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FY 2021-22
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:

April 20- 21, 2022

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 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.

MHP INFORMATION

MHP Reviewed — Santa Cruz

Review Type — Virtual

Date of Review — April 20-21, 2022

MHP Size — Medium

MHP Region — Bay Area

MHP Location — Santa Cruz

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 2,901

MHP Threshold Language(s) — English, Spanish

SUMMARY OF FINDINGS

Of the seven recommendations for improvement that resulted from the FY 2020-21 EQR, the MHP addressed four and partially addressed three.

California External Quality Review Organization (CalEQRO) evaluated the MHP on the following four Key Components that impact beneficiary outcomes; among the 26 components evaluated, the MHP met or partially met the following, by domain:

- Access to Care: 100 percent met (four of four components).
- Timeliness of Care: 83 percent met (five of six components) and 17 percent not met (one of 6 components).
- Quality of Care: 80 percent met (eight of ten components), 10 percent partially met (one of ten components), and 10 percent partially met (one of ten components).
- Information Systems: 83 percent met (five of six components), and 17 percent partially met (one of six components).

The MHP submitted two of two required Performance Improvement Projects (PIPs). The clinical PIP, “Increase of Outpatient Mental Health Therapeutic Engagement through Face-to-Face (in-person and telehealth) Services for Specialty Mental Health Services (SMHS) clients enrolled in Federally Qualified (FQ) Therapy Services”, is in the first remeasurement phase with a moderate confidence validation rating. The non-clinical

PIP, “Improve service provider response practices when consumers cancel or miss SMHS appointments”, is concept only and is in the planning validation phase.

CalEQRO conducted two consumer family member focus groups, comprised of a total of 13 participants.

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: actively working to increase access and services; the average psychiatric readmission rates were significantly lower than the corresponding statewide averages; the Quality Improvement (QI) Plan actively and positively impacts management decisions; surveys are utilized to reach staff and beneficiaries, increasing inclusion in QI processes; and participation in the Santa Cruz Health Information Exchange (HIE).

The MHP was found to have notable opportunities for improvement in the following areas: struggles to meet an increasing demand for children’s services; the Crisis Stabilization Unit (CSU) implements a diversion protocol on a near daily basis; the MHP lacks confidence in their no-show data and no-show clinical response protocol; the MHP struggles to track and trend the Healthcare Effectiveness Data and Information Set (HEDIS) measures; and the MHP would benefit from additional Information Technology (IT) analytics and data development support for QI functions.

FY 2021-22 CalEQRO recommendations for improvement include: investigating reasons and develop and implement strategies to: improve the MHP’s children’s access and services; reduce the CSU’s near daily diversions to hospitals; improve the MHP’s no-show data tracking and no-show clinical response; improve the MHP’s response to tracking and trending the HEDIS measures; and increase the MHP’s IT analytics and data development support for QI functions.

INTRODUCTION

BACKGROUND

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

DHCS contracts with 56 county MHPs to provide SMHS to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act. As PIHPs, the CMS rules apply to each Medi-Cal MHP. DHCS contracts with Behavioral Health Concepts, Inc., the California EQRO, to review and evaluate the care provided to the Medi-Cal beneficiaries.

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

This report presents the FY 2021-22 findings of the EQR for Santa Cruz County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on April 20-21, 2022.

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 system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

Data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files, unless otherwise specified. These statewide data sources include: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and Inpatient Consolidation File (IPC). CalEQRO reviews are retrospective; therefore, data evaluated are from CY 2020 and FY 2020-21, 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–overall, FC, transitional age youth, and Affordable Care Act (ACA). CalEQRO also provides individualized technical assistance (TA) related to claims data analysis upon request.

FINDINGS

Findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality of care – including responses to FY 2020-21 EQR recommendations.
- Review and validation of three elements pertaining to NA: Alternative Access Standards (AAS) requests, use of out-of-network (OON) providers, and rendering provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).
- Summary of MHP-specific activities related to the following four Key Components, identified by CalEQRO as crucial elements of QI and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- PM interpretation and validation, and an examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per SB 1291 (Chapter 844).
- Review and validation of submitted PIPs.
- Assessment of the Health Information System's (HIS) integrity and overall capability to calculate PMs and support the MHP's quality and operational processes.
- Consumer perception of the MHP's service delivery system, obtained through satisfaction surveys and focus groups with beneficiaries and family members.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11 and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data; its corresponding penetration rate percentages; and cells containing zero, missing data, or dollar amounts.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

In this section, the status of last year's (FY 2020-21) EQR recommendations are presented, as well as changes within the MHP's environment since its last review.

ENVIRONMENTAL IMPACT

This review took place during the second year of the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP works as part of a county Health Services Agency (HSA). In the past year the HSA has filled a new Director and two new Assistant Director positions. The MHP has experienced a significant demand for services for children and families following return to school that is exceeding the availability of services in many areas. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

MHP 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 has been awarded several grants that augment the development of homeless outreach; mobile crisis; suicide prevention, and adult and children's CSU and Children's Crisis Residential Units (CRU).
- The MHP is implementing the Behavioral Health Quality Improvement Program supported by a contract with Intrepid Ascent while expanding organizational QI through a consultant.
- Demands for services for children and families, following return to school, is exceeding the availability of services in many areas. The MHP recognizes the need and is actively working to expand children's services in both routine and crisis care.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

In the FY 2020-21 EQR technical report, CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2021-22 EQR, CalEQRO evaluated the status of those FY 2020-21 recommendations; the findings are summarized below.

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2020-21

Recommendation 1: Evaluate the effectiveness of available means of information for access to children's services and identify if additional efforts are needed to enhance this information for parents of children with no previous experience with the MHP services.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP's public internet Child and Adolescent Behavioral Health (BH) Services page provides resources to the community. Information includes the description of available services, how to access MH and Substance Use Disorder (SUD) services and how to access Crisis services. County BH is also listed on 211. In addition, MHP's contracted youth services community providers offer extensive information on their websites. Children's MH Division has a new team of Behavioral Health Navigators out of the County Office of Education (COE) which help link youth/families to services (Medi-Cal and Private Insurance).

Recommendation 2: Continue monitoring and investigating the 30-day post-hospitalization follow-up rate and its causes. Institute performance improvement steps, as needed, for more complete data collection.

(This recommendation is a carry-over from FY 2019-20.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The county meets or exceeds state average on 7-Day and 30-Day follow up post-hospitalization on both PM and ATA data.

Recommendation 3: Consider including more SB 1291 mandated HEDIS measures as part of the medication monitoring protocol, as applicable.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The Santa Cruz County Health Service Department (HSD), which includes Child & Family Services (social services), hired public health nurses in FY 2020-21 to support SB 1291, SB 319 and overall medical monitoring for Foster Care youth. County BH MHP Children Services has a working partnership with HSD on care management and coordination, including collaborating with the PH Nurses. BH and HSD leadership are presently working on a Memorandum of Understanding/Agreement to increase care coordination scope of work practices and monitoring of care, including psychotropic medication management.

Recommendation 4: Continue efforts to engage clinical line staff in the QIC and document the staff council prioritized areas for the QIC.

(This recommendation is a carry-over from FY 2019-20.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The QIC Committee Chair conducted outreach throughout the year to identified clinical line staff to extend an invitation to join the committee. No invitation has been accepted at time of inquiry due to reasons of high workload demands.
- The QIC Chair recently extended a repeated invitation to the County BH's Team Advisory Council (TAC) Committee, which is comprised of line staff from all BH divisions (County Adult MH, Children's MH, SUD, Administration) and who's aim is to improve participation in policy decision making and implementation practices within BH. The Committee members and QIC Chair have ongoing conversations as to role possibilities as a QIC Committee member or topic contributor.

Recommendation 5: Investigate any reasons for medication delays for FC beneficiaries and take remedial steps, as needed.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP implemented improvements to BH youth psychiatry referral process workflow, including provision of necessary assessment documents to psychiatrist prior to initial appointment.
- The MHP reviewed procedural guidelines for JV 220 paperwork process and made improvements.
- Specific JV 220 training for BH and Child & Family Services (CFS) staff was conducted in May 2020.
- CFS social workers were trained/retrained in the JV 220 / 220A procedure by CFS in October 2021.

Recommendation 6: Assure full eLab functionality with the development of interoperability between Order Connect and Quest Diagnostics eLab application, Orchard Harvest.

(This recommendation is a carry-over from FY 2019-20.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- Due to COVID and serious staffing shortages in key project management roles, this project continues to experience significant delays. Finalization of the project is anticipated before the end of June 2022.

Recommendation 7: Assess the contract providers training needs and consider offering the highest priority ones including on co-occurring substance use disorders.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP BH Trainer, a QI team member, initially conducted assessments on training needs in February 2019 and September 2020 for BH Workforce and with BH's largest contractors. The MHP monitors training needs of contract providers through ongoing engagement with agency leaders and agency training coordinators. Training needs identified as priority capacities inform the trainings offered by County BH.
- Examples of MHP training that included contract providers include but were not limited to: Co-occurring Conditions in Mental Health and SUD Settings; Advancing Excellence in Transgender and Gender Diverse Behavioral Healthcare Series; Motivational Interviewing ~ Integrated Motivational Interviewing Series; the Encompass Speakers Series on Equities, Inequities, Inclusion, and Othering; National Alliance on Mental Illness (NAMI); and Integrative (MH and SUD) Law & Ethics training scheduled for October 2022.

NETWORK ADEQUACY

BACKGROUND

CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, the California State Legislature passed AB 205 in 2017 to specify how NA requirements must be implemented in California. The legislation and related DHCS policies and Behavioral Health Information Notices (BHINs) assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA.

All MHPs submitted detailed information on their provider networks in July 2021 on the Network Adequacy Certification Tool (NACT) form, per the requirements of DHCS BHIN 21-023. The NACT outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers; it also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. DHCS reviews these forms to determine if the provider network meets required time and distance standards.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services, for youth and adults. If these standards are not met, DHCS requires the MHP to improve its network to meet the standards or submit a request for a dispensation in access.

CalEQRO verifies and reports if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews separately and with MHP staff all relevant documents and maps related to NA for their Medi-Cal beneficiaries and the MHP's efforts to resolve NA issues, services to disabled populations, use of technology and transportation to assist with access, and other NA-related issues. CalEQRO reviews timely access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

FINDINGS

For Santa Cruz County, the time and distance requirements are 60 minutes and 30 miles for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over)[1].

Alternative Access Standards and Out-of-Network Providers

The MHP met all time and distance standards and was not required to submit an AAS request. Further, because the MHP can provide necessary services to a beneficiary within time and distance standards using a network provider, the MHP was not required to allow beneficiaries to access alternative services providers.

Planned Improvements to Meet NA Standards

Not Applicable.

MHP Activities in Response to FY 2020-21 AAS

The MHP did not require AAS in FY 2020-21.

PROVIDER NPI AND TAXONOMY CODES

CalEQRO provides the MHP a detailed list of its rendering provider's NPI Type 1 number and associated taxonomy code and description. Individual TA is provided to MHPs to resolve issues which may result in claims denials, when indicated. The data comes from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. The data are linked to the NPPES using the rendering service provider's NPI, Type 1 number. A summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO will be presented in the FY 2021-22 Annual Aggregate Statewide report.

[1] AB 205 and BHIN 21-023

ACCESS TO CARE

BACKGROUND

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

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

ACCESS IN SANTA CRUZ COUNTY

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 34.3 percent of services were delivered by county-operated/staffed clinics and sites, 65.6 percent were delivered by contractor-operated/staffed clinics and sites, and 0.1 percent were delivered by network providers. Overall, approximately 95.4 percent of services provided are claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24 hours, 7 days per week that is operated by county staff during business hours and a contract staff during after business and weekend hours; beneficiaries may request services through the Access Line as well as through the following system entry points: which the MHP refers to as “gates”: The County MHP gates include the North County Santa Cruz Clinic and MHP’s South County Watsonville Clinic locations. Children’s Social Services Gate that collaborates with the County’s Family and Children’s Services (FCS/Child Welfare)/Human Services Department; Youth School/Education Gate that collaborates with Unified School Districts and the COE; and the Youth Probation Gate that collaborates with the County’s Juvenile Probation Division. The MHP Youth Access also has contract provider Gate locations for children that are community and school access points: Pajaro Valley Prevention and Student Assistance (PVPSA) Outpatient Clinic, Encompass Community Service’s Youth and Transition Age Youth Service Clinics, and the Parents Center Outpatient Clinic. The MHP operates a decentralized System of Care access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Gates refer children/youth to additional needed services or lower levels of care when appropriate. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary services. Beneficiaries can, email or walk-in to outpatient clinics to access services.

In addition to clinic-based mental health services, the MHP provides telehealth and mobile mental health services. Specifically, the MHP delivers psychiatry and mental health services via telehealth to youth and adults. In FY 2020-21 From July 1, 2021, through February 28, 2022, the MHP reports having served 847 adult beneficiaries, 397 youth beneficiaries, and 122 older adult beneficiaries across two county-operated sites and 13 contractor-operated sites. Among those served, 143 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

ACCESS KEY COMPONENTS

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

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

Table 1: Key Components – Access

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

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

- The MHP supports Spanish bilingual access needs by assuring access points across the county have Spanish speaking staff.
- The MHP is actively expanding mobile crisis and CSU/CRU adult and youth access.
- The lesbian, gay, bisexual, transgender, and questioning (LGBTQ) community receives much needed mental health support through the MHP's diversity centers in Santa Cruz and Watsonville; several campaigns and trainings; using

LGBTQ identity flags advertising safe space; and a LGBTQ treatment collaborative.

- The MHP's CSU diverts adults and/or children to hospital emergency rooms on a near daily basis.
- The MHP cannot currently meet the capacity needs of the expanding routine, urgent and emergent youth services.

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect access to care in the MHP:

- Total beneficiaries served, stratified by race/ethnicity and threshold language.
- Penetration rates, stratified by race/ethnicity and FC status.
- Approved claims per beneficiary (ACB) served, stratified by race/ethnicity and FC status.

Total Beneficiaries Served

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

Table 2: County Medi-Cal Eligible Population and Beneficiaries Served by the MHP in CY 2020, by Race/Ethnicity

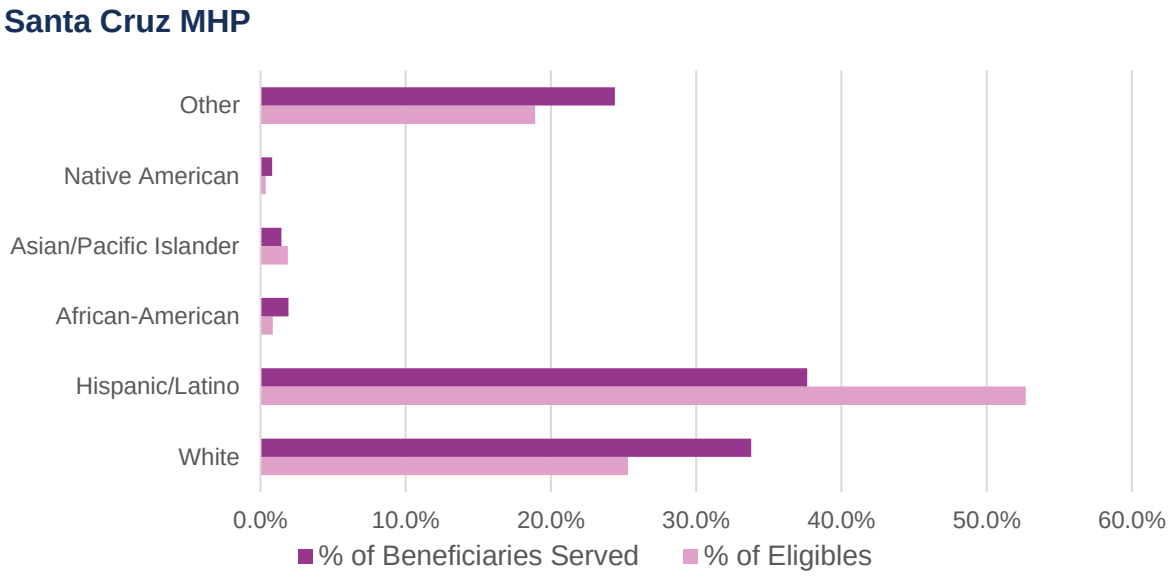
Santa Cruz MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Eligibles**	**Percentage of Average Monthly Unduplicated Medi-Cal Eligibles**	**Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP**	**Annual Percentage of Medi-Cal Beneficiaries Served by the MHP**
White	19,175	25.3%	980	33.8%
Latino/Hispanic	39,925	52.7%	1,092	37.6%
African-American	647	0.9%	56	1.9%
Asian/Pacific Islander	1,423	1.9%	42	1.4%
Native American	271	0.4%	23	0.8%
Other	14,340	18.9%	708	24.4%
Total	**75,781**	**100%**	**2,901**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Eligibles is not a direct sum of the averages above it. The averages are calculated independently.				

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS through the MHP. If they all had similar

patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

Santa Cruz served 2,901 unique beneficiaries in CY 2020. The eligible population was largely comprised of Latino/Hispanic beneficiaries with this group comprising 52.7 percent of the eligible population but only 37.6 percent of those served. White beneficiaries comprised the next largest race/ethnicity group with White being 25.3 percent of the eligible population and 33.8 percent of those served. The disproportionality between the percentage of Latino/Hispanic eligibles and percentage of beneficiaries (52.7 percent vs 37.6 percent) indicates that this populations may be underserved.

Figure 1: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020



Santa Cruz has one threshold language, Spanish, and served 608 unique beneficiaries (21.9 percent) who identified Spanish as a preferred language. The language in which these beneficiaries were served is not known.

Table 3: Medi-Cal Beneficiaries Served by the MHP in CY 2020, by Threshold Language

Santa Cruz MHP		
Threshold Language	**Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP**	**Percentage of Medi-Cal Beneficiaries Served by the MHP**
Spanish	608	21.9%
Other Languages	2,165	78.1%
Total	**2,773**	**100%**
Threshold language source: Open Data per BHIN 20-070 Other Languages include English		

The threshold language count is a total yearly count and not based on the average monthly calculation used for Table 2. Any discrepancy in total number of clients served between the two tables is attributed to the difference in methodology.

Penetration Rates and Approved Claim Dollars per Beneficiary Served

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The ACB served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. See Table D1 for the CY 2020 ACA Penetration Rate and ACB.

Figures 2 through 9 highlight three-year trends for penetration rates and average approved claims for all beneficiaries served by the MHP as well as the following three populations with historically low penetration rates: FC, Latino/Hispanic, and Asian/Pacific Islander (API) beneficiaries.

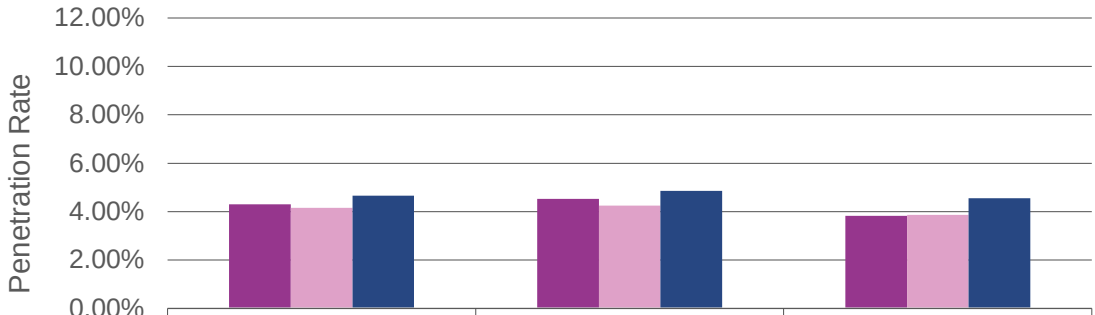
Santa Cruz's CY 2020 overall penetration rate (Figure 2) was comparable to the medium county average (3.83 percent vs. 3.87 percent) but lower than the statewide average (3.83 percent vs. 4.55 percent).

Santa Cruz's CY 2020 overall approved claims dollars per beneficiary (Figure 3) was significantly greater than both the medium county ($13,786 vs $8,399) and statewide averages ($13,786 vs. $7,155). The pattern of higher approved claims dollars per beneficiary, compared to medium county and statewide averages, was a pattern noted in all other approved claims dollar analyses (Hispanic/Latino, Asian/Pacific Islander, and foster care).

The CY 2020 Latino/Hispanic penetration rate (Figure 4) was equal to the medium county average (2.74 percent) but lower than the statewide average (2.74 percent vs. 3.83 percent). Santa Cruz's penetration rate for this sub-group ranked 39th of 56 MHPs.

Figure 2: Overall Penetration Rates CY 2018-20

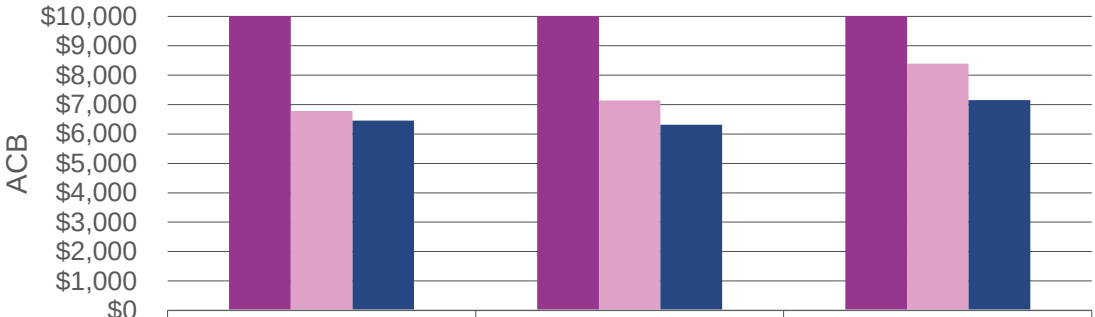
Santa Cruz MHP



	CY 2018	CY 2019	CY 2020
MHP	4.30%	4.52%	3.83%
Medium	4.16%	4.25%	3.87%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20

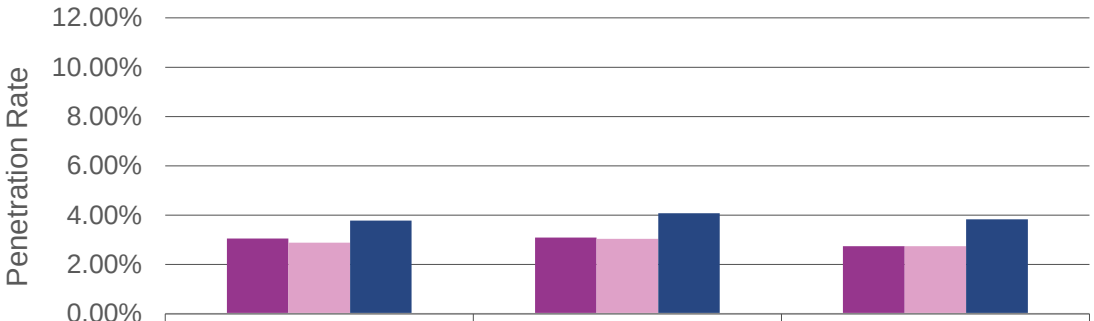
Santa Cruz MHP



	CY 2018	CY 2019	CY 2020
MHP	$10,302	$11,251	$13,786
Medium	$6,785	$7,143	$8,399
State	$6,454	$6,316	$7,155

Figure 4: Latino/Hispanic Penetration Rates CY 2018-20

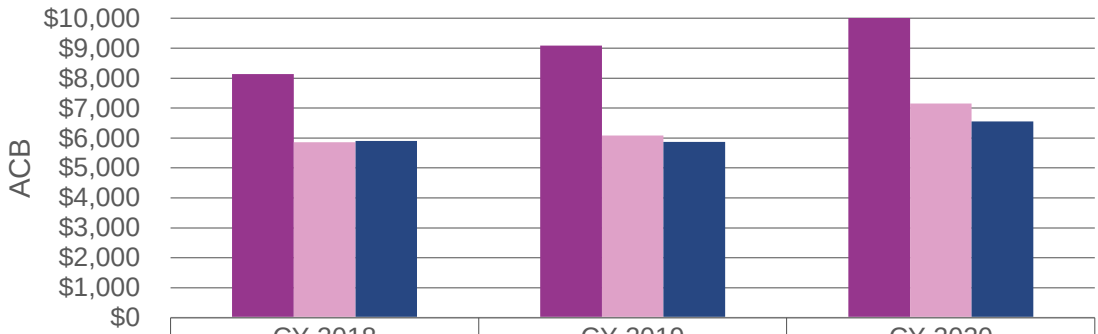
Santa Cruz MHP



	CY 2018	CY 2019	CY 2020
MHP	3.05%	3.10%	2.74%
Medium	2.88%	3.04%	2.74%
State	3.78%	4.08%	3.83%

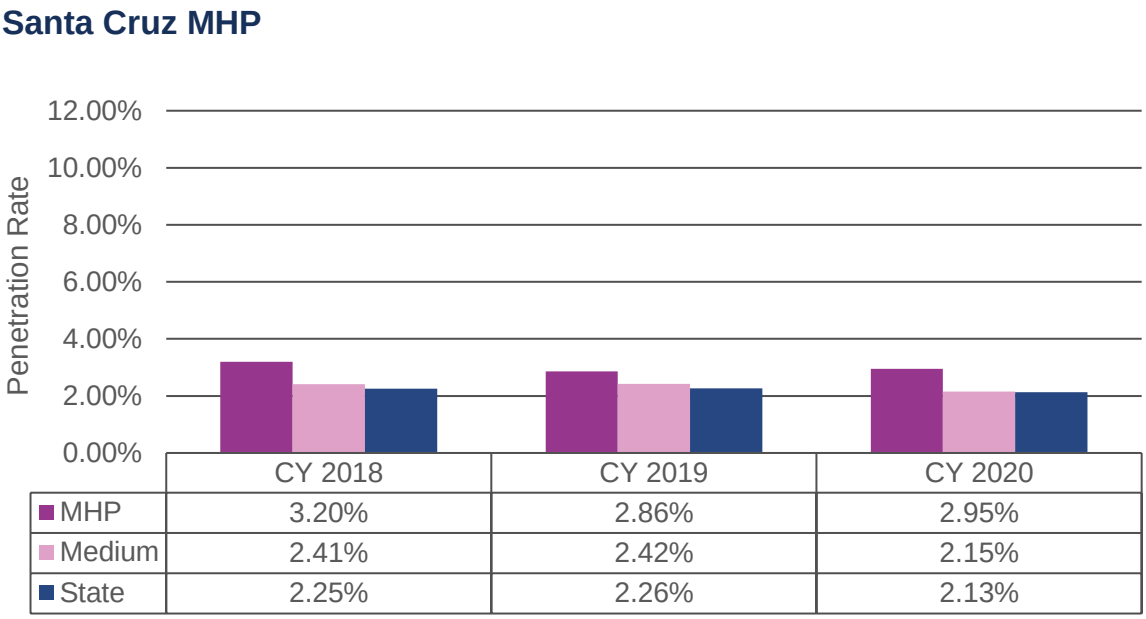
Figure 5: Latino/Hispanic ACB CY 2018-20

Santa Cruz MHP



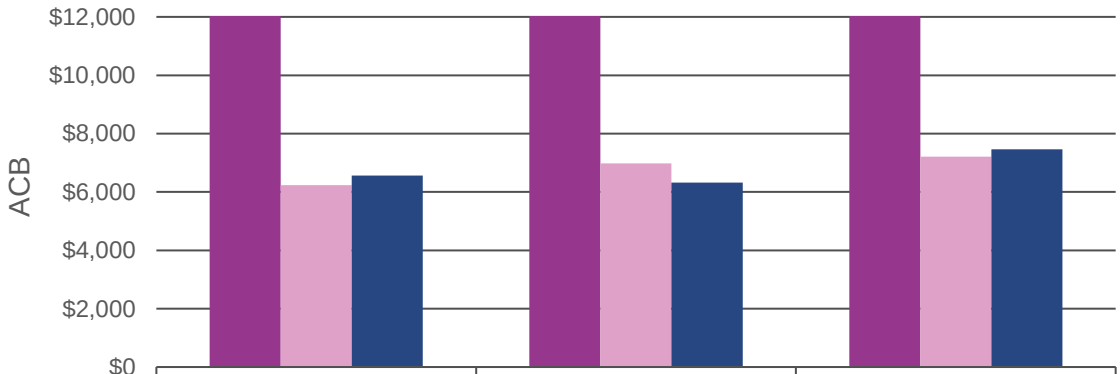
	CY 2018	CY 2019	CY 2020
MHP	$8,131	$9,087	$10,518
Medium	$5,858	$6,081	$7,153
State	$5,904	$5,869	$6,551

Figure 6: Asian/Pacific Islander Penetration Rates CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	3.20%	2.86%	2.95%
Medium	2.41%	2.42%	2.15%
State	2.25%	2.26%	2.13%

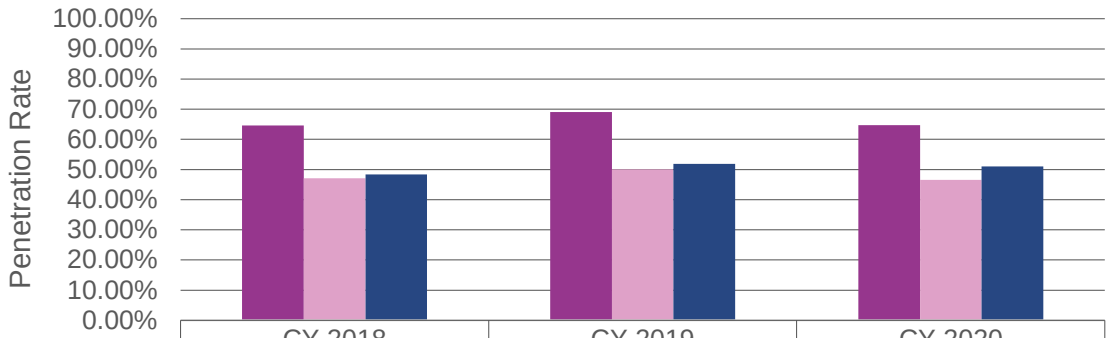
Figure 7: Asian/Pacific Islander ACB CY 2018-20



	CY 2018	CY 2019	CY 2020
MHP	$16,289	$15,724	$15,518
Medium	$6,232	$6,976	$7,214
State	$6,557	$6,325	$7,466

Figure 8: FC Penetration Rates CY 2018-20

Santa Cruz MHP



	CY 2018	CY 2019	CY 2020
MHP	64.61%	69.04%	64.76%
Medium	47.10%	50.12%	46.59%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20

Santa Cruz MHP

	CY 2018	CY 2019	CY 2020
MHP	$14,267	$13,909	$13,525
Medium	$8,276	$8,870	$10,465
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

The disproportionality between percentage of Latino/Hispanic eligibles and percentage of beneficiaries (52.7 percent vs 37.6 percent) may indicate that this population was underserved.

A pattern of higher approved claims dollars per beneficiary, compared to medium county and statewide averages, was noted in all approved claims dollar analyses (overall, Hispanic/Latino, Asian/Pacific Islander, and foster care).

The MHP is actively working to increase access and services for children, but there is not currently sufficient outpatient, CSU or CRU programs or staffing to manage the increasing demand.

TIMELINESS OF CARE

BACKGROUND

The amount of time it takes for beneficiaries to begin treatment services is an important component of engagement, retention, and ability to achieve desired outcomes. Studies have shown that the longer it takes to engage into treatment services, the more likely the delay will result in not following through on keeping 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 the timeliness and a process to review the metrics on a regular basis. Counties then need to make adjustments to their service delivery system in order to ensure that timely standards are being met. CalEQRO uses a number of indicators for tracking and trending timeliness, including the Key Components and Performance Measures addressed below.

TIMELINESS IN SANTA CRUZ COUNTY

The MHP reported timeliness data stratified by age and FC status. Further, timeliness data presented to CalEQRO represented the complete SMHS delivery system for clinical access timeliness and county-operated services only for psychiatric access timeliness.

TIMELINESS KEY COMPONENTS

CalEQRO identifies the following components as necessary elements to monitor the provision of timely services to beneficiaries. The ability to track and trend these metrics helps the MHP identify data collection and reporting processes that require improvement activities to facilitate improved beneficiary outcomes. The evaluation of this methodology is reflected in the Timeliness Key Components ratings, and the performance for each measure is addressed in the Performance Measures 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 4: Key Components – Timeliness

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	Not Met

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

- The MHP has lower readmission rates than the state for both the 7-day and 30-day measures.
- The MHP would benefit from improving the no-show monitors and clinical response protocols and is developing a new non-clinical PIP to address this area.
- The MHP would benefit from developing a process to monitor, track, tend and improve timely services post assessment, and for timely CSU crisis services, especially for youth.

PERFORMANCE MEASURES

Through BHINs 20-012 and 21-023, DHCS set required timeliness metrics to which MHPs must adhere for initial offered appointments for non-urgent SMHS, non-urgent psychiatry, and urgent care. In preparation for the EQR, MHPs complete and submit the Assessment of Timely Access form in which they identify MHP performance across several key timeliness metrics for a specified time period. Additionally, utilizing approved claims data, CalEQRO analyzes MHP performance on psychiatric inpatient readmission and follow up after inpatient discharge.

The following PMs reflect the MHP's performance on these and additional timeliness measures consistent with statewide and national quality standards, including HEDIS measures:

- First Non-Urgent Appointment Offered
- First Non-Urgent Service Rendered
- First Non-Urgent Psychiatry Appointment Offered
- First Non-Urgent Psychiatry Service Rendered

- Urgent Services Offered – Prior Authorization not Required
- Urgent Services Offered – Prior Authorization Required
- No-Shows – Psychiatry
- No-Shows – Clinicians
- Psychiatric Inpatient Hospital 7-Day and 30-Day Readmission Rates
- Post-Psychiatric Inpatient Hospital Discharge 7-Day and 30-Day SMHS Follow-Up Service Rates

MHP-Reported Data

For the FY 2021-22 EQR, the MHP reported its performance for FY 2020-21 as follows:

- Average wait time of 4.9 days from initial service request to first non-urgent appointment offered
- Average wait time of 8.7 days from initial service request to first non-urgent psychiatry appointment offered; the MHP measures this metric from the point of initial beneficiary request.
- Average wait time of 5.1 hours from initial service request to first urgent appointment offered for services that do not require prior authorization.
- The MHP was not able to report the average wait time hours for urgent services that require prior authorization. MHP staff manage data at the program-level using spreadsheets to manage prior-authorized service activity. Prior-authorized services include Adult Residential, Crisis Residential, and Therapeutic Behavioral Services. QI and program management are working on method for capturing and streamlining urgent prior-authorized data by ways of bringing the disparate spreadsheets under one data platform to collectively measure the time from client request to a prior-authorized service. Data in this category is under development with a target date to start meeting with program managers in the fourth quarter of FY 2021-22.
- The timely access to urgent services tracks traditional outpatient services, not CSU urgent requests. There is not an accurate tracking of beneficiaries diverted to hospital emergency rooms.
- In the Table 5 footnote, the MHP indicates low confidence in the no-show data. The MHP is developing a PIP to address no-show data and clinical response.

Table 5: FY 2021-22 MHP Assessment of Timely Access

FY 2021-22 MHP Assessment of Timely Access			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	4.9 Days	10 Business Days*	93%
First Non-Urgent Service Rendered	7.9 Days	10 Business Days**	78%
First Non-Urgent Psychiatry Appointment Offered	8.7 Days	15 Business Days*	85%
First Non-Urgent Psychiatry Service Rendered	12.7 Days	15 Business Days**	62%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	5.1 Hours	48 Hours*	98%
Urgent Services Offered – Prior Authorization Required	n/a ***	96 Hours***	n/a***
Follow-Up Appointments after Psychiatric Hospitalization	6.6 Days	7 Days	57%
No-Show Rate – Psychiatry	5%****	n/a	n/a
No-Show Rate – Clinicians	5%****	n/a	n/a
* DHCS-defined timeliness standards as per BHIN 20-012 ** MHP-defined timeliness standards ***MHP did not report data for this measure ****MHP reports on No Show data but indicated that there is low confidence in this data. The MHP is developing a PIP to address No-Show data and response.			
For the FY 2021-22 EQR, the MHP reported its performance for the following time period: FY 2020-21.			

Medi-Cal Claims Data

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 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 mental health professionals is critically important.

Follow-up post hospital discharge

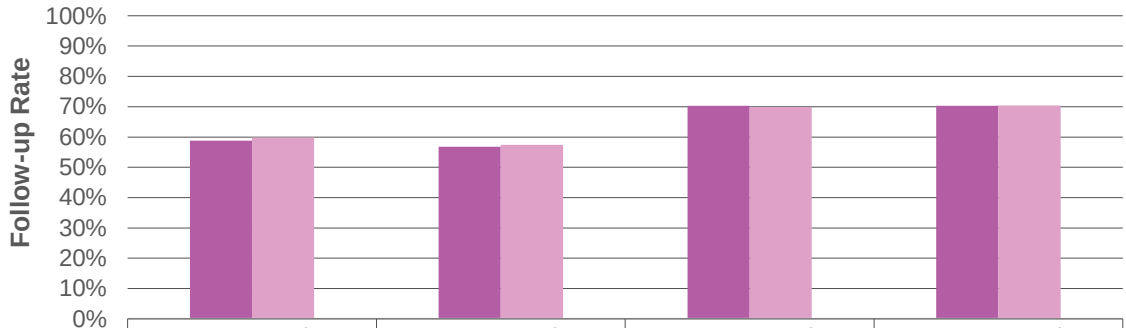
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care.

The 7-day post psychiatric inpatient follow-up rate was comparable from CY 2019 to CY 2020 (59 percent vs. 60 percent) and was slightly above the statewide average in CY 2020 (60 percent vs. 57 percent).

The CY 2020 30-day follow-up rate was unchanged from CY 2019 rate (70 percent) and was equivalent to the statewide average in CY 2020 (70 percent).

Figure 10: 7-Day and 30-Day Post Psychiatric Inpatient Follow-up CY 2019-20

Santa Cruz MHP



	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	59%	57%	70%	70%
CY 2020	60%	57%	70%	70%

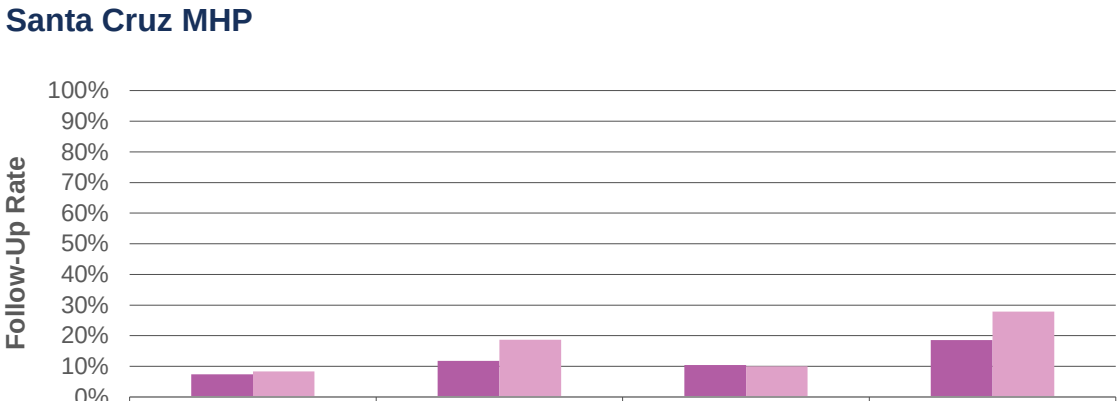
Readmission rates

The 7- and 30-day rehospitalization rates (HEDIS measures) are important proximate indicators of outcomes.

The 7-day psychiatric readmission rate was comparable from CY 2019 to CY 2020 (7 percent vs. eight percent) and was lower than the statewide average in CY 2020 (8 percent vs. 19 percent).

The 30-day psychiatric readmission rate was unchanged from CY 2019 to CY 2020 (10 percent) and was lower the statewide average in CY 2020 (10 percent vs. 28 percent).

Figure 11: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-20



	7-Day Rehospitalization MHP	7-Day Rehospitalization State	30-Day Rehospitalization MHP	30-Day Rehospitalization State
CY 2019	7%	12%	10%	19%
CY 2020	8%	19%	10%	28%

IMPACT OF FINDINGS

The MHP's average psychiatric readmission rates were lower than the corresponding statewide averages for both 7-day (8 percent vs. 19 percent) and 30-day (10 percent vs. 28 percent) inpatient readmissions.

The timeliness for children's services after assessment and CSU urgent service requests that are diverted to hospital emergency rooms are not available for this report. The MHP acknowledged capacity issues for children's services. EQR session discussions, and the MHP's efforts to increase outpatient, CSU and CRU children's services support the MHP's need to improve timely outpatient and crisis services for youth.

QUALITY OF CARE

BACKGROUND

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the beneficiaries through:

- Its structure and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based knowledge.
- Intervention for performance improvement.

In addition, the contract between the MHPs and DHCS requires the MHPs to implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services furnished to beneficiaries. The contract further requires that the MHP's quality program "clearly define the structure of elements, assigns responsibility, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement".

QUALITY IN SANTA CRUZ COUNTY

In the MHP, the responsibility for QI is assigned to the Behavioral Health Program Manager, Quality Improvement. On the BH administration organizational chart, this position is parallel to the Deputy BH Director and reports directly to the BH Director. The QI program consists of 13 Full-Time Equivalent (FTEs) and is responsible for QI and QA.

The MHP identifies the quality plan as a QI, but not a QA or QAPI, plan. The QI plan includes 6 Monitoring Categories (QI) that include 11 goals. Each goal includes up to 6 Value Based Focus Areas (QA) that overly each QI goal. There is also a COVID-19 Impact section. For this review, the MHP provided the FY 2021-22 QI Workplan; FY 2020-21 QI Plan Evaluation; FY 2021-22 Culturally and Linguistically Appropriate Services plan update; quarterly QIC minutes; and various tracking and monitoring tools and reports.

The MHP monitors its quality processes through the QIC, the QI workplan, and the annual evaluation of the QI workplan. The QIC is comprised of MHP, DMC-ODS, CBOs NAMI, as well as various levels of staff across the MHP, including the BH Director. The QIC meets quarterly and met all 4 quarters of this review period. Of the 11 identified FY 2020-21 QI workplan goals, the MHP identified the percentage of goals met; a summary of findings; an analysis of obstacles related to their plan; and if the goal will carryover to the next FY QI plan.

The MHP screens 100 percent for Level of Care (LOC) recommendations, referrals, and admissions. The MHP tracks reasons for referral and if the beneficiary was admitted to a program.

The MHP utilizes the following outcomes tools: Adult Needs and Strengths Assessment (ANSA), General Anxiety Disorder-7 (GAD-7) and Patient Health Questionaire-9 (PHQ-9) for adults and the Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist-35 (PSC-35) for youth. Information is reviewed at the client-provider level as well as supervisor level for case consultation and treatment plan monitoring, for ANSA and GAD-7 for adults, and the CANS, PHQ-9 and PSC-35 for children. Data also provided to program managers, senior leadership, and QI Steering Committee members. There is an ongoing committee working with the vendor Community Data Round Table for building outcomes reporting.

QUALITY KEY COMPONENTS

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

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

Table 6: Key Components – Quality

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

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

- The MHP is incorporating surveys to reach and include staff and beneficiary input.
- The QI performance of service gap analysis and the application of a grant evaluation tool has assisted the MHP to decisively seek and obtain grants to address areas of need.
- The adult system of care coordination of service transitions between the MHP and MCP would benefit from improved processes. Note, this area is not solely in the control of the MHP.
- The MHP medication review process does not actively provide reports to the prescriber of their reviewed cases.
- Due to the EHR/Avatar limitations, the MHP struggles to track and trend the following HEDIS measures as required by SB 1291
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD)

- The use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC)
- Metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)
- The use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)

PERFORMANCE MEASURES

In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP:

- Beneficiaries Served by Diagnostic Category
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay (LOS)
- Retention Rates
- High-Cost Beneficiaries (HCB)

Diagnosis Data

Figures 12 and 13 compare the percentage of beneficiaries served and the total approved claims by major diagnostic categories, as seen at the MHP and statewide for CY 2020.

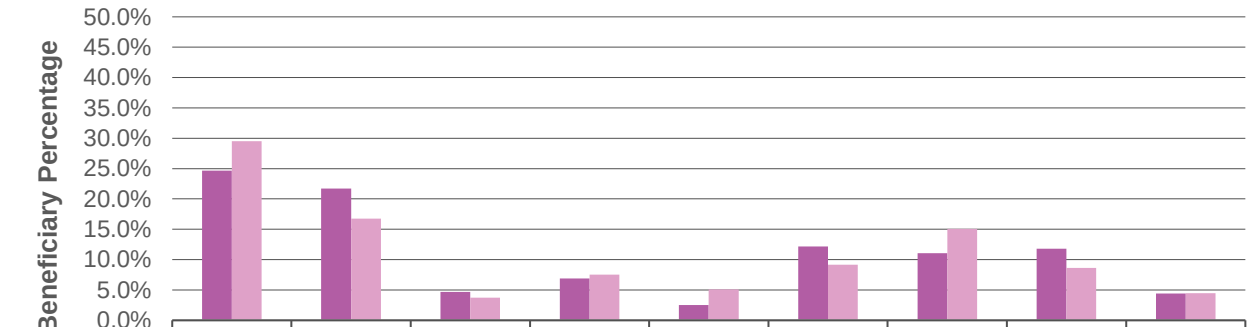
Over 45 percent of beneficiaries had one of two diagnoses: depression (24.7 percent) and psychosis (21.7 percent). Diagnoses patterns displayed no significant variations from comparable statewide averages.

Over 55 percent of claims had one of the same two diagnoses: depression (17.6 percent) and psychosis (37.4 percent claims). Except for the diagnoses of depression and psychosis, approved claims dollars were reasonably aligned with the distribution of services by diagnosis.

Claims for the diagnosis of depression were 28.7 percent below the diagnosis of depression (24.7 percent vs. 17.6 percent) and 33 percent below the state claims for depression (17.6 percent vs. 26.3 percent). Claims for the diagnosis of psychosis were 72.3 percent higher than the diagnosis of psychosis (37.4 percent vs. 21.7 percent) and 63.3 percent above the state claims for psychosis (37.4 percent vs. 22.9 percent).

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020

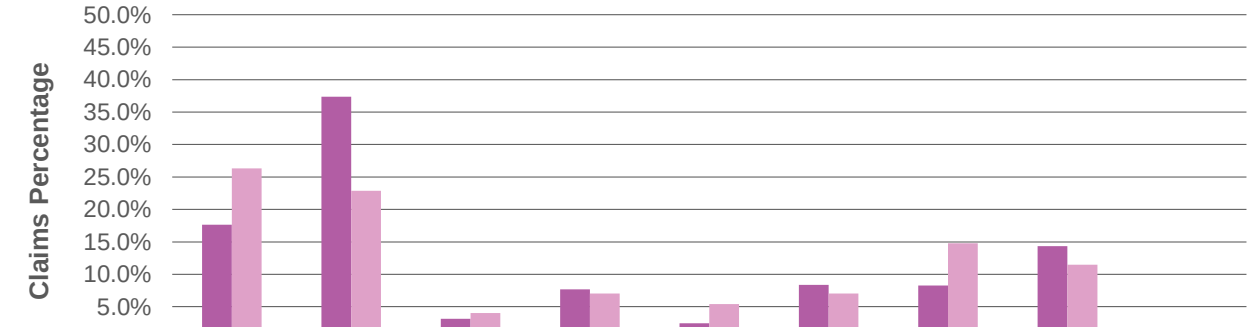
Santa Cruz MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-develop-ment Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	24.7%	21.7%	4.7%	6.9%	2.5%	12.2%	11.1%	11.8%	4.4%
State CY 2020	29.5%	16.7%	3.7%	7.5%	5.1%	9.2%	15.1%	8.6%	4.5%

Figure 13: Diagnostic Categories by Percentage of Approved Claims CY 2020

Santa Cruz MHP



	Depression	Psychosis	Disruptive	Bipolar	Neuro-develop-ment Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	17.6%	37.4%	3.2%	7.7%	2.4%	8.4%	8.3%	14.3%	0.8%
State CY 2020	26.3%	22.9%	4.0%	7.1%	5.4%	7.0%	14.8%	11.5%	1.1%

Psychiatric Inpatient Services

Table 7 provides a three-year summary (CY 2018-20) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

From CY 2019 to CY 2020, both the number of unique beneficiaries hospitalized (386 vs.293) and the total inpatient admissions (675 vs.503) declined. The CY 2020 average length of stay was 1.7 days longer than the statewide average (10.38 days vs. 8.68 days).

Table 7: Psychiatric Inpatient Utilization CY 2018-20

Santa Cruz MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2020	293	503	10.38	8.68	$18,448	$11,814	$5,405,144
CY 2019	386	675	9.21	7.80	$16,438	$10,535	$6,344,970
CY 2018	434	769	9.37	7.63	$15,468	$9,772	$6,713,009

High-Cost Beneficiaries

Table 8 provides a three-year summary (CY 2018-20) of HCB trends for the MHP and compares the MHP's CY 2020 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Tracking the HCBs provides another indicator of quality of care. High cost of care typically occurs when a beneficiary continues to require more intensive care at a greater frequency than the rest of the beneficiaries receiving SMHS. This often indicates system or treatment failures to provide the most appropriate care in a timely manner. Further, HCBs may disproportionately occupy treatment slots that may cause cascading effect of other beneficiaries not receiving the most appropriate care in a timely manner, thus being put at risk of becoming higher utilizers of services themselves. HCB percentage of total claims, when compared with the HCB count percentage, provides a proxy measure for the disproportionate utilization of intensive services by the HCB beneficiaries.

The percent of high-cost beneficiaries increased each year from CY 2018 to CY 2020 (8.96 percent vs. 9.98 percent vs. 12.58 percent) and was three times greater than statewide average in CY 2020 (12.58 percent vs. 4.07 percent).

The CY 2020 average approved claim per HCB exceeded the statewide average ($56,451 vs. $53,969) and the percentage of total claims for high-cost beneficiaries was greater than the statewide average (51.52 percent vs. 30.70 percent).

Table 8: HCB CY 2018-20

Santa Cruz MHP							
	Year	HCB Count	Total Beneficiary County	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
MHP	CY 2020	365	2,901	12.58%	$56,451	$20,604,558	51.52%
	CY 2019	336	3,368	9.98%	$51,893	$17,436,155	46.01%
	CY 2018	299	3,337	8.96%	$52,357	$15,654,882	45.54%

See Attachment D, Table D2 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Retention Data

Santa Cruz had a significantly higher percentage of beneficiaries receiving a single service when compared to the statewide average (16.24 percent vs. 9.76 percent).

The percentage of beneficiaries receiving five to 15 services is notably lower than the statewide average (19.96 percent vs. 29.47 percent) while beneficiaries who received more than 15 services exceeded the statewide average (50.12 percent vs. 45.33 percent).

Table 9: Retention of Medi-Cal Beneficiaries CY 2020

	Santa Cruz			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 Service	471	16.24	16.24	9.76	9.76	5.69	21.86
2 Services	183	6.31	22.54	6.16	15.91	4.39	17.07
3 Services	120	4.14	26.68	4.78	20.69	2.44	9.17
4 Services	94	3.24	29.92	4.50	25.19	2.44	7.78
5-15 Services	579	19.96	49.88	29.47	54.67	19.96	42.46
>15 Services	1,454	50.12	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

The percent of high-cost beneficiaries increased each year from CY 2018 to CY 2020 (8.96 percent vs. 9.98 percent vs. 12.58 percent) and was three times greater than statewide average in CY 2020 (12.58 percent vs. 4.07 percent). The MHP also

averaged significantly more claims for psychosis than the state (37.4 percent to 22.9 percent).

Over 45 percent of beneficiaries had one of two diagnoses: depression (24.7 percent) and psychosis (21.7 percent). These same two diagnosis accounted for 55 percent of claims: depression (17.6 percent) and psychosis (37.4 percent).

The MHP may benefit from further analysis of the correlations between diagnosis; claims by diagnosis; HCB; psychiatric inpatient stays; and rehospitalizations.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

All MHPs are required to have two active and ongoing PIPs, one clinical and one non-clinical, as a part of the plan's quality assessment and performance improvement program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. They should have a direct beneficiary impact and may be designed to create change at a member, provider, and/or MHP system level.

CalEQRO evaluates each submitted PIP and provides TA throughout the year as requested by individual MHPs, hosts quarterly webinars, and maintains a PIP library at www.calegro.com.

Validation tools for each PIP are located in Attachment C of this report. Validation rating refers to the EQRO's overall confidence that the MHP (1) adhered to acceptable methodology for all phases of design and data collection, (2) conducted accurate data analysis and interpretation of PIP results, and (3) produced significant evidence of improvement.

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Increase of Outpatient Mental Health Therapeutic Engagement through Face-to-Face (in-person and telehealth) Services for SMHS clients enrolled in FQ Therapy Services.

Date Started: 03/2021

Aim Statement: First year Aim Statement: Will providing clinician training on conducting engaging telehealth services inclusive of session role play, clinical outreach to beneficiaries, clinical interventions to address anxiety and other emotional barriers, and experiential practicing of video telehealth sessions increase beneficiary face-to-face therapy services to at least 60 percent of the total encounters and improve beneficiary ANSA average impact score by 25 percent.

[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

The new Revision for the second year: by December 31, 2022, will client clinical therapeutic engagement improve in outpatient Adult Mental Health (AMH) therapy services, as evident by an increase of at least 60 percent of face-to-face (in-person and telehealth) services of the total encounters from July-December 2020 baseline of 20 percent; as well as an increase of 25 percent of March 2020- February 2021 ANSA Average Impact baseline of 1.29 points?

Target Population: PIP population focuses on adults (age 18+) who meet SMHS criteria and who are receiving Adult MH therapy services. Individuals will be Santa Cruz County Medi-Cal beneficiaries living within the North to South regions and of all gender identifications and across all cultural and linguistic demographics.

Validation Information: The MHP's clinical PIP is in the first remeasurement phase and considered active and ongoing.

Summary

The MHP aim of this clinical PIP is to improve engagement and outcomes for adult individuals enrolled in Adult Mental Health therapy services. Identified outcome data previously described reflects a decrease in enrollment and worsening of symptoms and functioning for adult clients enrolled in mental health therapy since shifted to primarily telephonic services with the onset of COVID pandemic.

These improvement strategies are to increase the number of clients participating in face-to-face sessions by transitioning services from phone (non-video) to telehealth (video) and/or in-person services to improve overall outcomes as measured by ANSA scores and client satisfaction.

By the end of Q4 CY 2021, which is a quarter with often has a drop in services due to the holidays, the face-to-face (in-person and telehealth) rate increased to a 73 percent of total encounters, which surpasses the goal of at least 60 percent improvement. The PIP's interventions for increased face-to-face services were initiated in July 2021, therefore the ANSA Avg Impact Change data will be collected in October 2022 so that the same data markers (3/15-9/15) are repeated for the period post active PIP intervention. The results of the PIP's January 2022 survey for adult individuals receiving therapy services indicate that the PIP goal of 80 percent satisfaction and engagement rate of AMH therapy services was successfully met, as evident by a 97 percent rate of individuals feeling that they are listened to by their treating provider and 86 percent report that the services performed by their provider is helping them.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because: this PIP followed the PIP guide and utilized sound project management, including input from staff and beneficiaries. However, the PIP did not utilize the most current PIP version, needs to complete Tables 5.1, 7.1 and 8.1, as well as complete sections 8 and 9.

The TA provided to the MHP by CalEQRO consisted of:

- There was no TA session by this reviewer prior to the review.

CalEQRO recommendations for improvement of this clinical PIP include:

- Utilize the most current PIP development tool.
- Complete development tool tables 5.1, 7.1 and 8.1.
- Complete development tool sections 8 and 9 for the first year.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Improve service provider response practices when consumers cancel or miss SMHS appointments.

Date Started: In development

Aim Statement: Will establishing universal MHP administrative and clinical practices regarding consumer no-show and cancellation activity during FY 2022-2023 improve the accuracy of “no-show and cancellation” documentation, lead to consistent clinical care post no-show/cancellation activity and increase accurate tracking, monitoring and client engagement interventions strategies? A secondary gain is to establish a reliable benchmark baseline for the MHP No-Show performance measure due to the universal policies and procedures.

Target Population: Provisional goal: Enrolled MHP consumers of all demographics and language who are active in SMHS within the MHP Network.

Validation Information: The MHP’s non-clinical PIP is in the PIP planning phase and considered concept only and not an active PIP.

Summary

The current non-clinical PIP development has not progressed past worksheet 3. The AIM statement and Target population documented in this overview are the extent of the PIP development. The previous non-clinical PIP, Improving Client Engagement in Psychiatric Medication Services, was completed June 30, 2021.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because: it is not fully developed.

The TA provided to the MHP by CalEQRO consisted of:

- There was no TA session by this reviewer prior to the review.

CalEQRO recommendations for improvement of this non-clinical PIP include:

The PIP is attempting to address the lack of documentation and clinical practice standards for outpatient no shows and cancellations. The PIP identifies reaching universal implementation of documentation and clinical practice standards for outpatient no shows and cancellations as the primary goals.

- Recommend streamlining/consolidating the logistical interventions of developing documentation and clinical practices.
- Recommend utilizing California Behavioral Health Director's Association (CBHDA) county-to-county to obtain other counties policies and procedures, especially if they utilize the same EHR.
- Recommend utilizing researched no-show impacts and/or conducting a sample of active cases of cases with no-shows to determine the impact to clients and client outcome goals.
- Directly set measurable goals related to no-shows improved documentation, tracking and clinical follow-up.

INFORMATION SYSTEMS (IS)

BACKGROUND

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

INFORMATION SYSTEMS IN SANTA CRUZ COUNTY

California MHP EHRs fall into two main categories – those that are managed by county or MHP IT and those being 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 (Avatar), which has been in use for six years. Currently, the MHP has no plans to replace the Avatar system.

Approximately 1.2 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The 1.2 percent budget declined minimally from 1.3 percent reported in the prior year and is less than half the FY 2020-2021 medium county average (1.20 percent vs. 2.96 percent). The budget determination process for IS operations is allocated to the MHP but managed by the HSA.

The MHP has 550 named users with logon authority to the EHR, including approximately 206 county-operated staff and 344 contractor-operated staff. Support for the users is provided by 1.25 FTE IS technology positions. This is significantly less than the medium county IT staffing average of 7.1 FTEs in FY 2020-21. The 1.25 FTEs include portions of two IT Support Analyst positions and two IT Application Development positions. Currently, all IT FTEs allocated to behavioral health are filled.

As of the FY 2021-22 EQR, some but not all contract providers have access to directly enter clinical data into the MHP's EHR. Line staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

Table 10: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Submittal Method		Frequency	Submittal Method Percentage
☐	HIE between MHP IS	☐ Real Time ☐ Batch	0%
☐	Electronic Data Interchange (EDI) 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	80%
☒	Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	5%
☒	Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	15%
			100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP has a PHR and reports 489 beneficiaries have accessed their PHR in the past year.

Interoperability Support

The MHP is a member or participant in the Santa Cruz Health Information Exchange (SCHIE). The MHP can obtain information from SCHIE uploaded by other providers but currently does not provide beneficiary service information to the HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email and electronic consult. The MHP engages in electronic exchange of information with contract providers.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following key components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in

extracting and utilizing data for analysis must be present to demonstrate that analytic findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

Table 11: Key Components – IS Infrastructure

KC #	Key Components – IS Infrastructure	Rating
4A	Investment in IT Infrastructure and Resources is a Priority	Met
4B	Integrity of Data Collection and Processing	Met
4C	Integrity of Medi-Cal Claims Process	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 MHP continues to utilize the Avatar system in an Application Service Provider (ASP) model with Netsmart Technologies as their provider. The MHP engages in biweekly meetings with Netsmart to ensure communication regarding upcoming system changes as well as to monitor the status of requested system changes.
- The IT budget was reported to be 1.2 percent, a minimal decrease from 1.3 percent in FY 2020-21, but less than half of the FY 2020-21 medium county average of 2.96 percent.
- IT support is provided by 1.25 FTE technology positions. While this is significantly less than the medium county IT staffing average of 7.1 FTEs in FY 2020-21, additional Avatar specific support is received from their ASP, Netsmart Technologies.
- Due to the COVID-19 pandemic and the support of remote staff as well as increasing data/reporting needs, there have been sustained demands on IT resources that continued to exceed pre-pandemic levels.
- The MHP maintains a Structured Query Language (SQL) data warehouse that replicates the Avatar system to support data analytics.
- Fiscal analytic capacity is sufficient.

- Approximately 80 percent of contract provider services are entered directly into Avatar.
- The CY 2020 claim denial rate of 1.79 percent is less than the statewide average of 3.19 percent.
- There have been no EHR functionality upgrades in the past year. The project to link the Avatar Order Connect eLab module to the County's Orchard Harvest eLab software is anticipated to be completed by August 1, 2022.
- The CANS, PSC-35, and ANSA are available electronically.
- The MHP has a personal health record and reports 489 beneficiaries have accessed their PHR in the past year.
- The County Information Services Department Manager is the designated System Security Officer.
- County IT offers cyber security training. Email security tips are utilized to maintain and enhance staff security knowledge.
- While the MHP has not yet developed an Operations Continuity Plan to maintain critical business functions in the event of a cyber-attack, natural disaster, or other emergency, their ASP, Netsmart Technologies, providesback-up, support and maintenance for the Avatar system.
- The MHP is a member of the Santa Cruz HIE. The MHP can access information from the HIE but currently uploads only limited beneficiary demographic information to the HIE. Staff have the capability to use secure email to electronically exchange information with other service providers.

IMPACT OF FINDINGS

The IT budget was reported to be 1.2 percent, less than half the FY 2020-21 medium county average of 2.96 percent. IT support is provided by 1.25 FTE technology positions. While this is significantly less than the medium county IT staffing average of 7.1 FTEs in FY 2020-21, additional Avatar specific support is received from their ASP, Netsmart Technologies. The combination of a lower budget and lower staffing levels, compared to medium county averages, may contribute to the MHP finding it challenging to meet ongoing project deadlines in a timely manner.

The MHP maintains a SQL data warehouse that replicates the Avatar system to support data analytics.

The MHP has a personal health record and reports 489 beneficiaries have accessed their PHR in the past year.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

BACKGROUND

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CONSUMER PERCEPTION SURVEYS

The Consumer Perception Survey (CPS) consists of four different surveys that are used statewide for collecting beneficiaries' perceptions of care quality and outcomes. The four surveys, required by DHCS and administered by the MHPs, are tailored for the following categories of beneficiaries: adult, older adult, youth, and family members. MHPs administer these surveys to beneficiaries receiving outpatient services during two prespecified one-week periods. CalEQRO receives CPS data from DHCS and provides a comprehensive analysis in the annual statewide aggregate report.

The MHP oversees the CPS through the QI team. The most recent report was received from the University of California, Los Angeles a year after the survey was conducted. The rapid changes in the system of care due to COVID-19, QI improvement efforts and CalAIM, significantly reduce the value of the report. The MHP shares the report through the QIC and, appreciating the value of the survey, is developing more rapid internal surveys.

CONSUMER FAMILY MEMBER FOCUS GROUP

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

As part of the pre-review planning process, CalEQRO requested two 60-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held via Zoom and included eight participants; No language interpreters were used for this focus group. All consumers participating receive clinical services from the MHP.

Of the eight consumers in the focus group, three initiated services in the last years, two within the last four years and three had been receiving services approximately 10 years or longer. Overall, all participants were positive about their service experiences. Initial access was through walk-in clinics, transitions after crisis services at the MHP CSU or IP/PHF providers, or as a transition out of homelessness or jail. All reported receiving a variety of timely services and that the MHP/CBOs follow-up on no-shows or if there is a crisis need. COVID-19 increased telehealth and impacted groups and continuity of sessions. At this time, most services can be provided face-to-face. Consumers reported having choice of telehealth or face-to-face for many services, except psychiatry when the doctor is available only through telehealth. Transportation is available. Peer support wellness centers are active.

Recommendations from focus group participants included:

- Increase housing and housing options.
- Increase staffing at all levels but especially psychiatry face-to-face.
- Increase/intensify aftercare from crisis services.

Consumer Family Member Focus Group Two

CalEQRO conducted one 60-minute focus group with family members of youth consumers during the review of the MHP. CalEQRO requested a diverse group of family members of youth consumers who initiated services in the preceding 12 months. The focus group was held via Zoom and included five participants; a Spanish language interpreter was used for this focus group as Spanish was the preferred language of three of the five participants. All family members participating have a family member who receives clinical services from the MHP. Only two of the participants had youth who initiated services in the past 12 months.

The overall demeanor of the group was positive about the MHP and the services their family receives. Access had only two respondents but there was concern raised about a waiting of several weeks to access services. Services for ongoing care was reported as primarily weekly and timely. Text and call appointment reminders are appreciated, and many youths receive services directly in their home and school environments. Telehealth is now a choice option except for psychiatry. Several caregivers indicated that telehealth is difficult for youth due to ADHD, the compounded time of school Zoom, and family barriers to conducted services from their home. Caregivers report they feel informed and involved in the care delivery. Crisis options exist but can be difficult to attain if an inpatient stay is warranted.

Concerns were raised that the MHP may be transitioning youth to primary care based if the youth has been receiving services over 2.5 years due to the level of youth service needs exceeding capacity.

Recommendations from focus group participants included:

- Increase youth staffing and available services
- Maintain face-to-face services choice as well as telehealth options

IMPACT OF FINDINGS

Through the COVID-19 emergency, the MHP has implemented telehealth; trained staff; re-introduced face-to-face options when clinically appropriate; and offered choice. The efforts of the MHP were evident both by adult consumers and the caregivers for youth. All participants recognized the extraordinary impact of COVID-19 and voiced appreciation for the MHP/CBOs provider system. The impact of the increased youth service needs, also cited by the MHP, appears to be creating access, treatment, and transition barriers across routine, urgent, and emergent youth service needs.

CONCLUSIONS

During the FY 2021-22 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP is actively working to enhance outreach, routine, urgent, and emergent access services across adult and children's systems of care through grants, existing funds and CalAIM. (Access)
2. Unlike the state average 7-day and 30-day psychiatric readmission rates that increased under COVID-19 from CY 2019 to CY 2020, the MHP readmission rates did not evidence any significant increase. Furthermore, the MHP's average psychiatric readmission rates were significantly lower than the corresponding statewide averages for both 7-day (8 percent vs. 19 percent) and 30-day (10 percent vs. 28 percent) inpatient readmissions. (Timeliness)
3. The analysis evident in the QI Plan, QI Plan Annual Evaluation and Quarterly QIC actively and positively impacts management decisions to address service gaps across the continuum of care strategically utilizing available funding sources, including several new grants. (Quality)
4. The MHP is developing and implementing surveys to reach staff and beneficiaries that otherwise would not be able to be included in QI processes. (Quality)
5. The MHP is a member of the Santa Cruz HIE. The MHP can access information from the HIE but currently uploads only limited beneficiary demographic information to the HIE. Staff have the capability to use secure email to electronically exchange information with other service providers. (IS)

OPPORTUNITIES FOR IMPROVEMENT

1. The MHP leadership and the EQR sessions identified system overwhelming demand for children's routine, urgent and emergent services that has strained and overloaded system capacity. (Access)
2. The MHP's CSU implements a diversion protocol on a near daily basis that diverts adults and children with urgent needs to area hospital emergency rooms. (Timeliness)

3. The MHP has identified a lack of confidence in their reported no-show data as well as a lack of a no-show clinical response protocol that is able to be implemented with fidelity allowing QI tracking, trending, analysis, and implantation of improvement strategies. The MHP is developing a non-clinical PIP to address the no-show areas of need (Quality).
4. Due to the EHR/Avatar limitations, the MHP struggles to track and trend the following HEDIS measures as required by SB 1291: follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD; the use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC); metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM); and the use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP). (Quality)
5. IT support is provided by 1.25 FTE technology positions augmented by Avatar external vendor support. Increased grant monitoring, HEDIS measures, and CalAIM create a need for additional IT analytics and data development support for QI functions. (IS)

RECOMMENDATIONS

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

1. Investigate reasons and develop and implement strategies, to improve the MHP's response to the increased demand for children's routine, urgent and emergent services. (Access)
2. Investigate reasons and develop and implement strategies, to reduce the MHP's frequency of adult and children near daily CSU diversion to area hospital emergency rooms. (Timeliness)
3. Investigate reasons and develop and implement strategies, to improve the MHP's response to no-show data tracking and no-show clinical response in part utilizing the proposed non-clinical PIP currently under development. (Quality).
4. Investigate reasons and develop and implement strategies, to improve the MHP's response to tracking and trending the following HEDIS measures as required by SB 1291: follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD; the use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC); metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM); and the use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP). (Quality)
5. Investigate reasons and develop and implement strategies, to improve the MHP's IT analytics and data development support for QI functions. (IS)

REVIEW BARRIERS

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: REVIEW AGENDA

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

Santa Cruz EQRO Review Sessions
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Community-Based Services Agencies Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Electronic Health Record Deployment
Electronic Health Record Hands-On Observation

Santa Cruz EQRO Review Sessions
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Bill Walker, Quality Reviewer
Lisa Farrell, Information System Reviewer
Gloria Martin, Consumer Family Member

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

MHP Sites

Santa Cruz
All sessions were held via video conference

Contract Provider Site

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Lolley	Cybele	QI Director	Santa Cruz County HSA
Riera	Erik	Director of Behavioral Health	Santa Cruz County HSA
Bare	Adriana	Senior Health Services Manager	Santa Cruz County HSA
Eslami	Cassandra	Director of Community Engagement	Santa Cruz County HSA
Kern	Karen	Senior Behavioral Health Manager	Santa Cruz County HSA
Gutierrez-Wang	Lisa	Senior Behavioral Health Manager	Santa Cruz County HSA
Nair	Latha	Psychiatrist	Santa Cruz County HSA
Threlfall	Alexander	Chief of Psychiatry	Santa Cruz County HSA
Soria	Elizabeth	Administrative services manager	Santa Cruz County HSA
Fernandez	Jorge	IT manager III	Santa Cruz County HSA
Wong	Gian	IT App Dev/Sup Analyst lll	Santa Cruz County HSA
Turnbull	Andrea	Behavioral Health Program Manager	Santa Cruz County HSA
Russell	James	Program manager for adult forensic services	Santa Cruz County HSA
Barker	Shelly	Health Services Manager	Santa Cruz County HSA
Yarnell	Meg	Health Services Manager	Santa Cruz County HSA
Einhorn	Stan	Mental Health program manager	Santa Cruz County HSA
Fein	Lauren	Program Manager	Santa Cruz County HSA
Robertson	Sube	Quality improvement manager	Santa Cruz County HSA
Chicoine	David	Utilization review specialist	Santa Cruz County HSA
Flagg-Wilson	Leah	Utilization review specialist	Santa Cruz County HSA

Last Name	First Name	Position	Agency
Mast	Nancy	Utilization review specialist	Santa Cruz County HSA
DeGodoy	Claudette	Utilization review specialist	Santa Cruz County HSA
Nollenberger	Cynthia	Senior mental health client specialist	Santa Cruz County HSA
Annon	Robert	Mental Health Supervising Client Specialist	Santa Cruz County HSA
Aguilar	Ileana	QI Program Coordinator	Santa Cruz County HSA
Warnke	Maria Eugenia	IT Business system analyst	Santa Cruz County HSA
Oritz	Erica	ASO II	Santa Cruz County HSA
Cisneros	Kevin	Mental Health Client Specialist	Santa Cruz County HSA
Whiteside	Brian	Psychiatric Mental Health Nurse Practitioner	Santa Cruz County HSA
Brown	Robert	Psychiatrist	Santa Cruz County HSA
Majan	Amy	Medical Assistant	Santa Cruz County HSA
Valencia	Reina	Mental Health Client Specialist	Santa Cruz County HSA
Bolton	Beloved	Utilization Review Specialist	Santa Cruz County HSA
Borbely	Christina	Senior Staff Development Trainer	Santa Cruz County HSA
Suski	Ellen	Utilization Review Specialist	Santa Cruz County HSA
Campbell	David	Program manager el dorado	Encompass
Alves	Linda		Encompass
Russell	Lisa	Chief Officer	Encompass
Steigner	Lindsay	Youth and family manager	Encompass
Grijalva	Karen	Program manager casa pacific	encompass
Alves	Linda	Director of compliance in QI	Encompass

Last Name	First Name	Position	Agency
Bernard	Adrian	Manager of second story program	Encompass
Polansky	Davina	Executive Director	Haven of Hope
Otlin	Stacey	Clinical Director	Haven of Hope
Hansen	Kristine		PVPSA
Padilla Chavez	Erica	CEO PVPSA	PVPSA
Fisher	Hannah	Therapist	PVPSA
Wolff	Laura	Regional director of operations	Telecare corp
Mackinnon	Phoenix		
Rainforest	Jezzana		
Iriberri	Wendy		
Dreyer	Karl		
Eaton	Joseph		
Mackinnon	Susan		
Bouyer	Maria		

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	Clinical PIP Submitted for Validation: Increase of Outpatient Mental Health Therapeutic Engagement through Face-to-Face (in-person and telehealth) Services for SMHS clients enrolled in FQ Therapy Services.
General PIP Information	
MHP/DMC-ODS Name: Santa Cruz Behavioral Health	
PIP Title: Increase of Outpatient Mental Health Therapeutic Engagement through Face-to-Face (in-person and telehealth) Services for SMHS clients enrolled in FQ Therapy Services	
PIP Aim Statement: First year Aim Statement: Will providing clinician training on conducting engaging telehealth services inclusive of session role play, clinical outreach to beneficiaries, clinical interventions to address anxiety and other emotional barriers, and experiential practicing of video telehealth sessions increase beneficiary face-to-face therapy services to at least 60 percent of the total encounters and improve beneficiary ANSA average impact score by 25 percent. New Revision fir the second year: By December 31, 2022, will client clinical therapeutic engagement improve in outpatient AMH therapy services, as evident by an increase of at least 60 percent of face-to-face (in-person and telehealth) services of the total encounters from July-Dec 2020 baseline of 20 percent; as well as an increase of 25 percent of Mar 2020- Feb 2021 ANSA Avg. Impact baseline of 1.29 points?	

General PIP Information
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): PIP population focuses on adults (age 18+) who meet SMHS criteria and who are receiving Adult MH therapy services. We are in the process of obtaining additional demographic information. Individuals will be Santa Cruz County Medi-Cal beneficiaries living within the North to South regions and of all gender identifications and across all cultural and linguistic demographics.
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) Telehealth suites in clinics for beneficiaries who lack technology; clinical outreach to clients not participating in face-to -face and offering education on the benefits of face-to-face services
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Clinically focused modeling and experiential practicing of video-therapy/telehealth method to increasing comfort/understanding of service.
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) Ensuring staff have technology and training for telehealth services; assuring there is appropriate safe space for face-to-face services

Performance measures (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 Completed by MHP			☐ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ 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 part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: 1. Use the most current PIP development tool 2. Complete table 5.1, 7.1 and 8.1. in the most current tool 3. Complete sections 8 and 9 for the first year.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☐ →Moderate confidence ☒ →Low confidence ☐ →No confidence	This PIP is in the development stage and not fully developed.
General PIP Information	
MHP/DMC-ODS Name: Santa Cruz Behavioral Health	
PIP Title: Improve service provider response practices when consumers cancel or miss SMHS appointments.	

General PIP Information
PIP Aim Statement: Will establishing universal MHP administrative and clinical practices regarding consumer no-show and cancellation activity during FY 2022-2023 improve the accuracy of "no-show and cancellation" documentation, lead to consistent clinical care post no-show/cancellation activity and increase accurate tracking, monitoring, and client engagement interventions strategies? A secondary gain is to establish a reliable benchmark baseline for the MHP No-Show performance measure due to the universal policies and procedures.
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☐ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Enrolled MHP consumers of all demographics and language who are active in SMHS within the MHP Network. Further data analysis is needed of our EHR Avatar M400 Service Code associated demographics, specifically ethnicity and language and foster care to determine if there is a higher vulnerability/risk population for the PIP's primary initial focus.
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) Pending from the MHP
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Pending from the MHP
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) Pending from the MHP

Performance measures (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
Pending from the MHP			☐ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
			☐ 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 part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.)

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☒ Planning phase ☐ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: The PIP is attempting to address the lack of documentation and clinical practice standards for OP no shows and cancellations. The PIP identifies reaching universal implementation of documentation and clinical practice standards for OP no shows and cancellations as the primary goals. 1. Recommend streamlining/consolidating the logistical interventions of developing documentation and clinical practices. 2. Recommend utilizing CBHDA county-to-county to obtain other counties policies and procedures, especially if they utilize the same EHR. 3. Recommend utilizing researched no-show impacts and/or conducting a sample of active cases of cases with no-shows to determine the impact to clients and client outcome goals. 4. Directly set measurable goals related to no-shows improved documentation, tracking and clinical follow-up. That is, 5. Consider the miracle question: if you woke up tomorrow and a miracle occurred and Santa Cruz had perfect no-show capture, documentation, tracking and systematic no-show clinical response…. What would be different? How would you know?

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

Table D1: CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Santa Cruz MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,835,638	155,154	4.05%	$934,903,862	$6,026
Medium	533,873	19,077	3.57%	$143,009,074	$7,496
MHP	23,630	624	2.64%	$6,200,436	$9,937

Table D2: CY 2020 Distribution of Medi-Cal Beneficiaries by ACB Range

Santa Cruz MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
<$20K	2,292	79.01%	92.22%	$13,432,213	$5,860	$4,399	33.59%	56.70%
$20K-$30K	244	8.41%	3.71%	$5,955,658	$24,408	$24,274	14.89%	12.59%
>$30K	365	12.58%	4.07%	$20,604,558	$56,451	$53,969	51.52%	30.70%

Table D3: Summary of CY 2020 Short-Doyle/Medi-Cal Claims

Santa Cruz							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**107,210**	**$39,203,473**	**1,740**	**$702,649**	**1.79%**	**$38,500,824**	**$35,184,450**
JAN20	9,954	$3,726,746	64	$32,053	0.86%	$3,694,693	$3,068,115
FEB20	9,970	$3,698,443	97	$33,738	0.91%	$3,664,705	$3,008,222
MAR20	11,033	$3,505,069	216	$78,431	2.24%	$3,426,638	$2,813,110
APR20	10,026	$3,192,221	177	$51,942	1.63%	$3,140,279	$2,639,427
MAY20	8,662	$2,854,174	129	$35,892	1.26%	$2,818,282	$2,489,654
JUN20	8,597	$2,909,314	146	$46,181	1.59%	$2,863,133	$2,769,189
JUL20	8,794	$3,523,004	155	$59,114	1.68%	$3,463,890	$3,390,329
AUG20	8,251	$3,145,862	179	$68,645	2.18%	$3,077,217	$3,001,553
SEP20	8,492	$3,351,646	165	$71,082	2.12%	$3,280,564	$3,204,449
OCT20	8,887	$3,497,158	146	$66,675	1.91%	$3,430,483	$3,359,503
NOV20	7,522	$2,916,947	149	$73,287	2.51%	$2,843,660	$2,767,056
DEC20	7,022	$2,882,892	117	$85,610	2.97%	$2,797,282	$2,673,844

Includes services provided during CY 2020 with the most recent DHCS claim processing date of July 30, 2021. Only reports Short-Doyle Medi-Cal claim transactions and does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2020 was 3.19 percent.

Table D4: Summary of CY 2020 Top Five Reasons for Medi-Cal Claim Denial

Santa Cruz MHP			
Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible or non-covered charges	559	$201,160	29%
Medicare Part B or Other Health Coverage must be billed before submission of claim	305	$163,726	23%
Claim/service lacks information which is needed for adjudication	301	$130,408	19%
Beneficiary not eligible	220	$112,500	16%
Service date submitted prior to the service effective date	228	$60,641	9%
TOTAL	**1,613**	**$668,435**	**95%**