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FY 2022-23
MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

SANTA BARBARA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

April 18 – 19, 2023

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 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, "Santa Barbara" may be used to identify the Santa Barbara County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — April 18-19, 2023

MHP Size — Medium

MHP Region — Southern

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	4	1	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	4	2	0
Quality of Care	10	7	3	0
Information Systems (IS)	6	6	0	0
TOTAL	**26**	**20**	**6**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Mental Health Treatment Court	Clinical	11/2022	Planning phase	Moderate
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	09/2022	Planning phase	Moderate

Table D: Summary of Consumer/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	6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP made organizational changes including new management positions to provide dedicated focus on outpatient, inpatient, crisis, equity, and peer employment.
- The MHP has begun and has further plans to extensively evaluate its crisis services.
- The MHP demonstrates routine use of data for quality and capacity management.
- The MHP increased communications regarding workforce areas organization wide improving organizational understanding and morale.
- The MHP developed a well-organized plan for implementing the SmartCare electronic health record (EHR) in July 2023.

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

- The MHP hospital readmission rate is higher than the state rates at 7- and 30- day, and there is no performance improvement activity in this area.
- The MHP Hispanic/Latino PR remains consistently lower than other medium-sized counties and statewide but a high rate of “Other”, which lacks specificity for QI purposes.
- Intensive service programs such as Full-Service Partnerships and Assertive Community Treatment programs are not consistently providing the needed

support to beneficiaries. The reduction of CSU in the last year has further stressed managing crisis needs and overall capacity.

- There is a need to increase data exchange with partner agencies to improve care coordination for beneficiaries receiving mental health services outside of the MHP network.
- The MHP does not measure timeliness to initial access for the entire child and youth service system limiting the information available to monitor access.

Recommendations for improvement based upon this review include:

- Examine services patterns and identify barriers leading to hospital readmissions for Medi-Cal beneficiaries. Conduct performance improvement and measure outcomes at least quarterly.
- Measure the effectiveness of performance improvement activities directed toward increasing the Hispanic/Latino PR and develop processes to reduce the use of the “Other” race/ethnicity category. (Access, Quality)
- Complete the MHP planned comprehensive quality review of all crisis and intensive services. Conduct QI as indicated and measure the effectiveness of changes. (Quality)
  (This recommendation is a carry-over from FY 2021-22.)
- Research the HIEs, or other exchange of information processes, that are active or available in Santa Barbara County and initiate as appropriate. (IS)
- Incorporate timeliness measurements for initial offered and received appointments for all services. Develop ways to monitor timeliness comprehensively in children and youth services. (Timeliness)

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 protocol used for this review was updated in October 2019.

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 beneficiaries 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 beneficiaries.

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, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 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 2022-23 findings of the EQR for Santa Barbara County MHP by BHC, conducted as a virtual review on April 18-19, 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, beneficiaries, 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.

Data used to generate Performance Measures (PM) tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age 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 2021-22 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 beneficiary 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) – 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.
- 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 beneficiaries' perception of the MHP's service-delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

- 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, then "<11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

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 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic and following January 2023 local flooding. The MHP is operating under the workforce crisis with a 17 percent vacancy rate (80 vacancies out of 466 positions). Staffing capacity was also impacted periodically by reassigned staff to emergency operations related to the floods. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

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.

- Santa Barbara county combined the Health and Human Services and Public Safety departments and hired a new Assistant CEO to manage the new department.
- The MHP hired the former Alcohol and Drug Program Chief as Assistant MHP Director in July 2022. The MHP divided the Equity and Peer Employment Manager positions into two positions to increase focus in each of these areas. The MHP also created and filled an FSP Manager position.
- The MHP completed 125 hires in the last year comprised of new hires and promotions. Efforts to ensure pay equity and retaining telehealth services are being implemented to support staff recruitment and retention.
- Due to difficulties managing the requirements of Community Treatment teams, the MHP shifted to the FSP model.
- The MHP closed the South County Crisis Stabilization Unit (CSU) in May 2022 to reassign staff to the Psychiatric Health Facility (PHF). In the South County, the MHP is converting the CSU to a Lanterman-Petris-Short (LPS) CSU and will reopen it after construction in August 2023.
- The MHP contracted with Marian Regional Medical Center which opened a new LPS-designated CSU in North County, Santa Maria.
- The MHP operates three co-response crisis teams with law enforcement; three additional teams will begin by July 2023.

- The MHP has intensively focused staff resources on implementing the California Mental Health Services Authority (CalMHSA) SmartCare Electronic Health Record (EHR) Solution for Multi-County Behavioral Health Initiative in California and are scheduled to begin using the EHR in July 2023.
- The MHP continues to train staff on Narcan and participate in Narcan distribution. The MHP reports that 30 percent of beneficiaries served have a co-occurring substance use and mental health disorder.
- The MHP is instituting California Advancing and Innovation Medi-Cal (CalAIM) milestones. The MHP is beginning to implement the enhanced care management benefit.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

In the FY 2021-22 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2022-23 EQR, CalEQRO evaluated the status of those FY 2021-22 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 from FY 2021-22

Recommendation 1: Continue to focus attention and resources on successful recruitment of direct service staff to improve access, timeliness, and quality of services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- MHP activities include hiring a full-time recruitment analyst, forming partnerships with universities, and recruiting at events such as job fairs.
- To expedite and expand hiring, the MHP instituted a process change to enable simultaneously recruiting Practitioner 1 and Practitioner 2 positions, and simultaneously completing background and health checks. The MHP also revised the credentialing policy, removing a 6-year limit on intern status to expand the candidate pool.

Recommendation 2: Perform a comprehensive quality review on all crisis services to determine improvement strategies to address barriers to access.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP opened a new position, Branch Chief of Clinical Specialty Programs, intended to increase dedicated oversight of crisis programs.
- The MHP is in the process of hiring an external firm to conduct a comprehensive review of the crisis-service system.

- The MHP reports plans to analyze crisis service response times they have started to collect.
- The MHP started a consumer satisfaction survey post-crisis service in March 2023.
- The recommendation is partially addressed because the MHP has made plans to complete a review of crisis services but has not yet completed a comprehensive quality review. (This recommendation will carry-over to FY 2022-23.)

Recommendation 3: Identify the areas of services and practices within the MHP that differ across the county and develop uniform practices to ensure consistent services across the same system.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP conducted multiple activities towards this recommendation. Creating and filling the new position, Chief of Clinical Outpatient Services was central to these efforts. The MHP reviewed MHSA service-utilization data patterns across the three main regions, and established standards and staffing plans based on the findings, The MHP also began monthly regional outpatient-manager meetings.
- For communication consistency and effectiveness, the MHP uses the CenCal Smartsheet application to complete and track referrals, memos, policies and procedures.
- The MHP began reviewing beneficiary screening and referral practices, and staff hiring practices to increase consistency systemwide.
- Review discussions show that this is an area that needs to continue, however this is an area that is significantly improved with the MHP improvements.

Recommendation 4: Continue to move forward with the transition plan for the new EHR, ensuring that the system includes ongoing support for CalAIM initiatives and Office of the National Coordinator for Health Information Technology (ONC) 21st Century Cures Act Final Rule: Interoperability and Information Blocking.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation. They have a well-organized plan to implement the EHR in July 2023. The master services agreement, which is between CalMHSA and Streamline, the EHR vendor, ensures that the EHR addresses CalAIM and ONC 21st Century Cures Act requirements.

Recommendation 5: Develop consistent practice of monitoring medication utilization of youth in FC that includes the required HEDIS measures and document the review.

(This recommendation is a carry-over from FY 2020-21.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP added the HEDIS medication-monitoring measures for youth in the Smartsheet JV220 measures and produces dashboards with the information. Child psychiatrists review the report in monthly provider meetings. Further, the MHP plans to include these measures in the new EHR.

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 beneficiaries) 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 beneficiaries 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 beneficiaries 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 51 percent of services were delivered by county-operated/staffed clinics and sites, and 49 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 85 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county and contract provider staff; beneficiaries may request services through the Access Line as well as through the following system entry points: crisis clinics and outpatient clinics. The MHP operates a decentralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The initiation process includes a telephone screening, an in-person/telehealth assessment, a referral to an orientation group, and then a comprehensive assessment.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 1,268 adult beneficiaries, 1,259 youth beneficiaries, and 151 older adult beneficiaries across 14 county-operated sites and 30 contractor-operated sites. Among those served, 313 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries 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

[1] CMS Data Navigator Glossary of Terms

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 contained in Table 1A and Table 1B.

In November 2021, DHCS issued its FY 2021-22 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 Santa Barbara County, the time and distance requirements are 45 miles and 75 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

Table 1A: MHP Alternative Access Standards, FY 2021-22

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: MHP Out-of-Network Access, FY 2021-22

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

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

- The MHP completed a population needs assessment and developed an Engagement Measure with PUENTE Lab to assist collecting data for its cultural competence plan. The MHP also produced a Spanish resource guide of self-help support groups.
- To increase and manage access, MHP activities included: providing flexible staff schedules; reinitiated in-person group services while continuing online group services; and opening navigation centers that provide information and linkage to an array of community resources.
- The MHP trains staff on using the language line. Review discussions indicate there are challenges using the language line when a therapist who speaks the beneficiary's language is not available.
- The MHP reports that child and youth program capacity are significantly strained. Providers note a rise in acuity at the elementary schools, including an increase in suicidality consistent with national trends.
- Review discussions reveal the need to reopen the CSU and to increase dedicated crisis treatment options. There is a perception that these gaps impact the clinics which maintain the burden of crisis care.
- The MHP reports that implementing Senate Bill 317 resulted in more referrals to the MHP, exacerbating workforce demands.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rates, and Average Approved Claims per Beneficiary Served

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible

count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, beneficiaries may be experiencing more challenges accessing mental health services in Santa Barbara County than seen statewide.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	164,020	5,459	3.33%	$55,547,582	$10,175
CY 2020	151,614	5,490	3.62%	$58,154,456	$10,593
CY 2019	147,989	5,778	3.90%	$46,398,502	$8,030

*Note that the total annual eligibles may differ slightly in Tables 3, 4, and 7 due to calculating monthly averages from a different number of variables.

- The MHP's PR and Beneficiaries Served declined yearly from CY 2019 to CY 2021, while the number of annual eligibles increased during that timeframe.
- The AACB increased in CY 2020 and stayed relatively high in CY 2021. The increased AACB could be the result of DHCS raising interim rates during the COVID public health emergency.
- While the MHP's PR is lower than the statewide PR, the AACB is 36 percent higher than the statewide $7,478 AACB.

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	20,681	386	1.87%	1.08%	1.96%
Ages 6-17	43,603	1,735	3.98%	4.41%	5.93%
Ages 18-20	9,196	350	3.81%	3.73%	4.41%
Ages 21-64	78,987	2,717	3.44%	4.11%	4.56%
Ages 65+	11,556	271	2.35%	2.26%	1.95%

Age Groups	Annual Eligibles	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Total	**164,020**	**5,459**	**3.33%**	**3.67%**	**4.34%**

- The MHP's overall PR is lower than other medium-sized counties, however for age groups 0-5, 18-20, and 65+ the MHP's PR is higher than medium-sized counties.
- The MHP's PR is lower than the statewide rate in all age categories other than 65+.

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	1,056	19.34%
Threshold language source: Open Data per BHIN 20-070		

- Spanish is the only threshold language in the MHP. In CY 2021, almost one out of every five beneficiaries served identify Spanish as their primary language.

Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	45,216	1,377	3.05%	$12,749,643	$9,259
Medium	613,796	20,261	3.30%	$151,430,714	$7,474
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The MHP's 3.05 percent ACA PR is lower than its overall 3.33 percent PR. Likewise the $9,259 AACB is lower than the MHP's $10,175 AACB.

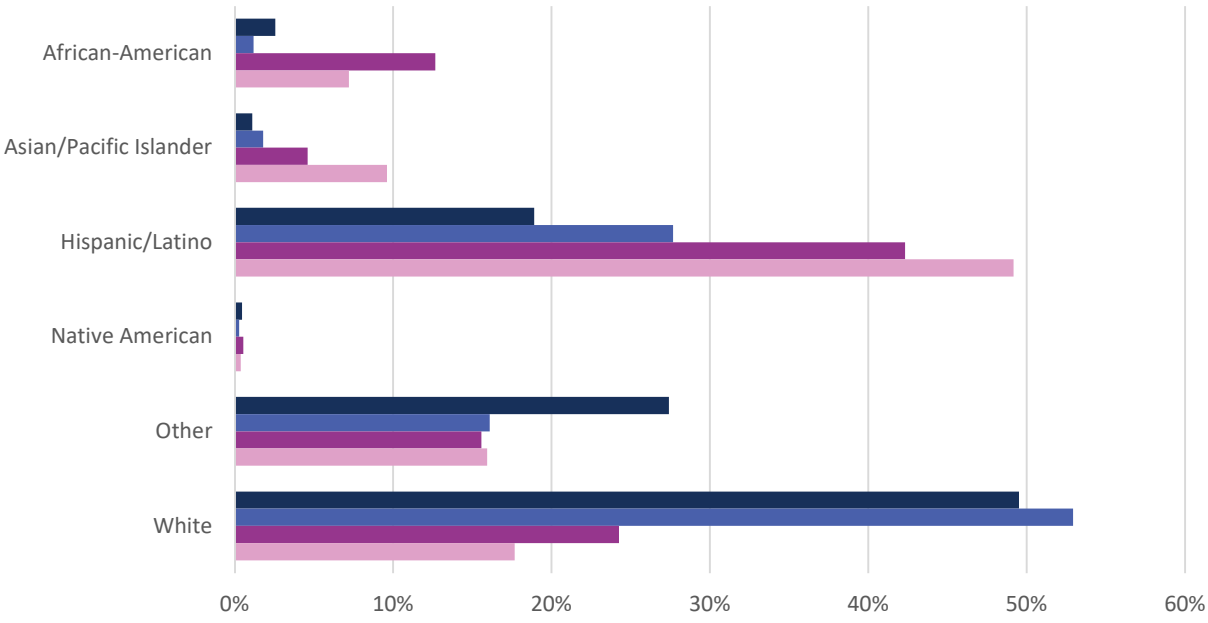
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	1,965	140	7.12%	7.64%
Asian/Pacific Islander	2,958	61	2.06%	2.08%
Hispanic/Latino	45,401	1,032	2.27%	3.74%
Native American	451	25	5.54%	6.33%
Other	26,422	1,497	5.67%	4.25%
White	86,826	2,704	3.11%	5.96%
Total	**164,023**	**5,459**	**3.33%**	**4.34%**

- The MHP's PRs by race/ethnicity are lower than the statewide PRs for all races/ethnicities except for the "Other" category. The Other category has the second highest PR in the county.
- The MHP suggested that many of the beneficiaries who selected Other as their ethnicity might be of Hispanic/Latino heritage, based on other population health assessments completed. The MHP plans to investigate reasons why the number of beneficiaries who identify as Other is very high. The MHP's rate of Other (5.67 percent) is 36 percent greater than the medium MHP rate (4.17 percent) and 33 percent greater than the state rate (4.25 percent).
- The Hispanic/Latino population makes up the second largest ethnicity of annual eligibles in the county and has one of the lowest PRs. The MHP Hispanic/Latino PR (2.27 percent) is 16 and 39 percent lower than the medium MHP (2.69 percent) and state PR (3.74 percent) respectively.

Figure 1: Race/Ethnicity for MHP Compared to State CY 2021

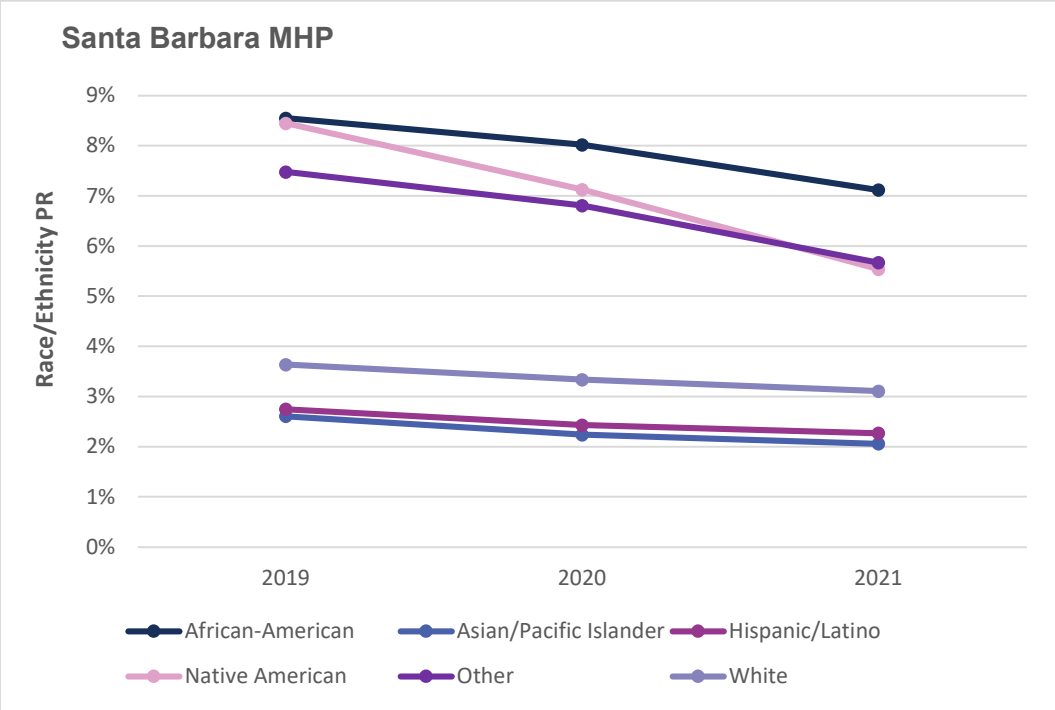


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	50%	27%	0%	19%	1%	3%
MHP % Eligible	53%	16%	0%	28%	2%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- This figure depicts the high proportion of beneficiaries in the Other race/ethnicity category receiving services in the MHP.
- Hispanic/Latino beneficiaries represent 28 percent of the MHP Medi-Cal eligibles and 19 percent of the population receiving services. Conversely, Other beneficiaries represented16 percent of the eligible population and 27 percent of those served.
- Statewide the percentage of White beneficiaries served is higher than their proportion of the eligible population. In the MHP, 50 percent of White beneficiaries received services, while they represented 53 percent of the eligible population.

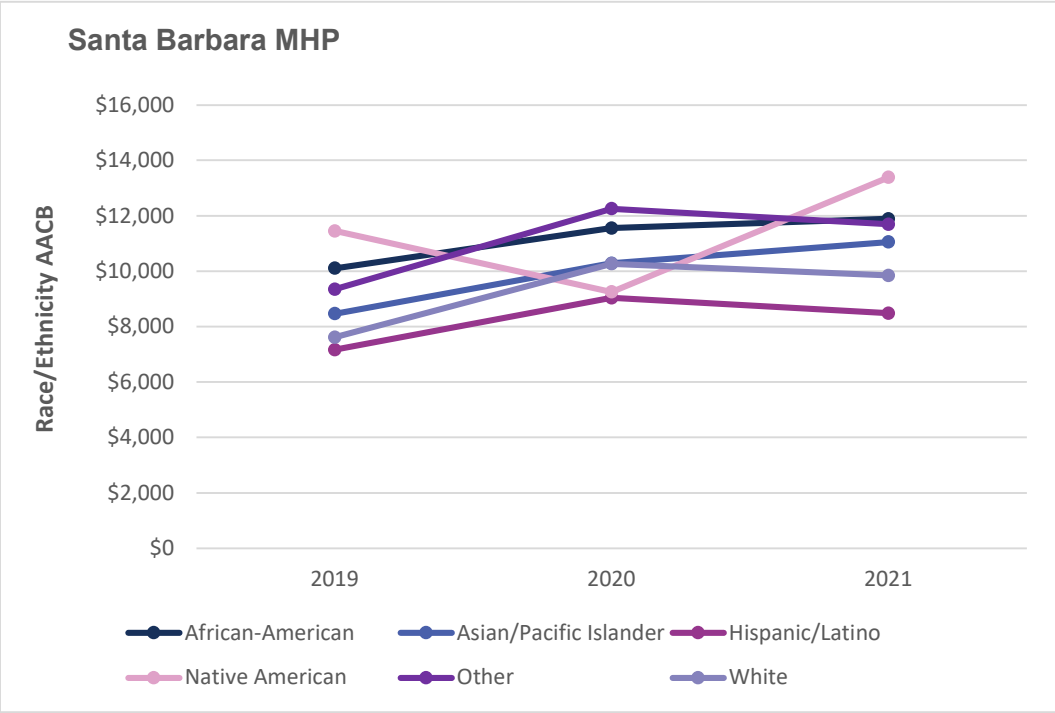
Figures 2 – 11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

Figure 2: MHP PR by Race/Ethnicity CY 2019-21



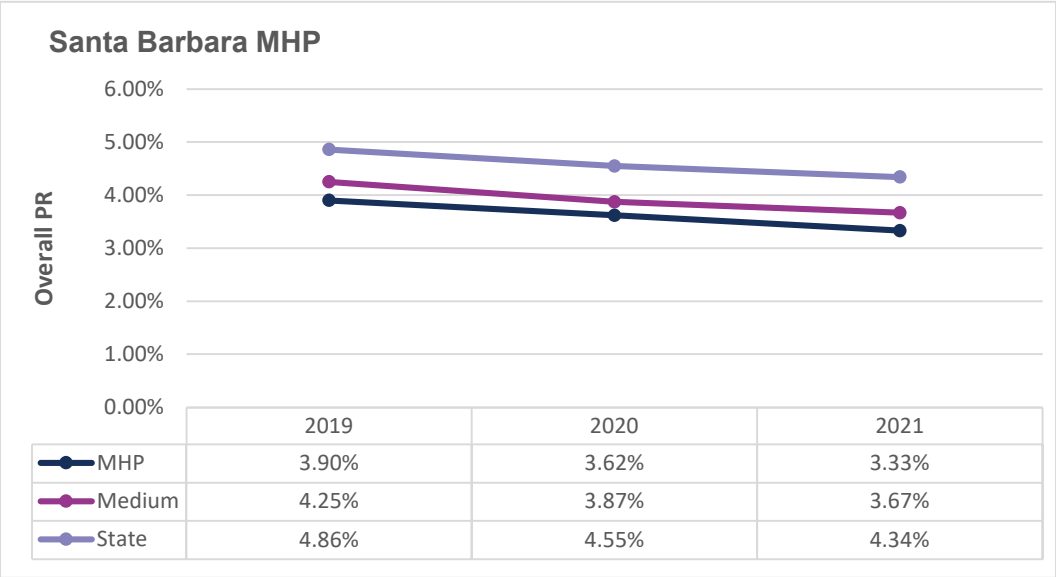
- The MHP has a group of race/ethnicities that consistently has higher PRs, and a group with consistently lower PRs. African-American, Native American, and Other all have higher PRs, while Whites, Hispanic/Latino and Asian/Pacific Islanders have lower PRs.
- All PRs have trended downward between CY 2019 and CY 2021.

Figure 3: MHP AACB by Race/Ethnicity CY 2019-21



- With the exception of Native Americans, there has been a fairly consistent pattern of which races/ethnicities have the highest AACBs and which have the lowest AACBs between CY 2019 and CY 2019. The pattern from highest to lowest AACB has been African-American, Other, Asian/Pacific Islander, White, and then Hispanic/Latino.
- The Native American population had the highest AACB in CY 2019, near the lowest in CY 2020, and the highest again in CY 2021. The MHP serves a relatively low number of Native American beneficiaries which can influence the large variations in AACB from year to year.

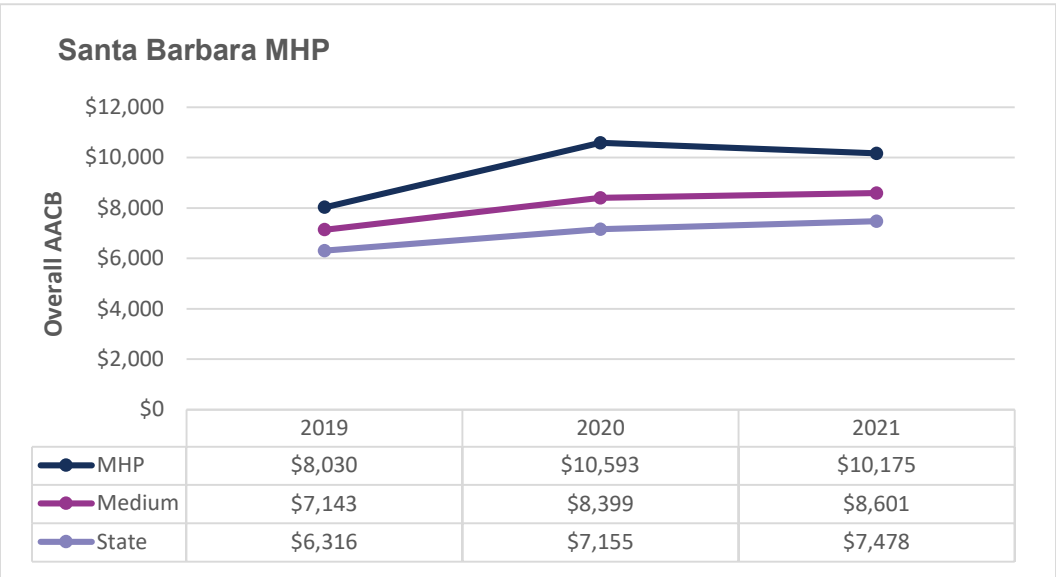
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	3.90%	3.62%	3.33%
Medium	4.25%	3.87%	3.67%
State	4.86%	4.55%	4.34%

- The MHP's PR is lower than the statewide PR and other medium-sized MHP rates from CY 2019 to CY 2021.

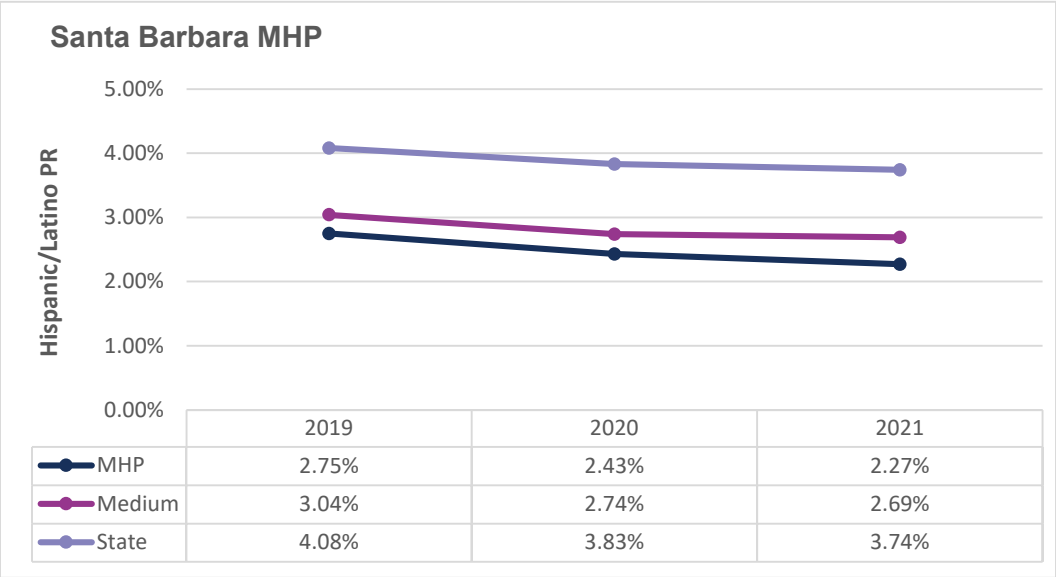
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$8,030	$10,593	$10,175
Medium	$7,143	$8,399	$8,601
State	$6,316	$7,155	$7,478

- For the past three years, the MHP's AACB has been higher than the statewide and other medium-sized MHP averages.

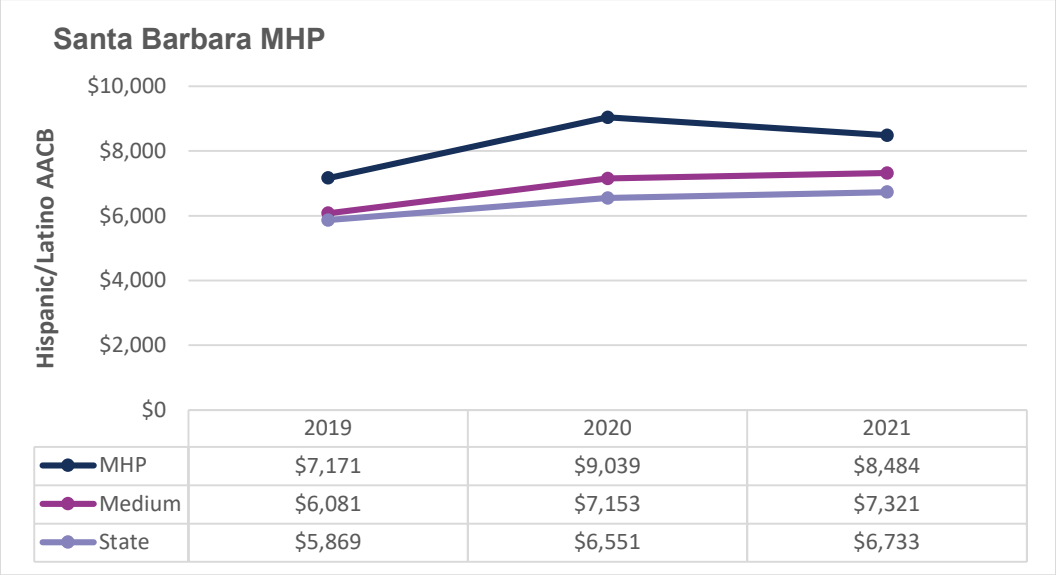
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	2.75%	2.43%	2.27%
Medium	3.04%	2.74%	2.69%
State	4.08%	3.83%	3.74%

- The Hispanic/Latino PR remains consistently lower than other medium-sized counties and statewide averages.

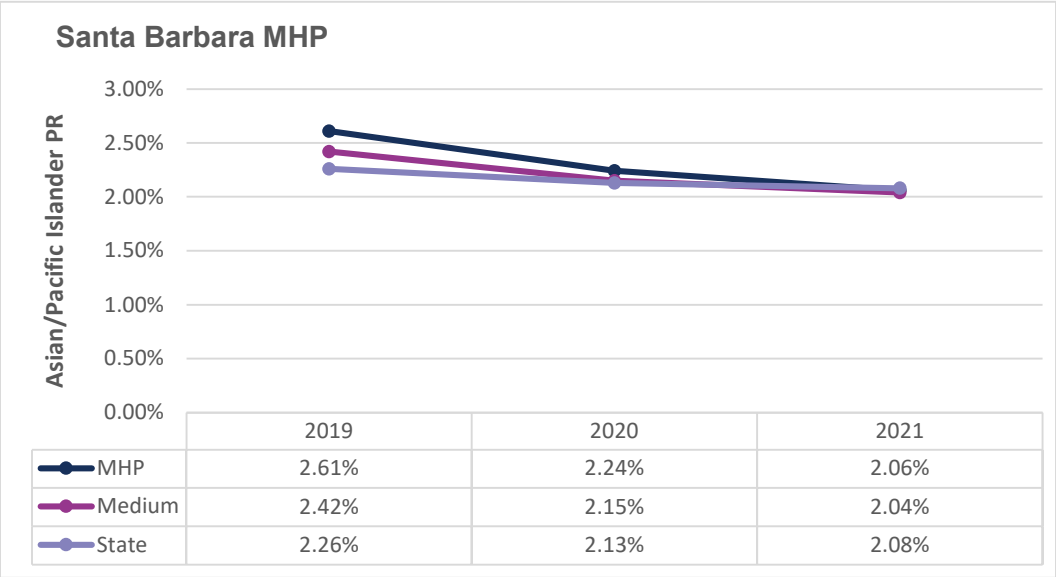
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$7,171	$9,039	$8,484
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

- Similar to the overall AACB, the Hispanic/Latino AACB is higher than the average in other medium-sized counties and statewide averages.

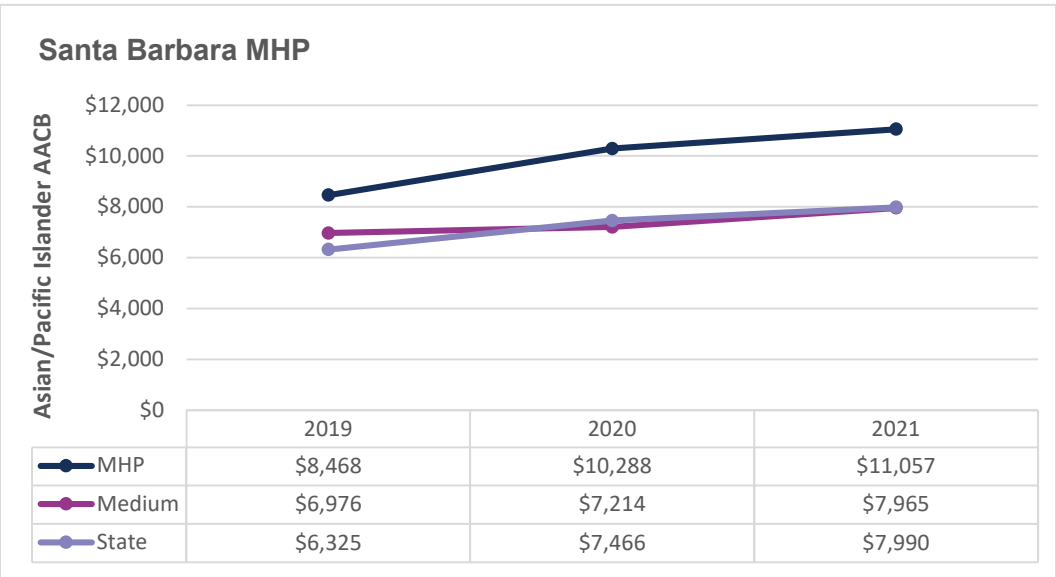
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.61%	2.24%	2.06%
Medium	2.42%	2.15%	2.04%
State	2.26%	2.13%	2.08%

- The Asian/Pacific Islander PR has decreased each year from CY 2019 to CY 2021 in the MHP. While the MHP's PR was higher than the statewide and medium-sized counties in CY 2019, by CY 2021 the MHP's Asian/Pacific Islander PR was nearly identical to those comparison rates.

Figure 9: Asian/Pacific Islander AACB CY 2019-21



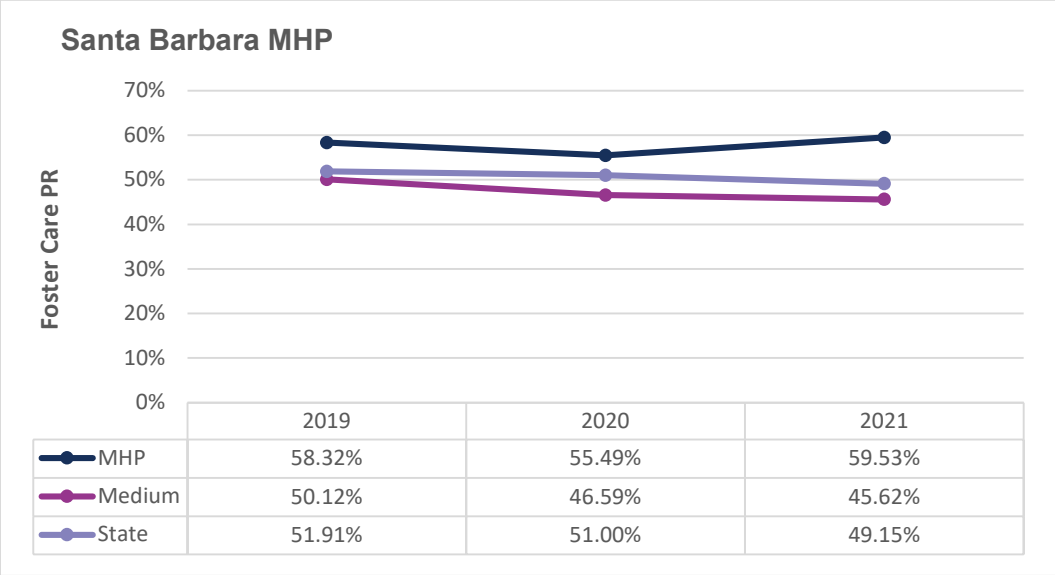
	2019	2020	2021
MHP	$8,468	$10,288	$11,057
Medium	$6,976	$7,214	$7,965
State	$6,325	$7,466	$7,990

- The Asian/Pacific Islander AACB increased every year between CY 2019 and CY 2021 and has been higher than the medium county and state averages each of

those years. In CY 2021 the Asian/Pacific Islander AACB was higher than the MHP's $10,175 overall AACB.

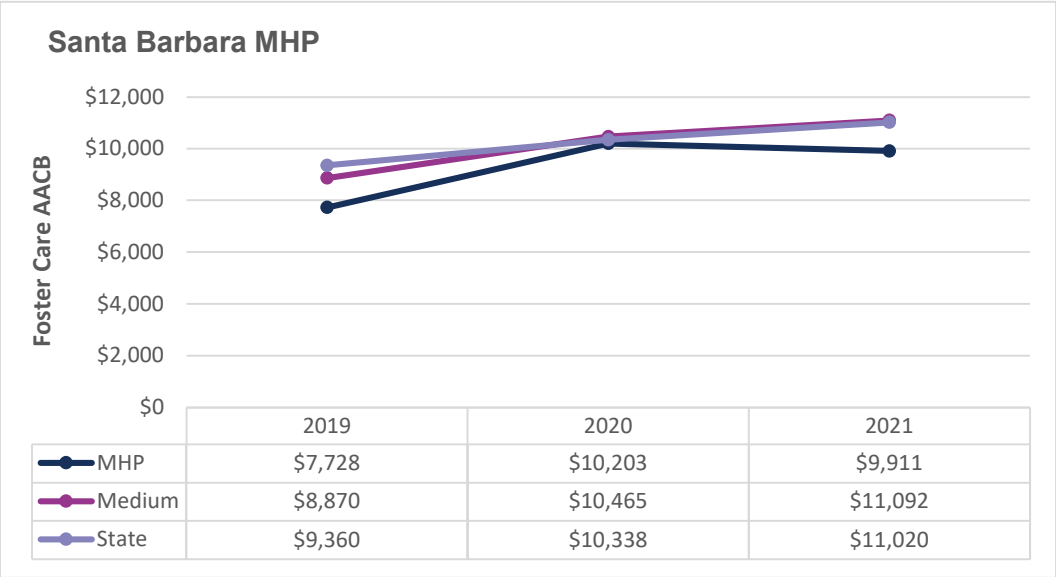
- In CY 2021, the MHP Asian/Pacific Islander AACB is 39 percent and 38 percent higher than the medium MHP and state averages Asian/Pacific Islander AACB respectively.

Figure 10: Foster Care PR CY 2019-21



- Statewide FC PR has remained steady at approximately 50 percent for the three years displayed. The MHP's FC PR has been higher than the state average each of those years, with its highest rate at 59.53 percent in CY 2021.
- In CY 2021, the MHP FC PR is 30 percent and 21 percent greater than the medium MHP and state PR averages respectively.

Figure 11: Foster Care AACB CY 2019-21



- Statewide FC AACB has increased each year. While the MHP's overall AACB is higher than the state average, the FC AACB has been consistently lower than the state average. The MHP indicated that they see all Voluntary Family Maintenance beneficiaries who might need fewer services than the general FC population. That could also be a factor in the relatively high FC PR.
    - The MHP rate of FC beneficiaries receiving four or fewer services is 44 percent higher than the state rate, aligning with the expected patterns with this practice.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 3,340				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	414	12.4%	8	4	11.6%	16	8
Inpatient Admin	147	4.4%	8	6	0.5%	23	7
Psychiatric Health Facility	<11	-	5	6	1.3%	15	7
Residential	<11	-	208	208	0.4%	107	79
Crisis Residential	240	7.2%	27	19	2.2%	21	14
Per Minute Services							

Crisis Stabilization	210	6.3%	1,412	1,200	13.0%	1,546	1,200
Crisis Intervention	941	28.2%	270	183	12.8%	248	150
Medication Support	1,831	54.8%	608	384	60.1%	311	204
Mental Health Services	2,287	68.5%	1,202	487	65.1%	868	353
Targeted Case Management	1,514	45.3%	337	131	36.5%	434	137

- While a larger percentage of adult beneficiaries receive inpatient and inpatient admin services, the MHP's average units/days is substantially less than the state average.
- Over three times as many Santa Barbara adult beneficiaries receive crisis residential services compared to the state average. They also average more units/days than the state average.
- Higher percentages of MHP adult beneficiaries received crisis intervention, and lower percentages received crisis stabilization services, than the state average. The MHP's crisis intervention rate is more than double the state rate. This could indicate a higher availability of crisis intervention services compared to crisis stabilization. These figures do not reflect the temporary closure of one of the crisis stabilization units in May 2022.
    - For overall services in CY 2021, the MHP's crisis intervention rate is 14 percent and 73 percent higher than the medium MHP (.79 percent) and state rate (.52 percent) respectively.
- For adult beneficiaries receiving medication support and mental health services, the MHP delivered more units compared to statewide. MHP beneficiaries received an average of 608 units of medication support compared to 311 statewide and 1,202 units of mental health services compared to 868 statewide.
- While a larger percentage of adult MHP beneficiaries received targeted case management, 45.3 percent compared to 36.5 percent statewide, beneficiaries received fewer units than delivered statewide, 337 compared to 434.

Table 9: Services Delivered by the MHP to Youth in Foster Care

Service Category	MHP N = 328				Statewide N = 37,489		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	14	4.3%	7	7	4.5%	14	9
Inpatient Admin	<11	-	4	4	0.0%	5	4
Psychiatric Health Facility	<11	-	8	8	0.3%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	<11	-	23	25	0.1%	17	12
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	0	0.0%	0	0	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	1,834	<11	3.1%	1,398	1,200
Crisis Intervention	28	8.5%	551	28	7.5%	404	198
Medication Support	94	28.7%	364	94	28.3%	394	271
TBS	17	5.2%	2,317	17	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Home Based Services	227	69.2%	807	227	40.0%	1,351	472
Intensive Care Coordination	63	19.2%	2,842	63	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	305	93.0%	1,383	305	96.3%	1,848	1,103
Targeted Case Management	158	48.2%	169	158	35.0%	342	120

- As in the adult population, FC youth were hospitalized for substantially fewer days and received more crisis intervention compared to statewide utilization rates.
- Unlike the adult population, FC youth received fewer units of medication support than the state average.
- A substantially higher percentage of MHP FC youth received intensive home-based services with a substantially lower number of services delivered than seen statewide. FC youth also received fewer mental health services units. This may be associated with the MHP's Voluntary Maintenance practice as well.

- A substantially higher percentage of MHP FC youth received targeted case management, though they only received about half the number of units delivered statewide. MHP FC youth receive more units of intensive care coordination than seen statewide.

IMPACT OF ACCESS FINDINGS

- The MHP's high rate of 'Other' race/ethnicity limits QM's ability to analyze and address disparities. Increasing specificity or understanding this anomaly compared to the state rate would strengthen QM.
- The MHP's lower units of targeted case management provided in adult services compared to the state could be an area to increase, consistent with the goal to adopt prevention and recovery treatment models.
- The closing of the South County CSU may have impacted routine outpatient access, outpatient crisis service teams, and the use of EDs. The impact of the CSU closure is not fully reflected in the CY 2021 claims data given the timing of the closure.
- The MHP's higher rates of crisis intervention utilization may also be impacting the outpatient delivery system to provide non-crisis services.

TIMELINESS OF CARE

The amount of time it takes for beneficiaries 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.

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- Timeliness measurement for first offered and delivered appointment does not include three children contract providers which significantly limits the MHP's children's information available for QM.

- The MHP met its timeliness standards at a high rate (93 percent overall) for first non-urgent offered appointment. However, the adult first service provided may be an orientation that includes a description of the services the MHP provides as well as collecting intake information, not an assessment.
- Review discussions represented that the time to a child and TAY assessments (not the first service intake) ranges two to seven months, and up to five months to begin receiving treatment after an assessment. There is no policy for prioritizing acuity levels.
- The MHP meets its 15-day standard for first non-urgent psychiatry offered appointment for 69 percent of appointments. For first non-urgent psychiatry service delivered, 62 percent of appointments meet the standard overall, and only 58 and 49 percent respectively for children and FC meet the standard. Review discussions reveal that the wait to initial psychiatry appointments for child or youth beneficiaries, including post-hospitalization, is seven to eight weeks.
- The MHP's psychiatry no-show rates for children (14 percent) and FC (13 percent) also exceed the MHP standard (10 percent), potentially contributing to delays in service. The MHP trained staff on using an automatic appointment reminder software to improve the no-show rates. Evaluation of the effectiveness of the training or reminders was not apparent. The MHP plans to send reminders through the new EHR.
- The MHP meets its timeliness standard to urgent services for FC beneficiaries for only 55 percent of beneficiaries. While the numbers are small (N=20), this is an area to assess and improve.
- The MHP measurements of psychiatric readmissions significantly differ from the EQR performance indicators. The MHP reports high performance in this area with a 4.6 percent 7-day readmission rate and a 13.5 percent 30-day readmission rate. Conversely, Medi-Cal approved claims data reported CY 2021 with a 31.6 percent 7-day readmission rate and a 41.97 percent 30-day readmission rate. The MHP did not conduct performance improvement activities toward reducing readmissions.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12 – 14 below display data submitted by the MHP; an analysis

follows. This data represented the entire system of care. Due to a limitation in the current EHR, the MHP measures time to Urgent Services Offered in days rather than hours, which the EQRO then converted to hours for the purposes of this EQR. The MHP timeliness standard is to offer an urgent appointment by the next day.

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

Table 11: FY 2021-22 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	4 Business Days	10 Business Days*	93%
First Non-Urgent Service Rendered	5 Business Days	10 Business Days**	68%
First Non-Urgent Psychiatry Appointment Offered	10.9 Business Days	15 Business Days*	69.2%
First Non-Urgent Psychiatry Service Rendered	13.2 Business Days	15 Business Days**	61.8%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0.5 days	1 day	91.5%
Follow-Up Appointments after Psychiatric Hospitalization	6 Days	7 Days**	62.9%
No-Show Rate – Psychiatry	10.4%	10%**	n/a
No-Show Rate – Clinicians	7.2%	5%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

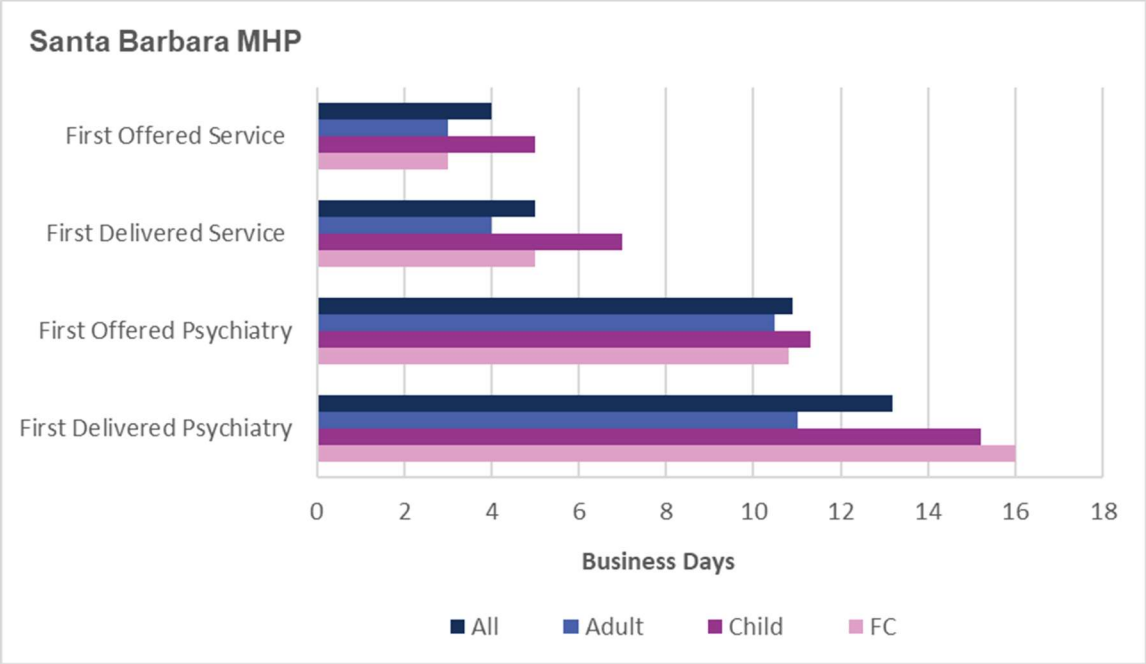


Figure 13: Wait Times for Urgent Services

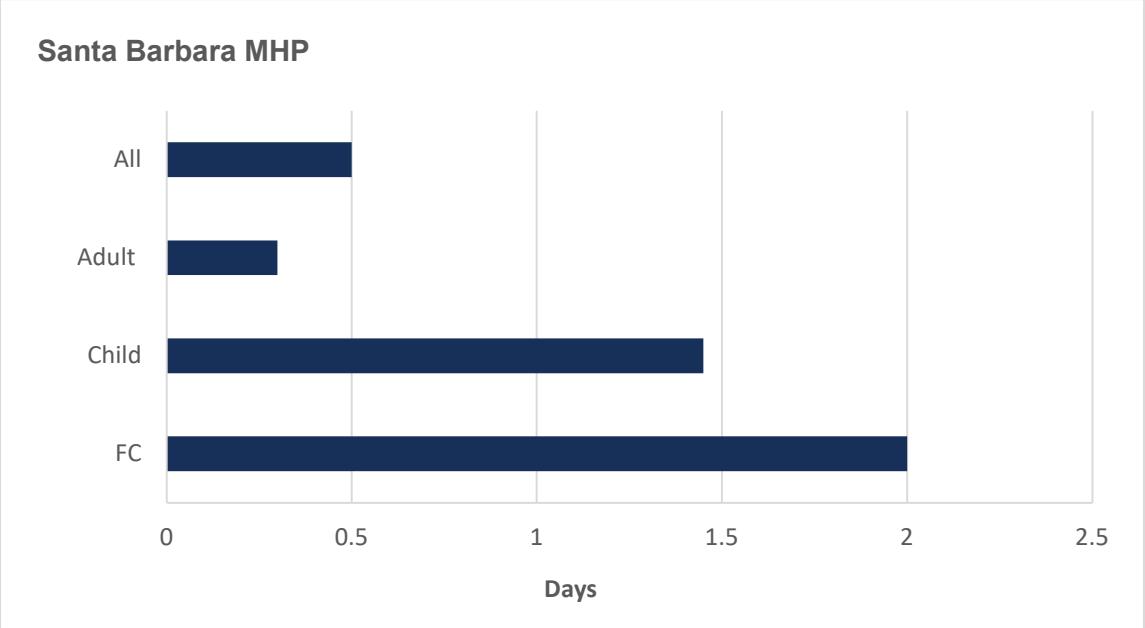
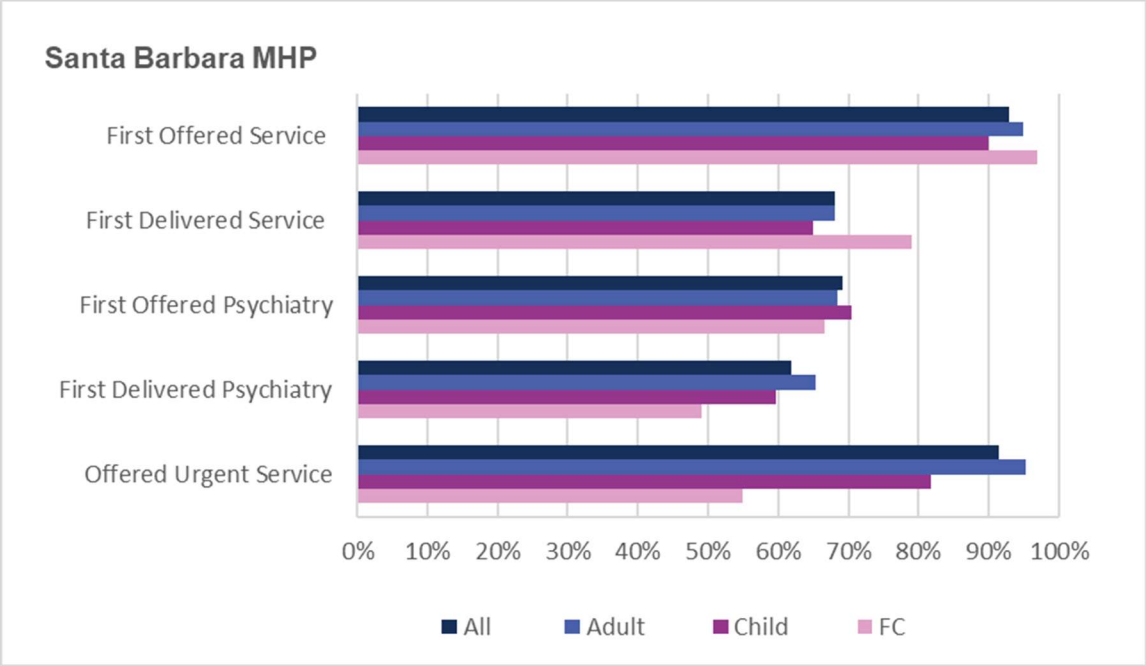


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned 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 13, represent scheduled or unscheduled routine appointments only; no crisis or urgent services or services provided by three contract providers, Casa Pacifica, CALM, or Family Service Agency are included. Routine first appointments include assessments for children's appointments and orientation or assessment for adult appointments.
- Definitions of "urgent services" vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an ED, or a referral to a CSU. The MHP defined "urgent services" for purposes of the ATA as services provided to beneficiaries "who without assistance would likely need inpatient hospitalization within 24 hours." The MHP reports 330 urgent service requests with an average wait time to services for the overall population of 0.5 days.
- The timeliness standards for first delivered psychiatry service may be defined by the County MHP. Further, the process as well as the definitions and tracking may differ for adults and children. The MHP defines psychiatry access from either the beneficiary's initial request for service or the first clinical determination of need for adults and children.
- 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 10.4 percent for psychiatrists and 7.2 percent for non-psychiatry clinical staff.

IMPACT OF TIMELINESS FINDINGS

- The MHP should analyze the discrepancy between the 93 percent of offered appointments that met the 10-day standard and the 68 percent of first-delivered services that met the standard. Key informants indicated that those figures seemed higher than what was observed in the clinics. Potential reasons suggested include measuring the adult orientation as a service. Another hypothesis was that appointments for services that came through the Access line were prioritized and requests for services that came directly through the clinics might not have been included in the ATA data.
- Because timeliness to first appointments does not include some contract providers that comprise the child and youth service system, the MHP metrics are not reliable to assess that system. The MHP should prioritize collecting comprehensive timeliness data.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries 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 beneficiaries. 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 QCM that is under the Office of Quality Care and Strategy Management. There are separate QCM managers for the MHP and the Drug Medi-Cal Organized Delivery System (DMC-ODS). The department has a separate compliance program, headed by a Compliance Chief.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of MHP and DMC-ODS management, direct service staff and QM staff, individuals served and family members of individuals served, and Patient Rights Advocates. It is scheduled to meet every other month. Since the previous EQR, the MHP QIC met five times. Of the 31 identified FY 2021-22 QAPI workplan goals, the MHP met 21 (67 percent) of the goals and partially met 6 (19 percent).

The MHP utilizes the following level of care (LOC) tools Milestones of Recovery Scale (MORS), Child and Adolescent Needs and Strengths (CANS), and the Level of Care and Recovery Inventory (LOCRI). Treatment teams review changes in LOC scores to determine if beneficiaries need to be stepped up or down. The MHP analyzes CANS data by program on a quarterly basis. MORS data is analyzed semi-annually. Both tools are included in a variety of reports.

The MHP utilizes the following outcomes tools: MORS, CANS, Patient Health Questionnaire-9, and Pediatric Symptom Checklist-35.

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 beneficiaries. These key components include an organizational culture that prioritizes quality, promotes the use of data to inform decisions, focused leadership, active stakeholder participation, and a comprehensive service delivery system.

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Partially Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The QIC examines access and beneficiary outcome area data to monitor goals and identify areas for improvement. However, lack of comprehensive data for timeliness to initial appointments impedes monitoring and QI in this area.
- The MHP increased mechanisms for bidirectional communication.
    - Beneficiary and family member participation in committees has been difficult to establish. To fill this gap, QM staff began attending the Child Family Action Team meetings to obtain input.
    - The MHP formed a direct service staff workgroup, Innovating from Within, to identify and address gaps and concerns in services. Review discussions indicate positive perceptions of the staff workgroup although some programs report an inability to have staff participate due to high workloads.
- The MHP uses the MORS in adult and youth ACT programs. Because the MORS will not be part of the new EHR, SmartCare, the MHP is considering selecting a new adult outcome tool.

- Component 3G is rated partial because the use of aggregated consumer-level outcomes to improve or adapt services at the program or system level was not evident.
- In addition to beneficiary satisfaction surveys, the MHP conducts a PHF satisfaction survey and a beneficiary network provider survey.
- The MHP has policies and procedures to monitor and track medication per program. Summary reports, trending, or performance improvement activities were not evident.
- As reported earlier in the report, the MHP has begun to track, but does not yet trend the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD):
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC):
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM):
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP):
- The MHP employs peers as recovery assistants who support care coordination. The MHP does not yet have a career ladder for consumer or family member employees or provide supervisory support to expand these roles. Review participants, including peer employees, shared there is growing acceptance and understanding of the peer role in treatment teams.

QUALITY PERFORMANCE MEASURES

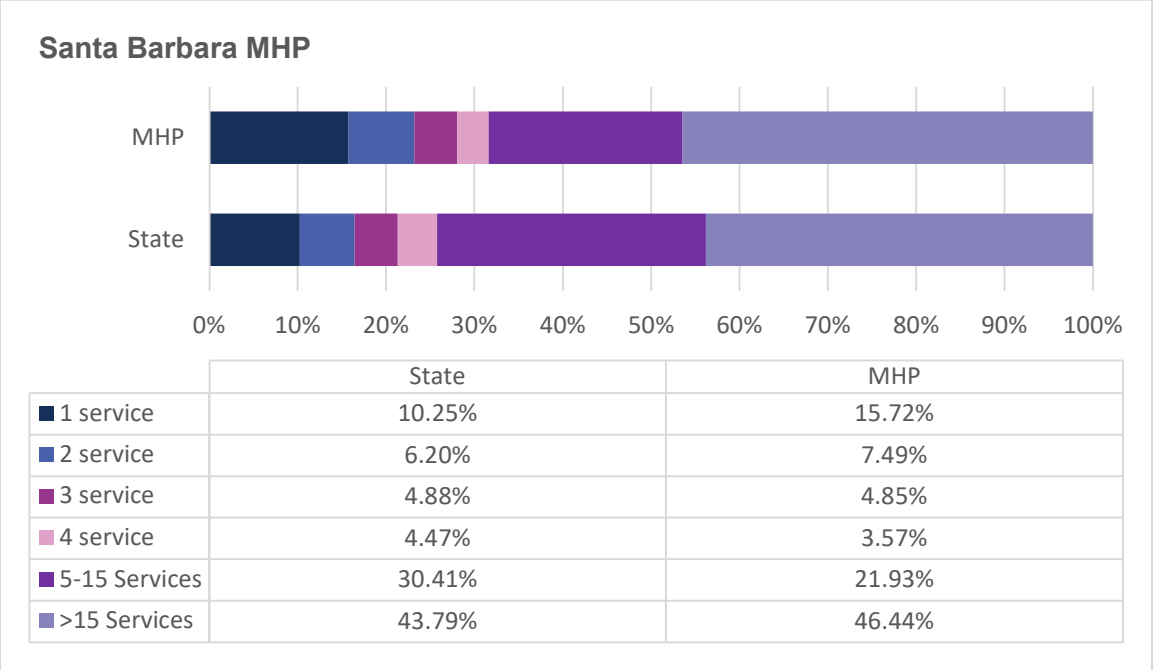
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries served by the MHP to require five or more services during a 12-month period. However, this table does not account for the length of stay, as individuals enter and exit care throughout the 12-month period.

Figure 15: Retention of Beneficiaries CY 2021



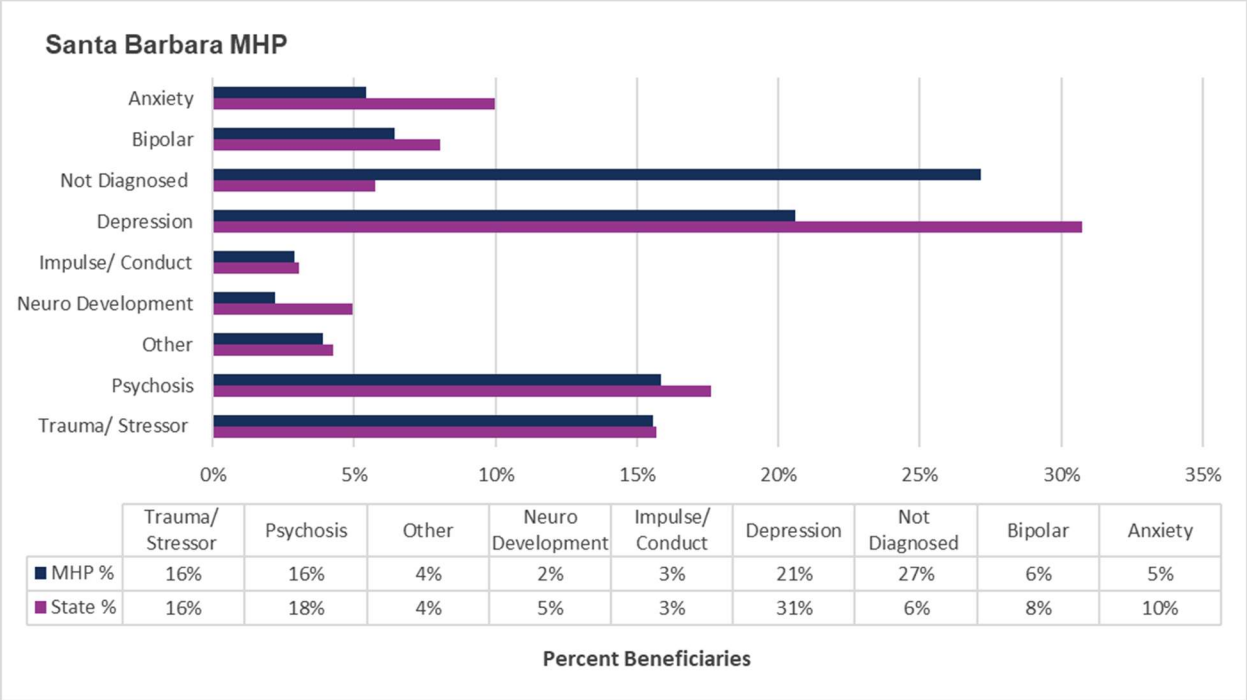
	State	MHP
1 service	10.25%	15.72%
2 service	6.20%	7.49%
3 service	4.88%	4.85%
4 service	4.47%	3.57%
5-15 Services	30.41%	21.93%
>15 Services	43.79%	46.44%

- The MHP rate for beneficiaries receiving one service is 53 percent higher than the state rate.
- The MHP rates for beneficiaries receiving 1-4 services and over 15 services statewide are also higher than the state rate. Fewer beneficiaries receive 5-15 services. The high percentage receiving particularly one or two services could be related to the high utilization of crisis intervention in the county.

Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, 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 beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary 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.

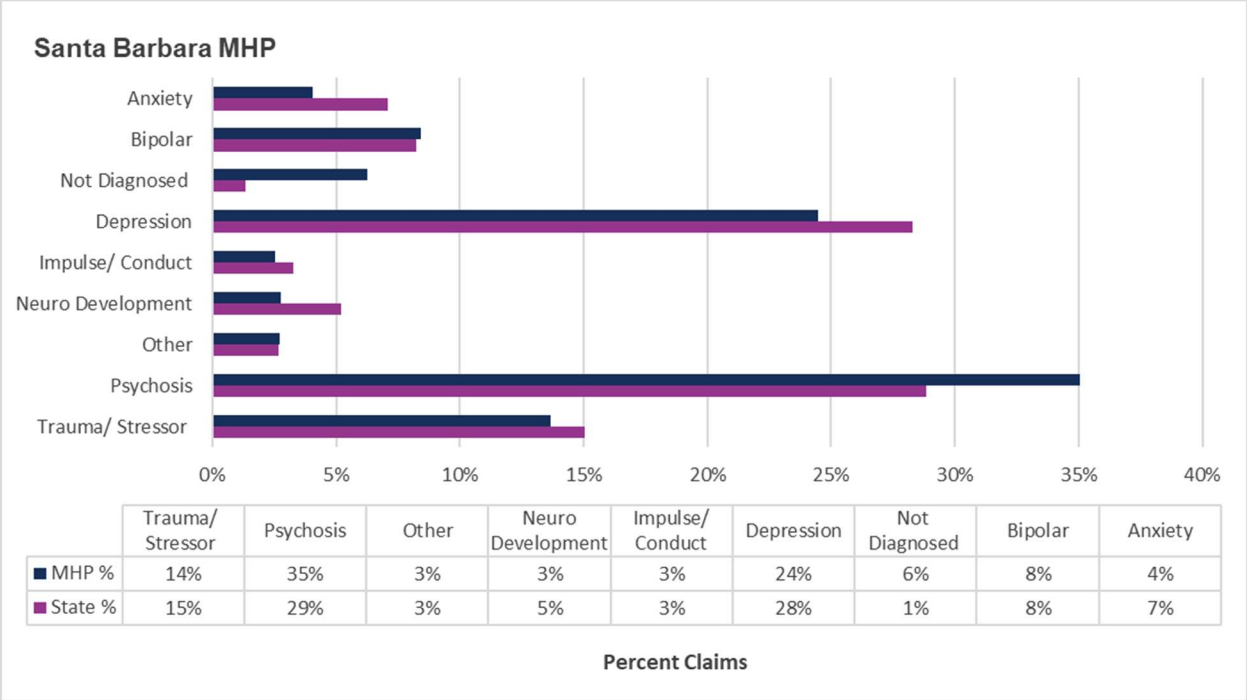
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	16%	16%	4%	2%	3%	21%	27%	6%	5%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- Over one out of four beneficiaries do not have a diagnosis. The MHP rate for Not Diagnosed is more than quadruple the state rate. Again, this may be associated with the high utilization of crisis intervention services or intake services that do not have a completed assessment.
- Depression, trauma/stressor related diagnoses, and psychosis are the most frequent diagnostic categories among beneficiaries served. The MHP rate for depression (21 percent) is 32 percent lower than the state rate (31 percent.) Similarly, the MHP rate for anxiety is 50 percent lower than the state rate (10 percent.)

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	14%	35%	3%	3%	3%	24%	6%	8%	4%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- Although still higher than the statewide proportion of claims attributed to beneficiaries with no diagnosis, the 6 percent of claims for beneficiaries without a diagnosis is much lower than the 27 percent of beneficiaries in that category. The high rate of crisis intervention and claims for orientation could factor into approved claims for beneficiaries without a diagnosis.
- Over one out of three claims is attributed to beneficiaries with psychosis. The MHP rate for psychosis (35 percent) is 20 percent higher than the state rate (29 percent.) Depression, followed by trauma/stressor related diagnoses are the next most frequent diagnostic categories generating claims.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average length of stay (LOS).

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	502	1,159	5.45	8.86	$10,021	$12,052	$5,030,752
CY 2020	490	2,368	5.73	8.68	$11,205	$11,814	$5,490,571
CY 2019	521	1,248	5.38	7.80	$7,964	$10,535	$4,149,331

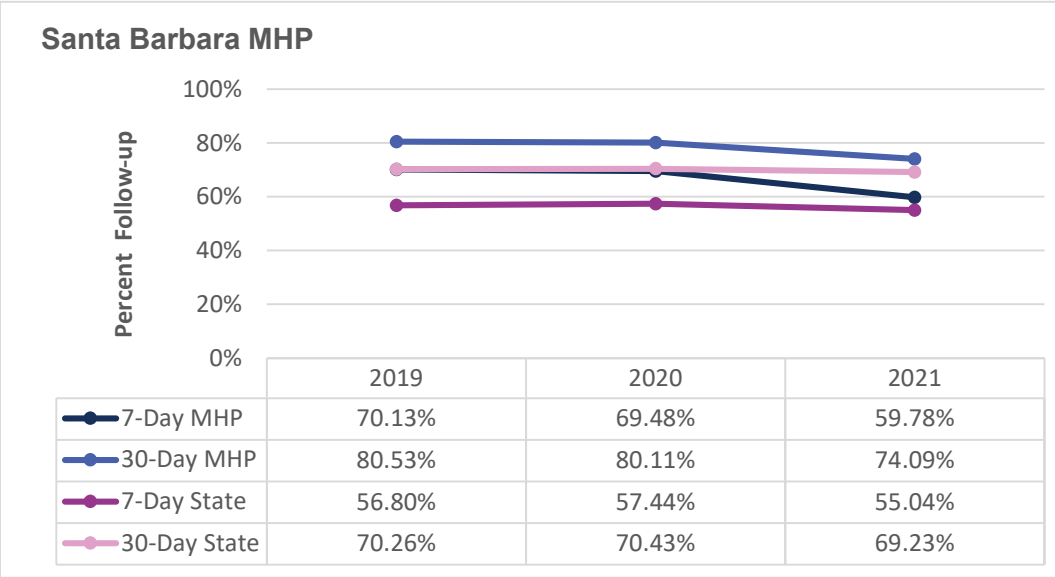
- The MHP average LOS is considerably lower than the state average. In CY 2021 it was 62 percent of the statewide average. However, the LOS does not include Inpatient Admin days after the acute days.

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 2021 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.

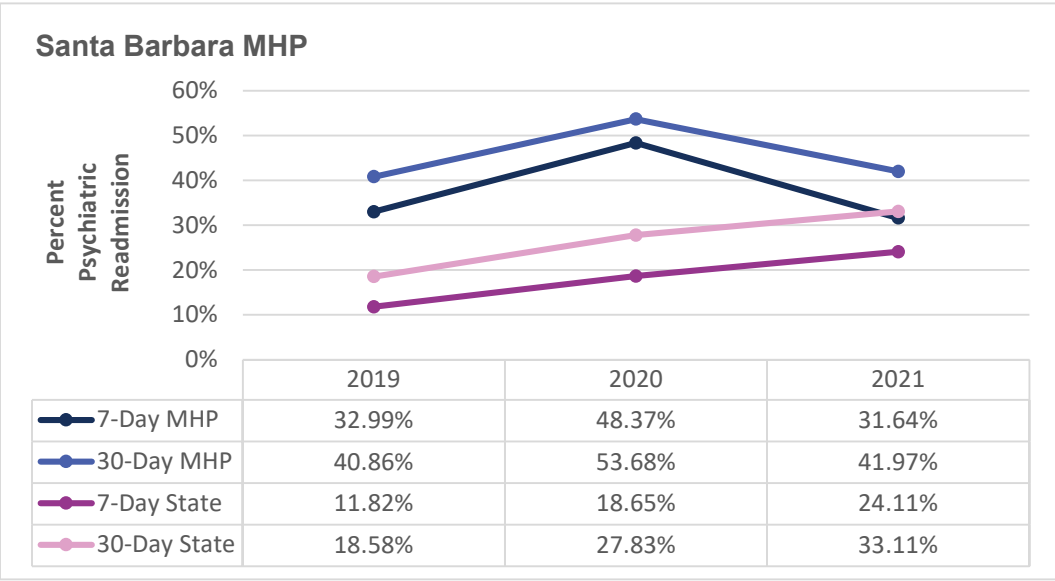
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-21



	2019	2020	2021
7-Day MHP	70.13%	69.48%	59.78%
30-Day MHP	80.53%	80.11%	74.09%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	32.99%	48.37%	31.64%
30-Day MHP	40.86%	53.68%	41.97%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- Although the 7- and 30-day post psychiatric inpatient follow-up rates decreased in CY 2021, the MHP's rates still exceeded the state rates. Despite the positive follow-up rates, the MHP 7- and 30-day psychiatric readmission rates are considerably higher than the statewide rates for each year between CY 2019 and CY 2021. While both rates decreased in CY 2021, the MHP's 7- day rate is 31 percent higher than the state rate (24.11 percent) and the 30- day rate is 24 percent higher than the state (33.11 percent).

- The MHP reported follow-up rates similar to CalEQRO's, however the MHP reported 4.6 and 13.5 percent 7- and 30-day readmission rates, respectively, for FY 2021-22 for all MHP clients, regardless of payor source. The difference between timeframe and payor source does not explain such a large variance. Some other theories were discussed such as whether hospital admin days or transfers to a crisis residential facility could have impacted CalEQRO data but were determined not to be compelling factors. At this time, there is no clear explanation for the wide discrepancy between CalEQRO and MHP readmission data.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs 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 AACB is $7,478, the median amount is just $3,269.

Tables 14-15, Figures 20-21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, nearly 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACB of $4,412 and median of $2,830.

Table 14: HCB (Greater than $30,000) CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	451	8.26%	40.77%	$22,645,584	$50,212	$43,183
	CY 2020	451	8.21%	42.23%	$24,558,456	$54,453	$43,896
	CY 2019	316	5.47%	35.23%	$16,347,093	$51,731	$44,145

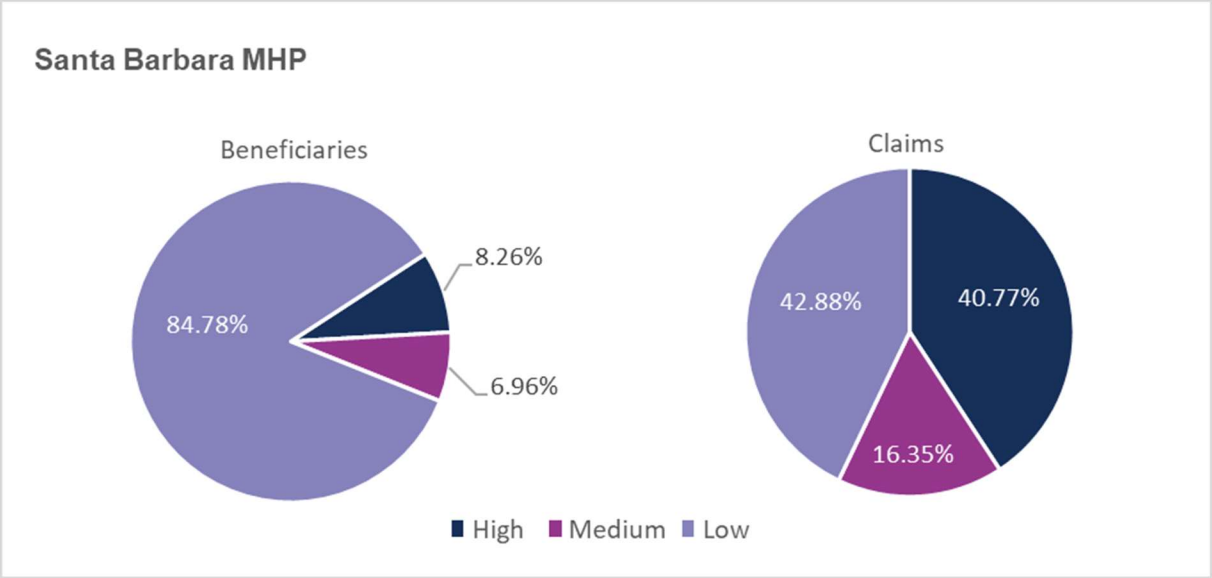
- The MHP's percentage of beneficiaries in the HCB category, and percentage of claims going towards those services, are both higher than the statewide average.

This could be related to the overall high AACB for the MHP and the slightly higher percentage of beneficiaries receiving more than 15 services.

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	380	6.96%	16.35%	$9,084,630	$23,907	$23,437
Low Cost (Less than $20K)	4,628	84.78%	42.88%	$23,817,368	$5,146	$3,123

Figure 20: Beneficiaries and Approved Claims by Claim Category CY 2021



- The MHP has fewer beneficiaries in the low-cost category than the statewide average. For the statewide average nearly 92 percent of beneficiaries are “low-cost.” In the MHP 84.78 percent of beneficiaries are considered low-cost, and they account for 42.88 percent of approved claims. Statewide, low-cost beneficiaries represent 54 percent of approved claims.

IMPACT OF QUALITY FINDINGS

- The MHP claims data have reflected consistently high psychiatric readmission rates, which are higher than the self-reported ATA data. The MHP should analyze reasons for the differences compared to CalEQRO data as started in

prior years. Independent of that need, performance improvement is needed to address the high readmissions.

- The MHP's higher rates of beneficiaries receiving one, two, or one to four services compared to the state rates may indicate engagement barriers. While there are programmatic elements such as the Voluntary Maintenance services for children and youth that likely contribute to the rates, this warrants examination to ensure effective access.
- The MHP's high rate of beneficiaries with no diagnoses can indicate access, engagement, and/or quality of services issues.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have two active and ongoing PIPs, 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 beneficiary satisfaction. They should have a direct beneficiary 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: Mental Health Treatment Court (MHTC)

Date Started: 11/2022

Aim Statement: "Will weekly group therapy sessions targeted at clients involved in the criminal justice system increase MHTC client engagement in mental health treatment services, as measured by an increase in average number of mental health services per week, from 0.46 services per week to 1.0 services per week?"

Target Population: Beneficiaries who participate in in the North County region MHTC

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

Summary

MHP staff, Santa Barbara Superior Court, and a criminal justice program identified the need to improve low engagement of MHTC beneficiaries. The MHP examined service utilization and found that despite highly individualized treatment plans in MHTC

[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

beneficiaries in the North County service region on average attend less than one service a week. The MHP convened its justice program staff and clinical staff in four stakeholder meetings and conducted stakeholder surveys. The MHP identified many root causes ranging from transportation, lack of staff knowledge of court processes, limited staff capacity, and low consumer motivation.

Based on stakeholder input, the MHP plans to add group therapy services to the options provided to beneficiaries beginning April 2023. The MHP completed an intervention plan that includes a warm hand off between the MHP and the specialized criminal justice program staff and an evidence-based group therapy curriculum for justice involved populations, Living in Balance. The intervention is designed for population with co-occurring substance use disorders which is relevant to the MHP's population based on baseline analysis. The MHP plans to provide resources and information in the groups which may also increase appeal. The MHP plans to pilot the PIP at the Calle Real clinic where the majority of MHTC participants are referred for services.

Performance indicators include the average number of services beneficiaries received per week. Process measures include the number of groups provided and the number of groups attended by beneficiaries. The MHP plans to collect service data for "planned services" for the PIP to measure engagement.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: the PIP is in the planning phase. The PIP identified a number of root causes, and the identified intervention thus far is limited.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this clinical PIP including:

- Consumer input has not been obtained for this PIP. Consider alternative MH or justice involved beneficiary input that may inform interventions and strategy given the apparent lack of access to MHTC consumers' input.
- Continue to develop ways to address other barriers identified, such as transportation. Consider telehealth access if not already planned.
- Consider examining impacts on unplanned service utilization as the PIP progresses. This information may be useful to the PIP strategies.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-Up After Emergency Department (ED) Visit for Mental Illness

Date Started: 09/2022

Aim Statement: “By December 2023, will EDs providing bilingual Access appointment cards to clients diagnosed with a primary mental health disorder improve their follow up appointment attendance rates, from 37% to 41% follow up within 7 days and 54% to 55% follow up within 30 days?”

Target Population: Beneficiaries with an ED visit and a primary mental health diagnosis illness

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

Summary

The MHP elected to participate in the CalAIM BHQIP and received information from DHCS that Santa Barbara fell within Quartile 4 for FUM7 (37 percent) and FUM30 (54 percent) in 2021. The MHP initially met with a range of stakeholders including ED staff, AOD staff, and ODS contract providers at monthly meetings to discuss high utilizers of services including behavioral health, justice programs, EDs, and crisis. The MHP collaborates with three hospitals with EDs. Later meetings included the MCP, Access staff and community-based organizations. Root cause analysis found that inconsistent communication methods between the ED and the MHP; lack of systems to track referrals; and lack of protocols for follow-up services; and difficulty making contact on the Access line and scheduling appointments. Other barriers include lack of transportation; lack of phones; homelessness; beneficiary perceptions of care at the ED; and health status.

Interventions include training ED staff on processes to refer to the MHP, the ED distributing bilingual Access Line Cards with an appointment, and creating a system to track universal releases of information. The MHP reports plans to add interventions as the project develops. The primary outcome is the percentage of beneficiaries with an ED visit for a MH condition and received a follow-up service within 7 and 30 days.

The MHP joined the Santa Barbara Health and Human Services data sharing framework. The MHP also reports that the new EHR will enable joining HIEs used by the local hospital system.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the PIP is in the planning phase.

CalEQRO provided TA to the MHP in the form of recommendations for improvement of this non-clinical PIP including:

- Consider setting a target goal closer to the State benchmark or provide rationale for the goal selected (1 percent increase).

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 Electronic Health Records (EHR), Information Technology (IT), claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs.

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Clinician's Gateway and Sharecare, which has been in use for 16 years. Currently, the MHP plans to implement the CalMHSA Streamline SmartCare semi-statewide EHR in July 2023.

Approximately 4.5 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency. The MHP added one full time equivalent to the IS staff due to increased data needs and to support the new EHR.

The MHP has 865 named users with log-on authority to the EHR, including approximately 363 county staff and 502 contractor staff. Support for the users is provided by 17 full-time equivalent (FTE) IS technology positions. Currently there are two IS vacancies. The MHP attributed the vacancies to a low pay scale and the requirement for some positions to be onsite rather than remote.

As of the FY 2022-23 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	93%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☒ Weekly ☐ Monthly	3%
Paper documents delivered to MHP IS	☐ Daily ☒ Weekly ☐ Monthly	4%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not have a PHR in place. They plan to implement the SmartCare PHR within the next two years.

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 contracted providers and substance use disorder providers, hospitals, and primary care providers.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary 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	Met
4C	Integrity of Medi-Cal Claims Process	Met
4D	EHR Functionality	Met
4E	Security and Controls	Met
4F	Interoperability	Met

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

- The MHP is a data-driven organization. They continue to leverage Smartsheet and additional tools to collect and report on data and improve efficiencies in the system of care.
- The MHP has a well-organized plan to implement SmartCare in July 2023. They have teams focused on communications, training, data conversion, systems impact, revenue management, security, go live, and ongoing support.
- The MHP provides interoperability by giving access to its EHR to contract providers and proprietary data exchange solutions with organizations such as the Medi-Cal Managed Care Plan. They are not a member of an HIE.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either adjudicated 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 2021.

This chart appears to reflect a largely complete or substantially complete claims data set for the time frame claimed.

Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	13,178	$5,268,246	$2,044	0.04%	$4,838,335
Feb	13,651	$5,619,104	$8,312	0.15%	$4,990,181
Mar	16,299	$6,527,888	$7,455	0.11%	$5,940,241
April	14,918	$6,392,099	$7,679	0.12%	$5,634,321
May	14,086	$6,055,591	$3,331	0.06%	$5,437,405
June	14,373	$2,824,190	$1,601	0.06%	$2,414,059
July	13,145	$5,041,766	$7,417	0.15%	$4,668,356
Aug	13,478	$4,689,520	$15,815	0.34%	$4,334,605
Sept	13,571	$4,626,842	$22,709	0.49%	$4,256,308
Oct	13,257	$4,605,710	$21,229	0.46%	$4,229,372
Nov	12,366	$4,353,895	$45,980	1.06%	$4,005,468
Dec	11,214	$4,298,079	$251,846	5.86%	$3,915,942
Total	**163,536**	**$60,302,930**	**$395,418**	**0.66%**	**$54,664,593**

Table 19: Summary of Denied Claims by Reason Code CY 2021

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible or non-covered charges	298	$182,204	46.08%
Other healthcare coverage must be billed before submission of claim	201	$125,960	31.85%
Medicare Part B must be billed before submission of claim	192	$73,758	18.65%
Late claim	7	$8,688	2.20%
Deactivated NPI	16	$3,225	0.82%
Other	4	$1,057	0.27%
Service line is a duplicate and a repeat service procedure code modifier not present	4	$527	0.13%
Total Denied Claims	**722**	**$395,419**	**100.00%**
Overall Denied Claims Rate	**0.66%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The MHP has a low claims denial rate of 0.66 percent, as compared to the statewide denial rate of 1.43 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP's well-structured plan for implementing the SmartCare EHR should help make a smooth transition.
- The MHP operates a sophisticated IS department that would benefit from more standards-based interoperability capabilities, such as those offered by HIEs.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of beneficiaries: adult, older adult, youth, and family members. MHPs administer these surveys to beneficiaries 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 completes and conducts annual analyses of CPS data sharing the information broadly. The MHP reviews the open-ended comments in subcommittees to identify and address actionable items.

CONSUMER FAMILY MEMBER FOCUS GROUPS

Consumer and family member (CFM) 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 CFM involvement. CalEQRO provides gift cards to thank focus group participants.

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of TAY consumers who initiated services in the preceding 12 months. The focus group was held virtually and included eight participants. Two family members of TAY consumers also participated in a separate interview; a Spanish language interpreter was used for the interview. All consumers and family members participating receive or have a family member who receives clinical services from the MHP.

Participants had received services between six months to ten years; most had received services for five years. Participants who began services in the last year report timely access and did not experience barriers.

All participants received information and support incorporating physical health needs as part of their care. Some were accompanied to physician by a MHP clinician. All participants report having received options for either in-person or video appointments for clinician or psychiatry appointments.

Participants reported high satisfaction and had a sense of hope from providers and services. Support received included transportation and help applying to colleges. Beneficiaries felt respected and valued the groups and activities such as hikes and day trips. Some identified as being “hard to treat” when starting services and appreciated how providers helped through that period. Participants were aware of crisis service options and received information often. They were aware and comfortable if they wanted a provider change. However, none of the beneficiaries had heard about wellness centers.

Recommendations from focus group participants included:

- Increase staffing. Participants perceived their providers as being “swamped.”
- Add more group services. There was a perception that some groups were discontinued for low attendance. Some expressed interest in more groups.
- Increase frequency of therapy appointments. Some received therapy every three weeks which felt too long of intervals.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included six participants; a Spanish language interpreter was used for this focus group. All consumers and family members participating receive or have a family member who receives clinical services from the MHP. Those who spoke Spanish in treatment receive interpreter help at the clinics and did not experience barriers.

Participants had received services between three months to 30 years; most had received services for two to seven years. One participant started services in that last year; experience was timely with no barriers. Beneficiaries received services at Lompoc and the Santa Barbara providers.

All participants reported flexible access to attend appointments in person, or via phone or video. Several participants who requested a change in provider had negative experiences while others did not know about that option.

Some participants had attended wellness centers or knew of them; the activities and food provided appealed to consumers. Some participants were not aware of the wellness centers. The sense of recovery and hope from services and providers was mixed. While some reported gaining a sense of hope, others report that the recovery perspective varies across staff. Some felt that that they needed more frequent appointments and some “felt judged” or discouraged when placed in situations where there is substance use and inappropriate behavior.

Recommendations from focus group participants included:

- Staff more highly trained professionals, rather than intern-level clinicians. Some perceived that clinicians were not effective in establishing rapport or trust.
- Provide more trauma-informed services or staff with expertise in trauma-informed care.
- “Listen” to beneficiaries if they would like to change providers.
- Increase the frequency of appointments.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Beneficiary feedback obtained was generally positive. Participants across the groups recommended more frequent service appointments and more experienced staff. Knowledge about wellness center availability was not consistent and appears to be a resource that may be underutilized.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary 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 made organizational changes including new management positions to provide dedicated focus on outpatient, inpatient, crisis, equity, and peer employment. (Quality)
2. The MHP has begun and has further plans to extensively evaluate its crisis services. (Access, Quality)
3. The MHP demonstrates routine use of data for quality and capacity management. (Quality, IS)
4. The MHP increased communications regarding workforce areas organization wide improving organizational understanding and morale. (Quality)
5. The MHP developed a well-organized plan for implementing the SmartCare EHR in July 2023. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP's 7-day and 30-day inpatient readmission rates are 31 percent and 26 percent higher than the State performance. There are no performance improvement activities in this area. (Access, Quality)
2. The MHP Hispanic/Latino PR remains consistently lower than other medium-sized counties and statewide. The MHP has a significant percentage of beneficiaries who identify as "Other" and hypothesizes this may contribute to the lower rate. (Access, Quality)
3. Related to workforce shortages, intensive service programs such as Full Service Partnerships and Assertive Community Treatment programs are not consistently providing the needed support to beneficiaries. The reduction of CSU in the last year has further stressed managing crisis needs and overall capacity. (Access, Quality)
4. There is a need to increase data exchange with partner agencies to improve care coordination for beneficiaries receiving mental health services outside of the MHP network. (Quality, IS)

5. The MHP does not measure timeliness to initial access for the entire child and youth service system limiting the information available to monitor access. (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 beneficiary outcomes:

1. Examine services patterns and identify barriers leading to hospital readmissions for Medi-Cal beneficiaries. Conduct performance improvement and measure outcomes at least quarterly. (Access, Quality)

2. Measure the effectiveness of performance improvement activities directed toward increasing the Hispanic/Latino PR. (Access)

3. Complete the MHP planned comprehensive quality review of all crisis and intensive services. Examine system service patterns, level of care information, and beneficiary outcomes to adapt treatment models, and provide clinical guidance and communications to providers. Include clinical staff input in the process. Conduct QI as indicated and measure the effectiveness of changes. (Quality)
   (This recommendation is a carry-over from FY 2021-22.)

4. Research the HIEs, or other exchange of information processes, that are active or available in Santa Barbara County and initiate as appropriate. (IS)

5. Incorporate timeliness measurements for initial offered and received appointments for all services. Assure assessment timeliness is monitored. Develop ways to monitor timeliness comprehensively in children and youth services. (Timeliness)

EXTERNAL QUALITY REVIEW BARRIERS

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

As a result of the continued consequences of the COVID-19 pandemic, California public health emergency (PHE) was in place until February 28, 2023, and a national PHE is scheduled to end May 11, 2023. Therefore, all EQR activities were conducted virtually through video sessions. The virtual review allowed stakeholder participation while preventing high-risk activities such as travel requirements and sizeable in-person indoor sessions. The absence of cross-county meetings also reduced the opportunity for COVID-19 variants to spread among an already reduced workforce. All topics were covered as planned, with video sessions necessitated by the PHE having limited impact on the review process.

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 –Santa Barbara MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
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 Beneficiary Satisfaction
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Contract Provider Group Interview – Operations and Quality Management
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Information Systems Billing and Fiscal Interview

CalEQRO Review Sessions –Santa Barbara MHP
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Rowena Nery, Lead Quality Reviewer
Zena Jacobi, Information Systems Reviewer
David Czarnecki, Consumer/Family Member Consultant

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Andersen	Celeste	Chief of Compliance	Behavioral Wellness
Anderson	Carla	Clinical Line Staff	Behavioral Wellness
Arteaga	Maria	Ethnic Services Manager	Behavioral Wellness
Avalos	Sandra	Clinical Supervisor	Behavioral Wellness
Azueta	Yane	Contract Provider Senior Management	CommUnify
Barbosa	Elizabeth	QCM Coordinator	Behavioral Wellness
Barkett	Anne	Clinical Line Staff	Behavioral Wellness
Bautista	Enrique	Client's Rights Advocate	Behavioral Wellness
Becker	Nicole	Lompoc Regional Manager	Behavioral Wellness
Behrendtsen	Ole	Medical Director	Behavioral Wellness
Blumenthal	Lauren	HIM Manager	Behavioral Wellness
Bowers	Seleste	Director of Behavioral Health	CenCal Health
Boyer	Christie	Fiscal Staff	Behavioral Wellness
Casiano	Tammy	QCM Coordinator	Behavioral Wellness
Castillo	Carmen	Administrative Office Professional	Behavioral Wellness
Cohen	Katie	Division Chief of Outpatient Services	Behavioral Wellness
Cross	Carla	Manager of Clinical Training and Special Projects	Behavioral Wellness
Dahlhauser	Michael	Contract Provider Senior Management	Merakey
Donati	Vanessa	Clinical Supervisor	Behavioral Wellness

Last Name	First Name	Position	County or Contracted Agency
Doyel	John	Deputy Director	Behavioral Wellness
Escobar	Alma	Peer Employee	Behavioral Wellness
Flores	Joseph	Clinical Line Staff	Behavioral Wellness
Garcia	Adolfo	Contract Provider Senior Management	CALM Inc
Garcia	Natalie	Clinical Supervisor	Behavioral Wellness
Grimmesey	Suzanne	PIO	Behavioral Wellness
Heinzelmann	Veronica	Santa Barbara Regional Manager	Behavioral Wellness
Herriman	Kimberly	Clinical Psychologist Post Doctoral Intern	Behavioral Wellness
Hunt	Margaret	Access Line Supervisor	Behavioral Wellness
Huthsing	Jamie	Branch Chief of Quality Care Management	Behavioral Wellness
Jensen	Chelsea	Contract Provider Senior Management	Good Samaritan Shelter
Jimeno	Rosanna	Clinical Line Staff	Behavioral Wellness
Johnson	Melanie	Contracts Manager	Behavioral Wellness
Jones	Amber	Clinical Line Staff	Behavioral Wellness
Kadada	Waseem	Business Specialist/ IT	Behavioral Wellness
Khatapoush	Shereen	Research and Evaluation	Behavioral Wellness
Klassen	Diana	QCM Coordinator	Behavioral Wellness
Knudsen	Kassie	QCM Coordinator	Behavioral Wellness
Korsan	Jessica	QCM Manager	Behavioral Wellness

Last Name	First Name	Position	County or Contracted Agency
Larsen	Stacey	QCM Coordinator	Behavioral Wellness
Lepore	Caitlin	Research and Evaluation	Behavioral Wellness
Llamar	Nicole	Clinician	
Lombard	Christina	MHSSA Program Manager	Behavioral Wellness
Lopez	Qiuana	Policy & Procedure Manager	Behavioral Wellness
Mann Jackson	Victoria	Peer Employee	Behavioral Wellness
Mariano	Jeffrey	Human Resources Manager	Behavioral Wellness
Martinez	Danielle	Santa Maria Regional Manager	Behavioral Wellness
Masuda	Jon	Homeless Services Manager	Behavioral Wellness
McBain	Katie	LMFT Practitioner	Behavioral Wellness
McCarthy	Marjorie	Clinical Line Staff	Behavioral Wellness
Morris	Hannah	Contract Provider Senior Management	PathPoint
Morris	Hannah	Contract Provider Senior Management	PathPoint
Navarro	Antoinette “Toni”	Director	Behavioral Wellness
Neupane	Dipak	Revenue Manager	Behavioral Wellness
Nuno	Gloria	Access Screener	Behavioral Wellness
Orozco	Patricia	Administrative Office Professional	Behavioral Wellness
Padilla	Emily	Clinical Line Staff	Family Service Agency
Palta	Raina	Research and Evaluation	Behavioral Wellness
Patarias	Elodie	Clinical Supervisor	Behavioral Wellness

Last Name	First Name	Position	County or Contracted Agency
Peinado	Diana	Clinical Supervisor	Behavioral Wellness
Perry	Whitney	Business Specialist/ IT	Behavioral Wellness
Pyper	Amanda	Manager	CenCal
Ramsey	Marshall	Division Chief of IT	Behavioral Wellness
Ranck	Nancy	Contract Provider Senior Management	Family Service Agency
Rankin	Robert	IT Staff	Behavioral Wellness
Raya	Jaciel	Clinical Line Staff	PathPoint
Ribeiro	Chris	Chief Financial Officer	Behavioral Wellness
Robb	Careena	Crisis Manager	Behavioral Wellness
Rocha	Jonelle	Administrative Office Professional	Behavioral Wellness
Rodriguez	Roberto	Clinical Supervisor	Behavioral Wellness
Rossi	Natalia	MHSA Manager	Behavioral Wellness
Ruiz	Monica	Patient's Rights Advocate	Behavioral Wellness
Sanborn	Kendra	Clinical Line Staff	Behavioral Wellness
Sanchez	Josue	Fiscal Manager	Behavioral Wellness
Schmidt	Abigail	Peer Employee	Behavioral Wellness
Scofield	Sara	Clinical Line Staff	PathPoint
Soderman	Susan	QCM Coordinator	Behavioral Wellness
Steadman	Krystina	Clinical Supervisor	Behavioral Wellness

Last Name	First Name	Position	County or Contracted Agency
Sturz	Susan	County Compliance & Accountability Officer	County Executive Office
Tennison	Jordan	Clinical Line Staff	Behavioral Wellness
Thompson	Jonathan	Clinical Line Staff	CALM, Inc
Valdovinos	Rafael	Peer Employee	Behavioral Wellness
Walters	Eric	Peer Employee	Behavioral Wellness
Wilkins	Melissa	Branch Chief of Alcohol and Drug Services	Behavioral Wellness
Winckler	John	Division Chief of Specialty Programs	Behavioral Wellness
Woody	Joshua	QCM Manager	Behavioral Wellness
Zeitz	Laura	Branch Chief	Behavioral Wellness

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	The PIP is in the planning phase.
General PIP Information	
MHP/DMC-ODS Name: Santa Barbara MHP	
PIP Title: Mental Health Treatment Court	
PIP Aim Statement: "Will weekly group therapy sessions targeted at clients involved in the criminal justice system increase MHTC client engagement in mental health treatment services, as measured by an increase in average number of mental health services per week, from 0.46 services per week to 1.0 services per week?"	
Date Started: 11/2022	
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:	
Target population description, such as specific diagnosis (please specify): All beneficiaries in the MHTC program in the Santa Barbara region's Calle Real clinic.	

General PIP Information						
Improvement Strategies or Interventions (Changes in the PIP)						
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Group therapy service						
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): Group therapy service						
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**
Average number of services per week that clients engage in at Calle Real Clinic	FY 22/23 Q1-Q2	n = 10 0.46 services per week	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 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
			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ 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:

Consumer input has not been obtained for this PIP. Consider alternative MH or justice involved beneficiary input that may inform interventions and strategy given the apparent lack of access to MHTC consumers input.

Continue to develop ways to address other barriers identified such as transportation. Consider telehealth access if not already planned.

PIP Validation Information
Consider also examining impacts on unplanned service utilization as the PIP progresses. This information may be useful to the PIP strategies and continuous QI.

Non-Clinical PIP

Table C1: 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 elected to participate in the CalAIM BHQIP FUM.
General PIP Information	
MHP/DMC-ODS Name: Santa Barbara	
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness	
PIP Aim Statement: "By December 2023, will EDs providing bilingual Access appointment cards to clients diagnosed with a primary mental health disorder improve their follow up appointment attendance rates, from 37% to 41% follow up within 7 days and 54% to 55% follow up within 30 days?"	
Date Started: 09/2022	
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:	
Target population description, such as specific diagnosis (please specify): Beneficiaries with an ED visit with a primary mental health diagnosis.	
Improvement Strategies or Interventions (Changes in the PIP)	

General PIP Information						
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): Providing appointment information cards including bilingual information cards						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Training ED staff on referral to MHP process						
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): Establishing data sharing, protocols to refer from ED to the MHP, and tracking systems to monitor referrals and follow-up.						
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 beneficiaries who attended follow up appointment within 7 days	CY 2021	360/970 37.1 %	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): n/a
Percentage of beneficiaries who attended follow up appointment within 30 days	CY 2021	527/970 54.3 %	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of MH referrals to Access by ED Includes MH Access calls designated routine, urgent, or crisis.	CY 2022	166 = 41.5/quarter	☒ Not applicable—PIP is in planning or implementation phase, results not available	CY 2023 Q1 (Jan-Mar) 45 calls	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 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
			☐ 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:

Consider setting a target goal closer to the State benchmark or provide rationale for the goal selected (1 percent increase).

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required to be included in this report.