Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 402
Emeryville, CA 94608

info@bhceqro.com
www.caleqro.com
855-385-3776

FY 2021-22
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 6-7, 2021

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

Highlights from the Fiscal Year (FY) 2021-22 Mental Health Plan (MHP) External Quality Review (EQR) are included in this summary to provide the reader with a brief reference, while detailed findings are identified throughout the following report.

MHP INFORMATION

MHP Reviewed — San Luis Obispo

Review Type — Virtual

Date of Review — October 6-7, 2021

MHP Size — Medium

MHP Region — Central

MHP Location — San Luis Obispo

MHP Beneficiaries Served in Calendar Year (CY) 2020 — 3,295

MHP Threshold Language(s) — English and Spanish

SUMMARY OF FINDINGS

Of the eight recommendations for improvement that resulted from the FY 2020-21 EQR, the MHP addressed or partially addressed six recommendations.

CalEQRO evaluated the MHP on the following four Key Components that impact beneficiary outcomes; among the 26 components evaluated, the MHP met or partially met the following, by domain:

- Access to Care: 100 percent (four of four components)
- Timeliness of Care: 100 percent (six of six components)
- Quality of Care: 100 percent (ten of ten components)
- Information Systems (IS): 100 percent (six of six components)

The MHP submitted both of the two required Performance Improvement Projects (PIPs). The clinical PIP, “Hospital Emergency Department Consults”, is in the first remeasurement phase with a low confidence validation rating. The non-clinical PIP, “Connecting Beneficiaries from the Psychiatric Health Facility (PHF) to their Post-PHF Appointments”, is in the baseline year with a low confidence validation rating.

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

SUMMARY OF STRENTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas: walk-in model for crisis stabilization services; expansion of services to Paso Robles, which will include physical, public, and mental health along with social services and will enable beneficiaries to get services closer to home; a workforce that went above and beyond to continue to provide services during an ongoing challenge of COVID-19 and position vacancies; timeliness to services reporting by Spanish language; collaboration with other county MHPs and California Mental Health Services Act (CalMHSA) on the CalMHSA Semi-statewide EHR; and its Justice Services Program that provides an alternative to detention or incarceration.

The MHP was found to have notable opportunities for improvement in the following areas: staff shortages that adversely affect service quality; monitoring of timeliness which does not reflect protracted time to services that stakeholders endorsed; incomplete tracking of post-hospitalization follow-up, which only captures those who are new to services; limited ability to sufficiently analyze data to present implications of findings and to drive decision-making; and medication monitoring reporting that does not differentiate youth in foster care (FC) from other beneficiaries prescribed psychotropic medications.

FY 2021-22 CalEQRO recommendations for improvement include: review data and analysis of timeliness to address discrepancies and determine why MHP reporting differs from the experience of staff and beneficiaries alike; develop a plan and begin to include the timeliness findings of contract providers in the overall MHP reporting of timeliness; include data analysis and implications as a regular part of data reporting. Data analysis ought to inform program decisions, quality improvement activities, and other initiatives within the MHP; provide separate reporting of youth in FC in the HEDIS audit measures; and incorporate Power BI and their dashboards into the quality improvement workflow, including the annual workplan and evaluation, so that that key indicators and system-wide metrics and outcomes are captured and used for continuous quality improvement efforts.

INTRODUCTION

BACKGROUND

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

The State of California Department of Health Care Services (DHCS) contracts with 56 county MHPs to provide specialty mental health services (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 Mental Health Plan (MHP). DHCS contracts with Behavioral Health Concepts, Inc., the California EQRO (CalEQRO), to review and evaluate the care provided to the Medi-Cal beneficiaries.

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

This report presents the fiscal year (FY) 2021-22 findings of the EQR for San Luis Obispo County MHP by Behavioral Health Concepts, Inc., conducted as a virtual review on October 6-7, 2021.

METHODOLOGY

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

year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations to improve quality.

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

FINDINGS

Findings in this report include:

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

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

ENVIRONMENTAL IMPACT

This review took place during the Coronavirus Disease 2019 (COVID-19) pandemic. The MHP has experiences loss of staff, disruption of and discontinuation of services, and decreased offering of some services. CalEQRO worked with the MHP to design an alternative agenda due to the above factors. CalEQRO was able to complete the review without any insurmountable challenges.

MHP SIGNIFICANT CHANGES AND INITIATIVES

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

- The MHP has resumed in-person services and as needed, provides some remote/virtual services.
- The MHP's services have been negatively affected by staff vacancies, including from family and medical leaves, (COVID-19) quarantines, burn-out, early retirements, and competition from other employers.
- The MHP has seen and responded to an increase in beneficiaries seeking treatment for eating disorders.
- The MHP has established a new clinic in Paso Robles (to open in October 2021), which will provide access for residents in this area who otherwise travelled to the clinic in Atascadero.

RESPONSE TO FY 2020-21 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

Recommendations from FY 2020-21

Recommendation 1: As per Title 42, CFR, Section 438.330, DHCS requires two active PIPs; the MHP is contractually required to meet this requirement going forward.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP presented two PIPs, both of which were deemed active.
- Both PIPs are new and were started earlier this year.
- The MHP presented baseline data, but as of the review did not have current data.

Recommendation 2: Include clinical measures that are tracked both before and after the implementation of an intervention.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has presented a different clinical PIP than in the previous year. Nevertheless, there is still an issue regarding having a clinical measure for the clinical PIP.
- While there are clinical implications of the phenomenon, the MHP uses an indirect measure of outcomes.

Recommendation 3: Evaluate barriers to beneficiary engagement following initial contact and premature departure from services and implement strategies to ameliorate findings.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP did not present evidence of its review of administrative closures and efforts to resolve them.

- The MHP presented its efforts to improve engagement and retention in outpatient services of beneficiaries discharged from the PHF.
- This recommendation will not be continued. This past year presented a number of challenges for the MHP, but premature departure from services, or administrative closure, was not among them.

Recommendation 4: Provide more complete and comprehensive reporting of timeliness, to include the entire system of service providers, youth in FC (first offered psychiatry appointment; follow-up appointments post-hospitalization; 30-day inpatient readmission rate; and no-shows), and established beneficiaries as well as new beneficiaries.

(This recommendation is a carry-over from FY 2019-20 and FY 2018-19.)

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP has included timeliness data for youth in FC in its submission of the MHP Assessment of Timely Access, which it had not previously been reporting.
- The timeliness data only included county-operated services. The Behavioral Health Department of San Luis Obispo provided 53.2 percent of mental health services and contract providers provided 46.8 percent of the services.
- The timeliness data on post-hospitalization follow-up appointments only represents beneficiaries who are new to mental health services and not the existing population, who likely constitute more of the hospitalizations.

Recommendation 5: Conduct and document the completion of more substantive evaluations that include outcomes and impact and that enable the MHP to improve effectiveness and make decisions about future projects.

☐ Addressed ☐ Partially Addressed ☒ Not Addressed

- The MHP did not present evidence of more substantive evaluations conducted over the past year.
- The focus over the past year has been on the maintenance of services and safe service delivery.

Recommendation 6: Continue plans for developing a clinically focused framework for treatment outcomes and transitioning beneficiaries, which are used as criteria for when to discontinue services.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP reviewed the Outpatient Discharge Planning policy and procedure to ensure consistent understanding and implementation of this procedure.
- The MHP provides targeted, refresher training regarding our Adult Annual Assessment updates to assist clinicians in using the Adult Needs and Strengths Assessment (ANSA).

Recommendation 7: Modify the EHR and/or other information systems to include a FC designation/status. Such a field should be compulsory to ensure that it is consistently indicated.

(This recommendation is a carry-over from FY 2019-20 and FY 2018-19.)

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP made and implemented these modifications in the Access Journal for the purposes of timely access reporting.

Recommendation 8: Collaborate with San Luis Obispo (SLO) Health Agency (HA) Information Technology (IT) division to assure the readiness of Business Continuity Plan to maintain critical business functions in the event of a cyber-attack, emergency, or disaster.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The Health Agency Interim IT Manager is having regular meetings with the Central IT project team for updates as to the status of the business continuity project.
- Central IT currently has targets of 1 Day (or less) restore time and 1 Hour (or less) loss of data for Tier 1 machines.

NETWORK ADEQUACY

BACKGROUND

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

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

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

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

FINDINGS

For San Luis Obispo County, the time and distance requirements are 75 minutes and 45 miles for outpatient mental health and psychiatry services. These services are further measured in relation to two age groups – youth (0-20) and adults (21 and over)[1].

Alternative Access Standards and Out-of-Network Providers

In FY 2020-21, DHCS required the MHP to submit an AAS request for one zip codes for which time and/or distance standards were not met: 93453. The MHP reports that the zip code represents a very rural part of the county with a small number of residents and an even smaller number of Medi-Cal beneficiaries. The SLO Behavioral Health Department (SLOBHD) referenced a 2017 report, which reported that there were less than 80 individuals residing in this zip code. Residents of this community who are Medi-Cal beneficiaries routinely drive to the Atascadero service area, which is within the time standard for services.

This zip code does not meet the distance standards by five miles. DHCS approved the MHP's AAS request for a 50-mile distance standard instead of 45 miles specified for this MHP.

In FY 2021-22, the MHP met time and distance standards, and therefore did not require AAS.

Planned Improvements to Meet NA Standards

The MHP proposed the following strategies to meet NA standards and enhance access for Medi-Cal beneficiaries:

- Expand the availability of telehealth services
- Collaborate with the MCP provider to arrange for transportation for in-person services as needed.

MHP Activities in Response to FY 2020-21 AAS

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

[1] AB 205 and BHIN 21-023

PROVIDER NPI AND TAXONOMY CODES

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

ACCESS TO CARE

BACKGROUND

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

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

ACCESS IN SAN LUIS OBISPO COUNTY

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 53.18 percent of services were delivered by county-operated/staffed clinics and sites, and approximately 46.82 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 78.04 percent of services provided are claimed to Medi-Cal.

The MHP has a toll-free Access Line available to beneficiaries 24-hours, 7-days per week that is 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 services. Upon assessment, beneficiaries are assigned to programs and outpatient clinics for ongoing services.

In addition to clinic-based mental health services, the MHP provides telehealth and mobile mental health services. Specifically, the MHP delivers psychiatry and/or mental health services via telehealth to youth and/or adults. In FY 2020-21, the MHP reports having served 1,158 adult beneficiaries, 162 youth beneficiaries, and 18 older adult beneficiaries across 5 county-operated sites and 6 contractor-operated sites. Among those served, 47 beneficiaries received telehealth services in a language other than English in the preceding 12 months.

ACCESS KEY COMPONENTS

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

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

Table 1: Key Components - Access

KC #	Key Components – Access	Rating
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	Met
1B	Manages and Adapts Capacity to Meet Beneficiary Needs	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 crisis stabilization unit (CSU) has been a resource for Medi-Cal beneficiaries and members of the community throughout the pandemic. The CSU has provided prevention services as well as stabilization.
- The Justice Services Program offers diversion from criminal justice proceedings and enables facile access to mental health services. The program has held three graduations in the past year.
- Access to services is critically affected by a shortage of therapists and psychiatrists. Outpatient caseloads in excess of 250 were not uncommon.

PERFORMANCE MEASURES

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

- Total beneficiaries served, stratified by race/ethnicity and threshold language.
- Penetration rates, stratified by race/ethnicity and FC status.

- Approved claims per beneficiary (ACB) served, stratified by race/ethnicity and FC status.

Total Beneficiaries Served

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

Latino/Hispanic individuals constitute 31.1 percent of the eligible Medi-Cal population in San Luis Obispo but only 14.9 percent of beneficiaries served by the MHP. White beneficiaries are 47.7 percent of those served by the MHP and constitute 40.3 percent of the total eligibles.

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

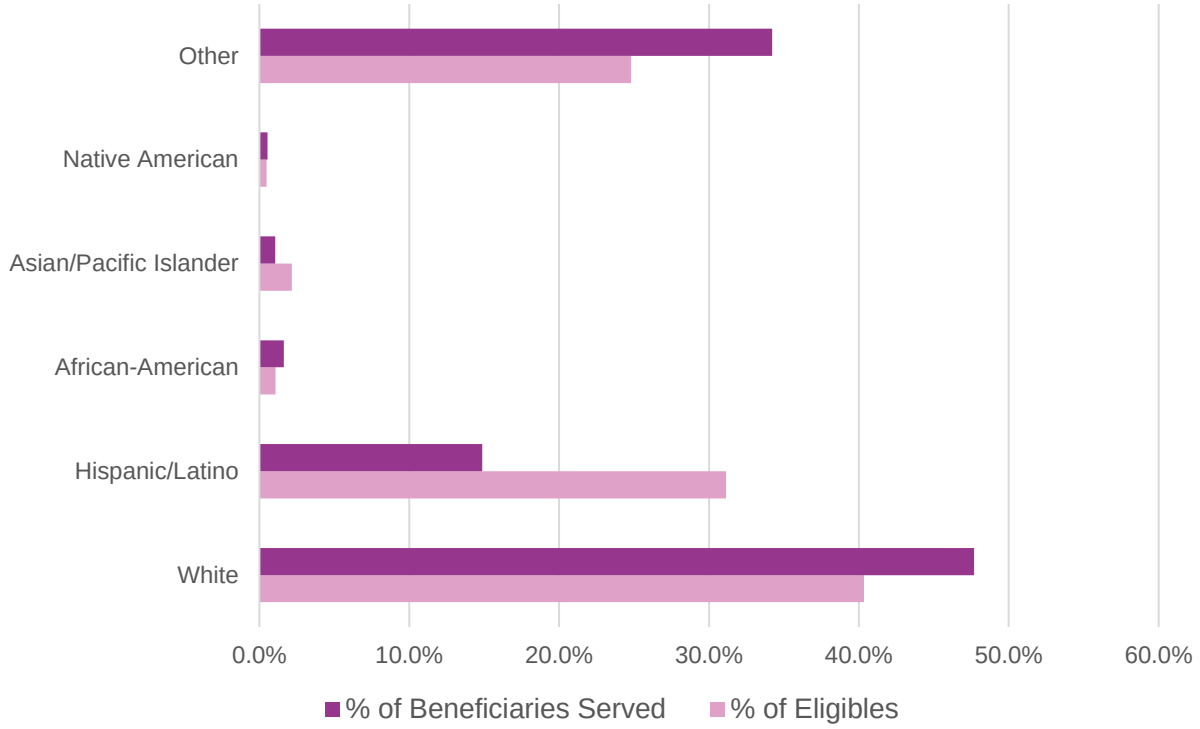
San Luis Obispo MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	23,766	40.3%	1,571	47.7%
Latino/Hispanic	18,341	31.1%	490	14.9%
African-American	636	1.1%	54	1.6%
Asian/Pacific Islander	1,274	2.2%	35	1.1%
Native American	285	0.5%	18	0.5%
Other	14,610	24.8%	1,127	34.2%
Total	**58,912**	**100%**	**3,295**	**100%**

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

The race/ethnicity results in Figure 1 can be interpreted to determine how readily the listed race/ethnicity subgroups access SMHS through the MHP. If they all had similar patterns, one would expect the proportions they constitute of the total population of Medi-Cal eligibles to match the proportions they constitute of the total beneficiaries served.

The disproportionate access to mental health services by White beneficiaries compared to Latino/Hispanic is illustrated in Figure 1.

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



Spanish is the only threshold language in San Luis Obispo and 7.0 percent of beneficiaries served stated that Spanish was their primary language. English accounted for most of the other languages spoken by beneficiaries.

Table 3: Beneficiaries Served in CY 2020, by Threshold Language

San Luis Obispo MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	224	7.0%
Other Languages	2,964	93.0%
Total	**3,188**	**100%**
Threshold language source: Open Data per IN 20-070 Other Languages include English		

Penetration Rates and Approved Claim Dollars per Beneficiary Served

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

CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment D provides further ACA-specific utilization and performance data for CY 2020. See Table D1 for the CY 2019 ACA penetration rate and ACB.

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

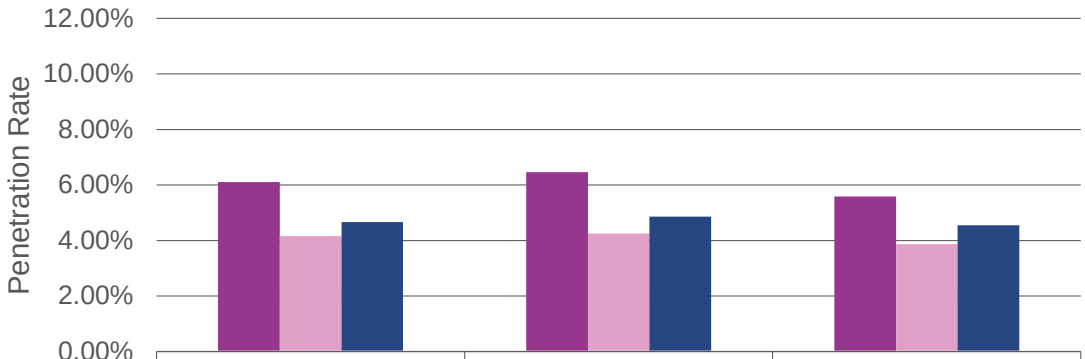
San Luis Obispo's overall penetration rate decreased in CY 2020, reflecting similar trends in other like-sized counties and statewide. Compared to medium-sized counties and statewide, the MHP had a higher penetration rate.

The ACB also increased in CY 2020, a trend also seen statewide. The increase in average claim per beneficiary is in part explained by an increase in the MHP claiming rates due to the impact of the COVID-19 Public Health Emergency on service delivery and volume as authorized by IN 20-024.

The penetration rate for Latino/Hispanic beneficiaries dropped slightly in CY 2020 for the MHP but was similar to like-sized counties. However, it was lower than the statewide rate. For Asian/Pacific Islander beneficiaries, the penetration rate was stable across calendar years and slightly higher than the rate for statewide and medium-sized counties.

Figure 2: Overall Penetration Rates CY 2018-20

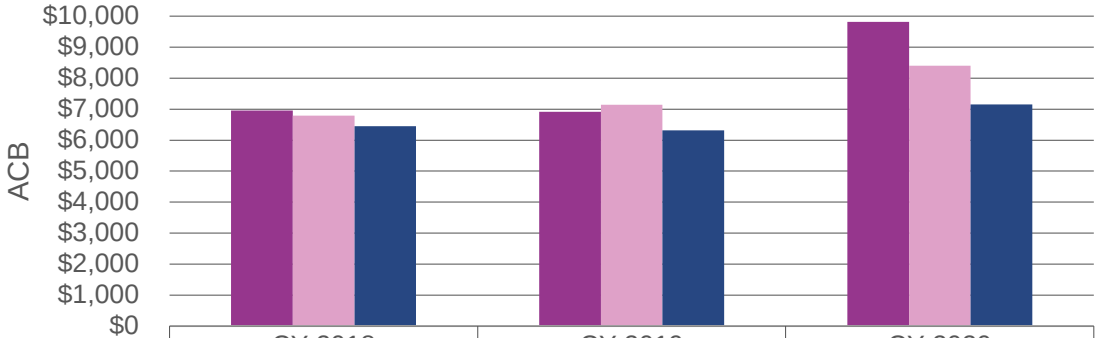
San Luis Obispo MHP



	CY 2018	CY 2019	CY 2020
MHP	6.11%	6.46%	5.59%
Medium	4.16%	4.25%	3.87%
State	4.66%	4.86%	4.55%

Figure 3: Overall ACB CY 2018-20

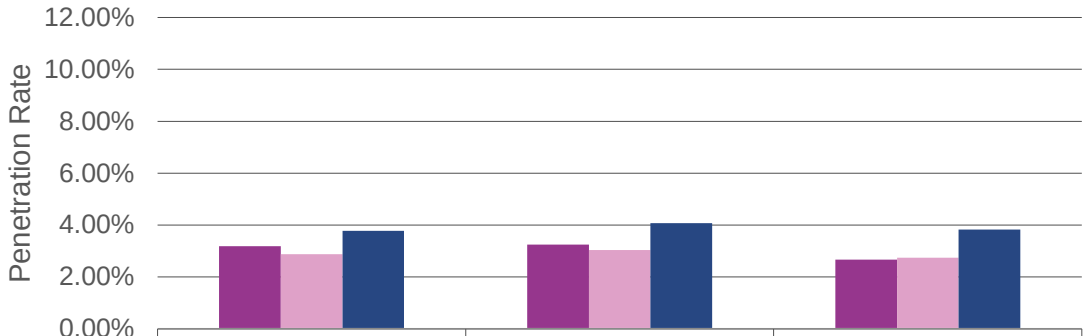
San Luis Obispo MHP



	CY 2018	CY 2019	CY 2020
MHP	$6,957	$6,914	$9,819
Medium	$6,785	$7,143	$8,399
State	$6,454	$6,316	$7,155

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

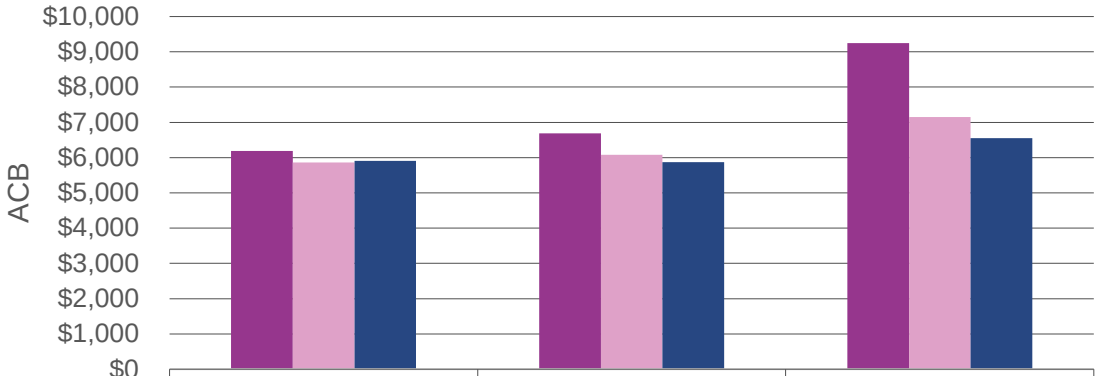
San Luis Obispo MHP



	CY 2018	CY 2019	CY 2020
MHP	3.19%	3.25%	2.67%
Medium	2.88%	3.04%	2.74%
State	3.78%	4.08%	3.83%

Figure 5: Latino/Hispanic ACB CY 2018-20

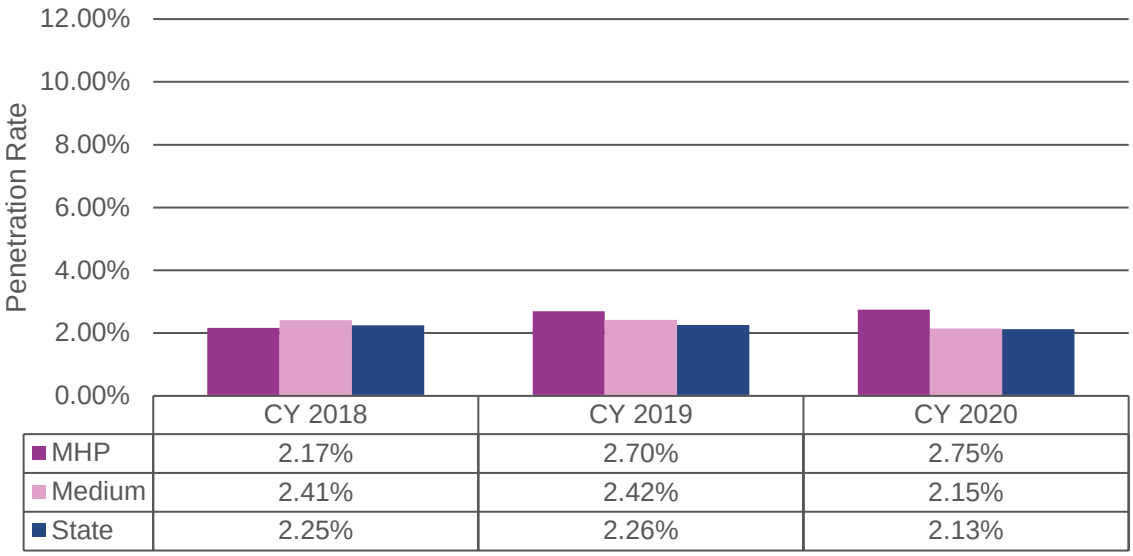
San Luis Obispo MHP



	CY 2018	CY 2019	CY 2020
MHP	$6,191	$6,684	$9,244
Medium	$5,858	$6,081	$7,153
State	$5,904	$5,869	$6,551

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

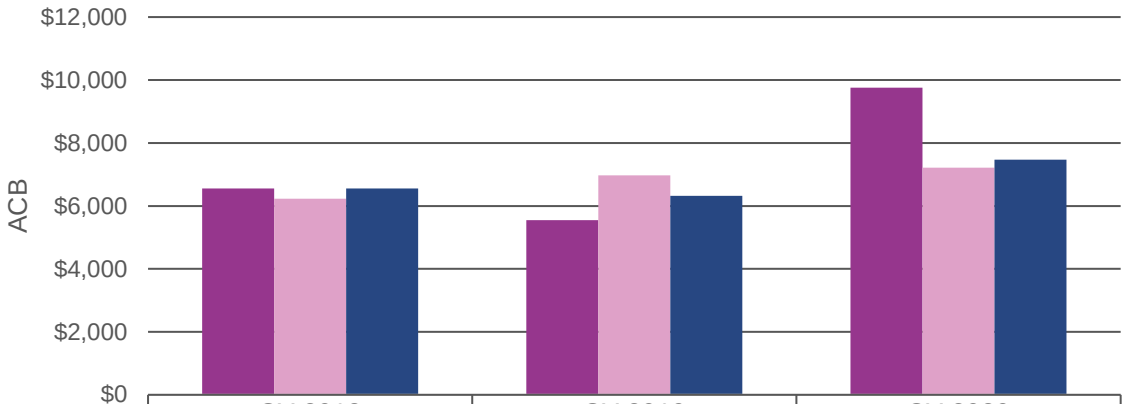
San Luis Obispo MHP



	CY 2018	CY 2019	CY 2020
MHP	2.17%	2.70%	2.75%
Medium	2.41%	2.42%	2.15%
State	2.25%	2.26%	2.13%

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

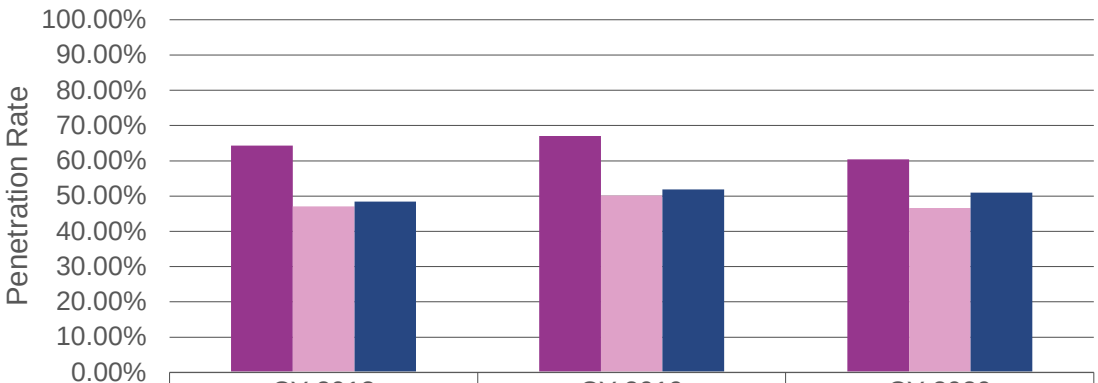
San Luis Obispo MHP



	CY 2018	CY 2019	CY 2020
MHP	$6,552	$5,546	$9,754
Medium	$6,232	$6,976	$7,214
State	$6,557	$6,325	$7,466

Figure 8: FC Penetration Rates CY 2018-20

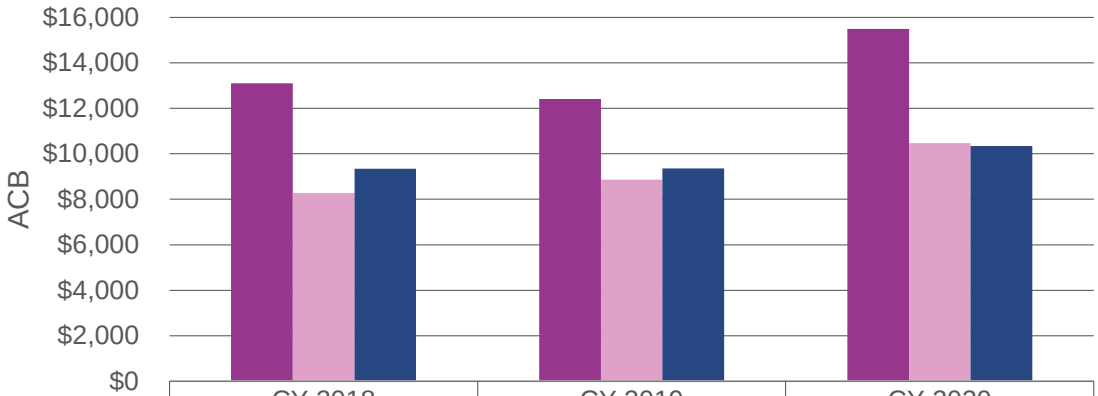
San Luis Obispo MHP



	CY 2018	CY 2019	CY 2020
MHP	64.29%	67.07%	60.45%
Medium	47.10%	50.12%	46.59%
State	48.41%	51.91%	51.00%

Figure 9: FC ACB CY 2018-20

San Luis Obispo MHP



	CY 2018	CY 2019	CY 2020
MHP	$13,098	$12,415	$15,487
Medium	$8,276	$8,870	$10,465
State	$9,340	$9,360	$10,338

IMPACT OF FINDINGS

The MHP experienced a decrease in overall penetration rates, which was likely driven by a decrease in beneficiaries accessing services following the onset of the pandemic. Conversely there was an increase in ACB in CY 2020. The MHP has disparities in access to services as demonstrated by the penetration rates for Latino/Hispanic and API beneficiaries. The disparity is particularly great for Latino/Hispanic individuals that made up just over 31 percent of the Medi-Cal eligibles, but less than 15 percent received services.

TIMELINESS OF CARE

BACKGROUND

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

TIMELINESS IN SAN LUIS OBISPO COUNTY

The MHP reported timeliness data stratified by age and FC status. Further, timeliness data presented to CalEQRO represented county-operated services only.

TIMELINESS KEY COMPONENTS

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

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

Table 4: Key Components – Timeliness

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

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

- The MHP serves a large Latino/Hispanic population and reports on timeliness to services by Spanish language.
- The MHP reported only on post-hospitalization follow-ups for beneficiaries discharged from the PHF and only those who were new to SMHS services.

PERFORMANCE MEASURES

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

The following PMs reflect the MHP's performance on these and additional timeliness measures consistent with statewide and national quality standards, including Healthcare Effectiveness Data and Information Set (HEDIS) measures:

- First Non-Urgent Appointment Offered
- First Non-Urgent Service Rendered
- First Non-Urgent Psychiatry Appointment Offered
- First Non-Urgent Psychiatry Service Rendered
- Urgent Services Offered – Prior Authorization not Required
- Urgent Services Offered – Prior Authorization Required

- No-Shows – Psychiatry
- No-Shows – Clinicians
- Psychiatric Inpatient Hospital 7-Day and 30-Day Readmission Rates
- Post-Psychiatric Inpatient Hospital Discharge 7-Day and 30-Day SMHS Follow-Up Service Rates

MHP-Reported Data

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

- The MHP reported nearly similar values for offered and rendered first services.
- The MHP reported on county-operated services only.
- The MHP has established benchmarks for no-shows. The benchmark for adult psychiatry is at 26 percent, an atypical benchmark value, which happens to be just above its no-show rate of 25 percent.

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

FY 2021-22 MHP Assessment of Timely Access			
Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	10 Days	10 Business Days*	85%
First Non-Urgent Service Rendered	10 Days	14 Calendar Days**	85%
First Non-Urgent Psychiatry Appointment Offered	18 Days	15 Business Days*	73%
First Non-Urgent Psychiatry Service Rendered	***	***	***
Urgent Services Offered (including all outpatient services) – Prior Authorization not Required	48 Hours	48 Hours*	96%
Urgent Services Offered – Prior Authorization Required	39 Hours	96 Hours*	97%
Follow-Up Appointments after Psychiatric Hospitalization	4 Days	7 Days**	88%
No-Show Rate – Psychiatry	20%	20%**	n/a
No-Show Rate – Clinicians	12%	10%**	n/a
* DHCS-defined timeliness standards as per BHIN 20-012 ** MHP-defined timeliness standards ***MHP did not report data for this measure			

Medi-Cal Claims Data

The following data represents MHP performance related to psychiatric inpatient readmissions and follow-up post hospital discharge, as reflected in the CY 2020 SDMC and IPC data. The days following discharge from a psychiatric hospitalization can be a particularly vulnerable time for individuals and families; timely follow-up care provided by trained mental health professionals is critically important.

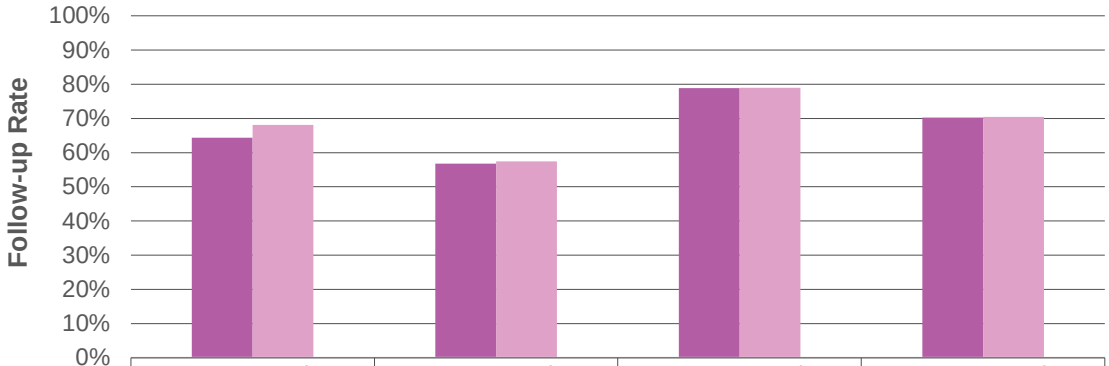
Follow-up post hospital discharge

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

The MHP has a higher post-inpatient 7- and 30-day follow-up rate compared to the state. The 7-day follow-up rate increased from 64 percent in CY 2019 to 68 percent in CY 2020. The MHP's self-reported data for FY 2020-21 was 88 percent, significantly higher than the CY 2020 CalEQRO calculation.

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

San Luis Obispo MHP



	7 Day Outpatient MHP	7-Day Outpatient State	30-Day Outpatient MHP	30-Day Outpatient State
CY 2019	64%	57%	79%	70%
CY 2020	68%	57%	79%	70%

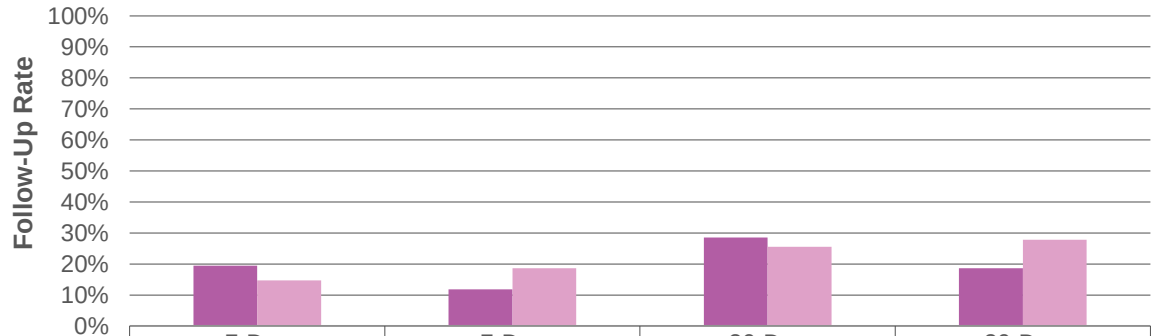
Readmission rates

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

The MHP had a 7-day rehospitalization rate of 15 percent, lower than the statewide rate of 19 percent. The 30-day rehospitalization rate was 26 percent, just under the statewide rate of 28 percent. The MHP reported a 7-day rehospitalization rate of 1.69 percent and a 30-day rate of 7.6 percent.

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

San Luis Obispo MHP



	7-Day Rehospitalization MHP	7-Day Rehospitalization State	30-Day Rehospitalization MHP	30-Day Rehospitalization State
CY 2019	19%	12%	29%	19%
CY 2020	15%	19%	26%	28%

IMPACT OF FINDINGS

The MHP monitors timeliness to services by Spanish language, which provides a measure of its capacity to serve and parity in timely access for Latino/Hispanic beneficiaries. The MHP has better follow-up and rehospitalization rates compared to the statewide rates. However, its self-reported data are different than the CalEQRO data, which may be partially explained by comparing different time periods (CY versus FY). The MHP's post-hospitalization follow-up measure does not capture all those who have been discharged from care and also need services. The MHP is not currently tracking urgent appointments that require prior authorization for children and youth in FC.

QUALITY OF CARE

BACKGROUND

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

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

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

QUALITY IN SAN LUIS OBISPO COUNTY

In the MHP, the responsibility for QI is the Quality Support Team (QST). The QST is responsible for compliance and training as well. The QST has seven full-time equivalents (FTEs), including a PHF nurse, an administrative services officer, and utilization review clinicians.

The MHP monitors its quality processes through the Quality Improvement Committee (QIC), the Quality Assessment and Performance Improvement (QAPI) workplan, and the annual evaluation of the QAPI workplan. The QIC, comprised of SLOBHD staff, contract providers, behavioral health board members, and SLO HA staff. 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 behavioral health meeting. Since the previous EQR (i.e., which was 10 months ago), the MHP QIC met eight times. The MHP identified 14 goals in the FY 2020-21 QAPI workplan goals, with a number of 'Planned Steps' to accomplish the goal. The MHP reported on whether or not the Planned Step was completed and not whether the goal itself was achieved.

The MHP utilizes the following level of care tool(s): Milestones of Recovery Scale.

The MHP utilizes the following outcomes tools: ANSA, the Child and Adolescent Needs and Strengths, the Pediatric Symptom Checklist-35, and the Ages and Stages Questionnaire.

Through one of its contract providers, the MHP has well established peer integration. This peer workforce integrations includes internship and training opportunities, as well as opportunities for leadership.

QUALITY KEY COMPONENTS

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

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

Table 6: Key Components – Quality

KC #	Key Components - Quality	Rating
3A	Quality Assessment and Performance Improvement are Organizational Priorities	Met
3B	Data is Used to Inform Management and Guide Decisions	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	Partially 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:

- There is leadership endorsement of QI initiatives and regular attendance at QIC meetings.

- Staff input is sought by MHP leadership and decision-makers, as evidenced by the formation of the Access and Transitions Workgroup in the past year. However, staff indicated that with high caseloads and short staffing, there is limited time to attend.
- MHP's health data analytics capacity was limited; there is more capacity for collecting and reporting, which does not give a complete picture of the beneficiaries' needs.
- While the MHP reports on whether planned steps occurred in the evaluation of its prior year QI program, this does not address whether the QI goal was achieved.
- The MHP has incorporated several HEDIS measures in its regular audits of medication practices.
- The MHP tracks and trends the following HEDIS measures as required by SB 1291:
    - Follow-up care for Children Prescribed Attention Deficit Hyperactivity Disorder medications (HEDIS ADD)
    - The use of multiple concurrent psychotropic medications for children and adolescents (HEDIS APC)
    - Metabolic monitoring for children and adolescents on antipsychotics (HEDIS APM)
    - The use of first-line psychosocial care for children and adolescents on antipsychotics (HEDIS APP)

PERFORMANCE MEASURES

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

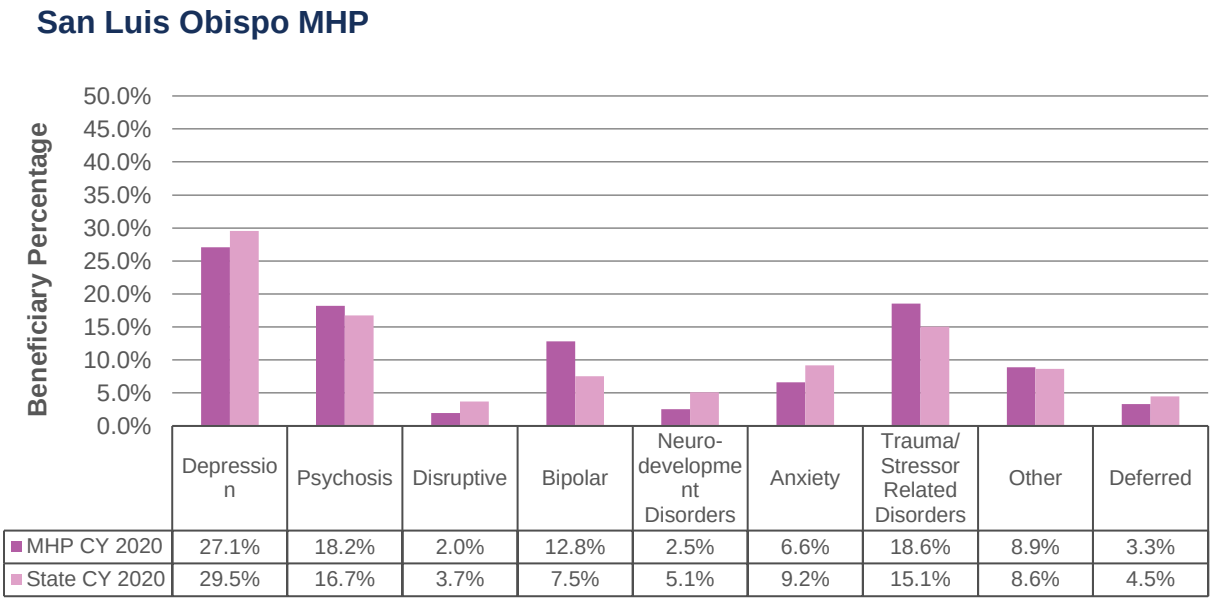
- Beneficiaries Served by Diagnostic Category
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay (LOS)
- Retention Rates
- High-Cost Beneficiaries (HCB)

Diagnosis Data

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

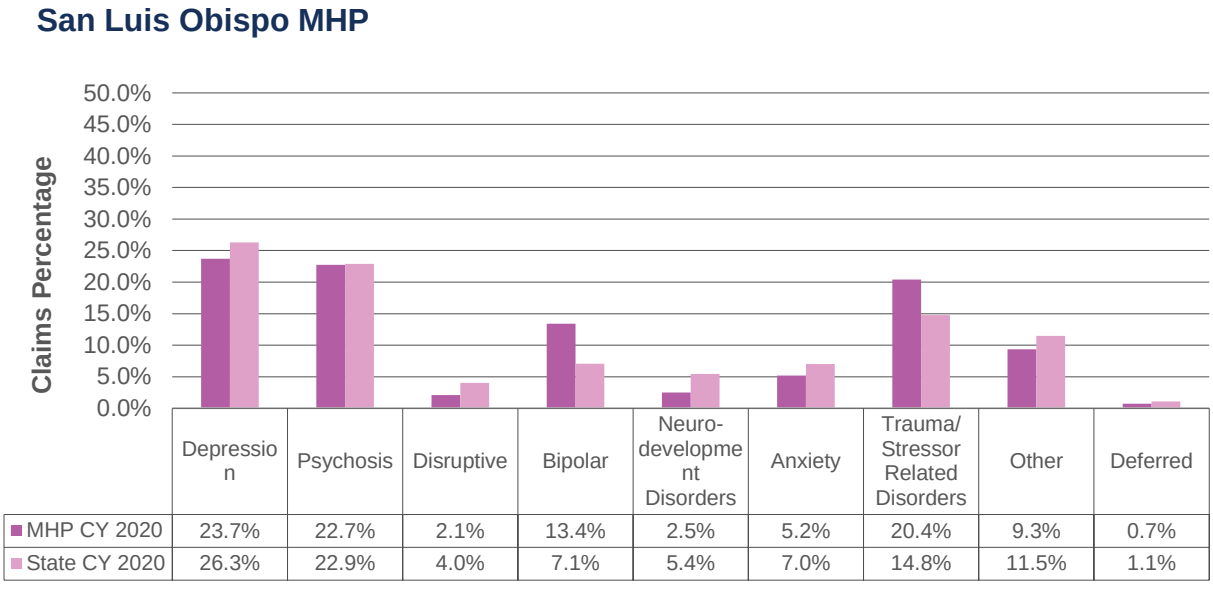
The MHP has similar patterns of diagnostic categories compared to statewide, with the majority of beneficiaries having a depression diagnosis (27.1 percent). The only diagnostic category that is different by more than four percentage points is Bipolar—the MHP has a higher percentage of beneficiaries with this diagnosis compared to statewide (12.8 percent vs. 7.5 percent).

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2020



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	27.1%	18.2%	2.0%	12.8%	2.5%	6.6%	18.6%	8.9%	3.3%
State CY 2020	29.5%	16.7%	3.7%	7.5%	5.1%	9.2%	15.1%	8.6%	4.5%

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



	Depression	Psychosis	Disruptive	Bipolar	Neuro-development Disorders	Anxiety	Trauma/ Stressor Related Disorders	Other	Deferred
MHP CY 2020	23.7%	22.7%	2.1%	13.4%	2.5%	5.2%	20.4%	9.3%	0.7%
State CY 2020	26.3%	22.9%	4.0%	7.1%	5.4%	7.0%	14.8%	11.5%	1.1%

Psychiatric Inpatient Services

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

The number of inpatient admissions decreased in CY 2020 while the average LOS stayed stable. The ACB for inpatient stays went up, perhaps another reflection of the increase in claiming rates.

Table 7: Psychiatric Inpatient Utilization CY 2018-20

San Luis Obispo MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2020	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
CY 2018	317	659	5.45	7.63	$10,630	$9,772	$3,369,633

High-Cost Beneficiaries

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

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

The MHP had more clients meeting the HCB threshold in CY 2020 compared to prior years, comprising 7.31 percent of all beneficiaries. The cost of HCB was 38.27 percent of all claims.

Table 8: HCB CY 2018-20

San Luis Obispo MHP							
	Year	HCB Count	Total Beneficiary County	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2020	24,242	595,596	4.07%	$53,969	$1,308,318,589	30.70%
MHP	CY 2020	241	3,295	7.31%	$51,371	$12,380,520	38.27%
	CY 2019	181	3,694	4.90%	$46,549	$8,425,354	32.99%
	CY 2018	173	3,616	4.78%	$50,799	$8,788,295	34.93%

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

Retention Data

The MHP's service retention of beneficiaries is similar to the statewide pattern. Most beneficiaries receive 5 or more services each year, or 75.14 percent of MHP beneficiaries.

Table 9: Retention of Beneficiaries

	San Luis Obispo MHP			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 Service	296	8.98	8.98	9.76	9.76	5.69	21.86
2 Services	243	7.37	16.36	6.16	15.91	4.39	17.07
3 Services	143	4.34	20.70	4.78	20.69	2.44	9.17
4 Services	137	4.16	24.86	4.50	25.19	2.44	7.78
5-15 Services	1,016	30.83	55.69	29.47	54.67	19.96	42.46
>15 Services	1,460	44.31	100.00	45.33	100.00	23.02	57.54

IMPACT OF FINDINGS

The MHP experienced a considerable increase in the proportion of beneficiaries who are HCB (from 4.90 percent last year to 7.31 percent), which may be related to purported increase in the severity of beneficiary needs and the need for specialized

services. Some of these specialized services (e.g., for eating disorders) were facilitated through outside contracted providers. The MHP is encouraged to conduct a more complete evaluation of its QI program, inclusive of progress towards goal achievement, contributes to better outcomes for beneficiaries.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

BACKGROUND

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

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: Hospital Emergency Department Consults

Date Started: July 2021

Aim Statement: "We will provide psychiatric treatment to clients on psychiatric holds in our [emergency department's] via telehealth and [physician] consultation to address the client's acute, psychiatric condition to prevent transfers to acute, inpatient psychiatric facilities. The time-period of this study is July 2021 through July 2022."

Target Population: Beneficiaries of all ages regardless of diagnosis, previous treatment enrollment, or demographic characteristics who are in the French Hospital emergency department on a psychiatric hold.

[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

Validation Information: The MHP's clinical PIP is in the First Remeasurement phase and considered Active.

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

Summary

The MHP has seen an increase in the number of beneficiaries referred to the emergency department following a crisis, and therefore an increase in wait times—and delays—to treatment. The MHP presented literature that shows that delays to treatment may exacerbate presenting conditions; however, the MHP did not present its own data and experience of this phenomenon. The intervention is to provide telehealth psychiatry, while beneficiaries are in the emergency department. The MHP uses a proxy outcome measure, diversion from hospitalization, rather than a measure of decrease or abatement of presenting symptoms. The project began in April 2021 and despite quarterly data analysis, no data or analysis were presented during the review (in October 2021).

TA and Recommendations

As submitted, this clinical PIP was found to have low confidence, because: the strategy is indirectly addressing the presenting issue. The telepsychiatry is meant to increase the time to an assessment, not to provide treatment.

The TA provided to the MHP by CalEQRO consisted of:

- Suggestions to articulate the clinical nature of the project and clarify the problem being addressed.
- Recommendation to restate the aim statement to include the timeframe and target for improvement.

CalEQRO recommendations for improvement of this clinical PIP include:

- Identify/state the negative outcome to beneficiaries of the protracted wait times for medical clearance at the emergency department
- Present the data that correlates with the negative outcomes.
- Collect data monthly and per the analysis plan, conduct analysis quarterly.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Connecting Beneficiaries from the PHF to their Post-PHF Appointments

Date Started: September 2021

Aim Statement: We will improve show rates for non-open individuals for their Post-PHF appointment by utilizing the support of our clinic Case Manager and Behavioral Health Peer Navigator to bridge the gap from the time the individual is on the PHF to the time of their Post-PHF appointment.

Target Population: Adults admitted to the PHF, with non-open mental health cases and then who are referred to a post-PHF appointment at the adult South County clinic.

Validation Information: The MHP's non-clinical PIP is in the baseline year and is considered active and ongoing.

Summary

The MHP reports that only 50 percent of beneficiaries who are discharged from the PHF and are not open to services adhere to the post-PHF follow-up appointment. The 7- and 30-day period following hospitalization are critical times in which continuity of care should be maintained. The MHP's intervention is to assign clinic staff to facilitate the transition from the PHF to the clinic and to provide a warm handoff. The warm handoff includes pairing the beneficiary with a case manager and a behavioral health peer navigator who will support the beneficiary in addressing and overcoming potential barriers that could contribute to no-show for the post-hospitalization follow-up.

TA and Recommendations

As submitted, this non-clinical PIP was found to have low confidence, because: the strategy for addressing a myriad of beneficiary concerns related to follow-up appointments are vague.

The TA provided to the MHP by CalEQRO consisted of:

- Recommendation to clarify how the case manager and peer navigator will address barriers.
- Recommendation to clarify the frequency of contacts for the case manager and peer navigator.

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

- Provide context for the baseline data.
- Explain how the targets were determined.
- Provide more detail on the implementation and how the staff are going to address identified barriers.

INFORMATION SYSTEMS (IS)

BACKGROUND

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

IS IN SAN LUIS OBISPO COUNTY

California MHP EHRs fall into two main categories-- those that are managed by county of MHP IT and those being operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is Cerner/Anasazi, which has been in use for 10.4 years. Currently, the MHP has joined CalMHSA's semi-statewide EHR effort which is aimed at collectively acquiring and customizing an EHR that meets the needs of county behavioral health departments.

Approximately 2.63 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 469 named users with log-on authority to the EHR, including approximately 243 county-operated staff and 226 contractor-operated staff. Support for the users is provided by five full-time equivalent (FTE) IS technology positions, which is the same as the last review year. Currently there is one unfilled position.

As of the FY 2021-22 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Line staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors, and it provides for superior services for beneficiaries by having full access to progress notes and medication lists by all providers to the EHR 24/7. If there is no line staff access, then contract providers submit beneficiary practice management and service data to the MHP IS as reported in the following table:

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

Submittal Method		Frequency	Submittal Method Percentage
☐	Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
☐	Electronic Data Interchange (EDI) to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
☒	Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☒ Monthly	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 (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 PHR enhances beneficiaries' and their families' engagement and participation in treatment. The MHP does not currently have on-line access to health records but plans to implement this in the next two years.

Interoperability Support

The MHP is a member or participant in a Health Information Exchange (HIE). The MHP engages in electronic exchange of information with the following departments/agencies/organizations: MH contract providers; alcohol and drug contract providers.

IS KEY COMPONENTS

CalEQRO identifies the following key components related to MHP system infrastructure that are necessary to meet the quality and operational requirements to promote positive beneficiary outcomes. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic

findings are used to ensure overall quality of the SMHS delivery system and organizational operations.

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

Table 11: Key Components – IS Infrastructure

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

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

- EHR functionality and interoperability are important aspects of IS infrastructure. The MHP has had its EHR for over ten years and has worked with contract providers to be able to do direct data entry or batch file transfer so that the record is complete.
- The MHP's Medi-Cal claims denial rate is 4.93 percent, which is higher than the statewide denial rate average of 3.19 percent.
- The MHP does not have a business continuity plan that is reviewed and tested on a regular basis. This leaves the MHP vulnerable in the event of a cyber-attack, disaster, or other emergencies. There is collaboration with Central IT to ensure that the status of the project to build out a system to meet established targets for restoring data and computer operations.

IMPACT OF FINDINGS

The IS staff are part of a centralized IT department; there are no dedicated staff with behavioral health data analytic expertise. The MHP has been creative in engaging Cal Poly engineering students to work on data dashboard projects with Power BI, and some helpful results have been made available to leadership. The Power BI tool should be rolled out for use by QI staff so that dashboards can be used for system-level analysis, trending, and decision-making for the MHP.

VALIDATION OF BENEFICIARY PERCEPTIONS OF CARE

BACKGROUND

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

CONSUMER PERCEPTION SURVEYS

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

There was a 60 percent reduction in CPS responses in CY 2020, albeit only one survey distribution period was conducted during the year. The survey data from CY 2020 showed a decrease in overall satisfaction with services.

CONSUMER FAMILY MEMBER FOCUS GROUP

Consumer and family member (CFM) focus groups are an important component of the CalEQRO site 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-site planning process, CalEQRO requested two 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 group of parents/caregivers/family members of youth beneficiaries aged 6-17 years who have initiated services in the past 12 months. The focus group was held at via Zoom and included four participants. All participants had a child who receives clinical services from the MHP.

The participants reported delays to appointments as well as frequent cancellations and rescheduling, which were initiated by clinicians. The participants noted variability in the skill level of therapists, particularly in working with children with trauma. Some parents/caregivers had experience with requesting change of providers but noted

difficulties and delays in this process. The participants received both telehealth and in person services but prefer in-person for their children. The participants remarked on limited staff at provider agencies. Some of the parents/caregivers remarked that should their therapists leave, they would relocate with the therapist, rather than risk being assigned a new, inexperienced therapist.

Recommendations from focus group participants included:

- Incorporate a whole-person approach in the treatment of children, noting that some of the etiology of the children's behavioral symptoms are physiological.
- Incorporate collateral contact with parents as a routine part of therapy.
- Recruit more clinicians that are trauma-informed and certified in children's mental health.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of adult beneficiaries who have received or are receiving mental health and supportive services through the Justice Services Division within the past 12 months. The focus group was held via Zoom and included five participants. All beneficiaries participating receive clinical services from the MHP.

The participants described an easy and timely process to services, following the court referral. The participants reported that staff validated their experiences, demystified the process, and welcomed them to the program. The participants were mostly unfamiliar with other mental health services besides their own program (e.g., the wellness centers and the PHF).

Recommendations from focus group participants included:

- Reduce the paperwork and reading for the programs. Some participants found it to be disengaging.
- Make the substance use portion of the groups optional as not all program members have a substance use disorder.

IMPACT OF FINDINGS

Focus group participants found the SMHS through the MHP effective and all participants would continue the treatment that they or their family members were receiving. The parents/caregivers in particular noticed the inadequate staffing of the MHP and were concerned about the quality of services.

CONCLUSIONS

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

STRENGTHS

1. The CSU incorporated a walk-in model for services, which contributed to an increase in utilization over the past year.

   (Access)

2. The MHP workforce, including county and contracted staff, went above and beyond to continue to provide services during an ongoing challenge of COVID-19 and position vacancies.

   (Access)

3. SLOBHD is expanding its service capacity in the Paso Robles with a new clinic and campus that will include physical, public, and mental health along with social services. Beneficiaries who travel to Atascadero will be able to get services closer to home.

   (Access)

4. The MHP reports on timeliness to services by Spanish language.

   (Timeliness)

5. The MHP is part of the CalMHSA Semi-statewide EHR, which leverages resources of other county MHPs and CalMHSA and enables plans to (more) quickly scale up and adopt the IS.

   (IS)

6. The Justice Services Program is meeting the needs of beneficiaries who have contact with criminal justice and is proving to be an effective alternative to detention or incarceration.

   (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Service quality is adversely affected by staff shortages. Beneficiaries may see multiple clinicians and or have reduced session times because their clinician has a high caseload, both of which affect engagement in services.

   (Access and Quality)

2. The MHP's reporting on timelines does not reflect the protracted time to services that most stakeholders reported was now commonplace.

   (Timeliness)

3. The MHP is not adequately tracking post-hospitalization follow-up for its beneficiaries, by only capturing those who are new to services.

   (Timeliness)

4. The MHP reports on data but appears to have limited ability to sufficiently analyze data to present implications of findings and to drive decision-making.

   (Quality)

5. The MHP's HEDIS measures internal review does not identify youth in FC, for whom this monitoring is particularly important.

   (Quality)

RECOMMENDATIONS

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

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).

   (Timeliness)

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

   (Access)

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

   (Quality) (This is a follow-up recommendation from FY 2020-21).

4. Provide separate reporting of youth in FC in the internal review of HEDIS measures.

   (Quality)

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 quality improvement efforts.

   (Quality, IS)

SITE REVIEW BARRIERS

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

In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited.

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: Additional Performance Measure Data

ATTACHMENT A: CALEQRO REVIEW AGENDA

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

Table A1: EQRO Review Sessions

San Luis Obispo
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Performance Improvement Projects
Acute and Crisis Care Collaboration and Integration
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Consumer and Family Member Focus Group(s)
Peer Employees/Parent Partner Group Interview
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Contract Provider Group Interview – Clinical Management and Supervision
Medical Prescribers Group Interview
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Telehealth
Final Questions and Answers - Exit Interview

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Ewurama Shaw – Taylor, PhD, Quality Reviewer
Melissa Martin, PhD, Assistant Director & Information Systems Reviewer
Diane Mintz, Consumer Family Member Reviewer
Joel Chain, Information Systems Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Autry	Traci	Clinical Director	Wilshire
Baker	Corey	Crisis Worker	Sierra Mental Wellness Group
Bahner	Kristin	BH Program Supervisor	SLOBHD
Bailey	Kathy	Admin Services Officer	SLOBHD
Barnett	Cyndi	Clinical Director	Family Care Network Inc.
Bauldry	Ciara	BH Clinician	SLOBHD
Boaz-Alvarez	Meghan	Clinical Director	Transitions Mental Health Association
Bolster-White	Jill	Executive Director	Transitions Mental Health Association
Bossenberry	Mike	Peer Support Specialist	Transitions Mental Health Association
Brannen	Alexis	BH Program Supervisor	SLOBHD
Carlotti	Stephanie	Peer Support Specialist	Transitions Mental Health Association
Clark	Tony	BH Clinician	SLOBHD
Clementi	Anthony	Peer Support Specialist	Transitions Mental Health Association
Coleman	Claude	Psychiatrist	SLOBHD
Dewitt	Jayana	Nurse Practitioner	SLOBHD
Elliott	Jeff	BH Clinician	SLOBHD
Epps	Sara	Admin Services Officer	SLOBHD
Feliciano	Katrina	Admin Services Officer	SLOBHD
Forgette	Gina	BH Program Supervisor	SLOBHD
Getten	Amanda	Division Manager	SLOBHD
Goodman	Ramona	Licensed Psychiatric Technician	SLOBHD
Gomez	Sandra	Peer Support Specialist	Family Care Network Inc.

Last Name	First Name	Position	Agency
Graber	Starlene	Division Manager	SLOBHD
Heintz	Molly	Admin Services Officer	SLOBHD
Hernandez	Alexandra	BH Clinician	SLOBHD
Hoffman	Christine	BH Program Supervisor	SLOBHD
Holland	Jason	Peer Support Specialist	Transitions Mental Health Association
Hooson	Jason	Licensed Psychiatric Technician	Sierra Mental Wellness Group
Ilano	M. Daisy	Medical Director	SLOBHD
Jiroudi	Tania	Peer Support Specialist	Transitions Mental Health Association
Joaquin	Tara	BH Clinician	SLOBHD
Johnson	Barry	Division Director	Transitions Mental Health Association
Krumheuer	Seth	Program Manager	Family Care Network Inc.
Kuester	Erin	IT Manager	SLOBHD
Kurtzmann	Joseph	Behavioral Health Board Representative	San Luis Obispo
Lamore	Mark	Program Manager	Transitions Mental Health Association
Lehman	Tina	Administrator	Seneca
Limon	Enrique	Accountant II	SLO Health Agency
Lords	Bonnie	Clinical Director	Seneca
Ma	Albert	Psychiatrist	SLOBHD
Madsen	Joe	Program Manager	Transitions Mental Health Association
Manning	Catherine	Department Administrator	SLO Health Agency
Masters	Melissa	Peer Support Specialist	Transitions Mental Health Association
Maxwell	Kevin	Licensed Psychiatric Technician	SLOBHD
McConnell	Launa	Crisis Worker	Sierra Mental Wellness Group

Last Name	First Name	Position	Agency
Mendez	Lisa	Accountant III	SLOBHD
Michels	Dave	Program Manager II	SLO Health Agency
Miller	Triesha	Licensed Vocational Nurse	SLOBHD
Miranda	Daniel	Licensed Psychiatric Technician	SLOBHD
Munyon	Lori	Peer Support Specialist	Transitions Mental Health Association
Nibbio	Jon	COO & Director of Clinical Services	Family Care Network Inc.
Page	Britteny	Peer Support Specialist	Family Care Network Inc.
Patlan Mendez	Juana	Peer Support Specialist	Transitions Mental Health Association
Pemberton	Teresa	Division Manager	SLOBHD
Peters	Josh	BH Program Supervisor	SLOBHD
Piper	Wendy	Nurse Practitioner	SLOBHD
Rankin	Samantha	Peer Recovery Specialist	Sierra Mental Wellness Group
Richardson	Julia	BH Program Supervisor	SLOBHD
Rietjens	Jill	Division Manager	SLOBHD
Robella	Tina	Accountant III	SLOBHD
Robin	Anne	Administrator	SLO Health Agency
Rodriguez	Nora	Peer Recovery Specialist	Sierra Mental Wellness Group
Schmidt	Julianne	BH Clinician	SLOBHD
Shelton	Kiana	BH Program Supervisor	SLOBHD
Shinglot	Jalpa	Accountant III	SLOBHD
Simpson	Joshua	Licensed Psychiatric Technician	SLOBHD
Tarver	Rachel	BH Clinician	SLOBHD
Taylor	Mark	Crisis Worker	Sierra Mental Wellness Group

Last Name	First Name	Position	Agency
Thomas	Bonita	Peer Support Specialist	Transitions Mental Health Association
Twaddell	Brian	Licensed Psychiatric Technician	SLOBHD
Vick	Judy	Division Manager	SLOBHD
Ventresca	Kristin	Program Manager	SLOBHD
Wallace	Alessia	BH Program Supervisor	SLOBHD
Warren	Frank	Division Manager	SLOBHD
Woodbury	Josh	BH Program Supervisor	SLOBHD

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 MHP's project seems to focus on timeliness to medical clearance, initially, which is not a clinical project. As the project is discussed, there appears to be a more clinical component (i.e., increased anxiety, frustration, and agitation because of protracted wait times), but this was mentioned only indirectly and the MHP did not present any data relative to these symptoms. Instead, the MHP is measuring diversion from inpatient hospitalization through psychiatry consultation in the emergency department. The project began in April 2021 and despite quarterly data analysis, no data or analysis were presented during the review (in October 2021).
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: San Luis Obispo	
PIP Title: Hospital Emergency Department Consults	
PIP Aim Statement: "We will provide psychiatric treatment to clients on psychiatric holds in our [emergency department's] via telehealth and [physician] consultation to address the client's acute, psychiatric condition to prevent transfers to acute, inpatient psychiatric facilities. The time-period of this study is July 2021 through July 2022."	
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☒ Both adults and children *If PIP uses different age threshold for children, specify age range here:	

Target population description, such as specific diagnosis (please specify):

Beneficiaries of all ages regardless of diagnosis, previous treatment enrollment, or demographic characteristics who are in the French Hospital emergency department on a psychiatric hold.

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)
n/a

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

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)
Addition of physician (i.e., psychiatrist) consultation services to agreement with local hospital.

Performance measures (be specific and indicate measure steward and NQF 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
Number of rescinded holds	2020-21 (partial year)	11 percent	☐ Not applicable—PIP is in Planning or implementation phase, results not available	Not provided	☐ 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.
EQRO recommendations for improvement of PIP: • Identify/state the negative outcome to beneficiaries of the protracted wait times for medical clearance at the emergency department • Present the data that correlates with the negative outcomes. • Collect data monthly and per the analysis plan, conduct analysis quarterly.

Non-Clinical PIP

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

PIP Validation Rating (check one box)	Comments
☐ →High confidence ☐ →Moderate confidence ☒ →Low confidence ☐ →No confidence	The area for improvement and goals for improvement are clear, but the improvement strategy is not as clear. The clinic case manager and behavioral health peer navigator make either an in-person or video-conference introduction as part of the improvement strategy, but the team has not articulated well how these two staff are supposed to address the barriers that individuals may have to adhering to the post-PHF appointment. The team did not present sufficient context for the baseline data to (1) know if they are aberrant or atypical and (2) to determine if the targets are attainable and realistic.
General PIP Information	
Mental Health MHP/DMC-ODS/Drug Medi-Cal Organized Delivery System Name: San Luis Obispo County	
PIP Title: Connecting Beneficiaries from the PHF to their Post-PHF Appointments	

PIP Aim Statement: We will improve show rates for non-open individuals for their Post-PHF appointment by utilizing the support of our clinic Case Manager and Behavioral Health Peer Navigator to bridge the gap from the time the individual is on the PHF to the time of their Post-PHF appointment.
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐ State-mandated (state required MHP/DMC-ODSs to conduct a PIP on this specific topic) ☐ Collaborative (MHP/DMC-ODS worked together during the Planning or implementation phases) ☒ MHP/DMC-ODS choice (state allowed the MHP/DMC-ODS to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here:
Target population description, such as specific diagnosis (please specify): Adults admitted to the PHF, with non-open mental health cases and then who are referred to a post-PHF appointment at the adult South County 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) n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Pre-discharge introduction to and support from clinic case manager and behavioral health peer navigator
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) n/a

Performance measures (be specific and indicate measure steward and NQF 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
Clinic show-rate	2020-21	50 percent	☒ Not applicable—PIP is in Planning or implementation phase, results not available		☐ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PHF readmission	2020-21	5.3 percent	☒ 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.

EQRO recommendations for improvement of PIP:

- Provide context for the baseline data
- Explain how the targets were determined
- Provide more detail on the implementation and how the staff are going to address identified barriers.

ATTACHMENT D: ADDITIONAL PERFORMANCE MEASURE DATA

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

San Luis Obispo MHP					
Entity	**Average Monthly ACA Enrollees**	**Beneficiaries Served**	**Penetration Rate**	**Total Approved Claims**	**ACB**
Statewide	3,835,638	155,154	4.05%	$934,903,862	$6,026
Medium	533,873	19,077	3.57%	$143,009,074	$7,496
MHP	18,081	856	4.73%	$7,067,273	$8,256

Table D2: CY 2020 Distribution of Beneficiaries by ACB Range

San Luis Obispo MHP								
ACB Range	**MHP Beneficiaries Served**	**MHP Percentage of Beneficiaries**	**Statewide Percentage of Beneficiaries**	**MHP Total Approved Claims**	**MHP ACB**	**Statewide ACB**	**MHP Percentage of Total Approved Claims**	**Statewide Percentage of Total Approved Claims**
<$20K	2,846	86.37%	92.22%	$14,917,405	$5,242	$4,399	46.11%	56.70%
>$20K-$30K	123	4.56%	3.71%	$3,020,783	$24,559	$24,274	13.54%	12.59%
>$30K	241	7.31%	4.07%	$12,380,520	$51,371	$53,969	38.27%	30.70%

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

San Luis Obispo MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percentage Denied	Dollars Adjudicated	Dollars Approved
JAN20	8,141	$2,308,299	338	$144,249	6.25%	$2,164,050	$2,007,068
FEB20	6,855	$2,141,378	205	$118,519	5.53%	$2,022,859	$1,894,012
MAR20	7,735	$2,863,143	207	$87,459	3.05%	$2,775,684	$2,638,262
APR20	7,681	$3,542,376	259	$156,175	4.41%	$3,386,201	$3,205,409
MAY20	7,135	$3,136,405	208	$128,173	4.09%	$3,008,232	$2,862,551
JUN20	7,434	$3,676,022	220	$150,487	4.09%	$3,525,535	$3,373,694
JUL20	7,972	$3,703,479	273	$323,840	8.74%	$3,379,639	$3,052,254
AUG20	7,931	$3,292,062	357	$159,527	4.85%	$3,132,535	$2,968,728
SEP20	8,102	$3,526,431	324	$199,188	5.65%	$3,327,243	$3,112,717
OCT20	7,938	$2,406,755	338	$104,110	4.33%	$2,302,645	$2,187,897
NOV20	6,465	$2,014,054	169	$50,458	2.51%	$1,963,596	$1,892,288
DEC20	7,085	$2,096,801	238	$89,026	4.25%	$2,007,775	$1,916,462
TOTAL	**90,474**	**$34,707,203**	**3,136**	**$1,711,211**	**4.93%**	**$32,995,992**	**$31,111,340**

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

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

San Luis Obispo MHP			
Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Beneficiary not eligible	1,183	$448,787	26%
Claim/service lacks information which is needed for adjudication	758	$389,723	23%
Medicare Part B or Other Health Coverage must be billed before submission of claim	851	$355,402	21%
Beneficiary not eligible or non-covered charges	93	$254,749	15%
Service line is a duplicate and a repeat service procedure code modifier not present	47	$202,157	12%
TOTAL	**2,932**	**$1,650,818**	**96%**