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

SANTA CLARA FINAL REPORT – REV. AUGUST 2023

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

December 13-15, 2022

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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 Clara" may be used to identify the Santa Clara County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — December 13-15, 2022

MHP Size — Large

MHP Region — Bay Area

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
6	5	1	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	8	2	0
Information Systems (IS)	6	3	3	0
TOTAL	**26**	**21**	**5**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Use of MHSA Client Support Services and Re-Engagement to improve outcomes	Clinical	07/22	First Remeasurement	Moderate
Improving the 24/7 Access Call Line Efficiency	Non-Clinical	05/22	First Remeasurement	High

Table D: Summary of Consumer/Family Focus Groups

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

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has an extensive range of options to provide crisis care.
- The MHP is implementing the Sequential Intercept Model to provide appropriate care to its justice- or court-involved beneficiaries.
- The law enforcement liaisons (LELs) ensure law enforcement training in mental health (MH) interventions, and collaborates with the various law enforcement units throughout the county.
- The MHP has a strong culturally competent system of care.
- The MHP also has extensive collaborations with many school districts.

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

- Ongoing care post-assessment can take a long time.
- Upon receipt of a referral, if the contract providers are unable to meet the needs of the beneficiary, the provider is responsible for finding alternative services rather than Behavioral Health Services Department (BHSD).
- The first offered psychiatry appointment data may not be complete yet.
- The MHP does not track all the applicable Healthcare Effectiveness Data and Information Set (HEDIS) measures applicable to mental health services.

- Not all providers have operations continuity plans.

Recommendations for improvement based upon this review include:

- Determine if there are delays in post-assessment services by service type, by cultural and demographic factors, and by service locations.
- Develop a workflow process that enables providers to refer cases back to MHP Access for more appropriate placement when warranted.
- Continue to further refine the first psychiatry appointment timeliness data and ensure complete and consistent reporting by the providers.
- Collect and monitor data for the currently untracked HEDIS measures for mental health across the adult and children's systems of care.
- Standardize contract provider expectations for disaster recovery and operations continuity plan timeliness to assure data security and timely availability in the event of a disaster or other data compromising event.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in 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 Section14197.05).

This report presents the FY 2022-23 findings of the EQR for Santa Clara County MHP by BHC, conducted as a virtual review on December 13-15, 2022.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public MH system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to 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 (PMs) 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 or its corresponding penetration rate (PR) percentages.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2021-22) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place after the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP had sustained significant staff turnover during the pandemic and also undergone organizational changes since the previous EQR. 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.

- The Santa Clara County Board of Supervisors (BOS) declared the state of mental health and substance use disorders (SUD) as a public health crisis and directed the BHSD to develop core strategies to address this crisis. BHSD has worked on this throughout CY 2022 and made presentations to the BOS.
- BHSD has developed strategies to address workforce shortage that focus on enhancing partnerships, strengthening the workforce pipeline, promotion of behavioral health field as a profession, recruitment programs, and ongoing analysis of the workforce.
- The MHP has been actively implementing the California Advancing and Innovating Medi-Cal related changes in three areas of payment reform, policy changes, and data exchange. In each of these areas, the MHP has undertaken a three-phase, comprehensive approach.
- BHSD has integrated its separate call centers for mental health and SUD services with an integrated screening process for referrals.
- The MHP was able to adjust its contract provider rates as part of an effort to aid the providers recruit and retain qualified, licensed staff. The MHP has also initiated sign-on bonus for newly hired clinical staff across the system.
- The BHSD leadership has undergone significant changes as a result of retirements. The MHP now has new deputy directors of administrative services and system delivery. The deputy director of system delivery oversees all the age specific systems of care. In addition, there is a new finance and administrative services manager, and a new director of quality management (QM).

- The MHP has a formalized presence in 24 of the 32 school districts in the county through its School Linked Services (SLS) initiative. The SLS school districts were selected based on a determination of high-risks and other social determinants.
- Since the FY 2021-22 EQR, the MHP has initiated a number of significant programs that are likely to positively impact access, quality, and beneficiary outcomes. A new youth drop-in center opened in downtown San Jose, as well as an open access drop-in clinic. The MHP also opened new culturally specific wellness centers in the past two years. Establishment of assisted outpatient treatment is meant to prevent repeat hospitalizations. In addition, the MHP evidenced continuous enhancement of its partnerships with criminal justice and law enforcement partners for better treatment for the justice-involved beneficiaries.
- Trusted Response Urgent Support Team (TRUST) program funded by the Mental Health Services Act (MHSA) that started in July 2022, seeks to maximize the ability to expand crisis response for individuals and families by adopting a community model that uses community residents, mental health workers, and emergency medical support to prevent crisis. It allows people to get the help they need as safely and smoothly as possible, starting with meeting them where they are.
- The local 988 crisis line is newly consolidated into the county's Access line.

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: Begin to track and report timeliness to first offered non-urgent psychiatry appointments, while looking into viable solutions to low first rendered service to non-urgent psychiatry.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP provided two rounds of training and a refresher to all its providers between September 2021 and August 2022 on how to accurately capture the non-urgent psychiatry timeliness data in the Timely Access Data Tool (TADT).
- The MHP sought TA from DHCS and received guidance and clarification on how to measure timeliness to first psychiatry appointments. This has allowed it to refine its methodology for capturing and recording the data on this metric in TADT. It appears that the methodology does not include all first-time non-urgent requests for psychiatry.
- The MHP reported that all providers are now submitting this data to the MHP, and it has been able to fully report the TADT data to DHCS and summarize the results for the EQRO.

Recommendation 2: Begin to track and report timeliness to urgent services system-wide to provide an accurate representation of timeliness to urgent services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- In January 2022, the MHP started tracking timeliness to urgent service requests according to the prescribed format in TADT. It has since submitted this data as part of the MHP's NA data submission to DHCS in August 2022 and timeliness data to the EQRO.
- The MHP's data on analysis of urgent requests show prompt response time of less than half an hour on average.

Recommendation 3: Review requirements of SB1291 and the Welfare and Institutions Code (WIC) § 14197.05 and ensure adherence to the requirements to ensure timely access to necessary care for this historically underserved beneficiary population.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Since the beginning of CY 2022, the MHP has begun tracking and reporting on most of the required HEDIS measures. The only exception was the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- The MHP has been coordinating with the Public Health Department FC medication monitoring nurses on a quarterly basis over the past year to work collaboratively in enhancing and refining data collection and sharing of information in order to track and trend this data over time.
- The MHP has worked with the contract providers to ensure timely access to services for the FC beneficiaries including the establishment of specialized FC programs capable of providing prompt response to urgent and crisis conditions.
- The FC timeliness data were comparable to or better than the overall timeliness metrics.

Recommendation 4: Implement a "no wrong door" policy for accessing mental health services to supplement referrals from the MHP call center, while consolidating contract monitoring to a specific liaison for each provider. Reestablish monthly meetings for each provider with MHP contract monitor, fiscal staff, and upper management to address capacity management, quality of care, and budgetary issues.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has developed a "no wrong door" policy and is awaiting DHCS approval. The MHP is developing a process and training on the "no wrong door" policy once the policy is approved. The MHP are waiting to implement the screening and transition tools when they are released by DHCS.
- The MHP meets on a monthly basis with contract providers around capacity, timeliness, quality of care, and budgetary issues.
- The QM division has begun the process of establishing a provider relations unit with the ultimate goal of a single liaison for each contractor.

- The contract providers noted improvement in communication, especially with the executive management. They also noted that a single liaison will allow a more efficient communication process so the contract providers are not left to find the right county staff for specific questions.

Recommendation 5: Implement strategies to increase attention and resources for behavioral health specific staffing issues; consider partnering with Santa Clara Health System and county administration in this effort. Consider a compensation study for the most impacted positions, including a full review of contracted providers compensation levels to ensure that providers will be able to maintain stability in staffing levels necessary to deliver services at all levels of care.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- BHSD has established collaboration and launched strategic efforts with key internal and external partners to address the behavioral health workforce shortage. Through an internal partnership with the Employee Services Agency (ESA), BHSD and ESA have launched weekly meetings through the Center for Leadership and Transformation's program for rapid transformation initiatives. These meetings have resulted in:
    - A sign-on bonus for newly hired clinical staff.
    - Creation of new classifications that provide supervisory support at the clinic level and a career path into management for clinicians, as well as more appropriate classifications for BHSD crisis intervention service.
    - Planned enhancement of BHSD's internship program by retaining interns through a clear path to permanent County employment within BHSD.
    - Implementation of specialized recruitments for prioritized clinical positions, as well as enhanced marketing and community outreach efforts, such as promotional online/virtual events.
- The MHP has worked with the Behavioral Health Contractors' Association (BHCA) to establish a strategic workgroup that are working on a number of initiatives including training, awareness of career paths in behavioral health, internship stipend, and pay structure review.
- The MHP has been able to increase the contract providers' rates to improve their staff hiring and retention capabilities.

Recommendation 6: Pilot myAvatar integration, including the development of timeliness reporting, with community-based organization (CBO) electronic health records (EHRs) with one or two CBOs to address implementation issues when the impact is relatively small and more easily managed. Communicate with all CBOs

throughout the process and provide ongoing opportunities for CBO input and partnership on system solutions.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- In December 2021, the pilot CBO site began testing the new Avatar integration connectivity via Provider Connect Enterprise (PCE). PCE is the Application Programming Interface (API) that is used for connectivity between the MHP and contractor provider organizations. In January 2022, the pilot agency began testing claim submittal functionality by sending 837 files. Upon completion of this pilot, the MHP began the rollout of the connections to other contract providers. There were three connectivity options offered to contract providers: 1. Full integration which as selected by the pilot agency (PCE + 837 files), 2. PCNX (web portal) + 837 files, and 3) PCNX (web portal) + manual billing.
- April 1, 2022, marked the next set of contract provider go-lives. Go-lives continued on the first of every month with the last group of contact providers scheduled to go-live on December 1, 2022. As of December 2022, 42 contract providers have implemented this functionality.
- The MHP reports that regular communication occurred with contract providers with the MHP implementation team members meeting with each contract provider to assure that the go-lives were appropriately planned, and the process understood by the contract provider. Weekly meetings were held with each contract provider from the implementation period through the project go-live.
- While the MHP reported that the year-long effort to roll out the Avatar integration is largely complete, both the MHP and contract providers reported that efforts continue in order to refine the integration process and correct varied provider issues that occurred during the integration process rollout due to the varied EHR systems utilized by the contract providers.

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 9 percent of services were delivered by county-operated/staffed clinics and sites, and 91 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 74 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 staff; beneficiaries may request services through the Access Line as well as through the San Jose Downtown Walk-in Access Clinic. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. The Access Line does the initial screening and makes referrals to the providers, both county and contracted. Upon assessment, the providers are responsible for the appropriate care, including referrals to alternate providers, if needed.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video/phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 5,476 adult beneficiaries, 5,412 youth beneficiaries, and 693 older adult beneficiaries across 17 county-operated sites and 49 contractor-operated sites. Among those served, 2,313 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

[1] CMS Data Navigator Glossary of Terms

and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information 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 Clara County, the time and distance requirements are 15 miles and 30 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.
- Per DHCS' findings, the MHP submitted an updated TADT based on which DHCS determined that the MHP met all time and distance standards.

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	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:

- In its cultural competency plan, the MHP provided extensive community behavioral health needs assessment findings.
- The MHP evidenced a number of strategies to address the identified cultural needs, including the establishment of a TAY drop-in center in downtown San Jose in September 2022, a Vietnamese outpatient program, the Q-corner for the LGBTQ beneficiaries, and a cultural communities wellness program including culturally specific wellness centers catering to Asian, Latino/Hispanic, and African American beneficiaries.
- In some instances, the stakeholders, including the beneficiaries, noted that linguistic and cultural preferences may delay access to services. In general, this appears to be limited to certain service locations due to staff turnover during the COVID-19 pandemic.
- The MHP has also opened an open access drop-in clinic in Downtown San Jose. For those who can access it, this provides same day intake screening and follow-up appointments.
- Santa Clara has an elaborate network of crisis programs which can be categorized by the source of crisis calls and the specific types of interventions. These include the following:
    - Psychiatric Emergency Response Team – This is activated by 911 calls that provides the most intense level of response through a combined team of law enforcement officers and clinicians.
    - Mobile Crisis Response Team – This is activated by the behavioral health access line calls and responded to by clinicians and waivered staff with consultation from LELs.
    - Mobile Response Stabilization Services – This provides crisis services to youth beneficiaries activated through the Pacific Clinic's crisis line.

- TRUST – This is also activated by the access line calls that employs a lower-level, community-based mobile response.

- The MHP has identified strategies to address its workforce turnover and shortages including enhancing partnerships, developing the workforce pipeline, promoting the behavioral health field of work, recruitment incentives, and ongoing evaluation of the workforce recruitment strategies.
- The contract providers noted issues with some of the referrals from the recently merged mental health and substance use disorder access call line when further assessment shows a lack of congruence with the services offered by a specific program. According to the contract providers, this results in the contract provider being responsible for finding a suitable, alternative service provider instead of being able to refer back to the access line for the same task.

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 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, the MHP's PR of 5.36 percent was 39 percent greater than the statewide average, and the average claim amount of $13,848 was more than twice the statewide average.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	434,609	23,316	5.36%	$322,878,662	$13,848
CY 2020	399,155	23,548	5.90%	$305,430,870	$12,971
CY 2019	393,195	24,232	6.16%	$218,740,031	$9,027

- While the number of beneficiaries served and penetration rate declined each year from CY2019 to CY 2021, AACB increased each year. The number of total

eligibles was stable from CY 2019 to CY 2020 but increased 8.9 percent from CY 2020 to CY 2021.

- Decreases from CY 2020 to 2021 may be the result of an incomplete data set for 2021.

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

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Similar Size Counties Penetration Rate	Statewide Penetration Rate
Ages 0-5	36,351	1,516	4.17%	1.29%	1.59%
Ages 6-17	91,663	7,346	8.01%	4.65%	5.20%
Ages 18-20	22,906	1,436	6.27%	3.66%	4.02%
Ages 21-64	217,077	11,967	5.51%	3.73%	4.07%
Ages 65+	66,613	1,051	1.58%	1.52%	1.77%
Total	**434,609**	**23,316**	**5.36%**	**3.47%**	**3.85%**

- Penetration rates exceeded statewide averages for all age groups with the exception of those ages 65+ (1.58 percent vs. 1.77 percent).

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	Percent of Beneficiaries Served
Cantonese	63	0.27%
Farsi	118	0.51%
Mandarin	150	0.65%
Spanish	5,345	23.31%
Tagalog	84	0.37%
Vietnamese	952	4.15%
Total Threshold Languages	**6,712**	**29.27%**
Threshold language source: Open Data per BHIN 20-070		

- Santa Clara had six threshold language other than English in CY 2021 with Spanish speakers comprising the largest of the six language groups. There were 5,345 beneficiaries served by the MHP who identified Spanish as a preferred language, 23.31 percent of the beneficiaries served by the MHP.

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

Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	142,591	6,399	4.49%	$76,366,462	$11,934
Large	2,153,582	62,972	2.92%	$387,366,612	$6,151
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

- 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 ACA PR is 36 percent greater than the statewide average (4.49 percent vs. 3.31 percent), and the AACB amount is more than twice the statewide average ($11,934 vs. $5,677).

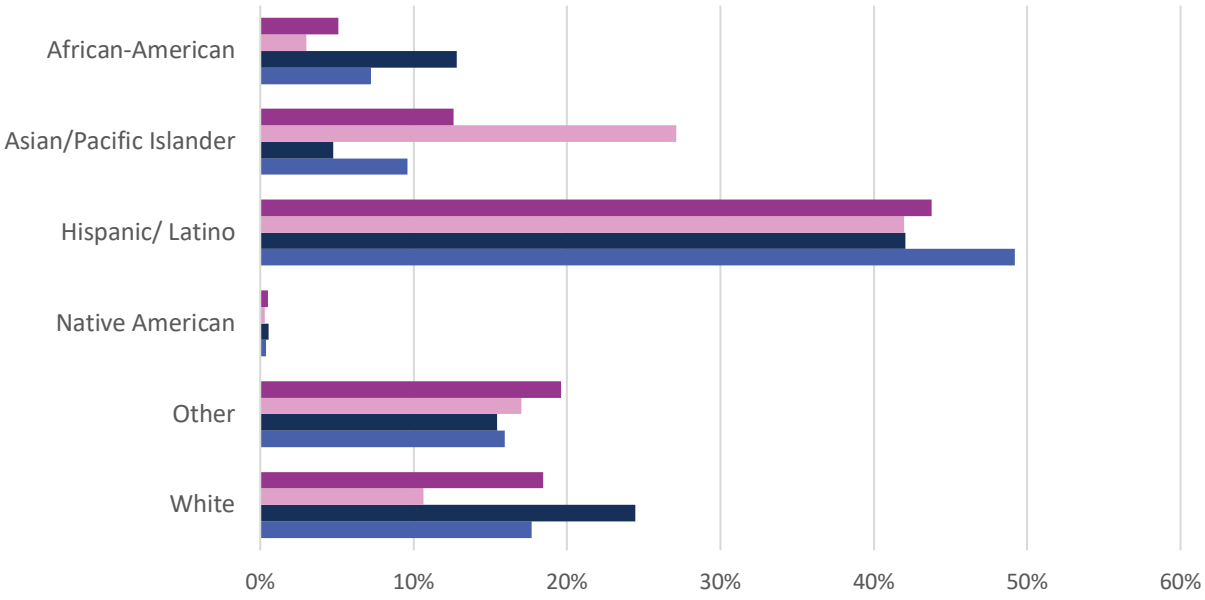
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions 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	# MHP Served	# MHP Eligibles	MHP PR	Statewide PR
African-American	1,183	13,024	9.08%	6.83%
Asian/Pacific Islander	2,940	117,814	2.50%	1.90%
Hispanic/Latino	10,206	182,409	5.60%	3.29%
Native American	114	1,218	9.36%	5.58%
Other	4,570	73,938	6.18%	3.72%
White	4,303	46,207	9.31%	5.32%
Total	**23,316**	**434,610**	**5.36%**	**3.85%**

- Santa Clara served 23,316 unique beneficiaries in CY 2021. The eligible population was largely comprised of Hispanic/Latino beneficiaries (42 percent of the eligible population). Penetration rates for all race/ethnicity groups exceeded statewide averages.

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

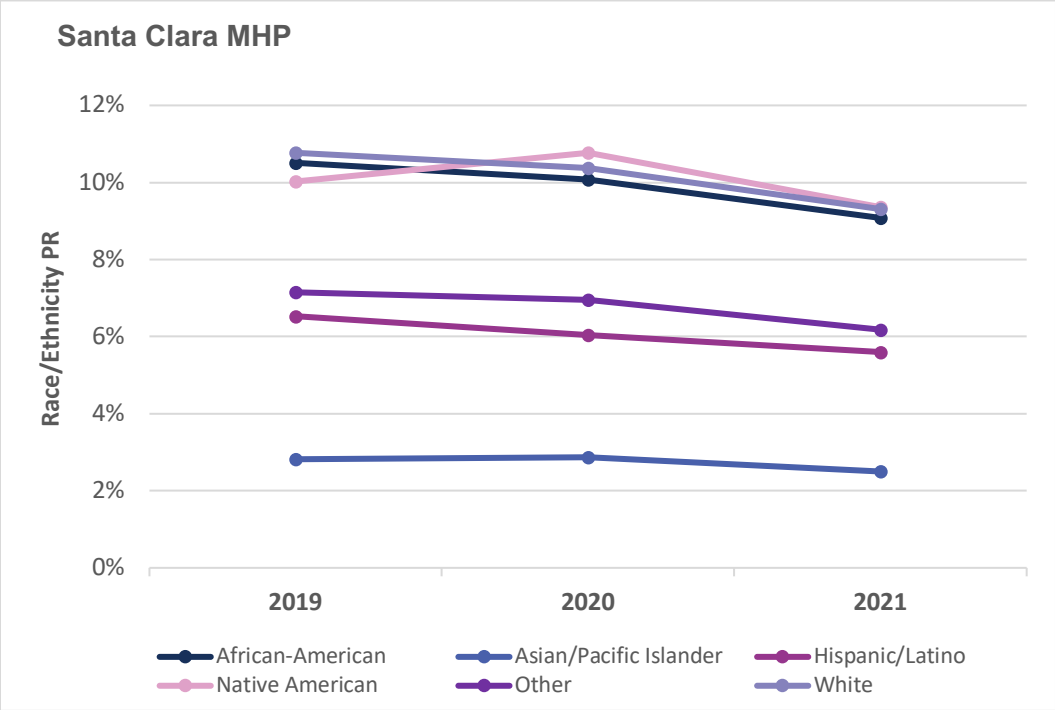


	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	18%	20%	0%	44%	13%	5%
MHP % Eligibles	11%	17%	0%	42%	27%	3%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

- While Santa Clara's Latino/Hispanic population comprised 42 percent of the eligible population, 44 percent of those served were Latino/Hispanic. Asian/Pacific Islanders comprised the next largest race/ethnicity group compromising 27 percent of the eligible population and 13 percent of those served. The lower percent of Asian/Pacific Islanders served compared to the eligible population indicates that this population may be underserved.

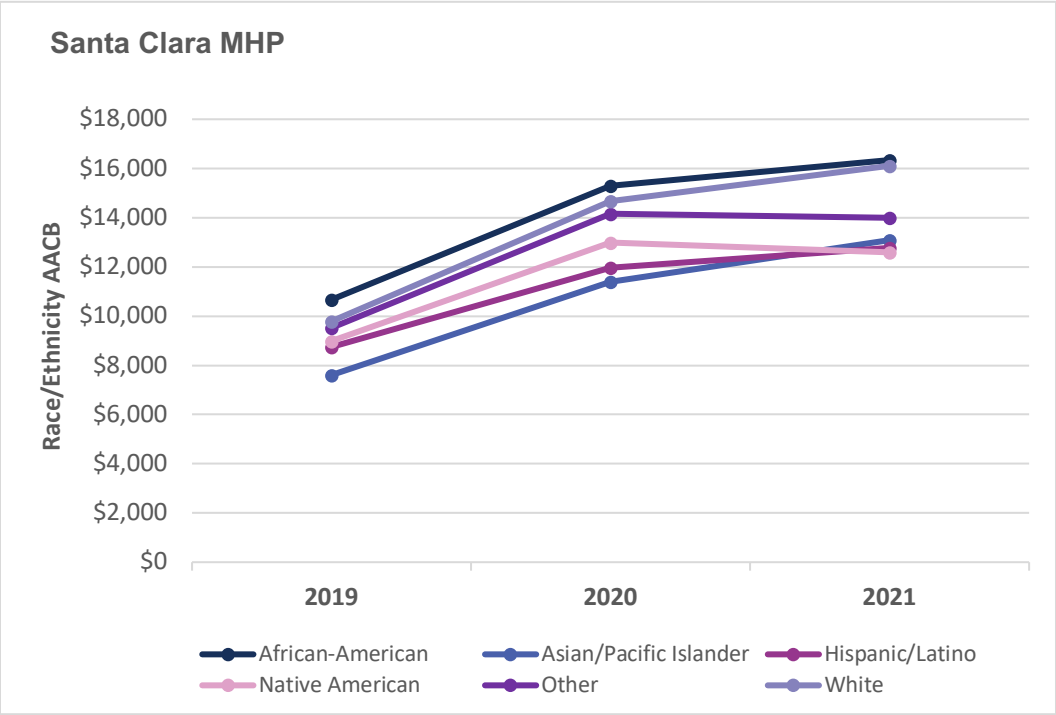
Figures 2 – 11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



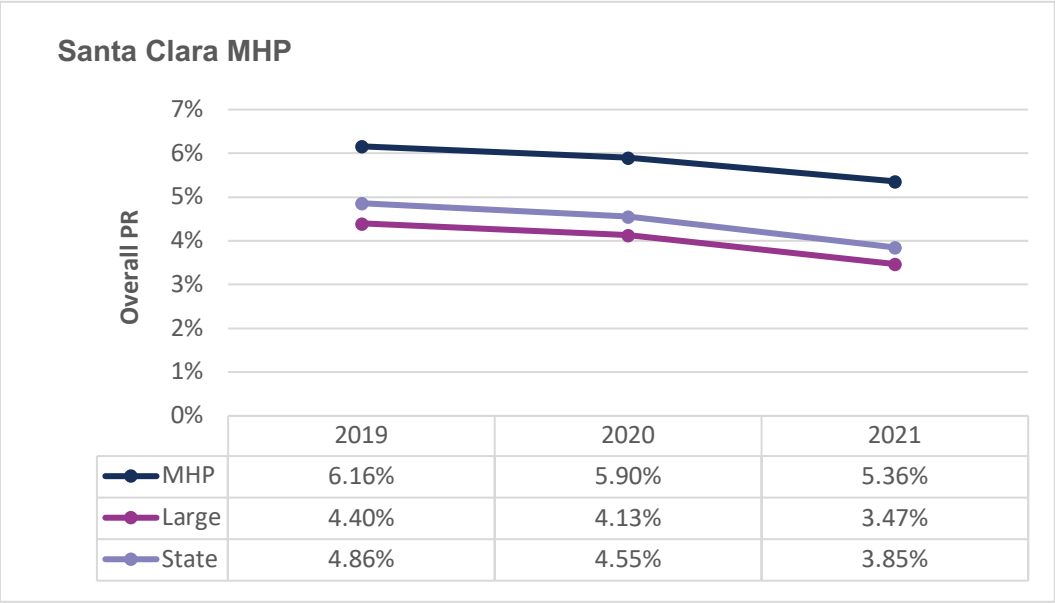
- From CY 2019 to CY 2021, Native American, White, and African American had the highest penetration rates. Asian Pacific Islander had notably lower penetration rates during this time. Penetration rates declined for all race ethnicity groups from CY 2020 to CY 2021.

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



- Billing rates impacted by the COVID-19 pandemic likely contributed to the CY 2019 to CY 2020 increase in AACBs for the overall data and all subpopulation data.
- Apart from Native American and Other, AACB increased each year from CY 2019 to CY 2021, with White and African American having the highest AACBs in CY 2021. Fewer than 1 percent of those served in CY 2021 were Native American and small beneficiary counts can cause increased variability in year over year data.

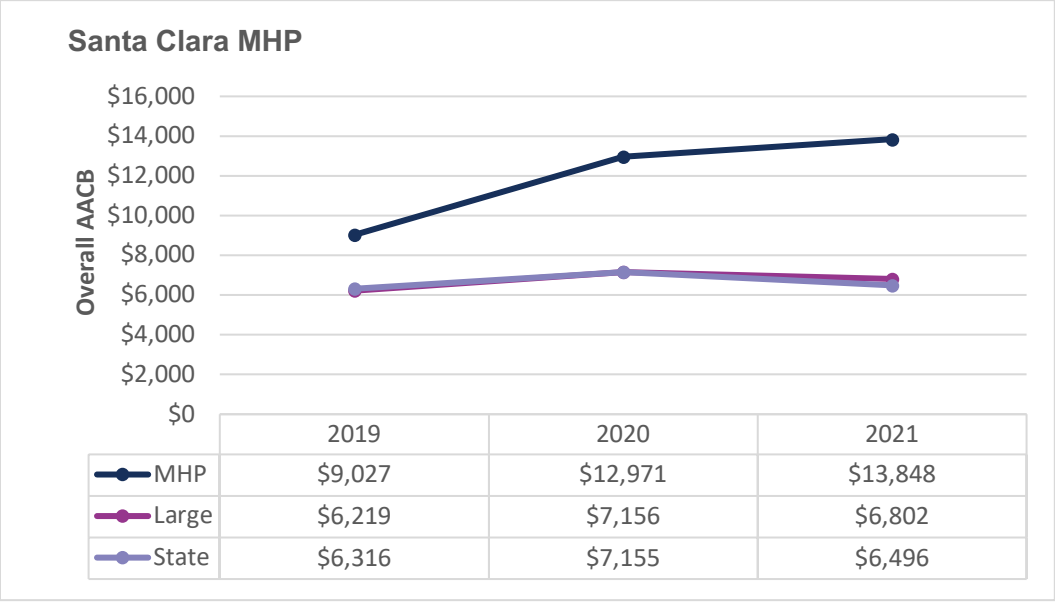
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	6.16%	5.90%	5.36%
Large	4.40%	4.13%	3.47%
State	4.86%	4.55%	3.85%

- Santa Clara's PR remain above statewide and large county averages. In CY 2021, Santa Clara's overall penetration rate was 39 percent greater than the statewide average (5.36 percent vs. 3.85 percent), ranking 16th of 56 MHPs.

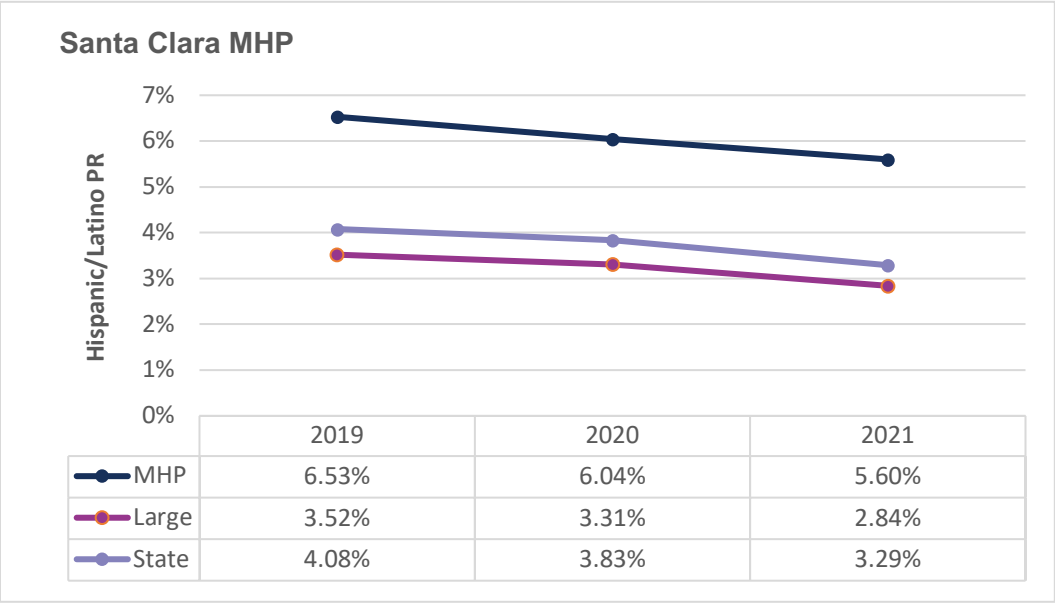
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$9,027	$12,971	$13,848
Large	$6,219	$7,156	$6,802
State	$6,316	$7,155	$6,496

- AACB increased each year from CY 2019 to CY 2021, while the statewide AACB remained almost the same. In CY 2021, Santa Clara's AACB was more than twice statewide and large county averages.

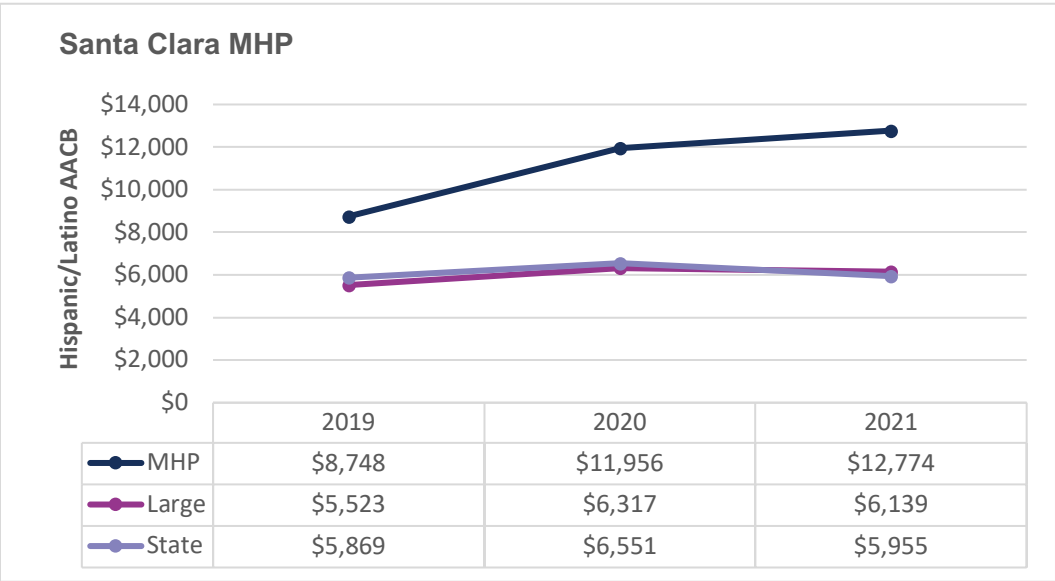
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	6.53%	6.04%	5.60%
Large	3.52%	3.31%	2.84%
State	4.08%	3.83%	3.29%

- While remaining significantly above statewide and large county averages, Santa Clara's Hispanic/Latino penetration rate declined each year from CY 2019 to CY 2021, mirroring the statewide trend for this time period. In CY 2021, Santa Clara's Hispanic/Latino penetration rate was 70 percent greater than the statewide average (5.60 percent vs. 3.29 percent), ranking 4th of 56 MHPs.

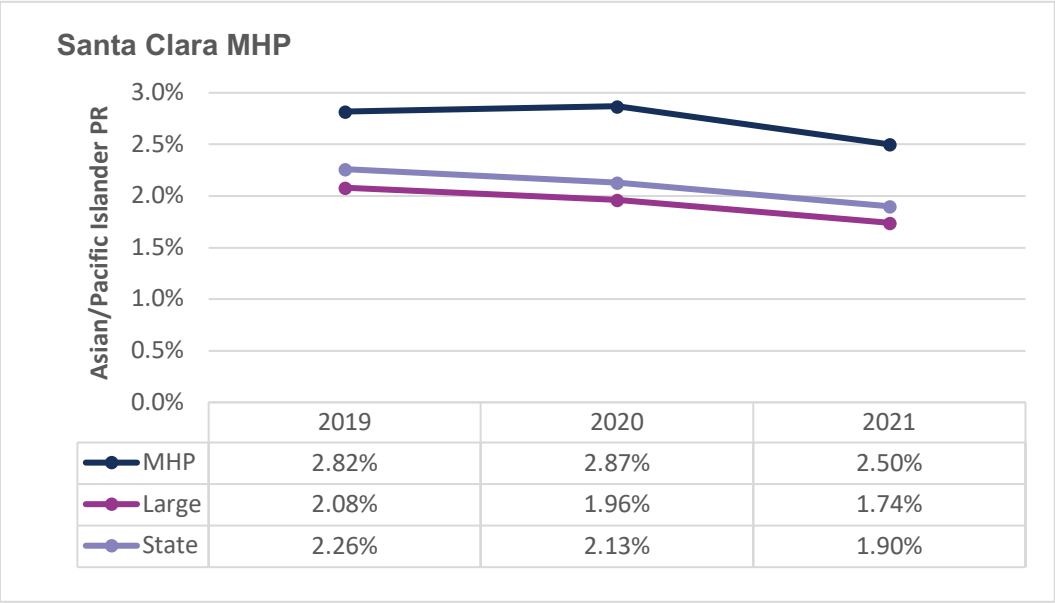
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$8,748	$11,956	$12,774
Large	$5,523	$6,317	$6,139
State	$5,869	$6,551	$5,955

- Hispanic/Latino AACB increased each year from CY 2019 to CY 2021. In CY 2021, Santa Clara's AACB was more than twice statewide average and large county averages.

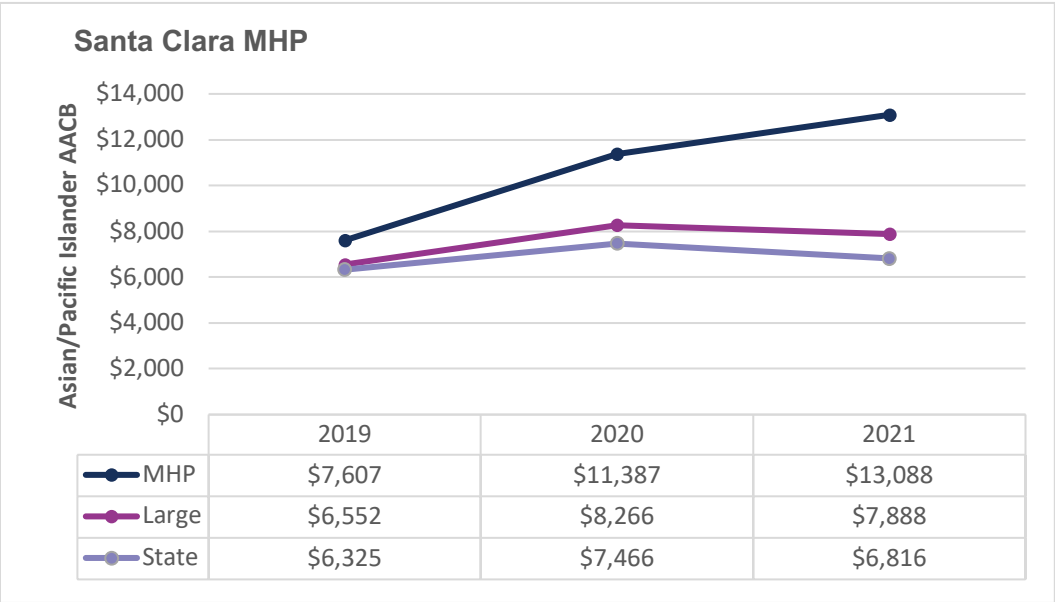
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.82%	2.87%	2.50%
Large	2.08%	1.96%	1.74%
State	2.26%	2.13%	1.90%

- Santa Clara's Asian/Pacific Islander penetration rate remains higher than large counties and statewide. In CY 2021, Santa Clara's Asian/Pacific Islander penetration rate was 32 percent greater than the statewide average (2.50 percent vs. 1.90 percent), ranking 15th of 56 MHPs.

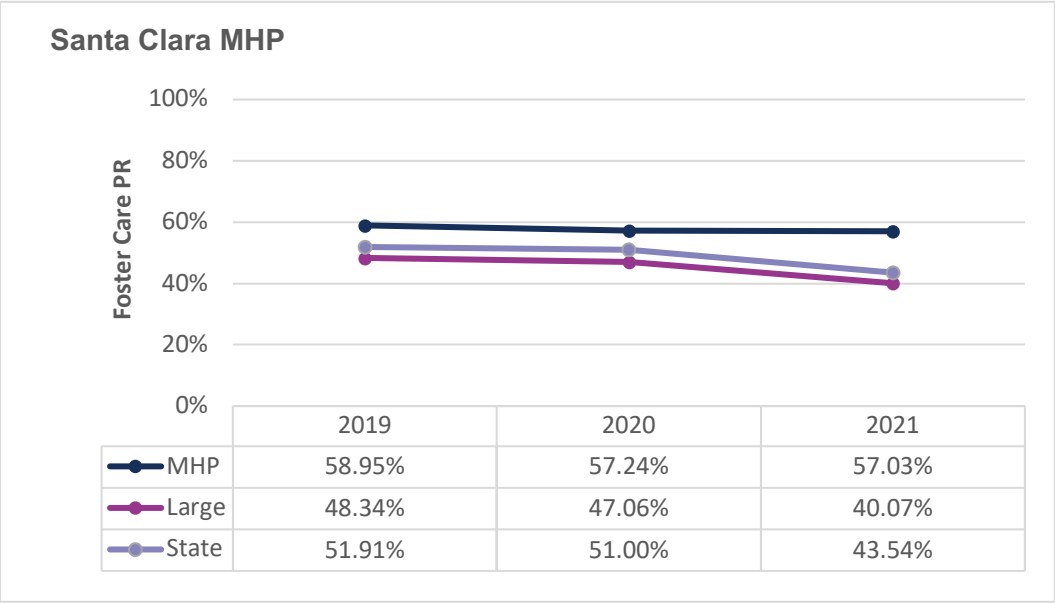
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$7,607	$11,387	$13,088
Large	$6,552	$8,266	$7,888
State	$6,325	$7,466	$6,816

- Asian/Pacific Islander AACB increased each year from CY 2019 to CY 2021. In CY 2021, Santa Clara's AACB was 92 percent greater than the statewide average ($13,088 vs. $6,816).

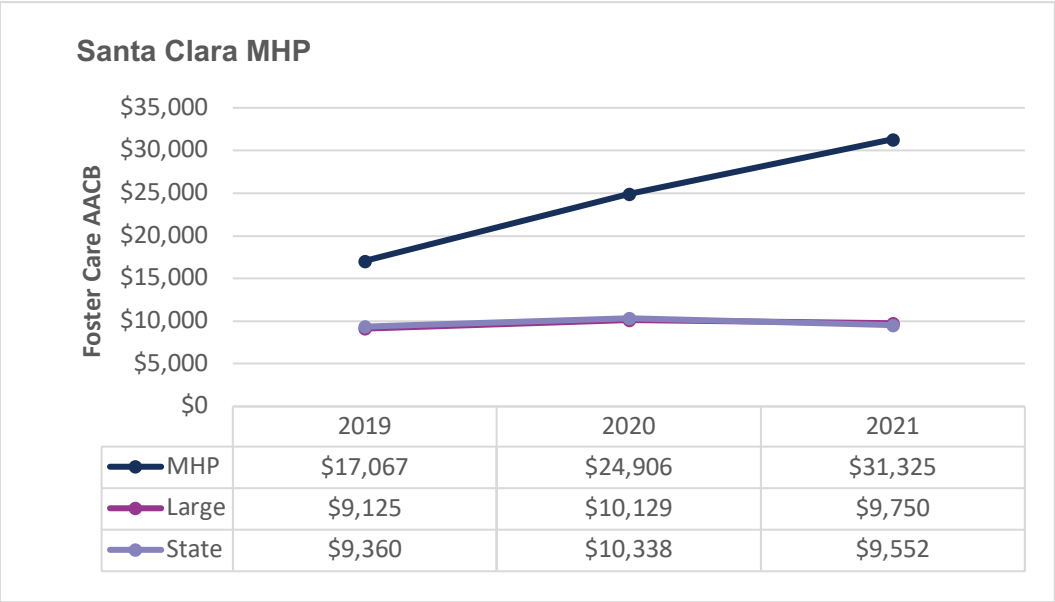
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	58.95%	57.24%	57.03%
Large	48.34%	47.06%	40.07%
State	51.91%	51.00%	43.54%

- The FC PR was stable from CY 2020 to CY 2021 and was 31 percent greater than the statewide average in CY 2021 (57.03 percent vs. 43.54 percent), ranking 4th of 56 MHPs.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$17,067	$24,906	$31,325
Large	$9,125	$10,129	$9,750
State	$9,360	$10,338	$9,552

- FC AACB increased each year from CY 2019 to CY 2021. In CY 2021, Santa Clara's AACB was more than three times the large county and statewide averages.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 14,455				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	428	3.0%	10	6	10.8%	14	8
Inpatient Admin	73	0.5%	33	19	0.4%	16	7
Psychiatric Health Facility	67	0.5%	20	14	1.0%	16	8
Residential	43	0.3%	51	44	0.3%	93	73
Crisis Residential	595	4.1%	26	25	1.9%	20	14
Per Minute Services							
Crisis Stabilization	2,092	14.5%	2,106	1,200	9.7%	1,463	1,200
Crisis Intervention	766	5.3%	146	89	11.1%	240	150
Medication Support	8,135	56.3%	294	195	60.4%	255	165
Mental Health Services	10,955	75.8%	1,098	689	62.9%	763	334
Targeted Case Management	9,511	65.8%	471	197	35.7%	377	128

- Santa Clara had a significantly fewer percentage of beneficiaries served compared to statewide averages for inpatient and crisis intervention and a notably greater percentage of beneficiaries served in the following service categories: crisis residential, crisis stabilization, and targeted case management.

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

Service Category	MHP N = 747				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	28	3.7%	12	8	4.5%	13	8
Inpatient Admin	≤10	-	-	-	0.02%	6	4
Psychiatric Health Facility	0	0.0%	0	0	0.2%	25	9
Residential	0	0.0%	0	0	0.0%	140	140
Crisis Residential	≤10	-	-	-	0.1%	16	12
Full Day Intensive	0	0.0%	0	0	0.2%	452	360
Full Day Rehab	0	0.0%	0	0	0.4%	451	540
Per Minute Services							
Crisis Stabilization	37	5.0%	1,849	1,200	2.3%	1,354	1,200
Crisis Intervention	51	6.8%	372	223	6.7%	388	195
Medication Support	213	28.5%	324	210	28.5%	338	232
Therapeutic Behavioral Services	63	8.4%	2,458	2,001	3.8%	3,648	2,095
Therapeutic FC	18	2.4%	1,542	1,125	0.1%	1,056	585
Intensive Home Based Services	359	48.1%	1,645	918	38.6%	1,193	445
Intensive Care Coordination	310	41.5%	3,141	1,914	19.9%	1,996	1,146
Katie-A-Like	0	0%	0	0	0.2%	837	435
Mental Health Services	720	96.4%	2,179	1,086	95.7%	1,583	987
Targeted Case Management	471	63.1%	793	275	32.7%	308	114

- Santa Clara FC youth had a notably greater percentage of beneficiaries served in the following service categories: therapeutic behavioral services, therapeutic FC, intensive care coordination and targeted case management. Data is suppressed if the number of beneficiaries served is ≤10.

IMPACT OF ACCESS FINDINGS

- Santa Clara MHP evidenced a strong culturally competent system of care that assesses the community needs, creates stakeholder-driven strategies and services to address these needs, and continually monitors progress and evaluates outcomes.
- The MHP also has an extensive psychiatric emergency and crisis system that ensures proper levels of response and engagement of the appropriate teams.
- The access call centers screening and referral processes need further examination and close monitoring to ensure engagement in ongoing care for beneficiaries.
- Santa Clara's PR of 5.36 percent was 39 percent greater than the statewide average, and the average claim amount of $13,848 was more than twice the statewide average.
- In CY 2021, 42 percent of the eligible population was comprised of Hispanic/Latino individuals and 44 percent of those served were Hispanic/Latino. The next largest race ethnicity group were Asian/Pacific Islanders. This group comprised 27 percent of the eligible population and 13 percent of those served, indicating a possible disparity in access for this subpopulation.
- The CY 2021 FC PR was 31 percent greater than the statewide average, ranking 4th of 56 MHPs. The AACB increased each year from CY 2019 to CY 2021 and in CY 2021 was more than three times the statewide average.

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 below.

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	Met
2B	First Non-Urgent Request to First Offered Psychiatric Appointment	Met
2C	Urgent Appointments	Met
2D	Follow-Up Appointments after Psychiatric Hospitalization	Met
2E	Psychiatric Readmission Rates	Met
2F	No-Shows/Cancellations	Met

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

- As noted in the response to recommendations, the MHP has successfully implemented tracking mechanisms for initial psychiatry appointments and urgent request timeliness.

- The MHP has a robust crisis response system which ensures very timely response to urgent requests with an average of 0.3-hour response time and 95 percent of the beneficiaries with urgent care needs being seen within the 48-hour standard. The beneficiary focus group participants noted being familiar with how to seek care in case of urgent needs.
- Both the first non-urgent request to first offered appointment and first offered psychiatry appointment timeliness metrics showed that the averages were slightly longer than the state standards, although the medians were lower than the state standards. This shows that at least half the beneficiaries requesting these services were receiving timely appointments while some beneficiaries were having to wait longer for their first appointments.
- The reported count of requests for first psychiatry appointments was significantly lower than the count of initial service requests. The MHP reported that while there may be some under reporting by providers, DHCS TA clarified that if beneficiaries switch programs and then needs their first psychiatry appointment, they are not considered new beneficiaries any longer, and therefore, not included in the first psychiatry appointment request metric.
- Various stakeholders reported that staff turnover and shortages due to the COVID-19 pandemic has resulted in delays in services post-assessment. The MHP tracks the timeliness of three subsequent appointments.
- Some access calls are transferred directly to the clinics for scheduling of intakes as the call center cannot see the clinic schedules. Avatar implementation will ultimately allow the call center to see the availability at the clinics.
- The MHP's non-clinical PIP this year was focused on improving the efficiency of its access call center which became a joint MH and SUD Access line since the last EQR.

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 display data submitted by the MHP; an analysis follows. This data represented the entire system of care.

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

Table 11: FY 2022-23 MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	10.42 Days	10 Business Days*	60%
First Non-Urgent Service Rendered	11.8 Days	10 days**	46%
First Non-Urgent Psychiatry Appointment Offered	18.31 Days	15 Business Days*	52%
First Non-Urgent Psychiatry Service Rendered	20.96 Days	15**	29%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	0.3275 Hours	48 Hours*	95%
Follow-Up Appointments after Psychiatric Hospitalization	8 Days	7**	45%
No-Show Rate – Psychiatry	6.81%	<10%**	n/a
No-Show Rate – Clinicians	3.36%	<10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-2022			

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

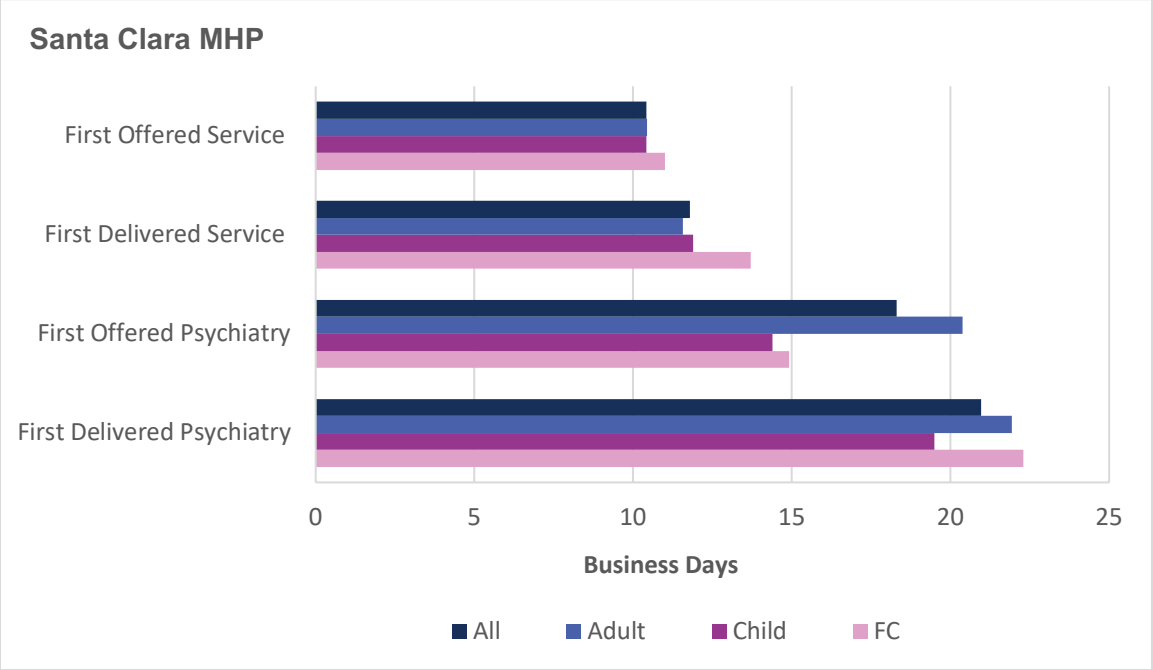


Figure 13: Wait Times for Urgent Services

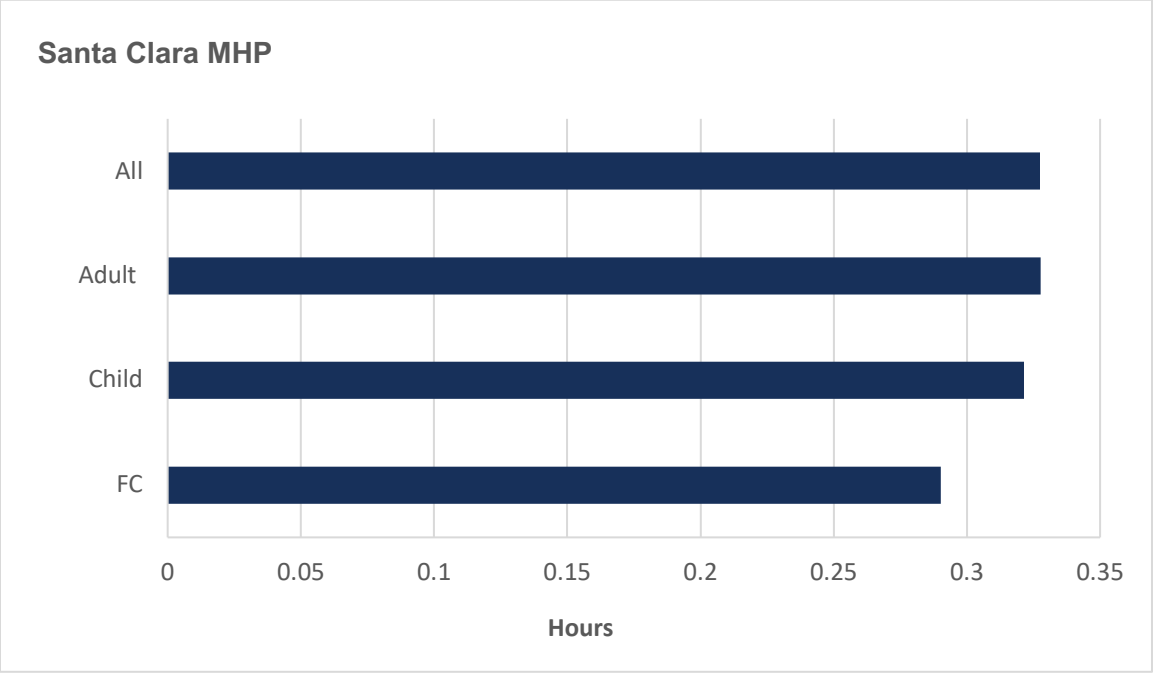
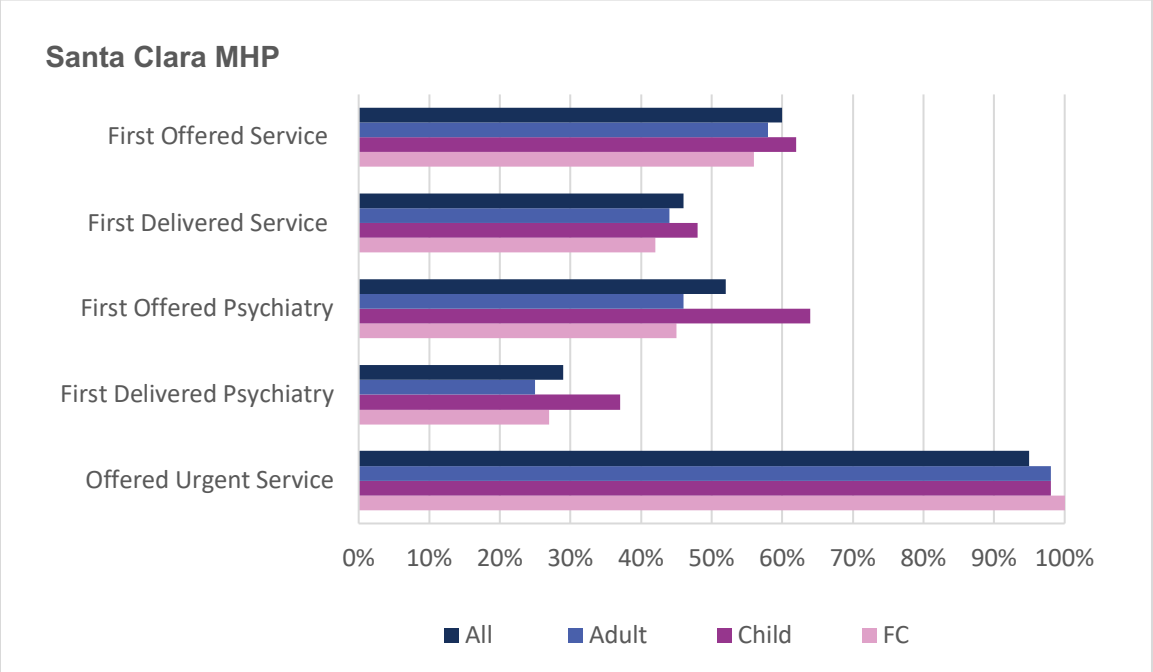


Figure 14: Percent of Services that Met Timeliness Standards



- 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 assessments.

- 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 Emergency Department, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as walk-in’s to the Mental Health Urgent Care. There were reportedly 3,906 urgent service requests with a reported actual wait time to services for the overall population at 0.4 hour.
- 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 as from the point of initial request for psychiatry services for both 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 6.81 percent psychiatry appointments and 3.36 percent for non-psychiatry appointments, which are both lower than the MHP’s target of less than 10 percent no-show rate.

IMPACT OF TIMELINESS FINDINGS

- In the past year, the MHP has established methodologies for tracking timeliness for psychiatry and urgent services. This has provided further insight into the MHP’s performance in providing timely services.
- The FY 2021-22 timeliness tracking data shows positive trends with some room for improvement in first offered appointment and first offered psychiatry appointment timeliness.
    - Further analyzing the differences between the mean and median of these two metrics will provide the MHP with an opportunity to examine whether there are cultural or linguistic barriers to timely services.
    - Since the MHP already collects timeliness of subsequent appointments from the providers, it could consider summarizing those to identify any delays by demographics and county service locations or regions.
    - It appears that the MHP has further work to do in refining the consistency of reporting across providers and staff.

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 located within the QM division of its managed care services. Additionally, there is an analytics and reporting division which is responsible for the development and production of various monitoring tools and data dashboards.

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 the executive team members, systems of care managers, contract providers, QM and QI staff, peers, and community representatives, is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met four times.

The MHP utilizes the following level of care (LOC) tool Child and Adolescent Needs and Strengths (CANS) and Milestones of Recovery (MORS): The MHP has instituted extensive analyses of CANS data and an evaluation process for the system using this data. Although the MORS has been used by the MHP for a number of years for determining LOC for the adult beneficiaries, at the time of this review the MHP was in the final stages of selecting a more detailed LOC tool for the adult system.

The MHP utilizes the following outcomes tools: CANS and PSC-35.

The MHP uses the CANS to identify actionable needs. In the past year, it has categorized these identified needs by service categories – prevention and early intervention, outpatient, intensive outpatient, intensive treatment and supports, and residential. Based on these needs, recommendations were made for the most appropriate services.

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	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:

- BHSD has forged an impressive array of collaborations and services for justice-involved adults and youth. It has been implementing the Sequential Intercept Model, and at every intercept using behavioral health screening and ensuring the right level of care for those in the need of behavioral health services.
- The MHP has created LEL positions who provide interactive video simulation training (IVST) to law enforcement (LE), crisis intervention team training to the county LEs, mobile crisis response team (MCRT) support, and outreach to all law enforcement agencies and the community. BHSD completed filming of 10 new IVST video scenarios in October 2022.
- For the first time, BHSD also provided training to 631 firefighters and paramedics from the San Jose Fire Department.
- The MHP's culturally responsive care system has a comprehensive array of culturally specific programs. Based on stakeholder feedback, the MHP has been continually investing in expanding its program options for underserved

communities. It also provided an extensive range of culturally specific trainings that addressed meeting the needs based on race/ethnicity, sexual orientation, gender, and language.

- The MHP has developed a strong primary care referral protocol to ensure that the physical healthcare needs of those receiving behavioral health care are met in a timely manner.
- The MHP communication with different stakeholders, including the beneficiaries, is mostly strong, especially with the community partners. Contract provider communication has improved over the past year, but there is still room for improvement with the particular group of service partners.
- While the MHP has a very good medication monitoring system in place, it did not evidence the monitoring of some of the HEDIS measures, both for adults and children. The ones it has started tracking are in the first year of implementation and further identification of improvement activities and evaluation of such remain to be done.
- The MHP has peer positions of various levels through the contract providers. In the past year, the MHP has been able to work with human resources to create county peer employee positions. The hiring for these positions has begun in the last quarter of 2022. A number of peer employees have passed the peer certification examination offered through California Mental Health Services Authority.
- The MHP has started tracking the following HEDIS measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD): 95 percent.
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC): ≤10.
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): 100 percent.
    - HEDIS APP: Not tracked yet.

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:

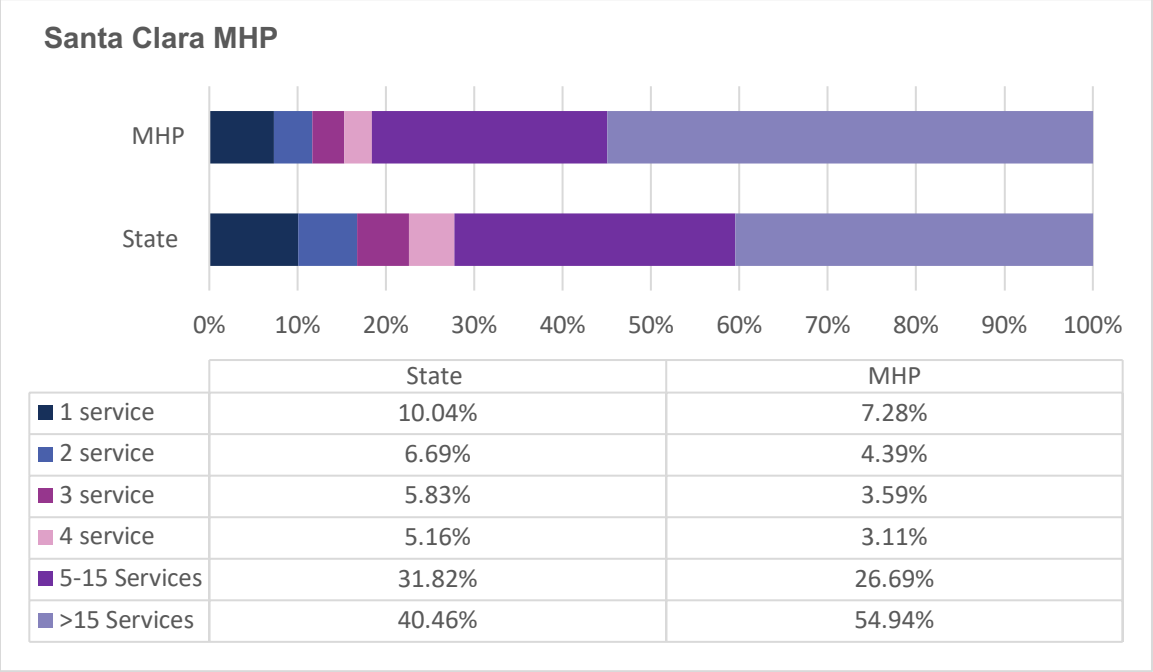
- Retention in Services
- Diagnosis of Beneficiaries Served
- Psychiatric Inpatient Services

- 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 5 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	10.04%	7.28%
2 service	6.69%	4.39%
3 service	5.83%	3.59%
4 service	5.16%	3.11%
5-15 Services	31.82%	26.69%
>15 Services	40.46%	54.94%

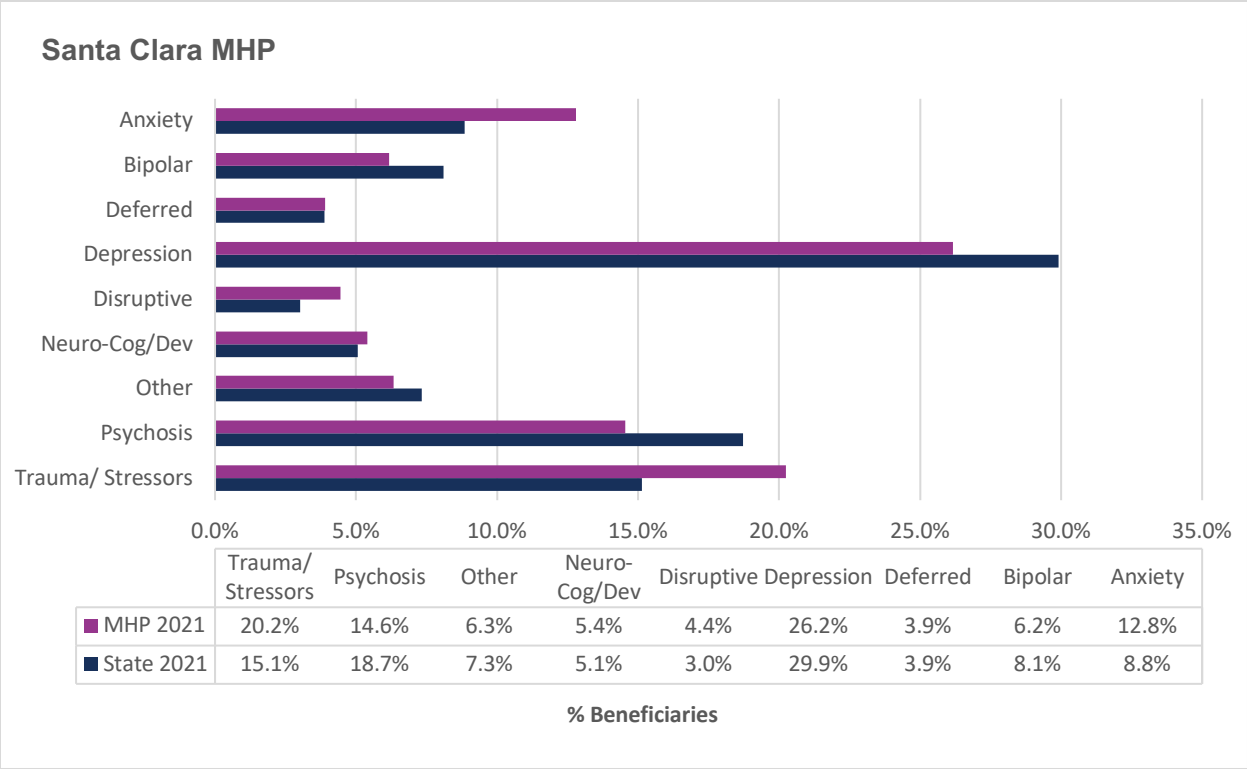
- Santa Clara provided more than 15 services to 54.94 percent of its beneficiaries, approximately 36 percent higher than the 40.46 percent statewide average.
- The Latino/Hispanic beneficiary greater than 15 service average was 54.31 percent and the Asian/Pacific Islander beneficiary greater than 15 service average was 55.86 percent, both showing no disparity compared to the overall greater than 15 service average of 54.94 percent. FC youth had the highest percentage of greater than 15 services, 71.72 percent.

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.

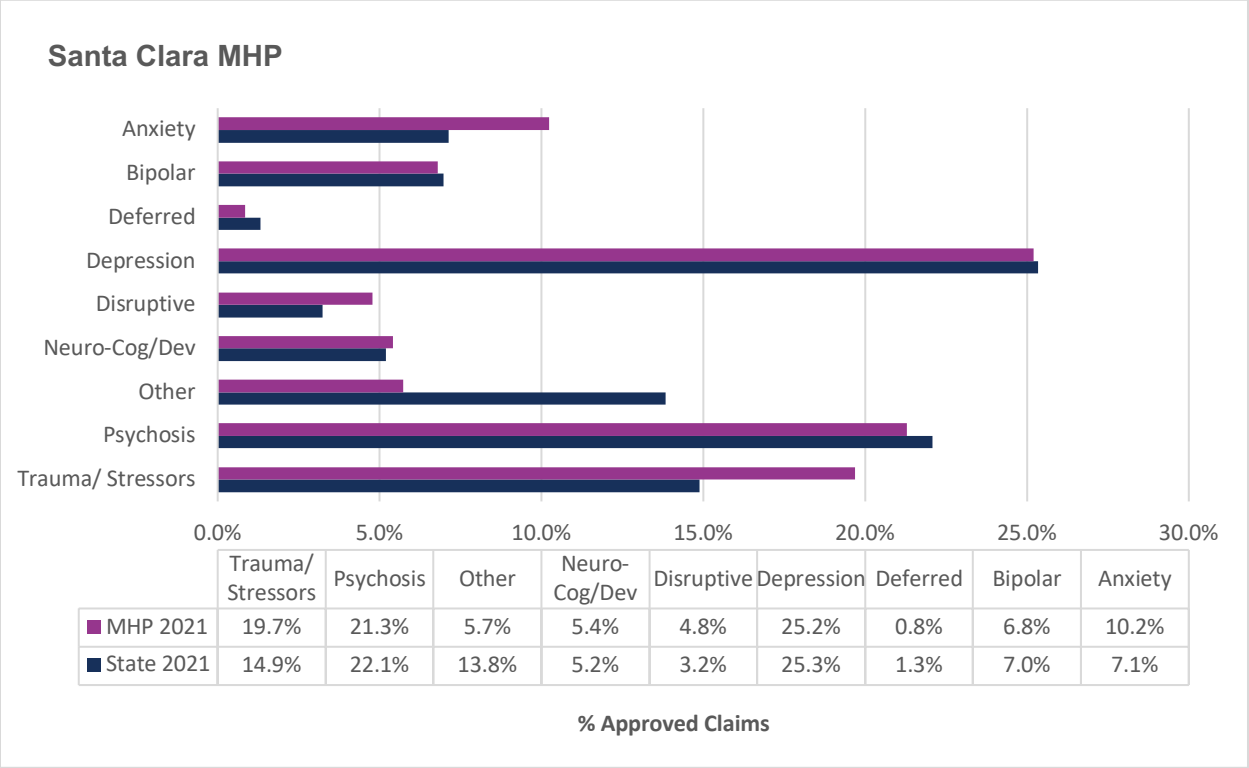
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	20.2%	14.6%	6.3%	5.4%	4.4%	26.2%	3.9%	6.2%	12.8%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

- Approximately 61 percent of beneficiaries had one of three diagnoses: depression (26.2 percent), trauma/stressor related (20.2 percent) and psychosis (14.6 percent). There was a higher percentage of trauma/stressor related diagnoses (20.2 percent vs. 14.9 percent) and anxiety disorders (12.8 percent vs. 8.8 percent) and a lower percentage of psychosis diagnosis (14.6 percent vs. 18.7 percent) when compared to the statewide averages.

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



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	19.7%	21.3%	5.7%	5.4%	4.8%	25.2%	0.8%	6.8%	10.2%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- Approved claims dollars were reasonably aligned with diagnostic patterns. Despite having comparatively fewer beneficiaries with depressive and psychotic disorders, their proportion of approved claims approximate the statewide pattern.

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	848	1,657	10.72	8.79	$16,992	$12,052	$14,409,403
CY 2020	914	1,937	12.33	8.68	$21,834	$11,814	$19,956,165
CY 2019	950	1,991	10.28	7.80	$15,434	$10,535	$14,662,179

- The unique beneficiary count utilizing inpatient services declined 7.2 percent from CY 2020 to CY 2021 (914 vs. 848), and the total number of inpatient admissions dropped 14.5 percent from CY 2020 to CY 2021 (1,937 vs. 1,657).

The inpatient LOS declined from CY 2020 to CY 2021 (12.33 days vs. 10.72 days) but remained greater than the statewide average in CY 2021 (10.72 days vs. 8.79 days).

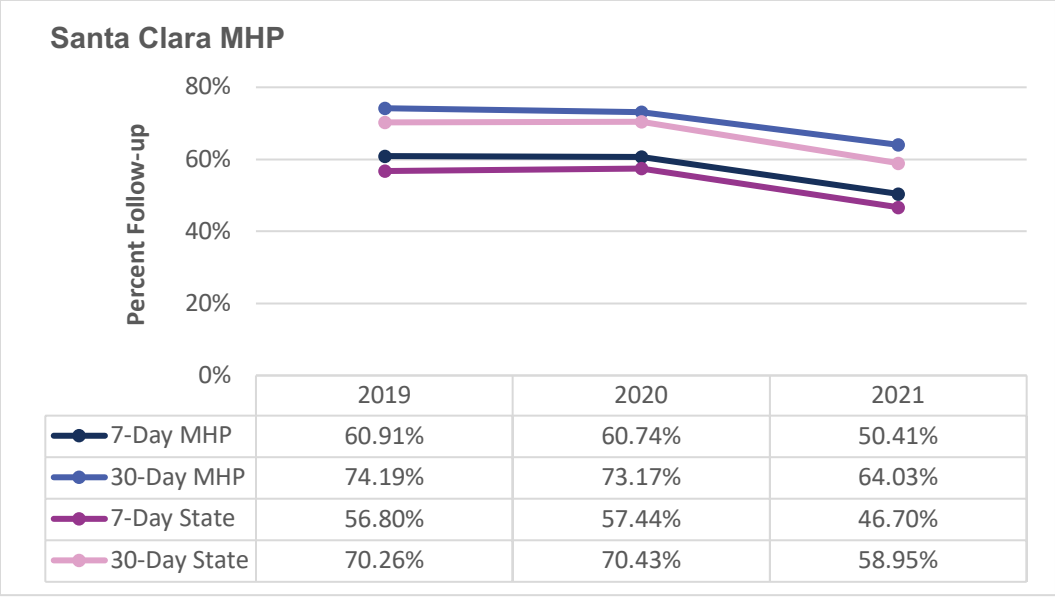
- AACB declined 22 percent from CY 2020 to CY 2021 ($21,834 vs. $16,992) but remained higher than the statewide average in CY 2021 ($16,992 vs. $12,052).
- The year to year decrease may be associated with incomplete CY 2021 data at the time of the review.

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.

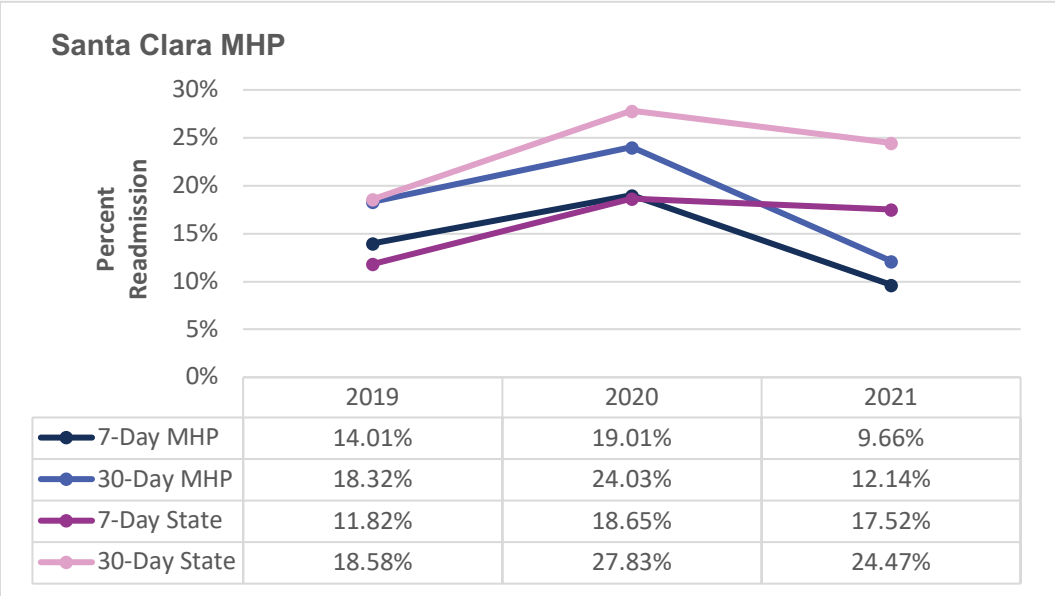
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which 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	60.91%	60.74%	50.41%
30-Day MHP	74.19%	73.17%	64.03%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

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



	2019	2020	2021
7-Day MHP	14.01%	19.01%	9.66%
30-Day MHP	18.32%	24.03%	12.14%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The 7-day post psychiatric inpatient follow-up rate declined 10 percentage points from CY 2020 to CY 2021 (60.74 percent vs. 50.41) but was above the statewide average in CY 2021 (50.41 percent vs. 46.70 percent).
- The 30-day post psychiatric inpatient follow-up rate also declined by 9 percentage points from CY 2020 to CY 2021 (73.17 percent vs. 64.03 percent) but was above the statewide average in CY 2021 (64.03 percent vs. 58.95 percent).
- The 7-day psychiatric readmission rate declined from CY 2020 to CY 2021 (19.01 percent vs 9.66 percent) and was significantly lower than the CY 2021 statewide average (9.66 percent vs. 17.52 percent).
- The 30-day psychiatric readmission rate declined from CY 2020 to CY 2021 (24.03 percent vs 12.14 percent) and was half the CY 2021 statewide average (12.14 percent vs. 24.47 percent).
- The year to year decreases noted above may be associated with an incomplete data set for 2021 rather than decreased performance.
- In its assessment of timely access, the MHP reported significantly higher number of beneficiaries who were hospitalized in FY 2021-22, and lower 7-and 30-day follow-up rates. The MHP's number included all beneficiaries regardless of the payor source.

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 LOC 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 $6,496, the median amount is just $2,928.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent of the statewide beneficiaries are “low cost” (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

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

Entity	Year	HCB Count	Total Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	545,147	3.46%	$53,476	$43,231
MHP	CY 2021	2,349	23,316	10.07%	$58,459	$45,138
	CY 2020	2,227	23,548	9.46%	$59,964	$45,606
	CY 2019	1,400	24,232	5.78%	$53,493	$43,704

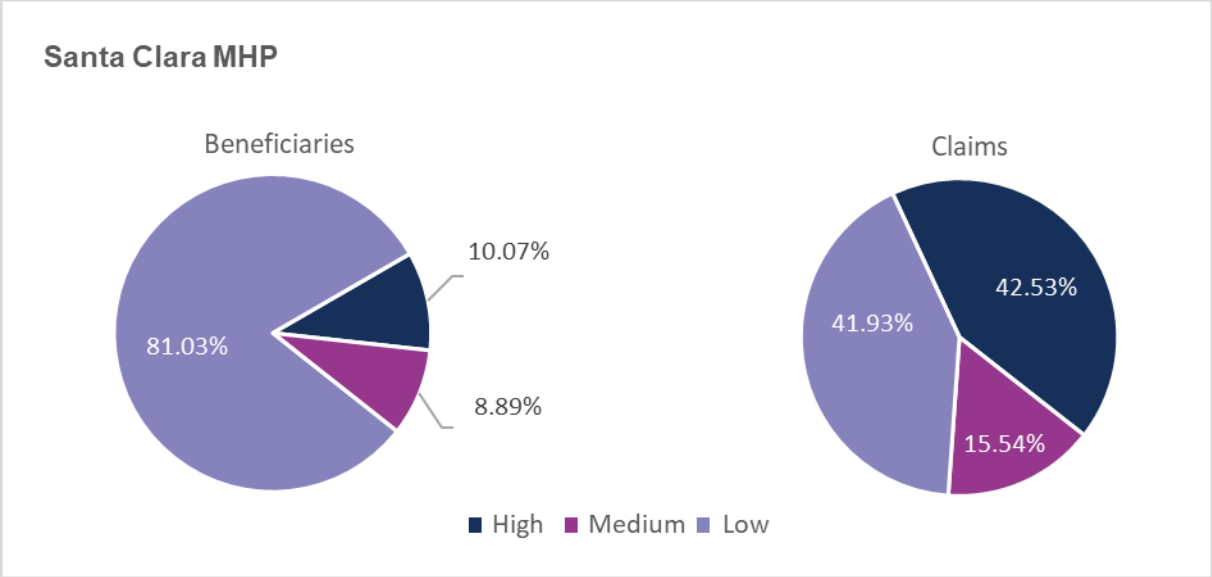
- Both the HCB count and percentage increased each year from CY 2019 to CY 2021. In CY 2021, the percent of HCBs served was approaching three times the statewide average (10.07 percent vs. 3.46 percent). The CY 2021 average approved claim per HCB was 9.3 percent greater than the statewide average ($58,459 vs. $53,476).

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)	2,073	8.89%	15.54%	$50,187,171	$24,210	$23,911
Low Cost (Less than $20K)	18,894	81.03%	41.93%	$135,371,405	$7,165	$6,100

- While low-cost beneficiaries comprised 81.03 percent of those served, 41.93 percent of approved claims dollars was spent on this subpopulation.

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



- Nearly equal claim amounts were spent on the top 10 percent of beneficiaries as the lower cost beneficiaries reflecting 81 percent of beneficiaries served.

IMPACT OF QUALITY FINDINGS

- Santa Clara provided more than 15 services to 54.94 percent of its beneficiaries, approximately 36 percent higher than the 40.46 percent statewide average. FC youth had the highest percentage of greater than 15 services, 71.72 percent. At the same time, the percentage of HCBs continued to rise, nearly doubling in two years from CY 2019-21.
- The MHP has a strong network of services to address the needs of beneficiaries in mental health crises and for those who come from different branches of the justice system.

- The MHP's efforts in the past year to address the needs of culturally specific communities saw the addition of specialty programs addressing those needs.
- While the MHP has made strides in tracking the HEDIS measures for the FC beneficiaries, further tracking, trending, and addition of further HEDIS measures in the adult medication monitoring protocol are needed.

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: "Use of MHSA Client Support Services and Re-Engagement to improve outcomes"

Date Started: 07/2022

Date Completed: N/A

Aim Statement: Will providing MHSA Client Support Services and Re-Engagement Services to beneficiaries enrolled in Full-Service Partnership (FSP), Intensive FSP (IFSP), Assertive Community Treatment (ACT), and Forensic ACT (FACT) programs increase successful discharges from baseline 55 percent to 60 percent (9 percent improvement rate), and decrease psychiatric hospitalizations from baseline 30 percent to 20 percent (33 percent decrease rate) both during and up to one year post discharge?

Target Population: Beneficiaries enrolled in the most intensive programs, FSP, IFSP, ACT, and FACT.

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[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

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

Summary

This PIP is the culmination of the MHP examining the outcomes of its most intensive programs that showed the importance of beneficiary engagement in producing the intended outcomes. In reviewing the data for two years, FY 2019 and FY 2020, the MHP found that the successful discharges from these programs accounted for less than 60 percent of the total discharges. A significant percentage of these discharges were for the reason of disengagement.

At the same time, the MHP also found that while these programs had some positive impact on the use of emergency services by their high-acuity beneficiaries, inpatient admissions both during and one-year post-treatment accounted for 28 and 30 percent respectively of the beneficiaries in the FSP, IFSP, ACT, and FACT programs.

The contract providers who run these high-intensity programs brought the issue of engagement to the MHP's attention. Together with them and other stakeholders the MHP determined that a "whatever it takes" approach is not fully realized because of the limitations imposed by the Medi-Cal approved services. The interventions identified as necessary for this PIP were instituted using the MHSA Client Support Services funding which pays for service activities to support the beneficiary's wellbeing that do not fall under Medi-Cal mental health services. These may include services related to basic needs, health, and safety in order to ensure whole person care and further the beneficiary's ability to engage in meaningful services.

The initial findings from the first remeasurement of this PIP during the third quarter of CY 2022 show some promising results in terms of successful discharges and reduced hospital admission during one-year post-treatment.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: although the results were promising, due to the EHR's data limitations, there is likely to be some undercounting of the beneficiaries who may have received the supportive intervention.

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

- Explore alternative data collection procedures that accurately capture all the supports received by the PIP beneficiaries.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: "Improving the 24/7 Access Call Line Efficiency"

Date Started: 05/2022

Date Completed: N/A

Aim Statement: Will the implementation of a new system method/procedure with supervision oversight improve information accuracy provided to beneficiaries from 43 percent to 65 percent within the first year of this PIP? Then the PIP's goal continues to increase from 65 percent to 80 percent for the second year while at the same time decreasing the beneficiaries' current average wait time from 43 minutes to 30 minutes per call.

Target Population: This PIP includes any beneficiaries and/or representative on behalf of the beneficiaries who call the MHP's 24-hours a day, 7-days a week, toll-free Access Line, which has the potential of helping all beneficiaries that could potentially access the services provided by the MHP. Age, diagnosis, ethnicity, race, length of enrollment, etc., will not be a factor in this study; instead, it will focus on everyone who calls the Call Center requesting services regardless of whether the call results in a referral.

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

Summary

The Access Call Center staff had reported that responding to incoming calls was often hampered by procedural steps including fragmented data entry process that resulted also in longer than necessary wait times for the callers. The test calls also showed that not all calls were being answered, and even if answered, was not being logged as required in the call log. With the merger of the mental health and SUD access call center functions, it became more imperative to improve the processes so that more staff time is spent on answering the calls and responding to the presenting needs of the callers.

The MHP developed a manual with step-by-step instructions, simplified the call logging process, and trained the access call center staff in the new procedure, with regular monitoring of the operation. In the first three months since the interventions started, the PIP seems to have significantly improved the test call logging, and reduced the number of abandoned calls and average wait times. The MHP also conducted interviews with the access call center staff who reported significant improvement to their workflow as a result of this PIP.

TA and Recommendations

As submitted, this non-clinical PIP was found to have high confidence, because of the significant improvement evidenced in the identified outcome variables and the integrity of data collection.

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

- CalEQRO suggested that the MHP should not rely on test call log accuracy as the sole measure of success of this PIP since the test calls account for a small percentage of calls. Instead, CalEQRO recommended using readily available information from the call center software reports for more robust indicators that reflect all calls. Per this recommendation, the MHP added the abandoned call rates and weighted average wait time before a call is answered as outcome indicators.

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 Netsmart Technologies, Inc./Avatar. The performance management module has been in use for four years and the EHR has been in use for two years. Currently, the MHP is actively implementing a new system which requires heavy staff involvement.

Approximately 1.31 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). This is significantly less than the 3.9 percent FY 2021-2022 large county average. The budget determination process for IS operations is a combined process involving MHP control and County IT.

The MHP has 950 named users with log-on authority to the Avatar system, including approximately 494 county staff and 456 contractor staff. The MHP reported that this is likely a high estimate and may include duplicate counts of individuals with Avatar access. Support for the users is provided by 10 full-time equivalent (FTE) IS technology positions which support Behavioral Health. Currently, there are three Business System Analyst positions vacant.

As of the FY 2022-23 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Contract providers maintain their own EHR systems. 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	29%
Electronic batch file transfer to MHP IS	☐ Daily ☒ Weekly ☒ Monthly	32%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	39%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		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. This functionality is expected to be implemented 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. The MHP engages in electronic exchange of clinical information with the following departments/agencies/organizations: contract providers, federally qualified health center and Indian health centers.

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	Partially Met
4D	EHR Functionality	Met
4E	Security and Controls	Partially Met
4F	Interoperability	Partially Met

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

- The Avatar system is operated in an application service provider (ASP) environment with Netsmart Technologies, Inc., hosting the system. The MHP is continuing to implement this system.
- The Avatar integration project decreases contract provider dual data entry for services, depending on the integration option selected by the contract provider, and allows for the contract provider to update other specific data including client demographics, financial eligibility, and diagnosis.
- The IT budget was reported to be 1.31 percent, significantly less than the FY 2021-22 large county average of 3.9 percent.
- While Netsmart provides a database for basic reporting, the MHP is developing a SQL database that mirrors the Avatar system. This database will contain more data fields and allow for the creation of views, increasing reporting capability.
- Additional data analytic support is provided by outside organizations, Palantir Technologies and MTM Services.
- While 91 percent of services are provided by contract providers, contract providers do not have full access to the myAvatar EHR and maintain individual EHRs.
- While the MHP does not have an operations continuity plan or a disaster recovery plan, Netsmart has a disaster recovery and operations continuity plan and offers the MHP system access accounts if the MHP's system is compromised. The disaster recovery and operations continuity plans for individual contract provider EHR systems are not standardized.
- The MHP is not a member of an HIE. They are in the process of joining the Carequality interoperability framework which will permit sharing of clinical electronic health information with all major EHRs, including Epic and Allscripts.
- The MHP's CY 2021 denied claims rate of 3.33 percent exceeds the CY 2021 statewide average of 2.78%.

- The MHP has experienced a delay in CSI reporting and is working collaboratively with Netsmart to obtain full availability of this functionality.
- While all county users utilize two-factor authentication, two-factor authentication to authorize user password change is not supported for contract provider staff. The MHP is planning to implement this functionality in the next year. Contract providers use two-factor authentication for the UniCare system.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in the table below, 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.

For the MHP, it appears that significant claims lag begins in October 2021 and likely represents approximately $60,000,000 in services not yet shown in the approved claims provided. The MHP reports that their claiming is current through October 2022.

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	71,830	$31,107,355	$1,041,465	3.35%	$30,065,890
Feb	71,995	$31,758,972	$1,185,400	3.73%	$30,573,572
Mar	83,327	$36,931,138	$1,299,525	3.52%	$35,631,613
April	79,141	$35,800,627	$1,475,919	4.12%	$34,324,708
May	70,149	$32,364,900	$1,211,991	3.74%	$31,152,909
June	71,707	$33,082,757	$951,860	2.88%	$32,130,897
July	66,938	$30,945,768	$816,548	2.64%	$30,129,220
Aug	66,760	$30,767,586	$946,963	3.08%	$29,820,623
Sept	65,966	$30,434,284	$824,451	2.71%	$29,609,833
Oct	52,340	$24,708,830	$661,160	2.68%	$24,047,670
Nov	13,968	$7,038,231	$408,086	5.80%	$6,630,145
Dec	8	$5,750	$0	0.00%	$5,750
Total	**714,129**	**$324,946,199**	**$10,823,368**	**3.33%**	**$314,122,831**

- It was reported the MHP did not experience a delay in claiming during CY 2021. Therefore, Table 18 may reflect an incomplete claims data set for October to December 2021.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Claim/service lacks information which is needed for adjudication	7,901	$4,031,392	37.25%
Beneficiary not eligible or non-covered charges	4,467	$3,478,239	32.14%
Medicare Part B or Other Health Coverage must be billed before submission of claim	2,623	$1,403,157	12.96%
Service line is a duplicate and a repeat service procedure code modifier not present	1,937	$975,831	9.02%
NPI related	677	$895,502	8.27%
Other	68	$39,247	0.36%
Total Denied Claims	17,673	$10,823,368	100.00%
Overall Denied Claims Rate	3.33%		
Statewide Overall Denied Claims Rate	2.78%		

- Claims with denial codes claim/service lacks information which is needed for adjudication and Medicare Part B or other health coverage must be billed prior to the submission of this claim are generally rebillable within State guidelines upon successful remediation of the reason for denial.
- The claim denial rate for CY 2021 of 3.33 percent is higher than the statewide average of 2.78 percent.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The operation of Avatar in an ASP environment, with Netsmart as the host, provides vendor support for the implementation of software patches and promotions. System access accounts in the event the MHP's system is compromised are available.
- Without contractor provider use of the myAvatar EHR, a significant amount of beneficiary health information is maintained in disparate electronic health records which impedes 24/7 access to a beneficiary's complete health information. In addition, the disaster recovery and operations continuity plans for individual contract provider EHR systems are not standardized, which may provide varied access times to beneficiary data in the event of a disaster or data compromising event.

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 uses the CPS data to track overall improvements in each of the domains of the instrument. The June 2021 report, the last summary report available, showed improvements in each of the domain averages from good to excellent status. In addition, in the first quarter of CY 2022, the MHP conducted a comprehensive community survey and community conversations the results of which were used for MHSA planning.

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 family members and caregivers who initiated services for their children in the preceding 12 months. The focus group was held via videoconference and included seven participants; a Spanish language interpreter was used for this focus group. All family members participating have at least one child or youth who receives clinical services from the MHP.

Most participants reported receiving their children's first appointments quickly, ranging from two days to two weeks. Only one participant reported taking four months to get a Spanish speaking therapist for her bilingual child so she could also communicate with the therapist. Conversely, another beneficiary said the clinic he goes to is all bilingual.

No one reported being on hold on the access line for too long. All participants reported receiving reminder calls and texts for their appointments. Sometimes the parents and siblings are included in the child's sessions.

The participants were aware of the 24/7 crisis number. Some have the direct number of the therapist. "We know what to do if she has a panic attack."

One parent was aware of the Youth Drop-in Center in San Jose, but it is too far for most.

Information from the county is provided through therapists, primary doctors, school, and "Parents Helping Parents" organization.

Overall, the participants were pleased with the services that their children had received. "In the beginning I had no hope, but I see many positive changes. I also learned how to give good directions to my daughter." Some parents also called out specific programs and individual therapists for providing excellent service.

Recommendations from focus group participants included:

- "If therapy was more connected to my child's school it would help more."
- If multiple children are receiving services from the MHP, it would be helpful to have the same therapist as the parents get fatigued from reporting some of the same histories to different therapists.
- Some participants would like to join any MHP level committee where they can provide meaningful input.

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 via video conference and included eight participants; No language interpreter was used for this focus group. All consumers participating receive clinical services from the MHP.

The six participants who entered services within the past year had varied experiences accessing care. Access was reportedly easy if referred to by the court. "I want to tell my story to young people in jail." Others also experienced fairly easy access processes. One participant reported receiving encouragement and support all the way.

Stigma was noted as one barrier to access, how to navigate around one's own family and friends. The participants reported that the family can be involved in their treatment if they choose to. For some, their families are not interested, while others noted that they benefited from their families' involvement.

Most beneficiaries were pleased with the services they receive, but noted that the psychiatrists can sometimes be not as helpful as other clinical staff. Most participants

receive reminder calls for their upcoming appointments. One beneficiary noted that housing resources are not available now that he is “clean and sober.”

Experience with coordination between primary care and psychiatry can be mixed. Some clinics do this routinely, while others did not seem to coordinate their care. Participants agreed this was important, stating “if you have a physical health doctor, they should know about your psych meds.”

Recommendations from focus group participants included:

- Better medication information sharing between primary care doctor and the psychiatrist.
- Use peer support in helping people understand and adapt to their medication.
- More gathering opportunity among peers, especially those further along in their recovery.
- Opportunities to help others going through the system.
- Publication of newsletters from the wellness centers.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall, the beneficiaries in the focus group were satisfied with the access process. There may be occasional cultural and linguistic barriers, but that appeared isolated.

The parents and family members would like some service enhancements that can be helpful to the families and the children such as more therapy being offered through the school sites and having a single clinician for parents with more than one child receiving services.

For the adult beneficiaries, it appeared that there may be room for improvement in psychiatrist and primary care communications about medications. In addition, gathering opportunities for those in more advanced stages of recovery can be a catalyst for further recovery.

The MHP’s efforts in enhancing the crisis system, better access and care for justice involved beneficiaries, and establishing more culturally specific programs seemed to have positively impacted some of the beneficiaries in the focus groups.

Both groups seemed to be interested in giving back to the system from which they have benefited. It can be through committees, or sharing experience with others going through similar circumstances.

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 has a strong network of services and specialized teams to address the needs of beneficiaries in mental health crisis. (Access)
2. BHSD has forged an impressive array of collaborations and services for justice-involved adults and youth. It has been implementing the Sequential Intercept Model, and at every intercept, using behavioral health screening to ensure the right level of care for those in need of behavioral health services. (Quality)
3. Santa Clara MHP evidenced a strong culturally competent system of care that assesses the community needs, creates stakeholder-driven strategies and services to address these needs, and continually monitors progress and evaluates outcomes. (Access, Quality)
4. The MHP has established an LEL position that facilitates training and collaboration with the law enforcement partners. (Quality)
5. The MHP has a formalized presence in 24 of the 32 school districts in the county through its SLS initiative. The SLS school districts were selected based on a determination of high-risks and other social determinants. (Access)
6. In the past year, BHSD has consolidated its MH and SUD access lines. (Access)

OPPORTUNITIES FOR IMPROVEMENT

1. Various stakeholders reported that staff turnover and shortages due to the COVID-19 pandemic has resulted in delays in follow-up appointments post-assessment. Although the MHP reported that it collects three subsequent appointment times, only the first assessment delivery timeliness data were available. (Timeliness)
2. The contract providers are made responsible for finding a suitable, alternative service provider when referrals from the access call center do not fit the provider's services, instead of being able to refer back to the access line for the same task. This can result in unbillable services and disruptive care for the beneficiaries. (Access)
3. While the MHP has started capturing the first offered psychiatry appointment data, there is still underreporting by providers in the system. (Timeliness)

4. While the MHP has made strides in tracking the HEDIS measures for the FC beneficiaries, it does not yet track the HEDIS APP measure. Further, the MHP does not track and trend some HEDIS measures for adults, such as Antidepressant Medication Management (AMM) and Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA). (Quality)
5. Without contractor provider use of the myAvatar EHR, a significant amount of beneficiary health information is maintained in disparate electronic health records. In addition, the disaster recovery and operations continuity plans for individual contract provider EHR systems are not standardized which may provide varied access times to beneficiary data in the event of a disaster or data compromising event. (Quality, IS)

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. Determine if there are delays in post-assessment services by service type, by cultural and demographic factors, and by service locations. Examine where staffing shortages are impacting quality of care. (Timeliness)
2. Consider changes in service access workflow whereby the placement of those beneficiaries who are determined not to be a good fit for a program upon completion of the full assessment is adjudicated centrally by the MHP Access. (Access)
3. Continue to further refine the first psychiatry appointment timeliness data with DHCS guidance and ensure complete and consistent reporting by the providers. (Timeliness)
   (This recommendation is a carry-over from FY 2021-22.)
4. Collect and monitor data for the currently untracked HEDIS measures for mental health across the adult and children's systems of care. (Quality)
5. Standardize contract provider expectations for disaster recovery and operations continuity plan timeliness to assure data security and timely availability in the event of a disaster or other data compromising event. (Quality, IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

There were no barriers to this FY 2022-23 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT F: PM Data CY 2021 Refresh

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 Clara MHP
Opening Session – 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)
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Network Adequacy Assessment and Evaluation
Beneficiary Satisfaction and Other Surveys
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care

CalEQRO Review Sessions – Santa Clara MHP
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Forensics and Law Enforcement Group Interview
Community-Based Services Agencies Group Interview
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Saumitra SenGupta, PhD. - Lead Quality Reviewer
Sandra Sinz, LCSW, CPHQ - Second Quality Reviewer
Lisa Farrell - Information Systems Reviewer
Diane Mintz - Consumer/Family Member Reviewer
Christin Zamora - Consumer/Family Member Reviewer

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

MHP County Sites

Santa Clara

All sessions were held via video conference.

MHP Contract Provider Sites

N/A

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Acevedo	Domingo	Compliance	HHS
Aggarwal	Shelley	Medical Director- Juvenile Services	VMC
Antons	Peter	Division Director- F&C Services	SCC-BHSD
Archdeacon	Kristin	PMII	SCC-BHSD
Aspiras	Catherine	PMIII	SCC-BHSD
Ballicki	David	Program Manager	Momentum for Health
Baran	Joan	Clinical Director	Children's Health Council
Beagay	Diane	Program Manager	Community Solutions
Birchard	Nick	Assistant Chief Probation Officer	Probation
Blaco	Tom	Admin Services Manager II	SCC-BHSD
Bray	Scott	Business System Analyst	SCC-BHSD
Briscoe	Jennifer	Program Manager	Telecare
Brown	LouMeshia	PMIII- Adult and Older Adult Services	SCC-BHSD
Buntic	Jazmin	Program Manger II- Evans Lane	SCC-BHSD
Cabrera	Brandon	Attorney IV	District Attorney Office
Caldwell-Holden	Dane	Director - Education Juvenile Schools	SCCOE
Calixterio	Ray	Lead Clinician-MCRT	SCC-BHSD
Callahan	Erin	Attorney IV-Public Defender	Public Defenders Office

Last Name	First Name	Position	County or Contracted Agency
Camese	Karen	MFT II- Re-entry Center	SCC-BHSD
Cammann	Matt	Director of Business Operations	Seneca
Castillo	Iris Carolina	PMII-VASC	SCC-BHSD
Castuciano	Carlo	Sr. Healthcare Program Analyst-QI	SCC-BHSD
Chen	Angela		SCFHP
Cho	Peggy	Peer Support Worker	SCC-BHSD
Chu	Dihn	PMIII	SCC-BHSD
Clark	Michael	Superior Court Judge	Superior Court
Copley	Bruce	Exec Team - Director, Access & Unplanned Services	SCC-BHSD
Cortez	Daniel	Supervising Probation Officer	Probation
Costa	John	Law Enforcement Liaison	SCC-BHSD
Cozzolino	Anthony	Psychiatrist	SCC-BHSD
Cross	Lindsay	Program Manager-IHOT	SCC-BHSD
Daye	Eureka	Dir. Custody Health Services	
Do	Thanh	Program Manager III	SCC-BHSD
Domenden	Gerald	Sr. Healthcare Program Analyst-QI	SCC-BHSD
Eng	Dustin	Supervising PO (Transformation Team)	Probation
Espinoza	Aurelia	PSWII	SCC-BHSD

Last Name	First Name	Position	County or Contracted Agency
Fan	Joe	Senior Data Analyst	SCC-BHSD
Faria Costa	Zelia	Exec Team - Director of Children, Youth, and Families (CYF) SOC	SCC-BHSD
Flink	Karen	Program Manager	OCA
Florenza	Hannah	MFT	Community Solutions
Flores	Jose	Program manager	SCC-BHSD
Gambataste	Janet		SCFHP
Garcia	Isabella	MGT Analyst	SCC-BHSD
Geilhufe	Ben	PMII	SCC-BHSD
Gomez	Desiree	Clinician - DIY & Cross-System Transformational Team	SCC-BHSD
Gomez	Allison	Attorney IV-Public Defenderr	Public Defenders Office
Gonzalez	Graciela	PMI- Secure Youth Track	SCC-BHSD
Gonzalez	Lorena	Program Manager II- Las Plumas	SCC-BHSD
Gonzalez	Abe	Program Manager	Community Solutions
Gonzalez-Ortiz	Gaby	PMII- Quality Improvement	SCC-BHSD
Gray	Courtney	Exec Team - Director of Quality Management	SCC-BHSD
Graze	Desire	Program Manager II- Downtown	SCC-BHSD
Gutierrez	Kim	TT Manager for Advocates	Community Solutions
Gutierrez	Veronica	SLS District Coordinator	Campbell Union School District

Last Name	First Name	Position	County or Contracted Agency
Hackett	Jamina	PMII	SCC-BHSD
Hames	Melody	MH Peer Worker	SCC-BHSD
Hao	Debbie	Director of Finance	Catholic Charities
Hauck	Michelle	PMII- F&C	SCC-BHSD
Hernandez	Sandra	Division Director- Unplanned Services	SCC-BHSD
Ho	Tiffany	Exec Team - Medical Director	SCC-BHSD
Ho	Michelle	Division Director- Residential Services	SCC-BHSD
Hsiao	Linda	PMII- F&C	SCC-BHSD
Ibarra	Roberto	PMII- Quality Improvement	SCC-BHSD
Iwu	Loretta	Program Manager II-Narvaez	SCC-BHSD
Janini	Yasmina	Sr. Healthcare Program Analyst-QI	SCC-BHSD
Jason	Magers	Clinician-PERT	SCC-BHSD
Juarez	Gabriela	MH Peer Worker	SCC-BHSD
Jung	Soo	Division Director	SCC-BHSD
Kihara	April	PMII-CYF	SCC-BHSD
Kim	Sarah	PSWII	SCC-BHSD
Kirkland	Brittney	Senior Director	Abode
Kitchens	Angela	Program Manager	Community Solutions

Last Name	First Name	Position	County or Contracted Agency
Kuzmich	Mathew	Program Manager	Evans
Lam	Thaibo	PMI-Urgent Care	SCC-BHSD
Landreneau	Todd	IT Manager	HHS
Lanteigne	Amy	PM II	SCC-BHSD
Le	Duy	PMII- Adult and Older Adult Services	SCC-BHSD
Ledesma	Margaret	PMIII	SCC-BHSD
Lemus	Rebeca	PMIII- CJS	SCC-BHSD
Liang	ShuNing	PMII- FDR	SCC-BHSD
Lim	Howard	TSS	HHS
Long	Rachel	Director of Business Operations	Children's Health Council
Lopez	Samantha	Sr. Healthcare Program Analyst-QI	SCC-BHSD
Lopez	Cynthia	MCRT	Pacific Clinics
Loth	Vandy	Program Manager	AACI
Lozano	Gustavo	PMII- Quality Improvement	SCC-BHSD
Lu	Katelyn	Financial and Admin Service Manager	SCC-BHSD
Ly	Karen	PSWII- DTMH	SCC-BHSD
Macatiag	Angeleah	Admin Services Manager II-contracts	SCC-BHSD
Manley	Stephen	Judge	SCC Superior Court

Last Name	First Name	Position	County or Contracted Agency
MannStock	Michael	PMI-Suicide Prevention and PEI	SCC-BHSD
Marquett	Renee	PMII-F&C	SCC-BHSD
Marquez	Veronica	PMII- Quality Improvement	SCC-BHSD
Marsh	Emmett	Community Outreach Specialist	SCC-BHSD
Mauboussin	Marie	Transformation Team Coordinator	DFCS
Maybhate	Dipty	Business System Analyst	SCC-BHSD
McNay	Misty	PMII- F&C	SCC-BHSD
Mendoza	Sandy	Sr. Healthcare Program Analyst-QI	SCC-BHSD
Mims	Cheryl	PSWII- Narvaez	SCC-BHSD
Mineta	David	President CEO	Momentum
Montoya	Rachel	Chief Financial and Operations Officer	Community Solutions
Moral	Jeanne	Exec Team - PMIII Systems Initiatives, Planning & Communications	SCC-BHSD
Morales	Dolores	PMIII-Secure Youth Track	Probation
Nation	Nancy	PMIII-F&C	SCC-BHSD
Nguyen	Hung	Division Director- Quality Improvement	SCC-BHSD
Nguyen	Duy	PMII- F&C	SCC-BHSD
Nguyen	Andrew	AMFT - VASC	SCC-BHSD

Last Name	First Name	Position	County or Contracted Agency
O'Keefe	Mairead	Attorney IV	Office of the Public Defender
Olivares	Gabby	Division Director- FDR	SCC-BHSD
Orozco	Elizabeth	MH Peer Worker	SCC-BHSD
Ortiz	Rosa J	PMII	SCC-BHSD
Palomo	Rosanna	Director of Student Services	Campbell Union School District
Partee	Alicia	PMII- Adult and Older Adult Services	SCC-BHSD
Parwiz	Mira	Division Director- DADS	SCC-BHSD
Pham	Jennifer	Division Director- F&C Services	SCC-BHSD
Pim	Maryna	Clinician - allcove Palo Alto	SCC-BHSD
Ponce	Mario	BHUC	SCC-BHSD
Poon	Edwin	Exec Team - Deputy Director of Managed Care	SCC-BHSD
Potens	Rachel	PMII- Quality Improvement	SCC-BHSD
Preader	Melissa	PMII- F&C	SCC-BHSD
Rector	Brian	Program Manager	Gardner
Reis	Elania	PMIII- Adult and Older Adult Services	SCC-BHSD
Reyes	Beverly	PMII-MCRT	SCC-BHSD
Reyes	Julianne	PMII	SCC-BHSD
Riera	Erik	Exec Team - Deputy Director of Service Delivery	SCC-BHSD

Last Name	First Name	Position	County or Contracted Agency
Robben	Vince	Healthcare Financial Manager	SCC-BHSD
Robles	Veronica	PMIII	SCC-BHSD
Roche	Amanda	Clinician	Caminar
Rodriguez	Arturo	Clinician - Outpatient Family and Children Services	SCC-BHSD
Romero	Erin	Clinician- Re-entry Center	SCC-BHSD
Ronell	Andrea	Program Manager	Community Solutions
Rosas-Atkins	Dwaimy	Clinician-Outpatient Family and Children Services	SCC-BHSD
Samphors	Mao	Program Manager II- Kidscope	SCC-BHSD
Santos Griffin	Sierra	Admin Services Manager II	SCC-BHSD
Satwani	Puja	Director of School Partnerships	Seneca Family of Agencies
See	Cha	Program Manager III	SCC-BHSD
Sentner	Tina	Program Director	Horizon Services
Silver	Christine	Program Manager	Community Solutions
Singh	Nira	Director of Behavioral Health	AACI
Sinwongsa	Amanda	MH Peer Worker	SCC-BHSD
Smith	Ronni	Social Worker (Transformation Team)	DFCS
Steed	Ayla	MCRT	Pacific Clinics

Last Name	First Name	Position	County or Contracted Agency
Stein	Fannie	Sr Research and Evaluation Specialist- A&R	SCC-BHSD
Suarez	Melissa		SCC-SSA
Sweet	Richard		Pacific Clinics
Talamantez	Rachel	Division Director- Cross Systems	SCC-BHSD
Tansek	Joe	PMII- Call Center	SCC-BHSD
Temores	Adriana	Clinician	Pacific Clinics
Terao	Sherri	Exec Team - Director of BH	SCC-BHSD
Tom	Dena	IT Manager	HHS
Torres	Sheri	MH Peer Worker	Gardner Health
Tran	Darren	Exec Team - Admin Svcs Mngr III	SCC-BHSD
Trieu	Penny	Program manager	Pacific Clinics
Trieu	Phoebe	Program Manager	AACI
Valenzuela	Paulina	MH Peer Worker	Alum Rock Counseling Center
Valles	Jenelle		Pacific Clinics
Varadharajan	Sodu	Clinician	Rebekah Children's Services
Vargas	Mayra	PM II- Juvenile Hall	SCC-BHSD
Vierra	Amanda	PMIII- Quality Improvement	SCC-BHSD
Villagomez	Maharlika	PMIII	SCC-BHSD
Villanueva	Leilani	Admin Services MGR II	SCC-BHSD

Last Name	First Name	Position	County or Contracted Agency
Viramontez	Dr. Shelly	Superintendent	Campbell Union School District
Viscaina	Sierra	MH Peer Worker	Alum Rock Counseling Center
Vohra	Munisha	Senior Director of Clinical Services	Catholic Charities
Vu	Amy	Admin Services Manager II	SCC-BHSD
Vu	Lily	PMII- QA	SCC-BHSD
Vu	Ni	MH Peer Worker	SCC-BHSD
Wagner	Brian	Exec Team - Director of A&R	SCC-BHSD
Weare	Christopher	Director of Research & Outcomes	SCC-BHSD
Wilson	Tyrone	Attorney IV-District Attorney	District Attorney Office
Wright	Aimee	Program Manager	Rebekah Children's Services
Yew	Erica	Judge	SCC Superior Court

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	Although the results were promising, due to the EHR's data limitations, there is likely to be some undercounting of the beneficiaries who may have received the supportive intervention.

General PIP Information
MHP/DMC-ODS Name: Santa Clara MHP
PIP Title: Use of MHSA Client Support Services and Re-Engagement to improve outcomes
PIP Aim Statement: Will providing MHSA Client Support Services and Re-Engagement Services to beneficiaries enrolled in FSP, IFSP, ACT, and FACT programs increase successful discharges from baseline 55 percent to 60 percent (9 percent improvement rate), and decrease psychiatric hospitalizations from baseline 30 percent to 20 percent (33 percent decrease rate) both during and up to one year post discharge?
Date Started: 07/2022
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:

General PIP Information
Target population description, such as specific diagnosis (please specify): Beneficiaries enrolled in the most intensive programs, FSP, IFSP, ACT, and FACT.
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): 1) MHSA Client Support Services in the areas of criminal justice, psychiatry, living situation, education, employment and career development, community life, and other basic needs. 2) Re-engagement activities including trying to make contacts at known locations and jails, juvenile detention, and hospitals.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): N/A
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): N/A

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Successful Discharges	FY 2020-21	N = 2,404 55%	December 2022	N = 747 60%	☒ 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
Hospital Admissions during treatment	FY 2020-21	N = 2,404 30%	December 2022	N = 719 10%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Hospital Admissions post treatment	FY 2020-21	N = 2,404 30%	December 2022	N = 209 17%	☒ 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: • Explore alternative data collection procedures that accurately capture all the supports received by the PIP beneficiaries.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	This PIP has shown significant improvement in its first quarter of implementation with indicators that are based on all calls which makes for very robust determination of the interventions' effectiveness.

General PIP Information
MHP/DMC-ODS Name: Santa Clara MHP
PIP Title: Improving the 24/7 Access Call Line Efficiency
PIP Aim Statement: Will the implementation of a new system method/procedure with supervision oversight improve information accuracy provided to beneficiaries from 43 percent to 65 percent within the first year of this PIP? Then the PIP's goal continues to increase from 65 percent to 80 percent for the second year while at the same time decreasing the beneficiaries' current average wait time from 43 minutes to 30 minutes per call.
Date Started: 05/2022
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 callers of the toll-free access line requesting behavioral health services.

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): N/A						
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Training and supervision in applying the interventions.						
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): Access call response step-by-step instructions, centralized call log system.						
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**
Increase the accuracy of test calls logged	March 2022	11 54%	July – September 2022	11 81%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 ☒ Other (specify): Small sample size. Statistical significance not computed.

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
Reduce the number of hung-up calls. *In the data hung-up calls are labeled as abandoned.	March 2022	908 50%	July – September 2022	July 11-22 N = 1179 Avg Abandoned: 15% Aug 15-26 N = 825 Avg Abandoned: 8% Sep 12-23 N = 885 Avg Abandoned: 12%	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Reduce the wait time for beneficiaries when calling the Call Center.	March 2022	908 42 min.	July – September 2022	July 11-22 N = 1179 Avg wait time: 5 min Aug 15-26 N = 825 Avg wait time: 2 min 27 sec Sep 12-23 N = 885 Avg wait time: 3 min 54 sec	☒ 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.

PIP Validation Information
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: Continue tracking the abandoned call rate and average wait time for at least a year to see how the fidelity to the interventions hold up and whether they continue to produce the same positive results.

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.

ATTACHMENT F: PM DATA CY 2021 REFRESH

At the time of the MHP's review, the data set used for the PMs was incomplete for CY 2021. Across the state, most of the approved claims data November and December 2021 was not included in the original data used for this report.

CalEQRO obtained a refreshed data set for CY2021 in January 2023. The PM data with the refreshed data set follows in this Attachment.

BHC | Behavioral Health Concepts, Inc

Santa Clara MHP Performance Measures

REFRESHED

FY22-23

Table 3: MHP Annual Beneficiaries Served and Total Approved Claims

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	434,609	24,962	5.74%	$391,245,071	$15,674
CY 2020	399,155	23,548	5.90%	$305,430,870	$12,971
CY 2019	393,195	24,232	6.16%	$218,740,031	$9,027

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

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	36,351	1,626	4.47%	1.69%	1.96%
Ages 6-17	91,663	8,028	8.76%	5.40%	5.93%
Ages 18-20	22,906	1,515	6.61%	4.06%	4.41%
Ages 21-64	217,077	12,690	5.85%	4.24%	4.56%
Ages 65+	66,613	1,103	1.66%	1.69%	1.95%
Total	**434,609**	**24,962**	**5.74%**	**3.99%**	**4.34%**

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	5,810	23.28%
Vietnamese	1,010	4.05%
Mandarin	156	0.62%
Farsi	127	0.51%
Tagalog	88	0.35%
Cantonese	66	0.26%
Total Threshold Languages	**7,257**	**29.07%**
Threshold language source: Open Data per BHIN 20-070		

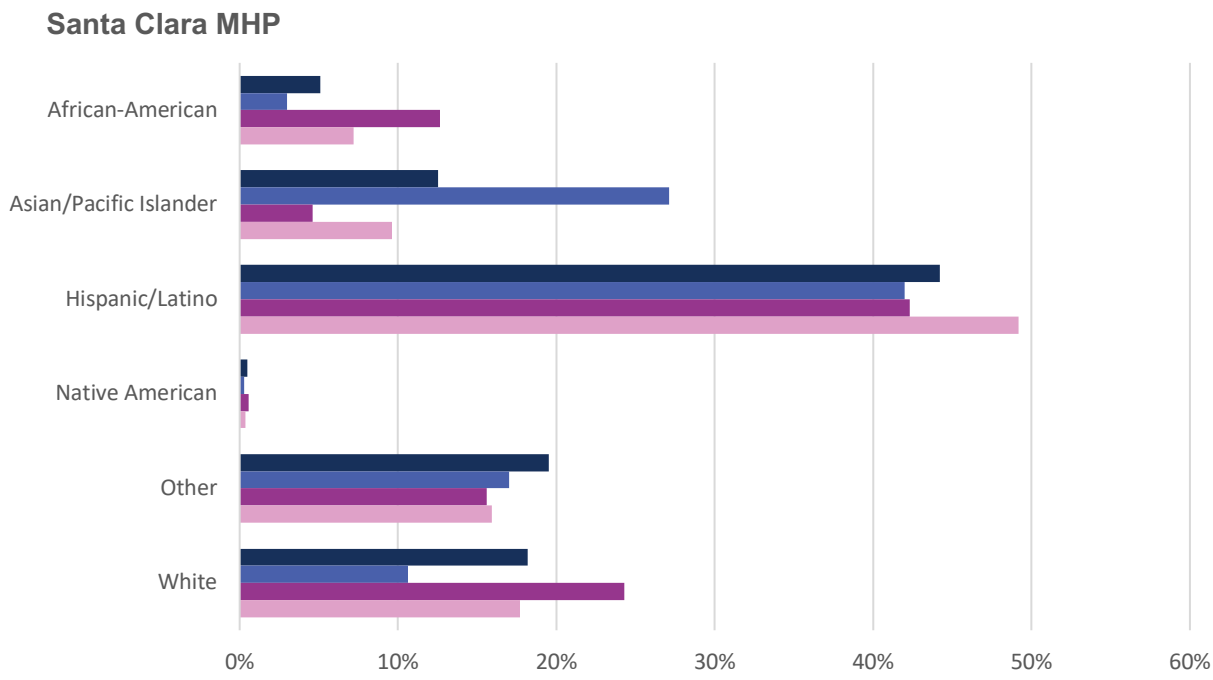
Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	142,591	6,888	4.83%	$91,734,384	$13,318
Large	2,153,582	74,042	3.44%	$515,998,698	$6,969
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	13,024	1,271	9.76%	7.64%
Asian/Pacific Islander	117,814	3,123	2.65%	2.08%
Hispanic/Latino	182,409	11,036	6.05%	3.74%
Native American	1,218	125	10.26%	6.33%
Other	73,938	4,870	6.59%	4.25%
White	46,207	4,537	9.82%	5.96%
Total	**434,610**	**24,962**	**5.74%**	**4.34%**

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



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	18%	20%	1%	44%	13%	5%
MHP % Eligible	11%	17%	0%	42%	27%	3%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

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

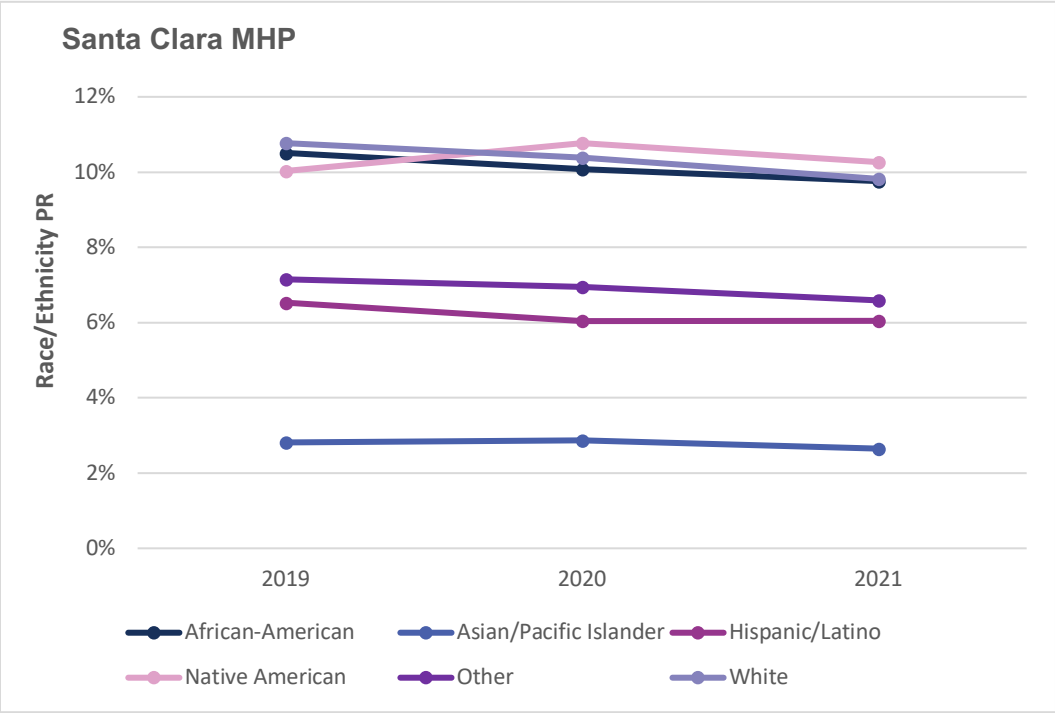


Figure 3: MHP AACB by Race/Ethnicity CY 2019-21

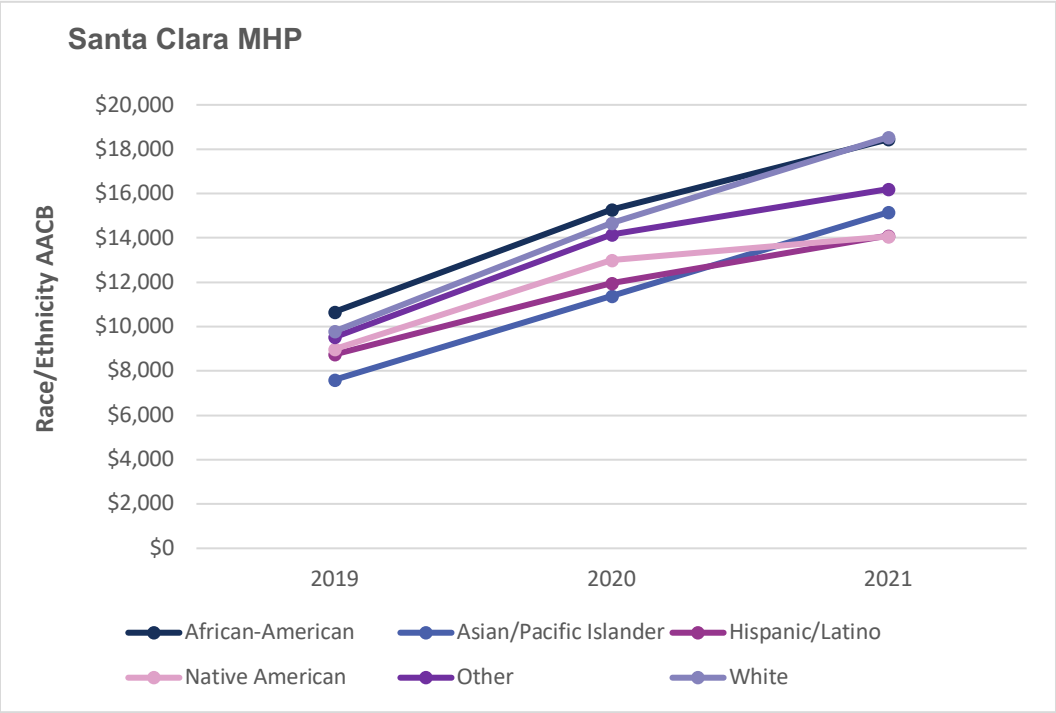
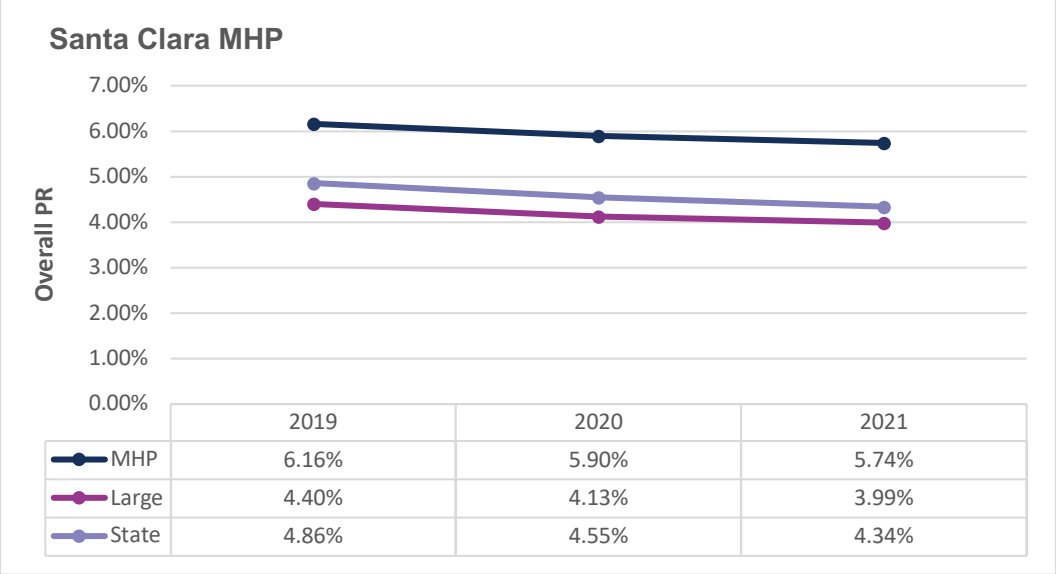
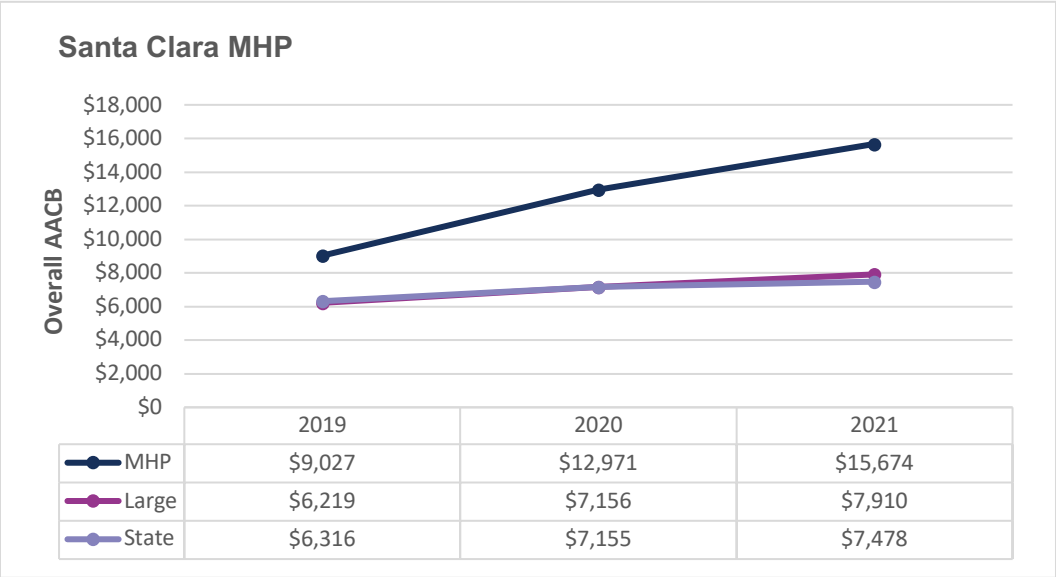


Figure 4: Overall PR CY 2019-21



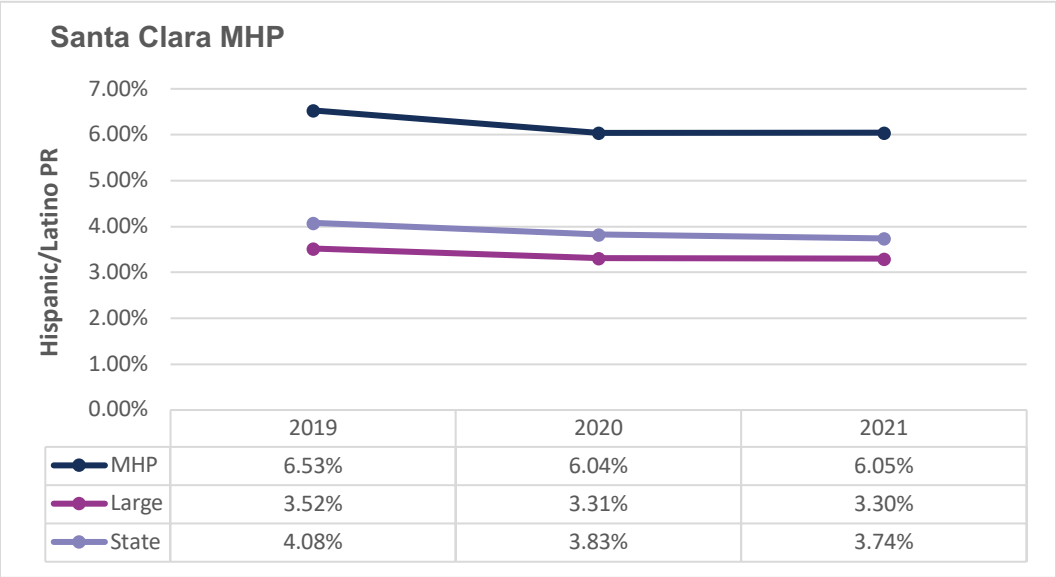
	2019	2020	2021
MHP	6.16%	5.90%	5.74%
Large	4.40%	4.13%	3.99%
State	4.86%	4.55%	4.34%

Figure 5: Overall AACB CY 2019-21



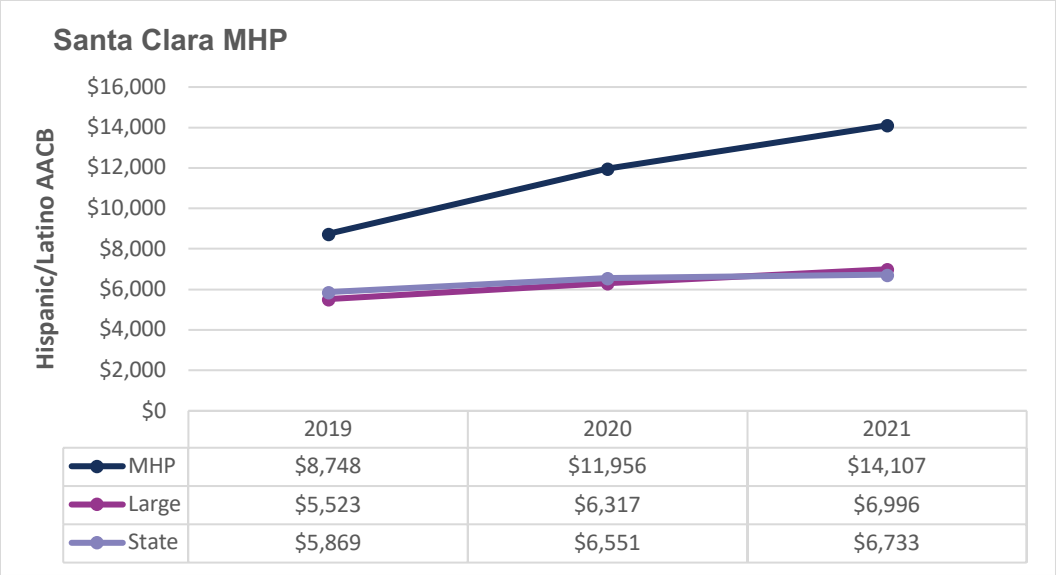
	2019	2020	2021
MHP	$9,027	$12,971	$15,674
Large	$6,219	$7,156	$7,910
State	$6,316	$7,155	$7,478

Figure 6: Hispanic/Latino PR CY 2019-21



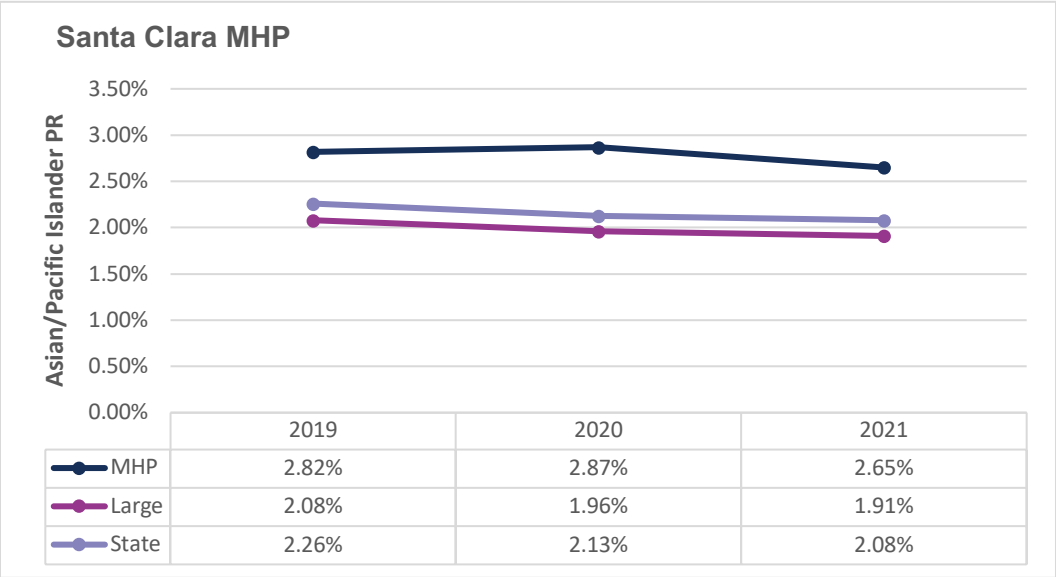
	2019	2020	2021
MHP	6.53%	6.04%	6.05%
Large	3.52%	3.31%	3.30%
State	4.08%	3.83%	3.74%

Figure 7: Hispanic/Latino AACB CY 2019-21



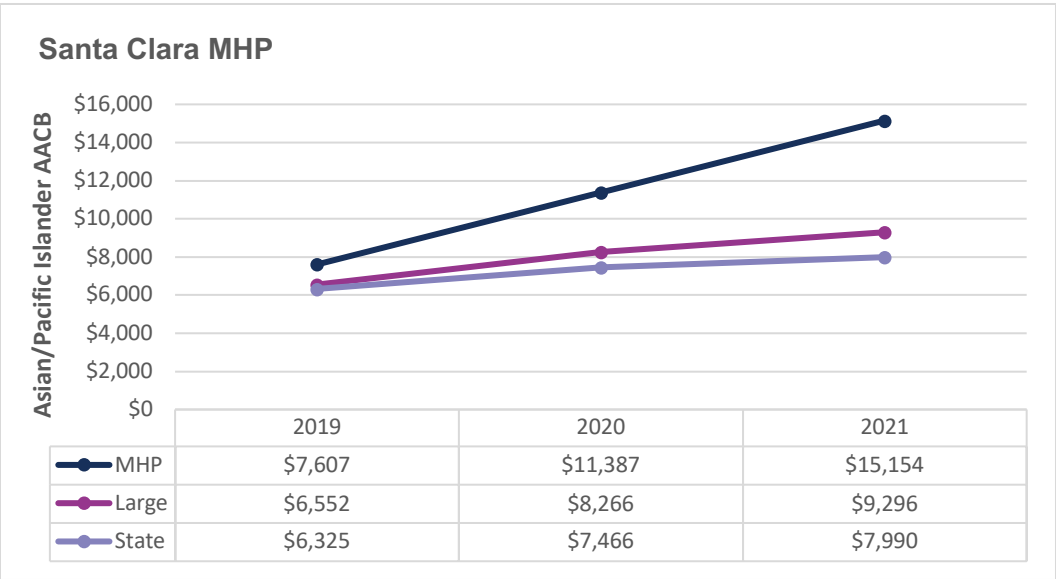
	2019	2020	2021
MHP	$8,748	$11,956	$14,107
Large	$5,523	$6,317	$6,996
State	$5,869	$6,551	$6,733

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



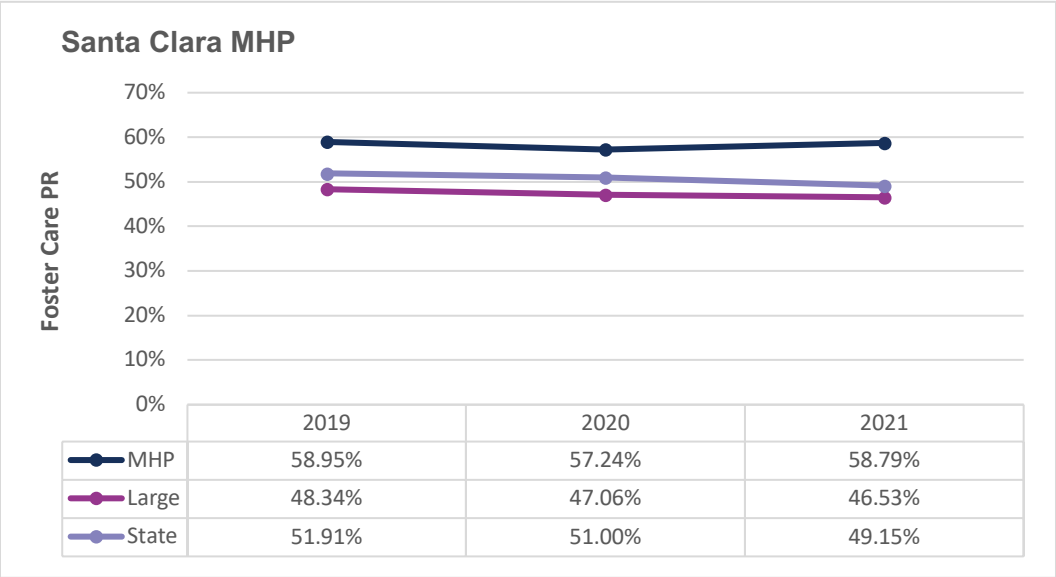
	2019	2020	2021
MHP	2.82%	2.87%	2.65%
Large	2.08%	1.96%	1.91%
State	2.26%	2.13%	2.08%

Figure 9: Asian/Pacific Islander AACB CY 2019-2021



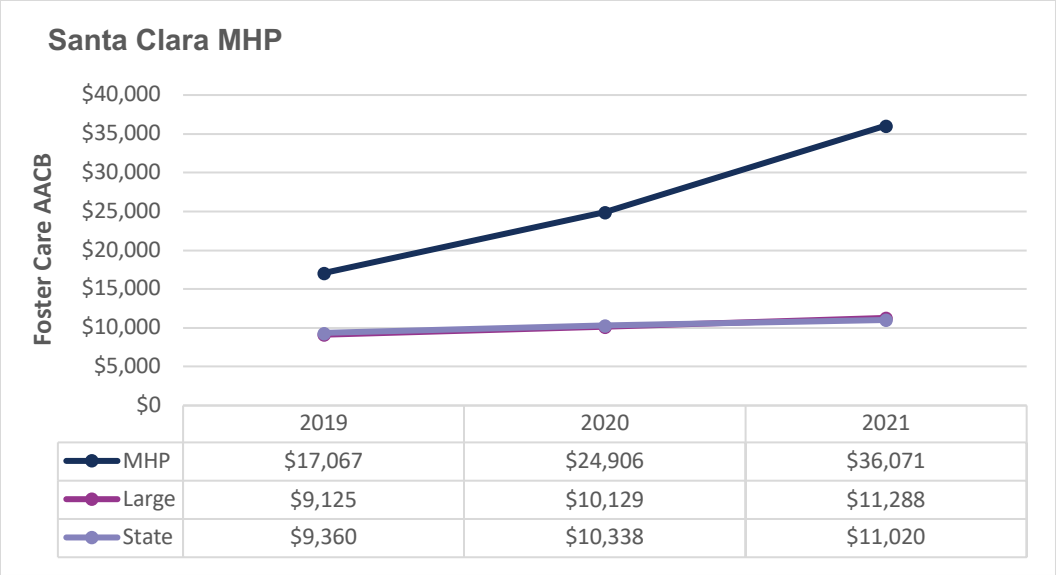
	2019	2020	2021
MHP	$7,607	$11,387	$15,154
Large	$6,552	$8,266	$9,296
State	$6,325	$7,466	$7,990

Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	58.95%	57.24%	58.79%
Large	48.34%	47.06%	46.53%
State	51.91%	51.00%	49.15%

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$17,067	$24,906	$36,071
Large	$9,125	$10,129	$11,288
State	$9,360	$10,338	$11,020

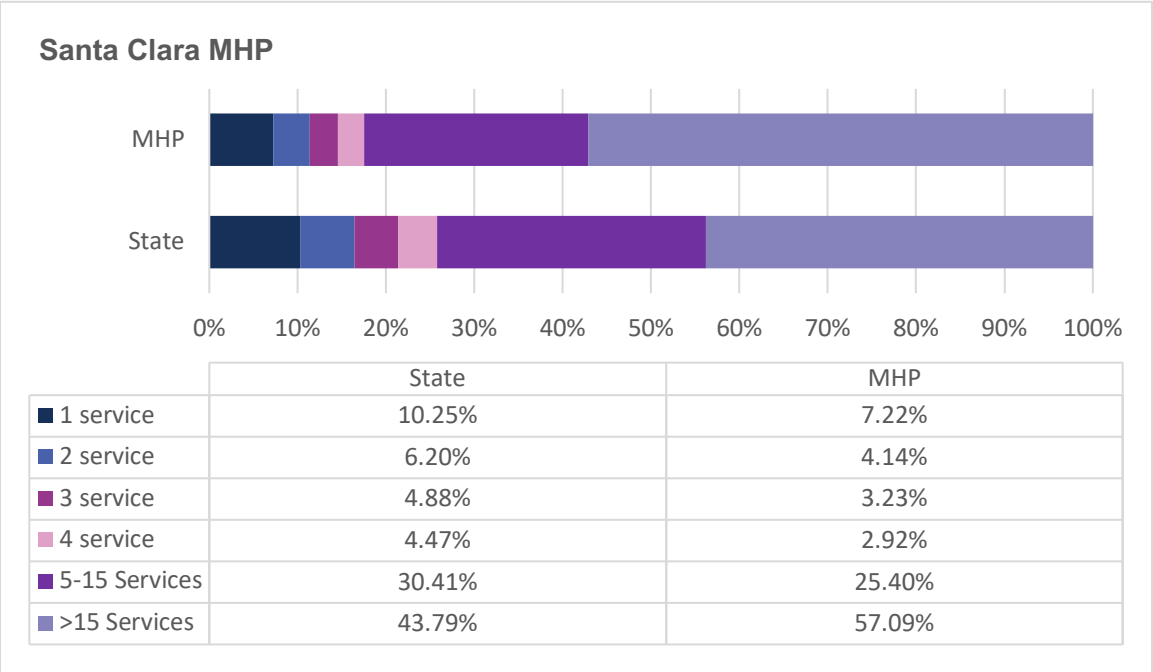
Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 15,309				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	521	3.4%	11	6	11.6%	16	8
Inpatient Admin	147	1.0%	49	28	0.5%	23	7
Psychiatric Health Facility	109	0.7%	29	15	1.3%	15	7
Residential	48	0.3%	52	45	0.4%	107	79
Crisis Residential	675	4.4%	27	26	2.2%	21	14
Per Minute Services							
Crisis Stabilization	2,569	16.8%	2,303	1,200	13.0%	1,546	1,200
Crisis Intervention	882	5.8%	155	90	12.8%	248	150
Medication Support	8,774	57.3%	336	219	60.1%	311	204
Mental Health Services	11,621	75.9%	1,233	757	65.1%	868	353
Targeted Case Management	10,074	65.8%	529	214	36.5%	434	137

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

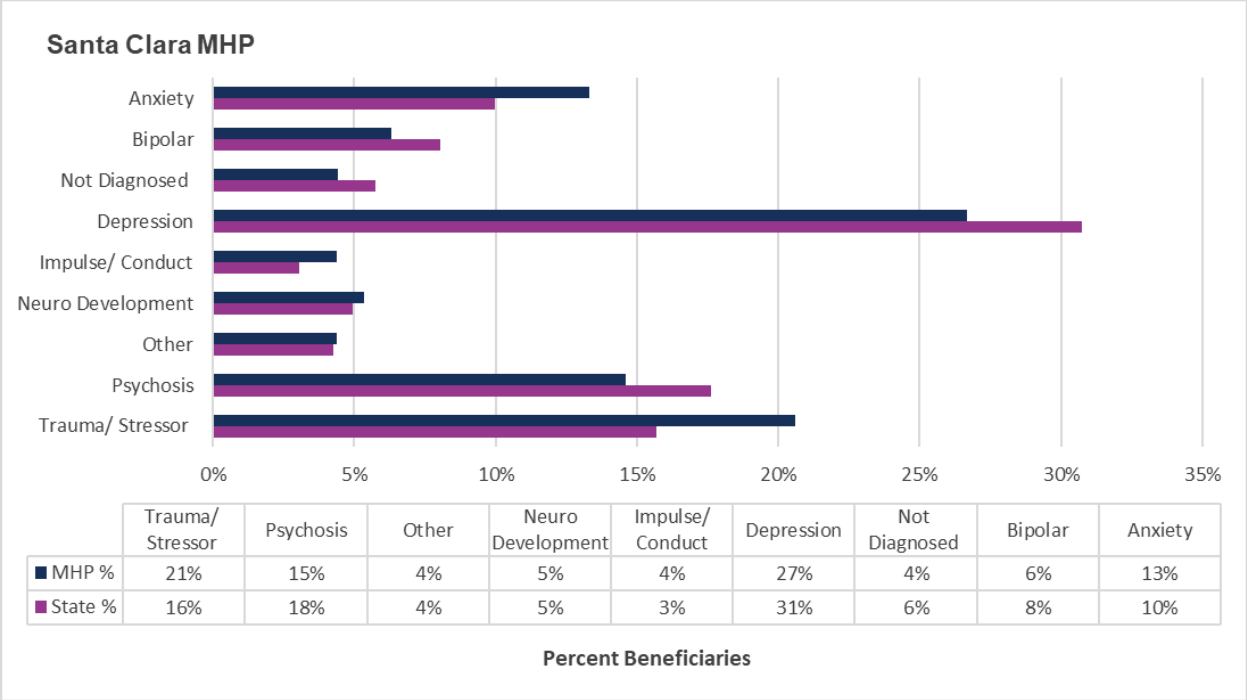
Service Category	MHP N = 760				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	27	3.6%	12	8	4.5%	14	9
Inpatient Admin	<11	-	1	1	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.2%	22	8
Residential	0	0.0%	0	0	0.0%	185	194
Crisis Residential	<11	-	30	30	0.1%	18	13
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	43	5.7%	1,885	1,260	3.1%	1,404	1,200
Crisis Intervention	60	7.9%	382	225	7.5%	406	199
Medication Support	232	30.5%	357	250	28.2%	396	273
TBS	69	9.1%	2,718	2,009	4.0%	4,020	2,373
Therapeutic FC	21	2.8%	1,704	1,380	0.1%	1,030	420
Intensive Care Coordination	383	50.4%	1,811	950	40.2%	1,354	473
Intensive Home Based Services	329	43.3%	3,472	1,992	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	738	97.1%	2,523	1,234	96.3%	1,854	1,108
Targeted Case Management	494	65.0%	917	329	35.0%	342	120

Figure 15: Retention of Beneficiaries CY 2021



	State	MHP
1 service	10.25%	7.22%
2 service	6.20%	4.14%
3 service	4.88%	3.23%
4 service	4.47%	2.92%
5-15 Services	30.41%	25.40%
>15 Services	43.79%	57.09%

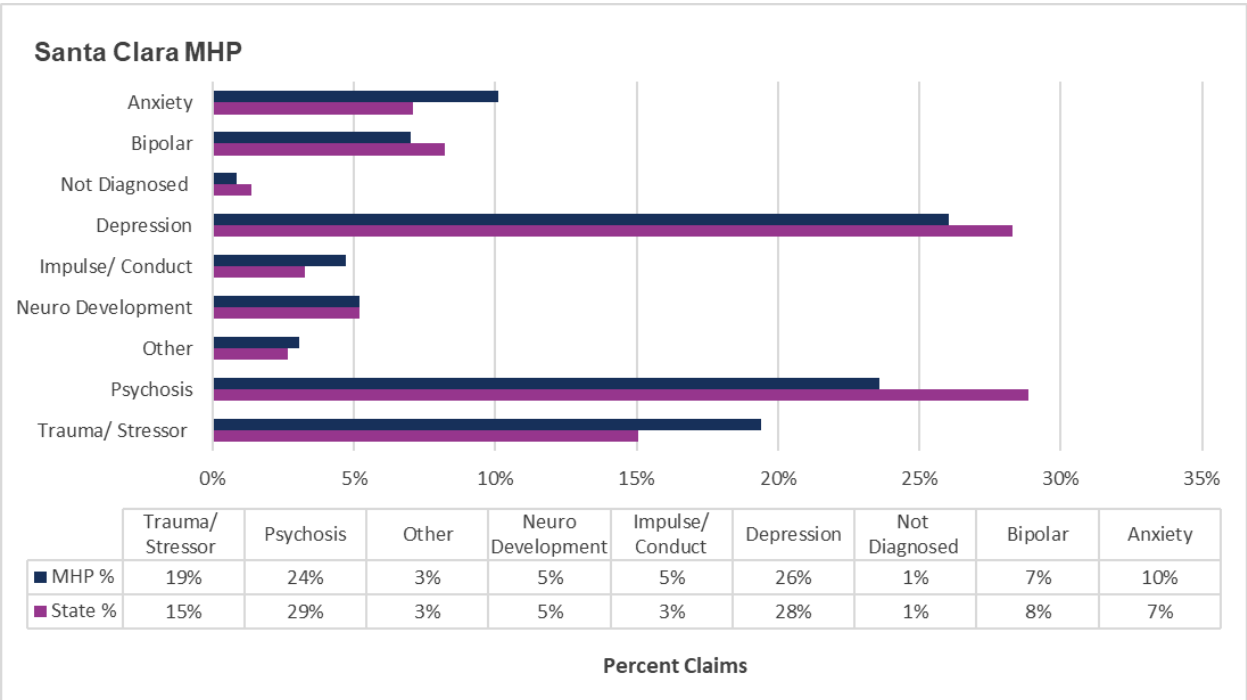
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	21%	15%	4%	5%	4%	27%	4%	6%	13%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Percent Beneficiaries

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 %	19%	24%	3%	5%	5%	26%	1%	7%	10%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Percent Claims

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	985	2,255	14.46	8.86	$22,831	$12,052	$22,488,666
CY 2020	914	1,937	12.33	8.68	$21,834	$11,814	$19,956,165
CY 2019	950	1,991	10.28	7.80	$15,434	$10,535	$14,662,179

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

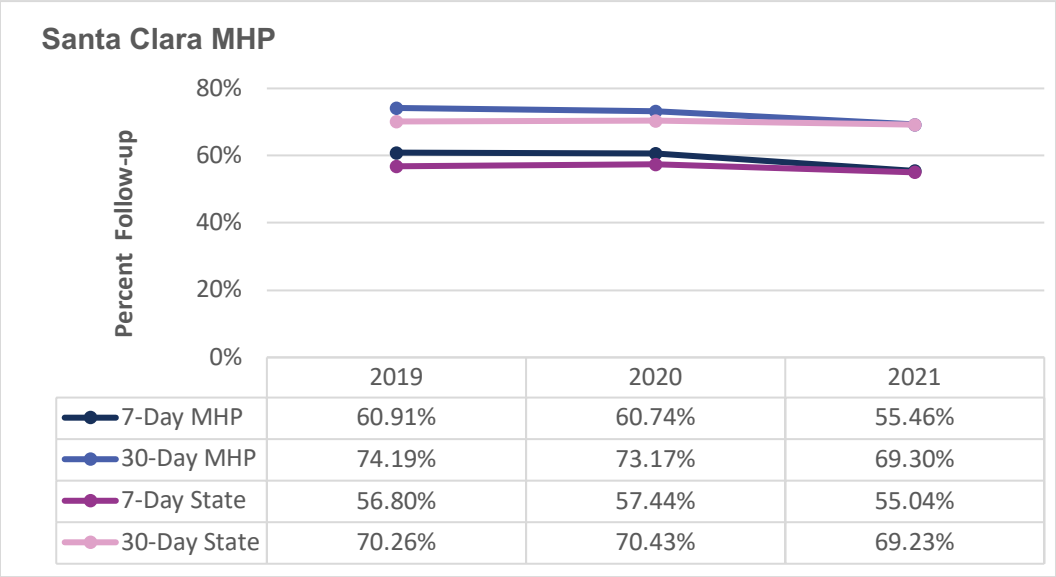
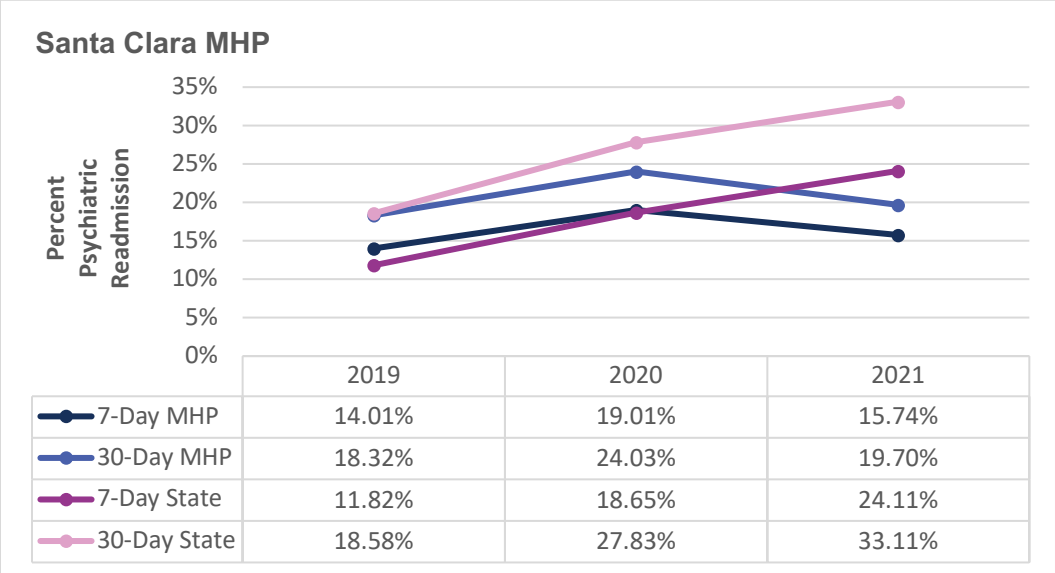


Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



	2019	2020	2021
7-Day MHP	14.01%	19.01%	15.74%
30-Day MHP	18.32%	24.03%	19.70%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

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	3,079	12.33%	48.32%	$189,035,682	$61,395	$45,850
	CY 2020	2,227	9.46%	43.72%	$133,540,270	$59,964	$45,606
	CY 2019	1,400	5.78%	34.24%	$74,889,958	$53,493	$43,704

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)	2,429	9.73%	15.14%	$59,217,714	$24,379	$24,100
Low Cost (Less than $20K)	19,454	77.93%	36.55%	$142,991,675	$7,350	$6,331

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

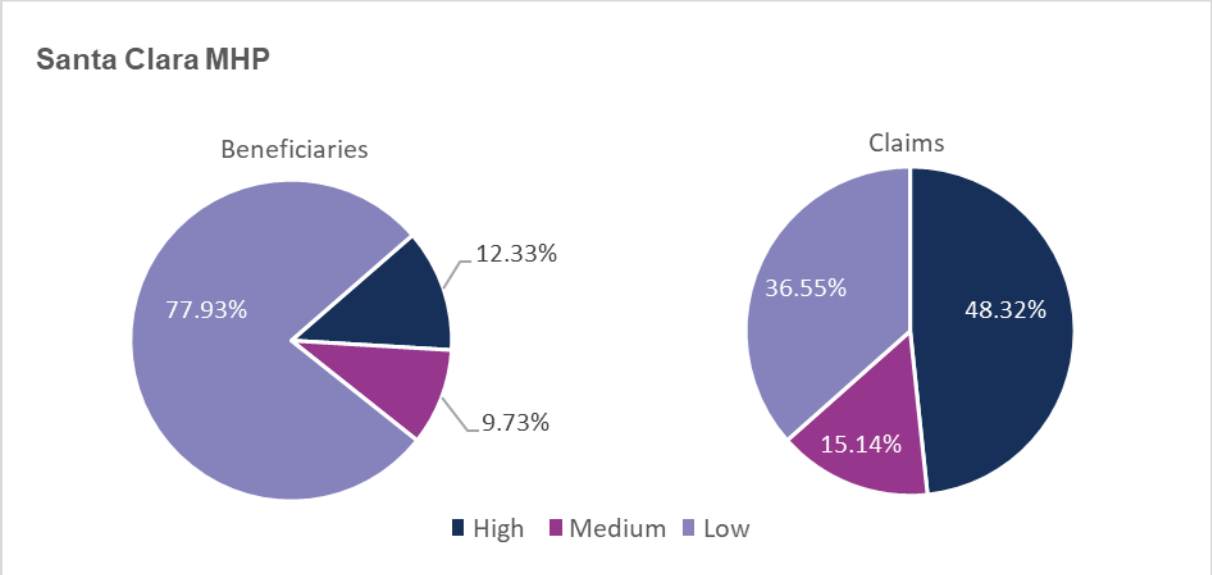


Table 18: Summary of SDMC Approved and Denied Claims CY 2021

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	73,466	$33,776,301	$896,178	2.65%	$30,024,900
Feb	73,138	$34,826,186	$1,031,665	2.96%	$31,053,673
Mar	84,778	$41,458,163	$1,574,260	3.80%	$36,358,653
April	79,771	$39,812,568	$1,629,742	4.09%	$34,742,698
May	70,959	$35,941,358	$1,036,251	2.88%	$31,955,746
June	72,883	$36,711,609	$441,728	1.20%	$33,436,593
July	68,310	$35,185,619	$495,768	1.41%	$31,803,644
Aug	68,909	$35,289,587	$281,480	0.80%	$31,785,033
Sept	68,590	$35,162,286	$236,107	0.67%	$32,172,490
Oct	61,424	$31,955,007	$285,789	0.89%	$29,243,386
Nov	64,999	$33,665,754	$739,194	2.20%	$30,458,564
Dec	62,129	$32,688,009	$1,021,667	3.13%	$29,304,065
Total	**849,356**	**$426,472,447**	**$9,669,829**	**2.27%**	**$382,339,445**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Late claim	1,313	$5,027,564	51.99%
Other healthcare coverage must be billed before submission of claim	2,288	$2,623,975	27.14%
Beneficiary not eligible or non-covered charges	866	$1,128,866	11.67%
Medicare Part B must be billed before submission of claim	734	$491,976	5.09%
Service line is a duplicate and a repeat service procedure code modifier not present	379	$364,132	3.77%
Service location NPI issue	22	$19,316	0.20%
Deactivated NPI	28	$12,864	0.13%
Other	5	$1,135	0.01%
Total Denied Claims	**5,635**	**$9,669,828**	**100.00%**
Overall Denied Claims Rate	**2.27%**		
Statewide Overall Denied Claims Rate	**1.43%**		