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FY 2023-24
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

SUTTER-YUBA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

January 9, 2024

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EXECUTIVE SUMMARY

Highlights from the fiscal year (FY) 2023-24 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, "Sutter-Yuba" may be used to identify the Sutter-Yuba County MHP.

MHP INFORMATION

Review Type — Virtual

Date of Review — January 9, 2024

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 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 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	3	1	0
Timeliness of Care	6	3	2	1
Quality of Care	10	1	8	1
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**11**	**13**	**2**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Improving Rates of Post-Psychiatric Hospitalization Follow-up (FUH)	Clinical	01/2023	Implementation	Low confidence
Follow-Up After Psychiatric Emergency Services	Non-Clinical	01/2023	Implementation	Low confidence

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	[redacted]

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP continues to maintain a unilateral front with contract providers and works for equality across the two-county system.
- Increasing the IS staffing provides the MHP with more resources to work through issues, as well as develop improved processes within the new electronic health record (EHR).
- The MHP has longevity of staff across many departments, especially true for the psychiatric providers and includes the medical director.
- Despite a lack of aggregate data for level of care (LOC) tools currently, the MHP has defined functional LOC tools separate from outcome measures. This is considered a strength to build upon.
- The MHP has embedded staff in many key areas in the system which clearly benefits member outcomes, among other positive results.

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

- The MHP continues to have challenges in addressing its timeliness measures.
- The penetration rate (PR) of Hispanic/Latino members has historically been lower than the state and other counties of comparable size.

- Line staff indicate that regular phone calls to members awaiting ongoing follow-up care after screening and initially offered appointment both add to their workload and can result in disengagement of members. Members validate that there is a long wait during this period.
- For reliable urgent services data to be tracked moving ahead with the hopes in the new EHR, the MHP should clearly define what is counted and train to this regularly.
- There are a high number of Medi-Cal claim denials indicating "Medicare Part B must be billed before submission of claim," and "Other healthcare coverage must be billed first," which impact the MHP's income stability.

Recommendations for improvement based upon this review include:

- Monitor timeliness on a quarterly basis, with documented evidence of review and analysis.
- Use capacity, language, caseloads, and/or service data to support advocacy for improved Hispanic/Latino resources for Spanish-speaking members as measured by improvements in the PR for this population.
- During the ongoing clinical staffing shortage, improve upon creative solutions to maintain engagement with adult members who are either awaiting ongoing therapy or being served during No Wrong Door.
- Develop clear protocols around urgent service requests and train staff to accurately capture these in the Credible EHR.
- Develop a process to improve identification of those members with Part B Medicare and/or other healthcare coverage to allow proper claiming.

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 February 2023.

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 members 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 members.

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, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill 1291 (Section 14717.5 of the 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 2023-24 findings of the EQR for Sutter-Yuba County MHP by BHC, conducted as a virtual review on January 9, 2024.

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, members, 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.

CalEQRO reviews are retrospective; therefore, county documentation that is requested for this review covers the time frame since the prior review. Additionally, the Medi-Cal approved claims data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and the Inpatient Consolidation (IPC) File. PMs calculated by CalEQRO cover services for approved claims for calendar year (CY) 2022 as adjudicated by DHCS by April 2023. Several measures display a three-year trend from CY 2020 to CY 2022.

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 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 member 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) – summary of the 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, and also as outlined DHCS's Comprehensive Quality Strategy.
- Validation and analysis of each MHP's 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 members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- 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, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding PR percentages.

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 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

While there were no environmental disasters reported this year, the MHP reported several issues that would impact operations. These include continuation of staffing shortages which reportedly impacted timeliness and consistency for services, aging buildings that limited adequate and confidential office space, and a significant increase in referrals for conservatorship.

SIGNIFICANT CHANGES AND INITIATIVES

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

- In addition to California Advancing and Innovating Medi-Cal (CalAIM) initiatives and payment reform, in May 2023 the MHP transitioned to a new EHR. This resulted in significant delays to workflows and the ability to review and analyze data.
- At the time of the review, the MHP had 39 vacant clinical positions. This requires significant adaptation by the MHP.
- The MHP was able to fill the Administration and Finance Assistant Director position that had been vacant for over a year.
- The peer mentorship program has certified [redacted] peer staff with [redacted] credentialed as a supervisor.
- The MHP is working to increase psychiatry support by implementing residency rotations at the psychiatric health facility (PHF).
- Several other key initiatives have begun including a mobile crisis unit, redesign of full service partnership and conservatorship teams, and efforts toward increased safety at the PHF.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 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 not addressed may be presented as a recommendation again for this review. However, if the MHP has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 1: Monitor timeliness on a quarterly basis, with documented evidence of review and analysis of MHP performance on:

- time to offered and delivered first services for youth
- time to Early Explorers group
- time to rendered psychiatry for youth; and
- time to second and third appointments for all beneficiaries.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Timeliness tracking has historically been unreliable, which the MHP suggests has been corrected with the new EHR. The last two reports have made recommendations in this area and the MHP is making progress.
- The MHP did take action to retrain staff on the access tracking processes and again for the new EHR tracking form. In this process, many errors in tracking were identified, including discovering that staff were not tracking psychiatric requests using the correct form.
- Dashboards for the new EHR are in production. The MHP reports an active dashboard for access to services and dashboards for follow-up after

hospitalization, rehospitalization rates, and no-show rates currently in development. The plan is to review this data at the quarterly Quality Improvement Committee (QIC) meeting and is incorporated into the FY 2023-24 QAPI plan.

- Despite the MHP's ability to offer a timely initial appointment most of the time, frequently the same day with open access clinics, members and line staff note months of wait for ongoing therapy services to begin for both individual therapy and other programs, most severely within the adult system of care.
- This recommendation is being continued to support development of reliable and accurate tracking, monitoring, and trending practices for timeliness using the new EHR's anticipated tools.

Recommendation 2: Include instructions on the SYBH website in Spanish and Hmong directing individuals to documents in those languages.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Document links have been updated on the website in Spanish and Hmong so that members can identify and utilize this information.
- The main business line and psychiatric emergency services line, however, are not listed in any language other than English on the main page. This was recommended during the review and the MHP said the update would be made.

Recommendation 3: Develop a SYBH process for reviewing medication utilization of youth in FC with quarterly review by the medical director or another assigned psychiatric provider. (Such a process may involve receipt/collection of requisite information from the JV-220 from the public health nurse on a monthly basis, audits of those records, aggregation of that information, and a committee review)

(This recommendation is a carry-over from FY 2021-22.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has plans to track and trend Healthcare Effectiveness Data and Information Set (HEDIS) measures for FC with the new EHR; however, only one was tracked, but not trended, this year. The MHP is confident that the tracking of these measures will be reliably tracked and trended. The MHP is encouraged to ensure a process wherein they are routinely monitored.
- There is a goal of reviewing all medication utilization at the Utilization Review Committee quarterly; however, dashboards are in development, and this has not yet occurred.
- The MHP does have some strengths and demonstrated progress on this item. The psychiatric team is long-standing with the stable guidance of a medical director. Further, there is a pharmacist under contract to review medication charts and regularly report to the psychiatric team. The contract is currently being updated to include reporting of trends from the HEDIS results.

- This recommendation is considered addressed with the current plan and in light of other priority recommendations identified.

Recommendation 4: Review the QAPI and incorporate QI goals that directly benefit beneficiary experience as versus compliance.

(This recommendation is a carry-over from FY 2021-22, FY 2020-21, and FY 2019-20.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- This recommendation is considered complete with the updated QAPI plan. It includes three goals relating to member satisfaction and four relating to access and timeliness, among many other goals. These goals do address the member experience, including test calls to the access line, expanding staff cultural competence, and exploring Consumer Perception Survey (CPS) results, requests for change in provider, and grievances related to access.

Recommendation 5: Develop and provide cross-training in the Finance/Billing unit to ensure preservation of processes and relevant history within the unit.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- This recommendation is considered addressed. The MHP conducted cross-training in the finance/billing unit including explanation of benefits processing. With the return of the open access process, three staff received finance refresher training. Due to the changes in the EHR, a minimum of two staff will be trained in the finance/billing processes.

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 members) 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 members 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 members 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 74 percent of services were delivered by county-operated/staffed clinics and sites, and 26 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 86 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff; members may request services through the Access Line as well as through open access clinics, crisis services, and referrals from schools. Sutter County Probation and Child Welfare are access points for specific programs. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. Members are screened using the CalAIM Screening Tools and then scheduled for services operated by the MHP or linked to managed care plan providers as appropriate.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 264 adults, 250 youth, and 81 older adults across nine county operated sites and eight contractor-operated sites. Among those served, 11 members received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for members 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 in Table 1A and Table 1B.

In December 2022, DHCS issued its FY 2022-23 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 Sutter-Yuba County, the time and distance requirements are 45 miles and 75 minutes for outpatient MH 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 2022-23

Alternative Access Standards				
The MHP was required to submit an AAS request due to time or distance requirements	☐ Yes ☒ No			
AAS Details	**Psychiatry**		**MH Services**	
	Adults (ages 21+)	Youth (ages 0-20)	Adults (ages 21+)	Youth (ages 0-20)

- 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 2022-23

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 member within time and distance standards using a network provider, the MHP was not required to allow members 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 members 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 member 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 Member Needs	Partially Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- Although the only threshold language is Spanish, the MHP offers documents and an outreach service for Hmong speakers. The MHP is in the process of providing documents in Punjabi. The development of documents in these languages is based on the needs of members.
- As reflected in the prior report, the MHP has close collaboration with its contract providers and community partners. This year, in preparation for the change of Medi-Cal managed care providers (MCPs) in the county, the MHP has already established a regular working relationship with Partnership Health Plan.
- The Cultural Competency Committee has been restructured and combined with the Health and Human Services branch, called the Diversity Equity Inclusion Committee, to prioritize efforts across Sutter and Yuba counties, provide mutual support, and ensure sustained progress.
- The QAPI plan now includes a goal to look at capacity, and the MHP could benefit from continued effort toward monitoring system demand. New dashboards for regular use by clinical supervisors are currently in development. The service and penetration data have been pulled for specific purposes, for example to support staffing increases, but is not routine. Further, implemented strategies do not appear to be evaluated.

ACCESS PERFORMANCE MEASURES

Members Served, Penetration Rates, and Average Approved Claims per Member Served

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

PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, the MHP's PR of 3.98 percent indicates slightly better access to care than was seen statewide.

Table 3: Sutter-Yuba MHP Annual Members Served and Total Approved Claims, CY 2020-22

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	84,778	[redacted]	[redacted]	$23,143,295	$6,865
CY 2021	79,919	[redacted]	[redacted]	$19,297,807	$5,936
CY 2020	75,136	[redacted]	[redacted]	$17,767,202	$5,344

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

- Eligible members increased by 6.1 percent, a total of 4,859 individuals. The number of members served increased by 120 members, or 3.7 percent, which resulted in a slight decrease in MHP's PR.
- Total approved claims and AACM both increased. Claims increased by over $3.8 million, or 19.9 percent, and AACM by $929 representing a 15.8 percent increase.

Table 4: Sutter-Yuba County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	9,485	[redacted]	[redacted]	1.31%	1.82%
Ages 6-17	20,814	936	4.50%	5.83%	5.65%
Ages 18-20	4,530	[redacted]	[redacted]	4.72%	3.97%
Ages 21-64	42,239	2,017	4.78%	4.53%	4.03%
Ages 65+	7,711	188	2.44%	2.25%	1.86%

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Total	**84,778**	[redacted]	[redacted]	**4.30%**	**3.96%**

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

- The PR in each of the youth age groups are lower than both the county size group and statewide PR. The ages 21-64 and 65+ are higher than both county size group and statewide PR.

Table 5: Threshold Language of Sutter-Yuba MHP Medi-Cal Members Served in CY 2022

Threshold Language	# of Members Served	% of Members Served
Spanish	[redacted]	[redacted]
Threshold language source: Open Data per BHIN 20-070		

- In addition to providing documents and information in the threshold language, the MHP also provides information in Hmong and are currently translating documents into Punjabi.

Table 6: Sutter-Yuba MHP Medi-Cal Expansion (ACA) PR and AACM, CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	22,625	[redacted]	[redacted]	$3,987,456	$5,192
Small	218,086	8,382	3.84%	$44,131,230	$5,265
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This trend holds true for Sutter-Yuba.
- The MHP PR for ACA members is in line with the statewide PR, but lower than small county totals.
- The ACA AACM for the MHP is comparable to the small county amount, and approximately $1,200 lower than the statewide average.

The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic 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 members

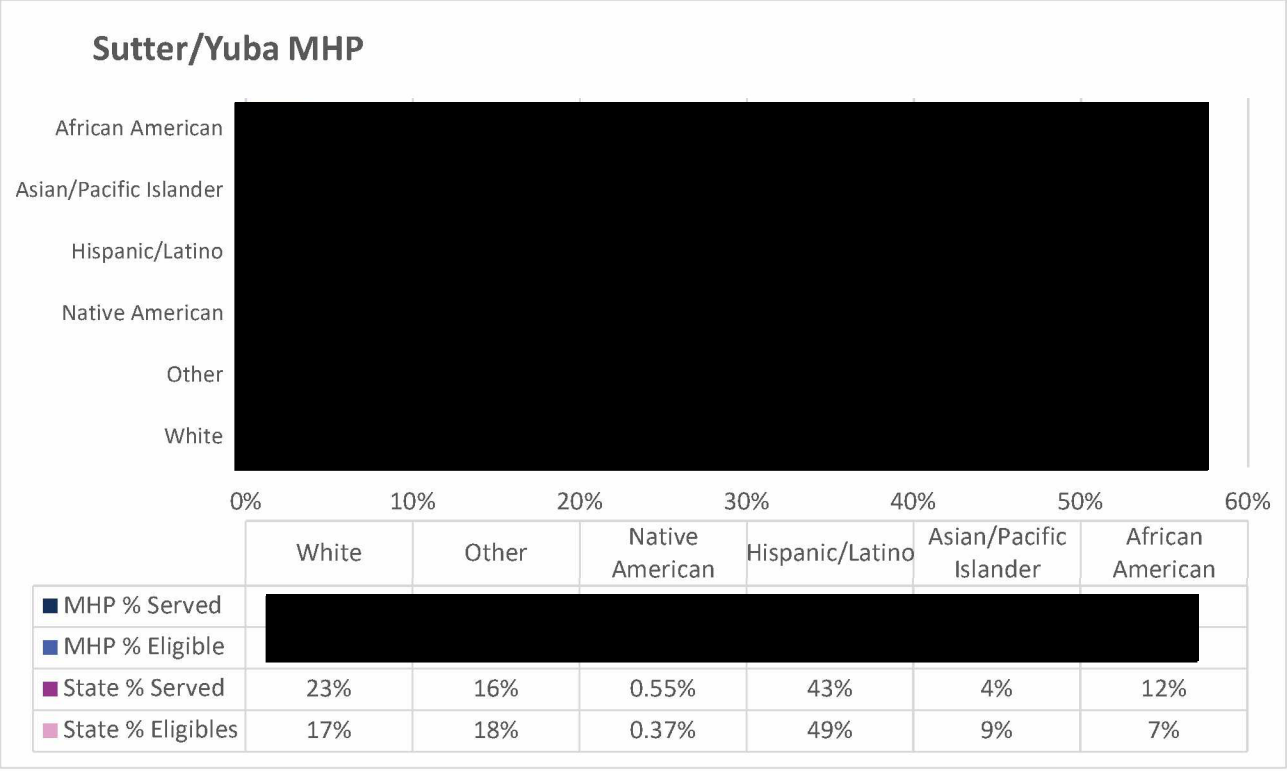
served. Table 7 and Figures 1-9 compare the MHP's data with MHPs of similar size and the statewide average.

Table 7: Sutter-Yuba MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	2,316	[redacted]	[redacted]	7.08%
Asian/Pacific Islander	12,258	[redacted]	[redacted]	1.91%
Hispanic/Latino	31,118	798	2.56%	3.51%
Native American	594	[redacted]	[redacted]	5.94%
Other	8,083	353	4.37%	3.57%
White	30,411	1,859	6.11%	5.45%

- The MHP's PR is lower than the statewide totals in all categories except Other and White. The growing Punjabi-speaking community in the region may fall into these categories, but usually is included under Asian/Pacific Islander (API).

Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022

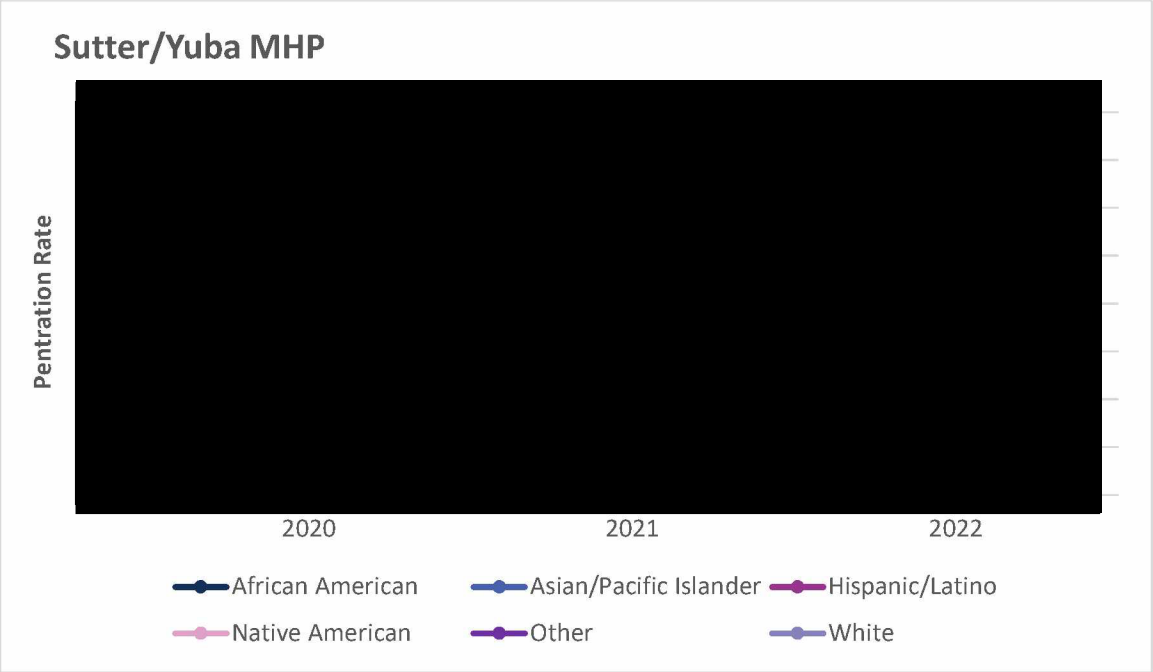


- API and Hispanic/Latino populations are proportionally underrepresented in the MHP, whereas the African American, Native American, Other, and White

populations are proportionally overrepresented in comparison to their representations in the population of eligibles.

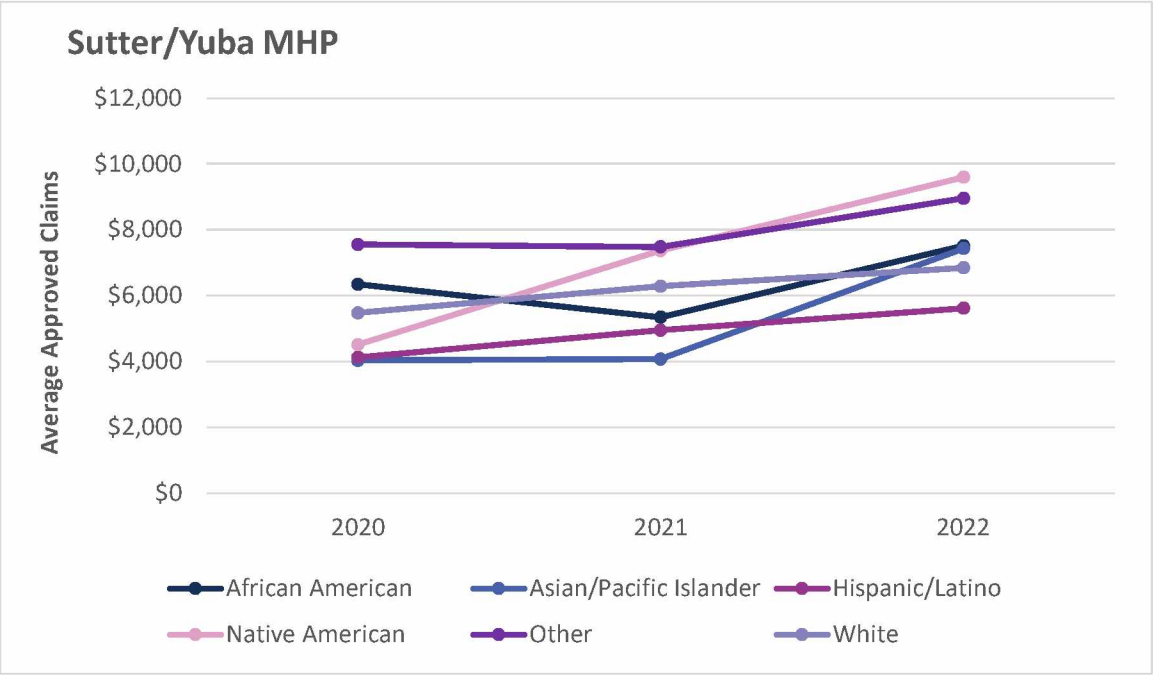
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and API), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year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

Figure 2: MHP PR by Race/Ethnicity, CY 2020-22



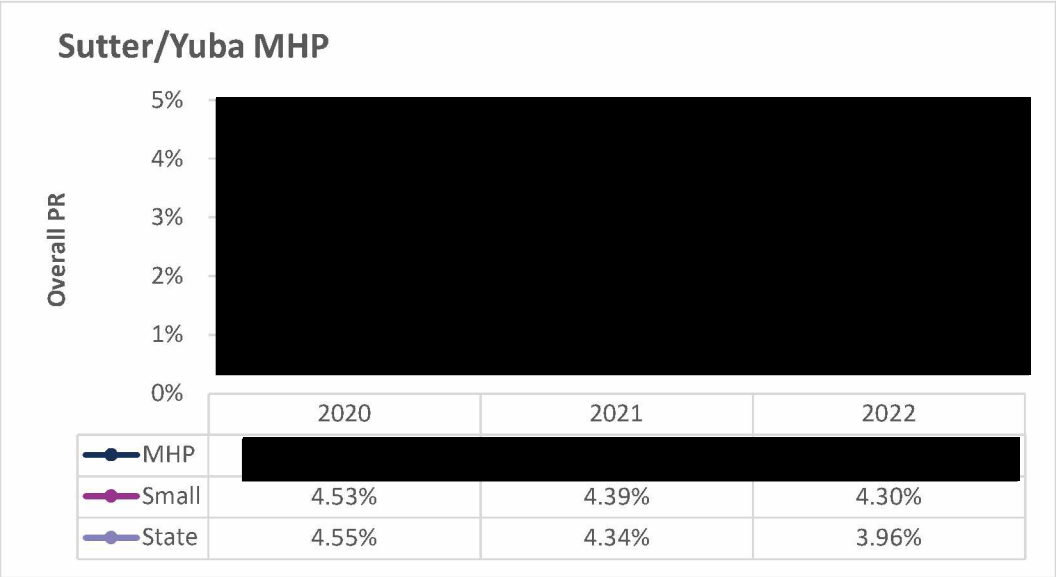
- All PRs except Native American show a downward trend since CY 2020.
- The PR for API and Hispanic/Latino members have consistently been the lowest across the past three CYs.
- The MHP is responsive to the community's cultural needs, but these resources require expansion efforts to positively impact the PR for API and Hispanic/Latino members. Two cultural outreach centers are offered, specifically for Hmong and Latino members, and there are plans to translate documents into Punjabi. Expanding these efforts may help improve this trend for API and Hispanic/Latino groups.

Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22



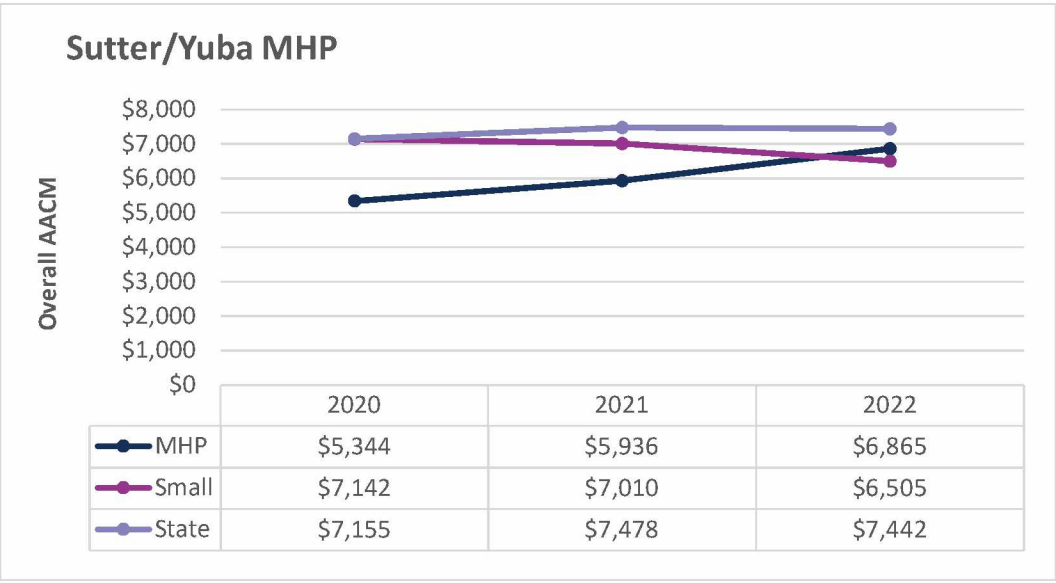
- The Native American AACM shows sharp increases from CY 2020 to CY 2021 and from CY 2021 to CY 2022. There are a small number of members from this population, and as a result outliers can have a noticeable impact on the average.
- The African American AACM reflected a decrease in CY 2021, with an increase from CY 2021 to CY 2022. It is now slightly higher than the CY 2020 AACM.
- The Hispanic/Latino AACM reflects a steady increase from CY 2020 to CY 2022.
- The Other AACM was stable from CY 2020 to CY 2021, with an increase from CY 2021 to CY 2022.

Figure 4: Overall PR CY, 2020-22



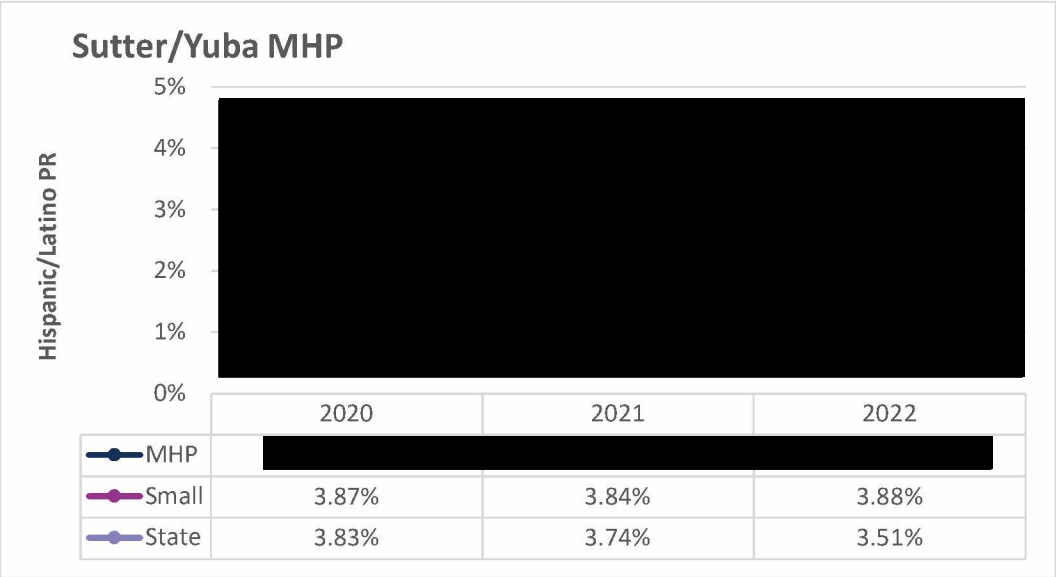
- PRs across the state are in a downward trend since CY 2020. One of the contributing factors is the eligible population has been increasing at a faster rate than eligibles entering services. The MHP's PR has consistently been slightly below small county and statewide PRs.

Figure 5: Overall AACM, CY 2020-22



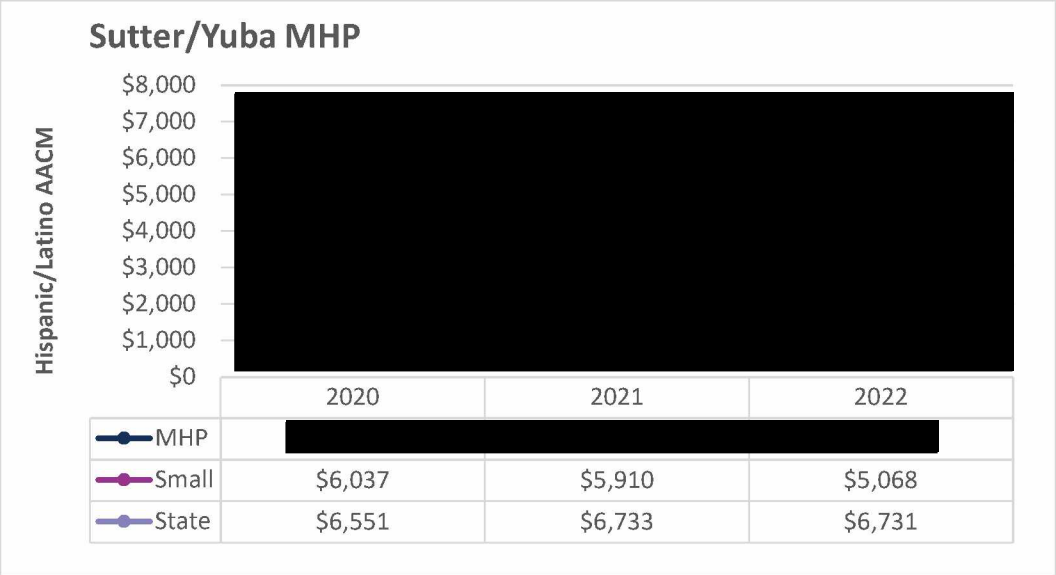
- The overall AACM for the MHP has steadily increased over the last three years, while the small county AACM has decreased. The statewide AACM had an increase from CY 2020 to CY 2021 with a very slight decrease from CY 2021 to CY 2022.

Figure 6: Hispanic/Latino PR, CY 2020-22



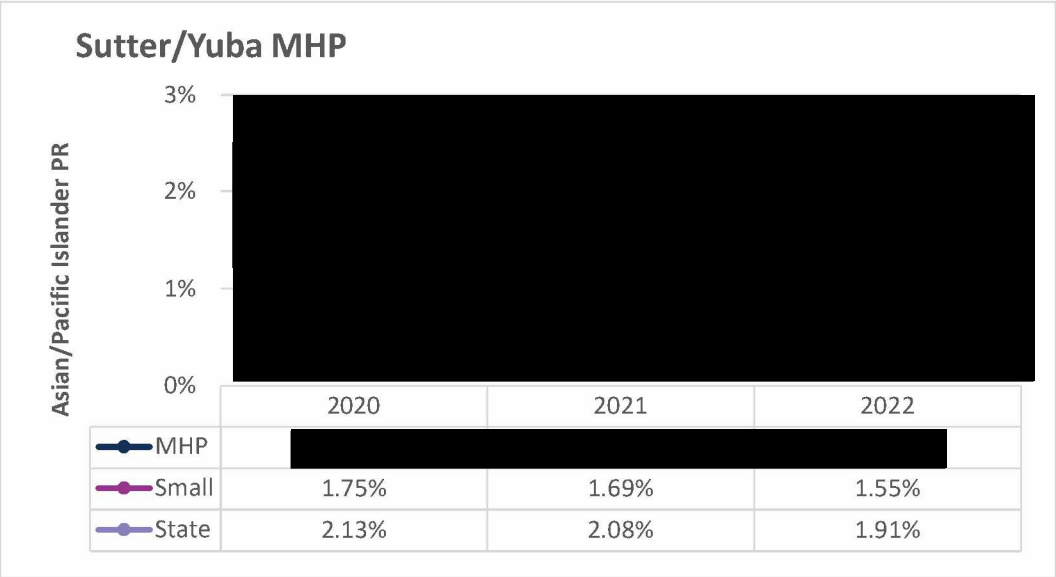
- Hispanic/Latino PRs reflect an overall slight downward trend with minor variations. The MHP's PR remains lower than small county and statewide rates.

Figure 7: Hispanic/Latino AACM, CY 2020-22



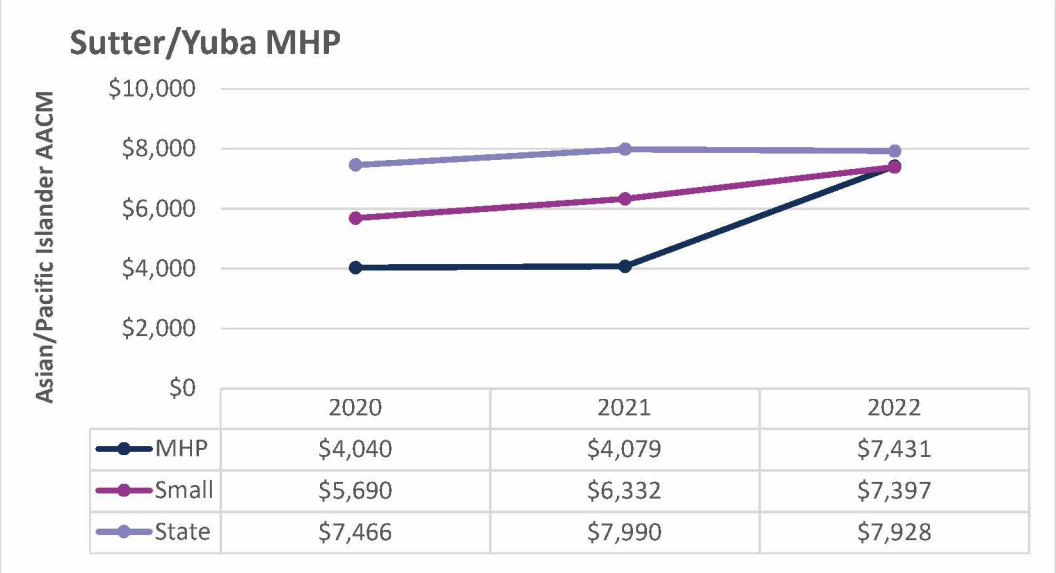
- The MHP's AACM for the Hispanic/Latino population has been on an upward trend for three years. The AACM for Sutter-Yuba is higher in CY 2022 than the small county AACM but has been consistently lower than the statewide average.

Figure 8: Asian/Pacific Islander PR, CY 2020-22



- The API PRs are reflective of a slight downward trend. The MHP PR has consistently been lower than the statewide PR and higher than the small county PR.

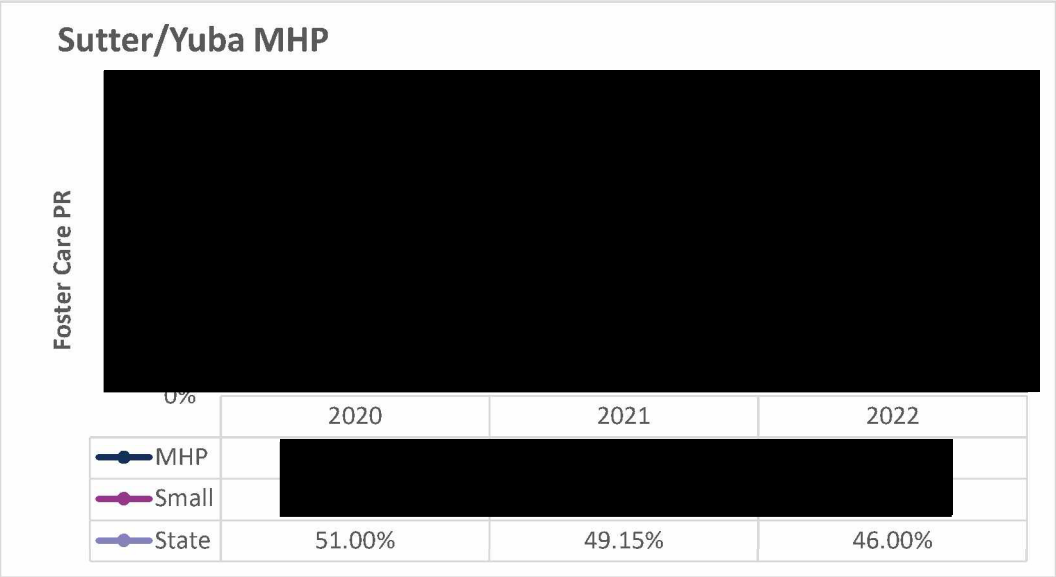
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



- The MHP's API AACM has historically been lower than the small county and statewide.

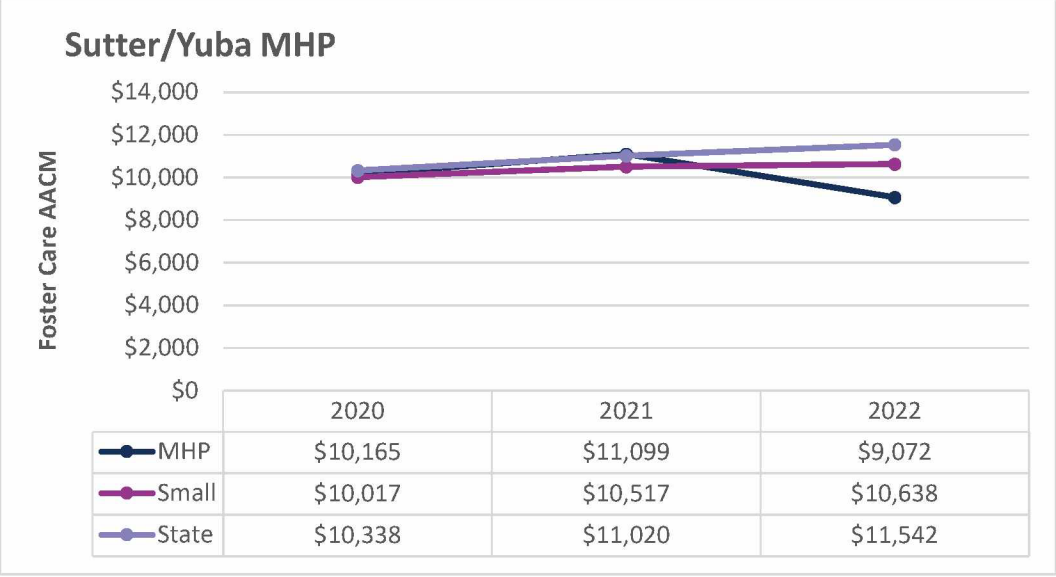
- In CY 2022 API AACMs increased in the MHP and the comparisons, and all three are comparable. The MHP's CY 2022 AACM increased by 82.17 percent.

Figure 10: Foster Care PR, CY 2020-22



- The statewide and small county FC PR decreased in CY 2022, while the MHP's increased. The MHP's PR remains below both small county and statewide PRs.

Figure 11: Foster Care AACM, CY 2020-22



- FC AACMs were similar in the MHP, small county and statewide in CY 2020 and CY 2021. In CY 2022 there was divergence with the statewide AACM increasing

by $520, the small county increasing by $121, and the MHP decreasing by $2,027.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Sutter-Yuba MHP to Adults, CY 2022

Service Category	MHP N = 2,363				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	[redacted]	[redacted]	7	6	10.3%	14	8
Inpatient Admin	<11	-	16	18	0.4%	26	10
PHF	214	9.1%	18	9	1.2%	16	8
Residential	<11	-	37	6	0.3%	114	84
Crisis Residential	<11	-	12	11	1.9%	23	15
Per Minute Services							
Crisis Stabilization	[redacted]	[redacted]	1,396	1,200	13.4%	1,449	1,200
Crisis Intervention	667	28.2%	206	135	12.2%	236	144
Medication Support	1,389	58.8%	244	145	59.7%	298	190
MH Services	1,308	55.4%	239	85	62.7%	832	329
Targeted Case Management	253	10.7%	540	259	36.9%	445	135

- Inpatient, inpatient administrative days, and PHF services are comparable between the MHP and statewide when all three inpatient services are taken together.
- There are noteworthy differences between the MHP and statewide average and median units for residential services, with residential stays in the MHP being substantially shorter than statewide. These are small numbers served, however.
- In the crisis intervention service category, the MHP's utilization rate is more than twice the statewide rate, while the average and median units are similar.
- In the MH services category, the MHP's utilization rate is 7.3 percentage points lower than statewide. Average units statewide are approximately three and a half times higher than the MHP total, and the median statewide units are almost four times higher than the MHP's total.

- The MHP provided targeted case management (TCM) to significantly fewer members than statewide, though at more units of service on average when provided.

Table 9: Services Delivered by the MHP to Sutter-Yuba MHP Youth in Foster Care, CY 2022

Service Category	MHP N = 97				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	9	7	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
PHF	<11	-	7	7	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	<11	-	6,600	6,600	3.1%	1,166	1,095
Crisis Intervention	[redacted]	[redacted]	301	176	8.5%	371	182
Medication Support	41	42.3%	221	143	27.6%	364	257
Therapeutic Behavioral Services (TBS)	0	0.0%	0	0	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	42	43.3%	417	219	40.8%	1,458	441
Intensive Home-Based Services	<11	-	1,348	713	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
MH Services	93	95.9%	1,574	803	95.4%	1,846	1,053
Targeted Case Management	50	51.5%	345	213	35.8%	307	118

- Medication support services in the MHP had a utilization rate that is 14.2 percentage points higher than the statewide rate, while the MHP has lower average and median units than statewide.

- TCM was also utilized at a higher rate in the MHP (51.5 percent) than statewide (35.8 percent).
- Though the number is suppressed due to the small number of members represented, the utilization rate for intensive home-based services (IHBS) is well below the statewide rate. Intensive care coordination (ICC) is provided at approximately the same rate as statewide, but with significantly fewer units of service provided.

IMPACT OF ACCESS FINDINGS

- The MHP is responsive to the language needs of members. Documents and instructions have been provided in languages other than the threshold Spanish language. Hmong documents and instructions are available and the MHP runs a Hmong Outreach Center. The MHP is currently in the process of translating documents into Punjabi based on this identified member need.
- Easing COVID-19 restrictions contributed to more in-person triage, assessment, and services which impacts the MHP due to a lack of enclosed office spaces for private and confidential therapeutic work. As there are no plans for a new location, the current facilities need attention and investment.
- Non-clinical Resource Specialists have been increased and are trained to use the CalAIM Screening Tools. These efforts are directed at expediting access and reducing the demands on clinical staff. No Wrong Door appears to be fully implemented.
- There is a robust collaboration with community resources including embedded staff in the emergency department of the local hospital and two cultural centers, to name just a few. As the MCPs change, relationships and collaboration have already been established. This is clearly a strength of the MHP.
- There is movement toward a new mobile crisis team, as the MHP is close to a contract for this service.
- The MHP has agreed to update their website to include the 24/7 Line in languages other than English.
- The MHP has strategically taken action to respond to an increase in conservatorship needs by integrating with the County Health and Human Services. It is hoped that this will improve efficiency and access for members of the community who require this LOC.
- The MHP takes action to assess and offer ICC and IHBS to youth who need that LOC, for both FC and non-FC youth. However, delivery of IHBS in particular is very low. Additionally, the PR for FC remains consistently lower than state and other small counties. Further, the AACM for FC decreased by a markedly larger amount than the comparisons. The MHP should review its implementation of ICC and IHBS, especially for the FC youth.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to members. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved member 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	Partially Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Not Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- The MHP has a long history of recommendations around improved timeliness tracking and has reportedly chosen Credible as their new EHR due to its improved data capabilities. So far six months of data has been collected and noted as reliable but will not be reported to CalEQRO until the next review. The

timeliness data reported this year, thus, continued to be unreliable. The MHP notes it is training staff and providing clear protocols in alignment with BHIN 23-041 to guide staff in the use of data collection tools. First non-urgent request to first offered appointment and first non-urgent request to first offered psychiatric appointment components are partially met this year and expected to improve at the time of the next review.

- Urgent data has not historically been tracked and was not provided again this year. This component is not met and is hoped to be improved with the new EHR capabilities and MHP-defined protocols.
- The MHP has improved its ability to accurately track follow-up after hospitalization and was able to provide data this year. Staff have been trained in the requirements, the line staff session validated the standard, and the MHP has implemented a PIP on the process. No-shows are historically tracked, and rates have met the MHP's standard over the last three years.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of ATA, representing access to care during the partial FY period of July 2022 to April 2023. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care. The MHP reports that it does not track timeliness for either type of urgent services. The MHP reports their timeliness data for first requests are unreliable for the reporting period but that additional training has been and will continue to be provided to staff to improve tracking of these metrics. This is particularly evident with First Non-Urgent Psychiatry Appointment Offered where it was discovered, during training, that staff were using the wrong form, entering the requests as new service requests rather than relevant to psychiatry.

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

Table 11: FY 2023-24 Sutter-Yuba MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	1.74 Business Days	10 Business Days*	93%
First Non-Urgent Service Rendered	4.90 Business Days	10 Business Days**	90%
First Non-Urgent Psychiatry Appointment Offered	96.65 Business Days	15 Business Days*	93%
First Non-Urgent Psychiatry Service Rendered	12.50 Business Days	15 Business Days**	71%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	***	48 Hours*	***
Urgent Services Offered (including all outpatient services) – Prior Authorization Required	***	96 Hours*	***
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	17.23 Calendar Days	7 Calendar Days	34.33%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	17.23 Calendar Days	30 Calendar Days	58.67%
No-Show Rate – Psychiatry	16%	15%**	n/a
No-Show Rate – Clinicians	9%	10%**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033

** MHP-defined timeliness standards

*** Not tracked

For the FY 2023-24 EQR, the MHP reported its performance for the following time period: July 2022 - April 2023

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

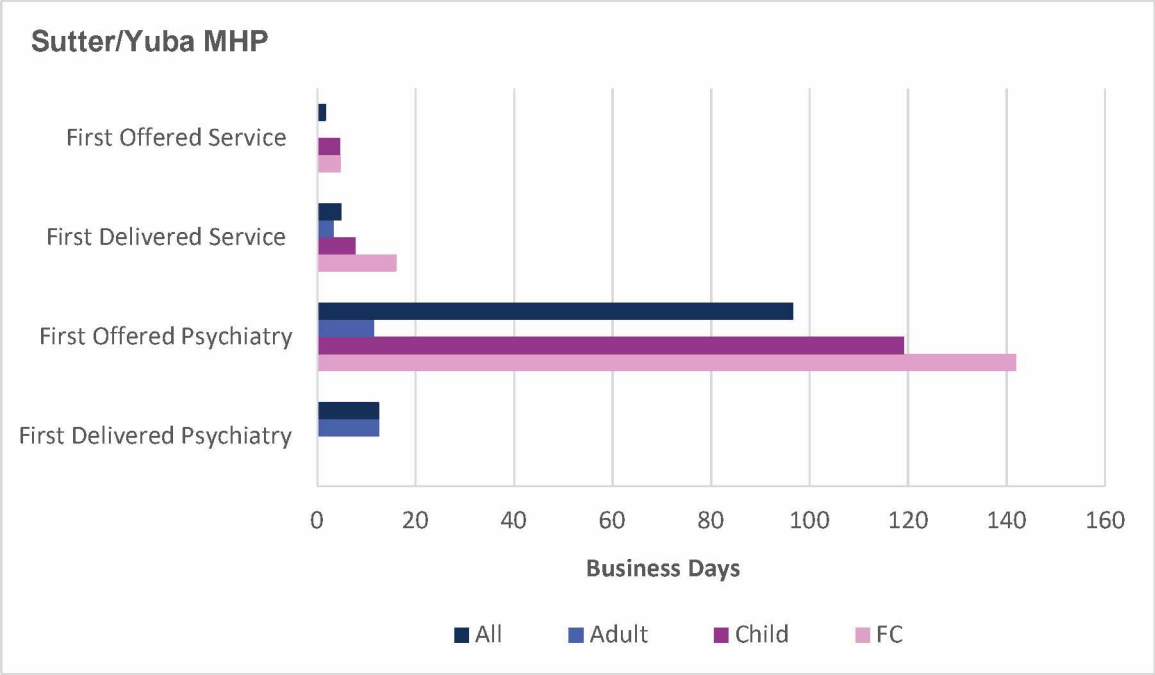


Figure 13: Wait Times for Urgent Services

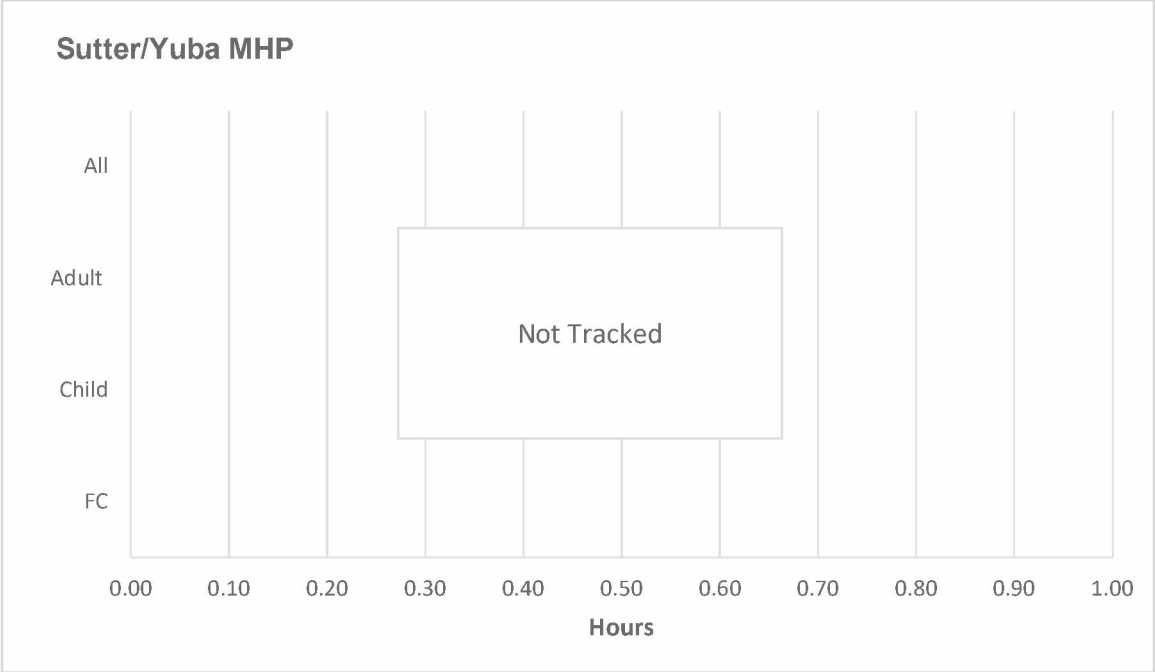
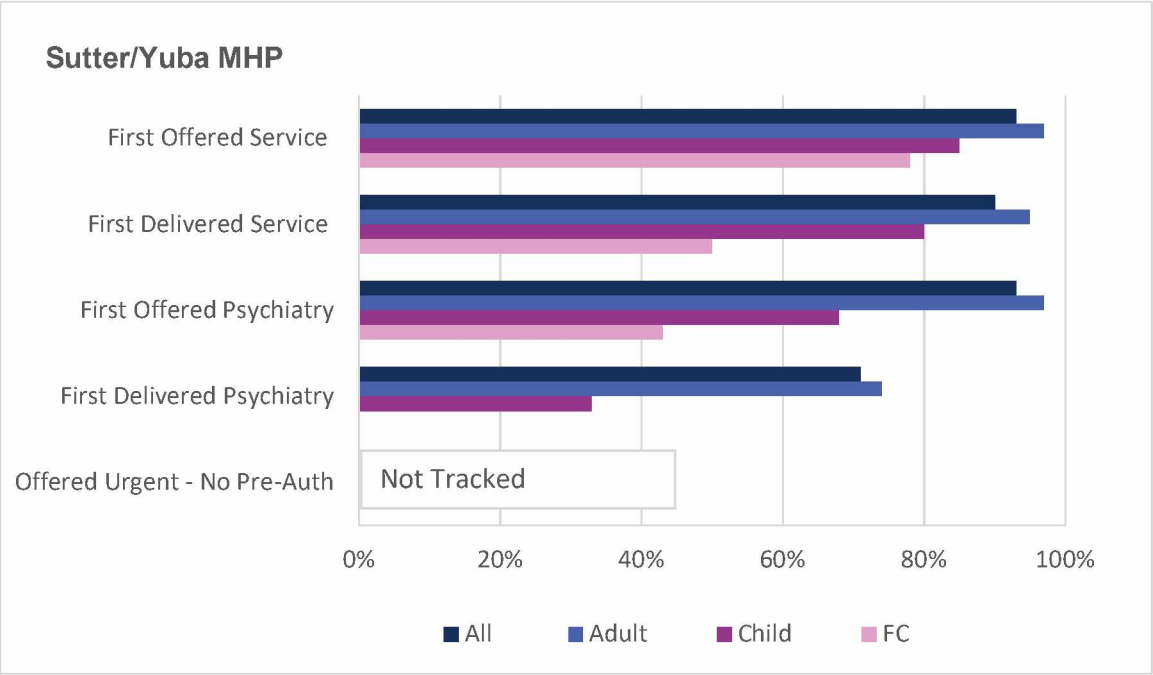


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide MH 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 14, represent scheduled and unscheduled/walk-in access. The MHP reported that it has been diligent to clear up ambiguities with staff around tracking these data points, particularly considering the post-pandemic return to an open access clinic model. Most of the data above was captured prior to the improved training, however.
- The MHP did not define "urgent services" and did not provide any data on its delivery of urgent services. The MHP has not set up a system to track urgent services of either type.
- The MHP defines timeliness to first delivered/rendered psychiatry services as from the point of a member's request for medication services to the initial visit with a psychiatric provider. The data above includes the entire service system including both adults and youth. However, it is also grossly impacted by data entry errors discovered when retraining to this process. Staff were reportedly not using the correct form, thus some of the requests for psychiatry are likely impacting the data for initial request for services in general.
- The MHP does track and monitor data for no-shows and it is inclusive of the entire system. The MHP reports an average no-show rate of 16 percent for all psychiatric providers and 9 percent for all non-psychiatry clinical staff. With standards set at 15 percent and 10 percent respectively, the MHP meets or is close to meeting its standard for all age groups. The only measure that exceeds

the standard by more than 1 percentage point is FC in psychiatry, which is at 20 percent.

IMPACT OF TIMELINESS FINDINGS

- Timeliness is difficult to assess from these measurements, as the data has historically been unreliable for numerous reasons, which the MHP is taking action to resolve. The MHP is encouraged to continue defining and training processes around tracking urgent requests, as this is a common difficulty across counties.
- Despite the MHP's ability to offer a timely initial appointment most of the time, frequently the same day with open access clinics, members and line staff note months of wait for ongoing therapy services to begin for both individual therapy and other programs, most severely within the adult system of care. However, access to psychiatric services is noted as being within two weeks of the request. The data above shows clearly that adults access medication services much quicker than youth.
- The MHP has continued to work on improving tracking of follow-up services after psychiatric discharge at both 7 and 30 days by developing a monitoring system and dashboard.
- The MHP has seen an overall increase in the percent of timeliness elements meeting the standard according to their last three ATAs.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the members 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 members. 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 falls under the Quality Assurance (QA) Officer who leads a staff comprised of a Staff Services Manager, Staff Analyst, QA Review Specialist, MH Therapist III, and Secretary. Compliance also falls under QA and has historically had a heavy influence on the QAPI plan. As recommended in the last report, improvements have been made to incorporate a greater focus on member satisfaction and quality experience measures.

The MHP monitors its quality processes through the QIC, the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC is scheduled to meet monthly and the MHP QIC met ten times during FY 2022-23, eight times since the last EQR. The QIC membership includes the BH Director, program managers, providers, contractor administrators, and QA staff. It does not appear to have other stakeholders such as peers or members. Since the previous EQR, the MHP has revamped the QAPI plan. The number of QAPI goals doubled from 12 for FY 2022-23 to 24 on the FY 2023-24 QAPI workplan and now includes PIPs and CalAIM Behavioral Health Quality Improvement Plan Program (BHQIP) goals as well. It is inclusive of substance use disorder treatment services. Due to the new EHR, many QI efforts are aimed at establishing staff buy-in, data entry/obtainment, and new tools or workflows. There are clear lists of interventions, or objectives for each goal, and the plan is quite comprehensive. The MHP does not expect to achieve all objectives within the next year but has established measurable goals. Most notably, Goal 14 is to "Implement a system for utilization of services and monitoring and analyzing LOC and outcomes" and Goal 16 to "develop data quality committee."

The MHP utilizes the following LOC tools: Level of Care Utilization System (LOCUS) for adults and the Child and Adolescent LOCUS (CALOCUS) for youth and TAY. One example of appropriate use of the CALOCUS is verifying appropriate LOC placement for youth discharging from inpatient care.

The MHP utilizes the following outcomes tools: The Child and Adolescents Needs and Strengths and the Pediatric Symptom Checklist-35 for youth, the Milestones of

Recovery Scale for adults and TAY. Outcomes are shared at the program staff meeting level, with Behavioral Health Advisory Board meetings, and at the Mental Health Services Act (MHSA) steering committee stakeholder meetings. Aggregate data is analyzed for strength of programs, areas for improvement, and any barriers. The information is used to determine what enhancements are needed to improve outcomes and quality of care.

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 members. 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	Partially Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Partially Met
3H	Utilizes Information from Member Satisfaction Surveys	Partially Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Member and Family Member Employment in Key Roles throughout the System	Partially Met

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

- The MHP has an updated QAPI Plan and has begun the efforts which make it met for prioritizing quality metrics; however, many of these practices are newly implemented or just now taking shape. This is considered the overarching reason

for many components being only partially met throughout this section. Three components have improved from last year and more are expected next year.

- The MHP is applauded for adding a goal to create a data quality committee. The MHP has a history of abundance of data that did not seem to be capitalized. Routinely tracking access, timeliness, and quality data and implementing improvement strategies that are documented would make the MHP met for Data is Used to Inform Management and Guide Decisions.
- Regarding stakeholder input and involvement, the MHP would be met if formal channels actively existed for members and their families. Members noted in validation sessions that they have not been invited to give any input about the system, although there is an informal system for this within the children's system of care. One idea may be expanding the Behavioral Health Advisory Board to include the community, members and their families, and other stakeholders. This could also be an opportunity to expand the substance use disorder specific community quality committee, the Quality and Improvement Committee, which is an open invitation but not easily found on the website.
- There are clear strengths around Evidence of a Systemic Clinical Continuum of Care. For example, there is a distinction between LOC tools and outcome measures, and evidence of appropriate use and protocols. This section would be met if the MHP routinely tracked and trended transitions in care on an aggregate basis. The FY 2023-24 QAPI does have a goal to "implement a system for utilization of services and monitoring and analyzing LOC and outcomes." It is hoped that the MHP will continue to expand use data from LOC tools.
- The MHP would be met for Measures Clinical and/or Functional Outcomes for a similar reason, a need to routinely track, trend, and report aggregate outcomes for adult programs, and to implement improvement plans when indicated.
- The MHP has a robust medication chart monitoring practice with a contractor but does not trend this data yet making Medication Monitoring also partially met. The MHP is encouraged to review medication trends and HEDIS measures at the Utilization Review Committee once the dashboards are ready.
- Psychotropic Medication Monitoring for Youth is not met, as the MHP does not track or trend the following HEDIS measures as required by WIC Section 14717.5. These are expected to be tracked and trended in the future as part of the new EHR.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)

- The MHP does track but does not trend the following HEDIS measure as required by WIC Section 14717.5.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): No results or samples were provided.
- The MHP is partially met for Utilizing Information from Satisfaction Surveys. Although results are tabulated, shared, and compared year to year, there was no example of its use to improve access, timeliness, and/or quality.
- Although the MHP utilizes peer staff embedded into programs, has certified peers, and one supervising peer within a contract agency, all of which are considered strengths, it is partially met for Member-Driven Programs and Member and Family Member Employment. Wellness centers are closed to the community, only for those actively in care, and seem to be managed by leadership rather than through a defined peer employment ladder. The MHP is encouraged to continue to expand leadership opportunities for peers.

QUALITY PERFORMANCE MEASURES

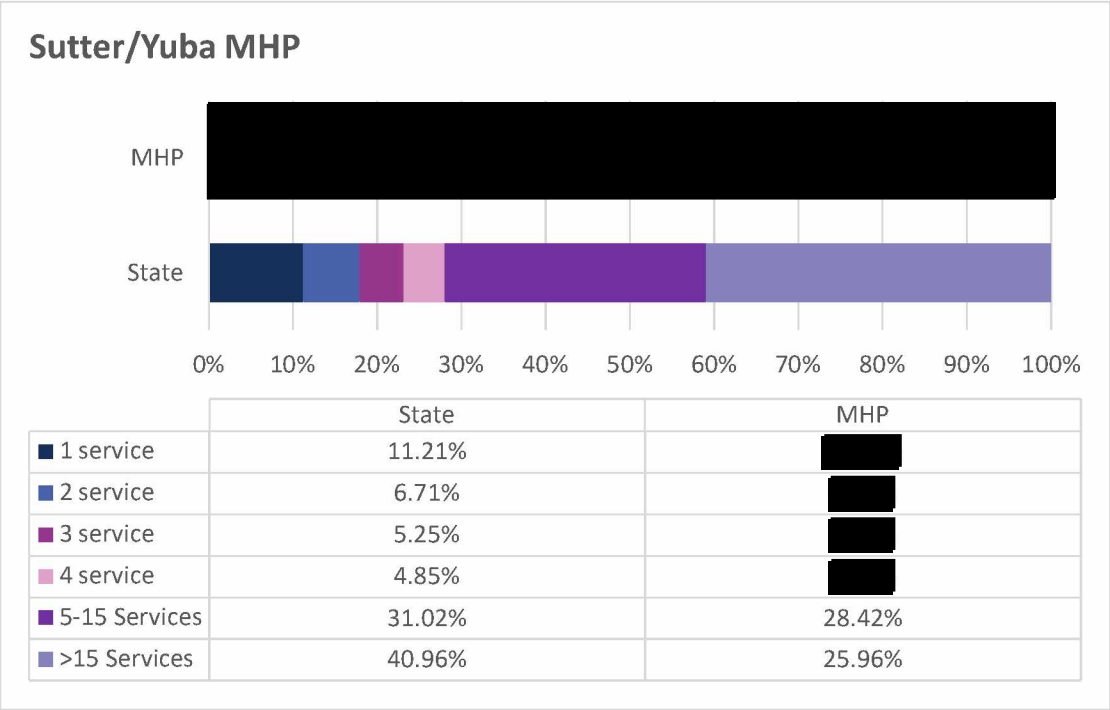
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

Retention in services is an important measure of member engagement in order to receive appropriate care and intended outcomes. One would expect most members 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 (LOS), as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Retention of Members Served, CY 2022



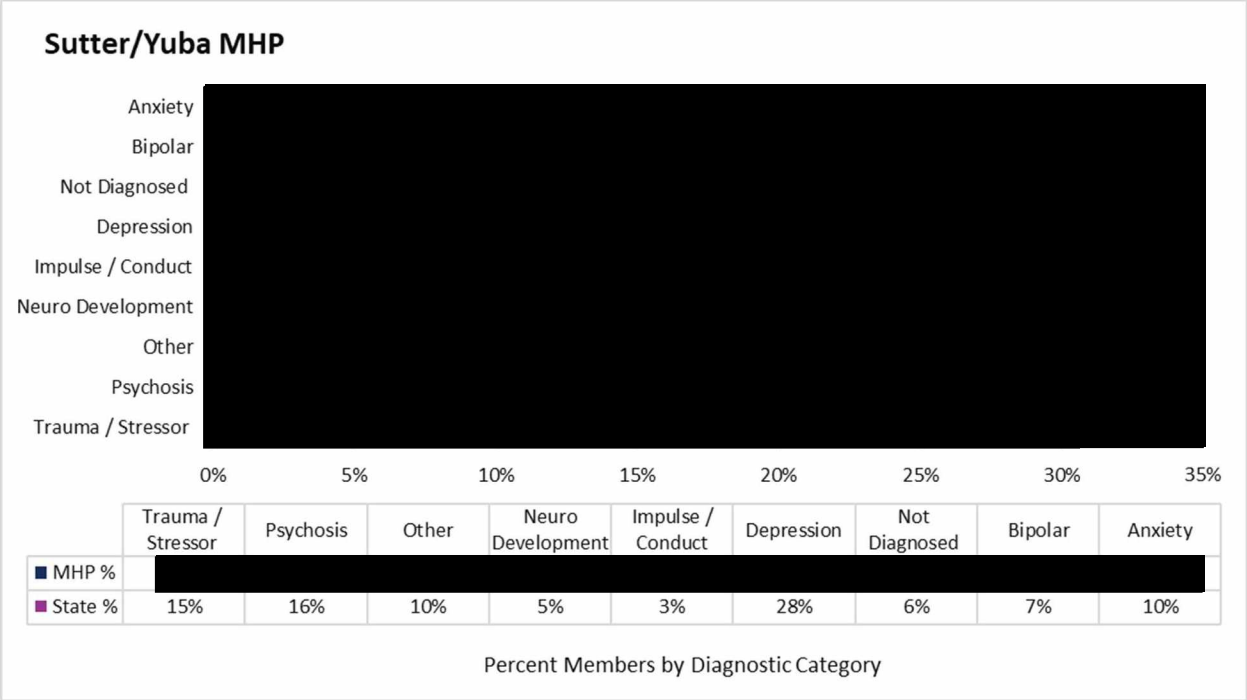
	State	MHP
1 service	11.21%	
2 service	6.71%	
3 service	5.25%	
4 service	4.85%	
5-15 Services	31.02%	28.42%
>15 Services	40.96%	25.96%

- The proportion of members receiving just one service in the MHP is more than double that of statewide. This is likely due to the MHP's policy of claiming to Medi-Cal the screening for all members who request services. Upon screening, members who qualify for non-specialty MH services are then linked to those providers.
- For members receiving between one and four services, the MHP rates are all higher than the state.
- A total of 54.38 percent of members in the MHP received five or more services, which is slightly lower than last year's rate of 58.40 percent. A much smaller proportion of members received 15 or more services in the MHP than statewide.

Diagnosis of Members Served

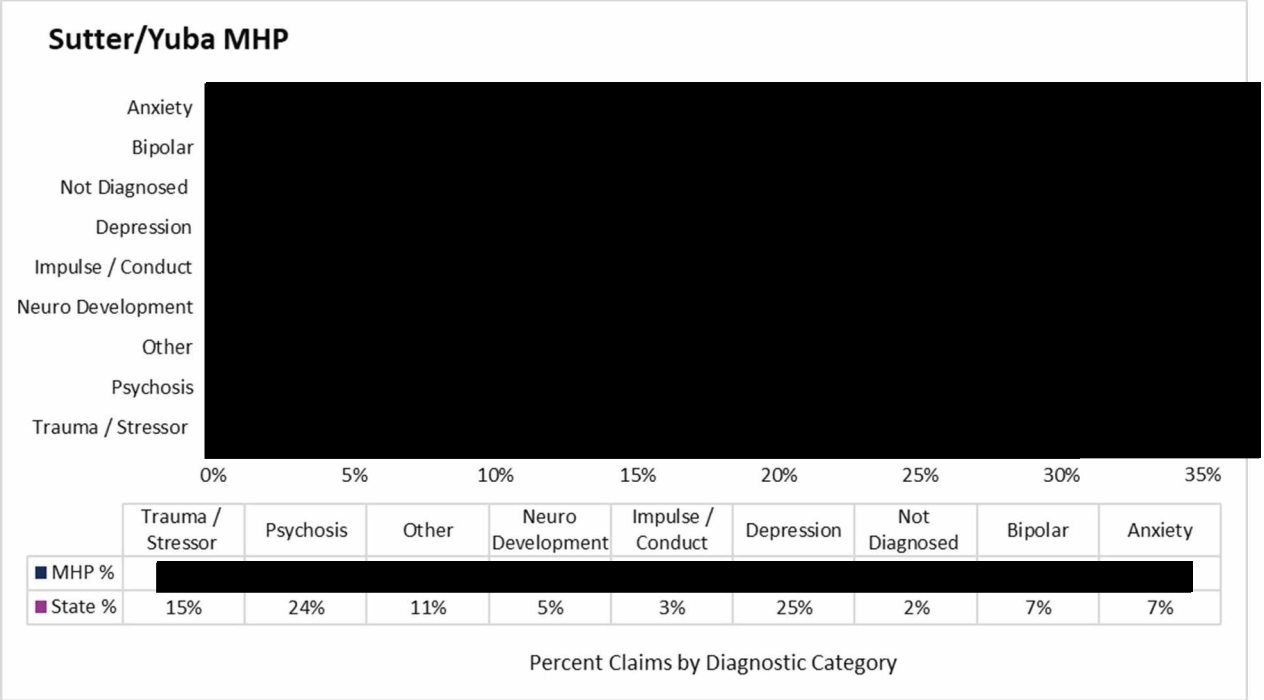
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared to statewide. This is not an unduplicated count as a member 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 Members Served, CY 2022



- The MHP has a higher proportion of members in the Not Diagnosed category than statewide, which may be related to the MHP's policy of screening all who seek service and referring to others as appropriate.
- In general, the diagnostic distribution in the MHP is similar to statewide.

Figure 17: Diagnostic Categories by Percentage of Approved Claims, CY 2022



- The distribution of approved claims across diagnostic categories was generally comparable to the distribution of diagnoses in the MHP, with the exception of psychosis. Psychosis accounts for the largest proportion of claims in the MHP.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS. CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

Table 13: Sutter-Yuba MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	356	463	1.30	12.54	8.45	$20,792	$12,763	$7,402,078
CY 2021	379	531	1.40	11.14	8.86	$16,674	$12,696	$6,319,427
CY 2020	330	445	1.35	11.45	8.68	$17,000	$11,814	$5,610,125

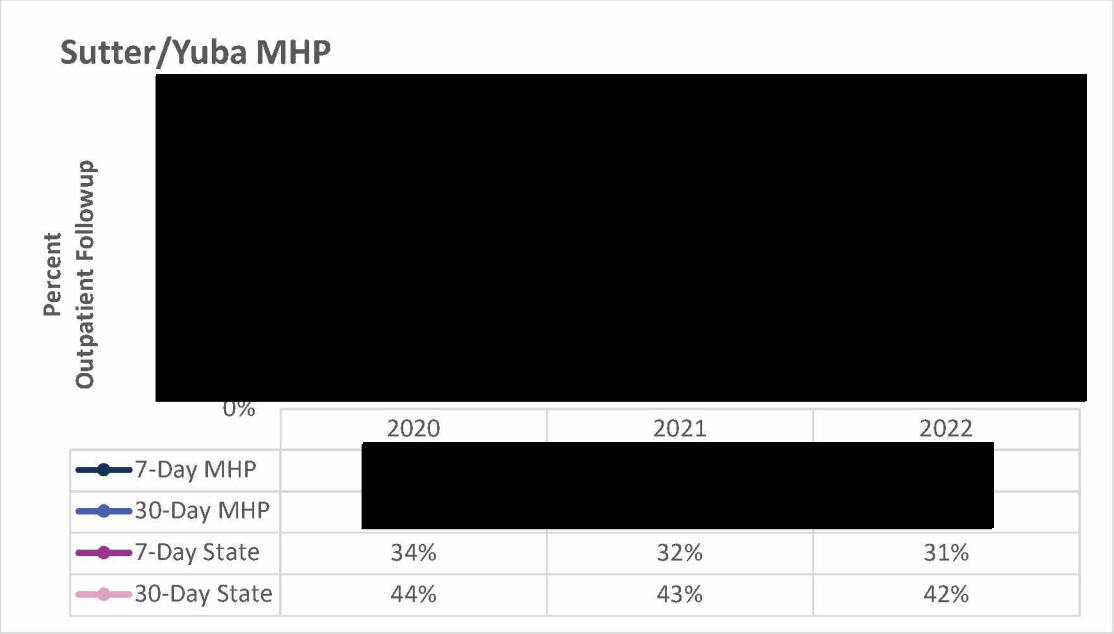
- Unique inpatient members decreased in CY 2022 by 6.06 percent from the prior year. Inpatient admissions decreased by 12.8 percent over the same period. The MHP's PHF is contracted out with current contract dated 2022-2025
- LOS increased by almost 1.5 days, from CY 2021 to CY 2022 and is 4.1 days longer than the statewide average LOS for CY 2022.
- AACM in the MHP is approximately 63 percent higher than the statewide AACM. The longer LOS described above contributes to the higher AACM in the MHP. The AACM has increased by $4,118 or 24.69 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 2022 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.

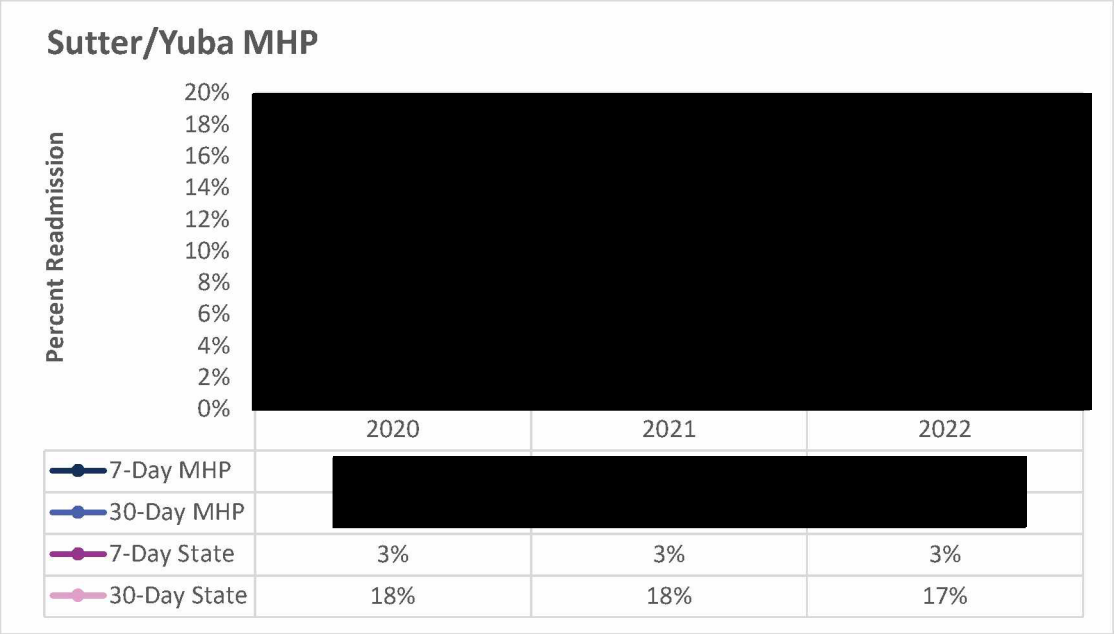
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and is reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis. As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the current methodology.

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



- The MHP's 7-day follow-up rate is slightly lower than statewide, while the 30-day follow-up rate is higher in the MHP than statewide.
- Hospitalizations services represent [redacted] percent of all Medi-Cal claims from the MHP.

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22



- The MHP's readmission rate at both 7 and 30 days are lower than the statewide rates.

High-Cost Members

Tracking the HCMs 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 members, 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, HCMs may disproportionately occupy treatment slots that may prevent access to levels of care by other members. HCM percentage of total claims, when compared with the HCM count percentage, provides a subset of the member population that warrants close utilization review, both for appropriateness of level of care and expected outcomes.

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs 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 AACM is $7,442, the median amount is just $3,200.

Tables 14 and 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

Table 14: Sutter-Yuba MHP High-Cost Members (Greater than $30,000), CY 2020-22

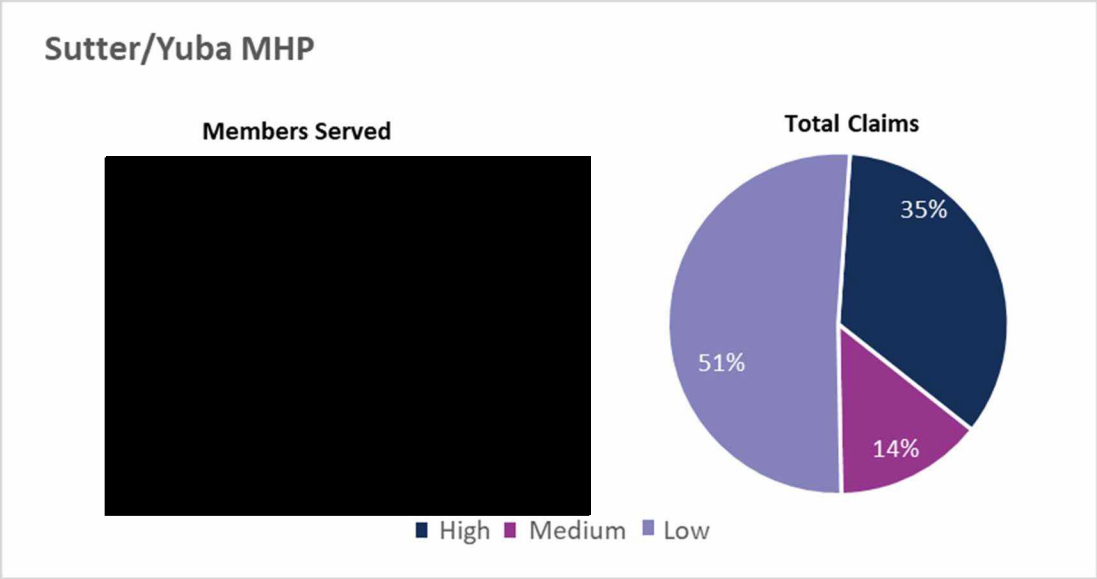
Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	[redacted]	[redacted]	34.54%	$7,992,839	$62,936	$45,746
	CY 2021	[redacted]	[redacted]	32.74%	$6,318,046	$61,340	$47,618
	CY 2020	[redacted]	[redacted]	29.49%	$5,240,263	$58,225	$46,163

- HCMs in the MHP have trended upwards in the last three years, representing 34.54 percent of claims. This is a comparable proportion to statewide.
- While the MHP percentage of members considered to be HCMs is smaller than statewide, the percentage of HCM claims, AACM, and median approved claims are higher than statewide.

Table 15: Sutter-Yuba MHP Medium- and Low-Cost Members, CY 2022

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	133	3.95%	14.06%	$3,253,481	$24,462	$24,267
Low-Cost (Less than $20K)	3,111	92.29%	51.41%	$11,896,975	$3,824	$1,968

Figure 20: Sutter-Yuba MHP Members and Approved Claims by Claim Category, CY 2022



- For CY 2022, [redacted] percent of the members served fell into the low-cost category, representing 51 percent of claims. Medium-cost members represented [redacted] percent of members served and 14 percent of claims, and HCMs represented [redacted] percent of members served and 35 percent of claims.

IMPACT OF QUALITY FINDINGS

- The MHP has made improvements in the Key Components of quality care this year and more progress is expected after new QAPI goals are fully structured and monitored. Further, the MHP has a positive expectation of having the tools it needs to support these functions with the new EHR. The new QAPI goals include the recommendation made in the prior report, to include member satisfaction goals and be more balanced with goals for compliance monitoring.
- The MHP had 39 clinical vacancies at the time of the review with a reported recent history of a 20 percent overall vacancy rate. Long wait times were creatively addressed within the children's system of care, where programs like Early Explorers attempt to bridge the gap. However, line staff validate that adults occasionally fall out of care prior to their regularly scheduled individual therapy service commencing.
- The MHP has a high rate of one service-only compared to the state which could partially be explained by their full implementation of CalAIM Screening Tools and a long wait for ongoing therapy appointments.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, 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 member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Improving Rates of Post-Psychiatric Hospitalization Follow-up (FUH)

Date Started: 01/2023

Date Completed: Ongoing

Aim Statement: "Will the use of a follow-up program consisting of a follow up care team, and a defined general follow-up structure, increase the rate of beneficiaries who are receiving follow-up services within 7-days after psychiatric hospitalization by 5% over a 12-month period in 2024?"

Target Population: All clients hospitalized

Status of PIP: The MHP's clinical PIP is in the implementation phase with adjustments required due to the new EHR implementation.

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

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

Summary

This PIP team presented this as the nonclinical PIP last year. Presented as clinical this year, the updated interventions are nonclinical in nature. There is a root cause analysis that found there was no consistent process for scheduling follow-up after a visit at the emergency department for MH condition. The PIP seeks to intervene by establishing a process, training staff, and monitoring new dashboards for this purpose. The PIP team expects that the dashboards will be ready soon and they will be able to begin data collection. The data collection plan had to be updated due to the new EHR. They are not yet leveraging the Health Information Exchange (HIE) for this purpose but there is one in place. If it is to remain a clinical PIP, the intervention will have to address clinical aspects of the member experience.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence because while this is a good start to the PIP, it is impacted by a new EHR system. Clarification on several points, as discussed in TA, and updates to the data collection process, due to the new EHR, are required prior to considering this a moderate confidence PIP. Further, the interventions should clearly target clinical aspects of care; this is designed more as a nonclinical PIP.

TA was provided during this review and after. Time was specifically spent on what defines a clinical PIP versus a nonclinical PIP. The county was given the option to adjust based on the TA; however, they were unable to do this timely enough to be included in the report. The MHP was advised to make specific improvements to each that would likely make both PIPs increase to moderate confidence. The PIP team is encouraged to schedule further TA and begin collecting regular results as soon as the new EHR process allows to keep both PIPs active throughout the year.

CalEQRO recommendations for improvement of this clinical PIP:

- Describe the existing discharge planning system that needs improvement. Clearly describe your new “program” and “care team” that are noted in the aim statement.
- Expand root cause analysis for both outcomes separately and identify a more clinical intervention as well.
- Consider the phase of the PIP and timing for the actual first measurement and full implementation. Begin data collection with regular analysis and clarify the numerator and denominator in Table 8.1 of the PIP submission.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-up After Psychiatric Emergency Services

Date Started: 01/2023

Date Completed: Ongoing

Aim Statement: "The MHP aims to improve coordination and quality of care of mental and behavioral health services by implementing an improved tracking and referral system and interventions such as assertive outreach for Medi-Cal beneficiaries who have reported to Psychiatric Emergency Services for mental illness with the goal of increasing the percentage of follow-up care within 7 and 30 days by 5% by January 1, 2026."

Target Population: Adults and children including all beneficiaries reporting to the MHP's Psychiatric Emergency Services facility.

Status of PIP: The MHP's non-clinical PIP is in the implementation phase with adjustments required due to the new EHR implementation.

Summary

This PIP was presented as the clinical PIP in the prior report and was recommended to be the nonclinical PIP. It is clear in the updated aim statement this year, that the intervention is clinical in nature. The PIP introduces a system for follow-up calls which apply assertive outreach techniques to maintain engagement after hospitalization by the MHP's Psychiatric Emergency Services. The PIPs goal is to increase the number of members receiving timely follow-up, a nationally accepted quality care indicator.

The PIP team had established a process for routine follow-up call delivery and tracking and was scheduled to begin collecting data when the EHR changed. They are currently learning how to mine the data out of the new EHR and plan to start with monthly tracking to ensure reliable measures prior to moving to quarterly data collection.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence because several sections need further definition and clarity to give the PIP increased confidence. There is a good root cause analysis and a direct link to quality member care. The plan seems likely to improve member follow-up care within 7 days.

As stated under the Clinical PIP, TA was provided during this review and after. Time was specifically spent on what defines a clinical PIP versus a nonclinical PIP. The county was given the option to adjust based on the TA; however, they were unable to

do this timely enough to be included in the report. The MHP was advised to make specific improvements to each that would likely make both PIPs increase to moderate confidence. The PIP team is encouraged to schedule further TA and begin collecting regular results as soon as the new EHR process allows to keep both PIPs active throughout the year.

CalEQRO recommendations for improvement of this non-clinical PIP:

- This PIP seems like it could be a clinical PIP due to assertive outreach applied directly to members. Adjust so that there is one of each type of PIP.
- Clearly define what aspects of assertive outreach are being used and how it links to keeping timely follow-up appointments.
- Add more definition to the population of study to describe all those who are eligible to receive the intervention, including if this includes all medical insurances or Medi-Cal members.
- Ensure baseline data is comparable to the data collected in the study and outline these in the PIP tool.
- Add more about the tracking tool that is being used in the PIP write-up, describing how it functions reliably in the new EHR.

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 Qualifacts/Credible, which has been in use for less than one year, and the MHP must dedicate staff and resources to implement all components.

Approximately 5 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is under MHP control.

The MHP has 237 named users with log-on authority to the EHR, including approximately 197 county staff and 40 contractor staff. Support for the users is provided by four full-time staff for IS technology positions, an increase of one full-time position since last year. Currently all positions are filled.

As of the FY 2023-24 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

Contract providers submit member practice management and service data to the MHP IS as reported in Table 16.

Table 16: Contract Provider Transmission of Information to Sutter-Yuba 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	100%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP has no plans to implement a PHR at this time.

Interoperability Support

The MHP is a member or participant in a HIE. The MHP engages in electronic exchange of information with MH contract providers and Alcohol and Drug contract providers.

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 member outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

Table 17: IS Infrastructure Key Components

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

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

- Strengths for the MHP's IS Infrastructure include the contracted providers having the ability to directly enter member service data into the EHR and the MHP being a member of an HIE. The MHP is participating in all three HEDIS PIPs for the BHQIP and is working to expand the HIE capability.
- The integrity of Data Collection and Processing Key Component is partially met as there is no data warehouse currently in place.
- The MHP is partially met for Integrity of Medi-Cal Claims Process as claims data did not fully reflect timely and consistent claiming. These issues are due to the implementation of a new EHR system.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved 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 2022.

Table 18 appears to reflect a very substantially complete claims data set for the time frame represented (CY 2022). However, a significant claims lag began in June 2023 with the implementation of the Credible EHR system. At the time of the review in January 2024, the MHP reported that they had submitted a claim for May 2023 in September 2023, and submitted claims for June and July 2023 in December 2023. On the date of the review, there was no response to any of these.

Table 18: Summary of Sutter-Yuba MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	3,560	$1,431,179	$30,856	2.16%	$1,400,323
Feb	3,402	$1,465,525	$36,671	2.50%	$1,428,854
Mar	4,329	$1,673,458	$17,521	1.05%	$1,655,937
April	3,914	$1,470,181	$20,176	1.37%	$1,450,005
May	4,094	$1,674,164	$21,751	1.30%	$1,652,413
June	3,724	$1,473,619	$27,092	1.84%	$1,446,527
July	3,415	$2,053,716	$40,234	1.96%	$2,013,482
Aug	4,389	$2,266,497	$52,515	2.32%	$2,213,982
Sept	4,388	$2,169,344	$17,469	0.81%	$2,151,875
Oct	4,181	$2,192,794	$14,808	0.68%	$2,177,986
Nov	3,812	$1,961,700	$25,041	1.28%	$1,936,659
Dec	3,432	$1,774,576	$9,899	0.56%	$1,764,677
Total	**46,640**	**$21,606,753**	**$314,033**	**1.45%**	**$21,292,720**

- CY 2022 claims appear to have been submitted in a timely manner and are relatively consistent with few anomalies.

Table 19: Summary of Sutter-Yuba MHP Denied Claims by Reason Code CY 2022

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Other healthcare coverage must be billed first	158	$140,736	44.82%
Medicare Part B must be billed before submission of claim	220	$101,428	32.30%
Beneficiary is not eligible or non-covered charges	48	$36,886	11.75%
Deactivated National Provider Identifier (NPI)	220	$27,233	8.67%
Other	[redacted]	$2,824	[redacted]
Place of service incomplete or invalid	[redacted]	$2,017	[redacted]
Service line is a duplicate and repeat service modifier is not present	[redacted]	$1,623	[redacted]
Service location National Provider Identifier (NPI) issue	[redacted]	$1,285	[redacted]
Total Denied Claims	**663**	**$314,032**	**100.00%**
Overall Denied Claims Rate	**1.45%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The MHP denial rate, at 1.45 percent, is considerably below the statewide denied claims rate of 5.92 percent.

- Identifying and claiming Medicare part B and Other Healthcare Coverage prior to Medi-Cal remains an issue, with total denied amount of $242,164.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The implementation of Credible has been impactful on the MHP. The MHP is currently working with Kings View on the development of numerous dashboards to monitor and evaluate systems and programs.
- The billing process has also been impacted by Credible, and the MHP is working with Kings View to resolve issues. Together they have a plan to bring claims up to date and submission back on a regular schedule.
- Information sharing with the MCPs is in the development process.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The CPS consists of four different surveys that are used statewide for collecting members' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of members: adult, older adult, youth, and family members. MHPs administer these surveys to members 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 collects and tabulates the CPS year to year. Results are shared with staff, posted on the website, and reported at QIC. The MHP did not yet have an example of using this data for quality improvement, but states intention to expand its application.

PLAN MEMBER/FAMILY FOCUS GROUP

Plan member and family member (PMF) focus groups are a vital 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 PMF involvement. CalEQRO provides gift cards to thank focus group participants.

As part of the pre-review planning process, CalEQRO requested a 90-minute focus group with MHP members and/or their family, containing 10 to 12 participants each.

Consumer Family Member Focus Group Summary

CalEQRO requested a diverse group of members. [redacted] of the participants had initiated services in the last 12 months. The focus group was held in hybrid format, as [redacted] members participated from the Latino Outreach Center and [redacted] used the Spanish language interpreter who was at the center for this focus group. All [redacted] members participating receive and/or have a family member who receives clinical services from the MHP.

Members confirm that wait times for therapy services are lengthy, three months specifically, but that access to psychiatry is within two weeks. Despite the wait, they seemed generally satisfied with many aspects of their care. They commented that services felt timely, that they get reminders for appointments, can reschedule easily, access telehealth options, and request additional appointments when needed. Positive outcomes were clear in direct quotes such as, "There are a lot less crises since services started," and "My confidence has increased."

Recommendations from focus group participants included:

- Several members reported talking with someone at the school about the behavioral health of their child, but at least [redacted] members requested more parent support groups within the schools or therapy groups after school when the parent could participate.
- More consistent translators were requested, stating problems and discomfort with the Language Line service.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Despite lengthy wait times for both adult and youth services, the members note satisfaction and access to care. Most stated clear benefits from care. The most notable comments were a desire for more parent services embedded in the schools and a need for more bilingual staff, specifically Spanish speakers. The MHP could benefit from formal channels to collect member input, as focus group participants indicated no invitation to share their input into the system beyond communication with their provider or previously participating in the EQR focus group.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member 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 continues to maintain a unilateral front with contract providers and works for equality across the two-county system. This was true in the last review and has remained stable despite the challenge of large systematic changes. (Access, Quality)

2. Increasing the IS FTEs is providing the MHP with more resources to work through issues, as well as develop improved processes within the new EHR. The MHP is more prepared to leverage the data it collects and navigate the rapidly changing quality landscape. (Quality, IS)

3. The MHP has longevity of staff across many departments, especially true for the psychiatric providers and includes the medical director. This is a testament to prioritizing positive relationships and collaboration, attention to gaining staff buy-in for change, and intentional development of processes. It allows for staff retention, consistent member care, and maintenance of the historic knowledge base. (Access, Quality)

4. Despite a lack of aggregate data for LOC tools currently, the MHP has defined functional LOC tools separate from outcome measures. This is considered a strength to build upon. The MHP is encouraged to capitalize on this important data tool, sharing results with staff to increase their understanding of the purpose, that LOC tools are not redundant outcome measures. Tracking movement through the LOC in the system can strengthen the MHPs ability to manage and adapt its compacity and meet member needs. (Access, Quality)

5. The MHP has embedded staff in many key areas in the system which clearly benefits member outcomes, among other positive results. This includes the Psychiatric Emergency Services which is 24/7 in the hospital's emergency department and has remained over eight years after starting as an award-winning MHSA innovation project. Peers are embedded in almost all programs and the Resource Specialist position is growing to alleviate clinician shortages and provide resources to address social determinates of health. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. In the previous two reports, the MHP had been asked to address its timeliness metrics. In FY 2021-22, it was asked to develop updated processes for collecting this data and improve its accuracy. Last report, FY 2022-23, it was noted that timeliness was not being monitored frequently enough to allow for continuous improvement, and the accuracy was again in question. This year, the data from the legacy system continues to be unreliable. The MHP has expanded its QAPI to encompass many goals in this area and has chosen a new EHR to support an increasingly data-driven system; these efforts are encouraging. (Timeliness)

2. The PR of Hispanic/Latino members has historically been lower than the state and other counties of comparable size. Although the MHP does have the Latino Outreach Center, member validation indicated that the language line is used more frequently than they would like, that there is not usually a consistent interpreter for their care, and that there is not enough bilingual staff. Further, they reported not being familiar with Promotores services and note that outreach in the schools would be particularly helpful to them. The MHP indicated that attempts to increase staffing for the Latino Outreach Center have thus far been unsuccessful at the county level. The situation is more complex for this MHP by nature of the two-county system. Perhaps root cause analysis could be done with Hispanic/Latino members to identify key areas for improvement. (Access, Quality)

3. Line staff indicate that regular phone calls to members awaiting ongoing follow-up care after screening and initially offered appointment both add to their workload and can result in disengagement of members. Members validate that there is a long wait during this period, which may be better monitored with improved timeliness tracking. The bridge program that has been successfully done in the children's system of care provides an opportunity to replicate similarly where needed. (Access, Timeliness)

4. Definitions of "urgent services" are inconsistent across counties and often staff track this data using their own definition of "urgent" need. For reliable data to be tracked moving ahead with the hopes in the new EHR, the MHP's definition of what is counted and training to this regularly is needed. (Timeliness)

5. There are a high number of Medi-Cal claim denials indicating "Medicare Part B must be billed before submission of claim," and "Other healthcare coverage must be billed first" impacts the MHP's income stability. (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 member outcomes:

1. Monitor timeliness on a quarterly basis, with documented evidence of review and analysis of MHP performance on:
    - time to offered and delivered first services for youth
    - time to Early Explorers group
    - time to rendered psychiatry for youth
    - time to second and third appointments for all members

    (Timeliness, Quality)

    (This recommendation is continued from FY 2022 23.)

2. Use capacity, language, caseloads, and/or other service data to support advocacy for improved resources for Hispanic/Latino and Spanish-speaking members as measured by improvements in the PR for this population. (Access, Timeliness, Quality)

3. During the ongoing clinical staffing shortage, improve upon creative solutions to maintain engagement with adult members who are either awaiting ongoing therapy or being served during while awaiting transition to the MCP in accordance with No Wrong Door. (Access, Timeliness)

4. Develop clear protocols around urgent service requests and train staff to accurately capture these in the Credible EHR. (Timeliness, Quality, IS)

5. Develop a process to improve identification of those members with Part B Medicare and/or other healthcare coverage to allow proper claiming. (IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2023-24 EQR.

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 – Sutter-Yuba MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and 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 and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being
Consumer and Family Member Focus Group
Clinical Line Staff Group Interview
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Heather Claibourn, LCSW, Lead Quality Reviewer
Leda Frediani, Information Systems Reviewer
MaryEllen Collins, Consumer/Family Member 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
Andersen	Tammy	Staff Analyst-Quality Assurance	County
Ayala	Connie	Office Services Supervisor	County
Benzel	Janet	Accounting Clerk III	County
Bingham	Rick	Health and Human Services Assistant Director, BH Director	County
Bradford	Rusti	Quality Assurance Review Specialist	County
Brooks	Renee	Intervention Counselor	County
Cann	Mary	Business Intelligence Analyst	Kings View
Chue	Xay	Quality Assurance MH Therapist II	County
Clavel	Melissa	Quality Assurance Officer	County
Cole	Tara	Interim Administrative Services Officer	County
Corbin	Ryan	MH Therapist I/II	County
Dunlap	Traci	MH Therapist I/II	County
Duran	Gina	Program Manager-Hospital & Emergency Services Psychiatric Emergency Supervisor	County
Ford	Paula	Resource Specialist	County
Garfias	Melissa	Crisis Counselor	County
Gowan	Betsy	Program Manager – Health and Human Services Branch Director Adult Services	County
Hallford	Jesse	Staff Services Manager-Adult Services	County
Hanson	Scott	Information Technology Supervisor	County
Heer	Parminder	MH Therapist III	County
Heir	Amy	Children and Family Services Staff Analyst	County
Hernandez	Phillip	Deputy Branch Director-Adult Services	County
Hughes	Kristine	Quality Assurance MH Therapist III	County

Last Name	First Name	Position	County or Contracted Agency
Kearns	Paula	Branch Director-Adult Services	County
Kroner	Nicole	Information Technology	County
Leahy	Steven	Deputy Director	County
Moore	Nikki	Staff Analyst-Adult Services	County
Pattison	Brandy	MH Worker	County
Redford	Susan	Acute Psychiatric Services Branch Director	County
Reeb	Adam	Program Manager-Hospital & Emergency Services - PHF	County
Reyes	Magdalena	EHR Trainer/Analyst	Kings View
Rowland	Kayla	MH Therapist I/II	County
Shields	Clinton	Business Services Analyst III	Kings View
Singh	Dr. Hardeep	Medical Director	County
Tate	April	Program Manager – Clinal Services, Adult Services	County
Thomas	Josh	Program Manager-Clinical Services, Children and Family Services	County
Thompson	Michael	Information Security Analyst	County
Utter	Misty	MH Therapist III	County
Vang	Tony	Staff Services Manager-Quality Assurance	County
Whitaker	Darrin	Program Manager – Clinical Services, Children and Family Services	County
Xiong	Vichai	Accountant II	County

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	This is a good start to the PIP which is impacted by a new EHR system. Clarification on several points, as discussed in TA, and updates to the data collection process, due to the new EHR, are required prior to considering this a moderate confidence PIP. Further, the interventions should clearly target clinical aspects of care; this is designed more as a nonclinical PIP.
General PIP Information	
MHP/DMC-ODS Name: Sutter-Yuba Behavioral Health	
PIP Title: Improving Rates of Post-Psychiatric Hospitalization Follow-Up (FUH)	
PIP Aim Statement: "Will the use of a follow-up program consisting of a follow up care team, and a defined general follow-up structure, increase the rate of beneficiaries who are receiving follow-up services within 7-days after psychiatric hospitalization by 5% over a 12-month period in 2024?"	
Date Started: 01/2023	
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: N/A	

General PIP Information
Target population description, such as specific diagnosis (please specify): "Because of the small size of Sutter-Yuba and the number of clients hospitalized, Sutter-Yuba Behavioral Health is utilizing all clients hospitalized in the study."
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): None
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Training of scheduling staff.
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): Use of data dashboards and more consistent monitoring of follow-up scheduling and identifying the process for hospitalization follow-ups.

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 appointments rendered to clients.	FY 21-22	450 32.29%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Readmission Rates.	FY 21-22	450 12.78%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ 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 parts 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: • Describe the existing discharge planning system that needs improvement. Clearly describe your new "program" and "care team" as in the aim statement. • Expand root cause analysis for both outcomes separately and identify a more clinical intervention as well. This is designed as a nonclinical PIP. • Consider the phase of the PIP, when will be the actual first measurement and full implementation post new EHR? Begin data collection with regular analysis and clarify the numerator and denominator in Table 8.1.

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	There is a good root cause and direct link to quality member care. The plan seems likely to improve member follow-up care within 7 days. However, several sections need further definition and clarity to give the PIP increased confidence. Also, this should likely be a clinical PIP.
General PIP Information	
MHP/DMC-ODS Name: Sutter-Yuba Behavioral Health	
PIP Title: Follow-up After Psychiatric Emergency Services	
PIP Aim Statement: "The MHP aims to improve coordination and quality of care of mental and behavioral health services by implementing an improved tracking and referral system and interventions such as assertive outreach for Medi-Cal beneficiaries who have reported to Psychiatric Emergency Services for mental illness with the goal of increasing the percentage of follow-up care within 7 and 30 days by 5% by January 1, 2026."	
Date Started: 01/2023	
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: N/A	
Target population description, such as specific diagnosis (please specify): Adults and children including all beneficiaries reporting to the MHP's Psychiatric Emergency Services facility.	

General PIP Information						
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): Linkages to care needs and engagement with Assertive Outreach Techniques.						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Assertive Outreach Application and consistent follow-up calls.						
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): Tracking tools for data share between Psychiatric Emergency Services team and outpatient care team and monitoring Assertive Outreach Technique fidelity.						
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 care received within 7 days. Goal: 5% Increase	CY 2021	243/368 66%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Follow up care received within 30 days Goal: 5% Increase	CY 2021	273/368 74%	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ 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 parts 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: • This PIP seems like it could be a clinical PIP due to Assertive Outreach applied directly to members. Adjust so that there is one of each type of PIP. • Clearly define what aspects of Assertive Outreach are being used and how it links to keeping timely follow-up appointments. • Add more definition to the population of study to describe all those who are eligible to receive the intervention. Will all medical insurances receive the follow-up service or will you only measure those who are Medi-Cal members? • Ensure baseline data is comparable to the data collected in the study and outline these in the PIP tool. • Add more about the tracking tool that is being used in the PIP write-up, describing how it functions reliably in the new EHR.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, ATA, PIP Validation Tool, and CalEQRO Approved Claims Definitions are available on the CalEQRO website: CalEQRO website

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required as part of this report.