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

TUOLUMNE MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review, or a desk review, of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also considers the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

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

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Tuolumne MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

MHP Information

MHP Size — Small

MHP Region — Central

MHP Location — Sonora

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 981

MHP Threshold Language(s) — None

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

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

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

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed Assembly Bill (AB) 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and BHINs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out-of-Network Access (ONA), Alternative Access Standards (AAS), and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS BHIN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS reviews these forms to determine if the provider networks meet required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services for youth and adults. If these standards are not met, DHCS requires the MHP to improve the network to meet the standards or submit an AAS Request. If approved by DHCS, CalEQRO will review the AAS Request and ONA information as part of its annual EQR.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

Validation of State and MHP Beneficiary Satisfaction Surveys

Beneficiary satisfaction survey documentation was not submitted for this review.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 video conference review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 video conference visit, CalEQRO reviewed the status of those FY 2019-20 recommendations. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

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

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

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: For both PIPs, the MHP should engage CalEQRO for ongoing and regular technical assistance (TA) to incorporate the recommendations in the PIP section and apply that TA to the PIP process and write-ups.

Status: Met

- Tuolumne County Behavioral Health Department (TCBHD) participated in PIP TA with CalEQRO via video conference in January 2021 and maintained consistent email correspondence throughout FY 2020-21.

- The MHP attended several CalEQRO PIP clinic webinars in FY 2020-21; furthermore, the clinics provided training on the development and submission of clinical and non-clinical PIPs according to CMS mandatory protocols.
- The clinical and non-clinical PIPs submitted for this review incorporate CalEQRO recommendations, such as clearly defining the study populations, refining the data collection and analysis plans, and evaluation of the PIPs' success.

Access Recommendations

Recommendation 2: Develop and implement evaluation methods for determining the impact of cultural competence activities on increasing engagement in mental health and substance use disorder (SUD) services, resulting in improved penetration rates. (*This recommendation is a follow-up from FY 2018-19.*)

Status: Met

- The FY 2020-21 TCBHD Community Cultural Collaborative (CCC) workplan incorporates a goal to improve assessment and engagement with beneficiaries diagnosed with a co-occurring disorder.
- The current non-clinical PIP is focused on improving a clinician's ability to diagnose co-occurring disorders more accurately by implementing a combined assessment (mental health and SUD) during intake. This allows for a more streamlined entry into the system of care.

Recommendation 3: The cultural competence work plan monitoring tool should be used and updated to reflect baseline measurements with clear, specific, and measurable goals and objectives to measure the impact of cultural competence activities on beneficiary access, timeliness, quality, and outcomes. (*This recommendation is a follow-up from FY 2018-19.*)

Status: Partially Met

- The FY 2020-21 TCBHD Quality Assurance Performance Improvement (QAPI) workplan includes a focus to update the CCC workplan with measurable action items.
- The current CCC workplan is in draft form, has three goals, and does not include process and outcome indicators.

- The CCC meetings were halted (currently in virtual format) at the beginning of the COVID-19 public health emergency; therefore, completion of the workplan was impacted by the pandemic, staffing shortages, and limited resources.

Recommendation 4: Ensure the methodology for assigning and coding co-occurring diagnoses is accurate and consistent among all clinicians. Train all staff on methodology and policies and procedures. Track and review the co-occurring rate monthly. *(This is a follow-up recommendation from FY 2018-19.)*

Status: Met

- Refer to Recommendation 2 response.
- The Case Administration Team (CAT) was created in FY 2019-20 to reduce initial access wait time, verify medical necessity, determine appropriate program and level of care (LOC) assignment. CAT ensures that co-occurring disorders are assessed and documented accurately.
- A weekly meeting is held with the MHP Director, management from clinical and SUD programs, information systems, medical billing, and quality management (QM) with a focus on improving integration of SUD and mental health services.
- TCBHD clinical staff attended a required American Society of Addiction Medicine (ASAM) training in August 2020; the training provided an overview of assessment and creation of treatment plans for individuals with SUD.

Timeliness Recommendations

Recommendation 5: The MHP should monitor all timeliness metrics, implementing strategies were needed to further reduce wait times *(This recommendation is a carry-over from FY 2017-18 and FY 2018-19.)*

Status: Met

- TCBHD collaborated with their EHR vendor, Kings View Behavioral Health Systems (KVBHS), in FY 2020-21 and created a tracking form capturing client services information and all timeliness metrics.
- Initial appointments are now completed via telehealth in response to the COVID-19 public health emergency which improved beneficiary access to quality care.

- The MHP's data shows that the time from request to initial appointment has improved from 16 business days in FY 2019-20 to 11 business days in FY 2020-21.

- Timeliness metrics are reviewed monthly by the Quality Improvement Committee (QIC) oversight team, during executive team meetings, and during quarterly QIC meetings.

Recommendation 6: Implement further strategies to reduce the wait time for first psychiatry appointments. (*This recommendation is a carry-over from FY 2018-19*.)

Status: Partially Met

- The TCBHD CAT's daily function is to reduce initial access wait time by verifying medical necessity, determining appropriate program assignment, and deciding LOC for new beneficiaries.

- The MHP reception staff are dedicated to making daily appointment reminder calls.

- The MHP's data showed that the average wait time for first offered psychiatry appointment has increased from an average of 19 business days in FY 2019-20 to 22 business days in FY 2020-21.

- TCBHD data shows the children's wait time for an initial psychiatry appointment is 30 business days this FY; the MHP states the extended wait time is attributed to no-shows, and MHP policy reflects that children must receive three clinical appointments before an initial psychiatry appointment.

Quality Recommendations

Recommendation 7: Through continuous monitoring of diagnostic patterns, explain MHP variations from statewide averages and determine if further intervention is necessary. *(This recommendation is a carry-over from FY 2017-18 and FY 2018-19.)*

Status: Partially Met

- The FY 2020-21 QAPI workplan includes a quality of care goal to track and monitor diagnostic patterns within the MHP; however, the goal does not include process and outcome indicators.

- TCBHD clinical staff attended an ASAM training in August 2020; the training provided an overview of assessment and creation of treatment plans for individuals with co-occurring disorders.

- The medication monitoring dashboard launched in September 2020 includes beneficiary demographic and diagnostic information; the dashboard only captures data from a small sample of beneficiaries receiving psychotropic medication.

Recommendation 8: From the monthly medication and prescribing reports obtained from Kings View, the MHP should further aggregate the data to produce a detailed analysis of medication monitoring and prescribing practices and determine if these are negatively impacting patient care. *(This recommendation is a follow-up from FY 2018-19.)*

Status: Met

- The FY 2020-21 QAPI workplan was updated to include a medication monitoring goal; a new dashboard was created in September 2020 to assist the QM committee with monitoring trends and to ensure medication safety and effectiveness.

- The MHP's medication monitoring data is disaggregated into psychiatrist, diagnosis, prescribed medication, gender, ethnicity, and age.

Recommendation 9: Investigate the disconnect between psychiatry staff and beneficiaries and identify issues that may potentially impact services, including but not limited to communication. Implement and track relevant solutions and their impact.

Status: Met

- The MHP employed three nurses in FY 2019-20 to regularly interface with physicians, beneficiaries, and outside agencies, e.g., hospitals and jails to provide a bridge with psychiatry.

- TCBHD tracks and monitors beneficiary grievances and change of provider requests which are reviewed during quarterly QM meetings.

- The MHP states their Annual Beneficiary Grievance and Appeal Report showed an overall decrease by 30 grievances (all categories) since the previous CY.

- Continuous monitoring by QM showed a decrease from ten psychiatry grievances in quarter three CY 2019 to four psychiatry grievances in the same quarter of CY 2020; concerns were with timeliness of medication refills rather than communication issues.

- A consumer family member (CFM) focus group was not held due to the MHP's limited resources caused by the COVID-19 public health emergency; therefore, beneficiary feedback was not possible during this review.

Recommendation 10: Investigate the low penetration and engagement rates for Native Americans and Latinos. Identify barriers and implement relevant solutions addressing the identified barriers.

Status: Met

- The MHP Hispanic and Latino penetration rate exceeded the statewide average (5.39 percent versus 4.08 percent) in CY 2019; additionally, the Native American penetration rates were comparable to the statewide average (7.69 percent versus 7.50 percent).
- TCBHD continuously monitors and compares Tuolumne County census reports to internal penetration rate reports to ensure adequate capacity to meet beneficiary service needs.
- The MHP utilizes a promotores de salud (community health worker) in Spanish speaking communities to engage and enhance Hispanic/Latino relations.
- TCBHD provides coordination of care and resources to members of the Tribal Community of the Tuolumne Band of Me-Wuk Indians such as:
    - Linkages to the Tuolumne County Me-Wuk Indian Health Center.
    - The Tuolumne County Board of Supervisors voted to create a homeless advisory committee in February 2021; the Chicken Ranch Rancheria of Me-Wuk Indians and the Tuolumne Band of Me-Wuk Indians are represented in the committee.

Beneficiary Outcomes Recommendations

Recommendation 11: Aggregate data from Child and Adolescent Needs and Strengths (CANS-50), Pediatric Symptom Checklist (PSC-35), and Level of Care Utilization System (LOCUS) reports and analyze data on a regular basis to make system changes and improvements. *(This recommendation is a follow-up from FY 2018-19.)*

Status: Partially Met

- TCBHD reports beneficiary outcome tools are not consistently completed throughout the system of care; in response the MHP instituted the following quality improvement (QI) activities in FY 2020-21:
    - Added goal to QAPI to monitor consistent completion of the CANS-50, PSC-35, and LOCUS outcome tools.
    - Added goal to QAPI to review, evaluate, and implement QI activities to assist ongoing clinical decisions.

- The current QAPI workplan does not include process and outcome indicators for outcome tool completion; however, the TCBHD medical records team established baseline measurements for the goal.
- TCBHD states QM continues to monitor outcome tool completion; however, documents submitted for this review focus on compliance rather than analyzing aggregate beneficiary outcomes to inform continuous QI activities.

Foster Care Recommendations

Recommendation 12: Identify and implement needed strategies to reduce the wait time for first psychiatry appointment for FC youth.

Status: Met

- Refer to Recommendation 5 and 6 responses.
- TCBHD data shows zero new FC youth psychiatry appointments for FY 2020-21.

Recommendation 13: Continue to pursue development of local Therapeutic Foster Care (TFC) resources, which involves working with local agencies and those within neighboring counties that may be inclined to expand into Tuolumne County.

Status: Met

- TCBHD collaborates with Child Welfare Services (CWS) during regular Inter Placement Committee (IPC) meetings to discuss capacity, needs, and resources for TFC services.
- The MHP approached a local TFC placement agency in Stanislaus County; however, the agency was not interested in providing those services due to a small FC youth population.
- TCBHD provides several intense wraparound services to FC youth such as the Full-Service Partnership (FSP) program and dedicating two case management clinicians to FC youth.

Information Systems Recommendations

- None noted

Structure and Operations Recommendations

Recommendation 14: Identify and implement strategies to address the lack of bi-directional communication between stakeholders and MHP management to improve employee relations.

Status: Met

- The TCBHD Director implemented weekly meetings between staff and clinical supervisors beginning August 2020; the meetings are designed to improve bi-directional communication.
- A monthly meeting between the director, clinical supervisors, and staff was implemented in August 2020 to discuss current clinical topics.
- The MHP management team recruited one QIC liaison from each TCBHD program in August 2020; the liaison distributes QIC meeting information to their respective team members.
- TCBHD QI team sends bi-monthly emails informing all staff about quarterly QI reports, QM initiatives, and QI activity updates.

Recommendation 15: To meet the requirements of DHCS Information Notice (IN)18-020, add the provider's California license number to the provider directory. (*This recommendation is a carry-over from FY 2018-19*.)

Status: Met

- The provider directory was updated in June 2020 and is verified monthly to ensure continued accuracy; provider license numbers are listed in both the paper and online format provider directory.

PERFORMANCE MEASURES

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to screenings, assessments, home-based mental health services, outpatient services, day treatment, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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

1. SB 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf
2. EPSDT POS Data Dashboards: https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx
3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
   - 5A (1&2) Use of Psychotropic Medications
   - 5C Use of Multiple Concurrent Psychotropic Medications
   - 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure
4. AB 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf
5. *Katie A. v. Bonta*:
   The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act Suppression Disclosure

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

Table 1 provides details on beneficiaries served by race/ethnicity.

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Tuolumne MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	10,131	75.8%	801	81.7%
Latino/Hispanic	1,483	11.1%	80	8.2%
African-American	67	0.5%	*	n/a
Asian/Pacific Islander	163	1.2%	*	n/a
Native American	130	1.0%	*	n/a
Other	1,391	10.4%	85	8.7%
Total	**13,362**	**100%**	**981**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

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

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

Tuolumne MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
No Threshold Languages	*	n/a
Total	**981**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

Penetration Rates and Approved Claims per Beneficiary

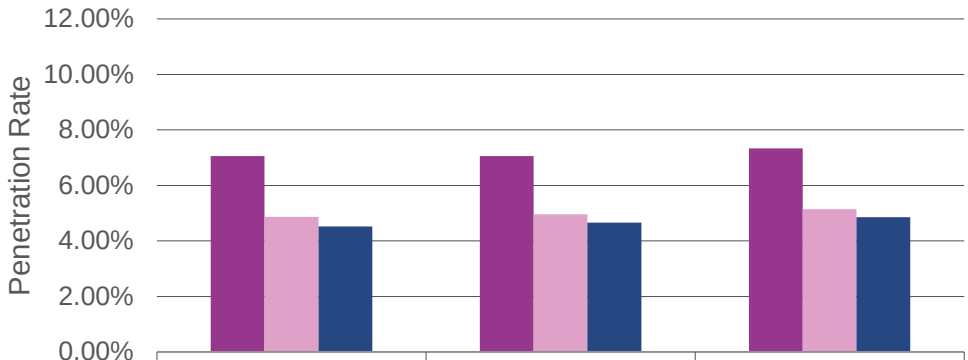
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2019. See Table D1 for the CY 2019 ACA penetration rate and ACB.

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

Figure 1: Overall Penetration Rates CY 2017-19

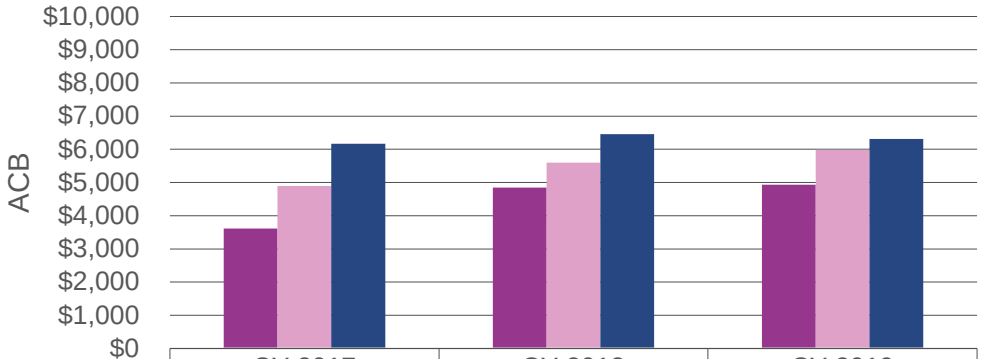
Tuolumne MHP



	CY 2017	CY 2018	CY 2019
MHP	7.06%	7.06%	7.34%
Small	4.87%	4.96%	5.15%
State	4.52%	4.66%	4.86%

Figure 2: Overall ACB CY 2017-19

Tuolumne MHP

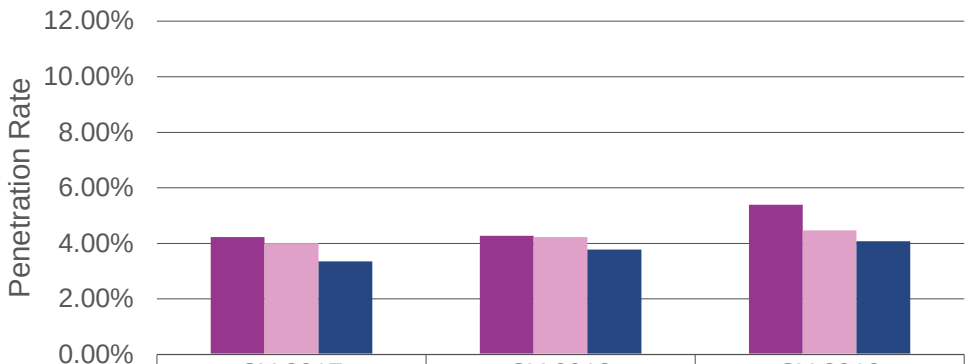


	CY 2017	CY 2018	CY 2019
MHP	$3,609	$4,846	$4,932
Small	$4,895	$5,602	$5,982
State	$6,170	$6,454	$6,316

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

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

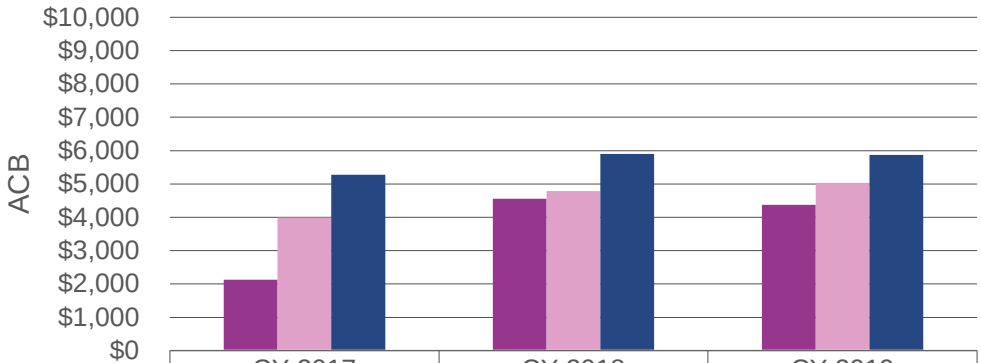
Tuolumne MHP



	CY 2017	CY 2018	CY 2019
MHP	4.23%	4.27%	5.39%
Small	4.01%	4.23%	4.47%
State	3.35%	3.78%	4.08%

Figure 4: Latino/Hispanic ACB CY 2017-19

Tuolumne MHP

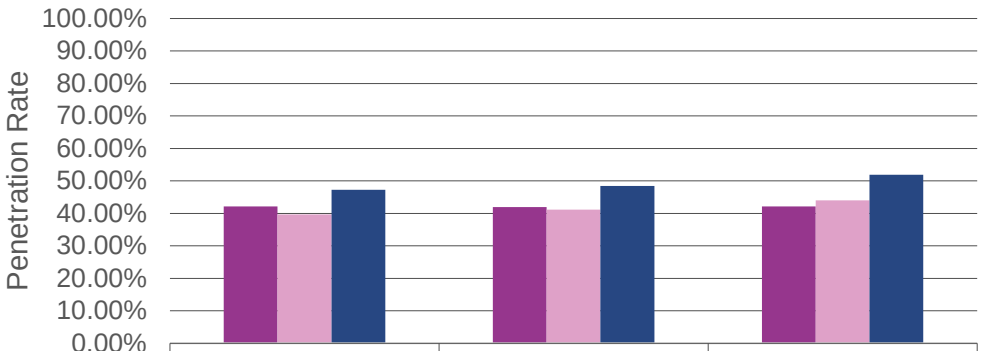


	CY 2017	CY 2018	CY 2019
MHP	$2,132	$4,560	$4,377
Small	$3,993	$4,788	$5,040
State	$5,278	$5,904	$5,869

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

Figure 5: FC Penetration Rates CY 2017-19

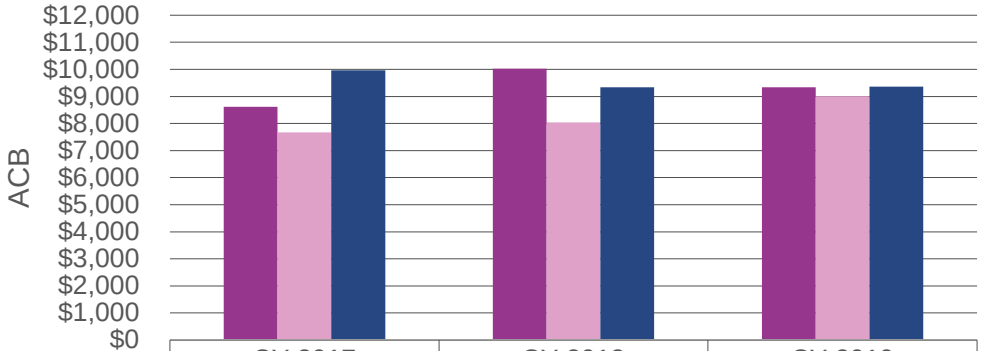
Tuolumne MHP



	CY 2017	CY 2018	CY 2019
MHP	42.11%	41.90%	42.11%
Small	39.64%	41.14%	44.00%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

Tuolumne MHP

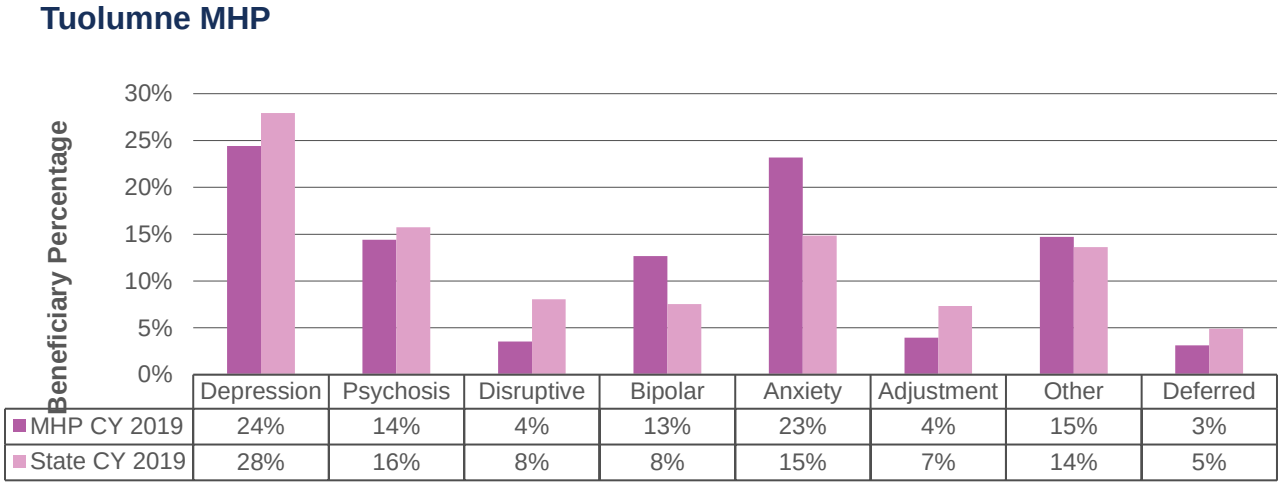


	CY 2017	CY 2018	CY 2019
MHP	$8,613	$10,023	$9,344
Small	$7,671	$8,033	$9,010
State	$9,962	$9,340	$9,360

Diagnostic Categories

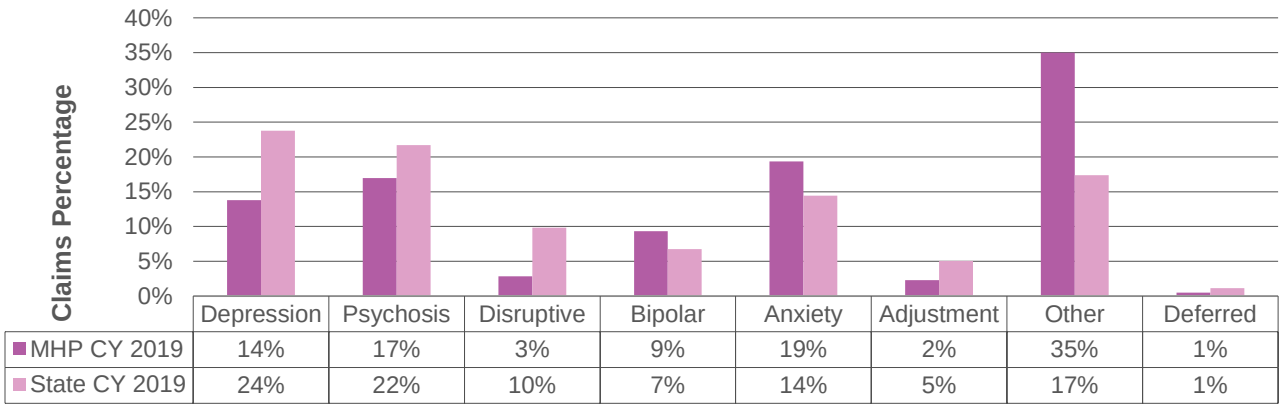
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	24%	14%	4%	13%	23%	4%	15%	3%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	14%	17%	3%	9%	19%	2%	35%	1%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

Tuolumne MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	22	981	2.24%	$63,487	$1,396,722	28.87%
	CY 2018	27	982	2.75%	$58,801	$1,587,631	33.36%
	CY 2017	17	1,011	1.68%	$54,986	$934,755	25.62%

See Attachment E, Table E1, for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

Table 4: Psychiatric Inpatient Utilization CY 2017-19

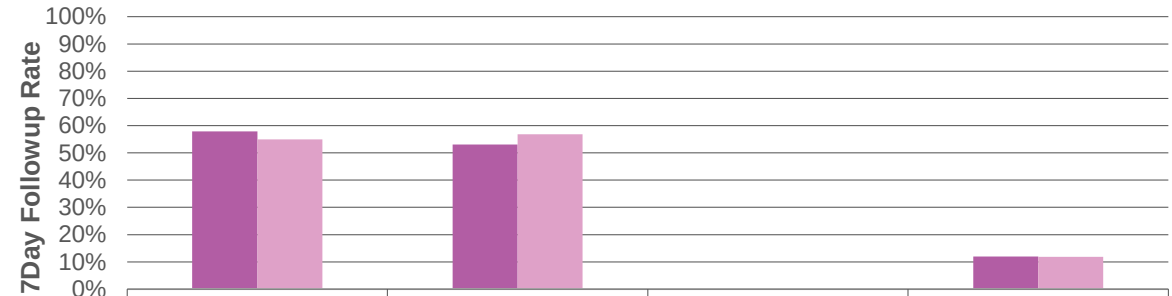
Tuolumne MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	106	178	10.23	7.80	$14,437	$10,535	$1,530,325
CY 2018	94	147	9.06	7.63	$17,077	$9,772	$1,605,204
CY 2017	76	141	8.36	7.36	$11,379	$9,737	$864,821

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

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

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

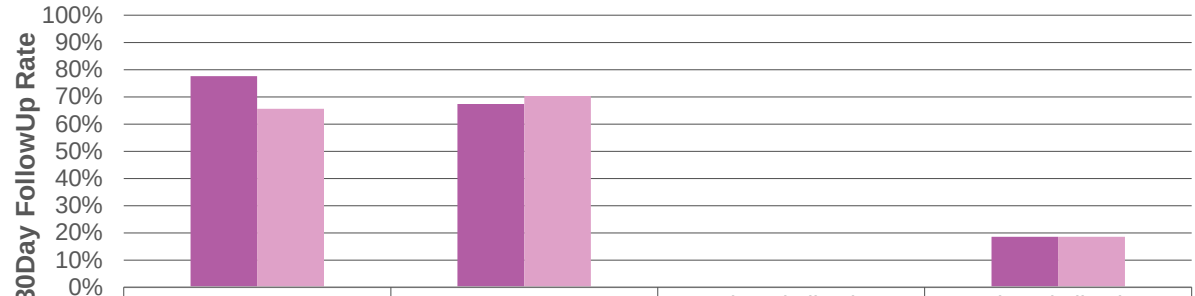
Tuolumne MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	58%	53%	0%	12%
CY 2019	55%	57%	0%	12%

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

Tuolumne MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	78%	67%	0%	19%
CY 2019	66%	70%	0%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

Tuolumne MHP PIPs Identified for Validation

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

Table 5: PIPs Submitted by Tuolumne MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Dual Diagnosis
Non-Clinical	1	Documentation by Peer Specialists

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Tuolumne
PIP Title	Dual Diagnosis
PIP Aim Statement	"Will dual diagnosis rates increase by creating a single assessment for both MH and SUD and training all clinicians to properly identify and treat dual diagnose at time of assessment?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	

MHP Name	Tuolumne
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): All new beneficiaries requesting services from TCBHD and existing beneficiaries during assessment updates.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): The following are interventions listed by TCBHD: • ASAM training for clinical line staff. • Develop combined mental health and SUD assessment. • Clinical use of combined assessment. • Update Utilization Review Committee (URC) tool to include SUD treatment language for beneficiary plans of care (POC).
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Number of dual diagnosis identified by clinicians	FY 2019-20	6 %	☒ n/a[5]		☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): n/a
					☒ No test of statistical significance	
Number of dual diagnosis beneficiaries that are dually enrolled in SUD and mental health	FY 2019-20	6 %	☒ n/a		☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): n/a
					☒ No test of statistical significance	

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percent of URC charts that include SUD treatment in POC	FY 2019-20	0 %	☒ n/a		☐ Yes ☒ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): n/a
					☒ No test of statistical significance	

Was the PIP validated?	☒ Yes ☐ No

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Validation rating:						
☐ High confidence[6] ☐ Moderate confidence[7] ☐ Low confidence[8] ☒ No confidence[9] Justification for validation rating: TCBHD clinical staff attended a required ASAM training in August 2020; the training provided an overview of assessment and creation of treatment plans for individuals with SUD. Although clinicians received the training, i.e., planning phase, this is not considered an active clinical intervention. Clinicians are using separate mental health and SUD assessments with beneficiaries, and the combined assessment has not been created, i.e., aim of the PIP. Utilization of separate assessments would still be considered in the planning phase, as it is focused on clinical training prior to the implementation of the combined assessment. Furthermore, data collection has not been initiated. "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: • The identified issue the PIP is attempting to address is not clear in the study narrative; the MHP should demonstrate that by not diagnosing co-occurring disorders accurately (compared to the national average), TCBHD beneficiaries are experiencing adverse outcomes. • The aim statement should be concise, answerable, measurable and time bound.						

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

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
• A performance measure should be chosen demonstrating how beneficiaries are impacted when they do receive an accurate dual diagnosis versus not receiving an accurate one, e.g., treatment drop-out, hospitalizations, and crisis services. • Clinical line staff training, development of combined mental health and SUD assessment, and updating the URC tool are not clinical interventions aimed at improving beneficiary outcomes; they appear focused on improving staff knowledge and skills. Furthermore, a URC tool is a method used for tracking, and would not be considered an intervention because it is not beneficiary focused. • Interventions should be evidenced based and suggest that the performance measure (test of change) would likely lead to the desired improvement in beneficiary outcomes; the study narrative is not clear how a combined assessment will improve beneficiary outcomes.						
TA provided to the MHP by CalEQRO consisted of: • Feedback regarding each section of the PIP such as PIP topic, aim statement, interventions, performance measures, data collection and analysis procedures. • Encouraged MHP to participate in ongoing and regular PIP TA with CalEQRO; the next TA is scheduled for June 2021.						

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Tuolumne
PIP Title	Documentation by Peer Specialist
PIP Aim Statement	"Can including peer recovery specialist documentation into the EHR benefit clients' plans of care to be more reflective of services received and inclusive of peer run programs"?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply)	

MHP Name	Tuolumne
☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): Adult beneficiaries enrolled in the FSP program and those receiving services as part of the Mental Health Wellness Act of 2013 (SB 82).	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Launch service activity log (SAL) with peer specialists working in the FSP program. • Launch SAL with peer specialists working in the SB 82 program.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): • Update URC tool to include auditing of peer support recovery in beneficiary plans of care.

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Average number of services provided by peer specialist per beneficiary	2019	353/78=5 services	October 2020 ☐ n/a	838/69=12 services	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): n/a
					☒ No test of statistical significance	
No-show rates for plans of care appointments	2019	22 %	January 2020 ☐ n/a	118/851= 14 %	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): n/a
					☒ No test of statistical significance	
	2019	38 %		29/39=	☒ Yes	☐ Yes

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Percent of beneficiary plans of care that are reviewed in URC that incorporate peer run programs			January 2020 ☐ n/a	74 %	☐ No	☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): n/a
						☒ No test of statistical significance
Percent of client plans that incorporate peer run programs that are discharged with met goals	2019	0 %	January 2020 ☐ n/a	7/39= 28 %	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): n/a
						☒ No test of statistical significance
						☐ No test of statistical significance
Was the PIP validated?				☒ Yes	☐ No	
Validation phase:			PIP status (per DHCS requirement):			

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ Implementation phase	Active and Ongoing					
☐ Baseline year						
☐ First remeasurement						
☐ Second remeasurement						
☒ Other, completed three months prior to the current EQR	Completed					
☐ PIP submitted for approval	Concept only, Not Yet Active					
☐ Planning phase						
☐ Other, inactive	Inactive, Developed in a Prior Year					

Validation rating:

☒ High confidence[6]

☐ Moderate confidence[7]

☐ Low confidence[8]

☐ No confidence[9]

Justification for validation rating: The MHP maintained fidelity to intervention utilization and adhered to the data collection and analysis plan. TCBHD reports that staff were able to continue providing peer specialist services with the onset of the COVID-19 public health emergency and did not adversely impact their study.

"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.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
EQRO recommendations for improvement of PIP: • Perform a thorough barrier analysis to determine the root causes of the identified issue prior to choosing PIP interventions.						
The TA provided to the MHP by CalEQRO consisted of: • Review of completed PIP results and discussion of potential future PIP topics. • Encouraged MHP to participate in ongoing and regular PIP TA with CalEQRO; the next TA is scheduled for June 2021.						

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the IS evaluation.

Key ISCA Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the video conference review.

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Tuolumne	1.60%	3.00%	3.00%	3.90%
Small MHP Group	n/a	2.95%	3.25%	3.54%
Statewide	n/a	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

- ☐ Under MHP control
- ☐ Allocated to or managed by another county department
- ☒ Combination of MHP control and another county department or agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☐ Yes	☒ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No
If the BCP status is "No," the MHP uses an Application Service Provider (ASP) model to host the EHR system, which provides 24-hour operational support.	☒ Yes	☐ No
If the BCP status is "Yes," it is tested at least annually.	☐ Yes	☒ No
There is at least one person within the MHP clearly identified as having responsibility for information security.	☒ Yes	☐ No
If no one within the MHP is identified as having responsibility for information security, the parent agency or county IT assume responsibility and control of information security.	☐ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

- While the IT budget reflects a drop from three percent in FY 2019-20 to 1.60 percent in FY 2020-21, the MHP cited no significant decline in budget; it may be caused by staffing changes and a variation calculation methodology.
- Cyber resiliency information is provided to staff in emails from the Tuolumne County IT Department.

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	99.98%
Contract providers	0%
Network providers	.02%
Total	**100%***

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

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	0.25	0	0	0
2019-20	0	0	0	0
2018-19	0	0	0	0

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	0.50	0	0	0
2019-20	1	0	0	0
2018-19	0.25	0	1	1

The following should be noted regarding the above information:

- Technology staffing has been stable over the past year; the 0.25 FTE technology analyst position is shared within Health and Human Services Agency (HHSA).
- There is 0.5 FTE dedicated to data analytics and consists of two agency managers; additional analytic support is available from KVBHS.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by the MHP and does not account for users' log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	10	0	10
Clinical Healthcare Professional	38	0	38
Clinical Peer Specialist	0	0	0
QI	2	0	2
Total	50	0	50

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Small MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	0.25	5.30
Total EHR Users Supported by IT (Source: Table 17)	50	200.00
Ratio of IT Staff to EHR Users	1:200	1:38

- The MHP receives EHR support from Cerner Corporation (Cerner) and KVBHS which is not included in the above staffing ratio.

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☐ Yes	☒ No
The MHP utilizes an ASP model to support EHR operations.	☒ Yes	☐ No
The MHP also utilizes QI staff to directly support EHR operations.	☐ Yes	☒ No
The MHP also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☐	☒	☐	☐
User profile and access setup	☐	☐	☐	☒
Screen workflow and navigation	☐	☐	☐	☒

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	1
Number of county-operated telehealth sites	1
Number of contract providers' telehealth sites	1
Total number of beneficiaries served via telehealth during the last 12 months	382
• Adults	260
• Children/Youth	69
• Older Adults	53
Total number of telehealth encounters (services) provided during the last 12 months:	0

- Telehealth services are available in Sonora. Two telehealth rooms allow for concurrent telehealth sessions to be conducted.

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☒ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☐ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☒ To serve special populations, i.e., children/youth or older adult
☐ To reduce travel time for healthcare professional staff
☒ To reduce travel time for beneficiaries
☐ To support NA time and distance standards
☒ To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- The MHP added individual therapy, new intake and assessment, group therapy, group education and support and case management telehealth services due to the COVID-19 pandemic.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☐	Cambodian
☐	Cantonese	☐	Farsi	☐	Hmong
☐	Korean	☐	Mandarin	☐	Other Chinese
☐	Russian	☐	Spanish	☐	Tagalog
☐	Vietnamese	☒	n/a		

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☐ Yes ☒ No ☐ Implementation Phase

The rest of this section is applicable: ☐ Yes ☒ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
n/a	

Current MHP Operations

- The MHP continues to utilize the CCBH system, implemented in 2010, in an ASP model hosted by Cerner with KVBHS providing operational support; CCBH software promotion 230.10 has been installed.
- The transition of the hosting of CCBH from KVBHS to Cerner occurred in January 2020.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SD/MC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
CCBH	EHR and Practice Management	Cerner Corporation	10	KVBHS

Major Changes since Prior Year

- Prior to the COVID-19 pandemic, telecommuting did not exist in Tuolumne county. The following infrastructure was developed to support telecommuting:
    - Thirty laptop computers were acquired.
    - Webcams were purchased for computers that did not have video capability.
    - Tuolumne County developed a telework eligibility document that was completed by approximately 600 county employees to determine telework appropriateness, related to both work requirements and the anticipated telecommute environment.
    - A training guide for providing Zoom services was developed.
    - CCBH functionality was expanded to support the CAT admission tracking functionality, CAT assessment updates, and the beneficiary plan of care.

- An in-house cultural competence training was developed using TargetSolutions software and assigned to staff.
- A CANS-50 and PSC-35 timelines tracking system was developed.
- SUD claiming structures were developed in preparation for providing DMC-ODS services.

The MHP's Priorities for the Coming Year

- Set up treatment team functionality in CCBH.
- Complete EHR capabilities assessment on CCBH. This will provide CCBH functionality as well as functionality gaps to be utilized to identify needs in a replacement EHR.
- Explore the potential for permitting behavioral health access to the forensic database.
- Prepare for the X12 274 provider information transaction project.
- Implement a video training program which is being developed by three clinical student interns to assist with intern training and the monitoring of quality of care in their delivery of services.
- Implement the CCBH authorization of services module.
- Broaden telehealth policies to create permanent structure for ongoing telehealth service delivery.
- Continue the development of engaging on demand animated/voiceover online trainings using TargetSolutions software.

Other Areas for Improvement

- Analytic capacity is challenged with meeting the needs of the organization.

Plans for Information Systems Change

- The MHP is considering a new system, but no formal project plan is in place and no project team has been assigned.
- An assessment of the CCBH EHR assessment is being completed to identify capabilities and functionality gaps.

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts				X	☐
Assessments	CCBH	X			☐
Care Coordination				X	☐
Document Imaging/Storage	CCBH	X			☐
Electronic Signature—MHP Beneficiary	CCBH	X			☐
Laboratory results (eLab)	Quest Care 360 (view results)		X		☐
Level of Care/Level of Service	LOCUS		X		☐
Outcomes	CCBH	X			☐
Prescriptions (eRx)	CCBH	X			☐
Progress Notes	CCBH	X			☐
Referral Management	CCBH	X			☐
Treatment Plans	CCBH	X			☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		8	2	2	0
FY 2019-20 Summary Totals for EHR Functionality:		8	2	2	0
FY 2018-19 Summary Totals for EHR Functionality:		8	1	3	0

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

- CCBH functionality was expanded to support the CAT; enhancements include CAT admission tracking functionality, updates to the CAT assessment, and plan of care.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☐ Yes ☒ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	0%	Not used
Direct data entry into MHP EHR system by contract provider staff	0%	Not used
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	0%	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	0%	Not used

- County operated clinics provide 99.98 percent of services and network providers provide 0.02 percent.

The rest of this section is applicable: ☐ Yes ☒ No

Some contract providers have EHR systems, which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Data Transmission from Contract Provider to MHP

EHR Vendor	Product	Count of Providers Supported
n/a		

Personal Health Record

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

☐ Yes ☒ No ☐ Implementation Phase

n/a

Expected implementation timeline:

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

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☐ Yes	☒ No
View list of current medications through portal.	☐ Yes	☒ No
Have ability to both send/receive secure text messages with provider team.	☐ Yes	☒ No

Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

- ☐ Dimension Reports application
- ☐ Web-based application, including the MHP EHR system, supported by vendor or ASP staff
- ☐ Web-based application, supported by MHP or DMC staff
- ☐ Local SQL database, supported by MHP/Health/County staff
- ☒ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

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

Table 29: Summary of CY 2019 SD/MC Claims

Tuolumne MHP							
Service Month	**Number Submitted**	**Dollars Billed**	**Number Denied**	**Dollars Denied**	**Percent Denied**	**Dollars Adjudicated**	**Dollars Approved**
TOTAL	**14,818**	**$3,982,804**	**71**	**$27,378**	**0.68%**	**$3,955,426**	**$3,308,072**
JAN19	1,360	$296,140	0	$0	0.00%	$296,140	$281,062
FEB19	1,106	$247,826	0	$0	0.00%	$247,826	$242,141
MAR19	1,340	$298,174	10	$2,864	0.95%	$295,310	$285,697
APR19	1,451	$319,403	10	$1,824	0.57%	$317,579	$303,930
MAY19	1,571	$340,318	16	$4,063	1.18%	$336,255	$321,012
JUN19	1,182	$270,793	4	$993	0.37%	$269,800	$260,637
JUL19	1,234	$408,746	3	$1,162	0.28%	$407,584	$297,483
AUG19	1,152	$359,047	2	$776	0.22%	$358,271	$259,355
SEP19	1,182	$360,892	5	$2,651	0.73%	$358,241	$266,216
OCT19	1,215	$411,714	6	$6,000	1.44%	$405,714	$300,448
NOV19	1,040	$340,287	9	$3,121	0.91%	$337,166	$248,824
DEC19	985	$329,464	6	$3,924	1.18%	$325,540	$241,267
The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments from Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.							
Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2019 was **2.99 percent.**							

- The MPH's CY 2019 denied claims rate of 0.68 percent is significantly below the 2.99 percent statewide average.

Table 30 summarizes the top five reasons for claim denial.

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

Tuolumne MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
Medicare or Other Health Coverage must be billed before submission of claim.	37	$10,619	39%
Beneficiary not eligible.	12	$10,099	37%
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	16	$4,733	17%
Beneficiary not eligible or non-covered charges.	1	$1,066	4%
Missing or incomplete or invalid codes.	2	$467	2%
Total	71	$27,378	NA
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

- Denied claim transactions with reason Medicare or other health coverage must be billed prior to submission of claim is generally re-billable within the State guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing TA in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS request would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For Tuolumne, the time and distance requirements are 90 minutes and 60 miles for mental health services, and 90 minutes and 60 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted key informant interviews during the review process to identify any problems or barriers for the beneficiaries relating to access and timeliness issues. The key informants included MHP staff.

Findings

The county MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

n/a

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	0
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	0
NPI Type 1 number reported is associated with two or more providers	0
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	0
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	0

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, and DHCS direction to pause review activity, as well as MHP lack of staff resources due to the public health emergency, no beneficiary focus group was conducted as part of CalEQRO's desk review of Tuolumne MHP this year. A letter from the MHP director is included later in this report with additional information identifying specific MHP circumstances.

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 32 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 32: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
Beneficiaries are routinely referred to TCBHD through contract and/or memorandum of understanding relationships with numerous community partners such as primary care, Adventist Health Sonora, the Amador-Tuolumne Community Action Agency			

Component		Maximum Possible	MHP Score
(ATCAA), and out-of-county referrals. The MHP also receives referrals from the Tuolumne County Sheriff and County Jail, Tuolumne County Probation Department, Tuolumne County Superior Court, and other law enforcement agencies. The MHP tracks and trends data on requests for services by walk-ins, fax, calls, and referral sources in the Access to Care Log. Beneficiaries may also learn about offered services by calling the access line (24 hours per day, 7 days per week), flyers, social media, newsletters, and outreach efforts. The MHP has been able to maintain all essential services during the COVID-19 public health emergency while limiting in-person contact as much as possible; most appointments have been shifted to telephone or telehealth. TCBHD maintains an Authorization of SMHS Policy which outlines the process and timeliness for authorizing requests for outpatient mental health services. Beneficiaries who are referred for services will participate in a screening process via telephone, telehealth, and/or in-person assessment to determine Medi-Cal eligibility. Individuals who do not meet the Medi-Cal requirements for treatment, will be provided with the appropriate referrals to any network provider. Beneficiaries who do meet Medi-Cal requirements for SMHS will be given an intake appointment with a licensed clinician within 10 business days of initial request. The CAT was developed in January 2020 to reduce authorization and assignment time. The CAT provides biopsychosocial assessment feedback to the assigned clinician, and the beneficiary is referred to the appropriate LOC. The MHP has an updated Provider Directory Policy which focuses on ensuring that updates are maintained, and the directory is available to beneficiaries in electronic form on the website. The agency's website is user friendly, and beneficiaries can learn about upcoming activities such as the Enrichment Center's monthly calendar of events. The wellness centers are closed for in-person services due to the COVID-19 public health emergency; however, beneficiaries can use the shower and laundry services if needed. The Lambert Community Center is only offering bagged lunches for beneficiaries. While the MHP does not currently have a threshold language, they do offer some beneficiary information in Spanish.			
1B	Capacity Management	10	10
The TCBHD QAPI workplan outlines the monitoring of several system demand variables, e.g., penetration rates, cultural needs, and geographic distribution to ensure the provision of an appropriate range of preventive, specialty, and long-term service supports services which are adequate for the anticipated number of enrollees in the counties' service area. Chronic staffing shortages were exacerbated with the onset of the COVID-19 public health emergency which resulted in increased clinician caseloads and staff burnout. Although the MHP struggles with staffing retention, clinicians were able to efficiently pivot to the provision of telehealth services, and system capacity was not negatively			

Component		Maximum Possible	MHP Score
impacted. The MHP is collaborating with the HHSA Director to improve staff recruitment and retention to ensure quality and timely access to care. The MHP tracks and monitors the implementation of performance improvement activities to ensure the county has sufficient capacity to make services available when medically appropriate 24 hours per day, 7 days per week. The MHP participated in several cultural competence outreach activities in the community prior to the COVID-19 public health emergency such as behavioral health fairs, Enrichment Center open houses, and support groups at Columbia University in Sonora, California. Although the MHP has paused in-person cultural competence activities, support groups and outreach activities are held via teleconference and telephone when needed.			
1C	Integration and Collaboration	24	24
The TCBHD Director reports directly to HHSA Director; the MHP is located under the HHSA umbrella, more specifically, the General Services Unit, which is not located on the same campus as the MHP. TCBHD maintains close working relationships with various community-based organizations including: Interfaith Food Pantry, Tuolumne Me-Wuk Indian Health Center, Adventist Health, Catholic Charities, local educational systems and law enforcement, and CWS. The MHP reports that outreach and collaboration with community partners, especially local schools, have continued throughout the COVID-19 public health emergency. The SB 82 Crisis Triage program collaborates with the Sheriff's Office, Sonora Police Department, the National Park Service, California Highway Patrol, local high schools, alternative school programs, community youth programs, and local hospitals to provide outreach and divert individuals in mental health crisis from going to the emergency room. The program provides peer support, brief case management and in-person crisis intervention (prior to the COVID-19 public health emergency) for adults between 16 and 25 years old; however, they can serve adults over 25 years old when needed. Services are available Monday through Friday from 8:00 a.m. to 5:00 p.m. The MHP reports that this program has relied more on telephone outreach to at-risk individuals in response to social distancing requirements; the SB 82 grant will expire at the end of CY 2021. TCBHD offers several SUD services such as individual and group treatment, dual diagnosis treatment, perinatal treatment program, the adolescent brief intervention program, adult drug court and Prop 36 services, and dependency drug court. Beneficiaries can request employment support from their case managers and may also receive assistance from surrounding community providers such as the Mother Lode Job Training (virtual services only); Interfaith Community Social Services; and Columbia College. TCBHD and the Tuolumne County Sheriff's Office jointly operate the Clean and Sober Experiences program which provides SUD treatment to			

Component	Maximum Possible	MHP Score
individuals in the county jail; furthermore, TCBHD offers mental health services to inmates upon referral. The MHP refers individuals to the Anthem Blue Cross Partnership Plan and California Health and Wellness when the needed service is one provided by the MCOs and not TCBHD, and when the MHP determines that the beneficiary does not meet the specialty mental health medical necessity criteria, i.e., mild to moderate beneficiaries. There are limited housing options in Tuolumne County due to the rural nature of the county, lack of affordable housing and high poverty rates compared to the rest of the nation. ATCAA operates a homeless shelter in Jackson and Sonora, California, and aids with rental and rapid-rehousing assistance when funds are available. In CY 2020, the ATCAA helped administer the funding for Project Roomkey in Tuolumne County and secured a contract with Old Oak Ranch to provide housing for 50 individuals living in homeless encampments. The church run Old Oak Ranch closed at the start of the COVID-19 public health emergency as the county positivity rate increased. Residents were provided a financial allotment to help them relocate, and the ranch is tentatively closed until CY 2022. Tuolumne County has not received further Project Roomkey funding. ATCAA also supports individuals with educational and employment assistance.		

Timeliness of Services

As shown in Table 33, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 33: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	15
The MHP has a standard of 10 business days for initial contact to first offered appointment and met the standard 52 percent of the time with a mean of 11 days (52 percent for adults, 52 percent for children, and 100 percent for FC youth). The MHP's own timeliness self-assessment shows that the percent of time that TCBHD met the 10 business day standard increased from 33 percent in FY 2019-20 to 52 percent in FY 2020-21; the average length of time from request to first offered appointment also improved from 16 business days to 11 business days. The MHP would benefit from continued QI activities to increase the percent of time that the 10 business day standard for first offered appointment is met. TCBHD tracks and reports on all first offered appointment data monthly and during quarterly QIC meetings which includes			

Component		Maximum Possible	MHP Score
the range; average number of days; and percentages of times the 10 business day standard is met. The MHP tracks the sources for all referrals and records whether they are walk-ins, phone calls or written requests. The MHP transitioned from completing initial assessments in-person to telehealth in response to the COVID-19 public health emergency. TCBHD reports that this change has provided a unique opportunity to improve timely access to quality care. A new initial intake protocol was implemented in November 2020 which allows for a stand-by assessment slot if the original individual is a no-show for their appointment contributing to additional access availability. The MHP created CAT in CY 2020 which consists of the TCBHD Director, Deputy Director, and the Business and Operations Agency Manager. The CAT convenes daily to review all new assessments and assigns beneficiaries to a clinician and psychiatrist depending on the assessed LOC. The MHP reports the CAT is focused on reducing the wait time for clinician and psychiatrist assignment.			
2B	First Offered Psychiatry Appointment	12	12
The MHP contracts with one local psychiatrist for eight hours of in-person (prior to the COVID-19 public health emergency) care every Friday. The MHP has a contract with KVBHS for psychiatric services, providing 22 hours for adults per week and 12 hours for children per month through telehealth, and for medication monitoring activities. The MHP employs a total of four nurses who regularly interface with physicians, beneficiaries, and outside agencies, e.g., hospitals and jails providing a bridge with psychiatry. The MHP tracks and reports on all first offered and first kept psychiatric appointment data on a quarterly basis, including the number of days and percentages of times the standard is met, and the range. TCBHD has a 15-business day standard for initial contact to first offered psychiatric appointment and met this standard 41 percent of the time (43 percent for adults and 27 percent for children). There were no initial requests for psychiatry appointments for FC youth in FY 2020-21. The average length of time from initial request to first offered psychiatry appointment is 22 business days (21 business days for adult and 30 business days for children). The third and fourth Tuesday of each month, a children's psychiatrist is available from 8:00 a.m. to 2:00 p.m. (12 hours per month). TCBHD reports that children requesting psychiatry services must participate in three clinical appointments with a therapist prior to meeting with a psychiatrist. The MHP's data reflects that the first offered psychiatry appointment timeliness for children has remained steady at 30 business days over the last two FY. Children experienced an initial psychiatry wait time between seven to 59 days in FY 2020-21. TCBHD reports that a small children's population, the required three clinical appointments prior to the first psychiatry appointment, and no-shows have contributed to the extended wait times. It appears			

Component		Maximum Possible	MHP Score
that there may be other factors contributing to the wait times for children's initial psychiatry appointments as the no-show rate has improved from an average of 17 percent in FY 2019-20 to 13 percent (below MHP's 15 percent standard) in FY 2020-21; furthermore, the MHP reports that there is sufficient capacity for children's psychiatry services, and it is difficult to fill all psychiatry appointments for child beneficiaries. It would benefit the MHP to identify if additional strategies are needed to reduce psychiatry wait times as this will assist the MHP to determine if there is adequate capacity needed to reduce wait times and increased adherence to the MHP standard. While the CAT has reduced the wait time for clinician and psychiatrist assignment after the initial assessment, wait times for initial psychiatry appointments have increased over the last FY. The MHP's data showed that the average wait time for first offered psychiatry appointment has increased from an average of 19 business days in FY 2019-20 to 22 business days in FY 2020-21. Although the average psychiatry caseload has increased from 455 beneficiaries in CY 2018 to 676 beneficiaries in CY 2019, the FY 2020-21 data shows a precipitous drop in caseload numbers in quarter one (365 cases) and quarter two (355 cases); the decrease may be influenced by the shelter in place proclamation with onset of the COVID-19 public health emergency.			
2C	Timely Appointments for Urgent Conditions	18	18
The MHP has a standard of 48 hours from service request for urgent conditions to actual encounter for appointments that do not require a prior authorization and met this standard 100 percent of the time with a mean of 45 minutes (48 minutes for adults, 22 minutes for children, and 81 minutes for FC youth). The MHP has a standard of 96 hours from service request for urgent conditions to actual encounter for appointments that require a prior authorization and met this standard 100 percent of the time with a mean of 74 minutes (55 minutes for adults and 145 minutes for children). The MHP tracks and reports quarterly on timely appointments for urgent conditions data, including the number of days, percentages of times the standard is met, average time and the range. The MHP compares the quarterly data to the mean for the two previous years for the entire system of care.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	10
The MHP has a standard of 2 business days for follow-up appointments post-psychiatric inpatient discharge and met the standard 42 percent of the time with a mean of 4 business days (2 days for adults, children, and FC youth). The percent of appointments that met the standard has decreased by nearly 20 percent since FY 2019-20. The MHP would benefit from updating their goal to match the HEDIS			

Component		Maximum Possible	MHP Score
measurement of 7 business days as a standard for this metric; this would more accurately reflect the percent of time that they are meeting the standard. On a quarterly basis, the MHP tracks and reports on timely access to follow-up appointments after hospitalization data, including the number of days and the percentages of times the standard is met. The MHP compares the quarterly data to the mean for the two previous years, including the average times.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The overall re-admission rate for the entire system of care is ten percent (ten percent for adults, fourteen percent for children, and zero percent for FC youth). The MHP tracks the number of beneficiary rehospitalizations for each hospital in the system of care. Hospitalizations are captured in the Access to Care Log and reviewed daily with the crisis team. The log is also reviewed weekly and quarterly by QM.			
2F	Tracks and Trends No-Shows	10	10
The MHP has a no-show standard of 15 percent for psychiatrists with an average overall no-show rate for psychiatrists of 13 percent (13 percent for adults, 13 percent for children, and five percent for FC youth). The MHP no-show standard for clinicians other than psychiatrists of 20 percent and met the standard approximately 17 percent of the time (18 percent for adults, 11 percent for children, and 11 percent for FC youth). The MHP tracks and reports on no-show data for initial assessments on a quarterly basis for psychiatric and clinician appointments for the entire system of care. Tracking includes the percentages of time the standard is met, and whether appointments were cancelled by the beneficiary or the MHP staff and clinicians. The MHP provides reminder calls and transportation assistance to its beneficiaries.			

Quality of Care

In Table 34, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that QI efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 34: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	11
The MHP has an updated cultural competence work plan with current data reflecting the population in Tuolumne County. QM participated in the development of specific goals and objectives that attempted to address equity and disparities; however, the goals and objectives are not quantified, and it is therefore difficult to measure the impact of cultural competence activities on beneficiary engagement and outcomes. The MHP created a cultural competency monitoring tool to track monthly progress of goals identified in the work plan; however, there is no documentation that the tool is being used; therefore, progress on the goals is unclear. The MHP participates in a Tri-County Cultural Collaborative with Amador and Calaveras Counties to discuss cultural competence needs for small rural counties, and to conduct joint training activities. The current CCC workplan is in draft form, has three goals, and does not include process and outcome indicators. The CCC meetings were halted (currently in virtual format) at the beginning of the COVID-19 public health emergency; completion of the workplan was impacted by the pandemic, staffing shortages, and limited resources.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
During a plan of care session, beneficiaries are directly involved in identifying their strengths, problems, setting goals and creating measurable goals to address in treatment. Behavioral health workers complement clinical services by engaging beneficiaries in skill-building activities identified in the plan of care. The MHP created CAT to verify medical necessity and LOC assignments by using beneficiary LOCUS scores. Utilization reports also highlight individual beneficiaries who may need a LOC transition. These reports are reviewed monthly. Beneficiaries who are referred to MCOs are tracked at 30-day, 60-day and 90-day timelines to verify successful transition. Requests for a hospital evaluation is captured in the access to care log. Hospitalizations are tracked in a log which is maintained by the TCBHD Hospital Discharge Coordinator and is reviewed daily with the crisis team.			

Component		Maximum Possible	MHP Score
3C	Quality Improvement Plan	10	7
The QM team implemented a quality assurance form in April 2020 to track clinical and quality issues, ensure collaboration with clinical supervisors, and to ensure timely follow-up on QI activities. The FY 2020-21 QAPI workplan was updated to include a medication monitoring goal; a new dashboard was created in September 2020 to assist the QM committee with monitoring trends and to ensure medication safety and effectiveness. It would benefit TCBHD to add process and outcome indicators to the QAPI workplan to inform QI activities. The workplan includes a focus to update the CCC workplan with measurable action items.			
3D	Quality Management Structure	14	14
The MHP has 1.5 FTE staff in the QM Department, including a full-time coordinator position. A 1.0 FTE Data Analyst position was added to the QM team in August 2019; however, they are only able to dedicate 0.5 FTE to this position due to TCBHD's absorption of contracts from HHSA. The QM staff are fully integrated with the leadership team, and there is a direct line of communication with administration. The MHP holds a monthly QIC meeting, with a standing agenda and documented meeting minutes. Attendance at the meetings varies from three to ten participants monthly, and includes QM, clinical staff, peer support specialists, beneficiaries, community advocates and council members.			
3E	QM Reports Act as a Change Agent in the System	10	10
The MHP implemented a new data analytics and reporting software system in CY 2019 that is now fully operational and accessible by QM, leadership, and clinical staff throughout the agency. The system produces routine (monthly and quarterly) reports, as well as point-in-time reports on demand. The MHP has one active clinical PIP and is in the process of developing new non-clinical PIP. Feedback in the stakeholder focus group demonstrates routine sharing of QM reports with staff.			
3F	Medication Management	12	10
The FY 2020-21 QAPI workplan was updated to include a medication monitoring goal; a new dashboard was created in September 2020 to assist the QM committee with monitoring trends and to ensure medication safety and effectiveness. The MHP's medication monitoring data is disaggregated into psychiatrist, diagnosis, prescribed medication, gender, ethnicity, and age. The dashboard only captures data from a small sample of beneficiaries receiving a psychotropic medication; additionally, FC youth HEDIS measures are not included.			

Beneficiary Progress/Outcomes

In Table 35, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 35: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	10
TCBHD reports beneficiary outcome tools are not consistently completed throughout the system of care; in response the MHP instituted the following QI activities in FY 2020-21: monitor consistent completion of the CANS-50, PSC-35, and LOCUS outcome tools; and review, evaluate, and implement QI activities to assist ongoing clinical decisions. The current QAPI workplan does not include process and outcome indicators for outcome tool completion; however, the TCBHD medical records team established baseline measurements for the goal. While monitoring for the completion of the CANS-50 and PSC-35 is carried out by QM, aggregate reporting and analysis is not done on a regular basis, nor is this data currently being used to make system changes and improvements.			
4B	Beneficiary Perceptions	10	10
The consumer perception surveys were not possible in FY 2020-21 due to the MHP's limited resources resulting from the COVID-19 public health emergency.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
The MHP employs peer workers throughout the system of care in various capacities. A career ladder exists for the peer employees and is being expanded. Peer staff positions accrue sick time, and when a leave of absence is taken, it does not impact employment status. The non-clinical PIP recently concluded which was focused on peer employees documenting their contacts with beneficiaries to improve engagement and outcomes. The peer run Enrichment Center closed at the onset of the COVID-19 public health emergency; the Tuolumne County Mental Health Services Act (MHSA) coordinator worked closely with the Public Health Office to ensure a safe re-opening of the center.			

Structure and Operations

In Table 36, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 36: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	22
The MHP has a full range of services available; however, some of these services are contracted with agencies outside of the county and beneficiaries must travel to obtain them. No psychiatric in-patient facilities are available in Tuolumne County. The MHP maintains a policy for Access to Urgent Adult Mental Health Services for Out-of-County Adults. Crisis services are available in Tuolumne County 24 hours a day, 7 days a week. The MHP contracts with Merced County to provide in-patient stays at the Multi-County Crisis Residential Unit which is operated by Central Star Behavioral Health, Inc. The MHP is not yet providing TFC services either directly or through a contract provider, as no foster family agencies are in Tuolumne County. TFC remains in the planning phase, and no timeline was provided.			
5B	Network Enhancements	18	14
TCBHD was able to pivot from offering most services in-person during FY 2019-20 to predominantly offering telehealth in response to the COVID-19 public health emergency. Previously, only psychiatry services were offered via telehealth. The MHP reports that beneficiaries were reluctant to request mental health services at the beginning of the public health crisis. Additionally, TCBHD offers mental health services via telephone, and in-person appointments are delivered on an as-needed basis. TCBHD provided a total of 1,311 total telehealth encounters between CY 2019 and CY 2020 compared to 1,033 encounters between CY 2020 and CY 2021. The MHP's data shows that the number of beneficiaries served via telehealth decreased from 441 beneficiaries between CY 2019-20 to 380 beneficiaries between CY 2020-21. The number of adults who received services via telehealth also decreased from 364 individuals between CY 2019-20 to 260 beneficiaries between CY 2020-21; conversely, children receiving services via telehealth increased from 27 individuals in CY 2019-20 to 69 individuals in CY 2020-21. Older adults saw a modest decline in telehealth encounters from 58 individuals between CY 2019 and CY 2020 to 53 individuals between CY 2020 and CY 2021.			

Component		Maximum Possible	MHP Score
The MHP utilizes a wide variety of adjunctive services delivery options; however, it does not use Whole Person Care. The MHP contracts with out-of-county inpatient hospital placement in lieu of psychiatric health facilities, as they do not have the capability to provide those services. The MHP is co-located within the Family Wellness Center and CWS Visitation Center. TCBHD operates the Lambert Community Center which is focused on providing support to individuals who are homeless, unemployed, or otherwise unable to meet their basic needs. The wellness center is closed due to the COVID-19 public health emergency; however, they are providing bagged lunches to individuals experiencing homelessness. The Enrichment Center offers laundry and shower services Monday through Friday between 8:00 a.m. and 2:30 p.m.; in-person activities are not occurring due to social distancing requirements. It would benefit the MHP to continuously track and monitor the modality of service provision, e.g., in-person, telephone, and telephone related to demographics and geographic locations to determine whether disparate patterns exist in access to quality care. The rural nature of Tuolumne County provides a unique challenge to beneficiaries such as lack of universal broadband and internet affordability. It may benefit TCBHD to determine the needs and demands of the population they serve to ascertain whether additional QI activities are warranted to improve telehealth access, e.g., research Rural Utilities Services grants. The MHP has a network adequacy policy and procedure for time and distance standards.			
5C	Subcontracts/Contract Providers	16	16
The MHP participates in quarterly meetings with the designated contact liaisons for California Health and Wellness and its subcontractor, Health Net, LLC. Contracts were transitioned from the overarching HHSA agency and were absorbed internally by TCBHDD in CY 2019; there are 100 contracts currently. The MHP found that several contracts were unused even though they were renewed each FY. This transition has led to improved fiscal oversight, increased monitoring (quarterly reports), frequent follow-up and a closer relationship between behavioral health and contract development.			
5D	Stakeholder Engagement	12	12
Feedback in the stakeholder focus group reflect staff participation in committees, system planning, and MHP initiative/policy development. QIC meeting minutes provided for this review demonstrate peer and community participation in quarterly meetings. The Mental Health Advisory Board committee, QI Council, CCC, and MHSA stakeholder feedback meetings stopped in response to the COVID-19 public health emergency; the meetings were switched to a virtual platform in July and August 2020, allowing the meetings to continue.			

Component		Maximum Possible	MHP Score
5E	Peer Employment	8	
While there is no designated peer position on the executive team, there are self-identified peer supervisors in the system of care and some peer employees report to executive team members. In CY 2018, the education and experience requirements for the Behavioral Health Worker I/II positions were changed to allow peer specialists to qualify based on experience, thereby expanding the career ladder. The MHP recently concluded a non-clinical PIP focused on the integration of peer specialists' documentation in the EHR and use of this data by the treatment team to fully integrate peer-beneficiary activities within the treatment planning process leading to improved outcomes.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Tuolumne MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Concept only, not yet active (not rated)

Non-clinical PIP Status: Completed

Access to Care

Changes within the Past Year:

- The MHP began providing the following services via telehealth: new intake and assessment, individual and group therapy, psychoeducation classes, and case management services in response to the COVID-19 public health emergency.
- The TCBHDD FSP program added a licensed vocational nurse to the team in CY 2020 which improved timely access to care and enhanced team dynamics.

Strengths:

- The MHP's clinical PIP is focused on creating a combined mental health and SUD initial intake assessment; TCBH's goal is to adapt resources to improve capacity and clinical decisions.

Opportunities for Improvement:

- None noted

Timeliness of Services

Changes within the Past Year:

- A new stand-by procedure was implemented to address initial appointment no-shows in November 2020; a back-up appointment is offered to the next individual if the original beneficiary cannot be reached.

Strengths:

- The MHP's data shows the time from request to initial appointment has improved from 16 business days in FY 2019-20 to 11 business days in FY 2020-21.
- The TCBHD CAT's daily function is to reduce initial access wait time by verifying medical necessity, determining appropriate program assignment, and deciding LOC for new beneficiaries.

Opportunities for Improvement:

- The MHP's data showed that the average wait time for first offered psychiatry appointment has increased from an average of 19 business days in FY 2019-20 to 22 business days in FY 2020-21.
- TCBHD data shows the children's wait time for an initial psychiatry appointment is 30 business days.

Quality of Care

Changes within the Past Year:

- The QM team implemented a quality assurance form in April 2020 to track clinical and quality issues, ensure collaboration with clinical supervisors, and to ensure timely follow-up on QI activities.
- The FY 2020-21 QAPI workplan was updated to include a medication monitoring goal; a new dashboard was created in September 2020 to assist the QM committee with monitoring trends and to ensure medication safety and effectiveness.

Strengths:

- Feedback in the stakeholder focus group reflect positive relations and communication between clinicians, case managers, and psychiatrists resulting in improved coordination of care.
- TCBHD clinical staff attended an ASAM training in August 2020; the training provided an overview of assessment and creation of treatment plans for individuals with co-occurring disorders.
- A weekly meeting is held with the director, management from clinical and SUD programs, IS, Medical Billing, and QM with the focus on improving integration of SUD and mental health services.

Opportunities for Improvement:

- The medication monitoring dashboard only captures data from a small sample of beneficiaries receiving a psychotropic medication; additionally, FC youth HEDIS measures are not included.

Beneficiary Outcomes

Changes within the Past Year:

- TCBHDD added a goal to QAPI to monitor consistent completion of the CANS-50, PSC-35, and LOCUS outcome tools; baseline measurements were formulated by the medical records team.

Strengths:

- The peer run Enrichment Center closed at the onset of the COVID-19 public health emergency; the MHSA coordinator worked closely with the Public Health Office to ensure a safe re-opening of the center.
- August 2020 QM meeting minutes reflect TCBHD came into compliance with consistently utilizing beneficiary outcome tools throughout the system of care.

Opportunities for Improvement:

- The CPS was not possible in FY 2020-21 due to the MHP's limited resources resulting from the COVID-19 public health emergency.
- The current QAPI workplan does not include process and outcome indicators for beneficiary outcome tool completion or QI activities to provide guidance with treatment and LOC placement.
- TCBHD states QM continues to monitor outcome tool completion; however, documents submitted for this review focus on compliance rather than analyzing aggregate beneficiary outcomes to inform QI.

Foster Care

Changes within the Past Year:

- TCBHD increased collaboration with CWS; monthly IPC and multidisciplinary meetings occurs between the two agencies and are attended by probation and executive management.
- The MHP updated their presumptive transfer policy in August 2020; the policy was approved by DHCS and is pending signature for completion.

- A clinician was placed in the local juvenile facility to collaborate care for FC youth.

Strengths:

- TCBHD, HHSA, and CWS are collaborating to create a unified Children System of Care (CSOC); an Integrated Core Practice Model (ICPM) training was implemented in January 2021 for TCBHD and CWS staff.
- The MHP is collaborating with several HHSA departments to increase services for FC youth such as the Family Urgent Response System to receive immediate assistance and mental health stabilization.
- EQRO data for CY 2019 shows penetration rates for FC youth ages six and over exceeds the statewide average (62.32 percent versus 53.18 percent).
- TCBHD collaborates with CWS during regular IPC meetings to discuss capacity, needs, and resources for FC youth.

Opportunities for Improvement:

- MHP penetration rates for FC youth ages zero to five has remained below the statewide average for the past three years.
- TCBHD reports lack of ongoing access to CWS data which results in inaccurate TCBHD FC youth penetration data.
- The medication monitoring tool does not capture HEDIS measures related to diagnoses and psychotropic medications for FC youth.
- TCBHD, CWS, and juvenile probation partners have not collaboratively conducted an assessment to determine the readiness to implement TFC.

Information Systems

Changes within the Past Year:

- TCBHD transitioned the hosting of CCBH from KVBHS to Cerner in January 2020.

Strengths:

- The MHP receives EHR, data analytic and fiscal support from KVBHS.
- Fiscal, analytic and EHR support is provided by KVBHS.
- TargetSolutions is being utilized to develop engaging, on-demand animated/voiceover online trainings.

Opportunities for Improvement:

- None noted

Structure and Operations

Changes within the Past Year:

- Technical support and equipment were provided to staff to support provision of services via telehealth in response to the COVID-19 public health emergency.

- The TCBHD Director collaborated with Tuolumne County HHSA for an agency wide reorganization in December 2020; the goals of this on-going integration are increased coordination of care; improved quality of care; and to streamline business operations.

- Significant staffing changes occurred in the past year including:

    - New Crisis, Assessment, and Intervention Program supervisor hired in February 2021.

    - New Planned Services Supervisor hired in May 2020.

    - Six behavioral health workers vacated their positions in CY 2020; as of January 2021, most positions have been filled.

    - As of March 2021, current vacancies include one behavioral health clinician, two peer specialists (relief), and one behavioral health worker (relief).

Strengths:

- TCBHD adapted to the inherent challenges of the COVID-19 public health emergency and pivoted from in-person service delivery to telehealth without impacting service delivery capacity.

- Feedback in the stakeholder focus group reflect staff participation in committees, system planning, and MHP initiative/policy development.

- The Mental Health Advisory Board committee, QI Council, CCC, and MHSA stakeholder feedback meetings stopped in response to the COVID-19 public health emergency; the meetings were switched to a virtual platform in July and August 2020, allowing the meetings to continue.

Opportunities for Improvement:

- The MHP's analytic capacity is challenged with meeting the analytic needs of the organization.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward and is encouraged to implement PIP recommendations contained in the EQR report.

Access to Care

None noted

Timeliness of Services

Recommendation 2: Implement further strategies to reduce the wait time for first psychiatry appointments for all age groups to adhere to state timeliness metrics as per BHIN 18-011. (*This recommendation is a follow-up from FY 2018-19 and FY 2019-20*.)

Quality of Care

Recommendation 3: Define measurable goals in the Quality Assurance Performance Improvement (QAPI) workplan and the Community Cultural Collaborative (CCC) workplan that reflect desired improvements in access, timeliness, and quality, in addition to compliance with required monitoring activity. Analysis of existing data should inform the selection of goals and provide baselines against which to measure improvement.

Beneficiary Outcomes

Recommendation 4: Aggregate data from Child and Adolescent Needs and Strengths (CANS-50), Pediatric Symptom Checklist (PSC-35), and Level of Care Utilization System (LOCUS) reports and analyze data on a regular basis to make system changes and improvements. *(This recommendation is a follow-up from FY 2018-19 and FY 2019-20.)*

Foster Care

Recommendation 5: Collaborate with EHR vendor or psychiatric telehealth provider to track and trend foster care (FC) Health Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications; regularly track and trend FC prescribing practices for performance improvement purposes as per SB 1291.

Recommendation 6: Continue on-going collaboration with Child Welfare Services during Interagency Placement Committee (IPC) meetings to address gaps in FC youth data sharing between TCBHD and Child Welfare Services (CWS); implement solutions to align with Continuum of Care Reform (CCR) principles.

Information Systems

None noted

Structure and Operations

Recommendation 7: Expand data analytic capacity to support behavioral health operations.

REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible.
- A CFM focus group was not held due to the MHP's limited resources caused by the COVID-19 public health emergency; therefore, beneficiary feedback was not possible during this review.

June 16, 2021

Samantha Fusselman, LCSW, CPHQ
Executive Director, CalEQRO
Behavioral Health Concepts, Inc.
5901 Christie Ave., Ste. 502
Emeryville, CA 94608

Dear Samantha,

On December 22, 2020 and in response to a surge in COVID-19 cases in the state, the Department of Health Care Services (DHCS) approved a pause on EQRO review activities through March 1, 2021. DHCS further approved flexibilities beyond March 1, 2021 as the COVID pandemic continued to impact county operations.

Accordingly, Tuolumne County requested flexibility during the March 2021 EQRO review. Specifically, Tuolumne requested to not have consumer family focus group session(s) because of one or more of the following related challenges:

- ☐ Lack of staff/resources
- ☐ Staff have been reassigned to other departments
- ☐ Lack of infrastructure
- ☒ Consumers did not have access to a phone or video
- ☐ Additional factors:_____

Please attach this letter to our FY2020-2021 annual report.

Sincerely,

Michael Wilson, LMFT

Tuolumne Behavioral Health Director

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: ACA Penetration Rates and ACBs

Attachment D: ACB Range Distributions

Attachment E: List of Commonly Used Acronyms

Attachment A—Review Agenda

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

Table A1: EQRO Review Sessions

Tuolumne MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Clinical Directors Group Interview
Peer Employees Group Interview
Peer Inclusion/Peer Employees within the System of Care
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Angela Kozak-Embrey, Quality Reviewer
Lisa Farrell, Information Systems Consultant
Deb Strong, Consumer Family Member Consultant

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

MHP Review Sites and Participants

All sessions were held via video conference due to COVID-19 restrictions.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Ambler	Misti	Business and Operations Agency Manger	TCBHD
Dietz-Neves	Debora	SUD Supervisor	TCBHD
Fone	Donna	MHSA Coordinator	TCBHD
Hoskins	Betty	Crisis Supervisor	TCBHD
Jacobs	Judy	Senior Accountant	TCBHD
Kolby	Brock	Deputy Director	TCBHD
Lujan	Lindsey	QI Agency Manager	TCBHD
Mariscal	Tami	Deputy Director	TCBHD
Porta	Robert	Planned Services Supervisor	TCBHD
Wilson	Michael	Behavioral Health Director	TCBHD
Villanueva	Donna	FSP Supervisor	TCBHD

Attachment C—ACA Penetration Rates and ACBs

Table C1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table C1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Tuolumne MHP					
Entity	**Average Monthly ACA Enrollees**	**Beneficiaries Served**	**Penetration Rate**	**Total Approved Claims**	**ACB**
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Small	171,297	8,082	4.72%	$39,384,225	$4,873
MHP	3,873	305	7.88%	$1,143,869	$3,750

Attachment D—ACB Range Distributions

Table D1 shows the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Table D1: CY 2019 Distribution of Beneficiaries by ACB Range

Tuolumne MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	932	95.01%	93.31%	$2,801,099	$3,005	$3,998	57.90%	59.06%
>$20K - $30K	27	2.75%	3.20%	$640,255	$23,713	$24,251	13.23%	12.29%
>$30K	22	2.24%	3.49%	$1,396,722	$63,487	$51,883	28.87%	28.65%

Attachment E—List of Commonly Used Acronyms

Table E1: List of Commonly Used Acronyms

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

Acronym	Full Term
COVID-19	Corona Virus Disease-2019
CPM	Core Practice Model
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CURES	Controlled Substances Utilization Review and Evaluation System
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FTE	Full Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

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

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

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