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

## SOLANO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

**California Department of Health Care Services (DHCS)**

Review Dates:

**May 16-17, 2023**

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# EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Solano" may be used to identify the Solano County MHP, unless otherwise indicated.

## MHP INFORMATION

**Review Type** — Virtual

**Date of Review** — May 16-17, 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 | 3 | 3 | 0 |
| Quality of Care | 10 | 4 | 6 | 0 |
| Information Systems (IS) | 6 | 4 | 2 | 0 |
| **TOTAL** | **26** | **15** | **11** | **0** |

### Table C: Summary of PIP Submissions

| Title | Type | Start Date | Phase | Confidence Validation Rating |
|---|---|---|---|---|
| Mobile Crisis | Clinical | 12/2021 | Other: Completed | Moderate |
| Creating Inclusive Care Sites | Non-Clinical | 07/2021 | Second Remeasurement | Low |

### Table D: Summary of Consumer/Family Focus Groups

| Focus Group # | Focus Group Type | # of Participants |
|---|---|---|
| 1 | ☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other | 5 |
| 2 | ☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other | 4 |

## SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP has prioritized delivering equitable services and reducing disparities in access. The MHP has leveraged its innovation project, the Interdisciplinary Collaboration and Cultural Transformation Model that focuses on highlighting the experiences and mental health needs of the Filipino American, Latino, and Lesbian, Gay, Bisexual, Transgender, Queer/Questioning Plus (LGBTQ+) communities the county.
- The internship program is a thoughtful and well-planned approach to developing a pipeline of clinical staff. Solano Behavioral Health (BH) has put resources where it is likely to gain more return on investment.
- The MHP has developed a transition team to review readiness for step-down and ensure seamless transition to mild-to-moderate level of care (LOC) with follow-up as needed.
- The claim review and submission process is effective and efficient, resulting in a Medi-Cal denial rate of 0.74 percent, which is lower than the statewide average.
- Solano BH has incorporated a new reporting and data visualization tool that will help in monitoring services and identifying areas needing improvement.

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

- The MHP has ongoing projects and activities and has implemented several new projects over the past year, some of which have not been fully executed or monitored because of competing priorities and limited resources.

- Due to a staffing crisis, the MHP paused its community-based mobile crisis for five months due to inadequate staffing. Services resumed on May 15, 2023, for part of the county.
- The MHP's Assessment of Timely Access (ATA) still shows average times to offered non-urgent psychiatry services in excess of 20 business days for children and youth in foster care (FC).
- Beneficiaries who have contact with law enforcement secondary to a mental health crisis or condition report negative interactions and experiences.
- The hours of operation are not included on the Provider Directory on the MHP website.

Recommendations for improvement based upon this review include:

- Focus quality improvement (QI) projects and activities on some few that can reasonably be implemented and monitored with the current resources; document this work and progress in the Quality Assessment and Performance Improvement (QAPI) program workplan.
- Prioritize efforts to resume and maintain the community-based mobile crisis service.
- Investigate reasons for longer wait times and develop and implement strategies to offer psychiatry services within 15 business days of identification of need.
- Continue the work being conducted with law enforcement to jointly train more law enforcement personnel on Crisis Intervention Team (CIT).
- Include hours of operation in the Provider Directory on the Solano BH website to provide beneficiaries with information that may assist them in accessing services.

# 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 review protocol is based upon the protocols published in October 2019.

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

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

This report presents the FY 2022-23 findings of the EQR for Solano County MHP by BHC, conducted as a virtual review on May 16-17, 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 (IPC) 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 QAPI program.
- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

## HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, then “<11” is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding percentages.

# MHP CHANGES AND INITIATIVES

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

## ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place after the Coronavirus Disease 2019 (COVID-19) pandemic, during which time the MHP and Solano County's Human Resources (HR) Department experienced loss of staff. This resulted in a reduction in the ability to recruit and hire candidates for vacant MHP positions. 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 streamlined the management of children's and adult system of care, including developing a centralized assessment team for adult assessments and a transition in care team to assist with LOC transitions for adults and children.
- In June 2022, the MHP established the Performance Improvement Team as an offshoot of the Quality Assurance (QA) team that will focus on improving clinical performance. The Performance Improvement Team strives to improve outcomes, customer service, and promote efficiency. The Performance Improvement Team is also responsible for overseeing trainings within/for the MHP.
- The MHP continues to implement California Advancing and Innovating Medi-Cal (CalAIM) and establish new services, supports, and operations as necessary, including upgrades to the electronic health systems; preparations to serve approximately 2,100 SMHS beneficiaries currently served through a Kaiser carve-out; and a contract with a national vendor to guide payment reform.
- The MHP has continued to expand, recruit, and integrate peer support throughout programs and services. The MHP has had 22 applicants for the peer support specialist certification, with 15 peer employees having been approved/certified.
- In October 2022, Solano BH initiated CIT trainings for law enforcement and has trained 42 officers.

# 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:** Address staffing issues that relate to civil service clinical staffing and develop a strategy, focused on recruitment and retention, that includes recommendations for Information Technology (IT) needs. This should include salary comparisons with neighboring counties, and work schedule flexibility considerations. Some positions, such as IS, can effectively perform duties remotely, depending on position expectations and duties. Lastly, the streamlining of the hiring process is essential to ensure that selected candidates are not lost during a protracted hiring process.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The recommendation is addressed as the MHP has reviewed its staffing challenges and has developed strategies for recruitment and retention.
- The MHP compiled a list of over 20 classifications in Solano BH that are outdated and need immediate revision to meet current regulations and standards and to be able to employ more candidates that meet the qualifications (e.g., licensed professional clinical counselors).
- The MHP has formalized the Internship Program, with dedicated staff to facilitate contracts, recruitment, placement, training, and onboarding of interns. The program positions the Solano BH to develop a pipeline of experienced and qualified candidates across several disciplines to join the MHP workforce.
- The MHP has developed a process to expedite internal HR processes; however, the County HR Department is now experiencing turnover and leadership

changes. A consultant has been brought in to help redesign HR and help departments, including Solano BH, in their recruiting and onboarding of staff.

**Recommendation 2:** Analyze and revisit strategies to improve access for the Hispanic/Latino population.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- Solano BH has finalized a request for proposals to secure a contractor for outreach services to Hispanic/Latino and other (e.g., African American, Asian/Pacific Islander (API)) communities.
- Solano BH has had a six percent increase in staff identifying as Hispanic/Latino. Currently, 18 percent of the BH workforce identify as Hispanic/Latino, which reportedly aligns with the proportion of Hispanic//Latino beneficiaries served in the first quarter of FY 2022-23.
- The MHP reports that an analysis of average time to services show that Hispanic/Latino beneficiaries were offered appointments in nine days.
- The impact of the MHP's efforts to improve access for the Hispanic/Latino population can best be evaluated at the next review when claims data for 2022 will be available. For now, the CalEQRO notes that there was a 12 percent increase in the number of Hispanic/Latino beneficiaries served from CY 2020 to CY 2021.

**Recommendation 3:** Develop a crosswalk for Child and Adolescent Needs and Strengths (CANS) assessment and the Pediatric Symptoms Checklist-35 (PSC-35) data to provide LOC guidance for children and youth.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- This recommendation is rated partially met as the MHP has yet to develop a crosswalk to provide guidance on using the CANS and PSC-35 findings for LOC decision.
- Solano BH has drafted a contract for a cloud-based software system that will include a CANS LOC tool.
- For the MHP to fully meet this recommendation, the MHP must complete the conversion of the outcomes measure into a LOC instrument in consultation with the CANS developer(s) so that it is ready to be integrated into the data system.
- This recommendation will not be continued as the MHP is actively consulting and collaborating with the developers to develop a LOC from the CANS, after which integration into the electronic health record (EHR) will be easier.

**Recommendation 4:** Provide training to staff involved in children's and FC services regarding the capture of first offered non-urgent psychiatric services, followed by periodic monitoring throughout the year to assure that expected data capture is

occurring. Also, identify, address, and monitor the factors that have resulted in the first offered non-urgent adult psychiatry appointment averaging over 20 business days.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- This recommendation is partially addressed because the MHP provided training but did not do periodic monitoring of data collection process.
- Through the QA team, the MHP provided training to children and FC services staff on capturing and recording the times related to non-urgent psychiatry services.
- The QA team was not able to provide ongoing training or refreshers to remind children's staff of required timeliness tracking nor perform routine monitoring of timely access to care.
- The MHP developed a dashboard to display and review timeliness to services. The dashboard shows average times to non-urgent psychiatry services in excess of 20 business days for children and FC youth. Given the information above about consistent data collection, the completeness and accuracy of the dashboard should be considered.
- The protracted time to non-urgent psychiatry services for children is attributed to insufficient number of psychiatric providers.
- For the MHP to fully meet this recommendation, timeliness to services should be reviewed on a quarterly basis, at a minimum, by QA along with the program staff. If average times continue to exceed the 15-day standard, the MHP must make modifications to its psychiatric provider capacity and/or scheduling to positively affect wait times to non-urgent psychiatry appointments.

**Recommendation 5:** Utilizing beneficiary feedback, determine effective mechanisms for the communication of information about services, changes, and opportunities for participation. Consider presenting options such as flyers with imbedded Quick Response (QR) codes, since these individuals reported primarily using their phones to access information.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP met this recommendation by expanding the methods of communication to beneficiaries, potential beneficiaries, and the community.
- Solano BH has developed a monthly, electronic newsletter; created new flyers to advertise services and events; and added QR codes to those flyers. Solano BH is continuing the social media posts (i.e., through Facebook, Instagram, and Twitter) and updates to its website.
- Solano BH is developing communication campaigns for mental health awareness and suicide prevention through the aid of a marketing firm. The goal of this campaign is to increase reach and maximize engagement of beneficiaries.

# 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 and contracted providers in the MHP. Regardless of payment source, approximately 60.27 percent of services were delivered by county-operated/staffed clinics and sites, and 39.73 percent were delivered by contractor-operated/staffed clinics and sites. Overall, 93.75 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by county staff; beneficiaries may request services through the Access Line as well as through the following system entry points: clinic sites, child welfare services, full-service partnership programs, and the homeless outreach programs. The MHP operates a centralized access for children and decentralized access for adults that link beneficiaries to appropriate, medically necessary services. After a screening call, beneficiaries are scheduled for an assessment at a local clinic.

In addition to clinic-based MH services, the MHP provides psychiatry and mental health services via telehealth video/phone to youth and adults. In FY 2021-22, the MHP reports having provided telehealth services to 2,223 adult beneficiaries, 875 youth beneficiaries, and 268 older adult beneficiaries across 9 county-operated and 22 contractor-operated sites. Among those served, 195 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

## NETWORK ADEQUACY

An adequate network of providers is necessary for beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In

[1] CMS Data Navigator Glossary of Terms

addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B.

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For Solano 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 |
| **OON Details** | |
| **Contracts with OON Providers** | |
| Does the MHP have existing contracts with OON providers? | ☐ 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. However, the MHP is in the process of establishing contracts with OON providers.

## ACCESS KEY COMPONENTS

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

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

### Table 2: Access Key Components

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

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

- In April 2022, the MHP expanded (adult) mobile crisis countywide. This year the MHP paused the services for five months, when the contracted agency experienced a reduction in its workforce. The MHP relaunched mobile crisis (in two cities) in May 2023 with a plan to resume countywide services in June 2023.
- The MHP is building upon its innovation project—to identify underserved populations within the county—by contracting with a provider with expertise in underserved populations.
- To monitor and manage capacity, the MHP:
  - conducts a Biweekly Referral Watch for the children's system of care to assist programs to uniformly report capacity.
  - is centralizing access in the adult system of care, thereby freeing up time for more clinicians to provide ongoing clinical services.
  - is piloting open access, walk-in appointments at one of its clinics.
- Solano BH has formalized and fully funded its internship program to train, recruit, and eventually employ clinical staff in multiple disciplines. Solano BH has 11 agreements with 24 of the local and national universities whose students intern with the department.

## ACCESS PERFORMANCE MEASURES

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

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

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

The Statewide PR is 4.34 percent, with an average approved claim amount of $7,478. Using PR as an indicator of access for the MHP, while the PR has declined by 1.17 percent over the last three years the number of annual eligibles has increased by 12.86 percent, and from CY 2020 to 2021 the beneficiaries served increased by 270 individuals or 6.18 percent.

### Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

| Year | Annual Eligibles | Beneficiaries Served | Penetration Rate | Total Approved Claims | AACB |
|---|---|---|---|---|---|
| CY 2021 | 132,286 | 4,639 | 3.51% | $33,183,322 | $7,153 |
| CY 2020 | 119,938 | 4,369 | 3.64% | $28,596,463 | $6,545 |
| CY 2019 | 117,209 | 4,821 | 4.11% | $32,645,640 | $6,772 |

*Total Annual eligibles may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

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

| Age Groups | Annual Eligibles | # of Beneficiaries Served | Penetration Rate | Similar Size Counties Penetration Rate | Statewide Penetration Rate |
|---|---|---|---|---|---|
| Ages 0-5 | 14,261 | 196 | 1.37% | 1.08% | 1.96% |
| Ages 6-17 | 30,283 | 1,018 | 3.36% | 4.41% | 5.93% |
| Ages 18-20 | 6,660 | 177 | 2.66% | 3.73% | 4.41% |
| Ages 21-64 | 69,006 | 2,959 | 4.29% | 4.11% | 4.56% |
| Ages 65+ | 12,078 | 289 | 2.39% | 2.26% | 1.95% |
| **Total** | **132,286** | **4,639** | **3.51%** | **3.67%** | **4.34%** |

*Total Annual eligibles may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The overall PR for the MHP is lower than both the Statewide and Similar Size MHP PRs. It is important to recognize, however, that a substantial portion of the

county's beneficiaries are provided specialty mental health services through Kaiser.

- For the 21-64 age group, the MHP PR is higher than Similar Size MHPs and in the 65+age group, the MHP PR is higher than both Similar Size MHPs and Statewide PRs.

### 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 | 371 | 8.00% |
| Threshold language source: Open Data per BHIN 20-070 | | |

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

| Entity | Annual ACA Eligibles | Total ACA Beneficiaries Served | Penetration Rate | Total Approved Claims | AACB |
|---|---|---|---|---|---|
| MHP | 39,323 | 1,187 | 3.02% | $7,234,765 | $6,095 |
| Medium | 613,796 | 20,261 | 3.30% | $151,430,714 | $7,474 |
| Statewide | 4,385,188 | 167,026 | 3.81% | $1,066,126,958 | $6,383 |

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.The ACA beneficiary PR is lower than the MHP overall PR of 3.51 percent.
- The number of ACA beneficiaries served by the MHP increased by 10.1 percent. while the PR decreased by 6.79 percent.
- As seen in many MHPs, while the number of beneficiaries served increased, the PR decreased from the previous year due to an 18.1 percent increase in annual ACA eligibles during the COVID pandemic.
- The MHP's AACB for the ACA population is lower than both the Statewide and Medium MHP totals; however, the MHP experienced an increase in AACB. The MHP rate increased by 16.4 percent while the Statewide AACB increased by 5.9 percent and the Medium MHP AACB decreased.

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.

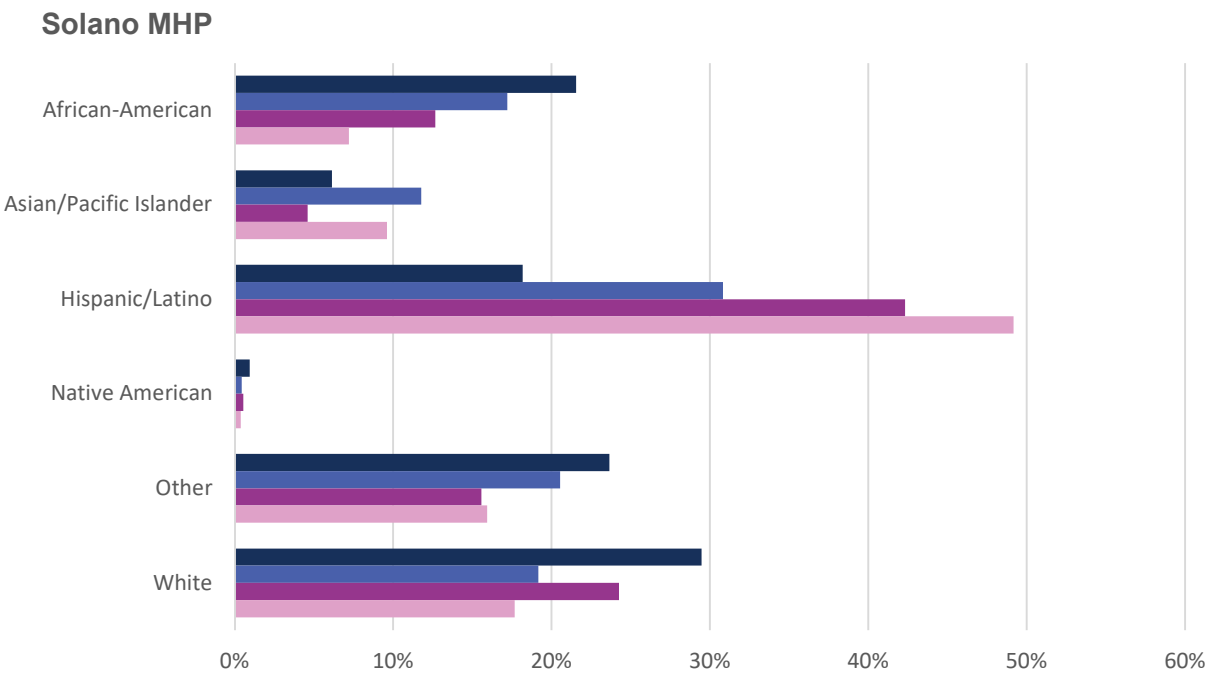
### Table 7: PR of Beneficiaries Served by Race/Ethnicity CY 2021

| Race/Ethnicity | Annual Eligibles | Beneficiaries Served | PR MHP | PR State |
|---|---|---|---|---|
| African-American | 22,778 | 1,000 | 4.39% | 7.64% |
| Asian/Pacific Islander | 15,579 | 285 | 1.83% | 2.08% |
| Hispanic/Latino | 40,792 | 844 | 2.07% | 3.74% |
| Native American | 591 | 44 | 7.45% | 6.33% |
| Other | 27,170 | 1,098 | 4.04% | 4.25% |
| White | 25,376 | 1,368 | 5.39% | 5.96% |
| **Total** | **132,286** | **4,639** | **3.51%** | **4.34%** |

*Total Annual eligibles may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- While the Hispanic/Latino population represents 30.83 percent of the annual eligibles, they represent only 18.16 percent of the beneficiaries served by the MHP. The percent of the Hispanic/Latino population served by the MHP increased by 17.12 percent served in the CY. It is noted that the MHP continues to make efforts to provide outreach to this community.
- The API community has a PR of 1.83 percent and represents 11.78 percent of the annual eligibles.
- African American and White communities comprise a higher percentage of beneficiaries served by the MHP compared to their proportion of annual eligibles in the county.

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

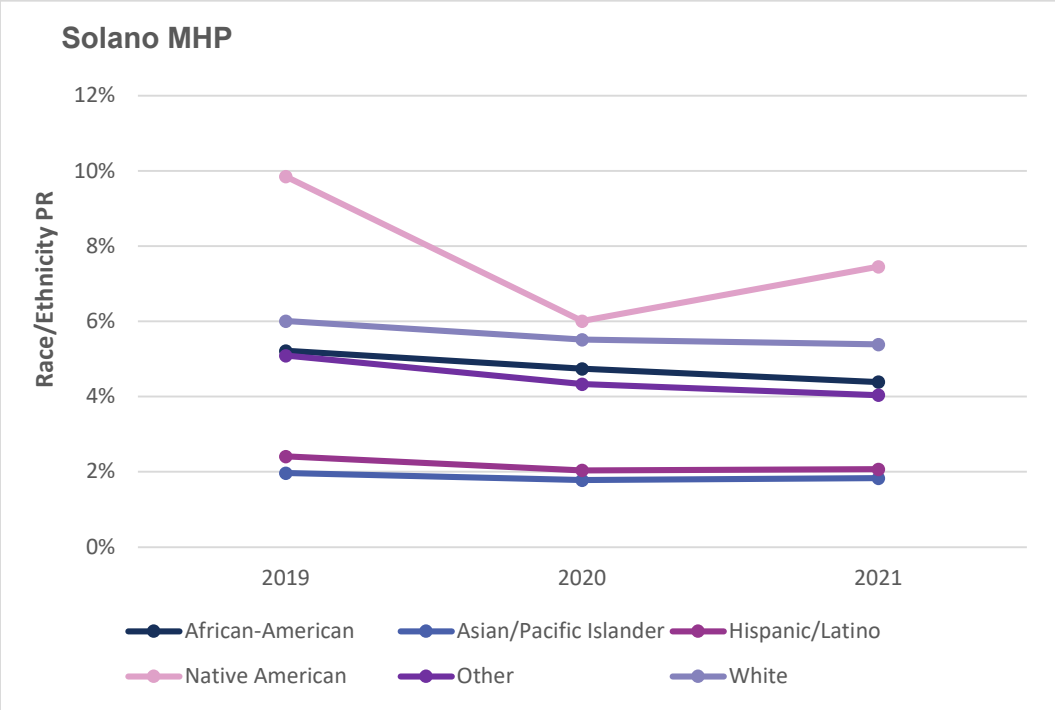



| | White | Other | Native American | Hispanic/Latino | Asian/Pacific Islander | African-American |
|---|---|---|---|---|---|---|
| MHP % Served | 29% | 24% | 1% | 18% | 6% | 22% |
| MHP % Eligible | 19% | 21% | 0% | 31% | 12% | 17% |
| State % Served | 24% | 16% | 1% | 42% | 5% | 13% |
| State % Eligible | 18% | 16% | 0% | 49% | 10% | 7% |

- The largest group served by the MHP were Whites, followed by Other, then African American.
- Whites and African Americans may be overrepresented in SMHS while API and Native Americans appear to be underrepresented.

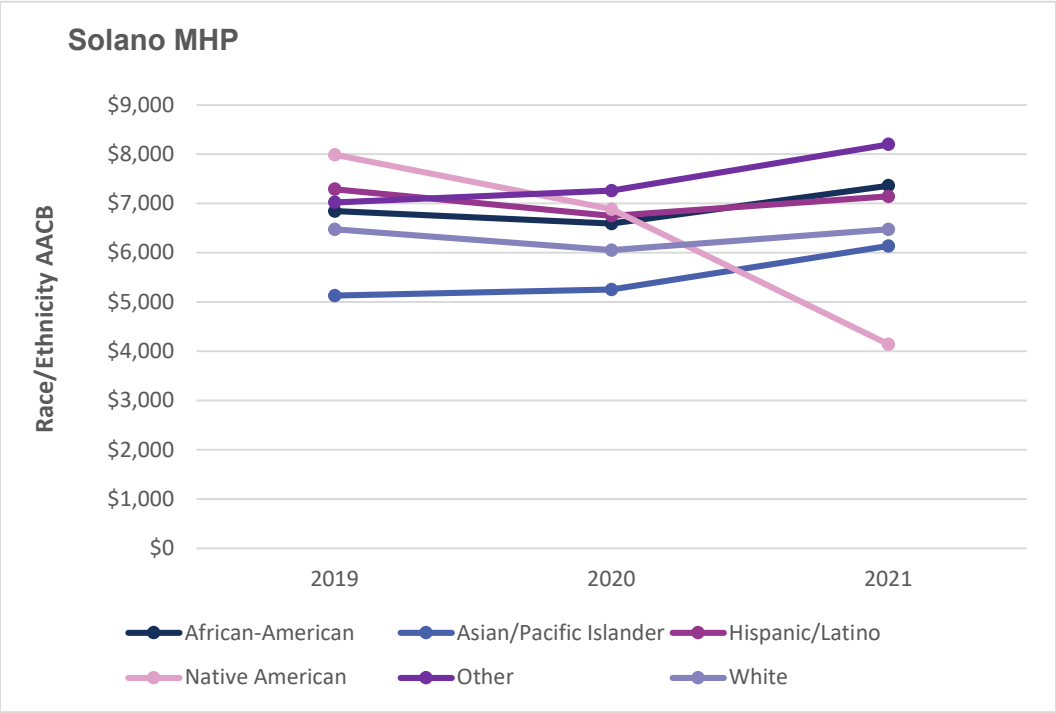
Figures 2-11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino and API), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar MHP size and the statewide for a three-year trend.

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



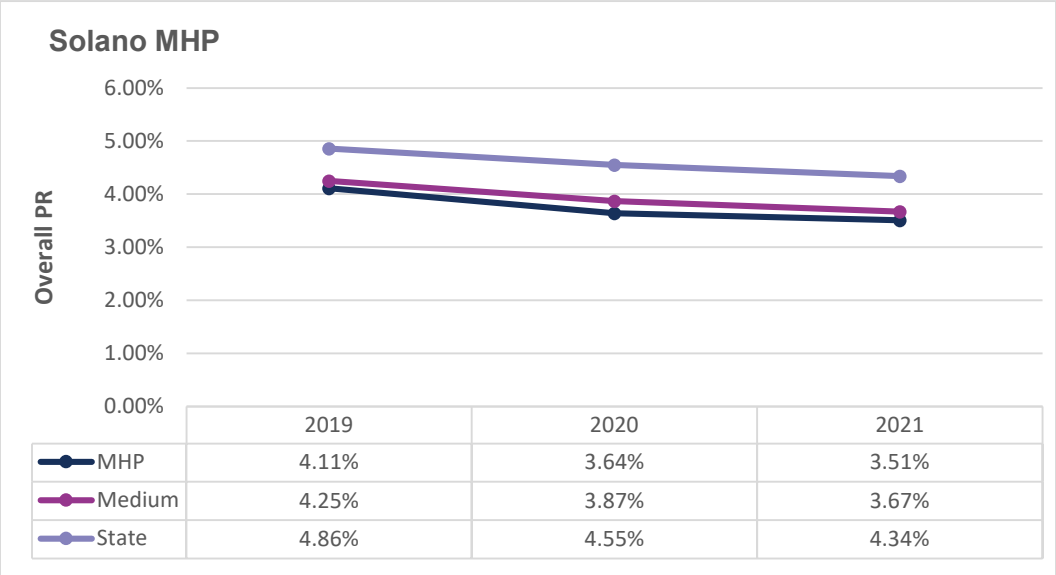

- There has been an overall decrease in PRs, due to an increase in the number of Medi-Cal eligibles in the county.
- While Native Americans have high PRs, their overall numbers are small. A change of a few Native Americans can have considerable effect on the PR, as it did in 2020.
- API and Hispanic/Latino have the lowest PRs compared to the other groups.

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




- The Native American AACB has declined sharply since 2019 by almost $4,000. Again, this variance is likely affected by small number of Native Americans being served.
- The AACBs for most other race/ethnicities have followed a similar pattern, a slight decrease in 2020 and then an increase in 2021.

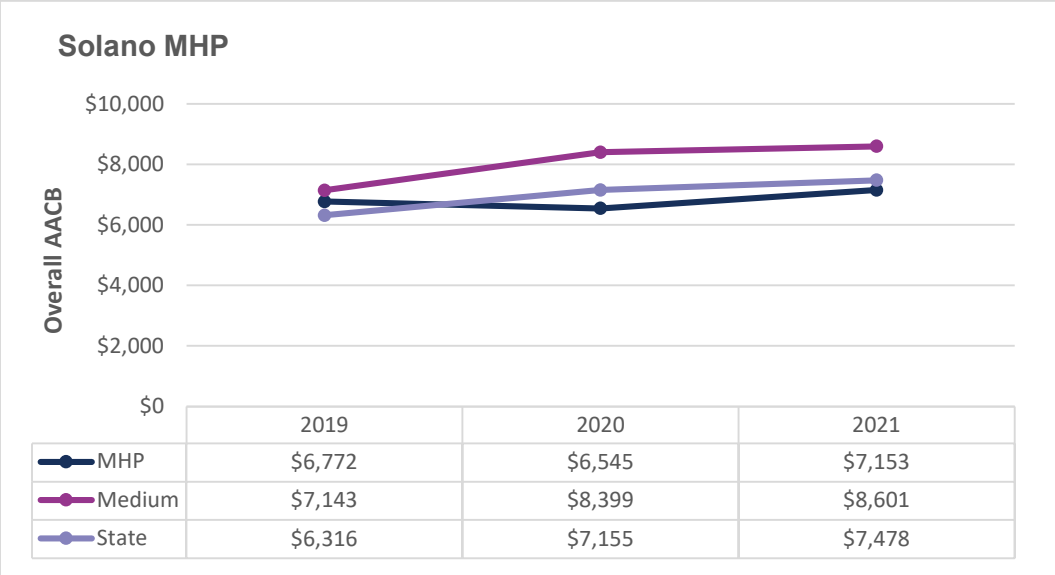
### Figure 4: Overall PR CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | 4.11% | 3.64% | 3.51% |
| Medium | 4.25% | 3.87% | 3.67% |
| State | 4.86% | 4.55% | 4.34% |

- The MHP's PR is lower than both the Medium and Statewide totals.

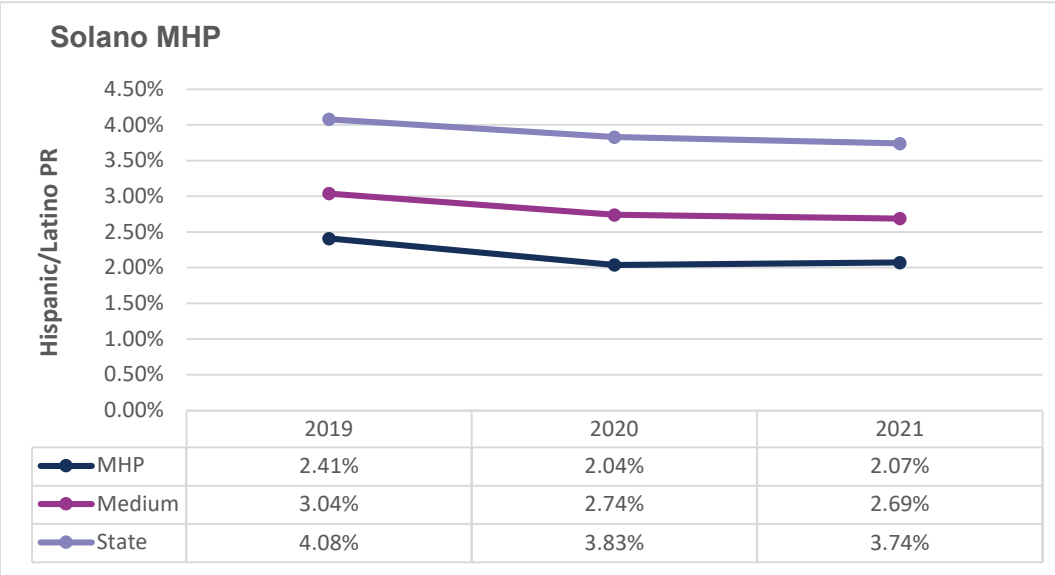
### Figure 5: Overall AACB CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | $6,772 | $6,545 | $7,153 |
| Medium | $7,143 | $8,399 | $8,601 |
| State | $6,316 | $7,155 | $7,478 |

- AACBs increased statewide in CY 2021. The MHP's AACB also increased in 2021, after a slight decrease in CY 2020, but remains lower than Medium and Statewide totals.

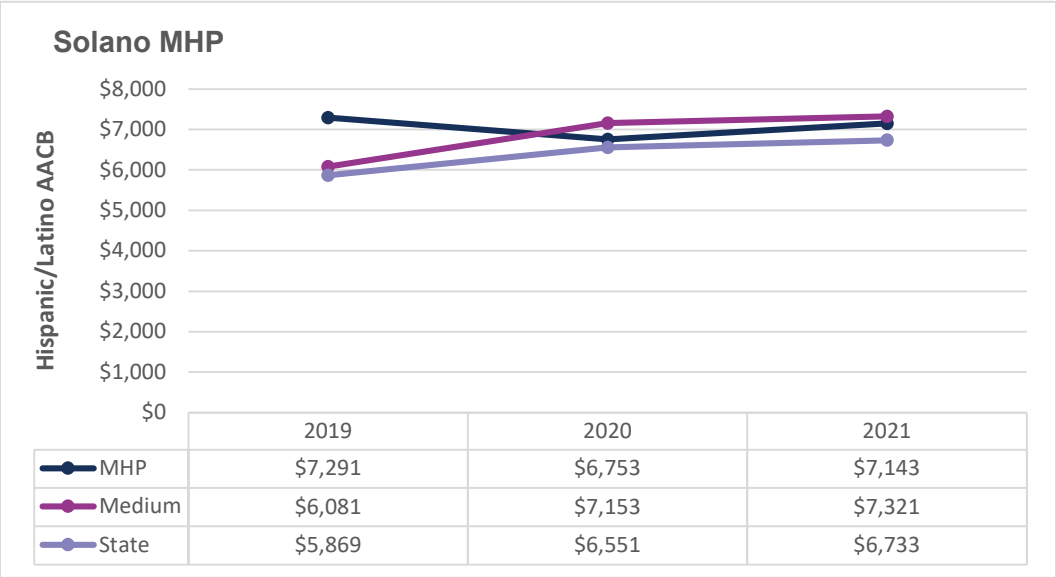
### Figure 6: Hispanic/Latino PR CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | 2.41% | 2.04% | 2.07% |
| Medium | 3.04% | 2.74% | 2.69% |
| State | 4.08% | 3.83% | 3.74% |

- There was a slight increase in the MHP Hispanic/Latino PR in 2021, but overall, the PR for this race/ethnicity remains below that of the Medium MHPs and the Statewide average.

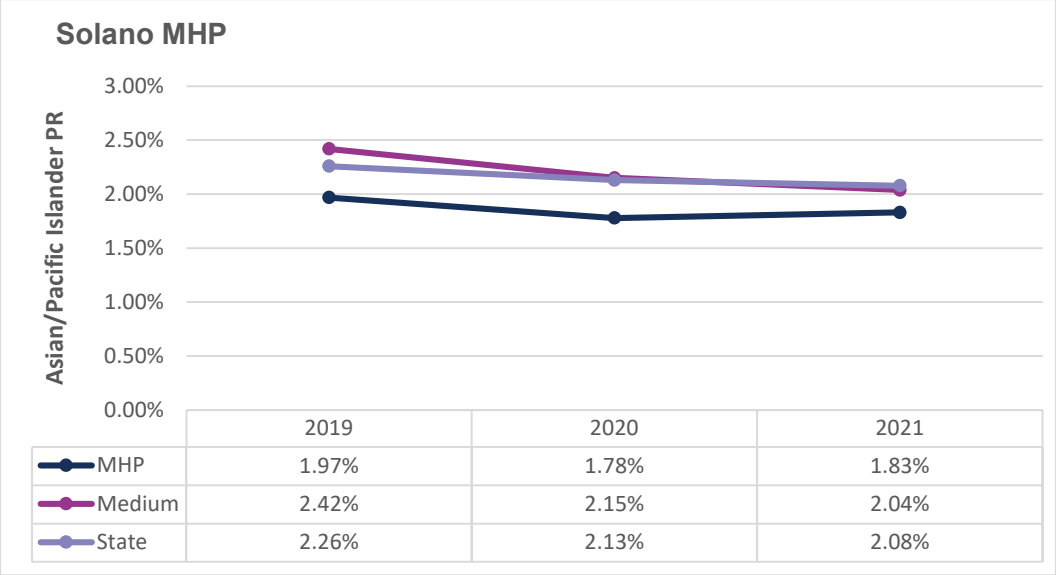
### Figure 7: Hispanic/Latino AACB CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | $7,291 | $6,753 | $7,143 |
| Medium | $6,081 | $7,153 | $7,321 |
| State | $5,869 | $6,551 | $6,733 |

- The AACB for the Hispanic/Latino beneficiaries in the MHP increased by 5.8 percent in 2021, following a decrease in 2020. Solano's AACB is lower than the Medium Counties and higher than the State total.

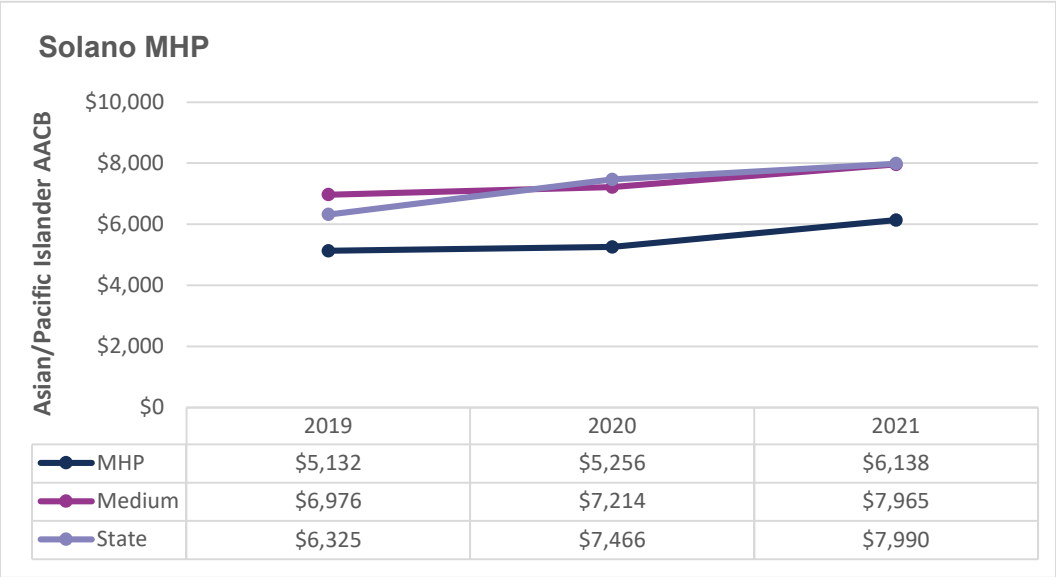
### Figure 8: Asian/Pacific Islander PR CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | 1.97% | 1.78% | 1.83% |
| Medium | 2.42% | 2.15% | 2.04% |
| State | 2.26% | 2.13% | 2.08% |

- While the PR for APIs in Medium MHPs and Statewide have decreased, there was a slight increase, by 2.8 percent, for the MHP in 2021.

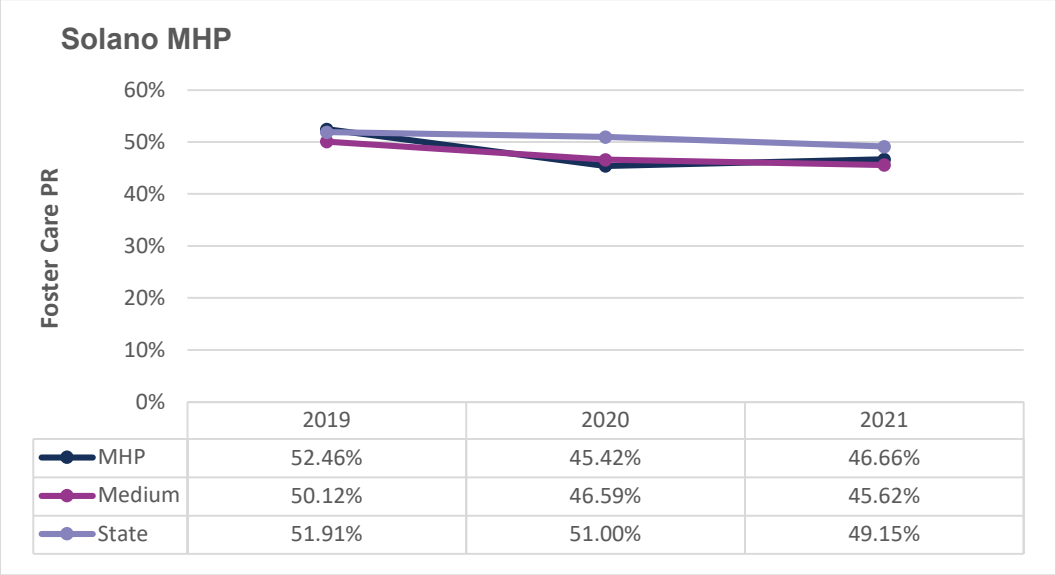
### Figure 9: Asian/Pacific Islander AACB CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | $5,132 | $5,256 | $6,138 |
| Medium | $6,976 | $7,214 | $7,965 |
| State | $6,325 | $7,466 | $7,990 |

- Statewide, there has been an increase in AACB for API beneficiaries, with the MHP average below that of the Medium MHPs and the State.
- The AACB increased by 16.78 percent for the MHP, 10.41 percent for Medium Counties, and 7.02 percent for the Statewide.

### Figure 10: Foster Care PR CY 2019-21

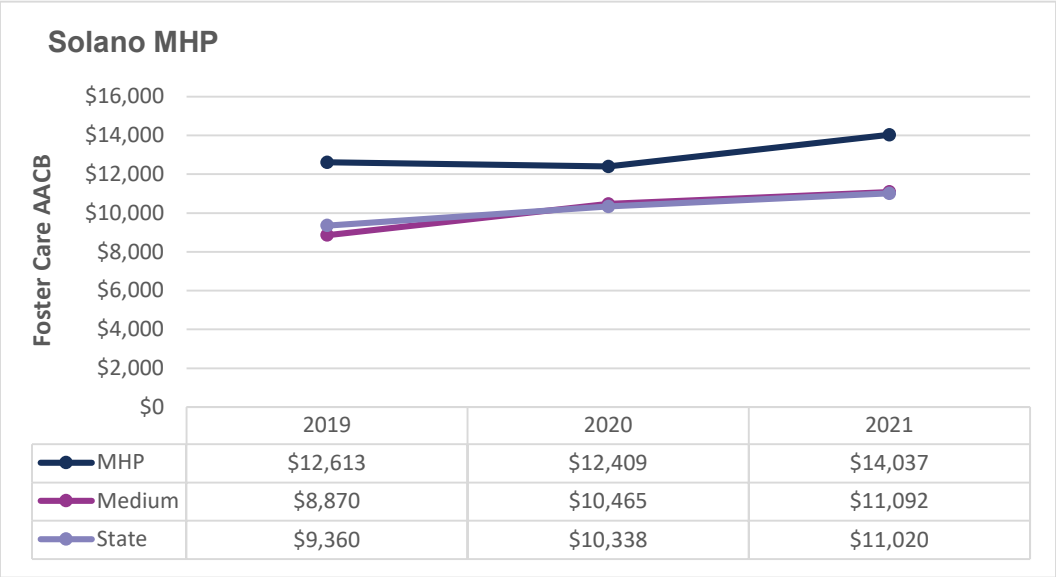



| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | 52.46% | 45.42% | 46.66% |
| Medium | 50.12% | 46.59% | 45.62% |
| State | 51.91% | 51.00% | 49.15% |

- Statewide, FC PR has remained steady at approximately 50 percent for the past three years.

- After a decrease in 2020, the MHP's FC PR increased by 2.7 percent. Both the Medium MHPs and State experienced decreases in the FC PR in 2021.

### Figure 11: Foster Care AACB CY 2019-21




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| MHP | $12,613 | $12,409 | $14,037 |
| Medium | $8,870 | $10,465 | $11,092 |
| State | $9,360 | $10,338 | $11,020 |

- AACB for youth in FC has increased each year statewide.
- The MHP AACB for youth in FC has been higher than Medium MHPs and the State for the past three years. The MHP's AACB for FC is 26.55 percent above the Medium MHPs and 27.38 percent above the State average. From 2020 to 2021 the MHP FC AACB increased by 13.12 percent.

## Units of Service Delivered to Adults and Foster Youth

### Table 8: Services Delivered by the MHP to Adults

| Service Category | MHP N = 3,426 | | | | Statewide N = 391,900 | | |
|---|---|---|---|---|---|---|---|
| | Beneficiaries Served | % of Beneficiaries Served | Average Units | Median Units | % of Beneficiaries Served | Average Units | Median Units |
| **Per Day Services** | | | | | | | |
| Inpatient | 94 | 2.7% | 10 | 8 | 11.6% | 16 | 8 |
| Inpatient Admin | 11 | 0.3% | 8 | 7 | 0.5% | 23 | 7 |
| Psychiatric Health Facility | 242 | 7.1% | 12 | 7 | 1.3% | 15 | 7 |
| Residential | <11 | - | 22 | 19 | 0.4% | 107 | 79 |
| Crisis Residential | 159 | 4.6% | 16 | 14 | 2.2% | 21 | 14 |
| **Per Minute Services** | | | | | | | |
| Crisis Stabilization | 555 | 16.2% | 1,590 | 1,200 | 13.0% | 1,546 | 1,200 |
| Crisis Intervention | 201 | 5.9% | 175 | 129 | 12.8% | 248 | 150 |
| Medication Support | 2,608 | 76.1% | 261 | 207 | 60.1% | 311 | 204 |
| Mental Health Services | 1,490 | 43.5% | 776 | 306 | 65.1% | 868 | 353 |
| Targeted Case Management | 1,136 | 33.2% | 332 | 130 | 36.5% | 434 | 137 |

- A smaller proportion of beneficiaries were served in inpatient settings (includes Inpatient, Inpatient Admin and Psychiatric Health Facility) by the MHP than the Statewide.
- The average units for Residential services were 22 days in the MHP compared to 107 days Statewide. This represented a small number of beneficiaries served.
- Medication Support services were provided to a higher proportion of beneficiaries at the MHP compared to statewide.
- Only 43.5 percent of beneficiaries received Mental Health Services compared to 65.1 percent beneficiaries statewide. COVID-19 precautions and limited access to some in-person services were thought to have contributed to the lower percentage.

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

| Service Category | MHP N = 279 | | | | Statewide N = 37,203 | | |
|---|---|---|---|---|---|---|---|
| | Beneficiaries Served | % of Beneficiaries Served | Average Units | Median Units | % of Beneficiaries Served | Average Units | Median Units |
| **Per Day Services** | | | | | | | |
| Inpatient | 17 | 6.1% | 13 | 6 | 4.5% | 14 | 9 |
| Inpatient Admin | 0 | 0.0% | 0 | 0 | 0.0% | 5 | 4 |
| Psychiatric Health Facility | <11 | - | 19 | 19 | 0.2% | 22 | 8 |
| Residential | 0 | 0.0% | 0 | 0 | 0.0% | 185 | 194 |
| Crisis Residential | <11 | - | 8 | 10 | 0.1% | 18 | 13 |
| Full Day Intensive | 0 | 0.0% | 0 | 0 | 0.2% | 582 | 441 |
| Full Day Rehab | <11 | - | 483 | 483 | 0.5% | 97 | 78 |
| **Per Minute Services** | | | | | | | |
| Crisis Stabilization | <11 | - | 1,187 | 1,200 | 3.1% | 1,404 | 1,200 |
| Crisis Intervention | 24 | 8.6% | 217 | 119 | 7.5% | 406 | 199 |
| Medication Support | 80 | 28.7% | 293 | 227 | 28.2% | 396 | 273 |
| Therapeutic Behavioral Services | <11 | - | 4,357 | 1,779 | 4.0% | 4,020 | 2,373 |
| Therapeutic FC | 0 | 0.0% | 0 | 0 | 0.1% | 1,030 | 420 |
| Intensive Care Coordination | 139 | 49.8% | 725 | 441 | 40.2% | 1,354 | 473 |
| Intensive Home Based Services | 87 | 31.2% | 1,793 | 880 | 20.4% | 2,260 | 1,275 |
| Katie-A-Like | <11 | - | 1,785 | 1,785 | 0.2% | 640 | 148 |
| Mental Health Services | 273 | 97.8% | 2,040 | 1,298 | 96.3% | 1,854 | 1,108 |
| Targeted Case Management | 175 | 62.7% | 259 | 81 | 35.0% | 342 | 120 |

- A greater proportion of youth in FC in the MHP received Intensive Home-Based Services and Intensive Care Coordination than received those services Statewide.
- The MHP also provided more youth in FC with Targeted Case Management (62.7 percent) than the compared to Statewide (35.0 percent). However, while more youth received these services, they had fewer average and median units of service.

## IMPACT OF ACCESS FINDINGS

- With the transition of the SMHS Kaiser carve-out back to the County MHP, the MHP may experience a 30 to 40 percent increase in its beneficiary population by the end of this year. This increase in caseload volume will be a challenge as the MHP is not receiving an increase in funding and already has challenges maintaining its workforce.
- The MHP has a much smaller PR for African Americans, APIs, and Hispanic/ Latino beneficiaries compared to the statewide PRs. This merits review and possible focused strategies to outreach to these populations. Collaboration with other county departments serving these groups may be beneficial.
- The impact of a reduced clinical workforce appears to be a reduction in the units of services provided on average.

# TIMELINESS OF CARE

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

## TIMELINESS KEY COMPONENTS

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

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

**Table 10: Timeliness Key Components**

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

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

- There are mental health clinicians embedded within child welfare services who facilitate timely assessments (and CANS) for all youth in FC. The MHP reported that 100 percent of assessments are offered within ten business days.

- Ostensibly, some of the timeliness performance measures were produced for the EQR and were not otherwise reviewed throughout the year (e.g., post-hospitalization follow-up for youth in FC; 7-day readmission rates).
- The MHP reported a 23 percent no-show rate for non-psychiatry clinical appointments in children's services. Documentation of timeliness did not indicate review of no-shows or efforts to improve the show rate.

## TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of ATA, representing access to care during the 12-month period of CY 2022. Table 11 and Figures 12-14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care. The MHP's criteria for some of the performance measures differ from what other MHPs typically report and thus bears noting:

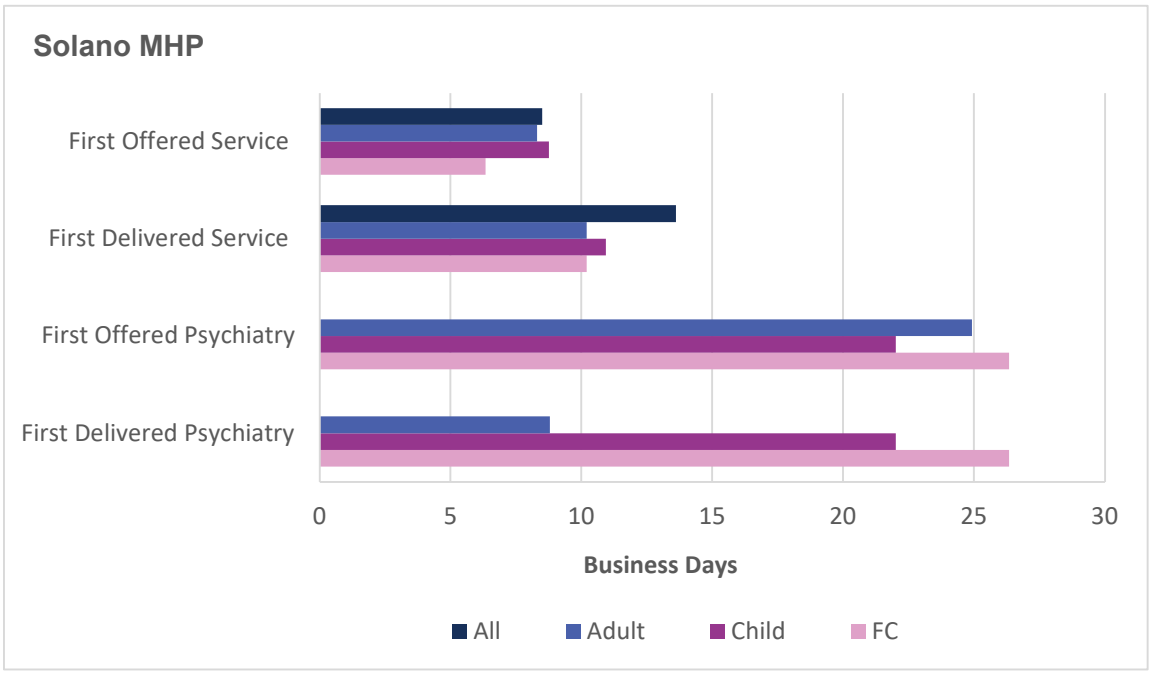
- For the time to first offered appointment, the MHP reported the time from request for services to assessment. For the time to delivered service, the MHP reported time from assessment to the first ongoing appointment. The MHP presented two different timeliness measures, which are not comparable.
- For urgent appointments, the MHP reported referrals from Access to an outpatient assessment within 48 hours. Referrals/appointments that took place at the crisis stabilization unit (CSU) or other crisis contact were not included in this metric.

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

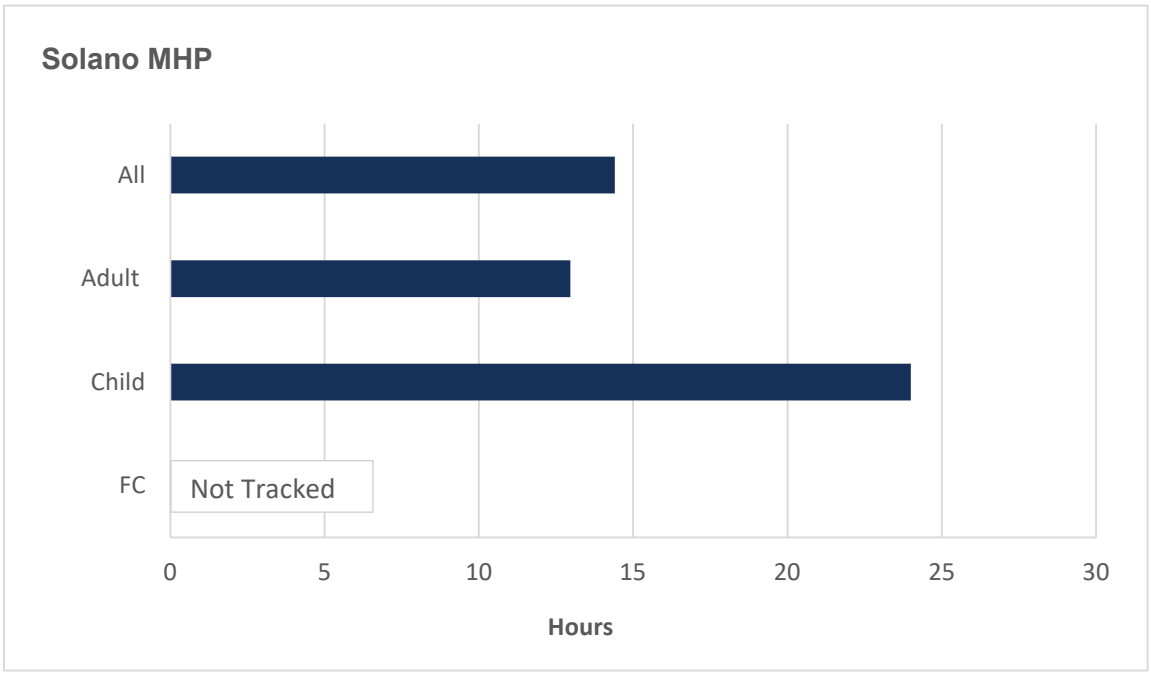
## Table 11: FY 2022-23 MHP Assessment of Timely Access

| Timeliness Measure | Average | Standard | % That Met Standard |
|---|---|---|---|
| First Non-Urgent Appointment Offered | 8.5 Business Days | 10 Business Days* | 70.8% |
| First Non-Urgent Service Rendered | 13.62 Business Days | 20 Business Days** | 80.3% |
| First Non-Urgent Psychiatry Appointment Offered | 24.93 – adults<br>22.02 – youth | 15 Business Days* | 32.5% |
| First Non-Urgent Psychiatry Service Rendered | 8.8 – adults<br>22.02 – youth | 20 Business Days** | 73.6% |
| Urgent Services Offered (including all outpatient services) – Prior Authorization not Required | 14.4 Hours | 48 Hours* | 100% |
| Follow-Up Appointments after Psychiatric Hospitalization | 43.67 Days | 7 days** | 43% |
| No-Show Rate – Psychiatry | 16% | *** | n/a |
| No-Show Rate – Clinicians | 14% | *** | n/a |
| * DHCS-defined timeliness standards as per BHIN 21-023 and 22-033<br>** MHP-defined timeliness standards<br>*** The MHP did not report data for this measure | | | |
| For the FY 2022-23 EQR, the MHP reported its performance for the following time period: CY 2022 | | | |

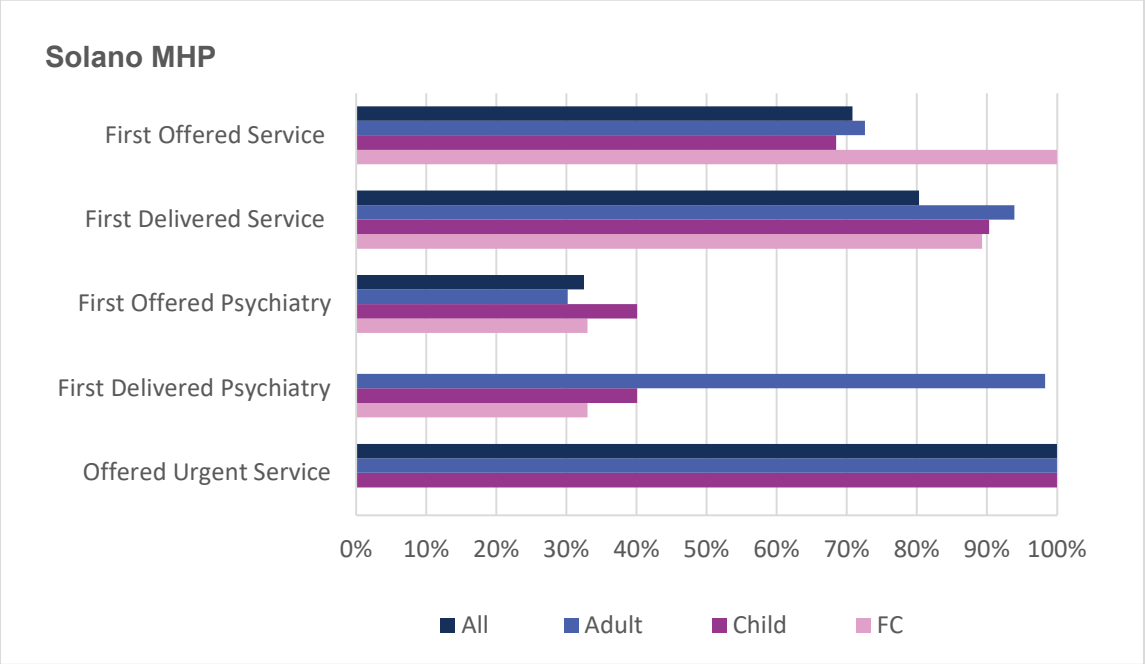
## Figure 12: Wait Times to First Service and First Psychiatry Service




## Figure 13: Wait Times for Urgent Services



### Figure 14: Percent of Services that Met Timeliness Standards




- Because MHPs may provide planned mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled mental health assessments.
- The MHP defined “urgent services” for purposes of the ATA as services that reduce the risk of decompensation or possible hospitalization if not seen within 48 hours of request for service. There were reportedly 15 urgent service requests with a reported actual wait time to services for the overall population at 14.4 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 from the beneficiaries’ (or family members’) request for services, not necessarily the initial request for services. The MHP did not routinely track psychiatry timeliness. After the review data was provided indicating average offered wait times exceeding 20 business days. There appear to be data integrity issues with this measure (e.g., more individuals received psychiatry than were offered, offered wait time for adults was longer than actual wait time).
- 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, for psychiatry services and non-psychiatry clinical staff. The MHP reports a no-show rate disaggregated by system of care. The MHP does not maintain a standard for no-show rates.

## IMPACT OF TIMELINESS FINDINGS

- The dashboard that is in development by Solano BH, in collaboration with the Department of Information Technology, is much needed in order for the MHP to have a complete picture of timely services for youth and adults alike. At present, some of the timeliness data for children and youth in FC comes from a different source and is not incorporated into overall data for timeliness to services.
- By tracking the time from assessment to first ongoing appointment, the MHP is monitoring flow and access to services beyond initial appointments (i.e., where the majority of services take place).

# 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 includes a QA Team and the Performance Improvement Team. The Quality Management Program consists of 17 full-time equivalents (FTEs) between the two teams. Compliance is part of the responsibilities of the QA Team. Quality is viewed as a continuous process across the systems of care and with the creation of the Performance Improvement Team will become more of a focus of the Quality Management Program.

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 administration, programs, providers, peers, beneficiaries, and family members, is scheduled to meet quarterly. Staff from Solano BH, contract providers, and other agency partners attended the QIC, but beneficiaries, peer employees, and community members could not be identified. Since the previous EQR, the MHP QIC met four times. The MHP had eight main goals identified in the FY 2021-22 QAPI workplan with several objectives to articulate the goals. Some of the goals were met, but many of the goals and objectives were suspended during the year (due to staffing issues).

The MHP utilizes the following LOC tool Recovery Needs Level (RNL) is used for adults, there is currently no LOC tool for children.

The MHP utilizes the following outcomes tools: Reaching Recovery, RNL, CANS and PSC-35.

## QUALITY KEY COMPONENTS

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

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

### Table 12: Quality Key Components

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

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

- The MHP has developed the Performance Improvement Team, differentiated from QA, to address beneficiary-focused quality components of services, including outcomes and impact of care.
- Several QI goals and objectives from the prior year were “put on hold” but subsequently were not carried forward into the current year QAPI.
- The MHP has increased the mechanisms to disseminate information and solicit input from its stakeholders. However, one group that was not well represented at meetings and other forums for decision-making were beneficiaries.
- As the MHP does not use a LOC to facilitate transitions in care for child/youth beneficiaries, it neither tracks nor trends transitions in care on an aggregate basis.
- The committee to review the effectiveness of clinical methodologies and medication practice, the Clinical Quality Review Committee, in the MHP was paused due to “resource scarcity” and has yet to resume.
- The MHP tracks the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5:

    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- The MHP neither tracks nor trends the following HEDIS measures:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- There are community-based consumer-run and consumer-driven programs that are endorsed by the MHP. The services require a referral from an MHP provider and are accessible to those open to SMHS.
- The MHP does not have peer employees in supervisory roles or in executive management roles. The opportunities for peer employees were limited to the peer support specialist position. The next level of advancement was a mental health specialist position that does not require lived experience.

## QUALITY PERFORMANCE MEASURES

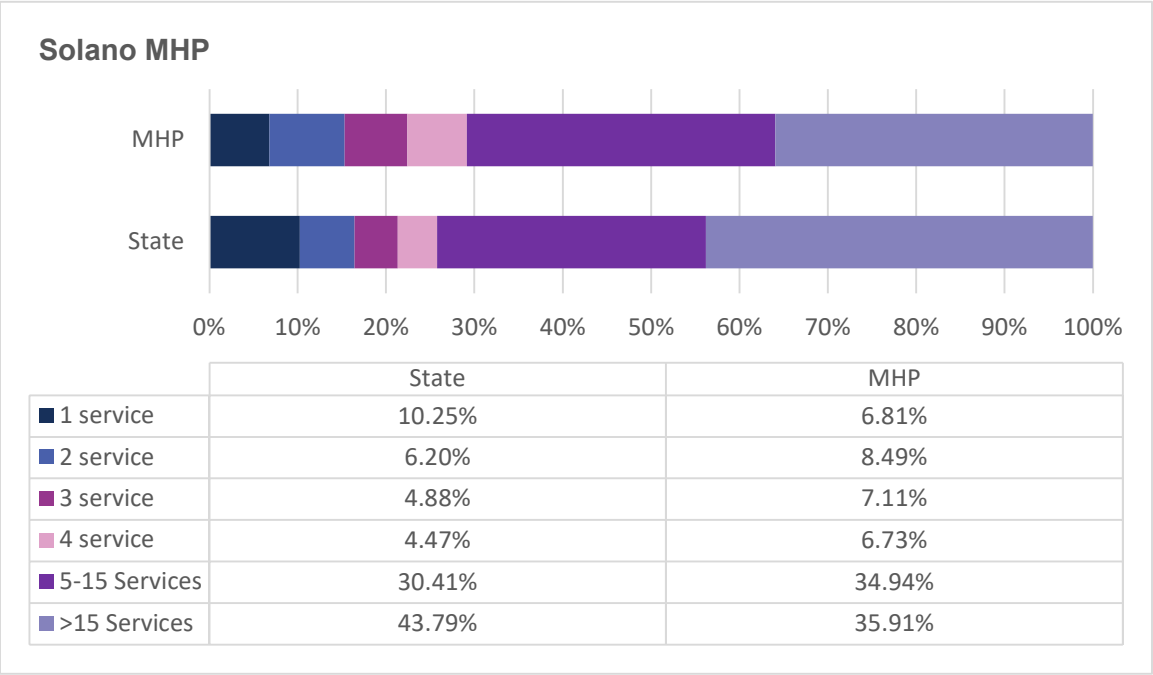
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

### Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries served by the MHP to require 5 or more services during a 12-month period. However, this table does not account for the length of stay, as individuals enter and exit care throughout the 12-month period.

### Figure 15: Retention of Beneficiaries CY 2021



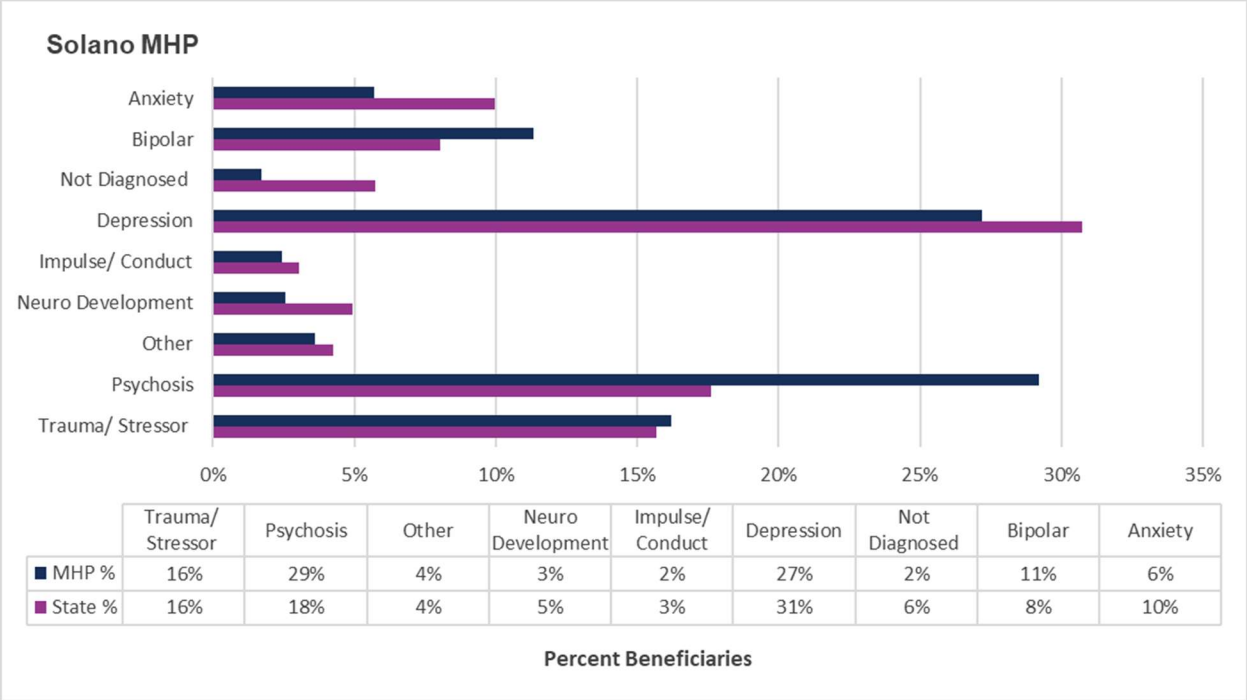

| | State | MHP |
|---|---|---|
| 1 service | 10.25% | 6.81% |
| 2 service | 6.20% | 8.49% |
| 3 service | 4.88% | 7.11% |
| 4 service | 4.47% | 6.73% |
| 5-15 Services | 30.41% | 34.94% |
| >15 Services | 43.79% | 35.91% |

- The MHP shows a lower percentage of its beneficiaries that receive only one service – potentially suggesting better engagement after assessment.
- Solano also has a lower rate of beneficiaries receiving greater than 15 services.

## 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.

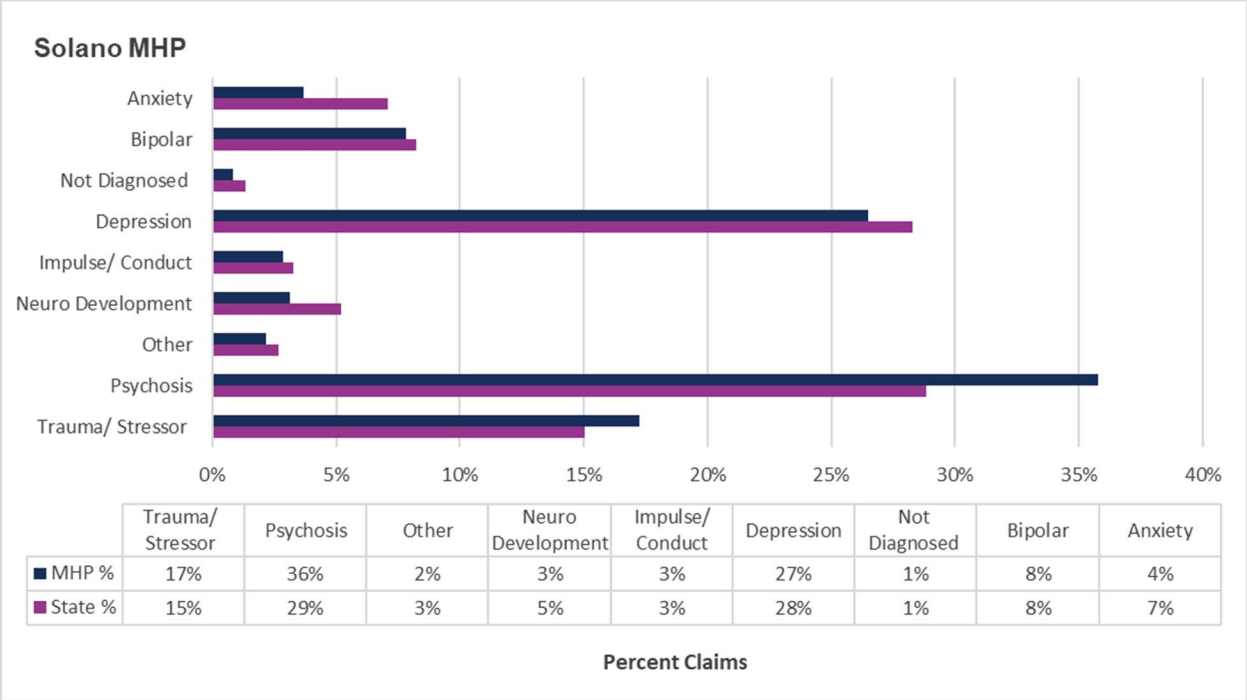
## Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021




| | Trauma/ Stressor | Psychosis | Other | Neuro Development | Impulse/ Conduct | Depression | Not Diagnosed | Bipolar | Anxiety |
|---|---|---|---|---|---|---|---|---|---|
| MHP % | 16% | 29% | 4% | 3% | 2% | 27% | 2% | 11% | 6% |
| State % | 16% | 18% | 4% | 5% | 3% | 31% | 6% | 8% | 10% |

- The top three diagnoses for the MHP are Psychosis, Depression and Trauma/Stressor.
- The high psychosis diagnosis for the MHP might be explained by its early psychosis/first break program (EDAPT) some years ago, which may have increased access for beneficiaries with psychotic disorders. Stakeholders also reported elevated methamphetamine use, which can result in drug-induced psychotic symptoms. (The county is part of a multi-jurisdiction effort to identify and reduce methamphetamine use).

### 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 % | 17% | 36% | 2% | 3% | 3% | 27% | 1% | 8% | 4% |
| State % | 15% | 29% | 3% | 5% | 3% | 28% | 1% | 8% | 7% |

- The top three diagnoses on approved claims are Psychosis, Depression and Trauma/Stressor.
- The diagnostic percentages at the MHP are aligned with the State totals with the exception of Psychosis. The MHP psychosis diagnosis is at 36 percent, while the State reports 29 percent.

## 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 | 442 | 780 | 9.42 | 8.86 | $14,300 | $12,052 | $6,320,555 |
| CY 2020 | 291 | 521 | 9.00 | 8.68 | $13,177 | $11,814 | $3,834,535 |
| CY 2019 | 398 | 717 | 9.25 | 7.80 | $11,855 | $10,535 | $4,718,263 |

- The unique inpatient beneficiary count increased by 51.9 percent from CY 2020 to 2021. Admissions increased by a count of 259 or 49.71 percent. It should be

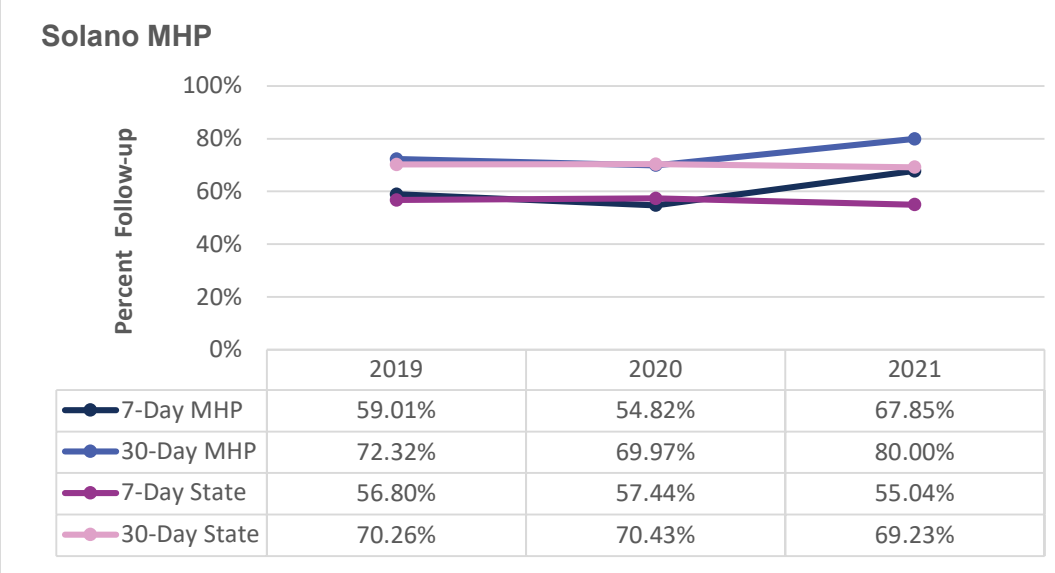
noted that the CY 2021 statistics are more in line with the 2019 statistics. CY 2020 may be anomalous in part due to the COVID-19 impact or increased use of Medi-Cal billable inpatient facilities.

## 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 file. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

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

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

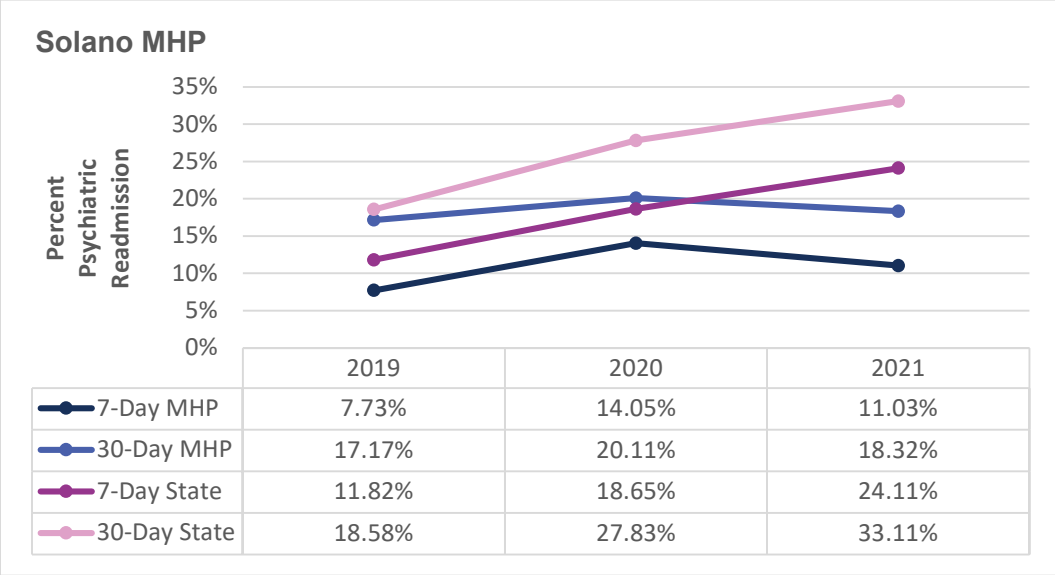



| | 2019 | 2020 | 2021 |
|---|---|---|---|
| 7-Day MHP | 59.01% | 54.82% | 67.85% |
| 30-Day MHP | 72.32% | 69.97% | 80.00% |
| 7-Day State | 56.80% | 57.44% | 55.04% |
| 30-Day State | 70.26% | 70.43% | 69.23% |

- The MHP 7- and 30-day follow up percentages were higher than the State average in 2021.
- The MHP has a focused team of clinician and specialists, the Crisis Aftercare and Recovery Engagement (CARE) team, that support beneficiaries discharged from hospitals and crisis services. The CARE team provides intensive short-term case management until the beneficiary can be connected with a higher level of care or an outpatient program. This CARE team likely contributes to high follow-up rates.

- From 2020 to 2021, the MHP improved the 7-day follow-up total by 23.77 percent and the 30-day follow-up by 14.34 percent.

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




| | 2019 | 2020 | 2021 |
|---|---|---|---|
| 7-Day MHP | 7.73% | 14.05% | 11.03% |
| 30-Day MHP | 17.17% | 20.11% | 18.32% |
| 7-Day State | 11.82% | 18.65% | 24.11% |
| 30-Day State | 18.58% | 27.83% | 33.11% |

- The 2021 MHP readmission rates are lower than the State and have been for the three years represented on this chart.
- After an increase in readmission rates in 2020, the MHP rate decreased again in 2021.
- The MHP has increased their percentage of post-psychiatric follow up and have percentages higher than the state. Contributing to this increase is the maintenance of the CARE team.

## 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 LOC 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 and 15, and Figures 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

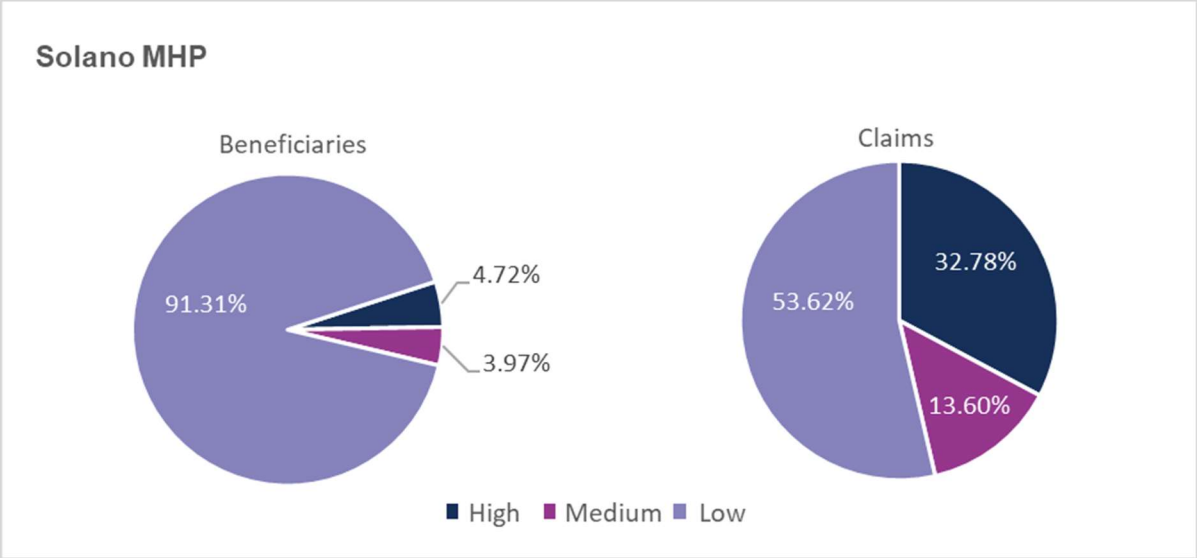
| Entity | Year | HCB Count | % of Beneficiaries Served | % of Claims | HCB Approved Claims | Average Approved Claims per HCB | Median Approved Claims per HCB |
|---|---|---|---|---|---|---|---|
| **Statewide** | CY 2021 | 27,729 | 4.50% | 33.45% | $1,539,601,175 | $55,523 | $44,255 |
| **MHP** | CY 2021 | 219 | 4.72% | 32.78% | $10,877,163 | $49,667 | $43,751 |
| | CY 2020 | 154 | 3.52% | 25.99% | $7,431,235 | $48,255 | $41,781 |
| | CY 2019 | 189 | 3.92% | 28.82% | $9,409,623 | $49,786 | $43,505 |

- HCB count increased by 65 (42.20 percent). The percentage of beneficiaries increased by 34.09 percent and the percentage of claims also increased by 26.13 percent.
- The increases noted among the HCBs may be influenced by the increase in beneficiary acuity following the COVID-19 pandemic, as noted by the MHP.

### 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) | 184 | 3.97% | 13.60% | $4,512,243 | $24,523 | $24,190 |
| Low Cost (Less than $20K) | 4,236 | 91.31% | 53.62% | $17,793,917 | $4,201 | $2,680 |

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




- While HCBs represent 4.72 percent of the beneficiary population, they represent 32.78 percent of claims, similar to the statewide pattern.

## IMPACT OF QUALITY FINDINGS

- With a new Performance Improvement Team, the MHP is in position to resume several QI projects and initiatives that were suspended or "put on hold" over the past year, partially due to the demands of the CalAIM implementation.
- The MHP has at least eight clinicians in the Quality Management Program. While it is smart to have clinicians inform QI and guide implementation of new initiatives (e.g., enhanced care management), the MHP might consider the feasibility of having clinical staff in non-clinical roles (e.g., disseminating information on regulations and policy), especially when there is a need for more staff to provide clinical care.
- The MHP leadership recognizes the barrier that a referral-based community wellness program might be for potential beneficiaries and would like to shift or grow providers that can do more drop-in center style programming.
- There has been a gradual increase in the proportion of HCB served in the county. There has also been an increase in the number of beneficiaries served. Further analysis of high-cost services is needed to ensure that it is not a result of the increased demand for services and reduced ability to meet the need at lower LOCs.

# 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: Mobile Crisis

Date Started: 07/2021

Date Completed: 12/2022

Aim Statement: Will mobile crisis services improve outcomes for individuals and reduce frequency of law enforcement acting as sole crisis responders as measured by community stabilization (no 5150 hold) over 24 months FY 2021-22 and FY 2022-23?

Target Population: Solano County residents who are experiencing an acute psychiatric crisis, are suicidal, homicidal, gravely disabled or a mix of these.

Status of PIP: The MHP's clinical PIP is in the Other: Completed stage.

[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

Over a three-year period, from FY 2017-18 to 2020-21, the MHP noted a steady increase in hospitalizations for youth and adults. The PIP team hypothesized that decreasing law enforcement response would decrease hospitalizations or return hospitalizations to pre-FY 2017-18 rates. The MHP's improvement strategy was to provide community-based mobile crisis through a contracted provider and a school-based mobile crisis through a partnership with the Solano County Office of Education (SCOE). Rather than law enforcement responding to all crisis calls or requests from schools, a clinician or clinician-peer team is dispatched to the crisis situation pending no safety risk or concerns. The mobile crisis response would bring a more therapeutic and trauma-informed approach, which would then reduce the number of individuals entering the mental health system through acute and more restrictive LOCs.

The outcome measures were psychiatric hospitalizations and stabilization in the community or school. The PIP team included a third outcome measure—placement in the CSU by law enforcement, but this is a process measure. (Placements by law enforcement will necessarily decrease as a function of the mobile crisis team responding to crises (i.e., the intervention). For the last remeasurement, the team reported a positive outcome, an increase in stabilizations in the community and schools, but an untoward outcome of an increase in psychiatric hospitalizations. The MHP intends to continue and expand the mobile crisis with additional staff.

## TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence. The team identified an area needing improvement; developed a clear strategy for improvement; implemented the strategy; and conducted periodic measurements. When the team had an unexpected outcome, they presented cogent, possible reasons as explanation. Two areas of the project needed more clarity—the root cause analysis and the data analysis—both were lacking some details (e.g., the PIP team did not explain or present the causal link between law enforcement contact and increased hospitalizations).

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

- Reframe the problem as increased involuntary holds and hospitalizations rather than increased suicides (as suicide numbers and rates are not part of the project).
- Include only involuntary hospitalizations (i.e., 5150s) resulting from crisis contacts in the analysis.

# NON-CLINICAL PIP

## General Information

Non-Clinical PIP Submitted for Validation: Creating Inclusive Care Sites

Date Started: 07/2021

Date Completed: ongoing

Aim Statement: For the LGBTQ+ population, will the creation of inclusive and safe spaces and culturally sensitive practices improve self-identification of this community, as measured by an increase in self-reporting over a 25-month period FY 2021-22 and FY 2022-23 (based on [beneficiaries] served)?

Target Population: New and existing BHP consumers that identify as LGBTQ+ regardless of age or diagnosis.

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

## Summary

SCBH has noted that in spite of efforts to capture sexual orientation and gender identity/expression (SOGIE) and improve self-reporting by beneficiaries, there is a lack of representation of non-binary individuals in services. The PIP team identified stigma, bias, and fear of victimization as barriers that prevent self-disclosing SOGIE and might delay mental health services. The PIP team has hypothesized that creating inclusive, safe spaces for LGBTQ+ beneficiaries will decrease concerns about accessing services and increase self-reporting and self-disclosure of SOGIE. The MHP's improvement strategy was to outfit reception and service areas with wall hangings, books, toys, and other materials representing diverse communities.

The safe spaces were created in July 2021, with no additional improvement strategy in the second year of the project. The PIP team had four outcome measures, disaggregated by population/system of care —youth and adults. The PIP team also presented the results from the survey assessing the inclusiveness of the space as an outcome measure, but it a process measure that tracks the intervention. Overall, there was neither increase in self-reporting of SOGIE nor a decrease in 'decline to answer' as a response, but there was positive change for youth beneficiaries. The team presented its theories on the negative outcomes (e.g., increased use of services at home during COVID-19 and lack of privacy). Another area that the team should consider is the efficacy of the material in creating an inclusive space that resonates with SOGIE, rather than one that promotes diversity in general (which could include by race, physical disability, language/hard of hearing, etc.)

### TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence. The MHP did not sufficiently establish that there was under-reporting of SOGIE and/or that there was room for improvement in beneficiary disclosure. The team hypothesizes that *not* indicating SOGIE (e.g., on an intake form) relates to one's non-binary identification. However, there are other reasons why that question may not be answered: lack of understanding; being overwhelmed or confused by the response options; and survey fatigue.

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

- For future projects, as this project will be ending this year, survey a relevant subset of individuals affected by the issue or problem.

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

## INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart/myAvatar, which has been in use for ten 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 2.77 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency. The prior year's budget was 3.28 percent and was decreased by 15.5 percent. The MHP described the reduction as primarily related to long term vacancies which were not included for the budget year in question.

The MHP has 380 named users with log-on authority to the EHR, including approximately 239 county staff and 141 contractor staff. Support for the users is provided by 1.5 FTEs IS technology positions. Currently there is a 1.0 FTE vacancy. IS technology staff are part of a centralized unit and are allocated based on time studies.

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

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

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

| Submittal Method | Frequency | Submittal Method Percentage |
|---|---|---|
| Health Information Exchange (HIE) between MHP IS | ☐ Real Time ☐ Batch | 0% |
| Electronic Data Interchange to MHP IS | ☐ Daily ☐ Weekly ☐ Monthly | 0% |
| Electronic batch file transfer to MHP IS | ☐ Daily ☐ Weekly ☒ Monthly | 58% |
| Direct data entry into MHP IS by provider staff | ☒ Daily ☐ Weekly ☐ Monthly | 42% |
| Documents/files e-mailed or faxed to MHP IS | ☐ Daily ☐ Weekly ☐ Monthly | 0% |
| Paper documents delivered to MHP IS | ☐ Daily ☐ Weekly ☐ Monthly | 0% |
| | | 100% |

### Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not have a PHR available. The MHP is planning to implement a PHR within six months.

### Interoperability Support

The MHP is a member or participant in a HIE. The MHP engages in electronic exchange of information with the Managed Care Plan.

## INFORMATION SYSTEMS KEY COMPONENTS

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

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

### Table 17: IS Infrastructure Key Components

| KC # | Key Components – IS Infrastructure | Rating |
|---|---|---|
| 4A | Investment in IT Infrastructure and Resources is a Priority | Met |
| 4B | Integrity of Data Collection and Processing | Partially Met |
| 4C | Integrity of 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:

- All information collected points to an efficient and effective claiming process at the MHP. The claim history is consistent and timely and the denial percentage at 0.74 is below the State denial rate of 1.43 percent.
- The MHP does not allow full use of the EHR by contractors that provide services and does not provide them an electronic transaction of data containing beneficiary claims and demographic information for their internal use.
- The MHP did not provide an Operations Continuity Plan and was unaware if there was one in the central IS/IT department. No standard or estimated timeline to restore the EHR to operational status was provided.

## 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.

For the MHP, there does not appear to be significant claims lag. This chart 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 | 8,715 | $2,734,976 | $11,355 | 0.42% | $2,546,897 |
| Feb | 8,559 | $2,533,051 | $7,945 | 0.31% | $2,468,038 |
| Mar | 9,608 | $2,871,603 | $10,510 | 0.37% | $2,782,347 |
| April | 8,918 | $2,613,225 | $14,135 | 0.54% | $2,493,376 |
| May | 8,617 | $2,614,455 | $11,217 | 0.43% | $2,459,195 |
| June | 8,960 | $2,920,218 | $9,438 | 0.32% | $2,698,260 |
| July | 7,956 | $2,699,983 | $42,297 | 1.57% | $2,522,625 |
| Aug | 8,338 | $2,994,453 | $61,578 | 2.06% | $2,801,038 |
| Sept | 10,062 | $3,549,693 | $10,572 | 0.30% | $2,590,021 |
| Oct | 11,994 | $4,257,468 | $20,813 | 0.49% | $2,468,171 |
| Nov | 7,553 | $2,691,681 | $15,853 | 0.59% | $2,654,281 |
| Dec | 6,901 | $2,394,113 | $42,873 | 1.79% | $2,299,810 |
| **Total** | **106,181** | **$34,874,919** | **$258,586** | **0.74%** | **$30,784,059** |

- The MHP has a low denial rate, which indicates an effective claims review and processing system.
- There are three anomalous months with denial rates much higher than the overall average.

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

| Denial Code Description | Number Denied | Dollars Denied | Percentage of Total Denied |
|---|---|---|---|
| Late claim | 289 | $80,502 | 31.13% |
| Medicare Part B must be billed before submission of claim | 116 | $35,319 | 13.66% |
| Beneficiary not eligible or non-covered charges | 69 | $34,944 | 13.51% |
| Other healthcare coverage must be billed before submission of claim | 40 | $34,613 | 13.39% |
| Service location NPI issue | 218 | $34,238 | 13.24% |
| Service line is a duplicate and a repeat service procedure code modifier not present | 73 | $32,662 | 12.63% |
| Other | 15 | $5,264 | 2.04% |
| Deactivated NPI | 14 | $1,047 | 0.40% |
| **Total Denied Claims** | **834** | **$258,589** | **100.00%** |
| **Overall Denied Claims Rate** | **0.74%** | | |
| **Statewide Overall Denied Claims Rate** | **1.43%** | | |

## IMPACT OF INFORMATION SYSTEMS FINDINGS

- The CalAIM and Fiscal Teams are currently working on identifying Common Procedural Terminology codes to be used for coding services and claiming. This change will allow the MHP to be compliant with CalAIM requirements and require alteration to the EHR and training for all staff involved in service entry.
- Reimbursement rates for contract providers must be updated to meet CalAIM regulations. The impacted teams at the MHP are working through this process.
- Assessment and documentation are being streamlined under CalAIM.

# 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 provides stakeholders with a succinct and easy-to-follow summary of the CPS survey findings and uses the survey findings (e.g., from the Service Verification Survey) to make improvements in service delivery.

## 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 adult consumers, including African American and Latino beneficiaries, who initiated services in the preceding 12 months. The focus group was held via videoconference and included five participants. All consumers participating receive clinical services from the MHP.

The two participants who recently started services reported ease of access or transition to SMHS. They noted that providers at the MHP were more responsive and supportive of their needs compared to other community providers. Established beneficiaries commented on the continued COVID-19 precautions, including the reductions in the number of participants per therapeutic groups. While they understood the need for physical distancing, they thought that groups were too restrictive. Participants endorsed that case managers and peer support specialists were an integral part of the services that they received. They appreciated the support that case managers provided with assistance with housing, victim services, and transportation assistance.

Recommendations from focus group participants included:

- Allow more clients into groups.
- Identify shelters and residences for fathers with their children.

### Consumer Family Member Focus Group Two

CalEQRO requested a culturally diverse group of adult consumers who are served by the Forensics Team and mostly have initiated services in the preceding 12 months. The focus group was held via videoconference and included four participants. All consumers participating receive clinical services from the MHP.

The participants for the focus group received services through a (jail) diversion program. Participants endorsed relatively timely access to the program, within two weeks. Case managers were responsible for the assistance to services. (Case managers may have been through the county jail rather than the MHP). Participants described their experience with MHP services relative to their experiences with jail services, which was largely not positive. The MHP services were therapeutic, as opposed to punitive, and trauma-informed, and delivered by responsive providers. In addition to concerns about jail services, the participants recounted problematic interactions with law enforcement interaction. Some of the participants have a need for dual diagnosis (substance use and mental health) treatment, which they receive through the forensics program.

Recommendations from focus group participants included:

- Have mental health staff on call to respond to community needs, in addition to or instead of the police.

## SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall, focus group participants had positive perceptions and experience of MHP services. They endorsed that MHP services had a positive impact on their mental health. From the feedback, community-based crisis response is needed—and wanted—by beneficiaries. Stabilizing staff should be a paramount focus of the MHP to ensure continuity of this service. CIT is also a timely initiative that the MHP has put in place. In addition to tracking the number of law enforcement personnel trained (relative to the total personnel who have community contact), there should be some measure of skill and competency in applying the training, which might require more assistance from the MHP.

# 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 prioritized delivering equitable services and reducing disparities in access. The MHP has leveraged its innovation project, the Interdisciplinary Collaboration and Cultural Transformation Model that focuses on highlighting the experiences and mental health needs of the Filipino American, Latino, and LGBTQ+ communities the county. (Access, Quality)
2. The internship program is a thoughtful and well-planned approach to developing a pipeline of clinical staff. Solano BH has put resources where there is likely to gain more return on investment. (Access, Quality)
3. The MHP has developed a transition team to review readiness for step-down and ensure seamless transition to mild-to-moderate LOC with follow-up as needed. (Quality)
4. The claim review and submission process is effective and efficient resulting in a Medi-Cal denial percentage of 0.74, which is lower than the Statewide average. (Quality, IS)
5. Solano BH has incorporated a new reporting and data visualization tool that will help in monitoring services and identify areas needing improvement. (Access, Timeliness, Quality, IS)

## OPPORTUNITIES FOR IMPROVEMENT

1. The MHP has ongoing projects and activities and has implemented several new projects over the past year, some of which have not been fully executed or monitored because of competing priorities and limited resources. (Quality, IS)
2. The MHP halted the community-based mobile crisis for five months due to inadequate staffing, much to the dismay of the community that began to rely on this service. (Access)
3. The MHP's ATA still shows average times to offered non-urgent psychiatry services in excess of 20 business days for children and youth in FC. (Timeliness)
4. Beneficiaries who have contact with law enforcement secondary to a mental health crisis or condition report negative interactions and experiences. (Access, Quality)

5. The hours of operation are not included on the Provider Directory on the MHP website. (Access, 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. Focus QI projects and activities on some few that can reasonably be implemented and monitored with the current resources and is documented as active in the QAPI. (Quality)
2. Resume the community-based mobile crisis [which occurred the day prior to the review] and implement strategies to ensure continuous operations. (Access)
3. Investigate reasons and develop and implement strategies to offer more children and youth in FC with non-urgent psychiatry appointments within 15 business days. (Timeliness)
   (This recommendation is a carry-over from FY 2021-22.)
4. Continue work with law enforcement to jointly train more law enforcement personnel on CIT. (Access, Quality)
5. Include hours of operation in the Provider Directory on the BH website to provide beneficiaries with information needed to help them select a provider. (Access, Quality, IS)

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

# ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

## ATTACHMENT 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 – Solano MHP |
|---|
| Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations |
| Access to Care |
| Timeliness of Services |
| Quality of Care |
| Validation and Analysis of the MHP's PIPs |
| Validation and Analysis of the MHP's PMs |
| Validation and Analysis of the MHP's Network Adequacy |
| Validation and Analysis of the MHP's Health Information System |
| Validation and Analysis of Beneficiary Satisfaction |
| Validation of Findings for Pathways to MH Services (Katie A./CCR) |
| Consumer and Family Member Focus Group(s) |
| Fiscal/Billing |
| Clinical Line Staff Group Interview |
| Clinical Supervisors Group Interview |
| Use of Data to Support Program Operations |
| Peer Employees/Parent Partner Group Interview |
| Peer Inclusion/Peer Employees within the System of Care |
| Information Systems Billing and Fiscal Interview |
| Telehealth |
| Closing Session – Final Questions and Next Steps |

# ATTACHMENT B: REVIEW PARTICIPANTS

## CalEQRO Reviewers

Leda Frediani, Information Systems Reviewer
Diane Mintz, Consumer/Family Member Reviewer
Ewurama Shaw-Taylor, PhD, CPHQ, Lead Quality 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 |
|---|---|---|---|
| **Ahmed** | Nadeem | Manager, Enterprise Application & Analytics | Solano County Behavioral Health (SCBH) |
| **Ayala** | Patty | Mental Health Clinician | SCBH |
| **Ballard** | Jockuela | Peer Support Specialist | Pacific Clinics |
| **Coleman** | Denise | Peer Support Specialist | SCBH |
| **Cooper** | Julie | unknown | SCBH |
| **Cordero** | Kattera | Clinical Supervisor | SCBH |
| **Cowan** | Emery | Behavioral Health Chief Deputy Director | SCBH |
| **Cruz** | Ashley | Mental Health Clinician | SCBH |
| **Davis** | Keirsha (Shai) | Project Manager | SCBH |
| **Delaney** | Susan | Peer Support Specialist | SCBH |
| **Durrah** | Eugene | Clinical Supervisor | SCBH |
| **Espinosa** | Lori | Mental Health Clinician | SCBH |
| **Esters** | Cheryl | Compliance Manager | SC Health & Social Services |
| **Ezenwa** | Yvonne | Planning Analyst, Performance Improvement Team | SCBH |
| **Fulford** | Joseph | Staff Analyst | SCBH |
| **Garcia** | Sandy | Mental Health Clinician | SCBH |
| **George** | Rob | Senior Mental Health Services Manager | SCBH |
| **Greco-Gregory** | Judeth | Clinical Supervisor | SCBH |
| **Halpin** | Dani | Clinical Supervisor | SCBH |
| **Jackson** | Traci | Peer Support Specialist | Nami |

| Last Name | First Name | Position | County or Contracted Agency |
|---|---|---|---|
| **Johnson** | Emily | Clinical Supervisor | SCBH |
| **Kitzes** | Michael | Senior Mental Health Services Manager | SCBH |
| **Larios** | Edith | Mental Health Clinician | SCBH |
| **Liberato** | Esmeralda | Peer Support Specialist | SCBH |
| **Lucchesi** | Michael | Mental Health Clinician | SCBH |
| **Ma** | Devin | Clinical Supervisor | SCBH |
| **Mauritz** | Genevieve | Clerical Support, Performance Improvement Team | SCBH |
| **Mauritz** | Sydney | Office Assistant, Performance Improvement Team, Internship Program | SCBH |
| **Mayfield** | Samele | Mental Health Clinician | SCBH |
| **Mitchell** | Julie | Mental Health Specialist | SCBH |
| **Naylor** | Rechelle | Mental Health Clinician | SCBH |
| **Neal** | Kristin | Policy & Financial Manager | SC Health & Social Services |
| **Pottenger** | Brent | Medical Director | SCBH |
| **Pottenger** | Maxine | Psychiatrist | SCBH |
| **Ramirez** | Miranda | Mental Health Services Manager | SCBH |
| **Ray** | Megan | Mental Health Clinician | SCBH |
| **Reese** | Julie | Clinical Supervisor | Seneca Family of Agencies |
| **Ryburn** | Lindsey | Clinical Supervisor | SCBH |
| **Salassi** | Anne | Mental Health Clinician | SCBH |

| Last Name | First Name | Position | County or Contracted Agency |
|---|---|---|---|
| **San Nicolas Tagliaboschi** | Laura | Information Technology Manager | SC Department of Information Technology |
| **Sandoval** | Mirelle | Intern | SCBH |
| **Sharp** | Nicole | Peer Support Specialist | SCBH |
| **Sheppard** | Mary Kate | Executive Director | Pacific Clinics |
| **Skillman** | Kristian | Supervisor | SC Office of Education |
| **Snyder** | Holly | Mental Health Clinician | SCBH |
| **Spars** | Jonathan | Clinical Supervisor | SCBH |
| **Stimmann** | Christina | Mental Health Services Manager | SCBH |
| **Stockton** | Joanna | Clinical Director | Pacific Clinics |
| **Tolentino** | Diana | Clinical Supervisor | SCBH |
| **Urrea** | Christina | Mental Health Services Manager | SCBH |
| **Verder-Aliga** | Rozzana | Senior Mental Health Services Manager | SCBH |
| **West** | Jaron | Physician's Assistant | SCBH |
| **Whal** | Mary Kate | Clinical Supervisor | SCBH |
| **Woodhall** | Cathy | Office Supervisor | SCBH |
| **Word** | Sabrina | Supervisor | Seneca Family of Agencies |

# 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<br>☒ Moderate confidence<br>☐ Low confidence<br>☐ No confidence | The MHP focused on decreasing law enforcement response to crisis as way to curb the steady increase in hospitalizations for youth and adults. The MHP's improvement strategy was to provide community-based mobile crisis through a contracted provider and a school-based mobile crisis through a partnership with the Solano County Office of Education (SCOE). |

| General PIP Information |
|---|
| **MHP/DMC-ODS Name:** Solano County |
| **PIP Title:** Mobile Crisis |
| **PIP Aim Statement:** Will mobile crisis services improve outcomes for individuals and reduce frequency of law enforcement acting as sole crisis responders as measured by community stabilization (no 5150 hold) over 24 months FY2021-22 and FY2022-23? |
| **Date Started:** 07/2021 |
| **Date Completed:** 12/2022 |
| **Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply)**<br>☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic)<br>☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases)<br>☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic) |
| **Target age group (check one):**<br>☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children<br>*If PIP uses different age threshold for children, specify age range here: |
| **Target population description, such as specific diagnosis (please specify):** Solano County residents who are experiencing an acute psychiatric crisis, suicidal, homicidal, gravely disabled or a mix of these. |

| 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):<br>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):<br>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):<br>to provide community-based mobile crisis through a contracted provider and a school-based mobile crisis through a partnership with the SCOE. |

| 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 placements in CSU by law enforcement | 07/2021–12/2021 | 460 and 48% | 07/2022-12/2022 | 365 and 42% | ☒ Yes<br>☐ No | ☒ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☒ <.05<br>Other (specify): |
| Psychiatric hospitalizations | 07/2021–12/2021 | 73 per month | 07/2022-12/2022 | 82 per month | ☐ Yes<br>☒ No | ☐ Yes ☒ No<br>Specify P-value:<br>☒ <.01 ☐ <.05<br>Other (specify): |
| Mobile crisis stabilization by Pacific Clinics, number and percent | 07/2021–12/2021 | 139 and 50% | 07/2022-12/2022 | 90 and 54% | ☒ Yes<br>☐ No | ☒ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☒ <.05<br>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 |
|---|---|---|---|---|---|---|
| Mobile crisis stabilization by SCOE, number and percent | 07/2021–12/2021 | 115 and 75% | 07/2022-12/2022 | 91 and 79% | ☒ Yes<br>☐ No | ☒ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☒ <.05<br>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.

**EQRO recommendations for improvement of PIP:**

- Reframe the problem as increased involuntary holds and hospitalizations rather than increased suicides (as suicide numbers and rates are not part of the project).
- Include only involuntary hospitalizations (i.e., 5150s) resulting from crisis contacts in the analysis.

## Non-Clinical PIP

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

| PIP Validation Rating (check one box) | Comments |
|---|---|
| ☐ High confidence<br>☐ Moderate confidence<br>☒ Low confidence<br>☐ No confidence | Despite efforts to capture sexual orientation and gender identity/expression (SOGIE) and improve self-reporting by beneficiaries in MHP documentation, there is a lack of representation of non-binary individuals in services. The MHP's improvement strategy was to create inclusive, safe spaces that welcome LGBTQ+ beneficiaries and encourage self-reporting and self-disclosure of SOGIE. |

| General PIP Information |
|---|
| **MHP/DMC-ODS Name:** Solano County |
| **PIP Title:** Creating Inclusive Care Sites |
| **PIP Aim Statement:** For the LGBTQ+ population, will the creation of inclusive and safe spaces and culturally sensitive practices improve self-identification of this community, as measured by an increase in self-reporting over a 25-month period FY 2021-22 and FY 2022-23 (based on [beneficiaries] served)? |
| **Date Started:** 07/2021 |
| **Date Completed:** ongoing |
| **Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply)**<br>☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic)<br>☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases)<br>☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic) |
| **Target age group (check one):**<br>☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children<br>*If PIP uses different age threshold for children, specify age range here: |
| **Target population description, such as specific diagnosis (please specify):** New and existing BHP consumers that identify as LGBTQ+ regardless of age or diagnosis. |

| 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):<br>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):<br>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):<br>outfit reception and service areas with wall hangings, books, toys, and other materials representing diverse communities |

| 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 |
|---|---|---|---|---|---|---|
| Clients self -reporting gender identity other than “male“ or “female“ (Access Callers) | 01/2021-06/2021 | 20/1,078=1.9% | 07/2022-12/2022 | 21/1037=2.0% | ☐ Yes<br>☒ No | ☐ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |
| Clients self-reporting Sexual Orientation LGBQ+(Access Callers) | 01/2021-06/2021 | 133/1,078=12.3 | 07/2022-12/2022 | 113/1037=10.9% | ☐ Yes<br>☒ No | ☐ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |
| Clients declining to answer Gender Identity (Access Callers) | 01/2021-06/2021 | 14/1078=1.3% | 07/2022-12/2022 | 11/1037=1.1% | ☐ Yes<br>☒ No | ☐ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>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 |
|---|---|---|---|---|---|---|
| Clients declining to answer Sexual Orientation (Access Callers | 01/2021-06/2021 | 74/1078=6.9% | 07/2022-12/2022 | 100/1037=9.6% | ☐ Yes<br>☒ No | ☐ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |
| Adult clients self-reporting Gender Identity other than “male“ or “female“(Service Utilization | 01/2021-06/2021 | 74/1078=6.9% | 07/2022-12/2022 | 100/1037=9.6% | ☐ Yes<br>☒ No | ☐ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |
| Adult clients self-reporting Sexual Orientation LGBQ+ (Service Utilization) | 01/2021-06/2021 | 74/1078=6.9% | 07/2022-12/2022 | 100/1037=9.6% | ☐ Yes<br>☒ No | ☐ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |
| Adult clients declining to answer Gender Identity (Service Utilization) | 01/2021-06/2021 | 74/1078=6.9% | 07/2022-12/2022 | 100/1037=9.6% | ☐ Yes<br>☒ No | ☐ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |
| Adult clients declining to answer Sexual Orientation (Service Utilization | 01/2021-06/2021 | 74/1078=6.9% | 07/2022-12/2022 | 100/1037=9.6% | ☐ Yes<br>☒ No | ☐ Yes ☐ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |
| Child/youth clients self-reporting Gender Identity other than “male“ or “female“(Service Utilization | 01/2021-06/2021 | 34/1022=3.3% | 07/2022-12/2022 | 47/971=4.8% | ☒ Yes<br>☐ No | ☐ Yes ☒ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>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 |
|---|---|---|---|---|---|---|
| Child/youth clients self-reporting Sexual Orientation LGBQ+ (Service Utilization) | 01/2021-06/2021 | 178/1022=17.4% | 07/2022-12/2022 | 215/978=22% | ☒ Yes<br>☐ No | ☐ Yes ☒ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |
| Child/youth clients declining to answer Gender Identity (Service Utilization) | 01/2021-06/2021 | 18/1022=1.8% | 07/2022-12/2022 | 14/971=1.4% | ☒ Yes<br>☐ No | ☐ Yes ☒ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |
| Child/youth clients declining to answer Sexual Orientation (Service Utilization | 01/2021-06/2021 | 136/1022=13.3% | 07/2022-12/2022 | 125/978=12.8% | ☒ Yes<br>☐ No | ☐ Yes ☒ No<br>Specify P-value:<br>☐ <.01 ☐ <.05<br>Other (specify): |

**PIP Validation Information**

**Was the PIP validated?** ☒ Yes ☐ No

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

**Validation phase (check all that apply):**

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

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

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

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

| PIP Validation Information |
| --- |
| **EQRO recommendations for improvement of PIP:** (For future projects) survey a relevant subset of individuals affected by the construct or problem |

## 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.