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FY 2022-23
Medi-Cal Specialty Behavioral Health External Quality Review

SANTA CRUZ FINAL REPORT

☒ MHP

☐ DMC-ODS

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California Department of Health Care Services (DHCS)

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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 Cruz” may be used to identify the Santa Cruz County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — April 11-12, 2023

MHP Size — Medium

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
5	3	2	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	7	2	1
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**21**	**4**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Face-to-Face Adult Therapeutic Services	Clinical	03/2021	Other: Completed	High
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	12/2022	Implementation	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other	6
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has a track record of successful award of grants and leveraging grant funds to expand existing programs and develop new ones.
- The MHP has a broad base of post-hospitalization supportive services, which likely contributes to low rehospitalization rate.
- Through the aid of a consultant group, the MHP has refocused its quality management program on outcomes and the beneficiary experience and less on compliance.
- The MHP is enhancing its peer integration efforts by: supporting peer certification for current peer employees; developing a peer respite facility, Second Story Peer Respite House; and developing peer-run center-based services.
- Despite vacancies and a small staff, the MHP has successfully implemented changes required under California Advancing and Innovating Medi-Cal (CalAIM), including 274 standard submissions of provider network data, integration of the Adult and Youth Screening and Transition of Care Tools into Avatar, and adaptation of progress notes in the electronic health record (EHR).

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

- The MHP noted that it has limited capacity to do community outreach; it does not have staff in Behavioral Health Services (BHS) who are dedicated to outreach to its population of underserved Hispanic/Latino eligibles.

- The108 percent increase in youth requests for service has impacted the timeliness of the first offered service, which decreased to 58 percent meeting the 10-day standard.
- High-cost beneficiaries (HCBs) comprise 14.44 percent of the beneficiaries served (compared to 4.5 percent statewide) and account for over 50 percent of the claimed services (compared to 33 percent statewide).
- Not all training platforms that were suspended during the height of pandemic have resumed, specifically the training lab has not been made operational. There may be a need to develop additional training opportunities.
- There are information systems (IS) and analyst vacancies that present challenges to timely implementation of upcoming CalAIM initiatives, including payment reform and the expansion of the use of data in quality improvement (QI) efforts (e.g., HEDIS ADD, APM, APC, and APP).

Recommendations for improvement based upon this review include:

- Investigate reasons and develop and implement strategies to improve outreach to Hispanic/Latino communities and Medi-Cal eligibles.
- Investigate reasons and develop and implement strategies to provide timelier first service appointments.
- Investigate reasons and develop and implement strategies to decrease or curb the increasing proportion of HCBs.
- Develop and implement strategies to provide training, particularly in evidenced-based practices and treatment modalities, to all service providers.
- Develop and implement concrete strategies for filling existing IS and analytic vacancies, which would improve data and analytics capability for QI and support IS functions necessary for CalAIM implementation.

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

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

This report presents the FY 2022-23 findings of the EQR for Santa Cruz County MHP by BHC, conducted as a virtual review on April 11-12, 2023.

REVIEW METHODOLOGY

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

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

CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (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 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 and 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 during the Coronavirus Disease 2019 (COVID-19) pandemic that has been marked by a considerable decrease in the MHP workforce. From December 2022 until one month before the review, the county of Santa Cruz experienced unprecedented storms and weather conditions including floods, landslides, breached river levees, and downed trees. The weather events reduced clinic and program access from road closures and disruptions in telecommunication services. The MHP was part of the community response to support residents and provide basic needs. 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 MHP continues to implement CalAIM, including payment reform, coordination with the managed care plan (MCP) providers, training, form development and documentation, and changes in operations.
- The MHP has expanded its crisis services, including adopting the Crisis Now model and plans to develop youth-only crisis services that include a mobile emergency response team and a youth crisis stabilization unit (CSU) and a crisis residential program.
- BHS reported a 26 percent vacancy rate for the department and an unspecified number of vacancies for contract providers. The workforce challenges are exacerbated by a decrease in the number of applicants for available positions.
- The MHP reports a more intentional focus on peer integration by supporting peer certification for current peer employees; developing a peer respite facility; Second Story Peer Respite House; and developing peer-run center-based services.
- The MHP has developed a Suicide Prevention Strategic Plan and has begun to implement activities as outlined in the plan including trainings to first responders and community members; emergency housing for domestic violence victims at risk of suicide; and distribution of lock boxes for firearm safety.

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: Investigate reasons and develop and implement strategies to improve the MHP's response to the increased demand for children's routine, urgent, and emergent services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP addressed this recommendation by investigating the reasons for the increased demand for children's services and implemented strategies to improve children's access to ongoing services throughout the system of care.
- The MHP attributed the increased demand to a return to in-person schooling and greater mental health needs of youth, mirroring the national trend of a children's mental health crisis. The MHP has also noted an increase in the intensity of children's needs, such as treatment for eating disorders.
- The MHP is attempting to meet the demand by expanding contracts with existing contract providers; bringing on a new outpatient services contract provider; contracting for eating disorders services; implementing walk-in crisis services in the north and south county clinics; and securing grants to develop a children's 8-chair CSU and a 16-bed crisis residential unit.

Recommendation 2: Investigate reasons and develop and implement strategies to reduce the MHP's frequency of adult and children near daily CSU diversion to area hospital emergency rooms.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has addressed this recommendation by investigating reasons and implementing strategies to reduce the frequency of beneficiary diversion from the CSU to hospital emergency departments (EDs).
- The MHP reported that the CSU provider had capacity issues and, simultaneously, a vacancy in a leadership position, which precluded the ability to affect change in the process.
- There has since been a leadership change at the contract provider and a focus on the coordination of services among the CSU, mobile units, and hospitals.
- Also, the MHP has assigned a psychiatry on-duty half-days at the CSU, which has helped to reduce transfers to the ED.
- For a long-term strategy, the MHP will construct a separate and dedicated youth CSU, expected in late 2024. In the immediate, the MHP will limit the CSU to adults only; youth will receive crisis stabilization at the ED.

Recommendation 3: Investigate reasons and develop and implement strategies to improve the MHP's response to no-show data tracking and no-show clinical response in part utilizing the proposed non-clinical PIP currently under development.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP has addressed this recommendation by investigating reasons for low confidence in no-show data tracking and has implemented strategies to improve the tracking and reliability of the data.
- The PIP team identified inconsistencies and variability in how staff documented no-shows and determined that there was no standard definition of no-show across the MHP.
- After establishing a uniform definition for no-shows, the PIP team established protocols and procedures for documenting no-shows in the EHR and trained care teams on the procedure.
- The MHP intends to monitor no-shows for three months, beginning in April 2023, for adherence to the procedure and to identify if there are differences by program, race/ethnicity, and language that might further affect no-show rates.
- The MHP was cautioned that the current ideas for a PIP on no-shows were not present as clinical; the MHP already has a non-clinical PIP, the FUM. The MHP was encouraged to seek TA from CalEQRO on development of this or another clinical PIP.

Recommendation 4: Investigate reasons and develop and implement strategies to improve the MHP's response to tracking and trending the following Healthcare Effectiveness Data and Information Set (HEDIS) measures: follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD); the use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC); metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM); and the use of first line psychosocial care for children and adolescents on antipsychotics (HEDIS APP).

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially met this recommendation as it was only able to track and trend HEDIS APM.
- The MHP provided two reasons for inability to track and trend the required HEDIS measures: ongoing challenges with maintaining medication support staff to maintain oversight of these indicators and shifting priorities and resources toward CalAIM measurements and tracking systems (e.g., FUM).
- For the MHP to fully meet this recommendation, the MHP must apply the necessary resources to complete the EHR systems upgrades or changes to enable tracking of these indicators and then assign someone(s) to routinely monitor the findings and present it at the appropriate stakeholder meetings.
- This recommendation will not be carried forward; however, the MHP is to continue making necessary changes and improvements to be able to track and trend all the required measures. This recommendation is related to the MHP's Information Technology (IT) capacity as covered in the next recommendation.

Recommendation 5: Investigate reasons and develop and implement strategies, to improve the MHP's IT analytics and data development support for QI functions.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- This recommendation is rated partially met due to the MHP's progress towards recruitment of additional staff and continued efforts to train Business Systems Analysts to support key CalAIM initiatives.
- The MHP has hired one analyst since the last EQR. Staff report that recruitment and retention remain challenges and that onboarding of new staff takes one year.
- Due to these factors, staffing remains insufficient to fully support the MHP's data needs (e.g., HEDIS APM, APC, ADD, and APP), especially in light of additional demands associated with CalAIM implementation.
- For the MHP to meet this recommendation, the MHP must have sufficient staffing to fully meet current data needs and to support additional demands associated with CalAIM implementation.
- This recommendation will be carried over for FY 2022-23 review.

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 33.8 percent of services were delivered by county-operated/staffed clinics and sites, and 65.9 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 94.9 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 during business hours and contract provider staff after-hours; beneficiaries may request services through the Access Line as well as through the following system entry points: north and south county clinics and other entry points that the MHP refers to as "gates"—children's social services es gates; youth probation gate; schools and education gate; and community-based provider gates. The MHP operates a centralized access team for adult services but a decentralized access process for children's services that are responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries are assessed at Access or through one of the gates and then referred for services depending on type and level of service needed.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video and phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 996 adult beneficiaries, 463 youth beneficiaries, and 140 older adult beneficiaries across 2 county-operated sites and 13 contractor-operated sites. Among those served, 160 beneficiaries received telehealth services in a language other than English in the preceding 12 months. The number of

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[1] CMS Data Navigator Glossary of Terms

beneficiaries who received services via telehealth increased since the last EQRO across all groups.

NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In 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 Cruz County, the time and distance requirements are 30 miles and 60 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

Table 1B: MHP Out-of-Network Access, FY 2021-22

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

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

ACCESS KEY COMPONENTS

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

the foundation of access to quality services that ultimately lead to improved beneficiary outcomes.

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

Table 2: Access Key Components

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

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

- The MHP has two forums, the Behavioral Equity Collaborative and the Cultural Humility Committee, that review various aspects of providing culturally responsive services to beneficiaries and eligibles in Santa Cruz County.
- BHS have been able to leverage the skill and experience of a current staff member in treating eating disorder and has offered trainings to BHS staff.
- Stakeholders noted ongoing delays in access to psychiatry services, especially for youth, and that the process for psychiatry services was confusing.

ACCESS PERFORMANCE MEASURES

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

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access, the MHP, with a total PR of 3.49 percent, demonstrates poorer access to care than was seen statewide.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	82,444	2,881	3.49%	$44,664,912	$15,503
CY 2020	75,778	2,901	3.83%	$39,992,428	$13,786
CY 2019	74,582	3,368	4.52%	$37,893,310	$11,251

- The number of eligibles, total approved claims, and AACB trended upwards between CYs 2019 and 2021, whereas the number of beneficiaries served and total PR trended downwards, similar to trends statewide.

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	7,731	67	0.87%	1.08%	1.96%
Ages 6-17	18,096	1,011	5.59%	4.41%	5.93%
Ages 18-20	4,081	148	3.63%	3.73%	4.41%
Ages 21-64	45,113	1,461	3.24%	4.11%	4.56%
Ages 65+	7,424	194	2.61%	2.26%	1.95%
Total	**82,444**	**2,881**	**3.49%**	**3.67%**	**4.34%**

- The largest group of eligibles by age was adults ages 21-64, followed by youth ages 6-17. These were also the groups with the largest numbers of beneficiaries served.
- The PRs in all of the age categories other than 65+ were lower than statewide. The highest PR was for the 6-17 age group, followed by TAY (18-20). Total PR was lower in the MHP than statewide and in similar sized MHPs.

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	530	18.40%
Total Threshold Languages	**530**	**18.40%**
Threshold language source: Open Data per BHIN 20-070		

- The only non-English threshold language was Spanish, with 18.40 percent of beneficiaries identifying as Spanish speakers.

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	27,133	683	2.52%	$7,180,379	$10,513
Medium	613,796	20,261	3.30%	$151,430,714	$7,474
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries. This pattern holds true in the MHP where the PR for the ACA population, as well as the AACB, are both lower than for the Medi-Cal population as a whole.
- For the ACA population in Santa Cruz County, PR was lower than in similarly sized counties and statewide, and AACB was higher than in similarly sized MHPs and statewide.

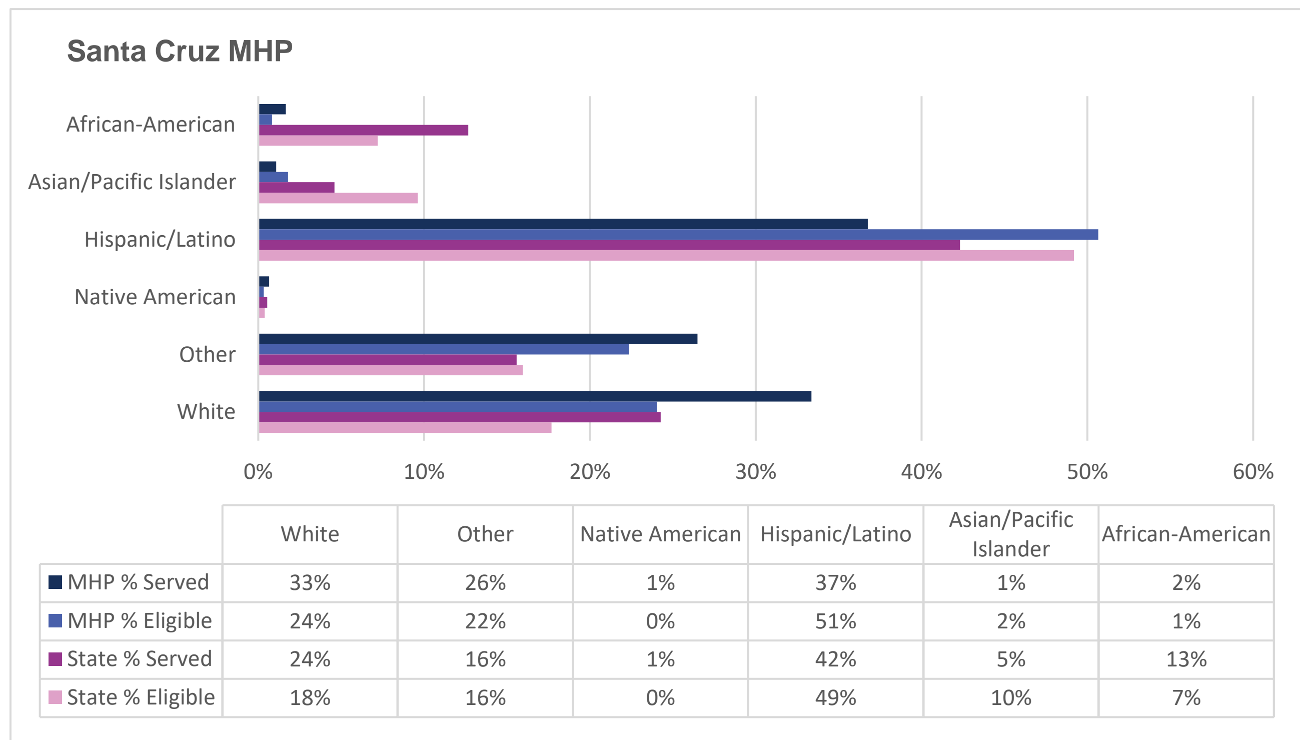
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	677	48	7.09%	7.64%
Asian/Pacific Islander	1,479	31	2.10%	2.08%
Hispanic/Latino	41,767	1,059	2.54%	3.74%
Native American	264	19	7.20%	6.33%
Other	18,437	763	4.14%	4.25%
White	19,820	961	4.85%	5.96%
Total	**82,444**	**2,881**	**3.49%**	**4.34%**

- The largest group of eligibles was Hispanics/Latinos followed by Whites, and those were also the two largest groups of beneficiaries served.
- The MHP's PRs were lower than the statewide PRs for all racial/ethnic groups with the exception of Asians/Pacific Islanders and Native Americans.

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

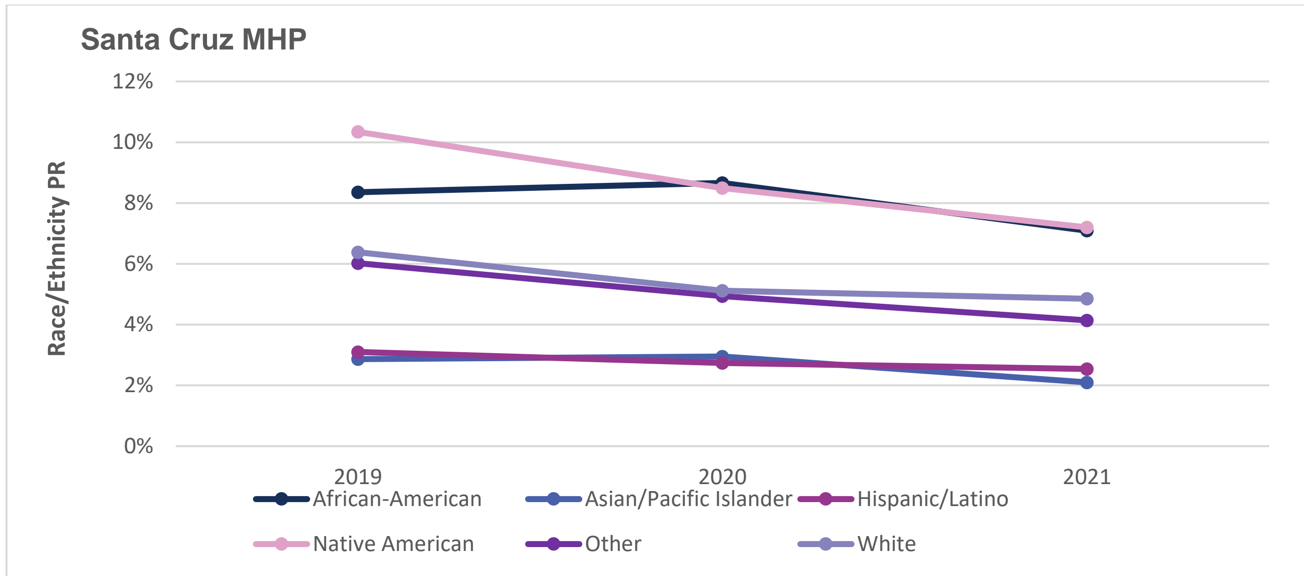


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	33%	26%	1%	37%	1%	2%
MHP % Eligible	24%	22%	0%	51%	2%	1%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- Proportionally, the most overrepresented group in the MHP was Whites, and the most underrepresented group was Hispanics/Latinos.

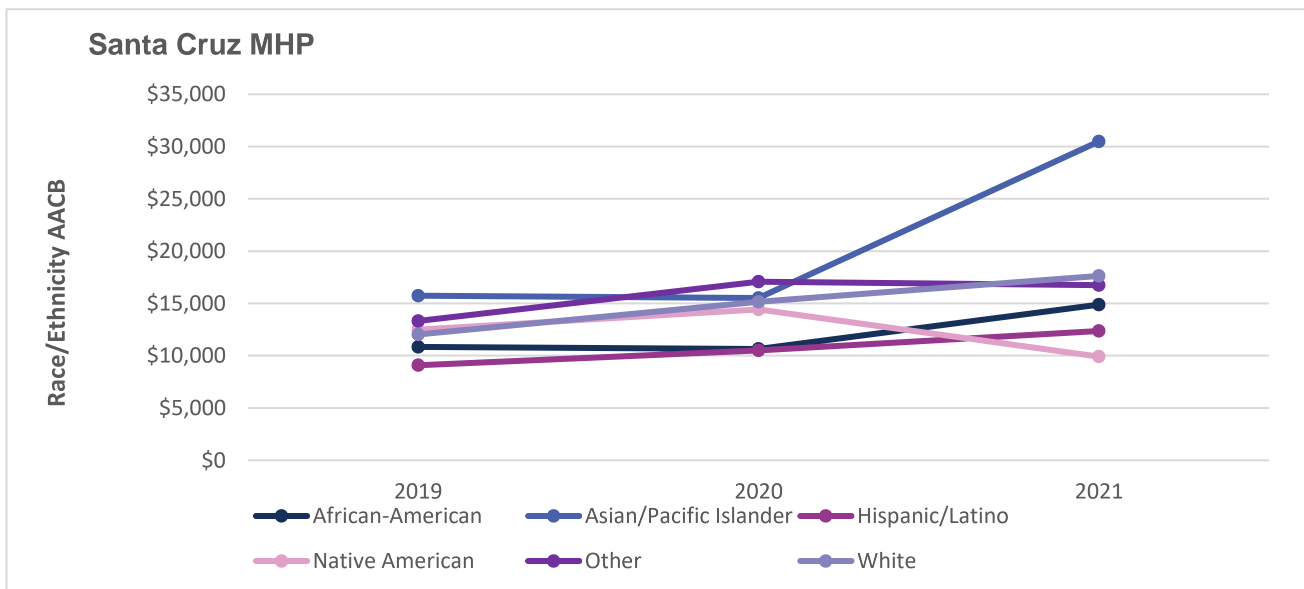
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data are compared to the similar size MHPs and the statewide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

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



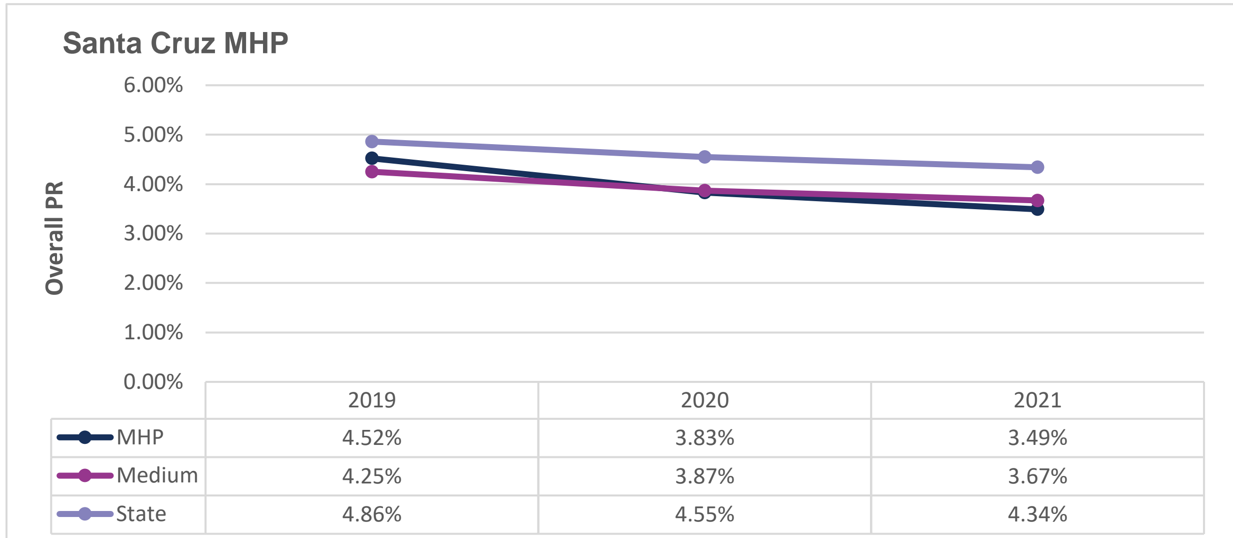
- PRs for most racial/ethnic groups have been trending downwards. PRs for Native Americans and African Americans are the highest, whereas PRs for Asians/Pacific Islanders and Hispanic/Latinos have consistently been the lowest.

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



- AACBs across racial/ethnic groups were generally higher in CY 2021 than in CY 2019. The groups with the largest shifts in AACBs, Asians/Pacific Islanders and Native Americans, could be due to a small number of beneficiaries served, 31 and 19, respectively, and one or two outliers that skew the average.

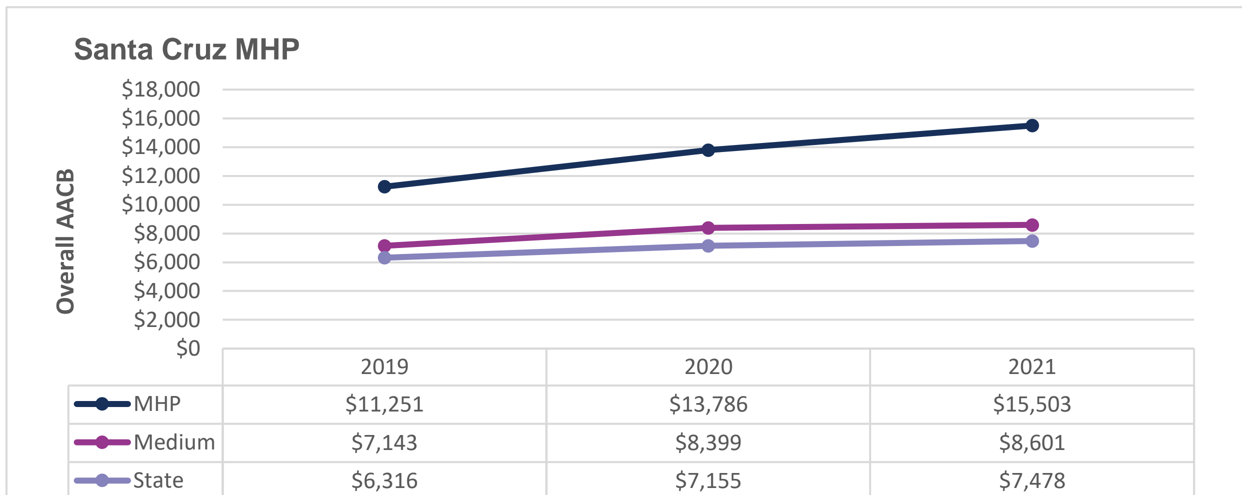
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	4.52%	3.83%	3.49%
Medium	4.25%	3.87%	3.67%
State	4.86%	4.55%	4.34%

- Over the past three years, PR has been trending downward in the MHP, other medium-sized MHPs, and statewide.

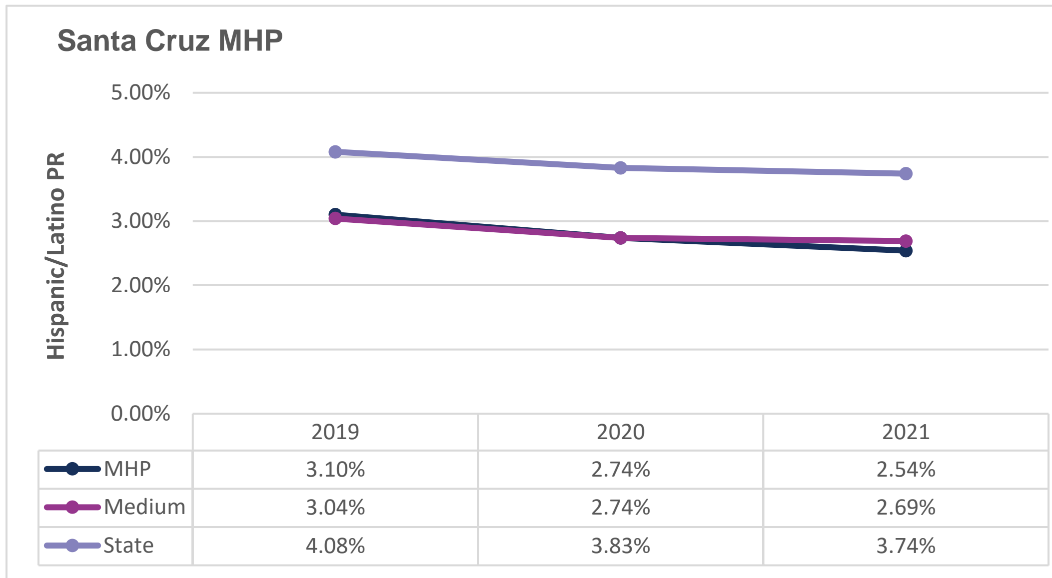
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$11,251	$13,786	$15,503
Medium	$7,143	$8,399	$8,601
State	$6,316	$7,155	$7,478

- AACB trended up in the MHP, in similarly sized MHPS, and statewide. AACB has been consistently higher for the MHP than other medium-sized MHPs and statewide. For CY 2021, the AACB was more than double the statewide AACB.

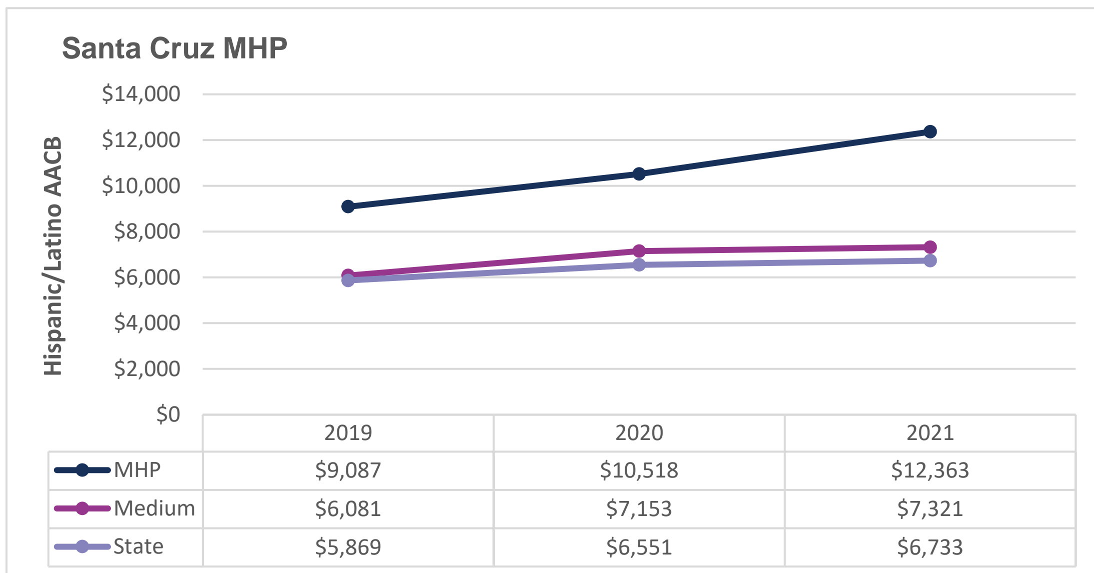
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	3.10%	2.74%	2.54%
Medium	3.04%	2.74%	2.69%
State	4.08%	3.83%	3.74%

- Similar to both other medium sized MHPs and statewide, Hispanic/Latino PR has been decreasing. Both the MHP and other medium sized MHPs have had lower PRs for this population than what was seen statewide.

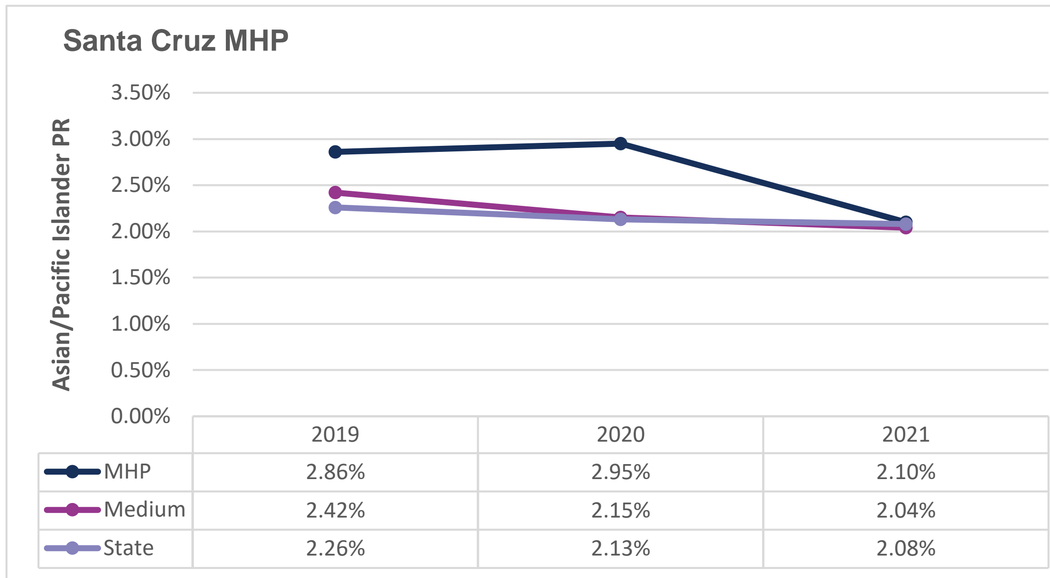
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$9,087	$10,518	$12,363
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

- By contrast, the AACB for Hispanic/Latino beneficiaries has been consistently increasing in the MHP, and has been consistently higher than AACBs in comparable sized MHPs and statewide over the past three years.

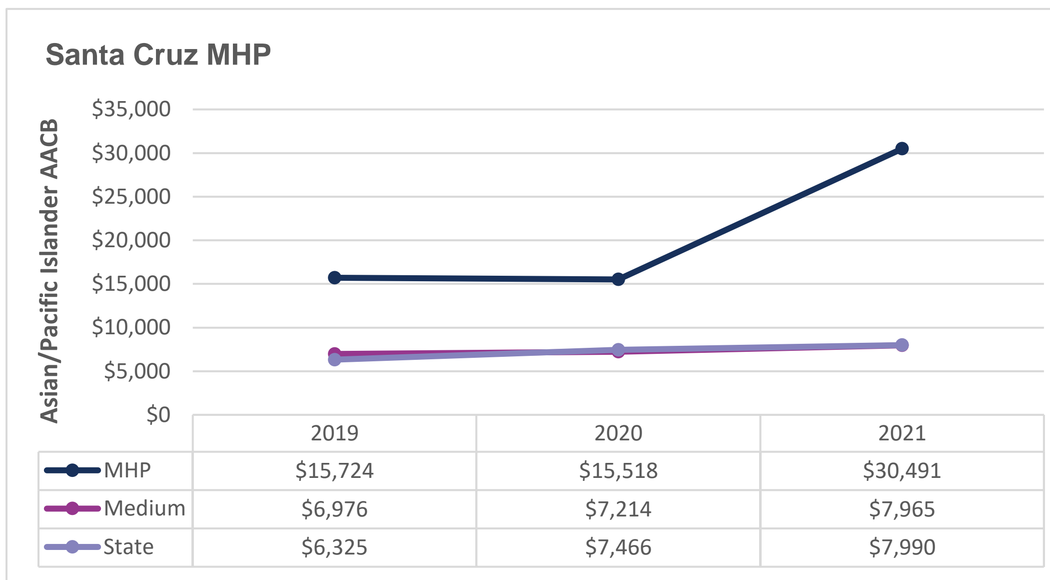
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.86%	2.95%	2.10%
Medium	2.42%	2.15%	2.04%
State	2.26%	2.13%	2.08%

- The PR for Asian/Pacific Islanders was higher than that in other medium sized MHPs and statewide in CYs 2019 and 2020 but decreased to a level that is comparable for CY 2021. Asian/Pacific Islanders are a small group and PRs can be affected by relatively small changes in the number of beneficiaries served.

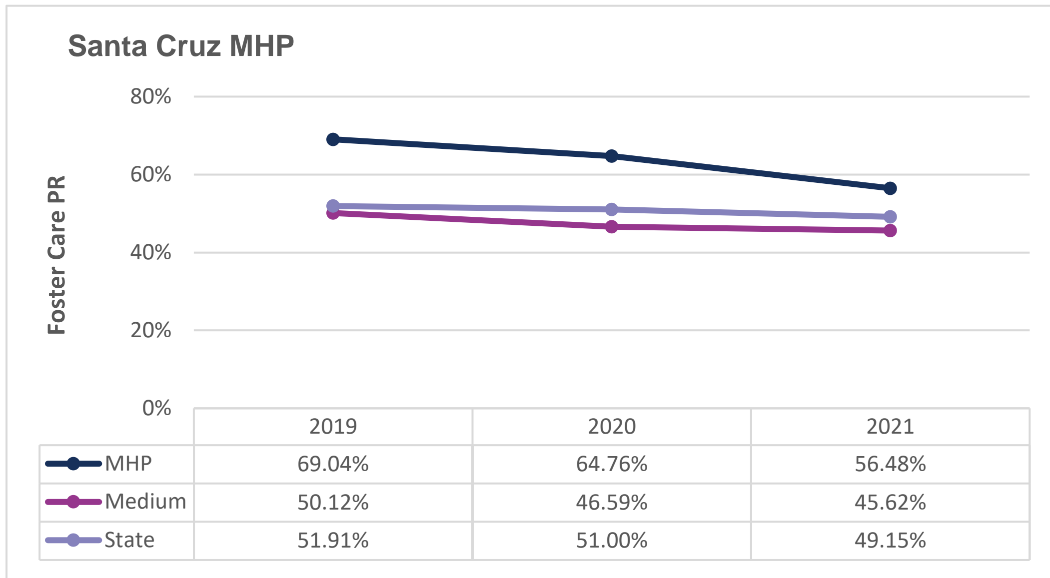
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$15,724	$15,518	$30,491
Medium	$6,976	$7,214	$7,965
State	$6,325	$7,466	$7,990

- AACB for Asian/Pacific Islanders was stable from CY 2019 to CY 2020, but nearly doubled between in CY 2021. The AACB for this group went from 249 percent higher than the state to nearly 382 percent higher in CY 2021.

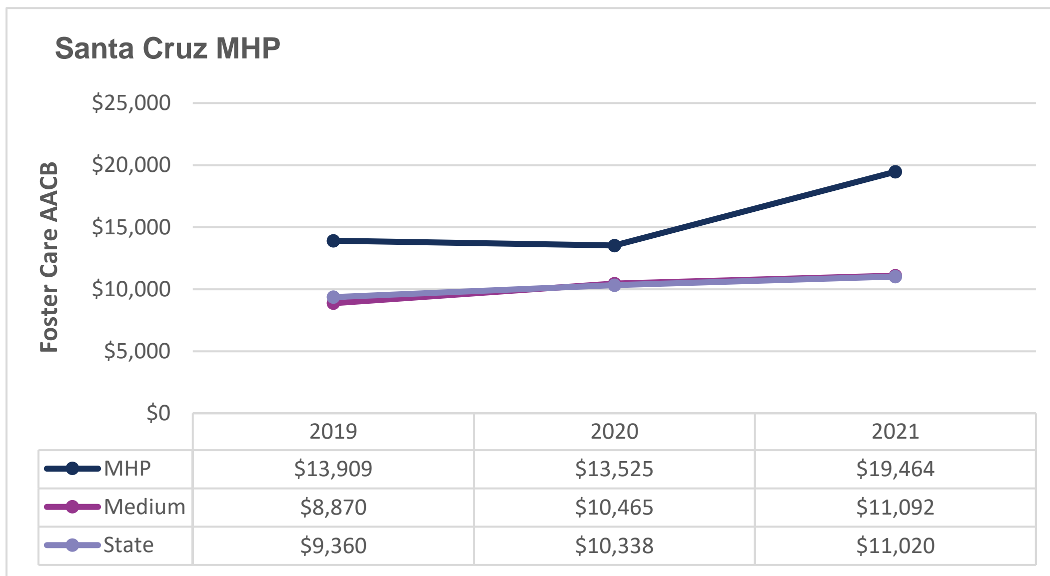
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	69.04%	64.76%	56.48%
Medium	50.12%	46.59%	45.62%
State	51.91%	51.00%	49.15%

- Statewide, FC PR has remained steady at approximately 50 percent over the past three years, whereas for the MHP, the PR has decreased.
- While the MHP's FC PR has been consistently higher than statewide and similarly sized MHPs, it decreased much more rapidly than both in CY 2021.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$13,909	$13,525	$19,464
Medium	$8,870	$10,465	$11,092
State	$9,360	$10,338	$11,020

- The FC AACB in the MHP has been higher consistently than in other medium MHPs and statewide. In CY 2021, there was a further substantial increase in MHPs AACB.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 1,804				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	225	12.5%	10	7	11.6%	16	8
Inpatient Admin	<11	-	39	19	0.5%	23	7
Psychiatric Health Facility	<11	-	14	9	1.3%	15	7
Residential	130	7.2%	49	33	0.4%	107	79
Crisis Residential	105	5.8%	21	15	2.2%	21	14
Per Minute Services							
Crisis Stabilization	514	28.5%	1,514	1,200	13.0%	1,546	1,200
Crisis Intervention	503	27.9%	197	132	12.8%	248	150
Medication Support	159	8.8%	1,444	480	60.1%	311	204
Mental Health Services	1,147	63.6%	1,748	499	65.1%	868	353
Targeted Case Management	761	42.2%	657	330	36.5%	434	137

- Inpatient treatment was the most used per day service, with units of service comparable to statewide. The next most used per day service was Residential that had a much higher utilization than statewide, followed by Crisis Residential. Average units (days) billed were lower for Inpatient and Residential services than those seen statewide.
- While few beneficiaries had Inpatient Admin days, the average number of billed days was longer than statewide.
- Mental Health Services and Targeted Case Management (TCM) were, by far, the most used services for adults. The Mental Health Services utilization rate was comparable to the statewide rate and TCM utilization was slightly higher; both of these services had more billed minutes than statewide averages.
- Crisis Stabilization (CS) and Crisis Intervention also had higher utilization rates than seen statewide, though some of the difference in CS utilization may be related to having a CSU in the county, which tends to increase utilization of that service.

- Medication Support services were utilized at a much lower rate than statewide. The MHP reports that most psychiatry services are provided through the county's Federally Qualified Health Center (FQHC) that is billed outside of SDMC approved claims. The Medication Support reported in Tables 8 and 9 reflects services delivered by contractor-operated providers only.

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

Service Category	MHP N = 105				Statewide N = 37,203		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	10	12	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	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	0	0.0%	0	0	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	<11	-	1,365	990	3.1%	1,404	1,200
Crisis Intervention	11	10.5%	365	221	7.5%	406	199
Medication Support	13	12.4%	376	300	28.2%	396	273
TBS	<11	-	3,810	3,515	4.0%	4,020	2,373
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination	27	25.7%	571	287	40.2%	1,354	473
Intensive Home Based Services	20	19.0%	1,934	1,791	20.4%	2,260	1,275
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	101	96.2%	2,241	1,776	96.3%	1,854	1,108
Targeted Case Management	62	59.0%	452	247	35.0%	342	120

- The most used service for youth in FC was Mental Health Services, with median units of service higher than statewide. The second most used service in the MHP was TCM, which was used by a greater proportion of beneficiaries in the MHP than seen statewide.

- As with adults, a much smaller proportion of youth in FC receive Medication Support services than statewide due to the provision of psychiatry through the FQHC.
- Intensive Care Coordination (ICC) was utilized at a much lower rate than statewide, with much fewer average billed minutes of service.
- The only per day service provided for youth in FC was inpatient services, which was utilized at a higher rate than statewide. The exact rate is suppressed due to the low number of FC beneficiaries who received this service.

IMPACT OF ACCESS FINDINGS

- The MHP had a negligible (less than 1 percent) decrease in the number of beneficiaries served in CY 2021 than CY 2020. In effect, the MHP has maintained services to beneficiaries despite various spikes in COVID-19 and staffing challenges during CY 2021.
- The MHP's low PR for the predominate Hispanic/Latino population in the county is affected by a lack of community outreach, which has stalled over the past year.
- The impact of low utilization of Medication Support services may contribute to the high utilization of crisis stabilization and crisis intervention services and requires close review.
- Longer average days for Inpatient Admin, but few beneficiaries having Inpatient Admin may be reflective of challenges in stepping beneficiaries down to subacute facilities, which reduces the availability of a bed for an actively acute beneficiary.
- Despite assessing all youth in FC for eligibility for Pathways to Well-Being services (at intake, every six months, and as needed), the MHP has low utilization of ICC (both in terms of the percentage of youth served and the average billed minutes of service). A review of the screening process and workflow for child and family team meeting delivery may be warranted to identify any barriers to delivering these services.

TIMELINESS OF CARE

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

- The MHP offered and delivered first appointments and first psychiatry appointment timely to most adult beneficiaries, with rates at 90 percent and greater.

- By contrast, the MHP offered and delivered first appointments and first psychiatry appointments timely for 50 to 75 percent of youth.
- The majority of psychiatry services and all urgent services are delivered through county-operated services. Psychiatry services delivered through contract providers were not reported.
- The MHP credits the low 7- and 30-day rehospitalization rates to early contact and rapport-building with the beneficiaries and collaboration among the psychiatric health facility, contract providers, and crisis residential programs.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of 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. These data represent the entire system of care for first offered and first rendered non-urgent services, post-psychiatric hospitalization follow-up, and no-show rates, and county-operated services for first offered and first rendered non-urgent psychiatry services, and urgent services offered.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	13.1 Business Days	10 Business Days*	71%
First Non-Urgent Service Rendered	14.6 Business Days	10 Business Days**	65%
First Non-Urgent Psychiatry Appointment Offered	9.0 Business Days	15 Business Days*	87%
First Non-Urgent Psychiatry Service Rendered	12.1 Business Days	15 Business Days**	75%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	2.3 Hours	48 Hours**	99%
Follow-Up Appointments after Psychiatric Hospitalization	6.9 Days	7 Days**	53%
No-Show Rate – Psychiatry	5.9%	5.0%**	n/a
No-Show Rate – Clinicians	4.4%	5.0%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

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

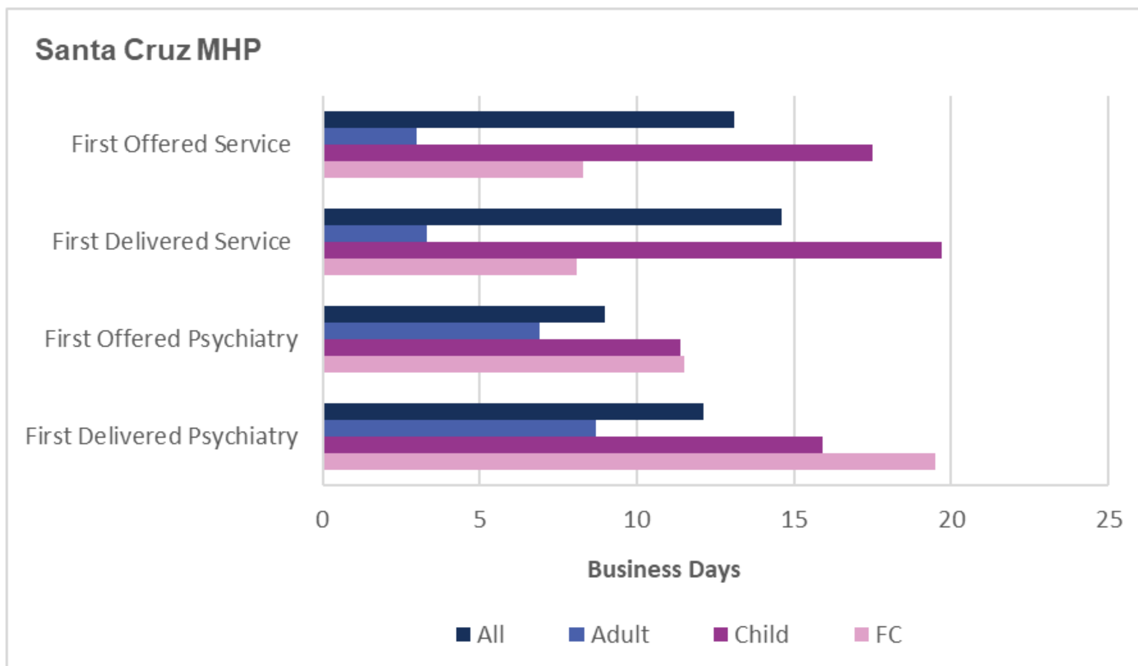


Figure 13: Wait Times for Urgent Services

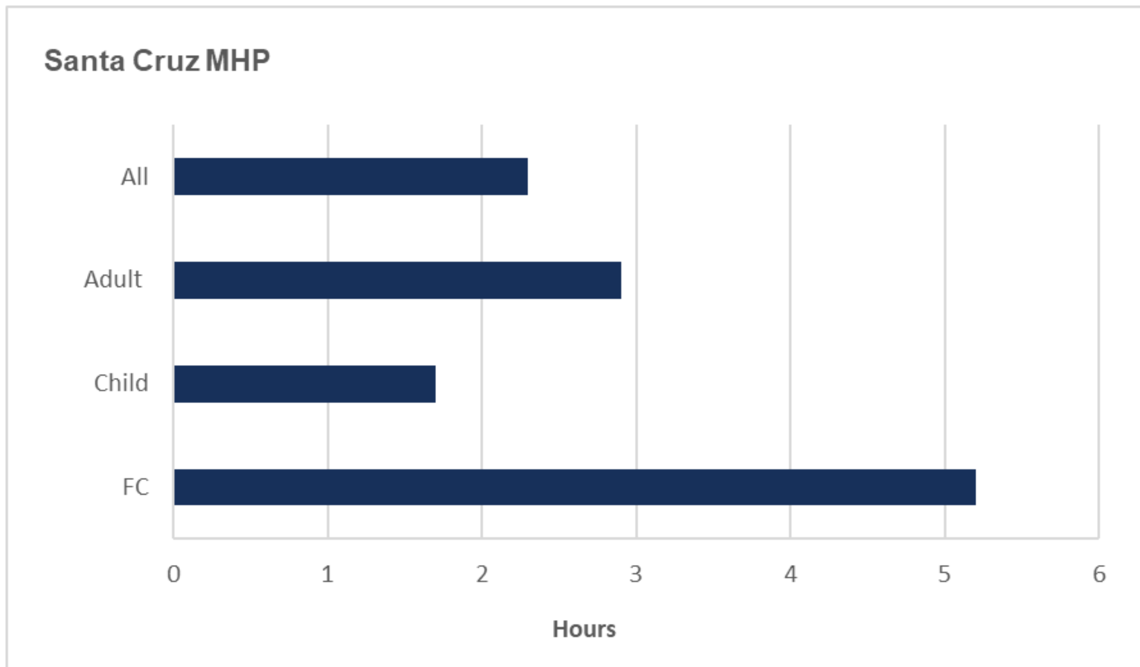
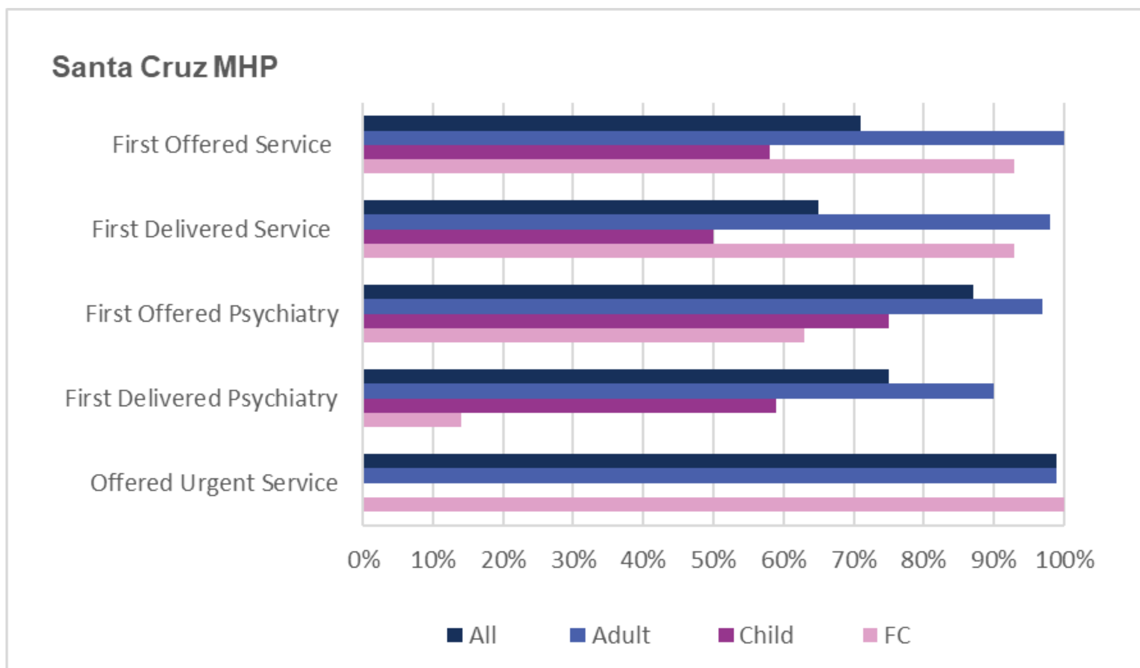


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in

Figures 12 and 14, represent all initial services regardless of provider or type of service.

- 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 (ED), or a referral to a CSU. The MHP defined "urgent services" for purposes of the ATA as: "Urgent appointments with non-physician or physician for a condition which requires prompt attention, but is not life threatening, in order to prevent imminent or serious deterioration in one's health and/or could jeopardize the enrollee's ability to regain maximum function. The condition disrupts normal activities of daily living and requires urgent assessment by a healthcare provider. Delay in decision-making process could be detrimental to one's health." There were reportedly 289 urgent service requests with a reported actual wait time to services for the overall population of 2.3 hours.
- 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 being from the date of request for service until the first psychiatry appointment provided via the county-administered FQHC. Psychiatry services delivered by contractor-operated providers are not included in Figures 12 and 14.
- 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 psychiatry no-show rates of 5.5 percent for adults, 10.9 percent for children, and 8.7 percent for FC youth, and non-psychiatry clinical no-show rates of 2.6 percent for adults, 8.3 percent for children, and 7.7 percent for FC youth.

IMPACT OF TIMELINESS FINDINGS

- The MHP reported a 108 percent increase in youth requests for service, FY 2020-21 (251) to FY 2021-22 (521). The increase seems to have impacted the timeliness of first offered service meeting the 10-business day standard, which decreased 40 percent, FY 2020-21 (96 percent) to FY 2021-22 (58 percent).
- The increase in youth requests for service has impacted the timeliness of the first offered service.
- The timeliness to psychiatry services delivered through contract providers, albeit few, is unknown because the MHP reported only county-operated psychiatry services.
- The impact of greater no-show rates for youth than adults may contribute to the longer time to first appointment and first psychiatry appointment for youth than compared to adults, as presented in the MHP's ATA.

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 the Quality Management program that consists of the QI team in partnership with MHP senior leadership and program directors. QA/Compliance are part of the responsibility of the QI Team. In 2022, BHS hired a consultant to evaluate the QI Team and identify high-impact opportunities for improvement and increase the team's efficiency. Through this initiative, BHS is working to expand resources for the QI Team and engage more of the MHP programs and disciplines in QI.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of MHP leadership, representatives from contract providers, beneficiaries, representatives from the National Alliance on Mental Illness, and individuals with lived experience who are active peer representatives. The QIC is scheduled to meet quarterly or four times per year. Since the previous EQR, the MHP QIC met four times. Of the 14 identified FY 2021-22 QAPI workplan goals that included both MHP and Drug Medi-Cal goals, the MHP determined that most (71 percent) required further work and presumably would be continued; only one goal was rated as met.

The MHP does not utilize a standardized level of care (LOC) tool.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths Assessment (ANSA), Child and Adolescent Needs and Strengths (CANS), General Anxiety Disorder-7, Patient Health Questionnaire, and Pediatric Symptoms Checklist. The MHP had a goal to implement Child and Adult Needs and Strengths Assessment, a universal outcome measure for children and adults.

The ANSA and CANS data are reviewed monthly, and a partner from the Community Data Round Table provides summary data on a quarterly basis. A monthly data dashboard is also made available to all providers in the MHP. The MHP reports it plans to begin reviewing these data in the quarterly meetings of the QI Steering Committee as well.

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	Partially Met
3E	Medication Monitoring	Partially Met
3F	Psychotropic Medication Monitoring for Youth	Not 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:

- The new initiative on QI has identified a need (for the MHP) to expand resources to enable the QI team to focus on improvement, beneficiary experience, and beneficiary outcomes in addition to the regulatory components that have dominated the team's focus.
- Stakeholders raised concerns about the MHP's current ability to transition beneficiaries to different, often lower, LOCs within the MHP and to the MCP. Capacity was thought to be a factor in determining program placement and services provided.
- The MHP tracks and trends some of the HEDIS and other national quality measures related to diagnoses, medication practices, and care standards.

- The MHP tracks but did not trend the following HEDIS measures as required by WIC Section 14717.5: HEDIS APM.
- The MHP does not track or trend the following HEDIS measures as required by WIC Section 14717.5: HEDIS ADD, HEDIS APC, or HEDIS APP.

QUALITY PERFORMANCE MEASURES

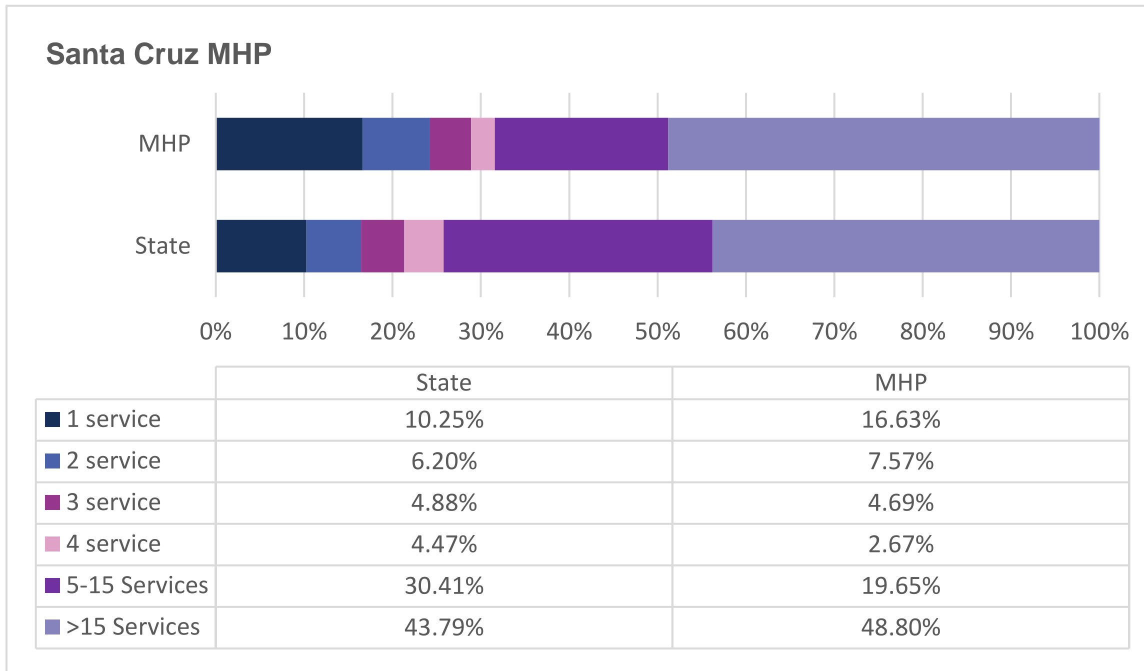
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

- Retention in Services
- Diagnosis of Beneficiaries Served
- Psychiatric Inpatient Services
- Follow-Up Post Hospital Discharge and Readmission Rates
- HCBs.

Retention in Services

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

Figure 15: Retention of Beneficiaries CY 2021



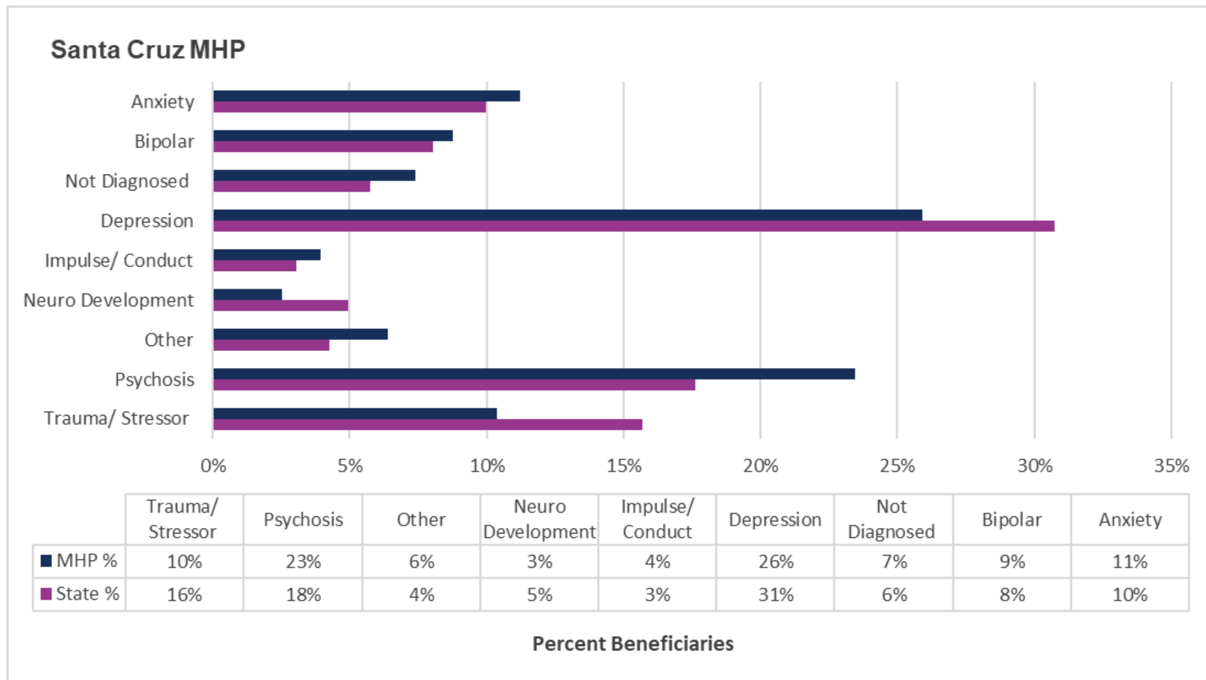
	State	MHP
1 service	10.25%	16.63%
2 service	6.20%	7.57%
3 service	4.88%	4.69%
4 service	4.47%	2.67%
5-15 Services	30.41%	19.65%
>15 Services	43.79%	48.80%

- The MHP had a higher proportion of beneficiaries who received just one service than statewide, but also had a higher proportion of beneficiaries receiving more than 15 services than statewide. Overall, the MHP had a smaller proportion of beneficiaries who received five or more services than statewide (approximately 68 percent vs. 74).

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 following figures represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP beneficiaries in a diagnostic category compared to statewide. This is not an unduplicated count as a beneficiary may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

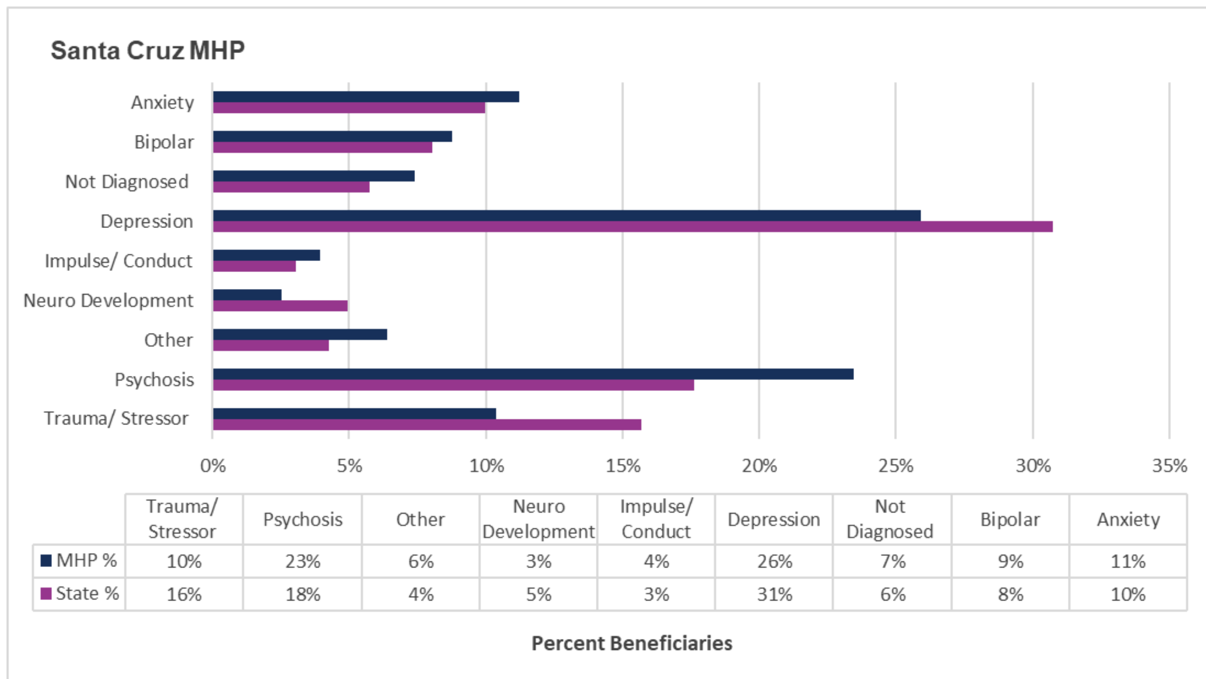
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	10%	23%	6%	3%	4%	26%	7%	9%	11%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- Depression and Psychosis were the most common diagnostic categories in the MHP. The Psychosis rate was higher than statewide but Depression (and Trauma/Stressor disorder) was lower than statewide.

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 %	10%	23%	6%	3%	4%	26%	7%	9%	11%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- In general, claims were proportionate to diagnostic rates in the MHP with the exception of Psychosis, which accounted for 23 percent of diagnoses and 41 percent of claims.

Psychiatric Inpatient Services

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

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	313	584	8.58	8.86	$16,107	$12,052	$5,041,589
CY 2020	293	503	10.38	8.68	$18,448	$11,814	$5,405,144
CY 2019	386	675	9.21	7.80	$16,438	$10,535	$6,344,970

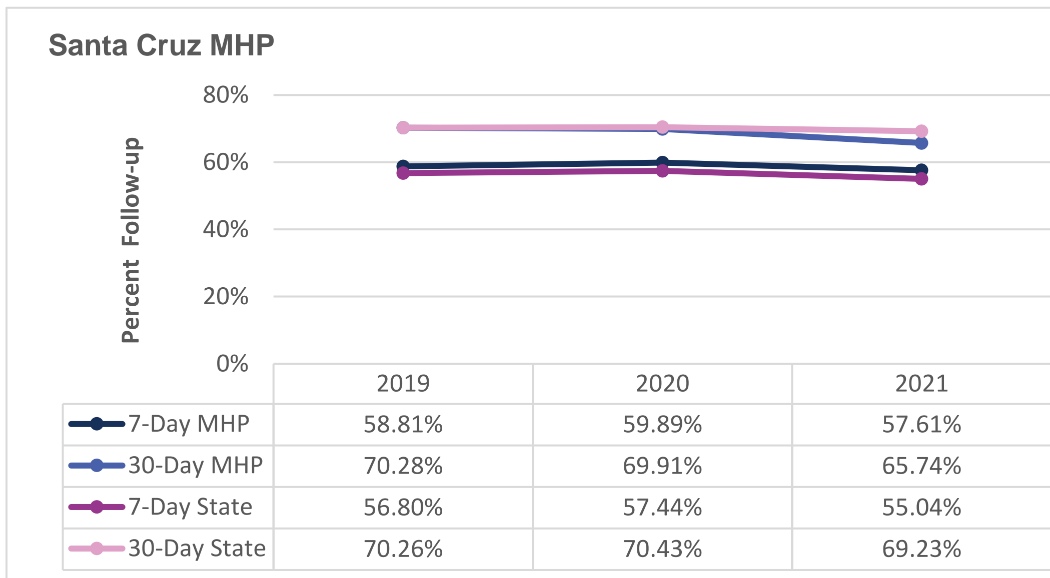
- The number of unique beneficiaries receiving psychiatric inpatient services declined in CY 2020 and then increased slightly (though not back to the CY 2019 number) in CY 2021. Total admissions followed the same pattern. The average LOS increased in CY 2020 but decreased below the CY 2019 LOS in CY 2021. Average LOS in the MHP was comparable to statewide for CY 2021.
- The MHP's AACB for inpatient services increased in CY 2020 but decreased in CY 2021 to lower than the CY 2019 average. AACB for psychiatric inpatient has consistently been markedly higher than the statewide AACB for each of the past three years, though the gap has narrowed slightly. Total approved claims for these services have been decreasing over the past three years.

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.

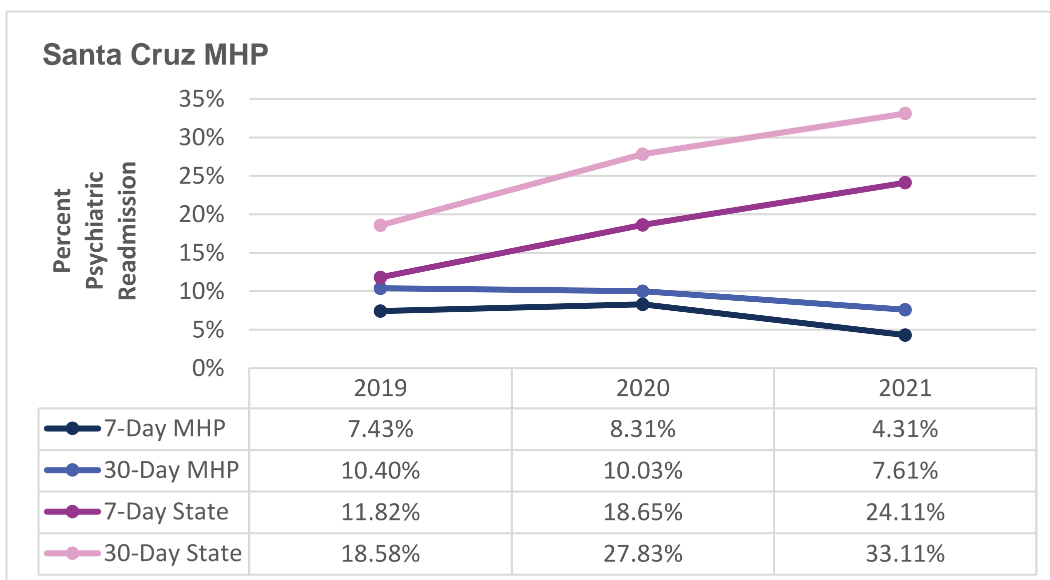
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact beneficiary outcomes and is reflected in the rate to which individuals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

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



	2019	2020	2021
7-Day MHP	58.81%	59.89%	57.61%
30-Day MHP	70.28%	69.91%	65.74%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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



	2019	2020	2021
7-Day MHP	7.43%	8.31%	4.31%
30-Day MHP	10.40%	10.03%	7.61%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

- Seven-day post psychiatric follow-up rates have been stable in the MHP and statewide over the past three years. The 30-day follow-up rate has decreased and is now somewhat lower than the statewide rate. Data submitted by the MHP as part of the ATA reflect comparable follow-up rates for FY 2021-22 (53 percent 7-day follow-up rate, 67 percent 30-day follow-up rate).
- The MHP's 7-day readmission rate decreased from CY 2020 to CY 2021, and 30-day readmissions decreased as well. Both 7- and 30-day readmission rates in the MHP are consistently much lower than statewide rates. Data submitted by

the MHP as part of the ATA reflect comparable readmission rates for FY 2021-22 (3.1 percent 7-day readmission rate, 8.7 percent 30-day readmission rate).

- The MHP reports utilization of IMD-excluded facilities as well, which are not included in the claims data used by the EQRO.

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 $7,478, the median amount is just $3,269.

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

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	416	14.44%	54.09%	$24,157,955	$58,072	$49,539
	CY 2020	365	12.58%	51.52%	$20,604,558	$56,451	$47,074
	CY 2019	336	9.98%	46.01%	$17,436,155	$51,893	$44,512

- The total count and percentage of beneficiaries in the HCB category have increased each of the past two years, as has the percentage of total claims for HCBs, the average approved claims per HCB, and median approved claims per HCB. For CY 2021, claims for HCBs represented a much higher proportion of beneficiaries (about 14.5 percent) than statewide (4.5 percent).

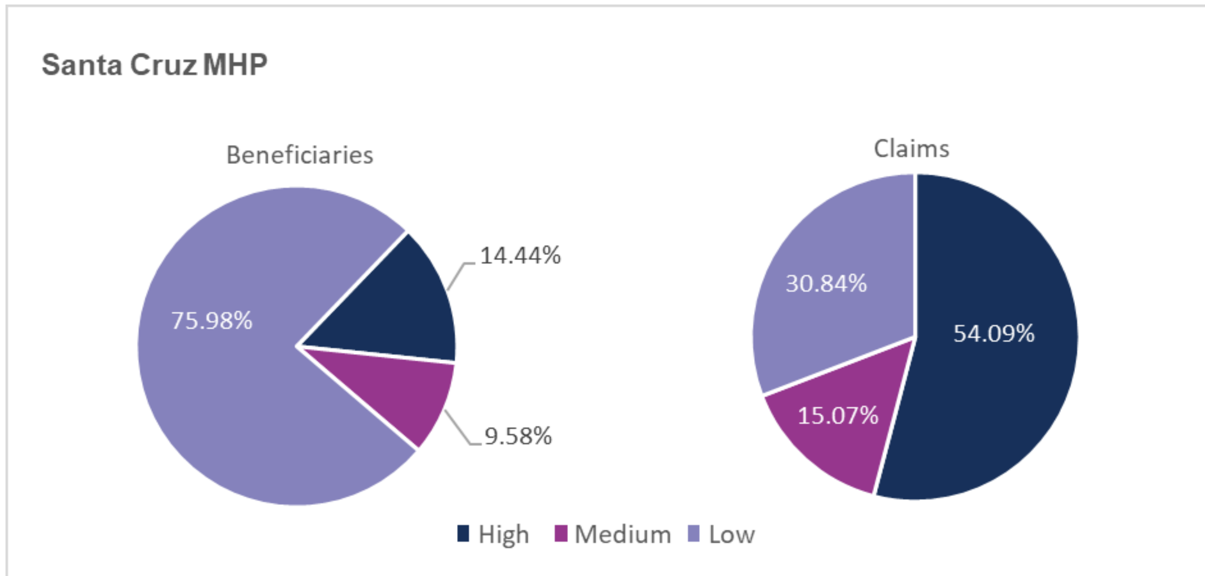
- HCBs represented 54 percent of claims in the MHP, a proportion that has been increasing. Both average and median approved claims per HCB in the MHP were higher than the statewide average and median.

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)	276	9.58%	15.07%	$6,730,543	$24,386	$24,009
Low Cost (Less than $20K)	2,189	75.98%	30.84%	$13,776,414	$6,293	$4,399

- Approximately 76 percent of beneficiaries were in the low-cost category, and the median approved claims per beneficiary in that category was $4,399. Less than 10 percent of beneficiaries were in the medium-cost category, with a median approved claims per beneficiary of $24,009.

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



- For CY 2021, approximately 76 percent of the beneficiaries served fell into the low-cost category, representing about 31 percent of claims. Medium-cost beneficiaries represented about 10 percent of the beneficiaries served and about 15 percent of claims, and HCBs represent about 14 percent of beneficiaries served and about 31 percent of claims.

IMPACT OF QUALITY FINDINGS

- The MHP has impressively low inpatient readmission rates. The collaborations between community-based providers, the MHP, and the psychiatric health facilities, as well as the resources the MHP has been directing to expand crisis care, may all be contributing factors to the MHP's success in this area.
- Increasing proportion of HCBs and allocation of over 50 percent of claims to high-cost services may suggest challenges in the MHP's ability to provide routine and ongoing low-cost services, such that beneficiaries are using crisis and acute services with increasing frequency.
- The MHP's focus on outcomes, rather than compliance or regulatory components of QI, is a rightly-timed endeavor for the system as well as the impending Comprehensive Quality Strategy.

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: Face-to-Face Adult Therapeutic Services

Date Started: 03/2021

Date Completed: 12/2022

Aim Statement: Can the Santa Cruz County MHP transition from 87 percent phone-based to at least 60 percent face-to-face adult therapeutic services—and as a result, achieve a 20 percent improvement in [the] ANSA Impact Scores and a 20 percent increase in [beneficiaries] served and services per [beneficiary]—between the second half of 2020 (baseline) and the second half of 2022 (conclusion of PIP)?

Target Population: Adults who were enrolled in the Adult Mental Health program.

Status of PIP: The MHP's clinical PIP is completed.

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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

Summary

The MHP noted a decrease in wellbeing of adult beneficiaries after the onset of COVID-19, as determined by a decrease in ANSA Impact Change Scores. The team hypothesized that this was, in part, due to increased use of telephonic services, which do not allow for the full range of therapy interventions, visual observation of the beneficiary's presentation, development of a therapeutic alliance, and use of therapeutic tools such as collaborative treatment planning. The team's intervention was to transition phone-based services to face-to-face services, either videoconferencing or in-person. To facilitate this transition, the team (1) prepared the office space and technologies to ensure COVID-19 safe environment; (2) trained clinicians on conducting video-therapy; (3) provided psychoeducation to beneficiaries and addressed concerns regarding videoconferencing and resuming in-person services; and (4) providing technology to beneficiaries who lacked technology or a confidential space to participate in treatment.

Over the course of the project, there was a shift in face-to-face appointments, from 36 percent at the start of the project, 64 percent midway through the project, and 77 percent at the conclusion of the project. However, the team did not see the expected increases in the five outcome measures: average impact change score; number of beneficiaries served; number of beneficiaries served per therapist; number of therapy sessions per beneficiary; and number of minutes of therapy per beneficiary. The team concluded the project with an analysis of factors that may have prevented the expected outcomes including the pandemic itself decreasing beneficiary wellbeing and reductions in the clinical workforce, which would affect the remaining outcome measures.

TA and Recommendations

As submitted, this clinical PIP was found to have high confidence. The MHP identified an area needing improvement, provided training then applied the intervention, and measured outcomes. While the outcomes were not as anticipated, the team learned lessons from the project (e.g., on beneficiary choice in service modality) and articulated confounds in the project, which could be used to apply to implementing future projects.

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

- To use past MHP performance as a benchmark for improvement, which the team did in a subsequent, post-review submission of the PIP.

NON-CLINICAL PIP

General Information

<u>Non-Clinical PIP Submitted for Validation</u>: FUM

<u>Date Started</u>: 12/2022

Aim Statement: By March 2024, the MHP aims to achieve or improve upon the 7- and 30-day follow-up rates (51.4 percent and 66.4 percent respectively) for Medi-Cal beneficiaries with primary diagnosis of mental illness by [improving communication between hospitals and the behavioral health departments].

Target Population: Medi-Cal beneficiaries, age 13 and older, who are admitted to an ED with a principal diagnosis of mental illness or intentional self-harm.

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

Summary

The MHP's 7- and 30-day follow-up rates for mental illness related to ED visits declined from FY 2020 and 2021. While the decline was not appreciable (1.9 and 3.8 percentage points, respectively), the FUM workgroup determined that reducing variability would contribute to increased access to an important service, post-ED follow-up appointments. The MHP attributed the decline in the follow-up rate to three factors: non-differentiated notification of ED admission diagnosis (i.e., including admissions for somatic conditions); delayed receipt of hospital discharge summary which precludes aftercare planning; and limited or no information about unenrolled individuals discharged from the ED. The MHP's intervention is to develop a real-time alert system between BHS and local EDs regarding upcoming discharges and referrals with a primary diagnosis of mental illness. Also, the MHP will appoint two liaisons, one at the ED and one in BHS, who will serve as primary contacts and champions of mental health services and prepare and distribute promotional information about MHP services.

The MHP's interventions are still in process. The PIP team is coordinating with HIE stakeholders to augment the existing electronic system to enable real-time automated alerts of admission, which are expected in the summer of 2023. The PIP team reports that the liaisons have been appointed, but that the promotional materials have not been developed or distributed.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence. The MHP seeks to reduce variability in a service that involves coordination between care providers. The improvement strategy is centered on the systems and processes for coordination. The MHP provided more information on the systems improvement than on the process improvements (i.e., the ED and MHP liaison process and the promotional material).

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

- Provide more detail on the role and function of the ED and MHP liaisons.
- Elaborate on the distribution of the promotional material and its effect on post-ED follow-up appointments.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart/Avatar, which has been in use for six years. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Approximately 1.2 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is allocated to the MHP but managed by another county department. The IS allocation is unchanged from the prior EQR.

The MHP has 513 named users with log-on authority to the EHR, including approximately 190 county staff and 323 contractor staff. Support for the users is provided by 5.42 full-time equivalent (FTE) IS technology positions. Currently there are two FTE IS vacancies, and no additional IS positions have been allocated since the last EQR.

As of the FY 2022-23 EQR, all contract providers have access to directly enter clinic data into the MHP's EHR. Contractor staff have 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 orders 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	5%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	90%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	5%
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 has a PHR that beneficiaries can use to view future appointments, schedule or request new appointments, receive appointment reminders, view active medication prescriptions, and send and receive secure messages. BHS is in the process of upgrading the PHR, and the MHP is coordinating the rollout with Netsmart.

Interoperability Support

The MHP is a member or participant in the Santa Cruz Health Information Exchange, a HIE. Currently, the HIE is used to receive alerts for ED visits for beneficiaries who are already receiving services through the MHP. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Mental health and alcohol and drug contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- Contract providers are able to directly enter clinical and service data into Avatar, facilitating strong interoperability and providing the MHP with robust data that can be used in QI efforts.
- The presence of longstanding fiscal/billing staff in the MHP, combined with cross training practices that have been implemented, contributes to the MHP's low claims denial rate and supports the financial stability of the MHP.
- Despite increased demands on staff, associated with the implementation of CalAIM initiatives, the budget allocation dedicated to IS (1.2 percent) was the same as the previous year and is low compared to other medium sized counties. The EQRO found an average allocation of 3.8 percent for medium sized counties for reviews conducted in FY 2021-22.
- While the MHP has an Operations Continuity Plan (OCP) in place to maintain readiness in case of a cyber-attack or other emergency, it does not execute annual testing of the OCP or maintain an estimated timeline for the restoration of the EHR to operational status in the event of a disruption.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either adjudicated or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2021.

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	7,290	$2,896,507	$8,042	0.28%	$2,796,250
Feb	7,597	$3,093,715	$0	0.00%	$3,012,463
Mar	9,119	$3,649,150	$17,814	0.49%	$3,531,540
April	10,140	$3,988,752	$2,660	0.07%	$3,394,710
May	8,897	$3,926,051	$50,093	1.28%	$3,276,781
June	7,346	$3,492,195	$106,230	3.04%	$3,124,248
July	7,308	$3,834,425	$149,949	3.91%	$3,454,570
Aug	7,726	$4,254,062	$114,485	2.69%	$3,756,252
Sept	7,575	$3,934,097	$82,864	2.11%	$3,722,540
Oct	7,652	$3,658,223	$3,351	0.09%	$3,586,809
Nov	7,035	$3,389,395	$37,106	1.09%	$3,323,625
Dec	6,558	$3,321,251	$22,333	0.67%	$3,163,952
Total	**94,243**	**$43,437,823**	**$594,927**	**1.37%**	**$40,143,740**

- The MHP's claims data reflects generally consistent billed amounts throughout CY 2021.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Late claim submission	51	$331,655	55.75%
Other healthcare coverage must be billed before submission of claim	16	$201,506	33.87%
Beneficiary not eligible or non-covered charges	27	$29,925	5.03%
Medicare Part B must be billed before submission of claim	33	$16,210	2.72%
Service line is a duplicate and a repeat service procedure code modifier not present	24	$15,630	2.63%
Total Denied Claims	**151**	**$594,926**	**100.00%**
Overall Denied Claims Rate	**1.37%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The majority of denied dollars were denied for being late (55.75 percent), followed by needing to bill other healthcare coverage first (33.87 percent). These two reasons accounted for nearly 90 percent of denied dollars in the MHP but only 67 claims out of 94,243 claim lines in CY 2021.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP has completed several IS projects since the last EQR and successfully navigated system-wide changes related to CalAIM:
    - The launch of a dynamic behavioral health provider directory that is bilingual and accessible to beneficiaries and providers alike.
    - Creation of a user compliance/peer review report that allows supervisors to look at EHR elements (e.g., problem lists, ANSA scores) in aggregate for their team members.
    - Integration of the statewide Adult and Youth Screening and Transition of Care Tools into Avatar.
    - Adaptation of progress notes in Avatar in response to CalAIM.
- Also, the MHP has been successful in transitioning to 274 standard submissions of provider network data since December 2022 (as per BHIN 22-032).
- Staff should be commended for their efforts in completing these projects despite vacancies and challenges with recruitment.
- The MHP's current IS budget and staffing levels are unlikely to be sufficient to respond to new demands and requirements (e.g., implement payment reform and expand reporting and tracking of HEDIS measures). For example, the MHP reports it will likely have to pause 274 standard submissions temporarily in order to direct staff resources to meeting other important CalAIM milestones. With the current staffing levels and resources, existing staff are challenged to figure out how to best prioritize and complete tasks.

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 provided a summary of the 2022 CPS survey results, including identifying some areas of improvement—in the outcomes, functioning, and social connectedness domains for older adults and youth.

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 culturally diverse group of eight-ten TAY beneficiaries who have initiated/utilized services within the preceding 12 months. The focus group was held via videoconference and included six participants. All consumers participating receive clinical services from the MHP.

Focus group participants described having a choice for service delivery, either in-person or telehealth. New beneficiaries had no concerns regarding the wait time for services; a coordinator helped them get connected with services and assisted with setting up transportation. Participants described a next-day response to urgent conditions. Through the MHP, participants were also connected to other supportive services (e.g., grief support and substance use services). The TAY participants were not aware of MHP resources or assistance for employment but they were aware of assistance with housing. The participant's primary interaction with the MHP was for mental health services; participants were not aware of opportunities to give input their input through stakeholder meetings; participate on committees; or work with peer employees. Much of

the participants' information about MHP services and events came through their treatment team and the "coordinator" in particular.

The focus group participants did not have any recommendations for service improvements.

Consumer Family Member Focus Group Two

CalEQRO requested a culturally diverse group, including of Latino/Hispanic, parents/caregivers of youth beneficiaries who mostly have initiated/utilized services within the diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held via videoconference and included six participants. A Spanish language interpreter facilitated this focus group. All family members participating have a family member who receives clinical services from the MHP.

Parents/caregivers reported one to two months for their children to get connected with ongoing services. Transportation to services was not a concern for the participants; however, they shared that there are some who need transportation assistance but are unsure of how to obtain it. Participants appreciated that if appointments were missed, it was easy to reschedule and conduct it through telehealth (videoconferencing). Participants learn information about the MHP and upcoming services and events from their treatment team members, especially the therapist. Regarding changes to services over the past year, participants remarked on the decrease in the number of counselors. When one participant had requested a change of provider for their child, it took four months to coordinate. Also, one participant remarked that timely psychiatry appointments could be difficult to obtain. Overall, the focus group participants were satisfied with the services that their children received and reported that the MHP made it possible for them to be active participants in their children's care.

Recommendations from focus group participants included:

- Provide more group service for youth.
- Hire more psychiatrists.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Line staff, of all disciplines, were a key source of disseminating information about SMHS and coordinators, in particular, are key to beneficiaries' perceptions of the quality of the services that they receive. The focus group participants were not aware of other ways to provide feedback besides directly to staff or the CPS. For the 2022 CPS, the MHP reported a 79 percent completion rate, which is approximately 13 percent of beneficiaries served in CY 2021. With the MHP's renewed focus on the beneficiary experience, there are opportunities to investigate the areas of low performance on the CPS. Besides the CPS, the MHP obtains stakeholder feedback from Mental Health Services Act focus groups and Mental Health Advisory Board.

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 track record of successful award of grants and leveraging grant funds to expand existing programs and develop new ones. (Access, Timeliness, Quality)
2. The MHP has a broad base of post-hospitalization supportive services, which likely contributes to low rehospitalization rate. (Access, Timeliness)
3. Through the aid of a consultant group, the MHP has refocused its quality management program on outcomes and the beneficiary experience and less on compliance. (Quality)
4. The MHP is enhancing its peer integration efforts by: supporting peer certification for current peer employees; developing a peer respite facility, Second Story Peer Respite House; and developing peer-run center-based services. (Access, Quality)
5. Despite vacancies and a small staff, the MHP has successfully implemented changes required under CalAIM, including 274 standard submissions of provider network data, integration of the Adult and Youth Screening and Transition of Care Tools into Avatar and adaptation of progress notes in the EHR. (Access, Quality, IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP noted that it has limited capacity to do community outreach; it does not have staff in BHS who are dedicated to outreach to its population of underserved Hispanic/Latino eligibles. (Access)
2. The108 percent increase in youth requests for service has impacted the timeliness of the first offered service meeting the 10-day standard, which decreased to 58 percent meeting the standard.
3. HCBs comprise 14.44 percent of the beneficiaries served (compared to 4.5 percent statewide) and account for over 50 percent of the claimed services (compared to 33 percent statewide). (Access, Quality)
4. Not all training platforms that were suspended during the height of pandemic have resumed, specifically the training lab has not been made operational. There may be a need to develop additional training opportunities. Quality)
5. There are IS and analyst vacancies that are presenting challenges to the timely implementation of upcoming CalAIM initiatives, including payment reform and the

expansion of the use of data in QI efforts (e.g., HEDIS ADD, APM, APC, and APP). (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. Investigate reasons and develop and implement strategies to improve outreach to Hispanic/Latino communities and Medi-Cal eligibles. The MHP might consider applying for grants that focus on community health workers (or promotoras) as a strategy to reach underserved populations. (Access, Quality)
2. Investigate reasons and develop and implement strategies to provide timelier first service appointments. (Access, Timeliness)
3. Investigate reasons for the increasing proportion of HCBs to determine whether the service patterns and levels of care are clinically appropriate; implement improvement strategies where needed. (Access, Timeliness, Quality)
4. Develop and implement strategies to provide training, particularly in evidenced-based practices and treatment modalities, to all service providers. (Quality)
5. Develop and implement concrete strategies for filling existing IS and analytic vacancies, which would improve data and analytics capacity for QI and support IS functions necessary for CalAIM implementation. (Quality, IS) (This recommendation is a follow-up from FY 2021-22.)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

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 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 Cruz MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Access to Care
Timeliness of Services
Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Satisfaction
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Specialized Service Systems: Children's Crisis Services
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Information Systems Billing and Fiscal Interview
EHR Deployment

CalEQRO Review Sessions – Santa Cruz MHP
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Leah Hanzlicek, PhD, MSW, Information Systems Reviewer
Ewurama Shaw-Taylor, PhD, CPHQ, Lead Quality 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.

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Acevedo, LMFT	Mariela	Senior Mental Health Client Specialist	Santa Cruz County Health Services Agency (HSA)
Aguilar	Ileana	QI Program Coordinator	Santa Cruz County HSA
Aguirre	Andres	Mental Health Manager, Opal Cliff Residential and Wheelock Residential	Front St. Inc.
Allemandi	Rocky	Program Manager, Children's Behavioral Health	Santa Cruz County HSA
Anderson	Sarah	Adult Behavioral Health Director	Encompass Community Services (Encompass)
Annon	Robert	Mental Health Supervising Client Specialist	Santa Cruz County HSA
Avila	Sara	Utilization Review Specialist	Santa Cruz County HSA
Bare	Adriana	Senior Health Services Manager	Santa Cruz County HSA
Barker	Shelly	Health Services Manager	Santa Cruz County HSA
Bassi	Christine	Clinical Manager	Encompass
Bauman	Zak	Lead Crisis Clinician	Pajaro Valley Prevention and Student Assistance (PVPSA)
Bernard	Adrian	Manager - Second Story Residential Program	Encompass
Blaskovich	Dagny	Director of Family, Youth and Clinical Services, Volunteer Center	SCBH
Bolton	Beloved	Utilization review specialist	Santa Cruz County HSA
Boyer	Maria	Peer Navigator & 2nd Story Night	Encompass
Brown, MD	B??	Chief Psychiatry	Santa Cruz County HSA

Last Name	First Name	Position	County or Contracted Agency
Cantrell-Warren	Tiffany	Director of Behavioral Health	Santa Cruz County HSA
Cantu	Genesis	North County Case Manager, Wellness Connect	Community Connection
Cartee	Ashley	Chief Executive Officer	Parents Center
Chicoine	David	Utilization review specialist	Santa Cruz County HSA
Cisneros, Sr.	Kevin	Mental Health Client Specialist II	unknown
Cozy	Tracy	Lead Intake Counselor	El Dorado, Telos, Casa Pacific
Crews	Daniel	Business Analyst, IT	Santa Cruz County HSA
Cunningham, LPHA	Jessica	LPHA Support	Front St. Inc.
Debbie	Garza	Direct Provider Staff	Santa Cruz County HSA
Dettle	Donovan	Associate Therapist	Parents Center
Dickely	Brianna	Mental Health Recovery Specialist	Parents Center
Eaton	Joseph	Residential Counselor	Encompass
Emery-Napp	Brianna	Mental Health Counselor	PVPSA
Engeldrum Magana	Amanda	QI, Outpatient Youth Services	PVPSA
Fernandez	Jorge	IT Manager III	Santa Cruz County HSA
Flagg-Wilson	Leah	Utilization review specialist	Santa Cruz County HSA
Goeckermann, LMFT	Celia	Clinical Manager	Encompass

Last Name	First Name	Position	County or Contracted Agency
Gonzales	Kaitlyn	Clinical Lead, Transition Age Youth Team	Encompass
Gosk	Jen	Lead Licensed Practitioner of the Healing Arts	Front Street Inc
Hackett	Karen	Program Coordinator	Santa Cruz County HSA
Harley	Gavin	Mental Health Coordinator	unknown
Harrison	Steven	Mental Health Client Specialist	Santa Cruz County HSA
Iles	Sabina	Youth and Family Director	Encompass
Jefferies, LCSW	Johanna	Supervisor, Access Team	Santa Cruz County HSA
Kern	Karen	Senior Behavioral Health Manager	Santa Cruz County HSA
Lansing, LCSW	Jeremy	Therapist	Santa Cruz County HSA
Long	Danielle	Manager, Crisis Continuum	Santa Cruz County HSA
MacGregor	Cynthia	MHSS Manager	Front St. Inc.
MacKinnon	Phoenix	Peer Counselor, 2nd Story Nighttime	Encompass
Marashian	Katherine	Therapist, Juvenile Hall	Santa Cruz County HSA
Mast	Nancy	Utilization review specialist	Santa Cruz County HSA
McCormick, LMFT	Eileen	Clinical Manager, Youth Services	Encompass
McLaughlin	Erin	Senior Manager for Residential Programs	Encompass
Miranda	Araceli	Clinical Manager	Parents Center
Movshovitz	Eileen	Team Supervisor, MOST Team	Santa Cruz County HSA

Last Name	First Name	Position	County or Contracted Agency
Nair	Latha	Medical Director	Santa Cruz County HSA
Olinger	Kayla	Program Director at Wellness Connect	Community Connection
Ortiz	Erica	Administrative Services Officer	Santa Cruz County HSA
Otlin	Stacey	Clinical Director	Haven of Hope
Owen	Madea	Utilization Review Specialist	Santa Cruz County HSA
Periasamy	Sankamitra	Mental Health Coordinator	unknown
Perry	Lily	Program Manager	Encompass
Polanko	Davina	unknown	Haven of Hope
Quiroga	Jose	Therapist	unknown
Ramirez	Ruth	Mental Health Coordinator	unknown
Ramirez-Plageman	Gina	Mental Health Liaison	Santa Cruz Police Department
Robertson, LCSW	Subé	QI Manager/Interim QI Director (Senior Behavioral Health Manager)	Santa Cruz County HSA
Rocha	Camille	Therapist, ASW	Haven of Hope
Russell	James	Senior Behavioral Health Manager	Santa Cruz County HSA
Sisti	Ryan	Supervisor	Santa Cruz County HSA
Soria	Elizabeth	Administrative Services Manager	Santa Cruz County HSA
Stroth, LCSW	Vince	Supervising MH Client Specialist, Children's Behavioral Health	Santa Cruz County HSA
Sumner	Kelly	Manager of Youth Services	Encompass

Last Name	First Name	Position	County or Contracted Agency
Suski	Ellen	Utilization review specialist	Santa Cruz County
Susskind	Jennifer	Project Management, Consultant	Praxis Consulting
Tisdale	Sarah	Director of Compliance and QI	Encompass
Travers	Amanda	Senior Mental Health Client Specialist II	Telecare
Turnbull	Andrea	Behavioral Health Program Manager	Santa Cruz County HSA
Turnbull-Pedrazzini	Kelsey	Senior Program Coordinator	Community Connection
unknown	Belinda	Clinician	Santa Cruz County HSA
unknown	Debs	On-Call Counselor	Encompass
unknown	Gabriela	Counselor, Youth Services	Encompass
unknown	Jonathan	Peer Navigator	Encompass
unknown	Joshua	unknown	unknown
unknown	Karl	Residential Counselor	Encompass
unknown	Wendy	Residential Specialist	Encompass
Wade	Jocelyn	Peer Navigator	Encompass
Warnke	Maria Eugenia	IT Business system analyst	Santa Cruz County HSA
Wong	Gian	IT App Dev/Sup Analyst III	Santa Cruz County HSA
Yarnell	Meg	Health Services Manager	Santa Cruz County HSA
Zamudio	Stephanie	Lead Early and Periodic Screening, Diagnostic, and Treatment Clinician	PVPSA

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP attributed a decreased in adult beneficiary outcomes during COVID-19 to a decrease in the use of therapeutic interventions, decline in visual observation of the beneficiary's presentation, and reduced therapeutic alliance due to the use of telephonic services. The intervention was to transition phone-based services to face-to-face services, either videoconferencing or in-person. The MHP effectively transitioned to face-to-face services but did not see the corresponding gains in outcomes.

General PIP Information
MHP/DMC-ODS Name: Santa Cruz
PIP Title: Face-to-Face Adult Therapeutic Services
PIP Aim Statement: Can the Santa Cruz County MHP transition from 87 percent phone-based to at least 60 percent face-to-face adult therapeutic services—and as a result, achieve a 20 percent improvement in [the] ANSA Impact Scores and a 20 percent increase in [beneficiaries] served and services per [beneficiary]—between the second half of 2020 (baseline) and the second half of 2022 (conclusion of PIP)?
Date Started: 03/2021
Date Completed: 12/2022
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): Adults who were enrolled in the Adult Mental Health program
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): 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): transition from phone-based to in-person therapy services

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Average Impact Change Score	July – December 2020	1.93 (n=28)	July – December 2020	1.92 (n=35)	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of clients served	July – December 2020	273	July – December 2020	227	☐ 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
Number of clients per therapist served	July – December 2020	34.1 beneficiaries/ therapist	July – December 2020	32.4 beneficiaries/ therapist	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of therapy sessions per client	July – December 2020	10.6 sessions/ beneficiary	July – December 2020	10.2 sessions/ beneficiary	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Minutes of therapy per beneficiary	July – December 2020	516 minutes/ beneficiary	July – December 2022	496 minutes/ beneficiary	☐ 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): Completed

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.

PIP Validation Information
EQRO recommendations for improvement of PIP: Use past MHP performance as a benchmark for expected outcomes, which the team did in subsequent post-review submission of the PIP.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The MHP's 7- and 30-day follow-up rates for mental illness for ED visits declined from FY 2020 and 2021. The MHP's goal is to reduce variability in the follow-up rates and to increase access to post-ED follow-up appointments for existing and new beneficiaries. The MHP's intervention is to develop a real-time alert system between the MHP and local EDs regarding upcoming discharges and referrals for mental health services.

General PIP Information
MHP/DMC-ODS Name: Santa Cruz County
PIP Title: FUM
PIP Aim Statement: By March 2024, the MHP aims to achieve or improve upon the 7- and 30-day follow-up rates (51.4 percent and 66.4 percent respectively) for Medi-Cal beneficiaries with primary diagnosis of mental illness by [improving communication between hospitals and the behavioral health departments].
Date Started: 12/2022
Date Completed: ongoing
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): Medi-Cal beneficiaries, age 13 and older, who are admitted to an ED with a principal diagnosis of mental illness or intentional self-harm.

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):

1. Appoint two liaisons, one at the ED and one BHS.
2. Prepare and distribute promotional information about MHP services.

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):

Develop a real-time alert system between BHS and local EDs regarding upcoming discharges and referrals with a primary diagnosis of mental illness.

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
7- and 30-day post ED follow-up rates	CY 2021	49.7% 62.6%	☒ Not applicable—PIP is in planning or implementation phase, results not available	n/a	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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: • Provide more detail on the role and function of the ED and MHP liaisons. • Elaborate on the distribution of the promotional material and its effect on post-ED follow-up appointments.

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.