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FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

SANTA CRUZ MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

April 28 – 29, 2021

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INTRODUCTION

The United States Department of Health and Human Services (HHS), 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). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO 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 Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review, or a desk review, of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also considers the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the Santa Cruz MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

MHP Information

MHP Size — Medium

MHP Region — Bay Area

MHP Location — Santa Cruz

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 3,368

MHP Threshold Language(s) — Spanish

CalEQRO obtained the MHP threshold language information from the DHCS Behavioral Health Information Notice (BHIN) 20-070.

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

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

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed Assembly Bill (AB) 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and BHINs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out-of-Network Access (ONA), Alternative Access Standards (AAS) request, and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS BHIN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS reviews these forms to determine if the provider networks meet required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services for youth and adults. If these standards are not met, DHCS requires the MHP to improve the network to meet the standards or submit an application for an AAS Request. If approved by DHCS, CalEQRO will review the AAS and ONA information as part of its annual EQR.

CalEQRO will verify and report 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 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.

Validation of State and MHP Beneficiary Satisfaction Surveys

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

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other 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.
- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted

providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.calegro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 site review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met 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 Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2019-20

PIP Recommendations

Recommendation 1: Clinical PIP: Ensure another active clinical PIP prior to FY 2020-21 EQR.

Status: Met

- The MHP submitted an active clinical PIP for this EQR that focuses on improving beneficiary engagement while services are provided through telehealth during the pandemic.

Recommendation 2: Non-Clinical PIP: Make the modifications and recalculations listed in the suggestions to improve this PIP.

Status: Met

- The MHP made the necessary adjustments to its non-clinical PIP that aims to reduce the drop-out rates for medication-only beneficiaries. The MHP reported significant success through this PIP.

Access Recommendations

Recommendation 3: Track service utilization by Latino/Hispanic beneficiaries at the new Watsonville clinic location as part of monitoring overall Latino/Hispanic penetration rates. (*This is a follow-up to an FY 2018-19 recommendation.*)

Status: Met

- The MHP did extensive analysis of its Latino/Hispanic beneficiaries service utilization and compared it to statewide trends using the CalEQRO data. However, the MHP was unable to separately track service utilization at the Watsonville clinic this past year due to the rapid shift in service delivery mode due to COVID-19.

Timeliness Recommendations

Recommendation 4: Investigate the reasons for longer psychiatrist wait times for children and FC beneficiaries and whether performance improvement activities need to be undertaken.

Status: Partially Met

- The MHP's timeliness for children's first offered psychiatry appointments continue to significantly lag behind the adult system.
- During the first three quarters of FY 2020-21, the MHP had to divert its resources to rapidly build up its telehealth capabilities including psychiatry services. This hindered the MHP's ability to attend to this recommendation. The MHP stated that this remains a priority and will be addressed during the next FY.
- During the review, the MHP cited a number of factors that currently affect child psychiatry, including:
    - A nationwide shortage of child psychiatrists exacerbated by retirement of senior psychiatrists, and about 40 percent of new psychiatrists coming out of residency programs going into private practice.
    - The county furlough has also been applied to the psychiatrists, further curtailing the child psychiatrist hours.
    - Child and family telepsychiatry sessions have presented some unique initial challenges and hesitancy among the beneficiaries.

- The MHP stated that it will move to train the support staff in active scheduling management, so there are few opportunities for unfilled intake slots.

Recommendation 5: Determine the reasons for the decline in 7-day post-inpatient follow-up rates and formulate ways to bring it back to previous reported rates of over 85 percent.

Status: Met

- The MHP focused on the state and national benchmarks for the Medicaid population. On both of these markers, the MHP has a higher follow-up rate.
- The MHP also found that some of the beneficiaries may have received services outside of those recorded in its EHR and noted its inability to properly incorporate these numbers into the follow-up rates.
- The Rapid Connect program and the newly implemented inpatient utilization management concurrent review activities through Beacon Health Options, the MHP is focusing on increasing the necessary follow-up appointments for non-SMHS beneficiaries who are hospitalized for psychiatric reasons.

Quality Recommendations

Recommendation 6: Consider direct representation of both county and contract provider clinical line staff representation on the Quality Improvement Committee (QIC).

Status: Partially Met

- The MHP reported that the outreach to clinical line staff to join the QIC has been unsuccessful. The reasons cited include workload demands and work-life balance during the pandemic. Clinical line staff reported the same to CalEQRO in the clinical line staff focus group.
- The MHP is focusing its efforts on viable alternatives to direct membership in the QIC. It has reached out to the clinical line staff invitees and the staff council to explore the possibilities of having a designated staff member who will report to the QIC any staff council-identified quality and performance areas.

Recommendation 7: Explore possibilities of an additional supervisory staff member to the QI unit.

Status: Not Met

- With the pandemic-induced budgetary issues, including furloughs of the current staff, the MHP is unable to hire new staff. However, the MHP is considering adding a QI supervisor when possible. In the interim, the MHP is exploring external partnerships to support QI and ongoing performance improvement needs.

Recommendation 8: Include SB 1291 Health Effectiveness Data and Information Set (HEDIS) measures for regular tracking as part of psychiatry peer review.

Status: Partially Met

- The MHP added metabolic monitoring for individuals prescribed any psychotropic medications.
- For the other HEDIS measures, the MHP has been stymied by key Information Systems (IS) staff turnover, longer than expected vacant positions, and diversion of resources due to the pandemic.

Beneficiary Outcomes Recommendations

- None noted.

Foster Care Recommendations

Recommendation 9: Ensure clarity in the understanding of the Intensive Home- Based Services (IHBS) procedure and modifier codes.

Status: Partially Met

- The MHP had previously created an exhaustive list of procedure codes for both Katie A. and non-Katie-A. beneficiaries, but had not created a separate one for IHBS specifically for the Katie A. beneficiaries.
- In FY 2020-21, the MHP updated its policies for establishing eligibility and authorizing Intensive Support Services. Subsequently, it provided trainings on pre-authorization of IHBS, along with service provision procedures and claiming to children's behavioral health staff and their contractor providers.
- Based on its experience, the MHP now recognizes the need to create specific Intensive Care Coordination (ICC) and IHBS codes specifically for the Katie A. beneficiaries.

Recommendation 10: Continue the efforts to establish Therapeutic Foster Care (TFC) services for FC beneficiaries who meet the medical necessity criteria for TFC. (*This is a follow-up to an FY 2018-19recommendation.*)

Status: Partially Met

- The MHP has issued request for proposals (RFPs) twice for a TFC provider, once in 2017, and again in 2020 as a tri-county RFP with San Benito and Monterey. Neither RFP resulted in TFC service availability in Santa Cruz.
- The MHP has trained its clinicians including the contract provider clinicians in the revised Intensive Support Services Eligibility (ISSE) Form which includes criteria for TFC. Clinicians must complete the ISSE Form within the initial assessment period and at re-assessment periods throughout the course of treatment.
- For FC beneficiaries meeting medical necessity criteria for TFC, the MHP will provide available intensive SMHS including ICC, IHBS, and Therapeutic Behavioral Services (TBS), as appropriate, to support the child/youth in their family environment; and will support foster parents in accessing training and building skills through IHBS. In this way, the MHP will provide TFC-equivalent services to FC beneficiaries until a TFC provider is secured and operational within the County.

Information Systems Recommendations

Recommendation 11: Assure full eLab functionality with the development of interoperability between Order Connect and Quest Diagnostics eLab application, Orchard Harvest.

Status: Partially Met

- The MHP had to discontinue this project due to other more urgent IS priorities during the pandemic. At the time of the review, the project had been revived and live tests were underway.
- The MHP expects the electronic lab order transfer capability to be fully operational by June 2021.

Structure and Operations Recommendations

- None noted.

PERFORMANCE MEASURES

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of TBS beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to screenings, assessments, home-based mental health services, outpatient services, day treatment, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. SB 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf
2. EPSDT POS Data Dashboards: https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx
3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
    - 5A (1&2) Use of Psychotropic Medications
    - 5C Use of Multiple Concurrent Psychotropic Medications
    - 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure
4. AB 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf
5. *Katie A. v. Bonta*:
   The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and HEDIS measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

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, to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

Table 1 provides details on beneficiaries served by race/ethnicity.

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

Santa Cruz MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	19,862	26.6%	1,268	37.6%
Latino/Hispanic	40,250	54.0%	1,247	37.0%
African-American	659	0.9%	55	1.6%
Asian/Pacific Islander	1,468	2.0%	42	1.2%
Native American	290	0.4%	30	0.9%
Other	12,055	16.2%	726	21.6%
Total	**74,582**	**100%**	**3,368**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

Table 2 provides details on beneficiaries served by threshold language identified in DHCS BHIN 20-070.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

Santa Cruz MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	684	20.3%
Other Languages	2,684	79.7%
Total	**3,368**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

Penetration Rates and Approved Claims per Beneficiary

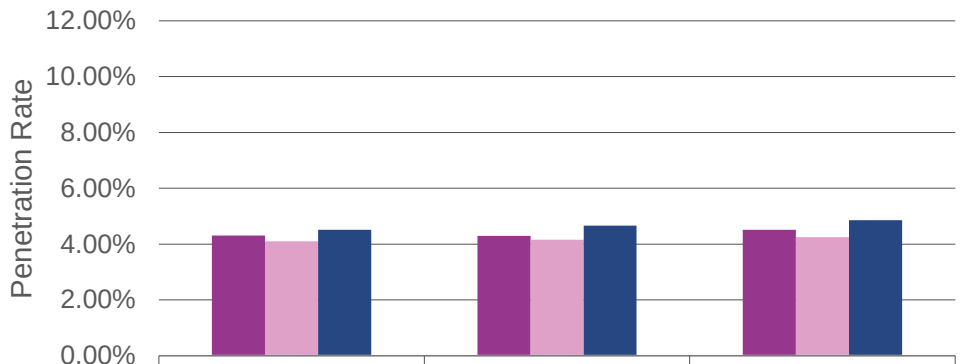
The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2019. See Table D1 for the CY 2019 ACA penetration rate and ACB.

Regarding the calculation of penetration rates, the Santa Cruz MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 1: Overall Penetration Rates CY 2017-19

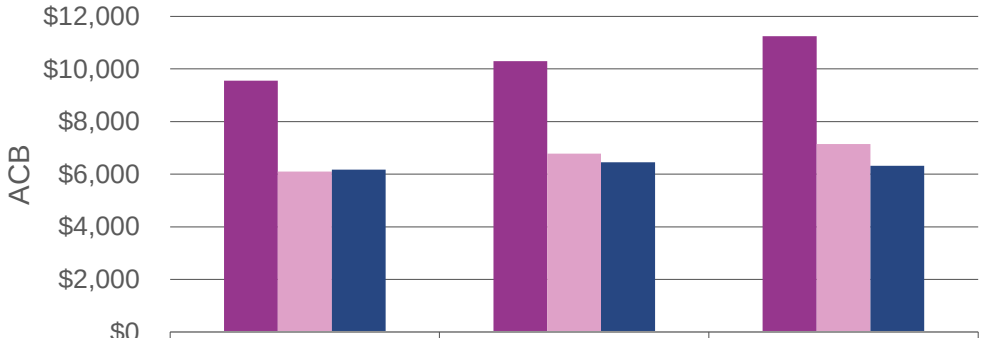
Santa Cruz MHP



	CY 2017	CY 2018	CY 2019
MHP	4.31%	4.30%	4.52%
Medium	4.10%	4.16%	4.25%
State	4.52%	4.66%	4.86%

Figure 2: Overall ACB CY 2017-19

Santa Cruz MHP

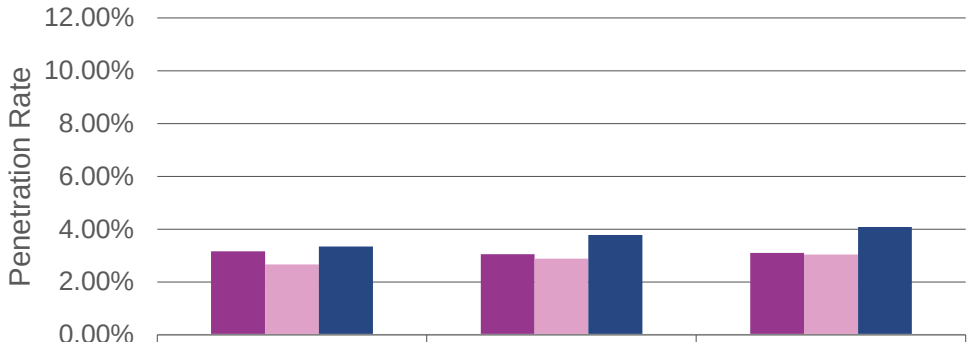


	CY 2017	CY 2018	CY 2019
MHP	$9,558	$10,302	$11,251
Medium	$6,103	$6,785	$7,143
State	$6,170	$6,454	$6,316

Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19

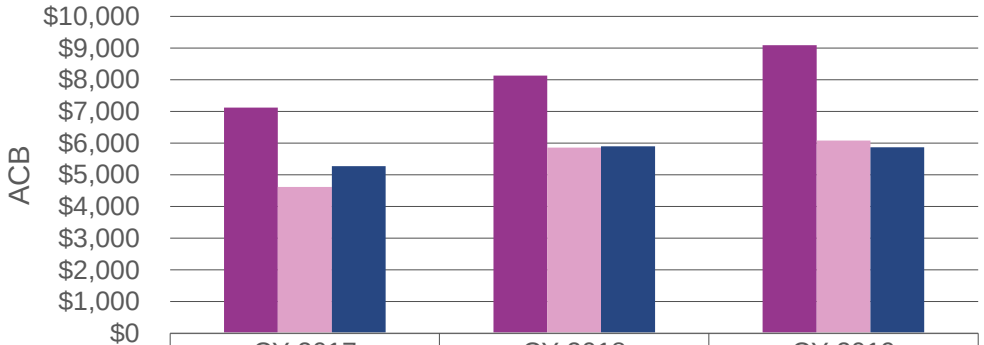
Santa Cruz MHP



	CY 2017	CY 2018	CY 2019
MHP	3.16%	3.05%	3.10%
Medium	2.67%	2.88%	3.04%
State	3.35%	3.78%	4.08%

Figure 4: Latino/Hispanic ACB CY 2017-19

Santa Cruz MHP

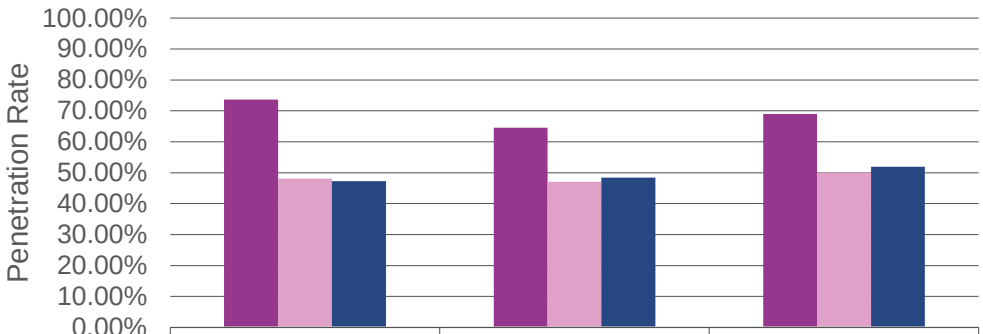


	CY 2017	CY 2018	CY 2019
MHP	$7,119	$8,131	$9,087
Medium	$4,622	$5,858	$6,081
State	$5,278	$5,904	$5,869

Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for medium MHPs.

Figure 5: FC Penetration Rates CY 2017-19

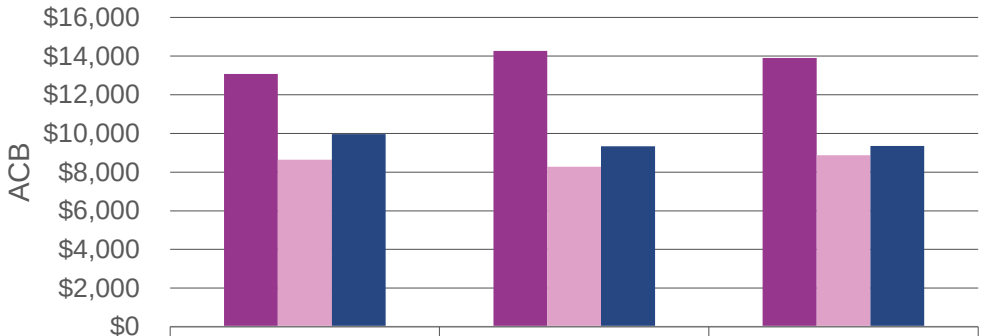
Santa Cruz MHP



	CY 2017	CY 2018	CY 2019
MHP	73.65%	64.61%	69.04%
Medium	48.15%	47.10%	50.12%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19

Santa Cruz MHP

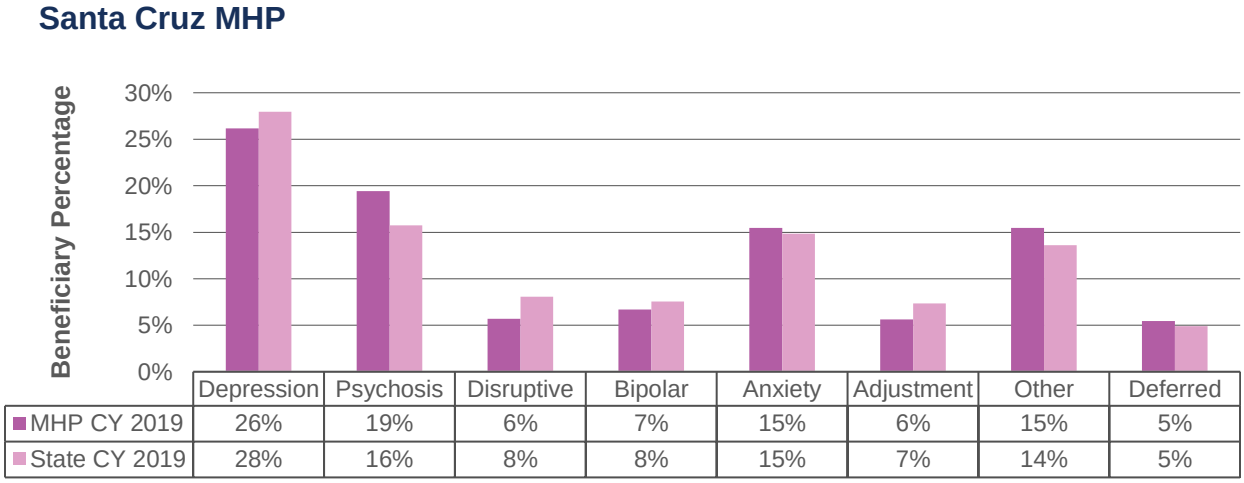


	CY 2017	CY 2018	CY 2019
MHP	$13,070	$14,267	$13,909
Medium	$8,642	$8,276	$8,870
State	$9,962	$9,340	$9,360

Diagnostic Categories

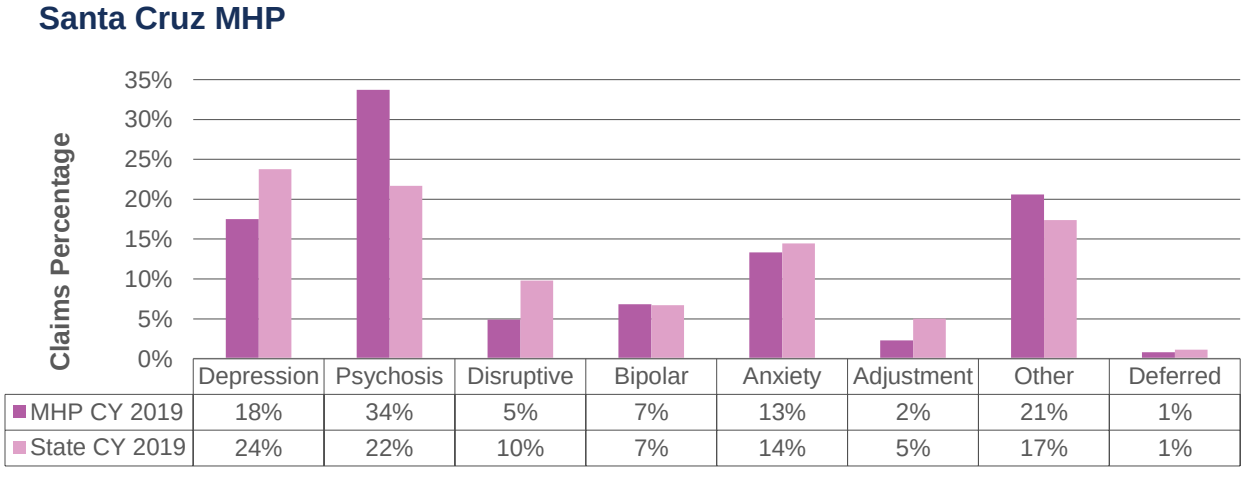
Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	26%	19%	6%	7%	15%	6%	15%	5%
State CY 2019	28%	16%	8%	8%	15%	7%	14%	5%

Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



	Depression	Psychosis	Disruptive	Bipolar	Anxiety	Adjustment	Other	Deferred
MHP CY 2019	18%	34%	5%	7%	13%	2%	21%	1%
State CY 2019	24%	22%	10%	7%	14%	5%	17%	1%

High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 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.

Table 3: High-Cost Beneficiaries CY 2017-19

Santa Cruz MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	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%
	CY 2017	247	3,427	7.21%	$53,297	$13,164,236	40.19%

See Attachment E, Table E1, 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.

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

Table 4: Psychiatric Inpatient Utilization CY 2017-19

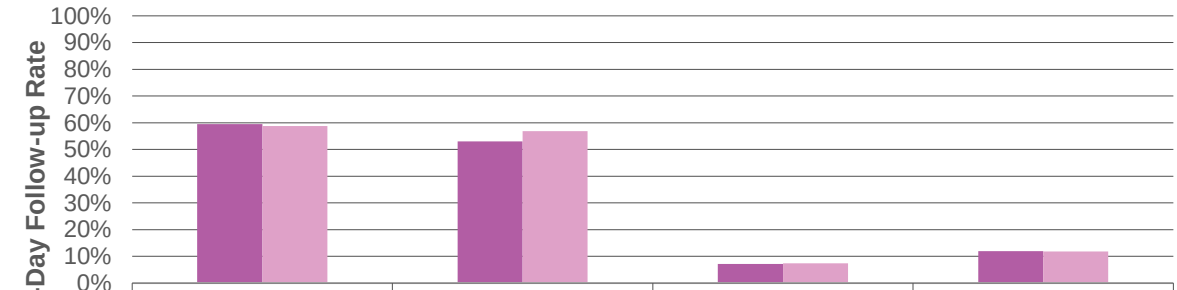
Santa Cruz MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	386	675	9.21	7.80	$16,438	$10,535	$6,344,970
CY 2018	434	769	9.37	7.63	$15,468	$9,772	$6,713,009
CY 2017	308	539	8.35	7.36	$16,584	$9,737	$5,107,980

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19

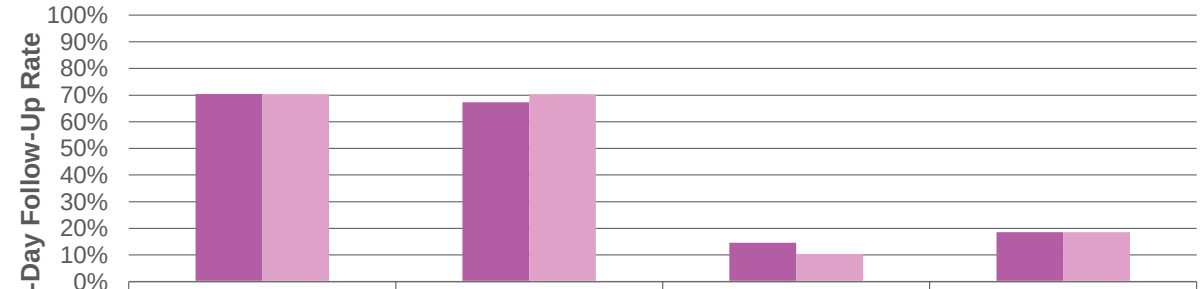
Santa Cruz MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	60%	53%	7%	12%
CY 2019	59%	57%	7%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19

Santa Cruz MHP



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	70%	67%	15%	19%
CY 2019	70%	70%	10%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

Santa Cruz MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs and validated two PIPs, as shown below.

Table 5: PIPs Submitted by Santa Cruz MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Increasing Outpatient Mental Health Therapeutic Engagement
Non-Clinical	1	Improving Beneficiary Engagement in Psychiatric Medication Services

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	Santa Cruz
PIP Title	Increase of Outpatient Mental Health Therapeutic Engagement through Face-to-Face (in-person and telehealth) Services for SMHS beneficiaries enrolled in Adult Mental Health Therapy Services
PIP 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 Adult Needs and

MHP Name	Santa Cruz
	Strengths Assessment (ANSA) average impact score by 25 percent?”
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The PIP population consists of adults (age 18+) who meet SMHS criteria and are receiving mental health therapy services.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested 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): • Support clients in moving from phone-only to face-to-face (in-person or video telehealth) platform. • ANSA completion. • Adult mental health therapy beneficiary survey.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): • Provide training to clinicians on best practices for telehealth effectiveness.

PIP Interventions (Changes tested in the PIP)
• Review of ANSA impact score data.
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): • Adequate space and technology to provide telehealth or in-person services.

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Increase adult mental health beneficiary engagement in face-to-face therapy either in-person or by telehealth by 40 percentage points.	2020 (six months from July to December	Average 710 per month total encounters. 20 percent face-to-face (56 telehealth, 88 in-person, rest by phone)	☒ n/a[5]		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
Increase the overall ANSA	March 2020				☐ Yes ☐ No	☐ Yes ☐ No

[5] PIP is in planning and implementation phase if n/a is checked for all performance measures.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
average impact score by 25 percent.	– February 2021	Average score: 1.29 Sample size: not reported	☒ n/a			p-value: ☐ <.01 ☐ <.05 Other (specify):
						☐ No test of statistical significance
Improve adult beneficiary satisfaction and self-reported engagement rates. (The MHP's goal is to have at least 80 percent rates in both).	Survey administration pending	Pending	☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
						☐ No test of statistical significance
						☐ No test of statistical significance

Was the PIP validated?	☒ Yes ☐ No

Validation phase:	PIP status (per DHCS requirement):
☒ Implementation phase	Active and Ongoing

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ Baseline year						
☐ First remeasurement						
☐ Second remeasurement						
☐ Other, completed in XX months prior to the current EQR	Completed					
☐ PIP submitted for approval						
☐ Planning phase	Concept only, Not Yet Active					
☐ Other, inactive	Inactive, Developed in a Prior Year					
Validation rating:						
☐ High confidence[6] ☒ Moderate confidence[7] ☐ Low confidence[8] ☐ No confidence[9] Justification for validation rating: The MHP has proposed credible performance measures and data collection methods for this PIP in its implementation phase. "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:						

[6] Credible, reliable, and valid methods for the PIP were documented.
[7] Credible, reliable, or valid methods were implied or able to be established for part of the PIP.
[8] Errors in logic were noted or contradictory information was presented or interpreted erroneously.
[9] The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
• Include individual(s) with lived experience of receiving adult mental health services in the PIP committee. • Establish the survey baseline as soon as possible.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Refining the PIP aim statement. • Clarifying the improvement goals for the performance measure • This TA was provided in March 2021. The MHP already made changes accordingly.						

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	Santa Cruz
PIP Title	Improving Beneficiary Engagement in Psychiatric Medication Services
PIP Aim Statement	Will developing standardized process for tracking unscheduled client face-to-face (F2F) appointments and utilizing client engagement interventions increase medication treatment engagement outcomes to 80% for active Meds-Only clients who have not completed a routine Face-2-Face monitoring appointment within 3 months and prevent potential termination of services due to disengagement for 6 months?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)*	

MHP Name	Santa Cruz
☒ Adults only (age 18 and above) ☐ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The PIP age population targets adult and older adult individuals, age 18+, who qualify for SMHS and are not connected to other SMHS such as therapy or care coordination services (medication -only).	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested 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): Provide the following outreach activities between three and six months: • Provide an engagement outreach call to beneficiary with no F2F scheduled appointment or completed service at 3-month marker since last completed F2F service. • Send first outreach engagement letter to beneficiary when there is no F2F scheduled appointment or completed service at 4-month marker since last completed F2F appointment. • Send second outreach engagement letter to beneficiary when there is no F2F scheduled appointment or completed service at 5-month marker since last completed F2F appointment. • Send Notice of Adverse Benefit Determination (NOABD) termination letter to beneficiary when there is no F2F scheduled appointment or completed service at 6-month marker since last completed F2F appointment, specifying date of discontinuation of services if there is no reply to schedule an appointment. Note: The MHP had already been doing reminder calls and rescheduling calls in the case of no-shows before the 3-month marker. Those activities were routine prior to this PIP and continued as such.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):

PIP Interventions (Changes tested in the PIP)
• Staff training on the new workflow (the PIP intervention). • Monitoring and updating caseload assignment on a monthly basis.
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): • Outreach activity workflow design and implementation.

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Increase Meds-Only 6-month Engagement Rate. (Note: the baseline was collected on a 6-month basis, but the MHP tracked and reported on each intervention results separately at 3-month, 4-month, and 5-month markers. CalEQRO did not consider those to be individual PMs)	October 2019	Sample size: 349 Engagement rate: 33 percent	December 2020 ☐ n/a	Sample size: 237 (Due to initial response to COVID-19, the MHP had to skip measurements in March and April of 2020.) Engagement rate: 71 percent	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
Decrease Meds-Only			December 2020	Sample size: 237	☒ Yes ☐ No	☐ Yes ☐ No

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
NOABD Termination Rate.	October 2019	Sample size: 349 Disengagement rate: 67 percent	☐ n/a	Disengagement rate (overall): 29 percent Because a significant part of the disengaged and NOABD termination group occurred in the first two months of the PIP, the MHP recalculated this metric for the last four months of the remeasurement period as below: Sample size: 192		p-value: ☐ <.01 ☐ <.05 Other (specify): ☒ No test of statistical significance

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
				Disengagement rate: 1.6 percent		

Was the PIP validated?	☒ Yes ☐ No

Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☐ Baseline year	
☒ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in XX months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☐ Planning phase	
☐ Other, inactive	Inactive, Developed in a Prior Year

Validation rating:

☒ High confidence[6]
☐ Moderate confidence[7]
☐ Low confidence[8]
☐ No confidence[9]

Justification for validation rating:
Although the MHP did not present any statistical significance test results, the improvement at first remeasurement was robust.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
"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: • Given the robust findings at first remeasurement period, the MHP should consider starting a new non-clinical PIP and convert this to a quality monitoring project status to ensure continuation of interventions with fidelity to what has demonstrated to be successful.						
The TA provided to the MHP by CalEQRO consisted of: • The MHP was advised to improve the baseline calculations due to unavoidable circumstances that impacted the early phase of this PIP and institute monthly tracking. The MHP implemented both changes.						

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key ISCA Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site review.

The following information is self-reported by the MHP through the ISCA and/or the site review.

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
Santa Cruz	1.3%	1.14%	4.71%	4.38%
Medium MHP Group	n/a	3.28%	3.34%	3.01%
Statewide	n/a	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

- ☐ Under MHP control
- ☒ Allocated to or managed by another county department
- ☐ Combination of MHP control and another county department or agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☐ Yes	☒ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☐ Yes	☒ No
If the BCP status is "No," the MHP uses an Application Service Provider (ASP) model to host the EHR system, which provides 24-hour operational support.	☒ Yes	☐ No
If the BCP status is "Yes," it is tested at least annually.	☒ Yes	☐ No
There is at least one person within the MHP clearly identified as having responsibility for information security.	☐ Yes	☒ No
If no one within the MHP is identified as having responsibility for information security, the parent agency or county IT assume responsibility and control of information security.	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	36.1%
Contract providers	67.7%
Network providers	0.2%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	7	1	2	2
2019-20	7.50	2	2	2
2018-19	7.50	2	2	2

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	3	0	1	1
2019-20	6	2	2	1
2018-19	5	2	2	1

The following should be noted with regard to the above information:

- Two positions were vacated by staff taking early retirement packages and recruitment to fill those positions cannot begin for two years per County policy on early retirement.

- The IT Business System Analyst position was filled, and that staff member has taken on key responsibilities such as coordinating the Avatar User Group.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by the MHP and does not account for users' log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	27	42	69
Clinical Healthcare Professional	166	296	462
Clinical Peer Specialist	0	3	3
Quality Improvement	13	5	18
Total	206	346	552

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Medium MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	7	7.87
Total EHR Users Supported by IT (Source: Table 17)	552	572.00

Type of Staff	MHP FY 2020-21	Medium MHP Average FY 2019-20
Ratio of IT Staff to EHR Users	1:78	1:73

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☐ Yes	☒ No
The MHP utilizes an ASP model to support EHR operations.	☒ Yes	☐ No
The MHP also utilizes QI staff to directly support EHR operations.	☒ Yes	☐ No
The MHP also utilizes Local Super Users to support EHR operations.	☒ Yes	☐ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☒	☒	☐	☒
User profile and access setup	☒	☒	☐	☐
Screen workflow and navigation	☒	☒	☐	☒

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No

Ongoing EHR Training and Support	Status	
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	15
Number of county-operated telehealth sites	2
Number of contract providers' telehealth sites	13
Total number of beneficiaries served via telehealth during the last 12 months	2,208
• Adults	903
• Children/Youth	1,146
• Older Adults	159
Total number of telehealth encounters (services) provided during the last 12 months:	262

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☐	Hiring healthcare professional staff locally is difficult
☒	For linguistic capacity or expansion
☐	To serve outlying areas within the county
☒	To serve beneficiaries temporarily residing outside the county
☒	To serve special populations (i.e., children/youth or older adult)
☐	To reduce travel time for healthcare professional staff
☒	To reduce travel time for beneficiaries
☐	To support NA time and distance standards
☒	To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- The MHP moved primarily to telephone services instead of video telehealth because many clients did not have access to laptops or screens. The MHP received a grant to get iPads to loan to clients so that they can connect to their therapist and psychiatrist.
- The Watsonville clinic is trying to use a telehealth option and extended hours as a way to engage clients who may struggle with attending appointments.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☐	Cambodian
☐	Cantonese	☐	Farsi	☐	Hmong
☐	Korean	☐	Mandarin	☒	Other Chinese
☐	Russian	☒	Spanish	☐	Tagalog
☒	Vietnamese	☐	n/a		

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Encompass	6
Pajaro Valley Prevention and Student Assistance (PVPSA)	2
Haven of Hope	2
Parent Center	1
Volunteer Center	2

Current MHP Operations

- The MHP continues to utilize the Avatar system, implemented in 2016, in an Application Service Provider (ASP) model with Netsmart Technologies as their provider.
- The MHP participates in the Santa Cruz Health Information Organization .

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SD/MC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Avatar	EHR	Netsmart	4	Netsmart
Epic	FQHC Billing	OCHIN	16	OCHIN
Santa Cruz Health Information Exchange (SCHIE)	Transcription service	SCHIE	20	Axesson

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
OrderConnect	Medication and Lab orders	Netsmart	4	Netsmart
Call Center Routing	Call routing	Avaya	0	ISD

Major Changes since Prior Year

- Create system of alerts from SCHIE
- Report delivery using extracts and Reporting Portal
- Supervisor Compliance Reports
- CANS/ANSA Data Reports
- Call Center Routing System (Avaya)
- Created CSI Assessment reporting model

The MHP's Priorities for the Coming Year

- Interoperability between OrderConnect and Quest Diagnostics eLab application, Orchard Harvest
- Report requests and automation
- Data Optimization with EHR vendor Netsmart
- Online release and consent tracking
- Provider directory (dynamic)

Other Areas for Improvement

- None noted.

Plans for Information Systems Change

- No plans to replace current system (in place more than five years).

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Avatar/ Netsmart	☒	☐	☐	☐
Assessments	Avatar/ Netsmart	☒	☐	☐	☐
Care Coordination	Avatar/ Netsmart	☒	☐	☐	☐
Document Imaging/Storage	Avatar/ Netsmart	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Topaz	☒	☐	☐	☐
Laboratory results (eLab)	OrderConnect/Netsmart	☒	☐	☐	☐
Level of Care/Level of Service	Avatar/ Netsmart	☒	☐	☐	☐
Outcomes	Avatar/ Netsmart	☒	☐	☐	☐
Prescriptions (eRx)	OrderConnect/Netsmart	☒	☐	☐	☐
Progress Notes	Avatar/ Netsmart	☒	☐	☐	☐
Referral Management	Avatar/ Netsmart	☒	☐	☐	☐
Treatment Plans	Avatar/ Netsmart	☒	☐	☐	☐
Summary Totals for EHR Functionality:		12	0	0	0
FY 2020-21 Summary Totals for EHR Functionality:		12	0	0	0

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
FY 2019-20 Summary Totals for EHR Functionality:		9	1	2	0
FY 2018-19 Summary Totals for EHR Functionality:		9	1	2	0

Progress and issues associated with implementing an EHR over the past year are summarized below:

- Since last year, the MHP was able to include Lab Results, Level of Care/Level of Service, and Referral Management as part of its EHR functionality.
- The CANS tool for children and adolescents is more embedded in the current clinical workflow than the ANSA, which is the Level of Care tool for adults.
- All contract providers have full access to the MHP EHR for service documentation and billing.
- The MHP is in the process of using Key Performance Indicators (KPI) tool to develop reports within Avatar for performance monitoring.

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	n/a	Not used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	n/a	Not used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	n/a	Not used
Direct data entry into MHP EHR system by contract provider staff	80%	Daily
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	n/a	Not used
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	20%	Weekly

The rest of this section is applicable: ☐ Yes ☒ No

Some contract providers have EHR systems, which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Data Transmission from Contract Provider to MHP

EHR Vendor	Product	Count of Providers Supported
n/a		

Personal Health Record

The beneficiaries have online access to their health records through a personal health record (PHR) feature provided within the EHR, a beneficiary portal, or a third-party PHR.

☒ Yes ☐ No ☐ Implementation Phase

Avatar - MyHealthPointe

Expected implementation timeline:

☐ Already in place	☐ Within 6 months
☐ Within the next year	☐ Within the next two years
☐ Longer than 2 years	☐ n/a

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☒ Yes	☐ No
Initiate appointment requests to provider/team.	☒ Yes	☐ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☒ Yes	☐ No
View list of current medications through portal.	☒ Yes	☐ No
Have ability to both send/receive secure text messages with provider team.	☒ Yes	☐ No

Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

☐ Dimension Reports application

☐ Web-based application, including the MHP EHR system, supported by vendor or ASP staff

☐ Web-based application, supported by MHP or DMC staff

☒ Local SQL database, supported by MHP/Health/County staff

☒ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☒ Electronic ☐ Clearinghouse

Table 29 summarizes the MHP's SD/MC claims.

Table 29: Summary of CY 2019 SD/MC Claims

Santa Cruz MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**110,426**	**$40,801,458**	**1,452**	**$589,270**	**1.42%**	**$40,212,188**	**$31,949,220**
JAN19	9,267	$3,535,192	135	$44,096	1.23%	$3,491,096	$2,557,139
FEB19	8,687	$3,258,765	90	$29,363	0.89%	$3,229,402	$2,336,271
MAR19	9,880	$3,629,363	102	$42,717	1.16%	$3,586,646	$2,633,921
APR19	10,138	$3,752,332	88	$45,658	1.20%	$3,706,674	$2,744,895
MAY19	10,404	$3,917,064	121	$62,694	1.58%	$3,854,370	$2,801,497
JUN19	8,792	$3,245,453	123	$64,617	1.95%	$3,180,836	$2,300,745
JUL19	8,840	$3,483,042	197	$72,698	2.04%	$3,410,344	$2,924,281
AUG19	9,262	$3,349,834	171	$49,641	1.46%	$3,300,193	$2,852,117
SEP19	8,522	$3,139,951	92	$48,726	1.53%	$3,091,225	$2,670,338
OCT19	10,193	$3,631,116	96	$45,292	1.23%	$3,585,824	$3,109,379
NOV19	8,321	$2,928,374	128	$40,967	1.38%	$2,887,407	$2,505,407
DEC19	8,120	$2,930,973	109	$42,802	1.44%	$2,888,171	$2,513,231

The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments from Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.

Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**.
Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims.
Statewide denial rate for CY 2019 was **2.99 percent.**

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

Santa Cruz MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	432	$200,376	34%
Beneficiary not eligible.	305	$141,207	24%
Medicare or Other Health Coverage must be billed before submission of claim.	274	$130,292	22%
Beneficiary not eligible or non-covered charges.	265	$62,292	11%
Service line is a duplicate and a repeat service procedure code modifier not present.	151	$52,414	9%
Total	1,452	$589,270	n/a
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

- Denied claim transactions with reason “Medicare or Other Health Coverage” are generally re-billable within the State guidelines.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS request would be submitted for approval by DHCS.

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. For Santa Cruz MHP, the time and distance requirements are 60 minutes and 30 miles for mental health services, and 60 minutes and 30 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted key informant interviews during the review process to identify any problems or barriers for the beneficiaries relating to access and timeliness issues. The key informants included beneficiaries and family members, MHP staff, contracted providers, and other stakeholders.

Findings

The county MHP met all time and distance standards and did not require an AAS request or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	0
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	12
NPI Type 1 number reported is associated with two or more providers	1
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	0
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that	0

Description of NPI Exceptions	Number of Exceptions
taxonomy code is generally not associated with providers who deliver behavioral health services	

CONSUMER AND FAMILY MEMBER FOCUS GROUPS

CalEQRO conducted two 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested two focus groups with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The 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 the CFM focus group participants.

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of adult beneficiaries who are mostly new to the system having initiated/utilized services within the past 12 months. The actual group closely resembled what was requested.
Total number of participants	Ten
Number of participants who initiated services during the previous 12 months	Four
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group:	
Access - new beneficiaries	All new beneficiaries present in this group were connected to MHP services through contract providers and reported that the process was smooth.

Topic	Description
Access – overall	Those who needed transportation, reported easy availability through their health plan or MHP's contract providers including the peer-run Mental Health Client Action Network (MHCAN). All participants reported availability of informational materials on MHP services at all the venues. They also reported easy access to services in Spanish and American Sign Language (ASL). During the pandemic, telehealth or telephone sessions have worked fine for those who were already connected and knew their clinicians. For new beneficiaries, video was preferred.
Timeliness	All participants except one reported getting timely appointments with their therapists or case workers. One participant felt the therapist was too busy and it was difficult to get an appointment. Those who have a psychiatrist reported receiving reminder calls.
Urgent care and resource support	All participants were aware of the crisis line. Some of them reported that they prefer to call their peer support worker at MHCAN.
Quality	All participants were aware of the availability of group therapy and peer groups, and most had utilized at least the ones offered at MHCAN. All participants reported that they have adequate say in their individual treatment plans. However, some felt that the pandemic has made it more difficult. The participants were unaware of the QIC but reported having received and completed surveys on a regular basis.
Peer employment	All participants were aware of peer employment opportunities. They had received help with their job search or employment from MHCAN, case worker, or the psychiatrist.
Structure and operations	Participants receive information on the medication prescribed by their psychiatrists. However, most were unsure if there is a medication information exchange between their psychiatrist and the primary care physician.
Recommendations from this focus group	• MHCAN needs to open in-person as soon as possible. • There needs to be more housing, especially independent living.

Topic	Description
Any best practices or innovations (optional)	• Some participants who attend MHCAN wanted to acknowledge all the facilities and services that MHCAN provides, and how helpful those have been in their lives including shower, laundry facilities, and food.

CFM Focus Group Two

Table 33: Focus Group Two Description and Findings

Topic	Description
Focus group type	A culturally diverse group of parents/caregivers of child/youth beneficiaries who are mostly new to the system having initiated/utilized services for their children within the past 12 months. The actual focus group was smaller than that requested, but consistent in characteristics with the above description.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	Five
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group: (1-3 sentences per area). This summary will be used primarily to aggregate data for the annual report, so please focus on themes that will be most relevant at the state level. Please avoid abbreviations. Remove this statement in red.	
Access - new beneficiaries	For foster parents, the local foster family agency facilitated transfer of children from out-of-county and provided assessment and linkage to services. Other parents located services through the MHP website.
Access – overall	Access to mental health services for foster parents and other parents is through different “gates.” Foster parents

Topic	Description
	reported that youth either came to them enrolled in services or had support through foster family agency to access services. Other parents reported searching Google and finding MHP website while one youth was referred by the crisis team. Foster parents reported more difficulties obtaining medication with delays due to legal requirements. All participants reported being aware of transportation options and some were aware of services offered in other languages.
Timeliness	All youth were seeing therapists weekly, by telephone, Zoom or in person and felt this was sufficient and felt supported. Families and youth were either offered or engaged in peer support (teen) or family therapy primarily on Zoom. Majority of youth see a psychiatrist monthly or bi-monthly. All reported that rescheduling appointments with therapists was easy, but difficult with psychiatrists as there is a long wait. Majority of the participants receive appointment reminders either via text or email.
Urgent care and resource support	All participants were aware of crisis telephone numbers, or reported being able to text therapist for urgent matters. Participants were not aware of a warm line but expressed the desire for a “chat line.” Parents were aware of support groups, but were not able to attend due to the demands on their time, multiple appointments, etc.
Quality	All participants reported being involved in treatment and care planning for their children. They also reported that their psychiatrist does not communicate with their primary care doctor, but some felt that would happen if requested.
Peer employment	n/a
Structure and operations	None reported participating on committees, or being asked to participate, although one parent indicated involvement in the Resiliency Project. Some of the participants have completed surveys, but had not been made aware of results
Recommendations from this focus group	• Need more child psychiatrists; intensive outpatient treatment; and youth crisis care. • There needs to be better communication between counties when transferring care of FC youth. Varying rules across counties are a barrier to timely care for FC children to access timely care.

Topic	Description
	• Need more appropriate substance use treatment for youth. • Need better insurance coverage for urgent care for youth when out-of-county.
Any best practices or innovations (optional)	• n/a

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 34 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 34: Access to Care Components

Component		Maximum Possible	MHP Score
1A	Service Access and Availability	14	14
The MHP provides comprehensive information on its website about its services and how to access them. The provider directory is updated monthly with information from both county and contract providers. The MHP monitors its Access line as part of its QI plan and contracts with a local community-based organization to evaluate the line's effectiveness in addressing the callers' urgent care needs, linguistic needs, and whether the callers receive all the needed information including checked for medical necessity if they need SMHS. The beneficiary focus group participants reported receiving all needed information at the service venues they attend. They were also aware of the availability of services in Spanish and ASL. The MHP monitors access by various service venues, referral types, and program types through its QI plan and evaluation.			
1B	Capacity Management	10	10

Component		Maximum Possible	MHP Score
The MHP does a comprehensive assessment of cultural and linguistic service needs of its beneficiaries as part of its cultural and linguistically appropriate services (CLAS) plan and updated it in February 2021. In so doing, the MHP utilizes its own sources of data, as well as data from the relevant EQRO performance measures. One of the noticeable metric that the MHP included show that the poverty rate in Santa Cruz county is significantly higher than both the state and national levels, and across all race/ethnicity groups. Consequently, the percentage of Medi-Cal eligible population and their service needs are higher in the county. Based on its analysis and community input, the population with the most significant SMHS disparities include the Latino/Hispanic, the Spanish-speaking, and the Lesbian, Gay, Bi-sexual, Transgender, Questioning, and Queer (LGBTQQ) populations. In addition to its identified strategies to address disparities using specific Mental Health Services Act funds, the MHP has also focused on developing a trauma-informed system of care (SOC), a number of initiatives for children through schools, and the local Diversity Center that caters to the LGBTQQ community. The QIC tracks the progress and success of these initiatives. The most significant changes in services and service capacity since the last EQR has been the rapid deployment of telehealth due to the pandemic, ramping up technical and clinical skills of staff, and orienting the beneficiaries to increase the number of services offered through telehealth. The MHP started a new PIP in order to improve beneficiary engagement in telehealth and other services provided over the telephone.			
1C	Integration and Collaboration	24	24
The MHP is a fully integrated behavioral health system, and also a part of the Health Department which includes public health. The MHP works very closely with the Central Alliance, the managed care plan for the county. The MHP has several initiatives with schools, housing programs, law enforcement for crisis calls, and social services. The MHP's SOC has strong collaborations and service provisions with the local community-based organizations (CBOs). Some beneficiary focus group participants mentioned getting employment assistance through one of the CBOs which connects with the Department of Rehabilitation. In addition, the MHP has worked closely with the local chapter of the National Alliance for Mental Health to improve feedback to its beneficiary and community surveys.			

Timeliness of Services

As shown in Table 35, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 35: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	16
The MHP meets the 10-business-day standard for first offered appointment 75 percent of the times overall with a median length of five days. According to the data presented, the MHP meets the standard at a higher rate for adult beneficiaries than children and FC beneficiaries. However, for the adults, there were some discrepancies in the data presented that need to be examined further.			
2B	First Offered Psychiatry Appointment	12	10
The MHP meets the 15-day standard for first offered psychiatry appointment for both adults and children. However, the children's psychiatry timeliness continues to lag well behind that of the adults. The MHP's psychiatry leadership is well aware of this issue and acknowledged inadequate staffing and also cited the national shortage of child psychiatrists and other prescribing staff who prefer to work in more lucrative private practice. The participants in the beneficiary family focus group also cited the need for more psychiatrists. In Santa Cruz, the situation is exacerbated by high housing costs and other cost-of-living indicators. The rollout of telehealth as a result of the pandemic may provide an opportunity for expanding the MHP's child psychiatry capacity through remote sessions.			
2C	Timely Appointments for Urgent Conditions	18	14
The MHP reported a median of 3 hours for urgent appointments that do not need a prior authorization and met the 48-hour standard 95 percent of the time. The reported mean was much higher at 11.5 hours that appeared to be the result of a data entry error for a small number of entries. The MHP reported not being able to identify or track any urgent appointment that required prior authorization. The MHP is looking into the data entry workflow and training staff for more accurate coding of this second metric. The MHP kept its walk-in crisis clinics operational for in-person crisis intervention throughout the pandemic.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	5
The MHP's self-reported 7-day post-hospitalization follow-up rate declined further for two years in a row to 59 percent overall. This is driven primarily by the decline in the adult follow-up rate which is driving down the overall rate. The percentage provided by the MHP matches the EQRO's own calculations. The MHP stated that it cannot consistently track those who receive non-MHP services following hospitalization, and when considering those receiving services recorded			

Component		Maximum Possible	MHP Score
through the MHP EHR, the rate is 79 percent. However, this does not explain why the follow-up rate would decline unless there has been significant shift in how the beneficiaries receive post-hospitalization services. This seems to be a prime topic for the MHP to consider as a PIP or other quality improvement projects.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The MHP fully tracks and trends this metric and reported a rehospitalization rate of 12 percent which is similar to EQRO's own finding of 10 percent for CY 2019. The rehospitalization rate primarily resulted from adult beneficiaries. The children's system of care had very few rehospitalizations and none for the FC beneficiaries.			
2F	Tracks and Trends No-Shows	10	10
The MHP follows a maximum of 10 percent no-show rate standard for both psychiatrists and other clinicians. While the overall rates are 5 and 4 percent respectively for psychiatrists and other clinicians, the psychiatry no-show rates for children and FC beneficiaries are 15 and 20 percent, respectively. During the review, in discussions related to child psychiatry first offered appointment timeliness, the MHP reported that it is engaging in work-flow adjustments to reduce children's no-shows and also to maximize the utilization of any open slots due to no-shows. The MHP has seen great success in improving engagement rate for medication-only for adult psychiatry appointments.			

Quality of Care

In Table 36, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 36: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	12
As described in the context of capacity management, the MHP has annually updated its cultural competency plan and provided comprehensive analysis of its beneficiaries' SMHS needs by demographics. It has also developed, implemented, and monitored			

Component		Maximum Possible	MHP Score
strategies to improve access and quality for groups facing disparities. For more details, see key component 1B, Capacity Management. The MHP has also formed a Cultural Humility Committee (CHC) that is meeting quarterly to dive deeper into the cultural issues of the beneficiary population. As part of this committee's work, the MHP is providing training on a tool call the Cultural Compass.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	9
The MHP is continuing its implementation of Child and Adolescent Needs and Strengths Assessment (CANSA) and ANSA tools. The MHP reported having augmented the CANS tool with additional adverse childhood experiences questions in the past year as part of its push to become a trauma-informed SOC. The clinical line staff reported being trained in these instruments and are just beginning to use them fully for treatment decision and level of care determinations. They reported this to be a work in progress at the time of the review.			
3C	Quality Improvement Plan	10	10
As part of an integrated behavioral health system, the MHP has a combined QI work plan (QIWP) with its Drug Medi-Cal-Organized Delivery System (DMC-ODS) plan. The plan addresses a comprehensive list of measures related to access, timeliness, quality of care, and outcomes. The MHP provides further analysis of access and service delivery of needs by various demographics in its CLAS plan. During the past year, in the QIC meetings, the MHP also regularly discussed the impact of the pandemic on service delivery and how the changes are affecting the beneficiaries, especially for children and families for whom service delivery by telehealth turned out to be more challenging. The QIC meeting minutes also document regular updates on the QI indicators. The FY 2020-21 QIWP and CLAS plan, as well as the FY 2019-20 QWIP evaluation are available to stakeholders, community groups, and the public through the behavioral health website.			
3D	Quality Management Structure	14	11
The MHP has a QM unit and function that is well-integrated into the MHP management and systems of care. While the MHP has a new QI data analyst, the QM unit has lost its bi-lingual coordinator. Due to current furlough in place, hiring for a replacement will take longer. The MHP is exploring external partnerships to fully support the QI and performance improvement functions in the interim.			

Component		Maximum Possible	MHP Score
The MHP's efforts to include clinical line staff in the QIC as per the previous year's EQRO recommendation were also hampered due to the furloughs. The line staff reported being stretched to the capacity with their regular workload to find time to join the QIC. The MHP is creating a liaison with the staff council to obtain their input into the QI functions and disseminate its findings. QM shares its data and findings with the administration and its QIWP evaluation is available through its website. However, the contract providers and line staff reported not being familiar with the QI findings. This calls for further notice to and education of the contract providers and their staff.			
3E	QM Reports Act as a Change Agent in the System	10	10
The MHP has done a number of analyses in the past year including on service delivery changes due to the pandemic that have guided its QI and PIP actions. While many of the analyses are presented in the QM reports, others are presented in the CLAS plan that have led to identifying new strategies to reduce disparities. Due to the pandemic, the implementation of the Power BI project intended to provide KPI capabilities to the staff got delayed as IT priorities shifted unexpectedly. During the review, the MHP reported that the project has restarted and should be completed during this FY. Availability of KPIs for the staff will allow more granular tracking by the managers and staff themselves for their own performance monitoring and management.			
3F	Medication Management	12	6
The MHP has a psychiatry peer review protocol in place. However, this protocol mostly concerns the basic safety measures rather than more comprehensive and robust ones that would include HEDIS quality measures. Tracking of two or more antipsychotics is the closest to a HEDIS measure currently in place. But it was not clear if the tracking of that indicator follows the HEDIS guidelines for that activity. In addition, the MHP has included metabolic monitoring for FC beneficiaries who are prescribed antipsychotics in its current QIWP, but no data is available yet. The updated peer review protocol shows that the MHP has incorporated the monitoring of its efforts to improve coordination with the primary care physicians. However, the latest quarterly data presented did not contain this additional language in describing the related item. The clinical line staff did report that they are specifically working on obtaining this information.			

Beneficiary Progress/Outcomes

In Table 37, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 37: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	12
The MHP uses CANSA in the children's SOC and ANSA in the adult SOC for level of care determination and treatment planning. The clinical line staff reported having been trained in these tools and are using these regularly. Over the past year, the MHP has developed reporting capabilities using these tools, but it remains a work in progress, especially in terms of wider distribution and understanding of these reports. The MHP website has a link to CANSA, but this link is not functional. In addition to these two tools that are used systemwide, the contract providers reported having additional outcomes they use specific to the populations they serve or that are required for their programs. The MHP also presented performance outcomes from its Focused Intervention Team (FIT) that works with mostly homeless and treatment-shy individuals involved in the criminal justice system, and Homeless Outreach and Proactive Engagement Services (HOPES) that works with homeless individuals with a history of non-engagement in behavioral health services.			
4B	Beneficiary Perceptions	10	10
The MHP administers the DHCS consumer perception survey (CPS) as required by the state. It creates extensive reports based on the survey data that are posted on the MHP website. The MHP's newly instituted kiosk system for immediate beneficiary feedback at the clinics was not used very much during the pandemic. The MHP plans to use the beneficiary feedback information obtained from these as soon as practicable.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	12
The MHP offers peer-run programs through their contract providers. MHCAN is a fully peer-run program that is located in Santa Cruz. Mariposa Wellness Center is a peer-driven program that operates in Watsonville.			

Component	Maximum Possible	MHP Score
The adult beneficiary focus group participants from Santa Cruz, noted that they missed attending the MHCAN groups during the pandemic. The Volunteer Center operated by Community Connections of Santa Cruz is the parent organization of the Mariposa Wellness Center and offers the MHP beneficiaries to reach their full potential in recovery and then through education and employment activities.		

Structure and Operations

In Table 38, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 38: Structure and Operations Components

Component		Maximum Possible	MHP Score
5A	Capability and Capacity of the MHP	30	28
The MHP offers a full spectrum of mental health services from acute care and most restrictive settings to fully wellness and recovery-oriented services. Some of these may be offered out-of-county, especially those in more restrictive settings. The MHP has not been successful in attracting any contract provider interested in setting up TFC services in the county. The MHP has started using the ISSE at initial and all subsequent assessments to determine the need for more intensive services including TFC. The MHP is ensuring that those meeting the medical necessity criteria for TFC receive other alternative intensive modalities of services including ICC, IHBS, and TBS.			
5B	Network Enhancements	18	16
The MHP has a number of contracts and collaborations to provide a number of adjunct services to enhance its core SMHS. These include wellness centers, Whole Person Care (WPC), Mobile Emergency Response Team and Mobile Emergency Response Team for Youth (MERTY), among many others. The most significant change from the previous year's EQR has been the MHP's ramping up of its telehealth services from ground zero. The MHP is also currently pursuing a PIP to improve engagement using telehealth.			
5C	Subcontracts/Contract Providers	16	16

Component		Maximum Possible	MHP Score
Contract providers are an integral part of the MHP's service delivery system offering both core SMHS, as well as adjunct services to supplement or enhance the MHP's service delivery system. The contract providers reported varying experiences during the pandemic and acknowledged that the furloughs due to the pandemic has made communication more difficult. Most contract providers would like more opportunities for greater input and asking questions at the existing meetings with the contract providers. They would also like further training in treating individuals with co-occurring substance use disorders.			
5D	Stakeholder Engagement	12	7
MHP engages its stakeholders in various venues including making presentation or receiving input. This includes the cultural competency initiatives, MHSA planning, and partly in its QIWP. However, the MHP has experienced challenges in including the line staff and beneficiaries in its QIC efforts. At present, the MHP is pursuing alternative approaches to ensure that the clinical line staff and beneficiary voices are included in all its efforts including working with the staff council and attending community groups such as NAMI.			
5E	Peer Employment	8	8
The MHP has its designated peer positions, but no career ladder. The expectation is that peer employees with experience will be able to compete in other mental health positions. The MHP has a strong system of peer employment, career advancement, outside education and employment, and volunteer opportunities through its contract providers. These contract providers have different job classifications for individuals with lived experience including supervisory positions.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of Santa Cruz MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Active and ongoing

Non-clinical PIP Status: Active and ongoing

Access to Care

Changes within the Past Year:

- The most significant changes in services and service capacity since the last EQR has been the rapid deployment of telehealth due to the pandemic, ramping up technical and clinical skills of staff, and orienting the beneficiaries to increase the number of services offered through telehealth.

Strengths:

- The MHP's SOC has strong collaborations and service provisions with the local CBOs to offer better access to its services.
- The MHP met all time and distance standards and did not require an AAS request or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.
- The beneficiary focus group participants reported receiving all needed information at the service venues they attend. They were also aware of the availability of services in Spanish and ASL.
- The MHP has significantly invested in housing initiatives and has a number of projects to increase housing options for beneficiaries receiving SMHS.
- The MHP now has MERTY in both north and south county locations allowing for more appropriate youth emergency response during its hours of operation.

Opportunities for Improvement:

- Parents of non-FC beneficiaries reported that finding access information can be challenging if one has no knowledge of mental health services.

Timeliness of Services

Changes within the Past Year:

- The furlough of county staff, including the psychiatrists, has further strained the MHP's child psychiatry capacity.

Strengths:

- The MHP reported a median length of 5 days wait time for the first offered appointment. The adult beneficiary focus group participants reported the intake process to be smooth and timely, while the family member focus group participants reported timely access once they connected with the MHP.
- The MHP is able to offer urgent appointments that do not require prior authorization within 48 hours 95 percent of the time with a median time of 3 hours.

Opportunities for Improvement:

- The MHP's first offered appointment for child psychiatry continues to lag well behind that for adults.
- The MHP's post-hospitalization follow-up rate has declined further making it a 3-year trend.

Quality of Care

Changes within the Past Year:

- The MHP has further implemented CANSA and ANSA. The clinicians reported being trained and using these tools in their treatment planning.
- A cultural humility committee started identifying strategies and trainings for the staff to become more proficient in understanding the beneficiaries' cultural and linguistic needs.
- The QM unit has a new QI analyst but lost a bilingual staff in the past year.

Strengths:

- The QIWP and the CLAS plans together provide valuable systems information and guide the service delivery system.
- The MHP provides strong peer support through contract providers, and these services were acknowledged by the beneficiary focus group participants.

Opportunities for Improvement:

- The MHP continues to face challenges in recruiting clinical line staff and individuals with lived experience in its QIC.
- The MHP has a basic medication monitoring protocol focusing mainly on beneficiary safety but lack any national level quality measures.

Beneficiary Outcomes

Changes within the Past Year:

- The implementation of KPIs and Power BI was delayed due to the pandemic and deployment of the IT staff to other priorities. At the time of the review, the MHP reported to have resumed implementation.

Strengths:

- The MHP tracks program-specific outcomes and presented performance outcomes from the FIT and HOPES programs. Contract providers noted additional outcomes tracking at their programs.

Opportunities for Improvement:

- None noted.

Foster Care

Changes within the Past Year:

- The MHP has started using the ISSE at initial and all subsequent assessments to determine the need for more intensive services including TFC.

Strengths:

- The MHP has a penetration rate for its FC beneficiaries that is almost a third higher than the statewide or medium-sized MHP averages.

- The MHP is transparent with its QIWP and evaluation results, and posts these on the MHP's website.

Opportunities for Improvement:

- The MHP has been unable to attract any contract provider to offer TFC services in the county.
- Foster parents reported more difficulties obtaining medication with delays due to legal requirements. This may be an issue beyond the MHP's sphere of influence.

Information Systems

Changes within the Past Year:

- The Avaya call center routing system has been installed to assist with monitoring critical indicators, such as call wait times, dropped calls, etc.

Strengths:

- Additional functionality of the EHR, including lab orders/results, level of care and referral management.
- The MHP started to disseminate supervisor compliance reports on a weekly basis that indicate all CANS and ANSA assessments due for each provider.

Opportunities for Improvement:

- The carryover priority, to have interoperability between OrderConnect and Quest Diagnostics eLab application, Orchard Harvest, was delayed due to shifting priorities that COVID-19 necessitated.

Structure and Operations

Changes within the Past Year:

- Contract providers reported varying experiences during the pandemic and the furloughs due to the pandemic has made communication more difficult.

Strengths:

- Contract providers are an integral part of the MHP's service delivery system offering both core SMHS, as well as adjunct services to supplement or enhance the MHP's service delivery system.

Opportunities for Improvement:

- Contract providers noted the need for more training in treating individuals with co-occurring substance use disorders.

FY 2020-21 Recommendations

PIP Status

None noted.

Access to Care

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.

Timeliness of Services

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 is a follow-up to a recommendation from FY 2019-20.*)

Quality of Care

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

Recommendation 4: Continue efforts to engage clinical line staff in the QIC and document the staff council prioritized areas for the QIC. (*This is a follow-up to a recommendation from FY 2019-20.*)

Beneficiary Outcomes

None noted.

Foster Care

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

Information Systems

Recommendation 6: Assure full eLab functionality with the development of interoperability between Order Connect and Quest Diagnostics eLab application, Orchard Harvest. (*This is a carry-over recommendation from FY 2019-20.*)

Structure and Operations

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

SITE REVIEW PROCESS BARRIERS

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

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP.
- The MHP provided very adequate logistical support to make the virtual sessions go smoothly.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Data

Attachment D: ACA Penetration Rates and ACBs

Attachment E: ACB Range Distributions

Attachment F: List of Commonly Used Acronyms

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
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
Performance Improvement Projects
Clinical Line Staff Group Interview
Clinical Directors Group Interview
Consumer and Family Member Focus Groups (Two)
Contract Provider Group Interview – Clinical Management and Supervision
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Saumitra SenGupta, Ph.D., Lead Quality Reviewer
Kiran Sahota, MA, Quality Reviewer
Melissa Martin, MSW, MPH, Ph.D., Information Systems Reviewer
Pamela Roach, CFM Reviewer

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

MHP Review Sites and Participants

MHP Sites

All sessions were held via video conference due to COVID-19 restrictions.

Contract Provider Sites

n/a

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Aguilar	Ileana	BH QI Program Coordinator	SCCBH*
Bare	Adrianna	Sr. BH Administration Director	SCCBH
Blaskovich	Dagny	Clinical Manager	Community Connection
Borbely	Christina	Sr. BH Training (QI)	SCCBH
Brown	Robert	BH Child Psychiatrist	SCCBH
Burt	Jeff	BH Patient Acct. Mgr.	SCCBH
Butler	JP	Vice-President	Front Street, Inc.
Chavez	Livier	MH Coordinator	Front Street, Inc.
Chicoine	David	Utilization Review Specialist (QI)	SCCBH
Cisneros	Kevin	BH Children MH Specialist	SCCBH
Einhorn	Stan	BH Children MH Manager	SCCBH
Eslami	Cassandra	Sr. BH Acute & Crisis Serv Dir. & MHSA Coordinator	SCCBH
Fein	Lauren	BH Children MH Manager	SCCBH
Fernandez	Jorge	HSA IT Manager	SCCBH
Flagg-Wilson	Leah	Utilization Review Specialist (QI)	SCCBH
Gray	Kayla	Psychiatry Program Coordinator	SCCBH
Gutierrez Wang	Lisa	Sr. BH Children MH Director	SCCBH
Hayes	David	BH Adult MH Clinician	SCCBH
Kauert	Micha	Utilization Review Specialist (QI)	SCCBH
Kern	Karen	Sr. BH Adult MH Director	SCCBH
Koebler	Suzanne	Clinician	Parent Center
Locascio	Teresa	Clinician	Heaven of Hope
Lolley	Cybele	Sr. BH Quality Improvement Dir.	SCCBH
Majan	Amy	BH Psychiatry Medical Assistant	SCCBH
Mast	Nancy	Utilization Review Specialist (QI)	SCCBH

Last Name	First Name	Position	Agency
McCuiston	Melissa	BH IT Business Analyst (QI)	SCCBH
McLaughlin	Erin	Clinical Manager	Encompass
Nair	Latha	BH MH Medical Director	SCCBH
Ochoa	Eric	Clinical Manager	PVPSA
Otlin	Stacey	Clinical Director	Heaven of Hope
Riera	Erik	BH Director	SCCBH
Robertson	Subé	Utilization Review Specialist (QI)	SCCBH
Rubalcava	Emilio	Director of Programs	Front Street, Inc.
Russell	James	BH Adult Forensic MH Manager	SCCBH
Simoni	Andrew	Clinician	Encompass
Soria	Elizabeth	BH Administration Mgr.	SCCBH
Suski	Ellen	Utilization Review Specialist (QI)	SCCBH
Threlfall	Alex	BH Chief of Psychiatry	SCCBH
Turnbull	Andrea	BH Acute Service Manager	SCCBH
Valencia	Reina	BH MH Specialist	SCCBH
Whiteside	Brian	BH Nurse Practitioner	SCCBH
Wong	Gian	HSA IT Dev/App Analyst III	SCCBH
Yarnell	Meg	BH Children MH Manager	SCCBH

*Santa Cruz County Behavioral Health

Attachment C—Approved Claims Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Attachment D—ACA Penetration Rates and ACBs

Table D1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table D1: CY 2019 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	3,719,952	159,904	4.30%	$824,153,538	$5,154
Medium	519,441	20,353	3.92%	$121,346,017	$5,962
MHP	22,555	810	3.59%	$5,946,235	$7,341

Attachment E—ACB Range Distributions

Table E1 shows 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.

Table E1: CY 2019 Distribution of 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	2,801	83.17%	93.31%	$14,774,416	$5,275	$3,998	38.99%	59.06%
>$20K - $30K	231	6.86%	3.20%	$5,682,739	$24,601	$24,251	15.00%	12.29%
>$30K	336	9.98%	3.49%	$17,436,155	$51,893	$51,883	46.01%	28.65%

Attachment F—List of Commonly Used Acronyms

Table F1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standards
AB	Assembly Bill
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
API	Asian/Pacific Islander
ASAM	American Society of Addiction Medicine
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts
BHIN	Behavioral Health Information Notice
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organizations
CBT	Cognitive Behavioral Therapy
CCC	Cultural Competency Committee
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services

Acronym	Full Term
COVID-19	Corona Virus Disease-2019
CPM	Core Practice Model
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CURES	Controlled Substances Utilization Review and Evaluation System
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FTE	Full Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Full Term
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HR	Human Resources
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IHBS	Intensive Home-Based Services
IMD	Institution for Mental Diseases
IN	Information Notice
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
KPI	Key Performance Indicator
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care
LOS	Length of Stay
LPHA	Licensed Practitioner of the Healing Arts
MAT	Medication Assisted Treatment
MCO	Managed Care Organizations
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MFA	Multi-Factor Authentication
MHBG	Mental Health Block Grant
MHP	Mental Health Plan
MHSA	Mental Health Services Act

Acronym	Full Term
MHST	Mental Health Screening Tool
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MSO	Management Services Organization
NA	Network Adequacy
n/a	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTP	Narcotic Treatment Program
OON	Out-of-Network
OTP	Opioid Treatment Program
PA	Physician Assistant
PDSA	Plan Do Study Act
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIN	Personal Identification Number
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RFP	Request for Proposal
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration

Acronym	Full Term
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SD/MC	Short-Doyle Medi-Cal
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
STCs	Special Terms and Conditions
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
VOIP	Voice Over Internet Protocol
WET	Workforce Education and Training
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan