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

SAN LUIS OBISPO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

October 5-6, 2022

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EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2022-23 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report. In this report, "San Louis Obispo" may be used to identify the San Louis Obispo County MHP, unless otherwise indicated.

MHP INFORMATION

Review Type — Virtual

Date of Review — October 5-6, 2022

MHP Size — Medium

MHP Region — Central

SUMMARY OF FINDINGS

The California External Quality Review Organization (CalEQRO) evaluated the MHP on the degree to which it addressed FY 2021-22 EQR recommendations for improvement; four categories of Key Components that impact beneficiary outcomes; activity regarding Performance Improvement Projects (PIPs); and beneficiary feedback obtained through focus groups. Summary findings include:

Table A: Summary of Response to Recommendations

# of FY 2021-22 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	3	2	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	3	1	0
Timeliness of Care	6	3	3	0
Quality of Care	10	5	5	0
Information Systems (IS)	6	5	1	0
TOTAL	**26**	**16**	**10**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Hospital Emergency Department Consults	Clinical	07/2021	Prematurely Terminated-staffing constraints	Low FY 2021-22 EQR Report
Connecting Individuals from the Psychiatric Health Facility (PHF) to their Post-PHF Appointments	Non-Clinical	09/2021	Prematurely Terminated-staffing constraints	Low FY 2021-22 EQR Report
Behavioral Health Quality Improvement Program (BHQIP) Milestone 3d Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Clinical	10/2022	Planning	Moderate
Continuity of Care Initiative	Non-Clinical	07/2022	Implementation	Moderate

Table D: Summary of Consumer/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☒Adults ☐Transition Aged Youth (TAY) ☐Family Members ☐Other	6
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	3

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- The MHP's overall penetration is greater than medium size county and state averages. The MHP expanded the Latino Outreach Program (LOP) to improve Latino/Hispanic penetration. (Access)
- The MHP outperformed the state in 7-day and 30-day post psychiatric inpatient follow-up and in 7-day and 30-day lower rehospitalization rates. (Timeliness)
- The MHP is proactively implementing the California Advancing and Innovating Medi-Cal (CalAIM) initiatives, taking advantage of California Mental Health Services Act (CalMHSA) products, and evidence collaboration with Managed Care Plan (MCP) partners and contract providers. (Quality)
- In partnership with CalMHSA, the MHP will be one of the first counties to implement the new SmartCare Electronic Health Record (EHR). (IS)
- The MHP's PIPs address linkage and access to MHP providers from emergency departments (EDs) BHQIP Milestone 3d, and improve retention after initial assessment. (Access and Quality, PIPs)

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

- The MHP evidence extended waits for assessments, services after initial assessment and obtaining timely services after specialty mental health (MH) services (SMHS) have been initiated, directly impacted by lack of available staffing. (Access)
- Several timeliness measures are incomplete or impacted by human error, may not be reliable, and do not include contractor provider data. (Timeliness)
- Track, trend and implement strategies to improve the continuity of timely access to therapist and psychiatric services after initial assessment. (Quality)
- Both previous year's PIPs were discontinued due to lack of resources. Although promising, both new PIPs require additional development and dedicated resources to implement. (Quality - PIP)
- The MHP's plan to implement the new EHR, SmartCare in July 2023 provides an opportunity to address several areas of need for data, timeliness tracking, and additional analytics to monitor current and CalAIM initiatives. (IS)

Recommendations for improvement based upon this review include investigating the reasons, develop strategies, and implement solutions to improve:

- Staffing recruitment and retention, contracted staffing, and tele-workforce staffing opportunities to improve access, timeliness, and availability of services for routine outpatient access. (access)
- Accuracy and use of timeliness analytics, inclusive of contract providers, through the implementation of a new EHR and/or other developed methods. (Timeliness)
- Track, trend and implement strategies to improve the continuity of timely access to therapist and psychiatric services after initial assessment. (Quality)
- Implementation and maintenance of the current PIPs. (Quality-PIPs)
- Implement the new EHR, SmartCare in July 2023 to provide an opportunity to address several areas of need for data, timeliness tracking, and additional analytics to monitor current and CalAIM initiatives. (IS)

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

DHCS requires the CalEQRO to evaluate MHPs on the following: delivery of SMHS in a culturally competent manner, coordination of care with other healthcare providers, beneficiary satisfaction, and services provided to Medi-Cal eligible minor and non-minor dependents in foster care (FC) as per California Senate Bill (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 2022-23 findings of the EQR for San Louis Obispo County MHP by BHC, conducted as a virtual review on October 05 – 06, 2022.

REVIEW METHODOLOGY

CalEQRO's review emphasizes the MHP's use of data to promote quality and improve performance. Review teams are comprised of staff who have subject matter expertise in the public 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 analyze data, review MHP-submitted documentation, and conduct interviews with key county staff, contracted providers, advisory groups, beneficiaries, family members, and other stakeholders. At the conclusion of the EQR process, CalEQRO produces a technical report that synthesizes information, draws upon prior year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

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

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

Findings in this report include:

- Changes and initiatives the MHP identified as having a significant impact on access, timeliness, and quality of the MHP service delivery system in the preceding year. MHPs are encouraged to demonstrate these issues with quantitative or qualitative data as evidence of system improvements.
- MHP activities in response to FY 2021-22 EQR recommendations.
- Summary of MHP-specific activities related to the four Key Components, identified by CalEQRO as crucial elements of quality improvement (QI) and that impact beneficiary outcomes: Access, Timeliness, Quality, and IS.
- Evaluation of the MHP's two contractually required PIPs as per Title 42 CFR Section 438.330 (d)(1)-(4) – validation tool included as Attachment C.
- Analysis and validation of Access, Timeliness, Quality, and IS 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.
- Review and validation of each MHP's NA as per 42 CFR Section 438.68 and compile data related to DHCS Alternative Access Standards (AAS) as per California WIC Section 14197.05, detailed in the Access section of this report.
- Assessment 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.
- Beneficiary perception of the MHP's service delivery system, obtained through review of satisfaction survey results and focus groups with beneficiaries and family members.

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

To comply with the Health Information Portability and Accountability Act, and in accordance with DHCS guidelines, CalEQRO suppresses values in the report tables when the count is less than 12, then "≤11" is indicated to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, with a dash (-) to prevent calculation of initially suppressed data, its corresponding penetration rate (PR) percentages, and cells containing zero, missing data, or dollar amounts.

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place during the fourth FY of the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP has experienced significant workforce recruitment and retention challenges: increased resignations, early retirements, and leaves. Recruitment challenges include fewer applications, lower response to invitations to interview, and an increased likelihood applications are seeking flexible telecommuting positions. CalAIM initiatives and reforms have resulted in many foundational changes to Behavioral Health (BH) policies and procedures and documentation guidelines. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP expanded their Mental Health Services Act (MHSA) funded LOP and contracted with the National Latino Behavioral Health Association (NLBHA) to provide bilingual, providers training addressing health disparities in the Latino Community.

- The MHP opened an urgent care clinic, operating Monday-Friday 3-7 PM, providing urgent medication support and psychiatric assessments to beneficiaries who are under the care of a County or community-based organization's contracted prescriber.

- A new MHSA funded Forensic Full-Service Partnership team, serving Criminal Justice involved individuals with complex needs, was launched.
- CalAIM initiatives redesigning documentation and access systems, in concert with CenCal, the MHP's County's Medi-Cal MCP, is standardizing the referral and transition of care processes. The MHP and CenCel are utilizing a cloud-based portal, SharePoint, to track referrals and share related clinical documentation.
- Information Technologies (IT) solutions in the past year included utilizing DocuSign to expeditiously collect electronic signatures for clients receiving telehealth services.

RESPONSE TO FY 2021-22 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2021-22

Recommendation 1: Review data and/or reporting of timeliness to resolve discrepancies in timeliness metrics. (e.g., urgent response, post-hospitalization follow-up, and rehospitalization rates).

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP tracks timeliness from initial routine requests, urgent requests, and post-hospitalization by utilizing Anasazi's Access Journal Reporting. This data is hand entered into Access Journal each time a service is scheduled and is a redundant duplication of data entry in Anasazi. Staff also enter scheduled services on a Customer Service Information Assessment Record Spreadsheet, in Anasazi's scheduler, and on the Service Request assessment.
- The recommendation is partially met due to the impact of the difficulties of accuracy and timely reporting caused by hand entries. Redundant data entries completed individually by hand increase the possibility for human error.
- The limitations of Anasazi and its inability to provide complete timely access data is a major contributor to the MHP's decision to switch to a new EHR, Smart Care, offered through CalMHSA. The EHR implementation is planned for July 2023.

Recommendation 2: Develop a plan and begin to include the timeliness findings of contract providers in the overall MHP reporting of timeliness.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The community-based organizations (CBOs) will be utilizing the new EHR, SmartCare. The MHP is prudently planning processes to enable the extraction of data and sharing health records with our CBOs more seamlessly.
- The recommendation is partially met in that a plan to incorporate CBOs has been developed but it is not yet executed.

Recommendation 3: Include data analysis and implications as a regular part of data reporting. Data analysis ought to inform program decisions, QI activities, and other initiatives within the MHP.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP reviews data during the monthly quality support team (QST) meetings attended by BH leadership and stakeholders. Data utilization examples include identification of access concerns to guide resource allocation decisions; analyzing utilization data to address staffing needs; reviewing Patients' Rights Notification of Adverse Beneficiary Determination data to identify trends that need to be addressed; utilizing diagnosis listing reports to inform evidenced based practices; and utilizing consumer perception survey data to guide diversity, equity, and inclusion efforts to create a more welcoming and inclusive environment.

Recommendation 4: Provide separate reporting of youth in FC in the internal review of following the Healthcare Effectiveness Data and Information Set (HEDIS) measures.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP implemented reviewing youth in FC HEDIS measures separately in the internal review process.

Recommendation 5: Incorporate Power BI and their dashboards into the QI workflow, including the annual workplan and evaluation, so that that key indicators and system-wide metrics and outcomes are captured and used for continuous QI efforts.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP begun utilizing Power BI to create a data dashboard that allows BH managers to monitor compliance, finance, medical billing, and utilization data. The MHP is using Power BI to present consumer perception survey results to program staff and stakeholders.
- The Quality Support division staff focused efforts on implementing the many reforms and initiatives resulting from CalAIM, including a plan to switch to a new EHR in July 2023, resulting in the QST not dedicating the work time to incorporating Power BI into the quality monitoring activities. The MHP is anticipating gaining new reporting and monitoring capabilities with the new EHR.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 55.73 percent of services were delivered by county-operated/staffed clinics and sites, and 44.27 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 72.03 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is staffed by county staff during business hours and staffed by contractor-operated staff afterhours, over weekends, and on holidays. Beneficiaries may request services through the Access Line as well as through the following system entry points: outpatient clinics, a children's early intervention centers, a homeless outreach program, and some full-service partnership programs. The MHP operates a centralized access team that is responsible for linking beneficiaries to appropriate, medically necessary youth, adult, or older adult services. The centralized access team performs adult assessments. Upon assessment, beneficiaries are assigned to programs and outpatient clinics for ongoing services. The centralized access team screens youth and makes the assessment appointment at the most appropriate youth serving clinic.

In addition to clinic-based MH services, the MHP provides telehealth and mobile MH services. Specifically, the MHP delivers psychiatry and/or MH services via telehealth to youth and/or adults. In FY 2021-22, the MHP reports having provided telehealth services to 1,747 adult beneficiaries, 945 youth beneficiaries, and ≤11 older adult beneficiaries across 7 county-operated sites and 6 contractor-operated sites. Among those served, 133 beneficiaries 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 beneficiaries to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information contained in Table 1A and Table 1B below.

In November 2021, DHCS issued its FY 2021-22 NA Findings Report for all MHPs based upon its review and analysis of each MHP's Network Adequacy Certification Tool and supporting documentation, as per federal requirements outlined in the Annual Behavioral Health Information Notice (BHIN).

For San Luis Obispo County, the time and distance requirements are 45 miles and 75 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 2021-22

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

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

Table 1B: MHP OON, FY 2021-22 {see NA Form EQRO Section III}

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- The MHP has expanded the LOP and contracted with NLBHA to provide bilingual, providers training addressing health disparities in the Latino Community.
- The MHP opened an urgent care clinic providing urgent medication support and psychiatric assessments to BH beneficiaries who are under the care of a County or CBO contracted prescriber.
- Manages and Adapts Capacity to Meet Beneficiary Needs was partially met due primarily to staffing vacancies and volume of workload. The MHP struggles to perform timely assessments and some services, especially timely psychiatric services, and MH therapist services. This concern was included in the FY 2021-22 report.

ACCESS PERFORMANCE MEASURES

Beneficiaries Served, Penetration Rates, and Average Approved Claims per Beneficiary Served

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

The PR is a measure of the total beneficiaries served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated beneficiaries served (receiving one or more approved Medi-Cal services) by the monthly average eligible count. The average approved claims per beneficiary (AACB) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Where the median differs significantly from the average, that information may also be noted throughout this report.

The Statewide PR is 3.85 percent, with an average approved claim amount of $6,496. Using PR as an indicator of access for the MHP, the MHP's PR of 4.84 percent was 20 percent higher than the statewide average. The MHP PR trend over the last three years is declining.

The race/ethnicity data can be interpreted to determine how readily the listed race/ethnicity subgroups comparatively access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

Table 3: MHP Annual Beneficiaries Served and Total Approved Claim

Year	Total Eligibles	Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
CY 2021	65,337	3,162	4.84%	$35,120,720	$11,107
CY 2020	58,909	3,295	5.59%	$41,711,950	$12,659
CY 2019	57,214	3,694	6.46%	$45,556,245	$12,332

- The MHP PR has trended down each year reported.

Table 4: County Medi-Cal Eligible Population, Beneficiaries Served, and Penetration Rates by Age, CY 2021

Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	MHP PR	Similar Size Counties PR	Statewide PR
Ages 0-5	7,043	166	2.36%	0.89%	1.59%
Ages 6-17	15,402	758	4.92%	3.93%	5.20%
Ages 18-20	3,377	167	4.95%	3.42%	4.02%
Ages 21-64	34,324	1,908	5.56%	3.75%	4.07%
Ages 65+	5,191	163	3.14%	2.13%	1.77%
TOTAL	**65,337**	**3,162**	**4.84%**	**3.33%**	**3.85%**

- The MHP PR outperforms similar counties across all age ranges and all but the state 6-17 age range.

Table 5: Threshold Language of Medi-Cal Beneficiaries Served in CY 2021

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percent of Beneficiaries Served
Spanish	236	7.65%
Threshold language source: Open Data per BHIN 20-070		

- The unduplicated count of Spanish speaking beneficiaries increased by five percent from the prior review period.

Table 6: Medi-Cal Expansion (ACA) PR and AACB CY 2021

Entity	Average Monthly ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	21,381	865	4.05%	$4,825,739	$5,579
Medium	613,796	18,023	2.94%	$122,713,843	$6,809
Statewide	4,385,188	145,234	3.31%	$824,535,112	$5,677

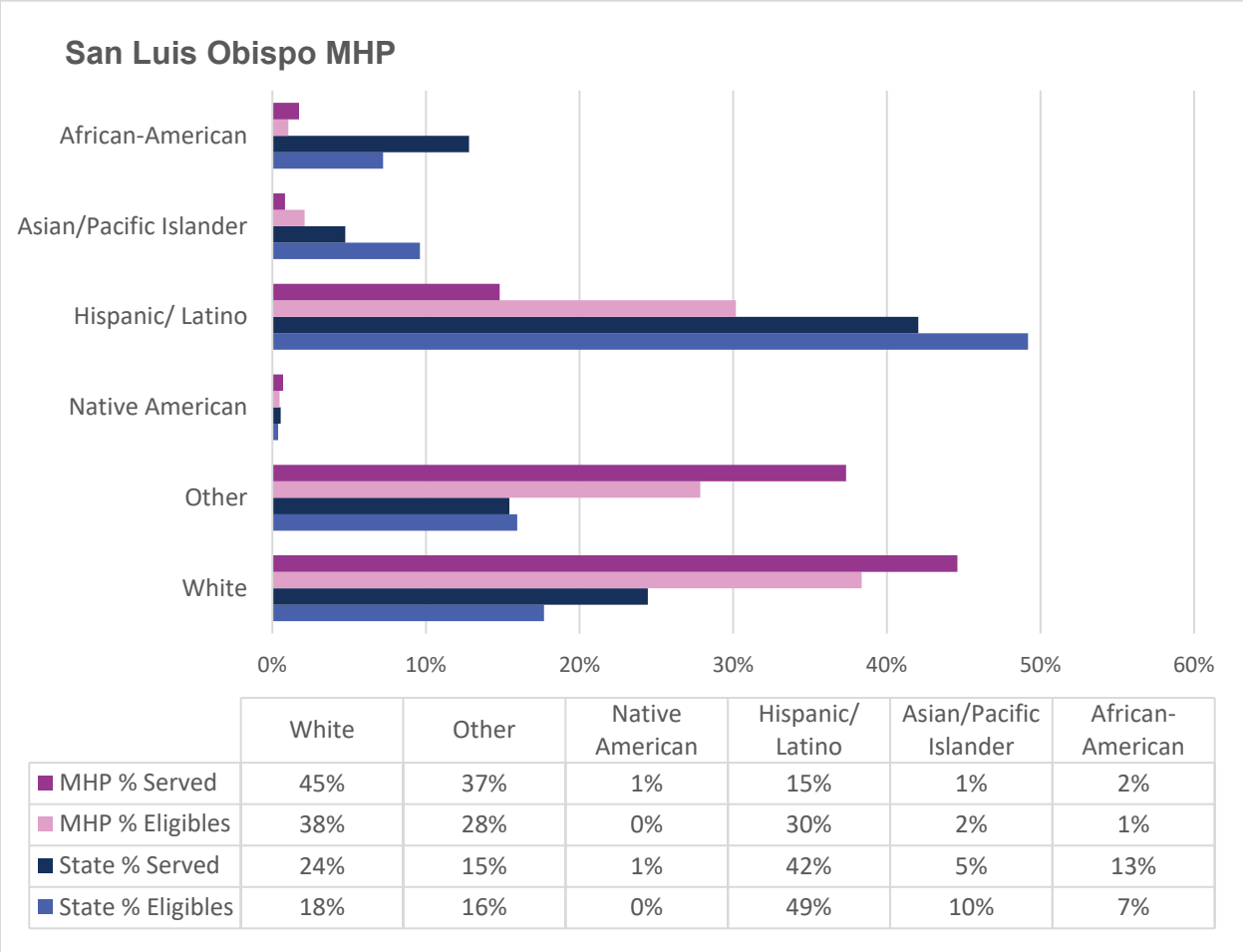
- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACB tend to be lower than non-ACA beneficiaries.
- The MHP has a higher percentage of ACA beneficiaries served than the medium size county and statewide averages.

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

Race/Ethnicity	# MHP Eligibles	# MHP Served	MHP PR	Statewide PR
African-American	681	55	8.08%	6.83%
Asian/Pacific Islander	1,373	26	1.89%	1.90%
Hispanic/Latino	19,713	468	2.37%	3.29%
Native American	306	22	7.19%	5.58%
Other	18,201	1,181	6.49%	3.72%
White	25,065	1,410	5.63%	5.32%
Total	**65,339**	**3,162**	**4.84%**	**3.85%**

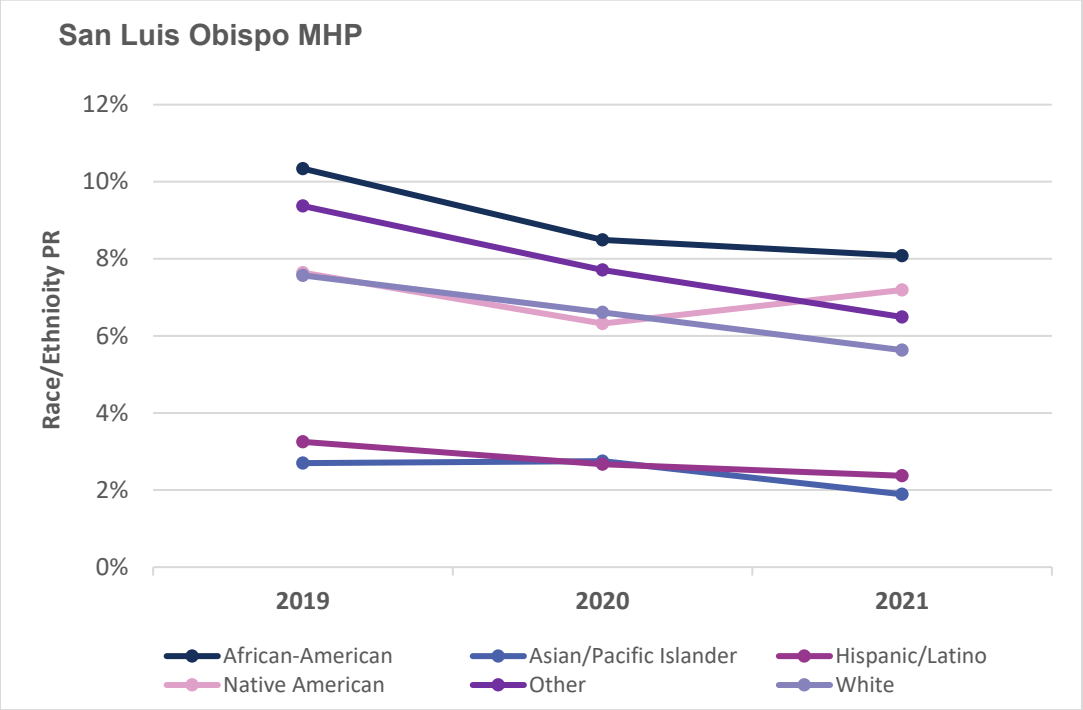
- The PR decreased in all race/ethnicity groups except for Native American beneficiaries which slightly increased.

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



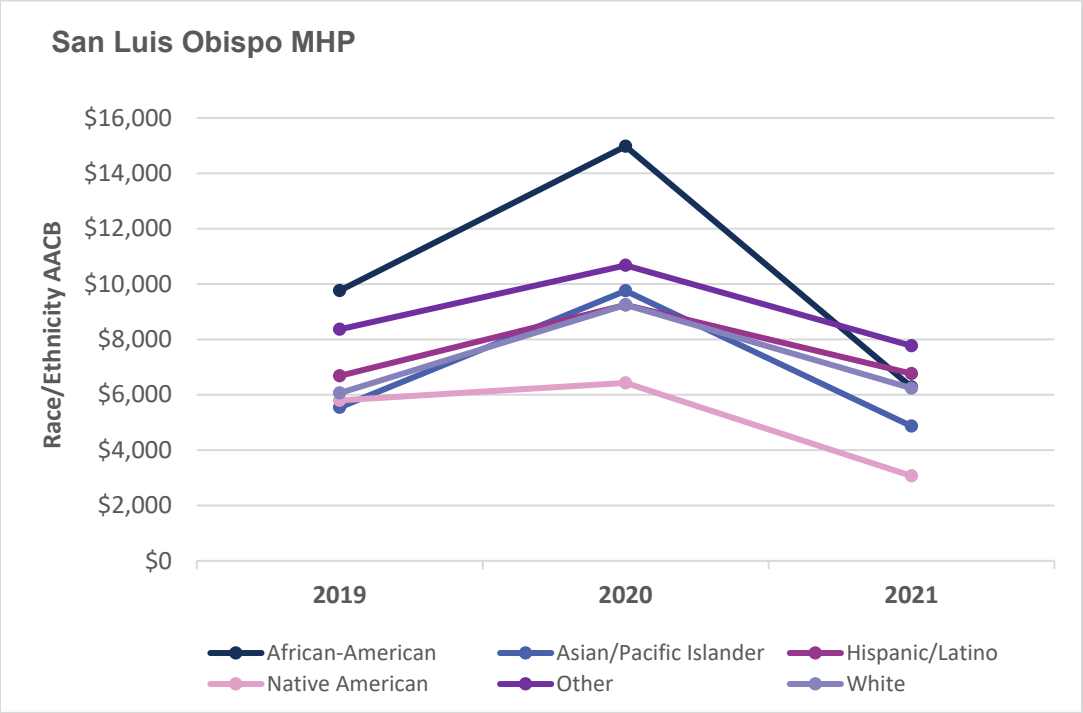
	White	Other	Native American	Hispanic/ Latino	Asian/Pacific Islander	African-American
MHP % Served	45%	37%	1%	15%	1%	2%
MHP % Eligibles	38%	28%	0%	30%	2%	1%
State % Served	24%	15%	1%	42%	5%	13%
State % Eligibles	18%	16%	0%	49%	10%	7%

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



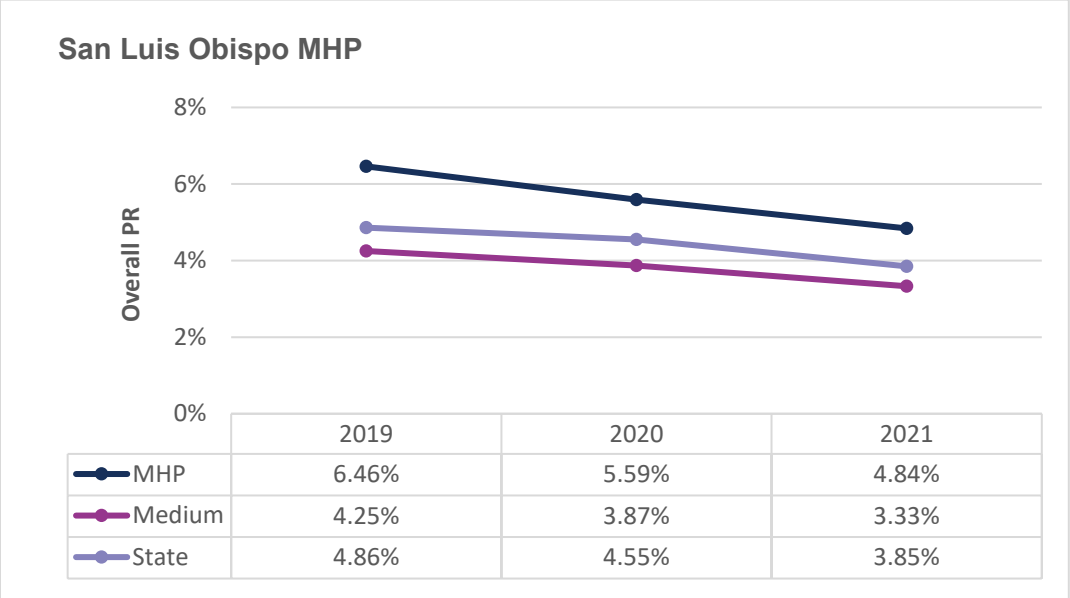
- While the PR by race/ethnicity has a downward trend within the MHP, it began to level out in CY 2021.

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



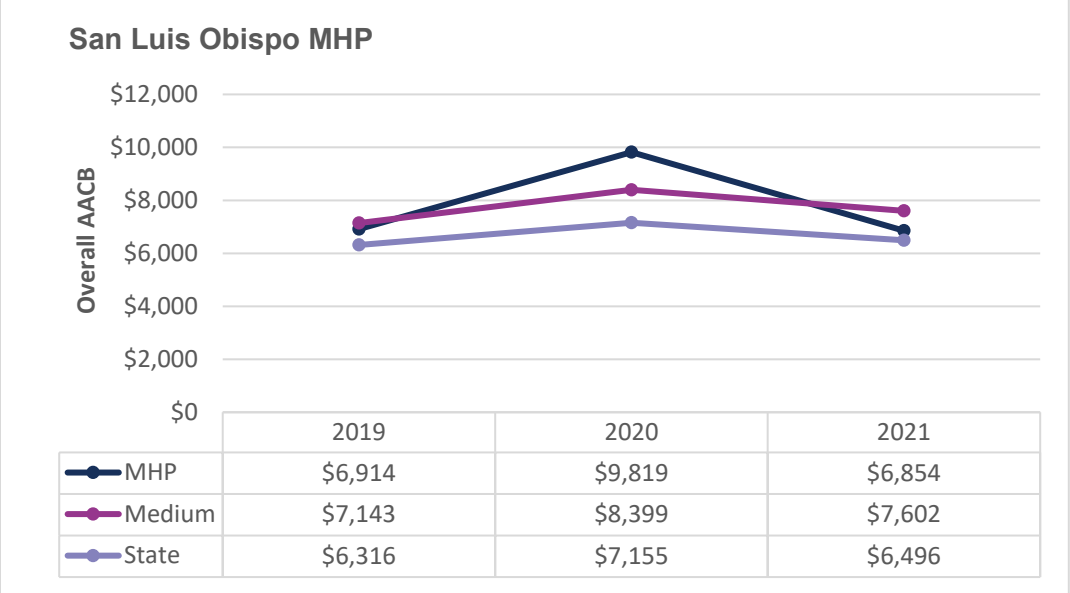
- The AACB by race ethnicity had a significant increase in CY 2020 and adjusted back to historic levels in CY 2021.

Figure 4: Overall PR CY 2019-21



	2019	2020	2021
MHP	6.46%	5.59%	4.84%
Medium	4.25%	3.87%	3.33%
State	4.86%	4.55%	3.85%

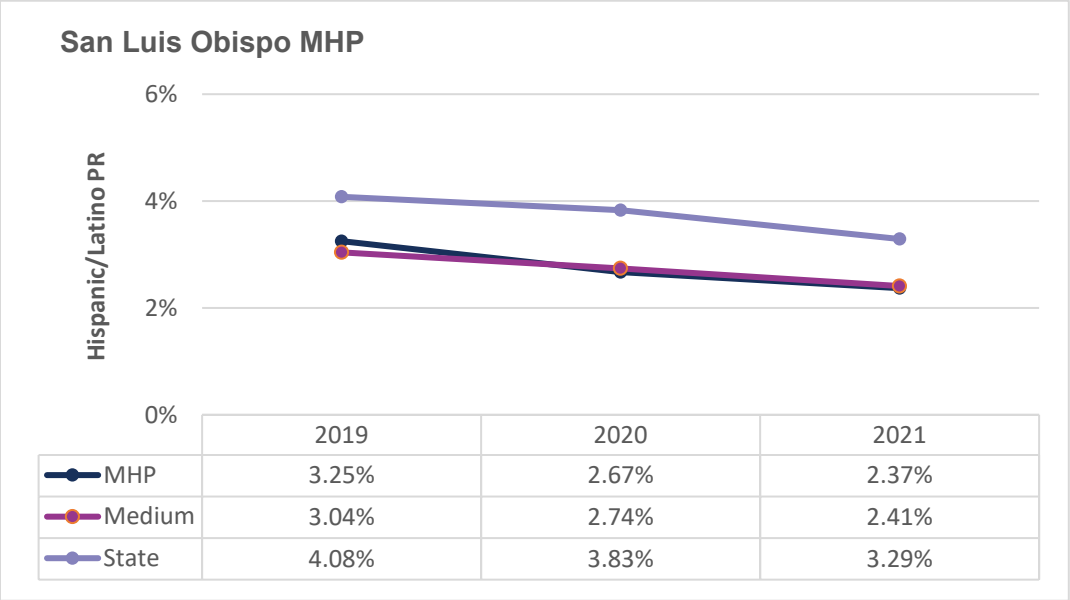
Figure 5: Overall AACB CY 2019-21



	2019	2020	2021
MHP	$6,914	$9,819	$6,854
Medium	$7,143	$8,399	$7,602
State	$6,316	$7,155	$6,496

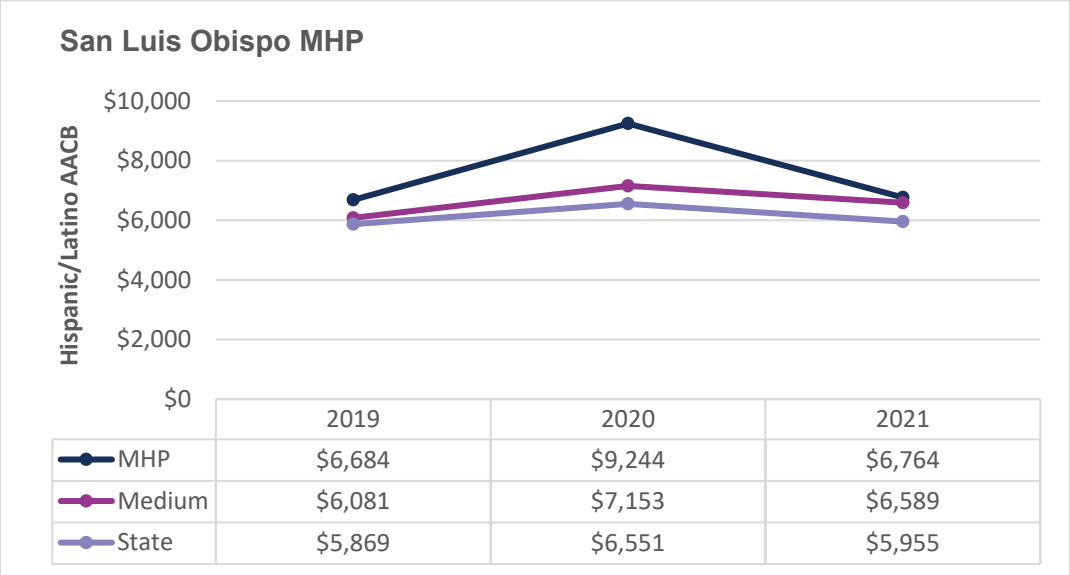
- While the overall PR has decreased over the last two years, the MHP PR still exceeds the medium-sized county and statewide averages.

Figure 6: Hispanic/Latino PR CY 2019-21



	2019	2020	2021
MHP	3.25%	2.67%	2.37%
Medium	3.04%	2.74%	2.41%
State	4.08%	3.83%	3.29%

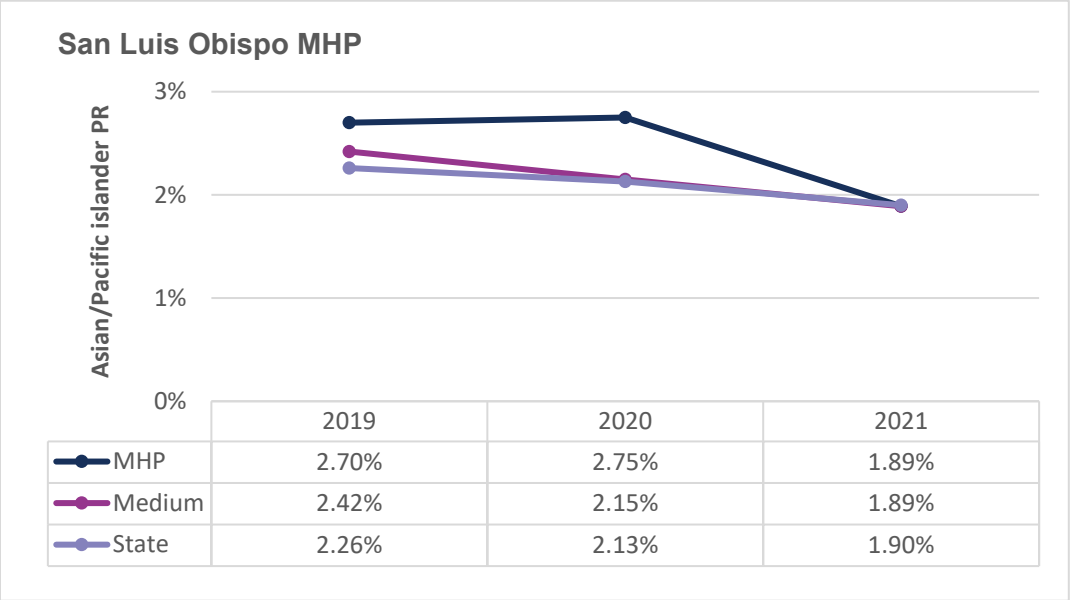
Figure 7: Hispanic/Latino AACB CY 2019-21



	2019	2020	2021
MHP	$6,684	$9,244	$6,764
Medium	$6,081	$7,153	$6,589
State	$5,869	$6,551	$5,955

- The MHP PR serving the Hispanic/Latino population is consistent with other medium-size counties and 28 percent lower than the statewide average.

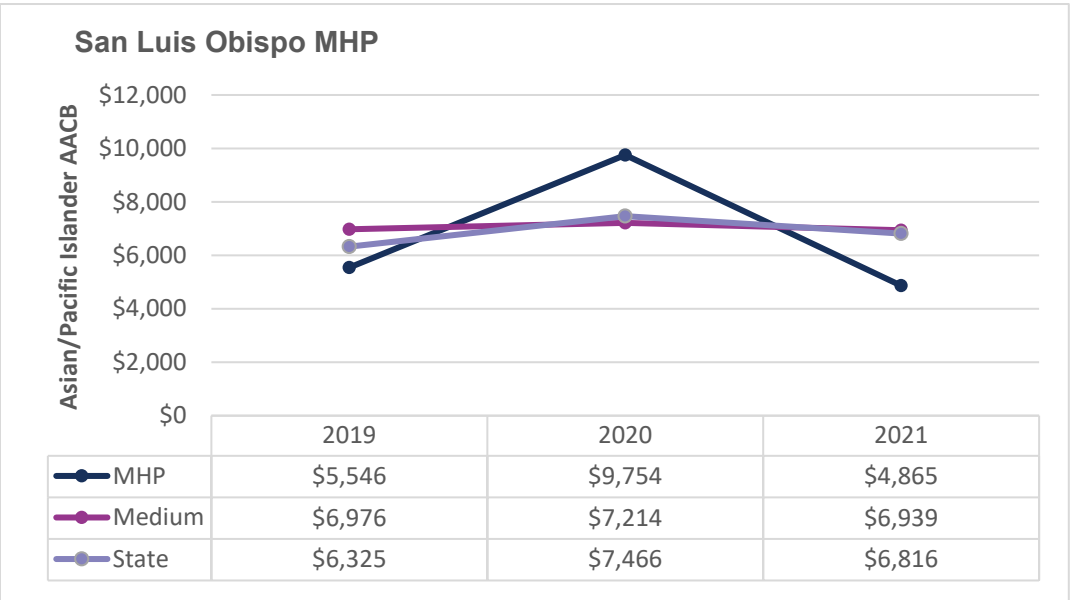
Figure 8: Asian/Pacific Islander PR CY 2019-21



	2019	2020	2021
MHP	2.70%	2.75%	1.89%
Medium	2.42%	2.15%	1.89%
State	2.26%	2.13%	1.90%

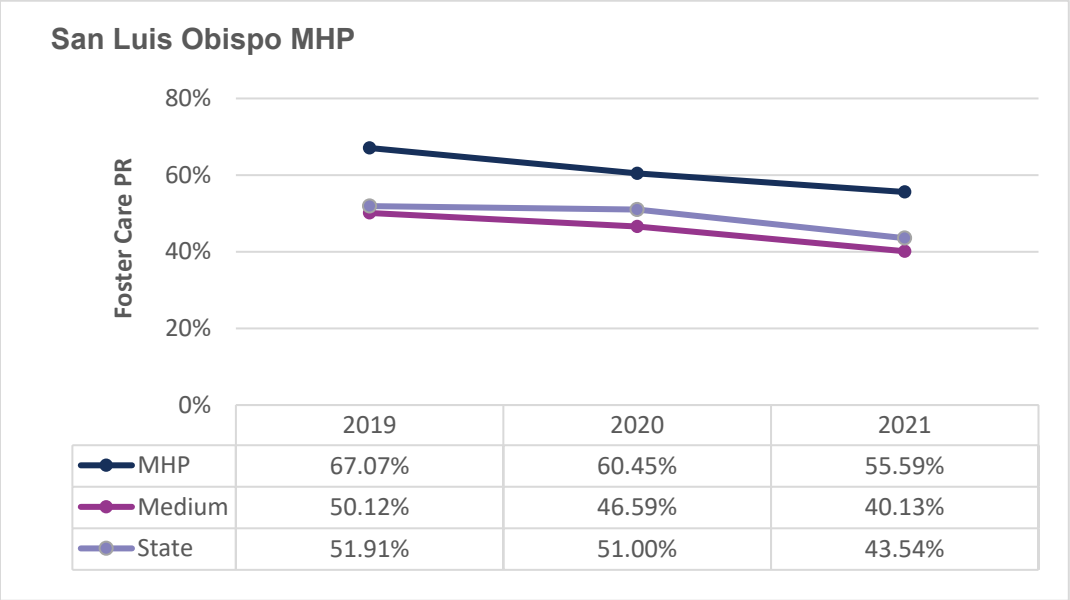
- The MHP PR serving the Asian/Pacific Islander population is consistent with other medium-size counties and the statewide average.

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



	2019	2020	2021
MHP	$5,546	$9,754	$4,865
Medium	$6,976	$7,214	$6,939
State	$6,325	$7,466	$6,816

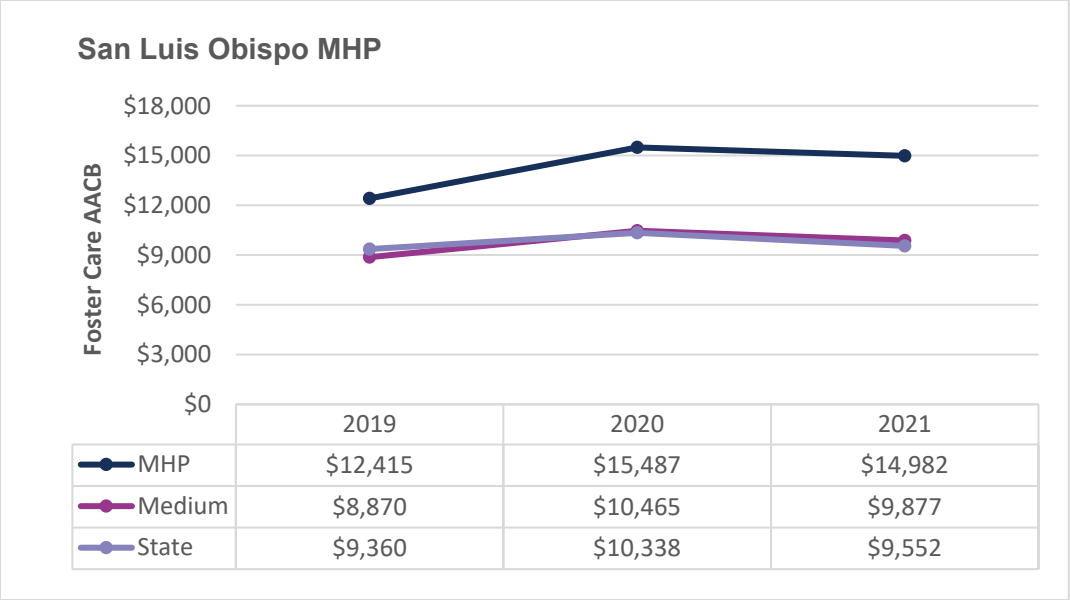
Figure 10: Foster Care PR CY 2019-21



	2019	2020	2021
MHP	67.07%	60.45%	55.59%
Medium	50.12%	46.59%	40.13%
State	51.91%	51.00%	43.54%

- The MHP FC PR is 39 percent higher than the medium-size county average and 28 percent higher than the statewide average.

Figure 11: Foster Care AACB CY 2019-21



	2019	2020	2021
MHP	$12,415	$15,487	$14,982
Medium	$8,870	$10,465	$9,877
State	$9,360	$10,338	$9,552

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the MHP to Adults

Service Category	MHP N = 2,238				Statewide N = 351,088		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	20	0.9%	9	6	10.8%	14	8
Inpatient Admin	≤ 11	-	3	1	0.4%	16	7
Psychiatric Health Facility	154	6.9%	6	4	1.0%	16	8
Residential	24	1.1%	60	52	0.3%	93	73
Crisis Residential	≤ 11	-	15	15	1.9%	20	14
Per Minute Services							
Crisis Stabilization	152	6.8%	1,325	1,200	9.7%	1,463	1,200
Crisis Intervention	296	13.2%	251	179	11.1%	240	150
Medication Support	1,446	64.6%	205	135	60.4%	255	165
Mental Health Services	1,411	63.0%	795	290	62.9%	763	334
Targeted Case Management	1,500	67.0%	265	93	35.7%	377	128

- Adults receiving acute care are served primarily through a Psychiatric Health Facility (PHF).
- The MHP Targeted Case Management PR, 67 percent, is almost twice the state average, 35.7 percent.

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

Service Category	MHP N = 199				Statewide N = 33,217		
	Beneficiaries Served	% of Beneficiaries Served	Average Units	Median Units	% of Beneficiaries Served	Average Units	Median Units
Per Day Services							
Inpatient	20	10.1%	11	9	4.5%	13	8
Inpatient Admin	≤ 11	-	-	-	≤11	6	4
Psychiatric Health Facility	≤ 11	-	-	-	0.2%	25	9
Residential	≤ 11	-	-	-	≤11	140	140
Crisis Residential	≤ 11	-	-	-	0.1%	16	12
Full Day Intensive	≤ 11	-	-	-	0.2%	452	360
Full Day Rehab	≤ 11	-	-	-	0.4%	451	540
Per Minute Services							
Crisis Stabilization	≤ 11	-	840	840	2.3%	1,354	1,200
Crisis Intervention	20	10.1%	371	257	6.7%	388	195
Medication Support	69	34.7%	309	250	28.5%	338	232
Therapeutic Behavioral Services	≤ 11	-	967	425	3.8%	3,648	2,095
Therapeutic FC	≤ 11	-	0	0	0.1%	1,056	585
Intensive Home Based Services	105	52.8%	1,227	836	38.6%	1,193	445
Intensive Care Coordination	67	33.7%	2,275	1,548	19.9%	1,996	1,146
Katie-A-Like	≤ 11	-	1,460	1,290	0.2%	837	435
Mental Health Services	192	96.5%	1,640	1,090	95.7%	1,583	987
Targeted Case Management	120	60.3%	228	111	32.7%	308	114

- All per day service categories were suppressed due to low utilization except for inpatient, which was higher than the state average.
- The percentage of youth beneficiaries served in per minute service categories for 4 urgent or intensive service types due to low utilization.
- The per minute service categories for Crisis Intervention; Medication Support; Intensive Home Based Services; Intensive Care Coordination; Mental Health Services; and Targeted Case Management all exceeded the state averages.

IMPACT OF ACCESS FINDINGS

- The MHP's Access to initial assessment PR (4.84 percent) is greater than the medium county (3.33 percent) and state (3.85 percent) average.
- The MHP is actively implementing strategies to improve the Latino/Hispanic PR and retention.
- The MHP staffing, reduced by recruitment and retention barriers, impacts access to services after the initial assessment. Multi-week delays for psychiatric and clinical services fluctuates based on day-to-day availability of staff.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- The MHP's Performance Measure 7-day (53.04 percent) and 30-day (67.96 percent) follow-up after hospitalization rates are higher than the state 7-day (46.7 percent) and 30-day (58.95 percent) averages.

- The MHP's Performance Measure 7-day (6.35 percent) and 30-day (11.88 percent) psychiatric rehospitalization rates are lower than the state 7-day (17.52 percent) and 30-day (24.47 percent) averages.
- Three components were partially met due to limitations of the current EHR to provide data. Components were also partially met due to staffing capacity impacting timeliness to first offered, first rendered and ongoing SMHS needs for clinical and psychiatric needs.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2022-23 EQR, the MHP reported in its submission of Assessment of Timely Access (ATA), representing access to care during the 12-month period of FY 2021-22. This data represented county-operated services. Table 11 and Figures 12 – 14 below display data submitted by the MHP; an analysis follows.

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

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

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	19 Days	10 Business Days*	42%
First Non-Urgent Service Rendered	23.4 Days	10 days**	42%
First Non-Urgent Psychiatry Appointment Offered	20 Days	15 Business Days*	36%
First Non-Urgent Psychiatry Service Rendered	*** Days	***	***%
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	2 Days****	48 Hours*	94%****
Follow-Up Appointments after Psychiatric Hospitalization PM data is 53.4% 7-days and 76.96% for 30-days	4 Days	7 Days**	97%
No-Show Rate – Psychiatry	20%****	20%**	n/a
No-Show Rate – Clinicians	8%****	10%**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033
** MHP-defined timeliness standards
*** The MHP did not report data for this measure
****County operated clinic data only, no CBOs

For the FY 2022-23 EQR, the MHP reported its performance for the following time period: FY 2021-22

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

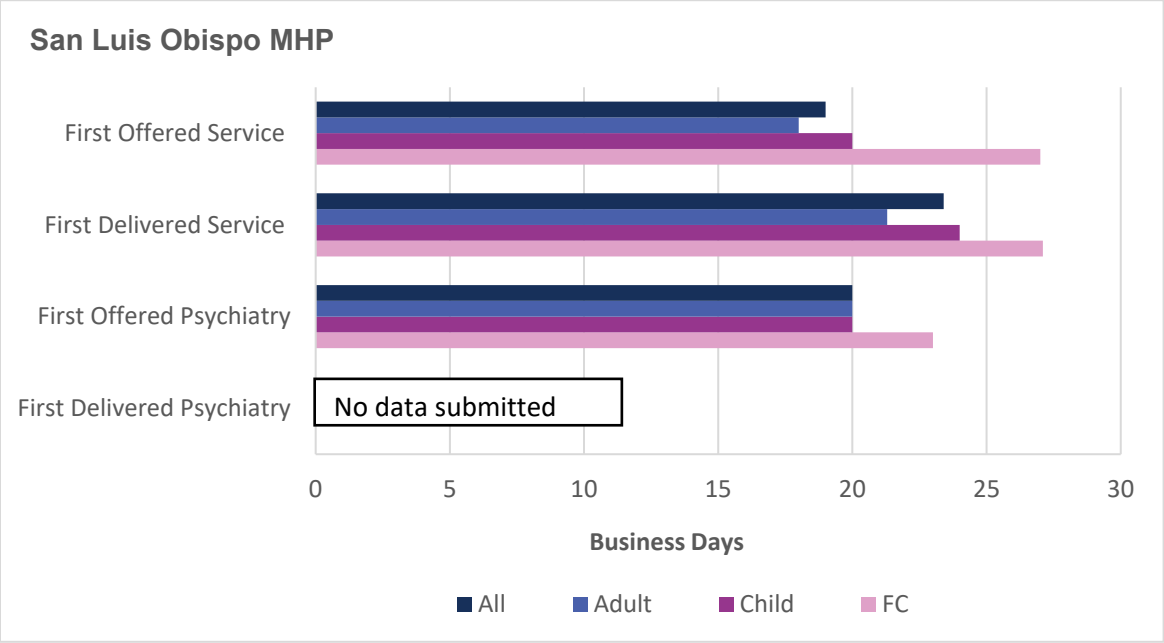


Figure 13: Wait Times for Urgent Services

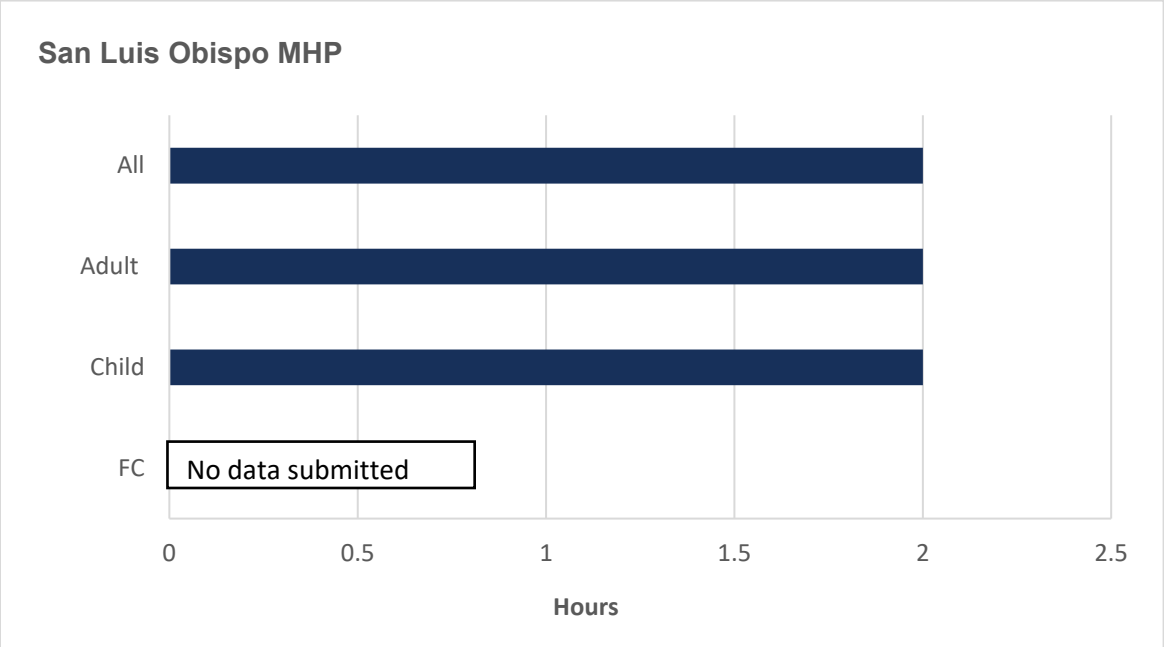
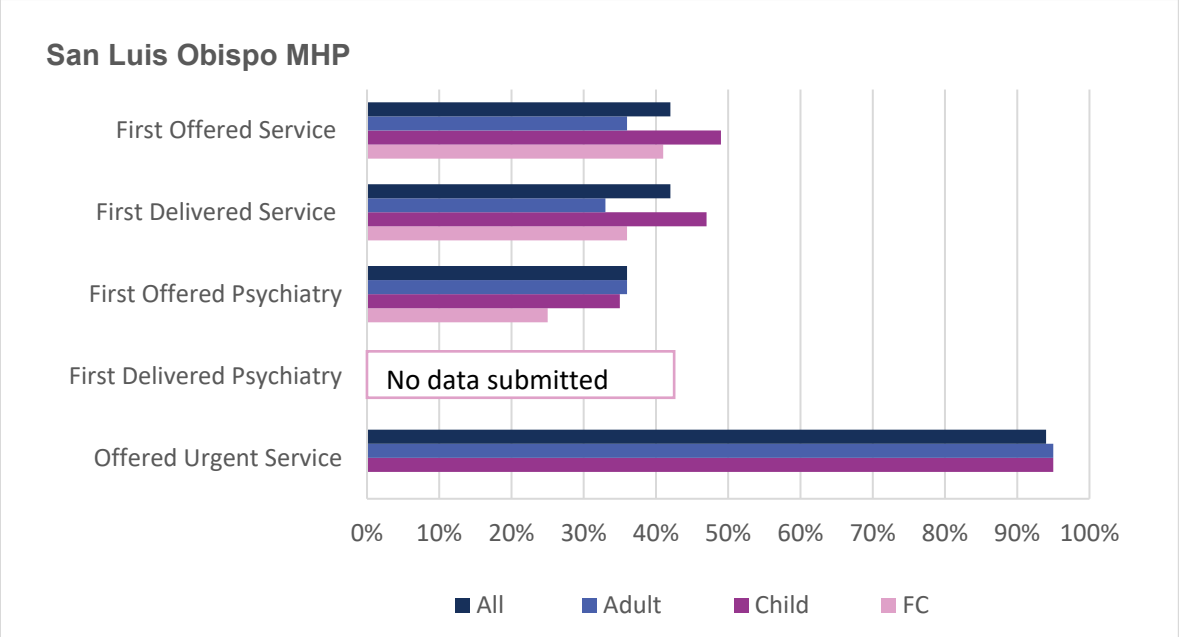


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide planned MH services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the

MHP, the data for initial service access for a routine service in Figures 12 and 13, represent scheduled assessments.

- Definitions of “urgent services” vary across MHPs, where some identify them as answering an urgent phone call and providing phone intervention, a drop-in visit, a referral to an ED, or a referral to a Crisis Stabilization Unit. The MHP defined “urgent services” for purposes of the ATA as services necessary to avoid a crisis which may include incarceration, hospital visit, psychiatric emergency, or loss of placement. There were reportedly 159 of urgent service requests with a reported actual wait time to services for the overall population at two days.
- The point of measurement for timely access to psychiatry may be defined by the County MHP. The process as well as the definitions and tracking may differ for adults and children. The MHP has defined psychiatry first offered non-urgent psychiatry appointment in the submission as from first service request for both adults and children, county- operated services only. EHR barriers prohibited the MHP reporting data on first non-urgent psychiatric service delivered.
- No-show tracking varies across MHPs and is often an incomplete dataset due to limitations in data collection across the system. For the MHP, no-shows are tracked for county-operated adult and children’s services only. The MHP reports a no-show rate for psychiatric services of 29 percent for adults, 9 percent for children, and 20 percent overall.
- The MHP does not track or did not report data for first non-urgent rendered psychiatry service.
- The MHP’s system limitations with the current EHR only allows tracking of urgent services measured in days instead of hours.

IMPACT OF TIMELINESS FINDINGS

- The MHP prioritizes access and initiation of psychiatric, clinical, and case management services for beneficiaries transitioning from urgent or acute facilities. The MHP outperforms state 7- and 30-day psychiatric hospitalization rate averages, evidencing greater follow-up after psychiatric hospitalizations and lower rehospitalization rates.
- Barriers in data reporting negatively impacts the MHPs ability to monitor psychiatric access non-urgent appointments rendered and all contractor service timeliness monitors.
- As noted in the Access to Care impact findings, the MHP staffing, reduced by recruitment and retention barriers, impacts routine access to services after the initial assessment.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is with the Quality Support Division (QST). The QST is responsible for Medical Records (21.0 FTEs); the Managed Care Access Program (11.5 FTEs); the Diversity, Equity, and Inclusion Manager (2.0 FTEs); the Clinical Supervision and Training Coordinator (1.0 FTE); the Patients' Rights Advocate (1.0 FTE); and the QST Program (6.0 FTEs).

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), a QI workplan, and the annual evaluation of the QI workplan. The QI workplan is inclusive of DMC-ODS and MHP goals and objectives. The QI workplan annual evaluation for FY 2021-22 identified 8 goal categories comprised of 32 objectives. Of the 32 objectives, the MHP identified 25 as completed, three as not completed, and four as in process. The 3 objectives that were not completed were all related to a need to postponed access line test calls due to a lack of staffing.

The NA and timeliness objectives were all completed. However, the MHP meets the first offered assessment within 10 days and first offered psychiatric request within 15 days only 42 percent and 36 percent respectively. Although not measured in the QI Workplan, all validation sessions conducted with clinical line staff, clinical supervisors, adult consumers and the parents and caregivers of youth expressed lengthy delays obtaining ongoing necessary services, especially clinical therapist provided services. The QIC, is comprised of San Luis Obispo Behavioral Health Department (SLOBHD) staff, contract providers, and BH board members. Regular attendance by beneficiaries, family members, and community members could not be ascertained from the meeting minutes. QIC meetings are scheduled to meet monthly, alternating between a PHF-specific QIC and a general BH meeting. Since the previous EQR, the MHP QIC provided minutes for 5 monthly meetings.

The MHP reports in its Information Systems Capabilities Assessment (ISCA) G.5 and G.6 that it does not capture Level of Care recommendations; referrals; admissions; aggregate analysis; or whether the beneficiary was admitted into a treatment program.

The MHP's ISCA submission section G.6 indicates the MHP utilizes the following children's outcomes tools: California Child and Adolescent Needs and Strengths and the Pediatric Symptom Checklist. The MHP's ISCA submission section G.6 indicates the MHP utilizes the following adult's outcomes tool: the Milestones of Recovery Scale. Adult and children's outcome tools are utilized on a case-by-case basis in the development of both formal and informal support systems that may assist beneficiaries and families with continued progress during and after treatment.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

KC #	Key Components – Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	Partially Met
3C	Communication from MHP Administration, and Stakeholder Input and Involvement in System Planning and Implementation	Partially Met
3D	Evidence of a Systematic Clinical Continuum of Care	Partially Met
3E	Medication Monitoring	Met
3F	Psychotropic Medication Monitoring for Youth	Met
3G	Measures Clinical and/or Functional Outcomes of Beneficiaries Served	Partially Met
3H	Utilizes Information from Beneficiary Satisfaction Surveys	Partially Met
3I	Consumer-Run and/or Consumer-Driven Programs Exist to Enhance Wellness and Recovery	Met
3J	Consumer and Family Member Employment in Key Roles throughout the System	Met

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

- The MHP is proactively developing processes to fully implement the CalAIM documentation reform, information exchange, and the screening and transition tools with active MHP leadership and health agency involvement.

- Similar to the previous report, the MHP's health data analytics capacity was limited. The MHP is proactively seeking to improve data quality management with the implementation of the new CalMHSA sponsored semi-statewide EHR, ShareCare.
- Measures partially met were due to data and data analytics shortcomings, a lack of beneficiary involvement in quality processes, and staffing recruitment and retention barriers.
- The MHP tracks and trends the HEDIS measures as required by WIC Section 14717.5
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder Medications (HEDIS ADD):
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC):
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM):
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

QUALITY PERFORMANCE MEASURES

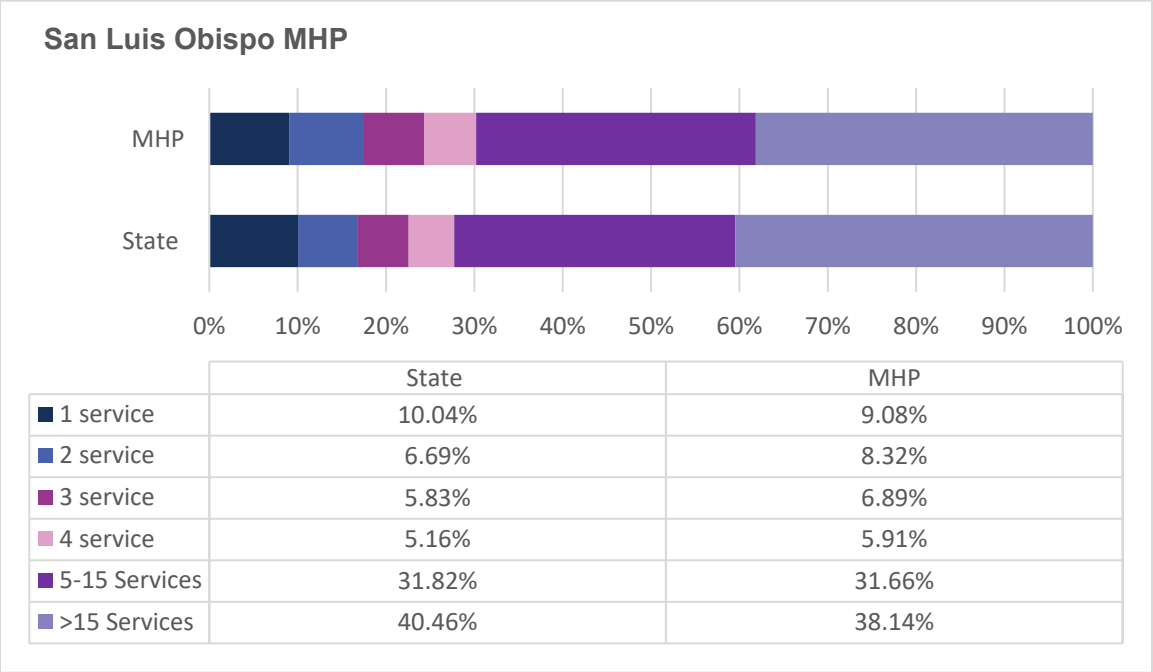
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

Retention in services is an important measure of beneficiary engagement in order to receive appropriate care and intended outcomes. One would expect most beneficiaries served by the MHP to require 5 or more services during a 12-month period. However, this table does not account for the length of stay (LOS), as individuals enter and exit care throughout the 12-month period.

Figure 15: Retention of Beneficiaries CY 2021



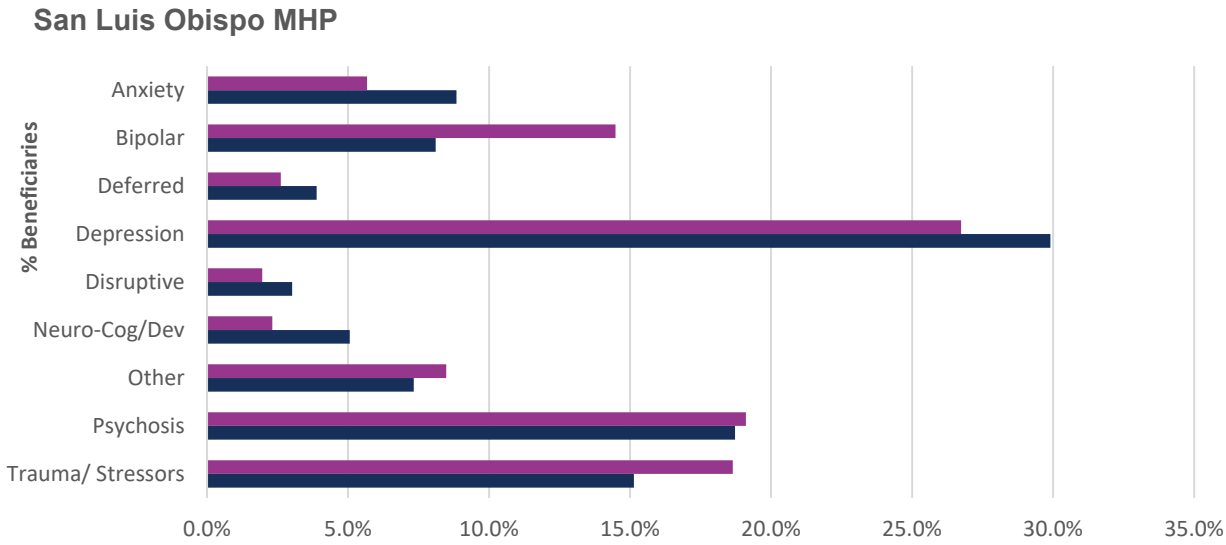
	State	MHP
1 service	10.04%	9.08%
2 service	6.69%	8.32%
3 service	5.83%	6.89%
4 service	5.16%	5.91%
5-15 Services	31.82%	31.66%
>15 Services	40.46%	38.14%

- Initial service and ongoing retention rates are generally similar between the MHP and statewide averages. The largest variance was for those clients receiving greater than 15 services in 2021, where the MHP was slightly lower (38.14 percent), than statewide average (40.46 percent).

Diagnosis of Beneficiaries Served

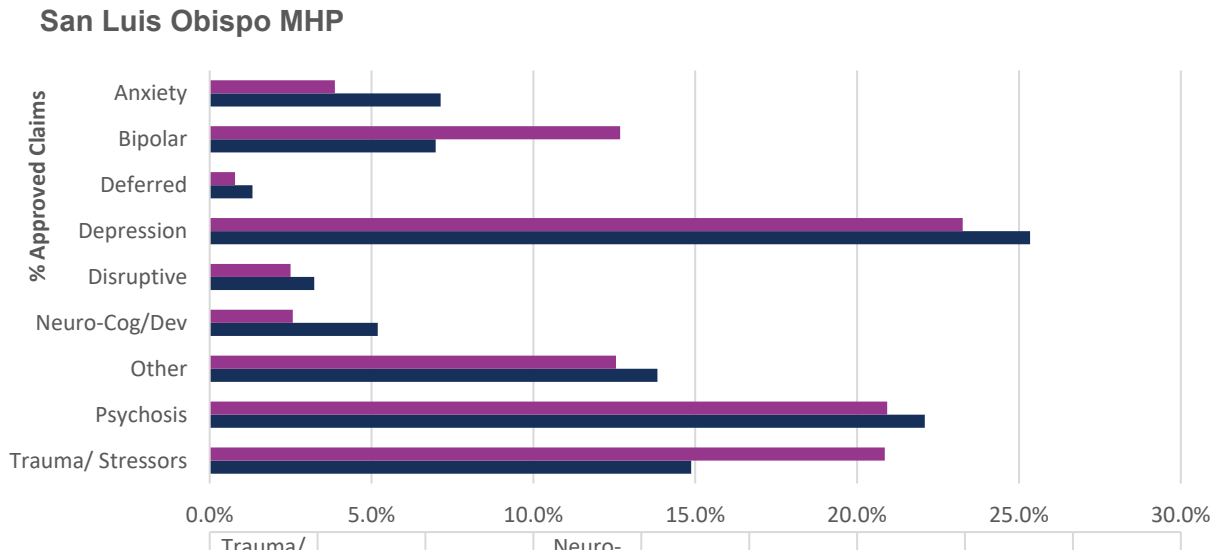
Developing a diagnosis, in combination with level of functioning and other factors associated with medical necessity and eligibility for SMHS, is a foundational aspect of delivering appropriate treatment. The figures below represent the primary diagnosis as submitted with the MHP's claims for treatment.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

Figure 16: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	18.6%	19.1%	8.5%	2.3%	2.0%	26.7%	2.6%	14.5%	5.7%
State 2021	15.1%	18.7%	7.3%	5.1%	3.0%	29.9%	3.9%	8.1%	8.8%

Figure 17: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressors	Psychosis	Other	Neuro-Cog/Dev	Disruptive	Depression	Deferred	Bipolar	Anxiety
MHP 2021	20.9%	20.9%	12.6%	2.6%	2.5%	23.3%	0.8%	12.7%	3.9%
State 2021	14.9%	22.1%	13.8%	5.2%	3.2%	25.3%	1.3%	7.0%	7.1%

- The MHP's depressive disorder percentages follow the statewide trends and are greater than psychotic disorders, followed by trauma/stress-related disorder (18.6 percent).

Psychiatric Inpatient Services

Table 13 provides a three-year summary (CY 2019-21) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and average LOS.

Table 13: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	280	516	6.78	8.79	$12,472	$12,052	$3,492,293
CY 2020	368	869	6.40	8.68	$14,270	$11,814	$5,251,336
CY 2019	385	989	6.01	7.80	$9,224	$10,535	$3,551,382

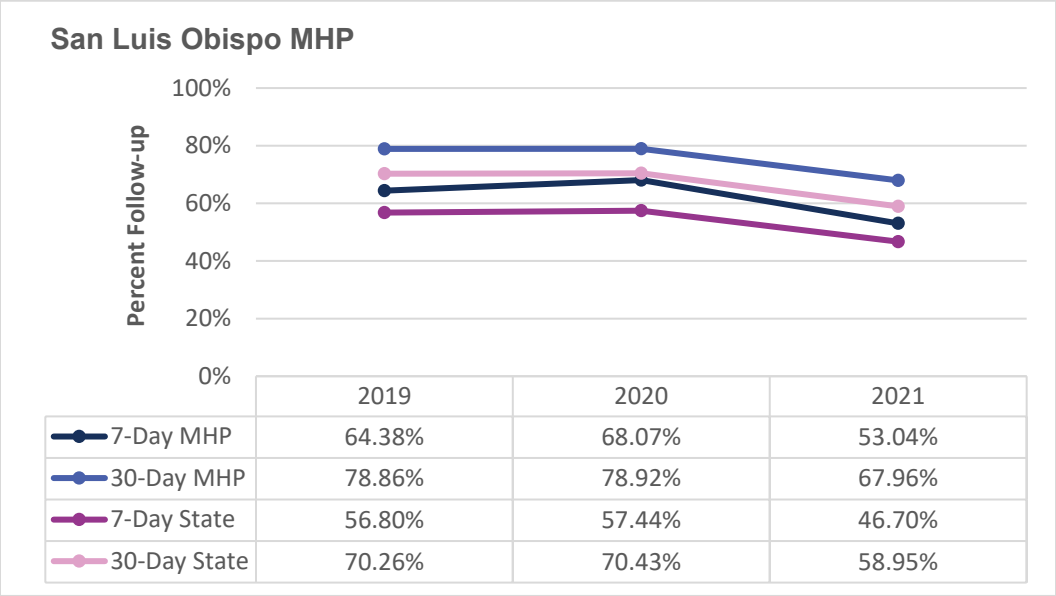
- Inpatient services have trended down each year with only a slight increase in average LOS.

Follow-Up Post Hospital Discharge and Readmission Rates

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

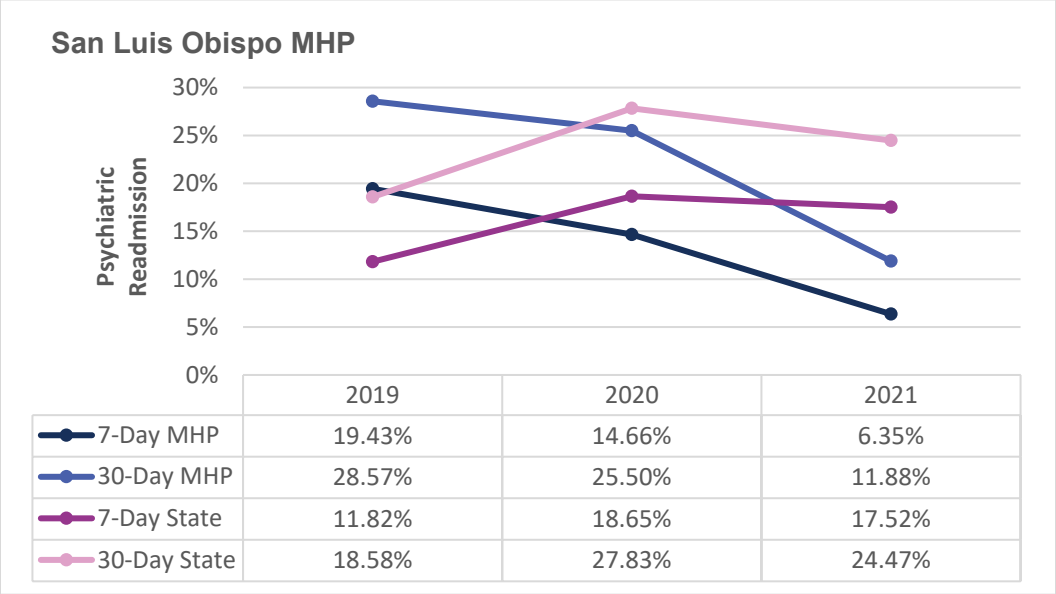
The 7-day and 30-day outpatient follow-up rates after a psychiatric inpatient discharge (HEDIS measure) are indicative both of timeliness to care as well as quality of care. The success of follow-up after hospital discharge tends to impact the beneficiary outcomes and are reflected in the rate to which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

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



	2019	2020	2021
7-Day MHP	64.38%	68.07%	53.04%
30-Day MHP	78.86%	78.92%	67.96%
7-Day State	56.80%	57.44%	46.70%
30-Day State	70.26%	70.43%	58.95%

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



	2019	2020	2021
7-Day MHP	19.43%	14.66%	6.35%
30-Day MHP	28.57%	25.50%	11.88%
7-Day State	11.82%	18.65%	17.52%
30-Day State	18.58%	27.83%	24.47%

- The MHP trend in psychiatric inpatient services is consistent with the statewide trends over the last year, with an increase in the average LOS as while the MHP AACB decreased from a prior significant increase and the statewide AACB continued to increase. The MHP continued to decrease in the unique beneficiaries in psychiatric inpatient services by 24 percent while there was a 40.6 percent decrease in the number of admissions.
- The MHP trend for follow-up care following psychiatric hospitalization is consistent with the statewide decrease in timely transitions. The MHP

continues to exceed the statewide average in timely transitions of care in both measured time periods.

- The rate of psychiatric readmissions has continued to decrease for the MHP, while the statewide averages have increased over the prior two years.

High-Cost Beneficiaries

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

Table 14 provides a three-year summary (CY 2019-21) of HCB trends for the MHP and the statewide numbers for CY 2021. HCBs in this table are identified as those with approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACB is $6,496, the median amount is just $2,928.

Tables 14 and 15, Figures 20 and 21 show how resources are spent by the MHP among individuals in high, middle, and low-cost categories. Statewide, about 92 percent of the statewide beneficiaries are "low cost" (less than $20,000 annually) receive just over half of the Medi-Cal resources, with an AACB of $4,131 and median of $2,615.

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

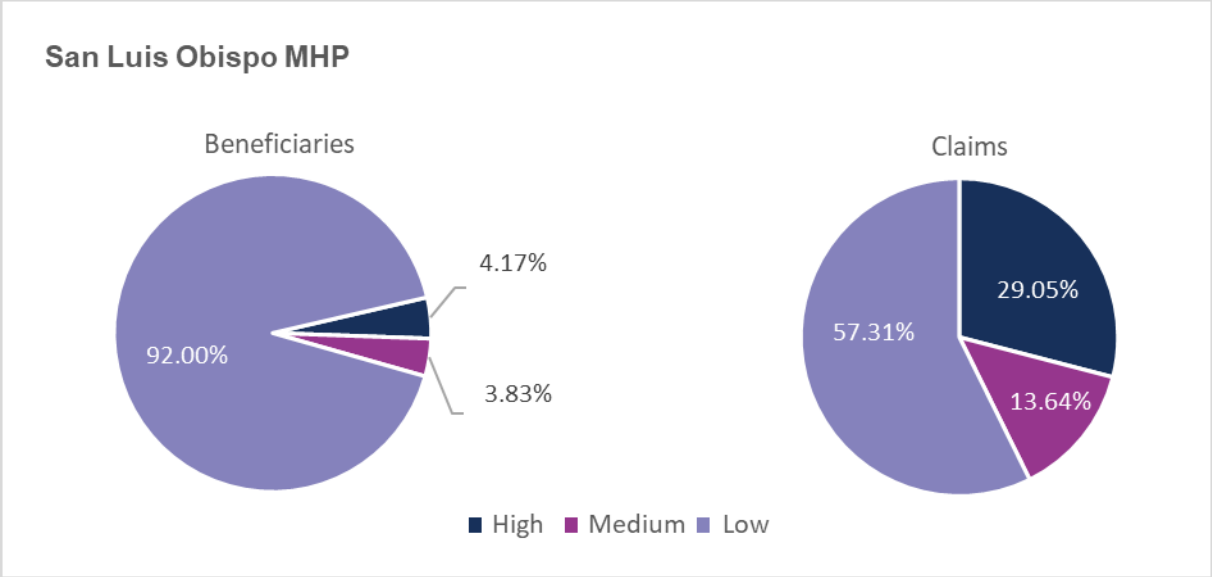
Entity	Year	HCB Count	Total Beneficiary Count	% of Beneficiaries Served	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	18,847	545,147	3.46%	$53,476	$43,231
MHP	CY 2021	132	3,162	4.17%	$47,691	$40,787
	CY 2020	241	3,295	7.31%	$51,371	$43,817
	CY 2019	181	3,694	4.90%	$46,549	$40,771

Table 15: Medium- and Low-Cost Beneficiaries CY 2021

Claims Range	Beneficiary Count	% of Beneficiaries Served	Total Approved Claims	% of Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	121	3.90%	$2,956,586	13.41%	$24,301	$24,242
Low Cost (Less than $20K)	2,846	91.84%	$12,420,779	46.11%	$4,057	$2,553

- The number of HCBs decreased by 109 (24.5 percent) from CY 2020 to CY 2021. The percent of HCBs in CY 2021 remains higher (4.17 percent) than the statewide average (3.46 percent) and the average approved claim amount per high-cost beneficiaries was 10.8 percent lower than the statewide average ($47,691 vs. $53,476).

Figure 20: Proportion of Beneficiary Count and Approved Claims by Claim Amount Grouping CY 2021



IMPACT OF QUALITY FINDINGS

- The MHP has developed prioritization processes that expedite service delivery for beneficiaries transitioning from urgent and acute facilities but struggle to provide the same level of service for routine access beneficiaries.
- The Quality plan is a QI format and not a QAPI format.

- Areas for QI are known to the to MHP and tracked in the QIC as part of a management involved process.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

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

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

Validation tools for each PIP are 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: Follow-Up After ED Visit for Mental Illness (FUM)

Date Started: 10/2022

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

Target Population: The target population are adults and minors who present to EDs with a qualifying event of an ED visit with a principal diagnosis of mental illness or intentional self-harm.

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

This PIP intends to improve follow-up MH services from the MHP for Medi-Cal beneficiaries with MH conditions with a target to increase the percentage seen within 7 and 30 days of ED discharge by 5% by June 30, 2023.

Interventions include EDs to provide consistent ED data and safety planning. MHP will implement processes to routinely review the data to identify utilization patterns and high-risk populations (e.g., individuals not engaged in services or who frequently use ED services) to inform follow-up care coordination of needs. The MHP will utilize a centralized referral tracking mechanism that allows for real-time referral coordination from the ED, including functionality to generate alerts for high-risk / urgent needs and other key information (e.g., language / communication needs). Post-discharge outreach with brief, regular phone contacts to support follow-up will also be provided by the MHP.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence, because the PIP is highly theoretical and does not yet address the practical issues of 24/7 ED systems; how people enter the ED system; how the ED captures ED data; if the data represents significant high utilizers; or if the data has a significant number of beneficiaries already open to the MHP.

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

- Review available data for specific details related to why and how the ED is utilized.
- Include stakeholders who utilize the ED for feedback on barriers and interventions.
- Expand the barrier review beyond referral systems and consider barriers to initial access.
- Consider a role for the Crisis Stabilization Unit for adult beneficiaries.
- Specify interventions.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Continuity of Care Initiative

Date Started: 07/2022

Aim Statement: For adults referred from the Initial MH Assessment to the admitting Regional Clinic (Specifically, Atascadero Clinic), will the interventions of replacing the Initial MH Assessment of 4 hours, to 3, 50 minute sessions with short term interventions provided for clients, and implementing "warm handoffs" through assigning a community partner (TMHA) navigator, improve initial retention from 75% to 80% or greater, as measured by beneficiary attendance of the first Admitting Regional Clinic (Atascadero) appointment over the time period between 7/1/2022 and 6/30/24.

Target Population: For the purposes of this PIP, the beneficiary population is all adult clients assessed by the Behavioral Health Managed Care Central Access team and referred into SMHS in the Atascadero Admitting Regional Clinic.

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

Summary

Multiple program supervisors identified a need for better support in the transition process from assessment to SMHS team assignment as well as the need to adhere to the ten calendar days state regulation. Multiple clients also reported dissatisfaction with having to wait for admitting clinic appointments.

The first PIP goal is to shorten time without a service between the assessment and initial appointment with the admitting SMHS regional clinic. The second PIP goal is to increase number of individuals who attend their first appointment at the admitting regional clinic(s). Interventions include allowing up to three appointments with the assessment team and assigning a peer navigator to assist with the transition process.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence, because: the PIP adds extended access staff contacts but does not address the gap of initiating full services faster. There is a risk that beneficiaries may discontinue if the initial access extension does not meet their needs.

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

- The MHP was encouraged to align terms so that there is standardized clarity of terms between sections.
- The MHP was requested to rewrite Table 5.1 so that the interventions are monitored by the variables and the goals are monitored by the PMs.
- The MHP was encouraged to develop a simple protocol for the actions and definition of "warm handoff".
- The MHP was requested to monitor closely the application of the 3 sessions by the assessment team to assure that the additional session do not become a

barrier to SMHS team assignment and have beneficiaries drop out of service prematurely.

- The MHP was encouraged to monitor the capacity of the central assessment team to manage the logistics of additional sessions.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN 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 Cerner Community Behavioral Health through Oracle/Cerner, which has been in use for 11 years. Currently, the MHP has selected a new system which requires heavy staff involvement to fully develop but it is not yet in the implementation phase.

Approximately 2.41 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.

The MHP has 691 named users with log-on authority to the EHR, including approximately 252 county staff and 439 contractor staff. Support for the users is provided by 19 FTE IS technology positions. Currently there are four vacant FTE positions. The 19 FTEs support the entire health agency, not solely the MH and substance use disorder systems of care.

As of the FY 2022-23 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for beneficiaries by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	30%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	60%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	5%
Paper documents delivered to MHP IS	☒ Daily ☐ Weekly ☐ Monthly	5%
		100%

Beneficiary Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of beneficiaries to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not currently have a PHR. This functionality is expected to be implemented within the next two years with the new EHR implementation.

Interoperability Support

The MHP is a member in a HIE, which is OCPRHIO. While the MHP is a member of the HIE, there is external access through the portal, however due to system limitations the current EHR cannot interface with the HIE to share data.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The MHP has selected the CalMHSA semi-statewide EHR, SmartCare, as the replacement for the current system. The MHP is engaged with CalMHSA in weekly meetings to begin planning for the implementation of the new EHR, with and anticipated go-live of July 2023.
- The MHP has ensured that contract providers do have direct access to the current EHR system regardless of the system limitations related to timeliness reporting.
- While the MHP maintains policies, procedures, and training on the Med-Cal claiming process the claim denial rate does exceed the statewide average claim denial rate.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

For the MHP, it appears that significant claims lag begins in October and likely represents $4 million in services not yet shown in the approved claims provided.

Table 18: Summary of CY 2021 Short-Doyle/Medi-Cal Claims

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	6,688	$1,936,581	$140,151	7.24%	$1,796,430
Feb	6,871	$1,960,460	$116,383	5.94%	$1,844,077
Mar	7,791	$2,336,405	$76,292	3.27%	$2,260,113
April	7,170	$2,529,052	$128,297	5.07%	$2,400,755
May	6,827	$2,625,417	$201,905	7.69%	$2,423,512
June	6,721	$2,348,166	$217,918	9.28%	$2,130,248
July	6,335	$1,762,579	$65,709	3.73%	$1,696,870
Aug	6,450	$1,772,240	$87,273	4.92%	$1,684,967
Sept	6,950	$2,130,362	$95,258	4.47%	$2,035,104
Oct	6,371	$1,983,179	$50,506	2.55%	$1,932,673
Nov	84	$26,880	$0	0.00%	$26,880
Dec	0	$0	$0	0.00%	$0
Total	**68,258**	**$21,411,321**	**$1,179,692**	**5.51%**	**$20,231,629**

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

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible or non-covered charges	506	$491,166	41.64%
Claim/service lacks information which is needed for adjudication	755	$425,460	36.07%
Medicare Part B or Other Health Coverage must be billed before submission of claim	855	$223,460	18.94%
NPI related	59	$28,280	2.40%
Other	6	$9,717	0.82%
Service line is a duplicate and a repeat service procedure code modifier not present	7	$1,605	0.14%
Total Denied Claims	2,188	$1,179,688	100.00%
Overall Denied Claims Rate	5.51%		
Statewide Overall Denied Claims Rate	2.78%		

- The MHP claim denial rate for CY 2021 of 5.51 percent is higher than the statewide average of 2.78%.
- Claims with denial codes: claim/service lacks information which is needed for adjudication, Medicare Part B or other health coverage must be billed prior to the submission of this claim, and NPI related are generally rebillable within State guidelines following claim corrections and resubmission.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- Strong collaboration with the contracted providers and ongoing communication will assist the MHP in the efforts implementing a new EHR.
- The base of 19 FTEs supporting the overall health agency IS functionality will provide a good foundation during the EHR transition. The dedicated data analytics staff assigned to the MH system of care may benefit from additional staffing resources as they confirm the new system reporting capabilities and what level of staffing is required to develop and maintain the system.
- The continued system limitations within the current EHR will prohibit efficient and fully reliable data collection efforts due to the current manual and workaround processes in place. Timeliness data, in particular, is significantly impacted by these limitations.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP reviews the surveys in the QIC. It was difficult to find survey results on the website and consumers could not recall seeing results posted or provided in any format. In 2021 the MHP adopted a multiaccess approach to delivering SMHS. This appears to have had a positive impact, the 2021 CPS survey data shows 87 percent of consumers were satisfied with the location of services, an increase from 82 percent in 2020. The 2021 youth and family survey results indicated that 90 percent liked services, similar to 2020. Adults and older adults reported 69 percent liked services, down from 87 percent in 2020.

CONSUMER FAMILY MEMBER FOCUS GROUPS

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

As part of the pre-review planning process, CalEQRO requested 2 90-minute focus groups with consumers (MHP beneficiaries) and/or their family members, containing 10 to 12 participants each.

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months". The focus group was held with each participant joining via telehealth and included six participants; a language interpreter was not used for this focus group as all participants spoke English. All consumers participating receive clinical services from the MHP.

Most of the consumers indicated that accessing services took 1-4 months and obtaining a therapist was an additional wait. Once receiving services most consumers reported they received clinical, case management and psychiatric services in a timely manner

and their providers of service include them in their treatment decisions and coordinate with physical health or other needed services. Consumers represented that transportation is difficult to obtain. Concerns were raised regarding the frequency of changes in staff, especially therapists and doctors. Crisis response from outpatient providers was represented as helpful. Crisis needs that necessitated ED, PHF or inpatient were represented as chaotic and needing improvement in communication and support.

Recommendations from focus group participants included:

- Increase trauma informed care training.
- Improve communication between programs, especially crisis systems.
- Leadership improve access to services.
- Leadership should go see and understand the service delivery on-site.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of parents and caregivers who initiated services in the preceding 12 months. The focus group was held via telehealth and included three participants; a language interpreter was not used for this focus group. All parents/caregivers participating have a family member who receives clinical services from the MHP.

Overall, all parents/Caregivers spoke positively about their experience with MHP providers. Access was represented to take up to several weeks. Services are provided weekly for most therapy services and approximately monthly inf psychiatric services are provided. Transportation can be provided but most do not need that assistance.

Recommendations from focus group participants included:

- Provide more parent coaching and education.
- Reduce therapist and doctor turnover.
- Help reduce stigma.

SUMMARY OF BENEFICIARY FEEDBACK FINDINGS

When services are provided with continuity of staff the MHP receives very high praise. Concerns regarding service disruption due to staff turnover and waits for initial access and waits for some services after initial access were pronounced. Concerns were also raised regarding continuity of services and communication across outpatient and crisis systems.

CONCLUSIONS

During the FY 2022-23 annual review, CalEQRO found strengths in the MHP's programs, practices, and IS that have a significant impact on beneficiary outcomes and the overall delivery system. In those same areas, CalEQRO also noted challenges that presented opportunities for QI. The findings presented below synthesize information gathered through the EQR process and relate to the operation of an effective SMHS managed care system.

STRENGTHS

1. The MHP's overall penetration is greater than medium size county and state averages. The MHP is expanding LOP to improve Latino/Hispanic penetration. (Access)
2. The MHP outperforms the state in 7-day and 30-day post psychiatric inpatient follow-up and 7-day and 30-day rehospitalization rates. (Timeliness)
3. The MHP is proactively implementing CalAIM initiatives, taking full advantage of CalMHSA products, and evidence significant connectivity and collaboration with MCP partners and contract providers. (Quality)
4. The MHP will be one of the first counties to implement the new SmartCare EHR, in development with CalMHSA (IS)
5. The MHP has introduced two new PIPs to address linkage and access to MHP providers from EDs (BHQIP Milestone 3d) and a PIP to improve retention after initial assessment. (Access and Quality, PIPs)

OPPORTUNITIES FOR IMPROVEMENT

1. Consumer, staff, and Key Component sessions validated extended waits for assessments, services after initial assessment and obtaining timely services after SMHS have been initiated, directly impacted by lack of available staffing. (Access)
2. Several timeliness measures are incomplete or impacted by human error, may not be reliable, and do not include contractor provider data. (Timeliness)
3. Track, trend and implement strategies to improve the continuity of timely access to therapist and psychiatric services after initial assessment. (Quality)
4. Both previous year's PIPs were discontinued due to lack of resources. Although promising, both new PIPs require additional development and dedicated resources to implement. (Quality - PIP)

5. The MHP's plan to implement the new EHR, SmartCare in July 2023 provides an opportunity to address several areas of need for data, timeliness tracking, and additional analytics to monitor current and CalAIM initiatives. (IS)

RECOMMENDATIONS

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

Investigate the reasons, develop strategies, and implement solutions to improve:

1. Staffing recruitment and retention, contracted staffing, and tele-workforce staffing opportunities to improve access, timeliness, and availability of services for routine outpatient access. (Access)
2. Improve accuracy and use of timeliness analytics, inclusive of contract providers, through the implementation of a new EHR and/or other developed methods. (Timeliness)
3. Track, trend and improve the continuity of timely access to therapist and psychiatric services after initial assessment. (Quality)
4. The implementation and maintenance of the current PIPs. (Quality-PIPs)
5. The plan to implement the new EHR, SmartCare in July 2023 to provide an opportunity to address several areas of need for data, timeliness tracking, and additional analytics to monitor current and CalAIM initiatives. (IS)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – San Luis Obispo MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and PMs
Timeliness PMs/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
PIP Validation and Analysis
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer and Family Member Focus Group(s)
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Clinical Management and Supervision
Services Focused on High Acuity and Engagement-Challenged Beneficiaries
Community-Based Services Agencies Group Interview
Validation of Findings for Pathways to MH Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment
Electronic Health Record Deployment
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Bill Walker, Quality Reviewer
Joel Chain, Information Systems Reviewer
Valerie Garcia, 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.

MHP County Sites

All sessions were held via video conference.

MHP Contract Provider Sites

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Adoptante	Dana	Health Information Technician	SLOBHD
Aguilar	Khrishna	Service Enhancement Team	Seneca
Allen	Amy	BH Clinician	SLOBHD
Alvarez	Meghan-Boaz	Clinical Director	Transitions- Mental Health Association (TMHA)
Atwell	Angela	MH Nurse	SLOBHD
Bahner	Kristin	BH Program Supervisor	SLOBHD
Berkman	Nasseem	BH Specialist	SLOBHD
Bolster-White	Jill	Executive Director	TMHA
Bouchar	Paula	Service Enhancement Team	Sierra Mental Wellness Group (SMWG)
Bouskos	Jordan	Service Enhancement Team	TMHA
Brannen (Fraser)	Alexis	BH Program Supervisor	SLOBHD
Castaneda	Susana	BH Specialist	SLOBHD
Cearley	Jana	Licensed Psych Tech/LV Nurse	SLOBHD
Clementi	Anthony	Service Enhancement Team	TMHA
Curry	Emilie	BH Specialist	SLOBHD
Curtis	Jeffrey	Agency Director	Pinnacle Treatment
Dabill	Jesse	Information Technology Manager	SLOBHD
Devaney-Frice	Vivien	Program Manager	TMHA

Last Name	First Name	Position	County or Contracted Agency
Drews	Nicholas	Health Agency Director	SLOBHD
Elliott	Jeffrey	BH Clinician	SLOBHD
Ellis	Patrick	Program Supervisor	Seneca
Epps	Sara	Administrative Services Officer	SLOBHD
Feliciano	Katrina	Administrative Services Officer	SLOBHD
Foglia	Anna	Program Manager	SunStreet
Folino	AJ	Lead Clinician	TMHA
Forgette	Gina	BH Program Supervisor	SLOBHD
Gendron	Linda	BH Program Supervisor	SLOBHD
George	Tony	Service Enhancement Team	Family Care Network Inc. (FCNI)
Getten	Amanda	Division Manager	SLOBHD
Gill	Scott	Program Manager	SLOBHD
Graber	Star	Division Manager BH	SLOBHD
Hansen	Carrie	BH Program Supervisor	SLOBHD
Heintz	Molly	Business Systems Analyst II	SLOBHD
Hernandez	Alexandra	BH Clinician	SLOBHD
Hoffman	Christine	BH Program Supervisor	SLOBHD
Hopkins	Denise	Administrative Services Manager	SLOBHD
Ilano	Daisy	MH Medical Director	SLOBHD

Last Name	First Name	Position	County or Contracted Agency
Jacobson	Ben	Mental Health Evaluation Team Program Supervisor	SMWG
Johnson	Barry	Division Manager	TMHA
Kever	Chad	Quality Assurance Specialist	TMHA
Klein	Donna	Service Enhancement Team	SMWG
Klever	Brooke	Service Enhancement Team	TMHA
Krumheuer	Seth	Mental Health Services Manager	FCNI
Kudrna	Michael	BH Clinician	SLOBHD
Kuester	Erin	Information Technology Supervisor	SLOBHD
Lamore	Mark	Program Supervisor	TMHA
Lehman	Tina	Program Director	Seneca
Levingston	Barbara	Consumer/Peer	Board of Supervisors
Limon	Enrique	Program Manager	SLOBHD
Lopez	Claudia	Patients' Rights Advocate	SLOBHD
Lopez	Maria	Service Enhancement Team	FCNI
Lords	Bonnie	Clinical Supervisor	Seneca
Manning	Cathy	Deputy Dir-Health Agency	SLOBHD
Maxwell	Kevin	Licensed Psych Tech/LV Nurse	SLOBHD
McAllister	Alicia	Supervisor	Bryans House
McGuire	Kathy	Medical Records Supervisor	SLOBHD

Last Name	First Name	Position	County or Contracted Agency
Mendez	Lisa	Accountant III	SLOBHD
Mendoza	CeCe	Program Director	Seneca
Murphy	Janeen	Clinical Supervisor	Seneca
Nibbio	Jon	Chief Operating Officer & Director of Clinical Services	FCNI
Olson	Carlos	BH Program Supervisor	SLOBHD
Parker	Samantha	BH Program Supervisor	SLOBHD
Pemberton	Teresa	Division Manager BH	SLOBHD
Peters	Josh	Division Manager BH	SLOBHD
Richardson	Julia	BH Program Supervisor	SLOBHD
Rietjens	Jill	Division Manager BH	SLOBHD
Robella	Tina	Accountant III	SLOBHD
Robin	Anne	BH Administrator	SLOBHD
Rogers	Robert	Service Enhancement Team	FCNI
Rubio	Kristel	BH Clinician	SLOBHD
Sahan	Gurpreet	BH Clinician	SLOBHD
Schmidt	Julianne	BH Program Supervisor	SLOBHD
Shinglot	Jalpa	Accountant III	SLOBHD
Soares	Traci	Administrator	Wilshire
Tarver	Rachel	BH Clinician	SLOBHD

Last Name	First Name	Position	County or Contracted Agency
Valencia	Mayra	Service Enhancement Team	TMHA
Vargas	Miram	Program Manager	TMHA
Vasquez	Fernando	Service Enhancement Team	TMHA
Vasquez	Esme	Service Enhancement Team	TMHA
Veloz-Passalacqua	Nestor	BH Program Manager	SLOBHD
Wakefield	Cynthia	BH Clinician	SLOBHD
Wallace	Alessia	BH Program Supervisor	SLOBHD
Warren	Frank	Division Manager BH	SLOBHD
Wortley	Sandy	Crisis Stabilization Unit Nursing Supervisor	SMWG
Wylie	Thomas	Service Enhancement Team	TMHA

ATTACHMENT C: PIP VALIDATION TOOL SUMMARY

Clinical PIP

Table C1: Overall Validation and Reporting of Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The confidence is moderate due to several elements not yet fully developed. The current PIP is highly theoretical and does not yet address the practical issues of: 24/7 ER systems; how people enter the ER system; how the ED captures ER data; if the data represents significant high utilizers; or if the data has a significance of beneficiaries already open to the MHP. In essence, it states the gap as a developed process: the lack of referrals and linkage from ERs to the MHP will be improved by implementing a referral and linkage process.
General PIP Information	
MHP/DMC-ODS Name: SLOBHD	
PIP Title: Follow-Up After Emergency Department Visit for Mental Illness	
PIP Aim Statement: For Medi-Cal beneficiaries with ED visits for MH conditions, implemented interventions will increase the percentage of follow-up mental health services with the MHP within 7 and 30 days by 5% by June 30, 2023.	
Date Started: 10/2022.	
Date Completed: not yet completed.	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

General PIP Information
Target population description, such as specific diagnosis (please specify): The target population are adults and minors who present to EDs with a qualifying event of an ED visit with a principal diagnosis of mental illness or intentional self-harm.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): None
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): EDs Provide consistent ED data and safety planning in EDs for suicide risk
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): • For data on historical utilization, implement processes to routinely review the data to identify utilization patterns and high-risk populations (e.g., individuals not engaged in services or who frequently use ED services) to inform follow-up care coordination of needs. • Utilize a centralized referral tracking mechanism that allows for real-time referral coordination from the ED, including functionality to generate alerts for high-risk / urgent needs and other key information (e.g., language / communication needs, • Post-discharge outreach with brief, regular phone contacts to support follow-up.

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

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

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

PIP Validation Information
EQRO recommendations for improvement of PIP: 1. Review available data for specific details related to why and how the ED is utilized. 2. Include stakeholders who utilize the ED for feedback on barriers and interventions. 3. Expand the barrier review beyond referral systems and consider care barriers. 4. Consider a role for the CSU for adult beneficiaries. 5. Specify interventions. 6. Complete all PIP elements.

Non-Clinical PIP

Table C1: Overall Validation and Reporting of Non-Clinical PIP Results

PIP Validation Rating (check one box)	Comments
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence	The PIP adds contacts with the access team prior to transition to a full SMHS team. There is risk that this may create a barrier to service.

General PIP Information
MHP/DMC-ODS Name: San Luis Obispo
PIP Title: Continuity of Care Initiative
PIP Aim Statement: For adults referred from the Initial MH Assessment to the admitting Regional Clinic (Specifically, Atascadero Clinic), will the interventions of replacing the Initial MH Assessment of 4 hours, to 3, 50 minute sessions with short term interventions provided for clients, and implementing "warm handoffs" through assigning a community partner (TMHA) navigator, improve initial retention from 75% to 80% or greater, as measured by beneficiary attendance of the first Admitting Regional Clinic (Atascadero) appointment over the time period between 7/1/2022 and 6/30/24.
Date Started: 07/2022
Date Completed: pending
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here:**

General PIP Information
Target population description, such as specific diagnosis (please specify): For the purposes of this PIP, the beneficiary population is all adult clients assessed by the Behavioral Health Managed Care Central Access team and referred into SMHS in the Atascadero Admitting Regional Clinic.
Improvement Strategies or Interventions (Changes in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): None
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): None
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): The Managed Care Team will see beneficiaries for up to 3 visits and a Peer Navigator will be assigned to assist in the transition to the SMHS team services.

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
Information was not presented.			☐ Not applicable—PIP is in planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

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

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

Validation phase (check all that apply):

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

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

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

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

PIP Validation Information
EQRO recommendations for improvement of PIP: • The MHP was encouraged to align terms so that there is standardized clarity of terms between sections. • The MHP was requested to rewrite Table 5.1 so that the interventions are monitored by the variables and the goals are monitored by the PMs. • The MHP was encouraged to develop a simple protocol for the actions and definition of “warm handoff”. • The MHP was requested to monitor closely the application of the 3 sessions by the assessment team to assure that the additional session did not becomes a barrier to SMHS team assignment and have beneficiaries drop out of service prematurely. • The MHP was encouraged to monitor the capacity of the central assessment team to manage the logistics of additional sessions.

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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