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

SONOMA FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

February 8-9, 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, "Sonoma" may be used to identify the Sonoma County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — February 8-9, 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	0	5	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	2	2	0
Timeliness of Care	6	6	0	0
Quality of Care	10	8	2	0
Information Systems (IS)	6	4	1	1
TOTAL	**26**	**18**	**7**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Enhancing Community Connection and Living Skills for High-Cost Beneficiaries	Clinical	08/2022	Implementation	Moderate
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	09/2022	Implementation	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	11
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	6

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP implemented several services to enhance initial and ongoing treatment access.
- The Performance Measures (PM) Medi-Cal beneficiaries' 7-day and 30-day post psychiatric inpatient follow-up for CY 2019-21 7-day and 30 -day follow-up was 70 and 81 percent. Psychiatric hospital recidivism for 2021 was 1.72 percent whereas the state average was 33.11 percent.
- The MHP uses data to analyze data for trends, determine outcomes, and make data driven decisions.
- Well-documented claims policies and procedures ensure a trained fiscal team and contributes to a consistent volume of claims, steady revenue stream, and low denial rate.
- The MHP Behavioral Health Quality Improvement Program (BHQIP) FUM PIP documented a root cause analysis to implement a navigator system with Emergency Departments (EDs).

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

- The overall PR, 2.49 percent, is 32 percent lower than medium counties and 43 percent lower than the state average.
- The Hispanic/Latino PR, 1.28 percent, is 52 percent lower than medium counties and 66 percent lower than the state average and ranks sixth of six race/ethnicities measured.

- Beneficiaries served meeting the MHP standard for timeliness to first requested psychiatry appointment is 48 percent, first delivered is 45 percent, and timeliness to first offered and delivered services has trended lower, year over year.
- The MHP Crisis Stabilization Unit (CSU) struggles to maintain required staffing, was utilized by 26 percent of the adult MHP Medi-Cal beneficiaries served, and admissions frequently stayed over the 23-hour limit.
- The MHP continues to have no interoperability with contract providers, resulting in inefficient workflows and double data entry.

All recommendations are a carryover from the previous year. Recommendations for improvement based upon this review include:

Investigate reasons and develop and implement strategies to:

- Increase the MHP overall PR of 2.5 percent.
- Increase the MHP Hispanic/Latino PR of 1.28 percent.
- Increase the percentages of beneficiaries served that meet the MHP standard for timeliness to first non-urgent request psychiatry appointment, and first non-urgent psychiatry appointments rendered.
- Improve CSU staffing and reduce MHP adult crisis services utilization, stays over 23 hours and overuse of diversion protocols.
- Improve HIE interoperability between the Community Based Organizations (CBOs) and county Electronic Health Records (EHR) system(s) and include the involvement of CBOs in planning, development, and implementation processes.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in October 2019.

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 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section14197.05).

This report presents the FY 2022-23 findings of the EQR for Sonoma County MHP by BHC, conducted as a virtual review on February 8-9, 2022.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public 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 PM tables and graphs throughout this report, unless otherwise specified, are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File.

CalEQRO reviews are retrospective; therefore, data evaluated represent CY 2021 and FY 2021-22, unless otherwise indicated. As part of the pre-review process, each MHP is provided a description of the source of data and four summary reports of Medi-Cal approved claims data, including the entire Medi-Cal population served, and subsets of claims data specifically focused on Early Periodic Screening, Diagnosis, and Treatment; FC; transitional age youth; and Affordable Care Act (ACA). These worksheets provide additional context for many of the PMs shown in this report. CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5.
- Validation and analysis of each MHP's network adequacy as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.
- Validation and analysis of beneficiaries' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic, February 2023. The COVID-19 impact was exacerbated by several fires and floods that Sonoma County has experienced over the past several years. 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.

During this review period the MHP county staff vacancy rate increased from 13 to 27 percent. Hiring and retention have impacted all aspects of the Behavioral Health service delivery system including but not limited to: leadership changes including the Director of Health Services, two Assistant Directors of Health Services, the Chief Financial Officer, Compliance Officer, Administrative Services Officer, and Behavioral Health Division Director. California Advancing and Innovating Medi-Cal (CalAIM) and the BHQIP required significant additional administrative resources.

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.

Significant Changes

- The MHP filled two vacant leadership positions: Department of Health Services (DHS) Director and Behavioral Health Division Director.
- In January 2022, the MHP launched InRESPONSE, a collaboration between the MHP, the City of Santa Rosa, Catholic Charities, Buckelew Programs, and Humanidad. InRESPONSE provides mobile crisis team services.
- In October of 2022, the MHP launched a Suicide Prevention Coalition to assist the MHP develop a suicide prevention strategic plan.
- In January 2022, the MHP opened a 16-bed adult Psychiatric Health facility (PHF), operated by Crestwood Behavioral Health. Sonoma County contracts for 14 beds.

Current Initiatives

- Sonoma County DHS created a new division, the Homeless Services Division.

- In collaboration with CalMHSA, the MHP is adopting a new EHR for the MHP and DMC-ODS systems of care. The expected go-live date is July 2023.
- The MHP has issued multiple requests for proposals (RFPs) to augment treatment capacity through telehealth providers. Youth and adult treatment programs will be added during CY 2023. The MHP is developing mobile clinics to support field-based teams in hard-to-reach rural areas.
- The MHP is adding 20 peer positions into county MHP and Drug Medi-Cal Organized Delivery System (DMC-ODS) programs, including career ladder positions.
- The children's services are planning to train all clinicians working in the Foster Youth Team and Child Full Service Partnerships (FSP) in Trauma-Focused Cognitive Behavior Therapy.
- The MHP received a Proposition 47 grant to conduct intensive jail in-reach to individuals with serious mental illness and/or substance use disorders who are repeatedly incarcerated but decline services.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: Investigate reasons and develop and implement strategies to improve the MHP overall PR of 2.5 percent.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially met this recommendation. From CY 2020 to CY 2021, the MHP increased the number of beneficiaries served from 2,981 to 3,227, representing an increase of 8.25 percent. From CY 2020 to CY 2021, The Medi-Cal eligibles for Sonoma County increased from 119,200 to 129,764, an increase of 8.86 percent. Despite the increase in individuals served the overall PR decreased slightly from 2.50 to 2.49 percent.
- Barriers to increasing the PR include but are not limited to: increased staff attrition, an overall lack of capacity, and difficulty obtaining initial and ongoing services.
- To fully meet this recommendation the MHP would need to fully implement the initiatives itemized and significantly increase treatment capacity.
- Initiatives from the MHP, competed or in progress:
    - The MHP conducted a Capacity Assessment in the Fall/Winter of 2022. The assessment consisted of a community survey (n=421 respondents), seven focus groups (including current & former clients, and CBOs), and eight key informant interviews. Findings indicate that both providers and clients reported the top two greatest issues of the MHP system were:

"Services are hard to access (difficult to get appointments, inconvenient locations/hours)," and "Crisis services not available to everyone." In addition, the most challenging part of receiving services was: "I have or my loved one has to wait a long time to get an appointment" and "I or my loved one don't know where to go for services or the location of services is not convenient."

- To address initial and on-going treatment access barriers, the MHP is implementing four separate initiatives:
  - Hiring of three additional behavioral health screeners at the Access Call Center to augment screening capacity.
  - Implementing several mobile clinics to support field-based teams in hard-to-reach rural areas.
  - Re-designing the prior Whole Person Care (WPC) pilot program into the new Enhanced Care Management and WPC Outpatient program to provide an additional access entry point, specifically for clients struggling with homelessness.
  - Implementing the DHCS Performance Improvement Project FUM to provide a BH care navigator for hospital emergency departments to facilitate timely connections to outpatient MHP services.
- To address the need to increase outpatient treatment capacity, particularly in treatment services, the MHP is implementing the following initiatives:
  - Behavioral Health School Partnership Program to provide crisis response in schools, direct linkage to the MHP Youth Access team, assessment of children and youth to determine recommended level of care, assistance in connecting youth and their families to needed mental health services through Sonoma County Behavioral Health (SCBH), and training for school staff on available SCBH services, and mental health topics.
  - An additional youth outpatient therapy program is currently under contract negotiations. The new contract provider will add individual and family therapy resources for up to 30 youth per fiscal year.
  - A newly selected adult outpatient therapy program is currently under contract negotiations. The new contract provider will add additional capacity to the adult system of care for up to 200 adult beneficiaries.
  - The department has issued an RFP to augment treatment capacity through telehealth providers.

Recommendation 2: Investigate reasons and develop and Implement strategies, to improve the MHP Latinx PR of 1.23 percent.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially met this recommendation. The MHP reported that in FY2021-22 the Hispanic/Latino PR increased to 1.85 percent, serving 977 of 52,694 Medi-Cal eligibles. The BHC provided CY 2021 claims data indicated an increase to 1.28 percent, serving 665 of 51,799 Medi-Cal eligibles. Although the MHP data represents a 50 percent increase over the 1.23 percent PR reported in baseline year CY 2020, both the MHP and Claims Data percentages would need to more than double to equal the state average PR of 3.74 percent.
- Barriers to increasing the PR include but are not limited to increased staff attrition; an overall lack of capacity; a lack of Hispanic/Latino staff; and an insufficient number of Spanish speaking staff.
- To fully meet this recommendation the MHP would need to fully implement the initiatives itemized and significantly increase treatment capacity and staffing, especially of Hispanic/Latino and Spanish speaking staff.
- Initiatives from the MHP, competed or in progress:
    - The MHP's Hispanic/Latino MH Access Workgroup is implanting two intervention strategies: behavioral health system capacity interventions intended to improve the system's ability to serve Hispanic/Latino beneficiaries with culturally appropriate services, and Mental Health outreach and engagement to Hispanic/Latino.

Recommendation 3: Investigate reasons and develop and implement strategies, to improve the percentages of beneficiaries served that meet the MHP standard for timeliness to first non-urgent request psychiatry appointment (44.94 percent), and first non-urgent psychiatry appointments rendered (42.41 percent).

(This recommendation is a carry-over from FY 2018-19 and FY 2020-21.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially met this recommendation. From FY 2020-21 to FY 2021-22 the timeliness to first non-urgent requested psychiatry appointment increased from 45 to 48 percent, a 6.67 percent increase. From FY 2020-21 to FY 2021-22 the timeliness to first non-urgent psychiatry appointments delivered increased from 42 to 45 percent, a 7.14 percent increase. Although the MHP data represents an increase, both offered and delivered first psychiatric services are less than 50 percent. In addition, staff; clients; the MHP's MHSA Capacity Assessment; and the ATA data indicate that this recommendation is not fully met.
- Barriers to increasing timeliness to first non-urgent request psychiatry appointment, and first non-urgent psychiatry appointments delivered include reduced initial access timeliness; difficulty for consumers to schedule initial and ongoing appointments as presented in the MHP's MHSA Capacity Assessment; and psychiatric capacity.

- To fully meet this recommendation the MHP would need to fully implement the initiatives itemized as many are not yet implemented; improve initial access to first non-urgent request and rendered appointments; assure capacity meets the need for an expanded penetration.
- Initiatives from the MHP, competed or in progress:
    - Psychiatry appointment no-show analysis revealed that 46 percent of all initial psychiatry no-shows were attributed to post-hospital clients. A second analysis showed that the clients who were unopened to MHP services at or prior to their hospitalization were far more likely to miss their post-hospital appointments, suggesting a need for greater engagement of "unopened" clients at the hospital.
    - Psychiatry capacity was increased by an additional .60 FTE.
    - The MHP is developing management tools for psychiatric services including productivity reporting, timeliness performance, and sharing results with stakeholders. The MHP presented a continued need to address data tracking, scheduling, and case assignment practices for psychiatrists.
    - The MHP plans to revert to a previous team-based model of psychiatry assignments in Adult System of Care.

Recommendation 4: Investigate reasons and develop and implement strategies, to improve CSU staffing and reduce MHP adult crisis services utilization, stays over 23 hours and use of diversion protocols.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially met this recommendation. Although the MHP implemented several strategies to improve CSU staffing and to reduce MHP adult crisis services utilization, stays over 23 hours and use of diversion protocols, the issues cited continue.
- Barriers to meeting this recommendation included: staff attrition that equaled or exceeded staff hires; the newly opened PHF experienced extended lengths of stays (LOSs); the MHP protocol sends urgent needs for assessment and medication to the CSU; the website promotes the CSU as the first option on the crisis services webpage; the MHP survey validated difficulties obtaining timely initial and ongoing OP appointments.
- To fully meet this recommendation the MHP would need to fully implement the initiatives itemized, stabilize the CSU staffing, and address any additional barriers.
- Initiatives from the MHP, competed or in progress:
    - Implemented regular monitoring and analysis of reports on CSU overstays.

- Continuously recruited for and hired staff (who subsequently resigned).
- Opened the PHF.
- Initiated a process to add peers to the CSU.
- Completed an MOU with West County Community Services to have students in their Peer Support Training intern at the CSU to help with the employment pipeline.
- Underfilled two Behavioral Health Clinician positions with Senior Client Support Specialists to have more staffing support at the CSU while not interfering with the mandated licensed staff-to-client ratio.
- Completed two (2) RFP's to add resources to treatment teams in an effort to reduce the need for crisis services.
- Launched Strengths Model Case Management training for staff on two selected FSPs.

Recommendation 5: Investigate reasons and develop and implement strategies, to improve HIE interoperability between the CBOs and county EHR system(s) and include the involvement of CBOs in planning, development, and implementation processes.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP partially met this recommendation. The MHP has elected to implement the CalMHSA semi-statewide EHR, Streamline's SmartCare product, and is in the first wave of counties to go live in July 2023. The MHP has taken a step to determine CBO's capabilities and desire to use the new EHR, however, investigating reasons and developing strategies to improve interoperability is still in the early stages and mostly undecided at the time of the review.
- Barriers to meeting this recommendation included the time needed to implement the new EHR, and the possibility that CBOs will not use the new EHR re-creating the same interoperability issues between CBOs and county EHR system(s).
- To fully meet this recommendation the MHP will need to implement the new EHR and include the CBOs, unifying the system of care under one EHR, or have developed HIE interoperability solutions for CBOs as part of the EHR implementation.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 56 percent of services were delivered by county-operated/staffed clinics and sites, and 44 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 85 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is operated by the MHP during regular business hours and by a contractor after hours, weekends, and holidays; beneficiaries may request services through the Access Line as well as through the following system entry points: for adults, all beneficiaries are assessed by the Access Team as the system entry point. However, if a beneficiary requests to be initially assessed at one of the county clinics closer to their residence, this can be facilitated by the Access Team doing the assessment at the county clinic. In addition, the Forensic Assertive Community Treatment and MH Diversion teams provided an additional direct access point and the MHP is introducing field assessments. For children, most beneficiaries are initially referred to services by the Youth Access Team via a screening process. The exceptions include the following: 1) Human Services refers foster youth directly to Foster Youth Team; 2) Juvenile Hall; 3) Valley of the Moon (children's shelter for kids removed from their homes by Human Services). In addition, in several cases the initial assessment (subsequent to the screening) is performed by the CBO directly. This is the case for wraparound, and Short-Term Residential Programs. Otherwise, it's the Youth Access Team, Foster Youth Team, Juvenile Hall, or Valley of the Moon that does the screening & assessment.

[1] CMS Data Navigator Glossary of Terms

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth video to youth and/or adults**.** In FY 2021-22, the MHP reports having provided telehealth services to 1063 (2223 previous year) adult beneficiaries, 873 (972 previous year) youth beneficiaries, and 201 (257 previous year) older adult beneficiaries across 11 county-operated sites and 9 contractor-operated sites. Among those served, 243 (388 previous year) 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 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 below.

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 Sonoma County, the time and distance requirements are 30 miles and 60 minutes for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

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

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

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

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP is actively working on multiple efforts to recruit and fill positions to improve initial access and access to routine and crisis services.
- The MHP has greatly enhanced their knowledge of service needs and gaps through strategic surveys of beneficiaries, staff, and CBOs.
- The MHP has increased Hispanic/Latino PR to 1.28 percent but is still 192 percent lower than the statewide average of 3.74 percent. System validation sessions with staff represented a shortage of Spanish speaking staff in many programs.
- Despite efforts to recruit staff, the delivery system is severely hampered by staff attrition that increased from 13 percent to 27 percent in the last year. Furthermore, children's crises access is represented as difficult to access and navigate.
- However, the coordination of CalAIM with the Managed Care Plans (MCP) is primarily through the Federally Qualified Health Clinic providers and not the MCP.

- However, it is difficult to convert to Spanish on the website and the website seems more academic than client friendly. The website crisis connection defaults to the CSU as the first point of contact.

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, the PR is noticeably lower than the statewide rate.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Annual Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	129,764	3,227	2.49%	$43,752,884	$13,558
CY 2020	119,200	2,981	2.50%	$36,264,933	$12,165
CY 2019	118,537	3,179	2.68%	$33,020,454	$10,387

- The eligible population and the number of beneficiaries served increased from the previous year. The average approved claim per beneficiary also increased in CY 2021.

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	13,072	78	0.60%	1.08%	1.96%
Ages 6-17	31,269	894	2.86%	4.41%	5.93%
Ages 18-20	7,025	212	3.02%	3.73%	4.41%
Ages 21-64	66,838	1,833	2.74%	4.11%	4.56%
Ages 65+	11,561	210	1.82%	2.26%	1.95%
Total	129,764	3,227	2.49%	3.67%	4.34%

- The PR in every age group is lower than both similar size counties and the statewide rate. The overall PR is also lower than both similar size counties and statewide. The largest PR is in the 18-20 age group followed by the 6-17 age group.

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	400	12.40%
Threshold language source: Open Data per BHIN 20-070		

- Nearly 1 in 8 beneficiaries served speaks Spanish.

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	42,134	824	1.96%	$10,132,728	$12,297
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.
- ACA eligibles represent 32.47 percent of the overall Medi-Cal population and the PR is noticeably less than the medium size county and statewide rate; however the AACB exceeds statewide.

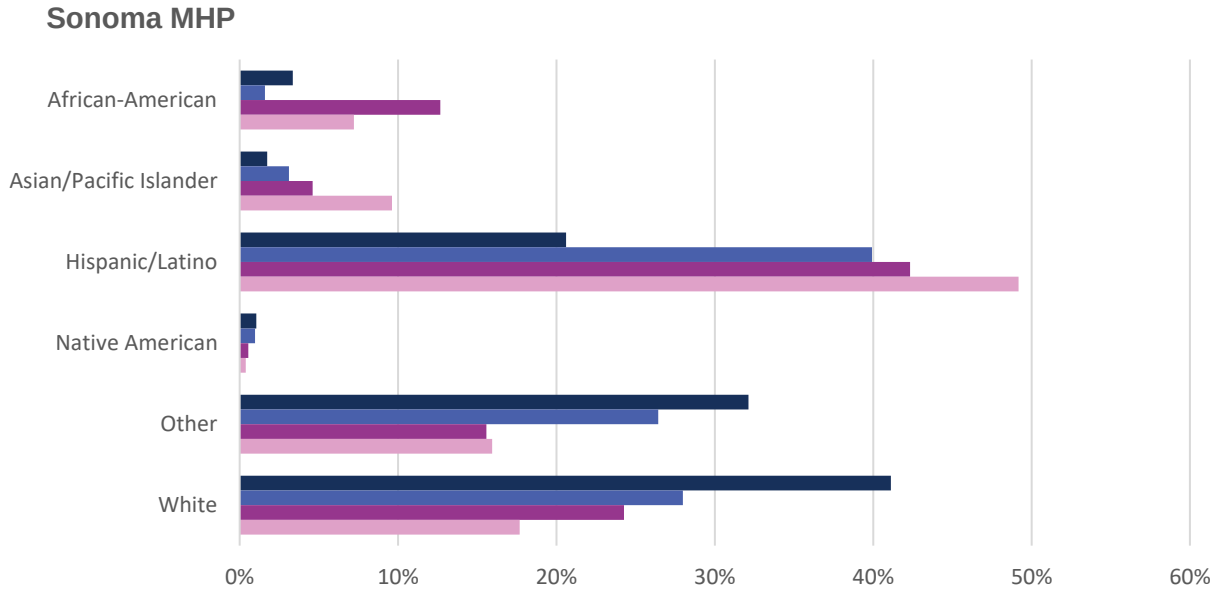
The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions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

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

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	2,058	108	5.25%	7.64%
Asian/Pacific Islander	4,038	56	1.39%	2.08%
Hispanic/Latino	51,799	665	1.28%	3.74%
Native American	1,260	34	2.70%	6.33%
Other	34,294	1,037	3.02%	4.25%
White	36,315	1,327	3.65%	5.96%
Total	**129,764**	**3,227**	**2.49%**	**4.34%**

- The MHP's PR is lower than statewide in every race/ethnicity category. The Hispanic/Latino PR is approximately 66 percent lower than the statewide rate and the White PR is approximately 39 percent lower than the statewide rate.

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

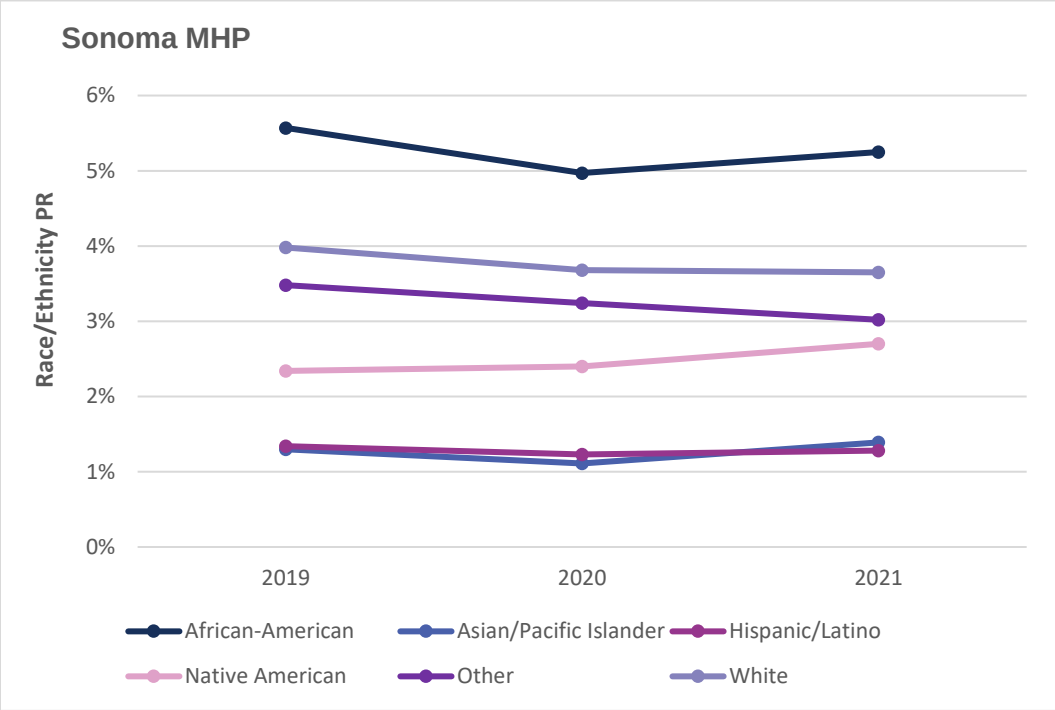


	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	41%	32%	1%	21%	2%	3%
MHP % Eligible	28%	26%	1%	40%	3%	2%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

- Similar to the pattern seen statewide, White beneficiaries are disproportionately overrepresented among beneficiaries served relative to the Medical eligible population, whereas Hispanic/Latino beneficiaries are underrepresented.

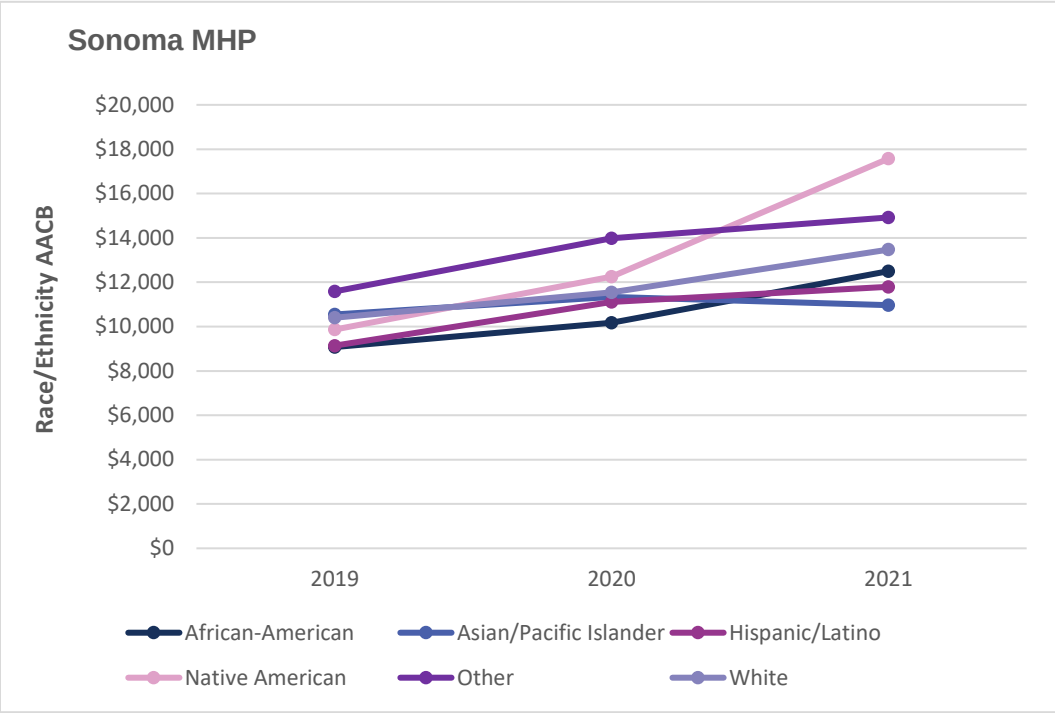
Figures 2–11 display the PR and AACB for the overall population, two race/ethnicity groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



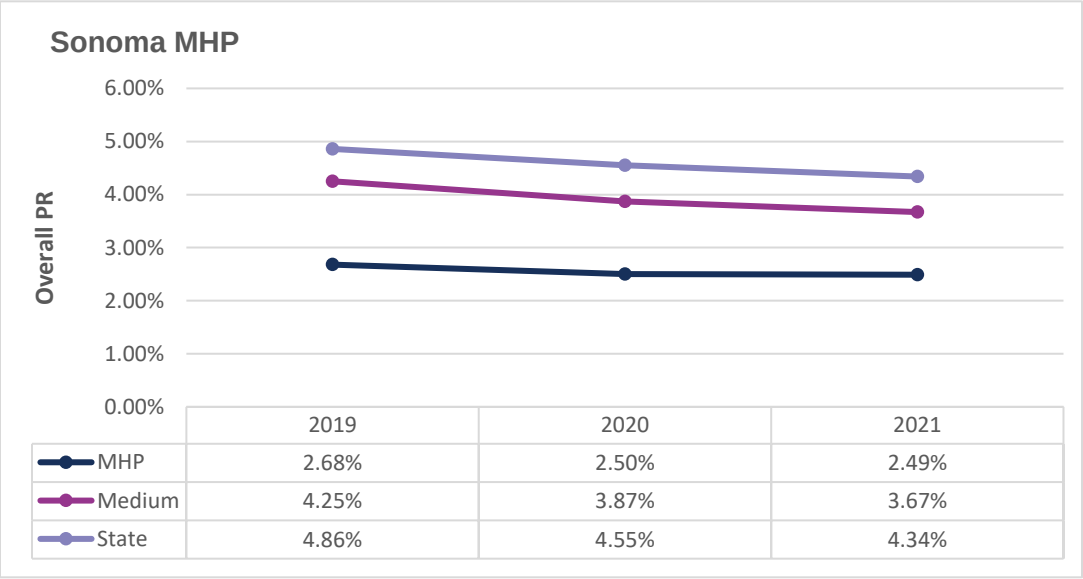
- The trend lines vary by category. The African-American, Native American and Asian/Pacific Islander trend lines appear to have risen since CY 2020, the White and Hispanic/Latino categories appear about the same and the Other category has taken a downward turn. The African-American PR has consistently been higher than other groups, whereas the Hispanic/Latino and Asian/Pacific Islander PR is the lowest.

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



- The AACB is on an upward trend for most race/ethnicity groups except for the Asian/Pacific Islander category that is trending downward.

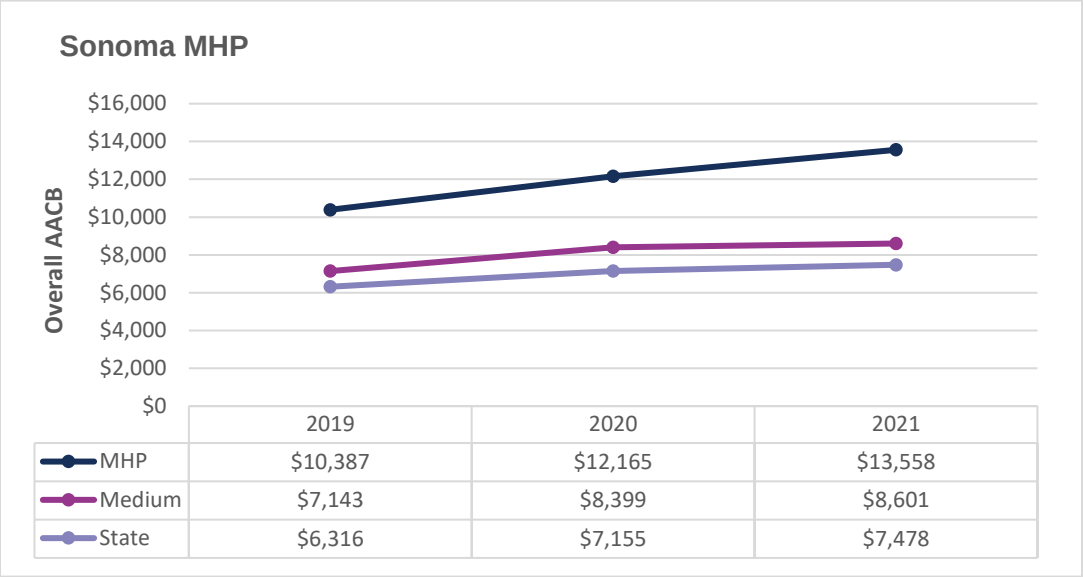
Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	2.68%	2.50%	2.49%
Medium	4.25%	3.87%	3.67%
State	4.86%	4.55%	4.34%

- The MHP's PR has stayed fairly level, especially the last two years, unlike the downward trend taken by medium counties and statewide. Overall, the PR has consistently remained lower than the medium and statewide PR.

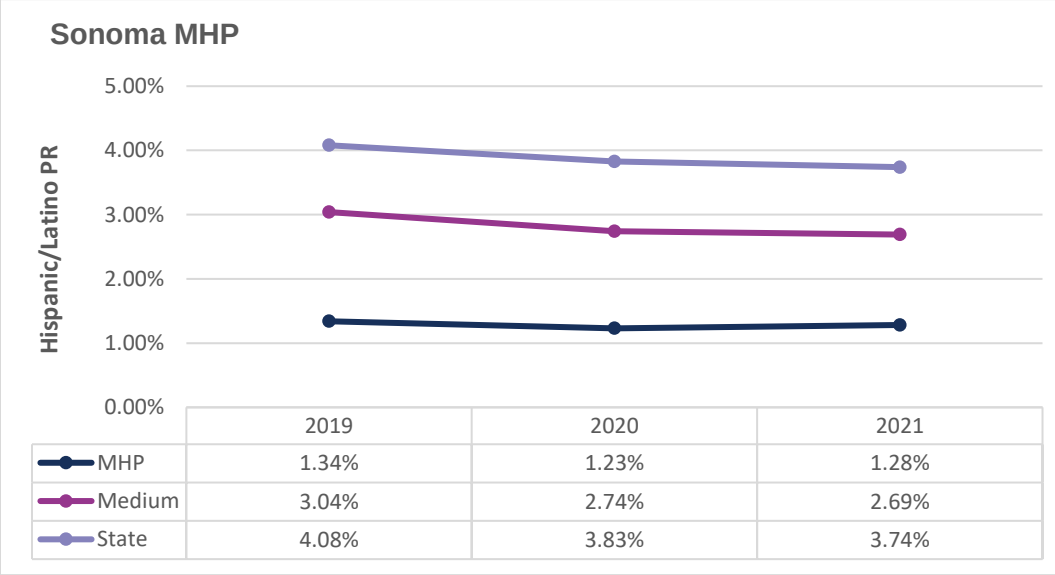
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$10,387	$12,165	$13,558
Medium	$7,143	$8,399	$8,601
State	$6,316	$7,155	$7,478

- The MHP's AACB has steadily increased since CY 2019 and has consistently surpassed both medium counties and statewide.

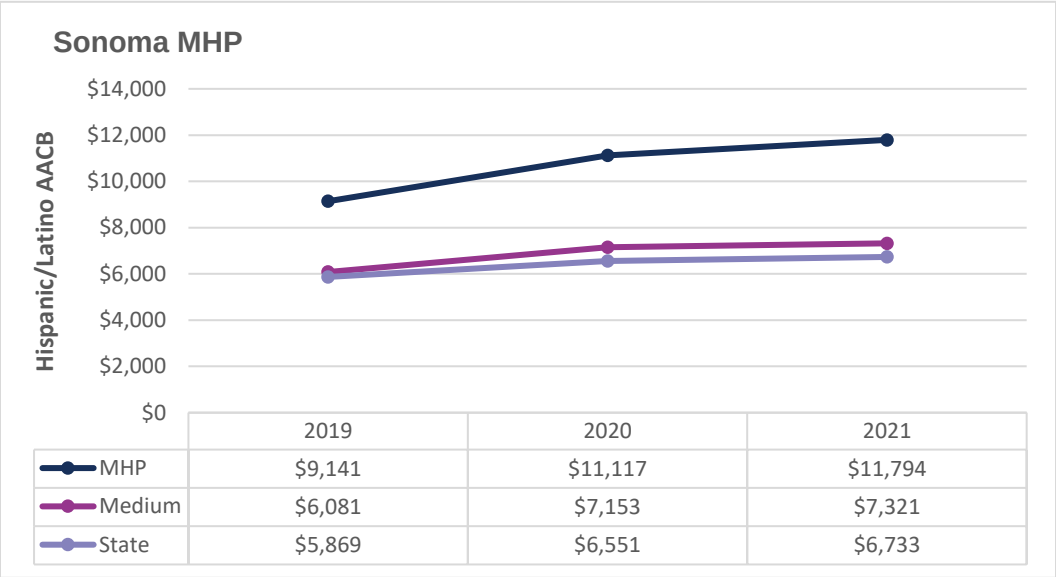
Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	1.34%	1.23%	1.28%
Medium	3.04%	2.74%	2.69%
State	4.08%	3.83%	3.74%

- The MHP PR has consistently stayed lower than medium county and statewide PR, but has remained mostly level the last three years, unlike the medium county and state downward trend.

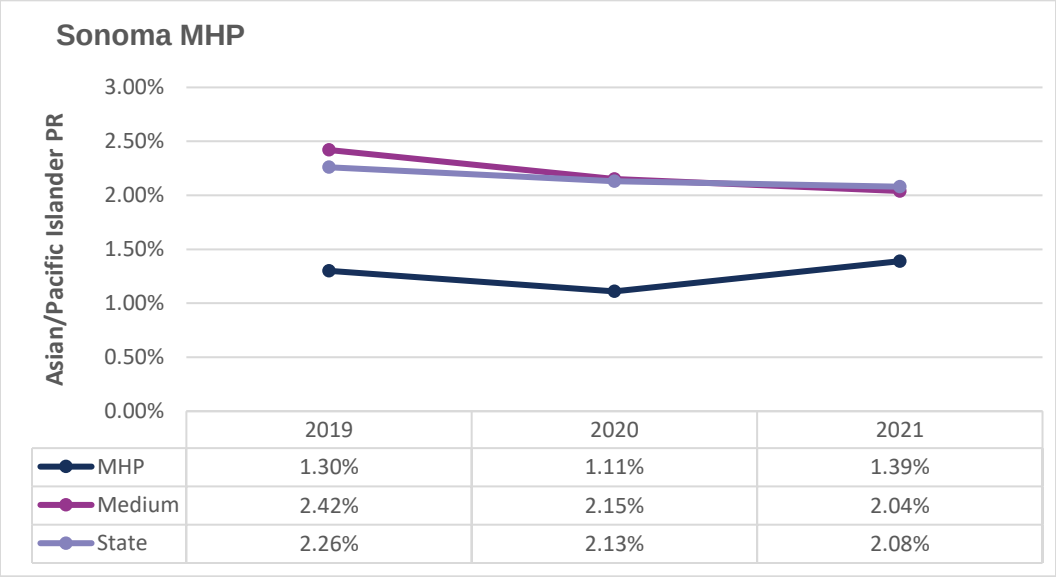
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$9,141	$11,117	$11,794
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

- The AACB for the Hispanic/Latino population is on an upward trend and exceeds both the medium county and state AACB.

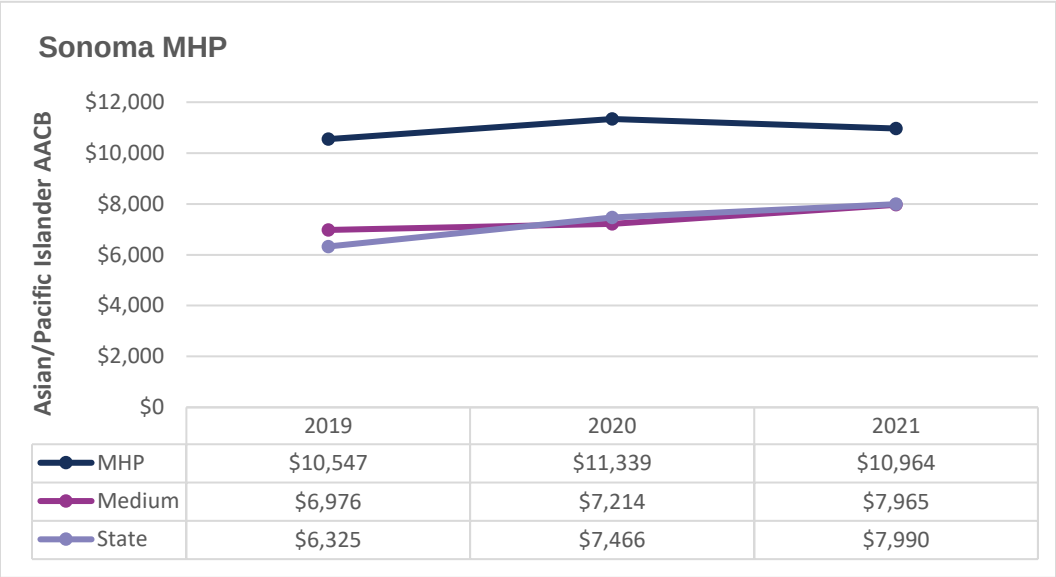
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	1.30%	1.11%	1.39%
Medium	2.42%	2.15%	2.04%
State	2.26%	2.13%	2.08%

- The PR for the Asian/Pacific Islander population is on an upward trend since CY 2020; however, the PR has consistently remained lower than the medium county and statewide PR for the last three years.

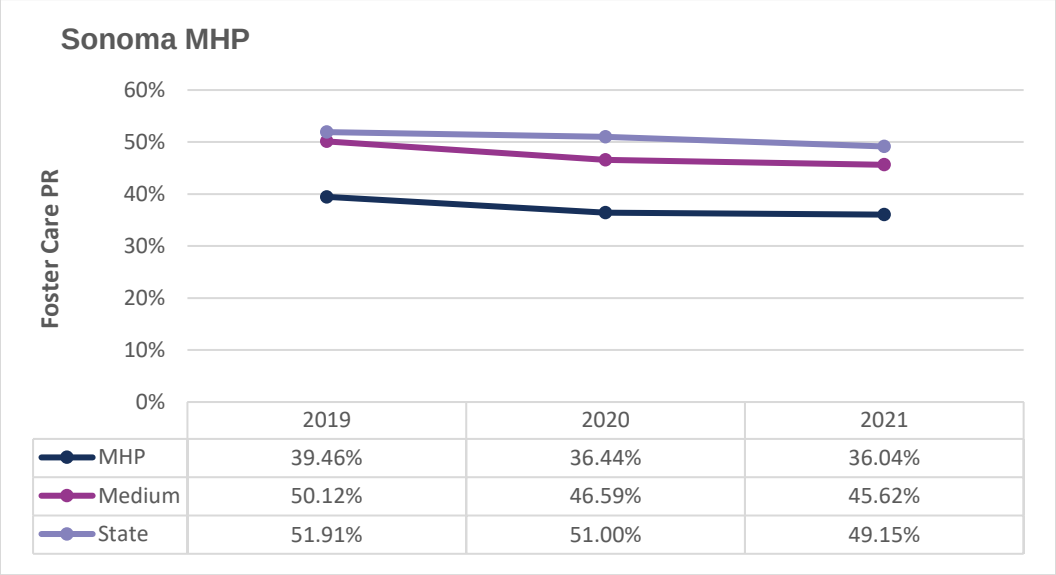
Figure 9: Asian/Pacific Islander AACB CY 2019-21



	2019	2020	2021
MHP	$10,547	$11,339	$10,964
Medium	$6,976	$7,214	$7,965
State	$6,325	$7,466	$7,990

- The AACB has decreased slightly in CY 2021, unlike the medium county and state upward trend; however, the MHP AACB remains higher than similar size counties and state.

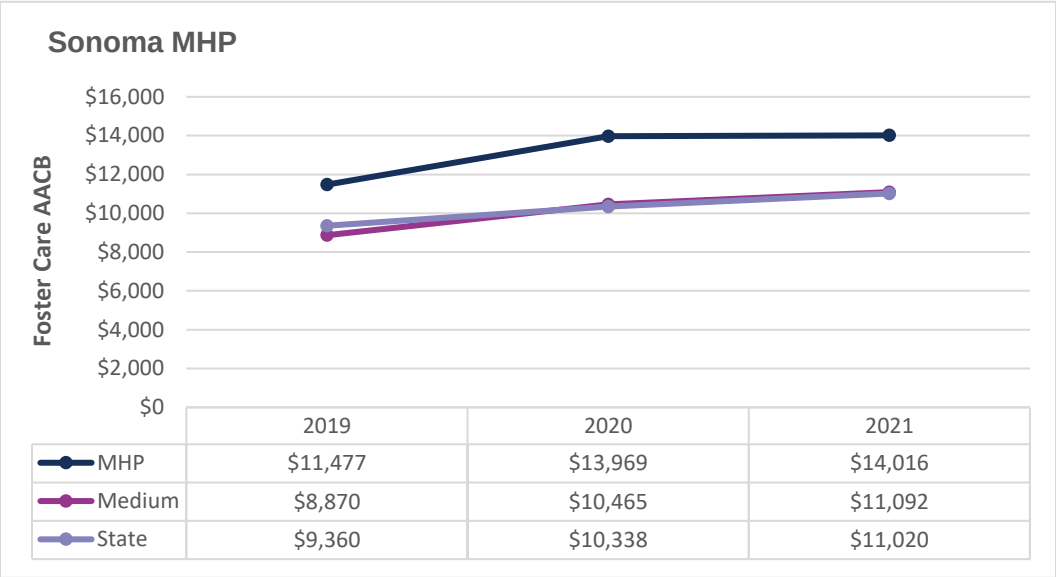
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	39.46%	36.44%	36.04%
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 three years displayed.
- The MHP FC PR has consistently remained lower than medium counties and statewide.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$11,477	$13,969	$14,016
Medium	$8,870	$10,465	$11,092
State	$9,360	$10,338	$11,020

- The MHP FC AACB has stayed fairly level between CY 2020 and CY 2021 and has consistently exceeded both medium counties and state FC AACB.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 2,255				Statewide N = 391,900		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	267	11.8%	10	7	11.6%	16	8
Inpatient Admin	<11	-	16	16	0.5%	23	7
Psychiatric Health Facility	<11	-	8	7	1.3%	15	7
Residential	64	2.8%	108	77	0.4%	107	79
Crisis Residential	218	9.7%	23	20	2.2%	21	14
Per Minute Services							
Crisis Stabilization	584	25.9%	1,779	1,200	13.0%	1,546	1,200
Crisis Intervention	312	13.8%	241	167	12.8%	248	150
Medication Support	1,486	65.9%	505	285	60.1%	311	204
Mental Health Services	1,570	69.6%	971	407	65.1%	868	353
Targeted Case Management (TCM)	1,460	64.7%	517	265	36.5%	434	137

- The percentage of adults in the MHP receiving Crisis Residential and CSU services is noticeably higher than statewide and the average number of units is also higher than statewide.
- A higher percentage of adults in the MHP receive TCM services with a higher average of units than seen statewide.

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

Service Category	MHP N = 191				Statewide N = 37,489		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	14	7.3%	15	11	4.5%	14	9
Inpatient Admin	0	0.0%	0	0	0.0%	5	4
Psychiatric Health Facility	0	0.0%	0	0	0.3%	22	8
Residential	<11	-	87	87	0.0%	185	194
Crisis Residential	<11	-	76	76	0.1%	17	12
Full Day Intensive	0	0.0%	0	0	0.2%	582	441
Full Day Rehab	<11	-	54	54	0.5%	97	78
Per Minute Services							
Crisis Stabilization	<11	-	2,709	1,200	3.1%	1,398	1,200
Crisis Intervention	16	8.4%	347	143	7.5%	404	198
Medication Support	88	46.1%	610	362	28.3%	394	271
TBS	11	5.8%	980	870	4.0%	4,019	2,372
Therapeutic FC	0	0.0%	0	0	0.1%	1,030	420
Intensive Care Coordination (ICC)	101	52.9%	898	394	40.0%	1,351	472
Intensive Home Based Services (IHBS)	55	28.8%	1,275	682	20.3%	2,256	1,271
Katie-A-Like	0	0.0%	0	0	0.2%	640	148
Mental Health Services	181	94.8%	1,799	877	96.3%	1,848	1,103
Targeted Case Management	93	48.7%	415	89	35.0%	342	120

- The percentage of FC youth receiving inpatient services is slightly higher than statewide and on average is one day more than state average units.
- A higher percentage of FC youth receive services in most categories except Mental Health Services, which is slightly lower than statewide; however, the average units and median units vary by category on the comparison with the state. The categories with the biggest differences between the MHP and statewide include Medication Support and TCM services.
- The largest disparity between the MHP average number of units and state are in the ICC, IHBS, and TBS service categories. The percentage of ICC, IHBS and

TBS services exceeds the statewide percentage, however, the MHP's average units of service is much lower compared to statewide.

IMPACT OF ACCESS FINDINGS

The MHP is proactively addressing service needs and gaps through identifying gaps and needs, securing funding, and improving program design. Unfortunately, planning is impacted by a 27 percent vacancy rate. In addition, the county has launched several new programs and that require additional staffing.

The MHP PR rates for all race/ethnicity categories are similar or slightly higher than the previous year, except for a decrease in the "other" category. The increase in the categories may be more a product of improved initial capture of race/ethnicity and not an improvement in actual penetration. Overall, the beneficiaries served increased by 246 but showed a drop in PR from 2.5 percent to 2.49 percent due to an increase of 10,564 additional Medi-Cal eligibles. If the Medi-Cal eligibles had not increased the PR would be 2.7 percent. The MHP provides a greater number and higher claims per beneficiary than the statewide averages. Given the staff attrition increase from 13 to 27 percent in this review period, the increased services and claims may be less due to overall service increases and more a result of the extensive use of CSU services (25 percent adult beneficiaries) and CSU overstays.

Children's services access, treatment after access, and crisis access are areas of concern for the MHP. In the context of the 2022 children's medical necessity criteria changes to include trauma exposure; wards of the court; dependents of the court; and homeless youth; the MHP is expected to experience an increased demand for Children's services while currently struggling to meet the current demand.

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.

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The MHP's follow-up after psychiatric hospitalization (2D) and psychiatric readmission rates (2E) evidence system is designed to directly assist those transitioning from acute crisis facilities to access services.

- The methodology of the timeliness subcomponents 2A-F are all met but the outcomes, already low, have generally decreased. Comparing the current timeliness key subcomponents, 2A-F, as presented in Table 11, to the previous year report, averages have increased and all percentages have decreased for meeting the standards except First Non-Urgent Psychiatry Appointment Offered (45 to 48 percent) and No-Show Rate – Clinicians (3.52 to 1.9 percent). The First Non-Urgent Psychiatry Appointment Offered improvement appears to be directly related to the MHP addressing the response to recommendation by increasing psychiatric services access. The No-Show Rate – Clinicians reduction appears to be directly related to a non-appointment model adopted by the adult system of care.
- As documented in the Access Key components, the MHP evidences excellent use of strategic surveys of beneficiaries, staff, and CBOs.
- As documented in the Access Key components, the MHP timeliness is impacted by staff vacancy increasing from 13 percent to 27 percent in the last year.
- Subcomponent 2C is met but the numbers are primarily reflecting CSU admissions.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP ATA report represents access to care during the 12-month period of FY 2021-22. Table 11 and Figures 12 – 14 display data submitted by the MHP; an analysis follows. This data represented the entire system of care. The MHP generally does not schedule appointments for clinician services so data is not available to measure the Clinician No-show rate.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	9.82 Business Days	10 Business Days*	72.83%
First Non-Urgent Service Rendered	13.62 Business Days	10 Business Days**	57.36%
First Non-Urgent Psychiatry Appointment Offered	19.49 Business Days	15 Business Days*	48%
First Non-Urgent Psychiatry Service Rendered	22.97 Business Days	15 Business Days**	45%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	2.48 Hours	48 Hours**	99%
Follow-Up Appointments after Psychiatric Hospitalization	9.08 Days	7 Days**	41.93%
No-Show Rate – Psychiatry	11.6%	<10%**	n/a
No-Show Rate – Clinicians	1.9%	<10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP did not report data for this measure			
For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22			

Comparing the current and previous year ATA data:

- The MHP overall First Non-Urgent Request to First Offered Appointment (KC 2.A) decreased by 25 percent (96.47 to 72.83 percent). The adult metric decreased by 14 percent (97.95 to 84.08 percent), the children's metric decreased by 34 percent (94.82 to 62.60), and FC decreased by 35 percent (81.69 to 53.17 percent). First delivered services saw similar decreases.
- The MHP overall First Non-Urgent Request to First Offered Psychiatric Appointment (KC 2.B) increased by 3 percent (45 to 48 percent). The adult metric increased by 3 percent (37 to 40 percent). The children metric increased by 2 percent (53.23 to 55 percent). The FC metric increased by 11 percent (45.45 to 56 percent). First delivered psychiatric services saw similar, although more modest, increases.
- The MHP overall 7-day and 30-day Follow-Up Appointment after Psychiatric Hospitalization (KC 2.D) trended an increase according to BHC PMs, Medi-Cal Claims data across CY 2019 through 2021.

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

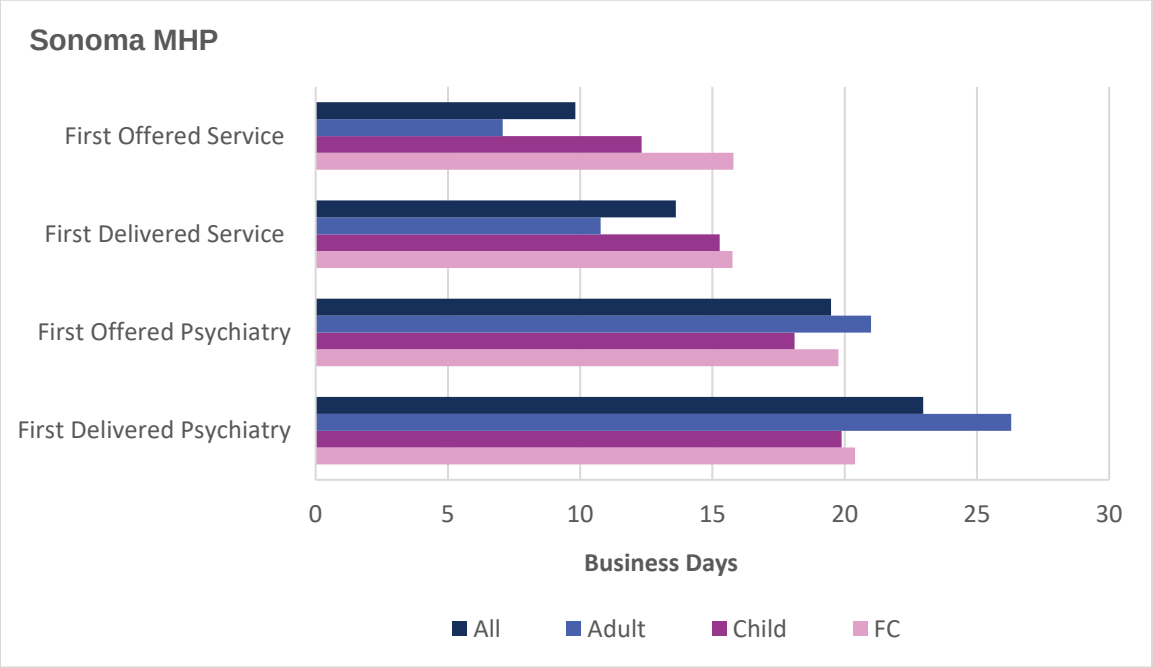


Figure 13: Wait Times for Urgent Services

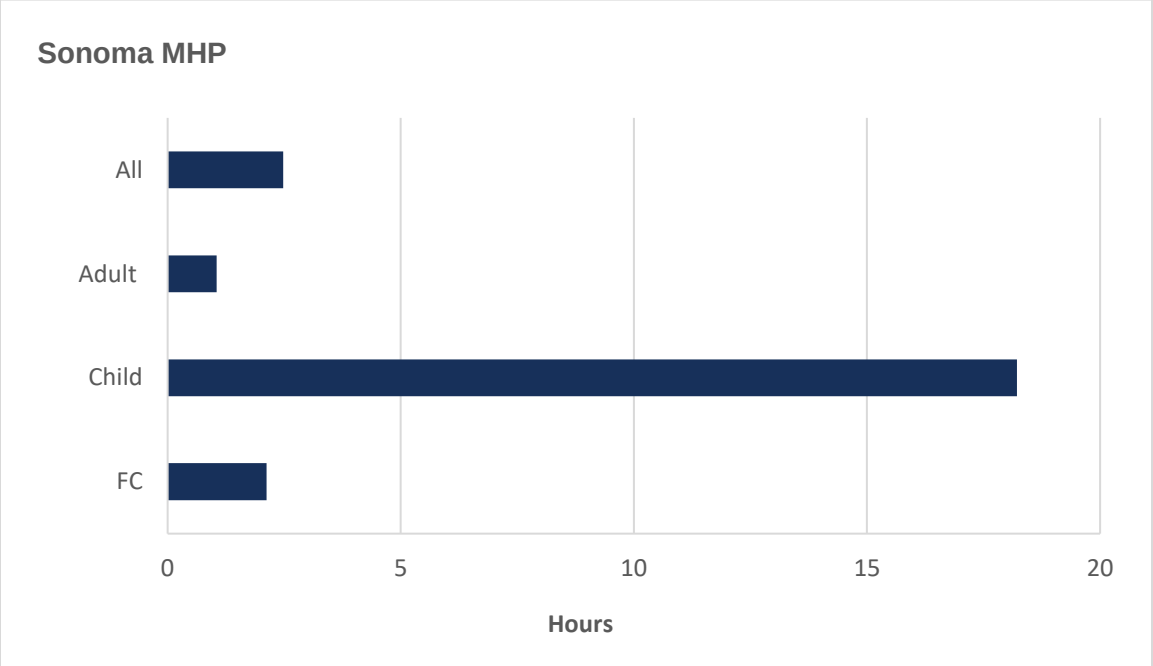
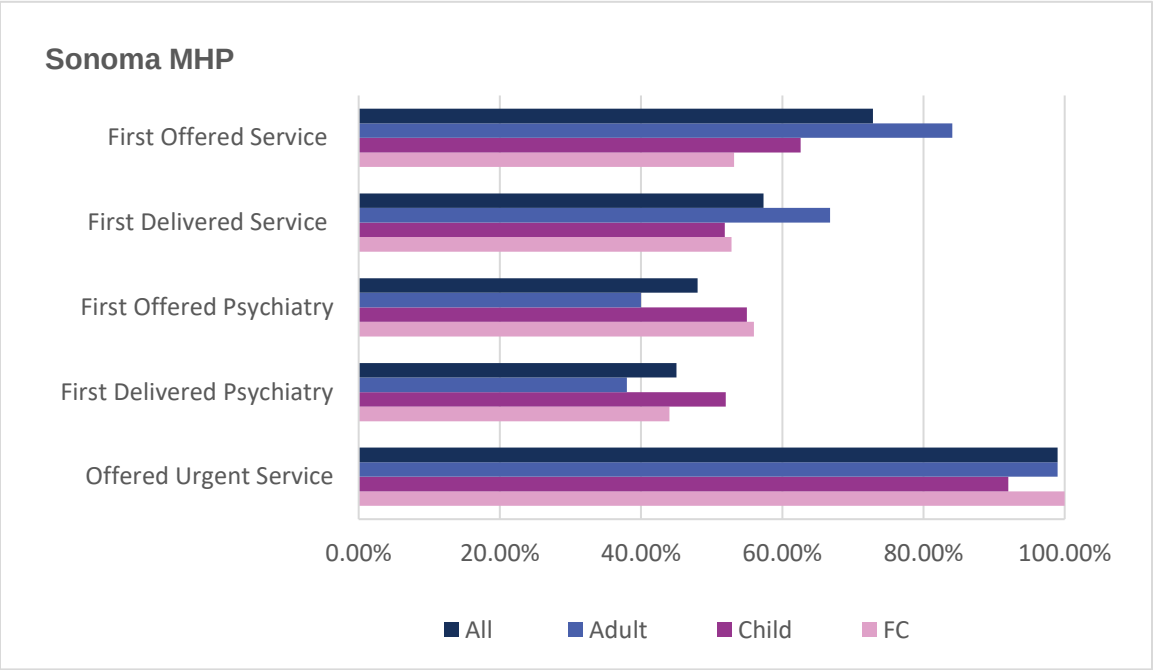


Figure 14: Percent of Services that Met Timeliness Standards



- 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 and unscheduled assessments.
- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an Emergency Department, or a referral to a CSU. The MHP defined “urgent services” for purposes of the ATA as “the beneficiary’s condition is an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the beneficiary’s life or health or could jeopardize their ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee’s condition, not to exceed 72 hours.” There were reportedly 1,194 urgent service requests with a reported actual wait time to services for the overall population at 48 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 the first clinical determination of need from the point of the assessment date or the discharge date from a psychiatric hospital.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are

tracked. The MHP reports a no-show rate of 11.6 percent for all psychiatry services and 1.9 percent for non-psychiatry services.

- The MHP does not schedule appointments for non-psychiatry services and could contribute to the low percentage of no-show rates for clinical services.

IMPACT OF TIMELINESS FINDINGS

The MHP was able to modestly improve psychiatric timelines in response to a recommendation by improving the psychiatric delivery system and increasing telehealth psychiatric services. The MHP was also able to prioritize transitions from acute crisis care facilities to outpatient services. Unfortunately, as documented in the access section, timeliness across the continuum of care is experiencing longer waits, primarily impacted by the number of budgeted positions for each component of care and the 27 percent vacancy of these budgeted positions.

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

The MHP has a QAPI Section Manager that oversees all MHP and SUD quality assurance (QA) /QI activities. The QAPI unit currently has 20 FTE. Breakdown is as follows: 8 MHP QA; 4 MHP QI; 2 SUD QA; and 6 BH QA. Of these 20 FTE, there are 6 vacancies. With State Plan Parity requirements, and pending DMC-ODS enrollment, the QAPI section has requested an additional 5 FTE for SUD. For this review, the MHP provided the QI Evaluation of FY 2021-22, but did not provide a current QI Workplan for the current FY.

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 is comprised of approximately 45 staff, representing county; contractors; administration; clinical; patients' rights and QI, for both MHP and DMC-ODS. Since the previous EQR, the MHP QIC met 12 times. Of the 15 identified FY 2021-22 QAPI workplan goals, the MHP met two, partially met five and did not meet eight. Primary contributors to unmet or partially met goals were staff vacancies, processes that will take longer than one year, and processes that would benefit from the implementation of a new EHR.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths (ANSA); Pediatric Symptom Checklist (PSC-35); and the Child and Adolescent Needs and Strengths (CANS50). The MHP has algorithms for the outcome tools and data is reviewed at the case and aggregate level and are used to inform changes in client LOC, program evaluation, and program planning.

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	Partially 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	Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The MHP has an extensive history of CBO peer programs. Currently the MHP is adding 20 Peer Certified staff positions as county MHP staff.
- The MHP implemented surveys of staff and consumers to help identify gaps and areas of need related to access, timeliness, waits for service after access, and satisfaction and recommendations.
- Subcomponent 3A was rated as partially met. The MHP does not have a current QAPI plan.
- Subcomponent 3D was rated as partially met. The children's outpatient component of the continuum of care appears to struggle to adequately provide for all necessary outpatient service needs. Approximately 25 percent of the adult outpatient system continues to utilize the CSU and frequently has overstays. Both the adult and children's systems reported extreme system and staff stress citing that staffing is not able to meet the demand.
- The MHP tracks and trends the following Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD)

- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)

QUALITY PERFORMANCE MEASURES

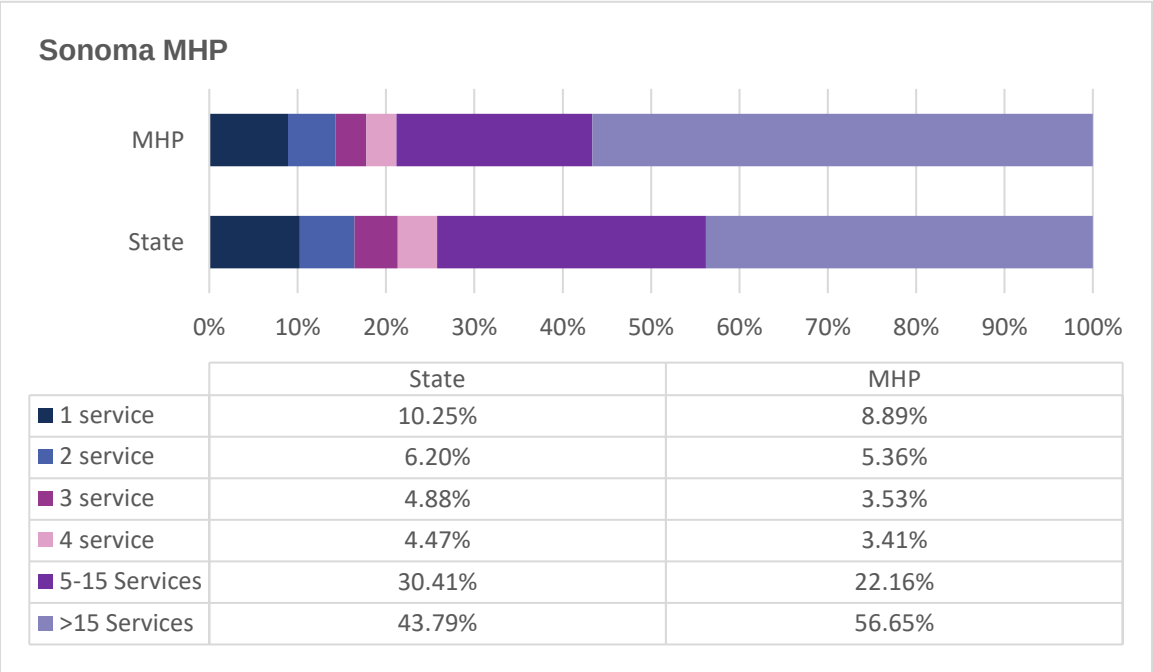
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs display the information as represented in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



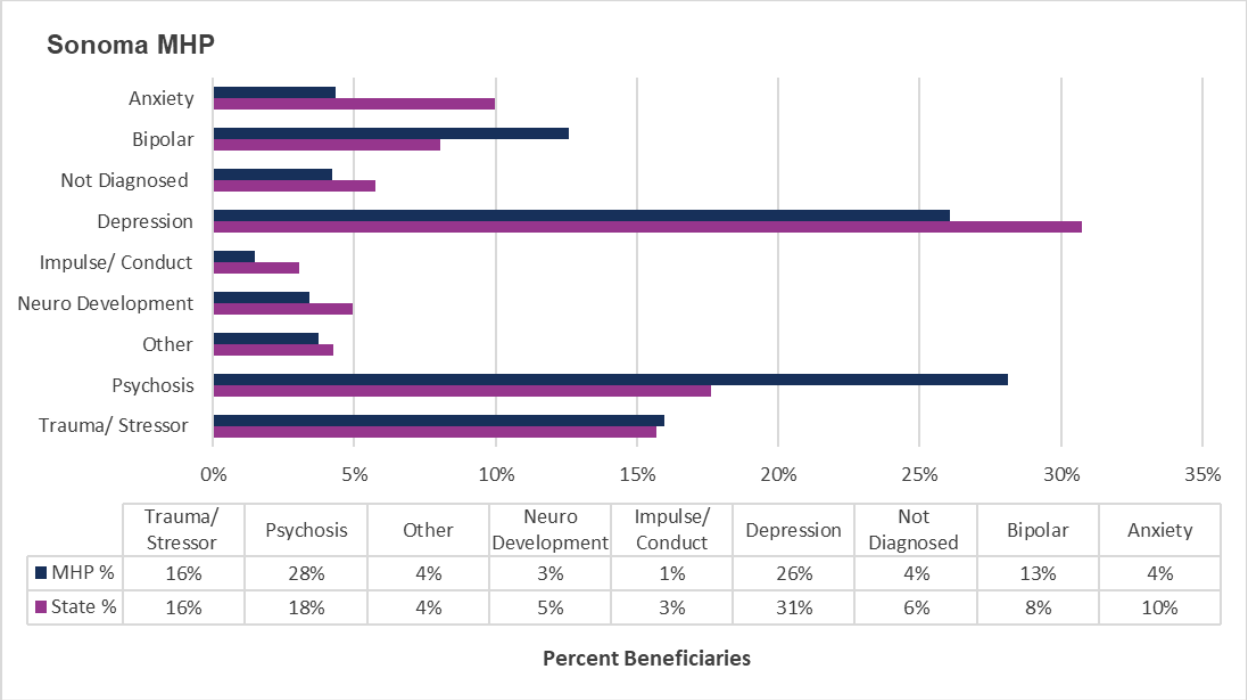
	State	MHP
1 service	10.25%	8.89%
2 service	6.20%	5.36%
3 service	4.88%	3.53%
4 service	4.47%	3.41%
5-15 Services	30.41%	22.16%
>15 Services	43.79%	56.65%

- The percentage of beneficiaries receiving only one service is lower than statewide. The percentage of beneficiaries receiving between 5-15 services is also lower than statewide, but the percentage of beneficiaries receiving over 15 services is higher than statewide.

Diagnosis of Beneficiaries Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures 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.

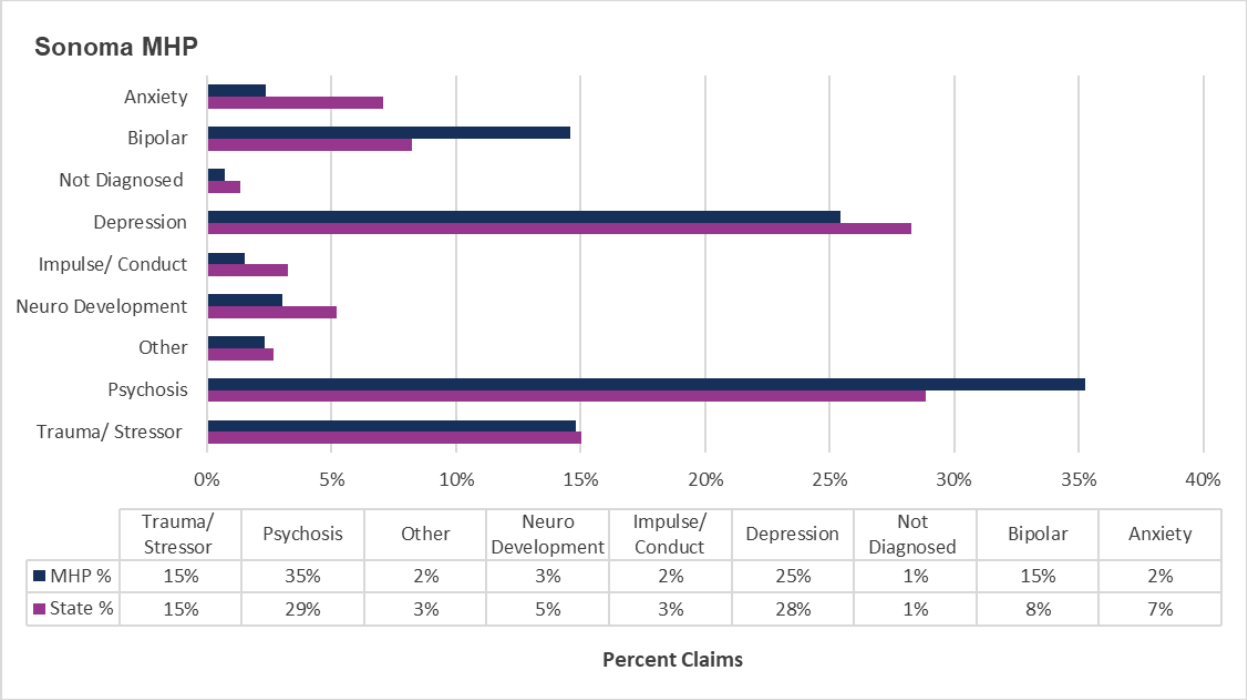
Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	16%	28%	4%	3%	1%	26%	4%	13%	4%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

- The MHP's most prevalent diagnostic category is Psychosis and is noticeably higher than the statewide percentage (28 percent vs 18 percent). The second highest diagnosis category is Depression followed by Bipolar. The percentage of Depression diagnosis is lower than the statewide percentage, however, the percentage of Bipolar diagnosis exceeds the statewide percentage.

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 %	15%	35%	2%	3%	2%	25%	1%	15%	2%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

- The distribution of approved claims is congruent with the diagnostic patterns displayed in Figure 16.

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 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	478	814	8.67	8.86	$13,233	$12,052	$6,325,364
CY 2020	474	778	8.04	8.68	$11,849	$11,814	$5,616,191
CY 2019	428	697	8.54	7.80	$12,243	$10,535	$5,240,134

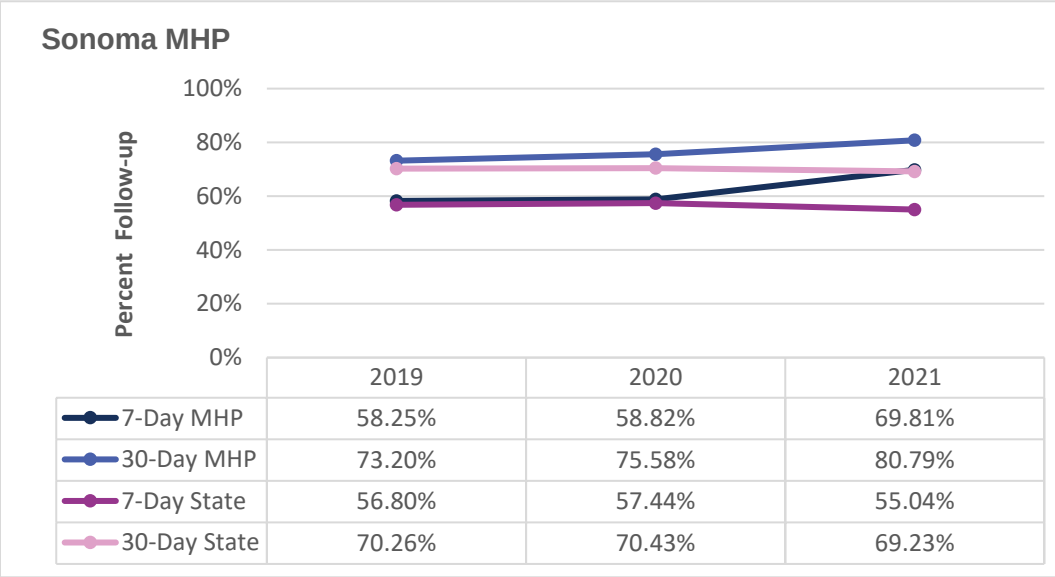
- The number of admissions has steadily increased over the last three years, however, the unique number of beneficiaries only increased by four between CY 2020 and CY 2021. The average LOS is similar to the statewide length of stay and the AACB is higher than the statewide AACB.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2021 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

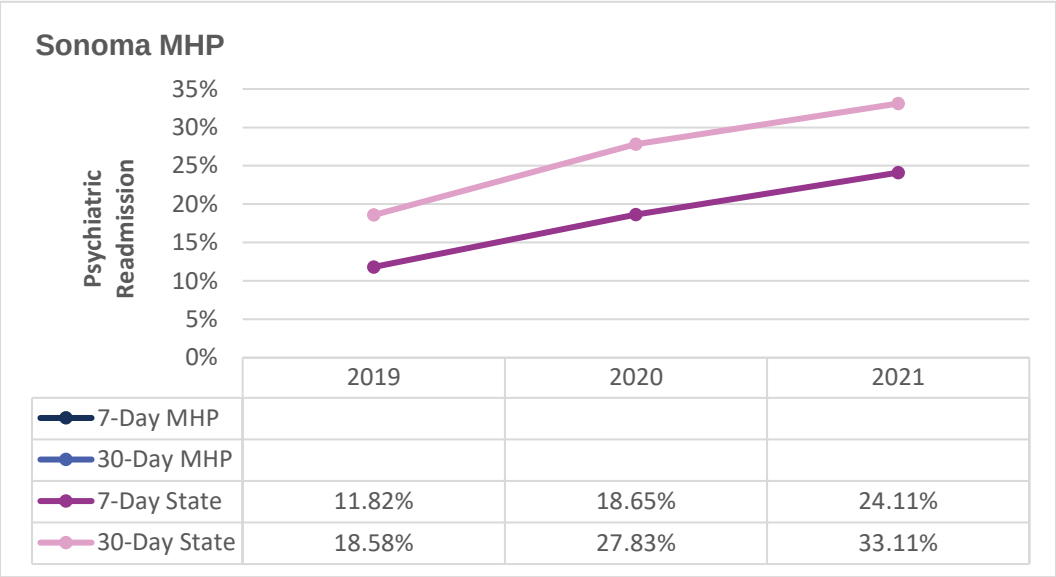
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	58.25%	58.82%	69.81%
30-Day MHP	73.20%	75.58%	80.79%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

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



	2019	2020	2021
7-Day MHP			
30-Day MHP			
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

*Due to small numbers, the MHP's readmission data is not displayed.

- Both the MHP's 7 day and 30 day follow-up rate is noticeably higher than the statewide rates in CY 2021.
- The MHP's follow-up rates reported on the ATA are lower because all beneficiaries, regardless of payor source, are included.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $7,478, the median amount is just $3,269.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, nearly 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) and

receive 54 percent of the Medi-Cal resources, with an AACB of $4,412 and median of $2,830.

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

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	379	11.74%	45.70%	$19,996,065	$52,760	$45,007
	CY 2020	292	9.80%	41.92%	$15,202,721	$52,064	$44,272
	CY 2019	248	7.80%	38.07%	$12,571,883	$50,693	$45,146

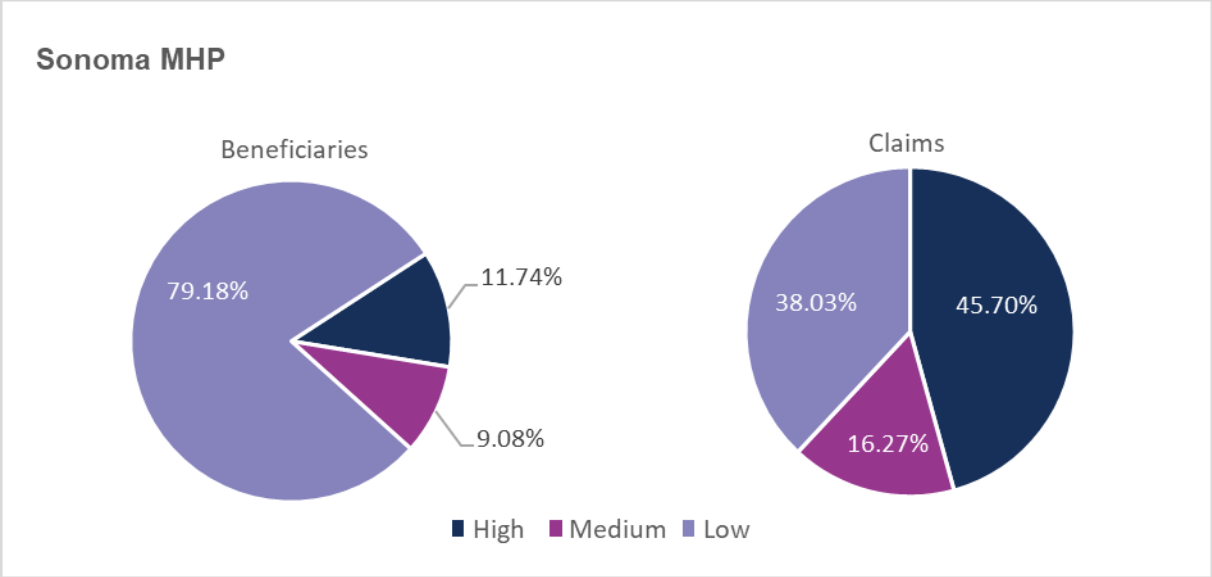
- The number of HCB's has steadily increased over the last three years and the percentage of HCB's is noticeably higher than statewide. The percentage of total claims submitted on behalf of HCBs has also steadily increased and exceeds the statewide percentage.

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)	293	9.08%	16.27%	$7,119,640	$24,299	$24,085
Low Cost (Less than $20K)	2,555	79.18%	38.03%	$16,637,179	$6,512	$4,870

- The percentage of beneficiaries in the low-cost category account for almost 80 percent of the beneficiaries served, but only 38 percent of the approved claims.

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



- The HCBs represent almost 12 percent of the beneficiaries served and 45 percent of claims.

IMPACT OF QUALITY FINDINGS

Although the MHP does not have a current QAPI plan, the QIC and subcommittees are actively addressing vital areas of QA and QI.

The MHP has historically experienced low PR which is now exacerbated by natural disasters; increased programs; easier access standards; increasing staff attrition; and an increasing Medi-Cal beneficiary base. Although QA and QI planning and design are actively addressing needs, there may not be sufficient core staff, even if all positions were filled, to meet the needs and increase PR. Current staff morale, services availability, and consumer satisfaction, are impacted.

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: Enhancing Community Connection and Living Skills for High-Cost Beneficiaries

Date Started: 08/2022

Aim Statement: To improve outcomes for High-Cost Beneficiaries receiving services from three targeted high-need Full-Service Partnership teams during FY 2022-23 through FY 2023-24 by implementing the Strengths Model Case-Management approach in order to 1) Reduce the average actionable item score on the ANSA for HCBs by 15 percent, from 20.49 to 17.42; 2) Reduce the HCB CSU utilization by 20 percent, from 46 percent (230/498) of all adult HCBs to 37 percent (184/498) over a two year period; and 3) Reduce the overall percentage of HCBs served by SCBH by 10 percent, from 18.1 percent to 16.3 percent.

Target Population: Adult HCBs receiving services on the TAY and IRT FSPs, and Outpatient AST.

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

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

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

Summary

The MHP implemented the Strengths Model Case-Management Approach on three adult teams: FSP TAY, FSP Integrated Recovery Team (IRT), and one AST. Full implementation of this model includes the following components: implementation of Strengths Model tools into clinical practice; utilization of treatment interventions focused on community connection and skill building; provision of clinical training and support; and establishment of strengths-based group supervision.

There are three PMs for this PIP. The first is the annual average actionable items on the ANSA for Adult HCBs. The second is the Annual percentage of Adult CSU utilization by HCBs. The third is a 10 percent reduction in the percent of HCBs served (from 18.1 percent to 16.3 percent).

Due to impacts related to COVID-19 the MHP recalculated the baseline year for this PIP and set a restart in August 2022. There are no results reported.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: the PIP is well developed and evidences very good data analysis. However, the MHP has experienced significant staff turnover and, in the last year, experienced a staff vacancy increase from 13 percent to 27 percent. In addition, there are many possible confounding variables that can influence the PMs.

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

- The MHP was advised to consider and document confounding variables that may impact the PIP results.
- The MHP was encouraged to complete Worksheet nine, the likelihood of significant improvement and sustained improvement through the PIP.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Follow-Up After Emergency Department Visit for Mental Illness, FUM

Date Started: 09/2022

Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023.

Target Population: The target population for this project is beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm, also referred to as “MH” or “MH conditions” throughout this document.

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

Summary

The MHP conducted a root cause analysis (RCA) with ER departments using 5 whys to identify and explore local factors contributing to delays in follow-up MH treatment services post-discharge from an ED visit for MH. Based on RCA activities, The lack of a coordinated central point of contact to identify MH eligibility &/or establish whether or not a patient is already open to MH services for follow-up constitute the biggest barrier to establishing a post-ED mental health follow-up appointment, and the root cause of the problem.

Based on root cause analysis and stakeholder engagement activities, the MHP identified the following preliminary intervention(s):

- Establish a “Behavioral Health Care Navigator” point of contact for EDs, available 24/7, who will perform the following functions upon contact from an E.D.
- Look up patients in the SMHS EHR to determine if and where client is already open to SMHS services.
- Schedule a follow-up appointment with an SMHS existing provider -or- schedule an intake appointment for new patients in need of outpatient mental health follow-up.

The primary outcome measure for this PIP is the percentage of ED visits for MH where the client received a follow up MH treatment service from the MHP within 7 or 30 days.

There are no results reported at this time.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the intervention to provide a MHP 24/7 single point of contact is sound. The moderate rating is due to the MHP has not developed a single point of contact system from the hospital(s).

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

- Develop a single point of contact system with each hospital. I may be a hospital transfer and referral coordinator, an officer of the day, or some other form of dedicated staff.

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/Avatar and which has been in use for 10 years. Currently, the MHP is actively participating in the CalMHSA semi-statewide EHR implementation of Smartcare by Streamline, with an expected go-live date of 7/1/2023.

Approximately 2.46 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is allocated to the MHP but managed by another county department. The budget allocation has increased from 2.14 percent the previous year.

The MHP has 431 named users with log-on authority to the EHR (myAvatar), all county staff with no contractor staff having access to Avatar. Support for the users is provided by 3 full-time equivalent (FTE) IS technology positions. Currently there is one vacant position. An additional limited term position has been allocated to support the EHR implementation and was vacant at the time of the review.

As of the FY 2022-23 EQR, no contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☐ Daily ☐ Weekly ☐ Monthly	0%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	100%
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 currently have a PHR but has plans to implement this feature in the next two years.

Interoperability Support

The MHP is not a member or participant in a HIE, but is currently negotiating access into Sac Valley Medshare HIE to participate once the new EHR is implemented. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and / or electronic consult. The MHP engages in electronic exchange of information with the following departments/agencies/organizations: Mental Health contract providers and Whole Person Care/Partnership Health.

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	Met
4F	Interoperability	Not Met

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

- The MHP has begun implementing the semi-statewide EHR, Streamline's SmartCare, with an expected go live date of July 2023.
- Once implemented, the MHP should explore HIE membership and provide beneficiaries access to a PHR.
- Including the contract providers in the implementation planning and providing them EHR access should improve workflows, reduce double data entry, and make client data available accurately and securely to provide client care efficiently and effectively. The MHP has recently started surveying the CBO's interest in accessing the EHR and remains undetermined.
- The MHP has solid and well-documented claims policies and procedures used for training staff and creating continuity amongst the fiscal team.
- Security components are in place to ensure systems are secure, and security training exists ensuring 100 percent of staff are trained on security practices.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

This chart appears to reflect a largely complete or 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	11,379	$3,014,005	$43,439	1.44%	$2,889,788
Feb	11,014	$2,910,176	$24,198	0.83%	$2,804,948
Mar	12,960	$3,447,872	$39,176	1.14%	$3,302,141
April	12,014	$3,367,435	$12,198	0.36%	$3,270,388
May	10,980	$3,088,397	$25,436	0.82%	$2,979,111
June	11,195	$3,190,447	$16,941	0.53%	$3,072,074
July	10,904	$3,363,839	$18,778	0.56%	$3,252,463
Aug	11,271	$3,475,992	$44,418	1.28%	$3,345,201
Sept	11,200	$3,486,926	$35,975	1.03%	$3,411,252
Oct	10,796	$3,390,994	$52,214	1.54%	$3,291,855
Nov	10,089	$3,207,347	$40,032	1.25%	$3,129,772
Dec	9,774	$3,145,867	$55,043	1.75%	$3,051,178
Total	**133,576**	**$39,089,297**	**$407,848**	**1.04%**	**$37,800,171**

- There is a consistent monthly volume of claims creating a steady Medi-Cal revenue stream.

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Medicare Part B must be billed before submission of claim	329	$104,447	25.61%
Other healthcare coverage must be billed before submission of claim	246	$102,854	25.22%
Beneficiary not eligible or non-covered charges	170	$101,270	24.83%
Late claim	191	$89,739	22.00%
Service line is a duplicate and a repeat service procedure code modifier not present	27	$6,871	1.68%
Deactivated NPI	10	$1,362	0.33%
Place of service incomplete or invalid	1	$960	0.24%
Other	4	$345	0.08%
Total Denied Claims	978	$407,848	100.00%
Overall Denied Claims Rate	**1.04%**		
Statewide Overall Denied Claims Rate	**1.43%**		

- The overall denied claims rate is lower than the statewide denied rate.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Implementing a new EHR in a short period of time is a major undertaking and requires significant staff resources to train and test to ensure fiscal and clinical operations are not negatively impacted.
- The semi-statewide EHR should enhance the MHP's ability to use one system for data collection, efficiently meet reporting requirements, and support the access, exchange, and use of electronic health information to benefit beneficiaries.
- Good collaboration and communication between the fiscal and QI team results in a consistent monthly claims volume, positive cash flow, and a claims denial rate of 1.04 percent, which is below the statewide average.
- Contract providers claim submission process requires MHP staff to manually input claims information and increases the likelihood of input errors occurring.
- The MHP successfully implemented monthly file production of 274 Provider Network Data Reporting to comply with state reporting requirements.
- The MHP has a functioning and tested OCP that confirms the counties capability of restoring critical systems and ensures readiness in the event of disasters or cyber-attacks.

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 completed the surveys, posts on the MHP website, and reviews the results in an all staff and QIC. The MHP also proactively performs surveys of consumers and staff on issues repeated to the continuum of care and levels of satisfaction. Consumer focus groups remember taking surveys, but they do not recall seeing the results.

Relative to 2020, satisfaction scores were consistently lower for adults and youth. In 2021 youth had the lowest overall satisfaction scores, and family members had the highest. For older adults and family members, satisfaction was more variable with some domains scoring higher and some lower than the previous year.

"Perception of Outcomes" of services was the lowest scored domain for both family members and older adults. Adults scored "Social Connectedness" lowest and youth scored "Participation in Treatment Planning" as the lowest—and this is a consistent trend that can be seen in 2020 scores for both adults and youth as well.

Youth and families were somewhat more likely to select multiple racial and ethnic categories in their self-descriptions. This bears some consideration when working with youth and families. Youth also consistently report feeling the least involved in their treatment planning for two years in a row.

Adults who identify as transgender scored consistently below the satisfaction threshold, although the sample size was low (n=3). Nevertheless, this finding may warrant additional programmatic and clinical interventions in the form of specialized trainings, for example. In addition, adults may benefit from more clinical and case management interventions that promote growth in social connections.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held via a telecommunication platform and included 11 participants; a language interpreter was not used for this focus group. All consumers participating receive clinical services from the MHP.

The adult consumers indicated that access had taken up to several weeks. Appointment reminders did not seem universal but were appreciated when they occurred. No adult consumer presented that transportation was a problem. No consumer indicated they use the MCP transportation benefit. Consumers utilized in-person services and telehealth. Psychiatry often was through telehealth. Overall services were presented as helpful and staff were presented as helpful and appreciated. The adult consumers were aware and participated in surveys of their care. The adult consumers could not recall receiving survey results or participating in any quality-of-care processes. All participants were aware of and had utilized the wellness centers and found the centers and their staff to be very beneficial.

Recommendations from focus group participants included:

- Please provide more activity based and social groups.
- Please provide more outings.
- Please provide more group counseling.
- Please provide transportation options in addition to bus passes.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of consumer family members of youth who initiated services in the preceding 12 months. The focus group was held via a telecommunication platform and included six participants; a language interpreter was not used for this focus group. All participating consumer family members have a youth who receives clinical services from the MHP.

The family members indicated that access had taken up to several months, either to obtain an initial assessment or to initiate services after an initial assessment. Appointment reminders did not seem universal but were appreciated when they occurred. Family members are generally able to be involved in the treatment. Transportation was assisted by the treatment teams seeing the youth at school or in the home. None of the family members seemed to be aware of the MCP transportation benefit. Telehealth psychiatric appointments were presented as limited to specific hours that conflicted with school schedules. Overall, family members spoke positively about

the services they received and the staff providing the care. There was a theme that coordinated of care seemed to fall on the family members.

An area of concern that was thematic across the participants related to crisis access. Some programs, SAFE as one example, were spoken of very positively. Thematically family members presented receiving mixed messages from contacts with the CSU and EDs leaving family members to need to be instructed to call another service or law enforcement verse having a one call response system that responded or provide a direct “warm” handoff.

Recommendations from focus group participants included:

- Please provide increased availability of clinicians.
- Please extend hours beyond 9:00 AM to 6:00 PM.
- Please improve the crisis response and crisis coordination system for youth.
- Please increase crisis psychiatric inpatient bed access for youth.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

Overall, both adult consumers and the family members of youth spoke positively about their providers of service. Adult consumers thematically do not wait as long for services and when asked about improvements focused on service enhancements, such as activities and group outings. Family members of youth thematically represented waits up to several months for standard services and when asked about improvements focused on difficulties obtaining vital services and experiencing problems navigating the delivery system when acute crisis response was needed. Although not discussed in the family member focus group, the MHP appears to have a cohesive and responsive system assisting youth transitioning from acute care facilities back to the community.

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 synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP implemented an adult PHF, additional access screeners, and will be adding 20 peer certified staff as enhancements of access and treatment. (Access)
2. The Performance Measures (PM) Medi-Cal beneficiaries' 7-day and 30-day post psychiatric inpatient follow-up for CY 2019-21 7-day and 30 -day follow-up was 70 and 81 percent. Psychiatric hospital recidivism for 2021 was 1.72 percent whereas the state average was 33.11 percent. (Timeliness)
3. The MHP uses data to analyze data for trends, determine outcomes, and make data driven decisions. (Quality, IS)
4. Well-documented claims policies and procedures ensure a trained fiscal team and contributes to a consistent volume of claims, steady revenue stream, and low denial rate. (IS)
5. The MHP BHQIP FUM PIP documented a root cause analysis to implement a navigator system with EDs. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. The overall PR, 2.49 percent, is 32 percent lower than medium counties and 43 percent lower than the state average. (Access)
2. The Latinx PR, 1.28 percent, is 52 percent lower than medium counties and 66 percent lower than the state average and ranks sixth of six race/ethnicities measured. (Access)
3. The percentages of beneficiaries served meeting the MHP standard for timeliness to first non-urgent request psychiatry appointment is 48 percent, and first non-urgent psychiatry appointments delivered is 45 percent. Psychiatric timeliness, despite modest improvement in FY2021-22, continues to be below the 50 percent threshold. (Timeliness)
4. The MHP CSU struggles to maintain required staffing; was utilized by 25 percent of the MHP Medi-Cal beneficiaries served, and admissions frequently stayed over the 23-hour limit. The staffing and usage patterns contribute to capacity saturation and diversion of beneficiaries to local emergency rooms. (Quality)

5. The MHP continues to have no interoperability with contract providers resulting in inefficient workflows and double data entry. (IS)

RECOMMENDATIONS

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

1. Investigate reasons and develop and implement strategies, to improve the MHP overall PR of 2.5 percent. (Access) (This recommendation is a carry-over from FY 2021-22.)
2. Investigate reasons and develop and Implement strategies, to improve the MHP Latinx PR of 1.28 percent. (Access) (This recommendation is a carry-over from FY 2021-22.)
3. Investigate reasons and develop and implement strategies, to improve the percentages of beneficiaries served that meet the MHP standard for timeliness to first non-urgent request psychiatry appointment (44.94 percent), and first non-urgent psychiatry appointments rendered (42.41 percent). (Timeliness) (This recommendation is a carryover from FY 2018-19, FY 2020-21, and FY 2021-22.)
4. Investigate reasons and develop and implement strategies, to improve CSU staffing and reduce MHP adult crisis services utilization, stays over 23 hours and use of diversion protocols. (Quality) (This recommendation is a carry-over from FY 2021-22.)
5. Investigate reasons and develop and implement strategies, to improve HIE interoperability between the CBOs and county EHR system(s) and include the involvement of CBOs in planning, development, and implementation processes. (IS) (This recommendation is a carry-over from FY 2021-22.)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Sonoma 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
PIP Validation and Analysis
Performance Measure Validation and Analysis
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Beneficiary Perceptions of Care
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision

CalEQRO Review Sessions – Sonoma MHP
Community-Based Services Agencies Group Interview
Information Systems Billing and Fiscal Interview
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Bill Walker (BW), Quality Reviewer
Rita Samartino (RS), Information Systems Reviewer
Pamela Roach (PR), Consumer/Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Alarie	Charlie	CSU Manager	SCBH
Barney	Helene	Health Program Manager	SCBH
Beard	Katy	Psychiatric Nurse	SCBH
Bhatti	Waheed	Systems Software Analyst	SCBH
Bhatti	Renee	Systems Software Analyst	SCBH
Bivin	Katie	Health Program Manager	SCBH
Bleman	Daniel	Medical Director	SCBH
Booth	Christy	Clinical Specialist	SCBH
Burrill	Phil	Health program Manager	SCBH
Carr	Trista	Patient Care Analyst	SCBH
Cassidy	Angel	Clinical Director	Telecare
Cobaleda-Kegler	Jan	BH Director	SCBH
Colvill	Amy	Health Program Manager	SCBH
Crutsinger	Lauren	CBO/Manager	Seneca
Dajalos	Roy	Assistant Director Health Services	SCBH
Ehrmann-Subia	Lizzy	Psychiatric Nurse	SCBH
Evans	Casey	Clinical Specialist	SCBH
Evans	David	Health Program Manager	SCBH
Fijalkowski	Marta	Department Analyst	SCBH
Francis	Patty	Psychiatric Nurse	SCBH

Last Name	First Name	Position	County or Contracted Agency
Gayowski	Will	Health Program Manager	SCBH
Ghassemy	Kimia	Health Program Manager	SCBH
Gilardi	Dani	CBO/Manager	SAY
Fijalkowski	Marta	Department Analyst	SCBH
Francis	Patty	Psychiatric Nurse	SCBH
Gayowski	Will	Health Program Manager	SCBH
Ghassemy	Kimia	Health Program Manager	SCBH
Gilardi	Dani	CBO/Manager	Child Parent Institute
Gonzalez	Janet	Department Analyst	SCBH
Hart	Todd	BH Clinician	SCBH
Herron	Johanna	Health Program Manager	SCBH
Hobbs	Nathan	Patient Care Analyst	SCBH
Ibarra	Ariana	CBO/Manager	Seneca
Jenkins	Sarah	Senior Client Support Specialist	SCBH
Kastrup	Jessica	BH Clinician	SCBH
Khlohe	Erika	CBO/Manager	Buckelew
Ladrech	Melissa	Patient Care Analyst	SCBH
Lara	Carrie	CBO/Manager	Community Support Network (CSN)
Larson	Rita	CBO/Manager	CSN

Last Name	First Name	Position	County or Contracted Agency
Lawrence	Donna	Accountant II	SCBH
Leon	Kenia	Clinical Supervisor	Buckelew
Marlow	Chris	BH Section Manager	SCBH
Mayne	Gregg	BH Clinician	SCBH
Gonzalez	Janet	Department Analyst	SCBH
Hart	Todd	BH Clinician	SCBH
Herron	Johanna	Health Program Manager	SCBH
Hobbs	Nathan	Patient Care Analyst	SCBH
Ibarra	Ariana	CBO/Manager	Seneca
Jenkins	Sarah	Senior Client Support Specialist	SCBH
Kastrup	Jessica	BH Clinician	SCBH
Khlohe	Erika	CBO/Manager	Buckelew
Ladrech	Melissa	Patient Care Analyst	SCBH
Lara	Carrie	CBO/Manager	CSN
Larson	Rita	CBO/Manager	CSN
Lawrence	Donna	Accountant II	SCBH
Leon	Kenia	Clinical Supervisor	Buckelew
Marlow	Chris	BH Section Manager	SCBH
Mayne	Gregg	BH Clinician	SCBH

Last Name	First Name	Position	County or Contracted Agency
McCarthy	Masha	Health Care Compliance Analyst	SCBH
McMane	Emily	CBO/Manager	Seneca
Meyer	Heather	Department Analyst	SCBH
Moreno	Gina	Department Analyst	SCBH
Nerell	Jodi	Program Manager	Sutter
Nosal	Lisa	Ethnic Services, Inclusion & Training Coordinator	SCBH
Ohlstrom	Dez	Health Program Manager	SCBH
Olcese	Henry	CBO/Manager	Lifeworks
Pickering	Elizabeth		SCBH
Pilgrim	Sarah	Health Program Manager	SCBH
Pimentel	Jennifer	Compliance Officer	SCBH
Ransom-Burr	Brooke	Director Of Counseling	SAY
Reed	Lauren	Senior Client Support Specialist	SCBH
Reynolds	Michael	CBO/Manager	West County Services
Ritter	Kelley	Department Analyst	SCBH
Robbins	Bruce	Administrative Services Officer I	SCBH
Sanchez	Serina	Clinical Specialist	SCBH
Sellite	Karin	BH Section Manager	SCBH
Shin-Caladrella	Susie	Psychiatrist	SCBH

Last Name	First Name	Position	County or Contracted Agency
Storm	Elizabeth	Health Program Manager	SCBH
Straight	Kat	Patient Care Analyst	SCBH
Struzzo	Melissa	Health Program Manager	SCBH
Surprise	Katrina	Patient Care Analyst	SCBH
Swan	Katie	CBO/Manager	Buckelew
Tappon	Wendy	Health Program Manager	SCBH
Tasseff	Ken	Health Care Privacy and Security Officer	SCBH
Thomas	Christine	Clinical Specialist	SCBH
Turner	Eric	Program Planning and Evaluation Analyst	SCBH
Wheelwright	Wendy	BH Section Manager	SCBH
Williams	Marcia	Clinical Specialist	SCBH
Wishart-Barnes	Tracie	Health Program Manager	SCBH
Zang	Ruby	Department Analyst	SCBH

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	There is the potential for significant confounding variables to impact to impact the performance measures and fidelity of the PIP.

General PIP Information
MHP/DMC-ODS Name: Sonoma County Behavioral Health Division
PIP Title: Enhancing Community Connection and Living Skills for High-Cost Beneficiaries
PIP Aim Statement: To improve outcomes for High-Cost Beneficiaries receiving services from three targeted high-need Full-Service Partnership teams during FY 22-23 through FY 23-24 by implementing the Strengths Model Case-Management approach in order to 1) Reduce the average actionable item score on the ANSA for HCBs by 15 percent, from 20.49 to 17.42; 2) Reduce the HCB CSU utilization by 20 percent, from 46 percent (230/498) of all adult HCBs to 37 percent (184/498) over a two year period; and 3) Reduce the overall percentage of HCBs served by DHS-BHD by 10 percent, from 18.1 percent to 16.3 percent.
Date Started: 08/2022
Date Completed: TBD
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:

General PIP Information
Target population description, such as specific diagnosis (please specify): Adult HCBs receiving services on the TAY and IRT FSPs, and Outpatient AST.
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): None
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): None
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): To improve outcomes for High-Cost Beneficiaries receiving services from three targeted high-need Full-Service Partnership teams during FY 22-23 through FY 23-24 by implementing the Strengths Model Case-Management approach.

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
PM 1. Annual avg actionable items on the ANSA for Adult HCBs	FY21-22	n=486 20.49	☒ Not applicable—PIP is in Planning or implementation phase, results not available	**TBD**	☐ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
PM 2. Annual % of Adult CSU utilization by HCBs	FY21-22	n=498 46%	☒ Not applicable—PIP is in Planning or implementation phase, results not available	TBD	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PM 3. 10% redux in the % of HCBs served (from 18.1% to 16.3%)	FY 21-22	n=3,455 18.1%		TBD	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

PIP Validation Information
EQRO recommendations for improvement of PIP: **Worksheet 8: Data Analysis and Interpretation of Results** Review, analyze and document confounding variables including but limited to, staffing impact, fidelity to the interventions, and external impacting events. **Worksheet 9: Likelihood of Significant and Sustained Improvement through The PIP** Document improvements and the context of data and process analysis from Worksheet 8 after each data review and/or remeasurement.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	Since this is the BHQIP FUM the PIP timeline requirements required the MHP to turn in the PIP prior to determining all aspects of the PIP design. One area that seems to need to be addressed is fidelity of communication assignment on the hospital side of the linkage and referral process between ERs and the MHP access systems
General PIP Information	
MHP/DMC-ODS Name: Sonoma County Behavioral Health Division	
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness, FUM	
PIP Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5 percent by June 30, 2023.	
Date Started: 09/2022	
Date Completed: TBD	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☒ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The target population for this project is beneficiaries with a qualifying event as defined in the FUM metric. A qualifying event is an ED visit with a principal diagnosis of mental illness or intentional self-harm, also referred to as “MH” or “MH conditions” throughout this document.	

General PIP Information
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): None
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): None
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): Based on root cause analysis and stakeholder engagement activities, the MHP identified the following preliminary intervention(s): Establish a "Behavioral Health Care Navigator" point of contact for EDs, available 24/7, who will perform the following functions upon contact from an ED. Look up patients in SMHS system to determine if and where client is already open to SMHS services. Schedule a follow-up appointment with an SMHS existing provider -or- schedule an intake appointment for new patients in need of outpatient mental health follow-up.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Total Number of E.D. patient information requests made to Care Navigator during normal business hours	2022	Not presented	☐ Not applicable—PIP is in Planning or implementation phase, results not available	New PIP, not available	☐ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Total Number of E.D. patient information requests made to Care Navigator during after-hours (inclusive of nights, weekends, and holidays)	2022	Not presented	☐ Not applicable—PIP is in Planning or implementation phase, results not available	New PIP, not available	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of patients identified by Care Navigator as open to SMHS services at time of ED request	2022	Not presented		New PIP, not available	☐ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of patients identified by Care Navigator as Not Open to SMHS services at time of ED request	2022	Not presented		New PIP, not available	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Total Number of follow-up appointments scheduled by Care Navigator	2022	Not presented		New PIP, not available	☐ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of follow-up appointments made by Care Navigator for ER patients already open to SMHS services	2022	Not presented		New PIP, not available	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Number of follow-up appointments made by Care Navigator for ER patients not open to SMHS services	2022	Not presented		New PIP, not available	☐ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Total Number of follow-up appointments scheduled by Care Navigator that were attended by patient.	2022	Not presented		New PIP, not available	☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Include consumers in ongoing feedback to the PIP development, implementation, and satisfaction. • Consider how the ED's ability to provide fidelity to 24/7 continuity of intervention is assured (like the Care Navigator for the MHP).

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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