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FY 2023-24 MEDI-CAL SPECIALTY BEHAVIORAL HEALTH EXTERNAL QUALITY REVIEW

SANTA CLARA FINAL REPORT

MHP

DMC-ODS

Prepared for:

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

Review Dates:

December 12-14, 2023

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — December 12-14, 2023

MHP Size — Large

MHP Region — Bay Area

Summary of Findings

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2022-23 EQR recommendations for improvement; four categories of Key Components that impact member outcomes; activity regarding Performance Improvement Projects (PIPs); and member feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

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

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	4	4	2
Information Systems (IS)	6	3	3	0
TOTAL	26	17	7	2

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Follow-Up After Emergency Department (ED) Visit for Mental Health (FUM)	Clinical	09/2022	Implementation	Moderate
Improving the 24/7 Access Call Line Efficiency	Non-Clinical	05/2022	Second remeasurement; Completed	Moderate

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	<input checked="" type="checkbox"/> Adults-Residential <input type="checkbox"/> Transition Aged Youth (TAY) <input type="checkbox"/> Family Members	
2	<input checked="" type="checkbox"/> Adults-Consumer Center <input type="checkbox"/> Transition Aged Youth (TAY) <input type="checkbox"/> Family Members	11
3	<input type="checkbox"/> Adults <input checked="" type="checkbox"/> Transition Aged Youth (TAY) <input type="checkbox"/> Family Members	

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Santa Clara has performed well over the last few years in providing access to eligible members and connecting them with services. The MHP’s overall penetration rate (PR), as well as the PRs for all race/ethnicity groups, have consistently exceeded similar-sized county and statewide rates.
- The robust outreach and engagement activities of the MHP has resulted in the creation of wellness centers across its system of care and within the community, including in juvenile hall and schools. Santa Clara established a Vietnamese wellness center, which includes onsite primary care.
- The MHP places emphasis on being a data-driven organization. It currently has two vibrant data-analytics teams that collectively embrace more than 30 analysts.
- Santa Clara successfully incorporated all relevant Current Procedural Terminology /Healthcare Common Procedure Coding System (CPT/HCPCS) codes into its electronic health record (EHR), with over 10,000 codes in their system.
- The MHP has 28 peer support staff, and 90 percent of them are certified peer support specialists.

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

- First offered psychiatry appointment data are not yet reported consistently and completely, making it difficult to fully assess timely access to care.
- In CY 2022, the MHP had an overall denied claims rate of 8.35 percent, which was 2.43 percentage points higher than the statewide denial rate.
- Contracted providers indicated inadequate support for changes that have been required due to California Advancing and Innovating Medi-Cal (CalAIM).
- The MHP does not currently have level of care (LOC) tools for adults and youth.
- Santa Clara does not possess a formally written operational continuity plan that focuses exclusively on the MHP.

Recommendations for improvement based upon this review include:

- Continue to further refine the first psychiatry appointment timeliness data with DHCS guidance and ensure complete and consistent reporting by the providers. (This recommendation was continued from FY 2021-22 and FY 2022-23.)
- Coordinate with billing and fiscal teams to research Santa Clara's overall denied claims rate exceeding the statewide denial rate. Develop strategies to proactively identify and remediate problematic claims lines before they are submitted to DHCS for adjudication.
- Continue efforts and ensure that all recipients (e.g., providers, staff) are aware of and understand how to apply communication from the MHP for changes due to CalAIM.
- Continue the collaborative process with the University of Kentucky in developing and implementing LOC tools for youth and adults.
- Consider investing time and resources into producing an IS operational continuity plan that is agency specific.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). The EQRO conducts an EQR that is an analysis and evaluation of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid (Medi-Cal in California) Managed Care Services. The Code of Federal Regulations (CFR) specifies the EQR requirements (42 CFR § 438, subpart E), and CMS develops protocols to guide the annual EQR process; the most recent protocol was updated in February 2023.

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

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

This report presents the FY 2023-24 findings of the EQR for Santa Clara County MHP by BHC, conducted as a virtual review on December 12-14, 2023.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public mental health (MH) system, including former directors, IS administrators, and individuals with lived experience as consumers or family members served by SMHS systems of care. Collectively, the review teams utilize qualitative and quantitative techniques to validate and analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, members, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

CalEQRO reviews are retrospective; therefore, county documentation that is requested for this review covers the time frame since the prior review. Additionally, the Medi-Cal approved claims data used to generate Performance Measures (PM) tables and graphs throughout this report are derived from three source files: Monthly Medi-Cal Eligibility Data System Eligibility File, Short-Doyle/Medi-Cal (SDMC) approved claims, and the Inpatient Consolidation (IPC) File. PMs calculated by CalEQRO cover services for approved claims for calendar year (CY) 2022 as adjudicated by DHCS by April 2023. Several measures display a three-year trend from CY 2020 to CY 2022.

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2022-23 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact member outcomes: Access, Timeliness, Quality, and IS.
- Validation and analysis of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – summary of the validation tool included as Attachment C.
- Validation and analysis of PMs as per 42 CFR Section 438.358(b)(1)(ii). PMs include examination of specific data for Medi-Cal eligible minor and non-minor dependents in FC, as per California WIC Section 14717.5, and also as outlined DHCS's Comprehensive Quality Strategy.
- Validation and analysis of each MHP's network adequacy (NA) as per 42 CFR Section 438.68, including data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Validation and analysis of the extent to which the MHP and its subcontracting providers meet the Federal data integrity requirements for Health Information Systems (HIS), including an evaluation of the county MHP's reporting systems and methodologies for calculating PMs, and whether the MHP and its subcontracting providers maintain HIS that collect, analyze, integrate, and report

data to achieve the objectives of the quality assessment and performance improvement (QAPI) program.

- Validation and analysis of members' perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with Plan members and their families.
- Summary of MHP strengths, opportunities for improvement, and recommendations for the coming year.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 11, and then "<11" is indicated to protect the confidentiality of MHP members.

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

The MHP did not experience any significant issues affecting its operations.

SIGNIFICANT CHANGES AND INITIATIVES

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

- In connection with addressing CalAIM requirements related to payment reform, the MHP successfully incorporated all relevant CPT/HCPCS codes into its EHR, Avatar, to support billing for all internal and contracted providers. The transition to the new schema of CPT/HCPCS codes was completed across Santa Clara's system of care in July 2023.
- Implemented services for youth at two county juvenile detention facilities. Each facility (i.e., Juvenile Hall and James Ranch) has a team of clinical staff that provide screening, assessment, life-skill groups, group therapy, crisis support, rehabilitation services, and care coordination. The redesign of services added a third team (i.e., Treatment Team) to focus on the continuity of care between facilities.
- Initiated 988 as the access point for individuals requesting crisis response services or emotional support. 988 staff provide a warm hand off to a crisis team, Mobile Crisis Response Team, Trusted Response Urgent Support Team, or Mobile Response and Stabilization Services. In the first year, the 988 team handled 3,489 calls that were dispatched for mobile crisis services and total calls handled by the team, including crisis de-escalation and support, were 56,843. Santa Clara hired nine additional staff due to the increase in calls. A 988-crisis text line and chat services were implemented for eight hours daily. The MHP plans to offer this service 24 hours 7 days a week starting in July 2024.
- Contracted with the Valley Health Foundation to administer a grant program that will support the development of school-based wellness centers on school campuses in Santa Clara County.
- Launched a same day access model for consumers at the downtown behavioral health outpatient program. Individuals seeking services referred to the clinic will receive an intake assessment on the same day. Additionally, behavioral health urgent care provides same day access to individuals discharged from emergency

psychiatric services, acute psychiatric hospitals, and contracted psychiatric hospitals to provide timely access for care coordination.

- Started the behavioral health navigator program in December 2022. The service is available through the access line for members seeking behavioral health (BH) services. The team provides support to county residents in obtaining services. In July 2023, the team established local sites within the county at community centers and libraries to see individuals in person. The MHP reported that it had received 8,000 calls from individuals seeking navigator services at the time of this report.
- Awarded the Collaborative Community Stakeholder Workgroup Program contract from the Department of State Hospitals on March 2, 2023. The contract is July 1, 2023, through June 30, 2028. The MHP will coordinate a collaborative community stakeholder workgroup in December 2023 that will focus on developing and implementing local solutions that reduce the number of individuals with serious mental illness arrested and incarcerated for behavior connected to their illness.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations not addressed may be presented as a recommendation again for this review. However, if the MHP has initiated significant activity and has specific plans to continue to implement these improvements, or if there are more significant issues warranting recommendations this year, the recommendation may not be carried forward to the next review year.

Recommendations from FY 2022-23

Recommendation 1: Determine if there are delays in post-assessment services by service type, by cultural and demographic factors, and by service locations. Examine where staffing shortages are impacting quality of care.

Addressed

Partially Addressed

Not Addressed

- In responding to this prompt, the MHP focused exclusively on the efforts made to craft remedies for challenges pertaining to workforce shortages. While Santa Clara discussed the partnerships it has cultivated with key internal and external agencies to promote the recruitment and retention of staff, no evaluation was performed to determine whether delays in post-assessment services are occurring, or the extent to which staff attrition is influencing it.
- Additional investment of time and resources are suggested to adequately investigate this concern. If delays in getting members to services following assessments are discovered, then the factors contributing to this situation need to be identified, and strategies developed, to improve the timely delivery of quality care to members.

- This recommendation was partially addressed; however, it will not be continued due to other priority recommendations.

Recommendation 2: Consider changes in service access workflow whereby the placement of those members who are determined not to be a good fit for a program upon completion of the full assessment is adjudicated centrally by the MHP Access.

Addressed Partially Addressed Not Addressed

- The MHP responded that its call center makes all attempts to honor member preference when making referrals and its contracted providers are responsible to refer a member to another provider when there is not a good fit.
- Santa Clara indicated that a referral back to the MHP could lead to delays in members receiving services. However, contracted providers have less awareness of where there is available capacity, and this process can cause additional wait time for the member.
- The MHP provided its No Wrong Door Policy.
- This recommendation was partially addressed; however, it will not be continued due to other priority recommendations.

Recommendation 3: Continue to further refine the first psychiatry appointment timeliness data with DHCS guidance and ensure complete and consistent reporting by the providers.

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

Addressed Partially Addressed Not Addressed

- The MHP conveyed that it participated regularly in TA sessions with DHCS and that monthly psychiatry tracking was implemented. Aside from these two points, no particulars were disclosed regarding the ways DHCS guidance was used to refine and/or improve the timeliness data and reporting associated with this metric.
- The MHP indicated that following its meetings with DHCS, a policy was created to govern the process of collecting data and reporting on this timeliness activity, including the creation of an operational definition guiding how to appropriately measure the metric. While the policy was reviewed by the state and presumably shared with contractors, no copy of this document was submitted for review nor was any evidence offered to illustrate how it was executed to positively shape and encourage complete and consistent reporting by providers.
- The MHP has been capturing and evaluating these data in a dedicated Excel spreadsheet. However, to bolster the completeness and accuracy of this information and centralize the process of capturing it, Santa Clara's Information

Technology (IT) department has created a form in Avatar that will be used by internal and contract providers to enter records of first offered psychiatry appointments directly into the system. This form will be released to end users in early CY 2024.

- This recommendation was partially addressed and will be continued.

Recommendation 4: Collect and monitor data for the currently untracked Healthcare Effectiveness Data and Information Set (HEDIS) measures for mental health across the adult and children’s systems of care.

Addressed Partially Addressed Not Addressed

- This recommendation was partially addressed. Although the MHP possesses a robust medication monitoring process that places an emphasis on tracking and reporting most HEDIS measures, due to functionality issues in the EHR, it was not able to previously collect data in Avatar relating to members who were prescribed medications for Antidepressant Medication Management (AMM) or Schizophrenia or Schizoaffective Disorder (SAA). These issues, however, have since been resolved, and Santa Clara has developed mechanisms in the system to capture this information.
- The MHP already plans to begin formally tracking and trending AMM and SAA data in January 2024; therefore, this recommendation will not be continued.

Recommendation 5: Standardize contract provider expectations for disaster recovery and operations continuity plan timeliness to assure data security and timely availability in the event of a disaster or other data compromising event.

Addressed Partially Addressed Not Addressed

- Santa Clara identifies circumstances when contractors would likely adhere to their own operational continuity plans as opposed to those instances where the MHP’s system would be affected, and it would take the lead; however, there was no discussion of efforts (e.g., targeted meetings, communications, or documentation) to standardize contract provider expectations to promote data security or restore system availability in a consistent and timely fashion. Additionally, the MHP stated that it has means of communicating quickly with contractors during one of these events, and there was no indication that strategies or protocols had been developed or articulated in advance to orchestrate coordinated disaster-recovery responses between the MHP and its contract providers.
- The MHP currently does not have an agency-specific operational continuity plan. Instead, it relies on the broad framework set forth in the Major Incident Management Process document, created by the Technology Services and Solutions (TSS) unit within Santa Clara’s countywide IS department, to inform decisions regarding the management of critical systems and disaster recovery.

- Santa Clara did not fully address this recommendation; however, the recommendation will not be carried over as is. A new recommendation is included related to creating an agency-specific operational continuity plan.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 7.8 percent of services were delivered by county-operated/staffed clinics and sites, and 92.2 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 78 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to members 24-hours, 7-days per week that is operated by county staff; members may request services through the Access Line. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services. The Access Line does the initial screening and makes referrals to the providers, both county and contracted. Upon assessment, the providers are responsible for the appropriate care, including referrals to alternate providers, if needed.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 4,497 adults, 6,372 youth, and 1,131 older adults across 14 county-operated sites and 64 contractor-operated sites. Among those served, 4,437 members received telehealth services in a language other than English in the preceding 12 months.

¹ [CMS Data Navigator Glossary of Terms](#)

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information in Table 1A and Table 1B.

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

For Santa Clara County, the time and distance requirements are 15 miles and 30 minutes for outpatient MH and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over).

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

Alternative Access Standards	
The MHP was required to submit an AAS request due to time or distance requirements	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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

Table 1B: MHP Out-of-Network Access, FY 2022-23

Out-of-Network (OON) Access	
The MHP was required to provide OON access due to time or distance requirements	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

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

ACCESS KEY COMPONENTS

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

the foundation of access to quality services that ultimately lead to improved member outcomes.

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

Table 2: Access Key Components

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

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

- During the last few years, the overall PR in the MHP has exceeded similar-sized county and statewide rates. Likewise, PRs for all race/ethnicity groups in Santa Clara have been higher than these comparisons.
- Santa Clara has several staff recruitment and retention initiatives in place and is collecting data to evaluate the strategies.
- The MHP has established a multitude of effective collaborations with a wide array of community agencies to help better serve the needs of its members.
- Santa Clara has an abundance of wellness centers, including in schools, juvenile hall, and a center specifically for Vietnamese members, which is a comprehensive care center with primary care providers.

ACCESS PERFORMANCE MEASURES

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

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

The PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount

of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar size county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of \$7,442. Using PR as an indicator of access for the MHP, Santa Clara demonstrated better access to care than was seen statewide.

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

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	467,115	25,205	5.40%	\$334,741,346	\$13,281
CY 2021	434,609	24,962	5.74%	\$391,245,071	\$15,674
CY 2020	399,155	23,548	5.90%	\$305,430,870	\$12,971

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

- Between CY 2020 and CY 2022, total eligibles and the number of members served trended upward, yielding, on average, a 12.04 percent increase; however, the MHP's overall PR decreased by 8.48 percent during this same time period.
- During the same three-year period, while total approved claims and AACMs initially increased between CY 2020 and CY 2021, both metrics ultimately decreased in CY 2022 below CY 2021 levels.

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

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	37,216	1,430	3.84%	1.50%	1.82%
Ages 6-17	94,482	8,073	8.54%	5.01%	5.65%
Ages 18-20	24,574	1,409	5.73%	3.66%	3.97%
Ages 21-64	239,785	13,092	5.46%	3.73%	4.03%
Ages 65+	71,060	1,201	1.69%	1.64%	1.86%

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

- The MHP served 25,205 members in CY 2022. The largest eligibility group for Santa Clara was adults ages 21-64, followed by youth, ages 6-17. These

categories also represented the age groups with the largest number of members served.

- The PRs in almost all age categories in the MHP exceeded both similar-sized county and statewide rates. The single exception was older adults, ages 65+, where the MHP's PR was comparable to similar-sized counties but slightly lower than what was seen statewide.

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

Threshold Language	# of Members Served	% of Members Served
Spanish	5,977	24.17%
Vietnamese	1,012	4.09%
Farsi	138	0.56%
Mandarin	131	0.53%
Tagalog	74	0.30%
Cantonese	64	0.26%
Members Served in Threshold Languages	7,396	29.91%
Threshold language source: Open Data per BHIN 20-070		

- The MHP had six threshold languages other than English that were identified in CY 2022. Spanish represented the largest of the six language groups that were served, with 24.17 percent of members who received services during this timeframe reporting Spanish as their primary language.

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

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	159,107	7,038	4.42%	\$81,549,306	\$11,587
Large	2,532,274	76,457	3.02%	\$535,657,742	\$7,006
Statewide	4,831,118	164,980	3.41%	\$1,051,087,580	\$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members. This trend was evidenced in the MHP as well.
- At 4.42 percent, the MHP's ACA PR was higher than both similar-sized county and statewide PRs.
- The ACA AACM for Santa Clara is more than 65 percent higher than the similar-sized county average, and almost twice the statewide average.

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

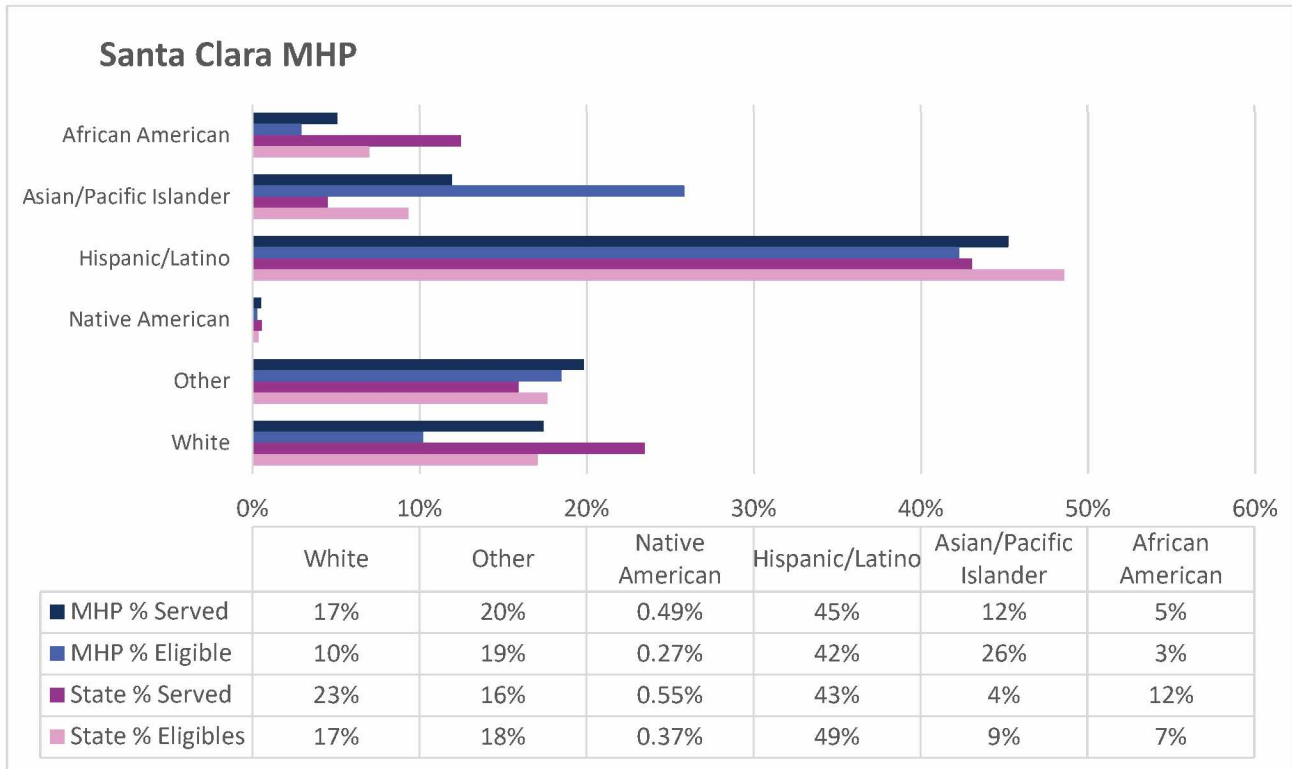
Table 7: Santa Clara MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	13,650	1,283	9.40%	7.08%
Asian/Pacific Islander	120,670	3,008	2.49%	1.91%
Hispanic/Latino	197,483	11,404	5.77%	3.51%
Native American	1,255	123	9.80%	5.94%
Other	86,427	5,002	5.79%	3.57%
White	47,633	4,385	9.21%	5.45%

Note: Total annual eligibles in Table 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- The largest group of eligibles during CY 2022 was Hispanic/Latino, followed by Asian/Pacific Islander. In terms of members served, however, while Hispanic/Latino members constituted the largest group, Other and White represented the next two most frequently served populations.
- PRs for all race/ethnicity categories were higher in Santa Clara than statewide.

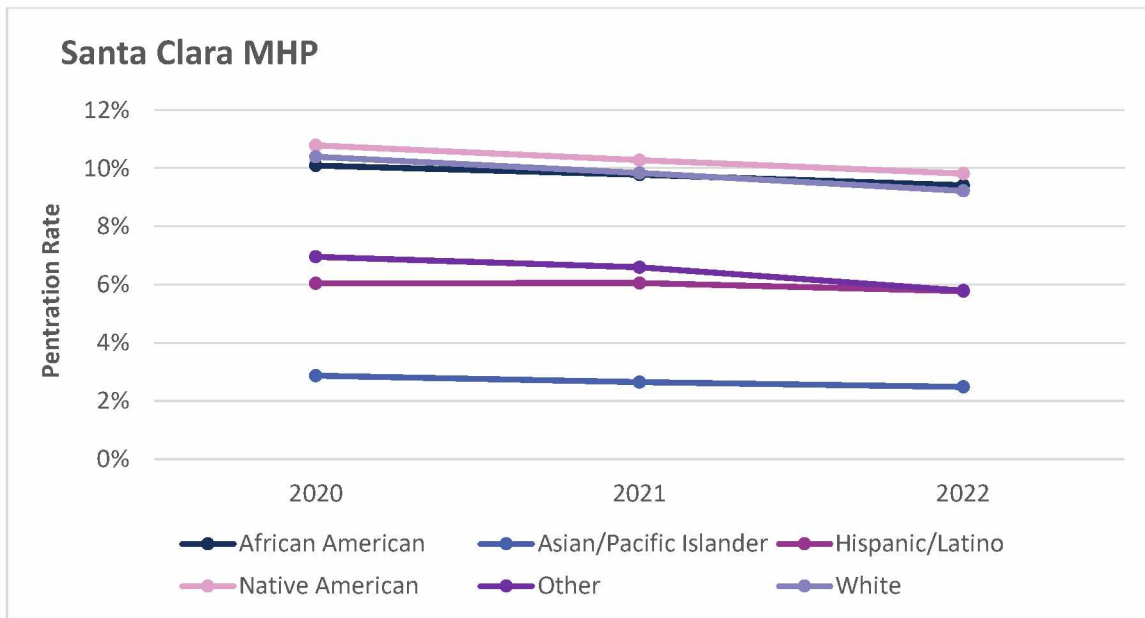
Figure 1: Race/Ethnicity for MHP Compared to State, CY 2022



- Proportionally, the most overrepresented populations of eligibles and members served in the MHP were White and Hispanic/Latino. Conversely, the most underrepresented group of eligibles and members served was Asian/Pacific Islander.

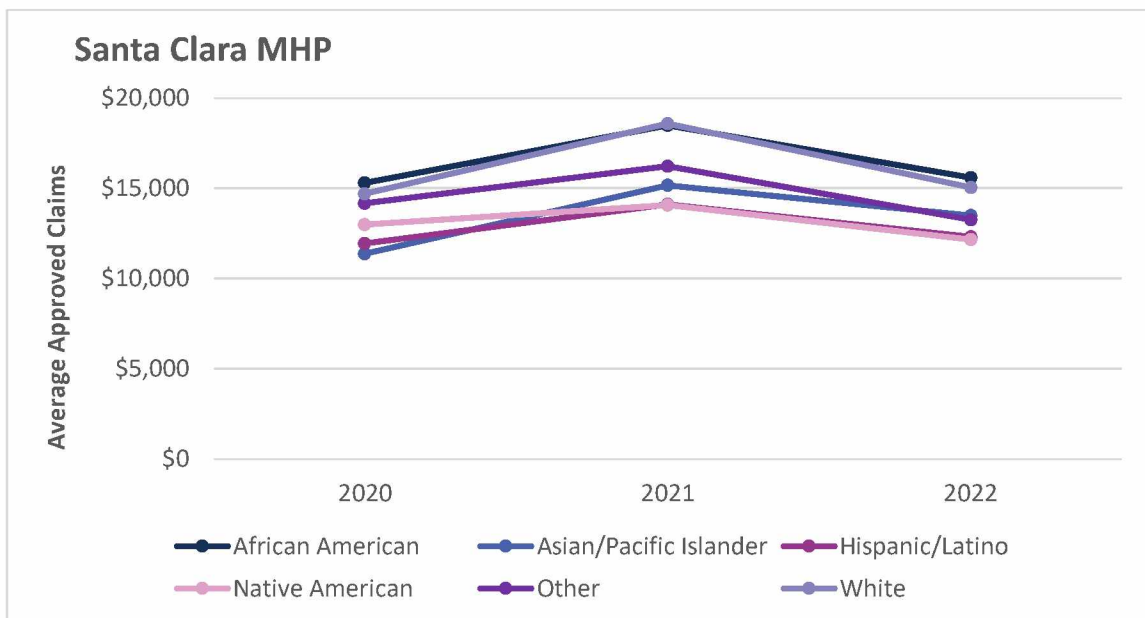
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

Figure 2: MHP PR by Race/Ethnicity, CY 2020-22



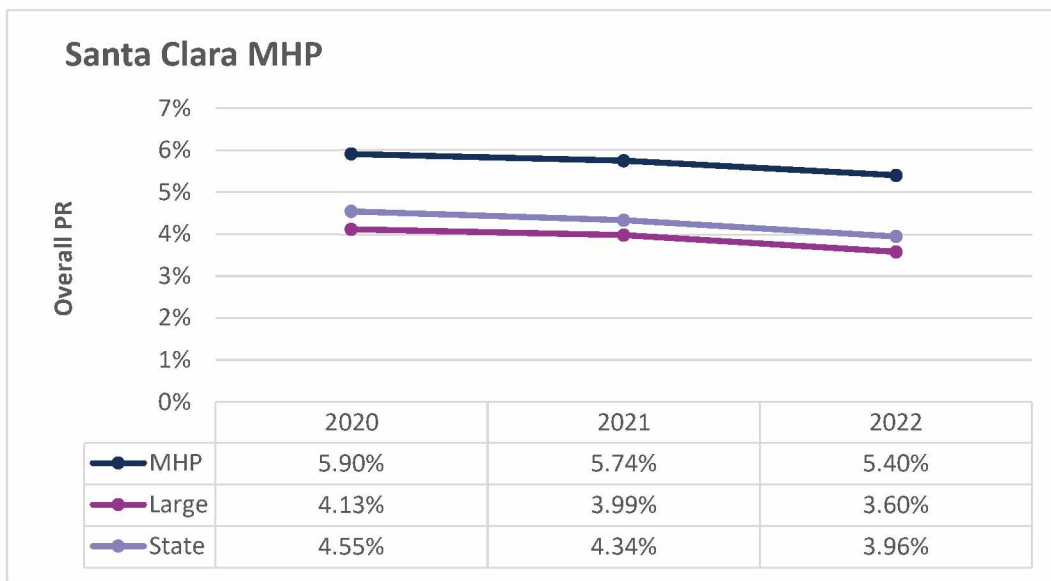
- Over the three-year period, all racial/ethnic group PRs were either flat or trended slightly downward.
- While Native American, White, and African American populations evidenced the highest PRs over time, Asian/Pacific Islanders invariably had the lowest.

Figure 3: MHP AACM by Race/Ethnicity, CY 2020-22



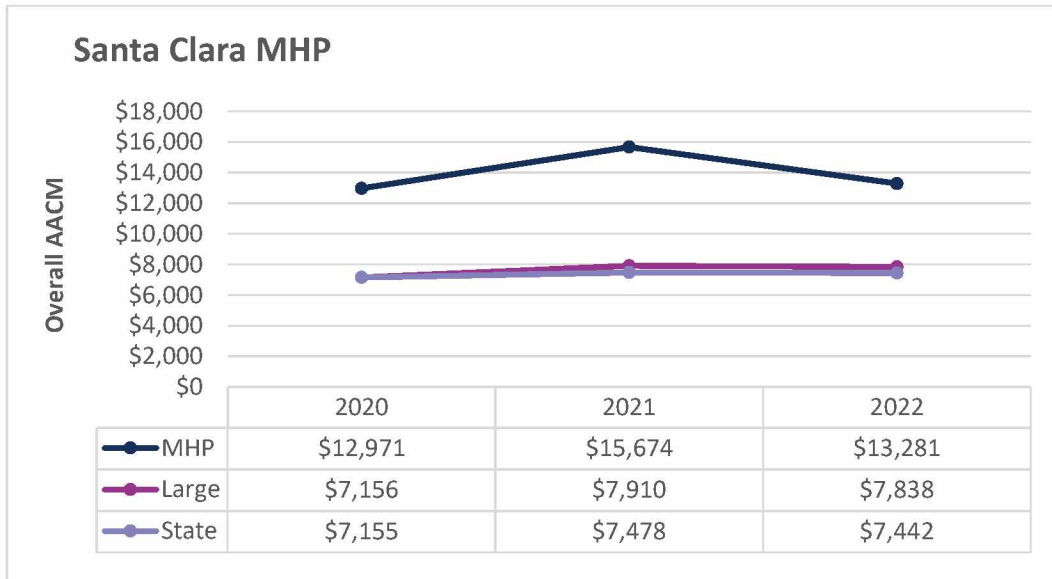
- AACMs for all race/ethnicity groups trended upward between CY 2020 and CY 2021; however, they declined in CY 2022 below CY 2021 levels.
- Even though Asian/Pacific Islander members had the lowest AACM in CY 2020, in CY 2022 this group had the third highest AACM in the MHP, exhibiting, on average, an 11.05 percent increase over the three-year period.
- In CY 2022, the two groups consistently showing the highest AACMs over this three-year period were African American and White. However, while Asian/Pacific Islanders and Hispanic/Latinos had the lowest AACMs in CY 2020, the two populations with the lowest AACMs in the MHP between CY 2021 and CY 2022 were Hispanic/Latino and Native American.

Figure 4: Overall PR CY, 2020-22



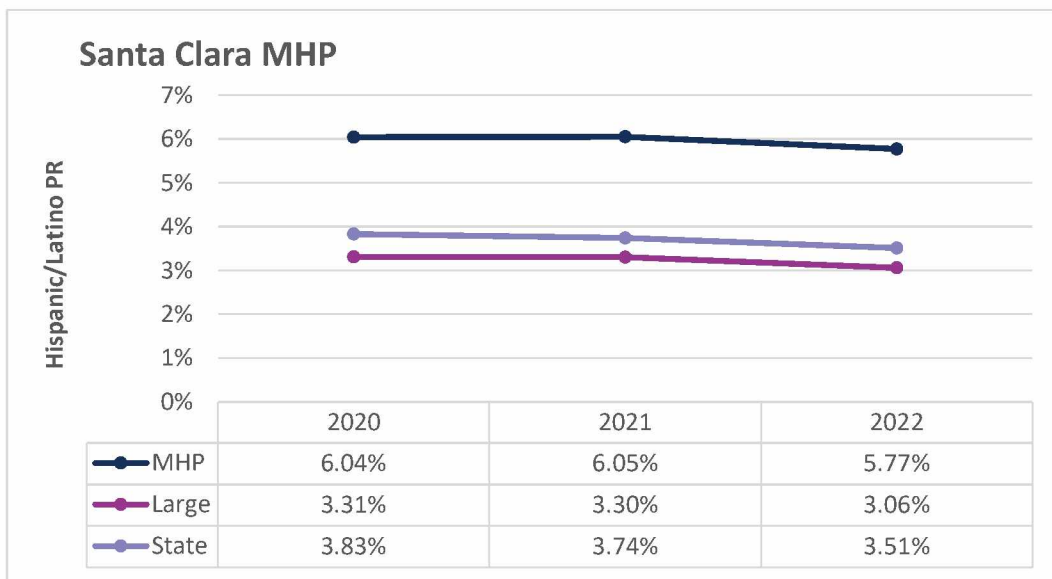
- The overall PRs for all comparative groups trended modestly downward between CY 2020 and CY 2022. Nonetheless, the MHP’s overall PR was consistently higher than what was seen in similar-sized counties or statewide.

Figure 5: Overall AACM, CY 2020-22



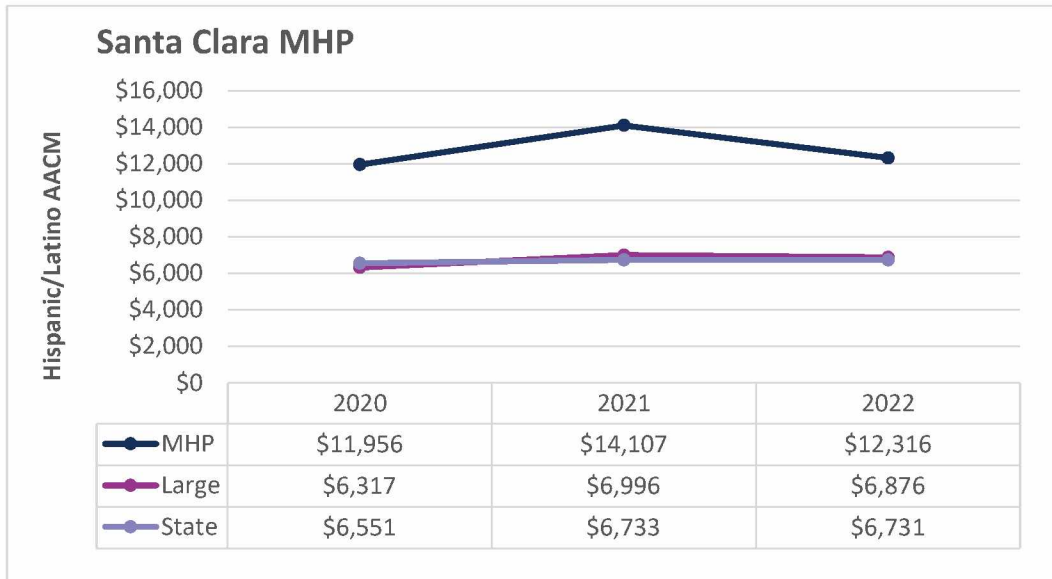
- Although the AACMs for each comparative group trended upward between CY 2020 and CY 2021, they all dropped in CY 2022 below CY 2021 numbers.
- During this same three-year interval, however, the overall AACMs for Santa Clara remained consistently higher than similar-sized counties or statewide.

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



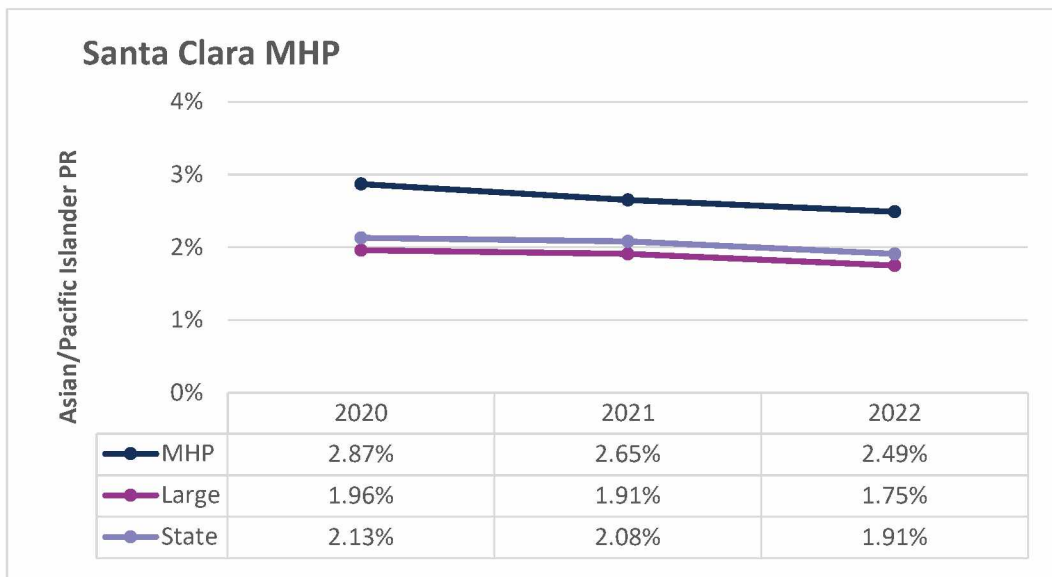
- While the MHP’s Hispanic/Latino PR was consistently higher than rates in either similar-sized counties or statewide over these three CYs, PRs for all groups have been slowly decreasing.

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



- Consistent with the pattern illustrated in Figure 5 relating to overall AACMs, Hispanic/Latino AACMs for both comparative groups initially increased between CY 2020 and CY 2021, and then fell in CY 2022 below CY 2021 levels.
- The AACMs for Santa Clara’s Hispanic/Latino population; however, were notably higher than averages in either similar-sized counties or statewide.

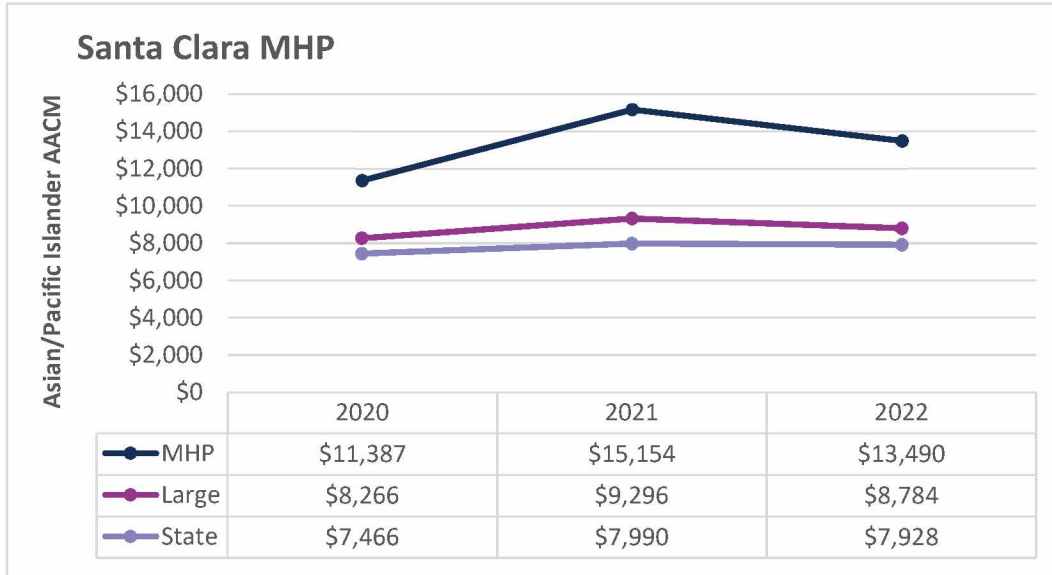
Figure 8: Asian/Pacific Islander PR, CY 2020-22



- Between CY 2020 and CY 2022, the PRs for Asian/Pacific Islander members for all comparative groups showed a modest, yet steady decline.

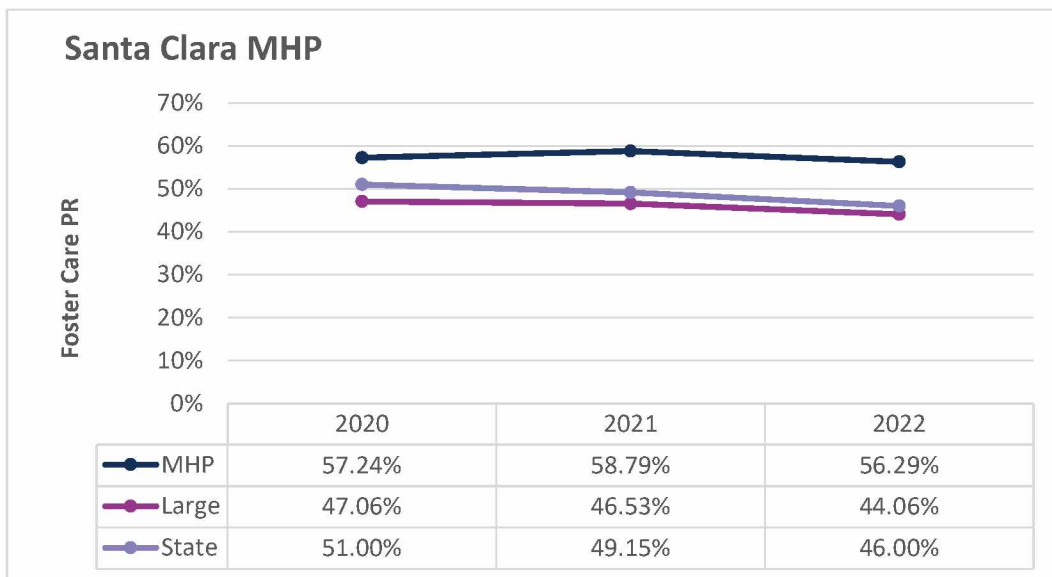
- The MHP’s Asian/Pacific Islander PRs; however, were higher than similar-sized county and statewide levels across all three years.

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



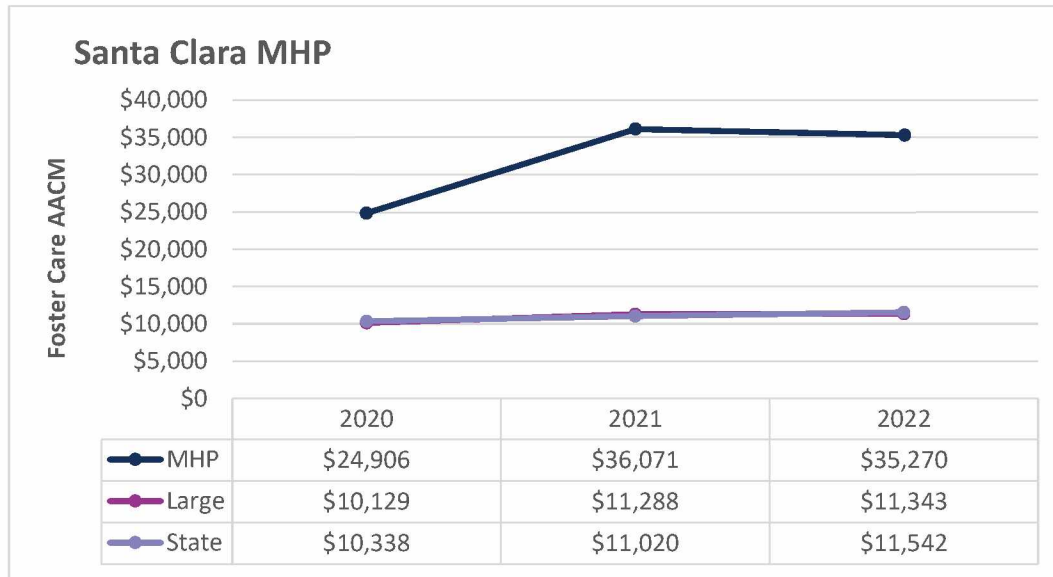
- Although Santa Clara’s AACMs for Asian/Pacific Islander members increased by 33.08 percent between CY 2020 and CY 2021, claims in CY 2022 for this group dropped below CY 2021 levels. Despite this downturn, however, AACMs for Asian/Pacific Islanders in the MHP remained higher than similar-sized counties and statewide.

Figure 10: Foster Care PR, CY 2020-22



- While FC PRs statewide and for similar-sized counties gradually decreased over these three CYs, this same metric in Santa Clara showed a fractional increase between CY 2020 and CY 2021, and by CY 2022, it dropped just below the CY 2020 threshold.
- FC PR in the MHP remained consistently higher than what was seen in either point of comparison.

Figure 11: Foster Care AACM, CY 2020-22



- Although FC AACMs statewide and in similar-sized counties have been trending steadily upward at a modest pace during this period, FC AACMs in the MHP showed almost a 45 percent increase between CY 2020 and CY 2021, before falling in CY 2022 by a little more than \$800 below the CY 2021 level.
- Over all three years, however, Santa Clara's FC AACMs were invariably higher than the numbers associated with the two comparisons.

Units of Service Delivered to Adults and Foster Youth

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

Service Category	MHP N = 15,707				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	420	2.7%	10	7	10.3%	14	8
Inpatient Admin	133	0.8%	63	37	0.4%	26	10
Psychiatric Health Facility	124	0.8%	23	13	1.2%	16	8
Residential	27	0.2%	46	30	0.3%	114	84
Crisis Residential	135	0.9%	21	20	1.9%	23	15
Per Minute Services							
Crisis Stabilization	2,270	14.5%	1,972	1,200	13.4%	1,449	1,200
Crisis Intervention	758	4.8%	143	81	12.2%	236	144
Medication Support	8,969	57.1%	309	210	59.7%	298	190
Mental Health Services	12,059	76.8%	1,145	662	62.7%	832	329
Targeted Case Management	10,420	66.3%	529	201	36.9%	445	135

- Inpatient was the most used per-day service, followed by crisis residential; however, the utilization rate for both service modalities in the MHP were lower than those seen statewide.
- Although the utilization for inpatient administrative days in the MHP was twice the statewide rate (0.8 percent vs. 0.4 percent) and the related average and median units billed were more than twice this comparison as well, overall inpatient utilization (i.e., inpatient, inpatient admin, and psychiatric health facility) in Santa Clara was collectively lower than what was seen statewide (i.e., 4.3 percent vs. 11.9 percent).
- The most frequently used per-minute services in the MHP during CY 2022 were mental health services, targeted case management (TCM), and medication support. While Santa Clara's utilization rate for mental health services was higher than the statewide comparison, its rate for the delivery of medication support services was slightly lower. The MHP also delivered more units of mental health service on average. Additionally, the utilization rate for TCM was 1.8 times higher than the corresponding statewide percentage (i.e., 66.3 percent vs. 36.9 percent) and with more units of service on average.

- The MHP’s utilization rates for crisis intervention services was 39 percent lower than statewide.

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

Service Category	MHP N = 586				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	27	4.6%	8	6	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	0	0.0%	0	0	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	0	0.0%	0	0	0.2%	673	435
Full Day Rehab	0	0.0%	0	0	0.2%	111	84
Per Minute Services							
Crisis Stabilization	32	5.5%	1,412	1,200	3.1%	1,166	1,095
Crisis Intervention	39	6.7%	259	144	8.5%	371	182
Medication Support	182	31.1%	354	255	27.6%	364	257
TBS	49	8.4%	2,670	1,760	3.9%	4,077	2,457
Therapeutic FC	18	3.1%	1,401	1,110	0.1%	911	495
Intensive Care Coordination	280	47.8%	2,122	1,113	40.8%	1,458	441
Intensive Home-Based Services	251	42.8%	3,622	2,227	19.5%	2,440	1,334
Katie-A-Like	0	0.0%	0	0	0.2%	390	158
Mental Health Services	569	97.1%	2,491	1,255	95.4%	1,846	1,053
Targeted Case Management	380	64.8%	987	304	35.8%	307	118

- The per-minute service types with the highest utilization rates among FC youth in Santa Clara were mental health services, targeted case management, and Intensive Care Coordination (ICC). The utilization rates for all three modalities were higher than what was seen statewide.
- Santa Clara’s utilization rate for Intensive Home-Based Services was more than double the statewide rate. Additionally, the average and median units billed for

this service type were higher than the statewide comparisons as well. The rate for the delivery of Therapeutic FC in the MHP was 31 times greater than statewide (3.1 percent vs. 0.1 percent), reflecting the slow implementation of this service statewide.

IMPACT OF ACCESS FINDINGS

- Santa Clara's overall PR has steadily decreased over the last three CYs; however, it has remained higher than both similar-sized counties and statewide rates. Additionally, the PRs relating to all race/ethnicity categories in the MHP were consistently higher than the comparisons as well.
- FC PRs statewide and in similar-sized counties steadily decreased between CY 2020 and CY 2022. Santa Clara's rate, however, increased by 1.55 percentage points in CY 2021 before declining in the next CY by 2.5 percentage points. Nonetheless, irrespective of this variation, the agency's rates were higher across all three years than those associated with the other two points of comparison. Moreover, in CY 2022, the FC AACMs in the MHP were more than twice the averages observed statewide and in similar-sized counties.
- Over the last few years, the two largest populations of eligibles and members served in the MHP were Hispanic/Latinos and Asian/Pacific Islanders. In CY 2022; however, while Hispanic/Latino members constituted 42 percent of total eligibles and 45 percent of members served, Asian/Pacific Islanders represented 26 percent of eligibles and only 12 percent of members served. Santa Clara is aware of the underrepresentation of the latter racial/ethnic group and has endeavored to address it through the implementation of various outreach and engagement strategies, including the creation of one of the nation's first Vietnamese wellness centers. Nevertheless, despite the MHP's vigorous efforts, more work is still required on this front to afford Asian/Pacific Islander members greater access to care.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- 7-day and 30-day post psychiatric inpatient follow-up rates in the MHP have been consistently higher than statewide levels. The MHP is performing well in terms of the process of connecting members to outpatient services following discharges from psychiatric hospitals.

- The MHP evaluates its performance on timeliness metrics routinely for county and contracted providers and has performance improvement activities in place to improve timeliness, including initiation of a peer navigator program.
- Santa Clara’s no-show rates for all categories (i.e., adults, children, FC) are well below the MHP’s 10 percent standard.
- There continues to be an opportunity to further refine the first psychiatry appointment timeliness data with DHCS guidance and ensure complete and consistent reporting by the providers.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of the ATA, representing access to care during the 12-month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care for most metrics, with the exception of urgent services data which reflect County-operated services only.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	12.0 Business Days	10 Business Days*	61%
First Non-Urgent Service Rendered	14.8 Business Days	10 Business Days**	44%
First Non-Urgent Psychiatry Appointment Offered	20.8 Business Days	15 Business Days*	36%
First Non-Urgent Psychiatry Service Rendered	26.3 Business Days	15 Business Days**	21%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required ***	0.40 Hours	48 Hours*	95%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	7.7 Calendar Days	7 Calendar Days	33%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	7.7 Calendar Days	30 Calendar Days	42%
No-Show Rate – Psychiatry	5.6%	10%**	n/a
No-Show Rate – Clinicians	1.54%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033 ** MHP-defined timeliness standards *** The MHP does not offer urgent services that require prior authorization separately.			
For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23			

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

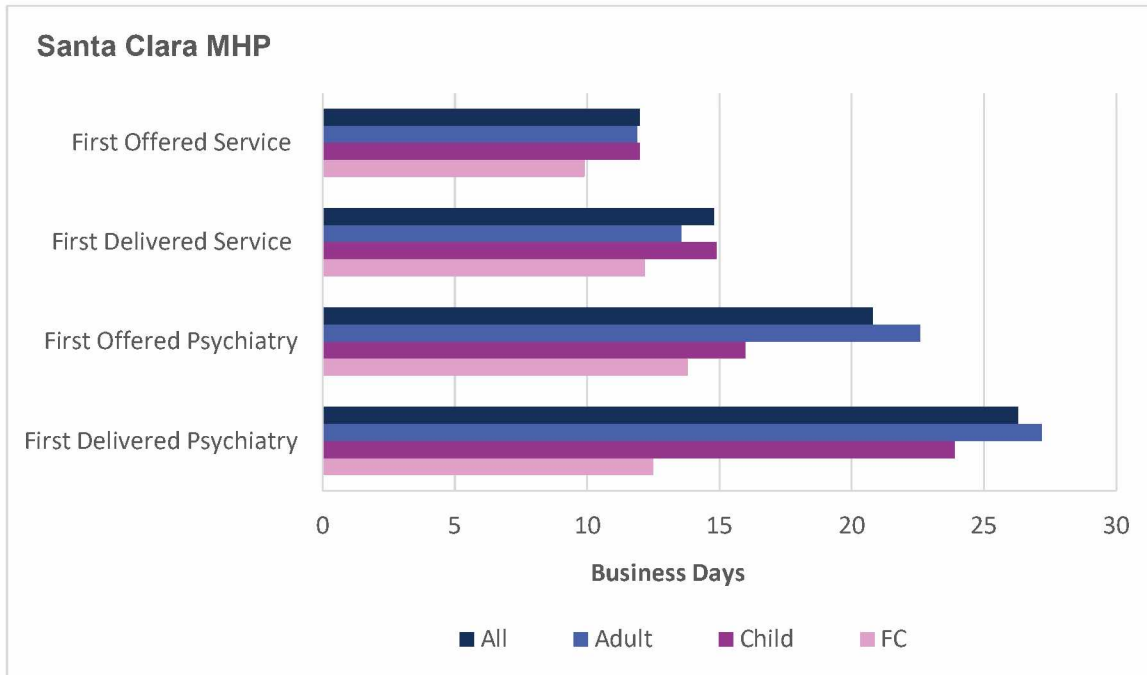


Figure 13: Wait Times for Urgent Services

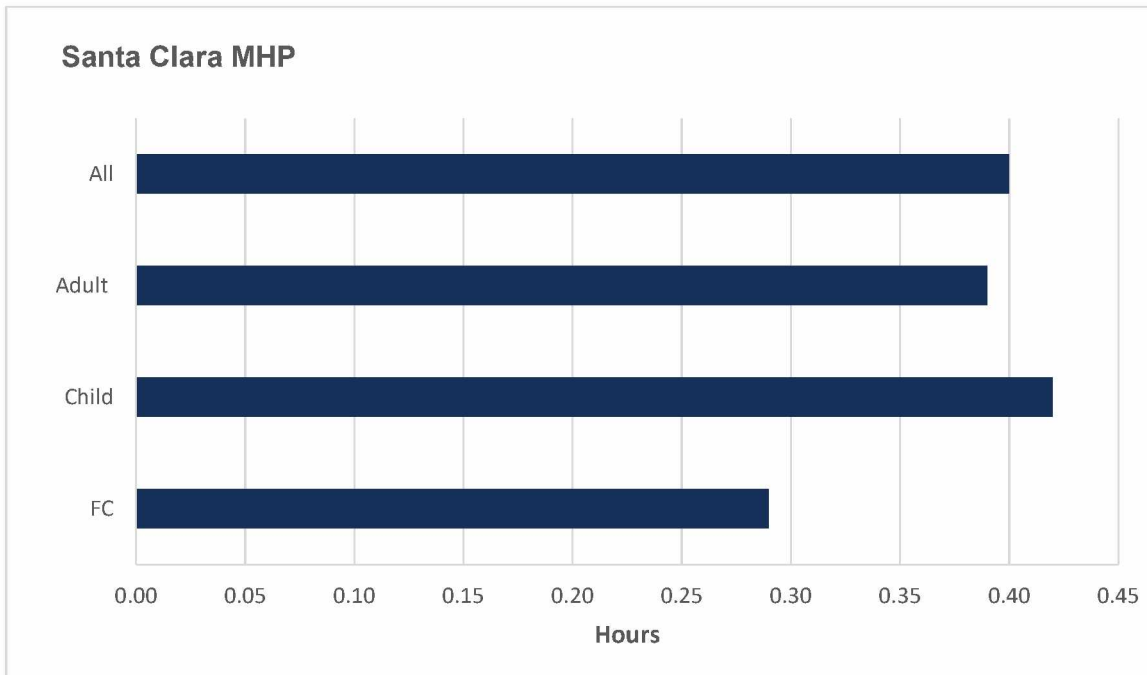
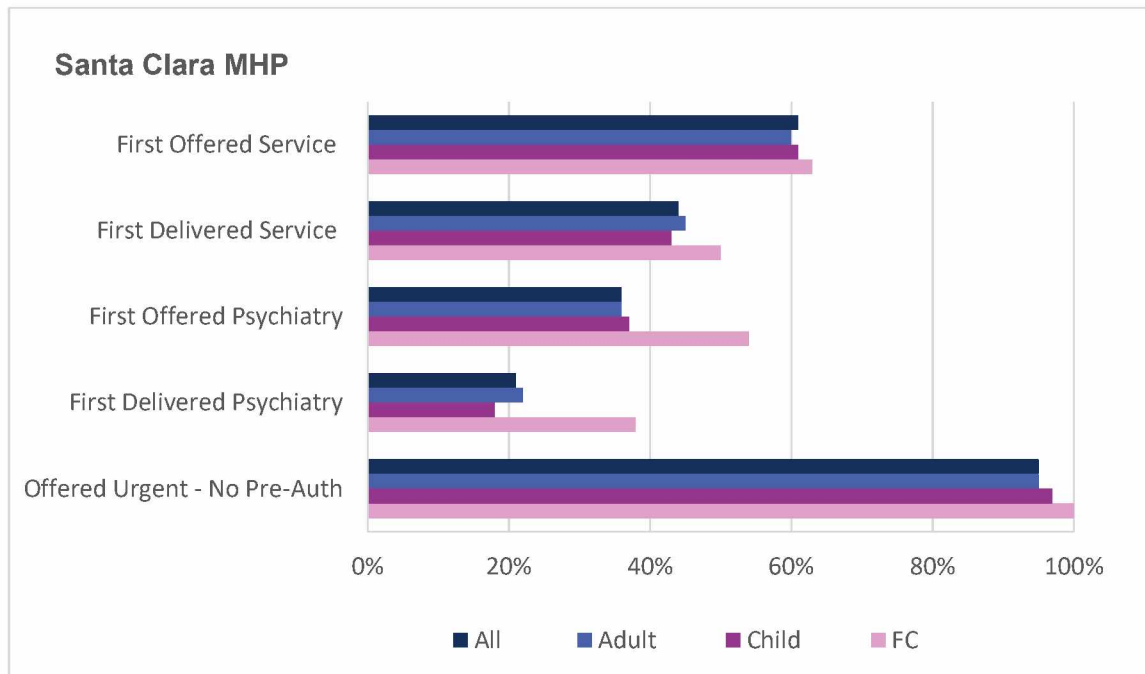


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments.
- The MHP defined “urgent services” for purposes of the ATA as walk-ins to behavioral health urgent care. There were reportedly 4,258 urgent service requests with a reported actual wait time to services for the overall population of 0.4 hours. The MHP does not offer urgent services that require pre-authorization separately.
- The MHP defines timeliness to first delivered/rendered psychiatry services as the time from the initial request for psychiatry services to the point of the first attended appointment. This operational definition applies to youth and adult members throughout the entire system of care.
- The MHP tracks and monitors data for no-shows. The MHP reports a no-show rate of 5.6 percent for psychiatrists and 1.54 percent for non-psychiatry clinical staff, which are both lower than the MHP’s standard of 10 percent in each category.

IMPACT OF TIMELINESS FINDINGS

- Santa Clara reported that members can arrive for appointments up to 15 minutes late and still be worked into the schedule, which may contribute to lower no-show rates.

- The MHP provides urgent services well within the 48-hour standard. Members are provided with urgent services on a walk-in basis at a behavioral health urgent care site, including screening, assessment, crisis intervention, referral, and short-term treatment.
- FC results performed better in all categories for the percent of services that met timeliness standards. The MHP partners with family and children's services to ensure that children are screened and linked to appropriate services. They have monthly meetings to support communication and collaboration.
- There is room for improvement in the timeliness of the first non-urgent service and first psychiatry service. Santa Clara attributed the lack of staff as contributing to the current rates and has initiated several staff recruitment and retention initiatives. Additionally, to facilitate faster credentialing, the MHP contracted with Valley Health Plan to credential providers for provisional status in 14 days.

QUALITY OF CARE

CMS defines quality as the degree to which the PIHP increases the likelihood of desired outcomes of the members through its structure and operational characteristics, the provision of services that are consistent with current professional, evidenced-based knowledge, and the intervention for performance improvement.

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is located within the Quality Management (QM) division of its managed care services. Additionally, there is an analytics and reporting division which is responsible for the development and production of various monitoring tools and data dashboards. The MHP monitors its quality processes through the Quality Improvement Committee (BHQIC), the QAPI workplan, and the annual evaluation of the QAPI workplan. The BHQIC, comprised of the executive team members, systems of care managers, contract providers, QM and QI staff, peers, and community representatives. It is scheduled to meet quarterly, and since the previous EQR, the BHQIC met four times. Of the 28 identified FY 2022-23 QAPI workplan goals, the MHP met 21 percent of them.

At present, the MHP does not use standardized LOC tools for youth or adult members. However, Santa Clara plans to modify the Child and Adolescent Needs and Strengths (CANS) instrument to function as an effectual LOC tool for youth. Additionally, the MHP intends to obtain and adapt the Adult Needs and Strengths Assessment (ANSA) to address this need for adults. More specifically, Santa Clara is collaborating with contract providers and the University of Kentucky to develop algorithms that will be used in concert with each of these measures to translate CANS and ANSA scores into precise LOC recommendations for youth and adult members. Once the algorithms are developed, both the CANS and ANSA will be modeled into Avatar to promote centralized access to these tools for end users. Reports will be crafted and made available in the system to support this process. The MHP indicated that the prospective date for bringing this plan to fruition is CY 2024.

The MHP utilizes the following outcomes tools: CANS and the Pediatric Symptom Checklist-35 (PSC-35).

The MHP utilizes the CANS as a functional assessment tool to identify actionable needs and important strengths that help to shape and inform the services that are delivered to children and youth members. The PSC-35 is employed as a vehicle to capture caregiver and parent insight on psychosocial questions for members ages 3 through 18. During treatment, these measures are administered at intake, every six months thereafter, and

at discharge. CANS and PSC-35 output are rigorously analyzed to evaluate member progress based on comparing scores over time and, along with clinical judgment, collectively produce a framework within which LOC determinations are rendered and treatment planning is guided and directed. One of the objectives of the MHP is to become a data-driven agency. In that connection, it generates myriad reports for these instruments that place an emphasis on the member, provider, and program levels. Moreover, the Research and Outcome Management team, which is subsumed under the MHP’s IT department, incorporates data from these measures into its semi-annually produced “180 Scan” report that provides end users with a macro-level analysis of the MHP’s performance in three strategic areas: access, equity, and agency-level outcomes.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- Santa Clara has robust data analytics and uses data for QI.
- The MHP has a comprehensive medication monitoring program and uses a multi-disciplinary team approach to ensure coordination of care.
- Santa Clara does not currently utilize LOC tools for youth and adults; however, has a plan in place to develop tools and process with the University of Kentucky.
- Santa Clara has adopted the ANSA as the outcome tool for adults; however, it is not being used yet.
- The MHP has a formal process to regularly communicate with stakeholders; however, Santa Clara should ensure that they are aware of avenues to provide input and receive support.
- The MHP has peer support staff and peer run programs; however, the program could benefit by having a more formal process to notify members of opportunities and a defined career ladder for advancement.
- The MHP tracks and trends the HEDIS measures as required by WIC Section 14717.5.

QUALITY PERFORMANCE MEASURES

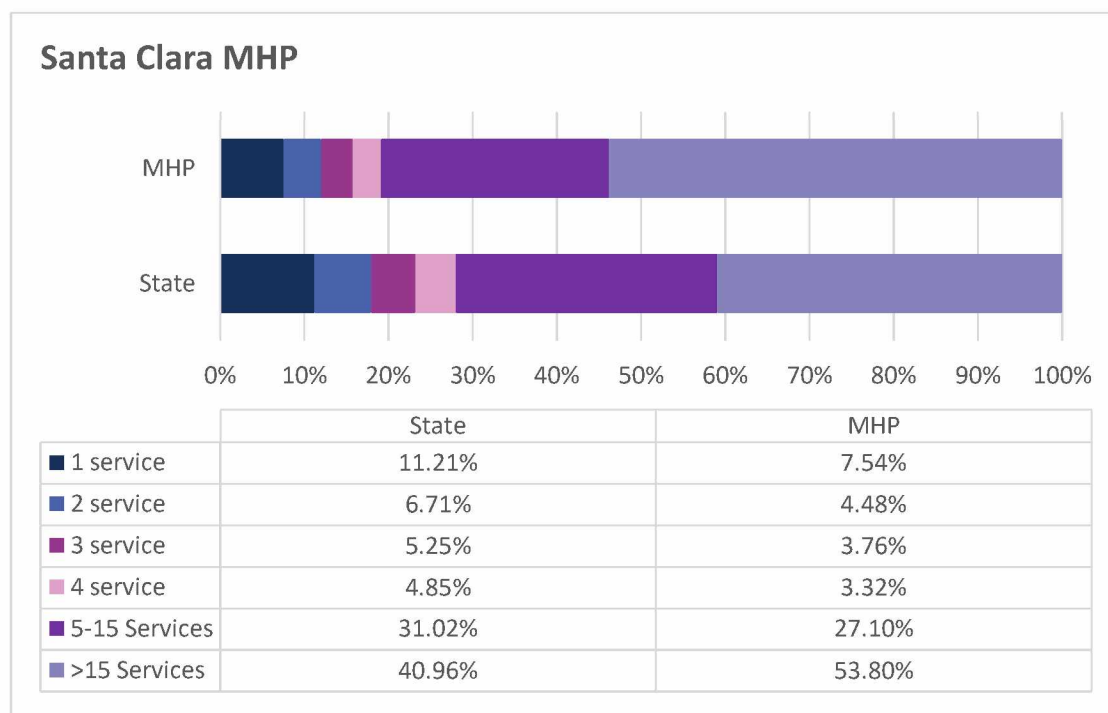
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

Retention in services is an important measure of member engagement in order to receive appropriate care and intended outcomes. One would expect most members served by the MHP to require five or more services during a 12-month period. However, this table does not account for the length of stay (LOS), as individuals enter and exit care throughout the 12-month period. Additionally, it does not distinguish between types of services.

Figure 15: Retention of Members Served, CY 2022

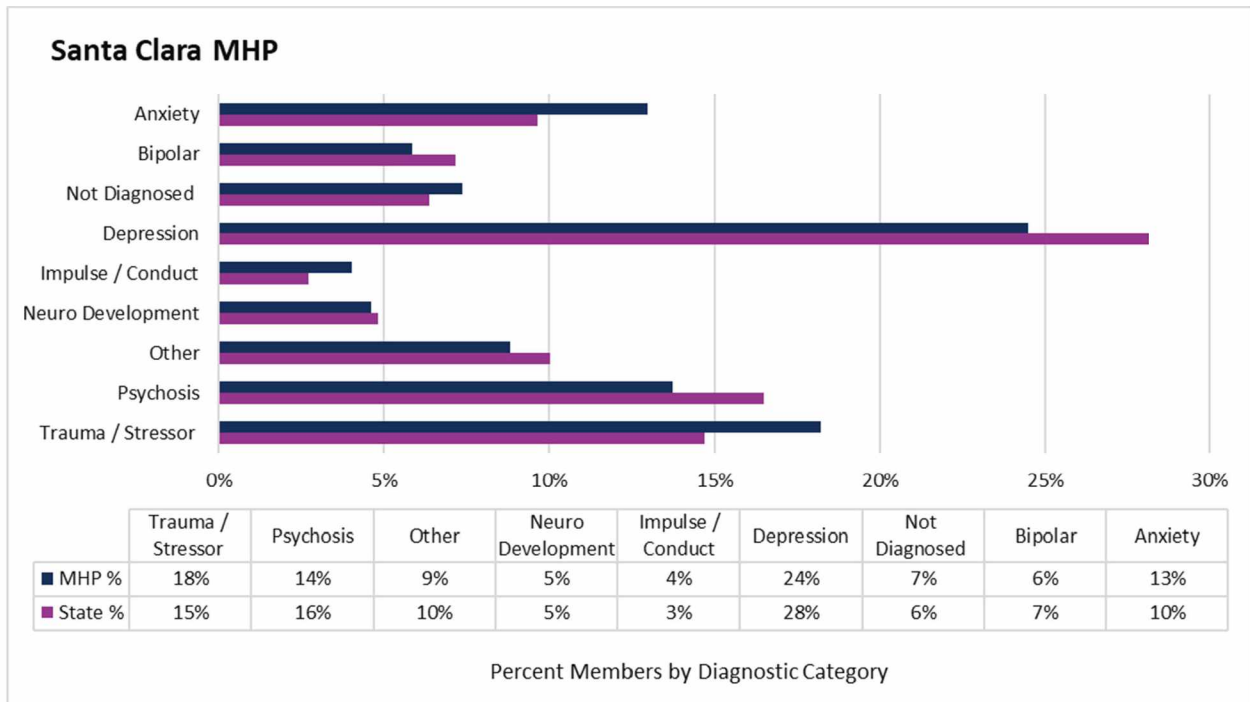


- In CY 2022, the MHP delivered five or more services to 80 percent of its members as compared to 72 percent statewide.
- The percentage of members who received between two and four services was collectively lower in the MHP than statewide (11.56 percent vs. 16.81 percent); however, the percentage of members statewide who received one service was almost 1.5 times the MHP rate (i.e., 11.21 percent vs. 7.54 percent).
- Although at first glance it appears that the MHP is performing well with respect to promoting the retention of members, it may also be possible that some of these individuals should have been transitioned to lower LOCs. In essence, the lengthy stays related to a preponderance of its members suggests an opportunity for the MHP to investigate, identify, and perhaps address the primary factors that are contributing to this situation.

Diagnosis of Members Served

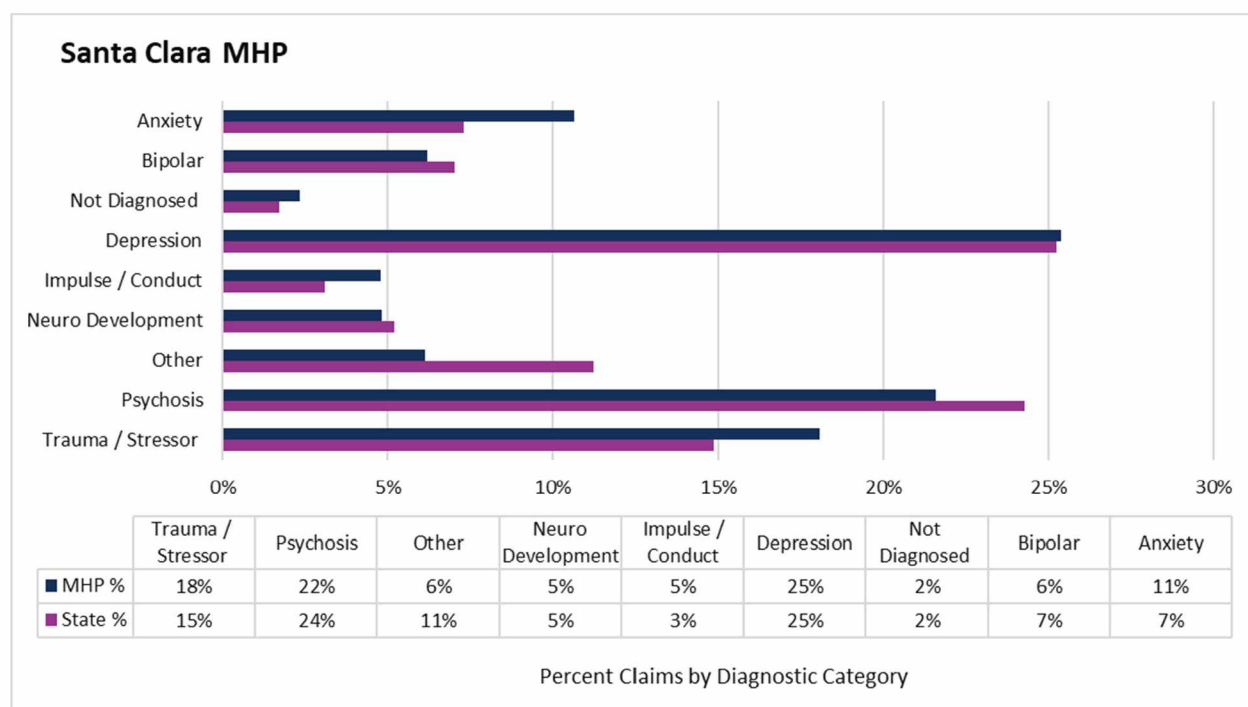
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP’s claims for treatment. Figure 16 shows the percentage of MHP members in a diagnostic category compared to statewide. This is not an unduplicated count as a member may have claims submitted with different diagnoses crossing categories. Figure 17 shows the percentage of approved claims by diagnostic category compared to statewide; an analysis of both figures follows.

Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



- The most prevalent diagnostic category in the MHP – as well as statewide – was depression, followed by trauma/stressor, and psychosis. More than half of all submitted claims were attributed to these three diagnostic categories. Furthermore, the distribution of diagnostic rates between the MHP and statewide across all categories was relatively comparable.

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



- In general, there was proportionality between claims and diagnostic rates, with the most conspicuous exception being psychosis, which accounted for 14 percent of diagnoses and 22 percent of claims. This incongruity may be attributed in part to the probability that members who receive this diagnosis likely require higher LOCs.

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2020-22) of MHP psychiatric inpatient utilization including member count, admission count, approved claims, and average LOS. CalEQRO has reviewed previous methodologies and programming and updated them for improved accuracy. Discrepancies between this year's PMs and prior year PMs are a result of these improvements.

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

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	877	1,088	1.24	16.27	8.45	\$24,906	\$12,763	\$21,842,966
CY 2021	985	1,360	1.38	14.46	8.86	\$22,831	\$12,696	\$22,488,666
CY 2020	914	1,281	1.40	12.33	8.68	\$21,834	\$11,814	\$19,956,165

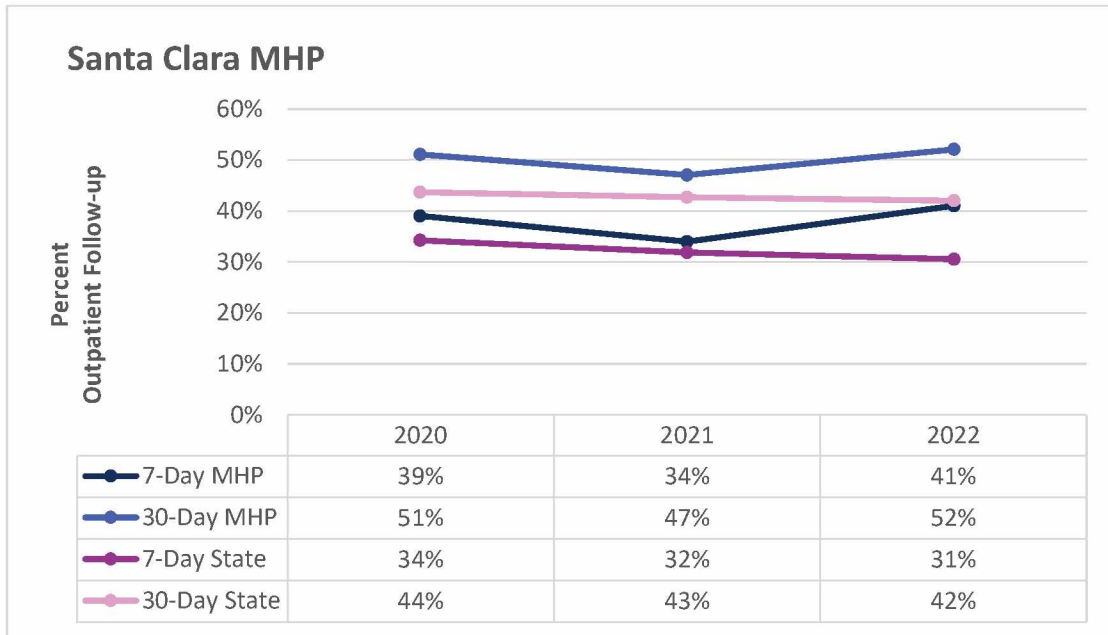
- Between CY 2020 and CY 2021, there was a slight increase in total inpatient admissions and the unique count of members served who received inpatient treatment; yet, from CY 2021 to CY 2022, both these numbers decreased below CY 2020 levels. Similar to this pattern, total approved claims in the MHP modestly increased between CY 2020 and CY 2021, but subsequently fell in CY 2022 below the CY 2021 threshold. Average admissions per member, however, steadily declined during this period.
- The MHP's average LOS in days and inpatient AACMs not only increased, respectively, by 31.95 percent and 14.07 over this three-year timeframe, but also these two metrics were consistently higher than what was seen statewide.

Follow-Up Post Hospital Discharge and Readmission Rates

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2022 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained MH professionals is critically important.

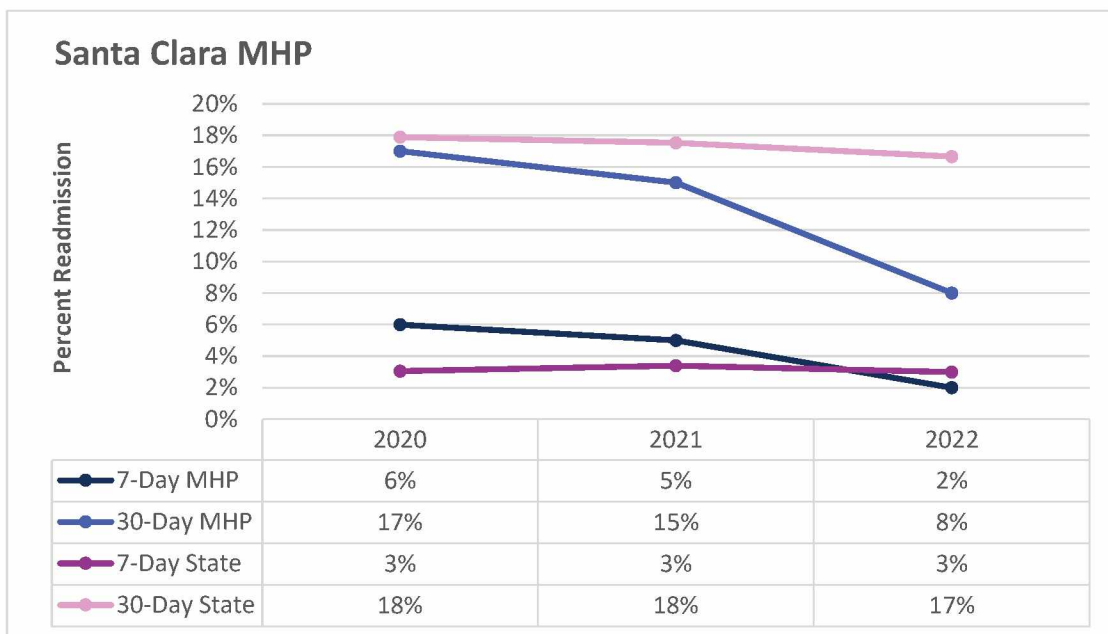
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the member outcomes and is reflected in the rate to which individuals are readmitted to psychiatric facilities within 30 days of an inpatient discharge. Figures 18 and 19 display the data, followed by an analysis. As described with Table 13, the data reflected in Figures 18-19 are updated to reflect the current methodology.

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



- The MHP’s 7-day and 30-day post psychiatric inpatient follow-up rates were consistently higher than statewide. Furthermore, although the proportion of members in the MHP who received an outpatient service following an inpatient stay decreased in both windows of time between CY 2020 and CY 2021, they ultimately increased in CY 2022 above CY 2020 levels.

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



- The MHP’s 30-day psychiatric readmission rates were invariably lower than statewide. The rates for readmission within 7-days, conversely, were higher in Santa Clara than statewide in CY 2020 and CY 2021. This dynamic, however, changed in CY 2022 when the percentage of members in the MHP who experienced a psychiatric readmission within 7-days fell below the statewide rate.
- While the statewide percentages for these metrics have been rather invariant over this three-year period, the MHP’s 7-day and 30-day psychiatric readmission rates have been steadily trending downward. More specifically, during this timeframe the MHP’s 7-day and 30-day psychiatric readmission rates decreased, respectively, by 66.67 percent and 52.94 percent. This performance suggests that Santa Clara’s efforts toward decreasing overall readmissions to psychiatric facilities are yielding dividends.

High-Cost Members

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

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with approved claims of more than \$30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is \$7,442, the median amount is just \$3,200.

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

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

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	\$1,514,353,866	\$55,518	\$44,346
MHP	CY 2022	2,394	9.50%	41.47%	\$138,802,189	\$57,979	\$43,954
	CY 2021	3,079	12.33%	48.32%	\$189,035,682	\$61,395	\$45,850
	CY 2020	2,227	9.46%	43.72%	\$133,540,270	\$59,964	\$45,606

- Compared to CY 2020, the count and percentage of HCMs and the proportion of total claims billed for services provided to them increased; however, between CY 2021 and CY 2022 each of these variables decreased. Despite these changes, the proportion of members considered HCMs as well as the percentage of claims that were related to the services received were higher in the MHP than statewide (HCM percentage of members served: 9.50 percent vs. 4.54 percent; HCM percentage of total claims: 41.47 percent vs. 33.86 percent).
- With some minor variations, total, average, and median approved claims for HCMs generally followed this pattern over the past three years. Consequently, while AACMs for these members were almost \$2,500 higher in Santa Clara than statewide in CY 2022, median approved claims were marginally lower.
- In CY 2022, although HCMs represented 9.50 percent of all Medi-Cal individuals who were served in the MHP, the services delivered to this group produced 41.47 percent of total claims.

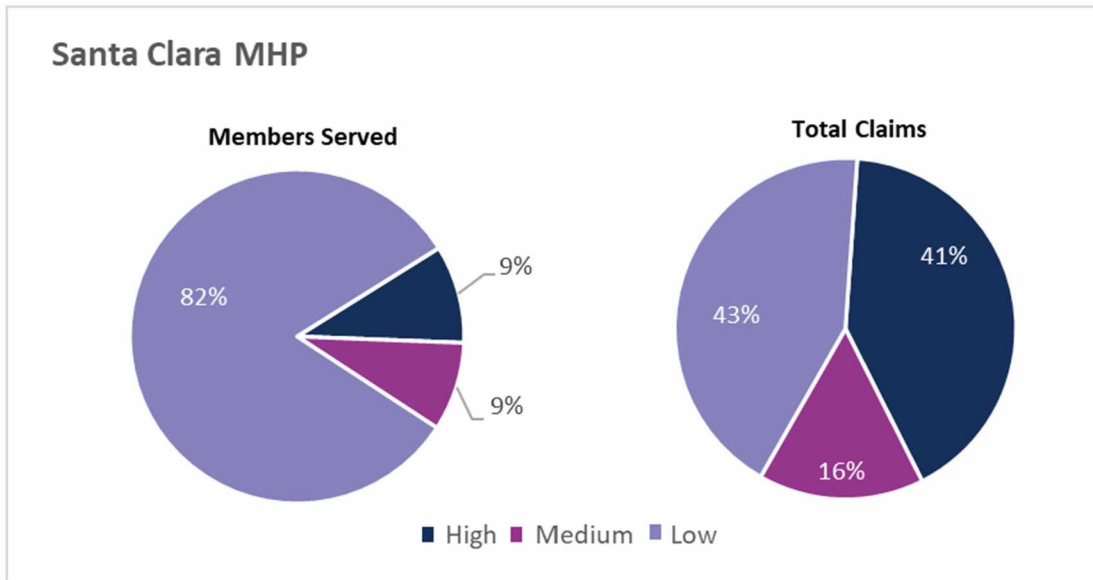
Table 15: Santa Clara MHP Medium- and Low-Cost Members, CY 2022

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost (\$20K to \$30K)	2,168	8.60%	15.70%	\$52,554,275	\$24,241	\$23,920
Low-Cost (Less than \$20K)	20,643	81.90%	42.83%	\$143,384,882	\$6,946	\$5,751

- About 82 percent of the Medi-Cal individuals receiving services in the MHP were identified as low-cost members. Median approved claims per member for this group was \$5,751, while the percentage of total claims that their services produced was almost 43 percent.

- At 8.60 percent, the MHP’s proportion of medium-cost members was slightly below its proportion of HCMs (9.50 percent). Additionally, median approved claims per member for this group was \$23,920, and the percentage of total claims that they generated was 15.70 percent.

Figure 20: Santa Clara MHP Members and Approved Claims by Claim Category, CY 2022



- Roughly 82 percent of members served were subsumed in the low-cost category which represented about 43 percent of all claims. Whereas over 9 percent of members were identified as HCMs and represented 41 percent of total claims.

IMPACT OF QUALITY FINDINGS

- CY 2022 PM data illustrated that the percentage of members who received five or more services were retained in the system of care at a higher rate in Santa Clara than statewide (80.90 percent vs. 71.98 percent). Although this observation suggests that the MHP is performing well in terms of promoting member engagement in services, it also poses an opportunity for the agency to explore the reasons for the protracted stays of these members and determine if further strategies are required to transition some of them to lower LOCs, or the mild/moderate system of care.
- Between CY 2021 and CY 2022, the percentage of members served identified as HCMs, as well the proportion of claims generated for their services, decreased; however, both numbers in the MHP were still higher than was seen statewide (HCMs: 9.50 percent vs 4.54 percent; Claims: 41.47 percent vs. 33.86 percent). The fact that Santa Clara has maintained such a large representation of HCMs

may be one of the variables that is contributing to the reality that the MHP's overall AACMs for the last few years have been more than 40 percent higher than the averages related to similar-sized counties or statewide.

- Over the last three CYs, while the 7-day and 30-day psychiatric readmission rates statewide have been rather flat and invariant, the MHP's rates for this metric have been trending steadily downward. Although Santa Clara's 30-day readmission rate has been consistently lower than the statewide comparison, its 7-day rate fell below state levels as well in CY 2022 (2 percent vs. 3 percent). This pattern suggests that the agency is improving in terms of tracking member inpatient care to reduce and avoid unnecessary readmissions to psychiatric hospitals.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330² and 457.1240(b)³. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: FUM Behavioral Health Quality Improvement Program

Date Started: 09/2022

Aim Statement: "By June 30, 2024, through the outreach efforts of Peer Navigators, 61 percent of members discharged from the emergency room with an identified mental health diagnosis will be open to outpatient services (an increase from the current baseline of 48 percent)."

Target Population: Members discharged from the emergency room with a noted behavioral health diagnosis.

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

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

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

Summary

Santa Clara reported that the MHP exceeded state and national benchmarks for FUM prior to implementation of the PIP. Additionally, their data revealed disparities across some populations, e.g., Hispanic, Black/African American, and Spanish-speaking. The MHP's goal is to increase access for all ethnicities and engage members in services. Santa Clara planned and facilitated a consumer/family member group to solicit input on the interventions. Overall, participants indicated that peer navigators are critical in guiding patients during the transition from the ED to outpatient programs.

The PIP includes member-focused interventions: informational materials (i.e., flyers) about mental health including referral contact information in threshold languages and a peer navigator program. The MHP started both interventions in August 2023. The PIP did not yet report post-intervention data.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence due to needing additional documentation to better describe the design and implementation.

BHC provided PIP TA before the review at the request of the MHP to discuss the annual PIP submissions.

CalEQRO recommendations for improvement of this clinical PIP:

- Ensure the PIP includes a PM that aligns with the aim.
- Provide a complete description of the data collection process for the PIP PMs.
- Consider including in the aim/measuring members who received follow-up within 7 and 30 days.
- Track how many member flyers are distributed.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Improving the 24/7 Access Call Line Efficiency

Date Started: 05/2022

Date Completed: 03/2023

Aim Statement: "Will the implementation of a new system method/procedure with supervision oversight improve information accuracy provided to members from 43 percent to 65 percent within the first year of this PIP? Then the PIP's goal continues

to increase from 65 percent to 80 percent for the second year? But also decrease the member's current average wait time from 43 minutes to 30 minutes per call."

Target Population: Any members and/or representative on behalf of the member who call the MHP's 24-hours a day, 7-days a week, toll-free Access Line, which has the potential of helping all members that could potentially access the services provided by the MHP. Age, diagnosis, ethnicity, race, length of enrollment, etc., were not a factor in this study; instead, it focused on everyone who calls the call center requesting services regardless of whether the call results in a referral.

Status of PIP: The MHP's non-clinical PIP provided a second remeasurement and is completed.

Summary

Call center staff reported that responding to incoming calls was often hampered by procedural steps including a fragmented data entry process that resulted in longer than necessary wait times for callers. Test calls showed that not all calls were answered, and if answered, were not always logged. The MHP developed a manual with step-by-step instructions, simplified the call logging process, and trained the access call center staff in the new procedure, with regular monitoring of the operation.

Interventions were implemented in May 2022 and July 2022. The MHP reduced the average number of abandoned calls and the wait time for members when calling the call center.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence. The first PM (i.e., accuracy of test calls logged when members contact the call center) demonstrated a decline for the second remeasurement, and the result was below the baseline.

BHC provided PIP TA before the review at the request of the MHP to discuss the annual PIP submissions.

CalEQRO recommendations for improvement of this non-clinical PIP:

- Examine the decline in performance for the first PM and make any needed adjustments to ensure continued improvement in the results.
- Ensure that factors that impact the validity of the findings are addressed as much as possible to minimize impact on the results.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Netsmart Technologies, Inc./Avatar, which has been in use for five years. Currently, the MHP has a new system in place that was installed within the past five years where the MHP must dedicate staff and resources to implement all components of the EHR.

Approximately 1.27 percent of the MHP budget is dedicated to support the IS (county IT overhead for operations, hardware, network, software licenses, ASP support, contractors, and IT staff salary/benefit costs). The budget determination process for IS operations is a combined process involving MHP control and another county department or agency (i.e., Technology Services and Solutions unit with County IS).

The MHP has 4,544 named users with log-on authority to the EHR, including approximately 416 county staff and 4,128 contractor staff. Support for the users is provided by 12 full-time equivalent (FTE) IS technology positions. Currently, there are two vacant positions (i.e., one Data Analyst, and one IT Business Analyst) for which the MHP is actively recruiting.

As of the FY 2023-24 EQR, while some contract providers have access to directly enter clinical data into the MHP's EHR, these agencies do maintain their own EHR systems to capture members' clinical data related to such things as progress notes, treatment plans, and problem lists. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to Santa Clara MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	<input type="checkbox"/> Real Time <input type="checkbox"/> Batch	%
Electronic Data Interchange to MHP IS	<input checked="" type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	37%
Electronic batch file transfer to MHP IS	<input type="checkbox"/> Daily <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly	33%
Direct data entry into MHP IS by provider staff	<input checked="" type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	30%
Documents/files e-mailed or faxed to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	%
Paper documents delivered to MHP IS	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members’ and their families’ engagement and participation in treatment. The MHP does not have a PHR; however, the agency plans to implement this functionality within the next two years.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and/or electronic consult. The MHP engages in electronic exchange of information with contract providers, Federally Qualified Health Centers, primary care providers, and Indian health centers.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- One of Santa Clara’s objectives is to become a data-driven agency. Toward that end, the MHP IT department has two teams (i.e., Research and Outcomes Management, and Analytics and Reporting), comprising 32 analysts that are dedicated to identifying and addressing the data-analytics needs of the agency. These teams are not only responsible for designing and crafting individual Crystal Reports that are loaded into Avatar and made available to end users to display information that has been captured in the EHR, but also assess and translate outcome and service-related data into reports that focus on the areas of access, equity, timeliness, and outcomes. These reports are then disseminated to clinical and QI staff, program managers, and executive leadership to promote the making of data-informed decisions regarding the system of care.
- The MHP’s overall denied claims rate of 8.35 percent was 2.43 percentage points higher than the statewide denial rate. Consequently, a rating of “Partially Met” was assigned to IS Infrastructure Key Component 4C relating to Integrity of Medi-Cal Claims Process.
- The MHP does not have an agency-specific operational continuity plan that it uses, reviews, or tests. Instead, it relies on the broad framework set forth in the Major Incident Management Process document, created by the TSS unit within Santa Clara’s countywide IS department, to inform decisions regarding the management of critical business functions in the event of a cyberattack, disaster, or another emergency. As a result, a rating of “Partially Met” was assigned to the IS Infrastructure Key Component 4E relating to Security and Controls.
- In terms of interoperability, Santa Clara is not a member of an HIE. The agency is, however, preparing to join the CareQuality system to engage in the electronic exchange of data with other network partners. The MHP indicated that the contract with this HIE organization should be signed and executed within the first few months of CY 2024. Furthermore, contract providers for the MHP do not have the ability to directly enter clinical data (e.g., progress notes, treatment plans, and problem lists) into Avatar; however, they can directly enter claims data, some demographics, and admission and discharge dates for a limited

number of programs. As a result, a rating of “Partially Met” was assigned to the IS Infrastructure Key Component 4F relating to Interoperability.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

The timing of Medi-Cal claiming is shown in Table 18, including whether the claims are either approved or denied. This may also indicate if the MHP is behind in submitting its claims, which would result in the claims data presented in this report being incomplete for CY 2022.

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	58,735	\$27,670,433	\$2,031,410	7.34%	\$25,639,023
Feb	63,690	\$30,897,496	\$3,128,446	10.13%	\$27,769,050
Mar	75,775	\$36,681,323	\$3,276,460	8.93%	\$33,404,863
April	66,510	\$32,453,881	\$2,543,581	7.84%	\$29,910,300
May	64,608	\$31,796,055	\$2,651,833	8.34%	\$29,144,222
June	63,395	\$30,850,024	\$2,722,904	8.83%	\$28,127,120
July	54,003	\$25,870,370	\$1,391,457	5.38%	\$24,478,913
Aug	65,930	\$31,022,337	\$2,420,861	7.80%	\$28,601,476
Sept	67,188	\$30,607,176	\$3,664,105	11.97%	\$26,943,071
Oct	57,531	\$27,483,216	\$1,919,528	6.98%	\$25,563,688
Nov	57,872	\$27,365,533	\$2,146,915	7.85%	\$25,218,618
Dec	53,334	\$24,737,031	\$1,951,396	7.89%	\$22,785,635
Total	748,571	\$357,434,875	\$29,848,896	8.35%	\$327,585,979

- The MHP generated relatively consistent monthly claim lines and made timely submissions throughout CY 2022.

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

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Service line is a duplicate and repeat service modifier is not present	29,145	\$10,660,026	35.71%
Other healthcare coverage must be billed first	12,771	\$7,649,967	25.63%
Beneficiary is not eligible or non-covered charges	8,876	\$6,505,424	21.79%
Medicare Part B must be billed before submission of claim	8,071	\$3,598,156	12.05%
Other	406	\$760,737	2.55%
Service location NPI issue	1,143	\$467,366	1.57%
Deactivated NPI	332	\$106,771	0.36%
Late claim submission	39	\$72,853	0.24%
Place of service incomplete or invalid	130	\$27,595	0.09%
Total Denied Claims	60,913	\$29,848,895	100.00%
Overall Denied Claims Rate	8.35%		
Statewide Overall Denied Claims Rate	5.92%		

- The MHP’s overall denied claims rate was 8.35 percent, which was 2.43 percentage points higher than the statewide denial rate.
- The largest proportion (35.71 percent) of denied claims dollars were related to the denial code for “Service line is a duplicate and repeat service modifier is not present.” The other primary reasons for denial were: “Other healthcare coverage must be billed first” (representing 25.63 percent of dollars denied in the MHP), and “Beneficiary is not eligible or non-covered charged” (identified as the rationale for denying 21.79 percent of total claims dollars).

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Although the MHP has made some strides toward promoting a measure of interoperability by engaging in the electronic transmission of data with MHP and SUD contract providers, some local primary care providers, Indian Health centers, and Federally Qualified Health Centers, it still has not become a member of an HIE. Moreover, Santa Clara has yet to electronically share information with either of its two managed care plans (i.e., Anthem Blue Cross and Santa Clara Family Health Plan). During the recent EQR, however, the MHP not only expressed its understanding of the importance of embracing a model of whole-person care that was predicated on and shaped by the electronic sharing of information between disparate healthcare agencies, but also in the absence of exchanging data with such partner agencies, the quality of care provided to its members could potentially be impeded or compromised.

- With respect to addressing obligations related to CalAIM payment reform, the MHP successfully incorporated all relevant CPT/HCPCS codes into Avatar to support the claiming process for all County and contract providers. The incorporation of more than 10,000 new codes into the EHR was completed in July 2023, requiring a significant investment of time and resources from the MHP IT department. Claim lines associated with the delivery of services by County-operated and contract providers have already been submitted with these new codes to DHCS for adjudication. Although quite a bit of work remains to be performed on this front to refine, optimize, and adequately train staff on how to use these codes strategically and effectively to bill for services, this accomplishment demonstrates the MHP's commitment to the ongoing process of satisfying CalAIM implementation requirements.
- In the last year, Santa Clara made progress toward better integrating contract provider EHRs with Avatar and expanded the ability of contract provider staff to interact with the system. Toward this end, the MHP fully implemented the Management Services Organization (MSO) module in Avatar. This functionality allows the agency to orchestrate more effectively the capture and control of information submitted by contract providers, including the electronic transmission of 837 batch files. Additionally, the MHP was able to establish a dedicated portal in Avatar, which affords contractors the ability to directly enter a variety of service-related and demographics data (e.g., billing records, admission and discharge dates, some diagnoses) into the system for certain programs.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP administers the annual CPS and analyzes the findings. Results are provided to contracted providers to distribute to members and in the quarterly report that is shared with the leadership and quality committee. Santa Clara does not currently have QI projects to address the findings.

PLAN MEMBER/FAMILY FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested three 90-minute focus groups with Plan members and/or their family, containing eight to 10 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who received services in the preceding 12 months. The focus group was held at a residential treatment facility and included [REDACTED] participants. [REDACTED] spoke Spanish; however, the MHP had not arranged for an interpreter to attend the session. All members participating receive clinical services from the MHP and [REDACTED] of them initiated services in the past 12 months.

Newer members reported some delays in beginning services. For psychiatry and therapy services, the wait between services seemed reasonable; however, there were some delays in receiving case management services. Some members were aware that they could receive transportation to mental health services. Members were aware that they can receive services via telehealth and are given a choice.

Members overall seemed to be aware of what to do if their provider wasn't a good fit, with only [REDACTED] indicating that they weren't sure what to do. None of the members recalled being invited to a committee and expressed interest in being

involved. No members were aware of peer support staff opportunities and several members expressed interest.

Overall members were satisfied, feel that everything has been covered in the services they have received, and life has improved since beginning mental health services. However, all members expressed concerns about housing and not being able to afford rent once they are on their own.

Recommendations from focus group participants included:

- Have a longer and better “exit plan” from residential treatment.
- Housing options and assistance; they feel there is “nowhere for them to go.”

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of adult consumers who received services in the preceding 12 months. The focus group was held at two consumer centers and included a total of 11 participants. There was an additional member [REDACTED] that was expected to join the group but was not able to attend. All members participating receive clinical services from the MHP and regularly attend the consumer centers. For those who started services in the last year, most reported receiving services quickly.

For all members in the group, the wait time between psychiatry and therapy services was acceptable. All members were aware of telehealth services. Members were aware of crisis services but indicated that it seemed that crisis services in the county could be “beefed up.” [REDACTED] noted that [REDACTED] needed crisis care but there were not any vans available at the time because of being out helping other members at the time. To receive information from the MHP, members indicated they receive flyers, search on Google, and the case manager provides them information. One member noted that it feels like an “Easter egg hunt” to find resources; they are there but can be hard to find. Members had concerns about housing and being able to afford a place to live.

Recommendations from focus group participants included:

- Provide a community meeting every quarter that members can attend and provide input.
- More housing resources, especially for people with disabilities and veterans.
- Offer better/more transportation options.

Consumer Family Member Focus Group Three

CalEQRO requested a diverse group of TAY consumers who received services in the preceding 12 months. All members participating receive clinical services from the MHP. The focus group included [REDACTED] participants and [REDACTED] of them began services in the last year.

All TAY members indicated that the services they receive and time between services is the right balance and works well for them. All members felt that they are involved in treatment planning and care. Members are given a choice of receiving services via telehealth and those services would be the same length as in-person services. Members believe they have input in mental health medications that they are prescribed. Members agreed that their family can be involved in their mental health treatment. Members did not appear to have a crisis plan as they were not aware of what to do in a crisis.

Members reported completing a satisfaction survey but did not see the results. Members were not aware of the MHP website, were not familiar with receiving resources through social media, but did not know about the peer support staff program. Overall members feel that their lives have improved since getting services from the MHP and that staff give them a sense of hope that long-term recovery is possible.

Recommendations from focus group participants included:

- Schedule future psychiatric appointments when a member is leaving the clinic. The clinic states they will call to schedule and then they do not call.
- Make efforts to ensure that members have a consistent therapist. They do not like frequent changes in therapists.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Overall MHP members who attended the focus groups expressed that their life has improved since starting mental health services and they were satisfied with services. A main concern expressed was the lack of housing options. Additionally, it did not appear that there was a formal process to ensure that all members are informed of critical information from the MHP including satisfaction survey results, subsequent activities to improve access, timeliness, and quality of services, and peer opportunities, such as employment and career advancement.

CONCLUSIONS

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

STRENGTHS

1. Santa Clara has performed well over the last few years in terms of providing access to eligible members and connecting them with services. This observation is supported by the fact that the MHP's overall PR, as well as the PRs for all race/ethnicity groups, have consistently exceeded similar-sized county and statewide rates. The MHP put additional initiatives in place such as 988 and access line combined, warm hand-offs, peer navigator program, and same day access model. (Access)
2. The robust outreach and engagement activities of the MHP has resulted in the creation of a profusion of wellness centers across its system of care and within the community. Funding secured from sources such as the Mental Health Services Act and the American Rescue Plan Act of 2021 has permitted the agency to forge an array of partnerships with the justice system and local school districts to expand wellness centers into juvenile hall and onto middle-school and high-school campuses. Furthermore, Santa Clara has established one of the first Vietnamese wellness centers in the country that boasts a comprehensive care center and includes primary care resources. (Access, Quality)
3. The MHP places an emphasis on being a data-driven organization. It currently has two vibrant data-analytics teams that collectively embrace more than 30 analysts. The primary function of these teams is to assay and translate raw service-related, demographics, and outcome data into well-crafted and intelligible reports and dashboards that can be used by executive leadership, QI, program management, and both internal and contracted clinical staff to support the rendering of data-informed decisions. These teams are also responsible for designing and creating myriad Crystal Reports that are loaded into Avatar and serve as vehicles to provide end users with the ability to generate immediate output based on information that has been entered into the EHR. (Access, Timeliness, Quality, IS)
4. Santa Clara successfully incorporated all relevant CPT/HCPCS codes into its EHR, Avatar, with over 10,000 codes in their system. (IS)
5. The MHP has 28 peer support staff, and 90 percent of them are certified peer support specialists. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. First offered psychiatry appointment data are not yet reported consistently and completely. (Timeliness)
2. In CY 2022, the MHP had an overall denied claims rate of 8.35 percent, which was 2.43 percentage points higher than the statewide denial rate. (Timeliness, IS)
3. Contracted providers indicated inadequate support for changes that have been required due to CalAIM. (Quality)
4. The MHP does not currently utilize LOC tools for adults and youth. (Quality)
5. Santa Clara does not possess a formally written operational continuity plan that focuses exclusively on the MHP. Instead, it is presently relying on a Major Incident Management Process document that was composed by a team within Santa Clara County's main IT department for the entire county. (IS)

RECOMMENDATIONS

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

1. Continue to further refine the first psychiatry appointment timeliness data with DHCS guidance and ensure complete and consistent reporting by the providers. (Timeliness)
(This recommendation was continued since FY 2021-22.)
2. Over the last few years, Santa Clara's overall denied claims rate has exceeded the statewide denial rate. In CY 2022, the largest proportion of denied claims dollars were related to the following denial code reasons: "Service line is a duplicate and repeat service modifier is not present," "Other healthcare coverage must be billed first," "Beneficiary is not eligible or non-covered charges," and "Medicare Part B must be billed before submission of claim." It is, therefore, suggested that the MHP coordinate with its billing and fiscal teams to research this situation and develop strategies to proactively identify and remediate problematic claims lines before they are submitted to DHCS for adjudication. (Timeliness, IS)
3. Continue efforts and ensure that all recipients (e.g., providers, staff) are aware of and understand how to apply communication from the MHP for changes due to CalAIM. (Quality)
4. Continue the collaborative process with the University of Kentucky in developing and implementing LOC tools for youth and adults. (Quality)
5. Given the proliferation of ransomware and other cyber-related attacks that have occurred across the country within the last few years, it is important that Santa

Clara consider investing time and resources into producing an IS operational continuity plan that is agency specific. This strategy will better prepare the MHP for the need to successfully navigate through a potential future event that may adversely impact critical business systems or compromise data. The lack of a current agency specific IS operational continuity plan represents a potential liability for the MHP. (IS)

EXTERNAL QUALITY REVIEW BARRIERS

There were no barriers to this FY 2023-24 EQR.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – Santa Clara MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year’s recommendations
Validation and Analysis of the MHP’s Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP’s PIPs
Validation and Analysis of the MHP’s PMs
Validation and Analysis of the MHP’s Network Adequacy
Validation and Analysis of the MHP’s Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being (Katie A./CCR)
Consumer and Family Member Focus Groups (Adults and TAY)
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Cultural Competence
Planning and Strategies to Address Staffing Shortages
Peer Employees Group Interview
Contract Provider Leadership Group Interview
Information Systems Billing and Fiscal Interview
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Christy Hormann, LMSW, CPHQ, CSSBB, Lead Quality Reviewer
Elaine Crandall, MS, CLSSBB, Quality Reviewer
Rick Jackson, IS Reviewer
Walter Shwe, Consumer/Family Member Reviewer
Pamela Roach, M.Ed., Consumer/Family Member Reviewer

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

All review sessions were held via Zoom.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Acevedo	Domingo	PM III	SCC-BHSD
Alcantar	Vanessa	Senior Health Care Program Analyst	SCC-BHSD
Anderson-Musquiz	Alicia	PMIII	SCC-BHSD
Anviah	Berelyan	Health Care Compliance Analyst	SCC-BHSD
Ascensio	Stephanie	Clinical Line Staff	Pacific Clinics
Aspiras	Catherine	Division Director	SCC-BHSD
Berelyan	Anviah	Health Care Compliance Analyst	SCC-BHSD
Bolton	Shirly	Psychiatric Social Worker	SCC-BHSD
Boulanger	Karen	Clinical Line Staff	Pacific Clinics
Bray	Scott	Business Systems Analyst	SCC-BHSD
Brown	LouMeshia	PMIII	SCC-BHSD
Buntic	Jazmin	PM II	SCC-BHSD
Cammann	Matt	Director of Business Operations	Seneca
Castuciano	Carlo	Management Analyst	SCC-BHSD
Chiu	Suzanne	PM III	SCC-BHSD
Chounhuri	Indira	Director, Information Technology	SCC-BHSD
Chu	Dinh	PMII	SCC-BHSD
Copley	Bruce	Exec Team - Director, Access & Unplanned Services	SCC-BHSD
Cozzolino	Anthony	Psychiatry Chief	SCC-BHSD
Dang	Nhu-Diem	Clinical Line Staff	Gardner

Last Name	First Name	Position	County or Contracted Agency
Diaz	Velicia	Psychiatric Social Worker	SCC-BHSD
Do	Thanh	PM III	SCC-BHSD
Domenden	Gerald	Health Care Program Analyst	SCC-BHSD
Fan	Joe	Senior Data Analyst	SCC-BHSD
Faria Costa	Zelia	Exec Team - Director of Children, Youth, and Families (CYF) SOC	SCC-BHSD
Ferris	Jeanette	PM III	SCC-BHSD
Fisher	Alissa	Psychiatric Social Worker	SCC-BHSD
Fong	Francis	Licensed Clinical Supervisor	SCC-BHSD
Galli	Angela	Psychiatric Technician II	SCC-BHSD
Geilhufe	Ben	PM II	SCC-BHSD
Gissible	Loren	Clinical Training Manager	Gardner
Gonzalez-Ortiz	Gaby	PM II	SCC-BHSD
Gray	Courtney	Exec Team - Director of Quality Management	SCC-BHSD
Herrera	Elizabeth	PM II	SCC-BHSD
Ho	Tiffany	Exec Team - Medical Director	SCC-BHSD
Janini	Yasmina	PM II	SCC-BHSD
Jung	Soo	Division Director	SCC-BHSD
Kaur	Kiran	Health Care Compliance Analyst	SCC-BHSD
Kim	Sarah	Licensed Clinical Supervisor	SCC-BHSD

Last Name	First Name	Position	County or Contracted Agency
Kuzmich	Matthew (Alex)	PM II	SCC-BHSD
Le	Mikelle	Division Director-	SCC-BHSD
Le	Duy	PM II	SCC-BHSD
Lemus	Rebeca	PM III	SCC-BHSD
Lien	Mego	PMIII-Prevention Services	SCC-BHSD
Lim	Howard	Senior Business Systems Analyst	SCC-BHSD
Lopez	Samantha	PM II	SCC-BHSD
Lozano	Gustavo	PM II	SCC-BHSD
Lu	Katelyn	FINANCIAL & ADM SERV MGR	SCC-BHSD
Macatiag	Angeleah	Program Manager III- contracts	SCC-BHSD
Marquez	Veronica	PMII-QI	SCC-BHSD
Mendoza	Sandy	Management Analyst	SCC-BHSD
Micheletti	Jennifer	Clinic Manager	RCS
Mineta	David	President CEO	Momentum
Montoya	Rachel	Chief Financial and Operating Officer	Community Solutions
Musquiz	Alicia	PMIII	SCC-BHSD
Nguyen	Hung	Division Director- Quality Improvement	SCC-BHSD
Obilor	Margaret	Exec Team - Director of Adult/Older Adult SOC	SCC-BHSD
O'Brein	Erin	President CEO	Community Solutions

Last Name	First Name	Position	County or Contracted Agency
Olivarez	Gabby	Division Director- FDR	SCC-BHSD
Ortiz	Rosa	PM II	SCC-BHSD
Osment	Matt	PMII	SCC-BHSD
Patterson	Jessie	Clinical Line Staff	Gardner
Pham	Anh T.	PM II	SCC-BHSD
Pham	Jennifer	Division Director- F&C Services	SCC-BHSD
Potens	Rachel	PM III	SCC-BHSD
Prahakaran	Sujatha	HEALTH CARE FIN ANALYST II	SCC-BHSD
Preader	Melissa	PM III	SCC-BHSD
Ramirez	Sabry	PM III	SCC-BHSD
Reich	Jenae	Clinical Line Staff	Caminar
Reis	Elania	Division Director- Adult and Older Adult Services	SCC-BHSD
Rensi	Matt	Licensed Professional Clinical Counselor	Community Solutions
Reyes	Beverly	PM II	SCC-BHSD
Rocco	Robert	PM III	SCC-BHSD
Selo	Josh	Chief Executive Officer	Bill Wilson
Sweet	Tova	PM III	SCC-BHSD
Talamantez	Rachel	Division Director- Cross Systems	SCC-BHSD
Talebi	Majid	Pharmacist Specialist	SCC-BHSD

Last Name	First Name	Position	County or Contracted Agency
Tan	Darren	BHS DEPT, DEPUTY DIRECTOR	SCC-BHSD
Tansek	Joe	PMII- Call Center	SCC-BHSD
Terao	Sherri	Exec Team - Director of BH	SCC-BHSD
Tere	Mendoza	AMFT	RCS
Tom	Dena	IT Manager	SCC-BHSD
Vasquez	Ricardo	Clinic Managers	Caminar
Vierra	Amanda	PM III	SCC-BHSD
Villanueva	Leilani	PMIII-QA	SCC-BHSD
Vu	Lily	PMII- QA	SCC-BHSD
Wagner	Brian	Exec Team - Director of A&R	SCC-BHSD
Weare	Christopher	Director of Research and Outcome Measures	SCC-BHSD

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
<input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence	Santa Clara reported that the MHP exceeded state and national benchmarks for FUM; however, data revealed disparities across some populations, e.g., Hispanic, Black/African America, and Spanish-speaking. The PIP includes member focused interventions, informational materials about mental health including referral contact information in threshold languages and peer navigation program. Both interventions started in August 2023.
General PIP Information	
MHP/DMC-ODS Name: Santa Clara	
PIP Title: FUM BHQIP	
PIP Aim Statement: “By June 30, 2024, through the outreach efforts of Peer Navigators, 61 percent of members discharged from the emergency room with an identified mental health diagnosis will be open to outpatient services (an increase from the current baseline of 48 percent).”	
Date Started: 09/2022	
Date Completed: In progress	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) <input type="checkbox"/> State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) <input checked="" type="checkbox"/> MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> 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): Members discharged from the emergency room with a noted behavioral health diagnosis.	

General PIP Information						
Improvement Strategies or Interventions (Changes in the PIP)						
<p>Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):</p> <p>Informational materials (flyers) about mental health including referral contact information in threshold languages in the ED to inform and engage members and their family members in follow up care. Peer navigator program will attempt to contact the referred client within one business day.</p>						
<p>Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):</p> <p>Click or tap here to enter text.</p>						
<p>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):</p> <p>Click or tap here to enter text.</p>						
PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Members discharged from the ED who are open to outpatient services			<input type="checkbox"/> Not applicable—PIP is in planning or implementation phase, results not available		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
PIP Validation Information						
<p>Was the PIP validated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>“Validated” means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.</p>						

PIP Validation Information

Validation phase (check all that apply):

- PIP submitted for approval Planning phase Implementation phase Baseline year
- First remeasurement Second remeasurement Other (specify):

Validation rating: High confidence Moderate confidence Low confidence No confidence

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

EQRO recommendations for improvement of PIP:

- Ensure the PIP includes a PM that aligns with the aim.
- Provide a complete description of the data collection process for the PIP PMs.
- Consider including in the aim/measuring members who received follow-up within 7 and 30 days.
- Track how many member flyers are distributed.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
<input type="checkbox"/> High confidence <input checked="" type="checkbox"/> Moderate confidence <input type="checkbox"/> Low confidence <input type="checkbox"/> No confidence	<p>Call center staff reported that responding to incoming calls was often hampered by procedural steps including a fragmented data entry process that resulted in longer than necessary wait times for callers. Test calls showed that not all calls were answered, and if answered, not logged. The MHP developed a manual with step-by-step instructions, simplified the call logging process, and trained the access call center staff in the new procedure, with regular monitoring of the operation. Interventions were implemented in May 2022 and July 2022. The MHP reduced the average number of abandoned calls and the wait time.</p>
General PIP Information	
MHP/DMC-ODS Name: Santa Clara	
PIP Title: Improving the 24/7 Access Call Line Efficiency	
PIP Aim Statement: "Will the implementation of a new system method/procedure with supervision oversight improve information accuracy provided to members from 43 percent to 65 percent within the first year of this PIP? Then the PIP's goal continues to increase from 65 percent to 80 percent for the second year? But also decrease the member's current average wait time from 43 minutes to 30 minutes per call."	
Date Started: 05/2022	
Date Completed: 03/2023	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) <input type="checkbox"/> State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) <input type="checkbox"/> Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) <input checked="" type="checkbox"/> MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): <input type="checkbox"/> Children only (ages 0–17)* <input type="checkbox"/> Adults only (age 18 and over) <input checked="" type="checkbox"/> Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information

Target population description, such as specific diagnosis (please specify): Any members and/or representative on behalf of the member who call the MHP's 24-hours a day, 7-days a week, toll-free Access Line, which has the potential of helping all members that could potentially access the services provided by the MHP. Age, diagnosis, ethnicity, race, length of enrollment, etc., will not be a factor in this study; instead, it will focus on everyone who calls the Call Center requesting services regardless of whether the call results in a referral.

Improvement Strategies or Interventions (Changes in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach):
 Click or tap here to enter text.

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach):
 Click or tap here to enter text.

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):
 Revise test call form to collect specific data, development of training manual to define procedures, call log in EHR system to centralize data collection, oversight - PIP team will hold bi-weekly meetings to ensure fidelity and help address potential barriers.

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Increase the accuracy of test calls logged when members contact the Call Center	March 7-18, 2022	54 % 6/11 calls	Q1 7/22-9/22 Q3 January-March 2023	53% 8/15 calls	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Reduce the number of hung-up calls *In the data hung-up calls are labeled as abandoned	March 7-18, 2022	908 (raw # of calls coming in) Avg Abandoned: 50% (calls received/calls abandoned)	Q2-2022 a. Oct 11-21, 2022 b. Nov 7-18, 2022 c. Dec 5-17, 2022	Oct 11-21 a.820 b.34.8% Nov 7-18 a.784 b.10.58% Dec 5-17 a.722 b. 22.56%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input checked="" type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):
Reduce the wait time for members when calling the Call Center	March 7-18, 2022	a. 14 hours b. 42 mins (weighted avg)	Q2 10/22-12/22	Oct 11-21 a. 1 hr 17min b. 4 min Nov 7-18 a. 18 hr 57 min b. 59 min Dec 5-17 a. 41 min 3 sec b. 2 min	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify P-value: <input checked="" type="checkbox"/> <.01 <input type="checkbox"/> <.05 Other (specify):

PIP Validation Information

Was the PIP validated? Yes No

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

PIP Validation Information

Validation phase (check all that apply):

- PIP submitted for approval Planning phase Implementation phase Baseline year
- First remeasurement Second remeasurement Other (specify): Completed

Validation rating: High confidence Moderate confidence Low confidence No confidence

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

EQRO recommendations for improvement of PIP:

- Examine the decline of the first PM measure and make any needed adjustments to ensure continued improvement in the results.
- Ensure that factors that impact the validity of the findings are addressed as much as possible to minimize impact on the results.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

All CalEQRO review tools, including but not limited to the Key Components, Assessment of Timely Access, PIP Validation Tool, and CalEQRO Approved Claims Definitions are available on the [CalEQRO website](#).

ATTACHMENT E: LETTER FROM MHP DIRECTOR

A letter from the MHP Director was not required as part of this report.