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FY 2023-24
Medi-Cal Specialty Behavioral Health External Quality Review

SANTA CRUZ FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

September 12-14, 2023

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2023-24 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "Santa Cruz" may be used to identify the Santa Cruz County MHP.

MHP INFORMATION

Review Type — Onsite

Date of Review — September 12-14, 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 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	1	4	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	6	3	1
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**20**	**5**	**1**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
No-Show PIP	Clinical	11/2022	Planning	Moderate
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Non-Clinical	12/2022	Implementation	Moderate

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	3
2	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	9

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Despite staffing shortages, the MHP implemented California Advancing and Innovating Medi-Cal (CalAIM) payment reform.

- The MHP values and collects data for data-driven decisions and advocacy.

- Healing the Streets, a grant-funded project, resulted in a multi-agency release of information (ROI) tool.

- The MHP is making significant strides toward closed-loop referrals under Healthcare Effectiveness Data and Information Set (HEDIS) FUM.

- Staff and members are welcome to give input and they validate this openness.

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

- While the Hispanic/Latino population represents nearly 50 percent of the eligibles, they represent 36 percent of the members served – with a PR lower than statewide.

- Provided data shows room for improvement to timeliness of first service appointments.

- There are insufficient step-down and housing resources in the county as evidenced by a higher than state average of claims for high-cost members (HCMs).

- Considering data demands and CalAIM changes, IS staffing levels are low.

- Significant changes due to CalAIM fee-for-service implementation threaten the stability of CBO programs which make up 68 percent of the MHP.

Recommendations for improvement based upon this review include:

- Investigate and improve outreach to Hispanic/Latino communities and members.

- Investigate and implement strategies for timelier first service appointments.

- Investigate reasons and determine service patterns related to HCMs and level of care (LOC); consider implementing a LOC tool for adults.

- Develop and implement strategies for increased IS and analytic support.

- Explore the needs of contract providers to ensure that the necessary service capacity is maintained. This includes the timely contracting in order to reimburse for services provided.

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 February 2023.

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs, comprised of 58 counties, to provide SMHS to Medi-Cal members 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 members.

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, member satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (SB) 1291 (Section 14717.5 of the California Welfare and Institutions Code [WIC]). CalEQRO also considers the State of California requirements pertaining to Network Adequacy (NA) as set forth in California Assembly Bill 205 (WIC Section 14197.05).

This report presents the FY 2023-24 findings of the EQR for Santa Cruz County MHP by BHC, conducted as an onsite review on September 12-14, 2023. It is important to note that this was the first combined MHP with Drug Med-Cal Organized Delivery System (DMC-ODS) review for the county. Thus, this review took place just five months after the FY 22-23 MHP review in order to conduct the reviews simultaneously.

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, members, family members, and other stakeholders. At the conclusion of the EQR

process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

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

CalEQRO reviews are retrospective; therefore, data evaluated represent Calendar Year (CY) 2022 and FY 2022-23, 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 (EPSDT); 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 2022-23 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 member 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) – summary of the 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, and as outlined DHCS's Comprehensive Quality Strategy.

- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.

- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its

subcontracting providers maintain HIS that collect, analyze, integrate, and report data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.

- 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, and then "<11" is indicated to protect the confidentiality of MHP members.

Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data or its corresponding penetration rate (PR) percentages.

MHP CHANGES AND INITIATIVES

In this section, changes within the MHP's environment since its last review, as well as the status of last year's (FY 2022-23) EQR recommendations are presented.

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place six months after significant flooding from December 2022 through March 2023. The storms caused severe damage to housing and resources throughout the county with ongoing impacts at the time of the review, including the continued closure of a supportive housing facility in South County due to flood damage. Additional outreach and case management efforts were provided to the unhoused community impacted by levee evacuations, and emergency response was provided 24/7 by the MHP staff. While these issues affected MHP operations, there was no impact on CalEQRO's ability to conduct this review.

SIGNIFICANT CHANGES AND INITIATIVES

Changes since the last CalEQRO review, identified as having a significant effect on service provision or management of those services, are discussed below. This section emphasizes systemic changes that affect access, timeliness, and quality of care, including those changes that provide context to areas discussed later in this report.

- The MHP continues to implement the CalAIM initiatives, including payment reform and contract negotiations with contracted providers, greater coordination with the managed care plan (MCP), training staff, form development and documentation updates, closed-loop referrals, and other related changes in operations.

- Due to staffing shortages, the crisis stabilization unit (CSU) now only provides services to adults as of July 1, 2023. However, efforts directed at service access for youth have resulted in a trend of fewer youth being diverted to the hospital emergency department. There are current initiatives for a youth-focused CSU and crisis residential program.

- There has been a vast turnover in senior leadership, including the hiring of a new Behavioral Health (BH) Director, BH Deputy Director, Crisis/Access Director, DMC-ODS leadership, QI Director and QI Manager, Adult Services Manager, and Children's Services Manager.

- The Healing the Streets program and the associated BH Street Medicine Team have been successful as a grant-funded project. The MHP has a plan to continue these efforts at the close of the grant in December 2023 by launching a new full-service partnership team focused on the unhoused.

- No Place Like Home Permanent Supportive Housing efforts continue with 96 BH specific units expected across the next two years, the first leasing planned for this fall.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

In the FY 2022-23 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2023-24 EQR, CalEQRO evaluated the status of those FY 2022-23 recommendations; the findings are summarized below.

It is important to acknowledge that this annual report is coming five months after the previous report and, thus, it is reasonably expected that many recommendations will be continued due to the time constraint.

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 2022-23

Recommendation 1: Investigate reasons and develop and implement strategies to improve outreach to Hispanic/Latino communities and Medi-Cal eligibles. The MHP might consider applying for grants that focus on community health workers (or promotoras) as a strategy to reach underserved populations.

☐ Addressed   ☒ Partially Addressed   ☐ Not Addressed

- The MHP is considering coordination with the county's enhanced care management (ECM) team, using community health workers, and additional bilingual staff to reach underserved populations.

- There has not been a clear investigation into the root cause of this challenge which will be helpful to resolving this recommendation.

- Validation sessions during the review indicate that there are fewer general resources directed at South County, which has a greater Hispanic/Latino population. Further, a wide variety of stakeholders indicated that additional representation and culturally specific services are needed for Hispanic/Latino population, including the growing population of Mixtecan-speaking individuals.

- This recommendation will be continued in this year's report.

Recommendation 2: Investigate reasons and develop and implement strategies to provide timelier first service appointments.

☐ Addressed   ☒ Partially Addressed   ☐ Not Addressed

- The MHP has dedicated much effort to improved youth timeliness to care, for both first service and first psychiatry service. Staff verify that there have been significant improvements in timeliness for youth and several projects are expected to continue this improvement. Improved percentages that meet the timeliness goal are expected at the next review.

- Line staff report that the No Wrong Door policy has resulted in adults getting case management services in a timelier manner; however limited clinician staff results in members waiting greater than a month prior to meeting with their therapist.

- The MHP is encouraged to explore ways to improve the percentage that meets their timeliness standard for adults accessing care, including continuing efforts to fill clinician vacancies.

- This recommendation will be continued in this year's report.

Recommendation 3: Investigate reasons for the increasing proportion of HCMs to determine whether the service patterns and LOC are clinically appropriate; implement improvement strategies where needed.

☐ Addressed   ☒ Partially Addressed   ☐ Not Addressed

- In response to this recommendation, the MHP has provided a thoughtful and comprehensive account of their hypotheses on the topic. This recommendation is considered partially addressed as data collection is in the early stages and it has only been five months since the previous review.

- The MHP has plans to increase its partnership with Telecare, which operates the CSU and PHF, to support data exploration and trends identification. One improvement strategy that may be supportive of these efforts would be implementing a standardized LOC tool (within SMHS) to allow consistent data collection.

- The MHP is launching initiatives and efforts directed at large and complex regional conditions including high cost of living, a large unhoused population, ongoing loss of shelter spaces, lack of sufficient residential and rehabilitation facilities, and difficulties placing conserved or older adult members, to name a few.

- This recommendation will be continued in this year's report.

Recommendation 4: Develop and implement strategies to provide training, particularly in evidenced based practices (EBPs) and treatment modalities, to all service providers.

☒ Addressed   ☐ Partially Addressed   ☐ Not Addressed

- The MHP implemented substantial efforts and that were validated by both staff and members during the review.

- The MHP launched a large training effort using a learning community model with 90-minute course sessions every other week on five different EBPs. Line staff shared positive reports about these experiences and the benefit to their work.

- Other efforts have also been launched for Motivational Interviewing, using a train-the-trainer model, and piloting Strengths-Based Case Management.

Recommendation 5: Develop and implement concrete strategies for filling existing IS and analytic vacancies, which would improve data and analytics capacity for QI and support IS functions necessary for CalAIM implementation.

(This recommendation was continued from FY 2021-22 and FY 2022-23.)

☐ Addressed   ☒ Partially Addressed   ☐ Not Addressed

- The MHP has made significant improvements to the hiring process but continues to evidence need for additional IS and analytic support especially considering CalAIM initiatives.

- Progress for general hiring has included allowing hiring departments to work from a complete list of applicants rather than ten applicants at a time and reducing interview response time from five to three days. The MHP allows for flexible work schedules, remote work, and supportive supervision to try to reduce turnover. Further, an additional full-time employee has been hired to support the administrative components of the hiring process.

- The MHP notes the barriers created by competing for staff with Bay Area counties that pay higher wages and identifying recent graduates who have the necessary skills.

- This is an ongoing challenge and will be continued as a recommendation in this year's report.

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 members) can obtain needed health care services from a health care system. It encompasses multiple factors, including insurance/plan coverage, enough providers, and facilities in the areas in which members 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 members are negatively impacted.

CalEQRO uses several 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 0.2 percent of services were delivered by the MCP, 32.1 percent of services were delivered by county-operated/staffed clinics and sites, and 67.7 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 95.4 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff during business hours and a contracted provider after-hours. The after-hours provider is capable of contacting on-call supervisors if required for a member's need and linking adults with urgent conditions to the in-county crisis stabilization program. Members may request services through the Access Line as well as through walk-in to north and south county clinics or, for youth, contract agencies. Referrals from primary care, social services, schools, jail, juvenile hall, or other community sources are processed by the access teams. The MHP operates two access teams, a centralized one for adults and a decentralized one for youth, which are responsible for linking members to appropriate, medically necessary services.

The MHP has implemented the CalAIM Screening Tools, CalAIM Transition Tool, and No Wrong Door policy. Contract agencies have opted to utilize the CalAIM Youth Screening Tools as well which standardizes access through all entry points. Access team staff complete the screening tool, prioritize urgent requests, and have ample authority to assist members in getting the support they require. Recent efforts to improve the efficiency of youth access along with implementation of the CalAIM Screening Tool have reportedly yielded positive results with vastly reduced wait times. The timeliness data will likely convey this improvement during the next review.

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[1] CMS Data Navigator Glossary of Terms

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 845 adults, 336 youth, and 111 older adults across 2 county operated sites and 13 contractor-operated sites. Among those served, 115 members received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for members 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 in Table 1A and Table 1B.

In December 2022, DHCS issued its FY 2022-23 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

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

Table 1A: Santa Cruz MHP Alternative Access Standards, FY 2022-23

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: Santa Cruz MHP Out-of-Network Access, FY 2022-23

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

- The MHP can provide necessary services to a member within time and distance standards using a network provider, thus the MHP was not required to allow members 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 members 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 member outcomes.

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

Table 2: Access Key Components

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

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

- As noted as a strength in the previous review, the MHP is adept in accessing and utilizing grants to benefit access to care. A good example is the Healing the Steets project which led to the development of a multi-agency ROI tool.

- The MHP has plans to expand resources allocated to South County and partner with the county's ECM program to support the need of Hispanic/Latino populations.

- Expansion of bilingual staff is a priority of the MHP wherever possible, although there are requests from staff, members, and peers to increase this resource.

- The MHP has worked toward expedition of the hiring process to improve capacity and continues to advocate for increased wages for its labor force. Reportedly, the county receives a federal rural designation for loan forgiveness, yet competes for staff with higher-wage counties in the Bay Area, which is a significant barrier.

ACCESS PERFORMANCE MEASURES

Members Served, Penetration Rates, and Average Approved Claims per Member Served

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

The PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, with a total PR of 3.34 percent, demonstrates more challenges with access to care than was seen statewide.

Table 3: Santa Cruz MHP Annual Members Served and Total Approved Claims, CY 2020-22

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	86,913	2,900	3.34%	$45,613,422	$15,729
CY 2021	82,444	2,881	3.49%	$44,664,912	$15,503
CY 2020	75,778	2,901	3.83%	$39,992,428	$13,786

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

- The number of members eligible, total approved claims, and AACM trended upwards between CYs 2020 and 2022, whereas the total PR trended downwards, like trends statewide.

Table 4: Santa Cruz County Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	7,449	68	0.91%	1.15%	1.82%
Ages 6-17	18,290	1,003	5.48%	4.80%	5.65%
Ages 18-20	4,437	169	3.81%	3.47%	3.97%
Ages 21-64	48,584	1,461	3.01%	3.60%	4.03%
Ages 65+	8,154	199	2.44%	1.98%	1.86%
Total	**86,913**	**2,900**	**3.34%**	**3.49%**	**3.96%**

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

- The largest group of eligibles by age was adults ages 21-64, followed by youth ages 6-17. These were also the groups with the largest number of members served.

- The PRs for all the age categories except for 65+ were lower than statewide. The highest PR was for the 6-17 age group, followed by the 21-64 age group. Total PR was lower in the MHP and in similar sized counties than statewide.

Table 5: Threshold Language of Santa Cruz MHP Medi-Cal Members Served in CY 2022

Threshold Language	# Members Served	% of Members Served
Spanish	588	21.29%
Threshold language source: Open Data per BHIN 20-070		

- The only non-English threshold language was Spanish, with 21.29 percent of members identifying as Spanish speakers.

Table 6: Santa Cruz MHP Medi-Cal Expansion (ACA) PR and AACM, CY 2022

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	29,362	690	2.35%	$6,792,360	$9,844
Medium	530,704	15,912	3.00%	$110,270,160	$6,930
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, the overall PR and AACM tend to be lower than non-ACA members. This

pattern holds true in the MHP where the PR for the ACA population, as well as the AACM, are both lower than for the overall Medi-Cal population.

- For the ACA population in Santa Cruz, the PR was lower than in similarly sized counties and statewide, whereas the AACM was higher than in similarly sized counties and statewide.

The race/ethnicity data can be interpreted to determine how readily the listed racial/ethnic 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 members served. Table 7 and Figures 1- 9 compare the MHP's data with MHPs of similar size and the statewide average.

Table 7: Santa Cruz MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	666	52	7.81%	7.08%
Asian/Pacific Islander	1,493	37	2.48%	1.91%
Hispanic/Latino	42,753	1,056	2.47%	3.51%
Native American	274	22	8.03%	5.94%
Other	21,789	791	3.63%	3.57%
White	19,940	942	4.72%	5.45%
Total	**86,915**	**2,900**	**3.34%**	**3.96%**

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

- The largest group of eligibles was Hispanics/Latinos followed by Other and White. Despite being the largest two groups served, Hispanic/Latino and White groups are the MHP's only racial/ethnic groups that show PR below the statewide average.

Figure 1: Race/Ethnicity for Santa Cruz MHP Compared to State, CY 2022

Santa Cruz MHP

	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	32%	27%	1%	36%	1%	2%
MHP % Eligible	23%	25%	0%	49%	2%	1%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%
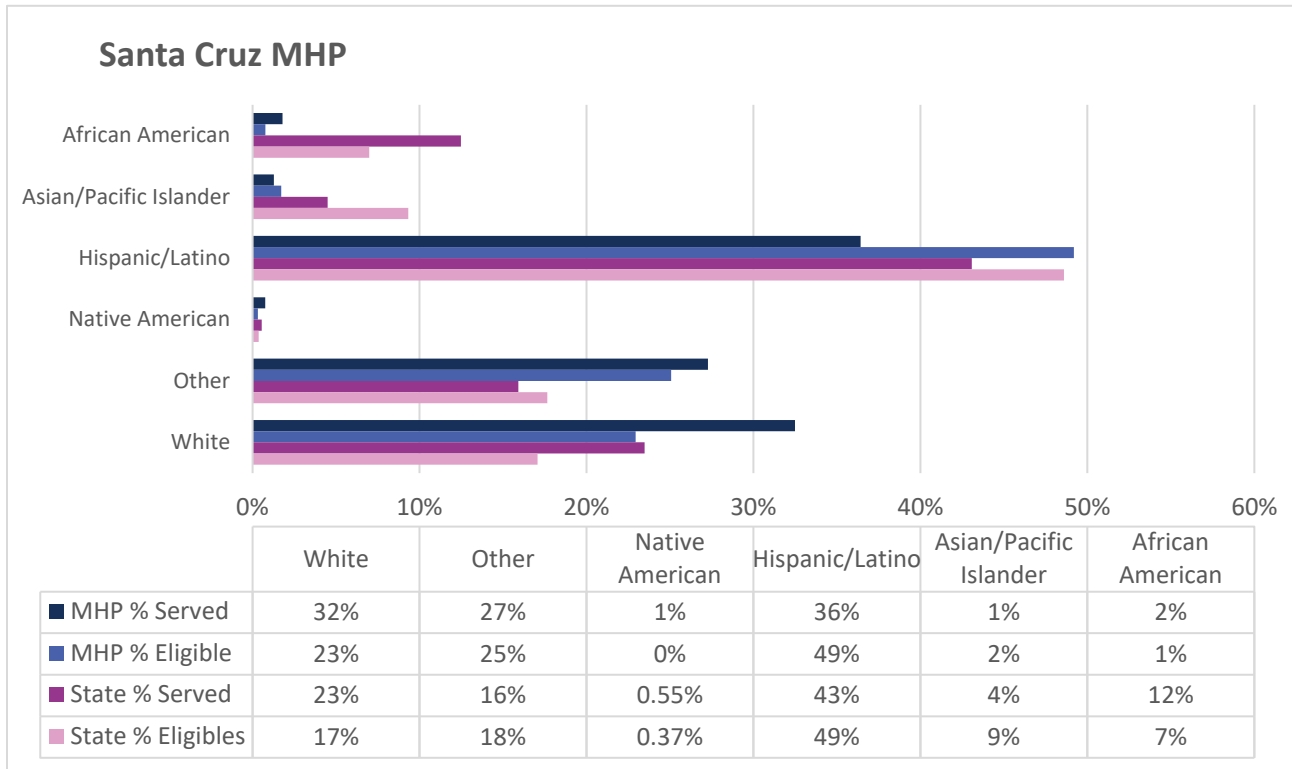
- Proportionally, the most overrepresented group in the MHP was White, and the most underrepresented group was Hispanic/Latino.

Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic 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: Santa Cruz MHP PR by Race/Ethnicity, CY 2020-22
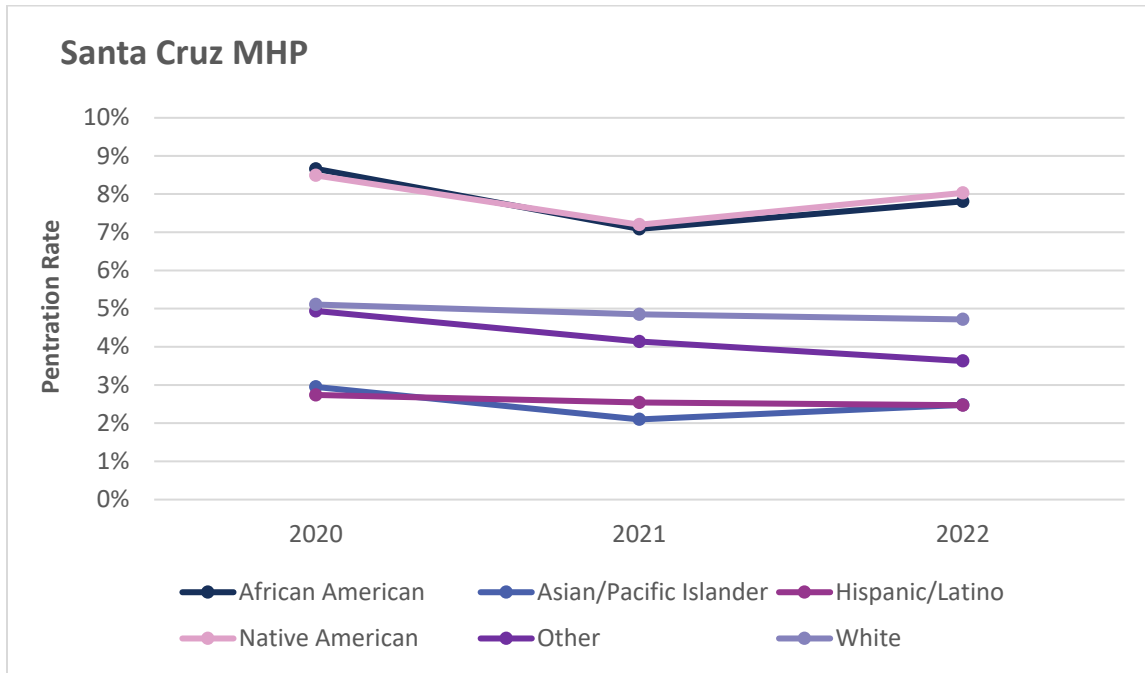
- PRs for Native Americans and African Americans are consistently the highest over the past three years, whereas PRs for Asians/Pacific Islanders and Hispanics/Latinos have consistently been the lowest.

Figure 3: Santa Cruz MHP AACM by Race/Ethnicity, CY 2020-22
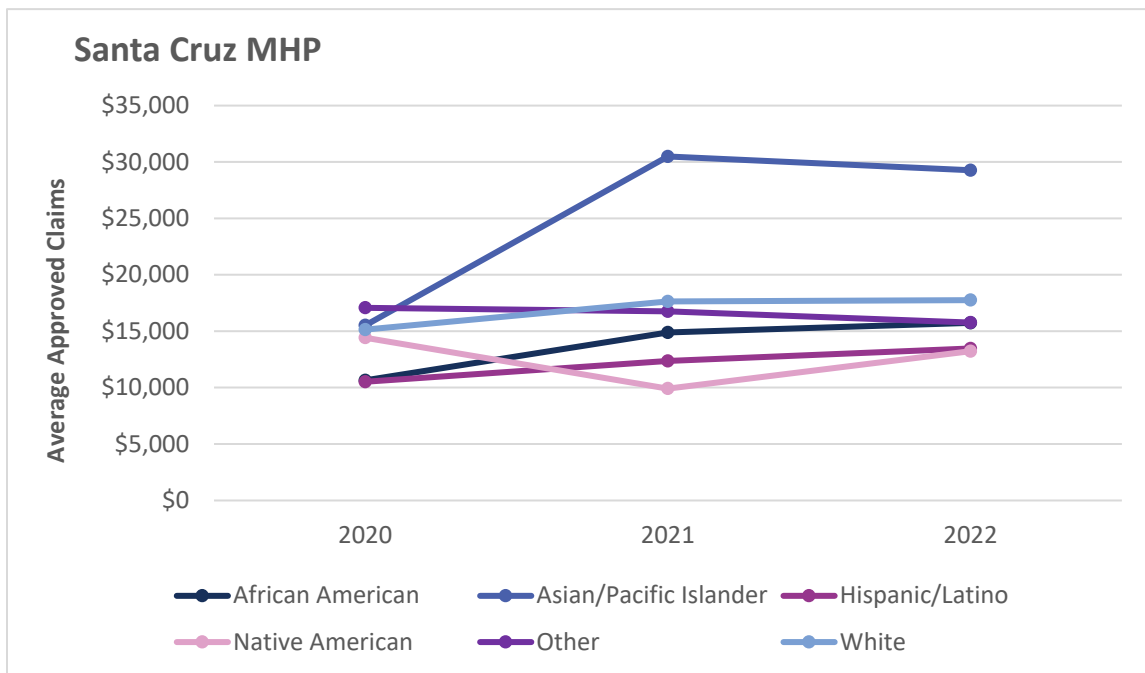
- AACMs across racial/ethnic groups were generally stable over the past three years. The groups with the largest shifts in AACMs were Asians/Pacific Islanders and Native Americans, though this could be due to the small number of members from those groups served, 37 and 22 respectively, and the impact of a small number of outliers on the averages.

Figure 4: Overall PR CY, 2020-22

Santa Cruz MHP

	2020	2021	2022
MHP	3.83%	3.49%	3.34%
Medium	3.87%	3.67%	3.49%
State	4.55%	4.34%	3.96%
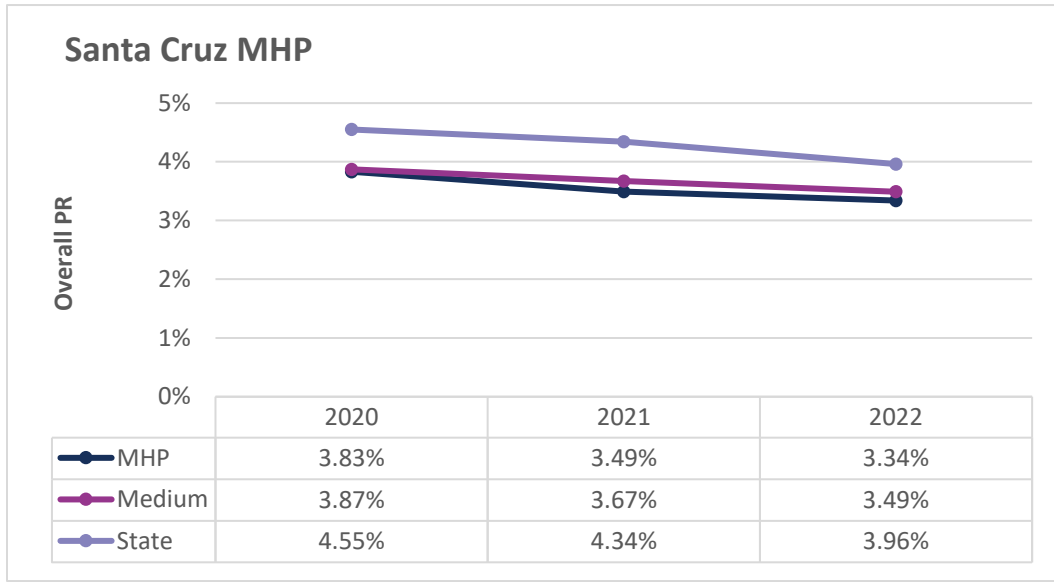
- Over the past three years, the overall PR has been trending downward in the MHP, other medium-sized MHPs, and statewide. The MHP's PRs have consistently been slightly lower than PRs in similar sized counties and statewide.

Figure 5: Overall AACM, CY 2020-22

Santa Cruz MHP

	2020	2021	2022
MHP	$13,786	$15,503	$15,729
Medium	$8,399	$8,601	$8,084
State	$7,155	$7,478	$7,442
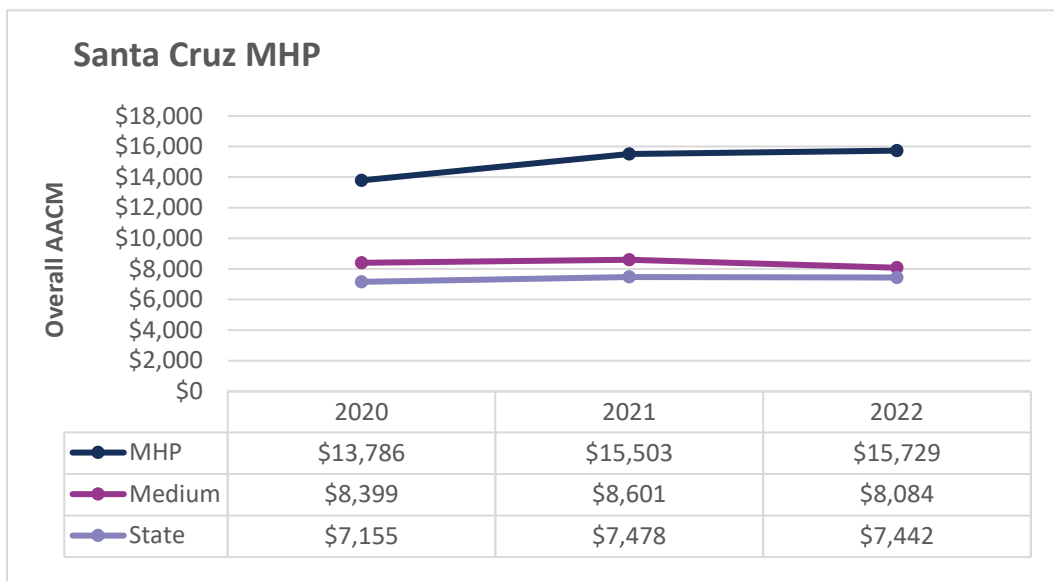
- AACM has been consistently much higher in the MHP than in medium-sized counties and statewide. For CY 2022, the AACM was more than double the statewide AACM.

Figure 6: Hispanic/Latino PR, CY 2020-22

Santa Cruz MHP

	2020	2021	2022
MHP	2.74%	2.54%	2.47%
Medium	2.74%	2.69%	2.68%
State	3.83%	3.74%	3.51%
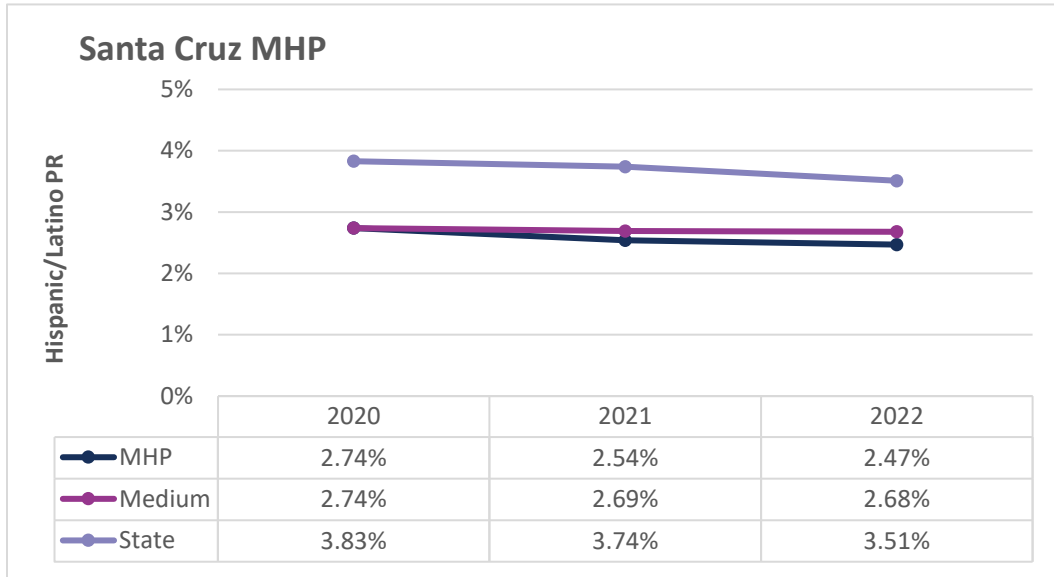
- Like both medium-sized counties and statewide, the PR for the Hispanic/Latino members has been decreasing. Both the MHP and medium-sized counties have had lower PRs for this population than what was seen statewide across the past three years.

Figure 7: Hispanic/Latino AACM, CY 2020-22

Santa Cruz MHP

	2020	2021	2022
MHP	$10,518	$12,363	$13,466
Medium	$7,153	$7,321	$6,842
State	$6,551	$6,733	$6,731
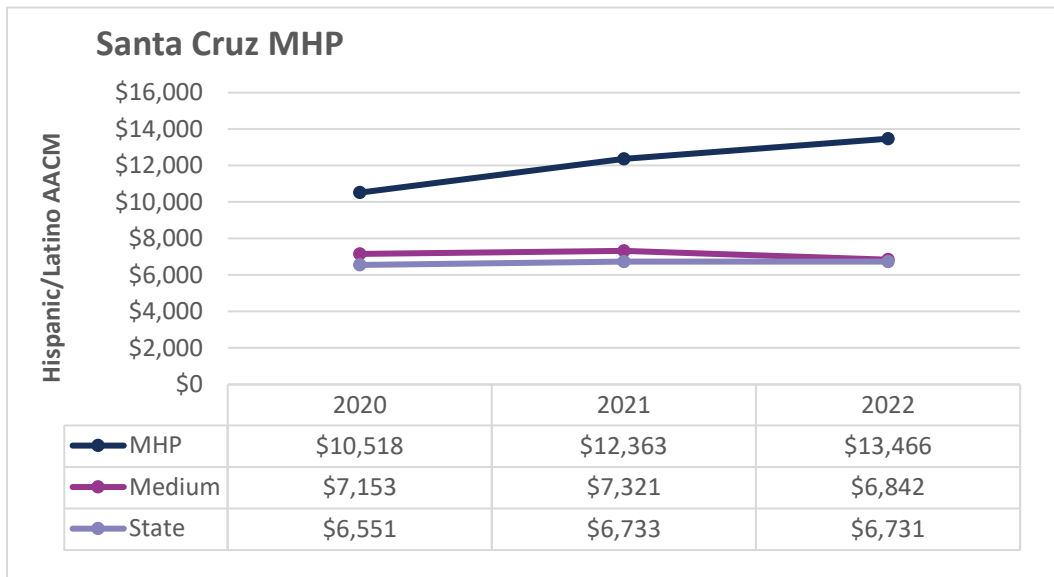
- The AACM for Hispanic/Latino members has been consistently increasing in the MHP and consistently much higher than AACMs in comparable sized counties and statewide over the past three years.

Figure 8: Asian/Pacific Islander PR, CY 2020-22

Santa Cruz MHP

	2020	2021	2022
MHP	2.95%	2.10%	2.48%
Medium	2.15%	2.04%	1.84%
State	2.13%	2.08%	1.91%
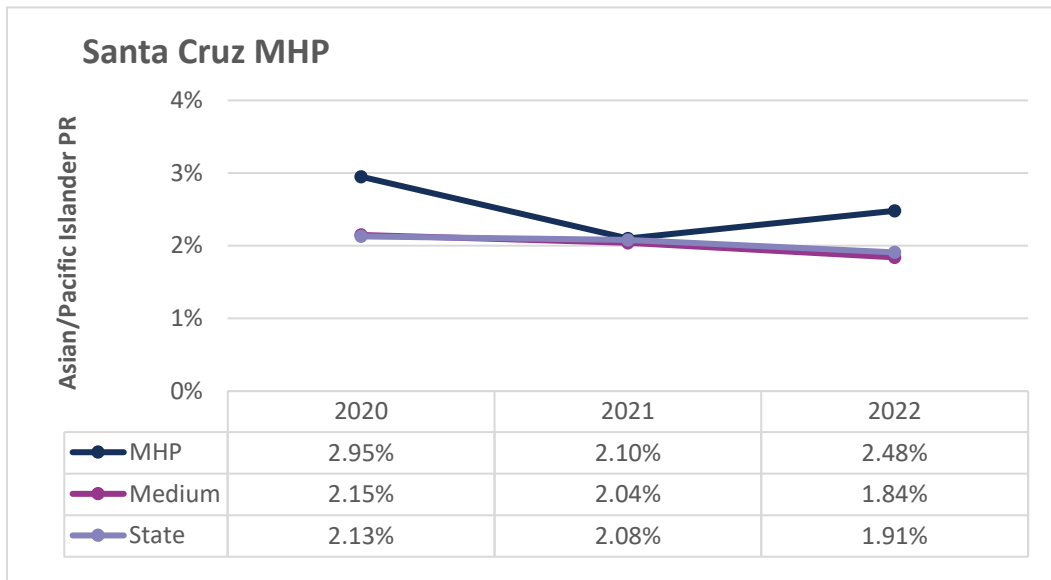
- The PR for Asians/Pacific Islanders was higher than in medium-sized counties and statewide in each of the past three years. Asians/Pacific Islanders are a small group in the MHP and PRs for small groups can be affected by relatively small changes in the number of members served.

Figure 9: Asian/Pacific Islander AACM, CY 2020-22

Santa Cruz MHP

	2020	2021	2022
MHP	$15,518	$30,491	$29,261
Medium	$7,214	$7,965	$8,425
State	$7,466	$7,990	$7,928
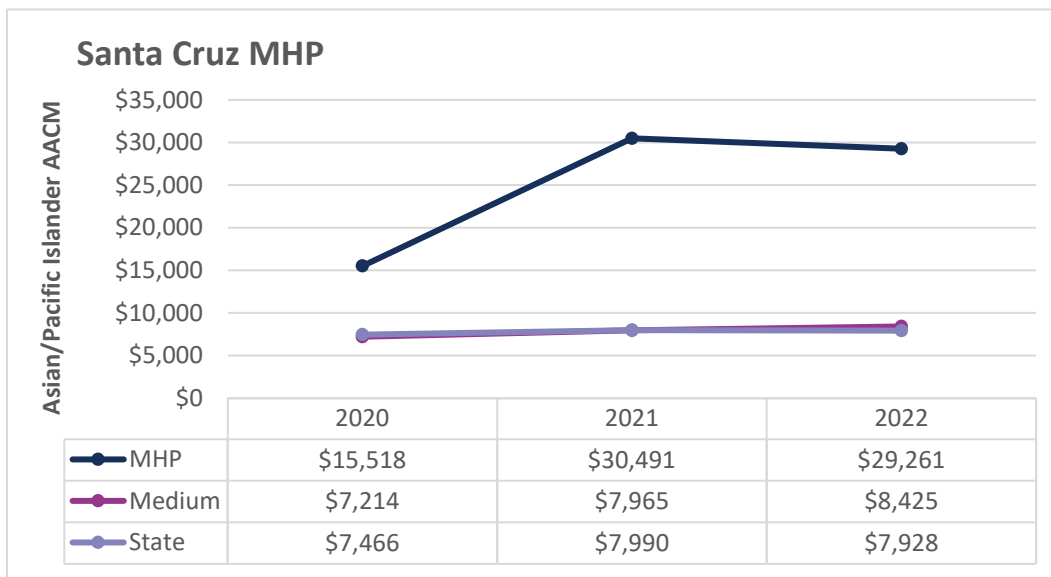
- AACM for Asians/Pacific Islanders nearly doubled between CYs 2020 and 2021, followed by a very slight decrease in CY 2022.
- The CY 2022 AACM for this group in the MHP was over three and a half times greater than the statewide AACM.

Figure 10: Foster Care PR, CY 2020-22

Santa Cruz MHP

	2020	2021	2022
MHP	64.76%	56.48%	60.00%
Medium	46.59%	45.62%	41.01%
State	51.00%	49.15%	46.00%
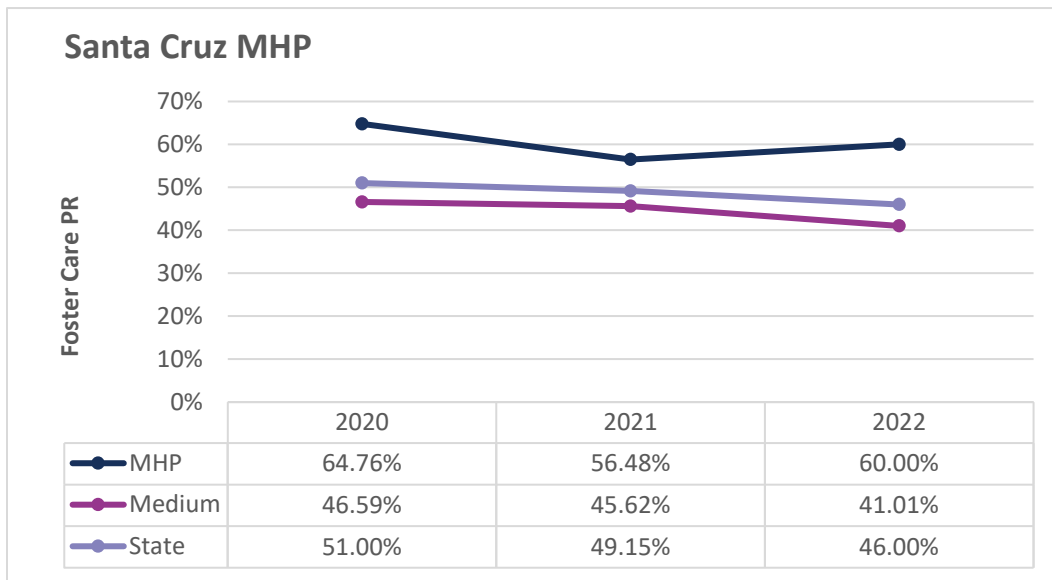
- While the MHP's FC PR has been consistently higher than statewide and similar sized MHPs, it increased from CY 2021 to CY 2022 while decreasing in medium counties and statewide.

Figure 11: Foster Care AACM, CY 2020-22

Santa Cruz MHP

	2020	2021	2022
MHP	$13,525	$19,464	$17,018
Medium	$10,465	$11,092	$10,979
State	$10,338	$11,020	$11,542
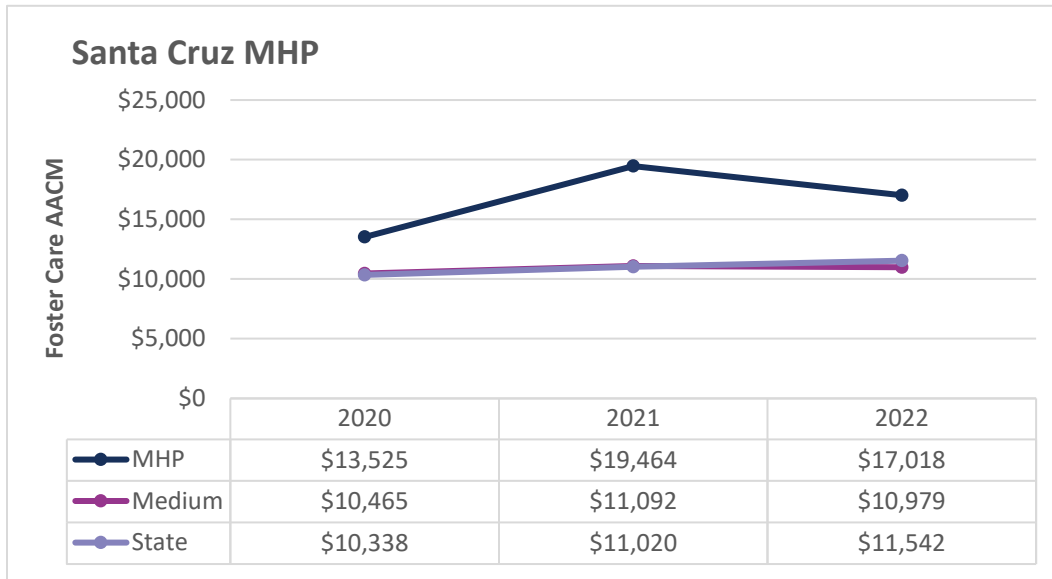
- Statewide FC AACM has increased each year for the past three years, while in the MHP it increased substantially between CYs 2020 and 2021, followed by a slight decrease in CY 2022.

- The FC AACM in the MHP has been consistently higher than in other medium counties and statewide. In CY 2022 it was nearly twice as large as the statewide FC AACM.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the Santa Cruz MHP to Adults, CY 2022

Service Category	MHP N = 1,829				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	156	8.5%	10	6	10.3%	14	8
Inpatient Admin	15	0.8%	39	15	0.4%	26	10
Psychiatric Health Facility	<11	-	6	4	1.2%	16	8
Residential	126	6.9%	58	31	0.3%	114	84
Crisis Residential	113	6.2%	15	13	1.9%	23	15
Per Minute Services							
Crisis Stabilization	372	20.3%	1,475	1,200	13.4%	1,449	1,200

Service Category	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Crisis Intervention	449	24.5%	192	136	12.2%	236	144
Medication Support	159	8.7%	1,240	410	59.7%	298	190
MH Services	1,233	67.4%	1,546	396	62.7%	832	329
Targeted Case Management	762	41.7%	554	297	36.9%	445	135

- Inpatient was the most used per day service, though lower than statewide (8.5 percent vs. 10.3 percent); additionally, the average units of service were also lower than statewide (10 days vs. 14 days).

- The MHP has unusually high rates of utilization for residential and crisis residential, but lower average units than statewide. Among other counties, for the adult population, the MHP has the highest PR for residential treatment and the fifth highest for crisis residential.

- MH services and targeted case management (TCM) were, by far, the most used services in the MHP. While the MH services utilization rate is higher than statewide, TCM utilization was slightly higher. Both services had more billed minutes than statewide averages.

- Crisis stabilization (CSU) and crisis intervention also had higher utilization rates than seen statewide, though some of the difference in the CSU utilization is due to having a CSU in the county. The statewide utilization rate includes many counties that do not have an in-county CSU and thus have low or no utilization of this service.

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

Table 9: Services Delivered by the MHP to Santa Cruz MHP Youth in Foster Care, CY 2022

	MHP N = 108				Statewide N = 33,234		
Service Category	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	<11	-	10	11	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	0.2%	19	8

Residential	<11	-	38	38	0.0%	56	39
Crisis Residential	<11	-	16	16	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	<11	-	2,370	2,370	3.1%	1,166	1,095
Crisis Intervention	11	10.2%	148	149	8.5%	371	182
Medication Support	12	11.1%	165	143	27.6%	364	257
TBS	<11	-	2,318	2,129	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	26	24.1%	572	335	40.8%	1,458	441
Intensive Home-Based Services	18	16.7%	2,104	1,302	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
MH Services	102	94.4%	1,574	896	95.4%	1,846	1,053
Targeted Case Management	52	48.1%	426	215	35.8%	307	118

- The only per day service provided for youth in FC was inpatient, which was utilized at a higher rate than statewide. The exact rate is suppressed due to the low number of FC members who received this service.

- The most used service for youth in FC was MH services. The second most used service was TCM, which was used by a greater proportion of FC members in the MHP than seen statewide.

- As with adults, a much smaller proportion of youth in FC receive medication support services than statewide due to the provision of psychiatry through the FQHC.

- Intensive care coordination (ICC) is utilized at a much lower rate than statewide, with a much lower average billed minutes of service.

IMPACT OF ACCESS FINDINGS

- The CalAIM Youth Screening Tool has reportedly had a notable impact on contracted programs for youth, now receiving far fewer members who qualify for SMHS. The expressed concerns include shortages in the community for non-specialty MH services (NSMHS) and an inability to focus on prevention, as they have done in the past, for lower need members. They report considering the closure of programs or contracting with the MCPs to address the problem.

- There has reportedly been a vast increase in adult members who qualify for SMHS since implementing the CalAIM Adult Screening Tool, compared to the decrease in youth members. Further, with implementation of No Wrong Door, the MHP is providing a wide range of support prior to assessment when needed by members.

- Regarding capacity and ongoing staffing shortage, a 27% vacancy rate at the time of the review, improvements in hiring expediency were noted and verified. However, the MHP states few applicants and new graduates are seemingly attracted to higher-paying counties in the Bay Area. Contract agencies shared that the high cost of living with lower wages reportedly forces even their higher-paid executives to move out of county and work remotely.

- With low ICC utilization, the MHP should examine its ICC and IHBS utilization and referral processes to fully assess Pathways implementation across the system.

TIMELINESS OF CARE

The amount of time it takes for members 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 adjust their service delivery system to ensure that timely standards are being met. DHCS monitors MHPs' compliance with required timeliness metrics identified in BHIN 22-033. Additionally, CalEQRO uses the following tracking and trending indicators to evaluate and validate MHP timeliness, including the Key Components and PMs addressed below.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to members. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved member 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 has met all the timeliness key components for a second year. However, the percentage of time that standards are met could be improved. There is no performance greater than 77 percent except for urgent access

where the MHP excels at 100 percent. The MHP seems diligent to track, trend, and continuously improve timeliness to care.

- The MHP's PIPs are both directed at aspects of timeliness, so improvements for FUM and no shows will hopefully be evident next year.

- During the review, validation sessions indicated satisfaction with timeliness to services in general.

TIMELINESS PERFORMANCE MEASURES

In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time. 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 2023-24 EQR, the MHP reported in its submission of Assessment of Timely Access, representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12 – 14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care for first offered and first rendered non-urgent services, post psychiatric hospitalization follow-up, and no-show rates, and county-operated services only for first offered and first rendered non-urgent psychiatric services, and urgent services offered.

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

Table 11: FY 2023-24 Santa Cruz MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	10.6 Business Days	10 Business Days*	71%
First Non-Urgent Service Rendered	10.7 Business Days	10 Business Days**	66%
First Non-Urgent Psychiatry Appointment Offered	10.4 Business Days	15 Business Days*	77%
First Non-Urgent Psychiatry Service Rendered	13.0 Business Days	15 Business Days**	71%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required ***	0.51 Hours	48 Hours*	100%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	14.9 Calendar Days	7 Calendar Days	46%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	14.9 Calendar Days	30 Calendar Days	61%
No-Show Rate – Psychiatry	7%	5%**	n/a
No-Show Rate – Clinicians	4%	5%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP does not separately track urgent services requiring pre-authorization.			
For the FY 2023-24 EQR, the MHP reported its performance for the following time: FY 2022-23			

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

Santa Cruz MHP

Business Days

■ All ■ Adult ■ Child ■ FC
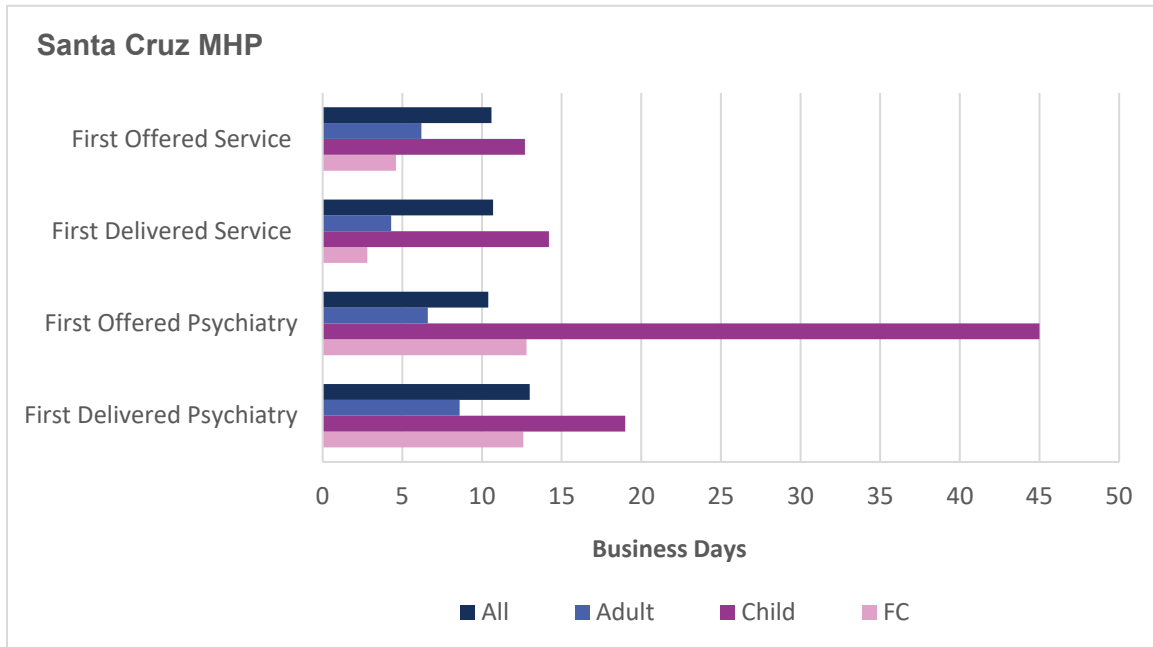
Figure 13: Wait Times for Urgent Services

Santa Cruz MHP

Hours
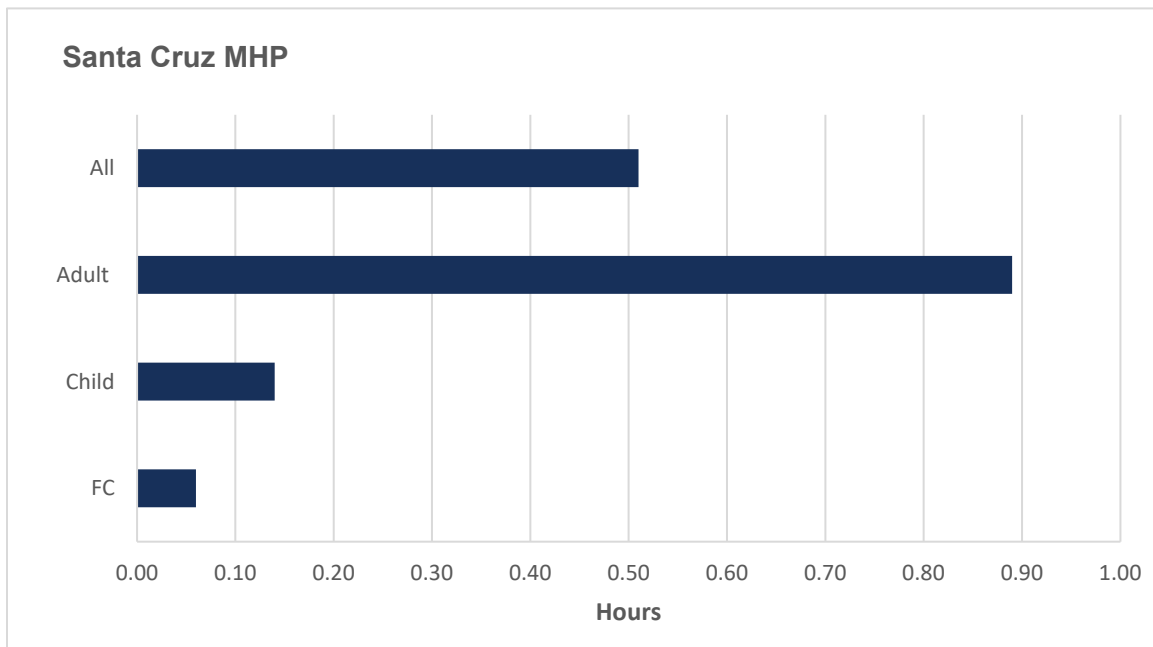
Figure 14: Percent of Services that Met Timeliness Standards

Santa Cruz MHP

(Bar chart showing Percent of Services that Met Timeliness Standards. Categories from top to bottom: First Offered Service, First Delivered Service, First Offered Psychiatry, First Delivered Psychiatry, Offered Urgent - No Pre-Auth. Legend: All, Adult, Child, FC. X-axis from 0% to 100%.)
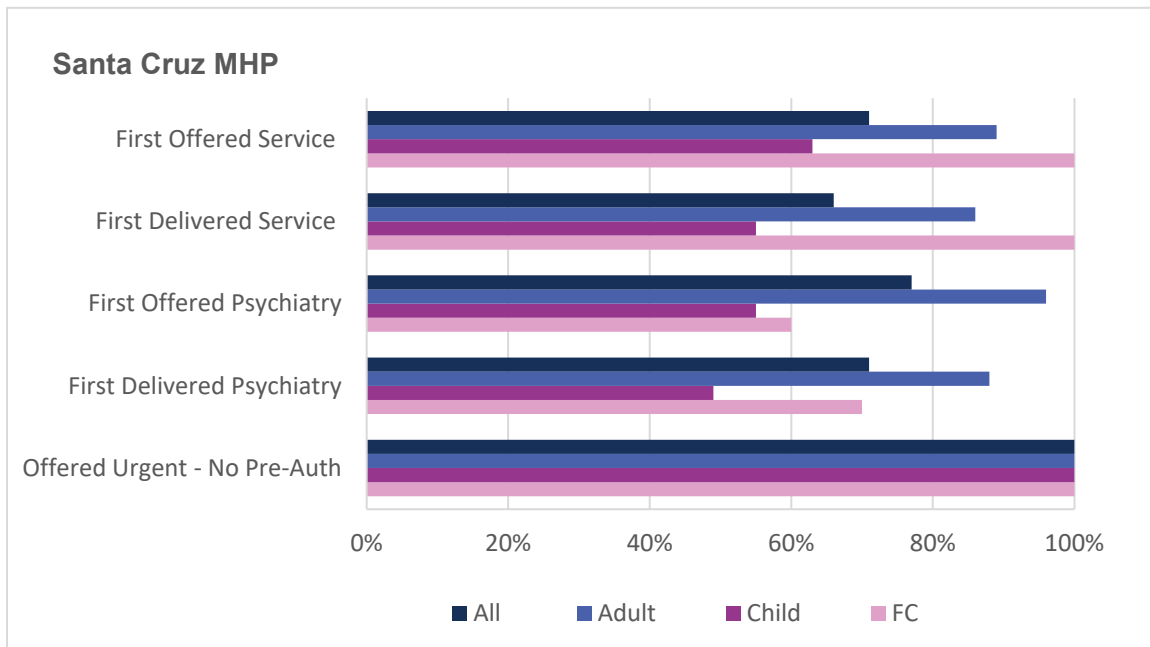
- Because MHPs may provide MH services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent all initial services regardless of provider or type of service.

- The MHP defined "urgent services" for purposes of the ATA as "Urgent appointments with non-physician or physician for a condition which requires prompt attention, but is not life threatening, in order to prevent imminent or serious deterioration in one's health and/or could jeopardize the member's ability to regain maximum function. A condition disrupts normal activities of daily living and requires urgent assessment by a healthcare provider. Delay in decision making process could be detrimental to one's health." There were reportedly 276 urgent service requests with a reported actual wait time to services for the overall population of 0.51 hours. The MHP does not track urgent services that require pre-authorization separately, though they are working on adding this capability to their Electronic Health Records (EHR) system.

- The MHP defines timeliness to first delivered/rendered psychiatry services as being from the date of request of service until the first psychiatry appointment provided via the county-administered FQHC.

- 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 no-show rates of 7 percent for adults, 8 percent for children, and 7 percent for FC youth, and non-psychiatry clinical no show

rates of 2.4 percent for adults, 7.2 percent for children, and 5 percent for FC youth. These rates are very low and suggest that the data may be incomplete.

IMPACT OF TIMELINESS FINDINGS

- The MHP has started a new PIP directed at no-show rates. Additional information can be found in the PIP Validation section of this report and in Attachment C.

- Post psychiatric follow-up rates at seven days have decreased over the past three years; however, readmission rates continue to be consistently lower than statewide. Follow-up appointments after psychiatric hospitalization average double the 7-day standard; however, this is likely influenced by outliers. The MHP reported an overall median of 4 days and sets the standard of 3 days.

- The MHP has improved their timeliness to both first non-urgent appointment and first non-urgent service rendered when compared to the previous review; however, the percentage that met the standard has remained the same.

- Implementation of the CalAIM Youth Screening Tool along with improved efficiencies in the youth access team's process have resulted in reports that youth members are recently waiting significantly shorter periods of time for access to care. An improved percentage is anticipated at the next review.

- Adult members are reportedly served for an extended period by case managers prior to the first treatment with a clinician. Validation sessions indicate that, while initial care is provided in a timely way, some adults would like quicker linkage to a clinician. The MHP seems to be making requisite adjustments to initial access while coping with staffing shortages and changes related to No Wrong Door and CalAIM in general.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the members 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 members. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN THE MHP

In the MHP, the responsibility for QI is in the quality management program that consists of the QI/UR team in partnership with MHP senior leadership and program managers. Quality and compliance are part of the responsibility of the QI team and is integrated with the DMC-ODS system. There is a specified role for staff training which seems important with rapid CalAIM changes. The last report shared efforts to become a more efficient team via hiring a consultant, and input this year seems to indicate success.

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 MHP leadership, representatives from contract providers, beneficiaries, representatives from the National Alliance on Mental Illness, and individuals with lived experience who are active peers. The QIC is scheduled to meet quarterly or four times per year. Since the previous EQR five months ago, the MHP QIC met two times. Of the 15 identified FY 2022-23 QAPI workplan goals, the MHP reviewed progress on all of them, providing highlights, successes, and barriers, during the fourth quarter QIC. Further, the 16 identified goals for FY 2023-24 were reviewed.

The MHP does not utilize a standardized LOC tool within SMHS. A departmental tool called Medical Necessity Criteria for SMHS was reported. Also, staff noted that they frequently complete the outcome measures like a LOC tool, in a way that gets the member services they believe will be helpful. Lastly, the CalAIM Screening Tools have been implemented to determine overarching SMHS versus NSMHS.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths Assessment (ANSA), Child and Adolescent Needs and Strengths (CANS), General Anxiety Disorder-7, Patient Health Questionnaire, and Pediatric Symptoms Checklist. The ANSA and CANS data are reviewed monthly, and a partner from the Community Data Round Table provides summary data on a quarterly basis which is shared at QIC. A monthly data dashboard is also made available to all providers in the MHP. Partner departments can access CANS data in a shared portal found on the website and, lastly, CANS data is supplied directly to members on a regular basis.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Not Met
3G	Measures Clinical and/or Functional Outcomes of Members Served	Met
3H	Utilizes Information from Member Satisfaction Surveys	Partially Met
3I	Member-Run and/or Member-Driven Programs Exist to Enhance Wellness and Recovery	Partially Met
3J	Member and Member Employment in Key Roles throughout the System	Met

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

- The MHP clearly values data-driven decision-making and collects a wide range of data to support the needs of the system and its members.

- The QI team notes consistent scores across years on the Consumer Perception Survey (CPS), significant collection numbers, and the plan to add one operational improvement goal for each MHP & DMC-ODS based on consumer feedback. The MHP shows concern with feedback delivered by members.

- There is a peer presence with two leadership positions in contracted providers and the MHP is actively working to incorporate peers into the county care teams, such as the older adult and crisis teams. However there is

no position within the county that requires lived experience without additional education for peers.

- Members widely use and state vast benefit from the programs in the Community Connection wellness centers in both North and South County. These are for members who are open to the department only and do not appear to be peer-driven.

- The MHP tracks but does not trend data for one of the HEDIS measures as required by WIC Section 14717.5.

  - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM): This data is collected by the psychiatry team and monitored by peer chart review for all psychotropics. The Public Health nurse reportedly has access to this information.

  - The MHP does not track or trend the other three required following HEDIS measures as required by WIC Section 14717.5.

QUALITY PERFORMANCE MEASURES

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

- Retention in Services

- Diagnosis of Members Served

- Psychiatric Inpatient Services

- Follow-Up Post Hospital Discharge and Readmission Rates

- HCMs

Retention in Services

Retention in services is an important measure of member engagement to receive appropriate care and intended outcomes. One would expect most members 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 (LOS), as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Retention of Members Served, CY 2022

Santa Cruz MHP

	State	MHP
■ 1 service	11.21%	17.72%
■ 2 service	6.71%	7.07%
■ 3 service	5.25%	4.07%
■ 4 service	4.85%	3.03%
■ 5-15 Services	31.02%	21.55%
■ >15 Services	40.96%	46.55%
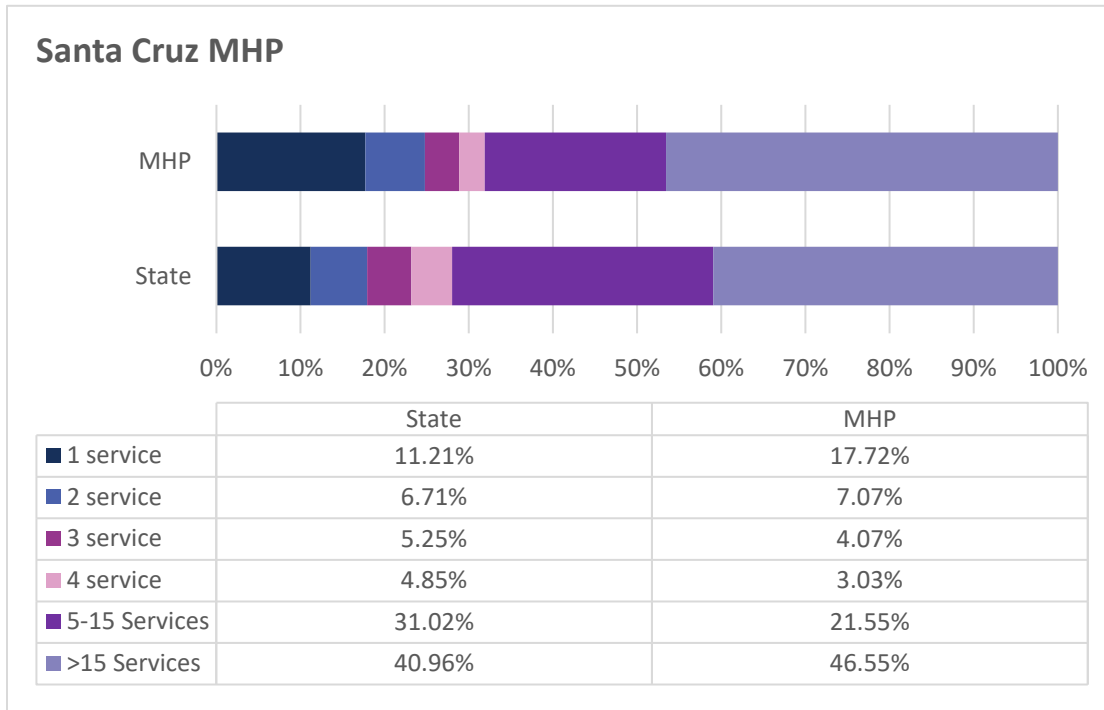
- The MHP had a higher proportion of members who received 1 service than statewide, but also had a higher proportion of members receiving more than 15 services than statewide. Overall, the MHP had a smaller proportion of members who received five or more services than statewide (approximately 68 percent compared to 72).

Diagnosis of Members Served

Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared to statewide. This is not an unduplicated count as a member 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 Members Served, CY 2022

Santa Cruz MHP

	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
■ MHP %	10%	21%	14%	3%	3%	20%	12%	6%	11%
■ State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

Percent Members by Diagnostic Category
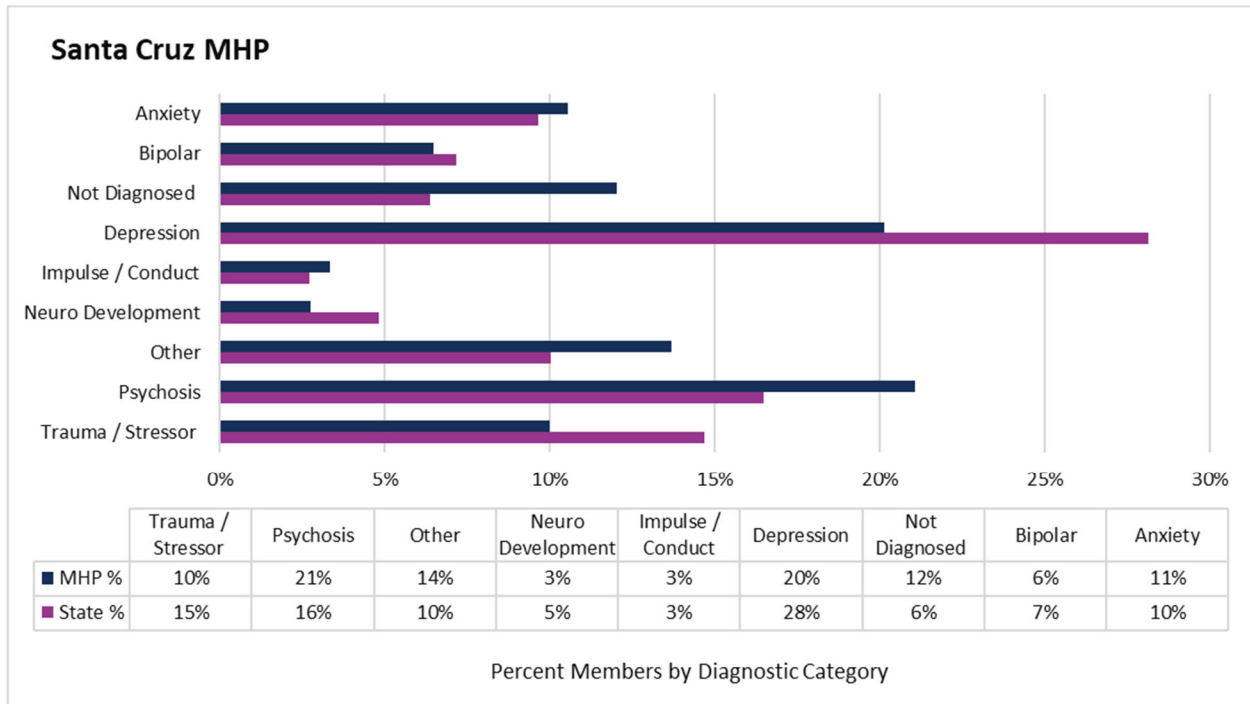
- Psychosis and depression were the most common diagnostic categories in the MHP. The psychosis rate was higher than statewide, but the proportions of members diagnosed with depression and trauma/stressor were lower than statewide.

- A greater proportion of members in the MHP were not diagnosed compared to statewide. This may be connected to the higher-than-statewide proportion of members receiving only one service in the MHP.

Figure 17: Diagnostic Categories by Percentage of Approved Claims, CY 2022

Santa Cruz MHP

	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
■ MHP %	10%	36%	12%	4%	3%	17%	2%	8%	8%
■ State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

Percent Claims by Diagnostic Category
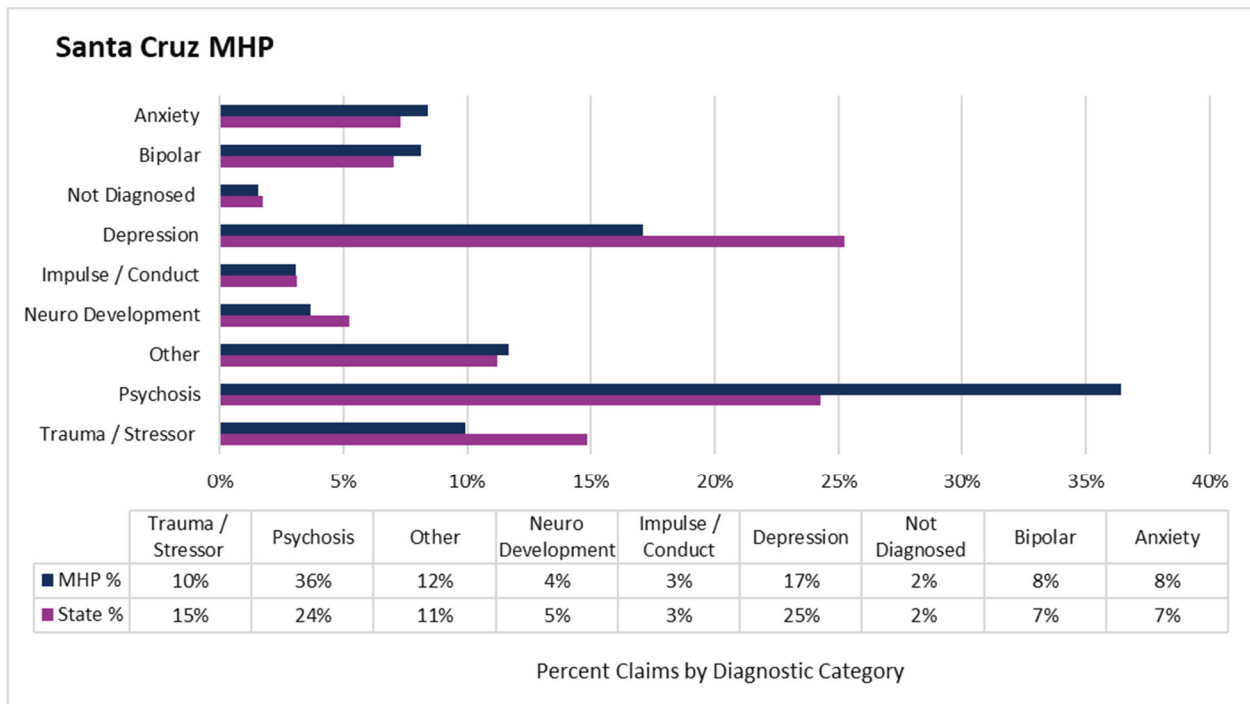
- In general, claims were proportionate to diagnostic rates in the MHP except for psychosis that accounted for 21 percent of diagnoses and 36 percent of claims.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS.

Table 13: Santa Cruz MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	219	238	9.38	8.45	$15,074	$12,763	$3,301,256
CY 2021	313	417	8.58	8.86	$16,107	$12,696	$5,041,589
CY 2020	293	368	10.38	8.68	$18,448	$11,814	$5,405,144

- CY 2022 showed lower numbers of members hospitalized and fewer admissions. The MHP claimed significantly fewer dollars to inpatient in CY 2022.
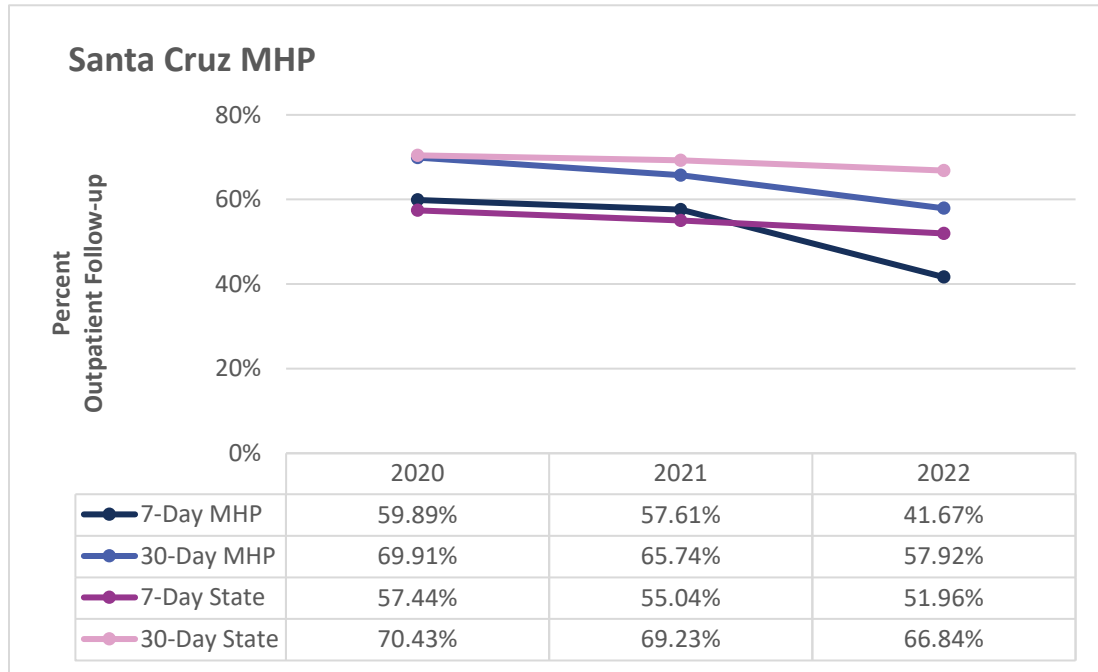
- An issue with the programming previously produced this table in prior reports with a higher number of admissions. The unique number of Medi-Cal members served in inpatient did not change but the number of admissions is corrected.

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 2022 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 BH 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 member outcomes and is reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis.

Figure 18: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up, CY 2020-22

Santa Cruz MHP

	2020	2021	2022
7-Day MHP	59.89%	57.61%	41.67%
30-Day MHP	69.91%	65.74%	57.92%
7-Day State	57.44%	55.04%	51.96%
30-Day State	70.43%	69.23%	66.84%

- Post psychiatric follow-up rates for 7-day have decreased in the MHP over the past three years to a greater degree than statewide. Whereas the MHP's follow-up rate was slightly higher than statewide in CY 2020, it was more than ten percentage points lower than statewide in CY 2022.

- The 30-day follow-up rate has also decreased and is also lower than the statewide rate.

Figure 19: 7-Day and 30-Day Psychiatric Readmission Rates, CY 2020-22

Santa Cruz MHP

	2020	2021	2022
7-Day MHP	8.31%	4.31%	7.50%
30-Day MHP	10.03%	7.61%	13.33%
7-Day State	18.65%	24.11%	21.00%
30-Day State	27.83%	33.11%	30.11%
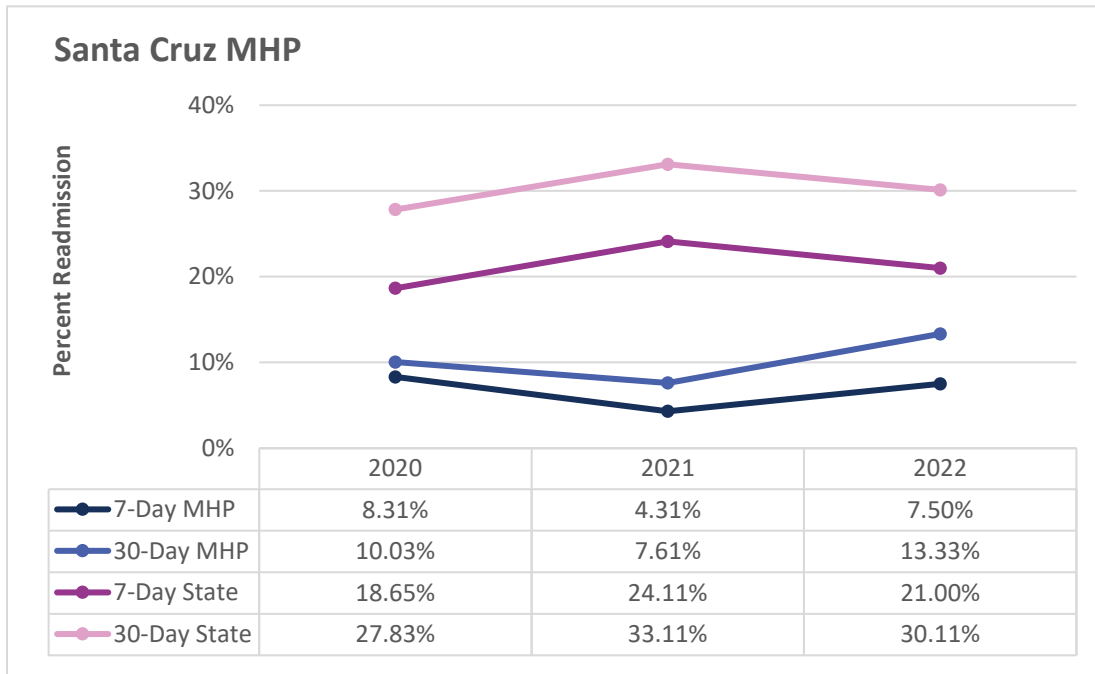
- Both 7-day and 30-day readmission rates in the MHP are consistently much lower than statewide rates across each of the past three years.

- Data submitted by the MHP reflect comparable readmission rates for FY 2022-23 (4.3 percent 7-day readmission rate, 11.2 percent 30-day readmission rate).

- The MHP reports utilization of institutions for mental disease excluded facilities, which are not reflected in the claims data used by the EQRO.

High-Cost Members

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

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs 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 AACM is $7,442, the median amount is just $3,200.

Tables 14 and 15 and Figure 20 show how resources are spent by the MHP among individuals in high-, middle-, and low-cost categories. Statewide, nearly 92 percent of the statewide members are "low-cost" (less than $20,000 annually) and receive 54 percent of the Medi-Cal resources, with an AACM of $4,364 and median of $2,761 for members in that cost category.

Table 14: Santa Cruz MHP High-Cost Members (Greater than $30,000), CY 2020-22

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	430	14.83%	55.11%	$25,136,645	$58,457	$46,867
	CY 2021	416	14.44%	54.09%	$24,157,955	$58,072	$49,539
	CY 2020	365	12.58%	51.52%	$20,604,558	$56,451	$47,074

- The total count and the percentage of members in the HCM category have increased each of the past two years, as has the percentage of total claims for HCMs and the average (mean) approved claims per HCM, and median approved claims per HCM is the only variable in Table 14 that has seen a decrease.

- For CY 2022, as in prior years, claims for HCMs represented a much higher proportion of members in the MHP (about 14.8 percent) than statewide (4.54 percent).

- The MHP's HCMs cross all age groups but the largest number are aged 21-59 (n=203) and age 6-17 (n=124).

- Both average and median approved claims per HCM in the MHP were higher than the state average and median.

- The data provided in Table 8 regarding adult utilization and units of service may provide a useful starting point to understanding the array of services being provided.

Table 15: Santa Cruz MHP Medium- and Low-Cost Members, CY 2022

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost	283	9.76%	15.34%	$6,998,515	$24,730	$24,850

($20K to $30K)						
Low-Cost (Less than $20K)	2,187	75.41%	29.55%	$13,478,261	$6,163	$4,465

- The MHP has more medium-cost and fewer low-cost members than statewide. Statewide, 4 percent of members were considered medium-cost and 92 percent were considered low-cost.

Figure 20: Santa Cruz MHP Members and Approved Claims by Claim Category, CY 2022
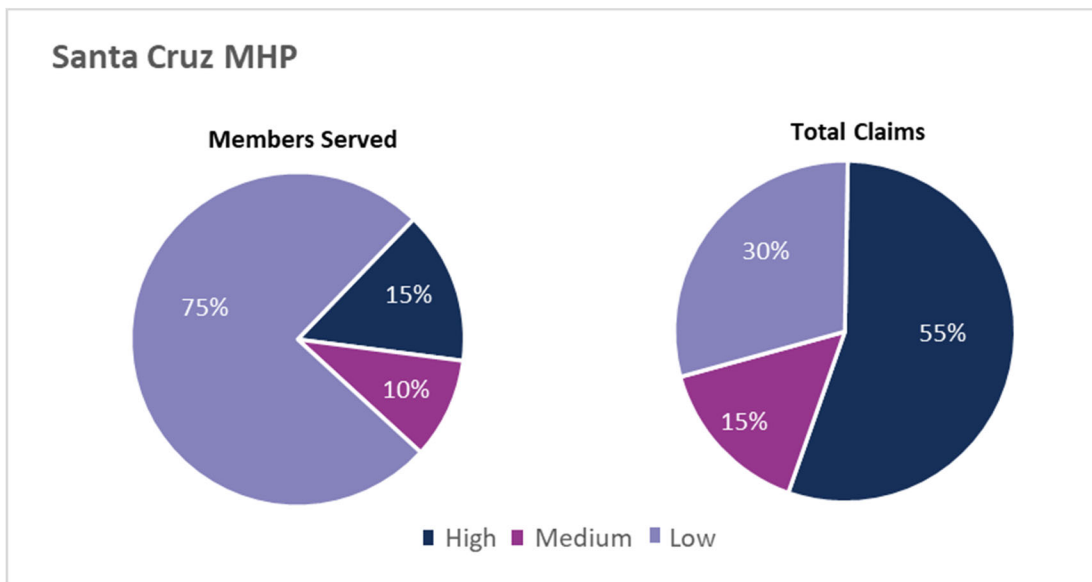
- For CY 2022 approximately 75 percent of the members served fell into the low-cost category, representing 30 percent of claims. Medium-cost members represented 10 percent of the members served and about 15 percent of claims, and HCMs represent 15 percent of members served and about 55 percent of claims.

IMPACT OF QUALITY FINDINGS

- Since July 2023, the CSU is serving adults only with deferral of youth to local emergency departments. Currently the mobile crisis teams are only available during business hours. The MHP outlined plans to expand crisis and residential services for its members including 24/7 mobile crisis and constructing a youth-only CSU and crisis residential.

- Given the comparatively high average units of service provided to adults, a LOC tool is important for ensuring that members are at the right LOC.

- The county has a large unhoused population, particularly in North County and reports that community resources such as shelters continue to close. Line staff share that there are few places left for members who are unhoused to shower and be easily found by MH staff for field-based services.

- The MHP is working closely with the jail and juvenile justice to close the gap between release and the onset of support for both behavioral health and substance use disorder (SUD) treatment.

- Many staff described decisions being made top-down and that the environment could be more inclusive, while simultaneously noting positive relationships with management. The MHP has supported peer certification, but having to bill and document in the EHR are deterrents for some peers. The MHP has plans to address this, but CalAIM and other changes had to be prioritized.

- It is widely evident that the MHP values and collects data for informed decisions and advocacy. Many examples are found and the MHP continues to develop tools for sharing across departments to the benefit of members. A good example of this is a shared portal across departments and regular reporting to the members for CANS data, the pilot multi-agency ROI, and movement toward closed-loop referrals for the PIP, and CalAIM Behavioral Health Quality Improvement Plan (BHQIP).

- Last review, the MHP had hired a consultant to help with improvements on the QI team and process. During this review, line staff validated improvements in QI processes including improved communication. Contract leadership validates improved communication for some but not all, and this picture is complex given the depth of CalAM reform impacting contracted providers.

- Contract providers continue to operate without a contract this FY and expressed concern during the review that changes to youth screening with CalAIM could force the shutdown of programs, especially those aimed at prevention.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, 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 member satisfaction. They should have a direct member 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 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: No-Show PIP

Date Started: 11/2022

Date Completed: Not Applicable

Aim Statement: "By the second quarter of 2025, Santa Cruz County Behavioral Health Services Division will improve overall and program-specific no-show rates by one percentage point over the May-July 2023 baseline (8.0%) by providing psychoeducation and other clinical interventions towards developing therapeutic alliance, build confidence that recovery is possible, and establishing clear expectations about attending appointments."

Target Population: The project involves the entire beneficiary population who participate in county-operated children's services, adult therapy, psychiatry, and the access team.

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

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

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

Summary

The MHP has done a thorough investigation into no-shows as a PIP topic which led to identification of inconsistencies in the definition and thus the data around no-shows. In response, an operational definition and universal protocol was established, and clinical care teams trained, prior to collecting a three-month baseline. The baseline rate of no-shows was established from May-July 2023 and found to be 8 percent. The root cause analysis has been qualitative with stakeholder feedback collected from staff and members. Variables and PMs have not yet been developed.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because the variable(s) and PMs consistent with a clinical PIP have not yet been established. However, methods thus far are credible and seemingly a great start with a strong root cause and efforts toward reliable baseline data.

This PIP started overlapping with the previous clinical PIP, thus the initial TA provided by CalEQRO was during this review. Feedback included tailoring this to a clinical PIP, with clinical interventions if it is to be a clinical PIP, as well as providing a greater description of work and data collection done thus far. The MHP provided an updated PIP, and this information is based on that updated document.

CalEQRO recommendations for improvement of this clinical PIP:

- Establish PIP variables and PMs consistent with a clinical PIP and based in the root causes identified.

NON-CLINICAL PIP

General Information

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

Date Started: 12/2022

Date Completed: Not Applicable

Aim Statement: "By Q4 2023, Santa Cruz County's MHP aims to increase by 5% over MY 2021 baseline the percentage of all mental illness and intentional self-harm (MI/ISH)-related emergency department (ED) visits with 7-day and 30-day follow-up services (51.4% and 66.4%, respectively) by contracting with Santa Cruz County's Health Information Organization (SCHIO) to provide (1) real-time alerts for active MHP clients upon admission to ED and (2) daily reports of beneficiaries discharged from the

ED into the community with principal diagnoses of (MI/ISH), implementing follow-up procedures by appointed and trained BHS providers, and conducting closed-loop referrals."

Target Population: MHP clients who admit to ED with documented MH/ISH (intentional self-harm)-related presenting complaint.

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

Summary

In this PIP, the improvement strategy is centered on the systems and processes for coordination of care between the MHP and the ED. Using the BHQIP form, it outlines the development since last year's submission. The primary shift has been from regular reports and liaisons to harnessing information sharing technologies accessed directly by MHP staff (a member's clinician or the access team, for example). Rather than a sample or single department, they are focusing on the entire population of eligible members, active members, and those at the ED who accept referral to the MHP.

The MHP is working closely with SCHIO to address barriers and delays in processes and bring stakeholders together across the county under a common platform, Unite Us which is a tool for closed-loop referrals. This PIP shows clear potential to support access and quality care for all Medi-Cal eligibles and MHP members, regardless of a visit to the ED.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence because performance measures, indicators, and general investment in this PIP suggest it is credible and valid.

The MHP received TA for this PIP during the previous review. CalEQRO suggested that there be more detail on the role of liaisons and the promotional materials intervention on follow-up appointments. This year, the MHP has omitted the promotional materials as an intervention and the PIP has been adjusted to focus primarily on information exchange technologies.

CalEQRO recommendations for improvement of this non-clinical PIP:

- Utilize the CalEQRO PMs and measurements chart to help organize results for a large number of outcomes across time.

- Collect data and requisite PIP information across time as regularly expected with a PIP, even though the BHQIP form may not require all items or allow enough space to provide them.

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. Currently, the MHP has no plans to replace the current system, which has been in place for more than five years and is functioning in a satisfactory manner.

Approximately 3 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is allocated to the MHP but managed by another county department. The IS allocation is unchanged from the prior EQR.

The MHP has 476 named users with log-on authority to the EHR, including approximately 415 county staff and 61 contractor staff. Support for the users is provided by 4.8 full-time equivalent (FTE) IS technology positions. Currently there is one FTE IS vacancy, and no additional IS positions that have been allocated since the last EQR.

As of the FY 2023-24 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to Santa Cruz 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	95%
Documents/files e-mailed or faxed to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	5%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP does have a PHR beneficiaries can use to view future appointments, schedule or request new appointments, receive appointment reminders, view active medication prescriptions, and send and receive secure messages. The PHR system is in the process of being upgraded as well, and the MHP is coordinating the rollout with Netsmart for the cloud based PHR, MyEvolve.

Interoperability Support

The MHP is a member or participant in the SCHIO, an HIE. Currently, the HIE is used to receive alerts for ED visits from members who are already receiving services through the MHP. The MHP engages in electronic exchange of information its contract providers, SUD contract providers, and hospitals.

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 member outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

Table 17: IS Infrastructure Key Components

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

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

- The presence of long-standing fiscal/billing staff in the MHP, combined with cross training practices that have been implemented, contributes to the MHP's low claim denial rate and supports the financial stability of the MHP.

- While the MHP has an Operations Continuity Plan (OCP) in place to maintain readiness in case of a cyber-attack or other emergencies, it does not execute annual testing of the OCP. The estimate timeline for restoration of the EHR to operational status in the event of a disruption is 24 hours.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved 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 2022.

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

Table 18: Summary of Santa Cruz MHP Short-Doyle/Medi-Cal Claims, CY 2022

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	6,542	$3,165,132	$37,199	1.18%	$3,127,933
Feb	6,834	$3,407,916	$32,818	0.96%	$3,375,098
Mar	8,611	$4,197,373	$48,686	1.16%	$4,148,687
April	7,948	$3,777,718	$44,328	1.17%	$3,733,390
May	7,755	$3,756,164	$24,295	0.65%	$3,731,869
June	7,102	$3,310,448	$14,826	0.45%	$3,295,622
July	6,788	$3,410,055	$33,077	0.97%	$3,376,978

Aug	7,979	$3,957,910	$25,782	0.65%	$3,932,128
Sept	8,496	$4,001,319	$23,810	0.60%	$3,977,509
Oct	8,316	$3,652,116	$20,136	0.55%	$3,631,980
Nov	7,958	$3,599,587	$27,375	0.76%	$3,572,212
Dec	7,048	$3,288,185	$18,738	0.57%	$3,269,447
Total	**91,377**	**$43,523,923**	**$351,070**	**0.81%**	**$43,172,853**

- The MHP's claims data reflects generally consistent billed amounts and claims volume throughout CY 2022.

Table 19: Summary of Santa Cruz MHP Denied Claims by Reason Code CY 2022

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Medicare Part B must be billed before submission of claim	163	$124,320	35.41%
Other healthcare coverage must be billed first	140	$105,076	29.93%
Beneficiary is not eligible or non-covered charges	75	$59,237	16.87%
Service line is a duplicate and repeat service modifier is not present	68	$21,994	6.26%
Other	56	$17,516	4.99%
Late claim submission	19	$11,486	3.27%
Service location NPI issue	24	$10,842	3.09%
Deactivated NPI	4	$600	0.17%
Total Denied Claims	**549**	**$351,071**	**100.00%**
Overall Denied Claims Rate	**0.81%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The majority of denied dollars were denied due to Medicare Part B needing to be billed first (35.41 percent), followed by needing to bill other healthcare coverage first (29.93 percent). These two reasons accounted for approximately 65 percent of denied dollars in the MHP.

- The MHP's denied claims rate (0.81 percent) was much lower than statewide (5.92 percent).

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The MHP is successfully navigating system-wide changes related to CalAIM, most recently payment reform.

- The CalAIM Adult and Youth Screening and Transition of Care Tools have been integrated into the EHR and extensive coding changes have been made

to support CalAIM payment reform. This has been successful despite vacancies, challenges with recruitment, and other environmental issues.

- The current IS staffing level in the MHP is unlikely to be sufficient for new demands and requirements. One example is continuing and expanding the HEDIS measures tracking and reporting. Further, with current staffing levels and resources, existing staff are challenged to prioritize and complete tasks. For example, the MHP had to suspend 274 Health Care Provider Directory submissions temporarily to redirect staff to the CalAIM changes.

- The MHP cross-trains staff for claims submissions, reportedly resubmits claims in a timely manner when required, and has a dramatically low denial rate.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

The CPS consists of four different surveys that are used statewide for collecting members' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of members: adult, older adult, youth, and family members. MHPs administer these surveys to members 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 collected an impressive number of surveys for the May 2023 CPS. A summary of the member comments was developed and presented to staff prior to submission. Feedback during the review indicates that members and staff have participated in these surveys. The summary survey results for 2022 were also provided at the time of the review. The QIC has planned to develop goals based on the member feedback, one each for the MHP and DMC-ODS. Year to year comparison reports have not been developed as the CPS ratings have reportedly been consistent across years.

PLAN MEMBER/FAMILY FOCUS GROUPS

Plan member and family member (PMF) 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 PMF 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 MHP members /or their family, containing 8 to 10 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a culturally diverse group of adult members from North County who initiated services in the preceding 12 months. Community Connection is a contract provider operating a wellness center in both North and South County. None of the participants who attended had initiated services in the last 12 months. The focus group was held at Community Connection in Santa Cruz, and included three participants; no language interpreter was required for this focus group. All members participating currently receive clinical services from the MHP.

This group was generally happy with the services including frequency, consistent providers over the last six months, linkage to needs such as primary care, and telehealth options. They shared that case managers are primarily used to link to resources in the community, that they had completed the CPS, and had been invited to QI meetings.

Recommendations from focus group participants included:

- No recommendations were provided, but one member offered the comment that Community Connection saved their life.

Consumer Family Member Focus Group Two

CalEQRO requested a culturally diverse group of adult members from South County who initiated services in the preceding 12 months. Three of the participants who attended initiated services in the last 12 months. The focus group was held at Mariposa Wellness Center in Watsonville and included nine participants; no language interpreter was required for this focus group. All members participating currently receive clinical services from the MHP.

This group of members indicated satisfaction with the availability of care, although they report that case managers are very busy. They shared that a member must be open to BH before attending the wellness center and that they generally come to the center at least weekly. Overall, they had been invited to participate in surveys, use the website, and attend quality improvement meetings, although none found these opportunities helpful. Most frequently, they share with their psychiatrist any input for the system.

Recommendations from focus group participants included:

- Make more varied services available at the wellness center, as they have not attended as often due to the short staffing. Ideas include more programming aimed at women, cultural wellness practices, and 12 Step programs. Gratitude for the Department of Rehabilitation being availability in the wellness center was shared.

- Hire more Hispanic providers and representation in the community to provide more culturally sensitive services such as holistic, natural, Eastern, or Aztec treatment options.

- Greater housing options in the county for single adults including reopening the Section 8 list.

- Provide another MH facility near public transportation.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Overall, the members were satisfied with services, having received them in a reasonable amount of time and frequent enough to meet their needs. They noted benefit from interactions with the MHP. They were aware of programs available to help them including the potential for family involvement, wellness centers, coordinators to help with housing, and connection to substance use treatment in addition to others. They verify that housing is a hardship in the county, staffing for services is short, and more culturally specific services directed at Latino/Hispanic populations will be helpful.

CONCLUSIONS

During the FY 2023-24 annual EQR, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on member outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. Despite an ongoing high vacancy rate across the department, the MHP has successfully implemented many changes required under CalAIM. Most recently payment reform which required necessary staff training was a significant demand on administrative and IS staff. (Access, Quality, IS)

2. It is widely evident that the MHP values and collects data for informed decisions and advocacy. Many examples are found and the MHP continues to develop tools for sharing across departments to the benefit of its members. A good example of this is a shared portal across departments and regular reporting to the members and their families for CANS data. (Quality, IS)

3. As part of the Healing the Streets project, which was funded by a SAMHSA grant, now on no cost extension, a multi-agency ROI was developed. This tool has proven accepted by members and useful in linking them to nonduplicated care across departments. This tool and this type of county partnership could support the county to effectively care for their large unhoused population, including leveraging of enhanced care management through the MCP. (Access, Quality)

4. The MHP has begun a large movement toward closed-loop referrals for their non-clinical PIP and has introduced a new IS tool to support this function. The PIP focuses on the entire population and age group under the HEDIS measure FUM. (Quality, IS)

5. Staff and members are aware that they are welcome to give input into the system. For example, members were able to outline various ways that they do this and confirmed receipt of invitation to the QIC. Line staff referenced the Practice Standards Committee where staff supply input about new BH Information Notices. (Access, Timeliness, Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. There are requests for increased representation of Hispanic/Latino populations in the county. Validation sessions indicate the need for culturally specific treatment options, an increase in bilingual staff, and a greater allocation of county's general resources to South County. (Access, Quality)

2. Efforts to improve timeliness to first service is evident, particularly for youth members; however, data and reports still show room for improvement. Particularly with changes prompted by the CalAIM Screening Tools, this area could use special investigation. (Access, Timeliness)

3. Line staff comment about a "revolving door" where there are insufficient step-down and housing or shelter resources to provide a smooth transition through LOCs for its members. The MHP and the most recent Civil Grand Jury Report acknowledge that members need this stability to benefit from treatment without recurrent needs for a higher LOC. HCMs comprise 15 percent of the members served (compared to 4.5 percent statewide) and account for over 55 percent of the claimed services (compared to 34 percent statewide). (Access, Quality)

4. The MHP has taken steps to improve efficiency in hiring staff; however, continues to face a significant barrier of competition with the rest of the Bay Area. This is particularly troublesome for IS staffing as changes for CalAIM and other data demands increase for MHPs. The MHP states no change in IS staffing since this opportunity was identified during the last review. (Quality, IS)

5. Significant changes due to CalAIM threaten the stability of contract provider agencies which make up 68 percent of the MHP. The MHP has advocated for additional financial support to help the agencies with this transition, yet some programs have already been terminated or paused. Innovative ideas and deeper partnership with contractors and other community resources seems key to navigating the transitions prompted by CalAIM and the loss of other community services. (Access, Quality)

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 member outcomes:

1. Investigate reasons and develop and implement strategies to improve outreach to Hispanic/Latino communities and Medi-Cal eligibles. The MHP might consider applying for grants that focus on community health workers (or promotoras) as a strategy to reach underserved populations. (Access, Quality)

   (This recommendation was continued from FY 2022-23.)

2. Investigate reasons and develop and implement strategies to provide timelier first service appointments. (Access, Timeliness)

   (This recommendation was continued from FY 2022-23.)

3. Consider implementation of a LOC tool – beginning with adults – as a mechanism for managing the increasing proportion of HCMs. This will help determine whether the service patterns and levels of care are clinically appropriate; implement other improvement strategies where needed. (Access, Timeliness, Quality)

(This recommendation was continued from FY 2022-23.)

4. Develop and implement concrete strategies for increasing the number of IS and analytic staff which would improve the data and analytics capacity for QI and support IS functions necessary for CalAIM implementation. (Quality, IS)

   (This is the continuation of a similar recommendation from FY 2021-22 and FY 2022-23.)

5. Explore the needs of contract providers at this time of massive change with CalAIM, identifying key methods for the county to support the transition and maintain the necessary service capacity. This includes the timely contracting in order to reimburse for services provided. (Access, Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

The MHP identified no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Santa Cruz MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being (Katie A./CCR)
Member Focus Groups
Clinical Line Staff Group Interviews
Clinical Supervisors Group Interview
Specialized Service Systems: Criminal Justice Stakeholders
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Inter-Agency Coordination
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Clinical Management and Supervision
Wellness Center Site Visit
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Heather Claibourn, Quality Reviewer
Marcia Marsh, Information Systems Reviewer
David Czarnecki, 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.

Sites for Santa Cruz's MHP Review

MHP County Sites

1400 Emeline, Building K
Santa Cruz, CA 95060

1430 Freedom Blvd., Suite F
Watsonville, CA 95076

PIP sessions were held via video conference on September 5, 2023.

MHP Contract Provider Sites

Community Connection
300 Harvey West Blvd.
Santa Cruz, CA 95060

Mariposa Wellness Center
10 Carr Street
Watsonville, CA 95076

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Aguilar	Ileana	QI Program Coordinator	Santa Cruz County Health Services Agency (HSA)
Alexander	Judy	Program Manager	Janus
Alves	Linda	Chief Operating Officer	Encompass
Annon	Robert	Program Manager	Santa Cruz County HSA
Arterberry	Jammie	Counselor	Sobriety Works
Avila	Sarah	Utilization Review Specialist	Santa Cruz County HSA
Balderas	Isarel	Application Development	Santa Cruz County HSA
Bare	Adriana	Senior Health Services Manager	Santa Cruz County HSA
Barker	Shelly	Health Services Manager	Santa Cruz County HSA
Bernabe	Jose	Peer Aide	Avenues
Blaskovich	Dagny	Director	Community Connection
Bogren	Michael	SUD	Santa Cruz County HSA
Bolton	Beloved	Utilization Review Specialist	Santa Cruz County HSA
Butler	JP	Vice President	Front Street Inc
Cains	Joann	Clinician	Encompass
Campbell	Brenda	Program Manager	Santa Cruz County HSA
Cantrell-Warren	Tiffany	Director of Behavioral Health	Santa Cruz County HSA
Cartee	Ashley	Director	Parents Center

Last Name	First Name	Position	County or Contracted Agency
Chairez	Gil	Client Spec	Santa Cruz County HSA
Chicoine	Dave	Utilization Review Specialist	Santa Cruz County HSA
Chuck	Estes	Direct Provider Staff	Santa Cruz County HSA
Cooper	Sarah	CEO	Sobriety Works
Crews	Daniel	Data Analyst	Santa Cruz County HSA
Crout	Wendy	Peer Specialist	Second Story
Crowder	Amanda	Program Manager	Santa Cruz County HSA
Cruz	Sibiliano	Application Development	Santa Cruz County HSA
DeAnda	Fernando	Case Manager	Santa Cruz County HSA
Debbie	Garza	Direct Provider Staff	Santa Cruz County HSA
Del Rosario	Kendra	SUD	Pajaro Valley Prevention and Student Assistance (PVPSA)
Dettle	Donovan	LPHA	Parents Center
Echols	Adam	Client Spec	Santa Cruz County HSA
Engeldram	Amanda	Director	PVPSA
Fernandez	Jorge	IT manager III	Santa Cruz County HSA
Flagg-Wilson	Leah	QI Manager	Santa Cruz County HSA
Franck	Leelia	Director	Encompass
Friedman	Claire	Director	Sobriety Works
Gannon	McKenzie	Care Coord	New Life

Last Name	First Name	Position	County or Contracted Agency
Garcia	Dominic	Counselor	New Life
Gil	Chairez	Direct Provider Staff	Santa Cruz County HSA
Goldfield	Gregory	SUDS Intake	Santa Cruz County HSA
Gonzalez	Maria	Supervisor	Santa Cruz County HSA
Gonzalez	Veronica	Supervisor	Santa Cruz County HSA
Grace	Saldivar-Napoles	Health Services Manager	Santa Cruz County HSA
Grijalva	Karen	Program Manager	Encompass
Gutierrez-Wang	Lisa	Senior Behavioral Health Manager	Santa Cruz County HSA
Haney	Kara	Clinical Manager	Encompass
Harrison	Steven	Client Specialist	Santa Cruz County HSA
Ismail	Jade	MHRS	Parents Center
Jeffries	Johanna	Supervisor	Santa Cruz County HSA
Kahoano	Briana	SUD Sup	Santa Cruz County HSA
Kern	Karen	Deputy Director	Santa Cruz County HSA
Ledvina	Emma	Director	Parents Center
Lewis	Angela	Supervisor	Santa Cruz County HSA
Long	Danielle	Program Manager	Santa Cruz County HSA
Mackinnen	Phoenix	Counselor	Second Story

Last Name	First Name	Position	County or Contracted Agency
Macwhorter	Stephanie	Operations Officer	Janus
Mast	Nancy	Utilization Review Specialist	Santa Cruz County HSA
McCormick	Eileen	Manager	Encompass
McEldowney	Carol	Counselor	Front Street Inc
McLaughlin	Colleen	Supervisor	New Life
Medina	Victor	Client Specialist	Community Connection
Miranda	Araceli	Manager	Parents Center
Montgomery	Courtney	Director	Janus
Morrison	Maisy	Director	Janus
Movshovitz	Eileen	Supervisor	Santa Cruz County HSA
Nair	Latha	Medical Director	Santa Cruz County HSA
Najera	Jasmine	CEO	PVPSA
Nicol	Aaron	Client Specialist	Santa Cruz County HSA
Nunez	Griselda	Representative	Janus
Olinger	Kayla	Director	Community Connection
Olivares	Mario	Case Manager	Santa Cruz County HSA
Ortiz	Erica	Administration Officer	Santa Cruz County HSA
Otlin	Stacy	Director	Haven of Hope
Owen	Madea	Utilization Review Specialist	Santa Cruz County HSA
Palau	Stacy	CEO	New Life

Last Name	First Name	Position	County or Contracted Agency
Polanco	Davina	Director	Haven of Hope
Randall	Vanessa	SUD	Janus
Renars	Gonzales	Direct Provider Staff	Santa Cruz County HSA
Robertson	Subé	Quality Improvement Director	Santa Cruz County HSA
Rocha	Angel	Children's Behavioral Health	Santa Cruz County HSA
Rocky	Allemandi	Health Services Manager	Santa Cruz County HSA
Rodriguez	Erica	Family Partner	Santa Cruz County
Rubacalva	Emilio	Director	Front Street Inc
Ruiz	Rosalba	Case Manager	Community Connection
Russell	James	Senior Behavioral Health Manager	Santa Cruz County HSA
Russell	Lisa	Chief Officer	Encompass
Salcedo	Maria	Program Manager	Encompass
Sandoval	Clinton	Director	Janus
Sarah	Tisdale	QI / Compliance Director	Encompass
Sellers	Emily	SUD	Santa Cruz County HSA
Sisti	Ryan	Supervisor	Santa Cruz County HSA
Smiley	Sage	Manager SUD	Encompass
Solano	Nash	Social Worker	Dominican Hospital
Soria	Elizabeth	Administrative Services Manager	Santa Cruz County HSA

Last Name	First Name	Position	County or Contracted Agency
Stautz	Ricki	Program Manager	Encompass
Steven	Harrison	Direct Provider Staff	Santa Cruz County HSA
Stone	Jessica	Director of Compliance	Janus
Suski	Ellen	Utilization Review Specialist	Santa Cruz County HSA
Swank	Casey	SUD Director	Santa Cruz County HSA
Tavarez	Minerva	MS	Encompass
Taylor	Steven	Clinician	Encompass
Tisdale	Sarah	QI Director	Encompass
Trejo	Olympia	Children's Behavioral Health	Santa Cruz County HSA
Turnbull	Andrea	Behavioral Health Program Manager	Santa Cruz County HSA
Uribe	Paulina	Supervisor	Janus
Vitali	Paul	Supervisor	Santa Cruz County HSA
Warnke	Maria Eugenia	IT Business system analyst	Santa Cruz County HSA
Weitzel	Nancy	SUD analyst	Santa Cruz County HSA
Wong	Gian	IT App Dev/Sup Analyst lll	Santa Cruz County HSA
Wooden	Julie	Prog Director	Sobriety Works
Yarnell	Meg	Health Services Manager	Santa Cruz County HSA
Zamudio	Stephanie	Lead Clinician	PVPSA
Zinsmeyer	Mary	Quality Assurance Manager	New Life

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The variable(s) and PMs consistent with a clinical PIP have not yet been established. However, methods thus far are credible and seemingly a great start with a strong root cause and efforts toward reliable data.
General PIP Information	

MHP/DMC-ODS Name: Santa Cruz County Behavioral Health Services

PIP Title: No-Show PIP

PIP Aim Statement: By the second quarter of 2025, Santa Cruz County Behavioral Health Services Division will improve overall and program-specific no-show rates by one percentage point over the May-July 2023 baseline (8.0%) by providing psychoeducation and other clinical interventions towards developing therapeutic alliance, build confidence that recovery is possible, and establishing clear expectations about attending appointments.

Date Started: 11/2022

Date Completed: Not Applicable

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):

The project involves the entire beneficiary population who participate in county-operated children's services, adult therapy, psychiatry, and Access services.

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):

No interventions have been developed at this time.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):

Clinical staff were trained on the operational definition and standard of documentation for a no-show.

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):

An operational definition and standard of documentation were introduced prior to beginning baseline data collection.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (If applicable)	Most recent remeasurement sample size and rate (If applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
			☒ Not applicable— PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information

Was the PIP validated?　☒ Yes　☐ No

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

Validation phase (check all that apply):

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

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

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

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

EQRO recommendations for improvement of PIP:

- Establish PIP variables and PMs consistent with a clinical PIP and based in the root causes identified.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The performance measures, indicators, and general investment in this PIP suggest it is credible and valid.

General PIP Information

MHP/DMC-ODS Name: Santa Cruz County Behavioral Health Services

PIP Title: Follow-Up After Emergency Department Visit for Mental Illness

PIP Aim Statement: By Q4 2023, Santa Cruz County's MHP aims to increase by 5% over CY 2021 baseline the percentage of all MI/ISH-related ED visits with 7-day and 30-day follow-up services (51.4% and 66.4%, respectively) by contracting with SCHIO to provide (1) real-time alerts for active MHP clients upon admission to ED and (2) daily reports of beneficiaries discharged from the ED into the community with principal diagnoses of MI/ISH, implementing follow-up procedures by appointed and trained BHS providers, and conducting closed-loop referrals.

Date Started: 12/2022

Date Completed: Not Applicable

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): MHP clients who admit to ED with documented MH/ISH (intentional self-harm)-related presenting complaint.

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): Not Applicable
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Liaisons were appointed and staff trained to use widget effectively.
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): Implementation of multiple, new data sharing tools.

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
Closed Loop Referral Transmission: # of MH/ISH-related referrals transmitted from ED to DMC-ODS through Unite Us platform.	2023	At least 1 referral in October followed by steady increase each month through December 2023.	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Closed Loop Referral Transmission: #/% of Unite Us referrals that were "resolved" within 30-day			☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Real-time alerts upon ED admission for active DMC-ODS clients: # of alerts that indicate an MH/ISH-related concern upon admission (currently, alerts do not specify reason for ED visit)			☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (If applicable)	Most recent remeasurement sample size and rate (If applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Real-time alerts upon ED admission for active DMC-ODS clients: #/% that have a documented follow-up attempt within 7 days of ED discharge			☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Daily discharge reports for all beneficiaries: # of discharge reports for unserved beneficiaries with a principal MI/ISH diagnosis			☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Daily discharge reports for all beneficiaries: #/% that have a documented follow-up attempt within 7 days of ED discharge			☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
% of all beneficiaries, Hispanic, and Spanish-speakers who had a follow-up service within 7 and 30 days of ED discharge	2021		☒ Not applicable—PIP is in Planning or implementation phase, results not available		☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PIP Validation Information
Was the PIP validated?   ☒ Yes   ☐ No "Validated" means that the EQRO reviewed all relevant parts of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):
 	
  ☐ PIP submitted for approval   ☐ Planning phase   ☒ Implementation phase   ☐ Baseline year
 	
  ☐ First remeasurement   ☐ Second remeasurement   ☐ Other (specify):
 	
Validation rating: ☐ High confidence   ☐ Moderate confidence   ☐ Low confidence   ☐ No confidence
 	
"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP: • Utilize the CalEQRO PMs and measurements chart to help organize results for a large number of outcomes across time. • Be sure to collect data and requisite PIP information across time as regularly expected with a PIP, even though the BHQIP form may not require all items or allow enough space to provide them.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, CalEQRO Approved Claims Definitions, 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 as part of this report.