,251,316	$1,205,031
OCT19	5,738	$1,485,796	170	$77,617	4.96%	$1,408,179	$1,292,427
NOV19	4,888	$1,235,097	154	$48,340	3.77%	$1,186,757	$1,107,337
DEC19	2,502	$674,250	48	$7,842	1.15%	$666,408	$628,301

The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments from Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.

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.**

Table 30 summarizes the top five reasons for claim denial.

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

Yolo MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Medicare or Other Health Coverage must be billed before submission of claim.	447	$155,685	40%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	594	$146,676	38%
Beneficiary not eligible.	217	$55,865	14%
Beneficiary not eligible or non-covered charges.	62	$19,475	5%
Service line is a duplicate and a repeat service procedure code modifier not present.	57	$7,206	2%
Total	1,390	$388,420	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 reason “ICD-10 diagnosis code” and “Medicare or Other Health Coverage” are generally re-billable within the state guidelines.
- The MHP’s inability to bill Medicare directly impacts the number of claims denied due to failure to bill “Medicare or Other Health Coverage”. These denials account for 40 percent of Yolo’s total denied claims for CY 2019.

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 Yolo, 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

Due to COVID-19 restrictions, CalEQRO was not able to conduct any key informant interviews to identify any problems or barriers for beneficiaries relating to access and timeliness issues. The key informants customarily include beneficiaries and family members, MHP staff, contracted providers, and other stakeholders.

Findings

The county 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

Not Applicable.

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 Type 1, NPI Type 2, 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	1
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	5

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number reported is associated with two or more providers	0
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	1
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	1

- It should be noted that the MHP reported that all exceptions were resolved prior to the EQR review date.

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

As part of the pre-site planning process, CalEQRO requested two focus groups with 10 to 12 participants each: one for adult/Transition-Age Youth (TAY) beneficiaries, and one for parents/caregivers of child/youth beneficiaries; however, due to a significantly modified review process designed to accommodate the MHP's involvement in the Yolo HHSA COVID-19 response, CalEQRO did not conduct focus groups with MHP beneficiaries and/or their family members during the review of the MHP.

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	No focus groups were held.
Total number of participants	n/a
Number of participants who initiated services during the previous 12 months	n/a
Interpreter used	Choose an item. If yes, specify language: Click or tap here to enter text.
Summary of the main findings of the focus group: n/a	

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 33 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 33: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
The MHP's website has most of the critical information available in English and Spanish, including crisis numbers and links to other resources such as the wellness centers and the teen runaway line. Information about transportation was not found.			
1B	Capacity Management	10	8
During the virtual review, the MHP reported changes in utilization as the service delivery system moved to virtual platforms. The MHP indicated that the tracking systems used last year are still in place. The MHP reported that CC activities were supported by MHSA staff during 2020 and that multiple re-engagement activities were launched in October 2020 when staff resumed their regular duties. A newly-conceived CC Committee has started holding meetings and is planning trainings as well as strategies for identifying systemic inequities and developing relevant programs.			

Component		Maximum Possible	MHP Score
The CY 2020 CC Plan draft provided a high level summary of underserved communities and cross-walked identified strategies/objectives/actions/timelines to improve access and utilization.			
1C	Integration and Collaboration	24	22
Examples of integration and collaboration include: • The MHP collaborated with stakeholders who serve children and families to create a Family Urgent Response System (FURS) to respond to crises in the community involving foster youth and former foster youth. • The MHP partnered with local school districts and Woodland Community College to provide mental health services on campuses. • CC staff and Davis Joint Unified School District counselors offered four mental health Ubuntu Listening Circles to Black Staff United educators, including instruction on how to offer circles to Black students to support student mental health. These activities began in 2020 and have increased in 2021.			

Timeliness of Services

As shown in Table 34, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 34: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	12
The MHP tracks and reports timeliness from initial service request to both first offered and first kept appointment. First offered is tracked relative to all service requests and to those requests that resulted in an offered appointment. The MHP reported that 69 percent of all requests for service resulted in an offered appointment within ten business days of the service request. Further, the MHP reported that of those service requests that resulted in an offered appointment, 83 percent of those offered appointments were within ten business days of initial request, with 95 percent for adult services, 78 percent for children’s services, and 76 percent for foster care services.			

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td colspan="4">The MHP also reported that 83% of all requests for service resulted in a service rendered within 30 business days of the initial request, with 91 percent for adult services, 79 percent for children’s services, and 75 percent for foster care services.
The MHP stated in the MHP Assessment of Timely Access (MATA) that for most measures, reporting has been at least annually or as needed. More frequent and consistent tracking and reporting would enable the MHP to identify problematic trends more quickly and take effective action if indicated.
In addition, the MHP identified data reliability issues resulting from multiple systems for entering the data points necessary to calculate timeliness metrics consistently.</td></tr>
<tr><td>2B</td><td>First Offered Psychiatry Appointment</td><td>12</td><td>6</td></tr>
<tr><td colspan="4">Of the 65 beneficiaries who were offered a psychiatry appointment after their initial request for services, overall, 62 percent of appointments met the 15 business-day standard. The MHP does not collect this information for children served by contract providers.
The MHP reported on this metric based on both the total number of initial service requests and only those who were offered a psychiatry appointment during their assessment or later in treatment.
The MHP’s calculation of this PM is complicated by the fact that all beneficiaries who request an initial service are offered a psychiatry appointment as well as an initial assessment (which is not a beneficiary-initiated request); however many do not accept one at that time. The MHP is encouraged to discuss all timeliness measure calculations with the EQRO.</td></tr>
<tr><td>2C</td><td>Timely Appointments for Urgent Conditions</td><td>18</td><td>11</td></tr>
<tr><td colspan="4">The MHP reported that overall, 97 percent of urgent requests for service met the timeliness standard of 48 hours to actual encounter. The MHP has adopted the stricter standard of 48 hours regardless of the need for prior authorization and therefore, does not require prior authorization for any appointment considered to be urgent.
These data reflect only calls to the Access Line or walk-ins; they do not capture data from contract providers. In addition, the MHP reported concerns about data reliability and an effort underway to create a form in Avatar to more consistently capture the data.</td></tr>
<tr><td>2D</td><td>Timely Access to Follow-up Appointments after Hospitalization</td><td>10</td><td>8</td></tr>
</table>

Component		Maximum Possible	MHP Score
The MHP reported a 15-day overall average to follow-up post-discharge, with 85.9 percent of appointments meeting the seven-day standard. The average was 14 days for adults and 17 days for children. There is a significant difference between the performance documented in the MATA for this metric (85.9 percent) and the PM for CY 2019 (55 percent. In addition, there is a significant gap between FY 2018-19 and 2019-20 in the reported average days to follow-up (5 versus 15, respectively). The MHP is encouraged to explore these discrepancies.			
2E	Psychiatric Inpatient Rehospitalizations	6	5
The MHP reported an overall 30-day readmission rate of 12.7 percent; adults were 11 percent; children were 17.4 percent, and there were no foster care readmissions. No evidence was provided that the MHP undertakes QI efforts if they are not meeting their own performance expectations.			
2F	Tracks and Trends No-Shows	10	7
The reported overall average no-show rate was 15 percent for psychiatrists and 2 percent for other clinicians. The no-show psychiatry rate for adults was 17 percent; for children, 4 percent; and 0 percent for foster care. For non-psychiatrists, the average was 2 percent, 1 percent, and 0 percent respectively. The MHP sets a 5 percent standard for both types of providers. Data reliability is an issue, as the service providers are responsible for ensuring that the billing codes and scheduler accurately reflect the no-show.			

Quality of Care

In Table 35, 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 35: Quality of Care Components

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td>3A</td><td>Cultural Competence</td><td>12</td><td>6</td></tr>
<tr><td colspan="4">The Cultural Competency function was moved to the Mental Health Services Act (MHSA) program under the Community Health Branch of HHSA at the end of 2019, and the CC Coordinator retired at the same time. A new position was created (Outreach Specialist/Ethnic Services Manager) and filled in March 2020 and was immediately deployed into the HHSA Department Operations Center (DOC) for the COVID-19 response. Due to these changes and COVID-19, the CC Committee did not meet in 2020; however, a draft of the 2020 CC Plan indicates that previously active programs were still functioning.
Narrative descriptions of progress on earlier goals were included in the update; the goals had not been structured with measurable targets, and while a new set of goals was included in the plan, most are not measurable. In addition, the identification of underserved populations listed all ethnicities and age ranges (based on the EQRO's penetration data), lacking a more thorough analysis and prioritization for targeted attention.
It is important to note that the MHP was attending to health equity issues as illustrated by:
• Yolo County became an approved member of the Government Alliance on Race and Equity (GARE), a national network of governments working to achieve racial equity and advance opportunities through trainings, resources, and networking. All county employees have access to these resources now.
• Yolo County issued a Request for Proposal for a vendor to continue the work to address racial equity in the workplace. HHSA will have a specific scope carved out, including sponsoring focus groups, listening sessions, employee surveys regarding understanding of diversity, equity, and inclusion concepts, training, and making recommendations to ensure racial equity in improved policies and programs.</td></tr>
<tr><td>3B</td><td>Beneficiary Needs are Matched to the Continuum of Care</td><td>12</td><td>10</td></tr>
<tr><td colspan="4">The MHP uses the LOCUS for adults and the Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35) for youth to establish LOC for all newly-entering beneficiaries and when a transition to a lower or higher LOC is being considered. In addition, all newly entering and transitioning adults are reviewed in UM Committee to confirm the decisions. All of the scales include items related to ethnic, cultural, and language needs and preferences.</td></tr>
</table>

Component		Maximum Possible	MHP Score
3C	Quality Improvement Plan	10	6
The FY 2020-21 QI Work Plan primarily reflects goals pertaining to compliance with mandated documentation and monitoring requirements as well as tracking DHCS-required PMs. There is little evidence that the MHP uses performance data to identify QI needs and develop relevant goals and plans to achieve them. In some cases, target performance is specified for monitoring requirements. During the review, the MHP reported that, due to the PHE, there have been no quarterly QI Committee meetings in the past year and that reports previously reviewed in that meeting are now reviewed in other meetings.			
3D	Quality Management Structure	14	9
The QM manager is also Deputy Director of the AA Branch, responsible for contracts, psychiatry and nursing services, and behavioral health (BH) administrative support. A QM team reports to that position and includes both clinical and analyst positions. QM functions for the CYF Branch are separate and under different leadership. The MHP reported that there are multiple cross-system meetings in which QM activity is reported and coordinated. The MHP reported that, while there were no QIC meetings during the year, quality discussions were incorporated into other meetings and forums in order to continue work on QI initiatives.			
3E	QM Reports Act as a Change Agent in the System	10	5
The MHP stated that reports such as those relating to timeliness, beneficiary protection activity (grievances, requests for new therapists), and follow-up after hospitalization had been produced and routinely reviewed, including trended data by quarter and year over year comparisons. The MHP described establishing a position to support beneficiaries being discharged from the hospital as a QI initiative that derived from PM tracking. It is not clear when this new system was initiated nor upon what data or reporting it was based.			
3F	Medication Management	12	6
The MHP reported having lost their senior QM nurse who facilitated the monitoring process conducted by a contracted pharmacist. The medical director position is also vacant. They reported being unsure if SB 1291 measures were tracked and thought that Child Welfare Services might have that responsibility.			

Beneficiary Progress/Outcomes

In Table 36, 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 36: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	8
Based on information from the last EQR, the MHP uses multiple scales to evaluate progress for children, including the CANS, which is administered at the beginning of treatment, every six months, and whenever a LOC change is being considered. The MHP has now adopted the LOCUS as the adult tool, administered at intake and for LOC change considerations. The MHP reported utilizing the RBA framework to track outcomes across multiple programs for adults and youth.			
4B	Beneficiary Perceptions	10	10
Consumer Perception Survey (CPS) administration was changed by DHCS – delayed and changed to an electronic format during spring 2020, and then cancelled for the fall; the MHP, therefore, had very little data to use for the last year. Information provided for the FY 2019-20 EQR report indicated that the MHP routinely reports on the CPS, including trending results, sharing with multiple stakeholders, and provided evidence of using the results for QI initiatives. The MHP reported that the wellness centers administer quarterly beneficiary satisfaction surveys which they share with peer support staff.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
There are three wellness centers serving each primary population area, located in Woodland, Davis, and West Sacramento. They are mainly staffed by peers. Due to the ongoing COVID-19 pandemic, support groups have moved to an online platform. Information about the wellness centers, including locations, hours, and contact phone numbers, can be found on the MHP website.			

Structure and Operations

In Table 37, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 37: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	26
The MHP does not provide day treatment intensive or day rehabilitation services; however, should the need arise, the MHP makes the appropriate arrangements.			
5B	Network Enhancements	18	14
MHP staff are embedded at Detention and at a multi-disciplinary center that coordinates care for alleged child abuse victimization; included at the center are Law Enforcement, the District Attorney, Child Welfare, and Behavioral Health, all of which constitute the Interagency Placement Committee (IPC). The MHP does not have Health Homes Programs or Whole Person Care.			
5C	Subcontracts/Contract Providers	16	10
The MHP reported that they meet monthly with children's providers to address QM and fiscal issues, among other topics. During the critical first several months of the pandemic, they met weekly; however, they have gradually returned to monthly meetings. They also reported frequent contact with the two adult contractors and the congregate care providers. During the previous EQR, providers reported a high level of satisfaction with MHP communication and collaboration, citing specific meetings as well as inclusion in CC activity. Providers also reported that, while they share a great deal of information with the MHP, they do not in turn receive useful reports or analyses. In addition, some providers expressed dissatisfaction with the amount of additional analysis and investigation required of them on a regular basis, believing much of it to be unnecessary. Some timeliness reporting (in the MATA) included contractors; however, no other reports were provided to determine the extent to which MHP data reports are system-wide.			
5D	Stakeholder Engagement	12	11
The MHP reported holding quarterly stakeholder meetings and included all relevant stakeholders in the planning for the redesign of their crisis response. Line staff and supervisors sit on various QI committees.			

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td colspan="4">Population-specific teams meet weekly or monthly.</td></tr>
<tr><td>5E</td><td>Peer Employment</td><td>8</td><td>4</td></tr>
<tr><td colspan="4">Peer Support Workers are employed at the wellness centers; however, there is only one position level with no supervisory or management opportunities.
The MHP has created a standing Peer Workforce Development Workgroup that aims to create a program that will ensure that peers are provided with skill building, professional development opportunities, training, and internal HHSA support designed to expand their foundation of marketable skills.</td></tr>
</table>

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Yolo 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: No PIP submitted (not rated)

Access to Care

Changes within the Past Year:

- Yolo's Mental Health Urgent Care clinic suspended services as of April 11, 2020. This change eliminated walk-in availability at the West Sacramento site during weekday evenings (4:30 p.m. to 8:00 p.m.) and weekends.
- Effective July 2020, Yolo stopped dispatching staff to emergency rooms (ERs) for assessments; hospital staff took over responsibility for completing 5150 assessments.
- At the same time, in July 2020 a re-designed crisis intervention model was implemented that included embedding a licensed clinician in the police departments in Woodland and West Sacramento, with plans to include Davis, a second West Sacramento clinician, and a shared clinician for the County Sherriff and Probation. A 24/7 Crisis Navigation Team was created to facilitate inpatient and residential placements for beneficiaries assessed by the ERs.
- HHSA medication support services were expanded to provide crisis/ urgent response to beneficiaries by phone in all three city clinics, with a plan for telehealth.
- The wellness centers transitioned to all virtual groups due to COVID-19.
- In an effort to improve diagnostic reliability and direct callers to appropriate care, and as part of a PIP, staffing of the 24/7 BH Access Line was changed from case managers to licensed clinicians.

Strengths:

- The roll-out of telehealth was quickly initiated and effectively executed once the need was identified. The MHP now has a service delivery infrastructure across the entire system of care that did not exist a year ago, and it is likely a permanent addition to their resources.
- Yolo MHP's Forensic Team, in coordination with collaborative court partners, was one of the first in the state to establish virtual court to ensure that beneficiaries maintain contact with criminal justice partners and can attend court hearings, which are critical to the success of the program.

Opportunities for Improvement:

- The Hispanic penetration rate, while having increased somewhat over CY 2018, continues to be half that of the state and a percentage point lower than the medium county average. Further investigation regarding this rate relative to Yolo County's Hispanic population could inform a measurable QI and/or CC goal and help the MHP understand the level and type of effort required to achieve it.

Timeliness of Services

Changes within the Past Year:

- None noted.

Strengths:

- None noted.

Opportunities for Improvement:

- The MHP is unable to capture complete and reliable timeliness data from contract providers.
- Timeliness tracking methods and calculations appear to be inconsistent and unreliable across several PMs and from year to year.

Quality of Care

Changes within the Past Year:

- The CC Coordinator retired in December 2019. In March 2020, the Community Health Branch hired a Cultural Competence Outreach Specialist to serve as the Ethnic Services Manager, who was immediately directed into the HHSA DOC for COVID-19 response. This person's role is

to support CC and equity, outreach engagement and trainings, the CC Committee, and the Yolo CC Plan.

- With the departure of the BH Quality Manager in September 2020, those duties were transferred to the Deputy Director of the AA Branch, with no immediate plan to replace that position.
- The MHP implemented the use of the LOCUS for LOC planning and initiated review of completed assessments in a weekly UM Committee.
- The BH Medical Director planned to step down effective February 2021; recruitment had begun at the time of the current EQR.
- In January 2021 the loss of the MH QM Senior Staff Nurse resulted in a temporary reassignment of functions such as hospital authorizations, QM support to medical staff, and facilitation of medication monitoring with the contract pharmacist. It was not clear if the MHP planned to fill this vacancy.

Strengths:

- The MHP implemented the use of the LOCUS for LOC planning and initiated review of completed assessments in a weekly UM Committee.
- The new CYF Clinical Manager, who has a system perspective, should be helpful in furthering integration of QI processes and activities across SOCs.

Opportunities for Improvement:

- The MHP lacks a robust medication monitoring and QI process that includes the requirements of SB 1291.
- As neither the QI Committee nor the CC Committee met during 2020 due to a combination of staffing changes and pandemic response, it will be important for the MHP to resume the regular schedule of both meetings.
- The MHP might consider structuring the goals included in both the QI and the CC Plan in a manner that can be measured using readily available data. Tracking and trending progress periodically, e.g., monthly or quarterly, would provide the MHP with more actionable information, particularly to understand early on if their QI activities are yielding the desired results.
- While the QI Plan addresses many quality assurance- and compliance-related activities, adding measurable goals targeting timely access and outcomes of care would facilitate improvement in quality and service delivery.

Beneficiary Outcomes

Changes within the Past Year:

- The MHP adopted the LOCUS as a LOC tool for adults.

Strengths:

- The wellness centers administer quarterly beneficiary satisfaction surveys that they share with peer support staff.
- There are three wellness centers that serve the main population centers in the county. They are staffed primarily by peers.

Opportunities for Improvement:

- The MHP does not aggregate or trend CANS or LOCUS results, thereby missing an opportunity to identify and address potential variances in service effectiveness across populations.

Foster Care

Changes within the Past Year:

- Since the last review period, Yolo met with the EQRO to confirm that the MHP was using a similar methodology to determine Foster Care penetration rates. Yolo MHP QM has since hired a dedicated data analyst and plans to compile and distribute this data on a quarterly basis.

Strengths:

- IPC meetings are held weekly to review the children and youth identified as needing intensive supervision and mental health services, as well as those placed in Short-Term Residential Treatment Programs. IPC meetings have allowed leadership to discuss options, validate or further discuss concerns with direct service providers and staff, and make decisions based on a whole child and system approach.
- Pursuant to AB 2043, the MHP is working collaboratively with stakeholders and community partners serving children and families to implement FURS, which will provide in-person mobile response to current and former foster youth during situations of instability in order to preserve the relationship of the caregiver and the youth. Anticipated completion date is March 2021.

Opportunities for Improvement:

- The MHP does not track any of the SB 1291 PMs related to medication administration.

Information Systems

Changes within the Past Year:

- The MHP migrated Avatar to a Netsmart hosted environment in April 2020.
- Due to COVID-19 limitations on face-to-face contact, the MHP expanded the use of remote service delivery where available.

Strengths:

- None noted.

Opportunities for Improvement:

- Claims data from contract providers continue to be submitted to the MHP on paper or by email, then entered into Avatar by Yolo staff. This process would benefit from automation to free up staff time and avoid errors in data entry.
- The MHP would realize increased efficiency if all contracted providers were required to use the same EHR and had access to enter data directly.

Structure and Operations

Changes within the Past Year:

- As described above, multiple senior level positions were vacated or re-assigned within BH in 2020.

Strengths:

- The MHP reported that they maintained frequent contact with contract providers in the last year, particularly early in the pandemic response as both parties were changing the service delivery system. The MHP ensured that all new guidance from the state and the county about services, billing, and other requirements was distributed to all providers.
- The stakeholder process for developing the new MHSA Three-Year Plan included 16 or more groups of stakeholders, some of which have been established as permanent groups.

- All contractors and other stakeholders were included in the development of the new crisis response system.
- The new CC Plan discusses a Peer Workforce Development Workgroup that aims to create a program to ensure that peers are provided with the evidence-based skill building, professional development opportunities, training, and internal HHSA support required to provide effective services to beneficiaries, reduce stigma, and expand their own foundation of marketable skills.

Opportunities for Improvement:

- The MHP does not currently have a mechanism to bill Medicare, which directly impacts the number of claims denied due to failure to bill "Medicare or Other Health Coverage". These denials account for 40 percent of Yolo's total denied claims for CY 2019.
- The MHP's IT and data analytic staffing resources are not robust enough to adequately support the MHP's current operations nor any future enhancements, particularly in comparison to other similar-sized MHPs.
- Peer positions within the MHP are part-time, with sick leave as the only benefit. There are no designated supervisory positions and no career ladder.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward. Access technical assistance (TA) from the EQRO in the development of a non-clinical PIP and improvement of the current clinical PIP. *(This is a carry-over recommendation from FY 2018-19.)*

Access to Care

None noted

Timeliness of Services

Recommendation 2: Review all timeliness measures to ensure that the data is reliable, the calculations are internally consistent, and the metrics comply with DHCS requirements. TA from the EQRO is highly recommended. *(This is a follow-up recommendation from FY 2019-20.)*

Quality of Care

Recommendation 3: Define measurable goals in the Quality Improvement (QI) Plan and the Cultural Competence (CC) Plan that reflect desired improvements in access, timeliness, and quality, in addition to compliance with required monitoring activity. Analysis of existing data should inform the selection of goals and provide baselines against which to measure improvement.

Beneficiary Outcomes

Recommendation 4: Continue work on aggregating and trending Child and Adolescent Needs and Strengths (CANS) and Level of Care Utilization System (LOCUS) results. Establish a reporting format and schedule to effectively use the information for QI purposes.

Foster Care

Recommendation 5: Develop and implement a medication monitoring review format that captures the requirements of SB 1291. Track and trend results over time and incorporate into a QI process that ensures follow-through on identified system-related issues.

Information Systems

Recommendation 6: Develop an automated system for inputting contract provider claims data. *(This is a carry-over recommendation from FY 2018-19 and 2019-20.)*

Structure and Operations

Recommendation 7: Complete the analysis of the Medicare billing workgroup and impact on Medi-Cal claiming, and proceed with implementing a Medicare billing process for all appropriate services.

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 EQRO developed the agenda and process for this review in collaboration with the MHP, respecting the state guidance issued regarding reducing audit impacts on the MHPs.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Data

Attachment D: ACA Penetration Rates and ACBs

Attachment E: ACB Range Distributions

Attachment F: List of Commonly Used Acronyms

Attachment A—Review Agenda

The following topics were discussed during the EQR virtual session.

Table A1: EQRO Review Sessions

Yolo MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Information Systems Capabilities Assessment (ISCA)
Telehealth

Attachment B—Review Participants

CalEQRO Reviewers

Harriet Markell, Quality Reviewer
Joel Chain, IS Reviewer
Gloria Marrin, 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.

MHP Review Sites and Participants

One session was held via video conference due to COVID-19 restrictions.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Christensen	Laura	Supervising Clinician, TAY	HHSA
Freitas	Julie	Manager, SUD, Forensic, & Homeless Services	HHSA
Gallegati	Mario	Manager, Access, Crisis, & Intensive Services	HHSA
Green	Mila	Deputy MH Director, QM Manager	HHSA
Hernandez-Fogle	Linda	Wellness Center Supervisor	HHSA
Jakowski	Karleen	Branch Director, Child, Youth, & Family Programs	HHSA
Kelly	Kristy	Supervising Clinician, Access	HHSA
Kildare	Tony	Manager, Children's Mental Health Services	HHSA
Leino	Amy	Supervising Clinician, QM	HHSA
Sidhu	Pam	Supervising Analyst, QM	HHSA
Smith	Tessa	Family Partner/Outreach Specialist	HHSA
Valle	Fabian	MHSA Analyst	HHSA
Samartino	Rita	System Administrator for Avatar	HHSA
Strachan	Colin	Manager, IT	HHSA
Villarreal	Robert	Supervising Clinician, Crisis	HHSA

Attachment C—Approved Claims 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 (-).

Attachment D—ACA Penetration Rates and ACBs

Table D1 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 D1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Yolo 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	16,167	322	1.99%	$2,422,057	$7,522

Attachment E—ACB Range Distributions

Table E1 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 E1: CY 2019 Distribution of Beneficiaries by ACB Range

Yolo 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	1,593	88.65%	93.31%	$7,159,213	$4,494	$3,998	47.29%	59.06%
>$20K - $30K	87	4.84%	3.20%	$2,104,162	$24,186	$24,251	13.90%	12.29%
>$30K	117	6.51%	3.49%	$5,874,509	$50,209	$51,883	38.81%	28.65%

Attachment F—List of Commonly Used Acronyms

Table F1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
AB	Assembly Bill
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
API	Asian/Pacific Islander
ASAM	American Society of Addiction Medicine
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts
BHIN	Behavioral Health Information Notice
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organizations
CBT	Cognitive Behavioral Therapy
CCC	Cultural Competency Committee
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services

Acronym	Full Term
COVID-19	Corona Virus Disease-2019
CPM	Core Practice Model
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CURES	Controlled Substances Utilization Review and Evaluation System
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EDI	Electronic Data Interchange
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
FTE	Full Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Full Term
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HR	Human Resources
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IHBS	Intensive Home-Based Services
IMD	Institution for Mental Diseases
IN	Information Notice
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
KPI	Key Performance Indicator
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care
LOS	Length of Stay
LPHA	Licensed Practitioner of the Healing Arts
MAT	Medication Assisted Treatment
MCO	Managed Care Organizations
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MFA	Multi-Factor Authentication
MHBG	Mental Health Block Grant
MHP	Mental Health Plan
MHSA	Mental Health Services Act

Acronym	Full Term
MHST	Mental Health Screening Tool
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MSO	Management Services Organization
NA	Network Adequacy
n/a	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTP	Narcotic Treatment Program
OON	Out-of-Network
OTP	Opioid Treatment Program
PA	Physician Assistant
PDSA	Plan Do Study Act
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIN	Personal Identification Number
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RFP	Request for Proposal
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration

Acronym	Full Term
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SD/MC	Short-Doyle Medi-Cal
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
STCs	Special Terms and Conditions
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
VOIP	Voice Over Internet Protocol
WET	Workforce Education and Training
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan