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

TUOLUMNE FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

March 28, 2023

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — March 28,2023

MHP Size — Small

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	4	1	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	5	1	0
Quality of Care	10	5	4	1
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**19**	**6**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Case Management Services	Clinical	0720/21	Second remeasurement	Moderate
Follow-up After Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	12/2022	Implementation	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	2*
*If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has a full complement of management staff who can provide program oversight and direction.
- The MHP opted for an initiative, retention payment, that contributes to retention of staff.
- The contract between Tuolumne County Behavioral Health (TCBH) and Kings View Health Information Support eliminates the need for TCBH to staff IS positions and maintain a larger IS infrastructure.
- The MHP is part of a multiagency children's system of care (CSOC) and can leverage those collaborations to improve access to youth, especially those in foster care (FC).
- The MHP has reports and procedures to review data entry errors prior to billing, which contributes to a very low claims denial rate of 0.21 percent.

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

- The process to provide individual therapy to beneficiaries who decline or are not well-suited for group therapy is perceived as complex and laborious, which may dissuade some beneficiaries from remaining in services.
- The penetration rate (PR), number of youth served, and units of services for youth in FC in the MHP are all lower than the statewide (and similar-sized MHP) averages.

- Beneficiaries do not have consistent and reliable access to the nonmedical transportation services through the MCP providers for their mental health services and appointments.
- The MHP is not yet able to use its electronic health record (EHR) to track and trend the required indicators for youth in FC prescribed psychotropic medications.
- Clinical staff, including program managers, stated that accessing reports on their own is difficult, which precludes the ability to meaningfully use the data and information gleaned from the reports to guide decision-making.

Recommendations for improvement based upon this review include:

- Review the process of providing adult beneficiaries with non-group/individual therapy services and identify opportunities and implement strategies to streamline the process.
- Continue to investigate reasons and develop and implement strategies to increase access and timeliness of services for youth in FC.
- Investigate reasons and develop and implement strategies in collaboration with the managed care plan (MCP) providers to ensure consistent and reliable access to transportation assistance for beneficiaries
- Develop a process that is not dependent on the EHR implementation and begin to track and trend the FC Healthcare Effectiveness Data and Information Set (HEDIS) measures.
- Engage staff (e.g., through a survey, focus group, or other structured feedback process) on the barriers that they are finding in accessing reports and develop and implement strategies to remove those barriers.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in FC as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2022-23 findings of the EQR for Tuolumne County MHP by BHC, conducted as a virtual review on March 28, 2023.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to validate and 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 (IPC) 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.
- Validation and analysis 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.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP has continued to experience loss of staff; vacancies were distributed across all programs and services. 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.

- TCBH has continued to implement California Advancing and Innovating Medi-Cal (CalAIM). Over the past year, TCBH has shifted policies, documentation, and the EHR to adhere to CalAIM. With a full complement of management staff, the MHP has directed more resources to develop new policies and trainings for documentation, Medical Necessity, and problem lists.
- Over the past year, TCBH has made progress in hiring both clinical and management staff. The management team is fully staffed for the first time in several years.
- TCBH was awarded the Crisis Care Mobile Units grant to develop a Crisis Mobile Unit, enabling more beneficiaries to be served in the field or in their communities.
- TCBH received approval from the Board of Supervisors for a new peer employee position, Peer Specialist III. TCBH filled this position in December 2022 in a full-service partnership program.

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: As a participant in the multiagency CSOC, leverage relationships with partnering agencies, especially child welfare services (CWS), to initiate quality improvement activities (QI) to increase MHP FC PRs.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- This recommendation is addressed, as the MHP leveraged relationships and initiated QI activities to improve access to youth in FC.
- The MHP appointed a Children's Services Supervisor to facilitate coordination between CWS, in particular, regarding referrals, placements, and Child and Family Teams. Through this collaboration, the MHP and CWS have improved data sharing and developed a referral for assessments process for all youth in FC.
- The MHP is a stakeholder on forums that include several youth-serving agencies, including the Child Assault Review Team; the Juvenile Justice Coalition Meetings; Tuolumne Resiliency Coalition; and the Tuolumne County's Superintendent's Office meetings.
- The CY 2021 claims data show further decline in the PR for youth in FC. The MHP's current efforts to improve the PR may not be evident until the CY 2022 or CY 2023 claims.

Recommendation 2: Continue to explore and pursue other solutions to improve psychiatry wait times for children and FC youth populations. (This recommendation is a carry-over from FY 2020-21.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- This recommendation was addressed as the MHP reports having increased psychiatry availability. Current providers will serve both adults and children. Also, TCBH has reviewed the psychiatry contract (through Kings View) and is considering an expansion of the contract.
- The average wait time to the first offered psychiatry appointment improved from the previous year, from 32 business days for children and 39 business days for youth in FC to 19 and 28 business days, respectively.

Recommendation 3: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward and is encouraged to implement PIP recommendations contained in the EQR report. (This recommendation is a carry-over from FY 2020-21.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation with the submission of two PIPs.
- The MHP is concluding its clinical PIP on case management and is implementing the new non-clinical PIP on FUM.

Recommendation 4: Collaborate with EHR vendor or psychiatric telehealth provider to track and trend FC HEDIS measures related to psychotropic medications; regularly track and trend FC prescribing practices for performance improvement purposes as per SB 1291. (This recommendation is a carry-over from FY 2020-21.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- This recommendation is partially addressed as the MHP collaborated with the EHR vendor to develop the reporting capabilities to track psychotropic medication utilization for youth in FC, but the MHP has yet to use and trend the findings.
- The MHP developed a dashboard titled “Senate Bill 1291” to provide comprehensive data about youth services. FC beneficiaries’ rates are compared to all other youth.
- Users of the dashboard have the choice of multiple parameters (e.g., race/ethnicity, gender, diagnosis, referral source) to drill down into more specific data.
- For the MHP to fully meet this recommendation, the MHP must begin tracking and trending the required HEDIS measures. The MHP may need to use manual

tracking if EHR implementation is further delayed, which should be possible given few youth in FC served and data sharing with CWS.

- This recommendation will be carried over to the FY 2022-23 Recommendations.

Recommendation 5: Work with vendor during transition to the new EHR to aggregate data from Child and Adolescent Needs and Strengths – 50 (CANS-50), Pediatric Symptom Checklist (PSC-35), and Level of Care Utilization System (LOCUS) reports. Analyze data on a regular basis to make system changes and improvements. (This recommendation is a carry-over from FY 2018-19, FY 2019-20, and FY 2020-21.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation. The MP is working with the vendor to aggregate the reports upon implementation of the new EHR
- The MHP included in the list of IS priorities transferring aggregate data from the legacy Cerner system into the Credible system that will go live in July 2023.
- In collaboration with the vendor, the MHP is actively working on this task as part of the implementation of the new EHR.

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 99.99 percent of services were delivered by county-operated/staffed clinics and sites, and 0.01 percent were delivered by contractor-operated/staffed clinics and sites. The contractor-operated/staffed clinics and sites are acute inpatient and residential facilities located out of county. Overall, approximately 62 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 county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: clinic walk-in, mobile triage, school, law enforcement, probation, CWS, juvenile court, and primary care provider referrals. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The Case Administration Team makes determinations about plans of care, medical necessity and then makes referrals for groups, medication services, and targeted case mgmt.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 457 adult beneficiaries, 135 youth beneficiaries, and 128 older adult beneficiaries across one county-operated site and no contractor-operated sites. Among those served, zero beneficiaries received telehealth services in a language other than English in the preceding 12 months.

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

[1] CMS Data Navigator Glossary of Terms

and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

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

For Tuolumne County, the time and distance requirements are 60 miles and 90 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

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

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	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 services a predominantly White population and routinely monitors access and service utilization for non-dominant and/or underserved populations, including Native American, Hispanic/Latino, Older Adults, and persons experiencing homelessness.
- In November 2022, the MHP implemented the group model as the primary method of service delivery for adult beneficiaries. The group model, inclusive of therapeutic, rehabilitation, and other focused groups, mitigates some of the impact of a reduced clinical workforce and expands the treatment modalities that the MHP offers.
- However, stakeholder feedback was that groups were not well-suited for some beneficiaries and that the process to provide individual therapy was complex and laborious.
- The MHP reports problems with the transportation benefit provided through the MCP provider—insufficient number of drivers, which affects availability of transportation service. As an interim solution, the MCP provider uses rideshare applications. Stakeholders still reported issues with the rideshare (drivers not showing up), which the MCP provider has not addressed.

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 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, the Tuolumne MHP's PR continues to exceed the statewide PR, as it did in CY 2019 and CY 2020. The Tuolumne MHP PR indicates that the MHP is accessible for County Medi-Cal beneficiaries. The MHP's average approved claim amount, however, was below the statewide average by 8 percent ($984 less).

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	14,738	780	5.29%	$5,374,018	$6,890
CY 2020	13,553	862	6.36%	$5,309,486	$6,159
CY 2019	13,362	981	7.34%	$4,838,076	$4,932

- For CY 2021, the MHP followed the trend for annual beneficiaries served as seen statewide. The number of Medi-Cal eligibles increased (9 percent), the number of beneficiaries served decreased (10 percent), and the overall PR decreased from 6.36 percent CY 2020 to 5.29 percent in CY 2021.

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

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	1,413	<11	-	1.27%	1.96%
Ages 6-17	3,055	167	5.47%	5.74%	5.93%
Ages 18-20	652	-	-	4.89%	4.41%
Ages 21-64	8,035	513	6.38%	4.73%	4.56%
Ages 65+	1,584	56	3.54%	2.45%	1.95%
Total	**14,738**	**780**	**5.29%**	**4.39%**	**4.34%**

- The PRs for adult and older adult beneficiaries are above the statewide and similar size MHP PRs.
- The PRs for child and youth beneficiaries are below the statewide and similar size MHP PRs. The MHP is collaborating with other agencies that serve children and youth to increase coordinated services across a larger system of care.

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
No Threshold	729	93.46%
Language Unknown	**51**	**6.54%**
Total Threshold Languages	**780**	**100.00%**
Threshold language source: Open Data per BHIN 20-070		

- The MHP does not have any threshold languages.

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	4,717	226	4.79%	$1,109,886	$4,911
Small	199,673	7,709	3.86%	$45,313,502	$5,878
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

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

the same for the MHP. The ACA PR is 10 percent lower than the overall MHP PR and the ACA AACB is 29 percent lower than the overall MHP AACB.

- The number of ACA eligibles in CY 2021 increased by 17 percent from CY 2020.
- The number of ACA beneficiaries served in CY 2021 decreased, from 237 beneficiaries in CY 2020 to 226 in CY 2021. The PR decreased as well, from 5.90 percent in CY 2020 to 4.79 percent in CY 2021.

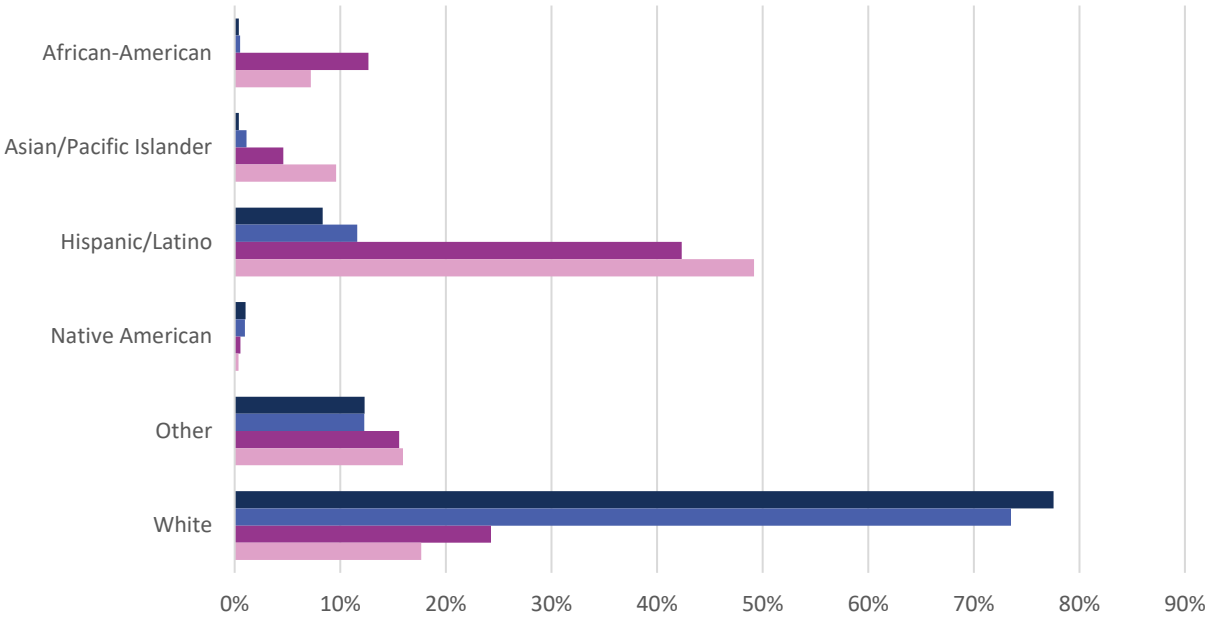
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	76	<11	-	7.64%
Asian/Pacific Islander	166	<11	-	2.08%
Hispanic/Latino	1,710	65	3.80%	3.74%
Native American	141	<11	-	6.33%
Other	1,810	96	5.30%	4.25%
White	10,835	605	5.58%	5.96%
Total	**14,738**	**780**	**5.29%**	**4.34%**

- Hispanic/Latino PR is slightly above the statewide PR. The PR for Other beneficiaries is more than a percentage point above the State PR.
- The PR for White beneficiaries is slightly below the State PR. The numbers of beneficiaries served and the PR for African-Americans, Asian/Pacific Islanders, and Native Americans are too low to display. Changes of just a few beneficiaries served have a large impact on the PR for all three of these groups

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

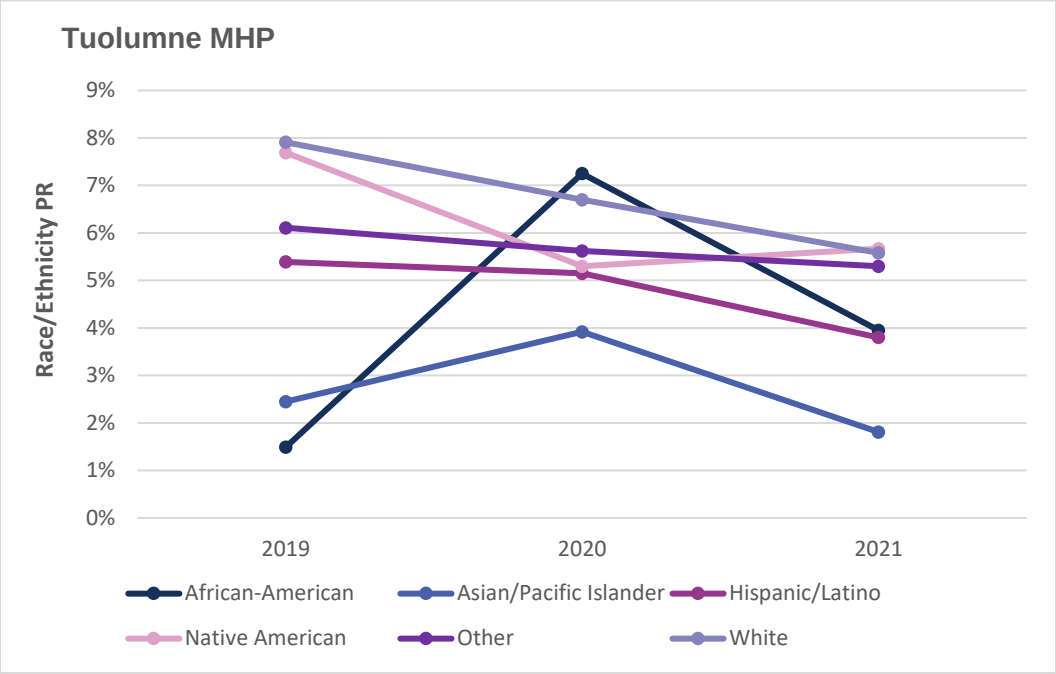


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	78%	12%	1%	8%	0%	0%
MHP % Eligible	74%	12%	1%	12%	1%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- The gap between the percent served and the percent eligible is the largest for Hispanic/Latino beneficiaries. This difference may suggest that Hispanic/Latino beneficiaries are underrepresented in the MHP.
- African-Americans and Asian/Pacific Islanders also show a lower number of beneficiaries served than eligibles indicating they are underrepresented as well.
- Native Americans and Other have the same percentages of beneficiaries served and eligibles.
- Whites show more beneficiaries served than eligibles indicating they are overrepresented in the MHP.

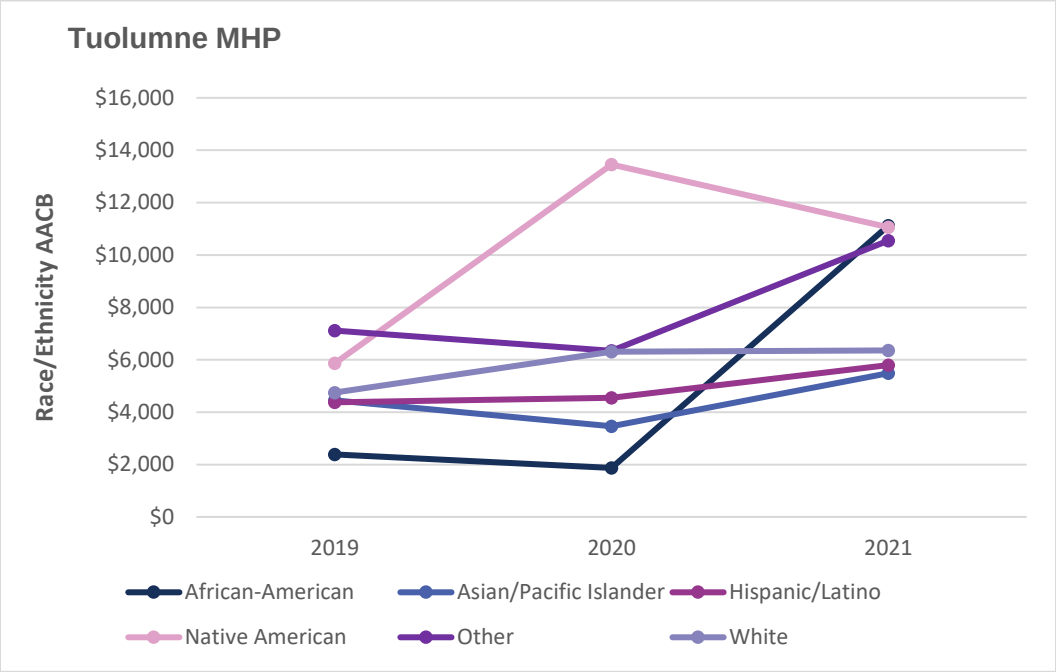
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data are compared to the similar county size and the statewide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

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



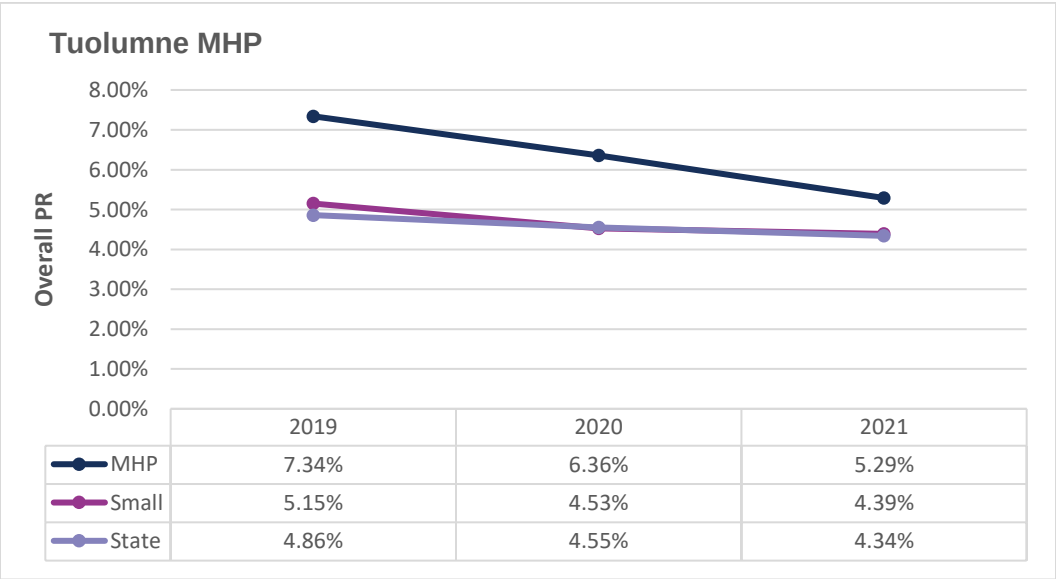
- PRs by race/ ethnicity have declined from CY 2019 through CY 2021 for Whites, Hispanic/Latinos, and Other beneficiaries. The cause of the trend is attributed to the COVID pandemic.
- African-Americans, Asian/Pacific Islanders, and Native Americans show larger changes over the three calendar year period. The low numbers of eligibles in these categories mean small changes in admissions and discharges have a large impact on PRs.

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



- With the exception of Native Americans, AACB increased for all race/ethnicity categories from CY 2020 to CY 2021. The reimbursement rates for Medi-Cal increased during the COVID pandemic and are the reason for the increased AACB.
- The increase in AACB for Native Americans in CY 2020 and decrease in CY 2021 demonstrates how low numbers of eligibles and a small number of beneficiaries served can have a large impact on the data.

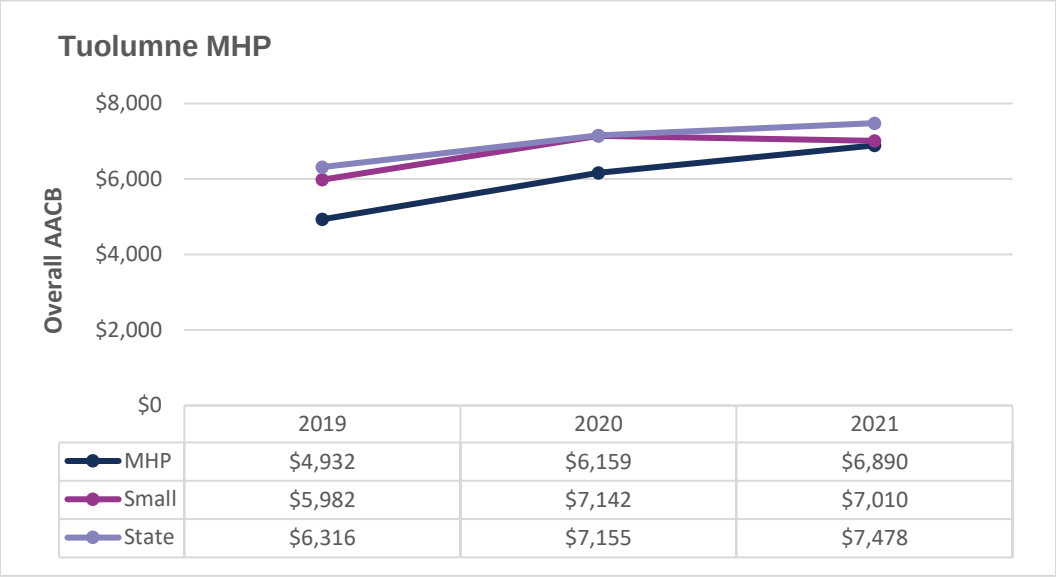
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	7.34%	6.36%	5.29%
Small	5.15%	4.53%	4.39%
State	4.86%	4.55%	4.34%

- The MHP PR over the three-calendar year period in Figure 4 is higher than that of other small counties and the State.
- The decrease in the MHP PR was close to a full percentage point from CY 2019 to CY 2020 and dropped again from CY 2020 to CY 2021.
- The decreases in PR for other small MHPs and the State are less than a percentage point across the three year period in Figure 4.

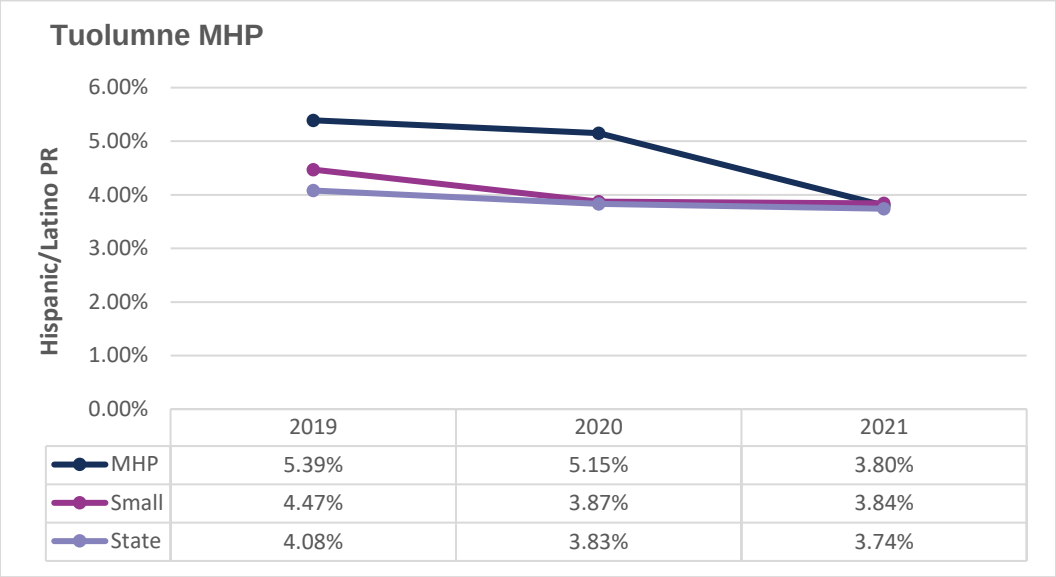
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$4,932	$6,159	$6,890
Small	$5,982	$7,142	$7,010
State	$6,316	$7,155	$7,478

- The increase in AACB over the three calendar years reduced the gap between the MHP and other small MHPs and the State.
- The MHP AACB increased by $1,958, or 39.7 percent. The increase by other small MHPs was $1,028, or 17.1 percent. The increase statewide was $1,162, or 18.4 percent.

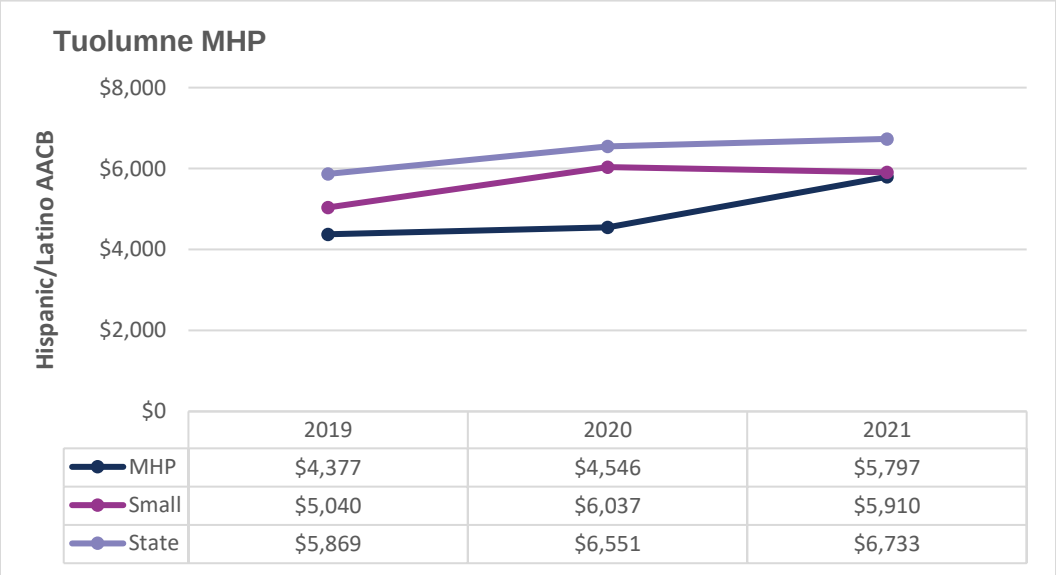
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	5.39%	5.15%	3.80%
Small	4.47%	3.87%	3.84%
State	4.08%	3.83%	3.74%

- In CY 2019 and CY 2020, the MHP's PR was higher than the Hispanic/Latino PR for other small MHPs and the State. In CY 2021, the PR fell to a level between other small MHPs and the State.
- From CY 2019 to CY 2021 the MHP PR for Hispanic/Latino beneficiaries declined 30 percent, from 5.39 percent to 3.80 percent.
- While the PR rates for other small MHPs and the State declined over the period shown in Figure 6, the decline was less than the MHP. The decline for other small MHPs was 14 percent and the decline for the State was 8.4 percent.

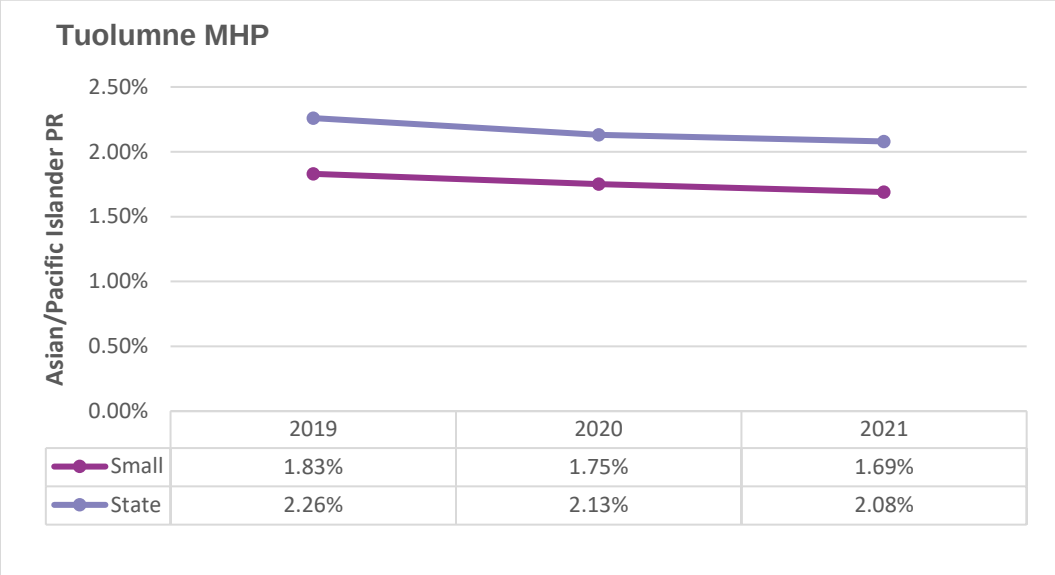
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$4,377	$4,546	$5,797
Small	$5,040	$6,037	$5,910
State	$5,869	$6,551	$6,733

- The MHP AACB for Hispanic/Latino beneficiaries increased from CY 2019 to CY 2021. By CY 2021, the MHP AACB increased to 98 percent of the AACB of other small counties.

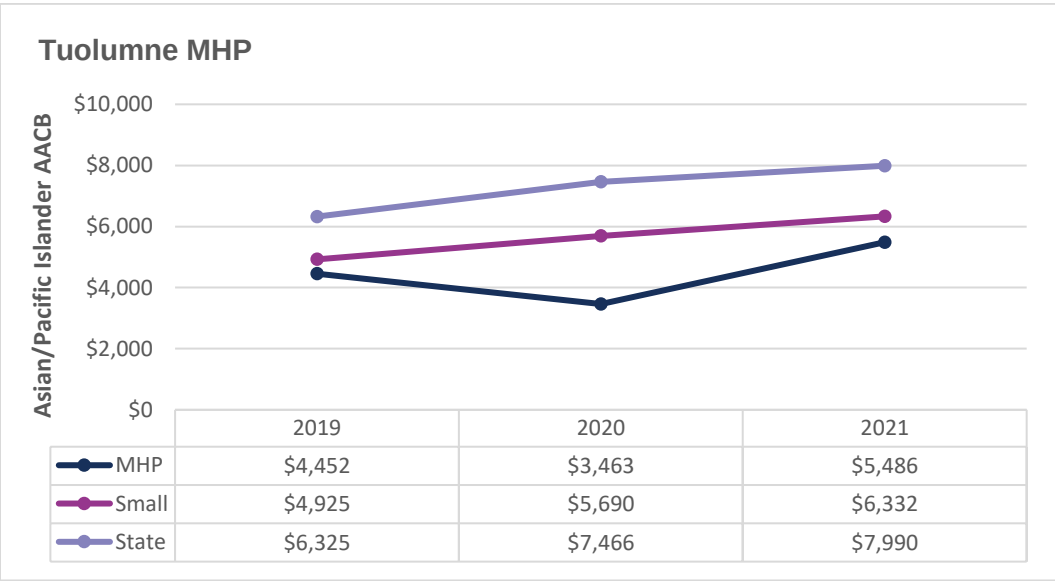
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
Small	1.83%	1.75%	1.69%
State	2.26%	2.13%	2.08%

- Due to small number of Asian/Pacific Islanders served, the MHP's Asian/Pacific Islander PR is not displayed in Figure 8 above.

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

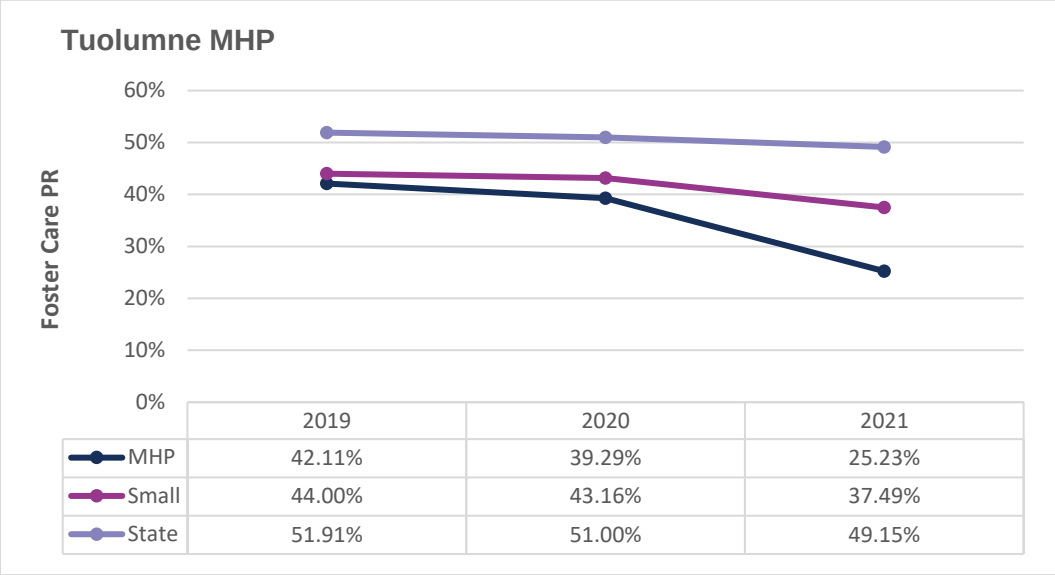


	2019	2020	2021
MHP	$4,452	$3,463	$5,486
Small	$4,925	$5,690	$6,332
State	$6,325	$7,466	$7,990

- Asian/Pacific Islander beneficiaries The AACB for Asian/Pacific Islanders increased from CY 2020 to CY 2021, returning to similar pattern observed statewide and for similar size MHPs. There was a 58 percent increase.

- The number of Asian/Pacific Islander beneficiaries was less than 11 individuals; therefore, changes of several admissions and/or discharges can have a large impact on both the PR and AACB.

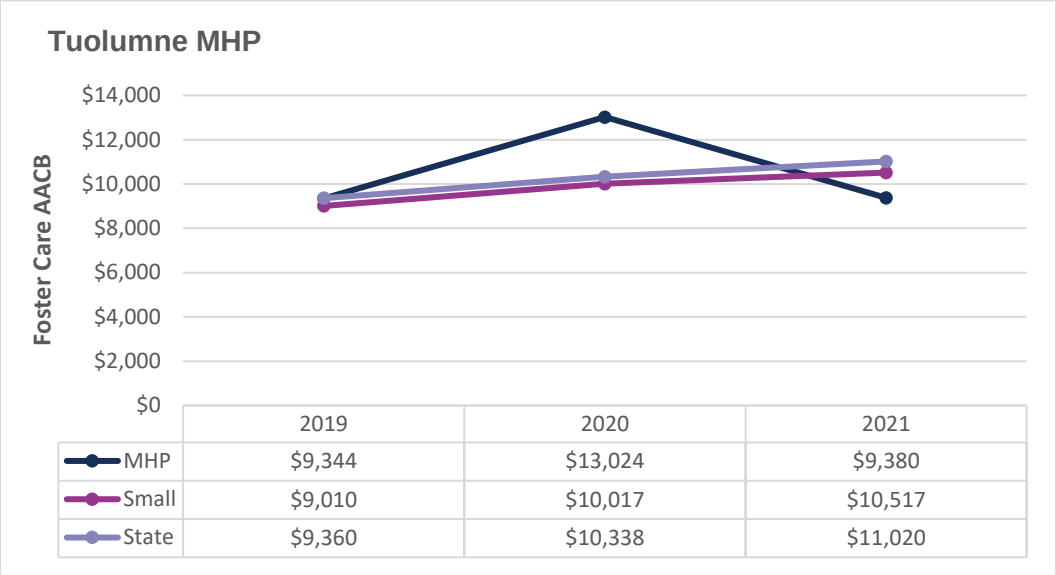
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	42.11%	39.29%	25.23%
Small	44.00%	43.16%	37.49%
State	51.91%	51.00%	49.15%

- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed.
- While the FC PR was steady across the State, there was a 17 percentage point over the three year report period.
- The decline for other small MHPs was 6.5 percentage points. Statewide, the decline was about 2.75 percentage points.
- In response to a question about the decline in PR, the MHP noted that most FC children are placed out of county and are not served by the MHP.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$9,344	$13,024	$9,380
Small	$9,010	$10,017	$10,517
State	$9,360	$10,338	$11,020

- Statewide FC AACB has increased each year.
- The MHP AACB for FC increased 39 percent ($3,680) from CY 2019 to CY 2020. The increase was followed by a decline of 28 percent ($3,644) from CY 2020 to CY 2021.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 604				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	61	10.1%	10	6	11.6%	16	8
Inpatient Admin	0	0.0%	0	0	0.5%	23	7
Psychiatric Health Facility	<11	-	1	1	1.3%	15	7
Residential	0	0.0%	0	0	0.4%	107	79
Crisis Residential	<11	-	24	24	2.2%	21	14
Per Minute Services							
Crisis Stabilization	<11	-	1,131	1,200	13.0%	1,546	1,200
Crisis Intervention	193	32.0%	281	179	12.8%	248	150
Medication Support	327	54.1%	298	225	60.1%	311	204
Mental Health Services	426	70.5%	483	196	65.1%	868	353
Targeted Case Management	212	35.1%	262	66	36.5%	434	137

- All MHP inpatient and residential services are provided outside Tuolumne County. The MHP had lower utilization of per day services than statewide.
- Most beneficiaries served (70.5 percent) received mental health services. The second highest utilized mental health service is medication support (54.1 percent). The third highest is targeted care management (35.1 percent).
- Compared to statewide, the MHP had high utilization of crisis intervention services. 32 percent of MHP beneficiaries received that service compared to 12.8 percent of beneficiaries statewide.
- The MHP average units for mental health services (483 units) are 55 percent of statewide average units. The MHP average units for targeted care management (262 units) are 60 percent of the statewide average.

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

Service Category	MHP N = 27				Statewide N = 37,489		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	0	0.0%	0	0	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.3%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	0	0.0%	0	0	0.1%	17	12
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	0	0.0%	0	0	3.1%	1,398	1,200
Crisis Intervention	<11	-	380	415	7.5%	404	198
Medication Support	<11	-	539	552	28.3%	394	271
Therapeutic Behavioral Services (TBS)	<11	-	1,000	1,000	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Home Based Services	<11	-	541	374	40.0%	1,351	472
Intensive Care Coordination	<11	-	1,691	670	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	26	96.3%	1,390	728	96.3%	1,848	1,103
Targeted Case Management	14	51.9%	507	166	35.0%	342	120

- Youth in FC did not receive any per day services from the MHP.
- Most FC beneficiaries (96.3 percent) received mental health services. The MHP utilization rate of this service is the same as the statewide utilization rate.
- The MHP provided 51.9 percent of FC beneficiaries with targeted care management, and that percentage exceeds the statewide rate of 35.0 percent.
- The MHP provided crisis intervention, medication support, TBS, intensive home based services and intensive care coordination to a small number of FC

beneficiaries. The numbers of beneficiaries are below the threshold to display based on HIPAA privacy rules.

- Only the MHP medication support and targeted case management average units exceed average units.
- The largest difference in average units between the MHP and statewide is for TBS. The MHP's average units are 25 percent of the statewide average.

IMPACT OF ACCESS FINDINGS

- While the individual PRs by race/ethnicity for the MHP have declined over the past three years, the rates are still above the statewide average for each race/ethnic group. The MHP should continue its outreach efforts to serve different populations in the county.
- The process to provide individual therapy to beneficiaries who decline or are not well-suited for group therapy merits review. If the process is perceived as complex and laborious, it may dissuade pursuit of this or any other services and increase drop-out/withdrawal from care.
- There has been a decline in the number of youth in FC served by the MHP and a corresponding decline in the PR. Some of this is likely due to COVID-19, and decreased referrals from schools during remote learning; however, the MHP had a sharp decline from CY 2020 to CY 2021. This decline and lower utilization of Intensive Care Coordination and Intensive Home-Based Services compared to statewide merits further investigation.
- The MHP reports improved coordination with CWS in Tuolumne County, which will ensure that all new youth FC are referred for an assessment. This collaboration may likely contribute to an increase or stabilization of access for youth in FC.

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 in 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	Partially 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:

- To improve the timeliness of services, the MHP has and continues to adapt its capacity and make changes to its service delivery, including implementing group services; expanding psychiatry contract and hours; and providing transportation to beneficiaries discharged from an acute setting.

- The MHP uses a 30-business day standard for rendered first appointment and meets this standard 95 percent of the time for adults and children. The MHP has a slightly lower rate for youth in FC, at 83 percent.
- The MHP reported that less than 11 youth in FC requested urgent services. By comparison, the MHP reported that 608 adults had urgent requests (for FY 2021 the MHP served at least 560 adults).

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 2021-22. Table 11 and Figures 12–14 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 2020-21 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	12 Business Days	10 Business Days*	43%
First Non-Urgent Service Rendered	14 Business Days	30 Business Days**	95%
First Non-Urgent Psychiatry Appointment Offered	20 Business Days	15 Business Days*	37%
First Non-Urgent Psychiatry Service Rendered	25 Business Days	15 Business Days**	32%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	1.57 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization	9 Days	7 Days*	53%
No-Show Rate – Psychiatry	12%	15%**	n/a
No-Show Rate – Clinicians	14%	20%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2020-21			

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

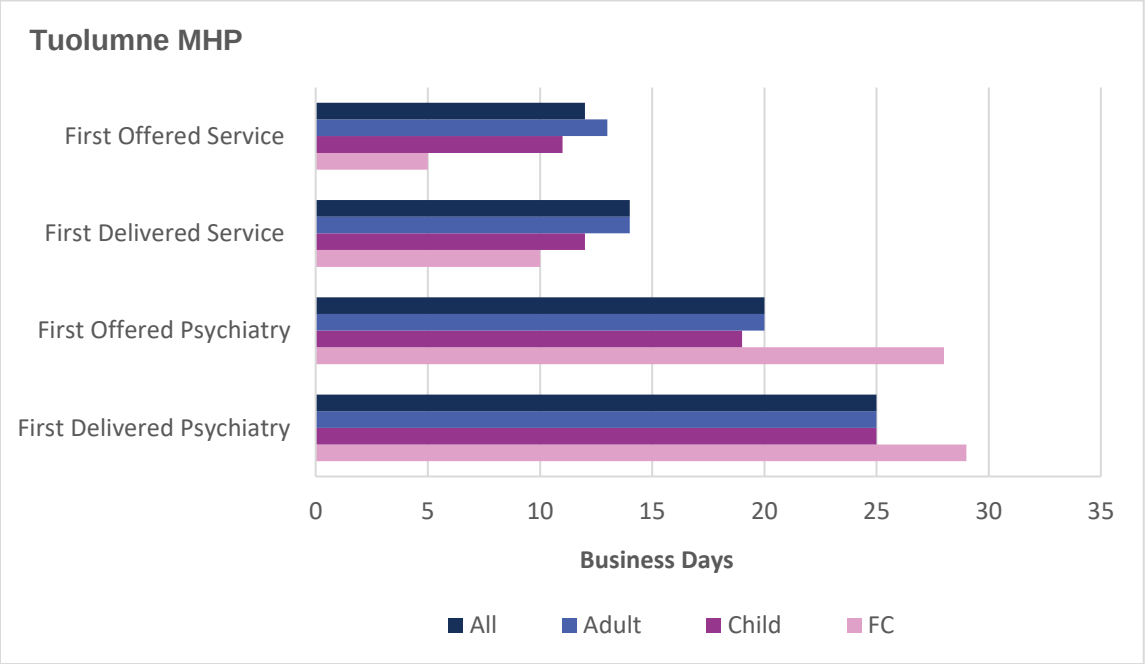


Figure 13: Wait Times for Urgent Services

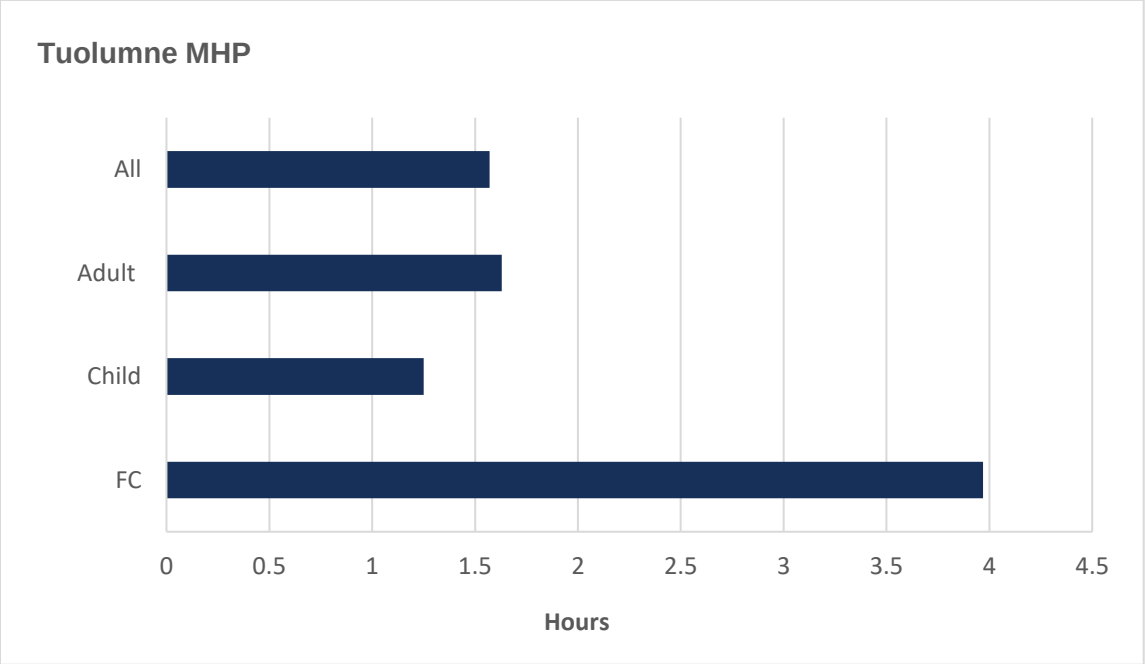
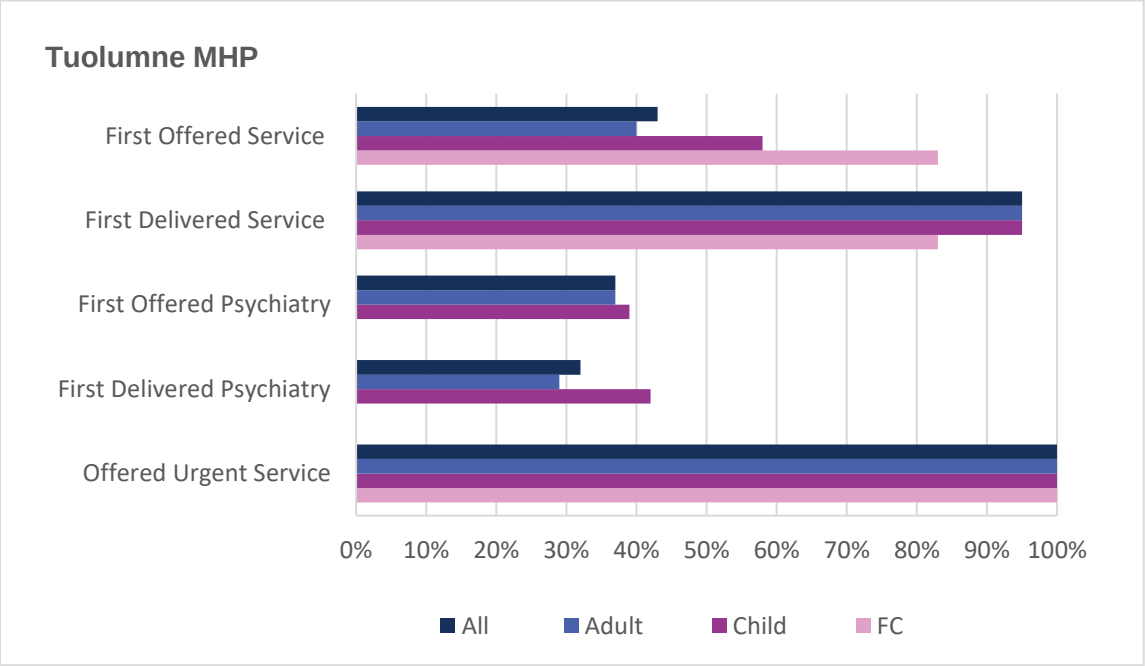


Figure 14: Percent of Services that Met Timeliness Standards



- 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 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 Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as sub-acute symptoms requiring follow-up contact with client within 48 hours. There were reportedly 748 urgent service requests with a reported actual wait time to services for the overall population at 1.56 hours.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access as from the first clinical determination of need.
- 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 12 percent for psychiatric appointments and 14 percent for clinician appointments. The MHP achieved a psychiatric appointment no-show rate that is 80 percent of the standard and a no-show rate that is 70 percent of the standard for clinician appointments.

IMPACT OF TIMELINESS FINDINGS

- A 30-business day standard for rendered first appointment is equivalent to six weeks, which may be an inordinate amount of time for a prospective beneficiary to wait for an initial appointment. Per the MHP's ATA, over one-third of individuals who request a first service do not return for and receive this service.
- A 10-business standard (similar to the first offered appointment) may give the MHP a better assessment of the capacity to provide timely first appointments and, as necessary, further enhance its capacity.
- The number of youth in FC who had urgent service requests is exceptionally low. The MHP should review closely its tracking and monitoring of urgent services to ensure that it is capturing all those who need this level of service and is prepared to serve them.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is the Quality Management (QM) Committee. The QM Committee consists of the full TCBH management team, the QM deputy director, three QI analysts, Business and Operations analysts, the Ethnic Services Coordinator, and additional staff as needed. The QM Committee meets monthly. Compliance is a separate function of the MHP that is managed by the Compliance Officer.

The MHP monitors its quality processes through the QI Council (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of behavioral health staff, representative from each program, community liaisons and members, beneficiaries, family members, and other stakeholder, is scheduled to meet monthly. Since the previous EQR, the MHP QIC met nine of twelve possible times. Of the three main goals related to timeliness, dual diagnosis, and quality assurance identified FY 2021-22 QAPI workplan goals, the MHP met one of the goals.

The MHP utilizes the following level of care (LOC) tools: the LOCUS and the Child/Adolescent Level of Care Utilization System (CALOCUS).

The MHP utilizes the following outcomes tools: CANS-50; PS-C35; LOCUS; and CALOCUS.

The MHP worked closely with the new software application vendor, Credible, to create dashboards to track and review beneficiary outcomes. Originally, the dashboards were to be implemented once Credible was live. When Credible implementation was delayed from mid-year 2022, to July 2023, the Quality Management team decided the dashboard information was too important to delay its use and went live with data from the Cerner application. Information from the outcomes dashboards is now discussed in clinical supervisor meetings.

The MHP validated that data is available from the Credible application and will migrate the dashboards to use Credible as the new data source when it is implemented.

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	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	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	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:

- The MHP has a number of reports that it uses to monitor access, timeliness, and quality of services (e.g., Productivity, High Utilization Report, Service Reports, 'Penetration Rates', and Engaged Clients by gender, age, distance, etc.) and is in the process of developing additional reports and dashboards to enable more comprehensive monitoring.
- The MHP has designated positions, different classifications, and supervisory roles for peer employees. Stakeholder feedback was that the roles and responsibilities of peer employees could be quite variable (e.g., run errands vs. orient new beneficiaries to the system of care) and that at times the differentiation between the classifications was unclear.

- Stakeholders had mixed perceptions of the leadership's efforts to include them in system planning, initiative/policy development, and on key committees. They reported that there was little information and consensus-building on the implementation of the new group model prior to its start. Purportedly, there are challenges around delivering group services effectively.
- The MHP does not track or trend the following HEDIS measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- The MHP is awaiting the EHR upgrade to enable automatic collection of relevant data to monitor the HEDIS measures above.
- The MHP will employ a registered nurse to help support monitoring and corrective action related to medication utilization for youth in FC. The position has been posted and is actively being recruited.

QUALITY PERFORMANCE MEASURES

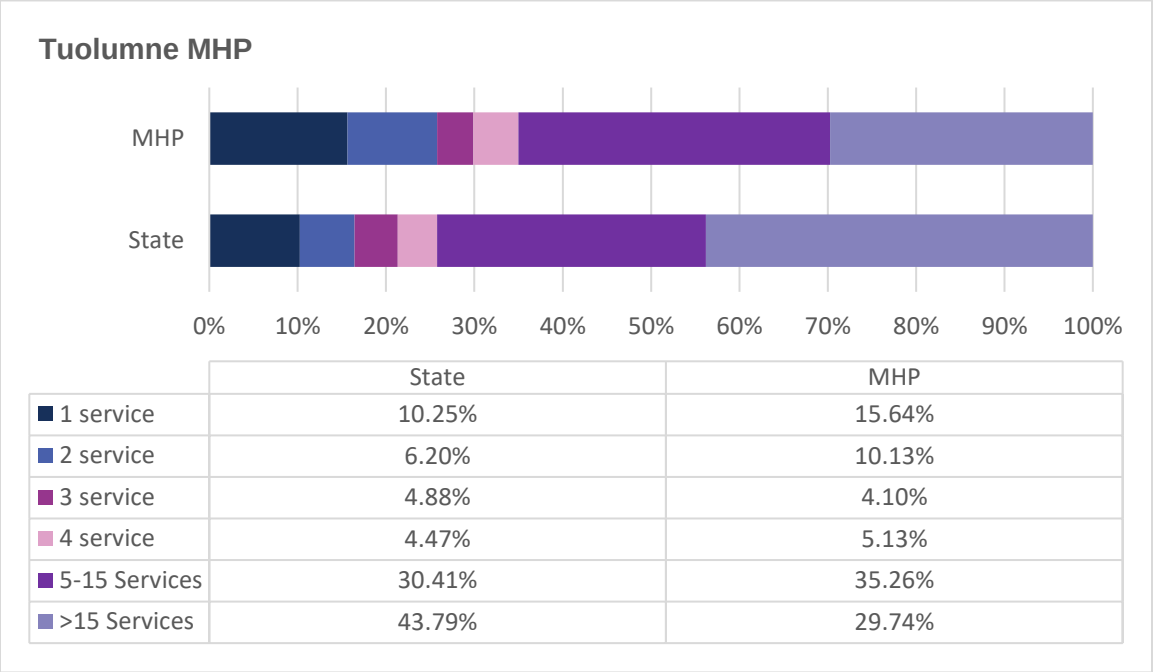
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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



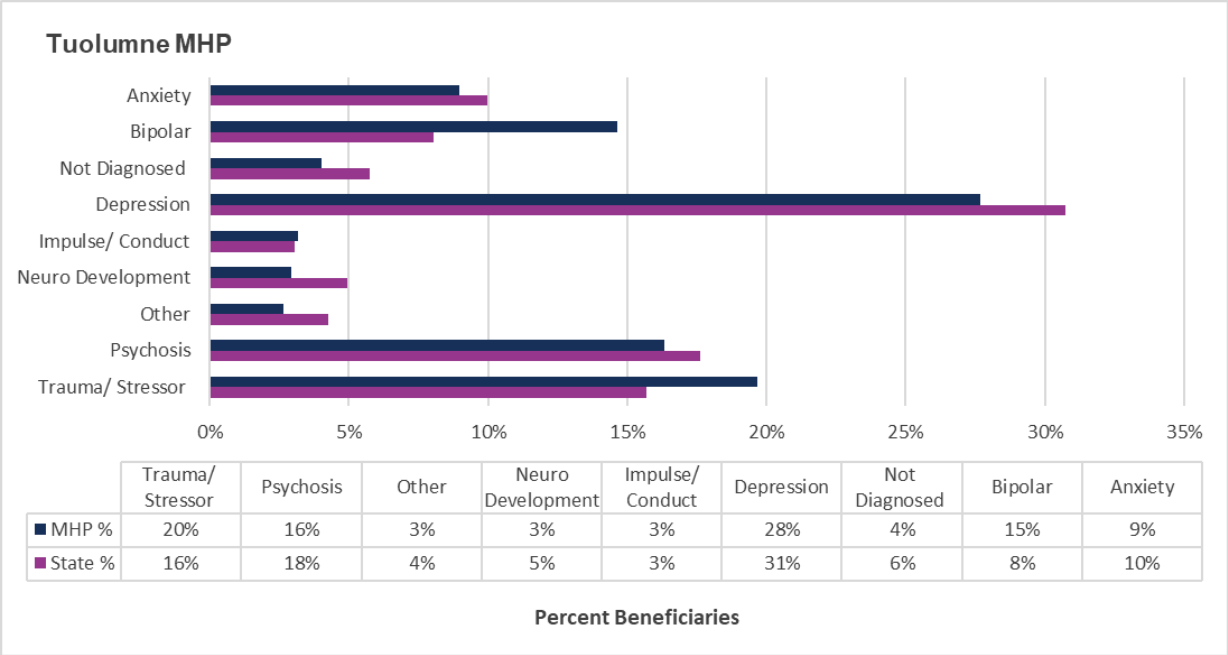
	State	MHP
1 service	10.25%	15.64%
2 service	6.20%	10.13%
3 service	4.88%	4.10%
4 service	4.47%	5.13%
5-15 Services	30.41%	35.26%
>15 Services	43.79%	29.74%

- In CY 2021, a higher percentage of MHP beneficiaries (25.77 percent) had only one or two services compared to 16.45 percent of statewide beneficiaries with only one or two services.
- Most MHP beneficiaries (35.26 percent) received between 5 and 15 services in CY 2021.
- 65 percent of MHP beneficiaries had five or more services in CY 2021 compared to the higher retention rate of 74.2 percent of beneficiaries statewide.

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 following figures represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

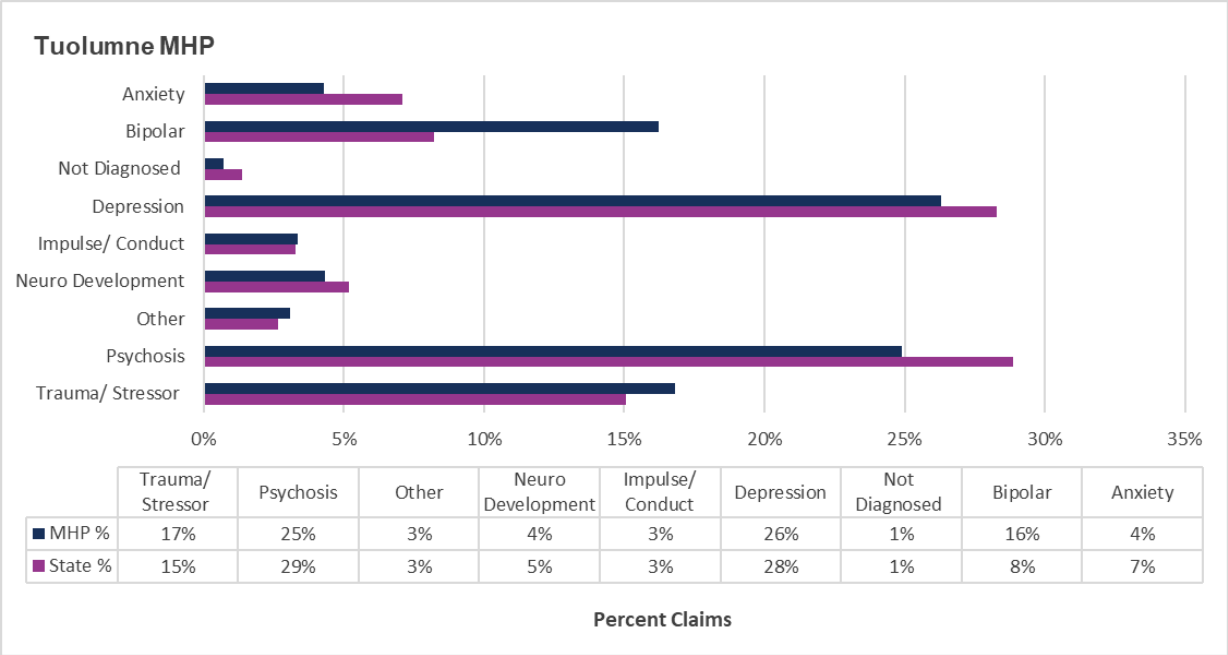
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	20%	16%	3%	3%	3%	28%	4%	15%	9%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The top four MHP diagnoses in CY 2021 are Depression, Trauma/Stressor, Psychosis, and Bipolar. The pattern is very similar to the data reported in CY 2020.
- In CY 2020, Other diagnosis was the second highest diagnostic category. In CY 2021, Other diagnosis was the MHP's lowest diagnosis percentage, at 3 percent.
- In CY 2020, the Bipolar diagnosis for the MHP exceeded the State percentage (15 percent vs. 8 percent). The MHP's Trauma/Stressor diagnosis exceeded the State percentage (20 percent vs. 16 percent).

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 %	17%	25%	3%	4%	3%	26%	1%	16%	4%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- Depression accounted for 26 percent of approved claims for beneficiaries in CY 2021.
- 25 percent of approved claims were for beneficiaries with a diagnosis of Psychosis, whereas 16 percent of beneficiaries had a Psychosis diagnosis. This difference indicates that beneficiaries with a Psychosis diagnosis either had a higher number of services or higher cost services.
- The Trauma/Stressor diagnosis accounted for 17 percent of MHP approved claims and Bipolar accounted for 16 percent of approved claims.

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 (LOS).

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	94	175	8.91	8.86	$14,039	$12,052	$1,319,665
CY 2020	90	145	8.70	8.68	$12,370	$11,814	$1,113,307
CY 2019	106	178	10.23	7.80	$14,437	$10,535	$1,530,325

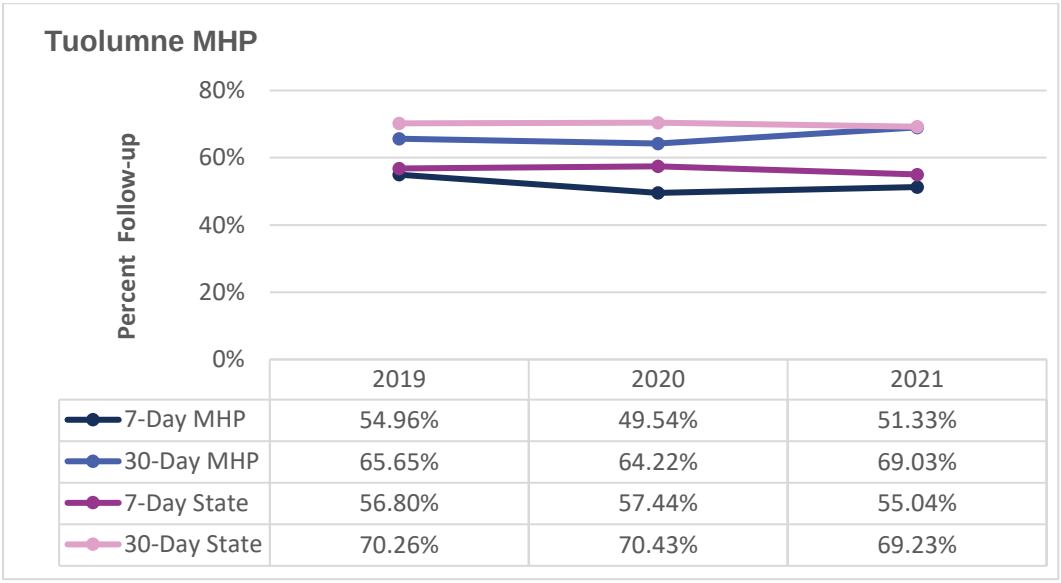
- The MHP's inpatient average LOS in CY 2021 (8.91 days) is very similar to the MHP hospital average LOS in CY 2020 (8.70 days) and the statewide average LOS for CY 2021 (8.86 days).
- The MHP AACB exceeded the statewide AACB over the three calendar years included in Table 13. In CY 2021, the MHP exceeded the statewide AACB by 16 percent.

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 is reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis.

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



	2019	2020	2021
7-Day MHP	54.96%	49.54%	51.33%
30-Day MHP	65.65%	64.22%	69.03%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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

	2019	2020	2021
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- In Figure 18, compared to the statewide follow-up rate, the MHP 7-day follow-up rate is lower by 3.71 percentage points. The MHP 30-day follow-up is comparable to the State. The MHP rate was 69.03 percent and the statewide rate was 69.23 percent.
- The MHP had increases in both 7- and 30-day follow-up rates post-psychiatric inpatient discharge from CY 2020 to CY 2021. The increase for 7-day follow-up was from 49.54 percent to 51.33 percent. The increase for 30-day follow up was from 64.22 percent to 69.03 percent.
- Figure 19 displays only State data for 7- and 30-day psychiatric readmission rates, due to the small number of readmissions that the MHP had. Such low rates suggest that the MHP's follow-up post inpatient discharge is effective.

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 LOCs by other beneficiaries. HCB percentage of total claims, when compared with the HCB count percentage, provides a subset of the beneficiary population that warrants close utilization review, both for appropriateness of LOC and expected outcomes.

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

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

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, nearly 92 percent of the statewide beneficiaries are “low cost” (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACB of $4,412 and median of $2,830.

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	36	4.62%	35.26%	$1,894,958	$52,638	$41,484
	CY 2020	32	3.71%	34.49%	$1,831,476	$57,234	$38,775
	CY 2019	22	2.24%	28.87%	$1,396,722	$63,487	$51,591

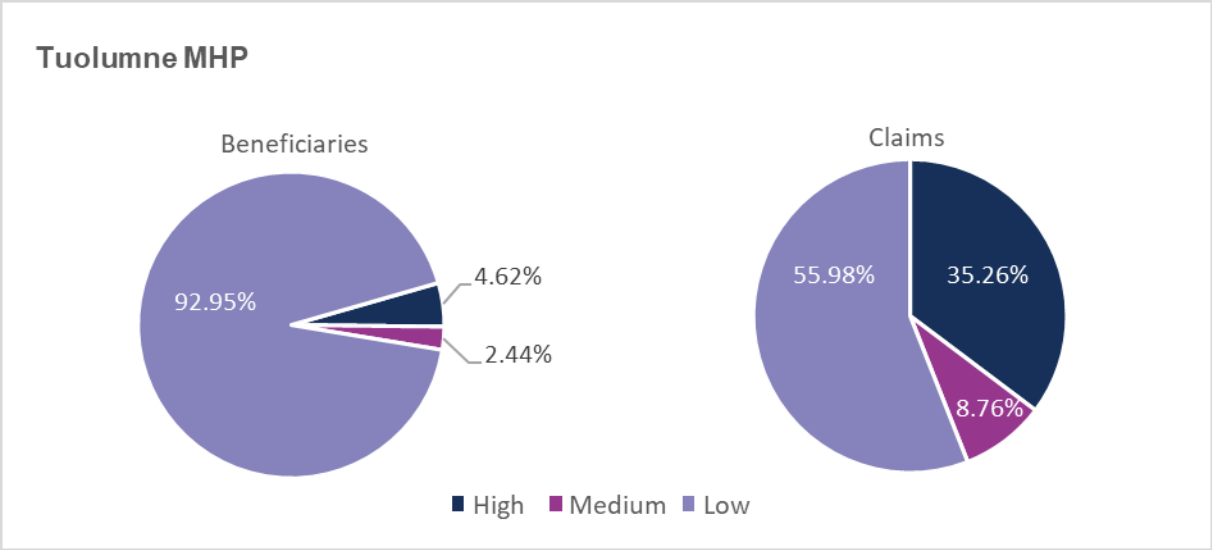
- In CY 2021, the percentage of HCBs and percentage of claims for HCBs increased. The percentage of beneficiaries served grew from 3.71 percent in CY 2020 to 4.62 percent in CY 2021.
- As the percentage of HCBs increased from CY 2020 to CY 2021, the percent of total claims increased as well from 34.49 percent to 35.26 percent.
- As reimbursement rates increased, the increase in HCB served follows. A larger number of beneficiaries received services whose claims exceeded the threshold for HCBs.

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

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	19	2.44%	8.76%	$470,681	$24,773	$24,734
Low Cost (Less than $20K)	725	92.95%	55.98%	$3,008,380	$4,149	$2,622

- Most of the beneficiaries served, 92.95 percent, are in the low-cost category and their approved claims accounted for 55.98 percent of total claims.
- The MHP had 2.44 percent of beneficiaries served fall into the medium cost category and accounted 8.76 percent of total approved claims.

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



- The charts in Figure 20 provide a graphic of the data from Table 15 above that visually display the differences between beneficiaries served and the share of approved claims for each cost category.

IMPACT OF QUALITY FINDINGS

- The MHP has more beneficiaries who receive only one service than the statewide. As mentioned previously, this may be an impact of longer waits for services, which could lead to drop-out in services.
- The number of youth in FC, prescribed psychotropic medications, and served by the MHP is small. The MHP should plan for contingencies on how to monitor the HEDIS measures (for less than 20 youth), if there are further delays in the EHR implementation or recruitment of the nurse.
- Of the reports and measures to monitor services and outcomes, stakeholders were most familiar with the productivity reports and the perception was that productivity was the primary focus of MHP leadership. Prominently featuring the other reports and performance measures would provide stakeholders with a better understanding of how the MHP evaluates access, timeliness, and quality of services.
- Regular review of medication support services, the second most utilized service by adult beneficiaries, and a forum to discuss and evaluate medication practices were not emphasized by TCBH. Purportedly, reviews happen through the contract provider, Kings View, that facilitates medication services for the MHP.
- The number of inpatient admissions increased without a comparable increase in the unduplicated number of beneficiaries admitted. This suggests that readmissions have increased in the MHP.

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: Case Management Services

Date Started: 07/2021

Aim Statement: Will assigning case managers caseloads and providing services after initial assessment result in an increase in timely services to first offered SMHS from 30 days to 15 days and increase crisis 48-hour follow-up compliance from 60 percent to 75 percent by 2023?

Target Population: All new and existing beneficiaries—youth and adults.

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

Summary

The MHP is in the second year of this project to improve timeliness and access to services and anticipates concluding the project in June 2023. Prior to the project, the single accountable individual who would coordinate services and carry a caseload was the clinician. With high caseload numbers and fewer clinicians, there were delays in initial assessments, delays to follow-up after crisis, and reduced contact with

[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

beneficiaries. In addition, clinicians had less time to provide clinical services. The MHP's intervention was to shift the single accountable individual to case managers who were greater in number and who did not have other clinical duties to perform. Case managers would be the primary contact for beneficiaries and would coordinate services and conduct crisis follow-up appointments.

The MHP reported improvement over the first year of the project. At six months, the average time to first offered appointment went from 30 to 21 business days; the average number of services provided to a beneficiary increased from two to five services; and first appointment no-show rate went from 15 percent to 13 percent. At 12 months (in July 2022), the average time to first offered was 14 days, the average number of services per beneficiary was 14, and the no-show rate remained at 13 percent. During this same period, there was no appreciable increase in the proportion of beneficiaries who received a post-crisis follow-up within 48 hours; the rates went from 57 percent and remained at 59 percent. The MHP reports that over the next six months, the project stalled due to changes in staffing including case managers and supervisors who signed off on all work performed by the case managers. At the December 2022 remeasurement, there were no or only minimal changes in the outcome measures. Now that staffing has stabilized, the MHP has resumed focus on the project and anticipates further improvements until the project concludes in July 2023.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence. The MHP identified an area needing improvement, applied interventions, and measured outcomes through performance measures. When there were external factors affecting consistent application of the intervention, the MHP paused the project and then regrouped.

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

- To highlight the clinical features or implications of this project. The project reads as a non-clinical PIP given that much of the focus is on timely services.
- To measure no-show for subsequent appointments, *after* the first appointment. The MHP's current measure of no-show actually measures application of the intervention itself.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: FUM

Date Started: 12/2022

Aim Statement: The goal of the PIP is to increase data communication with the hospital to improve the support and stabilization after crisis service for adults 18 and older by ten percent over the next two fiscal years.

Target Population: Adults, 18 years or older, who receive crisis services at the ED.

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

Summary

Crisis services for the MHP are facilitated through the local ED. The MHP has a 59 percent crisis follow-up rate within 48-hours (i.e., the MHP standard). Conversely, the MHP has a 68 percent and 78 percent post-ED follow-up rate within 7 and 30 days, respectively. Both ED follow-up rates are above the current HEDIS Medicaid benchmarks. The process for providing follow-up appointments for ED and crisis visits is the same and the root causes for reduced follow-up would likely be the same. If the MHP can improve the ED visit follow-up rate, then the MHP can also improve the crisis follow-up rate.

The MHP has identified two areas that contribute to reduced follow-up rate: no protocols or standardized practices for follow-up and minimal or no information from the ED about beneficiaries who are by the MHP. The MHP's interventions are to (1) develop and apply written policies and procedures; (2) implement a new EHR that facilitates data exchange; and (3) increase services from case managements so as to prevent or reduce crisis contacts in the first place. In advance of the EHR implementation (in July 2023), the MHP and EDs share a spreadsheet that tracks ED placement, discharge, and other service details for the beneficiary.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence. The MHP is leveraging the current opportunity, through the FUM project, to improve the 48-hour crisis follow-up rate. By standardizing processes and increasing data exchange, the MHP anticipates an improvement in all three measures.

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

- State the HEDIS 7- and 30-day benchmarks to which the MHP is comparing itself.
- Provide more detail on the increased case management services that are meant to prevent or reduce hospitalizations (e.g., number of contacts, beneficiaries to be selected, etc.).

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner/Kings View, which has been in use for 16 years. Currently, the MHP is actively implementing a new system which requires moderate staff involvement to fully develop. The MHP is maintaining the relationship with Kings View that will host the new EHR software, Credible.

Approximately 5.0 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 percentage allocated to IS support is unchanged from the previous fiscal year. The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 59 named users with log-on authority to the EHR, including approximately 53 county staff and 6 contractor staff. Support for the users is provided by 0.25 full-time equivalent (FTE) IS technology positions within the MHP. Currently the position is filled. In addition to the MHP staff, support is provided by the application service provider, Kings View. Kings View has a total pool of 48 FTEs who are available to address customer support needs and provide timely resolution.

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

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
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	98%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	2%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not have a PHR however they plan to implement a PHR within the next year based on their new EHR software application Credible.

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 departments/agencies/organizations. TCBH is working on an initiative that includes CWS, Juvenile Probation, and the County Office of Education to create a platform for data exchange to enhance child/youth services. At this point, only aggregate data is sent to a data platform. TCBH is working on governance, privacy, and security issues to share data across departments.

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	Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Partially Met
4E	Security and Controls	Met
4F	Interoperability	Met

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

- Tuolumne benefits from a good relationship with the ASP. Kings View provides stable application software hosting and maintenance, Help Desk support, and conducts data analysis, among other supports.
- The MHP partially met 4D EHR Functionality based on the Cerner application software. The Cerner EHR lacks several key components including Care Coordination, Laboratory Orders/Results, 'Level of Care', Referral Management, and PHR.
- The Cerner application checks for data entry errors for beneficiary services and the MHP developed reports and procedures to review data prior to billing. The MHP's denial rate is very low as a result.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

For the MHP, it appears that the MHP has no significant claims lag in CY 2021. This chart appears to reflect a largely complete or very substantially complete claims data set for the time frame claimed.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	1,054	$328,321	$0	0.00%	$322,385
Feb	1,171	$399,323	$321	0.08%	$385,572
Mar	1,375	$451,551	$1,139	0.25%	$443,820
April	1,158	$378,331	$349	0.09%	$371,288
May	942	$346,508	$0	0.00%	$341,650
June	985	$354,415	$0	0.00%	$346,147
July	927	$335,343	$0	0.00%	$329,111
Aug	927	$324,174	$520	0.16%	$314,587
Sept	984	$339,707	$1,104	0.32%	$332,785
Oct	963	$328,339	$55	0.02%	$322,498
Nov	862	$292,132	$2,427	0.83%	$284,849
Dec	890	$322,982	$2,720	0.84%	$317,300
Total	**12,238**	**$4,201,126**	**$8,635**	**0.21%**	**$4,111,992**

- MHP billing is consistent throughout CY 2021 and billing staff achieved very low rates of denied claims.
- The MHP staff expressed confidence that they will achieve similar success with the implementation of a new EHR software application, as well as CalAIM payment reform.

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 must be billed before submission of claim	6	$2,518	29.16%
Beneficiary not eligible or non-covered charges	2	$2,135	24.72%
Other	5	$1,503	17.40%
Other healthcare coverage must be billed before submission of claim	3	$897	10.39%
Late claim	2	$857	9.92%
Service location NPI issue	4	$726	8.41%
Total Denied Claims	**22**	**$8,636**	**100.00%**
Overall Denied Claims Rate	**0.21%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The MHP has a very low percentage of denied claims. This low denied claims rate indicates that the MHP has good policies and procedures in place for claiming services.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The longstanding good relationship between TCBH and Kings View Health Information Support benefits the MHP by relieving them of maintaining IS staff, software, and hardware. Kings View provides a stable platform and support for the TCBH EHR. Technology was not called out as an issue by staff.
- Staff are very familiar with their current EHR and did not report issues with it. Training for the current EHR across the MHP is provided by super users. With the implementation of the new EHR Credible, the MHP plans to continue to rely on superusers to provide support.
- TCBH provides reports related to caseloads, productivity, and services through emails monthly to line staff and weekly to supervisors but staff, including program managers, who attempt to access these reports themselves report difficulty. The reports are not within the Cerner application; they are in a separate folder that requires multiple steps to navigate to the desired report and entering certain parameters.
- Staff looked forward to the new EHR application, even though they have seen very little of the application and what it can do.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP participated in the 2022 CPS and compared the results to the previous two surveys. The findings from the 2022 survey show positive perceptions of services in all domains and much improved beneficiary perception of *Outcomes of Services.*

CONSUMER FAMILY MEMBER FOCUS GROUP

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 one 90-minute focus group with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a culturally diverse group of 10-12 adult beneficiaries, including Hispanic/Latino and Other beneficiaries, who have initiated services in the preceding 12 months. The focus group was held via videoconference and included two participants. All consumers participating receive clinical services from the MHP.

Due to the small number of participants, the feedback from this focus group is incorporated in the feedback of the other focus groups sessions and in the overall findings at the end of this section.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

The MHP obtains beneficiary feedback from the CPS, grievances, and input from the QIC. The supporting documents indicate that the MHP gathers the feedback, but subsequent action was not well documented, which is an important piece of accountability.

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 full complement of management staff who can provide program oversight and direct various aspects of CalAIM implementation. (Quality)
2. TCBH opted into an effort to fund retention payment for staff and distributed the payments at the end of the year (2022). This initiative that plans to be continued contributes to retention of staff. (Access, Timeliness, Quality)
3. The ongoing contract between TCBH and Kings View Health Information Support is a benefit to the MHP. It eliminates the need to staff IS positions and maintain a larger physical IS infrastructure. (IS)
4. The MHP is part of a multiagency CSOC and can leverage those collaborations to improve access to youth, especially those in FC. (Access, Quality)
5. Through the EHR system, the MHP has reports and procedures to review data entry errors prior that affect billing, which contributes to a very low claims denial rate, 0.21 percent. (IS, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The process to provide individual therapy to beneficiaries who decline or are not well-suited for group therapy is perceived as complex and laborious which may dissuade some beneficiaries from remaining in services. (Access)
2. The PR, the number of youth served, and units of services for youth in FC in the MHP are all lower than the statewide (and similar-sized MHP) averages. (Access, Timeliness, Quality)
3. Beneficiaries do not have consistent and reliable access to the nonmedical transportation services through the MCP providers for their mental health services and appointments. (Access)
4. The MHP is not yet able to use its EHR to track and trend the required FC HEDIS measures. (Quality)
5. Clinical staff, including program managers, stated that accessing reports on their own is difficult, which precludes the ability to meaningfully use the data and information gleaned from the reports to guide decision-making. (Quality, 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. Review the process of providing adult beneficiaries with non-group/individual therapy services and identify opportunities and implement strategies to streamline the process. (Access)
2. Continue to investigate reasons and develop and implement strategies to increase access and timeliness of services for youth in FC. (Access, Timeliness, Quality)
3. Investigate reasons and develop and implement strategies in collaboration with the MCP providers to ensure consistent and reliable access to transportation assistance for beneficiaries. (Access)
4. Develop a process that is not dependent on the EHR implementation and begin to track and trend the FC HEDIS measures. (Quality) (This recommendation is a carry-over from FY 2021-22 and FY 2020-21.)
5. Engage staff (e.g., through a survey, focus group, or other structured feedback process) on the barriers that they are finding in accessing reports and develop and implement strategies to remove those barriers. (Quality, IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

There were only two participants for the consumer/family member focus group, neither of whom identified as Hispanic/Latino, the requested beneficiary group.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, as part of the system validation and key informant interview process. Topics listed may be covered in one or more review sessions.

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Tuolumne MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Validation and Analysis of Beneficiary Perceptions of Care
Consumer and Family Member Focus Group(s)
Clinical Line Staff Group Interview
Program Managers Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Information Systems Billing and Fiscal Interview
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Patricia Rupe, Consumer/Family Member Reviewer
Ewurama Shaw-Taylor, PhD, CPHQ, Lead Quality Reviewer
Lorrie Sheets, Information Systems Reviewer
Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-review and the post-review meetings and in preparing the recommendations within this report.

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Ambler	Misti	Deputy Director/Compliance Officer	Tuolumne County Behavioral Health
Carter	William	Senior Behavioral Health Worker	Tuolumne County Behavioral Health
Coe	Betsey	Senior Behavioral Health Worker	Tuolumne County Behavioral Health
Duarte	Bree	Peer Support III	Tuolumne County Behavioral Health
Fischer	Danielle	Clinician	Tuolumne County Behavioral Health
Guhl	Jennifer	Agency Manager	Tuolumne County Behavioral Health
Hoskins	Betty	Clinical Manager	Tuolumne County Behavioral Health
Kolby	Brock	Deputy Director, Clinical	Tuolumne County Behavioral Health
Lawrance	Amanda	Staff Analyst	Tuolumne County Behavioral Health
Lujan	Lindsey	Deputy Director Quality Management	Tuolumne County Behavioral Health
Mariscal	Tami	Director	Tuolumne County Behavioral Health
Springer	Kathleen	Clinician	Tuolumne County Behavioral Health
Tamayo	Rayanne	Clinical Manager	Tuolumne County Behavioral Health
Taylor	Glenda	Peer Support II	Tuolumne County Behavioral Health
unknown	Katie	unknown	Tuolumne County Behavioral Health

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	The MHP is in the second year of this project to improve timeliness and access to services. The MHP reported improvement over the first year of the project. The project stalled over the next six months, with no or only minimal changes in the outcome measures. The MHP has resumed focus on the project and anticipates further improvements until the project concludes in July 2023.

General PIP Information
MHP/DMC-ODS Name: Tuolumne County
PIP Title: Case Management Services
PIP Aim Statement: Will assigning case managers caseloads and providing services after initial assessment result in an increase in timely services to first offered SMHS from 30 days to 15 days and increase crisis 48-hour follow-up compliance from 60 percent to 75 percent by 2023?
Date Started: 07/2021
Date Completed: ongoing
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): new and existing beneficiaries—youth and adults

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): shift the single accountable individual to case managers

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
Timeliness to first offered appointment	7/2021	30 days	12/2022	13 days	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Follow-up rate post crisis	7/2021	57%	12/2022	59%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Average number of rendered service	7/2021	2	12/2022	13	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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
No-show rate to first offered appointment	7/2021	15%	12/2022	18%	☐ 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:

- Highlight the clinical features or implications of this project. The project reads as a non-clinical PIP given that much of the focus is on timely services.
- Measure no-show for subsequent appointments, *after* the first appointment. The MHP's current measure of no-show actually measures application of the intervention itself.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP is leveraging the current opportunity, through the FUM project, to improve the 48-hour crisis follow-up rate. By standardizing processes and increasing data exchange, the MHP anticipates an improvement in the 2-day (i.e., post-crisis), 7-day, and 30-day, and follow-up rates.
General PIP Information	
MHP/DMC-ODS Name: Tuolumne County	
PIP Title: FUM	
PIP Aim Statement: The goal of the PIP is to increase data communication with the hospital to improve the support and stabilization after crisis service for adults 18 and older by ten percent over the next two fiscal years.	
Date Started: 12/2022	
Date Completed: ongoing	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): Adults, 18 years or older, who receive crisis services at the ED.	

Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): 1. Develop and apply written policies and procedures. 2. Implement a new EHR that facilitates data exchange. 3. Increase services from case managements.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

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
Follow-up rates 2-Day 7-Day 30-day	FY 2021-22	 59% 68% 78%	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • State the HEDIS 7- and 30-day benchmarks to which the MHP is comparing itself. • Provide more detail on the increased case management services that are meant to prevent or reduce hospitalizations (e.g., number of contacts, beneficiaries to be selected, etc.).

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 required and is attached to be included in this report.

Tuolumne County
Behavioral Health Department

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Tami Mariscal
Director

Misti Ambler
Deputy Director

Brock Kolby, LPCC
Deputy Director

May 3, 2023

EQRO Beneficiary Participation:

In pre COVID years Tuolumne County Behavioral Health utilized reaching out via mail to invite clients to participate in EQRO and were not able to get responses from clients easily. We then began utilizing our Enrichment Center to encourage those who were already actively engaged to participate, this strategy had much better results. With Tuolumne County now coming out into post COVID, the Enrichment Center has not come back to full capacity and beneficiaries are returning at a slow pace. This year we shifted our strategies to accommodate these changes and utilized the relationships with case managers to engage clients in the EQRO process. We advertised the gift card with clients through our case managers engagement with clients. This strategy resulted in three willing participants and resulted in one no show. We will continue to work on barriers on client engagement by re-strategize client engagement efforts for EQRO participation in the post COVID climate.

Thank you,

Tami Mariscal
Director
Tuolumne County Behavioral Health