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

SAN DIEGO FINAL REPORT

☒ MHP

☐ DMC-ODS

Prepared for:

California Department of Health Care Services (DHCS)

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EXECUTIVE SUMMARY

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

MHP INFORMATION

Review Type — Virtual

Date of Review — November 7-9, 2023

MHP Size — Large

MHP Region — Southern

SUMMARY OF FINDINGS

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

Table A: Summary of Response to Recommendations

# of FY 2022-23 EQR Recommendations	# Fully Addressed	# Partially Addressed	# Not Addressed
5	3	2	0

Table B: Summary of Key Components

Summary of Key Components	Number of Items Rated	# Met	# Partial	# Not Met
Access to Care	4	4	0	0
Timeliness of Care	6	6	0	0
Quality of Care	10	8	2	0
Information Systems (IS)	6	4	2	0
TOTAL	**26**	**22**	**4**	**0**

Table C: Summary of PIP Submissions

Title	Type	Start Date	Phase	Confidence Validation Rating
Improved Therapeutic Support for Youth Members who Identify as LGBTQ+	Clinical	01/2022	Implementation	Moderate
Improving the Experience of Teletherapy for Older adults	Non-Clinical	03/2023	Implementation	Moderate

Table D: Summary of Plan Member/Family Focus Groups

Focus Group #	Focus Group Type	# of Participants
1	☐Adults ☒Transition Aged Youth (TAY) ☐Family Members ☐Other	2*
2	☐Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	7
3	☒Adults ☐Transition Aged Youth (TAY) ☒Family Members ☐Other	8
* If number of participants is less than 3, feedback received during the session is incorporated into other sections of this report to ensure anonymity.		

SUMMARY OF STRENGTHS, OPPORTUNITIES, AND RECOMMENDATIONS

The MHP demonstrated significant strengths in the following areas:

- Six San Diego County Behavioral Health System (SDCBHS) programs received the National Association of Counties Achievement award this calendar year.
- California Advancing and Innovating Medi-Cal (CalAIM)/payment reform progress is underway. SDCBHS is currently developing provider rates under CalAIM.
- The MHP continues strong partnerships/collaboration with Optum and the University of California, San Diego (UCSD).
- The investment in IS and data analytical staffing and contract support remains a notable strength as the MHP continues to focus on data integrity while expanding the scope of programming.
- The MHP created a new medication monitoring committee for both adults and youth medication prescribing.
- The County was able to successfully add a peer support classification and hired staff in these positions in the past year.

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

- Based on stakeholder feedback and MHP data, timeliness to care continues to be impacted, with a notably high volume of referrals and ongoing staff recruitment and retention challenges.
- Review discussions indicated transitions to lower level of care (LOC) involve longer waits than timely and transitions do not appear to be standardized but are done on a case-by-case basis.
- Stakeholder feedback on MHP collaboration efforts and communication suggests the need for focused and intentional conversations with contract providers to address system issues and foster partnership.
- The electronic health record (EHR) replacement project remains a key priority, which is now delayed due to system limitations within the planned replacement system. Multiple long-term projects are linked to the EHR transition including ongoing CalAIM payment reform claiming updates, implementation of an enterprise data warehouse, personal health record functionality, and data integration and interoperability with contract providers.
- Stakeholders interviewed are not aware of peer support classifications and what job requirements and if there are opportunities for promotions.

Recommendations for improvement based upon this review include:

- Evaluate barriers to timely access to first appointment and first psychiatry appointments. Develop and implement strategies to reduce wait lists for direct outpatient children and adult services. Measure the effectiveness of changes. Include input from clinical providers to understand barriers and design interventions. Consider using Plan-Do-Study-Act cycles as indicated.

  (This recommendation is continued from FY 2022-23.)
- Evaluate barriers to timely access in transition to lower LOC. Develop a universal LOC process to address the wait times to these transitions.
- Increase collaboration with contract providers. Increase MHP knowledge of contract provider challenges in current service delivery, workforce, contracts, and sustainability strategies. Use input from contract providers to address current challenges.

  (This recommendation is continued from FY 2022-23.)
- Reach out to leverage the experience of other counties implementing the SmartCare EHR in collaboration with California Mental Health Services Authority (CalMHSA).
- Create and implement an information flow to allow employees to be aware of Peer Support employees and their duties as well as ensure that the peer support employees are educated to their role and the requirements for promotion.

INTRODUCTION

BASIS OF THE EXTERNAL QUALITY REVIEW

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

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

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

This report presents the FY 2023-24 findings of the EQR for San Diego County MHP by BHC, conducted as a virtual review on November 7-9, 2023.

REVIEW METHODOLOGY

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

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

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

Findings in this report include:

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

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

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

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT SUPPRESSION DISCLOSURE

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

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

MHP CHANGES AND INITIATIVES

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

ENVIRONMENTAL ISSUES AFFECTING MHP OPERATIONS

This review took place after the COVID-19 pandemic. The MHP is still experiencing the pandemic effects of loss of staff, due to both recruitment and retention challenges, and returning to in-person services.

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.

- SDCBHS is currently developing provider rates under CalAIM behavioral health payment reform utilizing program assumptions and data, while taking into consideration certain key variables that may impact rates, including but not limited to cost data, specialty services, geography, populations served, access to care, acuity, and other key elements of service delivery.
- SDCBHS organizational changes, through a phased approach, is focused on restructuring the internal structure, resources, and staffing to optimize the configuration of key activities and functions that support the delivery of data-driven, quality mental health, and substance use disorder (SUD) services to the most vulnerable individuals and families within the community.
- As part of the FY 2022-23 Operational Plan, the department added additional County positions to provide direct services as well as clinical and administrative oversight and support. The County was able to successfully add a Peer Support classification and hired staff in these positions in the past year.
- The MHP has begun efforts to assess the potential impact of the Governor's proposed 2024 ballot measure for modernization of the Mental Health Services Act (MHSA) that would enhance investments for dedicated housing for individuals with behavioral health conditions and provide increased flexibility in how counties utilize MHSA.
- SDCBHS in collaboration with the County's Child and Family Well-Being (CFWB) and Probation departments, is working to initiate several new services such as care coordination services as part of the Children's Crisis Continuum Pilot Program. The County was awarded $8.5 million in grant funding to support the pilot program over the first five years.
- SDCBHS has posted a competitive procurement for an intensive outpatient program (IOP) which offers diagnostic and clinical treatment services in a

structured and therapeutic environment that is time limited (approximately 6-8 weeks) with the goal of stabilization, skill building, and medication management. The IOP will include a half-day intensive program for children/youth up to age 21 with similar clinical needs.

- SDCBHS will be posting a competitive procurement for a partial hospitalization program (PHP). The PHP will include services through a full day intensive (FDI) program Monday to Friday, inclusive of educational instruction for children/youth up to age 21 with similar clinical needs (i.e., mental health and substance use). The FDI will include individual, family, and group sessions.

RESPONSE TO FY 2022-23 RECOMMENDATIONS

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

Assignment of Ratings

Addressed is assigned when the identified issue has been resolved.

Partially Addressed is assigned when the MHP has either:

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

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

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

Recommendations from FY 2022-23

Recommendation 1: Evaluate barriers to timely access to first appointment and first psychiatry appointments. Develop and implement strategies to reduce wait lists for direct outpatient children and adult services. Measure the effectiveness of changes. Include input from clinical providers to understand barriers and design interventions. Consider using Plan-Do-Study-Act (PDSA) cycles as indicated.

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

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- During the past year, the MHP conducted a PDSA working with 20 MH and the Drug Medi-Cal Organized Delivery System (DMC-ODS) programs as part of the MHP's process to establish an understanding of access times to first appointments and ensure data integrity. The PDSA provided analysis of access time data and was also conducted to determine the baseline and identify barriers and areas for improvement. Comparison between table 11 (pg. 35) Assessment of Timely Access in FY 23-24 and FY 22-23 showed slight improvement in all categories with the biggest improvement in first non-urgent psychiatry offered (86.7%) vs. the previous year (77.3%).

- As interventions were applied the MHP also conducted multiple stakeholder engagement efforts by presenting data to these groups which included the MH Contractors Association, the Quality Review Committee (QRC), which includes MHP representatives, provider representatives, community members with lived experience, and the Executive Quality Improvement Team (EQIT). These stakeholders provided feedback on potential barriers and solutions.
- In June 2023, the MHP sent out a FAQs tip sheet to the system of care (SOC) on the Access to Services Journal as a training effort in response to overwhelming provider feedback. The next step is to engage contracting officer representatives in the best ways of monitoring access to ensure services are provided in a timely manner.
- The recommendation will be carried forward this year to allow the MHP to continue work on increasing timeliness to first appointment and first psychiatry appointments.

Recommendation 2: Increase collaboration with contract providers. Increase MHP knowledge of contract provider challenges in current service delivery, workforce, contracts, and sustainability strategies. Use input from contract providers to address current challenges.

☐ Addressed ☒ Partially Addressed ☐ Not Addressed

- The MHP, through the Quality Assurance (QA) team, releases a monthly newsletter called "Up to the Minute" to all MHP providers which is posted on the Optum of San Diego website. Information is included on new state requirements, location of detailed documentation, frequently asked questions, and training events.
- The MHP QA team previously implemented open office hours beginning in September 2022 to provide a drop-in time for any provider to receive TA and provide answers related to system updates or programmatic questions. The MHP currently offers this support for one hour every week. Additionally, the MHP continued with contractor meetings to gather feedback and stress the importance of communication between levels of staffing.
- The MHP implemented office hours as a direct effort to increase opportunities for bi-directional communication with providers, modeled after the CalMHSA CalAIM office hours with California Counties during the initial roll out of CalAIM documentation reform. Additionally, the MHP continued with contractor meetings to gather feedback and stress the importance of communication between all levels of staffing.
- The MHP created a page on the existing BHS Provider Portal focused on CalAIM information focused on system updates with links to state guidance, provider memos, and required training. In addition, the MHP created a county website focused on CalAIM Payment Reform.

- Although the MHP does have multiple communication outlets, there is a lack of evidence of collaborative efforts to solicit feedback from contract providers. Feedback received from stakeholders noted an ongoing lack of connection and collaboration between the MHP and contract providers. Communication appears to be primarily from the MHP to contract providers and does not allow for bidirectional feedback and input into the system of care or planning process related to updates made within the continuum of care. This recommendation was focused on the MHP gathering input and strengthening collaborative relationships with the contract providers and stakeholder feedback suggests this has not occurred.
- The recommendation will be carried forward this year to allow the MHP to continue work on collaborative bidirectional communication that will benefit the ability of contractors in service delivery.

Recommendation 3: Focus resources to assess program capacity, timeliness issues, and a consistent monitoring and engagement process for LOC transitions within mandated service modalities under the MHP Medi-Cal contract. Ensure program stability considering widespread staffing issues by evaluating and considering longer-term contract partnerships and solutions that would enhance staff recruitment and retention in contracted programs.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP remains committed to effective monitoring of LOC changes within mandated services under the MHP Medi-Cal contract. Inconsistent tracking of LOCs, administrative load on contract providers, poor staff retention, and program service gaps have created barriers to monitoring LOC changes.
- SDCBHS, as procurements allowed, beginning February 2022, outpatient clinics were enhanced to include dedicated and fully funded walk-in components to increase accessibility to outpatient services. In addition, outpatient clinics were staffed with mobile outreach teams, consisting of both a clinician and peer support specialist. These mobile outreach teams were to engage or re-engage unconnected or disconnected members to available services, prioritizing members who had been discharged from acute care, jail, or inpatient settings, as well as those determined to be high risk. Staffing was expanded to include co-occurring specialists to better meet the needs of individuals with co-occurring conditions as well as care coordinators to facilitate both a warm handoff of individuals coming into the program and providing a warm handoff for individuals transitioning to another LOC. By January 2024, all outpatient clinics in the SOC will have these enhancements embedded within the programs.
- In April 2023, a QRC meeting included discussion of the implications of gaps in mental health services due to care coordination and staffing shortages. Part of the MHP's longstanding effort to address these challenges is the clinical redesign of procurements. The clinical redesign effort is geared to streamline and improve

a variety of systemic challenges, including helping to improve care coordination across providers and increase staff retention for county contracts.

- Some identified goals for redesigning the procurement process aim to reduce the administrative workload of contractual partners, aid contractual partners in forecasting LOC transitions, and increase the time between procurements.
- In the redesign effort SDCBHS created a Procurement Tracking Dashboard through PowerBI (the MHP platform for data analysis). The Procurement Tracking Dashboard aims to identify procurement timeframes to reduce the internal and external impacts procurement workload has on stakeholders and partners to enhance the impact of each contract countywide.
- As of July 2023, the new procurement strategy had been implemented countywide. The goal of the clinical design is to ensure the necessary resources and staffing allocations are determined in the planning process to ensure program stability and enhance contract relationships.

Recommendation 4: Evaluate barriers or address barriers identified in existing assessments to increase access for Hispanic/Latino members. As planned in the Cultural Competence Plan, examine access times by client language to determine if there are barriers. Conduct performance improvement.

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- During the past fiscal year, the MHP employed a combination of efforts to address the Hispanic/Latino penetration rate. The planning process started with examining data to identify potential barriers to services and enhancing outreach efforts to increase mental health awareness and reduce the stigma associated with mental health services. Through a variety of strategies, the QRC, members of the Network and Quality Planning team, contracted researchers, and community providers collectively participated in efforts to understand and improve Hispanic/Latino penetration rate trends.
- Utilization data for Hispanic/Latino services were analyzed through the Mental Health Performance dashboard on PowerBI. The dashboard allows for interpreting data related to utilization rates based on race and language. To explore if the low penetration rates of the Hispanic/Latino population could be understood by evaluating the utilization rate of Spanish speaking services, language data from FY 2022-23 were analyzed.
- In addition to access time rates based on language, other potential barriers impacting the county's Hispanic/Latino PR were discussed with the QRC on April 27, 2023. During this meeting, a root cause analysis was conducted to help identify specific trends of Hispanic/Latino PR related to the type of care accessed, gender, age, and political arena. The MHP worked with its contracted organization at the UCSD Health Services Research Center to conduct data analyses on the variables identified by the QRC members.

- In an effort to enhance the outreach to the Hispanic/Latino community, reduce stigma around mental health services, and increase awareness regarding services available, the MHP has partnered with several programs and committees dedicated to increasing Hispanic/Latino PR including Elder Multicultural Access and Support Services, San Diego County Promotores Coalition, and Breaking Down Barriers of Jewish Family Services. The Breaking Down Barriers program works specifically to reduce mental health stigma through implementing culturally responsive strategies for communities of color. They conduct various engagement activities to reach out to Spanish-speaking members.
- Future efforts to address the Hispanic/Latino PR include continued data analysis of mental health providers and services delivered. The MHP has created a Service Planning Tool to provide data on mental health services specific to geographical areas. Some goals of the Service Planning Tool include revealing areas of unmet needs, uncovering health equity impacts, and identifying the most beneficial locations for services. Once the Service Planning Tool is live (expected in two to three months), densely populated areas can be analyzed to help determine gaps in mental health sites impacting the Hispanic/Latino PR.
- San Diego is committed to performance improvement through continued analysis of the interventions conducted by providers and continue the conversation with community stakeholders, ensuring the continuous loop of plan, do, study, act.

Recommendation 5: Develop detailed testing, training, data conversion, integration, support, and risk-management plans to support the outpatient cutover to the Cerner Millenium Electronic Health Records (EHR) system. Ensure that all providers (community-based organizations [CBOs], network, and county) receive regular updates on the status of the project and that a wide range of providers are represented in all remaining phases of the project.

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

☒ Addressed ☐ Partially Addressed ☐ Not Addressed

- The MHP continued implementation efforts for Cerner Millenium and held Cerner-led design workshops beginning in April 2023 to provide stakeholder input (clinicians, support staff, and leadership) to assist with system design and informing development decisions. Additionally, stakeholders were able to attend Cerner demonstration sessions led by MHP staff, held twice per month. Input was gathered on user experience and system design.
- The MHP is working with Cerner to migrate substantial data from the Cerner Community Behavioral Health (CCBH) EHR including demographics, encounter information, diagnoses, allergies, vitals, and medications.
- A communication plan for Cerner updates was created which included website updates, monthly email status reports, and a dedicated newsletter and flyer to provide to all staff.

- Planned system testing had a target date of January and February 2024, with staff training to be completed through March 2024. During the EQR, the MHP reported that due to system limitations recently found in Cerner Millenium, implementation efforts will be shifting to the SmartCare EHR by Streamline, in collaboration with the CalMHSA. Details on implementation timelines of this new EHR are currently in development.

ACCESS TO CARE

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

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

ACCESSING SERVICES FROM THE MHP

SMHS are delivered by both county-operated and contractor-operated providers in the MHP. Regardless of payment source, approximately 6.4 percent of services were delivered by county-operated/staffed clinics and sites, and 93.6 percent were delivered by contractor-operated/staffed clinics and sites. Overall, approximately 74 percent of services provided were claimed to Medi-Cal.

The MHP has a toll-free Access and Crisis Line available to members 24-hours, 7-days per week that is operated by contract provider staff; members may request services through the Access Line as well as through walk-in and urgent walk-in services at regional clinics, mobile crisis response teams, school and medical referrals for children, and collaborations with law enforcement and the justice system. The MHP operates a centralized access team that is responsible for linking members to appropriate, medically necessary services.

In addition to clinic-based MH services, the MHP provides psychiatry and MH services via telehealth to youth and adults. In FY 2022-23, the MHP reports having provided telehealth services to 4,362 adults, 5,310 youth, and 450 older adults across 11 county operated sites and 334 contractor-operated sites. Among those served, 1,206 members received telehealth services in a language other than English in the preceding 12 months.

NETWORK ADEQUACY

An adequate network of providers is necessary for members to receive the medically necessary services most appropriate to their needs. CMS requires all states with MCOs and PIHPs to implement rules for NA pursuant to Title 42 of the CFR §438.68. In addition, through WIC Section 14197.05, California assigns responsibility to the EQRO

[1] CMS Data Navigator Glossary of Terms

for review and validation of specific data, by plan and by county, for the purpose of informing the status of implementation of the requirements of Section 14197, including the information in Table 1A and Table 1B.

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

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

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

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

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

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

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

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

ACCESS KEY COMPONENTS

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

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

Table 2: Access Key Components

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

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

- Ongoing efforts were demonstrated in submitted documents as well as provided information on recent analysis in partnership with the UCSD to identify cultural needs within specific communities.
- The MHP program has engaged in Faith-Based Community Dialogue Planning in the Central and the North Inland regions.

ACCESS PERFORMANCE MEASURES

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

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

PR is a measure of the total members served based upon the total Medi-Cal eligible. It is calculated by dividing the number of unduplicated members served (receiving one or more approved Medi-Cal services) by the annual eligible count calculated from the monthly average of eligibles. The average approved claims per member (AACM) served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal members served per year. Where the median differs significantly from the average, that information may also be noted throughout this report. The similar-sized county PR is calculated using the total number of members served by that county size divided by the total eligibles (calculated based upon average monthly eligibles) for counties in that size group.

The Statewide PR is 3.96 percent, with a statewide average approved claim amount of $7,442. Using PR as an indicator of access for the MHP, San Diego demonstrates poorer access to care than statewide.

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

Year	Total Members Eligible	# of Members Served	MHP PR	Total Approved Claims	AACM
CY 2022	1,030,000	33,473	3.25%	$184,145,335	$5,501
CY 2021	956,219	35,620	3.73%	$197,534,904	$5,546
CY 2020	856,965	35,583	4.15%	$204,924,657	$5,759

Note: Total eligibles in Tables 3, 4, and 7 may show small differences due to rounding of different variables when calculating the annual total as an average of monthly totals.

- PR for San Diego has decreased over the prior two years and was further impacted by a decrease in members served and an increase in eligibles in CY 2022.

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

Age Groups	Total Members Eligible	# of Members Served	MHP PR	County Size Group PR	Statewide PR
Ages 0-5	95,642	1,197	1.25%	1.50%	1.82%
Ages 6-17	225,552	8,642	3.83%	5.01%	5.65%
Ages 18-20	52,932	1,572	2.97%	3.66%	3.97%
Ages 21-64	551,324	20,578	3.73%	3.73%	4.03%
Ages 65+	104,358	1,484	1.42%	1.64%	1.86%
Total	**1,030,000**	**33,473**	**3.25%**	**3.60%**	**3.96%**

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

- The PR is lower than similar-sized county and statewide PRs for all age groups, with the exception of members ages 21-64, which matches similar-sized county PRs.
- Youth ages 6-17 have the highest PR in the MHP, while youth ages 0-5 have the lowest.

Table 5: Threshold Language of San Diego MHP Medi-Cal Members Served in CY 2022

Threshold Language	# of Members Served	% of Members Served
Spanish	4,611	13.97%
Arabic	692	2.10%
Vietnamese	315	0.95%
Tagalog	70	0.21%
Farsi	68	0.21%
Members Served in Threshold Languages	**5,756**	**17.44%**
Threshold language source: Open Data per BHIN 20-070		

- The number of members served in threshold languages decreased by 3 percent from CY 2021.
- Members served in threshold languages accounted for over 17 percent of the total members served, with Spanish being the most prevalent by a wide margin.

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

Entity	Total ACA Eligibles	Total ACA Members Served	MHP ACA PR	ACA Total Approved Claims	ACA AACM
MHP	355,757	10,679	3.00%	$53,960,987	$5,053
Large	2,532,274	76,457	3.02%	$535,657,742	$7,006
Statewide	4,831,118	164,980	3.41%	$1,051,087,580	$6,371

- For the subset of Medi-Cal eligible that qualify for Medi-Cal under the ACA, their overall PR and AACM tend to be lower than non-ACA members, and this pattern is reflected in the MHP.
- The MHP PR for the ACA eligible members remains lower than similar-sized counties and the statewide PR.

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

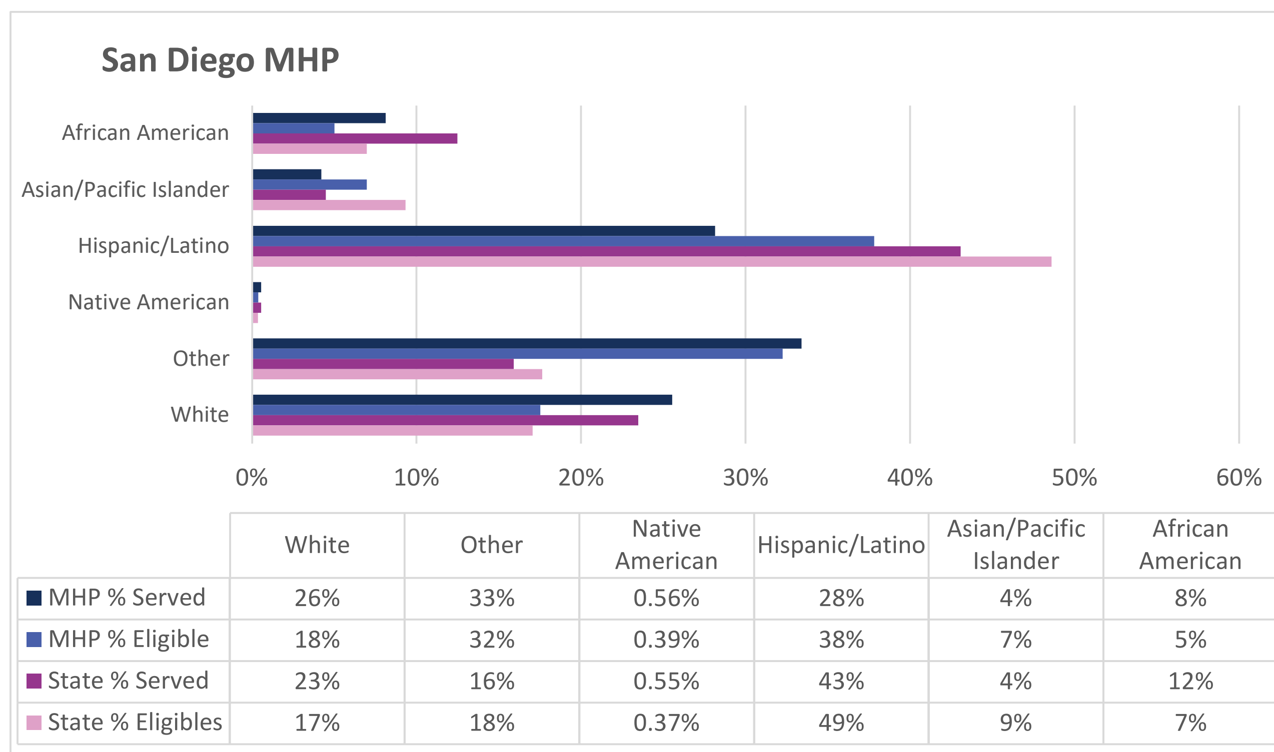
Table 7: San Diego MHP PR of Members Served by Race/Ethnicity, CY 2022

Race/Ethnicity	Total Members Eligible	# of Members Served	MHP PR	Statewide PR
African American	51,717	2,721	5.26%	7.08%
Asian/Pacific Islander	71,842	1,414	1.97%	1.91%
Hispanic/Latino	389,501	9,421	2.42%	3.51%
Native American	4,024	186	4.62%	5.94%
Other	332,200	11,183	3.37%	3.57%
White	180,524	8,548	4.74%	5.45%
Total	**1,029,808**	**33,473**	**3.25%**	**3.96%**

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

- The MHP's PRs for all racial/ethnic groups are lower than statewide PRs, with the exception of the Asian/Pacific Islander group which was slightly higher than statewide.

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



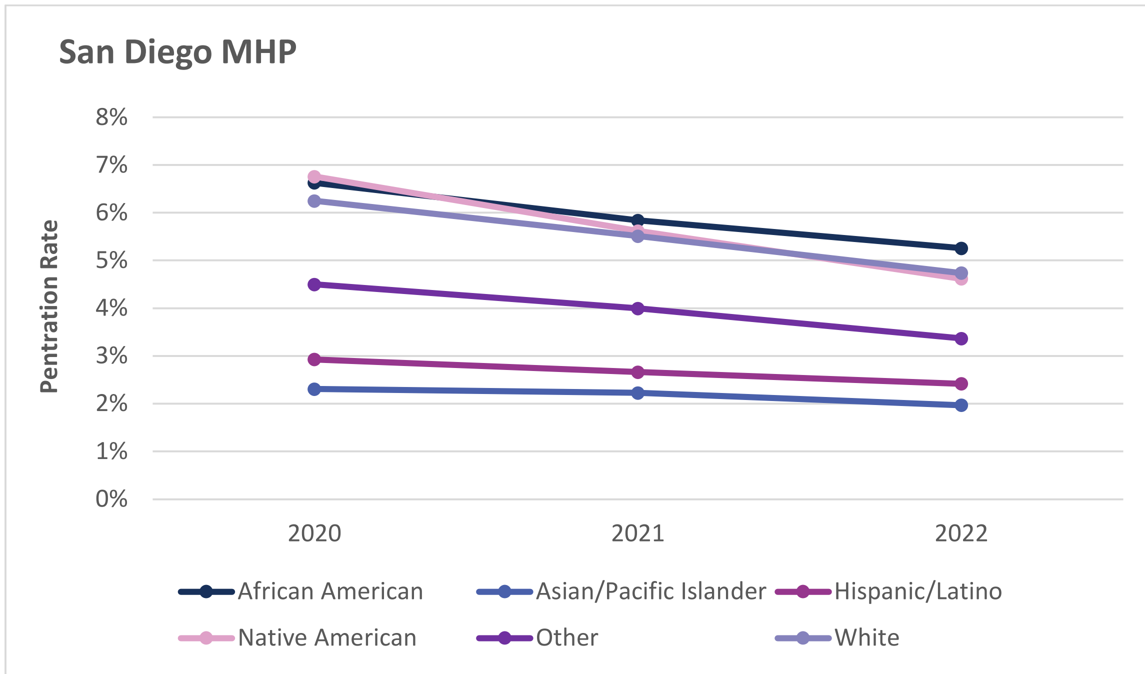
	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African American
MHP % Served	26%	33%	0.56%	28%	4%	8%
MHP % Eligible	18%	32%	0.39%	38%	7%	5%
State % Served	23%	16%	0.55%	43%	4%	12%
State % Eligibles	17%	18%	0.37%	49%	9%	7%

- The most notable gaps between members eligible and served are seen in the Hispanic/Latino and Asian/Pacific Islander populations, indicating these groups

are proportionally underrepresented in the MHP. The White population is proportionally overrepresented accounting for 26 percent of members served but only 18 percent of the eligible population.

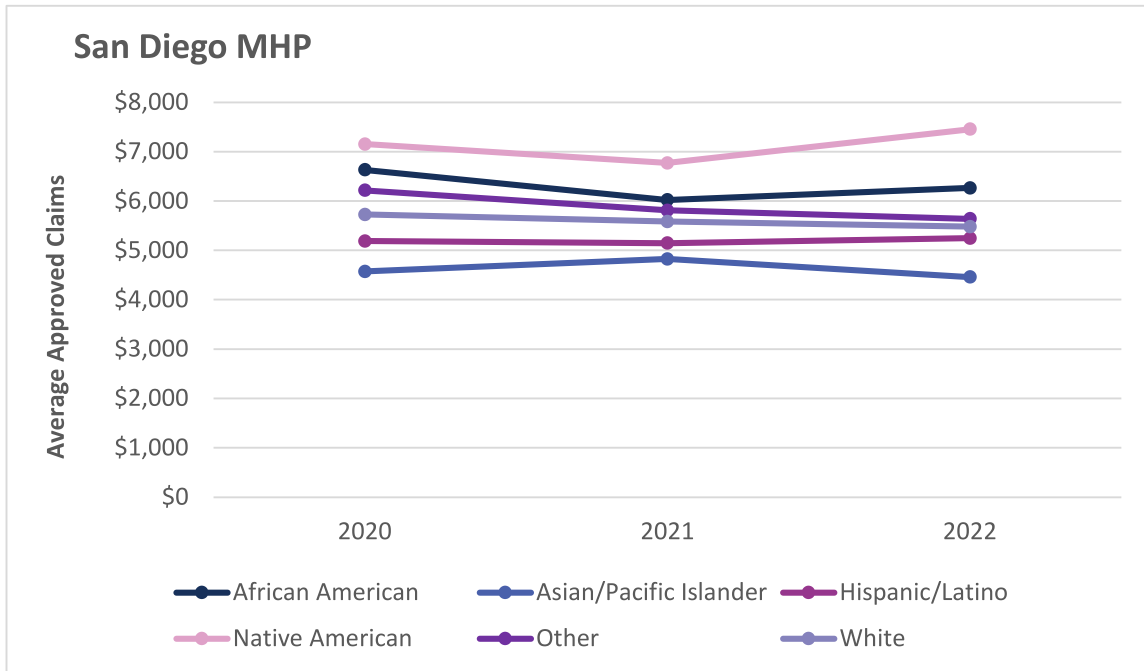
Figures 2-11 display the PR and AACM for the overall population, two racial/ethnic groups that are historically underserved (Hispanic/Latino, and Asian/Pacific Islander), and the high-risk FC population. For each of these measures, the MHP's data is compared to the similar county size and the statewide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

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



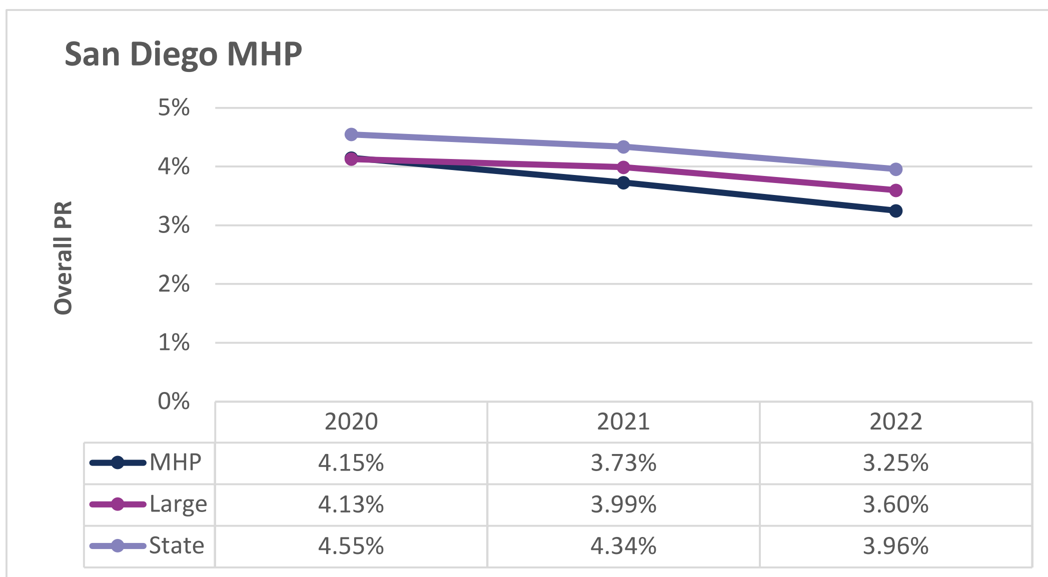
- The MHP’s PRs for all racial/ethnic groups have been declining slightly over the last two years.
- Native American, African American, and White PRs have consistently been the highest across the past three years, whereas the Asian/Pacific Islander PRs have consistently been the lowest.

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



- The AACM had differing levels of change across racial/ethnic groups since CY 2020, with a slight overall trend downwards.
- The AACMs for Native American, African American, and Hispanic/Latino members increased in CY 2022.

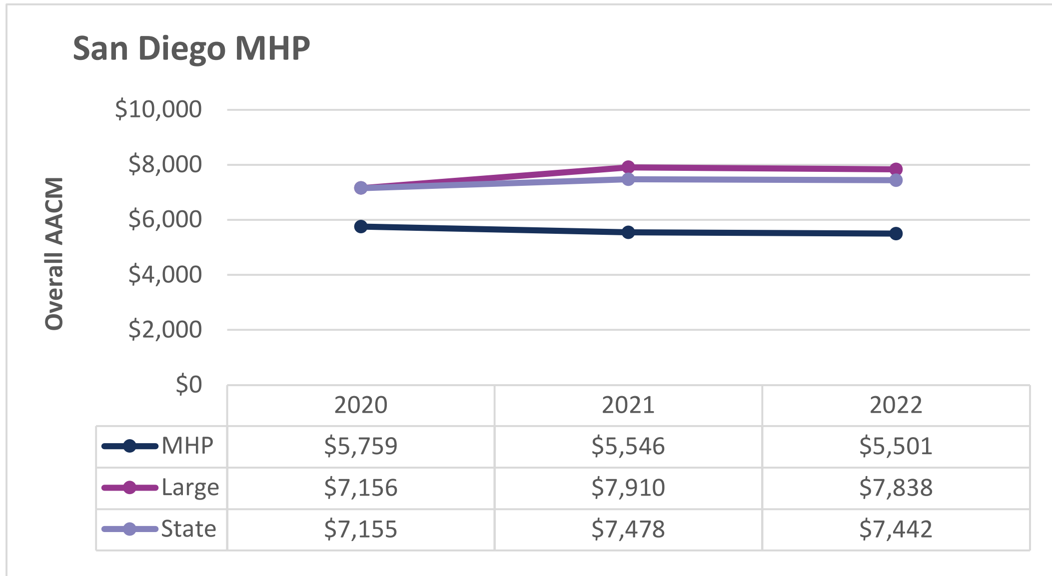
Figure 4: Overall PR CY, 2020-22



	2020	2021	2022
MHP	4.15%	3.73%	3.25%
Large	4.13%	3.99%	3.60%
State	4.55%	4.34%	3.96%

- The overall PR has decreased over the last two years, and the MHP PR remains lower than the large county and statewide PRs in CY 2022.

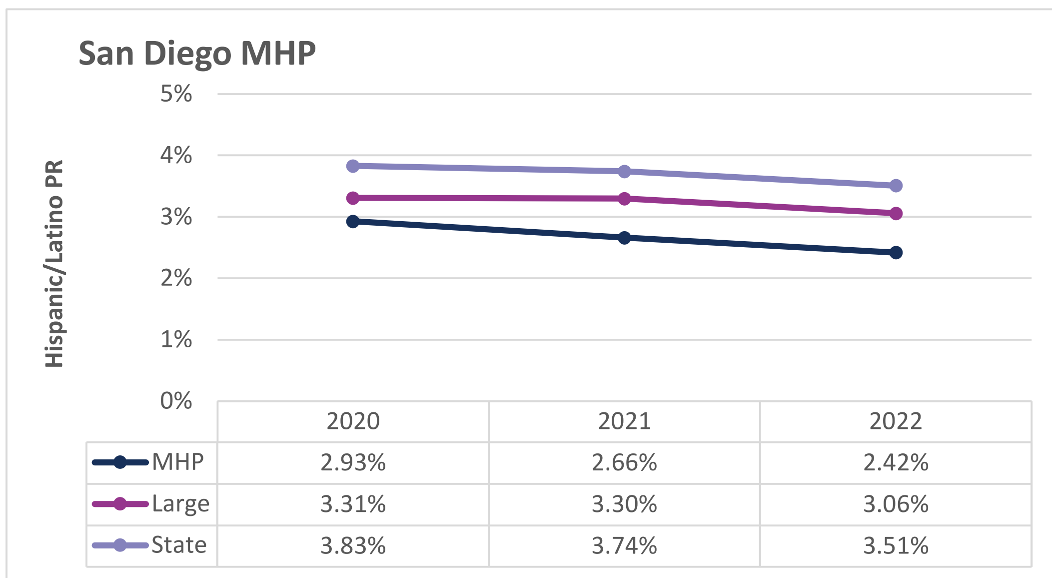
Figure 5: Overall AACM, CY 2020-22



	2020	2021	2022
MHP	$5,759	$5,546	$5,501
Large	$7,156	$7,910	$7,838
State	$7,155	$7,478	$7,442

- The overall AACM has consistently been lower than the large county average, as well as the statewide average, across the past three CYs.

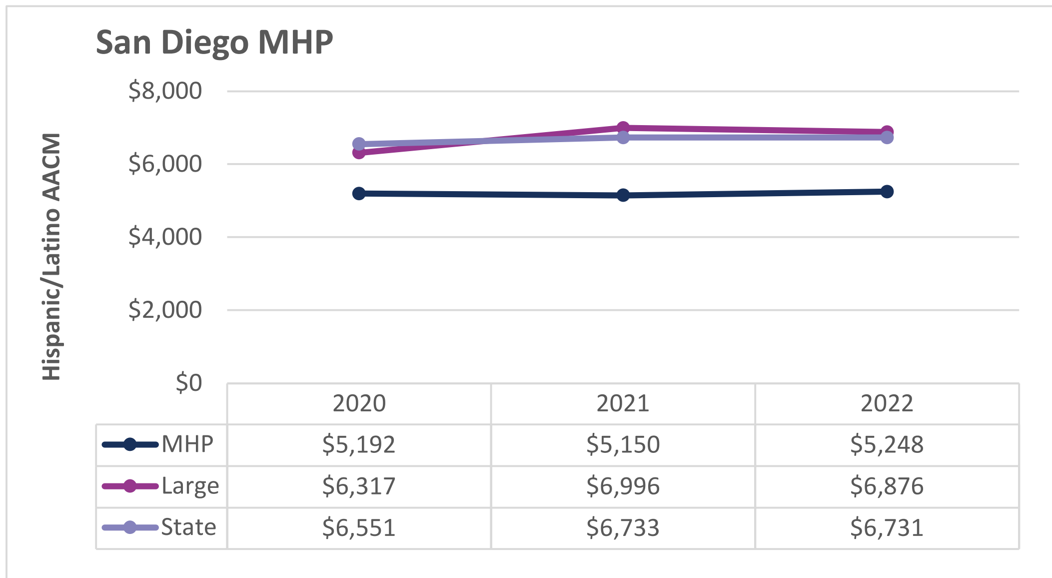
Figure 6: Hispanic/Latino PR, CY 2020-22



	2020	2021	2022
MHP	2.93%	2.66%	2.42%
Large	3.31%	3.30%	3.06%
State	3.83%	3.74%	3.51%

- The Hispanic/Latino PR decreased statewide over the past three CYs, while the PR in the MHP decreased by a larger margin and remains lower than the large county and statewide PRs.

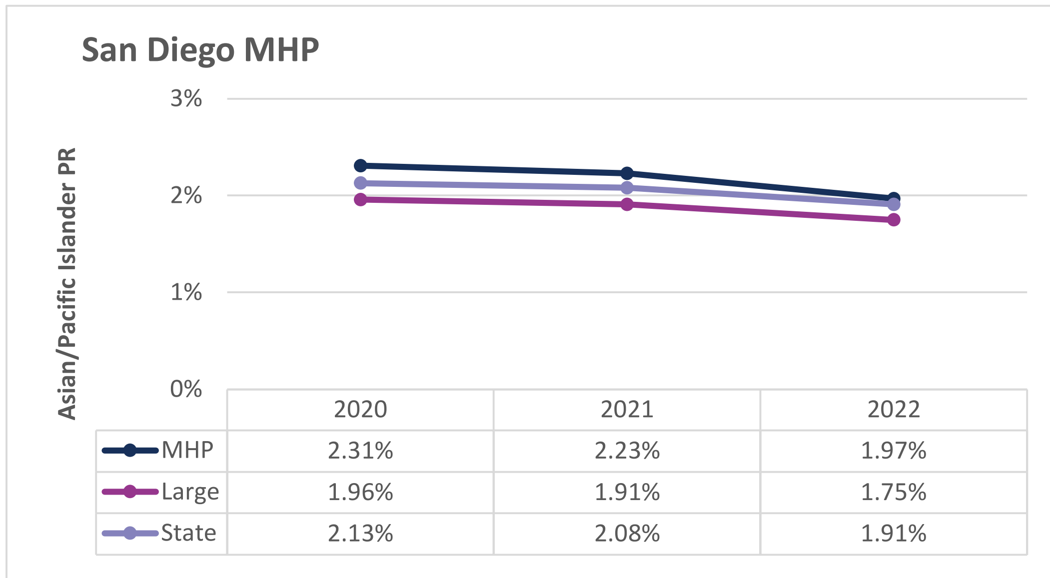
Figure 7: Hispanic/Latino AACM, CY 2020-22



	2020	2021	2022
MHP	$5,192	$5,150	$5,248
Large	$6,317	$6,996	$6,876
State	$6,551	$6,733	$6,731

- The AACM for the Hispanic/Latino population increased statewide in CY 2021, while the MHP AACM had a slight decrease. In CY 2022 the statewide AACM remained static and increased slightly in the MHP. Statewide and large county AACMs remain higher than the MHP AACM for CY 2022.

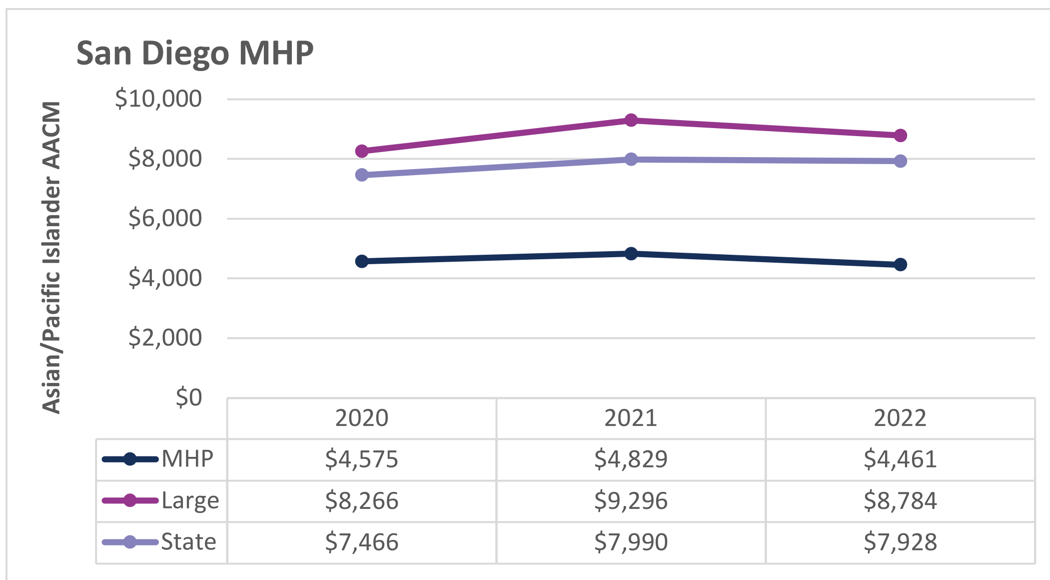
Figure 8: Asian/Pacific Islander PR, CY 2020-22



	2020	2021	2022
MHP	2.31%	2.23%	1.97%
Large	1.96%	1.91%	1.75%
State	2.13%	2.08%	1.91%

- The Asian/Pacific Islander PR has slightly decreased over the prior two years, though it remains slightly higher in the MHP than in similar-sized counties and statewide.

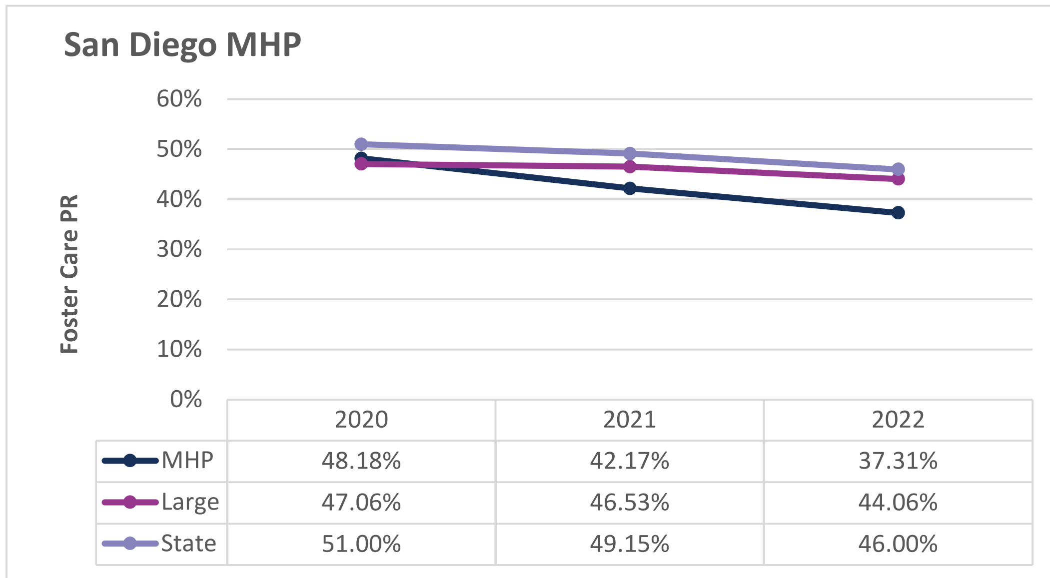
Figure 9: Asian/Pacific Islander AACM, CY 2020-22



	2020	2021	2022
MHP	$4,575	$4,829	$4,461
Large	$8,266	$9,296	$8,784
State	$7,466	$7,990	$7,928

- The Asian/Pacific Islander AACM increased slightly within the MHP in CY 2021, followed by a decrease in CY 2022. The MHP AACM has consistently been lower than the similar-sized county and statewide AACMs.

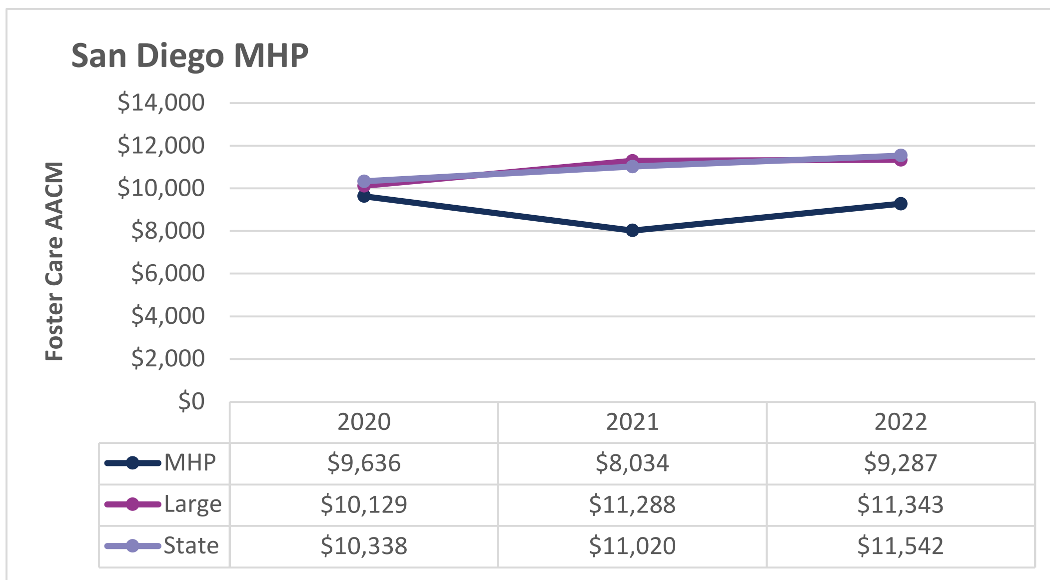
Figure 10: Foster Care PR, CY 2020-22



	2020	2021	2022
MHP	48.18%	42.17%	37.31%
Large	47.06%	46.53%	44.06%
State	51.00%	49.15%	46.00%

- The FC PR has decreased across the state over the prior two years, with the MHP decreasing at a higher rate than the similar-sized county and statewide PRs.

Figure 11: Foster Care AACM, CY 2020-22



	2020	2021	2022
MHP	$9,636	$8,034	$9,287
Large	$10,129	$11,288	$11,343
State	$10,338	$11,020	$11,542

- Statewide and similar-sized county FC AACM have increased each year for the past three years.
- The MHP FC AACM increased at a higher rate in CY 2022 but remains lower than the large county and statewide AACMs.

Units of Service Delivered to Adults and Foster Youth

Table 8: Services Delivered by the San Diego MHP to Adults, CY 2022

Service Category	MHP N = 23,638				Statewide N = 381,970		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	2,087	8.8%	11	6	10.3%	14	8
Inpatient Admin	-	-	11	8	0.4%	26	10
Psychiatric Health Facility	<11	-	25	11	1.2%	16	8
Residential	26	0.1%	105	93	0.3%	114	84
Crisis Residential	1,055	4.5%	15	11	1.9%	23	15
Per Minute Services							
Crisis Stabilization	4,508	19.1%	1,217	1,092	13.4%	1,449	1,200
Crisis Intervention	1,050	4.4%	108	75	12.2%	236	144
Medication Support	15,274	64.6%	281	170	59.7%	298	190
Mental Health Services	16,313	69.0%	446	219	62.7%	832	329
Targeted Case Management	8,372	35.4%	387	138	36.9%	445	135

- Crisis intervention was notably lower in claims for adults in the MHP (4.4 percent) compared to statewide (12.2 percent).
- Medication support and mental health services were provided at slightly higher rates than statewide but with fewer units of service on average.

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

Service Category	MHP N = 996				Statewide N = 33,234		
	Members Served	% of Members Served	Average Units	Median Units	% of Members Served	Average Units	Median Units
Per Day Services							
Inpatient	23	2.3%	8	4	4.5%	12	8
Inpatient Admin	0	0.0%	0	0	0.0%	5	3
Psychiatric Health Facility	<11	-	25	25	0.2%	19	8
Residential	0	0.0%	0	0	0.0%	56	39
Crisis Residential	0	0.0%	0	0	0.1%	24	22
Full Day Intensive	<11	-	1,107	1,032	0.2%	673	435
Full Day Rehab	50	5.0%	87	84	0.2%	111	84
Per Minute Services							
Crisis Stabilization	47	4.7%	1,283	1,200	3.1%	1,166	1,095
Crisis Intervention	43	4.3%	186	81	8.5%	371	182
Medication Support	304	30.5%	273	197	27.6%	364	257
TBS	36	3.6%	3,267	2,076	3.9%	4,077	2,457
Therapeutic FC	0	0.0%	0	0	0.1%	911	495
Intensive Care Coordination	538	54.0%	1,012	365	40.8%	1,458	441
Intensive Home-Based Services	208	20.9%	1,061	656	19.5%	2,440	1,334
Katie-A-Like	<11	-	204	120	0.2%	390	158
Mental Health Services	952	95.6%	1,248	797	95.4%	1,846	1,053
Targeted Case Management	345	34.6%	146	88	35.8%	307	118

- The MHP’s service utilization is largely comparable with statewide utilization for services delivered to FC members.
- 54.0 percent of FC youth in the MHP received Intensive Care Coordination (ICC) compared to 40.8 percent statewide, reflecting implementation of the Pathways to Well-Being initiative. However, the MHP delivered significantly fewer units of service on average for both ICC and Intensive Home-Based Services.
- The majority of foster youth in the state who participate in full day rehabilitation are in San Diego (87 of the 111 youth).

IMPACT OF ACCESS FINDINGS

- Review discussions indicated transitions to lower LOC indicate longer waits than timely and transitions do not appear to be standardized but are done on a case by case basis.
- PR for San Diego has decreased over the prior two years and was further impacted by a decrease in members served and an increase in eligibles in CY 2022. Workforce challenges and reduced provider capacity are evident in lower PRs and AACMs.
- The most notable gaps between members eligible and served are seen in the Hispanic/Latino PR, the MHP's largest group of eligible population, continues to be lower that state average, indicating these groups are proportionally underrepresented in the MHP. This warrants further evaluation and performance improvement.

TIMELINESS OF CARE

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

TIMELINESS KEY COMPONENTS

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

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

Table 10: Timeliness Key Components

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

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

- While the Urgent Appointment Key Component is met, the actual percentage of offered appointments that meet the 48-hour standard is only 62.3 percent. There was no information given indicating that any improvement activity is underway at the time of the review.

TIMELINESS PERFORMANCE MEASURES

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

For the FY 2023-24 EQR, the MHP reported in its submission of ATA, representing access to care during the 12 month period of FY 2022-23. Table 11 and Figures 12-14 below display data submitted by the MHP; an analysis follows. These data represent the entire system of care.

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

Table 11: FY 2023-24 San Diego MHP Assessment of Timely Access

Timeliness Measure	Average	Standard	% That Meet Standard
First Non-Urgent Appointment Offered	10.4 Business Days	10 Business Days*	79.7%
First Non-Urgent Service Rendered	19.7 Business Days	10 Business Days**	52.3%
First Non-Urgent Psychiatry Appointment Offered	6.4 Business Days	15 Business Days*	86.7%
First Non-Urgent Psychiatry Service Rendered	10.7 Business Days	15 Business Days**	78.1%
Urgent Services Offered (including all outpatient services) – Prior Authorization NOT Required	137.8 Hours ***	48 Hours*	62.3%
Follow-Up Appointments after Psychiatric Hospitalization – 7 Days	6.2 Calendar Days	7 Calendar Days	36.3%
Follow-Up Appointments after Psychiatric Hospitalization – 30 Days	6.2 Calendar Days	30 Calendar Days	49.7%
No-Show Rate – Psychiatry	17.7%	20%**	n/a
No-Show Rate – Clinicians	8.2%	15%**	n/a

* DHCS-defined timeliness standards as per BHIN 21-023 and 22-033

** MHP-defined timeliness standards

*** The MHP did not track urgent services requiring pre-authorization.

For the FY 2023-24 EQR, the MHP reported its performance for the following time period: FY 2022-23

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

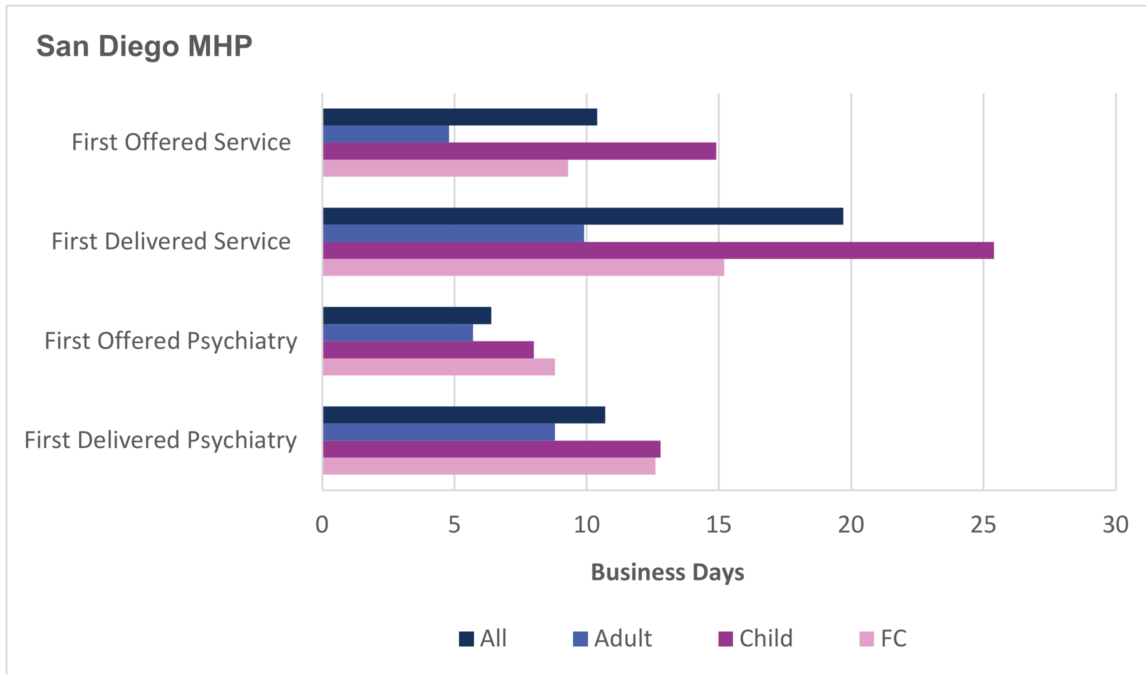


Figure 13: Wait Times for Urgent Services

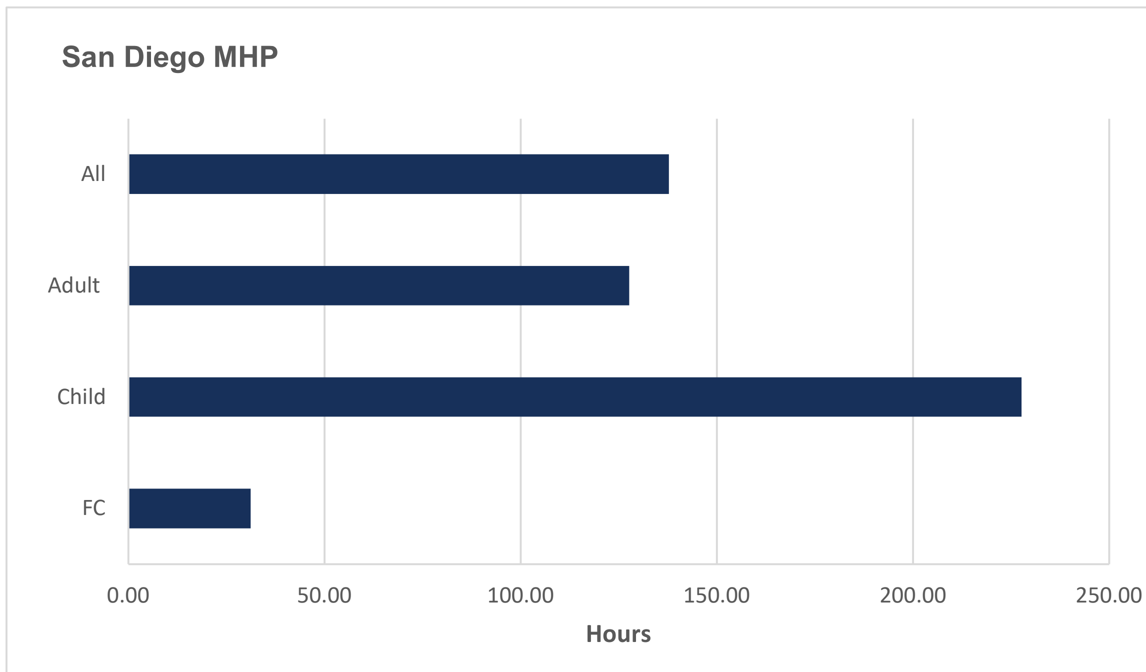
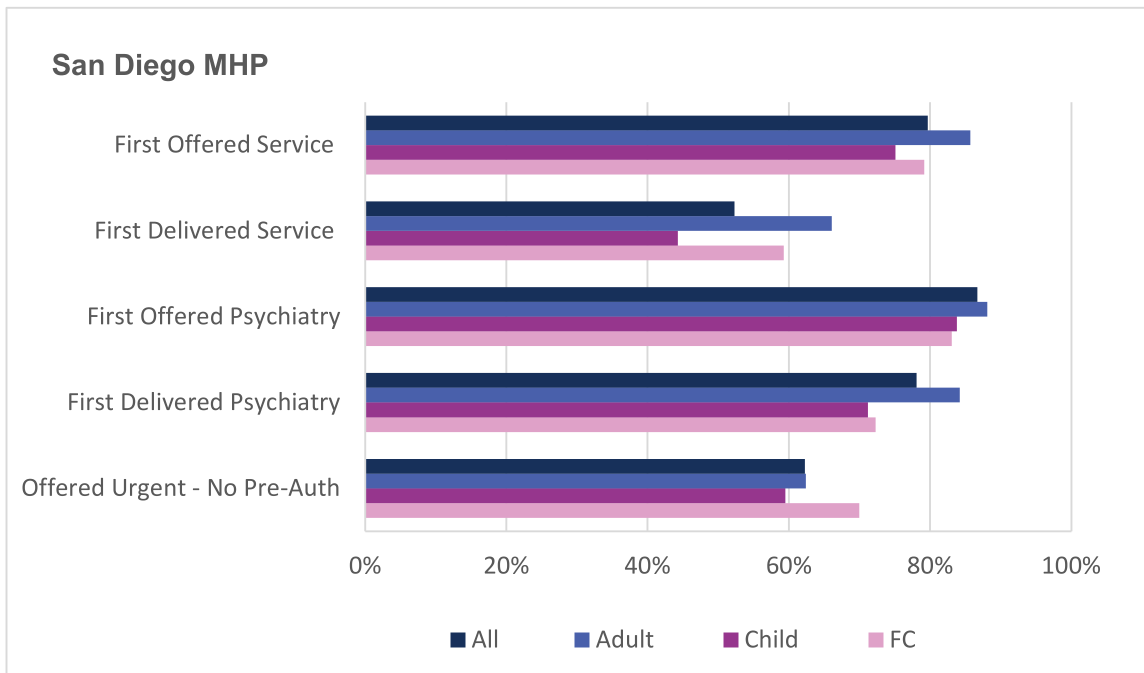


Figure 14: Percent of Services that Met Timeliness Standards



- Because MHPs may provide mental health services prior to the completion of an assessment and diagnosis, the initial service type may vary. According to the MHP, the data for initial service access for a routine service in Figures 12 and 14, represent scheduled assessments.
- The MHP defined "urgent services" for purposes of the ATA as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention. There were reportedly 265 urgent service requests with a reported actual wait time to services for the overall population of 137.8 hours. The MHP does offer urgent services that require pre-authorization, specifically crisis residential services, however these services were not tracked for timeliness.
- The MHP defines timeliness to first delivered/rendered psychiatry services as from the point of first request date to first delivered service date, averaging 10.7 business days' wait.
- For the MHP, no-shows are tracked and monitored for the entire service system. The MHP reports a no-show rate for psychiatry of 19.5 percent for adults and 10.5 percent for youth. The no-show rate for non-psychiatry clinical staff was reported as 11.6 percent for adults and 6 percent for youth.

IMPACT OF TIMELINESS FINDINGS

- The MHP meets the 48 hours standard for first offered for urgent appointment 62.3 percent of the time overall (per ATA). Wait times for service delivery exceed 100 hours with the exception of FC, which is 31.20 hours. This makes the opportunity for an urgent service need to become an emergency as it is not dealt with in a timely manner.
- Given the new mobile crisis requirements with CalAIM implementation of requirements for service delivery, the MHP could find it effective to consider providing the mobile response to assist in ameliorating long waits for urgent services.

QUALITY OF CARE

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

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

QUALITY IN THE MHP

In the MHP, the responsibility for QI is carried by the EQIT. The EQIT is responsible for implementing the QI Unit, responding to recommendations from the QRC, and identifying and initiating QI activities. The QRC is a standing body charged with the responsibility of providing recommendations regarding the QI activities for MH and SUD system and the Quality Improvement Work Plan (QIWP). Quality Improvement Committees (QICs) are subcommittees of the QRC and are composed of QRC members and QI staff.

The MHP monitors its quality processes through the QRC, the QIWP, and the annual evaluation of the QIWP. The QIC, comprised of MHP management and staff, is scheduled to meet quarterly. Since the previous EQR, the MHP QIC met four times. Of the 13 identified FY 2021-22 QIWP workplan goals, the MHP goals were met or were in progress of being met. The FY 2022-23 QIWP had not yet been evaluated.

The MHP does not currently utilize a standardized LOC tool, though the Level of Care Utilization System (LOCUS) is used within the Assertive Community Treatment and Strength Based Case Management programs.

The MHP utilizes the following outcomes tools: Child and Adolescent Needs and Strengths, Illness Management and Recovery, LOCUS, Milestones of Recovery Scale, Pediatric Symptom Checklist-35, Personal Experience Screening Questionnaire, and the Sutter-Eyberg Student Behavior Inventory-Revised.

The MHP, in coordination with UCSD, is analyzing data with the goal of creating a user-friendly service delivery tool for staff, which is currently under development. The efforts include the creation of public-facing dashboards with data on services, outcomes, school district data, and social determinants of health, which are available by geographic locations within San Diego County. The process began with community input meetings, with a goal of identifying specific areas with targeted service needs.

QUALITY KEY COMPONENTS

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

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

Table 12: Quality Key Components

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

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

- The MHP is a data driven system. Data is used to inform leadership and assist in creating continuous QI. The MHP has a comprehensive QI process.
- The MHP supports a network of ten clubhouses throughout San Diego County. Three specialize in the populations of TAY, deaf and hard of hearing, and homeless. Six offer Supplemental Security Income advocacy services.
- While there are meetings in which contract providers and stakeholders are members and able to provide input into system planning, feedback from focus group sessions report there is not a real mechanism to provide input, and the MHP does not solicit feedback. Communication appears to be directive and not bi-directional.

- The MHP administers member satisfaction surveys; however, no examples were given of using the findings to improve access, timeliness and/or quality of services.
- The MHP tracks and trends all Healthcare Effectiveness Data and Information Set (HEDIS) measures as required by WIC Section 14717.5.

QUALITY PERFORMANCE MEASURES

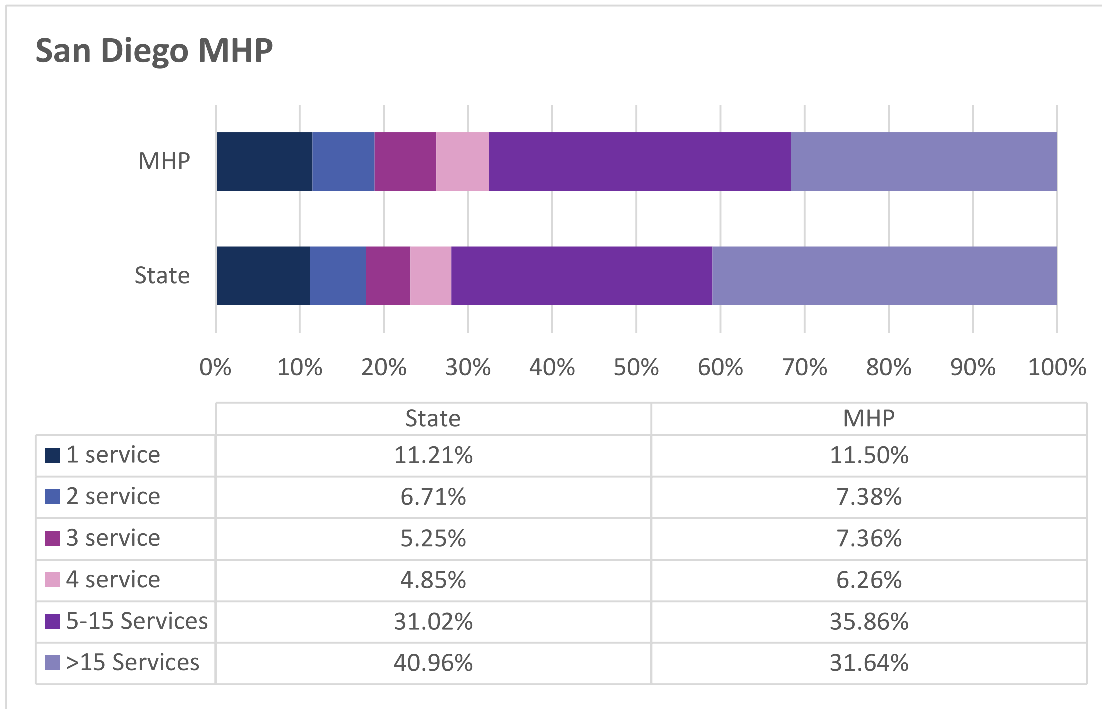
In addition to the Key Components identified above, the following PMs further reflect the Quality of Care in the MHP; note timely access to post-hospital care and readmissions are discussed earlier in this report in the Key Components for Timeliness. The PMs below display the information as represented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

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

Retention in Services

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

Figure 15: Retention of Members Served, CY 2022



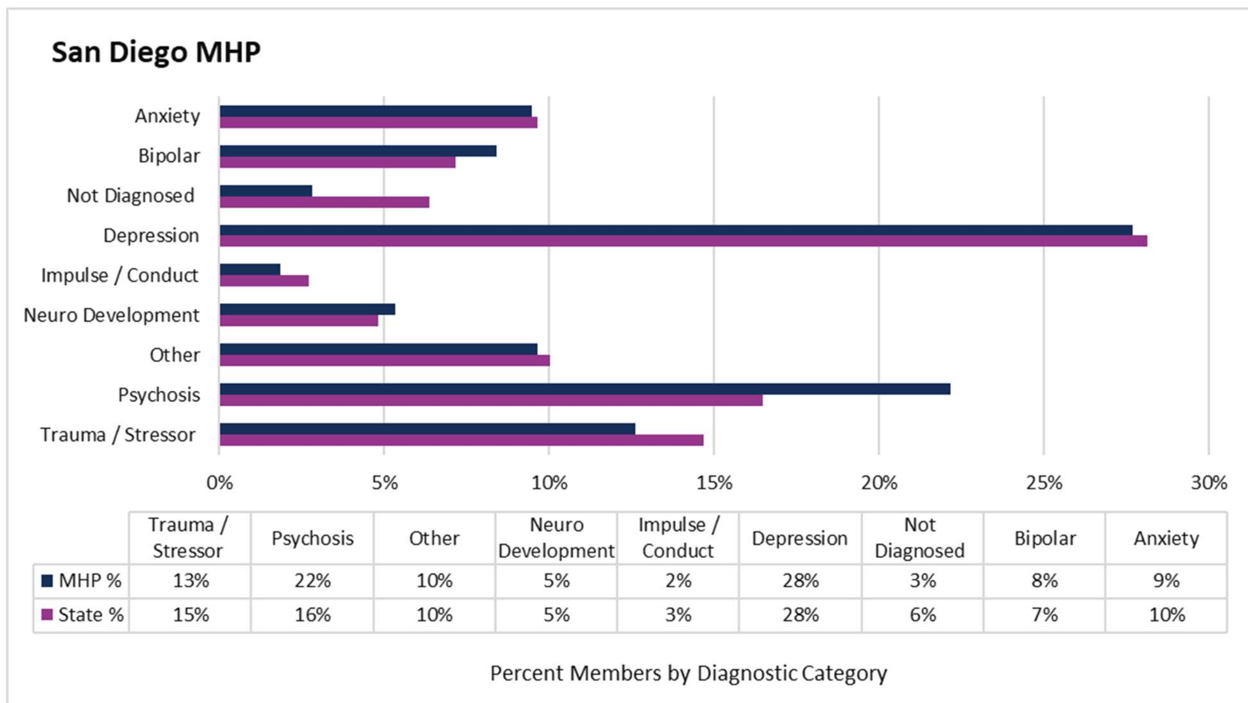
	State	MHP
1 service	11.21%	11.50%
2 service	6.71%	7.38%
3 service	5.25%	7.36%
4 service	4.85%	6.26%
5-15 Services	31.02%	35.86%
>15 Services	40.96%	31.64%

- The proportion of members receiving 15 or more services is smaller in the MHP than statewide.

Diagnosis of Members Served

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

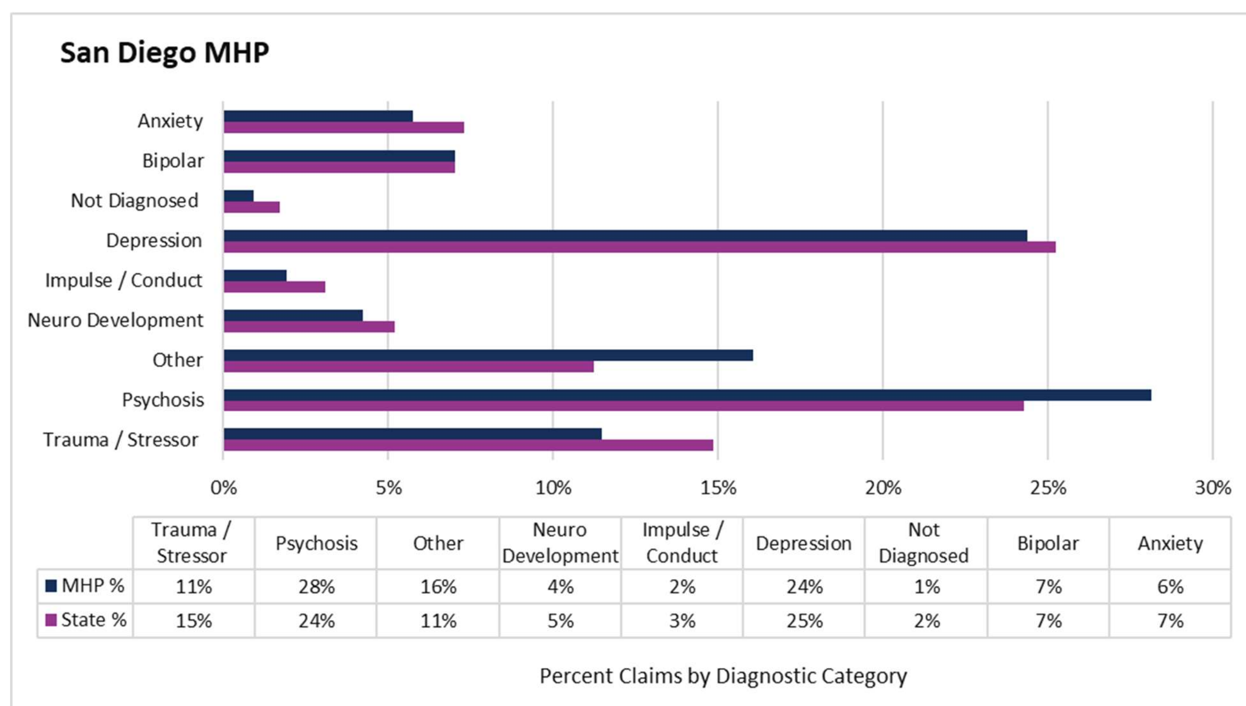
Figure 16: Diagnostic Categories by Percentage of Members Served, CY 2022



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	13%	22%	10%	5%	2%	28%	3%	8%	9%
State %	15%	16%	10%	5%	3%	28%	6%	7%	10%

- The distribution of diagnostic categories for members served by the MHP is comparable to the statewide distribution. The plurality of members had depression as their primary diagnosis. The rate of members diagnosed with psychosis was notably higher in the MHP (22 percent), compared to statewide (16 percent).

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



	Trauma / Stressor	Psychosis	Other	Neuro Development	Impulse / Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	11%	28%	16%	4%	2%	24%	1%	7%	6%
State %	15%	24%	11%	5%	3%	25%	2%	7%	7%

- Approved claims for those diagnosed with psychosis account for 28 percent of the total MHP Medi-Cal claims, which is higher than statewide (24 percent). Members with a depression diagnosis accounted for 24 percent of the MHP Medi-Cal claims, which is lower than statewide (25 percent).

Psychiatric Inpatient Services

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

Table 13: San Diego MHP Psychiatric Inpatient Utilization, CY 2020-22

Year	Unique Inpatient Medi-Cal Members	Total Medi-Cal Inpatient Admissions	Average Admissions per Member	MHP Average LOS in Days	Statewide Average LOS in Days	Inpatient MHP AACM	Inpatient Statewide AACM	Inpatient Total Approved Claims
CY 2022	2,585	3,521	1.36	7.69	8.45	$11,682	$12,763	$30,197,733
CY 2021	3,641	4,591	1.26	9.32	8.86	$10,384	$12,696	$37,807,296
CY 2020	3,809	5,427	1.42	8.52	8.68	$10,409	$11,814	$39,646,166

- The inpatient MHP AACM remains lower than statewide over the past three years.

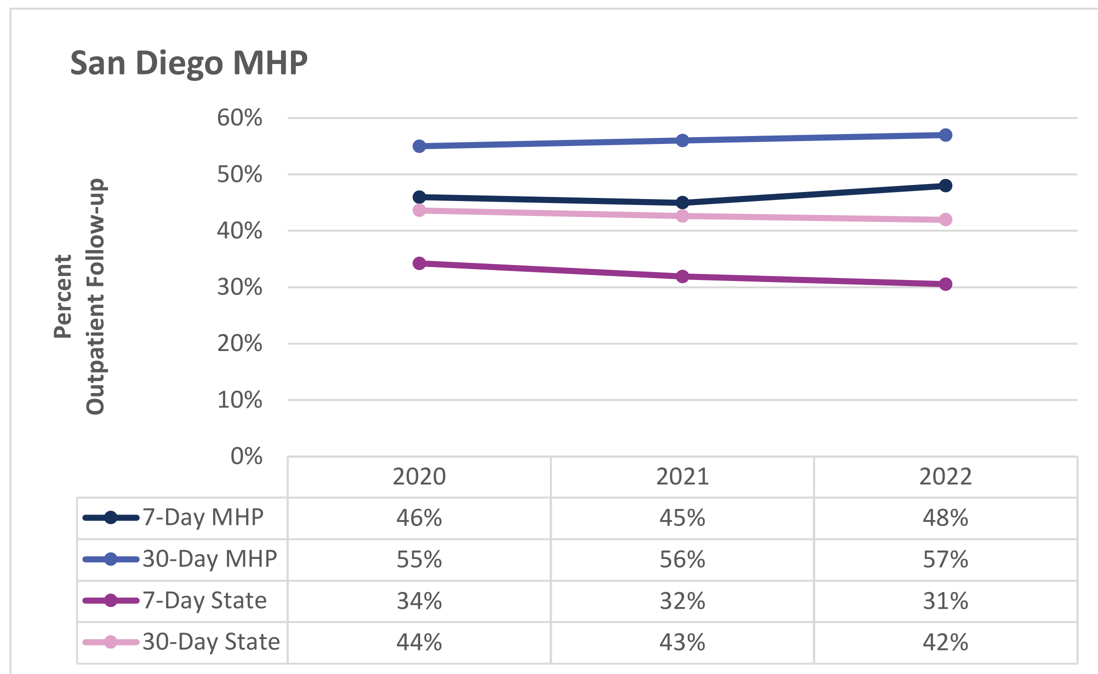
- The MHP average LOS in days is lower than the state the past three years, while both the MHP and state average LOS in days has declined each year.

Follow-Up Post Hospital Discharge and Readmission Rates

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

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

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

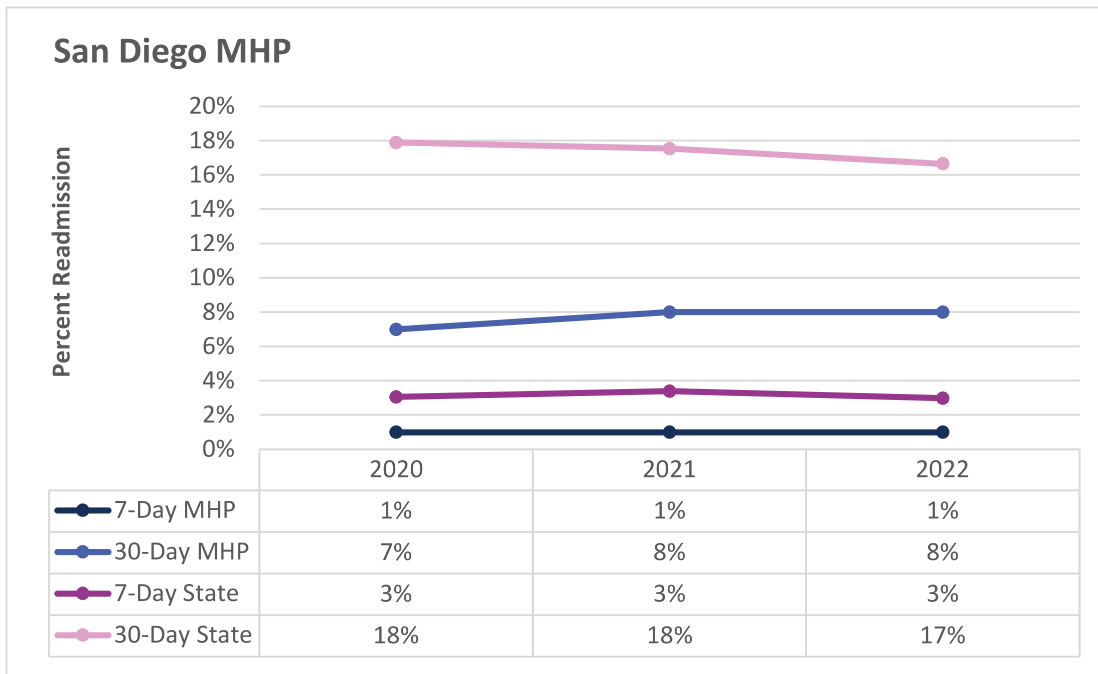


	2020	2021	2022
7-Day MHP	46%	45%	48%
30-Day MHP	55%	56%	57%
7-Day State	34%	32%	31%
30-Day State	44%	43%	42%

- Timely follow-up care for members following psychiatric inpatient stays had a slight increase in the MHP while decreasing statewide in CY 2022. Timely follow-up care within the 30-day time period remained stable in the MHP despite a statewide decrease.

- The MHP's rates of timely follow-up within 7-day and 30-day time periods after discharge from psychiatric inpatient services are higher than statewide for CY 2022.

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



	2020	2021	2022
7-Day MHP	1%	1%	1%
30-Day MHP	7%	8%	8%
7-Day State	3%	3%	3%
30-Day State	18%	18%	17%

- The MHP psychiatric readmissions at both 7 and 30 days remained stable in CY 2022 from the prior year.
- Overall, the MHP had notably lower readmission rates than those seen statewide for both measured time periods in each of the last three years.

High-Cost Members

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

Table 14 provides a three-year summary (CY 2020-22) of HCM trends for the MHP and the statewide numbers for CY 2022. HCMs in this table are identified as those with

approved claims of more than $30,000 in a year. Outliers drive the average claims across the state. While the overall AACM is $7,442, the median amount is just $3,200.

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

Table 14: San Diego MHP High-Cost Members (Greater than $30,000), CY 2020-22

Entity	Year	HCM Count	HCM % of Members Served	HCM % of Claims	HCM Approved Claims	Average Approved Claims per HCM	Median Approved Claims per HCM
Statewide	CY 2022	27,277	4.54%	33.86%	$1,514,353,866	$55,518	$44,346
MHP	CY 2022	801	2.39%	22.32%	$41,098,408	$51,309	$42,312
	CY 2021	885	2.48%	22.70%	$44,837,710	$50,664	$42,440
	CY 2020	1,038	2.92%	26.60%	$54,504,986	$52,510	$44,498

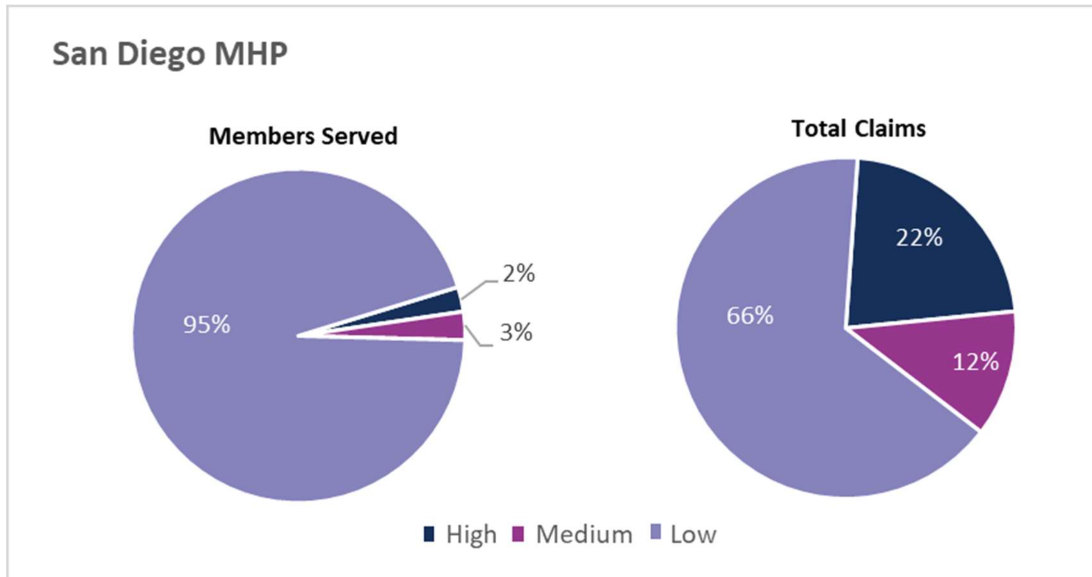
- The number of HCMs increased by 84 members (9.5 percent) in the MHP from CY 2021 to CY 2022.
- The proportion of HCMs in the MHP in CY 2022 (2.39 percent) remains lower than statewide (4.54 percent), and the average approved claims per HCM was over 7 percent lower than the statewide average ($51,309 vs. $55,518).

Table 15: San Diego MHP Medium- and Low-Cost Members, CY 2022

Claims Range	# of Members Served	% of Members Served	Category % of Total Approved Claims	Category Total Approved Claims	Average Approved Claims per Member	Median Approved Claims per Member
Medium-Cost ($20K to $30K)	918	2.74%	12.00%	$22,105,903	$24,081	$23,671
Low-Cost (Less than $20K)	31,754	94.86%	65.68%	$120,941,024	$3,809	$2,269

- The vast majority of members served (94.86 percent) are considered low-cost, with claims amounting to almost 66 percent of all annual Medi-Cal claims for the MHP.
- Members categorized as medium-cost represented only 2.74 percent of those served in the MHP, translating to 12 percent of all annual approved claims.

Figure 20: San Diego MHP Members and Approved Claims by Claim Category, CY 2022



IMPACT OF QUALITY FINDINGS

- The MHP's rates of timely follow-up within 7-day and 30-day time periods after discharge from psychiatric inpatient services may be an influence on readmission rates remaining below state average.
- There is a lack of bidirectional communication with provider staff across all levels and contract provider systems.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

All MHPs are required to have had two PIPs in the 12 months preceding the EQR, one clinical and one non-clinical, as a part of the plan's QAPI program, per 42 CFR §§ 438.330[2] and 457.1240(b)[3]. PIPs are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. They should have a direct member impact and may be designed to create change at a member, provider, and/or MHP system level.

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

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

CLINICAL PIP

General Information

Clinical PIP Submitted for Validation: "Improved Therapeutic Support for Youth Members who Identify as LGBTQ+"

Date Started: 01/2022

Aim Statement: "(Year 1) For CYF (Child, Youth and Family) clients who identify as LGBTQ+, will the revisions to and promotion of the *It's Up to Us* website's LGBTQ+ resource page result in higher utilization, as measured by the number of unique pageviews reported in each quarter in the year after the launch of the revised resource page?"

"(Year 2) For CYF youth clients across the CYFBHS system who identify as LGBTQ+, will the systemwide training of providers (1) decrease the need for additional services, (2) decrease the utilization of emergency/crisis services, (3) increase LGBTQ+-affirming mental health treatment (e.g., clinicians asking about sexual orientation and gender identity, providing LGBTQ+-specific information), and (4) increase satisfaction with

[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-sec457-1240.pdf

services, as measured by CCBH data and a comparison of the December 2021 Youth Services Survey (YSS) and the May 2023 YSS?"

Target Population: All youth served in the County of San Diego CYFBHS who identify as LGBTQ+.

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

Summary

The MHP designed the PIP to improve therapeutic support for youth who identify as lesbian, gay, bisexual, transgender, queer, questioning, intersex, two-spirit, and other diverse sexual orientations, gender identities and expressions. San Diego determined that these young people have higher rates of emergency/crisis service utilization, and experience more negative outcomes compared to their heterosexual and cisgender peers. Additionally, national and regional data indicated that LGBTQ+ youth rarely receive mental health resources and services specifically aimed at supporting the unique challenges they face associated with their sexual and gender identities.

San Diego researched experiences of the youth from key stakeholders and identified common themes that included lack of comfort and knowledge among clinicians, discomfort among clinicians about requesting additional training, and the need for a more comprehensive list of online resources and supports for youth. The PIP interventions were *It's Up to Us* resource page improvement and promotion and systemwide clinical training to increase provider knowledge of LGBTQ+ specific needs and supports. The MHP implemented the first intervention in October 2022 and the second intervention in March 2023. In this year's submission, San Diego reported remeasurement results for seven of the eight performance measures and there was improvement in five measures. The MHP did not yet have remeasurement results as of the EQR for the eighth performance measure, the percentage of LGBTQ+ youth admitted to emergency/crisis levels of care.

TA and Recommendations

As submitted, this clinical PIP was found to have moderate confidence. The PIP was methodologically sound and there was improvement in five measures. The MHP did not report how many of the eligible PIP population was directly impacted by the member focused intervention (i.e., updated website). The rate of youth who reported that providers asked about their sexual orientation was essentially the same from baseline to remeasurement, indicating that additional provider training may be needed and/or there is another reason providers are not inquiring. The percentage of LGBTQ+ youth that desired additional resources increased from baseline to remeasurement (lower result is better).

The MHP requested PIP TA from BHC in advance of the EQR.

CalEQRO recommendations for improvement of this clinical PIP:

- Determine how many of the MHP's eligible population for the PIP utilized the website and obtained resources when visiting the website.
- Design a process measure to ensure provider training was understood, well-received, and applied. Provide additional provider training, if necessary.
- Determine whether there are other reasons why providers may not ask youth about sexual orientation.

NON-CLINICAL PIP

General Information

Non-Clinical PIP Submitted for Validation: Improving the Experience of Teletherapy for Older Adults

Date Started: 03/2023

Aim Statement: "Will training and informational support increase older adult client's likelihood to utilize telehealth services by 10 percent from 33 percent and use the self-reported pre and post data from the population who received the intervention as the main outcomes measure. Improved utilization of telehealth services will be measured in the following ways from a client pre- and -post intervention self-report data: 1) improved self-report of knowledge on how to access telehealth services for older adult clients, 2) improved self-report of comfort with the privacy while utilizing telehealth services for older adult clients 3) improved self-report of the safety of utilizing telehealth services for older adult clients 4) improved self-report of likelihood to utilize telehealth services."

Target Population: Clients over the age of 60 years old who are active in programs within the San Diego County Mental Health System of Care (SDCMHSOC) that offer telehealth services. The PIP evaluation team contacted ten programs who serve older adults to participate in the PIP. Two programs that also participated in the older adult member feedback and provider feedback process agreed to participate in the PIP.

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

Summary

The MHP developed this PIP to address the gap in use of telehealth services among older adults aged 60 years and older. Data demonstrated differences of telehealth mental health services utilization by age group with older adults less likely than other age groups to utilize telehealth services by telephone or video. San Diego initially received feedback directly from older adult members during an older adult social isolation and loneliness workgroup conducted from September 2020 to September 2021. The MHP determined a main barrier for older adults was lack of knowledge and comfort utilizing technology and member training may address this barrier and improve telehealth use by older adults.

The MHP provided in-person training to increase the PIP population's knowledge and confidence using telehealth. San Diego wanted to increase the percentage of the PIP population who responded to the survey that they agreed it was safe to use telehealth and likely to utilize telehealth because of the training. The MHP provided the first round of training in May 2023 at East County with a focus on the refugee population, North County with a focus on the Filipino population, and North County with a focus on the Latino population. A second round of training was held in August and September 2023. San Diego reported baseline and remeasurement in this year's submission. There was improvement in four of the five measures. The fifth measure results were only reported for the most recent measurement because it related to older adults indicating whether they were likely to utilize telehealth due to the training that was provided by the MHP.

TA and Recommendations

As submitted, this non-clinical PIP was found to have moderate confidence because the PIP had one member-focused intervention — training for the eligible population ages 60 years and older. There was improvement in four of five measures related to member survey responses. Outcomes did not include how many members utilized telehealth services. There is further opportunity to assist the Filipino population as training did not appear to address the barriers for this population.

The MHP requested PIP TA from CalEQRO in advance of the EQR.

CalEQRO recommendations for improvement of this non-clinical PIP:

- Investigate and address the Filipino population barriers to receiving services via telehealth.
- Consider further efforts (e.g., additional members, provider, and/or system interventions) to build on improving use of telehealth by older adults.
- Report on how many individuals in the targeted population utilized telehealth services.

INFORMATION SYSTEMS

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

INFORMATION SYSTEMS IN THE MHP

The EHRs of California's MHPs are generally managed by county, MHP IT, or operated as an application service provider (ASP) where the vendor, or another third party, is managing the system. The primary EHR system used by the MHP is CCBH by Oracle/Cerner, which has been in use for 15 years. Currently, the MHP has been actively implementing a new system, Cerner Millenium, which requires heavy staff involvement to fully develop. During the review the MHP reported system limitations found within the new system, and the MHP was beginning the process to shift to the SmartCare by Streamline system under the CalMHSA semi-statewide EHR initiative.

Approximately 7 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 4,180 named users with log-on authority to the EHR, including approximately 450 county staff and 3,730 contractor staff. Support for the users is provided by 68.25 full-time equivalent (FTE) IS technology positions, which is an increase from 62 FTE reported in the last EQR. Currently there are ten vacant IS positions.

As of the FY 2023-24 EQR, all contract providers have access to directly enter clinical data into the MHP's EHR. Contractor staff having direct access to the EHR has multiple benefits: it is more efficient, it reduces the potential for data entry errors associated with duplicate data entry, and it provides for superior services for members by having comprehensive access to progress notes and medication lists by all providers to the EHR 24/7.

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

Table 16: Contract Provider Transmission of Information to San Diego MHP EHR

Submittal Method	Frequency	Submittal Method Percentage
Health Information Exchange (HIE) between MHP IS	☐ Real Time ☐ Batch	0%
Electronic Data Interchange to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Electronic batch file transfer to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Direct data entry into MHP IS by provider staff	☒ Daily ☐ Weekly ☐ Monthly	100%
Documents/files e-mailed or faxed to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
Paper documents delivered to MHP IS	☐ Daily ☐ Weekly ☐ Monthly	0%
		100%

Member Personal Health Record

The 21st Century Cures Act of 2016 promotes and requires the ability of members to have both full access to their medical records and their medical records sent to other providers. Having a Personal Health Record (PHR) enhances members' and their families' engagement and participation in treatment. The MHP does not currently have a PHR in place but anticipates implementing a PHR within the next year.

Interoperability Support

The MHP is not a member or participant in a HIE. Healthcare professional staff use secure information exchange directly with service partners through secure email, care coordination application/module, and electronic consult. The MHP engages in electronic exchange of information with its contract providers and hospitals.

INFORMATION SYSTEMS KEY COMPONENTS

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

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

Table 17: IS Infrastructure Key Components

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

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

- The investment in IS, data analytical staffing, and contracted support remains a remarkable strength of the MHP. The partnership formed with Optum provides added support for the system.
- Related to the integrity of data collection and processing, the MHP does not maintain a data warehouse replicating the EHR system to support data analytics, although development continues to be in process.
- While the current EHR has broad functionality in place, there are multiple components not present, including: lab orders/results, referral management, and a PHR. The MHP has allowed contract providers to enter clinical data directly into the EHR, which does support data collection and reporting efforts.

INFORMATION SYSTEMS PERFORMANCE MEASURES

Medi-Cal Claiming

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

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

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

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	44,935	$13,078,946	$160,636	1.23%	$12,918,310
Feb	45,839	$13,376,107	$178,294	1.33%	$13,197,813
Mar	52,672	$15,693,382	$237,048	1.51%	$15,456,334
April	47,703	$14,250,138	$222,071	1.56%	$14,028,067
May	45,307	$14,151,817	$221,092	1.56%	$13,930,725
June	39,663	$12,769,434	$295,053	2.31%	$12,474,381
July	42,850	$14,328,827	$248,795	1.74%	$14,080,032
Aug	50,019	$16,568,796	$306,817	1.85%	$16,261,979
Sept	49,258	$16,135,785	$292,862	1.81%	$15,842,923
Oct	50,078	$16,072,483	$382,125	2.38%	$15,690,358
Nov	47,257	$14,928,525	$279,194	1.87%	$14,649,331
Dec	1,422	$501,109	$13,791	2.75%	$487,318
Total	**517,003**	**$161,855,349**	**$2,837,778**	**1.75%**	**$159,017,571**

- The MHP had a relatively stable volume of claim lines across CY 2022.

Table 19: Summary of San Diego MHP Denied Claims by Reason Code CY 2022

Denial Code Description	Number Denied	Dollars Denied	% of Total Denied Claims
Other healthcare coverage must be billed first	2,442	$1,253,502	44.17%
Medicare Part B must be billed before submission of claim	1,883	$830,764	29.28%
Beneficiary is not eligible or non-covered charges	1,673	$665,381	23.45%
Service location NPI issue	93	$44,420	1.57%
Service line is a duplicate and repeat service modifier is not present	37	$18,347	0.65%
Deactivated NPI	94	$17,736	0.62%
Other	45	$7,309	0.26%
Place of service incomplete or invalid	1	$320	0.01%
Total Denied Claims	**6,268**	**$2,837,779**	**100.00%**
Overall Denied Claims Rate	**1.75%**		
Statewide Overall Denied Claims Rate	**5.92%**		

- The top three denial reasons account for $2.75 million and almost 97 percent of the denied claims amount.
- The MHP denied claims rate is less than half the statewide denial rate.

IMPACT OF INFORMATION SYSTEMS FINDINGS

- The base of 68.25 FTEs approved to support the overall IS functionality provides a solid foundation as EHR updates and development continue. The successful recruitment of the ten vacant FTEs will be key to successfully moving initiatives forward in a timely manner.
- The recent decision to discontinue implementation of the Cerner Millenium EHR, and to pursue implementation of the SmartCare by Streamline EHR, will impact long-term initiatives and development timelines.
- The MHP reports 41.9 FTEs approved for data analytics support. These positions are spread between teams within the MHP, Optum, and the UCSDFTE. The MHP continues to lead efforts to focus on data integrity, while simultaneously expanding the scope of analytics and reporting across programs. The shift to a new EHR implementation plan will require data analytics staff to adapt to assess and develop revised processes for data collection and reporting. The ability to leverage the experience and lessons learned by CalMHSA, and other counties adopting the SmartCare EHR, may ease the transition if system functionality is available to meet the data and reporting needs.
- The MHP Medi-Cal claiming process and the EHR were updated to align with CalAIM at the beginning of FY 2023-24. Claim submissions for services in FY 2023-24 are still pending at the time of the review due to system issues needing to be resolved. This impacts cash flow for the MHP for Medi-Cal claims, although the MHP is implementing payment reform requirements for contract providers in a phased approach in FY 2023-24.

VALIDATION OF MEMBER PERCEPTIONS OF CARE

CONSUMER PERCEPTION SURVEYS

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

The MHP administers the CPS to current MHP beneficiaries, and tabulates and reports findings to stakeholders, including beneficiaries and contractors. The most recent website available survey is May 2022.

PLAN MEMBER/FAMILY FOCUS GROUP(S)

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

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

Consumer Family Member Focus Group One

CalEQRO requested a diverse group of TAY consumers who initiated services in the preceding 12 months. The focus group was held virtually and included two participants receiving clinical services from the MHP. No language interpreter was necessary for this focus group.

The number of participants is less than three; therefore, feedback received during the session is incorporated into other sections of this report to ensure anonymity of the participants.

Consumer Family Member Focus Group Two

CalEQRO requested a diverse group of parent/caregivers of children, the majority of whom initiated services in the preceding 12 months. The focus group was held virtually and included seven participants receiving clinical services from the MHP. Five participants began receiving services in the past 12 months. No language interpreter was necessary for this focus group.

- Overall, services were experienced as helpful and positive. All participants in the groups found the services they receive to be helpful in their recovery.
- Multiple caregivers felt that their providers gave their loved ones a sense of hope.
- Participants agreed that entering services was timely. Referrals came from a variety of sources, including schools and physicians.
- Treatment planning involvement was a common theme within the group.
- Although none have been asked to serve on any committees or give their input on policies, most feel comfortable sharing their input with the MHP.
- The participants are aware of and utilize the SDCBHS website or searching the internet for information on resources within the MHP SOC.
- The MHP does not provide transportation to these participants as far as they are aware.

Recommendations from focus group participants included:

- It may be helpful to better coordinate MH care with primary healthcare, so they are aligned better because they are connected.
- “Staff should continue to take courses/improve skills so they can provide confidence to those in their care.”

Consumer Family Member Focus Group Three

CalEQRO requested a diverse group of adult consumers who initiated services in the preceding 12 months. The focus group was held virtually and included eight participants receiving clinical services from the MHP. There were no participants who had begun receiving services in the past 12 months, and the group included one family member. No language interpreter was necessary for this focus group.

- In general, the participants feel that the MH services they receive are useful and helpful in their recovery.
- Participants reported that initial services took over two weeks; one person stated it took six weeks.
- One participant utilized mobile crisis services to be assessed due to issues with her issues of going to the clinic.
- Routine outpatient therapy frequency was reported as one to two weeks, while psychiatry appointments were one to three months, depending on the situation. Some participants felt that more frequent therapy and psychiatric appointments would be more useful to their recovery.
- All agreed it was a plus to have walk-ins available during business hours at clinics with an on-duty crisis therapist.

- Most participants have worked with peer support staff and think they do an excellent job and are helpful with referrals and knowledge of resources available. One person had an uncomfortable experience and said the peer support specialist did not work for him. One person had volunteered at a couple of clubhouses and decided to go to a special training and work there.
- Some of the participants felt comfortable with sharing their input to the MHP regarding services and programs, as well as resources available to them.
- The participants have filled out a few surveys and participated in program advisory.
- When employment specialists are available, they can be helpful to those who are ready to seek employment.
- No one in the group has utilized the MHP website.
- There is dual diagnosis recovery group available to members.
- High staff turnover at the clinic is viewed as a negative. Sometimes the therapist leaves without a member knowing this will happen. The disrupts case management services. Also, groups may end without warning or closure for the members of the group.

Recommendations from focus group participants included:

- Members would like therapy to be longer term. Some participants were told they only had 3-4 appointments left, and it seemed to end abruptly.

SUMMARY OF MEMBER FEEDBACK FINDINGS

Overall, services were experienced as helpful and positive. All participants in the groups found the services they receive to be helpful in their recovery. They report that the staff as giving them hope and being respectful of their cultural and personal beliefs.

While services are available, it appears that frequency could be improved. There was an awareness of staffing issues that include staff leaving and recruitment and retention issues within the MHP.

Members who participated in these groups did not seem aware of whether they had transportation benefits for attending services.

CONCLUSIONS

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

STRENGTHS

1. SDCBHS programs received the National Association of Counties Achievement award this calendar year. The winning programs included three programs that have added new capacity responsive to community need and are now an essential part of the MHP's behavioral health continuum of care. (Quality)
2. CalAIM/Payment Reform progress is underway. SDCBHS is currently developing provider rates under CalAIM behavioral health payment reform utilizing program assumptions and data, while considering certain variables that may impact rates. (Quality)
3. The MHP continues strong partnerships/collaboration with Optum and UCSD. (Quality)
4. The investment in IS and data analytical staffing and contract support remains a notable strength as the MHP continues to focus on data integrity while expanding the scope of programming. (IS)
5. The MHP created a new medication monitoring committee for both adults and youth medication prescribing. (Quality)
6. The County was able to successfully add a peer support classification and hired staff in these positions in the past year. (Quality)

OPPORTUNITIES FOR IMPROVEMENT

1. Based on stakeholder feedback and MHP data, timeliness to care continues to be impacted, with a notably high volume of referrals and ongoing staff recruitment and retention challenges. (Access, Timeliness)
2. Review discussions indicated transitions to lower LOC involve longer waits than timely and transitions do not appear to be standardized but are done on a case-by-case basis. (Timeliness, Access)
3. Stakeholder feedback on MHP collaboration efforts and communication suggests the need for focused and intentional conversations with contract providers to address system issues and foster partnership. (Quality)
4. The EHR replacement project remains a key priority, which is now delayed due to system limitations within the planned replacement system. Multiple long-term

projects are linked to the EHR transition, including ongoing CalAIM payment reform claiming updates, implementation of an enterprise data warehouse, personal health record functionality, and data integration and interoperability with contract providers. (IS)

5. Stakeholders interviewed are not aware of Peer Support classifications and what job requirements and if there are opportunities for promotions.

RECOMMENDATIONS

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

1. Evaluate barriers to timely access to first appointment and first psychiatry appointments. Develop and implement strategies to reduce wait lists for direct outpatient children and adult services. Measure the effectiveness of changes. Include input from clinical providers to understand barriers and design interventions. Consider using Plan-Do-Study-Act cycles as indicated. (Access, Timeliness)

   (This recommendation is continued from FY 2022-23.)

2. Evaluate barriers to timely access in transitions of care to measure, monitor, and guide clinical treatment for adult and child/youth beneficiaries. Develop a universal LOC process to address the wait times to transitions, especially to lower LOC. (Access)
3. Increase collaboration with contract providers. Increase MHP knowledge of contract provider challenges in current service delivery, workforce, contracts, and sustainability strategies. Use input from contract providers to address current challenges. (Quality)

   (This recommendation is continued from FY 2022-23.)

4. Reach out to leverage the experience of other counties implementing the SmartCare EHR in collaboration with CalMHSA. This would provide insight into lessons learned, and potential barriers to prepare for, throughout the implementation process. Use the information to identify and replicate successful steps used this last year in preparation for the EHR transition, as well as providing clear communication to MHP staff and contract providers on updates and timelines as they are determined. (IS)
5. Create and implement an information flow to allow employees to be aware of Peer Support employees and their duties as well as ensure the Peer Support employees are educated to their roles and the requirements for promotion. (Quality)

EXTERNAL QUALITY REVIEW BARRIERS

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

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

ATTACHMENTS

ATTACHMENT A: Review Agenda

ATTACHMENT B: Review Participants

ATTACHMENT C: PIP Validation Tool Summary

ATTACHMENT D: CalEQRO Review Tools Reference

ATTACHMENT E: Letter from MHP Director

ATTACHMENT A: REVIEW AGENDA

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

Table A1: CalEQRO Review Agenda

CalEQRO Review Sessions – San Diego MHP
Opening Session – Significant changes in the past year; current initiatives; and status of previous year's recommendations
Validation and Analysis of the MHP's Access to Care, Timeliness of Services, and Quality of Care
Validation and Analysis of the MHP's PIPs
Validation and Analysis of the MHP's PMs
Validation and Analysis of the MHP's Network Adequacy
Validation and Analysis of the MHP's Health Information System
Validation and Analysis of Member Perceptions of Care
Validation of Findings for Pathways to Well-Being (Katie A./CCR)
Consumer and Family Member Focus Group(s)
Fiscal/Billing
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Use of Data to Support Program Operations
Cultural Competence / Healthcare Equity
Quality Management, Quality Improvement and System-wide Outcomes
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and MHP Collaboration Initiatives
Peer Inclusion/Peer Employees within the System of Care
Contract Provider Group Interview – Operations and Quality Management
Information Systems Billing and Fiscal Interview
EHR Deployment
Telehealth
Closing Session – Final Questions and Next Steps

ATTACHMENT B: REVIEW PARTICIPANTS

CalEQRO Reviewers

Lynda Hutchens, LMFT, Lead Quality Reviewer
Christy Hormann, LMSW, Quality Reviewer
Joel Chain, Information Systems Reviewer
Walter Shwe, Consumer Family Member Reviewer

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

All sessions were held via video conference.

Table B1: Participants Representing the MHP and its Partners

Last Name	First Name	Position	County or Contracted Agency
Amacher	Carlie	URQI Supervisor	SDCBHS – Network Quality and Planning
Ashton	Diane	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Banzon	Charles	Program Manager	Family Health Centers of San Diego - Community Circle Central
Baraceros	Mary Ellen	Director	Pathways Community Services
Basile	Warren	PERT Clinician	Community Research Foundation - PERT
Bergmann	Luke	Director	SDCBHS
Bertelle	Lisa	QM Coordinator	Union of Pan Asian Communities (UPAC)
Briones-Espinoza	Ana	Director of Finance and Business Operations	Optum San Diego
Brown	Rhonda	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Bryson	Polina	Clinical Supervisor	Community Research Foundation – Jary Barreto Crisis Center
Buby	Myra	Vice President of Behavioral Health Services	Family Health Centers of San Diego
Carroll	Theresa	Clinical Supervisor	Community Research Foundation – Downtown IMPACT
Collier	Ashley	Case Manager	Community Research Foundation – Casa Pacifica
Cooper	Fran	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Chadwick	Amy	System of Care Evaluation Coordinator	UC San Diego Child and Adolescent Services Research Center (CASRC)
Chang	Minoa	Clinical Supervisor	Union of Pan Asian Communities (UPAC) - MCC (Multicultural community counseling) and UPAC - CMH (Children and Adolescents

Last Name	First Name	Position	County or Contracted Agency
			Mental Health)
Cavanaugh	Adria	Chief, Agency Operations	SDCBHS – Contract Support Team
Crume	Henry (Joel)	Research Associate	UC San Diego Child and Adolescent Services Research Center (CASRC)
Cunningham	Conor	Case Manager	Telecare – Pathways to Recovery
David	Nora	Assistant Medical Services Administrator	SDCBHS – Population Health Office
Dean	Robert	CEO	Vista Hill Foundation
DeVoss	Angie	Program Coordinator	SDCBHS – Management Information Systems
Eftekhari	Alisha	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Escamilla	Adrian	IT Analyst	SDCBHS – Health Plan Operations, MIS
Esposito	Nicole	Chief Population Health Officer, Medical Director	SDCBHS – Population Health Office
Estrada	Brenda	Behavioral Health Program Coordinator	SDCBHS – Programs and Services
Evans Murray	Cara	Deputy Director	SDCBHS – Programs and Services
Fondren	Megan	Older Adult Clinician	Mental Health Services/ TURN BHS Inc.
Garcia	Piedad	Deputy Director	SDCBHS – Programs and Services
Garrett	Michael	Clinical Supervisor	Pathways – Kickstart
Glezer	Natanya	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Gonzaga	Alfie	Program Coordinator	SDCBHS – Health Plan Administration
Gonzalez-Fabiny	Lorena	Administrative Analyst III	SDCBHS – Health Plan Operations, Quality Assurance MH
Gordon	Chris	President	Family Health Centers of San Diego
Guevara	Christopher	Program Coordinator	SDCBHS – Strategy & Finance

Last Name	First Name	Position	County or Contracted Agency
Gruss	Dawn	Director of Technical Assistance and Training	Optum San Diego San Diego
Fettes	Danielle	Academic Researcher	UC San Diego
Fong	Erendy	Chief, Agency Operations	SDCBHS – Strategy & Finance
Hansen	Stephanie	Administrative Analyst III	SDCBHS – Management Information Systems
Hayes	Skylar	Reporting and Application Development Manager	Optum San Diego San Diego
Higgins	Alan	Data Analytics Manager	Optum San Diego
Houghton	Catherine	URQI Specialist	SDCBHS - Population Health, Network Quality and Planning
Ishida	Yo	Clinical Supervisor	Family Health Centers of San Diego - Community Circle East
Kelly	Channa	Assistant Medical Services Administrator	SDCBHS – Programs & Services
Kemble	Derek	Principal Administrative Analyst	SDCBHS – Data Sciences
Khamis	Marie	URQI Specialist	SDCBHS – Quality Improvement
Kiviat Nudd	Aurora	Assistant Director and Chief Operations Officer	SDCBHS – Operations
Klotz	Tina	VP of San Diego Programs	Exodus Recovery, Inc.
Kneeshaw	Stacey	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Koenig	Yael	Deputy Director	SDCBHS – Programs and Services
Krelstein	Michael	Chief Medical Officer, Clinical Director	SDCBHS – Healthcare Oversight
Jacquez	Jackie	IS Contractor	SDCBHS – Health Plan Operations
Lagare	Tiffany	Research Associate	UC San Diego Child and Adolescent Services Research Center (CASRC)

Last Name	First Name	Position	County or Contracted Agency
Lance-Sexton	Amanda	Assistant Medical Services Administrator	SDCBHS – Programs and Services
Lang	Tabatha	Operations Administrator	SDCBHS – Health Plan Operations
Luu	Peter	Research Analyst II	Rady
Magnuson	Mackenzie	Clinician	Mental Health Services/TURN BHS Inc. - North Coastal Mental Health Center
Manlutac	Annika	Administrative Analyst I	SDCBHS – Communication & Engagement Team
Marquez	Samantha	Administrative Analyst I	SDCBHS – Health Plan Administration
Martinez	Olivia	URQI Specialist	SDCBHS – Quality Improvement
McDonald	Kate	Senior Mental Health Researcher	UC San Diego Child and Adolescent Services Research Center (CASRC)
Mendoza	Thomas	Graduate Student Worker	SDCBHS – Data Sciences
Mockus-Valenzuela	Danyte	Health Planning and Program Specialist	SDCBHS – Prevention and Community Engagement
Michalski	Jill	Behavioral Health Program Coordinator	SDCBHS – Health Plan Operations, Quality Assurance MH
Miles	Liz	Program Coordinator, Quality Improvement	SDCBHS – Network Quality and Planning
Minton	Mona	General Management of Programs and Clinics	Neighborhood House Association
Mishra	Gaurav	Chief BH Officer	San Ysidro Health
Morgan	Maria	Assistant Medical Services Administrator	SDCBHS – Programs & Services
Murphy	Erin	Behavioral Health Program Coordinator	SDCBHS – Programs & Services
Musso	Stacey	Department Director	Southbay Community Services

Last Name	First Name	Position	County or Contracted Agency
Nishihara	Emi	Administrative Analyst II	SDCBHS – Data Sciences
Nwabueze	Conscilla	URQI Specialist	SDCBHS – Quality Improvement
Olaoshebikan	Olushola	Executive VP	MHS/ TURN Behavioral Health Services Inc.
Page	Gregory	Peer Recovery Coach	Telecare – Pathways to Recovery
Panczakiewicz	Amy	Senior Evaluation Research Associate	UC San Diego Health Services Research Center (HSRC)
Parson	Heather	Behavioral Health Program Coordinator	SDCBHS – Health Plan Operations, Quality Assurance MH
Parmentier	Benjamin	Health Policy and Program Specialist	SDCBHS – Clinical Director's Office
Pauly	Kimberly	Assistant Medical Services Administrator	SDCBHS – Programs & Services
Payton	Lilly	Administrative Analyst III	SDCBHS – Communication & Engagement Team
Penfold	William (Bill)	Senior MIS Manager	Optum San Diego
Peters	Elizabeth	PERT Clinician	Community Research Foundation – PERT
Post	Dave	Administrative Analyst III	SDCBHS – Data Sciences
Prescott	Lorissa	Peer Support Specialist	MHS/TURN BHS Inc. – North Coastal Mental Health Center
Privara	Nadia	Assistant Director, Chief Strategy & Finance Officer	SDCBHS – Strategy & Finance
Ramirez	Ezra	Administrative Analyst III	SDCBHS – Health Plan Administration
Ramos	Nilanie	Assistant Medical Services Administrator	SDCBHS – Healthcare Oversight
Raymond	Rebecca	Assistant Medical Services Administrator	SDCBHS – Programs & Services

Last Name	First Name	Position	County or Contracted Agency
Reyes	Ana	On-Call Mental Health Counselor	Community Research Foundation – Senior IMPACT
Rodriguez	Kanya	Certified Peer Support Specialist	Neighborhood House Association – Safe Connections
Rogers	Diego	COO	Community Research Foundation
Roman	Ricardo	CFO	Family Health Centers of San Diego
Rusit	Jennifer	Administrative Analyst III	SDCBHS – Healthcare Oversight, Workforce Education and Training
Sarabia	Brenda	Acting Deputy Director	SDCBHS – Programs & Services
Sarkin	Andrew	Director of Evaluation Research	UC San Diego Health Services Research Center (HSRC)
Shapira	Erin	Program Coordinator	SDCBHS – Quality Assurance
Shelton	Gwendolyn	Assistant Director	SD Center for Children – Wrapworks
Sizemore	Dawn	Peer Support Specialist	Palomar Health - CSU
Snook	Tina	Senior Vice President of San Diego Programs	Exodus Recovery
Sommerfeld	David	Projects Assistant	UC San Diego Health Services Research Center (HSRC)
Stoffel	Rebecca	Team Lead	Telecare - Pathways to Recovery
Stone	Brad	Peer Recovery Coach	Telecare - Agewise
Tally	Steve	Assistant Director of Evaluation Research	UC San Diego Health Services Research Center (HSRC)
Terrell	Justin	Data Analyst I	Optum San Diego

Last Name	First Name	Position	County or Contracted Agency
Thornton-Stearns	Cecily	Assistant Director and Chief Program Officer	SDCBHS – Programs & Services
Valenzuela	Leslie	Peer Support Specialist	Community Research Foundation – Downtown IMPACT
Velasquez Trask	Emily	Senior Mental Health Consultant	UC San Diego Child and Adolescent Services Research Center (CASRC)
Villalobos	Ana	Clinical Supervisor	Community Research Foundation – Nueva Vista Family Services
Vleugels	Laura	Supervising Psychiatrist	SDCBHS – Programs and Services
Volk	Samantha	Mobile Outreach Peer Support Specialist	MHS/TURN BHS Inc. - North Coastal Mental Health Center
Wan	Katherine	Project Manager	UC San Diego Health Services Research Center (HSRC)
Weakly	Margaret	PERT Peer Specialist	NAMI San Diego
White-Voth	Charity	Deputy Director	SDCBHS – Programs and Services
Wilkie	John	Behavioral Health Program Coordinator	SDCBHS – Programs & Services
Wilson	Samantha	URQI Specialist	SDCBHS – Quality Improvement
Zang	Joshua	Director of Mental Health Services	Union of Pan Asian Communities (UPAC)

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 designed the PIP to improve therapeutic support for youth who identify as lesbian, gay, bisexual, transgender, queer, questioning, intersex, two-spirit, and other diverse sexual orientations, gender identities and expressions. In this year's submission, San Diego reported remeasurement results for seven of the eight performance measures. There was improvement in five measures. The MHP did not yet have remeasurement results as of the EQR for the eighth performance measure, the percentage of LGBTQ+ youth admitted to emergency/crisis levels of care.

General PIP Information
MHP/DMC-ODS Name: San Diego
PIP Title: Improved Therapeutic Support for Youth Members who Identify as LGBTQ+
PIP Aim Statement: (Year 1) For CYF clients who identify as LGBTQ+, will the revisions to and promotion of the It is Up to Us website's LGBTQ+ resource page result in higher utilization, as measured by the number of unique pageviews reported in each quarter in the year after the launch of the revised resource page? (Year 2) For CYF youth clients across the CYFBHS system who identify as LGBTQ+, will the systemwide training of providers (1) decrease the need for additional services, (2) decrease the utilization of emergency/crisis services, (3) increase LGBTQ+-affirming mental health treatment (e.g., clinicians asking about sexual orientation and gender identity, providing LGBTQ+-specific information), and (4) increase satisfaction with services, as measured by CCBH data and a comparison of the December 2021 YSS and the May 2023 YSS?
Date Started: 01/2022
Date Completed: in progress
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)

General PIP Information
☒ 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: 13 to 23 years of age
Target population description, such as specific diagnosis (please specify): All youth served in the County of San Diego CYFBHS who identify as LGBTQ+.
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): It's Up to Us resource page improvement and promotion.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Systemwide clinical training to increase provider knowledge of LGBTQ+-specific needs and supports
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): NA

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The number of page visits to the *It's Up to Us* LGBTQ+ Resource Page.	10/26/2021 to 10/26/2022	233 Unique Page Views	4/28/2023 to 7/27/2023	314 Unique Page Views	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): No significance test was conducted
Percentage of LGBTQ+ youth enrollees who reported that their providers asked about their sexual orientation.	December 2021	N=226 122/226 54.0%	May 2023	N=317 173/317 54.6%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of LGBTQ+ youth enrollees who reported that their providers asked about their gender identity.	December 2021	N=226 141/226 62.4%	May 2023	N=317 200/317 63.1%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of LGBTQ+ youth enrollees who reported that providers talked to them about challenges they may face because of their LGBTQ+ identity.	December 2021	N=226 81/226 35.8%	May 2023	N=317 143/317 45.1%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of LGBTQ+ youth enrollees who reported that their providers shared LGBTQ+ specific resources with them.	December 2021	N=226 91/226 40.3%	May 2023	N=317 143/317 45.1%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurem ent 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
Percentage of LGBTQ+ youth enrollees who reported that they desired additional LGBTQ+ specific resources: peer support groups, group therapy, family therapy	December 2021	N=226 Peer Support Groups 58/226 (25.7%) Group Therapy 37/226 (16.4%) Family Therapy 67/226 (29.6%)	May 2023	N=317 Peer Support Groups 95/317 (30.0%) Group Therapy 86/317 (27.1%) Family Therapy 112/317 (35.3%)	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Mean scores of LGBTQ+ youth responding to the question: “Overall, I am satisfied with the services I received” (Strongly disagree = 1, Disagree = 2, Undecided = 3, Agree = 4, Strongly Agree = 5)	December 2021	N=222 M (SD): 4.14 (.865)	May2023	N=315 M (SD) 4.39 (.827)	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
Percentage of LGBTQ+ youth admitted to emergency/crisis levels of care	FY 2020-21	28% (N=1346) of youth who identify as LGBTQ+ in the CFY system used Emergency / Crisis Services in FY 2020-21, compared to 11% (12,132) systemwide.	FY 2021-22	Not available at the time of the EQR	NA	NA

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

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

PIP Validation Information
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☒ Implementation phase ☐ Baseline year ☐ First remeasurement ☐ Second remeasurement ☐ Other (specify): Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.
EQRO recommendations for improvement of PIP: • Determine how many of the MHP's eligible population for the PIP utilized the website and obtained resources when visiting the website. • Design a process measure to ensure provider training was understood, well-received, and applied. Provide additional provider training, if necessary. • Determine whether there are other reasons why providers may not ask youth about sexual orientation.

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 MHP developed this PIP to address a gap in the use of telehealth services among older adults 60 years and older. Data demonstrated differences of telehealth mental health services utilization by age group with older adults less likely to utilize telehealth services. The MHP provided in-person trainings in May, August, and September 2023. San Diego reported baseline and a remeasurement. There was improvement in four of five measures. The fifth measure had reported results only for the most recent measurement.

General PIP Information
MHP/DMC-ODS Name: San Diego
PIP Title: Improving the Experience of Teletherapy for Older Adults
PIP Aim Statement: Will training and informational support increase older adult client's likelihood to utilize telehealth services by 10 percent from 33 percent and use the self-reported pre and post data from the population who received the intervention as the main outcomes measure. Improved utilization of telehealth services will be measured in the following ways from a client pre- and -post intervention self-report data: 1) improved self-report of knowledge on how to access telehealth services for older adult clients, 2) improved self-report of comfort with the privacy while utilizing telehealth services for older adult clients 3) improved self-report of the safety of utilizing telehealth services for older adult clients 4) improved self-report of likelihood to utilize telehealth services
Date Started: 03/2023
Date Completed: in progress
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)

General PIP Information
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): Clients over the age of 60 years old who are active in programs within the SDCMHSOC that offer telehealth services. The PIP evaluation team contacted ten programs who serve older adults to participate in the PIP. Two programs that also participated in the older adult client feedback and provider feedback process agreed to participate in the PIP.
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): In-person trainings to improve knowledge and comfort with telehealth services among older adult clients.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): NA
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): NA

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The proportion of older adult clients who agreed or strongly agreed with the statement that they would understand how to utilize telehealth services by client self-report pre- and post-intervention	Two rounds of interventions Pre-Intervention Questionnaire between May 2023 and September 2023	n=96 24/96 25%	Two rounds of interventions Post-Intervention Questionnaire between May 2023 and September 2023	n=96 64/96 67%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
The proportion of older adult clients who agreed or strongly agreed with the statement that they would feel comfortable discussing personal information during telehealth services by client self-report pre- and post-intervention	Two rounds of interventions Pre-Intervention Questionnaire between May 2023 and September 2023	n=96 25/96 26%	Two rounds of interventions Post-Intervention Questionnaire between May 2023 and September 2023	n=96 64/96 67%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
The proportion of older adult clients who agreed or strongly agreed they think it is safe to use telehealth services by client self-report pre- and post-intervention	Two rounds of interventions Pre-Intervention Questionnaire between May 2023 and September 2023	n=96 28/96 29%	Two rounds of interventions Post-Intervention Questionnaire between May 2023 and September 2023	n=96 63/96 66%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
The proportion of older adult clients who agreed or strongly agreed they will likely use telehealth services to access mental health services in the future by client self-report pre- and post-intervention	Two rounds of interventions Pre-Intervention Questionnaire between May 2023 and September 2023	N=96 36/96 38%	Two rounds of interventions Post-Intervention Questionnaire between May 2023 and September 2023	n=96 61/96 64%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

PMs (be specific and indicate measure steward and National Quality Forum number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
The proportion of older adult clients who agreed or strongly agreed with the statement that they are more likely to use telehealth services because of the instructions they received from the training by client self-report post-intervention.	Two rounds of interventions Pre-Intervention Questionnaire between May 2023 and September 2023	NA	Post-Intervention Questionnaire between May 2023 and September 2023	n=96 67/96 71%	NA	NA

PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant parts 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:

- Investigate and address the Filipino population barriers to receiving services via telehealth.
- Consider further efforts (e.g., additional member, provider, and/or system interventions) to build on improving use of telehealth by older adults.
- Report on how may individuals in the targeted population utilized telehealth services..

ATTACHMENT D: CALEQRO REVIEW TOOLS REFERENCE

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

ATTACHMENT E: LETTER FROM MHP DIRECTOR

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