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

## YOLO FINAL REPORT

MHP

DMC-ODS

Prepared for:

**California Department of Health Care  
Services (DHCS)**

Review Dates:

**January 30-31, 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, “Yolo” may be used to identify the Yolo County MHP.

## MHP INFORMATION

- Review Type** — Virtual
- Date of Review** — January 30-31, 2024
- MHP Size** — Medium
- MHP Region** — Central

### Summary of Findings

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 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	2	2	1

**Table B: Summary of Key Components**

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	2	2	0
Timeliness of Care	6	5	0	1
Quality of Care	10	7	3	0
Information Systems (IS)	6	3	3	0
<b>TOTAL</b>	<b>26</b>	<b>17</b>	<b>8</b>	<b>1</b>

**Table C: Summary of PIP Submissions**

Title	Type	Start Date	Phase	Confidence Validation Rating
No PIP submitted	Clinical	N/A	N/A	N/A
Behavioral Health Quality Improvement Project (BHQIP) Follow Up After Emergency Department (ED) Visit for Mental Illness (FUM)	Non-Clinical	09/2022	Planning	No confidence

**Table D: Summary of Plan Member/Family Focus Groups**

Focus Group #	Focus Group Type	# of Participants
1	<input checked="" type="checkbox"/> Adults <input type="checkbox"/> Transition Aged Youth (TAY) <input type="checkbox"/> Family Members <input type="checkbox"/> Other	
2	<input type="checkbox"/> Adults <input type="checkbox"/> Transition Aged Youth (TAY) <input type="checkbox"/> Family Members <input checked="" type="checkbox"/> Other: (Parents/Caretakers of Youth 5 – 18 years)	

## SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Yolo’s Health and Human Services integration provides Behavioral Health (BH) efficiencies for both the children’s and adults’ systems of care.
- The MHP successfully initiated Netsmart’s Business Intelligence (BI) Analytic solution to support the monitoring and analysis of Healthcare Effectiveness Data and Information Set (HEDIS) measures.
- The MHP became member or participant in the SacValley Med Share Health Information Exchange (HIE) as they moved towards interoperability.
- The Adult and Aging forensics program collaborated with the county criminal justice system to increase access to Mental Health Court, Addiction Intervention Court, and other diversion programs offered by the District Attorney’s office.
- Stakeholders noted improved transparency and bi-directional communication with leadership that invites them to the table for planning of programs and services.
- The MHP has had strong billing practices and a low claim denial rate for the last three years.

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

- The MHP's Hispanic/Latino and Asian/Pacific Islander (API) penetration rates (PR) for CY 2022 were below the statewide rates and have remained largely unchanged for the past three years.
- The MHP has been inconsistent with EQR timeliness reporting. Last year they did not report first offered non-urgent clinical non psychiatry and first offered psychiatry appointments. This year they did not report first offered urgent appointments.
- There is not formalized, routine review of timeliness data.
- The MHP first offered non-urgent clinical non-psychiatry service (inclusive of adults, children, and youth in foster care (FC) scores below Department of Health Care Services (DHCS) requirements of 80 percent meeting standards.
- As an MHP that contracts out two-thirds of their services, Yolo has a particularly strong need for interoperability.
- While the MHP has a robust cadre of peer employees in both County and contracted provider programs, there is a lack of intentional supervision and support as well as an understanding by staff of the peer employees' job descriptions.
- The MHP was unable to submit a clinical PIP, citing staffing issues and work overload concerning California Advancing and Innovating Medi-Cal (CalAIM) and payment reform requirements.

Recommendations for improvement based upon this review include:

- Investigate reasons and develop and implement strategies to increase Hispanic/Latino and API PRs.  
(This is a modification of recommendations from FY 2021-22 and FY 2022-23).
- Implement the new methodology for all timely access tracking and incorporate routine review and analysis of the findings.  
(This is a modification of recommendations from FY 2021-22 and FY 2022-23)
- Research barriers, design, and implement processes to increase timeliness to first offered non-urgent clinical non-psychiatry service and first delivered non-urgent psychiatry service (inclusive of adults, children, and youth in FC), and incorporate routine review of the data and reports for accuracy.
- Develop operational plans for utilizing the HIE within MHP County programs and consider providing support to their contract providers to also use the HIE.  
(This a modification of recommendations from FY 2021-22 and FY 2022-23)
- Create a protocol and implement a system that provides intentional supervision and support to peer employees.

- Design and implement a clinical PIP for the current year. Engage in technical assistance (TA) with EQRO for assistance in this process.

# 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 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 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 Yolo County MHP by BHC, conducted as a virtual review on January 30-31, 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 (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 (EPSDT); FC; transition aged youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized 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. Data definitions are included as Attachment D.
- 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

- In the past year, the MHP experienced significant executive leadership team and BH leadership levels turnover, as well as vacancies in both leadership and staff.
- Yolo County Health and Human Services Agency (HHS) implemented a new fiscal system and is reorganizing fiscal services to align with the branch structure.

### SIGNIFICANT CHANGES AND INITIATIVES

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

- The implementation of CalAIM and payment reform has been a significant challenge for the MHP. It has consumed much of the administrative staff's time resulting in delays implementing other projects.
- HHS's new fiscal system to reorganize fiscal services to align with branch structure has created work that has resulted in delays in fully implementing payment reform.
- HHS is expanding its crisis continuum of care, forensics services, and homeless services programs. This increases staffing needs of several MHP programs.
- The Medical Director position has remained vacant since February 2021; administrative responsibilities are filled by the BH Director. The MHP is recruiting and hopes to fill the position within the next quarter.

## 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:** Investigate reasons and develop and implement strategies to increase staff engagement meaningfully in system improvement. This will require giving staff more information; staff having a seat at the table; and staff being empowered to make decisions regarding their programs and services, among other strategies.

Addressed                       Partially Addressed                       Not Addressed

- Over the course of the last year, the children's clinical supervisor and clinical manager held on-going discussions with the children's clinicians and case managers to identify ways to increase their engagement in system improvement and employee retention. Based on feedback from the team, the supervisor and manager adjusted tasks so that clinical staff were matched with tasks that aligned with their clinical interests and strengths. In addition, the supervisor collaborated with clinical staff on identifying other groups and community trainings that they would like to facilitate. They also encouraged staff participation in the Mental Health Services Act (MHSA) feedback sessions to voice their opinions on how to utilize MHSA funding to benefit the youth in the community.
- In forensics, homeless outreach, and substance use treatment programs, there were increased opportunities for staff participation and meaningful engagement

activities. Increased strategies of communication included agency newsletters, staff meeting briefs, and email briefs. Direct feedback was requested and received on program development. Tasks and activity delegation considered staff direct development. Staff were empowered to make more programmatic decisions and were offered more opportunities for feedback on all aspects of programming.

- Current crisis staff were included in the planning and preparation for implementation of the new mobile crisis benefit.
- The MHP provided examples that staff are receiving more transparency of the positive and negatives that are happening within the agency, through regular agency, department, and team meetings.

**Recommendation 2:** Investigate reasons and develop and implement strategies to increase API PR. This effort may present an opportunity to engage the quality management (QM) unit to assist in improving quality of services as opposed to utilization review.

(This recommendation was continued from FY 2021-22.)

Addressed                       Partially Addressed                       Not Addressed

- Over the past year, the County has emphasized the importance of having a culturally inclusive environment that is supportive of individuals from all culturally diverse backgrounds so that both staff and members feel welcome and safe when engaging in services at Yolo County. Executive leadership and management have made Diversity, Equity, Inclusion and Belonging (DEIB) training and education an ongoing focus for all current and new incoming staff.
- The cultural competency committee continues to send out culturally relevant resources that can be shared amongst staff and members. For example, in the aftermath of the Lunar New Year tragedy 2023, an email was sent out acknowledging the impact this event may have had on individuals, as well as resources that could be shared with members and the community.
- API PRs continue to be an ongoing area of concern as they have been historically lower than the similar county & statewide averages. To ensure this population is specifically an area of ongoing focus, this year's cultural competency plan has been updated to include a focus on investigation of the API PRs in order to identify efforts that can be made to improve them.
- For this recommendation to be rated as addressed, the MHP will need to investigate causes of lower API PRs, develop, and implement an intervention to increase API PR. This recommendation will be continued and include Hispanic/Latino PRs to offer the MHP an opportunity to focus on this issue for both populations.

**Recommendation 3:** Implement the new methodology for tracking time to first offered service and first offered psychiatry service (inclusive of adults, children, and youth in FC) and incorporate routine review of the data and reports for accuracy.

(This recommendation was continued from FY 2021-22.)

Addressed

Partially Addressed

Not Addressed

- The MHP developed a mechanism, based on existing data feeds, to track time to first offered service and first offered psychiatry service and reported the data, broken out by adults, children, and youth in FC, to the EQRO. The MHP indicated they are developing a more efficient and consistent method for data collection, validation, and analysis that they intend to pilot in spring 2024.
- This recommendation would have been rated as Addressed if the MHP had, at a minimum, piloted the more reliable methodology for collecting first offered appointment information in at least one of its programs.
- This recommendation will be continued as a revised recommendation to offer the MHP the opportunity to fully address the issue of timeliness tracking.

**Recommendation 4:** Implement solutions to produce reports that demonstrate tracking, monitoring, and analyzing of the requisite indicators for youth in FC prescribed psychotropic medications.

(This recommendation was continued from FY 2021-22.)

Addressed

Partially Addressed

Not Addressed

- In September 2023, Yolo County adopted Netsmart's BI Analytic solution to support the monitoring and analysis of HEDIS measures.
- As reported in the Pathways to Wellbeing document, the MHP created a Special Populations tracking form and a report in the electronic health record (EHR) that allows tracking of this data. Over the next year, the MHP plans to focus efforts on tasking the recently hired analyst in Child Youth & Family Mental Health to develop a process to monitor and analyze the data.
- Additionally, the HHS Information Technology Service Department Enterprise Applications team is currently in the process of creating a comprehensive dashboard. Continued work on this dashboard has been paused but will resume after payment reform changes have been fully implemented in the EHR.

**Recommendation 5:** Develop and implement a plan to amend existing contracts and resolve fiscal and operational issues, which would enable interested contract providers to gain full access to the EHR.

(This recommendation was continued from FY 2021-22.)

Addressed

Partially Addressed

Not Addressed

- Potential solutions to giving full EHR access to the contract providers have been presented to the MHP's BH executive team. However, decisions have been

delayed due to the implementation of payment reform. In the interim, new contract providers are required to document directly in the MHP EHR. One new contract provider has been onboarded into the EHR since the previous EQR.

- To receive an addressed rating, the MHP needed a plan to amend existing contract provider contracts and resolve associated fiscal and operational issues with current contract providers. This recommendation will be incorporated into a broader interoperability recommendation.

## 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.<sup>1</sup> 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 33 percent of services were delivered by county-operated/staffed clinics and sites, and 67 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 50 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 contract provider staff; members may request services through the Access Line as well as through crisis walk-in at three clinics, open-access at one clinic, schools, referrals from hospitals and managed care plan providers, and court-facilitated diversion programs. The MHP operates a decentralized access team that is responsible for linking members to appropriate, medically necessary services. Clinicians conduct mental health screenings to determine the service needed, subsequently either a referral to a community provider is made or a mental health assessment appointment is scheduled within the MHP. The assessments are meant to be scheduled within one week of the screening.

In addition to clinic-based mental health services, the MHP provides psychiatry and mental health services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 404 adults, 408 youth, and <11 older adults across 3 County operated sites and 12 contractor-operated sites. Among those served, 26 members received telehealth services in a language other than English.

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<sup>1</sup> [CMS Data Navigator Glossary of Terms](#)

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

**Table 1A: MHP Alternative Access Standards, FY 2022-23**

Alternative Access Standards	
The MHP was required to submit an AAS request due to time or distance requirements	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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

**Table 1B: MHP Out-of-Network Access, FY 2022-23**

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
OON Details	
Contracts with OON Providers	
Does the MHP have existing contracts with OON providers?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
OON Access for Members	
The MHP ensures OON access for members in the following manner:	<input checked="" type="checkbox"/> The MHP has existing contracts with OON providers <input type="checkbox"/> Other:

- 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	Partially 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:

- The MHP has been increasing their full service partnership (FSP) program slots every year for the past few years. This is increasingly important as the time members remain in the FSP program has been increasing. The Woodland Community College BH program also increased staffing to meet student needs.
- The homeless services team has housed 90 percent of their members in supportive housing.
- Peer workers provide transportation for members who need it to BH appointments and other essential destinations.
- The MHP Hispanic/Latino and API PRs continue to be lower than seen statewide or in medium-sized counties.

## 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.

The 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, with a 3.22 percent PR, members may be experiencing more challenges accessing mental health services in Yolo compared to what is seen statewide.

**Table 3: Yolo 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	63,759	2,052	3.22%	\$16,412,346	\$7,998
CY 2021	60,221	1,940	3.22%	\$17,355,865	\$8,946
CY 2020	55,914	1,824	3.26%	\$18,880,459	\$10,351

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 number of eligibles and number of members served has increased each year, resulting in a stable PR for CYs 2020 to 2022.
- The total approved claims and AACM has decreased each year between CY 2020 and CY 2022. There have been fewer claim lines billed year over year, even though the number of members served increased each year.

**Table 4: Yolo 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	6,212	102	1.64%	1.15%	1.82%
Ages 6-17	14,707	644	4.38%	4.80%	5.65%
Ages 18-20	3,351	110	3.28%	3.47%	3.97%
Ages 21-64	33,454	1,123	3.36%	3.60%	4.03%
Ages 65+	6,037	73	1.21%	1.98%	1.86%
<b>Total</b>	<b>63,759</b>	<b>2,052</b>	<b>3.22%</b>	<b>3.49%</b>	<b>3.96%</b>

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 MHP’s PR is lower than other medium-sized counties overall and in all age groups other than ages 0-5.
- The MHP’s PR is lower than statewide for all age groups. The biggest discrepancy is ages 6-17.

**Table 5: Threshold Language of Yolo MHP Medi-Cal Members Served in CY 2022**

Threshold Language	# of Members Served	% of Members Served
Spanish	188	9.81%

Threshold language source: Open Data per BHIN 20-070

- Almost one out of ten members served identify Spanish as their primary language.

**Table 6: Yolo 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	20,306	487	2.40%	\$4,211,089	\$8,647
Medium	530,704	15,912	3.00%	\$110,270,160	\$6,930
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. Yolo’s ACA PR is lower than what is seen for non-ACA members, but the ACA AACM is higher than the \$7,998 overall MHP AACM.

- Twenty-nine percent of the MHP’s ACA population served, 143 members, received inpatient services which could have contributed to the relatively high AACM.

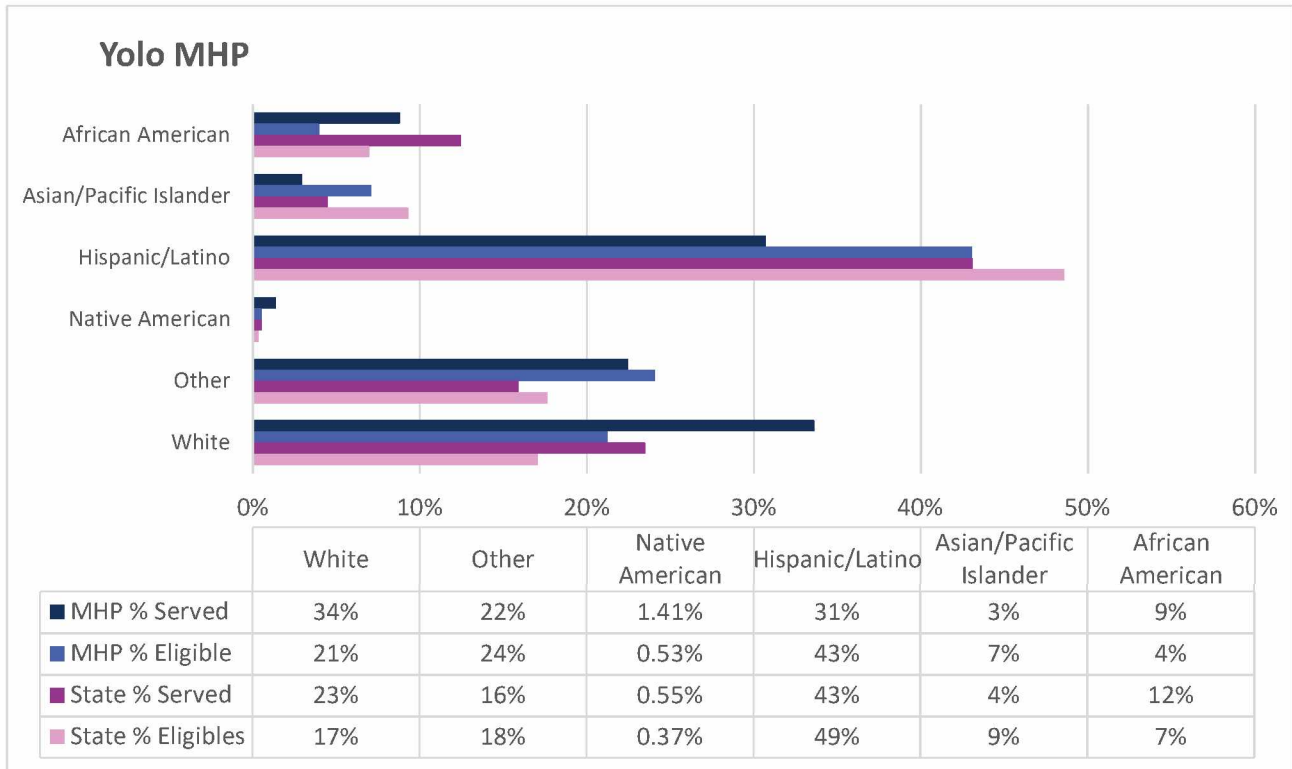
The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they 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: Yolo MHP PR of Members Served by Race/Ethnicity, CY 2022**

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	2,532	181	7.15%	7.08%
Asian/Pacific Islander	4,529	61	1.35%	1.91%
Hispanic/Latino	27,458	630	2.29%	3.51%
Native American	338	29	8.58%	5.94%
Other	15,360	461	3.00%	3.57%
White	13,544	690	5.09%	5.45%

- The Hispanic/Latino population is the largest racial/ethnic group of Medi-Cal eligibles in Yolo. The PR at 2.29 percent is one of the lowest PRs in the county, and well below the statewide average, for that population.
- Native American and African American members, who make up relatively small proportions of the overall Medi-Cal eligibles, both have higher PRs than seen statewide.

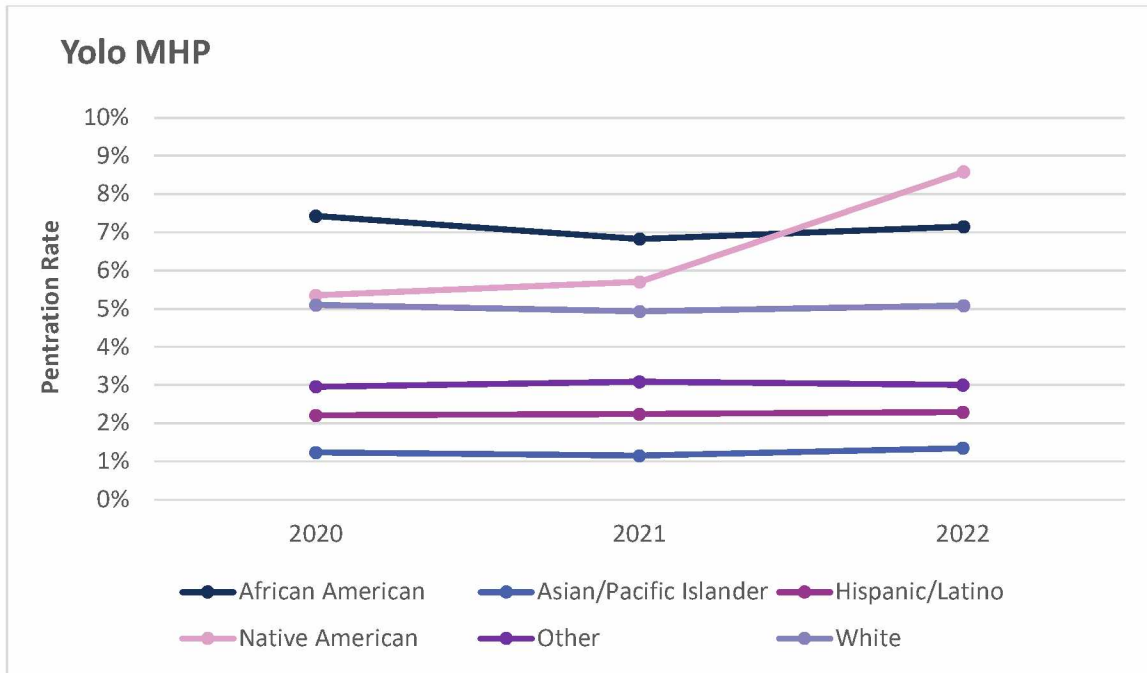
**Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022**



- White members represented 34 percent of the population receiving services, while they are only 21 percent of Medi-Cal eligibles in the county. Conversely, 31 percent of members serviced were Hispanic/Latino, though they are 43 percent of the eligible population.

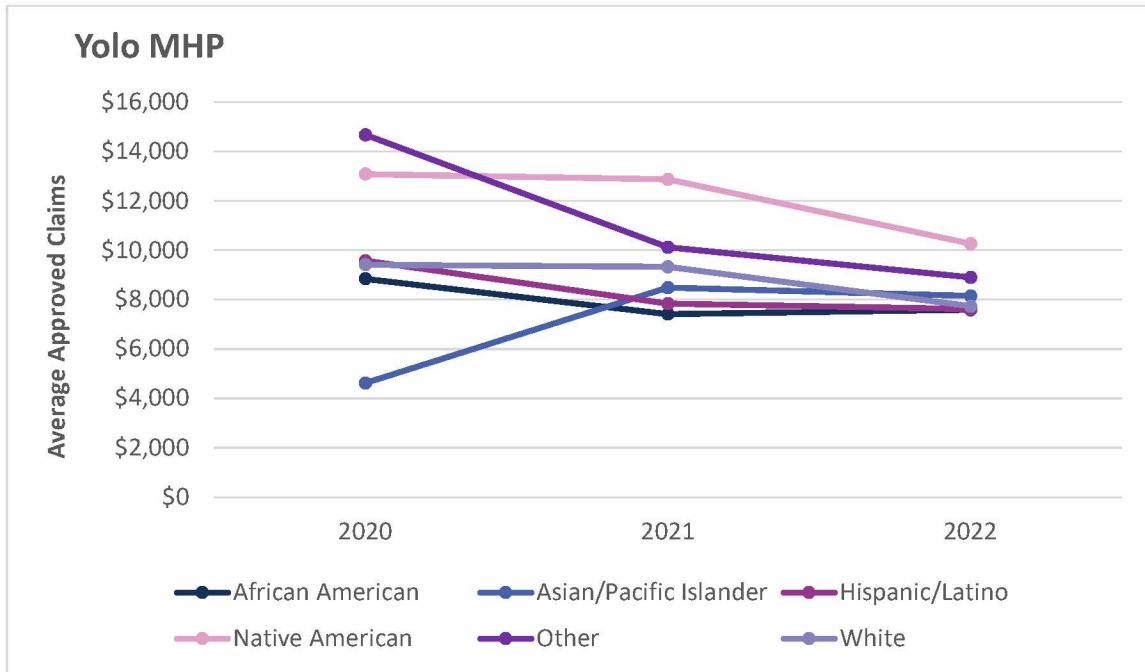
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and API), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide for a three-year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

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



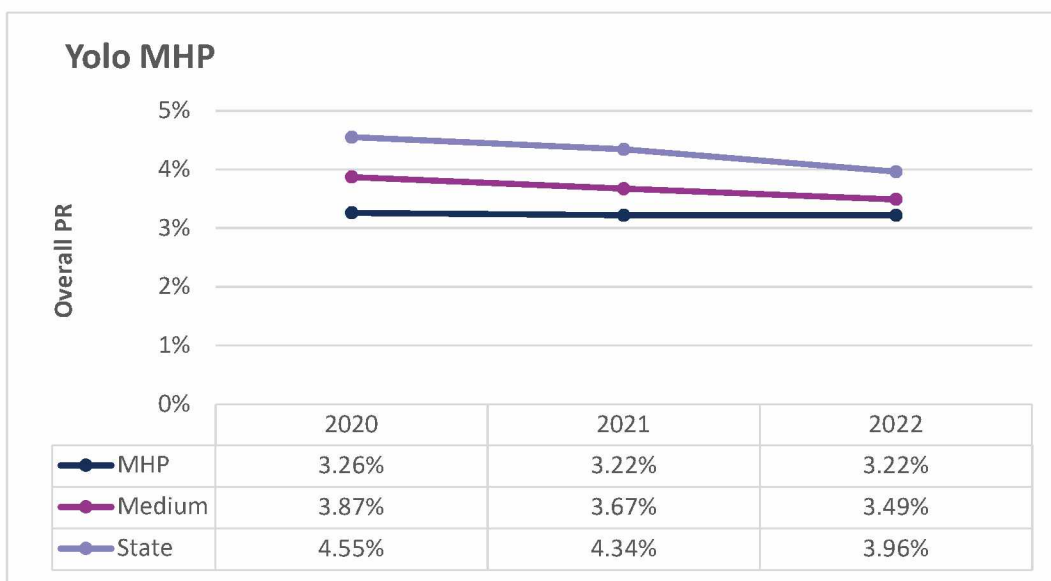
- Apart from Native Americans, who are small in number in Yolo, all racial/ethnic groups have had consistent PRs relative to each other between CY 2020 and CY 2022. African Americans have had the highest PR, followed by White, Other, Hispanic/Latino, and then API.

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



- The range of AACM by race/ethnicity has been decreasing between CY 2020 and CY 2022. In CY 2020 there was a \$10,000 difference between the lowest AACM (\$4,626 for API) and the highest AACM of \$14,675 for those who identified as Other. In CY 2022 the difference was about \$5,100 with the White AACM at \$7,737 and the Native American AACM at \$12,866.

**Figure 4: Overall PR CY, 2020-22**



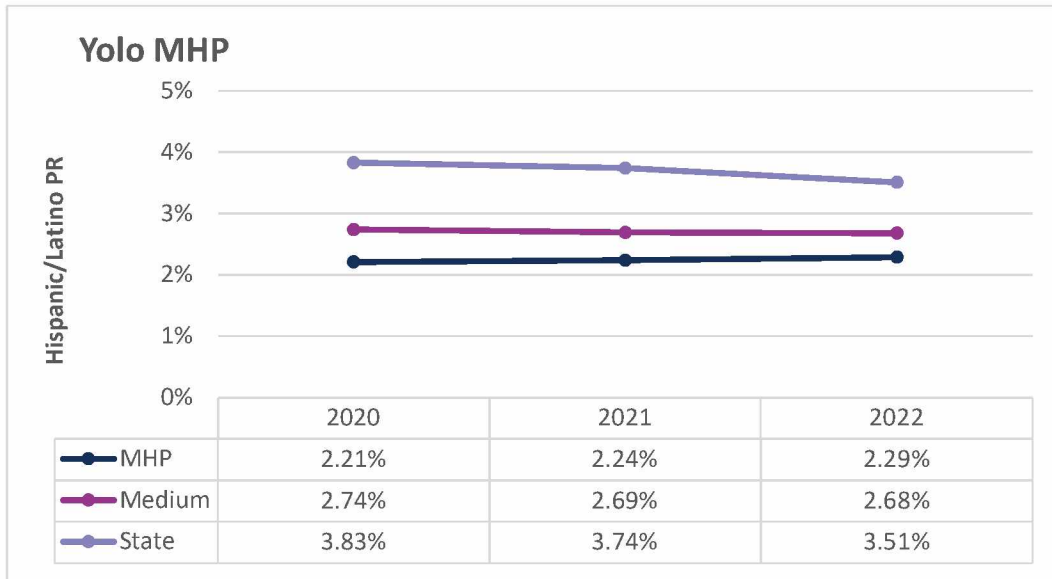
- The MHP’s PR has been lower than the statewide and medium-sized county rates from CY 2020 to CY 2022. However, Yolo County’s PR has remained steady while the statewide and medium county rates have been declining.

**Figure 5: Overall AACM, CY 2020-22**



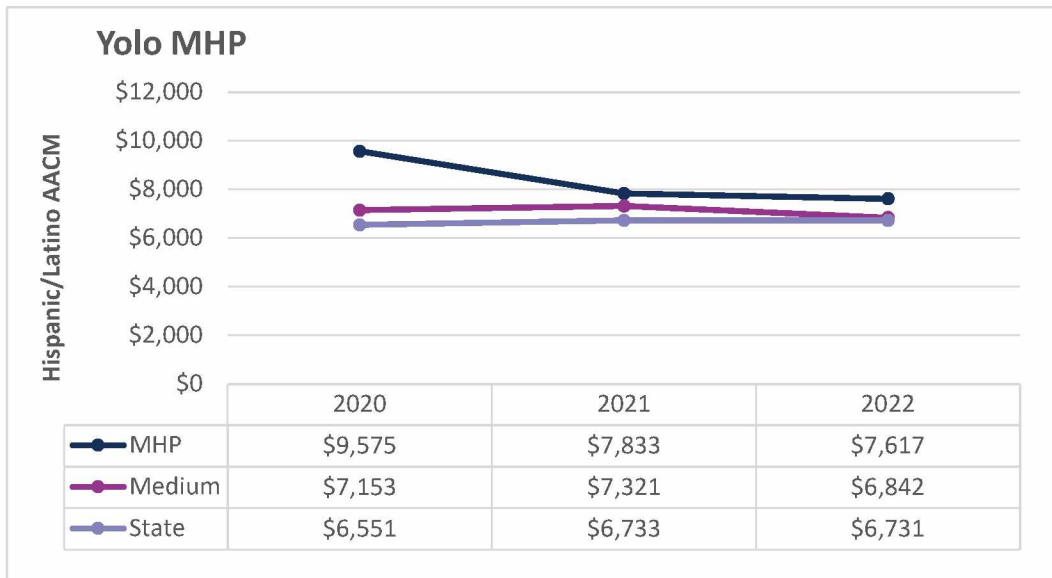
- The MHP’s overall AACM has been decreasing while state and medium-sized county averages have been relatively consistent. With the decreasing AACM in Yolo, the MHP’s AACM is now approaching the state average and is below the medium-sized county average.

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



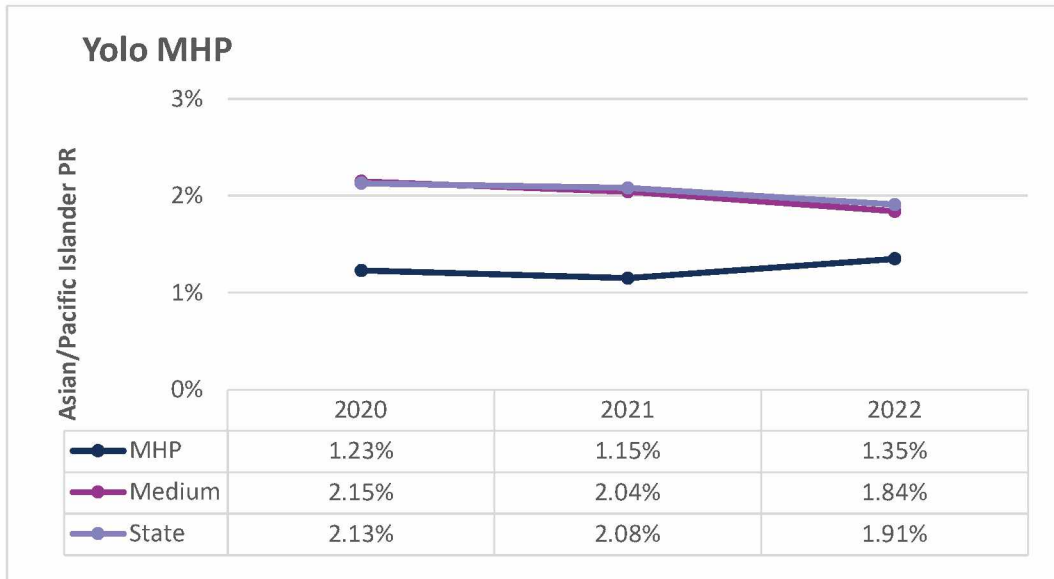
- The Hispanic/Latino PR has increased very gradually over the past three years. It remains consistently lower than medium-sized counties and statewide rates.

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



- The MHP’s Hispanic/Latino AACM came down sharply between CY 2020 and CY 2021 and remained around the CY 2021 average in CY 2022. It has been above the medium-sized counties and statewide AACMs all three CYs.

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



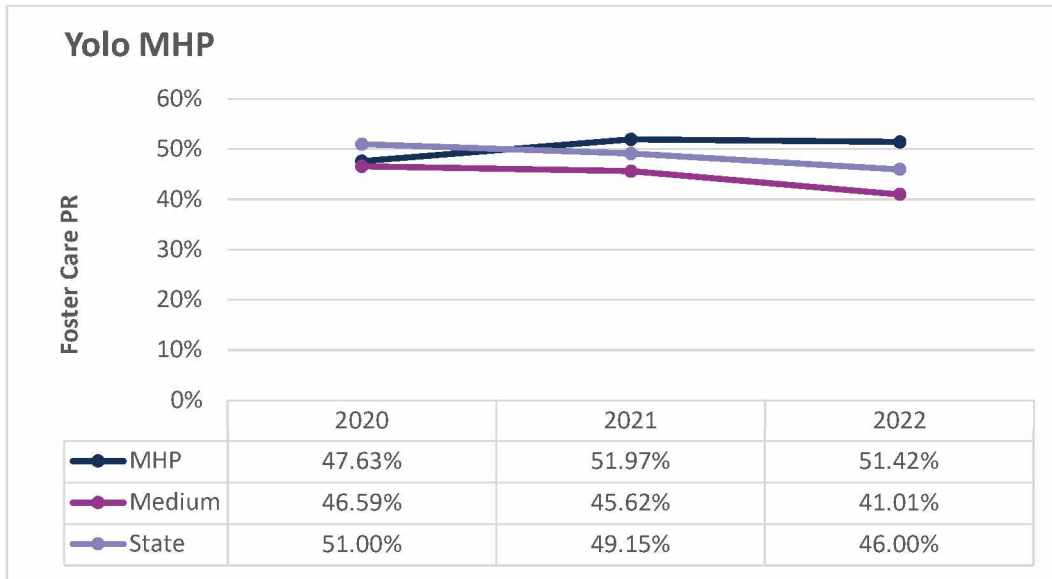
- The MHP API PR remains consistently lower than the statewide and medium-sized counties rates; however in CY 2022 the MHP API PR increased while the medium-sized county and statewide averages declined.

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



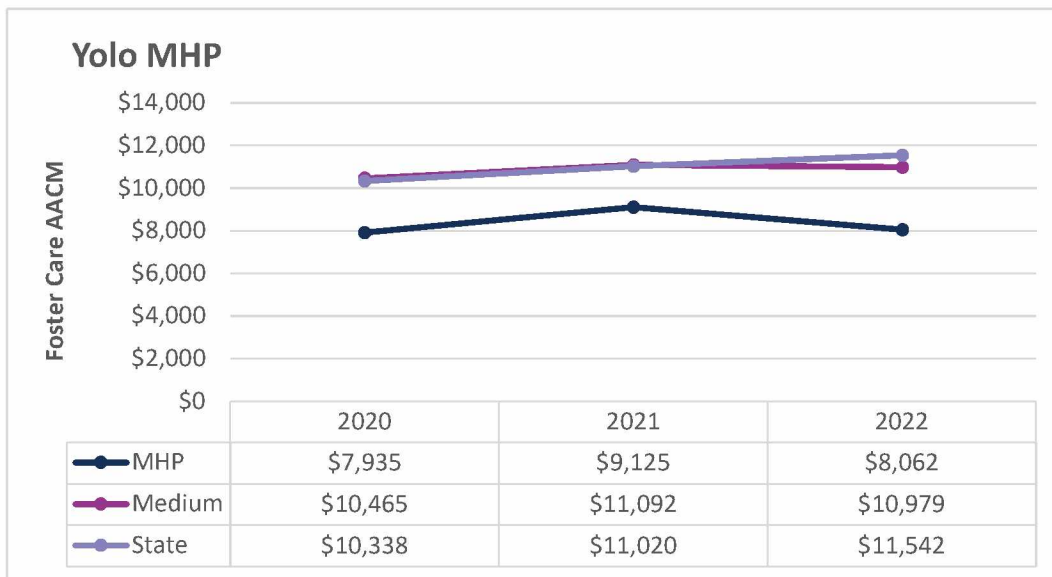
- The MHP’s API AACM increased sharply between CY 2020 and CY 2021 and remained close to the CY 2021 average in CY 2022. The MHP, medium-sized county and statewide rates were fairly close in CY 2022.

**Figure 10: Foster Care PR, CY 2020-22**



- The MHP’s FC PR has increased since CY 2020, while the statewide and medium-sized county rates have decreased. The MHP indicated that 60 percent of the Yolo FC youth are placed out of county, so FC data is impacted by treatment provided outside of the county.

**Figure 11: Foster Care AACM, CY 2020-22**



- Statewide FC AACM has increased each year for the past three years. The MHP FC AACM increased in CY 2021 and decreased in CY 2022. The FC AACM has

been lower than the state and medium-sized county averages each year between CY 2020 and CY 2022.

### Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Yolo MHP to Adults, CY 2022

Service Category	MHP N = 1,307				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
<b>Per Day Services</b>							
Inpatient	126	9.6%	8	6	10.3%	14	8
Inpatient Admin	0	0.0%	0	0	0.4%	26	10
Psychiatric Health Facility	117	9.0%	23	15	1.2%	16	8
Residential	18	1.4%	170	158	0.3%	114	84
Crisis Residential	73	5.6%	15	12	1.9%	23	15
<b>Per Minute Services</b>							
Crisis Stabilization	40	3.1%	1,031	1,200	13.4%	1,449	1,200
Crisis Intervention	252	19.3%	130	83	12.2%	236	144
Medication Support	788	60.3%	248	139	59.7%	298	190
Mental Health Services	784	60.0%	597	289	62.7%	832	329
Targeted Case Management	606	46.4%	614	194	36.9%	445	135

- The MHP has a far greater percentage of members served receiving psychiatric health facility (PHF) services compared to statewide and for a longer average number of days in the PHF. There are also higher percentages of members receiving residential and crisis residential services. Residential shows longer LOS and crisis residential shows shorter length of stay (LOS) than statewide.
- More members receive crisis intervention, though for fewer units of service; the MHP does not offer a crisis stabilization unit and so this rate is lower than statewide.
- Yolo members receive fewer units of mental health services than seen statewide and more units of targeted case management (TCM).

**Table 9: Services Delivered by the MHP to Yolo MHP Youth in Foster Care, CY 2022**

Service Category	MHP N = 219				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
<b>Per Day Services</b>							
Inpatient	<11	-			4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-			0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	<11	-	23	23	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	<11	-			0.2%	111	84
<b>Per Minute Services</b>							
Crisis Stabilization	<11	-			3.1%	1,166	1,095
Crisis Intervention	20	9.1%	214	102	8.5%	371	182
Medication Support	44	20.1%	375	346	27.6%	364	257
Therapeutic Behavioral Services (TBS)	<11	-			3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	108	49.3%	468	160	40.8%	1,458	441
Intensive Home-Based Services	34	15.5%	745	398	19.5%	2,440	1,334
Katie-A-Like	14	6.4%	419	336	0.2%	390	158
Mental Health Services	212	96.8%	1,485	848	95.4%	1,846	1,053
Targeted Case Management	134	61.2%	492	118	35.8%	307	118

- When hospitalized, the FC youth show shorter average LOS.
- A higher percentage of Yolo FC members receive Intensive Care Coordination (ICC) than statewide, but they receive about one-third of the average number of units. All MHP contractors assess and provide ICC services.

- Compared to statewide data, a lower percentage of MHP FC receive Intensive Home-Based Services (IHBS) and they receive 30 percent of the average number of units.
- A similar percentage receives about 80 percent of the statewide average number of units of mental health services.
- A far higher percentage of FC members receive 60 percent more TCM than statewide data.

## IMPACT OF ACCESS FINDINGS

- Yolo's children's system of care is fully integrated with the Child Welfare system under the same branch director. This provides efficiencies such as assigning BH clinicians to all youth in the Child Welfare system who are placed in STRTPs. They are focused on reducing the need to place children in Short-Term Residential Therapeutic Programs (STRTP). In 2020, 31 youth were placed in an STRTP; and by 2023 it was reduced to 17. At the time of the EQR, the number had been reduced to 5.
- Yolo demonstrates Pathways to Well-Being with both FC and other EPSDT youth receiving ICC and IHBS. The comparatively low number of units of IHBS provided warrants investigation into whether this service is provided in sufficient amount and for intended outcomes.
- The MHP needs to analyze the Latino/Hispanic PRs for potential action. It remains below medium-sized county and statewide averages and has remained largely unchanged across the past three years.
- With mobile crisis and crisis intervention being a focus, it is likely that number of members who need PHF, and the length PHF stays will decline. The MHP should monitor for improvement in their inpatient data and its correlation to crisis intervention.

## 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	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	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:

- While the MHP tracks and trends the data for first non-urgent request to first offered appointment that meets the 10-business days standard, overall, this is met 71 percent of the time, and the first service delivered meets the 15-business

days standard 61.97 percent of the time. FC is met only 25 percent and 50 percent on these metrics.

- The MHP was not able to provide urgent appointment data in hours. They are working on a new form to collect this information and expect to report it to the EQR next year.
- Follow up post-discharge from hospitalization meets the 7-day standard 61.49 percent of the time, and 30-day standard 84.20 percent of the time. This data includes all payer sources.
- The MHP tracks and trends no-shows/cancellation for County-operated services only. The standard for both psychiatry and non-psychiatry clinical staff is 5 percent. This is met for non-psychiatry clinical staff at 2.2 percent, and psychiatry is not met at 13.57 percent. FC is not tracked or reported. The MHP should investigate whether this data set is complete, as this is a quite low target and rate of no-shows.

## TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. Except for no-show rates, these data represent the entire system of care. The no-show rates reflected county-operated services only. Timeliness to urgent appointments is currently tracked in days rather than hours, so was not reported this year.

The MHP allows more days for delivering first non-urgent services (both psychiatry and non-psychiatry) than the DHCS standard for first offered services.

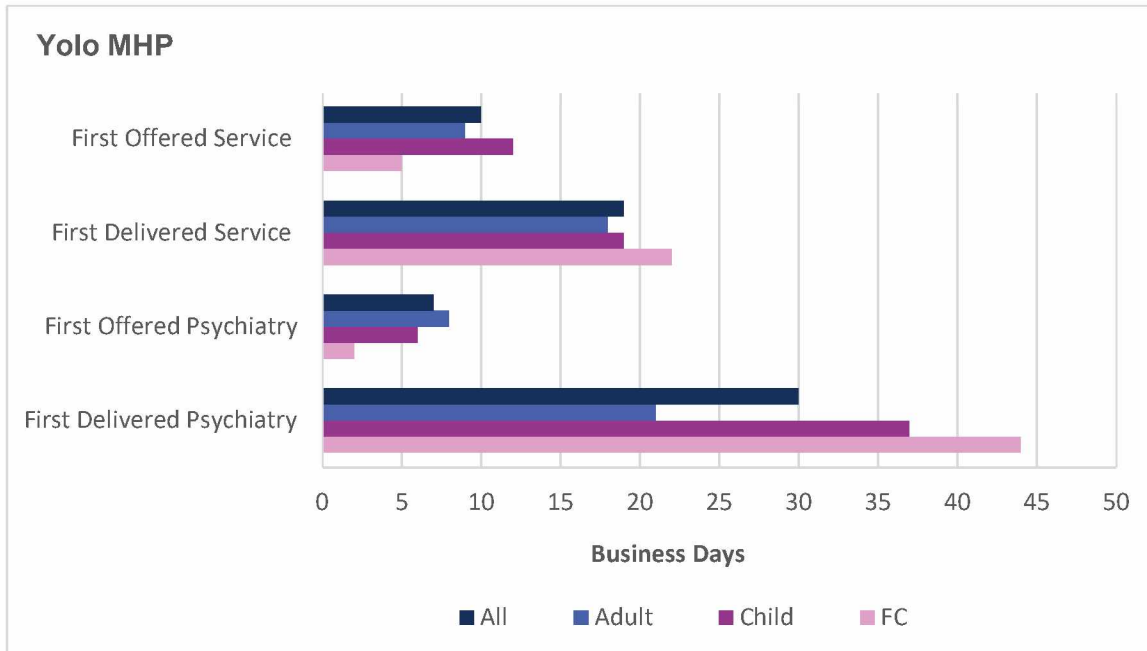
- The DHCS standard for first offered non-urgent appointment is 10-business days while the MHP standard for first delivered non-urgent appointment is 15-business days.
- The DHCS standard for first offered non-urgent psychiatry appointment is 15-business days while the MHP standard for first delivered non-urgent psychiatry appointment is 30 calendar days.

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

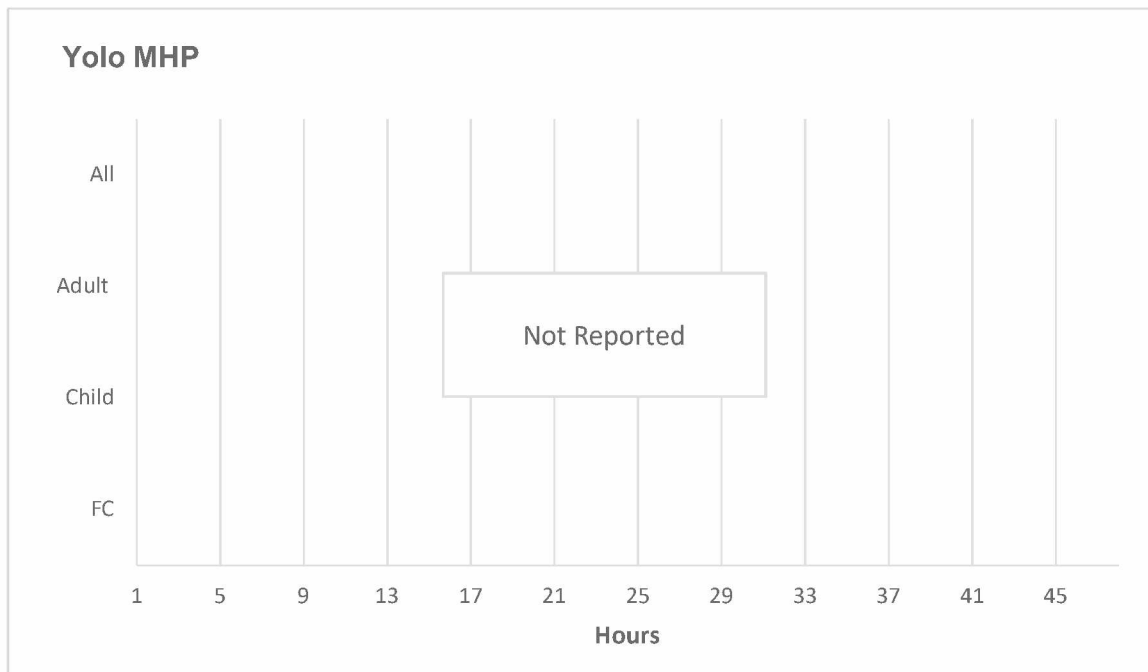
**Table 11: FY 2023-24 Yolo MHP Assessment of Timely Access**

<b>Timeliness Measure</b>	<b>Average</b>	<b>Standard</b>	<b>% That Meet Standard</b>
First Non-Urgent Appointment Offered	10 Business Days	10 Business Days*	71%
First Non-Urgent Service Rendered	19 Business Days	15 Business Days**	61.97%
First Non-Urgent Psychiatry Appointment Offered	7 Business Days	15 Business Days*	94.03%
First Non-Urgent Psychiatry Service Rendered	30 Business Days	30 Calendar Days**	54.29%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	***	48 Hours*	***
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	25 Calendar Days	7 Calendar Days	61.49%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	25 Calendar Days	30 Calendar Days	84.20%
No-Show Rate – Psychiatry	13.57%	5%**	n/a
No-Show Rate – Clinicians	2.2%	5%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23			

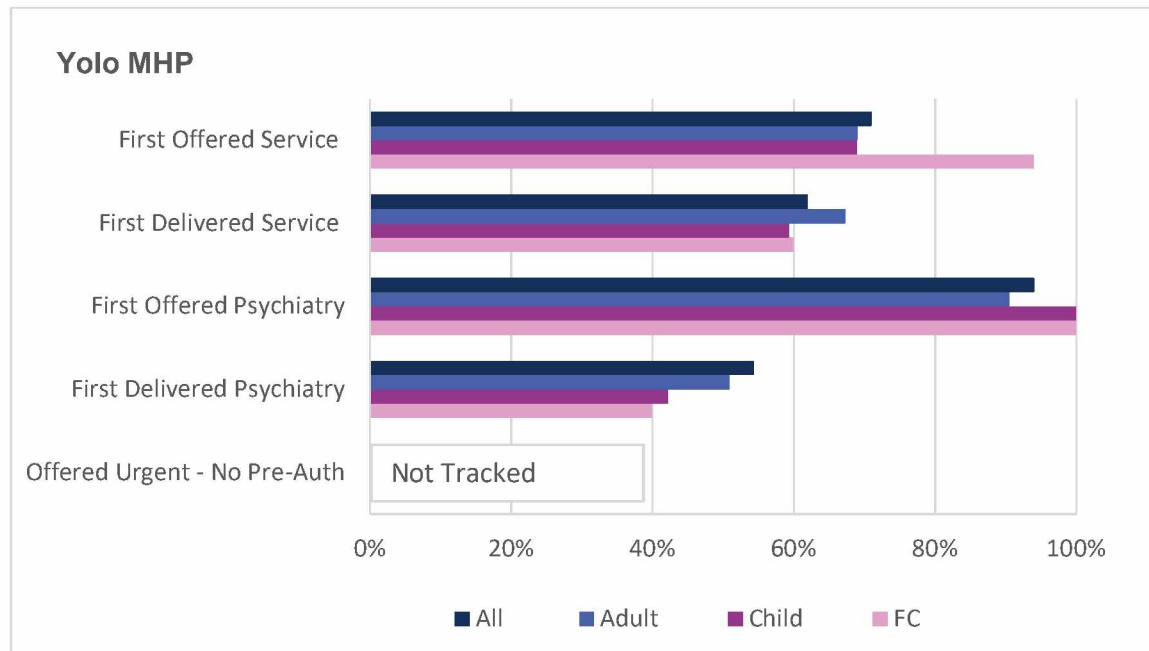
**Figure 12: Wait Times to First Service and First Psychiatry Service**



**Figure 13: Wait Times for Urgent Services**



**Figure 14: Percent of Services that Met Timeliness Standards**



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments.
- The MHP defined “urgent services” as services marked urgent in the Access Log or a Progress Note. Urgent service data was not provided on the ATA. The MHP does provide two youth urgent services that require pre-authorization.
- The MHP defines timeliness to first delivered/rendered psychiatry services as from the adult member’s initial service request and from the first clinical determination of need for children’s psychiatry services.

## IMPACT OF TIMELINESS FINDINGS

- The MHP sets a 15-day standard for first delivered service but only meets the standard 62 percent of the time. In contrast, a contract provider reported having access capacity for assessments. The MHP should do further analysis on system demand and availability throughout the county and implement strategies to match availability to need.
- There is a wide disparity between the 94 percent of first offered psychiatry appointments that meet the DHCS 15 business-day standard and the 54 percent of first delivered psychiatry appointments that meet the MHP 30 calendar day standard. The MHP needs to understand why so many members are not accepting the timely offer for a psychiatry appointment (or are there reasons for

member or provider rescheduling) and develop strategies to resolve the problem. The psychiatry delays may have other consequences such as increased crisis or ED contact.

- The MHP does not have an accurate and complete picture of its capacity to provide urgent services, given that it did not report on times to first offered urgent service.

## 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 is the QM Program that is led by the Acting QM Manager. The Acting QM Manager also holds the title of CalAIM Coordinator. The responsibility for Compliance is another staff member, the Compliance Officer. The QM Manager is supported by QM clinicians and analysts who are assigned to the adult and children's system of care.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC is comprised of county BH department staff, contracted providers, and other stakeholders whose roles are not defined in documentation. The QIC is scheduled to meet quarterly and since the previous EQR, it met four of four times. Of the 14 identified FY 2022-23 QAPI mental health workplan goals, the MHP met or partially met the majority of the goals.

The MHP utilizes the following level of care (LOC) tools: Level of Care Utilization System (LOCUS) (7/1/22 – 2/14/23); Child and Adolescents Needs and Strengths (CANS), Pediatric Symptom Checklist (PSC-35). The MHP provided documentation of sample monitoring reports. 100 percent of beneficiaries who request treatment are screened for referrals using LOC tools. Yolo County has aggregate reports for trending of CANS and PSC-35 data. Currently, when appropriate, the MHP is using FSP criteria in a utilization review meeting for placement in an appropriate program. This is in lieu of the LOCUS or what will be decided to replace the LOCUS.

The MHP utilizes the following outcomes tools: PSC-35, CANS, FSP criteria. Again, when appropriate, Yolo is using FSP criteria to determine the intensity/dosage of treatment for adult member needs. They are evaluating whether to return to using LOCUS. The CANS and PSC-35 are entered directly into Avatar and utilized for children's clinical decision making. Yolo has aggregate reports for trending of CANS and PSC-35 data.

The LOCUS was utilized from 7/1/2022 – 2/14/2023. The County is looking into other outcome tools for the adult system of care while continuing to clinically review LOC in

the Utilization Management Committee to assist in transitioning clients between internal care teams, the contracted Full Service Partnership provider, and Managed Care Program (MCP) community mild to moderate providers. Adult mental health staff continue to utilize the LOCUS as a decision-making tool in the utilization management committee to assist in transitioning clients between LOC within internal care teams as well as to refer step up to the contracted acceptance and commitment therapy team, and stepdown to MCP community mild to moderate providers.

## 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	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Partially Met
3H	Utilizes Information from Member Satisfaction Surveys	Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Member and Member Employment in Key Roles throughout the System	Partially Met

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

- The MHP uses data from a variety of BH and other sources to evaluate their programs. Yolo implemented the Netsmart Key Performance Indicators (KPI)

Dashboards product that is beginning to be used to track HEDIS measures, the DHCS screening and transition of care tools, and other measures. The K-12 School Partnerships project allows the county to consider school attendance and grades in assessing outcomes. West Sacramento police department data is also used for program development.

- Some aspects of medication management monitoring and coordination of care are not happening consistently because the MHP lacks a Medical Director. Creating a system to track and trend appropriate medication management will be a focus of the new Medical Director when hired.
- The MHP does not have a standardized universal outcome tool for adult beneficiaries. The use of LOCUS ended February 2023. The MHP is currently researching which tool to implement.
- Although the MHP employs peers in its system, there does not appear to be a career ladder nor supervisory positions available specifically for peers. In addition, newly certified peers are not yet fully incorporated into the clinical setting as their training allows.
- The MHP tracks and trends the four HEDIS measures as required by WIC Section 14717.5 and provided evidence in the form of de-identified reports.

## QUALITY PERFORMANCE MEASURES

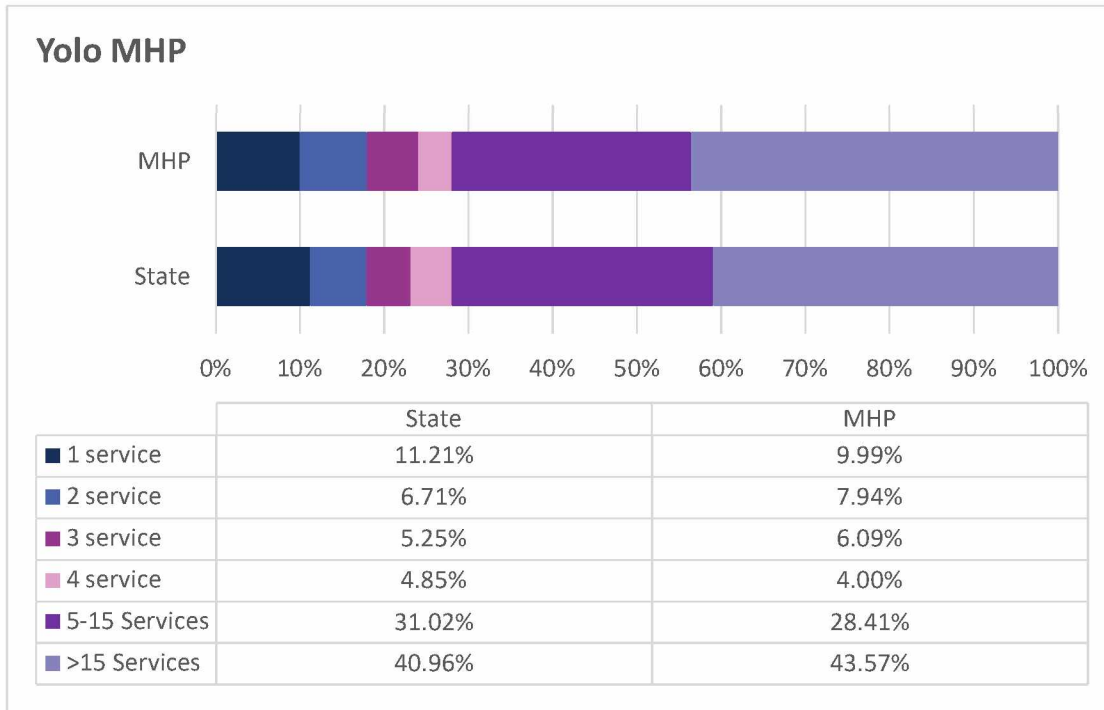
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

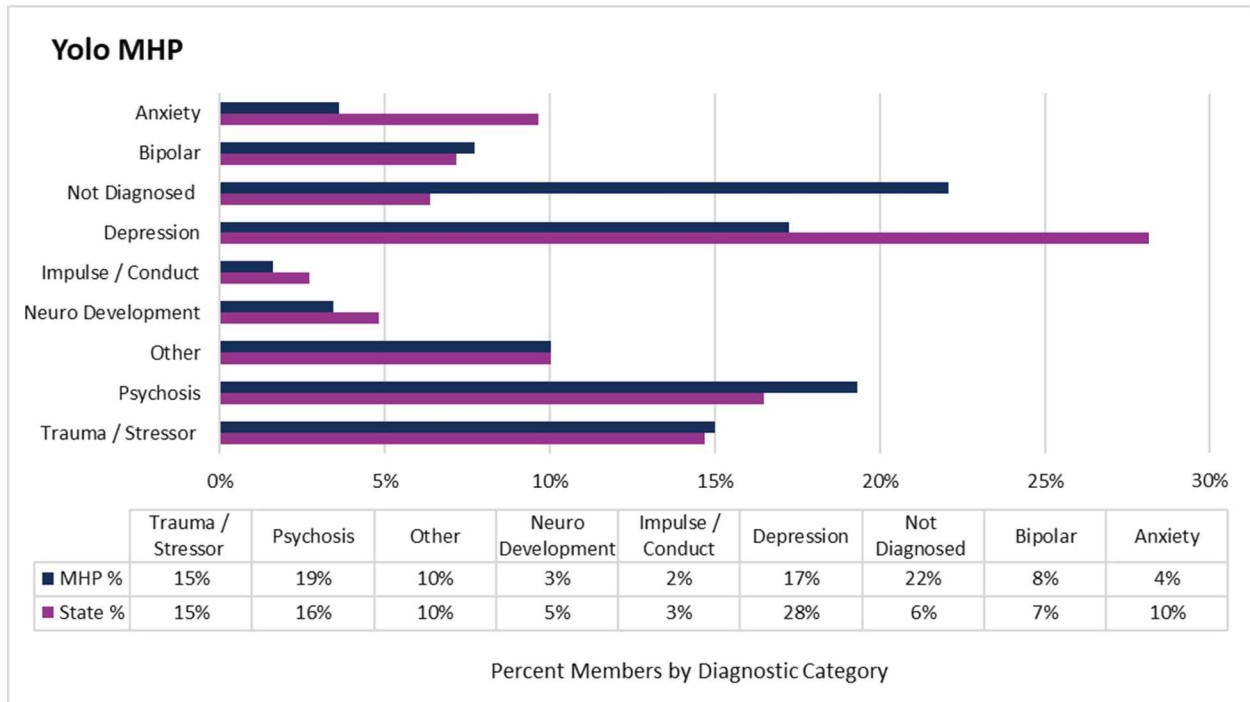


- The MHP’s service retention pattern is similar to the statewide pattern. About 28 percent of members served receive 1-4 services, another 28 percent receive 5-15 services, and the remaining 44 percent receive more than 15 services.

### Diagnosis of Members Served

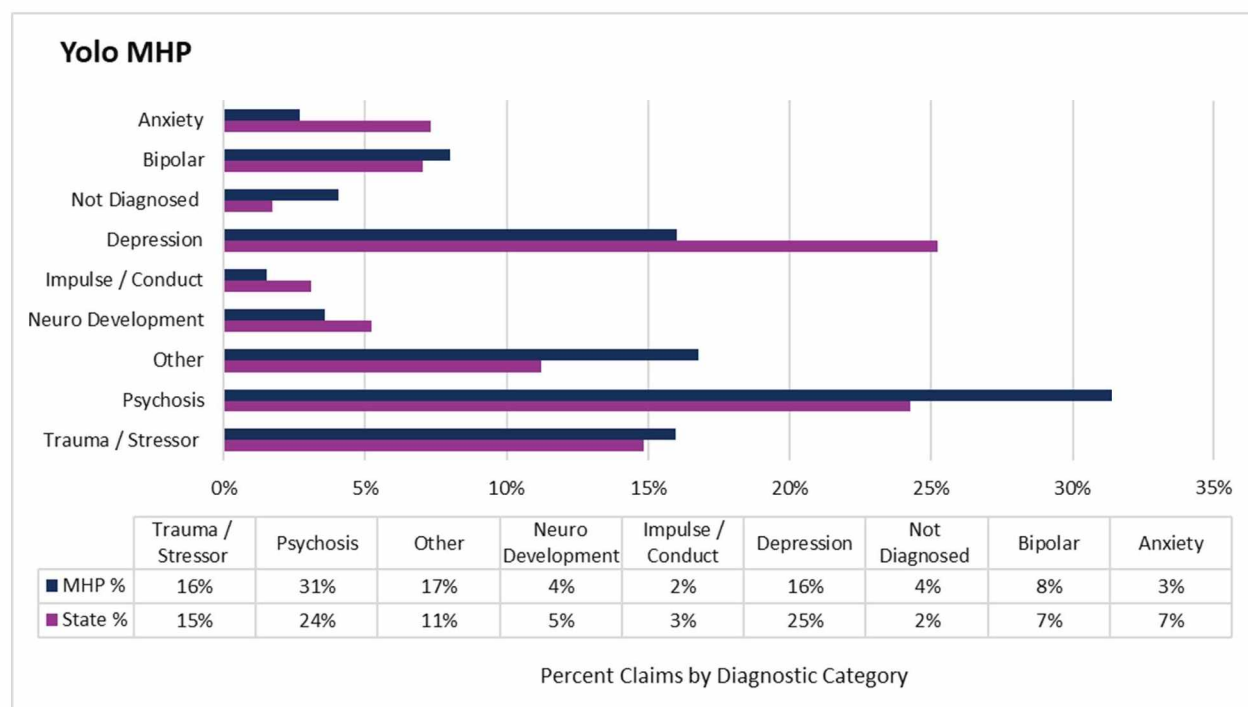
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP’s claims for treatment. Figure 16 shows the percentage 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**



- At 22 percent, not diagnosed was the most common diagnostic category in the MHP (as compared to 12 percent in CY 2021). The MHP reported that crisis intervention services increased between CY 2021 and CY 2022 and the EQRO data, in Tables 8 and 9, confirms that the county has a higher utilization of crisis intervention than seen statewide.
- The next most common diagnostic categories are psychosis (19 percent), depression (17 percent), and trauma/stressor related disorders (15 percent). Bearing in mind the not-diagnosed category, the MHP has a higher proportion of members with psychosis and trauma/stressor diagnoses, and a lower proportion of depression than seen statewide.

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



- Claims for members with psychosis diagnoses account for 31 percent of all approved claims compared to 24 percent statewide, relatively proportional given the rate shown in Figure 16.
- Other, depression, and trauma/stressor diagnostic categories are the next most common approved claim diagnoses. Trauma/stressor and other diagnostic categories are more common than seen statewide while depression accounts for a lower percentage of approved claims than seen statewide.
- The percentage of approved claims with a not diagnosed diagnostic category came down to 4 percent compared to 22 percent of members.

### 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: Yolo 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	318	403	1.27	11.85	8.45	\$15,973	\$12,763	\$5,079,374
CY 2021	297	387	1.30	11.61	8.86	\$15,630	\$12,696	\$4,642,110
CY 2020	266	332	1.25	12.63	8.68	\$16,940	\$11,814	\$4,505,917

- The number of Medi-Cal members and total inpatient admissions increased each year between CY 2020 and CY 2022.
- The average number of admissions per member has been consistent – between 1.25 to 1.30 in the three-year period above.
- The average LOS has been 30 to 40 percent higher than the statewide average LOS, resulting in higher inpatient costs.

### 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 mental health professionals is critically important.

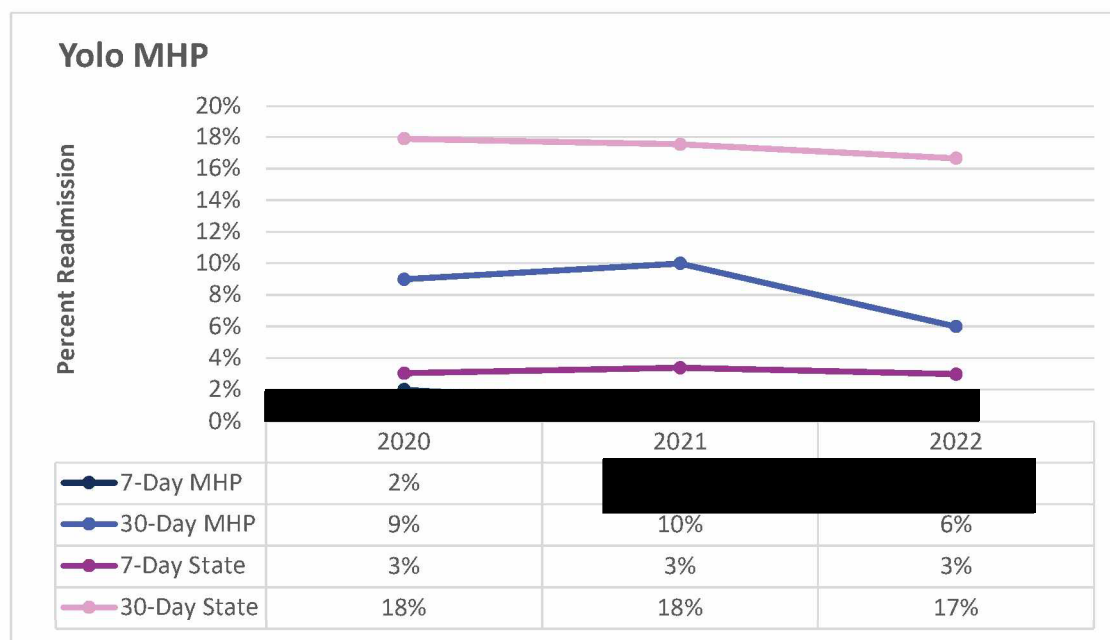
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and is reflected in the rate to which individuals 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 7-day post psychiatric inpatient follow-up has been very similar to statewide rates from CY 2020 to CY 2022.
- The 30-day post psychiatric inpatient follow-up has increased every year between CY 2020 to CY 2022. In CY 2022, 49 percent of members had a follow-up within 30 days, while the statewide the rate was 42 percent.

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



- The 7-day psychiatric readmission rates were one-third of the statewide rate in CYs 2021 and 2022.
- The 30-day readmission rate has been well below the statewide rate all three years and fell sharply in CY 2022.
- The MHP suggested that the low readmission rates are related to the provision of effective crisis services, including increased crisis residential and crisis intervention utilization. Appropriate treatment of members that are in crisis appears to prevent escalation to a readmission.

### 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 clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCMs may disproportionately occupy treatment slots that may prevent access to LOC 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 LOC 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: Yolo MHP High-Cost Members (Greater than \$30,000), CY 2020-22**

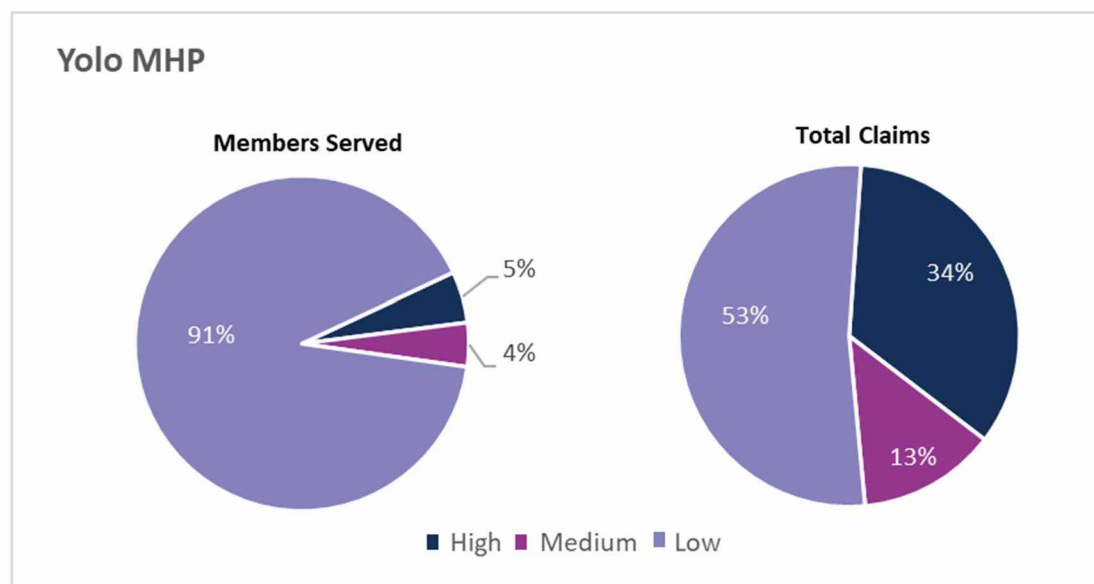
Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	\$1,514,353,866	\$55,518	\$44,346
MHP	CY 2022	101	4.92%	34.27%	\$5,624,142	\$55,685	\$45,731
	CY 2021	122	6.29%	37.62%	\$6,528,691	\$53,514	\$42,137
	CY 2020	144	7.89%	42.79%	\$8,078,517	\$56,101	\$45,367

- The MHP’s HCM count, percentage of members served, percentage of claims, and total HCM claims decreased every year between CY 2020 to CY 2022. The decrease in HCM members is a factor in the overall AACM decreasing between CY 2020 to CY 2022.
- The MHP reported that there has been focus on appropriate treatment of their HCMs and that is a factor in the reduction in all the measures in the table.

**Table 15: Yolo 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)	87	4.24%	13.13%	\$2,154,152	\$24,760	\$25,218
Low-Cost (Less than \$20K)	1,864	90.84%	52.61%	\$8,634,052	\$4,632	\$2,935

Figure 20: Yolo MHP Members and Approved Claims by Claim Category, CY 2022



- Over half (53 percent) of all approved claims were for serving the low-cost members, representing 91 percent of members served. Less than half of the claims (47 percent) went to serving the high and medium cost members.

## IMPACT OF QUALITY FINDINGS

- While the MHP employs a good number of peers, they could be utilized more broadly. The MHP reported that because peer employees are in the extra help category of employee, they are not included in the supervisor to staff ratio that determines how many employees are assigned to a supervisor. This makes it difficult for supervisors to provide intentional support and development to their peer employees. In addition, the MHP is not billing for peer services and certified peers reported that they are not using all the skills for which they were trained.
- Yolo utilizes crisis residential and crisis intervention services as an alternative to hospitalization. They launched a revised crisis residential treatment program in January 2024 to allow for short-term and longer-term crisis residential beds which may further impact their crisis residential utilization.
- The MHP looks at data from a variety of sources and implemented KPI Dashboards, a new analytic reporting tool, this past year. They also reported that much of the development and use of the new tool has been suspended due to the workload associated with payment reform. The MHP must complete all the work related to payment reform so they can resume the variety of projects that have been put on hold.

## 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<sup>2</sup> and 457.1240(b)<sup>3</sup>. 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](http://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

No clinical PIP was submitted. As required, a letter from Director is included in Attachment E.

### NON-CLINICAL PIP

#### General Information

Non-Clinical PIP Submitted for Validation: "Behavioral Health Quality Improvement Project (BHQIP) Follow Up After Emergency Department (ED) Visit for Mental Illness (FUM)"

Date Started: 09/01/2022

Date Completed: Projected 06/30/2024

Aim Statement: "By having real-time access to Medi-Cal beneficiary ED visit data and assigning staff to engage beneficiaries post-ED visit, Yolo County will improve follow-up and linkage to mental health services for any client who presents at an ED with a mental

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<sup>2</sup> <https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol4/pdf/CFR-2019-title42-vol4-sec438-330.pdf>

<sup>3</sup> <https://www.govinfo.gov/content/pkg/CFR-2020-title42-vol4/pdf/CFR-2020-title42-vol4-sec457-1260.pdf>

health issue and/or with self-harm behaviors by 4% and 1%, respectively, by the end of FY 23-24.”

Target Population: Medi-Cal beneficiaries who are seen in an ED with a primary mental health diagnosis and/or self-harm.

Status of PIP: The MHP’s non-clinical PIP is in the planning phase.

## Summary

The MHP has submitted one of the BHQIP projects, FUM, as its non-clinical PIP. The MHP initially reports 7-day and 30-day FUM rates of 36 percent and 53 percent, respectively. The MHP’s goal is to increase the rates by 4 percentage points and 1 percentage point respectively, which would bring its rate to the national average. (The team plans to continue the project and further increase its rates to the statewide averages). The MHP has four strategies: join an HIE; conduct reviews of identified members; assign MHP staff to engage the member; and complete a mental health screening. These strategies address what the MHP finds as the root cause—that the MHP is not routinely aware of when members are served at an ED—and other factors that contribute to the low follow-up rate.

During the past year, the MHP has not been able to implement the PIP as planned due to issues in entering an HIE and some EHR challenges. While the MHP continues to work towards actualizing this PIP, it currently still is at the planning phase.

## TA and Recommendations

As submitted, this non-clinical PIP was found to have no confidence because it remains at the planning phase for the second year. The MHP is in the process of resolving the barriers mentioned above and predicts that the PIP will be fully in process soon.

TA was provided to the MHP in preparation for the EQR.

CalEQRO recommendations for improvement of this non-clinical PIP:

- Fully implement PIP study using HIE or other contingencies for information.
- Provide relevant data and performance improvement in the PIP submission.
- Provide detail and specificity regarding member engagement process, to include how frequently they would make contact, the medium of the contact (e.g., in person, telephone, videoconference), and the nature and purpose of the contact (e.g., to provide linkages, problem-solve transportation, connect to social supports, etc.).
- The MHP indicated that they would schedule ongoing TA from the EQRO during the implementation of this PIP.

## 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 Netsmart/Avatar, which has been in use for 19 years. Currently, the MHP has no plans to replace the current system, which has been functioning in a satisfactory manner.

Approximately 1.9 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 a small IT and data analyst staff. There has been a lot of turnovers and a vacancy in their data analyst staffing which makes the increasing data requirements particularly challenging for the MHP.

The MHP has 202 named users with log-on authority to the EHR, including approximately 122 county staff and 80 contractor staff. Support for the users is provided by 1.7 full-time equivalent IS technology positions. Currently all positions are filled.

As of the FY 2023-24 EQR, some 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 the following table:

**Table 16: Contract Provider Transmission of Information to Yolo MHP EHR**

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	<input type="checkbox"/> Real Time <input type="checkbox"/> Batch	0%
Electronic Data Interchange to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
Electronic batch file transfer to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	0%
Direct data entry into MHP IS by provider staff	<input checked="" type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	50%
Documents/files e-mailed or faxed to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Monthly	50%
Paper documents delivered to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> 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 plans to implement the Netsmart PHR within the next six months. They have implemented the Fast Healthcare Interoperability Resources standard which is a CalAIM Behavioral Health Quality Improvement Program requirement as well as a Netsmart PHR requirement.

### Interoperability Support

The MHP is a member or participant in the SacValley Med Share HIE. They are not using the HIE in operations yet, but they regularly provide the HIE with an extract of members seen, while the HIE works with the MHP’s current EHR vendor to build a client dashboard. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult.

## 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	Partially Met

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

- The MHP had a low claims denial rate in CY 2022 as they have in previous years. They received a partially met in Medi-Cal claims processing because they have submitted so few claims since payment reform went into effect on July 1, 2023, and because many important projects have been put on hold due to payment reform. They did not make progress on submitting claims to Medicare or other insurers for their members who have additional coverage.
- There were some successes in data collection and processing including the implementation of the data analytical tool KPI Dashboards. The MHP provided examples of how it is being used, but most of the KPI Dashboards projects were put on hold due to payment reform. The challenges relating to data analytical staffing also contributed to the partially met rating in the data collection category.
- Interoperability was also rated as partially met. The MHP joined an HIE but could not say how it would be used in operations. They have a long-standing goal and EQR recommendation to onboard the contract providers to their EHR but did not make progress this past year on developing a plan to accomplish the goal. The contract providers provide two-thirds of the services delivered to Yolo members.

## 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 largely complete or very substantially complete claims data set for the time frame represented.

The MHP reports that their claiming is current through June 2023. The MHP has submitted a small number of FY 2023-24 claims to DHCS. Some have been paid, but they are awaiting further information on what is causing some of the denials. They are confident that they can scale up claiming to DHCS once they have a complete picture of what is causing the denials.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	4,240	\$1,107,349	\$8,682	0.78%	\$1,098,667
Feb	4,224	\$1,123,193	\$5,565	0.50%	\$1,117,628
Mar	4,920	\$1,287,505	\$8,814	0.68%	\$1,278,691
April	4,443	\$1,151,288	\$15,751	1.37%	\$1,135,537
May	4,673	\$1,274,994	\$22,646	1.78%	\$1,252,348
June	4,430	\$1,226,245	\$14,315	1.17%	\$1,211,930
July	4,138	\$1,148,018	\$18,262	1.59%	\$1,129,756
Aug	4,729	\$1,278,374	\$15,824	1.24%	\$1,262,550
Sept	4,562	\$1,334,003	\$30,108	2.26%	\$1,303,895
Oct	3,992	\$1,207,370	\$25,983	2.15%	\$1,181,387
Nov	3,834	\$1,168,157	\$50,858	4.35%	\$1,117,299
Dec	3,392	\$950,790	\$14,033	1.48%	\$936,757
<b>Total</b>	<b>51,577</b>	<b>\$14,257,286</b>	<b>\$230,841</b>	<b>1.62%</b>	<b>\$14,026,445</b>

**Table 19: Summary of Yolo 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	225	\$76,489	33.13%
Medicare Part B must be billed before submission of claim	134	\$55,463	24.03%
Other	199	\$45,032	19.51%
Deactivated National Provider Identifier (NPI)	65	\$26,546	11.50%
Beneficiary is not eligible or non-covered charges	102	\$18,080	7.83%
Service line is a duplicate and repeat service modifier is not present			
Service location NPI issue			
<b>Total Denied Claims</b>	<b>764</b>	<b>\$230,844</b>	<b>100.00%</b>
<b>Overall Denied Claims Rate</b>	<b>1.62%</b>		
<b>Statewide Overall Denied Claims Rate</b>	<b>5.92%</b>		

- The MHP will not be able to resolve other healthcare coverage and Medicare Part B denials until they begin to bill third party payers for members with additional coverage.

## IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP must resolve their issues with payment reform both for continual cash flow and so they can resume the many projects that are now on hold due to payment reform.
- The MHP noted that for years they have increased projects and services without increasing the administrative staff to track and trend the programs. This coupled with increasing data needs and data analytical staffing changes presents ongoing challenges meeting DHCS requirements such as the 274 Provider Network Data Reporting implementation.
- Interoperability is an increasingly important requirement for MHPs, especially for those who use contract providers for most of their services. The MHP has made some advances by joining an HIE but doesn't have a data sharing strategy yet for the two-thirds of services that are provided by their contract providers.

# VALIDATION OF MEMBER PERCEPTIONS OF CARE

## CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (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 with Yolo County HHSA facilitated the annual CPS which offered consumers and family members an opportunity to provide input/feedback on mental health for QI purposes. Surveys were conducted during the week of May 15-19, 2023, in partnership with University of California Los Angeles (UCLA) Integrated Substance Abuse Programs and HHSA's contracted mental health providers. UCLA produced a statistical report of survey data delivered to HHSA QM in December 2023. This report includes an analysis of data collected from adults, youth, and families actively receiving services in Yolo County. There were approximately 160 surveys returned across programs for adults, older adults, youth, and families of youth. Approximately 151 of those surveys were complete/accurate submissions. Yolo County utilized both the electronic (56 responses) and paper surveys (104 responses) for this survey period. All surveys included "Quality of Life" questions for the consumer to answer. Survey forms were available in twelve languages (English, Arabic, Armenian, Spanish, Chinese, Farsi, Khmer, Korean, Russian, Vietnamese, Tagalog and Hmong). However, all the surveys returned were in English and Spanish only.

The MHP leadership utilizes the CPS results to look at program needs.

The MHP provided to EQRO the current CPS Survey Summary with findings for May 2023, Survey Results Comparison Highlights:

- May 2023 completed surveys declined for the third straight year, down 7 percent year-over-year and down 44 percent when compared to June 2021 Survey Results.
- Online versus paper survey: One of the key findings across reporting periods was that consumers were more likely to complete the paper surveys (104) than the online survey (56). The online participation dropped in 2023, continuing from 2022 trends, and share of paper surveys increased again.
- Consumer survey population: Largest population in responses continues to be the adult population for all three years of comparison.

## PLAN MEMBER/FAMILY FOCUS GROUPS

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

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

### Consumer Family Member Focus Group One Summary

CalEQRO requested a diverse group of adult consumers, [REDACTED] who initiated services in the preceding 12 months. The focus group was held virtually through video platform and included [REDACTED] participants; a language interpreter was not needed for this focus group. All members participating receive clinical services from the MHP.

The participants who entered services within the past 12 months described their experiences as access within a month or significantly less than a month.

The group agreed that appointments were consistent, with flexibility on the part of the MHP if the member needed to change one. All agreed their needs were being met by the program they were enrolled in. The participants were all aware of transportation options, and noted that the peers and case managers often helped them with transportation. All agreed there was easy access to their service providers if they needed help with anything. Several participants remarked finding the wellness centers useful and a positive experience. All were aware of how to reach out if they had a mental health emergency. Overall, the group expressed satisfaction with their experience with treatment.

The group had no recommendations for improvement and expressed the following comments.

- “No room for improvement! The staff here really is there for us!”
- “I have improved greatly, 180 degree changed.”
- “I have my own apartment, maintain housing, and do community service.”
- “I have a sense of stability knowing the support HHSA Behavioral Health offers, rather than being alone.”
- “Could not have picked a better staff!”
- The group proffered that they all thought the staff deserved a raise.

## “Consumer Family Member Focus Group Two Summary

CalEQRO requested a diverse group of parents/caretakers of youth (ages 5-18) who mostly have initiated/utilized services in the preceding 12 months. The focus group was held virtually through video platform and included [REDACTED] participants; a language interpreter was not used for this focus group. All parents/caretakers participating have a family member or foster child who receives clinical services from the MHP.

The participants who entered services within the past 12 months described their experiences with access as surprisingly quick, within a week or two.

The participants agreed that service delivery was consistent, flexible, available, and providers were easy to communicate with, and provided a helpful array of services. All were aware of how to reach out if their child experienced a mental health crisis. There were no transportation services issues noted. One participant reported that the transportation provided to take children to appointments was an invaluable help. All had high regard for Victor Services.

They were pleased with services overall:

- “I can’t thank them enough.
- “Services have been a godsend.”
- “They introduce helpful charts, new ideas, ways to do things while respecting my background and beliefs.”
- “[My provider] was instrumental for setting up an IEP [individualized education program]; also, Victor Services was amazing.”

Recommendations from focus group participants included:

- Peer parents would be helpful, and support groups for those who are not foster parents.

## SUMMARY OF MEMBER FEEDBACK FINDINGS

Both member focus groups shared a positive view of the usefulness of the services they receive. They report that services are helpful in their recovery and that the staff give them hope and are respectful of their cultural and personal beliefs.

There was an awareness of staffing issues that result in staff having a burdensome schedule. However, all agreed that they continue to receive the services they need.

## 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. Yolo's Health and Human Services integration provides BH efficiencies for both the children's and adults' systems of care. (Quality)
2. The MHP successfully initiated Netsmart's BI Analytic solution to support the monitoring and analysis of HEDIS measures. (Quality, IS)
3. The MHP became member or participant in the SacValley Med Share HIE as they moved towards interoperability. (IS)
4. The Adult and Aging Forensics Program collaborated with the county criminal justice system to increase access to Mental Health Court, Addiction Intervention Court, and other diversion programs offered by the District Attorney's office. (Access, Quality)
5. Stakeholders noted improved transparency and bi-directional communication with leadership that invites them to the table for planning of programs and services. (Quality)
6. The MHP has had strong billing practices and a low claim denial rate for the last three years. (IS)

## OPPORTUNITIES FOR IMPROVEMENT

1. The MHP's Hispanic/Latino and API PRs for CY 2022 were below the statewide rates and have remained largely unchanged for the past three years. (Access)
2. The MHP has been inconsistent with timeliness reporting. Last year they did not report first offered and first offered psychiatry appointments. This year they did not report first offered urgent. They have developed a new methodology for collecting all the required information but still need to implement. The data provided this past year has areas of concern regarding first offered and delivered (non-psychiatry and psychiatry appointments) and requires review and strategies for improvement. (Timeliness)
3. With the exception of the first offered non-urgent psychiatry appointment, the MHP's timeliness for service access warrants improvement. (Timeliness)

4. As an MHP that contracts out two-thirds of their services, Yolo has a particularly strong need for interoperability. They have made some progress this past year by joining an HIE and onboarding a new contract provider to their EHR. However, they do not have a concept of how the HIE will be used operationally and they do not have a strategy for obtaining clinical data from their current contract providers that do not document services in Avatar. (IS)
5. While the MHP has a robust cadre of peer employees in both County and contracted provider programs, there is a lack of intentional supervision and support as well as an understanding of staff of the peer employees job descriptions. (Quality)
6. The MHP was unable to submit a clinical PIP, citing staffing issues and workload demands associated with CalAIM and payment reform requirements. (Quality)

## 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. Investigate reasons and develop and implement strategies to increase Hispanic/Latino and API PRs. (Access)  
(This is a modification of recommendations from FY 2021-22 and FY 2022-23).
2. Implement the new methodology for all timely access tracking and incorporate routine review and analysis of the findings. Routinely review the data for accuracy. (Timeliness, IS)  
(This is a modification of recommendations from FY 2021-22 and FY 2022-23)
3. Research barriers, design, and implement processes to improve timeliness to non-urgent psychiatry and non-psychiatry services (inclusive of adults, children, and youth in FC). (Timeliness)
4. Develop operational plans for utilizing the HIE within MHP County programs and consider providing support to contract providers to also use the HIE. Contract providers' use of the HIE would be an alternative to onboarding them to the MHP EHR. If that is not the direction the MHP chooses, continue the previous recommendation to develop and implement a plan to amend existing contracts and resolve fiscal and operational issues, which would enable interested contract providers to gain full access to the EHR. (IS)
5. Create a protocol and implement a system that provides intentional supervision and support to peer employees. This includes education of staff as to the peer employees' job descriptions and duties. Move forward with plan to develop two employment tracks and job descriptions for peers that recognizes peer certification as a classification. (Quality)

(This is a modification of recommendations from FY 2021-22 and FY 2022-23)

6. Design and implement a clinical PIP for the current year. Engage in TA with EQRO for assistance in this process. (Quality)

## EXTERNAL QUALITY REVIEW BARRIERS

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

- The MHP did not submit a clinical PIP, citing staffing issues and workload demands associated with CalAIM and payment reform requirements.
- As part of the EQR process, the MHP Director submitted a letter identifying specific barriers to the MHP's full participation in the review. Please see Attachment E.

## **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 – Yolo 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
Plan Member/Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Program Managers Group Interview
Specialized Service Systems: Homeless Outreach; STRTP; Crisis Residential, Crisis Stabilization; Forensics
Use of Data to Support Program Operations
Cultural Competence/Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Services Focused on High Acuity and Engagement-Challenged Members

**CaEQRO Review Sessions – Yolo MHP**

Forensics and Law Enforcement Group Interview

Information Systems Billing and Fiscal Interview

EHR Deployment

Telehealth

Closing Session – Final Questions and Next Steps

## ATTACHMENT B: REVIEW PARTICIPANTS

### CalEQRO Reviewers

Lynda Hutchens, NCC, LMFT, Lead Quality Reviewer  
Anita Catapusan, BSN, SUDCC-III-CS, Quality Reviewer  
Zena Jacobi, IS 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.

### MHP Sites

All sessions were held via video conference.

**Table B1: Participants Representing the MHP and its Partners**

<b>Last Name</b>	<b>First Name</b>	<b>Position</b>	<b>County or Contracted Agency</b>
<b>Ackerman</b>	Spring	Program Coordinator	Yolo County HHSA
<b>Aguiar</b>	Michaela	Clinician II	Yolo County HHSA
<b>Alves</b>	Holly	Chief Fiscal Administrative Officer	Yolo County HHSA
<b>Azevedo</b>	Marcie	Fiscal Administrative Officer	Yolo County HHSA
<b>Bano</b>	Zikryia	Office Support Specialist	Yolo County HHSA
<b>Barrett</b>	Katherine	Behavioral Health Compliance Officer	Yolo County HHSA
<b>Budhathoki</b>	Sajana	Program Coordinator	Yolo County HHSA
<b>Bueno</b>	Jocelyn	Administrative Clerk II	Yolo County HHSA
<b>Crespin</b>	Pamela	Administrative Services Analyst	Yolo County HHSA
<b>DeWein</b>	Kerri	Behavioral Health Case Manager II	Yolo County HHSA
<b>Duarte</b>	Sylvia	Accountant III	Yolo County HHSA
<b>Edwards</b>	Jennifer	Program Coordinator	Yolo County HHSA
<b>Franks</b>	Beverly	Behavioral Health Case Manager I	Yolo County HHSA
<b>Freitas</b>	Julie	Clinical Manager	Yolo County HHSA
<b>Fusselman</b>	Samantha	Branch Director	Yolo County HHSA
<b>Gallegati</b>	Mario	Clinical Manager	Yolo County HHSA
<b>Gay</b>	Jennifer	Manager II	Yolo County HHSA
<b>Gohn</b>	Kyle	Information Technology Manager	Yolo County ITS
<b>Graham</b>	Dana	Behavioral Health Case Manager II	Yolo County HHSA
<b>Harland</b>	Anthony	Clinician I	Yolo County HHSA
<b>Hendrickson</b>	Cheri	Supervising Clinician	Yolo County HHSA

<b>Last Name</b>	<b>First Name</b>	<b>Position</b>	<b>County or Contracted Agency</b>
<b>Inaba</b>	Audrey	Systems Software Specialist I	Yolo County ITS
<b>Jackson</b>	Sheryl	Senior Staff Nurse	Yolo County HHSA
<b>Jakowski</b>	Karleen	Assistant Director	Yolo County HHSA
<b>Johnson</b>	Timothy	Systems Software Specialist I	Yolo County ITS
<b>Johnston</b>	Robert	Program Director	Hope Cooperative
<b>Joy</b>	Michael	Clinician II	Yolo County HHSA
<b>Joyner</b>	Adriana	Clinician II	Yolo County HHSA
<b>Kildare</b>	Tony	CYF Branch Director	Yolo County HHSA
<b>Larson</b>	Justina	Clinician II	Yolo County HHSA
<b>Lipelt</b>	Terri	Behavioral Health Case Manager III	Yolo County HHSA
<b>Ludwig</b>	April	Chief Executive Officer	Hope Cooperative
<b>Ly</b>	Lynn	Clinician II	Yolo County HHSA
<b>Mueller</b>	Stacy	Clinician II	Yolo County HHSA
<b>Obregon</b>	Darlene	TBS Supervisor	Turning Point Community Program
<b>Overton</b>	Simmion	Behavioral Health Case Manager II	Yolo County HHSA
<b>Palmer</b>	Nate	Administrative Serv Analyst	Yolo County HHSA
<b>Parise-Simeon</b>	Nikole	Quality Assurance Manager	Turning Point Community Program
<b>Pedersen</b>	Lupe	Behavioral Health Case Manager II	Yolo County HHSA
<b>Peregrine</b>	Sarah	Behavioral Health Manager	CommuniCare- OLE
<b>Perez</b>	Patricia-Rose	Clinician I	Yolo County HHSA
<b>Rodriguez</b>	Allison	Associate Director of Youth & Family Services	CommuniCare- OLE

Last Name	First Name	Position	County or Contracted Agency
<b>Sandoval</b>	Blanca	Office Support Specialist	Yolo County HHSA
<b>Sandoval</b>	Sophia	Senior Administrative Services Analyst	Yolo County HHSA
<b>Sidhu</b>	Pam	Systems Software Specialist II	Yolo County ITS
<b>Smith</b>	Tessa	Diversity Equity and Inclusion Coordinator	Yolo County HHSA
<b>Soltero</b>	Ana	Accountant I	Yolo County HHSA
<b>Strachan</b>	Colin	Information Technology Manager	Yolo County ITS
<b>Tormey</b>	Timothy	Clinician II	Yolo County HHSA
<b>Torok</b>	Tara	Clinician I	Yolo County HHSA
<b>Valle</b>	Fabian	Program Coordinator	Yolo County HHSA
<b>Vierra</b>	Amanda	Clinician I	Yolo County HHSA
<b>Wisterman</b>	Michelle	Senior Accounting Technician	Yolo County HHSA
<b>Yung</b>	Mary	Clinical Manager	Yolo County HHSA

## 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
<input type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input checked="" type="checkbox"/> No confidence	No clinical PIP was submitted for FY 2023-24.
<b>General PIP Information</b>	
<b>MHP/DMC-ODS Name:</b> Yolo	
<b>PIP Title:</b> n/a	
<b>PIP Aim Statement:</b> n/a	
<b>Date Started:</b> n/a	
<b>Date Completed:</b> na	
<b>Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply)</b> <input type="checkbox"/> State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) <input type="checkbox"/> MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here: n/a	
<b>Target population description, such as specific diagnosis (please specify):</b> n/a	
<b>Improvement Strategies or Interventions (Changes in the PIP)</b>	

<b>Member-focused interventions</b> (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a						
<b>Provider-focused interventions</b> (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a						
<b>MHP/DMC-ODS-focused interventions/system changes</b> (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a						
PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
n/a			<input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
PIP Validation Information						
<b>Was the PIP validated?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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.						
<b>Validation phase (check all that apply):</b>						
<input type="checkbox"/> PIP submitted for approval <input type="checkbox"/> Planning phase <input type="checkbox"/> Implementation phase <input type="checkbox"/> Baseline year <input type="checkbox"/> First remeasurement <input type="checkbox"/> Second remeasurement <input checked="" type="checkbox"/> Other (specify): No clinical PIP submitted						
Validation rating: <input type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input checked="" type="checkbox"/> 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.						
<b>EQRO recommendations for improvement of PIP:</b> Design and implement a clinical PIP this year. Engaged with EQRO for TA in the design and implementation of the PIP.						

## Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
<input type="checkbox"/> High confidence <input type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input checked="" type="checkbox"/> No confidence	
<b>General PIP Information</b>	
<b>MHP/DMC-ODS Name:</b> Yolo	
<b>PIP Title:</b> Behavioral Health Quality Improvement Project (BHQIP) Follow Up After Emergency Department (ED) Visit for Mental Illness (FUM)	
<b>PIP Aim Statement:</b> "By having real-time access to Medi-Cal beneficiary ED visit data and assigning staff to engage beneficiaries post-ED visit, Yolo County will improve follow-up and linkage to mental health services for any client who presents at an ED with a mental health issue and/or with self-harm behaviors by 4% and 1%, respectively, by the end of FY 23/24."	
<b>Date Started:</b> 09/01/2022	
<b>Date Completed:</b> ongoing; projected 06/30/2026	
<b>Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply)</b> <input checked="" type="checkbox"/> State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) <input type="checkbox"/> MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
<b>Target age group (check one):</b> <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information						
<b>Target population description, such as specific diagnosis (please specify):</b> Medi-Cal beneficiaries who are seen in an ED with a primary mental health diagnosis and/or self-harm.						
Improvement Strategies or Interventions (Changes in the PIP)						
<b>Member-focused interventions</b> (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a						
<b>Provider-focused interventions</b> (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): <ul style="list-style-type: none"> <li>• Conduct reviews of identified members</li> <li>• Assign MHP staff to engage members</li> <li>• Complete a mental health screening for engaged members</li> </ul>						
<b>MHP/DMC-ODS-focused interventions/system changes</b> (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): Implement use of health information exchange (HIE)						
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
FUM7	(DHCS) CY2021	N = 451 Performance 36%	<input checked="" type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	(DHCS) CY2022 N = 300/606 Performance 49.5%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
FUM30	(DHCS) CY2021	N= 451 Performance 53%	<input checked="" type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available	(DHCS) CY2022 N = 408/606 Performance 67%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
% of beneficiaries in need of FUM that are existing MHP clients	10% more than baseline	Not yet established	<input checked="" type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
<b>PIP Validation Information</b>						
<p><b>Was the PIP validated?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>“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.</p>						
<p><b>Validation phase (check all that apply):</b></p> <p><input type="checkbox"/> PIP submitted for approval      <input checked="" type="checkbox"/> Planning phase      <input type="checkbox"/> Implementation phase      <input type="checkbox"/> Baseline year</p> <p><input type="checkbox"/> First remeasurement      <input type="checkbox"/> Second remeasurement      <input type="checkbox"/> Other (specify):</p> <p>Validation rating:    <input type="checkbox"/> High confidence      <input type="checkbox"/> Moderate confidence      <input type="checkbox"/> Low confidence      <input checked="" type="checkbox"/> No confidence</p> <p>“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.</p>						
<p><b>EQRO recommendations for improvement of PIP:</b></p> <ul style="list-style-type: none"> <li>• Fully implement PIP study using HIE or other contingencies.</li> <li>• Provide relevant data and performance improvement.</li> <li>• Provide detail and specificity regarding beneficiary engagement process.</li> </ul>						

## ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, PIP Validation Tool, and CalEQRO Approved Claims Definitions are available on the [CalEQRO website](#).

ATTACHMENT E: LETTER FROM MHP DIRECTOR



COUNTY OF YOLO

Health and Human Services Agency

Nolan Sullivan  
Director

MAILING ADDRESS  
137 N. Cottonwood Street • Woodland, CA 95695  
(530) 666-8651 • www.yolocounty.org

Sandra Sinz, LCSW, CPHQ  
Executive Director, CalEQRO  
Behavioral Health Concepts, Inc.  
52340 Powell St. #334  
Emeryville, CA 94608

Dear Behavioral Health Concepts, Inc:

Yolo County MHP is requesting flexibility during the FY 2023-24 EQRO review, as we were unable to fulfill one or more of the required elements for review:

- Specifically, we were not able to:
- submit a clinical PIP
  - submit a non-clinical PIP
  - hold a member and family member focus group
  - other:

Reasons for this include:

- Lack of staff/resources:
- Additional factors: Implementation of multiple statewide mandates took priority of limited MHP resources.

Please attach this letter to our FY 2023-24 review report.

Sincerely,

Karleen Jakowski,  
LMFT

Digitally signed by Karleen  
Jakowski, LMFT  
Date: 2024.03.25 07:54:53 -07'00'

Karleen Jakowski, LMFT  
Assistant HHS Director  
Mental Health Director