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

ORANGE FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 19-21, 2023

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EXECUTIVE SUMMARY

Highlights from the fiscal year (FY) 2023-24 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Orange" may be used to identify the Orange County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — September 19-21, 2023

MHP Size — Large

MHP Region — Southern

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
6	5	0	1

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	4	2	0
Quality of Care	10	4	5	1
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**16**	**9**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Rehospitalization Reduction in Children/Youth After First Hospitalization	Clinical	10/2022	Second remeasurement	Low confidence
Improving Adults' Timely Access to Mobile Crisis Support	Non-Clinical	06/2023	Implementation	No confidence

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	8
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	5
3	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☒Other	7

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has a strong data-driven decision-making culture.
- The efforts to reduce rehospitalization appear to be showing success.
- The MHP offers multiple walk-in and call-in options for initial access.
- The MHP has very strong partnerships and collaborations with external agencies.
- The MHP has been working diligently in developing and expanding supportive housing.
- The MHP demonstrates strong security and continuity controls in their Information Technology (IT) environment.

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

- The MHP's penetration rates (PRs) continued to be lower than those seen statewide across all racial/ethnic groups and all age groups, suggesting challenges with accessing services overall.
- The MHP's website and the additional ones containing various relevant service information need further work and clarity.
- The MHP's timeliness data have inconsistencies that require further work.

- The MHP's medication monitoring protocol does not fully incorporate the Healthcare Effectiveness Data and Information Set (HEDIS) measures or methodology.
- There is limited clinical information exchange between county and contract providers.
- According to its Assessment of Timely Access (ATA), the MHP did not meet the 10-business day standard for children and youth by a large margin.

Recommendations for improvement based upon this review include:

- Continue efforts to improve the overall PR, especially for adult, older adult, infant, and Asian-Pacific Islander (API) Medi-Cal members. Evaluate the current strategies to improve access for these groups and increase their PRs.
- Continue to streamline MHP access and service information working with both the health agency and the established search engines so those seeking information from the outside are directed straight to the latest and most comprehensive website.
- Additional IS staff positions within the Orange Health Care Agency (OHCA) are needed for ongoing support and development within the MHP system of care. OHCA would benefit from enhanced support from County HR for the successful recruitment of vacant data analytics positions that provide key support for making data-informed decisions.
- Incorporate the applicable HEDIS measures in medication monitoring protocol start tracking the remaining Pathways to Well-Being (PWB) mandated HEDIS measures for the FC plan members.
- Continue the efforts to enable clinical, demographic, and financial information exchange with contract providers, in lieu of a shared Electronic Health Records (EHR).
- Continue developing and implementing new strategies to improve children's timeliness to first offered non-urgent appointments.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

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

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

This report presents the FY 2023-24 findings of the EQR for Orange County MHP by BHC, conducted as a virtual review on September 19-21, 2023.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to validate and analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, members, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

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

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – summary of the validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5, and also as outlined DHCS's Comprehensive Quality Strategy.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report

data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then "<11" is indicated to protect the confidentiality of MHP members.

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

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

There were no significant environmental issues affecting MHP operations.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP has established a new full service partnership (FSP) to serve the Vietnamese members and added a therapeutic transportation team through another FSP.
- Orange has fully implemented the new DHCS screening tool and has collaborated with CalOptima, the managed care plan (MCP), to follow the No-Wrong-Door policy.
- The MHP has opened 120 new housing units funded by the Mental Health Services Act (MHSA). 350 more units are in the pipeline.
- To address the staff shortages that occurred during and after the pandemic, the MHP has prioritized hiring both by the county and the contract providers, detailed further in the Response to Recommendations.
- The MHP has had to hold FY 2023-24 outpatient claiming to Medi-Cal until the EHR vendor delivers an update that supports the payment reform billing methodology. The MHP has submitted billing requirements and meets with the vendor weekly to keep the project on track. The MHP expects to receive the update in late October 2023. Procedures are in place to claim for the services once the update is in place.
- The MHP has put an emphasis on rapid follow-up after psychiatric inpatient discharge. This was evidenced in the line staff and member focus groups conducted by the EQRO.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations not addressed may be presented as a recommendation again for this review. However, if the MHP has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 1: Improve access to services for established members and ensure regular frequency of appointments.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has undertaken various strategies to address the primary reason of lack of access for established members, vacancies in clinical line staff and psychiatry. It has worked with human resources to fast track hiring and increase salaries, added positions to contract providers, and contracted with the University of California, Irvine to increase psychiatry residencies.
- The MHP has also used the peer employees to improve the members' engagement with the services and thereby reducing the clinician workload for the same.
- The MHP continues to have low PR which points other barriers to new members accessing services in addition to the issue of existing members receiving regular appointments.

Recommendation 2: Provide additional or alternative supportive services at lower levels of care (LOC) that reduces the proportion of adults that are hospitalized annually. (Outcomes related to this recommendation may not be realized for two years, when the CY 2023 data would be available).

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has significantly increased its crisis stabilization unit (CSU) capacity as one of the strategies to divert and reduce inpatient hospitalization.
- It has also prioritized timely inpatient follow-up services in order to reduce rehospitalizations.
- The MHP has also increased peer employee staffing in its crisis response teams to better handle the crisis calls requiring the MHP and law enforcement co-response.
- While this is likely to be an issue that the MHP will need to address ongoing as a long-standing systems issue, based upon the amount of work done on this topic since the last review, it is rated as addressed.

Recommendation 3: Verify that all navigators have the same and accurate information on MHP services. Develop a process for regular (e.g., monthly) review and updating of MHP information disseminated through the OC Navigator.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The OC Navigator vendor has created a secure resource portal that allows trained MHP staff to log-in and update existing resources directly and not have to rely on the vendor for posting corrections. When there are changes to a program's information, program staff complete a Change Form and submit the form to OC Links. A dedicated OC Links staff person updates the information on the OC Navigator website and then alerts all other OC Links staff to the changes.

Recommendation 4: Continue the efforts to enable contract providers to sign onto the Orange County Partnership Regional Health Information Organization (OCPRHIO), in order to facilitate information exchange, in lieu of a shared EHR.

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

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The recommendation was not addressed. The MHP determined that working with the local Health Information Exchange (HIE), OCPRHIO, is not a successful strategy. Instead, they plan to build a cloud-based enterprise data warehouse which will consolidate data for reporting and analytical needs and allow bi-directional data exchange with all business partners, including contract providers. They also intend to build the infrastructure for contract providers to submit demographic and service data directly to the county's EHR. There is a proposal submitted to the Board of Supervisors to initiate a contract with an external systems integrator to begin the project.

- The MHP needed to demonstrate substantial progress in defining the requirements and implementation of this project in order to receive an Addressed rating on this recommendation.

Recommendation 5: Focus quality and analytic resources on further evaluating some few areas of services where improvements are clearly needed based on current, existing, empirical evidence.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has been working with the county's human services to improve FC PR by having more of them served by the MHP for behavioral health issues rather than by the human services.
- The MHP has invested in personnel and software to improve its data analytical capabilities in relation to crisis and acute care.
- The MHP has also worked toward improving capacity to serve underserved communities such as the API members.

Recommendation 6: If success is found in reaching a large audience through the Orange County (OC) Navigator's project, apply those strategies to targeted audience(s) that are served through SMHS, especially those who might currently be underserved (e.g., API). At present, the campaign seems to target a middle-income audience (of sports fans) and may not reach the population served though SMHS.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has expanded its outreach efforts to community events in addition to the sports venues.
- In Summer of 2023, the MHP ran a 10-day social media and online digital campaign to promote the OC Navigator. Ads were geolocated to reach people in areas surrounding each of the county's MHP and Drug Medi-Cal Organized Delivery System (DMC-ODS) facilities and showed promising results. During this period (June 29 – July 10), there was a substantial spike in website traffic, with 46,699 unique users having visited.
- The MHP has utilized chat lines to direct users to digital wellness resources that appears to be a promising method for promoting mental wellness.

ACCESS TO CARE

CMS defines access as the ability to receive essential health care and services. Access is a broad set of concerns that reflects the degree to which eligible individuals (or members) are able to obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, sufficient number of providers and facilities in the areas in which members live, equity, as well as accessibility—the ability to obtain medical care and services when needed.[1] The cornerstone of MHP services must be access, without which members are negatively impacted.

CalEQRO uses a number of indicators of access, including the Key Components and PMs addressed below.

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 22 percent of services were delivered by county-operated/staffed clinics and sites, and 78 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 51 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by an Administrative Service Organization (ASO), Carelon. Members may request services through the Access Line as well as through walk-in clinics, referrals from schools, primary care, the justice system, and through inpatient discharge. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. Both the ASO and walk-in clinic staff use the state screening tool and follow the No Wrong Door policy in providing assessment and referral services. Plan members discharged from psychiatric inpatient care are prioritized for access to services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 1,604 adults, 4,578 youth, and 66 older adults across 37 county operated sites and 73 contractor-operated sites. Among those served, 293 members received telehealth services in a language other than English in the preceding 12 months.

[1] CMS Data Navigator Glossary of Terms

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information in Table 1A and Table 1B.

In December 2022, DHCS issued its FY 2022-23 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Orange County, the time and distance requirements are 15 miles and 30 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

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

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Member Needs	Met
1C	Integration and/or Collaboration to Improve Access	Met
1D	Service Access and Availability	Met

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

- The MHP does a thorough assessment of the cultural, ethnic, racial, and linguistic needs of the eligibles. Cultural competence and responsiveness are infused in all aspects of the continuum of care, and there are extensive and innovative outreach strategies by the MHP to address diverse populations.
- The MHP tracks the attendance at its multiple, diverse large outreach events. In terms of the impact of these events on access to care, The MHP could measure their impact by tracking any increase in call volume to requests for services by the targeted groups. These outcomes would better demonstrate the impact of the outreach and engagement strategies.
- The MHP is actively involved in reducing homelessness and providing supportive housing, as evidenced by the opening of 120 new MHSA housing units, with another 350 units in the pipeline over the coming years.
- The MHP has strong partnerships with a number of external agencies. In the past year, it has worked on strengthening its law enforcement partnerships further to improve mobile response timeliness.
- Although many clinics and contract provider locations have many bilingual staff, the staff who are not bilingual must use the Language Line. Occasionally the interpretation line will drop, and the line staff are not all aware of the procedures to follow in such situations.
- The MHP has created a web-based comprehensive behavioral health services resource guide called the OC Navigator. However, simple web searches for these services do not bring this up as one of the top search results. There was confusion as to how best to access information from the OHCA website, especially regarding crises. At the time of writing this report, it appears that the agency and the MHP are working to clear up any confusion on the website with clearer links to crisis lines and the OC Navigator.

ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, members may be experiencing more challenges accessing mental health services in Orange than were seen statewide.

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

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	1,030,000	23,327	2.27%	$136,373,340	$5,846
CY 2021	954,392	25,442	2.67%	$155,555,131	$6,114
CY 2020	863,342	23,739	2.75%	$139,943,562	$5,895

Note: Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- There was a 19.3 percent increase in the number of eligible members between CY 2020 and CY 2022. The number of members served increased in CY 2021, then decreased to below the CY 2020 total in CY 2022. The increase in eligibles with an overall decrease in the number of members served resulted in a declining PR each year between CY 2020 and CY 2022.
- The AACM also increased in CY 2021 and decreased in CY 2022. In CY 2022, the MHP's AACM was 21 percent below the statewide average.
- The MHP takes a conservative approach to Medi-Cal billing and only billed 51 percent of services to Medi-Cal this past year. This lowers both the PR and the AACM.

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

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	84,162	555	0.66%	1.50%	1.82%
Ages 6-17	222,394	10,397	4.68%	5.01%	5.65%
Ages 18-20	57,183	1,782	3.12%	3.66%	3.97%
Ages 21-64	545,371	10,049	1.84%	3.73%	4.03%
Ages 65+	120,186	544	0.45%	1.64%	1.86%
Total	**1,030,000**	**23,327**	**2.27%**	**3.60%**	**3.96%**

Note: Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- PRs for all age groups, as well as overall PR, were lower than those for comparable-sized MHPs and statewide. The overall PR is 43 percent below the statewide PR, and is second lowest among all 56 MHPs.
- The largest differences between statewide and other large counties and MHP PRs were for adults and older adults.

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

Threshold Language	# of Members Served	% of Members Served
Spanish	5,949	25.99%
Vietnamese	618	2.70%
Korean	63	0.28%
Farsi	53	0.23%
Arabic	30	0.13%
Mandarin	23	0.10%
Members Served in Threshold Languages	**6,736**	**29.43%**
Threshold language source: Open Data per BHIN 20-070		

- Orange had six threshold languages, demonstrating the wide cultural diversity within the county. Almost three out of ten members served prefer one of the threshold languages. Over 25 percent of members served are Spanish speaking followed by 2.70 percent Vietnamese speakers.

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

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	355,836	6,237	1.75%	$41,220,333	$6,609
Large	2,532,274	76,457	3.02%	$535,657,742	$7,006
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This trend applies to the MHP's PR, but not to the AACM. The 1.75 percent ACA PR is lower than the 2.27 overall PR. The $6,609 ACA AACM is higher than the MHP's $5,846 AACM.
- The MHP's ACA PR is lower than the large county and half that of the statewide average for this group.

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

Table 7: Orange MHP PR of Members Served by Race/Ethnicity, CY 2022

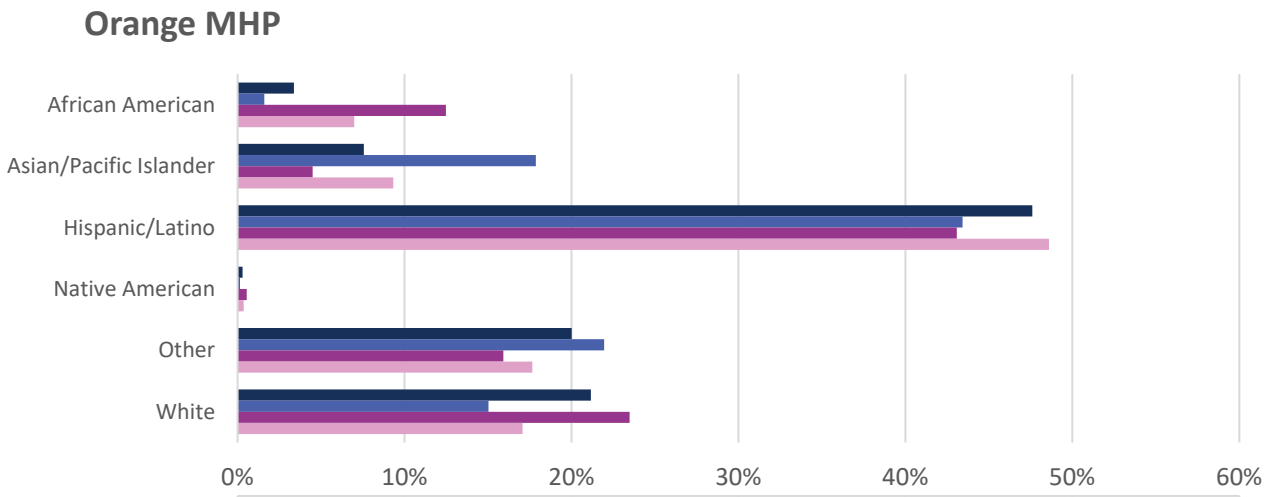
Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	16,493	787	4.77%	7.08%
Asian/Pacific Islander	183,843	1,765	0.96%	1.91%
Hispanic/Latino	446,908	11,103	2.48%	3.51%
Native American	1,474	69	4.68%	5.94%
Other	225,949	4,668	2.07%	3.57%
White	154,629	4,935	3.19%	5.45%
Total	**1,029,296**	**23,327**	**2.27%**	**3.96%**

Note: Total Annual eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- As the overall PR is far below the statewide numbers, all of the PR by race/ethnicity are lower as well.
- API and Other each had a PR lower than the 2.27 percent overall PR for the county. Hispanic/Latino, White, Native American and African American all had PRs higher than the MHP's overall PR.

- The API population makes up the third largest racial/ethnic group of annual eligibles in the county and has the lowest PR.

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

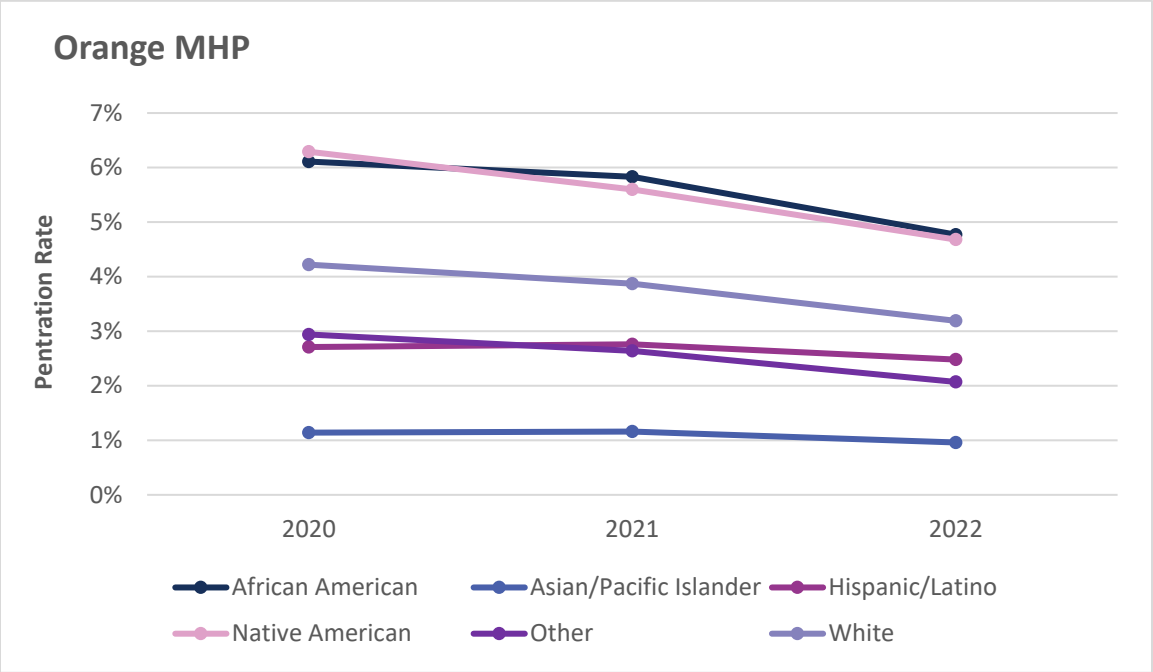


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	21%	20%	0%	48%	8%	3%
MHP % Eligible	15%	22%	0%	43%	18%	2%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- At 43 percent of the eligibles, Hispanics/Latinos make up 48 percent of the members served. Unlike statewide, a higher proportion of Hispanic/Latino members received services than their proportion of eligible members.
- The White and Other categories make up the next highest race/ethnicities receiving services. Similar to statewide, there are higher percentages of African American, Native American, and White members who received services than their total proportion of the Medi-Cal population.
- Also similar to statewide, lower proportions of API and Other members received services compared to their proportion of eligible members. API members were the most disproportionately underrepresented. They comprised 18 percent of eligibles but represented only 8 percent of those served.

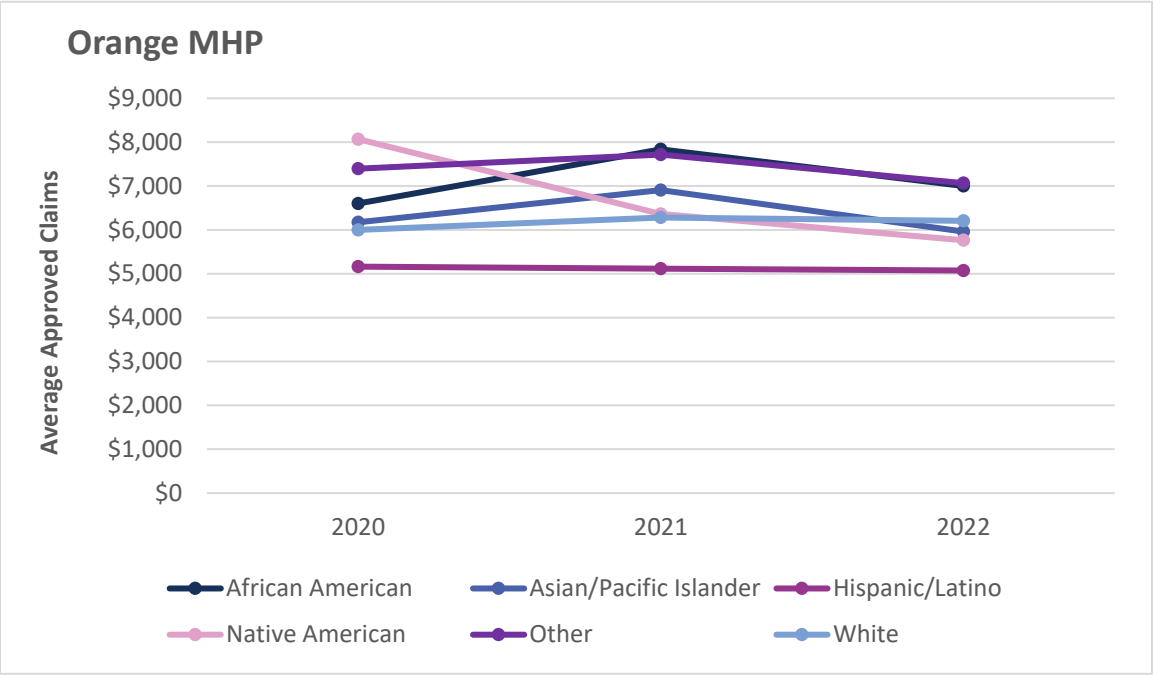
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



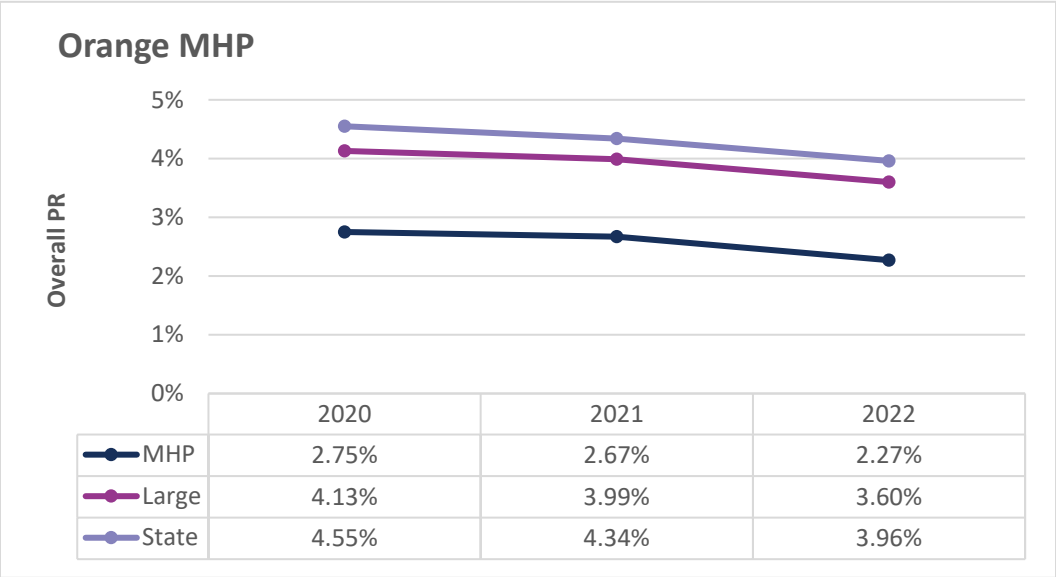
- The MHP shows a general downward trend of PR for all racial/ethnic groups between CY 2020 and CY 2022.
- The relative PRs for all racial/ethnic groups have been consistent for this three-year period. African Americans and Native Americans have had the highest PRs, followed by White, Hispanic/Latino and Other. The API groups had the lowest PR over the three-year period.

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



- Hispanics/Latinos had the lowest AACM each year between CY 2020 and CY 2022.
- With the exception of Native American members, AACMs by race/ethnicity have been relatively stable between CY 2020 and CY 2022. Other and African Americans have had the highest AACMs, followed by API, White, and Hispanic/Latino.
- Native Americans had the highest AACM in CY 2020, followed by decreases in CYs 2021 and 2022. Less than 1 percent of all members served are Native American which can factor into large variations in AACM from year to year due to outliers having an outsized impact on the average (mean).

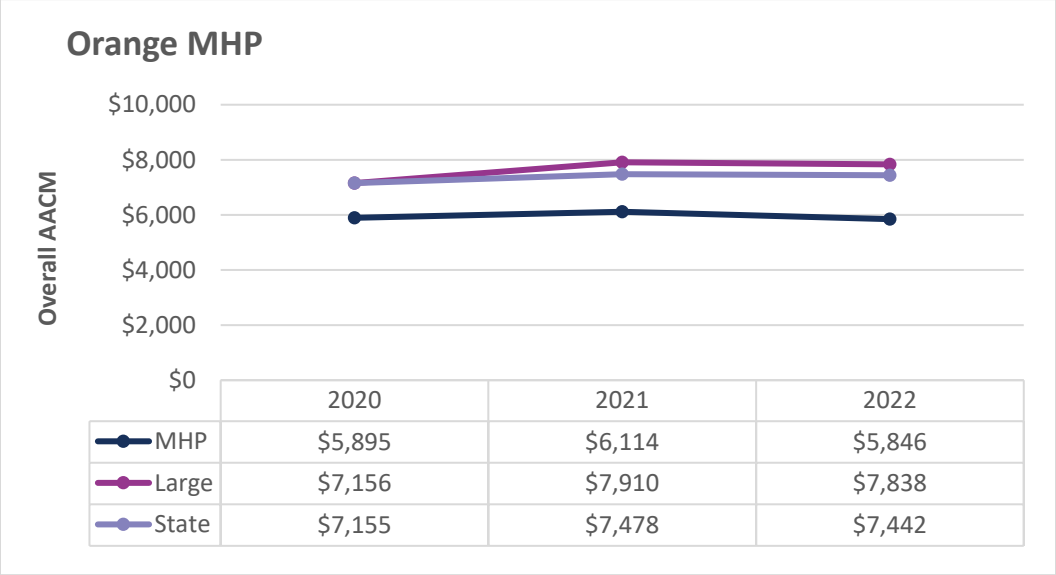
Figure 4: Overall PR CY, 2020-22



	2020	2021	2022
MHP	2.75%	2.67%	2.27%
Large	4.13%	3.99%	3.60%
State	4.55%	4.34%	3.96%

- PRs have been decreasing over the past three years across the state and large counties. The MHP's overall PR has been well below the statewide and other large county rates each of these years.

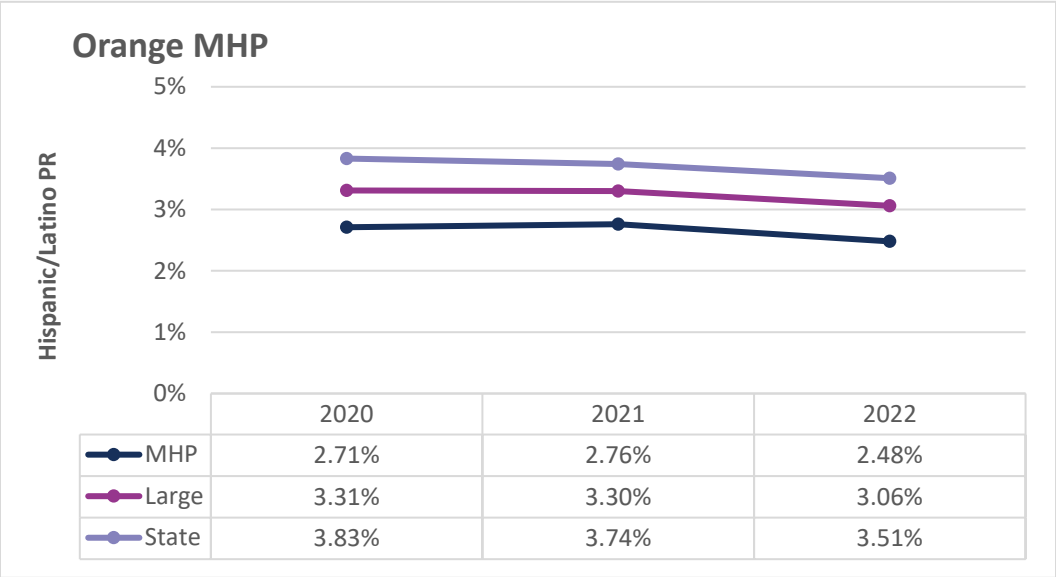
Figure 5: Overall AACM, CY 2020-22



	2020	2021	2022
MHP	$5,895	$6,114	$5,846
Large	$7,156	$7,910	$7,838
State	$7,155	$7,478	$7,442

- The MHP's AACM has been consistently lower than large county and statewide averages. While the statewide AACM increased between CY 2020 and CY 2022, the MHP's 2022 AACM was slightly lower than the CY 2020 AACM.
- The MHP did not increase its billing rate during the COVID-19 pandemic which contributed to relatively low AACMs in CYs 2020-22 compared to other counties.

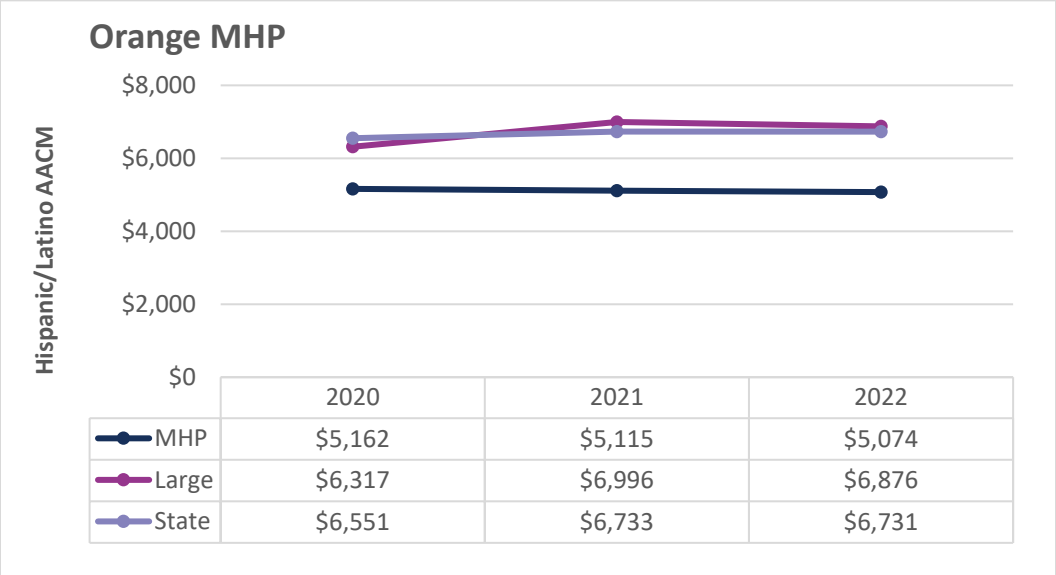
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	2.71%	2.76%	2.48%
Large	3.31%	3.30%	3.06%
State	3.83%	3.74%	3.51%

- Similar to the overall PR, the Hispanic/Latino PR is lower than large county and statewide rates, and has been decreasing these past three years.

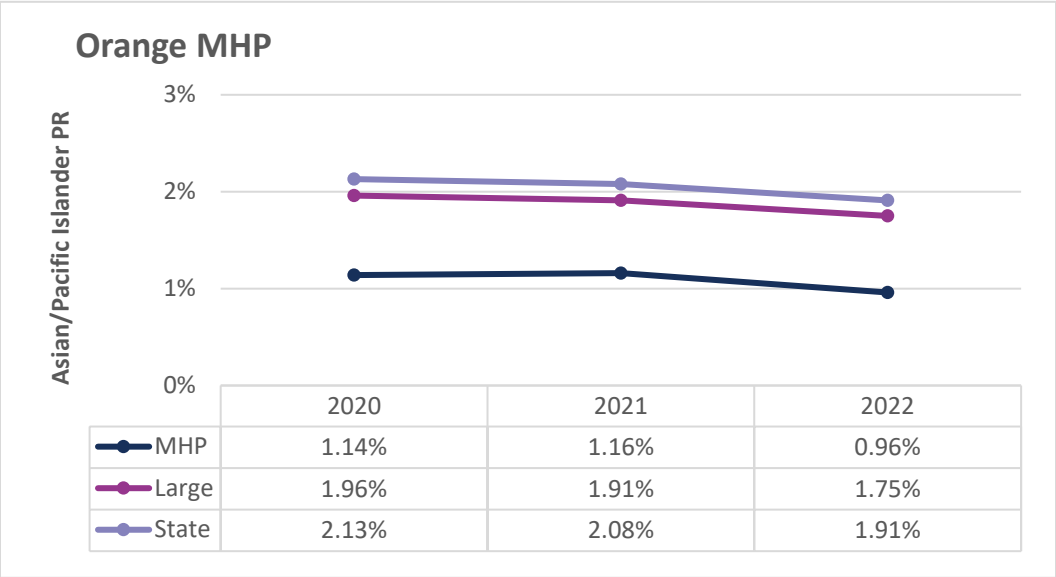
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$5,162	$5,115	$5,074
Large	$6,317	$6,996	$6,876
State	$6,551	$6,733	$6,731

- Similar to the overall AACM, the Hispanic/Latino AACM is lower than other large counties and the statewide rate. It has decreased slightly each year between CY 2020 and CY 2022.

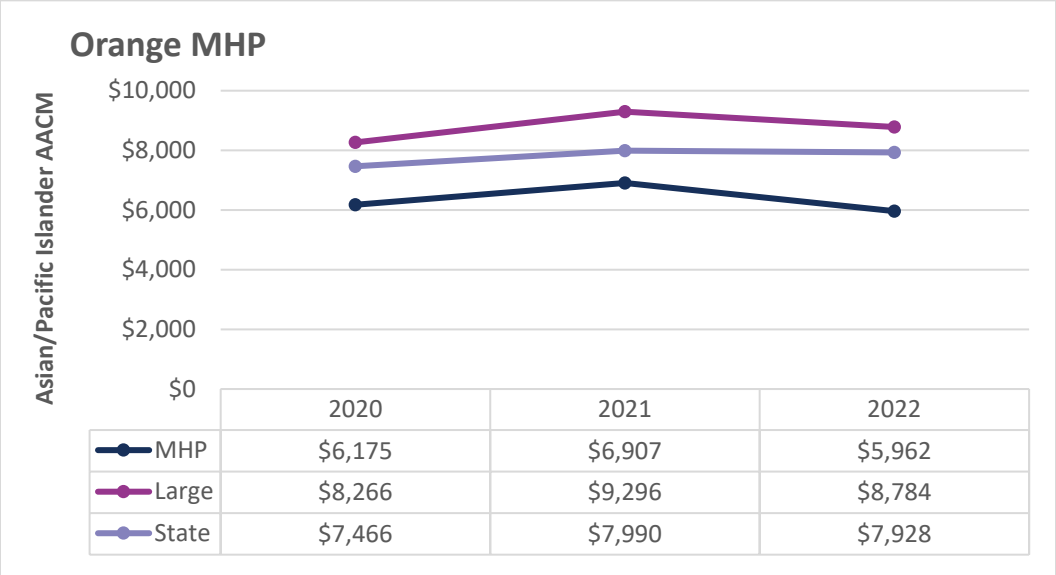
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	1.14%	1.16%	0.96%
Large	1.96%	1.91%	1.75%
State	2.13%	2.08%	1.91%

- The API PR continues to be well below PRs in large counties and statewide. In CY 2022 it was about half of the statewide rate.

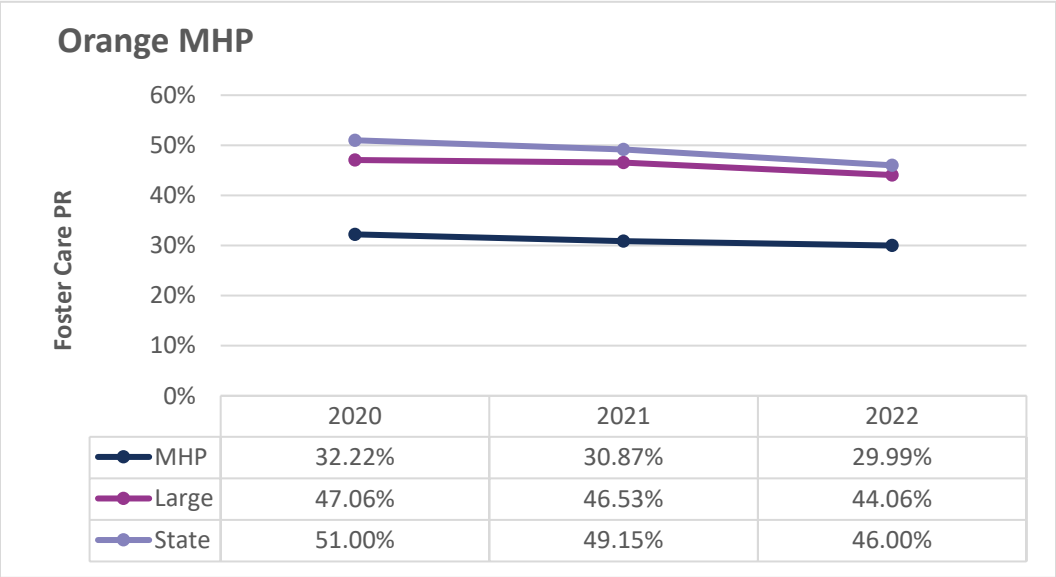
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$6,175	$6,907	$5,962
Large	$8,266	$9,296	$8,784
State	$7,466	$7,990	$7,928

- Similar to the overall AACM, the API AACM is lower than for large counties and the statewide. It went down steeply in CY 2022, to a lower rate than CY 2020. Despite being lower than other counties, in CY 2022, the API AACM was higher than the MHP's $5,846 overall AACM.

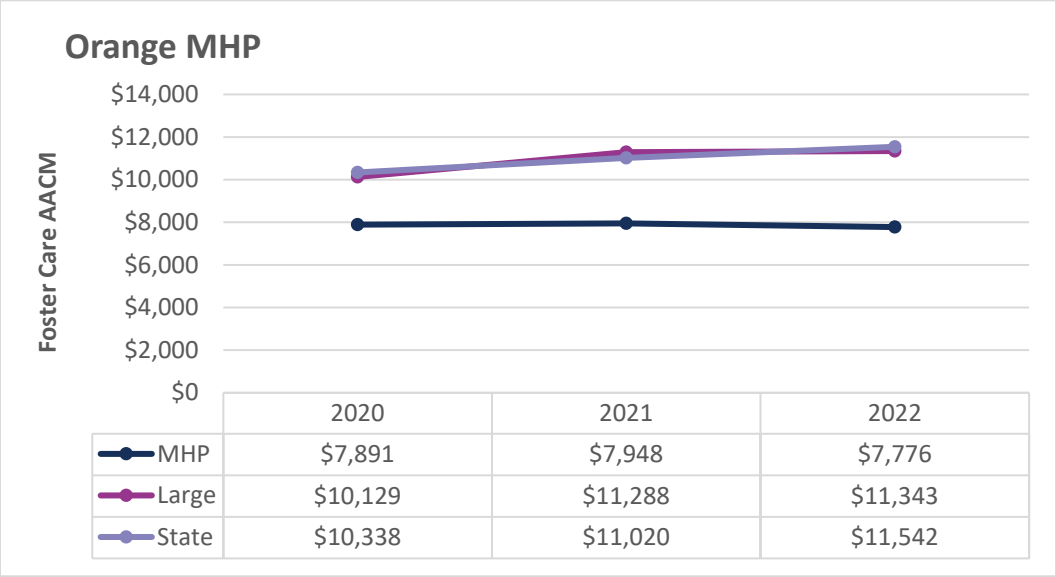
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	32.22%	30.87%	29.99%
Large	47.06%	46.53%	44.06%
State	51.00%	49.15%	46.00%

- Between CY 2020 and CY 2022 the MHP has consistently had a much lower PR for youth in FC as compared to the state as a whole and large counties. Each year the MHP's FC PR has been about two thirds of the large county PR.
- The MHP reported that the Child Welfare System (CWS) refers FC youth to their own network of contracted MH providers. The MHP is working with CWS to refer FC youth directly to the MHP. Referrals to the MHP have increased with implementation of the new screening tool, and they expect the FC PR to increase this year.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$7,891	$7,948	$7,776
Large	$10,129	$11,288	$11,343
State	$10,338	$11,020	$11,542

- Statewide FC AACM has increased each year for the past three years. The MHP's FC AACM has remained stable over the past three years, though it is consistently lower than the FC AACM for similar sized counties and statewide.

Units of Service Delivered to Adults and Foster Youth

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

Service Category	MHP N = 12,378				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	3,299	26.7%	10	6	10.3%	14	8
Inpatient Admin	<11	-	20	12	0.4%	26	10
Psychiatric Health Facility	<11	-	12	9	1.2%	16	8
Residential	0	0.0%	0	0	0.3%	114	84
Crisis Residential	456	3.7%	23	15	1.9%	23	15
Per Minute Services							
Crisis Stabilization	2,564	20.7%	1,485	1,200	13.4%	1,449	1,200
Crisis Intervention	1,935	15.6%	155	107	12.2%	236	144
Medication Support	5,936	48.0%	252	164	59.7%	298	190
Mental Health Services	7,001	56.6%	599	253	62.7%	832	329
Targeted Case Management	3,959	32.0%	268	123	36.9%	445	135

- Over one in four members served were hospitalized at some point in CY 2022. This represents a decrease from 29.4 percent of members in CY 2021. The number of hospitalized adults is also down from 4,145 in CY 2021. While the percentage of members served who received inpatient care is higher than statewide, the average inpatient length of stay (LOS) (10 days) was shorter than the statewide average (14 days).
- The percentage of members receiving crisis stabilization is up from 17.7 percent in CY 2021 to 20.7 percent in CY 2022. This is consistent with the increase from 10 to 51 crisis stabilization beds in the last three years.
- The most used adult services in the MHP were mental health services (MHS), medication support, and targeted case management (TCM), which was reflective of statewide utilization patterns. However, all three of these services were provided to a smaller proportion of members in the MHP than seen statewide,

and comparatively fewer average minutes were billed for those services. The greatest difference was in the units of service provided. The MHP provided an average of 599 minutes of MHS compared to 832 minutes statewide and 268 minutes of TCM compared to 445 minutes statewide.

- The MHP provided crisis residential services to 3.7 percent of members compared to 1.9 percent of members statewide. This is an important service to provide in light of the high inpatient utilization.

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

Service Category	MHP N = 774				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	56	7.2%	7	5	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	<11	-	17	17	0.1%	24	22
Full Day Intensive	<11	-	1,164	1,164	0.2%	673	435
Full Day Rehab	<11	-	114	114	0.2%	111	84
Per Minute Services							
Crisis Stabilization	29	3.7%	1,277	1,200	3.1%	1,166	1,095
Crisis Intervention	52	6.7%	338	155	8.5%	371	182
Medication Support	191	24.7%	366	182	27.6%	364	257
Therapeutic Behavioral Services (TBS)	35	4.5%	2,625	1,563	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	327	42.2%	1,054	398	40.8%	1,458	441
Intensive Home-Based Services	201	26.0%	2,176	826	19.5%	2,440	1,334
Katie-A-Like	<11	-	185	69	0.2%	390	158
Mental Health Services	733	94.7%	1,217	716	95.4%	1,846	1,053
Targeted Case Management	222	28.7%	152	73	35.8%	307	118

- The services provided most frequently to youth in FC were MHS, intensive care coordination (ICC), TCM, intensive home-based services (IHBS), and medication support. Compared to statewide FC service utilization, the MHP had lower utilization of TCM and higher utilization of IHBS.
- The utilization rates of ICC and IHBS suggest successful implementation of PWB services in the MHP.
- The MHP provided fewer average minutes in a number of service categories, most notably:
    - TCM – 152 minutes compared to 307 statewide.
    - Therapeutic Behavioral Services – 2,625 minutes compared to 4,077 statewide.
    - MHS – 1,217 minutes compared to 1,846 statewide.
    - ICC – 1,054 minutes compared to 1,458 statewide.
    - IHBS – 2,176 minutes compared to 2,440 statewide.
- A larger percentage of FC youth were hospitalized compared to statewide, though for fewer days.

IMPACT OF ACCESS FINDINGS

- Despite offering open access across multiple clinics and through contract providers, the MHP's PRs continued to be lower than those seen statewide across all racial/ethnic groups and all age groups, suggesting challenges with accessing services overall. The lowest PRs were among adults over the age of 65 (0.45 percent), children from birth to five (0.66 percent), API (0.96 percent), and adults aged 21-64 (1.84 percent). As the MHP works to stabilize staffing and then access, it may be prudent to evaluate and enhance the current strategies that aim to improve access for these particular populations.
- Declining inpatient readmission rates suggest that there is effective collaboration with psychiatric hospitals and provide evidence of success with quick follow-up services.
- The MHP's service utilization reflects an emphasis on high-acuity services, including inpatient and crisis services (i.e., use of inpatient, crisis stabilization, etc.) and lower utilization of planned outpatient services (e.g., MHS, medication support services, etc.). It is possible that staffing vacancies throughout the continuum of care may be contributing to this orientation. Consistent provision of services at lower levels of care may help decrease the need for crisis services and hospitalizations, but this requires adequate staffing. Additionally, the MHP might consider an analysis of service utilization to help prioritize limited resources.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to members. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved member outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the PMs section.

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

Table 10: Timeliness Key Components

KC #	Key Components – Timeliness	Rating
2A	First Non-Urgent Request to First Offered Appointment	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Partially Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Partially Met

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

- Staff and members indicate that there is a focus on engaging members quickly following hospitalization discharge, release from incarceration, and the homeless population in general. The focus on these populations does provide challenges in meeting timeliness standards for less immediate requests from other populations.

- The MHP indicated that the new screening tool has increased the number of non-urgent referrals they are receiving. Together with staffing issues, especially in children's services, is increasing the time to first non-urgent appointments.
- First offered non-urgent appointments varied greatly between adult and children's services. Adult services met the 10-day standard 99.9 percent of the time while children's services met the 10-day standard 53.7 percent of the time. There were similar discrepancies in first non-urgent services rendered data. To remedy the situation, the MHP has added 45 FTE through its children's services contracts. The contract providers remain in the process of filling these new positions because of the limited availability of qualified professionals.
- There was a discrepancy between the ATA reported timeliness to first offered psychiatric appointment data and what was anecdotally reported in EQR sessions. The ATA reported that 93.8 percent of first offered non-urgent psychiatry appointments met the 15-business day standard. Key informants reported that some first offered psychiatric appointments are being booked six weeks out. In contrast, the ATA reported data showed low rates of follow-up services after a psychiatric hospitalization, while staff and members felt that a follow-up appointment generally occurs within 24 hours of discharge.
- Unlike last year, the MHP was able to report on psychiatry first appointment timeliness for some contract providers, but still was not able to report on the entire system for this metric.
- The MHP is not able to report timeliness to urgent services in hours due to software limitations. The data for this metric is only available in days; it is converted to hours in Figure 13.
- The MHP's psychiatry no-show rates continue to be high, especially in the adult system of care (SOC) at 25 percent. The MHP is instituting automated reminders to address this issue. It also reported trying to fill psychiatrist vacancies so that the appointments can be provided faster than what is being offered now.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of ATA, representing access to care during the first three quarters of FY 2022-23. Table 11 and Figures 12- 14 below display data submitted by the MHP; an analysis follows. These data generally represent the entire system of care, although contract provider data for first offered psychiatric appointment and no-show rates are limited. Timeliness to urgent

services was reported in days. The EQRO converted the values to hours for consistent reporting across MHPs.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	9.3 Business Days	10 Business Days*	72.7%
First Non-Urgent Service Rendered	10.7 Business Days	10 Business Days**	64.1%
First Non-Urgent Psychiatry Appointment Offered	6.2 Business Days	15 Business Days*	93.8%
First Non-Urgent Psychiatry Service Rendered	7.9 Business Days	15 Business Days**	88.8%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required ***	33.6 Hours	48 Hours*	89.4%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	26.9 Calendar Days	7 Calendar Days	33.7%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	26.9 Calendar Days	30 Calendar Days	46.7%
No-Show Rate – Psychiatry	14.2%	15%**	n/a
No-Show Rate – Clinicians	7.0%	10%**	n/a

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

** MHP-defined timeliness standards

*** The MHP does not track separately any urgent services requiring pre-authorization.

For the FY 2023-24 EQR, the MHP reported its performance for the following time period: First three quarters of FY 2022-23

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

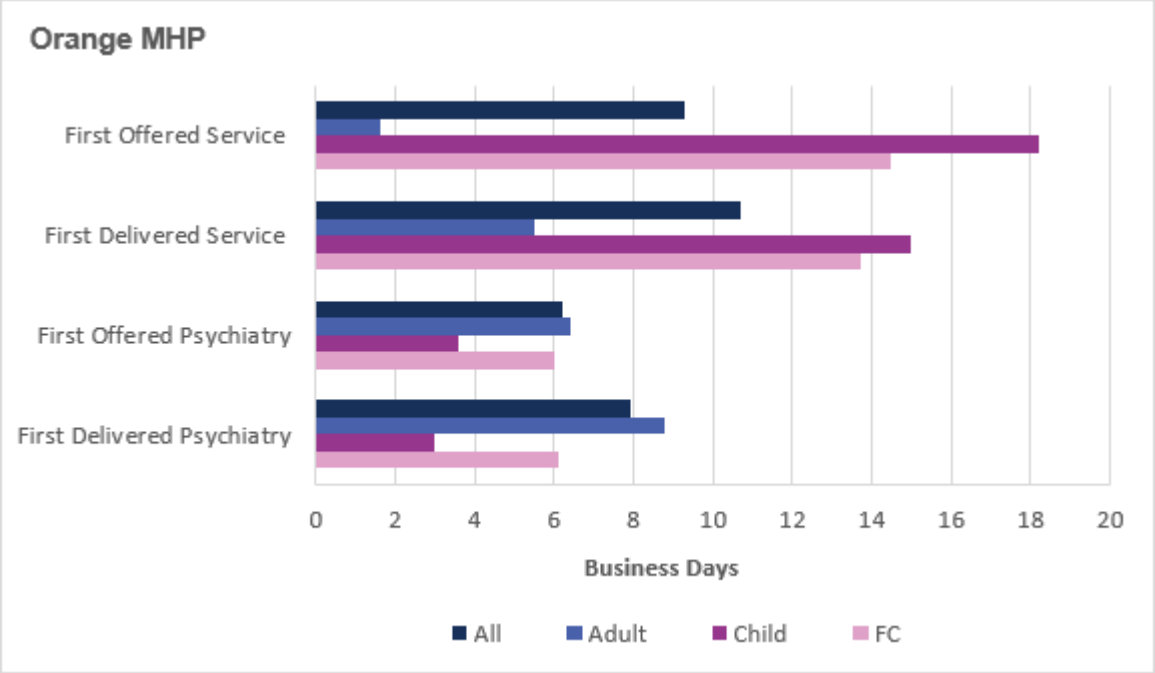


Figure 13: Wait Times for Urgent Services

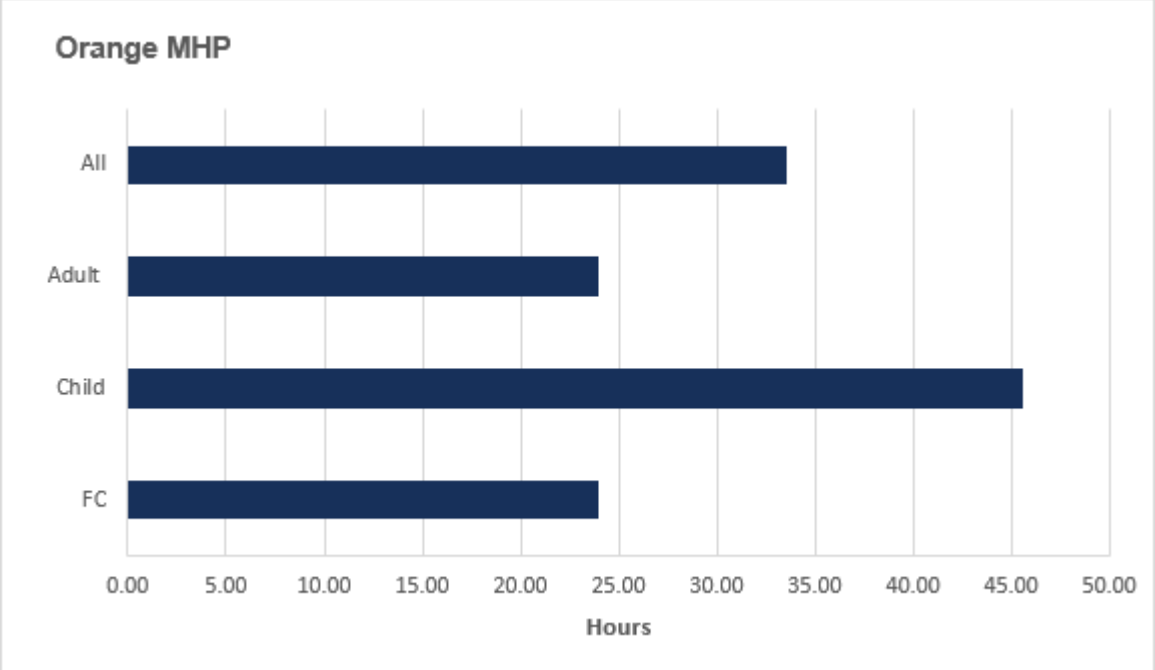
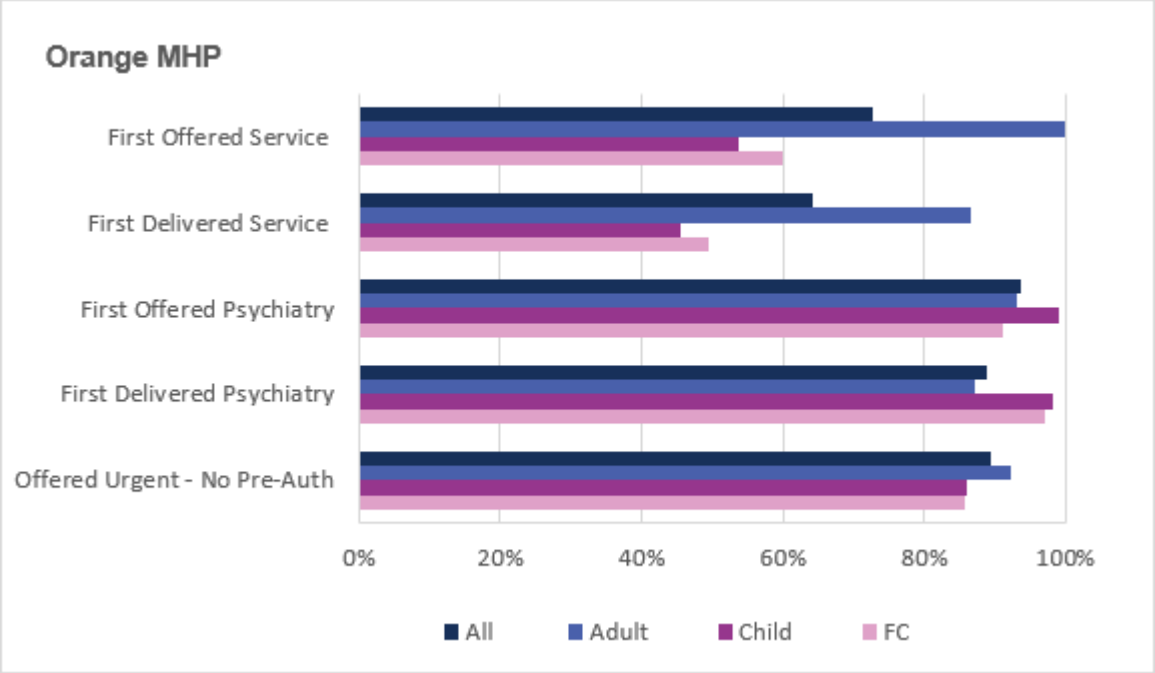


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments.
- The MHP reported that the FC timeliness data is based on an undercount of members because of its EHR limitations on capturing FC aid code for all FC members.
- The MHP defined “urgent services” for purposes of the ATA as typically hospital or jail transfers where a client has a near immediate need to be seen. There were reportedly 546 urgent service requests with a reported actual wait time to services for the overall population of 1.4 days (converted to 33.6 hours). The MHP does not offer urgent services that require pre-authorization.
- The MHP defines timeliness to first delivered/rendered psychiatry services as from the first clinical determination of need for both adults and children. The MHP included contract provider data; however, they indicated that they received limited contract provider data and are working with contractors to ensure the logging of critical information is done appropriately.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked. The MHP reports a no-show rate of 14.2 percent for psychiatrists and 7.0 percent for non-psychiatry clinical staff. The MHP reported that the no-show rates from contract providers were unrealistically low, and they are working with providers to improve the data.

- The MHP reported an average of 26.9 days from a psychiatric inpatient discharge to first follow-up service, 32.3 days for adults, 11.7 days for children and 14 days for FC.

IMPACT OF TIMELINESS FINDINGS

- There were inconsistencies in the ATA data and methodology that warrant follow-up. Psychiatric and no-show data reporting from contract providers was low and the MHP should continue working with the providers to insure they receive accurate data. First offered psychiatric appointments met the 15-day standard 93.8 percent of the time, but that figure was not consistent with what was reported during the review.
- Timeliness to urgent services was defined as mostly hospital or jail transfers where a member has a near immediate need to be seen. The MHP reported meeting the 48-hour standard 89.4 percent of the time while they only reported delivering 30-day follow-up services following a psychiatric discharge 46.7 percent of the time.
- Staffing shortages made it difficult for children and youth services to meet the 10-day standards for offering and delivering first non-urgent services. The increasing numbers of referrals is putting further stress on the system, creating staff morale issues, and contributing to ongoing staff vacancies.
- Psychiatry no-shows are a drain on valuable resources. While the MHP is trying out automated reminder calls and hiring more psychiatrists to improve appointment timeliness, it also provides an opportunity to utilize the peer workforce for reminder calls to add a human touch and potentially greater success in reducing the no-show rates.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is within the Quality Management Services (QMS) division which has multiple sub-divisions supporting the SOCs and the managed care services. In addition to QMS, Data Analytics is a separate division that works closely with QMS to provide all necessary QI-related program evaluation and data support including the PIPs.

The MHP monitors its quality processes through the Community Quality Improvement Committee (CQIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The CQIC comprises of the behavioral health director, SOC directors, QI director and staff, managers and line staff from both county and contract provider operated MHP and DMC-ODS programs, contract provider QI staff, plan members and family members. It is scheduled to meet quarterly and since the previous EQR, the MHP CQIC met three times. Additionally, the MHP has a monthly QI Coordinators' meeting, and a quarterly access and timeliness data meeting.

The MHP produces an integrated QAPI for both MHP and DMC-ODS. Of the 58 identified FY 2021-22 QAPI workplan goals, 40 were specific to the MHP or applicable to both MHP and DMC-ODS, and the MHP met 80 percent of these goals. There were various factors that contributed to the eight goals that were not met. For the access-related goals, the MHP set very high standards and narrowly missed them.

The MHP does not use a LOC tool. It has implemented the statewide screening tool to determine whether a member should be treated by the MHP or an MCP. The care team determines LOC based on program criteria. Given the high utilization of inpatient services, this is an area that warrants consideration.

The MHP utilizes the following outcomes tools: Ages and Stages Questionnaire, Child and Adolescent Needs and Strengths (CANS), General Anxiety Disorder scale, Milestones of Recovery Scale, Patient Health Questionnaire, and the Pediatric Symptoms Checklist (PSC-35). Additionally, FSP data on functional outcomes, including days spent homeless and days spent in jail, are collected and analyzed annually.

The MHP analyzes and produces CANS and PSC-35 findings by domains and summarizes these results by county and contract providers as well as at the program levels in a dashboard format. The MHP is in the process of developing dashboards for more automated, customized report production.

QUALITY KEY COMPONENTS

CalEQRO identifies the following components of SMHS healthcare quality that are essential to achieve the underlying purpose for the service delivery system – to improve outcomes for members. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Partially Met
3H	Utilizes Information from Member Satisfaction Surveys	Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Member and Member Employment in Key Roles throughout the System	Met

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

- Orange MHP is a data-driven organization that has invested heavily in creating QI, data analytics, and program evaluation units. The newly created data analytics division has several analyst positions that the MHP is currently recruiting for. The data dashboards presented to the EQRO and their utilization by different divisions provided testament to this organizational culture.

- The MHP is in the process of analyzing the outcomes findings in a new and more meaningful way that will be a shift from the traditional percentage changes and statistical significance testing.
- The MHP has been expanding peer mentoring in hospitals and the crisis assessment team. Field-based peer mentors follow members for up to 60 days after a psychiatric inpatient hospitalization or CSU admission.
- Crisis and acute services has a new program that focuses on high inpatient hospital utilizers with the goal to develop individual treatment plans to reduce hospitalizations.
- The MHP has a good partnership with the MCP and other agencies working to "end homelessness" in the county.
- New and expanding "bed boards" are dashboards that provide up-to-date information on bed availability and assist crisis and acute services and law enforcement. Public access to the data is also available.
- The EQRO sessions with various stakeholders revealed that there have been improvements in communication in the past year, but more work remains to be done.
    - Members report that some clinics have a monthly community meeting where they can provide input, but it did not appear universal.
    - While peer staff endorsed their ability to speak to a supervisor and opportunities for promotions, they also voiced the need for more communication from the leadership in clarifying their roles both for themselves and the clinicians they work with.
    - Line staff felt that they input a lot of data, but do not have access to or are unaware of their ability to access reports that summarize those data. Many also seemed unaware of opportunities to join various committees that may have staff members.
    - Contract providers noted improvements in communication in the past year. However, they also noted the need for further bi-directional communication and incorporating their voices in significant system changes taking place due to the implementation of California Advancing and Innovating Medi-Cal (CalAIM) and payment reform.
    - The cultural competency committee, known as the Behavioral Health Equity Committee (BHEC) in Orange County, has community partner agency and individual member representation.
    - Although the BHEC and CQIC both produce many reports on access, timeliness, quality, and outcomes, there is no clear and formalized communication structure between the two that is in their charters.
- The MHP produces comprehensive summary findings at the system and program levels from CANS and PSC-35 but does not utilize any LOC tool to guide clinical decisions regarding transitions between different LOCs for youth or adults.

- The MHP reported that it is working on revising its medication monitoring tool. As noted in the FY 2022-23 EQR report, the current medication monitoring tool does not emphasize the HEDIS measures and uses the same items across both adult and children's SOCs. Further, for the two HEDIS measures that the MHP reported tracking for the FC youth, relevant staff were not aware of them.
- While the MHP has excellent peer-run wellness centers in each of its service regions, there does not appear to be a process for informing the members of their existence or services.
- The MHP tracks but does not trend the following HEDIS measures as required by WIC Section 14717.5.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- The MHP does not track or trend the following HEDIS measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

QUALITY PERFORMANCE MEASURES

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

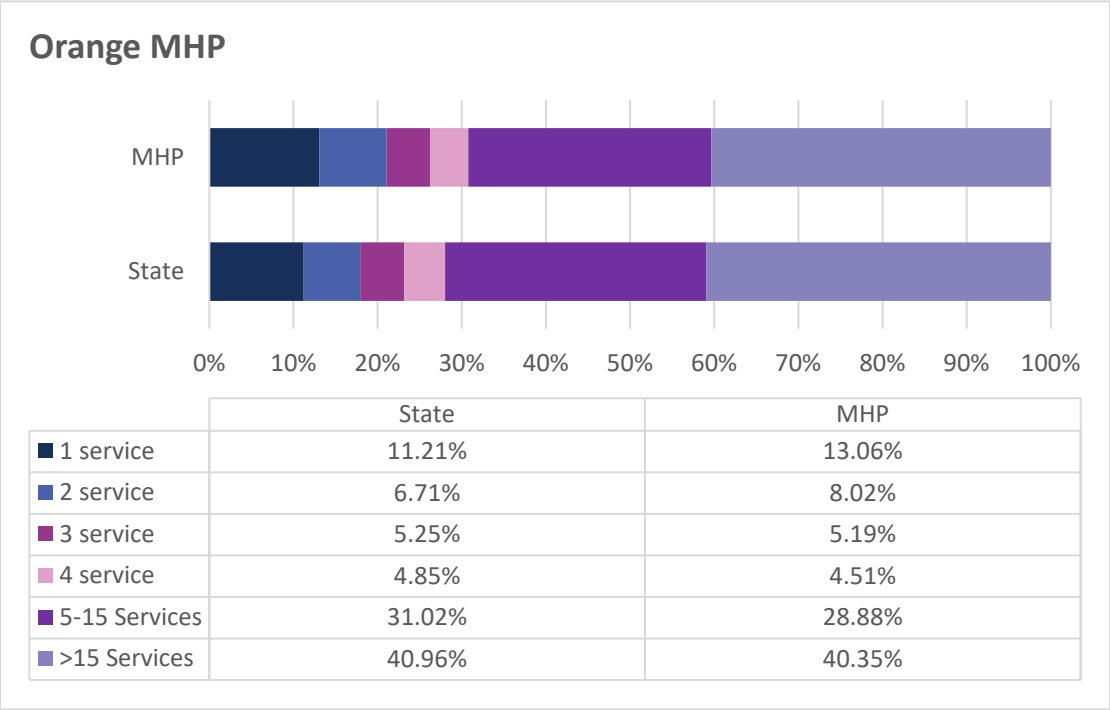
- Retention in Services
- Diagnosis of Members Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- High-Cost Members (HCMs)

Retention in Services

Retention in services is an important measure of member engagement in order to receive appropriate care and intended outcomes. One would expect most members served by the MHP to require five or more services during a 12-month period. However,

this table does not account for the LOS, as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Retention of Members Served, CY 2022



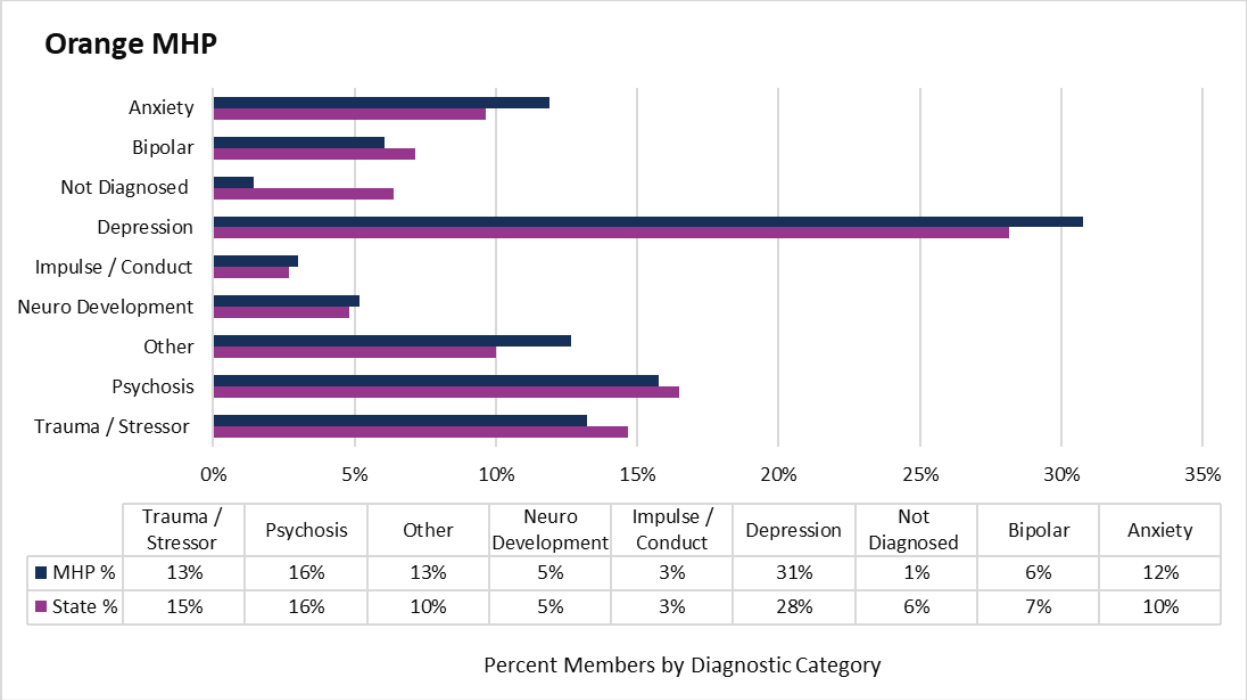
	State	MHP
1 service	11.21%	13.06%
2 service	6.71%	8.02%
3 service	5.25%	5.19%
4 service	4.85%	4.51%
5-15 Services	31.02%	28.88%
>15 Services	40.96%	40.35%

- The MHP had a slightly larger proportion of members receiving one or two services than was seen statewide and had a slightly smaller proportion of members retained for five or more services.

Diagnosis of Members Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared to statewide. This is not an unduplicated count as a member may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

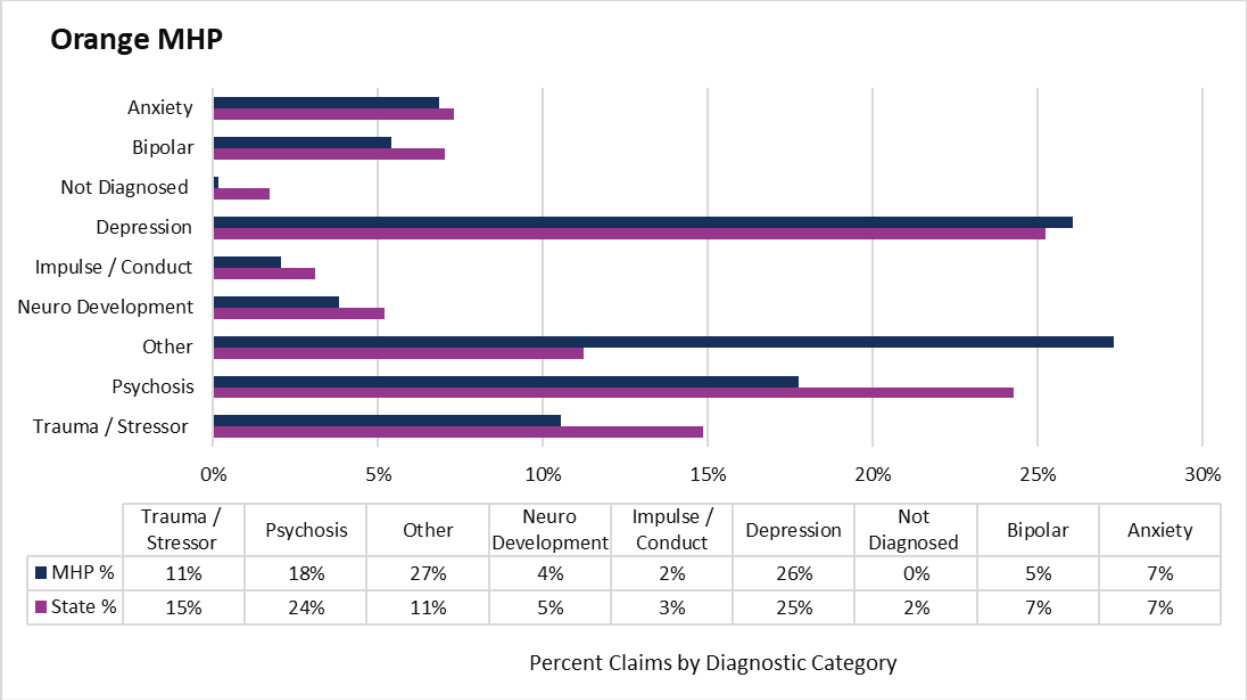
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	13%	16%	13%	5%	3%	31%	1%	6%	12%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- Diagnostic patterns in the MHP were similar to those seen statewide. The greatest difference was in category of not diagnosed, with a 5-percentage point lower rate than statewide. The MHP indicated that with a conservative approach to Medi-Cal billing, they were less likely to claim for services prior to a diagnosis than other counties. This data is validated by the MHP's medication monitoring report item on the same.

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



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	11%	18%	27%	4%	2%	26%	0%	5%	7%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- The diagnostic category with the highest percentage of approved claims is the Other category. Further analysis by CalEQRO showed that many of these claims were related to eating disorders and substance use disorders, indicating that the MHP is working with members with these disorders.
- The next most frequent diagnostic categories on claims were depression, psychosis, and trauma/stressor.

Psychiatric Inpatient Services

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

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

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	3,428	4,229	1.23	9.58	8.45	$10,925	$12,763	$37,452,286
CY 2021	4,033	4,881	1.21	13.49	8.86	$13,865	$12,696	$55,916,896
CY 2020	3,777	4,665	1.24	13.47	8.68	$12,882	$11,814	$48,657,074

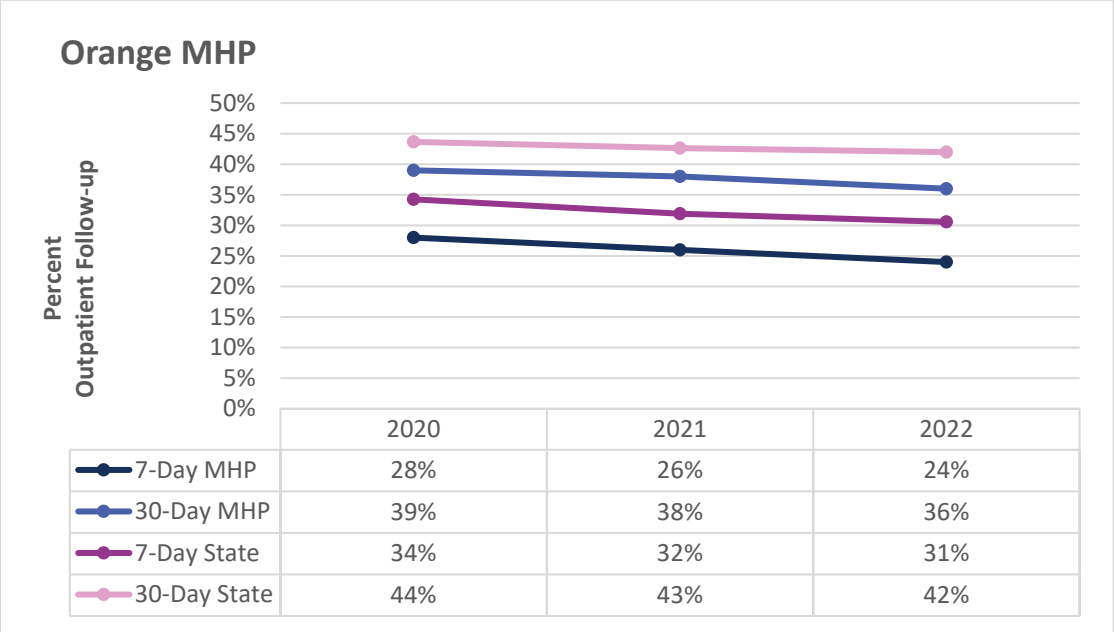
- In CY 2022 the MHP has evidenced some reduction in all inpatient-related measures displayed above, including a significant reduction in ALOS, now one day longer than the statewide ALOS.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

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

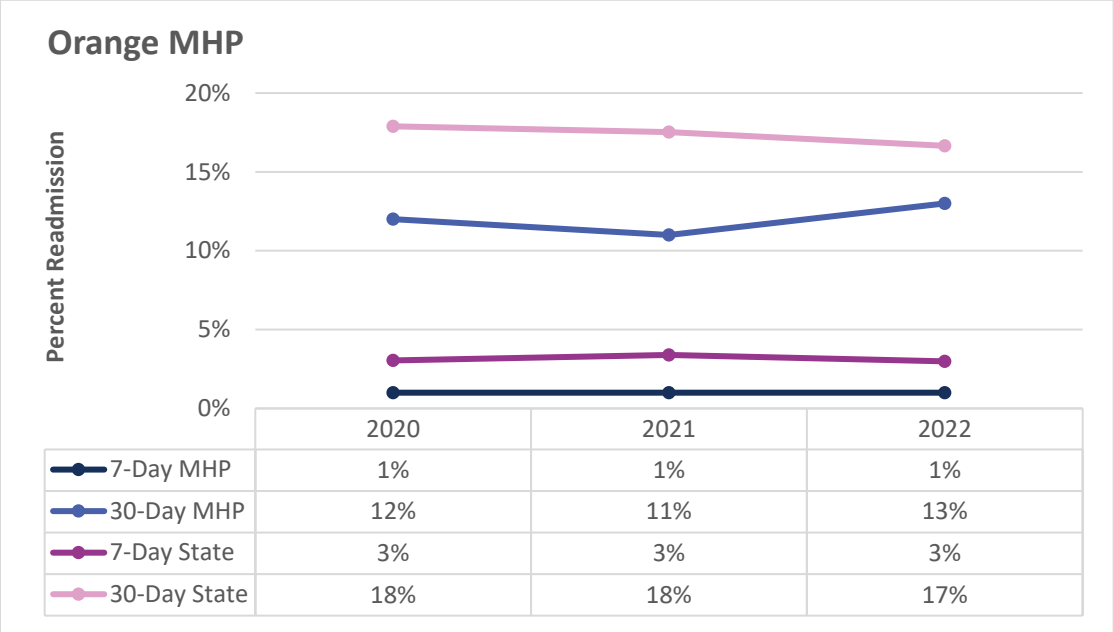
Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22



	2020	2021	2022
7-Day MHP	28%	26%	24%
30-Day MHP	39%	38%	36%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- Both claims data and MHP-provided data show relatively low 7- and 30-day post psychiatric inpatient follow-up rates, despite improving readmission rates. As reflected in Figure 18, the MHP's rates have been lower than statewide rates for all of the past three years.
- The MHP has field-based peer mentors follow members for up to 60 days after a psychiatric inpatient hospitalization or CSU admission. Consistent follow-up might have a more pronounced impact on readmissions than the date of the initial contact following a discharge.

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



	2020	2021	2022
7-Day MHP	1%	1%	1%
30-Day MHP	12%	11%	13%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- MHP readmission rates increased at 30-days in CY 2022, but remained below the statewide rates.
- Crisis and acute services has a new program that focuses on high inpatient hospital utilizers, with the goal of developing individual treatment plans to reduce hospitalizations.

High-Cost Members

Tracking the HCMs provides another indicator of quality of care. High cost of care represents a small population's use of higher cost and/or higher frequency of services. For some clients, this level and pattern of care may be clinically warranted, particularly when the quantity of services are planned services. However high costs driven by crisis services and acute care may indicate system or treatment failures to provide the most appropriate care when needed. Further, HCMs may disproportionately occupy treatment slots that may prevent access to levels of care by other members. HCM percentage of total claims, when compared with the HCM count percentage, provides a subset of the member population that warrants close utilization review, both for appropriateness of LOC and expected outcomes.

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

Tables 14 and 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of

the statewide members are “low-cost” (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

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

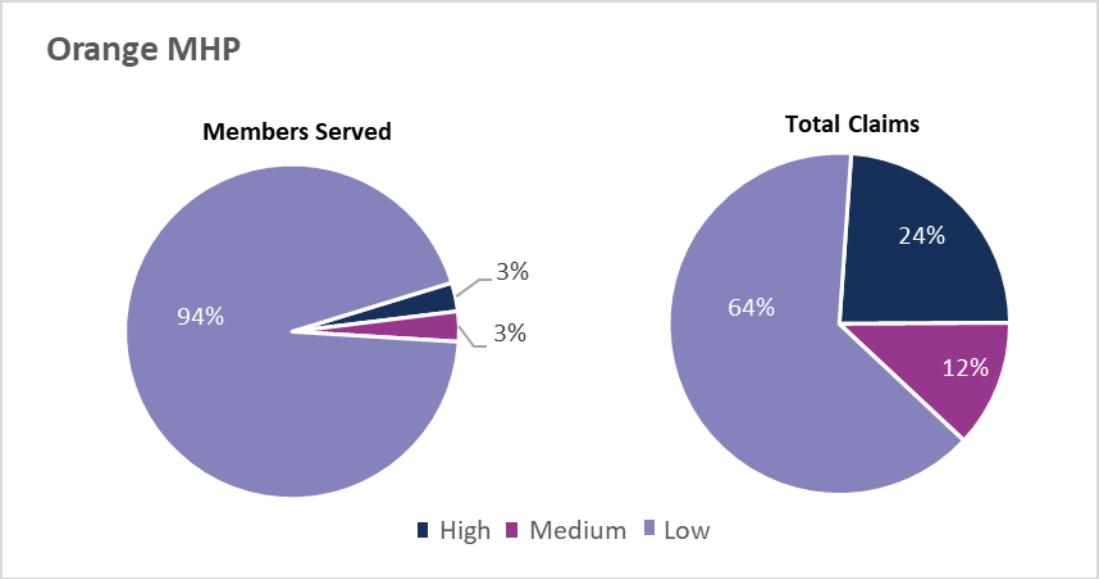
Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	648	2.78%	23.80%	$32,453,099	$50,082	$43,072
	CY 2021	829	3.26%	31.34%	$48,744,365	$58,799	$46,234
	CY 2020	666	2.81%	28.55%	$39,959,098	$59,999	$44,688

- The MHP has a low percentage of members and claims that are in the HCM category.

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

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	678	2.91%	12.06%	$16,443,877	$24,254	$23,925
Low-Cost (Less than $20K)	22,001	94.32%	64.14%	$87,476,363	$3,976	$2,569

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



- The MHP has more members in the low-cost category than statewide. While statewide nearly 92 percent of members are "low-cost," in the MHP 94 percent of members are considered low-cost, and they account for 64 percent of approved claims. Statewide, low-cost members represent 54 percent of approved claims.

IMPACT OF QUALITY FINDINGS

- The MHP's data-driven decision-making culture permeates through the system across the SOCs and the managed care services. It has invested heavily in data analytics and program evaluation, both in staffing and reporting software. Automated reporting through dashboards will allow for more error-free and customizable reports for more staff and supervisors.
- Under the new leadership, the MHP's communications with various stakeholders appear to be improving, but further strategic initiatives are needed for more uniform information sharing and bi-directional communication.
- As the MHP undertakes revising its medication monitoring forms and procedures, it will be important to incorporate HEDIS measures tracking and trending mechanisms.
- The MHP needs to improve its communication to plan members about the wellness centers including training its new clinical staff about how and when to incorporate such communication to enhance member wellness and recovery.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Rehospitalization Reduction in Children/Youth After First Hospitalization

Date Started: 10/2022

Date Completed: Estimated to be completed by 10/2024

Aim Statement: "Within one year, will implementing a FSP service referral option, compared to standard outpatient clinic services, for children/youth (Medi-Cal-funded) who were not open to the MHP and being discharged from their first ever psychiatric hospitalization reduce the 7-day baseline readmission rate of 8% to 4%, the 30-day rate of 27% to 14%, the 3-month rate of 28% to 14%, the 6-month rate of 8% to 4%, the 9-month rate of 7% to 4%, and the 5% 12-month readmission rate? Year 2 goals will be established at the end of Year 1."

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

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

Target Population: Children and youth aged 5 to 17 who are discharged from Children's Hospital of Orange County (CHOC) after their first hospitalization and have not received any prior MHP services.

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

Summary

Based on the existing literature, the MHP is expecting to significantly reduce rehospitalization rates for children and youth after their first hospitalization by connecting them to more intensive services as offered by the FSP programs. The target population for this PIP excludes those with records of previous MHP services as those children typically have more defined pathways for step-down treatment. The MHP chose CHOC as the initial roll-out site because of the existing connections and procedures already in place with the facility and the number of individuals who get hospitalized there. For the FSP connection, one children's FSP is the main recipient of the PIP target population, although other FSPs may be used if they provide a more appropriate venue for a particular child or youth.

In addition to the standard 7- and 30-day readmission rates, the MHP plans to track these rates for 60-, 90-, 180-, 270-, and 365-day periods as well. At the time of the review, the MHP submitted the second quarterly remeasurement data from March 2023. At that time, readmission rates were available only for up to the 90-day period. Despite some promising trends for the cohort that accepted FSP services, the count was low and the MHP was not able to establish any statistically significant improvements at that time.

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because based on the available data, the count of members impacted remains low, and any comparison with the naturally occurring groups, (i.e., treatment-as-usual and refused-any-follow-up-services) was not possible.

The MHP requested and received TA on this PIP prior to the review.

CalEQRO recommendations for improvement of this clinical PIP:

- The knowledge gained from this review can be further refined by tracking the findings with readily available clinical data from the EHR such as diagnosis, treatment intensity or dosage, and other concurrent services that were provided following inpatient discharge. CalEQRO provided this suggestion prior to the review in August 2023.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Improving Adults' Timely Access to Mobile Crisis Support

Date Started: 06/2023

Date Completed: N/A

Aim Statement: "Will the use of a standardized acuity tool introduce a reliable method for requesting law enforcement earlier in the dispatch planning process, thus improving timely access to mobile crisis services for adults as measured by:

- The CAT assessment, when law enforcement co-responds, starts no longer than 5 to 10 minutes after the median Arrival-to-Start time when law enforcement does not co-respond (in CY 2024), and
- The CAT assessment process starts within 60 minutes from the time the need for mobile crisis response is identified at least 70% of the time (after CAT is staffed at 80% or cross-training of staff is complete)"

Target Population: All adult members calling the OC Links phoneline and requesting a crisis response.

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

Summary

The goal of the PIP is to increase timely access to crisis services by introducing a standardized screening tool during phone requests for the Adult Crisis Assessment Team (CAT) so that, if safety concerns are identified, coordinating law enforcement co-response occurs earlier in the dispatch planning process. In turn, this will reduce unnecessary delays in starting the assessment once Adult CAT arrives on scene to support the person in crisis.

By streamlining the process of when the CAT is accompanied by co-responders from law enforcement, the MHP hopes to conform to the new state guidelines on new mobile crisis benefit standards which under the current set-up have not been met in the previous data examined by the MHP. At the time of the review, the MHP was in the process of developing the tool and implementing this PIP.

TA and Recommendations

As submitted, this non-clinical PIP was found to have no confidence because no baseline data were available.

The MHP received TA on this PIP in August 2023 when CalEQRO endorsed moving the project forward.

CalEQRO recommendations for improvement of this non-clinical PIP:

- Establish the baseline and determine percentage improvements for goals.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Oracle (formerly Cerner) Millennium Software Applications, which has been in use for 22 years. Currently, the MHP has no plans to replace the current system, as it is functioning in a satisfactory manner.

Approximately 5.1 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs), which is down from the reported 8.9 percent in the previous year. The budget determination process for IS operations is a combined process involving MHP control and another county department or agency.

The MHP has 4,389 named users with log-on authority to the EHR, including approximately 1,060 county staff and 3,329 contractor staff. The number of users has more than doubled since last year when there were 2,101 users reported. Support for the users is provided by 23.35 full-time equivalent (FTE) IS technology positions, which is a decrease of 0.7 FTE. Currently there are 2.5 unfilled FTE positions. In addition to the increase in the number of EHR users, the nature of the work is increasingly more complex with new programs, new functionality, new state and federal requirements, and the need for more interoperability.

As of the FY 2023-24 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to Orange MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	3%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	97%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. In previous years, county adult MHP members had a PHR to view histories, medications, and scheduled appointments. Access for minor-aged members was restricted due to confidentiality limitations. Now a technical issue is preventing access for adults as well. IT staff are working with the vendor to address issues and restore PHR functionality, but at the time of the review no timeline had been established for resolving the issues.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with MHP contract providers, substance use disorder contract providers, public health services, and correctional health services.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive member outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP has strong security controls in their IT environment. They perform annual penetration tests of the county network by a third-party vendor. They also successfully used their systems continuity plans several times this past year.
- The MHP's claims denial rate, 1.97 percent, is below the statewide denial rate of 5.92 percent, reflecting effective claiming processes and well-trained billing staff. They bill services in a timely manner and will begin billing for FY 2023-24 outpatient services after they receive a software upgrade from their vendor. Regular weekly meetings with the vendor are occurring with measures in place to capture services which are being provided in the meantime that will be claimed once updates are complete.
- The MHP indicated that with payment reform they plan to evaluate their processes regarding what are billable services since only 51 percent of services have been billed to Medi-Cal.
- Currently, contract providers must enter service and some outcomes data directly into the EHR, but they are not able to retrieve other clinical data from the EHR. Contract providers maintain independent EHRs, resulting in their staff needing to do double entry to submit information to two EHRs.
- IT and QM are working on a new cloud-based data warehouse which will refine the processes for data extraction, cleaning, and loading. The new process is expected to greatly reduce the time between generating reports from quarterly to weekly. The new process is also expected to be the platform for enabling bi-directional data exchange with contract providers while still maintaining separate EHR systems.
- In an increasingly complex IT environment, staff vacancies make it difficult to implement required and desirable projects. Data analytics approved positions are

more substantial than IS at 33.5 FTEs; however, MHP data analytics positions are at a 41 percent vacancy rate at the time of the review.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

Table 18 appears to reflect a largely complete or very substantially complete claims data set for the time frame represented.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	35,432	$7,499,777	$121,531	1.62%	$7,378,246
Feb	36,478	$8,001,377	$128,251	1.60%	$7,873,126
Mar	43,384	$9,657,886	$143,018	1.48%	$9,514,868
April	37,473	$8,450,525	$144,064	1.70%	$8,306,461
May	36,635	$8,580,296	$173,519	2.02%	$8,406,777
June	36,320	$8,629,862	$172,587	2.00%	$8,457,275
July	31,864	$7,711,461	$157,989	2.05%	$7,553,472
Aug	37,402	$9,201,182	$190,332	2.07%	$9,010,850
Sept	36,614	$9,227,904	$208,427	2.26%	$9,019,477
Oct	38,320	$9,412,887	$283,721	3.01%	$9,129,166
Nov	36,706	$8,538,296	$142,874	1.67%	$8,395,422
Dec	35,313	$8,379,170	$165,733	1.98%	$8,213,437
Total	**441,941**	**$103,290,623**	**$2,032,046**	**1.97%**	**$101,258,577**

Table 19: Summary of Orange MHP Denied Claims by Reason Code, CY 2022

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Other healthcare coverage must be billed first	2,268	$876,263	43.12%
Medicare Part B must be billed before submission of claim	1,348	$348,120	17.13%
Service line is a duplicate and repeat service modifier is not present	1,491	$317,777	15.64%
Beneficiary is not eligible or non-covered charges	831	$287,703	14.16%
Other	247	$173,344	8.53%
Service location National Provider Identifier (NPI) issue	18	$16,925	0.83%
Late claim submission	19	$4,898	0.24%
Deactivated NPI	3	$3,576	0.18%
Place of service incomplete or invalid	2	$3,439	0.17%
Total Denied Claims	**6,227**	**$2,032,045**	**100.00%**
Overall Denied Claims Rate	**1.97%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The MHP's denied claims rate, 1.97 percent, is lower than the statewide denial rate of 5.92 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Reviewing processes relating to what is a Medi-Cal billable service might result in more claims being billed and increased federal funds available for maintaining services. This is especially important with the implementation of payment reform.
- The current high vacancy rate for data analytics positions will continue to impact staff workload as well as system development efforts related to clinical care and interoperability. With the expanded development of CalAIM, increased and focused investment and recruiting for these positions would expedite development.
- Implementation of the new data warehouse, even with just county generated data, will vastly improve the timeliness of reports for administrative and operational use.
- The MHP continues to explore approaches to facilitate information exchange. The MHP should prioritize these efforts in order to improve interoperability, remove the duplicative processes its contract provider staff must engage in, and improve clinical data exchange.
- The system updates related to payment reform are negatively impacting cash flow for Orange County as well as contract providers due to the inability to claim under payment reform until the updates are implemented. While efforts are underway to implement these updates, continued delays will be increasingly difficult for programs to absorb ongoing costs without reimbursement.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP presented the last CPS data from May 2022. It routinely analyzes the CPS data extensively by age groups and domains, comparing each average to the corresponding statewide averages. The results are presented and discussed in the monthly QI coordinators' and the quarterly CQIC meetings.

In addition, the MHP requires its ASO to conduct an access satisfaction survey including member experience with the access call line.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held via videoconference and included eight participants of whom three initiated services in the last 12 months; a Spanish language interpreter was used for this focus group. All consumers participating receive clinical services from the MHP.

The participants reported quick access and intake into the programs they are currently receiving services from. Those with psychiatric hospitalization history received rapid follow-up services.

The participants also reported that they receive a good balance of services including medication support, therapy, case management, and opportunities for other activities.

They noted that the staff are always positive and promote recovery. The following statements from the participants testify to their positive experience:

- “I’m surrounded by hopeful people, positivity, given tools to succeed – it’s contagious!”
- “They (the staff) are preparing us to go back into society, not as normal, but as a better self.”

Recommendations from focus group participants included:

- Make it easier for homeless or mentally ill individuals to access information on qualifying criteria for any particular program.
- More staff to lessen their workload.
- More locations, bigger locations.
- More supplies for activities, as they are always running out.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of parents, family members, and caregivers of children and youth who had initiated services in the preceding 12 months. The focus group was held via videoconference and included five participants; a Spanish language interpreter was used for this focus group. All participants have one or more children who received clinical services from the MHP.

Those who started services within the past 12 months felt that access to services was timely and within two weeks, although they reported that access time can vary from program to program. They also reported that the programs offered flexibility and regularly scheduled appointments.

Services are mostly in-person, but the participants noted that as needed, they were able to switch to telehealth. The participants also reported easy access to service information in Spanish language and bilingual providers.

The participants reported that they had not been asked to be on any committees. At least two did not recall completing a satisfaction survey although that could be a function of how long their children have been receiving the services.

Recommendations from focus group participants included:

- Receptionists need to be welcoming to parents as well as children.
- Therapists need to “really listen” to parents, not just “talk at” the parents and caregivers.
- Doctors should show more empathy with children.

Consumer Family Member Focus Group Three

CalEQRO requested a group of adult consumers who are Vietnamese speakers and initiated services in the preceding 12 months. The focus group was held via videoconference and included seven participants; a Vietnamese language interpreter was used for this focus group; however, all participants were English speakers. All consumers participating receive clinical services from the MHP.

Those who entered services in the past 12 months noted that they had quick intake after hospitalization and received consistent services. They also reported that translation and transportation services were available and family members' involvement in their treatment was easy.

All participants were grateful to have housing, treatment, support, and medication available in one place and felt that it made a huge difference in their lives. "With everything more consistent, doctor, meds, housing, support – it's life changing."

The participants also reported that telehealth meets most of their needs. They were not aware of much information about the MHP nor any opportunities for involvement in committees. They felt that such opportunities should be advertised more so people in need know what it takes to get into different programs.

Recommendations from focus group participants included:

- For those needing non-psychiatric medication, better coordination is needed.
- Three days is too long for someone in urgent need; reduce wait times for urgent care.

SUMMARY OF MEMBER FEEDBACK FINDINGS

The MHP appears to be able to provide quick intake and assessment for new members seeking services. In particular, its efforts to provide rapid follow-up post-psychiatric hospitalization were validated by the focus group participants. The MHP provides flexibility in its services including telehealth on demand, transportation, and housing support.

The focus group participants did not have uniformly good experience with the clinic front desks. This was particularly true for monolingual (non-English-speaking) family members with children receiving MHP services.

The May 2022 CPS family survey domain averages also point toward some room for improvement as the scores were slightly lower than the statewide averages in all domains. These findings were different from the youth, adult, and older adult survey results where the MHP compared well with the state.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP has fostered a strong data-driven decision-making culture among its managerial staff. (Quality)
2. The MHP's appears to show some initial successes in its strategies for rapid inpatient follow-up services and a focus on high inpatient utilizers. (Timeliness, Quality)
3. The MHP offers multiple avenues for access to services beyond the regular access line that includes open access through designated clinics and contract provider programs. (Access)
4. The MHP has very strong partnerships and collaborations with external agencies such as the criminal justice system, law enforcement, social services, primary care, and MCPs, that enhance appropriate care. (Access, Quality)
5. The MHP has been working diligently in developing and expanding supportive housing for members. (Access, Quality)
6. The MHP demonstrates strong security and continuity controls in their IT environment. System continuity plans were used multiple times in the past year and all limited downtime to well below their 24-hour goal. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. Despite offering open access across multiple clinics and through contract providers, the MHP's PRs continued to be lower than those seen statewide across all racial/ethnic groups and all age groups, suggesting challenges with accessing services overall. The lowest PRs were among adults over the age of 65, children from birth to five, API, and adults aged 21-64. (Access)
2. Despite the MHP's significant efforts toward developing web portals for information on access to services, a lack of clarity remains for the outsiders who use established web searches to get to the MHP information sites. (Access)
3. There were inconsistencies in timeliness data that should be investigated and improved upon, including receiving complete contractor data sets for non-urgent psychiatric appointments and no-show data. A vacancy rate for data analysts at 41 percent makes this very difficult. (Timeliness, IS)

4. The MHP's medication monitoring protocol does not fully incorporate the required HEDIS measures or methodology. Further, it lacks distinctions in its current monitoring protocol between adult and youth members. (Quality)
5. There is limited clinical information exchange between county and contract providers. In addition, contract provider staff must enter service and financial into both their EHR and the county EHR. (Quality, IS)
6. According to its ATA, the MHP did not meet the 10-business day standard for children and youth by a large margin. (Timeliness)

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the EQR and are intended as TA to support the MHP in its QI efforts and ultimately to improve member outcomes:

1. Continue to work toward improving access as measured by the overall PR, with particular focus on the populations with the lowest PRs. Evaluate attrition from initial call to initial service as well as the current outreach and engagement strategies. (Access)
2. Continue to streamline MHP access and service information working with both the health agency and the established search engines so those seeking information from the outside are directed straight to the latest and most comprehensive website. (Access)
3. Additional IS staff positions within the OHCA are needed for ongoing support and development within the MHP system of care. OHCA would benefit from enhanced support from County HR for the successful recruitment of vacant data analytics positions that provide key support for the MHP in assessing system capacity, timeliness, and performance measures used in making data-informed decisions. (IS)
4. Incorporate the applicable HEDIS measures into the medication monitoring protocol; start tracking the remaining PWB mandated HEDIS measures for the FC members. (Quality)
5. Continue the efforts to enable clinical, demographic, and financial information exchange with contract providers, in lieu of a shared EHR. (IS)

   (This recommendation is a carry-over from FY 2021-22 and FY 2022-23.)

6. Continue developing and implementing new strategies to improve children's timeliness to first offered non-urgent appointments. (Timeliness)

EXTERNAL QUALITY REVIEW BARRIERS

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

The MHP did not identify any barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Orange MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for PWB (Katie A./Continuum of Care Reform)
Consumer and Family Member Focus Groups
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Clinical Directors Group Interview
Specialized Service Systems: Homeless Outreach and Housing
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Clinical Management and Supervision
Community-Based Services Agencies Group Interview
Information Systems Billing and Fiscal Interview
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Saumitra SenGupta, Ph.D., Lead Quality Reviewer
Naga Kasarabada, Ph.D., Quality Reviewer
Zena Jacobi, Information Systems Reviewer
MaryEllen Collins, Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Abbassi	Sherri	Regional Director	Mental Health Association (MHA)
Aguilar	Glenda	Health Services Manager	Orange MHP
Al Hawasli	Ashlee	Behavioral Health Clinician II	Orange MHP
Albie	Nicole	Regional Director	Western Youth
Alma	Ken	Service Chief II	Orange MHP
Amantine-Taylor	Liz	Administrative Manager I	Orange MHP
Anderson	Kyle		Orange MHP
Aparicio	Carla	Clinician	APCC Santa Ana Alt Residential
Athar-Macdonald	Huma	Clinical Psychologist II	Orange MHP
Ayala	Blanca Rosa	Behavioral Health Clinician II	Orange MHP
Balcom	Heather	Program Manager II	Orange MHP
Banicki	Wendy	Service Chief I	Orange MHP
Bart	Ashley	Behavioral Health Clinician II	Orange MHP
Bautista	Paola	Administrative Manager II	Orange MHP
Bennett	Andrew	Research Analyst IV	Orange MHP
Berardino	Stacey	Interim Assistant Deputy Director	Orange MHP
Borucki	Ewa	Research Analyst IV	Orange MHP
Brack	Yvonne	Service Chief I	Orange MHP
Brassaw	Robert	Behavioral Health Clinician II	Orange MHP
Briones-Montiel	Veronica	Program Director	Straight Talk's Gerry House
Button	Lisa	Outpatient Program Manager	The Teen Project
C	Christina		Orange MHP
Calvario	Cynthia	Program Manager	Western Pacific Med Corp
Camarena	Oscar		Orange MHP

Last Name	First Name	Position	County or Contracted Agency
Carmona	Vanessa	Clinician	Pathways
Carter	Jeffrey	Program Manager	Western Pacific Med Corp
Castaneda	Dolores	Service Chief II	Orange MHP
Castellanos	David	Information Security Officer	Orange MHP
Ceja	Eduardo		Orange MHP
Chang	Rina	Clinician	AMFT – Project Focus
Chang	Tina	Regional Programs Director	Olive Crest
Chavez	Jesi	Team Lead	Telecare - Contract
Choi	Susie	Health Program Specialist	Orange MHP
Crump	John	Health Services Manager	Orange MHP
Dabbs	Michelle	Regional Director	Telecare
Del Castillo	Andy	Clinician	Western Youth
DeMarco	Patricia	Medical Director	Orange MHP
Dimitriadis	Kindra	Administrative Manager II	Orange MHP
Dinicola	Jennifer	Administrative Manager II	Orange MHP
Duplesse	Nichole	Health Program Specialist	Orange MHP
Elliot	Wendy	Service Chief II	Orange MHP
Ernt	Tracy	Health Services Manager	Orange MHP
Ewing	Tanji	Behavioral Health Clinician II	Orange MHP
Fernandez	Jennifer	Behavioral Health Clinician II	Orange MHP
Fuentes	Edward	Behavioral Health Clinician II	Orange MHP
Garcia	Heather	Program Manager	Western Pacific Med Corp
Garcia	Joe	Mental Health Worker II	Orange MHP
Glinski	Michelle	Health Program Specialist	Orange MHP
Gonzalez	Claudia	Behavioral Health Clinician II	Orange MHP

Last Name	First Name	Position	County or Contracted Agency
Gonzalez	Claudia	Behavioral Health Clinician II	Orange MHP
Gonzalez	Sophia	Senior Program Director	Phoenix House OC
Hagos	Asmeret	Service Chief II	Orange MHP
Hayden	Erika	Behavioral Health Clinician II	Orange MHP
Heilman	Rebecca	Research Analyst IV	Orange MHP
Helmy	Deana	Acting Ethics Services Manager	Orange MHP
Henriquez	Jennifer	Administrative Manager I	Orange MHP
Hoang	Sharon		Orange MHP
Howard	April	Senior Research Analyst	Orange MHP
Huffman	Charles “Scott”	Associate Medical Director	Orange MHP
Ibarra	Marisela	Business Services Manager	Orange MHP
Inglis	Andrew	Associate Medical Director	Orange MHP
Ishikawa	Sharon	Interim Assistant Deputy Director	Orange MHP
Jannise	April	Health Services Manager	Orange MHP
Johnson	Kimberly	Program Manager	Western Pacific Med Corp
Jones	Eric		Phoenix House
Katsarov	Carmen	Executive Director	CalOptima Health
Kee	Matthew	Administrative Manager II	Orange MHP
Keefe	Nicole	Administrative Manager II	Orange MHP
Kelley	Veronica	Chief of Mental Health & Recovery Services	Orange MHP
Kemmer	Ian	Assistant Deputy Director	Orange MHP
Kettler	Marian	Service Chief II	Orange MHP
Khalil	Karim	Behavioral Health Clinician I	Orange MHP
Kim	Alice	Administrative Manager II	Orange MHP
Ko	Grace	Behavioral Health Clinician II	Orange MHP

Last Name	First Name	Position	County or Contracted Agency
Lam	Chi	Health Services Manager	Orange MHP
Lama	Christina	Clinician	Pathways in Tustin
Lawrenz	Mark	Interim Assistant Deputy Director	Orange MHP
Le	Anthony	Administrative Manager II	Orange MHP
Lee	Shaun	Behavioral Health Clinician II	Orange MHP
Lemire	Alicia	Division Manager	Orange MHP
Linares	Maria	Behavioral Health Clinician II	Orange MHP
Lopez	Ashley	Office Assistant	Orange MHP
Lopez	Azahar	Interim Assistant Deputy Director	Orange MHP
Lopez	Nathan	Program Manager II	Orange MHP
Lu	John		Orange MHP
Lum	Mark	Psychologist	Orange MHP
Malabanan	Chantelle	Program Director	MHA Lake Forest
Marshall	Richanne	Program Director	Waymakers CCFSP
Matsubayashi	Chiyo	Health Services Manager	Orange MHP
McCraney	Beau	Service Chief I	Orange MHP
Melear	Erika	Behavioral Health Clinician II	Orange MHP
Meyers	Jeannie	Behavioral Health Clinician II	Orange MHP
Miltmore	Matthew	IT Applications Developer II	Orange MHP
Mitchum	Liane	Clinician	Orange MHP – Psych at Orangewood
Moran	Berenice	Administrative Manager II	Orange MHP
Mugrditchian	Annette	MHRS Deputy Director	Orange MHP
Nguyen	Sarah	Behavioral Health Clinician II	Orange MHP
Nguyen	Thuy	Behavioral Health Clinician II	Orange MHP
Niino	Lisa		Orange MHP

Last Name	First Name	Position	County or Contracted Agency
November	Katie	Chief Operating Officer	Western Youth
Okubo	Sandra	Senior Research Analyst	Orange MHP
Parsley	Laura	Behavioral Health Clinician II	Orange MHP
Pelehberg	Skarlet	STRTP Head of Service	South Coast Community Services
Peralta	Hilary	Service Chief II	Orange MHP
Perez	Luis	Behavioral Health Clinician I	Orange MHP
Phan	Nina	Administrative Manager I	Orange MHP
Phan	Sarah	Mental Health Worker II	Orange MHP
Pitts	Cheryl	Behavioral Health Clinician II	QMS CYSST
Punchard	Erika	Administrative Manager II	Orange MHP
Radomski	Rebekah	Service Chief II	Orange MHP
Read-Gomez	Christy	Service Chief II	Orange MHP
Renteria	Teresa	Health Services Manager	Orange MHP
Richardon	Janice	Service Chief II	Orange MHP
Rick	Tracy	Administrative Manager II	Orange MHP
Roberts	Caroline	Behavioral Health Clinician II	Orange MHP
Rogers	Michael	Administrative Manager II	Orange MHP
Row	Lisa	Health Services Manager	Orange MHP
Ruelas	Maby	Staff Assistant	Orange MHP
Ruff	Simone	Director	Corporation for Supportive Housing
Saavedra	Sherylove	Health Program Specialist	Orange MHP
Sabet	Kelley	Chief Compliance Officer/Civil Rights Coordinator	Orange MHP
Sagubo	Erin	Behavioral Health Clinician I	Orange MHP
Secrist	Carolyn	Administrative Manager II	Orange MHP
Sering	Suzie	Program Director	Pathways Anaheim

Last Name	First Name	Position	County or Contracted Agency
Serna	Renee	Office Specialist	Orange MHP
Shreenan	Catherine	Service Chief II	Orange MHP
Shreenan	Catherine	Service Chief II	Orange MHP
Siddiqui	Adil	Chief Information Officer	Orange MHP
Siddiqui	Zara		Orange MHP
Sigafoos	Timothy	Service Chief II	Orange MHP
Smith	Carlee	Intake Coordinator	Contract – APCC Intake Coordinator
Smith	Dawn	Assistant Deputy Director	Orange MHP
Solano	Brenda	STRTP Program Supervisor	Olive Crest
Stroem	Ida	Research Analyst IV	Orange MHP
Taking	Felicia	Program Administrator	TAO Central
Tang	Sang-Patty	Behavioral Health Clinician I	Orange MHP
Taylor	Melody	Administrative Manager I	Orange MHP
Thomas	Vanessa	Senior Health Services Manager	Orange MHP
Thornton	April	Health Services Manager	Orange MHP
Tran	Annette	Health Services Manager	Orange MHP
Trujeque	Desiree	Clinical Director	Twin Town
Turakhia	Atur	Associate Medical Director	Orange MHP
Valenzuela	Miguel	Behavioral Health Clinician II	Orange MHP
Vazquez	Maria		Telecare - contract
Weckerly	Christina	Senior Health Services Manager	Orange MHP
Weidhaas	Susan	Health Services Administrator	Orange MHP
Yu	Angela	Associate Medical Director	Orange MHP
Zdeba	Michelle	Administrative Manager	Orange MHP

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence	As submitted, this clinical PIP was found to have low confidence, because the low count at the time of the second remeasurement, as well as since any comparison with the naturally occurring groups, i.e., treatment-as-usual and refused-any-follow-up-services was not possible.

General PIP Information
MHP/DMC-ODS Name: Orange
PIP Title: Rehospitalization Reduction in Children/Youth After First Hospitalization
PIP Aim Statement: "Within one year, will implementing a FSP service referral option, compared to standard outpatient clinic services, for children/youth (Medi-Cal-funded) who were not open to the MHP and being discharged from their first ever psychiatric hospitalization reduce the 7-day baseline readmission rate of 8% to 4%, the 30-day rate of 27% to 14%, the 3-month rate of 28% to 14%, the 6-month rate of 8% to 4%, the 9-month rate of 7% to 4%, and the 5% 12-month readmission rate? Year 2 goals will be established at the end of Year 1."
Date Started: 10/2022
Date Completed: N/A
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☒ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: 5-17

General PIP Information
Target population description, such as specific diagnosis (please specify): Children and youth experiencing their first hospitalization at CHOC with no previous MHP service history.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Offer FSP-level services in addition to clinic-based services as part of discharge process to the target population.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): N/A
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): N/A

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percent of Medi-Cal children/youth (previously not open to MHP) rehospitalized w/in 7 days, 30 days, 3 months, 6 months, 9 months, and 12 months	FY 2021-22	N=142 7-day - 8% 30-day – 27% 3-month – 28%	☐ Not applicable—PIP is in planning or implementation phase, results not available. March 2023	N=8 7-day - 13% 30-day – 13% 3-month – 13%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): N/A

PIP Validation Information
Was the PIP validated? ☒ Yes ☐ No "Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☒ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: Increase FSP Enrollment. Track additional available clinical data – diagnosis, service intensity, adjunct services.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence	The MHP is in the process of establishing the baselines for this PIP.
General PIP Information	
MHP/DMC-ODS Name: Orange	
PIP Title: Improving Adults' Timely Access to Mobile Crisis Support	
PIP Aim Statement: Will the use of a standardized acuity tool introduce a reliable method for requesting law enforcement earlier in the dispatch planning process, thus improving timely access to mobile crisis services for adults as measured by: • The CAT assessment, when law enforcement co-responds, starts no longer than 5 to 10 minutes after the median Arrival-to-Start time when law enforcement does not co-respond (in CY 2024), and • The CAT assessment process starts within 60 minutes from the time the need for mobile crisis response is identified at least 70% of the time (after CAT is staffed at 80% or cross-training of staff is complete)	
Date Started: 06/2023	
Date Completed: N/A	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): All adult plan members calling the OC Links phoneline and requesting a crisis response.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Implement Acuity Tool
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Train staff on Acuity Tool
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): 1) Develop and validate Acuity Tool; 2) Request calls for law enforcement, if needed, at start of CAT dispatch process

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Percentage of Level II recommendations from the Acuity Tool that coincide with CAT not requesting law enforcement after they have dispatched	2023	N/A	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of law enforcement requests originating from the Acuity Tool where law enforcement is present	2023	N/A	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Time in minutes, from arrival time to start of the assessment process (i.e., Arrival-to-Start)	2023	N/A	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Time in minutes, from the time the need for a mobile crisis response is identified to start of the assessment process (i.e., Assigned-to-Start)	2023	N/A	☒ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☐ Yes ☒ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year

☐ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☒ No confidence

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP: N/A

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM THE MHP DIRECTOR

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