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

TULARE FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

November 15-16, 2022

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — November 15-16, 2022

MHP Size — Medium

MHP Region — Central

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	1	4	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	6	4	0
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**20**	**6**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Fields Based Backup Crisis Response for Young People	Clinical	10/21	First Remeasurement	High
Mental Health Outreach to and Engagement with the Homeless	Non-Clinical	01/22	First Remeasurement	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	10
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	10

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has a robust outcome-oriented Cultural Competency Plan (CCP) and Cultural Competency Committee (CCC) and active management involvement in the CCC.
- The MHP has improved data tracking of timeliness measures, incorporated a Corrective Action Plan (CAP) model, and has plans to further improve data analytics through the implementation of a new Electronic Health Records (EHR).
- The MHP's strategic planning incorporates California Advancing and Innovating Medi-Cal (CalAIM) initiatives; the crisis services continuum; routine care systems; peer certification; HR flexibilities; and direct staff and Community Based Organizations (CBO) systematic bidirectional communication.
- The MHP has implemented a hybrid work environment that improves staff recruitment and retention; staff morale; and beneficiary flexibility of choice between tele, field, and office-based appointments.
- The MHP is in the first adopters cohort of the CalMHSA semi-statewide EHR, SmartCare, implementing July 2023.

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

- The access and treatment transitions of adult care coordination between the MHP and two Managed Care Plans (MCP) are not tracked, trended, monitored, analyzed, or coordinated utilizing Level of Care (LOC) tools and standardized procedures.
- The MHP averages meeting the offer of the DHCS standards for assessment and first psychiatric service between 50 and 64 percent of the time, with children's services lagging adult services. The current application of CAPs to focus on timeliness performance improvement is very promising.
- The MHP does not adhere to a QAPI plan format that specifies quality improvement targets, analysis, and recommendations. Although beneficiaries or families have been invited, there is little evidence of regular beneficiary input into QAPI, PIP, and QIC decision-making processes.
- The MHP does not evidence accurate no-show tracking, trending, or have a standardized no-show policy or procedure.
- Contract providers are not currently involved in the implementation planning for the new EHR, SmartCare.

Recommendations for improvement based upon this review include:

- Investigate reasons and develop strategies to improve the access and treatment transitions of adult care coordination between the MHP and MCP. It is further recommended that the MHP utilize the DHCS CalAIM Access and Screening Tool January 2023 implementation, and all relevant CalAIM initiatives.
- Investigate reasons and develop strategies to improve the timeliness to first *non-urgent* services rendered, first non-urgent psychiatry appointments offered, and first non-urgent psychiatry appointments rendered.
- Investigate reasons and develop strategies to develop and adhere to a QAPI plan format that specifies QI targets, analysis, and recommendations, and perform an annual evaluation of the plan. This could be completed by merging the QIC work with the QAPI plan. Include strategies to increase engagement of beneficiaries' input into QAPI, PIP, and QIC decision making processes.
- Investigate reasons and develop strategies to develop and adhere to accurate no-show tracking or trending with fidelity monitoring, including a standardized no-show policy or procedure.
- Include contract providers in the SmartCare planning phases as soon as possible and develop a communications plan to keep all stakeholders informed of the coming changes.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2022-23 findings of the EQR for Tulare County MHP by BHC, conducted as a virtual review on November 15-16, 2022.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

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

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs as per 42 CFR 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Review and validation of each MHP's NA as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of QAPI program.
- Beneficiary perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 12, then "≤11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the third year impacted by the Coronavirus Disease 2019 (COVID-19) pandemic. The impact of COVID-19 was continuous throughout the FY, up to and including the time of the site review. In addition, Tulare County was impacted significantly with record heat waves and severe drought. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP's Director was appointed to the Health and Human Services Agency (HHSA) Director. The MHP director position is currently in recruitment.
- The MHP has utilized a consultant, Recovery Innovations, to assist crisis services strategic planning and implementation. The executive team has included these recommendations in strategic planning efforts with community partners to address gaps in the crisis continuum. The MHP is developing a children's community crisis mobile response team and is building a children's crisis stabilization unit (CSU). In partnership with the Tulare County Sheriff's Department, the MHP launched the Ride Along program to respond to MH crisis county wide. Hours are 7:00p.m.-5:00p.m. Monday-Friday.
- The MHP has plans to implement the California Mental Health Services Authority (CalMHSA) SmartCare semi-statewide EHR. They are scheduled to begin using the EHR across the MHP in July 2023.
- The MHP is proactively implementing peer certification and has added two Peer Support Services positions to the 24/7 mobile crisis teams.
- The MHP is partnering on four No Place Like Home (NPLH) projects. The communities are located in Dinuba, Porterville, Tulare, and Visalia, and the number of dedicated NPLH units in each ranges from 9 to 33.
- Under CalAIM, the MHP is developing a plan to add a pharmacy onsite at the largest MHP adult clinic.
- Workforce development is implementing Loan Repayment opportunities for staff. The Tulare County grants team applied for and was awarded funding to

implement an in-house Mentored Internship Program and is currently collaborating with three educational partners to recruit and retain interns to strengthen and expand the behavioral health workforce in Tulare County.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: Investigate reasons and develop strategies to improve tracking and quality oversight of the adult transitions of care between MHP and MCOs.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP continues to discuss data exchange and access to care issues in quarterly meetings with the two MCPs. There has not been development of strategies to improve the processes, tracking, and quality oversight of the adult transitions of care between MHP and MCPs.
- To have this item fully met the MHP would need to fully implement the CalAIM screening and transitions tools as well as standardizing their LOC tools into a process to determine readiness for transitions between the plans.
- This recommendation will be a carry-over as a current recommendation.

Recommendation 2: Investigate reasons and develop strategies, utilizing QAPI methodology, to provide a full array of telehealth modalities.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The HHSA allows staff the opportunity to telework up to 50 percent of their time in efforts to entice new staff and increase current and future staff retention. Additionally, the MHP allows staff to work from home if they test positive for COVID-19 or are experiencing any other symptoms that prevents them from

coming into the office. Having hybrid staffing allows for consumer choice. Overall, the MHP has seen an increase in the use of telehealth for all age groups.

Recommendation 3: Investigate reasons and develop strategies, utilizing QAPI methodology, to improve timeliness to first non-urgent services rendered, first non-urgent psychiatry appointments offered, and first non-urgent psychiatry appointments rendered, especially for minors and FC.

(This recommendation is a carry-over from FY 2020-21.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP's QI Unit implemented a process to monitor timely access by age group for timely access to outpatient services, psychiatric services, and urgent condition services graphs monthly that it is disseminated MHP providers. The first delivered clinician service worsened in the past year, but the MHP believes it is more accurate data. The psychiatry appointment data improved but there is still room for improvement as 59.7 percent of offered appointments and 50.2 percent of delivered psychiatric services met the 15-day standard.
- Any MHP provider identified as being below standard is put on a CAP with a requirement to address and complete said CAP within 60 days. The QI Unit has observed a significant increase in the number of appointments meeting the required 80 percent compliance percentage post implementation.

Recommendation 4: Develop, implement, and adhere to a QAPI plan that specifies quality improvement targets, analysis, and recommendations.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The QI Unit is in the process of developing a QAPI tracking tool and an associated process to monitor several key performance indicators that have been identified as significant areas of deficiencies and opportunities for improvement. The implementation of the new EHR is expected to improve data analytics.
- The QI Unit has increased its staff capacity by four full-time equivalent positions.
- The QIC and CCP track, trend, and address several areas of timeliness, psychiatric care, and quality, although these areas are not addressed in the annual QI plan or QI plan annual evaluation.
- To fully meet this recommendation, the MHP would need to develop and adhere to a QAPI plan that specifies QI targets, analysis, and recommendations, and perform an annual evaluation of the plan. This could be completed by merging the QIC work with the QAPI plan.

Recommendation 5: Investigate reasons and develop strategies to increase engagement of beneficiaries input into QAPI, PIP, and QIC decision making processes.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has extended invitations to consumers, members of the community, and public to attend meetings including but not limited to: Adult System Improvement Committee, Children's System Improvement Committee, and Quality Improvement Committee with limited success.
- To fully meet this recommendation the MHP would need to actively recruit and possibly incentivize beneficiaries. The MHP would need to include alternative strategies, such as brief targeted contact surveys, to obtain feedback on specific MHP or beneficiary interests.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 29 percent of services were delivered by county-operated/staffed clinics and sites, and 71 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 83 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week that is operated by contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: the MHP website, by phone or in person, at any of the adult or children's outpatient clinics. The MHP operates a decentralized access system that is responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries may receive screening and assessment directly through the closest outpatient clinic to their residence or the clinic of their choice.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth, adults, and older adults. In FY 2021-22, the MHP reports having provided telehealth services to 1,100 adult beneficiaries, 4,168 youth beneficiaries, and 118 older adult beneficiaries. Telehealth use increased by 131 (13.5 percent) for adults, 138 (3.4 percent) for youth, and fewer than 12 for older adults. Services were provided across 3 county-operated sites and 13 contractor-operated sites. Among those served, 534 beneficiaries received telehealth services in a language other than English in the preceding 12 months. Telehealth services in a language other than English increased by 127 (31 percent).

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

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

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

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

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

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

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

Table 1B: MHP OON, FY 2021-22

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	☒ Yes ☐ No

- The MHP received Conditional Passes for adult psychiatry provider capacity, Children/youth outpatient SMHS provider capacity, and Children/youth psychiatry provider capacity. On February 28, 2022, the MHP provided DHCS with supplemental documentation of plan capacity. On April 26, 2022, DHCS resolved the CAP. The MHP is in full compliance.

ACCESS KEY COMPONENTS

CalEQRO identifies the following components as representative of a broad service delivery system which provides access to beneficiaries and family members. Examining service accessibility and availability, system capacity and utilization, integration and

collaboration of services with other providers, and the degree to which an MHP informs the Medi-Cal eligible population and monitors access and availability of services form the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

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

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- The MHP has a very active CCP and CCC and has demonstrated numerous approaches to serving their Spanish-speaking beneficiaries. There are efforts at both county-operated and contracted clinics to hire Spanish speaking staff; when a translator is not available the MHP uses an iPad for the language line, so the beneficiary sees a person rather than just the voice over the phone. They have also translated their entire website into Spanish rather than relying on a computerized translation process which doesn't always use correct or culturally appropriate language.
- The MHP is making plans to add an onsite pharmacy to their largest adult clinic to ensure access to medications.
- The MHP is proactively implementing CalAIM No Wrong Door, documentation simplification, and adult and child beneficiary access criteria. The MHP is seeing an increase in the number of beneficiaries they serve.
- The quarterly meeting interaction with the MCPs does not appear adequate to implement the CalAIM screening and transitions tools. There is not a current foundation for seamless screening and transition between the MHP and the MCPs.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, with a 3.55 percent PR, continues to provide access at a little lower rate than the state as a whole. The MHP's PR is on a downward trend similar to the statewide trend. This may be partly ascribed to the pandemic and a CY 2021 claims lag in the data that CalEQRO received.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	271,012	9,615	3.55%	$49,742,529	$5,173
CY 2020	255,316	9,924	3.89%	$55,444,800	$5,587
CY 2019	251,978	10,491	4.16%	$48,194,242	$4,594

- The MHP has experienced a 6 percent increase in Medi-Cal eligibles and a 3 percent decrease in beneficiaries served which has partly contributed to the declining PR.

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

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	32,080	249	0.78%	0.89%	1.59%
Ages 6-17	75,405	4,907	6.51%	3.93%	5.20%
Ages 18-20	16,221	588	3.62%	3.42%	4.02%
Ages 21-64	128,736	3,706	2.88%	3.75%	4.07%
Ages 65+	18,571	165	0.89%	2.13%	1.77%
TOTAL	**271,012**	**9,615**	**3.55%**	**3.33%**	**3.85%**

- The MHP has a particularly high PR in the ages 6-17 category. This could be a function of the MHP's partnership with the Tulare County Department of Education (TCOE).
- The adult age group, ages 21-64, PR is lower than the MHP and state average.

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percent of Beneficiaries Served
Spanish	2,243	23.80%
Total Threshold Languages	**2,243**	**23.80%**
Threshold language source: Open Data per BHIN 20-070		

- The MHP has a high percentage of beneficiaries served who identify Spanish as their primary language.

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

Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	67,489	1,724	2.55%	$9,326,745	$5,410
Medium	613,796	18,023	2.94%	$122,713,843	$6,809
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.

- The MHP's ACA PR is lower than the county average, while the AACB is 4.6 percent higher than the countywide AACB.

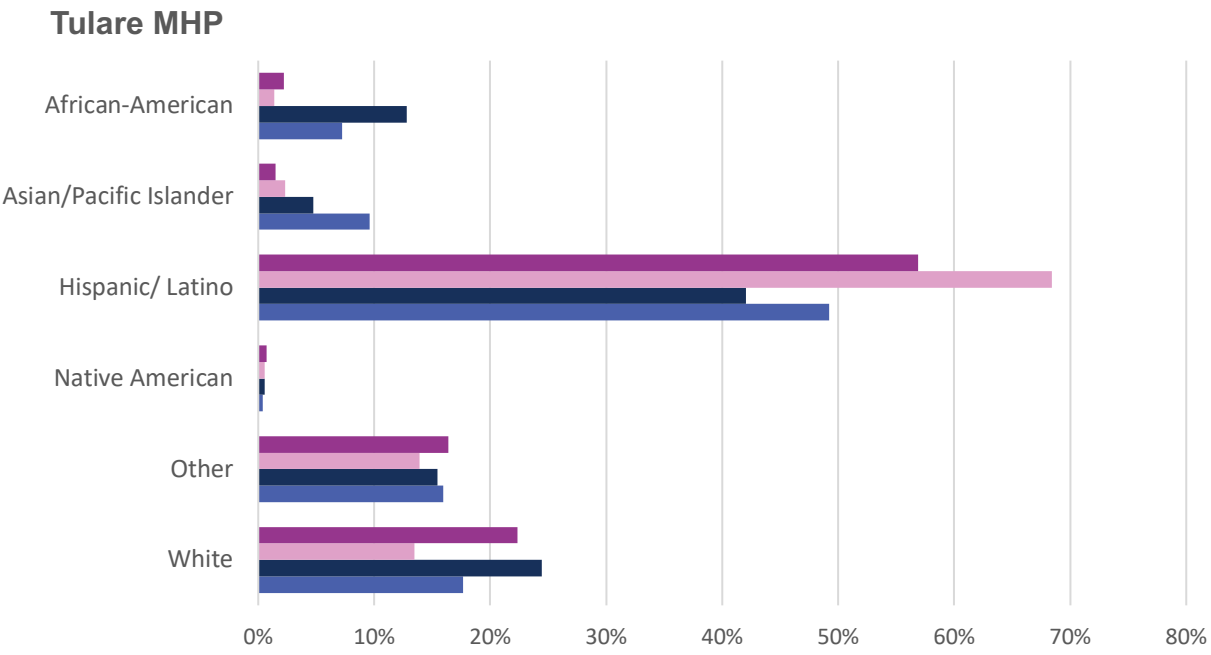
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	# MHP Served	# MHP Eligibles	MHP PR	Statewide PR
African-American	214	3,705	5.78%	6.83%
Asian/Pacific Islander	142	6,243	2.27%	1.90%
Hispanic/Latino	5,468	185,358	2.95%	3.29%
Native American	68	1,465	4.64%	5.58%
Other	1,575	37,695	4.18%	3.72%
White	2,148	36,548	5.88%	5.32%
Total	**9,615**	**271,014**	**3.55%**	**3.85%**

- Hispanic/Latinos make up 68 percent of the county eligibles. At 2.95 percent their PR is lower than the statewide average for Hispanic/Latinos and lower than the county's overall average.
- The PR for White beneficiaries is almost twice the PR of Hispanic/Latinos.

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

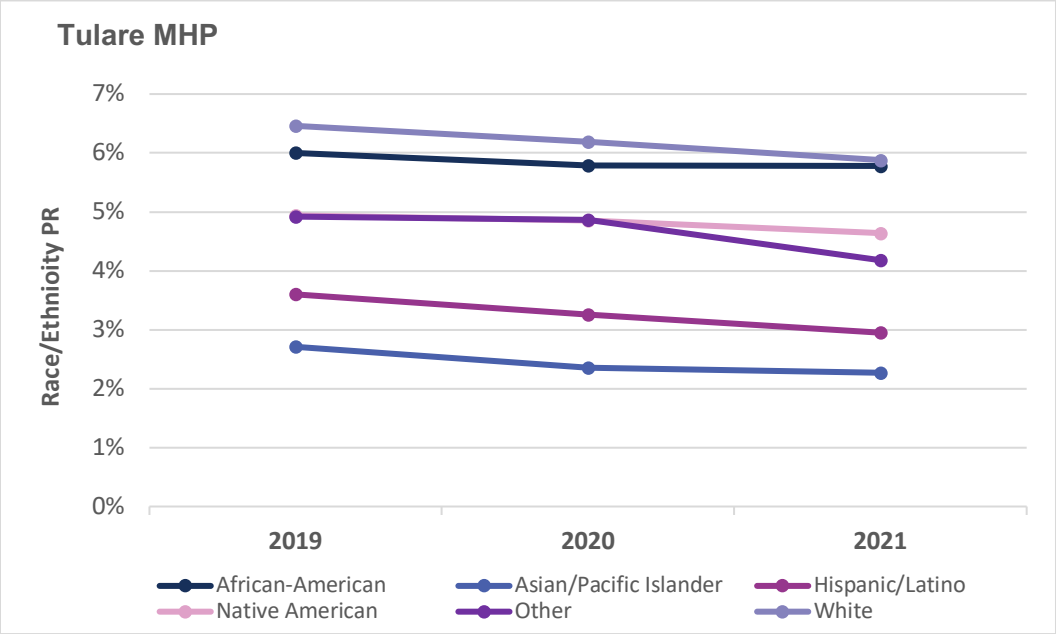


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	22%	16%	1%	57%	1%	2%
MHP % Eligibles	13%	14%	1%	68%	2%	1%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- The figure further demonstrates that Hispanic/Latinos make up a large percentage of both eligibles and those served within the county.

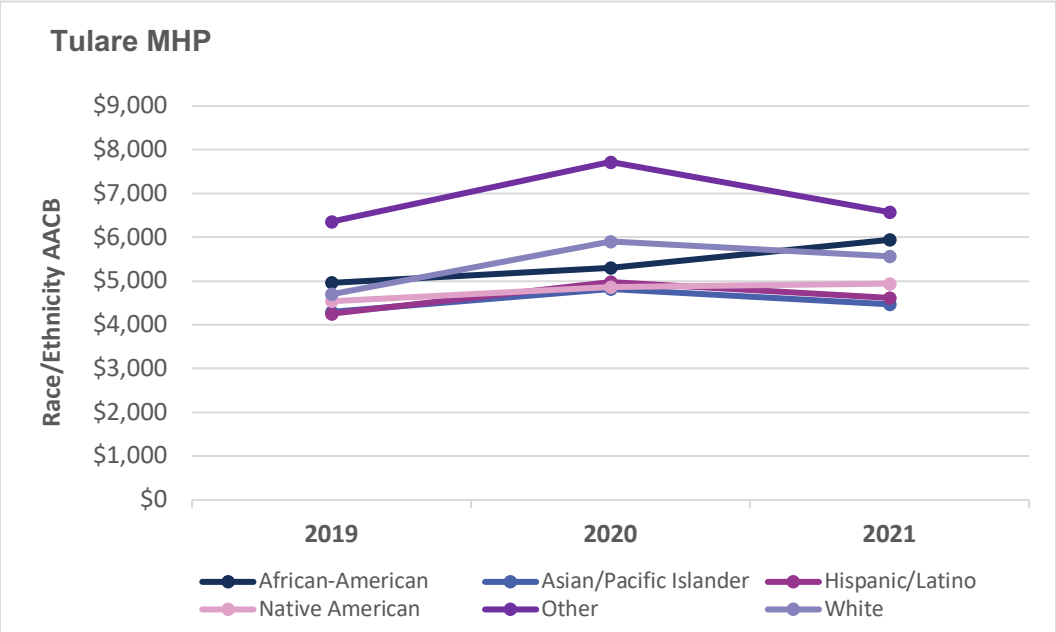
Figures 2 – 11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



- The figure demonstrates that White and African-American beneficiaries have the highest PRs in the county. Native American and Other beneficiaries are in the middle and Hispanic/Latino and Asian/Pacific Islanders have the lowest PRs in the county.

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



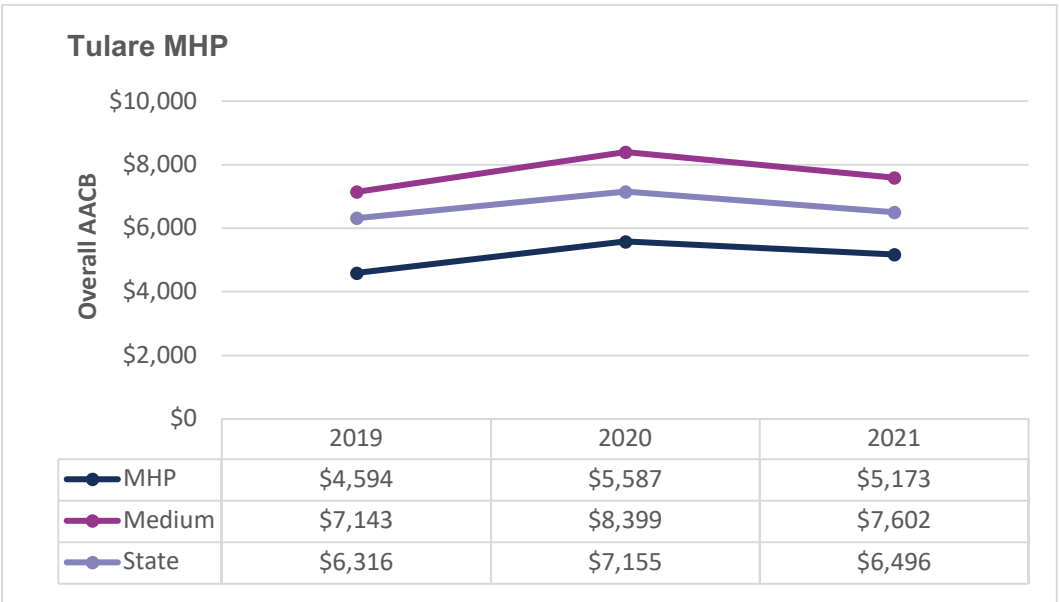
- Beneficiaries that fall in the Other race/ethnicity category have the highest AACB within the county. White and African-Americans fall in the middle. Native American, Hispanic/Latino and Asian/Pacific Islanders are clustered with the lowest AACBs.

Figure 4: Overall PR CY 2019-21

	2019	2020	2021
MHP	4.16%	3.89%	3.55%
Medium	4.25%	3.87%	3.33%
State	4.86%	4.55%	3.85%

- The MHP's PR is consistently lower than the statewide average. Like the state average it has been going down since 2019. To an extent, this decline is possibly linked to the claims lag in the data that CalEQRO had received which shows almost no claims for the last two months of CY 2021 for the MHP.

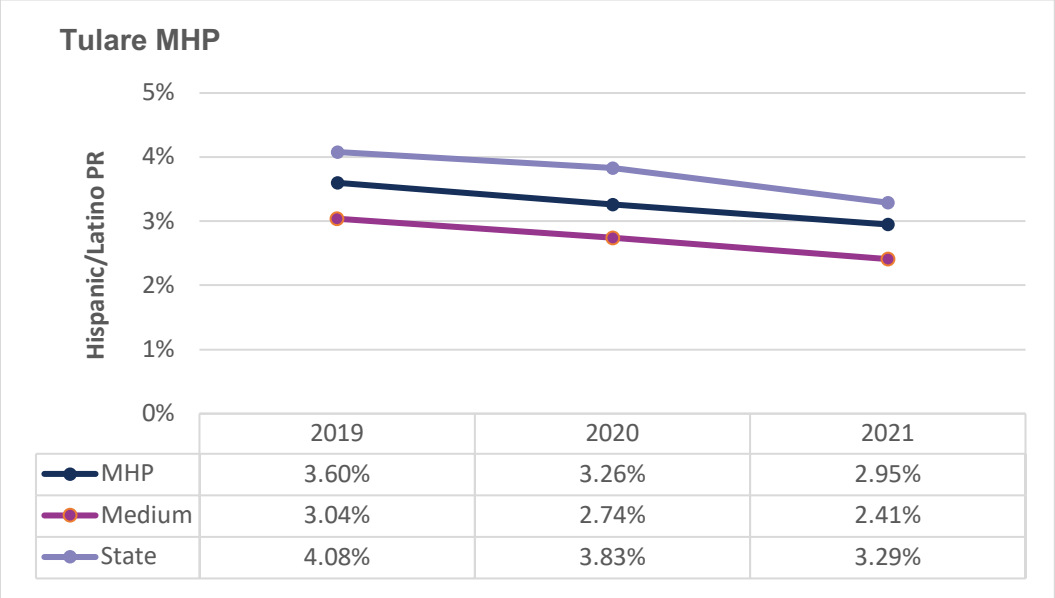
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,594	$5,587	$5,173
Medium	$7,143	$8,399	$7,602
State	$6,316	$7,155	$6,496

- The Tulare MHP AACB continues to be lower than the state as a whole. In FY 2021-22, its AACB was 79.6 percent of the state average.

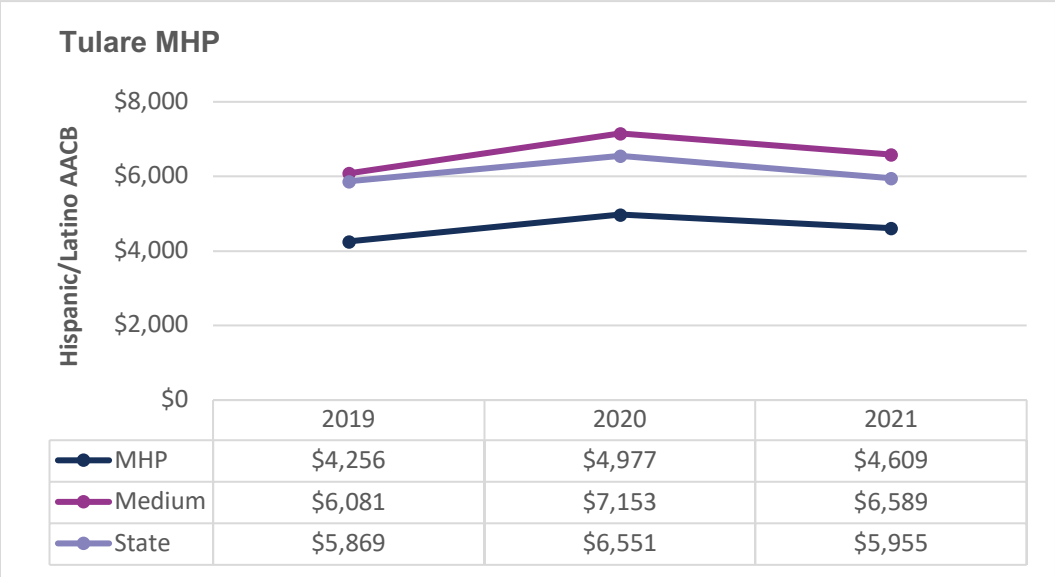
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	3.60%	3.26%	2.95%
Medium	3.04%	2.74%	2.41%
State	4.08%	3.83%	3.29%

- The Hispanic/Latino PR continues to be lower than the statewide PR. It continues to be higher than other medium-sized counties.

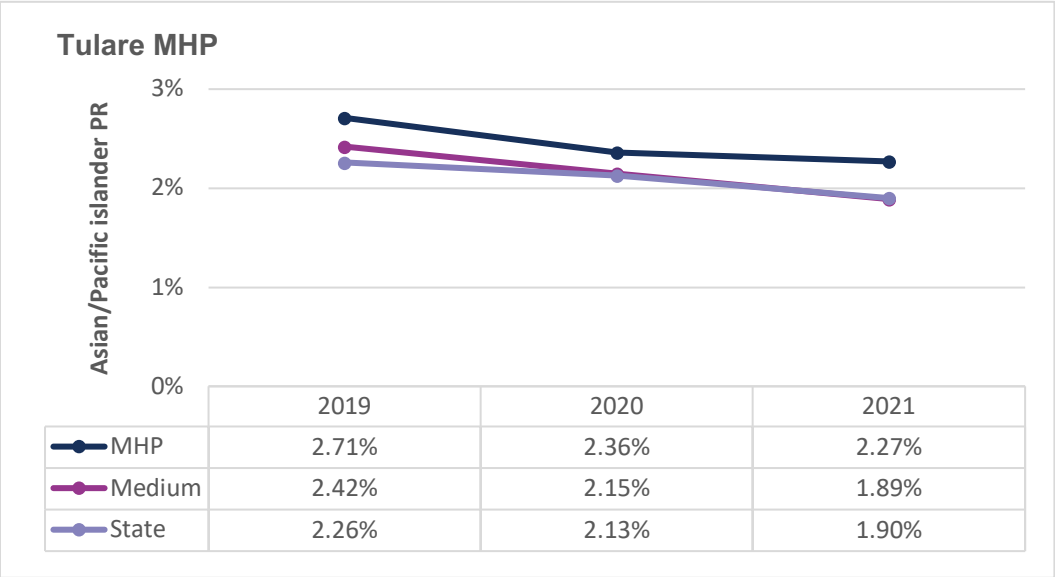
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,256	$4,977	$4,609
Medium	$6,081	$7,153	$6,589
State	$5,869	$6,551	$5,955

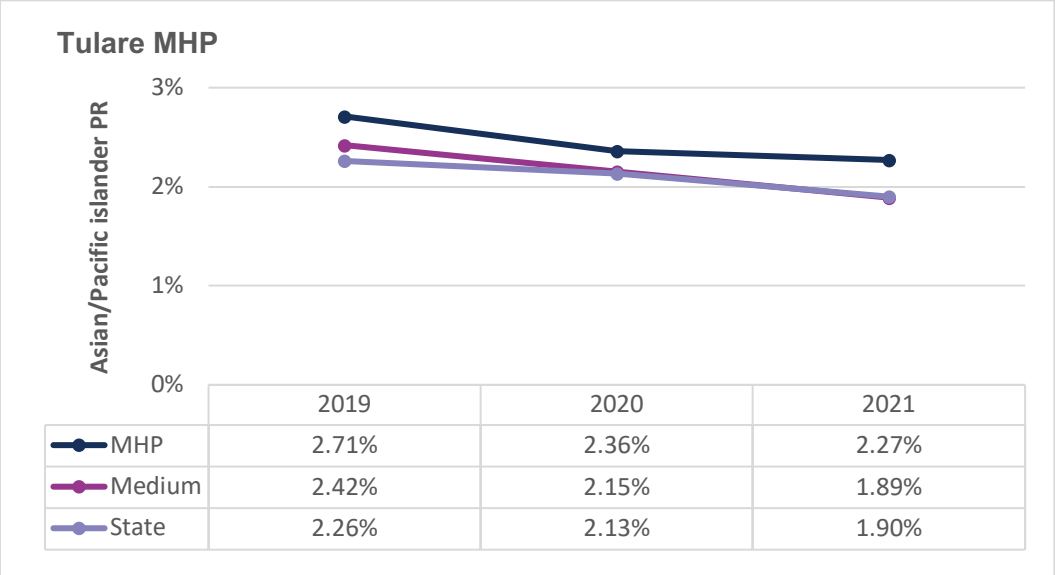
- The Hispanic/Latino AACB continues to be lower than other medium MHPs and the statewide PR.

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



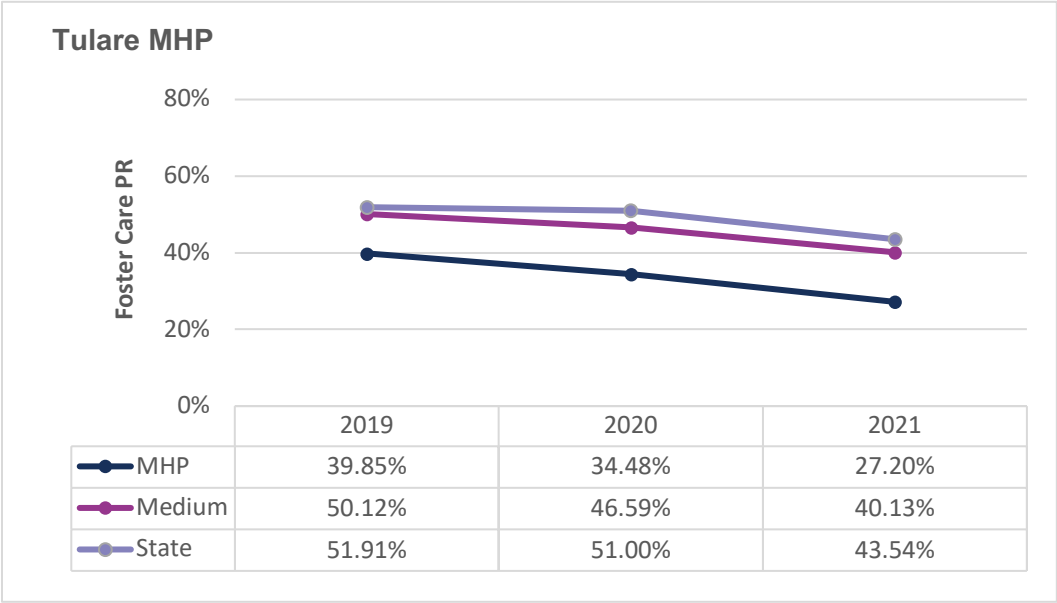
- The Asian/Pacific Islander PR continues to be higher than the state as a whole. In CY 2021, the PR was 19.5 percent higher than the state.

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



- While the Asian/Pacific Islander PR is higher than the state average, the AACB is less than two thirds of the state average. This is a large variation, but the Asian/Pacific Islander population is only 2.3 percent of the beneficiaries and 1.5 percent of those served.

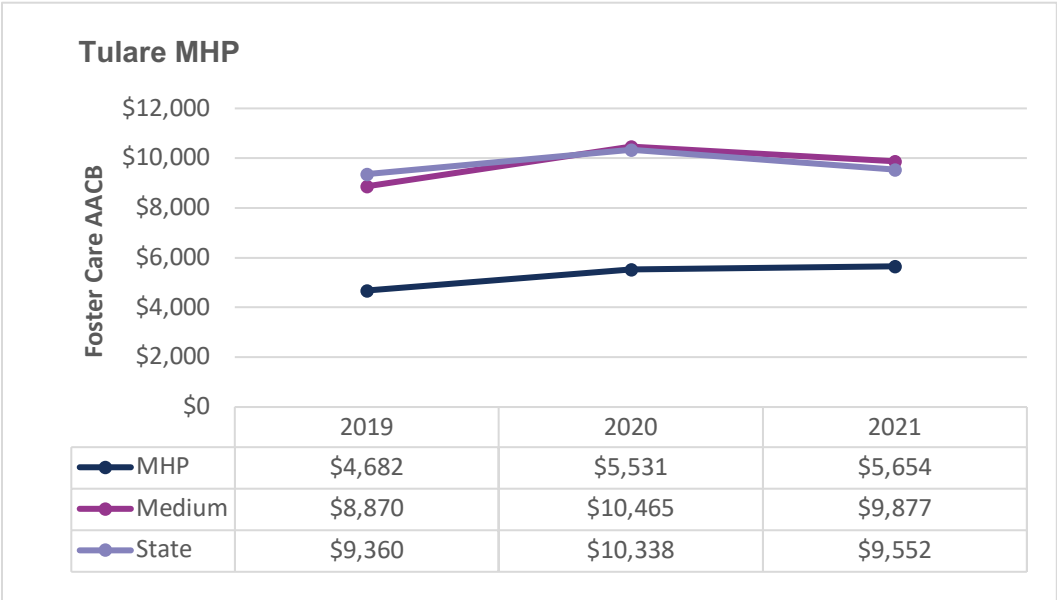
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	39.85%	34.48%	27.20%
Medium	50.12%	46.59%	40.13%
State	51.91%	51.00%	43.54%

- The FC PR is lower than the state average. Some FC services are provided by Child Welfare Services and not billed to the state. The MHP plans to Medi-Cal certify Child Welfare Services' newly renovated facility which will increase the FC PR.
- Many of the FC services for children under five are referred out to other agencies which also contributes to the lower FC PR.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$4,682	$5,531	$5,654
Medium	$8,870	$10,465	$9,877
State	$9,360	$10,338	$9,552

- The relatively low FC AACB is also impacted by the services that are not billed to DHCS.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 4,459				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	792	17.8%	15	8	10.8%	14	8
Inpatient Admin	≤11	-	-	-	0.4%	16	7
Psychiatric Health Facility	≤11	-	-	-	1.0%	16	8
Residential	≤11	-	-	-	0.3%	93	73
Crisis Residential	≤11	-	-	-	1.9%	20	14
Per Minute Services							
Crisis Stabilization	51	1.1%	1,380	1,200	9.7%	1,463	1,200
Crisis Intervention	1,152	25.8%	186	110	11.1%	240	150
Medication Support	2,330	52.3%	285	233	60.4%	255	165
Mental Health Services	2,954	66.2%	459	270	62.9%	763	334
Targeted Case Management	1,933	43.4%	322	138	35.7%	377	128

- The MHP continues to increase their crisis intervention programs which contributes to the high percentage of beneficiaries receiving crisis intervention. The high percentage could also be the result of efforts to correctly bill for the service.
- The MHP has received a grant to build a CSU. Once built some crisis intervention services could result in CSU rather than hospitalization which could bring down the high percentage of beneficiaries receiving inpatient services.

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

Service Category	MHP N = 398				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	24	6.0%	15	10	4.5%	13	8
Inpatient Admin	≤11	-	-	-	≤11	6	4
Psychiatric Health Facility	≤11	-	-	-	0.2%	25	9
Residential	≤11	-	-	-	≤11	140	140
Crisis Residential	≤11	-	-	-	0.1%	16	12
Full Day Intensive	≤11	-	-	-	0.2%	452	360
Full Day Rehab	≤11	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	≤11	-	-	-	2.3%	1,354	1,200
Crisis Intervention	40	10.1%	235	124	6.7%	388	195
Medication Support	126	31.7%	401	307	28.5%	338	232
Therapeutic Behavioral Services	≤11	-	-	-	3.8%	3,648	2,095
Therapeutic FC	≤11	-	-	-	0.1%	1,056	585
Intensive Home Based Services	54	13.6%	356	300	38.6%	1,193	445
Intensive Care Coordination	13	3.3%	1,060	404	19.9%	1,996	1,146
Katie-A-Like	≤11	-	-	-	0.2%	837	435
Mental Health Services	376	94.5%	1,197	680	95.7%	1,583	987
Targeted Case Management	249	62.6%	321	140	32.7%	308	114

- FC youth also have relatively high percentages of beneficiaries receiving crisis intervention and inpatient services.
- The MHP has started to screen all children for Intensive Home Based Services (IHBS) and Intensive Care Coordination (ICC) and expects the numbers receiving those services to go up.

IMPACT OF ACCESS FINDINGS

- The emphasis on crisis intervention and File-based Services (FBS) is part of the MHP's efforts to proactively serve their population and limit escalation of illness. They hired a consultant, Recovery Innovations, to analyze the county's current crisis response system and infrastructure to make recommendations about needed additions. And they were awarded a California Health Facilities Financing Authority grant to expand children's community crisis mobile response team with partners TCOE and to build a CSU with Kaweah Health. These efforts could serve to lower the numbers of county beneficiaries who are hospitalized.
- The MHP demonstrated numerous approaches to serving their Spanish-speaking beneficiaries. For instance, there are efforts at both county-operated and contracted clinics to hire Spanish speaking staff; when a translator is not available in the clinic they use an iPad when using the language line so the beneficiary sees a person rather than just the voice over the phone; they have translated their entire website into Spanish rather than relying on a computerized translation process which doesn't always use correct or culturally appropriate language. The Hispanic/Latino PR continues to be low suggesting that additional strategies to serve this population are warranted.
- The county's higher than state and like county averages, youth PR suggests that the partnership with TCOE is addressing the needs of the school-aged population. This might be at the expense of the adult-aged population, that is lower than state and like county averages, suggesting the need to study capacity within the adult system of care.
- The FC PR and AACB are consistently lower than the state average. This could be a function of services delivered by providers that are not Medi-Cal certified, leaving it difficult to make comparisons to state data. The planned Medi-Cal certification of the Child Welfare Services' newly renovated facility should improve the data that the EQRO generates.
- The low rates of IHBS and ICC services to FC youth suggest additional focus is needed.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- The MHP modified their process to collect first offered and first delivered appointments and moved their referral form to their EHR which made the timeliness data more reliable than when they first started timeliness tracking. The actual outpatient data reported to the EQRO showed that timeliness measures

declined since last year, but the MHP now has more accurate data to make process improvements.

- The MHP puts clinics that meet a DHCS timeliness standard less than 80 percent of the time on a CAP. Data from the first quarter of FY 2022/2023 shows improvement from the previous FY.
- The number of requested first appointments went up substantially in the past year; from 4,895 to 5,503 this year. This creates a challenge towards meeting the timeliness standards.
- The MHP does not have reliable no-show data or policy guiding fidelity of response when there is a no-show.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12 month period of FY 21-22. Table 11 and Figures 12 – 14 below display data submitted by the MHP; an analysis follows. This data represented the entire system of care.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	11.7 Days	10 Business Days*	63.4%
First Non-Urgent Service Rendered	17.6 Days	10 Business Days**	43.4%
First Non-Urgent Psychiatry Appointment Offered	17.4 Days	15 Business Days*	59.7%
First Non-Urgent Psychiatry Service Rendered	21.6 Days	15 Business Days**	50.2%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	39.56 Hours	48 Hours*	85.5%
Follow-Up Appointments after Psychiatric Hospitalization	15.2 Days	7 Days**	53.7%
No-Show Rate – Psychiatry	15.72%	20%**	n/a
No-Show Rate – Clinicians	13.31%	20%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22.			

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

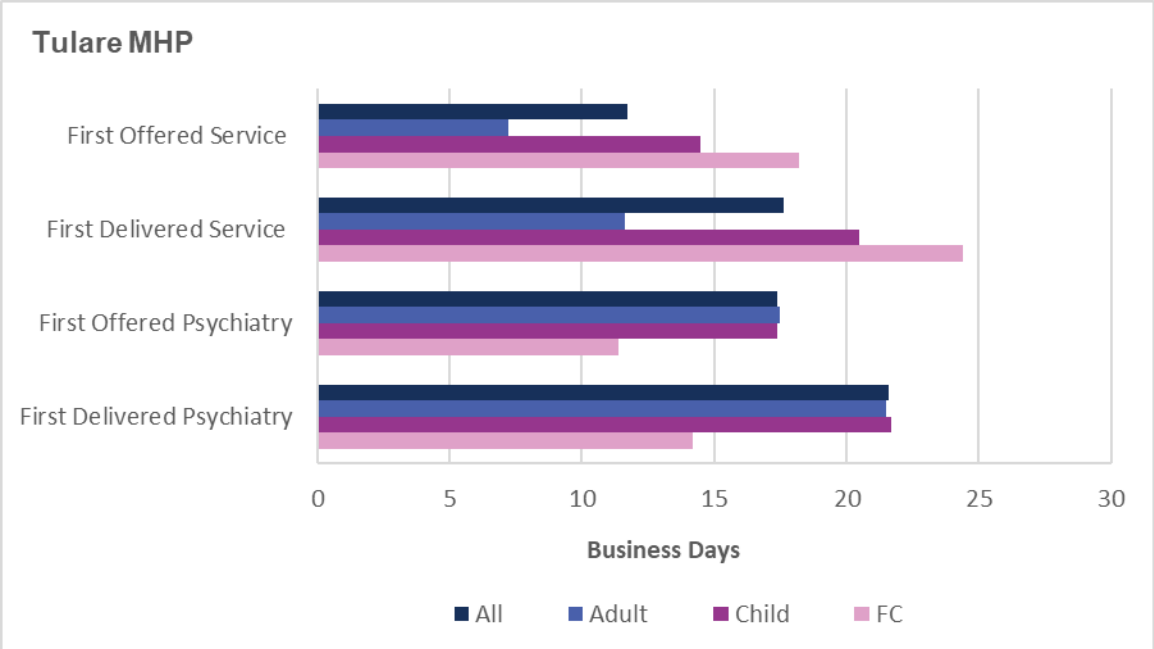


Figure 13: Wait Times for Urgent Services

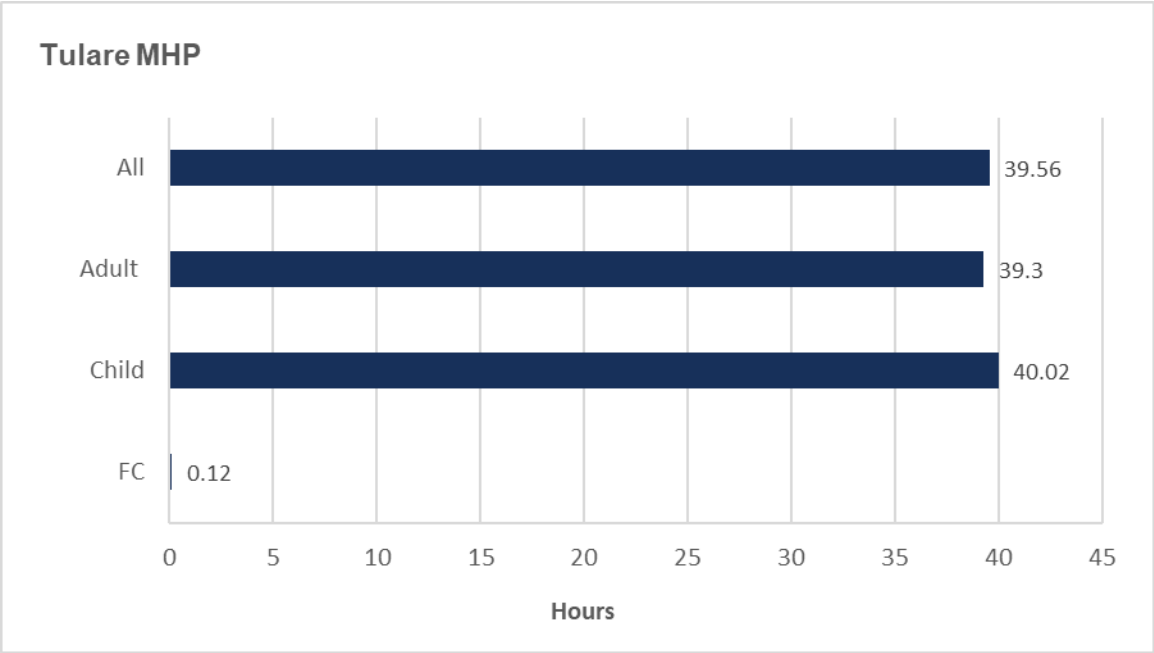
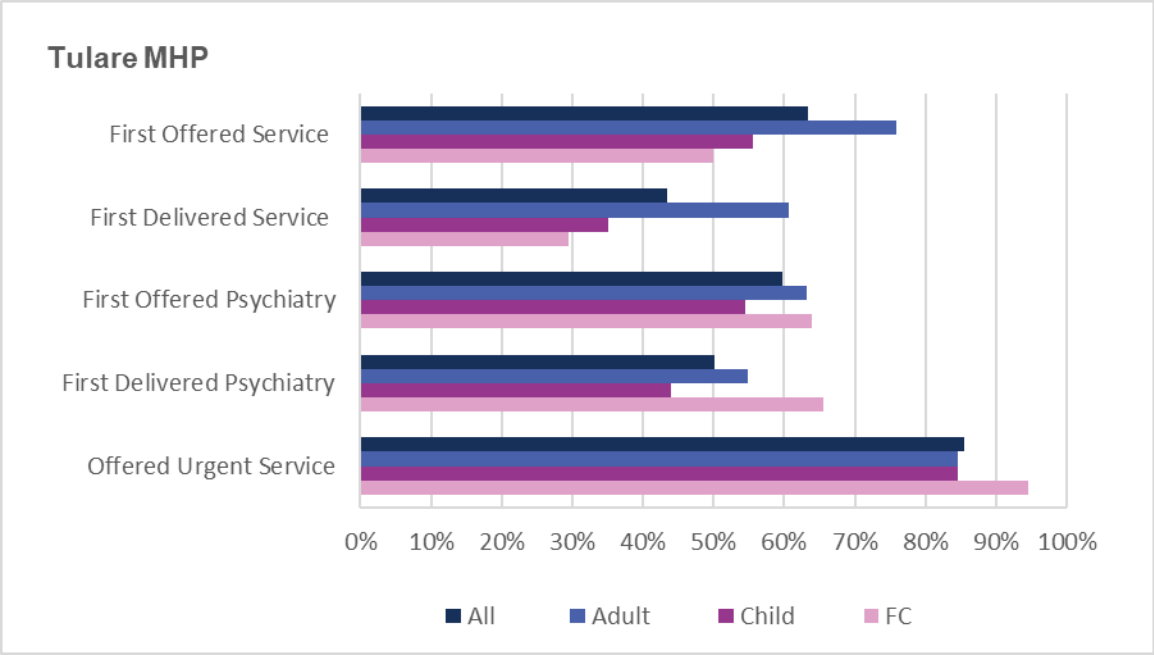


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled and unscheduled assessments.

- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department (ED), or a referral to a CSU. The MHP defined “urgent services” for purposes of the Assessment of Timely Access (ATA) as crisis intervention services not resulting in a hold. There were reportedly 5,298 urgent service requests with a reported actual wait time to services for the overall population at 39.56 hours.
- Timely access to psychiatry may be defined by the County MHP. The process as well as the definitions and tracking may differ for adults and children. The MHP has defined psychiatry access in the submission as from the beneficiary’s initial service request for both adults and children.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 15.72 percent for psychiatrist and 13.31 percent for clinical appointments.

IMPACT OF TIMELINESS FINDINGS

- The MHP tracks and trends crisis care, has a specific team to assist with transitions from inpatient psychiatric facilities, and evidences 7 and 30-day rehospitalization rates lower than the state averages.
- Implementation of psychiatric telehealth contracts has increased timeliness to receive psychiatric services. Collaboration between QI and the medical staff at Medication Monitoring meetings offers another opportunity to strategize ways to improve timeliness to services. The CalAIM initiative, which allows services to be provided before an assessment is completed, has also been beneficial towards providing more timely psychiatric services.
- The number of delivered first appointments went up substantially in the past year and could partially be the result of CalAIM access criteria changes. The increase in appointments demonstrates the need for added capacity at a time when it’s difficult to retain staff.
- While the MHP has put in place CAPs to improve first offered and rendered, clinician and psychiatrist appointments, they’ll need to continue to strategize approaches to improve their timeliness in each of these measures.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is managed through a Division Manager who oversees the MHP, Substance Use Disorder (SUD), and the HER quality oversight. The SUD organizational chart designates QI and QA but the MHP only designates QI. For this review, the MHP provided: the QI Evaluation of FY 2021-22 QI Workplan; the QI Workplan FY 2022-23; the QIC monthly meeting agendas and minutes; the Medication Management policy, agendas and minutes; and a sampling of the adult and children's QIC sub-committees agendas and minutes.

The MHP monitors its quality processes through the QIC. The QIC is comprised of approximately 60 staff, representing county; contractors; administration; clinical; patients' rights; and QI, for both MHP and SUD. The QIC is scheduled to meet monthly and has met as scheduled throughout the pandemic. Sub-committees for cultural competency; medication monitoring; children's services; and adult services report to the QIC.

Submitted QIC documents evidenced significant tracking and trending of compliance to targets. The QI Evaluation of FY 2021-22 and The QI Workplan FY 2022-23 are written as overview documents that are less than 10 pages. The MHP discusses, tracks, trends and develops improvement plans utilizing data in the QIC and sub-committees. These discussions do produce changes, often evidenced by memos or policy changes.

Although many of the QAPI elements appear to occur, the QI documents individually and collectively do not evidence improvement strategies, analysis of strategies/data, or recommendations in a clearly documented QAPI format.

The MHP utilizes a strengths-based assessment and the LOC Utilization System (LOCUS) for LOC determinations for adults. The LOCUS information can be extracted for a consumer at any given time by treatment staff via review of the electronic health record, and used to reflect and influence functional improvement. The LOCUS is also used to not only reflect and influence functional improvement at the treatment level, but is also queried to reflect overall use and consumer outcome for individual programs (reporting units) and sites.

The MHP utilizes the Pediatric Symptoms Checklist (PSC-35) and Child and Adolescent Needs and Strengths (CANS) for minor LOC determinations. CANS is within the electronic health record and can also be accessed at any given time through consumer charts. Tulare County MHP has not yet developed outcomes to report through these CANS data.

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

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Partially Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- Despite an EHR that negatively impacts some data analytics, the MHP develops, tracks, and trends data from aggregate reporting down to end-user applications

and utilizes a CAP process to maintain standards and implement process improvements.

- The MHP has developed a crisis services plan utilizing an external consultant, internal and external provider feedback, and leveraging existing and new fiscal resources as part of a strategic plan of improvement.
- CBOs are actively involved in the QIC, CCP, and policy development MHP efforts.
- Component 3A is partially met due to the MHP not having a current QAPI workplan and evaluation that establishes baselines and time-bound goals to enable tracking of measurable progress to QAPI Work Plan goals and organizational strategic initiatives. The QIC does track several areas independent of the workplan.
- Components 3D, 3G are partially met due to the MHP needing to develop strategies to improve utilization of LOC and outcome data, tracking, and quality oversight of the adult transitions of care between MHP and MCPs.
- Component 3C is partially met in that the MHP would benefit from beneficiary and caregiver feedback in QI processes, including PIPs.
- The MHP does track the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD):
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC):
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM):
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP):

QUALITY PERFORMANCE MEASURES

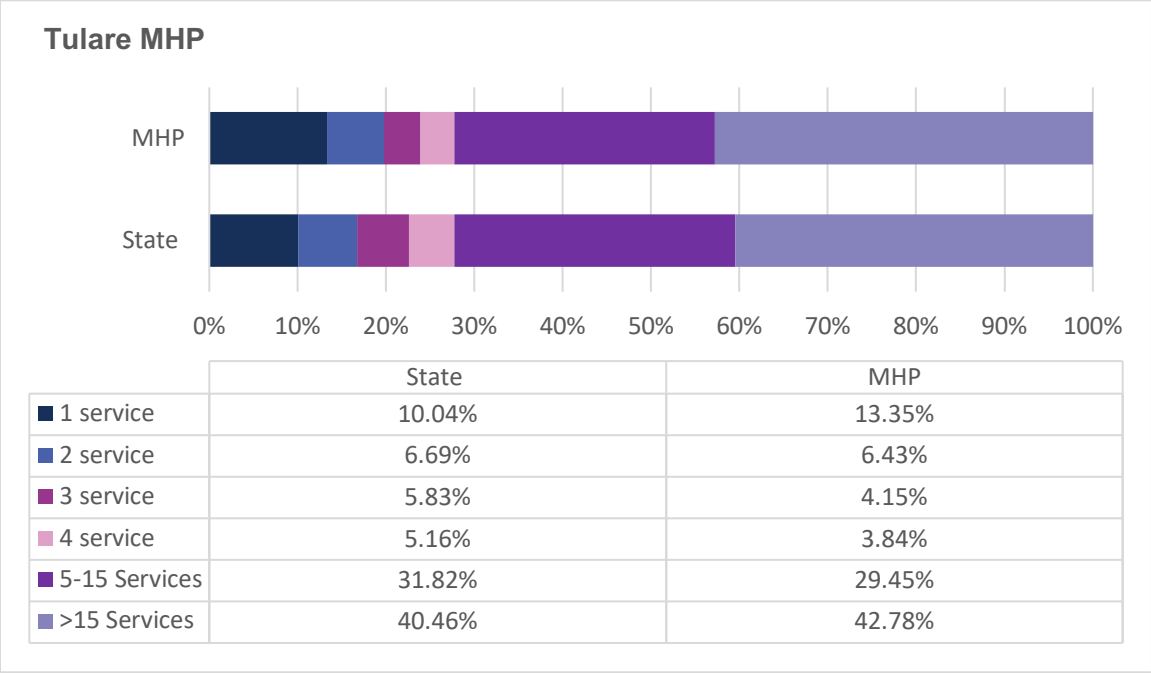
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



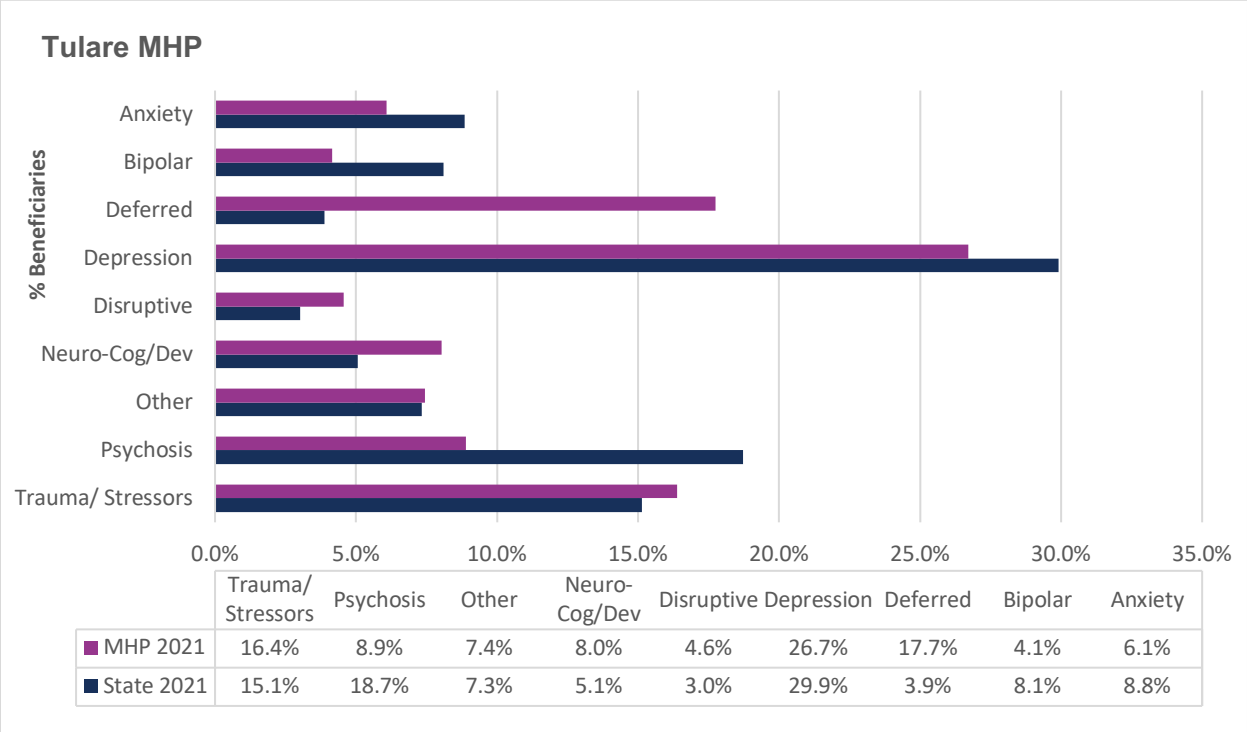
	State	MHP
1 service	10.04%	13.35%
2 service	6.69%	6.43%
3 service	5.83%	4.15%
4 service	5.16%	3.84%
5-15 Services	31.82%	29.45%
>15 Services	40.46%	42.78%

- The MHP's retention data is similar to the state average. The MHP has a slightly higher percentage that receive only one service or more than 15 services.

Diagnosis of Beneficiaries Served

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

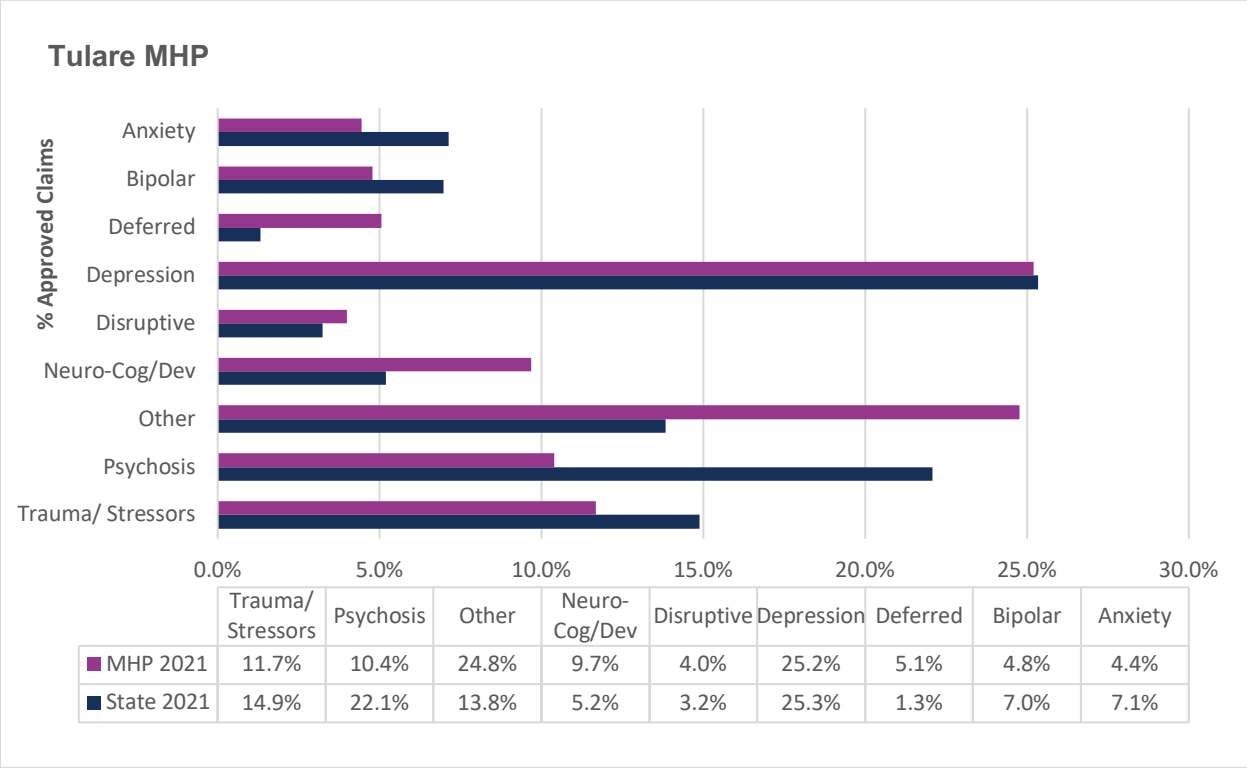
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	16.4%	8.9%	7.4%	8.0%	4.6%	26.7%	17.7%	4.1%	6.1%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- The MHP diagnoses bipolar and psychosis significantly less than the state averages; anxiety and depression less than the state averages; deferred significantly more than the state average; and disruptive and neuro-cognitive/development more than the state averages.

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



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	11.7%	10.4%	24.8%	9.7%	4.0%	25.2%	5.1%	4.8%	4.4%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- The MHP has a lower percentage of beneficiaries and claims with anxiety, bipolar and psychosis diagnoses.
- While the percentage of beneficiaries with a trauma/stressor diagnosis is higher than the state average, the percentage of approved claims is lower.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	825	1,549	10.08	8.79	$15,026	$12,052	$12,396,185
CY 2020	852	1,842	9.90	8.68	$15,578	$11,814	$13,272,532
CY 2019	813	1,453	9.52	7.63	$13,255	$10,212	$10,775,957

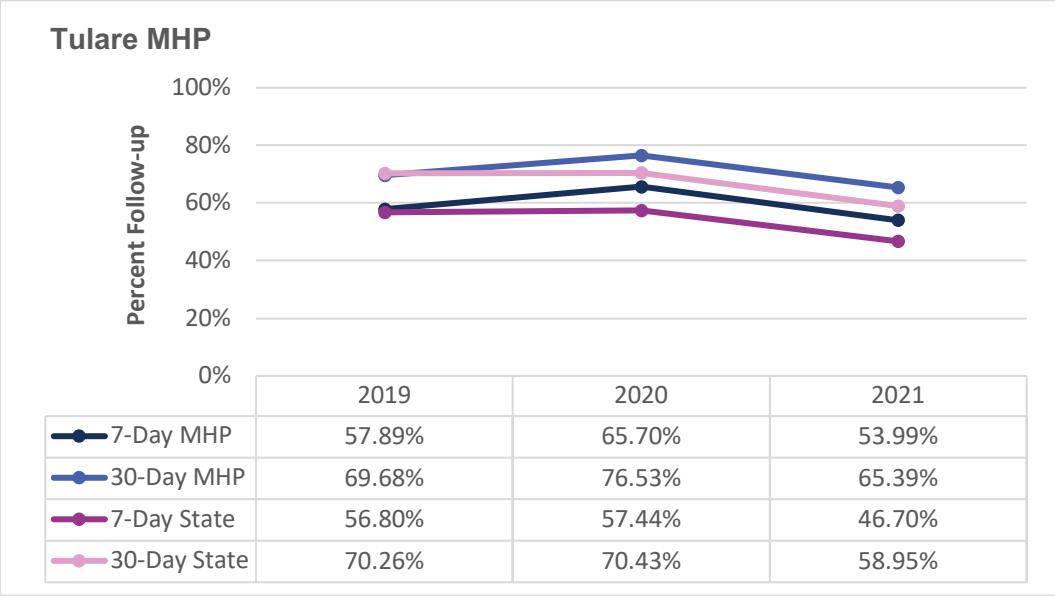
- Both the beneficiary count and the total number of inpatient admissions went up from CY 2019 to CY 2020 and down from CY 2020 to CY 2021. The average LOS has gone up each year from CY 2019 to 2021, however as seen below in Figure 19 readmission rates went down in CY 2021.

Follow-Up Post Hospital Discharge and Readmission Rates

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

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

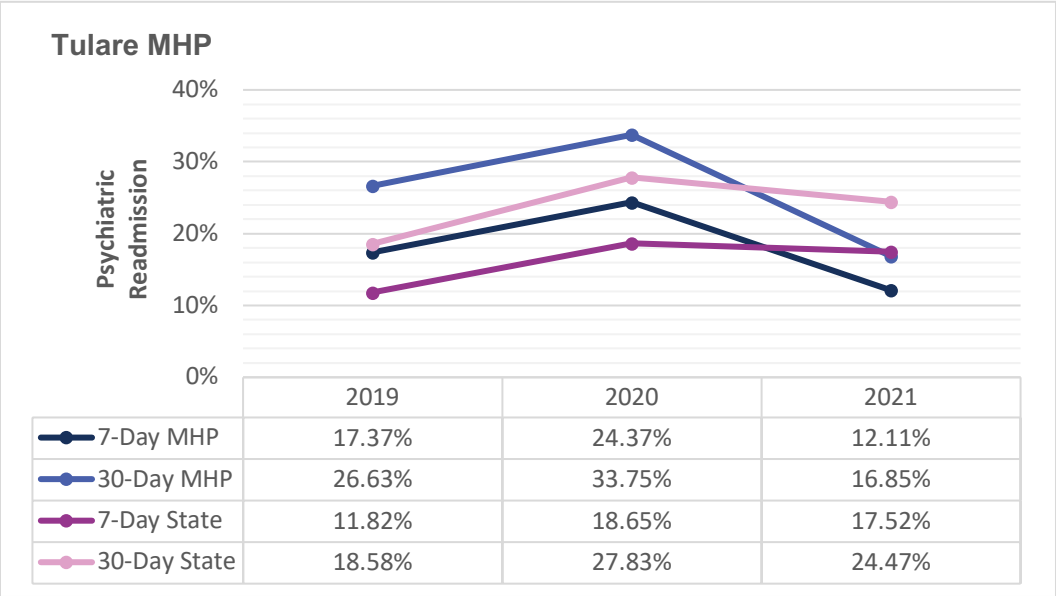
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	57.89%	65.70%	53.99%
30-Day MHP	69.68%	76.53%	65.39%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

- In both CY 2020 and 2021 the MHP had a higher percentage of psychiatric inpatient follow-up appointments at both 7- and 30-days than the state average.

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



	2019	2020	2021
7-Day MHP	17.37%	24.37%	12.11%
30-Day MHP	26.63%	33.75%	16.85%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The MHP had significant drops in readmission rates in CY 2021 at both 7- and 30-days.
- The MHP has a unit dedicated to hospital discharges that insures there is a follow-up appointment scheduled before discharge.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $6,496, the median amount is just $2,928.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent

of the statewide beneficiaries are “low cost” (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

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

Entity	Year	HCB Count	Total Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	545,147	3.46%	$53,476	$43,231
MHP	CY 2021	182	9,615	1.89%	$57,626	$45,790
	CY 2020	195	9,924	1.96%	$58,976	$43,007
	CY 2019	158	10,491	1.51%	$55,642	$43,183

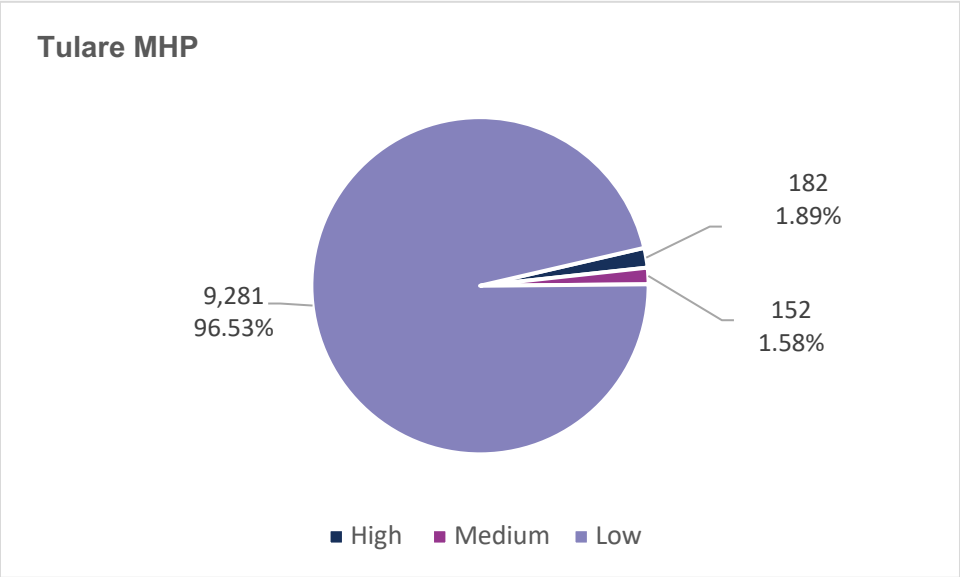
- The continues to have a lower than average percentage of HCB. Their average HCB AACB is higher than the state average.

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	152	1.58%	$3,684,904	7.41%	$23,874	$23,746
Low Cost (Less than $20K)	9,281	96.53%	$34,851,930	71.21%	$3,436	$2,666

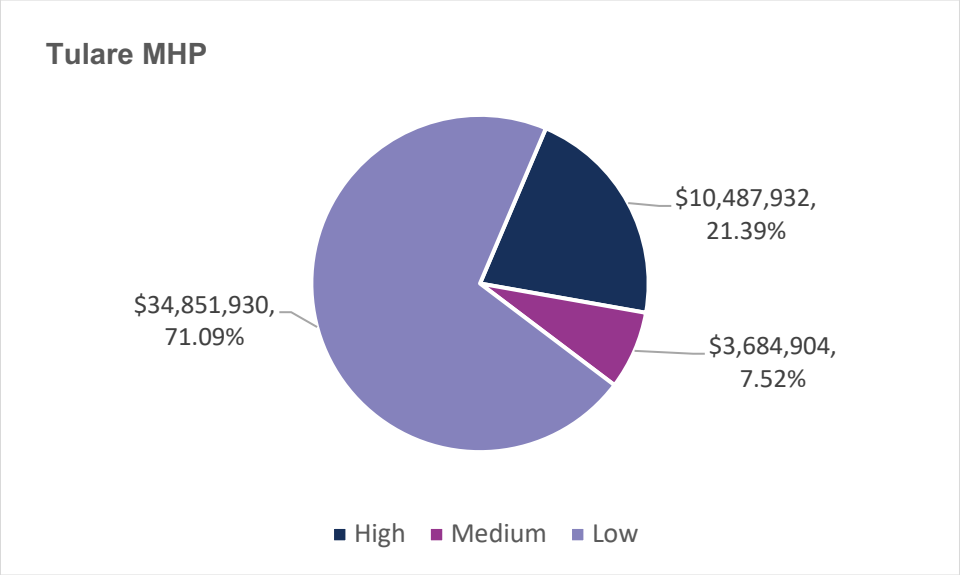
- The percentage of medium cost beneficiaries is also low, leaving the vast majority of beneficiaries in the low-cost category.

Figure 20: Proportion of Beneficiary Count by Claim Amount Grouping CY 2021



- As noted above the vast majority of beneficiaries are in the low-cost category.

Figure 21: Approved Claims by Claim Amount Grouping



- The distribution of approved claims is more evenly divided with 21.39 percent serving the HCB, 7.52 percent serving the medium cost beneficiaries and the remaining 71.09 percent serving the low-cost beneficiaries.

IMPACT OF QUALITY FINDINGS

- The MHP could review the high percentage of beneficiaries and claims with a deferred diagnosis to ensure diagnoses are determined timely and entered into the EHR once confirmed.
- The emphasis on crisis intervention and FBS is part of the MHP's efforts to proactively serve their population and limit escalation of illness. This is supported by the data they provided. From FY 2020-21 to FY 2021-21 the number of crisis contacts increased by 16.7 percent from 5,823 to 6,796, while the number of hospitalizations resulting from the crisis intervention services decreased from 1,561 to 1,500.
- While the MHP's average LOS has been going up, the MHP had significant drops in readmission rates in CY 2021 which might be attributed to the MHP's partnership with Kaweah Health Medical Center. That might have also contributed to the better than state average psychiatric inpatient follow-up rates. The improved readmission rate suggests that the higher LOS together with improved follow-up rates are providing better outcomes for hospitalized beneficiaries.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Fields Based Backup Crisis Response for Young People

Date Started: October 2021

Aim Statement: The aim is, over two years, to increase mental health crisis response in the field to individuals 21 years of age and younger, in grades kindergarten through 12 (K-12), from 8:00 a.m. to 5:00 p.m., Monday through Friday, by 4 percentage points per year in order to: lower the percentage going to a hospital ED for a crisis by 2 percentage points per year. A new mobile unit will provide backup crisis response in the field for young people. County and county-contracted specialty mental health clinics that regularly respond to young people in crisis can request the unit to respond in the field to crises in their catchment areas when they cannot respond in the field, or when they think the unit might be able to respond more quickly than they can.

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

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

Target Population: Individuals 21 years of age or younger in grades K-12 who experience a mental health crisis from 8:00 a.m. to 5:00 p.m., Monday through Friday.

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

Summary

This PIP enhances the County and CBO outpatient provider network response system Monday-Friday 8am to 5pm, with a backup mobile crisis response team, the FBS program. The FBS is operated by the Tulare County Office of Education's Behavioral Health Services (TCOE BHS) unit. The PIP is expected to increase field-based responses, reduce ED responses, and reduce psychiatric hospitalizations. The PIP produced a statistically significant increase in the percentage of crisis responses made in the field as well as statistically significant decrease in the percentage of crisis responses made to hospital EDs. This project originally included a third performance measure: "The percentage of mental health crises that result in a 5150 or 5585." The Project Team discussed this measure at length. The members concluded on June 1, 2022, that a reduction in the number of 5150s and 5585s was not a desirable goal. They are necessary and best for an individual in crisis, in some circumstances. The Team does not want to send the message that 5150s and 5585s are to be avoided.

TA and Recommendations

As submitted, this clinical PIP was found to have high confidence, because: the PIP maintained fidelity of the interventions, met regularly to track, trend, and analyze the data and implemented process improvements.

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

- The MHP invited the EQRO reviewer to join the PIP data reviews on a quarterly basis.
- Examine the antecedents, and discuss interventions as appropriate, of youth and families that directly access EDs.
- Examine the antecedents, and discuss interventions as appropriate, for the increase in youth crisis response requests.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Mental Health Outreach to and Engagement with the Homeless

Date Started: January 2022

Aim Statement: The aim of this two-year PIP is that, by increasing outreach to and engagement with the homeless population, more homeless individuals will complete intakes and receive specialty mental health services (Targets: 25 percent increase over two years in the MHP and 15 individuals per year due to the Multi-Disciplinary Team [MDT]) and become housed (Target: 15 per year contacted by the MDT moving into permanent housing).

The MDT – which includes a mental health clinician, alcohol and other drugs specialists, a social service worker, a Self-Sufficiency Counselor, a Health Education Assistant, and a Unit Manager – will provide outreach and refer individuals to a variety of services and supports, including housing. In the domain of mental health, the clinician will conduct screenings and assessments and connect willing individuals to providers of SMHS.

Target Population: Homeless beneficiaries

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

Summary

Interventions include: outreach by the MDT to homeless individuals, development of rapport and trust, and connection to a variety of needed services and supports; completion of mental health screenings for willing individuals by the MDT; and completion of mental health assessments by the MDT mental health clinician; referrals of Serious and Persistent Mentally Ill homeless individuals to MHP providers of clinical services and attempting to engage them in clinical services.

Performance Measure 1 is the number of unique homeless individuals who completed intakes and started to receive clinical services from MHP providers. There was a 36 percent increase in this measure, from 129 in 2020-21 to 176 in 2021-22. This exceeds the target for this project of 161 individuals (a 25 percent increase over baseline) by 12-31-2023.

Performance Measure 2 is the number of homeless individuals assessed by the MDT mental health clinician and who received at least one clinical service. There have been two such individuals thus far. The target is 15 per year. The program is not on track to meet or exceed this target in this first year of implementation.

Performance Measure 3 is the number of homeless individuals contacted by the MDT who have moved from shelters to permanent housing. There were seven such individuals. The program is nearly on track to meet or exceed the target of 15 in its first year of implementation.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the PIP has been impacted by staff shortages. There are many variables impacting beneficiary homelessness.

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

- Involve peers with homeless lived experience in the PIP processes.
- Utilize data review and analysis to map barriers and identify variables in need of further interventions.
- Utilize data review and analysis to develop specific PIP improvement strategies.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is the Netsmart Avatar system, which has been in use for ten years. Currently, the MHP plans to implement the CalMHSA Streamline SmartCare semi-statewide EHR in July, 2023.

Approximately three percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 634 named users with log-on authority to the EHR, including approximately 222 county staff and 412 contractor staff. Support for the users is provided by eight full-time equivalent IS technology positions. Currently there is one IS vacancy.

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

Contract providers who provide in-county outpatient services enter beneficiary practice management and service data directly into the MHP's EHR. Out of county and residential service data is e-mailed and/or faxed to the MHP as reported in the following table:

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	84%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	16%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP has a fully functional PHR which provides appointment and active medication information and allows the beneficiary to securely send and receive text messages.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: MH CBO/Contract Providers, Alcohol and Drug CBO/Contract Providers (SUD).

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP has a number of strengths in the IS area:
  - They were among the first counties to begin submitting the Network Adequacy Certification Tool data via the standard transaction.
  - They use their PHR for viewing active medications and secure communications with the treatment team as well as appointment information.
  - They stratify timeliness data by non-English speakers.
  - They stratify Consumer Perception Survey (CPS) data by provider site.
  - They have a data interface with the Managed Care Plan to support the CalAIM Enhanced Care Management initiative.
- The MHP received a partially met in Integrity of Data Collection and Processing because they don't have a data warehouse. They plan to implement a data warehouse in the coming year to store the data of beneficiaries who haven't been seen for some time and won't be brought into the SmartCare EHR.
- The MHP received a partially met Security and Controls rating because they don't test an operations continuity plan annually, have a standard to restore the EHR if it goes down or use two-factor authentication throughout the MHP. All of these items will be reevaluated as they convert to the SmartCare semi-statewide EHR.
- Contract providers have not been involved in the SmartCare implementation from either a planning or communications perspective.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

For the MHP, it appears that significant claims lag begins in November and likely represents $7,000,000 in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through June 2022.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	19,348	$4,088,772	$140,503	3.44%	$3,948,269
Feb	20,160	$4,211,000	$136,845	3.25%	$4,074,155
Mar	23,173	$4,834,088	$147,641	3.05%	$4,686,447
April	21,569	$4,637,225	$124,671	2.69%	$4,512,554
May	20,198	$4,324,721	$102,056	2.36%	$4,222,665
June	18,960	$4,042,564	$116,763	2.89%	$3,925,801
July	15,924	$2,952,265	$82,580	2.80%	$2,869,685
Aug	15,837	$2,899,158	$76,022	2.62%	$2,823,136
Sept	19,314	$3,482,079	$78,194	2.25%	$3,403,885
Oct	15,203	$2,780,688	$36,410	1.31%	$2,744,278
Nov	2,983	$569,307	$1,898	0.33%	$567,409
Dec	4	$1,249	$0	0.00%	$1,249
Total	**192,673**	**$38,823,116**	**$1,043,583**	**2.69%**	**$37,779,533**

- The November and December claims appear to be incomplete.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B or Other Health Coverage must be billed before submission of claim	2,083	$535,575	51.32%
Claim/service lacks information which is needed for adjudication	1,850	$439,421	42.11%
Beneficiary not eligible or non-covered charges	173	$42,645	4.09%
Service line is a duplicate and a repeat service procedure code modifier not present	88	$18,151	1.74%
National Provider Identifier related	28	$5,626	0.54%
Other	14	$2,165	0.21%
Total Denied Claims	4,236	$1,043,583	100.00%
Overall Denied Claims Rate	2.69%		
Statewide Overall Denied Claims Rate	2.78%		

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP has been a leader in some aspects of IS such as utilizing function rich features of the PHR and submission of the Network Adequacy Certification Tool data using the standard transaction set. They look at data in some unique ways such as timeliness specifically for non-English speakers and they use data to inform decision making and improve processes.
- Implementation of the SmartCare EHR is expected to standardize mandated reporting and timeliness tracking which will allow the MHP to better utilize the data they generate to improve care for their beneficiaries.
- CBOs provide over 70 percent of services delivered yet the CBOs have not had any role in the SmartCare project. For a successful implementation it's important to have all who will be impacted by the new EHR informed of what's coming and where possible have an active role in the project.
- The MHP will need to implement a plan of how to retain and provide access to historical beneficiary data that will not be converted into SmartCare. They do not have a data warehouse at this time and will be exploring options including use of a CalMHSA data warehouse or purchase and implementation of one for their own use.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP attempted, without success, to work with UCLA to improve the relevance of the data by identifying program specific data. The aggregate data was presented in the QIC and relevant subcommittees. The current year's report has not yet been received.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held via a telehealth platform and included 10 participants; a language interpreter was not needed for this focus group. All consumers participating receive clinical services from the MHP.

The adult beneficiaries universally reported that they initially accessed services more than a year ago and did not know the current access timelines.

Sessions ranged from bi-weekly to every three months (medication only). Face-to-face and telehealth appointments are offered. Appointment reminder texts and phone calls are received and missed appointments are followed up by MHP staff. All beneficiaries reported general satisfaction with their case manager, clinician and/or doctor, and the services provided. All indicated that the MHP gives them a sense of hope. All reported that their family members or loved ones have been included in their treatment or could be if needed. None of the beneficiaries interviewed were monolingual Spanish speaking but one beneficiary indicated they knew you could receive services in Spanish. Although

none of the beneficiaries have needed crisis services recently, they all were able to describe how they could access their care team. When asked about transportation assistance, bus passes provided by the MHP staff was the most common answer followed by their own transportation or family assistance.

Regarding MHP communication, none of the beneficiaries seemed to know how to get information about the MHP or how to be involved in any MHP committees or decision-making processes. Beneficiaries knew of the Wellness Centers.

Recommendations from focus group participants included:

- “Please listen more.”

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of parents and caregivers who’s youth initiated services in the preceding 12 months. The focus group was held via a telehealth platform and included 10 participants; a language interpreter was not used for this focus group. All parents and caregivers participating have at least one family member who receives clinical services from the MHP.

Only a few participants indicated initial access occurred in the last year, with time ranging from immediately (crisis access) to a few months. Most receive clinical services on a weekly or bi-weekly basis. Transportation is primarily by the family and other options were not universally known. Missed appointments are rescheduled. Appointment reminders are sent out regularly. Services range from at school, in-clinic, telehealth (phone and video). Almost universally the participants reported satisfaction and a sense of hope from the services received.

Universally the group did not seem to know how to get information about the department or how to be involved in department decision making. None of the participants had attended any MHP committees or workgroups.

Recommendations from focus group participants included:

- Share more information with parents.
- Offer more parent and caregiver support groups.
- It would be good to have a mentor (parent/partner) peer available.
- Increased frequency of therapy sessions.
- Reduce changing primary therapist.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall beneficiaries and caregivers report that they appreciate and benefit from the services provided. Stability of care provider case assignments and increased services was a common desire mentioned.

CONCLUSIONS

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

STRENGTHS

1. The MHP has a robust outcomes oriented CCP and CCC as evidenced by over 50 percent of staff being Spanish speaking; use of iPads in the field to allow for face-to-face translation; production of a non-English ATA for PI efforts; and active management involvement in the CCC. (Access)
2. The MHP has improved data tracking of timeliness measures, incorporated a CAP model of timeliness PI, and has plans to further improve data analytics tracking, trending and PI efforts through the implementation of a new EHR. (Timeliness, Quality, IS)
3. The MHP's strategic planning incorporates CalAIM initiatives; the crisis services continuum; routine care systems; peer certification; HR flexibilities; and direct staff and CBO systematic bidirectional communication. (Quality)
4. The MHP has implemented a hybrid work environment that allows some staff to split workdays between tele and office-based work. The impact improves staff recruitment and retention; staff morale; and beneficiary flexibility of choice between tele, field, or office-based appointments. (Quality)
5. The MHP is in the first adopters cohort of the CalMHSA semi-statewide EHR, SmartCare, implementing July 2023. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The access and treatment transitions of adult care coordination between the MHP and MCP are not tracked; trended; monitored; analyzed; or coordinated utilizing LOC tools and standardized procedures. (Access)
2. In the context that the number of first-time access and psychiatric appointment requests went up substantially in the past year, the MHP averages meeting the offer of the DHCS standards for assessment and first psychiatric service between 50 and 64 percent of the time, with children's services lagging adult services. The current application of CAPs to focus on timeliness PI is very promising. (Timeliness)
3. The MHP does not adhere to a QAPI plan format that specifies quality improvement targets, analysis, and recommendations. Although beneficiaries or

families have been invited, there is little evidence of regular beneficiary input into QAPI, PIP, and QIC decision-making processes. (Quality)

4. The MHP does not evidence accurate no-show tracking or trending and does not have a standardized no-show policy or procedure with fidelity monitoring. (Quality)
5. To ensure a successful SmartCare implementation, both from a technical and acceptance perspective, it would be beneficial to include contract providers in the SmartCare planning phases as soon as possible and to develop a communications plan to keep all stakeholders informed of the coming changes. (IS)

RECOMMENDATIONS

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

1. Investigate reasons and develop strategies to improve the access and treatment transitions of adult care coordination between the MHP and MCP by tracking; trending; monitoring; analyzing; and coordinating, utilizing LOC tools. It is further recommended that the MHP utilize the DHCS CalAIM Access and Screening Tool January 2023 implementation, and all other relevant CalAIM initiatives, in this effort. (Access)

   (This recommendation is a partial carry-over from FY 2021-22.)
2. Investigate reasons and develop strategies to improve the timeliness to first non-urgent services rendered, first non-urgent psychiatry appointments offered, and first non-urgent psychiatry appointments rendered. (Timeliness)

   (This recommendation is a partial carry-over from FY 2021-22.)
3. Develop and adhere to a QAPI plan format that specifies QI targets, analysis, and recommendations, and perform an annual evaluation of the plan. This could be completed by merging the QIC work with the QAPI plan. Include strategies to increase engagement of beneficiaries' input into QAPI, PIP, and QIC decision making processes. (Quality)

   (This recommendation is a partial carry-over from FY 2021-22.)
4. Investigate reasons and develop strategies to develop and adhere to accurate no-show tracking or trending including a standardized no-show policy or procedure with fidelity monitoring. (Quality)
5. Include contract providers in the SmartCare planning phases as soon as possible and develop a communications plan to keep all stakeholders informed of the coming changes. (IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT F: PM Data CY 2021 Refresh

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: CalEQRO Review Agenda

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

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Bill Walker, Quality Reviewer
Zena Jacobi, Information Systems Reviewer
Walter Shwe, Consumer Family Member

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-review and the post-review meetings and in preparing the recommendations within this report.

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Huff	Alisa	Program Director	Turning Point (TP)
Ruddy	Andrew	Staff Service Analyst, QI, Managed Care	TCBH
Sahagun	Angela	EHR Manager	TCBH
Citi	Aziza	Children's Authorization, QI Manager	TCBH
Ennis	Casie	Division Manager, Clinical Services	TCBH
Stapleton	Chad	HHSA	TCBH
Hernandez	Cynthia	Mental Health Clinic Manager	TCBH
Massey	Darcy	Family Advocate Manager, Managed Care	TCBH
Montes	Deanna	Budget Officer, Mental Health	TCBH
Hutcheson	Debbie	Administrative Specialist, QI, Managed Care	TCBH
Allen	Decinda	Children Authorization, QI, Managed Care	TCBH
Burlingame	Elodia	Staff Service Analyst, QI, Managed Care	TCBH
Rivas	Gilberto	Division Manager, Behavioral Health	TCBH
Zweifel	Grant	LMFT, URC & PRC, QI, Managed Care	TCBH
Rangel	Irma	Regional Clinical Director,	Turning Point
Blackmon	Jeff	Administrative Specialist, QI, Managed Care	TCBH
Newell	Jennifer	Clinical Director	TCOE
Hamilton	Joseph	Clinic Administrator	Porterville Mental Health Clinic
Mikesell	Kevin	Fiscal Manager, HHSA	TCBH

Last Name	First Name	Position	County or Contracted Agency
Love	Lester	Mental Health Medical Director	TCBH
Mason	Liz	LMFT, Clinic Administrator	TCBH
Cruz	Michele	MHSA Manager, Mental Health	TCBH
Kociemba	Michele	Cost Report	TCBH
Guglielmo	Monica	Supervisor, EHR	TCBH
Bolin	Natalie	Deputy Director, Clinical Services	TCBH
Stewart	Robert	Director of Fiscal Operations	TCBH
Zavala	Tim	Executive Director	Tulare Youth Services Bureau (TYSB)
Urrutia	Deisi	Clinical Supervisor, Dinuba Children's Services	TCBH
Bryan	Erin	Clinical Supervisor, Visalia Adult Integrated Clinic	TCBH
Castro	Gerardo	Clinical Supervisor, Porterville Mental Health Clinic	TCBH
Lucatero	Leticia	Clinical Supervisor,	Sequoia Youth Services
Forsyth	Michele	Clinical Supervisor, Porterville Mental Health Clinic	TCBH
Nace	Rebecca	Clinical Supervisor	TCOE
Mora	Alena	Program Director	Dinuba Children's Services
Gomez	Angela	Assistant Clinical Director	TCOE
Dodd	April	Clinical Supervisor	TYSB
Valdez	Artemisa	Regional Director	Kings View

Last Name	First Name	Position	County or Contracted Agency
Gates	Michael	Program Director	Turning Point MHSA
Rivas	Sandra	QI Manager	TYSB
Pinkerton	Toni	Program Director	TYSB
Farias	Victoria	Assistant Regional Director	Kings View
Cochran	Caitlin	Clinician, Visalia Adult Integrated Clinic	TCBH
Magallanes	Diana	Clinician	Visalia Youth Services
Bravo Mendoza	Elsa	Clinician, Porterville Mental Health Clinic	TCBH
Evaro	Jeanette	Clinician	Turning Point MHSA
Palafox	Jose	Clinician,	TCOE
Pendley	Nicole	Clinician, Porterville Mental Health Clinic	TCBH
Raya	Olga	Clinician	TYSB
Meader	Jeff	Division Manager, IT	TCBH
Jones	Jon	Manager, IT	TCBH
Salgado	Lawrence	Manager, IT	TCBH
Guglielmo	Monica	Supervisor, EHR	TCBH
Padjan	Nancy	Medical Billing Manager, HHSA	TCBH
Mock	Tyson	Deputy Director of IT	TCBH
Maldonado	Veronica	Staff Analyst, QI, Managed Care	TCBH

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	As submitted, this clinical PIP was found to have high confidence, because: the PIP maintained fidelity of the interventions, met regularly to track, trend, and analyze the data and implemented process improvements.
General PIP Information	
MHP/DMC-ODS Name: TCBH	
PIP Title: Fields Based Backup Crisis Response for Young People	
PIP Aim Statement: The aim is, over two years, to increase mental health crisis response in the field to individuals 21 years of age and younger, in grades kindergarten through 12 (K-12), from 8:00 a.m. to 5:00 p.m., Monday through Friday, by 4 percentage points per year in order to: lower the percentage going to a hospital ED for a crisis by 2 percentage points per year. A new mobile unit will provide backup crisis response in the field for young people. County and county-contracted specialty mental health clinics that regularly respond to young people in crisis can request the unit to respond in the field to crises in their catchment areas when they cannot respond in the field, or when they think the unit might be able to respond more quickly than they can.	
Date Started: 10/2021	
Date Completed: Not completed	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Individuals 21 years of age or younger in grades K-12 who experience a mental health crisis from 8:00 a.m. to 5:00 p.m., Monday through Friday.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Outpatient or a new field-based response team will response to crisis response requests M-F, 8AM to 5PM in order to provide as many of the crisis responses in the field as possible and not send to the ED or hospitals as the first intervention.
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): Outpatient or a new field-based response team will response to crisis response requests M-F, 8AM to 5PM in order to provide as many of the crisis responses in the field as possible and not send to the ER or hospitals as the first intervention.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. The percentage of crisis responses that are made in the field	July 2020 – June 2021	n=945 44.7%	July – Sept. 2022	n=297 60.2%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
PM 2. The percentage of crises that are responded to in an ED	July 2020 – June 2021	n=945 32.6%	July – Sept. 2022	n=297 20.2%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- Examine the antecedents, and discuss interventions as appropriate, of youth and families that directly access EDs.
- Examine the antecedents, and discuss interventions as appropriate, for the increase in youth crisis response requests.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	As submitted, this non-clinical PIP was found to have moderate confidence, because: the PIP has been impacted by staff shortages. There are many variables impacting beneficiary homelessness.
General PIP Information	
MHP/DMC-ODS Name: TCBH	
PIP Title: Mental Health Outreach to and Engagement with the Homeless	
PIP Aim Statement: The aim of this two-year PIP is that, by increasing outreach to and engagement with the homeless population, more homeless individuals will complete intakes and receive specialty mental health services (Targets: 25% increase over two years in the MHP and 15 individuals per year due to the Multi-Disciplinary Team [MDT]) and become housed (Target: 15 per year contacted by the MDT moving into permanent housing). The MDT – which includes a mental health clinician, alcohol and other drugs specialists, a social service worker, a Self-Sufficiency Counselor, a Health Education Assistant, and a Unit Manager – will provide outreach and refer individuals to a variety of services and supports, including housing. In the domain of mental health, the clinician will conduct screenings and assessments and connect willing individuals to providers of specialty mental health services.	
Date Started: 01/2022	
Date Completed: n/a	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	

General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Homeless beneficiaries.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 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): Development and implementation of a multidisciplinary team to outreach and engage homeless into MHP services, housing, and other services as needed.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 1. Number of homeless individuals who complete intakes and start to receive clinical services from MHP providers	Jul. 2020 – June 2021	Increase of 25% over baseline to 161 by 12/31/2023	Jul. 2021 – June 2022	n=176 [number, no rate] Increase of 36.4% compared to baseline	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 2. Number of homeless individuals assessed by the MDT who complete intakes and start to receive services from MHP providers	April – Oct. 2021	15 individuals per program year	April – Oct. 2022	n=2 [number, no rate]	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3. Number of homeless individuals contacted by the MDT who make the transition from sheltered to housed	April – Sept. 2021	15 individuals per program year	April – Sept. 2022	n=7 [number, no rate]	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☒ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Involve peers with homeless lived experience in the PIP processes. • Utilize data review and analysis to map barriers and identify variables in need of further interventions. • Utilize data review and analysis to develop specific PIP improvement strategies.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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

ATTACHMENT F: PM DATA CY 2021 REFRESH

At the time of the MHP's review, the data set used for the PMs was incomplete for CY 2021. Across the state, most of the approved claims data November and December 2021 was not included in the original data used for this report.

CalEQRO obtained a refreshed data set for CY2021 in January 2023. The PM data with the refreshed data set follows in this Attachment.

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Tulare MHP Performance Measures

REFRESHED

FY22-23

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	271,012	10,687	3.94%	$58,540,045	$5,478
CY 2020	255,316	9,924	3.89%	$55,444,800	$5,587
CY 2019	251,978	10,491	4.16%	$48,194,242	$4,594

*Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	32,080	296	0.92%	1.08%	1.96%
Ages 6-17	75,405	5,392	7.15%	4.41%	5.93%
Ages 18-20	16,221	649	4.00%	3.73%	4.41%
Ages 21-64	128,736	4,157	3.23%	4.11%	4.56%
Ages 65+	18,571	193	1.04%	2.26%	1.95%
Total	**271,012**	**10,687**	**3.94%**	**3.67%**	**4.34%**

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

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	2,475	23.16%
Threshold language source: Open Data per BHIN 20-070		

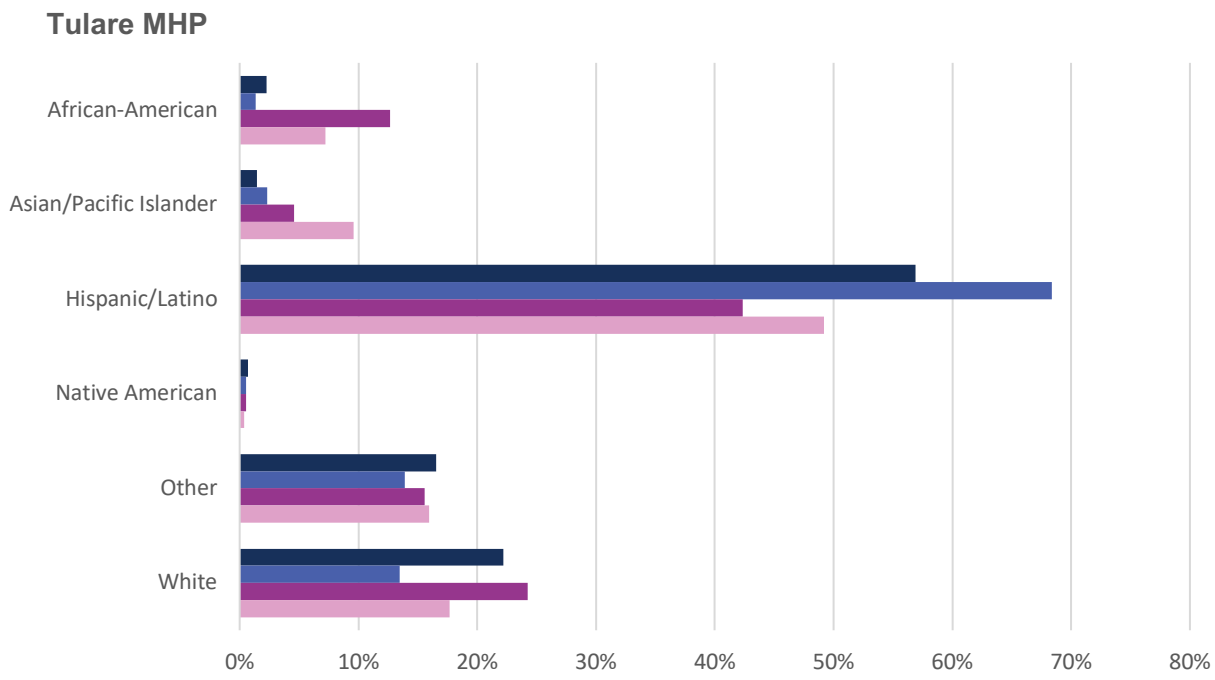
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	67,489	2,006	2.97%	$10,665,902	$5,317
Medium	613,796	20,261	3.30%	$151,430,714	$7,474
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	3,705	239	6.45%	7.64%
Asian/Pacific Islander	6,243	154	2.47%	2.08%
Hispanic/Latino	185,358	6,078	3.28%	3.74%
Native American	1,465	76	5.19%	6.33%
Other	37,695	1,769	4.69%	4.25%
White	36,548	2,371	6.49%	5.96%
Total	**271,014**	**10,687**	**3.94%**	**4.34%**

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



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	22%	17%	1%	57%	1%	2%
MHP % Eligible	13%	14%	1%	68%	2%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

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

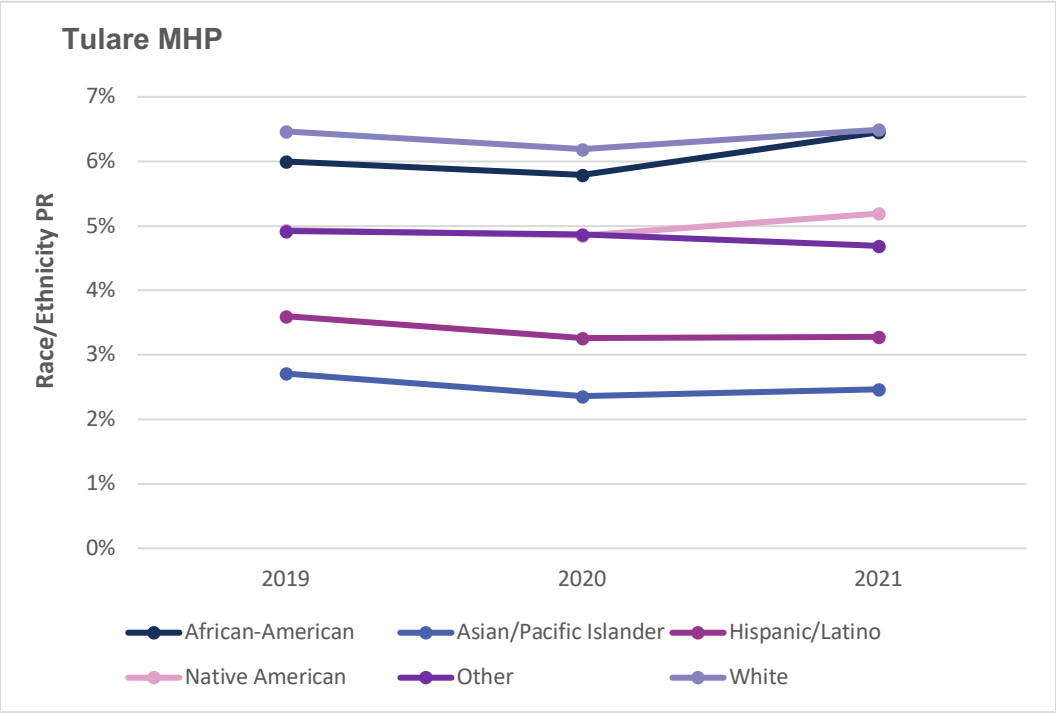


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

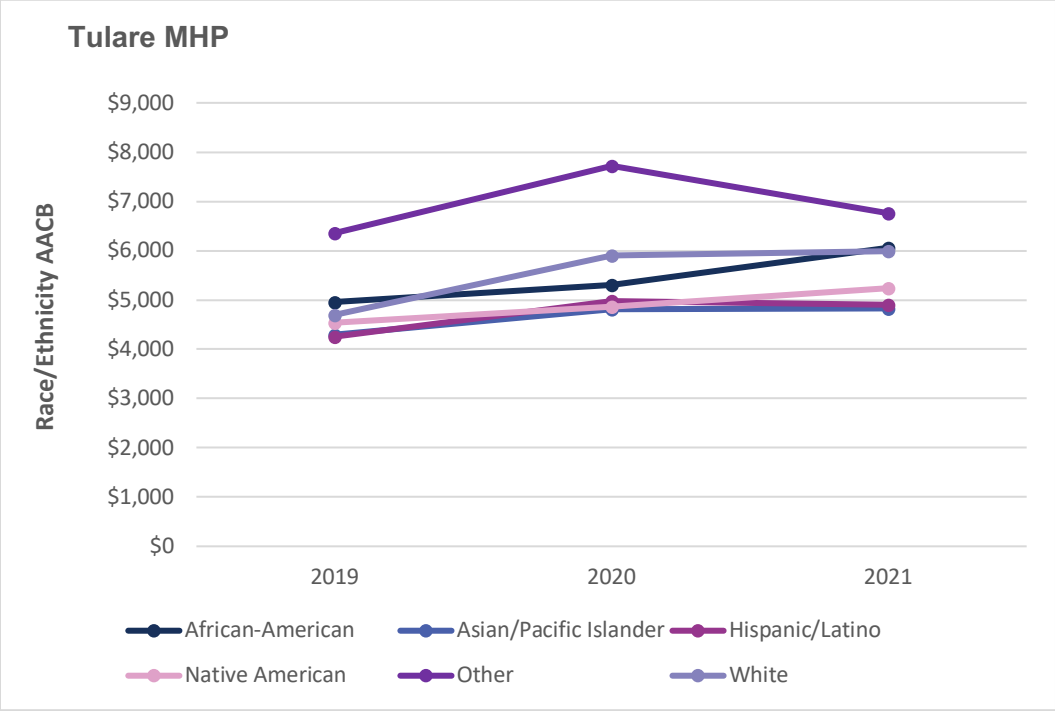
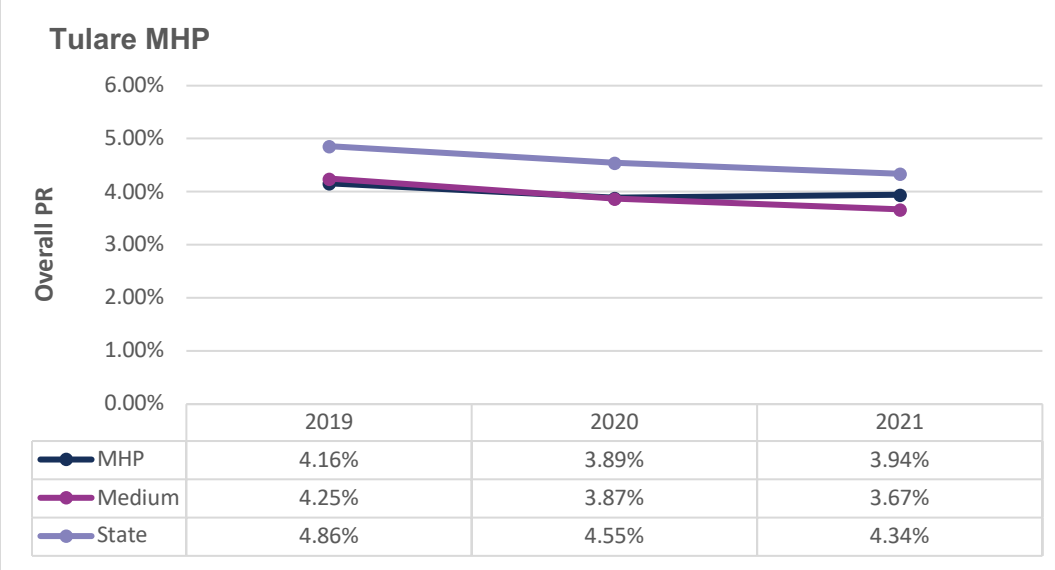
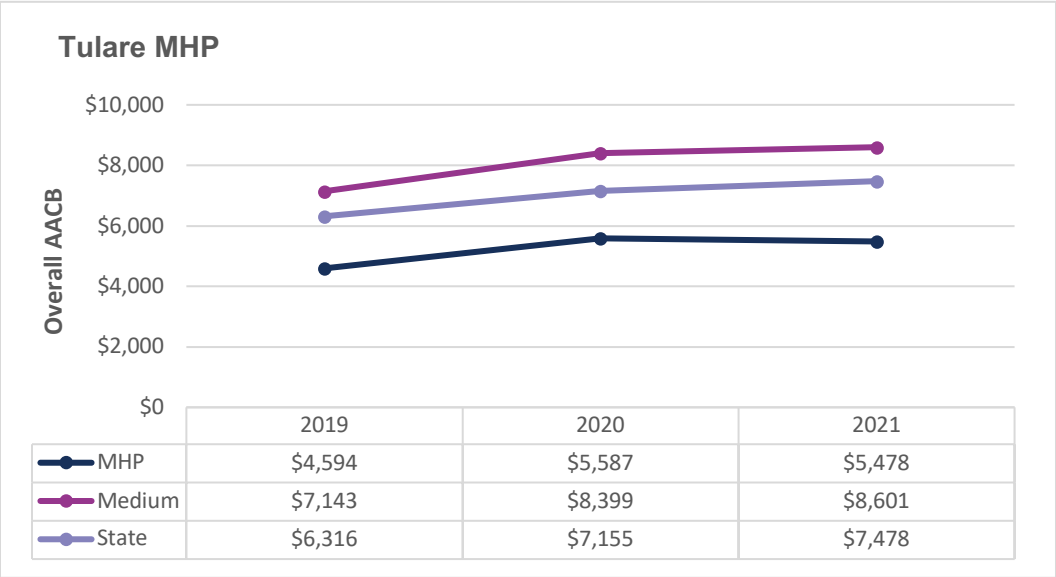


Figure 4: Overall PR CY 2019-21



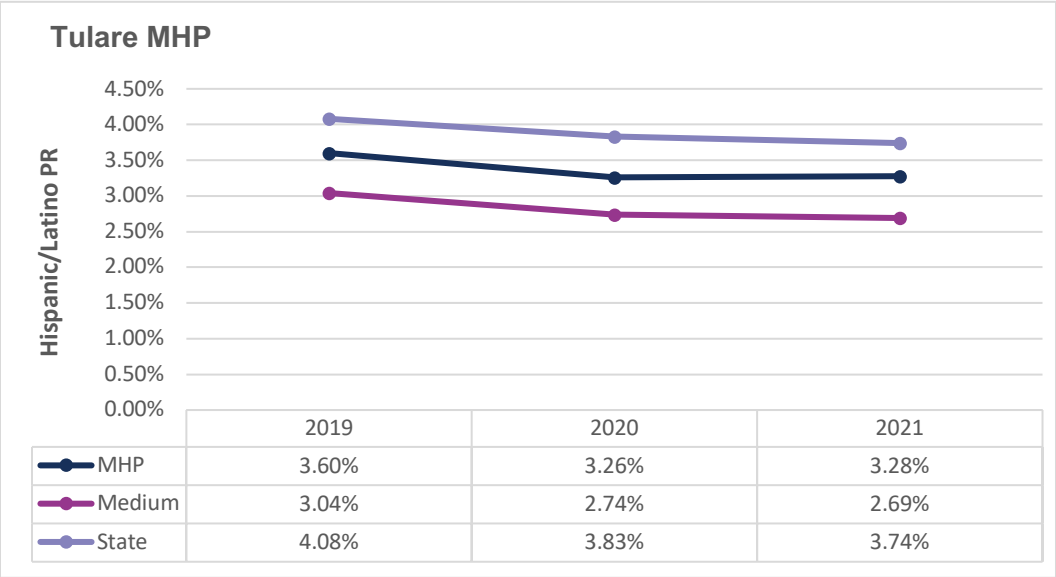
	2019	2020	2021
MHP	4.16%	3.89%	3.94%
Medium	4.25%	3.87%	3.67%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



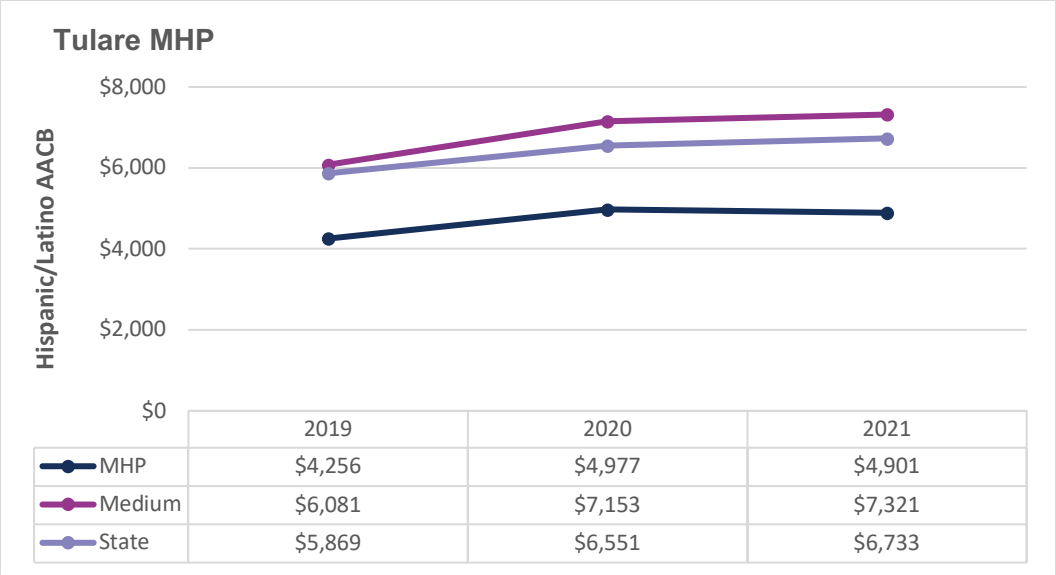
	2019	2020	2021
MHP	$4,594	$5,587	$5,478
Medium	$7,143	$8,399	$8,601
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21



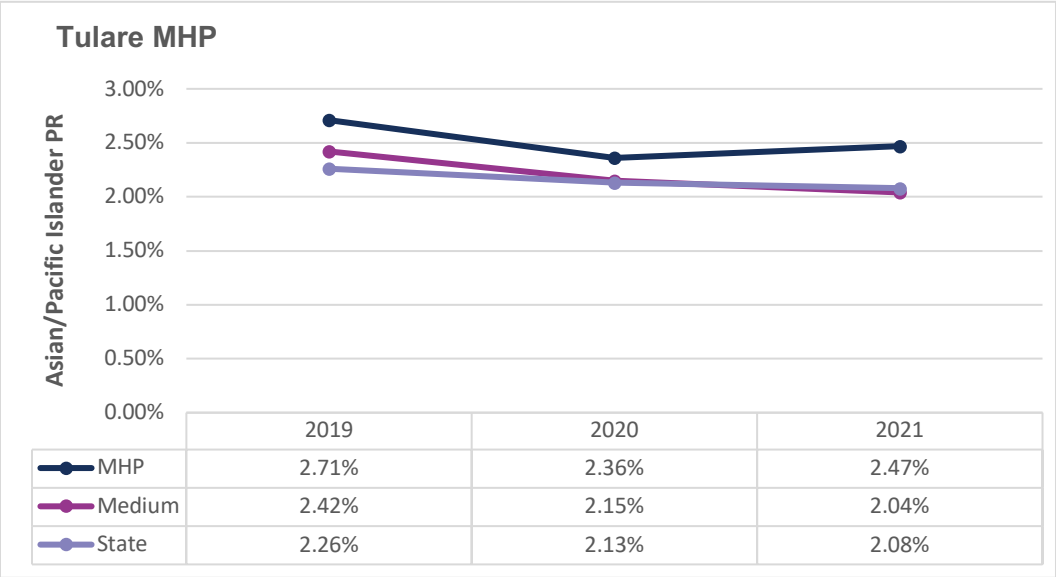
	2019	2020	2021
MHP	3.60%	3.26%	3.28%
Medium	3.04%	2.74%	2.69%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21



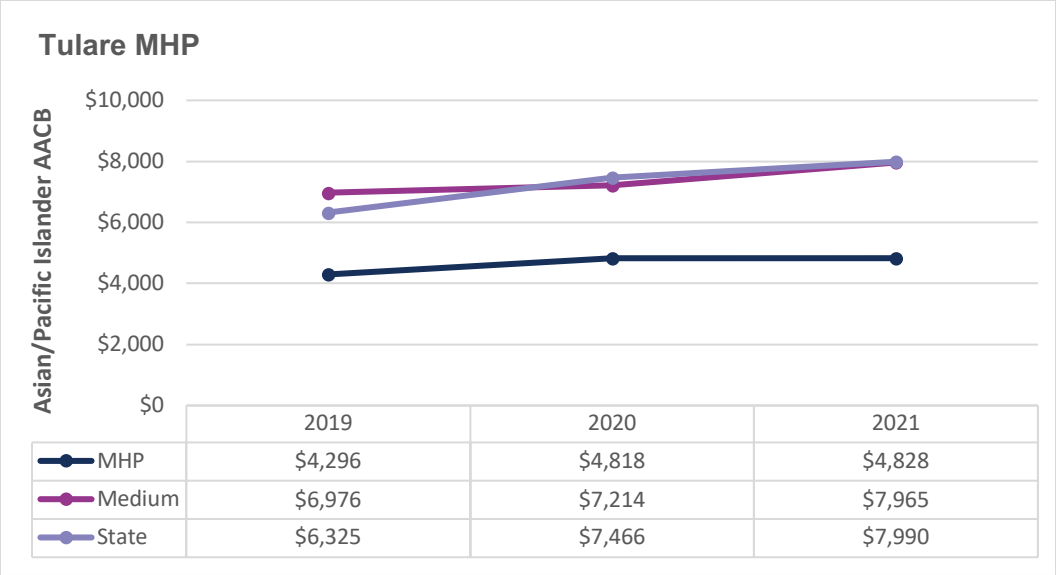
	2019	2020	2021
MHP	$4,256	$4,977	$4,901
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

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



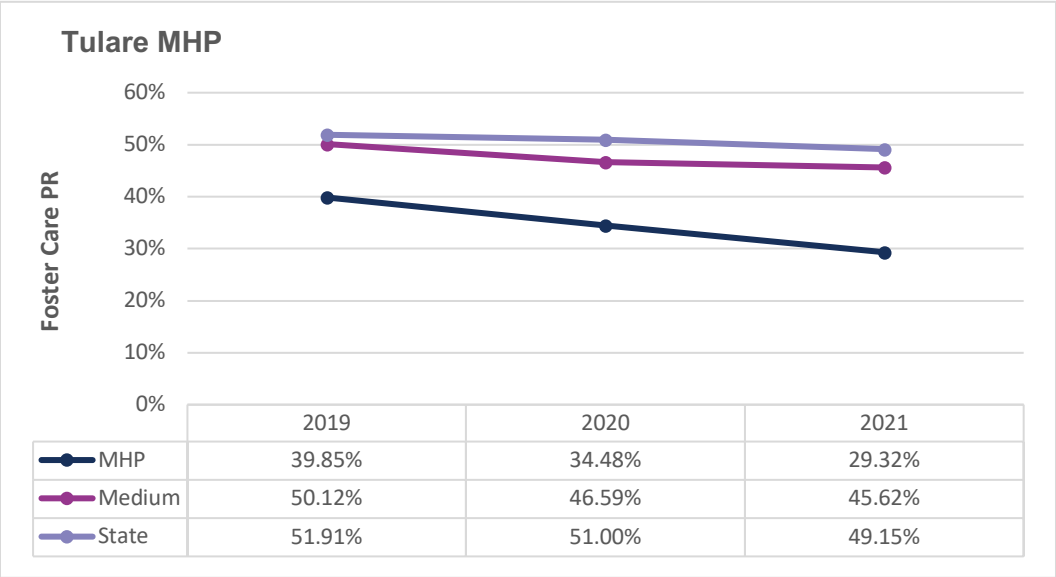
	2019	2020	2021
MHP	2.71%	2.36%	2.47%
Medium	2.42%	2.15%	2.04%
State	2.26%	2.13%	2.08%

Figure 9: Asian/Pacific Islander AACB CY 2019-2021



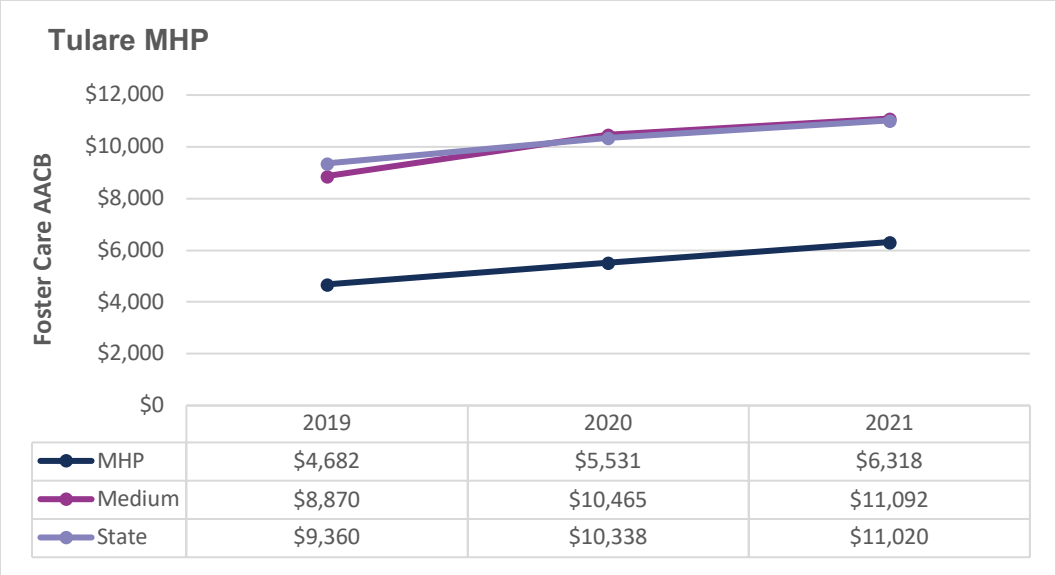
	2019	2020	2021
MHP	$4,296	$4,818	$4,828
Medium	$6,976	$7,214	$7,965
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	39.85%	34.48%	29.32%
Medium	50.12%	46.59%	45.62%
State	51.91%	51.00%	49.15%

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$4,682	$5,531	$6,318
Medium	$8,870	$10,465	$11,092
State	$9,360	$10,338	$11,020

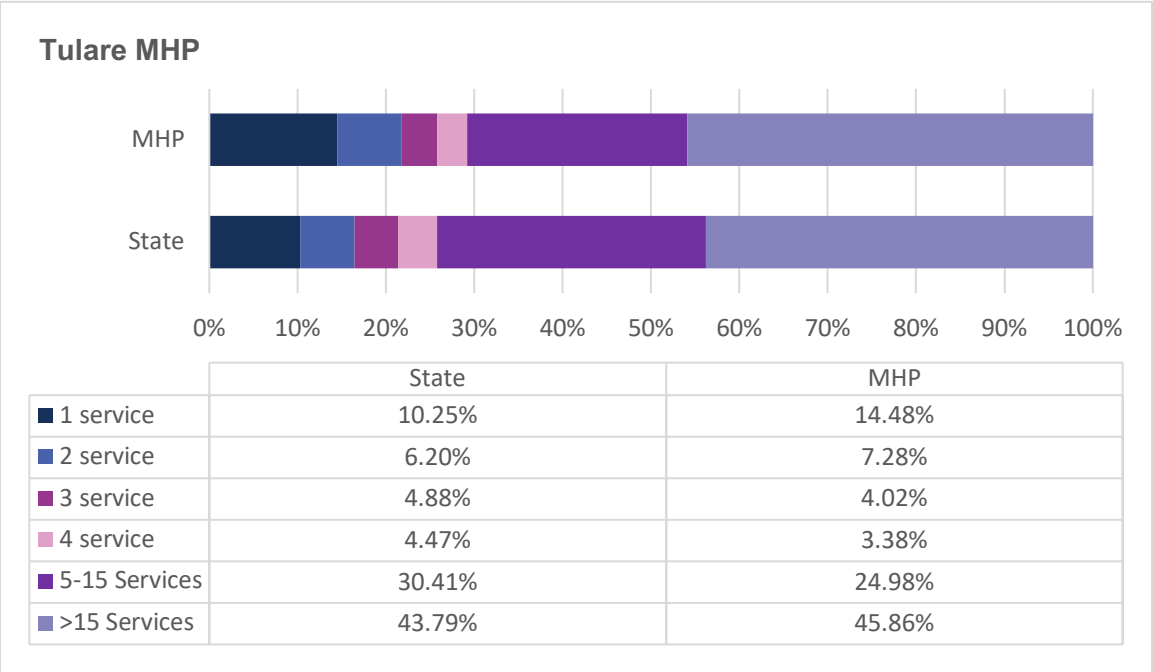
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 4,999				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	1,089	21.8%	12	5	11.6%	16	8
Inpatient Admin	<11	-	8	7	0.5%	23	7
Psychiatric Health Facility	<11	-	15	13	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	<11	-	25	26	2.2%	21	14
Per Minute Services							
Crisis Stabilization	91	1.8%	1,481	1,200	13.0%	1,546	1,200
Crisis Intervention	1,433	28.7%	194	110	12.8%	248	150
Medication Support	2,560	51.2%	346	283	60.1%	311	204
Mental Health Services	3,533	70.7%	498	270	65.1%	868	353
Targeted Case Management	2,150	43.0%	394	150	36.5%	434	137

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

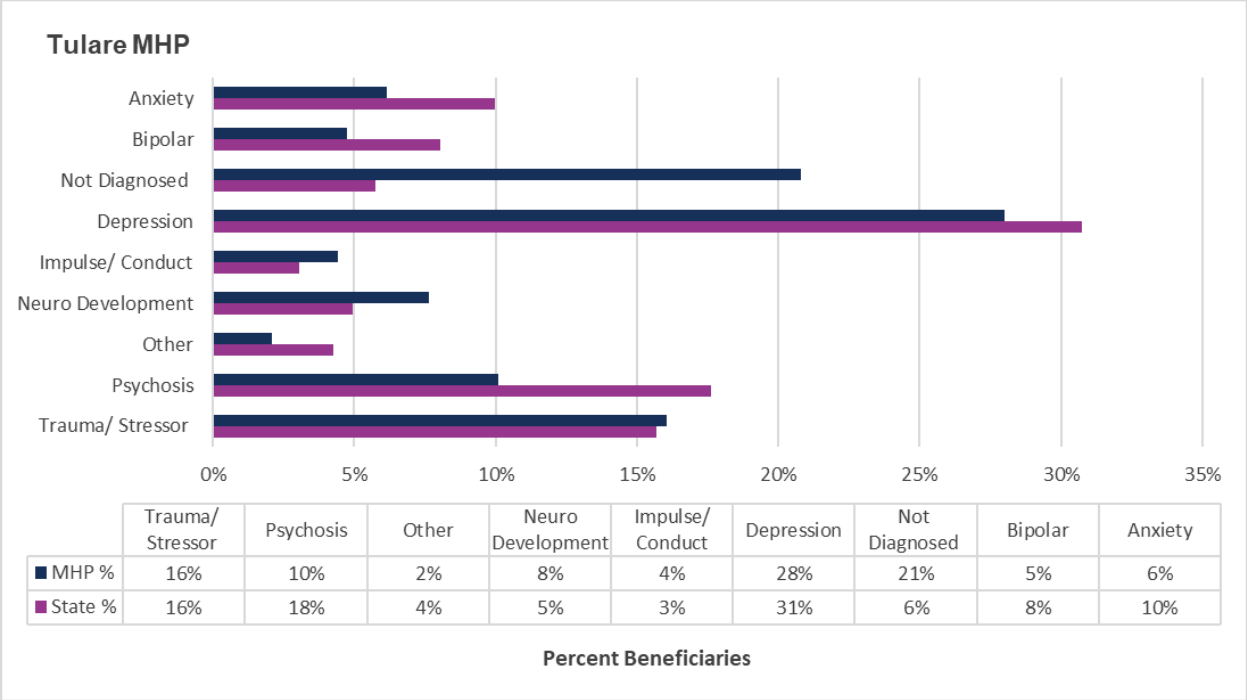
Service Category	MHP N = 428				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	28	6.5%	15	11	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	<11	-	7	7	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	18	13
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	1,940	1,800	3.1%	1,404	1,200
Crisis Intervention	51	11.9%	260	116	7.5%	406	199
Medication Support	140	32.7%	413	288	28.2%	396	273
TBS	10	2.3%	964	639	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	59	13.8%	368	306	40.2%	1,354	473
Intensive Home Based Services	13	3.0%	1,122	404	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	407	95.1%	1,342	692	96.3%	1,854	1,108
Targeted Case Management	268	62.6%	384	157	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	14.48%
2 service	6.20%	7.28%
3 service	4.88%	4.02%
4 service	4.47%	3.38%
5-15 Services	30.41%	24.98%
>15 Services	43.79%	45.86%

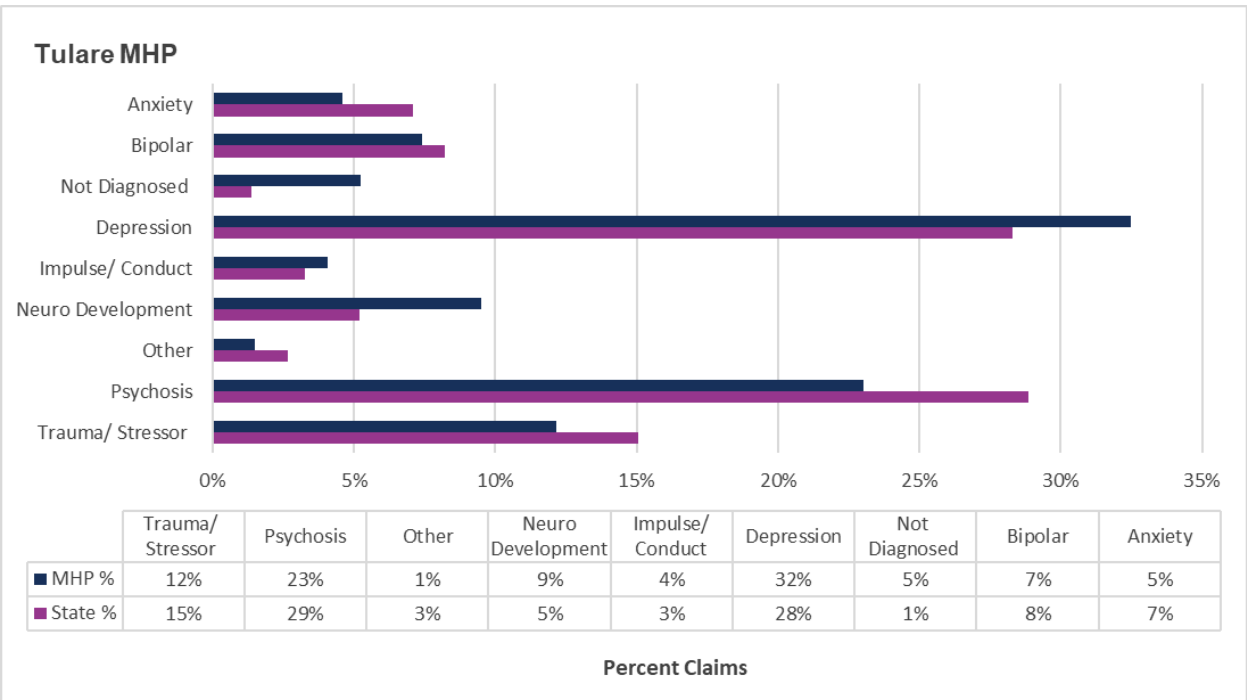
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	16%	10%	2%	8%	4%	28%	21%	5%	6%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Percent Beneficiaries

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



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	12%	23%	1%	9%	4%	32%	5%	7%	5%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Percent Claims

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	890	1,631	10.02	8.86	$14,754	$12,052	$13,131,401
CY 2020	852	1,842	9.90	8.68	$15,578	$11,814	$13,272,532
CY 2019	813	1,453	9.52	7.80	$13,255	$10,535	$10,775,957

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

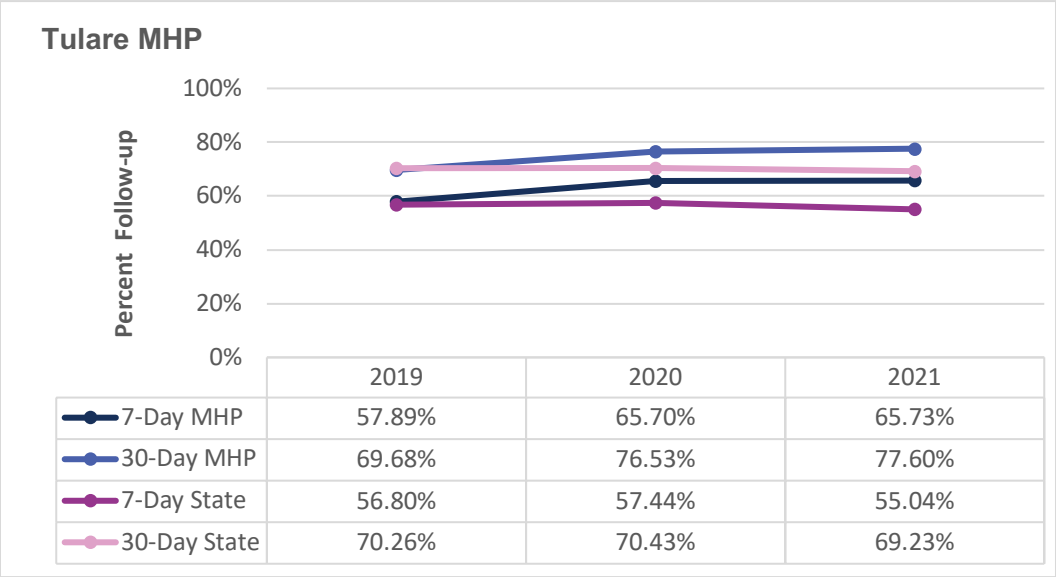
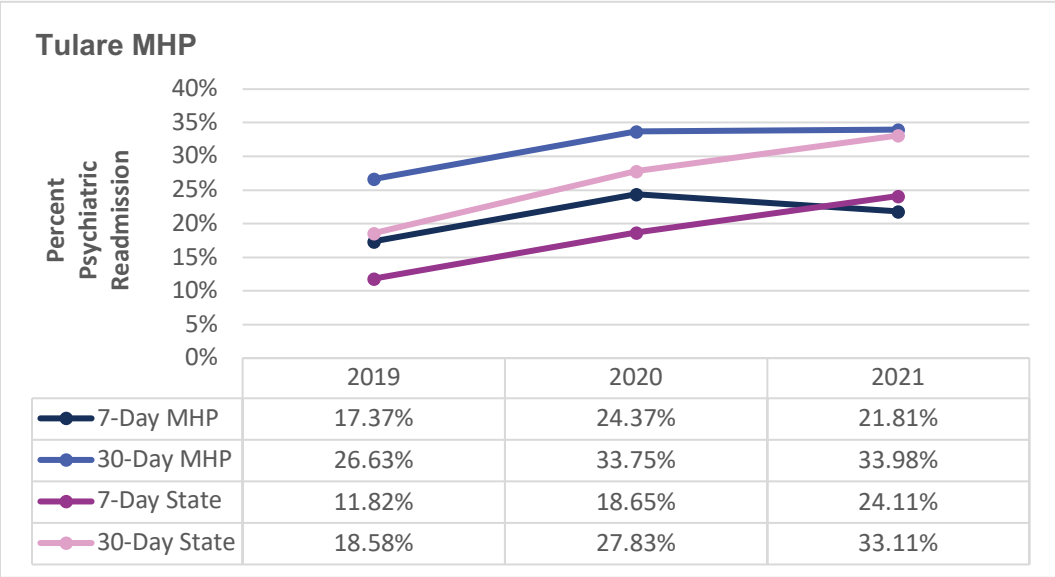


Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	17.37%	24.37%	21.81%
30-Day MHP	26.63%	33.75%	33.98%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45 %	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	224	2.10%	21.94 %	$12,842,219	$57,331	$45,463
	CY 2020	195	1.96%	20.74 %	$11,500,231	$58,976	$43,007
	CY 2019	158	1.51%	18.24 %	$8,791,461	$55,642	$43,183

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approv	Total Approved Claims	Average Approved Claims	Median Approved Claims

			ed Claims		per Beneficiary	per Beneficiary
Medium Cost ($20K to $30K)	199	1.86%	8.16%	$4,776,660	$24,003	$23,596
Low Cost (Less than $20K)	10,264	96.04%	69.90%	$40,921,166	$3,987	$2,669

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

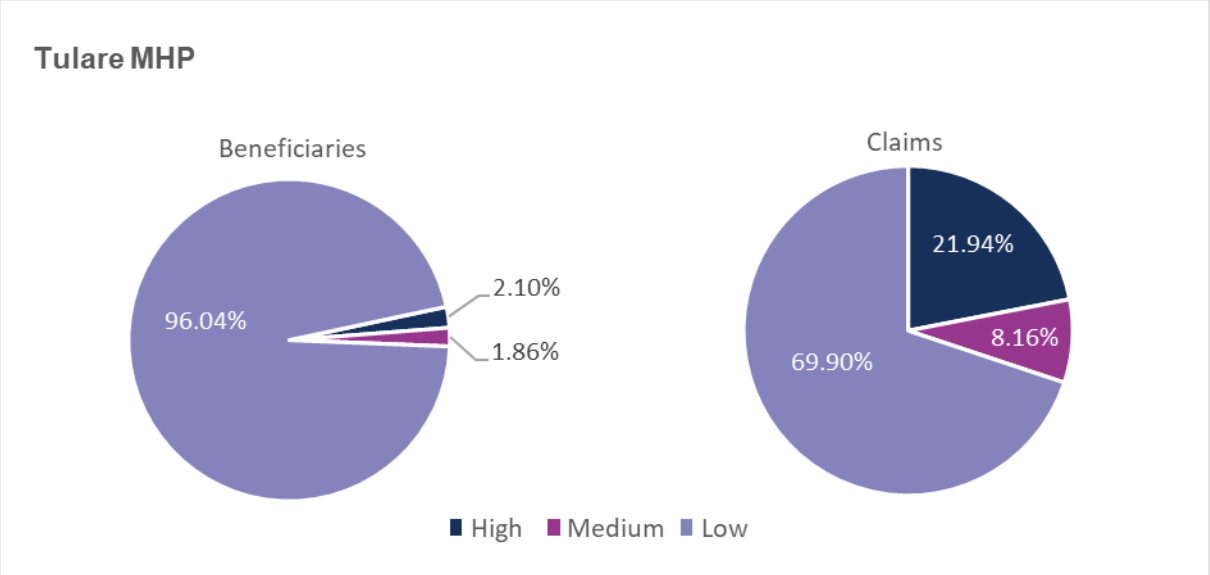


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	19,561	$4,231,543	$11,005	0.26%	$4,020,769
Feb	20,304	$4,331,797	$7,258	0.17%	$4,117,761
Mar	23,354	$4,937,743	$11,684	0.24%	$4,737,413
April	21,856	$4,760,500	$19,783	0.42%	$4,573,580
May	20,908	$4,496,412	$10,069	0.22%	$4,338,303
June	19,985	$4,311,745	$9,595	0.22%	$4,110,773
July	17,448	$3,297,199	$18,700	0.57%	$3,145,520
Aug	17,899	$3,310,941	$23,446	0.71%	$3,165,268
Sept	21,695	$3,976,499	$17,122	0.43%	$3,812,315
Oct	20,709	$3,833,281	$31,979	0.83%	$3,691,414
Nov	18,901	$3,558,074	$58,238	1.64%	$3,469,167
Dec	18,172	$3,597,760	$174,601	4.85%	$3,353,714
Total	**240,792**	**$48,643,494**	**$393,480**	**0.81%**	**$46,535,997**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Other healthcare coverage must be billed before submission of claim	339	$173,409	44.07%
Medicare Part B must be billed before submission of claim	540	$103,800	26.38%
Late claim	108	$48,374	12.29%
Beneficiary not eligible or non-covered charges	100	$30,768	7.82%
Service line is a duplicate and a repeat service procedure code modifier not present	51	$23,189	5.89%
Service location NPI issue	29	$8,094	2.06%
Other	34	$3,925	1.00%
Place of service incomplete or invalid	1	$1,920	0.49%
Total Denied Claims	**1,202**	**$393,479**	**100.00%**
Overall Denied Claims Rate	**0.81%**		
Statewide Overall Denied Claims Rate	**1.43%**		