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

ORANGE MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

November 17 – 19, 2020

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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 Orange 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 — Large

MHP Region — Southern

MHP Location — Santa Ana

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 25,321

MHP Threshold Language(s) — Spanish, Vietnamese, Farsi, Korean, Chinese, Arabic

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 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 INs 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 Standard (AAS)

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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.

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 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 will review these forms to determine if the provider networks met required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services to youth and adults. If these standards are not met, DHCS will require the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, these will be reviewed by CalEQRO as part of their annual quality review process with a structured protocol to assess access and timeliness and validation of the AAS and any plan of correction or improvement of the services to Medi-Cal recipients living in the zip codes requiring an AAS.

CalEQRO reviews the NACT provider files, maps of clinics closest to the AAS zip codes, and distances to the closest providers by type and population. If there is no provider within the time or distance standard, the MHP shall develop and propose an AAS plan, and access to any alternative providers who might become Medi-Cal certified for the MHP. The MHP shall submit a plan of correction addressing the needs to meet the AAS.

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 will review grievance and complaint log reports, facilitate beneficiary focus groups, review claims and other performance data, and review DHCS-approved corrective action plans.

Validation of State and MHP Beneficiary Satisfaction Surveys

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

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, contracted providers, advisory groups, beneficiaries, 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 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations with the MHP. 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 the clinical PIP, comprehensively describe linkage with a peer mentor and the peer mentor's interventions (as presented during the on-site review) in the PIP submission tool to make the clinical nature of the PIP clearer.

Status: Met

- The MHP adequately described the interventions and how these interventions can be considered clinical in nature.
- The MHP explained the involvement and role of the clinicians in delivering the PIP interventions.

Recommendation 2: For the non-clinical PIP, refine the methodology to capture more accurately those receiving five or more SMHS encounters each year. Modify the first performance indicator to reflect more of a survival analysis type approach wherein all members of the cohort have the least common time denominator to receive five or more encounters.

Status: Partially Met

- The MHP suspended this non-clinical PIP and its interventions due to COVID-19 restrictions.
- The MHP has embarked upon a new non-clinical PIP that remains in planning stages at the time of FY 2020-21 EQR.

Access Recommendations

Recommendation 3: Include in the Quality Assessment and Performance Improvement (QAPI) plan the evaluation of the 24/7 Access Line experiences of beneficiaries.

Status: Met

- The MHP uses a 7-item beneficiary satisfaction survey specifically to assess beneficiary experience with the Access Line.
- The results are tabulated for the previous four quarters and presented at the quarterly Quality Improvement (QI) meetings.
- While the results from this survey are generally positive, the response rate to this survey remained low at 5 percent or below, depending on the quarter. The MHP noted ongoing discussions with its Administrative Services Organization (ASO) for strategies to improve the survey response rate.
- Additionally, the MHP sets goals of 95 percent or higher for Access call response time of 30 seconds or less in its QAPI plan.

Timeliness Recommendations

Recommendation 4: Develop capability to track adult psychiatry timeliness for contract providers as well as direct county providers.

Status: Partially Met

- During the past year, the MHP has undertaken two performance improvement activities to better capture this information that has not gone system-wide yet.

- The MHP has developed a meds service access (MSA) report that uses a template for the contract providers to report uniformly on the needed data elements for this metric.
- At the time of the EQR, the MHP was in the process of drafting a letter to notify all contract providers on this data reporting requirement.
- The MHP is developing a programming script that will allow merger of these data from multiple sources and reporting on this metric system-wide.

Recommendation 5: Research and resolve the discrepancies in the MHP reports that 98.7 percent of urgent requests were offered an appointment within the same or next day and actual service encounters data of less than 50 percent.

Status: Partially Met

- This recommendation remains a work-in-progress.
- The MHP's analysis revealed many requests for urgent appointments from a single hospital.
- The MHP plans to remove these referrals from the data set, but it is unclear why that would be appropriate.

Recommendation 6: Develop capability to track no-shows for the entire SOC, to include contract providers and FC beneficiaries. Report quarterly disaggregated results by program.

Status: Partially Met

- MHP staff have developed a template that captures the data required for the MSA report, which includes no-shows. The template is intended to model the data required from contract providers.
- At the time of this EQR, the contract providers had not been notified of the new planned process.
- MHP staff described an initial plan to develop a process to leverage telehealth capability within clinics to cover urgent psychiatric need when there are psychiatric no-shows.

Recommendation 7: Establish and track timeliness data for a standard for no-shows for psychiatrists and clinicians other than psychiatrists, respectively.

Status: Partially Met

- The MHP established standards of 15 and 10 percent no-show rates respectively for psychiatrists and clinicians based on statewide averages and reported data for directly operated facilities.
- The MHP cannot yet capture and report no-shows for contract providers.

Quality Recommendations

Recommendation 8: Develop capability to track through the continuum of care for all programs, to include contract providers and FC beneficiaries.

Status: Not Met

- The MHP has defined the continuum of care by service type with a comprehensive listing of programs according to service intensity.
- No-shows are not tracked for foster care.
- Several timeliness measures do not include contract provider information.
- Hospitalizations of MHP beneficiaries are not consistently reported to the MHP.
- MHP clinical staff and contracted providers were not aware of the process to refer beneficiaries to a lower level of care to be provided by the managed care plan.

Recommendation 9: Develop and implement in a long-term and orchestrated effort to engage prospective new staff starting in high schools through graduate schools.

Status: Met

- During this past year, the Orange County Health Care Agency (OCHCA) has increased efforts to engage new prospective staff. Human resources and behavioral health staff have attended career days at local high schools, along with career fairs at two-year colleges, four-year colleges, and graduate schools. To-date, MHP staff attended two high school career days and fourteen career fairs; three additional career fairs are planned for the remainder of this year.
- Children and Youth Behavioral Health (CYBH) engages students in graduate schools through job fairs and intern/placement events. Intern placements vary by program. Student interns, both pre- and post-doctoral, are accepted in various placements throughout CYBH. MHP programs that focus on system-involved youth have California Psychology Internship Council (CAPIC) internship placements in Probation and Child Welfare facilities. Western Youth Services (WYS) has an American Psychological

Association (APA) approved internship/fellowship program for post-graduate psychologists, some of whom have remained with WYS as employees following their post-graduate placement.

- CAPIC and APA placements have led to multiple employment opportunities within the MHP.

Recommendation 10: Attend Job Fairs at both two and four-year colleges to advertise the availability of employment within the MHP.

Status: Met

- During this past year, MHP employees attended fourteen job fairs at two-year and four-year colleges to advertise positions available within the MHP and plan to attend three more job fairs planned for this year. In addition to the job fairs, Human Resources has advertised open positions on an external healthcare job board site called CareerVitals to increase the MHPs candidate pool.

- The CYBH Intern Coordinators regularly attend job fairs and intern/field placement events at local colleges and universities to provide information about OCHCA/MHP internship and field placement information and employment opportunities.

Recommendation 11: Speak to the graduating students in nursing, psychology, social work, and child development classes at both two and four-year colleges to advertise the availability of employment within the MHP.

Status: Met

- While at career fairs, human resources and behavioral health employees spoke to students regarding the employment opportunities within the MHP for nurses, psychologists, social workers, and psychiatrists.

- Human resources has been advertising open positions on an external health care job site called CareerVitals.

- CYBH has demonstrated a commitment to helping students gain experience in a clinical setting by identifying staff clinical supervisors to participate in the Southern California Regional Partnership's clinical supervision project for advanced training. This investment will be used to develop a reputation and record for providing high quality supervision and training for students in the field of behavioral health. Plans include this clinical supervisor becoming a "champion" for supervision and training, and being available for outreach to college and university internship programs in Orange County and contiguous counties.

- CYPBH has attended multiple psychiatry-related events in order to share information about psychiatry positions within OCHCA.

Recommendation 12: Establish internships and placements for all levels of students for the purpose of the MHP "growing your own" future staff.

Status: Met

- OCHCA has worked diligently over the past several years to develop and grow a robust intern program for the MHP as well as the Substance Use Disorder (SUD) clinics. OCHCA has collaborated with both local and on-line universities to bring in MSW/MFT first- and second-year master level students for MHP and SUD clinic placements. The OCHCA staff, along with volunteer services, attend various local university intern fairs to promote placement opportunities.

- Students are interviewed by OCHCA to determine the best clinic for placement based on the students' experience and their desired learning interests. Students attend an intern orientation day that includes the final on-boarding process through volunteer services and essential training before starting their placement. OCHCA provides both clinical and macro level placements. Many students apply for jobs with the County of Orange for employment after their placement is complete.

- Currently, the CYBH designated student intern coordinators (licensed clinicians) are responsible for recruitment, receipt of applications, and interviewing students from local colleges and universities who are looking to complete their practicum/internship placements in a children's outpatient clinic setting. These coordinators also attend internship fairs and events to talk to students about interning and working for OCHCA. In FY 2019-20, CYBH hired several former student interns from local colleges.

- The MHP contracted community-based organizations (CBOs) have multiple internship placements. WYS has an APA approved internship/fellowship program for post-graduate psychologists, some of whom have remained with WYS as employees following their post-graduate placement.

- CYBH accepts child psychiatry fellows from the University of California, Irvine, who provide psychiatric services to youth in in one of the MHP programs. Ongoing supervision and training are provided to these fellows. Several former fellows have sought employment with OCHCA following their placements with CYBH.

Beneficiary Outcomes Recommendations

None noted.

Foster Care Recommendations

Recommendation 13: Continue to meet with social services agency (SSA), probation, and foster family agencies (FFAs) to implement recruitment of Intensive Services Foster Care (ISFC) level resource families, to eventually be trained to implement Therapeutic Foster Care (TFC) services as ISFC families.

Status: Partially Met

- The MHP continues to work with SSA, juvenile probation and FFAs. However, it noted two reasons why SSA and FFA have not yet been able to implement IFSC or secure a IFSC home in the entire county:
    - Challenges in obtaining the Specialized Care Increment Rate approvals for ISFC homes.
    - Difficulty recruiting resource families who are willing and able to accept youth with higher levels of need.
- The agencies plan to recruit caregivers who are already trained to provide higher levels of services and supervision to high needs youth, and to incorporate the TFC services within these homes.
- The agencies have obtained the board of supervisors' approval for 20 additional Full-Service Partnership (FSP) slots dedicated to the ISFC homes when these become available.

Information Systems Recommendations

Recommendation 14: Complete the implementation of electronic laboratory results receiving and posting into the specific beneficiary record in the EHR. (This is a carry-over recommendation from FY 2018-19.)

Status: Not Met

- The MHP planned to begin the implementation of the electronic Lab orders and results interface after a Cerner Millennium upgrade. The upgrade go-live has been delayed due to outstanding issues that have been deemed to be so significant that the MHP cannot go live until they are resolved. The MHP plans to resume activity related to the lab orders and results interface after the upgrade is complete.

Recommendation 15: Complete an analysis of the diagnostic category "other" for total approved claims and total beneficiaries served. (This is a carry-over recommendation from FY 2017-18.)

Status: Met

- The MHP completed an analysis using available approved claims data from calendar years 2017 and 2018.

Recommendation 16: To support Information Notice 18-011 data tracking requirements, assign staff resources necessary to assure the data is captured efficiently, preferably by EHR, and available for analysis and reporting. (This is a carry-over recommendation from FY 2018-19.)

Status: Met

- OCHCA identified positions to work on the federal Medicaid managed care final rule projects. IT has successfully filled the open positions noted in the ISCA FY 2018-19 and brought in interns to assist with the projects.

Recommendation 17: Outreach through statewide advertising and one-on-one assistance in negotiating the hiring process for IT slots. Work closely with HR to be able to one-on-one walk applicants through the hiring process to decrease the 30 percent vacancy rate.

Status: Met

- OCHCA IT has successfully filled the open positions noted in the ISCA FY 2018-19. OCHCA has one unfilled position due to a recent retirement. This position is expected to be filled in November 2020.

Recommendation 18: Evaluate the type and level of IT resources dedicated to MHP service needs for daily operations, improved reporting capabilities, and the delivery of significant initiatives which will move the organization forward. (This is a carry-over recommendation from FY 2017-18.)
(This recommendation is a carry-over from FY 2018-19.)

Status: Not Met

- IT has successfully filled the open positions noted in the ISCA FY 2018-19. OCHCA has one unfilled position due to a recent retirement. This position is expected to be filled in November 2020.

- There is no indication that the MHP evaluated the type and level of IT resources needed by the MHP for daily operations, improved reporting capabilities, and the delivery of significant initiatives to move the organization forward.

Structure and Operations Recommendations

Recommendation 19: Consider one common EHR system for contract providers and the MHP.

Status: Met

- OCHCA is negotiating contracts with Cerner and Orange County Partnership Regional Health Information Organization (OCPHRIO) to provide a data exchange solution for data sharing between OCHCA and OCHCA's contract providers, using a modified form of the Continuity of Care Document (CCD) standard. The enhanced CCD standard will include specific additional data fields provided by OCHCA that are required for developing an interface with the Cerner EHR system.

Recommendation 20: Reorganize the MH Board report to include graphs and statistics to demonstrate community-wide engagement.

Status: Met

- The MHP plans to include graphs in the 2020 edition of the Mental Health Board Annual Report.

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]

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

1. Senate Bill (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: http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

3. Psychotropic Medication and HEDIS Measures: http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:

- 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 services or inpatient services, 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.
- 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).

- 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

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

4. Assembly Bill (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.

    - 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 (HIPAA) Suppression Disclosure

Values are suppressed to protect confidentiality of the individuals summarized in the data sets when the beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required 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

Orange 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	141,718	16.6%	6,660	26.3%
Latino/Hispanic	411,977	48.4%	11,809	46.6%
African-American	14,336	1.7%	921	3.6%
Asian/Pacific Islander	165,926	19.5%	2,170	8.6%
Native American	1,418	0.2%	106	0.4%
Other	116,636	13.7%	3,655	14.4%
Total	**852,008**	**100%**	**25,321**	**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.

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

Orange MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	6,300	24.9%
Vietnamese	919	3.6%
Farsi	68	0.3%
Other Languages	18,034	71.2%
Total	**25,321**	**100%**
Threshold language source: DHCS Information Notice 13-09.		
Other Languages include English		

Note: This threshold language summary was prepared using an older information notice. According to the most recent BHIN 20-070 on this matter, the MHP has three additional threshold languages, Korean, Chinese, and Arabic that are not reflected in this table and subsumed under Other Languages category.

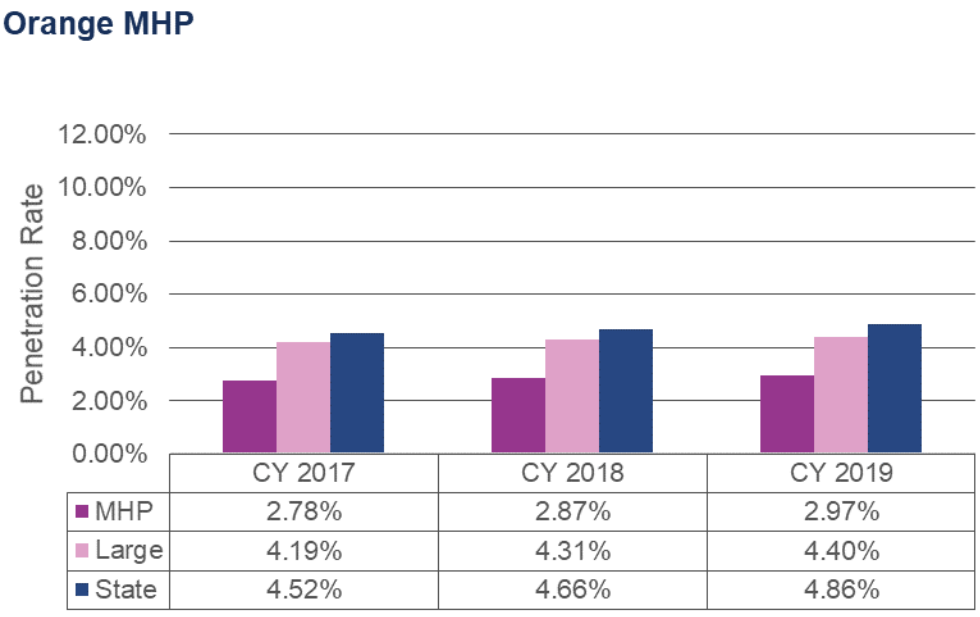
Penetration Rates and Approved Claims per Beneficiary

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 C provides further ACA-specific utilization and performance data for CY 2019. See Table C1 for the CY 2018 ACA penetration rate and ACB.

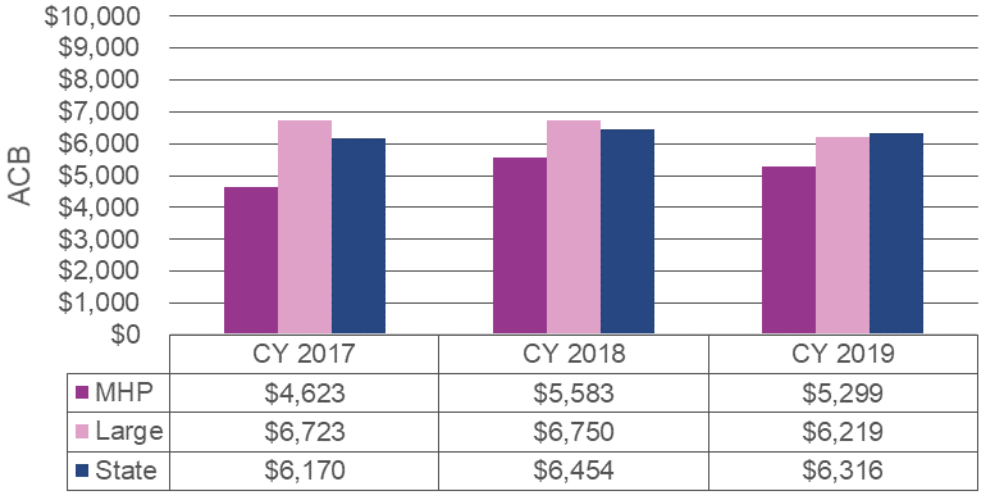
Regarding the calculation of penetration rates, the Orange MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	2.78%	2.87%	2.97%
Large	4.19%	4.31%	4.40%
State	4.52%	4.66%	4.86%

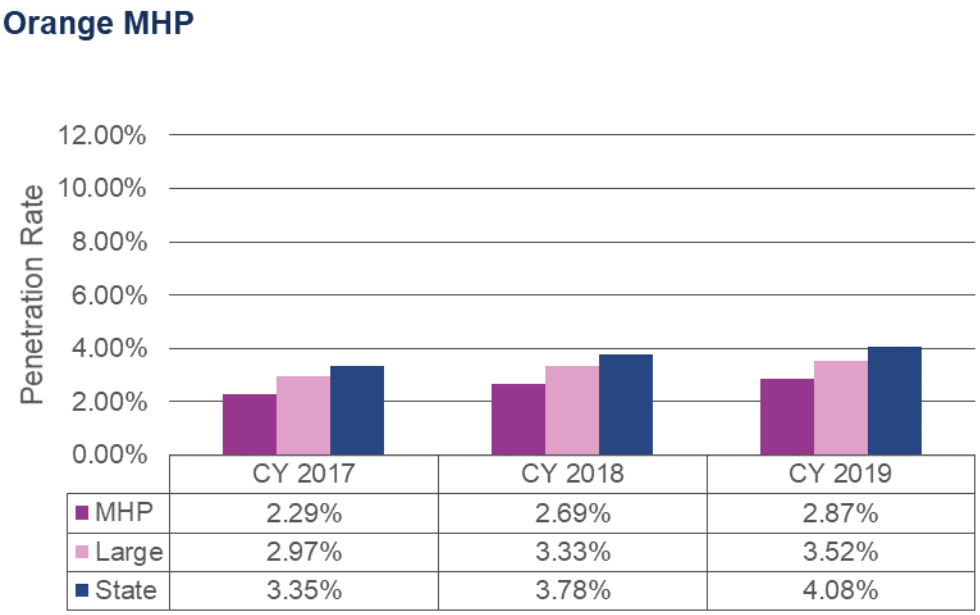
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$4,623	$5,583	$5,299
Large	$6,723	$6,750	$6,219
State	$6,170	$6,454	$6,316

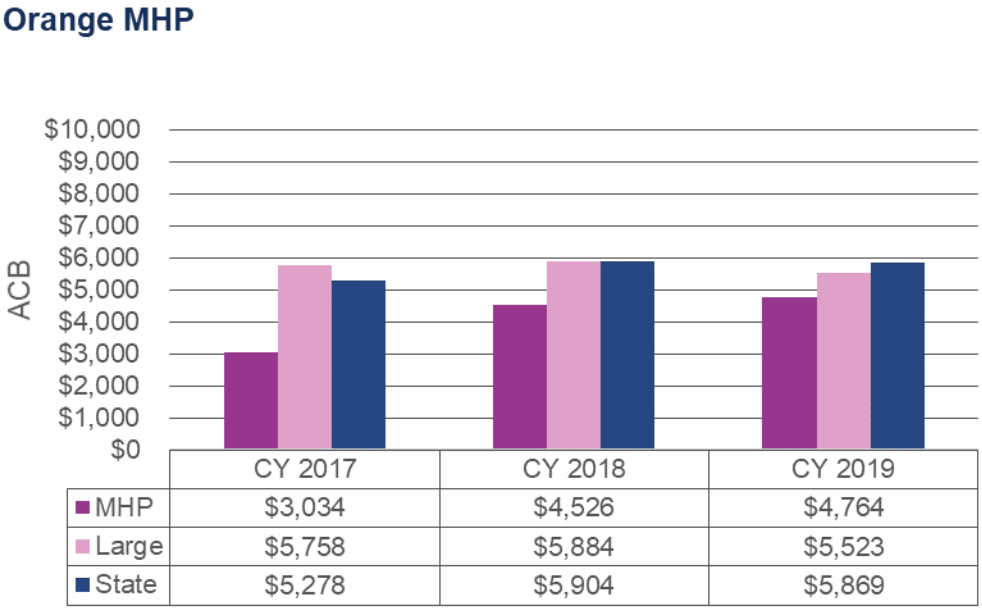
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

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



	CY 2017	CY 2018	CY 2019
MHP	2.29%	2.69%	2.87%
Large	2.97%	3.33%	3.52%
State	3.35%	3.78%	4.08%

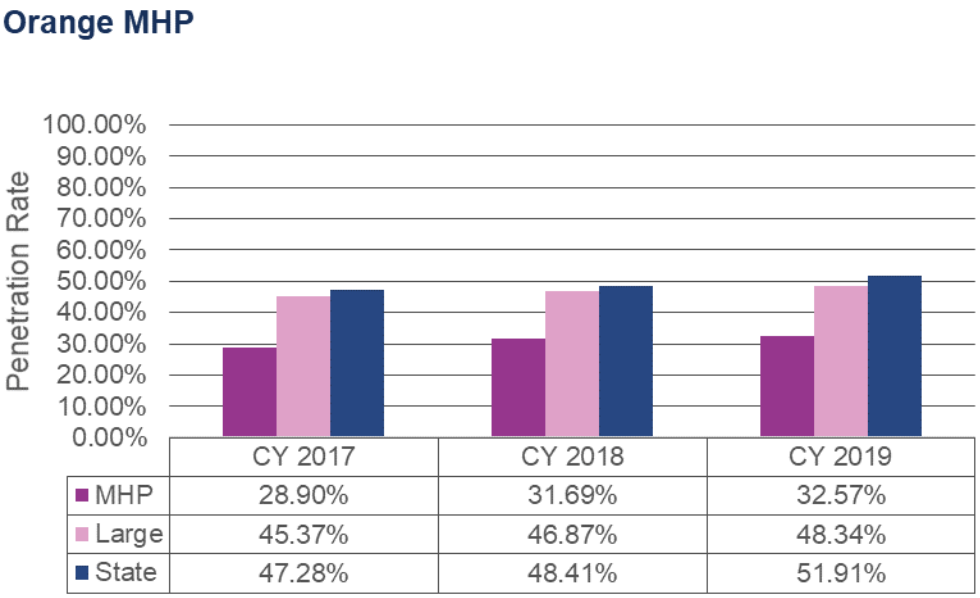
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$3,034	$4,526	$4,764
Large	$5,758	$5,884	$5,523
State	$5,278	$5,904	$5,869

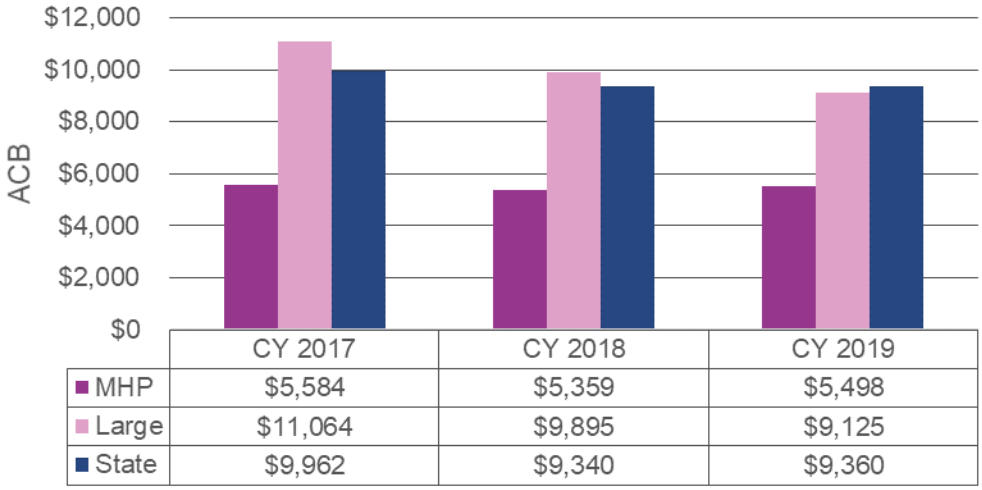
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for large MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	28.90%	31.69%	32.57%
Large	45.37%	46.87%	48.34%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

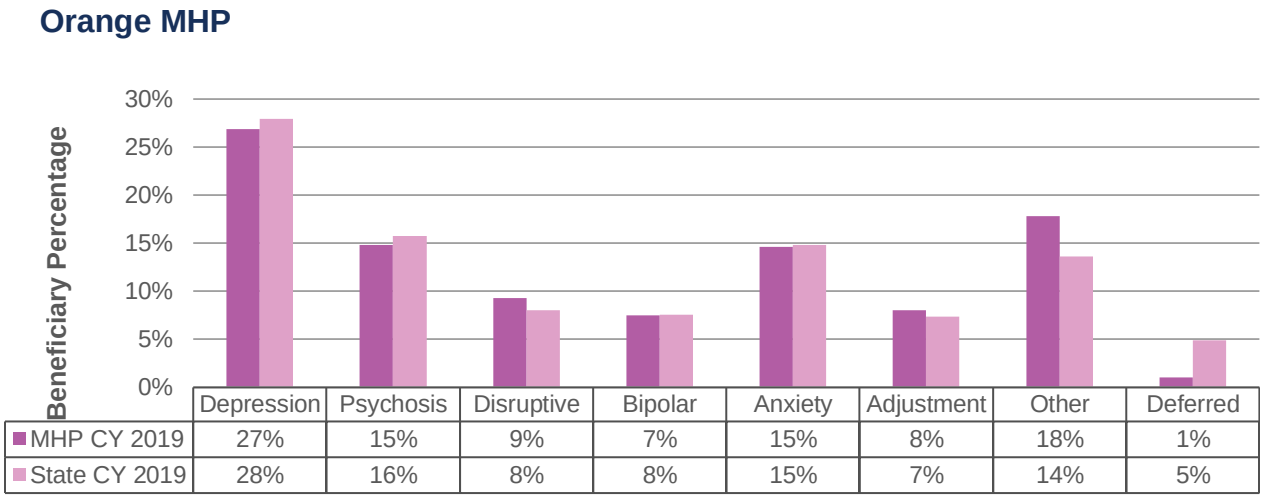


	CY 2017	CY 2018	CY 2019
MHP	$5,584	$5,359	$5,498
Large	$11,064	$9,895	$9,125
State	$9,962	$9,340	$9,360

Diagnostic Categories

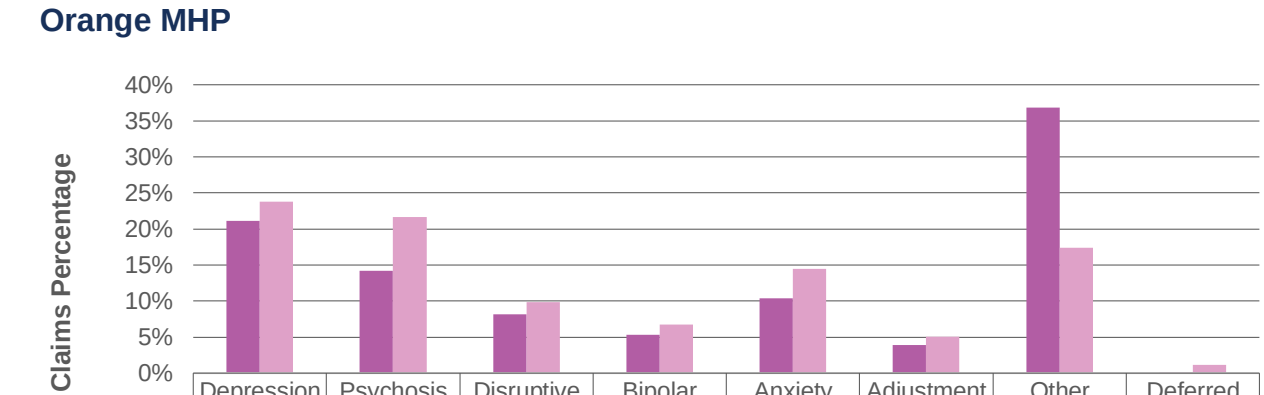
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	27%	15%	9%	7%	15%	8%	18%	1%
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	21%	14%	8%	5%	10%	4%	37%	0%
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

Orange 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	632	25,321	2.50%	$51,459	$32,521,820	24.24%
	CY 2018	853	25,505	3.34%	$62,884	$53,639,704	37.67%
	CY 2017	476	25,257	1.88%	$58,816	$27,996,295	23.98%

See Attachment C, Table C2 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

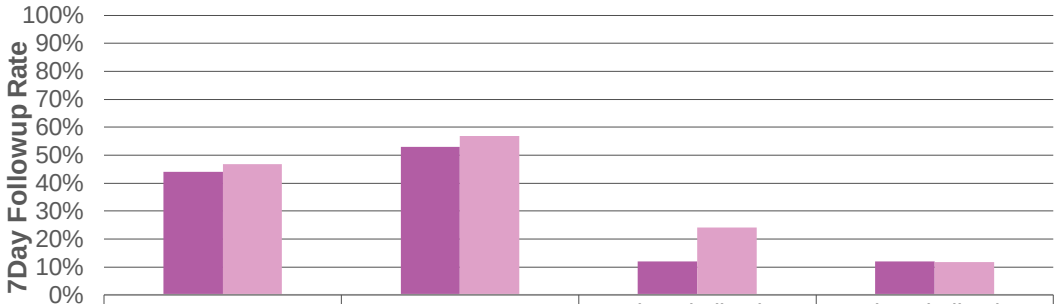
Orange MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	3,924	8,303	11.21	7.80	$11,357	$10,535	$44,566,799
CY 2018	3,810	8,470	15.28	7.63	$16,973	$9,772	$64,666,874
CY 2017	3,333	7,218	13.42	7.36	$11,366	$9,737	$37,882,832

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

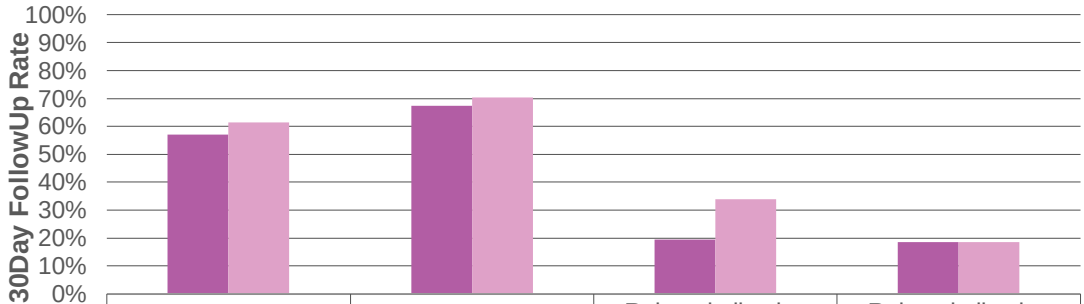
Orange MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	44%	53%	12%	12%
CY 2019	47%	57%	24%	12%

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

Orange MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	57%	67%	20%	19%
CY 2019	61%	70%	34%	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.

Orange 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 one PIP, as shown below.

Title 42, CFR, §438.330 requires two PIPs; the MHP is urged to meet this requirement going forward.

Table 5: PIPs Submitted by Orange MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Increasing rates of step-down to ongoing care following hospital discharge
Non-Clinical	1	Increasing Crisis Assessment Team (CAT) beneficiary linkage to outpatient services

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Orange
PIP Title	Increasing rates of step-down to ongoing care following hospital discharge
PIP Aim Statement	"Will providing peer mentoring services to adult clients who are hospitalized for psychiatric care during their transition to outpatient care improve the percentage who step-down to the first point of outpatient mental health services at Open Access from 38% to 55%, and for clients who made it to the first point of care, to more permanent ongoing outpatient mental health care from 75% to 84%."

MHP Name	Orange
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)	
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): The target population included in the first year of this PIP all adult beneficiaries who are receiving inpatient psychiatric care at Royal Therapeutic Residential Center (RTRC). The MHP has started the process of expanding the PIP to College Hospital, and in subsequent years, this PIP will be expanded to include beneficiaries receiving inpatient psychiatric care at other hospitals within Orange County.	

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):

PIP Interventions (Changes tested in the PIP)
Social workers who are stationed on the unit at the RTRC will identify beneficiaries who will be referred to the peer mentor intervention.
MHP/DMC-ODS-focused interventions/System changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The peer mentor intervention will involve embedding trained, experienced peers into the step-down process to assist beneficiaries with their transition from the inpatient setting to outpatient care.

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
Linkage indicator 1 - Step-down from inpatient hospitalization to Recovery Open Access (RAC).	2019	38%	2020 ☐ n/a*	58.3%	☒ Yes ☐ No	☒ Yes ☐ No p-value: ☒ <.01 ☐ <.05 Other (specify):
Linkage indicator 2 - Continuation to ongoing outpatient care. Note: This was affected by COVID-19. The results showed	2019	75%	2020 ☐ n/a*	76.2% .	☐ Yes ☒ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other

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
significant improvement (p<.05) the previous quarter						(specify): 0.46
30-day Hospital Readmission Rate for those who connected with a peer mentor vs. those who did not.	2019	n/a	2020 ☐ n/a*	With peer mentor 6% No peer mentor 11%	☒ Yes ☐ No	☐ Yes ☒ No p-value: ☐ <.01 ☐ <.05 Other (specify): 0.20
30-day Hospital Readmission Rate for those with step-down to RAC.	2019	n/a	2020 ☐ n/a*	RAC step-down 6% No RAC step-down 13%	☒ Yes ☐ No	☒ Yes ☐ No p-value: ☐ <.01 ☒ <.05 Other (specify):
Was the PIP validated?				☒ Yes	☐ No	
Validation phase: ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement						

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
☐ Other (specify):						
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence Justification for validation rating: The MHP presented all appropriate statistical test findings, as well as possible alternative explanations. Other than the impact of COVID-19, the results show that this PIP made a positive impact, and continued interventions are likely to maintain the improvement post-COVID-19. "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: • Expand this PIP to other psychiatric inpatient units in the county. • Incorporate staff and beneficiary survey feedback to enhance the PIP interventions.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • CalEQRO had previously provided TA in clarifying the clinical nature of this PIP. The MHP fully addressed this issue in this year's submission.						

*PIP is in planning and implementation phase if NA is checked.

Non-clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Orange
PIP Title	Increasing Crisis Assessment Team (CAT) beneficiary linkage to outpatient services
PIP Aim Statement	"Will implementing routine case management follow-up services for Medi-Cal-funded clients that are evaluated for hospitalization, but not hospitalized, by the Children's CAT increase the rate of linkage to outpatient services, defined as at least one non-CAT Specialty Mental Health Service, within 14 days of crisis 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)	
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: 0-21	
Target population description, such as specific diagnosis (please specify): The PIP population will be beneficiaries served by the Children's CAT. All beneficiaries that are served by CAT are eligible for case management services. However, the beneficiaries that will be initially included in the analysis are Medi-Cal-funded beneficiaries that were evaluated for hospitalization but were able to be diverted from inpatient care. The PIP analysis will further narrow the population to beneficiaries that were not open to behavioral health services prior to receiving crisis services. Those beneficiaries who are already open to the behavioral health system will already be established with a clinician and more likely to follow-up post-crisis. All beneficiaries served by Children's CAT will receive the intervention, but only the beneficiaries described above will be included in the analyses.	

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): Case management and linkage to outpatient services to children, youth, and their families following a crisis evaluation that results in inpatient diversion for the beneficiary.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Under development. Not clearly defined yet.
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): Under development. Not clearly defined yet.

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
Number of beneficiaries evaluated and diverted from hospital that received case management follow-up.	n/a	n/a	☒ n/a*	n/a	☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other

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
						(specify):
Number of beneficiaries receiving case management services	n/a	n/a	☒ n/a*	n/a	☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
Was the PIP validated?				☐ Yes	☒ No	
Validation phase: ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☒ Other (specify): The MHP was engaged in a different PIP trying to improve the engagement rate for children and youth beneficiaries until March 2020 when the interventions had to be suspended due to COVID-19 restrictions. Subsequently, the MHP embarked on the current non-clinical PIP, which remains in a planning phase at this time. This PIP was submitted during the review. CalEQRO was unable to validate or formulate any TA at the time of writing this report. This will be under discussion with the MHP and TA will be provided as and when appropriate.						
Validation rating: ☐ High confidence						

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
☐ Moderate confidence ☐ Low confidence ☒ No confidence Justification for validation rating: CalEQRO was unable to provide any validation rating due to the lack of detailed specifications in the submission at this time. "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: • Continue to develop this PIP by refining the performance and outcome indicators. • Further define the interventions, and how they relate to the identified gaps and barriers. • Justify the selection criteria for this PIP's target population, especially the reasons why it is narrowed.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • CalEQRO was unable to provide TA on this PIP due to timing of this submission. It will provide TA on this PIP throughout the period leading to next year's EQR.						

*PIP is in planning and implementation phase if n/a is checked.

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 information systems evaluation.

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site 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
Orange	4.40%	3.70%	3.00%	1.42%
Large MHP Group	n/a	2.81%	2.59%	2.88%
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 no BCP was selected above; the MHP uses an administrative service provider (ASP) model to host EHR system which provides 24-hour operational support.	☐ Yes	☐ No
The BCP (if the MHP has one) is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP organization clearly identified as having responsibility for Information Security.	☐ Yes	☒ No
If no one within the MHP organizational chart has responsibility for Information Security, does either the Health 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

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	33%
Contract providers	63%
Network providers	4%
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 equivalent (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	25	6	1	1
2019-20	20	2	2	6
2018-19	21	2	0	2

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	13	0	1	6
2019-20	14	0	1	6
2018-19	15	6	0	4

The following should be noted with regard to the above information:

- The number of data analytical FTEs has decreased over the last few years, and there is currently a 46 percent vacancy rate for these items. The MHP remains challenged to meet its needs for timely, accurate, and comprehensive information. This is especially true for services delivered by its contracted providers.

- MHP reports ongoing challenges to recruit qualified research analysts.
- The ISCA lists 12 projects for this FY, which is one project for every two technology FTEs. All 12 projects that started in FY 2019-20 or FY 2018-19 remained incomplete at the time of the review.
- Per Table 18 below, the MHP's count of EHR users supported by each IT employee is almost twice other large counties.
- The ISCA lists, in Table B.14, four user groups; contract provider employees do not participate in any of these. This is difficult to understand in an organization that delivers 63 percent of its services through contract providers.
- The OCHCA is building an enterprise data warehouse that will include MHP data. This project was not among the projects listed in the ISCA, yet it is particularly important to the MHP's ability to analyze its data and report information.

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 MHP and does not account for user's 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	165	290	455
Clinical Healthcare Professional	625	1395	2020
Clinical Peer Specialist	1	0	1
Quality Improvement	44	22	66
Total	835	1707	2542

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

Type of Staff	MHP FY 2020-21	Large Size MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	25.00	37.85
Total EHR Users Supported by IT (Source: Table 17)	2542.00	2084.00
Ratio of IT Staff to EHR Users	1:102	1:55

The following should be noted with regard to the above information:

- While there is no standard ratio of IT staff to support EHR user's, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 and FY 2020-21 ISCA.
- Table 18 results reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

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

- The following should be noted with regard to the above information:
- The "yes" answer regarding use of an ASP model, based on comments in the IS Leadership session, reflects a planned operational change rather than current operations.

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	☒	☐	☐	☐

The following should be noted with regard to the above information:

- The information applies to county-operated programs only. The corresponding table in the ISCA for contract providers was left blank.

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	101

Telehealth Services	Count
Number of county-operated telehealth sites	41
Number of contract providers' telehealth sites	60
Total number of beneficiaries served via telehealth during the last 12 months	1847
• Adults	126
• Children/Youth	1720
• Older Adults	1
Total Number of telehealth encounters (services) provided during the last 12 months:	31690

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

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

- The FY 2019-20 EQRO report indicates that the MHP did not use telehealth at that time. Before the state issued its COVID-19 guidelines in March 2020, the MHP began to rapidly deploy telehealth equipment and software as well as guidance for employees and contract providers on appropriate use. That rollout continues and is nearly complete.
- Contract providers, because they have more flexibility in purchasing, were able to make the transition to telehealth even more quickly than the MHP.

- Contract providers commented that the rapid shift in service delivery was accomplished through regular and clear communication and a spirit of collaboration that continues beyond the initial transition.

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				

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
AMHS Telecare	10
AMHS College Community Services	5
AMHS Mental Health Association	3
CYS Waymakers	8
CYS WYS	7
CYS Olive Crest	6

Contract Provider	Count of Sites
CYS Seneca	4
CYS Child Guidance Center	4
CYBH South Coast Children's Society	4
CYS Pathways	3
CYS Korean Community Services	2
CYS CHOC	2
Prevention Center	2

Current MHP Operations

- Millennium software version supporting EHR operations is: 2015.1.17.
- System-wide implementation of telehealth services has allowed the MHP and contracted providers to continue to provide services while offering flexibility to beneficiaries in how they receive services.
- The MHP has not closed clinics as the result of COVID-19. The number of employees on-site is greatly reduced to allow for appropriate distancing.

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 (SDMC) 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
Millennium	EHR Clinical & Billing	Cerner Corporation	17	Health Care Agency
ProCare	Pharmacy Benefit Management	ProCare	4	ProCare

The MHP's Priorities for the Coming Year

- Expand the use of Cerner EHR within the Drug-Medi-Cal-Organized Delivery System (DMC-ODS) EHR. Go-live is scheduled for December 2, 2020.
- Implement automated Medi-Cal eligibility checks through the use of 270/271 electronic data interchange (EDI) transaction set.
- Implement the 274 Expansion Project, a department-wide initiative to standardize the format, content and transmission of health plan provider network data submitted to DHCS.
- Implement the provider list (monthly) which is used to gather information about the MHP and DMC-ODS managed care clinicians and provider sites.
- Implement an appointment reminder system.
- Develop a model and technical design of an interoperability model to support data sharing and integration with contract providers.
- Implement a software to track the status of grievances.
- Implement a provider Credentialing tracking solution.
- Purchase an analytics solution.
- Improve and upgrade the overall Cerner EHR technical infrastructure to better support the use of the EHR.
- Implement electronic prescribing of controlled substances.
- Implement the quarterly NACT.

Major Changes since Prior Year

- Purchased and implemented additional Citrix licenses for staff to work from home.
- Augmented Security protocols for different threats with staff working from home.
- Rolled out 2,000 Laptops to OCHCA staff to support working from home.

Other Areas for Improvement

- The MHP lags timely upgrades to Millennium EHR system updates.
- The MHP has yet to implement electronic lab results.
- The MHP does not capture the language in which a telehealth session was conducted.
- All of the IS Priorities in this year's ISCA were previously listed in the FY 2018-19 ISCA and/or the FY 2019-20 ISCA. The COVID-19 public health emergency came into public view in February/March 2020, yet the only projects completed since the FY 2019-20 EQRO are COVID-19 related.
- The MHP's list of IS priorities does not overlap with the MHP's list of current initiatives. This may be the result of how EQRO asked for the information, but the IS priorities should also be business priorities. Projects that cannot be linked to the organization's business drivers should not be prioritized. Projects that require a heavy investment of resources with information technology skills are still fundamentally business projects.
- Between the IS list of priorities and the MHP's list of current initiatives, there are 16 projects. The two lists should be managed as a single portfolio of projects and prioritized based on the needs of the business. Only those that can be adequately resourced (staff and funding) and reliably completed in a reasonable time should be active at any time.

Plans for Information Systems Change

- There are no plans to replace the current system.

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	Cerner	☒	☐	☐	☐
Assessments	Cerner	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/Storage	Cerner	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Cerner	☒	☐	☐	☐
Laboratory results (eLab)	Cerner	☐	☐	☒	☐
Level of Care/Level of Service	Cerner	☐	☒	☐	☐
Outcomes	Cerner	☒	☐	☐	☐
Prescriptions (eRx)	Cerner	☒	☐	☐	☐
Progress Notes	Cerner	☒	☐	☐	☐
Referral Management	Cerner	☐	☐	☒	☐
Treatment Plans	Cerner	☒	☐	☐	☐
Summary Totals for EHR Functionality:					
FY 2020-21 Summary Totals for EHR Functionality:		8	1	3	0
FY 2019-20 Summary Totals for EHR Functionality:		8	0	4	0
FY 2018-19 Summary Totals for EHR Functionality:		8	0	4	0

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

- The MHP continues to work to develop and maintain the EHR, however improvements and development of priority projects continue to be impacted by IT and data staff capacity and COVID-19.
- Table 25 has changed very little in three years. Progress is slow.

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
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	15%	Weekly
Direct data entry into MHP EHR system by contract provider staff	85%	Daily
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

Table 26 does not reflect the content of the ISCA, which stated that 85 percent of contract provider services were submitted to the MHP through EDI. The MHP does not currently have the capability to exchange data with the contract providers using EDI.

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 Contract Provider to MHP Data Transmission

EHR Vendor	Product	Count of Providers Supported
None reported.		

NOTE: The MHP has not required contract providers to list or vet their EHR since services are directly entered into the MHP's system. However, the MHP stated they are working with the OCPHRIO to develop the capability to exchange data electronically with its contract providers who have their own EHR. Knowledge of the systems used by contract providers will likely be useful in that process.

Personal Health Record (PHR)

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

☒ Yes ☐ No ☐ Implementation Phase

The PHR is known as the OCHCA Portal. Some beneficiaries served by contract provider have access to their health records through the contract provider's EHR.

Expected implementation timeline:

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

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 SDMC claims. The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments by Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.

Table 29: Summary of CY 2019 Short-Doyle/Medi-Cal Claims

Orange MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**464,631**	**$96,051,978**	**7,690**	**$1,622,642**	**1.66%**	**$94,429,336**	**$92,134,011**
JAN19	40,066	$7,575,647	681	$138,701	1.80%	$7,436,946	$7,222,199
FEB19	35,380	$7,023,958	566	$103,617	1.45%	$6,920,341	$6,772,010
MAR19	40,572	$8,589,618	680	$131,611	1.51%	$8,458,007	$8,291,025
APR19	41,474	$8,848,370	612	$151,939	1.69%	$8,696,431	$8,447,424
MAY19	40,941	$8,751,501	612	$145,358	1.63%	$8,606,143	$8,408,941
JUN19	36,716	$7,828,176	572	$134,780	1.69%	$7,693,396	$7,507,409
JUL19	39,474	$8,143,515	583	$131,529	1.59%	$8,011,986	$7,852,525
AUG19	38,605	$8,051,646	673	$128,446	1.57%	$7,923,200	$7,721,842
SEP19	37,639	$7,820,948	701	$135,563	1.70%	$7,685,385	$7,489,891
OCT19	42,123	$8,745,450	710	$142,792	1.61%	$8,602,658	$8,435,780
NOV19	35,716	$7,287,904	745	$150,270	2.02%	$7,137,634	$6,951,477
DEC19	35,925	$7,385,244	555	$128,036	1.70%	$7,257,208	$7,033,488

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.**

Table 30 summarizes the top five reasons for claim denial.

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

Orange MHP			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	2,025	$462,954	29%
Medicare or Other Health Coverage must be billed before submission of claim.	1,839	$328,225	20%
Beneficiary not eligible.	1,655	$312,483	19%
Service line is a duplicate and a repeat service procedure code modifier not present.	1,579	$281,314	17%
Beneficiary not eligible or non-covered charges.	389	$176,604	11%
Total	7,690	$1,622,642	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 ICD-10 diagnoses code, and Medicare or Other Health Coverage are 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 technical assistance 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 recommendation 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 Orange County Behavioral Health, the time and distance requirements are 30 minutes and 15 miles for mental health services, and 30 minutes and 15 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, AAS) 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 two consumer and family member (CFM) focus groups, one stakeholder interview, two staff and contractor interviews, and discussed access and timeliness issues to identify problems for beneficiaries in these areas.

Findings

The 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

While the MHP is not under a Plan of Correction for Network Adequacy, it has incorporated the following strategies to enhance access has for Medi-Cal beneficiaries:

- The MHP has a translation service to provide assistance to beneficiaries who are hard of hearing. It has a Plan Coordinator who provides services to most of the deaf and hard of hearing beneficiaries who are admitted.
- The MHP has transportation programs available to beneficiaries accessing mental health services by using the CalOptima transportation program and the taxicab transportation program. The plan offers transportation vouchers through a contract with the company Yellow Cab. To access services, beneficiaries receive a card to authorize them from their plan coordinator and the beneficiary can then call yellow cab to set up transportation for his/her appointments.

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 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	8
NPI Type 1 and 2 numbers are the same	68
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	23
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	3
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	7

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested three focus groups with 10 to 12 participants each. However, due to COVID-19 restrictions, CalEQRO and the MHP agreed on two focus groups, the details of which can be found in each section below.

The CFM focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFMs for their participation.

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	Culturally diverse adult beneficiaries representing both high and low utilizers of service.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	None
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group:	
Access - new beneficiaries	n/a
Access – overall	The participants learned about SMHS from various sources, mostly from law enforcement and crisis services. Most participants use public transportation to receive in-person services. Those who use public transportation noted receiving assistance from the MCP.

Topic	Description
Timeliness	The participants were all satisfied with the frequency of services including case management, therapy, and psychiatry appointments. Most participants also reported receiving reminder calls for their appointments.
Urgent care and resource support	All participants in this group reported that they would call their therapist or case manager for any urgent needs.
Quality	The participants expressed diametrically opposite experience with telehealth. For those with children or who had other challenges in going to the clinics, telehealth opened a new way to address those challenges and yet receive the care they needed. For those with lack of privacy at home or residence, or difficulty understanding the therapist and establishing therapeutic alliance, telehealth has been an ongoing challenge that they are working through. Most participants reported receiving adequate information about their medications, and believed that their primary care physician and psychiatrist communicate about their physical health and prescriptions. One participant did not believe the two physicians communicated. One participant noted being in a program where the staff are nice and positive.
Peer employment	Most participants reported receiving information from about employment services either from the MHP or from other adjunct services, but all reported not yet being ready to work at this time.
Structure and operations	Most participants reported receiving information about events and happenings at the MHP through flyers or from the internet. One participant reported completing a satisfaction survey. None reported being involved in any MHP committees.
Recommendations from this focus group	• Provide more resources to become and stay active while COVID-19 restrictions are in place.
Any best practices or innovations (optional)	• Regular appointment reminders.

CFM Focus Group Two

Table 33: Focus Group Two Description and Findings

Topic	Description
Focus group type	Culturally diverse (including non-English speaking) parent/caregivers of children/youth beneficiaries, representing both high and low utilizers of service, most of whom started services within the past year.
Total number of participants	Four
Number of participants who initiated services during the previous 12 months	Four
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group:	
Access - new beneficiaries	Learning about the services for new foster parents can be difficult, but the MHP connected this group of participants' wards quickly. For experienced foster parents there is no access issues.
Access – overall	The participants reported that transferring services and connecting with new services were easy. They also noted that due to COVID-19, many of the services are done via telehealth, but they did not experience any issues with that. Some of the specialty services continue to be in person that cannot be done remotely.
Timeliness	Most participants were satisfied with the length of time it took to connect to services. It appeared that occasionally for FC access to mental health services there are delays that can be attributed to extraneous factors such as change in county of responsibility, not to the MHP's access process.
Urgent care and resource support	Participants were all aware of the ways to get urgent help and who to call if their children experience any crises.
Quality	Those who have experienced IHBS, noted it to be a very helpful service for their children. Some would like to see even greater communication during the weekly team meetings for non-IHBS services. Participants expressed the

Topic	Description
	need for more support group opportunities with other FC parents.
Peer employment	None noted.
Structure and operations	The participants did not know whose ultimate responsibility it is but noted that transitions involving out-of-county transfers can cause delays in service access.
Recommendations from this focus group	• Provide training or workshops for new foster parents about service access, availability, and what to expect. • A manual for the new foster parents will also be helpful. • Organize peer support groups for foster parents.
Any best practices or innovations (optional)	• IHBS was noted to be very helpful.

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 34 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 34: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	13
The MHP provides interpretation services, and the website has translations in all threshold languages. The MHP maintains an up-to-date and user-friendly provider directory that is linked to its website. The provider directory is searchable by type of provider and location. The search results can be displayed as a list or a map. The MHP has a combined beneficiary access line (BAL) with DMC-ODS to better facilitate appropriate screening and referrals. The MHP assesses the response time, use of the script to respond to BAL calls, and connection to and response of the language line as needed. The MHP has undertaken a new initiative called the OC Links. OC Links provides information and linkage to any of the Health Care Agency's Behavioral Health Services, including crisis services, via telephone and chat. Callers can be potential participants, family members, friends, law enforcement and other first responders, providers or anyone seeking out behavioral health resources and support. Trained Navigators provide information, referral, and linkage directly to programs in the			

Component		Maximum Possible	MHP Score
behavioral health continuum of care from prevention through crisis identification and response. It is fashioned after a model in place at the State of Arizona Medicaid Agency for a number of years. The MHP continues to lag full inclusion of contract provider access in its access metrics.			
1B	Capacity Management	10	9
The MHP made major and rapid adjustments to its service delivery to cope with the challenges posed by COVID-19 on face-to-face services. This MHP did not have any telehealth in place prior to the pandemic. It had to rapidly ramp up its telehealth capacity countywide and for mental health service modalities that are not typically offered through telehealth. This required significant staff and contract provider training. Since the beginning of the pandemic, the MHP has monitored the downward trends in its penetration rates specifically to evaluate the impact of the pandemic on SMHS access and has adopted strategies accordingly. The MHP conducts comprehensive analysis of disparities based on demographics and other factors and implements strategies to alleviate such disparities. One of the six strategies that the MHP has undertaken with the funds it received under the Coronavirus Aid, Relief, and Economic Security (CARES) Act is to address health disparities.			
1C	Integration and Collaboration	24	24
The MHP provided numerous examples of its integration and collaboration with other county agencies, the managed care plan CalOptima, law enforcement, courts, social services, and the MHP contract providers. The contract providers noted better communication from the MHP administration and increased transparency since the beginning of the pandemic. For its current clinical PIP on connection to and engagement with outpatient services post-inpatient hospitalization, the MHP has collaborated closely with RTRC, the inpatient unit accounting for the greatest number of hospitalizations for the MHP beneficiaries. The most ambitious and innovative collaborative project is the Anita Street Be Well (OC BeWell) campus that will offer various MHP and SUD treatment services within a single campus. The services here will include the county's first residential treatment facility to treat individuals with co-occurring mental illness and SUD diagnoses. The MHP is working with CalOptima to address the physical health care needs of the MHP beneficiaries at its county-operated clinic locations.			

Timeliness of Services

As shown in Table 35, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 35: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	16
The MHP combines two separate access logs to calculate the overall first offered appointment timeliness metric. The main access (MA) log is used to track approximately 85 percent of the access requests through access line, walk-ins, and e-mail and other means. This information is stored in and accessible from the MHP's EHR system. Another 15 percent of the calls for mental health access come in through a beneficiary access line (BAL) which primarily captures the calls originating from Medi-Cal beneficiaries primarily served by the Orange County managed care plan, CalOptima, who are referred to the county behavioral health services. Since the county has integrated behavioral health services, the BAL captures requests for both DMC-ODS and MHP services. The MHP stated that most of the calls to BAL are for DMC-ODS services, and a small percentage is deemed to require SMHS either standalone or in conjunction with DMC-ODS services. The overall first offered appointment timeliness report includes information from both MA and BAL, whereas the stratified first offered appointments for adults, children, and FC beneficiaries, included only the MA log data as the BAL data cannot be broken into these categories. However, the MA log captures all children and FC beneficiaries. The MHP reported an overall mean of 2.28 days for first offered appointments and met the 10 business days standard for 99.7 percent of the initial SMHS access requests. The MHP also has designated open access clinic locations where beneficiaries are able to walk-in for their first appointment.			
2B	First Offered Psychiatry Appointment	12	5
The MHP is able to report on this metric for the county operated sites only. This is an issue that CalEQRO has identified in previous reports, and made a recommendation to remedy it in the FY 2019-20 report. The MHP cited the primary barrier to capturing and reporting on contract provider data for first offered psychiatry appointment to be the different information systems used by the contract providers. The current state of the county's health information exchange (HIE) does not allow for uniform monitoring of this metric for the contract providers.			

Component		Maximum Possible	MHP Score
Further, the MHP does not have a defined set of parameters for the events that will count as the triggering events to start the clock. Lacking such definitions, the MHP uses the day stamp on its practice management software when a psychiatry appointment was scheduled as the triggering event. This precludes a true measurement of the time between the request for such service or treatment team decision point to seek psychiatry appointment and the offered date for such. During the past year, the MHP has undertaken two performance improvement activities to better capture this information that has not gone system-wide yet. It has developed the MSA report that uses a template for the contract providers to report uniformly on the needed data elements for this metric. At the time of the EQR, the MHP was in the process of drafting a letter to notify all contract providers on this data reporting requirements. The MHP is also developing a programming script that will allow merger of these data from multiple sources and reporting on this metric system-wide.			
2C	Timely Appointments for Urgent Conditions	18	13
The MHP handles all urgent appointment requests without requiring prior authorization. Therefore, the 96-hour standard for those requiring prior authorization does not apply. The MHP has a 2-day standard for all urgent appointments. The MHPs EHR does not have a time stamp, only a date stamp. This severely limits the MHP's ability to calculate this metric in an accurate manner. From the data presented in its own assessment of timeliness, it appears that this limitation artificially lowers the percentage of appointments that meet its standard. The MHP reported that it is in the process of remedying this issue with a proper time stamp for urgent requests across the system. The MHP has the CAT and a psychiatric emergency response team (PERT) that is a part of the CAT team. The PERT teams are specifically for ride along with law enforcement from local police departments (PDs). There are currently 17 PERT teams that are assigned to different PDs. While the CAT teams are available 24/7, the PERT teams are available for a limited number of days and hours depending on the arrangement with the respective PDs. In addition, all walk-in clinics have the capacity to provide crisis assessment. For this year's review, the MHP was able to furnish only one quarter worth data on this metric. At the time of the review, it was waiting for the completion of all 837 transactions to compute its annual figures.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	8
The MHP has developed a comprehensive data tracking, collection, and analysis for follow-up care post-inpatient discharge. It uses data matching between its hospital log			

Component		Maximum Possible	MHP Score
and claims data to calculate the metric. The hospital log consists of the treatment authorization requests (TARs). During FY 2019-20, the MHP developed the capability to separately compute this metric for its FC beneficiaries. This subset of beneficiaries had the highest rate of 83.5 percent of inpatient follow-up services, whereas the timeliness standard for all was met only 64.0 percent of the time. For the adult beneficiaries, this rate was even lower at only 30.5 percent; two-thirds of beneficiaries who were discharged from inpatient units did not receive a follow-up service within seven days of discharge. The MHP's current clinical PIP targets this issue through offering prompt assessment and connecting the discharged adult beneficiaries with peer mentors who ensure service continuity and treatment attendance through Recovery Open Access. However, in the initial phases, the MHP has kept the PIP limited to RTRC only, the inpatient unit accounting for the most inpatient episodes in the county. Due to COVID-19, the face-to-face peer services were curtailed. The MHP reported that a majority of adult beneficiaries who do not receive follow-up care within seven days were discharged from out-of-county hospitals. Those discharged from inpatient units within the county received care at a higher rate.			
2E	Psychiatric Inpatient Rehospitalizations	6	5
The MHP reported an overall 30-day rehospitalization rate of 15.8 percent. This was a decrease from the previous year's rate of 18.1 percent and closer to the MHP's stated goal of 15 percent for this year. Starting in FY 2019-20, the MHP separately tracks FC beneficiaries for this metric and found that while relatively few FC beneficiaries get hospitalized, one in four get rehospitalized within 30 days. This is an issue that will require further examination for ameliorative strategies to bring down the rate.			
2F	Tracks and Trends No-Shows	10	4
The MHP is currently not able to track no-show rates for its contract providers. Therefore, the no-show rates data consisted only of what is registered at the county-operated clinics. The MHP cited the limitations posed by its EHR scheduler system, which is only available to the county staff; contract providers with outpatient programs schedule appointments on their own EHR or scheduler systems. This remains an ongoing area for performance improvement activities. The MHP is unable to separately track FC no-show rates due to FC aid codes not being captured in its EHR scheduler module. The psychiatrist no-show rate continues to be two and a half times that for other clinicians. This is also an area that requires further investigation for causes and possible performance improvement activities.			

Component	Maximum Possible	MHP Score
MHP staff described an initial plan to develop a process to leverage telehealth capability within clinics to cover urgent psychiatric need when there are psychiatric no-shows.		

Quality of Care

In Table 36, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 36: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
The MHP's latest available update of its cultural competency plan (CCP) from CY 2019-20 is comprehensive. The MHP assesses the demographic trends and mental health needs of its Medi-Cal beneficiaries and larger countywide populations, and it identifies current strategies and programs to address disparities and social justice issues. The plan also provides the MHP's ongoing evaluation of its strategies and programs that address disparities or cultural issues including recovery-oriented services, like the wellness centers. The MHP provides a number of trainings on cultural competency topics, and reported during the review that more than 2,000 attended these trainings in the past year. At the time of the FY 2020-21 EQR, the MHP was nearing the end of its stakeholder-driven process for the annual update of its CCP. During the review, the MHP noted that COVID-19 has impacted the already vulnerable segment of county residents who are geographically concentrated in larger urban centers far worse than the others, and this is a new challenge both for behavioral health and for the health care agency as a whole. Due to COVID-19, the MHP moved its cultural competency committee (CCC) meetings from in-person format to Zoom calls, and noted that one positive outcome has been an increased attendance in its CCC meetings.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	8

Component		Maximum Possible	MHP Score
The MHP is developing a comprehensive classification of all its services by levels of care (LOC) that will allow it to make more appropriate treatment decisions and align LOC with the tools used to measure symptoms and needs. The currently identified LOC are prevention, navigation including access and linkage, outpatient, recovery support, residential treatment, housing including supportive housing, crisis, and inpatient. Within these LOC, the MHP has identified many sub-strata that fully capture its entire spectrum of services. The MHP uses the Milestones of Recovery Scale (MORS) in the adult system of care (SOC) and uses it for treatment decision making and level of care transitions. In the children's SOC, the MHP uses 50-item Child and Adolescent Needs and Strengths (CANS-50) and the 35-item Pediatric Symptoms Checklist (PSC-35). It uses the findings from the two tools to inform treatment planning for its children's SOC beneficiaries. The MHP has put in place a process to get all children's SOC clinicians certified in CANS-50 and maintain recertification. The MHP identified several challenges in CANS-50 for ongoing system improvements. These include ensuring the use of the appropriate version of CANS-50, coordination of care between and within the MHP programs, improving error alerts, automated reminders, EHR reporting capabilities, and improving the uniformity of CANS-50 workflow across the county-operated and contracted programs.			
3C	Quality Improvement Plan	10	10
At the time of the EQR, the MHP was finalizing its FY 2020-21 Quality Improvement (QI) work plan. Although it identifies its QI work plan areas and goals at the beginning of the FY and starts performing the activities to accomplish the current FY's goals, the internal process to finalize the plan typically takes four to five months. As a behavioral health agency, the MHP has an integrated QI work plan with the Drug Medi-Cal Organized Delivery System (DMC-ODS). In its plan, the MHP clearly delineates the MHP-specific or combined activities. The QI committee is comprised of the managers, beneficiaries and family members, and representatives of contract providers, and the managed care plan (MCP) CalOptima. This is an active committee which participates in a stakeholder-driven process in developing each year's QI work plan, monitoring of progress at the QI meetings, and reviewing the evaluation findings from previous FY's QI work plan. In addition to the other areas that the MHP has pursued in previous years, the MHP presented significant efforts in medication monitoring, especially the HEDIS measures mandated by SB 1291. The MHP noted the lack of complete data on all indicators at the state level; however, it conducts its own in-house analysis of the HEDIS measures. CalEQRO noted that the MHP maintains full transparency through			

Component		Maximum Possible	MHP Score
publicizing its psychotropic medications formulary alongside recommended dosages and related TAR requirements.			
3D	Quality Management Structure	14	13
The MHP's QI is a part of the larger Authority and Quality Improvement Services (AQIS) division. The AQIS is parallel to the adult and children's SOC. It provides all the QI and other data analytical support to the other divisions, and it is organized accordingly with designated staff for interfacing with each division. AQIS undertakes various data analytical projects, both on a routine and ad-hoc basis. An example of collaboration with other divisions and data analysis was the MHP's medication monitoring report on FC beneficiaries. This was a collaboration between AQIS analysts and the medical director's office. Routine analysis examples include the annual state-mandated satisfaction survey, CANS and MORS results, and tracking of timeliness metrics. Satisfaction survey results are shared widely in the system. While the data produced by AQIS are shared within the MHP divisions, the contract providers reported inconsistencies in the types of data they receive. The data and report sharing is partially dependent on who the contract monitor is even though the contract providers noted that their meetings with their respective contract providers as the most fruitful interaction with the administration. During the past 12 months, the MHP has had several vacancies listed, but the staffing and other resources for QI activities were adequate.			
3E	QM Reports Act as a Change Agent in the System	10	7
The MHP's analytical staff have produced a number of new reports and started tracking different metrics. The MHP has started more timeliness elements with the organizational contract provider data, an area where the MHP was previously lacking. There are remaining metrics where it is still working on getting more complete contract provider data. Other new data reports or processes that the MHP has put in place since the last EQR include direct service hours, penetration rates, data dashboard, and inpatient database. Further, the MHP continues to provide data reports to its contract and county operated programs that include outcomes data, beneficiary demographics and social determinants data, beneficiary satisfaction survey, and timeliness data. Provider staff and supervisors can themselves view and print a number of reports for beneficiary care from the EHR. There were some important data elements for quality metrics that the MHP had planned on implementing in the past year, but got delayed due to COVID-19 impacts			

Component		Maximum Possible	MHP Score
and changes in priorities for IS. These include lab alerts, suicide risk factors, primary care and general medical conditions information, and expiration of current care plan. These remain work in progress and once implemented, will both improve clinical practice and QI tracking of the related quality metrics. The MHP is also expecting a better automated system for verifying NPI numbers for NA purposes once the 274 transaction is in place.			
3F	Medication Management	12	10
Although the MHP remains without a permanent medical director, other psychiatrists in systems of care leadership alongside the AQIS psychologist conduct rigorous medication monitoring and evaluation of its findings. Based on the evaluation results, the MHP identifies possible root causes and activities for improving its performance in lower scoring activities. The medication monitoring questions reflect current best or standard practices associated with prescribing psychiatric medications, and the questionnaire is revised based on the evaluation findings to improve the accuracy of the information collected. In some instances, there are extraneous factors that may impact the quality of information such as EHR capabilities in properly capturing coordination with primary care physicians (PCPs) and any medications prescribed by the PCPs. During the review, the psychiatrists noted that there is now a greater emphasis on tracking and monitoring of the SB 1291 measures related to psychotropic medications. However, they pointed out that statewide data on some of the measures listed in Footnote 4 of this report that reference psychotropic medications remain unavailable. The MHP's EHR provides a number of care alerts on controlled medications, allergies, vital signs, medication interaction, and duplicate medications. The MHP is working on additional alerts to be implemented during FY 2020-21 that include labs; suicide risk factors; general medical conditions and primary care connection; and expiration of care plan. The MHP is transparent about its formulary and posts it on the website. The formulary also provides full information on the available strengths and which ones require a treatment authorization request (TAR), whether by the county or by Medi-Cal.			

Beneficiary Progress/Outcomes

In Table 37, 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 37: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	16
The MHP uses MORS in the adult SOC to make treatment decisions and LOC transitions. In the children's SOC, the MHP uses CANS-50 and PSC-35. For more details on the use of these instruments, please refer to key component 3B. The MHP is working on further system-wide aggregation of CANS-50 results in FY 2020-21. In addition to these instruments in use system-wide, the MHP provided a comprehensive list of outcomes tools used by adult and children's SOCs that cover multiple domains including functioning, symptoms, trauma, violence, substance use, recovery, quality of life on the adult side, and additionally social emotional functioning, family strengths and needs, and signs of human or sex trafficking on the children's side.			
4B	Beneficiary Perceptions	10	10
The MHP uses the DHCS-mandated Consumer Perception Surveys (CPSs) consisting of the Mental Health Statistics Improvement Survey (MHSIP) for adults and older adults, and the Youth Services Survey (YSS) for youth and family members. It tabulates the results and conducts significance tests year over year and by demographics. For instance, the MHP found that between 2019 and 2020 survey periods, the youth respondents indicated increased treatment participation while the adults indicated reduce access and quality. The MHP also conducts its own beneficiary surveys specific to select programs such as crisis; peer mentoring and other supportive programs; Prevention and Early Intervention (PEI); and inpatient. The MHP shares the information throughout the system including the contract providers, and plans activities based on the results.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
The MHP has a recovery-oriented, peer-driven service system. It has three wellness centers in three regions of the county, and past CalEQRO visits have indicated that they have exemplary practices in recovery, peer empowerment, and peer employment. The MHP encourages beneficiaries to attend the wellness centers, and some participants in the CFM focus groups indicated having attended one and benefitting from the experience.			

Component	Maximum Possible	MHP Score
The MHP's current clinical PIP is based on a peer navigation model whereby peer employees placed in a psychiatric inpatient unit help discharged beneficiaries to connect with and remain engaged in the step-down programs. The data presented this year shows some evidence of effectiveness of this approach. Stigma Free OC is an MHP initiative to educate those suffering from symptoms of mental illness, their friends and family members, and the public at large to eradicate the stigma associated with mental illness.		

Structure and Operations

In Table 38, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 38: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	29
The MHP offers all specialty mental health services as described in the DHCS contract except TFC. At the time of this review, the MHP was providing ISFC and increased its FSP slots to enhance ISFC recipients until it has providers fully capable of providing TFC. During the past year, the MHP has added more Short-Term Residential Treatment Programs (STRTPs) for FC beneficiaries. More crisis stabilization and residential treatment capacity will be added once the OC BeWell campus opens this year.			
5B	Network Enhancements	18	17
The MHP utilizes a number of adjunct service delivery options to optimize the care for its beneficiaries. The most notable of these since COVID-19 onset has been the rapid deployment of comprehensive telehealth services. Previously the MHP did not have any significant telehealth service delivery options. The MHP's wellness centers, as well as its peer support services in general, provide strong support to the beneficiaries in service linkage, engagement, recovery, and graduating to self-reliance and employment. Another significant piece of adjunct service delivery takes place through its crisis services partnership with law enforcement. The MHP offers crisis clinician ride-along services with local police departments in a number of jurisdictions in the county.			

Component		Maximum Possible	MHP Score
The MHP participates as one of the partnering agencies in the county's Whole Person Care pilot program to enhance the beneficiaries' overall care system. In partnership with CalOptima, the MHP is in the process of developing a Health Homes program for its beneficiaries to provide combined medical and behavioral health care.			
5C	Subcontracts/Contract Providers	16	13
The contract providers noted greater openness to contract provider challenges and more transparency from the MHP administration since the beginning of the pandemic. They also attributed these changes in part to the MHP director who has been in his position for a little over a year at the time of this EQR. Contract providers also noted that one-on-one communications with their MHP contract monitors are more likely to be useful compared to the meetings where all contractors are present. In the latter, the contract providers noted that the information is often mostly one-way from the MHP rather than a dialog with the contract providers. As noted earlier, the MHP is still working on improving the information flow related to access, timeliness, and quality from the contract providers. HIE and MHP EHR limitations remain some of the most salient barriers to this.			
5D	Stakeholder Engagement	12	11
The MHP has strong stakeholder communication and partnership with various external entities that touch the lives or care for the MHP beneficiaries. These include CalOptima, the school districts, law enforcement, probation, the county courts, primary care, and housing. During the review, these partners noted having good communication with their designated contacts within the. CalEQRO had noted communication with the contract providers as an area of improvement for the MHP in previous year's reports. The contract provider leadership group reported some improvement in this area since the new MHP director took over, and especially during the significant service delivery model changes that both the MHP and its contract providers underwent since March 2020. They participate in the SOC meetings and receive communication there but noted the one-on-one meetings with their individual contract monitors to be more productive in terms of program or contract specific needs. The beneficiaries reported receiving adequate information regarding the services from their case managers, peer employees, and therapists. The adult beneficiaries also reported staying informed about MHP events or happenings through flyers, brochures, and the MHP website.			

Component		Maximum Possible	MHP Score
The line staff and supervisors also reported participating in MHP committees and receiving regular communication and trainings. However, the contract provider staff and supervisors' experiences vary somewhat by the agency reporting structure.			
5E	Peer Employment	8	8
The MHP has designated peer positions throughout the system in both county and contract provider programs. The wellness centers are peer-run or peer-driven, and offer the peer employees a career ladder including managerial positions. The peer employees recognized their jobs as rewarding, supported by their peers and supervisors, and something that helps with their own recovery. They also reported that the transition through services adapting to COVID-19 imposed restrictions have impacted their in-person interaction and group sessions with the beneficiaries. Most peer employees would like to see better clarification in their roles. The MHP provided the job description for peer employees, but as reported by the peer employees, they would like better clarity on conducting groups, especially in engaging children in video groups during COVID-19.			

SUMMARY OF FINDINGS

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

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Concept only, not yet active (not rated)

Access to Care

Changes within the Past Year:

- The MHP experienced significant impact from COVID-19.
- County programs had to reduce onsite staffing by approximately 50 percent in order to comply with the physical distancing requirements.
    - The MHP continued to provide crisis assessment, nursing assessment, and ongoing injections in person.
    - It made provision of intake assessment, initial psychiatric evaluation, follow-up psychiatrist appointment, individual counseling, case management, and other outpatient mental health treatment through telehealth.
    - According to the MHP, many beneficiaries also stopped seeking in-person services due to COVID-19 fears which may have caused unintended worsening of symptoms and functioning.
- With the CARES Act dollars, the MHP was able to put in place the following strategies for service enhancement for during the pandemic and beyond:
    - Suicide prevention
    - Violence prevention
    - Youth resilience
    - Health disparities
    - Online resources and communications

  - Telehealth capacity development

- Project Roomkey has provided six facilities to house homeless individuals vulnerable to COVID-19.

Strengths:

- The roll-out of telehealth was quickly initiated and effectively executed when the need was identified. Now the MHP has a service delivery infrastructure across the entire SOC that did not exist a year ago and it is a permanent addition to their resources.
- The MHP has monitored the impact of COVID-19 on the delivery of mental health services and shown a willingness to adjust quickly when needed.
- The Anita Street Campus will house the OC BeWell Project for anyone in Orange County regardless of insurance and is expected to open in December 2020.
- The MHP has planned its first sobering center as an alternative to incarceration.
- The MHP appears to have an effective working relationship with the county's MCP, CalOptima. CalOptima has established its own network of providers for the mild-to-moderate population. The MHP and CalOptima have semi-monthly meetings to coordinate services for beneficiaries as they transition across the mild-to-moderate boundary, in either direction.
- The MHP is providing adjunctive services, such as psychiatric services, in coordination with CBOs when CBOs do not currently have the capacity.
- The MHP has designated open access clinic locations where beneficiaries are able to walk-in for their first appointment.
- The participants in both CFM focus groups were aware of the ways to get urgent help and who to call if their children experience any crises.

Opportunities for Improvement:

- Penetration rates remain below other large counties and the state. The MHP questions the methodology used by CalEQRO based on all Medi-Cal beneficiaries regardless of their risk of developing behavioral health issues; however, CalEQRO uses the same methodology with all MHPs. The MHP reported that it has extended its documentation window to 30 days which may increase its pool of services and improve its penetration rate to capture a bigger pool of service recipients. The MHP has also created a revenue cycle workgroup to investigate its internal determination of large amounts of non-billable services.

- Of 25,321 beneficiaries served in the CY 2019, less than 1 percent use the PHR provided through the OCHCA Portal. Had usage been more common, the OCHCA Portal may have been a useful communication tool during COVID-19.
- CBOs were not aware of the step-down referral process to CalOptima for beneficiaries to receive mild-to-moderate services.

Timeliness of Services

Changes within the Past Year:

- The MHP has developed a MSA report that uses a template for the contract providers to report uniformly on the needed data elements for first offered psychiatry timeliness and no-show rates.
- The MHP is also developing a programming script that will allow merger of these data from multiple sources and reporting on first offered psychiatric appointment metric system-wide.

Strengths:

- The MHP is able to offer first appointment within 10 business days for almost 100 percent of its new beneficiaries with an average of 2.28 business days.
- For first offered psychiatry appointments, the MHP is able to meet its 15 business day standard more than 85 percent of the time, and 80 percent of the time for the FC beneficiaries for county-operated programs only.

Opportunities for Improvement:

- The current state of the county's health information exchange (HIE) does not allow for uniform monitoring of first offered psychiatry appointment timeliness for the contract providers.
- The MHPs EHR does not have a time stamp, only a date stamp. This severely limits the MHP's ability to calculate urgent appointment timeliness metric in an accurate manner. From the data presented in the MHP's own assessment of timeliness, it appears that this limitation artificially lowers the percentage of appointments that meet its standard. The MHP reported that it is in the process of remedying this issue with a proper time stamp for urgent requests across the system.
- The MHP is not able to track no-show rates for contract providers nor for the FC beneficiaries.

Quality of Care

Changes within the Past Year:

- During the review, the MHP noted that COVID-19 has impacted the already vulnerable segment of county residents who are geographically concentrated in larger urban centers far worse than the others, and this is a new challenge both for behavioral health and for the health care agency as a whole.
- The MHP is developing a comprehensive classification of all its services by levels of care (LOC) that will allow it to make more appropriate treatment decisions and align LOC with the tools used to measure symptoms and needs.
- There were some important data elements for quality metrics that the MHP had planned on implementing in the past year, but got delayed due to COVID-19 impacts and changes in priorities for IS. These include lab alerts, suicide risk factors, primary care and general medical conditions information, and expiration of current care plan. These remain in work-in-progress status, and once implemented, will improve both clinical practice and QI tracking of the related quality metrics.

Strengths:

- In the CCP, the MHP assesses the demographic trends and mental health needs of its Medi-Cal beneficiaries and larger countywide population, and it identifies current strategies and programs to address disparities and social justice issues. The plan also provides the MHP's ongoing evaluation of its strategies and programs that address disparities or cultural issues including recovery-oriented services, like the wellness centers.
- Although the MHP remains without a permanent medical director, other psychiatrists in systems of care leadership alongside the AQIS psychologist conduct rigorous medication monitoring and evaluation of its findings. Based on the evaluation results, the MHP identifies possible root causes and improvement activities for improving its performance in lower scoring activities.
- The medication monitoring questions reflect current best or standard practices associated with prescribing psychiatric medications, and the questionnaire is revised based on the evaluation findings to improve the accuracy of the information collected.
- The MHP maintains full transparency through publicizing its psychotropic medications formulary alongside recommended dosages and which ones require TARs prior to prescribing.

- AQIS undertakes various data analytical projects, both on a routine and ad-hoc basis as needed. An example of collaboration with other divisions and data analysis was the MHP's medication monitoring report on FC beneficiaries. This was a collaboration between AQIS analysts and the medical director's office.

Opportunities for Improvement:

- 7-Day post-psychiatric inpatient follow-up rate has improved over the last year's rate but remains below 50 percent (the statewide average is 57 percent.)
- There are no uniform and formalized means of notification when existing beneficiaries are hospitalized for psychiatric reasons.
- In some instances, there are extraneous factors that may impact the quality of information such as EHR capabilities in properly capturing coordination with PCPs and any medications prescribed by the PCPs.
- Clinical supervision for telehealth services and for remotely located interns are a new challenge for the supervisors. As telehealth becomes a routine part of MHP services, the supervisors will need further training to ensure proper clinical supervision.

Beneficiary Outcomes

Changes within the Past Year:

- New data reports or processes that the MHP has put in place since the last EQR include direct service hours, penetration rates, data dashboard, and inpatient database.
- From the state mandated CPSs, the MHP found that between 2019 and 2020 survey periods, the youth respondents indicated increased treatment participation while the adults indicated reduce access and quality.

Strengths:

- The MHP's routine analysis examples include the annual state-mandated satisfaction survey, CANS-50 and MORS results, and tracking of timeliness metrics. Satisfaction survey results are shared widely in the system.
- The MHP uses the MORS in the adult SOC for treatment decision making and level of care transitions.
- In the children's SOC, the MHP uses CANS-50 and PSC-35. It uses the findings from the two tools to inform treatment planning for its children's

SOC beneficiaries. The MHP has put in place a process to get all its children's SOC clinicians to get certified in CANS-50 and keep up with the recertification process.

- The MHP provided a comprehensive list of outcomes tools used by adult and children's SOCs that cover multiple domains including functioning, symptoms, trauma, violence, substance use, recovery, quality of life on the adult side, and additionally social emotional functioning, family strengths and needs, and signs of human or sex trafficking on the children's side.
- MHP continues to provide data reports to its contract and county-operated programs that include outcomes data, beneficiary demographics and social determinants data, beneficiary satisfaction survey, and timeliness data. Provider staff and supervisors can themselves view and print a number of reports for beneficiary care from the EHR.

Opportunities for Improvement:

- CANS-50 data is entered differently by CBOs and the MHP and data quality issues have limited its utility for analysis.
- The MHP identified several challenges in CANS-50 use that are on its list of ongoing system improvements. These include ensuring the use of the appropriate version of CANS-50, coordination of care between and within the MHP programs, improving error alerts, automated reminders, EHR reporting capabilities, and improving the uniformity of CANS-50 workflow across the county-operated and contracted programs.

Foster Care

Changes within the Past Year:

- The MHP added another STRTP, increasing the number from three to four this year. Most importantly, all four contracted providers representing 14 homes with 106 beds have been fully certified.
- The agencies have obtained the board of supervisors' approval for 20 additional FSP slots dedicated to the ISFC homes when these become available.
- In addition to the other areas that the MHP has pursued in previous years, the MHP presented significant efforts in medication monitoring, especially the HEDIS measures mandated by SB 1291.
- Once the Anita Street OC BeWell campus opens this year, Orange County will have its first youth residential treatment facility.

Strengths:

- The FC parents reported that transferring services and connecting with new services were easy. They also noted that due to COVID-19, many of the services are done via telehealth, but they did not experience any difficulties with that. Some of the specialty services that cannot be done remotely continue to be in person.
- Most CFM focus group participants in the parents' group were satisfied with the length of time it took to connect to services. It appeared that occasionally for FC access to mental health services there are delays that can be attributed to extraneous factors such as change in county of responsibility, not to the MHP's access process.
- AQIS undertakes various data analytical projects, both on a routine and ad-hoc basis. The MHP's medication monitoring report on FC beneficiaries is an example of collaboration with other divisions and data analysis. This was a collaboration between AQIS analysts and the medical director's office.

Opportunities for Improvement:

- The MHP continues to work with SSA, juvenile probation and FFAs. However, it noted two reasons why SSA and FFA have not yet been able to implement IFSC or secure a IFSC home in the entire county:
    - Challenges in obtaining the Specialized Care Increment Rate approvals for ISFC homes.
    - Difficulties with recruiting for resource families that are willing and able to accept youth with higher level of need.
- It appeared that occasionally for FC access to mental health services there are delays that can be attributed to extraneous factors such as change in county of responsibility, not to the MHP's access process.
- FC parents would benefit from regular opportunities to network with other FC parents through support groups and information exchange.
- The MHP lacks TFC due to various barriers that have also hampered the rollout of IFSC.

Information Systems

Changes within the Past Year:

- OCHCA IT coordinated the deployment of 2,000 telehealth workstations to be fully deployed by the end of December 2020 to support staff who also work from home.

Strengths:

- The MHP's EHR provides a number of care alerts on controlled medications, allergies, vital signs, medication interaction, and duplicate medications. The MHP is working on additional alerts to be implemented during FY 2020-21 that include labs; suicide risk factors; general medical conditions and primary care connection; and expiration of care plan.

Opportunities for Improvement:

- The OCHCA IT strategic plan outline for 2018-2020 includes a statement that OCHCA IT needs to consider development of an advisory group consisting of leaders from IT, program, and administrative services to provide review and advice on IT opportunities and direction. This is an excellent idea and should be implemented.
- The MHP's ISCA submission itself is an opportunity for improvement. It contained information that was inaccurate, and more commonly, in conflict with information in other parts of the document.
- The MHP does not collect service timeliness data for all services delivered by contract providers in a manner that does not add to the documentation burden of the contract providers.

Structure and Operations

Changes within the Past Year:

- The MHP changed the documentation cut-off after which a claim would be considered non-compliant, and therefore unbillable, from 14 days to 30 days. While no specific prediction was made for the fiscal impact of this change, it was expected to be significant based on the discussion.
- The MHP anticipates about 90 percent reduction in MHSA funding this FY than was expected when the MHSA Plan was developed. This has necessitated an analysis of other available funding to minimize the impact on service delivery.
- Six IT positions have been added in this FY.

- The MHP data analytics staff decreased by 1 FTE this year, for the third year in a row.
- The MHP implemented coordination of care between home health services and the MHP.
- The Behavioral Health Integration program drew 27 applications that led to 12 projects for next year with $13M in funding.

Strengths:

- The MHP director established quarterly all-provider meetings to facilitate two-way communication during the COVID-19 pandemic.
- The CBOs report an increased level of collaboration with the MHP in coordinating services in response to COVID-19.
- Despite the COVID-19 impact on the MHP budget, it has been able to add peer employees to its workforce during the past year.
- The MHP's wellness centers, recovery-oriented services, and strategic deployment of peer employees all add up to a system able to move its beneficiaries toward independence and self-management of symptoms and functioning.

Opportunities for Improvement:

- Based on the rate at which MHP projects requiring IT and data analytic resources are completed, current IT and data analytic resources appear to be spread too thinly, with either too many simultaneous projects or too few resources assigned to successfully complete projects.
- Contract providers have had contracts with no cost of living increases for years. This potentially impacts the quality of care. The contract providers have great difficulty recruiting and retaining employees, especially licensed employees. While the costs of doing business increase (e.g., property taxes, rent, utilities, materials and supplies, and insurance), their resources have remained stagnant, and the difference has to come out of service delivery. This is not a sustainable model. COVID 19 has proven that contract providers are the more agile part of the MHP's SOC, but they cannot serve that role indefinitely on diminishing resources.

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. Ensure quick implementation of the non-clinical PIP that was in planning stages during the FY 2020-21 EQR.

Access to Care

Recommendation 2: Provide system-wide communication and training to MHP and CBO staff on the process for step-down referral to CalOptima.

Timeliness of Services

Recommendation 3: Develop capability to track adult psychiatry timeliness for contract providers as well as directly operated providers. (This is a carry-over recommendation from FY 2019-20.)

Recommendation 4: Develop capability to track no-shows for the entire SOC, to include contract providers and FC beneficiaries. Report quarterly results by program. (This is a carry-over recommendation from FY 2019-20.)

Quality of Care

Recommendation 5: Develop a formalized and uniform method for CAT to notify the program if an existing beneficiary gets hospitalized.

Beneficiary Outcomes

None noted.

Foster Care

None noted.

Information Systems

Recommendation 6: Evaluate the type and level of IT and data analytic resources dedicated to MHP service needs for daily operations, improved reporting capabilities, and the delivery of significant initiatives which will move the organization forward. (This is a slightly modified carry-over recommendation from FY 2017-18 and FY 2019-20.)

Recommendation 7: Complete the implementation of electronic laboratory results receipt and posting into the corresponding beneficiary records in the EHR. (This is a carry-over recommendation from FY 2018-19 and FY 2019-20.)

Structure and Operations

None noted.

SITE 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. All sessions were conducted via video conference.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: List of Commonly Used Acronyms

Attachment A—Review Agenda

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

Table A1: EQRO Review Sessions

Orange 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
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Clinical Directors Group Interview
Consumer and Family Member Focus Groups
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Medical Prescribers Group Interview
Forensics and Law Enforcement Group Interview
Community-Based Services Agencies Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview

Orange MHP
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Saumitra SenGupta, Lead Quality Reviewer
Samantha Fusselman, Executive Director and Second Quality Reviewer
Lynda Hutchens, Pre-review Planning and Second Quality Reviewer
Robert Greenless, Lead IS Reviewer
Joel Chain, Second IS Reviewer
Tilda DeWolfe, CFM Reviewer

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

Sites of MHP Review

n/a

(All sessions for this EQR were conducted via video conference.)

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
	Edgar		MHA of OC
	Jose	Peer Volunteer	OCHCA
Abassi	Sherri	Clinician	MHA of OC
Aguilar	Glenda	Program Manager II	OCHCA
Alma	Ken	Service Chief I	OCHCA
Amirshahi	Bijan	Ethnic Service Manager	OCHCA
Baker	Lisa	Clinician	Pathways
Bart	Ashley	Behavioral Health Clinician II	OCHCA
Benbrook	Jayson	Program Manager II	OCHCA
Benjamin	Hether	Clinician	Waymakers
Bennet	Andrew	Senior Research Analyst	OCHCA
Bienkowski	Ed	Regional Director	Telecare Corp
Cantrell	Brian	ST II	OCHCA
Canul	Rafael	BHC II	OCHCA
Carter	Cynthia	Police Officer	Newport Beach Police Department
Castellanos	David	Information Security Officer	OCHCA
Chang	Tina		Olivecrest
Conod	Patrick	Clinician	Telecare Corp
Cordova	Christina	Staff Specialist	OCHCA
Cortez	Nancy	Staff Specialist	OCHCA
Cowper	Chris	Clinician	Telecare
Dimitriadia	Kindra	Administrative Manager II	OCHCA
Esper	Emma	MHW	OCHCA
Espinoza	Carlos	Service Chief	OCHCA

Last Name	First Name	Position	Agency
Garcia	Nicole	Service Chief	OCHCA
Gibbs	Danny	MHW	OCHCA
Gonzalez	Pam	Clinician	Olivecrest
Guier	Tracie	MHW	Olivecrest
Gutierrez	Christie		Anaheim Unified School District
Haroon	Marina	BHC	MH Courts
Harrison	Joseph	IT Systems Tech II	OCHCA
Hasemi	Leila	Clinician	MHA of OC
Hayden	Erika	BHC II	OCHCA
Heilman	Rebecca	Research Analyst IV	OCHCA
Hein	Jeremiah	Clinician	Pathways- Opportunity Knocks
Henriquez	Jennifer	Administrative Manager I	OCHCA
Holley	Diane	Program Manager II	OCHCA
Holly	Diane	Program Manager II	OCHCA
Hong	Danny	MHW	OCHCA
Howard	April	Senior Research Analyst	OCHCA
Hudson	Jenny	Division Manager	OCHCA
Huffman	Scott	Associate Medical Director	OCHCA
Ibarra	Marisela	Administration Manager I	OCHCA
Inglis	Andrew	Associate Medical Director	OCHCA
Jannise	April	Administrative Manager II	OCHCA
Jett	Jimmi	BHC II	OCHCA
Jones	Jessica		Telecare Corp
Kee	Matthew	Program Manager II	OCHCA

Last Name	First Name	Position	Agency
Kemmer	Ian	Division Manager	OCHCA
Kim	Alice	Program Manager I	OCHCA
Kneubuhl	Chad	MHW	OCHCA
Lam	Chi	Program Manager II	OCHCA
Lawrenz	Mark	Division Manager	OCHCA
Le	Anthony	Administrative Manager II	OCHCA
Leal	Alejandra	Clinician	Seneca Center
Lee	Rosette	Clinician	WYS
Leigh	Lorrie Leigh		Wester Youth Services
Lemire	Alicia	Program Manager II	OCHCA
Lessa-Breuer	Jana	IT Business Analysts II	OCHCA
Lopez	Nathan	Program Manager II	OCHCA
Lopez	Armanda	Supervising Probation Officer	MH Courts, OC Probation
Ly	Olivia	Service Chief II	OCHCA
Martinez	Sandra	Clinician	WYS
McDowell	Vanessa	Program Manager II	OCHCA
Medina	Tawnya	Probation Officer	OC Probation
Molina	Linda	Director of AOABH	OCHCA
Mugrditchian	Annette	Director of Operations	OCHCA
Nagel	Jeff	Deputy Agency Director and MHP Director	OCHCA
Navarro	Teresita	MHW	OCHCA
Novida	Derek	Program Director	Pathways
O'Brien	Brett	Director of CYPBH	OCHCA
Okubo	Sandra	Senior Research Analyst Supervisor	OCHCA

Last Name	First Name	Position	Agency
Okuro	Denacia	MHW	OCHCA
Padilla	Anthony	Administrative Manager I	OCHCA
Parker	Andrew	Behavioral Health Clinician II	OCHCA
Pfister	Katherine	MHW	OCHCA
Pham	Chambrielle	Contract Monitor	OCHCA
Poon	Edwin	MD	Cal Optima
Pourvasei	Jen	Clinician	Waymakers
Ramirez	Lisanne	Regional Director	Pathways
Ramirez	Maynard	MHW	OCHCA
Rao	Bhuvana	Administrative Manager II	OCHCA
Renteria	Teresa	Administrative Manager II	OCHCA
Rich	Jonathan	Psychologist II	OCHCA
Rick	Tracy	Program Manager II	OCHCA
Rios	Christopher	Clinical Manager	Pathways
Rodriguez	Monica	MHW	OCHCA
Roy	Niyati	BHC II	OCHCA
Sabet	Kelly	Division Manager	OCHCA
Sanchez	Gabriel	MHW	Waymakers
Siddiqui	Adil	Chief Information Officer	OCHCA
Sigala	Rodrigo	Service Chief I	OCHCA
Smith	Dawn	Division Manager	OCHCA
Spellmeyer	Jody	BHC II	OCHCA
Thomas	Vanessa	Program Manager II	OCHCA
Thrash	Jeff	MHA Director	MHA of OC
Tran	Annette	Administrative Manager I	OCHCA

Last Name	First Name	Position	Agency
Triplett	Carol	BHC II	OCHCA
Truong	Brenda	Behavioral Health Clinician II	OCHCA
Turakhia	Atur	Associate Medical Director	OCHCA
Vasquez	Alberto	MHW	CNG
Vu	Hasan	Service Chief I	OCHCA
Wanzo	Tramaine	IT Business Analysts II	OCHCA
Weckerly	Christina	Program Manager II	OCHCA
Wee	Meghan	Clinician	Pathways
Weidhaas	Susan	Administrative Manager I	OCHCA
Wilson	Jade	MHW	OCHCA
Yu	Angela	Associate Medical Director	OCHCA

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

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

Orange 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
Large	1,791,890	69,726	3.89%	$372,190,347	$5,338
MHP	264,323	6,847	2.59%	$37,863,461	$5,530

Table C2 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 C2: CY 2019 Distribution of Beneficiaries by ACB Range

Orange 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	24,111	95.22%	93.31%	$87,675,527	$3,636	$3,998	65.34%	59.06%
>$20K - $30K	578	2.28%	3.20%	$13,982,192	$24,191	$24,251	10.42%	12.29%
>$30K	632	2.50%	3.49%	$32,521,820	$51,459	$51,883	24.24%	28.65%

Attachment D—List of Commonly Used Acronyms

Table D1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment
ART	Aggression Replacement Therapy
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CARE	California Access to Recovery Effort
CBT	Cognitive Behavioral Therapy
CCBH	Community Care Behavioral Health
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIT	Crisis Intervention Team or Training
CMS	Centers for Medicare and Medicaid Services
CPM	Core Practice Model
CPS	Child Protective Service
CPS (alt)	Consumer Perception Survey (alt)
CSD	Community Services Division
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services

Acronym	Full Term
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-based Program or Practice
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
FY	Fiscal Year
HCB	High-Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
ISCA	Information Systems Capabilities Assessment
IHBS	Intensive Home-Based Services
IT	Information Technology
LEA	Local Education Agency
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LOS	Length of Stay

Acronym	Full Term
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MCBHD	Medi-Cal Behavioral Health Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act (SB 82)
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
NA	Network Adequacy
n/a	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
ONA	Out-of-Network Access
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PM (alt)	Partially Met
QI	Quality Improvement

Acronym	Full Term
QIC	Quality Improvement Committee
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Planning Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOP	Safety Organized Practice
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment
WET	Workforce Education and Training
WRAP	Wellness Recovery Action Plan
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version